Billing Process Guide

Invoicing and E-Billing/Paper Invoice Generation

Contents

Billing

Overview

The **Billing** functionality at HHAeXchange is comprised of two internal auditing processes which ensure that:

1. Visit information is accurate before it is invoiced.
2. Invoices contain the proper export requirements before sending to the Payer.

If the billing data satisfies export requirements on each of these auditing, or *Exception*, pages, invoices may be exported as an E-Billing Claim or Paper Invoice. This category covers the **Billing** functionality in the HHAeXchange (HHAX) system.

The flowchart below provides a high-level view of this process (*Exception* pages highlighted in orange):
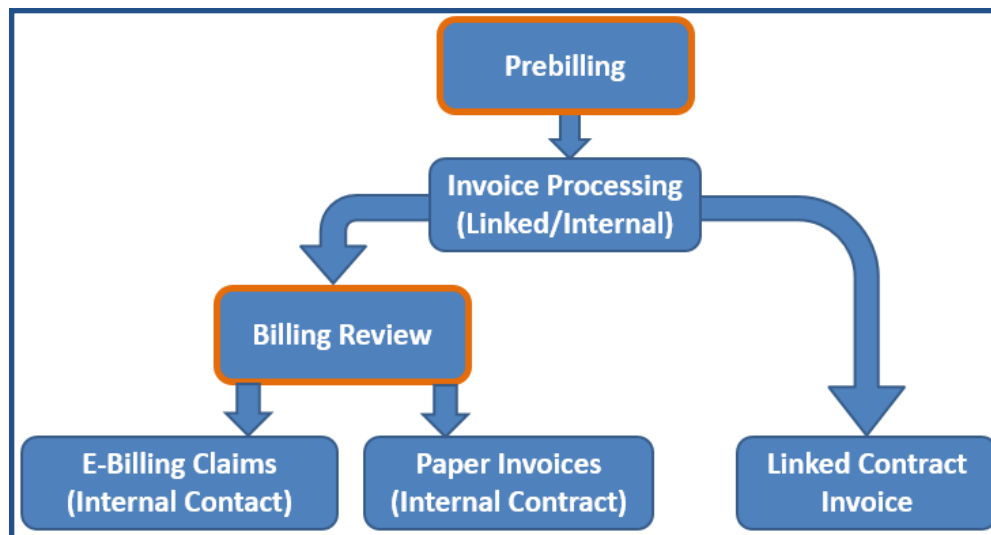
Please direct any questions, thoughts, or concerns regarding the content herein to HHAeXchange Customer Support.

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

Billing Diagnosis Codes

In the HHAX system, there are two **Diagnosis Codes** categories: **Billing Dx Codes** and **Clinical Dx Codes**.

Billing Dx Codes	Diagnosis Codes are assigned by the HHAX system **when the Invoice is generated**; if the contract is configured to require a Primary Dx Code for billing. Billing Dx Codes can be entered in one of three places to include: *Patient Authorization* page, *Patient Contract* page, and in the *Billing/Collections* tab under the Contract Setup page
Clinical Dx Codes	Diagnoses Codes entered on the *Patient Clinical Info* page, which appear on the Patient MD Orders.

Billing Dx Codes must be entered into the HHAeXchange (HHAX) system prior to generating an invoice; this allows for the system to assign a Billing Dx Code at the time of Invoice generation. The **Billing Dx Code** can be set in the sections highlighted below, with the system determining which Dx code to assign for billing based on the priority level.

Priority	Page	Description
Highest	Patient Authorization	If provided, then the system uses the **Billing Diagnosis Code(s)** set on the *Patient's Authorization Page* for billing purposes.
Secondary	Patient Contract	If no Dx code is set on the *Patient's Authorization* page*,* the system searches for a **Patient Diagnosis Code Override** on the *Patient's Contract* page.
Default	Agency Contract Level	If no Dx codes are set at the Patient level (*Patient Authorization* page or *Patient Contract* page), then the system defaults to values set at the Agency Contract level (**Default Billing DX Code**).
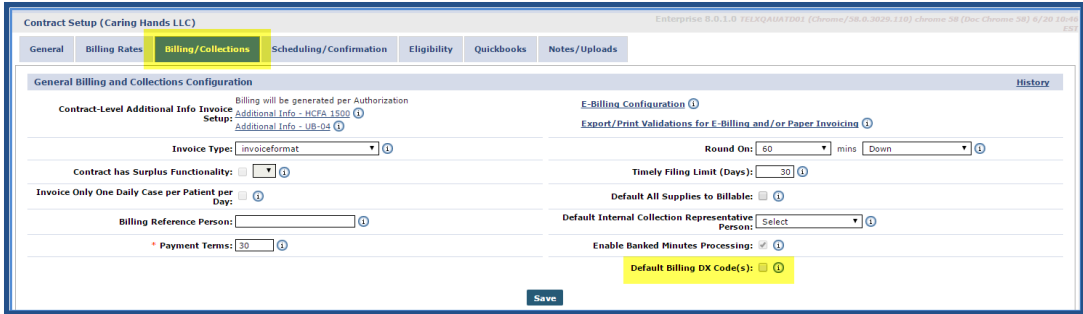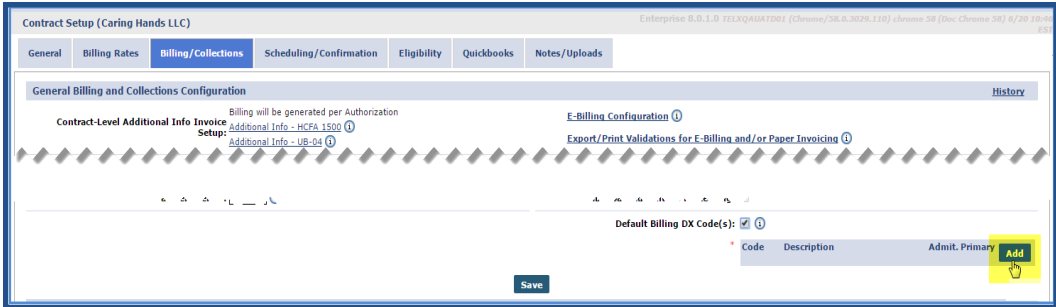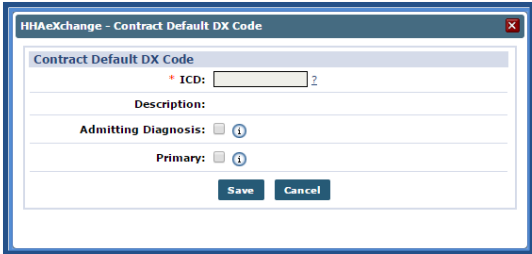
The following sections provide step-by-step instructions on how to set the Billing Dx Code in each area of the HHAeXchange system (as described above).

Note: *If the **Billing Dx Code** is not set before generating an invoice, or is changed after invoice generation, then the Invoice is held in Billing Review with a Missing Primary Diagnosis Code exception. In this case, the invoice must be deleted and re-generated after the Billing Dx Code is entered.*
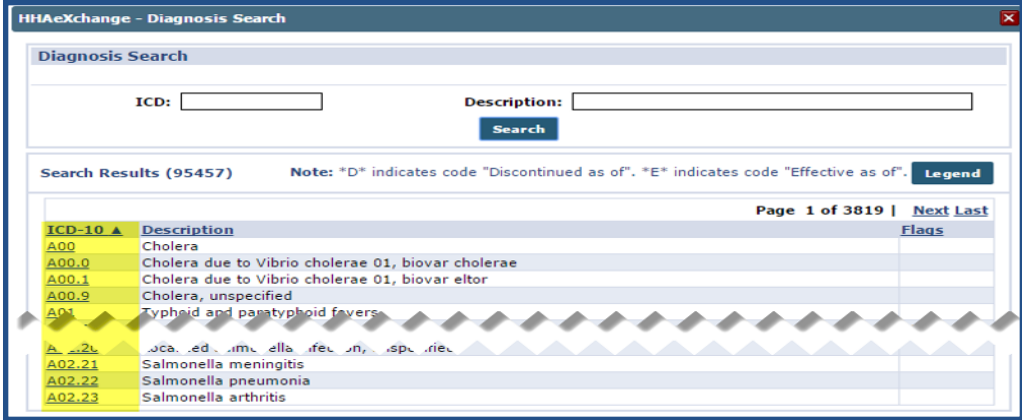
Refer to the *Resolving Missing Primary Dx Code Exceptions Job Aid* for further details*.*
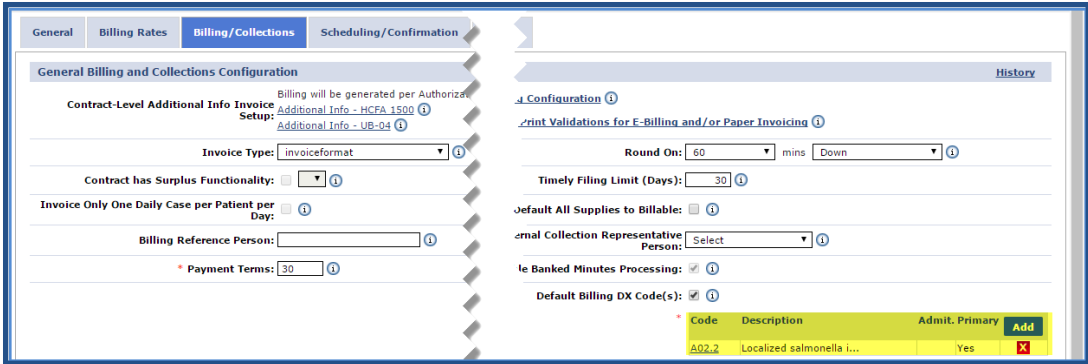
Agency Contract Level: Billing Dx Code Setup

Agencies may set a Contract-Level billing Dx code using the **Default Billing Dx Code(s)** field. The system assigns the default code provided on this page, unless a Dx Code is set at the Patient Level (refer to the Patient Level Dx Code Setup section). Complete the following steps to set an Agency Contract level Dx Code.

Step	Action
1	Navigate to **Admin > Contract Setup > Search Contract** and select the applicable Contract.
2	Click on the **Billing/Collections** tab. Select the **Default Billing DX Code(s)** checkbox. **Default Billing DX Code(s) Checkbox**
3	Once selected, a Diagnosis Code table opens. Click Add to apply a default Dx Billing Code. **Add Diagnosis Code**
4	On the *Contract Default DX Code* window, select the "?" link to the right of the **ICD** field to search for and select the ICD 10 code to apply. **Contract Default DX Code Window**

Step	Action
5	Use the *Diagnosis Search* window to search for and select ICD 10 Codes. To add an ICD Code, select the respective link from the highlighted column (as illustrated in the following image). **Diagnosis Search Window**
6	Once selected, the Dx Code populates (as illustrated in the image below). **Diagnosis Code Entered** *Note: By default, the system assigns the first Dx Code entered here as the "Primary" code. Users may manually designate the "Primary" or "Admitting Diagnosis" code on the Contract Default Dx Code window.*
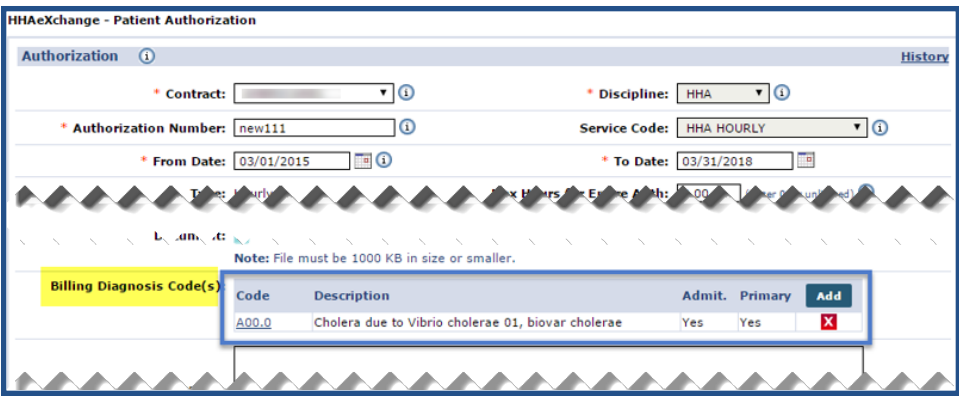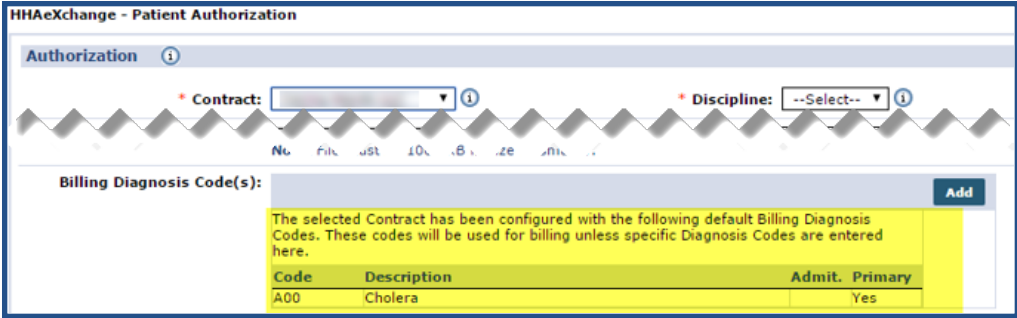
Patient's Authorization Level: Billing Dx Code Setup

Agencies can set a Patient's Authorization-Level Dx code using the **Billing Diagnosis Code(s)** field on the *Patient's Authorization* page to associate Dx Codes directly to Authorizations.

Dx Codes entered on Patient's Authorization page receive the highest priority. This means that the system assigns the Dx code on this page for billing purposes even if the Patient has one set on the Patient's Contract page (**Patient Diagnosis Code Override**) or at the Agency Contract level (**Default Billing DX Code**).

When adding a new Authorization, the **Billing Diagnosis Code(s)** field is available once a Contract is selected. Complete the following steps to apply a Dx Code in the Patient's Authorization page.

Step	Action
1	Navigate to the *Patient > Authorization* to access the **Billing Diagnosis Code(s)** field. **Patient Authorization – Billing Diagnosis Code(s) Field** *Note:* Dx codes already associated to the Patient from the Agency Contract or on the Patient's Contract page are displayed in the **Billing Diagnosis Code(s)** field with respective note. **Existing Billing Diagnosis Code** *The information for **Billing Dx Codes** already associated to the Patient from the Agency Contract or the Patient's Contract page is for reference purposes only. These Codes cannot be edited or deleted from the Patient's Authorization page. If a new **Billing Diagnosis Code** is entered, then the notes and Codes are*
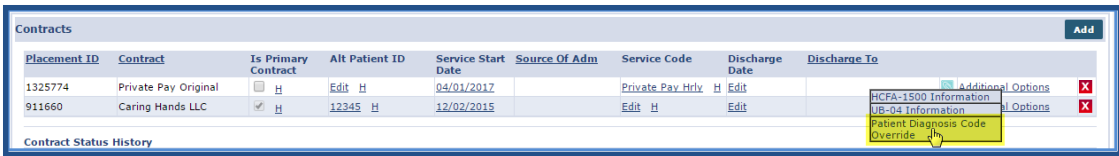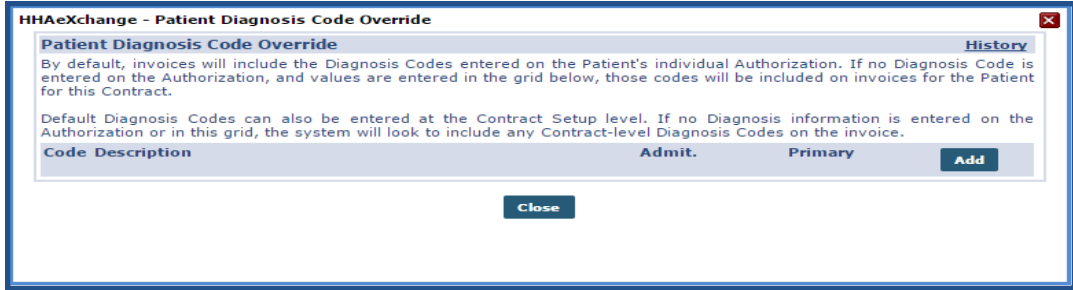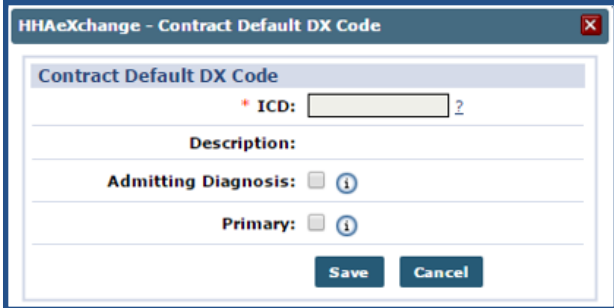
Step	Action
	removed.
2	Click the *Add* button to apply a new **Billing Diagnosis Code**. This removes any existing Dx Codes (as noted above).
3	On the Authorization Default DX Code window, select the "?" link to the right of the **ICD** field. *Note: By default, the system assigns the first Dx Code entered here as the Primary code. From here, Dx Codes can be assigned as the **Primary** or **Admitting Diagnosis** Code.* **Authorization Default Dx Code Window**
4	On the *Diagnosis Search* window search for and select ICD 10 Codes. To add an ICD Code, click on the appropriate Code link (as highlighted on the image below). **Diagnosis Search Window**

Patient's Contract Level: Billing Dx Code Setup

Agencies can set a Dx Code from the Patient Contract using the **Patient Diagnosis Code Override** field to associate Dx Codes directly to Authorizations.

Dx Codes entered on Patient's Contract page are of <u>secondary priority</u>. In this case, the system assigns the **Billing Diagnosis Code(s)** set on the Patient's Authorization page for billing purposes (if provided). However, the Dx Codes entered on the Patient's Contract page are assigned prior to any default values set at the Agency Contract Level.

Complete the steps below to set a Dx Code from the Patient Contract page.

Step	Action
1	Navigate to the *Patient > Contract > Additional Options* and select **Patient Diagnosis Code Override** from the dropdown. **Patient Diagnosis Code Override**
2	The *Patient Diagnosis Code Override* window opens. Click the **Add** button to apply an ICD code. The note displayed details how the system determines which Diagnosis Code to apply to an invoice. **Patient Diagnosis Code Override Window**
3	On the *Contract Default DX Code* window, select the "<u>?</u>" link to the right of the **ICD** field.

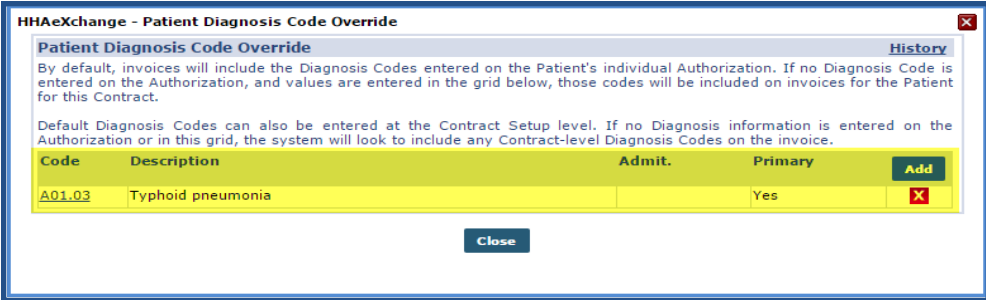| Step	Action
	Contract Default Dx Code Window
4	On the *Diagnosis Search* window search for and select ICD 10 Codes. To add an ICD Code, click on the appropriate Code link (as highlighted on the image below). **Diagnosis Search Window**
5	The selected code appears. **Diagnosis Code Entered**

Patient Diagnosis Code Override

When adding a **Patient Diagnosis Code Override**, the system alerts that the associated Contract has been configured with a **Default Billing Diagnosis Code** (as seen in the following image). These codes are used for billing unless specific Diagnosis Codes are entered in this window or at the Authorization level.

The **Default Billing Diagnosis Code(s)** is listed in the table underneath the message. Nothing appears if the associated Contract does not have a default code set.
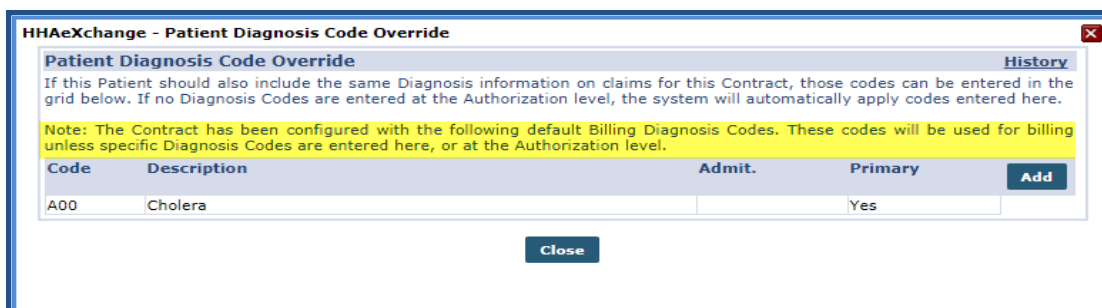
Invoicing Visits

This section covers the process of invoicing visits and the mechanisms within HHAeXchange to ensure invoices contain accurate export information (which may be unique for each Contract).

New Invoice: Internal

The **New Invoice – (Internal)** function is used to generate invoices for visits authorized by Internal Contracts only. Linked-Contract invoicing is covered in the following section.
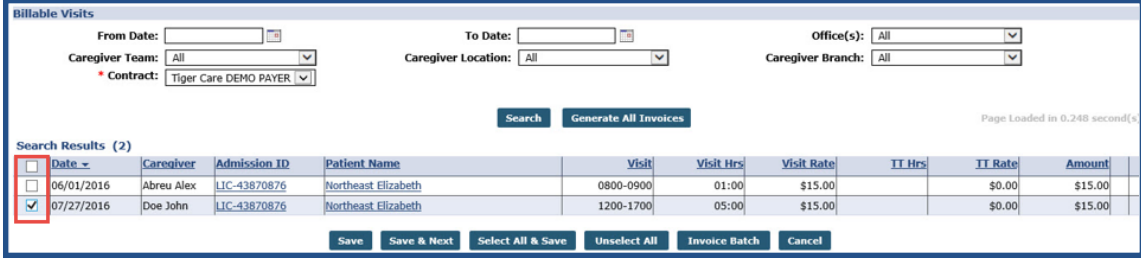
Complete the following steps to generate new Internal invoices.

Step	Action
1	Navigate to **Billing > New Invoice - (Internal)**.
2	Use the search filters to locate the visits to be invoiced. HHAX recommends leaving the **From Date** field blank to "pull in" all prior visits which are eligible for invoicing. Click **Search**.
3	The Search Results are generated according to selected search filters. Using the checkboxes, select the visits to be invoiced. Search Results, New Invoice – (Internal)
4	Click the **Save & Next** button to save all selections on the current page and navigate to the next (if applicable). Click the **Select All & Save** button to select ALL visits in the search results.
5	Once all selections are established, click the **Invoice Batch** button. Alternatively, click the **Generate All Invoice** button for the system to invoice every visit returned in the search results.
6	The system alerts that the batch is generating. Review processing status from the **Admin > Process Monitor** page.

New Invoice Batch

The **New Invoice Batch** function is used to generate Invoices for Linked Contracts. The **New Invoice – (Internal)** function operates the same as the Internal (above) with reduced search capabilities.

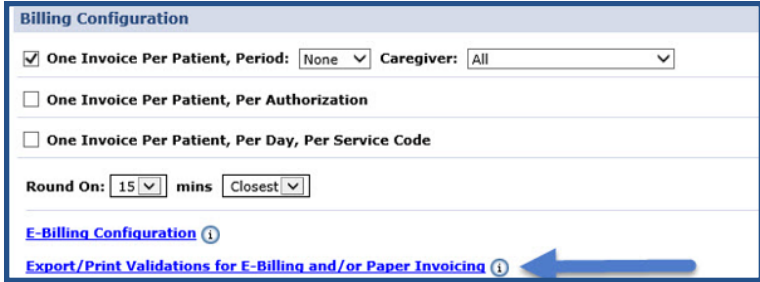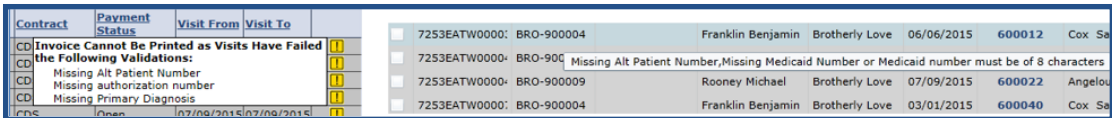Complete the following steps to generate new Linked invoices.

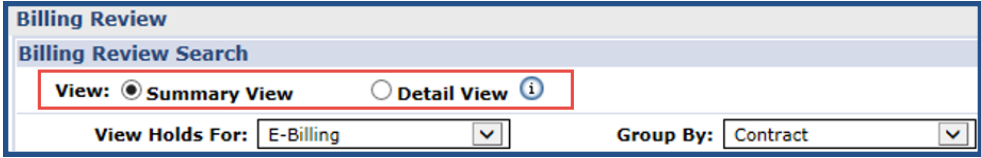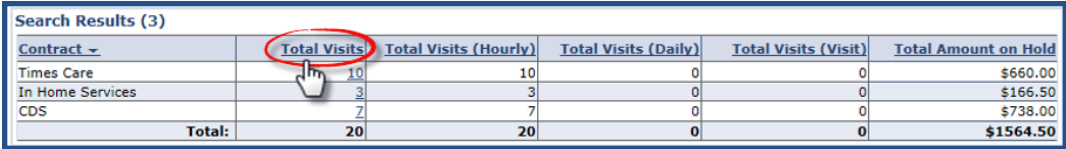| Step	Action
1	Navigate to **Billing > New Invoice Batch**.
2	Use the search filters to locate the visits to be invoiced. HHAX recommends leaving the **From Date** field blank to "pull in" all prior visits which are eligible for invoicing. Click **Search**.
3	The Search Results are generated according to selected search filters. Using the checkboxes, select the visits to be invoiced. **Search Results, *New Invoice Batch***
4	Click the ***Save & Next*** button to save all selections on the current page and navigate to the next (if applicable). Click the ***Select All & Save*** button to select ALL visits in the search results.
5	Once all selections are established, click the ***Invoice Batch*** button. Alternatively, click the ***Generate All Invoice*** button for the system to invoice every visit returned in the search results.
6	The system alerts that the batch is generating. Review processing status from the ***Admin > Process Monitor*** page.

