

# Product

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# Tooth Anatomy

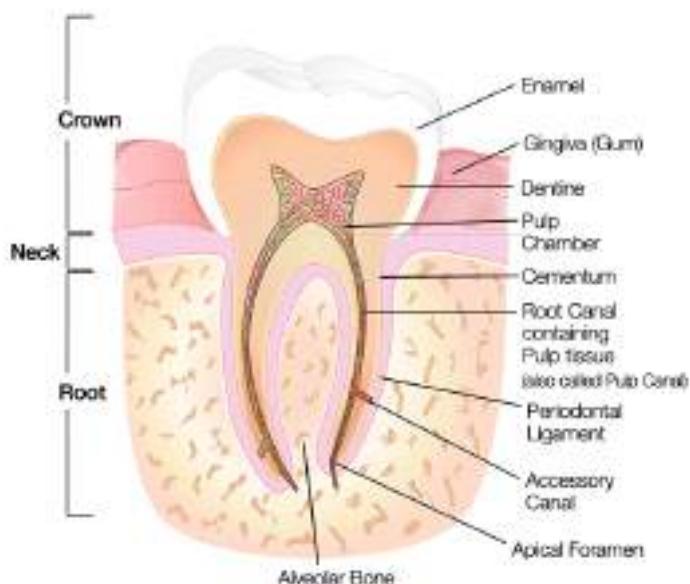
Written by Revati Krishnan | Last published at: July 28, 2022

## Overview

The tooth is one of the most individual and complex anatomical as well as histological structures in the body. The tissue composition of a tooth is only found within the oral cavity and is limited to the dental structures. Each tooth is paired within the same jaw, while the opposing jaw has teeth that are classified within the same category.

However they are not grouped according to structure, but rather by function. They are seated within the upper and lower alveolar bone in the maxilla and mandible respectively and this exclusive type of joint is known as gomphosis.

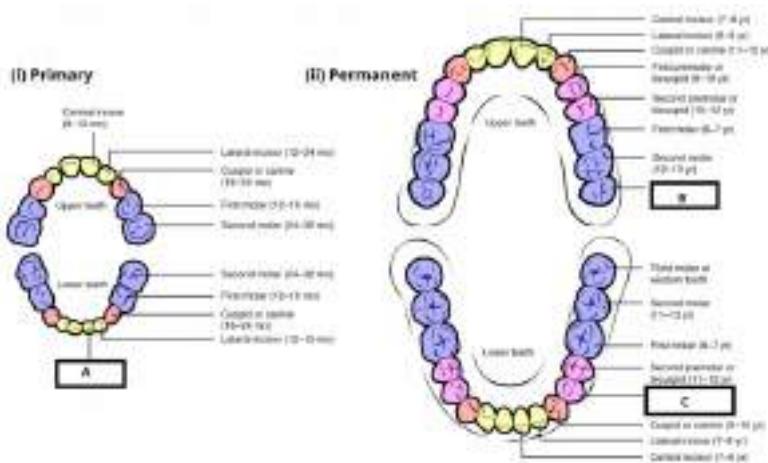
## Different Parts of a Tooth



- **Root** - The root is the part of the tooth that extends into the bone and holds the tooth in place. It makes up approximately two-thirds of the tooth. It's made up of several parts:
  - **Root canal**. The root canal is a passageway that contains pulp.
  - **Cementum**. Also called cement, this bone-like material covers the tooth's root. It's connected to the periodontal ligament.
  - **Periodontal ligament**. The periodontal ligament is made of connective tissue and collagen fiber. It contains both nerves and blood vessels. Along with the cementum, the periodontal ligament connects the teeth to the tooth sockets.
  - **Nerves and blood vessels**. Blood vessels supply the periodontal ligament with nutrients, while nerves help control the amount of force used when you chew.
  - **Jaw bone**. The jaw bone, also called the alveolar bone, is the bone that contains the tooth sockets and surrounds the teeth's roots; it holds the teeth in place.
- **Neck** - The neck, also called the dental cervix, sits between the crown and root. It forms the line where the cementum (that covers the root) meets the enamel. It has three main parts:
  - **Gums**. Gums, also called gingiva, are the fleshy, pink connective tissue that's attached to the neck of the tooth and the cementum.
  - **Pulp**. Pulp is the innermost portion of the tooth. It's made of tiny blood vessels and nerve tissue.
  - **Pulp Chamber**. The pulp chamber, sometimes called the pulp cavity, is the space inside the crown that contains the pulp.
- **Crown** - The crown of a tooth is the portion of the tooth that's visible. It contains three parts:

- **Anatomical crown.** This is the top portion of a tooth. It's usually the only part of a tooth that you can see.
- **Enamel.** This is the outermost layer of a tooth. As the hardest tissue in your body, it helps to protect teeth from bacteria. It also provides strength so your teeth can withstand pressure from chewing.
- **Dentin.** Dentin is a layer of mineralized tissue just below the enamel. It extends from the crown down through the neck and root. It protects teeth from heat and cold.

## Types of Teeth



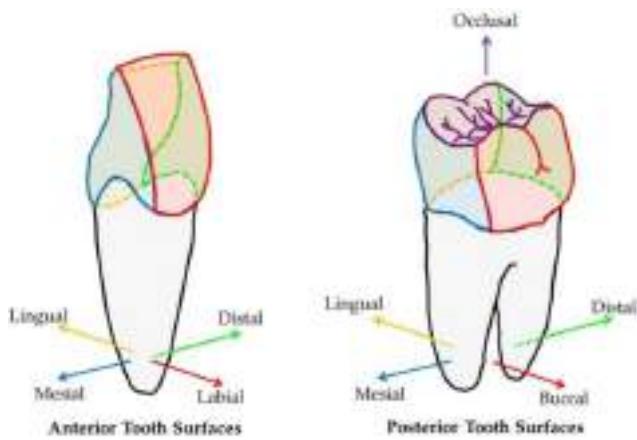
The human dentition is composed of two sets of teeth – primary and permanent. Teeth are organized into two opposing arches – maxillary (upper) and mandibular (lower). These can be divided down the midline (mid-sagittal plane) into left and right halves. Teeth are positioned in alveolar sockets and connected to the bone by a suspensory periodontal ligament.

The **primary dentition** is composed of 20 teeth, with 10 in each arch. There are five teeth in each quadrant, composed of two incisors (central and lateral), a canine, and two molars. These teeth are referred to as letters A, B, C, D and E. The primary teeth begin to erupt at 6 months of age.

The **permanent dentition** is composed of 32 teeth with 16 in each arch. There are eight teeth in each quadrant, composed of two incisors (central and lateral), a canine, two premolars, and three molars. These teeth are referred to as numbers, 1 (central incisor) to 8 (3rd molar or 'wisdom' tooth). The permanent teeth begin to erupt, and replace the primary teeth, at 6 years of age. The permanent teeth complete eruption by approximately age 13 years, with the exception of the 3rd molar 'wisdom' teeth, which usually erupt by the age of 21 years.

- **Incisors (8 total):** The middlemost four teeth on the upper and lower jaws.
- **Canines (4 total):** The pointed teeth just outside the incisors.
- **Premolars (8 total):** Teeth between the canines and molars.
- **Molars (8 total):** Flat teeth in the rear of the mouth, best at grinding food.
- **Wisdom teeth or third molars (4 total):** These teeth erupt at around age 18, but are often surgically removed to prevent displacement of other teeth.

## Teeth Surfaces

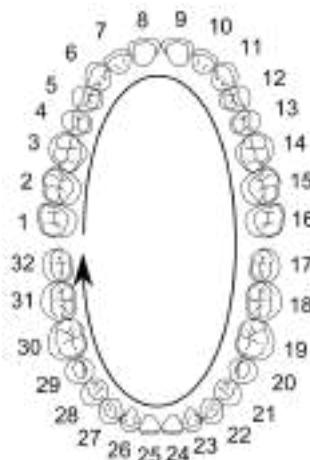


A tooth has five surfaces: one that faces the inner lip or cheek, one that faces the tongue, the chewing surface and the two that are next to other teeth.

The surface of a tooth is named depending on the location of the tooth, and teeth are named according to their location in the mouth.

- **Front Teeth (Anterior)**- The teeth that a person shows when they smile are commonly referred to as the front teeth. They are also known as the anterior teeth. There are 12 of them: The four fang-like teeth are called canines, while the eight centermost teeth are called incisors. The five surfaces of the anterior teeth are named as follows:
  - The **labial** surface is visible to the world; teeth whitening and veneers are used to enhance this surface.
  - The **lingual** surface is the back of the anterior tooth; it faces the tongue.
  - The **mesial** surface is the side of the tooth that faces the center of the mouth.
  - The **distal** surface is the side of the tooth closest to the back of the jaw.
  - The **incisal** surface is used for biting; in the front teeth, this biting surface is quite smooth and easily cleaned.
- **Back Teeth (Posterior)** - They are the molars and pre-molars. The back teeth are used for chewing and grinding and are not as visible as the anterior teeth. Posterior teeth also have five surfaces:
  - The **buccal** surface is the part of the back tooth that faces the inner cheek.
  - The **lingual** surface is the part of the back tooth that faces the tongue.
  - The **mesial** surface of the posterior tooth faces the center of the mouth.
  - The **distal** surface faces the very back of the jaw.
  - The chewing surface of the back teeth is called the **occlusal** surface. It is rough and has multiple cusps, ridges and troughs. The rough nature of this surface allows food particles and plaque to become lodged in all its nooks and crannies. This is why it is important to take extra care when cleaning the chewing surfaces of the molars and pre-molars.

## Tooth Numbering



The American Dental Association Universal Numbering System is a tooth notation system primarily used in the United States. Teeth are numbered from the viewpoint of the dental practitioner looking into the open mouth, clockwise starting from the distalmost right maxillary teeth. The uppercase letters A through T are used for primary teeth and the numbers 1 - 32 are used for permanent teeth. The tooth designated "1" is the maxillary right third molar.

("wisdom tooth") and the count continues along the upper teeth to the left side. Then the count begins at the mandibular left third molar, designated number 17, and continues along the bottom teeth to the right side. Each tooth has a unique number or letter, allowing for easier use on keyboards.

## Common Tooth Conditions

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- **Cavities (caries):** Bacteria evade removal by brushing and saliva and damage the enamel and deeper structures of teeth. Most cavities occur on molars and premolars.
- **Tooth decay:** A general name for disease of the teeth, including cavities.
- **Periodontitis:** Inflammation of the deeper structures of the teeth (periodontal ligament, jawbone, and cementum). Poor oral hygiene is usually to blame.
- **Gingivitis:** Inflammation of the surface portion of the gums, around and between the crowns of the teeth. Plaque and tartar buildup can lead to gingivitis.
- **Plaque:** A sticky, colorless film made of bacteria and the substances they secrete. Plaque develops quickly on teeth after eating sugary food, but can be easily brushed off.
- **Tartar:** If plaque is not removed, it mixes with minerals to become tartar, a harder substance. Tartar requires professional cleaning for removal.
- **Overbite:** The upper teeth protrude significantly over the lower teeth.
- **Underbite:** The lower teeth protrude significantly past the upper teeth.
- **Teeth grinding (bruxism):** Bruxism refers to grinding or clenching your teeth. Stress, anxiety, or sleep disorders can cause teeth grinding, usually during sleep. A dull headache or sore jaw can be symptoms. People with bruxism are often unaware that they have it, and many people only do it when sleeping. Over time, bruxism can wear down tooth enamel, leading to damage and even tooth loss. It can also cause tooth, jaw, and ear pain. Depending on the severity, it can also damage your jaw and prevent it from opening and closing properly.
- **Tooth sensitivity:** When one or more teeth become sensitive to hot or cold, it may mean the dentin is exposed.
- **Malocclusion:** Malocclusion is the misalignment of teeth. This can cause crowding, underbites, or overbites. It's often hereditary, but thumb-sucking, long-term use of a pacifier or bottles, impacted or missing teeth, and poorly fitting dental appliances can also cause it. Malocclusion can usually be corrected with braces.
- **Abscess:** A tooth abscess is a pocket of pus caused by a bacterial infection. It can cause tooth pain that radiates to your jaw, ear, or neck. Other symptoms of an abscess include tooth sensitivity, fever, swollen or tender lymph nodes, and swelling in your cheeks or face. See a dentist or doctor right away if you think you have a tooth abscess. Left untreated, the infection can spread to your sinuses or brain.
- **Tooth erosion:** Tooth erosion is the breakdown and loss of enamel caused by acid or friction. Acidic foods and drinks, can cause it. Stomach acid from gastrointestinal conditions, such as acid reflux, can also cause it. In addition, long-term dry mouth can also cause friction, leading to tooth erosion. Common signs of tooth erosion include pain, sensitivity, and discoloration.
- **Tooth impaction:** Tooth impaction happens when there isn't enough space for a new tooth to emerge, usually due to overcrowding. It's common in wisdom teeth, but it can also occur when a baby tooth falls out before the permanent tooth is ready to come in.

# Dental Care Providers

Written by Revati Krishnan | Last published at: August 11, 2022

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## Dentists

A dentist is an accredited medical professional who specializes in the care of teeth, gums, and mouths. As with most medical professions, a keen eye for detail, comprehensive medical understanding, manual dexterity, and strong interpersonal skills are important. Dentists deal with procedures that involve actual manipulation of the teeth or gums. Dentists have also evolved to provide cosmetic care that addresses society's perception of hygiene and health, as with the burgeoning business in whitening teeth. Problems dealing with the jaw or any invasive oral procedure are usually undertaken by an oral surgeon, and dental hygienists and dental assistants do much of the routine dental cleanings, maintenance, and X-rays. Each state requires dentists to be licensed and hold a degree from an accredited dental school. In addition, dentists are required to complete a residency program and work in their area of specialty before becoming fully licensed. Individuals who are interested in oral care, promoting healthy living and enjoy working closely with patients will likely excel as a dentist.

- Educating patients on their oral hygiene and dental care
- Examining patient's teeth and identifying or diagnosing any potential dental problems
- Performing dental treatments such as fillings and teeth extractions
- Teeth whitening
- Using technical equipment such as X-ray machines to identify potential issues
- Keeping records for each patient
- Referring patients to a dental hygienist or dental therapist
- Working with a practice receptionist and medical nurse
- Overseeing budgets
- Maintaining stocks of equipment.

## Hygienists

Under a Dentist's supervision, a Dental Hygienist provides preventative oral care to patients. This person is highly knowledgeable about oral health and has the highest level of technical and healthcare skills out of all three positions discussed today. A Dental Hygienist should stay up-to-date on up and coming dental technologies, have outstanding manual dexterity, and be passionate about helping patients achieve great oral health. This person must also be professional, detail-oriented, and friendly. Dental Hygienists usually work in one dental office or multiple offices of a single practice and don't always work a full-time schedule.

Typical responsibilities of a Dental Hygienist include:

- Conduct preliminary dental examinations on new patients
- Take and develop dental x-rays
- Educate patient on procedures and treatments
- Complete dental cleanings
- Evaluate oral health of patients
- Take notes on decay, conditions, and any treatment recommended by the dentist

## Dental Assistants

Dental Assistants are a crucial part of a dental office and work closely with both Dentists and Dental Hygienists. This position is primarily focused on preparatory responsibilities and assisting tasks. This position is perfect for someone who is hardworking, compassionate, highly organized, and who can listen and communicate effectively. Additionally, a Dental Assistant needs to have strong critical thinking skills and the ability to solve problems without getting flustered.

Common responsibilities of a Dental Assistant include:

- Readying patient treatment rooms for appointments
- Greeting patients, communicating dental care information, and answering questions
- Assisting during dental appointments, including positioning instruments and equipment
- Using high-tech dental lab and diagnostic tools
- Scheduling patient appointments and sending patient reminders
- Occasionally assisting patients with insurance billing issues

# CDT Codes & Categories

Written by Revati Krishnan | Last published at: July 28, 2021

The five-digit code is common in both dental and medical coding. The first digit describes the field in which the service was performed (medical or dental). The second digit describes the category, and the remaining digits describe the nature of the procedure or service. For example, code D1110 is interpreted as follows: The first digit (letter D) indicates a dental service, the second digit (1) indicates a preventive procedure or service, and the last three digits identify the procedure or service.

The below are the 12 CDT Categories and their corresponding number series:

## Diagnostic - D0100-D0999

Diagnostic codes apply to procedures common to patient examination and diagnosis and those which form the basis for treatment planning. These procedures typically fall into one of four diagnostic areas:

- Oral evaluations are conducted by the dental healthcare team to assess overall health status of new patients, check the evolution of existing patients, and diagnose and track progress of acute oral conditions.
- Radiographs document intraoral and extraoral conditions using a variety of diagnostic imaging techniques and materials.
- Biologic tests examine viral organisms and patient's vulnerability or predisposition to oral diseases.
- Pathologic evaluations diagnose conditions of oral tissues.

## Preventive D1000-D1999

Codes in the preventive category refer to procedures conducted by the dental healthcare team designed to prevent the occurrence or recurrence of oral diseases:

- Prophylaxis treatment, through which plaque, calculus, stains, and other accumulated substances are removed from the clinical crowns of the teeth.
- Fluoridization of the teeth.
- Preventive counseling to encourage healthy dietary and hygienic habits and discourage the use of products that increase the risk of oral diseases.
- Installation and management of space-maintaining appliances designed to prevent the space created by the premature loss of a tooth.

## Restorative D2000-D2999

Restorative codes apply to procedures concerned with the reconstruction of the hard tissues of a tooth or a group of teeth injured or destroyed by trauma or disease. These procedures are primarily classified by the restorative materials used in the reconstructive process. Common forms include the following:

- Amalgam
- Resin-Based
- Gold
- Porcelain (for some crowns)

## Endodontics D3000-D3999

Codes for endodontics involve the diagnosis, prevention, and treatment of diseases of the dental pulp. Typical procedures performed by the dental healthcare team include the following:

- Capping pulp with material that protects it from external influences.
- Surgical amputation of the pulp.
- Surgical removal of the apex of a root.
- Complete pulp removal from the pulp chamber and root canal.

## Periodontics D4000-D4999

Periodontal considerations concern the care of the supporting structures of the teeth. Coding for periodontics is usually assigned to procedures such as the following:

- Gingival surgery and treatment.

- Crown extension
- Osseous replacement grafting
- Scaling and root planning

## **Prosthodontics-Removable D5000-D5899**

Codes pertaining to the restoration and maintenance of oral function, comfort, appearance, and health through replacement of missing teeth fall under prosthodontics. Procedures used in conjunction with removable prosthodontics include the following:

- Creation and maintenance of complete, partial, and interim dentures
- Conditioning of dental ridge tissue
- Surgical prosthesis modification

## **Maxillofacial Prosthetics D5900-D5999**

Maxillofacial prosthetics codes apply to procedures used in the prosthetic restoration of facial structures that have been affected by disease, injury, surgery, or congenital defect. Some of these extensive procedures include the following:

- Fabrication of prosthetic pieces that restore damaged or missing areas of the nose, eyes, ears, or jaw
- Surgical lifts of the jaw
- Surgical shielding or splinting

## **Implant Services D6000-D6199**

Oral implantation procedures performed by the dental healthcare team involve the surgical insertion of materials or devices into the patients jaw. Codes in this category can apply to either occlusal rehabilitation or cosmetic dentistry, such as the following:

- Surgical installation of implants in the alveolar and/or basal bone
- Surgical installation of open-mesh frames designed to fit over the surface of the bone
- Surgical installation of implants threaded through the bone and into the oral cavity

## **Prosthodontics-Fixed D6200-D6999**

Fixed prosthodontics coded concern procedures performed by the healthcare team that replace or restore teeth via artificial substitutes that are not readily removable. Typical procedures in this category include the following:

- Insertion of an artificial tooth on a fixed partial denture, replacing a missing natural tooth
- Reuniting the abutment tooth with the suspended portion of the bridge
- Anchoring of a removable overdenture prosthesis
- Installation of a stress-relieving connector

## **Oral and Maxillofacial Surgery D7000-D7999**

Surgical procedures pertaining to facial extractions or closures are coded under oral and maxillofacial surgery. Classifications include the following:

- Removal of teeth, tissue-retained remnants, or other tooth structures by means of elevators and/or forceps
- Surgical shaping and smoothing of the margins of the tooth socket in preparation for the placement of prosthesis
- Surgical restoration of the alveolar ridge height through lowering of the jaw muscles
- Surgical removal of bone and/or lesions
- Fracture treatment
- Trauma repair

## **Orthodontics D8000-D8999**

Any procedures performed by the dental healthcare team concerned with the guidance and correction of growing and/or mature dentofacial structures are coded under orthodontics, including the following treatments:

- Management of transitional dentition
- Prevention of dentofacial malformations

- Removable or fixed appliance therapy
- Appliance maintenance and replacement

## **Adjunctive General Services D9000-D9999**

Any general procedures not classified in the previous categories are coded under adjunctive general services. Common procedures found in this category include the following:

- Administration of anesthesia
- Diagnostic consultation not involving treatment
- House calls
- Pharmaceutical administration
- Cosmetic bleaching
- Behavior management

# ICD Codes / Modifiers / Taxonomy Code

Written by Renganathan K | Last published at: August 15, 2021

## IDC Codes

International Statistical Classification of Diseases and Related Health Problems (ICD).

### ICD purpose and uses

ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion that allows for:

- Easy storage, retrieval and analysis of health information for evidenced-based decision-making
- Sharing and comparing health information between hospitals, regions, settings and countries
- Data comparisons in the same location across different time periods
- Embedding of guidelines

## Taxonomy Code

A taxonomy code is a unique 10-character code that designates your classification and specialization. To find the taxonomy code that most closely describes your provider type, classification, or specialization, use the National Uniform Claim Committee (NUCC) code set list.

Reference: <https://taxonomy.nucc.org/>

## Modifiers

Modifiers are valuable coding tools that explain to payers the specific work that was done by a physician during treatment of a patient. They're important for representing the medical decision-making (MDM) a physician must demonstrate in order to bill, and be paid for, all the services they render.

### What is a modifier user for?

The Active Treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment. Medicare pays only for active/corrective treatment to correct acute or chronic subluxation. Medicare does not pay for maintenance therapy. .

# Production Calendar Template

Written by Sarah Abraham | Last published at: July 28, 2022

## Overview

The production calendar is the functionality that helps a practice user set up their appointment calendar. The view that a user sees when opening their calendar is based on the instructions that you provide in the production calendar. We can set both provider availability templates as well as production templates.

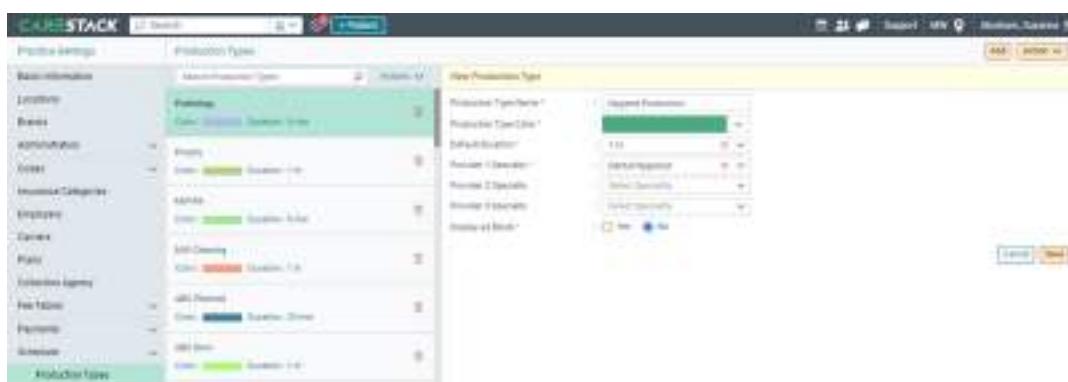
## Production Template

The production template is used by the practice to set all the production types that are preferred by a provider or practice in a particular operatory. To understand a production template we have to touch upon Production types and how they are used in a system.

## Production Types

A production type is used by the practice to denote the kind of appointment or production that is being serviced. This usually helps practices to schedule appointments as certain providers would have a specialty associated. By depicting that production type in scheduler, the person scheduling an appointment for a particular appointment slot against a provider would know the preferred choice of appointment for them. For example, 'Hygiene production' would be a production type and the user can assign a Dental Hygienist to it. So when setting up the calendar, a practice user would set the operatory to show the production type 'Hygiene Production'. Now when another user decides to take an appointment at that slot, the production type column would default to 'Hygiene Production'.

A user can add a production type from Practice settings> Scheduler > Production type.



Here, we can add a production type to the system. The user can assign a time which is the average time it would take to service this production type. Up to 3 specialties can be assigned.

There are two types of Production types, Block as well as Non-Block production type which is controlled by the setting, 'Display as Block'. A block production type allows the user to set the provider availability against each specialty. Also, the duration plays a more important role as the duration of the appointment would be defaulted to the one set here regardless of the slot size chosen by the user.

The user cannot delete a production type if it is used against an appointment but can only deactivate it.

## Setting up a production template

Users can navigate to Menu >Production calendar and choose the tab, Production template.



Hereupon choosing the particular location for which you want to set up a template, the user is shown all the operatories that are present in that particular location.

By default, every location will have a default template for each day. We can either edit the default template or add a new template.

The screenshot shows the CARESTACK Production Calendar interface. On the left, there's a sidebar with tabs for 'Production', 'Calendar', 'Scheduler', and 'Production'. Below these are sections for 'Work Schedule' and 'Current Work Schedule'. The main area displays five production templates: '10-Hour SI-Shift 1-6AM', '10-Hour SI-Shift 2-8AM', '10-Hour SI-Shift 3-10AM', 'Hospital Audit/Therapy - 8AM', and 'Support Services/Visitors/Terms...'. Each template has a list of operators assigned to it, represented by small icons. At the top right, there are buttons for 'Edit', 'Delete', and 'Save'.

Here we can see that a default template is present with multiple production types, set against operators. The user can click the edit button on the top right corner and on clicking and dragging on slots, a modal is opened.

This screenshot shows a modal dialog titled 'Production Type (07:30 AM - 08:30 AM)'. The 'Details' tab is selected. It contains fields for 'Production Type' (set to 'Retail Service'), 'Start Time' (07:30 AM), 'End Time' (08:30 AM), and 'Duration' (1 hour 00 mins). There are 'Cancel' and 'Save' buttons at the bottom right. In the background, the main production calendar interface is visible with other templates listed.

The user can choose the production type from the list of all active production types in the system and assign it a particular operator.

The default template will always be set to a recurrence mode every week. That is the same template that will be shown for that particular week every day. It cannot be changed.

If the user wishes to add a new template, they can do so by clicking on the Add button, a new modal is opened. Here the user is given the flexibility to change recurrence mode, start and end date.

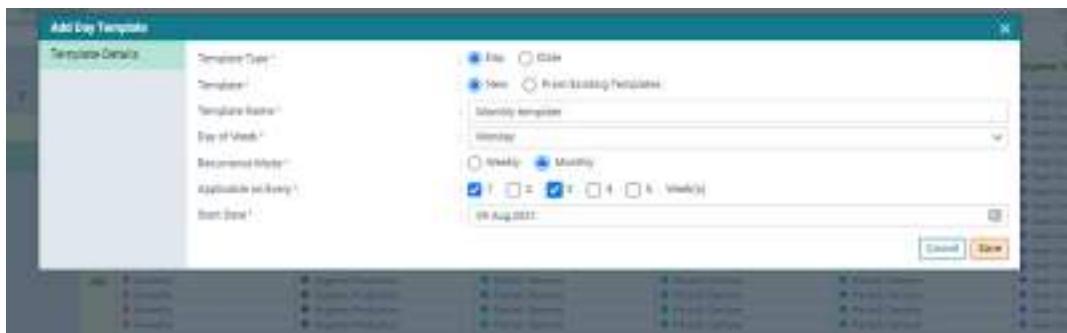
This screenshot shows a modal dialog titled 'Add Day Template'. It has two tabs: 'Template Details' and 'Template Settings'. Under 'Template Details', fields include 'Template Type' (radio buttons for 'Day' and 'Date'), 'Template' (dropdown), 'Template Name' (text input), 'Day of Week' (dropdown), 'Recurrence Mode' (radio buttons for 'Weekly' and 'Monthly'), 'Applicable After Every' (text input), and 'Start Date' (date picker). Under 'Template Settings', it shows 'Monday' selected under 'Weekly' mode. At the bottom are 'Cancel' and 'Save' buttons.

There are two types of templates, Day as well as Date. Here day template will be based on a recurrence mode for a particular day of the week. Date template will only reflect a particular date and has the highest priority.

The user also has the option to choose the same settings as that of an existing template. All the production types assigned would be brought over in this case.

The recurrence mode is of two types, Weekly or Monthly. The weekly template allows the user to choose the interval at which the template must be applied to that particular day. For example, if the user chooses the model, 'Weekly' and the Interval in which it is applicable as 3, then the template would repeat itself every 3 weeks.

If the user chooses the 'Monthly' mode, then they are given an option to choose from the first, second, third, fourth, and fifth particular day of the month.

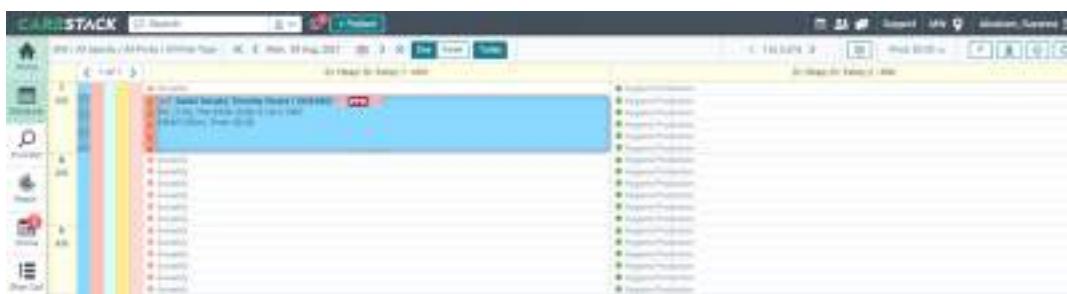


Here I have chosen the monthly template and the first and third week. So this template would reflect on the first and third Monday of every month.

When a new template is added, the priority defaults to the last. To raise the priority, the user can drag and drop the template in the templates section to the top and priority would be rearranged based on the position of the template.

A user can delete any template except for default templates.

Once the template is set up, if you navigate to the scheduler, all the changes made will be reflected according to the recurrence mode as shown below.



Now when we click and drag on the slots, with the template 'Hygiene Production', the appointment booking modal has the field Production type defaulted to it. The user is only prompted here and can change at any time.

The provider tab in the production calendar is used to assign providers to each operatory/chair so that the front office users know which provider will be working on each operatory that day and book appointments looking at their schedule for the day. Here also we have a day template and a date template for providers. Date templates are of the highest priority.

In the provider tab, the drop-down will list all the active Dentist and Hygienist providers that are in the practice.

- Availability settings - You can add a template for the chosen provider from the drop-down.



1. Add plan button will open the Add day template modal.
2. Template type - Choose between day or date template
3. Template name
4. Day of week
5. Recurrence mode
6. The start date signifies the date on which the template becomes active.
7. End date signifies the date on which the template becomes inactive.
8. Add location lets you add multiple locations
9. Location will list down the accessible locations for the selected provider.
10. Operatories will list down the operatories available for the selected location.
11. Start time and end time are assigned based on the provider's availability in the chair on that day.
12. Delete under the actions will delete the row added

### 13. Save will save the changes made to the template

Once a template is created, it gets listed at the bottom. The hierarchy of the template is based on the order in which it is set. Users can drag and drop the template to change the hierarchy. Based on the hierarchy, changes will be reflected in the Scheduler.



Edit icon under the Actions will let you edit the template. Delete will delete the template for the chosen provider.

Scheduler view will show the Provider's availability panel based on the templates assigned.

## Touchpoints & Impacts

---

- Users should have the production calendar view permission to view the production calendar setting in the System menu
- Users should have the Add/Edit production calendar permission to add/ edit templates.
- Add Plan button gets enabled only for users with access to all practice locations even with the Add/Edit production calendar permission.
- Users should have the Delete production calendar permission to delete the templates
- Production types should be created in the Practice settings > Scheduler > Production types to assign it to operatories
- The scheduler will be displayed based on the Production calendar setting
- While hovering over the operatory name in Scheduler, it will show the providers that are assigned to the operatory.

# Appointment Calendar

Written by Sarah Abraham | Last published at: August 08, 2021

## Overview

Appointment calendar or Scheduler is used by the practices to view the day-to-day schedule for every provider for chairs across locations. The scheduler is used to book appointments, block slots, reschedule, change status of appointments etc.

## Topics Covered in this Article

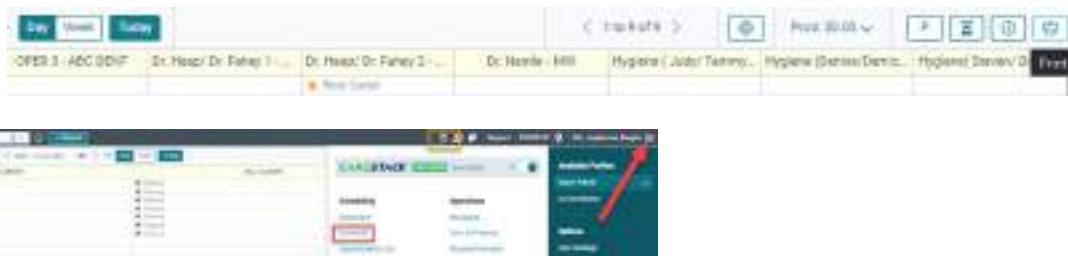
In this document we will cover the following areas related to scheduling.

- Appointment Calendar and Functionalities
- Appointment booking
- Blocking slots

## Appointment Calendar and Functionalities

The scheduler can be accessed from multiple areas in the PMS.

- The calendar icon on the left pane
- From the System menu > Scheduling > Scheduler.
- Calendar icon on the top bar



Based on the production calendar setting configured for the location, the operatories will be displayed. To know more on how the calendar is shown, please check the article on Production calendar.

- By default, the current day's calendar will be displayed. There are a couple of options provided to customise the calendar view.
  - Day:- Lets you view the scheduler for a particular day.
  - Week:- Lets you view the scheduler for the entire week.
  - Today:- Defaults to the present day.



- This will show the total no. of operatories which are in the scheduler for the selected day in that particular location.

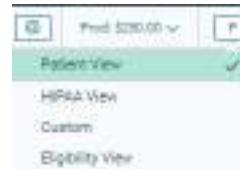


- There is a setting to allow the user to adjust the operatory count that can be viewed in the scheduler. Maximum of 20 is allowed.
- Shows the estimated production from the appointments booked for the day based on the production type.

● HOFMANN PROJECT/BAY	\$0.00	
● Minor Tx Only	\$62.00	
No Production Type	\$182.00	

- To change the scheduler view

- Patient view will show the complete patient information to the front office users
- HIPAA view will hide the sensitive patient information that comes under PHI
- Eligibility view will help the front office users to identify the patient's insurance eligibility information.



- To show the scheduler for extended working hours 
- Legend shows the various appointment labels, appointment status, production types and patient flags.
- Print icon will let you print the scheduler or the routing slip for a day.



- Hovering over the operatory name will show the Provider assigned to the operatory and the estimated production from the appointments booked in that operatory.
- This will open the custom filters tab .
- View in Scheduler - to change the location, providers, speciality and production types to be shown in the scheduler
- Find slots - to find a suitable slot in the scheduler based on the start date and appointment duration to book an appointment based on the selected location, provider, speciality and production types
- Custom filters - To customize the scheduler page based on location, provider, speciality and production types. If it is in View in Scheduler mode, custom filters can also be directly saved as a scheduler filter upon clicking on Save & Apply.
- Favorite filters will list down both the Account scheduler filters and user filters. Based on the selection, changes will be reflected in the scheduler.

## Booking an Appointment

To book an appointment, left click & drag on the available scheduler slot. An appointment details slide-out will appear.

- Inside the appointment summary, production type, start and end time, Provider 1 will be pre-selected based on the operatory setting.
- Appointment mode indicates whether it is an in office appointment or a tele-appointment.
- Set short call - If set to yes, will put the patient in the short call list. ( So that the practice can book an early slot if available for the patients in the short call list)
- Appointment note
- Book will book the slot for the patient
- Book & Add treatment will book the slot and open the Tx summary. Procedure codes can be added to the appointment from the Tx summary.
- Payment summary will show the current patient balance, insurance balance and the total balance, unapplied credits if any.
- Text to Pay button will open the text to pay modal

- Add payment button will open the Add new payment slide-out
- Lab summary will show the details of the lab case for the patient.
- Appt Status to update the status of the appointment
- Go to chart will take the user to the dental chart
- History - Upon hovering will show the appointment created date and user and the last modified date.
- Once an appointment is booked, it is displayed as a block in the scheduler. Hovering over the appointment block will show the appointment details in the UI
  - Patient name
  - DOB
  - Contact info
  - Allergy and conditions
  - Medications
  - Appointment details
  - Provider
  - Production type
  - Treatments
  - Appointment notes
  - Lab case details
  - Primary insurance
  - Eligibility update
  - Outstanding balances
  - Appointment created date and last modified information
- The details displayed on the appointment block is based on the scheduler setting configuration under Practice settings.

## Appointment Right Click Menu

Right clicking on the appointment block will open the Appointment right-click menu which will show the following details :-

- Change status - Shows the system defined appointment statuses first, followed by the custom appointment statuses.
- Patient overview - navigates to the patient overview page.
- View dental chart - navigates to the charting page.
- View ledger - navigates to the patient ledger
- View memo - opens the patient notes slide-out
- Email/Sms - opens the communication modal
- Text to pay - opens the text to pay modal
- Convert to Tele-appointment - converts the in office appointment to tele-appointment and sends the link to the patient via email.
- Details - opens the appointment details modal.
- Cut appointment
- Copy appointment
- Print routing slip Tx plan - Will be printed based on the routing slip setting configured in the Practice settings > Scheduler > General settings.
- Print routing slip code.

## Blocking a Slot

To block a slot on the calendar, click and drag the slot and choose Block. Start time , End time, Block color and the message to be shown on the Block can be entered

Start Time*	11:00 AM	<input checked="" type="checkbox"/>
End Time*	12:00 PM	<input checked="" type="checkbox"/>
Duration	40 mins	<input checked="" type="checkbox"/>
Publisher*	Silvia Alcalá & Z. Jiménez	<input checked="" type="checkbox"/>
Book Color		<input checked="" type="checkbox"/>
Book Name		<input checked="" type="checkbox"/>



# Lab Case

## Brief Description on the topic

Written by Ashly Abraham | Last published at: August 16, 2021

## Overview

Dental laboratories manufacture or customize a variety of products to assist in the provision of oral health care by a licensed dentist. These products include crowns, bridges, dentures, and other dental products. Dental labs fill prescriptions (Lab Cases) that a dentist submits to fabricate whatever appliance, restoration, or prosthesis the dentist requests in writing.

There are several different types of dental labs:

- Crown and Bridge/C&B (single teeth and bridges)
- Removable (full and partial dentures)
- Full-Service (does both C&B and removable)
- Ortho (retainers and appliances)

## Topics Covered in this Article

- How to add a Lab in Carestack?
- How to add Lab Case to an Appointment?
- How to add a Lab Case from the Patient Contest?
- What a Lab Case Looks Like
- Who uses this functionality

Permissions required

## How to add a Lab in Carestack?

- Navigate to Menu > Practice settings > Labs > Click Add.
- Enter the details about the Lab.
- Click Save.



- The lab has been added to Carestack. And this Lab would be listed in the Locations that were specified while adding the Lab.
- You can also Deactivate the Lab by clicking the Deactivate link in Action's column and henceforth that Lab would be inactive.
- There's an Activate link to re-activate it.

## How to add Lab case to an Appointment?

You can add lab cases to your appointment directly from the scheduler.

1. Click the Edit link next to the Lab Summary.

Appt Status		Scheduled	Print
Patient (details)		Adult, Adult (130002)	
Appointment Summary (edit)			
Production type	Loc - Priority Care		
Date	2023-09-19 (WED)		
Time	09:00 AM - 10:30 AM (45 mins)		
09:00 AM - 09:40 AM	Cancel		
09:40 AM - 09:50 AM	Print		
09:50 AM - 10:00 AM	Reschedule		
10:00 AM - 10:30 AM	Reselect		
Block/Call	No		
Appt Note			
Treatment Summary (Add / Edit)	Edit / Delete		
New services to schedule			
Payment Summary			
Current Net Balance	\$1,000.00		
Current Due Balance	\$0.00		
Current Total Balance	\$1,000.00		
Net Totals		Add Payment	
Lab Summary (Edit) 			

2. Details regarding the Lab case can be entered.
  3. Click Save or Save & Print.

Bank Account #999991 (S-2-Paid-FM) - July 22 2021, FM		[Edit] [More] [New] [Edit] [Delete] [Log] [X]	
Period: 2021-07-22	SEARCH BY:	Category:	
Refined: (104443)	From: JUN 01 (2021)		
<b>Statement Summary</b> (104443)		<b>Last Summary</b>	
Statement-type: Bmo - Prepaid Card	Amount: 100.00	Amount: 100.00	
Date: 07/22/2021 (FM)	Term date:	Amount: 100.00	
Time: 09:30 AM 18:30 AM CDT (WES)	Received Date:	Interest rate:	
00:00 AM - 09:00 AM - 000000	Labeled:		
09:00 AM - 09:30 AM - 000000	Reference #:		
09:30 AM - 10:00 AM - 000000	Debit by:		
10:00 AM - 10:30 AM - 000000			
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## How to add a Lab case from the Patient Context?

1. Select Appts from the Patient Navigation Bar.
  2. Select Lab Cases.
  3. Click Add Lab Case.

The screenshot shows the Stack Overflow search results page. The search query "what is the best way to learn Java" is entered in the search bar. The results list includes several posts, such as "How do I learn Java?" and "What's the best way to learn Java?". A green arrow points to the "Best Answer" button on the first result.

- 4. Complete the details about your lab case.**

5. Click Save.



## What a Lab Case Looks Like

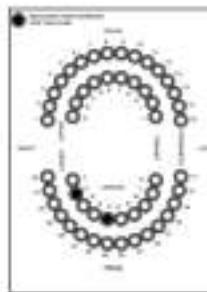
ADD(1) 11:07 AM

**Lab Case Details**

**Administrator:**  
Perry's Rx Address,  
Perry's Rx City, FL - 36000-0000

**Dental Office of Highland Village**  
P.O. Box 2400 Austin Road,  
Locality Highland Village,  
Highland Village, TX 75071-0000  
Email: Hygientechnology@outlook.com  
Phone: (817) 985-1234

**Provider's Name:** Dr. Paul, Dentist  
**Provider's License #:** 1234567890  
**Patient Name:** Davis, Taylor-12345  
**Case Send Date:**  
**Close Date:**  
**Received Date:**  
**Reference Number:**  
**Tooth Shape:**  
**Lab Case:** \$0.00  
**Notes:**



Printed Date: 08/08/2023

## Who uses this Functionality

Front office admin, providers, hygienists etc use this functionality.

## Permission Associated

Lab Case View - Permission to only view the Lab Cases.

Lab Case Edit - Permission to Edit the Lab cases.



# Scheduler Print

Written by Sarah Abraham | Last published at: August 08, 2021

## Overview

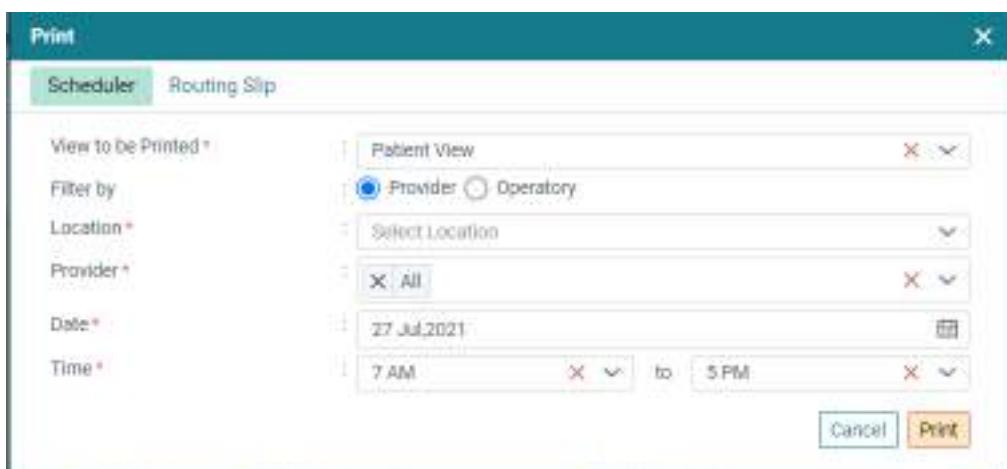
The scheduler print is a functionality that we provide that enables the practice to take a print of their schedule. They can do this for each location, operatory as well as provider. We also allow the practice to use these functionality to take a print in their preferred view, ie, Patient, Eligibility, HIPAA as well as the custom view that we provide.

## Scheduler Print and its Functionalities

The print button is available in the top right corner of the Scheduler.



On clicking on this button, the print modal is opened which is shown below.



Let us go through each of the options presented here.

- View to be printed: The user can choose either of the four options available, namely, Patient, HIPAA, Eligibility as well as the Custom view. The flags as well as the data available on the appointment tile are based on the scheduler customisation settings that are set in Practice settings.
- Filter by: This option allows you to choose whether to filter the print by the provider or Operatory for that particular location
- Location: This is a single select drop down that lists all the locations that the user has access to.
- Provider/ Operatory: Based on the filter by option, the user is allowed to choose the providers/ operatories which needs to be printed
- Date: The user can choose the date for which the print is taken
- Time: The user can choose the time period for which the print can be taken.

## Sample Print

[Scheduler\\_Print.pdf](#)

## Permissions Required

Any user who has permission to view scheduler is allowed to take print of scheduler.

# Routing Slip

Written by Sarah Abraham | Last published at: August 08, 2021

## Overview

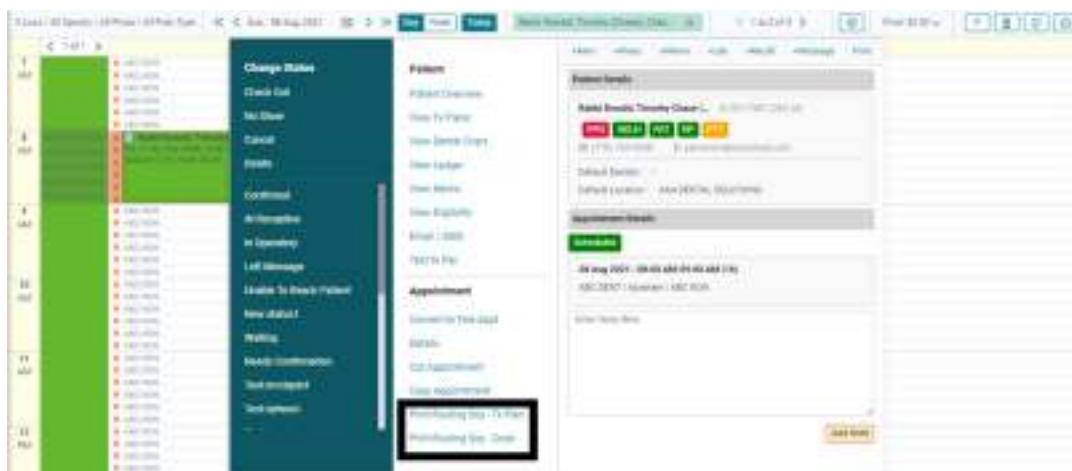
The routing slip is a document that contains pertinent patient information such as their health history, outstanding payments, appointment related information, insurance information etc. This document is usually printed for all the patients who have appointments on a particular day. The routing slip is handed over to the patient at the beginning of their visit and usually has information that is required by each and every department during their clinic visit.

## Printing a Routing Slip

The routing slip print can be taken from multiple areas in scheduler. If the user wishes to take the print for all the patients that have appointments in a particular location, they can do so by clicking on the Print icon on the scheduler top bar. Here the option for routing slip is available. The user can choose a date, location and time period and take the print.



You can also print routing slip for a patient, by opening the appointment details page and choosing Routing slip by code or Routing slip by treatment plan.



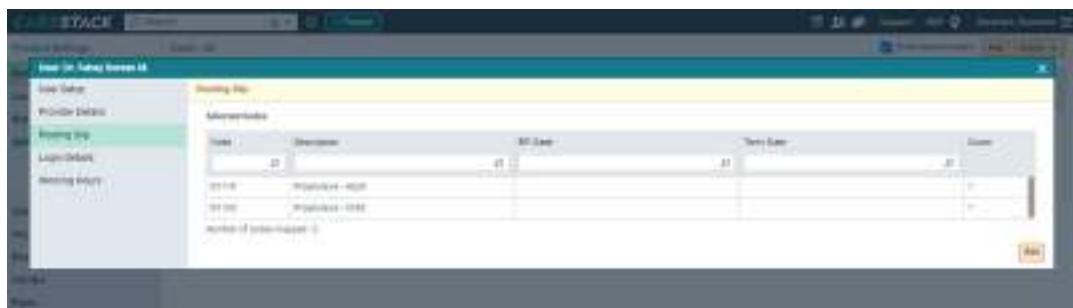
## Routing Slip by Treatment Plan

In this routing slip, all the codes added to the patient will be displayed in the Treatment plan sections. The treatments are grouped according to their appointments and the unscheduled codes are shown separately.

Treatment Plan Details								
Thrus	Surface	Code	Description	Provider	UCR	Par. Stat.	Ins. Est.	Total Fee
<b>Appointment: 07/06/2021 (Thu)   08:30 AM-09:30 AM (80m) CHAUDHRI, MALL   No Production Type   Scheduled</b>								
		10080	Intrusion, Change Of Address: Simple Or Single	SHAUJ		\$0.00	\$0.00	\$0.00
6	D0061		Implant Posterior Resin	SHAUJ		\$0.00	\$0.00	\$0.00
7	D0071		Implant Posterior Resin	SHAUJ		\$0.00	\$0.00	\$0.00
		10180	Aspirator Or Cyst	SHAUJ		\$0.00	\$0.00	\$0.00
8	DL	D2230	Resin Composite One Surface Anterior	SHAUJ		\$0.00	\$0.00	\$0.00
9	DL	D2230	Resin Composite One Surface Anterior	SHAUJ		\$0.00	\$0.00	\$0.00
10	DL	D2230	Resin Composite One Surface Anterior	SHAUJ		\$0.00	\$0.00	\$0.00
<b>Total:</b>					\$0.00	\$0.00	\$0.00	\$0.00
<b>Appointment: 07/07/2021 (Wed)   01:15 AM-02:00 AM (85m) FIGUER, MALL   No Production Type   Scheduled</b>								
		D0120	Periodic Oral Evaluation	FIGUER		\$0.00	\$0.00	\$0.00
		D0120	Periodic Oral Evaluation	FIGUER		\$0.00	\$0.00	\$0.00
CR		D0140	Limited Oral Eval Prob Focused	FIGUER	\$62.00	\$62.00	\$0.00	\$62.00
<b>Total:</b>					\$62.00	\$62.00	\$0.00	\$62.00
<b>Appointment: 07/24/2021 (Mon)   08:30 AM-09:00 AM (30m) ALBITE, MALL   KITCHENHORN DENT/PAN   Scheduled</b>								
		10081	Medical Test	TESTER		\$0.00	\$0.00	\$0.00
<b>Total:</b>					\$0.00	\$0.00	\$0.00	\$0.00

## Routing Slip by Code

Here instead of a treatment plan details, we have 'Productions' sections. The codes that are added to provider in User settings are listed here. This is done cause some practices prefer to see these codes that are mapped against a specific provider.



## Patient Related Information

The first section of the routing slip is patient related information like name, Date of birth, address, responsibility party details etc. This also includes medical information like allergies and conditions of the patient. We also provide information related to appointments, like the last appointment date, the number of missed appointments etc. All details of current appointment is also listed.

Metrowest Family Dentistry - Routing Slip								
<b>Patient:</b> Rishi Horwitz, Timothy Chase (1320080) <b>DOB:</b> 01/01/1987 (34) <b>Gender:</b> Male <b>Address:</b> Kentucky Plaza House street, Newton Falls, OH - 44444-4444 <b>Phone:</b> (716) 788-6564 <b>Email:</b> rishi.williams@comcast.net			<b>Resp. Party:</b> Rishi Horwitz, Timothy Chase (1320080) <b>Address:</b> Kentucky Plaza House street, Newton Falls, OH - 44444-4444 <b>Email:</b> rishi.williams@comcast.net <b>Phone:</b> (716) 788-6564 <b>Fax:</b> (330) 333-3333 <b>Last Appnt:</b> 08/05/2021 <b>Last Missed:</b> 06/12/2021 <b>Det. Provider:</b> AAA DENT			<b>Allergic To:</b> Brisket, Bacon, Jewelry, Latex, Metals, Teflon, Yellow <b>Medical Conditions:</b> Asthma, Atopic, Aergies, Angio, ne, Factions, Arthritis, Anti coag, Heart valve, Blood Transfusion, Bruise, Easyly Compromised, Headache, Seizure, Coagulase, Surgery, Diabetes, Diffi culty Breathing, Drug Abuse, Emphysema, Hay Fever, Heart Attack, Head, Surgery, Head, Migraine, Head Th...		
<b>Scheduled Appointment Details:</b> <b>Date:</b> 08/09/2021 (80m) <b>Date:</b> 08/09/2021 (80m) <b>Time:</b> 08:30 AM-09:30 AM (1h) <b>Time:</b> 07:10 AM-07:25 AM (15m) <b>Provider:</b> SARAH <b>Provider:</b> HEAP <b>Location:</b> ABC DENT <b>Location:</b> NW <b>Prod. Type:</b> ABC NOH <b>Prod. Type:</b> bowley <b>Appt Notes:</b> <b>Appt Notes:</b>			<b>Next Appointment Details:</b> <b>Date:</b> 08/09/2021 (80m) <b>Date:</b> 08/09/2021 (80m) <b>Time:</b> 08:30 AM-09:30 AM (1h) <b>Time:</b> 07:10 AM-07:25 AM (15m) <b>Provider:</b> SARAH <b>Provider:</b> HEAP <b>Location:</b> ABC DENT <b>Location:</b> NW <b>Prod. Type:</b> ABC NOH <b>Prod. Type:</b> bowley <b>Appt Notes:</b> <b>Appt Notes:</b>			<b>Periodic Exam:</b> 13 21/07/2021 <b>Biting Series:</b> 3 <b>Detailed Exam:</b> 10 <b>Prophyl:</b> 3 07/07/2021 <b>Complete Series:</b> 10 <b>Perio Maintenance:</b> 3 <b>Parasite/Films:</b> 10 <b>Scaling/Kerr Planning:</b> 3 <b>Patient Notes:</b> Jul 21 2021 EF:30 PM Sent via email to static@usingcarestack.com H:		

## Insurance Details

In this section all the insurances, both dental and medical as well as their status is listed. The user is also given information like the subscriber name and ID, carrier and employer name as well as Individual and remaining maximum along with the deductible.

Insurance Details								
Status	CARRIER	Employer	Group #	Phone	Subscriber	Sub ID	Intl. Max.	Intl. Min.
Pri   Active	Aetna PPO	Milner Medical	472703-31-003	(800) 451-7715	Rabbi Ronald, Timothy Chase (16206860)	1234567500	\$280.00	\$0.00
Sec   Active	Aetna Blue Cross And Blue Shield	Many names	2754710018	(877) 567-1860	Rabbi Ronald, Timothy Chase (16206860)	1111111111111111	\$1,580.00	\$1,580.00
Tier   Terminated	Aetna PPO	Continental Airlines	0000	(800) 451-7715	Rabbi Ronald, Timothy Chase (16206860)	1111111111111111	\$1,080.00	\$10100

## Account Details

Here all the active account members of the patient are listed as well as their appointment details. The individual balances and unapplied credits against each account member is also shown.

Account Details								
Name	DOB	Age   Gender	Last Visit	Next Visit	Pmt. Bal.	Inv. Bal.	Total Bal.	Unapplied
Rabbi Ronald, Timothy Chase (16206860)	01/01/1987	34   Male	08/06/2021	09/06/2021	\$200.00	\$280.00	\$400.00	\$0.00
Ronald, Bradley (16215981)	01/01/1987	34   Female	08/06/2021		\$0.00	\$80.00	\$80.00	\$0.00
Ronald, Luca (16217323)	01/01/1987	34   Female	08/06/2021		\$100.00	\$0.00	\$100.00	\$0.00
Hale, Cole (16217391)	02/02/1988	23   Female			\$0.00	\$0.00	\$0.00	\$0.00
Joller, Matthew (16217389)	02/03/1987	34   Male	09/14/2021		\$0.00	\$0.00	\$0.00	\$0.00
Patt, Jacely (16217387)	02/03/1979	43   Female			\$0.00	\$0.00	\$0.00	\$0.00

## Recall Information

All the recall related information of each account member is provided. Details like recall due date and their status is also depicted. In case the recalls are scheduled, the date of appointment is also shown.

Recall Information					
Patient Name	Code	Description	Due Date	Scheduled Date	Status
Rabbi Ronald, Timothy Chase (16206860)	D1110	Prophylaxis - Adult	01/03/2022	N/A	Overscheduled
Rabbi Ronald, Timothy Chase (16206860)	D11120	Prophylaxis - Child	01/07/2022	N/A	Unscheduled

## Find Slot

Written by Sarah Abraham | Last published at: August 22, 2021

## Overview

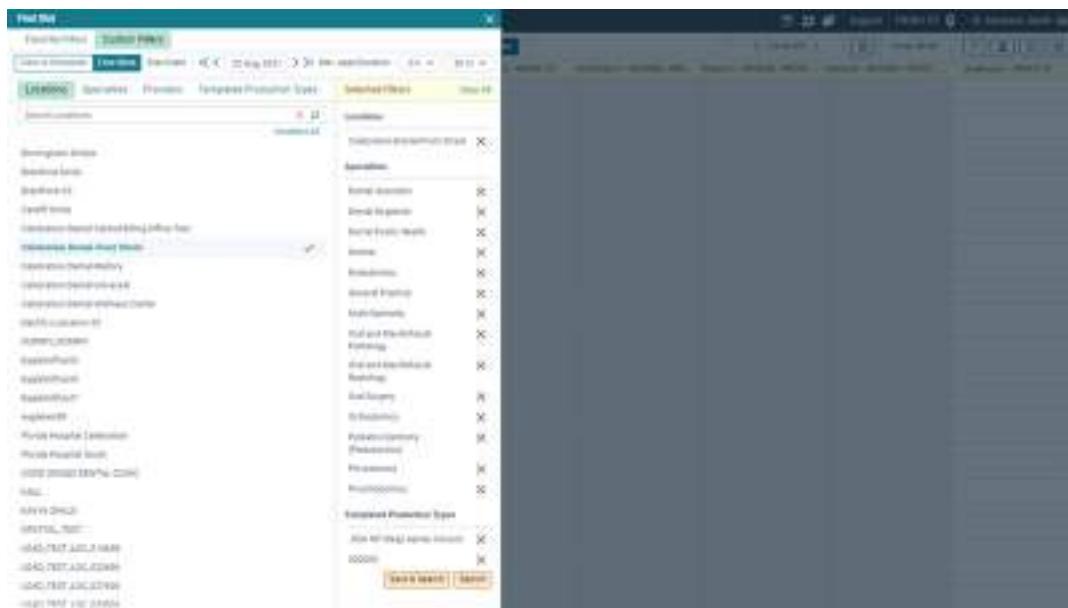
The find slot logic is a functionality that allows the user to find the next available free slot that fits the selected criteria.

## Find Slot Logic

The user can open the Find slot modal from the Find slot icon on the left panel in scheduler.



The user can also open the find slot modal from the Search filters in the top panel.



The user is provided the option to customize their search and is given four criteria to choose from.

The first is the location filter. All the locations the user has access to is shown here and the user is allowed to choose upto 10 locations at the same time.

The second filter is Speciality. Here all the specialities in system are listed and the user can choose any or All of them. The third is the provider filter which lists all the providers in the location and the last one is the production type filter. Here also the user can choose All or Any.

The criteria selected by the user is shown on the right side of the modal. The user can also eliminate choices from here as well.

When a user chooses specific providers and speciality, only the providers who belong to that functionality will be considered for the search.

The search first checks for the location and if the chosen providers have provider availability set for any of the operatories in that particular location. If that criteria is satisfied, then all the available slots that aren't booked or blocked is filtered. The maximum concurrent availability also comes into play and it is ensured that the maximum value is not exceeded.

When a production type is chosen, only the operatories that have any of the production types chosen, assigned to them are considered. Here the specialities that are assigned to the production types also comes into play. Irrespective of the provider or speciality chosen in filters, if the speciality chosen does not match that of the production type, no results are shown.

Eg: If a production type is added with speciality dentist and hygienist, then we need to add providers of types both dentist and hygienist to the chosen location. If both these providers are assigned to an operatory and slot is free, results are shown.

Holidays are avoided and the working hours of providers are also considered to give a complete experience to the user.

# Family Appointments

Written by Sarah Abraham | Last published at: June 01, 2022

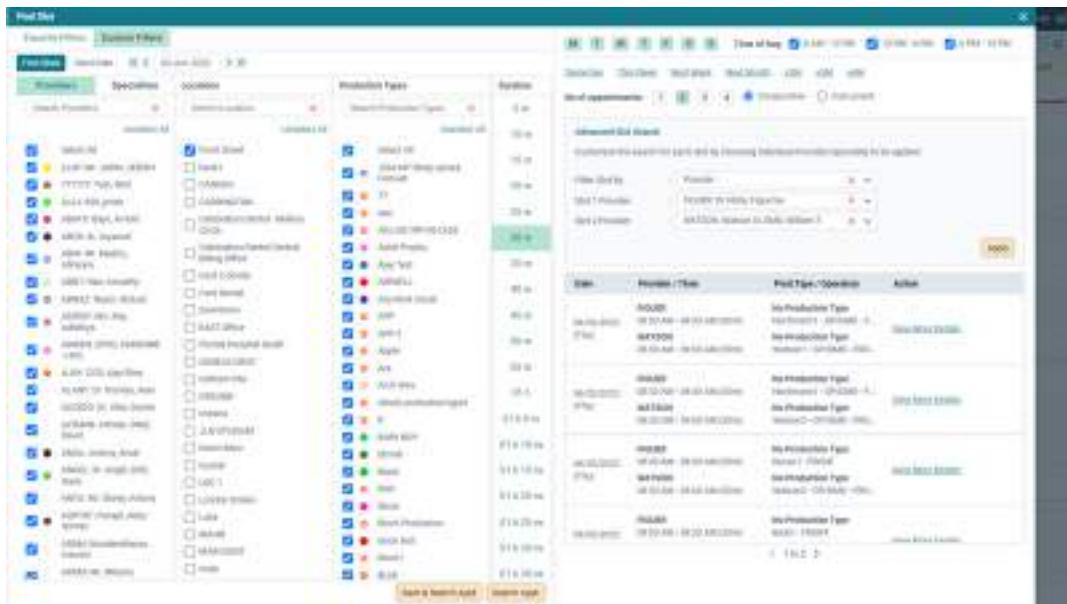
## Overview

When a patient calls in to book dental appointments, they very often ask for multiple appointment slots so that everyone in their family can complete all their dental checkups at once. This would involve booking slots at the same time with different providers or booking appointments one after the other with the same or different dentists.

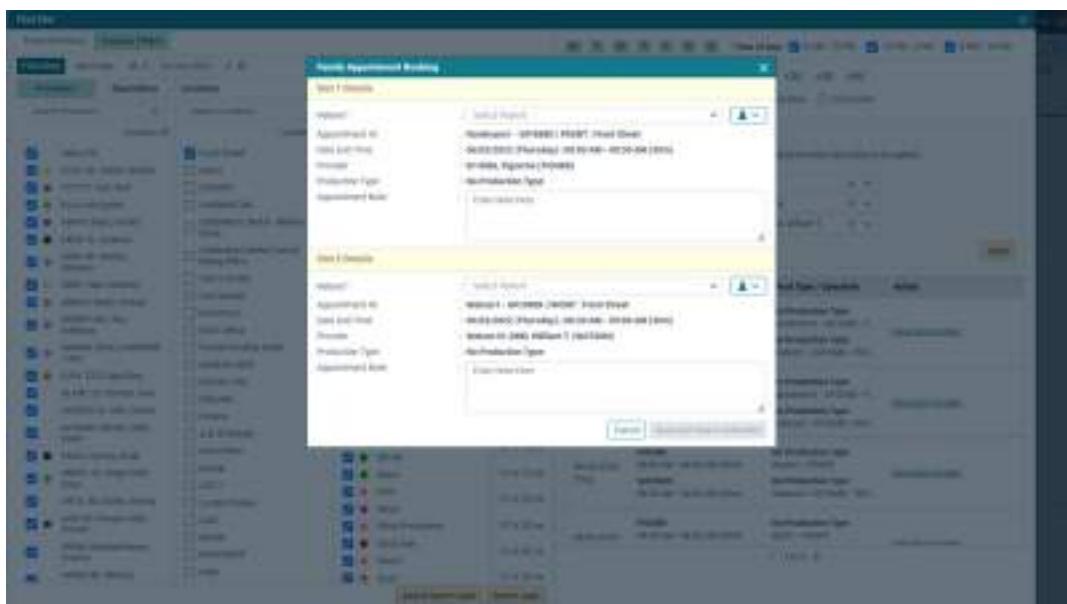
They also use this functionality daily to search for exam appointments followed by hygiene visits for the same day in back-to-back time-slots. This is also very relevant for Pediatric practices as parents prefer to bring their children to visit the dentist together.

## Booking a Family Appointment

The current find slot functionality would be extended to search for more than a single slot. Whenever a user opens the Find slot, it would be defaulted to search for a single appointment. Users can change this and choose to search for a maximum of 4 slots at a time. We can also choose whether to book concurrent or consecutive slots. We have set a maximum of 4 keeping in mind family cancellations could be costly to the clients. Consecutive Search looks for time slots one after the other and the concurrent Search for the same time slot across operatories.



Currently we can search for multiple providers and production types but in the case of family appointments we would require the ability to define which type of provider or speciality is required for each appointment. For eg: Choose speciality 'Dentist' for the first slot followed by a 'Hygienist' slot. The same would be applicable for speciality as well.



The user would book the slot one after the other from the Find Slot slideout without having to navigate to scheduler as the opening the flow could mean that the second slot never gets booked if they got out of context. Once all the slots are booked user should be navigated to the scheduler with the appointments booked highlighted.

# Scheduler Views & Appointment Tile Customization

Written by Sarah Abraham | Last published at: June 01, 2022

## Overview

The Appointment tile shown in scheduler and print of the schedule is one of the most information heavy areas in Carestack. Each practice works in different ways and the data they want to see on the tile in one glance is very varied. We have hence brought customisation to this view to help practices set up the tiles in the way that is most convenient and effective for them.

## Scheduler Views

There are five views that are provided for the Scheduler in Carestack. They are

- **Patient View** - This is the default view that is provided. It provides general patient and appointment data.
- **HIPAA View** - This is the view in compliance with HIPAA regulations. None of the patient data would be available for customization in this view.
- **Eligibility View** - This view has been designed to help users easily figure out whether Eligibility has been completed for the primary insurance of all the patients who have an appointment that day. All appointments with insurance eligibility not completed within the prescribed Eligibility Check Period would be shown in Red background color and the others in green. For all patients who do not have an insurance the background color would be red.
- **Claims View** - This view is designed to distinguish whether action has been taken against all codes that needed to have a claim raised for appointments that were checked out. Appointment blocks are colored red when no primary claim has been generated for the billable codes in the appointment and green when the claim has been generated. It will be shown in white if claim is not required.
- **Custom View** - The custom view can be used to configure the Appointment tile according to the practice's comfort. It provides flexibility in terms of choosing any background color and margin colors for each appointment tile.

## Configuring your customised Appointment tile

The practice can choose to customise the Appointment tile from Practice Settings under Scheduler > Scheduler Settings > Customization of Scheduler Views.

### Patient View

#### Appointment Block Settings

The users have the following options to choose from

- Appointment background color - All Providers, Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Left Margin Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Appointment Border Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.

#### Data Options

The following options are present

- Patient Name (Patient ID)
- Patient Nickname
- Appointment Status
- Medical Alerts
- Insurance Flag
- New Patient Notification
- Premedication Alert
- Phone Number
- Patient Age
- Linked Treatment
- Referral Information
- Provider Name and Duration
- Production Type
- Lab Due Date
- Lab Case Status
- Production Value
- Date Of Birth
- Appointment Note Indication
- Appointment Notes
- Insurance Carrier Name.

## HIPAA View

### Appointment Block Settings

The users have the following options to choose from

- Appointment background color - All Providers, Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Left Margin Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Appointment Border Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.

### Data Options

The following options are present

- Appointment Status
- Medical Alerts
- Insurance Flags
- New Patient Notification
- Patient Age
- Linked Treatment
- Referral Information
- Provider Name and Duration
- Production Type
- Production Value
- Appointment Note Indication

## Eligibility View

### Appointment Block Settings

The users have the following options to choose from

- Appointment background color - Insurance Eligibility Status
- Left Margin Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Appointment Border Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.

### Data Options

The following options are present

- Patient Name (Patient ID)
- Patient Nickname
- Appointment Status
- Medical Alerts
- Insurance Flag
- New Patient Notification
- Premedication Alert
- Phone Number
- Patient Age
- Linked Treatment
- Referral Information
- Provider Name and Duration
- Production Type
- Lab Due Date
- Lab Case Status
- Production Value
- Date Of Birth
- Appointment Note Indication
- Appointment Notes
- Insurance Carrier Name
- Insurance Plan Name
- Group Number
- Last Eligibility Verification Date

## Claim View

### Appointment Block Settings

The users have the following options to choose from

- Appointment background color - Insurance Eligibility Status
- Left Margin Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Appointment Border Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.

### Data Options

The following options are present

- Patient Name (Patient ID)
- Patient Nickname
- Appointment Status
- Medical Alerts
- Insurance Flag
- New Patient Notification
- Premedication Alert
- Phone Number
- Patient Age
- Linked Treatment
- Referral Information
- Provider Name and Duration
- Production Type
- Lab Due Date
- Lab Case Status
- Production Value
- Date Of Birth
- Appointment Note Indication
- Appointment Notes
- Insurance Carrier Name
- Last Eligibility Verification Date

## Custom View

### Appointment Block Settings

The users have the following options to choose from

- Appointment background color - All Providers, Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Left Margin Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.
- Appointment Border Color - Primary Provider, Production Type, Appointment Status, Appointment Status Group.

### Data Options

The following options are present

- Patient Name (Patient ID)
- Patient Nickname
- Appointment Status
- Medical Alerts
- Insurance Flag
- New Patient Notification
- Premedication Alert
- Phone Number
- Patient Age
- Linked Treatment
- Referral Information
- Provider Name and Duration
- Production Type
- Lab Due Date
- Lab Case Status
- Production Value
- Date Of Birth
- Appointment Note Indication
- Appointment Notes
- Insurance Carrier Name

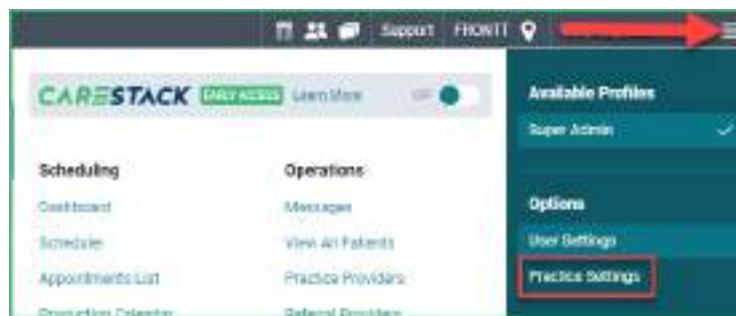
## Basic Information

Written by Aaqib Mohammed Sali | Last published at: August 15, 2021

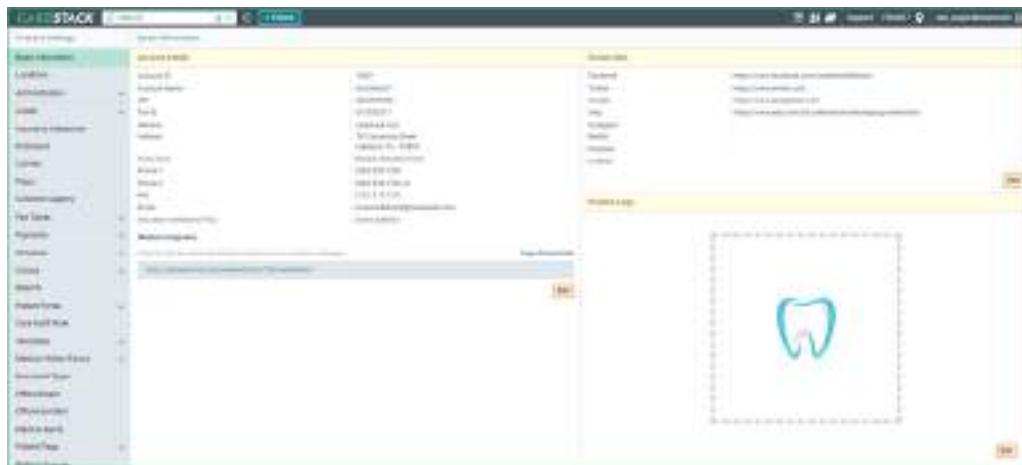
Your Basic Account Information is used to populate these details in claims, forms, letters, and other correspondence. This practice-level information can flow to the individual locations. You will also add location-specific information to override this account-level information.

**Update the details of your practice by following these steps below:**

1. From your system menu, select **Practice Settings**.



2. When the screen loads, you'll see the **Basic Information** page listing your account details. This is where you will update your practice information on the "account-level".



3. Click **Edit** in one of the corresponding sections to update the listed information:

## Account Details

- **Account Name:** Update the way your account name displays if necessary.
  - **NPI:** Update the practice-level NPI number if needed.
  - **Tax ID:** Update the Tax ID number if needed.
  - **Website:** Include the website for your account at the practice-level. If your websites are separate for each of your locations, this can be entered on the location-level instead.
  - **Address:** Enter the address for your account at the practice-level.
  - **Time Zone:** Select the time zone that your practice operates in.
  - **Phone Number:** Enter a phone number for your account at the practice-level.
  - **Fax:** Enter a fax number for your account at the practice-level.
  - **Email:** Enter an email address for your account at the practice-level.

**Note:** This is the information that will be automatically populated if you choose "Global Branding" for your marketing campaigns.

- **Patient Portal Terms of Use:** This is the disclaimer that patients will see when they sign up to use your portal online.
  - **Office Assistant Terms of Use:** This is the disclaimer that patients will see when they use your kiosk for the first time.
  - **Two-factor Authentication (Patient Portal):** This allows the patient to verify their identity using both their email address and mobile phone number when logging into the Patient Portal.
  - **Two-factor Authentication (Office Assistant):** This allows the patient to verify their identity using both their email address and mobile phone number when utilizing the kiosk.
  - **Insurance Verification Workflow:** This setting allows you to choose whether insurance plans should be directly added into the system, or if an additional step to verify the insurance information should be required first.

The screenshot shows a form titled 'Account Details' with the following fields:

- Account ID: 12345
- Account Name: Practice Name
- Address Line 1: 123 Main Street
- Address Line 2:
- City: Dallas
- State: TX
- Zip: 75201
- Phone 1: (999) 999-1234
- Phone 2: (999) 999-1234
- Fax: (999) 999-1234
- Email: info@practicename.com
- File Extension: .pdf

At the bottom right are 'Cancel' and 'Save' buttons.

## Social Links

In this section at the top-right of the page, enter the URL of your social links if you would like to include them in your marketing campaigns at any point.

The screenshot shows a form titled 'Social Links' with the following fields:

- Facebook: <https://www.facebook.com/practicename>
- Twitter: <https://twitter.com/practicename>
- Google: <https://plus.google.com/practicename>
- YouTube: <https://www.youtube.com/practicename>
- Instagram: [Link](#)
- Pinterest: [Link](#)
- LinkedIn: [Link](#)

At the bottom right are 'Cancel' and 'Save' buttons.

## Practice Logo

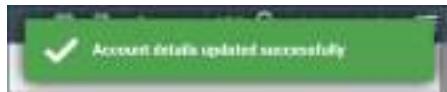
Upload a logo for your account at the practice-level. This is useful when you are using global branding for your forms and letters.

- Image should be not greater than 300px (length) and 300px (height)
- Files should have the extension .jpeg .jpg or .png
- File size should be between 1kb and 100kb

4. Remember to hit **Save** when you are done.

You will receive a green confirmation message:

**"Account details updated successfully."**

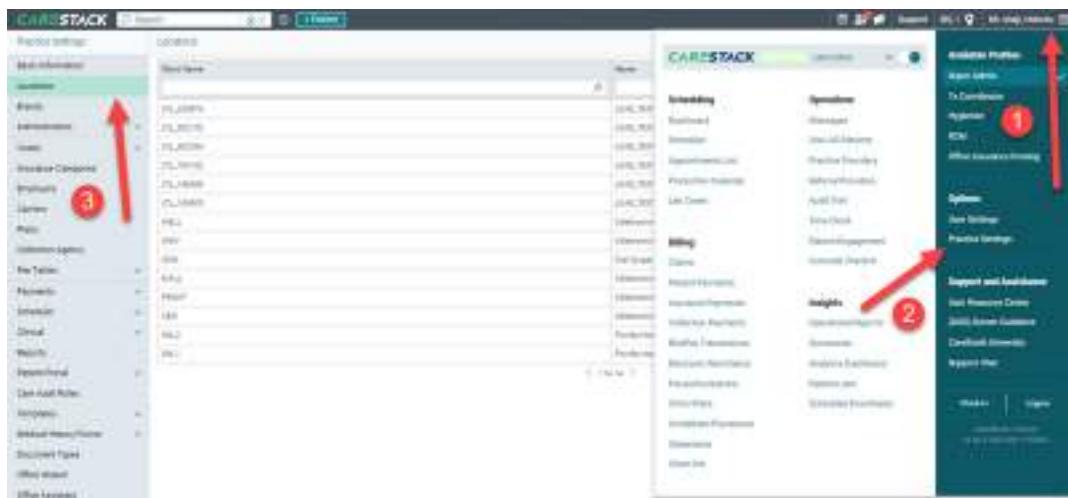


# Locations

Written by Geo Thomas | Last published at: August 19, 2021

## Location Level Settings

Locations are the individual offices where you serve your patients and/or process payments. For statements, patient engagement campaigns, letters, and forms, you may choose to show location versus account details. When you choose location-based settings, they come from these location settings. Locations are added to CareStack from the back end and so a service request is to be created if a practice requests to add a new location. Once the location has been added, it would be visible in **System Menu > Practice Settings > Locations**



Each of these location would have a Short Name and Name displayed here, clicking on any location would show more details, options and settings regarding that location under different tabs.

### Details

Here, the basic contact information regarding this location are to be added.

A screenshot of the 'Location Details' form. It contains several sections: 'Address' (Billing Address, Working Hours, Holidays), 'Operations Settings' (Address Line 1, Address Line 2, City, State, Zip, Phone 1, Phone 2, Email 1, Email 2), and 'Other Details' (Share Patient Profile in Scheduler, Skip Saturday/Sunday through Scheduler, Block Saturday/Sunday). The 'Address' section is highlighted with a yellow background. Buttons for 'Save' and 'Cancel' are at the bottom right.

If this location works only for certain days of the week, it is possible to skip the unwanted days in the scheduler by setting it up here.

A screenshot of the 'Location Details' form, similar to the previous one but with the 'Other Details' section highlighted by a red box. This section contains the 'Skip Saturday/Sunday through Scheduler' checkbox, which is checked. Other fields like 'Share Patient Profile in Scheduler' and 'Block Saturday/Sunday' are also present. The 'Address' section is also highlighted with a yellow background. Buttons for 'Save' and 'Cancel' are at the bottom right.

If location level Patient Portal is set to Enable, the link to this would appear here.

The screenshot shows the 'Location - L000\_TEST\_L00C\_4388014' details page. The 'Billing Details' tab is selected. Under 'Billing Details', there is a section for 'Billing Dentist' with fields for 'Last Name' (John), 'First Name' (Doe), 'Middle Name' (Jr.), 'Title' (Dr.), and 'Address'. Below this is a note: 'User: System Generated Using: Appt/Invoice/Promo/Billing/Referral/Invite/Care/Insurance/Billing/Custom/Location/No Location/None none'. There is also a 'Billing Entity' section with fields for 'Address Line 1' (1234 Main St), 'Address Line 2' (Suite 100), 'City' (Any City), 'State' (Any State), and 'Zip' (12345). A red arrow points to the 'Auto Fill' checkbox in the 'Billing Entity' section. At the bottom, there is a note: 'This configuration field controls how carestack.com links to your location. It can be used to automatically pre-populate certain fields on carestack.com forms.' with 'Edit' and 'Save' buttons.

## Billing Details

If the practice uses a location level billing, it can be set up here.

The screenshot shows the 'Location - L000\_TEST\_L00C\_4388014' details page. The 'Billing Details' tab is selected. Under 'Billing Details', there is a section for 'Use Account Settings' with a radio button labeled 'No'. Below this is a section for 'Billing Dentist' with fields for 'Last Name' (John), 'First Name' (Doe), 'Middle Name' (Jr.), 'Title' (Dr.), and 'Address'. There is also a 'Billing Entity' section with fields for 'Address Line 1' (1234 Main St), 'Address Line 2' (Suite 100), 'City' (Any City), 'State' (Any State), and 'Zip' (12345). At the bottom, there is a note: 'This configuration field controls how carestack.com links to your location. It can be used to automatically pre-populate certain fields on carestack.com forms.' with 'Edit' and 'Save' buttons.

If 'Use Account Settings' is set as No, CareStack would give the option select a Billing Dentist or a Dental Entity, where more details regarding the chosen option are to be entered.

If it is set as Yes, the details would get auto-populated.

The screenshot shows the 'Location - L000\_TEST\_L00C\_4388014' details page. The 'Billing Details' tab is selected. Under 'Billing Details', there is a section for 'Use Account Settings' with a radio button labeled 'Yes'. Below this is a section for 'Billing Dentist' with fields for 'Last Name' (John), 'First Name' (Doe), 'Middle Name' (Jr.), 'Title' (Dr.), and 'Address'. There is also a 'Billing Entity' section with fields for 'Address Line 1' (1234 Main St), 'Address Line 2' (Suite 100), 'City' (Any City), 'State' (Any State), and 'Zip' (12345). At the bottom, there is a note: 'This configuration field controls how carestack.com links to your location. It can be used to automatically pre-populate certain fields on carestack.com forms.' with 'Edit' and 'Save' buttons.

## Working Hours

If it is set to use account settings here, the details would get auto-populated from the account settings.

The screenshot shows the 'Location - L000\_TEST\_L00C\_4388014' details page. The 'Working Hours' tab is selected. Under 'Working Hours', there is a section for 'Use Account Settings' with a radio button labeled 'Yes'. Below this is a table for 'Day of Week' with columns for 'Start Time', 'End Time', 'Break Start Time', and 'Break End Time'. The table contains the following data:

Day of Week	Start Time	End Time	Break Start Time	Break End Time
Monday	12:00 PM	0:00 AM		
Tuesday	12:00 PM	0:00 AM		
Wednesday	12:00 PM	0:00 AM		
Thursday	12:00 PM	0:00 AM		
Friday	12:00 PM	0:00 AM		
Saturday	12:00 PM	0:00 AM		
Sunday	12:00 PM	0:00 AM		

At the bottom, there is a note: 'If the location level settings is enabled and a day has been set as a working day, all the other fields would become editable.' with 'Edit' and 'Save' buttons.

If the location level settings is enabled and a day has been set as a working day, all the other fields would become editable.

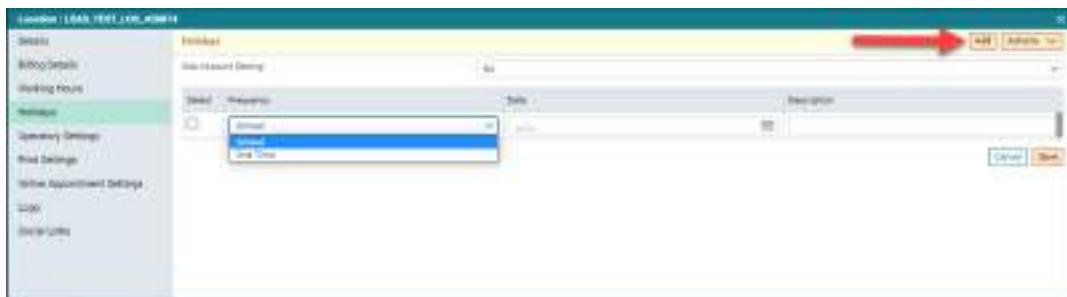


## Holidays

Holidays are the days that the location will be closed and will not accept appointments. Setting these holidays will automatically grey out the scheduler for the day. It would still be possible to book appointments for the day.

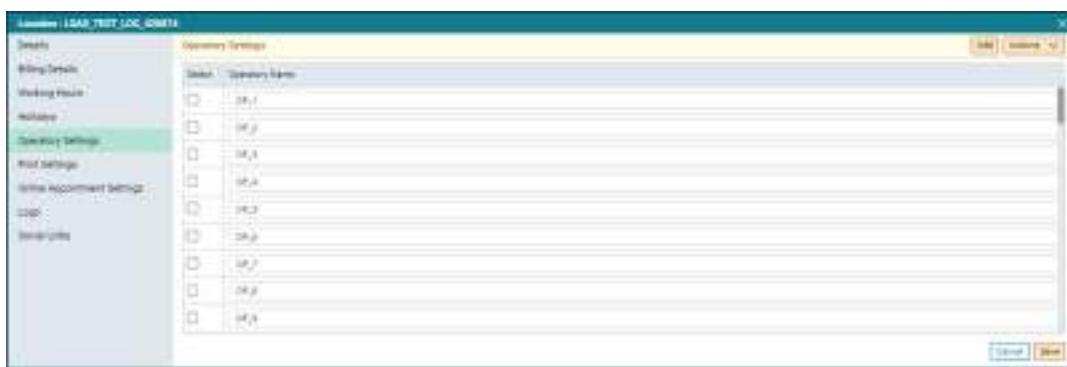


If location level settings is enabled, the user would be able to add/delete locations level holidays.



## Operatory Settings

There are no account settings for operatories. Operatories are added/deleted at the location level.



Operatories are arranged in the schedule alphabetically regardless of the order in which they were added. Many practices will add "Op1" or "OpA" as a preface to a provider's name. Operatories can also be deleted from here, but the ones with already booked appointment slots cannot be deleted.

## Print Settings

It is possible to set up what to appear while printing, at location level. This is possible in case of treatment plans and unscheduled recalls.

The image contains two side-by-side screenshots of a software interface titled 'Location : ISAR\_TEST.LOC\_028811'. On the left is a vertical navigation menu with items: Details, Billing Details, Working Hours, Holidays, Practice Settings, Print Settings (which is highlighted in green), Online Appointment Settings, Logos, and Social Links. The right side shows two tabs: 'Treatment Plan' and 'Unscheduled Recalls'. The 'Treatment Plan' tab is active, showing a list of various treatment plan items with checkboxes for 'Print' and 'Visible'. The 'Unscheduled Recalls' tab is also visible. At the bottom right of each screenshot are 'Save' and 'Cancel' buttons.

Embedded content from <https://www.loom.com/embed/dcd34544c5c54774975aeb61f6ce5dee>

## Online Appointment Settings

It is here that the online booking feature can be enabled for the location. It is possible to set it to account level or location level settings. This would enable the practice to set the production types that should appear while booking online appointments, at a location level if required.

The image shows the 'Online Appointment Settings' dialog box. The left sidebar has the same navigation menu as the previous screenshot. The main area is titled 'Online Appointment Settings' and contains a section for 'Appointment Booking Filters' with checkboxes for 'Enable' and 'Disable', and radio buttons for 'Yes' and 'No'. Below this is a table titled 'Production Types' with columns: Production Type, Description, Production Type, Return Type, Appointment Type, Status, and Action. Two rows are shown: 'New' (Description: 'Entered/Edited/View New Patient', Production Type: 'New Patient (Entered/Patient)', Return Type: 'New Patient (Entered/Patient)', Appointment Type: 'Office Visit-New', Status: 'Enabled', Action: 'Edit') and 'Existing' (Description: 'Entered/Edited/Patient-Able-Prod', Production Type: 'New Patient (Existing Patient)', Return Type: 'New Patient (Existing Patient)', Appointment Type: 'Office Visit-New', Status: 'Enabled', Action: 'Edit').

## Logo

If the location has its own logo, it can be added here.



If the location uses the account logo, the account level logo found in the Basic Information section will apply.

## Social Links

Social Media links like Facebook, Twitter, Google+, and Yelp can help increase the location's visibility. The links can be included in patient engagement campaign and in letters and documents for added communication.



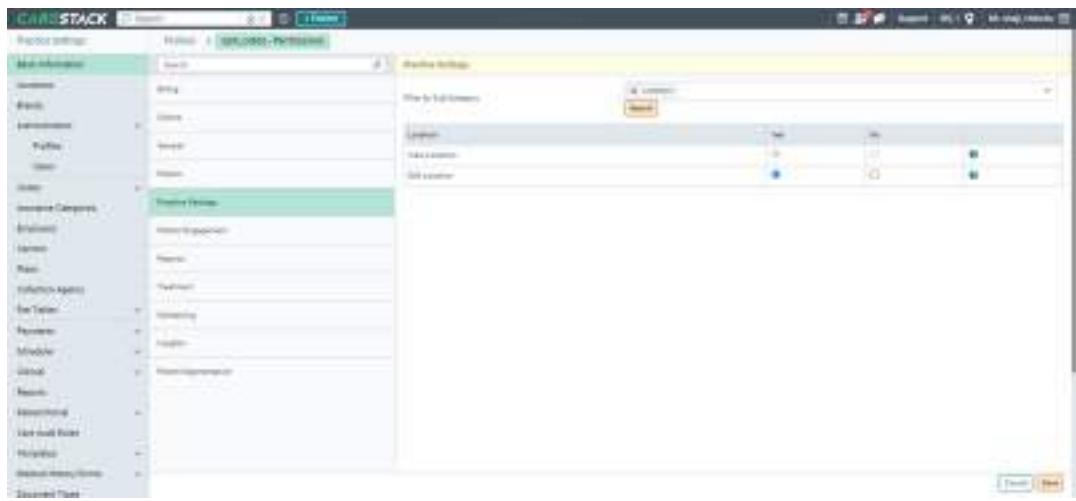
If the location has its own social media presence, location's respective links can be added here. If the location uses the account's links, the account level social links found in the Basic Information section will apply.

Location/account level branding can be selected while creating a campaign.

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## Required Permissions

Users would require separate permissions to view/edit locations



# Profiles

Written by Rahul Krishnan | Last published at: August 15, 2021

The items that a user can view or complete in the system are defined by their assigned Profile Type that is selected during the user setup. For example, a user could be tagged as an Insurance Verifier, Dental Assistant, Front Desk Receptionist, Treatment Coordinator, or just about any role type you can think up. Each of these roles would have a unique combination of permissions enabled, allowing them to complete their daily workflows throughout the system, while also restricting them from the things they do not necessarily need access to.

## Create a new Profile Type

From your practice settings, select **Administration > Profiles** on the left side menu.

- Click **Add** at the top-right of the screen to create a new profile type.
- Or, click **Edit** next to an existing one on the grid to change its details and logout time.

A screenshot of the CareStack software interface. On the left, there's a sidebar with 'Practices' and 'Administration' highlighted. The main area shows a table titled 'Profiles' with columns: 'Select', 'Profile Name', 'Description', 'Logout Time (in mins)', and 'Manage Permissions'. There are six rows: 'Super Admin', 'Insurance Verifier', 'Treatment Coordinator', 'Assisted', and 'Appointee'. Each row has a 'Manage Permissions' link under the last column. A red arrow points to the 'Add' button at the top right of the table area.

2. In the pop-up window:

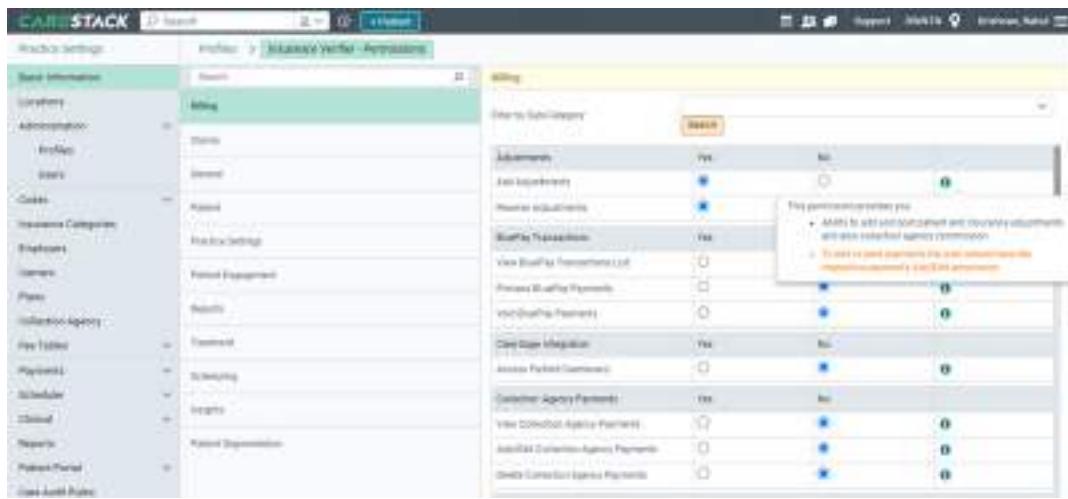
- Enter a fitting **name** for this user role profile type.
- Enter a clear **description** of the purpose of this user role.
- Enter a **number of minutes** that the system should wait (when the screen has been idle) before logging the user out.

3. When you are finished, hit **Save** (if you are editing an existing profile type), or hit **Save & Continue** (if creating a new one) to begin working on the permissions settings.

A screenshot of a 'Add Profile' dialog box. It has three input fields: 'Name' (with a red asterisk), 'Description', and 'Logout Time (in mins)' (with a red asterisk). Below the 'Logout Time' field is a note: 'Logout Time must be between 1 and 999'. At the bottom right is a large orange 'Save & Continue' button with a red arrow pointing to it.

## Assigning Profile Type Permissions

After clicking **Save & Continue** (or if you clicked **Manage Permissions** next to an existing profile type to update its permission settings -- pictured in the previous section) the following screen will appear:



- Go through each of the system permissions categories on the left side, while granting or revoking access on each permission setting within the category on the right side.
- When you have finished going through all categories and assigning the appropriate user permissions, hit **Save** at the bottom-right.

You can also click on the I button next to each permission line item so that you can view the actions that can be done by granting the permission.

## Permissions in CareStack

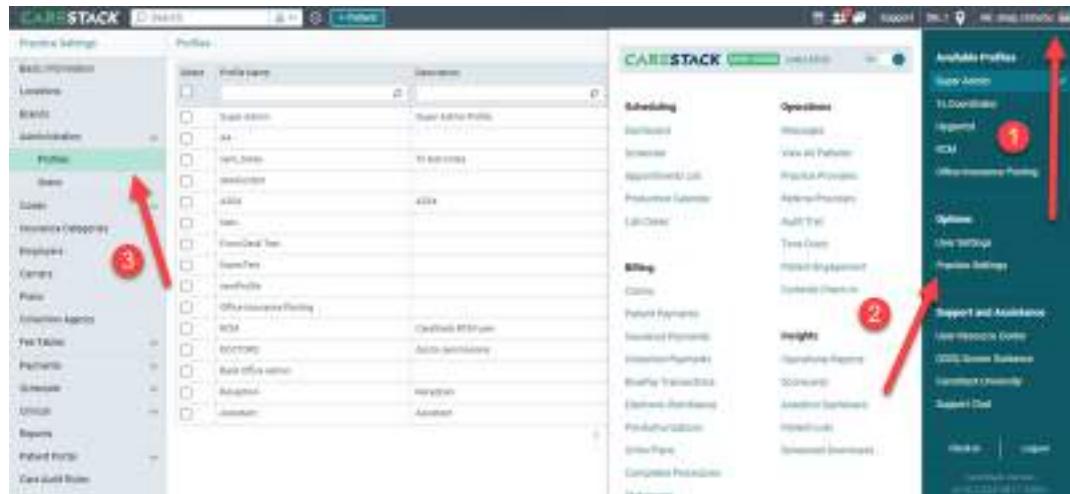
Written by Geo Thomas | Last published at: August 19, 2021

Permissions in CareStack enables the practice to decide what a user should see in CareStack. Since there would be multiple users and each user has their own specific duties, it would be better to grant them access to the specific sections of CareStack as they are dealing with patient's health information.

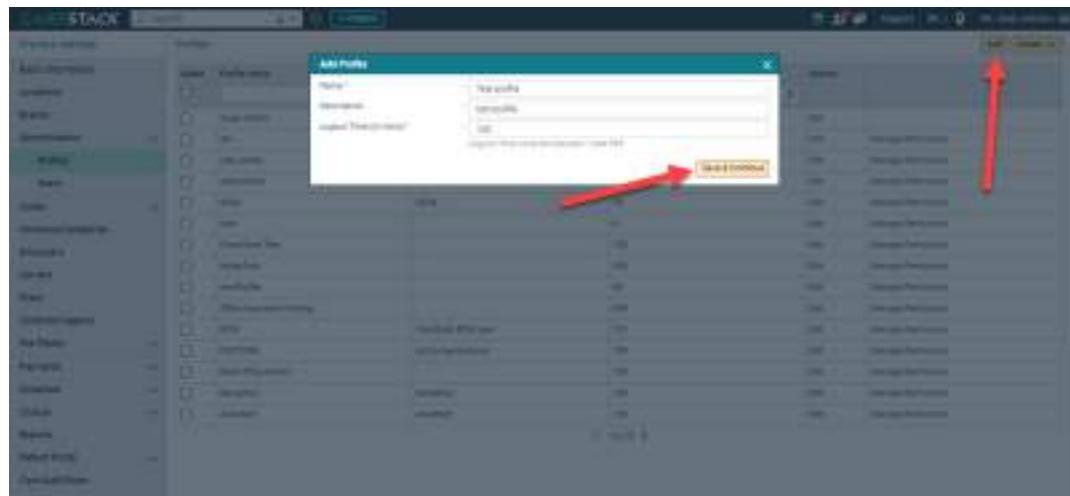
Different profiles can be created using any set of combinations of permissions. The **Super Admin** profile is the only profile that is system generated. This profile has all the permissions.

# Profiles

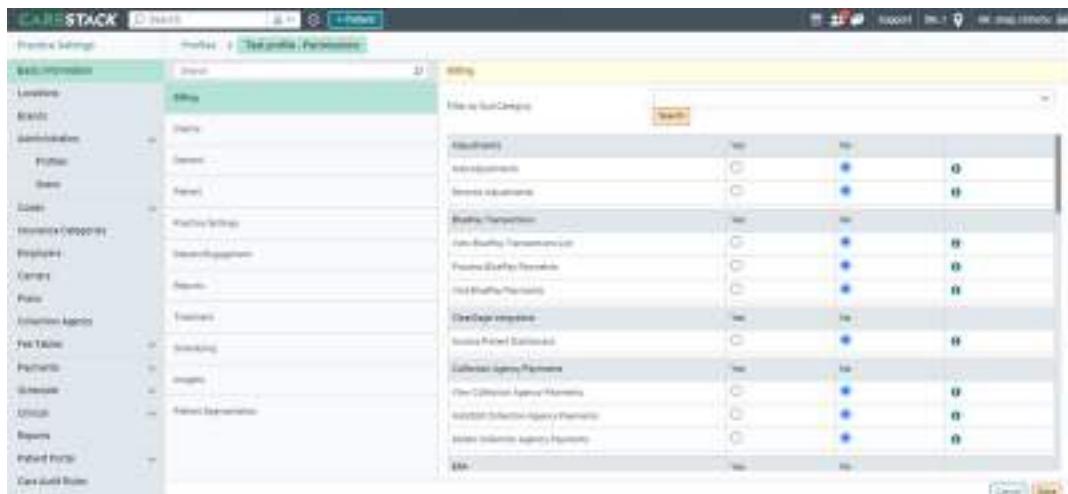
Profiles are used to set permissions. Since there would be multiple users with the same job role, a profile is to be created such that the permissions of the profile fall in line with the job role of the user. This can be done in **System Menu > Practice Settings > Administration > Profiles**



Upon clicking Add, a pop-up would appear, where the name of the profile, its description and the logout time has to be entered. Once this is done, click **Save & Continue**.



This would open the permissions page.



Here, by default all the permissions would be set to **No**. After giving the required permissions, click **Save** and thus the new profile would be created.

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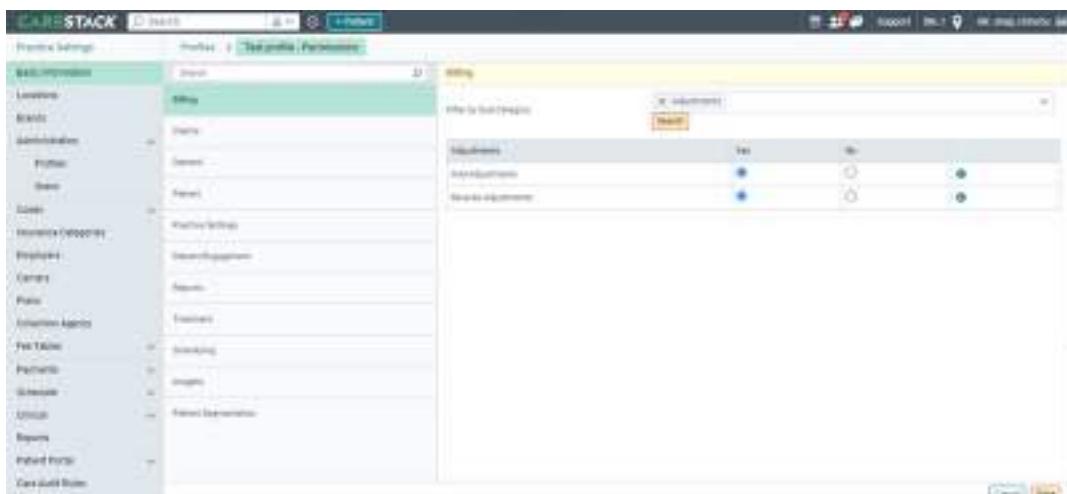
## Permissions

Each set of permissions give the users the following abilities.

### Billing

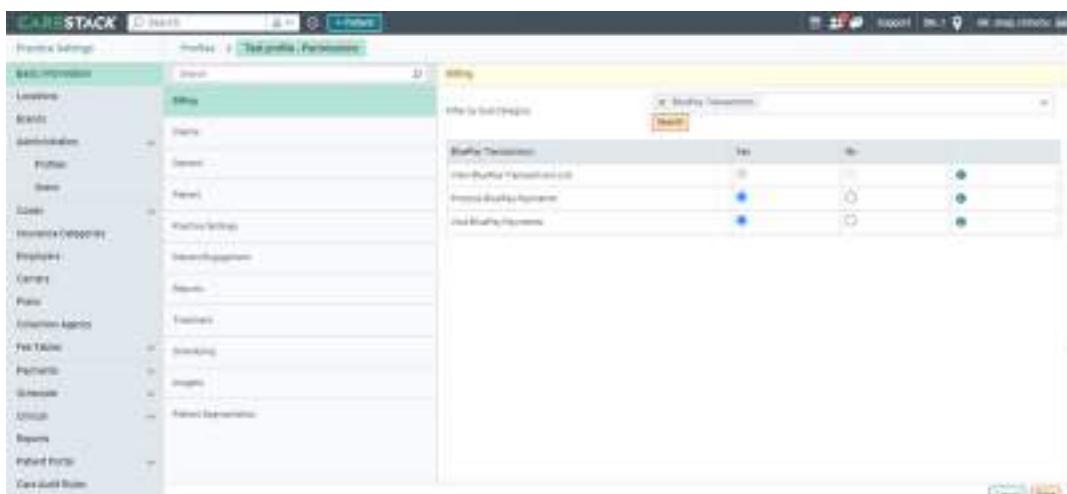
#### Adjustments

- **Add Adjustments:**
  - Ability to add and post patient and insurance adjustments, and collection agency commissions.
  - To add or post payments the user should have the respective payment's Add/Edit permission.
- **Reverse Adjustments:**
  - Ability to reverse adjustments from the code snapshot as well as from the completed procedures grid.
  - To reverse payments user should have Reverse permissions in respective payment section.
  - To use reverse action from Completed Procedures user should also have Reverse permissions in Patient Payments and Insurance Payments.



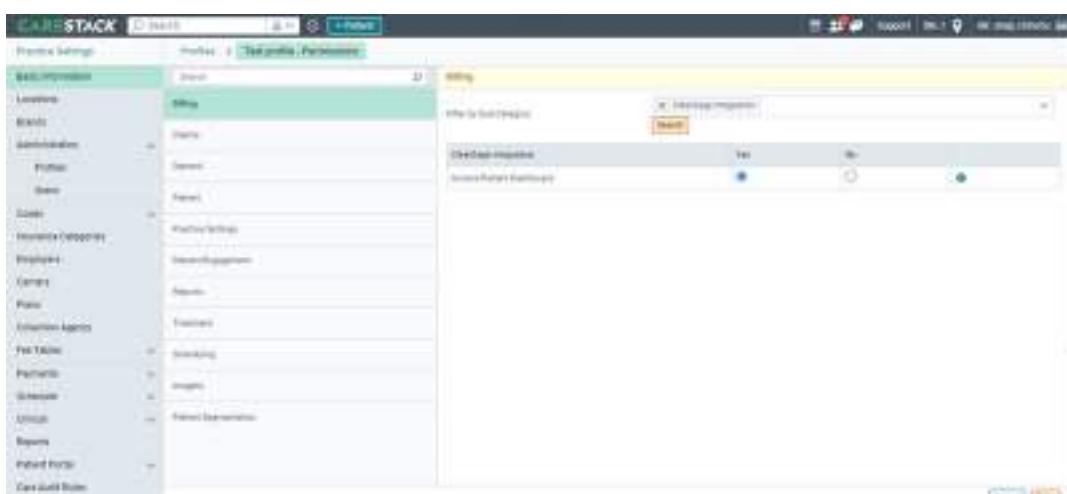
### BluePay Transaction

- **View BluePay Transactions List:**
  - Ability to view the BluePay transaction list.
- **Process Bluepay Payments:**
  - Ability to initiate Bluepay transactions list.
- **Void Bluepay Payments:**
  - Ability to delete payment receipts from the system and initiate a refund in Bluepay.



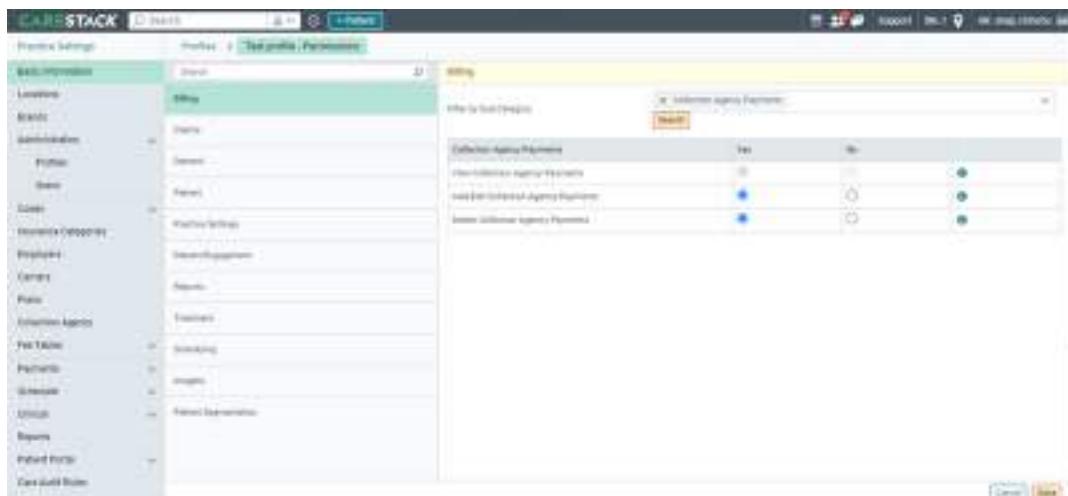
### ClearGage Integration

- **Access Patient Dashboard:**
  - Ability to access ClearGage's embedded dashboard for CareStack patients. Ability to create, view, and mange payment plans and one time payments via ClearGage.



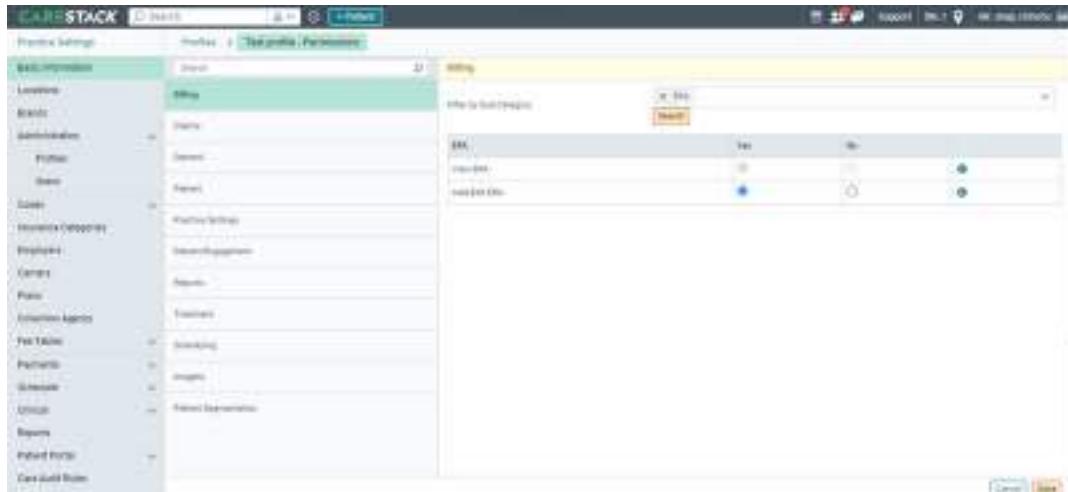
### Collection Agency Payments

- **View Collection Agency Payments:**
  - Ability to view collection agency payments and related information from collection payment screen.
- **Add/Edit Collection Payments:**
  - Ability to add collection agency payment receipts and post payments using them.
  - To apply collection commission and adjustments the user should have Adjustment permission.
- **Delete Collection Agency Payments:**
  - Ability to delete collection agency payment receipts.



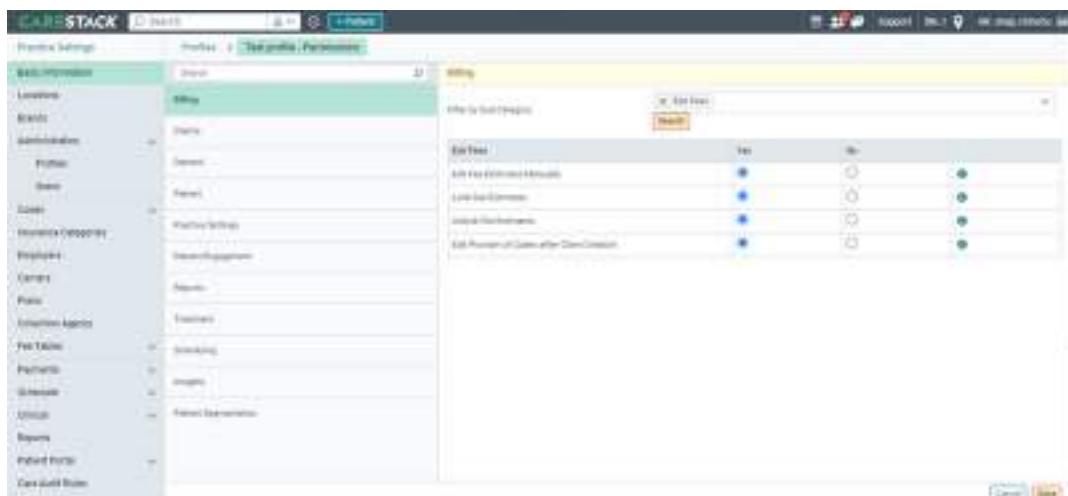
## ERA

- **View ERA:**
  - Ability to view electronic remittance advice and related information from the ERA screen.
- **Add/Edit ERA:**
  - Ability to add and post ERA payments and related information from ERA screens.



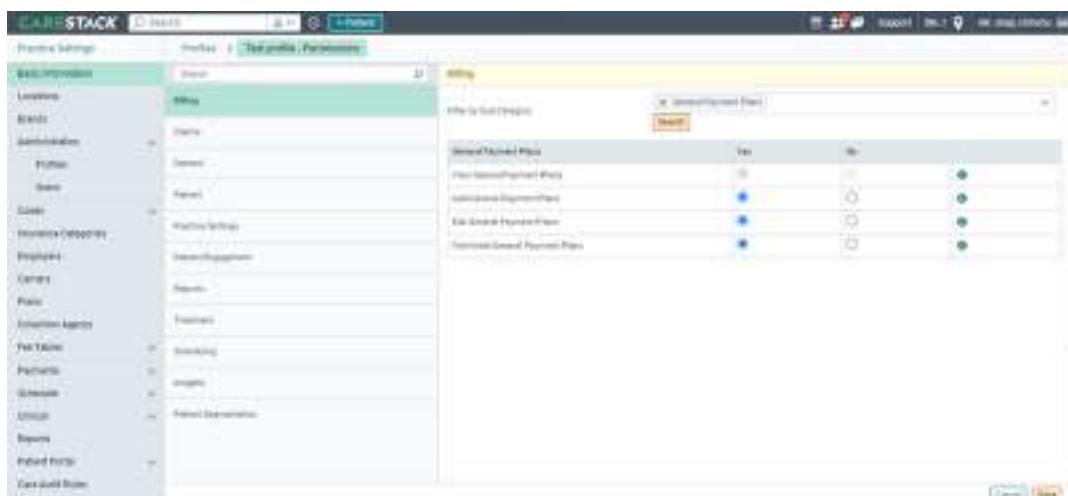
## Edit Fees

- **Edit Fee Estimates Manually:**
  - Ability to edit the fee estimates manually from the Fee pop-up or from the Code Snapshot.
- **Lock Fee Estimates:**
  - Ability to Lock the fee estimates of a procedure code.
- **Unlock Fee Estimates:**
  - Ability to unlock the fee estimates of a procedure code.
- **Edit Provider of Codes after Claim Creation:**
  - Ability to update the treatment provider shown for a code even after a claim has been created with the code.



## General Payment Plans

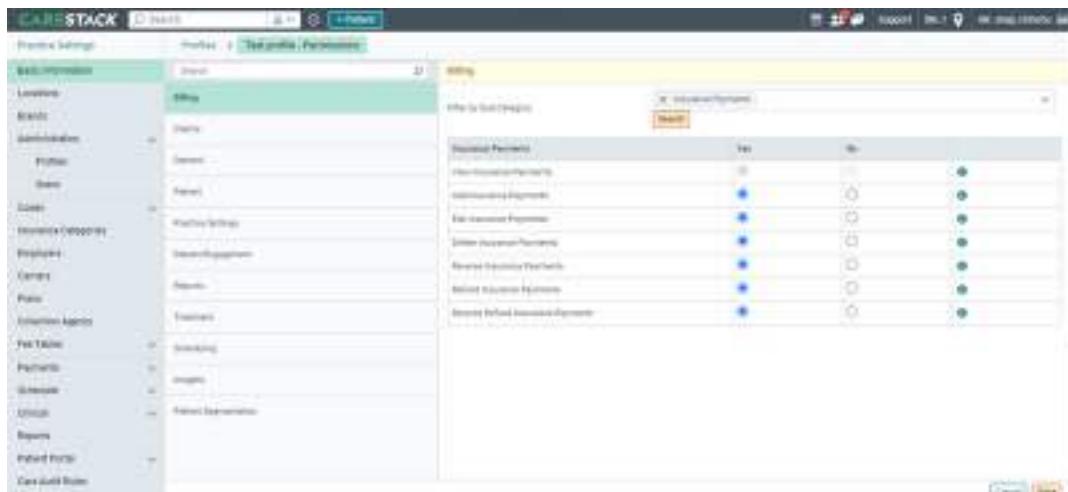
- **View General Payment Plans:**
  - Ability to view and print general payment plan details in the system.
- **Add General Payment Plans:**
  - Ability to add a general payment plan.
- **Edit General Payment Plans:**
  - Ability to edit a general payment plan and its amortization schedule.
- **Terminate General Payment Plans:**
  - Ability to terminate a general payment plan.



## Insurance Payments

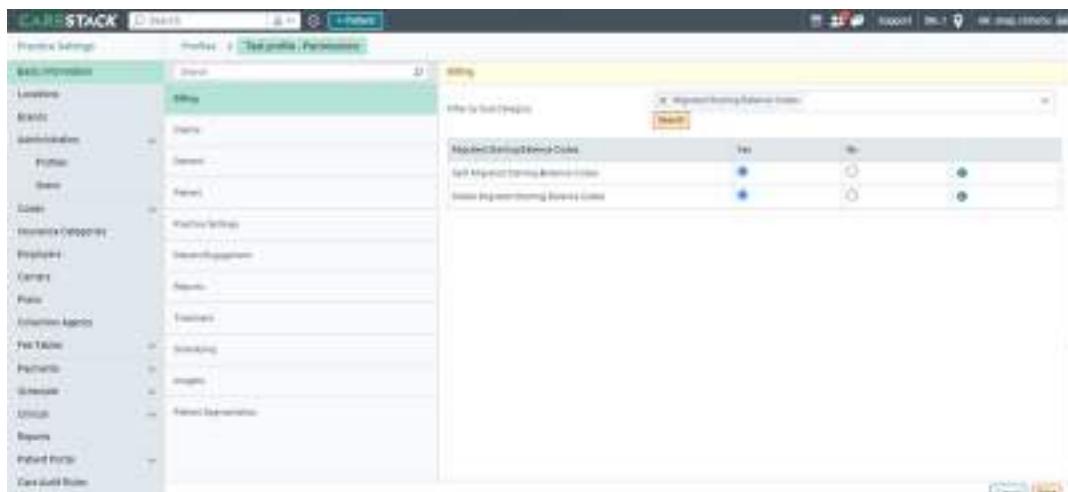
- **View Insurance Payments:**
  - Ability to view insurance payments and related information from the Insurance Payment screen.
  - Ability to view capitation payments and related information on the Capitation tab in the Insurance Payment screen.
- **Add Insurance Payments:**
  - Ability to add insurance payments receipts and post payments using them.
  - Ability to add capitation payments.
  - To apply adjustments the user should have adjustment permission.
  - To update fee register if there is a variation in payment, the user should have the permission to update Fee Registers
- **Edit Insurance Payments:**
  - Ability to edit insurance payments receipts and post payments using them.
  - To apply adjustments the user should have adjustment permission.
  - To update fee register if there is a variation in payment, the user should have the permission to update Fee Registers.
- **Delete Insurance Payments:**
  - Ability to delete insurance payment receipts and capitation payment receipts.
- **Reverse Insurance Payments:**
  - Ability to reverse insurance payments from codes they've been posted to.
  - To reverse adjustments the user should have the permission to reverse adjustments.
  - To reverse from the Completed Procedures screen, the user should also have permissions to Reverse Patient Payments and Reverse Adjustments

- **Refund Insurance Payments:**
  - Ability to refund credits from an insurance payment receipt
- **Reverse Refund Insurance Payments:**
  - Ability to reverse the refunding of credits originating from an insurance payment receipt.



### Migrated Starting Balance Codes

- **Split Migrated Starting Balance Codes:**
  - Ability to split the production from a migrated starting balance code among multiple providers.
- **Delete Migrated Starting Balance Codes:**
  - Ability to delete a migrated starting balance code.



### Orthodontic Payment Plans

- **View Ortho Payment Plans:**
  - Ability to view and print orthodontic payment plan details.
- **Add Ortho Patient Payments Plans:**
  - Ability to add ortho cases and the corresponding details.
  - Ability to add a patient payment plan to a case.
- **Edit Ortho Patient Payment Plans:**
  - Ability to edit or pause ortho patient payment plans.
- **Terminate Ortho Patient Payment Plans:**
  - Ability to terminate ortho patient payment plans.
- **Add Ortho Insurance Payment Plans:**
  - Ability to add ortho cases and the corresponding details.
  - Ability to add a insurance plans payment plan to a case.
- **Edit Ortho Insurance Payment Plans:**
  - Ability to edit or pause ortho insurance payment plans.
- **Terminate Ortho Insurance Payment Plans:**
  - Ability to terminate ortho insurance payment plans.

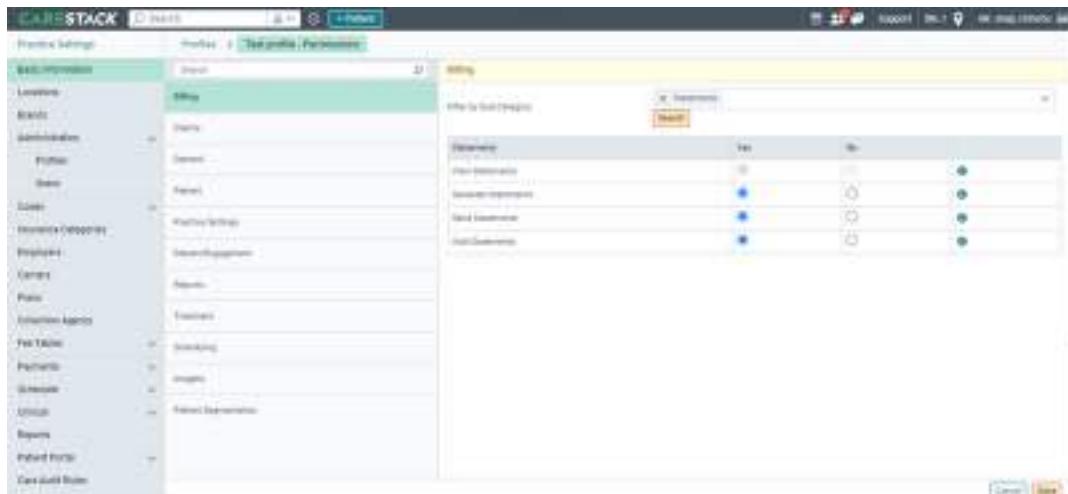
## Patient Payments

- View Patient Payments:**
  - Ability to view payment related information from the Completed Procedures slider, and the Patient Payment slider.
  - Ability to view the billing information section within the Code Snapshot.
  - Ability to navigate to the Patient Payment slider from the patient snapshot, patient search drop-down, recent patients drop-down, or other patient screen with the Payments link.
- Add Patient Payments:**
  - Ability to add patient payment receipts and post payments against codes.
  - To apply adjustments the user should have adjustment permission.
- Edit Patient Payments:**
  - Ability to edit the details of patient payment receipts and post payments against codes.
  - To edit adjustments the user should have adjustment permission.
- Delete Patient Payments:**
  - Ability to delete patient payment receipts.
  - The application of the payment must be reversed before it can be deleted.
  - The user should have the Reverse Patient Payment permission.
- Reverse Patient Payments:**
  - Ability to reverse the posting of patient payments in the patient payment page, receipt details page, or from the code snapshot.
  - To reverse adjustments user should have Reverse permissions in Adjustments.
  - To reverse payments from the completed procedures page, the user should also have the permission to reverse insurance payments and adjustments.
- Refund/Adjust -off Patient Payments:**
  - Ability to refund and adjust-off credits remaining from a patient payment receipt.
- Reverse Refund/Adjust-off Patient Payments:**
  - Ability to reverse the refunding or adjusting off of credits from a patient payment receipt.
- Batch Post of Unapplied Credits:**
  - Ability to post unapplied credits in a batch format.

## Statements

- View Statements:**

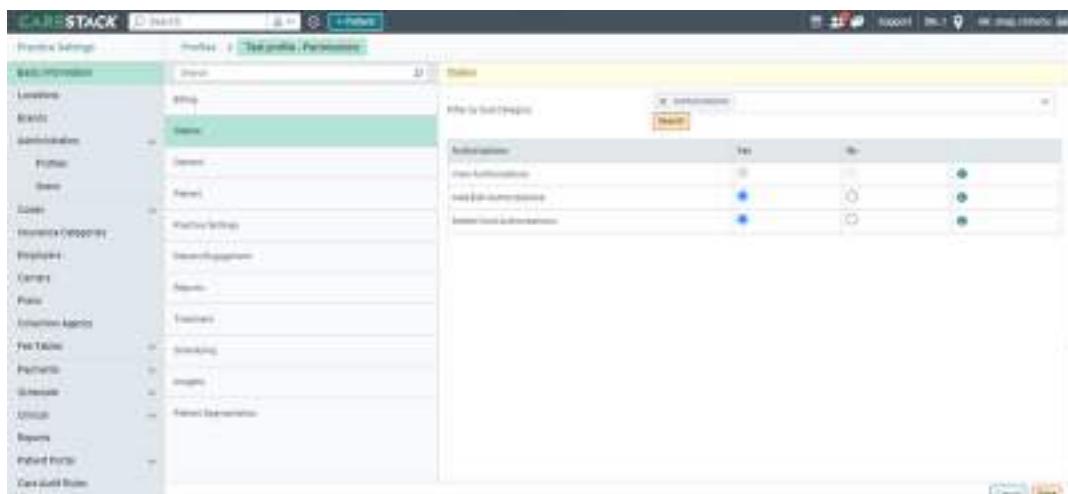
- Ability to view and print previously generated statements.
- **Generate Statements:**
  - Ability to set the criteria and generate a batch of statements from that criteria.
- **Send Statements:**
  - Ability to send or transmit already generated statements
- **Void Statements:**
  - Ability to mark an already generated statement as void.



## Claims

### Authorizations

- **View Authorizations:**
  - Ability to view authorizations and authorization requests within the patient profile.
  - Ability to view all dental and medical authorization requests.
  - Ability to view authorization forms, details, codes, and responses.
  - Ability to view the authorization history of every request form.
- **Add/Edit Authorizations:**
  - Ability to add dental and medical authorization requests.
  - Ability to edit authorization forms, details, and responses.
  - Ability to add codes to authorization forms.
  - Ability to create authorization forms.
  - Ability to create authorization requests from the patient's treatment plan.
- **Delete/Void Authorizations:**
  - Ability to delete an authorization.

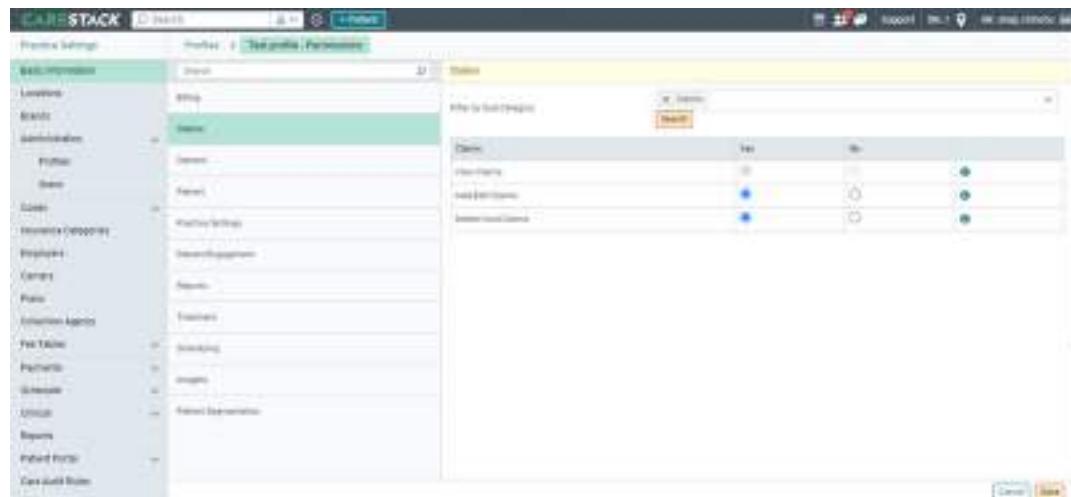


## Claims

- **View Claims:**
  - Ability to view claims within the patient profile and all claims from the Claims module.
  - Ability to view all claims of any status.
  - Ability to view the history and details of claim batch jobs.

- Ability to view claim details and claim forms.
  - Ability to Print claim forms.
- **Add/Edit Claims:**
- Ability to add dental and medical claims.
  - Ability to transmit electronic claims and print paper claims.
  - Ability to change the claim status of individual claims.
  - Ability to edit claims that are in the pending submission status.
  - Ability to create an individual claim from the appointment or treatment plan.

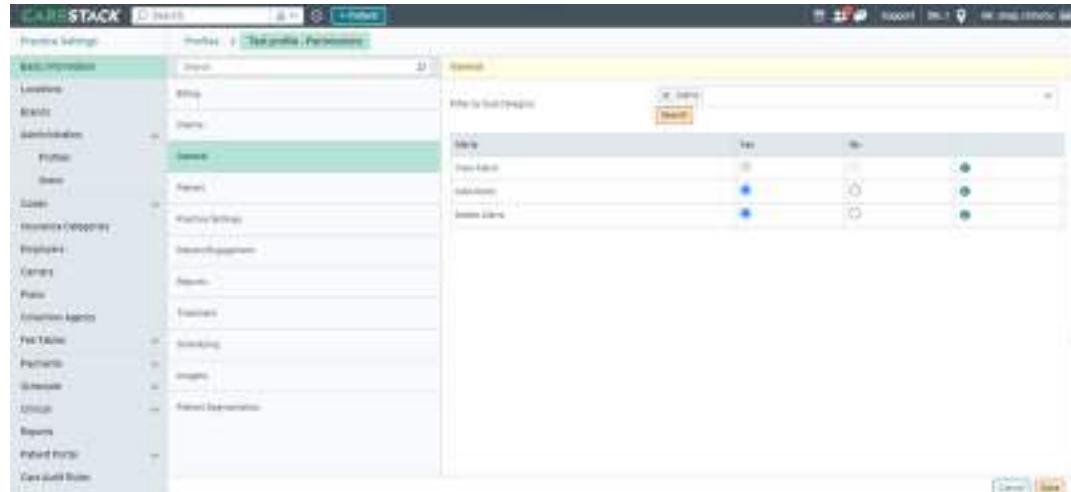
- **Delete/Void Claims:**
- Ability to delete or close claims.
  - Ability to void claims.



## General

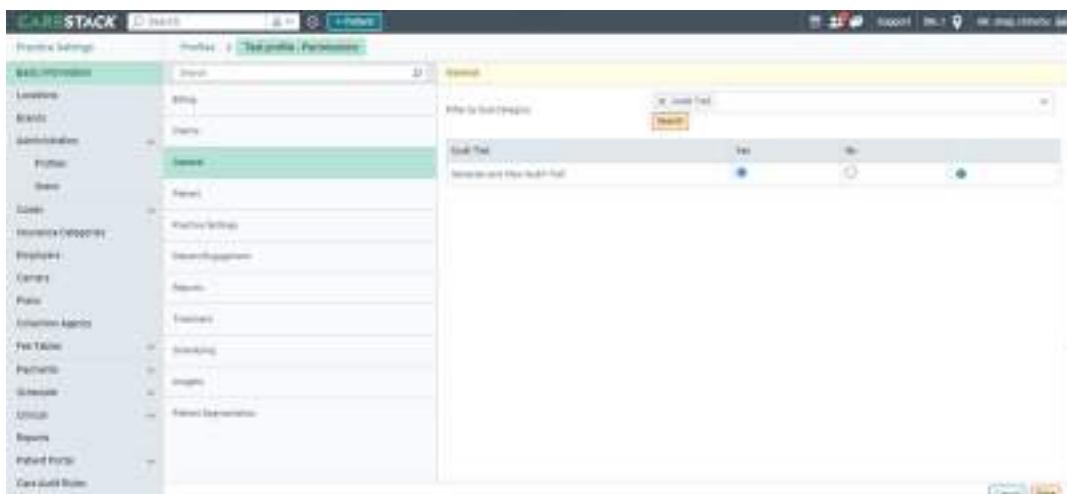
### Alerts

- **View Alerts:**
- Ability to view and snooze all general alerts that have been added to the patient profile.
- **Add Alerts:**
- Ability to add new alerts to multiple patients or profiles
- **Delete Alerts:**
- Ability to delete existing alerts from the patient profile.



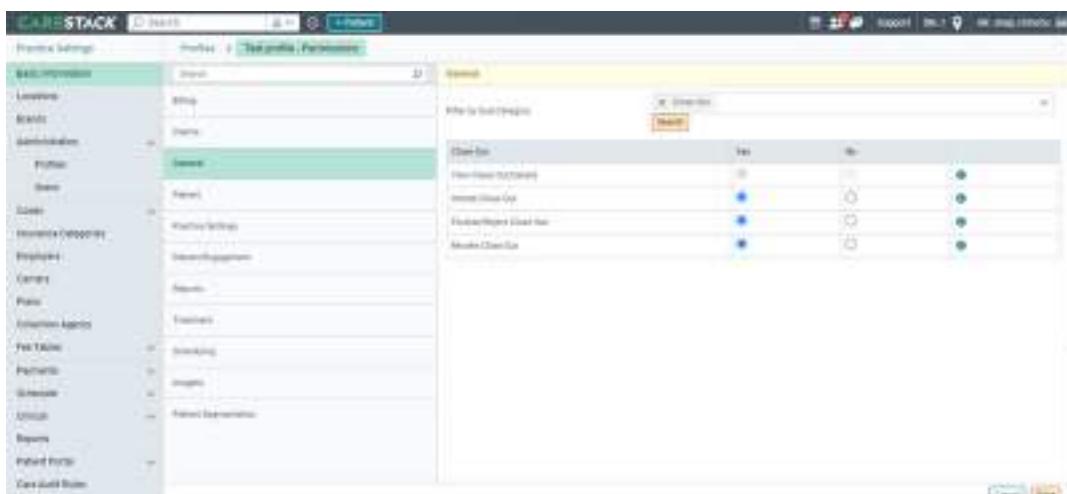
### Audit Trail

- **Generate and View Audit Trail:**
- Ability to view the audit trail.
  - Ability to synch the audit trail to the current time.



## Close Out

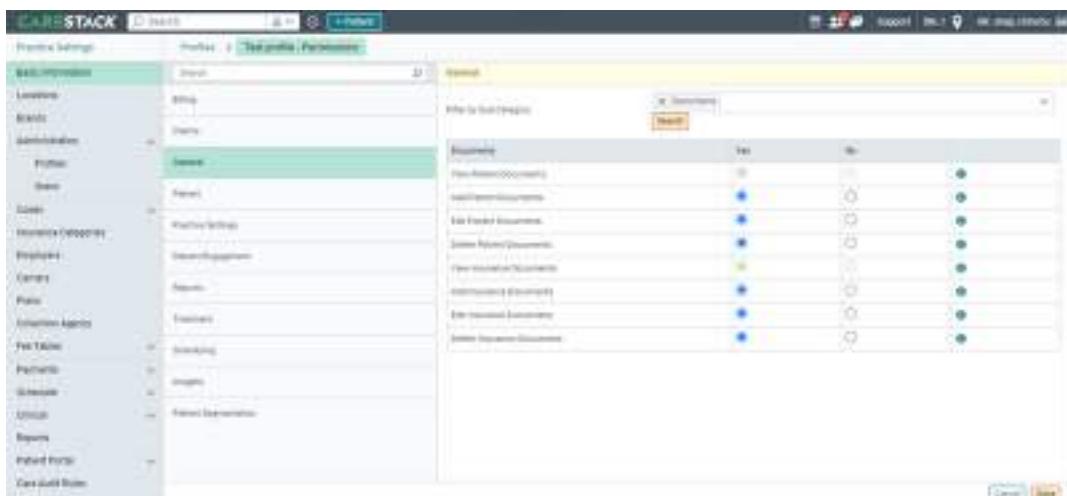
- **View Close Out Details:**
  - Ability to view details of a previously completed close out.
- **Initiate Close Out:**
  - Ability to initiate a new close out.
- **Finalize/Reject Close Out:**
  - Ability to finalize the close out process or to reject it so it does not occur.
- **Revoke Close Out:**
  - Ability to revoke a previously completed close out.



## Documents

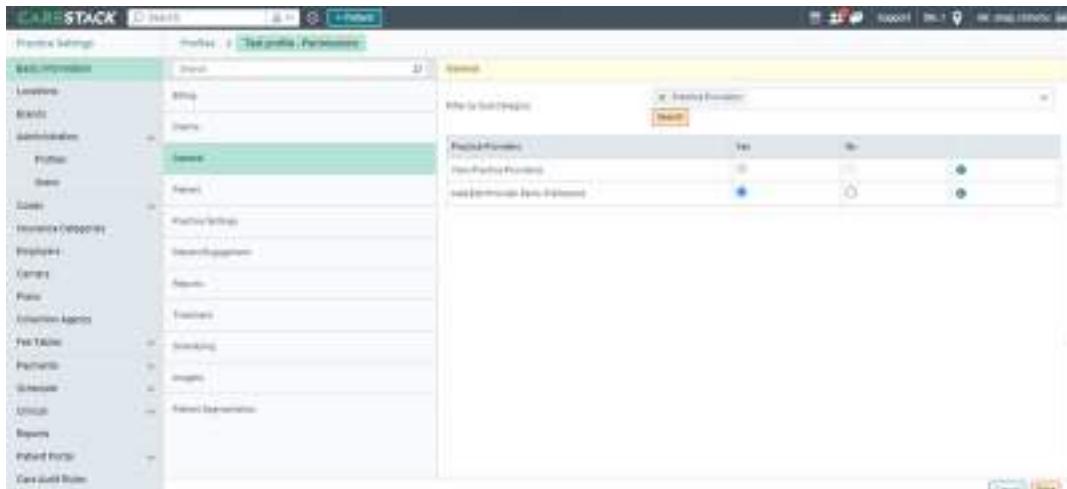
- **View Patient Documents:**
  - Ability to view and print documents from the patient document slider.
- **Add Patient Documents:**
  - Ability to add a new document to the profile.
  - Ability to link or attach already added documents to claims or receipts.
- **Edit Patient Documents:**
  - Ability to edit the details of an already added document.
- **Delete Patient Documents:**
  - Ability to delete a document already added to the patient's document slider.
- **View Insurance Documents:**
  - Ability to view and print documents attached to an insurance receipt.
- **Add Insurance Documents:**
  - Ability to add a new document.
- **Edit Insurance Documents:**
  - Ability to edit the details of an already added document.
- **Delete Insurance Documents:**
  - Ability to delete a document already added to the insurance document slider.

- Ability to delete a document already added.



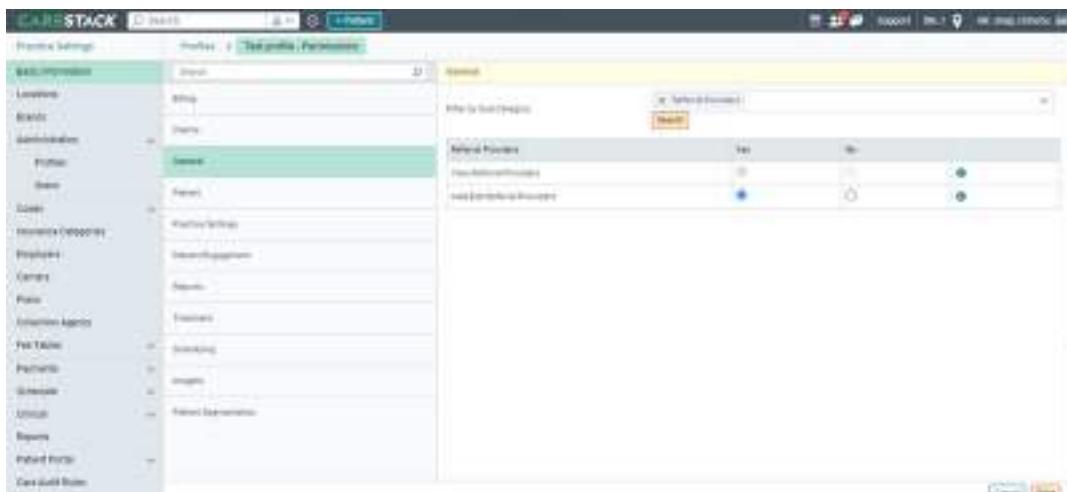
## Practice Providers

- **View Practice Providers:**
    - Ability to view a list of all the active and inactive providers in the practice.
    - Ability to view the individual perio preferences for each provider.
  - **Add/Edit Provider Perio Preference:**
    - Ability to edit the individual perio charting preferences for each provider.



## Referral Providers

- **View Referral Providers:**
    - Ability to view details of all active and inactive Referral Providers (Outgoing referrals)
  - **Add/Edit Referral Providers:**
    - Ability to add a new referral provider (outgoing).
    - Ability to edit details of existing referral providers (outgoing).



## Time Clock

- **Add/Edit My Time Clock Entries:**

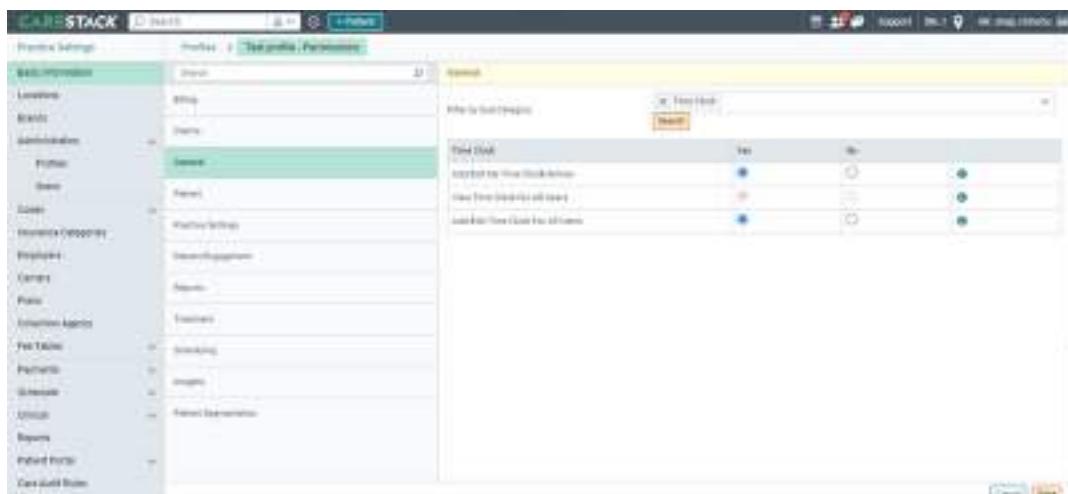
- Ability to add or edit the users own clock in or clock out entry.

- **View Time Clock for All Users:**

- Ability to view the clock in or clock out entries for any CareStack user.

- **Add/Edit Time Clock For All Users:**

- Ability to clock in and clock out any CareStack user.
- Ability to Edit Time Clock entries of each individual User

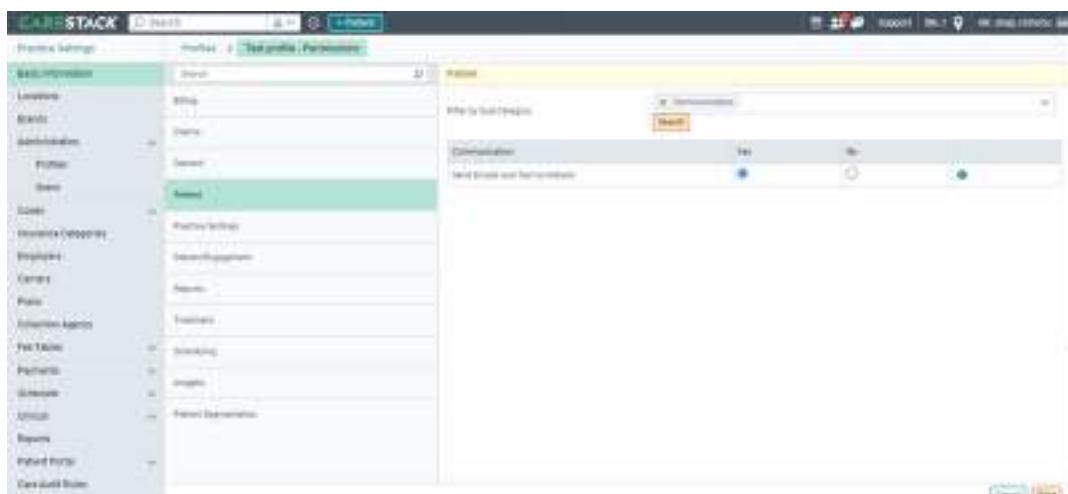


## Patient

### Communication

- **Send Emails and Text to Patient:**

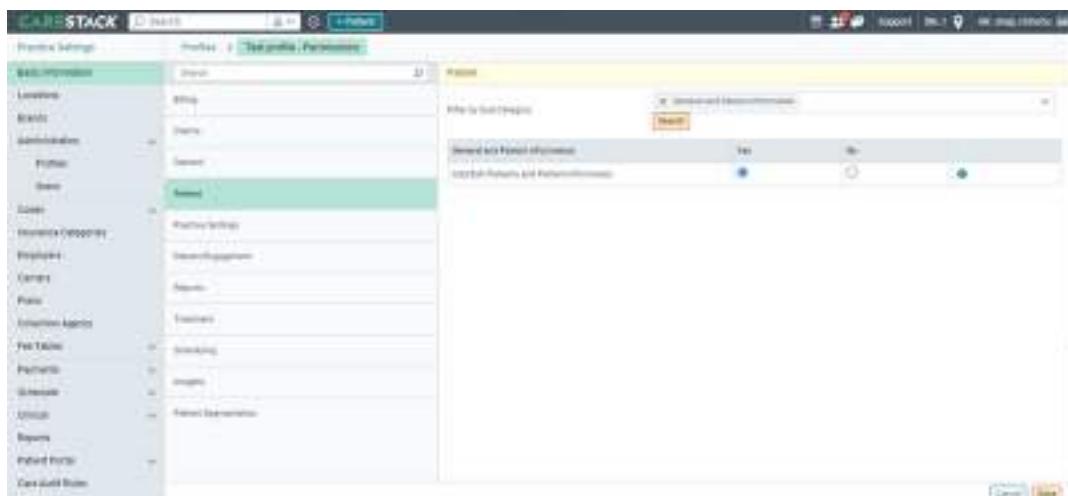
- Ability to send emails to a patient that has authorized emails and has an email address.
- Ability to send texts to a patient that has authorized texts and has a mobile number.



### General and Patient Information

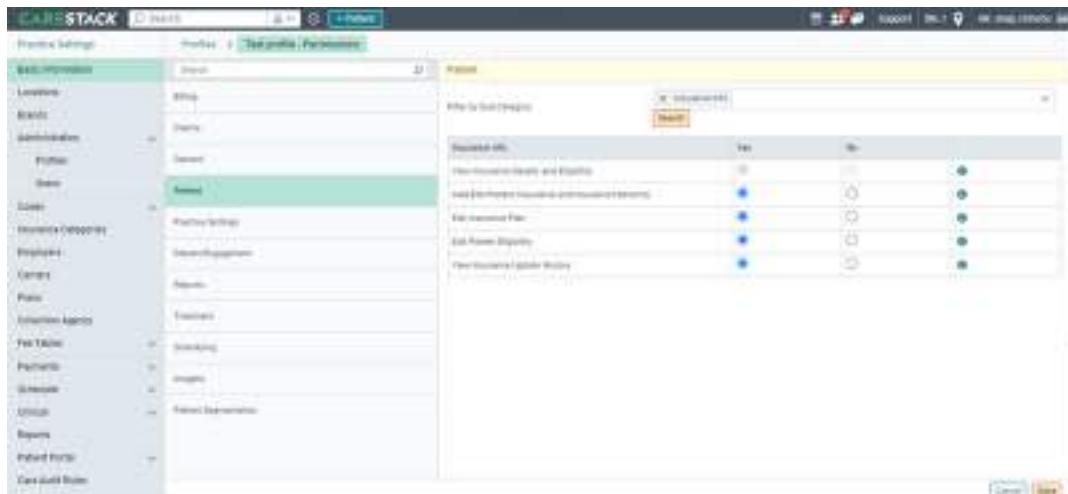
- **Add/Edit Patients and Patient Information:**

- Ability to add a new patient with the corresponding details.
- Ability to add new patients to an existing account.
- Ability to convert online patients to full patient profiles.
- Ability to edit basic information of existing patients.
- Ability to deactivate existing patients.



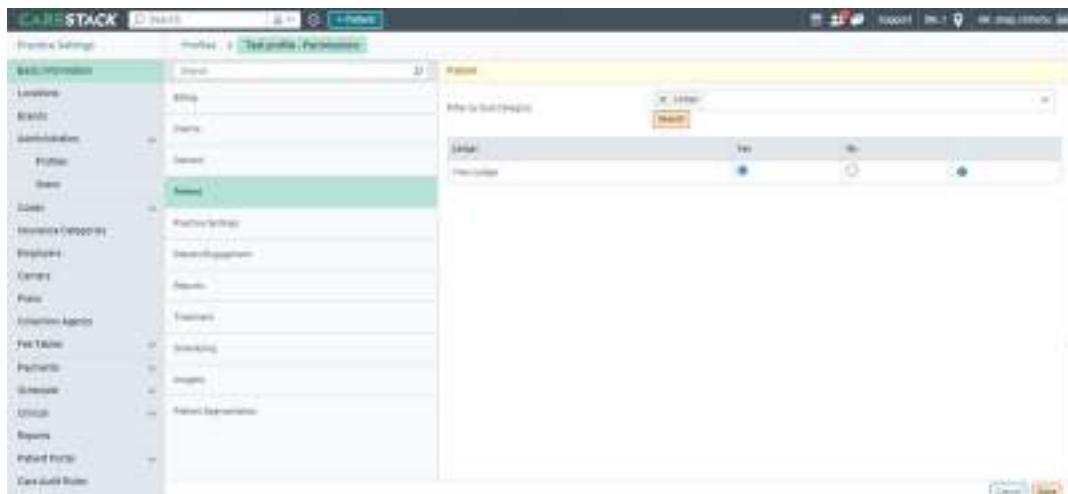
## Insurance Info

- **View Insurance Details and Eligibility:**
  - Ability to view all a patient's insurance plans.
  - Ability to view plan details of patient insurance plans.
  - Ability to view the eligibility details for each patient covered under the insurance plan(s).
- **Add/Edit Patient Insurance and Insurance Hierarchy:**
  - Ability to add new insurance plans to a patient.
  - Ability to assign hierarchy (primary, secondary, etc.) of insurance plans for patients.
  - Ability to edit the insurance eligibility for insurance plans in the pending verification status.
  - To change the plan details, the user should also have the add/edit permission for the plan itself.
- **Edit Insurance Plan:**
  - Ability to edit insurance plan details from the patient profile.
- **Edit Patient Eligibility:**
  - Ability to perform electronic eligibility request.
  - Ability to enter the eligibility details for a patient insurance plan.
- **View Insurance Update History:**
  - Ability to view the history of all updates made on the patient insurance plan details.



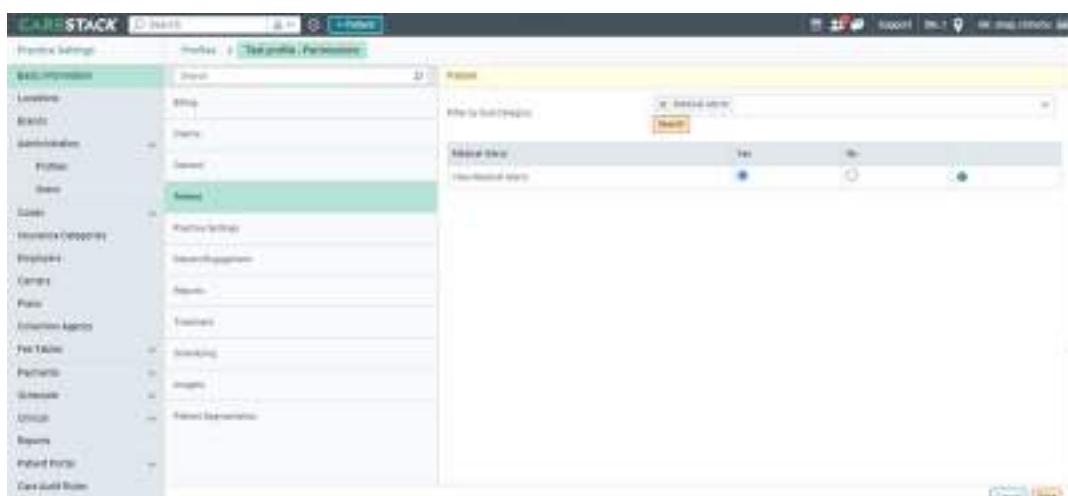
## Ledger

- **View Ledger:**
  - Ability to view both the account and patient ledgers with a variety of filter and sort options.
  - Ability to print the patient ledger.



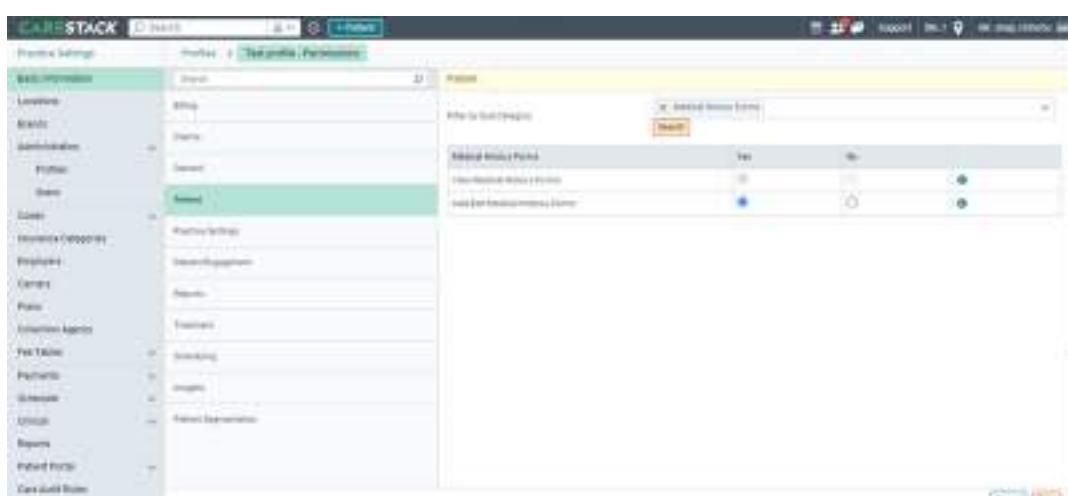
## Medical Alerts

- **View Medical Alerts:**
  - Ability to view the medical alerts associated with the profile through the health history form.



