Claim Monitoring User Guide

V12 – August 2025

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Overview

It can be difficult to identify what is going on with your claims after they have been accepted by the payer. To find out, you must follow up with payers which can be time-consuming and expensive. With the Claim Monitoring application, you can schedule automated claim status inquiries to connect more easily with payers and identify your claim statuses in a payer's adjudication system. Claim Monitoring also gives you more insight on when you should expect EOBs from payers.

Robotic Process Automation (RPA)

Claim Monitoring uses Robotic Process Automation (RPA) in addition to 276/277 transactions and Monitoring Schedules (see the Claim Monitoring Schedules section for more information on Monitoring Schedules) to perform automated claim status checks and identify claims that require further action.

For a list of Claim Monitoring supported payers via EDI and RPA, see the claim status payer coverage list.

RPA Claim Monitoring User Login Template

Before Waystar can provide you with claim statuses via RPA, you must first set up credentials with your payer(s). Payers may require you to set up security questions and answers. You will need to return all applicable payer credentialing information to Waystar, including any security questions and answers (matching the exact text with punctuation and capitalization) you set up with your payer(s).

Additionally, Waystar requires separate login credentials to be used exclusively by Waystar. Click **HERE** to download the RPA Claim Monitoring & FISS Automated Claim Entry Waystar Login Template.

Note: Click the **Download** button at the top of the document preview screen to download the Excel template.

276/277 Claim Monitoring Real-Time EDI API

For more information about this feature, or to have this feature activated, please contact Waystar Support.

As technology expands and integration opportunities increase with each PM and/or HIS system, Waystar wants to provide an integrated opportunity for clients to send and receive real-time EDI claim status updates.

With this feature, Waystar clients will be able to:

- Send a 276 request via a synchronous API call
- Receive a 277 response in return.

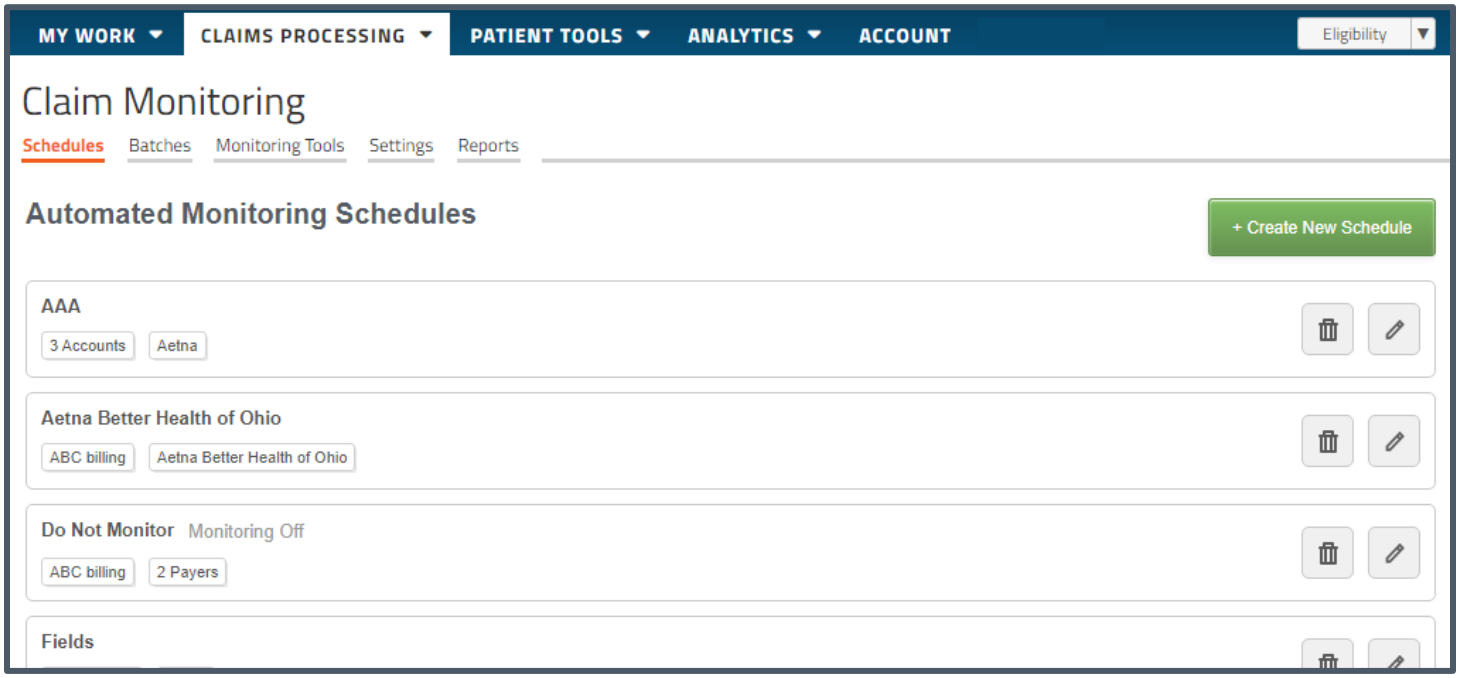
Utilizing this feature can result in benefits, such as:

- Reduced time on manual claim status checks
- Increased integration into streamlined end-user workflow within the host system.

Claim Monitoring schedules

Overview

The **CLAIMS PROCESSING** > **Claim Monitoring** > **Schedules** screen is where you will schedule your automated status inquiries to track claims throughout the payer adjudication process. Payer responses to these automated status inquiries will be available in the Payer Follow-up work center, the associated Claim History screens and the Monitoring Activity report. Additionally, if you work out of a practice management/health information system, your responses can also be delivered directly to your system via nightly-scheduled reports. To set up these automated status checks, you will need to create new and/or edit existing monitoring schedules.

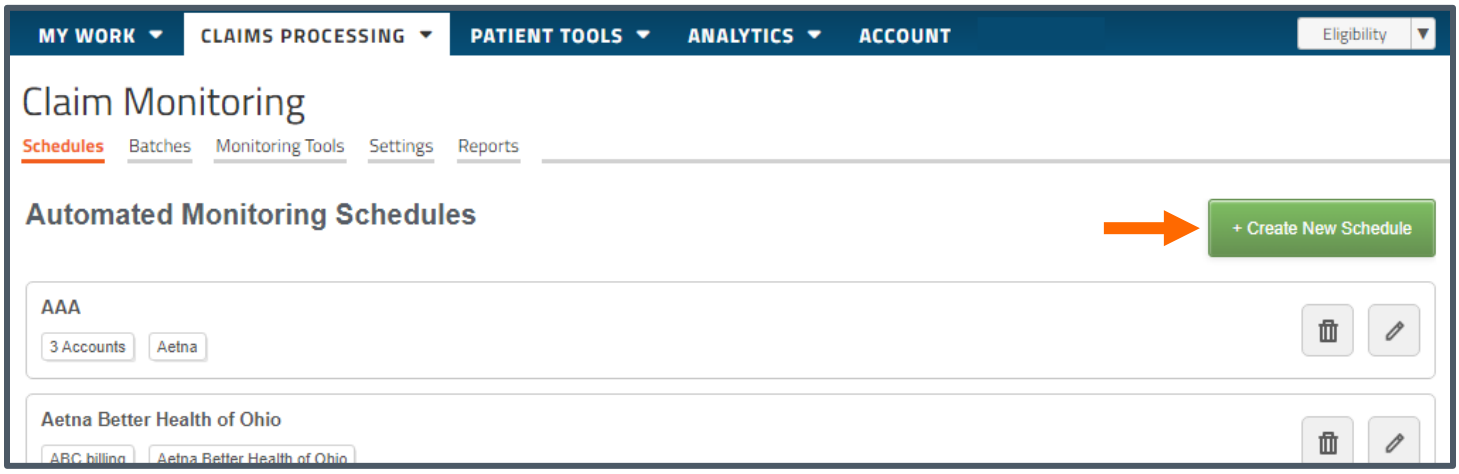


Creating a new Claim Monitoring schedule

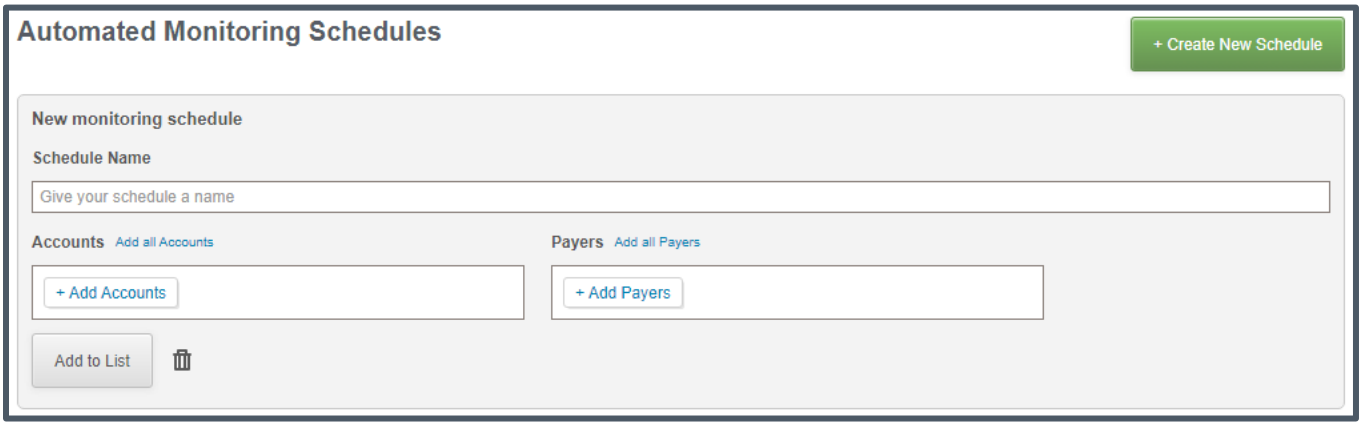
While the Catch-All Schedule will automatically be available to you, you may need to create a custom schedule to better accommodate your workflow.

To create a new Claim Monitoring schedule:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Schedules** screen.
2. Click the **Create New Schedule** button.



The **New monitoring schedule** area will open below the button.



3. Enter a unique **Schedule Name** for your new monitoring schedule. This name will typically be related to the payers, providers, or accounts you will be monitoring from the schedule.
4. Click the **Add Accounts** link and enter the account name(s) or ID(s) you would like to schedule for automated claim status checks.
5. Click the **Add Payers** link and enter the payer name(s) or ID(s) you would like to schedule for automated claim status checks.

   Note: To add all accounts or payers associated with your domain to the schedule, click the **Add all Accounts** or **Add all Payers** links.
6. After you are satisfied with the entered information, click the **Add to List** button to create the custom Claim Monitoring schedule.

Understanding custom schedule responses

You will not begin receiving responses for the combination of accounts and payers set up in your custom schedule until your first check status event date has passed (see the Adding a check status event to a Claim Monitoring schedule section for more information about adding check status events to a schedule). For example, if your first check status event is set up for day seven, you will receive your first payer response seven days after you created the custom schedule.

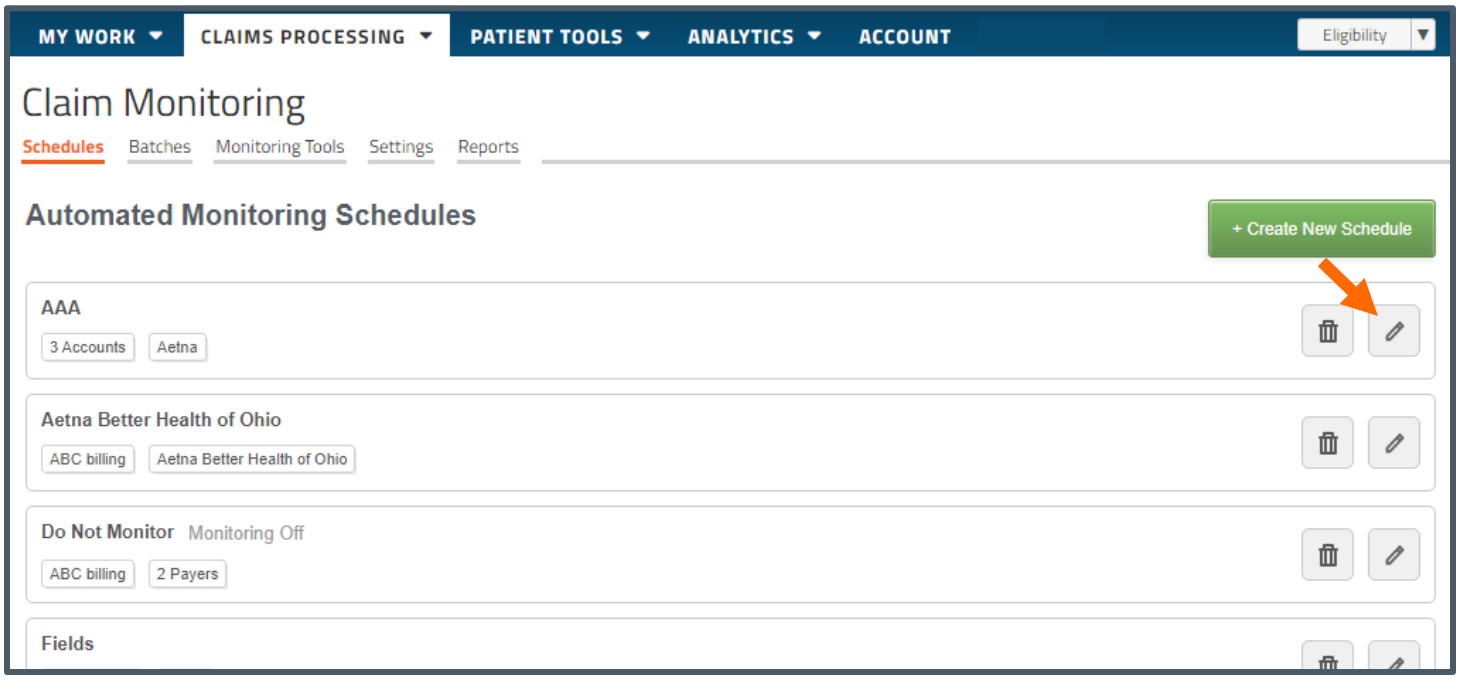
Editing an existing Claim Monitoring schedule

Waystar will provide a Catch-All Schedule, but you can also set up custom monitoring schedules that will better fit your follow-up workflow. Claim Monitoring allows you to update any of previously entered schedule information. You can also make changes to when and how frequently you would like automatic status checks sent to the payer(s).

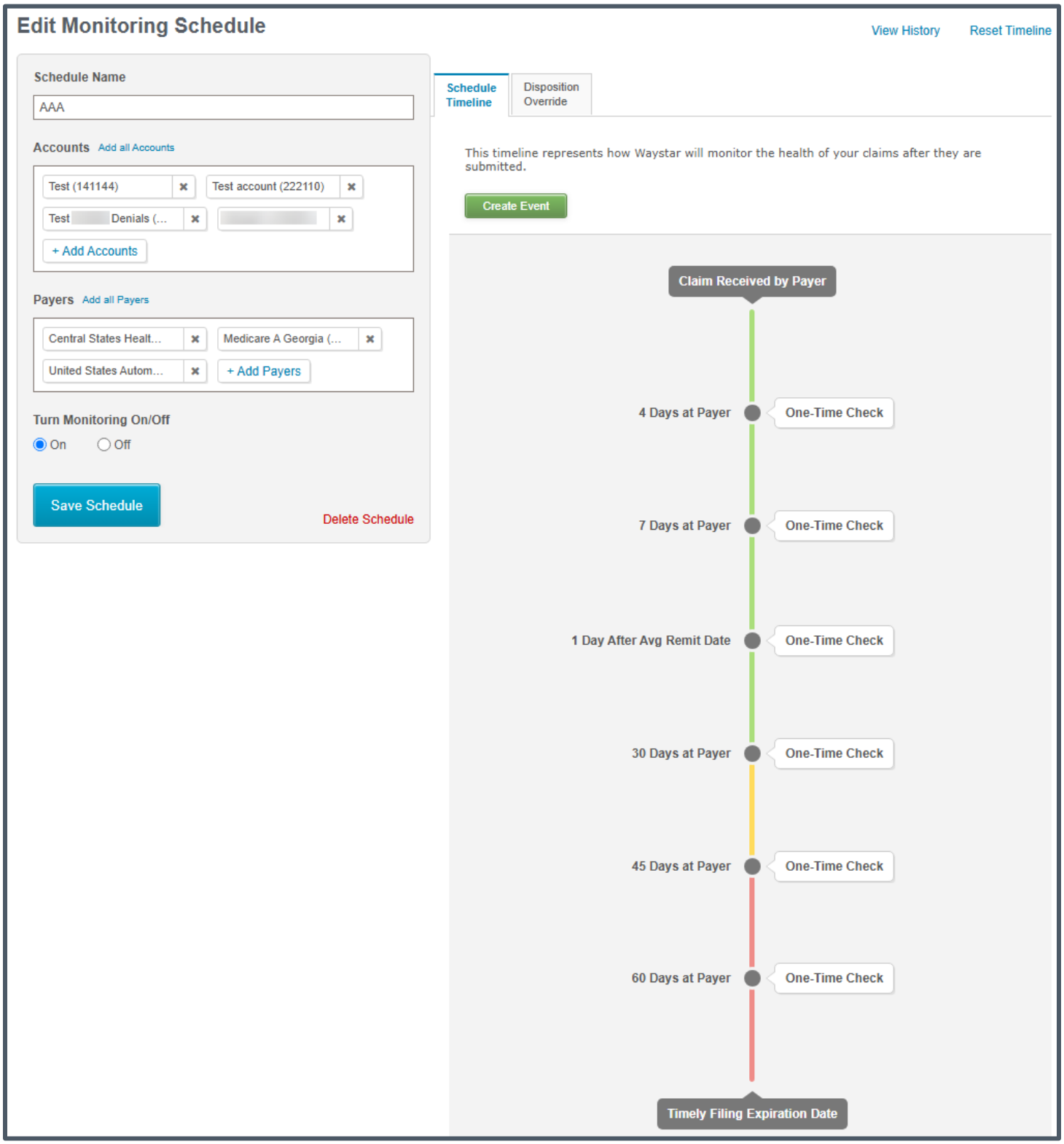
Starting to edit a Claim Monitoring schedule

To start editing any of the Claim Monitoring schedules:

1. Go to the **CLAIMS PROCESSING > Claim Monitoring > Schedules** screen.
2. Click the edit icon on the right of the appropriate monitoring schedule row.



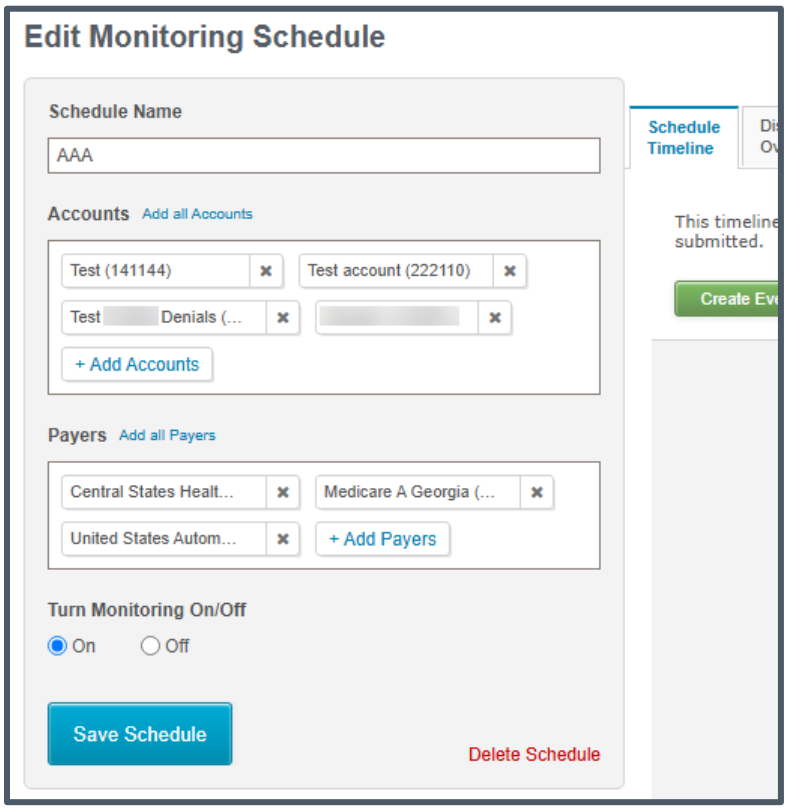
The Edit Monitoring Schedule screen will open, from where you can perform actions explained in this section.



Editing Claim Monitoring schedules

To edit Claim Monitoring schedules:

1. Go to the Edit Monitoring Schedule screen.
2. The following are edits you can make to accounts, payers, and other information related to the monitoring schedule:



   - Edit a schedule name in the **Schedule Name** field.
   - Add or remove accounts listed in the **Accounts** field. Automated status checks will be sent to the selected payers for these accounts.

     Note: Click the **Add all Accounts** link at the top of the field to add all accounts in your domain.
   - Add or remove payers listed in the Payers field. These payers will receive the automated status checks associated with this monitoring schedule.

     Note: Click the **Add all Payers** link at the top of the field to add all payers associated with your domain.
   - Monitor or stop monitoring for the selected combination of account(s) and payer(s) by selecting the **On** or **Off** radio buttons in the **Turn Monitoring On/Off** section. See the Turning monitoring schedules on or off section for more information.
3. When satisfied with your changes, click the **Save Schedule** button to update the monitoring schedule.

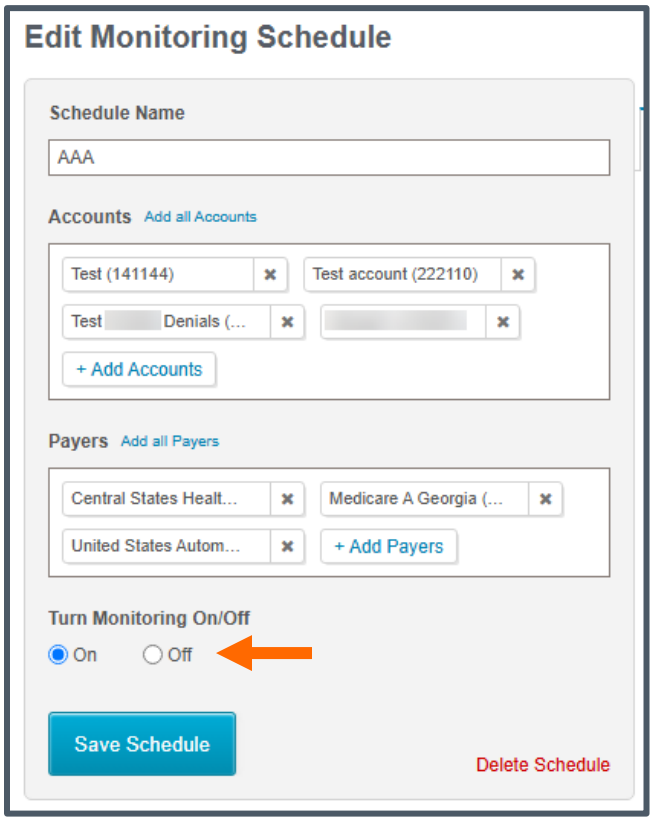
Turning monitoring schedules on or off

You can activate or deactivate any Claim Monitoring schedule without making any other changes to the schedule.

To turn monitoring schedules on or off:

1. Go to the Edit Monitoring Schedule screen.
2. Click either the **On** or **Off** radio button in the Turn Monitoring On/Off section.
   - If you turn OFF a monitoring schedule, no inquiries will be sent for the combination of payers and accounts included in that schedule.

     Note: If you do not want to monitor a specific payer, you will need to create a schedule for the appropriate payer and complete the above steps to turn off monitoring for that payer.
   - If you turn ON a monitoring schedule, Claim Monitoring will resume sending inquires for the accounts and payers in the schedule.
3. Click the **Save Schedule** button.



Deleting a Claim Monitoring schedule

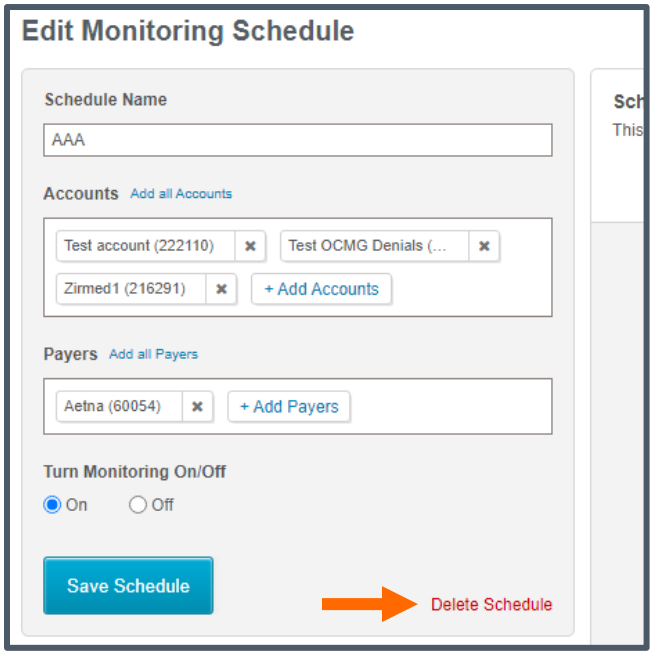
While you are editing a Claim Monitoring schedule, you also have the option of deleting the schedules.

To delete a monitoring schedule:

1. Go to the Edit Monitoring Schedule screen.
2. Click the **Delete Schedule** link at the bottom of the schedule detail fields.

   After clicking the link, you will then be asked to confirm the action.
3. Click **Yes** to continue to delete the schedule.

   All accounts and payers previously applied to the deleted schedule will be added to the Catch-All Monitoring Schedule (see the Viewing the Catch-All Schedule section for more information).



Claim Monitoring scheduled build times

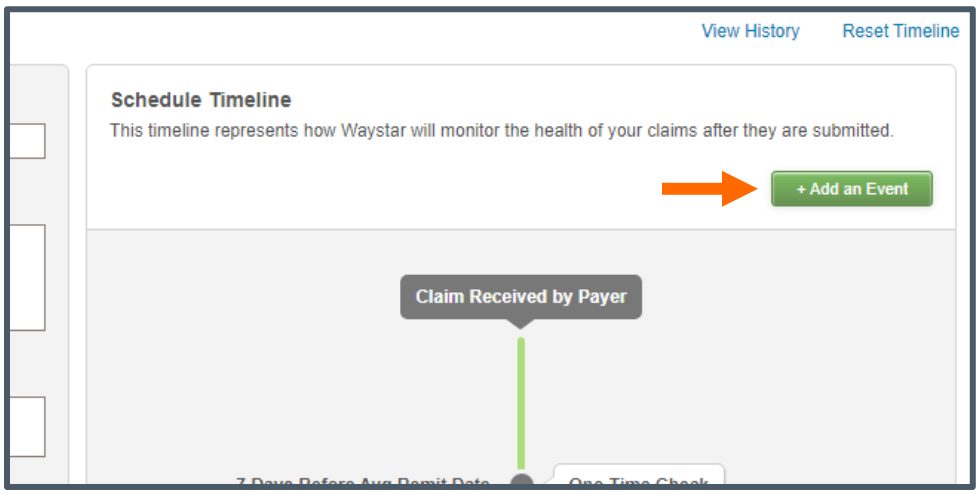
The following are the Claim Monitoring scheduled build times (all times Eastern):

- Clearinghouse: 6:30AM, 10:30AM, 2:30PM, 6:30PM, 8:30PM
- Non-clearinghouse: 12PM, 2PM, 4PM

Adding a check status event to a Claim Monitoring schedule

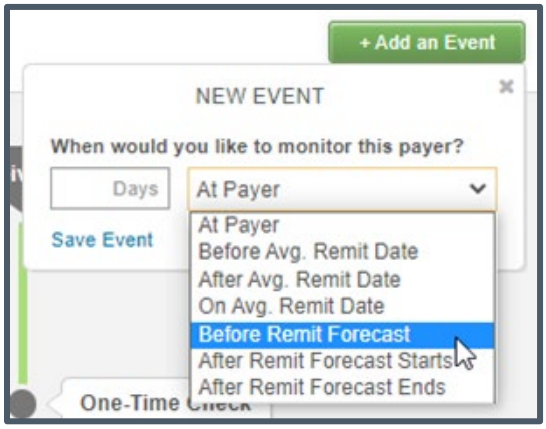
To add a check status event to an existing Claim Monitoring schedule:

1. Go to the Edit Monitoring Schedule screen.
2. Click the **Add an Event** button at the top of the screen.



The NEW EVENT screen will open below the button.