Billing Review

Billing Review is another exception page which checks visit information against export requirements specific to each Payer. If a visit violates a rule stipulated by a Payer, it is held at **Billing Review** until the error is corrected. Therefore, users are not able to print invoices or submit e-claims.

Refer to Billing Review Problems and Resolutions for instructions on how to resolve Billing Review issues.

Complete the following steps to review export requirements.

Step	Action
1	Navigate to **Admin > Contract Setup > Search Contract** and select the applicable Contract. *Note: "Payer" and "Contract" both refer to the company authorizing service.*
2	Scroll down to the *Billing Configuration* section and click on the **Export/Print Validations for E-Billing and/or Paper Invoicing** link. **Export Requirement Link**
3	A new window opens displaying every requirement managed by HHAX. If requirements in the **Apply to Export Process** are selected, visits cannot be added to e-billing batches unless the validation is met. If **Apply to Paper Invoice Process** is selected, visits cannot be added to a printed bill unless the validation is met. **Export Validations**
4	When a visit fails to meet the export requirement, the system warns that the record cannot be exported. The entire invoice is held unless the error is corrected or the visit(s) failing to meet the requirements are removed. **Invoice held at Billing Review**
5	Navigate to the **Billing > Billing Review** page to review and act on failed validations.

Step	Action
6	Select a view option: *Summary View* or *Detail View*. **Billing Review** **Billing Review Search** View: ◉ Summary View ○ Detail View ⓘ View Holds For: E-Billing [▼] Group By: Contract [▼] **Billing Review View Options**
7	The *Summary view* displays results based on the **Group By** filter selected. In the image below, the summary total of all failed validation visits displays by **Contract**, as well as the amount of money held from e-billing/paper invoicing because of the exception. Click the Total Visits link to switch to *Detail View*. Search Results (3) 	Contract ▾	Total Visits	Total Visits (Hourly)	Total Visits (Daily)	Total Visits (Visit)	Total Amount on Hold
---	---	---	---	---	---
Times Care	10	10	0	0	$660.00
In Home Services	3	3	0	0	$166.50
CDS	7	7	0	0	$738.00
Total:	20	20	0	0	$1564.50	 **Results in Summary View**
8	The Details View displays specific visits and reasons for detainment. Search Results (10) | Invoice	Invoice Date	Admission ID	Patient Name	Contract	Coordinator	Visit Date	Service Code	Units	Amount on Hold	On Hold Reasons
---	---	---	---	---	---	---	---	---	---	---
600037	08/13/2015	EAT-900012	Albertson, Rachel	Times Care	Amber Bremann	08/05/2015	HHA Hourly	8.00	$40.00	Alt Patient Id must be of X characters, Missing Primary Diagnosis
600036	08/13/2015	EAT-900011	Anderson, Ralph	Times Care	Jamie Patron	08/05/2015	HHA Hourly	8.00	$40.00	Alt Patient Id must be of X characters, Missing Primary Diagnosis
600035	08/13/2015	EAT-900012	Albertson, Rachel	Times Care	Amber Bremann	08/04/2015	HHA Hourly	8.00	$40.00	Alt Patient Id must be of X characters, Missing Primary Diagnosis	 **Results in Detail View**
9	Once the Patient/Visit information is updated to pass the Billing Review validation, the visit is removed from this page and can be added to an e-billing batch or a paper bill.

Billing Review Problems and Resolutions

Problem	Resolution
• Missing Patient Name • Missing Patient Address • Missing Patient City • Missing Patient State • Missing Patient Zip Code • Missing Patient Date of Birth • Missing Patient Gender • Missing Patient SNN • Medicaid Number must be 8 characters	1. Search and select the applicable Patient Profile (***Patient > Patient Search***). 2. In the Patient Profile, click on the **Profile** page (link) from the left navigation index. 3. Click on the ***Edit*** button. 4. Enter values for the missing Patient information in the corresponding field(s). 5. Click ***Save***.
• Alt Patient Number should not be blank • Alt Patient ID must be 11 characters • Missing Contract Start Date	1. Search and select the applicable Patient Profile (***Patient > Patient Search***). 2. In the Patient Profile, click on the **Contract** page (link) from the left navigation index. 3. Click on the **Edit** link in either the **Alt Patient ID** or **Service Start Date** column. 4. Enter a value for the **Alt Patient ID** and or the contract **Start Date**.
• Missing Primary Diagnosis	1. Search and select the applicable Patient Profile (***Patient > Patient Search***). 2. In the Patient Profile, click on the **MD Orders** page (link) from the left navigation index. 3. Click on the Add button to enter a new MD Order or click on the MD Order ID (link to edit an existing one. 4. In *Section 11* (**Primary DX**) click on the ***Add*** button to enter the Patient's Diagnosis.
• Missing Authorization Number	1. Search and select the applicable Patient Profile (***Patient > Patient Search***). 2. In the Patient Profile, click on the **Authorization/Orders** page (link) from the left navigation index. 3. Click on the ***Add*** button to enter a new Authorization or click on the Edit link to update an existing one.

Problem	Resolution
• Visit Start/End Time cannot be blank • Missing Service Code • Visit cannot have TEMP Authorization • Missing Caregiver Name • Scheduled hours exceed Authorization • Schedule Duration does not match Authorized Hours	1. Navigate to *Visit > Visit Search*. 2. Use the search filters to locate the visit with missing and/or incorrect information. 3. Click on the edit icon (🖉) to open the visit window. 4. Navigate to the appropriate tab to fix and/or enter the required information. 5. Click *Save*.
• Missing Export Code • Missing Revenue Code • Missing Taxonomy Code	1. Navigate to *Admin > Reference Table Management*. 2. Select *Contract Service Code* from the **Reference Table** dropdown field. 3. Locate and select the applicable Service Code. 4. Enter the respective value in the **Export**, **Revenue**, and/or **Taxonomy Code** fields. 5. Click *Save*.
• Invalid CNR Import Reference Number	1. Search and select the applicable Patient Profile (*Patient > Patient Search*). 2. In the Patient Profile, click on the **Calendar** page (link) from the left navigation index. 3. On the calendar date cell, click on the **V** link to access the visit. 4. In the *Schedule* tab enter the correct **CRN Import Reference Number**. 5. Click *Save*.
• Missing Caregiver NPI Number • Missing Caregiver Professional License Number (PLN)	1. Search and select the applicable Caregiver Profile (*Caregiver > Caregiver Search*). 2. In the Caregiver Profile, click on the **Profile** page (link) from the left navigation index. 3. Enter the **Caregiver NPI Number** and/or the **Caregiver PLN Number**. 4. Click *Save*.
• Missing CNR Employee Number	1. Search and select the applicable Caregiver Profile (*Caregiver > Caregiver Search*). 2. In the Caregiver Profile, click on the **Others** page (link) from the left navigation index. 3. Enter the **Caregiver CNR Emploee Number**. 4. Click *Save*.

Problem	Resolution
• Missing Physician NPI Number	1. Seach and select the applicalbe Physician (**Admin > Physician > Physician Setup**). 2. Enter the Physician's **NPI Number**. 3. Click **Save**.
• Pending Billing of Additional Shifts on Same Day	1. Navigate to **Action > Confirm Visits**. 2. Use the search filters to locate additional visits on the date in question. 3. Confirm any applicable visits and click on the **Save** link for each one.
• Visits on Same Day/Service Code must be Billed on same Invoice	1. Navigate to **Billing > Invoice Search > By Invoice**. 2. Use the search filters to locate the Invoice in question. 3. In the Invoice, review visits to verify they were billed on the same day and have the same Service Code. 4. To remove visits from the Invoice, click on the delete icon. 5. Click on the **Patient Name** (link) to route to the Patient Calendar. On the Calendar, select the visit to access the visit window. 6. On the visit window edit the **Service Code**. 7. Click **Save**.
• Visit should NOT be placed on Manual Hold	1. Navigate to **Billing > Invoice Search > By Visit**. 2. Use the search filters to locate the Invoice in question. 3. Click on the **Y** link in the **E-Billing Manual Hold** column. 4. Select *Single Claim* from the options. 5. Click **OK**.
• Does NOT meet POC Compliance Requirements	1. Review the Contract Required Compliance rules. 2. Click on the edit icon ( ) to open the visit window and select the *Visit Info* tab. 3. Manually enter the Dutes to satisfy the Required Compliance rule. 4. Click **Save**.

Problem	Resolution
• Review Contract Start Date and Alt Patient Number	1. Navigate to *Patient > Contract*. 2. Review the **Alt Patient ID**. Click on the **Edit** link and enter the **Alt Patient ID** in the text window. (Contact the Payer if the field is unavailable to edit.) 3. Click on the **Update** link. 4. Review the **Service Start Date**. Click on the date (link) to edit on the pop-out window. 5. Click *Save*.
• Dx Code May Fail Specificity Guidelines (if configured to validate for Flag 10 ICD Codes)	1. Navigate to *Patient > Authorizations/Orders*. 2. Click on the **Edit** link to open the Patient Authorization window. 3. Click on the *Add* button In the Billing Diagnosis Code(s) section. 4. On the **Authorization Default DX Code**, click on the **?** (to the right of the ICD field) to search for the diagnosis. 5. Click on the most specific ICD code that applies to the Patient (without a Flag code). 6. Click *Save* to apply the ICD Code to the authorization.

Review Invoice Details

Once an invoice batch finishes processing, batch details can be reviewed. Complete the steps below to review.

Step	Action
1	Navigate to **Billing > Invoice Search** and select a search method: **By Batch**, **Invoice**, or **Visit**.
2	If searching **By Batch**, the system provides Batch Summary details. Click the link in the **Batch Number** column to view the details of the invoices included in the Batch. **Search Results (25)** 	Batch Number	Contract	Batch Date ▼	Office	Invoice #	Status	Total Hours	Billed Units	Total Amount	3rd Party	
---	---	---	---	---	---	---	---	---	---	---
8379EATW00016	Times Care	08/19/2015	North NYC	1	N/A	N/A	1.00	$50.00	$0.00	X
7110EATW00013	In Home Services	08/19/2015	North NYC	1	N/A	N/A	5.00	$100.00	$0.00	X
8379EATW00015	Times Care	08/13/2015	North NYC	2	N/A	04:00	16.00	$80.00	$0.00	X
8379EATW00014	Times Care	08/13/2015	North NYC	2	N/A	04:00	16.00	$80.00	$0.00	X	 **Invoice Search by Batch**
3	From this page, select individual invoices by clicking on the lin in the **Invoice #** column to see the details of visits included within that invoice. **Search Results (2)** Print	Print V2	Print V3	Print All Invoices	Print All Duty Sheets **Invoices** 	Invoice#	Batch Number	Visit/Supply/ Expense From	Visit/Supply/ Expense To	Admission ID	Patient Name	Hours	Units	3rd Party	Billed	Paid	Balance	Payment Terms	Contract	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
600036	8379EATW00015	08/05/2015	08/05/2015	900011	Anderson Ralph	02:00	8.00	0.00	$40.00		$40.00	90	Times Care	X
600037	8379EATW00015	08/05/2015	08/05/2015	900012	Albertson Rachel	02:00	8.00	0.00	$40.00		$40.00	90	Times Care	X	 **Invoices in a Batch**
4	If searching **By Invoice**, the system displays individual invoices for the selection. Click the invoice number link under the **Invoice #** column to review the individual invoice details. **Search Results (30)** Page 1 of 2	Next Last 	Invoice #	Invoice Date	Batch #	Visit Duration	Admission ID	Patient Name	Office	Address	Total Hours	Billed Unit	3rd Party	Total Amount	Contract	Paid Amount	Discount	Payment Status	Re-Billed		
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
600004	03/09/2015	7253EATW00001	03/01/2015-03/01/2015	900004	Franklin Benjamin	Brotherly Love	7602 Flatlands Ave	N/A	28.00	$0.00	$126.00	CDS	$0.00	0.00	Open		✎	X
600010	07/09/2015	7253EATW00002	06/03/2015-06/03/2015	900004	Franklin Benjamin	Brotherly Love	7602 Flatlands Ave	N/A	28.00	$0.00	$126.00	CDS	$0.00	0.00	Open		✎	X
600012	07/09/2015	7253EATW00003	06/04/2015-06/06/2015	900004	Franklin Benjamin	Brotherly Love	7602 Flatlands Ave	N/A	80.00	$0.00	$360.00	CDS	$0.00	0.00	Open		✎	X	 **Invoice Search by Invoice**
5	If searching **By Visit**, the system displays individual invoiced visits for the selection. **Search Results (35)** Page 1 of 2	Next Last | Invoice #	Batch Number	Date	Admission ID	Patient Name	Office	Caregiver Name	Visit/Supply / Expense	Billed Hrs	Service Code	Billed Units	Rate	TT Hrs	TT Rate	OT Hrs	OT Rate	Amount	Contract	Export Status	E-billing manual Hold	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
600002	7110EATW00002	03/01/2015	EAT-900003	O'Hare Frank	North NYC	Capelli Peter	1500-1800	03:00	HHA Hourly	12.00	$18.50		$18.50		$0.00	$55.50	In Home Services	N	N	X
600018	7110EATW00009	07/01/2015	EAT-900001	Allen Kenneth	North NYC	N/A	Supply	N/A		3.00	$200.00		$0.00		$0.00	$600.00	In Home Services	N	N	X
600018	7110EATW00009	07/10/2015	EAT-900001	Allen Kenneth	North NYC	N/A	Supply	N/A		2.00	$200.00		$0.00		$0.00	$400.00	In Home Services	N	N	X	 **Invoice Search by Visit**

Edit Billing Dx Codes for Invoiced Visits

Users with the new **Edit Billing Diagnosis Code** permission can edit the **Billing Dx Code** to be applied to an invoiced visit on the **Invoice Details** page, as well as add a new **Billing Dx Code** in cases where one does not exist (and is stopped in the Billing Review step due to *Missing Primary Dx Code*).

Billing DX Code Column (Invoice Details)

The Billing DX Code displays the Billing code to be applied to the Invoiced visit.

Date	Admission ID	Patient Name	Caregiver Name	Visit/Supply/ Expense	Visit Hrs	Units	Visit Rate	Service Code	TT Hrs	Billed	Paid	Balance	3rd Party	Payment Status	Billing DX Code	Export Status	E-billing manual Hold	Export History	
07/05/2017	HHA-900020598537141	Shaw Dave	Akhtar Shoaib	1300-1800	05:00	0.00	$0.00			$0.00	$0.00	$0.00	$0.00	Paid	A00.0 (+1)	N	N	ⓘ	❌
07/07/2017	HHA-900020598537141	Shaw Dave	Akhtar Shoaib	1000-1200	02:00	0.00	$0.00			$0.00	$0.00	$0.00	$0.00	Paid	N/A	N	N	ⓘ	❌
07/08/2017	HHA-900020598537141	Shaw Dave	Akhtar Shoaib	1000-1200	02:00	0.00	$0.00			$0.00	$0.00	$0.00	$0.00	Paid	Z00.0 (+1)	N	N	ⓘ	❌

Search Results (3) — Un-Export All — Print Invoice — Print Duty Sheet — Visits/Supplies/Expenses
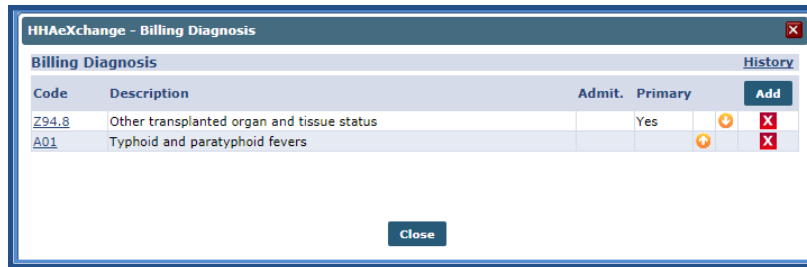
Billing DX Code Field

If more than one **Billing Dx Code** is associated with the visit, then the column displays a "+N" under the applied code. For example, User *Jon Frank* invoices a visit for Patient *Dave Shaw*. The system applies the billing code "*A00.0*" from the visit's **Authorization**; the **Billing DX Code** column displays "*A00.0*" for this visit.

- If Patient *Dave Shaw* has a **Patient Diagnosis Code Override** set, then the **Billing DX Code** column displays "*A00.0 (+1)*" for this visit. The "(+1)" indicates that there is another billing code associated with the visit.
- If Patient *Dave Shaw* has a **Patient Diagnosis Code Override** set and the associated Contract also has a **Default Billing DX Code**, then the **Billing DX Code** column displays "*A00.0 (+2)*". The "(+2)" indicates there are two billing codes associated with the visit.
- If no code has been applied to the visit, then the **Billing DX Code** column displays "*N/A*" for the associated visit.

Billing Diagnosis Window

Selecting the value in the **Billing DX Code** column for an invoiced visit opens the **Billing Diagnosis** window containing supplementary code information (such as the Code **Description**, and whether it is an **Admitting** and/or **Primary** diagnosis). Additional Codes are also displayed if more than one Code is associated with the visit.

From this window, users with the **Edit Billing Diagnosis Code** permission can add or delete Billing Codes. Users without the permission, can access *read-only* information.
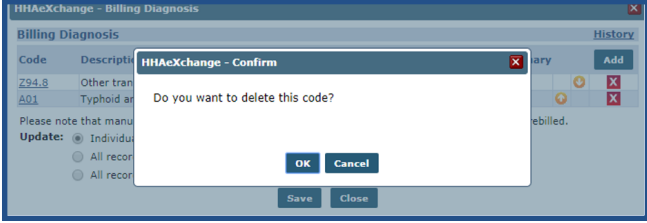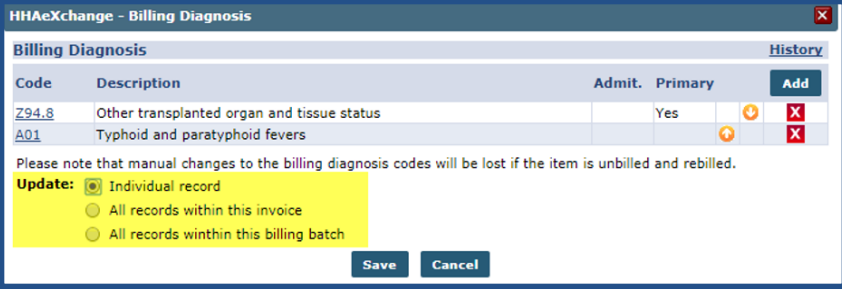
Billing Diagnosis Window

To access the **Edit Billing Diagnosis Code** permission, navigate to *Admin > User Management > Edit Roles*. Select *Billing* from the **Section** field on the **Edit Roles** page.

Adding or editing an **Invoice Dx Code** affects the Dx Code used for <u>Billing only</u>. Changes to the Patient's Authorization Dx Code must be done directly on the Patient's record. Complete the following steps to add or edit the Billing Diagnosis Code(s).

Step	Action
1	On the *Billing Diagnosis* window, click on the **Add** button.
2	The *Invoice DX Code* window opens. Select the new **ICD** Code to apply to the invoiced visit. Select the applicable checkboxes if the Code is an **Admitting Diagnosis** and/or the **Primary** diagnosis. Click **Save**. **Invoice DX Code Window**
3	To <u>edit</u> an existing code, click on the <u>Code</u> (number link) from the *Billing Diagnosis* window. On the Invoice DX window, specify whether that Code is/is not an **Admitting Diagnosis** and/or **Primary** diagnosis. Click **Save**. **Edit Existing Billing Code**
4	To <u>delete</u> an existing Code (from the associated invoiced visit), click on the "✖" icon for an existing code from the *Billing Diagnosis* window. Click **OK** to confirm deletion.

Step	Action
	Delete Existing Billing Code
5	In the **Update** field, select one of the following to indicate how to apply the **Billing DX Code**, as follows: • Only that specific visit (*Individual record*) • All visits for this invoice (*All records within this invoice*), or • All visits for that billing batch (*All records within this billing batch*) **Apply Updates to Individual Visit, Invoice, or Billing Batch**

Authorization Deletion

To delete Patient Authorization, the following permissions are necessary:
- **Delete Authorization**
- **Delete Authorization After Billed**

The Delete icon on the *Patient Authorization* page is only available to users who have the **Delete Authorization** permission enabled.

Users who attempt to delete an Authorization for a billed visit without the **Delete Authorization After Billed** permission are prompted with a validation message not allowing the deletion.

To access the Deletion permissions, navigate to ***Admin > User Management > Edit Roles***. Select *Patient* from the **Section** field on the *Edit Roles* page. These permissions are housed under the Authorization section.

Allow Concurrent Invoicing Across Offices/Contracts

Visits can be validated at a Visit level rather than at a Contract level allowing for visits for the same Contract to be saved across multiple Offices while preventing multiple invoices to be created for the same visit. Therefore, multiple users can work in the same Contract without creating multiple invoices for the same visit.

Biller 1 navigates to *Billing > New Invoice (Internal)* and searches for a specific **Contract**. Upon selecting visits and clicking on *Invoice Batch*, the system informs that the Billing Batch is generating.
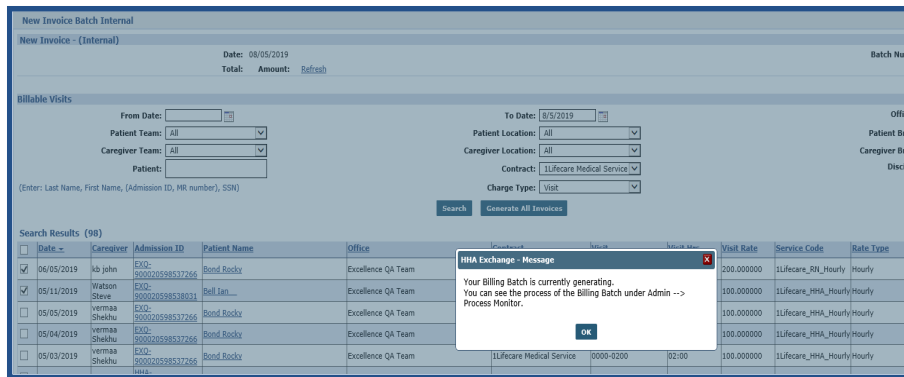
New Invoice (Internal) – Generating Billing Batch

At the same time, **Biller 2** also goes to *Billing > New Invoice (Internal)* and searches for the same **Contract** and gets the same results. From here, **Biller 2** selects the applicable visits and clicks on *Invoice Batch*.

If **Biller 1** has already invoiced the selected visits chosen by **Biller 2**, then **Biller 2** receives a validation stating that the applicable visits will be automatically deselected (as illustrated in the following image).
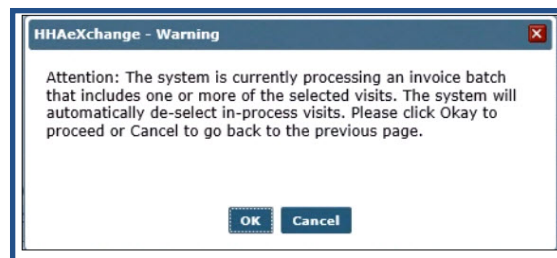
Validation Warning

The validation illustrated below is generated when attempting to save a visit within a batch when one or more visits have already been saved by another user.

Validation Warning

Billing Hold for Services Exceeding Maximum Hours Limits

The **Maximum hours should not exceed the limit specified** billing hold on the *Billing Review* page (***Billing > Billing Review*** prevents billing for services that exceed a configured number of daily maximum hours. When enabled, this billing hold displays in the **On Hold Reasons** column as *Maximum hours should not exceed the limit specified*, as seen below.

Billing Review Page: Maximum Hours Should not Exceed the Limit Specified Hold

For Linked contracts (UPR), the configured number of maximum hours (such as 12, 14, or 16 hours) is set up by authorized Payers and synced to the Provider application.

For Internal contracts, Providers configure the number of maximum hours per Service Code(s). To set up maximum hours for a Service Code, navigate to ***Admin > Reference Table Management > Contract Service Code***. Enter the **Max Billing Hours** that can be billed daily for the Service Code.