## Medical History Forms

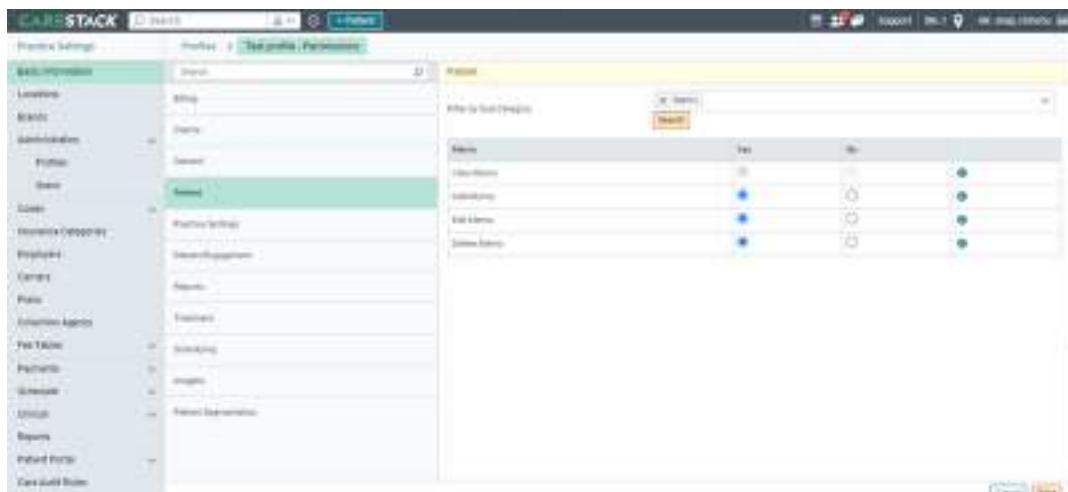
- **View Medical History Forms:**
  - Ability to view all existing medical history forms that are in the patient profile.
  - Ability to print any existing medical history form.
- **Add/Edit Medical History Forms:**
  - Ability to add a new medical history form to a patient.
  - Ability to edit and delete medical history forms still in the draft state.



## Memo

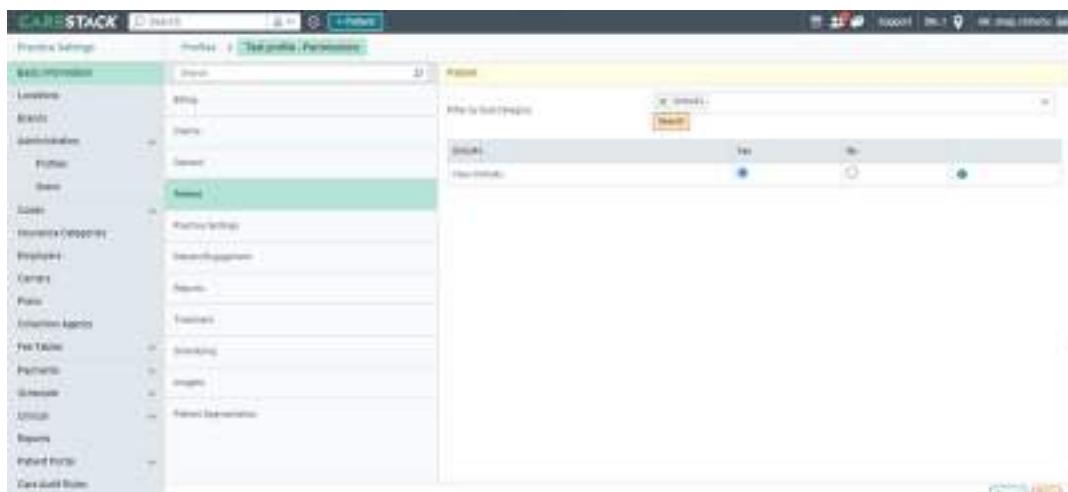
- **View Memo:**
  - Ability to view all existing memos that have been created within the patient profile.

- **Add Memo:**
  - Ability to add new memos from the Memo tab of the Patient Information panel in the chart or within the Memo slider.
  - Ability to add comments to existing memos within the patient profile.
- **Edit Memo:**
  - Ability to edit existing patient memos from the patient memo module.
- **Delete Memo:**
  - Ability to delete existing patient memo from the patient memo module.



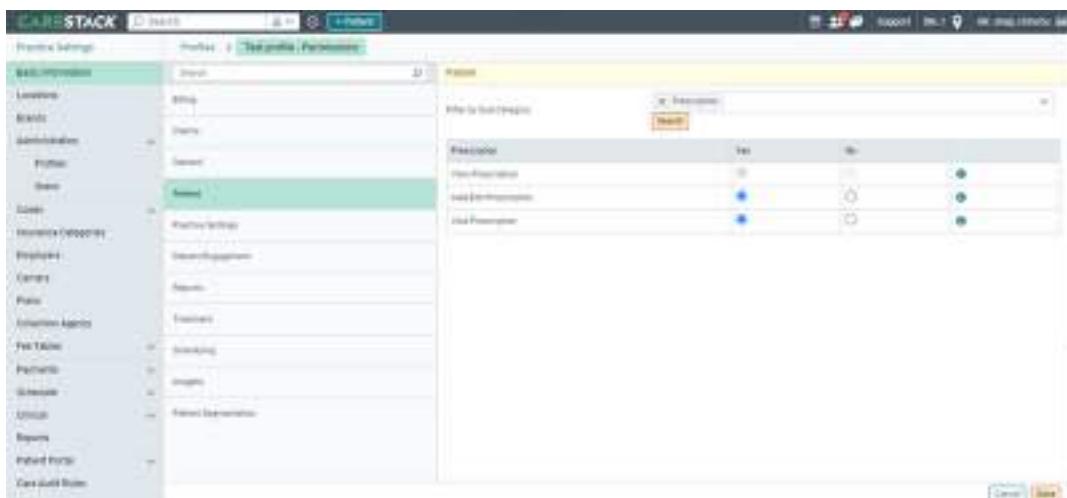
## OrthoFx

- **View OrthoFx:**
  - Ability to refer a patient to OrthoFX



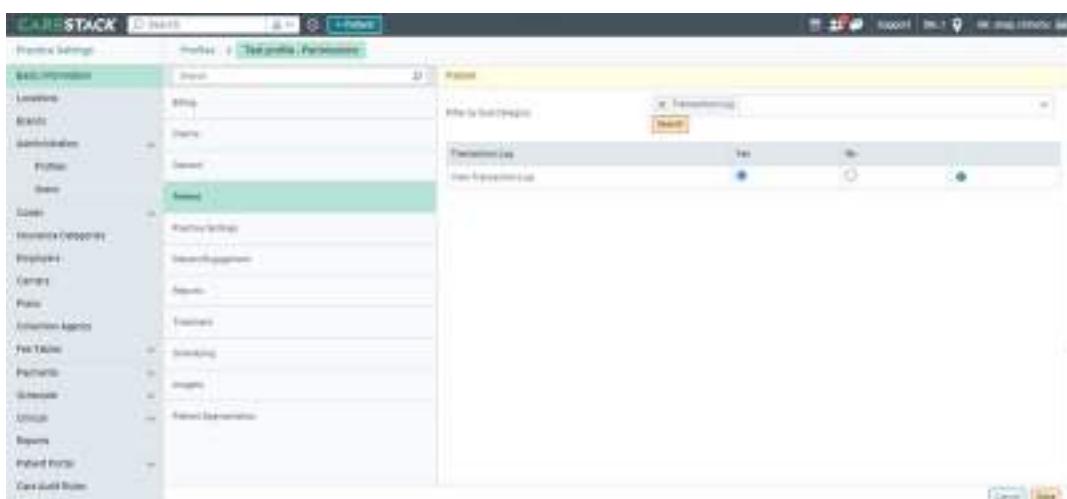
## Prescription

- **View Prescription:**
  - Ability to view all existing prescriptions that have been issued for a patient within the Prescriptions slider.
  - Ability to print any existing prescriptions.
- **Add/Edit Prescription:**
  - Ability to add new prescriptions for a patient.
  - Ability to add or edit the patient's current medications within the Prescriptions slider.
- **Void Prescription:**
  - Ability to void existing prescriptions.
  - Ability to delete items from the current medications list.



## Transaction Log

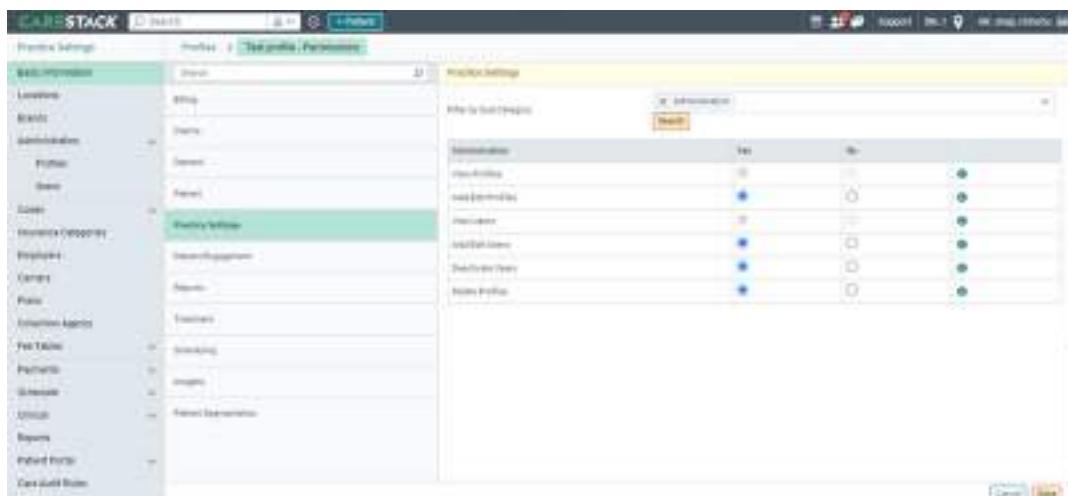
- **Transaction Log:**
  - Ability to view both system and migrated transactions.



## Practice Settings

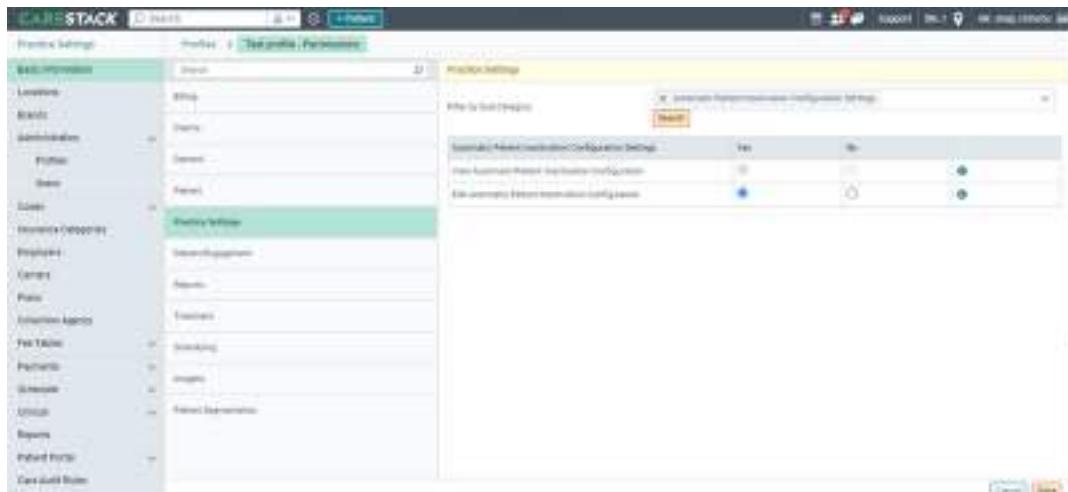
### Administration

- **View Profiles:**
  - Ability to view all existing profiles (permission sets).
  - Ability to see individual profiles and the permissions that have been allowed or disallowed for the profile.
- **Add/Edit Profiles:**
  - Ability to add new profiles and assign permissions for that profile.
  - Ability to edit profile details and the individual permission that have been allow or disallowed for the profile.
- **View Users:**
  - Ability to view all existing users.
  - Ability to view the details in the User Setup, Provider Details, Login Details, and Working Hours tabs of individual users.
  - Ability to use the "Show Inactive Users" checkbox in the users grid.
- **Add/Edit Users:**
  - Ability to add new users to CareStack.
  - Ability to edit details in the User Setup, Provider Details, Login Details, and Working Hours tabs for individual users.
  - Ability to reset the password when the user's login status is NOT *Login Disabled* or *No Login Access*.
  - Ability to create a temporary password from the User Details tab.
- **Deactivate Users:**
  - Ability to deactivate existing users.
  - Ability to re-activate (cancel the deactivation) deactivated users.
- **Delete Profiles:**
  - Ability to delete existing permission profiles.



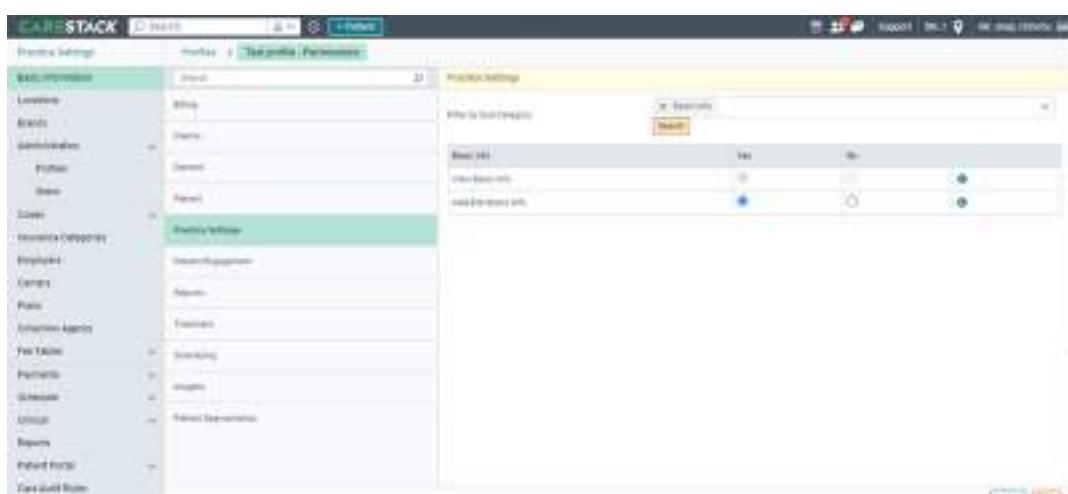
### Automatic Patient Inactivation Configuration Settings

- **View Automatic Patient Inactivation Configuration:**
  - Ability to view the automatic patient inactivation configuration that have been set for the account.
- **Edit Automatic Patient Inactivation Configuration:**
  - Ability to edit the automatic patient inactivation configuration that have been set for the account.



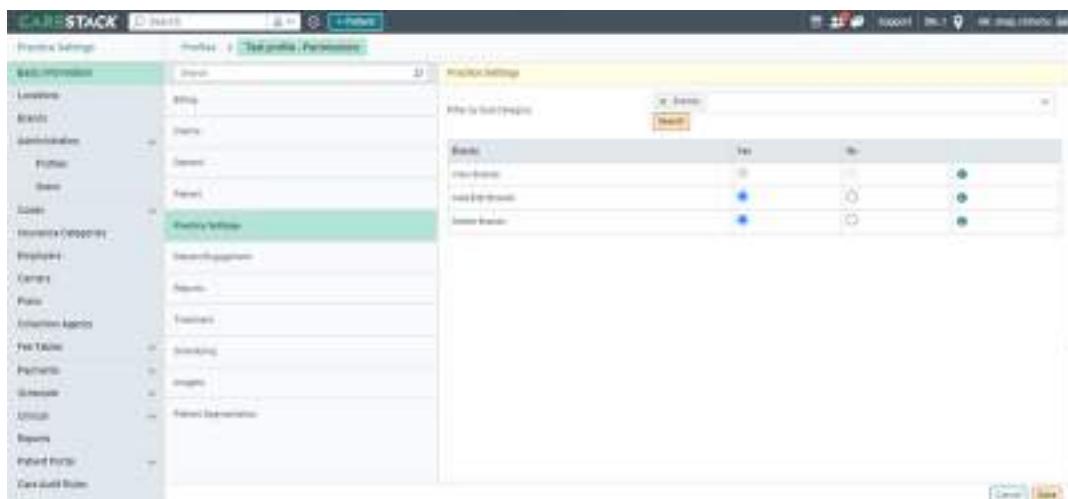
### Basic Info

- **View Basic Info:**
  - Ability to view the account details of the practice.
  - Ability to view social links. Ability to view the practice logo.
- **Add/Edit Basic Info:**
  - Ability to add to or edit the account details of the practice.
  - Ability to add or edit social links. Ability to add or edit the practice logo.



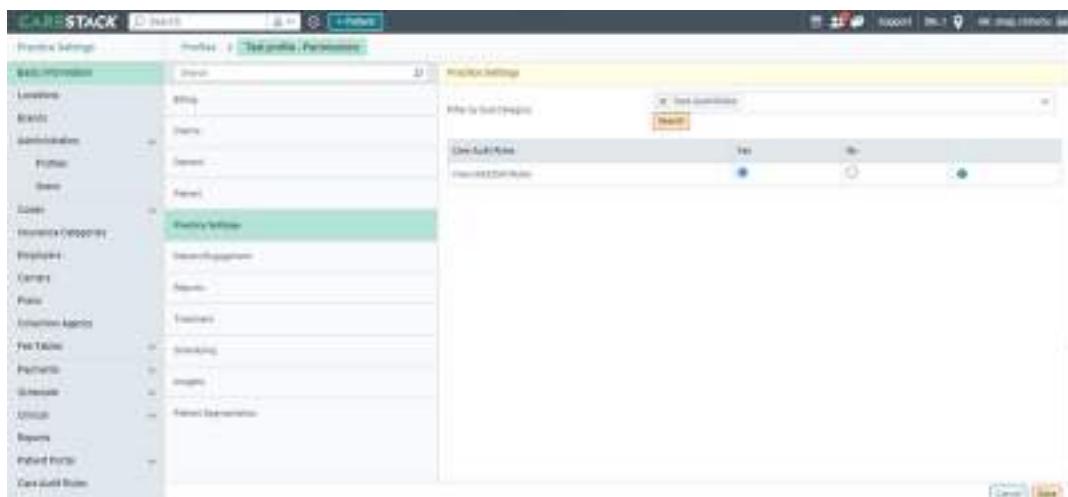
### Brands

- **View Brands:**
  - Ability to view the list of brands that have already been created for the practice
  - Ability to view a brand's details and assets
- **Add/Edit Brands:**
  - Ability to add brands
  - Ability to edit existing brand details and assets.
- **Delete Brands:**
  - Ability to delete existing brands.



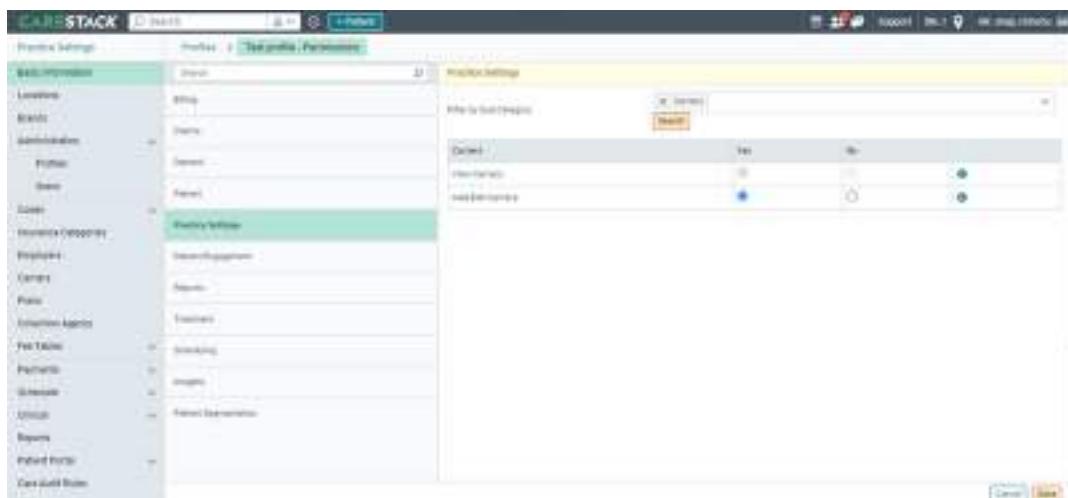
### Care Audit Rules

- **View/Add/Edit Rules:**
  - Ability to set care audit rules.
  - Ability to activate and deactivate care audit rules.



### Carriers

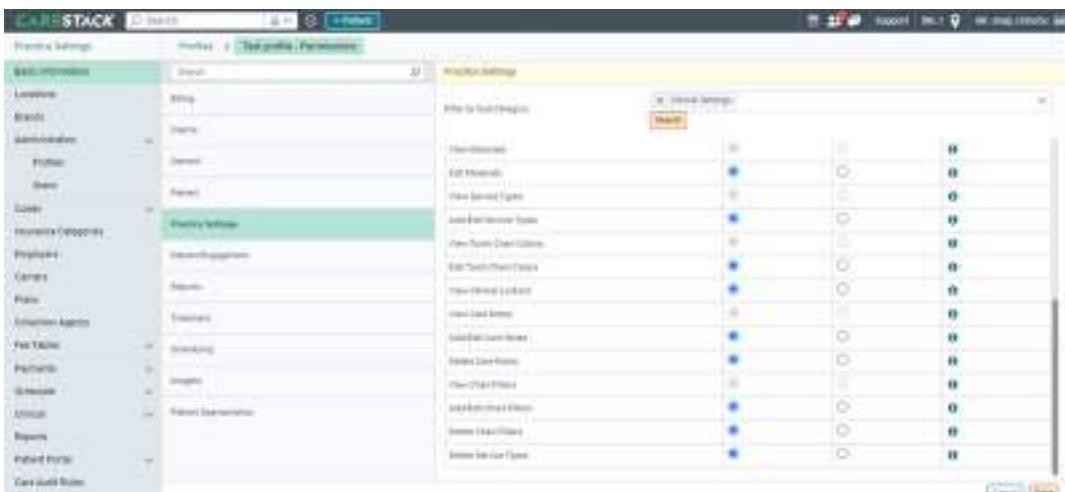
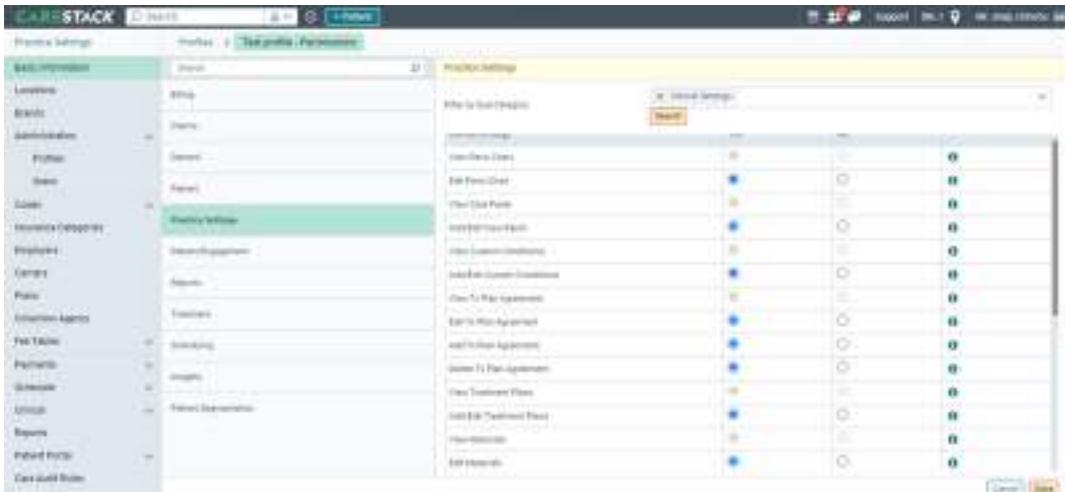
- **View Carriers:**
  - Ability to view the list of insurance carriers in CareStack.
  - Ability to view the details of an individual carrier.
- **Add/Edit Carriers:**
  - Ability to add a new carrier.
  - Ability to merge two or more carriers into a single carrier.
  - Ability to edit a carrier, including the details, address, provider insurance ID, and contact details of an individual carrier.
  - Ability to add new addresses to a carrier and to select the default address.
  - Ability to quickly add a carrier when adding a new plan for a patient.



## Clinical Settings

- **View Perio Chart:**
  - Ability to view a patient's perio chart and the default provider's perio settings.
- **Edit Perio Chart:**
  - Ability to edit a patient's perio chart and the default provider's perio settings.
- **View Care Panel:**
  - Ability to view any existing Care Panels in the practice
- **Add/Edit Care Panel:**
  - Ability to add a new Care Panel.
  - Ability to edit an existing Care Panel.
- **View Custom Conditions:**
  - Ability to view any custom conditions.
  - Ability to view details of an existing custom conditions.
- **Add/Edit Custom Conditions:**
  - Ability to add a custom condition.
  - Ability to edit the details of an existing custom condition.
  - Ability to activate or deactivate a custom condition.
- **View Tx Plan Agreement:**
  - Ability to view any Tx Plan Agreements.
- **Edit Tx Plan Agreement:**
  - Ability to edit a Tx Plan Agreement.
- **Add Tx Plan Agreement:**
  - Ability to add a new Tx Plan Agreement.
- **Delete Tx Plan Agreement:**
  - Ability to delete a Tx Plan Agreement.
- **View Treatment Plans:**
  - Ability to view the list of treatment plan options.
  - Ability to view details of an existing treatment plan.
- **Add/Edit Treatment Plans:**
  - Ability to add a new treatment plan option.
  - Ability to edit the details of an existing treatment plan option.
- **View Materials:**
  - Ability to view the list of available materials to be used for procedures.
  - Ability to view the details of an existing material.
- **Edit Materials:**
  - Ability to edit details for an existing material element.
- **View Service Types:**
  - Ability to view the list of available service types.
  - Ability to view the details of an existing service type.
- **Add/Edit Service Types:**
  - Ability to add a new service type.
  - Ability to edit the details of an existing service type.

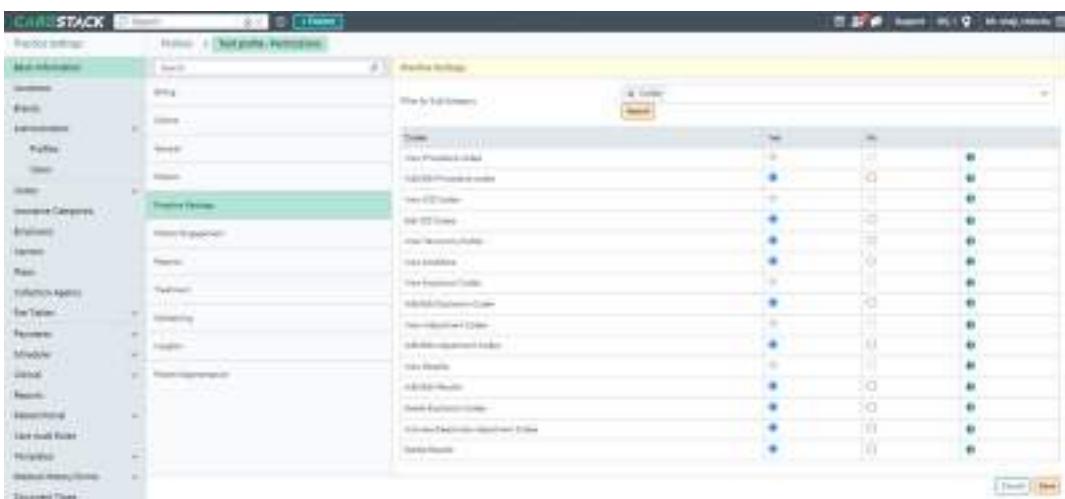
- **View Tooth Chart Colors:**
    - Ability to view the available options for tooth chart colors and the associated details.
  - **Edit Tooth Chart Colors:**
    - Ability to edit the colors used for different treatment types (planned, existing, completed, etc) within the Tooth Chart.
  - **View Clinical Lockout:**
    - Ability to view the details for a Clinical Lockout.
  - **View Care Notes:**
    - Ability to View the list of available Care Notes.
  - **Add/Edit Care Notes:**
    - Ability to add a new Care Note.
    - Ability to edit an existing Care Note.
  - **Delete Care Notes:**
    - Ability to delete one of the Care Notes from the library of notes.
  - **View Chart Filters:**
    - Ability to view the practice's available chart filters
    - Ability to view the details of an existing chart filter.
  - **Add/Edit Chart Filters:**
    - Ability to add a new chart filter.
    - Ability to edit the details of an existing chart filter.
  - **Delete Chart Filters:**
    - Ability to delete an existing chart filter.
  - **Delete Service Types:**
    - Ability to delete a service type from the list of options.



Codes

- **View Procedure Codes:**
    - Ability to view the list of all procedure codes in CareStack
    - Ability to view the details and options for an individual procedure code.

- **Add/Edit Procedure Codes:**
    - Ability to add a new procedure code.
    - Ability to edit the details and options of a procedure code.
  - **View ICD Codes:**
    - Ability to view the list of all ICD Codes in CareStack.
    - Ability to view the details of an individual ICD Code.
  - **Edit ICD Codes:**
    - Ability to edit the details of an individual ICD Code.
  - **View Taxonomy Codes:**
    - Ability to view the list of all Taxonomy Codes in CareStack.
    - Ability to view the details of an individual Taxonomy Code.
  - **View Modifiers:**
    - Ability to view the list of all Modifiers in CareStack
    - Ability to view the details of an individual Modifier.
  - **View Explosion Codes:**
    - Ability to view a list of all Explosion Codes added to CareStack.
    - Ability to view the details of an individual Explosion Code.
    - Ability to use the 'Actions' button to locate or work with an Explosion Code.
  - **Add/Edit Explosion Codes:**
    - Ability to add a new Explosion Code.
    - Ability to edit the details of an individual Explosion Codes.
  - **View Adjustment Codes:**
    - Ability to view the list of all Adjustment Codes used for payments and claims.
    - Ability to view the details of an individual Adjustment Code.
  - **Add/Edit Adjustment Codes:**
    - Ability to add a new Payment Adjustment Code.
    - Ability to edit the details of an individual Payment Adjustment Code.
  - **View Recalls:**
    - Ability to view the list of all Recall Types in CareStack.
    - Ability to view the details of a Recall Type.
  - **Add/Edit Recalls:**
    - Ability to add a new Recall Type.
    - Ability to edit the details of a Recall Type.
  - **Delete Explosion Codes:**
    - Ability to delete an Explosion Code.
  - **Activate/Deactivate Adjustment Codes:**
    - Ability to activate or deactivate an individual Payment Adjustment Code.
  - **Delete Recalls:**
    - Ability to delete a Recall Type.



## Collection Agency

- **View Collection Agency:**
    - Ability to view the list of all collection agencies in CareStack.

- Ability to view the details of an individual collection agency.

- **Add/Edit Collection Agency:**

- Ability to add a new collection agency.
- Ability to edit the details of an individual collection agency.

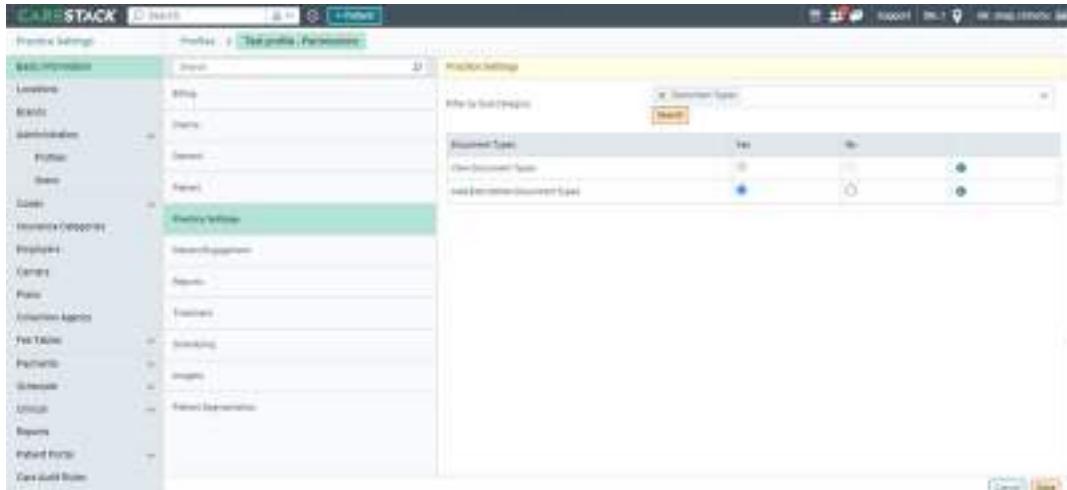
## Document Types

- **View Document Types:**

- Ability to view the list of document types.

- **Add/Edit Document Types:**

- Ability to add, edit, delete, activate, and deactivate an individual document type.



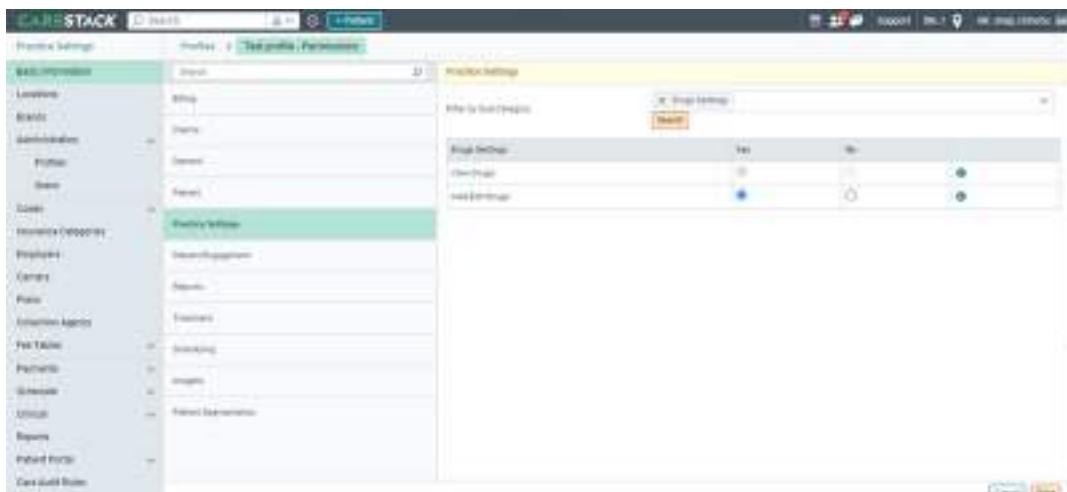
## Drugs Settings

- **View Drugs:**

- Ability to view the list of drugs in CareStack
- Ability to view the details of a drug.

- **Add/Edit Drugs:**

- Ability to add a new drug.
- Ability to edit the details of a drug.



## Employers

- **View Employers:**

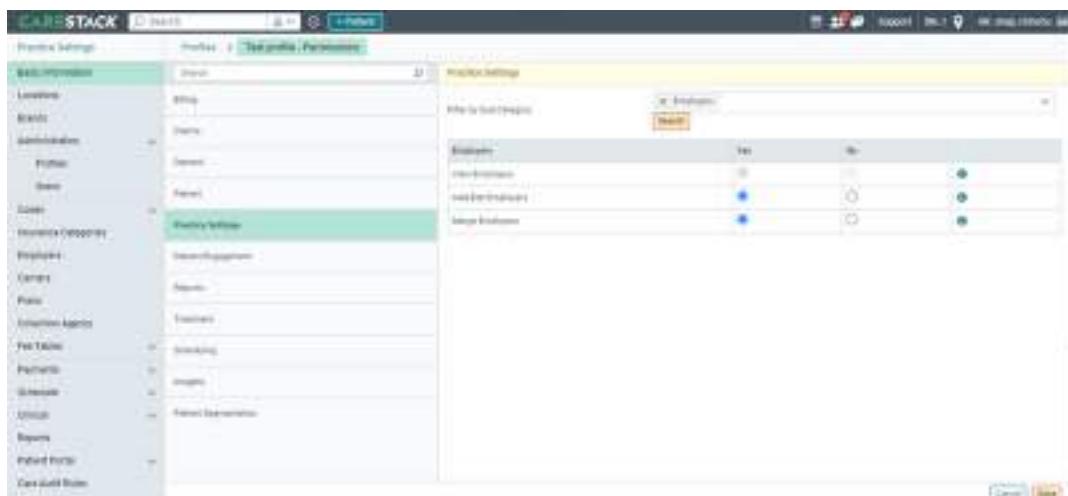
- Ability to view the list of employers in CareStack,
- Ability to view the details of an individual employer.

- **Add/Edit Employers:**

- Ability to add a new employer.
- Ability to edit the details of an individual employer.

- **Merge Employers:**

- Ability to merge two or more employers into one.



## Fee Table

- **View Fee Schedule:**
  - Ability to view the list of fee schedules in CareStack by schedule, provider, or code.
  - Ability to view the details and fees of an individual fee schedule.
  - Ability to print a fee schedule by schedule, code, or provider.
- **Add/Edit Fee Schedule:**
  - Ability to add a new fee schedule.
  - Ability to edit the details or fees in an individual fee schedule.
- **View Estimation Hierarchy:**
  - Ability to view the hierarchy used to estimate fees for treatment plans when the patient has an associated insurance plan.
- **Edit Estimation Hierarchy:**
  - Ability to edit the order of the fee estimation hierarchy when calculating fees for treatment plans when the patient has an insurance plan.
- **View Billing Hierarchy:**
  - Ability to view the hierarchy used for billing when no insurance plan is in place for the patient.
- **Edit Billing Hierarchy:**
  - Ability to edit the hierarchy used for billing when no insurance plan is in place for the patient.
- **View Assignments:**
  - Ability to view list of fee schedule assignments
  - Ability to view an assignment's specific location, provider, specialty, carrier, and/or plan.
- **Add/Edit Assignments:**
  - Ability to assign a fee schedule to a specific location, provider, specialty, carrier, and/or plan.
  - Ability to edit a fee schedule's assignment to a specific location, provider, specialty, carrier, and/or plan.
- **View Fee Register:**
  - Ability to view the list of all fee registers in CareStack.
  - Ability to view the details of a fee register by register or by code.
  - Ability to print a fee register by register or by code.
- **Edit Fee Register:**
  - Ability to edit the fees for a code within the fee register.
- **View Settings:**
  - Ability to view the fee table settings.
- **Add/Edit Settings:**
  - Ability to edit fee table settings.
- **Delete Fee Schedule:**
  - Ability to delete a fee schedule
- **Delete Assignments:**
  - Ability to delete the assignment of a fee schedule to a specific location, provider, specialty, carrier, and/or plan.
- **View Table of Allowance:**
  - Ability to view the list of tables of allowance by table and by code.
  - Ability to view details of an individual table of allowance.
  - Ability to print the table of allowance by table and by code.
- **Add/Edit Table of Allowance:**
  - Ability to add a new table of allowance.

- Ability to edit the details of a table of allowance.

- **Delete Table of Allowance:**

- Ability to delete a table of allowance.

## Insurance Categories

- **View Insurance Categories:**

- Ability to view the list of insurance categories in CareStack.
- Ability to view the details of an individual insurance category

- **Add/Edit Insurance Categories:**

- Ability to add a new insurance category.
- Ability to edit the details of an insurance category.

- **Delete Insurance Categories:**

- Ability to delete an insurance category.

## Lab Settings

- **View Labs:**

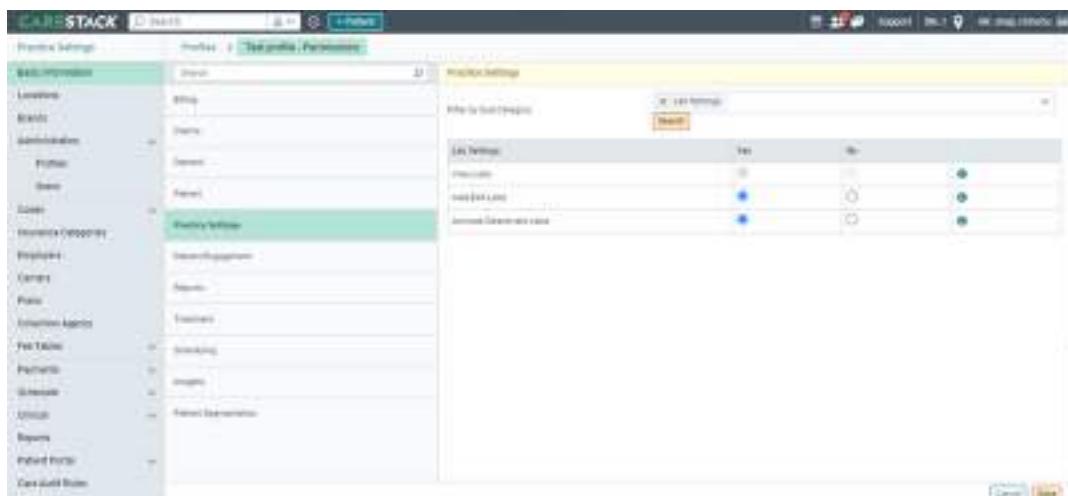
- Ability to view the list of labs in CareStack
- Ability to view the details of an individual lab.

- **Add/Edit Labs:**

- Ability to add a new lab.
- Ability to edit the details of a lab.

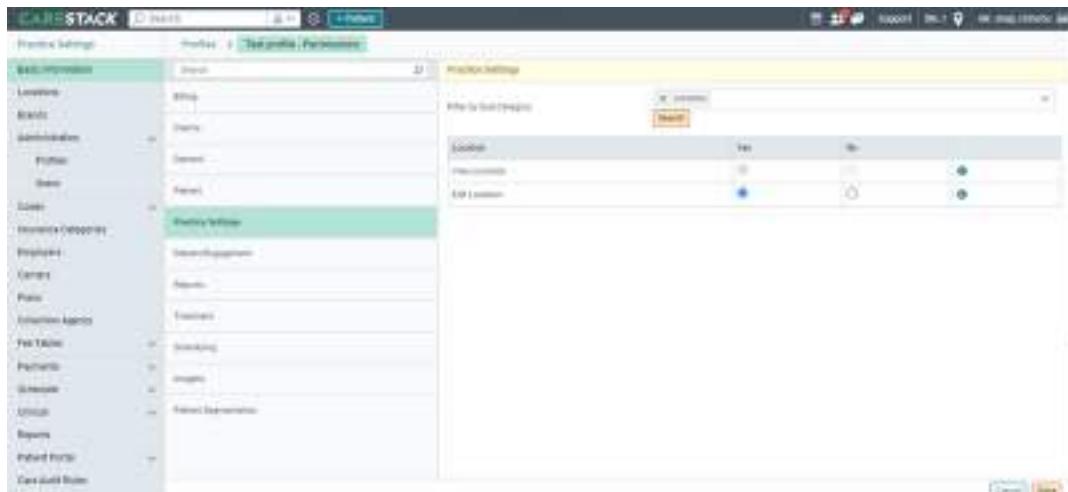
- **Activate/Deactivate Labs:**

- Ability to Activate/Deactivate Labs.



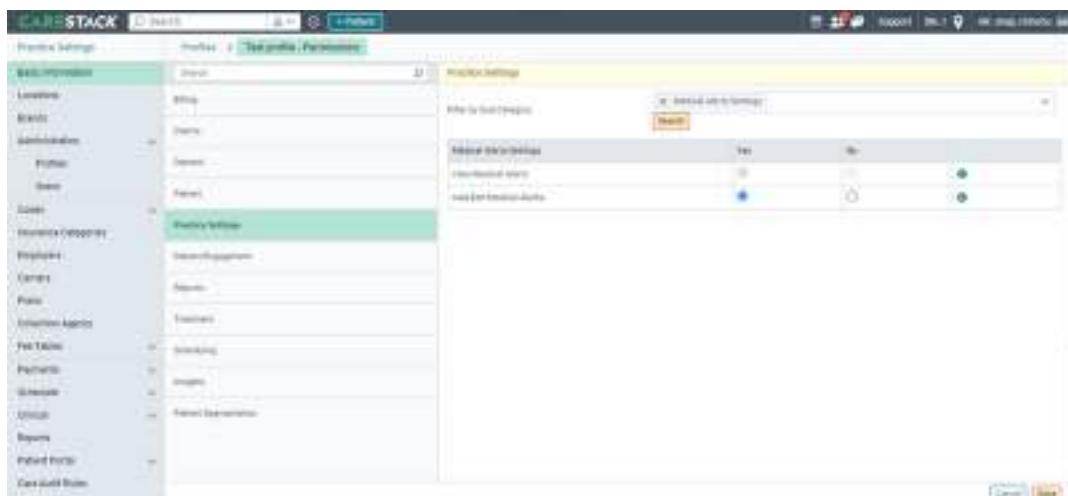
## Location

- **View Location:**
  - Ability to view a list of all locations.
  - Ability to view the location's details on the Location Details, Billing Details, Working Hours, Operatory Settings, Logo, and Social Media tabs.
- **Edit Location:**
  - Ability to edit the location's details on the Location Details, Billing Details, Working Hours, Operatory Settings, Logo, and Social Media tabs.
  - Ability to add or edit entries in the Additional Provider Settings for a location.



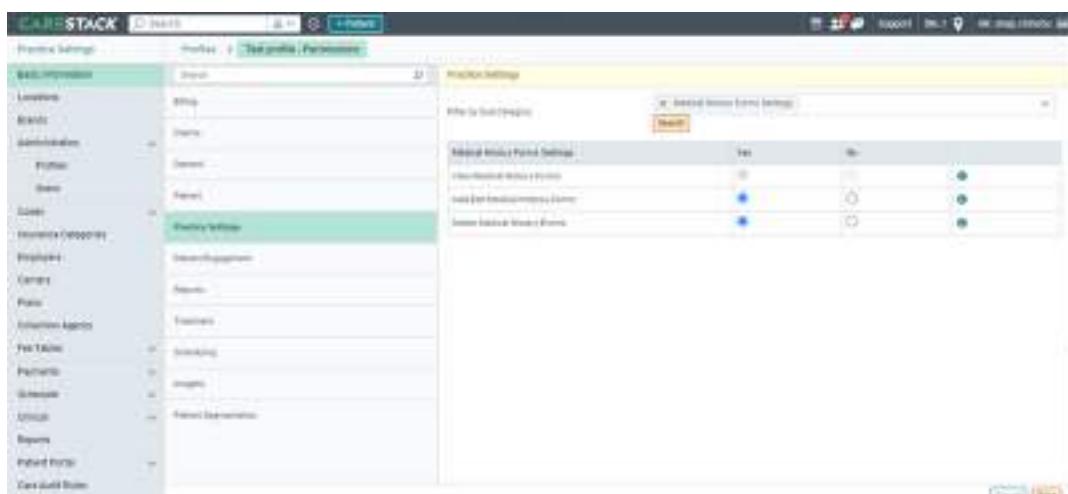
## Medical Alerts Settings

- **View Medical Alerts:**
  - Ability to view the list of medical alerts in CareStack.
  - Ability to view details of an individual medical alert.
- **Add/Edit Medical Alerts:**
  - Ability to add a new medical alert
  - Ability to edit the details of an individual medical alert.
  - Ability to activate or deactivate a medical alert.



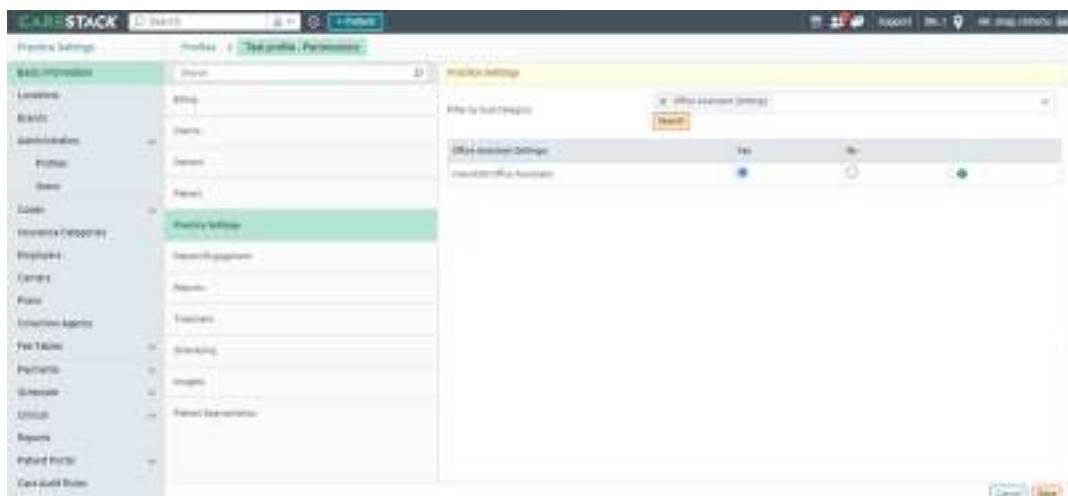
### Medical History Forms Settings

- **View Medical History Forms:**
  - Ability to view the dental and medical questionnaires for both the adult and child medical history forms.
  - Ability to view the settings for both the adult and child medical history forms.
- **Add/Edit Medical History Forms:**
  - Ability to add new sections or questions to the dental and medical questionnaires for both adult and child medical history forms.
  - Ability to edit sections or questions in the dental and medical questionnaires for both adult and child medical history forms.
  - Ability to edit the settings for both the adult and child medical history forms.
- **Delete Medical History Forms:**
  - Ability to delete both adult and child medical history forms.



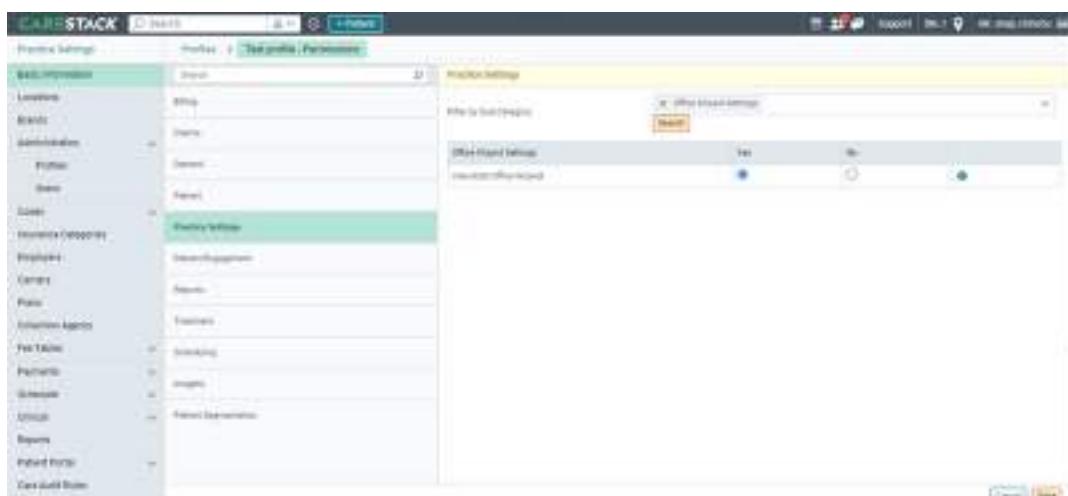
### Office Assistant Settings

- **View/Edit Office Assistant:**
  - Ability to view all locations that have subscribed to the office assistant.
  - Ability to view and edit the appointment status details for all locations.
  - Ability to enable or disable the office Assistant at individual locations.
  - Ability to edit the password for accessing the office Assistant at individual locations.



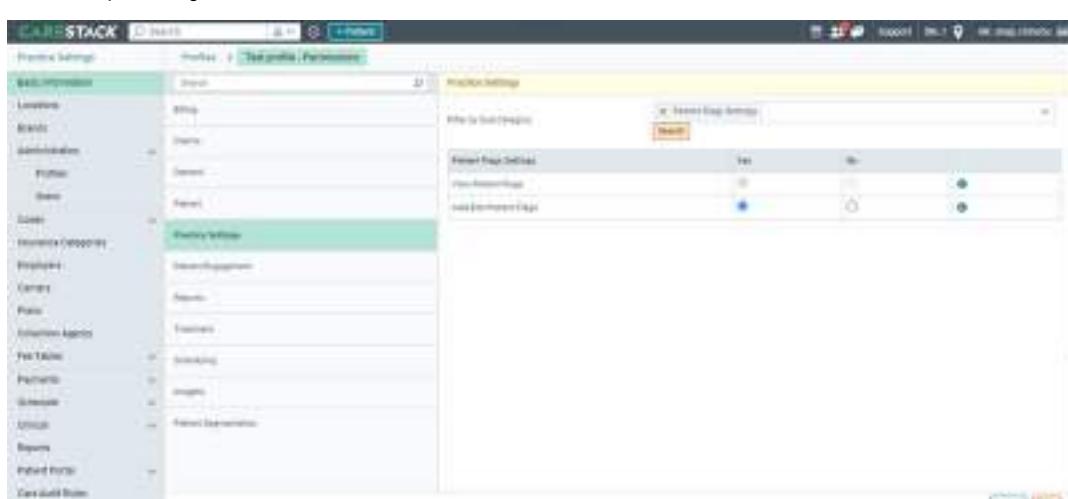
## Patient Flags Settings

- **View/Edit Office Wizard:**
  - Ability to view the lists of forms, letters, and preset questions.
  - Ability to add forms, letters, and preset questions.
  - Ability to edit and delete a form, letter, or preset question.



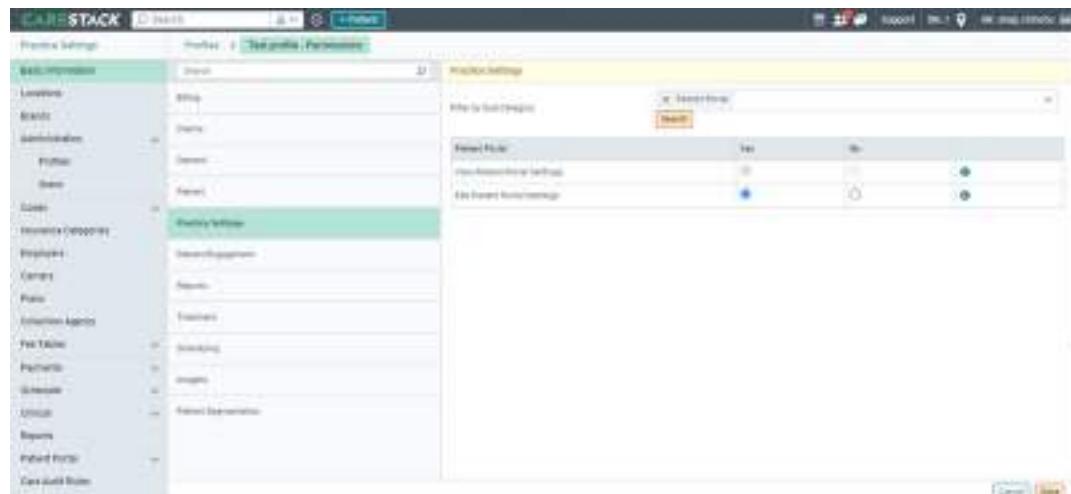
## Patient Flags Settings

- **View Patient Flags:**
  - Ability to view the list of patient flags in CareStack.
  - Ability to view the details of an individual patient flag.
- **Add/Edit Patient Flags:**
  - Ability to add a patient flag.
  - Ability to edit an individual patient flag.



## Patient Portal

- **View Patient Portal Settings:**
  - Ability to view the patient portal settings that have been set for the account.
- **Edit Patient Portal Settings:**
  - Ability to edit the patient portal settings that have been set for the account.



## **Payments Settings**

- **View Billing and Interest Details:**
  - Ability to view the billing and interest details set for the practice.
- **Add/Edit Billing and Interest Details:**
  - Ability to edit the billing and interest details.
- **View Banking Details and Payment Gateway:**
  - Ability to view the banking details and payment gateway set for the practice.
- **Add/Edit Banking Details and Payment Gateway:**
  - Ability to edit the banking details and payment gateway.
- **View Statement Details:**
  - Ability to view the address, exclusion, and other details set as defaults for the practice's statements.
- **Add/Edit Statement Details:**
  - Ability to add or edit the address, exclusion, and other details for statements.
- **View Other Billing Details:**
  - Ability to view the miscellaneous details related to billing.
  - Ability to view the patient portal payment details
  - Ability to view default insurance payment posting settings.
- **Add/Edit Other Billing Details:**
  - Ability to edit the miscellaneous details related to billing.
  - Ability to edit the patient portal payment details
  - Ability to edit default insurance payment posting settings.
- **View Claim Form Defaults:**
  - Ability to view claim form defaults.
  - Ability to add or remove claim flags.
- **Add/Edit Claim Form Defaults:**
  - Ability to update the claim form default preferences.
- **View Billing Services:**
  - Ability to view the location's billing service configurations
- **Edit Billing Services:**
  - Ability to update the billing service configuration for allowed locations.
- **View Ortho Plan Agreement:**
  - Ability to view the ortho contract agreement.
- **Edit Ortho Plan Agreement:**
  - Ability to update the orthodontic contract agreement and its settings.
- **View General Payment plan Agreement:**
  - Ability to view the general payment plan agreement.
- **Edit General Payment plan Agreement:**
  - Ability to update the general payment plan agreement.

- Ability to edit the general payment plan agreement and its settings.

- **View Payment Types:**

- Ability to view the practice's list of payment types.
  - Ability to view the details of an individual payment type.

- **Add/Edit Payment Types:**

- Ability to add a new payment type.
  - Ability to edit the details of a payment type.

- **Delete Payment Types:**

- Ability to delete a payment type that has not yet been used.

- **View Insurance Payments:**

- Ability to View settings for Insurance Flags, ERA posting, Adjustments and Other details.

- **Edit Insurance Payments:**

- Ability to Edit settings for Insurance Flags, ERA posting, Adjustments and Other details.

Project Settings		Project Permissions	
Basic Information		Advanced Settings	
Project Name	Project A	Allow for Full Access	<input checked="" type="checkbox"/> Project Manager
Description	Project Description	Allow for Edit Access	<input type="checkbox"/>
Category	Category 1	Allow for View Access	<input type="checkbox"/>
Sub-Categories	Sub-Categories	Allow for Create Access	<input type="checkbox"/>
Attachments	Attachment 1	Allow for Delete Access	<input type="checkbox"/>
Comments	Comment 1	Allow for Insert Access	<input type="checkbox"/>
Tags	Tag 1	Allow for Update Access	<input type="checkbox"/>
Relationships	Relationship 1	Allow for Read Access	<input type="checkbox"/>
File Types	File Type 1	Allow for Create Record	<input type="checkbox"/>
Reviewers	Reviewer 1	Allow for Delete Record	<input type="checkbox"/>
Modules	Module 1	Allow for Insert Record	<input type="checkbox"/>
Views	View 1	Allow for Update Record	<input type="checkbox"/>
Reports	Report 1	Allow for Read Record	<input type="checkbox"/>
Assessments	Assessment 1	Allow for Create Form	<input type="checkbox"/>
User Role Rules	User Role Rule 1	Allow for Delete Form	<input type="checkbox"/>
Properties	Property 1	Allow for Insert Form	<input type="checkbox"/>
External Identity Groups	External Identity Group 1	Allow for Update Form	<input type="checkbox"/>
Document Types	Document Type 1	Allow for Read Form	<input type="checkbox"/>

## Plans

- View Plans:

- Ability to view the list of insurance plans available in CareStack.
  - Ability to view merged plans.
  - Ability to view the details of an individual insurance plan.

- Add Plans:

- Ability to add a new plan.
  - Ability to add a plan from the patient page when associating a new plan with the patient

- **Edit Plans:**

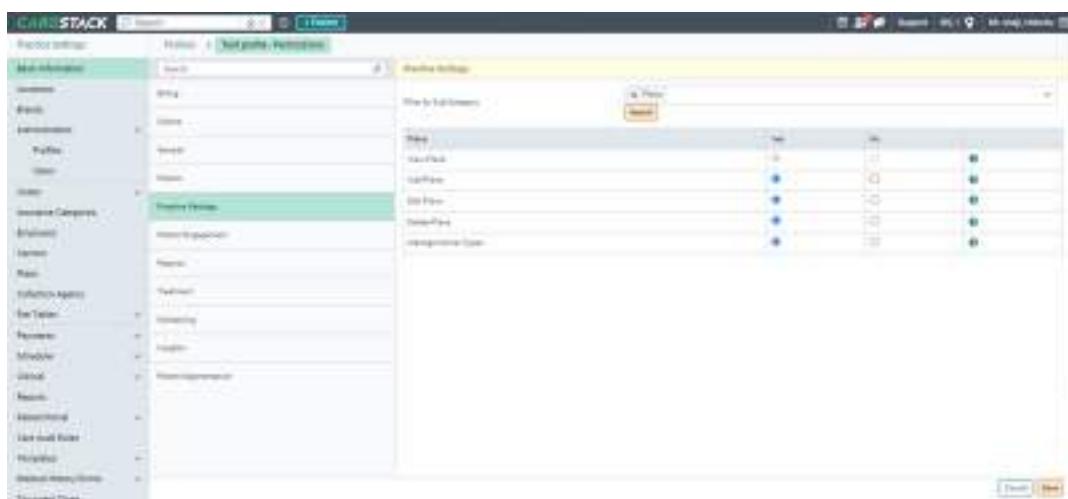
- Ability to merge two or more plans into one.
  - Ability to edit the details of a plan, including details, coverage, benefits, pre-authorization codes, and service restrictions.
  - Ability to assign a fee schedule to a plan.

- **Delete Plans:**

- Ability to delete service restriction requirements.
  - Ability to remove a plan's fee schedule assignment.

- **Manage Carrier Types:**

- Ability to view the list of carrier types.
- Ability to add a new carrier type.
- Ability to edit the details of a carrier type.



## Referral Sources

- **Add/Edit Referral Sources:**

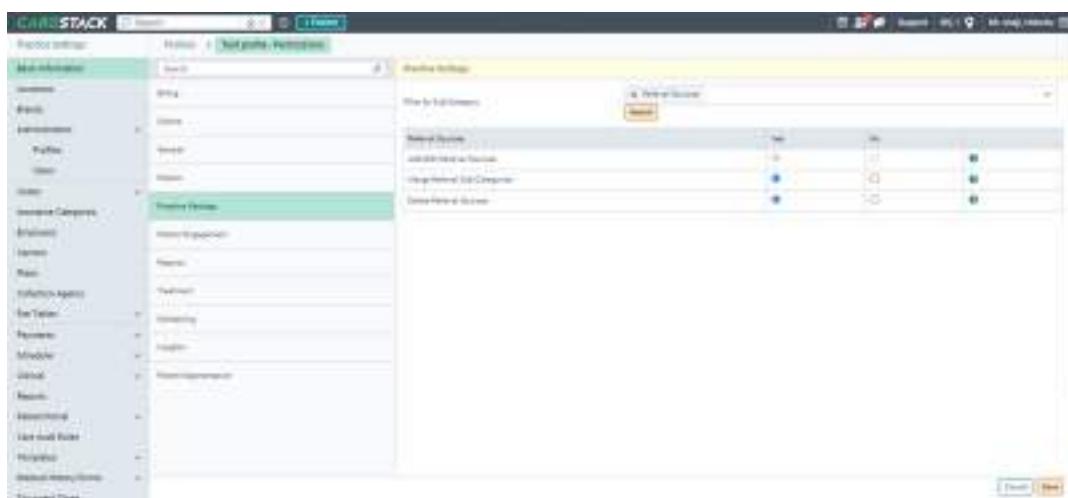
- Ability to add a new referral source and referral sub-categories.
- Ability to edit the details of a referral source and/or referral sub-categories.
- Ability to activate or deactivate a referral source and/or referral sub -category.

- **Merge Referral Sub-Categories:**

- Ability to merge two or more referral sub-categories.

- **Delete Referral Sources:**

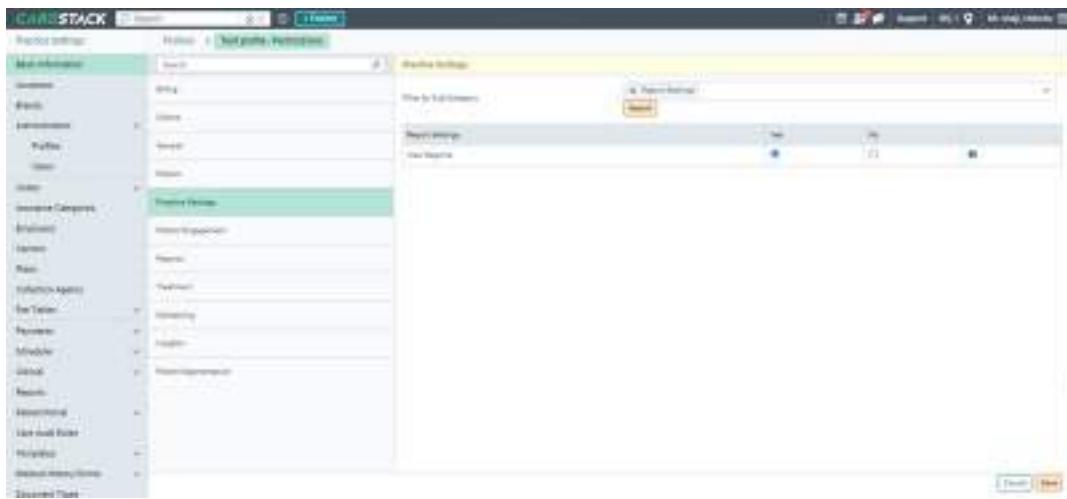
- Ability to delete a referral source and referral sub-category.



## Report Settings

- **View Reports:**

- Ability to view the settings available for an individual report.
- To generate the reports, the user will need permissions in the Reports category.



## Scheduler

- **View Production Types:**

- Ability to view the list of production types established in CareStack.
- Ability to view the details of an individual production type.

- **Add/Edit Production Types:**

- Ability to add a new production type.
- Ability to edit the details of a production type.
- Ability to delete a production type that is not in use.
- Ability to deactivate a production type.

- **View Working Hours:**

- Ability to view the working hours for any day of the week set at the practice (account) level.

- **Add/Edit Working Hours:**

- Ability to edit the working hours for any day of the week at the practice level.

- **View Holidays:**

- Ability to view the holidays set at the account (practice) level.

- **Add/Edit Holidays:**

- Ability to add holidays at the account level.
- Ability to edit the details of holidays at the account level.

- **View Appointment Status:**

- Ability to view the appointment status set at the account level.
- Ability to view the details of an individual appointment status.

- **Add/Edit Appointment Status:**

- Ability to add an appointment status.
- Ability to edit the details of an appointment status.
- Ability to activate or deactivate an appointment status.

- **View Account Filters:**

- Ability to view the list of account filters available to all users.
- Ability to view the details of an individual account filter.

- **Add/Edit Account Filters:**

- Ability to add a new account filter that will be available for all users.
- Ability to edit the details of an individual account filter.
- Ability to delete an account filter so that it is no longer available for any user.

- **View Custom Settings:**

- Ability to view the settings in the General Settings sub-section, including trigger and custom statuses, and routing slip settings.

- **Edit Custom Settings:**

- Ability to edit the settings in the General Settings sub-section, including trigger and custom statuses, and routing slip settings.

- **View Online Appointment Settings:**

- Ability to view the online appointment settings, including activation and preferences.

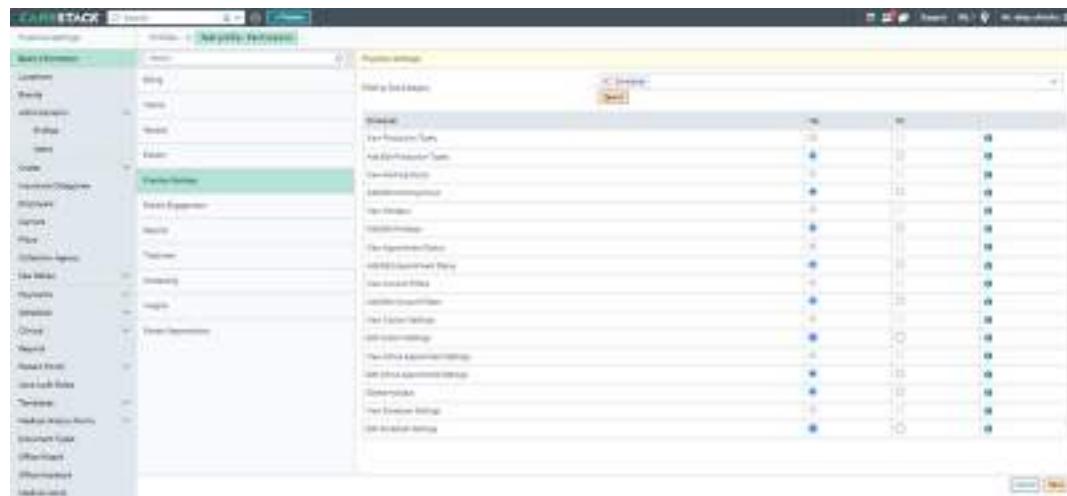
- **Edit Online Appointment Settings:**

- Ability to edit the online appointment settings, including activation and preferences.

- **Delete Holidays:**

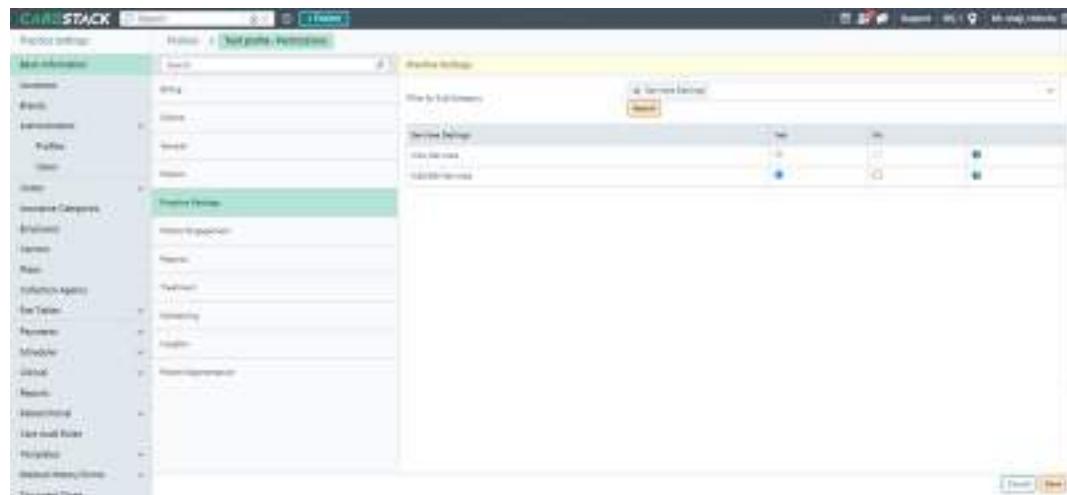
- Ability to delete an individual holiday set at the account level.

- **View Scheduler Settings:**
    - Ability to view the settings in the Scheduler Settings sub-section, including slots, cancellation, and block details.
  - **Edit Scheduler Settings:**
    - Ability to edit the settings in the Scheduler Settings sub-section, including slots, cancellation, and block details.



## Services Settings

- **View Services:**
    - Ability to View Services.
  - **Add/Edit Services:**
    - Ability to Add new Services.
    - Ability to Edit details of existing Services.



## Template Settings

- **View Memo Templates:**
    - Ability to view the list of available note templates
    - Ability to view the details of an individual note template.
  - **Add/Edit Memo Templates:**
    - Ability to add a new new note template.
    - Ability to edit a note template.
  - **View Email Templates:**
    - Ability to view the list of available email templates
    - Ability to view the details of an individual email template.
  - **Add/Edit Email Templates:**
    - Ability to add a new new email template.
    - Ability to edit an email template.
  - **View Text Templates:**
    - Ability to view the list of available text templates
    - Ability to view the details of an individual text template.
  - **Add/Edit Text Templates:**

- Ability to add a new new text template.
- Ability to edit a text template.
- **View Remark Templates:**
  - Ability to view the list of available remark templates
  - Ability to view the details of an individual remark template.
- **Add/Edit Remark Templates:**
  - Ability to add a new new remark template.
  - Ability to edit a remark template.
- **Delete Memo Templates:**
  - Ability to delete a note template
- **Delete Email Templates:**
  - Ability to delete an email template
- **Delete Text Templates:**
  - Ability to delete a text template
- **Delete Remark Templates:**
  - Ability to delete a note template

Template Settings	New Text Template
Use Default Template	<input checked="" type="checkbox"/>
Use Text Template	<input type="checkbox"/>
Use Memo Template	<input type="checkbox"/>
Use Email Template	<input type="checkbox"/>
Use Text Template	<input type="checkbox"/>
Use Memo Template	<input type="checkbox"/>
Use Email Template	<input type="checkbox"/>
Use Text Template	<input type="checkbox"/>
Use Memo Template	<input type="checkbox"/>
Use Email Template	<input type="checkbox"/>

## Patient Engagement

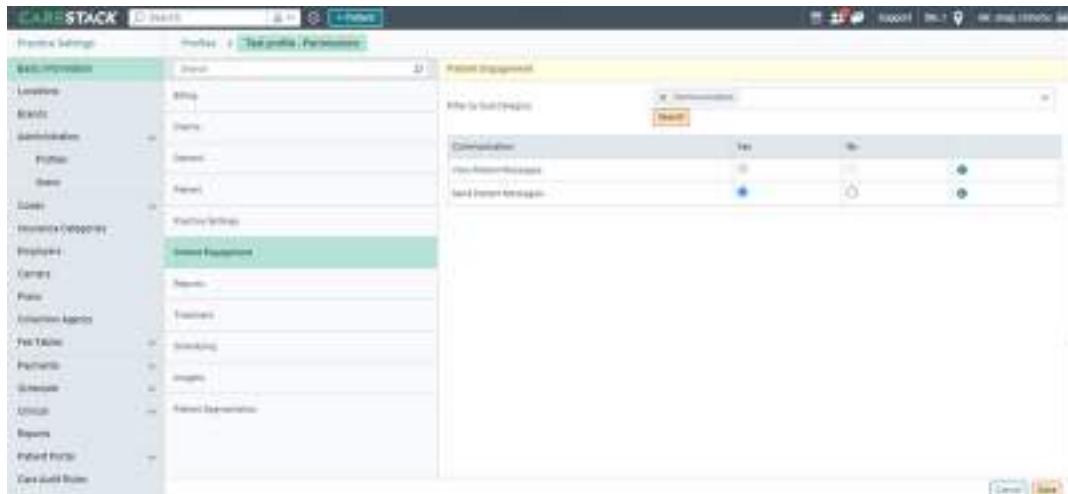
### Campaigns

- **View Campaigns:**
  - Ability to view all draft and completed campaigns.
  - Ability to view the details of draft and completed campaigns.
- **Add/Edit Campaigns:**
  - Ability to create a new promotional or ongoing campaign.
  - Ability to edit a campaign in draft form.
  - Ability to use images from the image gallery when creating campaign content.
  - Ability to use existing postcard, email, text, and voice templates when creating campaign content.
- **Delete Campaigns:**
  - Ability to delete a draft campaign.

Campaigns	New Campaign
Open Postcard	<input type="checkbox"/>
Send Postcard	<input checked="" type="checkbox"/>
Email Message	<input type="checkbox"/>

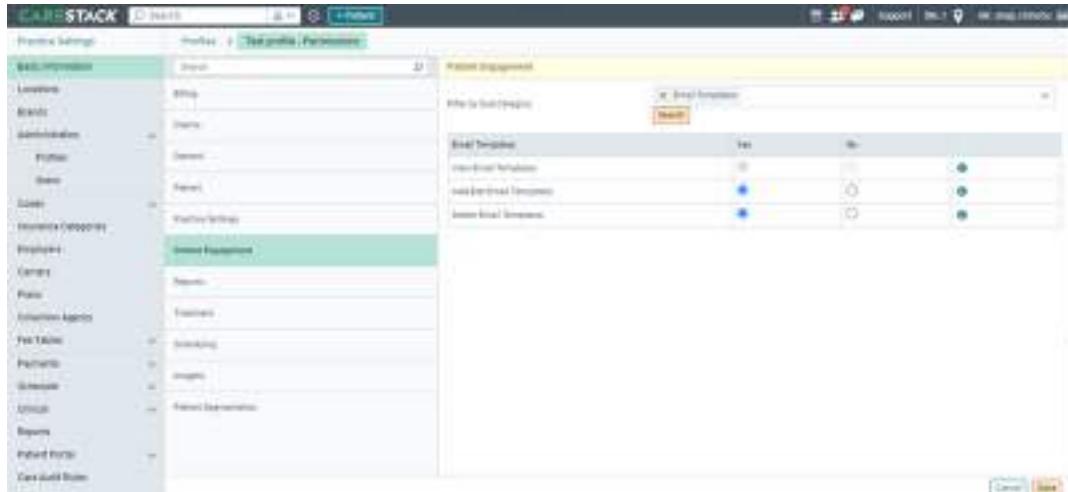
## Communication

- **View Patient Messages:**
  - Ability to view messages sent to and received from patients
- **Send Patient Messages:**
  - Ability to send new text or email messages to patients



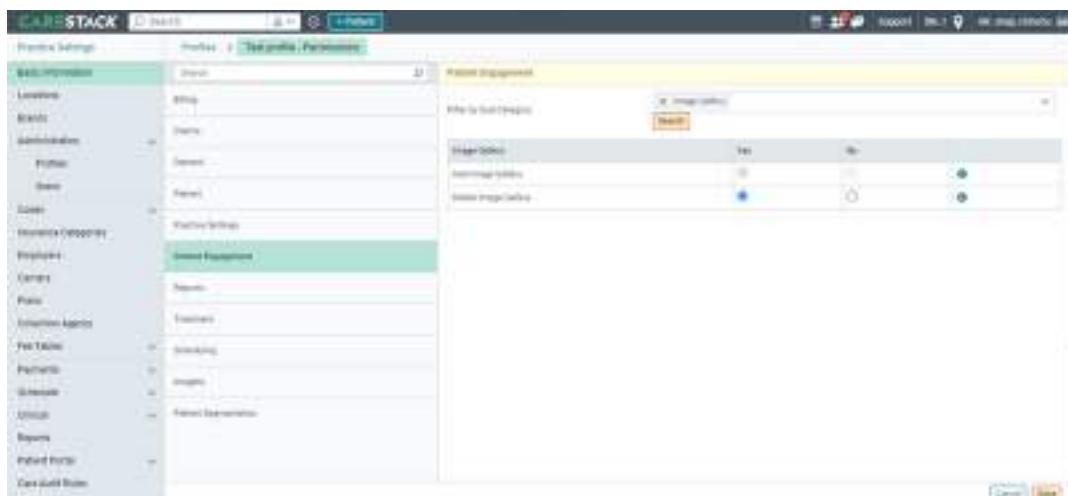
## Email Templates

- **View Email Templates:**
  - Ability to view the list of email templates.
  - Ability to view the details of an individual template.
- **Add/Edit Email Templates:**
  - Ability to add a new email template
  - Ability to edit the details or content of an email template.
- **Delete Email Templates:**
  - Ability to delete an email template.



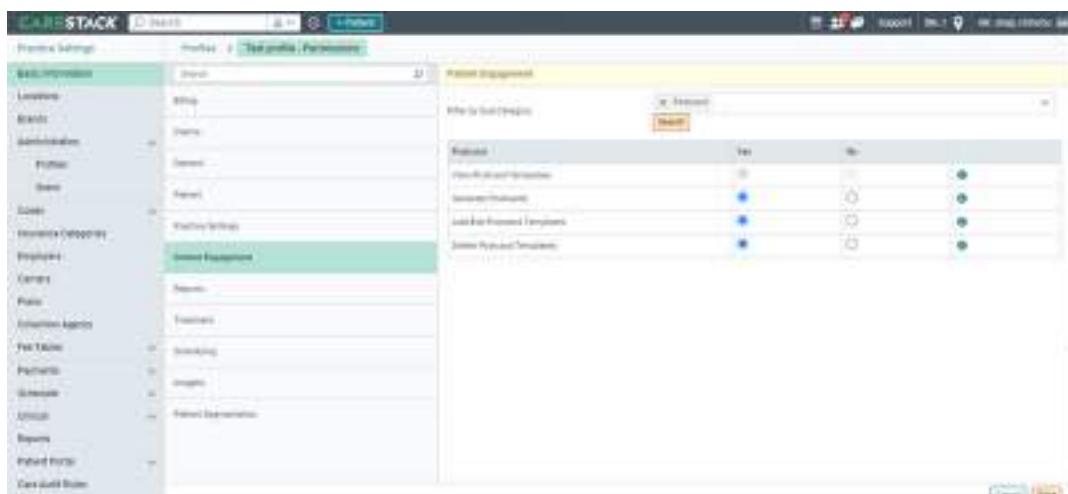
## Image Gallery

- **Add Image Gallery:**
  - Ability to view the images in the Image Gallery
  - Ability to add a new image to the Image Gallery
- **Delete Image Gallery:**
  - Ability to delete an image from the Image Gallery



## Postcard

- **View Postcard Templates:**
  - Ability to view the list of postcard templates.
  - Ability to view the details of an individual template.
- **Generate Postcards:**
  - Ability to generate and print postcards.
- **Add/Edit Postcard Templates:**
  - Ability to add a new postcard template
  - Ability to edit the details or content of a postcard template.
- **Delete Postcard Templates:**
  - Ability to delete a postcard template.



## Reputation Management

- **View Reputation Management:**
  - Ability to view the reputation management page
- **Add/Edit Settings:**
  - Ability to edit the settings for reputation management
- **Send Review Requests:**
  - Ability to send review requests to patients

The screenshot shows the CARESTACK software interface. The left sidebar contains a navigation menu with categories like Locations, Clients, Administration, Patients, Cases, Revenue Opportunity, Projects, Centers, Plans, Insurance Agents, PMS/EMR, Patients, Schedules, Utilization, Reports, Patient Portal, and Care Audit Suite. The main content area is titled 'Patient Engagement' and displays a table with columns for 'Module' (Revenue Opportunity, Case Management, and Utilization) and 'Status' (Yes or No). A search bar and filter options are also present.

## Reviews

- **View Reviews:**
  - Ability to view the reviews that have been sent by the patient.
- **Post Reviews:**
  - Ability to show, hide, and delete reviews that have been sent by the patient.

This screenshot is identical to the one above, showing the CARESTACK software interface with the 'Patient Engagement' module active. The left sidebar and main content area with its table and search/filter features are the same.

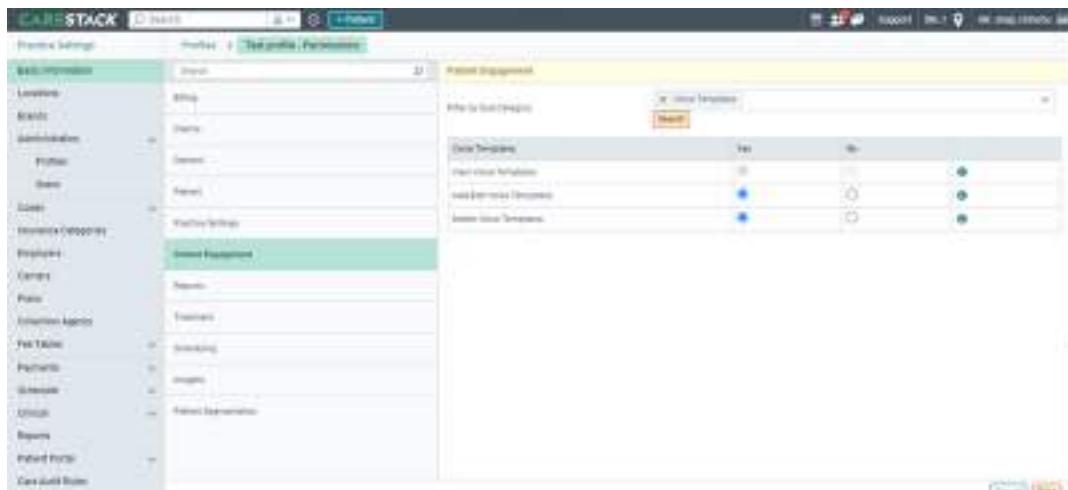
## Text Templates

- **View Text Templates:**
  - Ability to view the list of text templates.
  - Ability to view the details of an individual template.
- **Add/Edit Text Templates:**
  - Ability to add a new text template
  - Ability to edit the details or content of an text template.
- **Delete Text Templates:**
  - Ability to delete a text template.

This screenshot is identical to the ones above, showing the CARESTACK software interface with the 'Patient Engagement' module active. The left sidebar and main content area are consistent with the previous screenshots.

## Voice Templates

- **View Voice Templates:**
  - Ability to view the list of voice templates.
  - Ability to view the details of an individual template.
- **Add/Edit Voice Templates:**
  - Ability to add a new voice template
  - Ability to edit the details or content of an voice template.
- **Delete Voice Templates:**
  - Ability to delete a voice template.



## Reports

### Reports

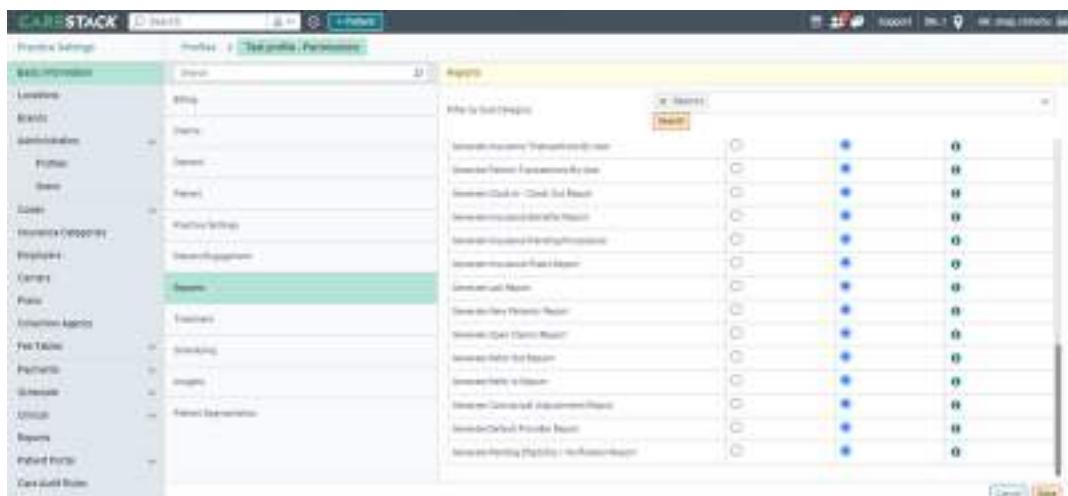
- **Generate Adjustments Report:**
  - Ability to Generate the Adjustments Report.
  - Ability to Export/Print the Adjustments Report.
- **Generate Appointments Report:**
  - Ability to Generate the Appointments Report.
  - Ability to Export/Print the Appointments Report.
  - Ability to view Appointment Report from Cancellation Trends widget if the widget permission is authorized.
- **Generate Claims Report:**
  - Ability to Generate the Claims Report.
  - Ability to Export/Print the Claims Report.
- **Generate Daily Journal:**
  - Ability to Generate the Daily Journal Report.
  - Ability to Export/Print the Daily Journal Report.
- **Generate Deposit Slip:**
  - Ability to Generate the Deposit Slip Report.
  - Ability to Export/Print the Deposit Slip Report.
- **Generate Missing Transactions Report:**
  - Ability to Generate the Missing Transactions Report.
  - Ability to Export/Print the Missing Transactions Report.
- **Generate Payment Log:**
  - Ability to Generate the Payment Log Report.
  - Ability to Export/Print the Payment Log Report.
- **Generate Special Transactions Report:**
  - Ability to Generate the Special Transactions Report.
  - Ability to Export/Print the Special Transactions Report.
- **Generate Executive Summary:**
  - Ability to Generate the Executive Summary Report.
  - Ability to Export/Print the Executive Summary Report.
  - Ability to view Executive Summary Report from Production - Dentist vs Hygienist widget if the widget permission is authorized.
- **Generate Procedure Code Details Report:**

- Ability to Generate the Procedure Code Details Report.
  - Ability to Export/Print the Procedure Code Details Report.
  - Ability to view Procedure Code Details Report from Case Acceptance Report widget if the widget permission is authorized.
- **Generate Production Summary:**
    - Ability to Generate the Production Summary Report.
    - Ability to Export/Print the Production Summary Report.
    - Ability to view Production Summary Report from Production Trends widget if the widget permission is authorized.
- **Generate Production Utilization Summary:**
    - Ability to Generate the Production Utilization Summary Report.
    - Ability to Export/Print the Production Utilization Summary Report.
- **Generate schedule vs Actual Production Report:**
    - Ability to Generate the schedule vs Actual Production Report.
    - Ability to Export/Print the schedule vs Actual Production Report.
- **Generate Transaction Estimates Report:**
    - Ability to Generate the Transaction Estimates Report.
    - Ability to Export/Print the Transaction Estimates Report.
- **Generate Aging Report:**
    - Ability to Generate the Aging Report.
    - Ability to Export/Print the Aging Report.
    - Ability to view Aging Report from Aging widget if the widget permission is authorized.
- **Generate Collection Agency Payments:**
    - Ability to Generate the Collection Agency Payments Report.
    - Ability to Export/Print the Collection Agency Payments Report.
- **Generate Collections By Carrier:**
    - Ability to Generate the Collections By Carrier Report.
    - Ability to Export/Print the Collections By Carrier Report.
- **Generate Income Allocation:**
    - Ability to Generate the Income Allocation Report.
    - Ability to Export/Print the Income Allocation Report.
- **Generate Insurance Payments Report:**
    - Ability to Generate the Insurance Payments Report.
    - Ability to Export/Print the Insurance Payments Report.
- **Generate Patient Payments Report:**
    - Ability to Generate the Patient Payments Report.
    - Ability to Export/Print the Patient Payments Report.
- **Generate Credit Balance Report:**
    - Ability to Generate the Credit Balance Report.
    - Ability to Export/Print the Credit Balance Report.
- **Generate Insurance Transactions By User:**
    - Ability to Generate the Insurance Transactions By User Report.
    - Ability to Export/Print the Insurance Transactions By User Report.
- **Generate Patient Transactions By User:**
    - Ability to Generate the Patient Transactions By User Report.
    - Ability to Export/Print the Patient Transactions By User Report.
- **Generate Clock In - Clock Out Report:**
    - Ability to Generate the Clock In - Clock Out Report.
    - Ability to Export/Print the Clock In - Clock Out Report.
- **Generate Insurance Benefits Report:**
    - Ability to Generate the Insurance Benefits Report.
    - Ability to Export/Print the Insurance Benefits Report.
- **Generate Insurance Pending Procedures:**
    - Ability to Generate the Insurance Pending Procedures Report.
    - Ability to Export/Print the Insurance Pending Procedures Report.
- **Generate Insurance Plans Report:**
    - Ability to Generate the Insurance Plans Report.
    - Ability to Export/Print the Insurance Plans Report.
- **Generate Lab Report:**

- Ability to Generate the Lab Report.
  - Ability to Export/Print the Lab Report.
- **Generate New Patients Report:**
    - Ability to Generate the New Patients Report.
    - Ability to Export/Print the New Patients Report.
- **Generate Open Claims Report:**
    - Ability to Generate the Open Claims Report.
    - Ability to Export/Print the Open Claims Report.
- **Generate Refer Out Report:**
    - Ability to Generate the Refer Out Report.
    - Ability to Export/Print the Refer Out Report.
- **Generate Refer In Report:**
    - Ability to Generate the Refer In Report.
    - Ability to Export/Print the Refer In Report.
- **Generate Contractual Adjustments Report:**
    - Ability to Generate the Contractual Adjustments Report.
    - Ability to Export/Print the Contractual Adjustments Report.
- **Generate Default Provider Report:**
    - Ability to Generate the Default Provider Report.
    - Ability to Export/Print the Default Provider Report.
- **Generate Pending Eligibility / Verification Report:**
    - Ability to Generate the Pending Eligibility / Verification Report.
    - Ability to Export/Print the Pending Eligibility / Verification Report.

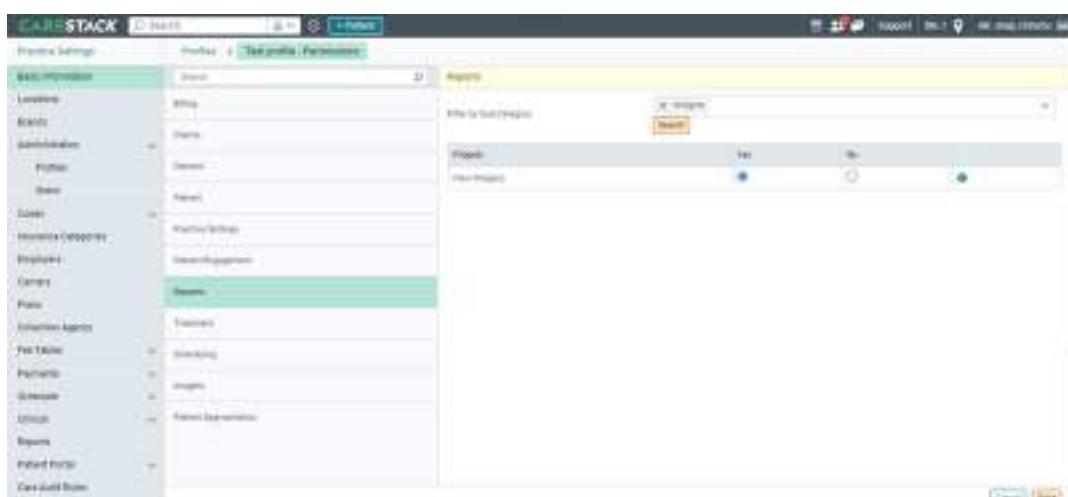
Report	Visible	Printable	Exportable
Newspaper Admissions Report	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Newspaper Assessments Report	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Discharge Report	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Daily Journal	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Receipts	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Billing Transactions Report	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Payment Log	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Special Transactions Report	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Summary	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Product Line Sales Report	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Product Line Summary	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Product Line Status (Summary)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Newspaper Customer or Client Transaction Report	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Report	Visible	Printable	Exportable
Newspaper Admissions Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Assessments Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Discharge Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Daily Journal	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Receipts	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Billing Transactions Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Payment Log	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Special Transactions Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Summary	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Product Line Sales Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Product Line Summary	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Product Line Status (Summary)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper Customer or Client Transaction Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Widgets

- **View Widgets:**
  - Ability to view the Aging widget.
  - Ability to view New Patient Trends Widget.
  - Ability to view Case Acceptance Report widget.
  - Ability to view Production -Dentist vs. Hygienist widget.
  - Ability to View Production Trends widget.
  - Ability to view Cancellation Trends widget.



## Treatment

### Treatment

- **View Treatments:**
  - Ability to view the existing, planned, and completed treatments in the Chart and Treatment Plan.
- **Add/Edit Treatments:**
  - Ability to add new existing, planned, or completed treatments in the Chart and Treatment Plan
  - Ability to edit the details of existing, planned, or completed treatments if unlocked.
- **Delete Perio Chart:**
  - Ability to delete a perio chart.
- **Delete Treatments:**
  - Ability to delete existing or planned treatments when possible.
- **Delete Completed Treatments:**
  - Ability to delete completed treatments when possible.

Patient	Status
Patient 1	In Progress
Patient 2	Pending
Patient 3	In Progress
Patient 4	Pending
Patient 5	Pending

## Scheduling

### Lab Cases

- **Lab Cases View:**
  - Ability to view lab cases associated with a patient or appointment.
- **Lab Cases Edit:**
  - Ability to edit the details of a lab case.

Lab Case	Status
Lab Case 1	In Progress
Lab Case 2	Pending

### Production Calendar

- **Production Calendar View:**
  - Ability to view the possible production calendar templates.
- **Production Calendar Add/Edit:**
  - Ability to add a production calendar template map.
  - Ability to edit the details or map of a production calendar template.
  - Ability to apply a production calendar template map to a day.
- **Production Calendar Delete:**
  - Ability to remove a production calendar template.

The screenshot shows the CareStack software interface with the title bar "CARESTACK" and a user profile "Profile: Dr. John Doe". The left sidebar menu is titled "Basic Information" and includes options like Locations, Branches, Administration, Patients, Cases, Insurance Agents, and Reports. The "Scheduler" option is highlighted with a green background. The main content area is titled "Scheduler" and contains a table with columns "Procedure Codes" and "Procedure Codes (Color)". The table lists four rows: "Production Codes", "Production Codes (Color)", "Production Codes (Color)", and "Production Codes (Color)". Each row has three columns: "Yes", "No", and "No". A search bar at the top right of the scheduler table is set to "Production codes".

## Scheduler

- **Scheduler View:**
  - Ability to view the columns in the Scheduler for allowed locations.
- **Scheduler Add/Edit:**
  - Ability to book appointments in allowed locations.
  - Ability to edit the details of an appointment, including duration, provider, production type, and treatments.
- **Scheduler Delete:**
  - Ability to delete an appointment.

This screenshot is identical to the one above, showing the CareStack software interface with the "Scheduler" module selected. The left sidebar and the main scheduler table with its columns and rows are visible.

## Insights

### Advanced Analytics

- **View Simple Scorecards:**
  - Ability to view Simple Scorecards.
- **Add/Edit Simple Scorecards:**
  - Ability to Add/Edit Simple Scorecards.
- **Delete Simple Scorecards:**
  - Ability to delete Simple Scorecards.

The screenshot shows the CARESTACK software interface. On the left is a navigation sidebar with a tree view of modules: Locations, Branches, Administrators, Projects, Items, Codes, Inventories & Opportunities, Employees, Centers, Posts, Commission Agents, Product Tables, Patients, Schedules, Units, Reports, Patient Portal, and Care Audit Rules. The 'Reports' node is expanded, and 'Analytics Dashboard' is selected, highlighted with a green background. The main panel is titled 'Analytics' and contains a search bar 'Enter by code (optional)' with a 'Search' button. Below the search bar is a table titled 'Analytics Dashboard'. The table has three columns: 'Analytics Dashboard' (with a 'Yes' checkbox), 'Open Analytics Dashboard' (with a 'No' checkbox), and 'Used Information Analytics Dashboard' (with a 'No' checkbox). At the bottom right of the main panel are 'Create' and 'Save' buttons.

## Analytics Dashboard

- **View Analytics Dashboard:**
  - Ability to View Analytics Dashboard.
- **Add/Edit/Delete Analytics Dashboard:**
  - Ability to Add/Edit/Delete Analytics Dashboard.

This screenshot is identical to the one above, showing the CARESTACK software interface with the 'Analytics Dashboard' module selected in the navigation sidebar. The main panel displays the 'Analytics Dashboard' configuration table. The 'Analytics Dashboard' column has a checked 'Yes' box. The 'Open Analytics Dashboard' and 'Used Information Analytics Dashboard' columns both have unchecked 'No' boxes. The bottom right of the main panel features 'Create' and 'Save' buttons.

## General Settings

- **View Custom Code Groups:**
  - Ability to view Custom Code Groups.
- **Add Custom Code Groups:**
  - Ability to add Custom Code Groups.
- **Edit Custom Code Groups:**
  - Ability to edit Custom Code Groups.
- **Delete Custom Code Groups:**
  - Ability to delete Custom Code Groups.
- **View KPI Setups:**
  - Ability to view KPI Setups
- **Add/Edit KPI Setups:**
  - Ability to add or edit KPI Setups

The screenshot shows the CareStack software interface. On the left is a sidebar with a tree view of 'Basic Information' categories: Locations, Branches, Administrators, Patients, Users, Codes, Insurance Companies, Employees, Centers, Plans, Insurance Agents, Payment Types, Patients, Schedules, Utilization, Reports, Patient Portal, and Care Audit Rules. The 'Patients' node is expanded, and 'Patient Documents' is selected. The main panel displays a table titled 'Search Results' with columns: 'Procedure Code', 'Type', 'Status', and 'Actions'. The table contains several rows of procedure codes with their status (e.g., 'New', 'In Progress', 'Completed') and actions (e.g., 'Edit', 'Delete').

## Goal Setting

- **View Location Goals:**
  - Ability to View Location Goals
- **Add Location Goals:**
  - Ability to Add Location Goals
- **Edit Location Goals:**
  - Ability to Edit Location Goals
- **Delete Location Goals:**
  - Ability to Delete Location Goals

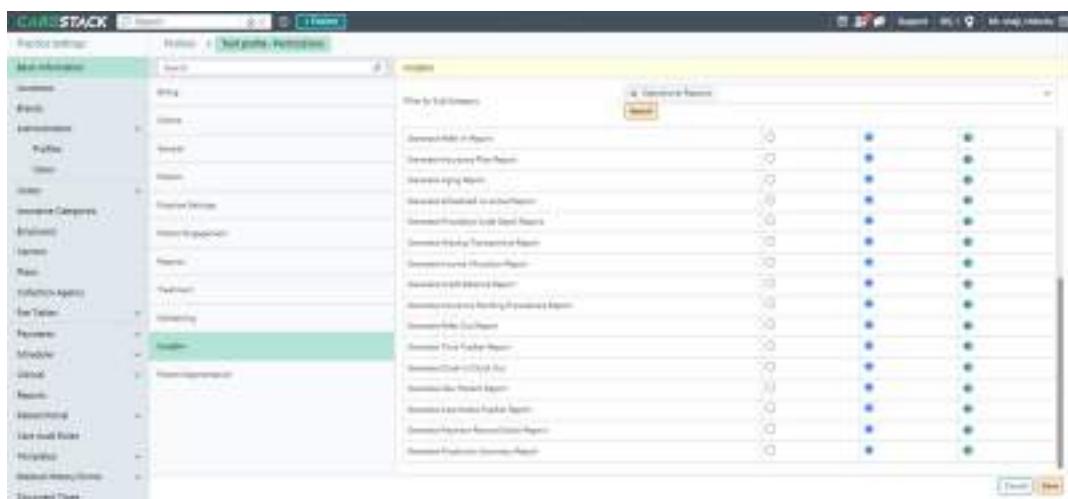
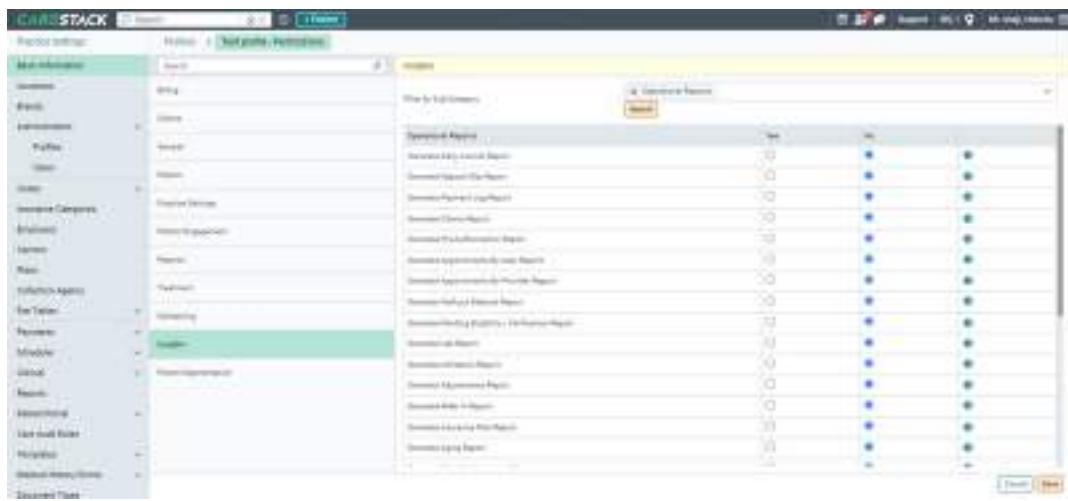
This screenshot is identical to the one above, showing the CareStack software interface with the 'Basic Information' sidebar and the 'Patient Documents' selection. The main panel displays the same 'Search Results' table with procedure codes and their details.

## Operational Reports

- **Generate Daily Journal:**
  - Ability to Generate the Daily Journal Report.
  - Ability to Export/Print the Daily Journal Report.
- **Generate Deposit Slip:**
  - Ability to Generate the Deposit Slip Report.
  - Ability to Export/Print the Deposit Slip Report.
- **Generate Payment Log:**
  - Ability to Generate the Payment Log Report.
  - Ability to Export/Print the Payment Log Report.
- **Generate Claims Report:**
  - Ability to Generate the Claims Report.
  - Ability to Export/Print the Claims Report.
- **Generate Pre-Authorization Report:**
  - Ability to Generate the Procedure Code Details Report.
  - Ability to Export/Print the Procedure Code Details Report.
- **Generate Appointments By User Report:**
  - Ability to Generate the Appointments by User Report.

- Ability to Export/Print the Appointments by User Report.
- **Generate Appointments By Provider Report:**
  - Ability to Generate the Appointments By Provider Report.
  - Ability to Export/Print the Appointments By Provider Report.
- **Generate Walkout Balance Report:**
  - Ability to Generate the Walkout Balance Report.
  - Ability to Export/Print the Walkout Balance Report.
- **Generate Pending Eligibility / Verification Report:**
  - Ability to Generate the Pending Eligibility / Verification Report.
  - Ability to Export/Print the Pending Eligibility / Verification Report.
- **Generate Lab Report:**
  - Ability to Generate the Lab Report.
  - Ability to Export/Print the Lab Report.
- **Generate Utilization Report:**
  - Ability to Generate the Utilization Report.
  - Ability to Export/Print the Utilization Report.
- **Generate Adjustments Report:**
  - Ability to Generate the Adjustments Report.
  - Ability to Export/Print the Adjustments Report.
- **Generate Refer In Report:**
  - Ability to Generate the Refer In Report.
  - Ability to Export/Print the Refer In Report.
- **Generate Insurance Plans Report:**
  - Ability to Generate the Insurance Plans Report.
  - Ability to Export/Print the Insurance Plans Report.
- **Generate Aging Report:**
  - Ability to Generate the Aging Report.
  - Ability to Export/Print the Aging Report.
- **Generate schedule vs Actual Report:**
  - Ability to Generate the schedule vs Actual Report.
  - Ability to Export/Print the schedule vs Actual Report.
- **Generate Procedure Code Detail Report:**
  - Ability to Generate the Procedure Code Detail Report.
  - Ability to Export/Print the Procedure Code Detail Report.
- **Generate Missing Transactions Report:**
  - Ability to Generate the Missing Transactions Report.
  - Ability to Export/Print the Missing Transactions Report.
- **Generate Income Allocation Report:**
  - Ability to Generate the Income Allocation Report.
  - Ability to Export/Print the Income Allocation Report.
- **Generate Credit Balance Report:**
  - Ability to Generate the Credit Balance Report.
  - Ability to Export/Print the Credit Balance Report.
- **Generate Insurance Pending Procedures:**
  - Ability to Generate the Insurance Pending Procedures Report.
  - Ability to Export/Print the Insurance Pending Procedures Report.
- **Generate Refer Out Report:**
  - Ability to Generate the Refer Out Report.
  - Ability to Export/Print the Refer Out Report.
- **Generate Time Tracker Report:**
  - Ability to Generate the Time Tracker Report
  - Ability to Export/Print the Time Tracker Report
- **Generate Clock In/Clock Out Report:**
  - Ability to Generate the Clock In/Clock Out Report.
  - Ability to Export/Print the Clock In/Clock Out Report.
- **Generate New Patient Report:**
  - Ability to Generate the New Patient Report.

- Ability to Export/Print the New Patient Report.
- **Generate Payment Posting Report:**
  - Ability to Generate the Payment Posting Report
  - Ability to Export/Print the Payment Posting Report
- **Generate Care Notes Tracker Report:**
  - Ability to Generate the Care Notes Tracker Report.
  - Ability to Export/Print the Care Notes Tracker Report.
- **Generate Payment Reconciliation Report:**
  - Ability to Generate the Payment Reconciliation Report.
  - Ability to Export/Print the Payment Reconciliation Report.



## Patient Segmentation

### Patient Segmentation

- **View Patient Lists:**
  - Ability to view and generate patient lists.
- **Add Patient List Templates:**
  - Ability to add new patient list templates.
- **Delete Patient List Templates:**
  - Ability to delete patient list templates.
- **Export Patient List:**
  - Ability to perform a simple export of the list results
  - Ability to perform an advanced export of the list results.
- **Send Text Message:**
  - Ability to send text messages to patients that have subscribed through the patient list.

CARESTACK

Profile Settings

Profile: **Administrator Permissions**

**Basic Permissions**

- Locations
- Bills
- Administrations
  - Print
  - Print
- Users
- Costs
- Insurance Companies
- Patients
- Careers
- Plans
- Insurance Agents
- PAT Tables
- Patients
- Schedule
- Office
- Reports
- Patient Portal
- Customized Roles

**Patient Permissions**

Profile: **Administrator Permissions**

Filter by User Groups

Search

Action	View	Edit	Delete
Print Dispositions	✓	✗	✗
View Disposition	✗	✓	✗
Print Disposition Details	✗	✓	✗
Print Disposition Response	✗	✓	✗
Print Patient List	✗	✓	✗
Send Test Message	✗	✓	✗

Cancel Save

# Users

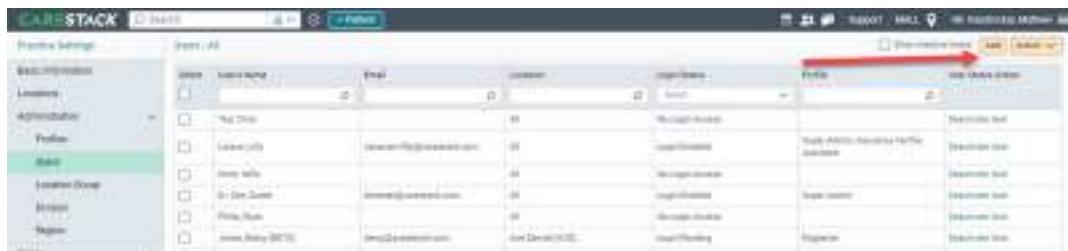
Written by Mathew Kandirickal | Last published at: August 15, 2021

To access and use CareStack, a person needs a user account which will be associated with one or more locations and one or more profiles. Once the user is created with a unique username and email address, the practice will be able to designate him or her as a provider and add other permissions.

## Adding a New User

To create a new user or provider in CareStack, we can follow these steps below:

- Select Practice Settings from the system menu.
- When the page loads, select **Administration > Users** on the left side panel, then hit **Add** at the top-right (pictured below).



- In the pop-up window, enter the new user's details. The items marked with a red asterisk (\*) are the only fields that are mandatory:

- First Name
- Last Name
- Allowed Locations (locations the user should have access to within the system)
- Default Location (the default location the user will be working for)



- Hit **Save & Continue** when finished Or click **Save** to come back to this later -- at this point the user will not yet have login access.

To continue entering the user's information, click on one of the tabs on the left side of the window, then click **Edit** to enter the relevant details (discussed further in the sections listed below).

## Provider Details

- Click the tab for **Provider Details**, then hit **Edit** to begin making your changes.



User: Edit Details

Provider Details

Set as Provider: Yes

Provider Type: Dentist

Short Name: Dentist

Specialty: Dentist

Max No. Of Concurrent Appts: 10

Color: Blue

License Numbers:

- State License Number: 1234567890
- National License Number: 1234567890
- Local License Number: 1234567890
- Other License Number: 1234567890

Data and License Number Entries

Cancel Save

- Set as Provider:** Select Yes if the person is a provider.
- Provider Type:** Select whether this person is a *Dentist* or *Hygienist*.
- Short Name:** Enter a short name for the provider. This is the shortened name that will appear for them whenever it is necessary to be brief.
- Specialty:** Enter the provider's specialty.
- Max No. Of Concurrent Appts:** Enter the maximum number of concurrent appointments this provider can be scheduled for.
- Color:** Enter the color that should represent this provider on the Scheduler.
- Enter any **license** or **identification numbers** that is deemed necessary.
- Hit **Save** when its all done.

## Login Details

Click the tab for **Login Details**, then hit **Edit** to make changes.

User: Edit Details

Login Details

Allow login access: Yes

Profiles: Default Profile

Auto clock-in on login: Yes

Hourly pay: Yes

Email Address: dentistschedule@gmail.com

Username: dentistschedule

Save

- Allow login access:** Select Yes to allow the user access to the system, or leave as No if the individual will not need to be logging in (such as in the instance this individual is a provider that does not need login access).
- Profiles:** Select the profile types that identify the roles and workflows this user will be performing in the system, then choose the default profile type that the user will use upon login.
- Auto clock-in on login:** Select whether this user should be automatically clocked-in upon login.
- Hourly pay:** Select whether this is an hourly employee. If Yes, then enter their hourly pay rate and overtime pay details.
- Hit **Save** when its done.
- Select the **Default Profile** for the user
- Enter the **Email Address** and **Username**



## Working Hours

- Entering working hours enables the practice to limit the hours of the day that the user can access the system.

- Click the tab for **Working Hours**, then hit **Edit** to make the changes.



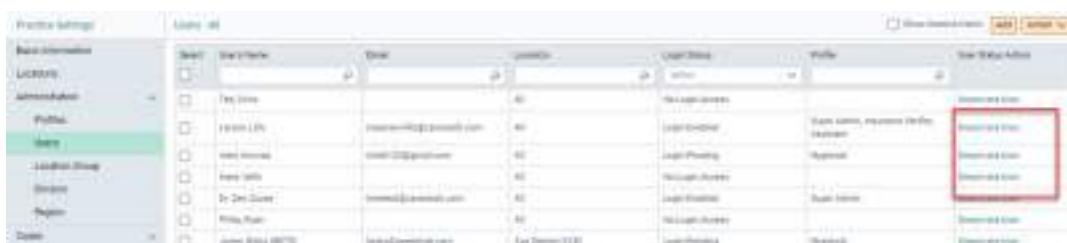
- Checkmark the option to **Enable Working Hours** if desired.

- **Use Account Working Hours:** Select this if the practice would like to use the working hours set on the account-level.
- **Use Location Working Hours:** Select this if the practice would like to use the working hours set on the location-level, then select the location.
- **Use Custom Working Hours:** Select this if the practice would like to enter unique working hours for this user (such as in the instance that they should be able to log in an hour before the office opens and stay online until an hour after the office closes).

## Deactivate a User or Provider

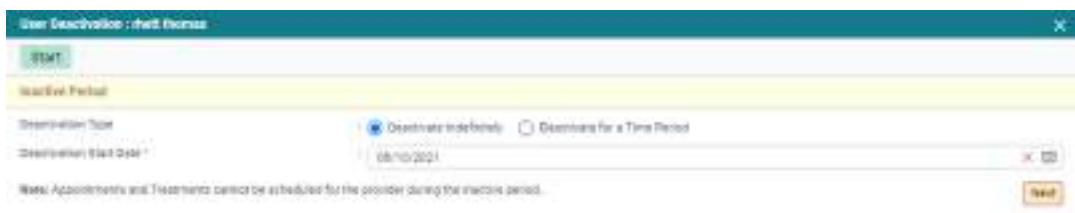
In order to deactivate a user or provider, follow these steps below :

- From the system menu, select **Practice Settings**.
- When the page loads, select **Administration > Users** on the left side menu, then search for the intended User or Provider who needs to be disabled.



- Once the user or provider is located, select **Deactivate User** in the far right column.

- In the pop-up window, the practice needs to confirm whether the correct User or Provider is selected. Choose whether this individual should be deactivated **Indefinitely** or for only a **selected Time Period**, then enter the **Start/End Date**.



- If this is a Provider that is set as the **Default Provider** for any patients within the system, the user will choose which Provider should take their place.
- If the Provider has any **future appointments scheduled**, the user will choose which treatment provider will take their place. (If needed, you are able to view a list of these appointments)
- If the Provider is assigned as an **Ortho Provider** for any **Ortho Payment Plans** within the system, the user will choose which ortho provider will take their place. (If needed, you are able to view a list of these Ortho Payment Plans).

By Deactivating the Selected User, the following changes will take place :

- The **Default Provider** for the affected patients will be changed to the **selected Replacement Provider**.
- **Scheduled Appointments** at the stated location(s) will be assigned to the **selected Replacement Provider**.
- The **Ortho Payment Plans** for this Provider at the stated location(s) will be assigned to the **selected Replacement Provider**.
  
- Users will no longer be able to assign Appointments and Treatments to this provider.
- Users will no longer be able to create New Appointments, Treatments, or Authorizations for this provider.
- The provider will no longer be listed in drop downs listing providers (except in Audit Trail, Claims, and Reports).
  
- Users will no longer be able to create or save Campaigns for this Provider.
- User Login for this Provider will be deactivated on the **selected starting date**.

# Division and Regions

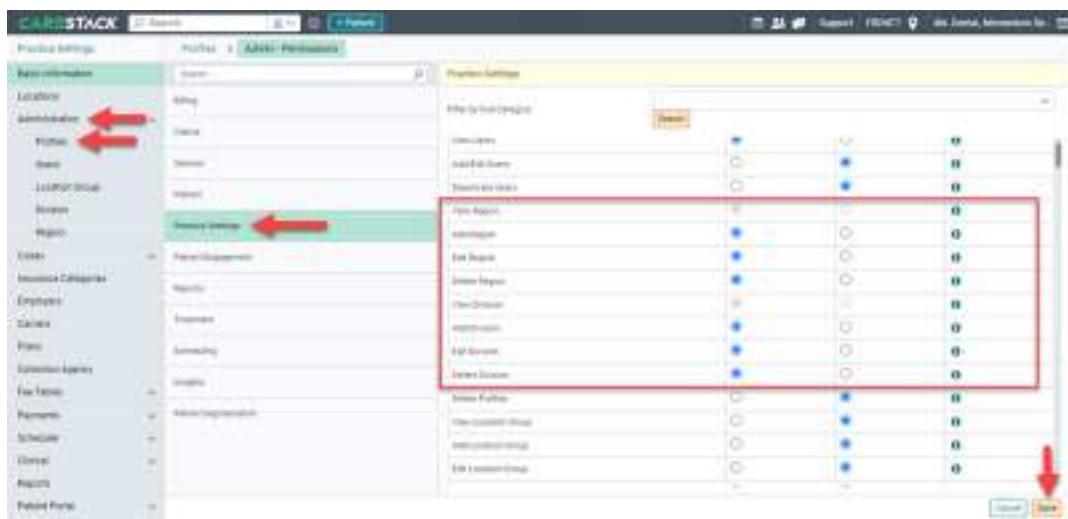
Written by Rinu Seba Joemon | Last published at: August 15, 2021

## Office Regions and Divisions

CareStack gives you the ability to group your office locations by Region and Division. To utilize this feature, the user will have to reach out to a CareStack Representative, and the feature would be enabled for the practice.

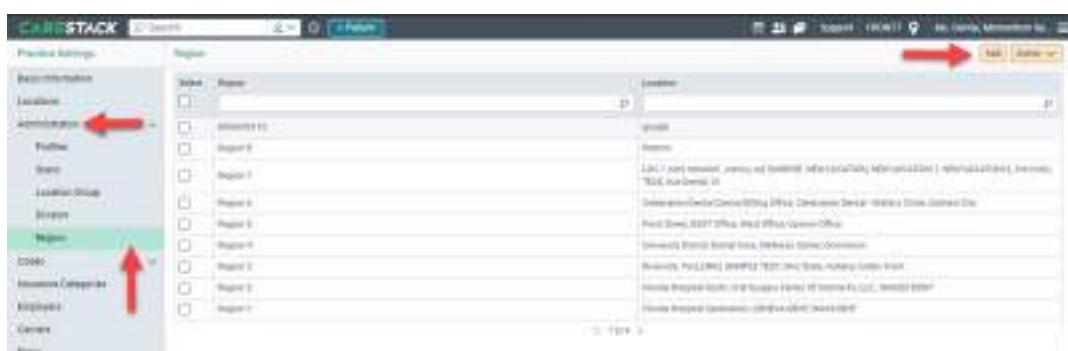
Once this feature is enabled you can follow the below-given steps to create your respective Regions and Divisions (as long as your user permissions are enabled for such). then use these in generating your business reports.

To check for permissions you may navigate to the **System Menu > Practice Settings > Administration > Profiles > Click on Manage Permissions at the right end of the profile type > Practice Settings.**



### Create Your Practice Regions

1. You can start by navigating to your System Menu > Practice Settings > Administration > Region > then hit Add at the top-right.

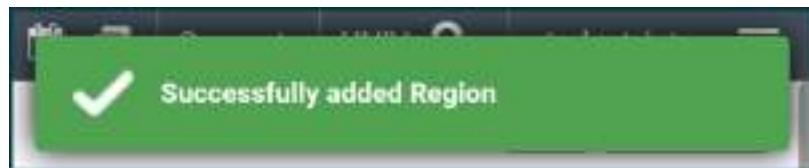


2. In the pop-up window, enter a name for the region you are adding, then select the Locations that should belong to this region.



3. Hit **Save** when you are done.

You will receive a green notification message: " **Successfully added Region .**"



## Create your Practice Division

1. On the left side menu of your practice settings, select **Administration > Division**, then hit **Add** at the top-right.

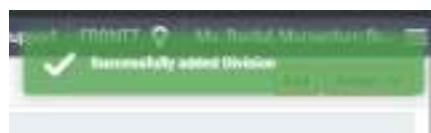
A screenshot of the CARESTACK software interface. On the left, there is a sidebar with various settings like 'Practice Information', 'Locations', 'Administrators', 'Regions', 'Regions Groups', 'Regions', and 'Regions'. A red arrow points to the 'Regions' link. In the center, there is a table titled 'Regions' with columns 'Type' and 'Region'. The table lists several regions: Region 1, Region 2, Region 3, Region 4, Region 5, Region 6, Region 7, Region 8, Region 9, Region 10, and Region 11. At the top right of the central area, there is a red arrow pointing to the 'Add' button.

2. In the pop-up window, enter a name for the division you are adding, then select the regions that should belong to this division.

A screenshot of a 'Add Division' pop-up window. It has a title bar 'Add Division' and a sub-section 'Division Setup'. There is a 'Name' input field containing 'Region 12' and a 'Regions' dropdown menu below it. At the bottom right of the window are 'Cancel' and 'Save' buttons. The background shows the main 'Division' list from the previous step.

3. Hit **Save** when you are done.

You will receive a green notification message: " **Successfully added Division .**"



# Insurance Categories

Written by Athul V Suresh | Last published at: August 15, 2021

Insurance companies/carriers group the ADA codes into different Insurance categories and determine coverages for each category. The coverage determined by the insurance carriers will be the percentage of the total fees the carrier will pay. Even though most categories like preventive, Diagnostics, endodontics is common, each carrier defines its own insurance categories and the codes that come under each category. Simply put not all categories and are common and codes under each category are not uniform.

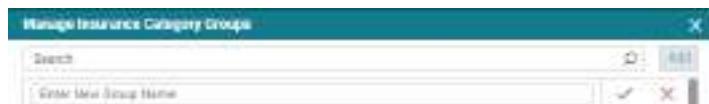
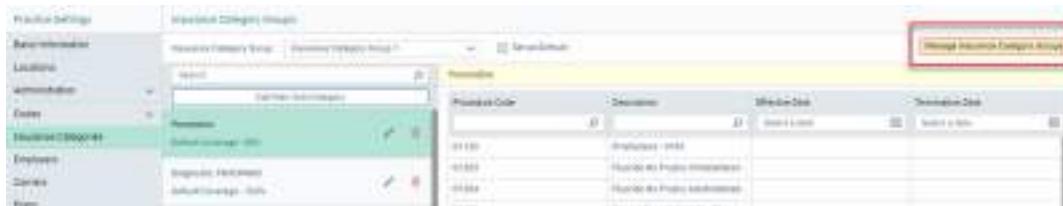
So how do you resolve this issue a practice might have multiple numbers of carriers they are associated with and all these carriers might define categories and coverages differently. CareStack has you covered here. you can add multiple coverage groups and subcategories for each category.

## Insurance Categories Groups

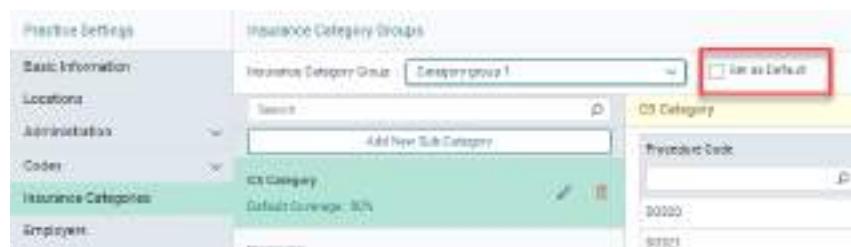
To add insurance categories navigate to System menu > Practice settings > Insurance categories > Manage new insurance groups > Add

To delete insurance categories navigate to System menu > Practice settings > Insurance categories > Manage new insurance groups > trash icon.

You can use the edit button to edit the name of the insurance category group.



To set an insurance category group as default you can click on the 'set as default' check box



## Subcategories

Once you add a new insurance category group you would need to add subcategories and add codes to those categories. You can specify the name and coverage of the category and add codes from the list codes in your practice. Codes ones added in subcategory cannot be added to another subcategory in the same insurance category group.

## Edit/Delete Subcategories

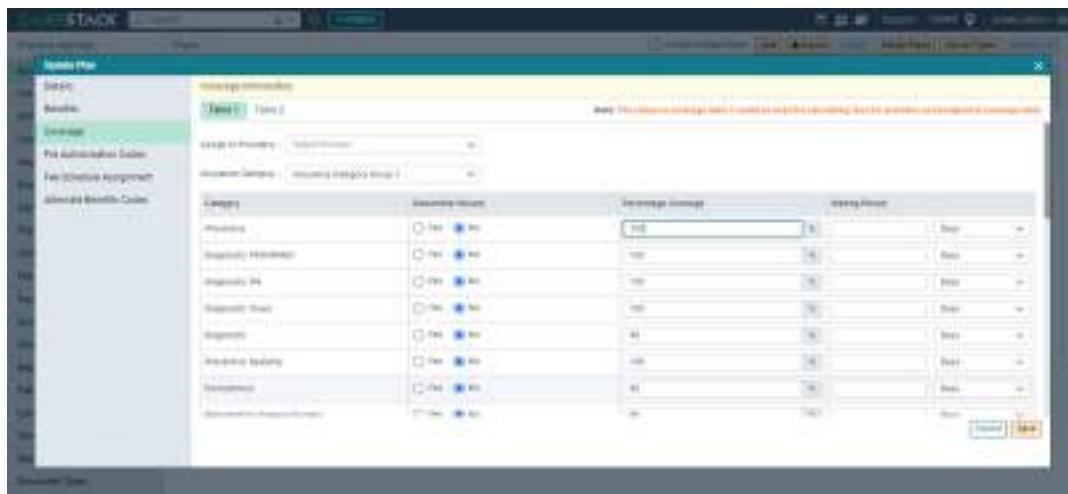
To edit subcategories you can click on the pen icon next to the subcategory and make the necessary changes as you wish. To delete the subcategory you can click on the trash can icon to delete the category.

## Viewing codes under each Category

To view codes under each subcategory you can just click on the subcategory.

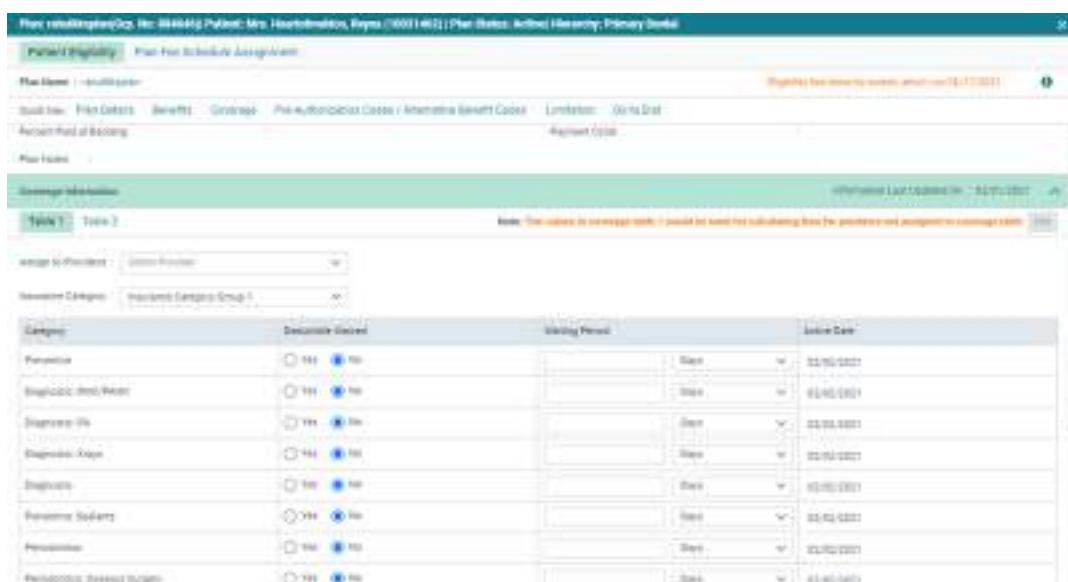
## Linking Insurance Category groups to Plans

To link the insurance groups to plans you can either navigate to system menu > Practice settings > plans > select the plan > Coverage.



Here you can select the insurance category group and even edit the coverage values for each sub-category. The values you enter here for percentage coverage won't change the values assigned for the subcategory under practice settings.

Or you can navigate to the patient's Insurance tab > select the plans > coverage > edit. Here you can give custom coverage values for each subcategory which will only affect the coverage values for the particular patient.



# Employers

Written by Abhishek Vijay | Last published at: August 15, 2021

You've seen a field of "Employer" while entering in the insurance for a patient, and are wondering what that means. Well, you've come to the right place!

The screenshot shows a software interface titled 'Add New Insurance to Family'. In the 'Subscriber' section, there is a dropdown menu with options: 'Search as PP', 'Select From Existing', and 'Add new'. Below this, there is a 'Subscriber Name' input field and a 'Subscriber ID Type' dropdown set to 'Subscriber ID'. An 'Effective Date' field is also present. A red box highlights the 'Employer' dropdown, which has 'Select' as its current value. To the right of the employer dropdown, there is a link 'Add Draft Employer Insurance'. Further down, there are 'Carrier' and 'Plan' dropdowns, each with 'Select' as its current value. To the right of these dropdowns are links: 'Add New Carrier' and 'Add New Plan'.

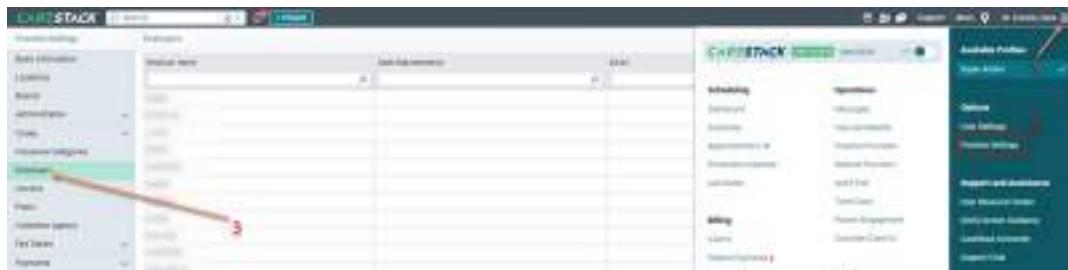
An employer-employee insurance policy is one in which the firm or employer acquires an insurance policy with its employees as the beneficiaries. It's a perk that a company offers to new workers as part of the onboarding process.

**"Associating an insurance plan with the company that provides it facilitates the process of adding the relevant plan to the patient's account."**

Instead of adding an employer detail every time we create an insurance account for a patient, we can create commonly used employer details as per the practice demand.

To set the same, we head to our beloved central setting page, Practice Settings.

## System Menu > Practice Settings > Employers



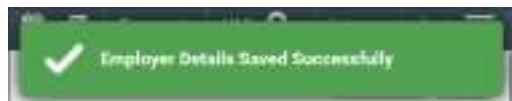
Once we're on this screen, we are presented with the option to Export the existing list, Add a new entry inside this list, or merge similar carriers together. Let's check the options one by one.

**port:** Once you click on the Export button, the existing entries of employers inside our system are downloaded as a CSV file. There you go, you have all the data now!

**d:** Once we click on the Add button, we have the option to add a completely new employer entry, complete with name, address and website.

The screenshot shows a modal dialog box titled 'Add Employer'. It has a tab labeled 'Employer Details' which is currently selected. Inside this tab, there are several input fields: 'Name', 'Address Line 1', 'Address Line 2', 'City', 'State', and 'Website'. To the right of these fields is a 'Verify' button. At the bottom right of the dialog box are 'Cancel' and 'Save' buttons.

Once you click on save, the entry added will now be available inside the insurance plan screen to be entered as an employer for that patient's insurance.



We can now go ahead and click on the field to bring up further options for the Employer.



Here, we can add the contact details of the employer, as per the information we have received from the patient's insurance details.

Once this is updated, the entries would show up under the Sales Representative, Email and Website columns of this page, which can be changed at any time.

**Merge Employers:** This button when selected gives us the option to merge two similar Employers in the system. Could have been created by mistake, could have been done by users without each other's knowledge, could be anything. We have the option to get rid of the duplicated information through this method. The clients can rest easy, phew!



The Destination Employer is the entry you want in the list and the Employers to be merged are the duplicated one's you want to get rid of in the list. Too confusing? Allow me to rephrase!

Destination Employer: The actual entry, you need this one to be in the list after the merge.

Employers to be Merged: The duplicated/mistaken entries made which we want to get rid of.

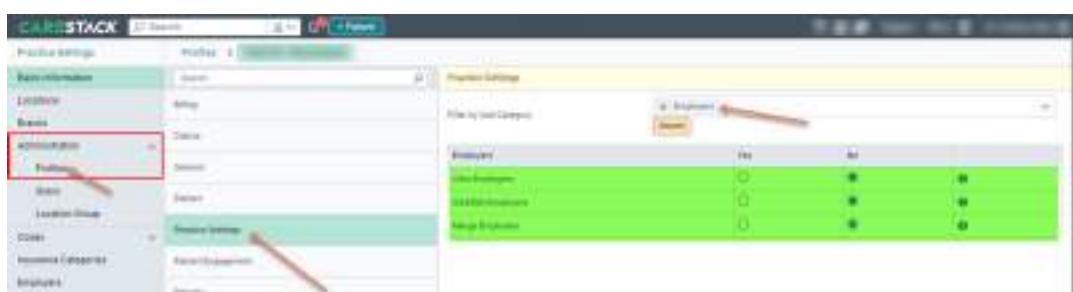
As the warning shows, once the Employers have been merged, it's hasta la vista! The merged entries cannot be unmerged (is that even a word?)

Since we're all human, we would have situations where we would still want to see the merged employers in the list right? Well we got that covered too!

You can simply click on the checkbox at the top "Include Merged Employers" and lo and behold! All the entries are back, but the merged entries will have the tag "merged" along with them.

Like every other entry inside the Practice Settings page, the Employer entries also require permissions for a user to have access to all the specified actions.

**System Menu > Practice Settings > Administrations > Profiles > Manage Permissions > Practice Settings > Employers**



Once the user has all these permissions, they can perform all the above stated changes.

The changes made here also reflect on the Audit Trail, and has been demonstrated below.



***Well there you go! Try it out for yourself and embrace the mastery of adding an employer!***

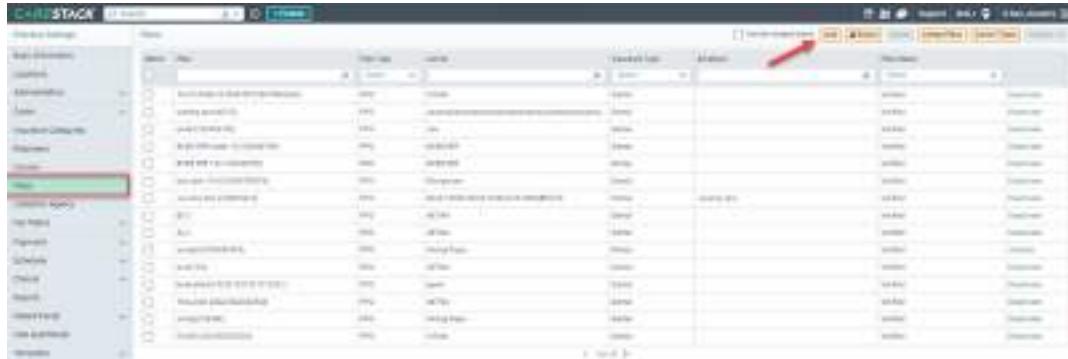
# Plans

Written by Aswathy B Nair | Last published at: August 10, 2021

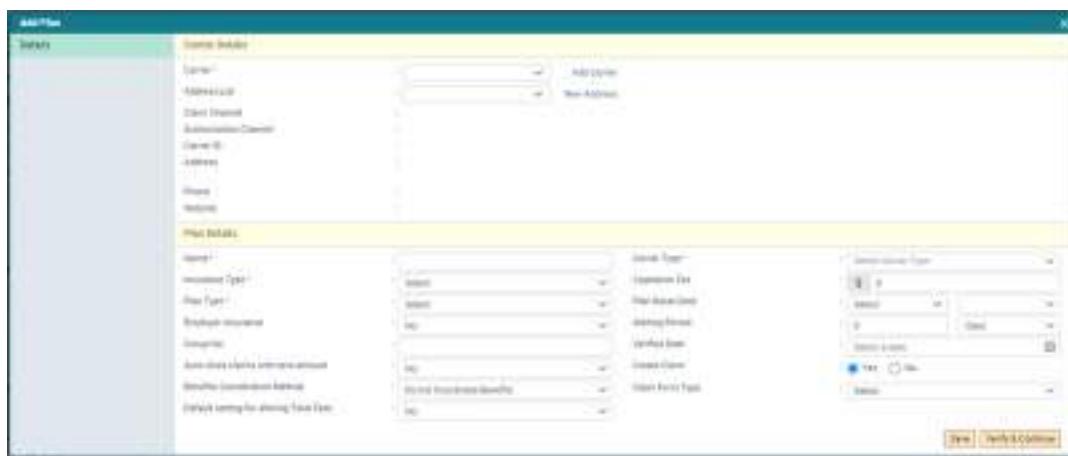
An insurance plan contract describes the details and requirements of the coverage being provided to the patient by the insurance carrier. An insurance plan can be either added from the Practice settings or from the patient's Insurance page while adding new insurance.

## How to Add an Insurance Plan

You can add an insurance plan by going to **System Menu > Practice settings > Plans > Add**



On clicking "Add", an "**Add Plan**" window opens where we enter the Carrier and Plan details.



### Carrier Details

*If you want to add a carrier from existing:*

- **Carrier:** This is a mandatory field, where the Carrier name is to be filled. The drop-down provides the carrier names that are already added to the system.
- **Address List:** If the carrier is already present in the system, then the Address List gets automatically filled in with the default address of the Carrier, and the drop-down list will have the other addresses saved for the carrier in the system.

- **Claim Channel:** Claim channel is the mode by which the claims are sent to the carrier. You can set it to Electronic or Paper-based. If the carrier and addresses are already added to the system, then the Claim Channel auto-populates from the carrier details.
- **Authorization Channel:** Determines how pre-authorization requests should be sent to the carrier, electronically or by paper.
- **Carrier ID:** This field also gets pre-filled if we are using the details of an existing carrier.
- **Phone:** the phone number you will use to follow up with the carrier.
- **Website:** the carrier's website details for reference purposes.

**If you want to add a new carrier:**

- **Carrier:** If you want to add a new carrier, you can click on **Add Carrier**. This in turn opens a new tab where you can fill in the details of the new carrier that you are going to add. Once you fill in the details, you can click on **Save and Return** which will take you to the previous page where you can continue with the plan details.

The image shows two overlapping windows. The top window is titled 'Carrier Details' and has a 'Carrier' dropdown set to 'Add Carrier'. The bottom window is titled 'Add Plan' and has a 'Address' section highlighted with a red box. Within the 'Address' section, there is a 'New Address' button, which is also highlighted with a red arrow.

- **Address List:** If you want to add a new address, just hit on New Address.

The image shows the 'Carrier Details' screen with the 'Carrier Details' tab selected. A red arrow points to the 'New Address' button located at the top right of the form.

This opens new mandatory fields.

The image shows the 'Add Plan' screen with the 'Carrier Details' tab selected. A red arrow points to the 'New Address' button located at the top right of the form.

- **Nickname\*:** This version of the carrier name appears on the claim forms so use the formal carrier name.
- **Claim Channel\*:** Select how the claims should be sent to the carrier, electronically or by paper.
- **Authorization channel\*:** how pre-authorization requests should be sent to the carrier, electronically or by paper.
- **Carrier ID:** This important number helps the clearinghouse identify the carrier for electronic communication. Each clearinghouse has its own carrier identifier; be sure to use the **Carrier ID specific for Change Healthcare** found on the [Change Healthcare Payer List](#).
- **Address Line 1\*:** Enter the address where claim forms should be sent, even when sent electronically.

- **Address Line 2:** The address where the claim should be sent
- **Zip\*:** Zip code of the location.
- Clicking on **Verify** helps to automatically fill the **City\*** and **State\***.
- **Phone:** the phone number you will use to follow up with the carrier.

## Plan Details:

- **Name\*:** This is the name you will use to identify the plan in the drop-down lists.
- **Insurance Type\*:** Choose whether this is a Dental or Medical plan depending on whether it provides coverage for Dental codes or Medical codes.
- **Plan Type\*:** Select whether the plan type is Co-Pay, Discount, HMO, Indemnity, or PPO. Plan types in detail will be discussed later.
- **Employer Insurance:** If you would like to tie this plan to an employer, select Yes, then select the Employer from the drop-down list. You can click on Add Employer to add a new one.
- **Group No.:** This is a unique number by which plans are identified by the carrier. This information is usually received from the carrier.
- **Auto close claims with zero amount:** DMO(Dental Maintenance Organization) plans often have claims for \$0.00 because many procedures are covered under the capitation umbrella. You can choose to automatically close these for this plan independent of the carrier selection.
- **Benefits Coordination Method:** This option tells CareStack how the plan interacts with other plans when the patient has more than one insurance plan.
- **Use Fee Registers for Fee Calculation:** Select 'Yes' to estimate fees based on payments the carrier has made rather than estimating using the fee schedule.
- **Default setting for altering Total Fees:** Select 'Yes' to allow users to change the total fee amount for procedures associated with this plan without utilizing a corresponding adjustment.
- **Carrier Type\*:** This gives us the added benefit of tagging carriers how you choose (such as in the instance you'd like to use this field to specify Patient Type), and therefore generating reports and statements based on this criteria.
- **Capitation Fee:** The capitation fee is similar to the amount given by the carrier to providers. Enter a capitation fee if applicable.
- **Plan Reset Date:** Enter the date that the carrier resets the deductible and maximum amounts for this plan. Most carriers use January 1st.
- **Waiting Period:** Enter the waiting period if applicable (for the plan to become active).
- **Verified Date:** This field is not mandatory. This will be the date the insurance plan has been verified in the system.
- **Create Claim:** Choose Yes if claims should be generated on behalf of the patient.
- **Claim Form Type:** Choose the claim form type that should be used when billing the carrier.

You can click on **Save** or **Verify and Continue**

If you click on Save, all the details that you have entered will be saved. A green toaster will be shown on the top right and the plan will be in the Pending Verification Status.

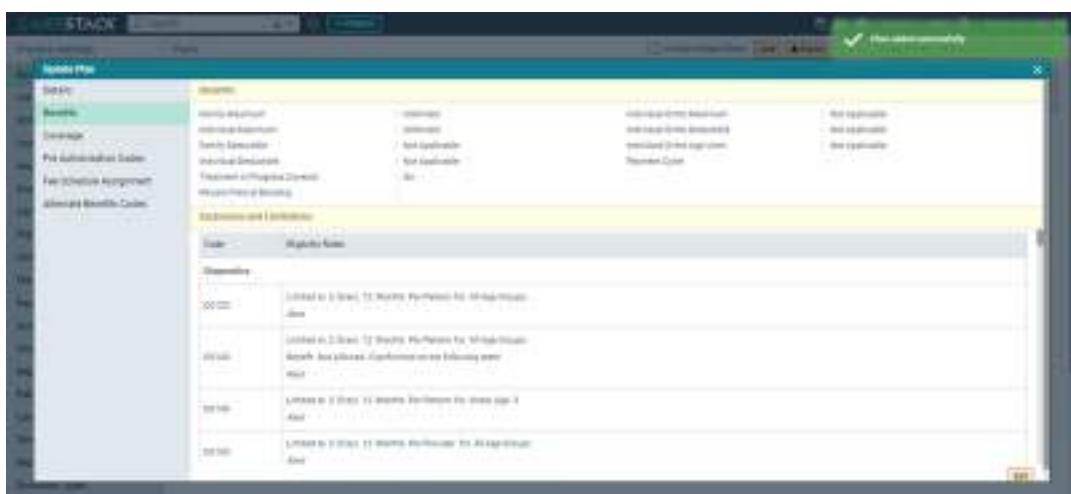


Now to verify the pending plan, you'd have to click on the plan > Edit > Verify and continue. Once you do that, it takes you to the Benefits tab. The same happens if you click **Verify and continue** in the first place without clicking on Save.

Now let's take a look into the various tabs.

## Benefits

You can enter the benefit details of the plan. Enter the family and individual maximums and deductibles as defined by the insurance plan, then enter the eligibility rules that define the plan's exclusions and limitations.



Hm.. not able to enter them? Scroll down and click on **Edit**. There you go!!!

Hit on **Save** when you have entered all the details.

## Coverage

CareStack uses Insurance Categories to define which procedure codes should be included in each dental category (in order to specify the coverage defined in the insurance plan). Select an insurance category group (or use the default), then enter the coverage percentage per dental category. In the bottom section, you can enter a coverage percentage for any specified procedure codes.

The screenshot shows a table with columns for 'Category', 'Value', 'Percentage', and 'Notes'. The 'Category' column lists various dental services like 'Extractions', 'Inlays', 'Inlays - Composite', etc. The 'Value' and 'Percentage' columns show values like 100, 100, 100, etc. A red arrow points to the 'Associate two coverage tables to Insurance Plans' checkbox, which is checked.

You can enter two different coverage tables for insurance plans, then assign the relevant treatment providers to the relevant coverage table for proper treatment fee calculations. This can be set under Practice settings > Fee tables > Settings. Click on edit and if you set Associate two coverage tables to Insurance Plans to 'Yes', then you would be able to see two tables.

The values in coverage table 1 would be used for calculating fees for providers not assigned to the coverage table.

The screenshot shows a form with several settings. One setting, 'Associate two coverage tables to Insurance Plans', has a red arrow pointing to it. The value for this setting is 'Yes'.

## Pre Authorization Codes

Click on Edit and then you can set the Categories and codes that should automatically draft an Authorization claim once the treatment has been accepted by the patient. Click on Save and the codes will be displayed there.

The screenshot shows a list of pre-authorization codes. A red arrow points to the 'Edit' button at the bottom right of the list.

You can delete a code from this list too! Click on the trash icon corresponding to the code and you'd be able to delete the codes from automatically drafting a pre-auth.

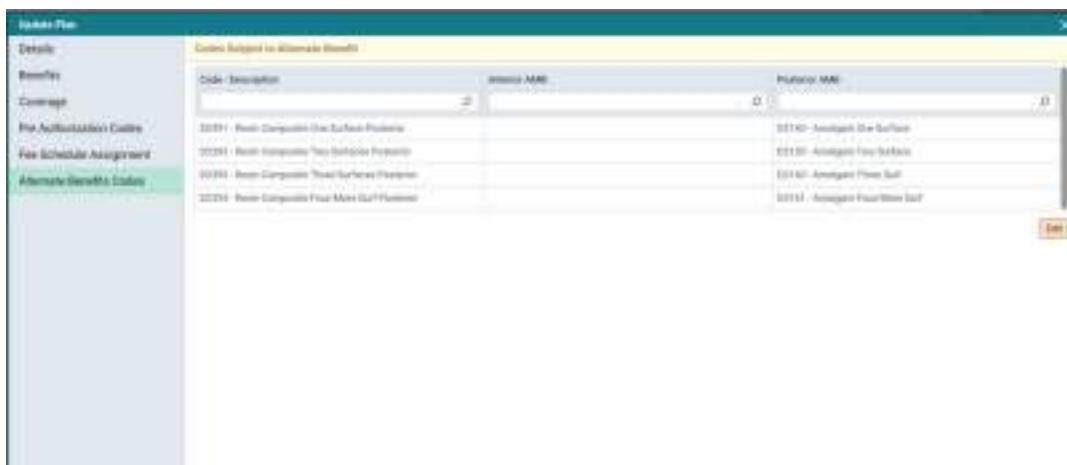
## Fee Schedule Assignments

Copy the fee schedule assignments of another plan that is in the system, or choose your own fee schedule assignments (select the fee schedule, then choose whether to limit this assignment to a location/provider/specialty).

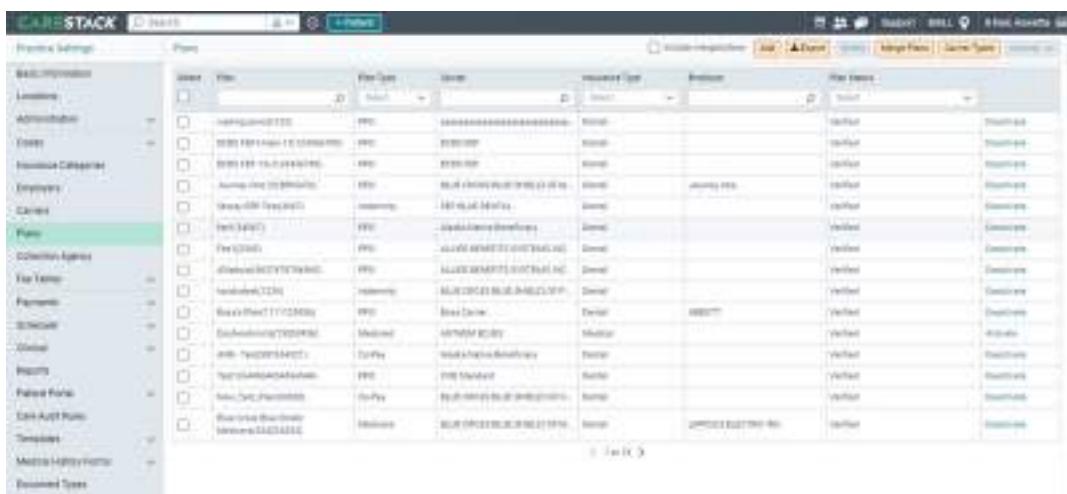


## Alternate Benefits Codes

Select any procedure codes that will be subject to an alternate benefit (such as in the instance that the insurance will cover a silver crown rather than a gold crown).



You might have seen some buttons on top right of the landing page for plans right?



Curious to know what they are? Let's see what each one of them is for.

- o **Add:** As we have seen earlier, Add helps us add a new plan into the system.
- o **Export:** Clicking on Export downloads an Excel sheet with all the plans that have been added to the system.
- o **Delete:** As the name says, you can delete plans using this option. Select the plans to be deleted and click on delete. Didn't work? This will work only for the plans that are in the Pending Verification Status. Now try it!

- o **Merge Plans:** If you find there are duplicate insurance plans entered into the system, then you can merge them. Click on Merge Plans. This will open a pop-up box where you need to enter the Destination Plan and the Plan to be merged



Enter the details and click on Merge which will merge the plans.

- o **Carrier Types:** As discussed earlier, this gives us the added benefit of tagging carriers which helps when generating Statements. When you click on Carrier Types, a slider opens where you can add the carrier types by clicking on Add.

To see the **inactive carrier types**, click on the check box "Show Inactive Carrier Types".

You can edit the details of the Carrier types by clicking on **Edit** and can Deactivate them by clicking on **Deactivate**. Also, you would be able to Activate the carrier types which were deactivated by clicking on **Activate**.

Carrier Types				
Select carrier type(s) to perform an action				
Select	Carrier Type	Description	Actions	
<input type="checkbox"/>	PPO	New	<a href="#">Edit</a>	<a href="#">Deactivate</a>
<input type="checkbox"/>	PPOI	PPO Carrier	<a href="#">Edit</a>	<a href="#">Activate</a>
<input type="checkbox"/>	TestT	Testing	<a href="#">Edit</a>	<a href="#">Activate</a>
<input type="checkbox"/>	Test	New	<a href="#">Edit</a>	<a href="#">Deactivate</a>
<input type="checkbox"/>	TestT	Test Type	<a href="#">Edit</a>	<a href="#">Activate</a>
<input type="checkbox"/>	HMO	Medicare	<a href="#">Edit</a>	<a href="#">Deactivate</a>
<input type="checkbox"/>	HIL	Medicare	<a href="#">Edit</a>	<a href="#">Deactivate</a>
<input type="checkbox"/>	PQ	PPO	<a href="#">Edit</a>	<a href="#">Activate</a>

- o **Actions:** Do you want to deactivate multiple plans at a single go? That could be done with the help of Actions. Select the Plans to be activated or Deactivated > Click on Actions And there you will have the option to Activate and Deactivate.

## Plan Types

Before we discuss the plan types, let's discuss what in-network providers and out of network providers are.

Networks are created by Insurance companies. Insurance companies ask providers if they will charge agreed-upon rates for specific services. If the providers agree to these rates, they can be called an "**in-network provider**." If the providers do not agree to join the network, the health insurance company will label them "**out-of-network**."

Now we can get into the Plan Types.

- **PPO (Preferred Provider Organization):** Comparing an HMO and a PPO plan, a PPO plan provides more flexibility because members can choose to visit an in- or out of network, and there's no requirement to have a primary care physician(PCP). But the plan provides a lower percentage of coverage for going out-of-network. However, these types of plans may cover a large percentage, if not 100%, of preventive services (cleanings and exams). They cover a lower percentage of more complicated services (root canals and crowns). PPOs are usually less expensive than comparable indemnity plans.
- **HMO (Health Maintenance Organization):** An HMO plan only covers medical services received at an **in-network provider**. All care is organized through a primary care physician (PCP). Patients must get a referral from their PCP if a medical condition requires treatment from a specialist. The only exceptions to getting a referral are for emergency room visits and routine, in-network care at an obstetrician or gynecologist.
- **Indemnity:** An indemnity plan allows individuals to select any dentist. The supplemental dental insurance providers of indemnity dental insurance only reimburse the individual after they have reviewed the dentist's bill. This forces individuals to pay for dental treatments in full and then submit a claim. The advantage of an indemnity plan is the freedom to select any dentist. However, individuals will most likely pay more out-of-pocket.
- **Copay:** A copay is a fixed fee that the patient is required to pay for specific medical services. Copays are predetermined and should be outlined in your health insurance plan. Fees vary depending on the service provided. For example, doctor's visits, specialist visits, prescription drugs, and trips to the emergency room will probably each have their own copay fee. A copay will always have a **Table of Allowance**. A Table of Allowance is used to determine co-pay amounts for patients or insurance

receivables according to the insurance plan contract (whether the fees entered on the table are for the patient or the insurance to pay should be specified by the insurance plan).

- **Discount:** Discount plans are neither insurance nor dental benefit. Rather, the discount plan is a fee list of discounted dental fees available to discount plan members. There may be a membership fee but there is no premium, waiting period, or exclusions. A dentist agrees to accept the discounted fee from plan members in exchange for the plan's access to its members. Some dentists offer their own private label discount plan. To combine a discount plan in conjunction with a member's dental benefit plan may cause conflict with the dental plan's participating agreement. For a discount plan to add certain prepaid benefit features like free diagnostic and preventive services may be in conflict with the state insurance law. The worst permutation of a discount plan is a percent discount on dental fees because the provider can change fees on a whim and the consumer rarely has access to fees in the community.
- **Medicare:** It is a federal program that provides health coverage if you are 65+ or under 65 and have a disability, no matter your income.
- **Medicaid:** It is a state and federal program that provides health coverage if you have a very low income. Medicare and Medicaid are both health insurance programs administered by the government.