3. Enter when, in days, you would like the inquiry sent in relation to the reference point.
4. From the dropdown, select one of the following points during the adjudication process:



- **At Payer**: When the payer received the claim.
- **Before Avg. Remit Date**: Before the calculated average date when you receive remits from the selected payer(s).
- **After Avg. Remit Date**: After the calculated average date when you receive remits from the selected payer(s).
- **On Avg. Remit Date**: The calculated average date when you receive remits from the selected payer(s).
- **Before Remit Forecast**: Set the number of days before the Remit Forecast screen starts for when you want to status a claim. Use for a proactive identification workflow with Claim Monitoring.
- **After Remit Forecast Starts**: Status claims if we haven't received a remit prior to the forecast screen starting. Use to status claims by exception (those that haven't received a remit or other finalized status), while still being a bit proactive.
- **After Remit Forecast Ends** allows you to status claims that have not received a remit or finalized status when expected. Use for an exception-based strategy with Claim Monitoring when you want to focus on claim follow-up for claims that should have completed processing.

For additional Remit Forecast information, see the Remit Forecast Guide.

What is your Average Remit Date?

Depending on whether you are a new or existing customer, your average remit date (mentioned above) is calculated as follows:

- **Existing Clients**: Waystar stores your claims and remit data for a minimum 120 days. Using this data, we calculate the average amount of time it takes for you to receive EOBs for claims that have been accepted by the payer. This Average Remit Date is recalculated daily.
- **New Clients**: For clients that are new to Waystar or don't have the minimum 120 days of claims and remit data, we calculate your Average Remit Date using an aggregate number across all clients submitting claims to that payer. This Average Remit Date is recalculated daily.

Note: If a schedule includes multiple payers, your Average Remit Date is calculated per payer/is payer-specific.

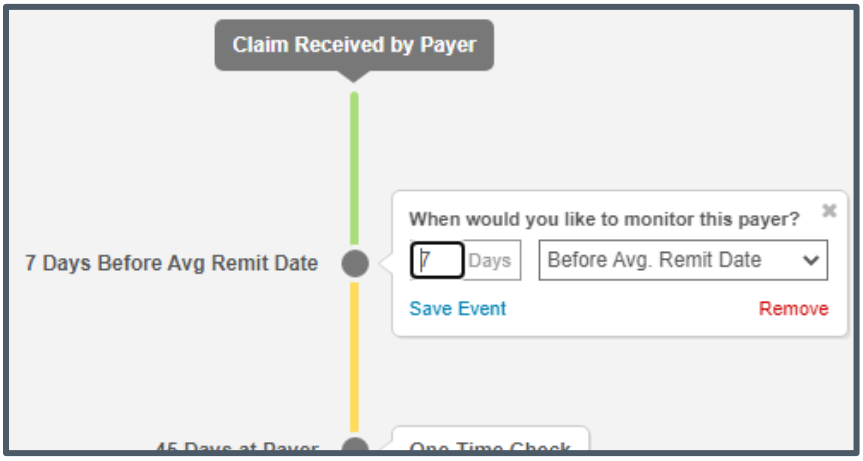
5. Click the **Save Event** button to apply your changes:

Editing a check status event on a Claim Monitoring schedule

To edit a check status event on an existing Claim Monitoring schedule:

1. Go to the Edit Monitoring Schedule screen.
2. Click the status check event that you would like to edit:

A popup will open next to the event.



3. To edit, in days, when inquiry will be sent in relation to the reference point, change the value in the **Days** field.
4. To edit the event reference point, use the dropdown to update:
   - **At Payer**: When the payer received the claim.
   - **Before Avg. Remit Date**: Before the calculated average date when you receive remits from the selected payer(s).
   - **After Avg. Remit Date**: After the calculated average date when you receive remits from the selected payer(s).
   - **On Avg. Remit Date**: The calculated average date when you receive remits from the selected payer(s).

   What is your Average Remit Date?

   Depending on whether you are a new or existing customer, your average remit date (mentioned above) is calculated as follows:

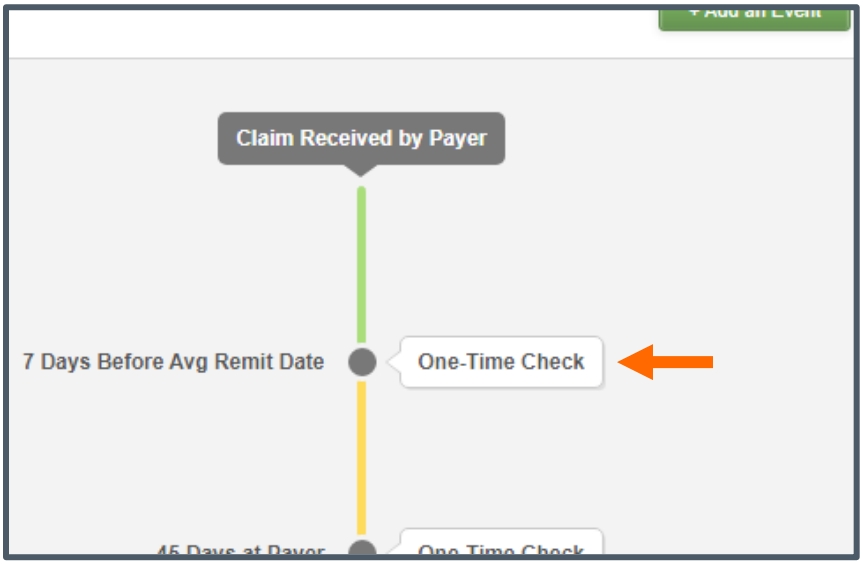
   - **Existing Clients**: Waystar stores your claims and remit data for a minimum 120 days. Using this data, we calculate the average amount of time it takes for you to receive EOBs for claims that have been accepted by the payer. This Average Remit Date is recalculated daily.
   - **New Clients**: For clients that are new to Waystar or don't have the minimum 120 days of claims and remit data, we calculate your Average Remit Date using an aggregate number across all clients submitting claims to that payer. This Average Remit Date is recalculated daily.

   Note: If a schedule includes multiple payers, your Average Remit Date is calculated per payer/is payer-specific.
5. Click the **Save Event** link to apply your changes.

Removing a check status event from a Claim Monitoring schedule

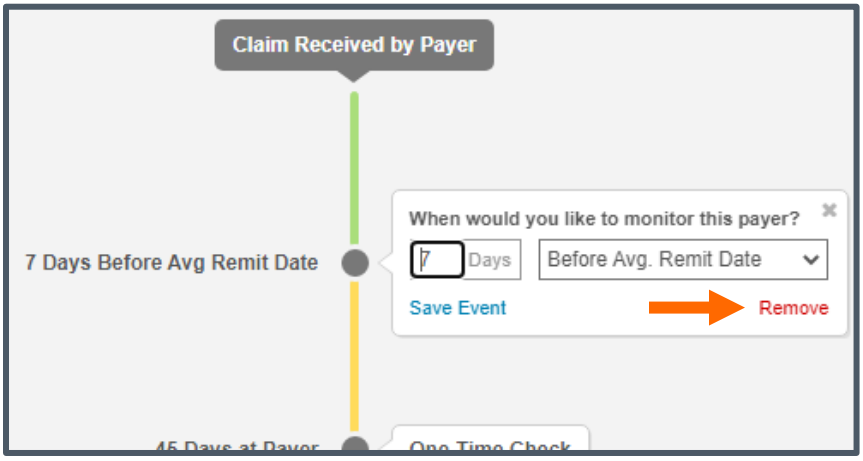
Follow these steps to remove a check status event from an existing Claim Monitoring schedule:

1. Go to the Edit Monitoring Schedule screen.
2. Click the status check event that you would like removed from your schedule:



A popup will open next to the event.

3. Click the **Remove** link.



The event will disappear from the timeline.

Adding Disposition Label overrides to schedules

This section explains how to set Disposition Label overrides for any of your existing Claim Monitoring schedules. Disposition Labels are created by your organization and are primarily backed by rules based on category codes and status codes. The override will appear only on the Disposition Override tab and will not appear in the Schedule Timeline.

An example override could be that your organization keeps receiving a P5-27 category/status code, which means for your organization that the claim is in a Pending status, you might have created a Disposition Label for that P5-27 code. Then when a claim response includes a P5-27 category code, rule that you established will create a “PENDING” Disposition Label into your nightly files. Your organization can then use that Disposition Label as an override for any of your existing scheduled events. And if the Disposition Label override conflicts with a scheduled event, the override will take precedence.

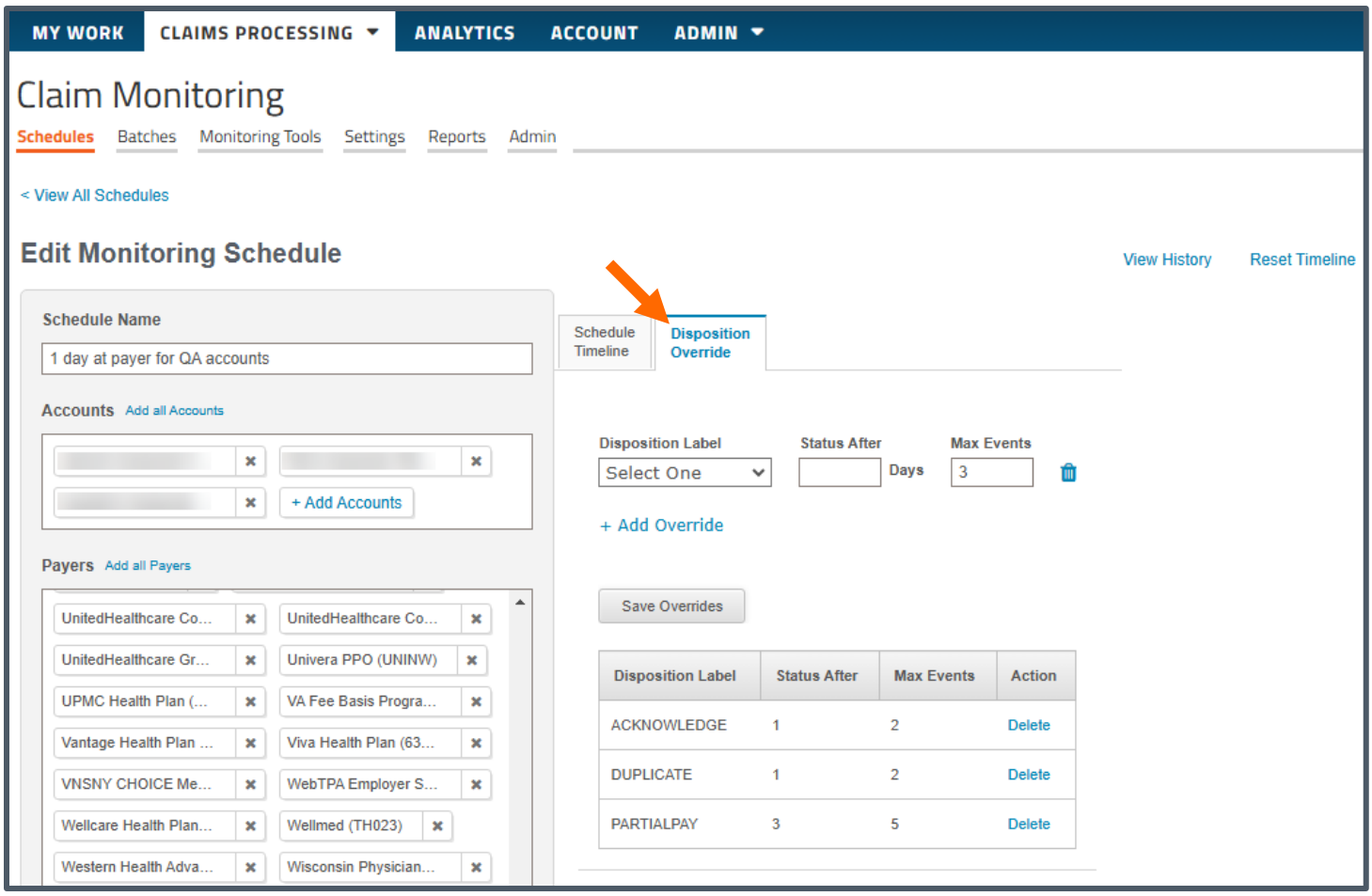
For information about managing Disposition Labels, see the Claim Monitoring Disposition Labels User Guide.

To add a Disposition Label override:

1. Start to edit a schedule.

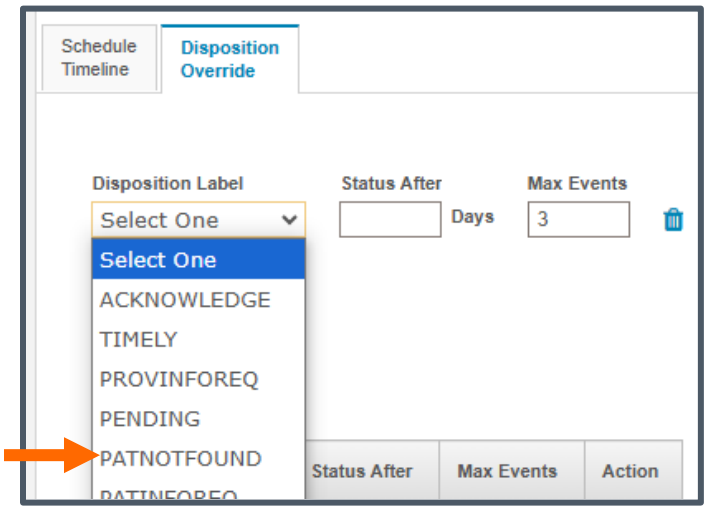
   The Edit Monitoring Schedules screen will open.

2. Click the **Disposition Override** tab.



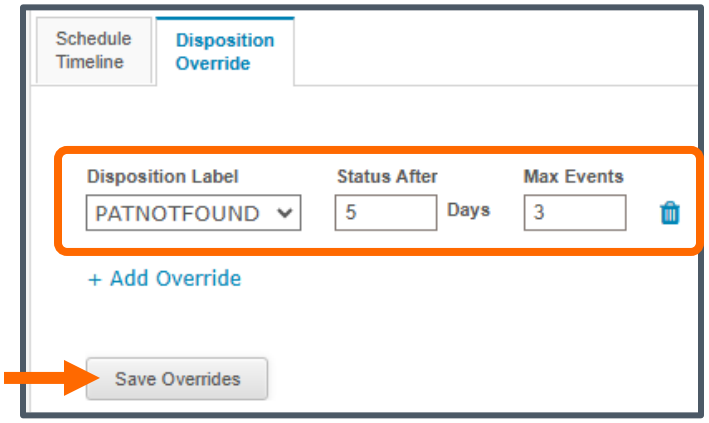
3. From the **Disposition Label** dropdown, select a Disposition Label.

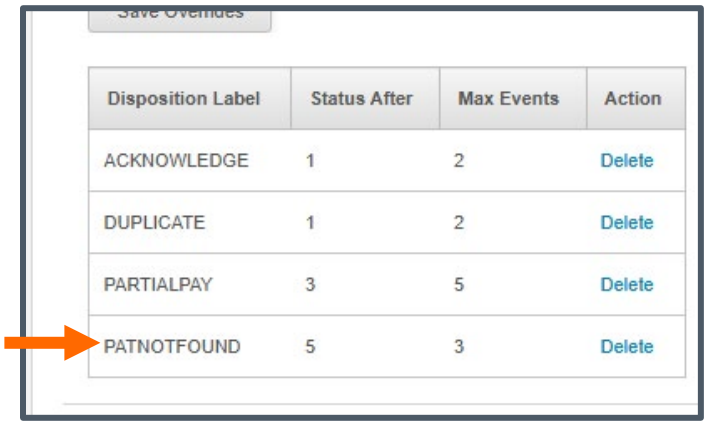
   Only Disposition Labels your organization created for that domain will appear in the list.



4. In the **Status After** field, enter the number of days ***after*** which you want the Disposition Label to status the claim. This is how many days after the disposition event is received that you want Claim Monitoring to status the claim.
5. In the **Max Events** field, enter the number of maximum events you want the Disposition Label to status. The default is 3, but you can update that value. This is the maximum number of times you want Claim Monitoring to status for the Disposition Label.
6. *Optional*. To create additional overrides, click the **Add Override** link and repeat the above.
7. When finished defining Disposition Label overrides, click the **Save Overrides** button.

   The override(s) will appear in the list.

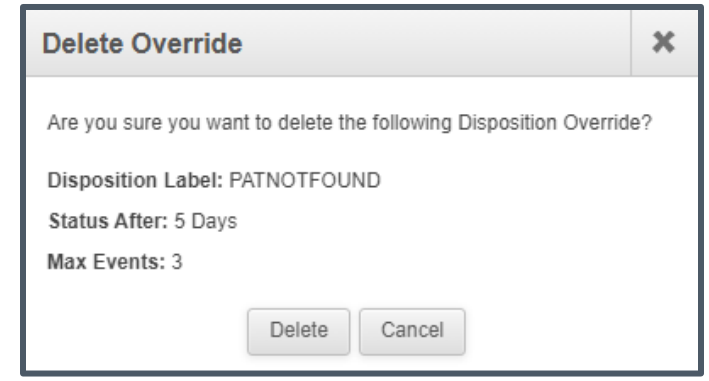




8. To delete an override:
   a. Click the **Delete** link to the right of the override.

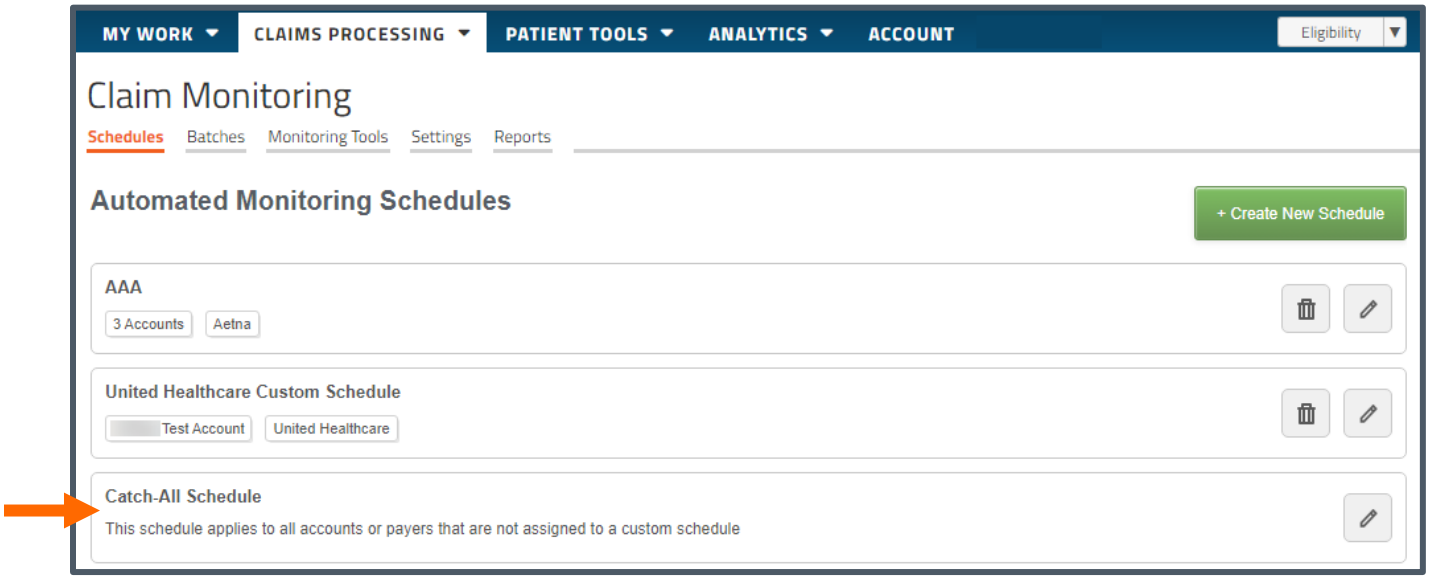
      The Delete Override confirmation screen will open.

   b. Click the **Delete** button.



Viewing the Catch-All Schedule

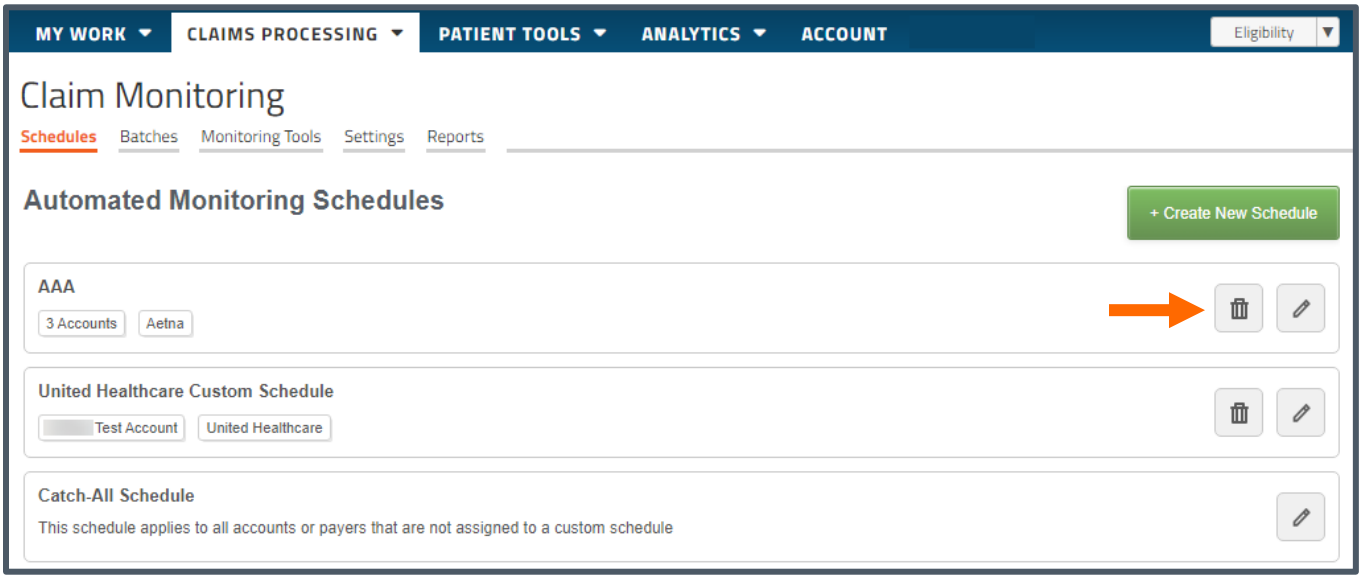
By default, the Catch-All Schedule will be available for managing the accounts and payers that were not assigned to a custom monitoring schedule. You might have to scroll to the bottom of the screen to see it.



Note: Users who view/edit the Catch-All Schedule will see monitoring schedule information only for the accounts they have access to.

Deleting an existing Claim Monitoring schedule

To delete an existing monitoring schedule, click the delete icon on the right side of the appropriate schedule row.



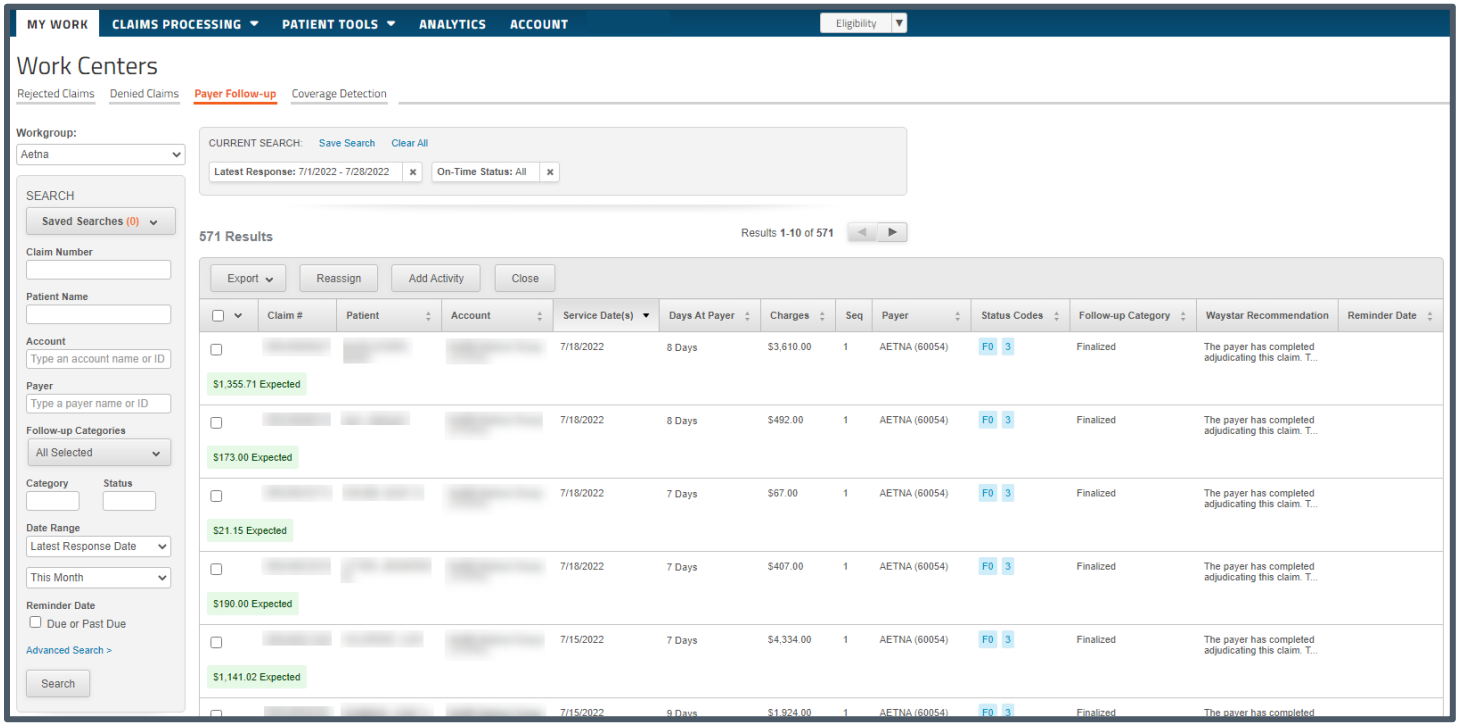
The Claim Monitoring schedule will be deleted and will no longer display on your Schedules screen.

Note: As shown above, this icon is not available for the Catch-All Schedule because it cannot be deleted.

Payer Follow-up work center

The Payer Follow-up work center for Claim Monitoring is a resource for working all claims that require follow up from one screen. In addition to being able to route claims to workgroups based on claim status responses, the Payer Follow-up work center also includes an aging service. The aging service allows you to set up rules to route claims to workgroups based on how long they have been at the payer. This work center also allows you to log activities and set follow-up reminder dates.

Go to the **MY WORK** > **Work Centers** > **Payer Follow-up** screen.



This screen will display the following claim and payer response details:

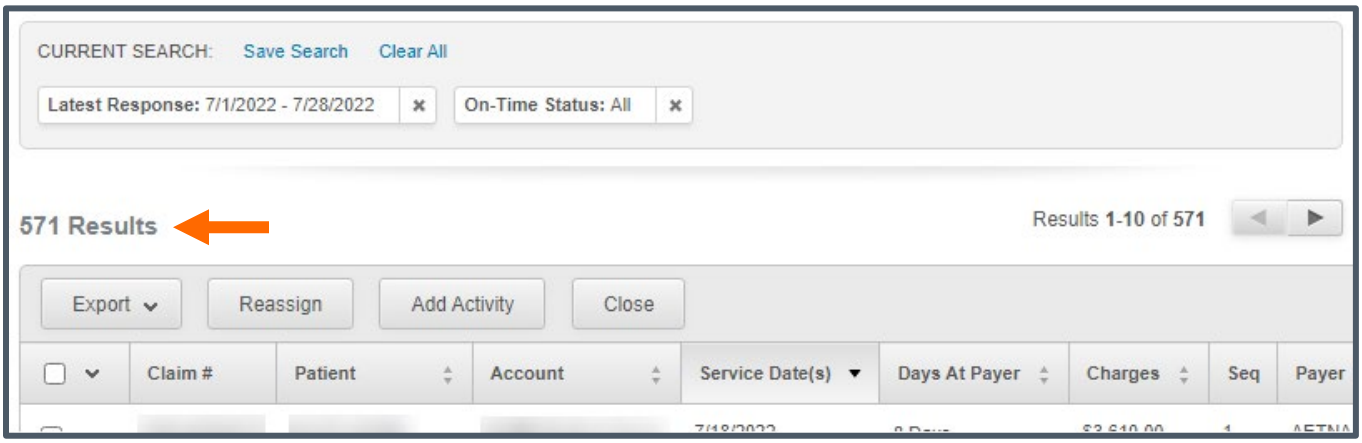
- **Claim #**: The patient control number submitted with the claim; this is typically the patient account number found in your practice management system.
- **Patient**: Last name, first name, middle initial
- **Account**: The account that the claim has been assigned to.
- **Service Date(s)**: The period in which services were rendered to the patient by the provider.
- **Days At Payer**: The number of days that have elapsed since the claim arrived at the payer.