Contract Service Code Window: Max Billing Hours Field

Note: The **Max Billing Hours** field allows values from 1-24. If a higher number is entered, the system automatically adjusts to 24.
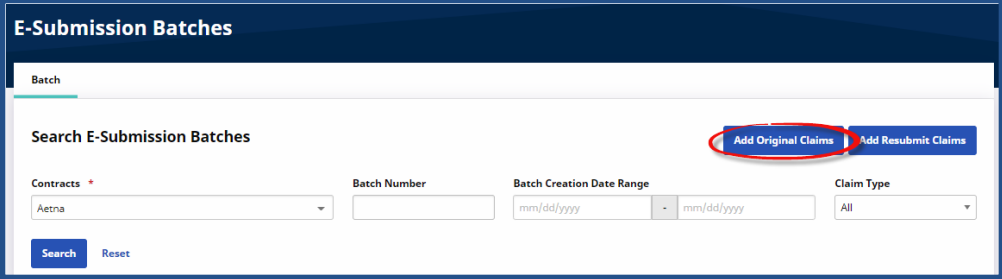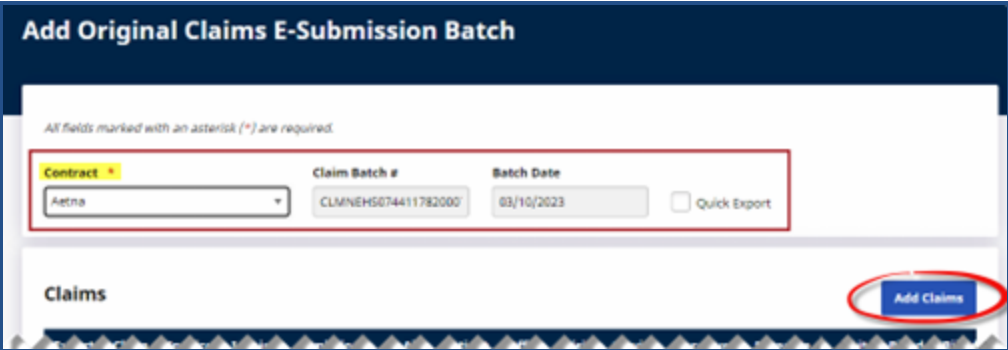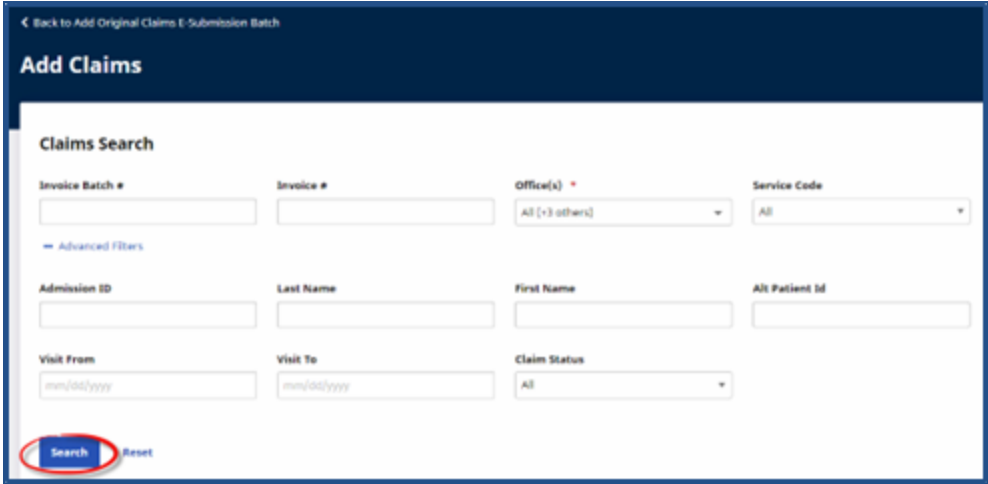
E-Billing
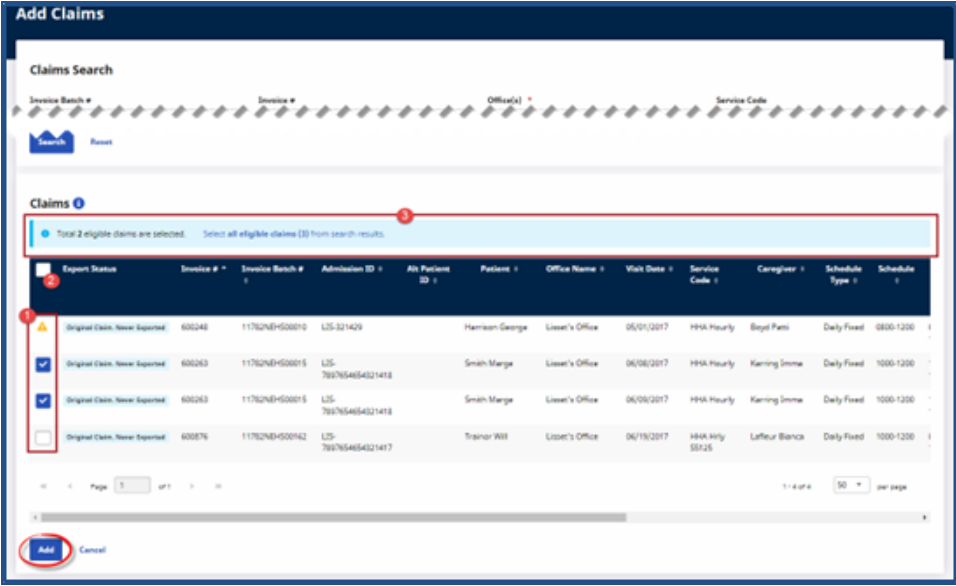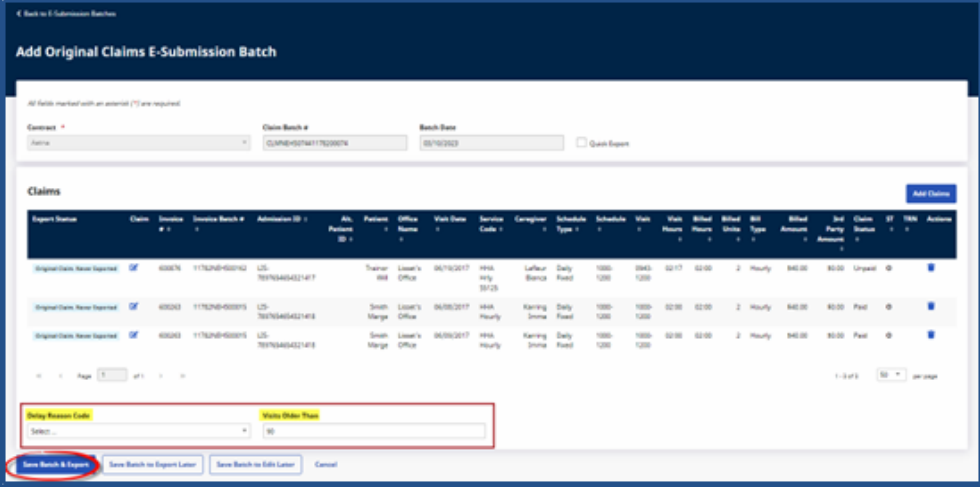
This section covers the submission of electronic claims and the steps required in adjusting rejected claims and resubmitting the files.

Create a New E-Billing Batch

Visits that have been invoiced and reviewed can be included in an E-Billing Claim batch. Claim files can be compiled and exported from HHAeXchange and delivered electronically to the Contract or Clearinghouse. Complete the steps below to export a claim.
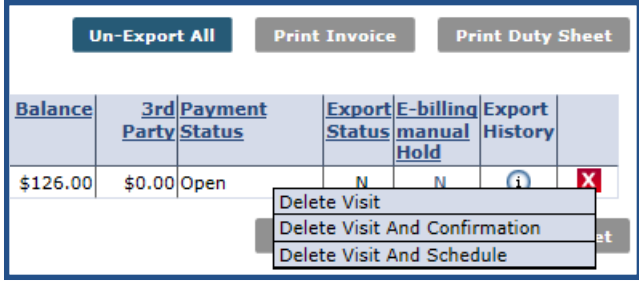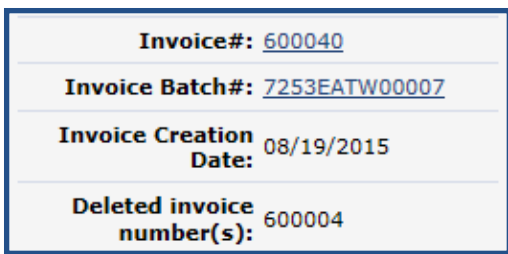
Step	Action
1	Navigate to *Billing > Electronic Billing > E-Submission Batches*.
2	The *E-Submission Batches* page opens. Select all applicable **Contracts** and click on the **Add Originial Claims** button to create a new batch. **New E-Submission Claim**
3	The *Add Original Claims E-Submission Batch* page opens. Select the **Contract** and the **Batch Number** and **Batch Date** fields automatically populate. Click on the **Add Claims** button to select specific invoices to include in the claim batch. **Add Claims**
4	On the *Claims Search* window, use the filter fields to narrow an invoice search. Click on *Search* to generate results.

Step	Action
	Search for Claims
5	A **Claim Search** page opens. There are several options to select claims to add to a batch (as listed below). A light-blue banner appears across the search results specifying the number of selected claims as well as a total number of eligible claims to select from the search. The following image illustrates the three options as follows: 1. Click on a specific row checkbox to select individual claim(s). 2. Select the header checkbox to select all the claims on the current page (only). Note that selecting this box does not select all claims in the search results. 3. Click on the **all eligible claims (count)** link on the light blue banner to select all eligible claims in the entire set of search results (across all pages). If a visit is held on the **Billing Review** *Exception* page, it displays an alert icon and cannot be selected until the exception is resolved. Hovering over the alert icon displays the reason for the hold. Select the claims and click ***Add*** at the bottom of the page.

Step	Action
	Add Claims to the Batch
6	The selected claims now appear on the batch page. If any of the invoiced visits require a **Delay Reason Code** due to delayed invoicing, select one from the corresponding dropdown. Visits older than the value in the **Visits Older Than** field have the selected reason added to the claim file. To adjust any of the selected claims, click on the edit icon (✎) and make updates, respectively. To remove a visit from the batch, click on the delete icon (🗑). Once all selections are finalized, click the ***Save Batch & Export*** button (at the bottom of the page). **Save Batch and Export**
7	The system creates the batch and prompts the user to name the file and save it locally. This is the file to be submitted to the Contract or Clearinghouse.

Unbilling
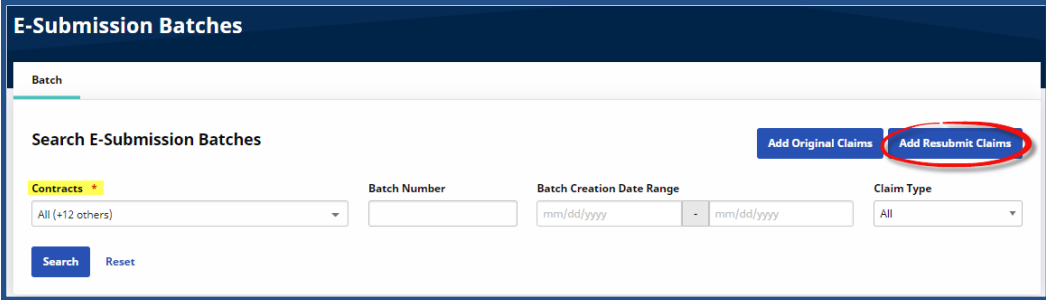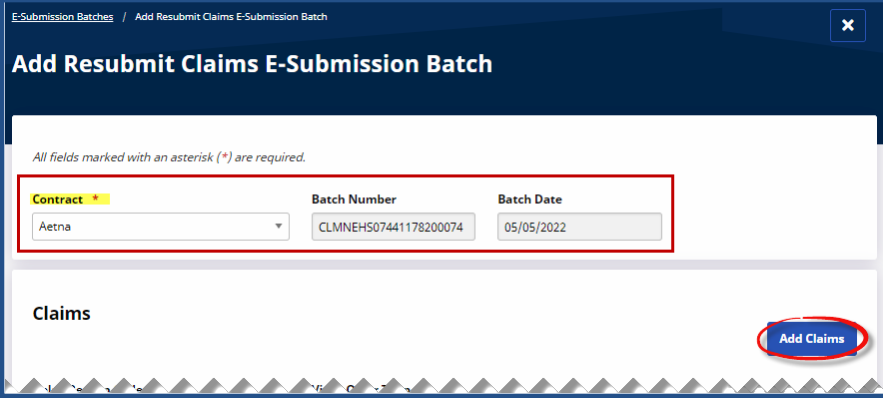
A visit can be un-billed if an error is discovered after it has been exported in a claim. Because these mistakes are typically clerical, they may not be detected by any of the system's *Exceptions* pages. Once the error has been corrected, the visit can be re-billed. If applicable, one can "un-bill" a single visit or all the visits within an invoice, or all visits within a batch. Complete the following steps to "un-bill" a visit.

Step	Action
1	Navigate to **Billing > Invoice Search**.
2	Locate the Visit /Invoice/Batch to un-bill.
3	From the *Search Results* page or *Batch/Invoice Details* page, click on the delete icon ([X]) to remove (un-bill) the visit, invoice, or batch (as seen in the image to right). **Un-Billing Options**

Select	To…
Delete Visit/Invoice/Batch	un-bill the record.
Delete Visit and Confirmation	un-bill the Visit/Invoice/Batch and remove all visit confirmation information.
Delete Visit and Schedule	un-bill the Visit/Invoice/Batch and delete all visit information (both schedule and confirmation).

Step	Action
4	The user is prompted to enter a Reason and Note explaining the deletion. Click **Delete** to finalize. Schedule and Confirmation details for any un-billed visits become available to edit.
5	Once corrections have been applied to the visit(s), it can be re-billed (refer to instructions in the Rebilling - Resubmission and Adjustments topic). The new invoice details and the **Deleted Invoice Number** display on the visit's *Bill Info* tab. **Invoice Details on the Bill Info Tab**

Step	Action
	Note: If a user invoices, runs payroll, and then un-bills and edits visit details, then a ***Payroll Adjustment*** is generated, which is applied during the next Payroll Batch. Refer to the *Payroll category* to apply an un-billed visit to a new payroll batch.

Rebilling - Resubmissions and Adjustments

Once a claim has been exported, it is either accepted by the Payer, or returned to the Agency due to an issue or discrepancy. If a Payer rejects a claim, the Agency can document the actions taken to either resubmit it, or ultimately void the claim. If the Agency modifies the rejected claim and resubmits it, it is defined as an **Adjustment**. If the Agency chooses to stop pursuing reimbursement for a claim, then it becomes a **Void**. Completed the following steps to adjust or void a claim.

Step	Action
1	Navigate to *Billing > Electronic Billing > E-Submission Batches*.
2	On the *E-Submissions Batches* page, select applicable Contracts and click on the *Add Resubmit Claims* button. **Add Resubmit Claims**
3	On the *Add Resubmit Claims E-Submission Batch* page, select the desired **Contract**. The **Batch Number** and **Batch Date** fields automatically populate. Click on the *Add Claims* button to search and add the claims. **Add Claims**
4	On the *Claims Search* window, use the filter fields to narrow an invoice search. Click on *Search* to generate results.
5	In the Search Results, under the *Claims* section of the page, the previously submitted claims appear. There are several options to select claims to add (as listed below). A light-blue banner appears across the search results specifying the number of selected claims as well as a total

Step	Action
	number of eligible claims to select from the search. The following image illustrates the three options as follows: 1. Click on a specific row checkbox to select individual claim(s). 2. Select the header checkbox to select all the claims on the current page (only). Note that selecting this box does not select all claims in the search results. 3. Click on the **all eligible claims (count)** link on the light blue banner to select all eligible claims in the entire set of search results (across all pages). Refer to the **Export Status** column to view any issues, as shown in the following image. Select the claims to add and click on the *Add* button at the bottom of the page. **Select Claims to Add**
6	On the *Add Resubmit Claims E-Submission Batch* page, click on the edit icon ( ) to open the Claim Adjustment window to make edits to each claim. To remove a visit from the batch, click on the delete icon ( ). **Edit Claims**
7	The *Claim Adjustment* window opens. On the **Submission Type** field, select *Original*, *Adjustment*, or *Void* (as described in the table below the image). Make any other necessary edits to the claim and click *Save* to finalize. Repeat this step for all applicable adjustments.
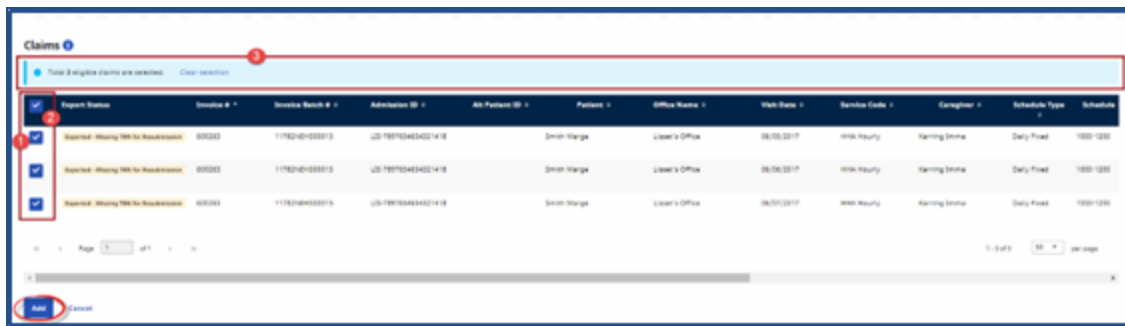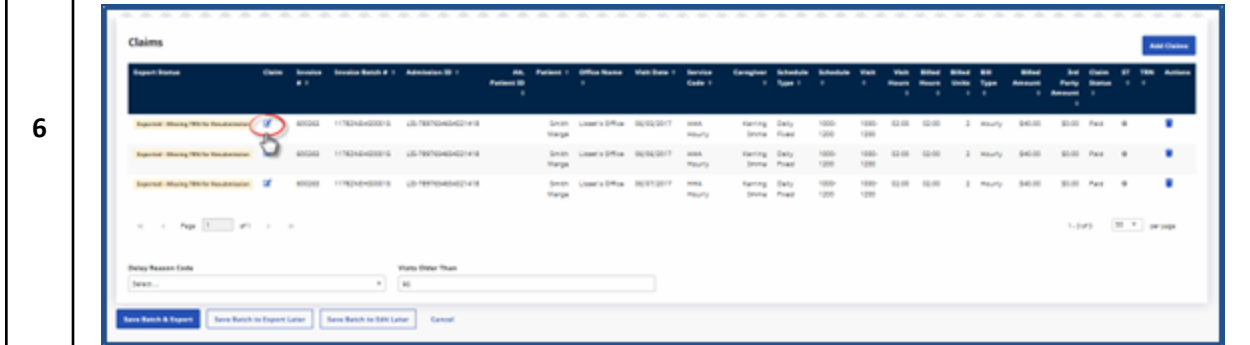
Step	Action
	Claim Adjustment Window

Select	If...
Original	the Contract has not yet received or processed the initial submission.
Adjustment	the Contract rejected the initial claim and the Agency is resubmitting it. Refer to *Step 8* below.
Void	the Agency has decided not to resubmit a rejected claim. Refer to *Step 9* below.

*Note: The **TRN Number** (field) is required for Adjustment and Void claims.*
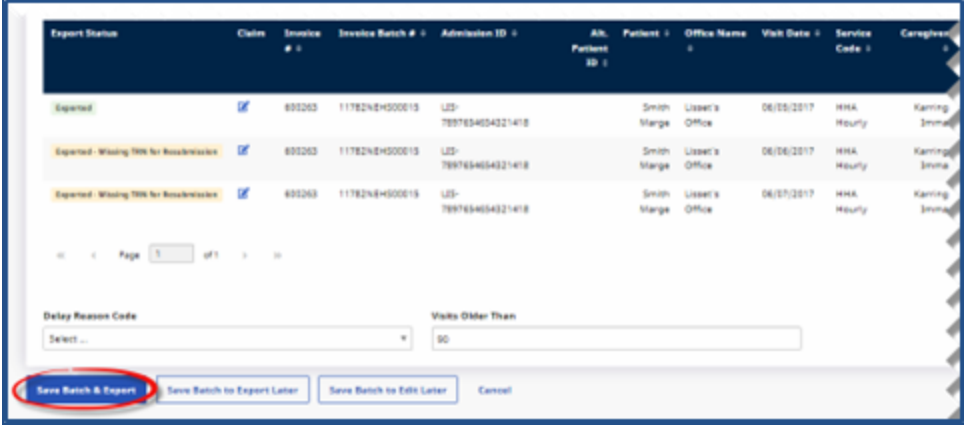
Step	Action
8	When making an *Adjustment*. the visit's **Contract Service Code, Caregiver Pay Code, Billed Rate, Units per Hour, TT Hours,** and/or **Payroll Adj Hours** can be revised. Use the **Update** dropdown to apply the *Adjustment* to either the selected claim, all the claims in the batch, or every claim within the batch with the same invoice number. *Note: Updating information here automatically updates visit information outside the normal Prebilling/Billing Review process.*
9	When *Void* is selected, the **TRN Number** is required. In the **Update** field, select whether to Void the selected claim, all the claims in the batch, or every claim within the batch with the same invoice number.

Step	Action
	Void Claim
	If the **Place Updated Visit on Hold** checkbox is selected, then visits are flagged as "On Hold" and do not pass the Billing Review. This prevents resubmitting claims before necessary changes are made to the visit. *Note: The Hold can only be removed by navigating to the **Billing > Invoice Search > By Invoice** page, locate the held visit, and click the hyperlinked **Y** in the **E-billing Manual Hold** column.* **Hold Removal**
10	Once the necessary (*Original*, *Adjustment*, or *Void*) claim adjustments have been made, click the **Save Batch & Export** button to create the resubmission batch. **Save Batch and Export Resubmission**
11	The system creates the batch and prompts the user to name the file and save it locally. This is the file to be submitted to the Contract or Clearinghouse.

Claim Resubmission Update

The system automatically marks claims with a TRN number as an *Adjustment* (rather than *Original*) **Submission Type** in the *E-Submissions Batches* page (***Billing > Electronic Billing > E-Submission Batches***). This facilitates the claim resubmission process for Providers.

E-Submission Batches: Submission Types

On the applicable claim, click on the edit icon to open the Claim Adjustment window.

On the *Claim Adjustment* window, make the necessary changes and ***Save***.

Claim Adjustment Window

Searching for E-Billing Batches

After New or Resubmitted Claims have been created, batch details can be reviewed and re-exported if necessary. Complete the following steps to review records.

Step	Action
1	Navigate to *Billing > Electronic Billing > E-Submission Batches*.
2	Select a **Contract** and a date range. Click *Search*.
3	On the *Search Results*, click the **Batch Number** link to view the claim(s) details within the batch. **Search E-Submission Batch**
4	Click on the *Export* button to re-export the claim file. **Export** ***Note:*** *Re-exporting simply regenerates the claim file in case the original file was lost; does NOT change visit, billing, or batch status information.*
5	Click the **View Details** link under the **Actions** column to view the *E-Submission Batch Claim Details* window for the visit.

Searching for Mixed Claim Types

An *Original/Adjustment Claims* option has been added to the **Claim Type** dropdown field in the *Search E-Submissions Batches* page (***Billing > Electronic Billing) > E-Submission Batches***). This allows Providers to search for batches that have a mix of *Original* (without TRN) and *Adjustment* (with TRN) claim types within the same batch.

The *Resubmit Claims* option has been renamed to *Adjustment Claims*, matching the **Claim Types**. Functionality remains the same.
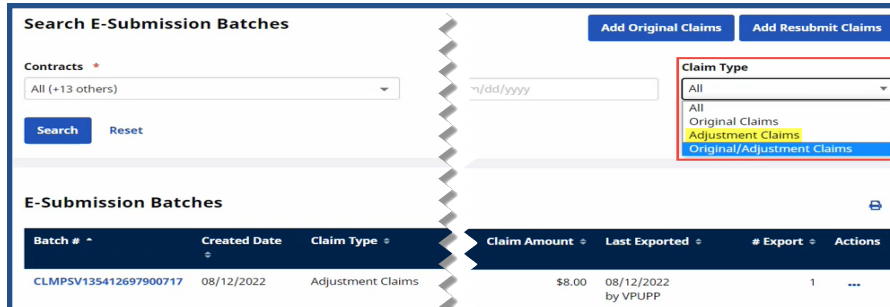
Search E-Submission Batches: Claim Type Dropdown Values

To view a mixed claim batch, select *Original/Adjustment Claims* from the **Claim Type** dropdown field and **Search**. From the Search Results, click on the **Batch #** link to open the batch. On the Batch page, a mix of claims are displayed, some with and some without a TRN (as seen in the image below).

Original/Adjustment Claims

On the *File Processing* page (***Admin > File Processing***), the *Original/Adjustment Claims* value is reflected in the search results under the **Claim Type** column, as seen in the image below.

File Processing: Claim Type Column

E-Billing with Configurable Overrides

Tip: Press **Ctrl-F** on your keyboard to search this topic.

The HHAX system allows Agencies with multiple Offices to setup E-billing configuration fields at both an Agency and Office Level.

Internal Contract Level Configuration

Once the E-Billing Configuration is activated, navigate to the *Admin > Contract Setup > Billing/Collections* tab and select the **Enable Office Level E-Billing Configurations** checkbox to set up overrides, as illustrated in the image below. If this option is not activated, then this checkbox (option) does not display in the Billing/Collections tab.

Enabling Office Level E-Billing Configurations Option

Once selected, the **Office(s)** field populates; otherwise the message "No office selected" is displayed. Click the Edit link to navigate to the E-Billing Configuration page to add or edit applicable Offices.

Once an *Office Group E-Billing Configuration* has been set, a list of groups and associated offices display to include the Group Start and End Dates, as illustrated in the following image. Click the Edit link to update as needed or to add new groups.

Office Group E-Billing Configurations

Adding/Editing Office Groups

In this case, a Group is defined as a collection of Offices that have the same E-Billing override settings. To add or edit an Office Group Configuration, click the Edit link (as seen in the image above).

The E-billing Configuration screen opens with the *Default* tab selected. The Default tab contains the default settings for the Contract (fields serve as a template and are not editable). Default settings (values) are initially defined by System Administration in conjunction with an Agency. To add a group, click the *Add Group* button.

E-Billing Configuration Window – Default Tab

The *E-Billing Office Groups* window opens. Enter a **Group Name** in the required field (as denoted with a red asterisk). If applicable, specify **Start** and/or **End** Date, to specify a timeframe during which the E-

Billing overrides should be applied. From the dropdown menu, select the applicable **Offices** which are part of the group.

Click the *Save* button to finalize. Click *OK* on the confirmation.

Creating an Office Group

Once the Group is saved, it appears as a tab in the E-Billing Configuration window (as pictured in the image below). In this example, a group named *Manhattan* has been created which includes 2 offices (UAT-Exclusion and Billing/Payroll) and has E-Billing override values to be used starting 6/1/2018 without any specified end date.

From this window the **Values** can be configured accordingly. In addition, the **Office(s)** as well as the **Start/End Dates** can be updated by clicking the Edit link. Click the *Save* button to save any changes. Click the *Reset* button to remove any applied changes and reload the last saved information (to include Values). To delete the Group, click the *Delete* button.

Editing an Office Group

Note: Contact HHAeXchange Support for questions regarding E-Billing values.

E-Billing Batch Search and Export

Navigate to the Batch Search page (***Billing > Electronic Billing > E-Submission Batches***) to locate the E-Billing batches. There are two options to export claims/visits according to configured e-billing groups.

One can either 1) click the **Batch Number** (link) to view details and export ***or*** 2) select the **Export** option (under the **Actions** column) to export directly.

E-Billing Batch Search Results to Export

Click the Batch Number to view the *Batch Details* (as illustrated in the following image). Click the ***Export*** button to continue.