#### A table that compares various plan types

Plan Type	Deductible	Premium	Referrals	Out of network Cov.
HMO	Low	Low	Required	No
PPO	Low	Low	Not Required	Yes
Indemnity	High	High	Not required	Yes
Copay			Required	
Medicaid/ Medicare	Low	Low	Not Required	Yes
Discount	No	No	Not Required	Yes

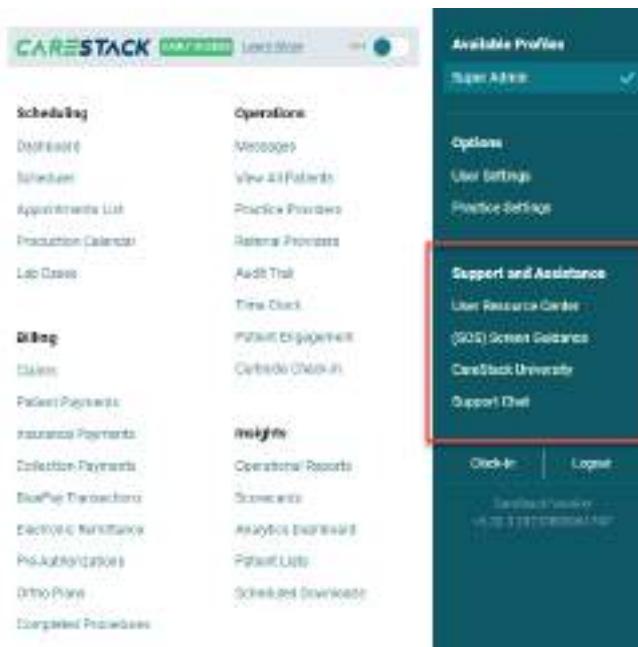
# Support Chat & Support Assistance

Written by Mathew Kandirickal | Last published at: August 15, 2021

## Support & Assistance

The users will have many queries regarding CareStack. Getting help with them becomes an easier task with the **Support & Assistance** in CareStack.

The user can navigate to Practice Settings > Support & Assistance.



## CareStack University

If the users are getting started with CareStack or taking a new role, they can learn the complete workflow and tasks through videos, instructions, and interactive elements.

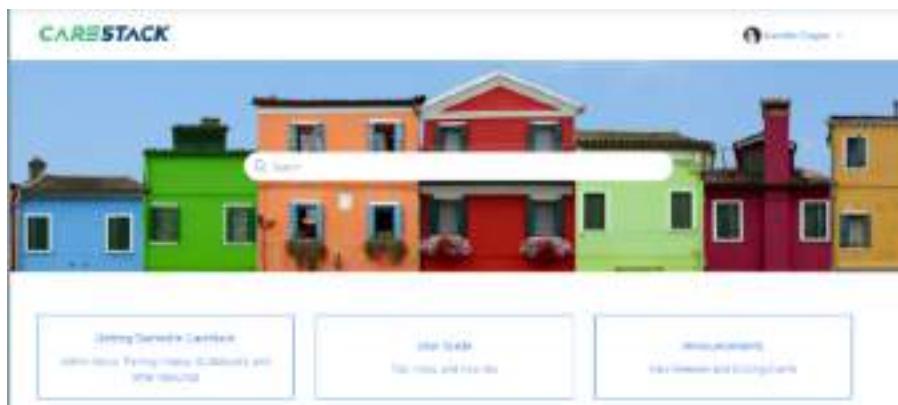
- Each lesson is focused on a specific job task within CareStack and combine videos, instructions and interactive elements
- Access CSU directly from under the System Menu
- Register for the weekly open workshops or request instructor-led training for the team.



## User Resource Center

URC is a self-help resource for task specific "How to" and "Problem Solution" articles. If they forgot what to click to add an insurance payment or if they want to get started with online scheduling, this is the best place to go for the user.

- Access the center directly from CareStack under the User Menu.
- Search by keyword, task, or function.
- Find information on upcoming and recent releases.

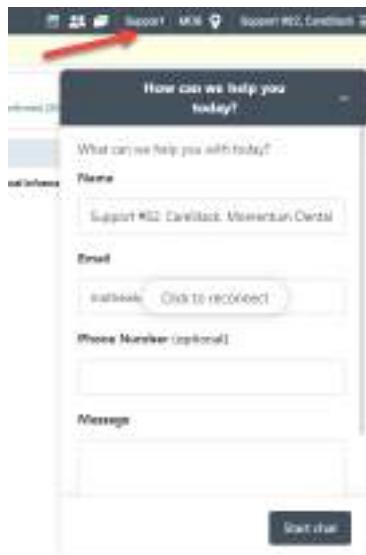


## Live Support

In case the user want any answers or help regarding any issues from a live support agent, they can opt for **Live Support** option.

- Click **Chat** in the Navigation bar to open up a live chat with an online agent.
- Email [support@carestack.com](mailto:support@carestack.com) to start a ticket for the issue.
- Or, call **407-883-6123** to talk with an expert right away.

The user can also open up the new support chat by clicking on the Support button from the Menu. Then the user would have to fill in some required details after which they will be connected to a support agent.



## Screen Guidance

Sometimes the support agent may have to access and see the screen of the user in order to provide more efficient assistance. The Screen Guidance will help in this regard.

The user would have to :

- Click on the (SOS) Screen Guidance button from the system menu.
- This will download an exe file which the user would have to run after downloading the file.
- Now a 9 digit code will be created and the user would have to share this with the agent.

## Audit Trail

Written by Renganathan K | Last published at: August 15, 2021

Audit trail is used to check the user's trail of activity to troubleshoot and assess workflow errors.

CARESTACK		Early Access	Login More	Support	BR	Support #77, CareStack
Scheduling	Operations			Available Profiles		
Dashboard	Messages			Super Admin		
Scheduler	View All Patients					
Appointments List	Practice Providers					
Production Calendar	Referral Providers					
Lab Cases	Audit Trail					
	Time Clock					
Billing	Patient Engagement			Support and Assistance		
Claims	Outside Check-In			User Resource Center		
Patient Payments				(BOS) Screen Guidance		
Insurance Payments	Insights			CareStack University		
Collection Payments	Operational Reports			Support Chat		
BluePay Transactions	Scorecards					
Electronic Remittance	Analytics Dashboard			Clock-in		Logout
Pre-Authorizations	Patient Lists					
Ortho Plans	Scheduled Downloads					
Completed Procedures						
Statements						
Close Out						

Select the **Sync** button at the top-right to refresh the module and sync it with the more recent actions that have been completed in the system since the last time this button was pressed.

Use the column headers to filter for the desired user / patient / action / etc. that you are looking for.

Embedded content from <https://www.loom.com/embed/fa2cfa4c54724f82bcdda6e534bb688>



# Patient Flags

Written by Rahul Krishnan | Last published at: August 15, 2021

Flags act as identifiers which help us in identifying specific type of patients that are defined by the flag. There may be a number of reasons to flag a patient's account: to label them as an employee at your practice, or a patient speaking a native language other English, or perhaps to flag their account as Sent to Collections... Luckily, your practice has the ability to craft as many custom flags as you can think up to suit any variety of needs. In addition to the custom flags, CareStack also has the following System labels/flags which are included by default-

**1. Mark as Inactive**- Used to flag inactive patients in a practice

**2. Mark as Duplicate**-When duplicate accounts exist for a patient, the second account can be marked as duplicate by using this system label. You also have the option to merge this duplicate account into the original account.

**3. Bankrupt**-Used to denote that the patient is broke and can no longer pay for any charges or the already existing balances. It helps the practice to avoid performing any new procedures for this patient until the existing dues are cleared.

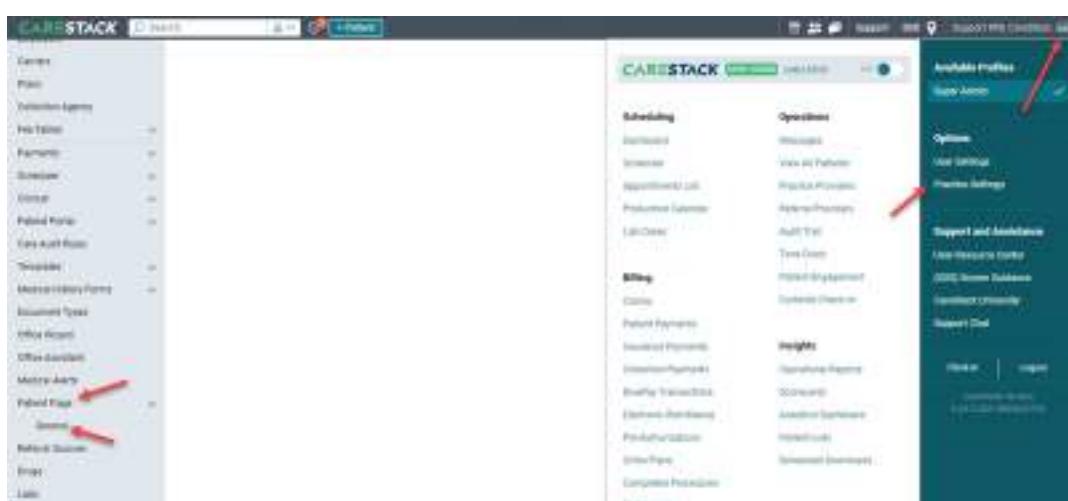
**4. Assign Benefits to patients**-When benefits are assigned to the patient, it means that the patient will be responsible for paying their treatment fees, and any insurance benefits will be reimbursed back to the patient.

**5. Sent To Collections**-Sometimes patients just don't pay their bills. The Practice tried. They prepared the treatment plan with the estimates and accepted payments when they could. They sent letter after letter. Maybe they even made a payment plan arrangement, but the patient still can't or won't pay. When the practice is ready to quit and pass the work over to a professional Collection agency

**6. Do not Send Statements**- If this flag is added to a patient, this patient will be skipped whenever generating batches of patient statements.

The patient flag is visible wherever there is a patient summary (on the patient's search result in the global search bar, on the appointment summary in the Scheduler, and on the patient's profile). Patient Flags are useful for excluding certain accounts with that label from receiving a patient engagement campaign or when generating a statement; you can also use it as a filter when running your reports/ generating patient lists.

In addition to the system flags mentioned above, a practice can create as many custom flags as they wish. One can view the custom patient flags that have been set for your practice by navigating to System Menu > Practice Settings > Patient flags > General.



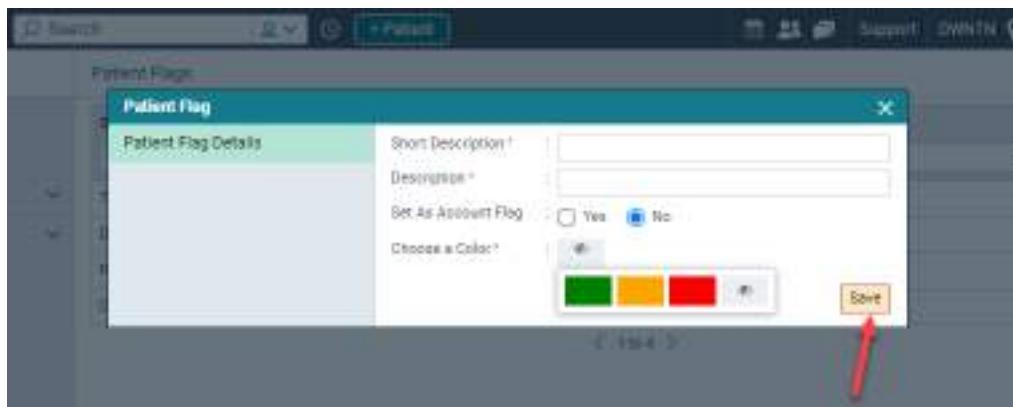
To add a new patient flag, you can click on **Add** at the top-right of the screen to create a new patient flag.

Short Description	Description	Account Flag	Color
T&T	TEST	No	
DC	Deceased	No	
PRM	Pt. Pre-Medicate	No	
CD	Child	No	

1 to 4

Enter the following information:

1. **Short Description:** Enter a short name that will appear whenever the patient is tagged with this flag. It can be up to 3 letters (for example: CH = Child).
2. **Description:** Enter a description that easily identifies the purpose of this flag.
3. **Set as Account Flag:** Select Yes if the flag should be tagged to all members of the account when selected.
4. **Choose a Color:** Select a color that will represent this flag.



Click Save when you are finished. You will see a green confirmation message at the top-right of the screen.

You can edit the information of an existing Patient Flag type by clicking on it and selecting Edit. However the account flag setting of a patient flag cannot be changed once it has been defined.

## Flag a Patient or Account

To tag a Patient Flag to a particular individual, follow these steps below:

1. Open the patient's profile by searching for them in the global search bar.
2. On the patient's overview page, you'll click on the [Edit Labels](#) hyperlink at the very top-right.
3. In the drop-down window, select the flag(s) you would like to tag to this patient.

Please Note: Patient Flags listed in the Account Labels section will be tagged to all family members in this patient's account.

The screenshot shows a patient profile for "Sam, Jerry (JR)". The profile includes basic information like name, gender, date of birth, and address. On the right side, there are two columns of flags:

- Default Labels:** Includes flags for "Adult", "Male", "Female", "Unknown", "Default Name", and "Default Address".
- Custom Labels:** Includes flags for "Child", "Pt. Preference", "Informed", "Informed - Yes", and "Test".

Red arrows point to the "Informed" and "Test" flags under the "Custom Labels" section.

If any label has been attached to the patient, it will be shown in the Patient's overview page and this will update to the patient's demographics.

The screenshot shows the patient's overview page for "Sam, Jerry (JR)". The top navigation bar includes links for Patient, Home, Report, Print, List, Message, and Help. The main area displays the patient's name, gender, and address. To the right, there is a summary section with a "Patient Flags" heading and a list of flags:

- Default Labels: Default Name, Default Gender, Default Preference, Default Fee, Informed.
- Custom Labels: Child, Pt. Preference, Informed, Informed - Yes, Test.

Red arrows point to the "Informed" and "Test" flags under the "Custom Labels" section.

The flag can be removed by simply unticking the label.

## Permissions Required

A user needs to have the necessary permissions to view patient flags as well as to Add/Edit Patient flags set to 'Yes' so as to perform the above mentioned actions.

The screenshot shows the "Patient Settings" screen. On the left, there is a sidebar with "Basic Information" and "Administrative" sections. The "Administrative" section includes "Print", "Delete", "Audit", "Labels", and "Labels Categories". The "Labels Categories" section is expanded, showing categories like "Patient", "Pharmacy", "Collection Agency", "Refillable", "Payments", and "Scheduler". A red arrow points to the "Patient" category.

The main area contains a table titled "Patient Settings" with rows for "Office Appointment Setting", "Non-Bill Office Appointment", "Other Patient Setting", "Non-Cust Patient Setting", "Patient Flag Setting", "Non-Office Flag", and "Non-Cust Patient Flag". Each row has three checkboxes: "View", "Edit", and "Delete". The "Patient Flag Setting" row is highlighted with a red border, and a red arrow points to the "Edit" checkbox in that row.

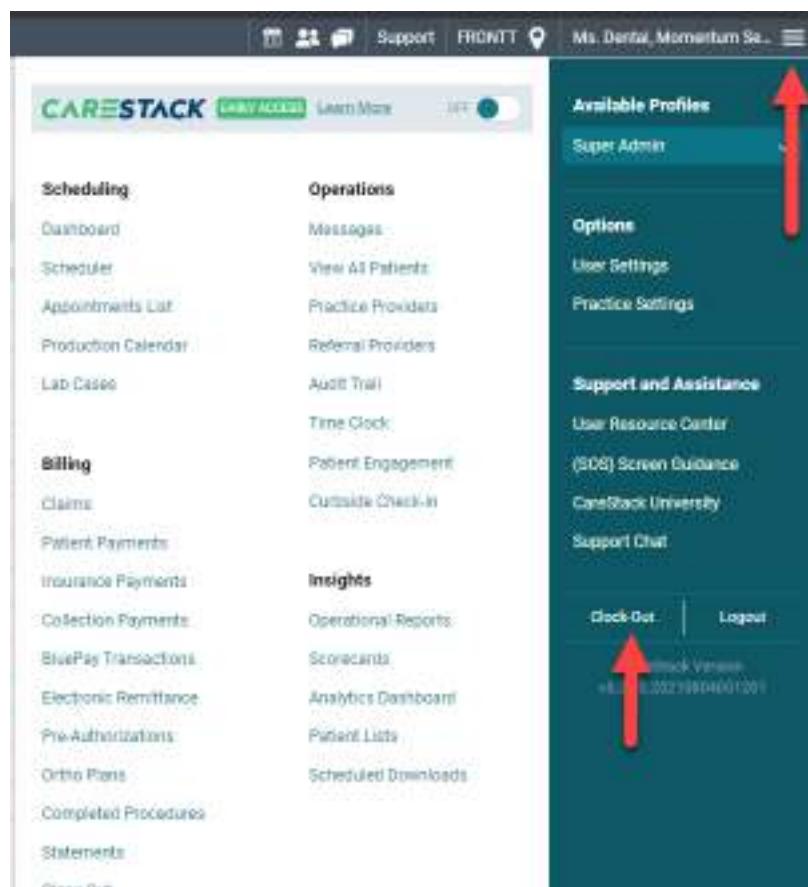
# Time Clock

Written by Rinu Seba Joemon | Last published at: August 15, 2021

## Time Clock

### Clocking In & Clocking Out of CareStack

1. Open your system menu by clicking the icon on the far-right of the CareStack toolbar.
2. Select Clock In (or Out) from the drop-down menu.



**NOTE:** Clocking Out will cause the system to automatically sign you out of CareStack as well.

### Automatically Clock in Upon Login

Enable automatic clock-in on a per-user basis from your Practice Settings:

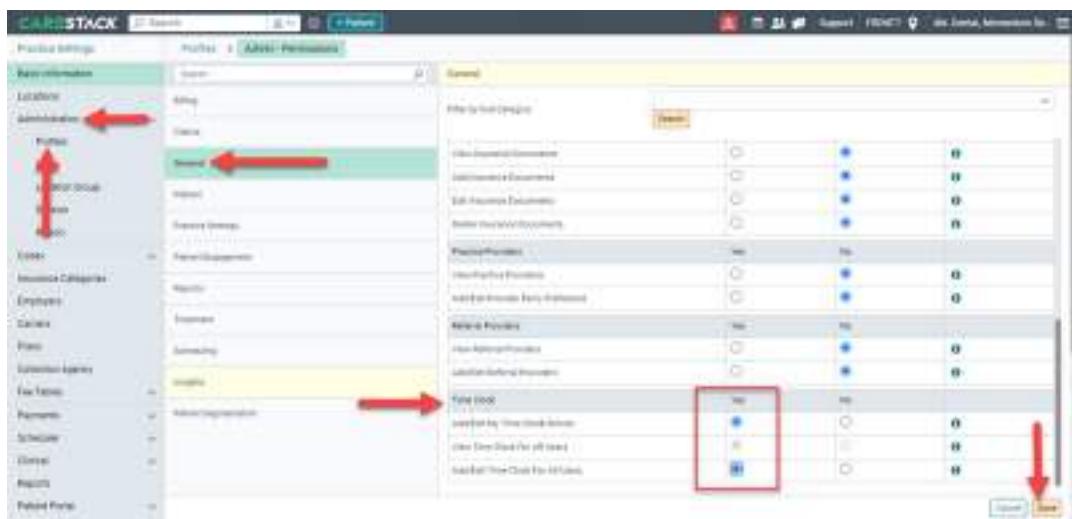
- System Menu > Practice Settings > Administration > Users > select the intended user > Login Details > Edit > Set Auto clock in on Login as 'Yes' > Click on Save.



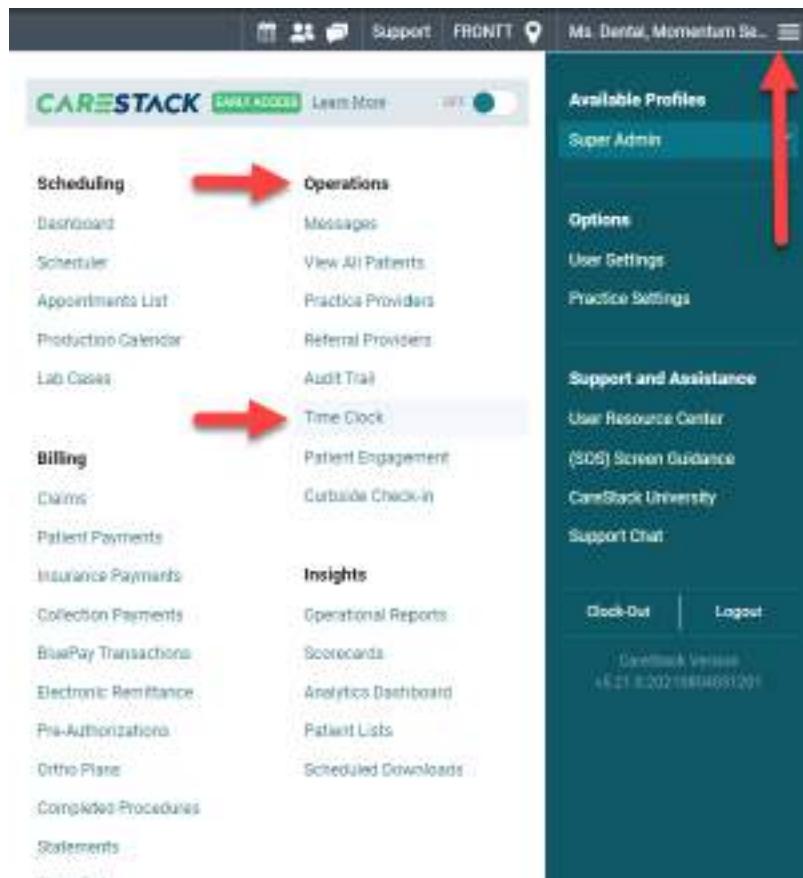
## Edit Time Clock Entry

Note: Your ability to edit time clock entries will be dependent upon your profile type permissions.

To check permissions navigate to the **System Menu > Practice Settings > Administration > Profiles > Click on Manage Permissions next to the user profile > General > Time Clock.**



To update a user's time clock entry, open your **System Menu > Operations > Time Clock**



1. At the top-left of the screen, choose the tab titled **Time Clock Entries for all Users**.
2. Select the user's name from the left-side menu to view their time entries.

The screenshot shows the 'Time Clock Details' page. At the top, there is a green button labeled 'Edit Clock Details for all users'. In the center, there is a table with columns: Date, Location, Clock In, Clock Out, and Name. The first row shows a date of 01/03/2023, location 'Sales Office', clock in at 09:30, and clock out at 17:00. To the right of this table is a red arrow pointing to the 'Edit' link located in the top right corner of the table header. Another red arrow points to the 'Save' button at the bottom right of the table.

3. Click the **Edit** hyperlink to the far right of the item you would like to update.

4. Make your changes, then hit **Save**.



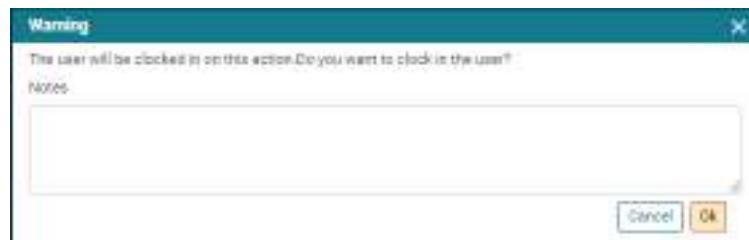
Note: The red font indicates that the time entry has been altered.

The screenshot shows the 'Time Clock Details' page again. The central part is a table of clock-in entries. The first two rows are highlighted with red boxes. The first row shows a date of 01/03/2023, location 'Sales Office - 100000-00000', clock in at 09:30:00, and clock out at 17:00:00. The second row shows a date of 01/03/2023, location 'Sales Office - 100000-00000', clock in at 09:30:00, and clock out at 17:00:00. Both rows have red annotations in the notes column. A red arrow points to the 'Click here to clock in the user' link at the top right of the table.

## Forgot to clock in today?

If the user forgot to clock in today, select **Click here to clock in the user** on the far right.

- The following window will appear:



- Enter your notes, then hit **Ok**.
- If needed, edit the time entry to state the correct clock-in time.

## Forgot to Clock in on Another Day?

If the user forgot to clock in on a past date, select **Add time clock for a specific date**.



- The following window will appear:



- Select the date for this time entry.
- Select the clock-in/out times.
- Enter your notes, then hit **Save**.

## Clock In Clock Out Report

For a report of each user's time clock data and time-based pay details, check out the **Clock In- Clock Out Report**. Kindly navigate to the **System Menu > Insights> Operational Reports > Clock In - Out Report**.

**Operational Report Scorecards**

## Report

Clock In/Clock OUT

This report shows real time data

## Filter Criteria

Default

## Date Range (Max 6 months)

06/12/2021 - 08/12/2021

## Division

7 Selected



## Region

10 Selected



## Location \*

1 Selected



## User \*

1 Selected

 Save Filter Criteria**Download****Generate**

Note: This report would be too large if it contains more than 5 Locations or has a date range of more than 1 Month. If generating a report with these criteria, it will be made available in the Scheduled Downloads section for download once it is completed.

Clock In/Clock Out | 2 Locations | 2 Users | 06/12/2021 - 08/12/2021

No. Clock In/Clock Out

Date	User ID	User Name	Location	Time Worked	Normal Pay Rate/Hr	Normal Pay	Overtime Pay Rate/Hr	Overtime Pay	Gross Pay	Notes
06/12/2021	0000001	J. Smith	Seattle	8.00	\$10.00	\$80.00	\$10.00	\$16.00	\$96.00	
06/12/2021	0000002	M. Johnson	Seattle	8.00	\$10.00	\$80.00	\$10.00	\$16.00	\$96.00	
Total				16.00						

**Kindly take a look into the workflow and practice!**

# Services

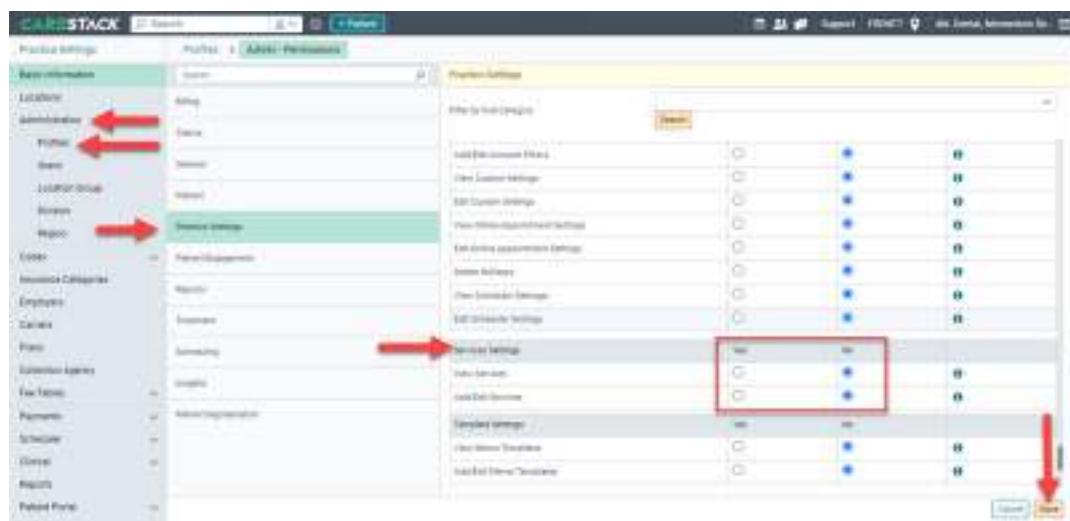
Written by Rinu Seba Joemon | Last published at: August 22, 2021

Services include the third-party software that the practices have enabled such as DoseSpot, NEA FastAttach, CareStack Imaging, Apteryx XV Web, etc.

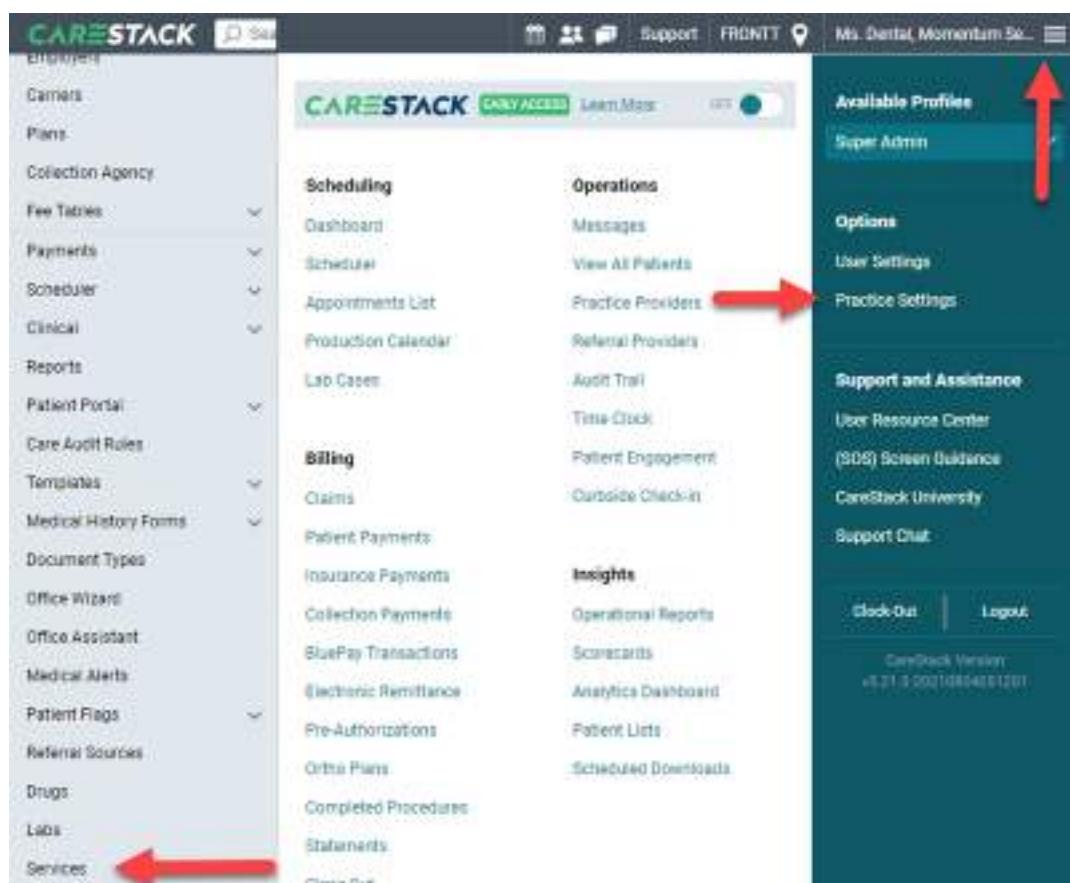
## Permissions:

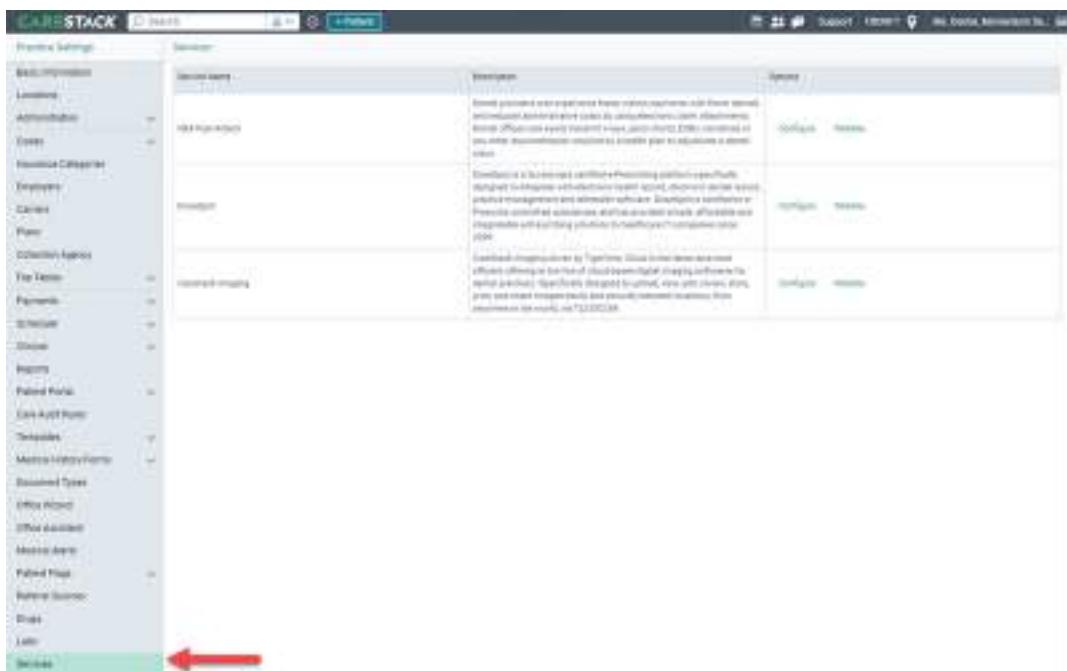
To access the permission page the user would have to have certain permissions. The required permissions can be set by navigating to the System Menu > Practice Settings

> Administration > Profiles > Click on manage permissions next to the user profile > Practice Settings > Service Settings > Set 'yes' to enable to permissions > Click on Save.



You may navigate to the System Menu > Practice Settings > Services to view a specific practice's software.





CARESTACK			
Practices Settings	Services	Information	
Basic Information	Services Name	Description	Options
Locations	Services Name	Integrate with your practice management system to view services offered, book appointments online, and communicate effectively.	Configure Website
Administrators	198 Administrators	Integrate with your practice management system to view services offered, book appointments online, and communicate effectively.	Configure Website
Users	198000+ users	Integrate with your practice management system to view services offered, book appointments online, and communicate effectively.	Configure Website
Insurance Companies	Integrate	Integrate with your insurance companies to view services offered, book appointments online, and communicate effectively.	Configure Website
Employees	Integrate	Integrate with your employees to view services offered, book appointments online, and communicate effectively.	Configure Website
Careers	Integrate	Integrate with your careers to view services offered, book appointments online, and communicate effectively.	Configure Website
Plans	Integrate	Integrate with your plans to view services offered, book appointments online, and communicate effectively.	Configure Website
Collection Agencies	Integrate	Integrate with your collection agencies to view services offered, book appointments online, and communicate effectively.	Configure Website
Top Docs	Integrate	Integrate with your top docs to view services offered, book appointments online, and communicate effectively.	Configure Website
Payments	Integrate	Integrate with your payments to view services offered, book appointments online, and communicate effectively.	Configure Website
Software	Integrate	Integrate with your software to view services offered, book appointments online, and communicate effectively.	Configure Website
Clouds	Integrate	Integrate with your clouds to view services offered, book appointments online, and communicate effectively.	Configure Website
Imports	Integrate	Integrate with your imports to view services offered, book appointments online, and communicate effectively.	Configure Website
Patient Portal	Integrate	Integrate with your patient portal to view services offered, book appointments online, and communicate effectively.	Configure Website
Care Anywhere	Integrate	Integrate with your care anywhere to view services offered, book appointments online, and communicate effectively.	Configure Website
Telephones	Integrate	Integrate with your telephones to view services offered, book appointments online, and communicate effectively.	Configure Website
Medical History Items	Integrate	Integrate with your medical history items to view services offered, book appointments online, and communicate effectively.	Configure Website
Assessment Types	Integrate	Integrate with your assessment types to view services offered, book appointments online, and communicate effectively.	Configure Website
Office Ward	Integrate	Integrate with your office ward to view services offered, book appointments online, and communicate effectively.	Configure Website
Office Assistant	Integrate	Integrate with your office assistant to view services offered, book appointments online, and communicate effectively.	Configure Website
Medical Forms	Integrate	Integrate with your medical forms to view services offered, book appointments online, and communicate effectively.	Configure Website
Patient Flag	Integrate	Integrate with your patient flag to view services offered, book appointments online, and communicate effectively.	Configure Website
Referral Sources	Integrate	Integrate with your referral sources to view services offered, book appointments online, and communicate effectively.	Configure Website
Drugs	Integrate	Integrate with your drugs to view services offered, book appointments online, and communicate effectively.	Configure Website
Labs	Integrate	Integrate with your labs to view services offered, book appointments online, and communicate effectively.	Configure Website
Services	Integrate	Integrate with your services to view services offered, book appointments online, and communicate effectively.	Configure Website

The services page shows the Service Name, Description, Options.

**Service Name:** The name of the service the practice has enabled.

**Description:** A short explanation regarding the service.

**Options:** This includes the Configure icon and the Website hyperlink that takes you to the service website.

# Payment Types

Written by Revati Krishnan | Last published at: August 15, 2021

So, you've added a treatment and completed the services, what's next? The most important part for the practice and in fact all of us, getting paid!

**"Payment types describe how you might receive a payment."**

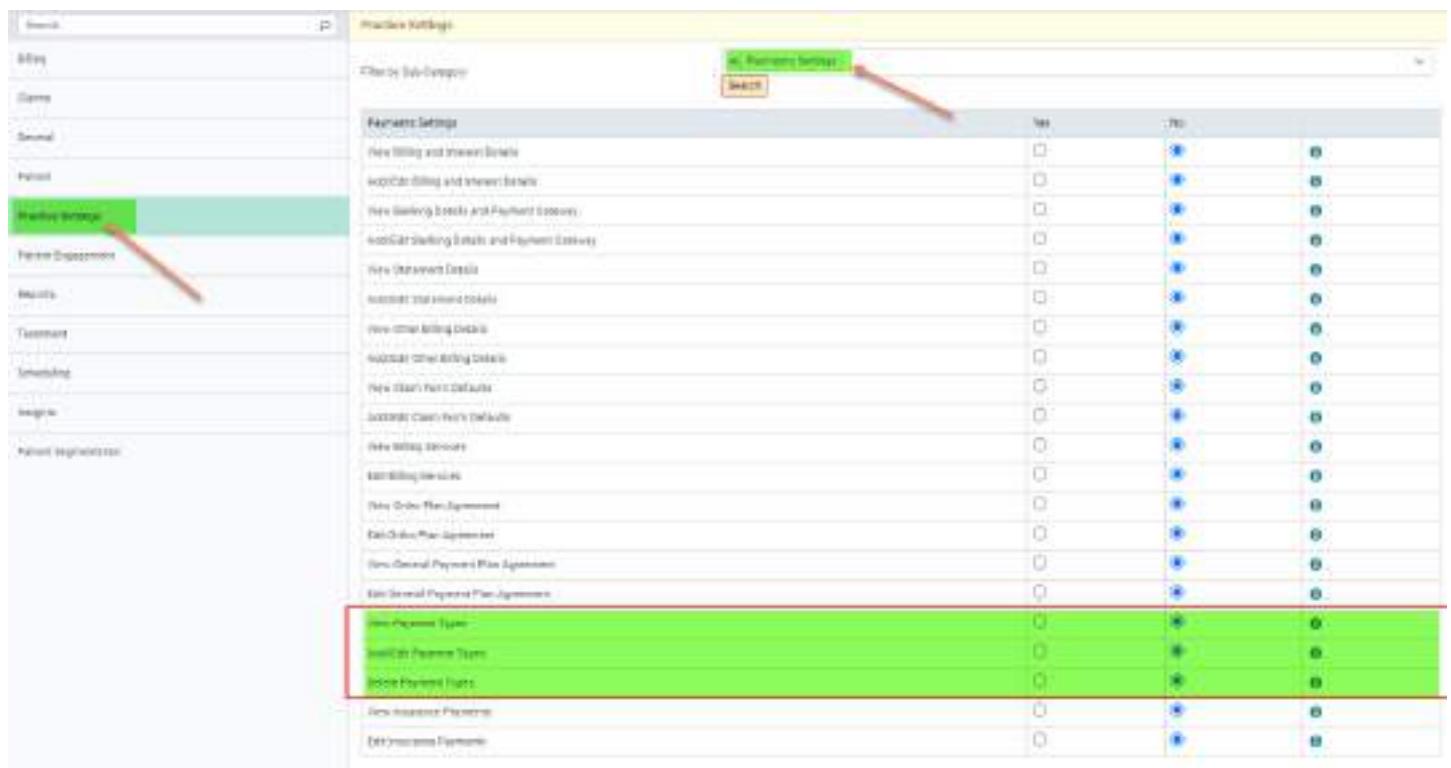
CareStack has the facilities to accommodate a variety of payment options, which will then be available for patients to provide the payment for services completed. Making sure that the practice accommodates numerous payment methods is a sure fire way of ensuring more business. It could range from a simple cash transaction to a variety of Credit/Debit Cards or even custom types as suited for the practice.

The payment types available for a practice can be seen at every inlet of adding a payment, be it adding a patient payment, adding an advance payment, adding an insurance payment and so on.

A major point to be noted here is that once a payment type is **created** and **used**, **it cannot be deleted**, though it can be **deactivated**. So make sure that the client and yourself are in complete agreement before initiating a request for the same.

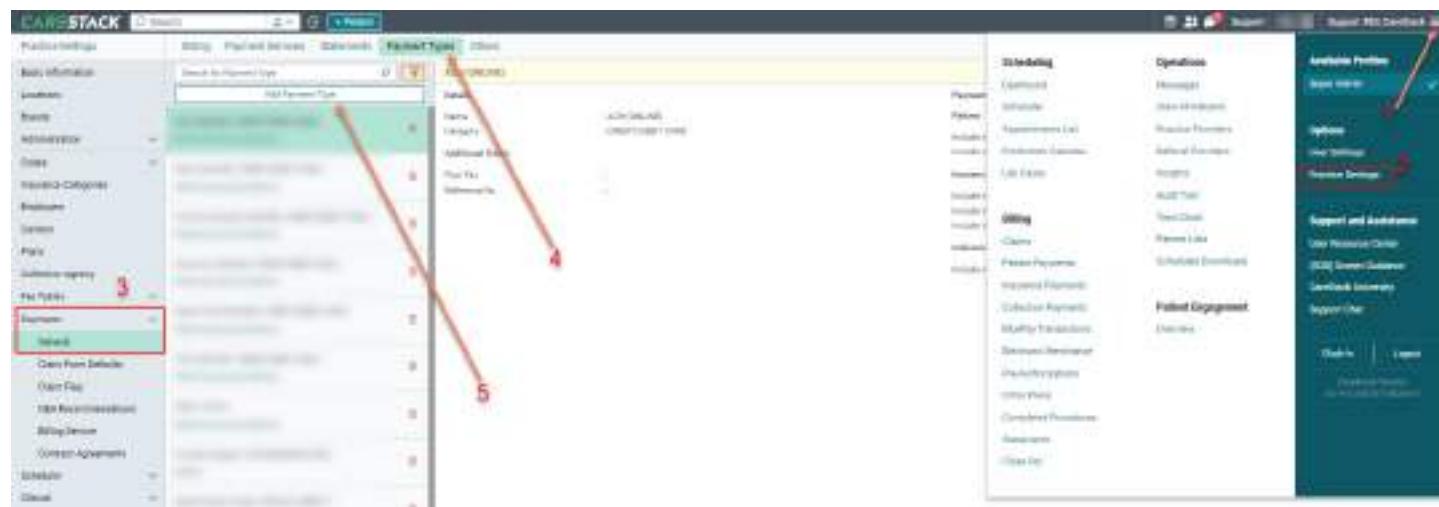
In case any of these settings are unavailable for you or any client, make sure that you check the permission of the user's profile. Tell you what, check that at the beginning of the process to ensure that we are not fiddling in the dark! The permission are available at:

**System Menu > Practice Settings > Administration > Profiles > Manage Permissions > Practice Settings > Payments Settings**



Similar to any process of making practice wide changes, we move on to Practice Settings to add a new payment type. The path for the same is as follows:

**System Menu > Practice Settings > Payments > General > Payment Type > Add New Payment**



### Add payment Type

<b>Details</b>	<b>Payment Type Inclusion</b>
Name: <input type="text"/>	Patient: Include in Payments: <input checked="" type="radio"/> Yes <input type="radio"/> No Include in Refunds: <input checked="" type="radio"/> Yes <input type="radio"/> No
Category: <input type="text"/> CASH	Insurance: Include in Payments: <input checked="" type="radio"/> Yes <input type="radio"/> No Include in Capitation: <input checked="" type="radio"/> Yes <input type="radio"/> No Include in Refunds: <input checked="" type="radio"> Yes <input type="radio"/> No</input>
Additional Fields: Flex Pay: <input type="text"/> Reference No: <input type="text"/>	Collection: Include in Payments: <input checked="" type="radio"/> Yes <input type="radio"/> No
<input type="button" value="Cancel"/> <input type="button" value="Save"/>	

**Name:** The name required for the Payment Type to be referred to.

**Category:** The category to which this payment type falls to, namely Cash, Check, Credit/Debit Card, Direct Transfer, Income Reduction, Special Credit, and Care Credit. It could be noted that these are system-defined and can not be customized. We have kept this as such for reporting purposes.

<b>Add payment Type</b>	
<b>Details</b>	<b>Payment Type Inclusion</b>
Name: <input type="text"/>	Patient: Include in Payments: <input checked="" type="radio"/> Yes <input type="radio"/> No Include in Refunds: <input checked="" type="radio"/> Yes <input type="radio"/> No
Category: <input type="text"/> CASH CARE CREDIT <b>CASH</b> CHECK CREDIT/DEBIT CARD DIRECT TRANSFER INCOME REDUCTION SPECIAL CREDIT	Insurance: Include in Payments: <input checked="" type="radio"/> Yes <input type="radio"/> No Include in Capitation: <input checked="" type="radio"/> Yes <input type="radio"/> No Include in Refunds: <input checked="" type="radio"> Yes <input type="radio"/> No</input>
Additional Fields: Flex Pay: <input type="text"/> Reference No: <input type="text"/>	Collection: Include in Payments: <input checked="" type="radio"/> Yes <input type="radio"/> No
<input type="button" value="Cancel"/> <input type="button" value="Save"/>	

**Flex Pay:** A label used by the person/practice for availing discounts if any. If the field is enabled, it categorizes the payments by adding a label to the patient.

**Reference No:** A Reference number is included in the transactions as a method of identifying and searching for a transaction. Primarily used for card payments in insurance transactions.

**Payment Type inclusion:** This field is used to define whether the added payment type is to be included inside Patient/Insurance/Collection payments. Only if each category is set to yes will it appear on the respective page as an option. Similarly with the refunds of the transactions specified above.

**Transaction Charges:** Process a payment with a transaction charge by using the Care Credit payment type. CareStack will calculate the amount of the fee to include as an adjustment type. The transaction fee will be deducted from the amount of the patient payment so that the net is applied to the patient balance. That fee will then be adjusted off the patient with an adjustment.

Now that the payment type has been created, you can check the points of impact and then make sure that everything is reflecting as per the requirement.

In order to edit an already existing payment type, you can simply click on Edit towards the bottom right of the entry you require, and then make the necessary changes.

Payment Types can be edited only if it has **NOT** been set as default payment type for anything. It is recommended that the practice user performs such actions with us guiding the workflow alone.

This screenshot shows the 'Details' section of a payment type creation form. It includes fields for Name (set to 'CHECK'), Category (set to 'PATIENT'), Additional Fields (Flexi Pay set to 'X PATIENT'), and Reference No. On the right, the 'Payment Type Inclusion' section is visible, which includes sections for Patient, Insurance, and Collection. Each section has three checkboxes: 'Include in Payments', 'Include in Refunds', and 'Include in Cancellation'. The 'Include in Payments' checkbox is checked for all three sections. A red arrow points to the 'Edit' button at the bottom right of the inclusion section.

This screenshot shows the 'Details' section of a payment type editing form, identical to the creation screen. The 'Payment Type Inclusion' section is also present. The 'Include in Payments' checkboxes are checked for all three categories (Patient, Insurance, Collection). A red arrow points to the 'Save' button at the bottom right of the inclusion section.

If the requirement is to delete a payment type, it can only be done if the payment type is not set as the default payment type for anything. If so, you may just click on the dustbin icon for the same.

Once all the required changes have been made, you can click on save at the bottom, and voila! You will be greeted with a green toaster at the top right stating "**Payment Type updated successfully**"

Now let's have a look at all the regions where payment types are present and available for use!

#### Adding a patient payment

**Add Patient Payment** (0000118)

**Add New Payment** Unapplied Credits Refund Worklist All Payments Payment Plans **Post Payment Summary** **GL Ledger**

**Step 1: Add new payment**

Method:  **Regular Payment**  **Advance Payment**  **Payment Plan**

Payment Account: \$ 1000.00 Location: 10001 - Main Office Payment Date: 07/01/2021 **Print**

**Payment Type:** **CASH - Cash**

**Remarks:**

**Step 2: Select provider**

Provider: 000 - (0000118)  **To Patient**  **To Bill**  **Allow Amt**  **Set Due Date**  **Patient Amt**  **Refunds**  **Adjust**

**Balance Summary**

- Total Account Balance: \$0.00
- Total Unapplied Credits: \$0.00
- Unapplied Credits: \$0.00
- Total Receipts: \$0.00

**Next Steps:** [Print](#) [Save](#)

### Adding an Advance Payment

**Add Patient Payment** (0000118)

**Add New Payment** Unapplied Credits Refund Worklist All Payments Payment Plans **Post Payment Summary** **GL Ledger**

**Step 1: Add new payment**

Method:  **Regular Payment**  **Advance Payment**  **Payment Plan** **Provider:** **Select Provider** Payment Date: 07/01/2021 **Print**

**Payment Type:** **CASH - Cash**

**Remarks:**

**Balance Summary**

- Total Account Balance: \$0.00
- Total Unapplied Credits: \$0.00
- Unapplied Credits: \$0.00
- Total Receipts: \$0.00

**Next Steps:** [Print](#) [Save](#)

### Adding a Payment Plan

**Add Patient Payment - Miss. June (0000118)**

**Add New Payment** Unapplied Credits Refund Worklist All Payments Payment Plans **Post Payment Summary** **GL Ledger**

**Step 1: Add new payment**

Method:  **Regular Payment**  **Advance Payment**  **Payment Plan**

Payment Plan Details: **Payment Plan #:** **1** **Due Date:** **07/01/2021** **Print**

**Amount:** **\$ 1000.00** **Location:** **10001 - Main Office** **Payment Date:** **07/01/2021** **Print**

**Previous Amount:** **\$ 1000.00** **Due Date:** **07/01/2021** **Print**

**Contracted Amount:** **\$ 1000.00** **Print**

**Remaining Amount:** **\$ 1000.00** **Print**

**Payment Type:** **CASH - Cash**

**Remarks:** **Amounts are added**

**Balance Summary**

- Total Account Balance: \$0.00
- Total Unapplied Credits: \$0.00
- Unapplied Credits: \$0.00
- Total Receipts: \$0.00

**Next Steps:** [Print](#) [Save](#)

### Adding an insurance payment receipt

Add Insurance Payment	
Select Carrier	AETNA
<b>Payment Details</b>	
Payment Amount <sup>*</sup>	\$ 1000.00
Location <sup>*</sup>	Bronx Street
Payment Date <sup>*</sup>	07/22/2021
Deposit Date	07/22/2021
Payment Type <sup>*</sup>	<input type="button" value="Select"/> <div style="background-color: #ffffcc; border: 1px solid #ccc; padding: 5px; margin-top: 5px;">           CHECK - Check            CREDIT/DEBIT CARD - American Express            CREDIT/DEBIT CARD - Visa            CREDIT/DEBIT CARD - Master Card            CREDIT/DEBIT CARD - Discover            DIRECT TRANSFER - EFT/Direct Bank Transfer            CASH - Other            CREDIT/DEBIT CARD - dMngmgt            CREDIT/DEBIT CARD - Cover's card            CARE CREDIT - Leasing Club            CASH - Check Payment            CARE CREDIT - VISA         </div>
Remarks	
<b>Carrier Details</b>	
Total No of Payments	1
Paid till Date	
Applied till Date	
Refunded Credits	
Unapplied Credits	
Last Payment Date	

So wait, does this mean you can make any change you require inside the payment type settings? **Wrong!**

All the changes you make inside the Practice Settings are logged inside the Audit Trail under Setup as shown below.

This is a great method to find out about which user made the changes, just so the practice can keep track. The practice can also find out if you make changes and mess up, so always be careful while making changes!

You're the master of it all now! Go ahead and try it out for yourself. Practice makes perfect!

# Adjustment Codes

Written by Revati Krishnan | Last published at: August 23, 2022

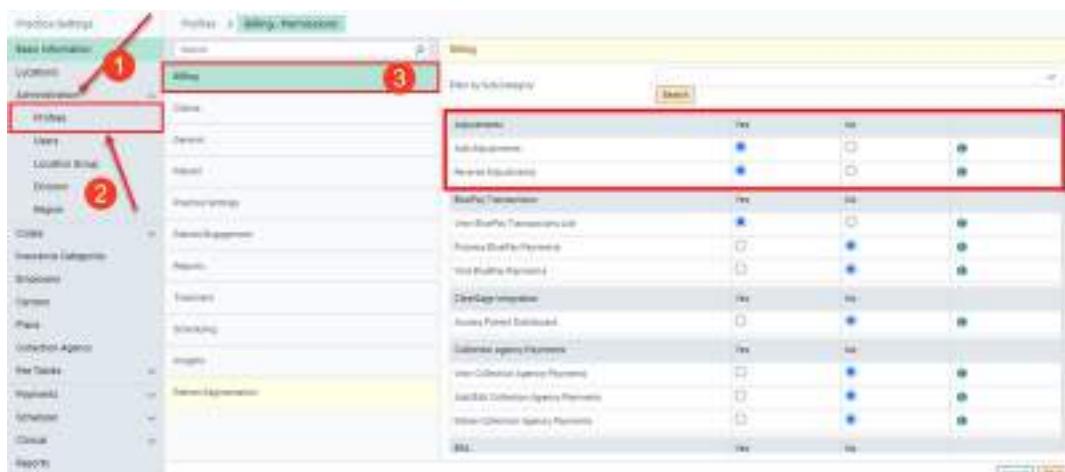
CareStack's detailed tracking of procedures, codes, and charges makes for more accurate accounting and a clearer picture of your practice's financial health. To that end, you'll probably make more use of Adjustment Codes in CareStack than in your previous software. Adjustment codes are used to modify the split between carrier and patient or to identify changes in fees. Using specific codes allows your practice to move funds between the carrier and patient and to carefully track that movement and its consequences. In CareStack, each adjustment represents an action to either increase or decrease the amount owed by the patient, by the insurance carrier, or both. In summary

An adjustment is a transaction that corrects or modifies the amount or details of a payment entry. Adjustment codes are used to apply adjustments to patient or insurance charges for them to get reflected correctly in the ledger. Adjustments could be used to write-off balance, to add on extra charges, or to transfer charges from patient to insurance or vice versa. In CareStack, Adjustment Codes are categorized into two:

- **Payment Adjustments codes** are those codes used to alter balances of procedure code while posting payments. They are of two again divided into two:
  - Custom Codes
  - System Codes
- **Claim adjustment codes** are those codes that describe why a claim or service line was paid differently than it was billed. They are a defined list of non-editable codes.

## Permissions

If you are not able to add or reverse an adjustment, then you wouldn't be having the required permission. You can set the Permission from **System menu > Practice settings > Administration > Profile > Manage Permissions > Billing > Adjustments**



## Payment Adjustment - Custom Codes

### How to Create an Adjustment Code?

You can create an Adjustment Code from **System Menu > Practice Settings > Codes > Adjustment Codes > Add**. When you click on **Add**, a new blank grid appears where you need to enter the details and click on **Save**.

Code	Description	Category	Action	Apply As	Profile	Status	Detail
001	Active Codes	Production	Add to Patient	Amount	None	Active	
002	0001-00000000000000000000000000000000	Production	Add to Insurance	Amount	None	Active	
003	0002-00000000000000000000000000000000	Production	Add to Patient	Percentage	None	Active	
004	0003-00000000000000000000000000000000	Production	Add to Insurance	Percentage	None	Active	
005	0004-00000000000000000000000000000000	Production	Decrease from Patient	Amount	None	Active	
006	0005-00000000000000000000000000000000	Production	Decrease from Insurance	Amount	None	Active	
007	0006-00000000000000000000000000000000	Production	Decrease from Patient	Percentage	None	Active	
008	0007-00000000000000000000000000000000	Production	Decrease from Insurance	Percentage	None	Active	
009	0008-00000000000000000000000000000000	Production	Transfer to Patient	Amount	None	Active	
010	0009-00000000000000000000000000000000	Production	Transfer to Insurance	Amount	None	Active	
011	0010-00000000000000000000000000000000	Production	Transfer to Patient	Percentage	None	Active	
012	0011-00000000000000000000000000000000	Production	Transfer to Insurance	Percentage	None	Active	
013	0012-00000000000000000000000000000000	Production	Add to Patient	Amount	None	Active	
014	0013-00000000000000000000000000000000	Production	Add to Insurance	Amount	None	Active	
015	0014-00000000000000000000000000000000	Production	Decrease from Patient	Amount	None	Active	
016	0015-00000000000000000000000000000000	Production	Decrease from Insurance	Amount	None	Active	
017	0016-00000000000000000000000000000000	Production	Decrease from Patient	Percentage	None	Active	
018	0017-00000000000000000000000000000000	Production	Decrease from Insurance	Percentage	None	Active	
019	0018-00000000000000000000000000000000	Production	Transfer to Patient	Amount	None	Active	
020	0019-00000000000000000000000000000000	Production	Transfer to Insurance	Amount	None	Active	
021	0020-00000000000000000000000000000000	Production	Transfer to Patient	Percentage	None	Active	
022	0021-00000000000000000000000000000000	Production	Transfer to Insurance	Percentage	None	Active	

PS: On the above picture, "Add" is greyed out as it was already clicked and you can also see a bank grid there to be completed.

Now let's take a look into the field in each code.

- **Code:** A short name that is easy to recognize when viewing the adjustments made. Type the Code that will identify this Adjustment in CareStack modules and reports. You have four to six characters to use. Many practices use the best abbreviation they can.
- **Description:** A description to explain or clarify the purpose of the code. It should be descriptive since users will select the code during billing processes based on this description and the code
- **Category:** You can choose the category like adding this adjustment as a production adjustment or as a collection adjustment.
  - **Production adjustments** are those given for the codes from the practice side without any receipt. Use Production adjustments if the increase or decrease should affect how much is considered earned from the charge.
  - **Collection adjustments** are the adjustments made against the payments collected either from the patient or from the insurance. Use Collection adjustments if the increase or decrease should affect how funds are brought in from the practice
- **Action:** Select whether this adjustment will deduct from, add on, or transfer the credits from the patient or insurance receipt. Let's see what each action does. This action describes whether the patient or insurance portion will be increased or decreased.
  - **Add to patient:** Increase the patient component.
  - **Deduct from patient:** Decrease the patient component.
  - **Add to Insurance:** Increase the Insurance component.
  - **Deduct from Insurance:** Decrease the Insurance component.
  - **Transfer to Patient:** Reduces an amount from the Insurance component and adds a corresponding amount in the Patient component
  - **Transfer to Insurance:** Reduces an amount from the Patient component and adds a corresponding amount in the Insurance component
- **Apply As:** Select whether you want to apply this adjustment as an amount (dollar figure) or as a percentage.
- **Profile:** You can give the user profiles that can use this adjustment code.

Once you fill in all the details and click on **Save**, you get a green toaster as shown below indicating that the adjustment codes are added successfully to the system.



To **Edit an Adjustment Code**, click on **Edit**, and all the fields except Code would be editable. Once you have made the corrections, you can go ahead and click on **Save** which will save the changes with a green toaster that says Adjustment codes updated successfully.



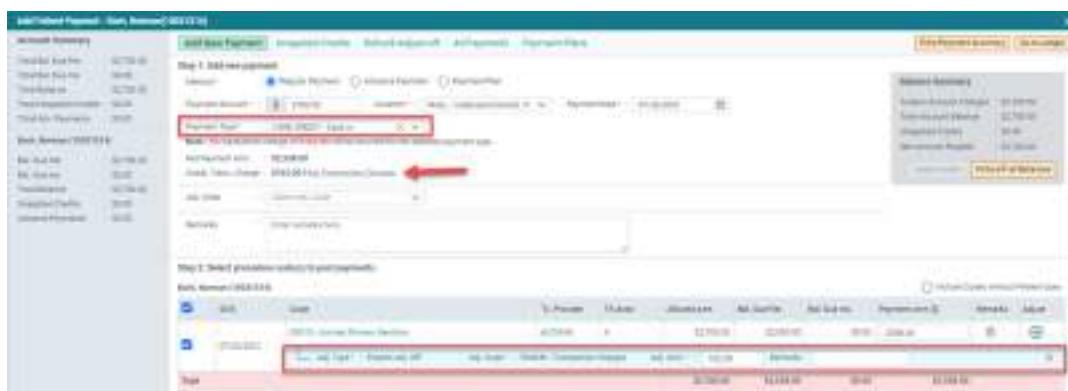
You can **Deactivate** an active plan (or vice versa) by clicking on **Deactivate (or Activate)** to the side of the corresponding code. Or if you want to Deactivate more than one code at a single go, then you may **select the codes > Action > Deactivate**.

Adjustment Action	Result	Common Use
Add to Patient	Increases the patient's portion of the charge.	Pass fees to patients such as NSF fees.
Add to Insurance	Increases the insurance portion or allowed amount.	Insurance overpays compared to estimate.
Deduct from Patient	Reduces the patient's portion of the charge.	Discounts or promotions
Deduct from Insurance	Reduces the insurance portion.	Write off Insurance – in-network
Transfer to Patient	Increases the patient's portion AND simultaneously reduces the insurance portion.	Insurance underpaid compared to estimate and the difference should be passed to the patient.
Transfer to Insurance	Increases the insurance portion AND simultaneously reduces the patient's portion.	Insurance overpays compared to the estimate because of an unknown eligibility or coverage issue.

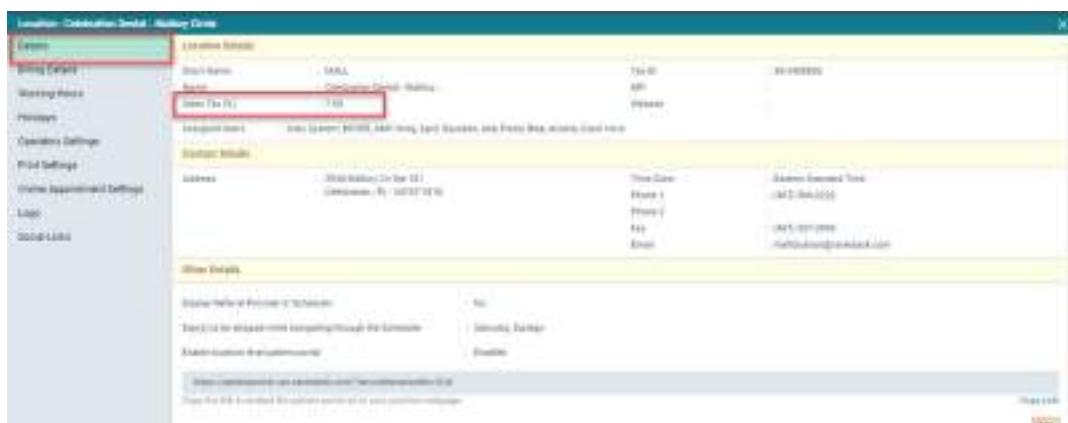
## Payment Adjustment - System Codes

System codes are pre-defined adjustment codes. Let's see one by one.

- **TRNCH:** Transaction charges are production adjustments that are deducted from the patient. That is, they will be added as patient adj off. Suppose we are making a patient payment of \$ 100 and the payment type is Care Credit-Cash in then a transaction charge of 6% will be applied. If we click on “**Post transaction charges**”, then the Adjustment code TRNCH falls for the procedure codes.



- **The ERA adjustment codes(ERATRP, ERA TRI, ERAPOFF, ERA PON, ERA OFF, ERA ON)** are the adjustment codes applied at the time of ERA auto-posting.
  - **AOINS:** Insurance ortho adjustments are production adjustments that are added to the insurance. This is used when we have a patient payment plan for an ortho case and we are adding an insurance payment plan, then the down payment of the insurance payment plan will fall as an insurance Adj. On using this adjustment code.
  - **AOPAT:** Patient ortho adjustments are production adjustments that are added to the patient. This is used when we have a patient payment plan for an ortho case and we are adding another patient payment plan, then the down payment of the patient payment plan will fall as a patient Adj. On using this adjustment code.
  - **STAX:** Sales tax is a collection adjustment that is added to the patient. Sales tax depends on the location and it could be set under **System menu > Practice settings > Locations > Details > Sales tax**. **This code is set as the Default Code for applying Sales Tax in System menu > Practice settings > Payments > General > Others.**



- **PBAL:** The automatic transfer of remaining insurance balance over to the patient's side due to incomplete insurance payment and will fall as the adjustment PBAL. It is a collection adjustment that transfers the balance to the patient.
    - In the example below, you can see that the Insurance paid is \$90 even though the Ins. Bal is \$500. On submitting this, we will get a **pop-up warning** that the amount will be transferred to the patient as an adjustment. So the remaining amount of \$410 will be pushed to the patient side as PBAL.

New Payment										Print Document		
<input type="checkbox"/> Previous		<input type="checkbox"/> Next		<input type="checkbox"/> Previous Period		<input type="checkbox"/> Next Period		<input checked="" type="checkbox"/> Add Line Item Payments		<input type="checkbox"/> Add Client as Down		
Date	Customer	Debit	Credit	Amount	Fee Paid (\$)	Inv Total (\$)	Inv Paid (\$)	Actual	Debit	Credit	Remarks	Object
10/01/2023	BBB LLC - Business Consulting LLC	\$100	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00	\$100	<input type="checkbox"/>	<input type="checkbox"/>	BB	④
<b>Total:</b>		\$100.00	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00					



System adjustment codes cannot be deleted or deactivated and none of its corresponding fields are editable.

## Claim Adjustments

These codes describe why a claim or service line was paid differently than it was billed. These codes could be along with the ERA claim responses. The codes that are displayed here are:

- [Claim Adjustment Reason Codes \(CARC\)](#)
  - [Remittance Advice Remark Codes \(RARC\)](#)

Application of these codes can be seen by navigating to **System menu > Electronic Remittance > Electronic Remittance Advice(ERA) > Select the Receipt > Click on the claim of the patient** and there corresponding to the codes, you'd be able to see the Claim Adjustment codes.

The explanation of the adjustment codes will also be given below on the same page.

The claim adjustment codes could also be seen under Pre-Authorization Remittance. There you can select the Pre-authorization and the patient and you'd be able to see the Adjustment codes, the adjustment amounts, and the explanation of the codes just like in ERA.

The screenshot shows the CARESTACK interface for Pre-Authorization Remittance. On the left, there's a sidebar with various menu items. In the center, a main window displays 'Pre-Authorization Remittance' details. A red box highlights the 'Pre-Authorization Remittance' section. On the right, there's a grid titled 'Pre-Authorization Remittance' with columns for 'Adj Type', 'Adj Code', and 'Remarks'. Another red box highlights this grid area.

Now that we have discussed the different adjustment codes and how to add them, we have to see where we need to apply these codes. So let's think like this. Why do we need adjustments or where do we need to apply them? Yea.. you are correct, we apply them while making a payment- Patient Payments or Insurance Payments or you can simply add an adjustment to a procedure like a Production Adjustment.

## Applying Payment Adjustments

**Case 1: While posting Patient payments.** Under Billing > Payments, you would be able to apply the adjustment for each code separately by:

- Clicking on ‘+’ to the side of each code. When you click ‘+’, a grid opens below the code where you can enter the Adjustment type, the Adjustment Code, and Remarks(not mandatory)

The screenshot shows the CARESTACK interface for adding a new payment. It's divided into two main sections: 'Step 1: Add new payment' and 'Step 2: Select procedure code(s) to post payment'. In Step 1, there are fields for Payment Amount (\$194.00), Payment Type (Check Payment Type), and other details. In Step 2, a grid lists procedure codes (008, 0110, 0114) with their descriptions and payment details. A red arrow points to the 'Add Adjustment' button in the bottom right corner of the payment grid.

- When you add a new payment and apply it against codes, you could add an adjustment to the total by adding an **Adj code** just below the Payment Type. If you enter the amount here, the amount would be split for the codes and reflect below the codes just like we add an adjustment by clicking on ‘+’.

Add New Payment | Unapplied Credits | Refund Adjustment | All Payments | Payment Plans | Post Payment Summary | Go To Ledger

**Step 1: Add new payment**

Method:  Regular Payment  Advance Payment  Payment Plan

Payment Amount: \$ 100.00 | Location: HALL | Expression: Serial # | Payment Date: 01/12/2023 |

Payment Type: CASH |  Paid By

Adj. Code:	40006 - ADJ-BAT-Closure	IC:	Adj. Amount:	\$ 10.00
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Remarks: Enter remarks here.

**Step 2: Select procedure code(s) to post payments.**

HCPCS, Draft (00001-0999)

Code	Description	To Physician	To Office	Allocated Amnt	Bal Due Fiz	Bal. Due Inv	Patient Adj (2)	Remarks	Adjust
<input checked="" type="checkbox"/> 000	000			\$100.00	\$100.00	\$0.00	<input type="button" value="..."/>		<input type="button" value="X"/>
<input checked="" type="checkbox"/> 07115-000	07115 - Arterial Thigh Surface	ACTRMAN	0	\$100.00	\$100.00	\$0.00	<input type="button" value="..."/>		<input type="button" value="X"/>
<input checked="" type="checkbox"/> 07116-000	07116 - Lymphatic Thigh Block Procedure	ACTRMAN	0	\$100.00	\$100.00	\$0.00	<input type="button" value="..."/>		<input type="button" value="X"/>
<b>Total:</b>				<b>\$100.00</b>	<b>\$100.00</b>	<b>\$0.00</b>	<b>\$100.00</b>		

Pmt. Bal. in Selected Codes: \$100.00

Apply to Other Fiz Inv

**Case 2: While posting Insurance payments.** While posting Insurance Payments, we can apply adjustments for codes through multiple workflows. One way to post an adjustment would be while posting insurance payments at a line by selecting a receipt > Select the patient > Enter the amount > Click on + and add an adjustment in the line level posting flow.

Add New Payment | Unapplied Credits | Refund Adjustment | All Payments | Payment Plans | Post Payment Summary | Go To Ledger

**Step 1: Select codes to post payment items.**

Select	Procedure	Patient	Office	Allocated	Bal Due Fiz	Bal. Due Inv	Patient Adj (2)	Remarks	Adjust
<input type="checkbox"/>									

No Results Found

**Step 2: Select procedure code(s) to post payments.**

HCPCS, Draft (00001-0999)

Code	Description	To Physician	To Office	Allocated Amnt	Bal. Due Fiz	Bal. Due Inv	Patient Adj (2)	Remarks	Adjust
<input checked="" type="checkbox"/> 000	000			\$100.00	\$100.00	\$0.00	<input type="button" value="..."/>		<input type="button" value="X"/>
<input checked="" type="checkbox"/> 07115-000	07115 - Arterial Thigh Surface	ACTRMAN	0	\$100.00	\$100.00	\$0.00	<input type="button" value="..."/>		<input type="button" value="X"/>
<input checked="" type="checkbox"/> 07116-000	07116 - Lymphatic Thigh Block Procedure	ACTRMAN	0	\$100.00	\$100.00	\$0.00	<input type="button" value="..."/>		<input type="button" value="X"/>
<b>Total:</b>				<b>\$100.00</b>	<b>\$100.00</b>	<b>\$0.00</b>	<b>\$100.00</b>		

Unapplied in Selected Fiz: \$0.00 Pmt. Bal. in Selected Codes: \$100.00 Difference Amount: -\$100.00

**Case 3: While posting Collection payments.** While posting Collections Payments, we can apply adjustments for codes either as a Patient Adjustment or as Collection Commission both impacting just the patient's balance.

## Reversing Adjustments

**From the Code Snapshot:** If you want to reverse a wrongly posted adjustment, you could the procedure code on which the adjustment has been posted and then click the X icon beside the adjustment row to reverse it. **An adjustment can be reversed only if it is the last transaction that has been applied on that particular code.** When you click on the 'X' mark, a confirmation pop-up comes on the screen. Click on **Proceed Anyway** to continue.

This screenshot shows the 'Insurance Payments' screen with the 'Code' tab selected. The right pane displays a grid of payments against a code. A red arrow points to the 'X' icon in the 'Actions' column of the grid, indicating where to click to reverse an adjustment.

This reverses the Adjustment made against the code.



Once the Adjustment is reversed, a green toaster could be seen on the top right which says that the transactions are reversed successfully.



**From the Code tab in the Right pane in the Insurance Payments screen:** When posting payments at a line level, clicking on any of the editable fields of the code, you'd be able to see the payments made against the codes on the right pane under 'Code'. From there, you can click on the 'X' mark to reverse the payments just as we discussed above.

This screenshot shows the 'Insurance Payments' screen with the 'Code' tab selected. The right pane displays a grid of payments against a code. A red arrow points to the 'X' icon in the 'Actions' column of the grid, indicating where to click to reverse an adjustment.

## Partial Reversal

When an adjustment of action "**Deduct from patient**" or "**Transfer to Insurance**" is added to a procedure code, it should reduce the total patient receivables of that procedure code. Similarly, when an adjustment of action "Deduct from Insurance" or "Transfer to Patient" is added to a procedure code, it should reduce the insurance receivables of that procedure code. This should be done while posting adjustments while adding either patient, insurance or collection payments

If the posted payment amount **exceeds the net receivable** after posting adjustments, the excess payment amount should be reversed back into the original payment receipts. If payment was done using multiple receipts, the last applied ones will be reversed first.

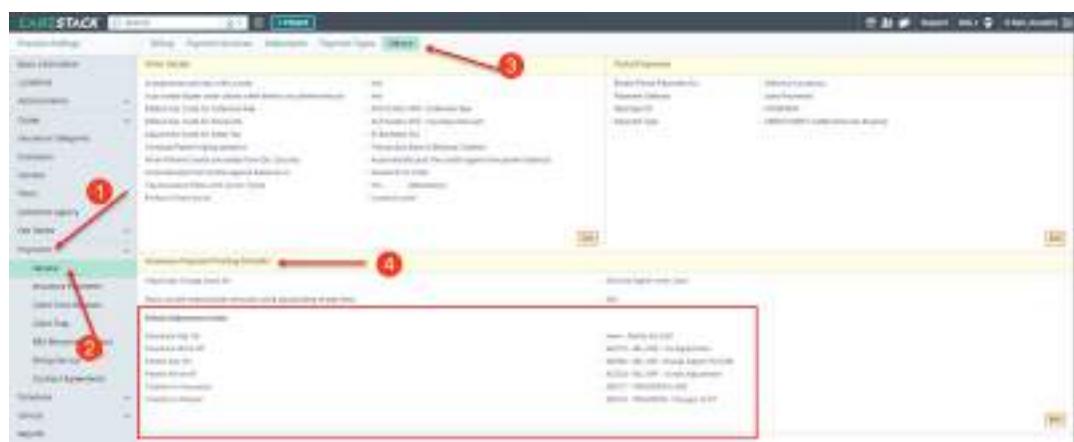
Total of all Credit Adjustments  $\geq$  Patient/Insurance Amount + Total of all Debit Adjustments. Total of "Deduct from Patient/Insurance" and "Transfer to Insurance/Patient" adjustments should not exceed the total receivables for that codes patient component. Total patient receivable is the sum of actual payable and all the "Add to Patient/Insurance", "Transfer to Patient/Insurance" adjustments against the code.

If Total of all Credit Adjustments < Patient/Insurance Amount + Total of all Debit Adjustments, then action would be blocked and a warning, 'The total adjustment amount is greater than the total patient/insurance receivable'.

## Adjustment Code Defaults

Unlike the payments screen, you would have noticed a difference while adding adjustments to Insurance payments. Yes, when you select the Adjustment Type an Adjustment code automatically fills in the Adj. Code column. This falls by default and this can be set under **System menu > Practice settings > Payments > General > Others > Insurance Payment Posting Defaults**.

Here for each adjustment type, you would have a default adjustment code. You can make changes to that by clicking on **Edit**.



In this picture, you would be able to see two other adjustment codes as well.

**Default adjustment code for collection fee:** The collection Commission in a collection Payment posting is added as an adjustment.

Collection Agency : Big B Agency											
Mr. Profit Test (110000047)		Date	Search	Search	Search	Search	Search	Search	Search	Search	
Date of Service	Code	Technique	Provider	Pmt. Amnt.	Bal. Due Per	Total Pmt (\$)	Pmt To Practice (\$)	Collection Commission (\$)	Ending Balance	Remarks	Adjustments
01/15/2021	001234		APPROV	\$100.00	\$0.00	\$100.00	\$100.00	\$10.00	\$80.00		TEST
Apply											

Entry	Credit	Description	Third Party Balancer	Provider	LOB	Max Allowed	My Limit	Per Unit	Assessing Tech	User Name
FT11112021		Big B Agency - Col payment of 100 to provider by CDRN - Cash from Big B Agency/Bank 01/15/2021 100.00				\$0.00	\$0.00	\$0.00	01/15/2021	01/15/2021
FT12122021		Collection Commission - 01/15/2021 100.00 - Collection Test				\$0.00	\$0.00	\$0.00	01/15/2021	01/15/2021

**Default Adjustment code for Discount:** This code is applied by default when we apply a discount to a code. This can be seen when we **right-click on a recommended or proposed or accepted code > Apply discount > Select the discount Type as Amount**.

**Adjustment Code for Sales Tax:** This code is applied when we sales tax is posted to a code.

### Apply Discount

Discount Type:

 Percentage  Amount

Discount Amount:

\$ 10

Discount Code:

4CB14-ADJ OFF - Courtesy Discount

	Pmt. Est.	Net Est.	Total Fee
Actual Fee	\$86.00	\$0.00	\$86.00
Discount	\$10.00		
Sales Tax	\$0.00		
Net Fee	\$25.00	\$0.00	\$25.00

Discount will not be applied for Pmt. Est = 0.00

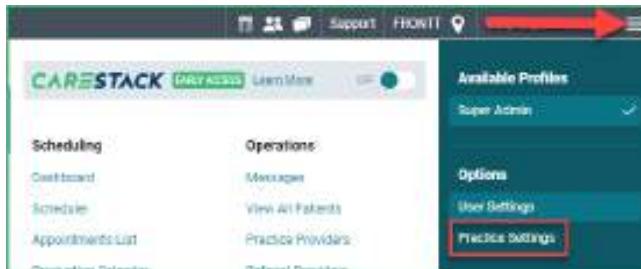
# Carriers

Written by Aaqib Mohammed Sali | Last published at: August 15, 2021

## Adding an Insurance Carrier

Insurance Carriers are entered into the system from your Practice Settings. The carriers entered here will flow throughout CareStack's modules so you can easily select the intended carrier as needed throughout your daily workflows.

1. From your system menu, select **Practice Settings**.



2. When the page loads, select **Carriers** on the left side menu. You'll see a list of all carriers that are currently in your CareStack database. (To update an existing carrier, locate it on the grid, then click it to open the carrier details)

A screenshot of the CareStack 'Carriers' list grid. The left sidebar shows a navigation menu with 'Carrier Details' selected. The main grid displays columns for 'Name', 'Carrier ID', 'Status', and 'Last Update'. There are 10 rows of carrier data listed. A red arrow points to the 'Add' button in the top right corner of the grid area.

3. Click the Add button in the upper-right corner to enter a new insurance carrier.

4. Complete the details for the new insurance carrier:

A screenshot of the 'Add Carrier' dialog box. It has tabs for 'Carrier Details' and 'Carrier Settings'. The 'Carrier Details' tab is active and contains fields for 'Name', 'Name to be printed in forms', 'Claim Channel', 'Pre-Authorization Channel', 'Carrier ID', 'Auto close claims with zero amount', 'Nickname', 'Address Line 1', 'Address Line 2', 'City', 'State', 'Phone', and 'Email'. The 'Carrier Settings' tab is visible but not active. At the bottom are 'Save' and 'Save & Continue' buttons.

- **Name:** This is the name that will appear in the drop-down lists, so use a name that will make it easy for you to identify and select this carrier.
- **Name to be printed in forms:** This version of the carrier name appears on the claim forms so use the formal carrier name.
- **Claim Channel:** Select how the claims should be sent to the carrier, electronically or by paper.
- **Authorization Channel:** Select how pre-authorization requests should be sent to the carrier, electronically or by paper.
- **Carrier ID:** This important number helps the clearinghouse identify the carrier for electronic communication. Each clearinghouse has its own carrier identifier; be sure to use the Carrier ID specific for Change Healthcare found on the [Change Healthcare Payer List](#).
- **Auto close claims with zero amount:** DMO plans often have claims for \$0.00 because many procedures are covered under the capitation umbrella. You can choose to have these claims automatically closed (you will also have this option at the plan level).
- **Nickname:** Adding a nickname helps to identify the multiple addresses for the carrier. For example, carriers might have separate addresses for the east versus the west. If this is the only address, you can use Main.
- **Address:** Enter the address where claim forms should be sent, even when sent electronically. Type the zip code and click Verify to have CareStack populate the City and State.

- **Phone:** Enter the phone number you will use to follow up with the carrier.
- **Website:** Enter the carrier's website details for your reference purposes.

5. If you'll be adding secondary addresses, carrier contact information, or eligibility template information at this time, click **Save and Continue**. This will allow you to enter the remaining information using the tabs on the left of the carrier window (detailed below).

Otherwise, click Save to save this record and move on with your tasks.

## Carrier Details & Carrier Address

The information in these sections will have already been entered in the previous steps.

## Provider Insurance ID

This section will allow you to select the providers that have a contract with the insurance company.

1. Click **Edit > Add** at the top right.
2. Select the **provider** and **location**.
3. Enter their assigned **Insurance ID**, **Medicaid #**, or **Medicare #** to be submitted along with their claims.
4. Hit **Save** when you are done.

## Contact Details

This section allows you to store the contact information relevant to this plan.

## Eligibility Form

This tab allows you to create an Eligibility Form template at the carrier level. Setting eligibility rules provides more accurate fee estimations, as well as providing an alert message that may help the user while treatment planning.

When a new plan is entered into the system under a carrier that has an eligibility form template, the plan will inherit the eligibility rules. This relieves some of the work of entering this information from scratch when entering the new insurance plan; simply review and adjust the specifications as needed.



1. Hit the Edit button at the bottom of the window to make your changes.



2. On this grid, you will find the following columns:

- **Code:** This column lists the code(s) to which the eligibility rules will pertain.
- **Enabled:** Select whether to enable a limitation rule for the selected code(s).
- **Eligibility Rules:** In this column, enter the exclusion or limitation rule for the patient's contracted coverage.
  - **Alert:** Enter an alert message that should appear to the user when treatment planning the selected procedure code.

3. Remember to hit **Save** when you are done.

## Results

If one of the procedure codes has an alert and is treatment planned, a red ( i ) icon will appear next to the code on the patient's chart:

Date	Description	Tooth/Area
	D4341 - Perio Sdg Rt Pln 4+T/P... <span style="color:red;">(i)</span>	UR

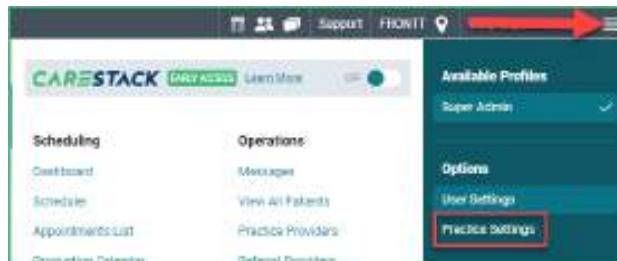
Clicking the icon will reveal the Alert message:



## Merge Insurance Carriers

If you find there are duplicate insurance carriers entered into the system, follow the steps below to merge them:

1. From your system menu, select **Practice Settings**.



2. When the screen loads, select **Carriers** on the left side menu, then click **Merge Carriers** at the top-right corner of the page.



3. In the pop-up window, select the carrier(s) that you want to merge and the destination carrier that they will merge with (destination carrier means it is this carrier the others will be consolidated into).

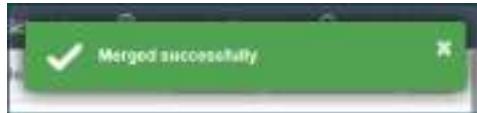


4. Click **Merge** to continue. You will receive the following warning message:

- **Carriers once merged cannot be unmerged.**
- **All the plans of the selected carriers will be transferred to the destination carrier.**
- **The fee schedule assignments may be affected.**

5. If you are sure you want to proceed, click **Ok**.

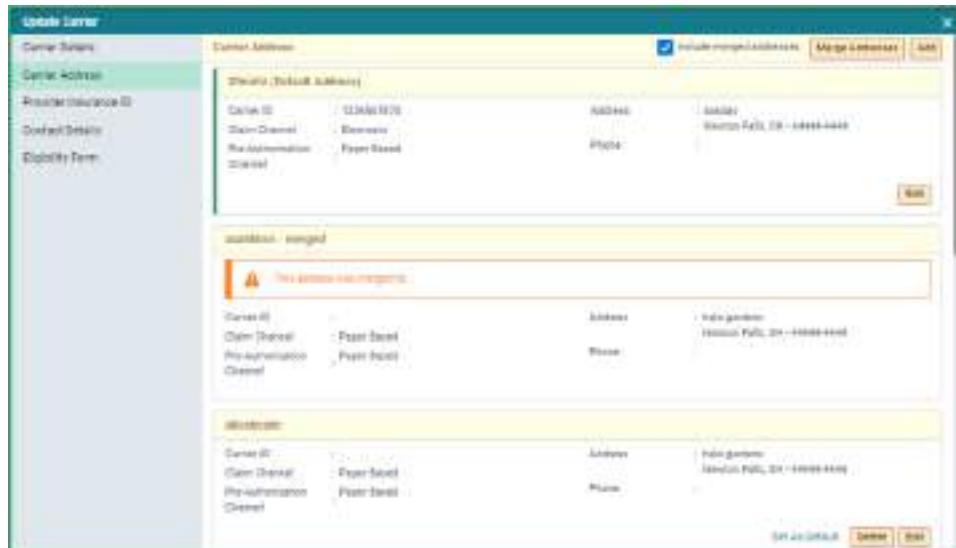
You will receive a green notification message at the top corner of the screen: **Merged Successfully**.



## Next Steps:

1. Search for your destination carrier on the grid and click it to review its details.

- Select the Carrier Address tab. You will find the addresses from the merged carriers listed here. Edit them if necessary, and select which one to use as the default.



2. Review the associated insurance plans and make sure they have the correct fee schedule assignments, or make a new fee schedule assignment.

# User Settings

Written by Aaqib Mohammed Sali | Last published at: August 15, 2021

Your User Settings allow you to save your preferred contact information, set your default settings, create your preferred Scheduler filters, as well as enable phone plugins for integrated use.

- Navigate to your **User Settings** by selecting it from your system menu:



Your User Settings will be organized into three tabs on the left-side panel:

## General

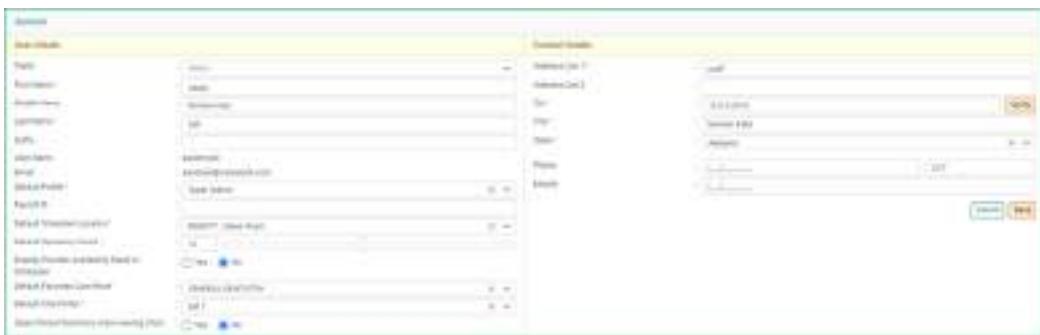
On this tab: Edit your contact info, update your login credentials, and choose your default settings.



## User and Contact Details

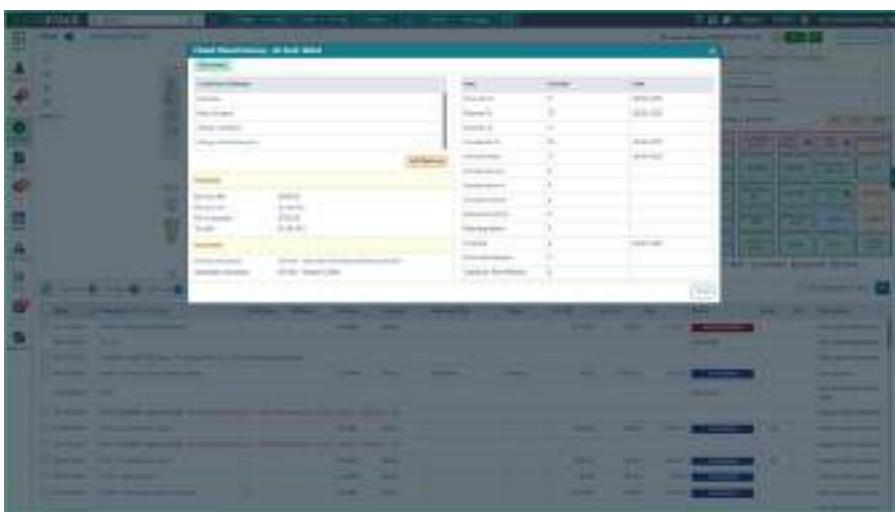
- Click **Edit** to update the information in the User Details and Contact Details sections (*username is not editable*).
- Click **Change Email** or **Change Password** to update your login credentials.

A screenshot of the 'Change Email' dialog box. It has fields for 'Current Email' (aaqib.sali@carestack.com), 'New Email' (disabled), and 'Current Password' (disabled). A note below says 'Entering the email address will result in logging out of all active sessions.' There are 'Cancel' and 'Save' buttons at the bottom.A screenshot of the 'Change Password' dialog box. It has fields for 'Current Password', 'New Password', and 'Confirm Password'. A note above says 'This new password must be different than old password. It should have a combination of uppercase, lowercase, numbers & special characters (@#&%)'. It also says 'It should not be the same as old password.' There are 'Cancel' and 'Save' buttons at the bottom.



## Defaults

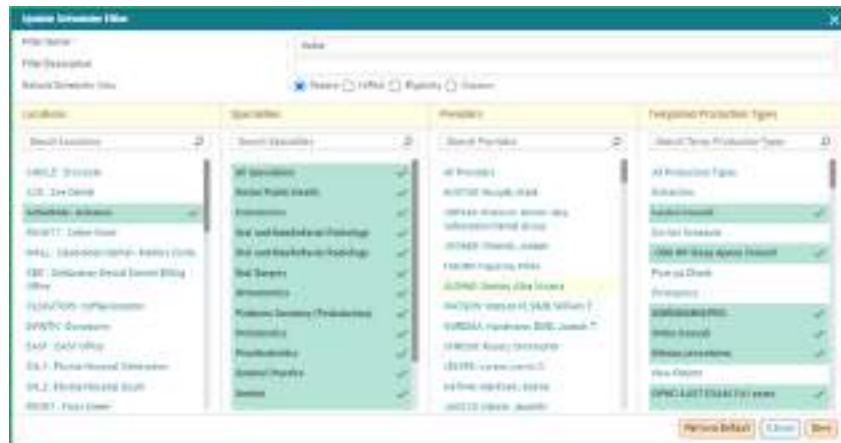
- **Default Profile:** If you have more than one profile type, choose the default that you would like to use upon login.
- **Default Scheduler Location:** Select the default location that you would like to see on the Scheduler.
- **Default Operatory Count:** Choose the number of operatories that you would like to see on the Scheduler (1-20).
- **Display Provider Availability Panel in Scheduler:** This is the vertical column(s) on the left side of the Scheduler that provides insight into provider availability based on scheduled appointments for the day. Choose whether this panel should appear in your Scheduler view or not.
- **Default Favorites Care Panel:** Choose the default care panel that you would like to see or use on the dental charts.
- **Default Chart Filter:** Choose the default filter to see only what you need to see on the patient charts.
- **Open Clinical Summary when viewing Chart:** Select Yes if you would like the patient's clinical summary to appear whenever their dental chart is accessed (pictured below).



## Scheduler Filter

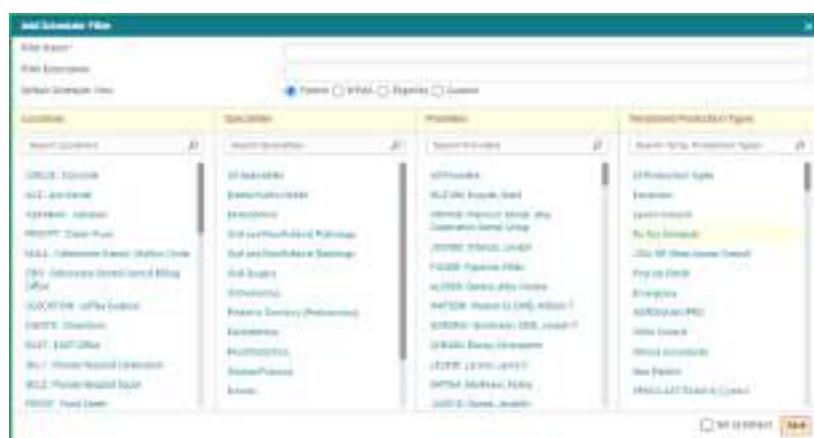
On this tab, you are able to create your preferred Scheduler filters, allowing you to see only the necessary operatories for your daily workflows (such as when confirming/scheduling appointments, verifying eligibility, and so on).

- Edit a Scheduler filter by clicking on it.
- Delete a Scheduler filter by clicking the checkmark next to it, then hit **Actions > Delete**.



To create a new filter, follow the steps below:

1. Click **Add** at the top-right of the screen. The following window will appear:



2. Enter the preferred details for your new filter:

- **Filter Name:** Enter an easily identifiable name for the use of this filter.
- **Filter Description:** Enter a description to help identify the purpose of this filter.
- **Locations:** Select the locations that should be viewable when using this filter on the Scheduler.
- **Specialties:** Select the preferred specialties to see only those operatories when using this filter.
  - When you select a specialty, the Scheduler will only show the providers that have that specialty assigned to them in their Provider Details AND have been assigned to operatories in the selected location(s).
- **Providers:** Select the preferred providers to see only those operatories when using this filter.
  - Make sure the treatment providers have been assigned to the correct operatories by setting this up in the Production Calendar.
- **Templated Production Types:** Select the intended production types to see only those operatories when using this filter.
  - Assign production types to certain operatories and time periods by setting this up in the Production Calendar.

3. Hit **Save** when you are done.

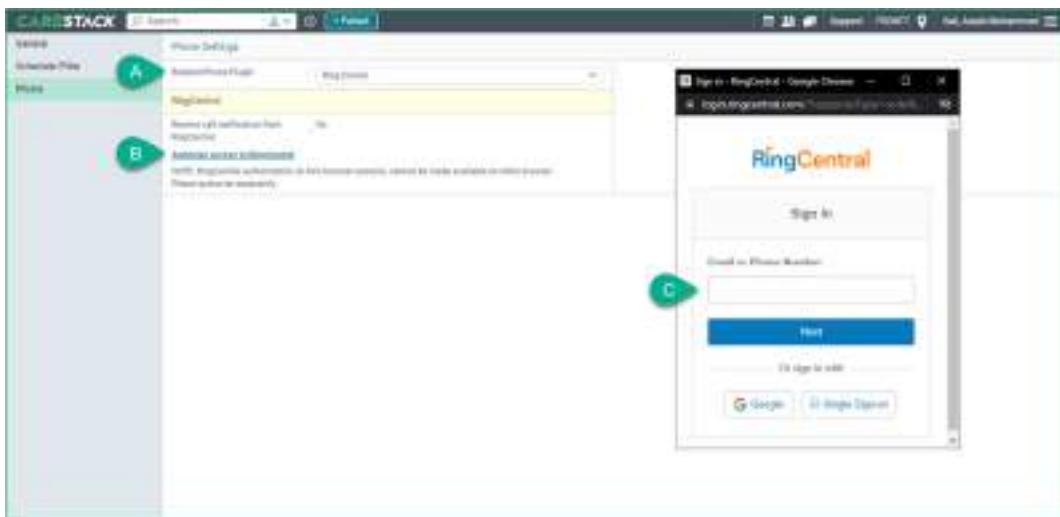
- Create as many filter views as you need to assist you in your workflow, and set one as the default if you so choose.

## Phone

On this tab: Enable a phone plugin (Jive or RingCentral) to integrate with your workflow in CareStack.

- Select your Phone Plugin to enable it.
- Click **Authorize Access** (a window will pop-up).
- Enter your unique login credentials for the selected plugin.

Once this is complete, you can enable the setting to receive a call notification within your CareStack system, allowing you to easily access the patient's record.



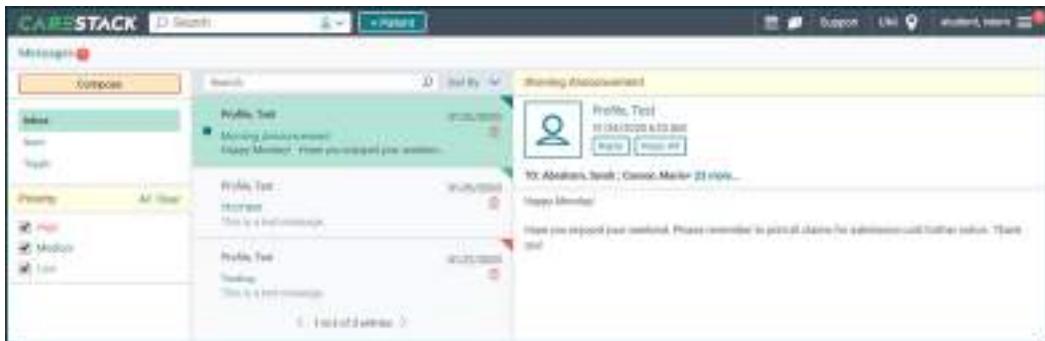
# Office Messages

Written by Aaqib Mohammed Sali | Last published at: August 15, 2021

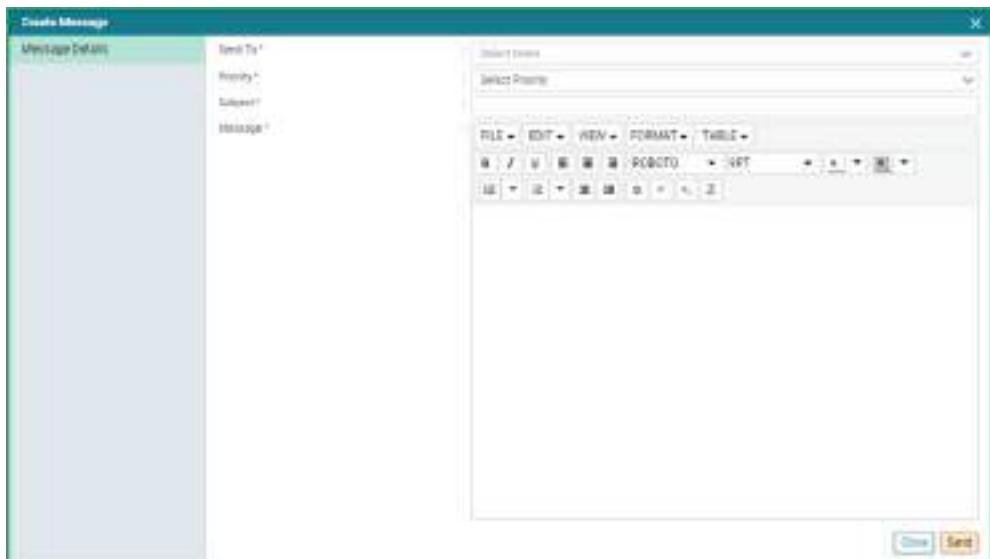
1. To navigate to your Messages inbox, click on System Menu > Messages.



- Unread messages are shown with a teal dot indicator.
- The priority of the message is shown with a colored flag in the corner to indicate the level of urgency. Filter through these messages by selecting or deselecting a Priority on the left side menu.
- Delete a message from your inbox by clicking the red trash can icon next to it.



2. Click **Compose** in the upper-left corner to start a new message. The following window will appear:



- **Send To:** Select the user(s) that this message is intended for (or select All to send to all users).
- **Priority:** Select the level of urgency for this message, whether it is High, Medium, or Low.
- **Subject:** Enter the subject line for this message.
- **Message:** Enter the body of this message and format as necessary using the formatting toolbar.

3. Hit **Send** at the bottom when you are finished. The notification icon will appear with a red indicator on the user's system menu.

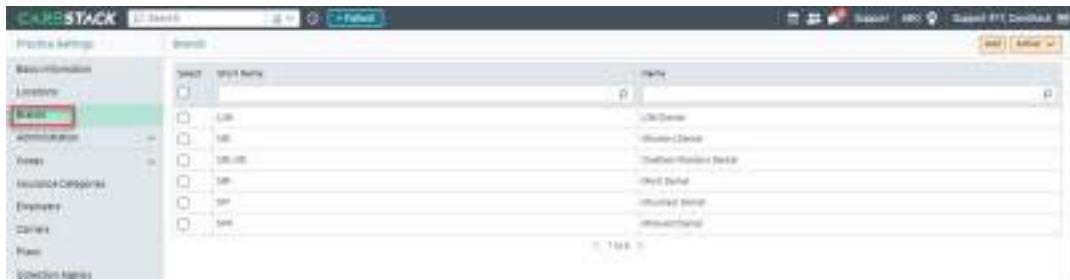
## Brands

Written by Renganathan K | Last published at: August 15, 2021

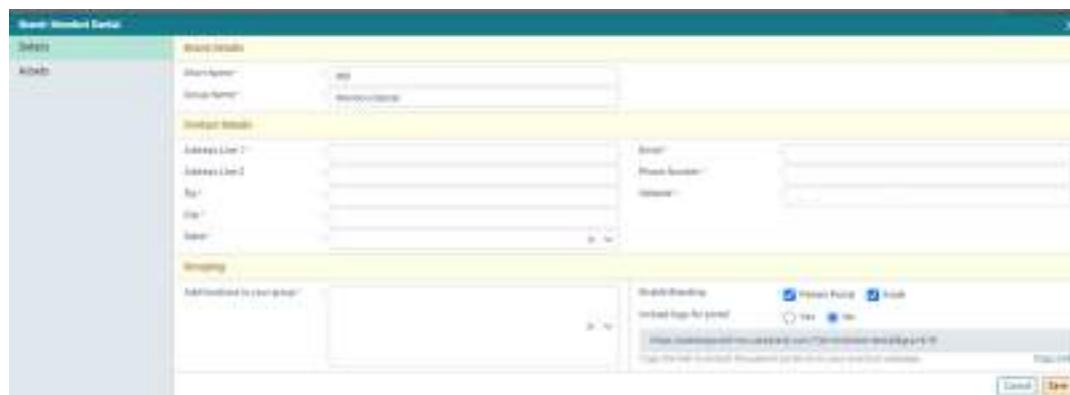
## Brands

Branding to be used in the patient portal and kiosk. On the login and Identification page of the patient portal, we should be able to bring in branding on a group level.

In practice settings, we have a section called **Brands** to list/add/edit location groups. Inside this section, the user will be able to define the group details and group assets along with a list of locations which come under this brand.



Basic details of the brand will include details like name and contact info. Along with this, we will be able to add locations to the brand (A location cannot be included inside multiple groups). Here, the user will be able to enable branding on the patient portal / kiosk (Campaigns will be treated separately since it is independent to PMS but it will be using the same branding provided here). Once we enable branding for the patient portal, we will be able to generate and copy a URL that can be embedded on to the practice website. All the patients redirected from this URL will see group level branding on the patient portal.



## Brand Assets

All the branding related assets go here. These assets will be used for patient portal branding, or while resolving quick links inside patient engagement campaigns. They can choose a brand logo and update the image here.



Embedded content from <https://www.loom.com/embed/2953b5b1466840729311201ba0138f42>



# Periodontal Charting

Written by Megha Jayakumar | Last published at: June 01, 2022

## Objective

Periodontal charting is a way of measuring the space between a tooth and the gum tissue next to it. A dentist or dental hygienist uses an instrument called a probe and gently inserts it into this space. This probe has markings like a tape measure that shows them how deep it can reach into the space to check the health of your gums.

## Users

- o Dental assistants
- o Providers
- o Clinical staffs

## Workflows

There are multiple ways in which you can start a new perio-chart in Carestack.

- o Start a new Perio Chart by navigating to the Perio section of the patient chart (use the global search bar to locate your patient and select the Perio shortcut).
- o Navigate to the Patient Overview, Click on the quick link " Perio Chart" on the overview page.
- o Navigate to Patient Overview page > Clinical tab > Perio chart.
- o Navigate to Patient Overview page > Menu > Treatments > Periodontal charting.

The perio-chart page loads now. If no periodontal exams are recorded, the page will show “ No Prior Perio Examinations”.



Hit " Add" at the top-right. The following window will appear to fill in the exam details.



Provider: Select the treating provider for this perio-chart. By default, the priority is as follows :

- o If the logged-in user is a provider, his/her name will be preselected.
- o If the patient has any default dentist selected, his/her name will be automatically preselected.
- o If both the conditions don't satisfy, the user will need to choose a treatment provider from the drop-down.

Location: Select the treatment location. By default, the patient's default location will be preselected.

Exam Date: The current date will be entered by default, or you can checkmark "**Select a Previous Date**" to select the previous date for this perio-exam.

A new perio-chart gets added. The exam date, provider name, and location of the charting will be shown on top.

Before inputting the measurements, the providers/dental assistants can take a look at the patient's clinical history by clicking on the Clinical summary on the top right. This will open up the clinical slide-out which shows the Patient's latest added prescription, lab cases, allergies and conditions, medications if any, medical history forms.

The 'i' icon below the clinical summary gives the users an idea about what each abbreviation stands for.

Add note will open up the clinical notes modal.

The print will print the perio-chart once the chart is finished or else the Print button will be greyed out.

You can record the following gum measurements into the system :

**1. Pocket Depth:** Pocket Depth is the most important variable for evaluating the health of a pocket. PD is measured in millimeters from the gum line. PD is the most common measurement recorded.

PD will display in color on the chart if it meets or exceeds the alert depth specified in the Practice settings.

**2. Gingival Margin:** Gingival Margin is the area of the gingiva closest to the tooth surface, commonly referred to as the 'gum line'.

GM reflects the recession of the gum line. GM measures from the Cemento-Enamel Junction (CEJ). GM is assigned a positive value when the gum line is below the CEJ and a negative value when the gum line is above the CEJ.

**3. Clinical Attachment Level:** CAL is a calculation of Pocket Depth and Gingival Margin:  $CAL = PD + GM$ . The CAL rating reflects the overall risk of losing the tooth. The higher the CAL number, the greater the chance of losing the tooth.

**4. Mucogingival Junction:** MGJ is the meeting of the thick, protective gingival tissue around the teeth and the friable mucous lining of the cheeks and lips. MGJ concerns the health of the area where the gum tissue and cheeks meet. MGJ is assigned a value between 0-9.

**5. Mobility:** MOB is the amount of mobility a tooth has within its socket, and one of the following ratings is assigned to each tooth. MOB is assigned a value between 0-3.

Grade 0: No apparent mobility

Grade I: Slightly more than normal (<0.2mm horizontal movement)

Grade II: Moderately more than normal (1-2mm horizontal movement)

Grade III: Severe mobility (>2mm horizontal or any vertical movement)

**6. Furcation Grade:** FG is the amount of tissue destruction in areas on a multi-rooted tooth where the roots diverge. FG is measured if the gums have receded enough to expose the roots. FG cannot be measured on anterior teeth because they only have one root.

FG is assigned grade ratings as follows:

1 = Incipient bone loss.

2 = Partial bone loss

3 = Total bone loss with through and through an opening of furcation.

4 = Grade 3 with gingival recession exposing the furcation to view.

**7. Bleeding on probing:** BoP refers to bleeding that is induced by gentle manipulation of the tissue at the depth of the gingival sulcus or interfaces between the gingiva and a tooth. BoP is a sign of periodontal inflammation and indicates some sort of destruction.

**8. Plaque:** A sticky film that coats teeth and contains bacteria. Dental plaque can damage a tooth and lead to tooth decay or tooth loss.

**9. Suppuration:** The production or discharge of PUS.

Enter the number of your measurements in the blue-highlighted box (pictured below). The chart may auto-advance to the next field to help you complete the chart faster (determined by your practice settings). The probing directions and site details are also configured in the practice settings. If a measurement of 10+ is required, Hold the **ALT** key then type the full number. To enter a negative gingival margin, Hold the **ALT** key then type the number.

There will be a note in the top left on editing a perio chart stating 'Press and hold alt key + number key to enter double digit'

The periodontal charting page is divided into four basic sections.

1. Perio chart
2. Numeric chart
3. Perio graph
4. Numeric comparison

## 1. PERIO CHART

There is a Measurement summary box on the right end of the page which captures the following details.

**Tooth #:** Indicating the currently selected tooth

**GM**

**CAL**

**MGJ**

**BOP**

**SUP**

**PL**

**MOB**

#### **Conditions**

**Missing:** Marks the tooth as missing.

**Impacted:** Marks the tooth as impacted.

**Hide 3rd molar:** Hides the 3rd molar from Maxilla and Mandible region.

**Bleeding :** This will open the tooth selector modal and can be used to mark bleeding on multiple teeth.

**Interproximal bleeding:** Conversion of bleeding to a non-bleeding state.

**Bleeding All:** Marks bleeding on all teeth.

The perio-chart will allow the users to enter the following probing measurements :

**Pocket depth (PD) ,Gingival Margin (GM), Mucogingival Junction(MGJ).**

The probing measurements can be inputted into the respective fields by placing the cursor on the required teeth and on the required column or they can use the Measurement summary box on the right side of the page to key in the measurements. Either way, measurements can be recorded. Once it is selected, the selected box will be highlighted in Blue. Users can type in the probing measurements. A colored indication of the depth (based on the practice settings configuration ) will be shown alongside the teeth as you input the measurements. Once a value is entered, it automatically jumps to the next box selecting it in both places. If a measurement of more than 10 is required, hold the **ALT** key and then input the full measurements. If the inputted value exceeds the warning/danger level configured in the practice settings, the entries will be in Red.

**BOP,SUP,FUR,PL** can be inputted by using the measurement summary box on the right side where you can choose the tooth and input as required. Also, another way to indicate Bleeding on probing , Suppuration is by holding B & S when a pocket is selected. This will mark the bleeding sites/suppuration on the selected pocket.

**MOB** can be inserted here separately since Mobility is charted per tooth and not by surface



If a tooth is marked missing / Hide 3rd molar, then the pocket depth boxes and tooth in the Perio chart page will be greyed out. While auto-advancing of pocket depth, the selector will skip if the tooth is greyed/check-boxes are greyed out. The same will be indicated in the patient's odontogram with the condition added accordingly. If the Missing/Hide 3rd molar is unselected, the same will be removed from the odontogram as well.

There is a draw tool inside the perio chart which will let the user draw on the perio chart and the same will be shown in the perio chart print.

Also the dentition shown in the perio chart will be the same shown in the charting page. That is if its a primary dentition, primary will be shown, if it is a permanent dentition, permanent will be shown.



## 2. Numeric Chart

A numeric chart lets you enter all the charting measurements in a single page without the tooth representation in a single go.

## 3. Perio Graph

This tab gives a graphical representation of your pocket depth measurements. Generates graphs based on the previous examination measurements which will help the clinical staff/providers in analyzing the patient's health over a period of time. This is ideal for a visual presentation to the patient. Values cannot be inputted/edited in this tab.



From the above image, the users can choose which measurements are to be compared. From the exam dropdown, the previous examination results can be selected to compare the present perio-chart data.

## 4. Numeric comparison

This tab compares the measurements with the previous exam data in terms of numbers rather than the graphical representation. There is a print icon at the top right that will print the entire numeric comparison page.

Once the measurements are recorded, navigate to the bottom of the chart and click on 'Finish' to save the measurements.

'Cancel' will cancel the whole action. 'Reset' will reset the entire measurements recorded back to how it was created.

A finished perio-chart will be editable only for a day.(Based on the practice setting configuration)

The next time a user tries to add another perio-chart, the latest perio-chart will be displayed by default along with the Exam date, provider associated with the charting, and the location at the top. Exam dropdown will list the previous exams in descending order. We can switch between the various exams using the exam drop-down. Now when a new Perio chart is added, there is an additional checkbox 'Copy from previous exam'. By default, it is unchecked. On checking the box, previous measurements will be copied to the chart and override the existing measurements if any.

The comparison summary displayed at the bottom of the numeric chart is based on the standards defined by  
The American Academy of Periodontology (AAP).

Slight - 1-2 mm

Moderate - 3-4 mm

Severe - >5mm

These are the ranges shown in the numeric chart comparison summary.



## Perio Charting Configuration

Basic perio-chart settings can be configured on a practice level. This is done by navigating to System menu > Practice settings > Clinical > Perio chart > Edit

### 1. Perio Chart

- We can configure on a practice level what measurements(PD,GM,MGJ,BOP,SUP,PL,FUR,MOB) have to be taken by using checkboxes as shown here in the image below. Whether three pockets have to be showed or not, is also configurable.



Drop-down lists down the following four options :

- All sites - Shows all 3 pocket depths
- F/L center only - shows only the central pocket depth on the Facial/Lingual sites
- Lingual center only - shows only the central pocket depth on the Lingual sites
- Facial center only - shows only the central pocket depth on the Facial sites.
- Enable probing for Implants - If enabled, probing measurements are allowed for an implant. If not enabled, the implanted tooth will be skipped.
- Allow editing of perio chart(a day) - When checked, lets the users edit the finished perio chart on the day it was finished.
- Under the Configure depth levels, we can set the warning/danger levels for PD,GM,CAL. When the entries exceed the warning level, users will be notified by inputting the entries in Red while charting.

### 2. Default Provider settings

- Auto Advance - If auto-advance is enabled, the cursor will jump onto the next pocket once a value is inputted. Probing direction can be chosen from the eight diagrams shown in the perio-chart edit window.

- o Select Parameters To Auto Advance - This lets you customize the pocket depth measurements that will be auto-advanced once the entry is inputted.



- o Select parameters to copy from the previous exam - This lets the user configure the measurements that need to be copied from a previous exam.
- o Print chart after finishing exam - If this check box is enabled, the print panel will open up once the perio-chart is marked as finished. If the checkbox to print the numeric chart is also ticked in, both the numeric chart and perio-chart will open up in the print panel.
- o Select data display preference - This setting is used to change the visual representation of depth measurements in the perio-chart. It is up to the practice's discretion to use Bar graph/Line graph/Both to indicate the data visually. Once the changes have been made, click on Save at the bottom to save the changes you have made.
- o Mark Bleeding on - The user can choose between two options, 'Previous pocket' and 'Current pocket'. On choosing previous pocket, when a user is adding a perio exam, the pocket that they had just probed must be marked when user clicks B. On choosing current pocket, when a user is adding a perio exam, the pocket that they are currently probing must be marked when user clicks B. By default, the option 'Previous pocket' must be chosen.

## Impacts

- User should have the permission to View treatments to view the perio-chart
- User should have the permission to Add/Edit treatments to add & edit a perio-chart
- User should have the permission to delete a perio-chart from the Charting page.
- User should have the View/Edit perio-chart to configure the perio-chart settings on a practice level
- If a tooth is marked Missing/Hide 3rd molar, the same will be indicated in the patient's odontogram with the condition added accordingly.
- If the Missing/Hide 3rd molar is unselected, the same will be removed from the odontogram accordingly.

# Dental Imaging

Written by Sarah Abraham | Last published at: August 09, 2021

## Overview

The dental imaging software provides dental practitioners and assistants with a platform for taking and storing dental x-rays and other images. The capabilities of these products can include imaging interfaces, patient browsers, and tools for enhancing image resolution. Dental assistants and dentists themselves will utilize these tools to properly photograph patient's mouths, identify problem areas, map out procedure plans, and track treatment progress. Dental image software often integrates with a variety of cameras and imaging technology, as well as a dental practice management software to help store and organize patient dental records alongside their other information.

CareStack supports various cloud-based and desktop-based clinical software. The main ones are TigerView and SOTA.

## Topics Covered in this Article

- **How to configure desktop-based clinical software.**
- **How to configure cloud-based clinical software.**

## How to configure desktop-based clinical software

- Go to the Charting page.
- Open the clinical software page



- Install the CareStack Link software.
- Then click on the settings icon



- Select the tool
- Define the path
- Click "Add" and close the modal.



Click "Open Imaging Software"

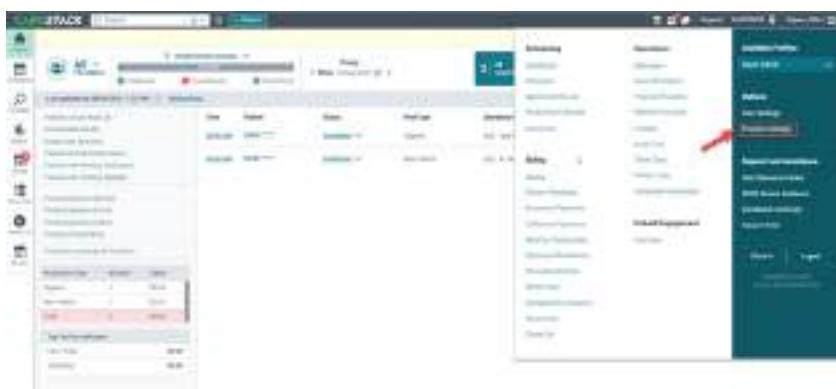


Select the software



## How to configure cloud-based clinical software

Go to Practice Settings.



- Click "Services"



- Click "Configure".
- Enter the username and password.
- Click "Save".



## How to view images from a cloud-based clinical software

- Go to the Charting page.
- Open the clinical software page.



- Click on an image thumbnail from the clinical software page.



The image is open from the clinical software within CareStack.



# SOTA Imaging Software

Written by Sarah Abraham | Last published at: September 28, 2021

## Overview

The SOTA Imaging bridge is a third party imaging software that we support. SOTA Imaging is one of the most efficient offering in the line of cloud-based digital imaging softwares for dental practices. Specifically designed to upload, view, edit, review, store, print, and share images easily and securely between locations, from anywhere in the world, via TLS DICOM.

## Using SOTA

It can be configured for a practice by raising a ticket. SOTA credentials can be set up from the Services tab in Practice settings. Once it is enabled, the user can set up the username and password. These fields are mandatory. We also have the ability to add practice Id to the account as well. This would only be required in the case where there are more than one practice in the instance.



Now when user moves into chart and then clicks on 'Clinical Imaging', the images for the patient are shown as thumbnails. On clicking on the thumbnail or on 'Open imaging software', the SOTA cloud solution is opened.

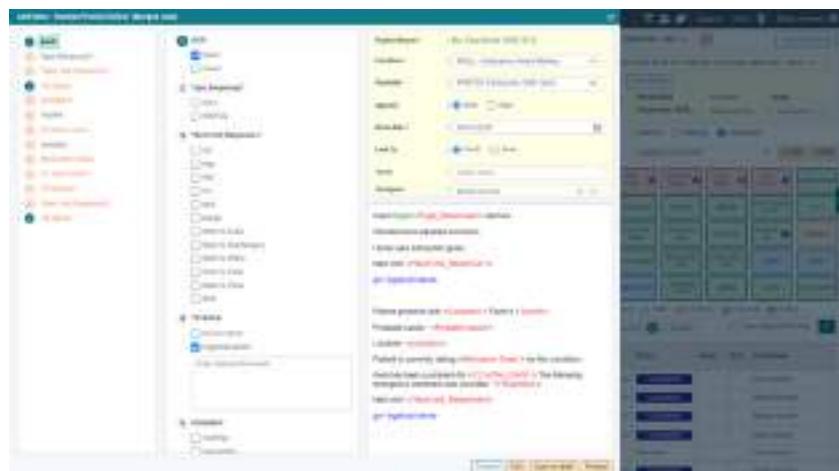


# Care Notes

Written by Nayana Netto | Last published at: August 16, 2021

## Overview

Care Notes are pre-written notes that you'll complete by answering prompt questions with pre-set response options -- just like a multiple-choice question. The notes can be set to launch automatically when certain treatments or conditions are charted. This trigger can be set to launch notes for conditions, or when treatment is planned, and/or completed.



Once the user completes answering the responses, they can either finalize it or Save the note as Draft so that the doctor can review it.

There are 2 ways by which care notes are added:

- Adding note from charting page/perio chart/ortho cases.
- Notes triggered when procedure codes are planned/completed/added as existed.

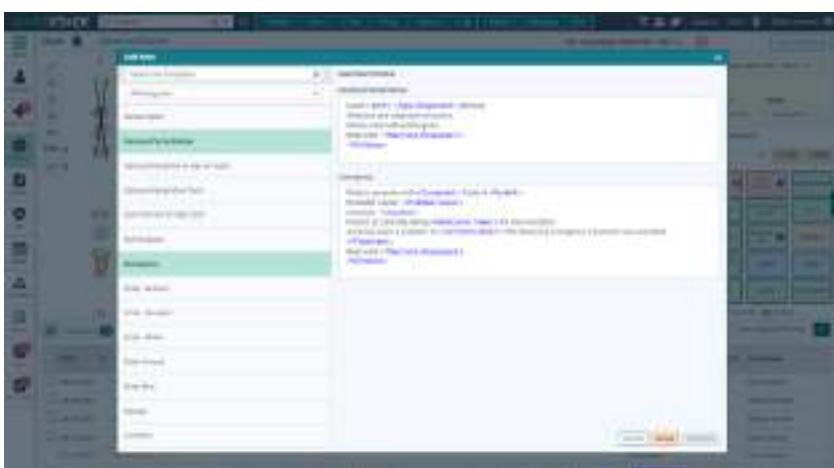
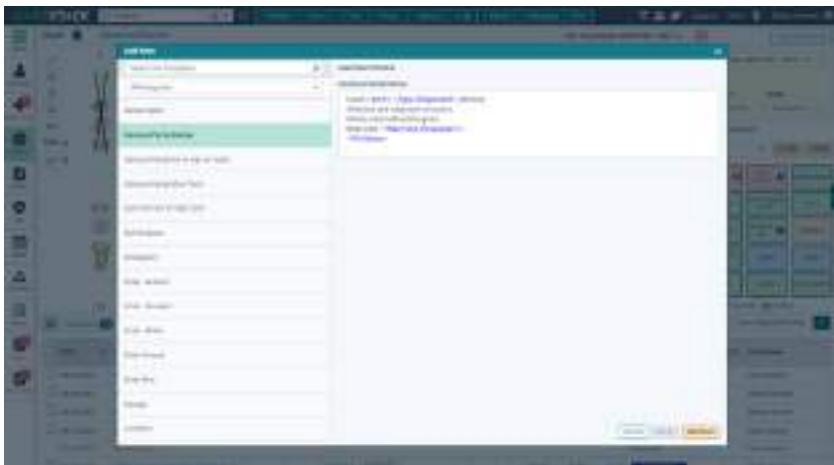
### Step by step to add care note:

1. From the charting page click on '+Note'.



2. Select the note template and from the required category.

3. Click on Add note or user can multiselect notes and choose to merge them.



There are 2 modes:

- In normal mode: When completing a code from the chart ledger or advance planner or appointment details, if there are multiple Care Notes, then a modal with mandatory Care Notes preselected(cannot be deselected) opens. Here the user can select non-mandatory notes by the user. This mode opens all the added notes once the user selected them.
- In burst mode: On the charting page, all the care notes are automatically saved as drafts.Burst Mode/Charting Mode functionality is applicable only to the charting page.

4. Once the note is added, answer the prompt question with one or more of the available answer choices. You may be able to choose a **single answer**, **multiple answers**, or add **custom text**.

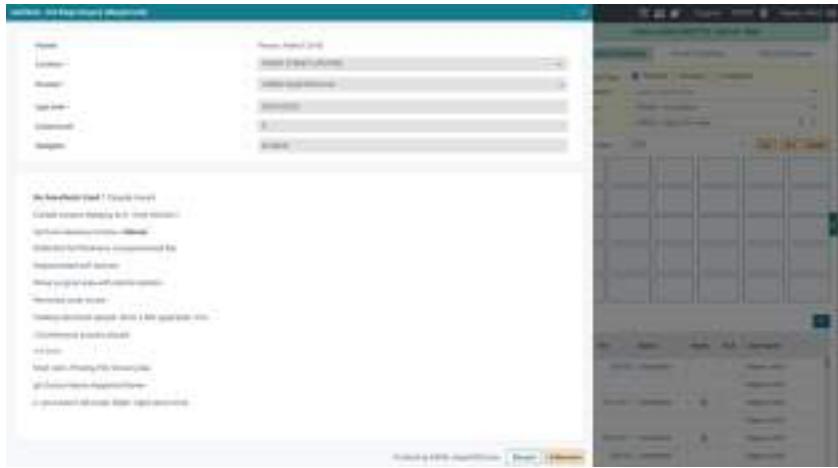
The note contains 3 sections:

- Left pane: contains all the response questions. This section shows an indication for the answered questions, mandatory ones and the questions that are not answered.
- Center pane: Lists down all the responses in a single stretch and the corresponding response type.
- Right pane: contains two main areas where one area shows details like patient name, location, provider, note/appointment date, linked tooth/area and assignee. The other section shows the full description of the filled in responses. The unanswered questions are in red, answered ones in blue and the currently selected response in green.

**Save as Draft:** Allows you to save the answers and return to it later.

**Finalize:** Completes the note so that it cannot be edited or returned to later. If the note requires provider approval, it can only be finalized if the provider is logged in or available to enter the password.

Once finalized, you cannot modify the note, though an Addendum can be added. If you delete a note after it has been finalized, it will still show with a strikethrough.

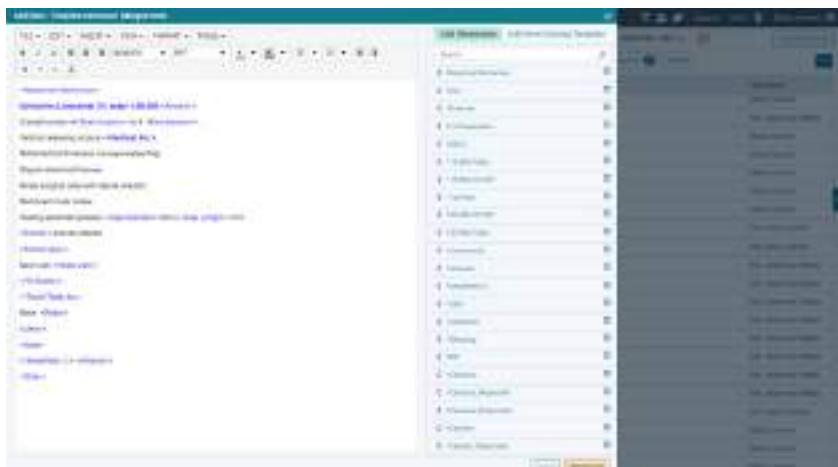


## Editing a Care Note

A user can edit carenote until it is finalized. Edit button will let the user edit the content even if mandatory responses are skipped.

Note: Mandatory responses are the responses that cannot be left unanswered while finalizing a care note.

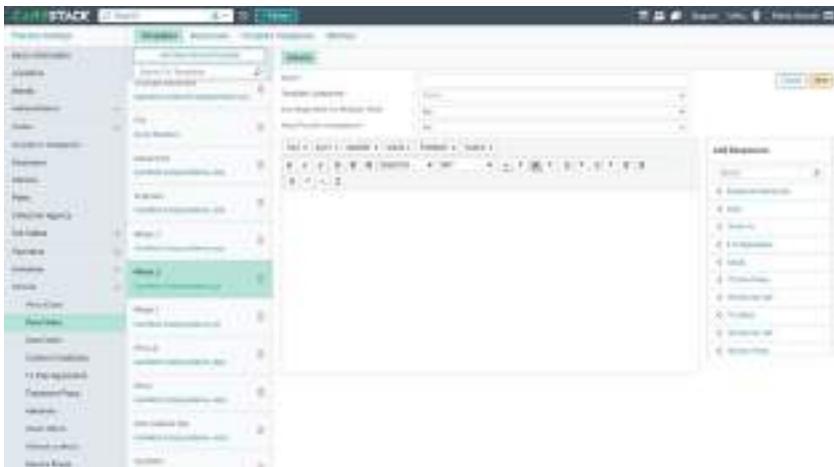
Upon clicking on Edit, the user can edit/delete the contents of the note. Any new responses or a whole new template can even be added to the selected note.



Once all the required actions have been made, click on Update Note.

## **Setting up a template in practice settings:**

- System menu > Practice settings > Clinical > Care Notes.
  - Here the user can create a new care note template.



- The following are the details user can add to the template:
  - Name
  - Template Categories
  - Use Single Note for Multiple Teeth - Yes/No
  - Need Provider Acceptance
- Now description can be added along with the responses.
- Once the note is finalized, users can link items(procedure codes/conditions) to the selected template.
  - With this setting, notes can be set to launch automatically when certain treatments or conditions are charted.
  - Users can set the code/condition status when the note should be triggered(Planned/Existing/Completed).
  - User can also choose to keep the note mandatory, if required.
  - A single entry containing multiple codes: When a user adds multiple codes to a patient, where all these codes are linked to the same care note template, only one entry will be triggered on the charting page.
  - More options lets the user set form rules and field rules.
    - Field rules: Lets the user skip some responses while a specific answer of a response is answered.
    - Form rules: Lets the user set a message to be displayed while a specific answer of a response is answered.

#### **Setting up a response:**

- From practice settings > clinical > Care Notes > Responses tab > Add new custom response.

- The following are the details user can added to setup a response:

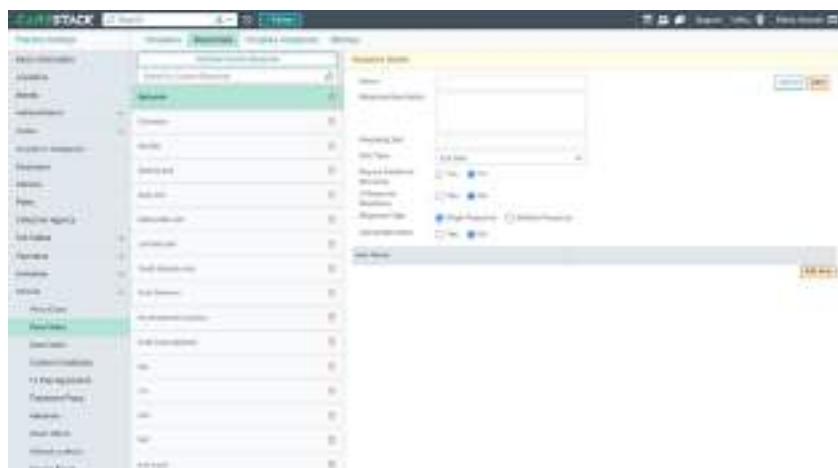
- o Name
- o Description
- o Preceding text
- o Item type
- o Is Response Mandatory - Yes/No

- Item type: Lets the user choose the type of answer the response should have. This includes:

- o List items: This includes radio button and checkbox responses. Selecting list item would display additional fields:

- Require Additional Text Area - Yes/No
- Response Type - Single(radio button)/Multiple(checkbox)
- Use default value - Yes/No

- o Text box
- o Date picker
- o Tooth selector
- o Area
- o Surface



Setting up a category:

- Practice settings > Clinical > Care Notes > Template categories tab > Add New Template Category.
- Here the user can set a new category.

## Care Note Status

Care notes can be broadly classified as:

1. Notes to be started: Notes in which not even a single response is answered.
2. Notes to complete: Notes in which the user has started answering the response but not yet completed.
3. Notes to review
4. Finalized notes: Notes which are finalized.



## Care Note Merge Functionality

Users are given the flexibility to merge multiple care notes (Maximum 10).

What happens while multiple notes are merged?

While notes are merged, they become a single note. All the responses and description of each note gets concatenated into the merged note. Primary note is an important part of merge functionality since some details of only the primary note are retained. These are :

- Location
- Provider
- Date/appt
- Assignee
- Link to field

In order to enable the Merge functionality there is an account level setting which needs to be turned on. System menu > Practice settings > Clinical > Care Notes > Settings > Enable Note Merge - Yes.

Notes can be merged as part of 3 workflows:

1. +Note
2. Code addition workflow
3. Merging existing notes

### 1. +Note

- When the user tries to add care notes from the charting page using +Note button, Add note modal opens. If multiple templates are selected, the Merge button will be enabled but the Add Note button will be greyed out.
- If multiple care templates are selected, the Care note preview section will show the preview of multiple care note responses.
- The order of templates in preview is the same as the order in which the user selects the corresponding template.
- The template first selected by the user is considered as the primary note.
- Upon clicking the Merge button, the merged care note window appears.
- If more than 10 notes are selected, there would be a warning that reads 'Max 10 notes can be selected'.
- Care notes can also be merged from the Perio charting and Ortho cases.

## 2. Code addition workflow

- Notes can be merged while multiple notes are triggered automatically when certain treatments or conditions are charted.
- After selecting the required notes, the user can now merge the selected notes by clicking on the Merge button or add them separately.
- Defining primary note:

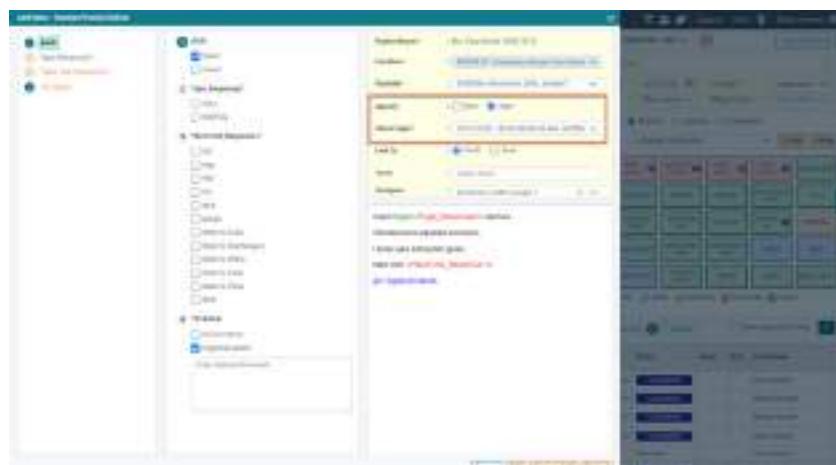
- If only mandatory notes are to be concatenated, the first note in the list is considered as the primary note.
- If the user selects a non-mandatory note, the first selected note is considered as the primary note, even though there are mandatory notes in the list.
- When the user tries to merge notes, mandatory notes selected as default are also considered.

## 3. Merging existing notes

- Users can merge already added notes from the charting page. For this select 2 or more incomplete care notes, by right-clicking on any of these codes, the 'Merge' option is available.
- The note first selected by the user is considered as the primary note.
- Linked to items(tooth/area) of all the selected notes will be listed down in the merged note if the primary note was added as part of the code addition workflow.
- If the primary note was added as part of '+Note', then the 'link to' will remain the same selectable option in the merged note.
- The answered list items of responses of the primary note will be retained.
- Finalized, deleted and clinically locked out notes cannot be merged.

## Linking Appointment to a Care Note

A user can link an appointment to a care note. This is to make sure that all the care notes are completed along with the appointment checkout process.



- Inside a care note, there is a field "Specify" where the user can set a note date or an appointment date.
-

When Specify Appt is selected, the Select appt field lists down the appointments of the patient.

- The list will not contain checked out appointments.
- By default the Note date is selected and the date on which the note is added pre-populates.
- If the user changes this to Appt date, and if there is an appointment for that day, this will be pre populated in the Select Appt field.
- 

If an appointment linked to a note is deleted/cancelled/No show:

- The notes will be delinked, and notify the user about the same.
- If the appointment is deleted the warning message now reads "This will delete the selected appointment, unschedule the associated procedures and delink the care notes linked to it. Are you sure you want to continue ?"
- If the appointment is changed to cancelled/No show, a warning inside the Appointment Status modal, below the checkboxes reads "This will delink the care notes linked to the appointment."
- The date of the delinked note should change to Note date.
- If the notes were finalized before deleting the appointment, Appt date remains the same.
- If an Appt is selected in the Specify field as Appt date, then the Location and Provider of that appointment is populated in the note as the note's location and provider.
- An appointment can/cannot be checked-out if a clinical note is linked to that appointment and a warning can be shown based on the practice setting configuration.

## Practice settings - Appointment settings

- This setting lets the user know that there are care notes linked to an appointment while checking it out.
  - The practice can decide if the user should be able to/not able to checkout an appointment, if there are incomplete/not yet started care notes linked to it.
  - From practice settings > care notes > settings, the user can select the required option for this use case.
  -
- The user can select between:
- Do not warn if linked notes are incomplete.
  - Warn if linked notes are incomplete.
  - Completion of linked note is mandatory.
- Upon selecting Warn if linked notes are completed and Completion of linked note is mandatory, additional options are also displayed.
  - This setting is flexible enough to let the user choose the categories under which the care notes should belong to.
  - The options are Notes to be started, Notes to complete, Notes to review.





### Checking out an appointment:

- - The user cannot check out an appointment if it is linked to care notes that are not yet started/incomplete/reviewed.
    - This is configured by " On checkout : Completion of linked note is mandatory" from practice settings.
    - This enables additional options Notes to be started, Notes to complete, Notes to review.
    - Warning pops up "The appointment cannot be checked out since the linked care notes have not yet been started/completed. Please complete the care notes to check out the appt".
- - The user can either proceed with checking out an appointment or leave it without checking out if it is linked to care notes that are not yet started/incomplete/reviewed.
    - This is configured by " On checkout : Warn if linked notes are incomplete" from practice settings.
    - This enables additional options Notes to be started, Notes to complete, Notes to review.
    - Warning pops up "This appointment has linked care notes that have not been started/completed. Click Proceed to continue to check out."
    - Proceed lets the user proceed with the checkout process.
    - Cancel lets the user cancel the action.
- - The user is able to check out an appointment even if it is linked to care notes that are not yet started/incomplete/reviewed.
    - This is configured by " On checkout : Do not warn if linked notes are incomplete." from practice settings.
    - There would be no warning.

## Reviewing Notes in the Dashboard

Notes that have been saved as a draft are collected in the Dashboard. You land on the Dashboard when you login to CareStack, or you can get there at any time by clicking the CareStack logo in the header bar.



From there, open the notes section:

1. Select Clinical Notes.

2. Select the desired note from the slider.

The selected Care Note window will open. Any prompts that were already completed will be saved and shown in the window.

3. Complete the note as usual by answering the prompts with the pre-set answers and add any information as appropriate.

4. Click Finalize.

5. Click Yes in the warning window to complete and finalize the note.

# Care Audit Rules

Written by Sarah Abraham | Last published at: August 02, 2021

## Overview

Care Audit Rules are instructions in order to assist the clinical practice users to select the appropriate treatments for the patients. For example, D0120, Periodic Evaluation, is mostly eligible for insurance, twice a year for a patient. Or if the practice user wrongly selects D1110 Adult Prophylaxis for a child, if appropriate Care Audit Rule was configured, then a message along with the alternative code will be listed. With the help of Care Audit Rules, the practices can create awareness among its users about this to help them make the appropriate treatments for their patients.

## Topics Covered in this Article

- How to set configure Care Audit Rules
- Impact of Care Audit Rules in the practice workflow

## How to set configure Care Audit Rules

- Select “Care Audit Rules” from Practice Settings.



- Click on Add Rule at the top right corner to create a new rule.



- Select the procedure code from which the Care Audit Rule needs to be configured from “Code”
- Select the “Rule Type” between “Message” and “Alternative code”.
  - If the “Message” is selected, then when the rule is triggered, the message will display.
  - If the “Alternative code” is selected, then when the rule is triggered, along with the message the alternative code will be listed which the user can replace with the original code.

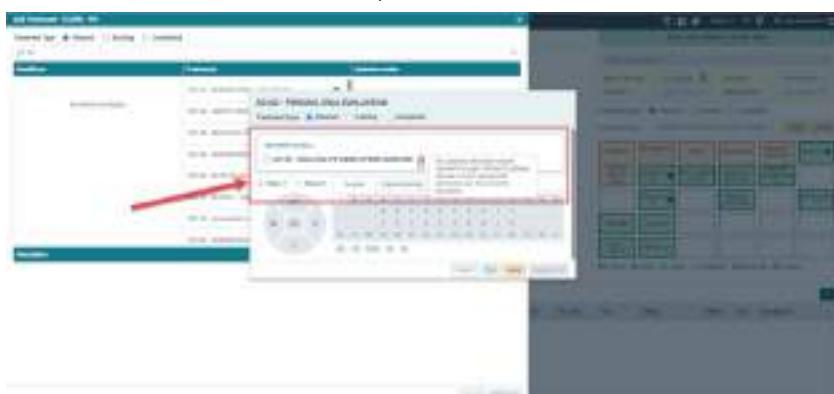
- Click "Save" to save the rule.



## Impact of Care Audit Rules in the practice workflow

- **Addition of treatment procedure**

The user can select the alternative code required



- **Completion of treatment procedure**

The user can select the code and proceed to replace the original code with alternative code.



# Smart Code Logic

Written by Sarah Abraham | Last published at: August 09, 2021

## Overview

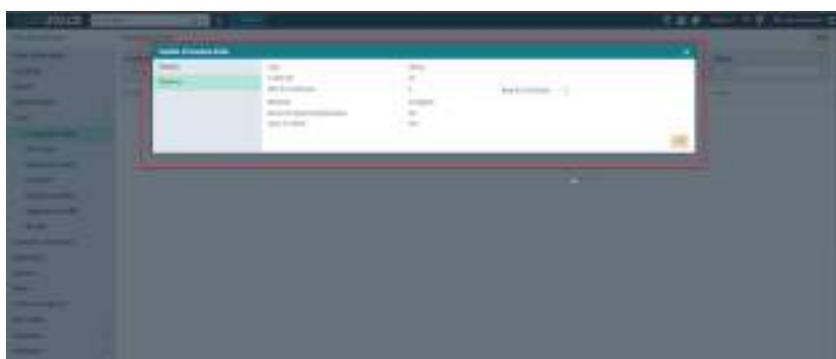
Smart Code is an intelligent treatment addition workflow in CareStack that ensures the correct treatment procedures are planned for the patient for the diagnosed conditions and thereby eliminates claim denial.

## Smart Codes

The system will consider the following attributes for the smart code logic after Apply Smart Code Logic is set to "Yes"

- Service type
- Type
- Applicable to : Tooth / Mouth / Quad / Tooth or Quad
- Tooth set
- Area
- Surface
- Material
- Applicable on up to 3 teeth

For example, here in the below screenshot, the advanced code configuration of **D2140** and **D2150** is shown:



Now when the user tries to add procedure code D2140 to the patient record but selects two surfaces, then D2150 is added instead of D2140 as the system identifies the correct treatment.



Here, in the image below we can see that the code is changed to D2150 as per smart code logic.



This feature thus helps reduce human error and intelligently ensures that the right kind of treatment is provided to the patient.

# Clinical Lockout

Written by Sarah Abraham | Last published at: August 14, 2021

## Overview

In the CareStack system, Clinical Lockout is what keeps your records intact by not allowing any further changes once it's been locked down. Some practices choose to do this monthly, that way all the records are verified correct and then locked down to prevent any further changes going into the next month.

## Enabling Clinical Lockout

This setting can be found in your Practice Settings, then choose Clinical > Clinical Lockout on the left side menu.



Once Clinical Lockout is Enabled:

- Procedure Codes, Tooth Conditions, Patient Documents, and Clinical Notes shown in the dental charting grid will be struck off if they are deleted but have already been previously locked down.
- Clinical Notes will not be editable once it has been locked out.
- Clinical details of a Procedure Code cannot be edited once it has been locked out.
- Clinical details of a Tooth Condition cannot be edited once it has been locked out (but they can be marked as 'Not Applicable' to hide the corresponding drawing from the chart).
- Prescriptions shown in the dental charting grid will be struck off if they are voided but have already been previously locked down.

## Disabling Clinical Lockout

If disabling your Clinical Lockout feature that has previously been enabled, please be aware that your users (with the appropriate profile permissions) will be able to go back and update these clinical details that were previously locked down. This includes: procedure codes, tooth conditions, and clinical notes. The other items that would naturally be struck off from the dental chart while locked-down, users will now be able to delete those as usual once Clinical Lockout is disabled.

# Recalls

Written by Sarah Abraham | Last published at: December 13, 2021

## Overview

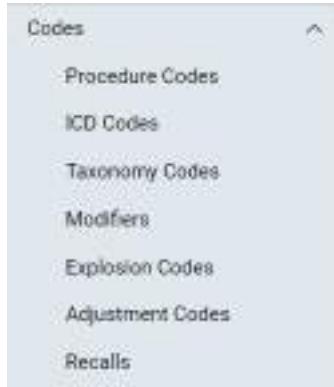
Dental recall is used to call the patient back for the completion of a sequence of procedures which are related to a certain treatment plan recommended by the provider. Recall exam appointments are regularly scheduled checkup appointments that help dentists to have an ongoing knowledge of the status of their patients. This exam is usually done after a regular interval by your Dentist.

## What is a recall?

A provider may examine the patient's teeth and may perform some prerequisite procedures before performing the main procedure. Before the main procedure a waiting period might be required for the right conditions to perform the treatment. Hence, a feature called recall allows the system to automatically recall the patient for conducting the sequential procedure. These settings for the Treatment are set by the provider and would be applied whenever a particular treatment.

## Setting up Recalls in Carestack

In practice settings under the Codes section, we have Recalls listed. We currently provide two types of recalls, procedure code as well as production type recalls. The users have options to trigger recalls based on the type of appointment completed (Production type) as well as when a certain type of procedure is completed (Procedure code).



Here you can add a recall by clicking on the add button and a box would open as shown below.

- Type - Denotes the Recall type, either procedure code or production type.
- Procedures/ Production Type - The procedure code(s) or production type which triggers the recall can be chosen depending on the type selected.
- Recall - Provides the procedure codes which are sequential to the previous procedures, for which recall is required.
- Duration - The waiting period after which the recall for the patient occurs. (years or months or weeks or days can be opted).

Once the recall has been added. You'll be able to see the recall type, procedures/ production type, corresponding recall and the duration of the recall listed in the Recalls subsection.

## Adding Recalls to Patients

Let us consider an example of a patient who requires a Root canal for which an oral evaluation and a 3D image of the teeth are required as a prerequisite for the Root canal procedure. Here, the provider would have to complete the oral evaluation ( D0191) and the recall for the next procedure ( 3D image D0351) has to be made. For this the recall should be added and the duration should be specified.

Appt ID:

Recall Type:

Procedures:  Procedure Code  Production Type

Recall Date:  X: 00:00

Duration:  Months  +1 day

Note: Procedure codes can be linked only against one recall. Codes linked to other recalls are not listed here.

**Cancel** **Save**

Similarly we could configure a recall for the production type, cleaning. This would ensure that a patient comes in for a hygiene appointment at regular intervals.

Name:

Recall Type:

Production Type:  Procedure Code  Production Type

Duration:  Months  +1 day

Note: A production type can be linked only against one recall. Production types linked to other recalls are not listed here.

**Cancel** **Save**

Once we have set the recalls, we can add them to a patient. Recall can be added from 3 different places in the PMS

1. +Recall button in the top bar.
2. Account Summary in the Patient Overview an All recalls button exists
3. Appts > Recalls



When adding a recall to a patient, the user can choose either the production type or procedure code. Depending on the type chosen, all the recalls under the type are listed. The user can choose the date and duration of recall as well as link an appointment. The Linked Appointment associates this recall to a scheduled appointment for that treatment or production type. Status shows whether the Recall is scheduled or unscheduled, if the recall is associated with an appointment then the status changes to Scheduled.

The Visit frequency can be changed for the recall but the corresponding due date will not change. Updating visit frequency, won't update the due date of existing recalls, both in scheduled, unscheduled, and overdue status as changes would only impact recalls added afterward.

Updating the visit frequency for a particular recall, changes the recall duration on the patient level. So once the visit frequency is updated for a recall code, then existing recall's due dates don't change, but when adding a new recall for the same code, the new visit frequency set will be set as the duration.

Even if the duration is changed for that recall code in the Practice Settings, the duration will still be the same as the updated visit frequency duration as this Patient Level change has precedence over the update in the practice settings.

Every time the procedure code linked to a recall is completed or a new appointment with production type linked to a recall is checked out, a new recall is added to the patient with a due date depending on the interval set. This would ensure that the patient is booked and visits the clinic at regular intervals.

## Recall Status

- Overdue: When the current date has crossed the due date. It will be in Overdue status.
- Unscheduled: When due date is a future date.
- Scheduled: When the recall code has been linked to a future appointment, the recall is in scheduled state.

# Prescriptions and DoseSpot

Written by Megha Jayakumar | Last published at: August 16, 2021

## Objective

Prescription slide-out is used by the providers/general users to prescribe medications to the patients.

## Users

- Providers
- Dental assistants
- Hygienists

## Workflows

There are two ways in which you can access the prescription slide-out in carestack. One way is to use the +Presc quick link at the top or the Menu icon > Add prescriptions. This will open the prescription slide-out for the patient.

The prescription slide-out will show the allergies and conditions of the patient along with the details of the current medication the patient is taking at the moment. The patient's allergies and conditions are shown on the basis of the medical history form filled by the patient. The medications taken by the patient have to be entered manually in the prescription slide-out, so that whenever a clinical staff/another provider access this slide-out, they get an idea about the medications the patient is taking.

To add an existing medication

- Click Edit in the grey panel on the right side of the slider.
- Click the +Add New link.
- Complete the medication details. You don't need dosage, just the medication, and dates.
- Click the check-mark to accept the medication

To edit/delete an existing medication

- Click Edit in the grey panel on the right side of the slider
- Click on the pencil icon to edit the medication
- Click on the trash icon to delete the medication

If no prescriptions are entered for the patient, the slide-out will display the message "No prescriptions are added for this patient. Click to add a new prescription".

Prescriptions can be added by the provider either in paper or send electronically using third party vendors ( DoseSpot )

### 1. Paper-Prescriptions

- To add a new prescription for a patient, click on the "Click to add a new prescription" or on the "Add new" button on the top right.
- Add a title to the prescription for your reference
- Choose the provider from the drop-down
- Choose the medications from the drop-down list. Multiple medications can be selected and it will be listed down along with the dispensing details configured in the practice settings ( System Menu > Practice settings > Drugs )
- You can update the dispensing details if required.
- When the State of the system location is Ohio, show Diagnosis also in the prescription detail. (Diagnosis means selected ICD Codes)
- When the State of the system location is Indiana, show Total Quantity Range also in the prescription detail
- Click on Save to save the prescription or Save & Print to save and print the prescription on a new tab.

Once the prescriptions are added, it will display the following details in the Prescription History:

- Title - Displays the title given at the time of prescription addition
- Provider - The prescribing provider

- o The user who added the prescription on behalf of the provider or the provider itself along with the date stamp
- o Copy - lets the provider/dental assistants/hygienist edit/update the dispensing details
  - Click on the trash icon next to the drug to delete a drug from the prescription
  - At least one drug has to be there in the edited Prescription to save the changes or else the following error will occur :



- The updated prescription will show on top of the list as a new separate entry.

- o Void- Equivalent to delete. It voids the entire prescription. Voided prescriptions will not be shown in the prescription history unless the 'show voided prescriptions' checkbox is checked.
- o Print - Prints the drugs in the chosen prescription on a new tab.



## 2. Electronic-Prescriptions

Electronic prescriptions are sent electronically to pharmacies by the use of a third-party vendor DoseSpot. DoseSpot is an E-prescribing platform integrated with our software which lets the practices prescribe medications electronically and save their time and paper.

To configure DoseSpot with your practice, the following are the steps required.

1. Login to <https://pss.dosespot.com/Admin/Account/Login> to create the clinics for the practice
2. The default/accessible locations given in the Google sheet(shared by each practice) are the clinics that you must add in Dosespot. The information about the locations can be obtained from System Menu > Practice settings > Locations.
3. Once the clinic is added into DoseSpot, copy and paste the Clinic ID and Clinic key to the respective locations under System Menu > Practice settings > Services > DoseSpot > Configure > Locations. Set the location status to active in Carestack and Save.
4. Once the locations are added, add the users in the google sheet shared by the practice either as a Prescriber or as a proxy user.User's basic informations are available under System Menu > Practice settings > Administration > Users.
5. Add the prescribing locations for a clinician
6. Once the details are entered, copy and paste the Clinician ID to System Menu > Practice settings > Services > DoseSpot > Configure > Users. This will activate the user in CareStack
7. After this has been done, the Prescribing clinician will have to complete the TFA process and for a non-clinician profile, TFA is not required.
8. Create a Jira ticket to enable DoseSpot services for the client and also create a DoseSpot salesforce ticket for URL Whitelisting.
9. Once the DoseSpot services are configured and URL whitelisting is complete,DoseSpot becomes active for the client and they can start E-prescribing.
10. If any one of the steps mentioned in 3,6,8,9 is missing, E-prescription button will not be visible

To E-prescribe, please navigate to the Prescription slide-out either through the Menu icon or + Presc quick link.

To E-prescribe medications:

- i. Click the E-Prescribe button to link to DoseSpot and synchronize the patient profiles.
- ii. E-prescribe button will be visible only when the logged-in user is active in both CareStack and DoseSpot
- iii. E-prescribe button will be greyed out if the location of the clinic is inactive in carestack and DoseSpot
- iv. Following pop-up will show when clicking on the E-prescribe button if the patient's mobile number /address is not entered in CareStack.



2. The DoseSpot prescription slide-out will appear

- Edit patient info - This lets you add additional patient information
- Add/Edit Drugs Allergies - To add allergies and conditions (Won't be pulled up from carestack)
- Add/Edit pharmacies -To enter the patient's preferred pharmacy

3. In the DoseSpot iFrame, click the Add Prescription button.

4. Select the medication from the drop-down list including the medication strength if required.

5. Review or update the dispensing details as appropriate ( Effective date, Patient directions,Dispense, Refills)

6. Click Save Prescription. You can repeat these steps to prescribe more than one medication.

7. When you are finished prescribing, the added prescriptions will be shown in the Pending medications list.

8. Select the prescription(s) to send and click Approve and Send.

9. Modal will appear asking for the prescribing doctor's Pin and Submit. The prescription will then be sent successfully to the pharmacy.

10. The electronic prescriptions will be listed down in the prescription history along with other paper prescriptions.

## Set-Up

- Drugs can be added to the system by navigating to System Menu > Practice settings > Drugs.
- Drugs can also be added from the Prescription slider > Add new > Add a new drug to the system > Add drug modal appears > Enter the details and Save.

## Impacts

- The prescriptions will be listed down on the charting page but no checkboxes won't be there.
- Clicking on the prescription from the charting page will open the prescription slide-out. On closing the slide-out, the user will stay in the charting page.
- Voided prescriptions will not be shown on the charting page.
- While referring out a patient, prescriptions print out can be attached along with the referral letter
- Logo and details shown in the prescription printout are based on the branding configured in System Menu > Practice settings > Logged in location > Print settings.
- Prescriptions can also be printed using the Print quick link at the top.

# Fee Calculation

Creating, assigning, and calculating a fee schedule

Written by Nayana Netto | Last published at: September 06, 2021

## Fee Calculation

### SCOPE OF THIS DOCUMENT

- Fee schedule
- Assignment
- Hierarchy – Estimation & Billing
- Calculation of fees
- Billing Order
- Fee Auto Re-calculation

### FEE SCHEDULE

Fee schedules are tables which contain the list of procedure codes and fees that can be levied for those codes. Fee schedules can be created in three ways:

1. Manually entering the fees for required procedure codes.
2. Uploading a document in the required format.
3. Copying from an existing fee schedule and then editing.