  Note: A red warning icon will appear in this column when the Aging Warnings data limiter has been triggered. For more information on how to set up the Aging Warnings data limiter, see the Working with the Workcenter Data Limiters screen section.
- **Charges**: The total charge amount for the claim.
- **Seq**: The sequence of the payer listed on the claim: 1 = Primary, 2 = Secondary, 3 = Tertiary, etc.
- **Payer**: The payer the claim was sent to.
- **Status Codes**: The WPC category and status codes associated with the claim.

- **Follow-up Category**: Displays one of the following payer follow-up categories:
  - **Payer Outreach**: The recommended follow-up activity for the response is to contact the payer.
  - **Provider Info Request**: Waystar recommends that you retrieve the information being requested and send it to the payer.
  - **Patient Outreach**: The recommended follow-up activity for the response is to contact the patient/guarantor.
  - **Coordination of Benefits**: The claim has been denied or pended because the payer requires more information related to the patient's benefits.
  - **Denied**: The claim or lines within the claim have been denied by the payer.
  - **Claim Not Found**: The payer has acknowledged that a status could not be provided because the claim could not be found in their system.
  - **Paid**: The claim has been paid by the payer.
  - **Finalized**: The payer has completed processing the claim.
  - **Processing at Payer**: The claim is being processed by the payer. No action is being requested from the provider or patient.
  - **Under Payer Review**: The payer has pended the claim for review. No action is being requested from the provider or patient.
  - **Informational**: A general update sent from the payer in response to the status inquiry. For example, a payer may respond that their system is down, and the inquiry needs to be resubmitted at a later time.
  - **Uncategorized**: Waystar has not assigned a category for the response.
  - **Patient Deductible**: Remaining amount(s) apply to the patient or subscriber's deductible.
- **Waystar Recommendation**: Waystar's recommended follow-up action for the status returned by the payer.
- **Reminder Date**: To help manage follow-up workflow, you can set reminder dates to display claims in the Payer Follow-up work center when they require additional follow-up activity. In such cases, you can apply filters so that only claims due for follow-up activity display in your workgroups. See the Sorting Payer Follow-up work section below for instructions on how to sort follow-up work.

Searching for work

When you go to the **MY WORK > Work Centers > Payer Follow-up** screen, you will see all open follow-up work that was assigned to your workgroup. The number of open work items in your workgroup will display above the work list:



Filter your worklist using the SEARCH pane on the left side of the workgroup as explained in this section.

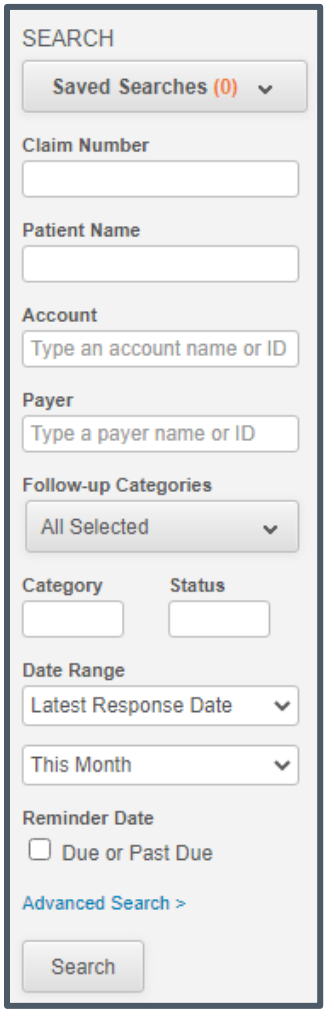
Performing a custom search

You can use the SEARCH pane on the left to perform custom searches. To save the search for future use, see the Saving a custom search section.

To perform a custom search:

1. Go to the **MY WORK > Work Centers > Payer Follow-up** screen.
2. Enter any of the following search criteria in the SEARCH pane.
   - **Claim Number**: Displays responses including the entered patient control number; this is typically the patient account number found in your practice management system
   - **Patient Name**: Displays responses for the entered patient
   - **Account**: Displays responses for the entered account
   - **Payer**: Displays responses from the entered payer
   - **Follow-up Categories**: Click the dropdown and select any of the following checkboxes to display work items in the associated Follow-up Category:
     - **Payer Outreach**: The recommended follow-up activity for the response is to contact the payer.

       Note: This follow-up category will include work that has never been monitored but has hit an aging warning. See the Aging Warnings description for more information.
     - **Provider Info Request**: Waystar recommends that you retrieve the information being requested and send it to the payer.
     - **Patient Outreach**: The recommended follow-up activity for the response is to contact the patient/guarantor.



  - **Coordination of Benefits**: The claim has been denied or pended because the payer requires more information related to the patient's benefits.
  - **Claim Not Found**: The payer has acknowledged that a status could not be provided because the claim could not be found in their system.
  - **Denied**: The claim or lines within the claim have been denied by the payer.
  - **Finalized**: The payer has completed processing the claim.
  - **Processing at Payer**: The claim is being processed by the payer. No action is being requested from the provider or patient.
  - **Under Payer Review**: The payer has pended the claim for review. No action is being requested from the provider or patient.
  - **Paid**: The claim has been paid by the payer.
  - **Patient Deductible**: Remaining amount(s) apply to the patient or subscriber's deductible.
  - **Informational**: A general update sent from the payer in response to the status inquiry. For example, a payer may respond that their system is down and the inquiry needs to be resubmitted at a later time.
  - **Uncategorized**: Waystar has not assigned a category for the response.
  - **Aging Warnings**: The associated claims are reaching user-defined dates/deadlines and may require additional follow-up activity. See the Working with the Workcenter Data Limiters screen section for instructions on how to enter/modify these dates.
- **Category**: Displays responses including the entered WPC category code only.
- **Status**: Displays responses including the entered WPC claim status code only.
- **Date Range**: Select one of the following dropdown options and a corresponding date range to filter your results accordingly:
  - Latest Response Date
  - Service Dates
  - Date Sent to Payer.
- **Reminder Date**: To help manage follow-up workflow, you can set reminder dates to display claims in the Payer Follow-up work center when they require additional follow-up activity. In such cases, select the **Due** or **Past Due** filter to see only claims in your workgroups that are due or past due for follow-up activity. See the Sorting Payer Follow-up work section for instructions on how to sort follow-up work.

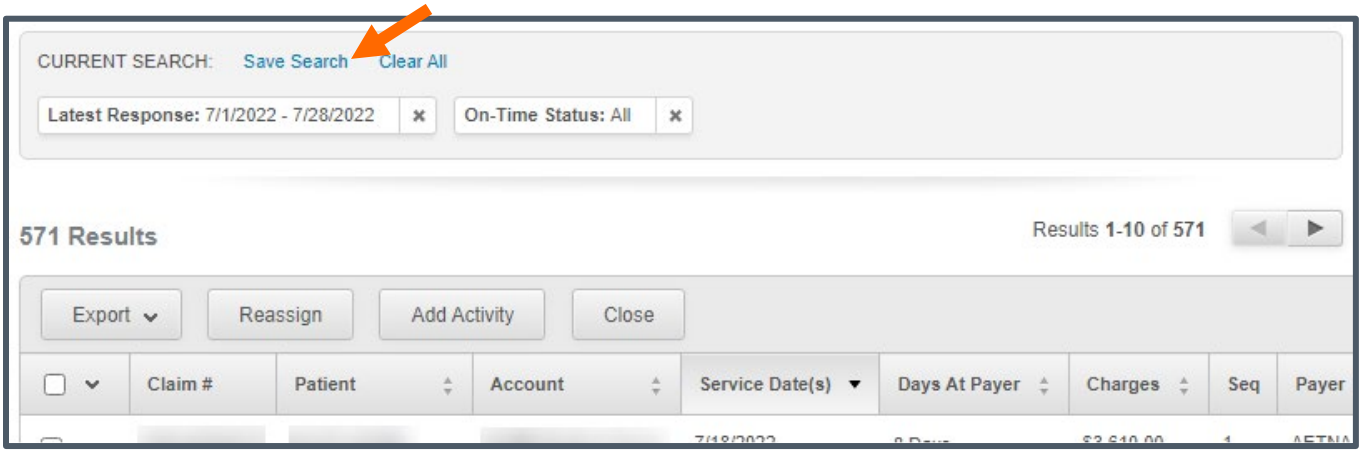
3. If necessary, click the **Advanced Search** link at the bottom of the SEARCH menu to enter the following search criteria:
   - **Rendering Provider**: Displays responses for the entered provider. The rendering provider is the service provider in an outpatient setting (professional claims).
   - **Attending Provider**: Displays responses for the entered provider. The attending provider is the service provider in an inpatient/hospital setting (institutional claims).
   - **On-Time Status**: Displays responses for on-time, delayed, and/or overdue statuses.
4. To perform the search after you have entered all the necessary search criteria, click the **Search** button or press the [**Enter**] key.

Saving a custom search

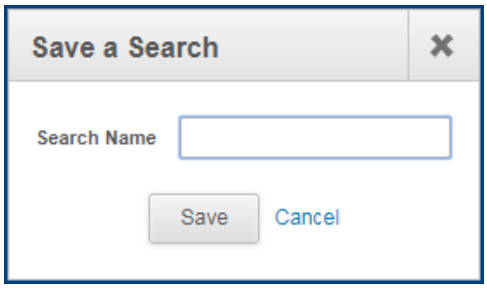
If you will be performing a particular search often, you can save it to perform that search with one click.

To save a custom search:

1. Go to the **MY WORK** > **Work Centers** > **Payer Follow-up** screen.
2. Use the **SEARCH** pane on the left to perform the desired search.
3. Click the **Save Search** link in the CURRENT SEARCH pane:



The Save a Search screen will open.



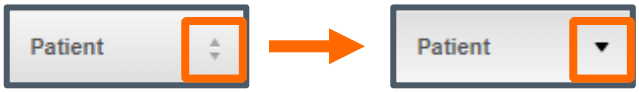
4. Enter a unique custom search name in the Search Name field.
5. Click the **Save** button. The search will be added to the Saved Searches dropdown.
6. To perform a saved search, select the appropriate custom search name from the **Saved Searches** dropdown.

Sorting Payer Follow-up work

To sort the Payer Follow-up work items:

1. Go to the **MY WORK** > **Work Centers** > **Payer Follow-up** screen.
2. As needed, perform a search.
3. To sort the results table, click a column header that has the gray double-arrow to the right of the column name.

A single black arrow will appear in place of the gray double-arrow.



With the initial click:

- Text columns will sort A to Z.
- Numeric columns will sort high to low.

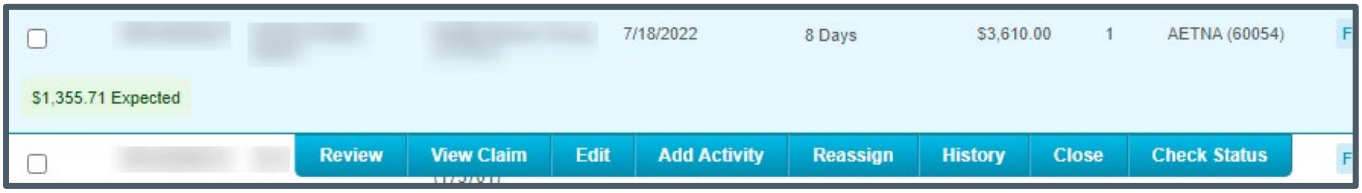
4. To reverse the order of the current sort (ascending vs. descending), click the same column header a second time. The black arrow will reverse its direction, and the table will sort accordingly.

Using the Payer Follow-up work center action menu

You can work the associated claim directly from the work center using the action menu.

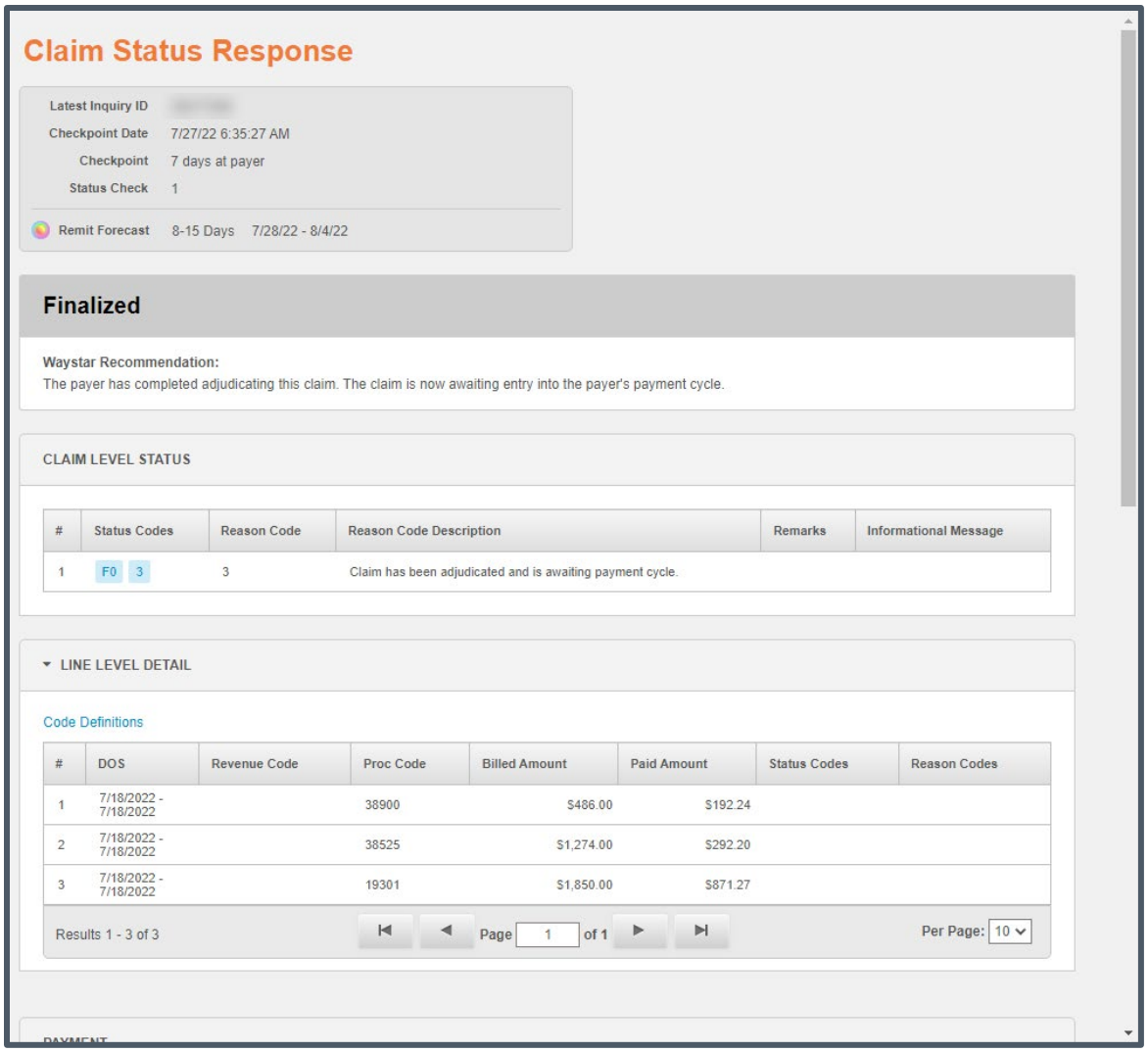
To access the action menu:

1. Go to the **MY WORK** > **Work Centers** > **Payer Follow-up** screen.
2. As needed, perform a search.
3. Hover over the appropriate work row.



The action menu will open with the following options:

- **Review**: Opens the associated Claim Status Response screen. You might have to scroll to see all the information.



The response screen provides the following action items and claim status inquiry response details:

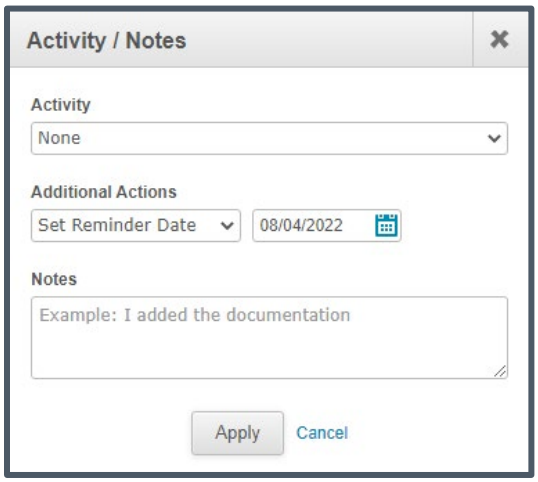
- **Latest Inquiry ID**: The Waystar-assigned identification number applied to the most recent instance of the inquiry.
- **Checkpoint Date**: For inquiries set up via CLAIMS PROCESSING > Claim Monitoring > Schedules, this field indicates the date the inquiry was submitted from the Waystar system. See the Claim Monitoring schedules section for more information on creating and managing schedules.
- **Checkpoint**: For inquiries set up via CLAIMS PROCESSING > Claim Monitoring > Schedules, this field indicates the scheduled event that triggered the automated inquiry. See the Claim Monitoring schedules section for more information on creating and managing schedules.
- **Waystar Recommendation**: Displays the payer's response and Waystar's recommended resolution (if available).
- **Claim Level Status**: Includes the following claim-level response details:
  - **Status Codes**: The WPC status codes associated with the claim.
  - **Reason Code**: WPC or Proprietary Reason Codes captured from the payer's portal through RPA (Robotic Processing Automation).
  - **Reason Code Description**: WPC or Payer Proprietary description/definition of the reason code.
  - **Remarks**: Indicates any payer remarks for the associated claim.
  - **Informational Message**: Indicates any additional information provided by Waystar for the response.
- **Line Level Detail**: View all the line-level details provided by the payer, including specific Status Codes and Reason Codes. This menu also provides the following links and interactions:
  - **Code Definitions**: Click the link to view descriptions for the full list of status codes and reason codes that were reported across all of the associated claim service lines.
  - **Status Codes**: Hover over a status code to view the associated code description.
  - **Reason Codes**: Hover over a reason code to view the associated code description.
- **Payment**: Displays all payment-related information associated with the claim, including billed amounts, patient responsibility, and, if available, all payments returned.
- **Payer**: Displays payer and insurance plan information associated with the claim.
- **Patient**: Displays patient details and their associated insurance information.

- **View Claim**: Displays a PDF version of the CMS-1500 08/05 form
- **Edit**: Opens the HIPAA-compliant Claim Edit Screen where you can edit the claim as necessary (see the Claims User Guide for more information about the Claim Editor).

- **Add Activity**: Opens the Activity / Notes screen where you can perform the following actions:
  - **Activity**: After completing follow-up work for a response, select the appropriate option from the **Activity** dropdown to indicate that work was performed for the item. If no other changes are needed, click the **Apply** button to update the work item.
  - **Additional Actions**: Select one of the following action items from the **Additional Actions** dropdown and then click the **Apply** button to save your changes:
    - **Set Reminder Date**: Select the dropdown option and a date on the right to apply a reminder date to the follow-up work item. This date will display for that item in the Reminder Date column back in your Payer Follow-up workgroup.

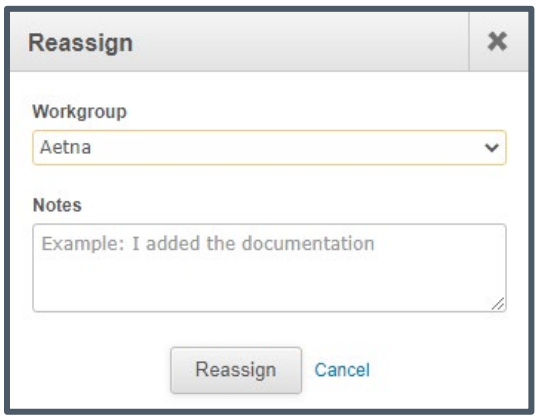
      Note: Use the **Reminder Date** filter in the Payer Follow-up SEARCH pane to find follow-up work by these reminder dates (see the Performing a custom search section for more information).
    - **Reassign**: Select the dropdown option and a destination workgroup to move the follow-up work to another workgroup in your account.
    - **Close Follow-up Case**: Select the dropdown option and a close type if the follow-up work is complete.

      IMPORTANT: Closing a follow-up case removes the work from all workgroups. By closing the case, you are indicating that all follow-up work has been completed.
    - **None**: Select the dropdown option if you would not like to perform any additional actions on the follow-up work.
  - **Notes**: In the free-text **Notes** field, enter a note regarding any changes to the follow-up work and then click the **Apply** button to add the note to the item back on the Payer Follow-up workgroup.

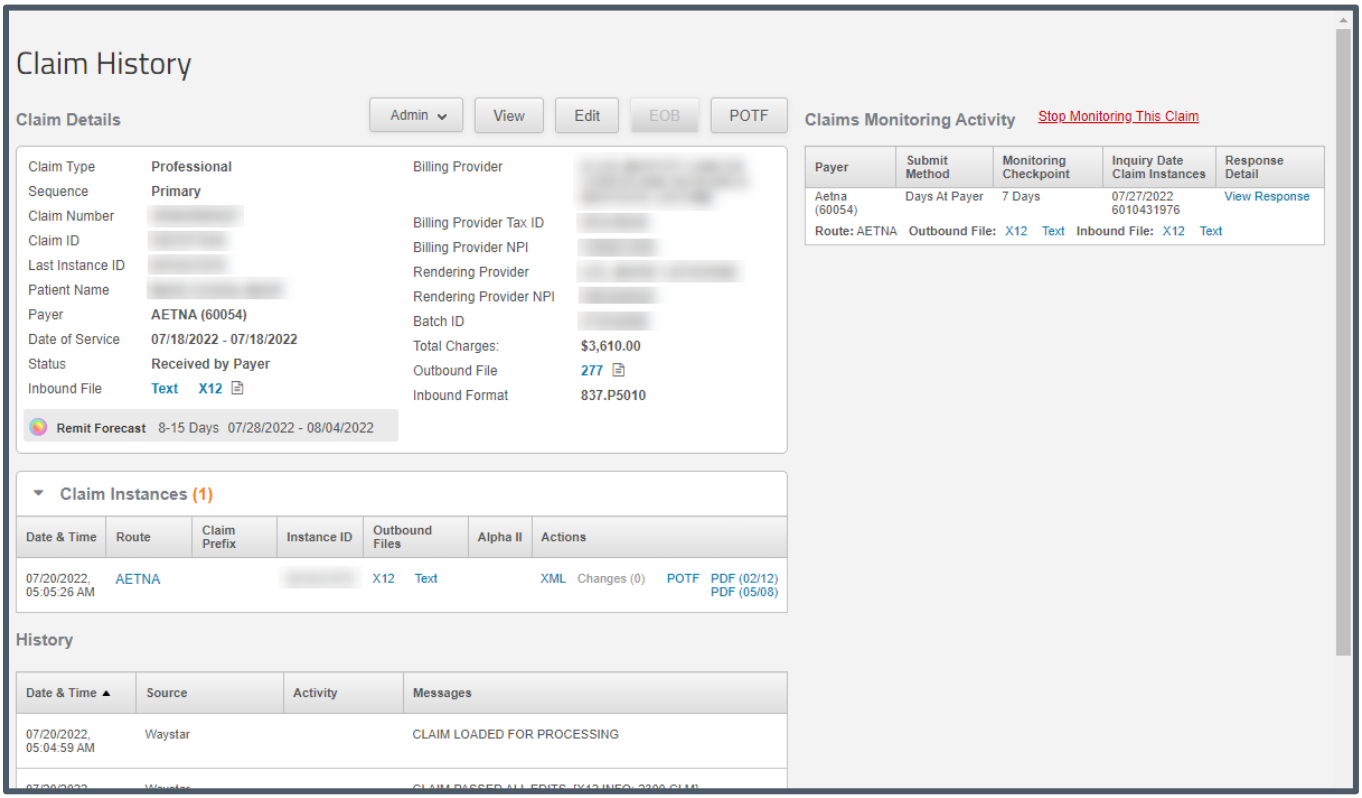


- **Reassign**: Opens the Reassign screen where you can select a destination workgroup to move the follow-up work to another workgroup in your account. If necessary, you can add a note regarding the change in the **Notes** free-text field.

  To send the work to another workgroup and add your note (if entered), click the **Reassign** button.



- **History**: Displays the Claim History screen, which provides all the associated claim's basic information and event history. You might have to scroll to see all the information.



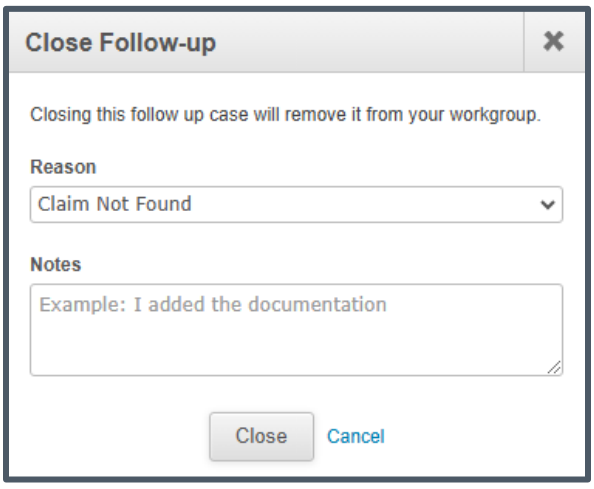
The following action options are also available on the Claim History screen:

- To view the claim status inquiry response, click the **View Response** link in the Response Detail column on the right side of the screen.
- To turn off monitoring for this claim, click the **Stop Monitoring This Claim** link at the top of the screen, and then confirm the action.

  IMPORTANT: After monitoring for a claim has been deactivated, it cannot be reactivated.

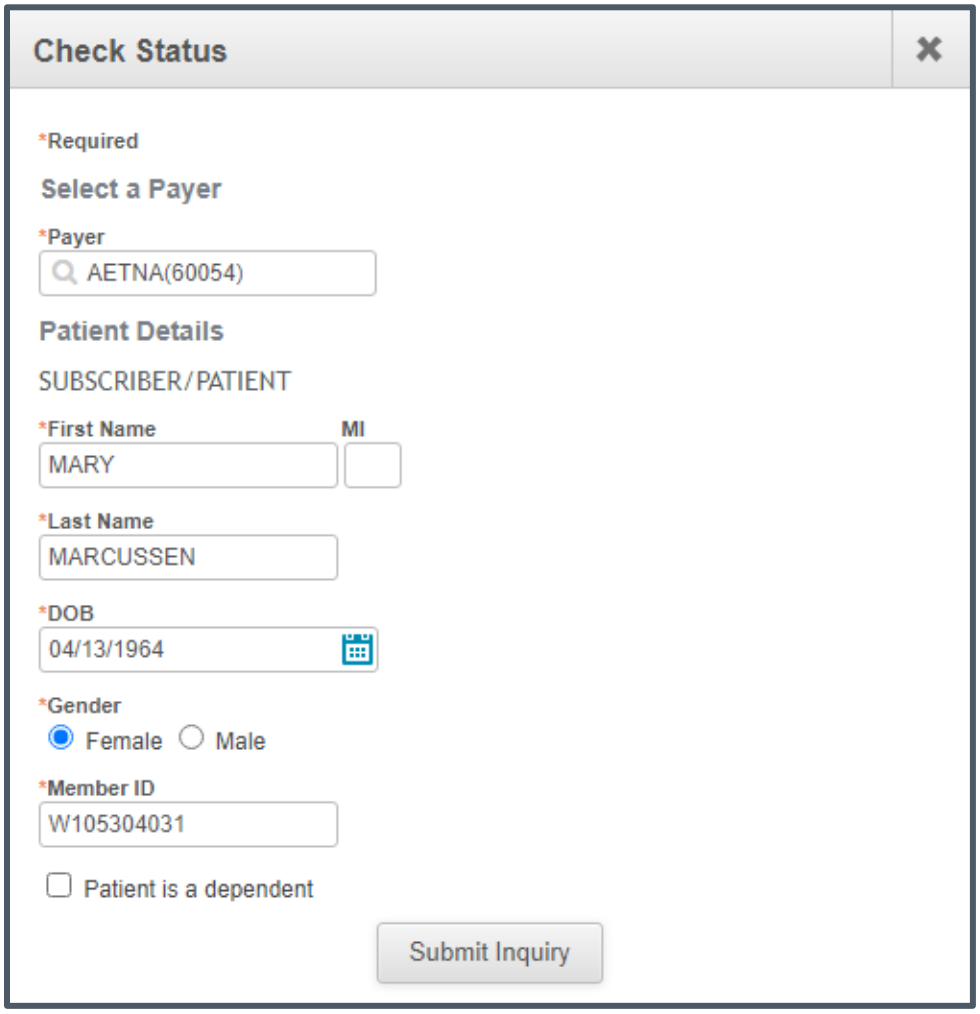
- **Close**: Opens the **Close Follow-up** screen where you can select a **Reason** for closing the follow-up work case, add a note regarding the close, and click the **Close** button to close the case.