Batch Details Export

Clicking on the *Export* button opens the *Export E-Submission Batch Claim* window, click the *Download* button to continue.
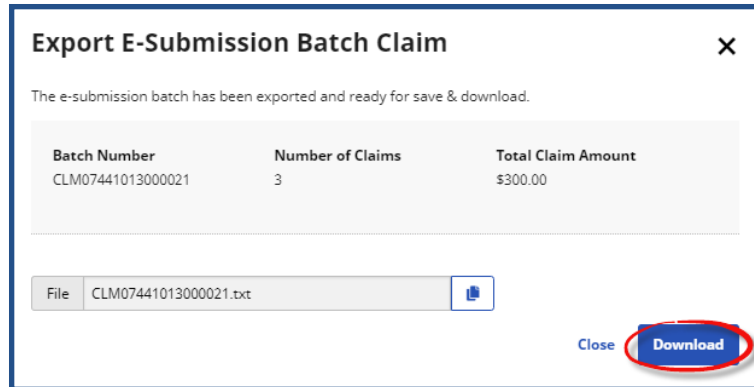
Download Export File

Note: Additional files may appear available to download if there are other associated Office groups.

The downloaded file appears on the lower left side of the screen, as seen in the image below. Click on the file and follow the system prompts to open the file.
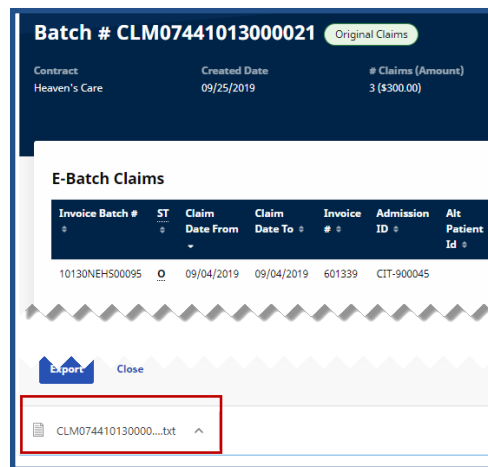
Downloaded file

Removing an Office Configuration

To prevent accidentally deleting any Office E-Billing Configurations, the system has been set with a double-alert (warnings) in the *Billing/Collection* tab of Contract Page.

An Office E-Billing Configuration cannot be removed if the following conditions apply:
- the **Enable E-Billing Office Configurations** checkbox is selected, ***and***
- there is data (visits) in at least one office configuration.

If the **Enable E-Billing Office Configuration** checkbox is ***deselected***, then the system alerts with the following messages in respective order:

Warning	Description
1	"This action will DELETE all office configurations in addition to deactivating this feature. Are you sure you want to do this?" • Select **Yes** to proceed or **No** to cancel.
2	"Confirmation. This action will DELETE ALL OFFICE CONFIGURATIONS. Are you sure you want to do this?" • Select **Yes** to disable Office Configurations and delete ALL Groups (NOT ALL OFFICES). • Select **No** to cancel.

E-Billing Mileage and Post Payments

DISCLAIMER
This feature is activated by HHAX System Administration. Please contact [HHAX Support Team](#) for details, setup, and guidance.

The **Mileage Event** feature in the *e-Billing* and *Cash Payment* modules provide the ability to export mileage and post payments against new Mileage Events. Use this feature to create claims, resubmit claims and post payments against invoices with mileage. The following sections demonstrate how mileage is shown in the various applicable screens.

Cash Payment

On the Cash Payment module, the Mileage feature is implemented in the following pages: *Search Payment*, *New Payment*, *New Refund*, *Search Invoice*, and *Bulk Adjustments* (same as visit).

E-Billing

Several Billing Review validation rules apply to Mileage, where required fields must include values (such as Patient Name, Patient Address, Caregiver NPI Number, etc.).

The following rules do NOT apply to Billing Review, but are used in Export process:
• Bill all visits on the same day with the same Service Code in 1 claim (Medicaid Flag)
• Bill the visits with same Patient, same Visit Date and same Export Code in one LX loop.
• **TRN Number** Required
• Require **Delay Reason Code** when visits in claim are older than limit.

Search Claims

After mileage is billed and E-billing roles are satisfied, mileage records display on the *Claim Search* page. From here, select and add/delete a Mileage Event to the original claim e-submission batch window (just like a service). The following image displays the various columns where mileage is indicated:

• The **Billed Hours** column displays the number of miles
• The **Billed Units** column displays number of units

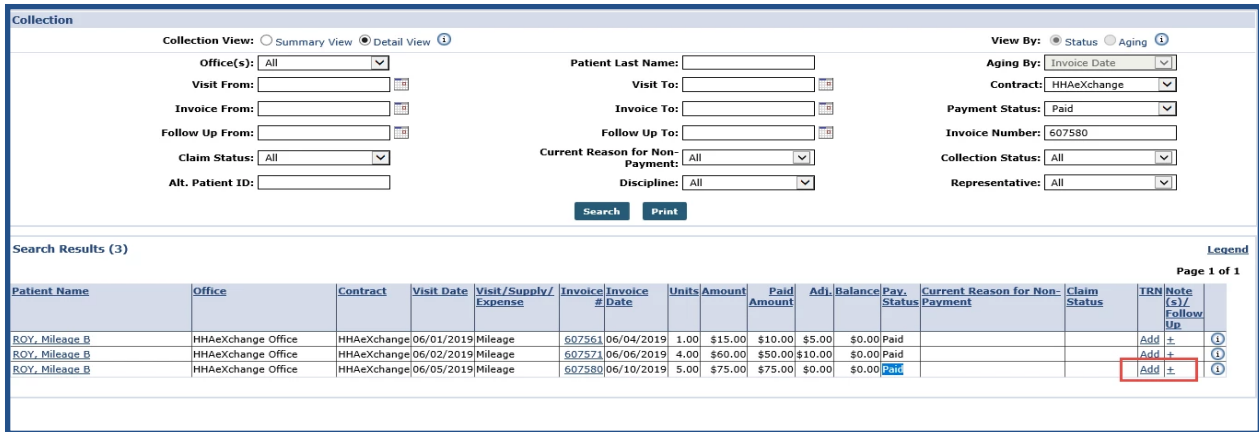- The **Billed Amount** column provides the total billed amount

Resubmit Claims

On the *Resubmit Claims E-submission Batch* page, mileage is indicated under the **Schedule** column. The functionality mirrors that of a visit; click the edit icon (📝) to edit mileage and resubmit as an *Adjustment* of *Void*.

Note: Mileage may be placed on Manual Hold to stop it from being exported.

Collection Module

In the *Collection* Module (***Action > Collection***), Add TRN (link to add a TRN) and + (link to Add Notes) have been added for Mileage Events, as illustrated in the following image.

Collection Module: Mileage Events

Billing Diagnosis Code

The Billing Diagnosis Code functionality applies to both Billing Diagnosis Update types and Validation rules (same as the Mileage functionality for visits).
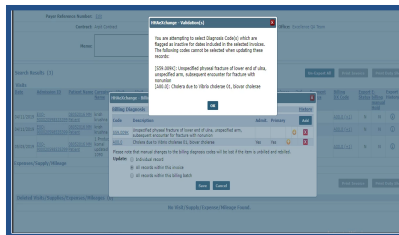
Billing Diagnosis Validation

There are 3 options when updating a diagnosis including: update Diagnosis for one *Individual record*, *All records within the invoice*, or *All records within the billing batch* (as seen on the image).

Billing Diagnosis Code

E-Billing for Legacy Linked Contracts

Tip: Press **Ctrl-F** on your keyboard to search this topic.

This section covers functionality for legacy Linked Contracts to include resubmission of claims (Rebilling), Claims Search, and Batch Search.

Rebill (Resubmit Claims) for Legacy Linked Contract

Providers with legacy Linked Contracts can rebill a claim without having to submit a request to the HHAX Support Team; like the existing Rebill functionality for Internal Contracts. Under the Billing tab (*Billing > Electronic Billing*), two menu items exist to support this feature: **Batch Search (Linked)** and **Resubmit Claims (Linked)**, as seen in the image below.

Note: This functionality applies to Payers whose 837 are exported via the HHAX system.
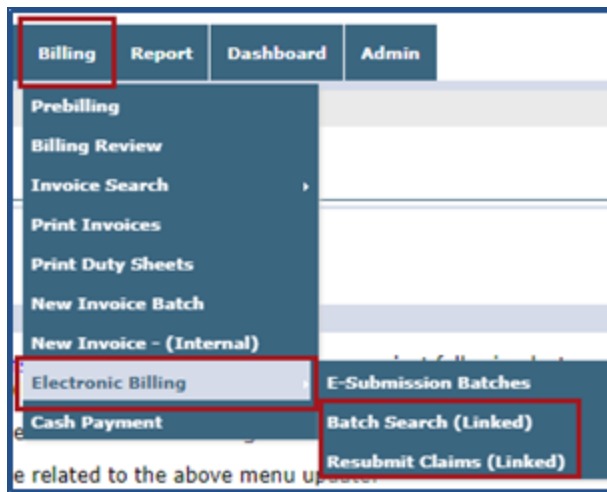
Billing > Electronic Billing >Batch Search (Linked)/Resubmit Claims (Linked)

Resubmit Claims (Linked)

On the *Resubmit Claims E-submission Batch* screen, select the Payer from the **Payer** field to generate a new Batch Number.

The **Office** field is also required (based on e-billing configuration). Once both fields are selected the ***Add Claims*** button is enabled. Click the ***Add Claims*** button to open the Claims Search page.
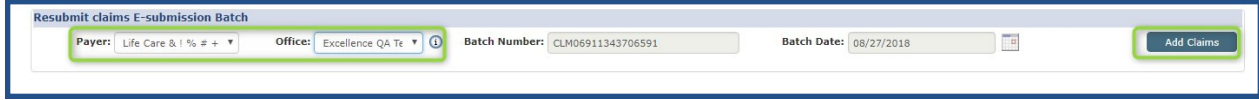

On the *Claim Search* screen, use the search filters to locate the claim. Searches can be generated by **Batch Number**, **Invoice Number**, and **Claim Status** as well as **Visit dates** and **Patient Name**.
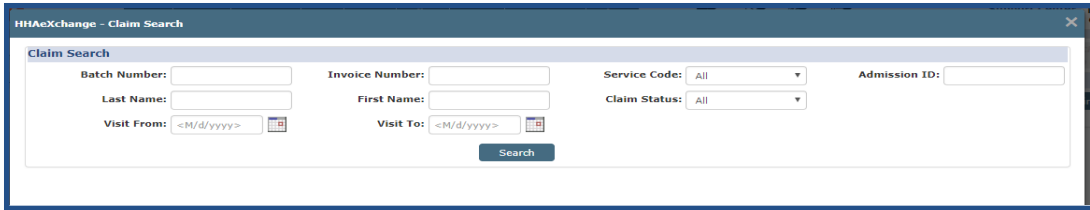
Claim Search Window

Search results are generated according to the selected search filters. From the search results, batch numbers can be selected using the checkboxes on the left-most column. Invoice Numbers are color-coded as a visual aid.

Note: If search criteria is changed, a warning window alerts the user that the previous selection will be lost.
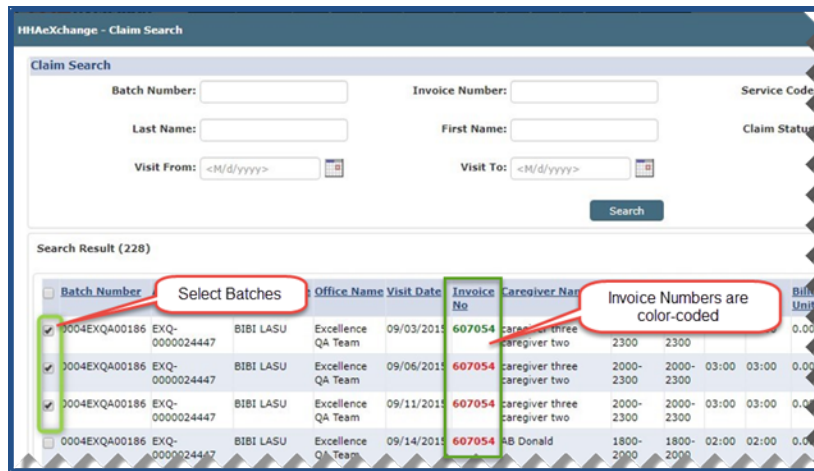
Claim Search Results

Click the Legend link (to the right of the screen) to open/view the Legend pop-up window indicating what the various colors define (as seen in the image).

Claim Search Legend

The bottom of the search results page offers three action buttons: *Select All & Add*, *Add*, and *Close* (pictured below), as described in the table below.

Action Buttons

Select	To...
Select All & Add	Save **all** records displayed on the page and include in the resubmit claim page.
Add	Save all **selected** records and include in the resubmit claim page.
Close	Close claim search popup and route back to the resubmit claim page.

On the *Resubmit Claims* page (pictured below), Providers can *edit* or *delete* a record. Click the **Pencil** icon to access the Claim Adjustment screen. Click the red "X" icon to remove an individual record from the claim resubmission.
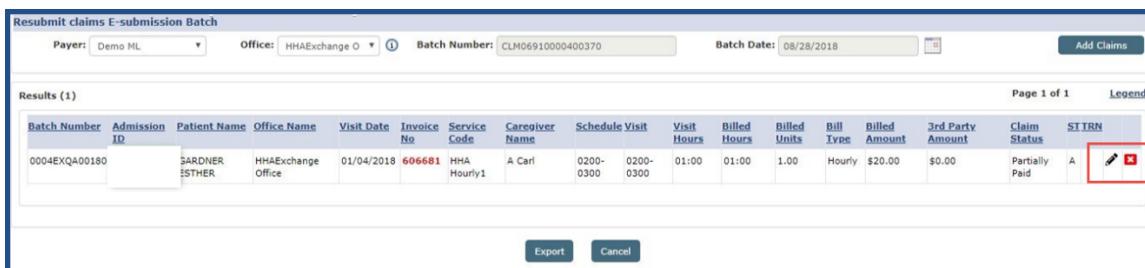
Resubmit Claims E-Submission Batch Screen

On the *Claim Adjustment* screen, the **Submission Type** field is required (as denoted with a red asterisk). There are three Submission Types: *Original*, *Adjustment*, and *Void*, described in the table below the image.

Claim Adjustment Window (with Original Submission Type)

Select	To...
Original	Default option; used if the Provider does not edit the Submission Type. This option may be restricted by a Payer. Refer to Removal of Original Option for Rebilling section below.
Adjustment	The **TRN Number** and **Update TRNfor** fields populate 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*. • Items such as Service Code, Pay Code, Rates, and Hours which appear below the line can only be adjusted as a *Single Claim*.
Void	In addition to the **TRN Number** and **Update TRN for** fields, the **Place Updated Visit on Hold** checkbox also becomes available. If selected, the required **Manual Hold Reason** field populates when selecting *Void*.

Note: Selecting Void hides other adjustment information fields on the window.
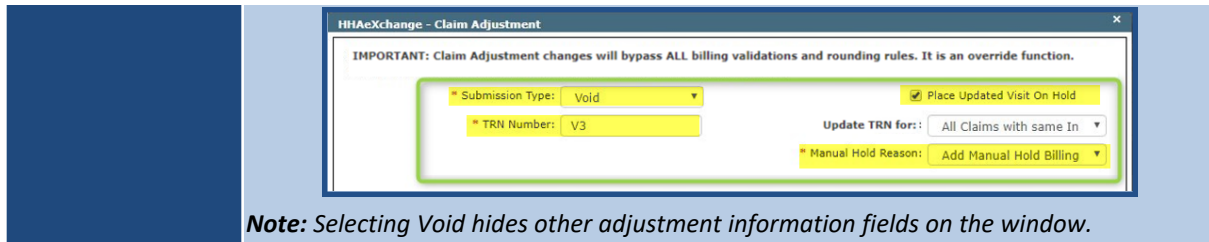
Upon adjusting, click **Save** to update the selected record(s). Based on the selected **Submission Type**, respective **TRN Number**, and **Update TRN for** to the claim, selected records are updated accordingly.

If *Single Claim* is selected (from the **Update TRN for** field), then only the current record for the selected **Submission Type** and **TRN Number** is updated. If *Void* is selected, then the visit can be placed on hold if if/and according to the chosen **Manual Hold Reason**.

If the *All Claims with same invoice number* is selected (from the **Update TRN for** field), then all matching records with the same Invoice Number are updated according to the chosen Submission Type and TRN Number. If *Void* is selected, then all records within the same Invoice Number can be placed on hold if/and according to the selected **Manual Hold Reason**.

If *All Selected Claims* is selected, then all records are updated with chosen Submission Type and TRN Number. If *Void* is selected, then all corresponding visits can be placed on hold if/and according to the selected **Manual Hold Reason**.

Click the **Export and Download** button to generate a Resubmit Export Claim. The system generates an 837 which is exported to the Payer and the user has the option to download the file to their local workstation. Once complete, the system routes back to the Batch Search page.
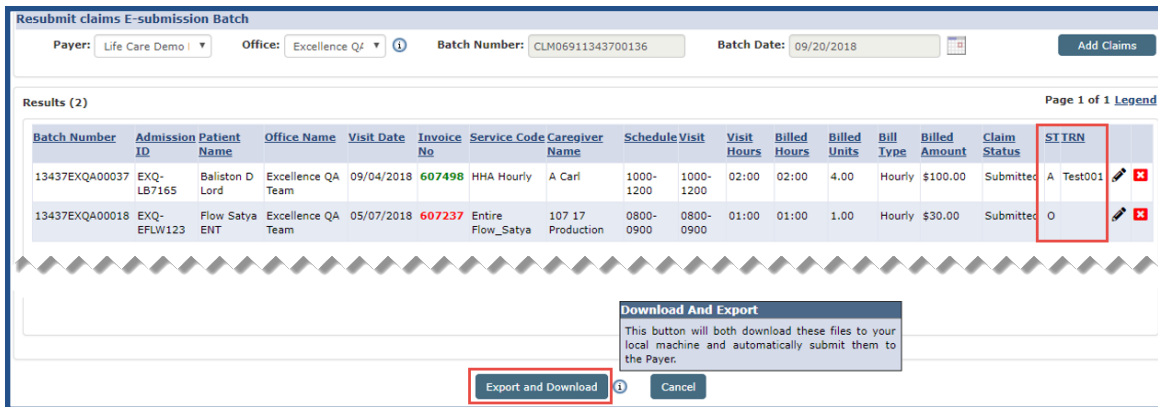
Export Resubmitted Claims

The system checks if the below-listed fields are updated/changed on the adjustment screen. When processing Adjustments, the system updates invoice detail information with changed fields and marked at rebill invoice.

1. Payroll Adj Hours
2. Service Code

3. Caregiver Pay Code
4. Unit per Hours/Daily/Visit

Once a Claim is rebilled, a Y link appears under the **Rebilled** column. The image below illustrates search results by Invoice (***Billing > Invoice Search***). Click the Y link to view the rebilling history for the Invoice.

View Invoice Details

The Re-Billed Details pop-up opens providing Invoice details.

Rebilled Details Window

Resubmitted Claim Batch Search (Linked)

Linked Providers can search for exported claims by navigating to ***Billing > Electronic Billing > Batch Search (Linked)***. The **Payer** and **Claim Type** fields are preselected to *All* (by default). To narrow searches, select the applicable **Payer**(s) and **Claim Type**(s) as well as a date range.

Claim Types include: *All*, *Original Claims*, and *Resubmit Claims*.

Batch Search (Linked) Claim Types

The image below illustrates a search result according to the *Resubmit Claims* type.

Resubmitted Claims Search Results

Searches can also be generated by **Payer** and **Claim Batch Number**, as seen in the image below.

Batch Search by Payer and Claim Batch Number

Click the Export link to download the exported batch or click the Batch Number link to open and view the batch details.

Note: The system does not generate a new export or resend to the Payer via this option.

File Processing Search

On the *File Processing* page (**Admin > File Processing**), the **Batch Number** search filter allows users to search for both batch and electronic claim numbers (CLM).

File Processing Batch Number Search Filter/Column

Rebilling Permissions

The Rebilling functionality is controlled by the Payer; therefore, the Payer must grant Providers permission.

Once the Payer grants permission, navigate to *Admin > User Management > Edit Roles* to enable the **Resubmit Claims (Linked)** and **Batch Search (Linked)** permissions under the Billing section (as illustrated in the image) for the options to be available to an assigned role.
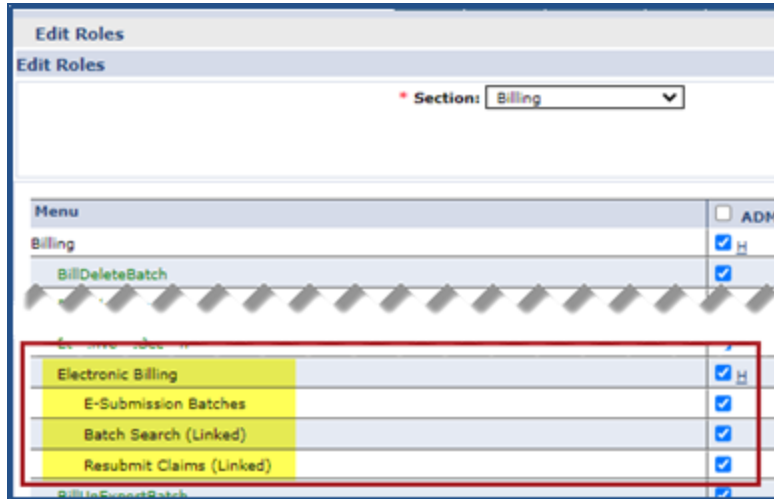
(Linked) Rebilling Permissions

Restrict Rebilling of "Original" Claims (Linked Contracts)

Payers can remove the **Original** option from the *Rebilling* options on the **Claims Adjustment** (*Billing > Electronic Billing > New Batch > Resubmit Claims (Linked)*). The **Restrict Rebilling of Original Claims** feature allows Payers to eliminate any duplicate claims that may be resubmitted. This feature is enabled and managed by the Payer.

When this feature is enabled, the **Submission Type** (**ST**) column in the *Resubmit Claims* page displays "**A**" for those claims that have been resubmitted as an Adjustment and have a TRN Number. Records without a TRN Number display blank.

Resubmit Claims: Claims with "A" Status

Only claims with a **TRN Number** and *Submission Type* of **Adjustment** or **Void** can be downloaded and exported.

Resubmit Claims Search															Legend
Search Results (4)			Delay Reason Code :	Select				Visits Older Than :	90						Page 1 of 1
Batch Number	Admission ID	Patient Name	Visit Date	Invoice No	Service Code	Caregiver Name	Schedule	Visit	Visit Hours	Billed Hours	Billed Units	Bill Type	Billed Amount	ST	TRN
0004EXQA00096	EXQ-135976181	Gan181 Patient	07/08/2016	600692	PA SC	C`aregiver` T`est	0100-0500	0100-0500	04:00	04:00	4.00	Hourly	$40.00		✎ ✖
0004EXQA00097	EXQ-0000024447	BIBI LASU	07/11/2016	600701	PA SC	Caregiver Accrued	0800-0800	0800-0800	24:00	24:00	24.00	Hourly	$240.00		✎ ✖
0004EXQA00126	EXQ-0000024447	BIBI LASU	08/2...				0900-1000	0900-1000	01:00	01:00	1.00	Hourly	$20.00	A 1011	✎ ✖
0004EXQA00145	EXQ-0000024447	BIBI LASU	11/1...				1000-1200	1000-1200	02:00	02:00	0.00	Hourly	$40.00	A jhjhkjhkhkjhk	✎ ✖

HHAeXchange-Validation(s) ✖

Please enter a TRN Number for all Claims.

OK

TRN Required Validation

Note: If this feature is not enabled by the Payer, then the system continues to function with the Original option available.

Claim Adjustment: Submission Type Field

On the *Claim Adjustment* window, if the **Restrict Rebilling of Original Claims** feature is enabled by the Payer, then only the *Adjustment* and *Void* options are available from the **Submission Type** field (the *Original* option does not display). If the *TRN* is available in the **TRN** field, then *Adjustment* is selected by default in the **Submission Type** field; displayed as "A" in the Resubmit Claims page.

HHAeXchange - Claim Adjustment	
Claim Adjustment	
IMPORTANT: Claim Adjustment changes will bypass ALL billing validations and rounding rules. It is an override function.	
Visit Date: 07/11/2016	
* Submission Type:	Select / Adjustment / Void
Start Time: 07/11/2016 0800 (HHMM)	
End Time: 07/12/2016 0800 (HHMM)	
Note: Items below this line must be updated one claim at a time.	
Service Hours: 24:00	Billed Hours: 24:00
Payroll Adj Hours: 0000 (-) HHMM	
Caregiver Name: Caregiver Accrued	
Employment Type: PCA, HHA, HSK	
* Service Code: PA SC	
Rate Type: Hourly	
* Caregiver Pay Code: HHA Hourly ⓘ	

Claim Adjustment: Submission Type Field

Invoice Batch Size Limitations

To enhance system performance, a 5000-visit per batch limit has been implemented to prevent users from creating large batches. When a user attempts to create a single batch with more than 5000 visits, the system issues a validation stating the Contract and the potential impacted batches, as seen in the following image.
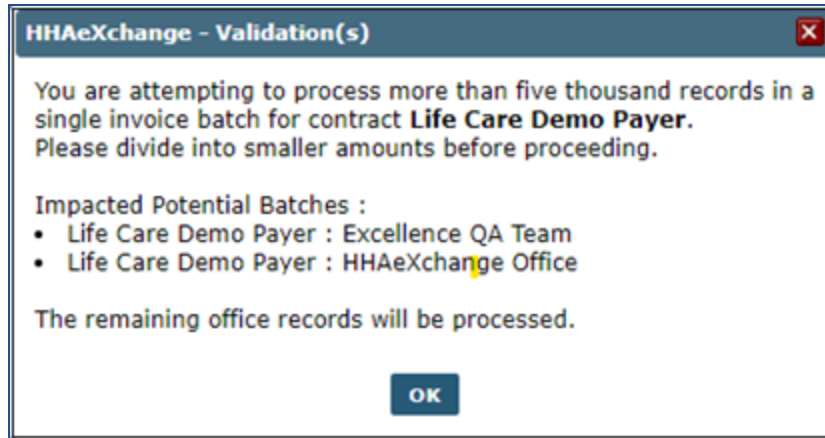
Validation: Invoice Batch Limit

Paper Billing

After a visit is invoiced and reviewed, a paper invoice can be generated to send to the Payer. Complete the steps below to create a paper invoice.