A particular code may be present in multiple fee schedules with or without a difference in the fees against it. This difference may be due to the difference in:

1. Insurance carrier
2. Insurance plan
3. Plan type
4. Treatment provider
5. Treatment location
6. A combination of any of these factors.

When a fee schedule is created, we capture its name and type mandatorily and along with description which is optional. There are three types of fee schedules which can be created:

1. Max Allowable
2. HMO
3. UCR

*Note: Earlier we had four types. Later PPO and Indemnity fee schedules were merged to form Max Allowable Fee Schedules.*

*(PPO – Preferred Provider Organization; HMO – Health Maintenance Organization; UCR – Usual Customary and Reasonable Fee.)*

If the type chosen is Managed Care-HMO, then the fee for each code has to be entered as insurance and patient component in the columns “Ins. Amt” & “Pat. Amt” respectively.

For Max Allowable, the total fee is entered along with and AMB code if available. AMB (Alternative Minimum Benefit) code is a procedure code which the insurance carrier use to downgrade the insurance of the actual procedure. For example, the insurance carrier may downgrade the payment for a resin filling (costly) with that of an amalgam filling (cheaper).

In every fee schedule, regardless of the type, there is an additional column for capturing “Associate Codes” which are associated with the selected procedure code. In all fee schedules, there are options to enter future fees and a date when that fee becomes effective in replacing the current fees.

If the fee against a procedure code is not given, but an AMB code is given, then the fee of that AMB code can be considered as the fee of the actual procedure. But this is almost a non-existent scenario according to the available information.

*Note: Fees is mandatory for procedures in fee schedules. The above-mentioned scenario can occur only through migrated data.*

## ASSIGNMENT

Fee Schedules are not usable until they are assigned to a particular carrier, plan, provider, specialty, location, or any combination of these. There are certain rules which need to be satisfied when fee schedule assignment is done.

1. While assigning a fee schedule, the Carrier + Plan + Provider/ Specialty + Location + Type of Fee Schedule combination should always be unique.
2. Whenever a fee schedule is assigned to a combination involving plan, type of the plan and the type of the fee schedule should match.
3. If the Fee Schedule selected is of UCR type, then it should be assigned to a provider, location or a combination of both. i.e. no carrier or plan involved.
4. If the fee schedule selected is not of UCR type, then a plan or carrier is mandatory.
5. Any fee schedule can be assigned for a patient, but this is done in the patient's page.

*Note 1: Either a Provider or a Specialty is allowed. Both cannot be used together.*

*Note 2: PPO, Indemnity, Discount PPO and Co-pay should be considered as the same plan type in this context (point 2 above). i.e., It should be possible to assign any (and only) Max Allowable fee schedule to these plan types.*

It is not mandatory to enter a carrier to assign a fee schedule to a combination of factors involving a plan. But when it gets saved, the carrier should be automatically saved along with it.

Since the type of fee schedule is also considered, a combination which involves a carrier (and without a plan) can have a Max Allowable Fee Schedule assigned to it and another HMO Fee Schedule assigned to it. This won't happen if a plan is involved because if a plan is involved, the plan type has to match with fee schedule type.

## HIERARCHY

Hierarchy is an order in which the system should check for fee schedules containing a particular procedure code. For example, if the first rule in the hierarchy is "Plan" and the second rule is "Provider", then the fee schedule for the particular plan (if present) gets priority over the fee schedule assigned for the particular provider.

In other words: Hierarchy is an order set to fetch the most appropriate fee for a procedure code, from a fee schedule which correlates with the available details like – procedure code, carrier, plan, plan type, provider/specialty, and location.

There are two set of hierarchies namely "Estimation Hierarchy" and "Billing Hierarchy".

- The Billing Hierarchy should be used to determine which of the UCR Fee Schedule Assignments should be taken into consideration for the Fee calculation when a claim or authorization is raised. That is while raising a claim or an authorization, the Billing Hierarchy should be run and corresponding fee schedule should be selected.
- The Estimation Hierarchy is used to calculate the fees for a procedure code in every other case. Patient estimates are calculated and subsequently collected using the estimation hierarchy.

An example of an Estimation Hierarchy is given below:

1. Fee Schedule assigned to a specific provider for an insurance plan for a specific location.
2. Fee Schedule assigned to a specific specialty for an insurance plan for a specific location.
3. Fee Schedule assigned to a specific provider for an insurance plan.
4. Fee Schedule assigned to a specific specialty for an insurance plan.
5. Fee Schedule assigned to a specific insurance plan for a specific location.
6. Fee Schedule assigned to a specific insurance plan.
7. Fee Schedule assigned to a specific carrier for a specific provider for a specific location.
8. Fee Schedule assigned to a specific carrier for a specific specialty for a specific location.
9. Fee Schedule assigned to a specific carrier for a specific provider.

10. Fee Schedule assigned to a specific carrier for a specific specialty.
11. Fee Schedule assigned to a specific carrier for a specific location.
12. Fee Schedule assigned to a specific carrier.
13. Fee Schedule assigned to a specific provider for a specific location.
14. Fee Schedule assigned to a specific specialty for a specific location.
15. Fee Schedule assigned to a specific provider.
16. Fee Schedule assigned to a specific specialty.
17. Fee Schedule assigned to a specific patient.
18. Fee Schedule assigned to a specific location.

An example of a Billing Hierarchy is given below:

1. Fee Schedule assigned to a specific provider for a specific location.
2. Fee Schedule assigned to a specific specialty for a specific location.
3. Fee Schedule assigned to a specific provider.
4. Fee Schedule assigned to a specific specialty.
5. Fee Schedule assigned for a specific location.

Note 1: The above hierarchies are used for the examples in this document.

Note 2: They may be different from the ones existing in the prototype or build.

Note 3: In the estimation hierarchy given above, Fee Schedules obtained for 13,14,15,16 & 18 will be of UCR type. 17 can be of any type. And the rest will be either Max Allowable or HMO types.

Note 4: Any fee schedules obtained via billing hierarchy may also be obtained via the estimation hierarchy, but it is not true conversely.

## CALCULATION OF FEES

Fees are calculated after taking into consideration the available data and context. This is driven by the hierarchical setup.

**Step 1:** Identify the required hierarchy – Billing or Estimation hierarchy.

Billing Hierarchy is chosen in the following cases:

1. UCR fees are being calculated.
2. Billed amount is being calculated.
3. Fees are calculated for raising claims or pre-authorization request.

Estimation Hierarchy is chosen for every other scenario, for example:

1. To calculate the patient estimate and insurance estimate in treatment tabs.
2. This is used to calculate the patient payable and insurance payable in payments.
3. To calculate the fees shown in the grid in fee overlay.

**Step 2:** Find the applicable line in the chosen hierarchy. This is done as follows:

1. Take the first line in the chosen hierarchy and check if all the required details as required by the line are available. For example, If the hierarchy says "Fee Schedule assigned to a specific provider for an insurance plan for a specific location", for choosing this the provider, location, and plan (in active status for the date of service) should be available.

2. If the required details are not available, then the next line in the hierarchy is checked and so on.

**Step 3:** Check for the fee schedule according to the applicable line in the hierarchy. This is done as follows:

1. If the applicable line is the third line of estimation hierarchy – “Fee Schedule assigned to a specific insurance plan for a specific location.”, then the plan, carrier, and location available are taken and made as a combination and a check will be done to see if a fee schedule is assigned for the exact same combination. It should also be ensured that the type of fee schedule thus obtained (if available) matches the plan type (HMO fee schedules for HMO plans, and Max Allowable for other plan types).

If the insurance plan type is PPO, Indemnity, Co-Pay or Discount, then the fees can be obtained only from Max. Allowable or UCR type fee schedules.

If the insurance plan type is HMO, then the fees can be obtained only from HMO or UCR type fee schedules.

*Note 1: Here the carrier is taken from the plan details and added to create the combination, just as it was done in fee schedule assignment. This will create a consistency – the carrier will always be considered with the plan.*

*Note 2: Plan type is checked even if only the carrier is taken into consideration (without the plan) as is the case in lines 7,8,9,10,11 & 12 of the estimation hierarchy.*

2. For the hierarchy line number 17 in the sample above, the patient's page should be checked.

3. After obtaining the fee schedule, a check is done to see if the required code is available in that. If it is not available, then the next line of the hierarchy is considered, and so on until a fee is obtained or every line in the hierarchy is done with – whichever occurs first.

**Step 4:** Once the fee is obtained, split it into patient and insurance component if required according to the context. This following section explains how fee split is calculated for each of the plan types and what should happen if there is no plan. Also, the impact of AMB code, Deductibles, Plan maximums will be explained. Overall, fee calculation is a simple process with two steps. First is to find out the fees that can be charged and second is to split it into patient and insurance components.

#### PPO, Indemnity & Discount

- Once the fee is obtained, determine if fee split should be taken or not.
  - If the fee is obtained from Max Allowable fee schedules, fee split should be taken.
  - If the fee is obtained from UCR fee schedules, it depends on account level setting.
  - If fee split is not required due to the above setting or in special cases like "Assign Benefits to Patient", "Raise Claim = No" (Discount is a case under this), calculations can stop with step one and entire amount can be pushed to the patient.
- Check if fee register is enabled for the plan. If yes, the insurance component can be obtained using the fee register. Remaining will be the patient component.
  - If there is a remaining deductible amount for the patient, in the scope of the current treatment plan to which the code is added AND if the deductible is not waived for the code, then fee register cannot be used. Fee registers are essentially a notebook to register the amount paid by insurance the previous time. Hence the calculation for deductible is not possible with it. This is a limitation of fee register.
  - AMB code has no effect with the fee register since the amount paid by insurance is calculated after considering the AMB code.
- If the fee register is not enabled OR if the fee is not present in fee register, fee split should be obtained using the coverage percentages.

1. When the fee for the required code is obtained from a Max Allowable type fee schedule, then the fee should be split to obtain the insurance and patient estimate according to what is set then at first, check if the code has a special coverage mentioned in the plan. If not check in the “Insurance Categories” inside the plan details of the patient. For example, if the amount obtained from the fee schedule is \$100, and the coverage according to the insurance category is 75%, then the patient estimate is \$25 and insurance estimate is \$75.

*Note 1: Insurance categories initially captured in the setup page can be overridden in the plan details of the patient.*

*Note 2: Insurance categories and ADA categories are different, with the latter holding no particular significance in fee calculation.*

*Note 3: Each plan may be using a different insurance category grouping which is set up in practice settings.*

2. If the code is not present in any category and is not assigned a value inside the plan, it should be considered as zero percentage coverage. Then the entire amount should be populated as the patient estimate. In the case of PPO, Indemnity and Discount plan types, fee split can be taken even if the fees were obtained from UCR fee schedule. This is driven through settings.

3. If the fee for a procedure code is obtained from a fee schedule where there is a corresponding AMB code against it, the insurance estimate of the AMB code should be calculated and shown as the insurance estimate of the actual procedure. This amount should be reduced from the total amount of the actual code and shown as the patient estimate.

For example, if the actual code costs \$250, with an AMB code against it which costs \$100 (with a 50-50 split – which means the insurance will pay only \$50), then the insurance estimate should be shown as \$50 and the patient estimate should be \$200 ( $250 - 50 = 200$ ).

4. Whenever a patient component and insurance component is calculated, If there is a remaining deductible amount for the patient, in the scope of the current treatment plan to which the code is added AND if the deductible is not waived for the code, then deductible should be considered for fee calculation as explained below.

5. If no fee is obtained until the hierarchy is exhausted, “\$0.00” should be populated as both patient and insurance component.

6. Whenever the fee is obtained using the billing hierarchy (claims and authorizations), it will be the UCR type (by design) and the fee is not split into any component.

#### Co-pay plan

- Once the fee is obtained, determine if fee split should be taken or not.
  - If the fee is obtained from Max Allowable fee schedules, fee split should be taken.
  - If the fee is obtained from UCR fee schedules, it depends on account level setting.
  - If fee split is not required due to the above setting or in special cases like "Assign Benefits to Patient", "Raise Claim = No", calculations can stop with step one and entire amount can be pushed to the patient.
- If the fee split has to be calculated then check if the fee register is enabled for the plan.
  - If yes, insurance component can be obtained using fee register. Remaining will be the patient component.
    - If there is a remaining deductible amount for the patient, in the scope of the current treatment plan to which the code is added AND if the deductible is not waived for the code, then fee register cannot be used.
    - AMB code has no effect with fee register since the amount paid by insurance is already after considering the AMB code.
  - If the fee register is not enabled OR if the fee is not present in fee register, fee split should be obtained using the table of allowance mentioned inside the plan.
    - Table of allowance gives the Insurance component:
      - Put the fee obtained from the table of allowance as the insurance component.
      - If the value obtained through fee schedule is less than or equal to the value in the table of allowance, the patient component will be zero. Here the insurance component will be the fees from the fee schedule.
      - If the value obtained through fee schedule is more than the value in the table of allowance, the patient component will be the difference. Here the insurance component will be the fees from the table of allowance.
    - Table of allowance gives the Patient component
      - Put the fee obtained from the table of allowance as the patient component.
      - If the value obtained through fee schedule is more than the value in the table of allowance, the insurance component will be the difference. Here the patient component will be the fees from the table of allowance.
      - If the value obtained through fee schedule is less than or equal to the value in the table of allowance, the insurance component will be zero. Here the patient component will be the fees from the fee schedule.
      - In case there is no table of allowance attached to the plan or the procedure code is absent in the table of allowance, then the entire fee goes to the patient.

*Note: In the current implementation, the fee is capped to the value obtained from fee schedule in case the value from the table of allowance is higher than that in the fee schedule. This needs to be validated and maybe the table of allowance should be given more priority.*

- AMB code should not be considered in case of co-pay plans.
- If there is a deductible, whichever is lower among deductible value and total fee, will become the patient component. The rest, if any will be the insurance component.
  - Code A is a treatment code with Fee = X
  - Case 1: Table of allowance gives the insurance component as I.
    - If deductible remaining is zero or if Deductible is waived for the category of the current code, the fee should be calculated normally as mentioned above.
    - If Deductible = D
      - If  $D \geq (X - I)$ , D or X whichever is lower becomes the new patient component P. Insurance component will be  $(X-P)$  or 0 whichever is higher.
      - If  $D < (X - I)$ , then the insurance component will remain as I and the patient component will be  $(X-I)$ .
  - Case 2: Table of allowance gives patient component as P.
    - If the deductible is zero or if  $P \geq X$  or if Deductible is waived for the category of the current code, the fee should be calculated normally as mentioned above.
    - If Deductible = D
      - If  $D < P$ , then P remains as patient component and  $(X-P)$  becomes the insurance component.
      - If  $D \geq P$ , then D or X whichever is lower becomes the new patient component P. Insurance component will be  $(X-P)$  or 0 whichever is higher.
- In any case, if the insurance maximum remaining is burned out, remaining should be pushed to the patient.
- If no fee is obtained until the hierarchy is exhausted, "\$0.00" should be populated as both patient and insurance component.
- Whenever the fee is obtained using the billing hierarchy (claims and authorizations), it will be the UCR type (by design) and the fee is not split into any component.

#### HMO

- For HMO plans, the fee is obtained through either HMO or UCR fee schedule.
  - If the fee for the required code is obtained from an HMO type fee schedule, then the patient estimate and insurance estimate is obtained directly from the fee schedule. There is no need to check the insurance categories (It shouldn't be checked).
  - If the fee split is not directly obtained from an HMO type fee schedule, then the fee obtained from UCR type fee schedules should be populated as the patient estimate and \$0.00 as insurance estimate.
  - There is no case with AMB codes.
  - Deductible - It is not handled currently. If it needs to be handled in the future, then the following details could be used.
  - Compare the patient component and remaining deductible, if the patient component is higher than or equal to the deductible remaining, then there needn't be any calculations. The deductible can be considered as finished.
  - If the patient component is lesser than deductible will become the patient component capped to the total fee obtained by adding patient and insurance components.
  - Insurance Component = I ; Patient Component = P ; Deductible remaining = D
  - Case 1:  $D \leq P$ 
    - New Patient Component = P

- New Insurance Component = I
  - Remaining Deductible after this code = 0.
- Case 2: D > P
  - Case 2.1: D > (P+I)
    - New Patient Component = (P+I)
    - New Insurance Component = 0
    - Remaining deductible after this code = D-(P+I).
  - Case 2.2: D < (P+I)
    - New Patient Component = D
    - New Insurance Component = (P+I) - D.
    - Remaining deductible after this code = 0.
- If no fee is obtained until the hierarchy is exhausted, "\$0.00" should be populated as both patient and insurance component.
- Whenever the fee is obtained using the billing hierarchy (claims and authorizations), it will be the UCR type (by design) and the fee is not split into any component.

#### **General Rules**

- Whichever method is used to obtain fee split, once the individual remaining is finished inside the treatment plan where the codes are added to, the remaining amount should be pushed as the patient component.
- If in any case, while subtracting to obtain a component, the fees become negative, it should be displayed as \$0.00.
- In all cases, fees shown in the grids inside fee overlay should be the fees before deductible and individual maximums are applied. That is, it should be as if there is no deductible and the individual maximum remaining is infinite.
- Sales tax and the discount should not influence any fee calculations including deductible remaining. Both these act as separate adjustments once the code is marked as completed.

#### **Deductible Calculation**

- When there is a code with an AMB code and deductible:
- Code A is a treatment code with Fee = X. Code B is the AMB code with Fee = Y (Ins payable is IP which is obtained using the percentage splits) and the Deductible = Z
- Case 1: When an adjustment is not done (deductible is not applied)
  - Total = X
  - Insurance payable = IP
  - Patient payable = (X - IP)
- If there is a deductible Z, but no AMB code, then (X - Z) has to be split to obtain Q as the insurance component and (X - Q) as the patient component.
- This is working fine
- Case 2: When an adjustment is done (deductible is applied)
  - Total = X
  - Now (Y - Z) has to be split using the percentage for code B. Insurance payable according to this split is Q.
  - Insurance Payable is Q
  - Patient payable is (X - Q)
- This is not working fine as the split is taken for (X - Z) instead of (Y - Z)

Also, in the bottom of treatment plans where the eligibility details are shown please show the value of "Rem. deductible" in red color when it is a non-zero value.

#### **BILLING ORDER**

Billing order gives the type of insurance (dental/medical) to which a procedure code should be raised in claims – primary claim, secondary, etc. If the billing order of a procedure is “DM”, it means that the primary claim for that code should be raised to a dental carrier and the secondary claim should be raised to a medical carrier.

The default billing order for a procedure code may be set in the setup page for codes as either of:

1. Bill to dental(D)
2. Bill to medical(M)
3. Bill to dental then medical(DM)
4. Bill to medical then dental(MD)
5. Do not bill to insurance(N)

This gets reflected in the treatment plan of a patient while adding the codes into it, but only after taking into consideration the existing insurances of the patient.

1. If the billing order says “Bill to dental” then the patient should have primary dental insurance. If not, no value will be displayed. i.e, “D” (Case insensitive). Possible values: D, DD, and N.

2. If the billing order says "Bill to medical" then the patient should have primary medical insurance. If not, no value will be displayed. i.e., "M". Possible values: M, MM and N.
3. If the insurance says "Bill to dental then medical", the patient should have primary dental and medical insurances. Billing order will be "DM". If the patient has only primary dental insurance, then the billing order will be "D" and if not, then no value will be displayed. Possible values: D, DD, DM, DDM, DMM and N.
4. If the insurance says "Bill to medical then dental", the patient should have primary medical and dental insurances. Billing order will be "MD". If the patient has only primary medical insurance, then the billing order will be "M" and if not, then no value will be displayed. Possible values: M, MM, MMD, MDD, and N.
5. If the insurance is "Do not bill to insurance", billing order will be "N". Possible values: N.

Billing order can be overridden in the treatment planning modal window. Validation exists to ensure that the billing order matches with the existing insurances of the patient. Primary, secondary and subsequent claims for the codes are generated according to the billing order. Only codes with the same billing order are allowed on the same claim form. Billing order for a procedure in treatments can be edited only until the first claim is raised for that code. It becomes editable if that claim is void.

Billing order gives the type of carrier to which the claim should be sent. But the form on which the claim is raised depends also on the codes involved. The dental claim form (ADA 2012 or ADA 2002) can be used only for generating claims against dental codes to a dental carrier. For every other scenario, medical claim form CMS 1500 is used. Medical and custom codes (Codes with type 'Other') can be raised only in CMS 1500. It is also used for any claims to a medical carrier.

*Note: The secondary claim doesn't necessarily mean that the claim is being raised to a secondary medical or secondary dental insurance. It just means that a claim is being raised to the carrier suggested by the second letter of the billing order.*

## FEE AUTO RE-CALCULATION

When this feature is turned on, the fees of every planned code gets automatically recalculated whenever a user visits the patient's clinical chart/advanced planner/appointment slide out when the codes are listed down. There is an account level setting to enable and disable automatic recalculation of fees for the account.

- If it is set to Yes to automatically recalculate the fees then,
  - All warnings and pop-up warning the user that there could be change in the fee would be removed from all areas across the system - chart, scheduler, advanced planner, insurance plans etc. The existing warnings would also be removed and fee should be recalculated automatically when an update is made to the provider/location/billing order or tooth#.
  - Whenever a change has been made to any component which could alter the fees for a code, then the fees for that would be automatically recalculated if its in Proposed, Accepted, Scheduled, Hold, Alternative status.
  - Fees would be automatically recalculated at a treatment plan level for all codes whose fee could have changed due to update in the account upon saving update.
  - No warnings will be provided to prompt the users that there would be a change in fee.
  - The fee of a code would be recalculated automatically on code completion.
  - If a user wants to restrict auto recalculation, they can make use of Lock fees functionality.
- If it is set to No to prevent automatic recalculation of fees then,
  - The system would function as it is now with all the warnings and notifications prompting the user that they should recalculate the fees.
  - If an update has been made anywhere in the system that could alter the fees of the codes in various treatment plans then,
    - A warning pop-up would appear prompting the user to initiate the recalculation functionality whenever the user navigates to the treatment plan or to anywhere the code could be seen like the chart or in the appointment details slide out. This should be a blocking warning forcing the user to take action to proceed.
    - Also, a visual overlay would be shown against codes to let the user know that there could be a change in the fees. This indicator should remain against the codes until the user hits the Recalculate button in that treatment plan.
  - At no point would the fees be automatically recalculated for any treatment plan.
  - Warnings would be shown to indicate that the fees may need to be recalculated to get the actual fee on code completion.

### Factors that may impact the existing fee - FEE UPDATION:

1. Treatment level changes - Affecting only the patient

- Updating Attributes of the Code
  - Changing Location or Provider of the code
  - Changing the Billing Order of the code
  - Changing Tooth #
  - Manual Fee updation
- Altering the Treatment Plan and Code Order
  - Reordering of codes within a Tx. Plan
  - Moving of codes from one Tx. Plan to another (drag and drop + right-click)
  - Completing codes in incorrect order not as planned
  - Deleting & Rejecting Codes
- Completing codes for other account members (Causing change in family max and ded values)
- Linking to appointment and code completion

## 2. INS. PLAN LEVEL CHANGES - Affecting only the patient subscribed to that instance of the ins plan

- Changing the associated Insurance Plan
- Updating the Insurance Plan Hierarchy
- Updating Plan Benefits (Maximums, deductibles, dates)
- Updating Eligibility - Limitations and Exclusions Rules - Benefit Remaining Checkbox
- Updating effective and termination dates
- Waiting period

## 3. INS. PLAN LEVEL AND SETUP CHANGES - Affecting multiple patients using that plan

- Updating Eligibility - Limitations and Exclusions Rules
- Updating Coverage Values
- Changing Plan Type
- Changing Benefit Coordination Method and Use Fee Registers for Fee Calculation settings
- Updating Insurance Category Groups
- Updating AMB code section
- Updating the Create Claim option
- Updating Fee Schedule Assignments
- Updating Fee Schedule Hierarchy
- Updating the Fee Schedules / Table of Allowance / Fee Register values
- Updating the Take percentage split for UCR type fee schedule
- Automatic update to fee schedule values on reaching a particular date on which the future fee.

## FEE LOCK

There is a feature to lock the fee of a code which is not in Completed, Referred Out and Referred Out Completed status would need to be added.

- Using this feature the fee for that code would be locked either until it is unlocked manually or until a particular number of days has passed. Once a fixed specific period passes, the fees for that code (if not in completed or rejected status) would be recalculated automatically using a daily running web job.
- This functionality would be brought at both a treatment plan level and at a procedure code level and would be added a new item in the right click menu.
- The fees for the selected code(s) would be locked/unlocked without any additional warnings. If the fee for a code is locked, then the same would be indicated with a padlock icon against that code.
- The fees for a code in locked status would not be updated when recalculated either manually or automatically.
- The lock period would be an account level setting which the practice could set up.
- On code completion, recalculation would be initiated automatically only if the fee for that code is not in locked state.

# Lab-Case

Written by Megha Jayakumar | Last published at: December 13, 2021

## Objective

The Lab cases are used to record and track the lab work being done for your patients. It shows the lab works, laboratories they were sent to, sent date, expected date of arrival, appointments linked etc for a patient.

## Users

- Providers
- Hygienist
- Dental assistants

## Workflows

If a patient's treatment requires a lab, create a case to track the details. This case may be linked to or separate from an appointment. To associate a lab:

1. Select Appts in the patient navigation bar.
2. Select Lab Cases.
3. Click Add Lab Case.
4. Complete the details about your lab case.
5. Click Save or Save & Print
  - For labs to appear in the drop-down list, the lab must be added in the System menu > Practice Settings > Labs
  - Appointment - Lists down all the appointments
  - Provider
  - Sent date - The date on which the order was sent out to the laboratory
  - Due date - Expected date of return
  - Received date - The date on which the order was received by the practice
  - Lab cost
  - Reference # - To track the order
  - Tooth #
  - Tooth shade
  - Notes

You can easily add lab details as you schedule the appointment with the built-in tools.

- Select the appointment block from the scheduler
- Click on Add lab .
- The same add lab case modal opens up
- Complete the details about the lab case.
- Click on Save
- Once the lab case is saved, the lab case information linked to the appointment will be shown on the left grid and the Add Lab changes to Edit lab.

Other ways to add lab cases are by using the +Lab quick link at the top of the patient's profile, by using the Add Lab case under the Menu icon from the patient's profile and from System Menu > Lab cases.

The added lab cases will be listed down in the order it was added, there is a delete and print option next to each lab case. Delete will delete the lab and delink it from the appointment if any. The print will print the lab case. While printing a lab case, Based on the Provider associated with the Lab Case, if that provider has a valid License # in the appointment location, then that value should be shown on the lab case print beneath the Provider's Name. If an appointment is not linked, then the license number associated with the Patient's Default Location should be shown on the lab case print. If no license number is available, then it should be left blank.

By default, received lab cases wouldn't be shown. Once the checkbox is enabled, it will list down the received lab cases also.

## Set-Up

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- Laboratory names are added into the PMS from System Menu > Practice settings > Labs > Add labs.
- Labs can be deactivated but cannot be deleted once added



## Impacts

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- By default, inactive labs wouldn't be shown. Show inactive labs checkbox has to be checked to view deactivated labs.
- In all lab cases, the pending lab case (due date exceeded but not yet received lab cases ) grid will be shown in Hex color #fdddd (Shade of pink)
- Users should have View labs permission to view lab cases
- Users should have Add/Edit lab cases permissions to add/edit lab cases
- Users should have activate/deactivate lab case permissions to activate/deactivate lab cases.

# Codes, Explosion Codes, ICD Codes & Recalls (Configuration)

Written by Megha Jayakumar | Last published at: December 13, 2021

## Procedure Codes

A five-character alphanumeric code beginning with the letter "D" that identifies a specific dental procedure. Each procedure code is printed in boldface type in the CDT manual and cannot be changed or abbreviated. A dentist is also obligated to select the appropriate diagnosis code for patient records and claim submission

## Workflows

### Procedure codes

Users can configure any code-related settings in the System menu > Practice settings > Codes. This page will display the procedure codes added to the system so far. Procedure codes can be added or edited here. To add a new procedure code, click on Add. This will open the Add procedure code modal which contains the following fields :

- o **Code type:** Dental, Medical, or other
- o **Code:** The value of the Code field for all types should be unique.
- o **Description:** The description of the procedure code. For example Amalgam one surface
- o **Service type:** Category of service the code comes under. For example Amalgam restorations
- o **CDT category:** The CDT Code is a set of procedural codes for oral health and adjunctive services that are provided in dentistry. For example: Diagnostic, Preventive, Restorative, etc
- o **Default billing order:** To set the default billing order for a code whether it is billable to dental insurance or medical insurance or both etc.
- o **Effective date:** This determines when the code can be added. The user can choose two options either make Code available for Past Dates or Set a date from which date onwards the code can be added. If the effective date is a future date, the code status will be Inactive until the effective date.
- o **Termination Date:** This determines that from which the code can be added. The user can choose two options: either make Code available for Future Dates or Set a date after which the code cannot be added. When the code gets terminated, the code status will change to Terminated.
- o **ICD Code Mandatory:** If this is checked to Yes a code cannot be added without adding an ICD code first. Only 4 ICD codes can be added to a procedure code.
- o **Is code ortho? :** To let the system know it is an ortho procedure code
- o **Apply smart code logic:** This setting determines whether smart code should run for this procedure code or not.
- o **Use only for patients under 18: The age** restriction for codes that are applicable only to children
- o **Apply Sales Tax:** If this is checked to Yes, a code when added, the sales tax based on the percentage set at location level will be added to that code.

Code Type	Code	Description	Service type	CDT category	Default Billing Order	Effective date	Termination Date	ICD Code Mandatory	Is code ortho?	Apply smart code logic	Use only for patients under 18	Apply Sales Tax	Label
Dental	DD101	Amalgam one surface	Amalgam restorations	Diagnostic	By appointment	From today	From tomorrow	Yes	No	No	No	No	No
Medical				Preventive	From today	From tomorrow	From next week	No	No	No	No	No	No
Other				Restorative	From today	From tomorrow	From next month	No	No	No	No	No	No

### Advanced code settings

Once the above details are entered, click on Save and continue to move to the advanced code settings.

- o By default Type and Application To will be defaulted to Custom and None respectively.
- o The type determines the additional settings required for the code. Following are the types that can be chosen from the drop-down - Crown, Filling, Inlay, Onlay, Bridge abutment, Bridge pontic, Sealant, Veneer, Tooth extraction, Root canal, Implant, Post, Apicoectomy,  $\frac{3}{4}$  crown, Spacer, Pins, Partial denture, Full denture, Core buildup.
- o Only one Material is assigned to a code
- o Codes applicable may have option to select surfaces where user can select Min. and Max. surfaces between 1 & 5. For example Lingual, Mesial, Distal, Incisal/Occlusal(I/O), Buccal/Facial(B/F)
- o Code can be applied either to one of these: Tooth, Mouth, Quadrant & None.
- o Selecting Tooth has additional options such as Primary, Permanent, Anterior, Posterior, Bicuspid, Molar and Custom(this option allows us to select regular/supernumerary primary/permanent teeth of our choice).

## ICD Codes

ICD code is a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs, and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

ICD codes can be added/edited through Practice Settings > Codes > ICD Codes. ICD codes can only be tagged against Procedure Codes. They are also shown in Claim Forms. They can be set as mandatory for a code in code settings.



- o Only Code Version 10 is selected by default. The field isn't editable
- o ICD code field: 10 char limit. Cannot be edited once added.
- o Effective Date: This determines when the code can be added. The user can choose two options either make Code available for Past Dates or Set a date from which date onwards the code can be added.
- o Termination Date: This determines till when the code can be added. The user can choose two options: either make Code available for Future Dates or Set a date after which the code cannot be added.
- o ICD code once added cannot be deleted

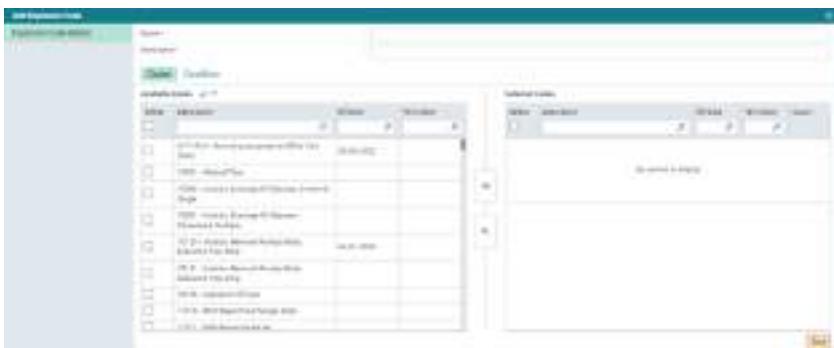
## Touchpoints

- o ICD codes if mandatory are usually asked at the time of code addition for a dental code
- o If a code is billed to a medical insurance and ICD code is set to NO in code settings -, then during code completion, validation will show the ICD code as mandatory.
- o ICD codes are shown in claim forms

## Explosion Codes

Procedure codes are specific and not usually done in isolation. For eg: Before doing a Filing, a cleaning code may be performed. Explosion codes are used to group these codes so that the user does not have to individually add them.

Explosion codes can be added/edited through Practice Settings > Codes > Explosion Codes.



On clicking Add, the update explosion code modal appears.

- o Users can give a name and description based on their treatment requirements.
- o Available codes will display all the procedure codes entered in the system. Users can choose the set of procedure codes to be grouped together and move them to the selected codes section.
- o All codes will be available to add to an explosion code. There is no restriction in any of the codes which can be added.
- o A column named Count is available in the Selected code section where users can specify count between 1- 99. Count dictates no of times a code will be triggered when the explosion code is added.
- o Upon saving the action, a new explosion code gets added to the list. This explosion code will be listed as a separate entry in the code addition slide out.
- o Similarly, this can be done for conditions and they can be grouped together.
- o Providers/clinicians can add a bunch of codes/conditions simply by choosing the explosion code category from the explosion code list in the charting/advanced planner/tx summary page

Explosion Codes	
CHLD PREP/P	
CHLD PREP/P (LAB)	
DRWNS	
DRWNS (EMERG)	
DRWNS (EMERG)	
DRWNS (EMERG)	
DRWNS CUSTOM LAB POST	
DRWNS POST	

Explosion codes can be edited/deleted from the same page. The list can also be sorted based on the name or date modified under the Actions.

## Touchpoints

- o Explosion codes are shown on the Charting page
- o Explosion codes are shown in the Advanced planner
- o Explosion codes are shown in the Treatment summary in the Appointment details tab

The above-mentioned touchpoints will vary with the new code addition workflow.

## Recalls

Procedure codes can be added/edited through Practice Settings > Codes > Recalls.

After the treatment is completed, patients enter the recall system, in which periodic dental appointments are established for the prevention and maintenance of dental health.

Recalls give practices a steady flow of predictable income. Recalls can vary between 3- 24 months usually.

Most services such as prophylaxis, x-rays, and periodic oral evaluations are set as recall codes. Most insurance plans have these services free of cost for patients. These codes are triggered once the base services are performed.



- Type: This is used to add description to a recall code/specify the category of recall
- Procedures: This is used to map the codes for which the recall needs to be triggered. Multiple procedure codes can be selected here.
- Recall codes: The periodic treatment code which follows once the above-mentioned procedure codes are completed. Only one recall code can be selected at a time.
- Duration: Set the time-frequency of the code trigger.  
+1 checkbox sets the recall date one day after the day code was performed (Date of Service). This can override on the patient level.

## Touchpoints

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- Recalls can be added on a patient-level manually ( Overview>Appointments>Recalls slide-out)
- Recalls triggered automatically will be listed here.
- Patient-level settings override the practice level settings

# Treatment Plan (Advanced Planner)

Written by Megha Jayakumar | Last published at: December 13, 2021

## Objective

Treatment planning is used by Tx coordinators to prepare and plan tx plans for the patients once a condition is diagnosed. In large DSO's, treatment coordinators prepare a well-detailed Treatment plan, divided into different phases and present it to the patients on chair.

## Workflows

The advanced planner can be accessed from :

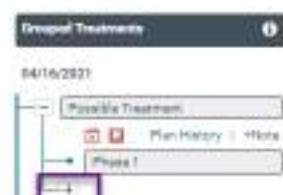
- o Patient overview > Tx plan quick link.
- o Patient overview > Menu > Treatments > Tx planning
- o Patient overview > Clinical > Tx planning
- o Patient overview > Charting > Advanced planner
- o Patient search tool > Tx plan

A new tx plan can be created by clicking on Create a treatment plan. A modal opens up with the following details :

- o Tx plan type
- o Tx plan name
- o Diagnosed conditions - The conditions diagnosed for the patients
- o Tx coordinator - The one who presents the plan to the patient



Once a tx plan has been created, it will be listed under the Grouped Treatments. By default, a tx plan will be created with a single phase. If the user wants to break it down into phases, they can click on the “+” icon to add a new phase into the plan.



- o Alternative Tx plan :- Tx plans created with Alternative as the base status will be indicated by an icon next to the plan name



- o Tx plan details can be edited by clicking on the Edit button on top of the Tx plan name .

Treatment Breakdown										
	Phase	Code	Description	Unit	Quantity	Fee	Fee Total	Net Fee	Net Total	Discount
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00

- +Code:- The treatments proposed for the patient's treatment can be added into the Tx plan by clicking on the +Code button at the top. A code addition slide-out will appear and based on the phase selected the code gets added onto them.

Treatment Breakdown										
	Phase	Code	Description	Unit	Quantity	Fee	Fee Total	Net Fee	Net Total	Discount
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00

- Treatment specific odontogram :- Displays the tooth chart specific to the Tx plan, along with the conditions diagnosed in the charting page.

Treatment Breakdown										
	Phase	Code	Description	Unit	Quantity	Fee	Fee Total	Net Fee	Net Total	Discount
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00

- Show insurance breakdown - If enabled, will show the insurance split for primary and secondary based on the COB.

Treatment Breakdown										
	Phase	Code	Description	Unit	Quantity	Fee	Fee Total	Net Fee	Net Total	Discount
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00

- Codes can be moved to / copied to another tx plan by right clicking on the selected codes
- Codes can be moved to another phase either by drag & drop or by right clicking on the code>Add to phase
- Treatment metrics :- Will show the percentage of unscheduled treatments and the estimated amount from scheduled and unscheduled codes.



- Clinical summary :- To view the clinical history of the patients such as Allergies/conditions if any, last added prescriptions , medical history form etc

Treatment Breakdown										
	Phase	Code	Description	Unit	Quantity	Fee	Fee Total	Net Fee	Net Total	Discount
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00

- Total estimate :- Shows the total estimate for each phase. If any adjustments/sales tax is applied to any one of the codes in a phase, the total estimate will be indicated by an asterisk \* next to the total estimate.

Treatment Breakdown										
	Phase	Code	Description	Unit	Quantity	Fee	Fee Total	Net Fee	Net Total	Discount
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00
		1000-1000-1000-1000	1000-1000-1000-1000	each	1	\$100.00	\$100.00	\$100.00	\$100.00	0.00

- Present Tx plan/Phase :- To present the Tx plan created by the tx coordinator to the patient on chair. Under the present plan drop-down, there are 3 options :

1. Preview - To get a preview of the tx plan before presenting it to the patient
2. Present with fee details - Presents the Tx plan to the patient with the code estimates and adjustments made.(These details can vary based on the location Print settings under Practice settings > Locations > Print settings)
3. Present without fee details - Presents the tx plan to the patient without any fee details.



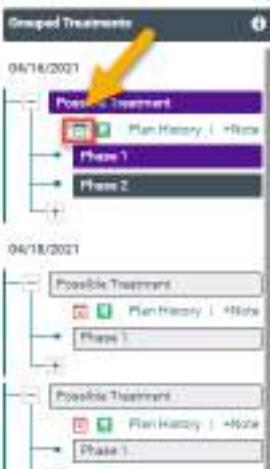
- o When a tx plan is presented to the patient, the patient may or may not choose to accept all the codes presented in the Tx plan. Tx coordinators have the flexibility to select and deselect the codes and then the patient can sign and accept the tx plan.
- o Presented button at the bottom of the Tx plan estimate will change all the codes to Presented status irrespective of the codes selected.
- o Send to patient will send the Tx plan to the patient portal and the patient will receive an email to review the tx plan
- o Once the tx plan is signed and saved, all the selected codes will change back to Accepted status ( If the accepted toggle is on for the client) and the deselected ones will change to Presented status
- o The tx plan estimate will change based on the selection inside the Tx plan estimate. By default, all codes will be pre-selected when presenting a Tx plan
- o Once the Tx plan is signed, Tx plan consent form inside the documents will only show the selected codes when a Tx plan is signed by the patient



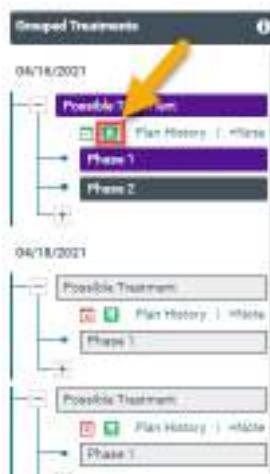
- o Print Tx plan/Phase :- Opens up the print preview modal in a new tab to print the tx plan
- o Reject tx plan :- To mark a tx plan/phase as rejected. This will change all the codes inside the selected plan/phase to Rejected status.
- o Accept tx plan :- To accept a tx plan/phase. This will change all the codes inside the selected plan/phase to Accepted status
- o Schedule tx plan :- To schedule the tx plan/phase proposed for the patient. This button will navigate the user to the scheduler to the current day. Once a slot is booked, the selected phase/plan gets linked to the appointment and the change will be indicated in the Tx plan as such :



- o Insurance breakdown:- shows the Primary and secondary insurance information such as the deductible used, deductible remaining, individual max remaining, individual max remaining after plan based on the chosen treatments (Ungrouped / Grouped treatments)
- o Calendar icon :- To indicate whether all the codes inside a plan have been scheduled or not. By default, when a plan is created the icon will be in red. If the entire tx plan has been scheduled, the icon will switch to Green.

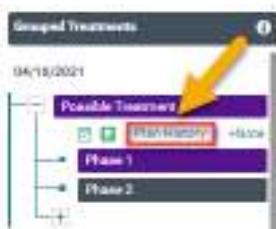


- Tooth icon :- Indicates whether a tx plan has been presented or not. By default, the icon will be red. When all the codes in the Txplan are in Presented or Accepted or Completed or rejected statuses, the icon will switch to Green.

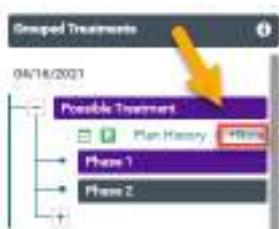


- Plan History:- Opens the tx plan history slide out which will show the following details :

- Created date of Tx plan
- Code addition and code deletion
- Codes moved from a plan or moved to a phase
- Status change of codes



- +Note :- To add treatment specific notes.Notes will get deleted once the treatment plan is deleted.



- Tx plan/Phase color :- Users can now visually differentiate a tx plan's status based on the color code. The hierarchy of codes are as described below :

- Presented
- Proposed/Recommended/Alternative/Hold

- Accepted/Referred out
  - Completed
  - Rejected

- Legend - Shows the color code assigned to each status. These color codes are predefined and cannot be changed.



- By default, Hide completed items and Hide rejected items will be checked.



## Impacts

- Items shown in the tx plan will be based on the location print settings.(System menu > Location > Print settings > Tx plan). If Enable send to the patient is set to Yes, then show completed items, show rejected items, and show referred out items will be set to No and greyed out. (Tx plan send to the patient do not show completed, rejected or referred out codes)
  - The initial Billing order of the codes will be based on the code settings. ( System menu > Practice settings > Codes >Procedure codes
  - Sales tax will be added to the codes if it is enabled for the treatment location. (System menu >Practice settings > Locations > Sales tax
  - Care audit alerts/benefits remaining warning (Patient > Insurance > Limitations and Exclusions > Benefits remaining )will be indicated by an 'i' icon next to the added code in the grid.
  - Tooth chart colors indicated on the odontogram based on the code status can be configured in System menu > Practice settings > Clinical > Tooth chart colors
  - The diagnosed conditions drop-down will show both the System conditions and the custom conditions. New custom conditions can be added by navigating to System Menu > Practice setting > Clinical > Custom conditions > Add
  - The treatment coordinator drop-down will only list active non-provider users with login enabled.
  - Tx plan agreement shown inside the Tx plan estimate can be changed or edited in the System menu > Practice settings > Clinical > Tx plan agreement
  - Predefined tx plan types along with the base status can be configured in System menu > Practice settings > Clinical > Treatment plans
  - If clinical lockout (to prevent data tampering ) is set to Yes for the practice (Backend configuration), then after the locked out period :
    - Deleted procedure codes that are locked out will be shown in dental charting grids and will be struck off.
    - Clinical details of a locked-out procedure code cannot be edited.
    - Clinical details of a locked-out condition cannot be edited. Conditions can be marked as 'Not Applicable' and the corresponding drawing will be removed from the chart.



# Clinical Chart - Odontogram & Code Addition

Written by Megha Jayakumar | Last published at: September 28, 2021

## Clinical Chart

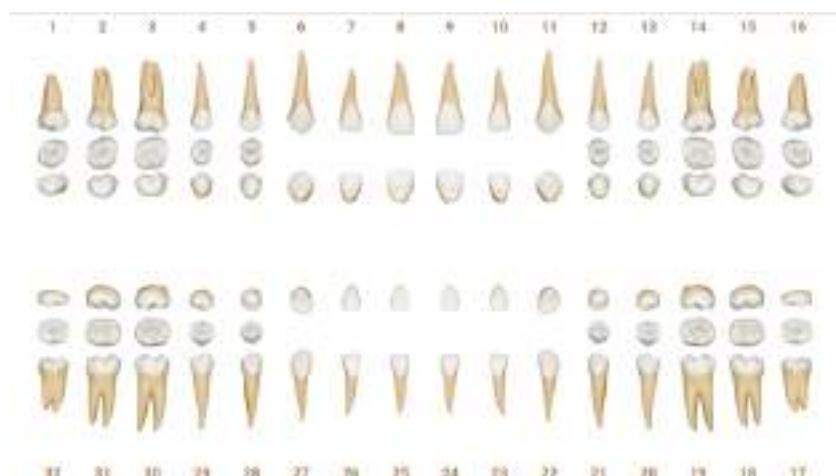
Clinical chart displays the patient's odontogram where each condition or procedure codes added to individual tooth can be clearly differentiated based on the precedence order.

## Users

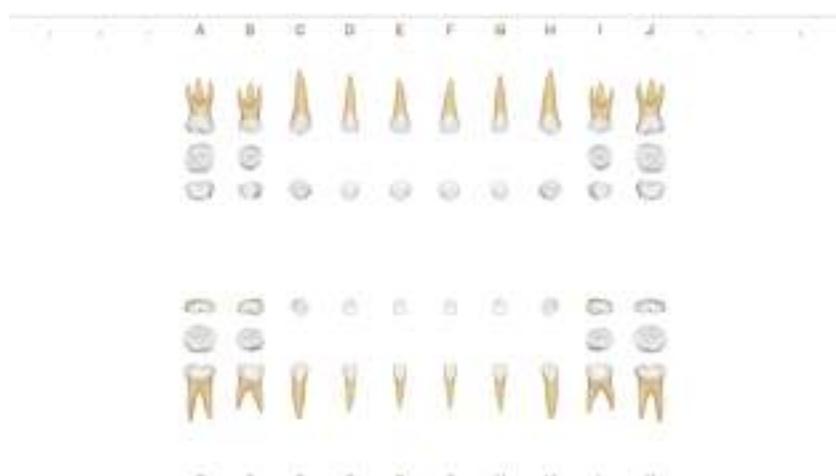
- Providers
- Hygienists
- Dental assistants

## Odontogram Dentition

### Permanent



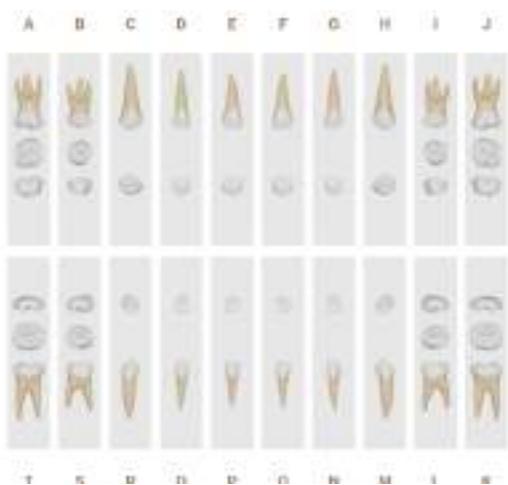
### Primary



### Combination of Primary & Permanent

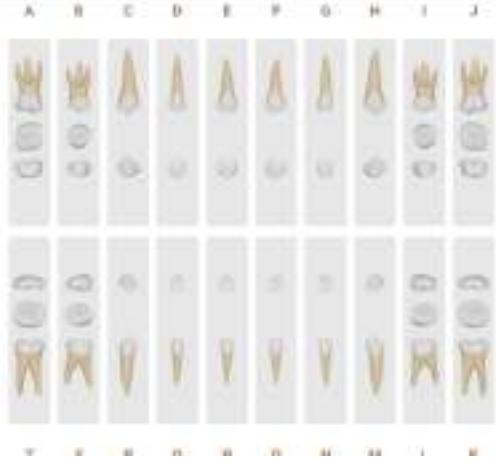


### Unerupted

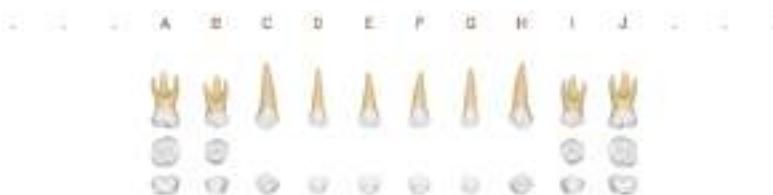


### Default Dentition

- For patients aged between 0-2, all the chart teeth(primary and permanent) should be greyed out indicating that they are non-erupted.



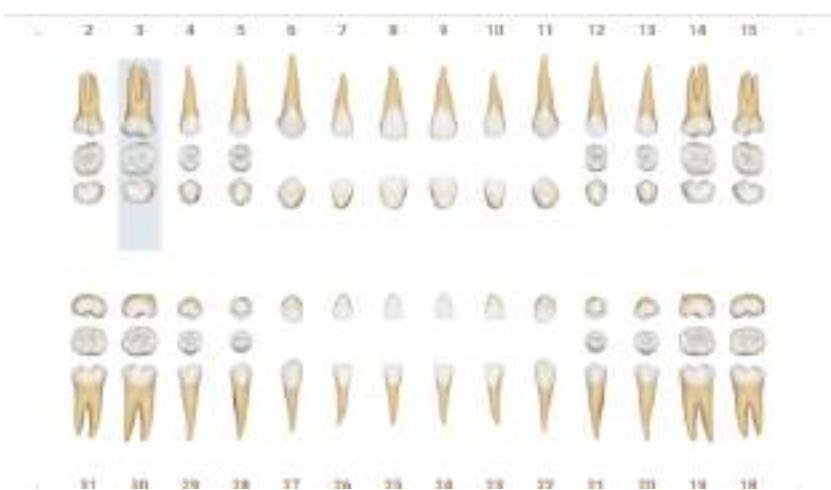
- If the patient's age is between 3 and 6, primary dentition is displayed.



- o If the patient's age is between 7 and 10, Tooth : 3 A B C 7 8 9 10 H I J 14 19 K L M 23 24 25 26 R S T 30.



- o If the patient's age is between 11 and 18, teeth 1, 16, 17 and 32 should be primary. All the remaining teeth should be permanent.

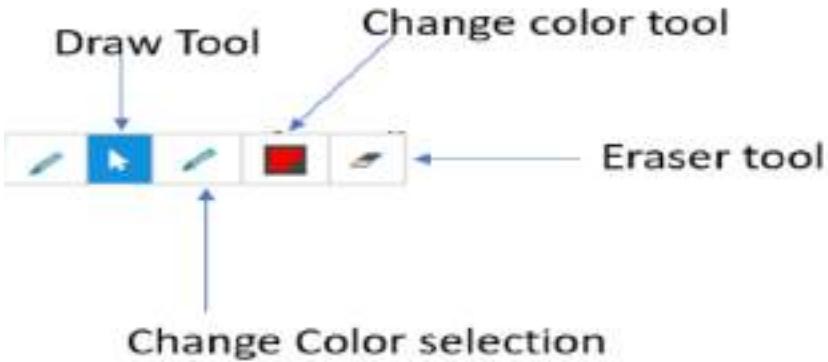


- o If the patient's age is greater than 18, permanent dentition is displayed.
- o Patient dentition will only be set upon patient addition and will not change if the patient's age is changed.
- o Dentures cannot be applied to primary teeth.

### Tooth multi-selection through click and drag

- o In case of an unerupted tooth, clicking and dragging should enable the tooth and not select it.
- o If the user is dragging over multiple with a few tooth selected and a few deselected, the selection should toggle.
- o The selection is cleared when a user clicks anywhere else on the chart.
- o If the user clicks and drag over both rows of teeth , the entire chart should get selected.

### Draw Toolbar



#### Dentition changer



- Clicking on Dentition Changer after selecting tooth user should get the options as



- Clicking on Dentition Changer without selecting tooth user should get the options as



#### Legend



Clicking on the Legend a pop up gets opened with four tabs

1. Conditions
2. Treatments
3. Materials
4. Tooth Chart Color
5. CDT category

## STS/NOR/CDT



- o STS - Chart ledger will be visually differentiated based on the code status
- o NOR - Normal chart view
- o CDT - Codes based on CDT category will be visually differentiable in the chart ledger

## BURST MODE/NORMAL MODE

- o Burst mode - Care note gets automatically saved as draft without prompts
- o Normal mode - Prompts for care notes and should be added individually

## Conditions

- o Abscess - a buildup of pus that forms inside the teeth or gums
- o Abrasion - wearing away of tooth surface caused by friction or a mechanical process
- o Abfraction - the loss of tooth structure where the tooth and gum come together
- o Diastema - a gap or space between the teeth
- o Open Contact distal
- o Open Contact mesial
- o Fractured - a break or crack in the hard shell of the tooth
- o Drifting Distal & Mesial - When you lose a tooth, the remaining teeth no longer have the support that the bone and missing tooth once provided. Because there is no longer support, the teeth begin to shift or move out of its anatomical position and into the open area.
- o Missing/Extracted
- o Impacted Distal & Mesial - a tooth that, for some reason, has been blocked from breaking through the gum. Sometimes a tooth may be only partially impacted, meaning it has started to break through. Oftentimes, impacted teeth cause no obvious symptoms and are only discovered during a routine X-ray at the dentist's office.
- o Rotated Distal
- o Rotated Mesial
- o Super Erupted - occurs when your teeth emerge too far from the bone in your jaw so that there's not enough root in the jaw to hold the tooth in place
- o Supernumerary - Teeth that appear in addition to the regular number of teeth (32 in the average adult)
- o Caries mesial/distal/occlusal/incisal/buccal/facial/lingual - commonly known as tooth decay, are caused by a breakdown of the tooth enamel.
- o Cavitation - dental cavitation is a hole in the jawbone, even though "dental" usually refers to the teeth
- o Root Tip - A root tip infection occurs when the body tries to fight off bacterial infection inside the tooth in the innermost layer called the pulp. This is most often caused by severe tooth decay
- o Hypocalcification - occurs when your tooth enamel contains an insufficient amount of calcium. This insufficiency causes your enamel to be thin and weak. Hypocalcification also gives your teeth an opaque or chalky appearance and can lead to white, yellow, or brown discoloration.
- o HyperSensitivity - dental pain which is sharp in character and of short duration, arising from exposed dentin surfaces in response to stimuli

- Defective Restoration
- Fractured Root
- Food Impaction - The typical phenomenon that food particles or fibers are embedded in the gap of adjacent teeth during the process of chewing
- Watch - When you have a dental exam, we are looking for these spots and will chart them as "Watches". This means we are going to watch this spot to see if it progresses
- Sub Erupted(same as under erupted) -
- Overhang - refers to the extension of restoration material from the cavity.
- Braces
- Tipped distal
- Tipped facial
- Tipped lingual
- Tipped mesial
- Fused/Germinated tooth
- Cracked tooth- mesial
- Cracked tooth- distal
- Cracked tooth- occlusal/incisal
- Cracked tooth- Facial/buccal
- Cracked tooth- Lingual
- Chipped tooth- mesial
- Chipped tooth- distal
- Chipped tooth- occlusal/incisal
- Chipped tooth- Facial/buccal
- Chipped tooth- Lingual

## Treatments

- Sealant :- Thin coatings that when painted on the chewing surfaces of the back teeth (molars) can prevent cavities (tooth decay) for many years.(prevention method, unlike filling).



- Spacer :- To create a little space between certain teeth, usually molars.



- Mesial filling
- Distal Filling
- Buccal/Facial Filling
- Occlusal/Incisal filling
- Lingual Filling
- Crown :- Dental crowns are tooth-shaped "caps" that can be placed over your tooth



- 3/4 Crown
- Inlay :- A dental inlay is a pre-molded filling fitted into the grooves of your tooth. It's most often used as restoration for cavities (also known as dental caries) that are centered in your tooth instead of along the outer edges or "cusps."
- Onlay :- Onlays fit over your tooth's biting surface and are made of a solid piece of porcelain, composite, resin, or gold. This type of restoration is used to fix a tooth that has been damaged by decay or injury. Onlays are similar to inlays but differ in the amount of your tooth they cover.



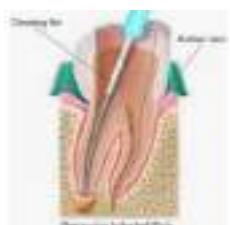
- o Post :- Dentists use a dental post to help stabilize and secure a tooth that has undergone root canal treatment (also called endodontic treatment)



- o Pins :- When a tooth has very little left to rebuild upon, pins can be used to help hold the filling on. Pins do have a certain level of risk attached to them.
- o (How are dental pins different from dental posts? Dental pins are much smaller and we insert them into the peripheral tooth structure. Whereas, dental posts are larger and dentists insert them into the central area of a tooth where the nerve was. We place dental posts in teeth with root canals. Pins can go in either teeth with or without root canals).
- o Veneer :- Thin, tooth-colored shells that are attached to the front surface of teeth to improve their appearance.



- o Root canal :- Removal of the soft center of the tooth, the pulp. The pulp is made up of nerves, connective tissue, and blood vessels that help the tooth grow. In the majority of cases, a general dentist or endodontist will perform a root canal while you're under local anesthesia.



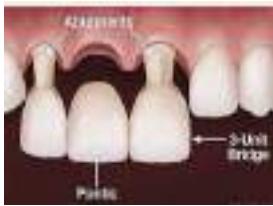
- o Apicoectomy :- Straightforward, minor surgical procedure that's done on children and adults as a way to save at-risk teeth and prevent potentially serious complications. An apicoectomy is also known as root end surgery. This is because it involves the removal of a tooth's root tip and surrounding tissue



- o Implant :- Surgical fixture that is placed into the jawbone and allowed to fuse with the bone over the span of a few months.



- o Bridge Abutment :- A bridge is a fixed dental restoration used to replace one or more missing teeth by joining an artificial tooth definitively to adjacent teeth or dental implants.
- o Bridge pontic :- A false tooth called pontic that is held in place by the abutment teeth on either side of the gap.



- Tooth Extraction
- Braces
- Full Denture :- A denture is a removable replacement for missing teeth and surrounding tissues. Two types of dentures are available -- complete and partial dentures. Complete dentures are used when all the teeth are missing
- Partial denture :- Partial dentures are used when some natural teeth remain.



## Surfaces

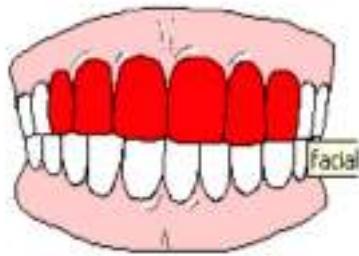
- Mesial - Surface of the tooth that is closest to the midline of the mouth. This term is used on both anterior and posterior of the teeth



- Distal - Surface of tooth that is farthest from the midline of the mouth. This term is used for both anterior and posterior of the teeth



- Facial - Surface of the tooth that faces or touches the lips and it represents the outer surface of an anterior tooth.



- Buccal - Surface of the tooth that faces or is towards the cheeks. This term can be used on all maxillary teeth and mandibular posterior teeth



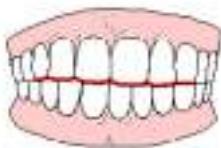
- Lingual - Surface of a tooth that faces or is towards the roof of the mouth or tongue.



- Occlusal - Surface of a tooth that is the chewing or occluding surface on a posterior tooth



- Incisal - Surface on a tooth that is the biting surface on an anterior tooth.



## Materials

- Composite
- Gold
- Amalgam
- Resin with high noble metal
- Resin with base metal
- Resin with noble metal
- Ceramic/Porcelain
- Porcelain
- Ceramic
- Porcelain Fused to High Noble Metal
- Porcelain Fused to Metal
- Porcelain fused to Titanium
- Porcelain Fused to Noble Metal
- Hi noble metal
- Base Metal
- Noble Metal
- Metal
- Titanium
- Resin
- Stainless steel
- Cast Metal

## Tooth Chart Colors

- Conditions
- Planned Treatment
- Existing Treatment(This Practice)
- Existing Treatment(Other Practice)
- Completed Treatment
- Referred out
- Referred out completed
- Rejected Treatment
- Alternative
- Hold
- Accepted
- Presented

## Patterns

- Composite - White filled and Outline
- Gold - Solid
- Amalgam - Solid
- Resin with high noble metal - Cross hatch
- Resin with base metal - Cross hatch
- Resin with noble metal - Cross hatch
- Ceramic/Porcelain - White filled and Outline
- Porcelain - White filled and Outline
- Ceramic - White filled and Outline
- Porcelain Fused to High Noble Metal - White filled and Outline
- Porcelain Fused to Metal - White filled and Outline
- Porcelain fused to Titanium - White filled and Outline
- Porcelain Fused to Noble Metal - White filled and Outline

- Hi noble metal - Solid
- Base Metal - Solid
- Noble Metal - Solid
- Metal - Solid
- Titanium - Solid
- Resin - Vertical hatch
- Stainless steel - Vertical hatch
- Cast Metal - Solid
- Cast Noble Metal - Solid

## Precedence

- Planned
- Presented
- Accepted
- Referred out
- Completed,
- Ex This
- Ex Other
- Referred out completed,
- Condition
- Alternative
- Hold
- Rejected

If multiple items of the same type(planned, completed...etc) are present on a single tooth, it will be layered in the latest added first order.

### Exceptions

- There will be an exception(Rule) logic to hide all conditions in a tooth if an (Implant, Full Denture, Partial Denture or a Bridge Pontic) is completed on it. That is, if the above mentioned procedures when added in in Existing others, Existing this ,Completed status ) followed by a condition, then only the latest entry gets shown in the odontogram
- If there exists any hidden condition then it should get displayed on deleting the added completed treatment (Implant, Full Denture, Partial Denture or a Bridge Pontic).
- If an extraction code is added to a tooth ( Existing this/other ), then it will be indicated as a missing tooth on chart & not with the regular vertical cross draw type.

## Code addition

- Procedure codes can be added from
  - Patient > Clinical > Chart
  - Patient > Clinical > Treatment planning
  - Scheduler > Appointment details > +Code
- The + code button in the charting page is used to chart treatment/procedure codes for the diagnosed conditions for the patient.
- While adding a code, a location and treatment provider need to be considered.
- If the user chooses tooth from the odontogram and then clicks on ' +Code ' and then adds code, the tooth is retained and the user need not apply it gain from code specifics modal.
- If a hygienist is selected, billing dentist is required except for an in-house treatment provider.
- Codes can be directly added to an appointment by pre-selecting the appointment.
  - The added codes will get linked to the appointment
  - If codes are added to a future appointment, completed radio button becomes disabled
  - When a checked out appointment is selected, the treatment type switches to completed
  - If appointment context is not set, codes should be linked to the Date of service
- +Code button will open the Add treatment slide-out which consists of Treatment type, Conditions (System and Custom) , Procedure codes , Explosion codes and Description
- Treatment Type - decides whether the treatments are planned or completed or an existing one
- Description - The selected codes get added here upon left-clicking on the grid and will be highlighted in red if there are any additional informations needed for the code
- Right clicking on the code grid will open the code snapshot for the selected code and additional informations like tooth # , surface , ICD codes , Surface selector can be captured if required for the selected treatment
- Mandatory fields if any for the codes will be shown when the code is added to the Description box



- Ortho patient validations - Shows the following messages in the orange icon
  - If a general procedure code is checked out against an ortho patient, the following message will be shown ' You're about to check-out a general procedure code against an ortho patient'
  - If an ortho code is checked out against a general patient, the following message will be shown ' You're about to check-out an ortho procedure code against a general patient'



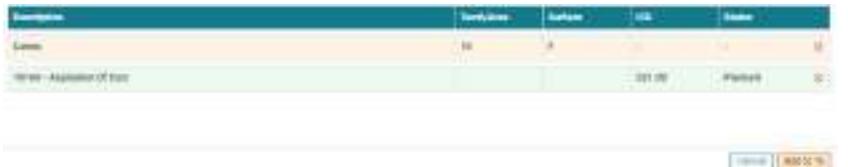
- Multiple teeth can be selected for a single code.
  - Skip - Skips the current selection of tooth
  - Apply - Applies the code for the current selection of tooth
  - Apply for all - Applies the codes for all the tooth selected
- Codes can be added to the charting page by preselecting a tooth from the odontogram. The selection will be retained inside the code snapshot.



- If smart code is enabled for the code ( System menu >Practice settings >Code > Procedure code settings > Apply smart code logic ) , on clicking Apply/Apply for all , smart code logic will be applied.
- The message "Smart code applied " will be displayed on the row of the procedure code in the orange icon
- If care audit rules are enabled for a procedure code, it will be displayed in the code snapshot.



- Once the codes are in the description lay-out, Add to treatment will add the codes to the chart ledger



## Chart Ledger

- All the codes added in the present day will be shown inside the Today tab. Today's tab is entirely reflected based on the code creation date.



- Codes with the following statuses will be categorized under the Planned tab
  - Proposed/Recommended
  - Presented
  - Accepted
  - Alternative
  - Hold
  - Referred out

Sorting order - Ascending and descending order based on DOS

- No sorting based on created date

- Conditions will be listed down in the Conditions tab and sorted based on the created date
- Completed codes are listed down in the Completed tab

Sorting order - Ascending and descending order based on DOS & No sorting which is entirely based on the created date

- Existing tab will list down codes in Existing and referred out completed status
- Notes tab will list down the care notes based on the note date
- Notes to be started will list down the care notes which are yet to be started/answered
- Notes to complete will list down the care notes which have been started but not yet completed
- Notes to review will list down the care notes with all responses answered but not yet finalized by the provider
- Documents tab will list down the completed clinical documents sorted based on the created date
- The last tab will show based on the default chart filter configured. Default chart filter is configured on an user level. (System menu>User settings>Default chart filter). However, different chart filters can be created in two ways
  - System Menu >Practice settings >Clinical >Chart filters > Add filter
  - Patient > Charting > Custom filter

The odontogram representation of treatment codes will also change based on the chart filter configuration

## Clinical summary : -

- Shows conditions and allergies if any.
- Add/remove will navigate to the patient's medical history form with a warning
- Financial information
- Insurance details
- Basic overview of the clinical exams performed by the patient along with the latest date
- If "Show the pop-up every time the chart is opened" will pop up the clinical summary page every time the user opens the charting page. (User configuration)

Multiple actions can be performed against a code and a clinical note by selecting the checkbox and right clicking on the code :-

- Proposed,presented,accept,alternative,hold,reject,complete,referred out,referred out completed are the procedure code statuses. Hence, the status change of a code can be updated by doing so. However, one or more items mentioned in the above list will be greyed out or not depending on the status. For example :- If an accepted code is selected, items like alternative and hold will be greyed out in the right-click.
- Delete - To delete a code / note.
- Lock fees - Locks the fee for a period of time. The Recalculate button will note affect the fees.
- Unlock fees
- Create pre-auth request - To create a pre-auth. This is only applicable for non completed codes with B.O other than N

- Create claim - To create claim for completed codes with B.O other than N
- Copy to tx plan
- Move to tx plan
- Add to phase
- Add to appointment - To directly link the codes to an appointment
- Delink from appointment - Delinks the code from the appointment
- Update billing dentist - To change the billing dentist for the procedure code. Applicable only if raising a claim.
- Apply discount - Applicable to non completed codes only. Adjustment codes for discount are configured in System menu > Practice settings > Codes > Adjustment codes > Add > Deduct from patient
- Link to payment plan - Directly links the code to the patient payment plan
- Marks as N/A - removes the representation of the code from the Odontogram and will be marked as N/A in the ledger and in the chart ledger.
- Print

## Care Panel

One-click addition of items is possible with Care Panels in CareStack. It allows adding up to 30 tiles in each care panel between procedure codes, explosion codes, conditions, carenotes, forms, or letters. Based on the treatment categories, users can configure the most commonly used procedure codes, conditions, notes, forms, etc in each tile.



- Users can switch between various care panel types configured. Based on the selection, the changes will be reflected.
- A care panel legend to differentiate the contents on each tile based on color.
- Procedure codes and conditions will open the code snapshot.
- Note till will open the care note slide-out.
- Explosion code tile will open the code addition slide-out with the codes listed down in the description box.



- Forms and letters will open the respective modals.
- If multiple procedure codes, conditions and notes are configured in a single tile, upon clicking, they will be listed down.

Care Panel Type: ENDOODONTICS +Code +Note

ENDO CODE	CBCT SCAN	RETAINERS/PMI	PULPOTOMY	XRAY CODES	WORKER INJ/ISSUE
RCT MOLAR	RCT ENDO/PMTM	APICO/ ROTATION	RETX MOLAR/MI	INFECTION CTRL	RETX ANT/PMI
RCT MILK/PMI	HEMO	VITALITY TEST	AMOL	RETX/IMPL	FAILED APP
RCT MODULAR	RCT ANTERIOR	ADOT	D3410 - Apicoectomy - Anterior		
RCT BISSECT	RCT PERIOD.	MEX	D3421 - Apicoectomy - Bicuspid		
			D3425 - Apicoectomy - Molar		
			D3426 - Apicoectomy Additional Root		
			D3427 - Periradicular Surgery Without Apicoectomy		

Forms Note Letter Condition Disp Code Codes

W D Documents B Default

Care Panel Type: PERIODONTICS +Code +Note

X-RAYS	PERIODONS	PREOP	OSS- OCQUAD	OTR/ DRIFT	EXTRACTION
NEXT VISIT	SK-STAGE 2	SOFT TISSUE	IMPLANTS	SHU/LIFT	RAISED APP
INFECTION CTRL	SPINT/BLA OF	IMPLANT MANAGEMENT	OSS- EX/NITR	FRACTURE	MISSING
ANESTHESIA	REFLIM- TED	SRP	Fractured		
CBCT SCAN	SPL. PROSTHETIC C	BB	Drifting Mesial		
			Impacted Distal		
			Rotated Distal		
			Rotated Mesial		
			Sub-Erupted		

Forms Note Letter Condition Disp Code Codes

W D Documents B Default

Care Panel Type: PERIODONTICS +Code +Note

X-RAYS	PERIODONS	PREOP	OSS- OCQUAD	OTR/ DRIFT	EXTRACTION
NEXT VISIT	SK-STAGE 2	SOFT TISSUE	IMPLANTS	SHU/LIFT	RAISED APP
IMP	Next Visit				MISSING
	Final Implant Report				
ONE	Implant Prosthetic Part Replacement		OTR / WDT	NOTES	
CBCT SCAN	SPL. PROSTHETIC C	BROKEN APP/PT			

Forms Note Letter Condition Disp Code Codes

## Touchpoints

- o Completed codes with claims created cannot be deleted.
  - o Completed codes that are paid cannot be deleted
- Warning**

Code(s) used as base code of ortho payment plan and/or with claim issued against it cannot be deleted. All payments made against the deleted code will be reversed.
- o If clinical lock out is enabled for the practice ( backend configuration), completed codes and clinical notes will be stricken off .

**Warning**

One or more of the item(s) has been locked! Locked items cannot be deleted from the record and will remain with a strikethrough. Do you want to proceed?

- o Clinical notes linked to a procedure code/condition , locked out notes and finalized note will be stricken off once deleted

**Warning**

Are you sure you want to delete the care notes? Finalized, inaccurate and locked out care notes will be struck off indicating it is deleted. Do you want to proceed?

- o Voided prescriptions won't be shown in the chart ledger

# What is Revenue Cycle Management?

Written by Revati Krishnan | Last published at: August 09, 2022

## Overview

Revenue cycle management(RCM) is a well-known topic in the medical world, and it is slowly becoming seen as an important concept in the dental industry as well. It is the process used by healthcare systems in the United States to track the revenue from their patients from their initial appointment or encounter with the healthcare system to their final payment of balance. The cycle can be defined as, "all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue." It is a cycle that describes and explains the life cycle of a patient (and subsequent revenue and payments) through a typical healthcare encounter from admission (registration) to final payment (or adjustment off of accounts receivables).

If the cycle is long, the cash is sitting in someone else's bank account instead of yours, and the longer the cycle, the greater the likelihood that you'll end up writing-off some of the balance. Conversely, if the cycle is shorter, you receive payment faster, which of course, increases your revenue. Also, faster payments mean fewer collection problems and fewer write-offs.

The medical billing process is not undertaken by a single individual. Medical coding involves front office administrators, such as receptionists, as well as back-office staff, including the medical biller and coder. The primary job of medical billing specialists is to:

- Understand everyone's responsibility for payment, as they may differ from patient to patient.
- Evaluate and analyze insurance coverage and medical charges, and prepare accurate billing forms.
- Collect accurate payments from insurance plans and/or individual patients.

These three primary tasks require many specific responsibilities within the medical billing process.

## General RCM Workflow

### Appointment Scheduling

- The revenue cycle begins the moment patient calls to schedule an appointment. The front-desk staff should be equally skilled in dealing with the new and returning patient. Appointments, of course, are potential revenue. Without spending much time on this topic, let me highlight two points. First, except for walk-ins, without appointments, you won't have a revenue cycle to manage. Yet, many offices are not very good at making appointments, and they limit the hours when appointments can be made. Second, by shortening the time between when the appointment is scheduled and when treatment is rendered, the entire cycle is shortened.
- In case of the new patient, it is necessary to collect and verify patient insurance and demographic details accurately. Get those wrong and your claims will be rejected right away. For a returning patient, ask for any change in details and remind them of past non-payments.

### Accuracy of Pre-Treatment Estimates

- Next, after scheduling and registering the patient (which by itself deserves discussion), one of the most important tasks for insurance patients is determining insurance eligibility and plan benefits. Why? It's important to be able to accurately estimate the patient payment portion of a treatment plan and collect that portion at the time of treatment. The lack of doing this one task can more than triple the length of the revenue cycle. To do it correctly, however, can often mean a 30 – 45 minutes telephone call and loss of a staff member sitting on the phone.

### Claims Submission

- Next comes the claims submission process, which of course entails a number of steps. Good revenue cycle management means you are submitting claims electronically. But, this then involves management of the clearinghouse claims process. It also means dealing with potential re-submissions because of inaccurate data or need for attachments.

### Insurance Payments

- Once payer payment is received, a new round of activity is required. EOBs must be posted in a timely manner. If the expected payment is received, which is not the norm, the process is straight forward. More likely, there will be yet further steps.

### Patient Billing

- Finally, if there's a balance due, it's time to bill the difference to the patient. Again, the process can take different pathways until an acceptable final payment is made. Of course, if the acceptable final payment is different from the billed amount, adjustment is required. If patient payment is not received in a timely fashion, further efforts must be taken for collection.

By analyzing all the steps, and realizing that this cycle is repeated for every single insurance patient, it's easy to see how things can fall through the cracks. Staffing properly for consistently good revenue cycle management can be daunting. There is typically a long learning curve to develop the

knowledge and skills simply to perform the most basic of these tasks, much less dealing with any complications. And, who oversees the people performing these tasks? It's usually not the dentist, since he or she probably doesn't know how to manage all the steps. Unfortunately, in most practices, there is only one person managing the cycle – with little or no oversight. A typical solo office will have only one full time employee – or maybe even a part timer – handling all these tasks for hundreds of transactions in the cycle at any given time. Letting things slide – or just simple burn out – is not unusual.

## References

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# Overview of RCM inside CareStack

Written by Revati Krishnan | Last published at: October 20, 2021

Revenue Cycle Management (RCM) encompasses getting paid for the work the office did. Though this focus seems to be more on collection activity, but in effective practice, it is much more a setup (fee schedules, exclusions, etc) and preparation (eligibility verification) activity.

At a high level, patients receive treatment/services in the dental practice and are charged for these services. Since many patients have insurance, it is necessary to determine how much is to be paid by the patient, and how much is to be paid by insurance. This process is estimation. Based on the estimates, payment is taken from the patient in the office, and claims are sent off to the insurance company to be paid. When the insurance company responds, the office will either post payment, transfer the balance to the patient, post adjustment, resubmit the claim, or some combination of those.

When various aspects of the process fall apart - payment is not collected from the patient at the time of service or the claim is paid for less than expected - the office ends up with accounts receivable that must be managed.

## Major Areas

- General Setup
  - **Service Codes** - Service codes are the procedures or services offered to the patient. They have various clinical properties that impact RCM (whether they require a tooth number, etc) and have standardized CDT code attached used for billing to carriers.
  - **Payment Types** - Ability to define the payment method used by the patient/carrier to make the payment. It could be Cash, Check, Credit/Debit Card etc.
  - **Adjustment Types** - Payment and Claim Adjustments - A categorization of adjustments that both indicate the system action (credit production, transfer to patient, etc) as well as reporting categorization.
- Insurance & Eligibility
  - **Employer Setup** - The employers connected to various insurance plans. Users will have the ability to setup basic details of the contact details of the carrier
  - **Insurance Carrier Setup** - The part of CareStack lets users setup various insurance companies along with their basic contact details and other preferences associated with claim and eligibility processing
  - **Insurance Plan Setup** - Plans represent individual sets of fees and benefits offered by a carrier. There is the ability to add plans of types - HMO, PPO, Indemnity, Discount, Medicare, Medicaid, etc.
  - **Fee Schedules, Assignments and Hierarchy** - Fee schedules are lists of service codes and the associated fees. They generally vary by plan, geography, and specialty.
  - **Eligibility Benefits** - Eligibility is a term for the coverage a patient has, which includes whether the patient is covered, and at what level, as well as limitations and exclusions that may apply to the patient's coverage. This information comes from a combination of the fee schedule, the carrier's provider manual, and the patient's own history.
  - **Coverages** - The coverage book (HMO/Medicaid) and/or coverage percentages (PPO) will provide information about how much will be paid by insurance.
  - **Limitations and Exclusions** - Limitations and exclusions primarily reduce the amount covered by insurance and therefore push the remaining estimation to patient, though there are situations where these limit the ability to charge the patient for the amount not covered.
  - **Eligibility Form** - The forms consist of a set of codes and associated rules (eg, D1110 - frequency limitation). These provide an outline for the information that a practice desires to collect related to the limitations and exclusions for insurance estimation.
  - **Table of Allowances** - Table of allowances are associated with Co-Pay plans and can be used to obtain either the patient or the insurance component of the fee for a code associated with such an insurance plan.
  - **Fee Registers** - Fee registers are dynamically updating fee schedules. It more like a Blue Book which would be used to store insurance estimates based on the payment receiving history. There exists a fee register for an insurance plan. And we also give the option to update the fee register values upon posting insurance payments according to that insurance companies allowable fees.
- Treatment Planning and Estimation
  - **Fee estimation for codes based on the insurances linked to the patient** - When the patient is treatment planned, or services are completed, the limitations and exclusions from the eligibility information will combine with the existing fee schedule and coverage information to produce a more accurate insurance estimation.
  - **Coordination of Benefits** - Coordination of benefits (COB) takes place when a patient has more than one dental plan and is able to use both of them to cover their dental procedures. When this occurs, the two plans work together to coordinate benefits to eliminate over-billing or duplication of benefits. It is the procedure the insurance companies use to determine which one covers procedures first and which plan picks up as secondary.
  - **Discount and Sales Tax application**
  - **Pre-authorization submission**
- Billing and Accounting
  - **Completing Treatment Procedure Codes**
  - **Posting Patient Payments & Adjustments** - When posting credits, the user can choose to apply the credits against the debits of their choosing. If, for example, the patient chooses to pay for their crown, but does not wish to pay for their extraction, the user, knowing this, can apply the payment accordingly. This additional granularity provides additional reporting capability, allowing the practice to better examine their ability to collect. Debits (charges or debit

adjustments) increase the balance owed. Credits (payments or credit adjustments) decrease the balance owed. The overall balance is simply the sum of the transactions, or the net of debits and credits.

- **Ledger** - CareStack uses line item accounting and dual ledgers for accounting (patient and insurance ledgers are kept separately). These combine to form a robust patient accounting system that provides significant reporting and management capability.
- **System Transactions and Migrated Transactions** - The system transaction is a log of all RCM activities for a patient / account. An entry for every action taken against a procedure code's life cycle would be logged in this page. This can be seen on selecting a Patient and clicking on the System Transaction sub-tab under the Archives. When the system transaction is accessed, the user would be taken to the last page of the system transaction with the latest entry in view. There would be a maximum of 30 entries per page and would require only a page level scroll.
- **Patient Credit Refunding** - Refunding of credits means for the dental practice to return unallocated credits back to the source from which it was received from. Refunding of credits can be done from either a patient receipt or an insurance receipt which has some amount of unallocated credits in them
- **Marking a Patient Check as an NSF check** - Non - sufficient funds (NSF) is a term used in the banking industry to indicate that a check cannot be honored because insufficient funds are available in the account on which the instrument was drawn. A check is an 'NSF check' when it bounces due to insufficient balance in the patient's bank account. NSF checks are those checks given by a patient in whose bank account, amount equaling the check isn't available. In such a situation, the practice would need to not be able to post any payments further from that receipt and at the same time not delete it from the system. Users are able to maintain a proper audit trail as the receipt wouldn't actually get deleted from the system. Patients could also be duly notified about the issue through statements. Once the amount comes to the practice correctly, users can use the same receipt to post payments
- **Collection Agency Payment Posting** - CareStack provides the ability to mark patients who need to be sent to the collection agency to recover funds that are past due. There is a different section which allows users to add collection agencies into the system and to also create payments against these agencies.

- **Claim Submission and Claim Management**

- **Claim Generation & Submission** - CareStack allows users to submit claims both electronically and paper based. After patient visits the practice for a checkup or service, the practice users will submit a claim form to the patient's dental insurance carrier requesting payment. The dental claim outlines the services and procedures the dentist performed at the patient's visit.
- **Claim Status Tracking** - Claim status helps to identify the current status of the claim. The status of the claims that are sent electronically are generally updated on the basis of EDIs that would provide the current status of the claims. Insurance companies can fail to pay promptly and accurately. Regular follow-ups with insurance companies provide the current claim status which helps to determine the state of the claim.
- **Insurance Payment Posting** - Paper EOBs have detailed claim payment information based on which users will be able to post insurance payments for codes accordingly. Accurate payment posting also affects the accuracy of claims submissions to secondary and tertiary payers. If the primary payment is not posted correctly, it is possible for the secondary and tertiary payers may get billed out incorrectly.
- **Electronic Remittance Advice** - Electronic Remittance (ERA) is an electronic form of an Explanation of Benefits (EOB). Responses are generally received not just for claims but also pre-authorization. It is a structured, delimited text file. The contents represent payment or non payment (denial) of claims the provider has submitted. Each item received represents something the office should act upon - posting the payment, resubmitting/appealing the claim, adjusting the claim, etc. These items are parsed, matched to the appropriate claim, and acted upon.
- **Handling Provider Level Adjustments** - Provider-level adjustments can increase or decrease the transaction payment amount.
- **Attaching documents electronically via NEA Fast Attach** - Enclosure requirements of claims submitted electronically are handled by NEA which allows users to attach documents like X-Rays, Narratives, Perio charts etc.
- **Denial Management** - The submitted claim can be rejected by insurance due to missing or incomplete information. CareStack allows users to track claims correctly and thereby help to amend the error and re-submit it for processing without much delay.
- **Dental to Medical Cross Coding** - With cross coding we can claim dental procedure codes with corresponding CPT codes on a medical claim and have a higher chance of getting paid for them when claimed medically.

- **Accounts Receivable Management**

- **Statements** - Statements are always generated for an account. An account is a group of patients that share a common responsible party. Statements are addressed to the responsible party of the group.
- **Payment Plans** - Ability to set up financial contracts to handle recurring payments. There is a balance owed and a series of payments made periodically that will ultimately pay off that balance.
- **Transactional Close Out** - The close out feature prevents the users from editing / posting against transactions which are older than a point of time.

# Dental Billing Terminology

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Glossary of key dental billing terms serve as a reference to help you get a better grasp on the language of this field. Check out the dental billing terminology definitions and explanations in the alphabetized list below:

## A

**ADA Dental Claim Form:** The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim Form by dentists and payers.

**Allowed Amount:** The sum an insurance company will reimburse to cover a healthcare service or procedure. The patient typically pays the remaining balance if there is any amount left over after the allowed amount has been paid. This amount should not to be confused with co-pay or deductibles owed by a patient.

**American Dental Association (ADA):** The ADA is a not-for-profit organization working to power the profession of dentistry on the national, state and local level. There are 162,000 ADA members representing all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Membership in the national organization includes membership in one of our 53 state and 545 local dental societies. A member-run organization, the ADA is managed by an elected Board of Trustees and governed by a 483-member House of Delegates.

**American Medical Association (AMA):** The AMA is the largest organization of physicians in the U.S. dedicated to improving the quality of healthcare administered by providers across the country. The current procedural technology (CPT) code set is maintained and revised by the AMA in accordance with federal guidelines.

**Aging:** A formal medical billing term that refers to insurance claims that haven't been paid or balances owed by patients overdue by more than 30 days. Aging claims may become denied if they aren't filed in time with a health insurance company.

**Ancillary Services:** Any service administered in a hospital or other healthcare facility other than room and board, including biometrics tests, physical therapy, and physician consultations among other services.

**Appeal:** Appeal occurs when a patient or a provider tries to convince an insurance company to pay for healthcare after it has decided not to cover costs for someone on a claim. Medical billing specialists deal with appeals after a claim has been denied or rejected by an insurance company.

**Applied to Deductible (ATD):** This term refers to the amount of money a patient owes a provider that goes to paying their yearly deductible. A patient's deductible is determined by their insurance plan and can range in price.

**Assignment of Benefits (AOB):** This term refers to insurance payments made directly to a healthcare provider for medical services received by the patient. Assignment of benefits occurs after a claim has been successfully processed with an insurance company.

**Application Service Provider (ASP):** ASP is a digital network that allows healthcare providers to access quality medical billing software and technologies without needing to purchase and maintain it themselves. Providers who use ASP typically pay a monthly fee to the company that maintains the billing software.

**Authorization:** This term refers to when a patient's health insurance plan requires them to get permission from their insurance providers before receiving certain healthcare services. A patient may be denied coverage if they see a provider for a service that needed authorization without first consulting the insurance company.

## B

**Beneficiary:** The beneficiary is the person who receives benefits and/or coverage under a healthcare plan. The beneficiary of an insurance plan may not be the person paying for the plan, as is the case for young children covered under their parents' plans.

**Blue Cross Blue Shield:** Blue Cross Blue Shield is a federation of 38 health insurance companies in the U.S. (some of which are non-profit companies) that offer health insurance options to eligible persons in their area. Blue Cross Blue Shield offers healthcare plans to over 100 million people in the U.S.

## C

**Capitation:** Capitation fee, or capitation rate, is the fixed amount paid from an insurer to a provider. This is the amount that is paid (generally monthly) to cover the cost of services performed for a patient. Capitation fees can be lower in higher population areas. A capitation is different from a deductible or co-pay.

**Clean Claim:** This refers to a medical claim filed with a health insurance company that is free of errors and processed in a timely manner. Some providers may send claims to organizations that specialize in producing clean claims, like clearinghouses.

**Clearinghouse:** Clearinghouses are facilities that review and correct medical claims as necessary before sending them to insurance companies for final processing. This meticulous editing process for claims is known in the medical billing industry as “scrubbing.”

**Centers for Medicare and Medicaid Services (CMS):** The CMS is the federal entity that manages and administers healthcare coverage through Medicare and Medicaid. CMS coordinates with providers and enrollees to provide healthcare to over 100 million Americans.

**CMS 1500:** The CMS 1500 is a paper medical claim form used for transmitting claims based on coverage by Medicare and Medicaid plans. Commercial insurance providers often require that providers use CMS 1500 forms to process their own paper claims.

**Code on Dental Procedures and Nomenclature (CDT Code):** The purpose of the CDT Code is to achieve uniformity, consistency and specificity in accurately documenting dental treatment. One use of the CDT Code is to provide for the efficient processing of dental claims, and another is to populate an Electronic Health Record. On August 17, 2000 the CDT Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure codes from the version of the CDT Code in effect on the date of service. The CDT Code is also used on paper dental claims, and the ADA's paper claim form data content reflects the HIPAA electronic standard.

**Coding:** Coding is the process of translating a physician's documentation about a patient's medical condition and health services rendered into medical codes that are then plugged into a claim for processing with an insurance company. Medical billing specialists must be familiar with many code sets in order to perform their job duties.

**Co-Insurance:** The percentage of coverage that a patient is responsible for paying after an insurance company pays the portion agreed upon in a health plan. Co-insurance percentages vary depending on the health plan.

**Collection Ratio:** This refers to the ratio of payments received relative to the total amount owed to providers.

**Contractual Adjustment:** This refers to a binding agree between a provider, patient, and insurance company wherein the provider agrees to charges that it will write off on behalf of the patient. Contractual adjustments may occur when there is a discrepancy between what a provider charges for healthcare services and what an insurance company has decided to pay for that service.

**Coordination of Benefits (COB):** COB occurs when a patient is covered by more than one insurance plan. In this situation one insurance company will become the primary carrier and all other companies will be considered secondary and tertiary carriers that may cover costs left after the primary carrier has paid.

**Co-Pay:** A patient's co-pay is the amount that must be paid to a provider before they receive any treatment or services. Co-pays are separate from a deductible, and will vary depending on a person's insurance plan.

**Current Procedural Technology (CPT) Code:** CPT codes represent treatments and procedures performed by a physician in a 5-digit format. CPT codes are entered together with ICD-9 codes that explain a patient's diagnosis. Medical billing specialists will enter CPT codes into claims so insurance companies understand the nature of healthcare a patient received with a provider.

**Credentialing:** The application process for a provider to coordinate with an insurance company. Once providers have become credentialed with an insurance company, they have the opportunity to work with that company in providing affordable healthcare to patients.

**Credit Balance:** Refers to the sum shown in the “balance” column of a billing statement that reflects the amount due for services rendered.

**Crossover Claim:** When claim information is sent from a primary insurance carrier to a secondary insurance carrier, or vice versa.

## D

**Date of Service (DOS):** The date when a provider performed healthcare services and procedures.

**Day Sheet:** A document that summarizes the services, treatments, payments, and charges that a patient received on a given day.

**Deductible:** The amount a patient must pay before an insurance carrier starts their healthcare coverage. Deductibles range in price according to terms set in a person's health plan.

**Demographics:** The patient's information required for filing a claim, such as age, sex, address, and family information. An insurance company may deny a claim if it contains inaccurate demographics.

**Date of Birth (DOB):** The exact date a patient was born.

**Downcoding:** Downcoding occurs when an insurance company finds there is insufficient evidence on a claim to prove that a provider performed coded medical services and so they reduce or remove those codes. Downcoding usually reduces the cost of a claim.

**Duplicate Coverage Inquiry (DCI):** A formal request typically submitted by an insurance carrier to determine if other health coverage exists for a patient.

**Dx:** The abbreviation for diagnosis codes, also known as ICD codes.

## E

**Electronic Claim:** A claim sent electronically to an insurance carrier from a provider's billing software. The format of electronic claims must adhere to medical billing regulations set forth by the federal government.

**Electronic Funds Transfer:** A method of transferring money electronically from a patient's bank account to a provider or an insurance carrier.

**Electronic Medical Records (EMR):** EMR is a digitized medical record for a patient managed by a provider onsite. EMRs may also be referred to as electronic health records (EHRs).

**Enrollee:** A person covered by a health insurance plan.

**Explanation of Benefits (EOB):** A document attached to a processed medical claim wherein the insurance company explains the services they will cover for a patient's healthcare treatments. EOBs may also explain what is wrong with a claim if it's denied.

**Electronic Remittance Advice (ERA):** The digital version of EOB, which specifies the details of payments made on a claim either by an insurance company or required by the patient.

**ERISA:** Stands for the Employee Retirement Income Security Act of 1974. This act established guidelines and requirements for health and life insurance policies including appeals and disclosure of grievances.

## F

**Fee for Service:** This refers to a type of health insurance wherein the provider is paid for every service they perform. People with fee-for-service plans typically can choose whatever hospitals and physicians they want to receive care in exchange for higher deductibles and co-pays. (Concept of Indemnity or Point-of-sale)

**Fee Schedule:** A document that outlines the costs associated for each medical service designated by a CPT code.

**Financial Responsibility:** Whoever owes the healthcare provider money has financial responsibility for the services rendered. Insurance companies or patients themselves may be financially responsible for the costs associated with care, and these responsibilities are typically outlined in a healthcare plan contract.

**Fiscal Intermediary (FI):** The name for Medicare representatives who process Medicare claims.

**Formulary:** A table or list provided by an insurance carrier that explains what prescription drugs are covered under their health plans.

**Fraud:** Providers, patients, or insurance companies may be found fraudulent if they are deliberately achieving their ends through misrepresentation, dishonesty, and general illegal activity. Medical billing specialists who deliberately enter incorrect or misleading information on claims may be charged with fraud.

## G

**Group Health Plan (GPH):** A plan provided by an employer to provide healthcare options to a large group of employees.

**Group Name:** The name of the group, insurance carrier, or insurance plan that covers a patient.

**Group Number:** A number given to a patient by their insurance carrier that identifies the group or plan under which they are covered.

**Guarantor:** The party paying for an insurance plan who is not the patient. Parents, for example, would be the guarantors for their children's health insurance.

## H

**Healthcare Financing Administration:** The former name for what is now the CMS.

**Healthcare Financing Administration Common Procedure Coding System (HCPCS):** HCPCS is a three-tier coding system used to explain services, devices, and diagnoses administered in the healthcare system. Medical billing specialists utilize codes in the HCPCS on a daily basis to file claims.

**Healthcare Insurance:** This is insurance offered to a group or an individual to cover costs associated with medical care and treatment. Those covered by healthcare insurance typically must pay a premium for their plans in addition to various co-pays and/or deductibles.

**Healthcare Provider:** These are the entities that offer healthcare services to patients, including hospitals, physicians, and private clinics, hospices, nursing homes, and other healthcare facilities.

**Healthcare Reform Act:** The major healthcare legislation passed in 2010 designed to make healthcare accessible and less expensive for more Americans.

**Health Insurance Claim:** The unique number ascribed to an individual to identify them as a beneficiary of Medicare.

**Health Insurance Portability and Accountability Act (HIPAA):** HIPAA was a law passed in 1996 with an aim to improve the scope of healthcare services and establish regulations for securing healthcare records from unwanted parties.

**Health Maintenance Organization (HMO):** HMOs are networks of healthcare providers that offer healthcare plans to people for medical services exclusively in their network.

**Hospice:** This refers to medical care and treatment for persons who are terminally ill.

## I

**ICD-9 Codes:** ICD-9 codes are an international set of codes that represent diagnoses of patients' medical conditions as determined by physicians. Medical billing specialists may translate a physician's diagnoses into ICD-9 codes and then input those codes into a claim for processing.

**ICD-10 Codes:** ICD-10 codes are the updated international set of codes based on the preceding ICD-9 codes. ICD-10 codes are estimated to be mandatory in the American healthcare system by October 2014.

**Indemnity:** A type of health insurance plan whereby a patient can receive care with any provider in exchange for higher deductibles and co-pays. Indemnity is also known as fee-for-service insurance.

**In-Network:** This term refers to a provider's relationship with a health insurance company. A group of providers may contract with an insurance company to form a network of healthcare professionals that a person can choose from when enrolled in that insurance company's health plan.

**Inpatient:** Inpatient care occurs when a person has a stay at a healthcare facility for more than 24 hours.

**Independent Practice Association (IPA):** The IPA is a professional organization of physicians who have a contract with an HMO.

**Intensive Care:** Intensive care is the unit of a hospital reserved for patients that need immediate treatment and close monitoring by healthcare professionals for serious illnesses, conditions, and injuries.

## M

**Medicare Administrative Contractor (MAC):** MACs are contract with the federal government to process Medicare claims.

**Managed Care Plan:** A health insurance plan whereby patients can only receive coverage if they see providers who operate in the insurance company's network.

**Maximum Out of Pocket:** The amount a patient is required to pay. After a patient reaches their maximum out of pocket, their healthcare costs should be covered by their plan.

**Medical Assistant:** An employee in the healthcare system such as a physician's assistant or a nurse practitioner who perform duties in administration, nursing, and other ancillary care.

**Medical Coder:** A medical coder is responsible for assigning various medical codes to services and healthcare plans described by a physician on a patient's superbill.

**Medical Billing Specialist:** A medical billing specialist is responsible for using information regarding services and treatments performed by a healthcare provider to complete a claim for filing with an insurance company so the provider can be paid.

**Medical Necessity:** This term refers to healthcare services or treatments that a patient requires to treat a serious medical condition or illness. This does not include cosmetic or investigative services.

**Medical Record Number:** A unique number ascribed to a person's medical record so it can be differentiated from other medical records.

**Medicare Secondary Payer:** The insurance company that covers any remaining expenses after Medicare has paid for a patient's coverage.

**Medical Savings Account (MSA):** An MSA is an optional health insurance payments plan whereby a person apportions part of their untaxed earnings to an account reserved for healthcare expenses. A person with an MSA can only contribute a certain amount of their earnings per year. Any unused funds in an MSA at the end of the year will roll over to the next.

**Medical Transcription:** The process of converting dictated or handwritten instructions, observations, and documentation into digital text formats.

**Medicare:** Medicare is a government insurance program started in 1965 to provide healthcare coverage for persons over 65 and eligible people with disabilities.

**Medicare Coinsurance Days:** Referring to 61st through 90th days of inpatient treatment, the law requires that patients pay for a portion of their healthcare during Medicare coinsurance days.

**Medicaid:** Medicaid is a joint federal and state assistance program started in 1965 to provide health insurance to lower-income persons. Both state and federal governments fund Medicaid programs, but each state is responsible for running its own version of Medicaid within the minimum requirements established by federal law.

**Medigap:** Medigap is supplemental health insurance under Medicaid for eligible persons who need help covering co-pays, deductibles, and other large fees.

**Modifier:** Modifiers are additions to CPT codes that explain alterations and modifications to an otherwise routine treatment, exam, or service.

## N

**Non-Covered Charge (N/C):** N/Cs are procedures and services not covered by a person's health insurance plan.

**Not Elsewhere Classifiable (NEC):** A term used to describe a procedure or service that can't be described within the available code set.

**Network Provider:** A provider within a health insurance company's network that has contracted with the company to provide discounted services to a patient covered under the company's plan.

**Non-participation:** This is when a provider refuses to accept Medicare payments as a sufficient amount for the services rendered to a patient.

**Not Otherwise Specified (NOS):** This term is used in ICD-9 codes to describe conditions with unspecified diagnoses.

**National Provider Identifier (NPI) Number:** A unique 10-digit number ascribed to every healthcare provider in the U.S. as mandated by HIPAA.

## O

**Office of Inspector General (OIG):** The organization responsible for establishing guidelines and investigating fraud and misinformation within the healthcare industry. The OIG is part of the Department of Health and Human Services.

**Out-of-Network:** Out-of-network refers to providers outside of an established network of providers who contract with an insurance company to offer patients healthcare at a discounted rate. People who go to out-of-network providers typically have to pay more money to receive care.

**Outpatient:** This term refers to healthcare treatment that doesn't require an overnight hospital stay, including a routine visit to a primary care doctor or a non-invasive surgery.

## P

**Patient Responsibility:** This refers to the amount a patient owes a provider after an insurance company pays for their portion of the medical expenses.

**Primary Care Physician (PCP):** The physician who provides the basic healthcare services for a patient and recommends additional care for more serious treatments as necessary.

**Point of Service Plans:** A plan whereby patients with HMO membership may receive care at non-HMO providers in exchange for a referral and paying a higher deductible.

**Place of Service Code:** A two-digit code used on claims to explain what type of provider performed healthcare services on a patient.

**Preferred Provider Organization (PPO):** A plan similar to an HMO whereby a patient can receive healthcare from providers within an established network set up by an insurance company.

**Practice Management Software:** Software used for scheduling, billing, and recordkeeping at a provider's office.

**Preauthorization:** Some insurance plans require that a patient receive preauthorization from the insurance company prior to receiving certain medical services to make sure the company will cover expenses associated with those services.

**Pre-Certification:** A process similar to preauthorization whereby patients must check with insurance companies to see if a desired healthcare treatment or service is deemed medically necessary (and thus covered) by the company.

**Pre-determination:** A maximum sum as explained in a healthcare plan an insurance company will pay for certain services or treatments.

**Pre-existing Condition (PEC):** PEC is a medical condition a patient had before receiving coverage from an insurance company. A person might become ineligible for certain healthcare plans depending on the severity and length of their PEC.

**Pre-existing Condition Exclusion:** The existence of a PEC denies a person certain coverage in some health insurance plans.

**Premium:** The sum a person pays to an insurance company on a regular (usually monthly or yearly) basis to receive health insurance.

**Privacy Rule:** Standards for privacy regarding a patient's medical history and all related events, treatments, and data as outlined by HIPAA.

**Provider:** A provider is the healthcare facility that administered healthcare to an individual. Physicians, clinics, and hospitals are all considered providers.

**Provider Transaction Access Number (PTAN):** This refers to a provider's current legacy provider number with Medicare.

## R

**Referral:** This is when a provider recommends another provider to a patient to receive specialized treatment.

**Remittance Advice (R/A):** The R/A is also known as the EOB, which is the document attached to a processed claim that explains the information regarding coverage and payments on a claim.

**Responsible Party:** The person who pays for a patient's medical expenses, also known as the guarantor.

**Revenue Code:** A three-digit code used on medical bills that explains the kind of facility in which a patient received treatment.

**Relative Value Amount (RVA):** The median amount Medicare will repay a provider for certain services and treatments.

## S

**Scrubbing:** A process by which insurance claims are checked for errors before being sent to an insurance company for final processing. Providers scrub claims in an attempt to reduce the number of denied or rejected claims.

**Self-Referral:** When a patient does their own research to find a provider and acts outside of their primary care physician's referral.

**Self-Pay:** Payment made by the patient for healthcare at the time they receive it at a provider's facilities.

**Secondary Insurance Claim:** The claim filed with the secondary insurance company after the primary insurance company pays for their portion of healthcare costs.

**Secondary Procedure:** This is when provider performs another procedure on a patient covered by a CPT code after first performing a different CPT procedure on them.

**Security Standard:** The security standard serves as the guidelines for policies and practices necessary to reduce security risks within the healthcare system. The security standard policies work in concert with the security guidelines set in place with the passage of HIPAA.

**Skilled Nursing Facility:** These are facilities for the severely ill or elderly that provide specialized long-term care for recovering patients. Skilled nursing facilities are alternative healthcare establishments to extended hospital stays and may be covered by eligible patients' insurance policies.

**Signature on File (SOF):** A patient's official signature on file for the purpose of billing and claims processing.

**Software as a Service (SAAS):** Medical billing software hosted off site by another company and only accessible with Internet access. SAAS is useful for providers who don't want to maintain and update in-house medical billing software.

**Specialist:** A physician or medical assistant with expertise in a specific area of medicine. Oncologists, pediatricians, and neurologists are among the many specialists in the medical field.

**Subscriber:** The subscriber is the individual covered under a group policy. For instance, an employee of a company with a group health policy would be one of many subscribers on that policy.

**Superbill:** A document used by healthcare staff and physicians to write down information about a patient receiving care. The superbill can contain demographic information, insurance information, and especially any diagnoses or healthcare plans written by the physician. A medical billing specialist inputs the information on a patient's superbill into a claim.

**Supplemental Insurance:** Supplemental insurance can be a secondary policy or another insurance company that covers a patient's healthcare costs after receiving coverage from their primary insurance. Supplemental insurance policies typically help patients cover expensive deductibles and copays.

## T

**Treatment Authorization Request (TAR):** A unique number the insurance company gives the provider for billing purposes. A provider must receive the insurance company's TAR number before administering healthcare to a patient covered by the company.

**Taxonomy Code:** Medical billing specialists utilize this unique codeset for identifying a healthcare provider's specialty field.

**Term Date:** The end date for an insurance policy contract, or the date after which a person no longer receives or is no longer eligible for health insurance with company. Term dates are typically determined on a case-by-case basis.

**Tertiary Insurance Claim:** A claim filed by a provider after they have filed claims for primary and secondary health insurance coverage on behalf of a patient. Tertiary insurance claims often cover the remaining healthcare costs such as deductibles and co-pays left over after the primary and secondary

claims have been processed.

**Third Party Administrator (TPA):** The name for the organization or individual that manages healthcare group benefits, claims, and administrative duties on behalf of a group plan or a company with a group plan.

**Tax Identification Number (TIN):** A unique number a patient or a company may have to produce for billing purposes in order to receive healthcare from a provider. The TIN is also known as the employment identification number (EIN).

**Triple Option Plan (TOP):** Also referred to as the cafeteria plan, this plan gives an enrolled individual the options to choose between an HMO, a PPO, or a traditional point of service plan for their health insurance. Some companies offer triple option plans to their employees to accommodate the needs of a diverse staff.

**Type of Service (TOS):** A field on a claim for describing what kind of healthcare services or procedures a provider administered.

**TRICARE:** TRICARE is the federal health insurance plan for active service members, retired service members, and their families, in addition to survivors of service members. TRICARE was previously known as CHAMPUS.

## U

**UB04:** A form used by providers for filing claims with insurance companies. The UB04 form has a format similar to that of the CMS 1500 form.

**Unbundling:** This term refers to the fraudulent practice of ascribing more than one code to a service or procedure on a superbill or claim form when only one is necessary.

**Untimely Submission:** Claims have a specific timeframe in which they can be sent off to an insurance company for processing. If a provider fails to file a claim with an insurance company in that timeframe, it is marked for untimely submission and will be denied by the company.

**Upcoding:** Upcoding is the fraudulent practice of ascribing a higher ICD-9 code to a healthcare procedure in an attempt to get more money than necessary from the insurance company or patient.

**Unique Physician Identification Number (UPIN):** A unique six-digit identification number given to physicians and other healthcare personnel, which has subsequently been replaced by a national provider identifier (NPI) number.

**Usual Customary and Reasonable (UCR):** The UCR is the amount of money stipulated in a contract that an insurance company agrees to pay for healthcare costs. After passing the UCR a patient is typically responsible for covering their healthcare costs.

**Utilization Limit:** The limit per year for coverage under certain available healthcare services for Medicare enrollees. Once a patient passes the utilization limit for a service, Medicare may no longer cover them.

**Utilization Review (UR):** An investigation or audit performed to optimize the number of inpatient and outpatient services a provider performs.

## W

**Worker's Compensation:** Worker's compensation is paid by an employer when an employee becomes ill or injured while performing routine job duties. Most states have laws requiring that companies provide worker's compensation.

**Write-Off:** This term refers to the discrepancy between a provider's fee for healthcare services and the amount that an insurance company is willing to pay for those services that a patient is not responsible for. The write-off amount may be categorized as "not covered" amounts for billing purposes.

# Migrated Payments

Written by Rahul Krishnan | Last published at: August 02, 2022

## Migrated Balances

### Overview

As you transitioned to CareStack from another software, you tried to collect insurance and patient balances and close accounts. Yet some of those patients and carriers didn't pay before it was time to let that software go. Your practice had to decide what to do with those leftover balances.

In some cases, whatever was left to pay may have been transferred to CareStack as a general balance, shown in CareStack as an **MSB** (Migrated Starting Balance). In other cases, those balances were left behind so you could start fresh.

Without the MSB, you would need to add a code/charge to create a balance deficit for the patient and apply the patient payment for the newly added code but doing so will inflate your production. If you ignore the credit that the patient owes the practice, your collections are off. Instead, CareStack lets you apply the payment to the migrated balance -either one that was brought over, or one you create.

### Create a Migrated Balance

When your practice didn't migrate balances, or you received a payment on a balance that was not migrated, you can create your own migrated balance transaction. It will reflect what was owed in your legacy system but not inflate your production. Apply your new credits against that balance and everything matches and reflects correctly in your financial records.

You can create the migrated balance entry wherever you are working in the patient's financial record, including the Ledger, Insurance Payment module or Patient Payment slider.

Each entry would apply to only one provider and one location, so you may need to create more than one balance code. It helps keep the financial records straight.

### Allocate an Insurance Payment to an MSB

Allocate an insurance payment to a migrated balance in much the same way you allocate an insurance payment to a current claim, you just use a slightly different tab.

- Start at the Insurance Payments module with your payment receipt selected.
- Select the **Migrated Payment** tab.
- Select the **Patient**.
- Enter the payment details from your EOB. CareStack will calculate the difference between the expected insurance payment and the actual insurance payment.
  - Underpayments are shown in **Orange**
  - Overpayments are shown in **Green**.
- Select how to handle the difference (**Action**). Follow your practice's guidelines for handling an overpayment or underpayment. Depending on the action, you may need a corresponding **Adjustment Code**.

Shown below is an example of an insurance payment posting where the insurance paid amount matches the MSB balance in which case there is no need for any adjustments.

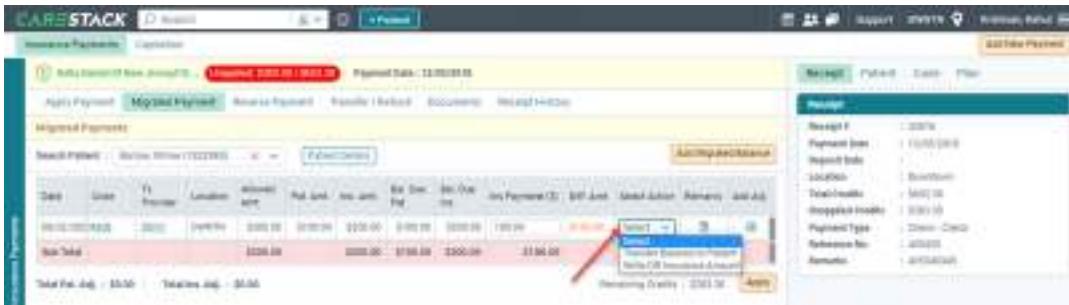
Date	Code	Tx. Provider	Location	Allowed Amt	Pst. Amt	Ins. Amt	Bal. Due Pmt	Bal. Due Ins.	MSB Payment (\$)	Dif. Amt.	Direct Action	Remarks	Add A/B
08/03/2021 MSB	DOCT	DIAMOND	\$300.00	\$100.00	\$200.00	\$100.00	\$200.00	\$200.00	200.00	\$0.00			
<b>Sub Total</b>				<b>\$300.00</b>		<b>\$200.00</b>		<b>\$200.00</b>	<b>\$200.00</b>				

Total Pst. Adj.: \$0.00    Total Ins. Adj.: \$0.00    Remaining Credits: \$183.30    **Apply**

## Allocate an Insurance Payment to an MSB

If the Allowed Amount from the EOB does NOT match the Allowed Amount in CareStack, you'll need to add an adjustment to account for the difference. This will be a separate adjustment.

1.If the insurance amount is less than the Balance due Insurance, there is an **underpayment** and the difference amount will be highlighted in red color. You can either transfer the deficient balance back to the patient or write off the difference amount in this scenario. You can choose any one of these two actions and the appropriate adjustment codes will be applied to the difference amount.



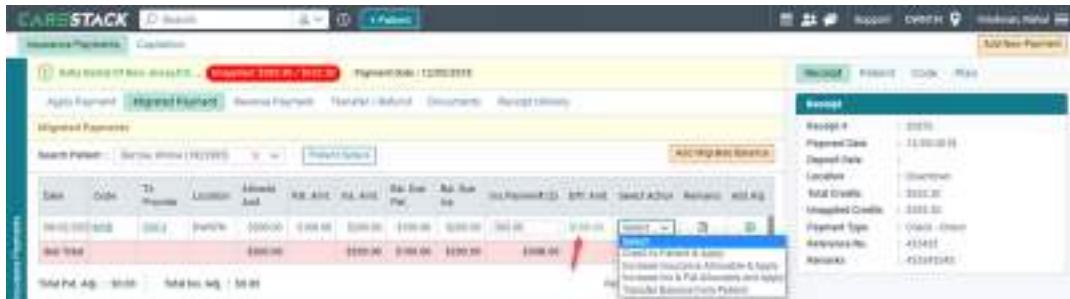
2. If the insurance amount is more than the Balance due Insurance, there is an **overpayment** by the insurance company and the excess amount will be shown in green. In case of an overpayment you can choose any of the following actions.

**Credit to Patient and Apply-** The excess amount will be transferred as patient unapplied credits.

**Increase Insurance Allowable and Apply-** Insurance Adj On adjustment will be triggered which will increase the insurance balance for the MSB code so as to make up for the difference in amounts. This can be done in case the excess amount need not be transferred to the patient as credits.

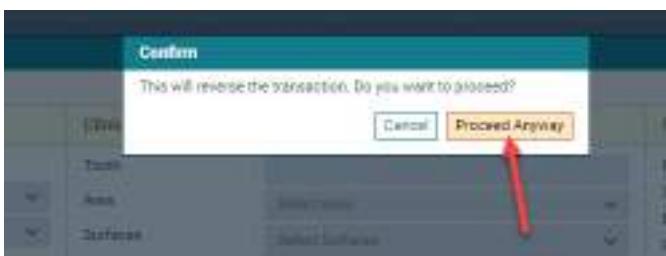
**Increase Ins & Pat Allowable and Apply-** The Ins Adj On and the Pat Adj On adjustments will be triggered. The difference in amounts can be counterbalanced by a combined increase in the patient balance as well as the insurance balance.

**Transfer balance from Patient-** A transfer adjustment will be applied where the patient balance will be reduced and the reduced amount will be pushed as insurance balance and the excess credits can be applied against this pushed insurance balance.



## Reversing MSB payments

In order to reverse the payments applied against an MSB code, one can navigate to the ledger and click on the MSB code which will open the code snapshot and the payments applied against the MSB code will be displayed. To reverse a payment, one can click on the X icon next to the payment line item and click on Proceed Anyway when an alert pops up indicating that you are about to reverse the payment. On reversing a Patient Payment applied against the MSB, the reversed amount will be pushed back as patient's unapplied credits. On reversing an Insurance Payment applied against the MSB, the reversed amount will be pushed back to the insurance receipt from which the payment was added.



# Computing Interest on Codes

Written by Revati Krishnan | Last published at: August 08, 2021

## What is Interest?

Interest is the payment from a borrower or deposit-taking financial institution to a lender or depositor of an amount above repayment of the principal sum (i.e. the amount borrowed). It is distinct from a fee which the borrower may pay the lender or some third party. The rate of interest is equal to the interest amount paid or received over a particular period divided by the principal sum borrowed or lent.

Compound interest means that interest is earned on prior interest in addition to the principal. Due to compounding, the total amount of debt grows exponentially. It is most often calculated on a daily, monthly, or yearly basis, and its impact is influenced greatly by its compounding rate.

## Business Rules and Requirement

An interest would be applied to those patient accounts with code payments overdue for more than a specified number of days. Accounts which has a net balance due patient above a certain amount and are overdue for more than a specified number of days after checkout. The overdue amount and overdue period can be set in practice settings, along with interest rates and codes for interest application.

Interest would be compounded, i.e. interest is earned on prior interest in addition to the actual balance. Interest is first applied to a patient on the date mentioned in the settings. It is then reapplied on the same patient if applicable on the same date every subsequent month.

For example, if Interest is first applied on the code on March 5th, then it will be reapplied (provided the settings are not changed) on April 5th, May 5th and so on till the code is paid fully. If interest was first applied on January 31st, then it will be applied again on Feb 28th, March 31st, April 30th, May 31st and so on till it's paid. So, if 29, 30 or 31 is chosen, then for months without that date, the last date of the month would be used.

Some practices may also want to set a minimum amount during interest application, which could be set as a threshold and if the amount calculated using premium rates is lesser than that value, the interest amount set would get applied.

## Setup

In Practice Settings > Payments > General > Billing Details, there would be a section to add Interest Details. It contains:

- Apply Interest on codes: Drop-down with values Yes and No(default). Choosing Yes will list the following fields.
- Apply interest on amounts overdue for: This is a text field where the user is allowed to type in a number specifying the number of overdue days after which interest would be applied. This field would be followed by days as text. The value in this field would be greater than 0.
- Apply interest when the overdue amount is greater than: This is an amount field with value \$0.00 populated by default.
- Interest Amount: an amount field would be shown beneath, wherein the user can enter an amount which will be added as interest to the patient account. Zero would be populated by default.
- Premium Rates: Two fields would be shown below - Monthly Rate and Annual Rate. Both fields would be percentage fields and would be interlinked. That is if the monthly rate is entered by the user, then the annual rate would be calculated automatically (Monthly rate\*12) and vice versa(Annual rate/12). Zero would be populated by default in both fields.
- Interest type to be applied: This would be drop down, with 4 choices
  - Apply whichever is greater(Default)
  - Apply whichever is lower
  - Interest Amount
  - Premium Rates
- Code to Apply Interest: Chosen box listing all custom codes(Codes with Code Type = Other in Practice Settings > Codes > Procedure codes)
- Date for Interest Generation: Contains dates 1-31 in a drop-down. A warning is shown if the user updates any detail after the interest generation has happened for the current month. OK button would be there.
- Provider: A chosen box listing all active providers. If the chosen provider doesn't work in the chosen location, the field for location would reset to "Select"
- Location: Location would be pre-populated with the current user location and all locations of the user is available in the drop-down.

All fields are mandatory

Interest would be calculated on patient codes only after the user sets up the above-mentioned settings.

## Process

Initially, all the basic settings in Practice Settings mentioned above would be set up only after which can Interest be applied to patient records. All codes of all patient records across the system with the balance due patient greater than zero would be inserted into a queue either at the end of the day or as and when the balance due patient value of a code becomes greater than zero. Removal of codes from this queue when its balance due patient becomes lesser than zero would also happen in a similar manner.

All patients belonging to accounts where the total unapplied credits equal or exceed the total balance would be ignored (Balance in the required aging bracket minus the current un-applied credits). For each patient, the Net Patient Balance in aging brackets exceeding the minimum number of days for interest generation would be used for interest generation.

The Net Patient Balance is the balance of the patient after reducing the current un-applied credits of that patient and interest would be generated only if that amount is still above the threshold amount.

Aging would be calculated using the transaction date of code completion - any adjustment or payment against the code will be tagged to the transaction date of code completion. Calculate the interest and generate the codes for each patient as per other criteria in practice settings.

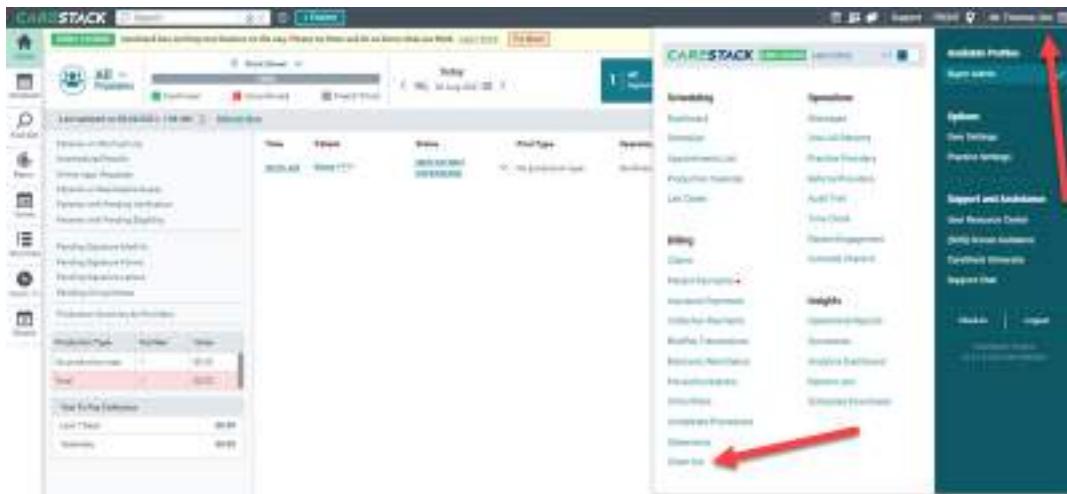
For each patient, a code would be checked out (Interest code that was set up in Practice Settings) in that patient account (inside a treatment plan named Interest) with billing order N and patient payable value the interest value that was computed. The provider and location of the checked out code would be those mentioned in the practice setting.

# Close out

Written by Geo Thomas | Last published at: July 25, 2022

The close out option enables the practice to wrap up all the previous activities of the practice. This is used to ensure that no further changes are done to their records. The frequency and the date of closeout depends on the policy of the practice.

In CareStack, this option is available under **System menu > Close out**.



Upon close out, the system goes into a locked state wherein updates/deletion to the following line items will be frozen

1. Deletion of receipts: Deletion of patient, insurance and collection receipts whose payment date precedes close out date will not be possible.
2. Backdated addition of receipts : Backdating payment receipts for a date preceding close out will not be possible.
3. Payable modification : Payable modification for procedure codes which are checked out and whose date of service is before the closeout date will not be possible.
4. Appointment details update : Modification of appointment details for appointments scheduled before close out date will not be possible.
5. Checkout of procedure codes : Procedure codes cannot be checked out on dates preceding the close out date.
6. Procedure code details update : Modification of procedure code details for codes which are checked out and whose date of service is preceding the close out date will not be possible.
7. Deletion of checked out codes : Deletion of procedure codes checked out before the close out date will not be possible.

All these details are available in CareStack once the user enters the **close out** menu.



If location level Close Out is enabled for the practice, the screen would appear as this.

The screenshot shows the 'Initiate Close Out' screen. At the top, there's a note about the process: 'Initiate a close out procedure to release assets and conclude delivery of the service or item to provider'. Below this are two tabs: 'Initiate Pre-Close Out' (selected) and 'Finalize Close Out'. The main area has fields for 'Close Out Date' (set to '2023-09-20') and 'Closing Remarks' (left empty). A large button at the bottom right says 'Initiate Pre-Close Out'.

To initiate a close out, the details to be entered are **New Close Out Date** and **Closing Remarks**, which are mandatory fields.

There would be two options, **Initiate Pre-Close Out** and **Finalize Close Out**.

Upon clicking **Initiate Pre-Close Out**, a confirmation would be asked and after confirming, it would appear under the **Finalize Close Out** tab.

The screenshot shows the 'Finalize Close Out' screen. It includes a note about the process: 'Open order can be closed once all assets have been released and no further delivery is required'. Below is a table titled 'Close Out Details' with columns: Order, Order ID, Close Out Date, Received Date, and Closing Remarks. One row in the table is highlighted with a red border, indicating a rejected entry: '100-0001-01-001' with 'Rejected' status and '2023-09-20' date.

There would be two options, **Finalize** and **Reject**.

Clicking **Reject** would terminate the close out process and it would appear in the **Close Out Details** tab as rejected.

The screenshot shows the 'Finalize Close Out' screen. It includes a note about the process: 'Open order can be closed once all assets have been released and no further delivery is required'. Below is a table titled 'Close Out Details' with columns: Order, Order ID, Close Out Date, Received Date, and Closing Remarks. One row in the table is highlighted with a red border, indicating a completed entry: '100-0001-01-001' with 'Received' status and '2023-09-20' date.

Now instead of **Reject**, if the **Finalize** option is selected, the process would be completed.

This would also appear in the **Close Out Details** tab, but with an option to **Revoke** it.

This is also possible to finalize a close out by clicking **Finalize Close Out** under the **Initiate Close Out** section directly.

However, clicking **Revoke** would undo all the effects of the previous close out.

Similarly it would always be possible to revoke the just previous close out by clicking the **Revoke** button next to it.

Embedded content from <https://www.loom.com/embed/3e5d0f35b69e4533a34d89f816f201ab>

## Permissions

The permissions related to close out comes under the General settings.

Users would require separate permissions to **View**, **Initiate**, **Finalize** and **Revoke** a Close Out.

The screenshot shows the 'Audit Trail Permissions' page in the Oracle BI Stack interface. On the left, there's a sidebar with a tree view of 'Audit Trail' permissions categorized under 'Audit Trail' and 'Audit Trail - Advanced'. The main area displays a table titled 'Audit Trail Permissions' with columns: 'Name', 'Type', 'Value', and 'Actions'. The table contains several rows, including 'Audit Trail', 'Audit Trail - Advanced', 'Audit Trail - Close Out', and 'Audit Trail - Close Out - Advanced'. At the bottom right of the table, there are 'Find' and 'Reset' buttons.

## Audit Trail entries

Any action related to **Close Out** would be logged in the **Audit Trail**.

The screenshot shows the 'Audit Trail' page in the Oracle BI Stack interface. It features a large table with columns: 'ID', 'Time', 'User', 'Event', 'Value', and 'Details'. The table lists several audit entries, such as 'Audit Trail - Close Out' and 'Audit Trail - Close Out - Advanced' events. A tooltip is visible over one of the entries, providing a detailed description of the audit event. The table has a header row and multiple data rows.

ID	Time	User	Event	Value	Details
00000000-0000-0000-0000-000000000000	10/10/2012 10:10:10	BI Admin	Audit Trail	00000000000000000000000000000000	Initial creation of audit trail
00000000-0000-0000-0000-000000000001	10/10/2012 10:10:10	BI Admin	Audit Trail	00000000000000000000000000000001	Initial creation of audit trail
00000000-0000-0000-0000-000000000002	10/10/2012 10:10:10	BI Admin	Audit Trail	00000000000000000000000000000002	Initial creation of audit trail
00000000-0000-0000-0000-000000000003	10/10/2012 10:10:10	BI Admin	Audit Trail	00000000000000000000000000000003	Initial creation of audit trail
00000000-0000-0000-0000-000000000004	10/10/2012 10:10:10	BI Admin	Audit Trail	00000000000000000000000000000004	Initial creation of audit trail
00000000-0000-0000-0000-000000000005	10/10/2012 10:10:10	BI Admin	Audit Trail	00000000000000000000000000000005	Initial creation of audit trail

# Payment Gateways

Written by Revati Krishnan | Last published at: October 03, 2022

A payment gateway is the technology that captures and transfers payment data from the paying entity to the acquirer and then transfers the payment acceptance or decline back to the payor. A payment gateway validates the customer's card details securely, ensures the funds are available and eventually enables merchants to get paid. It acts as an interface between a merchant's website and its acquirer. It encrypts sensitive credit card details, ensuring that information is passed securely from the customer to the acquiring bank, via the merchant. Here, CareStack is the merchant and the practice is the acquirer. The paying entity is either the patient or the insurance carrier.

CareStack supports two payment gateways,

- Bluepay
- Apex

## Bluepay

Bluepay is a provider of technology-enabled credit card payment processing services for enterprise, small and medium-sized businesses in the United States and Canada. Through physical POS(card processing machine), online and mobile interfaces, Bluepay processes payments and provides real-time settlement, reporting and reconciliation along with robust security features such as tokenization and point-to-point encryption.

To be able to process card/check payments within the CareStack software & Patient Portal through Bluepay, the practice will need to create an account with Bluepay. This can be done by following the steps below.

### Setting up a Bluepay account

The Bluepay account has to be set up by contacting Bluepay <https://www.clover.com/>

The account credentials will be emailed to the practice once Bluepay contacts them to confirm the registration.

The account ID and the secret key can be found by following the steps below.

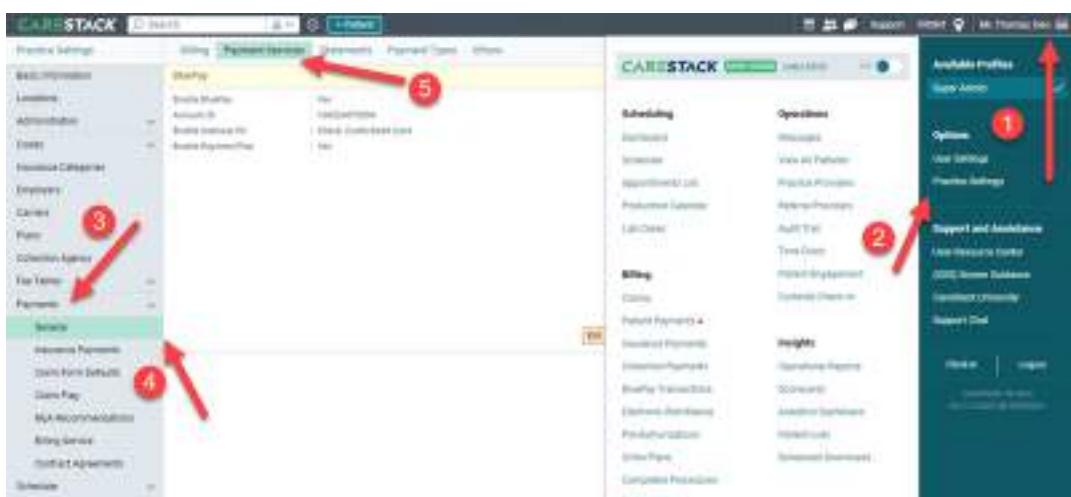
- Go to: <https://secure.bluepay.com/>
- Once you enter the login credentials, go to **Accounts > List**.
- Click on the relevant account to view the associated **Account ID** and **Secret Key**.

If no secret key is found, you can opt to generate one by clicking **Create New Key**.

Once the account is created, the practice will need to contact Bluepay to enable the Bluepay JS module. This can be done by emailing the Bluepay Account ID to the Bluepay Integration Support team ([integrationsupport@bluepay.com](mailto:integrationsupport@bluepay.com)).

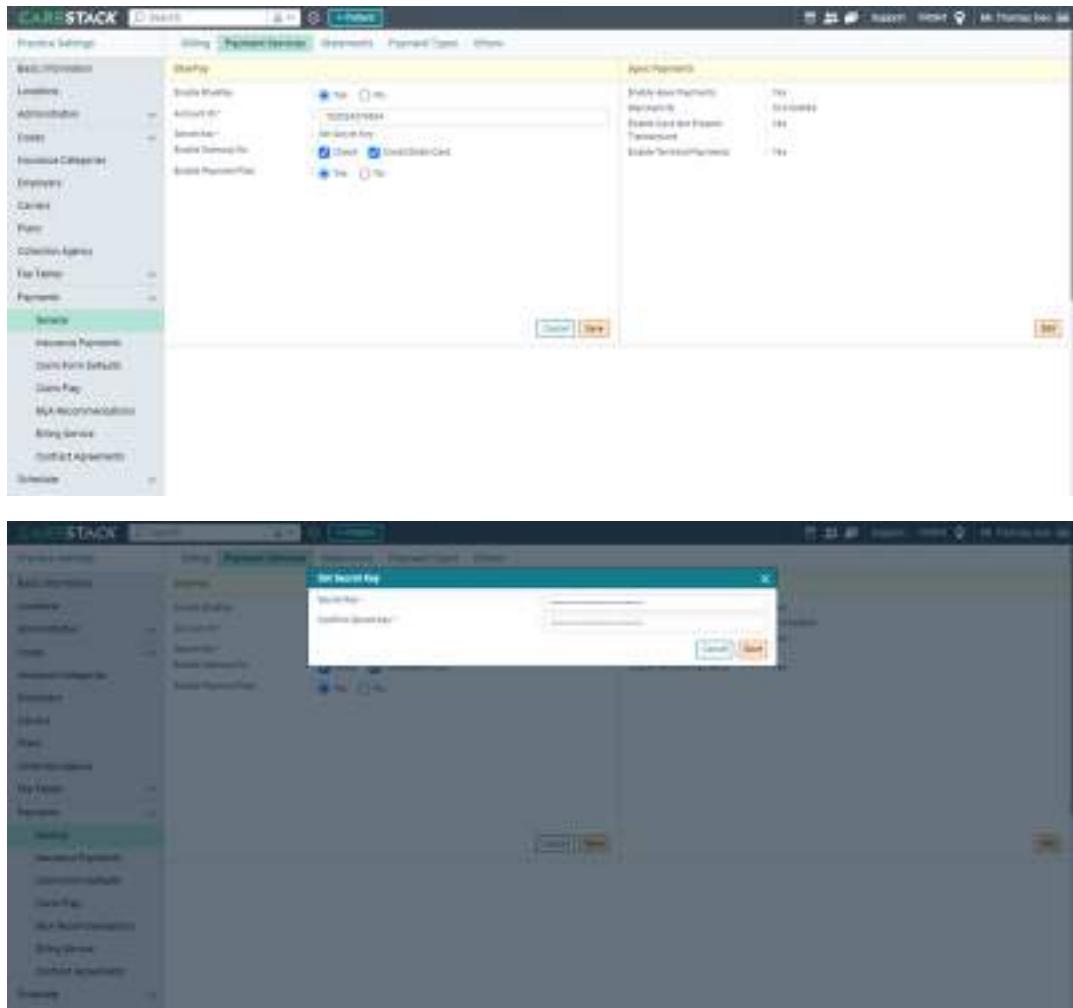
### Setting up Bluepay inside CareStack at a Account level

Once the above prerequisites are accomplished, the following steps will need to be performed to start processing card/check payments within CareStack:  
Navigate to **System menu > Practice Settings > Payments > General > Payment Services**

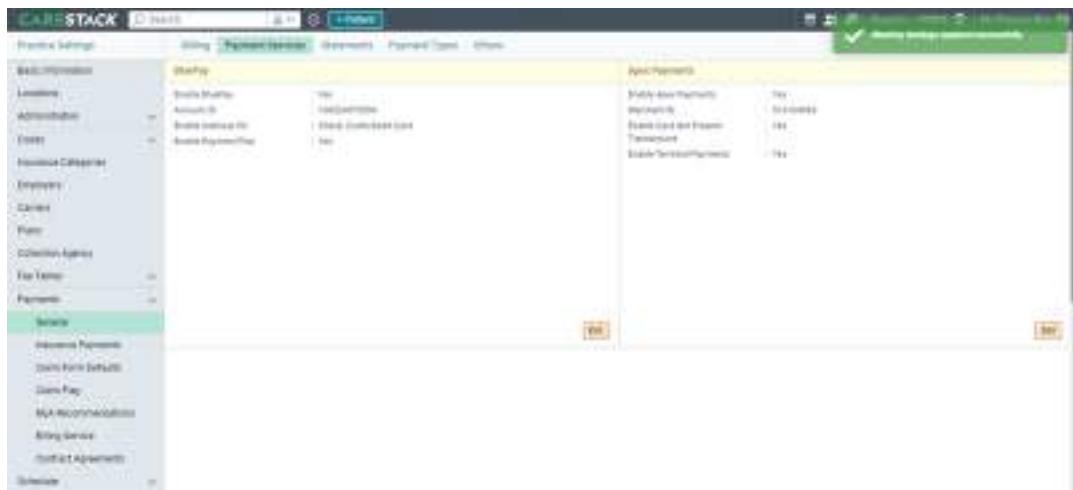


In the **Bluepay** section, click **Edit** to enter the following details:

- **Enable Bluepay:** Choose Yes for Bluepay account integration.
  - **Account ID:** Enter the identification number that corresponds with your Bluepay account.
  - **Secret Key:** Enter the Secret Key that corresponds with your Bluepay account.
  - **Enable Gateway for:** Choose whether to enable Bluepay payment processing for check or credit/debit card payments (or both) that are deposited during patient visits.
  - **Enable Payment Plan:** Setting this as 'Yes' would enable automated credit capture for payment plans(auto-debit from patient account).

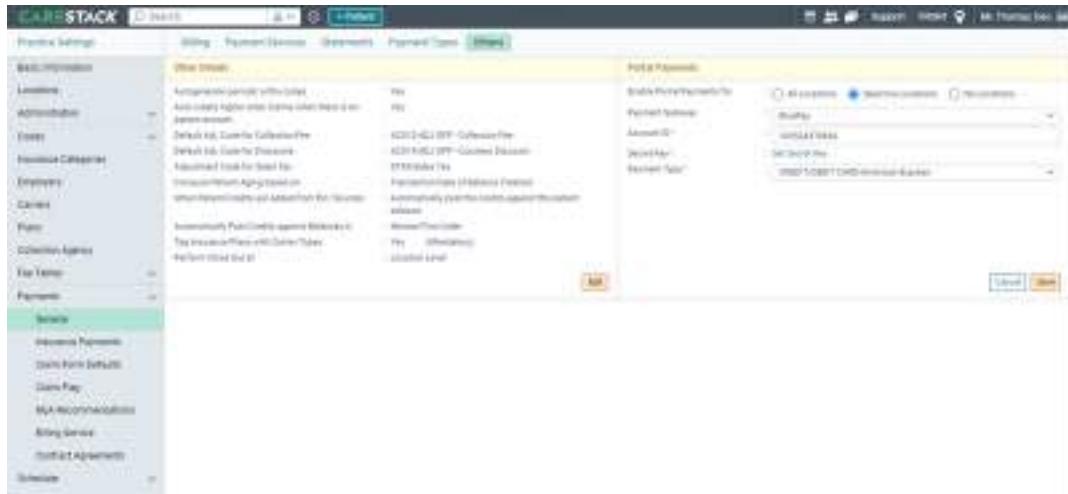


Hit **Save** when you are finished. The Payment Gateway is now configured for processing online payments.



In the **Portal Payments** section, hit **Edit** to enter the following details:

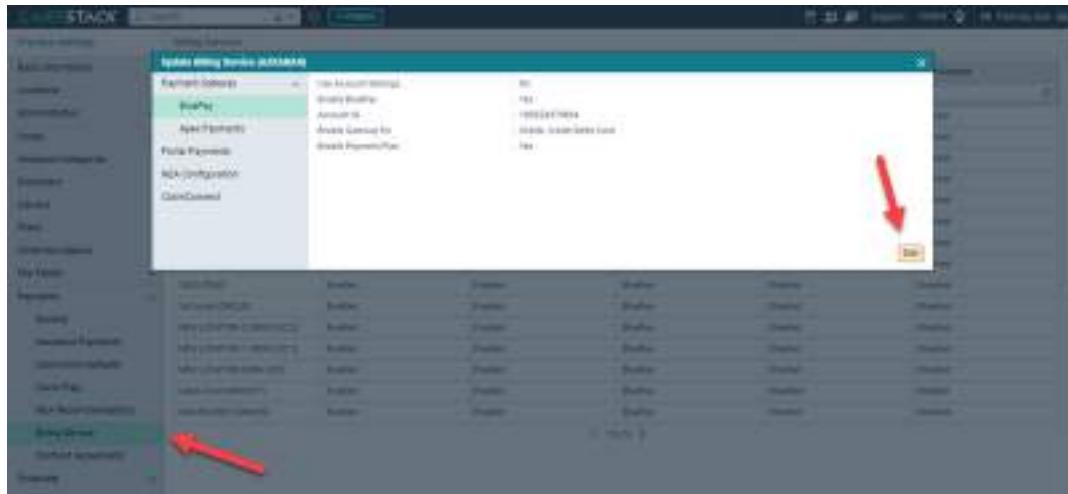
- In the **Enable Portal Payments for** section, set it as per the requirement of the practice. The available options are all locations, selective locations or no locations.
- Enter your Bluepay **Account ID**.
- Click **Set Secret Key** to enter your secret key.
- Select your **Default Payment Location**. At this time, all patient payments made via the Patient Portal will be tagged to this selected location. Some practices do not enable this if their locations operate as separate entities.
- Select the **Payment Type** that will help you identify patient payments made via the portal for reporting purposes. Patient payments made via the portal will also be posted to the patient's ledger with this payment type listed
- Set the **Tag Payments To** field as default payment location or patient default location as per requirement. The preference would vary for each practice.



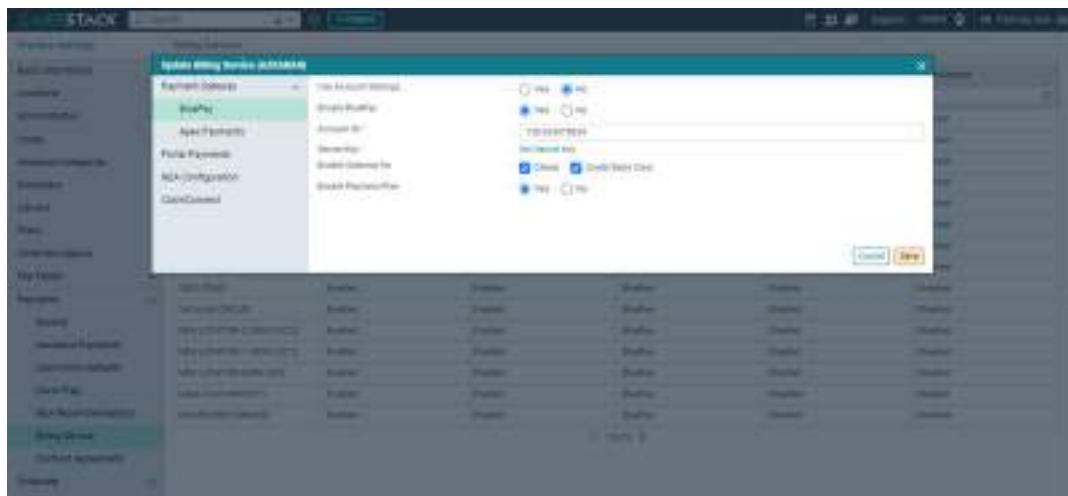
Hit **Save** when you are finished. The Payment Gateway is now configured for processing online payments.

## Setting up Bluepay inside CareStack at a Location level

For this, you would have to navigate to the **Billing Service** tab under **Payments**, select your location and click **Edit**.



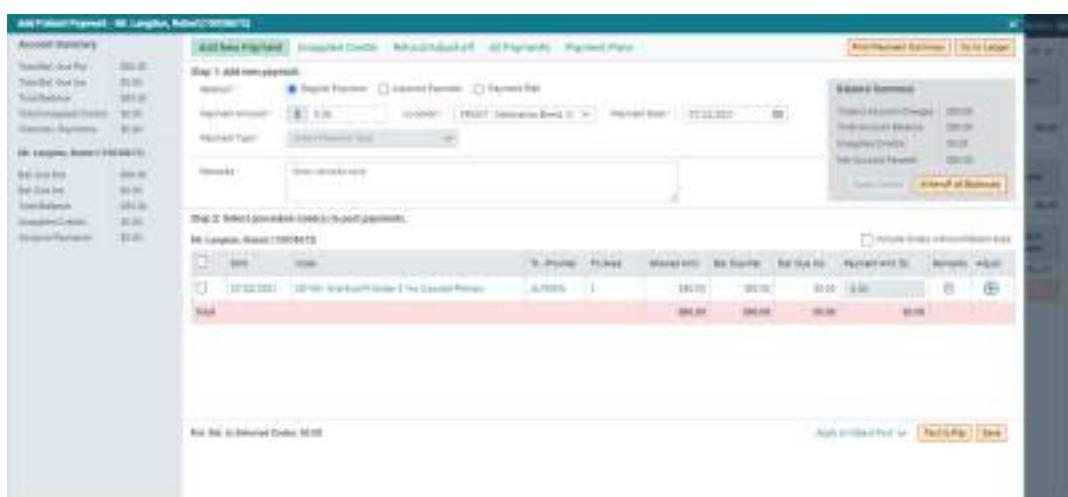
Once you set **Use Account Settings** as 'No', you would be asked to enter the **Account ID** and **Secret key**, if the Payment Gateway is set as Bluepay. The other fields are to be entered as per the interest of the practice and then hit **Save**.



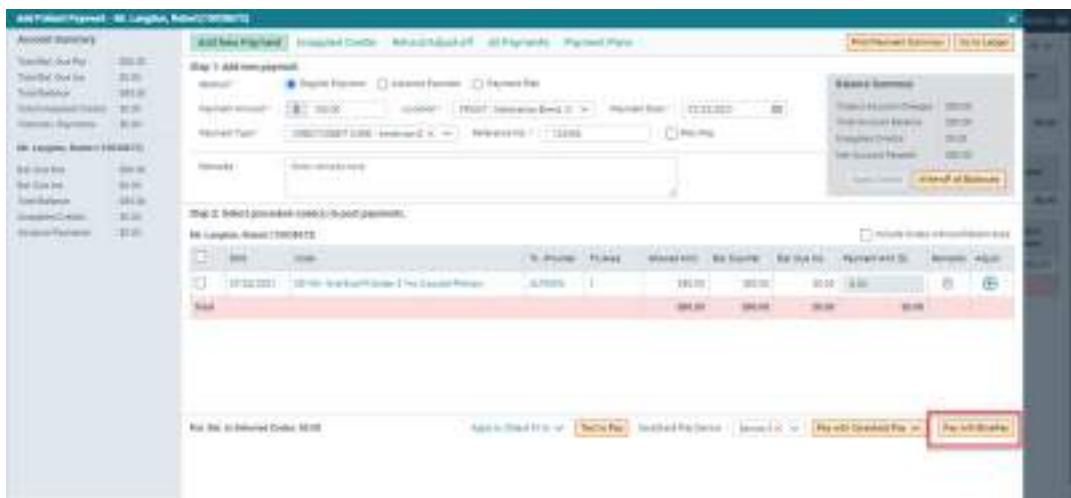
Embedded content from <https://www.loom.com/embed/41449634b9d040f9a53bc371799d594c>

## Payments using Bluepay

By default the payment screen would appear like this. Here, Robert Langdon is a test patient.



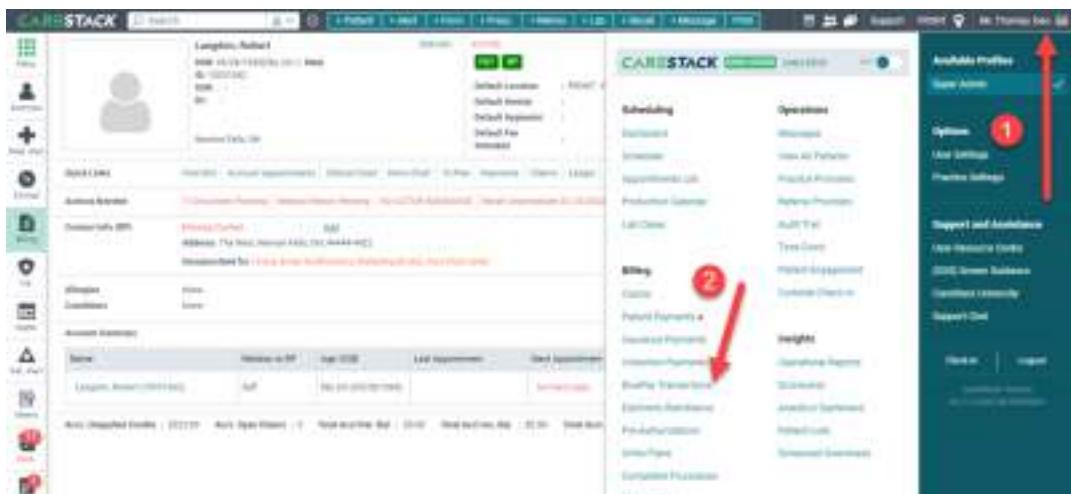
Notice the changes when a payment amount is entered and the payment method is changed to Credit/Debit Card or Check.



Once you click on **Pay with Bluepay**, this payment screen would appear where the card details have to be entered.



Clicking **Make Payment** would process the payment, and a receipt would be created. All transactions done through Bluepay would be visible under **System menu > Bluepay transactions**



Here, next to each payment, there would be an option to **void** the transaction. Clicking this would delete the receipt and refund the amount back to its source.

The screenshot shows the 'All Payments' tab in a medical software application. The interface includes a sidebar with account statements and a main grid for viewing and managing payments. The grid has the following columns:

Date	Account #	Account Name	Applied	Due Date	Payment Type	Location	Amount	Tax Applied	Credit Memo	Comments	Action
08-09-2021	1234567890	John Doe	0.00	08-15-2021	Check	Office	100.00	0.00		Lab Test Fee	<a href="#">Edit</a>
08-10-2021	1234567890	John Doe	0.00	08-15-2021	Check	Office	100.00	0.00		Lab Test Fee	<a href="#">Edit</a>
08-11-2021	1234567890	John Doe	0.00	08-15-2021	Check	Office	100.00	0.00		Lab Test Fee	<a href="#">Edit</a>

This could be done from the **All Payments** tab under **Billing > Payments** in the patient account as well.

Embedded content from <https://www.loom.com/embed/b587f7a1cda74952afeab6761671228b>

## Editing a payment

Unlike other payment methods, transactions done through Bluepay are not fully editable. The user would only be able to edit the Payment type, Location, Payment date, etc by clicking **more info** from the receipt.



## Unprocessed payments

In some cases, the Bluepay transaction would have been initiated, but the payment would not have been processed. The amount would have been debited from the patient's account, but the practice would not have received the payment. Though the real cause of this issue is unknown, this issue could be resolved by navigating to **System menu > Bluepay transactions**. The transaction would appear here as in the image below.



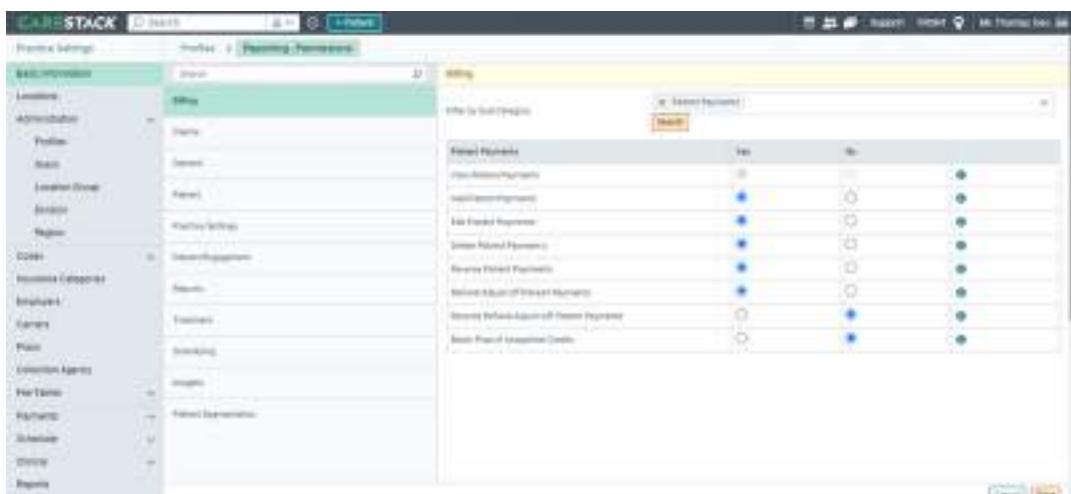
In such cases, clicking **Process Payment** would complete the transaction.

## Refunding a payment

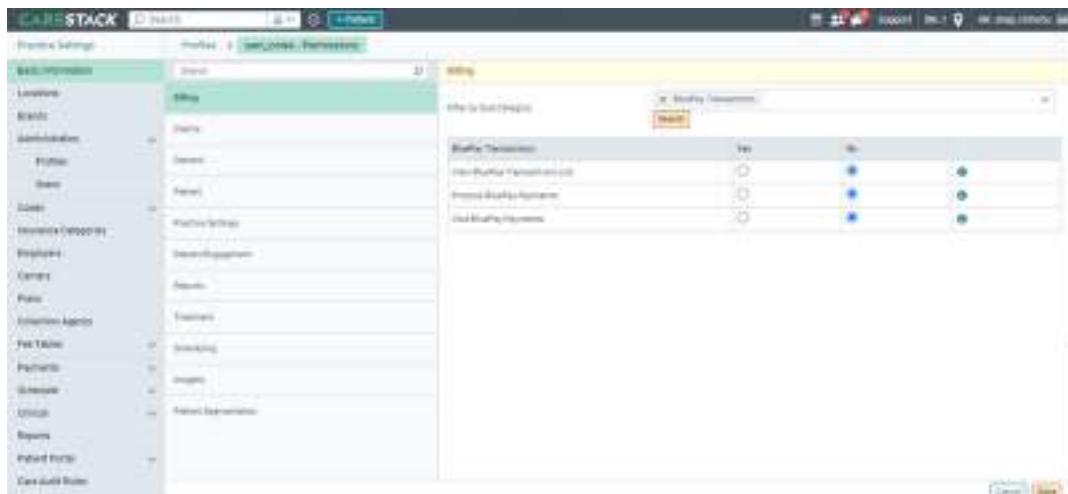
As mentioned before, a payment could be refunded by **voiding** the transaction. But in cases where a payment is to be refunded partially, the user would have to login to the Bluepay portal.

## Required Permissions

The following are the permissions required to carry out Bluepay transactions.



The following permissions are required to carryout bluepay related operations from the bluepay transactions list.



## Apex Payments

Apex is a payment gateway similar to Bluepay.