  IMPORTANT: Closing a follow-up case removes the work from ***all*** workgroups. By closing the case, you are indicating that all follow-up work was completed.



- **Check Status**: Opens the **Check Status** screen where you can enter the requested payer and patient information and click the **Submit Inquiry** button to send a manual claim status inquiry:

  Note: The requested fields will be pre-populated with payer and patient data from your claim(s).

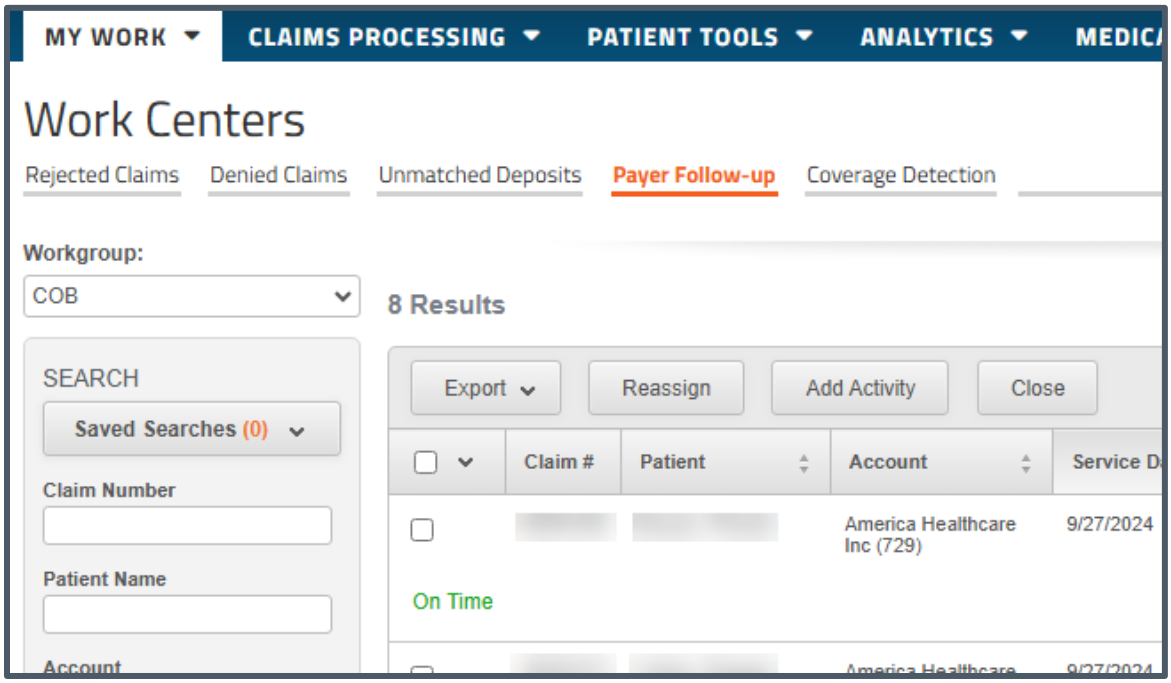


Using the Payer Follow-up work center toolbar

The row of buttons at the top of the Payer Follow-up work center allows you to select one or more follow-up work items and perform the actions described in this section.

To use the Payer Follow-up work center toolbar:

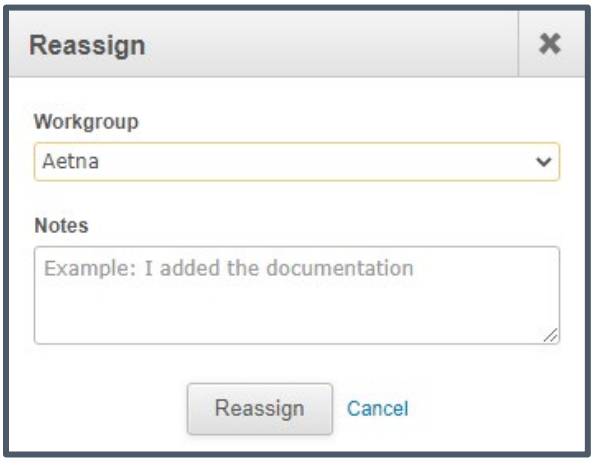
1. Go to the **MY WORK** > **Work Centers** > **Payer Follow-up** screen.
2. As needed, perform a search.



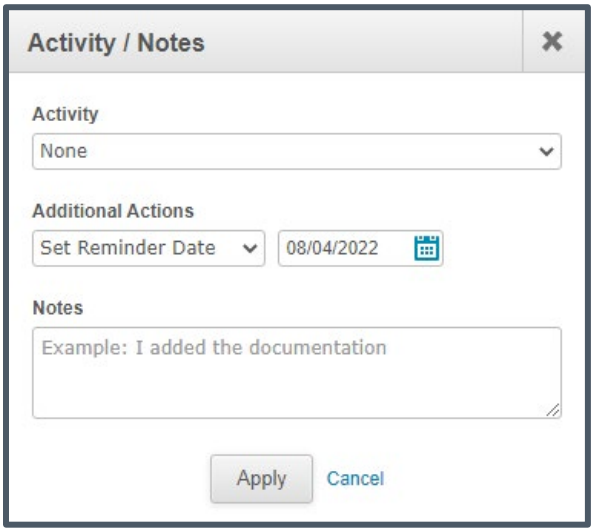
3. To select work items:
   - Individually, click the associated checkbox to the left of one or more work items.
   - For multiple work items, open the checkbox dropdown in the column header to select/unselect all returned work items or all work items on the current page of results. If you select the column header checkbox, that will select/unselect work items on the ***current page***.

4. After selecting the desired work items, use the following buttons to perform the associated action:
   - **Export**: Select **Excel** or **PDF** from the dropdown to export the selected claim(s) data to an Excel spreadsheet or a PDF. The claims will be listed in these exported files as they are shown in your Payer Follow-up workgroup.
   - **Reassign**: Opens the Reassign screen where you can select a destination workgroup to move the follow-up work to another workgroup in your account. If necessary, you can add a note regarding the change in the **Notes** free-text field.

     To send the work to another workgroup and add your note (if entered), click the **Reassign** button.



   - **Add Activity**: Opens the Activity / Notes screen where you can perform the following actions:
     - **Activity**: After completing follow-up work for a response, select the appropriate option from the **Activity** dropdown to indicate that work was performed for the item. If no other changes are needed, click the **Apply** button to update the work item.
     - **Additional Actions**: Select one of the following action items from the **Additional Actions** dropdown and then click the **Apply** button to save your changes:
       - **Set Reminder Date**: Select the dropdown option and a date on the right to apply a reminder date to the follow-up work item. This date will display for that item in the Reminder Date column back in your Payer Follow-up workgroup.



         Note: Use the **Reminder Date** filter in the Payer Follow-up SEARCH pane to find follow-up work by these reminder dates (see the Performing a custom search section for more information).
       - **Reassign**: Select the dropdown option and a destination workgroup to move the follow-up work to another workgroup in your account.

- **Close Follow-up Case**: Select the dropdown option and a close type if the follow-up work is complete.

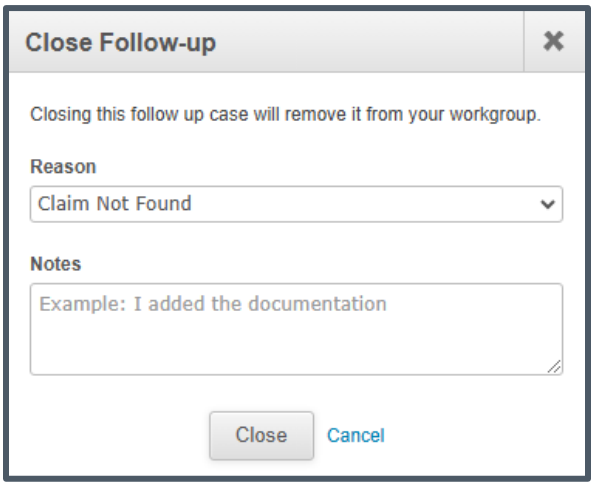
  IMPORTANT: Closing a follow-up case removes the work from all workgroups. By closing the case, you are indicating that all follow-up work has been completed.

- **None**: Select the dropdown option if you would not like to perform any additional actions on the follow-up work.

– **Notes**: In the free-text **Notes** field, enter a note regarding any changes to the follow-up work and then click the **Apply** button to add the note to the item back on the Payer Follow-up workgroup.

- **Close**: Opens the **Close Follow-up** screen where you can select a **Reason** for closing the follow-up work case, add a note regarding the close, and click the **Close** button to close the case.

  IMPORTANT: Closing a follow-up case removes the work from ***all*** workgroups. By closing the case, you are indicating that all follow-up work was completed.



Using Payer Follow-up work icons

Work items may receive icon indicators if certain actions were performed on them. These icons will help you to track your work and quickly identify work performed by other users.

You can hover over each of the work icons to see a brief description of the corresponding icon.

Icon	Usage
	**Claim Warning**: Indicates that there is a claim warning attached to this claim. Click the icon to launch the claim warning window, read warnings, and if you choose, mark them addressed. If you indicate that the claim warning is addressed, this icon will disappear from the My Work screen.
	**Attached Note**: Indicates that there is at least one note attached to this claim. Click on the icon to open a window with the note details and a text field to add new notes.
	**Resubmitted**: Indicates that this claim has been resubmitted. Click on the icon to open the Claim History window where you can view the resubmission details. Hover over the icon to view the timestamp of the most recent resubmission.
	**Attached EOB**: Indicates that an EOB has been returned for this claim. Click on the icon to open a PDF version of that EOB.

Manual claim status inquiries submissions

While the Claim Monitoring application auto-submits claim status inquiries for claims set up on the **CLAIMS PROCESSING > Claim Monitoring > Schedules** screen, you can also manually submit individual and mass claim status checks.

IMPORTANT: The manual claim status checks that are specifically performed using the Check Status button within Waystar ***cannot*** be performed for RPA-only payers at this time. To view a list of the RPA-only payers, click **HERE**.

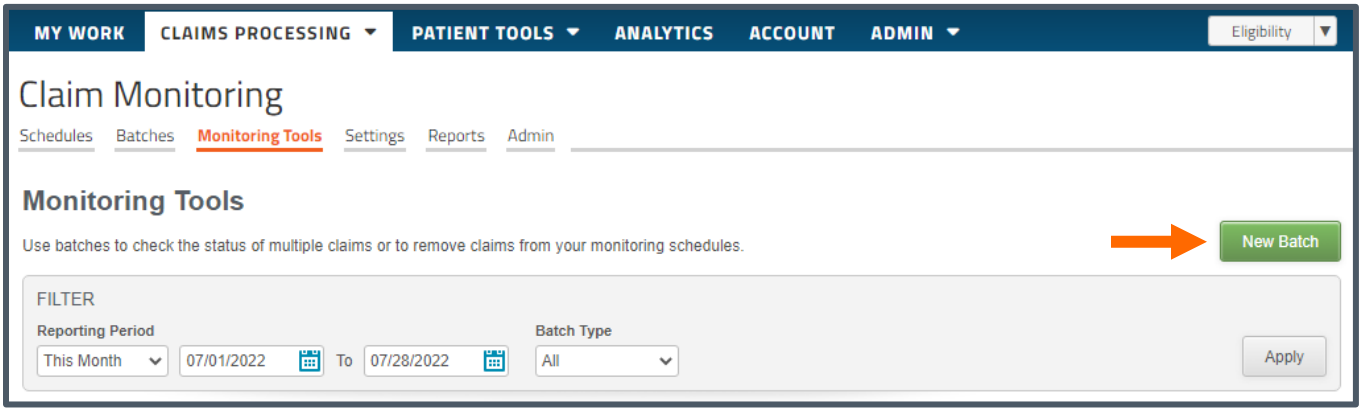
Using the Monitoring Tools screen

The Monitoring Tools screen allows you to enter/upload a list of claim instance IDs to trigger status checks or to let Claim Monitoring know to STOP monitoring those claim Instance IDs. When applicable, status checks triggered from Monitoring Tools will be routed to the payer in the appropriate format (x12 vs. Commercial RPA or Medicare A RPA).

Uploading claim Instance IDs for mass status check or removal

To perform a mass status check on a group of claims or to have them removed (stop monitoring them) from your monitoring schedules:

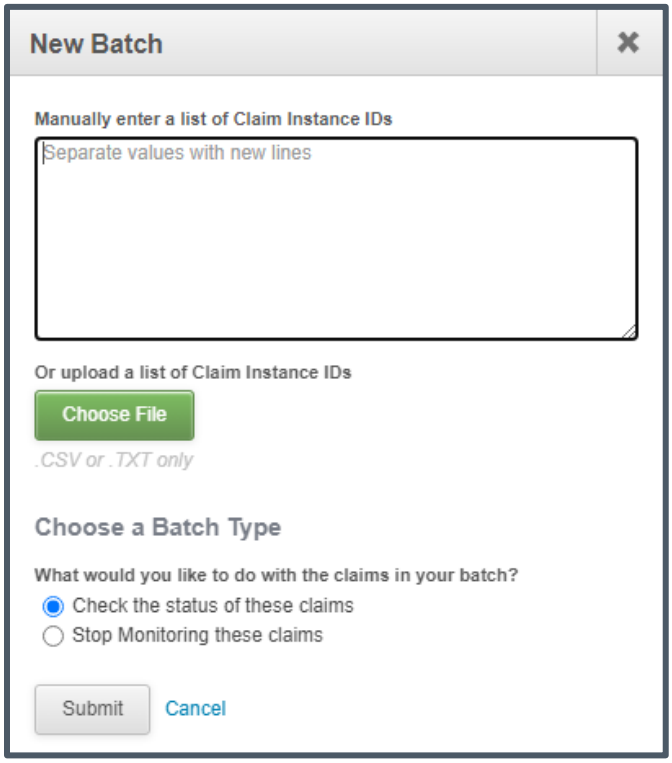
1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Monitoring Tools** screen.
2. Click the **New Batch** button at the top of the screen.



The New Batch screen will open.

3. Do ONE of the following:
   - Enter the claim instance IDs of the claims that you would like mass checked/removed in the **Manually enter a list of Claim Instance IDs** free text field.
   - Click the **Choose File** button to upload a spreadsheet or simple text file of the associated claim instanced IDs.

   Note: The Claim Monitoring system will accept .CSV spreadsheet or .TXT files only.
4. Depending on whether you would like to perform a mass status check on the claims or remove them from your monitoring schedules, select one of the following radio buttons under **What would you like to do with the claims in your batch?**
   - Check the status of these claims
   - Stop Monitoring these claims
5. To upload the list of claim Instance IDs, click the **Submit** button.



Viewing mass status checks and mass removals

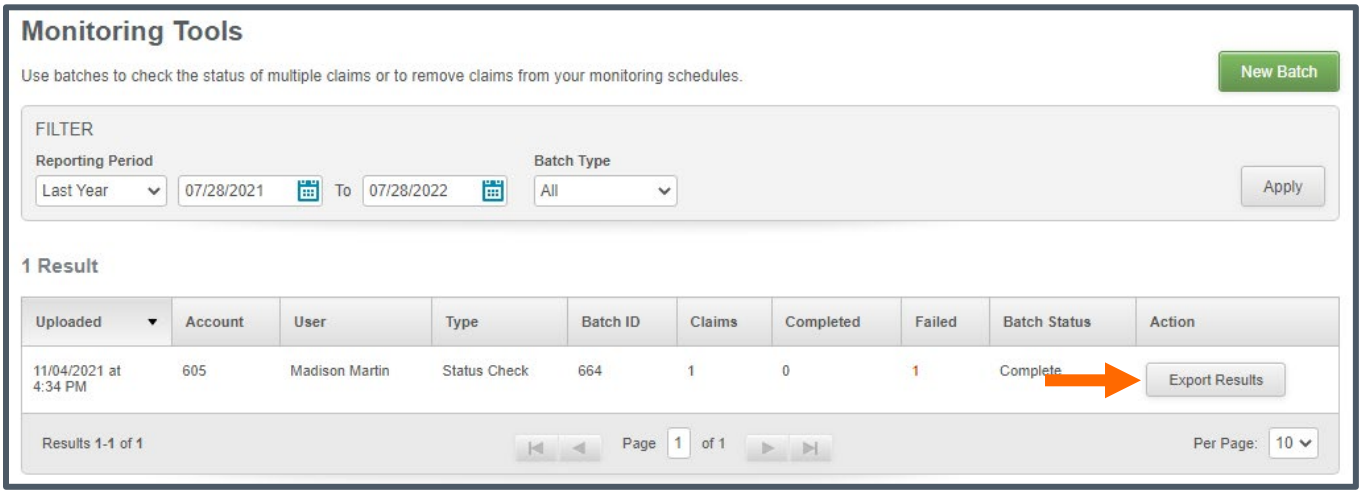
After uploading a list of claim instance IDs to perform a manual status check on the associated group of claims or have those claims removed from your monitoring schedules, the associated action will appear on the Monitoring Tools screen list after the upload is processed. From this list, you can preview/export the results of the mass status check/removal.

To preview/export the results of a mass check status/removal:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Monitoring Tools** screen.
2. To find your batch, enter the following search criteria in the **FILTER** section at the top of the screen:
   - **Reporting Period**: Select a pre-defined or custom date range to display batches submitted in that timeframe.
   - **Batch Type**: A batch for **Status Check**, **Stop Monitoring**, or **All**.
3. Click the **Apply** button.

Batches matching your entered search criteria will display below the FILTER menu.

4. While the results of the mass status check/removal will be previewed in the Batches list, click the **Export Results** button in the associated Action column for a detailed spreadsheet of the results.



The following are the possible statuses:

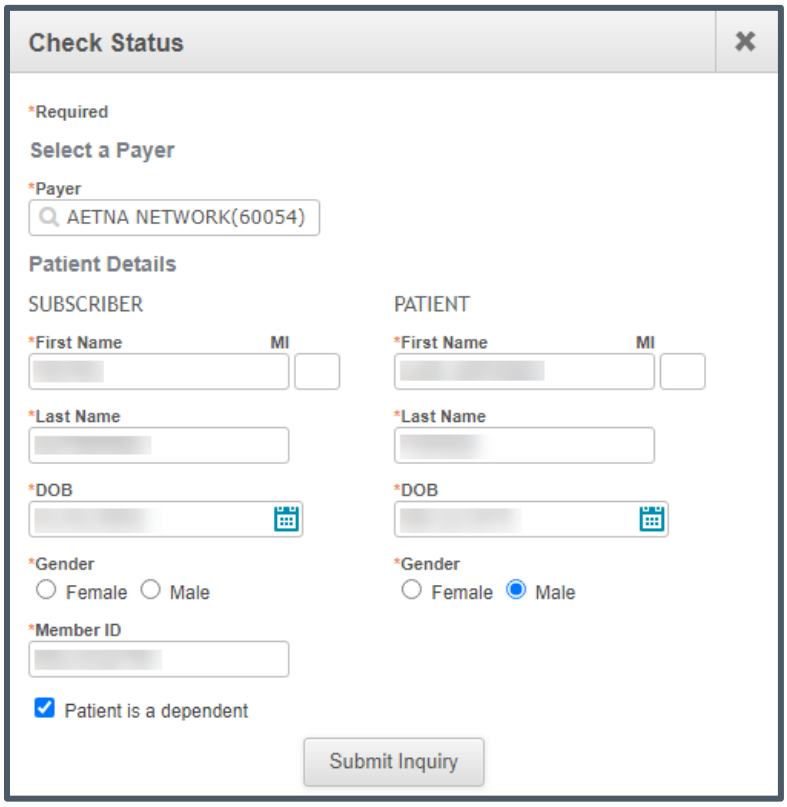
- **New (0)**: Newly added and unprocessed claim.
- **Invalid (1)**: Invalid claim for the client. For example, the claim is not attached to the account where it was uploaded in Monitoring Tools.
- **Ineligible (2)**: Claim is not eligible for a status check. The payer is not active for Claim Monitoring, or the payer is RPA (robotic process automation) and the client does not have valid credentials.
- **Queued (3)**: Claim validated and ready to be processed.
- **Not Monitored (4)**: Claim is not currently being monitored.
- **In Progress (5)**: Claim is currently being processed.
- **Request Error (6)**: There was an error performing the status check.
- **Response Error (7)**: There was an error receiving the claim response or in tying it back.
- **Complete (8)**: Claim has completed processing.
- **Stale (9)**: Claim did not receive a response in the configured time.
- **Error (99)**

Submitting an individual claims status check in Claims

To submit an individual claims status check in Claims:

1. Go to **CLAIMS PROCESSING** > **Professional Claims** or **Institutional Claims** > **Claims**.
2. Hover over the claim that you would like to submit the status inquiry for.
3. From the **action** menu that will open, click the **Check Status** button.

The Check Status screen will open.



4. Do one of the following as needed:
   - Enter/edit the payer name/ID in the **Payer** field.
   - Search for the payer using the magnifying glass icon.
5. Enter the requested subscriber (if applicable) and patient information.

   Note: The requested fields will be pre-populated with payer, subscriber (if applicable), and patient data from the claim.
6. Click the **Submit Inquiry** button to send the claim status inquiry.

Viewing Claim Monitoring responses

When you begin receiving responses from payers, you can view them in the **MY WORK** > **Work Centers** > **Payer Follow-up** work center > **Monitoring Activity report** or by performing the following steps:

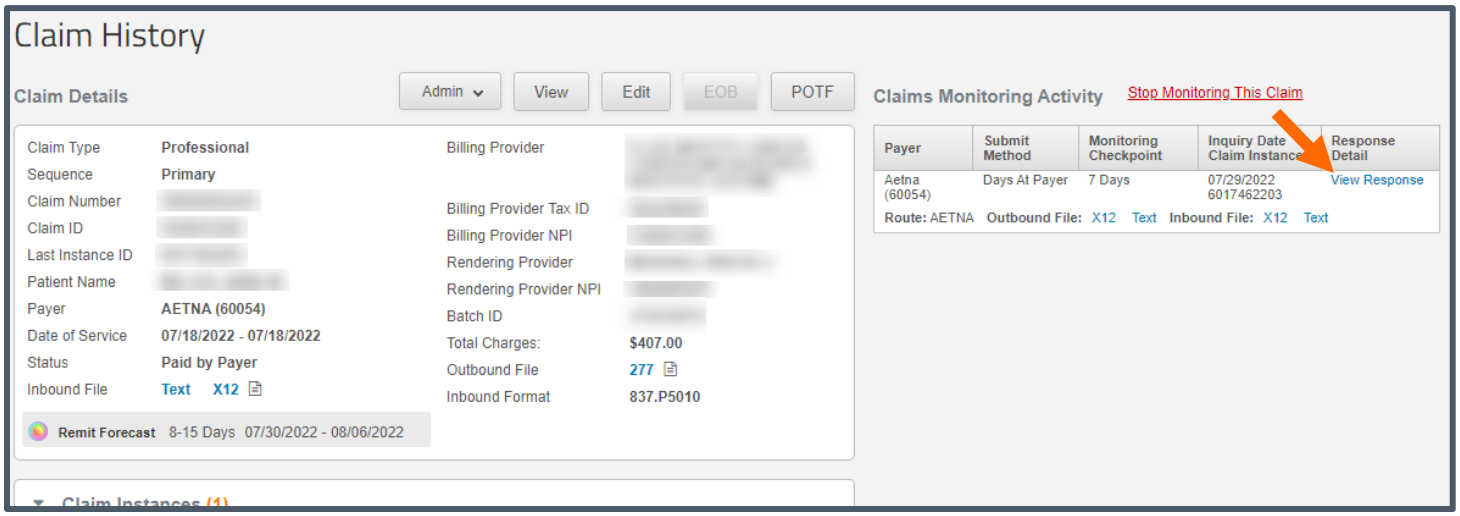
1. Go to **CLAIMS PROCESSING** > **Professional Claims** or **Institutional Claims** > **Claims**.
2. Enter the appropriate search criteria in the **Search** pane on the left.
3. Click the **Search** button.
4. Locate the claim you want to view a payer response for and hover over that line item.

   The action menu will open.

5. Click the **History** button:

   The Claim History screen will open.

6. Go to the **Claim Monitoring Activity** section of the screen and click the **View Response** link. This area will either be on the right side of the screen, as shown below, or you might have to scroll to the bottom to find it.



The appropriate claim status inquiry response will appear.

Note:

- All claim status inquiry responses viewed in Waystar will provide the same up-to-date information regardless of where you are viewing them.
- See the Washington Publishing Company (WPC) website for more information about codes returned in your responses.

Claim Monitoring reporting

The **CLAIMS PROCESSING** > **Claim Monitoring** > **Reports screen** provides the following reports to help you track claims and payer performance:

- **Monitoring Activity Report**: View payer responses to the automated inquires sent from the Claim Monitoring application.
- **Average Days to Remit Report**: View a list of payers' average remit dates. A payer's average remit date (for a specified provider) is the calculated average number of days it takes them to send remits to a provider.

Working with the Monitoring Activity report

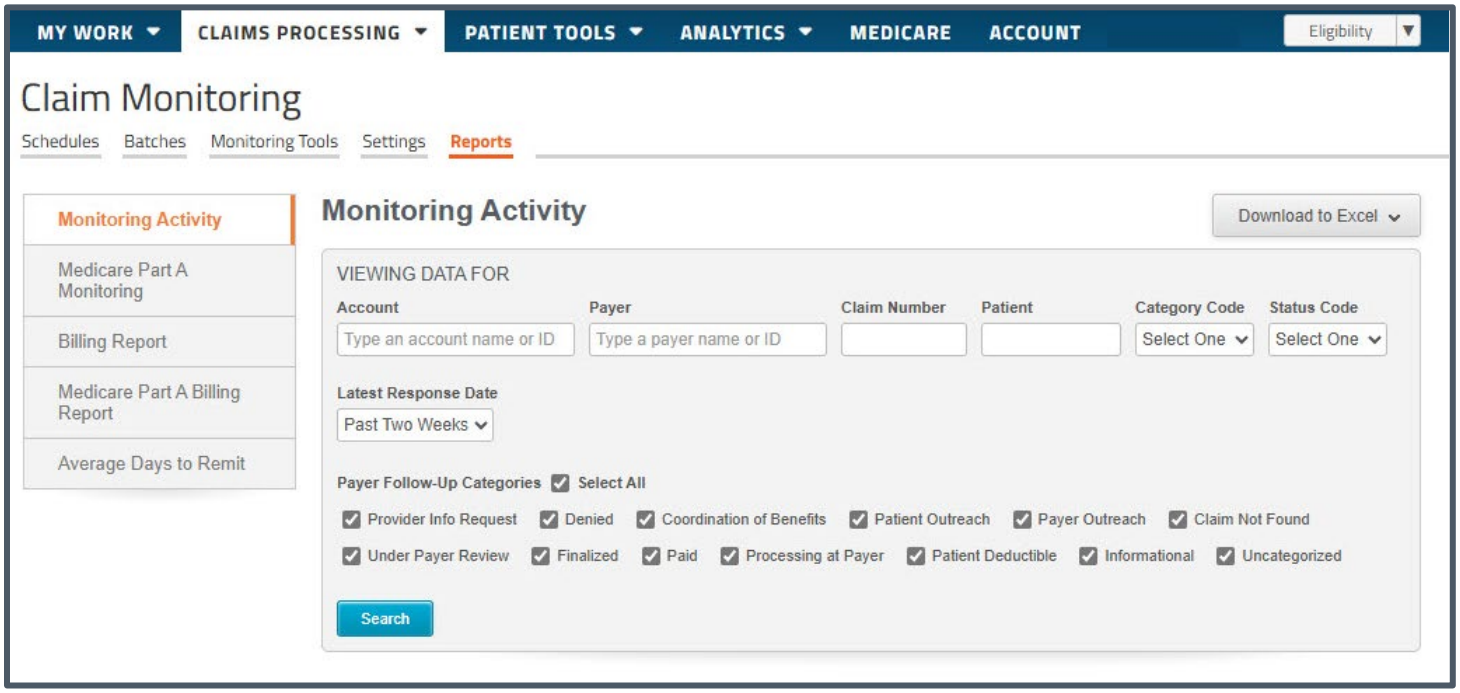
Generating the Monitoring Activity report

Once you are receiving payer responses from automated Claim Monitoring checks, generate the Monitoring Activity report to view these responses.