Step	Action
1	Navigate to *Admin > Contract Setup > Search Contract* and select the desired **Contract**.
2	Select the print format for the Contract from the **Invoice Type** field. **General** * Contract Name: Brooklyn Care Invoice Type: Invoice 34 Billing will be generated per Authorization Contract-Level Additional Info Invoice Setup: Additional Info - HCFA 1500 Additional Info - UB-04 **Select Invoice Type** *Note: Unlike e-claims, the Agency can choose the paper claim format. Contact HHAX Customer Support for more information on the **Invoice Type** field and the available format types.*
3	After selecting/verifying the Invoice Type, navigate to *Billing > Print Invoices* to print the claim.
4	Select the desired **Contract** and set any other filter parameters. Click **Search** to return matching invoices. **Print Invoices** Search Admission ID: * Contract: In Home Servic Batch Number: Service Start Date: Service End Date: Invoice Number: Invoice From Date: Invoice To Date: Payment Status: All Branch: All Vendor: Expert Aides 2 Search Print Invoice Print Duty Sheet Print All Invoices Search Results (11) Page 1 of 1 | Batch #	Invoice #	Invoice Date	Adm. ID	Patient Name	Contract	Payment Status	Visit From	Visit To
7110EATW00001	600001	03/09/2018	900001	Allen Kenneth	In Home Services	Paid	03/03/2018	03/03/2018
7110EATW00011	600028	08/10/2018	900001	Allen Kenneth	In Home Services	Open	08/04/2018	08/04/2018
7110EATW00009	600018	07/27/2018	900001	Allen Kenneth	In Home Services	Open	07/01/2018	07/27/2018
7110EATW00008	600015	07/17/2018	900001	Allen Kenneth	In Home Services	Open	06/02/2018	07/11/2018	 **Print Invoices**
5	Click **Print All Invoices** to generate a PDF version of all invoice information returned OR select the checkboxes (to the left of each record) for the desired invoices and click the **Print Invoice** button. Invoices print in the selected format set on the *Admin > Contract Setup* page.
6	Select the **Print Duty Sheet** button to print paper Duty Sheets for the selected invoices. Duty Sheets display as a PDF summary of the visits in the invoice, featuring schedule, confirmation and duty information.
7	Visits held on the **Billing Review** *Exception* page cannot be included in the paper invoice. These visits display in grey. Hover over the exclamation icon (**!**) to see the hold reason.

Step	Action
	Billing Review Validation Issue

	7110EATW00008	600015	07/17/2018	900001	Allen Kenneth	In S...	Invoice Cannot Be Printed as Visits Have Failed the Following Validations:				
☐	7110EATW00005	600006	04/16/2018	900001	Allen Kenneth	In Services	Manual Hold - Under Review				
☐	7110EATW00003	600003	03/09/2018	900002	James Patricia	In Home Services	Paid		03/02/2018	03/02/2018	

HCFA 1500 and UB 04 Invoices

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

The HCFA 1500 and UB 04 invoices are two of the most common invoice formats. Like all other invoices, information is pulled from Patient Profiles, visit, and billing information in the system and mapped to these invoice formats. Additionally, certain values can be overridden on the HCFA 1500 and UB 04 at either the Contract or the Patient level.

Complete the following steps to override invoice values at the Contract level.

Step	Action
1	Navigate to **Admin > Contract Setup** and click on desired invoice format link (<u>Additional Info HCFA 1500</u> or <u>Additional Info UB 04</u>).
2	The selected Invoice window opens (as seen in the image below) allowing one to override information based on the locator field number. In this example, "Test Name 123" is set to print in Location 4 (Insured Name field) on all invoices for Patients under this Contract. If no fields are modified here, then invoices print with information pulled from the Patient record, or with no values at all. **Edit Invoice Information**

HCFA 1500 Modifications

To facilitate the process of completing the HCFA 1500 Claim Form, there are several areas within the system to enable users to populate certain fields. Users can edit the following HCFA 1500 fields directly from the system, from a Contract and/or Patient Level.

- 24I: ID Qual
- 24J(top): RENDERING PROVIDER ID #
- 24J(bottom): RENDERING PROVIDER ID #

Contract Level

Navigate to the **Billing > Collections** tab of the *Contract Setup* page to access the *Additional Info - HCFA 1500* page. As illustrated in the following image, three distinct fields have been added and described on the table following the image.

Additional Info HCFA 1500 Page
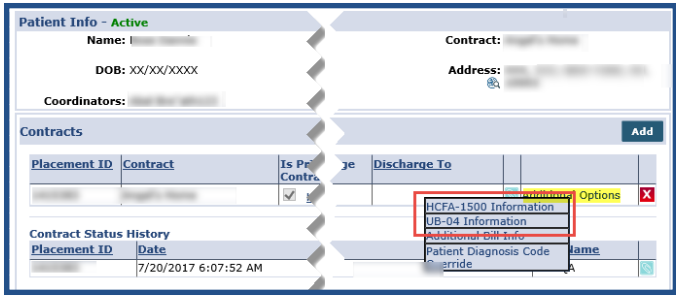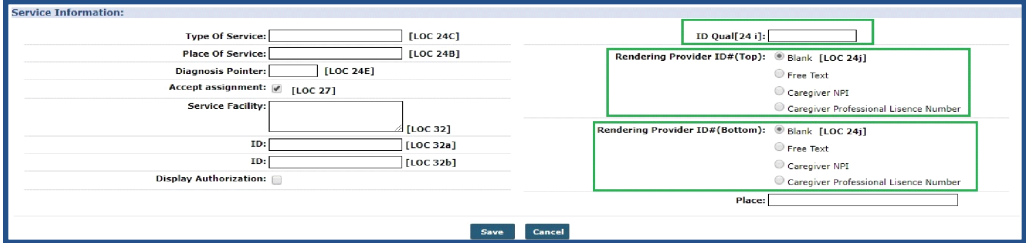
Field	Description
ID Qual (LOC 24i)	• Updates location 24i • Defaults to Blank • Allows two alpha-numeric characters
Rendering Provider ID # (LOC 24j) - TOP	Updates top row of location 24 J. Select radio button options as follows: | Radio Button	If selected...
Blank	Default
Free Text	Requires information entered in the free text box to the right of option. ○ Maximum of 12 alpha-numeric characters.
Caregiver NPI	Provide the Caregiver's NPI associated with service. ○ Only displays the first 12 characters. ○ If no NPI, then displays blank on invoice.
Caregiver Professional License Number	Provide Caregiver's PLN associated with service. ○ Only displays the first 12 characters. ○ If no PLN, then displays blank on invoice.	
Rendering Provider ID # (LOC 24j) - BOTTOM	Updates bottom row of location 24j. Refer to the description above for Radio button options.

Patient Level

Complete the following steps to override invoice values at the Patient level.

Step	Action
1	Navigate to **Patient > Patient Search** and select the desired Patient.
2	Click on the **Contracts** link in the Index.
3	From the *Contracts* page, click the Additional Info HCFA 1500 or Additional Info UB 04 link to open similar locator modifiers (see *Edit Invoice Information* image above). **Patient Contracts Page**
4	Edit the desired fields for the Patient and click **Save**.

Complete the following steps to modify HCFA 1500 Information on the Patient's Contract.

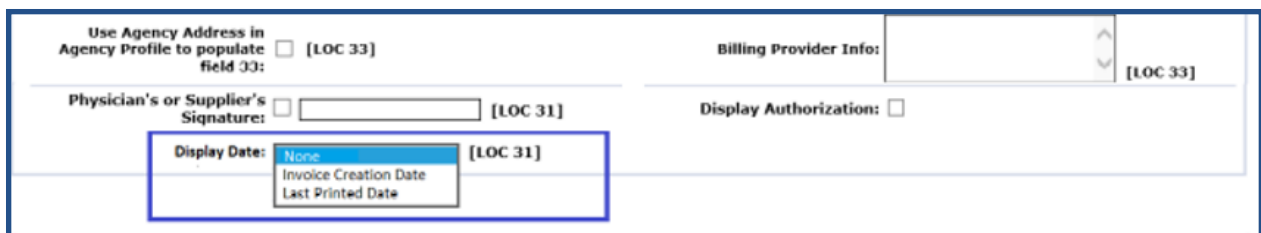| Step	Action
1	Navigate to **Patient > Search Patient > Contract** to access a Patient's HCFA 1500 Information.
2	From the *Contracts* section, click on the **Additional Options** link and select *HCFA-1500 Information* from the options. **Patient Contract HCFA-1500 Information**
3	The *HCFA-1500 Information* page opens. Under the *Service Information* section, the three fields described in the Contract Level section appear. Complete this section based on the options outlined in the previous section. **Service Information Page**
4	Click **Save**.

Note: Although functionality is identical to that described above, these fields impact the Patient level and override any configuration made at the Contract level. The only exception is if "Blank" is selected at the Patient Level, which does not override Contract level configurations for something other than Blank.

Invoice Creation Date Field Added to HCFA 1500/UB-04 (Contract-Level)

Several agencies have requested that a specific date be automatically printed in the date fields on the HCFA 1500 and UB-04 Invoices. This modification allows Agencies to determine which date (such as *Invoice Creation Date* or *Last Printed Date*) is to be printed on these invoices, by Contract (as applicable).
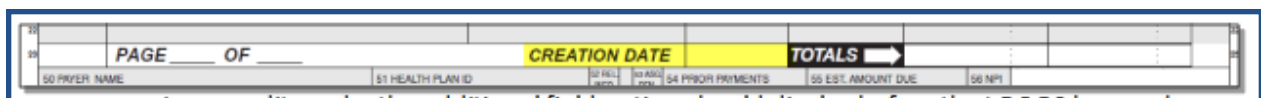
Changes to HCFA 1500

On the *Contract-Level Additional Info Setup page* there are HCFA 1500 options to select which date to display in LOC 31 on all invoices for the contract. The following image illustrate the options in the **Display Date** [LOC 31] field to include *None*, *Invoice Creation Date*, or *Last Printed Date*.

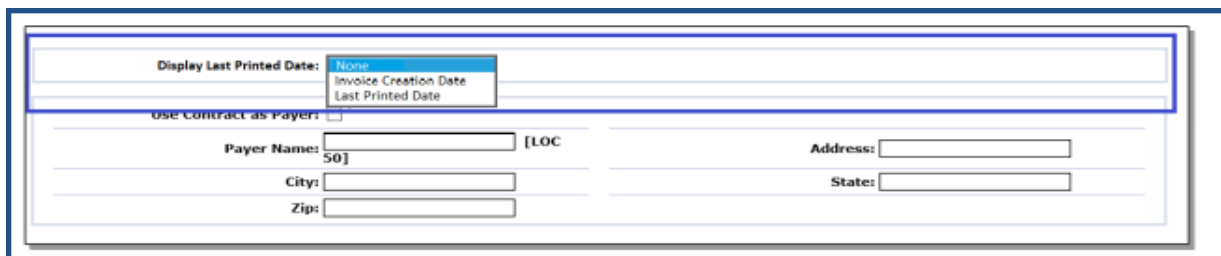HCFA 1550 – Contract-Level Setup

Changes to UB-04

On the *Contract-Level Additional Info Setup page* there is a UB-04 option to select which date to display in the **CREATION DATE** field as shown in the image below.

Note: There is no LOC designator on the paper invoice for this field.

The **Display Last Printed Date** field is located above the **LOC 50** box as shown in the image below with the options of: *None*, *Invoice Creation Date*, and *Last Printed Date*.

Patient Contract Grid Changes

On a Patient's *Contract* page, click on the **Additional Options** link for the applicable Contract (as illustrated on the image below).

Patient Contract Page

For example, select the **UB-04 Information** option to open the Additional Info window. The **Display Date** field is a dropdown menu with options to *Select*, *Invoice Creation Date*, or *Last Printed Date*.

UB-04 Display Date Options

HCFA/UB04 Printing (Linked Contracts)

Linked Contracts can set a default printing format which can be changed (to a different one) when desired. The **Invoice Type** field in the *Billing/Collections* tab is enabled to select options based on the billing setup.

Billing/Collections – Invoice Type field

Selecting a different **Invoice Type** impacts the formatting of invoices printed for visits under the selected contract. Available options are those which an Agency has selected. Additional invoice formats can be added by System Administration by contacting HHAX Technical Support.

*Note: The person listed in the **Billing Reference Person** field is the Contract's primary point of contact at for billing-related queries. This information may display on certain printed invoice types.*

TRN Number on the HCFA 1500 and UB-04 Forms

For Providers who use paper invoices, the **TRN Number** is added to the HCFA 1500 and UB-04 forms. The TRN Number is pulled from either the Collections level or the Invoice level. If the TRN Number exists in both places, then the TRN Number at the Invoice level is used.

To ensure that the exact TRN Number is added in the paper invoice, it is recommended to verify and update the TRN Number in the *Invoice Detail* page (***Billing > Invoice Search > By Invoice*** to locate the Invoice). On the *Invoice Details* page, click on the Edit link to the right of the **Payer Reference Number** field and enter the TRN Number in the text box (as illustrated in the image below). Click the Save link to finalize.

Invoice Details: Payer Reference Number (TRN Number)

To enter in the *Collection* page (***Action > Collection***) click on the Add link under the TRN column from the respective Invoice row, as seen in the following image.

Collection Page: Add TRN Link

On the TRN window, enter the TRN Number in the **TRN** field.
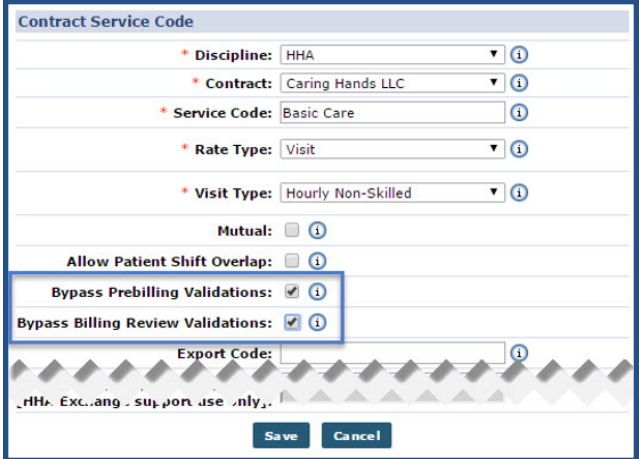

Adding TRN Number

Alternative Billing Scenarios

The Billing process is subject to variations depending on the Agency's configuration, the type of billed service or item, and the billed Contract. This section covers the variations and the impact to the billing process.

Service Code Validation Bypass

Service Codes can be setup to bypass *most* Prebilling validations and/or *all* validations on the *Billing Review* page. Therefore, visits scheduled with certain Service Codes can be billed without fulfilling requirements specified by the Agency or by the authorizing Contract.

Complete the following steps to setup Service Codes to bypass Prebilling and/or Billing Review validations.

Step	Action
1	Navigate to **Admin > Reference Table Management**.
2	Select *Contract Service Code* from the **Reference Table** field (dropdown).
3	Click the **Add** button to add a new Service Code or click on the existing Service Code (link) to edit.
4	The *Contract Service Code* window opens. Select the **Bypass Prebilling Validations** and/or **Bypass Billing Review Validations** checkbox(es). Contract Service Code: Bypass Prebilling/Billing Review Validations
5	Click **Save**.

Visits setup to Bypass Prebilling are still held for the following validations:

- Incomplete Confirmation
- With TEMP Caregiver
- OT/TT Not Approved
- Restricted Caregiver

On the Patient *Calendar* page, any scheduled visit with a Service Code set up to ignore **Prebilling** validations display in white to indicate it is not governed by any Authorizations (as illustrated in the following image).

Monday	Tuesday	Wednesday	Thursday	Friday
30	31	1 S:1000-1200 T ⓘ V: B: N 📄 Abreu Alex T ❌	2 S:1000-1200 T ⓘ V: B: N 📄 Abreu Alex T ❌	3 S:1000-1200 ⓘ V: B: N 📄 Abreu Alex ❌
6 S:1000-1200 ⓘ V: B: N 📄 Abreu Alex ❌	7 S:1000-1200 ⓘ V: B: N 📄 Abreu Alex ❌	8 S:1000-1200 ⓘ V: B: N 📄 Abreu Alex ❌	9 S:1000-1200 ⓘ V: B: N 📄 Abreu Alex ❌	10

Visit Scheduled with "Bypass Prebilling Validation" Service Code

Enforcing "POC Compliance" at Billing Review

The **POC Compliance** validation can be set to hold visits at either **Prebilling** or **Billing Review**. By default, **POC Compliance** holds visits on the **Prebilling** page until an Agency representative contacts HHAX to switch the validation to hold visits on the *Billing Review* page.

Billing Review validations can be reviewed in the *Billing/Collections* tab of the **Contract Setup** page. Click the Export/Print Validations for E-Billing and/or Paper Invoicing link. For example Item 36, **Visit meets POC Compliance requirements**, controls whether the system applies this validation rule for E-Billing and/or Paper Invoicing.

POC Compliance Billing Validation

The **POC Compliance** validation behaves identically whether set for **Prebilling** or **Billing Review**. Therefore, visits must meet the Contract's **Required Compliance** before they can pass either Exception page. The difference is determined by where in the billing process a visit is held due to non-compliance, as follows:

- When **POC Compliance** is set for **Prebilling**, visits that do not meet the **Required Compliance** cannot be invoiced.
- When **POC Compliance** is set for **Billing Review**, visits that do not meet the **Required Compliance** can be invoiced, but the invoice cannot be exported or printed for billing purposes.
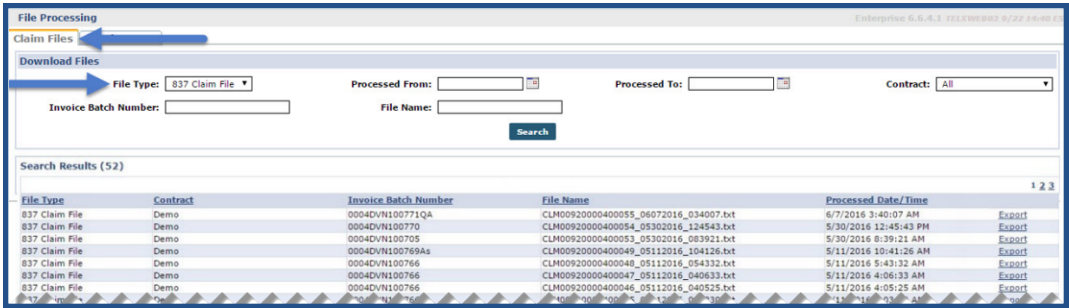
837 Claim Files and Linked Contracts

Linked Contracts using the **837** Invoice format must be manually exported from HHAeXchange. The following section covers this process, as well as how to review the **835 Remittance** files sent by the Contract or Clearinghouse**.**
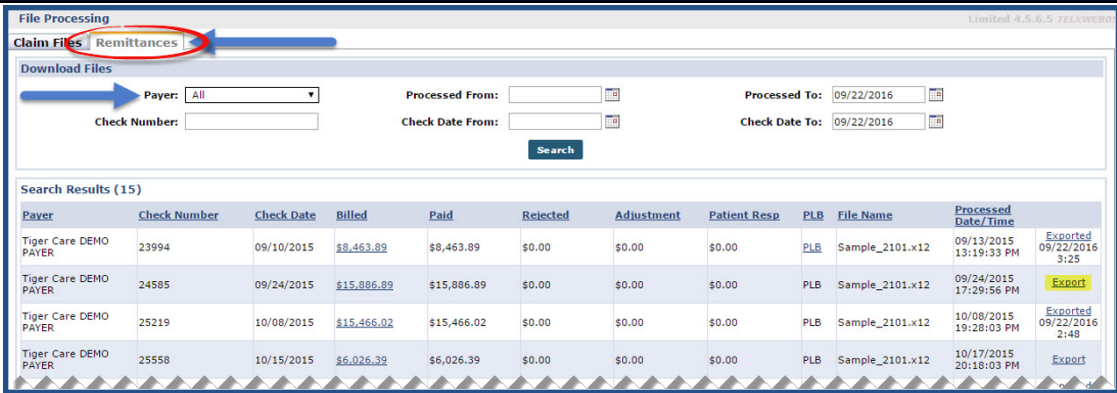
Manually Exporting 837 EDI Claim Files

Linked Contracts that require billing submissions using the **837 Claim** format must be manually exported. Complete the following steps to do so.

Step	Action
1	Navigate to *Billing > New Invoice Batch*.
2	Generate a new invoice (claim) batch. Once processed, **837 Claim** files are automatically generated as "Original" claims.
3	Navigate to *Admin > File Processing*. Select the *Claim Files* tab at the top of the page.
4	Select the *837 Claim File* value for the **File Type** field and click ***Search***. **Download 837 Claim file**
5	The search returns all **837 Claim** files generated by the Agency. Click the Export link in the rightmost column to download the claim file.
6	The **837 Claim** file is ready to be sent to the appropriate Clearinghouse or Contract.

Review 835 Remittance Files
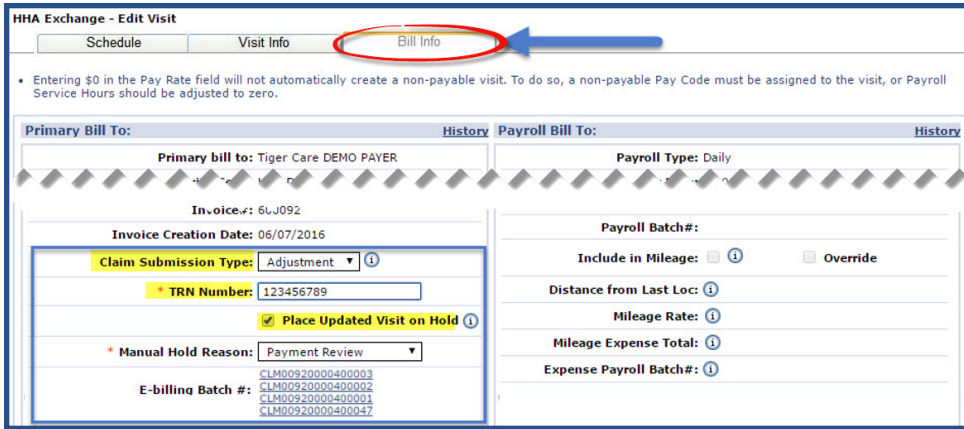
Linked Contracts that require billing submissions using the **837 Claim** format require manual export. Complete the following steps to do so.

Step	Action
1	Navigate to *Admin > File Processing*.
2	Select the *Remittances* tab at the top of the page and perform a search.
3	The search returns all **835 Remittance** according to the selected search parameters. Click the Export link in the rightmost column to download the file.

Step	Action
	Download Remittances

Adjusting and Voiding 837 Claims Files

If a claim included in an 837 EDI file must be adjusted or voided, the claim(s) must be placed on "hold" to ensure that they are not automatically applied to a future claim batch. Complete the following steps to place a hold on a claim.

Step	Action
1	Navigate to the visit associated with the denied claim.
2	Select the *Bill Info* tab (in the Visit window).
3	Select the **Place Updated Visit on Hold** checkbox (under the **TRN Number** field) to stop the claim from being included in a new claim batch. **Bill Info Tab – Claim Adjustment**
4	Select a **Manual Hold Reason**. This value is associated with the claim when searching on the **Billing Review** exception page. *Note: Values for this field are generated via the **Reference Table Management** function.*
5	On the **Claim Submission Type** field, select whether it is an *Original, Adjusted,* or *Voided* claim.
6	Enter the required **TRN Number** field for *Adjusted* or *Voided* claims.

Step	Action
7	Once the corrections are completed, unselect the **Place Updated Visit on Hold** checkbox and *Save*.
8	The claim is now ready to be included in a new batch.

Each time a claim is included in a new batch, the reference number is recorded by the **E-billing Batch #** field on the **Bill Info** tab. Click on the reference number to navigate directly to the claim batch.

View Claim Status Based on 999/277ca

Payers and Providers can view a claim status once a Provider submits an 837 to the Payer. With this feature enabled, Providers have the ability to capture any issues prior to receiving the 835 as well as reduce duplicate billing. A **Claims Status** column has been added to the *Invoiced Visit Search* page (**Billing > Invoice Search > By Visit**) and the *Patient Financials* page under the *E-Submission/Batch Info* tab (**Patient > Financial > E-Submission/Batch Info**).

The image below illustrates the **Claim Status** column in the search results grid of the *Invoiced Visit Search* page. Once a visit is submitted, the Claim Status appears as a hyperlink.

Claim Statuses include: *Not Submitted*, *Submitted*, *Accepted (999)*, *Rejected (999)*, *Unexported*, *Resubmitted*, *Accepted (277ca)* and *Rejected (277ca)*.

Invoiced Visit Search: Claim Status Column

Hovering over the Claim Status link provides a tool tip for the status. In this example, the 837 file has been Created, but not yet Submitted.
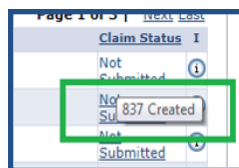
Status Tool Tip

Click on the Claim Status (hyperlink) to view the claim history on the Visit History.

Note: The latest submitted Claim Status displays for invoices that are submitted multiple times.
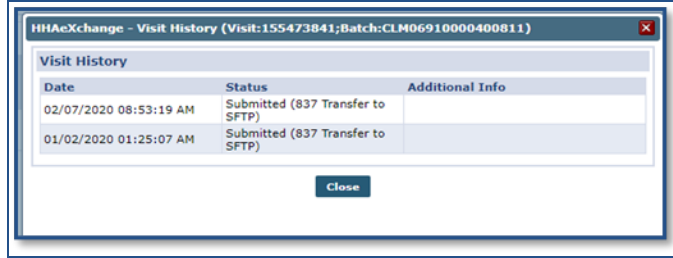
Claim Status: Visit History Window

Note: *The same system behavior applies to the Patient Financial page.*

Banked Minutes

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

The **Banked Minutes** feature offers Providers visibility and direct access to banked time on a Patient's Calendar per applicable Service Code. Banked Minutes are calculated on a visit level instead of at the invoice level and can be overwritten by the Agency (based on role permissions, enabled by HHAX System Administration). All banks reset to 0 at the beginning of a calendar month (no balance is carried from one month to another).