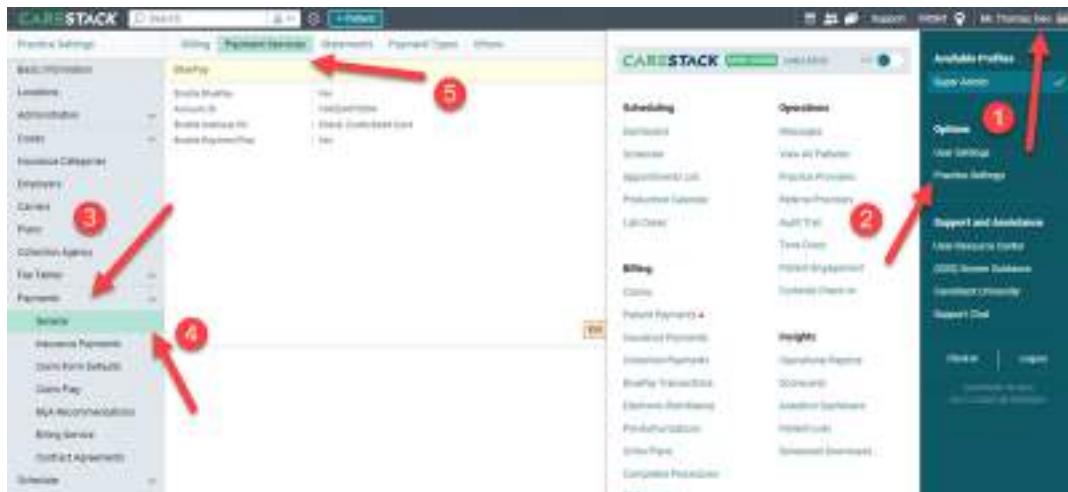
### Setting up an Apex account

To set up an account and to use their services, the practice would have to contact Apex Payment Solutions. <https://www.emcrey.com/>

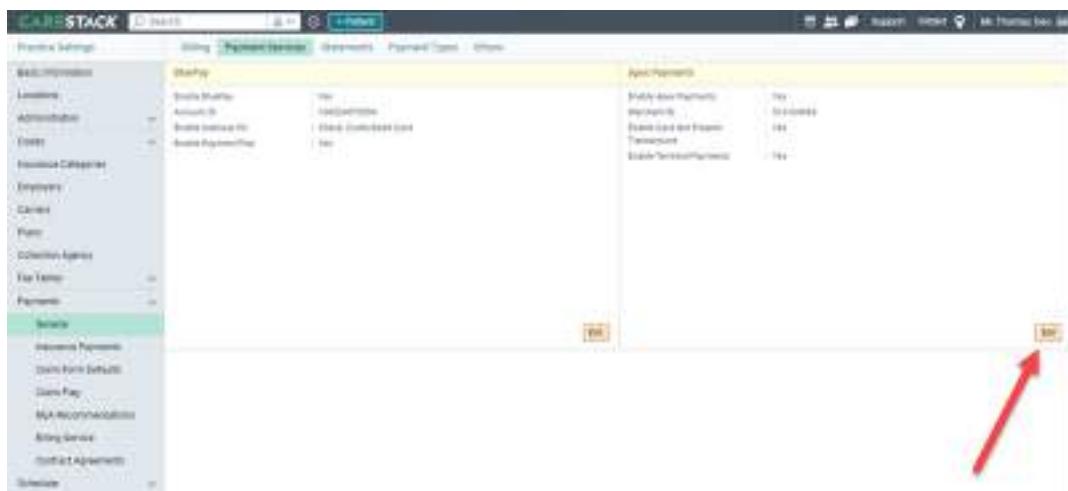
### Setting up Apex inside CareStack(Account level)

The following steps will need to be performed to start processing card/check payments within CareStack:

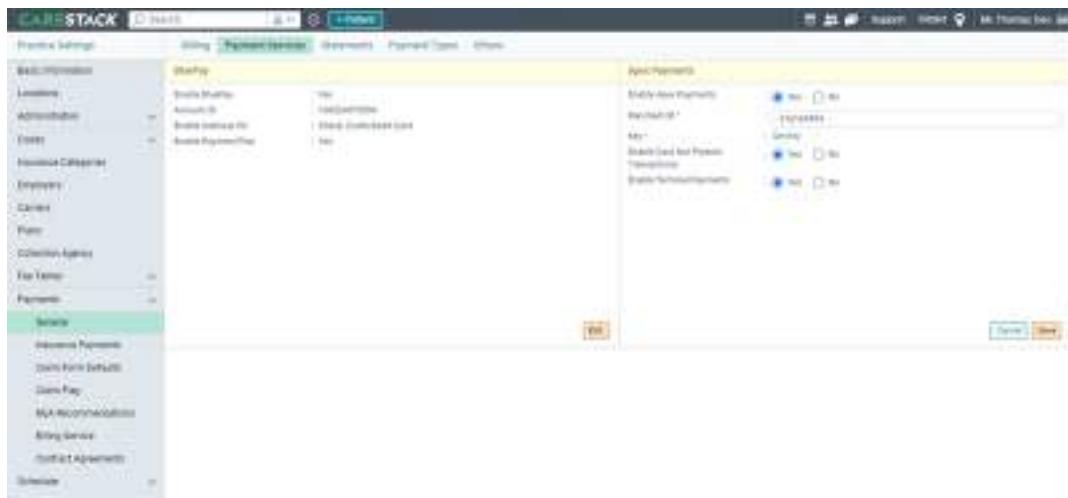
Navigate to **System menu > Practice Settings > Payments > General > Payment Services**



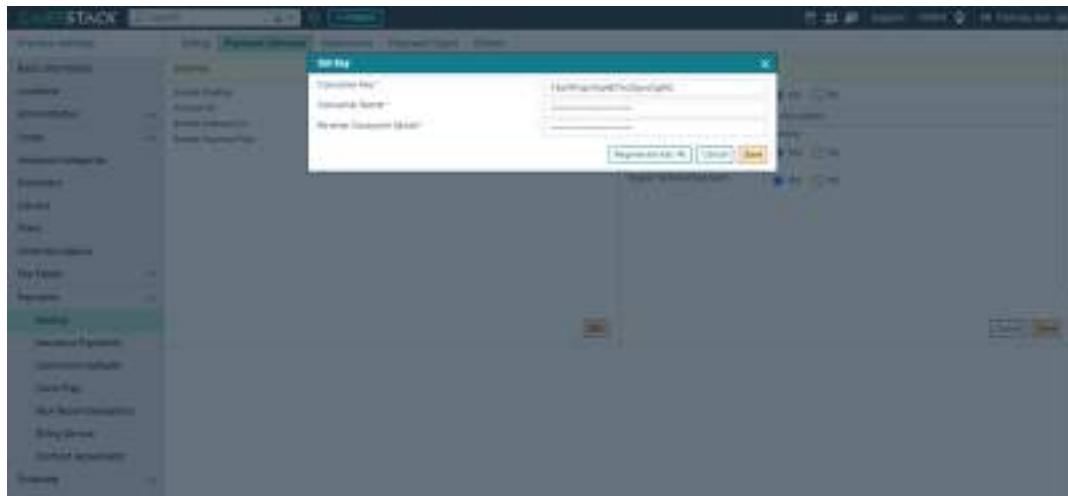
There, in the **Apex Payments** section, click edit.



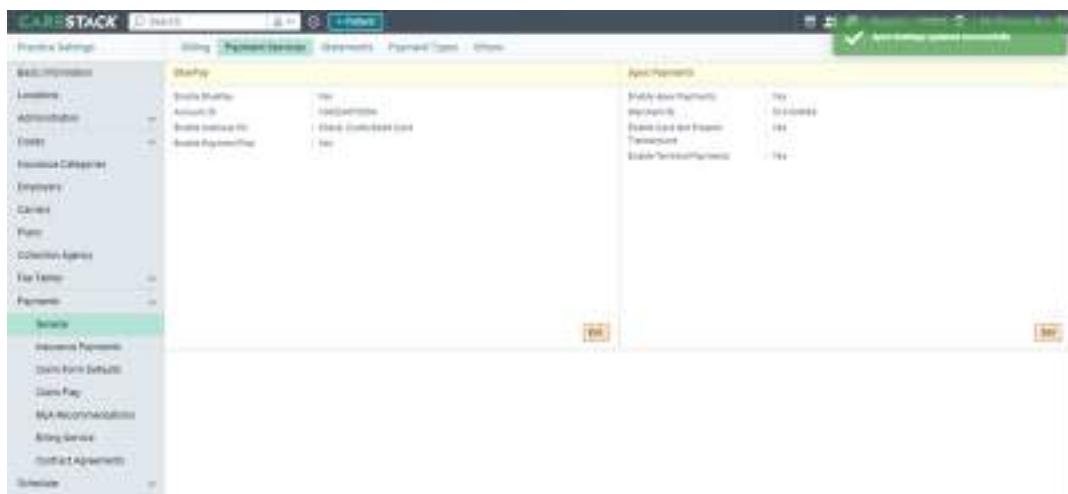
This is where you would have to set **Enable Apex Payments** as Yes, which would ask you to enter the **Merchant ID** and the other details.



The user would have to enter the secret key by clicking the **Set key**.

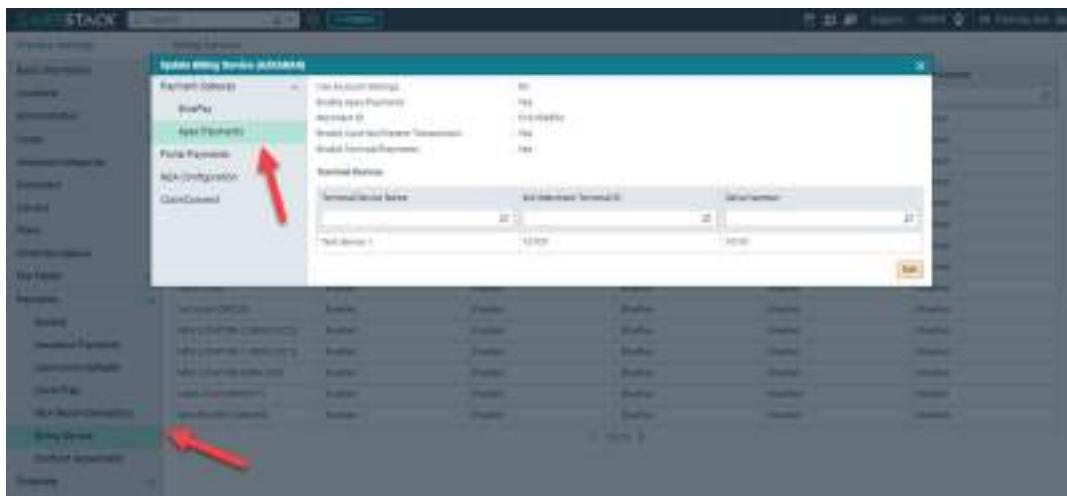


After this, clicking **Save** would complete the integration process.



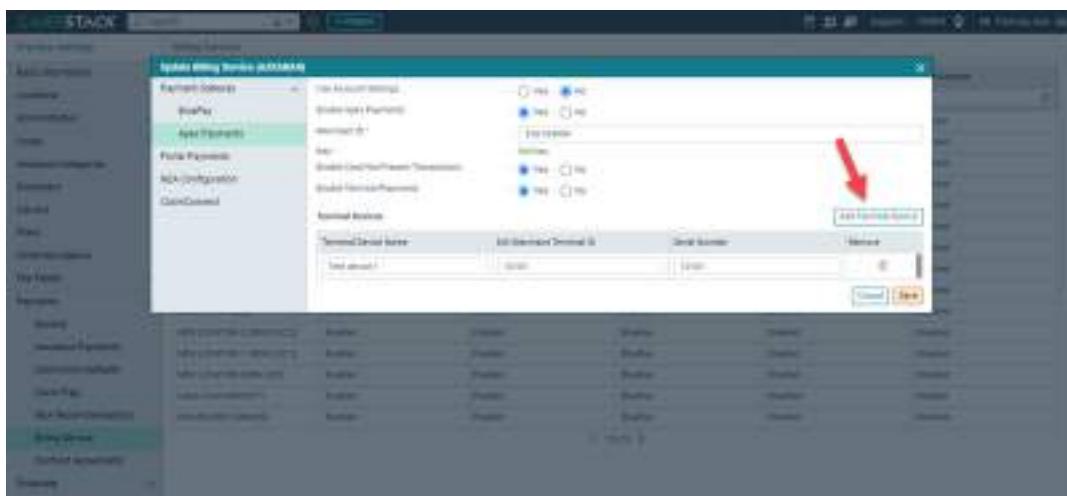
### Setting up Apex inside CareStack (Location level)

To set up Apex payment at the location level, the user would have to navigate to the **Billing services** tab under payments and select a location, and then move on to the **Apex payments** tab in the pop-up that appears.



Here, once you click edit, you would have the option to choose account level settings or location level settings. Some practices prefer to use location level settings, which would let them enable this feature only for certain locations. However, a device has to be set up to capture the payments.

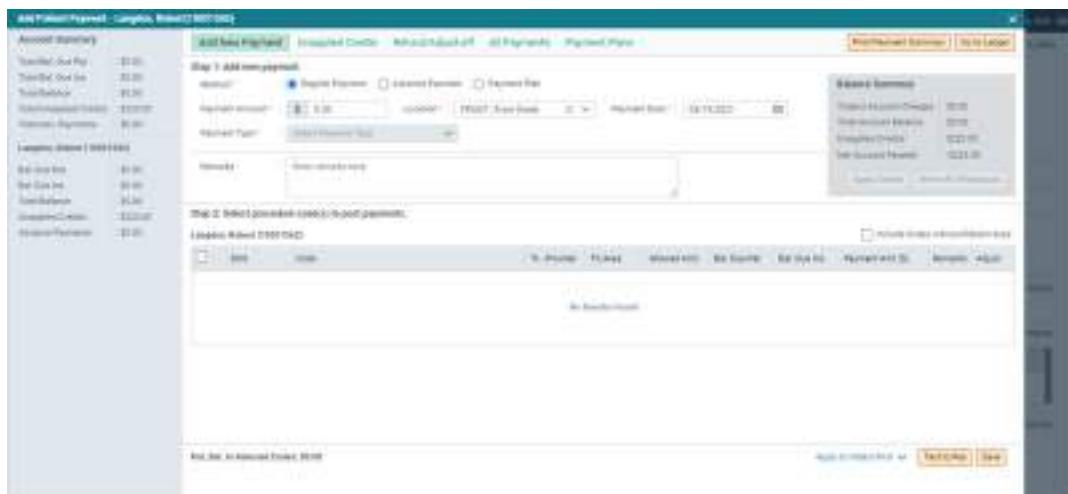
This can be done by clicking **Add Terminal Device**. The user would have to enter the details of the device and click save.



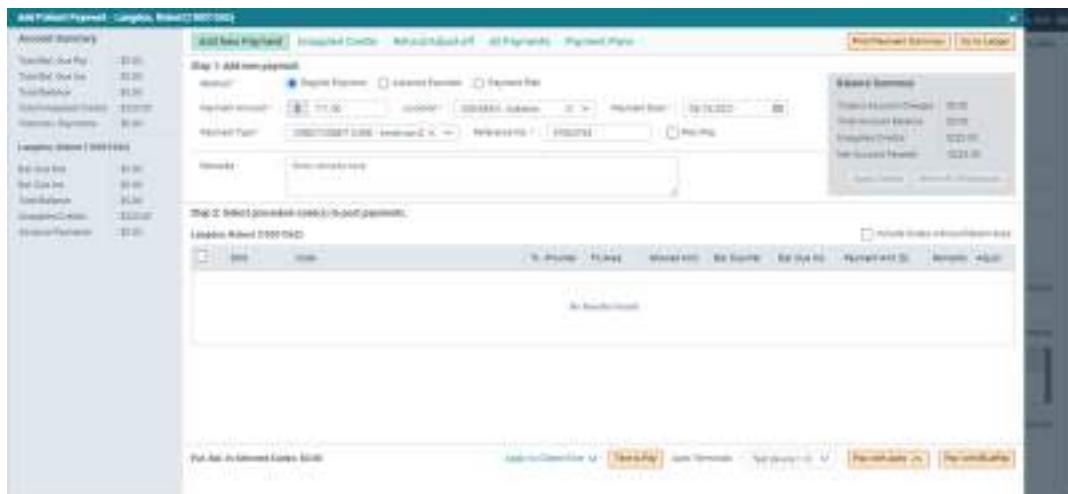
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## Payments using Apex

As mentioned before, the payments screen appears like this by default.



Now if the payment type is selected as CREDIT/DEBIT Card, the option **Pay with Apex** would appear.



Once the user clicks this button, there would be two options, **Pay with Terminal** and **Card Not Present**. The machine that can be used to capture card payments would have an application named **AnyPay Cloud**. Once the user opens this application, a screen would pop up on the device, waiting for transactions.



Now, clicking the **Pay with Terminal** option in CareStack would show the payment amount on the device screen, letting the patient swipe the card and complete the payment. Apex also provides an option to pay without swiping the card. For this, the user would have to select the **Card Not Present** option.

This would open a payment screen similar to that of Bluepay, where the payment amount and the patient name would have been auto-populated. The patient would have to enter the details like card number, cvv, expiry date, etc.



Either way, a receipt would be created after the completion of a successful transaction.

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## Refunding a payment

Unlike Bluepay, it is not possible to refund an Apex payment from CareStack. Deleting the receipt would only remove the record of the payment from CareStack. To initiate a refund, the user would have to login to their Apex payment portal and then initiate the refund from there.

## Required Permissions

The permissions required to add/process apex payments is same as that of Bluepay.

## FAQs

1. I added a payment using Bluepay but no receipt was created. The amount was debited from the patient. Where can I find the receipt?
  - o The payment would have been initiated, but might not have been processed. The payment would be visible under System Menu> Bluepay transactions. Clicking 'process payment' would complete the transaction.
2. How do I initiate a partial refund?
  - o Partial refunds can be initiated only from the payment gateway's portal.

# Adding a Patient Payment

Written by Revati Krishnan | Last published at: July 31, 2021

It's time to look at the payments that patients make on their accounts. The first thing you probably think of when we talk of patient payments is the payment itself. The amount, the type, and so forth.

You are correct!

Those payment details are entered into CareStack and kept as a receipt record. But there is more to it. The payment needs to be assigned to the different charges in the account, so we always know when and how a charge was paid for.

## Patient Payment Slider

You can kick off the patient payment process from a variety of different locations, including the profile, search results, ledger, or the appointment.

**From Search:** You can quickly leap to the payment slider by clicking the **Payment** link in the grey quick link bar.

**BE CAREFUL!!** The slider opens on top of your current task. When you are finished, you will return to the task and patient you were working on before.

**From the Patient Profile:** Click the **Billing** icon in the Patient Navigation Bar and select **Payment**.

**From the Patient Menu:** Click the **Menu** icon in the Patient Navigation Bar and select **Add Payment**.

You'll also find links to the payment screen elsewhere in the profile, like the appointment and the ledger.

Once you are there, you'll find a great deal of information about the patients in the account, balances, charges, and credits organized into tabs:

- **Add New Payment:** You'll primarily work in this tab to add payment details and apply the payment to codes by accepting CareStack's default, or by selecting the desired codes and amounts.
- **Unapplied Credits:** On this tab, you can apply the patient's advanced payment or other credits to current charges.
- **Refund/Adjust-off:** Use this tab to remove credits in a write-off or other adjustment, or by issuing the patient a refund check.
- **All Payments:** This tab lists all the payments associated with the account with summary details made in the account since the beginning of time. You can even click a receipt for more information.
- **Payment Plans:** If your practice has enabled payment plans, you will be able to build payment plans to help patients pay for large balances with regular, automatic payments over time.

## Add a Payment Receipt

Remember that patient payments have two components:

- Add the payment details
- Apply the payment to the patient portion of the outstanding treatment codes

The patient payment slider builds these components into the window. Since the first element is the payment itself, you'll begin by capturing its details:

Enter the payment details.

- **Payment Method** helps CareStack allocate the payment. If you are taking a payment for charges NOT YET posted, use the Advance Payment option.
- The **Payment Amount** is the amount you are collecting. CareStack automatically adds the current balance, but you can enter another amount. That amount will be allocated across the selected procedures.
- Your current location is defaulted as the **Location** for the payment. The location CANNOT be changed after the payment is posted.
- The **Payment Date** will be the current date by default; change it by typing a new date if needed.
- Select the **Payment Type** from the drop-down list. Some types may give you additional fields such as entering a reference number.
- The **Remarks** field allows you to add additional information about the payment. This field is not required, but helpful for your fellow staff members viewing the receipt.
- To apply a discount to the patient balance, select the desired code from the **Adj Code** drop-down. (We'll cover discounts in more detail in a later lesson.)

## Add Payment to Charges

Now we are ready to deal with the important second step, applying the payment to the patient portion of the outstanding treatment codes.

Show all your codes, even those without balances, with the **Include Codes without Patient Dues** checkbox.

By default, CareStack will apply the **Payment Amount** to the charges from oldest to newest. That's easy because it is often exactly what you want.

You can also change the allocation to newest to oldest with the dropdown at the bottom of the screen

## Apply to Specific Patients or Codes

- Things are not always as simple as applying the payment using the easy "Oldest to Newest" or "Newest to Oldest" methods.
- A patient may want to pay for a single specific code, or only certain types of codes, or only codes for certain family members. To do that:
- Use the checkboxes beside the treatment(s) to tell CareStack which treatments to apply the payment to. CareStack will allocate the full patient portion, if available, to the treatment charge. You can change the amount to apply to that treatment if desired.
- Click **Save, Apply, Pay with BluePay, or Pay with Apex** when you are ready.

**Watch Carefully! If you change the charges the payment should apply to, the Payment Amount will change**

## Advanced Payments & Unapplied Credits

**Unapplied credits** are funds that are held on behalf of a patient that have not been applied against any charges. It is credits which are available in the patient's account and have not been applied against any charges. When the practice takes advance payments they just won't have to apply the funds to the charges right away. Instead, the funds are held as Unapplied Credits. The patient's account will show this credit balance until the credits are applied. There are many scenarios which may lead to the unapplied credits being added to the patient's account such as :

- You take payments before treatment so the patient isn't digging around for a credit card when they are numb.
- The patient needs to use an FSA and the appointment is next week.
- The patient paid their portion already and the insurance paid more than expected.
- Charges were reversed on a code that had been paid.
- The patient paid for a treatment that hasn't been performed.

## Accept an Advance Payment

Taking an advance payment is similar to taking a regular payment; you just won't have to apply the funds to the charges right away.

Instead, the funds are held as **Unapplied Credits**. Your patient's account will show this credit balance until the credits are applied. As with traditional payments, start at the **Add Payment** slider.

To accept an advance payment:

- Select the **Advance Payment** option.
- Select the **provider** for the credits. Typically, this is the provider that will ultimately perform the treatment.
- Enter the **payment details**.
- Click **Save or Pay with BluePay**.

## Allocating Unapplied Credits

Unapplied Credits will appear in an account when a payment, transfer, or adjustment has been added but not applied against a charge. You can apply the credits directly on the Add Payment slider.

To apply credits:

- Select the **Unapplied Credits** tab if required.
- Select the **entry for the credits** you will apply.
- If required, select the treatments. CareStack will allocate the credits to the selected treatment charge(s). You can change the treatments or the amount to be applied.
- Click **Apply Credits** when you are finished.

# Refunding Patient Credits

Written by Revati Krishnan | Last published at: August 22, 2021

## Refunds

Consider a scenario when the patients have credits and they don't owe anything, they might want to hold the credit to apply to future treatments, or, they might want the money back. This is where 'Refunds' have a role to play - when the patient wants their money back.

Refunding of credits means for the dental practice to return unallocated credits back to the source from which it was received. Refunding of credits can be done from either a patient receipt or an insurance receipt which has some amount of unallocated credits in them.

During refunds, the user would be able to select one or more of these credit sources and then proceed to create a refund for the patient / insurance.

In order to do a patient refund, the user should :

- Navigate to the Patient Payment screen
- Select the Refund/Adjust-off tab if required.
- Select the entry for the credits you will refund.
- Enter the details for the refund, including person, amount, date, location, and details
- Click Refund or Refund and Print to print the refund summary too.

## Making a Patient Refund

Refunding from a patient receipt can be done either to the patient for whom the receipt was added or to an insurance carrier. Every patient refund is associated with the following :

Refund To: A radio button option with labels - Patient (Default) and Insurance

- If Patient is chosen, the remaining field would be:
  - **Refund Amount:** An editable amount field which is populated by the sum of unapplied credits in the receipts selected. It would be greater than \$0.00 and less than the total remaining credits of the selected patients. User would be allowed to enter only numerical data in this field.
  - **Refund Date:** A mandatory date field which is populated by the current date by default. The corresponding date picker would only allow users to select a date after the closeout date and would not allow the selection of a future date.
  - **Payment Type:** A single select drop-down listing all the payment types marked to be used for Patient Refunds. When one is chosen, all its associated additional fields must also be shown as per its Practice Setting beneath this field. The Reference Number field would a text field allowing users to add alphanumeric.
  - **Location:** A mandatory single select chosen box listing all allowed locations of the user with the current location of the user, populated by default
  - **Remarks:** A free form text area.
- If Insurance is chosen, the remaining field would be:
  - **Carrier Name:** All the insurance carriers in CareStack would be listed here.
  - **Refund Amount:** An editable mandatory amount field which is populated by the sum of unapplied credits in the receipts selected. It should be greater than \$0.00 and less than the total remaining credits of the selected patients. User would be allowed to enter only numerical data in this field.
  - **Refund Date:** A mandatory date field which is populated by the current date by default. The corresponding date picker would only allow users to select a date after the closeout date and should not allow the selection of a future date.
  - **Payment Type:** A single select drop-down listing all the payment types marked to be used for Insurance Refunds. When one is chosen, all its associated additional fields must also be shown as per its Practice Setting beneath this field. The Reference Number field would a text field allowing users to add alphanumeric, as well as special characters.
  - **Location:** A mandatory single select chosen box listing all allowed locations of the user with his current location populated by default.
  - **Remarks:** A free form text area

The user has two options- **Refund** and **Refund and Print** and there is also a checkbox called **Print Refund Check**.

Print Refund check helps the user to print the refund check directly from CareStack (The user must have the specialty paper to print them). Refund button is used to apply/initiate the refund. Refund and Print button is to print a receipt about the refund while the checkbox prints the literal check.

On refunding, if the Amount entered is less than the total unapplied credits in the selected receipts, the credits should be refunded from the receipts in the FIFO order of receipt creation.

If the amount is greater than the total unapplied credits in the selected receipts, an inline warning must be shown blocking the user from proceeding with it. (Warning: "Refund amount should be less than or equal to the total unapplied credits in the selected receipts")

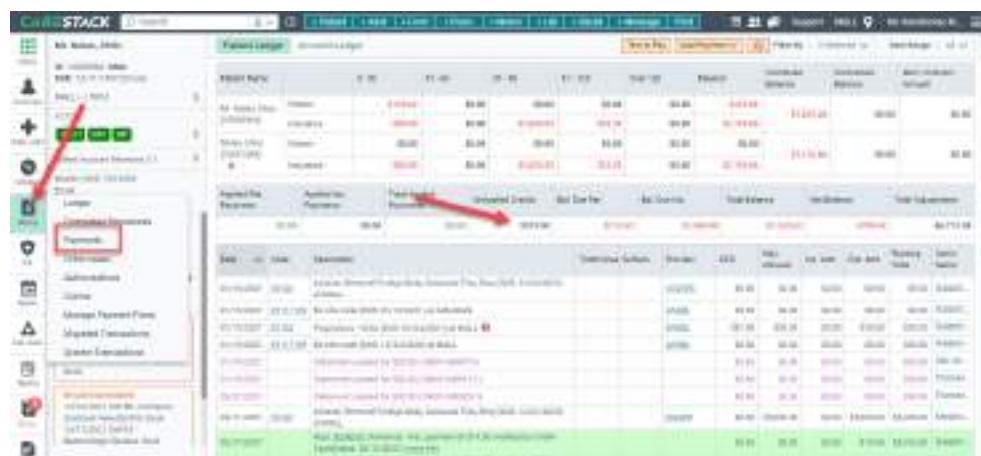
After the refund, the unapplied credits against each receipt should be changed automatically to reflect the actual remaining credits without the user having to refresh the page.

## Permission Required

The following permission needs to be set to yes in order to perform the action :

### ***Refunds/Adjust Off Patient Payments***

## Example Scenario



In the above scenario, the patient has an unapplied of \$373.

After refunding \$60, this will be reflected in the ledger as shown below:

Refunded \$30.00 to account from Dept. 10240001 by ECRP - Cash at time of delivery date: 07/22/2011

After refunding the amount, the unapplied is reduced by \$60. Now the unapplied is \$313.

Present Usage		Allocated Usage		Total Usage		Allocated Capacity		Used Capacity		Remaining Capacity	
Allocated Name		Allocated	Allocated	Allocated	Allocated	Allocated	Allocated	Allocated	Allocated	Allocated	Allocated
Resource		22.12 MB	0.00	-22.12	0.00	0.00	0.00	22.12 MB	0.00	0.00	0.00
Allocations		0.00 MB	0.00	0.00 MB	0.00	0.00	0.00	0.00 MB	0.00	0.00	0.00
Total		22.12 MB	0.00	-22.12	0.00	0.00	0.00	22.12 MB	0.00	0.00	0.00
Allocated		0.00 MB	0.00	0.00 MB	0.00	0.00	0.00	0.00 MB	0.00	0.00	0.00

## Refund Reversal

The amount that has been refunded from a receipt can always be reversed and reversing the amount would push the amount back to the receipt.

In order to do this, you can navigate to the patient ledger and click on the More info next to the receipt. This will open the payment details pop up for that receipt. Now select the Refund amount which you want to reverse and click on Reverse Refund. This will push the amount back to the receipt.



This will push back the amount to the receipt and the unapplied credits for the patient will be \$373 again.

You can also see the refund activities in the history tab of the receipt.



#### Permission Required

The following permission needs to be set to yes in order to perform the action :

#### ***Reverse Refunds/Adjust Off Patient Payments***

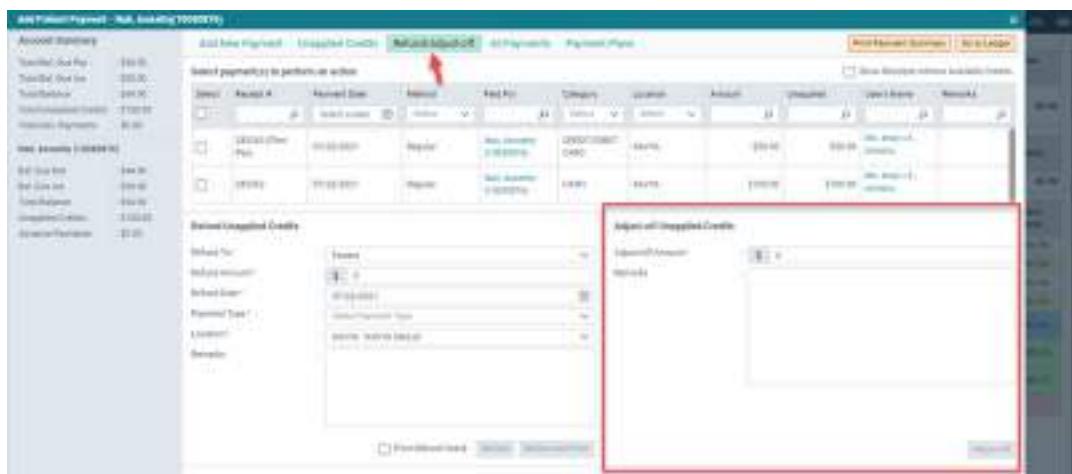
# Adjusting-off Patient Credits

Written by Revati Krishnan | Last published at: August 22, 2021

When there are excess credits in a patient receipt and if those credits are not to be refunded, but would need to remove them in order to clear the books at the end of a month or so, the Adjust off Credits functionality can be used.

You can always write-off or adjust off the entire unapplied credits or a portion of the unapplied credits from a receipt using the adjust off unapplied credits feature.

In order to do this, please navigate to the **Refund/Adjust Off** tab from the **Patient overview > Billing > Payments > Refund/Adjust Off**.



Here, you would have to select the receipt from which you want to write-off the unapplied credits and in the right side of the window, you can choose the amount you would like to adjust off, enter the remarks and click on Adjust Off.

This section would contain two fields:

- **Amount:** This field would be enabled only if at least one receipt is chosen. The amount field would be pre-populated with the sum of available credits in the selected receipts. The amount value must be greater than \$0.00 and less than or equal to the total of unapplied credits available in the selected receipts. This would be a non-mandatory field which would allow only numerical values to be entered.
- **Remarks:** Free form text area which would hold remarks to be captured against the Adjust-off.

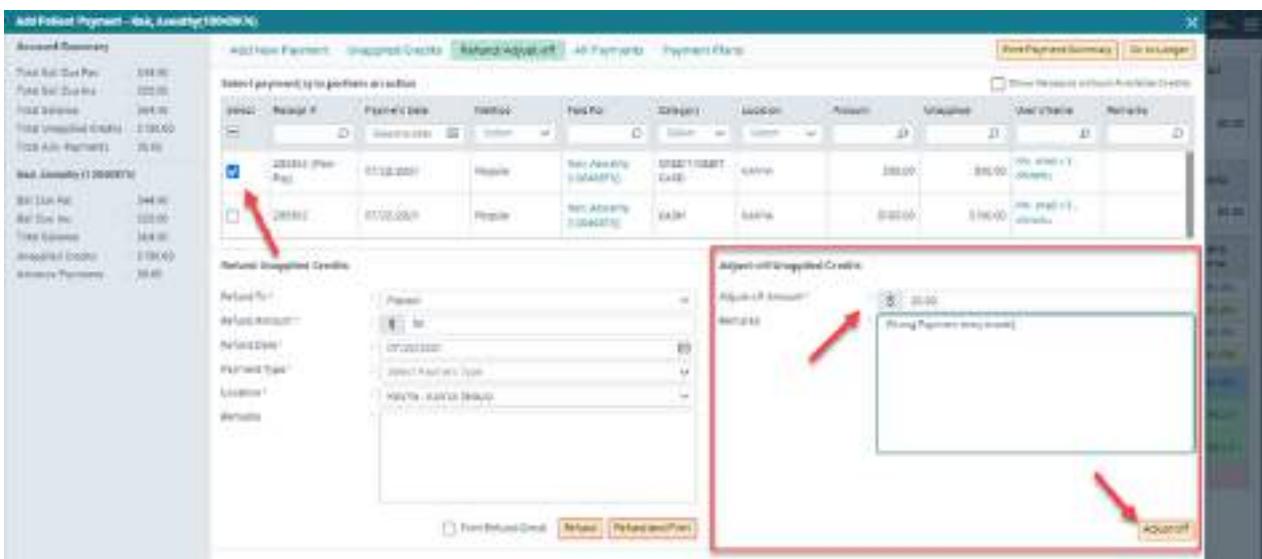
There would be an Adjust-Off button which would be enabled only if the Amount is greater than \$0.00. Clicking Adjust-Off would reduce the unapplied credits in the receipt with the Amount mentioned. If the Amount entered is less than the total unapplied credits in the selected receipts, the credits would be adjusted off from the receipts in the FIFO order of receipt creation. If the amount is greater than the total unapplied credits in the selected receipts, an inline warning would be shown blocking the user from proceeding with it. (Warning: "Adjust-off amount would be less than or equal to the total unapplied credits in the selected receipts").

After the adjust-off, the unapplied credits against each receipt would be changed automatically to reflect the actual remaining credits without the user having to refresh the page.

Entries for adjust off for each receipt would be there in the ledger and its print, system transaction and its print, walkout report, statements, payment summary, receipt's payment details modal (Adjust-Off tab & Receipt History tab) and also in several Operational Reports like Payment Log report.

## Example Scenario

Taking the above scenario, to write off \$20 from the \$50 receipt, you can choose the \$50 receipt and enter the adjust-off amount as \$20 and click on Adjust-Off.



These adjustments will now reflect in the patient's ledger and an adjust-off adjustment will be shown along with the payment receipt.

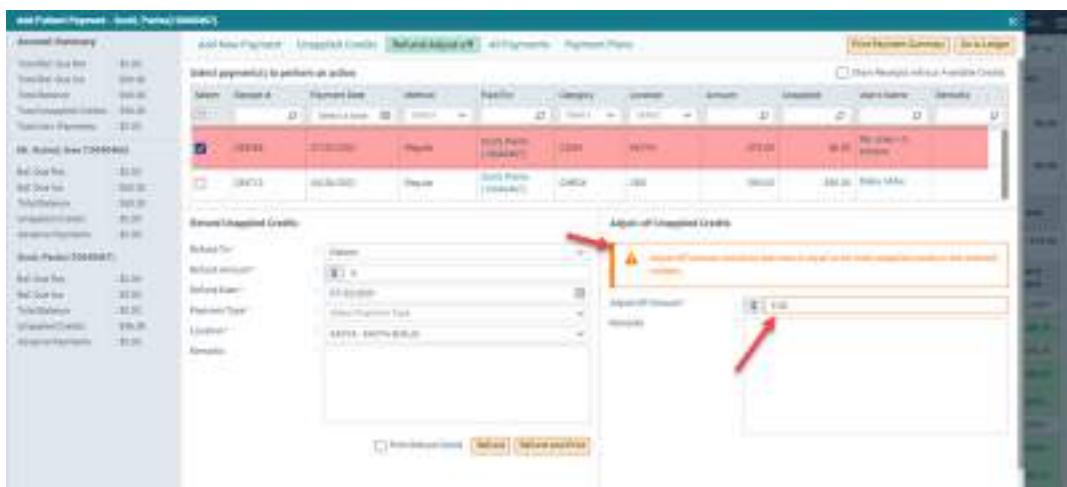
This would be how the ledger of the above patient will come up after the adjustment has been made.



On clicking the receipt row, the adjust off applied against that receipt would be highlighted. Here, you can also see that the unapplied credit balance of the patient now stands at \$30 which was \$50 before adjusting off \$20. You can also hover over the note icon on the adjust off row to view the remarks that you had for the adjustment.



You will only be able to adjust off the unapplied credits that are left in the receipt. So the adjust off amount should be equal to or less than the unapplied credits left in the receipt. If the adjustment amount is greater than the unapplied credit that is left, the following error toaster will be displayed as shown in the screenshot below.

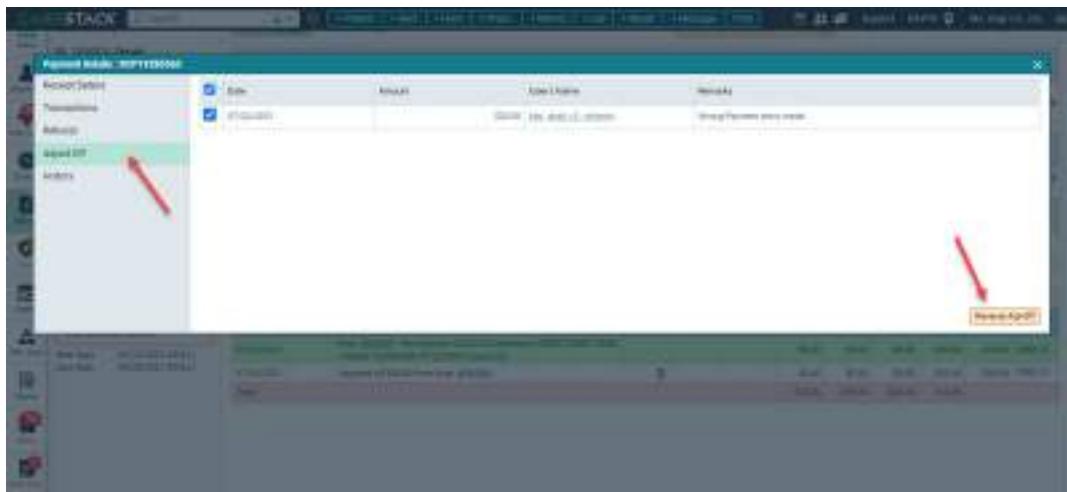
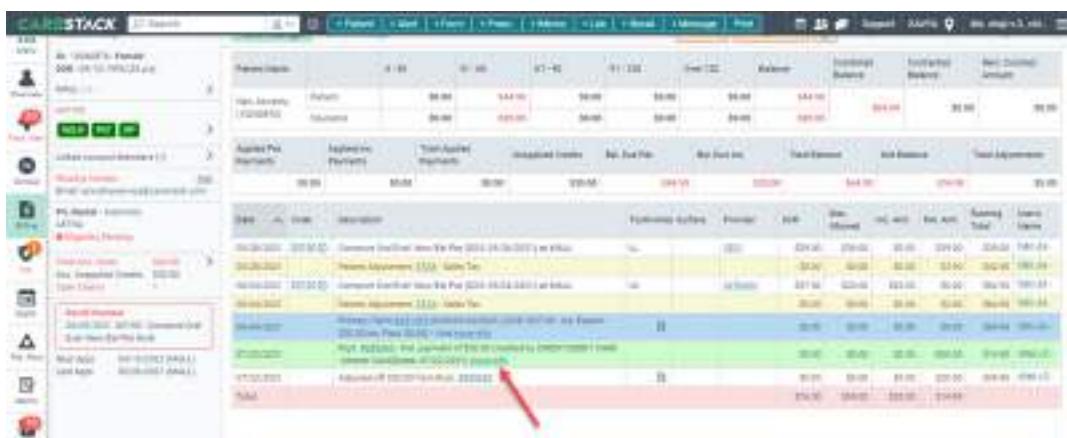


Here the error is encountered because the receipt only has an unapplied credit amounting to \$6 left ; whereas you are trying to adjust off \$9 from the receipt.

## Reverse Adjusted Off Entries

The amount that has been adjusted off from a receipt can always be reversed and reversing the amount would push the amount back to the receipt.

In order to do this, you can navigate to the patient ledger and click on the More info next to the receipt. This will open the payment details pop up for that receipt. Now click on Adjust Off where you will be able to see the amounts that have been adjusted off from the receipt. Now select the adjustment amount which you want to reverse and click on Reverse Adj-Off. This will push the amount back to the receipt.



After reversing the adjustment and refreshing the ledger, the adjustment of \$20 which was shown along with the payment receipt will be removed from the ledgePerm

## Permissions needed

A user would need to have the necessary permissions assigned to his/her profile in order to perform the refund and reverse refund actions.

The screenshot shows the CARESTACK software interface with the title 'CARESTACK' at the top. The main menu includes 'HOME', 'SEARCH', 'LOGOUT', 'SUPPORT', 'MAIL', and 'INBOX'. On the left, there's a sidebar with sections like 'Profile Settings', 'Locations', 'Administrators', 'Users', 'Groups', 'Incomes (Funds)', 'Access', 'Regions', 'Cases', 'Incomes (Payments)', 'Employees', 'Carriers', 'Places', 'Incomes Agents', 'Per Diems', 'Parameters', 'Schedules', 'Drugs', and 'Events'. The main content area is titled 'Laura - Permissions'. It has tabs for 'Edit' and 'Search'. Below the tabs is a search bar with placeholder text 'Enter to find...'. A large grid table is displayed with columns for 'Edit', 'View', and 'Delete'. The table rows include:

Action	Edit	View	Delete
View Patient Payments	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Update Patient Payments	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Print Patient Payments	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Print Initial Payment	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
<b>Demand Adjustment/Patient Payments</b>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Print Print of Demand/Tickets	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
<b>Statement</b>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Print Statement	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Generate Statement	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Send Statement	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Download Statement	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

# Deleting a Patient Receipt

Written by Revati Krishnan | Last published at: August 22, 2021

You might now know how to post a patient payment. Mistakes might happen while posting a patient's payment. This will force the user to get rid of the incorrect payment that has been posted. In such instances, CareStack helps its users to delete a payment receipt that would eventually reverse the patient's payment.

## Workflow to Delete a Patient Receipt

In order to delete a patient payment, it is necessary that a user has the required permissions. To check the permissions navigate to the **System Menu > Practice settings > Administration > Profiles > Look for your profile > Click on Manage permissions**

- To delete a patient payment receipt you will have to move to the required **Patient's overview > Billing > Payments**.



- In the window that slides open, move your cursor and select the '**All Payments**' tab.



- Now you will be able to see all the payment receipts that have been made for the patient.
- The headline '**Select payment(s) to perform an action**' makes it clear that you would have to select the receipt(s) that you have to delete.
- Tick Mark the small square box to the left of the receipt that you want to delete.



- The '**Delete**' icon now becomes active. This icon remains grayed out until selecting a receipt.
- Click on the '**Delete**' icon.
- This would open a warning pop-up window. In the window, you can see what changes would happen if a payment receipt is deleted.
  1. All patient payments posted using the receipt will be reversed.

2. All refunds and adjust-offs made using the receipt will be reversed.
3. Transaction charges and their associated write-off adjustments will be reversed
  - o Also, CareStack will ask you to fill in the reason why you want to delete the receipt as remarks.



- o A green toaster will appear in the top right corner after the successful deletion of a receipt.



- o When a receipt is deleted, the entry for the receipt addition, payment posting using that receipt, entries for any adjust-off or refunds associated with the receipt would be removed from the ledger and its print, walkout report, statements, payment summary, and Transaction tab and Refund tab of receipt's payment details modal.
- o The system transaction and the receipt history tab would contain all the reversal entries as well in addition to the entry for receipt deletion.
- o The receipt entry would be removed from the grid immediately on deletion.
- o This button would be shown only if the user has Delete Patient Payments Permission.

### Example Scenario

Consider the patient Rinu Jac, for whom payment receipt # 249688 has been deleted. The amount the patient paid was \$2000 and the unapplied credits were \$1028.09. The deletion of this receipt would reverse this payment, which would make the **Total Bal. Due Pat.** the amount the patient has to pay and the unapplied credits become zero again.





**Do watch this video for reference.**

Embedded content from <https://www.loom.com/embed/2f92fe2977ac47d8840c96d03670b95f>

**Now you are all set to delete an insurance payment. Give it a try!**

# Ledger

Written by Abhishek Vijay | Last published at: August 25, 2022

Quite possibly the heart of the Revenue Cycle Management module of CareStack, the Ledger.

The ledger records the summarized financial information of the patient and their account members as debits & credits as well as displays their current balances.

The ledger is a reflection of all the financial transactions initiated and completed by the user, something like a footprint. A feature like this enables the user to have a real-time look at the financials of the patient.

In CareStack, while navigating to Patient > Billing > Ledger, there would be two sub-tabs; Patient Ledger, and Account Ledger.



The patient ledger lists out the details concerning the patient profile, while the Account Ledger lists out the transactional history of the Account members as a whole.

There would be three grids in either tab to show the various details of transactions done for the patient, the **Summary Grid**, the **Aging Grid**, and the **Transactions Grid**.

## Aging Grid

This grid would show the aged patient and insurance balance of the codes of the patient and the account members, grouped into different aging buckets:

- **0-30:** Shows the current balance of all the corresponding patient codes that were completed(transaction date) in the date range of 0-30 days from the current date.
  - **31-60:** Shows the current balance of all the corresponding patient codes that were completed(transaction date) in the date range of 31-60 days from the current date.
  - **61-90:** Shows the current balance of all the corresponding patient codes that were completed(transaction date) in the date range of 61-90 days from the current date.
  - **91-120:** Shows the **current** balance of all the corresponding patient codes that were completed(transaction date) in the date range of 91-120 days from the current date.
  - **Over 120:** Shows the current balance of all the corresponding patient codes that were completed(transaction date) in the date range of over 120 days from the current date.

- **Contracted Balance:** Contracted balance is the balance which the patient has to pay from the contracted amount.
- **Contracted Amount:** Contracted amount is the amount that the patient has to pay in the payment plan.

There would also be a column to show the individual balance totals as well as the combined balance total.

*If balance > 0, then it would be shown in red color.*

The aging summary would be visible above the itemized transaction grid in both the Patient and Account Ledger tabs.

This would show the aged patient as well as the insurance balances of all the account members in both tabs.

## Summary Grid

Applied Pat. Payments	Applied Ins. Payments	Total Applied Payments	Unadjusted Charges	Bal. Due Pat.	Bal. Due Ins.	Total Balance	Adjustments	Total Adjustments
\$1,200.00	\$100.00	\$1,300.00	\$1,300.00	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00

The Summary Grid in the Patient tab would show the summarized view of the financial status at a patient level and an account level.

It would consolidate the data for all members of the account, irrespective of the ledger tab.

The grid at all times must have the following columns:

- **Applied Pat. Payments:** Total credits applied to the patient codes from any patient receipt or collection receipt
- **Applied Ins. Payments:** Total credits applied to the patient codes from any insurance receipt.
- **Total Applied Payments:** Applied Pat. Payments + Applied Ins. Payments.
- **Unapplied Credits:** Total credits available in the respective patient's receipt.
- **Bal. Due Pat.:** Balance due Patient of all codes completed for the patient.
- **Bal. Due Ins.:** Balance due Insurance of all codes completed for the patient.
- **Total Balance:** Bal. Due Pat + Bal. Due Ins.
- **Unadjusted Transaction Charges**
- **Net Balance:** Total Balance - (Unapplied Credits + Unadjusted Transaction Charges).
- **Total Adjustments:** The net sum of adjustments made against all codes of the patient.

Irrespective of it being the Patient Ledger or Account Ledger,

*If balance > 0, then it would be shown in red color*

&

*All the applied payments must be green.*

## Transactions Grid

Date	Code	Description	Tooth/Area	Surface	Provider	UCR	Max Allowed	Ins. Amt.	Pat. Amt.	Running Total	User's Name
01/22/2021	04049	Crown Lengthening (D01-01/22/2021) at FRONT	4		ALTMAN	\$912.00	\$476.00	\$0.00	\$476.00	\$476.00	
01/22/2021	05219	Mon Porcelain Denuvo Cast Metal (D03-01/22/2021) at FRONT	4		ALTMAN	\$1,898.00	\$1,240.00	\$0.00	\$1,240.00	\$1,718.00	
01/23/2021		Primary Class #186289 (D05-01/11/2021) (UCR: \$3169.00 - Ins. Expect: \$0.00 Ins. Paid: \$0.00) - Submitted (Patient more info)				\$0.00	\$0.00	\$0.00	\$0.00	\$1,718.00	
02/07/2021		Refund #245926 (Advance) - Pmt. payment of \$1000 ill created by CASH - Cash (Dated: 02/07/2021) - more info				\$0.00	\$0.00	\$0.00	\$1,000.00	\$1,718.00	
02/07/2021		Refunded \$1,000.00 to patient from Refnl #245926 by CASH - Cash at FRONT (Refund Date: 02/07/2021)				\$0.00	\$0.00	\$0.00	\$1,000.00	\$1,718.00	
02/07/2021		Statement created for 31718.00 (10001-000420-T)				\$0.00	\$0.00	\$0.00	\$0.00	\$1,718.00	
02/16/2021		Authorization #10001 issued for ACCEPTANCE INSURANCE - Completed (more info)				\$0.00	\$0.00	\$0.00	\$0.00	\$1,718.00	

This grid would show the itemized list of all transactions done in the latest last order, as default, but can be sorted. The Transactions Grid ideally has the following columns:

- **Date:** The date of transaction of when the corresponding action was performed
- **Code:** The procedure code that was completed.
- **Description:** The detailed description of what action was done

- **Tooth/Area:** The Tooth/Area associated with the completed code
  - **Surface:** The surface associated with the completed code
  - **Provider:** The short name of the treating provider associated with the completed code
  - **UCR:** The UCR fee of the completed code from the fee schedule
  - **Max Allowed:** The sum of the current patient and insurance payable amounts associated with the completed code
  - **Insurance Amount and Patient Amount**
  - **Running Total:** Ins. Amt + Pat. Amt + Previous Running Total.

The patient ledger and account ledger grids have a column that displays a running total representing the balance up to that transaction. It represents the balance after that transaction was posted.

There would also be a Total row that would show the totals of UCR, Max Allowed, Ins. Amt. and Pat. Amt. fields.

Now that we have an idea about the framework of a typical ledger page, let's have a look at the constituent elements inside.

## Completed Codes

An entry would appear in the ledger when a code is marked as completed.

The entry description would be Date, Code, Procedure Code Description, followed by the DOS. The date in the corresponding entry is the transaction date on which a code was completed. The tooth/area, surface and provider associated with the completed code is populated. The code is clickable, showing the associated code snapshot when clicked.

The UCR fee from the respective fee schedule is shown, and \$0.00 is populated if a UCR fee cannot be obtained. The Max Allowed fee is set as the sum of Insurance and Patient estimates.

D0155 - Payment Allocation						
Date	Description	Pat. Amt.	Ins. Amt.	Total	Username	
07/25/2021	Updated receivable amount for the code with D08 07/20/2021	\$45.00	\$45.00	\$90.00	Mr. Vijay. Abnesek	
Balance		\$45.00	\$45.00	\$90.00		

The entry must have positive values in both of the Ins. Amt and Pat. Amt columns signifying an increase in the balance dues

If the fee or other details of the completed code is updated, the changes are to be made on the same entry itself by overwriting the old details with the updated values.

If the code is deleted, then the entry for the newly added code must also be removed. When an entry for code addition is clicked, the code's payment allocation modal is:

D9974 - Payment Allocation						
Date	Description	Pat. Amt.	Ins. Amt.	Total	Username	
06/21/2021	Consulted Bleaching Per Toon, intestinal with D08-06/17/2021	\$90.00	\$90.00	\$90.00		
06/21/2021	Payment of \$30.00 applied from patient Rcpt. #285106 of [REDACTED] (10045553)	-\$30.00	\$0.00	-\$30.00		
07/25/2021	Ins. payment of \$90.00 applied from carrier DELTA-DENTAL OF TEXAS Rcpt. #289378	\$0.00	-\$90.00	-\$90.00		
Balance		\$0.00	\$0.00	\$0.00		

Date	Description	Amount	Balance
06/21/2021	Patent [REDACTED]	\$90.00	\$90.00
06/21/2021	Insurance [REDACTED]	-\$30.00	\$60.00
07/25/2021	Insurance [REDACTED]	-\$90.00	\$0.00
Balance		\$0.00	\$0.00

Applied Pat. Payments	Applied Ins. Payments	Total Applied Payments	Un-Applied Credits	Bal. Due Pat.	Bal. Due Ins.	Total Balance	Net Balance	Total Adjustment
\$1,000.00	\$0.00	\$1,000.00	\$0.00	\$0.00	\$1,000.00	\$1,000.00	\$1,000.00	\$0.00

If any notes have been linked to the code, then it must be shown when clicked upon a notes icon beside the code.

Entries for code addition must appear in a similar manner in the ledger print as well.

When a code is completed as a result of an ortho payment plan termination the description is:

**Patient ortho payment plan terminated - Completed <Procedure\_ID> - <proc\_desc> (DOS: <termination date>)**

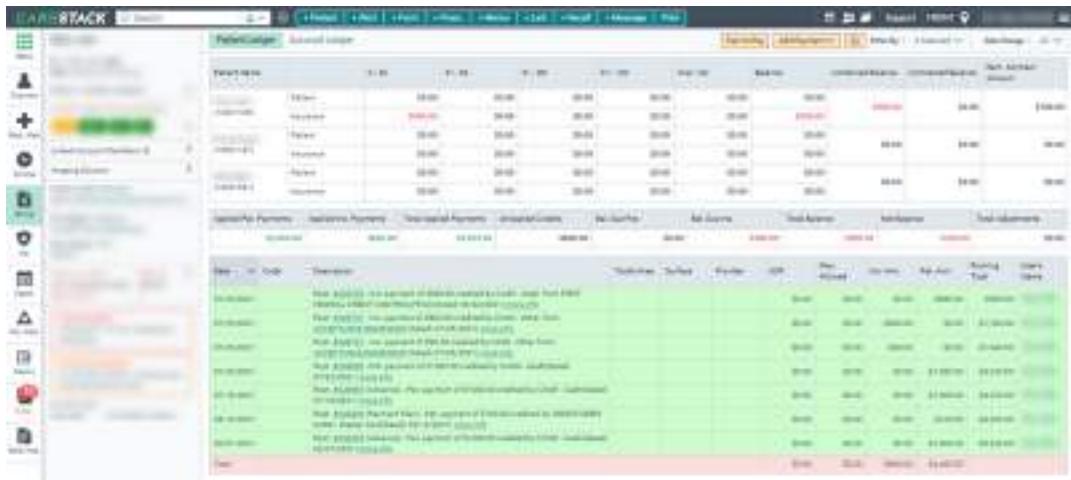
Procedure ID	Description	Fee	DRF	Max Allowed	Ins. Amt.	Pat. Amt.	Running Total	User's Name
01121/0001	01121 Q1 Composite (004) Blue Wave (005) PMS (003, 001) at ALL	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Vivek
01121/0021	01121 Q1 Strong Gencoplast (004) 007/20/2007) at ALL	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Vivek
01121/0021	01121 Q1 Resin Bonded Fused Inlay (004, 011/20/2021) at FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Vivek
01121/0021	01121 Q1 Crown Lengthening (004, 011/20/2021) at FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Vivek
01121/0021	01121 Max Partial Denture Cast Metal (003, 01/23/2021) at FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Vivek
	Total:				\$1,000.00	\$0.00	\$1,000.00	

If an insurance ortho payment plan is terminated:

**Insurance ortho payment plan terminated - Completed <Procedure\_ID> - <proc\_desc> (DOS: <termination date>)**

## Payments

An entry would appear in the ledger whenever a payment is credited or posted on a patient account from either patient, insurance or a collection receipt.



The screenshot shows the e-Stack software interface with the 'Payments' tab selected. The main area displays a ledger table with columns for Date, Description, Debit, Credit, and Balance. The ledger shows various entries for Patient Payments, Insurance Payments, and Collection Payments. The interface includes a sidebar with navigation links and a top menu bar.

Date	Description	Debit	Credit	Balance
2023-01-01	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-01	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-01	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-02	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-02	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-02	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-03	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-03	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-03	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-04	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-04	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-04	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-05	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-05	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-05	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-06	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-06	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-06	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-07	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-07	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-07	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-08	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-08	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-08	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-09	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-09	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-09	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-10	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-10	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-10	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-11	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-11	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-11	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-12	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-12	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-12	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-13	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-13	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-13	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-14	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-14	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-14	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-15	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-15	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-15	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-16	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-16	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-16	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-17	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-17	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-17	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-18	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-18	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-18	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-19	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-19	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-19	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-20	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-20	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-20	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-21	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-21	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-21	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-22	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-22	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-22	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-23	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-23	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-23	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-24	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-24	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-24	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-25	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-25	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-25	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-26	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-26	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-26	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-27	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-27	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-27	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-28	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-28	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-28	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-29	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-29	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-29	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-30	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-30	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-30	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00
2023-01-31	Patient Payment credited from receipt #123456 using Cash	100.00		100.00
2023-01-31	Insurance payment credited from receipt #123456 using Health Insurance	100.00		100.00
2023-01-31	Collection Payment credited from receipt #123456 using Bank Transfer	100.00		100.00

The descriptions for each of the entries is as follows:

- Patient Payment: **Patient payment credited from receipt #xxxxxx using <payment-type>**
- Insurance transfer to a patient: **Transferred credits from insurance receipt #xxxxxx of <carrier name> to patient receipt #xxxxxx**
- Insurance Payments: **Insurance payment credited from receipt #xxxxxx using <payment-type>**
- Collection Payments: **Collection payment credited from receipt #xxxxxx using <payment-type>**

Receipt #xxxxxx would be the receipt ID of the associated receipt from which the payment was posted. For transferred receipt, the patient receipt #xxxxx of the newly created receipt is shown. This is a link, clicking on which would open up a snapshot which contains the following details about the receipt:

- Receipt #xxxxx is mentioned in snapshot header
- Patient/Carrier/Collection Agency Name for whom the payment was added
- Payment Date
- Location
- Amount
- Unapplied Credits (Only for patient receipts and transferred receipts)
- Payment Type : In the format - <Payment Category> - <Payment Type Name>
- Reference Number if associated with the receipt
- Remarks

There is a more info link beside each entry which when clicked would show the associated Payment Details modal.

The amount shown against a patient receipt must be the amount for which the receipt was added.

The amount shown against insurance receipts is the sum total of payments posted from it and refunds made from it and tagged to that patient. The entry is grouped first by the patient, then by receipt and date of transaction of either payment posting or making the refund.

The amount shown against collection receipts is the sum total of payments posted from it. The entry is grouped first by the patient, then by receipt and date of transaction of the payment posting.

Such entries would have a mild green background color.

When such entries are clicked, all codes against which payments were posted using that receipt, would get highlighted.

Three kinds of payments (Patient, Insurance and Collection) would appear in the filter

Such entries must also be shown as such in the ledger prints as well.

The date associated with the payment entry in the ledger is the transaction date on which the payment gets linked to the patient context.

If payment was credited from a patient or a collection agency then there is a negative entry in the Pat. Amt. column.

If payment was credited from an insurance company then there is a negative entry in the Ins. Amt. column.

Patients from the insurance and collection agency are grouped by patient, receipt and date of posting.

If payment is deleted or reversed, its corresponding addition entry must also be removed.

If only a part of a payment gets reversed only that portion needs to be removed from the respective payment column.

If receipt has been marked as an NSF, there would be an NSF tag beside the description to mark that the receipt is an NSF receipt.

## Adjustments

An entry would appear in the ledger whenever an adjustment is posted on a completed code of a patient from either patient, insurance or a collection agency payment posting context.

Type	Adj. Code	Description	Transaction	Number	Payer	EMR	Plan Allowed	Ins. Amt.	Pat. Amt.	Running Total	Chk. Amt.
PT	ADJ00001	Transfer Adjustment: ADJ00001 - TRANSFER TO INS				\$0.00	\$0.00	\$000.00	\$000.00	\$0.00	
PT	ADJ00001	Patient Adjustment: ADJ00001 - PAT CPT - Clean				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
PT	ADJ00001	Insurance Adjustment: ADJ00001 - INS CPT - Pay Adjustment				\$0.00	\$0.00	\$00.00	\$0.00	\$00.00	
PT	ADJ00001	Transfer Adjustment: ADJ00001 - TRANSFER TO INS				\$0.00	\$0.00	\$00.00	\$00.00	\$00.00	
PT	ADJ00001	Collection Commission: ADJ00001 - COLLECT - Collection Fee				\$0.00	\$0.00	\$0.00	-\$5.00	-\$5.00	
						\$0.00	\$0.00	\$000.00	\$000.00		

The descriptions for each of the entries is as follows:

- **Patient Adjustment: (Adjustments with actions Add to Patient and Deduct from Patient): Patient Adjustment: <Adj Code>-<Adjustment Description>**
- **Insurance Adjustment: (Adjustments with actions Add to insurance and Deduct from insurance): Insurance Adjustment: <Adj Code>-<Adjustment Description>**
- **Transfer Adjustment: (Adjustments with actions Transfer to Insurance and Transfer to Patient): Transfer Adjustment: <Adj Code>-<Adjustment Description>**
- **Collection Commission: Collection Commission: <Adj Code>-<Adjustment Description>**

Adjustment Code & Description is the code using which the respective adjustment was made. The code is a link, clicking on which would open up a snapshot which contains the following details about the adjustment code.

- Adjustment Code is mentioned in the snapshot header
- Adjustment Description
- Adjustment Action
- Adjustment Category
- Apply As

Adjustments posted for a patient on a day using the same adjustment code is grouped together into a single entry.

Such entries would have a mild yellow background color.

When such entries are clicked, all codes against which adjustments were posted using that entry, would get highlighted.

I adjustments as an entry in the Type filter.

Such entries must also be shown as such in the ledger prints as well.

The date associated with the adjustment entry in the ledger is the transaction date on which the adjustment was posted.

en an adjustment is reversed, the entry for adjustment reversal would also be removed. If only a part of the adjustment amount posted using a code for a patient on a day is reversed, then only that amount is subtracted from the corresponding amount column.

The entry to be posted in the Amt columns is based on the action of the adjustment code.

## Refunds

### Patient Refunds

An entry would appear in it only when refunds are made from patient/account members receipts. The entry description is:

Date	Inv. Code	Description	Transf. Accts. Surface	Provider	ICD	Days Allowed	Inv. Amt	Pat. Amt	Billing Total	User's Name
10/01/2001		Refund \$1,000.00 to patient from Rcpt. AG4021 for FASH - Cash or PAYT (Refund Date: 10/01/2001)				30-09	\$0.00	\$0.00	\$1,000.00	\$1,000.00
10/01/2001		Refund \$1,000.00 to AGCERT/ACCE/HSH/HSC/Prem Rpt. AG4021 for FASH - Cash or PAYT (Refund Date: 10/01/2001)				30-09	\$0.00	\$0.00	\$1,000.00	\$1,000.00
		Total				30-09	\$0.00	\$0.00	\$1,000.00	

If refunded to patient :

'Refunded \$xx.xx to patient from Rcpt #xxxxx by <Payment Category - Payment Type> at <Refund Location Short Name> (Refund Date: <MM/DD/YYYY>)".

If refunded to insurance :

'Refunded \$xx.xx to <carrier name> from Rcpt #xxxxx by <Payment Category - Payment Type> at <Refund Location Short Name> (Refund Date: <MM/DD/YYYY>)".

#xxxxx is Receipt ID of the receipt from which credits are being refunded.

The date is the transaction date of refund.

Clicking on the entry would highlight the receipt from which the credits were refunded.

All refunds made from the same receipt are grouped together on the basis of a patient first then by the date of refund.

Refunds must be added as an entry in the Filter as well.

Refund entry must also appear in a similar manner in the ledger print as well (both patient and account ledger prints).

If any remark is added to it, it is shown in a notes icon pop up.

Such entries must have a brown font color.

Refund entry must be removed from the ledger once it is reversed. If multiple entries are grouped together, only that refund which was reversed must be reduced.

A positive entry in the Pat. Amt. column is shown for refunds.

### Insurance Refunds

Date	Inv. Code	Description	Transf. Accts. Surface	Provider	ICD	Days Allowed	Inv. Amt	Pat. Amt	Billing Total	User's Name
10/01/2001		Refund \$1,000.00 to AGCERT/ACCE/HSC/Prem Rpt. AG4021 for FASH - Cash or PAYT (Refund Date: 10/01/2001)				30-09	\$0.00	\$0.00	\$1,000.00	\$1,000.00

An entry would appear in it only when refunds are made from insurance receipts and tagged to the patient/account member or their claim.

The entry description is :

'Refunded \$xx.xx to <carrier name> from Rcpt #xxxxx by <Payment Category - Payment Type> at <Refund Location Short Name> (Refund Date: <MM/DD/YYYY>)".

#xxxxx is Receipt ID of the receipt from which credits are being refunded.

The date is the transaction date of refund.

Clicking on the entry would highlight the receipt from which the credits were refunded. It would also highlight the claim entry if it is linked to a claim.

All refunds made from the same receipt are grouped together on the basis of a patient first then by the date of refund.

Refund entry must also appear in a similar manner in the ledger print as well (both patient and account ledger prints).

If any remark is added to it, it is shown in a notes icon pop up.

Such entries must have a brown font color.

Refund entry must be removed from the ledger once it is reversed. If multiple entries are grouped together, only that refund which was reversed must be reduced.

Once a refund linked to a patient is reversed, it would not only remove the entry for a refund from the ledger but also reduce the equivalent amount from the associated Ins Receipt entry.

A positive entry in the Ins. Amt. column is shown for refunds

## Claims & Authorizations

## Claims

Date	Inv. Code	Description	Task/Action	Status	Priority	LOR	Min. Missed	Max. Missed	Max. Due	Pending Total	Entered Total
2023-01-01	INV-001	Demolition Crew A (00000000000000000000) - 00000000000000000000 - Inv. Pending		0		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
2023-01-01	INV-002	Demolition Crew B (00000000000000000000) - 00000000000000000000 - Inv. Pending		0		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
2023-01-01	INV-003	Demolition Crew C (00000000000000000000) - 00000000000000000000 - Inv. Pending		0		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
2023-01-01	INV-004	Demolition Crew D (00000000000000000000) - 00000000000000000000 - Inv. Pending		0		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
		Total:				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

An entry would appear in it only when a Claim is submitted (Submitted (Payor)/Ready to Send Status).

The entry description is: '**<Claim Order> Claim #xxxxx created for <carrier name> - <current Claim status>**'.

#xxxxx is Claim ID and must show the claim snapshot.

The date is the transaction date of claim submission.

Clicking on the entry would highlight all codes that were sent in that claim.

Claims must be added as an entry in the Filter as well.

Claims entry must also appear in a similar manner in the ledger print as well.

If any remark is added to it against any status, it is shown in a notes icon pop up.

Such entries must have a light blue color background.

There is a more info link beside the claim entry which when clicked would show the corresponding View Claim Details modal of the claim.

## Pre-Authorization

An entry would appear in it only when an Authorization is sent (Pending/Ready to Send Status).

The entry description is: '**Authorization #xxxxx created for <carrier name> - <current Auth status>**'

#xxxxx is Auth ID and must show the Auth snapshot

The date is the transaction date of Auth submission.

Clicking on the entry would highlight all codes that were sent in that authorization if those exact codes are checked out. (This happens only if the authorization was raised through treatment planning pages).

Authorizations must be added as an entry in the Filter as well.

Authorization entry must also appear in a similar manner in the ledger print as well.

If any remark is added to it against any status, it is shown in a notes icon pop up.

Such entries must have a light blue color background.

There is a more info link beside the authorization entry which when selected would show the corresponding View Authorization Details modal of the auth.

## Statements

When a statement has been generated for a patient, there is an entry in the corresponding patient ledger with the net balance due mentioned in it.

Payer	Acct. Code	Description	Primary/Secondary	Provider	UIC#	Max. Allowed	Inv. Amt.	Pmt. Amt.	Running Total	Interest Rate%
Healthcare		Statement created for \$1779.00 (11600-000042>)				\$0.00	\$0.00	\$0.00	\$0.00	
Healthcare		Statement created for \$1779.00 (11600-000042>)				\$0.00	\$0.00	\$0.00	\$0.00	
		Total				\$0.00	\$0.00	\$0.00	\$0.00	

In the account ledger, there are entries for each patient for whom the statement was sent along with their respective balances dues.

The entry description is: **Statement created for \$xx.xx - <Current statement status>**

Here \$xx.xx - is the net balance due of the patient.

The date associated with the entry must be the transaction date on which the last status change was made.

All amount columns would have \$0.00 as the corresponding amount columns.

This entry would have a deep pink font color.

When the entry is clicked it would open up the corresponding statement pdf in a new tab.

A statement entry is removed from the ledger if it has been voided.

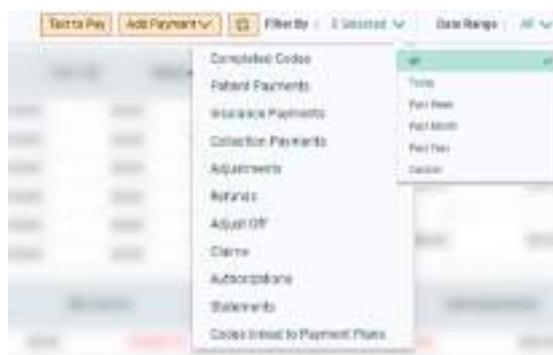
The amount mentioned in the statement is the net balance due for that patient.

A similar entry would appear in the ledger print as well.

An entry in the Type filter to obtain all statements would also be available.

## Filters

---



**Date Filter:** A custom date filter must be available on top allowing users to filter and view records during that time slot.

**Type Filter:** Must include an entry for each action shown in the ledger, allowing users to filter using those. It is a multi-select filter with None selected by default. None selected and all selected would have the same functionality of listing all kinds of entries. The entries is in the following order:

- Completed Codes
- Patient Payments
- Insurance Payments
- Collection Payments
- Adjustments
- Refunds
- Claims
- Authorizations
- Statements

## Print

---

Patient Ledger	Amount Ledger	Due to Pay	Add Payment/Inv		Filter By:	Printed	Date Range:		
Patient Name	0-30	31-60	61-90	91-110	Over 120	Balance	Outstanding Balance	Outstanding Balance	Item Count
John Doe	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	1000
Jane Smith	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	1000
Bob Johnson	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	1000
Susan Williams	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	1000
Mike Brown	\$100	\$200	\$300	\$400	\$500	\$600	\$700	\$800	1000

There is a print icon in both sub tabs which when clicked will print the ledger as it is being viewed on the screen at the moment the print icon was clicked with all filters applied.

All three grids are printed as such.

Embedded content from <https://www.loom.com/embed/dab7806fa05543d389eaec76fca51d86>

# Transaction Charges

Written by Revati Krishnan | Last published at: August 22, 2021

Some of the third-party financiers may charge a small fee for the processing and handling of charges. CareStack allows you to track these fees and manage them as your process payments using special payment types.

In this article, we'll look at :

- What needs to be setup
- How to process the payment

## Initial Setup

### Setup a Payment Type

The first step in tracking these transaction charges is to create a payment type that identifies the fee. To add a Payment Type go to Practice Settings > Payments > General > Payment Types tab.

- Click **Add Payment Type**.
- Complete the information for your payment type



- The **Name** of the payment type could be based on the requirement and need to be something recognizable.
- Select Care Credit for the **Category** to enable the transaction charge option.
- Add the percentage that is charged as a **Transaction Charge**.
- If desired, you can require a **Reference Number** when the payment is applied to patient, insurance, or collection payments.
- Select the types of payments this type can be used for. Please note that **CareStack will only calculate the transaction charges for patient payments.**

- Click **Save**.
- Once your payment type is established, you can select it as you process payments.

### Default Adjustment Code for Posting Transaction Charges

CareStack already includes a system level adjustment code called TRNCH for Transaction Charges that will reduce the patient portion by the amount of the charge when applied.

## Process a Payment

Process a payment with a transaction charge the same way you process any other payment, just use your Care Credit payment type. CareStack will calculate the amount of the fee to include as an adjustment type.

The transaction fee will be deducted from the amount of the patient payment so that the net is applied to the patient balance. That fee will then be adjusted off from the patient with an adjustment. To process a care credit payment with a transaction fee:

- Review or update the payment amount, location, and payment date as appropriate.
- Select the payment type of category Care Credit.



CareStack will calculate the transaction charge based on the payment type setup and the payment amount.

- Click the Post Transaction Charges link



CareStack will add the TRNCH adjustment code to the codes and apply the adjustment amount in your selected application order (oldest to newest or newest to oldest).



Depending on your codes and amounts, not all codes may have an adjustment applied. You can manually change the code the charge adjustment is applied to or the split of the adjustment code.

- Click **Apply** when you are ready to finish posting a payment.

The payment and discount will be applied to the patient account. Your patient will see that they were reimbursed the transaction charge and yet your practice will be able to fully track the charge.

## Impact in Ledger

There will be three entries in the Ledger :

- Receipt for the Care Credit.
- Transaction Charge amount applied for Receipt that was credited by CARE CREDIT.
- Entry of the Patient Adjustment TRNCH Transaction Charges

## Impact in Statements

In Menu > Statements, under the Minimum Account Balance to Generate section, there should be an option "Exclude Unadjusted Transaction Charges" which would by default reflect the value which is set in Practice Setting > Payments > General > Statements "Exclude Unadjusted Transaction Charges from Net Account Balance".

If this option is set to No, while considering the minimum balance to generate, it should also subtract the unadjusted transaction charges of all the considered patients from the net balance.

If it is Yes, then all balances should be considered how it is now.

# Text to Pay

Written by Revati Krishnan | Last published at: August 22, 2021

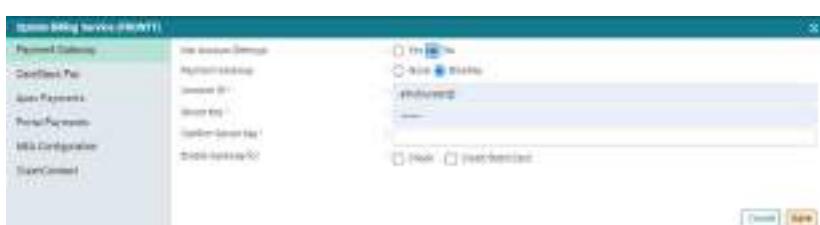
Naturally, you enjoy caring for people and providing treatment, but it is important to get paid. Patients are much more likely to pay when you give them many different ways to do so. CareStack is on the forefront of contactless care and is now offering Text to Pay. In this way, you can text your patients asking them to pay, and they can pay directly from their phones with a link in the message.

## Steps to enable Text to Pay

There are some Practice Settings you'll need to select before you can use Text to Pay at your practice. That's probably been done, but it is worth a check. **Practice Settings > Payments > General > Others > Portal Payments**

- Enable Portal Payments and set the details.
- Set the default option for credits added from external sources.

If your practice chooses to use location level settings for portal payments you may enable the under **Practice settings > Payments > Billing Services**, where you may click on the location, select the **Portal Payments** tab and select **Use Account Setting** as 'No' and then enter the locations **Account ID** and **Secret Key**.



## Send a Text to Pay Message

CareStack has made it easy for you to send the Text to Pay message to your patients. A Text to Pay button is available on the Home Dashboard while scheduling an appointment when you right-click on the appointment block and the Ledger.



Patient Name	31-02	31-03	31-04	31-05	Over 120	Balance	Overdue Balance	Overdue Ledger	Bal. Overdue Amount
Revati, John (123456789)	Payment	\$1,140.00	\$8.00	\$0.00	\$3.00	(\$0.00)	\$1,140.00	\$1,140.00	\$0.00

Appt Status: Scheduled ✓ History

Patient ( Details ) Mr. Dominic, Danvers (10031351)

**Appointment Summary** ( Edit )

Production Type	No Production Type
Date	08/03/2021 (Tue)
Time	06:15 AM - 07:30 AM (1 hrs 15 mins)
06:15 AM - 06:30 AM - DOCTWO	
06:30 AM - 06:45 AM - DOCTWO	
06:45 AM - 07:00 AM - DOCTWO	
07:00 AM - 07:15 AM - DOCTWO	
07:15 AM - 07:30 AM - DOCTWO	

Short Call	:	No
Appt Note	:	

Treatment Summary ( Add / Edit )

Go to chart

No entries to display

**Payment Summary**

Current Pat. Balance	\$0.00
Current Inv. Balance	\$0.00
Current Total Balance	\$0.00

[Text to Pay](#) [Add Payment](#)**Lab Summary ( Edit )**

No active lab case

Task

**Change Status**

Check Out

No Show

Cancel

Delete

Confirmed

In-Office

All Reception

Left Message

Unable To Reach Patient

Phone Number

Disconnected

SENT TEXT MESSAGE

SENT EMAIL

NEW PATIENT

PAPERWORK

**Patient**

Patient Overview

View To Page

View Dental Chart

View Ledger

View Warnings

View Reminders

Email / SMS

View Review Patient

Text to Pay

**Appointment**

Convert To Day-Adult

Delete

Edit Appointment

Copy Appointment

Print Existing Day-Treatment Plan

Print Existing Day-Care

**To send the message:****Text to Pay - (790) 713-0704**

X

Select the balance amount to be collected

 Front Street

- |   |             |
|---|-------------|
| <input checked="" type="checkbox"/> Assistant Victor (10031038) | :\$320.00   |
| <input checked="" type="checkbox"/> Transita John (10031403)    | :\$2,323.16 |
| <input checked="" type="checkbox"/> Total Balance               | :\$2,623.16 |

 Celebration Dental - Mallory Circle

- |  |             |
|--|-------------|
| <input type="checkbox"/> Assistant Victor (10031038) | :\$323.64   |
| <input type="checkbox"/> Transita John (10031403)    | :\$1,096.00 |
| <input type="checkbox"/> Total Balance               | :\$1,323.64 |

 Custom Balance[Cancel](#)[Send Message](#)

- Click Text to Pay.
- Select the option for the patient, location, and amount. The total balance for the patients is grouped by location. So text to pay must be sent for each location separately.
- Click Send Message.
- If there is no mobile number entered for the patient in the account you will receive a pop-up window to enter the mobile number of the patient. Once you enter the mobile number you can proceed as mentioned above.



Your patient will receive a text with everything they need to pay the balance amount. Nothing to download, the patient just clicks the link and follows the easy instructions.



Once the patient clicks on the link they will be redirected to the secure Bluepay transactions window.

Celebration Dental -  
Mallory Circle  
2940 Mallory Circle 101,  
Orlando, FL, 32814-7118

Balanc Due:  
**\$123.00**

## Welcome

This is a PCI and HIPAA compliant payment system. Your privacy and the security of your credit information is our

[Proceed to Payment](#)



Here they can click on **Proceed to Payment** which allows them to enter the card details to make the payment.

Card number ends in 1234567890

Celebration Dental -  
Mallory Circle  
2940 Mallory Circle 101,  
Orlando, FL, 32814-7118

Balanc Due:  
**\$123.00**

First Name: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Card Number:      
Card Expiry:  /   
Security Code:      
[Make Payment](#) [Reset](#)

HIPAA BluePay

The user can enter their card details and click **Make Payment** to submit the payment.

Card number ends in 1234567890

Celebration Dental -  
Mallory Circle  
2940 Mallory Circle 101,  
Orlando, FL, 32814-7118

Balanc Due:  
**\$123.00**

**Payment Success**

Your payment has been processed successfully. Please retain the transaction reference  
SH-456789

Enter email address to receive instant via email  
 [Send](#)

[RESEND](#)

HIPAA BluePay

Once the payment is successful the user will be to get an invoice at the mentioned email address. If the payment fails they can restart the payment by clicking on the **Go to home button**.



To receive the invoice the patient can enter the email ID at space provided. The Invoice will be sent to the patients email ID.



Payment Invoice \$123.00 Print

Email [niallcoyle@corestack.com](mailto:niallcoyle@corestack.com) 10:05 PM (1 minute ago)

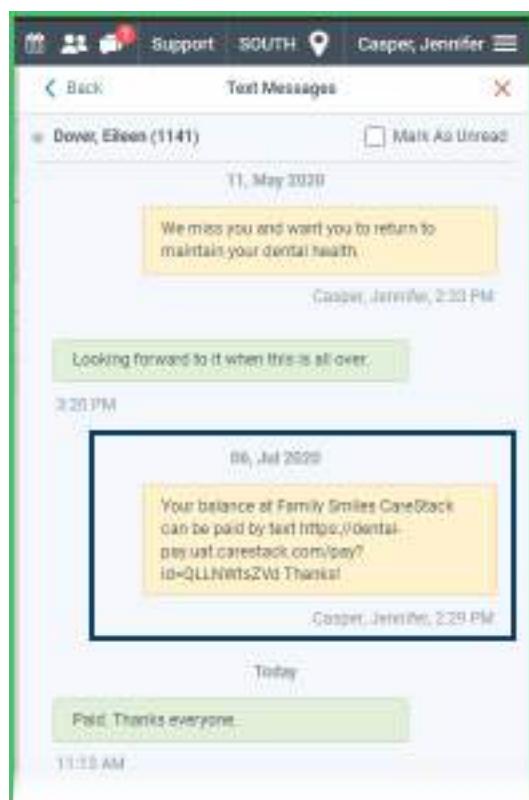
**Celebration Dental - Mallory Circle**  
Payment Confirmation

**Payment Received**

Amount	\$123.00
Date	01/27/2020
Transaction ID	418718
Payment Type	Credit/Debit Card

1948 Mallory Circle, Celebration, FL 34747-9919

You'll always be able to find the history of the text messages in your Patient Text module.



## Working with Payments

The patient has made the payment by text. Now what? It depends on your practice's settings.

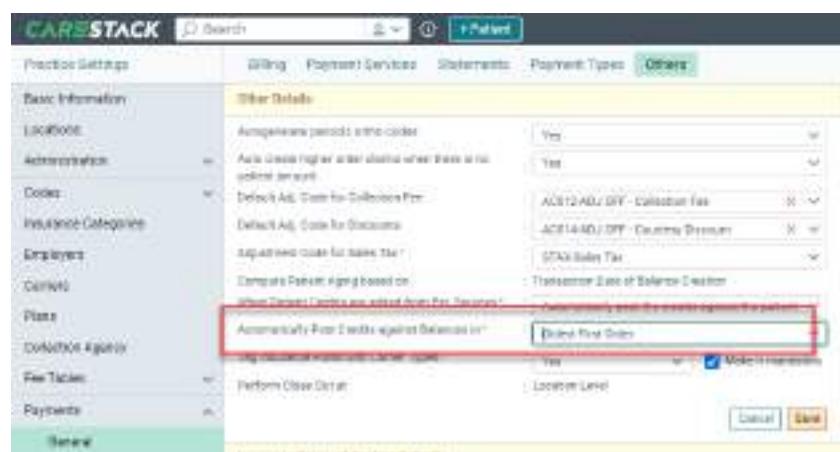
The screenshot shows the 'Payment Types' tab in the Practice Settings. It lists several payment types with dropdown menus:

- Other Details:**
- Payments:**  
  - Auto-create a new ledger entry when this is a patient amount.
  - Default A/R Code for Collection Fee.
  - Default A/R Code for Dismissal.
  - Adjustment Code for Dismissal Tax.
  - Compute Patient Aging based on When Patient Credits are added from Ent. Summary.
  - Automatically Post Credits against Balance in Collection Agency.
  - Tag Insurance Plans with Doctor Types.
  - Perform Close (Surge).
- Statements:**  
  - Automatically post the credits against the patient balance.
  - Automatically post the credits against the account balance.
  - Automatically post the credits against the patient balance first, then post the remaining against the account balance.
- Payment Types:**  
  - ACR12-A5-JWPF - Collection Fee.
  - ACR14-KLJ-OFI - Courtesy Discount.
  - ETAX/Sales Tax.
  - Transparen Date of Balance Creation.
  - Automatically post the credits against the patient.
  - Leave them as unapplied credits in the patient account.
  - Automatically post the credits against the patient balance.
  - Automatically post the credits against the account balance.
  - Automatically post the credits against the patient balance first, then post the remaining against the account balance.
- Others:**

Your practice can choose to handle the payments in a few different ways:

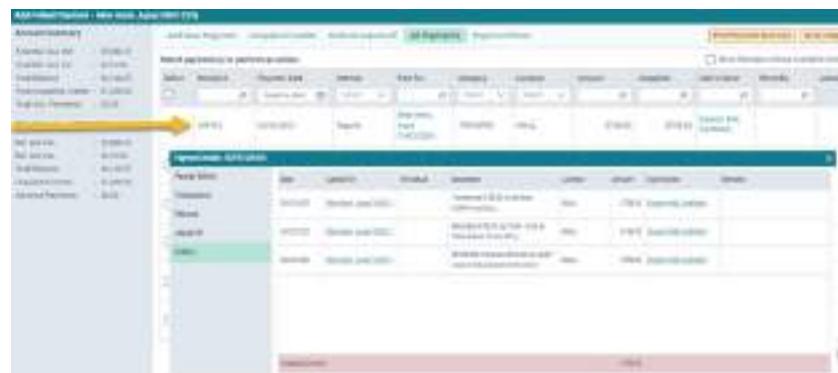
- Leave Payments as Unapplied Credits in the Patient Account:** The payment is added to the account but not applied to any codes.
- Automatically Post the Credits Against the Patient Balance:** The payment is added to the patient and applied to codes under that single patient member..
- Automatically Post the Credits Against the Account Balance:** The payment is added to the patient and applied to the codes under any account member.
- Automatically post the credits against the patient balance first, then post the remaining against the account balance:** This option combines the two automatic options into one. When your practice chooses this option, the payment is automatically applied to the codes under the patient member. If there are remaining funds, they will be automatically applied to the codes under any account member.

The order to apply credits can also be chosen, using the option, **Automatically Post Credits against Balance** in option which is populated if the previous option is set to any other option but the one to leave the payments as unapplied credits.



## Viewing Payments

However your practice handles those payments, you'll be able to see the details of the payment and how it was applied on the **Receipt Details**. Payments added via Text to Pay has payment method set as **Payment Portal**. Access it from the **Payment Slider** or from the **Ledger**:



## Tracking down Payments

The Text to Pay message heads off through cyberspace to the patient. Even though it is incredibly easy to pay using the text, the patient might not do it immediately. They might do it in an hour. They might do it in six hours, or six days. All reports showing patient collection will show payments made through 'Text to Pay'. Find **Insights** under your **System Menu** to generate the reports.

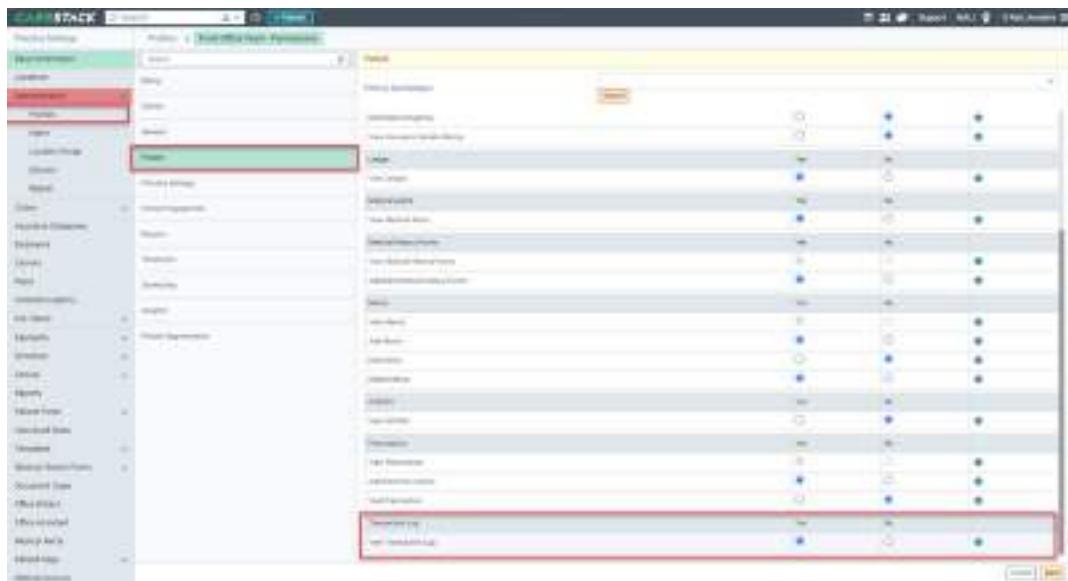
# Walkout Report

Written by Revati Krishnan | Last published at: August 22, 2021

A walkout report shows a summary of the treatments and payments which includes the balances, charges, and credits that the patient has. It also shows the details of the upcoming appointments.

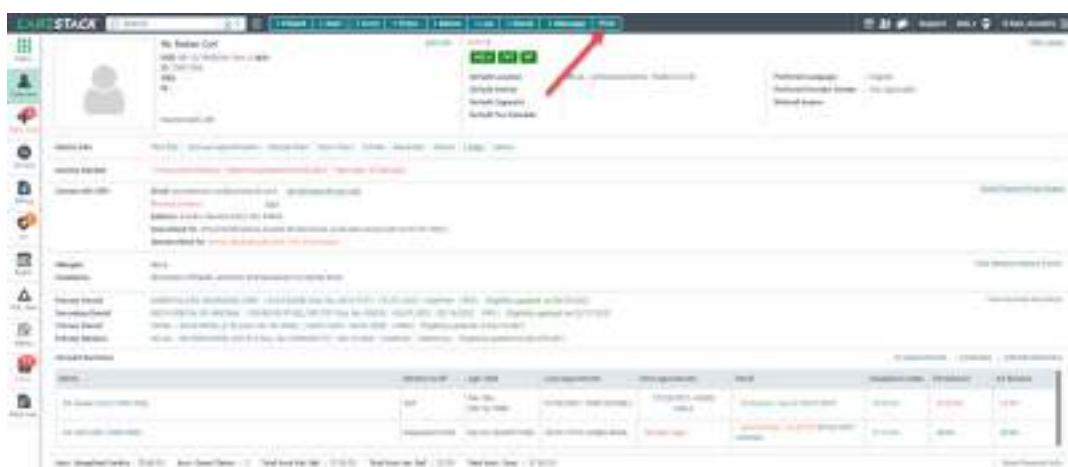
## Permissions

To Print the report, the user Profile needs the required Permission. The Permission to Print the Walkout report is set from **Administration > Profiles > Patient > Transaction Log > Set that to Yes**.



## How to obtain a walkout report?

A walkout report can be printed by clicking on the Print quick link on the top. Now choose the time frame and check the box for the walkout report. On clicking Print, the report opens on a new tab.



The top left portion of the Walkout report shows the patient details like the Patient name, Patient ID, and the Responsible party. The printed date and selected time frame will be also shown here.

### Statements of Services Rendered

Patient: Mr. Rader, Carl | ID#912061  
SSN: 091211111  
Resp. Party: Mr. Rader, Carl | ID#912061

Century Dental 1 - Celebration Dental - Maloy-Carroll  
2840 Maloy Cir Ste 101 Celebration  
FL 34747-0516  
Email: maloycarroll@centurydental.com  
Phone: (407) 505-2322

Printed Date: 07/23/2021  
Selected Period: 07/16/2021 - 07/22/2021

Date	Description	Code	Th/Area	Surf	UCR	Pat.Amt	Ins.Amt	Pat.Credits	Total
Previous Balance									
									-8219.00
07/16/2021	Cosmeto American Two Surface Ant. D005 (07244500)	D005	S		\$194.00	\$128.00	\$0.00	\$0.00	\$128.00
Total for Selected Period					\$194.00	\$128.00	\$0.00	\$0.00	\$128.00
Grand Total					\$1,272.00	\$128.00	\$0.00	-4239.00	\$196.00

Payment Summary as on 07/22/2021

	8-39	31-60	61-98	99-128	129+	Total Bal	Contract Bal	Res. Cont. Amt
Pat. Due	\$720.00	\$0.00	\$0.00	\$0.00	\$0.00	\$128.00	\$0.00	\$0.00
Inv. Due	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Appointments scheduled after 07/22/2021

Next Appnt Date	Start Time	Patient	Provider	Location
07/28/2021 (Wednesday)	01:30 AM-10:00 AM	Rader, Carl	Dr. Angel, DDS, Isaac	Celebration Dental - Maloy-Carroll
07/29/2021 (Thursday)	02:40 PM-03:15 PM	Rader, Carl	Dr. Angel, DDS, Isaac	Celebration Dental - Maloy-Carroll

The location on the Walkout report(on the top right) is the user location from where the report has been initiated. The location is pulled up from **Practice settings > Locations > Print settings**.

If the branding is set on account level:

- Account Name(given in bold) - Account Name
- Address: Account address
- Email: Account email
- Phone: Account phone number 1

If the branding is set on location level:

- Account Name(given in bold) - Location Name
- Address: Location address
- Email: Location email
- Phone: Location phone number 1

The Walkout report has three grids:

The first grid gives the consolidated view of the system transactions in the defined time frame. The first entry in the grid would always be the Previous Balance which is the total due as of the previous day of the time frame chosen. For instance, if the time frame chosen is from 01/27/2020 to 01/30/2020, then the Previous Balance should display the total Patient Balance as of 01/26/2020. The columns in this grid are as follows:

- **Date:** The transaction date on which the entry was recorded in the system.
- **Description:** Provides description of the about the transaction. For example, if it's code completion, then details like the name of the procedure along with the Date of Service (DOS) would be displayed.
- **Code:** The Procedure code against which the transaction has been posted.
- **Th/Area:** Gives the tooth or area on which the procedure has been performed.
- **Surface:** The surface on which the procedure is performed
- **UCR:** The UCR value of the code
- **Pat. Amt:** Shows the patient amount associated with the transaction.
- **Ins. Amt:** Show the insurance amount associated with the transaction.
- **Pat. Credits:** Reflects the amount is in the receipt. That is, when a receipt is added a negative entry is recorded and when the amount is used, a positive entry is recorded.
- **Total:** The running total in the given time frame. The negative value shows that the patient has credits remaining.

The entry descriptions for the different entries are given below.

Actions	Entry descriptions

Procedure checked out	Procedure code-Completed with DOS  <i>Eg: Completed Retreat RCT/Bicuspid with DOS 01/26/2021</i>
Updated payable amount from the EOB/manually	The updated receivable amount for the code with DOS  <i>Eg: Updated receivable amount for the code with DOS 01/26/2021</i>
Insurance transfer to patient	Transferred amount from ins. receipt # of carrier <carrier name> to pat. Receipt # of patient <patient name>(patient ID)  <i>Eg: Transferred \$80.00 from Ins.Rcpt. #249510 of carrier AMERITAS LIFE INSURANCE CORP. to Pat.Rcpt. #249511 of patient Mr. Rudan, Carl (10031296)</i>
Patient payment by any payment type	Receipt #xxxxxx - Pat. payment credited by <Payment category> payment type>  <i>Eg: Rcpt. # 249311 - Pat. payment credited by CASH - Cash</i>
The patient payment was applied from a receipt	Pat. Payment of \$xx was applied from patient Rcpt. #xxxxx of <patient name> (patient id)  <i>Eg: Pat. Payment of \$1026.00 was applied from patient Rcpt. #249311 of Mr. Rudan, Carl (10031296)</i>
Adjustment against Patient component	<Procedure code> - Adjusted \$xx.xx for patient against <adj_desc>  <i>Eg: D0120 - Adjusted \$0.03 for patient against STAX / Sales Tax</i>
Insurance payment applied from receipt	Ins. payment of \$xx.xx was applied from carrier <carrier name> Rcpt. #xxxxxx  <i>Eg: Ins. payment of \$38.00 was applied from carrier AMERITAS LIFE INSURANCE CORP. Rcpt. #249324</i>
Adjustment against Insurance component	<Procedure code> - Adjusted \$xx.xx for insurance against <adj_desc>  <i>Eg: D0120 - Adjusted \$42.03 for insurance against AC003 / ADJ OFF</i>
Collection payment is applied from receipt	Col. Payment of \$xx.xx applied from <collection agency name> Rcpt. #xxxxxxxx  <i>Eg: Col. payment of \$20.00 was applied From col. Agency First Federal Credit Control(FFCC) Rcpt. #249678</i>
Patient refund by any payment type	Refund: Rcpt. #xxxxxxxx \$xx.xx by <Payment Category -Payment Type>  <i>Eg: Refund: Rcpt. #2342156 \$25.62 by CASH</i>

Patient refund to insurance by any payment type	Refunded \$xx.xx from Rcpt. #xxxxxx by CASH - Cash at <Location> (Refund Date:xx/xx/xx)
	<i>Eg: Refunded \$200.00 from Rcpt. #249404 by CASH - Cash at MALL (Refund Date:07/22/2021)</i>
Patient ortho payment plan terminated	Patient ortho payment plan terminated - <Procedure code> - <code description> with DOS xx/xx/yyyy  <i>Eg: Patient ortho payment plan terminated - D8010 - Completed Limited Primary Dentition with DOS 07/21/2021</i>
Insurance ortho payment plan terminated	Insurance ortho payment plan terminated - <Procedure code> - <code description> with DOS xx/xx/yyyy  <i>Eg: Insurance ortho payment plan terminated - D8010 - Completed Limited Primary Dentition with DOS 07/21/2021</i>
Receipt labelled as a non sufficient fund check	Rcpt. #xxxxxxxx - has been marked as a non sufficient fund check  <i>Eg: Rcpt. #291766 - has been marked as a non sufficient fund check</i>
Non sufficient fund label removed from a receipt	Rcpt. #xxxxxxxx - NSF label has been removed from the check  <i>Rcpt. #291766 - NSF label has been removed from the check</i>
Transfer from Patient to Insurance	<Procedure code> <adj_amt> transferred from patient to insurance against <Adj code> <Adj_desc>
Transfer from Insurance to Patient	<Procedure code> <adj_amt> transferred from insurance to patient against <Adj code> <Adj_desc>
Receipt amount adjusted	Adjusted off \$xx.xx from Rcpt. #xxxxxx.  <i>Eg: Adjusted off \$367.50 from Rcpt. #249386</i>

The second grid shows both the patient and insurance balance aging summary as on the end date of the time frame we are using. It shows the outstanding balance owed by the insurance or patient within the time frame(0-30,30-60, ...).

- **0-30 days:** The outstanding balance owed by insurance carriers and/or patients at the location that are 30 days old or less.
- **30-60 days:** The outstanding balance owed by insurance carriers and/or patients at the location that are between 31 and 60 days old.
- **60-90 days:** The outstanding balance owed by insurance carriers and/or patients at the location that are between 61 and 90 days old.
- **90-120 days:** The outstanding balance owed by insurance carriers and/or patients at the location that are between 91 and 120 days old.
- **120+ days:** The outstanding balance owed by insurance carriers and/or patients at the location that have been outstanding for 121 days or more.
- **Total Balance:** The total outstanding balance owed by insurance carriers and/or patients at this location regardless of days.
- **Contract. Bal.:** The sum of patient balances of all codes currently linked to a payment plan. For instance, if 2 codes are linked to a payment plan, then the sum of the patient balances of those codes is the contracted balance.
- **Rem. Cont. Amt:** Remaining contracted amount is the amount that is yet to be received in a payment plan. Let's take an example, if in a payment plan the contracted amount is \$100.00 and we have received say, \$20.00, the remaining contracted amount would be \$80.00 (\$100.00 - \$20.00).

Now the third grid gives the details of the future appointments that are scheduled from the end date of the time frame that is used to generate the report. It has the following columns:

- Next appointment date: Shows the date of the next appointment scheduled.
- Appointment time: Shows the time of the scheduled appointment.
- Patient: Gives the name of the patient for whom the appointment has been scheduled.
- Provider: The provider who is going to treat the patient for the appointment.
- Location: The treatment/appointment location.

The future appointments shown in the walkout report should be based on the time zone of the location of that appointment. For example, an appointment in Mallory at 12 pm should be shown as a future appointment till it is currently 12 pm in Mallory.

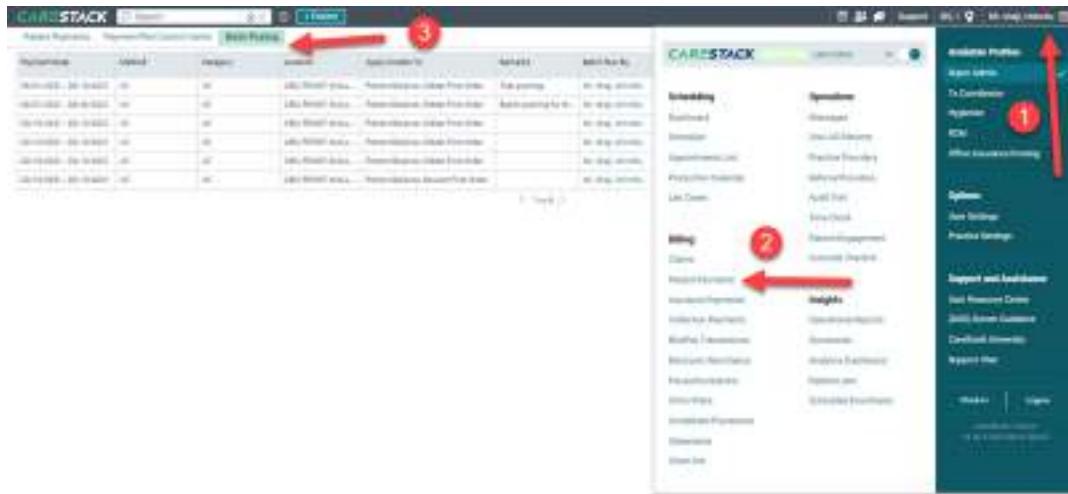
# Batch Posting of Patient Payment

Written by Revati Krishnan | Last published at: August 22, 2021

In CareStack, it is possible to post payments in a batch, that is to post the unapplied credits against the balances for multiple patients at once. You would have to tell CareStack which credits are to be posted and how to post them, and CareStack will take care of everything all at once.

## Workflow

This could be done by navigating to the **System menu > Patient Payments > Batch Posting** tab. Only users with the respective permission from **Practice Settings > Administration > Profiles > Manage Permissions > Billing > Patient Payments > Batch Post of Unapplied Credits**. would be able to to View and Perform all actions in the Batch Posting tab.



In the Batch Posting tab, you will see a list of all the batches that have been posted at your practice(if any) with the summary details. When this is chosen, there would be a grid with the following columns:

Barcode	UoM	Category	Supplier	Approximate %	Reason	Stock Qty (P)	Stock Min Qty	Current Stock Status	Current Min Qty	Alert
1001-001-001-0001	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0002	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0003	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0004	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0005	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0006	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0007	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0008	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0009	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert
1001-001-001-0010	PC	PC	EPIC BUSINESS AUS.	100.00%	Normal	100	100	OK	100	No Alert

- Payment Date: The to and from Payment Dates that were mentioned while creating a batch.
  - Payment Method: The Types of payments chosen to be batch posted
  - Payment Category: The payment categories chosen while creating the batch
  - Location: The payment locations that were chosen to be batch posted
  - Posting Method: This would combine how the user chose to post the payments in that batch. It would show first against which balance the payments would have to be posted and then show in what order they need to be batch posted.
  - Remarks: Remarks if entered any while running the batch.
  - Batch Run By: The name of the user who initiated the batch.
  - Batch Initiated On: The date and time of when the batch was initiated.
  - Credits Before Posting: The sum of unapplied credits in the receipts considered filter before running the batch
  - Credits After Posting: The sum of unapplied credits in the receipts considered filter after running the batch
  - Actions: The Actions column should have the options:
    - **Show Filtered Results:** This should be a link which when clicked would redirect the user to the Patient Payments tab with all the filters set based on the batch details already set so that users can understand all the receipts that were impacted by the batch posting.
    - **Exceptions:** This should be visible only if at least one payment was skipped because of any errors.

This grid would be paginated with 15 entries and would be sorted in the latest first order.

On this page, there would be an action button on the header, **Post Unapplied Credits**. This when clicked would open up a pop-up.

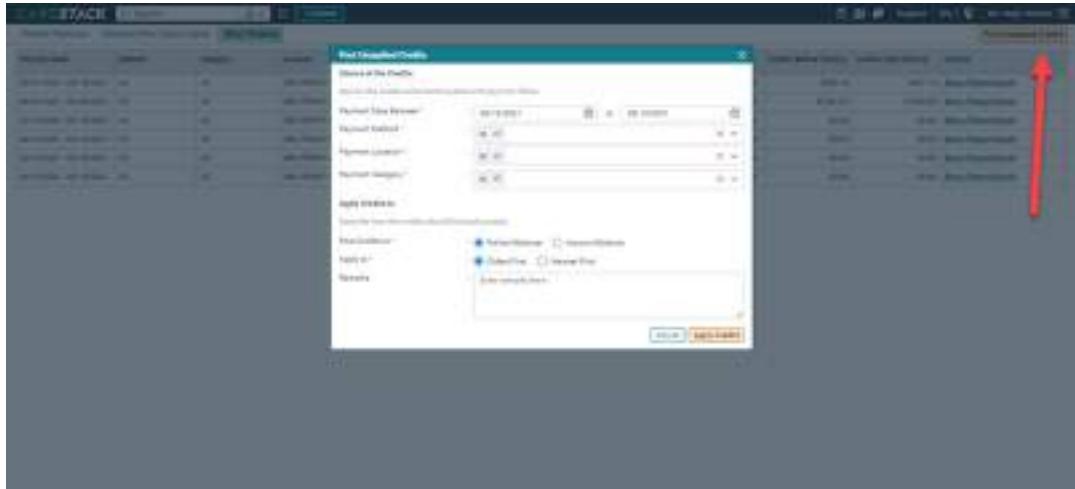
This popup would be divided into two sections.

- **Source of the Credit:** This would have a sub text "Narrow the credits to be batch posted with payment filters." to provide more information for the user. This section would have the following options:

- Payment Date: This would allow users to pick a date range. Both dates would be mandatory and it would both default to the current date. The maximum date range that can be selected at a time would be 30 days. If the date range chosen is over 30 days, the user would be warned of the same, "The date range chosen would not be over 30 days".
  - Payment Method: This would list all the payment methods (Regular, Advance, Patient Portal, Payment Portal, Payment Plan) and would have an "All" option. This would be a mandatory multi-select drop-down option with "All" selected by default.
  - Payment Location: This would list all the allowed locations of the user and would have an "All" option. This would be a mandatory multi-select drop-down option with "All" selected by default.
  - Payment Category: This would list all the payment categories and would have an "All" option. This would be a mandatory multi-select drop-down option with "All" selected by default.

● **Apply Credits to:** This would have a sub text, "Describe how the credits would be batch posted." to provide more information for the user. This section would have the following options:

  - Post Credits to: This would be a mandatory radio button choice with options - Patient Balance (default) & Account Balance.
  - Apply to: This would be a mandatory radio button choice with options - Oldest First (default) & Newest First
  - Remarks: This would be a non-mandatory free form text area. The remarks entered here would be associated with all the payments posted in this flow.



There would be a **Cancel** and **Apply Credits** button as well.

**Cancel** would abort the process and close the modal (similar to the cross button on the modal header) and **Apply Credits** would apply credits to all applicable balances. When Apply Credits is clicked, all payments that satisfy the above criteria would be considered and payments would be posted against the respective patient/account balances in the oldest/newest first order.

This payment application would be run as a background job and wouldn't hinder with the user's workflow. When Apply Credits is clicked, the pop-up would be closed and an orange toaster "Apply Credits functionality initiated" would be shown indicating that the process has started. Similarly when the posting is completed, a green success toaster indicating the completion of the process "Credits applied successfully" would be shown to the user irrespective of the page the user is currently in.

The **Post Unapplied Credits** button would be disabled as long as one is being processed so that users wouldn't initiate multiple requests at the same time. This button would be usable only if at least one payment has been added for any of the allowed locations of the user. The button would be disabled.

In case, no receipts are available to be posted, the completion toaster would be in blue color and would say, "No payments to be posted", indicating that there are no payments matching the criteria that have unapplied credits to be posted.

This would take a few minutes and the screen would appear as in the image below.



Once the posting is complete, its summary would appear as in this image.

Batch Number	Batch Date	Comments	Location	Assigned Party ID	Party Name	Batch Type	Batch Status	Batch Creation Date	Batch Last Post Date	Creditable Reason	Action
10010001-00-00-0001	00		10010001-KAL	10010001-KAL	10010001-KAL	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	Show Filtered Result
10010001-00-00-0002	00		10010001-KAL	10010001-KAL	10010001-KAL	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	Show Filtered Result
10010001-00-00-0003	00		10010001-KAL	10010001-KAL	10010001-KAL	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	Show Filtered Result
10010001-00-00-0004	00		10010001-KAL	10010001-KAL	10010001-KAL	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	Show Filtered Result
10010001-00-00-0005	00		10010001-KAL	10010001-KAL	10010001-KAL	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	Show Filtered Result
10010001-00-00-0006	00		10010001-KAL	10010001-KAL	10010001-KAL	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	00-0000000000000000	Show Filtered Result

Clicking on the **Show Filtered Result** would automatically navigate to the **Patient Payments** tab and show the details of the posted payments.

When the Exceptions link is clicked, it would allow users to download a report as in the attached link. It would have the following details:

It would have all the batch details specified when the batch was initiated. There would also be information pertaining to when the report was printed as well.

It would also have the following details:

- Patient Name: Name of the patient
- Patient ID: Patient ID
- Responsible Party Name: Name of the responsible party
- Responsible Party ID: Responsible party's ID
- Patient Type: Type of Patient (General/Ortho)
- Location: Default Location of the Patient
- Individual Outstanding: Current Patient Balance
- Patient Credits: Total unapplied credits linked to the patient
- Account Outstanding: Sum of patient balances of all members in the account
- Account Credits: Sum of all unapplied credits associated with all members in the account

This would show only one patient once even if two payments associated with the same patient failed to post.

All details shown on this report would be based on the financial details of the patient as of the day on which the report is being printed.

Embedded content from <https://www.loom.com/embed/f2319d9bde7a48448805f9878227f9fb>

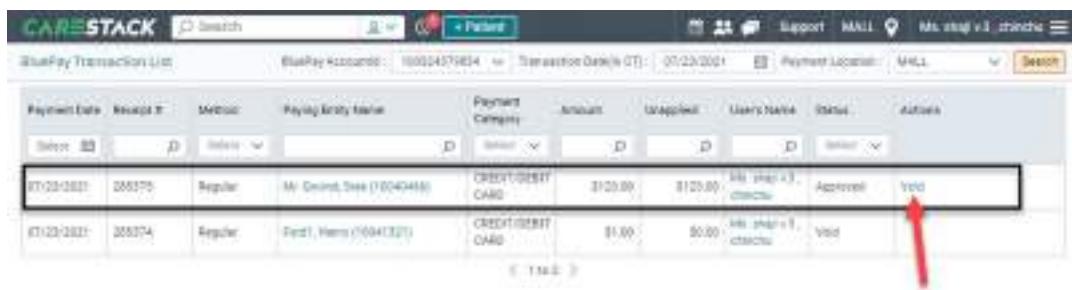
# Voiding a BluePay Payment

Written by Revati Krishnan | Last published at: August 22, 2021

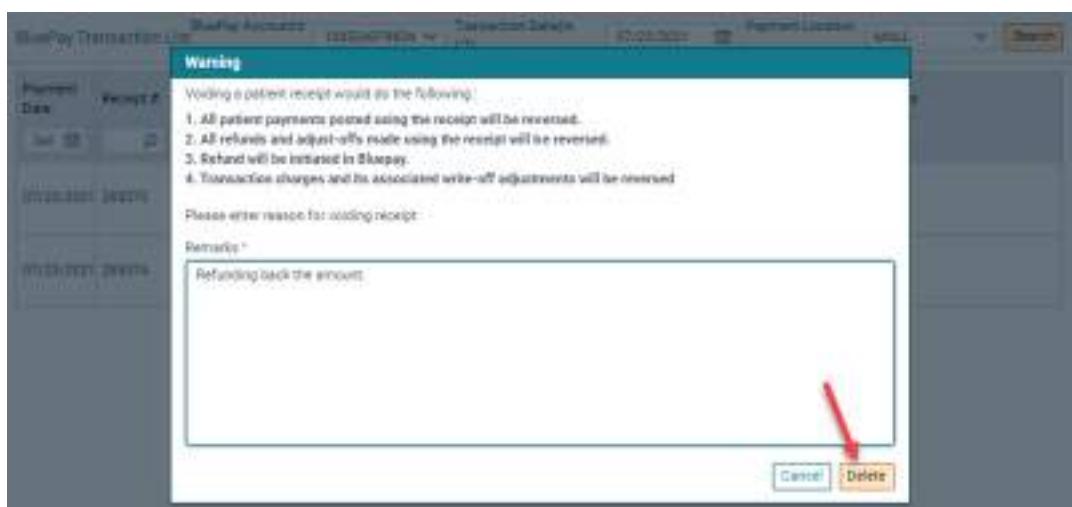
Instead of logging into BluePay to void a Patient payment or to view the status of a payment, an exclusive tab has been provided to monitor and perform action on BluePay Payments. When a payment is made on CareStack through BluePay , the transaction is shown in the BluePay transactions. The BluePay transactions tab in CareStack shows only the transactions up to the last 7 days.

Voiding a BluePay payment will reverse the BluePay transaction and the voided amount will be credited back to the patient's bank account.

The payment receipt will also be deleted from the patient's ledger and any postings or adjustments made against the receipt will be reversed as well. You can void a BluePay transaction by clicking on the Void button in BluePay transactions.

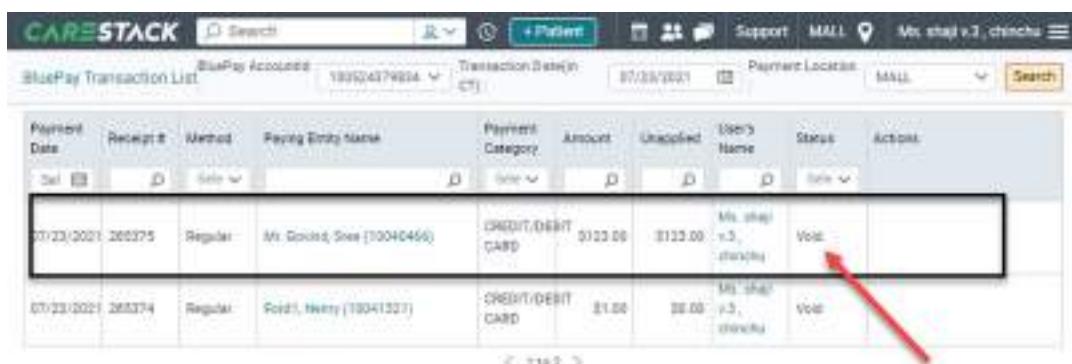


On clicking the Void button, a warning message will appear which will remind the user the impact that the void action would bring about. The user can also enter any remarks and click on Delete when it is done.



Once the transaction is voided, the status of the transaction will change to Void and the Void button will no longer be displayed under the Actions column.

Attached below is the screenshot of the transaction after it has been voided. (Before; the status of the transaction was Approved and the Void button could be seen under the Actions column)



The receipt will also be deleted from the patient ledger once the transaction has been voided.

## Permissions Required

A user will need to have the necessary permissions to view and void BluePay transactions list.

The screenshot shows the CARESTACK software interface with the title 'CARESTACK' at the top. The main menu on the left includes 'Practice Settings', 'Profiles', 'Users - Permissions', 'Locations', 'Administrators', 'Profiles', 'Skills', 'Location Groups', 'Regions', 'Regions', 'Codes', 'Insurance Companies', 'Employees', 'Vendors', 'Plans', 'Commission Agents', 'Partners', 'Payments', 'Statements', 'Reporting', and 'Reports'. The 'Users - Permissions' tab is selected, indicated by a green bar at the top of the page. In the center, there is a grid titled 'Edit' with a search bar. The grid has columns for 'Description' and three checkboxes labeled 'Read', 'Write', and 'Delete'. A red arrow points from the bottom-left towards the 'BluePay Transactions' row, which is highlighted with a yellow box. This row contains the following data:

Description	Read	Write	Delete
View BluePay Transactions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Process BluePay Payments	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Void BluePay Payments	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# System Transactions

Written by Revati Krishnan | Last published at: August 01, 2021

A system transaction is a record of all RCM activity associated with a patient or account. This page would keep track of every action made during the life cycle of a procedure code. This may be observed by selecting a Patient and then going to the Archives and clicking on the System Transaction sub-tab. When a user accesses a system transaction, they are directed to the last page of the transaction with the latest entry in view. There would be a maximum of 30 entries per page and only a page level scroll would be required.

The System Transactions tab can be viewed from Patient > Billing and the option would only for users with View Transactions Logs permission.

There are 2 sub-tabs on the landing page — one for Patient Transactions and the other for Account Transactions.

Both these sub-tabs have a common grid with columns as stated below:

- Patient: Shows the total balance due patient value of either the patient / account based on the current sub tab.
- Insurance: Shows the total balance due insurance value of either the patient / account based on the current sub tab.
- Total: Sum of the values in corresponding Patient and Insurance columns

There is also a column to display the Patient/Account unapplied credits based on the current sub tab.

Patient Transactions sub-tab — all transactions due to payments made for this patient. A grid with the columns of the grid as stated below is displayed:

- Date - Date of transaction
- Proc. Code - The code against which the transaction is made. This column will be left blank when the log entry is not about a transaction done against a code. When present, this would be a link which opens up the code snapshot when clicked.
- Trans. Code - The code corresponding to the action being done. The various transaction codes as mentioned below.
- Description - A descriptive entry for the action being performed. The various descriptions are mentioned below
- Pat. Amt.
- Ins. Amt.
- Pat. Credit
- Total Pat. Bal. = Pat. Amt. + Ins. Amt. + Pat. Credit + Previous Total Pat. Balance
- User's Name - Name of the user who performed the action. This would be a link which opens up the user snapshot when clicked.

Account Transactions sub-tab — all transactions due to payments made for this patient's account members. A grid with the columns of the grid as stated below is displayed:

- Patient - The name of the account member against whom the transaction was done. This would be a link which opens up the patient snapshot when clicked. The respective patient ID would also be shown in brackets.
- Proc. Code - The code against which the transaction is made. This column will be left blank when the log entry is not about a transaction done against a code. When present, this would be a link which opens up the code snapshot when clicked.
- Trans. Code - The code corresponding to the action being done. The various transaction codes as mentioned below.
- Description - A descriptive entry for the action being performed. The various descriptions are mentioned below
- Pat. Amt.
- Ins. Amt.
- Acc. Credit
- Total Acc. Bal. = Pat. Amt. + Ins. Amt. + Acc. Credit + Previous Total Acc. Balance
- User's Name - Name of the user who performed the action. This would be a link which opens up the user snapshot when clicked.

There should also be a Total row at the end, which would sum up the Pat. Amt, Ins. Amt. and Credits columns in each page.

Entries would appear in the system transaction whenever one of the following transactions are done:

- Code Completion: A positive entry for the Pat Est (derived from the appropriate fee schedule) is made in Pat. Amt. at the time of the code completion. Also, a positive entry for the Ins Est (derived from the appropriate fee schedule) is made in Ins. Amt. at the time of the code completion.
- Fee Updates: When the fee of a completed code is updated, the previous positive entries for patient & insurance estimates are reversed and the updated positive entries are posted in the Pat And Ins. Amt columns.
- Code Deletion: When a code is deleted, negative entries with the code's existing patient and insurance estimates would be posted respectively in the Pat And Ins. Amt columns.
- Patient Receipt Addition/ Credits transferred to the patient from insurance: When a new patient receipt is added, a negative value equivalent to the receipt amount must be posted in the Pat. Credits column. This entry would be clickable and would open the Payment Details modal of the receipt must be shown
- Patient Receipt Deletion: When a patient receipt is deleted, a positive value equivalent to the receipt amount must be posted in the Pat. Credits column
- Refunds from Patient Receipts: When a refund is made from a patient receipt, a positive value equivalent to the refund amount must be posted in the Pat. Credits column
- Adjust-offs from Patient Receipts: A single entry would appear in the log while adjusting credits from a receipt. When a adjust off is made from a patient receipt, a positive value equivalent to the adjust-off amount must be posted in the Pat. Credits column
- Marking and un-marking a check as Non-Sufficient Fund (NSF) Check: When a check is marked as NSF, reversal entries of all payments posted using that receipt must be first posted. Then a positive value equivalent to the receipt amount must be posted in the Pat. Credits column.

- Patient/Insurance/Collection payment posting:
  - When a patient payment is posted from the patient's receipt, the value equivalent to amount posted must be made both in the Pat. Amt. (as a negative entry) and Pat. Credits(as a positive entry) column.
  - When a patient payment is posted from an account member's receipt, a value equivalent to amount posted must be made as a negative entry in the Pat. Amt. for the patient and an equivalent value as a positive entry must be made in the Pat. Credits column for the account member.
  - When an insurance payment is posted a negative value equivalent to the amount posted would be made in the Ins. Amt. column
  - When a collection payment is posted a negative value equivalent to the amount posted would be made in the Pat. Amt. column
- Patient/Insurance/Collection adjustment posting: When an adjustment is posted, the entry to be made depends on the action of the adjustment code being used.

Adjustment Action	Entry in System Transaction
Add to Patient	When an adjustment with this action is posted, a positive entry with an amount equivalent to the amount adjusted must be made in Pat. Amt. Column
Add to Insurance	When an adjustment with this action is posted, a positive entry with an amount equivalent to the amount adjusted must be made in Ins. Amt. Column
Deduct from Patient	When an adjustment with this action is posted, a negative entry with an amount equivalent to the amount adjusted must be made in Pat. Amt. Column
Deduct from Insurance	When an adjustment with this action is posted, a negative entry with an amount equivalent to the amount adjusted must be made in Ins. Amt. Column
Transfer to Patient	When an adjustment with this action is posted, a positive entry with an amount equivalent to the amount adjusted must be made in Pat. Amt. Column and a negative entry with the same amount must be made in the Ins. Amt column.
Transfer to Insurance	When an adjustment with this action is posted, a positive entry with an amount equivalent to the amount adjusted must be made in Ins. Amt. Column and a negative entry with the same amount must be made in the Pat. Amt column.

- Payment and adjustment reversals: All reversals must have REVERSED in the appended along with actual application entry description and the amount values to be posted would be equal but with opposite signs of the corresponding application entry
- Code Completion on Ortho-Plan termination: A single entry in log used to represent ortho plan termination and associated code creation. The entry value would be the same as that for a normal code completion
- Claim Submission and Voiding: A single entry must appear whenever a claim is submitted or voided for the patient with zero populated in all of the amount columns. The Claim ID that appears in the description must be a link that displays the corresponding claim snapshot.
- Statement Generation and Voiding: An entry would appear when a statement is generated or voided for a patient with zero populated in all of the amount columns. The entry would be a link using which, the user will be able to view that patient's statement from the log itself. A single entry would appear on marking a statement as void. Once a statement has been voided its corresponding generation entry would not be clickable.
- Patient Inactivation and Re-activation: A single entry must each appear when a patient is made inactive and when the patient is reactivated with zero populated in all of the amount columns.
- Marking and un-marking a patient as Bankrupt: A single entry must each appear when a patient is made bankrupt and when the bankruptcy label has been removed from the patient with zero populated in all of the amount columns.

#### Consolidated View & Legend

There is an option to switch between a consolidated view and an expanded view in the system transactions. This is implemented by including a checkbox labeled Consolidated View at the top right. If this checkbox is selected, only the final updated payable values against a code would be shown, by consolidating all the reversals that had happened in between. If this is not selected, show the full list of transactions involved with all the historical reversals would be shown properly. Consolidated view also will not include any payment or adjustment reversals as well. This checkbox would be unchecked by default when the system transaction page loads first and when a user switches from the Account Transactions tab to the Patient Transactions the checkbox selection state is retained.

For example, if an amount of \$50 is posted against a procedure code for a patient and it is later changed to \$30:

If in the consolidated view, the system transaction should include only the final entry of \$30 posted against the procedure code. The description of the original entry should be retained, and the values would be the updated values.

If not consolidated, the system transaction should include all the associated entries such as \$50 posted against the procedure code, reversal and the changed amount of \$30 posted against the procedure code.

There is also a Legend (info icon on the top right corner), which would list all possible transaction code that could be shown in the system transaction along with its corresponding action.

**System Transaction Entry Description**

Trans. Code	Action	Entry Description	Pat. Amt.	Ins. Amt.	Credits
PROC-D	Procedure checked out	<	Positive Entry	Zero	
PROC-RP	Procedure code deletion	<	Negative Entry	Zero	
PROC-UR	Updated Payable amount from EOB / manually	<	Positive Entry	Zero	
PROC-PB	Updated Payable amount - when remaining balance gets pushed to the patient on closing a claim	<	Negative Entry	Zero	
PPMT-CD	Patient payment by credit or debit card	Rcpt. #xxxxxxxx - Pat. payment credited by Credit/Debit Card - <Payment Type name>	Zero	Zero	Negative Entry
PPMT-CS	Patient payment by cash	Rcpt. #xxxxxxxx - Pat. payment credited by Cash - <Payment Type name>	Zero	Zero	Negative Entry
PPMT-CH	Patient payment by check	Rcpt. #xxxxxxxx - Pat. payment credited by Check - <Payment Type name>	Zero	Zero	Negative Entry
PPMT-CC	Pat. payment by care credit	Rcpt. #xxxxxxxx - Pat. payment credited by Care Credit - <Payment Type name>	Zero	Zero	Negative Entry
PPMT-CA	Patient payment by special credits	Rcpt. #xxxxxxxx - Pat. payment credited by Special Credits - <Payment Type name>	Zero	Zero	Negative Entry
PPMT-DT	Patient payment by direct transfer	Rcpt. #xxxxxxxx - Pat. payment credited by Direct Transfer - <Payment Type name>	Zero	Zero	Negative Entry
PPMT-IR	Patient credit added as an income reduction	Rcpt. #xxxxxxxx - Pat. payment of \$	Zero	Negative Entry	
IPMT-TR	Insurance transfer to a patient	Transferred \$	Zero	Negative Entry	
PPMT - RU	Payment amount of the receipt updated	Payment Amount for	Zero	Positive Entry, Negative Entry	
PPMT-XX	Patient receipt deletion	Patient Rcpt. #xxxxxxxx was deleted	Zero	Zero	
PROC-PP	Patient payment is applied from receipt	Pat. Payment of \$	Zero	Positive Entry	
PROC-PA	Adjustment against Patient component	Adjusted < Positive Entry	Zero	Zero	
PROC-IP	Insurance payment is applied from receipt	Ins. payment of \$	Negative Entry	Zero	
PROC-IA	Adjustment against Insurance component	Adjusted <	Negative Entry, Positive Entry	Zero	
PROC-CP	Collection payment is applied from receipt	Col. Payment of \$	Zero	Zero	
PROC-CA	Collection commission applied against	Negative Entry	Zero	Zero	
PROC-TP	Transfer from Patient to Insurance	Transferred <	Positive Entry	Zero	
PROC-TI	Transfer from Insurance to Patient	Transferred <	Negative Entry	Zero	
CLM-S	Claim submitted	Claim #<Claim_ID> - Claim submitted	Zero	Zero	Zero
CLM-V	Claim voided	Claim #<Claim_ID> - Claim voided	Zero	Zero	Zero
PRF-CS	Patient refund by cash	Refunded \$	Zero	Positive Entry	
PRF-CH	Patient refund by check	Refunded \$	Zero	Positive Entry	
PRF-CD	Patient refund by credit or debit card	Refunded \$	Zero	Positive Entry	
PRF-CC	Patient refund by care credit	Refunded \$	Zero	Positive Entry	

PRF-DT	Patient refund by direct transfer	Refunded \$	Zero	Positive Entry	
PRF-SC	Patient refund by special credits	Refunded \$	Zero	Positive Entry	
PRFI-CS	Patient refund to insurance by cash	Refunded \$	Zero	Positive Entry	
PRFI-CH	Patient refund to insurance by check	Refunded \$	Zero	Positive Entry	
PRFI-CD	Patient refund to insurance by credit or debit card	Refunded \$	Zero	Positive Entry	
PRFI-CC	Patient refund to insurance by care credit	Refunded \$	Zero	Positive Entry	
PRFI-DT	Patient refund to insurance by direct transfer	Refunded \$	Zero	Positive Entry	
PRFI-SC	Patient refund to insurance by special credits	Refunded \$	Zero	Positive Entry	
ADJ-OFF	Receipt amount adjusted	Adjusted off \$	Zero	Positive Entry	
OPPT-P	Patient ortho payment plan terminated	Patient ortho payment plan terminated - <	Positive Entry	Zero	
OPPT-I	Insurance ortho payment plan terminated	Insurance ortho payment plan terminated - <	Positive Entry	Zero	
MNSF-CH	Receipt	Zero	Zero	Positive Entry	
UNSF-CH	Non-sufficient fund label removed from a receipt	Rcpt. #xxxxxxxx - NSF label has been removed from the check	Zero	Zero	Negative Entry
STMT-G	Statement generated for the patient	Statement generated for \$	Zero	Zero	
STMT-V	Statement voided	Statement generated for \$	Zero	Zero	
INACT-P	Patient has been marked as Inactive	Patient has been marked Inactive	Zero	Zero	Zero
ACT-P	Patient has been unmarked as Inactive	Patient has been marked Active	Zero	Zero	Zero
BR-P	Patient has been marked as Bankrupt	Patient has been marked Bankrupt	Zero	Zero	Zero
RBR-P	Patient has been unmarked as Bankrupt	Patient bankruptcy has been removed	Zero	Zero	Zero
SYSREV & MANREV	System and Manual Reversals	For all RCM reversals, append REVERSED to the above lines and keep font as orange			

The various entries in the system transactions are

#### Ledger code

Mild yellow as the background

Mild green as the background

Mild green as the background

Mild green as the background

Mild blue as the background

Purple as the font

Light red as the font

Light red as the font

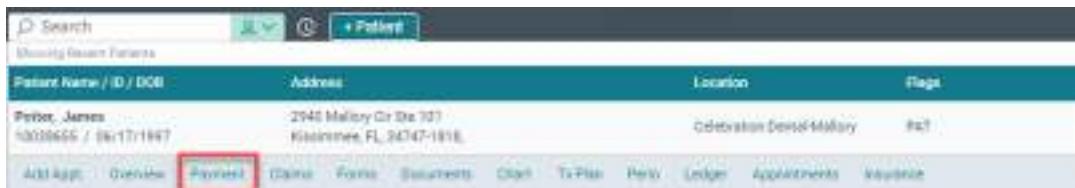
Would be in black font

NSF checks are those checks given by a patient in whose bank account, amount equaling the check isn't available. In such a situation, the practice would need to not be able to post any payments further from that receipt and at the same time does not delete it from the system. Users are able to maintain a proper audit trail as the receipt wouldn't actually get deleted from the system. Patients could also be duly notified about the issue through statements. Once the amount comes to the practice correctly, users can use the same receipt to post payment.

## Mark a Patient Check as NSF

Mark a check as Non-Sufficient Funds (NSF) by following the steps below:

- Search for the patient in the global search bar, then select the **Payment** shortcut.



- Locate the intended receipt under the **All Payments tab** or the **Refund/Adjust-Off tab**. If the payment has already been allocated towards completed treatments, you will have to checkmark the option "**Show Receipts without Available Credits**" (pictured below).



- Once the intended receipt is located, click on it to open the Payment Details window.



- Click **Mark as NSF** on the bottom right of the pop-up window( pictured above).
- You will receive the following warning message: "**This will reverse all transactions done using this receipt and label the receipt as a non-sufficient fund check**"



- On clicking Proceed the check will be marked as NSF.

## Outcomes

Clicking Proceed will tell the system to go ahead and reverse all transactions associated with this payment; therefore the balance due to patient will increase (since that balance has no longer been met).

If part of this check was also used for other members of the account, those transactions will also be reversed.

Once the receipt is marked as NSF, you will receive a confirmation message at the top-right which says “**The receipt has been marked as NSF**”



The receipt will now display on the grid with **NSF** next to the receipt number to indicate the status of this check (as well as on the **ledger**).

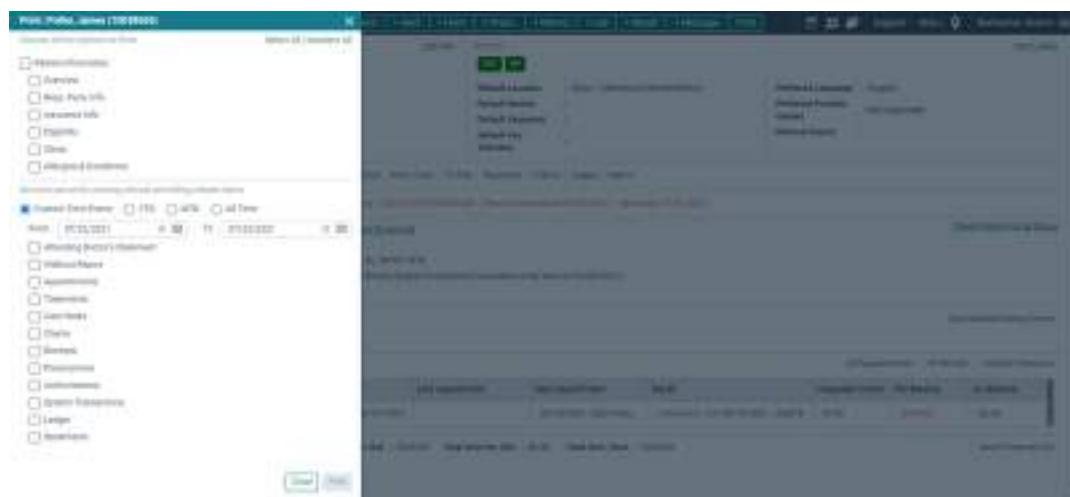


## Print a Receipt of this transaction

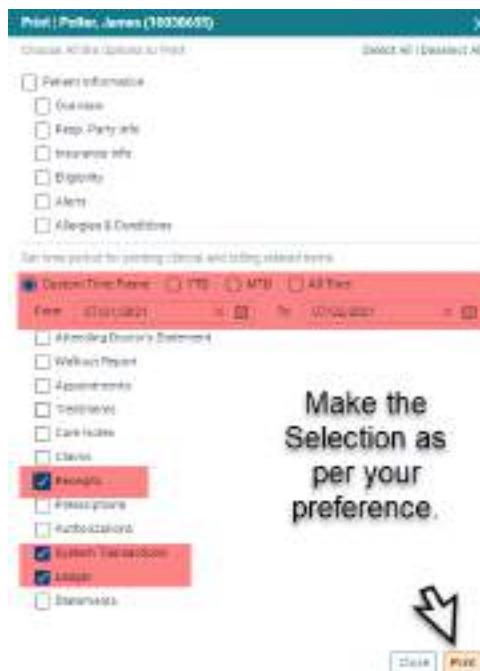
1. At the top of every page of the patient's profile, you'll find a row of Quick Links. Click the one on the far right titled **Print**.



The Print module will open in a slide-out panel.



2. You'll select the **date** of this transaction occurred, then choose the type of printout that meets your needs (examples of each type will be pictured below).



3. Hit **Print** when you are ready. Your printout will open in a new tab for you to print or download.

**Receipts (printout example):**

**Celebration Dental-Malory**  
John Malory, D.C.M.S. #101  
Celebration, FL 34747-1116  
(407) 567-2222

SECRET

Pending Date 05/22/2021  
Request # 291794  
Patient Name Peller, Jerome (130388818)

Date: 10/01/2014 Disbursement: \$0.00 Amount: \$0.00

Signature: \_\_\_\_\_  
Name: \_\_\_\_\_

#### **System transactions (printout example) :**

Celebration Dental-Malvern

2940 Wadsworth Ct. No. 134  
Clyburn, SC 29428-2008  
P.O. Box 2010  
E. 304-458-4734 FAX 304-458-1386

## SYSTEM TRANSACTIONS

Printed On: 07/02/2011

		Patient		Insurance		Total	
Date Disposition		Initial		Billable		Paid	
Date	Description	Plan/Refund	Inv. Refund	Pmt/Credit	Total Pmt	Balance	
07/23/2011	08401-CH	Billed 42517500 - has been marked as a non sufficient payment	\$0.00	\$0.00	\$0.00	\$0.00	

#### **Ledger (Printout example) :**

Celebration Dental Mallory

1044 Wadsworth Ct Ste 904  
Edmonton, AB T6T 2T8  
Ph: 780-738-2020  
E-MAIL: CLEVERLYTRUST@PCINTER.NET

LEDGER

Patient Name : Peller, Jensen (1180386895)  
Address : 2940 Mallory Cr Blk 16A  
Elohimas St, 26747-1811

Date: 07/22/2021

Date	Description	Debit Area	Credit Area	Previous	U.S.	Mar Change	Jan Total	Feb. Total	Running Total
2023-03-01	Multi-Bank Transfer from account 10000000000000000000 to Citi Corp. Checking account 10000000000000000001				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Total:				\$0.00	\$0.00	\$0.00	\$0.00	

Balance Summary as on 09/09/2027

## Unmark a Patient Check as NSF

- In the Patient Payment slide-out module, select either the **All Payments** tab or the **Refund/Adjust-Off** tab.
  - Checkmark “Show Receipts without Available Credits” to reveal the NSF check (pictured below).

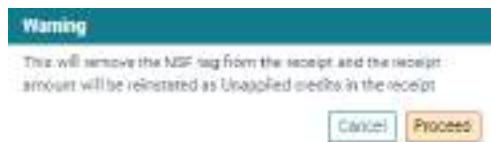
The screenshot shows the 'Add Payment Payment' window for 'Rosen\_Jessica (10000000)'. The main area displays a grid of receipts. One receipt is highlighted with a red border. At the top right of the window, there is a button labeled 'Unmark NSF' which is also highlighted with a red border.

- Locate the receipt on the grid, then click on it to open the Payment Details window.

The screenshot shows the 'Payment Details' window for receipt ID 101710140. The receipt details are listed on the left, and the right side shows the payment breakdown. At the bottom right, there is a button labeled 'Unmark NSF' which is highlighted with a red border.

- Hit Unmark NSF at the bottom-right( as pictured above).

The following warning message will appear: "This will remove the NSF tag from the receipt and the receipt amount will be reinstated as Unapplied credits in the receipt"



If you choose to proceed, you will receive a green confirmation message at the top-right of the screen: "**NSF label has been removed from the receipt**". This payment will now be available to apply towards any outstanding balances.

The screenshot shows the 'Payment Details' window for receipt ID 101710140. The receipt details are listed on the left, and the right side shows the payment breakdown. A green success message at the top right states: '✓ NSF label has been removed from the receipt'. At the bottom right, there are two buttons: 'View Transaction Details' (gray) and 'Search for Receipt' (orange).

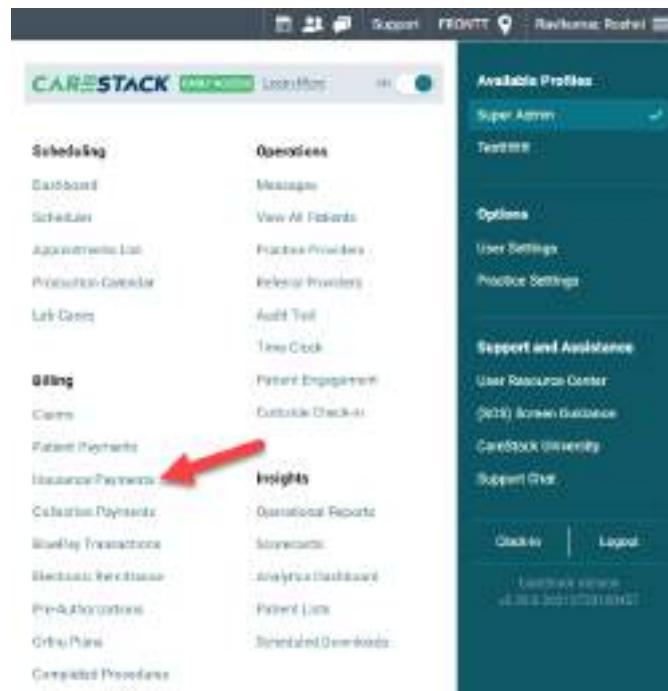
# Patient and Insurance Receipt Editing

Written by Roshni R | Last published at: August 18, 2021

## Edit Insurance Receipt

With the appropriate permission settings, users are able to edit an insurance receipt's details as needed by following these steps below:

1. From your system menu, select **Insurance Payments**.



2. When the page loads, locate your intended receipt on the left side menu, then click **Edit** and make your necessary changes in the drop-down box. All fields in the Receipt would be auto-populated with the currently saved data.



3. Hit **Save** when you are done. You will receive a green confirmation message on the top right of the screen : " **Receipt updated successfully.** "



The following details of an insurance receipt should be allowed to be edited after it has been added.

- **Receipt Amount:** The updated amount of a receipt cannot be less than the amount that has already been applied.
- **Payment Date:** The updated date must be a date between the last close-out date and the current date.
- **Location:** You will only be allowed to change the location of the receipt to another location to which you are allowed access.
- **Payment Type**
- **Reference number**
- **Remarks**

Embedded content from <https://www.loom.com/embed/48dfe2b67d544258874065f092a1e0a5>

## Impact Areas

All changes made will be separately logged in the **Receipt History** section of the corresponding insurance receipt details and it is audited in the **Audit Trail** as well.

A screenshot of the CARDSTACK software interface. On the left, there's a grid titled 'Receipt History' showing several rows of receipt details. One row is highlighted in red, indicating it's selected. On the right, there's a detailed view panel titled 'Receipt' containing fields for Receipt #, Payment Date, Receipt Date, Location, Insurance Details, Payment Type, Reference No., and Remarks. The 'Remarks' field contains the text 'Updated Details'.

The screenshot shows a software interface titled 'CARISTACK'. At the top, there are tabs for 'Dashboard', 'Faster', 'Alerts', 'Forms', 'Print', 'Merge', 'List', 'Report', 'Search', and 'Logout'. Below the tabs, a message states 'Last updated by Ruthmara, Ruthmara (12/29/2022, 11:21 AM) (PTW-0425) (Owner) (Last Update)'. The main area is a grid table with columns: 'Entry Date', 'Type', 'Patient', 'Status', 'Address', and 'Actions'. There are four rows in the grid. A red arrow points to the fourth row, which contains the text 'Insurance Receipt Details' under the 'Type' column.

Updating the details of an insurance receipt will also update the same corresponding information provided in the following areas:

- Insurance Receipt Details
- Insurance Receipt History
- Deposit Slip
- Payment Log
- Collections By Carrier
- Insurance Payments Report
- Ledger (Insurance Receipt Details modal and receipt snapshot)
- Insurance Transactions By User

## Permissions

Only users with **Add/Edit Insurance Payments** permission should be allowed to edit the details.

The screenshot shows the 'Permissions' section of the CARISTACK software. On the left, a sidebar lists categories like 'Locations', 'Locations Details', 'Billing', 'Claims', 'Collections', 'Carrier', 'Finance Categories', 'Employees', and 'Clients'. On the right, a table lists 'Insurance Payments' with various permission levels (Read, Write, Edit, Delete) for different roles. A red arrow points to the 'Edit' button in the 'Actions' column for the 'Add/Edit Insurance Payments' row.

## Edit Patient Receipt

With the appropriate permission settings, users are able to edit a patient receipt's details as needed by following these steps below:

1. Navigate to Patient's **Billing > Payments > All Payments**.
2. Locate the intended receipt under the **All Payments** tab or the **Refund/Adjust-Off** tab.

The screenshot shows the 'Payments' screen for a patient named 'Ruthmara, Ruthmara (12/29/2022, 11:21 AM) (PTW-0425) (Owner) (Last Update)'. The left sidebar includes links for 'New Visit', 'New Refill', 'New Rx', 'New Payment', 'New Adjustment', 'New Refund', 'New Transaction', and 'New Procedure'. The main area displays a table of payments with columns: 'Patient', 'Visit Date', 'Visit ID', 'Procedure', 'Description', 'Amount', 'Status', and 'Actions'. A red arrow points to the 'Edit' button in the 'Actions' column for the first payment entry.



If the payment has already been allocated towards completed treatments, you will have to checkmark the option "**Show Receipts without Available Credits**" (pictured above).

3. Once the intended receipt is located, click on it to open the Payment Details window.

4. Click **Edit Payment Details** on the bottom right of the pop-up window.



5. After making the changes in the intended receipt, you can click on **Save**.



You will receive a green confirmation message on the top right of the screen : " **Receipt updated successfully.** "



**Please Note:**

The following details of a Patient receipt should be allowed to be edited after it has been added.

- **Payment Amount** : The updated amount of a receipt can be greater than or less than the amount that has already been applied.
- **Payment Date**
- **Location**: You will only be allowed to change the location of the receipt to another location to which you are allowed access.
- **Payment Type**
- **Reference number**
- **Remarks**

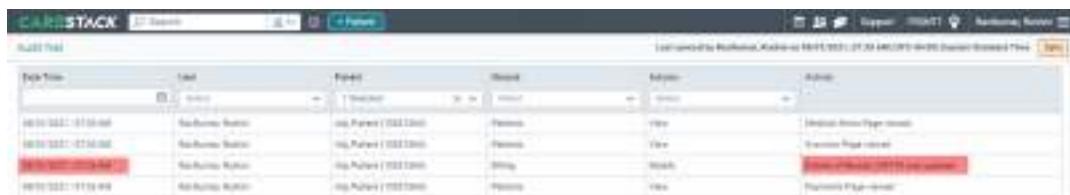
Embedded content from <https://www.loom.com/embed/2b657d7d92d64bf2afea8ec46c183523>

## Impact Areas

All changes made will be separately logged in the **Receipt History** section of the corresponding insurance receipt details and it is audited in the **Audit Trail** as well.



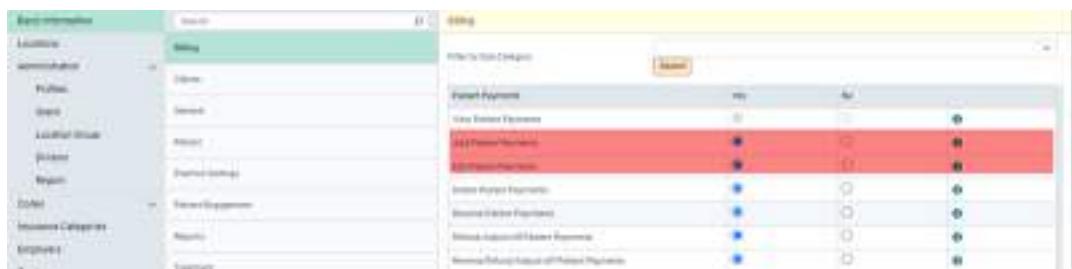
Record Details	Actions	Comments	Created	Updated	User's Name	Remarks
Revised Details	Approve	Initial Approval	2023-01-01 10:00:00	2023-01-01 10:00:00	Administrator	
Revised Details	Adjust CTR	Adjusted CTR	2023-01-01 10:00:00	2023-01-01 10:00:00	Administrator	



Date	Action	Details	Result	Notes
2023-01-01 10:00:00	Initial Approval	Initial Approval	Approved	Initial Approval
2023-01-01 10:00:00	Adjusted CTR	Adjusted CTR	Approved	Adjusted CTR
2023-01-01 10:00:00	Initial Approval	Initial Approval	Approved	Initial Approval
2023-01-01 10:00:00	Adjusted CTR	Adjusted CTR	Approved	Adjusted CTR

## Permissions

Only users with **Add/Edit Patient Payments** permission should be allowed to edit the details.



# Completed Procedures Grid

Written by Athul V Suresh | Last published at: August 08, 2021

The completed procedure code grid shows the list of completed procedure codes for the patient.

To access the grid navigate to Billing > completed procedure code.

This screenshot shows the CARESTACK software interface. On the left, there is a vertical sidebar with various icons and menu items. In the center, there is a main window titled "Completed Procedures". The main window contains a table with columns: Status #, Procedure Code, To Procedure, Description, Fee paid, Net paid, Tax paid, Tax Free, Tax, Net, and Status. There are approximately 10 rows of data in the table. The status column includes entries like "Completed", "Revised Date Entered", and "Revised Date Entered". The "Status" column also includes "Open", "Revised Date Entered", and "Closed".

Or you can access the universal completed procedures grid for your practice By navigating to System menu > Completed procedures

This screenshot shows the CARESTACK software interface with the "System" menu open. The "Completed Procedures" option is highlighted with a red arrow. The system menu also includes other options like "Scheduling", "Billing", "Reports", and "Support and Assistance". The main workspace shows a "Completed Procedures" grid with some data visible.

This screenshot shows the CARESTACK software interface with the "Completed Procedures" grid displayed in the main workspace. The grid has columns: Item, Date of service, To, Service, Procedure code, To procedure, Description, Fee paid, Net paid, Tax paid, Tax Free, Tax, Net, and Status. The data in the grid is identical to the one shown in the previous screenshots.

The completed procedure grid has the following columns,

- Date of service- The date the procedure was completed.
- Procedure code- The procedure code that was completed each procedure that is completed will have separate entries.
- Tx. Provider- The name of the provider that completed the procedure.
- Billed Amt- The fees associated with the procedure according to any assigned fee schedules.
- Pat. Amt- The patient due of the billed amount.
- Ins. Amt- The insurance due of the billed amount.
- Pat. Paid- The amount the patient paid for the code.
- Ins. Paid- The amount the insurance paid for the code.
- 
- Status- The current balance status of the code.
  - Balance due Insurance-the remaining balance is supposed to be paid by Insurance
  - Balance Due Patient -the remaining balance is supposed to be paid by patient
  - Paid - The fees for the code has been paid
- Billing Status- The billing status shows the current billing status of the code, like whether the claim is to be created for the completed code, the claim status of the codes and so on. The billing status of codes include:
  - Do not bill to insurance - The billing order of the code is N and the fees of the code is entirely patient due.
  - PRIMARY NOT CREATED-Dental- The billing order of the code is D or DD but a claim is yet to be created for the code.
  - PRIMARY NOT CREATED-Medical- The billing order of the code is M or MD but a medical claim is yet to be created for the code.
  - SECONDARY NOT CREATED-Dental- The billing order of the code is DD but a secondary claim is yet to be created for the code.
  - SECONDARY NOT CREATED-Medical- A secondary medical claim is not created for the code
  - TERTIARY NOT CREATED-Dental- The billing order of the code is DDD and tertiary claim is not created for the code.
  - TERTIARY NOT CREATED-Medical- Tertiary medical claim has not been created for the code.
- Other billing statuses includes all statuses associated with the claim submission

## Reversing Payments

To reverse payments you can select the row and click on actions and select the reverse option.

Date of service	Procedure code	Tx. Provider	Billed Amt	Pat. Amt	Ins. Amt	Pat. Paid	Ins. Paid	Status
01-01-2023	00100	Doctor A	\$100.00	\$50.00	\$50.00	\$0.00	\$0.00	Balance Due Patient

This will reverse all only all the transactions (payments & adjustments) applied to the code.

# General Payment Plan

Written by Aaqib Mohammed Sali | Last published at: August 15, 2021

## Overview

Let's face it. Dental treatment can be expensive, and even if the patient is lucky enough to have insurance, it probably won't cover everything.

The more options you give your patients to pay for treatment, the more likely it is that they will. With CareStack, you can offer a **payment plan** as an option.

A Payment Plan is a set of structured regular payments against a balance or future treatment. It's a little like a credit card. The cost of the treatment is the balance and then the patient pays a little each month to reduce the balance.

## Before You Start a Plan

Payment plans connect the patient's current balance or anticipated charges with the details of how the patient will pay the charges over time.

Adding a payment plan in CareStack is almost as easy as entering a payment, but there are three separate components:

- The financed amount
- The periodic payments

Let's look at those before we get clicking.

### Financed Amount

The financed amount is the total balance we'll be spreading into payments over the life of the plan. It starts with a simple calculation: **Total Amount – Down Payment = Financed Amount**.

- **Total Amount:** The total amount the patient will pay. Different practices use different numbers as a starting place. Find out which yours uses: Current balance, Projected treatment cost, or a combination.
- **Down Payment:** The portion of the total amount the patient will pay at the beginning of the plan. It is the most common way for the patient to show his/her willingness to pay. Different practices have different requirements.

There may be one small wrinkle in the calculation. If your practice charges **interest** on the amount financed. You will need to know the **APR (Annual Percentage Rate)**. CareStack will calculate the interest and add it to the financed amount.

Once you know the financed amount, we'll need to figure out how to spread that amount over time into the regular payments.

### Periodic Payments

The periodic payment is the amount that will be paid each period for the life of the plan. It too is a simple calculation: **Financed Amount ÷ Number of Payments = Amount of Payment**

CareStack will do that calculation for you and even turn it around and figure out the number of payments for a specific amount.

- **Number of Payments:** The number of payments the patient is willing and able to make.
- **Periodic Payment Amount:** The amount the patient is willing and able to make.

With these details in hand, you are ready to add your payment plan.

## Add a Payment Plan

Payment plans are added in the **Payment slider** just like regular payments. To add a payment plan:

1. Select the **Payment Plan** option.
2. Complete the details for the payment plan.
3. Click **Pay with BluePay**.

The screenshot shows the CareStack software interface for managing patient payments. On the left, there's a sidebar with various patient information. The main area has tabs for 'Add New Payment', 'View Existing', 'Printed Receipts', and 'Printed Plans'. A large blue arrow points from the 'Add New Payment' button on the right towards the 'New Payment' tab on the left. Below this, another screenshot shows the 'New Payment' tab selected, displaying payment plan details and a signature field.

Your Truth In Lending Agreement will open automatically for the patient's signature. If you are using BluePay, you'll be ready to charge the patient's card for using the BluePay partner window.



## Periodic Billing

Though CareStack does most of the work, you might want to check into the payment plan details. They are held for you on the Payment Plan tab in the Payments slider.

View the periodic schedule by clicking the plan's row.

The screenshot shows the CareStack software interface for managing payment plans. On the left, there's a sidebar with various patient information. The main area has tabs for 'Add New Payment', 'View Existing', 'Printed Receipts', and 'Printed Plans'. A table titled 'Payment Plan' is displayed, showing details like Periodic Amount, Due Date, and Status. The table has columns for 'Periodic Amount', 'Due Date', 'Status', 'Last Paid', 'Next Payment', 'Comments', 'Last Paid', 'Next Payment', and 'Comments'.

The screenshot shows the 'Payment Plan' window with the following details:

Plan Overview		Actions	
Payment Plan Name	Payers Plan #2	No. of Payments	1
Latitude	PHONETT CHILD - PAUL	Per Pay Amount	\$600.00
Total Amount	\$600.00	First Pay Date	05/05/2021
Down Payment	\$0.00	Payment Frequency	Monthly
Forecasted Amount	\$600.00	Payment Type	CREDIT/DEBIT CARD / American Express
APR(%)	0	Paying Method	Leave as unapplied credits
(Unadjusted) Amount	\$600.00	Notes	

**Amortization Schedule**

Amount Paid	Remaining No. of Payments	Last Payment Date	Next Payment Date
\$0.00	1		05/05/2021

**Table: Date, Auto-Draft Amount, Amount Paid, Amount Paid to Date, Status, Action**

Date	Auto-Draft Amount	Amount Paid	Amount Paid to Date	Status	Action
05/05/2021	\$600.00			Pending	

Not only can you see the periodic payment structure in the window, but you can also use it to edit or skip a payment in the series. To edit a payment:

1. Click the **Edit** link beside the payment
2. Change the payment amount.
3. Click **Save**.

The screenshot shows the 'Payment Plan' window with an edited payment row highlighted. The original amount was \$600.00, but it has been changed to \$100.00. The status is now 'Edited'.