To generate the Monitoring Activity report:

1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Reports**.

   The Monitoring Activity screen will open.



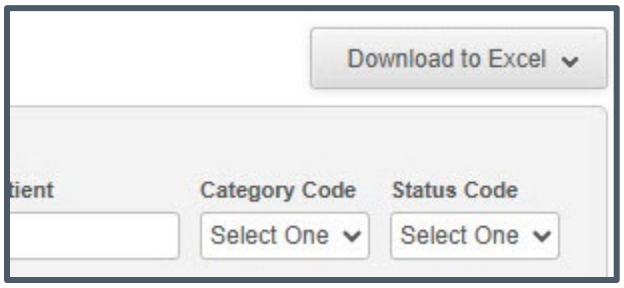
2. Enter any of the following filtering criteria in the VIEWING DATA FOR area at the top of screen:
   - **Account**: Displays responses for the specified child account.
   - **Payer**: Displays responses for the specified payer.
   - **Claim Number**: Displays responses for claims with the specified patient control number; this is typically the patient account number found in your practice management system.
   - **Patient**: Displays responses including the specified patient (last name, first name, middle initial).
   - **Category Code**: Displays responses including the selected WPC category code only.

- **Status Code**: Displays responses including the selected WPC claim status code only.
- **Latest Response Date**: Displays the most recent responses received within the selected date range. The Today option will be selected by default which will populate responses received that day.
- **Payer Follow-Up Categories**: Click any of the following checkboxes to view responses in that stage:
  - **Provider Info Request**: Waystar recommends that you retrieve the information being requested and send it to the payer.
  - **Denied**: The claim or lines within the claim have been denied by the payer.
  - **Coordination of Benefits**: The claim has been denied or pended because the payer requires more information related to the patient's benefits.
  - **Patient Outreach**: The recommended follow-up activity for the response is to contact the patient/guarantor.
  - **Payer Outreach**: The recommended follow-up activity for the response is to contact the payer.
  - **Claim Not Found**: The payer has acknowledged that a status could not be provided because the claim could not be found in their system.
  - **Under Payer Review**: The payer has pended the claim for review. No action is being requested from the provider or patient.
  - **Finalized**: The payer has completed processing the claim.
  - **Paid**: The claim has been paid by the payer.
  - **Processing at Payer**: The claim is being processed by the payer. No action is being requested from the provider or patient.
  - **Patient Deductible**: The claim includes a patient deductible amount.
  - **Informational**: A general update sent from the payer in response to the status inquiry. For example, a payer may respond that their system is down and the inquiry needs to be resubmitted at a later time.
  - **Uncategorized**: Waystar has not assigned a category for the response.

3. When finished selecting filters, click the **Search** button.

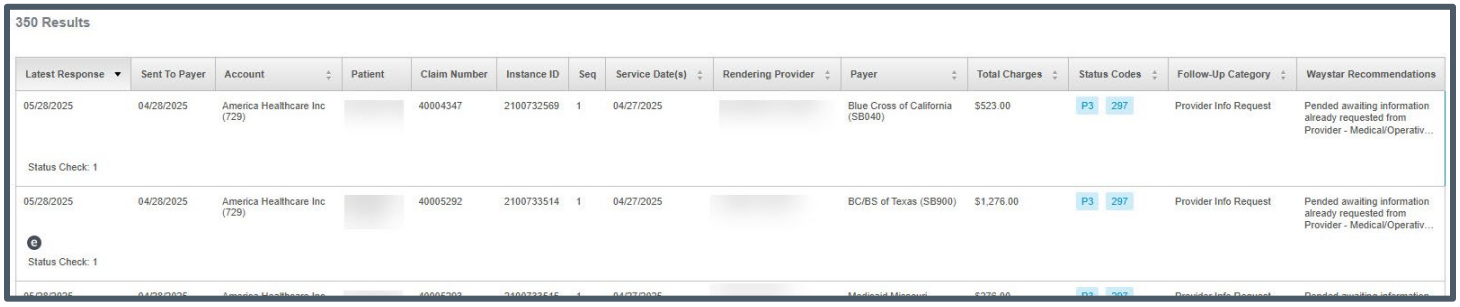
   Response data will display at the bottom of the screen matching the entered criteria.

4. To download an Excel spreadsheet of the reported response data (line-level or claim-level), select the **Claim Level Report** or **Line Level Report** from the **Download to Excel** button at the top of the screen.



Viewing Monitoring Activity report results

After generating the report, the following response data will display:



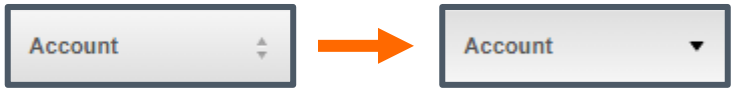
- icon: The Coverage Detection icon appears in a row when a coverage detection transaction was triggered. Click the icon to open and view these results in the Coverage Detection solution.
- icon: The Eligibility icon appears in a row when an eligibility transaction was triggered. Click the icon to open and view these results in the Eligibility solution.
- **Latest Response**: The date the most recent response was received for the associated claim status inquiry.
- **Sent To Payer**: The date the claim was sent to the payer.
- **Account**: The account that received the response.
- **Patient**: The patient name (last name, first name, middle initial) listed on the associated claim.
- **Claim Number**: The patient control number listed on the associated claim; this is typically the patient account number found in your practice management system.
- **Instance ID**: The Waystar-assigned tracking number listed on the associated claim.
- **Seq**: The payer sequence (1 = primary, 2 = secondary, 3 = tertiary, etc.) of the associated claim.
- **Service Date(s)**: The services date(s) listed on the associated claim.
- **Rendering Provider**: The rendering provider (individual who orders or refers an item or service) listed on the associated claim.
- **Payer**: The payer listed on the associated claim.
- **Total Charges**: The total cost of services (paid by insurance and patient responsibility) listed on the associated claim.
- **Status Codes**: The WPC claim status code listed on the response.
- **Follow-Up Category**: The Payer Follow-up category the response is currently in (see above for category definitions)
- **Waystar Recommendations**: Waystar's recommended follow-up action for the response.

Sorting the Monitoring Activity report results

After generating the report, you can sort the results data:

1. To sort the results table, click a column header that has the gray double-arrow to the right of the column name.

   A single black arrow will appear in place of the gray double-arrow.



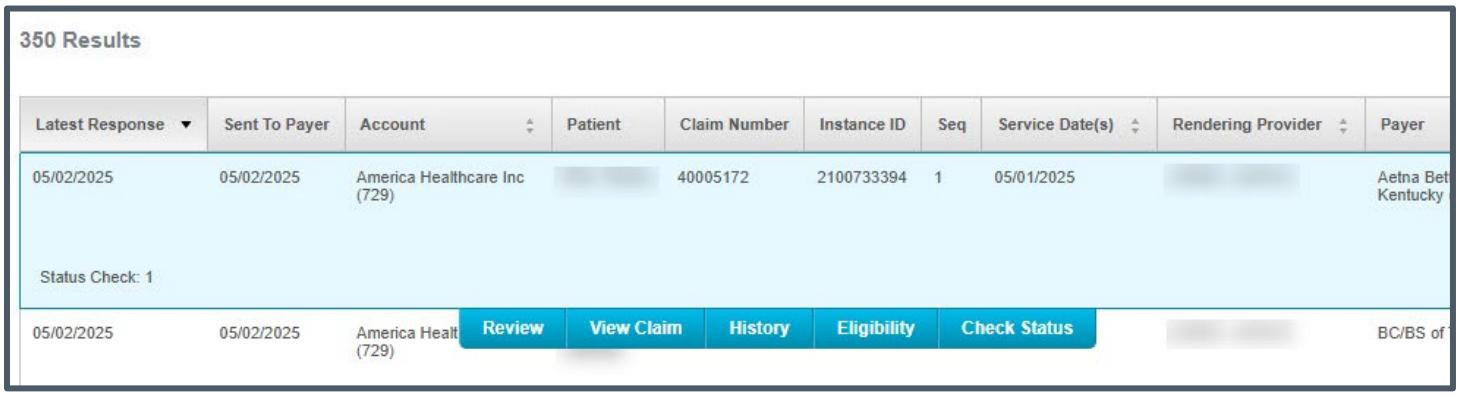
   With the initial click:

   - Text columns will sort A to Z.
   - Numeric columns will sort high to low.

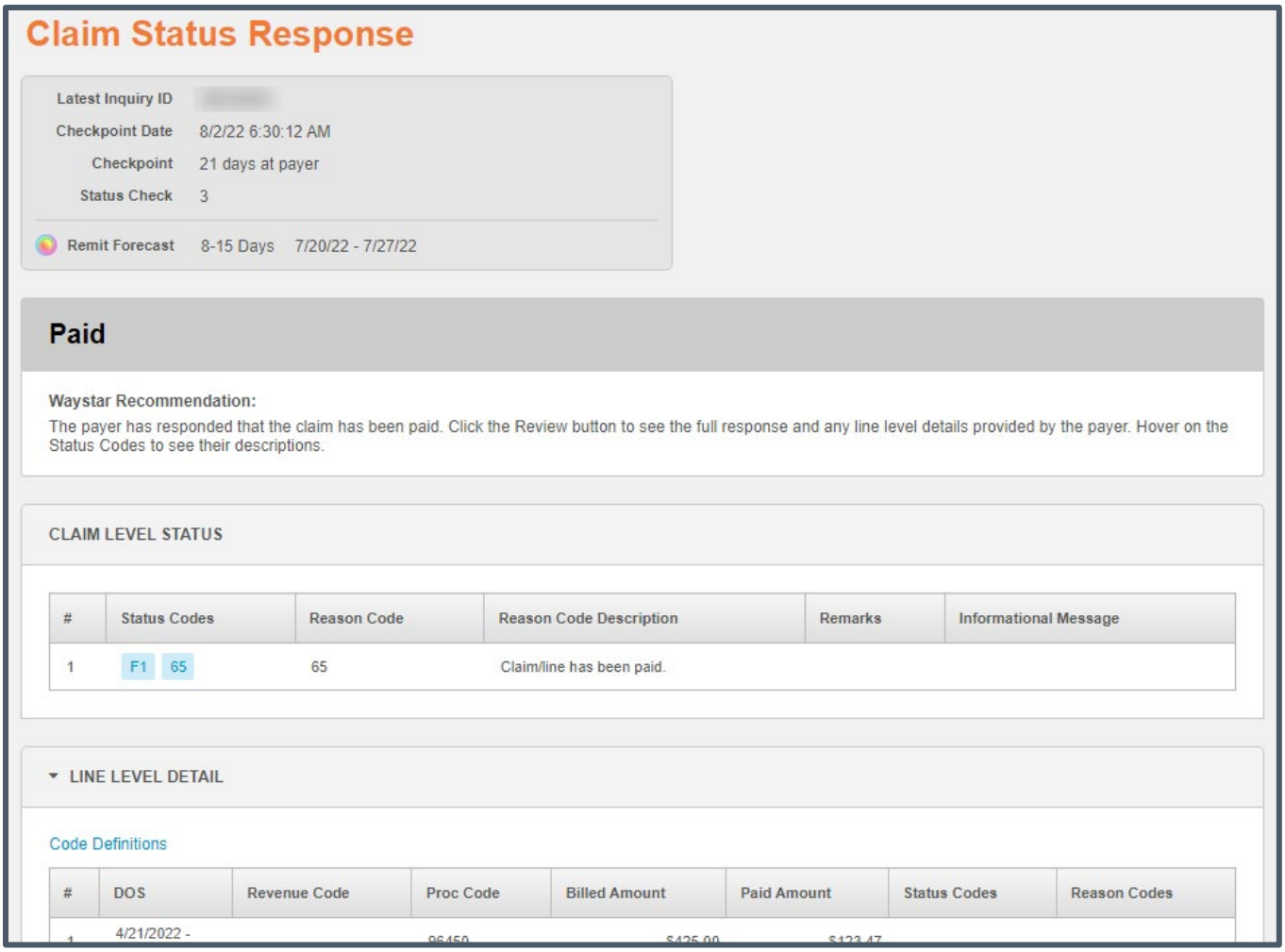
2. To reverse the order of the current sort (ascending vs. descending), click the same column header a second time. The black arrow will reverse its direction and the table will sort accordingly.
3. Sorting by Follow-Up Category is based on follow-up work priority. This work priority is defined as follows (high to low):
   1. Provider Info Request
   2. Denied
   3. Coordination of Benefits
   4. Patient Outreach
   5. Payer Outreach
   6. Claim Not Found
   7. Under Payer Review
   8. Finalized
   9. Paid
   10. Processing at Payer
   11. Patient Deductible
   12. Informational
   13. Uncategorized
   14. Patient Deductible

Using the Monitoring Activity report action menu

After generating the report, hover over a data row in the Monitoring Activity report to open the action menu with the following options:



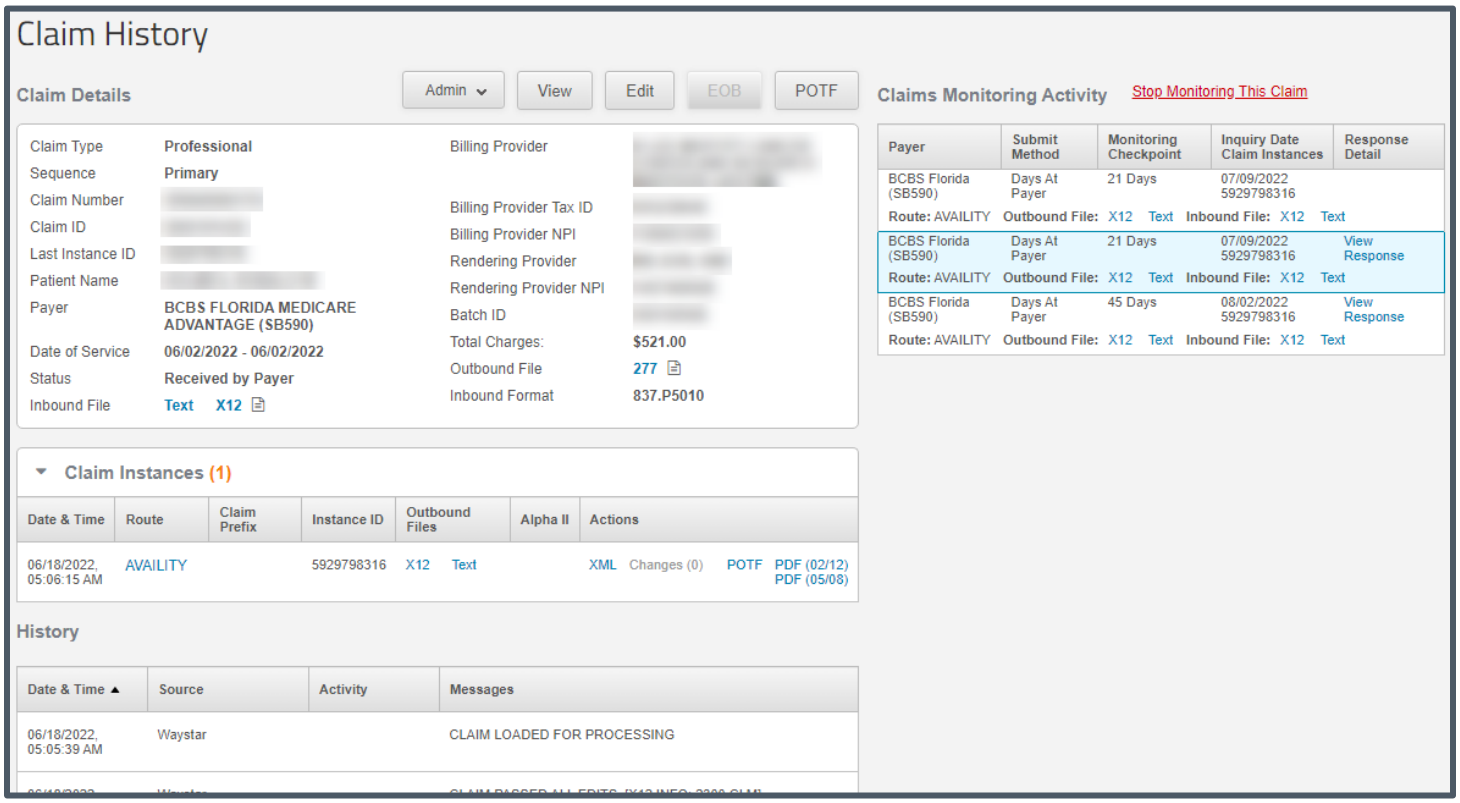
- **Review**: Opens the associated response detail screen, providing the following action items and claim status inquiry response details.



- **Latest Inquiry ID**: The Waystar-assigned identification number applied to the most recent instance of the inquiry
- **Checkpoint Date**: For inquiries set up via Claim Monitoring > Schedules, this field indicates the date the inquiry was submitted from the Waystar system. See the Claim Monitoring schedules section for more information on creating and managing Claim Monitoring schedules.
- **Checkpoint**: For inquiries set up via Claim Monitoring > Schedules, this field indicates the scheduled event that triggered the automated inquiry. See the Claim Monitoring schedules section for more information on creating and managing Claim Monitoring schedules.
- **Waystar Recommendation**: Displays the payer's response and Waystar's recommended resolution (if available).
- **Claim Level Status**: Includes the following claim-level response details:
  - **Status Codes**: The WPC status codes associated with the claim.
  - **Reason Code**: WPC or Proprietary Reason Codes captured from the payer's portal through RPA (Robotic Processing Automation).
  - **Reason Code Description**: WPC or Payer Proprietary description/definition of the reason code.
  - **Remarks**: Indicates any payer remarks for the associated claim.
  - **Informational Message**: Indicates any additional information provided by Waystar for the response.
- **Line Level Detail**: View all the line-level details provided by the payer, including specific Status Codes and Reason Codes. This menu also provides the following links and interactions:
  - **Code Definitions**: Click the link to view descriptions for the full list of status codes and reason codes that were reported across all of the associated claim service lines.
  - **Status Codes**: Hover over a status code to view the associated code description.
  - **Reason Codes**: Hover over a reason code to view the associated code description.
- **Payment**: Displays all payment-related information associated with the claim, including billed amounts, patient responsibility, and, if available, all payments returned.
- **Payer**: Displays payer and insurance plan information associated with the claim.
- **Patient**: Displays patient details and their associated insurance information.

- **View Claim**: Displays a PDF version of the CMS-1500 08/05 form.
  - All claim status inquiry responses viewed in Waystar will provide the same up-to-date information regardless of where you are viewing them.
  - See the Washington Publishing Company (WPC) website for more information about codes returned in your responses.

- **History**: Opens the Claim History screen that provides all the claim's basic information and event history.



The following actions items are also available on the Claim History screen:

- Click the **View Response** link in the **Response Detail** column on the right side of the screen to view the claim status inquiry response.
- If you would like to turn off monitoring for this claim, click the **Stop Monitoring This Claim** link at the top of the screen and confirm the action.

IMPORTANT: After monitoring for a claim is deactivated, it ***cannot*** be reactivated.

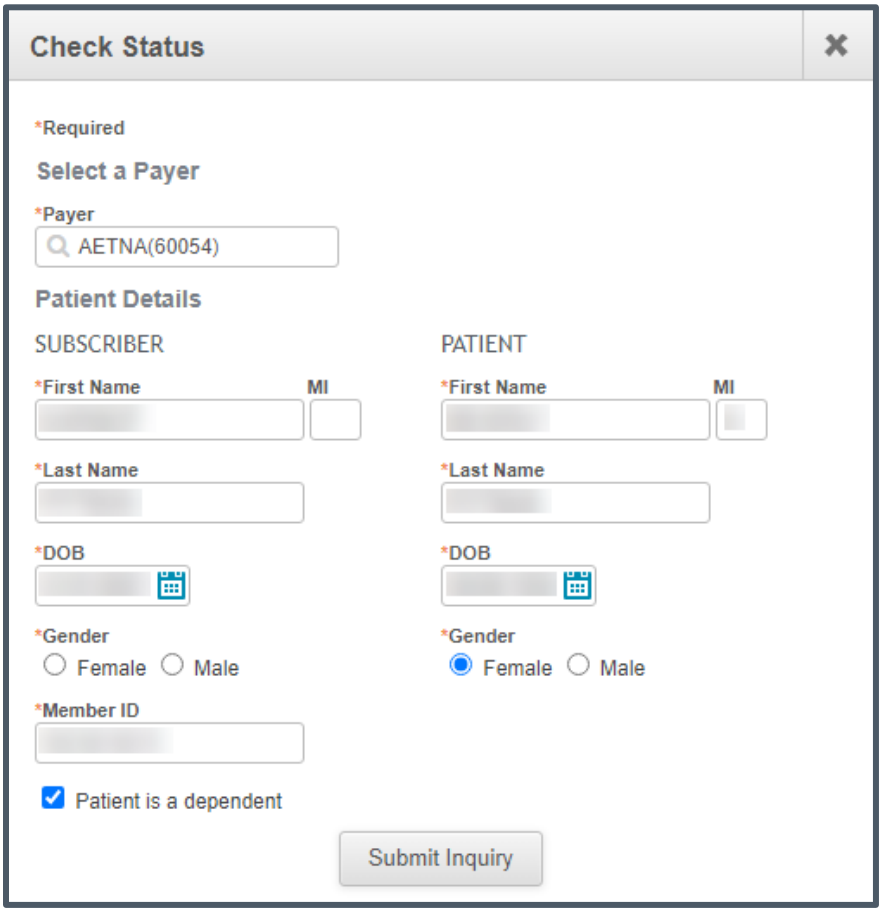
- **Eligibility**: Opens the New Eligibility Inquiry screen where you can manually submit an inquiry for the associated patient (see the Eligibility User Guide for more information on the Eligibility application and the process of submitting eligibility inquiries).

  Note: The Eligibility action button will be available only if you have subscribed to the Eligibility application.

  - The New Eligibility Inquiry screen will be pre-populated with the associated patient details.
  - After an eligibility request is submitted using the Eligibility action button, an eligibility icon ( ) will display on the associated report line. Click this icon to view the most recent payer response for the inquiry (if available).

- **Check Status**: Opens the Check Status screen where you can enter the requested payer and patient information and click **Submit** to send a manual claim status inquiry.

  Note: The requested fields will be prepopulated with payer and patient data from your claim(s).



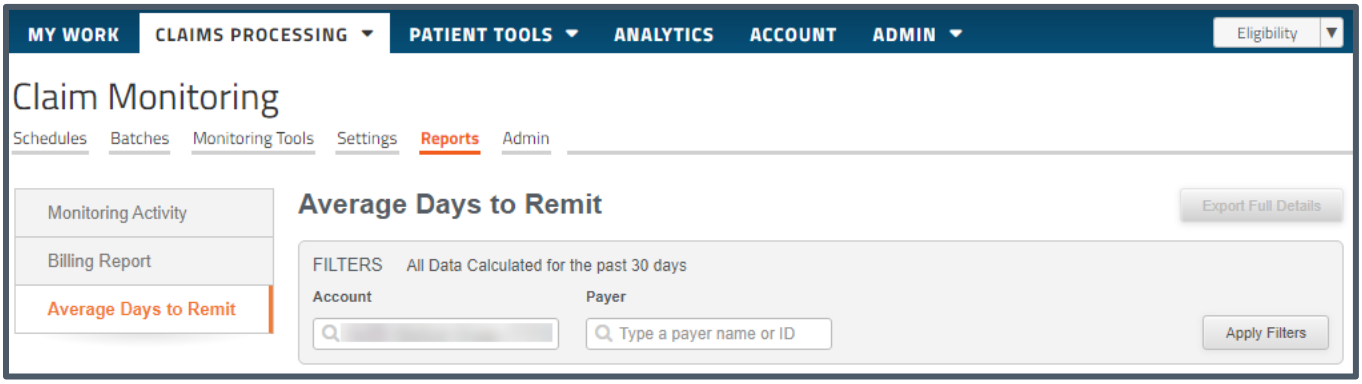
Working with the Average Days to Remit report

The Average Days to Remit report displays a list of payers' average remit dates for a selected account. A payer's average remit date (for a specified account) is the calculated average number of days it takes them to return remits from the time they received the claims. Use this report to determine when you should expect remits from your payers. This report also displays the aggregate average amount of time it takes for payers to return remits across the larger Waystar client base as a point of comparison.

Generating the Average Days to Remit report

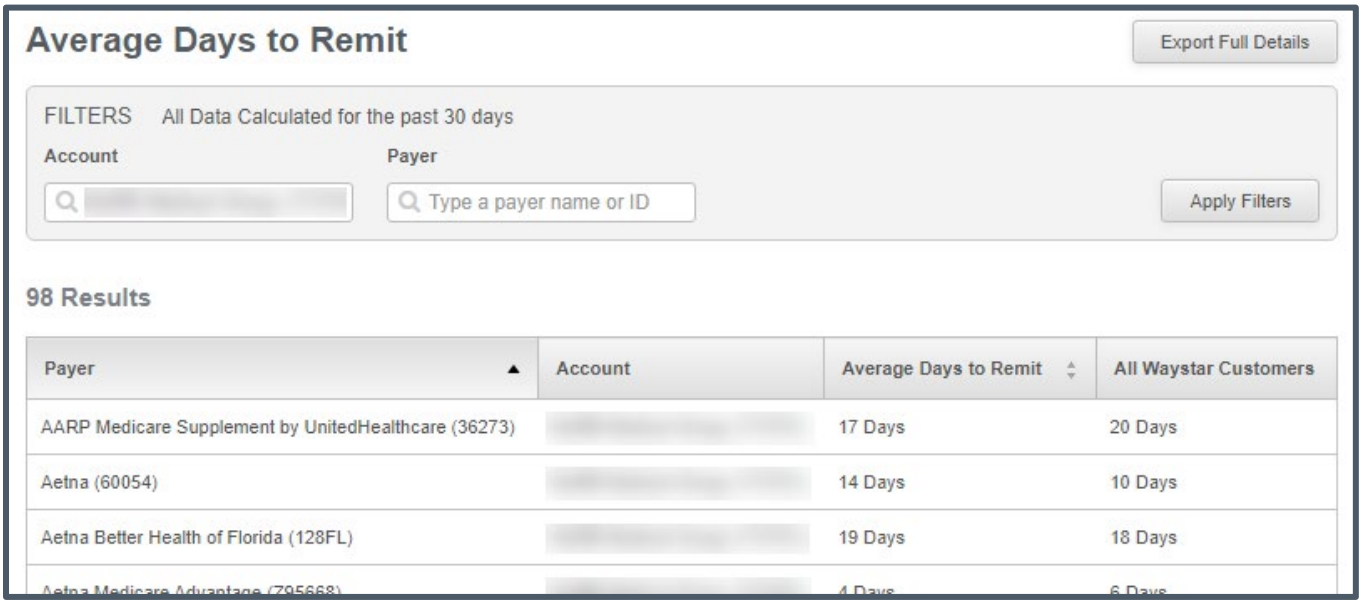
To generate the Average Days to Remit report:

1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Reports** > **Average Days to Remit**.



2. If desired, filter the report by **Account** or **Payer**.
3. Click the **Apply Filters** button.

The report details will open below the FILTERS pane. Just above the results you will see the number of payers included. Details will display for each payer, including their calculated Average Days to Remit.