The Banked Minutes functionality is configured and managed by HHAX System Administration. To view specific settings at a Contract level, navigate to **Admin > Contract > Billing/Collections** tab and click on the Banked Minutes Configuration link, as seen in the following image.
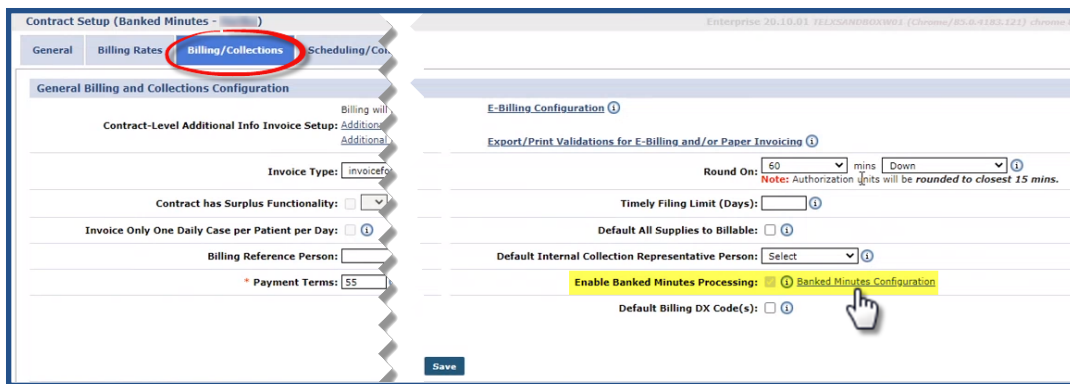
View Banked Minutes Configuration

On the *Banked Minutes Configuration* window, fields are read-only. The **Bank Period** is set to *Month*, as all banks reset to 0 at the beginning of a calendar month.
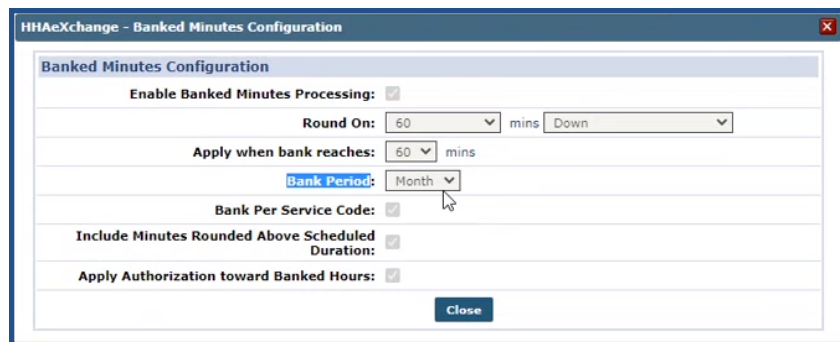
Banked Minutes Configuration Window

The following table describes the fields in the Banked Minutes Configuration window.

Banked Minutes Configuration

Field	Description
Enabled Banked Minutes Processing	Indicates if an Agency/Office is configured for Banked Minutes
Round On	The time to round to (15-minute intervals). Regardless of selected rounding duration, *this setting must be set to "Down" for this functionality to work*.
Apply when bank reaches	Applied Banked Minutes as a billing adjustment when the total bank reaches the selected time.
Bank Period	The period is automatically set to *Monthly* for this functionality. All banks reset to 0 at the beginning of a calendar month (no balance is carried from one month to another).
Bank Per Service Code	Automatically selected as Banked Minutes are categorized and used according to the Service Code. Each Service Code is calculated in its own bank.
Include Minutes Rounded Above Scheduled Duration	Rounded minutes are added to the bank, even if the rounding reduces from a value more than the scheduled duration. Rounding is applied to Confirmation Time.
Apply Authorization toward Banked Hours	The banked period is applied to its own **Banked Hours** field for each visit. If selected, the Service/Billable Hours for each visit includes Banked Hours. Totals are added to Billed Hours on the Authorization section; otherwise, only visit service hours are indicated.

Banked Minutes on the Patient Calendar

The *Banked Minutes* section has been added to the *Patient Calendar* page, displaying applicable **Banked Minutes** per Service Code (as links), as seen in the image below. To the right of the link, the time balance is shown in parenthesis. To view Banked Minutes details, click on the respective Service Code link.

Patient Calendar: Banked Minutes

The *Banked Minutes Detail* window opens providing activity details (described in the table under the image) for the selected *Service Code* and *month*.

Banked Minutes Detail Window

Note: The window opens to the current month selected. To navigate to past or future months from the current, click on the applicable (previous/next month) links available.

Column	Description
Record Type	Specifies the type of transaction used to calculate the banked minutes based on the action taken for the visit (such as *Manual Adjustment*, *Visit Deleted*, *Auto Adjustment*, etc.)
Visit Date	The date the visit took place where banked time was allotted.
Confirmed Time	Specifies the duration based on the confirmation times.
Billable	The number (time) that is billable.
Banked	The banked time for the visit.
Bank Adjustment	Indicates any adjustments applied based on the overall bank balance. This balance can be positive or negative. *Note: Negative balances appear in parenthesis.*
Total Bank	Specifies the total bank balance. The **Edit** link to the right of the field allows manual adjustments to accommodate changes to confirmation times, deleting a visit, or a Service Code change which may impact the Banked Minutes bank. *Note: The **Override Banked Minutes** permission must be enabled by HHAX System Administration for the role performing this task.*
Updated	Displays the update details (date, time, and system user who performed the update).

Manually Editing Banked Minutes

To manually override a bank balance, click on the **Edit** link to the right of the **Total Bank** field in the *Banked Minutes Detail* window. When in edit mode, the **Total Bank** field becomes available allowing updates to be applied along with a **Save** and a **Cancel** links. Once updated, click on the **Save** link to finalize.
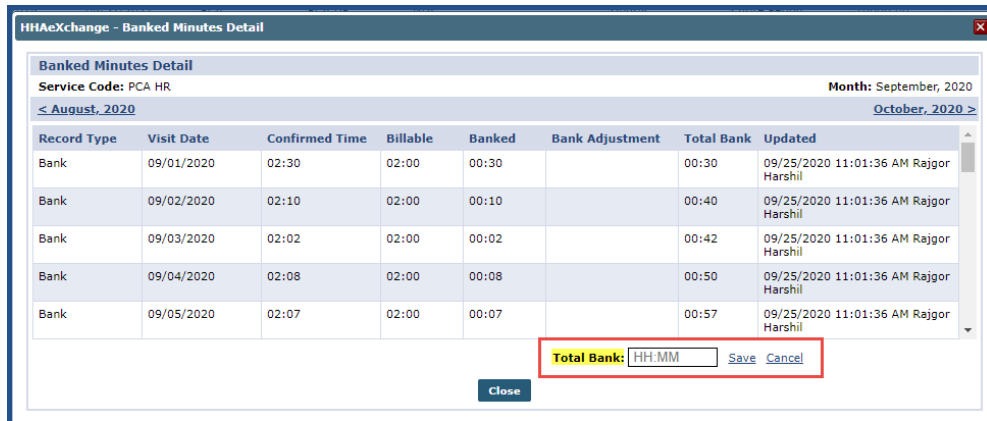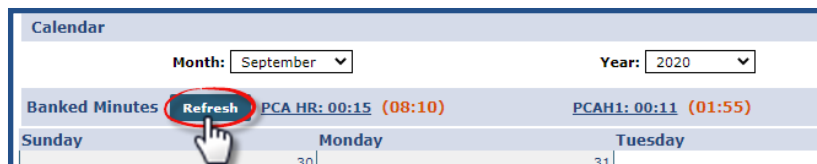
Manually Editing Banked Minutes

*Note: The **Override Banked Minutes** permission must be enabled by HHAX System Administration for the role performing this task.*

Refresh the Patient Calendar

On the Patient Calendar, click on the **Refresh** button in the *Banked Minutes* section to recalculate any updates made to visits (such as scheduled time, confirmed time, or Service Code) with banked minutes.
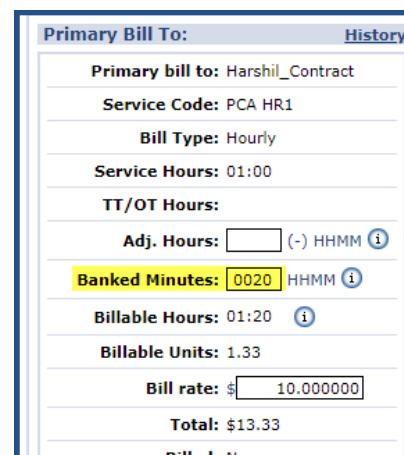

Banked Minutes Refresh Button

Manually Applying Banked Minutes via the Bill Info Tab

Banked Minutes can be manually adjusted via the *Bill Info* tab. For example, adding minutes in the **Banked Minutes** field debits the Banked Minutes balance, as seen on the image to the right. This is considered a *Manual Adjustment* (**Record Type**).

On the *Banked Minutes Details* window, the debit displays as a *Manual Adjustment* under the **Record Type** column and the adjustment is shown under the **Bank Adjusted** column (as seen in the image below).

Bill Info Tab: Banked Minutes

Banked Minutes Adjusted

Deleting a Visit with Banked Minutes

When a visit with applicable Banked Minutes is deleted, the applied minutes are returned to the bank. In the *Banked Minutes Details* window, the **Record Type** for these instances is *Visit Deleted*.

If a deleted visit had calculated banked minutes and the visit was unconfirmed, then the banked minutes are returned to the Total Bank. If the **Total Bank** reaches a minus (-) balance, then the application searches for unbilled visits with an available banking adjustment, and then reverses it.

Removing Banked Minutes for a Visit Deleted from an Invoice

When a visit with applied banked minutes is deleted from an invoice, there is no difference in the calculations and bank minutes adjustment.

Changing the Service Code and Contract with Banked Minutes

When a Service Code is changed for any visit, the associated banked minutes are calculated accordingly. Note that for bank balances to transfer, the receiving Contract must also have Banked Minutes enabled.

For example, the 9/1 visit is scheduled with *PCA H1* as the Service Code. After the Banked Minutes calculation is applied, 10 minutes are manually adjusted leaving the bank with 5 minutes for Service Code PCA H1.

In the image to the right, Service Code *PCA H1* is changed to *PCA Hourly H10*. Once refreshed, the bank balance transfers to the changed Service Code.
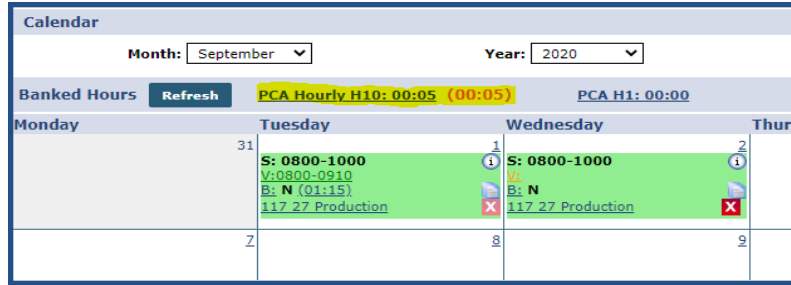
Applying Banking Adjustments to Negative Balances

When the bank remains with a negative time balance, the system searches for unbilled visits with a banking adjustment to apply to the negative balance.

For example, suppose there are 6 visits, and Visit 2 and Visit 6 have Banking Adjustments. The confirmation time for Visit 1 changes resulting in banking minutes (reversal) adjustment; the adjustment is removed from the latest unbilled visit.
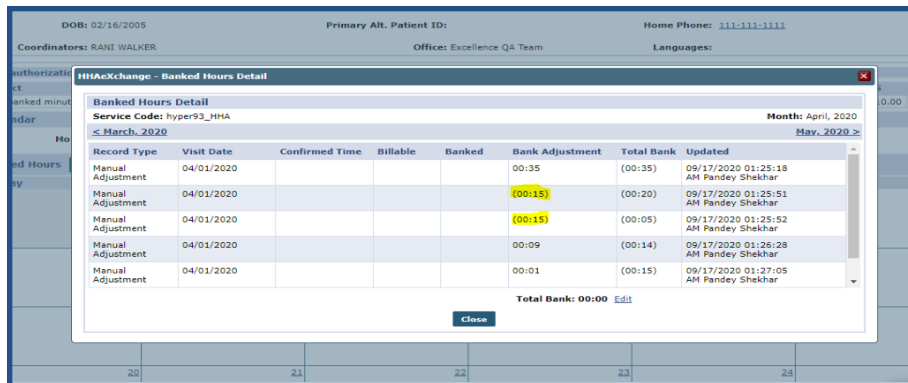
Banked Minutes: Negative Balances

Banked Minutes Nightly Refresh

The system performs an overnight (daily) refresh of all Patient records for an Agency. Those records that are auto-processed display as Auto Process (Banked Minutes) in the *Banked Minutes Detail* window, under the **Updated** column, as seen in the following image.

Auth. #	From Date	To Date	Discipline	Svc. Code	Max units for Auth	Type	Period	Max.	M	T	W	T	F	S	
Rp_Auzfd	01/01/2020	12/31/2020	HHA	hyper93_HHA	N/A	Hourly	Daily		10.00	10.00	10.00	10.00	10.00	10.00	

HHAeXchange – Banked Hours Detail

Banked Hours Detail
Service Code: hyper93_HHA   **Month:** September, 2020
< August, 2020

Bank	09/04/2020	01:30	01:00	00:30		00:55	09/17/2020 09:18:59 AM Auto Process (Banked Minutes)
Adjustment	09/04/2020				00:15	00:40	09/17/2020 09:18:59 AM Auto Process (Banked Minutes)
Bank	09/05/2020	01:30	01:00	00:30		01:10	09/17/2020 09:18:59 AM Auto Process (Banked Minutes)
Adjustment	09/05/2020				00:15	00:55	09/17/2020 09:18:59 AM Auto Process (Banked Minutes)
Bank	09/06/2020	01:10	01:00	00:10		01:05	09/17/2020 09:18:59 AM Auto Process (Banked Minutes)
Adjustment	09/06/2020				00:15	00:50	09/17/2020 09:18:59 AM Auto Process (Banked Minutes)

Total Bank: 00:50 Edit

[Close]

28	29	30	1	2

Banked Minutes: System Adjustments via Nightly Process

Matching Duration Contribution Function (DFTA)

The **Matching Duration Contribution** function allows Agencies to split billing between an Internal Contract and Private Pay Contract. This function was developed specifically for Agencies who manage DFTA cases, as Patients receiving service under a DFTA Contract frequently contribute for a portion of the services they received.

The amount contributed by the Patient is based on the rate of a specific Service Code which may be unique to the Patient. Furthermore, both the DFTA and Private Pay invoices must be generated for the full duration of the services.

For more information on the setup and logic of the **Matching Duration Contribution** function, refer to the Matching Duration Contribution (DFTA) Job Aid.
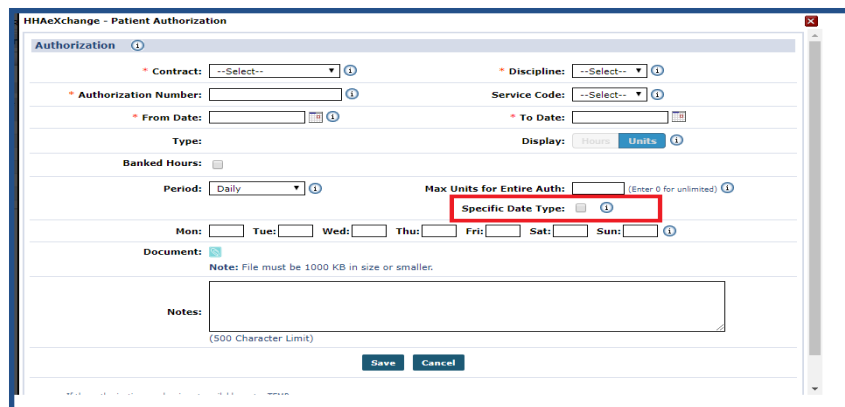
Universal Billing Codes

For Agencies who are following the Medicaid mandate which requires separate billing codes for Weekdays and Weekends, the HHAX system accommodates Providers who are implementing Universal Billing Codes. The system enables Providers to create and split Authorizations by selecting a Day Type allowing the use of a single Service Code for Weekday, Weekend, and Holidays.

The **Specific Date Type** field in the Patient Authorization page and the **Holiday and Weekend Code** functionality in the Service Contract Code window is covered in this section.

Specific Date Type Field in the Patient Authorization

In the Patient Authorization window, the **Specific Date Type** checkbox (below the **Max Unit for Entire Auth** field) allows one to create Weekend, Weekday, and Holiday Authorization limits. This checkbox is only visible if the **Period** type selected is *Daily* or *Weekly*. The option hides if any other Period type is selected (such as *Monthly* or *Entire Period*).

Specific Date Type Checkbox

When the **Specific Date Type** checkbox is selected, the **Weekday** and **Weekend** radio buttons populate underneath (as seen in the image below). By default, **Weekday** is selected.
- If *Weekday* is selected with a *Daily* **Period**, then weekdays Monday through Friday are enabled while Saturday and Sunday are unavailable.
- If *Weekend* is selected with a *Daily* **Period**, then Saturday and Sunday are enabled while the weekdays (Monday-Friday) are unavailable.

Weekday/Weekend Radio Buttons

Note: Holidays can be created with either the Weekday or Weekend authorization options.

If the **Period** type value is changed, the **Specific Date Type** checkbox and *Weekday*/*Weekend* radio buttons reset to default settings.

Scenario 1

Auth 1 has been created with a *Weekly* **Period** and *40* **Max Unit per Period** for the month of April. The **Specific Date Type** is checked with the *Weekday* radio button selected.

Using the parameters selected above, a Master Week is created with visits of 2 hours per day.

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Upon Master Week rollover, the Authorization is only applied to visits according to the selected **Specific Date Type** field.

Scenario 2

Auth 2 is created with a *Weekly* **Period** and *40* **Max Unit per Period** for the month of March. The **Specific Date Type** is checked with the *Weekend* radio button selected.

Using the parameters selected above, a Master Week is created with visits of 2 hours per day.

Upon Master Week rollover, the Authorization is only applied to visits according to the selected Specific Date Type field type (Weekend).

Holiday and Weekend Code Updates

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

Numerous states require Providers to pay higher rates to staff who work during holidays or weekend schedules. To accommodate this need, the system allows Providers to apply different Codes for the various pay types.

Weekend/Holiday Codes Option

Weekend/Holiday Codes are set via the Reference Table Management function (*Admin > Reference Table Management > Contract Service Code*). The **Contract Service Code** table has various components to include two checkboxes titled **Weekend/Holiday Codes** and **Apply the Holiday Code to Weekday**.

On the *Contract Service Code* window, a *Code Configuration* section is used to apply applicable Codes to respective fields, including: **Export Code**, **Revenue Code**, **Taxonomy Code**, **HCPCS Code**, and the **GL Code**. Selecting a Contract (from the **Contract** field dropdown) populates any existing Codes.

When the **Weekend/Holiday Codes** checkbox is selected, the current set of codes becomes two columns of codes, allowing Providers to define the Codes for Weekday separate from Weekend/Holiday.

Reference Table Management - Contract Service Code

Note: This checkbox is unselected by default; therefore, must be selected to display the Weekend/Holiday column.

If the **Weekend/Holiday Codes** checkbox is unchecked, only a "Code" column is available indicating that differentiation between Weekday Codes, and Codes used for Weekend/Holiday is not applicable.

Weekend/Holiday Rates (Unselected)

Apply the Weekend/Holiday Codes to Weekday Option

In conjunction with the **Weekend/Holiday Rates** checkbox is the **Apply the Weekend/Holiday Codes to Weekday** checkbox. This checkbox is only visible when the **Weekend/Holiday Codes** checkbox is selected and overrides the Weekday Codes on Weekdays that fall on a Holiday (based on the Holiday Table set in the Reference Table Management, as explained below).

A **View/Edit Holidays** link on the *Contract Service Code* window (lower-right corner) provides a Holiday List (based on the Contract setup). This link is only available if the **Weekend/Holiday Codes** checkbox is selected. Refer to the **Contract Holiday Template** section for further details.

Managing Holiday/Weekend Codes

A **Holiday/Weekend Codes** Reference Table in the Reference Table Management list provides Holiday templates which can be edited as necessary (as illustrated in the image below).

Reference Management Table: Holiday/Weekend Codes (Templates)
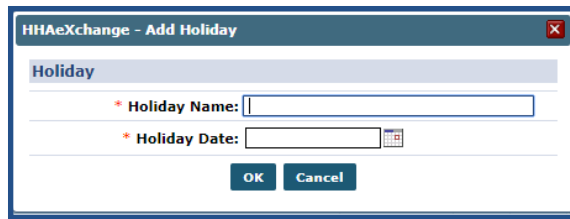
To edit a Holiday template, select the Template Name (hyperlink) to open the *Edit Holiday Template* window. The **Template Name** populates at the top followed by the **Status** of the template. The Holidays

are listed by *Holiday Name*, *Date*, and the options to Edit or Delete (hyperlinks). From this window, one can rename the **Template**, adjust the **Status** (Active/Inactive), and *add*, *edit*, or *delete* Holidays from the template.
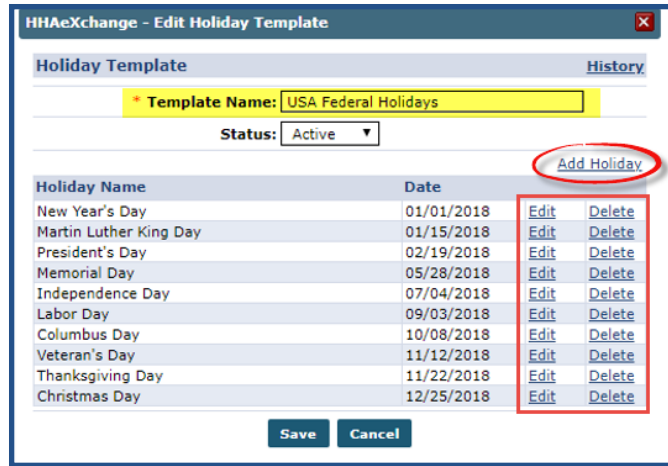
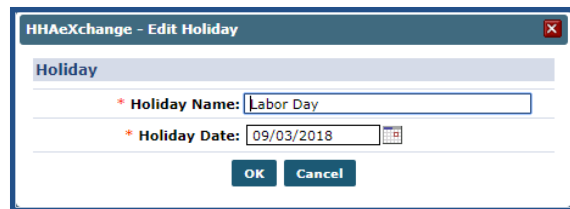
Edit Holiday Template Window

To add a Holiday, click the Add Holiday (hyperlink) to open the **Add Holiday** window. Enter the **Holiday Name** and enter/select the **Holiday Date**. Click the *OK* button to apply to the template.


Add Holiday to Template

To edit a Holiday, click the Edit (hyperlink) for the corresponding holiday to open the **Edit Holiday** window. Edit the **Holiday Name** or the existing **Holiday Date**. Click the *OK* button to apply to the template.

Edit Holiday on Template

Note: The system does not allow duplicate Holiday Dates or Holidays that do not fall within the current year.

Three years of Holidays for the previous, current, and following year can be seen. When viewing the Holiday List History, the *Edit* and *Delete* options are only enabled for the current year; disabled for the previous and following year holidays.
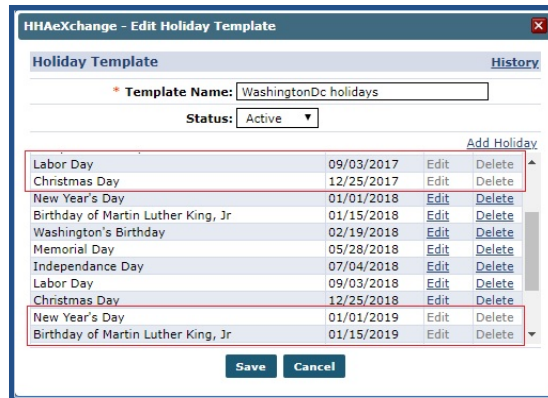
**Holiday List History**

Federal Holidays

In the US, the following holidays are federal holidays:

- New Year's Day
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veteran's Day
- Thanksgiving Day
- Christmas Day

Click here to view further details on these federal holidays. To accommodate Agency calendars, these holidays are pre-populated at the Agency level using the 'US Federal Holiday' template. This template is a 10-holiday template which populates every year accordingly. Agencies can modify their calendars as needed via the Reference Table Management function in the Holiday/Weekend Codes table (Fiscal section).

The **US Federal Holiday** template is selected by default. When selected as the default template on a Contract level, then the holidays are copied at a Contract level; hence, the template remains unchanged. If the template is rolled over and if the Federal template is selected at a Contract level, then the new holidays are added at Contract level as well.

*Note: The process to rollover holidays for the following year run on the 25th of Dec of every year.*
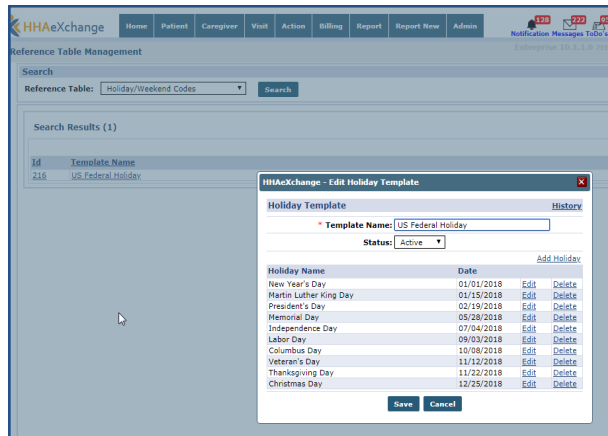
US Federal Holiday Template

Contract Holiday Template

Click on the View/Edit Holidays link on the Contract Service Code window (only visible if a Non-Linked Contract is selected) along with the selected **Weekend/Holiday Codes** checkbox to open the *Contract Holiday Template* window allows one to assign a Holiday Template to the selected Contract.