Plan Overview		Actions	
Payment Plan Name	Payers Plan #2	No. of Payments	1
Latitude	PHONETT CHILD - PAUL	Per Pay Amount	\$100.00
Total Amount	\$600.00	First Pay Date	05/05/2021
Down Payment	\$0.00	Payment Frequency	Monthly
Forecasted Amount	\$600.00	Payment Type	CREDIT/DEBIT CARD / American Express
APR(%)	0	Paying Method	Leave as unapplied credits
(Unadjusted) Amount	\$600.00	Notes	

**Amortization Schedule**

Amount Paid	Remaining No. of Payments	Last Payment Date	Next Payment Date
\$100.00	1		05/05/2021

**Table: Date, Auto-Draft Amount, Amount Paid, Amount Paid to Date, Status, Action**

Date	Auto-Draft Amount	Amount Paid	Amount Paid to Date	Status	Action
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>
05/05/2021	\$600.00	\$100.00	\$100.00	Edited	<a href="#">Edit</a>

When you edit a payment, CareStack recalculates the remaining payments to incorporate the changed payment.

## Applying Credits

Your practice will decide how to handle payments made through these plans. Some choose to credit them to the patient balance directly; others prefer to hold the credits as unapplied so they can be allocated appropriately.

If your practice holds them as unapplied, you will need to apply them. To know how to apply credits, kindly refer the end of [this article](#).

## Edit Or Terminate A Plan

You carefully built your patient payment plan so the patient would pay the initial payment and each periodic payment after that until the treatment was paid for. But things happen and sometimes you'll need to change or give up on a plan.

We'll begin on the **Payment Plans** tab in the Payment Slider or in the Payment Plan Control Center.

### Edit a Plan

You won't be able to edit every field, but you can work with the total. It is especially helpful if the patient's insurance covered more or less than you anticipated.

You can edit:

- Payment Plan Name
- Total Amount
- Tokenized Card

To edit a payment plan:

1. Open the desired plan.
2. Click **Edit**.
3. Update the relevant details for the payment plan.
4. Click **Save**.



**Payment Plan #2**

**Plan Overview**

Payment Plan Name:	Payment Plan #2	No. of Payments:	1
Location:	HR0311 - Care4-Hans	Per Pay Amount:	\$600.00
Total amount:	\$600.00	Print Per Pay Date:	08/05/2021
Down Payment:	\$0.00	Print H/H Frequency:	Monthly
Financed amount:	\$600.00	Payment Type:	CREDIT/DEBIT CARD - American Express
APR (%)	0	Posting Method:	Leave as unattached entries
Contracted amount:	\$600.00	Notes:	

**Amortization Schedule**

Amount Paid:	\$0.00	Remaining No. of Payments:	1
Last Due Amount:	\$0.00	Last Payment Date:	
Amount Remaining:	\$600.00	Next Payment Date:	08/05/2021

Date	Auto-Draft Amount	Amount Paid	Amount Paid to Date	Status	Action
08/05/2021	\$600.00			Pending	Add

**Payment Plan #2**

**Plan Overview**

Payment Plan Name:	Payment Plan #2	No. of Payments:	1
Location:	HR0311 - Care4-Hans	Per Pay Amount:	\$600.00
Total amount:	\$600.00	Print Per Pay Date:	08/05/2021
Down Payment:	\$0.00	Print H/H Frequency:	Monthly
Financed amount:	\$600.00	Payment Type:	CREDIT/DEBIT CARD - American Express
APR (%)	0	Posting Method:	Leave as unattached entries
Contracted amount:	\$600.00	Notes:	

**Amortization Schedule**

Amount Paid:	\$0.00	Remaining No. of Payments:	1
Last Due Amount:	\$0.00	Last Payment Date:	
Amount Remaining:	\$600.00	Next Payment Date:	08/05/2021

Date	Auto-Draft Amount	Amount Paid	Amount Paid to Date	Status	Action
08/05/2021	\$600.00			Pending	Add

## Terminate a Plan

You would terminate a payment plan if the patient is discontinuing treatment or if this payment plan no longer suits them because of the number of payments.

To terminate a patient payment plan:

1. Open the desired plan.
2. Click **Terminate**.
3. Confirm by clicking **Proceed**.



**Payment Plan #2**

**Plan Overview**

Payment Plan Name:	Payment Plan #2	No. of Payments:	1
Location:	HR0311 - Care4-Hans	Per Pay Amount:	\$600.00
Total amount:	\$600.00	Print Per Pay Date:	08/05/2021
Down Payment:	\$0.00	Print H/H Frequency:	Monthly
Financed amount:	\$600.00	Payment Type:	CREDIT/DEBIT CARD - American Express
APR (%)	0	Posting Method:	Leave as unattached entries
Contracted amount:	\$600.00	Notes:	

**Amortization Schedule**

Amount Paid:	\$0.00	Remaining No. of Payments:	1
LAST DUE AMOUNT:	\$0.00	LAST PAYMENT DATE:	
Amount Remaining:	\$600.00	NEXT PAYMENT DATE:	08/05/2021

Date	Auto-Draft Amount	Amount Paid	Amount Paid to Date	Status	Action
08/05/2021	\$600.00			Pending	Add



# Payment Details Pop-Up of a Receipt

Written by Rinu Seba Joemon | Last published at: August 22, 2021

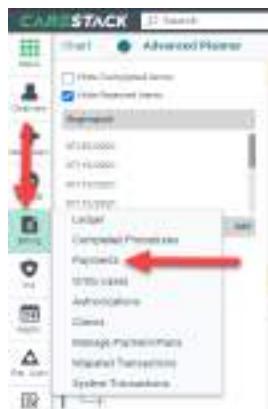
## Overview

The 'Payment Details' pop-up window of a receipt provides CareStack users with plenty of information regarding the completed patient payments. The payment details pop-up opens up when a receipt is selected. Please see the image below for an indication of how the window will appear.



## Workflow

This could either be done by navigating to the patient's Overview > Billing > Payments > All payments > Select the receipt.



You can click on the 'Go to Ledger' icon to directly move to the patient ledger.

Or else, navigate to the patient's Overview page > Billing > Ledger > You will be able to see the patient's payment on the patient ledger with the receipt number > Click on the 'more info' icon in the blue colored text under the description column.

**Note:** Clicking on the payment receipt row highlights the codes associated with the receipt in red pale color as you could see in the below image.

You can also get the patient payments receipt by navigating to the System Menu > Billing > Patient Payment > Search for the receipt.

## Receipt Details:

Now let us go through each tab in the payments details window. There are five tabs in the payment details window.

1. Receipt Details
2. Transactions
3. Refunds
4. Adjust-Off
5. History

### 1. Receipt Details

The receipt details tab includes the below details.

- **Receipt#:** This is nothing but the receipt number/ID. Each and every patient/insurance payment done will have a receipt and each receipt will have a unique receipt number/ID. This way it becomes easy for CareStack users to track specific payments.
- **Paid For:** The patient name for whom the payment has been done.
- **Payment Amount:** The amount the patient paid.

- **Unapplied Amount**: The additional amount the patient paid than what was actually required.
- **Location**: The location at which the payment is done.
- **Payment Date**: The date on which the payment was done.
- **Payment Type**: A patient can complete their payment in any mode such as Cash, Cash-Check, Credit/Debit Card, Special Credit, etc. The payment type the patient had chosen to pay the payment will be shown on the receipt.
- **User's Name**: The name of the user who had made the payment for the patient.
- **Source**: BluePay/CareStack Pay/Apex  
**BluePay** is a leading provider of technology-enabled payment processing for merchants and suppliers of any size in the United States and Canada.  
**Apex** is a payment gateway similar to BluePay.
- **Remarks**: The remarks entered by the user who does the patient payment.

## 2. Transactions

The **transactions** tab shows all the transactions that were completed under this receipt. Reversing transactions is possible in this tab. You just have to tick mark the transaction(s) that you want to reverse and click on the '**Reverse**' icon.

## 3. Refund

The **refund** tab shows the payment refunds that were completed under this receipt. The refunds can be reversed by tick marking and clicking on the '**Reverse Refund**' icon.

## 4. Adjust-Off

The **Adjust-Off** tab contains all the adjustments that have been done in the receipt. Similar to refunds the adjustments also can be reversed from the receipt by tick marking the square box and by clicking on the '**Reverse Adjust-Off**' icon.

## 5. History

As the name suggests the **history** tab contains all the transaction history of the receipt.



The aging buckets are grouped into buckets of 0-30days, 31-60 days, 61-90days, and older dues greater than 90 days.

- 0-30 days: The outstanding balance owed by insurance carriers and/or patients at the location that is 30 days old or less.
- 31-60 days: The outstanding balance owed by insurance carriers and/or patients at the location is between 31 and 60 days old.
- 61-90 days: The outstanding balance owed by insurance carriers and/or patients at the location that is between 61 and 90 days old.
- 90+: The outstanding balance owed by insurance carriers and/or patients at the location that have been outstanding for 91 days or more.
- Total Balance: The total outstanding balance owed by insurance carriers and/or patients at this location regardless of days.
- Contract. Bal.: The sum of patient balances of all codes currently linked to a payment plan. For instance, if 2 codes are linked to a payment plan, then the sum of the patient balances of those codes is the contracted balance.
- Rem. Cont. Amt: Remaining contracted amount is the amount that is yet to be received in a payment plan. Let's take an example, if in a payment plan the contracted amount is \$100.00 and we have received say, \$20.00, the remaining contracted amount would be \$80.00 (\$100.00 - \$20.00).

If the patient has any future appointments after the day of generation of payment summary that would show up too.

Appointment scheduled after 08/09/2021				
Patient Name	Next Appt Date	Appt Time	Provider	Location
Dan, Lin	11/16/2021 (Thursday)	10:10 AM-11:00 AM	Hygienist, Substitute	Front Street

The most important thing to note is that the payment summary will be printed based on the transaction date. All payments and balances due before the date of generation will be shown in summary as previous balance.

How data is organized in the payment summary

The ins balance and patient balance are displayed in the payment summary based on the date of generation.

If N codes are marked as completed today irrespective of the date of completion those codes will have separate entries on the payment summary. Similarly, if N payments are entered in CareStack today these payments will have separate entries irrespective of the actual payment date.

**Ace Dental 1 - Front Street**  
741 Front St Ste 210, Celebration, FL-34747-4993  
PH : (407) 566-2222  
Email : frontstr@celebration.com

#### PAYMENT SUMMARY

Patient	Date (Description)	Ref. Amnt	Inv. Amnt	Balance
Previous Balance		\$20.00	\$0.00	\$20.00
Mr. (Amelia, Emma (10031012))	09/09 - Payment Oral Evaluation- Completed with DDX	\$300.00	\$0.00	\$270.00
Mr. (Amelia, Emma (10031012))	09/09 - \$21.00 adjusted for patient against STAX / Sales Tax	\$21.00	\$0.00	\$248.00
Mr. Dan, Lin (10031012)	09/09 - Payment General Cleaning with DDX 09/09/2021	\$200.00	\$0.00	\$248.00
Mr. Dan, Lin (10031012)	09/09 - Complete Oral Eval- New/Evt Per Completed with DDX 09/09/2021	\$80.00	\$0.00	\$168.00
Mr. Dan, Lin (10031012)	09/09 - Payment Oral Evaluation- Completed with DDX	\$300.00	\$0.00	\$168.00
Mr. Dan, Lin (10031012)	09/09 - \$21.00 adjusted for patient against STAX / Sales Tax	\$21.00	\$0.00	\$147.00

All other transactions done previous to the day of generation of payment summary will only be displayed after calculating the sum total in the previous balance row.

Previous balance is the balance in the patient's account after deducting the credits in the account from the balance the patient owes for complete procedure codes.

The payment summary will show the code and payment details for all patients in the account. It will show receipts added through all payment types.

#### Entries in the payment summary.

Actions	Entry descriptions
Procedure checked out	<Procedure_ID> - Completed <proc_desc> with DOS <Date of Service>
Patient payment by any payment type	Rcpt. #xxxxxxxx - Pat. payment credited by <Payment Category - Payment Type>
Patient payment by special patient credit	Rcpt. #xxxxxxxx - Pat. payment credited by special patient credit <adjcode> <adjdesc>
Patient credit added as provider payback	Rcpt. #xxxxxxxx - Pat. payment of \$xx.xx credited as provider payback amount
Pat. payment by care credit	Rcpt. #xxxxxxxx - Pat. payment credited by <Card type> type care credit
Patient payment credited as Other	Rcpt. #xxxxxxxx - Pat. payment of \$xx.xx credited by other (Ref # xxxxxxx)
Receipt amount partially reversed	Credited back off \$xx.xx to Rcpt. #xxxxxxxx.
Insurance transfer to patient	Transfer: \$xx.xx from Ins.Rcpt. #xxxxxx from payer <payer_name> to Pat.Rcpt. #xxxxx of patient <patient_name>
Insurance payment by any payment type	Rcpt. #xxxxxxxx - Ins. payment credited by <Payment Category - Payment Type>
Collection payment by any payment type	Rcpt. #xxxxxxxx - Col. payment credited by <Payment Category - Payment Type>
Adjustment against Insurance component	<Procedure_ID> - <adj_amt>adjusted for insurance against <Adj_ID> / <Adj_desc>
Collection commission applied against Patient component	Collection commission applied against Patient component
Transfer from Insurance to Patient	<Procedure_ID> - <adj_amt> transferred from insurance to patient against <Adj_ID> / <Adj_desc>
Transfer from Patient to Insurance	<Procedure_ID> - <adj_amt> transferred from patient to insurance against <Adj_ID> / <Adj_desc>
patient by any payment type	Refund: Rcpt. #xxxxxxxx \$xx.xx by <Payment Category - Payment Type>
Patient refund to insurance by cash/check	Refund to carrier: Rcpt. #xxxxxxxx \$xx.xx by cash/check
Patient ortho payment plan terminated	Patient ortho payment plan terminated - <Procedure_ID> - Completed <proc_desc>
Insurance ortho payment plan terminated	Insurance ortho payment plan terminated - <Procedure_ID> - Completed <proc_desc>
Receipt labeled as a non-sufficient fund check	Rcpt. #xxxxxxxx - has been marked as a nonsufficient fund check
NSF label removed from a receipt	Rcpt. #xxxxxxxx - NSF label has been removed from the check

# Authorization Status Flow

Written by Matheus Kandirickal | Last published at: August 08, 2021

## Pre-Authorizations

Insurance claim is the tool for getting paid for completed treatment from the patient's insurance company. To speed up the claims process, many practices will submit a pre-authorization request before treatment is completed; or sometimes an insurance plan might define which procedures will require a pre-authorization check with them first before moving forward.

With pre-authorization, the practice will submit the treatment codes to the carrier and ask what they will pay, instead of completing the treatment and then crossing their fingers and hoping they pay.

## Dental Authorization Status Flow

### Paper Based Authorizations

- When an authorization is created, it will be saved in **Draft** Status.
- On printing and submitting the authorization after filling all the mandatory fields, the authorization status will be changed to **Pending**.
- 

Pending: For authorization in **Pending** status, any of the following actions can be done :

- **Void**
- **Complete**

•

Completed

- Once the authorization response is filled correctly, an Auth can be closed.

- For a completed Auth, the following options would be available
  - **Pending**
  - **Void**

•

Void: An Auth can be voided and the charge lines associated with the Auth will become unbilled. An Auth can be voided after entering a mandatory remark.

- On proceeding further, a warning "Do you want to generate a new Auth from the voided Auth?" will appear with Ok and Cancel buttons. Clicking on Ok, will void the Auth and create a new Auth with the details as in the voided Auth and the new Auth would be in **Draft** status. All the details should be taken from the corresponding treatment plan of the patient

## Electronic Authorizations

- When an authorization is created, it will be saved in **Draft** Status.
- **Document Pending**
  - The **Print** button should be present in the Auth Form tab.
  - NEA Status check job will check the status of Document Pending Auth's and changes Auth status to **Ready To Send** once electronic attachment process is completed in NEA Fast attach.
  - Force Submit button should also be available in the Auth Form, clicking on which will allow the user to Force submit the authorization. An Auth in Document Pending status can be force submitted and the claim status will be changed to **Ready to Send**.
- **Ready to Send Status**
  - On transmitting an electronic authorization from the system, the claim status will become **Ready To Send**. If the authorization requires an electronic attachment then the authorization status will become **Documents Pending** before it becomes **Ready To Send**. If attachments are added to the Auth, then its corresponding NEA reference ID must be tagged and shown in the Auth History against the **Ready To Send** status.
  - The Electronic Auth submission job which is being configured will pick up the claims which are in **Ready To Send** status and submits/resubmits those claims.
  - EDI 837D is generated for claims in **Ready to Send** status and the Auth is submitted/resubmitted to the clearinghouse. The Auth status will become **Pending**.
  - Authorizations in **Ready to Send** status must be allowed to get deleted and printed. Deleting it should prevent the Auth from being submitted to the carrier electronically.
- **Completed Status**
  - When in **Completed** status, there will be a Print button in the Authorization Form tab.
- **Rejected Status**
  - If an authorization is in Rejected status, it would work similarly to the Auth being in Completed Status.
  - The status of the Auth can be made to **Pending** from both *Patient > Billing > Authorizations* and *Menu > Authorizations* grid if the corresponding Authorization Number hasn't been used in any claim. If it has been used, then the user will be blocked from doing so.
  - On changing the status to **Pending** from **Completed** or **Rejected** status, a mandatory Remark is captured which would get saved against the auth. On proceeding further, the status of Auth will be changed to **Pending**.
  - Once the Auth status is changed to **Pending**, the previously saved Authorization number, Effective Date, Expiry Date, and the individual code level Auth Statuses (if exists) will be retained in edit mode (Auth Response tab) from where the user will be able to Save or Save & Complete with the changes made.
    - Clicking Save would Save the changes and Auth status remains as **Pending**.
    - Clicking Save & Complete would save any changes made and would also change the Auth status to **Completed** if all mandatory fields (Authorization Number and Authorization record status) are filled
- **Resubmit**
  - An Auth which is in Pending or Rejected status can be resubmitted.

## Medical Authorization Status Flow

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- When authorization is created, it will be saved in **Draft** Status.
- On printing and submitting the authorization after filling all the mandatory fields, the authorization status will be changed to **Pending**.
- Pending: For authorization in **Pending** status, any of the following actions can be done :
  - **Void**
  - **Complete**
- Completed
  - Once the authorization response is filled correctly, an Auth can be closed
    - For a completed Auth, the following options would be available
      - Pending
      - Void
- - Void: An Auth can be voided and the charge lines associated with the auth will become unbilled. An Auth can be voided after entering a mandatory remark.
    - On proceeding further, a warning "Do you want to generate a new Auth from the voided Auth?" will appear with Ok and Cancel buttons. Clicking on Ok, will void the Auth and create a new Auth with the details as in the voided Auth and the new Auth would be in Draft status. All the details will be taken from the corresponding treatment plan of the patient.

# Pre Authorization

Written by Rinu Seba Joemon | Last published at: August 18, 2021

## Overview:

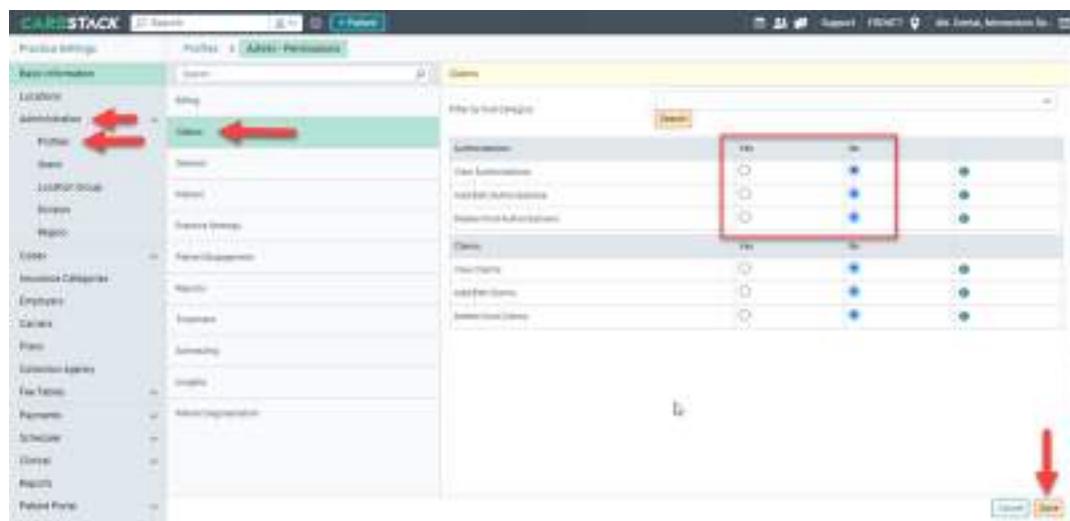
Insurance claims are your tool for getting paid for completed treatment from the patient's insurance company. Many practices will submit a pre-authorization request before treatment is completed to speed up the claims process. Or sometimes, an insurance plan might define which procedures will require a pre-authorization check with them first before moving forward.

With pre-authorization, you submit the treatment codes to the carrier and ask what they will pay, instead of completing the treatment and then crossing your fingers and hoping they pay.

**Note:** An Authorization is NOT a guarantee of payment.

## Permissions:

To enable permissions kindly navigate to the **System Menu > Practice Settings > Administrations > Profiles > Click on Manage Permissions Next to the profile you want to enable permissions > Claims > Authorizations > Mark Yes for the permissions you want to enable > Click on Save.**



## Audit Trail:

The activities that have been done by any user would be reflected in the audit trail. To see these details you may navigate to the **System Menu > Operations > Audit Trail**.

The screenshot shows the CareStack software interface. On the left, there is a table titled 'Authorization' with columns for 'Date/Time', 'Type', 'Patient', and 'Status'. The table contains several rows of data. To the right of the table is a vertical sidebar with a dark teal header containing the CareStack logo and navigation links. A red arrow points to the 'Available Profiles' dropdown menu, which is open and displays 'Super Admin' as the selected option. Other profiles listed include 'Dental' and 'Medical'. The sidebar also features sections for 'Scheduling', 'Billing', 'Options', 'Support and Assistance', and 'Insights', each with a list of sub-links.

## Authorization Dashboard:

To see the authorization dashboard you may navigate to the **System Menu > Billing > Pre authorizations**.

This screenshot shows the CareStack interface with a focus on the 'Billing' section of the navigation menu. The 'Billing' tab is highlighted with a red box and a red arrow points to the 'Pre-Authorizations' link under it. Other links in the 'Billing' section include 'Claims', 'Patient Payments', 'Insurance Payments', 'Collection Payments', 'BluePay Transactions', 'Electronic Remittance', and 'Ortho Plans'. The main content area shows two columns of links: 'Operations' (Messages, View All Patients, Practice Providers, Referral Providers, Audit Trail, Time Clock, Patient Engagement, Curbside Check-In) and 'Insights' (Operational Reports, Scorecards, Analytics Dashboard, Patient Lists, Scheduled Downloads). The right sidebar contains sections for 'Available Profiles' (Super Admin), 'Options' (User Settings, Practice Settings), 'Support and Assistance' (User Resource Center, (SOS) Screen Guidance, CareStack University, Support Chat), and 'Clock-Out' (Logout, CareStack Version v6.3.0.20210722182457).

The Authorizations tab is the first page you'll see. It lists all authorizations that currently exist in your system.

**Note:** Select the Dental or Medical tab at the top to view only the relevant authorizations.

- Use the column headers at the top to filter, sort, and search for authorizations on the grid.
  - Select the Action Required checkbox at the top-right to filter for authorizations that have not been completed and still require work.

			Support	FRONTT	Ms. Dental, Momentum Se...	
				<input checked="" type="checkbox"/> Action Required		

- To print or delete, select the checkbox next to an authorization, then choose **Actions > Print or Delete**.

- Hit the **Add** button at the top-right to start a new authorization from scratch.

	Mode	Insurance Type	Submitted Date	Status
	Select	Select	Select	Select
Jan New	Electronic	Dental		Draft
	Paper Based	Dental		Draft
Billing Period	Electronic	Dental		Draft
	Paper Based	Dental		Draft
	Paper Based	Dental		Draft
	Paper Based	Dental		Draft

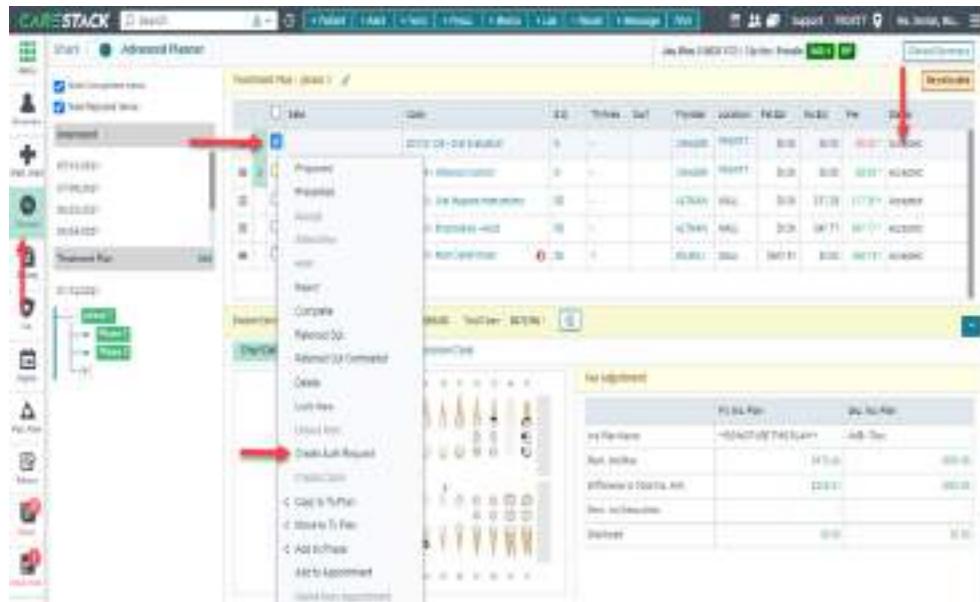
## How to Raise Pre-Authorization Manually?:

Manually start an authorization by following the steps below:

**Option 1:** Navigate to the **System Menu > Billing > Pre-Authorisation > Authorizations dashboard** > Click **Add** at the top-right to start an authorization from scratch.

**Note:** Any procedure codes that are added to the authorization from here will not be added to the patient's treatment plan.

**Option 2:** Navigate to the patient's **Overview > Clinical > Treatment Planning** > Locate the procedure codes that you want to raise a pre-auth > Select the relevant procedure codes, then right-click and select **Create Auth Request**.

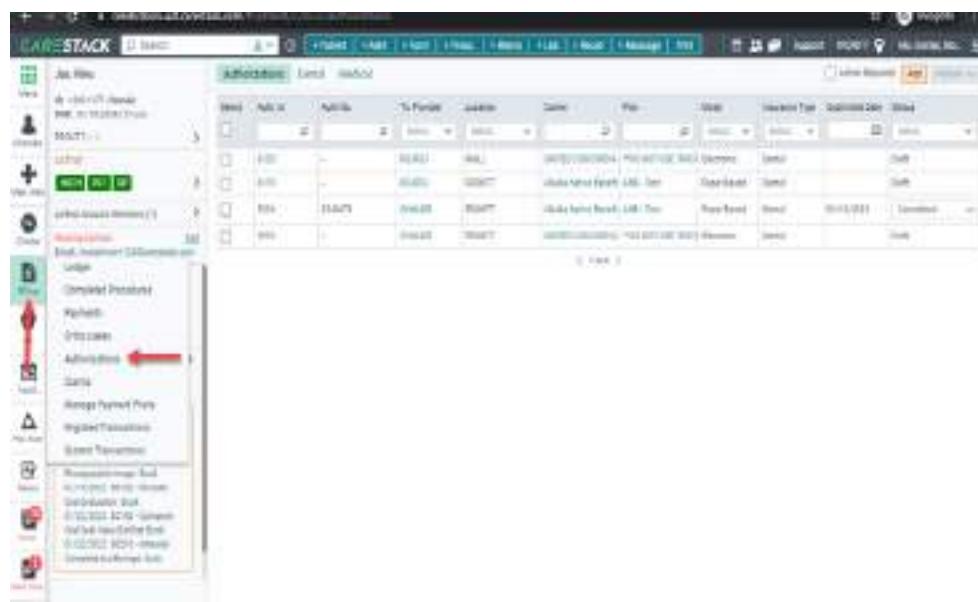


**Note:** A pre-authorization can be raised only for those codes that have a billing order 'D' and the status of the codes should be either Proposed or Accepted. For completed codes, a Pre-Authorization cannot be raised.

## How to Submit an Authorization to Dental?

When an authorization claim is drafted, you will still need to review it and submit it to insurance.

**1. From the patient's profile:** Hover over **Billing** on the left side navigation panel, then select **Authorizations** or you may navigate to the **System Menu > Billing > Pre-authorizations**.



**2.** Click on the authorization claim to open it, then review the following information in the '**DETAILS**' tab:

**3. Save & Continue** will take you to the **Codes** tab.

- Plan Name:** Confirm or select the patient's insurance plan.
- Subscriber Name:** This field will state the name of the subscriber on the patient's insurance plan.
- Other Coverage:** Select and enter the patient's other insurance plan if needed.
- Claim Form:** This field will indicate whether the authorization is being completed on an ADA 2012 form or ADA 2002 as according to the insurance set up in your Practice Settings.
- Authorization Channel:** This field will indicate whether the authorization will be delivered electronically or paper-based according to the insurance set up in your Practice Settings. If the claim channel is electronic and you'd rather print and mail it instead, you can change your selection here to paper-based to do so.
- Location:** Confirm or select the correct treatment location.
- Billing Dentist / Dental Entity:** Confirm or select the relevant billing dentist or entity for this outgoing claim.
- Treating Provider:** Confirm or select the correct treatment provider.

- Hit the **Save & Continue** icon to move forward.
- Save as Draft** icon will allow you to save and come back to complete this claim at a later time.
- The **Advanced Edit** icon will take you to the claim form to review and complete the form line by line.

**Save & Continue** will take you to the **Codes tab**.

- Diagnosis Code (ICD-10):** Select the ICD-10 codes identifying the diagnosis for the intended treatment if needed.
  - Record of Services Provided:** This section will list the codes that have been included in this claim, to add another simply click Add at the top-right (any codes added here will only appear on this form and will not be added to the patient's treatment plan).
  - Remarks:** Included any remarks here if necessary. (Hint: Click Templates to select a pre-written remark set up by your practice for those commonly billed codes.)
  - Attachments:** If this is a paper-based claim, you will have the option to select the paper clip at the top-right of the window to search for and select the documents you would like to include.
- 
- If you are finished with this claim and it is paper-based, you can hit **Print & Submit**. The finished document will open in a new tab where you can print it out to mail or download it if needed.
  - If you are finished with this claim and it is electronic, you'll hit **Save & Submit**. The claim will go into a **Ready to Send** status and will be sent out to the clearinghouse at approx. 8 pm EST along with the rest of the claims, or **Document Pending** status indicating that you or a team member will need to make your necessary attachments in the NEA FastAttach portal first.
  - Save** will allow you to save and come back to complete this claim at a later time.
  - Advanced Edit** will take you to the claim form to review and/or edit the form line by line.

4. The Authorization Form tab (advanced editing): Here, you can review the claim for accuracies such as the place of treatment (line #38) if your doctor was performing at a hospital other than your usual clinic for example.

The sections included in this form are as follows:

- Primary Payor Information (line #3):** This is where you can change out the insurance plan if needed.
- Other Coverage (lines #4-11):** You can choose to enter any additional insurance plans the patient may have.
- Policyholder / Subscriber Information (lines #12-17):** This will include the policy holder's information along with the subscriber ID and the plan or group number.
- Patient Information (Lines #18-23):** This includes the patient's information and relationship to the policyholder.
- Record of Services Provided (Lines #24-34a):** This will include the procedure codes, tooth surfaces, treatment date, diagnosis codes, fees, and other information relevant to the treatment.
- Remarks (Line #35):** This is where your enclosed remarks will go (Hint: Click Templates to select a pre-written remark set up by your practice for those commonly billed codes).
- Authorizations (Lines #36-37):** This is where the patient and subscriber signatures are recorded.
- Ancillary Claim / Treatment Information (Lines #38-47):** This section provides the carrier with additional necessary information regarding the treatment such as place of treatment, months of treatment, or how many attachments have been enclosed.
- Billing Dentist or Dental Entity (Lines #48-52a):** This section will display the information of the identified billing dentist or entity, otherwise, you can select a more accurate billing entity here if necessary.
- Treating Dentist and Treatment Location Information (Line #53-58):** This section identifies the treating dentist and treatment location, including the provider's NPI.

When you are finished and ready to submit:

- Hit **Print & Submit** if it is paper-based, and the finished document will open in a new tab where you can print it out to mail or download it if needed.
- Hit **Save & Submit** if it is electronic, and the claim will go into a Ready to Send status (to be sent out to the clearinghouse at approx. 8 pm EST along with the rest of the claims, or Document Pending status indicating that you or a team member will need to make your necessary attachments in the NEA FastAttach portal first).
- Save** allows you to save and come back to complete this claim at a later time. and license number.

Some practices like managing their electronic claim status and payments using Change Healthcare's claim management program, Dental Connect. Otherwise, keep an eye out for the carrier's response (whether by phone, online, or mail correspondence) and once the authorization response is received, you can return to CareStack to complete the response details, update the expected receivables if necessary, and continue with the next steps of your patient care process.

## Manually Complete an Authorization Response:

Once you receive the carrier's response, you can navigate to the authorization in CareStack (from the patient's profile or the Authorizations dashboard) to record the authorization response.

- Navigate to the relevant authorization claim, then click on it to open. You will need to enter the following response details:

The screenshot shows the 'Authorization Response' screen in CareStack. At the top, there are fields for 'Primary Plan Name' (HealthCare Partners), 'Secondary Plan Name' (None), 'Treatment Period' (10/01/2018 - 10/31/2018), and 'Carrier Response' (Covered). Below this is a grid titled 'Authorization Status' with columns: 'Procedure Codes', 'Status', 'Effective Date', and 'Expiration Date'. A red arrow points to the 'Status' column header. A context menu is open over the first row of the grid, with 'Covered' highlighted. At the bottom right, there are 'Save & Complete' and 'Cancel & Continue' buttons.

1. At the top of the window, enter the: **Authorization Number, Effective Date, and Expiration Date**.
2. On the grid, you'll select the status of the code (**Covered or Not Covered**), then enter the actual patient and insurance estimates according to the authorization response.
3. Enter any necessary notes at the bottom, then hit **Save & Complete**. The authorization status will now reflect a **Completed** status, and you can update the expected collection for the patient's treatment if necessary.

## Enter and Complete an Authorization to Medical:

Some health plans require you to run a pre-authorization before completing specific procedures. You'll raise the authorization as normal (from the advanced planner or appointment details), but only the procedure codes with an M or MD billing order will create a medical authorization.

### To save the medical authorization request:

1. Hover over Billing on the left side navigation panel of the **patient profile**, then select **Authorizations Or, System Menu > Pre-Authorizations** to see authorizations for all patients.
2. Click on the authorization claim to open it, then review the following information:

The screenshot shows the 'View Authorization' window. The 'Patient Details' section includes fields: Patient Name (HealthCare Partners), Plan Name (2018/2019 HSA/HF), Subscriber Name (DentistOffice), Treatment Period (10/01/2018 - 10/31/2018), and Billing Dentist / Dental Entity (Dental Office - HealthCare Partners). The 'Details' section lists procedure codes: 101, 102, 103, 104, and 105, along with their dates (10/15/2018, 10/16/2018, 10/17/2018, 10/18/2018), treatment times (10:00 AM, 10:15 AM, 10:30 AM, 10:45 AM), and descriptions (Tooth Extraction, Removal of Residual Root of Molar, Removal of Residual Root of Molar).

### Details

- **Patient Name:** The name of the patient
- **Plan Name:** The patient's insurance plan.
- **Subscriber Name:** This field will state the name of the subscriber on the patient's insurance plan.
- **Location:** Confirm or select the correct treatment location.
- **Billing Dentist / Dental Entity:** Confirm or select the relevant billing dentist or entity for this outgoing claim.
- **Treating Provider:** Confirm or select the correct treatment provider.
- **Codes:** This section will list the codes that have been included in this claim, to add another simply click Add at the top-right (any codes added here will only appear on this form and will not be added to the patient's treatment plan).
- Click on the Print Icon to Print the authorization.

### Auth Response

**New Authorization, Auth #10000 (Dashboard,Orthina) (1000000)**

<b>Details</b>	Payer Name: <b>OrthoCare</b> Subscriber Name: <b>OrthoCare,Orthina</b> Subscriber Number: <b>0000000000000000</b> Provider Name: <b>AMERIGROUP</b> Authorization Status: <b>Pending</b>	Assignment Date: <b>06/16/2021</b> Date of Birth: <b>09/16/2010</b> Treating Provider: <b>Abraham,Sarah</b> Billing Period: <b>Every Year*</b>	Total Amount: <b>\$0.00</b> Total Insurance Estimate: <b>\$0.00</b> Total Actual Insurance Estimate: <b>\$0.00</b>																																								
<b>Auth Response</b>																																											
<b>Authorization History</b>																																											
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	<input type="button" value="Save"/> <input type="button" value="Save &amp; Continue"/>																																										

- Hit **Save & Continue** if you are finished entering the relevant information here. This will lock in the authorization details and put it in a Pending status. ( Auth in Not Covered status)
- **Save** will otherwise allow you to save and come back to complete the authorization draft at a later time. ( Auth in Not Covered status)

**New Authorization, Auth #10000 (Dashboard,Orthina) (1000000)**

<b>Details</b>	Payer Name: <b>OrthoCare</b> Subscriber Name: <b>OrthoCare,Orthina</b> Subscriber Number: <b>123456789</b> Effective Date: <b>02/08/2013</b> Authorization Status: <b>Completed</b>	Assignment Date: <b>06/16/2021</b> Date of Birth: <b>09/16/2010</b> Treating Provider: <b>Abraham,Sarah</b> Billing Period: <b>Every Year*</b>	Total Amount: <b>\$0.00</b> Total Insurance Estimate: <b>\$0.00</b> Total Actual Insurance Estimate: <b>\$0.00</b>																																								
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	<input type="button" value="Print"/>																																										

- Hit **Print** to print the authorizations. ( Auth in covered status)

**Ace Dental 1 - Celeb- Front**  
2954 Mallory Circle  
Kissimmee, FL 34747-1234  
Ph:  
E-MAIL: [rxauthor@caristack.com](mailto:rxauthor@caristack.com)

### MEDICAL AUTHORIZATION

Printed Date	: 08/12/2021	Location	: Celebration Dental - Mallory Circle
Patient	: Dashboard,Orthina	Date of Birth	: 09/16/2010
Carrier Name	: AMERIGROUP	Plan Name	: DISCOUNT TESTING
SubscriberID	: 01010101010	Subscriber Name	: Dashboard,Orthina
Effective Date	: 02/08/2013	Termination Date	: 02/18/2016
Billing Dentist/ Dental Entity	: Platinum Dental ,dba Celebration Dental Group	Treating Provider	: Abraham,Sarah
Authorization Number	: 1234567789	Authorization Status	: Completed
Submitted Date	: 10/17/2019	Completed Date	: 06/04/2021

Proc. Code	Description	Est. Pat. Resp.	Est. Ins. - Resp.	Fee	Status	Actual Pat. Est.	Actual Ins. Est.	Units
07272	Tooth Transplantation	\$800.00	\$0.00	\$800.00	Covered	\$700.00	\$100.00	12
07540	Removal Reactive Foreign Body	\$729.00	\$0.00	\$729.00	Covered	\$100.00	\$29.00	1
07920	Skin Graft	\$2,821.00	\$0.00	\$2,821.00	Covered	\$2,000.00	\$800.00	1

Notes:

Total Billed Amount	: \$4,360.00
Total Insurance Estimate	: \$0.00
Total Actual Insurance Estimate	: \$0.00

3. Once you have obtained a response from the health plan, you can record the Auth. Response in CareStack before setting it to Complete by following these next steps: Navigate to the relevant authorization request, then click on it to open.

#### You will see the following response details:

- At the top of the window, you'll see the: **Plan Name, Subscriber Name, Authorization Number, Effective Date, Authorization Status, Submitted Date, Date of Birth, Treating provider, and Expiry Date.**
- Units:** The number of units approved for if required.
- Notes:** Enter any necessary notes you would like to include here.

#### Authorization History

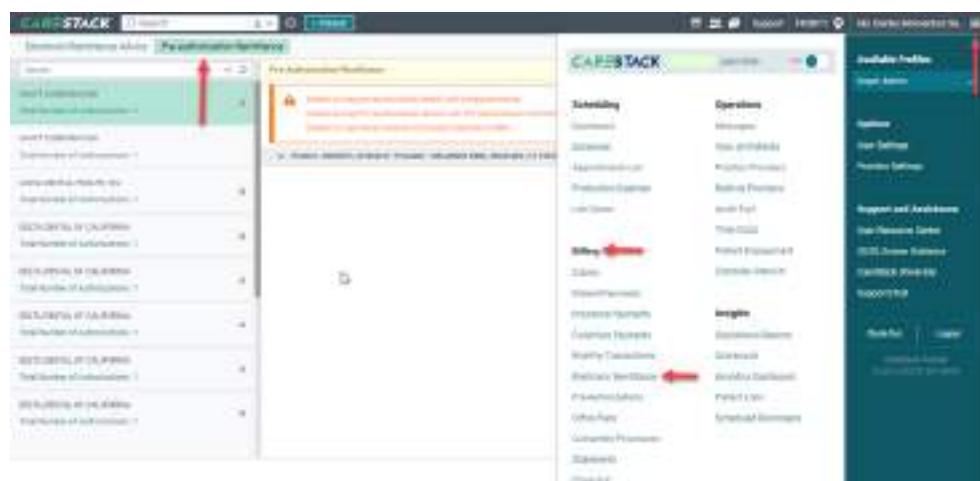
The authorization history shows the history of medical pre-auths.

View Authorizations Auth #110001   Subscribers/Invoices (1500001)											
Detail	Action	Search	Print	Export	Grid	Print	Export	Grid	Print	Export	Grid
ID#	Date	Auth Date	Appl No	Plan	Effective Date	Expiry Date	Fee	Auth Status	Last Update	In RLT Pending	Info
1000	03/03/2023	20230303	1234567890	20230303	03/03/2023	03/30/2023	100.00	Approved	03/03/2023	03/03/2023	100.00
1000	03/03/2023	20230303	1234567890	20230303	03/03/2023	03/30/2023	100.00	Approved	03/03/2023	03/03/2023	100.00
1000	03/03/2023	20230303	1234567890	20230303	03/03/2023	03/30/2023	100.00	Approved	03/03/2023	03/03/2023	100.00

#### Pre-Authorization Remittance Advice(ERA):

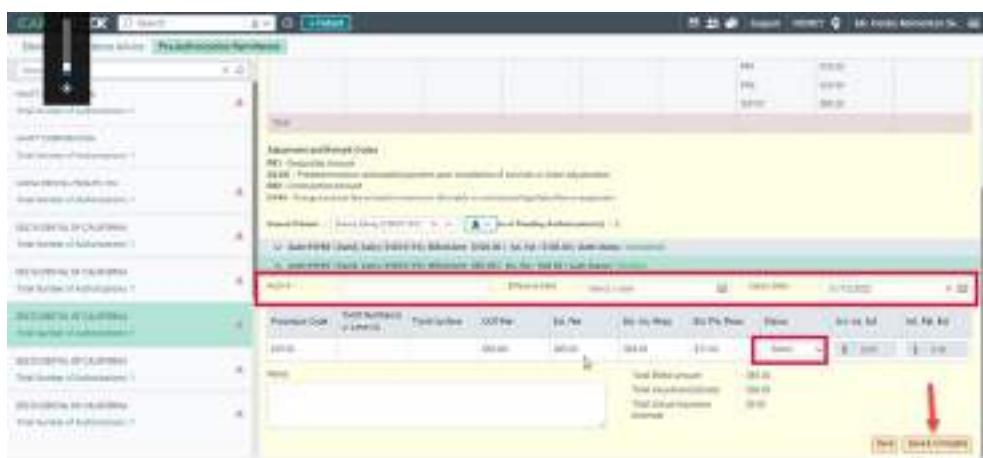
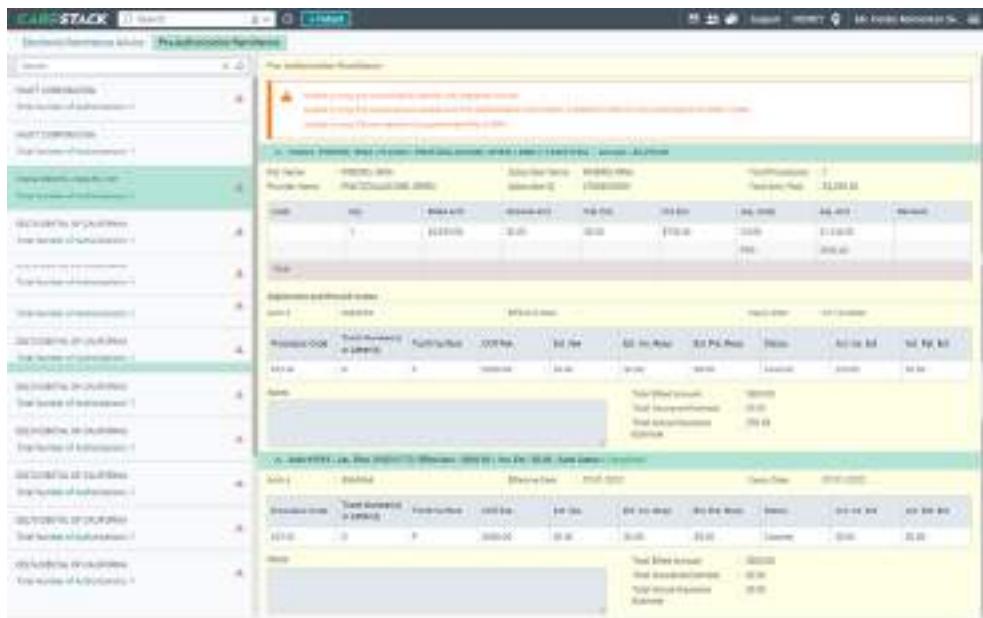
To access Electronic Remittance Advice received from insurance carriers for your pre-authorization requests, follow these steps below:

Navigate to the System Menu > Billing > Electronic Remittance > When the page loads, click the Pre-Authorization Remittance tab at the top-left.



Note: In the above example, the patient name did not match a patient that is currently in the system. This often happens if the patient goes by their maiden name or a nickname. Simply match this to the correct patient by selecting them at the bottom.

- When you have the Pre-Authorization tab selected, select the ERA receipt on the left side menu to view the enclosed details. You'll see the list of patients included in this batch in the main body of the screen. Select one to view the ERA response related to that patient's care.
- In the body of the ERA details, you'll be able to view the carrier's response to your authorization request. At the bottom of the window, you'll find CareStack's record of this authorization request that was created and saved to the patient's profile. Click it to open and complete it with the carrier's response.
- You'll enter the Authorization Number, Effective Date, Expiry Date in the first fields below the authorization record. Then, on the grid below, you'll complete the response information for the services mentioned (including the status of whether they were Covered or Not Covered, along with the actual patient and insurance estimates as described in the authorization response).

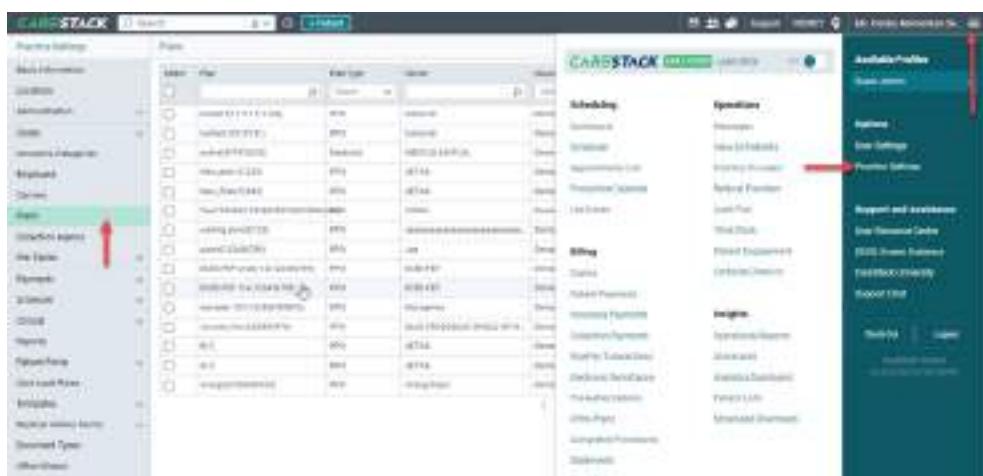


- You can include any necessary notes if desired, then hit Save & Complete when you are done. Otherwise, hit Save to come back and complete this later.
- Now that this authorization is complete, you can update the expected collection for the patient's treatment if necessary before moving on to other tasks.

## Automatic Pre-Authorization:

Specifying these procedure codes requiring a pre-authorization in an insurance plan ensures the required authorization claim is created at the time of treatment acceptance. Simply follow these steps below:

- Navigate to the **System Menu > Practice Settings > Plan > Select the insurance plan** to open the Insurance Plans window.



- You'll select the **Pre-Authorization Codes** tab in the Insurance Details window and then hit the **Edit** button to make your changes.

- You'll use the two fields at the top to add search for and select your codes: the first field allows you to filter by a category, and in the second field you can Select All codes in this category or checkmark the individual codes.
- Once you select the procedure codes, click **Add** to include them here.

**Note:** This tells the system that whenever a patient with this insurance plan accepts treatment including one of the codes specified here, an authorization claim should be drafted for you to send to the carrier.

- Remember to hit **Save** when you are done.

## Results:

- When treatment is planned for a patient with this insurance plan, the Advanced Planner will display a warning that an Authorization is Required.

Date	Code	SI	Visiting	Self	Priorior	Put Fld	Vis Fld	Fee	Status
12/10/2010 - Pulpnat - devol - modifi...	0	14			Accepted	\$0.00	\$0.00	\$0.00	Approved with Response

- When this treatment is added to a treatment plan with a status of Accepted, or once the code itself is Accepted, an authorization claim will be automatically raised. All that's left is reviewing and submitting to insurance.

Date	Code	SI	Visiting	Self	Priorior	Put Fld	Vis Fld	Fee	Status
	12/10 - Pulpnat - devol - modifi...	0	14		Accepted	\$0.00	\$0.00	\$0.00	Accepted with Response

This is all about pre-authorizations. Try this on your own now!

# Limitations and Exclusions

Written by Geo Thomas | Last published at: August 19, 2021

## Eligibility Rules

Carriers have many rules that can impact if a service will be covered. CareStack calls this section Limitations and Exclusions. Some carriers include these details in Benefit Levels, or Covered Services.

These are the most common eligibility rules(with examples)

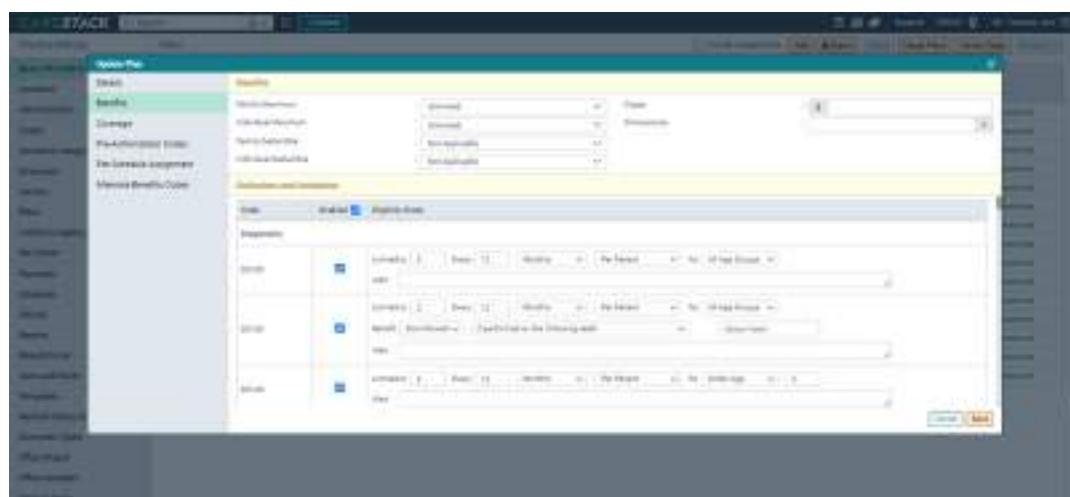
- Age of the patient: Sealants will only be covered up to age 14
- Frequency: Emergency exams will only be covered one time per year
- Date of Service: Prophy will only be covered if the date of service is more than six months since the last one.
- Pre-authorization: Extraction will be covered only if the treatment was pre-authorized.

### Setting up the eligibility rules

The eligibility rules could be set up under a plan by navigating to **System Menu> practice Settings> Plans**



After selecting the **Plan**, navigate to the **Benefits** tab and click **Edit** at the bottom right corner of the pop-up screen. Under the **Exclusions and Limitations** section, the user would be able to set the eligibility rule for each code. It is to be noted that no new additions can be made to this list as CareStack follows a fixed template for this.



Embedded content from <https://www.loom.com/embed/47f85ce86d5d417cb44bccf7ae6d0ee6>

## Setting up a patient's Limitations and Exclusions

This could be set by clicking **Limitations** inside a patient's insurance.



The user would be able to edit the list of limitations and set eligibility rules from here by clicking **Edit**.

Here, only the **Benefit Rem.**(benefit remaining) section would have any effect on the patient's insurance coverage as all other fields are set at the plan level. If it is unchecked, it means the patient has no remaining benefits after considering that particular limitation. But it is to be noted that this would not automatically apply to the code. This data is only for informational purposes. The user would have to set the **Billing Order** of the code as **N** manually.

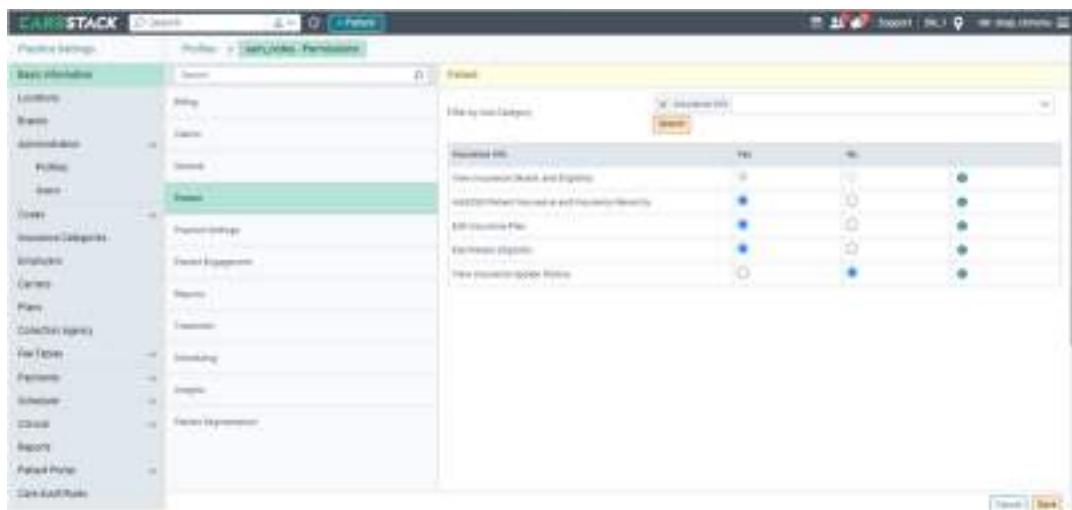
After making the required changes, the user would have to click **Save and Update Eligibility**



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## Permissions required

The minimum required permissions to set the limitations and exclusions of a patient are as in this image.



## FAQs

1. The patient is not eligible for coverage as he/she is over the allowed age limit. Why is the insurance estimate still being calculated?  
A. The eligibility details are only for information purposes. They do not have any effect on the patient's coverage. If the **Benefits Rem.** is marked as **No**, the billing order of the code is to be changed to **N**

# Alternate Benefit Codes

Written by Mathew Kandirickal | Last published at: August 08, 2021

The Alternate Benefit Clause is a stipulation in many dental plans stating that certain dental procedures must convert to a less expensive treatment. The patient can still receive the more expensive treatment but is reimbursed for the amount of a procedure that

- 1) **is less expensive**
- 2) **serves the same function.**

The most frequently cited examples of the AMB clauses being administered are when composite fillings are alternately benefited to amalgams and when crowns are alternately benefited to large fillings. Although there may be alternative treatments that are clinically acceptable, often the least expensive treatment may not be what is in the best interest of the patient.

## Points To Note

- The option to set up resides at a plan from where users can set up alternate benefit codes to any procedure codes. Users have the option to choose one AMB code each as Anterior AMB and Posterior AMB.

Tooth Set	Maxillary Teeth	Mandibular Teeth
Anterior Teeth	#6-#11/ #C-#H	#27-#22/#R-#M
Posterior Teeth	#1-#5, #12-#16/#A,#B,#I,#J	#17-#21, #32-28/#T,#S,#L,#K

- When computing fees depending on the teeth selected, the corresponding AMB code and its associated fees would be considered for fee calculation.
- When an AMB code is involved, the coverage and deductible related information of the AMB code should be considered while computing the insurance component.
- If for a procedure code there is an AMB code mapped against it in the associated plan setting, then the insurance estimate of the AMB code will be calculated and shown as the insurance estimate of the actual procedure. This amount will be reduced from the total amount of the actual code and shown as the patient estimate.
- If an AMB code is used in the fee calculation process, then that will be mentioned in the fee overlay after the code has been marked as completed.

## Setting Up AMB Codes

- In order to set up AMB codes, the user may navigate to **Practice Settings > Plans > Update Plan > Alternate Benefits Codes**.



- This Alternate Benefits Code tab consists of 3 columns :
  - Code-Description
  - Anterior AMB Code
  - Posterior AMB Code
- The user will be able click on the **Edit** button > **Add** to select a code and add their respective AMB code.
- Once the code is selected and added to the Selected Codes list, users would be allowed to select one active code each as an Anterior AMB code and Posterior AMB Code.

The same section can be seen under the Patient Eligibility section, under the tab **Pre-Authorization Codes / Alternative Benefit Codes**

When there is a code with an AMB code and deductible. Code A is a treatment code with Fee = X. Code B is the AMB code with Fee = Y (Ins payable is IP which is obtained using the percentage splits) and the Deductible = Z

- Case 1: When an adjustment is not done (deductible is not applied)
  - Total = X
  - Insurance payable = IP
  - Patient payable =  $(X - IP)$
  - If there is a deductible Z, but no AMB code, then  $(X - Z)$  has to be split to obtain Q as the insurance component and  $(X - Q)$  as the patient component.
- Case 2: When an adjustment is done (deductible is applied)
- Total = X
- Now  $(Y - Z)$  has to be split using the percentage for code B. Insurance payable according to this split is Q.
- Insurance Payable is Q
- Patient payable is  $(X - Q)$

## Examples

- If the patient has only one associated insurance (assigned as primary dental, resulting in the code having a D billing order), if the actual code costs \$250, with an AMB code against it which costs \$100 (with a 50% coverage for the AMB code – which means the insurance will pay only \$50), then the insurance estimate should be shown as \$50 and the patient estimate should be \$200 ( $250 - \$50 = \$200$ )
  -
- If the patient has dual coverage, and the code added has AMB codes and both associated plans have a remaining deductible and fees are coordinated using Non-Duplication of Benefits. For the code, the Primary plan max allowable is \$500. But that code has an AMB code which has a max allowable of \$400 at 60% coverage. The remaining deductible is \$50. The Secondary plan max allowable is \$600, but an AMB code exists with allowable of \$350 at 50% coverage. The remaining deductible is \$10
  - Primary would pay → 60% of  $(\$400 - \$50) = 60\% \text{ of } \$350 = \$210$
  - Secondary would pay → 50% of  $(\$350 - \$10) = 50\% \text{ of } \$340 = \$170 \rightarrow \$170 - \$210 = \$0$
  - Patient would have to pay →  $\$500 - \$210 = \$290$
  - Insurance would pay → \$210
- If the patient has dual coverage, and the code added has AMB codes and both associated plans have a remaining deductible and fees are coordinated using Standard Coordination of Benefits. For the code, the Primary plan max allowable is \$500. But that code has an AMB code which has a max allowable of \$400 at 60% coverage. The remaining deductible is \$50. The Secondary plan max allowable is \$600, but an AMB code exists with allowable of \$350 at 50% coverage. The remaining deductible is \$10
  - Primary would pay → 60% of  $(\$400 - \$50) = 60\% \text{ of } \$350 = \$210$
  - Secondary would pay → 50% of  $[(\text{Less of } \$290 \text{ and } \$350) - 10] = 50\% \text{ of } \$280 = \$140$
  - Patient would have to pay →  $\$500 - (\$210 + \$140) = \$150$
  - Insurance would pay → \$350



# Hierarchy Assignment

Written by Renganathan K | Last published at: August 22, 2021

Some individuals and families have secondary insurance plans, which could “fill the gaps in a policy holder’s dental or medical coverage. Gaps in coverage can occur when the primary policy’s annual spending limit is reached, or when a policy doesn’t provide coverage for necessary or desired dental treatments” (“Supplemental Dental Insurance”). Since some dental insurance provides little to no coverage for more expensive treatments, dual coverage helps make treatments more affordable for patients. However, clinics and patients must follow its rules and policies.

Patients must categorize their primary and secondary insurance plans. According to the Delta Dental website, “The general rule is that the plan that covers [the patient] as an enrollee is the primary plan and the plan which covers [him or her] as a dependent is the secondary plan” (“If you are covered by two dental plans”). For instance, a patient’s insurance plan from the employer is primary, while his or her spouse’s plan is secondary (Lowery 2016). Regarding their children, clinics and patients must follow “the birthday rule,” which means that the “coverage of the parent whose birthday—month and day, not year—comes first in the year is considered to be [the parents’] children’s primary coverage” (“If you are covered by two dental plans”). In a divorce, the parent to whom the court chose for “financial responsibility for the child’s health care bills” has the primary plan (Duncan 2013). However, if the court does not choose a parent for this responsibility, the birthday rule will still be in effect (Duncan 2013). For an individual with two jobs that provide dental insurance plans, “the primary plan is usually the one that has provided coverage the longest” (Lowery 2016).

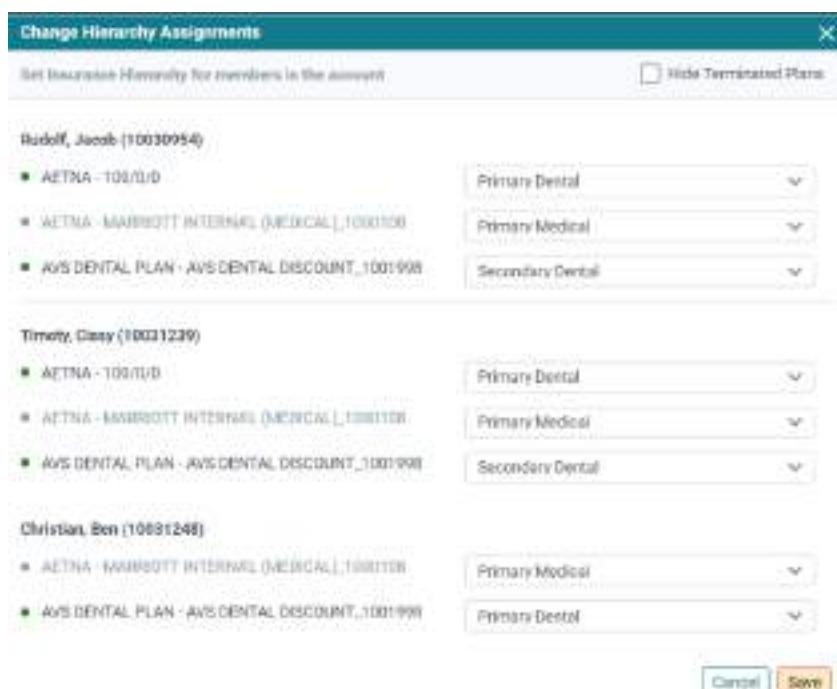
Hierarchy assignment comes into picture when the patient has more than one insurance plan. Defining a Hierarchy is very important as this plays a major part in the billing process. You can use the global search bar to find the patient and then click on the insurance shortcut.



Make use of the Hierarchy Assignments button to change the hierarchy.



Once you click on this you will be greeted with a popup window.



Make the necessary hierarchy assignments for each account member's insurance plans, then click **Save**.

Embedded content from <https://www.loom.com/embed/d1c5bf20b2184ea7bdcbef0804020ca>

## Auto- Assignment of Insurance Hierarchy

Insurance hierarchy would be auto assigned when an insurance is added to a patient.

Action	Context	Expected
A new dental insurance is added	No prior dental insurance	Upon addition, the plan should be auto-assigned as primary dental
A new dental insurance is added	1 or more existing unverified dental insurances	Upon addition, the plan should be auto-assigned as primary dental
A new dental insurance is added	1 or more existing verified but unassigned ins	Upon addition, the plan should be auto-assigned as primary dental
A new dental insurance is added	Previously assigned but terminated pri ins	
	a) If the new ins is "self"	Upon addition, the plan should be auto-assigned as primary dental
	b) If the new ins is not self AND secondary is self (and not terminated)	Upon addition, secondary ins becomes primary and the new ins becomes secondary
	c) If the new ins is not self AND secondary is not self/is terminated/not assigned	Upon addition, the plan should be auto-assigned as primary dental
A new dental insurance is added	Already assigned and not terminated primary dental ins, but no/terminated secondary ins	
	a) The primary ins is "self"	Upon addition, the new ins should be auto-assigned as secondary
	b) The primary is not self AND new ins is "self"	Upon addition, new ins should be auto-assigned as primary dental primary should become secondary
	c) The primary is not self AND new ins is not self	Upon addition, the new ins should be auto-assigned as secondary
A new dental insurance is added	Already assigned and not terminated primary and secondary dental ins	
	a) Primary and Secondary are self	Upon addition no change in assignments
	b) Primary is self, secondary is not self and new ins is self	Upon addition, the new ins should be auto-assigned as secondary
	c) Primary is self, secondary is not self and new ins is not self	Upon addition, no change in assignments
	d) Primary and Secondary are not self and New ins is self	Upon addition, new ins becomes primary and the existing primary

		secondary.
	d) Primary, Secondary and New ins are not self	Upon addition, no change in assignments
A new medical insurance is added	No prior medical insurance	Upon addition, the plan should be auto-assigned as primary medical
A new medical insurance is added	1 or more existing unverified medical insurances	Upon addition, the plan should be auto-assigned as primary medical
A new medical insurance is added	1 or more existing verified but unassigned ins	Upon addition, the plan should be auto-assigned as primary medical
A new medical insurance is added	Previously assigned but terminated pri ins	
	a) If the new ins is "self"	Upon addition, the plan should be auto-assigned as primary medical
	b) If the new ins is not self AND secondary is self (and not terminated)	Upon addition, secondary ins becomes primary and the new ins becomes secondary
	c) If the new ins is not self AND secondary is not self/is terminated/not assigned	Upon addition, the plan should be auto-assigned as primary medical
A new medical insurance is added	Already assigned and not terminated primary medical ins, but no/terminated secondary ins	
	a) The primary ins is "self"	Upon addition, the new ins should be auto-assigned as secondary
	b) The primary is not self AND new ins is "self"	Upon addition, new ins should be auto-assigned as primary medical and the existing primary should become secondary
	c) The primary is not self AND new ins is not self	Upon addition, the new ins should be auto-assigned as secondary
A new medical insurance is added	Already assigned and not terminated primary and secondary medical ins	
	a) Primary and Secondary are self	Upon addition, no change in assignments
	b) Primary is self, secondary is not self and new ins is self	Upon addition, the new ins should be auto-assigned as secondary
	c) Primary is self, secondary is not self and new ins is not self	Upon addition, no change in assignments
	d) Primary and Secondary are not self and New ins is self	Upon addition, new ins becomes primary and the existing primary becomes secondary.
	d) Primary, Secondary and New ins are not self	Upon elig verification, no change in assignments

# Insurance Payments

Written by Abhishek Vijay | Last published at: August 09, 2021

The patient came over, the provider completed the procedure, the code was added and completed. The patient then paid his dues and settled his debt with the practice, what's next?

Here is where the insurance companies and their corresponding insurance plans come into play. Depending on the kind and breadth of the insurance plan, dental insurance can assist cover the costs of dental treatment, ranging from basic preventative coverage to extensive dental work.

CareStack can bill and send completed procedures to the insurance companies. The insurance companies then verify the claim sent to them and cross-check it with the patient's benefits. Once they obtain an estimate of the amount to be paid, they will share a document called "Explanation of Benefits" (EOB), which will address the financial details of the sent claim and the payment for the same.

Once the user receives the same, we can initiate the process of insurance payments. Let's begin by having a look at how to add an insurance payment receipt.

## Insurance Payment Receipts

Once we receive the payment from the insurance, the user has to create an insurance payment receipt to reflect the payment on to CareStack. Once the receipt is added, similar to adding a patient payment, the user can credit the codes with the insurance portion.

To add an insurance payment receipt, we have two methods:

### From the Ledger

While on the patient's ledger, you can add the insurance payment receipt via the Add Payment option at the top.

*Ledger > Add Payment > Add Insurance Payment*



Once here, you may select the Add New Payment option to create a new receipt.



You may then select the carrier and then fill in the necessary payment details. Once the details are entered, click on save to create the insurance payment receipt.

### From the Insurance Payments Module

Another method is to create a receipt via the Insurance payments module on the System Menu.

*System Menu > Insurance Payments > Add New Payment*



Once all the relevant details are filled in, you may click on Save to create the receipt, just like the previous method.

Once the receipts have been added fresh, or if there is already a receipt added, we can move forward to posting an insurance payment.

## Insurance Payment Posting

Now it is time to allocate the amounts received from the insurance into the completed codes as the insurance portion. We can break this process down into 3 steps.



Similar to creating a receipt, we can post the insurance payments from the ledger, as well as the insurance payments page.

- The list of entered payments appears down the left slide, tucked away in a slider.
- Click the slider border to open it. Click an insurance payment to select it.
- Details about your selected payment will be displayed and the slider will close so you can select your patient.
- Select the patient from the drop-down list. Only patients with **OPEN** claims will appear in the list.
- Once you select a patient, you'll see some basic details about the claim:
  - Billing Order (D, DD, M)
  - Claim Order (Primary, Secondary)
  - Plan Name
  - Status from the clearinghouse

### From the Ledger

### From the Insurance Payments Module

Embedded content from <https://www.loom.com/embed/0ea81ad5ecbe4be5b47577dc6dce4670>

As you may have seen, there are five different options once the patient is selected. Let us go through each section in detail.

- Pending Payment:

19601980	Total Bal Due Per 38.00	Detail: Claims: 1	<input type="checkbox"/> Show Draft Claims
Date 4/16/2011	BB# 37352931	██████████	<b>Block Amt: \$60.00</b>
			<b>Inv. Del: \$30.00</b>
<input checked="" type="checkbox"/> Primary		<input type="checkbox"/> Acceptance Medicare	<input type="checkbox"/> Submitted Payment
<input checked="" type="radio"/> Pending Payment: <input type="radio"/> Paid as Expected (\$30.00) <input type="radio"/> Add Claim Level Payment: <input type="radio"/> Add Line Level Payment: <input type="radio"/> Block Claim as Delinquent			

Once we click on the insurance payment receipt and search and select the patient from the drop-down list, the default setting of the claim payment is Pending Payment. The state signifies that the claim has been sent out from CareStack, and is awaiting action from the Insurance carrier. To post the insurance amount to a patient's completed procedures, we have to shift the status from Pending Payment to any of the below-mentioned statuses.

- Paid as Expected:

118031180	Total Collected Pmt: \$0.00	Claims (0/0)	<input type="checkbox"/> Show Closed Claims
> Claims #108791 Date: 07/26/2011 [ ] <span style="float: right;">Printed Amt: \$0.00</span>		Inv. Ref: 100-01	<input type="checkbox"/> Attach Description
<input type="checkbox"/> Primary <input type="checkbox"/> Acceptance Disclosure <input type="checkbox"/> Submitted (Final)		<input type="radio"/> Pending Payment <input checked="" type="radio"/> Paid as Expected (\$0.00) <input type="checkbox"/> Add Claim Level Payment: <input type="checkbox"/> Add Line Level Payment: <input type="checkbox"/> Mark Claim as Denied	

With our patient selected, we are ready to apply the payment to the claim. Naturally, we like it best when the payment matches what we expected. If the insurance paid exactly as we expected, we can just select the "Paid as Expected" option and then click on submit. You're not mistaken, that is all there is to it! The payment has been successfully applied to the codes and will be visible on the ledger.

- Add Claim Level Payment:

<input checked="" type="checkbox"/> Primary	<input type="checkbox"/> Assistance Recipient	<input type="checkbox"/> Estimated Payment									
<input type="radio"/> Pending Payment <input type="radio"/> Paid as Expected (\$0.00) <input checked="" type="radio"/> Add Claim Level Payment <input type="radio"/> Add Line Level Payment <input type="radio"/> Mark Claim as Sealed											
Inv. Payment (\$)	15.00	Interest:									
Select Action:		Transfer Balance to P. v.									
Adj. Type:	Transfer Debit to Patient	Adj. Accr. (\$)	5.00	Adj. Code:	AD10 - TRANSFER - Charge v.						
Date	Code	Thru Date	Qty	Billed	Allowed	Pac. Amt	Inv. Amt	Ref. Inv. Pd	Ref. Inv. Inv	Inv. Pd(\$)	Balance
10/15/2022	2010 - Estimated Inv Bal Inv/Get Pmt		1	\$10.00	\$10.00	\$10.00	\$10.00	\$0.00	\$0.00	\$10.00	Transfer balance to patient - \$5.00
<b>Sub Total:</b>				<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$10.00</b>	<b>\$10.00</b>
<input checked="" type="checkbox"/> Close Claim <input type="checkbox"/> Mark for Appeal <input type="checkbox"/> Mark Claim as Denied <input type="checkbox"/> Post 30.00 Transactions				Claim Remarks:		Remarks:		Total Inv. Amt	55.00	Total Inv. Inv	-55.00

Some practices may elect to apply insurance payments and modifications to the whole claim amount by completing them on the total claim amount, rather than through individual codes. CareStack will automatically calculate the difference between the insurance payment and the expected insurance payment, allowing you to decide what to do with the under or overpayment.

- Add Line Level Payment:

(18001188) [View Bill Detail](#) [Print \(\\$0.00\)](#) [Close, Continue](#) [Show Closed Claims](#)

<input checked="" type="checkbox"/> <a href="#">Claim #186761</a>	DOB: 07/25/2001	<a href="#">Edit Amt: \$0.00</a>	<a href="#">Net Amt: \$0.00</a>	<a href="#">Attach Documents</a>							
<a href="#">Print</a>	<a href="#">Acceptance/Mediation</a>	<a href="#">Basic Info (Print)</a>									
<input type="radio"/> Pending Payment   <input type="radio"/> Paid as Directed (\$0.00)   <input type="radio"/> Add Item Level Payment   <input checked="" type="radio"/> Add Line Level Payment   <input type="radio"/> Mark Claim as Denied											
Date	Code	Th/Arms	Billed	Allowed	Pmt Basis (T)	Inv. Resp (T)	Inv. Pmt (\$)	Apptd	Denied	Remarks	Adjust
07/29/2021	PT0101 - Cystic Fibrosis Nutritional Plan		\$40.00	\$40.00	13.00	30.00	25.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<a href="#">Edit</a>
	<a href="#">Add Type</a>	<a href="#">Transfer Bill to F-44</a>	<a href="#">Add Code</a>	AD010 - TRANSFER-F-44		<a href="#">Add Inv. (\$)</a>	<a href="#">0.00</a>	<a href="#">Remarks</a>	<a href="#">X</a>		
<b>Sub Total</b>			<b>\$40.00</b>	<b>\$40.00</b>	<b>\$16.00</b>	<b>\$30.00</b>	<b>\$25.00</b>				
<input checked="" type="checkbox"/> Close Claim		<input type="checkbox"/> Mark for Appeal	<input type="checkbox"/> Mark Claim as Denied	<a href="#">Open Remarks</a>		<a href="#">Review</a>		Total Pmt:	\$0.00	Total Inv.:	\$0.00
<input type="checkbox"/> Print \$0.00 Transactions								Total Inv. Adj.:	\$0.00	Total Inv. Adj.:	\$0.00

When the payment received from the carrier on the claim for one or more codes is different than what was expected, we complete the payment via the line payment method. It is called line level because you apply the payment to each code line separately. CareStack will use the information to apply the adjustments following the logic you just learned. Many practices decide to post the payment on the line item level to carefully describe the applied payment and its actions, such as any adjustments made.

Under the claim posting scenarios, we often use the Line Payment Method to post the amounts in the case of the patient having dual insurances. Take care to always post the primary payment first, so that the payment hierarchy is not affected. Let's have a look at an example of the same.

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- **Mark Claims as Denied:**

<input checked="" type="checkbox"/> Primary	<input type="checkbox"/> Acceptance Medicare	<input type="checkbox"/> Submitted (Patient)	<input type="checkbox"/> Pending Payment	<input type="checkbox"/> Paid as Received (\$0.00)	<input type="checkbox"/> Add Claim Level Payment	<input type="checkbox"/> Add Line Level Payment	<input checked="" type="checkbox"/> Mark Claim as Denied				
<input type="radio"/> Pending Payment <input type="radio"/> Paid as Received (\$0.00) <input type="radio"/> Add Claim Level Payment <input checked="" type="radio"/> Add Line Level Payment <input checked="" type="checkbox"/> Mark Claim as Denied											
Date	Code	To/From	Entered	Allowed	Pmt. Resp.(\$)	Ins. Resp.(\$)	Ins. Paid(\$)	Appeal	Deduct	Remarks	Adjus.
07/26/2021	861.00 - Corrective Oral Dent New/2nd Pmt			\$80.00	\$48.00	10.00	30.00	0.00	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Reason Code - CR4 - Remarks											Add Note
200 Total				300.00	\$48.00	\$19.00	209.00	0.00			
<input checked="" type="checkbox"/> Clear Case <input type="checkbox"/> Mark For Appeal <input checked="" type="checkbox"/> Mark Claim as Denied <input type="checkbox"/> Post \$0.00 Transactions				Claim Remarks		Remarks:		Net Pmt. (\$)	\$0.00	Total Inv. (\$)	\$0.00
Initial Code:		CR - Corrections and Reversals		Reason Code:		4 - The procedure is not in:		Remarks:	Add Note		

If the claim was rejected due to any number of reasons, we can mark the collective treatment codes as denied. Once this option is selected, you would have to specify the rejection reasons via the Group Code and Reason code, which would be specified on the insurance EOB received. Once all the fields have been entered, we may click on Submit to post the codes as denied, and push the balance towards the patient or write it off as required.

## Adjustments

Sometimes what we billed and expected isn't what we receive. For one reason or another, the carrier has paid more or less than we expected on at least one code.

Sometimes the payments are **greater** than you expected. You might find this when:

- A deductible was paid by the patient but wasn't required.
  - The plan benefits and coverage details are incorrect, so the plan covered a greater percentage of the procedure code than expected.
  - The carrier's fee schedule is not correctly associated.

When payments are **less** than you expected, it might be because:

- A deductible was not collected when it should have been.
  - The patient reached the maximum and you didn't realize it.
  - The plan benefits and coverage details are incorrect, so the plan covers a smaller percentage than you thought.
  - The fee schedule is not correctly assigned.
  - The carrier requires additional information before they will cover the treatment.

Whatever the reason for the carrier paying more or less than we expected, we need to account for what happened in CareStack. You cannot change what you got. Instead, you must change what you thought. The solution is to add sufficient adjustments while posting the payment.

An adjustment is a way of expressing an action. The action increases or decreases either the patient side or the insurance side so what you expected matches what you got.

- **Add to Patient:** Increases the patient expected amount.
  - **Deduct from Patient:** Reduces the patient expected amount.
  - **Add to Insurance:** Increases the insurance expected amount.
  - **Deduct from Insurance:** Reduces the insurance expected amount.

When one goes up and the other goes down by the same amount, it is processed as a transfer.

- **Transfer to Patient:** Increases the patient expected while simultaneously decreasing the insurance expected.
  - **Transfer to Insurance:** Increases the insurance expected while simultaneously decreasing the patient expected.

CareStack will add adjustments for you to do just that, but you'll want to understand how that happens.

## Examples

We submitted a claim for an extraction. Using the code's details, let's decide what adjustments CareStack will use when we receive different amounts.

Fee Details	
Code	: D7140 - Extraction, erupted tooth...
Billing Order	: 0
Pat. Estimate	: \$30.00
Ins. Estimate	: \$120.00
Fee	: \$150.00
Pat. Applied	: \$0.00
Ins. Applied	: \$0.00
Remaining Pat. Bal.	: <b>\$30.00</b>
Remaining Ins. Bal.	: <b>\$120.00</b>

### Example A

The carrier pays \$165 and expects the patient to pay \$30. What adjustment would be needed?

#### Adjustments:

- Nothing has changed about the patient expected so no adjustments are required on the patient side.
- The carrier paid \$15 more than we expected. We need to bring the insurance expected UP by \$15.
- There will be an adjustment to Add to Insurance \$15.

### Example B

The carrier pays \$110 and expects the patient to pay \$40. What adjustment would be needed?

#### Adjustments:

- The carrier wants the patient to pay \$10 more than we expected. We need to bring the patient side UP by \$10.
- The carrier will pay \$10 less than we expected. We need to bring the carrier side DOWN by \$10.
- Rather than having two separate adjustments one for Patient Adjust On and one for Insurance Adjust Off, we'll transfer \$10 of the expected amount from the Insurance to the Patient.
- Transfer to Patient.

## Submission and Results

The final part of the process is to click the submit button as part of applying the funds. It's the final step that formalizes what you've done by posting the payment and any adjustments or transfers.

At this stage, we are going to explore the results when you click **Submit**.

## Payment Receipt

The Payment Receipt always reflects the amount of the payment yet to be applied (available credits) as well as the amount of the original payment.

After you apply a payment to a claim, the remaining credits in the payment are reduced by the amount you just applied. That will be shown in red on the receipt and within the receipt tile.



## Receipt's History Tab

The Receipt History tab shows the application of the payment against the codes included in the claim.

RECEIVABLES - RECEIVED									
Appo Recipient		Recall Recipient		From Date		To Date		Report Date	
Appo Recipient		Recall Recipient		From Date		To Date		Report Date	
<b>RECEIVABLES - RECEIVED</b>									
Term Type	Period	Code	Description	Y1 Period	Y2 Period	Amount	Class #	Line Number	Remarks
RECEIVED	0000000000000000	000000	No payment of \$2,000.00 (amount) (2014-01-01 to 2014-12-31)	000000	000000	2000.00	101	1000000000000000	
RECEIVED	0000000000000000	000000	No payment of \$2,000.00 (amount) (2014-01-01 to 2014-12-31)	000000	000000	2000.00	101	1000000000000000	
RECEIVED	0000000000000000	000000	No payment of \$2,000.00 (amount) (2014-01-01 to 2014-12-31)	000000	000000	2000.00	101	1000000000000000	
RECEIVED	0000000000000000	000000	No payment of \$2,000.00 (amount) (2014-01-01 to 2014-12-31)	000000	000000	2000.00	101	1000000000000000	
<b>Total Received:</b>						8000.00			

## Patient Ledger

The patient's colorful ledger displays a great deal of information about the claim, payments, and component procedures.

Claim lines are **blue**, payments are **green**, and adjustments are **yellow** for quick identification. Each contains a link for additional details. Many of these line items also have a more information link.

You may click on the More Info link on the claim line to show the claim or click on the More Info link on the payment line to show details of the insurance receipt.

## Claims Module

Even after the claim is closed, you'll be able to find it in the All Claims tab in the Claims module with the Closed status. A patient's closed claim can also be found in the Claims area of the patient profile.

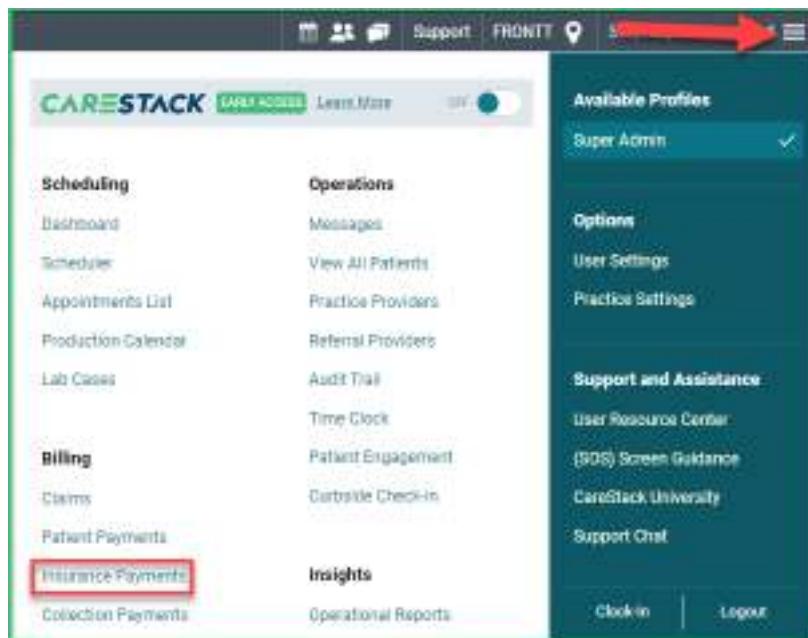
# Insurance Payment Receipt Creation

Written by Aaqib Mohammed Sali | Last published at: August 15, 2021

CareStack makes it easy to manage both bulk and single insurance payments in the Insurance Payment module. There are two ways to add Insurance Payments within CareStack:

## From the Insurance Payments Module

If you aren't already there, yet, navigate to the Insurance Payments module by selecting Insurance Payments from the System Menu.



1. Click **Add New Payment** in the upper-right corner.



2. In the pop-up window, select the **Insurance Carrier**, then enter the following payment details:

- Payment Amount:** Enter the correct dollar amount of the payment that you are accepting from this carrier (This field can be updated later if a typo has been entered at this stage).
- Location:** Your current location will be automatically selected, or you can select the correct location to tag to this payment.
- Payment Date:** Enter the date the payment has been made.
- Deposit Date:** By default, today's date will be entered as the deposit date, but you can select a more appropriate date if necessary.
- Payment Type:** Select the mode of payment (such as check, direct deposit, VISA, and so on) and enter a Reference Number if necessary.
- Remarks:** Enter any important remarks you'd like to save with these payment details.

A screenshot of the 'Add Insurance Payment' pop-up window. The window is divided into two main sections: 'Payment Details' on the left and 'Carrier Details' on the right.   
**Payment Details:** This section contains fields for 'Payment Amount' (with a value of '\$10'), 'Location' (set to 'Select - Front'), 'Payment Date' (set to '08/08/2021'), 'Deposit Date' (set to '08/09/2021'), 'Payment Type' (set to 'Check'), and 'Remarks' (a text area). A red box highlights the 'Payment Amount' field, and a red circle with the number '1' is positioned above the 'Carrier Details' section.  
**Carrier Details:** This section displays information about the payment carrier:

Total No of Patients	10
Pay Off Date	08/08/2021
Applied Off Date	08/08/2021
Reference Credit	\$0.00
Unapplied Credit	\$0.00
Last Payment Date	08/18/2018

A red circle with the number '2' is positioned below the 'Carrier Details' section.  
**Action Buttons:** At the bottom of the window, there are three buttons: 'Cancel' (red), 'Save' (green), and 'Print' (blue). A red circle with the number '3' is positioned at the bottom center of the window.

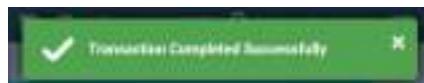
The **Carrier Details** are also shown on the right.

- **Total No of Payments:** The total number of payments the carrier has made to date.
- **Paid till Date:** The total amount the carrier has paid till date.
- **Applied till Date:** The total amount that has been applied till date.
- **Refunded Credits:** The total amount of credits that have been refunded back to the carrier.
- **Unapplied Credits:** The total amount of credits that are yet to be applied.
- **Last Payment Date:** The last date on which the carrier made a payment.

3. When you are finished entering the payment details, hit **Apply** to begin allocating the payment towards the relevant insurance claims, or hit **Save** to save this payment come back to it later.

You will receive a green confirmation message:

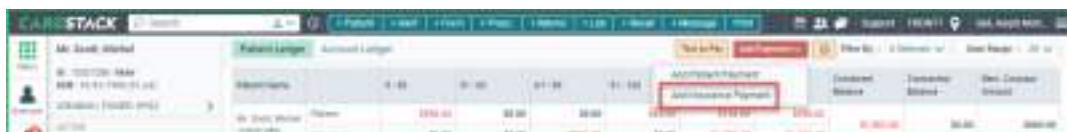
"**Transaction completed successfully.**"



## From the Patient's Ledger

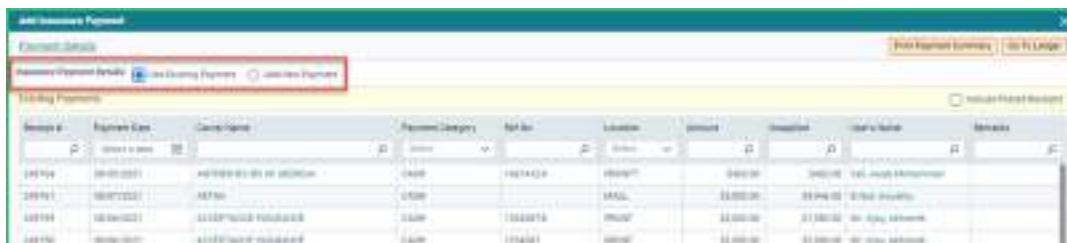
1. Navigate to the Patient's Ledger by following any of the methods within [this article](#).

2. When the page loads, select Add Payment > Add Insurance Payment in the upper-right corner.

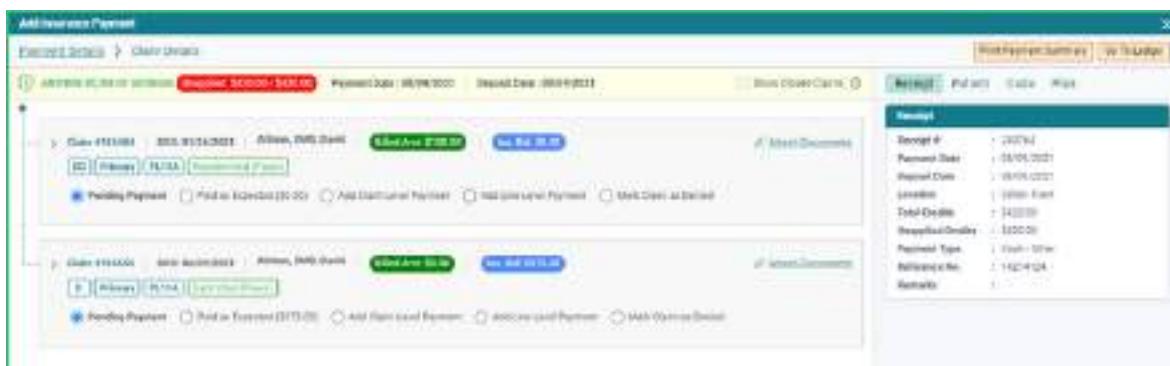


3. In the pop-up window, proceed as follows:

Selecting Use Existing Payment and selecting a receipt would direct you to the Insurance Payments page in order to apply payments against the receipt.



You would then be redirected to the Insurance Payments page, to apply the payments against that particular receipt that you selected.



In our case, we shall select Add New Payment to proceed to add a new insurance payment and complete the following details:

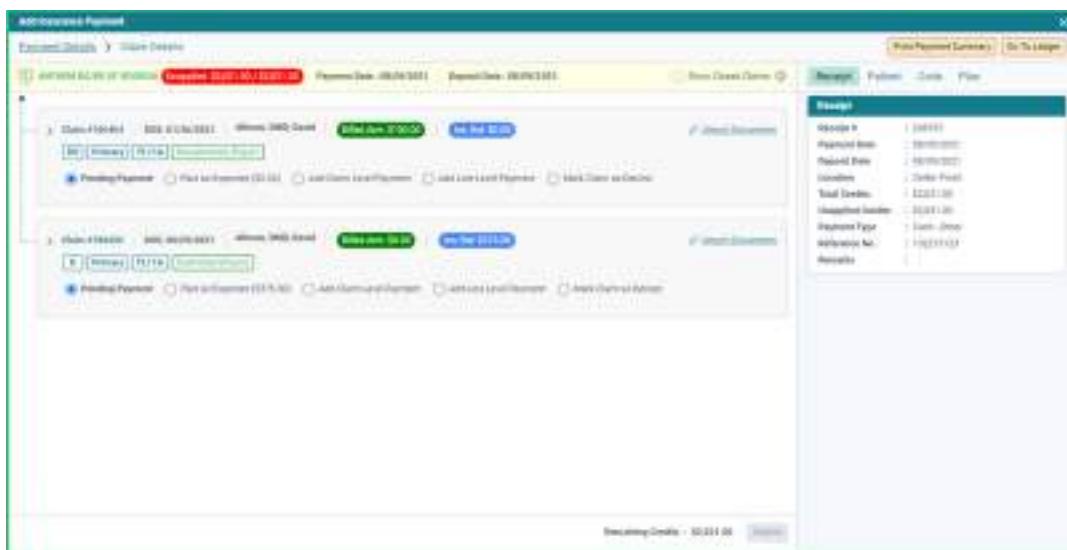
- **Payment Amount:** Enter the correct dollar amount of the payment that you are accepting from this carrier (This field can be updated later if a typo has been entered at this stage).
- **Location:** Your current location will be automatically selected, or you can select the correct location to tag to this payment.

- Payment Date:** Enter the date the payment has been made.
- Deposit Date:** By default, today's date will be entered as the deposit date, but you can select a more appropriate date if necessary.
- Payment Type:** Select the mode of payment (such as check, direct deposit, VISA, and so on) and enter a Reference Number if necessary.
- Remarks:** Enter any important remarks you'd like to save with these payment details.



4. Hit **Apply** to save the payment and begin applying it.

Next, the pop-up window will display the patient's open claims, allowing you to begin allocating the payment towards the necessary procedures.



# Secondary Insurance

Written by Aswathy B Nair | Last published at: August 08, 2021

Sometimes patients have more than one insurance plan to cover their dental treatments.

When there are two plans, you need to account for the differences in benefits and coverage and manage the payments between the carriers.

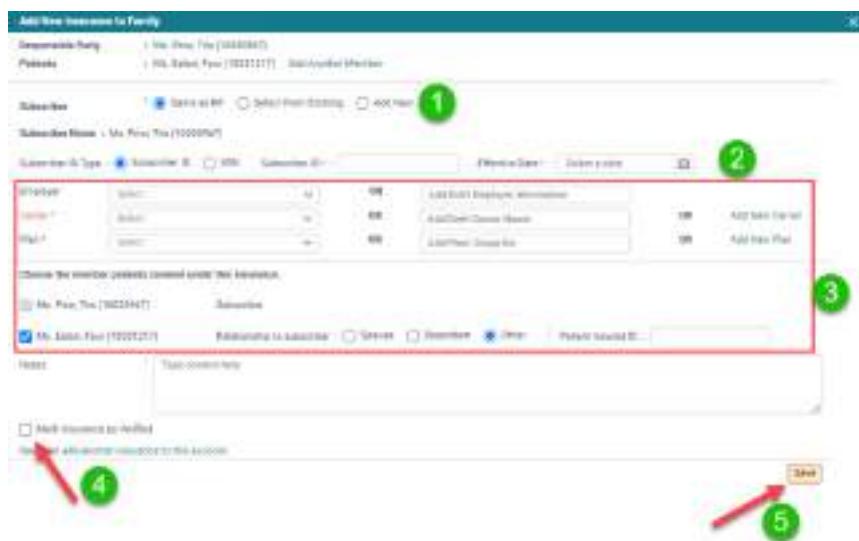
- When a patient has more than one dental insurance plan, we call it **dual coverage**. That doesn't mean that the patients gets the benefit twice.
- The carriers of the two plans rarely share responsibility equally. Typically, one plan, known as primary, pays the brunt of the insurance portion, while the other, the secondary plan, covers some or all of the remaining patient portion.
- Very industrious patients can have even more coverage. There is such a thing as tertiary (3) and even quaternary (4) insurance coverage.

To deal with such cases, we would have to follow the process just like in the case of patients with one insurance but a little more, which we will look upon in the coming sections.

## Attach a Secondary Plan

Attaching a separate or secondary plan is nothing more than attaching a primary insurance.

1. Select or enter the Subscriber.
2. Enter the Subscriber ID or SSN and Effective date of the plan if you have those details available.
3. Locate or add details for your plan, by finding it in your database, entering draft details, or adding a new plan.
4. Select any other patients from the account that need to be added under the same plan and set their relationship to the subscriber.
5. Decide if you are ready to complete the plan and select the Mark Insurance as Verified checkbox accordingly.
6. Click Save.



## Hierarchy

Once the plan is added, you would have to set the Hierarchy. Hierarchy tells which plan has the first benefit and payment priority. You can set the Hierarchy from the Hierarchy Assignments o the Insurance page of patient.

1. Click Hierarchy Assignments
2. For each patient, set the hierarchy for each plan from the drop down list
3. Click on Save.



## Secondary Claims

No that we have seen how to add a Secondary Insurance, we shall go ahead and see how to create a secondary claim by which we request the carrier for the payment of the treatments. Billing order determines whether the code needs to be billed for a single carrier or for more.

### Billing Order

Billing Order determines how the codes should be billed. You can see the Billing Order of the codes from the Treatment Planner or from the Code Snapshot.

- N** - Do Not Bill to Insurance, the patient bears the full responsibility.
- D** - Bill to Dental Insurance Carrier
- DD** - Bill to Primary Dental Carrier and then to Secondary Dental Carrier
- M** - Bill to Medical Carrier

Also you may use the combinations like DM, MD, MM depending on for which carrier you want the claim to go first.



If the codes have Billing order D or DD, then the Dental Claims could be generated for them. For generating a Secondary Claim, the Billing Order should be DD. Secondary claims are automatically generated when the primary claim is closed.

When the Primary claim is closed, a waring pop up shows that higher order claims have been created along with an orange toaster.



## Secondary Payments

The real trick with secondary insurance comes when the secondary carrier pays. That's because we can't always forecast what they'll pay since it greatly depends on what the primary carrier has paid.

You are already accustomed to entering three pieces of information for each code in your claim:

- **Patient Responsibility:** The amount the carrier expects the patient to pay according to the EOB
- **Insurance Responsibility:** The amount the carrier is expected to pay according to the EOB.
- **Insurance Paid:** What the carrier actually paid.

In a primary payment, you will adjust the Insurance Expected Responsibility to match what the carrier paid, so the figures in the **Insurance Expected Responsibility** field and **Insurance Paid** field are the same.

Primary	Secondary	Adjusted	Pt. Resp. (\$)	Ins. Resp. (\$)	Ins. Paid (\$)
\$100.00 - BAL R...			110.00	110.00	210.00
30.00 - 90/10...			\$110.00	\$110.00	\$210.00

When it comes to secondary payments, you will use the same fields, BUT instead of copying the amounts directly from the EOB, you'll do some math for the Insurance Expected Responsibility field.

It will be:

**Insurance Paid in Primary + Insurance Paid by Secondary**

For example:

- The secondary EOB says the insurance responsibility is \$210.
- The primary carrier paid \$300
- The secondary carrier paid \$210
- Enter \$510 in the **Insurance Responsibility** field which is  $\$300 + \$210$ . In the **Insurance Paid** field, enter the \$210.00 the secondary carrier paid.

CareStack will then add the adjustments.

Date	Code	Description	Primary	Secondary	Adjusted	Pt. Resp. (\$)	Ins. Resp. (\$)	Ins. Paid (\$)
06-12-2022	11020 - Primary Ortho Current 30/10		\$100.00 - BAL R...			110.00	110.00	210.00
		Insurance Adj. On Line - Add to primary (\$110.00)				\$110.00	\$110.00	\$210.00
		<b>Total</b>	<b>\$100.00 - BAL R...</b>			<b>\$110.00</b>	<b>\$110.00</b>	<b>\$210.00</b>

Here's what you will do to apply the secondary payment:

1. Select the **Add Line Level Payment** option.
2. Type the **Patient Responsibility** from the EOB in the fields as appropriate.
3. Add the amount the primary carrier paid with the amount the secondary carrier paid and type that total amount in the **Insurance Responsibility** fields.
4. Type the **Insurance Paid** from the EOB in the fields as appropriate.
5. Review the adjustment codes CareStack automatically adds.
6. Click **Submit** when you are ready to apply the payments and adjustments entered for all procedure codes on the claim.

## Frequently Asked Questions

**1. The patient's primary insurance claim is paid and closed when the patient tells the practice that they have a Secondary Insurance.**

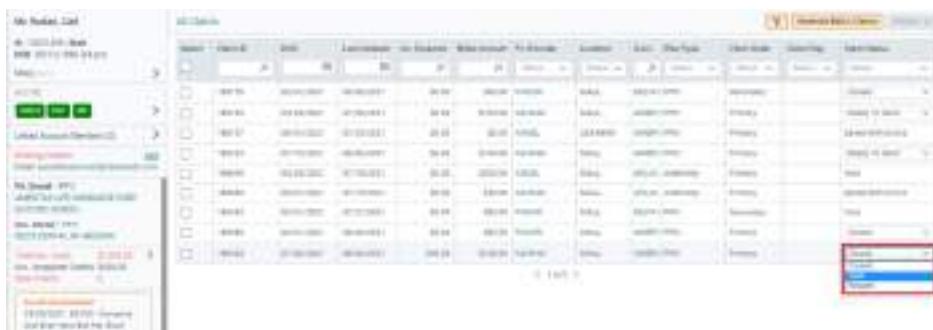
Working with a patient's secondary insurance is relatively simple and automated, driven by the Billing Order. Until and unless the patient fails to tell you that there is a secondary plan until after you've done all the primary work. To bill the secondary insurance that you didn't even know was there, you are going to have to undo and redo the primary claim work you've already done. It's frustrating, but not difficult. You are good at all this by now.

**First you will have to undo your primary claim work.**

1. In the Insurance Payment module, locate the primary insurance payment.
2. Select the Reverse Payment tab.
3. Find and reverse all the transactions for the patient.



4. Void the primary claim. We would not be able to change the Billing Order of the codes from D to DD if they already have a claim attached. This is the reason why we void the claim before making changes to the Billing Order of the codes. It isn't enough to reopen it, you must start over.



**Now we have to make sure that the secondary insurance is Active for the patient.**

1. Attach the Secondary Insurance to the patient.
2. Check the Eligibility.
3. Change the Billing Order of the Codes from D to DD.

**Now Redo the Primary work.**

1. Recreate the Primary claim

2. Change the claim channel to Paper Based. Locate the new claim. Write yourself a note and/or use your practice's claim flag so everyone understands what happened. Print the claim so it shows as Submitted.

ADA American Dental Association® Dental Claim Form		Submit Payment	View Previous Submissions	Attach Document
<b>Header Information</b> <input checked="" type="checkbox"/> Patient Treatment Name of practice name <input checked="" type="checkbox"/> Insurance/Health Services <input type="checkbox"/> Return to Referrer/Referrals/Resubmissions <input type="checkbox"/> DRG/DRG-Plus DRG  <input type="checkbox"/> Payee/Collector/Payor/Corporation Name 		<input type="text" value="Last Name"/> <span style="color: red;">1</span> <input type="button" value="Find"/>		
		<input type="button" value="Print-Preview"/> <input type="button" value="Print-Email"/> <input type="button" value="Print-Submit"/>		
<b>PREMIARY PAYOR INFORMATION</b> <input type="checkbox"/> Commercial Practice, 400-400-0000-0000-0000  <b>SECONDARY PAYOR INFORMATION</b> <input type="checkbox"/> AMERICAN LIFE INSURANCE CO OF NEW YORK  <b>PPO/BLOCK INFORMATION</b> <b>Primary PPO</b> <input type="checkbox"/> Cigna <input type="checkbox"/> BCBS <input type="checkbox"/> Aetna  <b>Other Coverage</b> (Select applicable box underinsured health plan if none apply below) <input checked="" type="checkbox"/> Self <input type="checkbox"/> Health <input type="checkbox"/> Both complete b-1 for dental plan  <input type="checkbox"/> A copy of Policyholder Information is in the claim form tabular record table  <b>Request Date</b> <input type="text" value="01-Nov-2010"/> <input type="button" value="Find"/>		<b>Patient Information</b> <input type="checkbox"/> Preferred/Primary Submitter or 4th Utilization <input checked="" type="checkbox"/> Self <input type="checkbox"/> Domestic <input type="checkbox"/> International <input type="checkbox"/> Other  <input type="checkbox"/> Non-Hospital Discharge from Hospital DRG/DRG-Plus DRG <input type="checkbox"/> Self <input type="checkbox"/> Domestic <input type="checkbox"/> International <input type="checkbox"/> Other  <b>Other Insurance Details/Initial Billing/Other Address/On State/On Code</b> <b>DETAILED DRG/DRG-Plus DRG</b> <input type="text" value="PC 001-40018"/>		
		<span style="color: green;">2</span> <input type="button" value="Print-Email"/> <input type="button" value="Print-Submit"/>		

3. Apply the primary payment to your recreated claim the same way as before. Close the claim when you are finished.

Customer ID	Customer Name	Address	City	State	Zip Code	Phone Number	Email Address	Last Visit	Notes/Comments
Customer 1	John Doe	123 Main Street	Anytown	CA	90210	(555) 123-4567	johndoe@example.com	2023-01-01	Initial Visit
Customer 2	Jane Smith	456 Elm Street	Anytown	CA	90210	(555) 123-4568	janesmith@example.com	2023-01-02	Follow-up Visit
Customer 3	Bob Johnson	789 Oak Street	Anytown	CA	90210	(555) 123-4569	bobjohnson@example.com	2023-01-03	Annual Checkup
Customer 4	Sarah Williams	543 Pine Street	Anytown	CA	90210	(555) 123-4570	sarahwilliams@example.com	2023-01-04	Annual Checkup
Customer 5	David Miller	210 Cedar Street	Anytown	CA	90210	(555) 123-4571	davemiller@example.com	2023-01-05	Annual Checkup
Customer 6	Mary Lewis	321 Birch Street	Anytown	CA	90210	(555) 123-4572	marylewis@example.com	2023-01-06	Annual Checkup
Customer 7	Tommy Lee	654 Chestnut Street	Anytown	CA	90210	(555) 123-4573	tommylee@example.com	2023-01-07	Annual Checkup
Customer 8	Linda Green	897 Spruce Street	Anytown	CA	90210	(555) 123-4574	lindagreen@example.com	2023-01-08	Annual Checkup
Customer 9	Mike Brown	432 Chestnut Street	Anytown	CA	90210	(555) 123-4575	mikebrown@example.com	2023-01-09	Annual Checkup
Customer 10	Susan White	765 Elm Street	Anytown	CA	90210	(555) 123-4576	susanwhite@example.com	2023-01-10	Annual Checkup

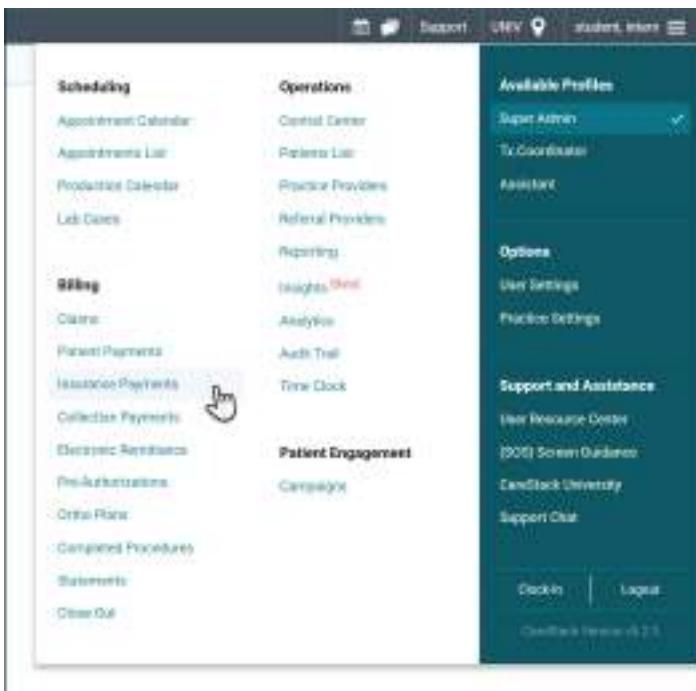
4. When you close the primary claim again, CareStack will create the secondary claim. Send it on as you normally would.

# Insurance Refunds

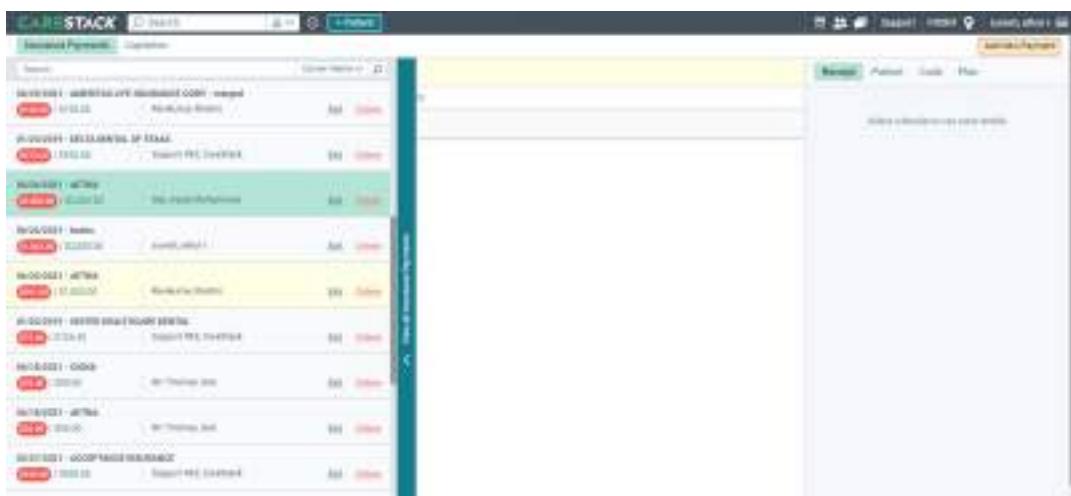
Written by Athul V Suresh | Last published at: August 08, 2021

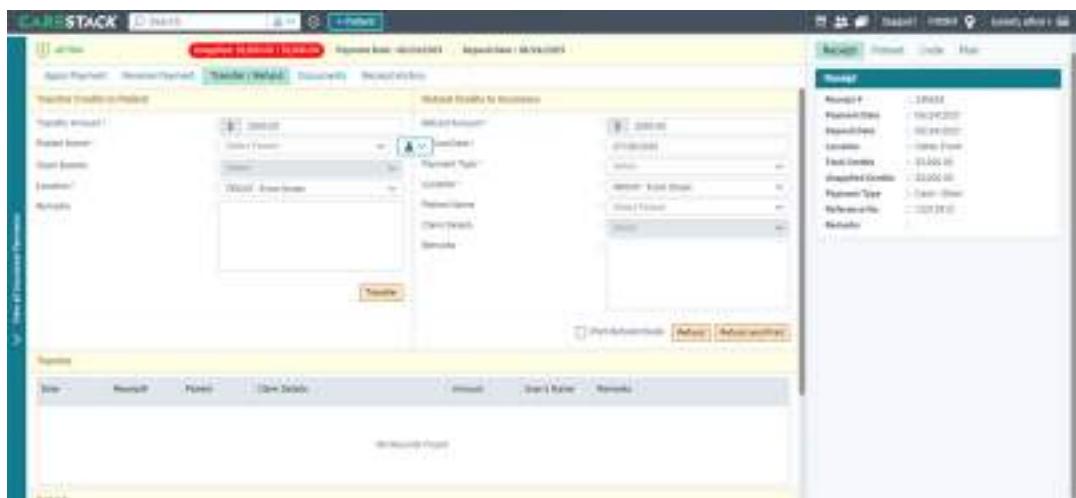
Say if insurance paid more than they intended and wants a refund how do we note that in CareStack.

Start by navigating to the **Insurance Payments** module (System menu > Insurance Payments).



1. When the page loads, search for and select the intended receipt on the left side menu, then select the tab titled **Transfer / Refund** at the top of the page.





2. In the section titled Refund Credits to Insurance (second quadrant), complete the following details:

- **Refund Amount\***: Enter the dollar amount that you would like to refund to this insurance carrier. Please note, you will only be able to refund the Available Credits on the receipt. To refund an amount that has already been applied toward a claim, you'll first need to reverse the transaction(s).
- **Refund Date\***: Verify the date this refund is being made.
- **Payment Type\***: Select the mode of this refund, whether it will be a direct transfer, check, or so on.
- **Location\***: Select the location this refund should be coming from.
- **Patient Name**: Select the name of the patient to which this refund pertains, if necessary.
- **Claim Details**: Select the patient's claim to which this refund pertains, if necessary.
- **Remarks**: Enter any necessary remarks (this will be displayed on the Memo line if printing a refund check with this transaction).

3. Decide whether or not to **Print a Refund Check** (if so, checkmark this option), then select **Refund** to complete this in the system, or **Refund and Print** to complete this transaction and print a receipt of the same.

This transaction will appear in the **Receipt History** tab of the Insurance Receipt details.

The refund check and refund receipt will appear in new, separate tabs to be printed and/or downloaded.



## Refund Receipt

### Ace Dental 1 - Front Street

Tel: Front St Ste 500  
Calexico, CA, 92231-4999  
Ph: (619) 564-1232  
E-MAIL: [front@acecaledental.com](mailto:front@acecaledental.com)

### REFUND RECEIPT

Printed Date: 07/28/2021  
Carrier Name: AETNA

Refund Date	Description	Amount
07/28/2021	Refunded to insurance by CASH - Cash at Front Street	\$1,000.00

## Refund Check Printing



To be able to print checks you will need to enable the print check options as 'yes' inside Practice settings > Payments > general > Payment services > banking details and fill in the required details.

## Reverse Refund

To reverse a refund navigate to:

1. Transfer / Refund tab of the Insurance Receipt details, checkmark the intended refund transaction (pictured above).
2. Select **Reverse Refund**.



The dollar amount that was refunded will become Available Credits that can be reapplied.

# Deleting an Insurance Receipt

Written by Abhishek Vijay | Last published at: August 08, 2021

Oops! Did you make a mistake while creating an insurance receipt? No need to worry at all, as we are able to delete an insurance receipt added.

You can delete a payment, but all the work you've done will be reversed. You will need to re-open the claims to apply the receipt towards another payment.

To delete an insurance payment:



Click the **Delete** link on the desired payment.

Review the consequences in the warning.

Click on Ok.

## Permissions

There you go! Nobody else will know of your mistake. Not unless they look through the Audit Trail that is. Once a receipt has been added or deleted, it would show up under the Audit Trail as demonstrated below.

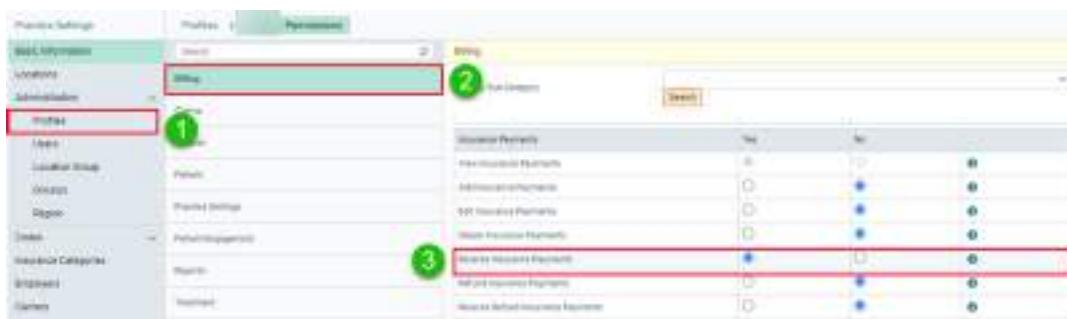
Audit Trail						
Date	User	Action	Module	Activity	Details	Links
2022-08-08 10:00:00	Abhishek	Delete	Billing	Deleted: Payment Receipt #248734 - CASH		
2022-08-08 10:00:00	Abhishek	Add	Billing	Added: Payment Receipt #248734 - CASH		

# Reverse Insurance Payments

Written by Aswathy B Nair | Last published at: August 08, 2021

Oops! Made an error while posting an insurance payment? Don't worry, you can easily undo all payments and adjustments posted against the claim, and the claim will be reopened for you to post again. This can be done right from the insurance payments page, without having to navigate to the patient's ledger.

The Permissions to Reverse Insurance payments is set under **System Menu > Practice Settings > Administration > Profile > Billing**



## How do we reverse an insurance payment

- Navigate to **System menu > Insurance Payments**



- Select payment receipt.
- Toggle to the **Reverse Payment** tab
- Click on the Reverse payments button next to the claim transaction you would like to reverse if you want to reverse all the payments made against the codes in that claim. ( If you want to selectively reverse, you may click on the caret to expand the entry > select the codes > and click on reverse on the bottom to reverse the selected transaction. But this would not reopen the claim but will just reverse the payments applied for the selected codes)



- A warning pop up comes with the list of activities that are going to happen when you reverse the payment where you need to enter the remarks(like any reason why you are reversing the payment).



- Once you click OK, after entering the remarks, all the payments made will be reversed and the claim will be reopened.
- You will receive a green confirmation message: "**Claim payments reversed.**"

Embedded content from <https://www.loom.com/embed/6fe56ff3b0e54148a97be7041a42e842>

## What happens when we reverse a payment?

- All payments posted for that claim using the considered receipt would be reversed
- All adjustments posted during the payment posting from that receipt would be reversed
- All credit transfers made against that claim from that receipt would be deleted after reversing all its associated posting entries if any
- The claim would be reopened.

### Note:

- If there is a higher-order claim generated that is still in a status that can be deleted (*Saved*, *Saved with Errors*, or *On Hold* status), then the generated claim must be deleted before this claim can be reopened.
- If there is a higher order claim in a status where it can't be deleted, then the user should be presented with a warning asking whether or not they want the payments and adjustment alone to be reverted without reopening the claim or to abort the process altogether.



- If payments or adjustments are made from multiple receipts, then the user should be allowed to reverse only the payments/adjustments posted from the last receipt which is still active.



# Insurance Payment Receipt History

Written by Rinu Seba Joemon | Last published at: August 08, 2021

By this time you would have learned how to add a new insurance payment. Once a new payment has been added to the insurance payments page a receipt would be created. A tab that is included in the insurance receipt is the '**Receipt History**'. As the name suggests the receipt history tab shows all the transactions that were completed under this receipt. Let's take a look at this.

Resource Planning								Resource Allocation		Resource Utilization	
Resource Type		Resource Status		Resource Allocation		Resource Utilization		Resource History		Resource Metrics	
Resource ID	Resource Name	Status	Last Update	Allocated	Allocated %	Utilized	Utilized %	Allocated Date	Allocated To	Utilized Date	Utilized By
RP-001	Resource A	Active	2023-01-01	Allocated	100%	Utilized	100%	2023-01-01	Team Alpha	2023-01-01	Team Alpha
RP-002	Resource B	In Progress	2023-01-02	Allocated	100%	Utilized	100%	2023-01-02	Team Beta	2023-01-02	Team Beta

- **Trans. Date:** The date on which the transaction was done/completed.
  - **Patient:** The name of the patient(s) for which the payment was done. Clicking on the patient name will open a window from which you would be able to view the patient details, insurance details, Account details, and Medical Alerts. You can also navigate to other pages of the patient from this window.

	Mrs. Joemon, Rita Sitas (10041094)	DOB: 01/11/1997 (59 yrs)	Ins. payment of \$40.30 with Aetna/HSA (GMA)	HALL	\$40.30	01/11/2017
<b>Mrs. Joemon, Rita Sitas (10041094) (F)</b>						
	<a href="#">Details</a>	<a href="#">Insurance</a>	<a href="#">Account</a>	<a href="#">Med. Alerts</a>	<a href="#">Transfer</a>	
					<a href="#">Logout</a>	
					<a href="#">Treatment</a>	
					<a href="#">Chart</a>	
					<a href="#">Payment</a>	
					<a href="#">e-Mails</a>	
					<a href="#">e-Documents</a>	
					<a href="#">e-Communication</a>	
					<a href="#">Insurance</a>	

- Code:** The code against which the insurance payment was posted. Clicking on the code will open the code snapshot.

Recent History									
Trans. Date	Post No.	Card	Description	To Provider	Location	Amount	Cards #	User's Name	Remarks
01/15/2021			Int. payment of \$100.00 credited by CASH-Dollar at PRINCE (040001101010221)		FRONT	\$100.00		Mr. Thomas See	
01/15/2021	MC Lyleh, Balanc (10001100)		Transferred \$100.00 to Pr. Rec. #040001 et 455647		FRONT	-100.00	100000	Mr. Thomas See	
01/15/2021	MC Lyleh, Balanc (10001100)	01110	Int. payment of \$100.00 was posted for MTRIA	ANSELL	FRONT	-100.00	100002	Mr. Thomas See	
<b>Grand Total:</b>						<b>\$0.00</b>			

- **Description:** The description tab briefs about the details for each transaction that was done in the receipt.
  - **Tx. Provider:** The name of the provider who completed the treatment to the patient. Clicking on the name of the treatment provider will open a small window that shows the details of the provider.

Mr. shai v3, chinchu	Mr. shai v3, chinchu
Provider Name	Mr. shai v3, chinchu
Short Name	SHAI
Linked Locations	All
Phone 1	(777) 777-7777
Phone 2	
Email	chinchu@casenlock.com

- **Location:** The location where the transaction was done.
  - **Amount:** The amount for which the transaction was completed.
  - **Claim #:** The claim ID of the corresponding code. If you click on the claim number, the claims tab will slide open.
  - **User's Name:** The user who completed the transaction. Clicking on the username will open a small window that shows the user details such as profile, production, appointments, and billing information.

Profile	Production	Appointments	Billing
Provider Name	: Ms. Dental, Momentum Seba		
Linked Locations	: All		
Linked Patients			
Phone 1			
Phone 2			
Email	: mmojemon@cerestack.com		

- **Remarks:** Included any remarks here if necessary.

# Patient Insurance

Written by Rahul Krishnan | Last published at: August 22, 2021

Insurance is a contract, represented by a policy, in which an individual or entity receives financial protection or reimbursement against losses from an insurance company. The company pools clients' risks to make payments more affordable for the insured.

There are a multitude of different types of insurance policies available, and virtually any individual or business can find an insurance company willing to insure them—for a price. The most common types of personal insurance policies are auto, health, homeowners, and life. Most individuals in the United States have at least one of these types of insurance, and car insurance is required by law.

## Overview of Dental Insurance

A dental insurance company plan helps to cover the costs of preventative dental care while softening the blow on pricier dental procedures like crowns, bridges, and fillings. First, here's a breakdown of how individual dental insurance works. You select a plan based on the providers (dentists) you want to be able to visit and what you can afford to pay. The monthly premiums will depend on the insurance company, your location, and the plan you choose.

Most dental insurance plans have a waiting period during which major procedures are not covered for a year after the plan begins, with minor ones not covered for three months. If you're thinking that you'll just hold out and purchase dental insurance when you need it, think again. Because of what's called a waiting or probationary period, this strategy won't work (you didn't really think you'd found a way to outsmart the insurance companies, did you?). Waiting periods mean that, for example, one year after you first become insured, your insurance will not cover any major work (such as crowns or root canals) and for three months after you first become insured, it won't pay for any minor work (such as fillings). Waiting periods vary by policy.

It is not necessary that the patient always has dental insurance. He/she can also have medical insurance that may cover certain dental codes as well. A patient can also have both medical as well as dental insurance. When a patient has multiple insurance plans, one will be the primary and the remaining will be the secondary/tertiary insurance.

Any insurance plan will have a subscriber who is the person who holds the contract for the plan with the carrier. The subscriber pays the premium to the carrier in exchange for coverage for members as described in the plan. (The subscriber should not be confused with the RP who is the person who is in charge of the patient not only for the bill, but for treatment decisions, communication, statements, and coordination efforts.) However both the RP and the subscriber can be the same person or they can be different persons as well.

## Exploring Patient Insurance

The Patient Insurance page in CareStack has everything you ever wanted to know about the patient insurance plan, organized into tree structures. You can easily navigate to the page using the Insurance icon or with the different insurance links on the Patient Overview. The insurance page gives you detailed information about the patient and their account's insurance, past and present. By default, the insurance tab shows the insurance of all the account members in a tree structure and it hides the terminated insurance plan that was previously added for the account members.

By selecting the 2 checkboxes on the top, you can choose to view only the current patient's insurances as well as view the terminated insurance plans.

## Attach Insurance

Attaching insurance to the patient's profile is the first link in the critical insurance chain. CareStack associates detailed insurance plan records with the patient so you have complete, accurate treatment estimates that reflect the member patient's current relationship with the insurance plan.

To add a new insurance for a patient, one can navigate to the Insurance tab from the Patient Overview and click on Add Insurance on the top right.



On clicking the Add button, the landing page will look something like this.

**Add New Insurance to Family**

Responsible Party	: Arnold, Alexander (10031034)
Patient	: Arnold, Steve (10031035) <a href="#">Add Another Member</a>
Subscriber	<input checked="" type="radio"/> Same as RP <input type="radio"/> Select From Existing <input type="radio"/> Add New
Subscriber Name	: Arnold, Alexander (10031034)
Subscriber ID Type	<input checked="" type="radio"/> Subscriber ID <input type="radio"/> SSN <input type="radio"/> Other
Subscriber ID	<input type="text"/>
Effective Date	<input type="button" value="Select a date"/>
Employee	<input type="button" value="Select"/>
Carrier	<input type="button" value="Select"/>
Plan	<input type="button" value="Select"/>
Choose the member patients covered under this insurance.	
<input type="checkbox"/> Arnold, Alexander (10031034)	Subscriber
<input checked="" type="checkbox"/> Arnold, Steve (10031035)	Referencing to subscriber : <input type="radio"/> Spouse <input checked="" type="radio"/> Dependent <input type="radio"/> Child <a href="#">Patient Incentive</a>
Notes	<input type="text"/>
<input type="checkbox"/> Mark Insurance as Verified <a href="#">Save and add another insurance to this account</a> <input type="button" value="Save"/>	

You will be able to view the RP and other members in the account on top and the same members will be listed out in the bottom too. If you wish to add a new member to be a part of this account, you can click on Add Another Member which will take you to the Create New Patient landing page.

The first step involved in attaching an insurance for a patient is to choose the subscriber. We've already defined Subscriber as the person that holds the contract for the plan with the carrier. CareStack lets you choose between 3 options.

**Add New Insurance to Family**

Responsible Party	: Arnold, Alexander (10031034)
Patient	: Arnold, Steve (10031035) <a href="#">Add Another Member</a>
Subscriber	<input checked="" type="radio"/> Same as RP <input type="radio"/> Select From Existing <input type="radio"/> Add New
Subscriber Name	: Arnold, Alexander (10031034)
Subscriber ID Type	<input checked="" type="radio"/> Subscriber ID <input type="radio"/> SSN <input type="radio"/> Other
Subscriber ID	<input type="text"/>
Effective Date	<input type="button" value="Select a date"/>

**1. Same as RP:** The same person that is financially responsible for THIS patient (Responsible Party) can be the subscriber. This would be the default setting that is selected.

**2. Select from existing:** A person that is NOT THIS patient's responsible party, but is in your database as a patient. You can select any other patient from the existing database of patients. When you select a patient, you can select any of the plans that are attached to that patient's insurance for your current patient by choosing **Use Subscriber's insurance**. If the new patient does not have any existing plan, then they would have to add a new plan for the subscriber as it is mandatory. To add a new plan

for the subscriber, you can select the option **Add New Plan to subscriber**. If the new patient does not have any existing plan, then they would have to add a new plan for the subscriber as it is mandatory.

**3.Add New:** You can add a brand new person not yet in your database as the subscriber. Please note that by doing so, you are actually creating a new subscriber who is not a patient. A person who is subscriber only will only have the insurance tab in his patient overview screen. There won't be any other tabs like Clinical, Medical History Forms, etc which are exclusively meant for patients. However, you can always convert a subscriber who is a non-patient to a patient. Shown below is one such subscriber who has been created and is not a patient.



After the subscriber has been chosen, you will have to enter a Subscriber ID type which is like a unique identification number provided for each of the subscriber. You can choose either a subscriber ID or your SSN number as the subscriber Identity number. The subscriber ID number will be present in the subscriber's insurance card and the SSN number is the Social Security Number which exists for every citizen in the United States. Any one of them is mandatory. After choosing the ID, then the effective date has to be chosen after which the insurance plan will be active.

## Attach a Plan

With the subscriber element out of the way, we are ready to focus on attaching the plan. Locate or add details for your plan. Depending on what you know and what you are ready to commit to, you have three options:

- Find a plan you already have in your database by typing the group or plan no in the plan field by searching the drop down lists.
- Typing what you know in the draft fields so you have the details without the commitment
- Add a new carrier or plan to your database.

When you select a particular employer/carrier, all the plans linked to those plans or employer will show up.

After the plan has been added, you can now associate the plan with other members of the patient's family. You can select any other patient from the account that need to be added under the same plan and set their relationship to the subscriber. The subscriber will be selected by default.

Choose the member patients covered under this insurance.

<input type="checkbox"/> Arnold, Alexander (10031084)	Subscriber
<input checked="" type="checkbox"/> Arnold, Steve (10031085)	Relationship to subscriber: <input type="radio"/> Spouse <input checked="" type="radio"/> Dependent <input type="radio"/> Other
Patient Insured ID: <input type="text"/>	
Notes:	Type content here

If you have identified and selected the right plan for the right patient and has completed all the mandatory fields, you proceed to verify the plan. **Please note that verified plans are fully associated with the patient and cannot be removed or deleted.**

### Add New Insurance to Family

Responsible Party: : Arnold, Alexander (10031084)  
 Patients: : Arnold, Steve (10031085) [Add Another Member](#)

Subscriber: :  Same as RP  Select from Existing  Add New

Subscriber Name: : Arnold, Alexander (10031084)

Subscriber ID Type:  Subscriber ID  SSN [Subscriber ID](#) Effective Date: [Select a date](#)

Employer: [Select](#) [Add Draft Employer Information](#)

CARRIER: [Select](#) [Add Draft Carrier Name](#) [Add Carrier](#)

Plan: [Select](#) [Add Plan Group No.](#) [Add New Plan](#)

Choose the member patients covered under this insurance.

<input type="checkbox"/> Arnold, Alexander (10031084)	Subscriber
<input checked="" type="checkbox"/> Arnold, Steve (10031085)	Relationship to subscriber: <input type="radio"/> Spouse <input checked="" type="radio"/> Dependent <input type="radio"/> Other
Patient Insured ID: <input type="text"/>	
Notes:	Type content here

[Mark Insurance as Verified](#)

[Save and add another insurance to this account](#)

[Save](#)

If you do not have all the details at the moment say the plan details or the employer details, you can enter the other details that you can fill right now and save the plan without selecting the Mark Insurance as Verified checkbox. This will save the insurance in the Draft status with the details you have entered so far. Once you have the complete information, you can complete entering the remaining details and mark the plan as verified.

An insurance that has been saved without marking it as verified will be in the draft status as you can see in the screenshot below.



Insurance that are still in the draft status can be deleted but those which have been marked as verified cannot be deleted.

## Different Insurance statuses

**1.Active:** When the insurance is saved after marking it as verified, it will be active if the effective date is reached. However it will be still showing an eligibility pending status in red. Also if the hierarchy has not been set for a plan, that too will be displayed in red (when multiple plans are added for a patient).



The hierarchy can be set by clicking on the Hierarchy Assignments on top right next to the add button. From here, you can define if an insurance plan is primary/secondary insurance if a patient has multiple insurance plans. You can add any number of insurance plans for a patient but you will be able to set the hierarchy only upto the tertiary insurance. So in effect, at a time, a patient can have at most a primary, a secondary and a tertiary plan in CareStack.

Shown below is the hierarchy of a patient with 4 insurance plans but the hierarchy is defined only for 3 of them.

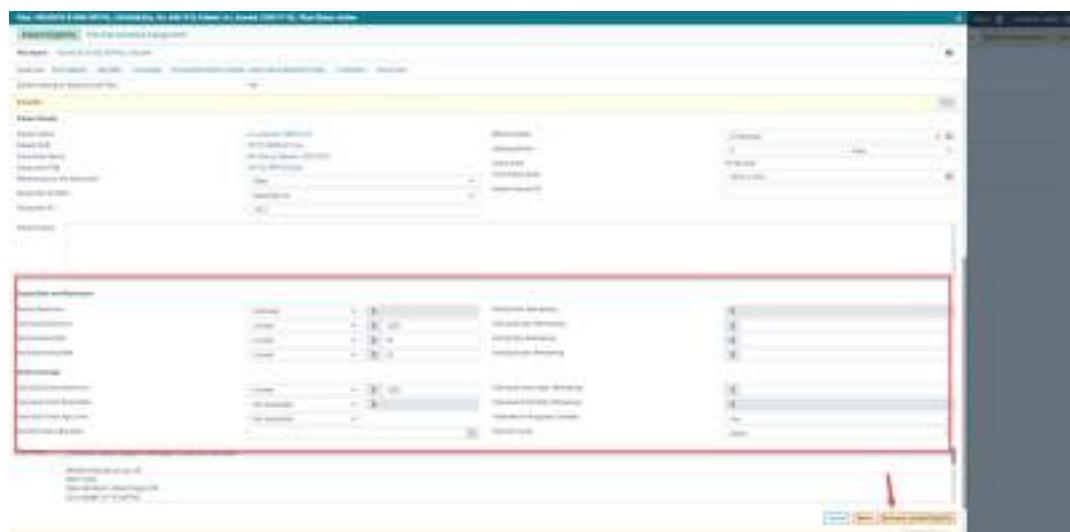
**Change Hierarchy Assignments**

Set Insurance Hierarchy for insurances in the account  Hide Terminated Plans

A.J. Aravind (100011118)

- AETNA - 100 FEE SCH/FEE SCH 3+5/0 ORTHO\_AE13 Primary Dental
- ALTERNATIVE INSURANCE RESOURCES - INACTIVE PLAN UNITED SURGICAL #8888TANTS\_1000870 Secondary Dental
- AETNA - 100/0/0 Tertiary Dental
- ALLIED BENEFITS SYSTEMS INC - 100/80/50 31000 ORTHOL\_1000648 Hierarchy Not Set

A plan is active and the eligibility updated when you have checked the patient's eligibility under the plan and have the coverage details. You will have to edit the Benefits by opening the plan and then save and update eligibility.



Once this is done, the insurance plan will show as eligibility updated.

ACCOUNT NUMBER: 100011118

Show Current Patient's Insurance Only  Hide Terminated Plans  Hierarchy Assignments  Add

Insurance Plan	Primary	Secondary	Tertiary	Eligibility
DENTAL DENTAL OF MINNESOTA - Bryant, Bolt (10000057) - Indemnity   100/10/10 32080 ORTHO_3969 (Grp. No. 001054080)   01/01/2019 - Inactive	Primary Dental	Secondary Dental	Tertiary Dental	Eligibility updated on 01/01/2020 13:32:12 AM by [User]
DETA DENTAL OF MARYLAND AND PENNSYLVANIA - Bryant, Bolt (10000057) - PPO   00/00/00000 (Exp. No. 0000000000)   01/01/2018 - Inactive	Secondary Dental	Primary Dental	Tertiary Dental	Eligibility updated on 01/01/2020 13:32:12 AM by [User]
AFLAC - Bryant, Bolt (10000057) - Indemnity (Medical)   ND EMPLOYER_10010119 (Grp. No. 0000000000)   01/01/2021 - Inactive	Secondary Medical	Primary Medical	Secondary Dental	Eligibility updated on 01/01/2021 01:16:28 AM by [User]
AETNA - Bryant, Bolt (10000057) - Indemnity   100/5/0 (Grp. No. 000000)   01/01/2021 - Inactive	Hierarchy Not Set	Primary Dental	Secondary Dental	Eligibility Pending

**2. Inactive:** An insurance plan whose active date has not yet been reached will be shown as Inactive. An insurance plan whose active date has been reached but if an additional waiting period has been defined for the plan and the effective date is not yet reached, the insurance plan will be displayed as inactive too. Such plans will be active once the active date or effective date is reached.

Alaska Native Beneficiary - Dept. Che, Bo (10031024) - PPO | Fmt1 (Grp. No. 34567) | 08/05/2021 - Indefinite

Dept. Che, Bo (10031024) Eligibility Not Set Eligibility Pending

Dr. Gopi, Sunish (10031565) Primary Dental Eligibility Pending

**3. Draft**-Draft plans contain incomplete details used as a placeholder until they can be matched or completed. With this option, you can begin a draft insurance plan with whatever information you do have. When you have the rest, you can complete and verify the plan, or discard your draft. To delete a draft insurance plan, you can click on Delete.



**4.Terminated**- An insurance plan which has been saved after marking as verified cannot be deleted. However any active insurance plan can be terminated by updating the termination date. The termination date is like the expiry date of the insurance plan and if that date is reached, insurance is no longer active. The termination date of any insurance plan can be seen next to the plan name along with the effective date. If no termination date has been set for a plan, it will show as Indefinite. However, you can always change the termination date of an active insurance. If you wish to terminate an insurance which is active right now, you can click on Update Termination Date and set the termination date to a past date after which the insurance plan will be termed/terminated.

Account Insurance  Show Current Patient's Insurance Only  Show Terminated Plans  Hide All Assignments  Act

AKTNA - 44, Kavinit (10031110) - Medicare | Disney (1234) | Grp. No. 101168 | 01/02/2018  Initiates  Update Termination Date

A.J. Alvarez (10031110) Primary Dental Eligibility updated on 01/16/2021 10:19:03 AM to **Indefinite**

+ Add another member

ACCEPTANCE INSURANCE - 47, Agent (10030970) - HMO | aapa (Grp. No. 7887) | 12/28/2020 - 03/21/2020  Update Termination Date

47, Agent (10030970) Primary Dental Eligibility updated on 03/03/2021 03:31:07 AM to **Support HGL, Cleveland**

+ Add another member

The termination date can only be updated if an insurance plan is active. There will not be an option to update the termination date for an inactive plan. Shown below is an inactive plan for which there is no option to update termination date.

ALTERNATIVE INSURANCE RESOURCES - Dept. Che, Bo (10031024) - PPO | Crowdmm (Grp. No. 21) | 02/14/2021 - Indefinite

Dept. Che, Bo (10031024) Primary Dental Eligibility updated on 01/30/2021 03:31:08 AM by **Initiates, Recd.**

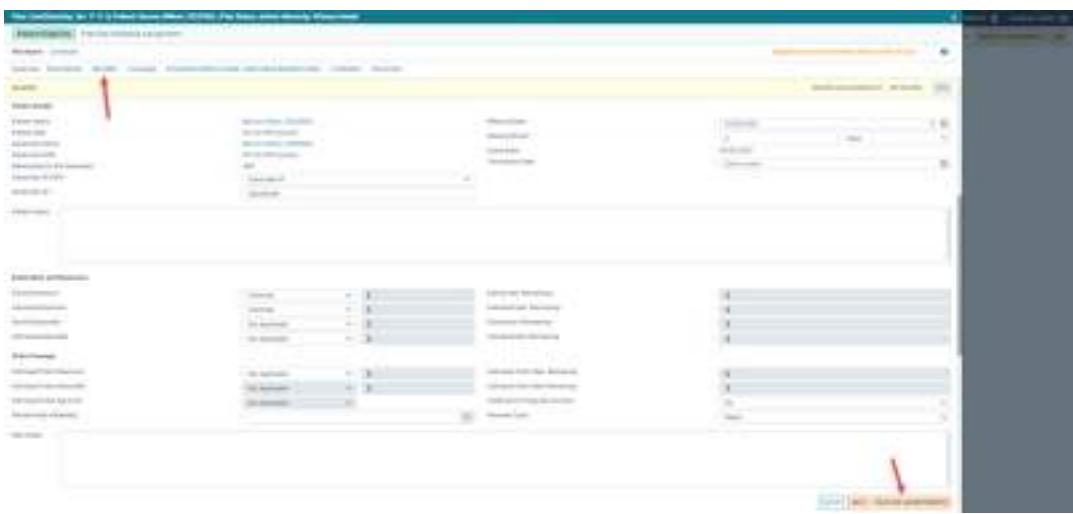
+ Add another member

By default, the terminated insurances of a patient are hidden. You can view them by ticking the Show Terminated Plan checkbox on the top which will display the terminated plans for a patient.

**5.Pending verification**- An insurance plan in the pending verification status indicates that the benefits associated with the insurance plan have not been updated. On opening the plan details and updating the plan benefits for a patient, one can click on Save and update Eligibility and the plan will no longer be in this status.

Pending Verification AARP Dental Ins Plan (Delta Dental), P O Box 2059, Mechanicsburg, PA, 170552059, 18662614275, 1672 - Barrow, Willow (1822985) - Co-Pay | CareStack (Grp. No. 11111) | 09/02/2020 - Indefinite

Barrow, Willow (1822985) Primary Dental Eligibility Pending



## Credit Transfer & Deletion

Written by Geo Thomas | Last published at: August 19, 2021

Here in this article, credit transfers refer to the transfer of money(credits) from an insurance receipt to the patient's account. When, why and how does such a thing happen?

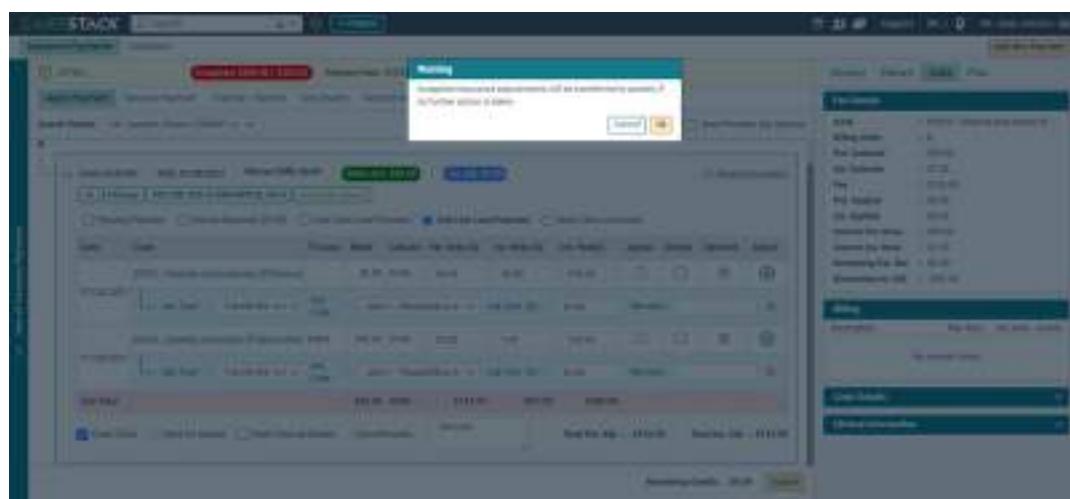
**When?:** This usually happens when the insurance overpays. If the amount the insurance paid is more than the actual fee of the code, the remaining amount is either refunded to the insurance or transferred to the patient's account as unapplied credits.

**Why?**: The amount paid by the insurance is actually the patient's money. If the insurance pays and the practice does not use it, the patient loses the money, and it would also mess up their end-of-the-day reports.

**How?:** In CareStack, this is done by the creation of **Transfer Receipts**. CareStack automatically creates transfer receipts in the situation mentioned above.

Even though the idea behind transfer receipts is good, the creation of a transfer receipt is not much appreciated. The reason behind this is that such receipts are created from another receipt and not an actual payment source. Hence, this would also mess up reports. Insurance payments are therefore posted in such a way that transfer receipts are not generated. This is done by adding **adjustments** to the codes for which there are chances of creation of **transfer credits**.

### **Example of creation of transfer credits**



These credits would show up as a **transfer receipt** under **Billing > Payments > All Payments**



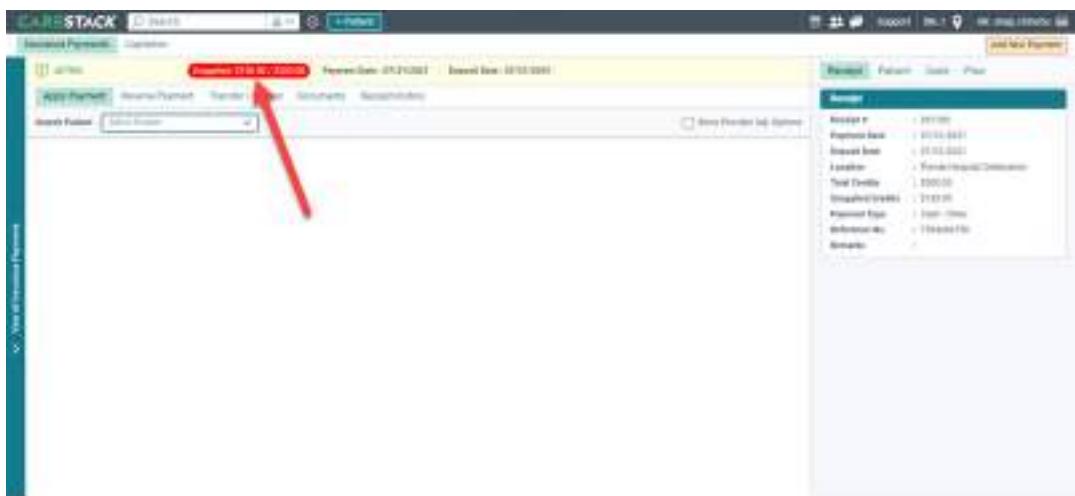
## **Deletion of a transfer receipt**

To delete a transfer receipt, select the receipt and then click **Delete**.



This would not only delete the receipt, but also reverse all the transactions done on it.

Upon checking the **Insurance Payments** section under the **System Menu**, the receipt would have this amount credited back to it.



Embedded content from <https://www.loom.com/embed/326b963285ab4a358ad5b8fe83ab4624>

## Required Permissions

The minimum permissions required for the above operations are as in this image.

CAVIS STACK

Project settings Project A [Admin - Permissions]

File Edit Insert View Tools Help

Left sidebar:

- Categories
- Administrators
- Groups
- Users
- Customizing
- Devices
- Regions
- Locations
- Inventory Categories
- Equipment
- Parts
- Alarms
- Subscription Agents
- Log Tables
- Persons
- Surveys
- Units
- Metrics
- Process Flow
- Task List Rules
- Thresholds

Main content area:

User for full access: **A - Administrators**

Access Level	Read	Write	Execute	Change	Delete
Administrators	<input checked="" type="checkbox"/>				
Groups	<input checked="" type="checkbox"/>				
Users	<input checked="" type="checkbox"/>				
Customizing	<input checked="" type="checkbox"/>				
Devices	<input checked="" type="checkbox"/>				
Regions	<input checked="" type="checkbox"/>				
Locations	<input checked="" type="checkbox"/>				
Inventory Categories	<input checked="" type="checkbox"/>				
Equipment	<input checked="" type="checkbox"/>				
Parts	<input checked="" type="checkbox"/>				
Alarms	<input checked="" type="checkbox"/>				
Subscription Agents	<input checked="" type="checkbox"/>				
Log Tables	<input checked="" type="checkbox"/>				
Persons	<input checked="" type="checkbox"/>				
Surveys	<input checked="" type="checkbox"/>				
Units	<input checked="" type="checkbox"/>				
Metrics	<input checked="" type="checkbox"/>				
Process Flow	<input checked="" type="checkbox"/>				
Task List Rules	<input checked="" type="checkbox"/>				
Thresholds	<input checked="" type="checkbox"/>				

Buttons: Save, Print

CAVIS STACK

Project settings Project A [Admin - Permissions]

File Edit Insert View Tools Help

Left sidebar:

- Categories
- Administrators
- Groups
- Users
- Customizing
- Devices
- Regions
- Locations
- Inventory Categories
- Equipment
- Parts
- Alarms
- Subscription Agents
- Log Tables
- Persons
- Surveys
- Units
- Metrics
- Process Flow
- Task List Rules
- Thresholds

Main content area:

User for full access: **B - Persons**

Access Level	Read	Write	Execute	Change	Delete
Administrators	<input checked="" type="checkbox"/>				
Groups	<input checked="" type="checkbox"/>				
Users	<input checked="" type="checkbox"/>				
Customizing	<input checked="" type="checkbox"/>				
Devices	<input checked="" type="checkbox"/>				
Regions	<input checked="" type="checkbox"/>				
Locations	<input checked="" type="checkbox"/>				
Inventory Categories	<input checked="" type="checkbox"/>				
Equipment	<input checked="" type="checkbox"/>				
Parts	<input checked="" type="checkbox"/>				
Alarms	<input checked="" type="checkbox"/>				
Subscription Agents	<input checked="" type="checkbox"/>				
Log Tables	<input checked="" type="checkbox"/>				
Persons	<input checked="" type="checkbox"/>				
Surveys	<input checked="" type="checkbox"/>				
Units	<input checked="" type="checkbox"/>				
Metrics	<input checked="" type="checkbox"/>				
Process Flow	<input checked="" type="checkbox"/>				
Task List Rules	<input checked="" type="checkbox"/>				
Thresholds	<input checked="" type="checkbox"/>				

Buttons: Save, Print

# Provider Adjustments & Reversals

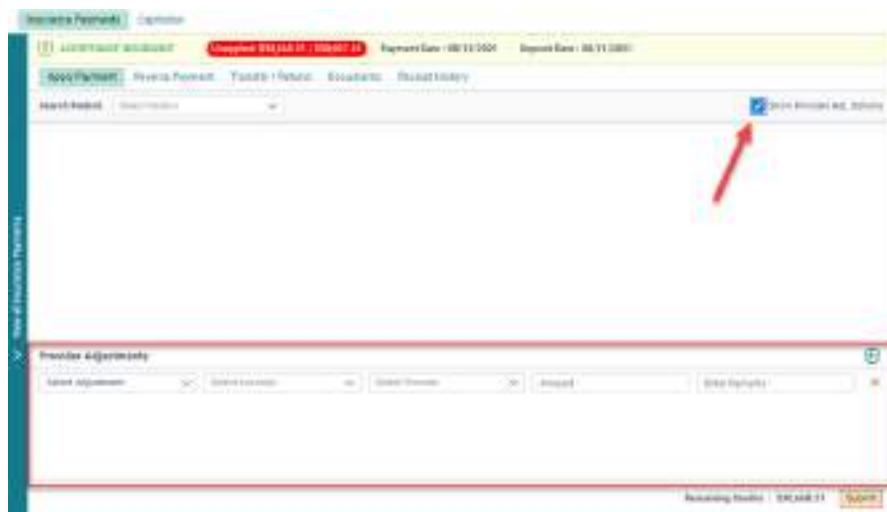
Written by Mathew Kandrickal | Last published at: August 15, 2021

## Provider Adjustments

Provider adjustments are basically not associated with a production or procedure code that was completed or claimed.

- It could be related to a claim or not as well.
- Provider-level adjustments can increase or decrease the transaction payment amount.
- Adjustment codes are located in PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1 and PLB13-1.
- The PLB is not always associated with a specific claim, but must be used to balance the transaction.

You can find the Provider adjustment option by navigating to System Menu > Insurance Payments > Select the Receipt > Check the 'Show Provider Adj. Options'.



The provider adjustment consist of 5 tabs :

- **Adjustment Type** - CareStack support two Adjustment types : Interest and Rebate
- **Location** - The specific location against which it is going to be tagged.
- **Provider** - The specific provider against which it is going to be tagged.
- **Amount** - The specified amount.
- **Remark**

Consider this example :-



When the user click on the submit button, the \$200 is going to be deducted from the receipt and is tagged against the provider.

The following will appear in the receipt history :

08/11/2021	Dr. Wimmer, Leinenweber (00021016) □	300123	The payment of \$29.12 was derived from: <b>ACCEPTANCE INSURANCE</b>	ALTMAN	BR → DBS	00012	186771	Revert 405. Callback
08/11/2021			Provider Adjustment of \$120.00 applied to: Type interest was applied to Dr Payment, H10.	BR → FRONT		\$120.00		AK, Kandrika, Marie

## Reversal

If the added adjustment needs to be reversed, the user can navigate to the **Reverse Payment** tab > Select the adjustment > **Reverse**.

Provider Adjustment						
<input checked="" type="checkbox"/> Instrument type	Period	Interest	Amount	Interest Rating	Comments	
<input checked="" type="checkbox"/> Interest	Interest	FRONT		000121	AK, Kandrika, Marie	

**Reverse**

# ERA

Written by Abhishek Vijay | Last published at: January 03, 2022

## What is an ERA?

An electronic remittance advice (ERA) is an electronic data interchange (EDI) version of a medical insurance payment explanation. It provides details about providers' claims payment, and if the claims are denied, it would then contain the required explanations. The explanations include the denial codes and the descriptions, which is present at the bottom of ERA. ERA is provided by plans to Providers.

EDI Health Care Claim Payment/Advice Transaction Set (835): is the specific code number for making claim payments and sending the explanation of benefits remittance advice.

ERAs are sent from the payor (insurance carrier) to the payee (the practice/provider) and the system maps the information received to the data in CareStack via a Parsing EDI process. Parsing an EDI, means to map all the segments in an EDI transaction file and uniquely mapping it to a segment in the corresponding file format.

Once the ERAs are parsed the same will be available in the left pane/ERA Slide out.

The Pending Posting section contains the ERAs which have not yet been posted.

The Posted section contains the ERAs which have been completely posted.

- The insurance posting agent can either proceed to complete the payment and once all the responses are completely posted, the ERA is pushed to the Posted section.
- The insurance posting agent can also manually 'Mark as Posted' the ERA which will push the same to the Posted section.

## ERA Details

- Carrier Information
  - Carrier Name, Carrier ICN, Carrier ID
- ERA Amount
- Payment Type
- Receipt
- EFT Effective Date :This field contains the date the record was approved for payment.
- EFT Trace # : The trace number links the ERA and the payment. It is unique within the sender/receiver relationship.
- Account #
- Routing # : The routing number is used to identify the financial institution from which the money was drawn.
- Total Patients

\*The ERA Details of a selected ERA, is available from the right pane of the Electronic Remittance screen.

## The Electronic Remittance Screen in CareStack

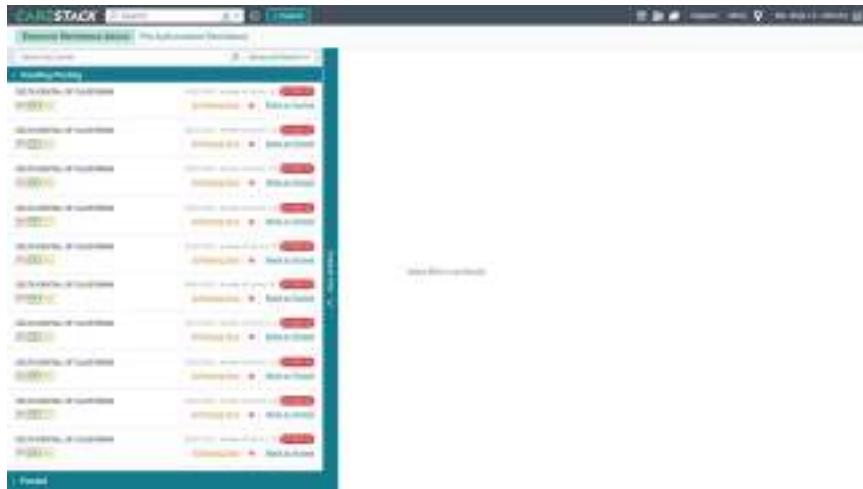
An insurance posting agent can navigate to the Electronic Remittance section by navigating to System Menu > Electronic Remittance.