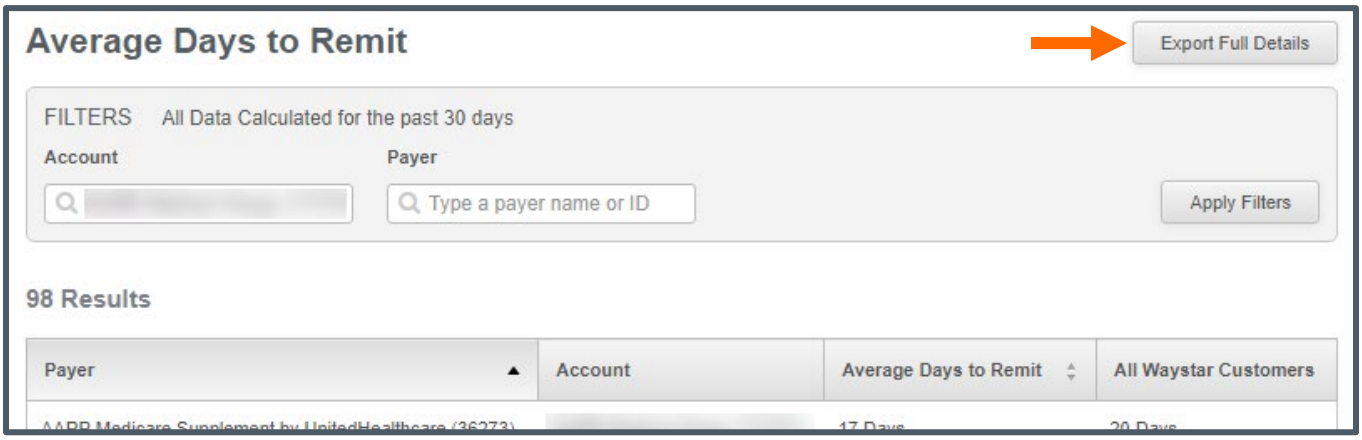


The following information will display for each reported payer:

- **Payer**: Payer name and ID
- **Account**: Account receiving the remits
- **Average Days to Remit**: The calculated average number of days it takes the corresponding payer to send remits to the reported provider.
- **All Waystar Customers**: A benchmark calculation of the average number of days it takes the corresponding payer to send remits for all Waystar customers. This helps you determine a payer's performance by comparing the amount of time it takes a payer to send them remits (Average Days to Remit) to how long it takes that payer to send remits to other Waystar customers.

Exporting the Average Days to Remit report

After generating the Average Days to Remit report, click the **Export Full Details** button above the search menu to see a more detailed version of the report in an Excel spreadsheet:



Claim Monitoring settings

Working with domain settings

This section explains how to work with your organization's Claim Monitoring domain settings.

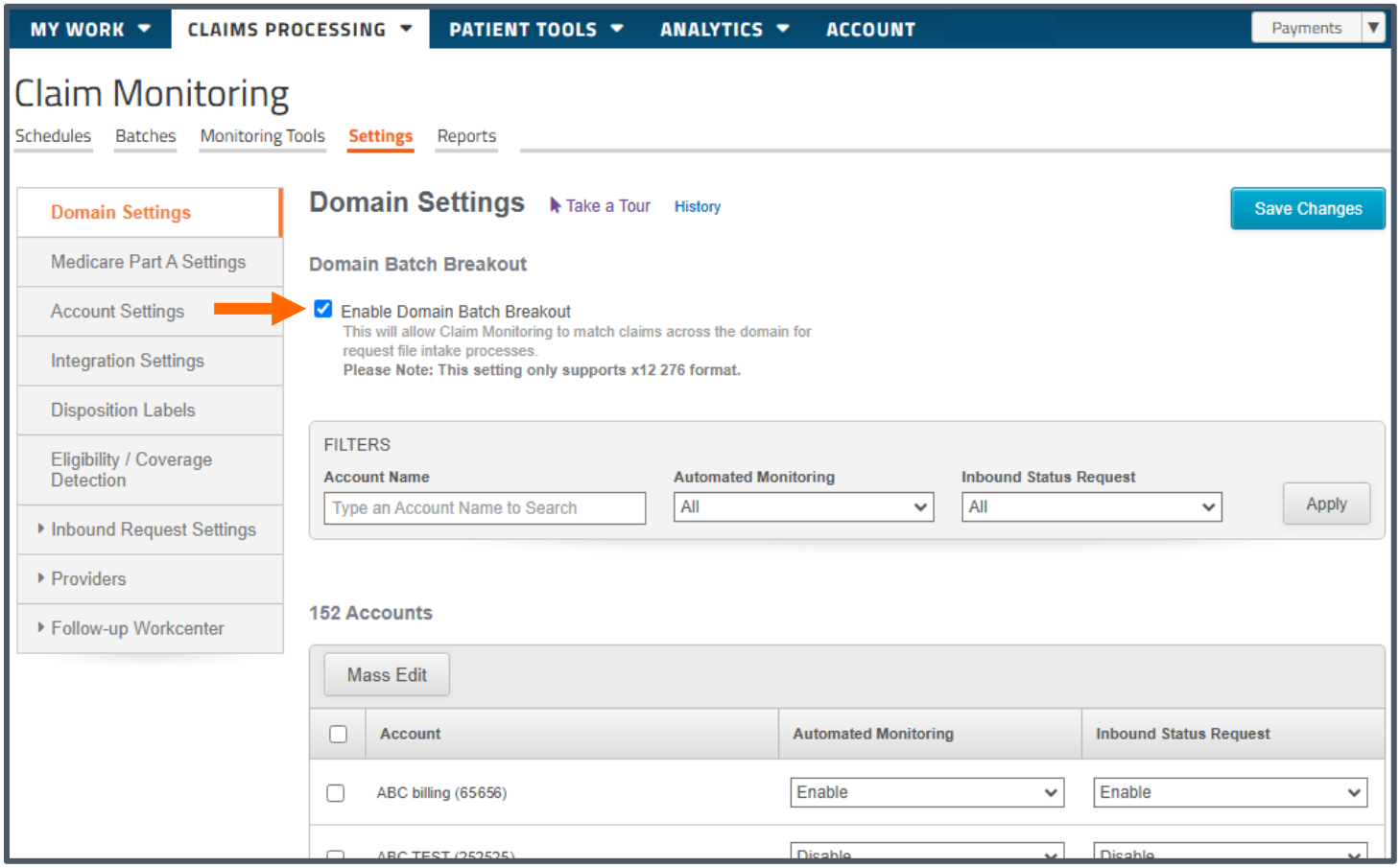
Enabling/disabling domain batch breakout

This section explains how to enable or disable domain batch breakout. When enabled:

- **X12 276**: This setting will allow Claim Monitoring to match claims in the **x12 276 format** across the domain for request file intake processes.
- **Flat file**: When leveraging domain batch breakout utilizing the **flat-file format and inbound requests**, Claim Monitoring will honor the flat trigger file mapping at the domain level. To map flat trigger files, see the Working with inbound request settings section.

To enable/disable domain batch breakout:

1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Domain Settings**.
2. Enable/disable as appropriate:
   - To **enable** domain batch breakout, select the checkbox.
   - To **disable** domain batch breakout, clear the checkbox.
3. When finished making your selection, click the **Save Changes** button in the upper-right corner of the screen.



Enabling/disabling domain and account settings

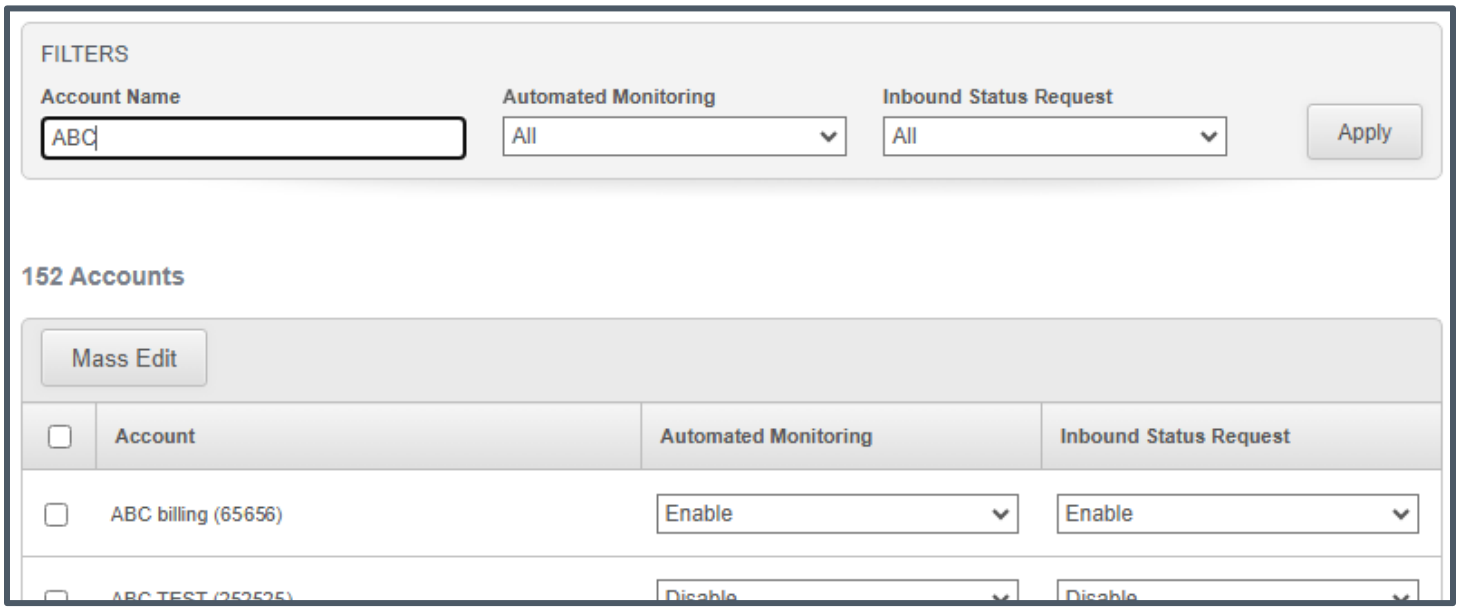
Filtering accounts

This section explains how to filter the accounts that appear in the list.

To filter the number of accounts that appear in the list:

1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Domain Settings**.
2. In the FILTERS area near the top, use the following criteria to narrow the accounts that appear in the list:
   - **Account Name**: Type part or all of an account name.
   - **Automated Monitoring**: From the dropdown, select **All**, **Disabled**, or **Enabled**.
   - **Inbound Status Request**: From the dropdown, select **All**, **Disabled**, or **Enabled**.
3. Click the **Apply** button.

   The list will update based on your filters.

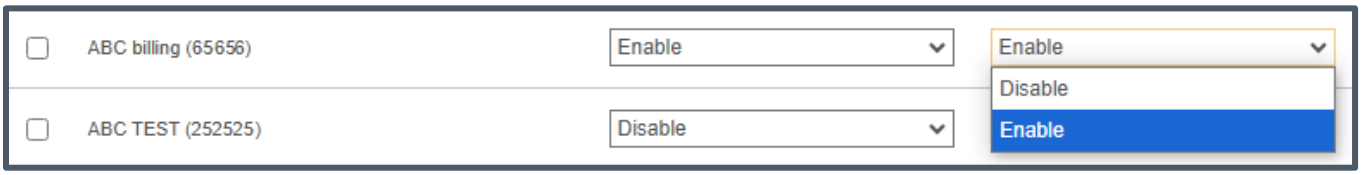


Enabling/disabling individual domain and account settings

This section explains how to enable/disable individual domain and account settings.

To edit an individual domain and account setting:

1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Domain Settings**.
2. As necessary, filter for the appropriate accounts.
3. From an account, make the appropriate selections:
   - **Automated Monitoring**: From the dropdown, select **Disable** or **Enable**. When enabled, the account will be leveraging schedules to begin monitoring claims.
   - **Inbound Status Request**: From the dropdown, select **Disable** or **Enable**. When enabled, the account will send realtime EDI claim status updates. Your organization will be able to send 276 requests and flat file requests via a synchronous (realtime) API call and receive a realtime 277 response in return.
4. When finished enabling/disabling, click the **Save Changes** button in the upper-right corner of the screen.

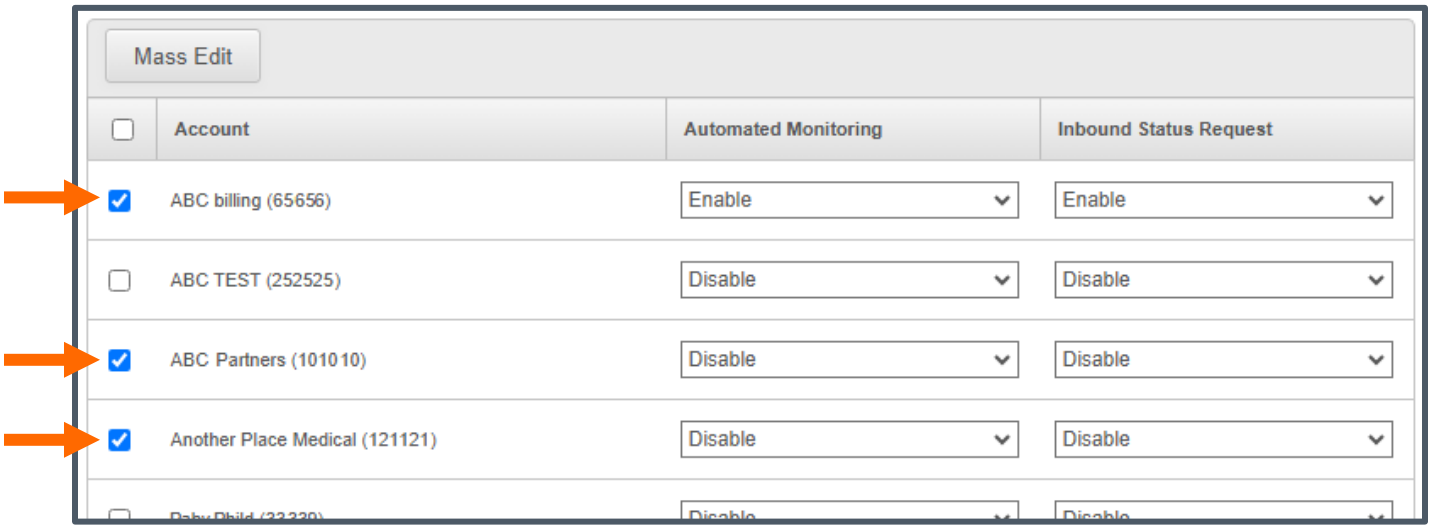


Mass editing accounts

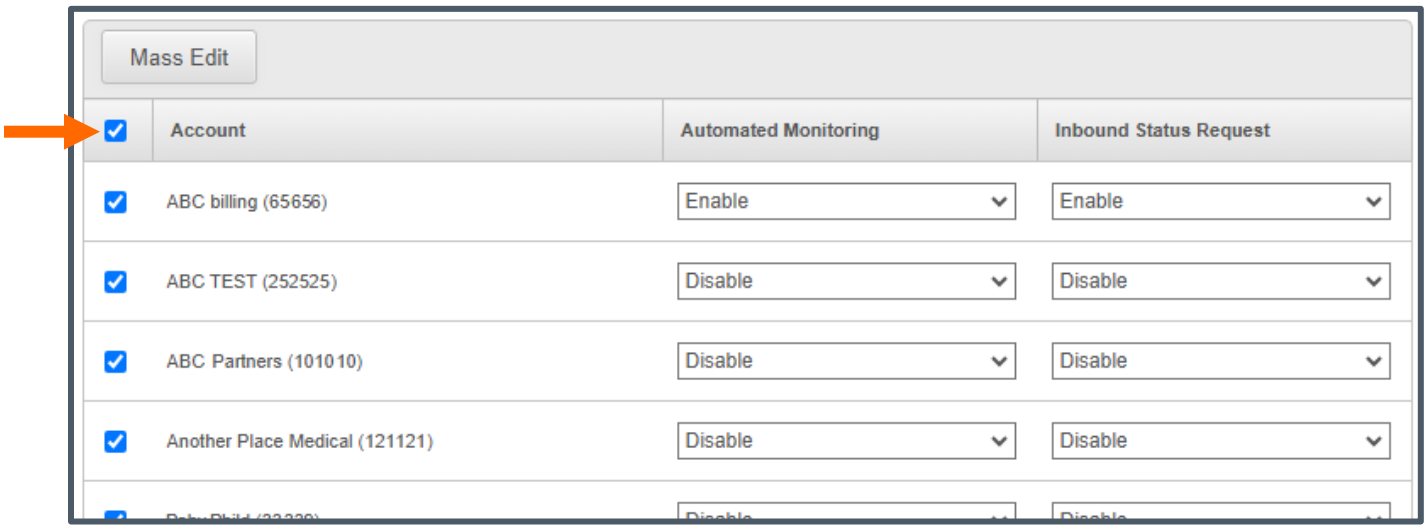
This section explains how to select multiple accounts and edit them all at the same time.

To mass edit your accounts:

1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Domain Settings**.
2. As necessary, filter for the appropriate accounts.
3. Select accounts:
   - To select individual accounts, click the checkboxes on the left side of the accounts.



- To select all accounts on the ***current page***, click the checkbox in the first column header.

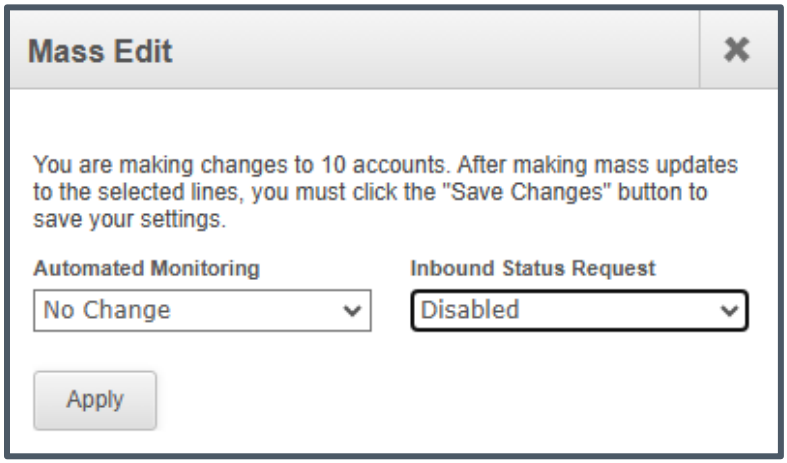


4. When finished making your account selections, click the **Mass Edit** button.

   The Mass Edit screen will open.

5. Make the appropriate selections:

   - **Automated Monitoring**: From the dropdown, select **No Change**, **Disabled**, or **Enabled**. When enabled, the account will be leveraging schedules to begin monitoring claims.
   - **Inbound Status Request**: From the dropdown, select **No Change**, **Disabled**, or **Enabled**. When enabled, the account will send realtime EDI claim status updates. Your organization will be able to send 276 requests and flat file requests via a synchronous (realtime) API call and receive a 277 response in return.



6. When finished making your selections, click the **Apply** button.

   All selected accounts will update in the list.

7. When finished with the mass edit, click the **Save Changes** button in the upper-right corner of the screen.

Working with Medicare Part A settings

These settings allow you to add the NPIs that you want monitored for Medicare Part A claims and, when appropriate, to remove them. For complete information, see the Medicare Part A Claim Monitoring Add-On User Guide.

Working with account settings

Enabling/disabling API passthrough

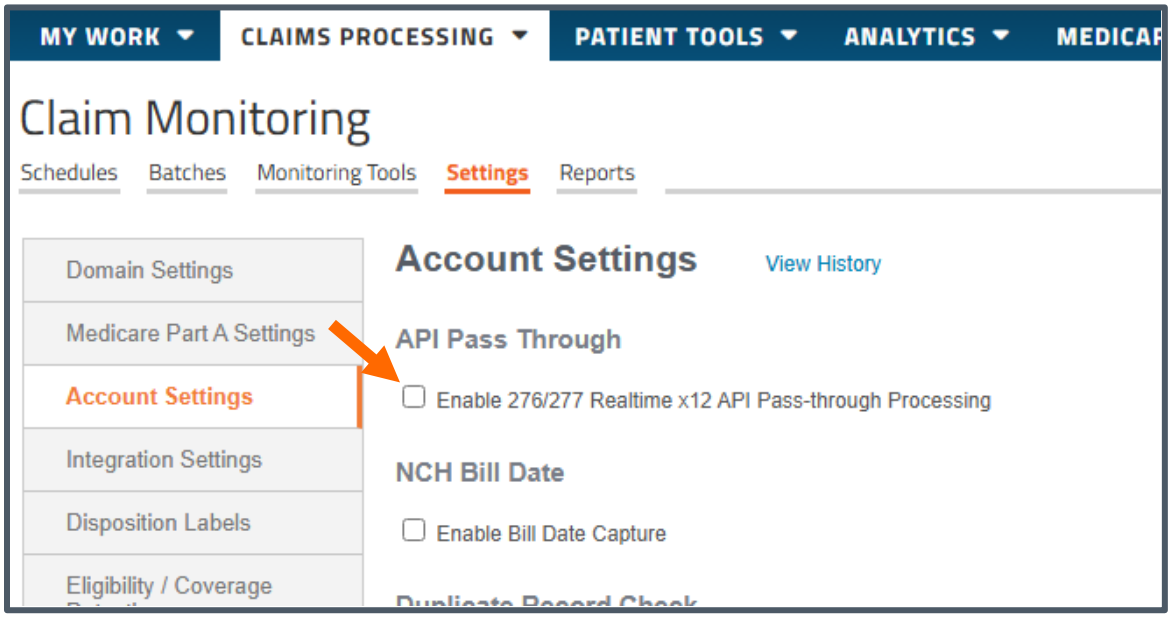
IMPORTANT: Enabling API passthrough will result in additional billing to your organization. Before enabling API passthrough, contact your Waystar Representative for details.

This section explains how to enable/disable API passthrough, which will allow your organization to send a realtime 276 request via a synchronous API call and receive a realtime 277 response in return.

Note: To enable API passthrough, the Inbound Status Request must also be enabled, which should have been done during Onboarding.

To enable/disable API passthrough:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Account Settings** screen.
2. Enable/disable as appropriate:
   - To **enable**, select the **Enable 276/277 Realtime x12 API Pass-through Processing** checkbox.
   - To **disable**, clear the **Enable 276/277 Realtime x12 API Pass-through Processing** checkbox.
3. When finished enabling or disabling, click the **Save Changes** button.



Enabling/disabling non-clearinghouse bill date capture

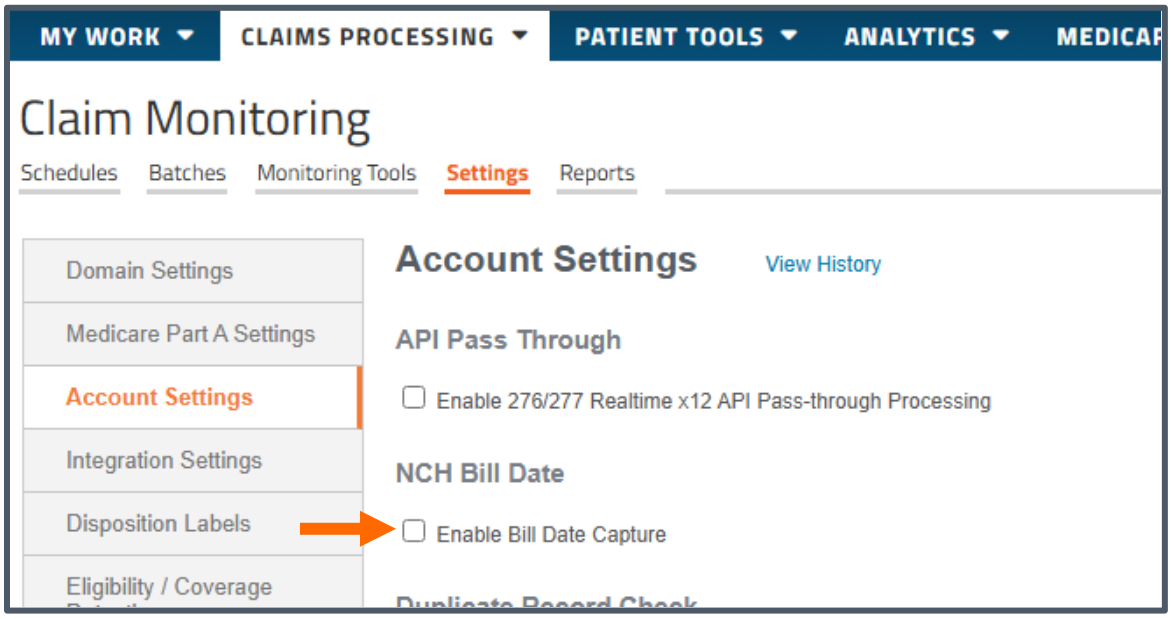
For non-clearinghouse (NCH) clients, Claim Monitoring will utilize the GS*04, which is the date the transaction was transmitted and equates to “original submission date” on the 837.

Use this setting if you want to utilize the original transmission date versus the traditional bill date. In Claim Monitoring, the traditional bill date equates to the date the claim was uploaded, whereas the original transmission date is the date that the claim was submitted as reported on the 837.

When you turn on this feature and schedule a “days at payer” event, Claim Monitoring will pull the original submission date.

To enable/disable NCH bill date capture:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Account Settings** screen.
2. Enable or disable as appropriate:
   - To **enable**, select the **Enable Bill Date Capture** checkbox.
   - To **disable**, clear the **Enable Bill Date Capture** checkbox.



3. When finished enabling or disabling, click the **Save Changes** button.

Enabling/disabling duplicate record check

This section explains the Duplicate Record Check setting that allows Claim Monitoring to identify when a new claim record is the same as a previous record that we are currently monitoring based on the matching method shown in this section. When we see two versions of the same claim, we will stop monitoring the original (previous) version and status the latest version based on these settings.

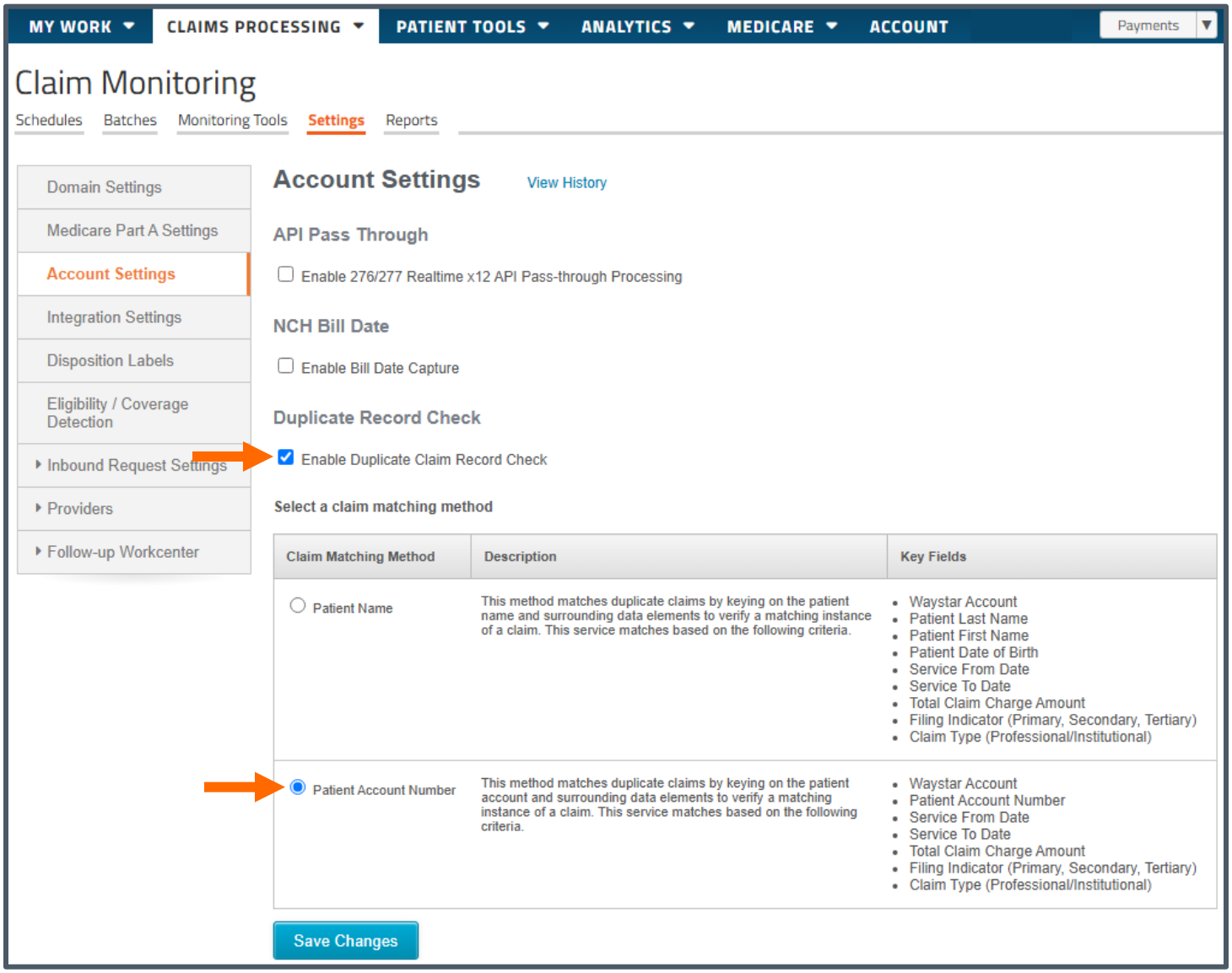
- You apply this setting at the individual account level.
- Duplicate records will be considered after the setting is enabled. Records found prior to that will not qualify.
- When Duplicate Record Check is enabled and the records do not match on the key fields per the matching method (see the following), Claim Monitoring will view them as two distinct records and will continue to status both claims.