The Add and Edit functions work the same as what is covered in the Managing Holiday/Weekend Codes (previous) section.
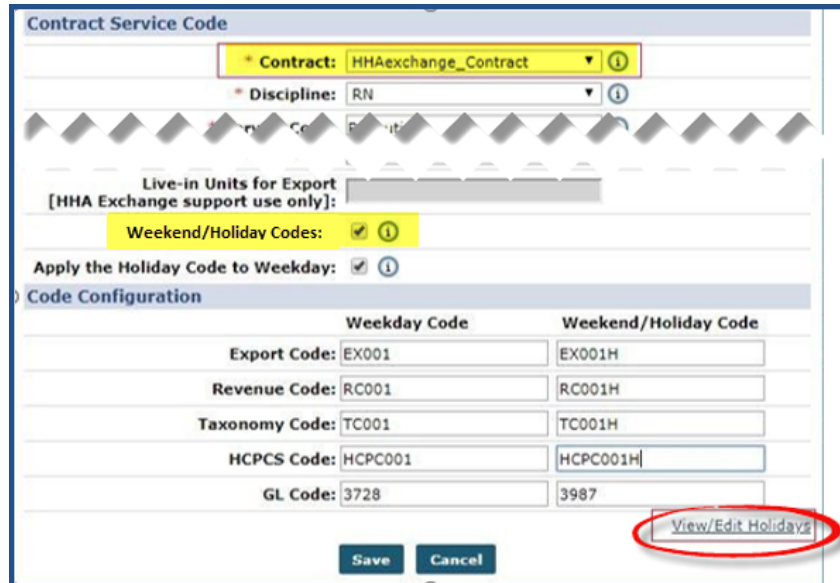
View/Edit Holidays

On the *Contract Holiday Template* window, one can *add*, *edit*, or *delete* holidays at a Contract level. By default, the **Holiday Template** *US Federal Holidays* is selected with the defined Holiday List underneath (managed via the Reference Table Management function).

Note: Appling changes to the selected Holiday Template, repopulates the applicable Holiday List defined at the Provider level.
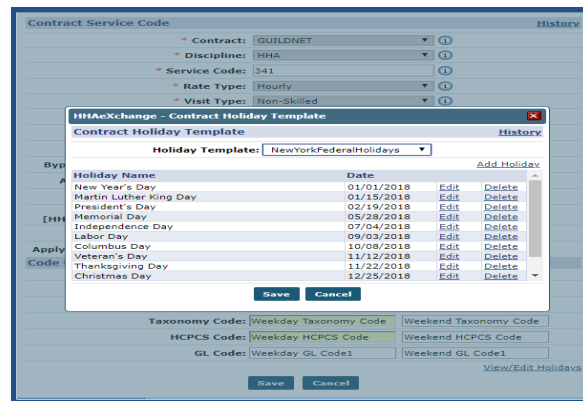
Contract Holiday Template Window

The **Holiday Template** dropdown shows only *Active* templates, except when an assigned template for the selected Contract is changed to *Inactive*. The *Inactive* template is included in the selection dropdown listed as *Template Name (Inactive)*.

Saving the selected Template assigns it to the selected Contract in the Service Code page, and the Holiday List is saved for the Contract in the database.

Adding a Holiday Template

A **Holiday Template** can be added to the existing **Holiday/Weekend Codes** Reference Table (***Admin > Reference Table Management > Holiday/Weekend Codes***). Click the ***Add*** button to add a new template, as seen in the image below.

Holiday/Weekend Codes Reference Table – Add Template

The *Add Holiday Template* window opens. Enter a new **Template Name** (required field). Under the Holiday Name, *New Year's Day* with *Jan 1* is the date provided as the default value when creating a new Holiday Template. On this screen one can [Add a Holiday](), [Edit]() or [Delete]() any existing holiday by clicking the respective links.
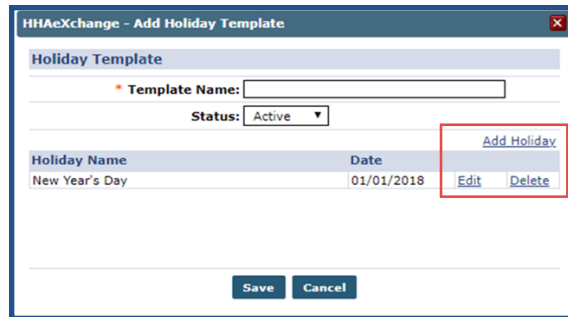
Add Holiday Template

On the *Edit Holiday* window, specify a **Holiday Name** and **Holiday Date** (required fields). Click *OK* to add the edited holiday to the Holiday Template. Once complete, click *Save*. Upon saving, the new **Holiday Template** appears in the *Holiday/Weekend Codes* Reference Table.
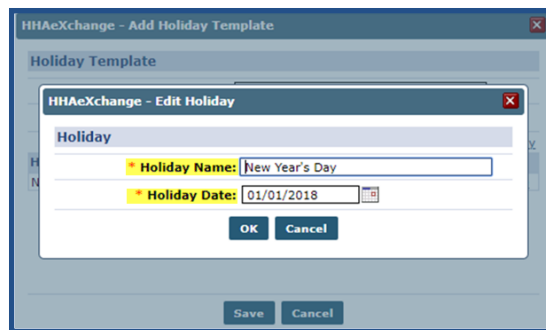
Add Holiday Template

A template becomes independent once a Service Code is assigned. New changes on the Service Code Template do not reflect on the Holiday Template Reference Table, and vice versa.

Holiday Templates

Yearly Job Update

The **Yearly Job Update** (performed every year on December 25) updates the holiday schedule for the coming year based on the **Federal Holiday Template**. The system is set to also update and adjust authorizations based on the Service Code settings which have the **Apply Holiday Codes to Weekday** selected.

Authorization Alignment with Holiday Billing on Weekdays

The Authorization functionality is aligned with the Service Code functionality as described in the [Apply the Weekend/Holiday Codes to Weekday Option](#) allowing Providers to apply **weekend/holiday** authorizations to holidays that fall on a weekday. On the Contract level (*Admin > Contract Search > Billing Rates*), when the **Apply the Holiday Codes to Weekday** checkbox is selected in the *Contract Service Code* window, the applicable *Holiday Service Code* can be applied to a Visit if it happens to fall on a weekday.

Patient Authorization

On the *Patient Authorization* page (*Patient > Authorizations*), The **Weekend/Holiday** radio button accommodates authorization for holidays which fall on a weekday. Select the **Specific Date Type** checkbox to enable the **Weekday** and **Weekday/Holiday** radio buttons. Selecting the **Weekend/Holiday** radio button opens all weekdays to allow adjustments (as seen in the image below). This selection automatically applies specified holiday service codes for visits (worked hours) on a weekday.

Patient Authorization

*Note: All changes made for a Patient Authorization are also reflected in the **Visit-> Appointments-> View Authorizations** screen.*

Bill Info Tab

This is also reflected in the *Bill Info* tab in the **Visit Details** window (as seen in the image below).

Bill Info Tab (Visit Details)

Holiday Billing on Weekdays for Banked Hours

This applies only to Agencies who are using the Banked Hours functionality.

When checking for authorization availability before allocating banked hours, authorization is checked against the **Contract Holiday List** and the applicable Service Code when **Apply the Holiday Codes to Weekdays** is selected.

For example, suppose there are 45 banked minutes and the **Apply when Bank Reaches** field is set to 60. A visit is created on a Friday (which is added in Contract Holiday List and the applicable Service Code applies when the **Apply the Holiday Codes to Weekdays** option is selected); adding 15 minutes to the bank to complete the hour. In this case, the system checks if the authorization available for Friday is at least 1 hour greater than scheduled time.

- If the Authorization Type is set to **Weekend**, then the banked hour is applied.
- If the Authorization Type is set to **Weekday**, then the system does not apply the banked hour to the Friday visit, even if the weekly authorization has sufficient hours.

The same applies if the authorization is set with a *Daily* **Period**.

Service Code Billing Overrides

Billing identifier fields, in the *Contract Service Code* window, are used to override any Service Code billing information entered at another level in the system (such as the Agency and/or Office level).

Navigate to **Admin > Reference Table Management > Contract Service Code** and select the applicable Service Code. On the *Contract Service Code* window the **NPI**, **Tax ID**, and **Caregiver NPI** (billing identifiers) fields have been added, as seen in the following image and described in the table below.

Contract Service Code Window: Billing Identifier Fields

Field	Description
NPI	Enter the 10-digit number to override billing information for the Service Code in all other levels. The NPI is then included in paper invoices and electronic billing claims. Select the **Use Blank Value** checkbox to hide the NPI. When selected, the **NPI** field becomes unavailable and the NPI is not included in the invoice (paper or electronic billing); regardless of where the NPI is entered.
Tax ID	Enter the 9-digit number to override billing information for the Service Code in all other levels. The Tax ID is then included in paper invoices and electronic billing claims.
Always List Caregiver NPI as Blank	Select the **Always List Caregiver NPI as Blank** checkbox to override a Caregiver NPI number entered in the Caregiver Profile; consequently appearing as a blank Caregiver NPI in the invoice (paper and electronic billing claims).

Billing Identifier and Overrides Validations

For all Contracts (*Internal* and *Linked*), the **NPI** and **Tax ID** values used in invoices are taken from the system in the following order (starting with lowest level):

1. Service Code (***Admin > Reference Table Management > Contract Service Code > Contract Service Code window***)
2. Contract Level (***Admin > Contract Setup > General tab***)
3. Office Level (***Admin > Office Setup > General section***)
4. Agency Level (***Admin > Provider Info > Agency Info General section***)

It is recommended that the **NPI** and **Tax ID** fields are reviewed in each of these pages to ensure that the data is valid and correct. When saving values for these fields, validations have been added to each page to ensure entered data format is correct.
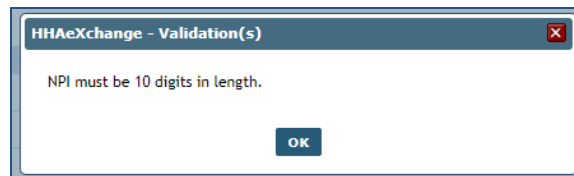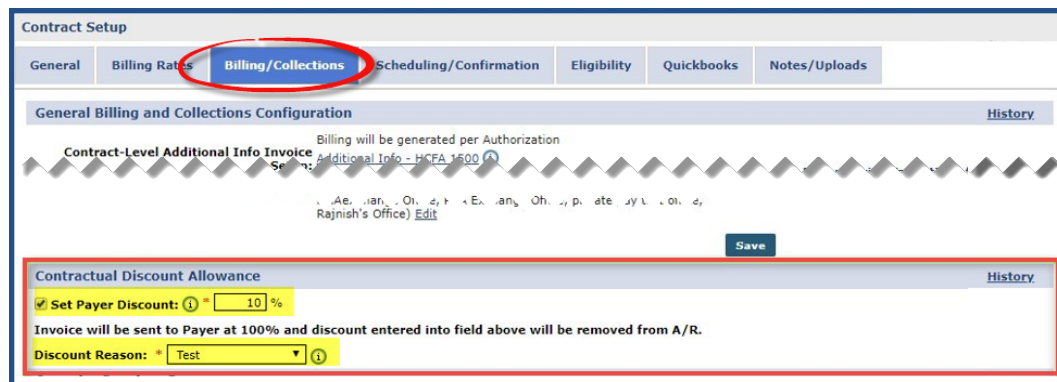
NPI Field Validation
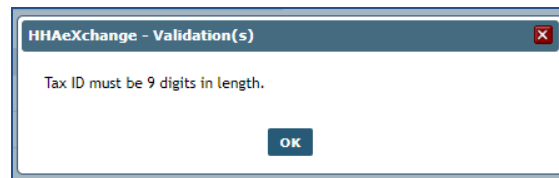
Tax ID Field Validation

Discounted Payer Contracts

Providers can set Payer discounts at a Contract level; particularly for national Payers who require discounts. When billing for these Payers, the Total Invoice Amount on the HHAX system shows the full billed amount as well as the breakdown of the actual amount discounted, and revenue paid. To set up discounts, locate the **Contractual Discount Allowance** section in the *Contract Setup* page in the *Billing/Collections* tab (**Admin > Contract Setup > Billing/Collections**).

Contractual Discount Allowance

To activate the discount feature, select the checkbox to the left of the **Set Payer Discount** to enable the **Set Payer Discount** (%) field and the **Discount Reason** field. Once the fields are available, enter the discount rate (the percentage discounted at the time of invoice) in the text field and select the **Discount Reason** from the dropdown (as illustrated in the image above). The **Discount Reason** appears on the Payer's Invoice under the *Other Adjust* column. The Discount does not appear on the actual Invoice that is sent to the Payer.

*Note: When activating this feature note that all Surplus and Multiple Payers settings in **Additional Bill Info** (**Patient > Contract > Additional Options**) are removed from the selected Contract.*

Reference Table Management: Payment Adjustment Reason

The **Discount Reason** field is managed via the *Reference Table Management* function (**Admin > Reference Table Management**). On the **Reference Table** field, select *Payment Adjustment Reason* under the Fiscal section.

Discount Reason Reference Table

Deleting Invoices

Upon creating a check, the adjustment and discount payments are NOT automatically deleted when the user tries to delete the invoice. Adjustments made to the invoice changes the status to *Partially Paid*.

When a user attempts to delete an invoice with a *Partially Paid* status, the system warns that the visit cannot be deleted due to Contractual Discount or Payer Maximum Limits (as illustrated in the image below). To delete such invoices, the adjustments must be removed first.

Invoice Delete

For example, a 10% **Payer Discount** is entered for a Contract with "Contractual Agreement" as a **Discount Reason**.

Contract Setup – Contractual Discount Allowance

When an invoice is created for visits under this Contract, the Visit Bill Amount shows as $10.

New Invoice

A Primary invoice is created with a 10% adjusted discount or $1.00 (as shown below). Click the Invoice Number (link) to view the Invoice Details.

Primary Invoice

On the *Invoice Details* page, this Primary Invoice shows as Partially Paid with the Discount Amount of $1.00 as the Paid Amount.

Invoice Details

The Payment Details can also be seen on the Patient's Financials page under the Payments tab.

Patient Financials/Payments tab

Payer Maximum Limits

Providers can limit the maximum Payer Contribution on some Contracts. The Provider can enter this maximum amount which is tracked according to the defined billing parameters before and after the maximum is reached.

Navigate to *Patient > Contract > Additional Options > Additional Bill Info* to access the **Limit Maximum Payer Contribution per Period** section in the *Additional Bill Info* window.

Access to Additional Bill Info

On this window, set billing limits per Patient at a Contract Level for the purpose of collecting revenue. Limits can be set *per day*, *per week*, *per month*, *per year*, and/or *per lifetime* of the Contract once this feature is enabled.

Limit Maximum Payer Contribution Option

Once activated, the Provider can also designate which Contract to bill once the Limit is reached. As a required field ("**When Limit is reached, send additional invoice to**"), *Private Pay* is selected by default. The **Payer Adjustment Reason** dropdown field is also required. The dropdown options are the same as the *Payment Adjustment Reason* Reference Table under the Fiscal category.

For example, the **Limit Maximum Payer Contribution** feature is selected and a **$40 per day** limit is set for this Patient for the selected Contract. With this setting, any amount exceeding the $40 limit for the day is invoiced to *Private Pay* as selected (as illustrated in the image below).

Limit Maximum Payer Contribution

In this example, the total visit Amount is $60. Upon invoicing this visit, two invoices are created because the total Amount exceeds the $40 daily limit set for this Patient (illustrated in the image below).

Total Invoice Amount

A Primary invoice is created for the full amount with a *Partially Paid* status. A Secondary invoice is created for Private Pay with the $20 balance (with an *Open* status). The adjustment made for the Paid Amount can be verified from Patient Profile according to the check number generated.

Invoice Details – Primary Invoice

The Invoice Details for the Secondary (Private Pay) invoice shows the balance with an *Open* status.

Invoice Details – Secondary (Private Pay) Invoice

Example: Combining Payer Discount and Limit Payer Maximum

The following example demonstrates when both the Payer Discount and the Limit Payer Maximum features are combined.

The **Payer Discount** is set at **10%** for the selected Contract. At the Patient level, the **Limit Maximum Payer Contribution** is set for **$50 per day** for the Contract. A visit is invoiced for a **Total Amount of $100**. In this case, two invoices are created. The Primary invoice is generated for the full amount with a 10% discount as an adjustment and a Partially Paid status.

A Secondary invoice is also generated to Private Pay for the balance of the exceeded Limit Max amount with an Open status (as shown in the image below).

Limit Maximum Payer Contribution

Primary/Secondary Invoice Details

Therefore, two adjustments are made for this combination; one for *Discount Percentage* and the other for the *Limit Maximum* with the selected Payment Adjustment Reason.

Patient Financials

Setting Multiple Limits

Providers can set multiple limits to allow for other billing rules to engage when a maximum limit has been reached; allowing one or more limit maximums per Contract, per Patient. Therefore, a Provider can set a _daily_ amount limit, a _monthly_ amount limit AND a _yearly_ amount limit for the same Contract for the Patient.

Setting Multiple Limits

Once limits are defined, select the applicable party to invoice from **When limit is reached, send additional invoice to** field (as described in the previous section, Secondary Insurance Billing Enhancement).

To access this setting, navigate to the Patient's *Contract* page (***Patient > Contract***). Click on the Additional Options link for the applicable Contract. Select the **Additional Bill Info** option from the menu to access the window.

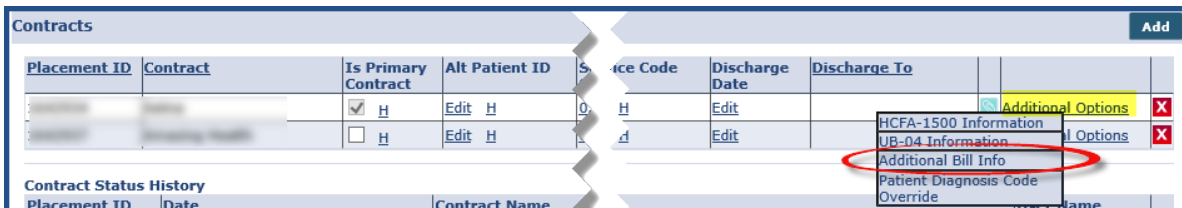**Additional Options > Additional Bill Info**

Billing Elimination Period

Some Contracts require a Patient to cover 100% of the cost of service for a set number of days before the Payer covers anything. This is referred to as the **Elimination Period**. Although the Patient is expected to pay the full amount, the Payer must be invoiced for 100% of the service during the Elimination Period.

The system has been adjusted to create a second invoice for the Patient to accommodate the Elimination Period. A full invoice is sent to both Private Pay (Patient) and to the Payer. The Payer's invoice is automatically adjusted to $0.

This setting is applied on a per Patient per Contract basis. The Patient must have an active Private Pay applied to their Contracts.

To apply *Elimination Period* settings, navigate to the Patient *Contract* page (**Patient > Contract**). On the *Contract* page, click on the Additional Options link for the applicable contract and select *Additional Bill Info* from the menu.

Additional Options > Additional Bill Info

On the *Additional Bill Info* window, select the newly added checkbox titled **Elimination Period** and complete the applicable fields as described in the table under the image.
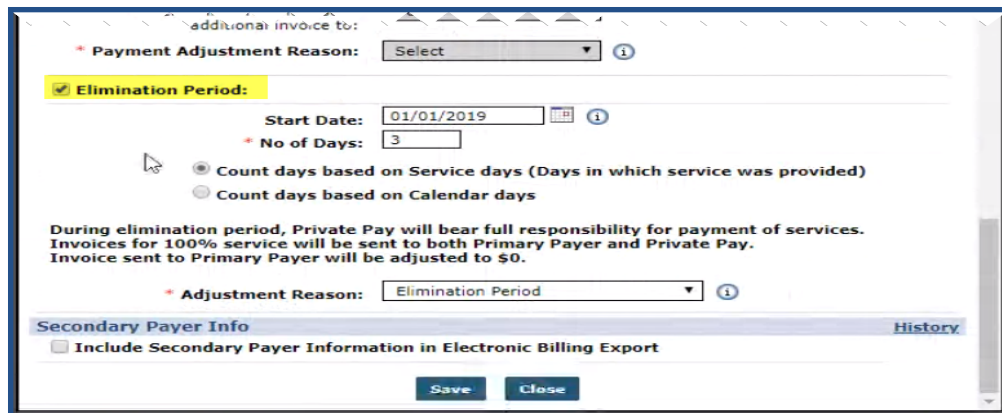
Additional Bill Info – Elimination Period Options

Field	Description
Start Date	Specify a Start Date OR leave blank. Leaving this field blank sets the first day of service as the Start Date of the Elimination Period.
***No. of Days**	(Required) Enter the number of days of the Elimination Period.

Field	Description
Count Days based on…	The available radio buttons are to specify how the Elimination Period is calculated. The set number of days can either be **Calendar Days** (one week is 7 Days) or **Service Days** (days in which a service is performed).
*Adjustment Reason	(Required) Select *Elimination Period* from the menu to specify the adjustment reason.

Using the configuration set in the image above as an example, the Patient is financially responsible (under Private Pay) for the first 3 **Service Days** (days in which service is provided – in this case January 5, 7, and 9) before the Payer coverage takes effect on the 4th day of service (in this case, January 10, as illustrated in the image below).

Patient Calendar – Elimination Period based on Service Days

If **Calendar Days** is selected, then the first 3 days are counted as Elimination Period; even if no service is scheduled on the 3rd day (in this case, January 1, 2, and 3) before the Payer coverage takes effect on the 4th Calendar Day (in this case, January 4, as illustrated in the image below).

Patient Calendar – Elimination Period based on Calendar Days

Secondary Insurance Billing Enhancement

Some Patients have multiple long-term contracts, each having their own billing rules such as Weekly Maximums and Elimination Periods. To ensure that these billing rules work consecutively when there are two simultaneous long-term contracts, a *Secondary Contract* option has been added to the **Limit Maximum Payer Contribution** feature (initially only allowing for Private Pay).

To access this setting, navigate to the Patient's Contract page (***Patient > Contract***). Click on the Additional Options link for the applicable Contract. Select the **Additional Bill Info** option from the menu to access the window.
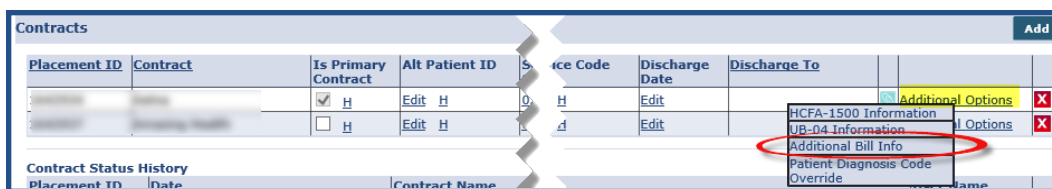
Additional Options > Additional Bill Info

On the *Additional Bill Info* window, select the Limit Maximum Payer Contribution per period option, and enter the applicable maximums per period. On the **When limit is reached, send additional invoice to** field, select the applicable Contract from the available options.
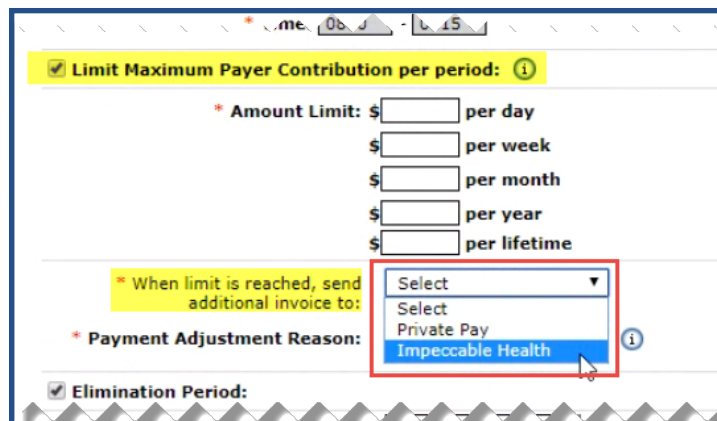
Limit Maximum Payer Contribution - Secondary Contract Options

Secondary Billing for Linked Contracts

The system supports Secondary Billing for Linked Contract Patients who have additional insurance, aside from Medicaid. Once enabled and configured, Secondary Billing key information is included in the claim sent to Payers. Refer to the Secondary Billing Job Aid for details and instructions.

Combined Monthly Invoice Date

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

Several Providers work with Contracts that require a combined monthly invoice. Typically, Providers invoice every week to run their Payroll. The **Monthly Invoice Date** field (dropdown) in the *Billing/Collections* tab (***Admin > Contract Setup > Search Contract***) is used to indicate the date per month (*1-28*) to merge invoices, as illustrated in the following image. The number indicated specifies the day of the month to merge existing invoices for the previous month for the selected Contract.

This setting allows Providers to invoice weekly yet hold exports until a specified date (day of the month) to create one Invoice, per Contract, per Patient, per month for transmission to a Payer.

Contract Setup – Monthly Invoice Date Field

Specifying a **Monthly Invoice Date** overwrites and disables the **Organize Invoices By** settings and sets it to **One Invoice Per Patient, Period Month Caregiver All**. This setting also deselects the **Invoice Only One Daily Case per Patient Per Day** checkbox.

The Monthly Invoice process is only enabled for the Contract when a date (number) is specified in the **Monthly Invoice Date** field; otherwise, the invoice process runs according to contract setup configurations.

Merge Invoice Job

The **Merge Invoice Job** runs on the specified date at 1:00 AM EST. This job merges all invoices for the previous month producing one invoice per Contract, per Patient, per month and then exporting. The process also creates invoices for up to 12 months for any visits that have invoiced since the last Monthly Invoice Job.

If after Merge Invoice Job runs, the **Monthly Invoice Date** is changed to a greater number (day) than the current, then the Merge Invoice Job runs again on the new date.