The Electronic Remittance screen consists of two tabs:

1. Electronic Remittance Advice
2. Preauthorization Remittance

## Electronic Remittance Advice

The left pane/slide out consists of the ERAs sent to the practice from the payor.

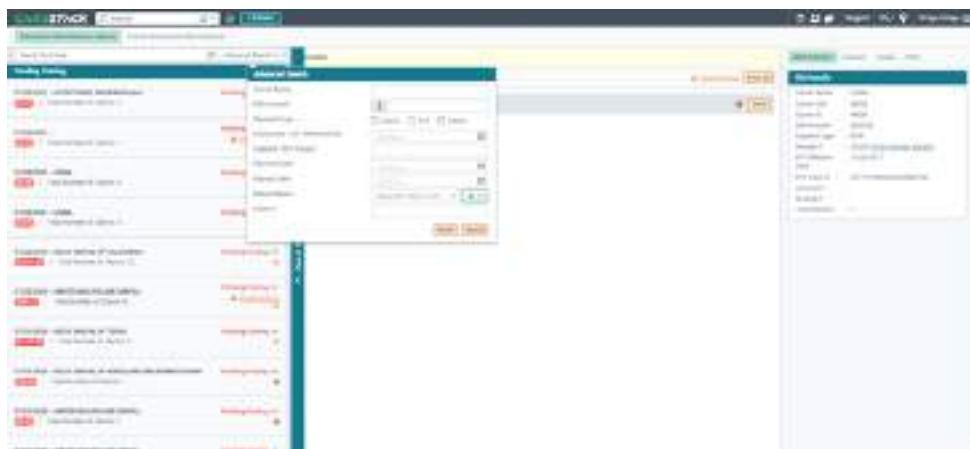


This provides the information such as:

- The payor name, insurance flags added to the receipt, the payment date of the ERA, number of claim responses within the ERA.
- The amount of payment. (Red if a receipt is not yet created / Green if a receipt has been created).
- If any Parsing Errors were experienced, the same is shown on the slide out, which the insurance posting agent can click to access the detailed error information.
- The **Needs Attention** / **Partially Posted** / **Posted** icons denote whether the ERA is yet to be posted/partially posted/completely posted.
- The insurance posting agent is provided with the 'Mark as Posted' functionality to manually push the ERA to the posted section.

The Search box works by filtering the responses with the Carrier Name as the search criteria.

The insurance posting agent is also provided with an Advanced Search option, which will allow the insurance posting agent to search using more specific details and specific criteria.



**The Claims Payments section consists of the responses made by the carrier against a claim.**

Upon opening the claim accordion, the details such as the patient info, procedure info and charge lines detailing the procedure and the fee/adjustments are available.

The screenshot shows the CareStack software's Insurance Payments screen. The main area displays a grid of payments with columns for Date, Payment Type, Amount, and Status. A specific row is highlighted in red. To the right, there is a detailed view panel for a selected payment, showing patient information like Name, Address, and Phone number, along with payment details and a summary table.

## How to post an insurance payment from an ERA?

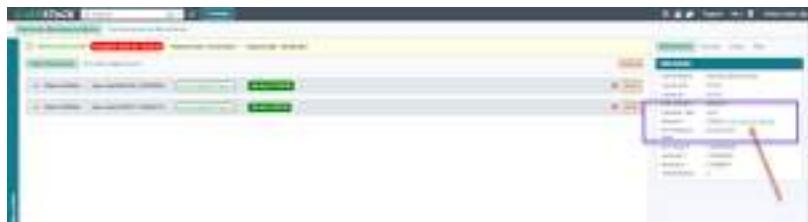
1. Add Payment using the ERA response.



2. Enter the required details like creating a receipt from the Insurance Payment screen. (\*\*The Carrier Name and Payment Amount are disabled as this information is taken from the response)

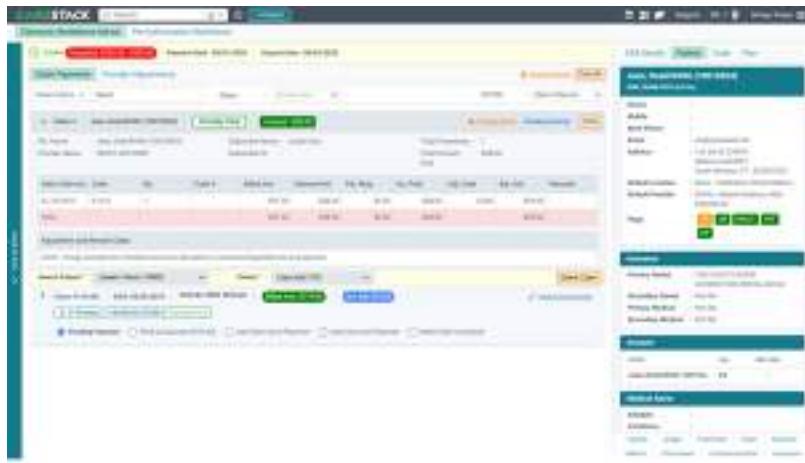


Once a receipt is created, the Receipt # is shown and the same can be accessed from the Insurance Payment screen.



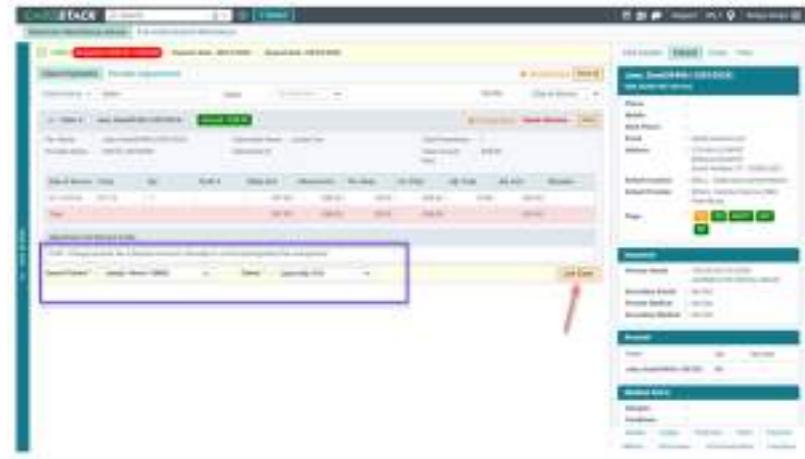
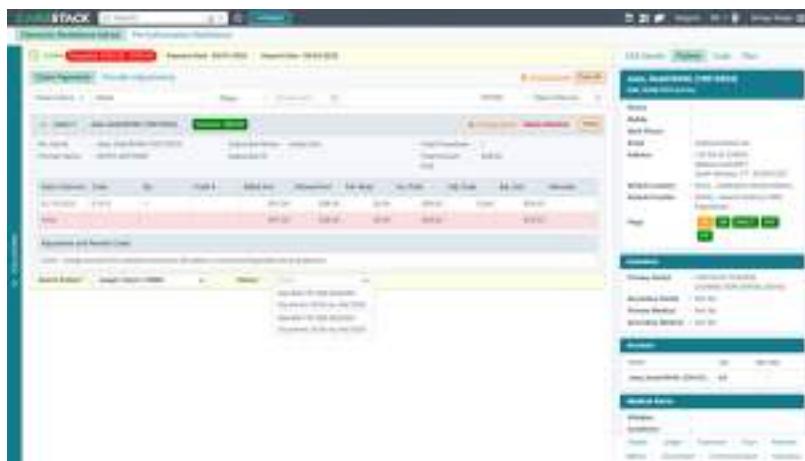
3.

- a. If a claim has been mapped correctly to a patient/claim in CareStack, (i.e. no parsing errors) then the payment can be posted from the claim like the Insurance Payments screen.

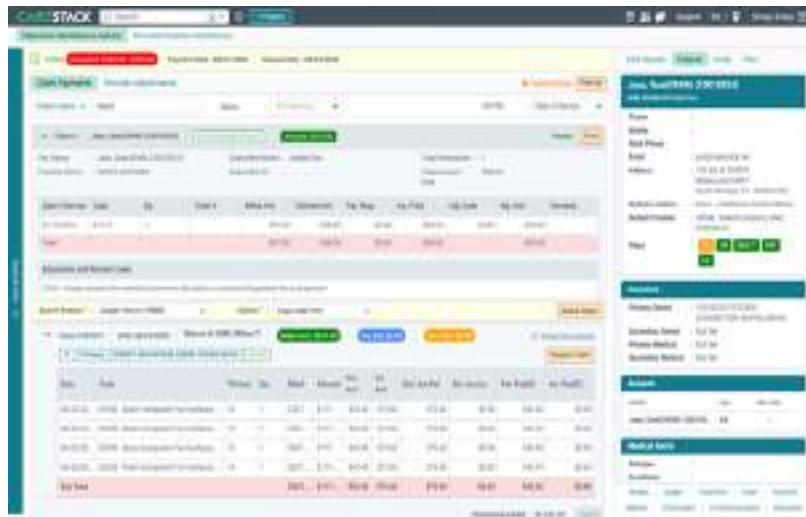


The insurance posting agent can proceed with 'Paid as Expected', 'Add Claim Level Payment', 'Add Line level Payment' or 'Mark as Denied'.

- b. \*\* If the claim has not been mapped properly (i.e., Parsing Errors are present), the claim response status would be in '**Needs Attention**'. If this is the case, the insurance posting agent can manually select a Patient and corresponding claim inside CareStack and link it to the same. This would change the status from '**Needs Attention**' to '**Pending Posting**'.



4. Once the claim has been linked/mapped, the insurance posting agent proceeds with the payment options available, and once the linked/mapped claim is in 'Closed' status, the status of the Claim Response will be changed to '**Posted**'.



## Provider Adjustments

The Provider Adjustments section allows the insurance posting agent to credit some or the complete insurance payment against a provider. This is useful in cases where the Insurance may overpay due to being late in remitting the payment and the practice prefers crediting it to the provider instead of the patient.

How to link a Provider Level Adjustment to a claim in CareStack?

- Once you have selected an ERA which has a Provider Adjustment segment, navigate to the Provider Adjustment tab. Click on the Associate Button to link a claim.



- Select the required Patient and Claim > Hit 'Save' to complete the action.



- A green success toaster will be shown denoting that the claim has been linked.



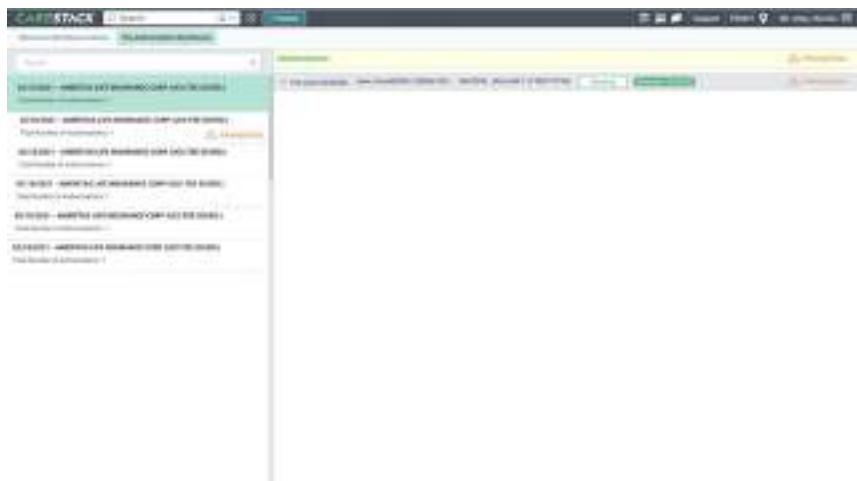
The insurance posting agent can proceed to another action or delink the claim, which will reverse the provider level adjustment, reinstate the credits, and unlink the claim.



## Pre-authorization Remittance



The insurance posting agent can select an ERA Response from the slide out and proceed with completing the Pre-Auth Response (i.e., Submitting the coverage information – Covered/Not Covered).

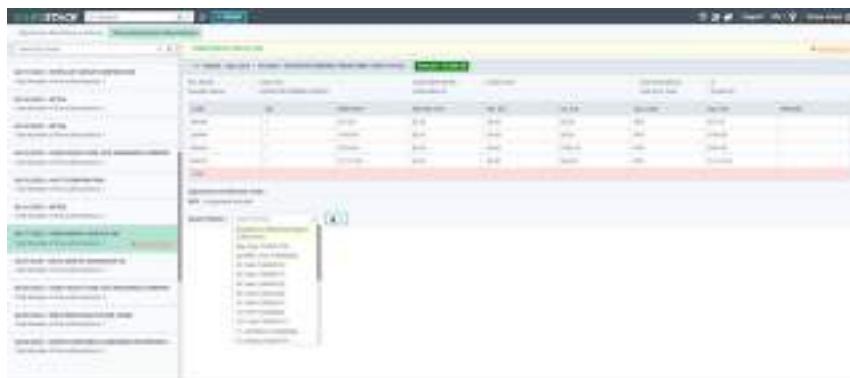


Like the Electronic Remittance Advice – Claim Payments, the insurance posting agent can either have a parsed/mapped pre-authorization response.

- If the pre-authorization response has been parsed correctly, then the insurance posting agent can proceed with the pre-authorization response directly.



- If there are Parsing Errors, then the insurance posting agent can manually select a patient and then proceed with completing the pre-authorization response for the required pre-authorization.



The completed pre-authorization response would be shown below.

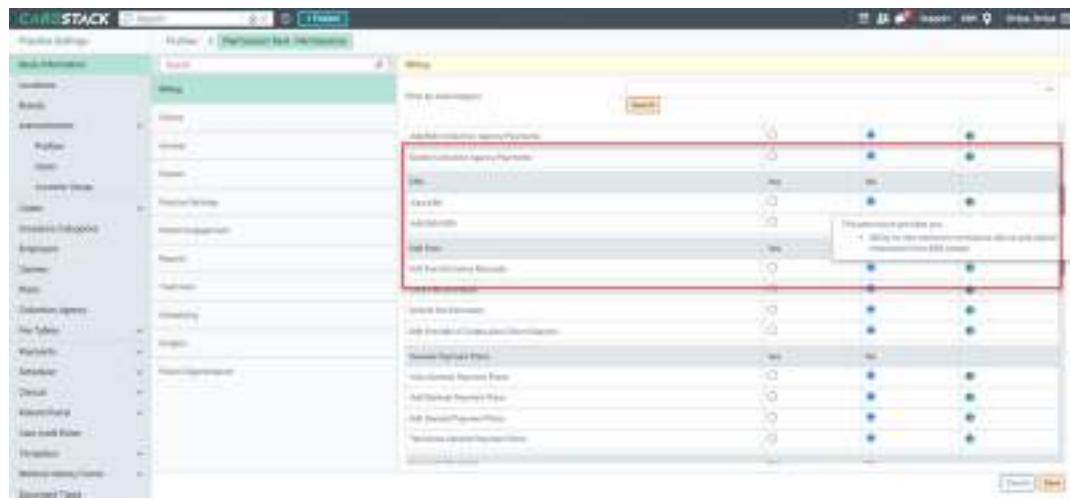


Once a pre-authorization response has been submitted from the ERA screen, the response section of the pre-authorization screen shows the response.

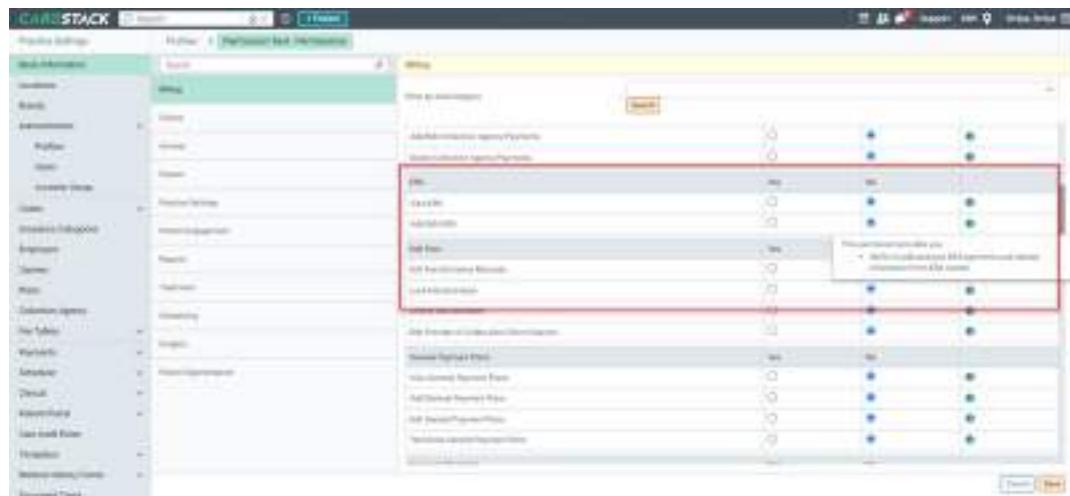
## Profile Permissions for Using ERA

The Super Admin can provide permissions to different user profiles to access the ERA information at different levels. The same can be managed from System Menu > Practice Settings > Administrations > Profiles > Manage Permission > Billing > ERA.

- View ERA



- Add/Edit ERA



## Advantages of Using ERA

- ERA usage allows the PMS to automate the activities within a practice with regards to remittances and insurance payments.
- Easier coordination of benefits processing: Allows for easy transmission of information, over manual scanning copying / attaching papers.
- ERA facilitates faster payments and reimbursements.
- Since ERA follows the EDI formats, this allows for easier standardisation.

## What is the difference between EDI & EFT?

**Electronic data interchange (EDI)**, or electronic data processing, is the electronic transmission of data between computers in a standard, structured format.

**Electronic funds transfer (EFT)** is the term used for EDI that involves the transfer of funds between financial institutions.

## ERA Auto-posting

CareStack provides the users with a built-in functionality of ERA Auto-posting, which is provided only by a few other competitors. The ERA contains all the information with regards to the insurance payment made against a claim. Since this is available, CareStack processes the information and posts/submits the payment against the claim to which it has been mapped. This allows the practice's insurance posting flow to be automated efficiently and saves time and manpower.

The user is provided with the same functionalities available while posting manually from the Insurance payments screen. But the auto-posting functionality automates the process to save the hassle for the user.

### How to enable ERA Auto-posting?

1. Navigate to System Menu > Practice Settings > Payments > Insurance Payments > ERA Posting.



2. Enable the 'Auto-post ERAs when available' by setting it as 'Yes'.



3. A central billing office user (generally) can also set the Auto-Posting preferences.

- a. Do not Auto-post ERAs with Payment Type: Enables the user to discard ERAs with the selected payment types, from the Auto-Posting flow.
- b. Default Payment Type for Check
- c. Default Payment Type for Direct Transfer
- d. Auto-Adjust at Claim Level: Allows the user to customise the adjustments added while auto-posting the payment amounts based on the ERA amounts, while posting claim level payments.
- e. Auto-Adjust at Line Level: Allows the user to customise the adjustments added while auto-posting the payment amounts based on the ERA amounts, while posting line level payments.

4. Hit ‘Save’ and you are ready to go.

**\*\*The adjustments added while auto-posting ERAs are the system adjustments which are available at System Menu > Practice Settings > Codes > Adjustment Codes > System Adjustments**



## How does CareStack post the ERA automatically?

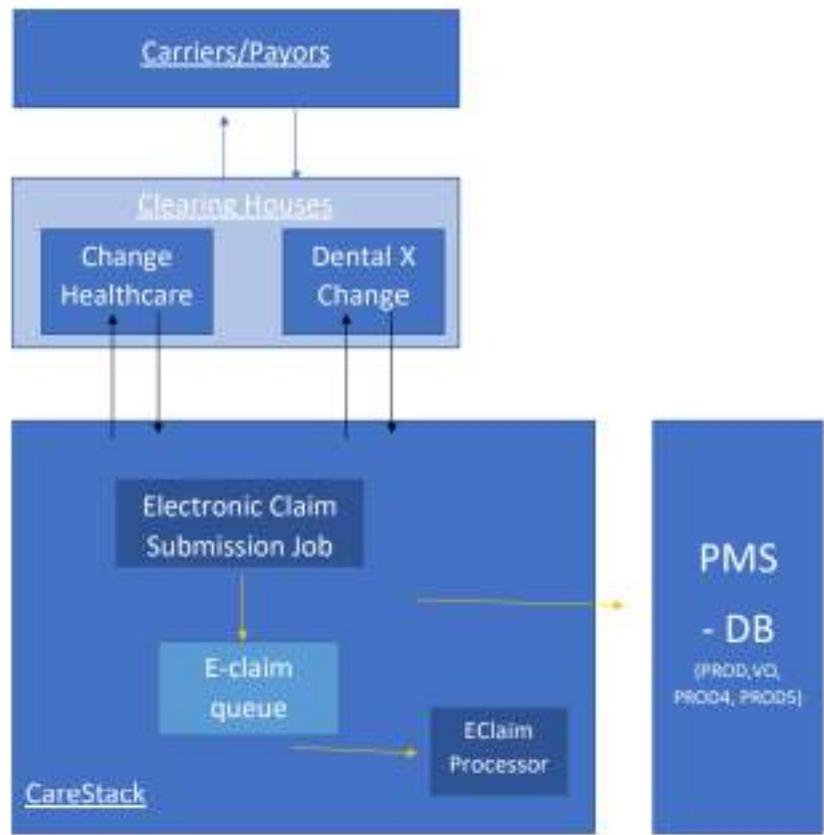
Before moving onto the ERA auto-posting process, let's discuss the statuses available to an ERA.

1. **Pending Auto-posting:** If 'Auto-post ERAs when available' is set as 'Yes', then the ERAs parsed are changed to this status by the E-Claim submission Job. ERAs having these statuses are not available to the user in the UI and are made available in the UI only after the Auto-posting job has been completed.

    - a. Creates an insurance receipt.
    - b. The ERA auto posting job picks up each claim response and then posts the payment accordingly (add adjustments if any)
    - c. Once the job is completed, it is sent either to the Pending Posting section or Posted section as per the status.
  2. **Pending Posting:** ERAs parsed correctly without any errors are made available to the user for manual posting from the System Menu > Electronic Remittance > Electronic Remittance Advice > Claim Payments tab of an ERA.

    - This status also has the ERAs which have been Partially Posted.
  3. **Posted:** If an ERA has been posted completely (either via manual or auto-posting flow), i.e., if all the claims mapped against the ERA are in Posted status, then the ERA would be available in the Posted section of the slide-out.

E-Claim Jobs



## ERA Auto-posting

**Auto Posting History** shows the list of auto-posting batches happened from the PMS. Details such as Batch#, Carrier Name, Check # / EFT Trace #, Receipt, Amount, Date of Posting, User, Status.

# Orthodontic Payment Plan - Guide Book

Written by Revati Krishnan | Last published at: August 19, 2022

## [Detailed Document on Ortho Payment Plans](#)

## Orthodontic Billing

Introduced 2 workflows for orthodontic billing:

1. Case level - Payment plans are created based on the case details. Here the ortho payment plans are dependent on the ortho case.
2. Plan level - New workflow where the user is given the flexibility to change the payment plan details irrespective of the case information. Here the ortho payment plans are independent of the ortho case.

This is an account level configuration a practice can set according to their requirement.

## Add a Case

Orthodontic cases provide the structure for the clinical and billing elements of the patient's orthodontic treatment. Remember that a patient may have multiple cases that represent different parts of the overall treatment. Before you begin, there are a few things you'll need:

- Treatment Start Date: The date you plan to begin orthodontic treatment. Your practice might use the day of the first consultation, or the day the treatment plan was signed.
- Treatment End Date: The date when the treatment is expected to end.
- Banding Date (Date of Service): The date that will be used as the date of service for the treatment and in the Claim Form.
- Treatment Code: The primary treatment code that drives this orthodontic plan.
- Periodic Billing Code: The treatment code that should be used for the ongoing claims sent to the carrier over the course of the treatment.
- The Patient Amount and the Insurance Amount: The relative total charges that will be billed to the carrier and to the patient over the course of the treatment.

1. Click the Add Case button.

2. Complete the fields as appropriate for your case:

3. Click Save.

## Clinical Elements

The Ortho Console includes several clinical elements to provide more details about the treatment.

### Treatment Objective:

A Treatment Objective is a way for the orthodontist to describe the treatment for the case outside of the context of ADA codes. After all, a code is just two sentences of general description.

To add a treatment objective:

1. Click Add Tx Objective.
2. Type the objective, tapping Enter to save.

### Visit Summary

A Visit Summary is a free-form description of an appointment that can be used to provide findings and additional details. You might appreciate being able to type notes outside of the Care Note function.

To add a visit summary

1. Click Add Visit.
2. Type the Details
3. Click Save.

### Clinical Notes

Having the clinical notes visible in the chart and in the orthodontic case makes it easy for the provider to review previous notes and to add new ones using CareStack's Care Note tool. Your practice will design your notes with the appropriate questions and prompts.

To add a note:

1. Click Add Note
2. Select the Care Note template from your practice's list and click Add Note.
3. Complete the Care Note as appropriate.
4. Click Finalize or Save as Draft.

## Orthodontic Billing - For Insurance

The Insurance Payment Plan connects all the elements of the case with the details of how the patient's insurance carrier will cover its portion of the cost of the treatment. For each of these tasks, you'll begin on the Payment Plans tab of the ortho console.

### Before You Begin

Before you begin entering the payment plan, there are a few things you'll need to do to prepare. First, gather the details of the patient's insurance benefits and orthodontic coverage from the patient's insurance eligibility page:

- The orthodontic maximum
- The percent of the cost paid as the initial payment -typically at banding
- The payment cycle or claim frequency
- Percent coverage borne by the insurance carrier.

Since you cannot change the case details once the payment plan is created, be sure to confirm your case details, especially the dates and amounts which are important for claims.

To build out the insurance payment plan, you'll need these details:

- Total Amount: The total amount the insurance will pay over the course of the treatment which cannot exceed the plan maximum
- Down Payment (Treatment Code Amount): The portion of the total amount the carrier should pay in the initial claim. Typically, this is the amount or percent paid at banding from the patient's insurance eligibility page.
- Number of Terms: The number of periodic payments the remaining insurance amount will be spread across. The number of claims may be different than this number of terms.

### Add an Insurance Payment Plan

Now, build the plan with these details. To add an insurance payment plan:

1. Switch to the Payment Plans tab if required.
2. Click Add Insurance Plan
3. Complete the details for the payment plan.
4. Click Save or Save and Print. This saves the payment plan in draft.
5. Now click on Start to activate the payment plan.

CareStack uses this information to build the billing schedule for those periodic payments.

### Initial/Periodic Billing

View the payment schedule by clicking the View/Update Schedule link on the payment plan summary.

### Edit a Plan

You carefully built your insurance payment plan so the insurance carrier would pay the initial payment and each periodic payment after that until the treatment was paid for. But things happen and sometimes you'll need to change or give up on a plan.

You would edit an insurance payment plan to change the number of payments or the treatment amount. To edit an insurance payment plan:

1. Switch to the Payment Plans tab if required.
2. Click Edit.
3. Update the relevant the details for the payment plan. Though it looks like you can change the plan, you should terminate the plan and create a new one for the new carrier.
4. Click Save.

### Terminate a Plan

You would terminate an insurance payment plan to change carriers, or if the patient is discontinuing treatment.

When you terminate a plan, you must decide what to do with the remaining scheduled payments. Your options are:

- **Push to Patient:** Push the balance of the remaining payments to the patient. From there, you can take further action.
- **Push to the Patient and Write-off:** Pass the total balance of the remaining payments to the patient and write it off in the same step.

- **Convert to a Patient Payment Plan:** Pass the payment schedule in its current form to the patient.

To terminate an insurance payment plan:

1. Switch to the Payment Plans tab if required.
2. Click Terminate.
3. Add the Termination Date and click Continue.
4. Select how you will handle the remaining balance.
5. Click Terminate.

The plan will remain on the Payment Plans Tab with the Terminated label. You can still review the details and original payment schedule.

## Orthodontic Billing - For Patient

The Patient Payment Plan connects all the elements of the case with the details of how the patient's insurance carrier will cover its portion of the cost of the treatment.

### Before You Begin

Before you begin entering the payment plan, there are a few things you'll need to do to prepare. Since you cannot change the case details once the payment plan is created, be sure to confirm your case details, especially the dates and amounts which are important for claims.

To build out the patient payment plan, you'll need these details:

- Total Amount: The total amount the patient will pay over the course of the treatment.
- Down Payment (Treatment Code Amount): The portion of the total amount the patient should pay at the beginning of treatment
- Number of Terms: The number of periodic payments the remaining patient amount will be spread across.

### Add a Patient Payment Plan

Now, build the plan with these details. To add a patient payment plan:

1. Switch to the Payment Plans tab if required.
2. Click Add Patient Plan.
3. Complete the details for the payment plan.
4. Click Save or Save and Print.

CareStack takes this information and builds the billing schedule for those periodic payments.

### Periodic Billing

View the periodic schedule by clicking the View/Update Periodic Billing Details link on the payment plan.

Once the billing structure is in place, you still might need to work with it. For example, if the patient might need to skip one of the planned payments. To skip a payment:

1. Open the Periodic Billing Details.
2. Place a check mark beside the payment to be skipped.
3. Click Save.

CareStack will recalculate the remaining payments to incorporate the missed payment. If the patient is taking a break from treatment, you can pause the payment plan:

1. Click Pause

2. Review the schedule and click Pause.

When you are ready to resume the plan, click Resume and confirm. CareStack will recalculate the remaining payments.

### Edit a Plan

You carefully built your patient payment plan so the patient would pay the initial payment and each periodic payment after that until the treatment was paid for. But things happen and sometimes you'll need to change or give up on a plan.

You would edit a patient payment plan to change the number of payments or the treatment amount. To edit a patient payment plan:

1. Switch to the Payment Plans tab if required.
2. Click Edit.
3. Update the relevant details for the payment plan. You will only be able to change the patient total and the number of terms.
4. Click Save.

### Terminate a Plan

You would terminate a patient payment plan to change carriers, or if the patient is discontinuing treatment. When you terminate a plan, you must decide what to do with the remaining scheduled payments. Your options are:

- Push to Patient: Push the balance of the remaining payments to the patient. From there, you can take further action.
- Push to the Patient and Write-off: Pass the total balance of the remaining payments to the patient and write it off in the same step.

To terminate a patient payment plan:

1. Switch to the Payment Plans tab if required.
2. Click Terminate.
3. Add the Termination Date and click Continue.
4. Select how you will handle the remaining balance.
5. Click Terminate.

The plan will remain on the Payment Plans Tab with the Terminated label. You can still review the details and original payment schedule.

# Collection Agencies & Collection Payments

Written by Mathew Kandrickal | Last published at: August 14, 2021

Sometimes patients just don't pay their bills. The Practice tried. They prepared the treatment plan with the estimates and accepted payments when they could. They sent letter after letter. Maybe they even made a payment plan arrangement, but the patient still can't or won't pay. When the practice is ready to quit and pass the work over to a professional Collection agency. CareStack can help with that part too.

## Collection Agencies

The user need to setup a Collection Agency, the professional organization that can collect debts on their behalf, usually for a fee. They will find these settings in Practice Settings -> Collection Agency.

To add an agency:

1. Click **Add**.
2. Complete the details for the agency.



3. Click **Save** or **Save and Continue** to add an individual contact person to the agency.

## Patient Profile

Once the practice has decided to throw in the towel and pass the patient on to a collection agency, they would want to set the **patient flag**, or label, to show they've been sent to collections:

1. On the Patient Overview, click the **Edit Labels** link.
2. Select **Sent to Collections**.



## Permissions

The user would require the following permissions for the above mentioned.

Collection Agency	Yes	No	
View Collection Agency	<input checked="" type="radio"/>	<input type="radio"/>	
Add/Edit Collection Agency	<input checked="" type="radio"/>	<input type="radio"/>	

## Collection Payments

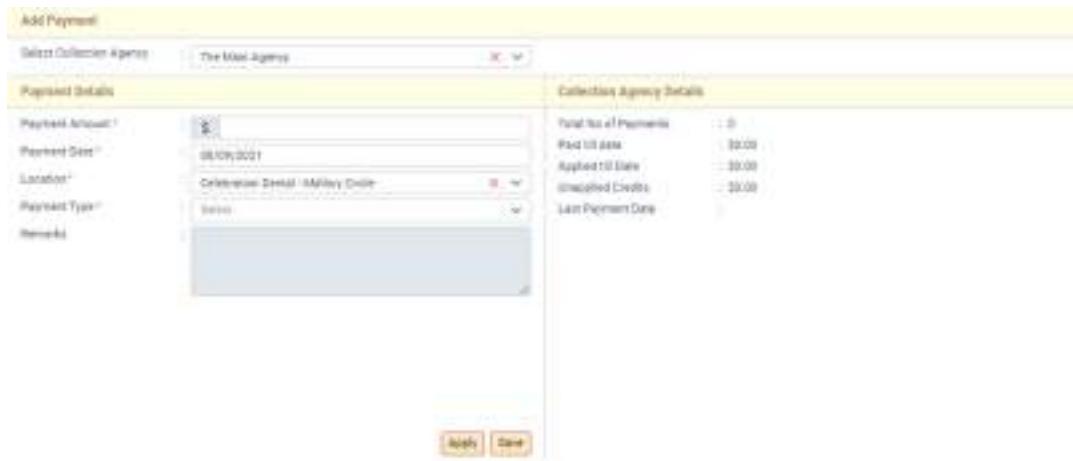
Once the practice send the patient details off to the collection agency, they wait. With any luck, that agency will be able to collect something from the patient. When they do, they'll send the funds and a statement. The user would have to enter the payment into CareStack and show how it should be allocated to the patient. Sound familiar? It's a lot like the work they do with insurance payments.

### Add a Collection Payment

It's important to capture the key details that identify the payment and transactions. We'll start at the Collection Payments module. *System Menu -> Collection Payments*.

1. Select the **Collection Agency** from the drop-down list.
2. Enter the payment details, including the **Payment amount**, **Date**, **Location**, **Payment Type** and **Remarks** pertaining to this payment.
3. Click **Apply** or **Save**.

On the right side we can see the Collection agency details including - Total No of Payment, Paid Till Date, Applied Till Date, Unapplied Credits, Last Payment Date.



Add Payment	
Select Collection Agency	The Mail Agency
Payment Details	
Payment Amount	\$100
Payment Date	08/09/2021
Location	Cedars-Sinai Hospital
Payment Type	Service
Remarks	
Collection Agency Details	
Total No of Payments	0
Paid till date	\$0.00
Applied till date	\$0.00
Unapplied Credits	\$0.00
Last Payment Date	

The Location will be populated from the current location shown in the upper right corner by the system menu. We can change it from the drop-down list. Many practices enter the date from the check or statement as the Payment date. The practice's guidelines can be followed here.

Some Payment Types need a reference. The field will appear when required. The new payment will be ready for to apply to the profiles. The list of payments and the receipt details will be found on the left side of the screen.

### Apply Collection Payment

Now we can apply the collection payment to the patient accounts. With the payment selected:

1. Select the Patient from the drop-down list. ONLY patients whose accounts have the "Sent to Collections" flag will appear.
2. Click Search to display a list of the codes the patient still owes a balance on. If desired, narrow the codes by date or provider.



3. Enter the details provided by the collection agency about what was paid to the practice and what was held as commission.

4. Click **Apply** when you are finished.

When the user clicks on **Apply** a warning message will pop up asking the user whether they want to remove the label Sent to Collection from the patient. They can click Yes or No.

## Adjustments

If the user is willing to accept the payment from the collection agency as the final word on the patient's balance, they can write-off the remaining amount with an adjustment directly in collections window:

1. Click the **More** link under the Adjustments column for the code line.
  2. Select the **Adjustment Code** used by the practice and enter the amount.
  3. Click **Apply**.

Collection Agency - The Main Agency										
Area: Monroe, Roma (00011005)		Submit a new	Select Provider	Search						
Date of Service / Code	Item #	Provider	Pmt. Amt.	Bal. Due Rec.	Total Pmt (\$)	Paid To Provider (\$)	Collection Commission (\$)	Pending Balance	Remarks	Adjustments
07/18/2021	00918	ALTMAN	\$120.00	\$306.00	176.00	100.00	30.00	\$10.00		100
Adj. Date:	4/20/2021	ADM OFF-Open X	46 APR (D)	\$0.00						
Category: Payment					Action: Subtract from Payment			Remarks		

**Note:**

After applying the above mentioned payment, the following will appear in the patient ledger:

08/08/2021	Forward Adjustment - AUS01-AU100T - Over-Drawn Revenue	\$0.00	\$0.00	\$0.00	-\$25.00	3001.00	Reversal
08/08/2021	Customer Correction - AUS12-AU100E - Suspension Fee	\$0.00	\$0.00	\$0.00	-\$30.00	2471.00	Reversal
08/08/2021	Rept. The Max Agency (Event: 00000000000000000000)	\$0.00	\$0.00	\$0.00	-\$45.00	(51.00)	Reversal

## Permissions

The user would require the following permissions for the above mentioned.

Collection Agency Payments	Yes	No	
View Collection Agency Payments	<input type="radio"/>	<input type="radio"/>	
Add/Edit Collection Agency Payments	<input checked="" type="radio"/>	<input type="radio"/>	
Delete Collection Agency Payments	<input checked="" type="radio"/>	<input type="radio"/>	

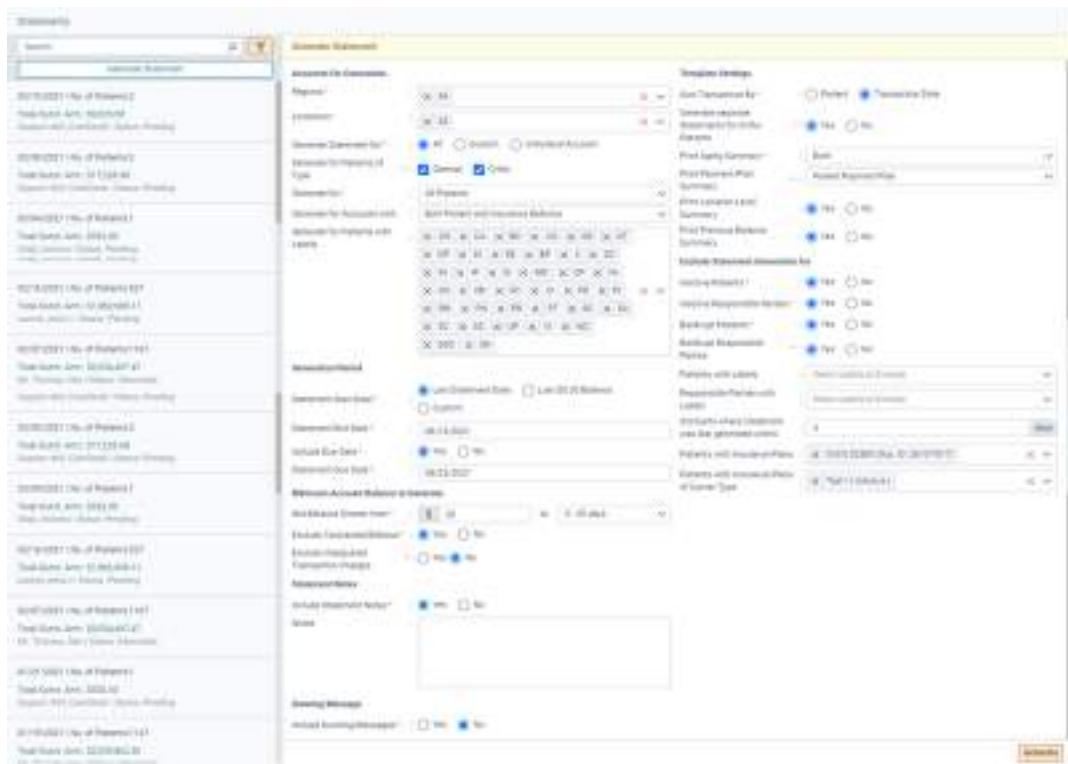
# Statements

Written by Rinu Seba Joemon | Last published at: August 31, 2022

## Statements

### Generation Criteria

Statements can be generated for an individual patient and an account. An account is a group of patients that share a common responsible party. Statements are addressed to the responsible party of the group. Users have the privilege to set default values in Practice Settings > Payments > Statements > Generation Criteria. Based on the values set there, the values would get populated by default while generating statements.



### Accounts for Generation

**Region:** This criterion is used to define the location where the statement needs to be generated. It would be All by default. Statements are generated for an account if the mentioned location(s) matches with the default location of the responsible party in the account.

**Location:** This criterion is used to define the location where the statement needs to be generated. It would be All by default. Statements are generated for an account if the mentioned location(s) matches with the default location of the responsible party in the account.

**Generate Statements for:** This criterion is used to define the accounts in the system that needs to be considered during statement generation. There are 3 choices:

1. All: Considers all the accounts in the system
2. Custom: Generates statements for accounts depending on the Last name's starting letter of the responsible party of the account. Users can choose the alphabet period. (For example, if A to E is selected, all accounts whose responsible party last name starts with letters between A and E (both inclusive) would be considered during statement generation)
3. Individual Account: Generates statement for a single account, whose responsible party was chosen from the drop-down

**Generate for Patients of Type:** A user can choose the account type of patients for whom statements should be generated for like **General and ortho**.

**Generate for:** The user can choose the 'Generate for' option to choose for whom all the statements should be generated. There are 3 choices

1. All Patients
2. Patients sent to Collection Agency Only
3. All Patients except those sent to Collection Agency.

**Generate for Accounts with:** A user can choose the accounts for which the statements could be generated. There are 3 options.

1. Both Patient and Insurance Balance
2. Patient Balance Only
3. Insurance Balance Only

**Generate for Patients with Labels:** A user can choose the labels so that the statements would be generated for patients who have specific labels. The dropdown shows all the patient labels.

### Minimum Account Balance to Generate:

- **Net Balance Greater than** This determines the minimum net account balance to generate the statements. The net balance of an account is the total balance of codes are eligible for statement generation minus the total unapplied credits of all patients who share the same responsible party.
  - **Exclude Contracted Balance:**
- Exclude Unadjusted Transaction Charges:** You can choose if you would want to exclude or not Unadjusted Transaction Charges

### Exclude Statement Generation for:

- **Inactive Patients**
- **Inactive Responsible Parties**
- **Bankrupt Patients**
- **Bankrupt Responsible Parties**

Setting the above options to **Yes**, would exclude statement generation for the corresponding patient/ accounts.

- **Patients with labels:** Select the labels from the drop-down
- **Responsible Parties with labels:** Select the labels from the drop-down
- **Accounts where the statement was last generated within:** Fill in the number of days
- **Patients with Insurance Plans:** Choose the patient from the drop-down.
- **Patients with Insurance Plans of Carrier:** Type: Choose the patient from the drop-down.

### Generation Period

- **Statement Start Date:** This determines the start date for a generation. There are two choices.
    1. Last Statement Date: Considers entries from the time statement were last generated for that account.
    2. Custom: Consider entries from the mentioned date. Future dates would be blocked from the corresponding date picker
  - **Statement End Date:** This determines the end date for generation, i.e. only those entries with transaction dates between the start date and end date would be shown as itemized entries. Future dates would be blocked from the corresponding date picker
  - **Include Due Date:** This determines whether or not to include the field "Payment Due Date" field within the statements
  - **Statement Due Date:** This field determines the date that would be printed as the due date. This is auto-populated with its corresponding setting in Practice Settings (Current Date + Default Period for Payment Due (setting in Practice Settings)
- 

### Statement Notes

- **Include Statement Notes:** This option determines whether or not Notes have to be printed on statements.
- **Notes:** Text area to enter notes that would be displayed at the end of the statements.

### Dunning Message:

Statement dunning is a process of gradually reminding patients about their overdue balances as they "age". If you would like to include dunning messages, select Yes, to select the note template you would like to use for each aging bucket (0-30 days, 31-60 days, 61-90 days, and 90+ days).

Dunning Message	
Include Dunning Message	<input checked="" type="radio"/> Yes <input type="radio"/> No
Aging in 0 - 30 days	Select Note Template
Aging in 31 - 60 days	Select Note Template
Aging in 61 - 90 days	Select Note Template
Aging in 90+ days	Select Note Template

### Template Settings

#### Group Transactions by Patient

- This determines how the entries would be sorted within the statement print. There are two choices:
- Yes: All the transactions in an account would be grouped patient wise and displayed in separate grids with separate opening and closing balances
- No: All the transactions of all patients in the account would be listed in a grid and would be sorted based on the transaction date of entries thus the entries of various patients would be mixed. So the grid also contains an additional column showing the patient name.

**Generate separate Statements for Ortho Patients:** This is set to **Yes** would generate separate statements for Ortho patients in the account.

For example: If Patient A, B, and C have the same responsible party D, and if patients B and C are ortho patients and A and D general patients, then if statements are generated with this option set as **Yes**, 3 statements would be generated for this account, all addressed to D. One for D and A (general patient) and one each for B and C. The statements would be 3 individual statements and would be printed on separate statements.

**Print Aging Summary:** This option determines whether or not the Aging Summary has to be printed on statements. There are 4 options:

- **Both:** Displays details of both patient and insurance aging
- **Patient Aging:** Displays a summary of only the balance due patient of the members in the account
- **Insurance Aging:** Displays a summary of only the balance due insurance of the members in the account
- **None:** Details of neither patient nor insurance aging would be displayed

**Print Payment Plan Summary:** This option determines whether or not the Payment Plan Summary has to be printed on statements. This grid would be hidden from the print if the account has no payment plans. There are 4 options:

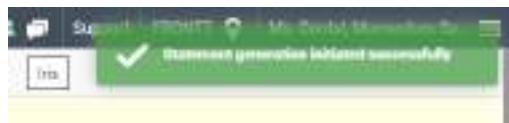
- **Both:** Displays details of both patient and insurance payment plans
- **Patient Payment Plans:** Displays a summary of only the patient payment plans in the account
- **Insurance Payment Plans:** Displays a summary of only the insurance payment plans in the account
- **None:** Details of neither payment plans would be displayed

**Print Location Level Summary:** This option determines whether or not the Location Level Summary has to be printed on statements.

**Print Previous Balance Summary:** This option determines whether or not the Previous Balance Summary has to be printed on statements.

When you are finished entering your statement criteria, click **Generate** at the bottom-right of the screen.

- **Note: It may take the system a bit of time to pull together the data required to generate your batch of statements.**
- When it is finished, you will see a green notification at the top-right of the screen, "**Statement successfully generated.**" The generated statements will now be visible on the patients' ledger.



Date	Inv. Code	Description	Batch/Line Number	Payer	PCP	Max Allowed	Std. Amt.	Pct. Amt.	Running Total	User ID	Name
08/13/2021		Statement created for 0141784 [11001-00000001]				\$0.00	\$0.00	\$0.00	\$0.00	Dentist	
08/13/2021		Statement created for 0141784 [11001-00000001]				\$0.00	\$0.00	\$0.00	\$0.00	Dentist	
08/13/2021		Statement created for 0141784 [11001-00000001]				\$0.00	\$0.00	\$0.00	\$0.00	Dentist	
08/13/2021		Statement created for 0141784 [11001-00000001]				\$0.00	\$0.00	\$0.00	\$0.00	Dentist	

## Review Your Batch Statements

Review your new batch of statements by clicking on its record listed on the left side panel.

## Take Actions on the Statements

**Exclude:** If a patient had a statement generated and you do not want to send it to them, you can toggle the same in the the **Exclude** column.

**Status History:** The info button in the status column, shows a timeline of the status history of the statement.

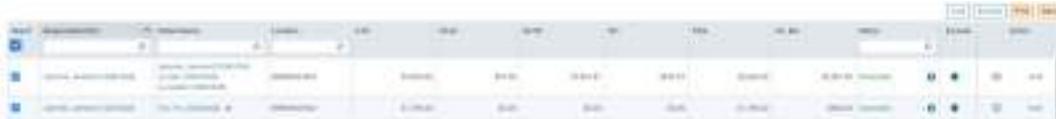
Timestamp	User Name	Action
11/03/2017, 11:15 AM	John Doe	Update
11/03/2017, 11:16 AM	Jane Doe	Void

## Action

**Print:** The print button allows the user to print the statement.

**Void:** The void button allows the user to void an individual statement. If the batch was generated on accident or with incorrect generation criteria.

*The user will also be able to do the same for multiple statements, once the user selects the statements and proceeds with doing the same actions available on the top right of the grid.*



**Send :** The user will be able to send the batch of statements to your patients, via the Printing & Mailing Service, if they have enabled the 'Use Printing and Mailing Service' as 'Yes' (*Practice Settings > Payments > Statements > Other Settings*).

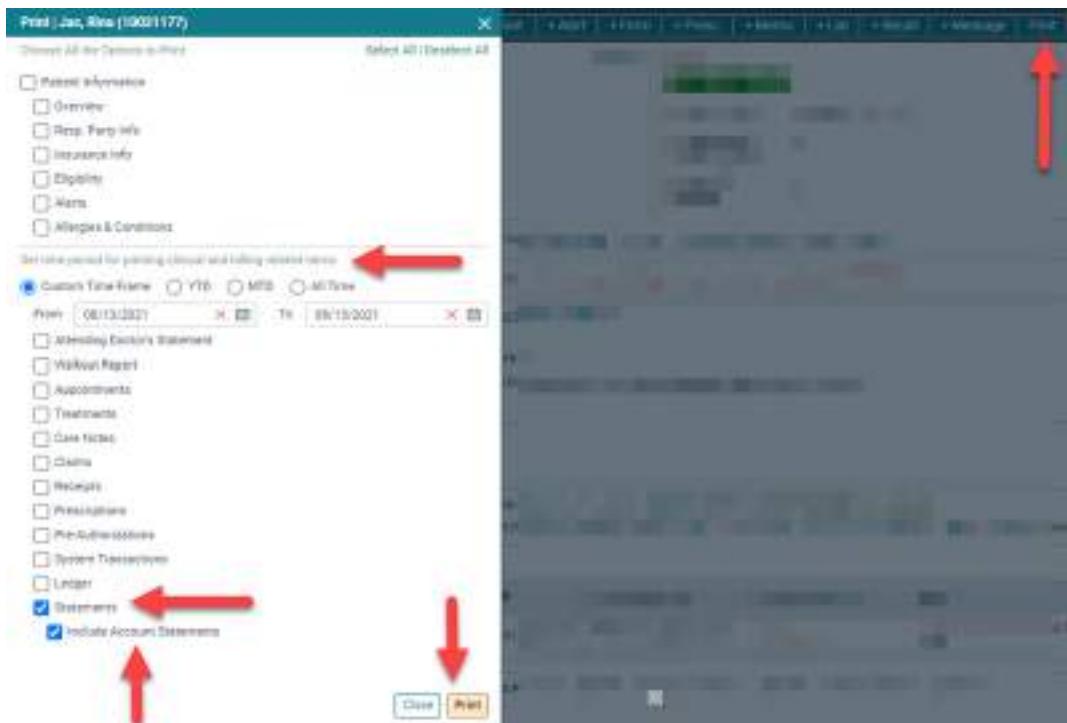


The header provides the batch level information and also helps the user download the additional data regarding the batch statement generation : Generation Criteria and Exclusion List.

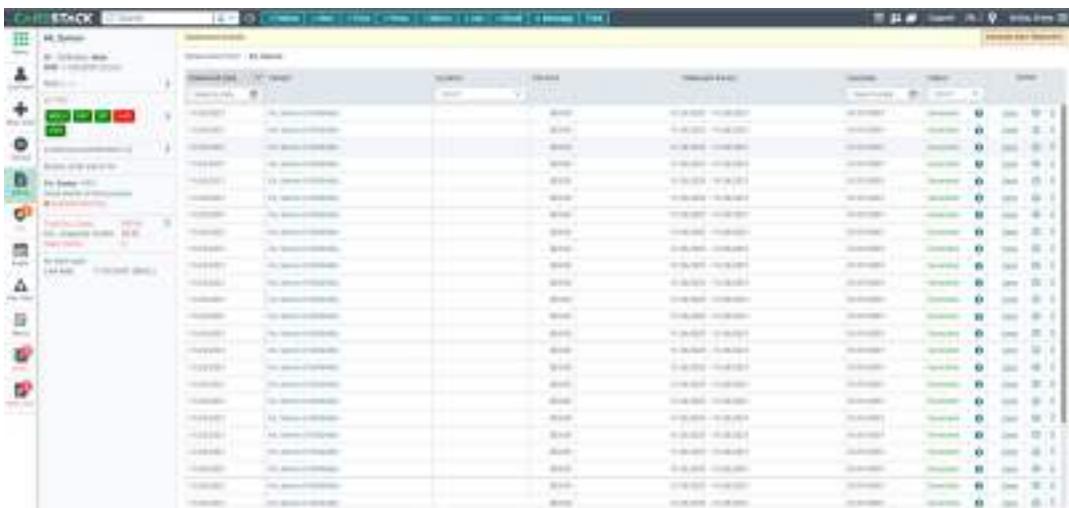
- If nothing happens when you click to download the statement, or when hitting the Print icon, you may have a Pop-Up Blocker.

## Generating a statement from a patient profile:

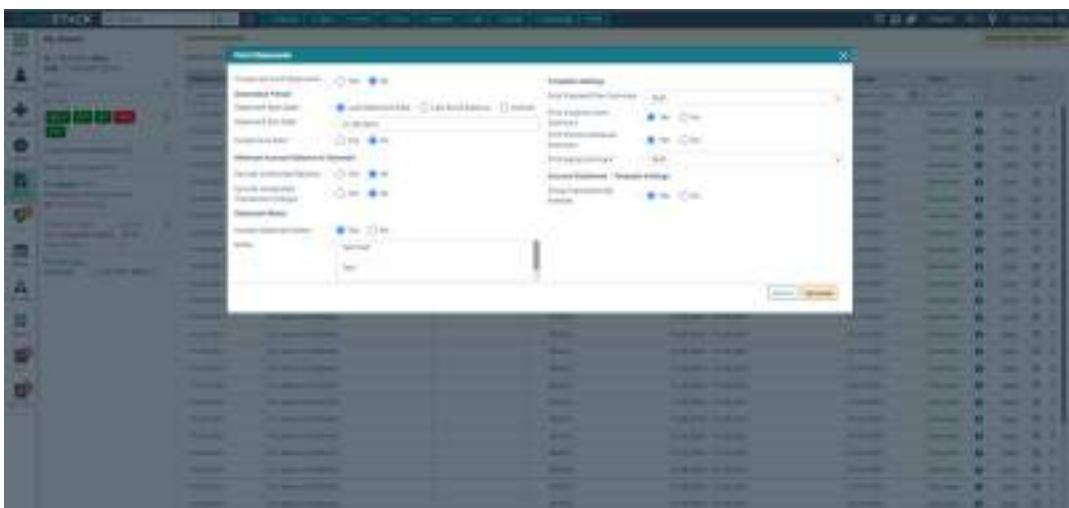
To generate statements from a patient profile you may navigate to the Patient's Billing > Statements / Patient's overview > Click on the Print icon > In the window that slides open > Set time period for printing clinical and billing-related items > Select **Statements** > You could also tickmark on **Include Account Statements** if you would like to view the whole account statements > Click on Print.



Upon navigating to the same, all of the patient's statement will be shown in a grid similar to the Batch statements screen.



The 'Generate New Statement' allows the user to generate a new statement for the patient. A set of generation criteria specific to individual statements will be shown where the user will be able to generate a statement for a specific account.



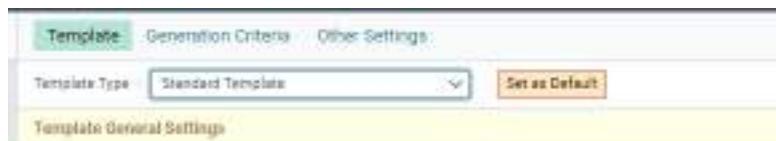
The user could proceed with generating a statement based on the criteria selected.

## Practice Settings

The user can edit three different categories of settings with regards to statements.

## 1) Template

**Template Type:** The user can select the template type they want and set the same default, by clicking on the 'Set as Default' button.



Upon selecting the same, the user will be able to edit the template general settings.

**Name of Billing Entity :** The user can enter the name of billing entity to be printed on the statements.

Front Side	
Name of Billing Entity*	Celebration Dental Group
Return Address:	
Practice Name to be Printed*	Account Name - Location Name
Address to be Printed*	Account Address
Address:	739 Back Street Suite 318 ████████ Somers, NY - 12345-6789
Phone	(887) 654-3210
<b>Residence Address</b>	
Practice Name to be Printed*	Account Name
Address to be Printed*	Custom Address
Address Line 1*	████████
Address Line 2	███████████████
Zip*	44444-4444
City*	Newton Falls
State*	Ohio
Phone	████████████████
	<input type="button" value="Verify"/>
	<input type="button" value="X"/>
	<input type="button" value="EXIT"/>

The options available for setting the Address (Return & Remittance) to be Printed are **Account Address**, **Location Address**, **Brand Address** (if enabled) and provision of a **Custom address**.

In the case of **Advanced Template**, the user can enter a **General Message** to be shown on the statement. This can be a general help text the user can set.



## 2) Generation Criteria

The user can set the default generation criteria they would want to have throughout the PMS, in the 'Generation Criteria' tab. The criteria have the same impact as the one in the batch generation context and patient generation context.



### 3) Other Settings

The ancillary settings regarding statements and the postal service are provided under the 'Other Settings' tab.

- *Use Print & Mailing Service* : Determines whether the Print & Mailing Service is to be availed by the practice. If set to Yes, the user will have the send button alongside statements and the exclude column (Excluded status too).
- *When an Account has a Balance in more than one Location, Send* : Determines whether to send combined statements or separate statements for patients when they have balances in multiple locations.



## Statement Templates

The different types of templates available are Standard Template, Print & Mail Service Template & Advanced Template (*new*)

### Standard Template

## Print & Mail Service Template

## Advanced Template

**That is all about statements. Take a look at this by yourself!**

# Dental Claims

Written by Aaqib Mohammed Sali | Last published at: August 15, 2021

## Overview

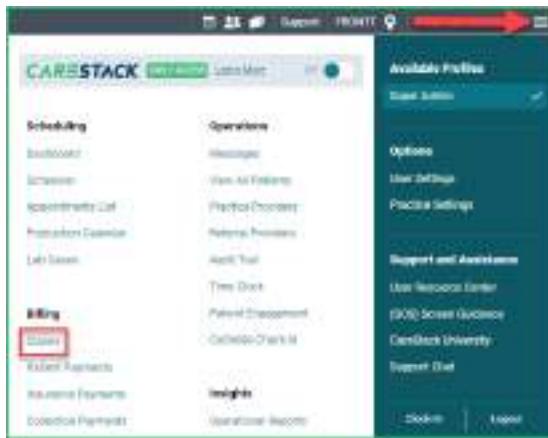
Insurance Claims are an essential part of your billing process. This is your way of requesting payment from insurance carriers for the care you have given and the treatments you have performed. CareStack has several tools dedicated to the claims process so that you can easily create, transmit, and track them.

## Explore the Claims Module

In the centralized **Claims** module, you are free from the context of an individual patient. In this global view, you can:

- Identify the claims of a given status
- See or work with an individual claim
- Transmit or print claims
- Look back at historical claims

Launch the **Claims** module from the **System Menu**.



## Claim Tabs

The claims module covers everything you ever wanted to know about your claims but were afraid to ask. The tabs in the module filter and display different categories of claims.

- **Claims Pending Submission:** Shows all the claims that are created, but have NOT been printed or transmitted to the clearinghouse. It's a great way to see the claims and check for errors before they leave.
- **Document Pending:** Holds the claims that require someone to add the attachments in the NEA App. These claims will appear in the app automatically.
- **Denied/Action Required:** The perfect reminder for claims you need to revisit. You'll find claims that the carrier has denied or only partially paid so you can work on them further.
- **Rejected:** Shows claims that were rejected out of hand. They often need more work too but are rarely as far along as denied.
- **Pending Payment:** This shows the claims that have been submitted to the carriers and haven't been rejected or denied, or even paid.
- **On Hold:** These claims are set aside by you or someone in your practice. They haven't been submitted and probably need research.
- **All Claims:** Holds all claims of all statuses all the way back to your very first CareStack claim.
- **Batch Jobs:** Instead of showing claims, you can create them in bulk.

## Column Headers

Even with the segmented tabs that group claims of a specific status, you may need to target your work even further. Narrow down your listed claims by choosing some filters.

Order ID	Customer Name	Order Date	Order Type	Status	Product Information		Total Price	Tax	Grand Total
					Product ID	Quantity			
ORD-001	John Doe	2023-01-01	Standard	Pending	PROD-001	10	\$100.00	\$10.00	\$110.00
ORD-002	Jane Smith	2023-01-02	Standard	Pending	PROD-002	5	\$200.00	\$20.00	\$220.00
ORD-003	Bob Johnson	2023-01-03	Standard	Pending	PROD-003	3	\$300.00	\$30.00	\$330.00
ORD-004	Sarah Williams	2023-01-04	Standard	Pending	PROD-004	2	\$400.00	\$40.00	\$440.00
ORD-005	David Lee	2023-01-05	Standard	Pending	PROD-005	1	\$500.00	\$50.00	\$550.00

Most frequently, you'll use these to:

- Display only claims for certain offices by selecting the office from the **Location** field all on any tab.
  - Display only claims for a specific carrier by typing all or part of the carrier's name in the **Carrier** field on any tab.
  - Display your closed claims by selecting the **All Claims** tab, then filter by claims in the **Closed** status.
  - Display claims based on the claim flags you've added with the **Claim Flag** filter.

You can use a combination of filters too. For example, on the pending payment tab, you might choose one location and one carrier. Besides filters, many of the column headers can be used to sort the list in ascending or descending order.

## Digging Deeper

With those sort and filter options, you can easily find the information you need about sets of claims that meet the criteria. But how do you learn more once you've found the claim?

Customer Name	Address	City	State	Zip Code	Phone	Email	Notes	Created Date	Last Update	Open Order
John Doe	123 Main St	Anytown	CA	90210	(555) 123-4567	john.doe@example.com	The customer is a frequent buyer.	2023-01-01	2023-01-01	Order #12345
Jane Smith	456 Elm St	Anytown	CA	90210	(555) 123-4567	jane.smith@example.com	The customer has a loyalty card.	2023-01-01	2023-01-01	Order #12346
Mike Johnson	789 Oak St	Anytown	CA	90210	(555) 123-4567	mike.johnson@example.com	The customer is a new customer.	2023-01-01	2023-01-01	Order #12347

Click within the claim's row to open the details of a specific claim

[View Claim](#) | [Claim #1186754](#) | Patient: **Sabriel, Shantel** | Claim Status: Submitted (Payor)

[Print Claim](#) [Attach Document](#)

**ADA American Dental Association® Dental Claim Form**

<b>Header Information</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Type of Payment: <b>Self Pay</b> <input checked="" type="checkbox"/> Insurance</li> <li><input checked="" type="checkbox"/> Treatment of Record <input type="checkbox"/> Previous Treatment/Prosthodontics</li> <li><input type="checkbox"/> Emergency <input type="checkbox"/> CDT</li> <li><input type="checkbox"/> Preferred Payment Requirements: <b>None</b></li> </ul>	Date Entered: <b>2023-01-12</b> <a href="#">Edit</a> <a href="#">Delete</a>
<small>For Professional Services Rendered Prior to January 1, 2023, Please Use Form CMS-1500.</small>	
<b>Patient/Provider Submission Information</b> <small>(For insurance companies listed in AII)</small>	

- On the **Details** tab, you'll find a nice summary of the patient, subscriber, billing and code information that was or will be sent to the carrier.
  - On the **Claim Form** tab, you'll find an electronic copy of the claim form, making it easy to review and work with any missing information. You can also add remarks for the narrative.
  - If your claim was denied or had a denial for a code, you will find the details on the **Denials** tab.

- Each tab shows the **Claim History** that illustrates the typical claim milestones like Saved, Submitted, Accepted, and custom flags and comments created by your practice.

## Generate a Single Claim

You have two different options for generating your insurance claims within CareStack, individually or in batches. Let's start simply with the individual claim.

You can easily create an individual claim by selecting the treatments to be included, either in the appointment or in the chart.

Whichever place you choose, to create a single claim:

1. Select the treatment(s) that should be part of the claim. Please note that the billing order for those treatments should be D or DD to bill to the carrier.
2. Right-click beside the treatments to open the pop-up menu.
3. Select Create Claim.
4. Confirm by clicking Ok.



## Generate Batch Claims

Imagine going the whole day working with your patients, but not doing anything with claims as you complete treatments or close-out appointments.

As the day winds up, you tell CareStack to review all the appointments, charges, and insurance information to create every claim all at once. You just decide when to kick off the process and what Date of Service to use. To kick off the batch, start at the Claims module, on the Batch Claims tab.

1. Click **Generate Batch Claims**.
2. Complete the details for the batch.
3. Click **Generate**.



When we say to complete the details for the batch, we are saying to describe the claims you want CareStack to create for you:



- **Claim Channel:** CareStack will create claims in Electronic, Paper-based, or in both formats. In the example above, CareStack will create claims in all channels (electronic and paper).
- **Locations:** CareStack will create claims for treatments completed in the selected location(s). In the example above, CareStack will create the claims for treatments completed only in the Downtown, University, and City Center locations.
- **Providers:** CareStack will create claims for treatments completed by the selected provider(s). In the example above, CareStack will create the claims for treatments completed by Dr. Pepper and Dr. Molar.
- **Date of Service Between:** CareStack will create claims for treatments completed with a date of service within and including the window. In the example above, CareStack will create claims for treatments completed between from November 30th to and including December 7th.

## Get Claims Out the Door

The carriers can't pay if the claim sits in your printer tray. Once they are generated, you need to get the claims out the door, either in envelopes or through cyberspace. Just as with creating the claims in a batch, the easiest way to get the claims out the door is to transmit them all at once.

We'll do that from the Claims module on the Pending Payment tab.

1. Click **Transmit All Claims**.
2. Click **Ok** on the confirmation message.



CareStack even saves you from yourself by NOT sending the claims that have errors, even if they are included in the category of "All".

If you do want to pick and choose which claims are sent or printed. You can do that too.

1. Select the claim(s) you want to send.
2. Click **Actions**.
3. Select **Transmit Selected Claims or Print Selected Claims**.



## Resolving Errors

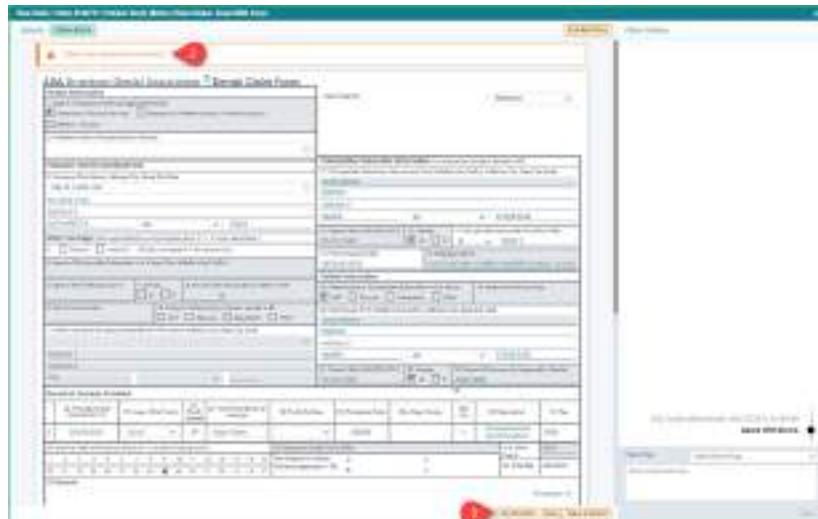
When a generated claim has an error or issue that needs attention, CareStack flags that claim as **Saved With Errors**.

While CareStack won't catch every potential issue that could cause the claim to be rejected, it will catch common errors from missing information, mismatched providers, and incomplete fields. To correct an error:

1. Click the claim row to open it.



2. CareStack will identify the error at the top of the claim form. Correct the error by completing the missing field or updating the information. The patient or provider profile won't change, but you will be able to submit the claim.



3. When you have corrected the error, click Save, Submit, or Print & Submit as appropriate.

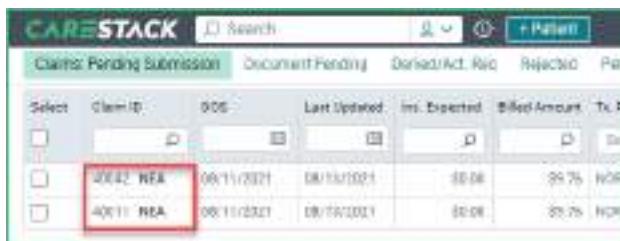
## Claims with Attachments

Many carriers require you to include attachments with your claims, but nobody wants documents flying back and forth through cyberspace. NEA Fast-Attach is a separate service that allows you to include the attachments the carriers want when you submit claims and authorizations using CareStack.

You will need to log into your NEA FastAttach application or portal to complete the document attachment process.

When you generate claims that need an attachment, CareStack will identify those claims for you with the NEA designation.

You'll add the attachments using the NEA application and its connection to CareStack.



In the NEA Application:

1. Double-click the claim row in the NEA App.
2. Select the method you will use to add the attachments. The steps will be a bit different for different types of attachments.
3. Describe the attachment by answering the prompt questions.

4. When you've added all your attachments for the claim, click Save.



Once you are finished adding attachments to all your claims, click Send to send the finished claims back to CareStack for transmission to the clearinghouse.



The claims and their attachments will be transmitted from CareStack in the next claims sweep at **8 PM EST**.

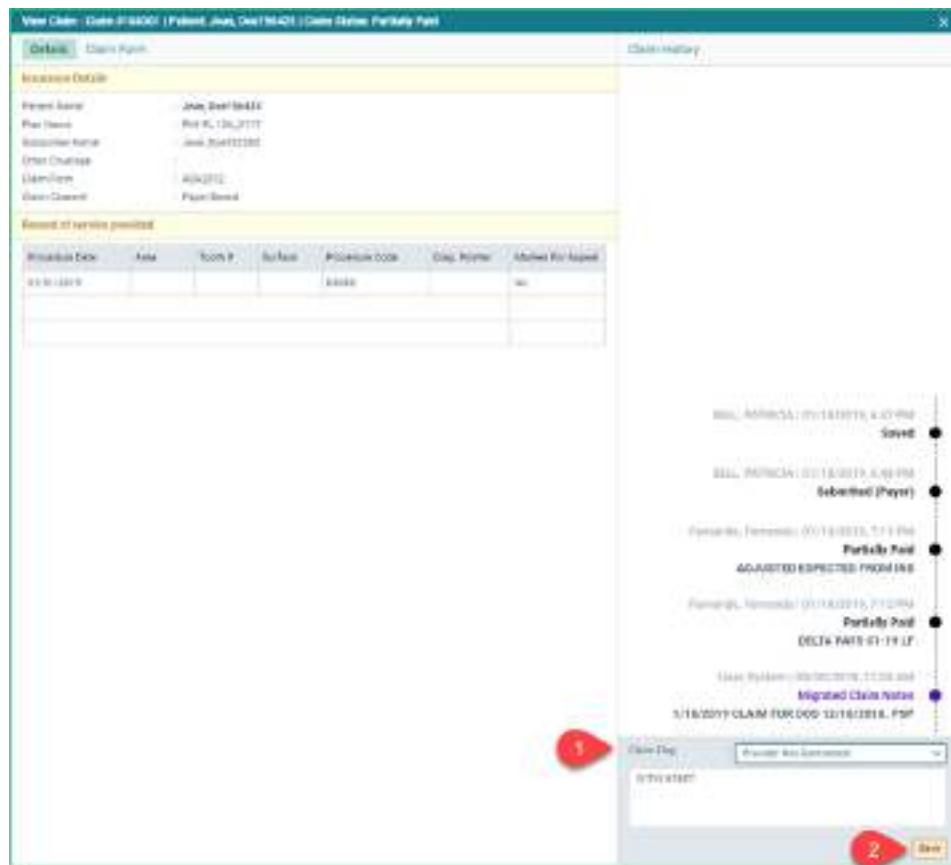
## Claim Flags

Each tab on the Claim Slider features the Claim History -a timeline of the claim's story. In the timeline, you can track the claim's path through typical milestones:

- CareStack timestamps from your actions -generating the claim, submitting it, etc.
- Automated responses from the clearinghouse -claim received or accepted.
- Flags and notes added by you and your team -what your team is tracking or describing. Many practices use flags to track communications with the carrier about the claim like messages from the carrier's website, conversations with carriers, and responses to carrier requests.

CareStack has provided a set of the most common milestones as claim flags. Your practice can customize or add to them. To add the claim flag:

1. Select the flag you want from the drop-down list. You can even add free-form text to add more details to the claim flags.
2. Click **Save**.



## Claims Gone Bad

Your claims won't always go according to plan. Despite your careful work, sometimes you need to crumple a claim and just start over. In CareStack you can do just that, literally or figuratively.

You might have to give up on a claim you created when:

- Completed codes were added after the claim was generated.
- There are incorrect codes in the claim.
- The patient had different insurance on the date of service and didn't tell you so your claim is for the wrong carrier.
- Your patient has secondary insurance they didn't mention.
- The tooth or surface is incorrect.
- Entries were completed and a claim was generated for the wrong patient.
- Some details are incorrect on the claim.

No matter what happened to get you to this place, there are three options for abandoning or updating the claim (Which of those you get to do depends on whether or not the claim has been transmitted (submitted) and what went wrong):

If the claim was NOT printed or Transmitted,

- DELETE:** You can delete a claim if it **only** exists inside the CareStack system. These claims can be found on the Claims: Pending Submission tab and have either the Saved or Saved With Errors status. After all, it doesn't count if the insurance company hasn't seen it, right?

Else if the claim was printed or transmitted, and the error was unrelated to the ADA codes within the claim or the patient,

- EDIT AND RESUBMIT:** You can edit and resubmit a claim when the issue doesn't impact the claim's underlying CODES. In this case, you can change the tooth number, surface, or subscriber details. You cannot change the code itself. Since the claims have been transmitted, they can be found on the Pending Payment tab. They don't even have to be accepted by the carrier yet, just on their way.

Else if the claim was printed or transmitted, and the error relates to the codes - incorrect code, too many codes, not enough codes, or to the patient.

- VOID:** You must void a claim if the error involves the codes or the patient and has left the CareStack system whether by electronic transmission or by printing. These claims can be found on the Pending Payment tab. They don't even have to be accepted by the carrier yet, just on their way. Once the carrier might see it and the codes are wrong, you've got to cancel the thing.

## Delete a Claim

If you've made a mistake on a claim that hasn't been submitted, it is easy to delete the claim draft and update the details for a fresh new claim.

You can only delete a claim that has NOT yet been printed or submitted.

To delete a claim, you'll work in the **Claims** module. Claims that can be deleted will be found on the **Claims: Pending Submission** tab. To delete a claim:

1. Select the claim to delete.
2. Click the orange **Actions** button.
3. Select **Delete** from the drop-down menu.



4. Click **Ok** on the confirmation window.

If you try to delete a claim that has been submitted, CareStack will warn you.



Whether you click Cancel or click Ok, your claim will not be deleted, and you'll be returned to the tab. Instead of deleting the claim, you'll have to void it.

Once you delete the claim, you'll need to return to the chart and make the needed corrections.

Once you've corrected the issue, the new and improved claim will be created when you or your team generates a batch job with that date of service or you can create the claim from the patient's original appointment.

## Edit and Resubmit a Claim

If you've made a mistake on a claim that you submitted, but the error doesn't affect the patient or code details, you can correct your mistake and resubmit it.

To edit and resubmit a claim, you'll work in the Claims module. Claims that can be edited will be found on the **Claims: Pending Payment** tab. To Edit and Resubmit a claim:

1. Select the claim and open the Claim Form tab.
2. Click the **Edit & Resubmit** button.
3. Update the details directly on the claim. Only the fields you can update are unlocked. You will not be able to update patient fields.
4. Click **Submit**.



5. Add the reason for your change and click **Ok**. This reason will be included in the claim history.

CareStack **DOES NOT** synchronize the changes between the claim and the clinical record.

**You must make any corresponding change in the patient's chart!**

Once you delete the claim, you'll need to return to the chart and make the needed corrections.

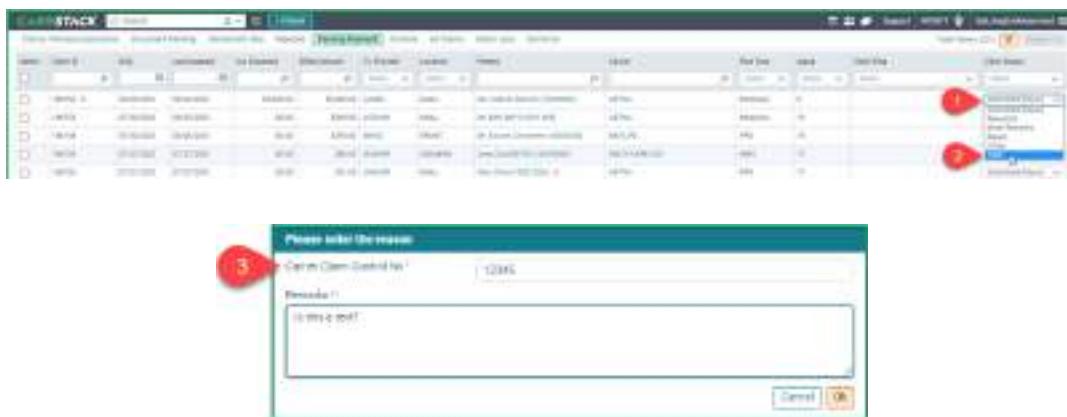
Once you've corrected the issue, the new and improved claim will be created when you or your team generates a batch job with that date of service, or you can create the claim from the patient's original appointment.

# Void a Claim

If you've made a mistake with the treatments, provider, or codes, on a claim you've submitted, you'll need to **void** it. When you delete a claim, it is as if it never existed. When you void a claim, there is still a record of the claim. It will still be listed in your All Claims tab and in the patient's ledger for your reference.

To void a claim, you'll work in the Claims module. You can work from the Pending Payments tab or the **All Claims** tab. To void a claim:

1. For the claim, you wish to void, click the **Status** drop-down.
  2. Select **Void** from the status list.
  3. Complete the details in the Reason window and click **Ok**.



Once the claim has been voided, CareStack will prompt you to regenerate the claim. If you've corrected the issue, click **Yes**. CareStack will create the claim right away. If you still have corrections to make, click **No**.



You must make any corresponding change in the patient's chart before recreating the claim.

## The Aftermath

Whether you have voided the claim or edited the claim and resubmitted it, chances are you need to make corrections to the code.

Your best tool for that is the **Code Snapshot**. Access it from the chart, ledger, or appointment by clicking the **code's link**.



If you were able to edit a code and resubmit a claim, you'll still need to make the corresponding edit in the Code Snapshot:

1. Change the surfaces if needed.
  2. Add a note to help communicate and document what happened.
  3. Click **Save**.

## Column Headers

For a voided claim, you'll need to remove the incorrect treatment code. However, a code cannot be simply deleted since it was once part of an active claim. Instead, you must cancel the code out:

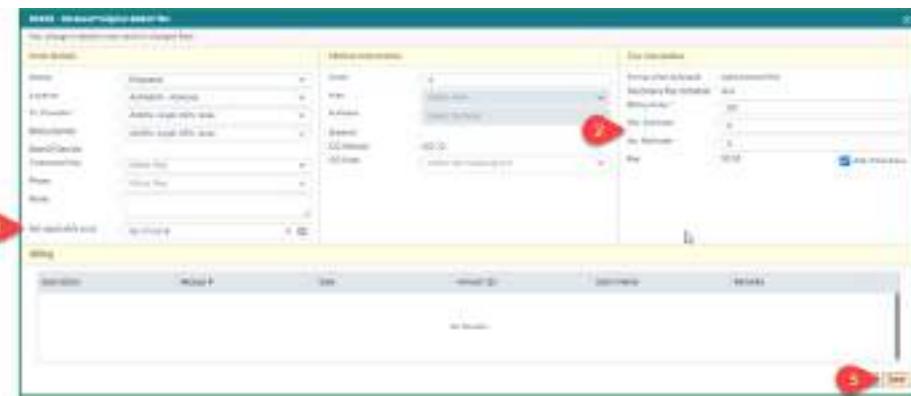
- Mark the treatment code as n/a.
- Change the fee to \$0.

In the Code Snapshot:

1. Add the date in the **Not applicable as of** field.

2. Change the **total fee** to \$0.

3. Click **Save**.



# Electronic Data Interchange (EDI)

Written by Athul V Suresh | Last published at: August 08, 2021

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business documents in a standard electronic format between business partners.

## ASC X12 Claim Transaction Life Cycle



In healthcare EDI, there are several transaction types. The following transactions, included in the 5010 version of HIPAA-mandated healthcare ASC X12 transactions, are used most frequently in the dental industry. Through the collaboration of our members, NDEDIC (National Dental EDI Council) works to standardize data sets and implementation guidelines that will maximize the value of the transactions for dental.

- **ASC X12 270: Eligibility, Coverage or Benefit Inquiry-** Allows providers to check whether a patient has insurance coverage, as of a specific date.
- **ASC X12 271: Eligibility, Coverage or Benefit Information-** A response to an eligibility inquiry stating whether patient has coverage and often providing additional information on patient benefits. NDEDIC is making great strides in promoting effective use of these eligibility transactions within the dental industry.
- **ASC X12 837: Health Care Claim Transaction-** Request for payment from a provider to an insurance company or a statement of the proposed services sent as a predetermination. This transaction can also be used to report encounter information. There are three types of claims: dental claims, medical claims, and hospitals claims, with each type of claim warranting its own transaction. The dental claim is referred to as the ASC X12 Health Care Claim: Dental (837D). Claims may be sent either in batches or individually. Individual claims usually are sent only when requesting Real-Time Adjudication (RTA).
- **ASC X12 999: Functional Acknowledgement.** Serves as a receipt for an ASC X12 837 claim or encounter file or the contents of an ASC X12 837 claim or encounter file, and offers information on the validity of the data content and syntax of the transaction. The ASC X12 999 is a superset of the ASC X12 997 Functional Acknowledgement transaction that was part of the first version (4010A1) of HIPAA-mandated X12 transactions for healthcare. The ASCX 12 997 is now obsolete. The following graphic illustrates the life cycle of a claim or encounter transaction.
- **ASC X12 277CA: Health Care Claim Acknowledgment-** Generated by an insurance company or clearinghouse to return information about the delivery or processing of a claim to the provider in a standardized electronic format. The ASC X12 277CA transaction is created without the need for the provider to request information using an ASC X12 276 Claim Status Inquiry. Today, many insurance companies respond to claims using their own report formats and/or electronic transaction formats. The ASC X12 277CA offers a common interface to the insurance company and the provider, thus standardizing the response. Because a claim may progress through several different statuses before reaching a final processing disposition, a provider may receive multiple ASC X12 277CA transactions for a single claim.
- **EDI Health Care Claim Status Request (276)-** This transaction set can be used by a provider, recipient of health care products or services or their authorized agent to request the status of a health care claim.
- **EDI Health Care Claim Status Notification (277):** This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient or authorized agent regarding the status of a health care claim or encounter, or to request additional information from the provider regarding a health care claim or encounter. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, is not used for account payment posting. The notification is at a summary or service line detail level. The notification may be solicited or unsolicited.
- **ASC X12 835: Health Care Claim Payment/ Advice-** Created and sent by insurance companies to providers. The transaction contains payment and adjudication information for multiple claims or predeterminations from an insurance company to a single payee (provider). The ASC X12 835 transactions are typically used when a

provider uses EFT (Electronic Funds Transfer) as a means of payment from the insurance company. NDEDIC is working to make the ASC X12 835 transaction more uniform and useful for the dental industry.

# Batch Claim Creation

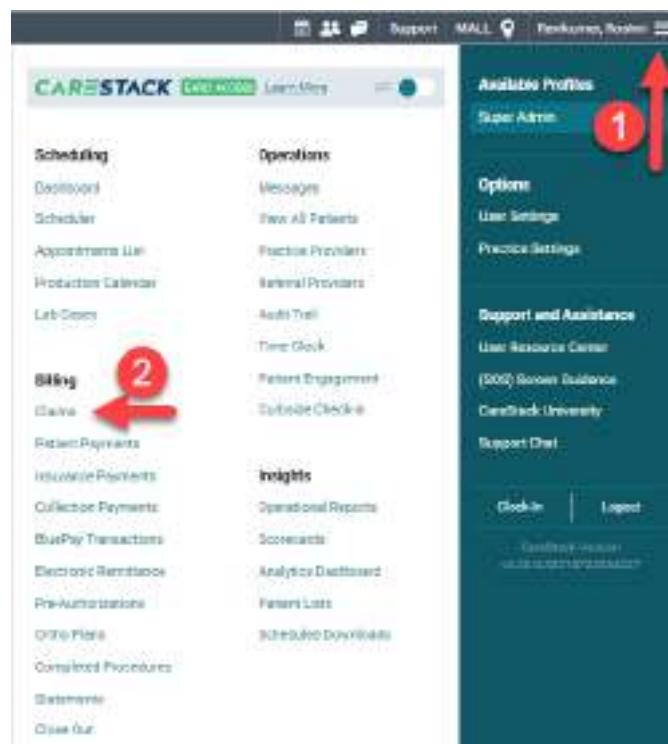
Written by Roshni R | Last published at: August 08, 2021

Imagine as the day winds up after reviewing all the appointments, charges, and insurance information and you just want to create every claim all at once, just like that. Yes!! That is possible within CareStack !!

You can just decide when to kick off the process and what Date of Service to use and these are in just a few clicks away. CareStack can do all the work to create every claim all at once

To kick off the batch, start at the **System Menu > Claims module > Batch Jobs tab**. Then,

- Click **Generate Batch Claims**.
- Complete the details for the batch.
- Click **Generate**.



The screenshot shows the 'Generate Batch Claims' dialog box. It contains four dropdown fields: 'Claim Type' (set to 'All'), 'Location' (set to 'SC - All'), 'Provider' (set to 'X - All'), and 'Date of Service Between' (set to 'Select a date'). A red arrow labeled '4' points to the 'Generate' button at the bottom right of the dialog.

When we say complete the details for the batch, we are saying to describe the claims you want CareStack to create for you:

- **Claim Channel:** Choose whether you want to batch your paper claims, electronic claims, or both.
- **Locations:** Choose the locations for which you would like to batch claims. This would list only the allowed locations for this user.
- **Providers:** Choose the providers for which you would like to batch claims.
- **Date of Service Between:** Generate claims for treatment completed within your selected date range, or leave the first date field blank to generate any claim that might have been missed in the past up till the date you enter in the second field.



In the example above,

- CareStack will create claims in all channels (electronic and paper).
- CareStack will create the claims for treatments completed only in Mallory location.
- CareStack will create the claims for treatments completed by all Providers.
- CareStack will create the claims for any days between from **July 19th** to and including **July 26th**.

Once you click on Generate, you will receive a green confirmation message at the top-right of the screen: "**Claim Generating Process Started Successfully**"



After this message, you will be able to see an icon stating "**Generating Claims**"



When the Claims have been successfully generated, a green toaster will appear at the top-right of the screen : "**Batch paper/electronic claim(s) have been successfully generated**"



After the Claim creation is completed , you would be able to see the status of the Batch Details in the Batch Jobs as **Completed** instead of pending. You can click on **Apply Filter and View Claims** to view the claims that have been created with details we used to create this batch.



The claims will soon appear in the **Claims: Pending Submission** tab.

**NOTE:** You will still need to transmit or print the claims. Click **View Claims** to go directly to the Claims module.

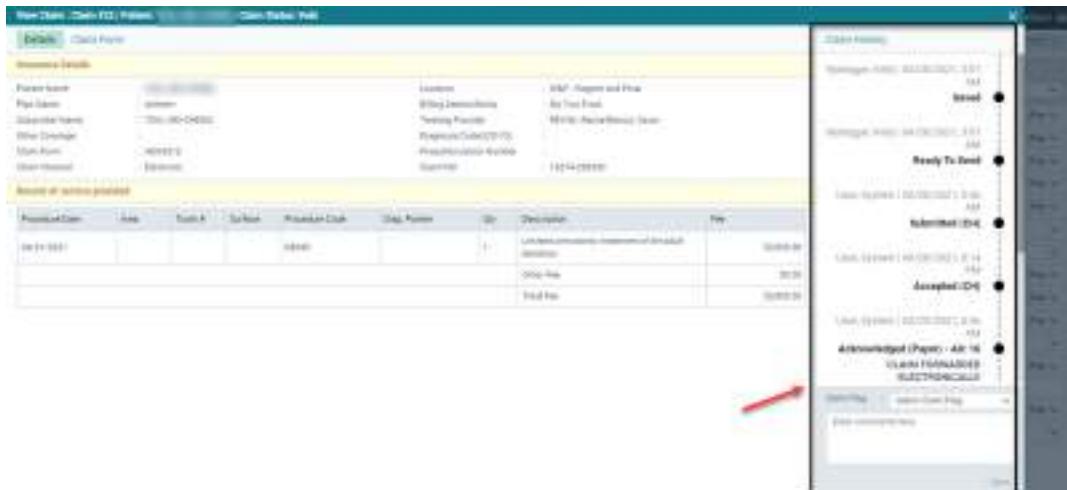
# Claim Flags and Claim History Timeline

Written by Rahul Krishnan | Last published at: August 08, 2021

## Claim Flags

Each tab on the **Claim Slider** features the **Claim History** -a timeline of the claim's story. In the timeline, you can track the claim's path through typical milestones:

- CareStack timestamps from your actions -generating the claim, submitting it, etc.
- Automated responses from the clearinghouse -claim received or accepted.
- Flags and notes added by you and your team -what your team is tracking or describing
- 



Many practices use flags to track communications with the carrier about the claim:

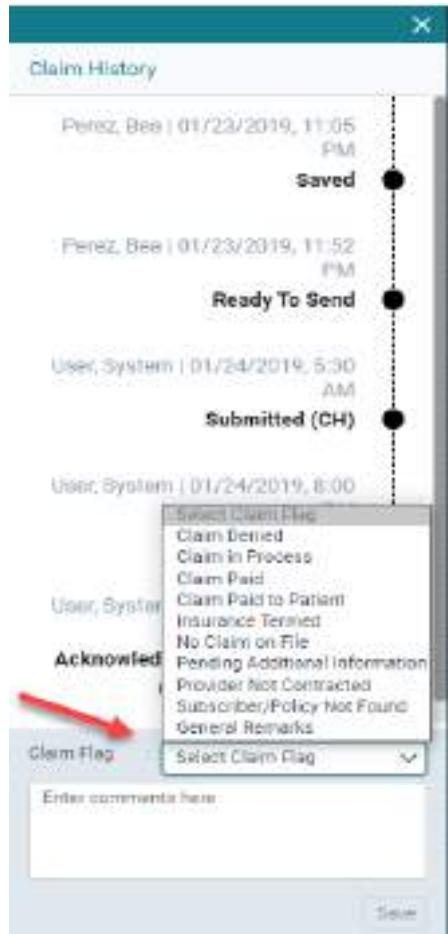
- Messages from the carrier's website
- Conversations with carrier's representatives
- Additional information needed by the carrier
- Responses to carrier requests
- Tracking or turnaround details
- Rejection reasons

## Adding Claim Flags

CareStack has provided a set of the most common milestones as claim flags. Your practice can customize or add to them.

To add the claim flag:

1. Select the flag you want from the drop-down list. The drop down list will display all the claim flags that are active. You can even add free-form text to add more details to the claim flags.
2. Click **Save**



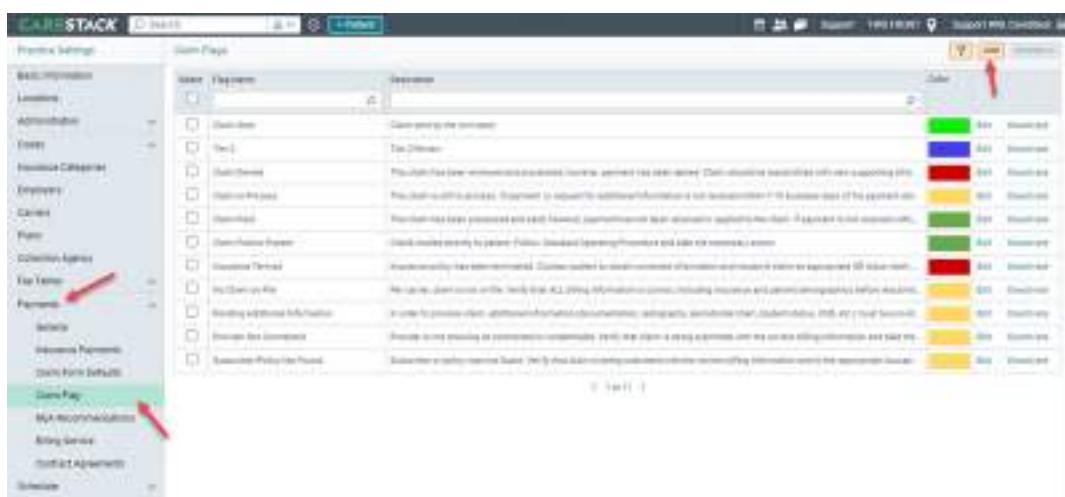
The claim flag will be added to the claim history and CareStack will automatically imprint the date and time as well as the name of the user who added that flag.



## Creating and Viewing Claim Flags

To view the current claim flags in your system:

1. From your system menu, navigate to **Practice Settings > Payments > Claim flag** option.
2. You can view all the claim flags that have been set for your practice along with the description and color. You can also see if they are active or inactive.
3. To create a new claim flag, click **Add** at the top-right corner.



4. A new line will appear on the grid:

- a. Enter the desired **Flag Name**.
- b. Add a **description** that will fully identify the purpose and use of the flag.
- c. Select the desired color to be associated with this flag.

5. Hit **Save** in the last column once you are finished.



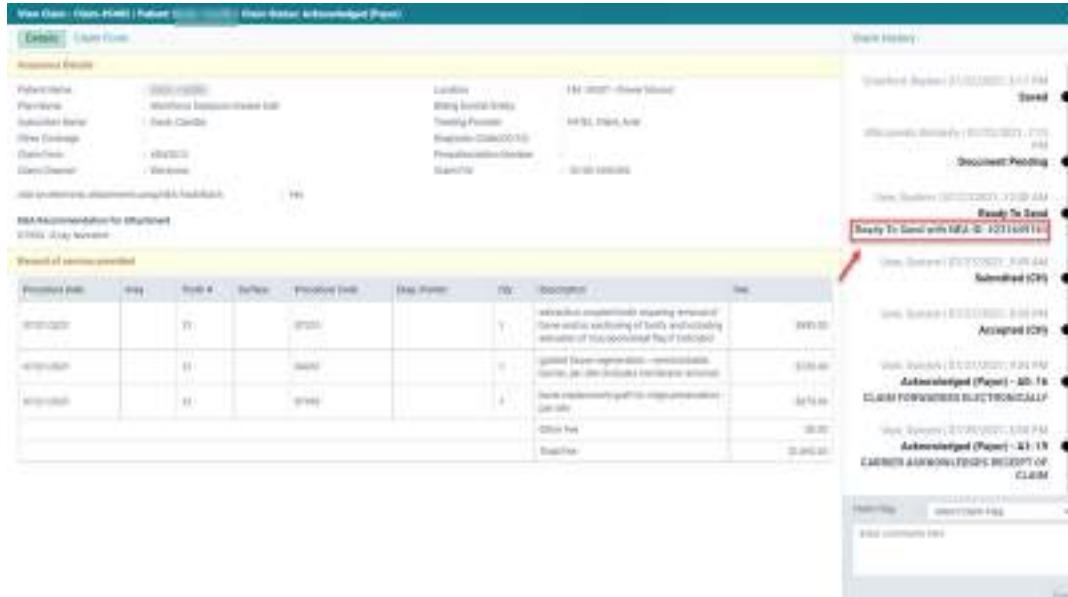
## Claim History Timeline

The claim history would be shown as a different section in the Claim Details modal. The last entry would be shown at first with the rest of the status shown above by scrolling up

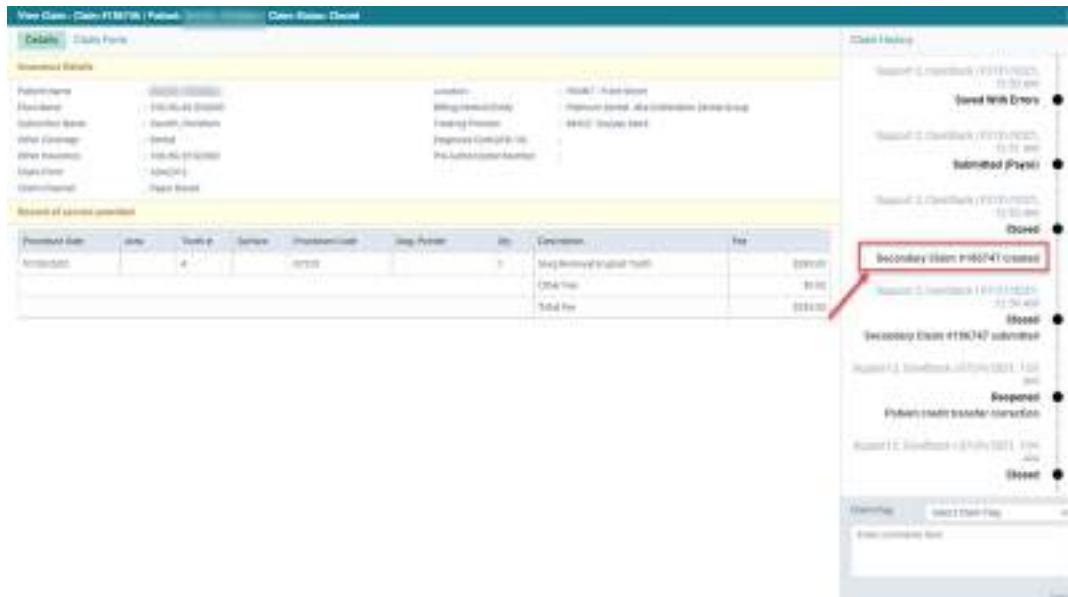
The Claim Statuses would be shown in blue color with each entry displaying the name of the user who changed the status, the timestamp of when it was changed and also if remarks or reference ids(NEA id) if available any.

Users would also be able to add custom claim flags to each status which would link that flag to the history timeline at the point of addition.

All active Claim Flags must be listed in a drop down from where user can choose a flag and add a comment to it and then post it to the history timeline which can be used to track the claim activity.



The below screenshot shows the claim status flow for a primary claim which has a secondary claim associated with it.



# Claim Status Flows

Written by Geo Thomas | Last published at: August 19, 2021

A claim can either be created manually for each patient, or it can be executed as a batch job. Whatever be the mode of claim creation, it passes through different stages. These stages are different for paper-based claims and electronic claims. In CareStack, each of these stages is known as a **claim status**.

## Paper-based claims

The paper based claims are those which are sent to the carriers either as a hardcopy via post or as an attachment via email.

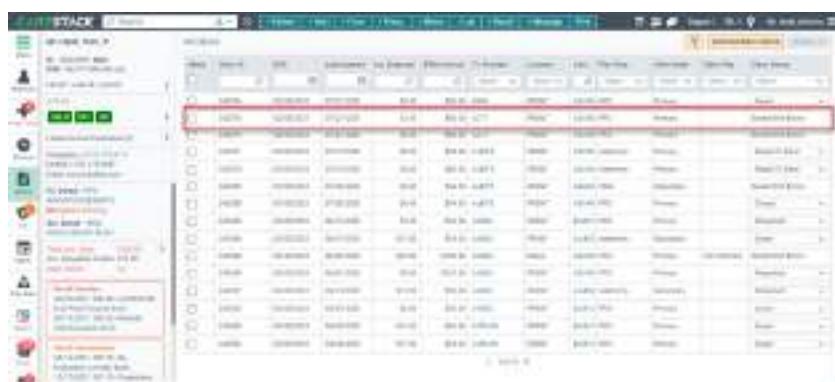
### Saved

When a claim is created, it will be in this status when all the required information are available



### Saved with Errors

If there are any errors or missing information, then the claim would be in this status upon creation. The user could click on the claim, correct the errors and then click **Save** which would change the claim status to **Saved**.



### Submitted(Payor)

When the user clicks **Print and Submit**, the claim status will be changed to **Submitted(Payor)**.





For a claim in this status, any of the following actions can be done :



If there is any error in the claim, it can be corrected and resubmitted to the carrier and claim status becomes **Resubmitted(Payer)**. When changing to this status, a mandatory remark has to be captured after which the claim form should be opened in edit mode with the current data pre-populated. There should be **Print & Resubmit** as well as **Cancel** buttons.



If the carrier requests to Enter Remarks for the claim, the required data can be entered and the claim is submitted again to the carrier. The previous status of the claim will be retained. A mandatory remark is to be captured on marking it so.

The claim can be **Voided**

The claim can be **Closed**

The claim can be marked as **Rejected**

If the carrier makes partial payments or rejects some or at least one of the procedure codes raised in the claim, the claim status will be changed to **Partially Paid**.

The user has the option to change the status of a claim to **On Hold** before submission once all mandatory fields are filled. This status is generally used for claims that shouldn't get transmitted alongside with other claims

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## Closed

When the claim raised is covered by the carrier, the claim status should be changed to **Closed**. A claim can be closed after posting payments or from the Claims grid. When a claim is closed, depending on the Billing order and insurance hierarchy of the patient higher order claims will be raised.



When a claim is to be closed, a warning, "Any remaining insurance balances will be pushed to the patient if there are no higher order claims to be raised. Are you sure you want to continue?", should appear with **Yes** and **No** buttons. Clicking on **Yes** and proceeding further, modal should appear to capture Carrier Claim Control No. It can be a max of 18 characters long and can hold any character. There would also be a provision to capture a remark. Both these fields are non-mandatory.

For a closed claim, the following options will be available

Create higher order Claim( If higher order claim is not auto-generated)

Reopen

Void



## Rejected

When a claim is rejected by the carrier, the claim status will be changed to **Rejected**. When a claim is marked as rejected, modal should appear to capture Carrier Claim Control No. This is non-mandatory. It can be a max of 18 characters long and can hold any character. There should also be a provision to capture a mandatory remark.



For a rejected claim, the following options are available

Resubmit

Reopen

Create Higher Order Claim ( depending on the billing order and insurance plan)

Close

Void



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## Reopened

A claim is reopened to revise or change the applied payments. For a reopened claim, it can be brought back to its previous statuses

Close

Resubmit

Rejected

If partial payments are done against a reopened claim, the claim status will become **Partially Paid**.



## Partially Paid

A claim becomes partially paid when any of the charge lines in the claim is marked for appeal during payments.



For a claim in partially paid status, any of the following actions can be done :

Resubmit ( Claim can be resubmitted with the charge lines marked for appeal)

Close

Void

Reject



## Resubmitted

A claim can be resubmitted when the claim sent was either rejected by the carrier, partially paid or carrier reports Error in Claim. The further actions for a resubmitted claim will be the same as that of a claim in **Submitted(Payor)** status.



## Void

This is the final stage a claim can ever be in. Once a claim has been voided, no further actions can be taken over this claim. When a claim is voided, the charge lines associated with the claim will become unbilled. A claim can be voided after entering the Carrier Claim Control Number(CCN) and the remarks associated. Both CCN and Remarks are mandatory fields.

: CCN can be a maximum of 18 characters long and can hold any character.



proceeding further, a warning "Do you want to generate a new claim from the void claim?" would appear with Yes and No buttons. Clicking on Yes, will void the claim and create a new claim with the details as in the voided claim and the new claim would be in **Saved** status.



All the details should be taken from the corresponding treatment plan of the patient



As mentioned before, the status of a voided claim cannot be changed further. The only option available would be to print the claim.



This option would be seen when the claim is opened.

Embedded content from <https://www.loom.com/embed/8dddec8dd1d34b0f88729413539b2ce0>

## Electronic claims

When a claim is created it will be saved in any of the following statuses

- Saved
- Saved with Errors

The user will have the option to change the status of a claim to **On Hold** after checking all validations.



For an electronic claim, electronic attachments can be added if the payor is supported by **NEA fast attach**. Electronic attachments may be required for some or all the procedures in a claim as mandated by the payor. Claims which have electronic attachment are being sent to NEA Fast attach.

Claims which are in **Saved** or **On Hold** status, and **Saved with Errors** statuses can be transmitted(sent to the carrier) by following any of these 3 methods:

- Manually opening the claims and clicking on the **Save & Submit** button



- Transmit all claims or Transmit filtered claims job from **System Menu> Claims**

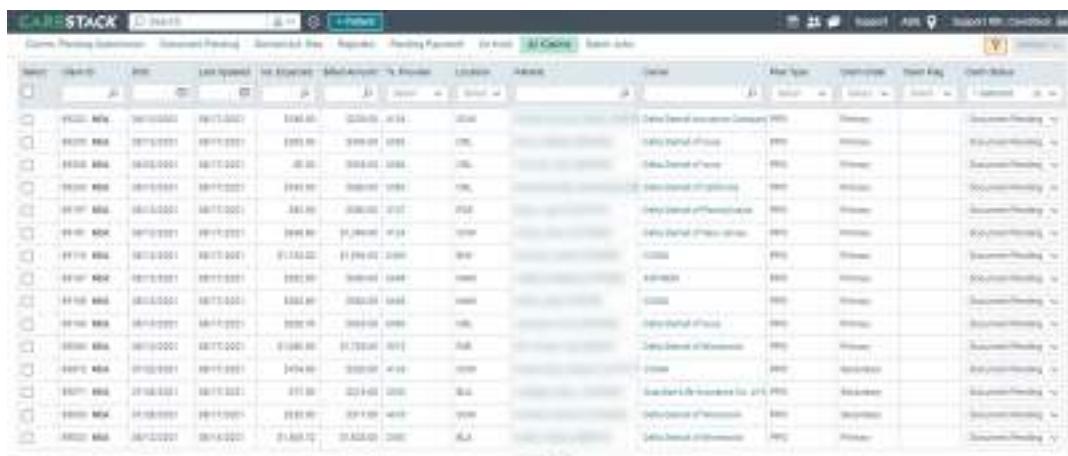


- Transmit selected claims from **System Menu > Claims > Actions**.



On transmitting an electronic claim from the system, the claim status will become **Ready To Send**.

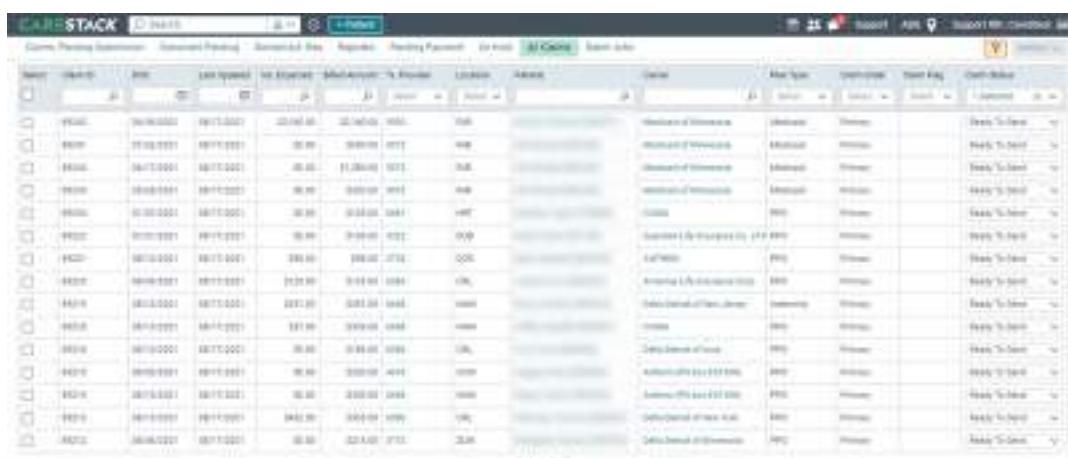
If the claim requires an electronic attachment then the claim status will become **Documents Pending**.



During the transmission process, NEA recommended codes which have **set electronic attachment** as **No**, being handled throws a warning toaster where the user can either send them to **NEA Fast attach** or can skip. Transmit job process always sends the NEA recommended codes to **NEA Fast attach**.

## **Stage 1: E-Claim Electronic Attachment Submission, Electronic Claim Submission/Resubmission**

NEA Status check job will check the status of **Document Pending** claims and changes claim status to **Ready To Send** or **Ready To Send(R)** once electronic attachment process completed in NEA Fast attach.



A claim in Document Pending status can be **force submitted** and the claim status will be changed to **Ready to Send** or **Ready To Send(R)**.

The Electronic Claim submission job which is being configured will pick up the claims which are in the above statuses and submits/resubmits those claims. The claim is submitted/resubmitted to the clearinghouse which would change the claim status to **Submitted(CH)** or **Resubmitted(CH)**.

## **Stage 2: Submission/Resubmission to Clearing House, Clearing House Response**

The claim statuses **Submitted(CH)** or **Resubmitted(CH)** will be updated after receiving the response from the clearinghouse.

The claim status may become

- Accepted(CH)
  - Rejected(CH)
  - Accepted with Error(CH)

If a claim is rejected from the Clearing House, the necessary changes are made and the claim needs to be submitted/Resubmitted again to the clearinghouse.

When resubmitting a claim from **Rejected(CH)** status and that claim had previous NEA attachment, then before submitting/resubmitting the claim, a validation would be asked:

- Retain Attachment - On clicking the **Retain Attachment**, the existing electronic attachment will be retained and the claim will be moved to **Ready to Send** or **Ready to Send(R)** status.
  - Remove and Add New Attachment - On clicking the **Remove and Add New Attachment**, the existing electronic attachment will be removed and the claim will be moved to **Document Pending** status, so new electronic attachment can be added.
  - Remove Attachment - On clicking the **Remove Attachment**, the **NEA required** radio button inside claim will be set to **No**, existing electronic attachments will be removed and the claim will be moved to **Ready to Send** or **Ready to Send(R)**status.

When submitting/resubmitting a claim from **Rejected(CH)**, and if the claim had no previous attachments, and if the treatment code is not being recommended by the carrier for NEA Attachment; then the claim will be moved to **Ready to Send** or **Ready to Send(R)** status.

And if it is recommended by NEA, a warning toaster will be shown where the user can decide whether to send that claim to NEA. ie, **Document Pending** or not sent to NEA so claim changes status to **Ready to Send** or **Ready to Send(R)** status.

For a claim in **Rejected (CH)** status, it can be submitted [not resubmit] again to the clearinghouse, then the previous claim status will be retained.

The claims accepted by the clearinghouse will be sent to the payor. Once the claim reaches the payor, their response will be received. Based on the response the claim status will be updated to any of the following based on the claim status category codes.

- Acknowledged(Payor)
  - Rejected
  - Pending(Payor)
  - Finalized(Payor)
  - Req Addl Info(Payor)
  - Error(Payor)
  - Searches(Payor)

For an electronic claim in any of the above status, the following actions can be done.

- Close
  - Reject
  - Void
  - Error in Claim

### **Stage 3: Applying Insurance Payments to claims, Resubmitting Claims, Changing Claim status with respect to response**

Electronic claims status can be manually changed or will be changed on applying insurance payments to the following statuses:

## Closed

Claim status can be changed to **Closed** from the following claim statuses:

- Payor Response
  - Rejected
  - Reopened
  - Partially Paid

Claim status can be changed to **Closed** either manually or after posting the insurance payment against the claim by selecting close claim checkbox.

When manually closing claims, a warning message will be shown "Any remaining insurance balances will be pushed to the patient if there is no higher order claim to be raised. Are you sure you want to continue?"

On proceeding further modal shown with fields,

- Claim Control Number
  - Remarks

Claim Control Number is a non-mandatory field and being auto-populated if the value being previously available and Remark is a non-mandatory text field.

If the code has billing order **M** or **D** then no higher order claim will be raised, else corresponding higher order claim will be raised when moving a claim to **Closed** status.

Claims which are in **Closed** status will have following options in claim status drop-down:

- Reopen
  - Void
  - Create Secondary Claim/Create Tertiary Claim

Above option will be visible only if possible to raise higher order claims and auto-generated higher order claims are deleted for some reason.

While opening a **Closed** claim, both the **Details** tab and the **Claim form** tab will be non-editable and only have a **Print** button in both tabs.

## Rejected

Claim status can be changed to **Rejected** from the following claim statuses:

- Payor Response
  - Partially Paid
  - Clearing House Response
  - Reopened

While changing claim status to **Rejected**, a modal would be shown with fields

- Claim Control Number
  - Remarks

where **Claim Control Number** is a non-mandatory field and being auto-populated if the value being previously available and **Remark** is a mandatory text field.

Claims which are in **Rejected** status will have following options in claim status drop-down:

- Resubmit
  - Reopen
  - Close
  - Void

While opening a **Rejected** claim, both **Details** tab and **Claim form** tab will be non-editable and only have a **Print** button in both tabs.

## Reopened

Claim status can be changed to **Reopened** from the following claim statuses:

- Closed
  - Rejected

While reopening claims, if they already have higher order claims raised, then a warning would be shown "You cannot reopen this claim since higher order claim(s) exist for it" and would not allow to change the claim status.

If no higher order claim is present a modal with mandatory **Remark** text field will be shown where the user can enter remarks and reopen the claim.

Claims which are in **Reopened** status will have following options in claim status drop-down:

- Close
  - Reject
  - Void

While opening a **Reopened** claim both **Details** tab and **Claim form** tab will be non-editable and only have a **Print** button in both tabs.

If the payor makes partial payments or rejects some or at least one of the procedure codes raised in the claim, the claim status will be changed to **Partially Paid**.

Void

Claim status can be changed to **Void** status from the following claim statuses:

- Clearing House
  - Payor Response
  - Reopened
  - Close
  - Partially Paid

While changing the claim status to **Void**, a modal would be shown with fields

- Claim Control Number
  - Remarks

where **Claim Control Number** is a mandatory field and will be auto-populated if the value is previously available and the **Remark** field is also a mandatory text field.

After that, a modal popup showing the message "Do you want to generate a new claim from the void claim?"

- If the user selects **Ok**, then a new claim corresponding to the voided claim would get generated with status **Saved** or **Saved with Errors** and the current claim status changes to **Void**
  - If the user selects **Cancel** then current claim status changes to **Void**.

Claims which are in **Void** status won't have any option in claim status section. While opening such a claim, both the **Details** tab and **Claim form** tab will be non-editable and will only have a **Print** button.

## Claim Rejection statuses

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There are a few claim rejection statuses that the carriers use when they reject a claim. These can be seen in case of electronic claims. The details regarding these are available in the attached link.

<https://x12.org/codes/claim-status-category-codes>

# NEA FastAttach & NEA Recommendations

Written by Renganathan K | Last published at: August 15, 2021

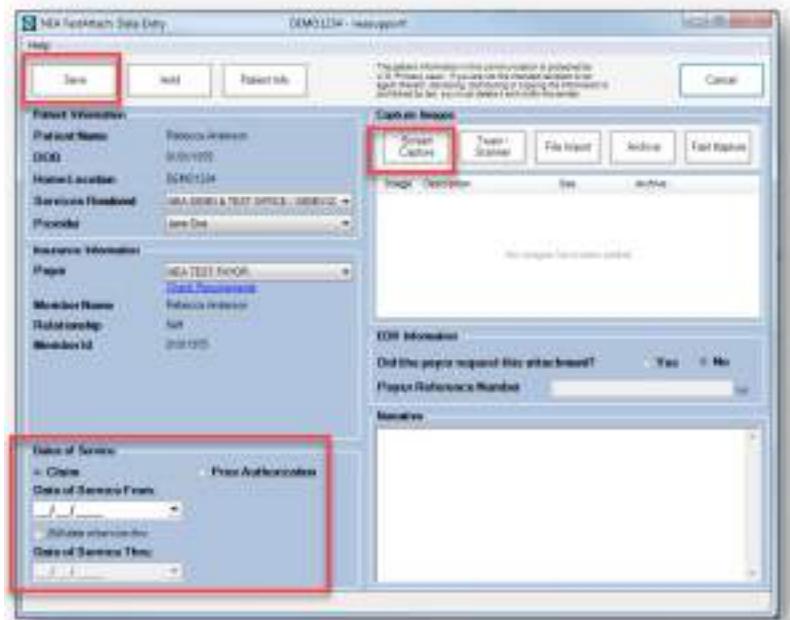
Many insurance companies need you to submit attachments with your claims, but no one wants paperwork flying about on the internet. When you submit claims and authorizations using CareStack, you may use NEA Fast-Attach to include the attachments that the carriers require. You will need to log in to your NEA FastAttach application or portal to attach the required documents.

When a generated claim is required to have documents attached to it CareStack will identify them and tag them as NEA next to the claim id as shown in the image below.

Select	Claim ID	DOS	Last Updated
<input type="checkbox"/>			
<input type="checkbox"/>	83449 NEA	05/11/2021	07/23/2021
<input type="checkbox"/>	83448 NEA	07/13/2021	07/23/2021
<input type="checkbox"/>	83446 NEA	06/22/2021	07/23/2021

Once you are on the NEA application

- Double-click the claim row in the NEA App.
- Select the method you will use to add the attachments. The steps will be a bit different for different types of attachments.
- Describe the attachment by answering the prompt questions.
- When you've added all your attachments for the claim, click Save.



Once you are finished adding attachments to all your claims, click **Send** to send the finished claims back to CareStack for transmission to the clearinghouse.

The screenshot shows the NEA FastAttach software interface. At the top, there's a menu bar with 'Help', 'Manage', and the NEA logo. Below the menu is a toolbar with buttons for 'New', 'Edit', 'Delete', 'Details' (which is highlighted with a red box), 'Interface Input', 'Provider Information', and 'Custom Features'. A blue circular icon with a white arrow is also part of the toolbar. The main area has tabs for 'Quick Inquiry', 'Claim Mapping', 'Save Layout', 'Read Layout', and 'Report'. The status bar at the bottom right says 'Last Refreshed: 7/12/2011 9:46 PM'.

Action	Patient/Claim Number	Entered By	Carrier/Payer Name	Payer Name	Date of Service	Carrier Code	Date of Birth	Entered By
Print/Email	John Smith	00000000	John Doe	H&L	07/11/2008 - 8	0000000000	00000000	00000000
Print/Email	Jane Doe	00000000	Jane Doe	H&L	07/11/2008 - 8	0000000000	00000000	00000000
Print/Email	Jane Doe	00000000	Jane Doe	H&L	07/11/2008 - 8	0000000000	00000000	00000000
Print/Email	Jane Doe	00000000	Jane Doe	H&L	07/11/2008 - 8	0000000000	00000000	00000000

The claims and their attachments will be transmitted from CareStack in the next claims sweep.

You may also refer to this webpage for more information : <https://vynedental.com/>

## NEA Recommendation

Practices can set their NEA recommendation codes under

System Menu > Practice settings > Payments > NEA Recommendation

Here we can add the required codes and their corresponding Document type to be attached and their corresponding Carrier details.

Once this is done whenever these codes get completed and a claim is raised they will be having NEA tag . These claims will be searched in

The screenshot shows the CareStack software interface. The left sidebar has a tree view with categories like 'Practice Settings', 'Locations', 'Claims', 'Insurance Companies', 'Bills', 'Invoicing', 'Reports', 'Invoicing Settings', 'Histories', 'Payments', 'NEA Recommendation', 'Billing Center', 'Search Accounts', and 'Utilities'. The 'NEA Recommendation' tab is highlighted with a green box. The main area shows a table with columns 'Code', 'Description', 'Document Type', and 'Carrier Details'. There are two rows of data:

Code	Description	Document Type	Carrier Details
1000	Information of patient including all relevant details	1000	Academy of dentists
1001	Information of carrier including all relevant details	1001	Academy of dentists

NEA applications and required documents can be attached and sent.

# Claim Forms : ADA 2002 Dental Claim Form

Written by Aswathy B Nair | Last published at: August 08, 2021

1. ADA 2002 form have dual usage in our system

Used as a claim form for sending the claim to the insurance companies on behalf of the patient.

Used as a pre-authorization form for sending preauthorization requests to the insurance companies on behalf of the patient.

2. Below are the fields which are mentioned as boxes in an ADA 2002 form

## HEADER INFORMATION

(The 'header' provides information about the type of submission being made.)

### Box 1

In form, the value that needs to be marked is 'Statement of Actual Services'.

P-authorization form, the value to be marked is 'Request for Predetermination/Preadmission' and the box will be disabled and grayed out.

### Box 2

In form, this field should be populated with the preauthorization number(if any) applicable to the services entered under the 'Record of Services Provided' section in the claim. If there are multiple authorization numbers applicable, then the auth numbers should be separated by ','. If the data to be entered in this field exceeds the max limit, then the user can enter the remaining auth numbers in the 'Remarks' field(Box 35).

P-authorization form, the field is not applicable so this box can be disabled and grayed out

## PRIMARY PAYER INFORMATION

### Box 3

Id should be populated with the payor name and address to which the form needs to be sent.

- In the form, this field will be populated with the payor's name and address of the insurance plan of the patient under which the claim/pre-authorization request is processed. The value in this box should be in the format :
  - Insurance Company Name
  - Address Line 1
  - Address Line 2
  - City, State, ZIPThe address details(Address Line 1, Address Line 2, City, State, ZIP) should be populated with the data as that saved under the insurance plan.
- In the editable format of the form

i. Insurance Company Name: This should be populated with the name of the insurance company to whom the form is to be sent and should be disabled.

ii. Address Line 1: This should be a text field populated with the first line of address as saved in the field 'Address Line 1' under Practice Settings > Plan screen of the respective plan and is editable.

iii. Address Line 2: This should be a text field populated with the second line of address as saved in the field 'Address Line 2' under Practice Settings > Plan screen of the respective plan and is editable. If the address of the insurance company does not have address line 2, then the area for 'Address Line 2' should be left blank.

iv. City: This should be a text field populated with the city as saved in the field 'City' under Practice Settings > Plan screen of the respective plan and is editable.

v. State: This should be a chosen box that lists all states in the US and pre-populated with the state as saved in the field 'State' under Practice Settings > Plan screen of the respective plan and is editable. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc

vi. Zip Code: This should be populated with the zip code as saved under the field 'Zip Code' under Practice Settings > Plan screen of the respective plan and is editable.

- The values Insurance Company Name, Address Line 1, City, State, and Zip Code are mandatory in this box.

## OTHER COVERAGE

(This area of the claim form provides information on the existence of additional dental or medical insurance policies.)

### Box 4

box will be pre-populated based on the data saved for the patient and will be disabled(cannot be edited). The data is populated from Patient > Insurances.

If the patient has any other plan coverage(other than that to which the form is going to be submitted) saved in the system, then, 'Yes' should be marked in the form.

i. If the coverage is 'Dental', then boxes 5 through 11 will get populated with the details of the applicable dental plan.

ii. If the coverage is 'Medical', then boxes 5 through 11 will get populated with the details of the applicable medical plan.

iii. If the patient has both medical and dental coverage, boxes 5 through 11 will get populated with the details of the dental plan.

- c. If no other coverage is saved in the system for the patient then 'No' will be marked and boxes 5 through 11 will remain empty.

**Box 5**

box will be populated with the policy holder's name of the patient's other plan coverage indicated in Box 4. The data is populated from the field 'Policy Holder Name' under s>Insurances screen of the respective patient, in the format: Last Name, First Name, Middle Initial, Suffix

field will be mandatorily populated if Yes is marked in Box 4.

box will be disabled, grayed out and empty if No is marked in Box 4.

**Box 6**

field will be populated with the date of birth of the policyholder identified in Box 5 from Patient > Insurances in the format MM/DD/CCYY.

field will be mandatorily populated if Yes is marked in Box 4.

box will be disabled, grayed out and empty if No is marked in Box 4.

**Box 7**

field is marked with the gender of the policyholder identified in Box 5. The data populated in this field is from Patient > Insurances.

field will be mandatorily populated if Yes is marked in Box 4.

box will be disabled, grayed out and empty if No is marked in Box 4.

**Box 8**

field will get populated with the unique identifying number assigned by the payor to the person named in Item 5, which is on their identification card. This field should be read from the field 'Patient Insured ID' under Patient>Insurances of the patient on behalf of which the form is to be submitted, if this is not saved in the system then value from 'Subscriber ID' under Patient > Insurances of the policyholder(identified in box 5) will be populated.

field will be mandatorily populated if Yes is marked in Box 4.

box will be disabled, grayed out and empty if No is marked in Box 4.

**Box 9**

field will be populated with the 'Group Number' of the plan. The value is retrieved and populated from Practice Settings > Plans.

field will be mandatorily populated if Yes is marked in Box 4.

box will be disabled, grayed out and empty if No is marked in Box 4.

**Box 10**

field will be marked with the patient's relationship to the policyholder(person named in item 5). This value is retrieved and gets populated from Patient > Insurances.

field will be mandatorily populated if Yes is marked in Box 4.

box will be disabled, grayed out and empty if No is marked in Box 4.

**Box 11**

box will get populated with the name and address of the carrier under which the patient has other plan coverage.

values Insurance Company Name, Address Line 1, City, State, Zip Code in this box should be mandatorily populated if Yes is marked in Box 4. This box will be disabled, grayed out and empty if No is marked in Box 4. The value in this box should be in the format : Insurance Company Name Address Line 1 Address Line 2 City, State, Zip Code

address details(Address Line 1, Address Line 2, City, State, Zip Code) should be populated with the data as that saved under the insurance plan.

values in this box are populated as defined below:

i. Insurance Company Name: This should be populated with the name of the insurance company and should be disabled.

ii. Address Line 1: This should be a text field populated with the first line of the address of the carrier as saved under the insurance plan (Practice Settings > Plan) and is editable.

iii. Address Line 2: This should be a text field populated with the second line of the address of the carrier as saved under the insurance plan(Practice Settings > Plan) and is editable. If the address of the policyholder does not have address line 2, then the area for 'Address Line 2' should be left blank.

iv. City: This should be a text field populated with the city of the carrier as saved under the plan (Practice Settings > Plan) and is editable.

v. State: This should be a chosen box that lists all states in the US and prepopulated with the state as saved under the insurance plan and is editable. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc

vi. Zip Code: This should be a text field populated with the zip code as saved under the insurance plan and is editable.

## POLICYHOLDER/SUBSCRIBER INFORMATION

(This section (Box 12-Box 17) documents the information of the person(policyholder) who holds the insurance(indicated in box 3) to which the form is going to be submitted)

**Box 12**

field will be populated with the name and address of the policyholder. The value in this box should be in the format : Policyholder Name Address Line 1 Address Line 2 City, Zip Code

values in this box are populated as defined below:

i. Policyholder Name: This value should be in the format 'Last Name, First Name, Middle Initial, Suffix'. This value is populated from the field 'Policy Holder Name' under Patients > Insurances. This value will be pre-populated and in disabled format.

ii. Address Line 1: This value will be populated from the field 'Address Line 1' under Patient > General > Basic Information of the policyholder(a policyholder is also identified as a patient in our system.). This will be a text box and will be editable.

iii. Address Line 2: This value will be populated from the field 'Address Line 2' under Patient>General>Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a text box and will be editable. If the address of the policyholder does not have address line 2, then the area for 'Address Line 2' should be left blank.

iv. City: This value will be populated from the field 'City' under Patient>General>Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a text box and will be editable.

v. State: This value will be populated from the field 'State' under Patient>General>Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a chosen box with the lists of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc

vi. Zip Code: This value will be populated from the field 'Zip Code' under Patient > General > Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a text box and will be editable.

The values Policy Holder Name, Address Line 1, City, State, and Zip Code are mandatory fields.

#### **Box 13**

field will be populated with the date of birth of the policyholder identified in Box 12 in the format MM/DD/CCYY. This box will be populated from the field 'Date of Birth' under >General>Basic Information of the policyholder(a policyholder is also identified as a patient in our system.)

box is mandatory and needs to be populated and disabled.

field will be marked with the gender of the policyholder identified in Box 12. This box will be populated from the field 'Gender' under Patient > General > Basic Information of cyholder(a policyholder is also identified as a patient in our system.)

box is not mandatory and will be disabled.

#### **Box 15**

field will be populated with the unique identifying number assigned by the carrier to the person named in Item 12, which is on their identification card. This field should be ed from the field 'Patient Insured ID' under Patient > Insurances of the patient on behalf of which the form is to be submitted, if this is not saved in the system then value from 'Subscriber ID' under Patient > Insurances of the policyholder(identified in box 12) will be populated.

is a mandatory field and should be disabled.

#### **Box 16**

box will be populated with the group number of the plan (identified in box 3) under which the form is to be submitted.

value in this box should be populated from the field 'Group No.' under Practice Settings > Plan. This is a mandatory field and will be disabled.

#### **Box 17**

box will be populated with the employer(if any) of the plan under which the form is to be submitted.

value in this box should be populated from the field 'Employer' under Practice Settings > Plan. This is not a mandatory field and will be disabled.

### **PATIENT INFORMATION**

(This section (Box 18-Box 23) documents the information of the patient on behalf of which the form is to be submitted.)

#### **Box 18**

box will be marked with the relationship of the patient(on behalf of which the form is to be submitted) to the policyholder(identified in box 12).

value is populated from the field 'Relationship to PolicyHolder' under Patient > Insurances. This is a mandatory field and will be disabled.

#### **Box 19**

Leave this box blank and this will be disabled.

#### **Box 20**

field will be populated with the name and address of the patient on behalf of which the form is to be submitted. The value in this box should be in the format : Patient Name s Line 1 Address Line 2 City, State, Zip Code

values in this box are populated as defined below:

i. Patient Name: This value should be in the format 'Last Name, First Name, Middle Initial, Suffix'. This value is populated from the respective fields under Patients > Insurances. This value will be pre populated and in disabled format.

ii. Address Line 1: This value will be populated from the field 'Address Line 1' under Patient > General > Basic Information of the patient(on behalf of which the form is to be submitted). This will be a text box and will be editable.

iii. Address Line 2: This value will be populated from the field 'Address Line 2' under Patient > General > Basic Information of the patient(on behalf of which the form is to be submitted). This will be a text box and will be editable. If the address of the patient does not have address line 2, then the area for 'Address Line 2' should be left blank.

iv. City: This value will be populated from the field 'City' under Patient > General > Basic Information of the patient(on behalf of which the form is to be submitted). This will be a text box and will be editable.

v. State: This value will be populated from the field 'State' under Patient > General > Basic Information of the patient(on behalf of which the form is to be submitted). This will be a chosen box with the lists of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected

state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc

vi. Zip Code: This value will be populated from the field 'Zip Code' under Patient > General > Basic Information of the patient(on behalf of which the form is to be submitted).

This will be a text box and will be editable.

: values Policy Holder Name, Address Line 1, City, State, and Zip Code are mandatory fields.

#### **Box 21**

- This box is populated by the date of birth of the patient(on behalf of which the form is to be submitted) from the field 'Date of Birth' under Patient > General > Basic Information.
- This is a mandatory field and should be populated and disabled.

#### **Box 22**

nder of the patient(on behalf of which the form is to be submitted), is marked in this box from the field 'Gender' under Patient > General > Basic Information. not a mandatory field and will be disabled.

#### **Box 23**

box should be populated with the ID of the patient(on behalf of which the form is to be submitted). This will be the Patient ID assigned to the patient in the system. Id is mandatorily populated and will be disabled.

### **RECORD OF SERVICES PROVIDED**

(The 'Record Of Services Provided' section (Box 24 - Box 35) contains a grid that contains information regarding the proposed treatment (predetermination/preauthorization), or treatment performed (actual services)).

#### **Box 24**

lumn needs to be filled with the date on which the procedure is performed.

lumn is not applicable in a pre authorization request, and hence it should be left blank, disabled and grayed out.

#### **Box 25**

field is to enter the area of the oral cavity in which the procedure is performed. This is a conditional field.

lays report the area of the oral cavity when the procedure reported in box 29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely identified by the procedure's nomenclature. But in MVP perspective, this is not validated and entering this field is purely user discretion, so this is not a mandatory field under any condition.

will be a chosen drop-down that lists all the areas defined below and 'Select' being the default value. But only the code should be displayed in the field, once the value is selected. **Code Area** 00 entire oral cavity 01 maxillary arch 02 mandibular arch 10 upper right quadrant 20 upper left quadrant 30 lower left quadrant 40 lower right quadrant

#### **Box 26**

column will be populated with the tooth system for designating teeth. We are using the ADA's Universal/National Tooth Designation System, so the column needs to be filled with 'JP'.

column in a row will be populated and disabled if any column in that row is filled. This column will remain empty for the rest of the rows in which no value is entered in any of the other columns in the grid.

#### **Box 27**

column should be populated with the teeth on which the procedure reported in box 29 is performed. Clicking on this field lists the teeth numbers and letters as per JP tooth chart. The user can select the teeth applicable(only one tooth can be selected at a time).

is not a mandatory column under any condition.

#### **Box 28**

column should be populated with the tooth surface on which the procedure is performed. This is a multi-select drop-down field that lists all the surfaces of a tooth.

values will be listed in this multi-select drop-down of a row, only if teeth is selected in Box 27 of that particular row. This is not a mandatory field under any condition.

#### **Box 29**

column needs to be filled with the code of the procedure performed(in claim form) or to be performed(in pre-authorization form).

is a chosen box that lists all the ADA codes in the format 'Code - Description' saved in the system for eg: D0120 - Periodic Oral Evaluation. On selecting a value from the list, the code should get populated in the field for eg: D0120. The values in this list are retrieved from the fields 'Procedure Code' and 'Description' under Codes > Procedure Codes. This is a mandatory column for a row, only if any other column in that row is filled.

#### **Box 30**

column will be filled with the description of the procedure selected in box 29.

column will be auto-populated from the field 'Description' under Codes > Procedure Codes, once the procedure code is selected in box 29. This column will be disabled.

#### **Box 31**

field needs to be filled with the fees of the procedure code selected in box 29.

will be a text field which will be auto-populated from the field under Practice Settings > Fee Schedules but will be editable.

lumn in a row will act as mandatory if any other column of that row is filled.

#### **Box 32**

box can be filled when other charges applicable to dental services provided must be reported. Charges may include state tax and other charges imposed by regulatory

will be an editable text field and is not mandatory.

#### **Box 33**

box will be auto-populated with the sum of all fees from lines in box 31, plus any fees entered in box 32.

field will be auto-populated and disabled.

#### **Box 34**

box is used to enter the missing teeth information of the patient.

: on the missing teeth numbers, so that an **X** will be placed over it. It is mandatory that the user should mark the missing tooth(if any) of the patient.

#### **Box 35**

space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional  
ition you believe is necessary for the carrier to process the claim (e.g., for a secondary claim, the amount the primary carrier paid). This is not a mandatory field.

information that had been entered in the Remarks field of the Details tab should be populated in this field.

## **AUTHORIZATIONS**

(This section(Box 36 - Box 37) provides consent for treatment as well as permission for the carrier to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.)

#### **Box 36**

ix is used to capture the signature of the patient or the patient's representative and the Date.

igning (or "Signature on File" notice) in this location of the form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the  
f treatment and the release of any information necessary to carry out payment activities related to the claim.

will be a dropdown with values 'Signature on File' and blank with 'Signature on File' being the default value.

Date will be a calendar widget populated with the current date. The user can remove or change the date if required.

Signature and Date are not mandatory.

#### **Box 37**

box is used to capture the signature(signature of the policyholder) and date (or "Signature on File" notice) are required when the Policyholder/Subscriber named in Item #12  
to have benefits paid directly to the dentist/provider. This is an authorization of payment.

will be a dropdown with values 'Signature on File' and blank with 'Signature on File' being the default value.

Date will be a calendar widget populated with the current date. The user can remove or change the date if required.

Signature and Date are not mandatory.

## **ANCILLARY CLAIM/TREATMENT INFORMATION**

(This section(Box 38 - Box 47) of the claim form provides additional information to the third party payer regarding the claim.)

#### **Box 38**

- a. This box needs to be filled with the Place of treatment code by marking the appropriate checkbox.
- b. This would contain a set of 4 checkboxes:
  - i. Provider's Office
  - ii. Hospital
  - iii. ECF
  - iv. Other
- c. This is not a mandatory field.

#### **Box 39**

box indicates the number of enclosures

actual number of attached Radiograph(s), Oral Image(s) and Models) should be specified in their respective columns.

could be left blank.

#### **Box 40**

box indicates whether the treatment is for orthodontics or not. If 'Yes' is marked then 41 and 42 should be mandatorily filled. If 'No' is marked then 41 and 42 will be disabled and grayed out.

default value of this field will be as specified in the field 'Is Treatment for Orthodontics' under Practice Setting > Payment > Claim form Defaults > Dental.

#### **Box 41**

should be a calendar widget that should be filled with the date of the appliance placed in the format MM/DD/CCYY.

box will be enabled and should be mandatorily filled if 'Yes' is marked in Box 40. If 'No' is marked under box 40, then this box will be disabled and grayed out.

#### **Box 42**

should be a text field that needs to be filled with the total number of months required to complete the orthodontic procedure

box will be enabled and should be mandatorily filled if 'Yes' is marked in Box 40. If 'No' is marked under box 40, then this box will be disabled and grayed out.

#### **Box 43**

box indicates whether the procedure involves a prosthetic restoration. If 'Yes' is marked in this box then Box 44 will become mandatory. If 'No' is marked in this box the box 44 will be disabled and grayed out.

box will be initially populated with the default value as specified in the field 'Replacement of Prosthesis' under Practice Setting > Payment > Claim form Defaults > Dental.

#### **Box 44**

box needs to be mandatorily filled with the date of prior placement of the prosthetic restoration in the format MM/DD/CCYY if 'Yes' is marked in box 43. This box will be disabled and grayed out if 'No' is marked in box 43.

will be a calendar widget.

#### **Box 45**

box indicates whether the treatment is resulting from 'Occupational illness/Injury', 'Auto Accident', 'Other Accident'.

'Occupational illness/Injury' is marked, then box 46 will become mandatory and 47 will be blank, disabled and grayed out. If 'Auto Accident' is marked then box 46 and 47 will be mandatory. If 'Other Accident' is marked, then box 46 will become mandatory and 47 will become blank, disabled and grayed out. If nothing is marked in this box, then boxes 47 will be blank, disabled and grayed out.

is not a mandatory field

#### **Box 46**

field will be a calendar widget that needs to be filled with the date of accident in the format MM/DD/CCYY.

is mandatory if any value is marked under Box 45. If nothing is marked in box 45, then this box will be blank, disabled and grayed out.

#### **Box 47**

field indicates the state where the accident happened.

should be a chosen box that lists all states in the US with 'Select' being the default value. The full name of the states should be shown in the list for eg: Florida, Alabama etc, the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc

is a mandatory field if 'Auto Accident' is marked under box 45. If any other value is marked in Box 45 or if nothing is marked in box 45, then this box will be blank, disabled and grayed out.

## **BILLING DENTIST OR DENTAL ENTITY**

(The 'Billing Dentist' or 'Dental Entity' section(Box 48 - Box 52) provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state license, or the name of the group practice/corporation that is responsible for billing and other pertinent information.)

#### **Box 48**

- a. This box needs to be filled with the name and complete address of a dentist or dental entity.
- b. There will be a dropdown above the box 48 that holds two values 'Billing Dentist' and 'Dental Entity'. This drop-down determines the value to be populated in box 48(name and address of the dental entity or the name and address of the dentist). The default value of this dropdown is specified in the field 'Billing Provider or Dental Entity' under Practice Setting > Payment > Claim form Defaults > Dental.
- c. The box should be populated in the format Billing Provider Name/Dental Entity Name Address Line 1 Address Line 2 City, State, Zip Code
- d. If 'Billing Dentist' is selected in the drop-down above the box 48, the value in box 48 should be as follows:
  - i. Billing Provider Name - This value should be populated from the field 'Default Billing Provider' under Practice Setting > Payment > Claim form Defaults > Dental. This will be a chosen box that lists the name of all providers saved for the account in the system. The names should be in the format Last Name, First Name, Middle Initial, Suffix. This is editable and the user can change the provider if required.
  - ii. Address Line 1 - This value should be populated from the field 'Address Line 1' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable.
  - iii. Address Line 2 - This value should be populated from the field 'Address Line 2' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable. If the address of the billing dentist does not have address line 2, then the area for 'Address Line 2' should be left blank.
  - iv. City - This value should be populated from the field 'City' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable.

- v. State- This value should be populated from the field 'State' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This will be a dropdown with the list of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc.
- vi. ZIP- This value should be populated from the field 'ZIP' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable.
- e. If 'Dental Entity' is selected in the drop down above the box 48, the value in box 48 should be as follows:
  - i. Dental Entity Name - This value should be populated from the field 'Name of Dental Entity' under Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
  - ii. Address Line 1 - This value should be populated from the field 'Address Line 1' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
  - iii. Address Line 2 - This value should be populated from the field 'Address Line 2' in the screen Practice Setting > Payment > Claim form Defaults > Dental.. This is a text field and is editable. If the address of the dental entity does not have address line 2, then the area for 'Address Line 2' should be left blank.
  - iv. City - This value should be populated from the field 'City' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
  - v. State- This value should be populated from the field 'State' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This will be a dropdown with the list of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc.
  - vi. Zip Code- This value should be populated from the field 'Zip Code' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
- f. The mandatory field in this section are: Name(Billing Provider Name/Dental Entity Name), Address Line 1, City, State, Zip Code

#### **Box 49**

- a. This box will get filled with the appropriate Provider ID (NPI) of the billing entity/billing provider (based on that specified in box 48).
  - i. If the billing entity is specified in box 48, then NPI will get populated from the field NPI in the screen Practice Setting > Payment > Claim form Defaults > Dental. In this case, this box will be an editable text field.
  - ii. If the billing provider is specified in box 48, then NPI will get populated from the field NPI in the screen Practice Setting > Administration > Users of the respective provider. In this case, this box will be non-editable.
- b. This is a mandatory box.

#### **Box 50**

- a. This box is to be filled with the License Number of the billing provider in the treatment location mentioned in Box 56. This field will not be applicable and can be disabled, if 'Dental Entity' is specified in box 48. If 'Billing Provider' is specified in box 48, then this field will get auto-populated from Practice Setting > Administration > Users screen of the respective provider.
- b. This is not a mandatory field under any conditions.

#### **Box 51**

- a. This box is to be filled with the TAX ID of Billing Dentist/Dental Entity specified in Box 48.
  - i. If the billing entity is specified in box 48, then TAX ID will get populated from the field TIN in the screen Practice Setting > Payment > Claim form Defaults > Dental. In this case, this box will be an editable text field.
  - ii. If the billing provider is specified in box 48, then TAX ID will get populated from the field TAX ID in the screen Practice Setting > Administration > Users of the respective provider. In this case, this box will be non-editable.
- b. This is not a mandatory field.

#### **Box 52**

- a. This box is to be filled with the Phone number of Billing Dentist/Dental Entity specified in Box 48.
  - i. If the billing entity is specified in box 48, then this box will get populated from the field Phone in the screen Practice Setting > Payment > Claim form Defaults > Dental.
  - ii. If the billing provider is specified in box 48, then this box will get populated from the field Phone in the screen Practice Settings > Administration > Users of the respective provider.
- b. This is not a mandatory field and will be an editable text field.

## **TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

(Information that is specific to the dentist or practitioner acting within the scope of their state licensure who has provided treatment is entered in this section (Box 53 - Box 58))

#### **Box 53**

original authorized signature of the treating provider and the date the form is signed. This box may also be inserted with the treating dentist's name. signature field in this box will be a dropdown prepopulated with the treating dentist's name(in the format Last Name, First Name, Middle Initial, Suffix). date field in this box should be a calendar widget prepopulated with the current date. The date should be in the format MM/DD/CCYY, and this is an editable field.

**Box 54**

box should get populated with the Provider ID (NPI) of the treating provider specified.  
value is retrieved from the field 'NPI' in the screen Practice Settings > Administration > Users of the respective provider.  
should be a mandatory field and will be pre-populated and disabled.

**Box 55**

box should get populated with the license number of the treating provider in the state mentioned in Box 56.  
value is retrieved from the field 'License No'(if any) in the screen Practice Settings > Administration > Users of the respective provider.  
should be mandatory and will be an editable text field.

**Box 56**

box should be filled with the address of the treating provider specified.  
Address should get populated in the format Address Line 1 Address Line 2 City, State, Zip Code  
values in this box are as defined below:  
i. Address Line 1: This should be an editable text field populated with the first line of the address of the provider from the field 'Address Line 1' in the screen Practice Settings > Administration > Users of the respective treating provider.  
i. Address Line 2: This should be an editable text field populated with the second line of the address of the provider from the field 'Address Line 2' in the screen Practice Settings > Administration > Users of the respective treating provider. If the address of the provider does not have address line 2, then the area for 'Address Line 2' should be left blank.  
iii. City: This should be an editable text field populated with the city of the provider from the field 'City' in the screen Practice Settings > Administration > Users of the respective treating provider.  
iv. State: This should be an editable chosen box that lists all states in the US and prepopulated with the state of the provider from the field 'State' in the screen Practice Settings > Administration > Users of the respective treating provider. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc  
v. Zip Code: This should be an editable text field populated with the zip code of the provider from the field 'Zip Code' in the screen Practice Settings > Administration > Users of the respective treating provider.

**Box 57**

box is to be filled with the phone number of the treating provider specified.  
value in this box is populated from the field 'Phone'(if any) under the screen Practice Settings > Administration > Users of the respective treating provider.  
box is not mandatory and will be an editable text field.

**Box 58**

box needs to be filled with the treating provider specialty code of the treating provider specified.  
Id should be auto-populated with the taxonomy code of the specialty specified in the field 'Specialty' under the screen Practice Settings > Administration > Users of the respective treating provider.  
Taxonomy code is defined under Setup > Codes > Taxonomy Codes  
box should be mandatory and will be populated and disabled.

## ASSIGN BENEFITS TO PATIENT

**Case 1:** An ABP label is added to the patient and the claims are not submitted:

- The subscriber signature field (field 37) should be disabled and empty for both paper based and electronic claim channels.
- The Billing dentist/Dental entity information fields (fields 48-52) should be filled and mandatory for electronic claims.
- The Billing dentist/Dental entity information fields (fields 48-52) should be optionally filled (can either be filled or empty) and non-mandatory for paper based claims.
- For paper based claims, the fields 48-52 should be left blank by default and can be edited whereas for electronic claims it should be filled and can be edited.
- The Billing dentist/Dental entity information fields (fields 48-52) should not retain information in case of higher order claims.

**Case 2:** A claim has been submitted and the ABP flag is added after submission

- The values in field 39 & 48-52 should be retained with the values before submission. This should also be retained/consistent while printing claims.
- If the user tries to 'Edit and Resubmit', then the current ABP state of the patient should be updated. i.e the ABP functionality related changes should be brought to the claim form. The user should have the updated changes if they proceed with resubmission.
- If the user discards the changes by clicking on 'Cancel', then the fields should be reverted to how it was before the 'Edit & Resubmit' action.

**Note:**

for electronic claims will have default values for the items mentioned above.

en the Assign Benefits to Patient (ABP) flag is ON, the CLM08 (Assign Benefit to Provider) in EDI should be N.

ase the default values are not available, such claims must be raised as paper claims without an option to convert to electronic.

ing Batch generation, validation for Billing dentists/ Dental entity should not be fired

ABP flag	CLM08
ON	N
OFF	Y

## **ADA 2002 Claim Form**

# Claim Forms : ADA 2012 Dental Claim Form

Written by Aswathy B Nair | Last published at: August 22, 2021

## 1. ADA 2012 form have dual usage in our system

Used as a claim form for sending a claim to the insurance companies on behalf of the patient.

Used as a pre-authorization form for sending preauthorization requests to the insurance companies on behalf of the patient.

## 2. Below are the fields which are mentioned as boxes in an ADA 2012 form

### HEADER INFORMATION

(The 'header' provides information about the type of submission being made.)

- Box 1
  - a. In a claim form, the value that needs to be marked is 'Statement of Actual Services'.
  - b. In a pre-authorization form, the value to be marked is 'Request for Predetermination/Preadmission' and the box will be disabled and grayed out.
- Box 2
  - a. In a claim form, this field should be populated with the preauthorization number(if any) applicable to the services entered under the 'Record of Services Provided' section in the claim form. If there are multiple authorization numbers applicable, then the auth numbers should be separated by ','. If the data to be entered in this field exceeds the max limit, then the user mentions the remaining auth numbers in the 'Remarks' field(Box 35).
  - b. In pre-authorization form, the field is not applicable so this box can be disabled and grayed out

### INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

: 3

- a. This field should be populated with the payor name and address to which the form needs to be sent.
- b. In both claim form and pre-authorization form, this field will be populated with payor's name and address of the insurance plan of the patient under which the claim/pre-authorization request is processed. The value in this box should be in the format :
  - Insurance Company Name
  - Address Line 1
  - Address Line 2
  - City, State, ZIP
- c. The address details(Address Line 1, Address Line 2, City, State, ZIP) should be populated with the data as that saved under the insurance plan.
- d. In the editable format of form
  - i. Insurance Company Name: This should be populated with the name of the insurance company to whom the form is to be sent and should be disabled.
  - ii. Address Line 1: This should be a text field populated with the first line of address as saved in the field 'Address Line 1' under Practice Settings > Plan screen of the respective plan and is editable.
  - iii. Address Line 2: This should be a text field populated with the second line of address as saved in the field 'Address Line 2' under Practice Settings > Plan screen of the respective plan and is editable. If the address of the insurance company does not have address line 2, then the area for 'Address Line 2' should be left blank.
  - iv. City: This should be a text field populated with the city as saved in the field 'City' under Practice Settings > Plan screen of the respective plan and is editable.
  - v. State: This should be a chosen box that lists all states in the US and prepopulated with the state as saved in the field 'State' under Practice Settings > Plan screen of the respective plan and is editable. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
  - vi. ZIP: This should be populated with the zip code as saved under the field 'ZIP' under Practice Settings > PlanFF screen of the respective plan and is editable.
- e. The values Insurance Company Name, Address Line 1, City, State, and ZIP are mandatory in this box.

### OTHER COVERAGE

(This area of the claim form provides information on the existence of additional dental or medical insurance policies.)

- Box 4
  - a. This box will be pre-populated based on the data saved for the patient and will be disabled(cannot be edited) and have the same behavior in both claim form and pre-authorization form. The data is populated from Patient > Insurances.
  - b. If the patient has any other plan coverage(other than that to which the form is going to be submitted) saved in the system, then
    - i. If the coverage is 'Dental', then the box after 'Dental' will get marked and boxes 5 through 11 will get populated with the details of the applicable dental plan.

- o ii. If the coverage is 'Medical', then the box after 'Medical' will get marked and boxes 5 through 11 will get populated with the details of the applicable medical plan.
  - o iii. If the patient has both medical and dental coverage, then both boxes after 'Dental' and 'Medical' will get marked and boxes 5 through 11 will get populated with the details of the dental plan and will be disabled.
- c. If no other coverage is saved in the system for the patient then both the boxes will remain unmarked and boxes 5 through 11 will remain empty.
- Box 5
  - a. This box will be populated with the policy holder's name of the patient's other plan coverage indicated in Box 4. The data is populated from the field 'Policy Holder Name' under Patients > Insurances screen of the respective patient, in the format: Last Name, First Name, Middle Initial, Suffix
  - b. This box will have the same behavior in the claim form and pre-authorization form.
  - c. This field will be disabled and mandatorily populated if Dental and/or Medical is marked in Box 4.
  - d. This box will be disabled, grayed out and empty if nothing is marked in Box 4.
- Box 6
  - a. This field will be populated with the date of birth of the policyholder identified in Box 5 from Patient > Insurances in the format MM/DD/CCYY.
  - b. This box will have the same behavior in the claim form and pre-authorization form.
  - c. This field will be disabled and mandatorily populated if Dental and/or Medical is marked in Box 4.
  - d. This box will be disabled, grayed out and empty if nothing is marked in Box 4.
- Box 7
  - a. This field is marked with the gender of the policyholder identified in Box 5. The data populated in this field is from Patient > Insurances.
  - b. This box will have the same behavior in the claim form and pre-authorization form.
  - c. This field will be disabled and populated if Dental and/or Medical is marked in Box 4.
  - d. This box will be disabled, grayed out and empty if nothing is marked in Box 4.
- Box 8
  - a. This field will be populated with the unique identifying number assigned by the payor to the person named in Item 5, which is on their identification card. This field should be populated from the field 'Patient Insured ID' under Patient > Insurances of the patient on behalf of which the form is to be submitted, if this is not saved in the system then value from the field 'Subscriber ID' under Patient > Insurances of the policyholder(identified in box 5) will be populated.
  - b. This box will have the same behavior in the claim form and pre-authorization form.
  - c. This field will be disabled and mandatorily populated if Dental and/or Medical is marked in Box 4. This box will be disabled, grayed out and empty if nothing is marked in Box 4.
- Box 9
  - a. This field will be populated with the 'Group Number' of the plan. The value is retrieved and populated from Practice Settings > Plan.
  - b. This box will have the same behavior in the claim form and pre-authorization form.
  - c. This field will be disabled and mandatorily populated if Dental and/or Medical is marked in Box 4. This box will be disabled, grayed out and empty if nothing is marked in Box 4.
- Box 10
  - a. This field will be marked with the patient's relationship to the policyholder(person named in item 5). This value is retrieved and gets populated from Patient>Insurances.
  - b. This box will have the same behavior in the claim form and pre-authorization form.
  - c. This field will be disabled and mandatorily populated if Dental and/or Medical is marked in Box 4. This box will be disabled, grayed out and empty if nothing is marked in Box 4.
- Box 11
  - a. This box will get populated with the name and address of the payor under which the patient has other plan coverage.
  - b. This box will have the same behavior in the claim form and pre-authorization form.
  - c. This values Insurance Company Name, Address Line 1, City, State, ZIP in this box should be mandatorily populated if Dental and/or Medical is marked in Box 4. This box will be disabled, grayed out and empty if nothing is marked in Box 4.The value in this box should be in the format : Insurance Company Name Address Line 1 Address Line 2 City, State, ZIP
  - d. The address details(Address Line 1, Address Line 2, City, State, ZIP) should be populated with the data as that saved under the insurance plan.
  - e. The values in this box are populated as defined below:
    - o i. Insurance Company Name: This should be populated with the name of the insurance company and should be disabled.
    - o ii. Address Line 1: This should be a text field populated with the first line of the address of the payor as saved under the insurance plan (Practice Settings > Plan) and is editable.
    - o iii. Address Line 2: This should be a text field populated with the second line of the address of the payor as saved under the insurance plan(Practice Settings > Plan) and is editable. If the address of the policyholder does not have address line 2, then the area for 'Address Line 2' should be left blank.
    - o iv. City: This should be a text field populated with the city of the payor as saved under the plan (Practice Settings > Plan) and is editable.
    - o v. State: This should be a chosen box that lists all states in the US and prepopulated with the state as saved under the insurance plan and is editable. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
    - o vi. ZIP: This should be a text field populated with the zip code as saved under the insurance plan and is editable.