To enable/disable duplicate record check:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Account Settings** screen.
2. Enable or disable as appropriate:
    - **To enable duplicate record check**:
        a. Select the **Enable Duplicate Claim Record Check** checkbox.
        b. Select ONE of the claim-matching methods:
            - **Patient Name**: This method matches duplicate claims by keying on the patient name and surrounding data elements to verify a matching instance of a claim. This service matches based on the following criteria:
                – Waystar Account
                – Patient Last Name
                – Patient First Name
                – Patient Date of Birth
                – Service From Date
                – Service To Date
                – Total Claim Charge Amount
                – Filing Indicator (Primary, Secondary, Tertiary)
                – Claim Type (Professional/Institutional).

- **Patient Account Number**: This method matches duplicate claims by keying on the patient account and surrounding data elements to verify a matching instance of a claim. This service matches based on the following criteria:
  - Waystar Account
  - Patient Account Number
  - Service From Date
  - Service To Date
  - Total Claim Charge Amount
  - Filing Indicator (Primary, Secondary, Tertiary)
  - Claim Type (Professional/Institutional).
- **To disable duplicate record check**, clear the **Enable Duplicate Claim Record Check** checkbox.

3. When finished enabling or disabling, click the **Save Changes** button.



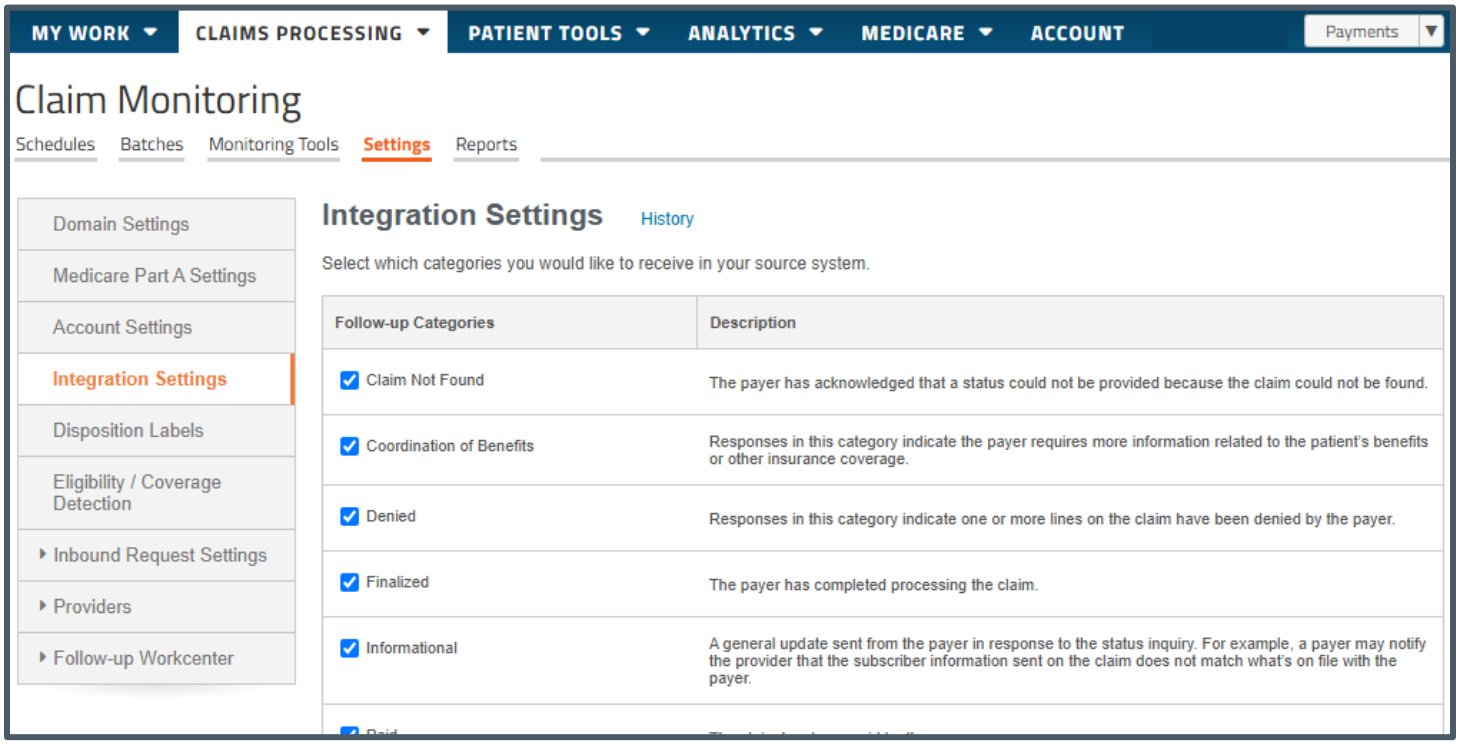
Working with integration settings

This section explains how to update your integration settings and control which follow-up categories are sent in your nightly 277.214 or CDR file directly to your source system.

Note: You can view these files after they are generated by going to **CLAIMS PROCESSING** > **Professional Claims** or **Institutional Claims** > **Reports** > **Claims Integration Report**.

To select Claim Monitoring responses:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Integration Settings** screen.



2. Select any of the following category checkboxes to limit your responses accordingly:
   - **Claim Not Found**: The payer has acknowledged that a status could not be provided because the claim could not be found in their system.
   - **Coordination of Benefits**: The claim has been denied or pended because the payer requires more information related to the patient's benefits.
   - **Denied**: The claim or lines within the claim have been denied by the payer.
   - **Finalized**: The payer has completed processing the claim.
   - **Informational**: A general update sent from the payer in response to the status inquiry. For example, a payer may respond that their system is down, and the inquiry needs to be resubmitted later.
   - **Paid**: The claim has been paid by the payer.
   - **Patient Outreach**: The recommended follow-up activity for the response is to contact the patient.
   - **Patient Deductible**: Waystar recommends that you review the patient deductible amount and follow up with the patient accordingly
   - **Provider Info Request**: Waystar recommends that you retrieve the information being requested and send it to the payer.

- **Payer Outreach**: The recommended follow-up activity for the response is to contact the payer.
- **Processing at Payer**: The claim is being processed by the payer. No action is being requested from the provider or patient.
- **Under Payer Review**: The payer has pended the claim for review. No action is being requested from the provider or patient.
- **Uncategorized**: Waystar has not assigned a category for the response.

3. When finished making your selections, click the **Save Changes** button at the bottom of the screen.

Working with Disposition Labels settings

These settings allow you to drive integrated workflows based off an assigned Disposition Label that you identify through these settings. For complete information, see the Claim Monitoring Disposition Labels User Guide.

Working with Eligibility/Coverage Detection settings

Enabling/disabling automatic eligibility verification

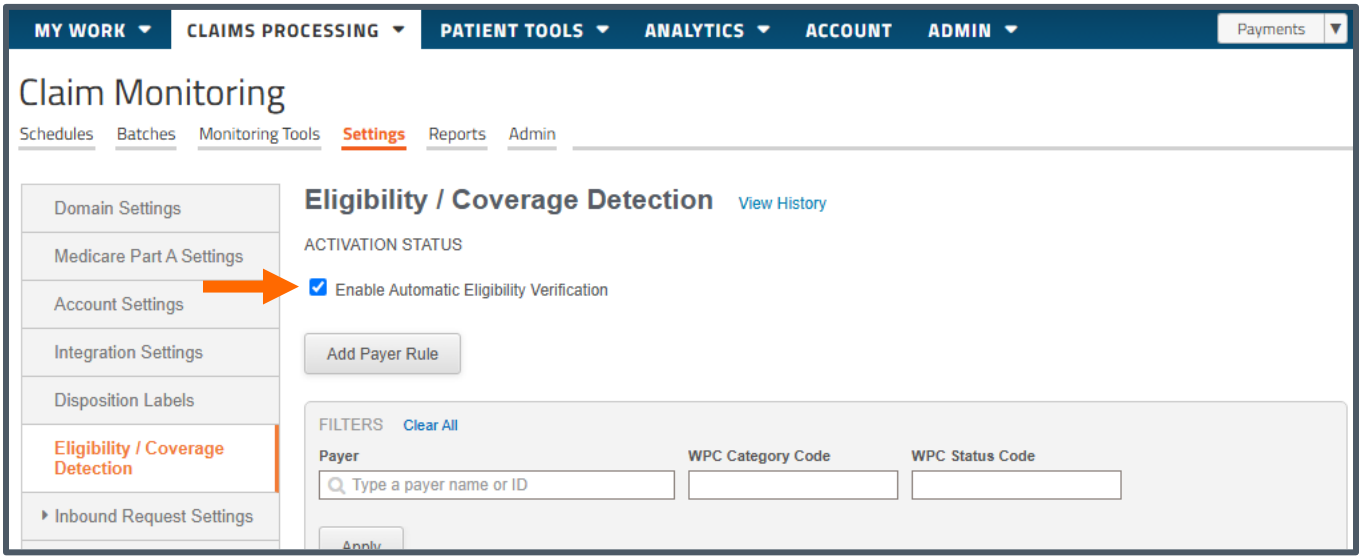
This section explains how to enable/disable the automatic eligibility verification. When enabled, this integrates between Claim Monitoring and Eligibility/Coverage Detection. The integration allows Claim Monitoring to run an eligibility inquiry or a coverage detection inquiry, if applicable, based on response data.

Note: Your organization also needs to add payer rules for Claim Monitoring to trigger an eligibility or coverage detection inquiry.

To enable/disable automatic eligibility verification:

1. If this setting is grayed out, contact your Waystar Representative to turn on the setting for your organization.
2. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Eligibility / Coverage Detection** screen.
3. Select the **Enable Automatic Eligibility Verification** checkbox.

   Note: If you are unable to select the Enable Automatic Eligibility Verification checkbox, contact your Waystar representative to have them turn on this feature.



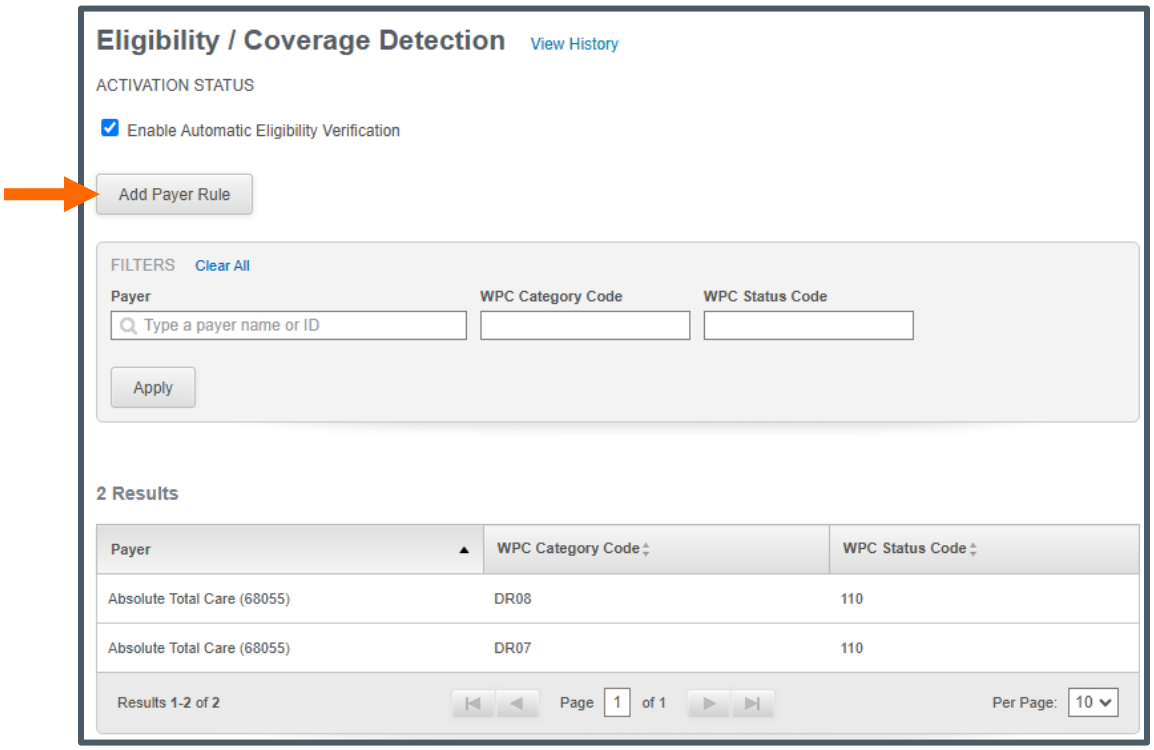
Working with payer rules

On the Eligibility / Coverage Detection settings screen your organization needs to create a payer rule to trigger an eligibility or coverage detection inquiry as applicable.

Adding a new payer rule

To add a new payer rule:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Eligibility / Coverage Detection** screen.
2. Click the **Add Payer Rule** button.



The New Payer Rule screen will open.

3. Complete the following fields, which are combined to trigger an applicable eligibility/coverage detection inquiry.
   - **Payer**: Begin typing a payer name or number and, from the list that will open, select the payer for which Claim Monitoring will trigger an eligibility/coverage detection inquiry.
   - **Category Code**: From the dropdown, select the appropriate WPC category code.
   - **Status Code**: *Optional*. From the dropdown, select the appropriate status code.

4. Click the **Save** button.

   The new payer rule will appear in the list.

Editing a payer rule

To edit a payer rule:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Eligibility / Coverage Detection** screen.
2. From the list of payers, hover over a row.

   The action menu will open.

3. Click the **Edit** button.

   The Edit Payer Rule screen will open.

4. Update any of the following fields:
   - **Payer**: Begin typing a payer name or number and select the payer for which Claim Monitoring will trigger an eligibility/coverage detection inquiry.
   - **Category Code**: From the dropdown, select the appropriate WPC category code.
   - **Status Code**: *Optional*. From the dropdown, select the appropriate status code.
5. Click the **Save** button.

Deleting a payer rule

To delete a payer rule:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Eligibility / Coverage Detection** screen.
2. From the list of payers, hover over a row.

   The action menu will open.

3. Click the **Delete** button.

   The Delete Rule confirmation screen will open.

4. To confirm the deletion, click the **Delete Rule** button.

   The rule will be removed from the list.

Copying a payer rule

To copy a payer rule:

1. Go to the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Eligibility / Coverage Detection** screen.
2. From the list of payers, hover over a row.

   The action menu will open.

3. Click the **Copy** button.

   The Copy Payer Rule screen will open.

4. Update any of the following fields:
   - **Payer**: Begin typing a payer name or number and, from the list that will open, select the payer for which Claim Monitoring will trigger an eligibility/coverage detection inquiry.
   - **Category Code**: From the dropdown, select the appropriate WPC category code.
   - **Status Code**: *Optional*. From the dropdown, select the appropriate status code.
5. Click the **Save** button.

   The copied payer rule will appear in the list along with the original payer rule.

Understanding inbound request settings

There are inbound request settings that, when enabled by a Waystar team member, allow your organization to initiate statusing for 276.5010 files and flat trigger files along with mapping flat trigger files. Contact Waystar Support for details.

Working with provider overrides

Overview

You may need to apply a provider override to receive statuses for certain providers. These are exception-based scenarios and are typically related to how a specific payer has the provider's information stored in their system.

The **CLAIMS PROCESSING > Claim Monitoring > Settings > Providers** screens allow you to apply provider overrides to receive statuses back in exception-based scenarios when payers have atypical provider information stored in their system.

Creating a provider override

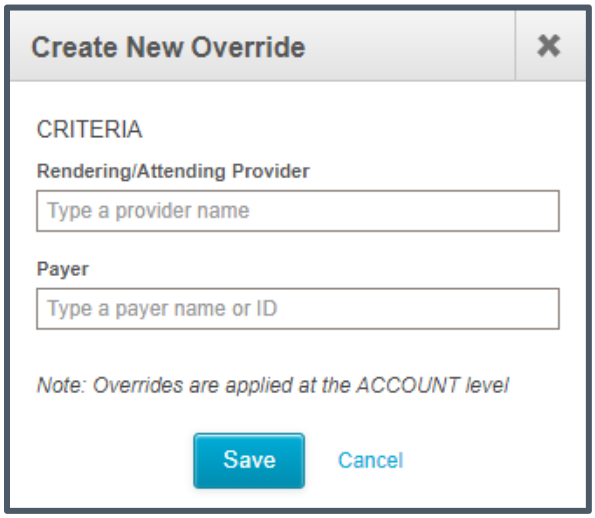
If a payer has provider information stored in their system that does not match what you will be sending in your claim status inquiries, you can create a provider override from both the Rendering/Attending Providers and Billing Providers screens (see the Working with the Rendering/Attending Providers screen and the Working with the Billing Providers screen section below for more information on how to navigate and use these screens).

Note: Creating provider overrides are needed only for ***exception-based scenarios***. Most provider information stored in the Claim Monitoring system should match the payer's information.

To create a provider override:

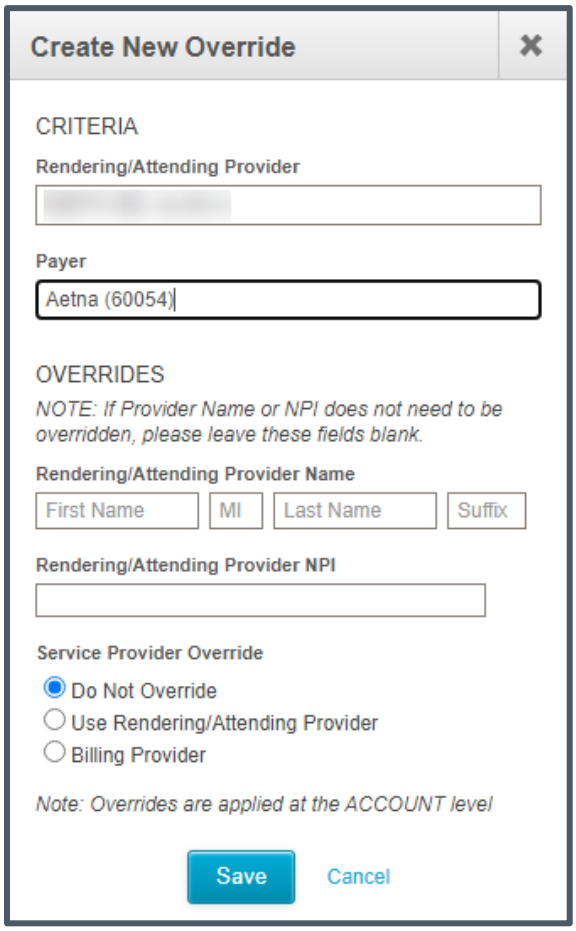
1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Providers** > **Rendering/Attending Providers** or **Billing Providers** screen.
2. From the Rendering/Attending Providers or Billing Providers screen, click the **Create Override** button.

The Create New Override screen will open.



3. Based on the Provider screen you're working from, enter either the **Rendering/Attending Provider** name or the **Billing Provider** name sent in the claim status inquiry.
4. Enter the **Payer** name and/or ID you would like to apply the override for.

   After entering the above, the screen will automatically expand as needed.
5. Based on the Provider screen you're working from, enter the **Rendering/Attending Provider Name** or the **Billing Provider** name that will override the payer's provider name.
6. Based on the Provider screen you're working from, enter the desired **Rendering/Attending Provider NPI** or the **Billing Provider NPI** that will override the payer's NPI.
7. (The following is only available for Rendering/Attending Providers) To override the service provider loop, select the appropriate **Service Provider Override**:
   - **Do Not Override**: The claim status inquiry will be sent according to the default value (used for all providers) set for the selected payer.
   - **Use Rendering/Attending Provider**: If a payer is configured globally to have the billing provider sent as the service provider in the claim status inquiry, this override will send the rendering/attending provider as the service provider instead.
   - **Use Billing Provider**: If a payer is configured globally to have the rendering/attending provider sent as the service provider in the claim status inquiry, this override will send the billing provider as the service provider instead.
8. When finished entering information, click the **Save** button.



Working with the Rendering/Attending Providers screen

The **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Providers** > **Rendering/Attending Providers** screen displays an alphabetical list (by last name) of the providers in your account with previously applied overrides.

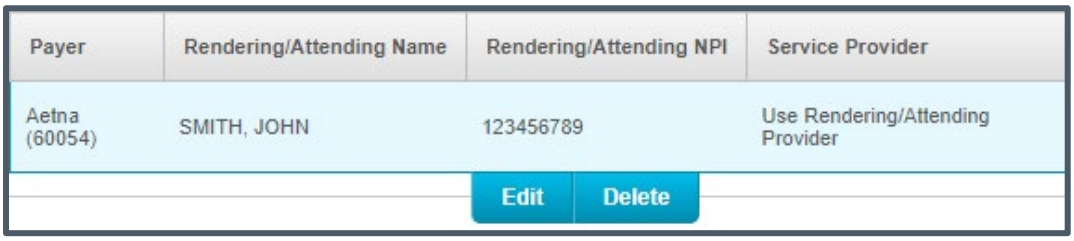
To view the associated provider details, click a provider name on the left side of the screen.

Note: The first provider in the list is selected by default.

- **Payer**: Payer receiving the claim status inquiries (276s).
- **Rendering/Attending Name**: The rendering/attending provider name sent in the claim status inquiry.
- **Rendering/Attending NPI**: The rendering/attending provider NPI sent in the claim status inquiry.
- **Service Provider**: The override will send one of the following values to the selected payer as the service provider in the claim status inquiry:
  - **Do Not Override**: The claim status inquiry will be sent according to the default value (used for all providers) set for the selected payer.
  - **Use Billing Provider**: If a payer is configured globally to have the rendering/attending provider sent as the service provider in the claim status inquiry, this override will send the billing provider as the service provider instead.
  - **Use Rendering Provider**: If a payer is configured globally to have the billing provider sent as the service provider in the claim status inquiry, this override will send the rendering/attending provider as the service provider instead.

Using the Rendering/Attending Providers screen action menu

When hovering over a provider/override on the right side of the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Providers** > **Rendering/Attending Providers** screen, the item will highlight, and the action menu will open below the row.



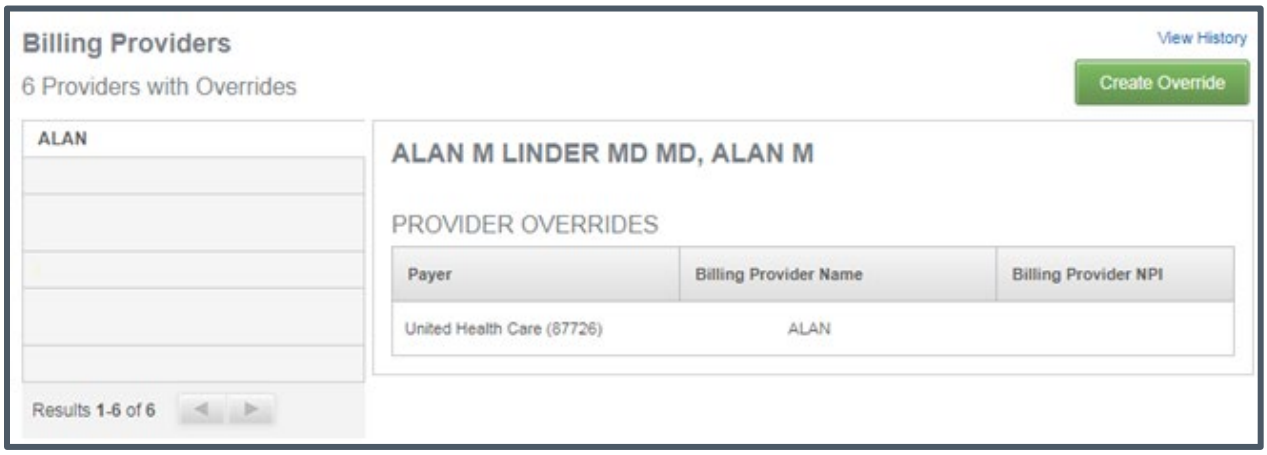
- **Edit**: Opens the Edit Provider Override screen where you can modify the following provider information:
  - **Overrides**
    - **Rendering/Attending Provider Name**: The Rendering/Attending Provide Name that you would like sent to the payer for Claim Monitoring claims status inquiries.
    - **Rendering/Attending Provider NPI**: The Rendering/Attending Provider NPI that you would like sent to the payer Claim Monitoring claim status inquiries.
  - **Service Provider Override**
    - **Do Not Override**: The claim status inquiry will be sent according to the default value (used for all providers) set for the selected payer.
    - **Use Billing Provider**: If a payer is configured globally to have the rendering/attending provider sent as the service provider in the claim status inquiry, this override will send the billing provider as the service provider instead.
    - **Use Rendering Provider**: If a payer is configured globally to have the billing provider sent as the service provider in the claim status inquiry, this override will send the rendering/attending provider as the service provider instead.

  When you are satisfied with the entered information, click the **Save** button to apply your changes.

  Note: These changes will be applied at the account level only.
- **Delete**: Removes all the previously applied overrides and the associated provider record. After clicking this button, you will be asked to confirm the deletion. Click the **Confirm Remove** button to clear the overrides and the associated provider record.

Working with the Billing Providers screen

The **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Providers** > **Billing Providers** screen will display a list of overriding payer-specific billing provider names and NPIs:



This provider list is sorted alphabetically by last name. Note, however, you cannot override the service provider in the 276 file on this screen.

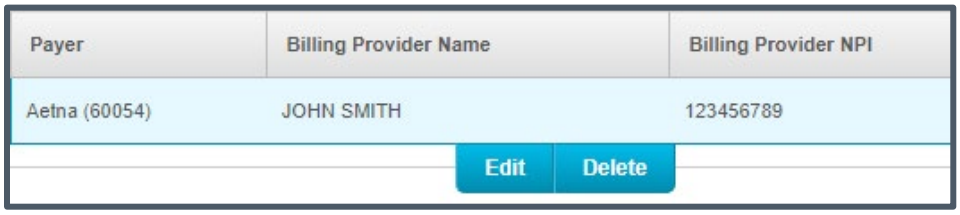
Click any of the provider names on the left side of the screen to view the associated provider details:

Note: The first provider in the list is selected by default.

- **Payer**: Payer receiving the claim status inquiries (276s).
- **Billing Provider Name**: The billing provider name sent in the claim status inquiry.
- **Billing Provider NPI**: The billing provider NPI sent in the claim status inquiry.

Using the Billing Providers screen action menu

When hovering over a provider/override on the right side of the **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Providers** > **Billing Providers** screen, the item will highlight, and the action menu will open.



- **Edit**: Opens the Edit Provider Override screen where you can modify the following provider information:
  - **Billing Provider Name**: The Billing Provide Name that you would like sent to the payer for Claim Monitoring claims status inquiries.
  - **Billing Provider NPI**: The Billing Provider NPI that you would like sent to the payer Claim Monitoring claim status inquiries.

  When you are satisfied with the entered information, click Save to apply your changes.

  Note: These changes will be applied at the account level only.
- **Delete**: Removes all the previously applied overrides and the associated provider record. After clicking this button, you will be asked to confirm the deletion. Click Confirm Remove to clear the overrides and the associated provider record.

Working with the Follow-up Workcenter settings

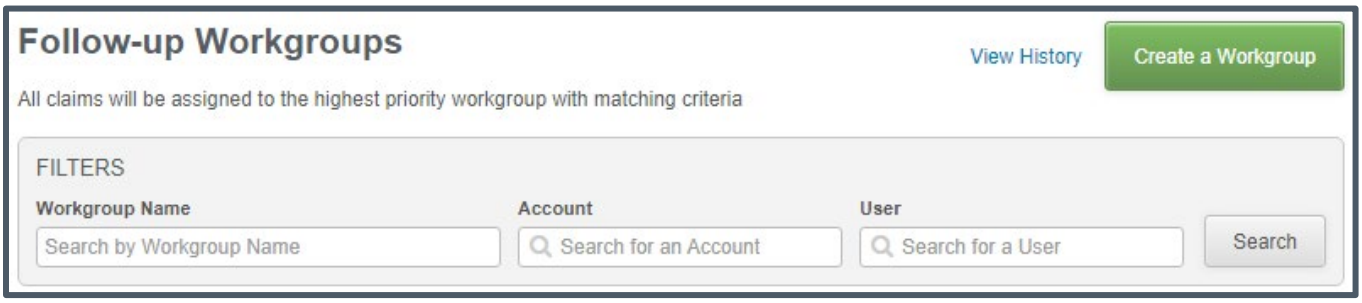
The **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Follow-up Workcenter** screens allow you to configure your Payer Follow-up workcenter to automatically assign follow-up tasks to a user or group of users, based on a set of defined rules. See the Payer Follow-up work center section for more information on how to complete follow-up work from the Payer Follow-up workcenter. You can also configure the Follow-up Workcenter settings to assign priority levels to different workgroups in your account to send the right work to the right people.