Merge Multiple Billed Visits into a New Invoice Batch

DISCLAIMER
Agencies must be on the latest version of the Prebilling module. Please contact HHAX Support Team for details, setup, and guidance.

To run Payroll, Agencies must first invoice the corresponding visits in the system. While Payroll is *generally* processed on a weekly basis, some Contracts require an Agency to submit a consolidated invoice on a monthly basis. Agencies with these Contracts previously took steps to un-batch, delete, and re-invoice the weekly billed visits to match the monthly billing process.

With this feature enabled, Providers can select and merge multiple previously billed visits directly without having to un-batch and re-invoice. Once merged, all existing invoice information (such as Invoice and Batch Number) associated to the visits are updated accordingly.

Once executed, progress can be tracked on the *Process Monitor* (**Admin > Process Monitor**).

Notes:
- *Exported, Paid, or Linked Contract visits cannot be merged.*
- *This feature does not apply to Mileage, Supply, Expense, or Banked Minutes.*
- *Role-based permission must be enabled. Refer to the Permissions to Merge Invoiced Billed Visits section.*

Merging Previously Invoiced Visits

To merge previously billed visits, navigate to **Billing > Invoice Search > By Visit** and search for applicable visits (use the search filters to narrow searches, such as a date range). This function applies only to eligible visits; visits that have not been exported or paid.

From the search results, on the *Invoiced Visit Search* page, select the visits individually or use the left most selector column to choose all eligible visits (on this page). Ineligible visits are not available to select. At the top of the page a selection count indicates how many visits have been selected, as seen in the image below. This counter increases/decreased as visits are selected/unselected.

Invoiced Visit Search (Selection Counter)

From here, save the selected visits and continue to generate other visit searches to add to the new merged invoice batch. Refer to the table under the following image for descriptions of actionable buttons.
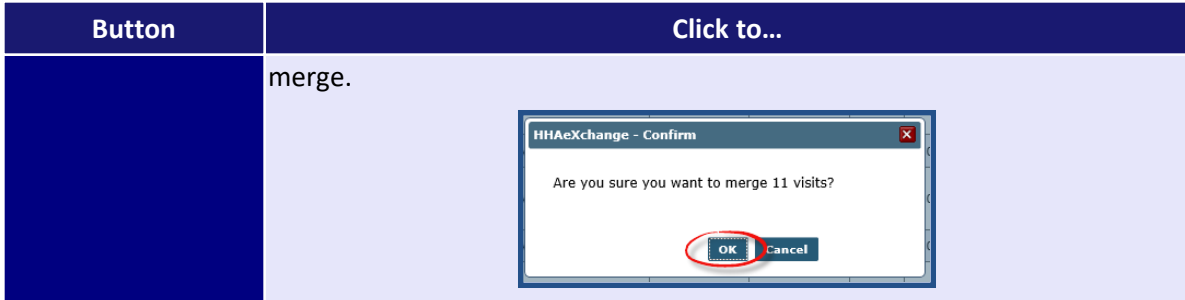

Eligible Visits to Merge

Note: If another user has already selected and saved visits to merge, then the system does not allow those visits to be saved/merged by the current user. Refer to the Multi-User Validation Options *section for details.*

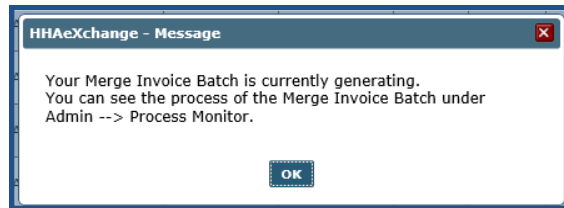| Button	Click to…
Save	save the selected visits for the merge function. Users can conduct further searches and click on *Save* to add to the merge.
Select All & Save	select *all* visits on the search results (on all pages) for the merge function. *Note: The* **Save** *and* **Select All & Save** *buttons save selections as one navigates from page to page or reinitiates login. Saved visits are not merged until* **Merge Invoice** *is selected.*
Reset	deselect all selected visits and clear search criteria; routes back to the *Invoiced Visit Search* page.
Merge Invoice	merge all selected saved visits to a new invoice. Click *OK* to confirm the

Button	Click to…
	merge. ![HHAeXchange - Confirm dialog: "Are you sure you want to merge 11 visits?" with OK and Cancel buttons; OK is circled in red]

Upon clicking on the **Merge Invoice** button, a confirmation window appears to confirm the merge. Click **OK** to continue.

HHAeXchange – Confirm

Are you sure you want to merge 11 visits?

OK   Cancel
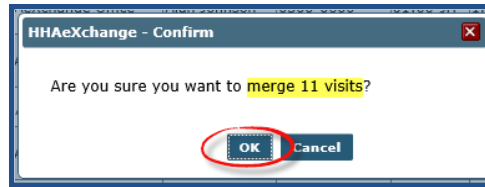
Another message window appears. The merge process can be tracked on the *Process Monitor* (**Admin > Process Monitor**). Click **OK** to continue.

HHAeXchange – Message

Your Merge Invoice Batch is currently generating.
You can see the process of the Merge Invoice Batch under
Admin --> Process Monitor.

OK

On the *Process Monitor*, merged invoice batches appear as *Generate Merge Invoice Batch* with process details such as the user who executed the merge, the Batch Date and Number, and other particulars (as seen in the following image).

HHAeXchange - Process Monitor

Category: Billing   Current Status: Completed - Last Hour

Page 1 of 1

Process	Started By	Details	Request Start Time	Process Start Time	Process End Time	Duration
Generate Merge Invoice Batch	krunalml	Batch Date - 02/24/2020 Batch # - 24005EXQA00012	02/24/2020 02:21:46AM	02/24/2020 02:21:50AM	02/24/2020 02:21:50AM	00:00
Generate Merge Invoice Batch	shekhussp	Batch Date - 02/24/2020 Batch # - 13611EXQA00213QA	02/24/2020 02:19:05AM	02/24/2020 02:19:14AM	02/24/2020 02:19:14AM	00:00
Generate Merge Invoice Batch	shekhussp	Batch Date - 02/24/2020 Batch # - 13611EXQA00212	02/24/2020 02:19:05AM	02/24/2020 02:19:12AM	02/24/2020 02:19:13AM	00:00

Close

Process Monitor: Generate Merge Invoice Batch

On the *Bill Info* tab (**Patient Calendar > Bill Visit**), a new **Invoice Number** is displayed. The **Deleted Invoice Number(s)** field shows the previous invoices which were deleted and merged to form the new invoice in the process.

Bill Info Tab: Merged Invoice

Permissions to Merge Invoiced Billed Visits

To assign permissions to a role, navigate to *Admin > User Management > Edit Roles*. Select *Billing* under the **Section** field and select applicable roles from the **Roles** dropdown. Select the **Merge Invoiced Billed Visits** checkbox and click *Save* to finalize.
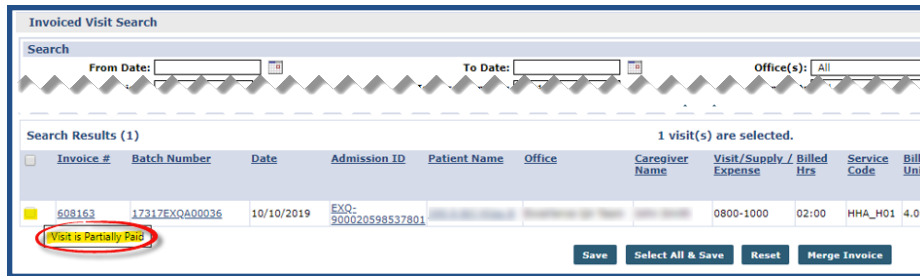

Permission: Merge Invoiced Billed Visits

Ineligible Visits

Ineligible visits are unavailable to select, and a validation reason can be seen when hovering over the checkbox, as seen in the following image.

Ineligible Visit to Merge

The selection checkbox for visits that cannot be merged is disabled for the following conditions:

- Visit is Locked
- Batch is In Review
- Batch is Approved
- Batch is Billed
- Visit Is Exported
- Visit is Partially Paid
- Visit is Paid
- Payer Patient's visits (i.e., this functionality does not apply to Linked Payer Contract Patients)

This action cannot be completed as the invoice includes records from both before and after the Closing Date. Invoices cannot be updated if they contain any records which fall before the Closing Date.

Merge Process Validations

Validations on Save and Select All & Save

The following validations are applicable when clicking on the *Save* or *Select All & Save* buttons.

If an invoice batch is currently processing for a selected visit, then the system issues a warning indicating that one or more of the selected visits is already in process. Select *OK* to process the batch with the newly selected visits and the previously selected visits are automatically removed from the batch.
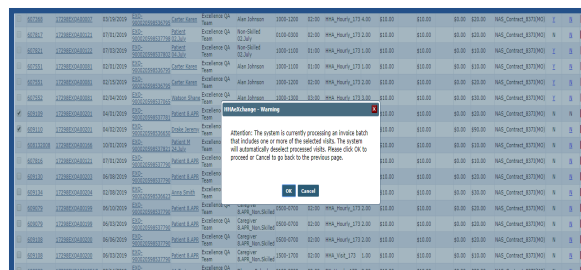
If a *Delete Invoice Batch* is pending, then the system issues a warning stating that no invoice batch can be created for the selected visits (under a specific Contract) until the current batch is merged.
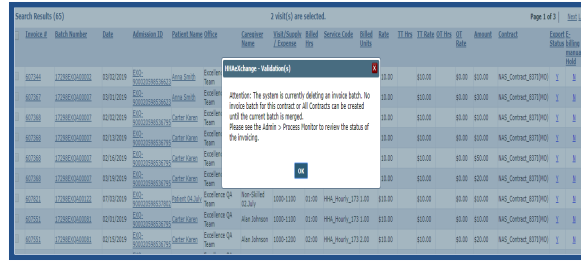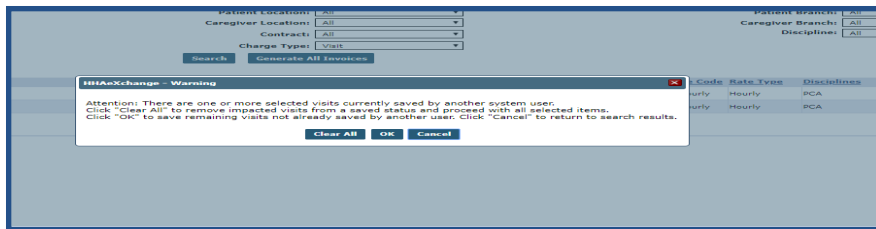

If general system issues are occurring, then the system issues a warning asking to attempt the operation at a later time.
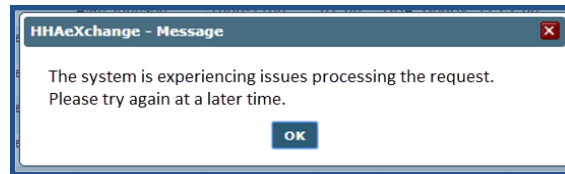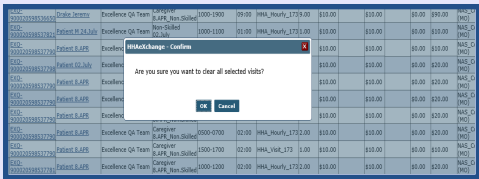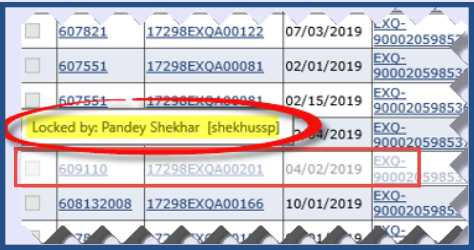

Multi-User Validation Options

If a visit has already been saved by a user (User A) and another user (User B) attempts to save the same visit for merging, then the system issues a validation prompting for further action from User B: *Clear All* or *OK*.

Validation: Multi-Users/Same Billed Visits Selected

If selected…	Then…
Clear All	a confirmation window appears to confirm clearing for User B to proceed.
OK	all visits are saved minus the commonly selected which appear as un-selectable, with a tooltip indicating that it is locked by another user (Locked by Username).

If selected…	Then…

For example:
- User A selects and saves visits V1, V2, V3, V4, and V5 (5 visits saved).
- User B selects visits V1, V2, V6, and V7. Because User A has already selected V1 and V2, User B is presented with a system message prompting to either *Clear All* or *OK*.

If *Clear All* is selected, then:
Visits V3, V4, and V5 remain selected while V1 and V2 are cleared for User A.
For User B, visits V1, V2, V6, and V7 are selected.

If *OK* is selected, then:
Visits V1, V2, V3, V4, and V5 are selected for User A.
For User B, visits V6 and V7 are selected; visits V1 and V2 are saved for User A.

Attempting to Delete a Visit in the Merge Process Validation

This validation stops a visit from being deleted if it is in the merging process. The **Reason** field populates the details stating that the visit cannot be deleted because it is within a batch that is merging (as seen in the following image).

Validation: Deleting Visit Within a Batch in Merge Process

Billing Review Details

When the **Monthly Invoice** rule is enabled for any Contract, visits are not allowed for export unless the **Monthly Invoice Date** is passed. To review such visits, select **Monthly Invoice** from the **On Hold Reason** dropdown field in the *Billing Review* page (***Billing > Billing Review***) search filters.

On Hold Reason Filter – Monthly Invoice

*Note: The **Monthly Invoice** rule/option is enabled by System Administration.*

If any visit is held because of the Monthly Invoice rule, then **Held until Monthly Invoice Date** is indicated under the **On Hold Reason** (column) for that visit, as seen in the image below.

On Hold Reason Column – Held Until Monthly Invoice Date

Entering Revenue and Taxonomy Codes (Linked Contracts)

In the HHAX system, Payers set the Service Code Rates to include the **Revenue** and **Taxonomy Codes** (per rate). Payers have the option to require Providers to enter their own unique **Revenue** and **Taxonomy Codes** via the *Reference Table Management* functionality (***Admin > Reference Table Management > Contract Service Code***). If a Provider is required to enter these codes, the **Revenue Code** and **Taxonomy Code** fields are required (as denoted with a red asterisk).

Contract Service Code – Reference Table Managment

If a Payer does not enable the Provider to set the **Revenue Code** and/or the **Taxonomy Code**, the system applies the Payer-assigned codes by default (although the fields may appear editable on the Service Code screen).

Contract Service Code – Reference Table Management

Billing Review

The Billing Review verifies existing Revenue and Taxonomy Codes for a particular visit based on settings on the Provider level. Therefore, if a setting is enabled at the Provider level, the Service Code for that visit has Revenue and Taxonomy data based on those settings. If a setting is not enabled on the Provider level, then the Revenue and Taxonomy Code requirements are applied based on a Payer Service Code level.

If a visit fails any of the set rules, then it appears in the *Billing Review* page (as seen in the images below). The Billing Review function holds visits without a Revenue and/or Taxonomy Code so that claims are not rejected.

Missing Taxonomy Code

Missing Revenue Code

Processing Files - Change Export to Apply Provider Data

Once an e-billing batch is created, selected records appear in the Processing Files page and an Export can be performed. E-Billing exports must use the Provider Revenue and Taxonomy Codes associated with a given Service Code for a visit (as required by the Payer).

File Processing

E-Billing > Void and Adjustment Claim - Export changes to apply Provider Codes data

Once an e-billing batch has been generated, a Provider can resubmit claims (as an *Original*, an *Adjustment*, or a *Void*). In this case, the new batch export contains Provider/Payer Service Code details based on the Provider-level setup. Click on the Details link to view on the Batch Details window (as seen in the image below). To search for claims, navigate to ***Billing > Electronic Billing > Batch Search (Linked)***. To resubmit claims, navigate to ***Billing > Electronic Billing > Resubmit Claims (Linked)***.

Batch Details

Override Patient Rate for Mileage

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

Rate Update

Rates can be updated retroactively when adding a new rate, as if updating a service. Click on the **Update Rate** button on the *Contract Setup* page (**Admin > Contract Setup**) under the *Billing Rates* tab.

On the *Update Rate* window, update the **From/To Date** and **Rate** fields, as applicable. Click *Save* to finalize.

Update Rate

Override Rate for Mileage Event

In addition, a Patient Override Rate for Mileage can be updated at the Patient level (**Patient > Rates**). This rate also displays in the Invoice level (as seen in the image below).

Mileage Rate Override at the Patient Level

Mileage Rate displayed on Invoice Page

Other Updates to the Mileage Events Function

History Audit

The system has been updated to track and archive all Mileage events. This allows Providers to view Mileage history from creation to modification. When a shift is modified, the change is reflected on the audit log. To access, navigate to *Patient > Calendar*, click on the applicable Mileage Event, and click on the History link.

Mileage History

Prevent Service Flag from Unselecting Mileage Event

This validation states that once a Mileage service is set and saved, then the visit cannot be edited, as seen in the image below.

Mileage Service Validation

Utilize Billable Service for Authorization Allocation

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

DISCLAIMER

This feature applies only to Agencies that have been updated/migrated to the latest versions of the Caregiver Compliance, Prebilling Optimizations, and Authorization Optimizations (Phases 1 and 2). Please contact HHAX Support Team for further details and/or to enable the feature.

The system calculates the Authorization units used based on Billable Service Time rather than the Scheduled Time. If the Billable Service Time is less than the Scheduled Time, then the Authorization units are returned to the Authorization. For example, the system applies 2 Authorization units for a visit that is scheduled for 2 hours. If this visit is confirmed for 1.5 hours, then the system adjusts the applied Authorization units to 1.5 and returns the remaining .5 to the Authorization.

This feature applies only to *Hourly Type* visits. Authorization units are rounded to the nearest 15-minute interval.

Once the feature is enabled by HHAX System Administration (HHAX Support Team), the **Allocate Visit Authorizations based on Billable Service** checkbox shows as selected (read-only) in the *Scheduling/Confirmation* tab of the *Contract Setup* page (***Admin > Contract Setup > Contract Search***).

To enable at the Agency level, select the **Recalculate Visit Authorization units based on Billing Adjustment** checkbox, as illustrated in the image below.
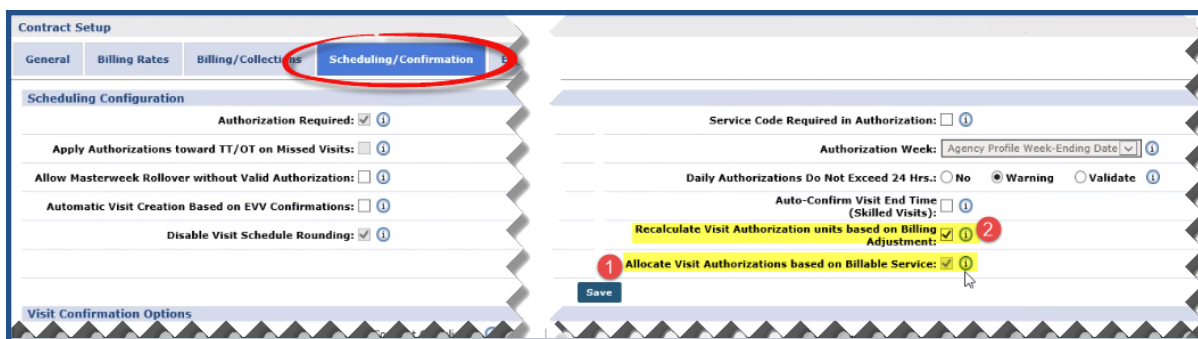
Authorization Allocation Adjustment in Contract Setup

Once this feature is enabled, all active Authorizations are recalculated. Once recalculated, if there are any visits (from start date of active authorization) that have Billable Service Time less than Scheduled Time, then the Authorization units are updated and the difference is returned to the active Authorization.

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Scenarios

Billable Service Adjustments Based on Confirmed Times

As mentioned above, this feature applies only to visits with an *Hourly* Rate Type. Adjustments apply to the Visit Confirmation Time. The scenarios below apply to *Skilled* and *Non-Skilled visits*.

	Details	Outcome
1	**Visit Rate Type:** Hourly **Schedule Time:** 4 hours **Confirmed Time:** 2 hours	System uses only 2 Authorized units based on the Confirmed Time; the remaining 2 units are returned to the Authorization. Billable Time is 2 hours (2 units).
2	**Visit Rate Type:** Hourly **Schedule Time:** 4 hours **Confirmed Time:** 5 hours	System uses 4 Authorized units based on Scheduled time; Confirmed Time exceeds Scheduled Time.

Visit Rounding Scenarios

For the following scenarios, the **Disable Visit Schedule Rounding** and **Disable Visit Confirmation Rounding** checkboxes have been selected in the *Scheduling/Confirmation* tab (**Admin > Contract Setup**).

	Details	Outcome
1	**Visit Rate Type:** Hourly **Schedule Time:** 13:00-16:00 (3 hours) **Confirmed Time:** 13:00-14:07 (1 hour, 7 minutes)	System uses 1 Authorization unit based on the Confirmed Time; rounded (down) to the nearest 15-minute interval.
2	**Visit Rate Type:** Hourly **Schedule Time:** 13:00-16:00 (3 hours) **Confirmed Time:** 13:00-14:08 (1 hour, 8 minutes)	System uses 1.25 Authorization units based on the Confirmed Time; rounded (up) to the nearest 15-minute interval.

Calculation of Billing Adjustment

The scenarios below apply to both *Skilled* and *Non-Skilled* visits. In addition to the selected **Allocate Visit Authorizations based on Billable Service** checkbox, the **Recalculate Visit Authorization Units based on Billing Adjustment** checkbox must also be selected (both in the *Scheduling/Confirmation* tab in the *Contract Setup* page). Only *Hourly* **Rate Type** applies to these scenarios. For all other Rate Types, the system applies the scheduled time Authorization units.

	Details	Outcome
1	**Visit Rate Type:** Hourly **Schedule time:** 4 hours **Confirmed Time:** No confirmed time yet **Billing Adjustment:** +1	System uses only 4+1=5 Authorized units (Schedule time +Billing Adjustment).

	Details	Outcome
2	**Visit Rate Type:** Hourly **Schedule Time:** 4 hours **Confirmed Time:** 2 hours **Billing Adjustment:** -1	System uses 2-1=1 Authorized unit (Billable time =Confirmation time - Billing Adjustment)
3	**Visit Rate Type:** Hourly **Schedule Time:** 4 hours **Confirmed Time:** 2 hours **Billing Adjustment:** +1	System uses only 2+1=3 Authorized units (Billable time =Confirmation time +Billing Adjustment)
4	**Visit Rate Type:** Hourly **Schedule Time:** 4 hours **Confirmed Time:** 4 hours **Billing Adjustment:** +10	System uses 4+10=14 Authorized units (Confirmation time +Billing Adjustment). A validation window warns when the used Authorized units exceed the allocated Authorized units. • If *Yes* is selected, then the system looks for 14 Authorization units. If not available, then the visit(s) turn Pink in the calendar (marked as Unauthorized). • If *No* is selected, then the system removes the entered billing adjustment. The visit is only calculated based on the units used at Confirmation Time. If available, then the visit remains Green (marked as Authorized).

EDI Providers Billing Rates (Linked Contracts)

DISCLAIMER
This feature is activated by HHAX System Administration. Please contact [HHAX Support Team](#) for details, setup, and guidance.

EDI Providers who manage their own rates (with Payer permissions) can import rate information into the HHAX system using the EDI Tool. In turn, Providers can bill visits directly from the system without having to enter/configure complex rate logic in HHAX to match their own system. Via the EDI Tool, Providers can import the **Units**, **Rates**, and **Total Billed Amount** (fields in the Visit *Bill Info* tab).

Midnight Value in Claim File Setup

In the system the **Midnight** value is defined as "*0000*", used to identify the end of one day and the start of the next. While this is a common representation, some Payers define midnight differently. HHAX can configure e-billing to define alternate designations for the **Midnight** value (used to control how these times are treated in claim files). The following table shows the available options.
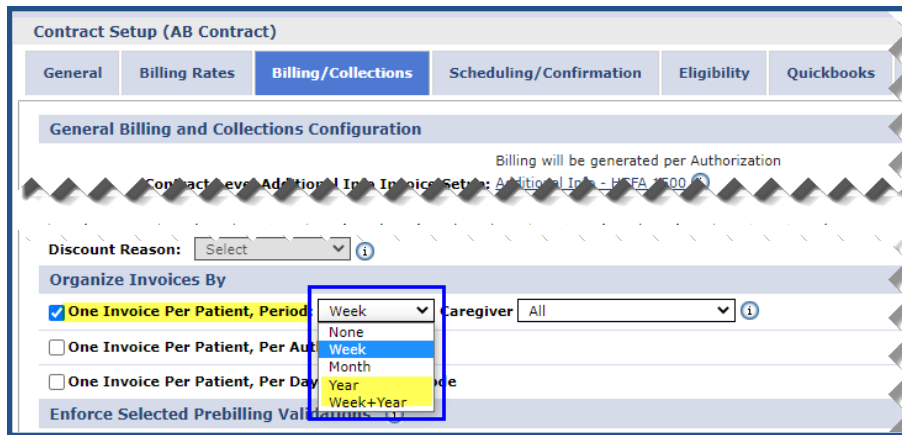
Midnight Start Time Configuration	Midnight End Time Configuration
1 - 0000	1 - 0000
1 - 0000	1 - 0000
2 - 0001	2 - 2359
3 - 2400	3 - 2400

Note: *This only applies to 837P.*

Invoice Grouping Options

In an effort to prevent claim rejections, *Year* and *Week+Year* invoice grouping options have been added to the *Contract Setup, Billing/Collections* page (***Admin > Contract Setup > Billing/Collections***) to prevent visits from different years to be grouped into one invoice.

For the selected Contract, navigate to the *Organize Invoices By* section and select *Week* or *Week+Year* from the **One Invoice Per Patient, Period** dropdown field, as seen in the image below.

Invoice Grouping Options: Year & Week+Year

Select…	To…
Year	Group invoices by year for a specific calendar year (for example, one invoice for 2020, and one invoice for 2021)
Week+Year	Group invoices by week and for a specific calendar year. In this case, invoices are separated by week, and then by year. For example, in the week of Sunday 12/26/2021-Saturday 1/1/2022, two invoices are created, as follows: • Invoice 1: 12/26/2021 - 12/31/2021 • Invoice 2: 1/1/2022 - 1/1/2022