Note: A work item can appear in only one workgroup at a time, even if it meets the criteria for multiple workgroups.

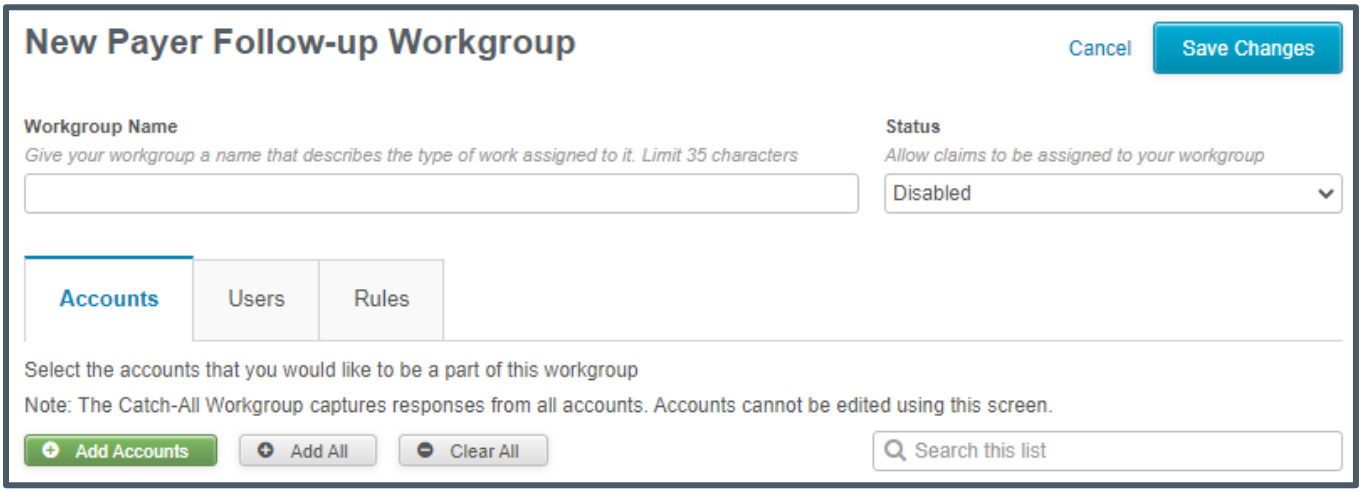
Creating a workgroup

Follow these steps to create a new workgroup in the Payer Follow-up workcenter:

1. Go to **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Follow-up Workcenter** > **Follow-up Workgroups**.
2. Click the **Create a Workgroup** button.



The New Payer Follow-up Workgroup screen will open.



3. Enter a unique workgroup name in the **Workgroup Name** field. This name should be descriptive enough to make it easily identifiable on the Payer Follow-up workcenter.

Adding accounts

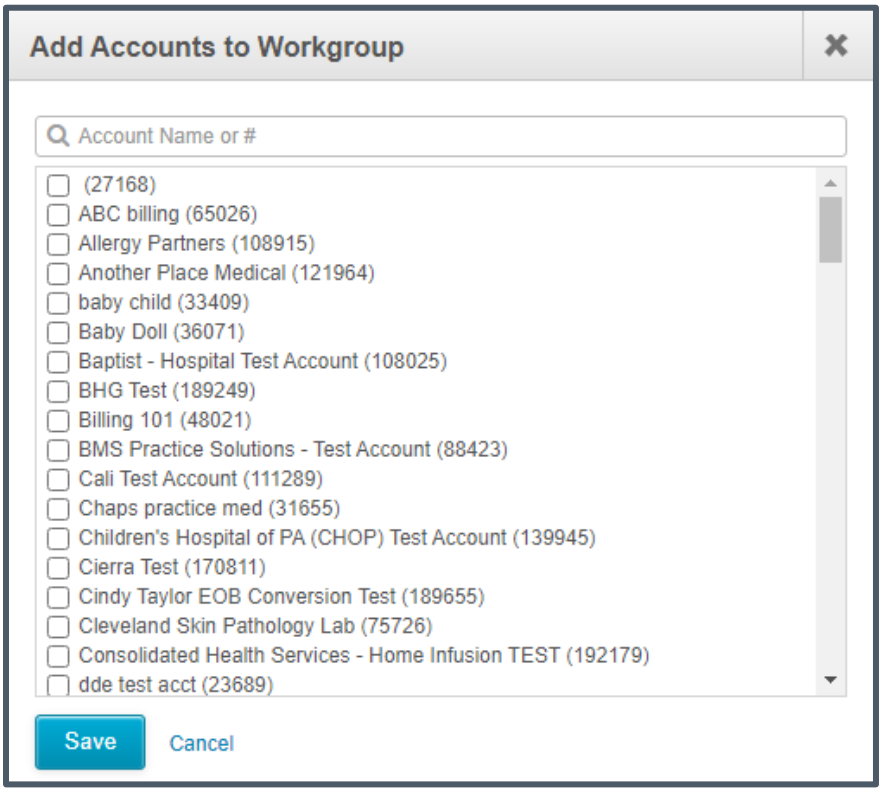
Near the bottom of the screen, the Accounts tab is selected by default.

4. From the **Accounts** tab, to add new accounts:

   a. Do ONE of the following:

   - To add all the accounts in your domain to the workgroup, click the **Add All** button. You can skip the rest of these steps.
   - To select individual accounts, click the **Add Accounts** button.

   The rest of these steps are based on clicking the **Add Accounts** button, which will open the Add Accounts to Workgroup screen.



   b. On the Add Accounts to Workgroup screen, either scroll the list to find the appropriate account name/ID or search for the desired account by entering the account name and/or ID in the search field at the top.

   Note: When entering text in the search field, the results will automatically display.

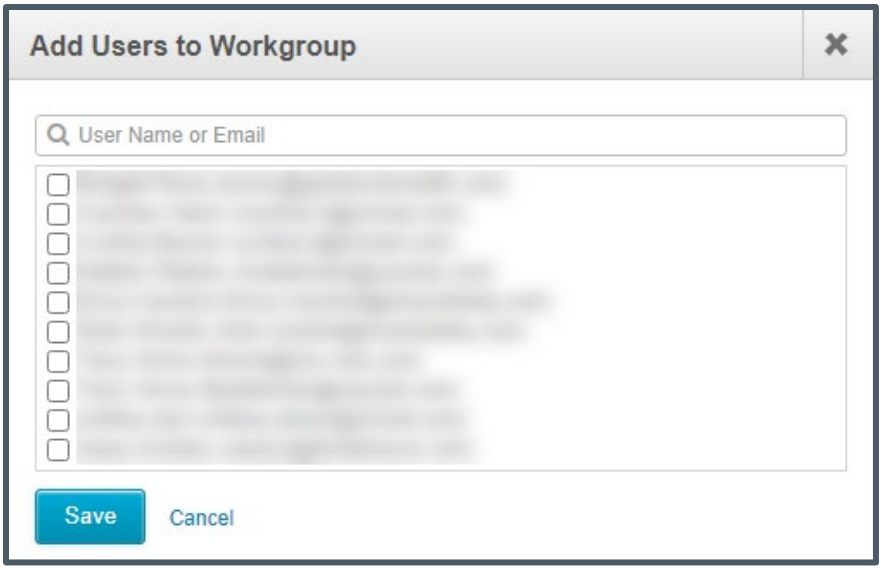
   c. Click the checkbox to the left of the account(s) you would like to add to the workgroup.

   d. When all the desired accounts are selected, click the **Save** button to add them to the workgroup. The selected accounts will appear back on the New Payer Follow-up Workgroup screen.

Adding users

5. From the **Users** tab, to add new accounts:
   a. Do ONE of the following:
      - To add all users in your domain to the workgroup, click the **Add All** button. You can skip the rest of these steps.
      - To select individual users, click the **Add Accounts** button.

      The rest of these steps are based on clicking the **Add Users** button, which will open the Add Users to Workgroup screen.



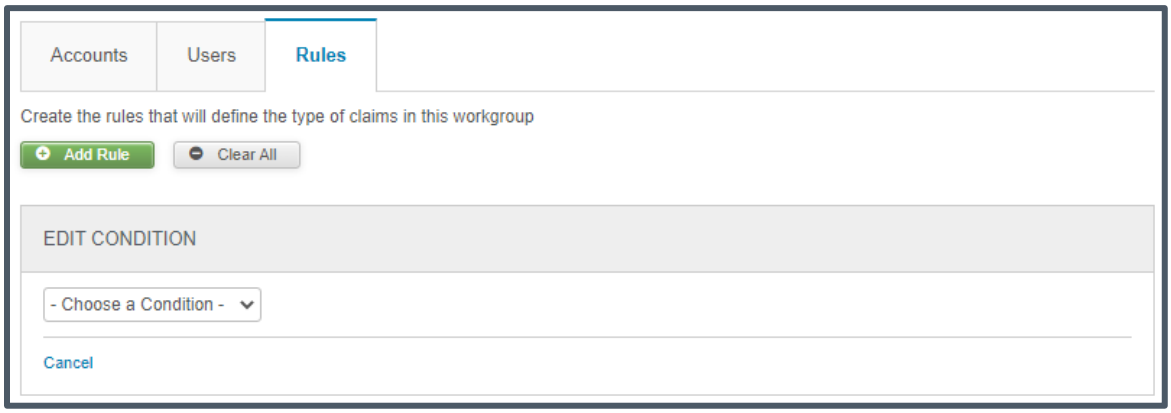
   b. On the Add Users to Workgroup screen, either scroll the list to find the appropriate user or search for the desired user by entering the user name in the search field at the top.

      Note: When entering text in the search field, the results will automatically display.

   c. Click the checkbox to the left of the user(s) you would like to add to the workgroup.
   d. When all the desired users are selected, click the **Save** button to add them to the workgroup. The selected users will appear back on the New Payer Follow-up Workgroup screen.

Adding rules

6. From the **Rules** tab, to add rules that will automatically assign follow-up tasks to the selected accounts and users:
   a. Click the **Add Rule** button. The EDIT CONDITION section will open.



IMPORTANT: For the purpose of this user guide, the steps below will provide instructions on how to create a specific set of rules ***as an example***. You will need to create rules based on the workflow required for your workgroup.

   b. From the **Choose a Condition** dropdown, select the first work attribute subject to the rule (e.g. **Waystar Payer**). The system may request more information about this piece of the rule.
   c. In the secondary field to the right of the condition, enter the more specific information about the first part of the rule.

      For this example, **Aetna** was entered as the Waystar Payer.

      This first rule will cause all follow-up work for the payer Aetna to be sent to this workgroup.

      Note: In addition to all entered rules, follow-up work must also agree with the settings applied on the Workcenter Data Limiters screen before they will display on the workgroup. See the Working with the Workcenter Data Limiters screen section for more information.
   d. From the **Choose a Condition** dropdown, select the ***second*** work attribute subject to the rule (e.g. **Rendering Provider**). Again, the system may request more information about the second piece of the rule.
   e. In the secondary field to the right of the condition, enter the more specific information about the second part of the rule.

      For this example, **Test** was entered as this provider.

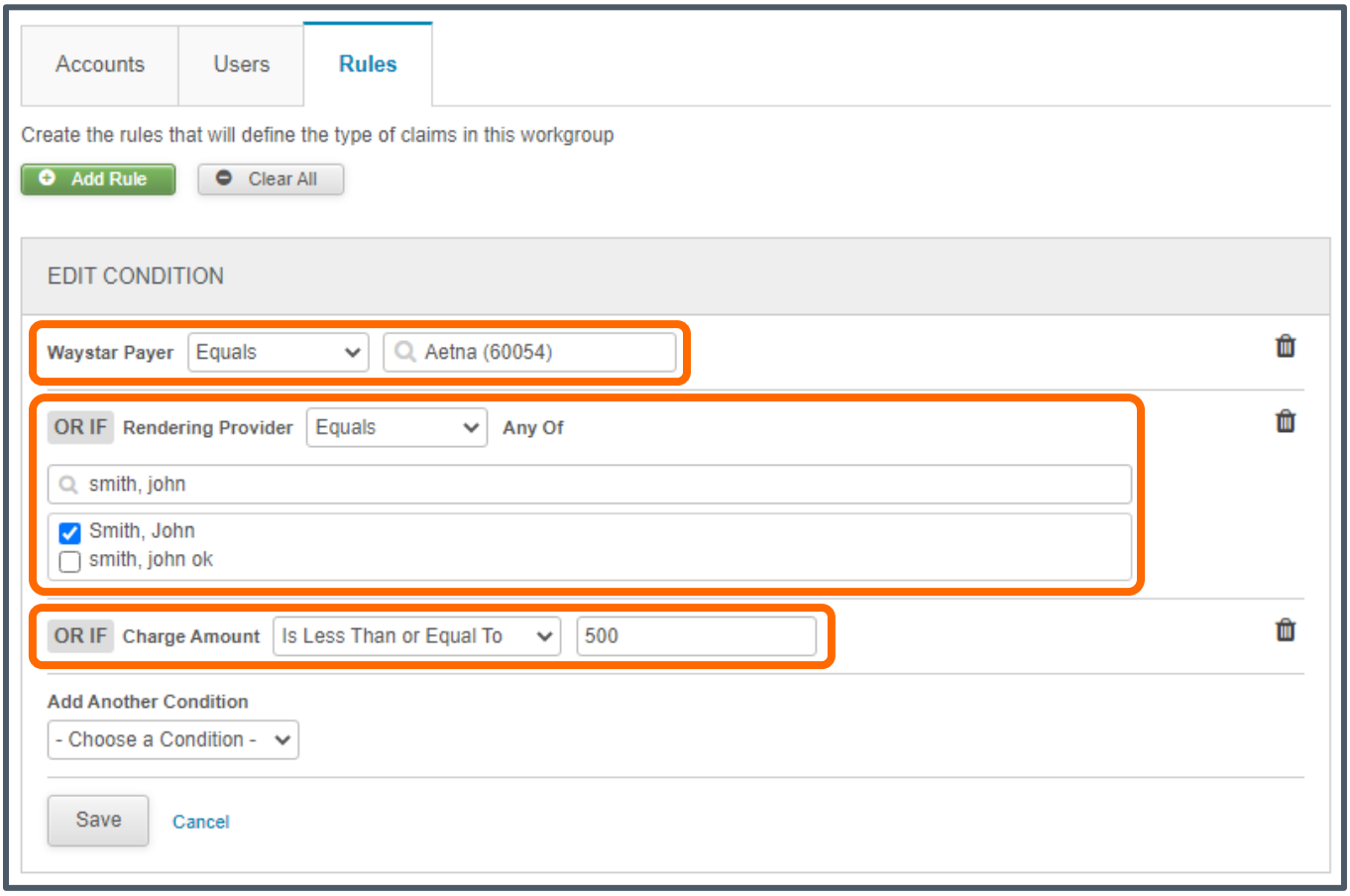
      This second rule will cause all follow-up work for the Test rendering provider (used for this example only) to be sent to this workgroup.
   f. From the **Choose a Condition** dropdown, select the third work attribute subject to the rule (e.g. **Charge Amount**). In the case of some attributes, you will need to select an operator to join the attribute to a specific value.
   g. Select the appropriate operator from the dropdown.

      For this example, **Is Less Than or Equal To** was entered to connect that attribute to a numeric value.
   h. In the tertiary field, enter a specific value related to the first primary attribute.

      For this example, **500** was entered as the specific value.

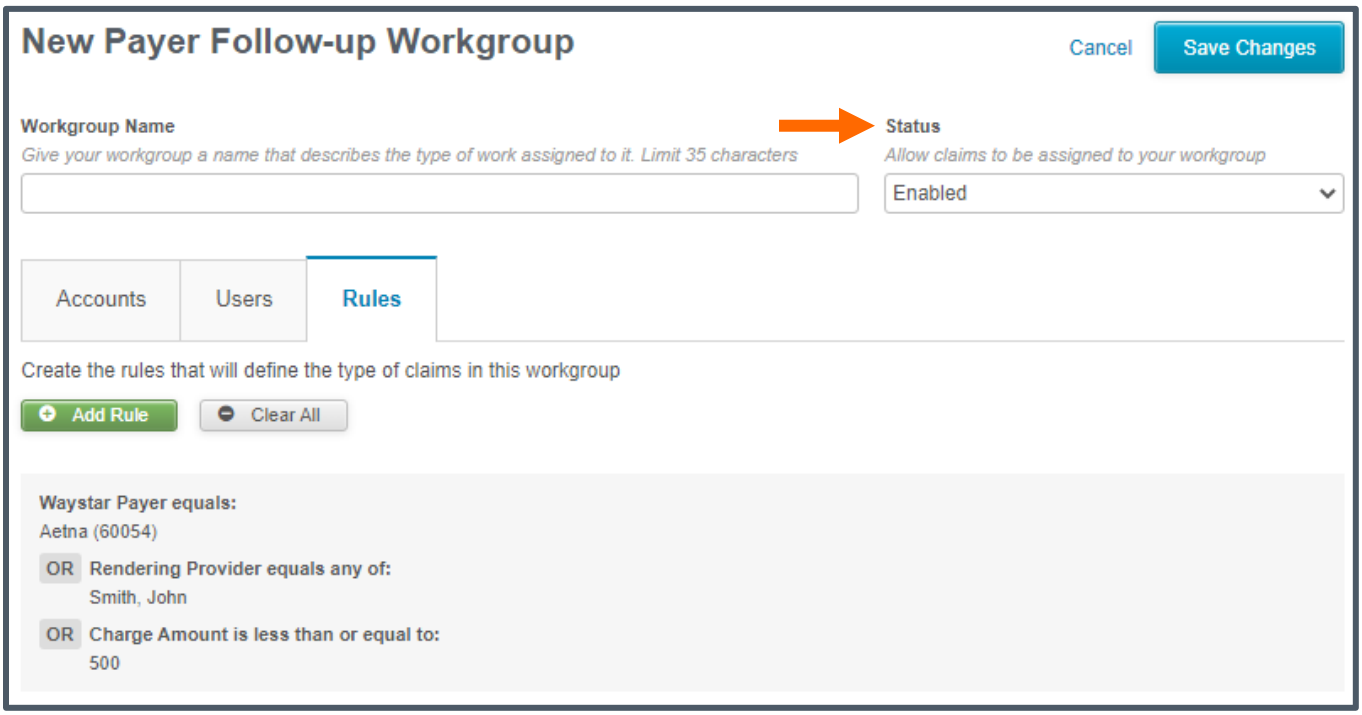
This third rule will cause all follow-up work for claims with a Charge Amount less than or equal to $500 to be sent to this workgroup.

The above example rules setup looks like this:



i. When you are satisfied with the entered rules, click the **Save** button at the bottom of the EDIT CONDITION section.

The rules will appear on the New Payer Follow-up Workgroup screen.



j. For the **Status**, do one of the following:

- If you would like this workgroup to be active in the Payer Follow-up workcenter immediately after it was saved, click **Enabled** from the Status dropdown. After the workgroup is saved, work items will begin moving into it when available.
- If you would ***not*** like this workgroup to be active after it was saved, leave the Status set to **Disabled**.

k. When you are satisfied with all your changes, click the **Save Changes** button.

If your workgroup status is set to **Enabled**, work items will begin moving into it when available.

Working with the Workcenter Data Limiters screen

The **CLAIMS PROCESSING** > **Claim Monitoring** > **Settings** > **Follow-up Workcenter** > **Workcenter Data Limiters** screen allows you to activate/deactivate the Payer Follow-up workcenter in your account and manage which follow-up work types are sent to your workgroups.

Turning on/off the Payer Follow-up Workcenter

Note: It is best practice to first set up your Data Limiters (Claim Type and Follow-up Categories) and then enable the Payer Follow-up workcenter. See the Managing Follow-up data sent to workgroups for more information about setting up your data limiters.

To enable/disable all features of the Payer Follow-up workcenter for your account, select/deselect the **ENABLE FOLLOW-UP WORKCENTER** checkbox and then click the **Save Changes** button at the bottom of the screen.

Managing Follow-up data sent to workgroups

To control which types of follow-up work that will be sent to your Payer Follow-up workgroups, select/deselect any of the following options in the **DATA LIMITERS** section and click the **Save Changes** button at the bottom of the screen:

Claim type

- **Professional**: Select to have Professional Claims follow-up work sent to your workgroups.
- **Institutional**: Select to have Institutional Claims follow-up work sent to your workgroups.

Note: If neither the Professional nor Institutional options are selected, your workgroups will not receive follow-up work items.

Follow-up categories

Select any of the following to have follow-up work in the associated categories sent to your workgroups:

- **Payer Outreach**: The recommended follow-up activity for the response is to contact the payer.

  Note: This follow-up category will include work that has never been monitored but has hit an aging warning. See the Aging Warnings description below for more information.
- **Provider Info Request**: Waystar recommends that you retrieve the information being requested and send it to the payer.
- **Patient Outreach**: The recommended follow-up activity for the response is to contact the patient.
- **Coordination of Benefits**: The claim has been denied or pended because the payer requires more information related to the patient's benefits.
- **Denied**: The claim or lines within the claim have been denied by the payer.
- **Claim Not Found**: The payer has acknowledged that a status could not be provided because the claim could not be found in their system.
- **Aging Warnings**: Enter a number in the Days field below Aging Warnings and if a claim has not received a remit by the time it reaches the entered value, a warning message will display in the Days At Payer column on the My Work > Work Centers > Payer Follow-up screen.
- **Paid**: The claim has been paid by the payer.
- **Finalized**: The payer has completed processing the claim.
- **Processing at Payer**: The claim is being processed by the payer. No action is being requested from the provider or patient.
- **Under Payer Review**: The payer has pended the claim for review. No action is being requested from the provider or patient.
- **Informational**: A general update sent from the payer in response to the status inquiry. For example, a payer may respond that their system is down, and the inquiry needs to be resubmitted at a later time.
- **Uncategorized**: Waystar has not assigned a category for the response.
- **Patient Deductible**: Remaining amount(s) apply to the patient or subscriber's deductible.

Excluding Payers without an 835 Connection

For payers that cannot send electronic remittances, it may be helpful for you to exclude their follow-up work from your workgroups. To do this, click the checkbox in the **PAYER EXCLUSION** section and click the **Save Changes** button at the bottom of the screen.

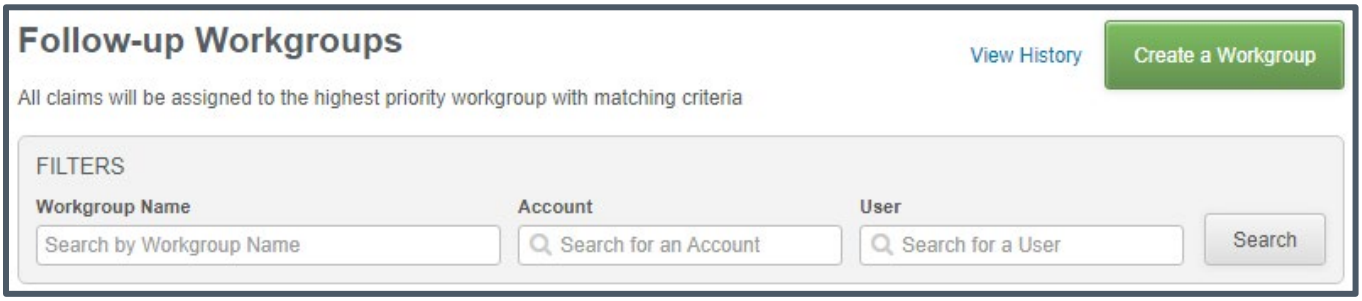
Working with the Follow-up Workgroups screen

Use the **CLAIMS PROCESSING > Claim Monitoring > Settings > Follow-up Workcenter > Follow-up Workgroups** screen to manage all Payer Follow-up workgroups available in your account. This includes both active and disabled workgroups as well as the Catch All Workgroup.

Searching for workgroups

To filter the list of workgroups on the Follow-up Workgroups screen, enter any of the following workgroup search criteria in the **FILTERS** section and click the **Search** button.

Note: When entering information in the following **Account** or **User** fields, a list of search results will automatically display below the field. Select any of the populated results to enter that search criteria.



- **Workgroup Name**: Displays the workgroup with the user-specified workgroup name.
- **Account**: Displays all workgroups for the entered account name/ID.
- **User**: Displays all workgroups including the specified use.

After completing a search, the workgroups list will update accordingly.

Understanding the Catch All Workgroup

All users and accounts for your domain assigned to the Catch All Workgroup will receive follow-up work in no particular order.

There is one catch-all workgroup per account. You will only be able to manage the users added to this workgroup. See the Using the Follow-up Workgroups action menu and editing workgroups section below for instructions on how to edit workgroups.

Using the Follow-up Workgroups action menu and editing workgroups

When hovering over a workgroup in the Follow-up Workgroups list, it will be highlighted and the action menu will open.

- **Preview**: Displays a snapshot of the Follow-up workgroup including the Accounts, Users, and Rules applied to the workgroup.
- **Edit**: Directs you to the Edit Payer Follow-up Workgroup screen where you can make all necessary changes to the workgroup fields and/or rules described in the Creating a workgroup section.
- **Copy**: Directs you to the New Payer Follow-up Workgroup screen where all fields of the selected workgroup have been copied and applied to a new workgroup. See the Creating a workgroup section for more information about building the rest of the workgroup.
- **Delete**: Opens a screen asking you to confirm whether you want to delete the workgroup. Click the **Yes, Continue** button to permanently delete the workgroup from your account.

Reordering workgroups

You can set priorities for your Payer Follow-up workgroups. This allows you to control how follow-up work flows through the workgroups in your account.

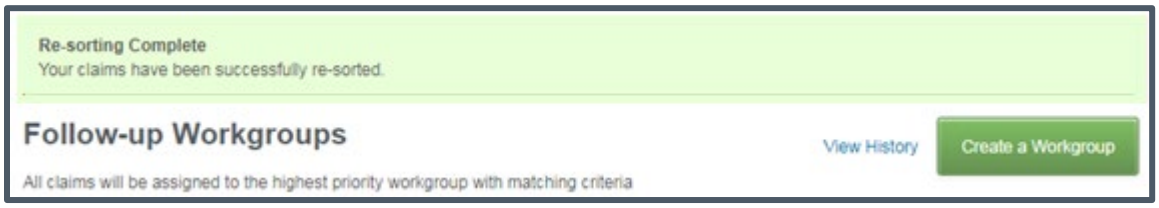
To reorder/reassign workgroup priorities:

1. Click the **Reorder Workgroups** link on the right side of the screen to unlock the workgroup list.
2. Assign an appropriate priority level to each workgroup by dragging and dropping them accordingly.

   Note: Work items will flow through this list in a top-down fashion, getting assigned to the first workgroup with a matching rule set. Follow-up items can only be matched to a single workgroup.
3. When you finish rearranging the workgroups, click the **Apply Changes** button to apply these settings.

Understanding workgroup auto-sorting and notifications

Workgroup priorities may automatically reorder because of changes made to your workgroups (e.g., add accounts, edit rules, etc.). Any time your workgroups are automatically changed or scheduled to change, a green notification will open at the top of the Follow-up Workgroups screen identifying the automated action.



Revision Log

Date	Description	Version
August 2025	Updated the “Understanding inbound request settings” section	12
June 2025	Updated the “Working with the Monitoring Activity report” section: • Added new screenshots • Removed Edit and Notes from the action menu • Added the C (Coverage Detection) and E (Eligibility) icon descriptions	11
March 2025	Updated the introductory overview of the “Working with integration settings” section	10
March 2025	• Added the “Adding Disposition Label overrides to schedules” section • Added the following to the “Claim Monitoring settings” section: – Working with domain settings – Working with Medicare Part A settings – Working with account settings – Working with Disposition Labels settings – Working with Eligibility/Coverage Detection settings – Working with inbound request settings	9
August 2024	Added status descriptions for the Export Results CSV in the “Viewing mass status checks and mass removals” section	8
April 2024	• Added Remit Forecast definitions to the “Adding a check status event to a Claim Monitoring schedule” section as well as a link to the Remit Forecast Guide • Added the “Claim Monitoring scheduled build times” section	7