## POLICYHOLDER/SUBSCRIBER INFORMATION

(This section (Box 12-Box 17) documents the information of the person(policyholder) who holds the insurance(indicated in box 3) to which the form is going to be submitted)

- Box 12
  - a. This field will be populated with the name and address of the policyholder. The value in this box should be in the format : Policyholder Name Address Line 1 Address Line 2 City, State, ZIP
  - b. The values in this box are populated as defined below:
    - i. Policyholder Name: This value should be in the format 'Last Name, First Name, Middle Initial, Suffix'. This value is populated from the field 'Policy Holder Name' under Patients>Insurances. This value will be pre populated and in disabled format.
    - ii. Address Line 1: This value will be populated from the field 'Address Line 1' under Patient>General>Basic Information of the policyholder(a policyholder is also identified as a patient in our system.). This will be a text box and will be editable.
    - iii. Address Line 2: This value will be populated from the field 'Address Line 2' under Patient>General>Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a text box and will be editable. If the address of the policyholder does not have address line 2, then the area for 'Address Line 2' should be left blank.
    - iv. City: This value will be populated from the field 'City' under Patient>General>Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a text box and will be editable.
    - v. State: This value will be populated from the field 'State' under Patient>General>Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a chosen box with the lists of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
    - vi. ZIP: This value will be populated from the field 'ZIP' under Patient>General>Basic Information of the policyholder(a policyholder is identified as a patient in our system.). This will be a text box and will be editable.
- The values Policy Holder Name, Address Line 1, City, State, and ZIP are mandatory fields.
- Box 13
  - a. This field will be populated with the date of birth of the policyholder identified in Box 12 in the format MM/DD/CCYY. This box will be populated from the field 'Date of Birth' under Patient>General>Basic Information of the policyholder(a policyholder is also identified as a patient in our system.)
  - b. This box is mandatory and needs to be populated and disabled.
- Box 14
  - a. This field will be marked with the gender of the policyholder identified in Box 12. This box will be populated from the field 'Gender' under Patient>General>Basic Information of the policyholder(a policyholder is also identified as a patient in our system.)
  - b. This box is not mandatory and will be disabled.
- Box 15
  - a. This field will be populated with the unique identifying number assigned by the payor to the person named in Item 12, which is on their identification card. This field should be populated from the field 'Patient Insured ID' under Patient>Insurances of the patient on behalf of which the form is to be submitted, if this is not saved in the system then value from the field 'Subscriber ID' under Patient>Insurances of the policyholder(identified in box 12) will be populated.
  - b. This is a mandatory field and should be disabled.
- Box 16
  - a. This box will be populated with the group number of the plan (identified in box 3) under which the form is to be submitted.
  - b. The value in this box should be populated from the field 'Group No.' under Practice Settings > Plans. This is a mandatory field and will be disabled.
- Box 17
  - a. This box will be populated with the employer(if any) of the plan under which the form is to be submitted.
  - b. The value in this box should be populated from the field 'Employer' under Practice Settings > Plans. This is not a mandatory field and will be disabled.

## PATIENT INFORMATION

(This section (Box 18-Box 23) documents the information of the patient on behalf of which the form is to be submitted).

- Box 18
  - a. This box will be marked with the relationship of the patient(on behalf of which the form is to be submitted) to the policyholder(identified in box 12).
  - b. The value is populated from the field 'Relationship to PolicyHolder' under Patient>Insurances. This is a mandatory field and will be disabled.
- Box 19
  - a. Leave this box blank and this will be disabled.
- Box 20

- a. This field will be populated with the name and address of the patient on behalf of which the form is to be submitted. The value in this box should be in the format : Patient Name Address Line 1 Address Line 2 City, State, ZIP
- b. The values in this box are populated as defined below:
  - i. Patient Name: This value should be in the format 'Last Name, First Name, Middle Initial, Suffix'. This value is populated from the respective fields under Patients>Insurances. This value will be pre populated and in disabled format.
  - ii. Address Line 1: This value will be populated from the field 'Address Line 1' under Patient>General>Basic Information of the patient(on behalf of which the form is to be submitted). This will be a text box and will be editable.
  - iii. Address Line 2: This value will be populated from the field 'Address Line 2' under Patient>General>Basic Information of the patient(on behalf of which the form is to be submitted). This will be a text box and will be editable. If the address of the patient does not have address line 2, then the area for 'Address Line 2' should be left blank.
  - iv. City: This value will be populated from the field 'City' under Patient>General>Basic Information of the patient(on behalf of which the form is to be submitted). This will be a text box and will be editable.
  - v. State: This value will be populated from the field 'State' under Patient>General>Basic Information of the patient(on behalf of which the form is to be submitted). This will be a chosen box with the lists of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
  - vi. ZIP: This value will be populated from the field 'ZIP' under Patient>General>Basic Information of the patient(on behalf of which the form is to be submitted). This will be a text box and will be editable.
- The values Policy Holder Name, Address Line 1, City, State, and ZIP are mandatory fields.
- Box 21
  - This box is populated by the date of birth of the patient(on behalf of which the form is to be submitted) from the field 'Date of Birth' under Patients>General>Basic Information.
  - This is a mandatory field and should be populated and disabled.
- Box 22
  - The gender of the patient(on behalf of which the form is to be submitted), is marked in this box from the field 'Gender' under Patients>General>Basic Information.
  - This is not a mandatory field and will be disabled.
- Box 23
  - This box should be populated with the ID of the patient(on behalf of which the form is to be submitted). This will be the Patient ID assigned to the patient in the system.
  - This field is mandatorily populated and will be disabled.

## RECORD OF SERVICES PROVIDED

(The 'Record Of Services Provided' section (Box 24 - Box 35) contains a grid that contains information regarding the proposed treatment (predetermination/preauthorization), or treatment performed (actual services)).

- Box 24
  - a. This column needs to be filled with the date on which the procedure is performed. This column is not applicable in the pre-authorization request, and hence it should be left blank, disabled and grayed out.
  - b. For claim, this should be a calendar widget. This column will act as mandatory for a row if any other column of that row is entered.
- Box 25
  - a. This field is to enter the area of the oral cavity in which the procedure is performed. This is a conditional field.
  - b. Always report the area of the oral cavity when the procedure reported in box 29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. But in MVP perspective, this is not validated and entering this field is purely user discretion, so this is not a mandatory field under any condition.
  - c. This will be a chosen drop-down that lists all the areas defined below and 'Select' being the default value. But only the code should be displayed in the field, once the value is selected. **Code Area** 00 entire oral cavity 01 maxillary arch 02 mandibular arch 10 upper right quadrant 20 upper left quadrant 30 lower left quadrant 40 lower right quadrant
- Box 26
  - a. This column will be populated with the tooth system for designating teeth. We are using the ADA's Universal/National Tooth Designation System, so the column needs to be populated with 'JP'.
  - b. This column in a row will be populated and disabled if any column in that row is filled. This column will remain empty for the rest of the rows in which no value is entered in any of the other columns in the grid.
- Box 27
  - a. This column should be populated with the teeth on which the procedure reported in box 29 is performed. Clicking on this field lists the teeth numbers and letters as per JP tooth system. The user can select the teeth applicable(only one tooth can be selected at a time).
  - b. This is not a mandatory column under any condition.

- Box 28
  - a. This column should be populated with the tooth surface on which the procedure is performed. This is a multi-select drop-down field that lists all the surfaces of a tooth. Please refer CSD-357 DONE for what and how the values should be populated while selecting teeth surface.
  - b. These values will be listed in this multi-select drop-down of a row, only if teeth is selected in Box 27 of that particular row. This is not a mandatory field under any condition.
- Box 29
  - a. This column needs to be filled with the code of the procedure performed(in claim form) or to be performed(in pre-authorization form).
  - b. This is a chosen box that lists all the ADA codes in the format 'Code - Description' saved in the system for eg: D0120 - Periodic Oral Evaluation. On selecting a value from the list, only the code should get populated in the field for eg: D0120. The values in this list are retrieved from the fields 'Procedure Code' and 'Description' under Codes > Procedure Codes.
  - c. This is a mandatory column for a row, only if any other column in that row is filled.
- Box 29a
  - a. This column needs to be filled with the diagnosis pointer applicable for the dental procedure entered in box 29.
  - b. This will be a dropdown with the letters corresponding to the diagnosis code in Box 34a. Only the letters corresponding to the diagnosis codes entered in 34a will be listed in this drop-down.
  - c. If you complete Box 29a Diagnosis Pointer, you must also complete Box 34 Diagnosis Qualifier and Block 34a Diagnosis Code(s).
  - d. All the diagnosis code entered in box 34a should be pointed to one or other procedure in the grid i.e, there should not be unused diagnosis codes entered in 34a
  - This is not a mandatory field.
- Box 30
  - a. This column will be filled with the description of the procedure selected in box 29.
  - b. This column will be auto-populated from the field 'Description' under Codes>ADA Codes, once the procedure code is selected in box 29. This column will be disabled.
- Box 31
  - a. This field needs to be filled with the fees of the procedure code selected in box 29.
  - b. This will be a text field which will be auto-populated from the field " under Practice Settings > Fee Schedules but will be editable.
  - This column in a row will act as mandatory if any other column of that row is filled.
- Box 31a
  - a. This box can be filled when other charges applicable to dental services provided must be reported. Charges may include state tax and other charges imposed by regulatory bodies.
  - b. This will be an editable text field and is not mandatory.
- Box 32
  - a. This box will be auto-populated with the sum of all fees from lines in box 31, plus any fees entered in box 31a.
  - b. This field will be auto-populated and disabled.
- Box 33
  - a. This box is used to enter the missing teeth information of the patient.
  - b. Click on the missing teeth numbers, so that an X will be placed over it. It is mandatory that the user should mark the missing tooth(if any) of the patient.
- Box 34
  - a. The appropriate code to identify the diagnosis code source should be filled in this box.
  - b. This will be a dropdown with one value 'ICD-10' and 'Select' being the default value. When the user selects 'ICD-10' from the dropdown, then the box should be populated with the code 'AB'(which is the code for ICD-10)
  - c. If the user completes 34 Diagnosis Qualifiers, then he must also complete Block 29a Diagnosis Pointer and Block 34a Diagnosis Code(s).
- Box 34a
  - a. This box is used to enter up to 4 applicable diagnosis codes after each letter (A - D). There will be a chosen box after each letter with the list of all diagnosis codes saved in the system. The values in these chosen boxes should be in the format 'Code - Description' and is retrieved from Practice Settings > ICD Codes.
  - b. Enter the primary diagnosis code adjacent to the letter "A". Enter subsequent diagnosis codes adjacent to the letters "B", "C" and "D" in sequential order.
  - c. No two dropdowns should hold the same diagnosis codes. The user should add the primary diagnosis code(A) first before entering B, C or D. Similarly B should be filled before C and C should be filled before D.
  - d. If the user completes Block 34a Diagnosis Code(s), then he must also complete Block 29a Diagnosis Pointer and Block 34 Diagnosis Qualifier.
  - e. All the diagnosis code entered should be pointed to one or other procedures in box 29a i.e, there should not be unused diagnosis codes entered in box 34a
- Box 35
  - a. This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim (e.g., for a secondary claim, the amount the primary carrier paid). This is not a mandatory field.
  - b. Any information that had been entered in the Remarks field of the Details tab should be populated in this field.

## AUTHORIZATIONS

(This section(Box 36 - Box 37) provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.)

- Box 36
  - This box is used to capture the signature of the patient or the patient's representative and the Date.
  - a. By signing (or "Signature on File" notice) in this location of the form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.
  - b. This will be a dropdown with values 'Signature on File' and blank with 'Signature on File' being the default value.
  - c. The Date will be a calendar widget populated with the current date. The user can remove or change the date if required.
  - d. Both Signature and Date are not mandatory.
- Box 37
  - a. This box is used to capture the signature(signature of the policyholder) and date (or "Signature on File" notice) are required when the Policyholder/Subscriber named in Item #12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment.
  - b. This will be a dropdown with values 'Signature on File' and blank with 'Signature on File' being the default value.
  - c. The Date will be a calendar widget populated with the current date. The user can remove or change the date if required.
  - d. Both Signature and Date are not mandatory.

## ANCILLARY CLAIM/TREATMENT INFORMATION

(This section(Box 38 - Box 47) of the claim form provides additional information to the third party payer regarding the claim.)

- Box 38
  - a. This box needs to be filled with the 2 digit Place of treatment code.
  - b. This will be a chosen box that lists all the places of service saved in the system, for example, O/P Hospital, Office etc. On selecting any value from the list, the box should be populated with the 2 digit code of the selected place of treatment for eg: 11, 12 etc
  - The default value of this field will be as set for the corresponding field in Practice Setting > Payment > Claim form Defaults > Dental.
  - c. This is not a mandatory field.
- Box 39
  - a. This is a drop-down with values 'Yes' and 'No', with the default value specified in the field 'Enclosures' under Practice Setting > Payment > Claim form Defaults > Dental.
  - b. This box indicates whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).
- Box 40
  - a. This box indicates whether the treatment is for orthodontics or not. If Yes is marked then 41 and 42 should be mandatorily filled. If 'No' is marked then 41 and 42 will be disabled and grayed out.
  - b. The default value of this field will be as specified in the field 'Is Treatment for Orthodontics' under Practice Setting > Payment > Claim form Defaults > Dental.
- Box 41
  - a. This should be a calendar widget that should be filled with the date of the appliance placed in the format MM/DD/CCYY.
  - b. This box will be enabled and should be mandatorily filled if 'yes' is marked in Box 40. If 'No' is marked under box 40, then this box will be disabled and grayed out.
- Box 42
  - a. This should be a text field that needs to be filled with the total number of months required to complete the orthodontic procedure
  - b. This box will be enabled and should be mandatorily filled if 'yes' is marked in Box 40. If 'No' is marked under box 40, then this box will be disabled and grayed out.
- Box 43
  - a. This box indicates whether the procedure involves a prosthetic restoration. If 'yes' is marked in this box then Box 44 will become mandatory. If 'No' is marked in this box the box 44 will be disabled and grayed out.
  - b. The box will be initially populated with the default value as specified in the field 'Replacement of Prosthesis' under Practice Setting > Payment > Claim form Defaults > Dental.
- Box 44
  - a. This box needs to be mandatorily filled with the date of prior placement of the prosthetic restoration in the format MM/DD/CCYY if 'yes' is marked in box 43. This box will be disabled and grayed out if 'no' is marked in box 43.
  - b. This will be a calendar widget.
- Box 45

- a. This box indicates whether the treatment is resulting from 'Occupational illness/Injury', 'Auto Accident', 'Other Accident'.
- b. If 'Occupational illness/Injury' is marked, then box 46 will become mandatory and 47 will be blank, disabled and grayed out. If 'Auto Accident' is marked then box 46 and 47 will become mandatory. If 'Other Accident' is marked, then box 46 will become mandatory and 47 will become blank, disabled and grayed out. If nothing is marked in this box, then boxes 46 and 47 will be blank, disabled and grayed out.
- c. This is not a mandatory field
- Box 46
  - a. This field will be a calendar widget that needs to be filled with the date of accident in the format MM/DD/CCYY.
  - b. This is mandatory if any value is marked under Box 45. If nothing is marked in box 45, then this box will be blank, disabled and grayed out.
- Box 47
  - a. This field indicates the state where the accident happened.
  - b. This should be a chosen box that lists all states in the US with 'Select' being the default value. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
  - c. This is a mandatory field if 'Auto Accident' is marked under box 45. If any other value is marked in Box 45, then this box will be blank, disabled and grayed out.

## BILLING DENTIST OR DENTAL ENTITY

(The 'Billing Dentist' or 'Dental Entity' section(Box 48 - Box 52a) provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information.)

- Box 48
  - a. This box needs to be filled with the name and complete address of a dentist or dental entity.
  - b. There will be a dropdown above the box 48 that holds two values 'Billing Dentist' and 'Dental Entity'. This drop-down determines the value to be populated in box 48(name and address of the dental entity or the name and address of the dentist). The default value of this dropdown is specified in the field 'Billing Provider or Dental Entity' under Practice Setting > Payment > Claim form Defaults > Dental.
  - c. The box should be populated in the format Billing Provider Name/Dental Entity Name Address Line 1 Address Line 2 City, State, ZIP
  - d. If 'Billing Dentist' is selected in the drop-down above the box 48, the value in box 48 should be as follows:
    - i. Billing Provider Name - This value should be populated from the field 'Default Billing Provider' under Practice Setting > Payment > Claim form Defaults > Dental. This will be a chosen box that lists the name of all providers saved for the account in the system. The names should be in the format Last Name, First Name, Middle Initial, Suffix. This is editable and the user can change the provider if required.
    - ii. Address Line 1 - This value should be populated from the field 'Address Line 1' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable.
    - iii. Address Line 2 - This value should be populated from the field 'Address Line 2' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable. If the address of the billing dentist does not have address line 2, then the area for 'Address Line 2' should be left blank.
    - iv. City - This value should be populated from the field 'City' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable.
    - v. State- This value should be populated from the field 'State' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This will be a dropdown with the list of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc.
    - vi. ZIP- This value should be populated from the field 'ZIP' in the screen Practice Setting > Administration > Users of the provider specified in 'Billing Provider Name'. This is a text field and is editable.
  - e. If 'Dental Entity' is selected in the drop down above the box 48, the value in box 48 should be as follows:
    - i. Dental Entity Name - This value should be populated from the field 'Name of Dental Entity' under Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
    - ii. Address Line 1 - This value should be populated from the field 'Address Line 1' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
    - iii. Address Line 2 - This value should be populated from the field 'Address Line 2' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable. If the address of the dental entity does not have address line 2, then the area for 'Address Line 2' should be left blank.
    - iv. City - This value should be populated from the field 'City' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
    - v. State- This value should be populated from the field 'State' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This will be a dropdown with the list of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc.
    - vi. ZIP- This value should be populated from the field 'ZIP' in the screen Practice Setting > Payment > Claim form Defaults > Dental. This is a text field and is editable.
  - f. The mandatory field in this section are: Name(Billing Provider Name/Dental Entity Name), Address Line 1, City, State, ZIP
- Box 49
  - a. This box will get filled with the appropriate NPI of the billing entity/billing provider (based on that specified in box 48).

- o i. If the billing entity is specified in box 48, then NPI will get populated from the field NPI in the screen Practice Setting > Payment > Claim form Defaults > Dental. In this case, this box will be an editable text field.
  - o ii. If the billing provider is specified in box 48, then NPI will get populated from the field NPI in the screen Practice Setting > Administration > Users of the respective provider. In this case, this box will not be editable.
- b. This is a mandatory box.
- Box 50
  - a. This box is to be filled with the License Number of the billing provider. This field will not be applicable and can be disabled, if 'Dental Entity' is specified in box 48. If 'Billing Provider' is specified in box 48, then this field will get auto-populated from Practice Setting > Administration > Users screen of the respective provider.
  - b. This is not a mandatory field under any conditions.
- Box 51
  - a. This box is to be filled with the TAX ID of Billing Dentist/Dental Entity specified in Box 48.
    - i. If the billing entity is specified in box 48, then TAX ID will get populated from the field TIN in the screen Practice Setting > Payment > Claim form Defaults > Dental. In this case, this box will be an editable text field.
    - ii. If the billing provider is specified in box 48, then TAX ID will get populated from the field TAX ID in the screen Practice Setting > Administration > Users of the respective provider. In this case, this box will not be editable.
  - b. This is not a mandatory field.
- Box 52
  - a. This box is to be filled with the Phone number of Billing Dentist/Dental Entity specified in Box 48.
    - i. If the billing entity is specified in box 48, then this box will get populated from the field Phone in the screen Practice Setting > Payment > Claim form Defaults > Dental.
    - ii. If the billing provider is specified in box 48, then this box will get populated from the field Phone in the screen Practice Setting > Administration > Users of the respective provider.
  - c. This is not a mandatory field and will be an editable text field.
- Box 52a
  - a. This box is to be filled with the provider ID provided by the payor to the provider.
  - b. This box will be empty, disabled and grayed out if data specified in box 48 is a dental entity. If the value specified in box 48 is billing provider, then this box should be populated with the Provider Insurance ID(if exists) from the field 'Insurance ID' in the screen Practice Settings > Carriers.
  - c. This is not a mandatory field and will be an editable text field.

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

(Information that is specific to the dentist or practitioner acting within the scope of their state licensure who has provided treatment is entered in this section (Box 53 - Box 58))

- Box 53
  - a. The original authorized signature of the treating provider and the date the form is signed. This box may also be inserted with the treating dentist's name.
  - b. The signature field in this box will be a dropdown prepopulated with the treating dentist's name(in the format Last Name, First Name, Middle Initial, Suffix) as specified in the field 'Provider' under 'Authorization Details' tab. This drop-down should contain a blank entry so that the treating provider's original signature can be added here.
  - c. The date field in this box should be a calendar widget prepopulated with the current date. The date should be in the format MM/DD/CCYY, and this is an editable field.
- Box 54
  - a. This box should get populated with the NPI of the treating provider specified in the field 'Provider' under 'Authorization Details' tab.
  - b. The value is retrieved from the field 'NPI' in the screen Practice Setting > Administration > Users of the respective provider.
  - c. This should be a mandatory field and will be pre-populated and disabled.
- Box 55
  - a. This box should get populated with the license number of the treating provider specified in the field 'Provider' under 'Authorization Details' tab.
  - b. The value is retrieved from the field 'License No'(if any) in the screen Practice Setting > Administration > Users of the respective provider.
  - c. This should be mandatory and will be an editable text field.
- Box 56
  - a. This box should be filled with the address of the treating provider specified in the field 'Provider' under 'Authorization Details' tab.
  - b. The Address should get populated in the format Address Line 1 Address Line 2 City, State, ZIP
  - c. The values in this box are as defined below:
    - i. Address Line 1: This should be an editable text field populated with the first line of the address of the provider from the field 'Address Line 1' in the screen Practice Setting > Administration > Users of the respective treating provider.

- i. Address Line 2: This should be an editable text field populated with the second line of the address of the provider from the field 'Address Line 2' in the screen Practice Setting > Administration > Users of the respective treating provider. If the address of the provider does not have address line 2, then the area for 'Address Line 2' should be left blank.
  - iii. City: This should be an editable text field populated with the city of the provider from the field 'City' in the screen Practice Setting > Administration > Users of the respective treating provider.
  - iv. State: This should be an editable chosen box that lists all states in the US and prepopulated with the state of the provider from the field 'State' in the screen Practice Setting > Administration > Users of the respective treating provider. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
  - v. ZIP : This should be an editable text field populated with the zip code of the provider from the field 'ZIP' in the screen Practice Setting > Administration > Users of the respective treating provider.
- Box 56a
  - a. This box needs to be filled with the provider specialty code of the treating provider specified in the field 'Provider' under 'Authorization Details' tab.
  - This field should be auto-populated with the taxonomy code of the specialty specified in the field 'Specialty' under the screen Practice Setting > Administration > Users of the respective treating provider.
  - The taxonomy code is defined under Practice Setting > Codes > Taxonomy Codes
  - This box should be mandatory and will be populated and disabled.
- Box 57
  - a. This box is to be filled with the phone number of the treating provider specified in the field 'Provider' under 'Authorization Details' tab.
  - b. The value in this box is populated from the field 'Phone'(if any) under the screen Practice Setting > Administration > Users of the respective treating provider.
  - c. This box is not mandatory and will be an editable text field.
- Box 58
  - a. This field needs to be populated with the Additional Provider ID(if any) of the treating provider specified in the field 'Provider' under 'Authorization Details' tab.
  - b. This box should be populated with the Provider Insurance ID(if exists) from the field 'Insurance ID' of the respective treating provider in the screen Practice Setting > Carriers > Provider Insurance ID.
  - c. This is not a mandatory box and will be an editable text field.

## ASSIGN BENEFITS TO PATIENT

**Case 1:** An ABP label is added to the patient and the claims are not submitted:

- The subscriber signature field (field 37) should be disabled and empty for both paper based and electronic claim channels.
- The Billing dentist/Dental entity information fields (fields 48-52) should be filled and mandatory for electronic claims.
- The Billing dentist/Dental entity information fields (fields 48-52) should be optionally filled (can either be filled or empty) and non-mandatory for paper based claims.
- For paper based claims, the fields 48-52 should be left blank by default and can be edited whereas for electronic claims it should be filled and can be edited.
- The Billing dentist/Dental entity information fields (fields 48-52) should not retain information in case of higher order claims.

**Case 2:** A claim has been submitted and the ABP flag is added after submission

- The values in field 39 & 48-52 should be retained with the values before submission. This should also be retained/consistent while printing claims.
- If the user tries to 'Edit and Resubmit', then the current ABP state of the patient should be updated. i.e the ABP functionality related changes should be brought to the claim form. The user should have the updated changes if they proceed with resubmission.
- If the user discards the changes by clicking on 'Cancel', then the fields should be reverted to how it was before the 'Edit & Resubmit' action.

Note:

for electronic claims will have default values for the items mentioned above.

en the Assign Benefits to Patient (ABP) flag is ON, the CLM08 (Assign Benefit to Provider) in EDI should be N.

ase the default values are not available, such claims must be raised as paper claims without an option to convert to electronic.

ing Batch generation, validation for Billing dentists/ Dental entity should not be fired

ABP flag	CLM08
ON	N

OFF

Y

## **ADA 2012 Claim Form**

ADA American Dental Association® Dental Claim Form

**HEADER INFORMATION**

1. Type of Insurance (check all applicable boxes)	
<input type="checkbox"/> Commercial Group Insurance	<input type="checkbox"/> Dental for Professionals/Healthcare
<input checked="" type="checkbox"/> Medicare/Medicaid	

2. Relationship to Insured/Claimant:

**INSURANCE COMPANY/DENTAL INSURER PLAN INFORMATION**

3. Company/Payer Name, Address, City, State, Zip Code:

**OTHER COVERAGE** (check applicable boxes and complete items 3.11-3.14 if applicable)

3.1. Other dental plan coverage (check all applicable boxes):

3.2. Name of other dental plan company (if different from above, attach name of plan):

3.3. Name of other dental plan company (if different from above, attach name of plan):

3.4. Name of other dental plan company (if different from above, attach name of plan):

3.5. Name of other dental plan company (if different from above, attach name of plan):

3.6. Name of other dental plan company (if different from above, attach name of plan):

3.7. Name of other dental plan company (if different from above, attach name of plan):

3.8. Name of other dental plan company (if different from above, attach name of plan):

3.9. Name of other dental plan company (if different from above, attach name of plan):

3.10. Name of other dental plan company (if different from above, attach name of plan):

3.11. Other insurance company/payer name, address, zip, state, zip code:

**DETAILS OF SERVICES RENDERED**

3.12. Procedure Code (check all applicable)	3.13. Date of Service	3.14. Name of Provider or Dentist	3.15. Description	3.16. Fee
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# Claim Forms: CMS 1500 Medical Claim Form

Written by Aswathy B Nair | Last published at: August 22, 2021

1. CMS 1500 form is used as a claim form for sending claims to the insurance companies on behalf of the patient.

2. Below are the fields which are mentioned as items in CMS 1500 form

## Payer Block

(The 'Carrier Block' located in the upper center and right margin of the form)

- The white, open carrier area should contain the name and address of the Carrier to whom the claim is to be sent.
- The address of the Carrier associated with the Plan that is selected for the claim should be printed in this area.
- In **Practice Settings > View Plan > Carrier Details**, there is a drop-down labeled 'Details same as Carrier'. If that is set as 'YES', the address of the Carrier itself should be auto-populated. If it is set to 'NO', the user should enter a separate address for the PLAN.
- The format for entering name and address is: Carrier Name Address Line 1 Address Line 2 City State ZIP
- The values in this box will be populated as defined below:
- Name: Name of the Carrier which is associated with the plan selected for the claim in the 'Add Claim Details' section. The name is populated from the field 'Name' under the **PRACTICE SETTINGS > CARRIERS** screen of the Carrier to whom the claim is to be sent.
- Address Line 1: This should be an editable text field that should be populated with the first line of the address of the Carrier as saved in the field ADDRESS LINE 1 under the **PRACTICE SETTINGS > VIEW PLAN > CARRIER DETAILS** section of the plan under which the claim should be sent.
- Address Line 2: This should be an editable text field that should be populated with the second line of the address of the Carrier as saved in the field ADDRESS LINE 2 under the **PRACTICE SETTINGS > VIEW PLAN > CARRIER DETAILS** section of the plan under which the claim should be sent. If the address does not have ADDRESS LINE 2, then the area for Address Line 2 should be left blank. Please refer 'Address with 4 lines.png', 'Address with 3 lines.png'.
- iv. City: This should be an editable text field that should be populated with the city of the Carrier as saved in the field CITY under **PRACTICE SETTINGS > VIEW PLAN > CARRIER DETAILS** section of the plan under which the claim should be sent.
- v. State: This should be a chosen box that lists all states in US and prepopulated with the state as saved in the field STATE under **PRACTICE SETTINGS > VIEW PLAN > CARRIER DETAILS** section of the plan under which the claim should be sent. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
- vi. ZIP: This should be an editable text field populated with the zip code as saved under the field ZIP under **PRACTICE SETTINGS > VIEW PLAN > CARRIER DETAILS** section of the plan under which the claim should be sent.
- Do not use punctuation (i.e., commas, periods) or other symbols in the address. For a 9-digit ZIP code, include the hyphen.

## Patient And Insured Information (ITEMS 1–13)

- **Item Number 1** (Indicates the type of health insurance coverage applicable to this claim)
- Contains the check-box options with titles: Medicare (Medicare#), Medicaid (Medicaid#), TRICARE (ID#/DoD#), CHAMPVA (Member ID#), Group Health Plan (ID#), FECA BLK LUNG (#ID), OTHER.
- Only one option can be chosen at a time.
- **Item Number 1a** (The INSURED'S ID NUMBER is the identification number of the Policyholder. This information identifies the insured to the carrier.)
- Field Title is INSURED'S ID NUMBER.
- This box will be pre-populated based on the data saved for the patient and will load the data from PATIENT > GENERAL > INSURANCE > INSURANCE DETAILS.
- If the RELATIONSHIP TO POLICYHOLDER for the selected insurance is SELF then the SUBSCRIBER ID is loaded. Else the PATIENT INSURED ID will be loaded. If the PATIENT INSURED ID is blank, then the SUBSCRIBER ID of the Policyholder is taken. The Policyholder is identified as a patient in the system.
- **Item Number 2** (Patient's name)
- Field Title is PATIENT'S NAME
- The Patient's name will be loaded from the PATIENT > BASIC INFORMATION section and shall be pre-populated in the format last name, first name, and middle initial.
- Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. Do not include Prefixes and Titles.
- **Item Number 3** (Patient's Birth Date, Sex)
- The fields will be auto populated from PATIENT > BASIC INFORMATION.
- Patient's Birth Date: The Date of Birth of the patient should be loaded in the format MM/DD/CCYY.
- Sex: The gender of the patient will be marked (If Available, Else leave blank)

- **Item Number 4** (Insured's Name)
- Field Title is INSURED'S NAME.

- This field should be auto populated with the name in the POLICYHOLDER field for the selected insurance in PATIENT > GENERAL > INSURANCES. Should not be editable.
- If the RELATIONSHIP TO INSURED for the selected insurance is SELF then the value in this field will be the Patient Name itself, Else the name of the Policyholder of the selected Insurance will have been selected.
- Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. Do not Include Prefixes and Titles.

- **Item Number 5** (The "Patient's Address" is the patient's permanent residence Address)

- Field Contains multiple titles
- This field will be auto populated with the address of the Patient from the system.
- The Format for displaying address is:
  - Patient's Address (No., Street): this should be a text field populated with the first and second line of address of the patient as saved under the ADDRESS in PATIENT > GENERAL > BASIC INFORMATION and is editable. Do not use punctuation (i.e., commas, periods) or other symbols in the address.
  - City: This value will be populated from the field 'City' under PATIENT > GENERAL > BASIC INFORMATION of the policyholder(a policyholder is identified as a patient in our system.). This will be a text box and will be editable.
  - State: This value will be populated from the field 'State' under PATIENT > GENERAL > BASIC INFORMATION of the patient. This will be a chosen box with the lists of all states in the US. The full name of the states should be shown in the drop-down for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
  - ZIP Code: This value will be populated from the field 'ZIP' under PATIENT > GENERAL > BASIC INFORMATION of the Patient. This will be a text box and will be editable. For a 9-digit ZIP code, include the hyphen.
  - Telephone:(Optional) Phone Number along with Area code, Phone extensions are not supported. Can be pre-populated from the PHONE field in PATIENT > GENERAL > BASIC INFORMATION but kept editable.

- **Item Number 6** (The "Patient Relationship to Insured" indicates how the patient is related to the insured. SELF would indicate that the insured is the patient.)

- Contains the options: SELF, SPOUSE, CHILD, OTHER.
- Only one option can be selected at a time
- Will be pre-selected based on the selected Insurance from PATIENT > GENERAL > INSURANCES.

- **Item Number 7** (The Insured's Address is the insured's permanent residence Address)

- This field will be auto populated with the Address of the Policyholder for the selected insurance.
- If the RELATIONSHIP TO POLICYHOLDER for the selected insurance is SELF then this field will be populated with the Patient Address itself, Else the Address of the Policyholder of the selected Insurance will be loaded in the field. The Policyholder is identified as a patient in the system.
- The Format for displaying address is:
  - Insured's Address: This value will be populated from the field ADDRESS LINE 1 and ADDRESS LINE 2 under PATIENT > GENERAL > BASIC INFORMATION of the policyholder. This will be a text box and will be editable. Do not use punctuation (i.e., commas, periods) or other symbols in the address.
  - City: This value will be populated from the field CITY under PATIENT > GENERAL > BASIC INFORMATION of the policyholder. This will be a text box and will be editable.
  - State: This value will be populated from the field STATE under PATIENT > GENERAL > BASIC INFORMATION of the policyholder. This will be a chosen box with the lists of all states in the US. The full name of the states should be shown in the list for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc
  - ZIP Code: This value will be populated from the field ZIP under PATIENT > GENERAL > BASIC INFORMATION of the policyholder. This will be a text box and will be editable. For a 9-digit ZIP code, include the hyphen.
  - Telephone:(Optional) Phone Number along with Area code, Phone extensions are not supported. Can be pre-populated from the PHONE field in PATIENT > GENERAL > BASIC INFORMATION of the Policyholder.

- **Item Number 8** (Reserved for National Uniform Claim Committee(NUCC) Use)

- Disabled

- **Item Number 9** (If a secondary insurance plan is also included with the claim, The Other Insured's Name is the name of the policyholder of the included secondary insurance.)

- The field name is Other Insured's Name
- This field is required and enabled only if Item Number 11d is set as "YES". Otherwise the field remains disabled.
- If the RELATIONSHIP TO POLICYHOLDER for the selected insurance is "self" then the value in this field shall be the Patient Name itself. Else the name will be loaded from PATIENTS > GENERAL > BASIC INFORMATION of the selected Policyholder.
- Displayed in the format last name, first name, and middle initial(commas are to be used as separators). A hyphen can be used for hyphenated names. Do not use periods within the name. Do not include Prefixes and Titles.

- **Item Number 9a** (the policy or group number for coverage of the insured as indicated in Item Number 9)
- This field is required and enabled only if Item Number 11d is set as YES.
- The group number of secondary insurance is pre-populated from the field GROUP NUMBER from PRACTICE SETTINGS > PLANS > PLAN DETAILS.

- **Item Number 9b** (Reserved for NUCC Use)
- Disabled

- **Item Number 9c** (Reserved for NUCC Use)
- Disabled

- **Item Number 9d** (The name of the secondary insurance plan)
- This field is required and enabled only if Item Number 11d is set as YES.
- The Plan name of the Secondary Insurance gets auto populated from the field named PLAN in PATIENT > GENERAL > INSURANCES.

- **Item Number 10a-10c** (indicates whether the patient's illness or injury is related to employment, auto accident, or other accident.)
- 10a: Contains Radio boxes with Options YES or NO.
- 10b: Contains Radio boxes with Options YES or NO and a State List (a chosen box with the lists of all states in the US. The full name of the states should be shown in the drop-down, for eg: Florida, Alabama etc, but only the code of the selected state should be displayed in the collapsed view of the chosen box. for eg: FL, AL etc)
- 10c: Contains Radio boxes with Options YES or NO

- **Item Number 10d** (The Claim Codes identify additional information about the patient's condition or the claim)
- Text-box input

- **Item Number 11**

- The Group Number of the Primary Insurance plan. It is to be pre-populated from the field GROUP NUMBER from PRACTICE SETTINGS > PLANS > PLAN DETAILS of the Plan that was selected for the claim.

- **Item Number 11a** (The birth date and gender of the insured as indicated in Item Number 1a)

• Insured's Date of Birth: If the RELATIONSHIP TO PATIENT for the selected Insurance is SELF, the date should get pre-populated from the DATE OF BIRTH field in PATIENT GENERAL > BASIC INFORMATION. Else the date should get pre-populated from the DATE OF BIRTH field in the PATIENT > GENERAL > BASIC INFORMATION of the selected Policyholder. It should be in the format MM/DD/CCYY.

• Sex: If the RELATIONSHIP TO PATIENT for the selected insurance is SELF, the data should be pre-populated from the GENDER field in PATIENT > GENERAL > BASIC INFORMATION of the patient itself. Else the date should get pre-populated from the GENDER field in PATIENT > GENERAL > BASIC INFORMATION of the selected Policyholder. This field is optional, if there is no value available, then it should be left blank.

- **Item Number 11b**

- The Other Claim ID is another identifier applicable to the claim
- The field allows for the entry of the following: 2 characters to the left of the vertical line and 28 characters to the right of the dotted line

- **Item Number 11c** (name of the plan indicated in Item Number 1a)

- The plan name of primary insurance gets auto populated from the field named PLAN in PATIENT > GENERAL > INSURANCES.

- Item Number 11d**

- Contains two Radio buttons YES and NO.
- If the YES option is marked. The Item numbers 9, 9a, 9b, 9c and 9d become required and enabled.

- Item Number 12**

- The SIGNED field will have a drop down with options: EMPTY, SIGNATURE ON FILE and the Patient's Name.
- The Date field will be Auto populated with the current date in the format MM/DD/CCYY.

- Item Number 13**

- The Signed field will have a drop down with options: EMPTY, SIGNATURE ON FILE and the Patient's Name.

## Physician Or Supplier Information(ITEMS 14–33)

- Item Number 14**

- Date: Used to identify the first date of onset of illness, the actual date of injury, or the LMP for pregnancy. Should be in the format MM/DD/CCYY.
- Qual: Field to input the applicable qualifier to identify which date is being reported. Dropdown with following values -
  - 431 Onset of Current Symptoms or Illness
  - 484 Last Menstrual Period

- Item Number 15**

- Date: Enter date related to the patient's condition or treatment in the format MM/DD/CCYY
- Qual: Field to input the applicable qualifier to identify which date is being reported. Dropdown with the following values -
  - 454 Initial Treatment
  - 304 Latest Visit or Consultation
  - 453 Acute Manifestation of a Chronic Condition
  - 439 Accident
  - 455 Last X-ray
  - 471 Prescription
  - 090 Report Start (Assumed Care Date)
  - 091 Report End (Relinquished Care Date)
  - 444 First Visit or Consultation

- Item Number 16** (time span the patient is or was unable to work)

- Will Contain From date and To date fields to enter dates in the format MM/DD/CCYY
- The To date should be higher than From Date

- Item Number 17** (The name of the referring provider, ordering provider, or supervising provider)

- There will be a qualifier field and a text entry field separated by a vertical line:
- Chosen box to select qualifier is to the left of the vertical line. The chosen box should list the values DN, DK and DQ.
- Input field to enter the Referring Provider. Auto-populated with the name of the Referring Provider(if any selected) in PATIENT > GENERAL > BASIC INFORMATION(if IS THIS A REFERRED PATIENT? is set to YES and REFERRAL SOURCE is PROVIDER). Qualifier should be auto-populated with DN if there is a Referring Provider for the patient. Should be populated as FirstName LastName.

- Item Number 17a**

- There will be a qualifier field and a text entry field separated by a vertical line:
- Chosen box to select qualifier is to the left of the vertical line. The chosen box should list the values OB, 1G, G2 and LU.
- Input field to enter the relevant ID of the provider.

- **Item Number 17b**
- Input field to enter the HIPAA NPI number.
  
- **Item Number 18** (time span of inpatient stay and indicates the admission and discharge dates associated with the service)
- Will Contain from date and to date fields.
- The To date should be higher than From Date.
  
- **Item Number 19** (identifies additional information about the patient's condition or the claim)
- Text-box to input data.
  
- **Item Number 20** (services have been rendered by an independent provider mentioned in Item number 32)
- There will be a Radio button group and a text entry field
- The Radio buttons will have Values YES and NO, If yes is chosen Item number 32 will become required and enabled.
- The charges title will have two text areas to denote the dollar and cent amounts ( Do not use dollar signs, commas, or a decimal points)
  
- **Item Number 21** ( Information of the diagnosis and illness condition is given in this box)
- ICD Indicator denotes the Version of the ICD code being used. The ICD indicator for ICD-10 codes is **0** and for ICD-9 codes is **9**.
- Diagnosis or Nature of Illness or Injury has 12 Fields labeled from A to L. These fields will be related to the lines of service in 24E by the Diagnosis Pointer given for the line. Each field should be a chosen field which lists all the ICD-10 codes in the system.
- The codes can only be filled in the proper order (e.g Filling C after A by skipping on B is not allowed)
  
- **Item Number 22**
- The fields will contain two parts RESUBMISSION CODE and ORIGINAL REF NO.
- There will be a drop down with values **7** and **8** in the RESUBMISSION CODE section on the left hand side. Originally left blank.
- There will be a text input field to enter the Original Ref No i.e., the Claim Control Number which is mandatory, if a value is selected in the RESUBMISSION CODE drop-down.
- Not mandatory.
  
- **Item Number 23** --This field should be populated with the latest pre-authorization number relating to the current plan, associated with a code used in the claim, provided there are any units left to use.
- If there are multiple authorization numbers applicable, then the auth numbers should be separated by ','.
  
- **Section 24** ( ITEM NUMBER 24A to ITEM NUMBER 24J )
- There are six service lines in Section 24 that have been divided horizontally like a table. The top area of the six service lines is shaded and is the location for reporting supplemental information
  
- **Item Number 24A** (Time span in which the service(s) was provided)
- Will Contain from date and to date fields
- The To date should be higher than From Date
  
- **Item Number 24B**
- The Place of Service Code identifies the location where the service was rendered.
- A chosen box will be provided from which appropriate two-digit code can be selected from the Place of Service Code list
- For Place of Service Codes, refer <https://docs.google.com/spreadsheets/d/1kr7wl4q7fTqge6QDzUgtKjM8arqFK76HBIF9WJi8Ixg/edit#gid=745816296&vpid=A31>
  
- **Item Number 24C** (Denotes if the service was an emergency)
- This field will have a drop down with values YES and NO.
- If YES is selected ,Y should be shown. Otherwise, leave blank.

- **Item Number 24D**

- There will be two sections: CPT or HCPCS code and MODIFIER(s)
- CPT or HCPCS code: 6 characters. Chosen field which should list all the Medical Codes available in the system.
- MODIFIER: four sets of 2 characters. Each set should be a chosen field which lists all the Procedure Modifier Codes available in the system.

- **Item Number 24E**

- The DIAGNOSIS POINTER is the line letter from Item Number 21 that relates to the reason the service(s) was performed
- It is a multi-select chosen box with characters A to L.
- A maximum of 4 characters is allowed in one field.

- **Item Number 24F** (total billed amount for each service line)

- The amount should be expressed as the dollar and cents in the two boxes
- not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number

- **Item Number 24G** (number of days corresponding to the dates entered in 24A)

- Numeric field with maximum of 3 characters allowed.

- **Item Number 24H**

- The field will have a drop-down with values YES and NO. If the value is YES, the field will be populated with Y and if the value is NO, the field will be N.
- If the value chosen is YES, the shaded area above the drop-down will be enabled and will contain a drop down with the following two-character codes: AV, S2, ST, NU. Default will be blank.

- **Item Number 24I**

- A drop down will be there in the Shaded Area with values 0B , 1G, G2, LU, ZZ. Default will be blank.

- **Item Number 24J**

- The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care
- There will be two input boxes, one in the shaded area (For entering the ID number corresponding to the selected provider) and another in the non-shaded area (For entering the NPI Number).

- **Item Number 25**

- The FEDERAL TAX ID of the Billing Provider. It can be either the Employer ID No. or the Provider's Social Security Number.
- There is a Text Input field and two selectable options, EIN and SSN. Only one option can be selected at once.
- The value should get pre-populated from the field TAX ID in PRACTICE SETTINGS > BASIC INFORMATION and the option EIN should be selected by default. If SSN is selected, the TAX ID field should be left blank and editable. If EIN is selected, the TAX ID of the Practice should be populated again.

- **Item Number 26**

- The Value gets pre populated with the PATIENT ID of the particular patient.

- **Item Number 27**

- A radio button group will be provided with values YES and NO.

- **Item Number 28**

- Total of all the charges in 24F will be calculated and be auto-filled in this field.
- It should be filled in the two fields on either side of the vertical line to denote the dollars and cents as applicable. If the whole number, cents field should be populated with 00.

- **Item Number 29** (payment received from the patient or other carriers)
- The amount should be expressed as the dollar and cents in the two boxes
- Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number
- Should be populated with the amount(if any) that has been paid for the charges in the claim.

- **Item Number 30** (Reserved for NUCC Use)
- Leave Disabled

- **Item Number 31**
- The Signed field will have a drop down with options: Empty, SIGNATURE ON FILE and the Billing Provider's Name. If a Provider is selected, the Name of the Provider and his credentials should be displayed in the format FirstName LastName Credentials. For eg: Mark Huzyak DMD.
- The Date field will be Auto populated with the current date

- **Item Number 32**
- This field should become required and enabled only when YES is selected in Box 20.
- This field provides the name and address of facility where services were rendered identifies the site where service(s) were provided
- A chosen box listing all the locations from PRACTICE SETTINGS > LOCATIONS available should be given.
- Based on the user selection the name and address is auto populated according to the following format:
  - Name: Name of the facility should be populated from the NAME field in PRACTICE SETTINGS > LOCATIONS > LOCATION DETAILS.
  - Address Line: First and second lines of address should be populated from PRACTICE SETTINGS > LOCATIONS > LOCATION DETAILS.
  - City, State (2 characters) and ZIP Code (For a 9-digit ZIP code, include the hyphen.)
- Do not use punctuation (i.e., commas, periods) or other symbols in the address.

- **Item Number 32A**
- The NPI number of the location selected in ITEM NUMBER 32 should be pre populated from PRACTICE SETTINGS > LOCATIONS > LOCATION DETAILS if a separate NPI is given for the location. Else, the NPI should be populated from PRACTICE SETTINGS > BASIC INFORMATION.

- **Item Number 32B**
- This item provides a drop down list and a text field
- Drop-down list values 0B,G2,LU. Default will be blank.
- The text field is for the user to enter the corresponding ID for the Location.

- **Item Number 33**
- The Item will contain a name and address field and a Phone number field
- The Billing Provider name and address should be entered according to the following format:
  - Name: Name of the Billing Provider or Practice should be populated according to default set for the 1500 form.
  - Address Line: First and second lines of address should be populated from the USER > CONTACT DETAILS of the selected Billing Provider.
  - City, State (2 characters) and ZIP Code (For a 9-digit ZIP code, include the hyphen) should be populated from the USER > CONTACT DETAILS of the selected Billing Provider.
- Do not use punctuation (i.e., commas, periods) or other symbols in the address.

- **Item Number 33A**
- Numeric Text field to Enter The NPI number of the Billing Provider.

- **Item Number 33B**
- Has a drop-down and a text field.
- Dropdown list values 0B,G2,ZZ. Default will be blank.
- Numeric Text field - Will be populated with the Provider Insurance ID that is entered for the particular carrier, if any. Kept editable.

## Assign Benefits To Patient

The Assign Benefits to Patient (ABP) flag can be added to the patient to ensure that the claims/pre-auths are billed against the patient and not the Billing Dentist/Dental Entity on behalf of the patient.

Once the label is added this would have impacts on the fields 13 & 33 of Medical Claim form

**Case 1:** An ABP label is added to the patient and the claims are not yet submitted:

- The subscriber signature field (field 13) should be empty and disabled.
- The Billing dentist/Dental entity information fields (field 33) should be optionally filled (can either be filled or empty) and non-mandatory for paper based claims i.e. should be left blank by default and can be edited. This field should not retain information in case of higher order pre-auth.

**Case 2:** A claim has been submitted and the ABP flag is added after submission

- The values in field 13 & 33 should be retained with the values before submission. This should also be retained/consistent while printing claims.
- If the user tries to 'Edit and Resubmit', then the current ABP state of the patient should be updated. i.e the ABP functionality related changes should be brought to the claim form. The user should have the updated changes if they proceed with resubmission.
- If the user discards the changes by clicking on 'Cancel', then the fields should be reverted to how it was before the 'Edit & Resubmit' action.

## CMS 1500 Claim Form

The image shows a sample of a CMS 1500 Health Insurance Claim Form. The form is a grid of fields for medical billing information. A large, diagonal 'SAMPLE' watermark is overlaid across the entire form. The top section includes fields for patient identification, insurance information, and treatment details. The bottom section contains a large area for listing services with columns for procedure codes, descriptions, and charges.

# Claim Connect and Denti-Cal

Written by Rinu Seba Joemon | Last published at: August 08, 2021

## Claim Connect

### Overview

CareStack integrates with DentalXChange as a partner organization to facilitate the transmission and processing of electronic dental and medical claims from dental organizations. These organizations must enroll with DentalXChange and request the linkage for CareStack from the support team.

This document contains the integration status, scope, steps to configure, existing clients using ClaimConnect, clients requesting claim connect, and limitations & restrictions on using integration.

### About DXC ClaimConnect

ClaimConnect is the premiere EDI solution for online dental claims delivery and real-time services. This platform processes dental insurance claims sends attachments and retrieves eligibility and benefits info. ClaimConnect also has superior customer service, offering you the perfect solution for all of your EDI dental claims needs.

### Features available in ClaimConnect

- Claims Processing
  - Online claims editing and management tools
  - Instant claim validation
- Real-Time Services
  - Instantly verify Eligibility and Plan Benefits
  - View and print EOB & ERA
  - Real-Time Claim Status transactions
  - ERA transactions
  - Receive Electronic Remittance Advice instantly for Real-Time Payers.
- DentalXChange Attachment Service.

### Scope of Integration

Practices who have the clearinghouse 'DentalXChange' would have an option to enable the ClaimConnect (location level) by entering the username and password they received from DXC. Also when enabled the NEA configuration (if present) would be cleared. After enabling ClaimConnect, all electronic claims and preauthorizations in the 'Ready to Send' or 'Ready to Send(R)' status would be uploaded to the ClaimConnect portal at the end of every day.

### Status of Integration

#### Status: Completed the Current Scope

CareStack provides the option to configure ClaimConnect credentials and thus enables users to submit electronic claims and preauthorizations to the ClaimConnect portal. Once the claims and preauthorizations are uploaded to the portal, the users can see the entire claim and preauthorization information.

### Steps to Enable & User ClaimConnect Portal

When DXC ClaimConnect is enabled for a location, all electronic claims and preauthorizations created for that location will be uploaded to the ClaimConnect portal (claims are automatically uploaded to the portal every day at 08:30 PM EST).

#### • Steps to Configure ClaimConnect

CareStack provides DXC ClaimConnect configuration where users can enter username and password and thus enable ClaimConnect for that specific location. When ClaimConnect is enabled for a location the NEA configuration set for that location will get automatically removed.

#### • Uploading claims to ClaimConnect Portal

Users can change the electronic claims and preauthorizations status to Ready To Send or Ready to Send(R) status and these claims will be uploaded to the ClaimConnect portal every day at 08:30 PM EST. Once uploaded the claim and preauthorization status will be changed to Submitted(CH) and Pending respectively.

### CareStack Integration Additional Details

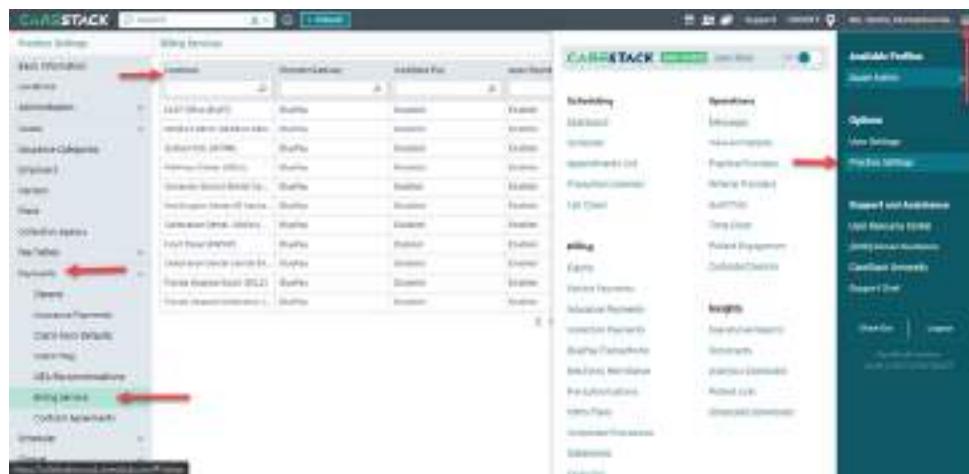
#### • CareStack completed the integration

- Completed pre-live testing and validated sample test file.

- Production environment configured with live URI
- IP whitelisting is required so that the VM(virtual machine) can successfully connect to the ClaimConnect APIs (to connect and upload EDIs).
- EClaim submission job is equipped with uploading these claims to the ClaimConnect portal.
  - EClaim submission job first authenticates the user on ClaimConnect. And the second uploads the file as an attachment.

## Add DentalXChange Credentials

Once the DentalXChange option for ClaimConnect is enabled by the CareStack support team, you will be ready to enter your credentials and set up your locations. You may navigate to the **System menu > Practice Settings > Payments > Billing Services**.



Click the desired location's row to open the individual details > Select the Claim Connect tab > Click Edit to enable the fields > Enter the DentalXChange Claim Connect credentials provided by DentalXChange > Click Save.



**NOTE:** Claim Connect does not integrate with NEA so enabling Claim Connect will disconnect NEA from this location. You will need to send attachments another way.

## Denti-Cal

EDI enrolled providers will be ready to start submitting electronic Claims and Treatment Authorization Requests (TARs) once the practice management system vendor has verified that their system is able to connect to the DentiCal EDI system either directly or through a clearinghouse, data format testing has been successfully completed, and Denti-Cal's EDI Support Department has confirmed enrollment in the Electronic Data Interchange (EDI)Program.

### Four Basic Steps

There are four basic steps to follow to submit claims electronically

1. Enter claim information
2. Transmit data
3. Retrieve and review reports and files returned from Denti-Cal
4. Prepare and mail EDI labels - only for claims and TARs that require radiographs or attachments.

#### 1. Enter Claim Information

- The software vendor will advise providers how to enter Denti-Cal claims using their computer system.

- All information must be entered completely and accurately. Processing criteria remain the same as for paper TAR/claim forms -- if radiographs and documentation are needed to process a paper claim, they will also be required to process an EDI claim.
- If digitized images are not received with EDI claim information, documents with procedures that require radiographs and/or attachments are automatically "suspended" to wait for them to be mailed to DentiCal using EDI labels and envelopes.
- Providers may also enter a "Y" in the x-ray or attachment fields to put the document in a "suspended" status to wait for the documentation to be received by DentiCal.

**Note: The registration number must be included.**

## 2. Transmit Data

- The vendor will advise providers on how to transmit claim information to Denti-Cal.
- If a provider submits attachments digitally, the image reference number with the claim information would be transmitted as directed by the vendor.

## 3. Retrieve and Review Reports and Files

- The vendor will also advise providers on how to retrieve any reports and files (including labels, if applicable) that may be available.
- It is important for providers to compare their list of transmitted claims to Denti-Cal's list of EDI claims received, located on report CP-O-973-P, and determine which claims require radiographs and/or attachments, noted on report CP-O-971-P.
- Denti-Cal will acknowledge all received transactions with an ASC X12 999 transaction, Acknowledgment for Health Care Insurance.
- The ASC X12 999 transaction provides confirmation that Denti-Cal received the submitted transaction file and communicates: which transactions were received without errors and therefore accepted for processing, and which transactions contained structural or syntactical errors based on the X12 837D, version 5010, Implementation Guide and therefore were rejected.
- If any transactions are rejected, Denti-Cal will also provide an HTML Error Report describing the reason(s) for rejection.

## 4. Prepare and Mail Radiographs/Attachments with EDI Labels

- The CP-O-971-P report will show claims that have been put into a suspended status until Denti-Cal receives radiographs and/or required documentation.
- Providers who use partially preprinted labels will need to write the Base DCN (also referred to as the Denti-Cal Document Control Number) from this report onto the EDI label before mailing radiographs and/or attachments to Denti-Cal.

**Note: This step is not needed if submitting radiographs and images digitally and the digitized image reference numbers are received by Denti-Cal with EDI claim data.**

## EDI Labels

If procedures submitted electronically require radiographs and/or attachments or if a provider indicates they wish to submit documentation, the claim/TAR will be "suspended" until the documentation is received. Special self-adhesive EDI labels and EDI envelopes printed in red ink are available to facilitate mailing Xrays/attachments to process "suspended" EDI claims and TARs.

### Preparing EDI Labels

EDI labels may be ordered in one of three styles to accommodate different types of printers; laser labels, 1-up (across), or 3-up continuous labels. Most providers use partially preprinted labels, however, providers may wish to check with their vendor to determine which type of labels will work best for their system.

**Note: EDI labels are only required to submit radiographs and/or attachments when a claim is initially sent electronically. EDI labels are not requested if digitized images are received.**

### Labels must have the following

- 1.Billing NPI next to "Denti-Cal Provider ID"
- 2.Beneficiary first and last name below "Patient MEDS ID"
- 3.Denti-Cal DCN also referred to as the Base DCN
- 4.Provider's name and return address

DENTI-CAL PROVIDER ID: XXXXXXXXXX PATIENT MEDS ID: Beneficiary Name	①
PROV. DCN: DENTI-CAL DCN: XXXXXXXXXXXX	②
DCC: _____ PREVIOUS X-RAYS AND/OR ATTACHMENTS: _____	③
Provider Name/Business Name Address City, State ZIP	

EDI labels without these items cannot be processed and must be returned for completion. Other information may be included but is not mandatory. The pink area is only used by Denti-Cal during processing.

#### Sending Digitized Images of Radiographs & Attachments

In conjunction with electronically submitted documents, Denti-Cal accepts digitized images submitted through electronic attachment vendors: DentalXChange, National Electronic Attachment, Inc. (NEA), National Information Services (NIS), and Tesia Clearinghouse, LLC.

<b>Images That CAN Be Transmitted:</b>	<b>Images That CANNOT Be Transmitted:</b>
<ul style="list-style-type: none"> <li>&gt; Documentation related to claims and TARs to be submitted electronically:           <ul style="list-style-type: none"> <li>▪ Radiographs</li> <li>▪ Justification of Need of Prosthesis Forms (DC054)</li> <li>▪ Photos</li> <li>▪ Narrative documentation (surgical reports, etc.)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>&gt; Any documentation related to claims and TARs submitted on paper.</li> <li>&gt; Claim Inquiry Forms (CIFs)<sup>a</sup></li> <li>&gt; Resubmission Turnaround Documents (RTDs) issued for paper or EDI documents</li> <li>&gt; Notices of Authorization (NOAs) issued for paper or EDI documents</li> </ul>

<sup>a</sup> Digitized image reference numbers may be handwritten on CIFs that must be mailed.

#### Electronic Vendor and Document Specifications

**DentalXChange Users:** Create the claim or TAR. Before transmitting a document electronically, include the radiographs/photographs and attachments. Each attachment must include the date the images were created. For additional information, providers can call DentalXChange at (800) 576-6412 ext. 455 or visit <http://www.DentalXChange.com/provider/claimconnect/AttachmentPage>.

**NEA Users:** Radiographs/photographs and attachments must be transmitted to NEA before submitting an EDI claim or TAR. NEA's reference number must be entered on the EDI claim or TAR using the following format: "NEA#" followed by the reference number, with no spaces - Example: NEA#9999999. It is important to use this format and sequence.

Some dental practice management and electronic claims clearinghouse software have an interface with NEA that automatically enters the reference number into the notes of the claim. For additional information, providers can visit [www.nea-fast.com](http://www.nea-fast.com) or call (800) 782-5150 option3.

#### Resubmission Turnaround Documents (RTDs) & Notices of Authorization (NOAs)

Depending on how the provider's software is set up, providers will receive RTDs and Notices of Authorization (NOAs) electronically or by mail from Denti-Cal along with other EDI reports. It is standard procedure to enroll providers to receive their EDI RTDs and NOAs electronically for documents submitted electronically. They are issued along with other EDI reports. However, providers may opt to receive RTDs and/or NOAs on paper through the mail.

**RTDs:** RTDs (also referred to as Notices of Resubmission) will be issued by Denti-Cal if additional information is needed to process the EDI document. RTDs cannot be returned electronically. Providers should retrieve EDI RTDs, print them to paper, and mail them to Denti-Cal with any necessary documentation attached. RTDs should be returned promptly. Documents will be denied if no response to the RTD is received within 45 calendar days. EDI labels and envelopes should not be used for RTDs.

**NOAs:** Providers should also retrieve EDI NOAs and either print them to paper for submission by mail or if the provider's system or clearinghouse can accept them, transmit them electronically to Denti-Cal.

**Note: Printed RTDs and NOAs should be completed and signed in blue ink and mailed to Denti-Cal in a white mailing envelope for processing.**

**Claim Inquiry Forms (CIFs): Claim Inquiry Forms cannot be submitted electronically.** A CIF can be mailed only after a document is processed to request a change or reevaluation or to request the status of a claim or TAR.

## Status of Integration

The grid in Menu > Claims > Denti-Cal would have the following columns:

- Report ID (using the value from the Report Type)
- Report Description (from attachment)
- Report Date
- Report Status

The Report Type and Descriptions are as follows:

Report ID	Report Description
CP-O-973-P	EDI Documents Received Today
CP-O-971-P	X-Ray/Attachment Request
CP-O-971-P2	X-Ray/Attachment Labels
CP-O-RTD-P	Notice of Resubmission (RTD)
CP-O-NOA-P	Notice of Authorization
CP-O-970-P	EDI Documents Waiting Return Information > 7 Days
CP-O-959-P	Document Rejections
HTML Error Report	Error Report of Rejected Transactions

- The status change procedure would be implemented similarly with that in other tabs in claims where there would be a dropdown with the current status shown by default and users would be able to change to any status depending on their need. The drop-down would contain 3 values - Pending, In-Progress, Completed.
- There would be a Print button beside the Action button which would Print all the selected reports.
- The Action button values would be changed to the following:
  - Mark as Pending
  - Mark as In-Progress
  - Mark as Completed
- Both the Action and Print buttons would remain disabled if there is no data in the grid or if no data in the grid is selected.
- Each status change must be audited
- The grid would by default be sorted on the latest first order of Report Date. The grid would be sortable based on all the other columns as well.
- The grid would be paginated to show 15 entries per page.
- Only users with Add/Edit/Delete permission in Claims would be allowed to view this tab.

# Medical Claims & Cross Coding

Written by Abhishek Vijay | Last published at: August 08, 2021

**Added medical insurance to a patient: ✓**

**Made sure that the insurance is verified: ✓**

**Created a claim for the services rendered: ✓**

But wait, why does the claim look all different than the usual ones?

A health insurance claim, also known as a medical insurance claim, is a request made by the policyholder for reimbursement of treatment costs incurred to a healthcare provider.

The sum allocated by the dental insurance will not be enough to cover the procedures needed in a given year for many patients, especially those with serious tooth concerns. If the circumstances of these patients' ailments fit under the medical billing codes for dental procedures, accepting medical insurance may make it possible for them to receive the dental treatments they require.

Medical billing is a payment method used in the United States healthcare system. To get paid for services given, including testing, treatments, and procedures, a healthcare professional must submit, follow up on, and appeal claims with health insurance companies.

Many dentists are asked to submit dental procedures to a patient's medical plan, either at the request of the patient's dental plan or at the request of the patient. Submitting medical claims for dental treatments such as surgical extractions, trauma-related procedures, and biopsies can leave dental team members feeling overwhelmed and angry. However, filing a medical claim is not as difficult as it may appear, and it differs from filing a dental claim.

We can add Medical Insurance, raise a claim for services rendered, and bill for payments. The procedure is similar to that of Dental Insurance/claims, with slight variations.

So consider a situation where you have added and completed a Medical Code. Now, since the patient has a medical claim, we can bill the services rendered.



For a Medical Code, if the medical insurance is active, the Billing Order would reflect 'M', indicating medical. You can now right-click on the code and select create a claim.

Voila! Now you have created a medical claim. (if the claim isn't created and errors are present, whelp, it's troubleshooting time.) A Medical Claim would look a little something like this.



HEALTH INSURANCE CLAIM FORM

APPROVED BY THE LOCAL UNION OFFICER'S COMMITTEE AND SIGN

While creating a medical claim in CareStack, it would reflect in this manner.

**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNION MEDICAL ASSOCIATION AND KELCO

1. MEDICARE		MEDICAID		TRICARE		DISABILITY		HEALTH MAJOR		PRES. BILLED		OTHER			
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> DISABILITY		<input type="checkbox"/> HMO		<input type="checkbox"/> PBM		<input type="checkbox"/> Other			
2. PATIENT'S NAME (Last Name, First Name, Middle initial)				3. PATIENT'S BIRTH DATE		365									
4. PATIENT'S ADDRESS (Incl. Street)				5. PATIENT'S RELATIONSHIP TO INSURED		Son		<input type="checkbox"/> Son		<input type="checkbox"/> Daughter		<input type="checkbox"/> Other			
Patient's Address Line 1				6. RESERVE FOR HMO USE				7. RESERVE FOR HMO USE				8. RESERVE FOR HMO USE			
CITY		STATE		CITY		STATE		CITY		STATE		CITY			
ZIP CODE		TELEPHONE		ZIP CODE		TELEPHONE		ZIP CODE		TELEPHONE		ZIP CODE			
9. OTHER INSURER'S NAME (Last Name, First Name, Middle initial)				10. IN PATIENT'S CREDITOR RELATIONSHIP				11. INSURER'S POLICY OR PLAN IDENTIFICATION NUMBER				12. IN PATIENT'S DATE OF BIRTH		13. OTHER CLAIMS	
12. OTHER INSURER'S POLICY OR PLAN NUMBER				13. EMPLOYMENT (Current or Previous)		<input type="checkbox"/> HOH <input type="checkbox"/> MHI		14. INSURER'S DATE OF BIRTH		15. OTHER CLAIMS		16. OTHER CLAIMS		17. INSURER'S PLAN NAME OR PROGRAM NAME	
14. RESERVE FOR HMO USE				15. AUTO ACCOUNT		<input type="checkbox"/> HOH <input type="checkbox"/> MHI		18. RESERVE FOR HMO USE				19. RESERVE FOR HMO USE		20. RESERVE FOR HMO USE	
16. RESERVE FOR HMO USE				17. OTHER ACCOUNT		<input type="checkbox"/> HOH <input type="checkbox"/> MHI		21. RESERVE FOR HMO USE				22. RESERVE FOR HMO USE		23. RESERVE FOR HMO USE	
24. INSURANCE PLAN NAME OR PROGRAM NAME				25. CLAIM CODE (Insurance Plan Number)				26. IS THERE ANOTHER HEALTH BENEFIT PLAN?				27. RESERVE FOR HMO USE		28. RESERVE FOR HMO USE	
								<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, continue items 25, 26, and 27.					
29. SIGNATURE OR AUTHORIZED PERSON'S SIGNATURE		30. DATE		31. RESERVE FOR HMO USE		32. RESERVE FOR HMO USE		33. RESERVE FOR HMO USE		34. RESERVE FOR HMO USE		35. RESERVE FOR HMO USE		36. RESERVE FOR HMO USE	
37. DATE OF CURRENT CLINICAL ALERT OR PREVIOUSLY ISSUED		38. OTHER ALERTS		39. DATES OF PATIENT'S RELATIONSHIP TO PAYOR TO CURRENT OCCUPATION		40. DATES OF PATIENT'S RELATIONSHIP TO PAYOR TO CURRENT SERVICES		41. OUTSIDE LAB		42. INSURER'S DATE CODE		43. PRIOR AUTHORIZATION ALERT		44. RESERVE FOR HMO USE	
37. DATE OF CURRENT CLINICAL ALERT OR PREVIOUSLY ISSUED		38. OTHER ALERTS		39. DATES OF PATIENT'S RELATIONSHIP TO PAYOR TO CURRENT OCCUPATION		40. DATES OF PATIENT'S RELATIONSHIP TO PAYOR TO CURRENT SERVICES		<input type="checkbox"/> HOH <input type="checkbox"/> MHI		41. OUTSIDE LAB		42. INSURER'S DATE CODE		43. PRIOR AUTHORIZATION ALERT	
45. ADDITIONAL CLAIM INFORMATION (Designated for HMO)				46. PROCEDURES, SERVICES OR SUPPLIES (Established Circumstances) CDT/CPT/HCPCS/Other		47. DIAGNOSES & CHARGES CPT/HCPCS/Other		48. DATES OR UNITS		49. PAYOR ID		50. RENDERING PROVIDER ID		51. RENDERING PROVIDER ID	
45. ADDITIONAL CLAIM INFORMATION (Designated for HMO)				46. PROCEDURES, SERVICES OR SUPPLIES (Established Circumstances) CDT/CPT/HCPCS/Other		47. DIAGNOSES & CHARGES CPT/HCPCS/Other		48. DATES OR UNITS		49. PAYOR ID		50. RENDERING PROVIDER ID		51. RENDERING PROVIDER ID	
52. RESERVE FOR HMO USE		53. PLACE OF SERVICE		54. DATE(S) OF SERVICE		55. PATIENT'S GROUPING		56. ACCEPT AGREEMENT (For Govt. Names, see back)		57. TOTAL CHARGE		58. AMOUNT PAID		59. RESERVE FOR HMO USE	
52. RESERVE FOR HMO USE		53. PLACE OF SERVICE		54. DATE(S) OF SERVICE		55. PATIENT'S GROUPING		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 137.00		\$ 0		59. RESERVE FOR HMO USE	
56. ACCEPT AGREEMENT (For Govt. Names, see back)		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		57. TOTAL CHARGE		58. AMOUNT PAID		59. RESERVE FOR HMO USE							
56. ACCEPT AGREEMENT (For Govt. Names, see back)		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		57. TOTAL CHARGE		58. AMOUNT PAID		59. RESERVE FOR HMO USE							
56. ACCEPT AGREEMENT (For Govt. Names, see back)		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		57. TOTAL CHARGE		58. AMOUNT PAID		59. RESERVE FOR HMO USE							

Print

You would have noticed terms like CDT, CPT, and CDT-CPT Crosswalk. What are those?

**CDT:** (Current Dental Terminology) Dentists are most familiar with and use the CDT code set to report dental treatments. When reporting dental operations to a dental payer, CDT procedure codes are utilized. The American Dental Association is responsible for the maintenance of the said codes.

**CPT:** (Current Procedural Terminology) CPT codes are also referred to as Level I codes and are used to convey information to medical payers. Different from CDT codes, CPT codes are maintained by the American Medical Association.

If there are no applicable medical cross codes or when the CDT is the most accurate code to reflect the dental procedure performed, many medical payers will accept the CDT code.

**CDT-CPT Crosswalk:** Easily bill medical claims for your dental procedures by cross-coding the CDT dental codes with CPT medical codes.

Locate your claim in the patient's profile or the Claims module (Menu > Claims), then click the row of the claim to open the claim details.

Click the CH hyperlink next to the dental procedure code needing cross-coding (Line #24). The standard CPT codes, if any, will appear for the selected dental code.

1. A DATE(S) OF SERVICE	2. PLACE OF SERVICE	3. END	4. PROCEDURES, SERVICES OR SUPPLIES (Established Circumstances)	5. DIAGNOSES & CHARGES	6. DATES OR UNITS	7. PAYOR ID	8. RENDERING PROVIDER ID
08/27/2018 - 08/27/2018	11	No	[0010] CH	A 30.00	1	187	1234567890
08/27/2018 - 08/27/2018	11	No	[0020] CH	A 30.00	1	187	1234567890
08/27/2018 - 08/27/2018	11	No	[0030] CH	A 30.00	1	187	1234567890
29. FEDERAL TAX ID NUMBER	888-00-0000	28. PATIENT'S GROUPING	27. ACCEPT AGREEMENT (For Govt. Names, see back)	29. TOTAL CHARGE	30. AMOUNT PAID	31. RENDERING PROVIDER ID	32. RESERVE FOR HMO USE
11-1111111		1163	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ 137.00	\$ 0		

Hint: Click Add on the top-right to search for and select your preferred CPT code if needed.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service				ICD Ind : 0	22 RESUBMISSION CODE
line below(24E)					
A. V88.99	B.	C.	D.		
E.	F.	G.	H.		
I.	J.	K.	L.		
<div style="border: 1px solid #ccc; padding: 5px;">         Select medical codes to be cross coded         <span style="float: right;">Add</span> </div> <div style="background-color: #f0f0f0; padding: 5px;"> <b>Select Procedure</b>   <input checked="" type="checkbox"/> 70300 - Radiologic Exam, Teeth, Partial, single tooth           <input checked="" type="checkbox"/> 70310 - Radiologic Exam, Teeth, Partial, Less than full mouth       </div>					
24-A DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCE RIES	
From	To				
08/27/2019	08/27/201	11 *	No *	D0140 CH	<span style="color: green; font-size: 2em; vertical-align: middle;">A</span>
<span style="border: 1px solid #ccc; padding: 2px 10px; margin-right: 10px;">Close</span> <span style="border: 1px solid #ccc; padding: 2px 10px; background-color: #0070C0; color: white; font-weight: bold;">Apply</span>					
08/27/2019	08/27/201	11 *	No *	D0220 CH	+ * * * * A 31.00 1 *

Checkmark the codes you want to include on the claim, then click Apply. Repeat until all of the necessary procedures have been cross-coded. The selected CPT codes will replace the dental code on the claim. (Note that the original dental codes will remain in the patient's treatment plan, ledger, etc.)

24. A DATE(S) OF SERVICE		B PLACE OF SERVICE	C- E/M SUPPLIES (Explain unusual circumstances)	D PROCEDURES, SERVICES OR CPT/ICD-9-CM CODES/ICD-9-CM MODIFIER	E DIAGNOSIS CHARGES PENTER	F DAYS OR UNITS	G EPOT Family Plan	H ID QUAL	I RENDERED PROVIDER ID
From	To								
08/07/2010	08/07/2011	11 +	See	D0140 OH	+ + + + A	80.00	1	+ APR	1234567890
08/07/2010	08/07/2011	11 +	See	D0290 OH	+ + + + A	20.00	1	+ APR	1234567890
dental code has been replaced by the chosen medical code									
08/07/2010	08/07/2011	11 +	See	70000	+ + + + A	35.00	1	+ APR	1234567890
25. FEDERAL TAX ID NUMBER		SSN EN <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S GROUP NO		27. ACCEPT ASSIGNMENT? (For part. claims, see back) <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	28. TOTAL CHARGE	29. AMOUNT PAID	(b) Above by HCPCS	
					\$ 181	\$ 0			

**Hint:** For a list of the standard codes for cross-coding, click the CDT - CPT Crosswalk tab at the top of the window.

Once all of the cross-coding is done, complete and submit your claim as usual!

Solely a few payers will only accept an electronic medical claim; the majority will still accept a paper form.

When making a medical claim, it is critical to follow the claim form instructions to the letter. The use of punctuation (i.e., a decimal point in the ICD code), the absence of a description when reporting an unlisted CPT code, and the inclusion of the appropriate modifier or qualifier, where required, are all examples of common claim form errors.

# Bluepay

Written by Aravind M | Last published at: October 06, 2022

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BluePay, a leading provider of technology-enabled payment processing for North American merchants, has been integrated into Clover as part of the First Data/Fiserv family. The company has consolidated its payment processing solutions and content under the Clover brand, which helps add additional features and functionality to Clover's comprehensive offering of small business merchant services.

<https://www.clover.com/>

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## Integration Support Contacts:

bluepay-integration@fiserv.com, mel.sleight@fiserv.com, tommy.miller@fiserv.com

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## FAQs:

1. The timezone is used to show the transaction date in the Bluepay portal?

All times reported by BluePay are Central Time with changes for daylight savings. Currently, times are Central Standard Time (CST)  
CST = UTC - 6 hours  
CDT = UTC - 5 hours

*As per the email sent on December 9th, 2021.*

2. "ERROR SELECTING PROCESSOR" when trying to make Bluepay payments

This error happened because the Bluepay account isn't configured to process ACH.

3. How to review whether the BluePay payment was initiated from CareStack or not?

Bluepay payment can be done either from PMS (patient or insurance or collection payments) or from external portal (t2p portal or patient portal). The payment initiated information can be identified using the **shpf-form-id** value under the 'Merchant Data' section (Login to BluePay portal and go open the transaction). If the payment initiated is from :

1. PMS then **shpf-form-id** value will be **CarestackPMS01**.
2. T2P or Patient Portal or Statement Scan & Pay then **shpf-form-id** value will be **CarestackPrtl01**.

Also the Custom ID 1 and Custom ID 2 feild will have value, where Custom ID 1 will have the value from billing.paymenttransaction table and Custom ID 2 will have the accountid value.

4. How transactions can happen with a different **shpf-form-id** other than **CarestackPrtl01** and **CarestackPMS01**?

1. If the value is VT then it is the Virtual Terminal. That means someone logged into the gateway account and ran the transaction manually.
2. Origin = bp10emu form id = mobilecap01D means that a customer ran the transaction through the below payment form.

[https://secure.bluepay.com/interfaces/shpf?SHPF\\_FORM\\_ID=mobilecap01D](https://secure.bluepay.com/interfaces/shpf?SHPF_FORM_ID=mobilecap01D)

1. The payment form is something the practice generate using BluePay URL generator (<https://secure.bluepay.com/interfaces/support/urlgeneratorform>)

**Note: All the payments with these shpf-form-id will not create the invoice inside CareStack. User needs to manually create the receipt for the patient by selecting payment type and overriding the payment gateway workflow.**

# NEA

Written by Aravind M | Last published at: December 17, 2021

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National Electronic Attachments, Inc. (NEA) is a clearinghouse that uses its FastAttach service to transmit attachments, in support of electronic claims, to payors via the Internet.

## Integration Support Contacts:

[greg.samford@vynedental.com](mailto:greg.samford@vynedental.com), nicole.smith@vynecorp.com, nicole.smith@vynecorp.com

## FAQs:

1. Showing error 'Invalid Login credentials' when trying to create/submit claims/preauthorizations
  - o One reason can be user configured wrong (completely wrong facility ID, expired facility ID, facility ID with additional space or symbols) NEA facilityID.
  - o Practice might have configured the master facility ID. Attached email thread with NEA regarding this.

That facility ID BJ124057 is for their master account, which cannot receive claim information. The claim information would need to be sent to either BJ124054 (Sun City West practice) or BJ124055 (Sun City practice). The purpose of the master account is to provide FastAttach users with a single login to manage and send attachments from all other accounts linked to the master account. The users can log into FastAttach using BJ124057. However, Carestack needs to be configured to send claim info to BJ124054 and/or BJ124055. For example, if they have two Carestack accounts (1 per location), each account can be configured to send claim info to their respective facility ID. When the user logs into BJ124057, they will see all of the attachment requests for both accounts and will be able to work the attachments from there. When they send the attachments, the NEA#s will route to the appropriate claims in Carestack.

- o Letters in the facility ID need to be capitalized

# DentalXChange - Clearing House

Written by Aravind M | Last published at: February 16, 2022

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## **DXC Payor List:**

### [DXCPayerList](#)

Claim: Live means they are supported either via print or electronically.

Eligibility: This means the payer supports a basic eligibility check and returns “yes” or “no” responses.

Benefits: This means the payer offers more detailed benefit information.

ClaimStatus: This means the payer offers claims status updates.

ERA: It will be live if the payor sends ERA.

RT Claim: If “true” means the claim goes to the payer in real-time/instantly.

DXCAttachment: It will be live if the payor supports electronic attachments.

# CPS Statements

Written by Aravind M | Last published at: October 03, 2022

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CareStack collaborates with CPS, a third-party print and mail processing business, to send (mail) to patients.

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## Integration Support Contacts:

Kyle Richmond - [krichmond@cpsstatements.com](mailto:krichmond@cpsstatements.com)

Kim - [ktrenner@cpsstatements.com](mailto:ktrenner@cpsstatements.com)

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## FAQ:

1. Average Time to Receive Patient Statement.

The USPS states 3-5 business days for delivery. We have the file for 1-2 days depending on the weekend or when the files come in before entering the USPS.

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# Medical History Forms & Medical Alerts

Written by Aswathy B Nair | Last published at: August 25, 2022

Medical History forms are records that keep track of the medical history of the patient like the allergies, conditions, and the other records as required by the practice.

The medical History form has three parts: ***Medical Alerts, Dental Questionnaire, and Medical Questionnaire***.

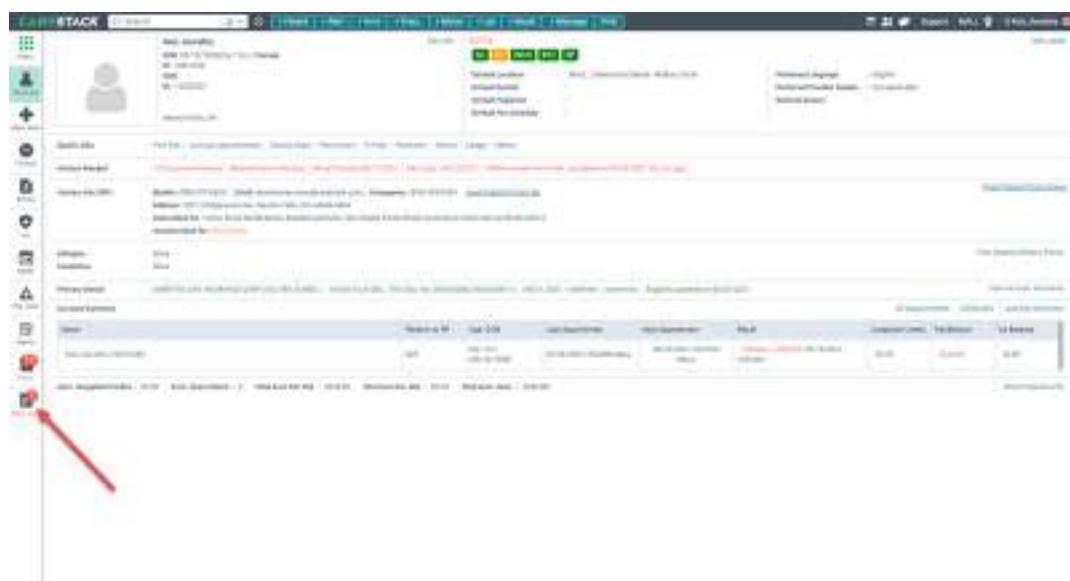
Before going into the details let's see the permissions required for the feature.

## Permissions

Permissions for Medical Alerts and Medical History forms are set under **System menu > Practice settings > Administration > Profiles > Manage Permissions > Patient > Medical Alerts and Medical History Form**.

## Overview

Medical History form of a patient can be accessed under the patient profile. To access the same, you can go to the patient's profile and there on the left side, you can see a tab, Med. Hist.



When you click that, you will be taken to the Medical History forms of the patient.



You will be able to see the red notification on the tab if the medical history form is patient/provider signature pending. A provider signature pending is highlighted in Yellow, while a patient signature pending is highlighted in Red. You would also be able to know that there is a pending medical history form by looking into the

- overview of the patient.



- appointment tile of the patient in the scheduler.

Service	Rate	Fee	Total
Private E... - Nitrous Oxide	\$20.00	\$20.00	\$20.00
Insurance - New Art... - Novocaine Pr...	\$100.00	\$100.00	\$100.00
<b>Total</b>	<b>\$120.00</b>	<b>\$120.00</b>	<b>\$120.00</b>

Note: Changes made after 11/14/2018 will not affect this appointment.

## Medical History Form Settings

As discussed earlier, Medical History form has three parts. **Medical Alerts, Dental Questionnaire and Medical Questionnaire**. So let us first discuss where we set all these in order to get them reflected on the form.

### Medical Alerts

#### Where do we set Medical alerts?

Lets see how we can create a Medical Alerts. Medical Alerts are set under **System Menu > Practice Settings > Medical Alerts > Add**. A pop up box appears where you can enter the details.

- **Name:** Enter a **name** for the medical alert as it should appear on your Medical History forms.
- **Condition:** Select whether it should be labeled as a **Condition** or **Allergy**.
- **Pre-Med:** Some allergies and conditions might need the patients to have some sort of premedication. You can choose whether premedication is required or not.

Click on Save and a green toaster will be seen on the top right showing that the Alert is created successfully.

\*Note: The newly added Alerts would reflect only to the forms that are added after the alert was created.

To deactivate a Medical Alert, you can **select the alert > Click on Actions > Deactivate**.

Under Practice Settings, we can set questions for Adults and Children separately. This helps us to set different questions for the patients depending on their age category.

The screenshot shows the 'Medical History Form (Adult)' settings page. On the left, there's a sidebar with various practice settings like 'Patient Information', 'Locations', 'Amenities', 'Facility Codes', 'Insurance Categories', 'Employers', 'Dentists', 'Plans', 'Collector Agency', 'Fee Tables', 'Payments', 'Schedulers', 'Clinical Reports', 'Patient Portal', 'Care Audit Rules', 'Templates', 'Medical History Forms', 'Medical Alerts', 'Adult Questionnaire' (which is highlighted in green), and 'Child Questionnaire'. The main area has tabs for 'Dental Questionnaire', 'Medical Questionnaire', and 'Settings'. Under 'Dental Questionnaire', there are sections for 'PATIENT HISTORY tx', 'HOT', 'COLD', and 'Other'. There are also dropdowns for 'Rampant caries (tx)' and 'Description\_3' with a checkbox for 'Yes'.

## Dental Questionnaire

The Dental Questionnaire allows you to ask dental question to the patient through the medical history form. You will be able to add sections and questions from **System menu > Practice settings > Medical History Forms > Adult(or child) > Dental Questionnaire**.

**Add Section:** The Section component can be used to Add a new Section.



**Add Question:** This will help you add new questions.

When you add a new question, you will have to fill three fields

- **Description:** You can enter the question here.
- **Response Type:** This determines how you want the patient to answer to this question. You have options like Text line, Text Area, Date, Yes/No and Check box. You can select the one that is applicable.
- **Mark as Mandatory:** You can choose whether you want this question to be marked as mandatory or not. If it is marked as mandatory then the patient wont be able to go to the next tab without filling this question.

You want to change the position of question? You will be able to drag and bring questions under different sections. Just click and hold on the three lines to the left of each question and drag to where you want the question to be placed.

To delete a Section or Question, you can click the trash icon corresponding to each of them.

## Medical Questionnaire

You will be able to ask other medical questions here. Here also you have the provision to add section and question just like we saw in Dental Questionnaire.

**Add Section: The Section component can be used to Add a new Section**

**Add Question:** This will help you add new questions just like we did in the Dental Questionnaire.

When you add a new question, you will have to fill three fields

- **Description:** You can enter the question here.
- **Response Type:** This determines how you want the patient to answer to this question. You have options like Text line, Text Area, Date, Yes/No and Check box. You can select the one that is applicable.
- **Mark as Mandatory:** You can choose whether you want this question to be marked as mandatory or not. If it is marked as mandatory then the patient wont be able to go to the next tab without filling this question.

You want to change the position of question? You will be able to drag and bring questions under different sections. Just click and hold on the three lines to the left of each question and drag to where you want the question to be placed.

To delete a Section or Question, you can click the trash icon corresponding to each of them.

## Settings

Settings has two sections: **Signatures and Triggers**

**Signatures:** By clicking the check mark you can include the provider sign in the Medical History form.

**Triggers:**

- **Retain answers from previously completed form:** If the answers from the previous medical history form of the patient carries over to the next from, it would lessen your and patients' job right. So if you want answers to get retained, check mark this feature.
- **You can select when the form should be triggered.**
  - For new patients, you can have it triggered for every new patient.
  - For existing patients, you can have it triggered it after an interval of time. If you select this, you have to set the number of days after which you want the form to get triggered.
- **Override for specific locations:**

Responses	Setup												
<input type="checkbox"/> Add Patient Signature	<b>Trigger</b> <input type="checkbox"/> Create account from previous completed form Please enter/edit where the form should be triggered: <input type="checkbox"/> For new patient <input type="checkbox"/> After last form filled by existing patient Trigger a new form every: <input type="text" value="100"/> days (from the date of completion of the last form) Triggered for specific location: <input checked="" type="radio"/> Yes <input type="radio"/> No Can you enter it another day(s) for other locations: <input checked="" type="radio"/> Monday <input type="radio"/> Friday <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Location</th> <th style="width: 20%;">Auto Trigger (days)</th> <th style="width: 20%;">Trigger time(s)</th> <th style="width: 20%;"> </th> </tr> </thead> <tbody> <tr> <td>Local Office</td> <td><input type="text" value="100"/></td> <td><input type="text" value="10:00"/></td> <td><input type="button" value="Edit"/></td> </tr> <tr> <td>Globalization Central - Helpdesk 2012</td> <td><input type="text" value="100"/></td> <td><input type="text" value="00:00"/></td> <td><input type="button" value="Edit"/></td> </tr> </tbody> </table>	Location	Auto Trigger (days)	Trigger time(s)		Local Office	<input type="text" value="100"/>	<input type="text" value="10:00"/>	<input type="button" value="Edit"/>	Globalization Central - Helpdesk 2012	<input type="text" value="100"/>	<input type="text" value="00:00"/>	<input type="button" value="Edit"/>
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Globalization Central - Helpdesk 2012	<input type="text" value="100"/>	<input type="text" value="00:00"/>	<input type="button" value="Edit"/>										

## How to add a New Medical History Form for a Patient

To add a new Medical History Form, you can click on **Add New Form** on the Med. Hist page of a patient. This will create a new form which populates all the previously added answers(in case of existing patients). So here, you have three tabs: Medical Alerts, Dental Questionnaire and Medical Questionnaire.

## Medical Alerts

**Medical Alerts** are the allergies and conditions the patient has. This gets automatically tagged to a patient stemming from the answers they provided on their Medical History Form.

The very first tab in Medical History form is Medical Alerts. Here, all the active Medical Alerts will be listed. The patient will have to fill all of them.

Only once you fill all the fields in this tab, you will be able to go to the next tab. Until then the 'Next' button on the bottom right will be greyed out.

You have an option to **Mark all as No**. This is an easier way to fill the Medical Alerts. You can click on this button which marks all the fields in this tab as **No** and then you can mark the necessary ones to Yes as per the patient. This feature is very helpful as this will make sure that all the alerts are filled.

Embedded content from <https://www.loom.com/embed/ad19c0a2e4d549f0b67a6fe39f67a0ab>

## Dental Questionnaire

Dental questionnaire has all the questions from the one we have set under Practice settings. You have to fill all the mandatory questions under this tab and then only you would be able to move to the next tab. All the mandatory questions will have a red asterisk(\*) on them.

The previous version of Medical History Forms are available in the Patient's Documents.

New Previous Form

Print Back Form | Add New Form

PATIENT HISTORY & C

DENTAL HISTORY & C | Medical Questionnaire

ARE THERE ANY SPECIFIC CONCERN(S) WHICH YOU WOULD NOW LIKE TO REPORT?

ARE YOU HAVING ANY DISCOMFORT AT THE PRESENT?

WHAT WERE ANY PARTICULAR REASONS WHY YOU LEFT YOUR PREVIOUS DENTIST?

HOT

COLD

TOOTHACHE

Have you performed any other dental procedures in the last six months?

Yes

No

Sample toothache?

Print | Save | Print Back Form

## Medical Questionnaire

Just like we saw for Dental Questionnaire, we have to fill the questions for Medical Questionnaire as well. And you have to fill in the mandatory questions, only then you will be able to print and sign the form. On this page, the patient and the provider can sign.

The previous version of Medical History Forms are available in the Patient's Documents.

New Previous Form

Print Back Form | Add New Form

PATIENT HISTORY & C

DENTAL HISTORY & C | Medical Questionnaire

IN CASE OF EMERGENCY, CONTACT THIS PRACTICE

WHICH DO YOU THINK FOR REFERRING YOU TO OUR OFFICE?

PATIENT TREATMENT CONSENT

I AUTHORISE THE DENTAL STAFF TO SUBMIT INSURANCE CLAIM FORMS AND RECEIVE PAYMENT DIRECTLY FROM THE INSURANCE WITH THE NOTATION 'SIGNATURE CAPTURE'?

I AUTHORISE THE DENTAL STAFF OR CLERICAL STAFF TREATING ME TO PERFORM SUCH EXAMINATIONS AS ARE NECESSARY TO MAKE A THOROUGH ASSESSMENT OF MY DENTAL NEEDS

Print | Save | Print Back Form

The form will be completed only when the provider signs it. Or if you hit 'Print and Sign', the form changes to completed and then the provider has to sign the form in the printed form.

Note:

- A form once signed by the patient but still in the draft status can't be edited. If you want to do that, you have to remove the sign of the patient. But this is not advisable as the patient would have to sign it again.
- A Medical History form once completed can't be deleted.
- A Medical History form once completed can't be edited. You can only add a note to the fields by clicking '+note'.

The Medical History forms that are pending to be signed by the provider can be seen in the **Huddle Dashboard** under **Pending Signature Med Hx**



## Where can a patient fill the Med Hx form

A patient can fill his medical history forms from three different places.

### 1. Patient's profile > Med Hx tab on the left

As we have seen earlier, a patient can fill his Medical History form from the patient profile when at the practice assisted by a user.

### 2. From the Patient Portal

The patients can fill their Medical history forms from the Patient Portal. If the form is in the draft status, the patient will be able to find them in the patient portal Home tab as Pending forms or under the Forms tab.

The screenshot shows the patient portal interface for Celebration Dental. At the top, there's a blue header bar with the practice name. Below it is a green navigation bar with the user's name, "An Aswathy Nair", and a "BOOK AN APPOINTMENT" button. The main content area has tabs for "HOME", "FORMS", and "TREATMENTS". Under "TREATMENTS", it says "No Treatments Pending". On the left, there's a sidebar with "ACCOUNT DETAILS" and "SIGN OUT" buttons, and a message about account verification.

### 3. From the Kiosk

Under forms pending completion, you will be able to see the pending forms. So if the Medical History form is in the draft status, you will be able to find it under the pending forms.

The screenshot shows a medical history form titled "(Hx) Medical History Form". It includes options to "View in English" or "View in Spanish". The form asks if the patient has ever had various conditions, with radio buttons for "Yes", "No", and "I don't know". The conditions listed are: High Blood Pressure, Low Blood Pressure, Thyroid Problems, Asthma, Arthritis, Chest Pain Upon Exertion, Sinus Trouble, Emphysema, Shortness of Breath, Hives / Skin Rash, Bronchitis, and Fainting Spells. At the bottom, there are buttons for "MARK ALL AS NO", "SAVE & EXIT", and "NEXT".

### Medical Hx form - Spanish

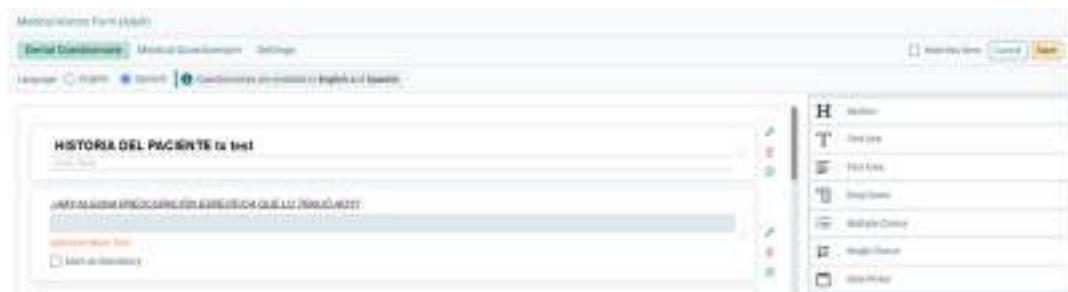
Since a completed Medical Hx. is vital before a patient's treatment, the difficulty faced by the Hispanic patients to complete the English Medical Hx should be addressed due to the increasing priority and the no: of customers requesting to have this. The Front Office is forced to have a translator to assist a Hispanic patient completing the Medical Hx. thus affecting the resource management and a longer waiting time for the patient before the appointment.

## Spanish Medical Hx configuration

Both the Medical Alerts and the questionnaire can be configured in Spanish version for the Hispanic population. While adding a Medical Alert a corresponding Spanish version can be added as a toggle. The English version continues to remain the basic template and the Spanish version is only a carbon copy of the English component (for example, a follow up question cannot be added for a Spanish translation alone, instead it retains the behavior of the English component)



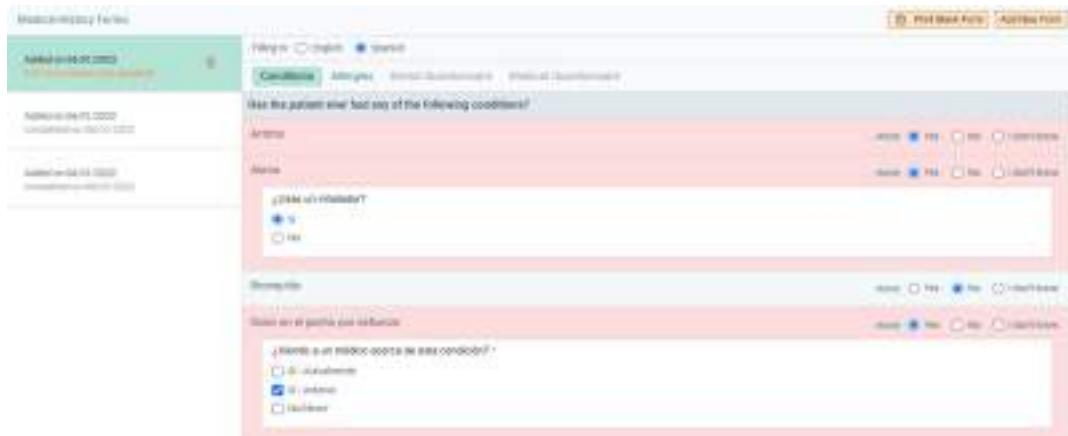
Each question inside the Medical Hx form questionnaire can have its Spanish version and can be configured accordingly inside the Practice Settings for the Medical Hx form.



## Spanish Medical Hx Presentation

Spanish patients can choose to fill a Medical Hx form in the Spanish version for easier convenience. As listed earlier, a Med Hx form can be filled via the PMS, the Patient Portal and the kiosk mode of the Patient Connect.

### 1. PMS



### 2. Kiosk Mode & Patient Portal





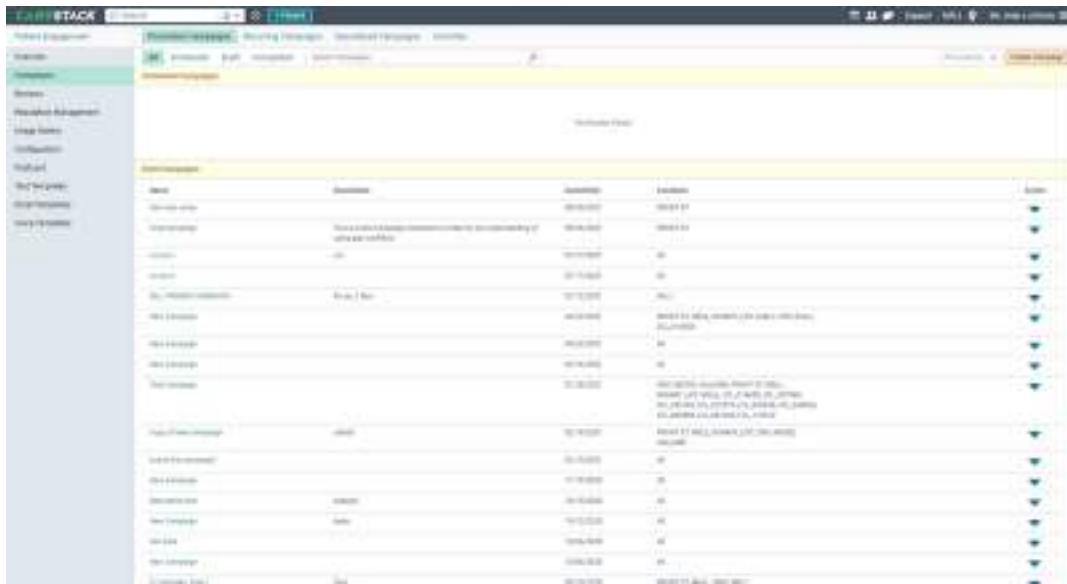
# Promotional Campaigns

Written by Aswathy B Nair | Last published at: July 29, 2022

Promotional campaigns are structured as one-and-done **email communications**. They are typically used for promotions like specials or coupons, but also for other types of targeted communications like announcements, or insurance letters.

## Promotional Campaigns Landing Page

Promotional campaigns can be seen under **System menu > Patient Engagement > Campaigns > Promotional Campaigns**. The below given picture shows the landing page of Promotional Campaigns.



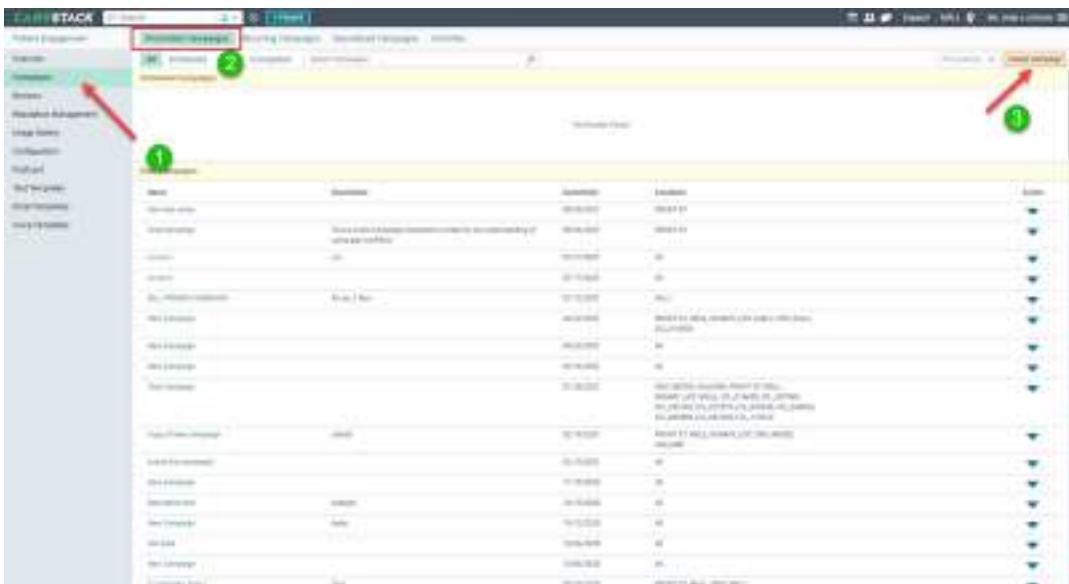
- Under the **All tab**, you would be able to see all the promotional campaigns that are already sent and yet to be sent. It has sections like Scheduled Campaigns, Draft Campaigns, and Completed Campaigns.
  - Scheduled Campaigns** are those which are scheduled and yet to be sent out to the patients. It has columns like *Name, Description, Scheduled Date, and Locations*. (We will discuss the fields when we create a campaign)
  - Draft Campaigns** are those which are incomplete are saved as drafts. They could be edited and could be changed to the scheduled status. It has columns that give you the *Campaign Name, Description, the date on which the Campaign was Saved, and Locations*.
  - Completed Campaigns** are those campaigns that were already sent out to the patients. It gives you the details like the *Campaign Name, Description, the date on which the Campaign was sent, the Locations, the total number of patients who received the Campaign, the number of emails that were read, and the Appointments that were booked as a part of this campaign*.
- Now if you go into the **Scheduled tab**, you would be able to find all the Scheduled Campaigns under it. It has the same columns as we have discussed above but the only thing is you would be able to separate all the scheduled from the rest under this tab which reduces the confusion.
- The **Draft tab** shows all the Campaigns in the Draft status.
- The **Completed tab** shows all the campaigns that were sent out to the patients.

The **Search bar** helps you to find the campaign easily if you know the name of the campaign beforehand.

The **Location Filter** helps you to filter the campaigns by Location. You can select the Location and it will show all the campaigns that have the specified location.

## How to Create a Promotional Campaign

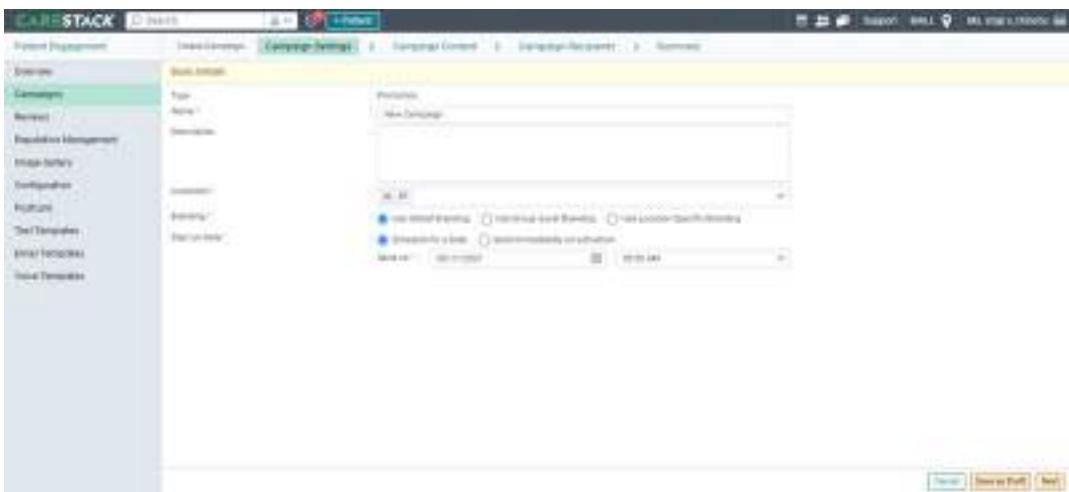
You can create a promotional Campaign from **Promotional Campaigns Landing Page > Create Campaigns**



## Campaign Settings

When you click on Create Campaign, it will take you to the **Campaign Settings** tab. Let's see the field one by one.

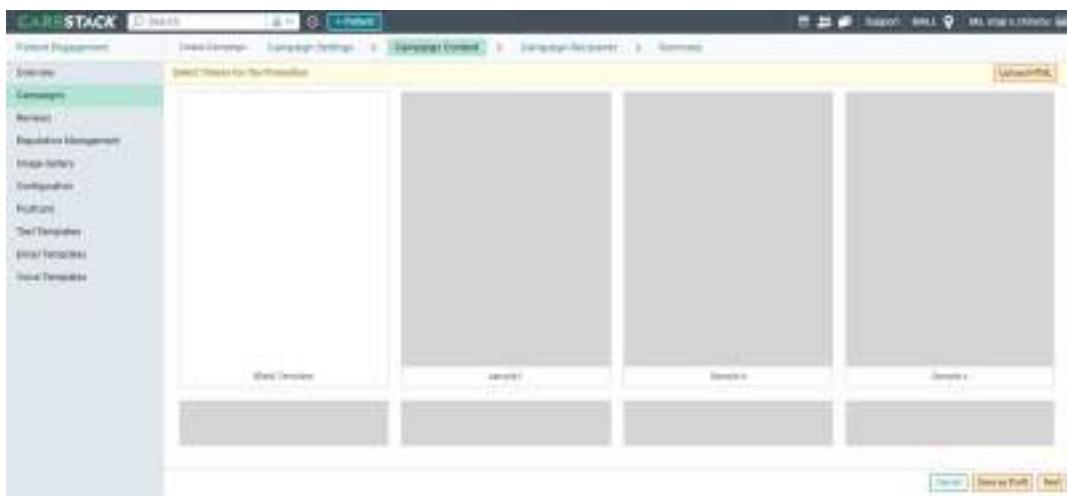
- **Type:** The type of the campaign would be pre-set as Promotion. This is a noneditable field.
  - **Name:** You can choose a name, an easily identifiable name, for your campaign By default it would be set to "New Campaign".
  - **Description:** Enter a description for the use of this Promotional campaign.
  - **Locations:** Select the default location(s) of the patient to whom the campaigns are sent.
  - **Branding:** Decide whether to use your Account details (Global Branding) or Location details (Location Specific Branding) – this will be used to draw the correct office name, logo, phone number, and so on.
  - **Start on Date:** Select the date and time this campaign should be sent out, or choose to send out immediately upon activation.



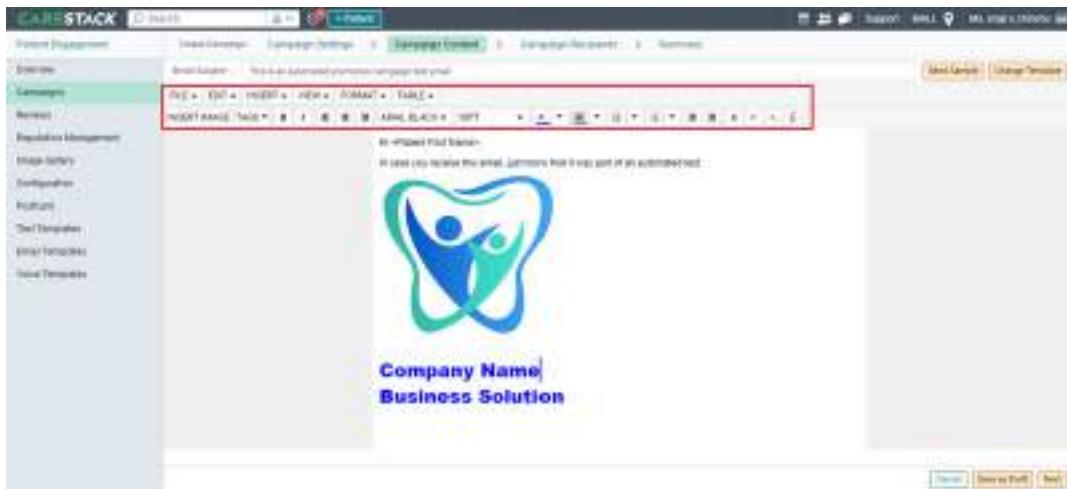
Hit **Next** on the bottom left to go to the next tab

## Campaign Content

You would be able to set the content for your campaign from this page. You could either use the email templates available or you could create a new template by choosing the **Blank Template**. You could also click on "[Upload HTML](#)" at the top-right to browse for an HTML template saved on your computer.



- Confirm how you want the Subject Line to appear to the recipient.
- Update or edit the body of your message as needed using the provided formatting toolbar.
  - Add **Tags** or **Quick Links** to insert personal or custom information (Type “@” key then select the appropriate field).
  - If desired, select an option from the **Insert** menu to include hyperlinks, social media icons, or buttons as part of your content.
  - CareStack gives you the option to edit the template in this section.



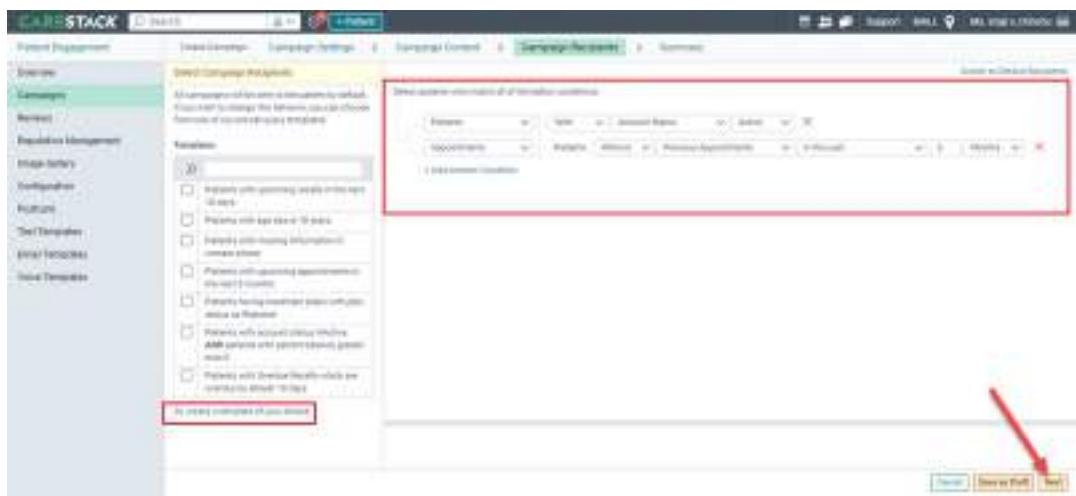
You can try sending yourself a sample message if desired. Just click on **Send Sample**. But please be aware that the practice name and the organization-based fields would be filled with dummy values and would only populate the right ones when sent to the patients.

Oh, you chose the wrong template? No worries, you can always change the template by clicking **Change Template** on the top right. A pop-up comes to confirm if you want to change the template. Once you confirm, it takes you to the page where you choose the templates(the landing page of Campaign Content).

Hit **Next** to go to the next tab

## Campaign Recipients

Here you may select to whom you want the campaign to be sent. There are certain existing templates from which you can select or you can create a list of patients or templates of your choice by clicking on '**create the template of your choice**' just below the existing templates. On clicking 'create a template', you would get the option to set the conditions just like when we generate a patient list.



\*Hit **Next** at the bottom-right of the screen to continue.

## Summary

The final section is the **Summary** tab. This allows you to review any final details before saving and sending out your campaign.



- Click **Save as Draft** to hold your promotion and continue to work on it. Your campaign will be visible in the Draft section on the Promotion Campaigns page.
- Click **Run Promotion** to enable it to run on your selected delivery date. Your campaign will be visible in the Scheduled section on the Promotion Campaigns page. You may still change any details in the campaign up until the delivery.



# Curbside Check-in

Written by Aswathy B Nair | Last published at: August 15, 2021

Curbside check-in is a campaign that gives the ability for patients to come and check in for their appointment from the parking area of the dental office so that they don't have to wait in a public space with other patients. This functionality was introduced to specifically cater to the problems introduced due to the Covid pandemic.

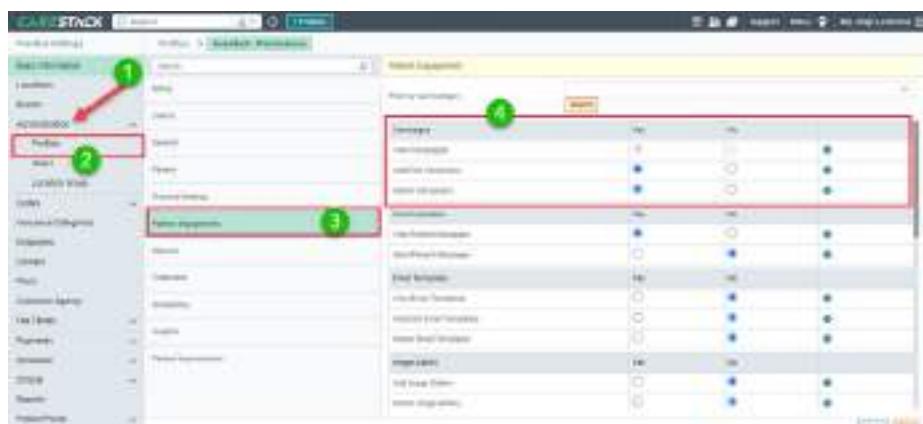
Curbside check in allows us to send a special text message to the patient before the appointment, letting them know that they can check-in with their phones directly from the parking lot.

When the patient arrives at the parking lot, they simply respond with 'c'. The appointment status will get updated in the Scheduler and the patient will receive an automated response. Thus the patient can wait comfortably in the car until someone from the practice calls or texts that it is time to come in.

## Permissions

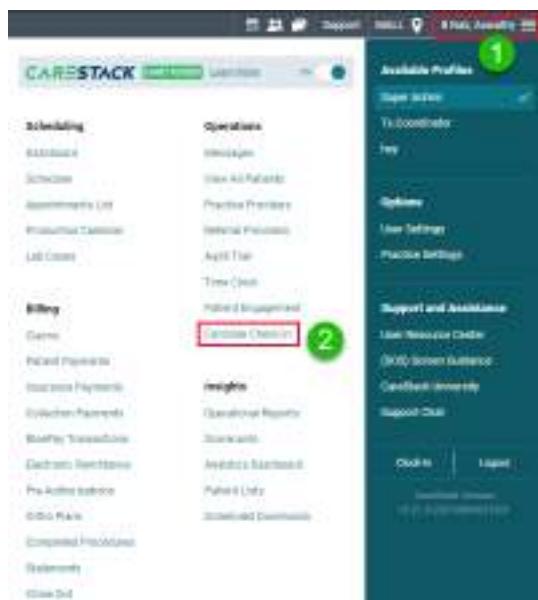
Before you set up a campaign, make sure that you have the necessary permissions to add/ edit it.

You can set the permissions under **System Menu > Practice settings > Administration > Profiles > Manage permissions > Patient Engagement > Campaigns**.



## How to set up a curbside check-in Campaign?

You would be able to create or set up a curbside check in campaign by navigating to **System menu > Curbside check in**



This will take you to the Curbside Check-in Pop up box where you can enter the details for the set up.



Let's go through the fields real quick!

1. **Select the appointment locations:** You would have to select the locations for which you need to trigger this campaign.
2. **Select the appointment statuses that should trigger the initial text message:** Here you would have to choose the appointment status for which you need to trigger the campaign.
3. **Select a new appointment status to display once the patient responds:** This is where you choose the new status to be displayed on the appointment once the patient confirms the campaign text with a 'C'.
4. This last field is where you set the time when you want to trigger the campaign. By Default, it would be 30 minutes.

\*All these fields would get pre populated if there is an existing Curbside check in Campaign.

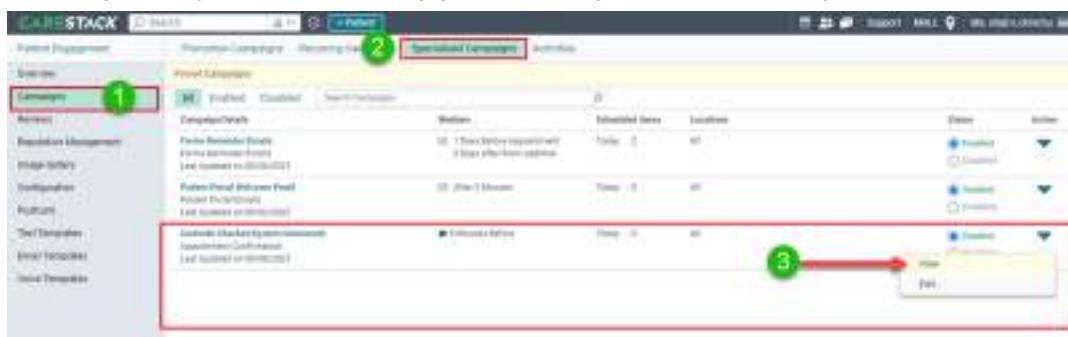
Once you enter all the details and click on Save settings you will see an Information pop up box.



**\*\*Note:** It will take about 24 hours for the campaign to become active after it has been set up or modified.

## How to View a Curbside Check in Campaign

You'd be able to find the campaign under System menu > Patient Engagement > Campaigns > Specialized Campaign.



Click on the **Action** Drop down and there you will have the option to **view** the curbside check in campaign. The View option directly takes you to the **Summary** of the campaign where you'd be able to see all the information with regards to the Curbside Check in campaign. You could also toggle between the other tabs.

## How to Edit a Curbside Check in Campaign

You'd be able to **Edit** the campaign under **System menu > Patient Engagement > Campaigns > Specialized Campaign > Actions > Edit**.

- On clicking the Edit button in the Curbside Check In campaign, we'd be taken to the **Campaign Settings** tab. Here you would be able to edit and make changes in the **description**, **locations** and the **Branding** fields.
- On the **Campaign content** tab
  - You would be able to edit the time frame to send the curbside before an appointment.
  - All the General and the Appointment Confirmation text templates would be listed here from which you can choose the template to be used for the campaign.
- Under the **Campaign Recipients** tab
  - You'd be able to make changes to the campaign criteria like the Location, Trigger Statuses and New Status.

- Also you would be able to select whether you want to send a single message for the Family appointments or not.
- Under the **Summary** tab, you would be able to **Save**, **Save and Enable** or **Cancel** the changes made.

**When a patient replies with 'C' to their curbside check-in request the following takes place:**

- A **green toaster** with patient details would be seen on the user screen. The toaster would be seen for confirmation in the logged in location. This toaster would be shown to all the users with "View" permissions for patient messages.
- The **status of the appointment** changes to the new status that is set in the campaign.
- In the **Audit trail**, the change would reflect and show that the appointment has been updated by User, System.

# Appointment Campaigns

Written by Aswathy B Nair | Last published at: August 16, 2021

Recurring campaigns, as the name suggests, are used for repeated communications like reminders and confirmations. Each recurring campaign can have multiple email, text, and/or voice messages delivered at specific intervals as the campaign runs. Once your recurring campaign is set up with your desired generation criteria, you can run the campaign and forget about it; it'll continue to do its job in the background, sending preset messages to your patients for you. **Appointment Campaigns** are recurring campaigns. There are three kinds of Appointment Campaigns: *Appointment Reminders*, *Appointment Confirmation* and *Appointment Notification*. Lets look into it one by one.

## Appointment Reminder Campaigns

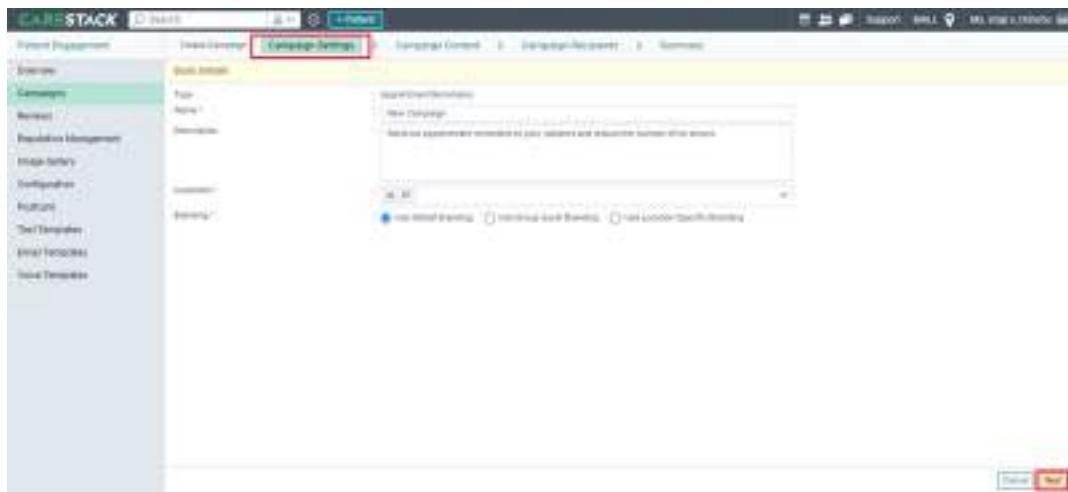
Appointment Reminders are campaigns that reminds the patient of an upcoming Appointment. To add an appointment remainder Campaign, you would have to navigate to **System menu > Patient Engagement > Campaigns > Recurring Campaigns > Create Campaign > Appointment Reminders**.

This takes you to the **Campaign Settings** tab.

### Campaign Settings

Here you would have to enter the Basic Details of the campaign.

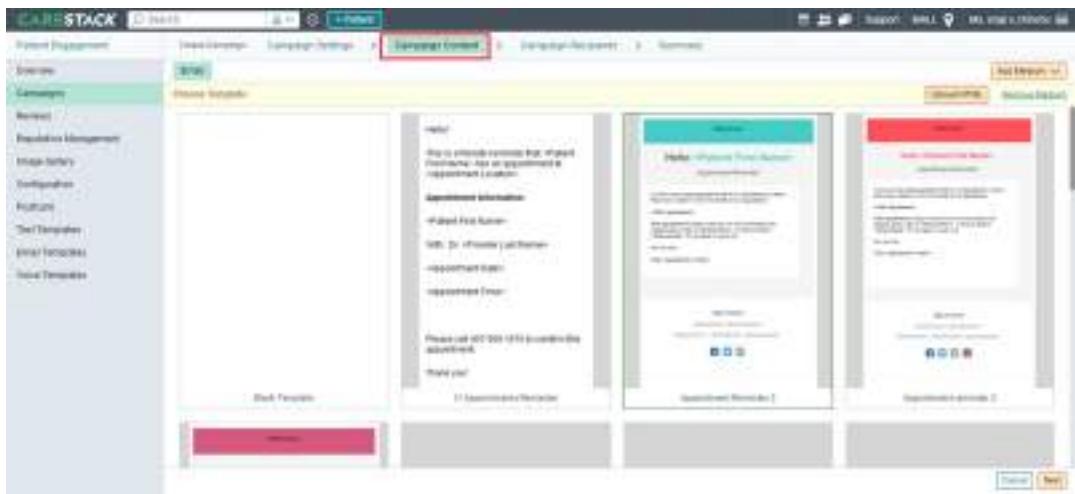
- **Type:** It would be pre populated as " Appointment Remainders"
- **Name:** You could give an easily identifiable name to your campaign. By default, it would be New Campaign.
- **Description:** CareStack always gives the perfect description there. But you can always give the description according to your choice.
- **Locations:** You have to choose the default location of the patients for whom the campaign should go. By default it would be set to All locations
- **Branding:** Decide whether to use your Account details (Global Branding) or Location details (Location Specific Branding) -- this will be used to draw the correct office name, logo, phone number, and so on. By default it would be set to use Global Branding.



Hit **Next** on bottom left to go to the next tab

### Campaign Content

You would be able to set the content for your campaign from this page. You could either use email templates available or you could create an new template by choosing the **Blank Template**. You could also click on "**Upload HTML**" at the top-right to browse for an HTML template saved on your computer.

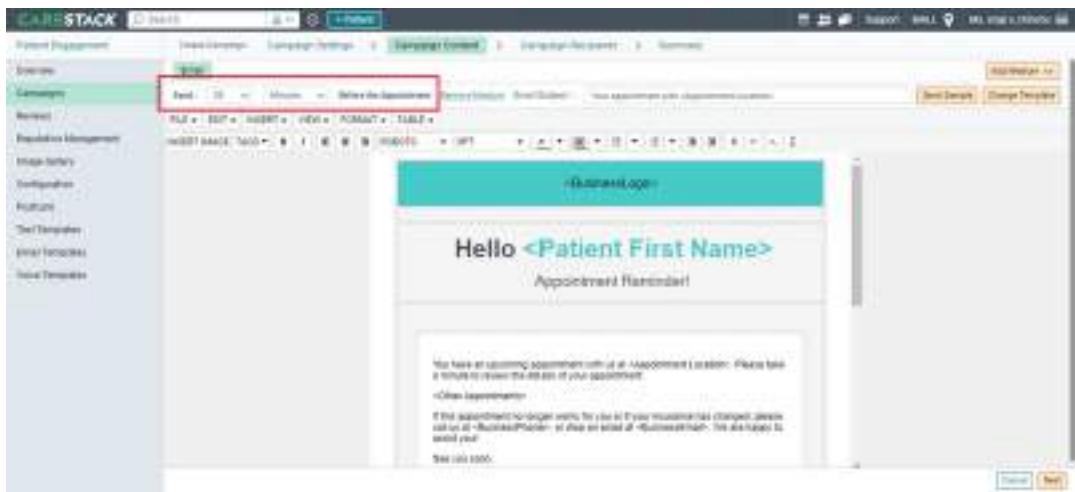


Did you see **Add medium** on top right? Yea, you guessed it right! It is used to add mediums like text , email and voice. From the dropdown, you can choose the medium by which you want to send the campaign. You also have an option to remove a medium. If you click on **Remove Medium**, you will have the option to choose the medium from the start.



When you choose the template, you would be taken to a page where you can make changes to the existing template, make edits or add a link etc.

The most important thing here is the option which allows us to **set the time of the campaign**. Here you would be able to set the time, in days, hours or minutes, by which you like the campaign to be sent before the appointment.



- Confirm how you want the Subject Line to appear to the recipient.
- Update or edit the body of your message as needed using the provided formatting toolbar.
  - Add **Tags** or **Quick Links** to insert personal or custom information (Type "@" key then select the appropriate field).
  - If desired, select an option from the **Insert** menu to include hyperlinks, social media icons, or buttons as part of your content.
  - CareStack gives you the option to edit the template in this section.

You can try sending yourself a sample message if desired. Just click on **Send Sample**. But please be aware that the practice name and the organization based fields would be filled with dummy values and would only populate the right ones when sent to the patients.

Oh you chose the wrong template? No worries, you can always change the template by clicking **Change Template** on top right. A pop up comes to confirm if you want to change the template. Once you confirms, it takes you to the page where you choose the templates(the landing page of Campaign Content).

Hit **Next** to go to the next tab

## Campaign Recipients

Here you may select to whom you want the campaign to be sent.



## Campaign Criteria

You can set the Campaign Criteria from here and note that the campaign would only go to those patients who satisfies the criteria of the campaign.

- Provider: The campaign would go out to the appointments in which the chosen providers are the treating providers.
- Location: Campaigns would go only to the appointments in these locations.
- Production Type: Select the production types(which is linked to the appointment) for which you want the campaign to go.
- Codes: You can specify the codes for which you want the campaign to trigger
- Trigger Statuses: The appointment Status for which you need the campaign to get triggered.

## Family Appointments

You can choose to send the campaigns either to each patient in a family account separately or merge the appointment details of all the campaigns sent to a single phone number.

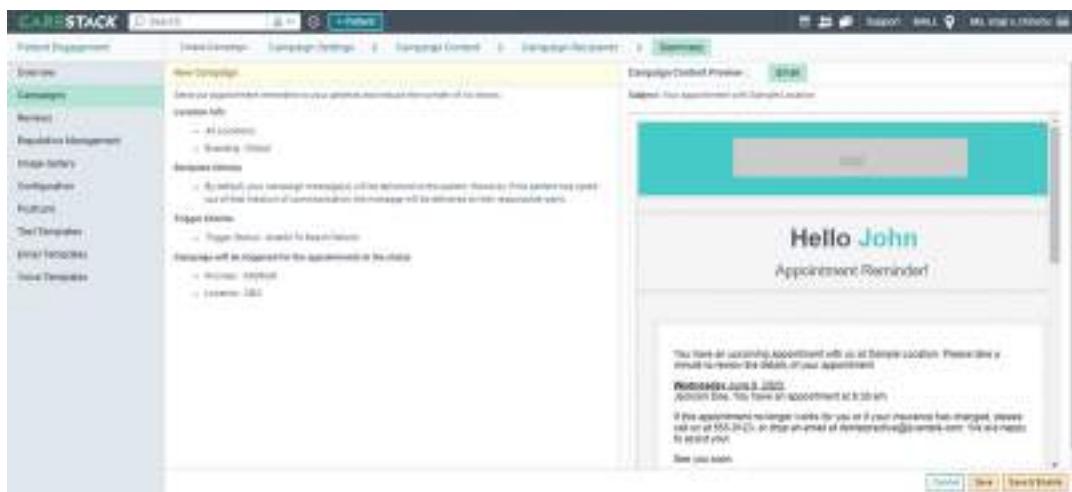
Note:

- It would club together all the messages sent to 1 particular phone number on the same day.
- If this option is enabled, it would append an appointment list to the template.
- If confirmed, all the appointments mentioned in the message would be confirmed.
- If one particular number has only 1 appointment, then the Appointment block should not be added to the template.

## Summary

After setting the Campaign criteria, you can click Next, which would take you to the last tab.

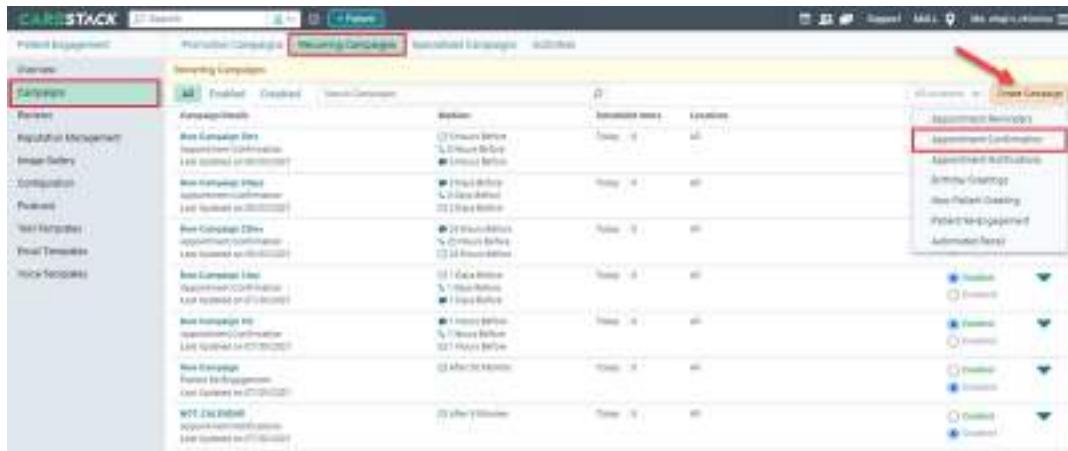
Here you would be able to see all the information that we have entered regarding the campaign. This is the best place where you can check all the details that you have entered before you could save and enable the campaign.



- Click **Save** to hold your promotion and continue to work on it. Your campaign will be visible in the All section on the Recurring Campaigns page.
- Click **Save and Enable** to enable it to run.
- You can even **Cancel** the campaign and the system will discard all the changes made

## Appointment Confirmation Campaigns

Appointment Confirmation Campaigns are sent to patients for them to confirm their upcoming appointments. This way the practice can make sure that the patient would be coming to the practice for the treatment. To create an appointment confirmation campaign you could navigate to **System menu > Patient Engagement > Campaigns > Recurring Campaigns > Create Campaign > Appointment Confirmation**.

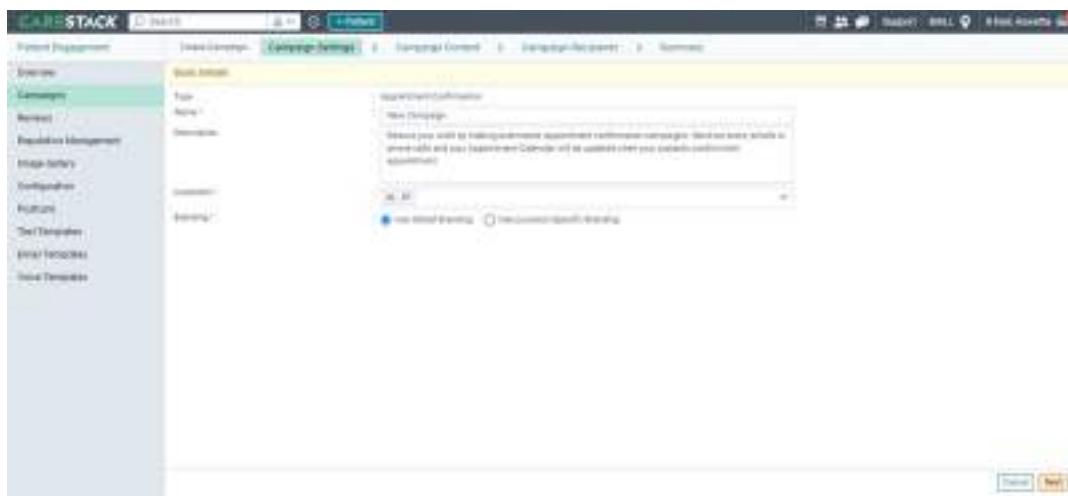


This would take you to the Campaign Settings tab.

### Campaign Settings

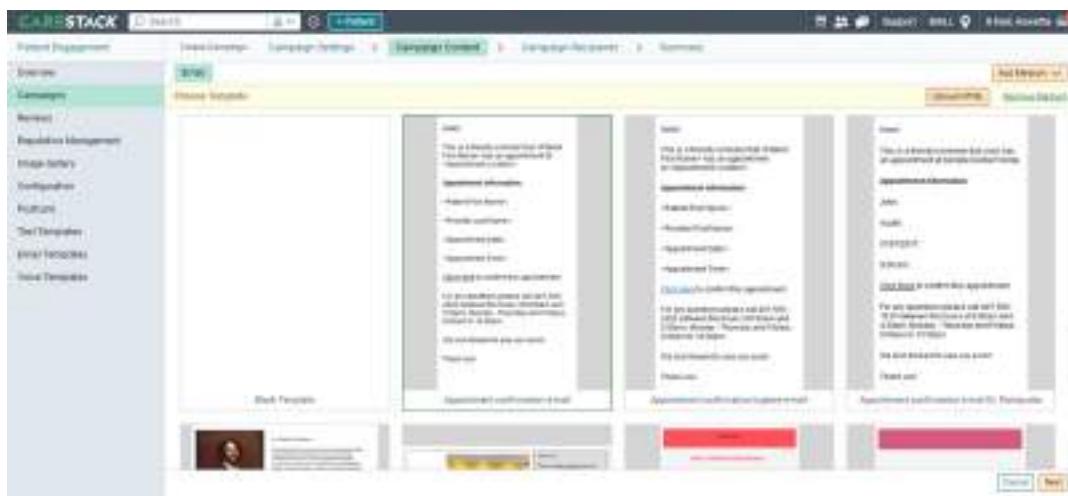
Here you have to fill the **Basic details** of the campaign just like we did for Appointment Remainder campaign. Give it a try yourself, lets see how much you recall!!

Yes, you have to enter the **Name, Description, Locations and Branding**. All the field would have default values prepopulated as in the screenshot below but you are always free to change the contents according to your will. On clicking the Next button, you will land in the Campaign Content tab.

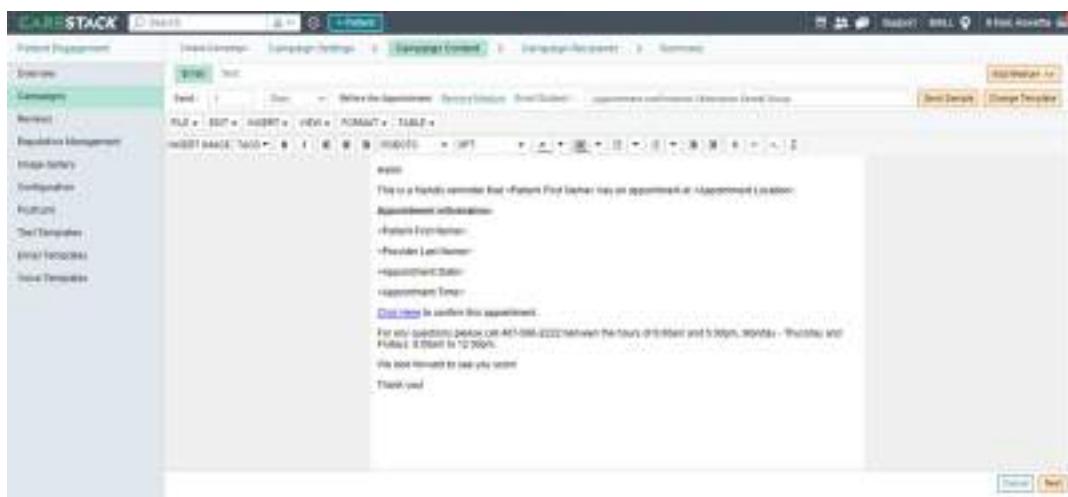


### Campaign Content

Similar to Reminder campaign, you can choose a template or can create one of your own. You can also upload HTML files from your system using **Upload HTML**. You can add mediums or remove them from here.

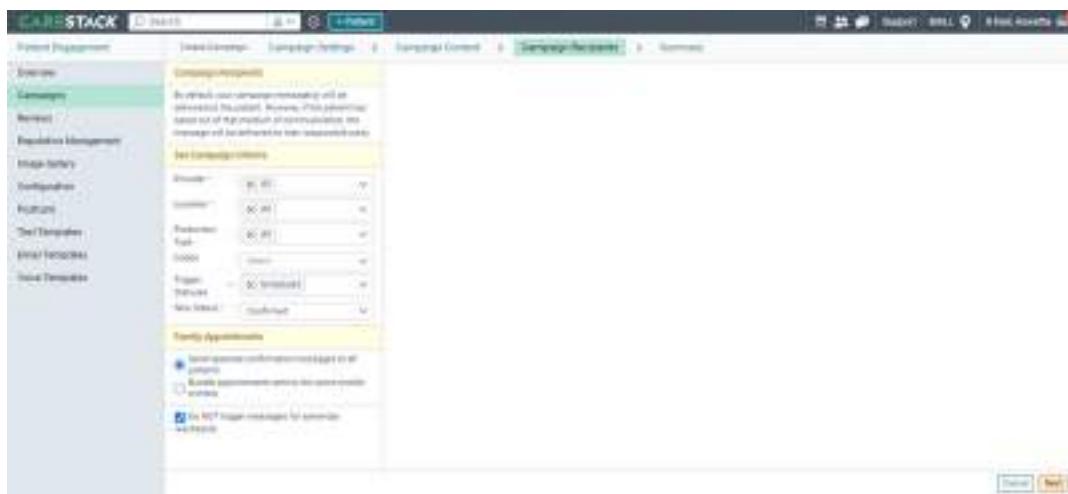


When you select a template, you would be taken to the page where you can edit the campaign content.



- You have a field where you can enter the **Email Subject**.
- Appointment confirmations are to be send before the appointment, right? So here you have the provision to **choose the time**, how many days, hours or minutes before the appointment you want to send the campaign.
- In the Campaign content, you would have a link where the patients can **click to confirm** the appointment. "[Click here](#) to confirm this appointment". In case of text messages, the patient would have to send 'C' to confirm the appointment.

## Campaign Recipients



You can set the campaign criteria here just like we did for Appointment Reminder Campaigns.

- **Provider:** The campaign would go out to the appointments in which the chosen providers are the treating providers.
- **Location:** Campaigns would go only to the appointments in these locations.
- **Production Type:** Select the production types(which is linked to the appointment) for which you want the campaign to go.
- **Codes:** You can specify the codes for which you want the campaign to trigger
- **Trigger Statuses:** The appointment Status for which you need the campaign to get triggered.
- **New Status:** This is unique to confirmation campaigns. That is once the patient confirms the campaign, the status of the appointment status changes tp the new status so that the user would be aware that the patient has confirmed the campaign by simply looking into the Scheduler.

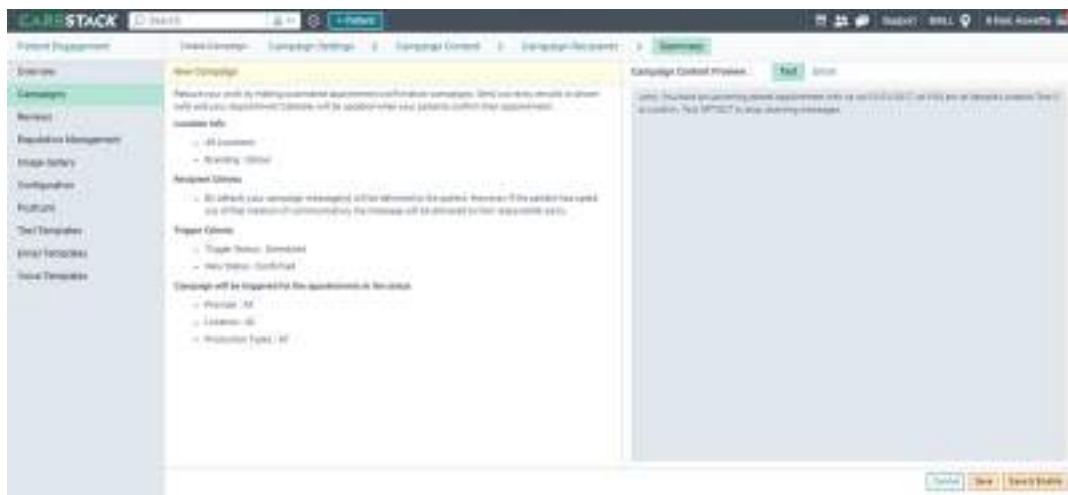
## Family Appointments

You can choose to send the campaigns either to each patient in a family account separately or merge the appointment details of all the campaigns sent to a single phone number.

## Summary

After setting the Campaign criteria, you can click Next, which would take you to the last tab.

Here you would be able to see all the information that we have entered regarding the campaign. This is the best place where you can check all the details that you have entered before you could save and enable the campaign.



- Click **Save** to hold your promotion and continue to work on it. Your campaign will be visible in the All section on the Recurring Campaigns page.
- Click **Save and Enable** to enable it to run.
- You can even **Cancel** the campaign and the system will discard all the changes made.

## What happens when a patient confirms an appointment?

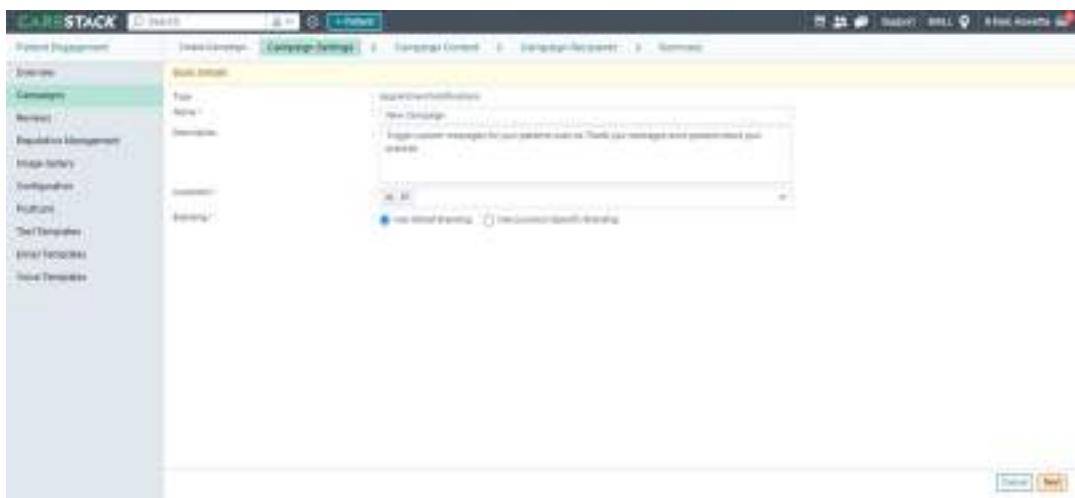
When a patient confirms an appointment either through text or email campaign,

- The status of appointment changes to the **new status** as set in the campaign criteria.
- In the **Activities** log, it shows that the patient has confirmed the campaign.
- In the **Audit trail** it shows that the appointment has been updated by System user.

## Appointment Notification Campaigns

Appointment Notification campaigns are send to the patients after the appointment inorder to thank the patients for visiting the practice and or even some measures to be taken after the services rendered.

To create an Appointment Notification campaign, you would have to navigate to **System menu > Patient Engagement > Campaigns > Recurring Campaigns > Create Campaign > Appointment Notification**. This would take you to the campaign settings.



The campaign settings are similar to that of Appointment Reminder and Appointment Confirmation Campaigns.

## Campaign Content

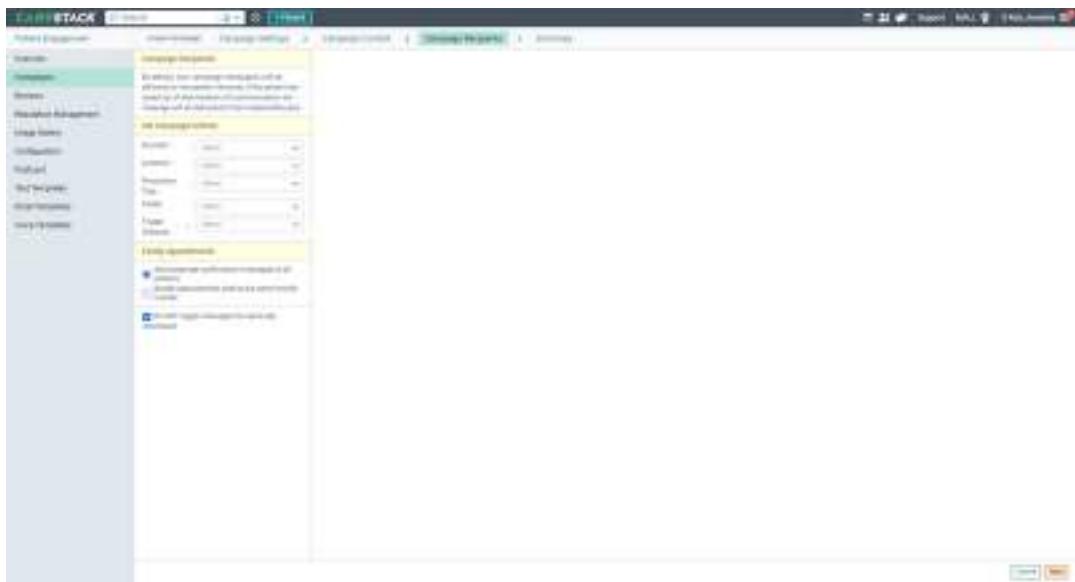
In the campaign content, you can select the template, add medium or remove one. Once you select the template, you would be taken to the page where you can edit the contents and make changes if you please.



You can enter the Email subject and also confirm the number of **after** before the appointment to send this campaign. So the important difference that you see here is that the Appointment Notification campaigns are sent after the appointment.

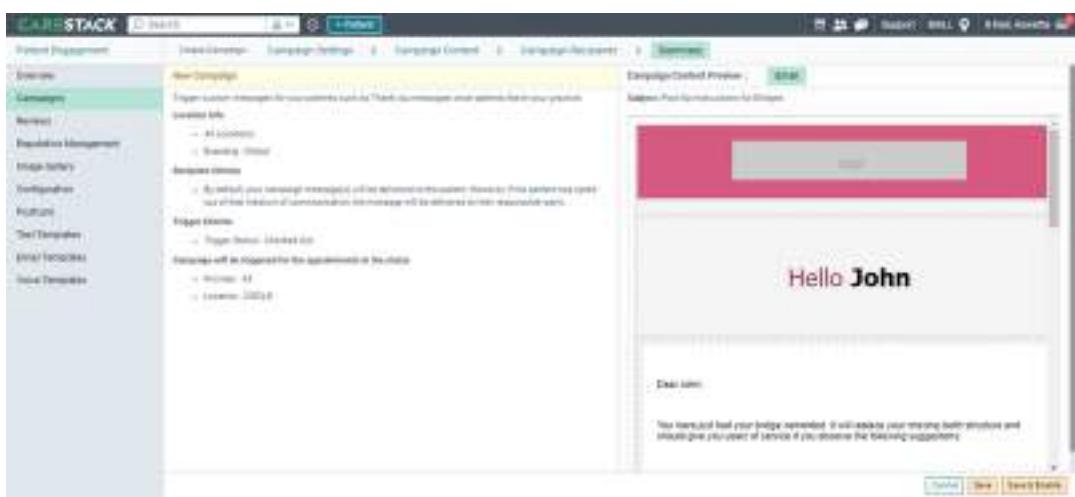
## Campaign Recipients

Just like in the other appointment campaigns, you have to set the criteria for the campaign to get triggered. Since the campaign is sent after the appointment, the trigger status would be probably **Checked out**.



## Summary

Here you would be able to see all the information that we have entered regarding the campaign. This is the best place where you can check all the details that you have entered before you could save and enable the campaign.



- Click **Save** to hold your promotion and continue to work on it. Your campaign will be visible in the All section on the Recurring Campaigns page.
- Click **Save and Enable** to enable it to run.
- You can even **Cancel** the campaign and the system will discard all the changes made.



# New Patient and Birthday Greetings

Written by Aswathy B Nair | Last published at: August 16, 2021

Both New Patient Greetings and Birthday Greetings are the campaigns sent to the patient to show the hospitality of the practice, to show that they care for their patients. New patient greetings are sent to the patients once they come to the practice for the first time and Birthday greetings, as the name suggests, is sent out on the Birthdays of the patients.

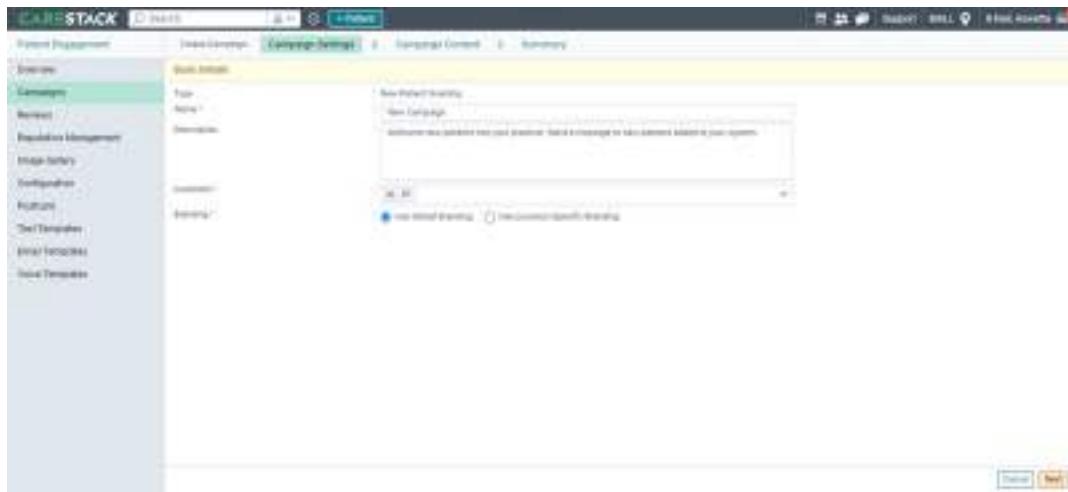
## New Patient Greetings

As discussed above, the New Patient Greetings are sent out to the patients to welcome the patients to the practice. Through this campaign, the practice usually sends the patient portal link so that the patient can fill the forms (like the onboarding forms) from the link.

To create a New Patient Greeting, you can navigate to **System menu > Patient Engagement > Campaigns > Recurring Campaigns > Create Campaign > New Patient Greeting.**

### Campaign Settings

You can enter the Basic Details of the greetings here like the Name, Description, Locations and Branding.



- **Type:** It would be pre populated as " New Patient Greeting"
- **Name:** You could give an easily identifiable name to your campaign. By default, it would be New Campaign.
- **Description:** CareStack always gives the perfect description there. But you can always give the description according to your choice.
- **Locations:** You have to choose the default location of the patients for whom the campaign should go. By default it would be set to All locations
- **Branding:** Decide whether to use your Account details (Global Branding) or Location details (Location Specific Branding) -- this will be used to draw the correct office name, logo, phone number, and so on. By default it would be set to use Global Branding.

You can click '**Next**' to navigate to the next tab.

### Campaign Content

Here, on the landing page of the Campaign Content, you will have the opportunity to choose the email template. Once you select the templates, you would be taken to the page where you can make changes to the existing template.

- Since the campaign is supposed to go **after the patient creation**, you can choose the time for it to get triggered from this page as well. By default, it would be set to 5 minutes. You can set it to days, hours or minutes according to your choice.
- Also, you have to enter the **Email Subject** here. By Default, it would populate the subject as per the template used.
- You can also add different mediums from here. Just click on **Add Medium** and choose your desired medium for sending the campaign.

Once you click '**Next**', it takes you to the Summary Tab.

## Summary

On the Summary tab, we would be able to see details of the campaign. You can verify the details and make changes if required.

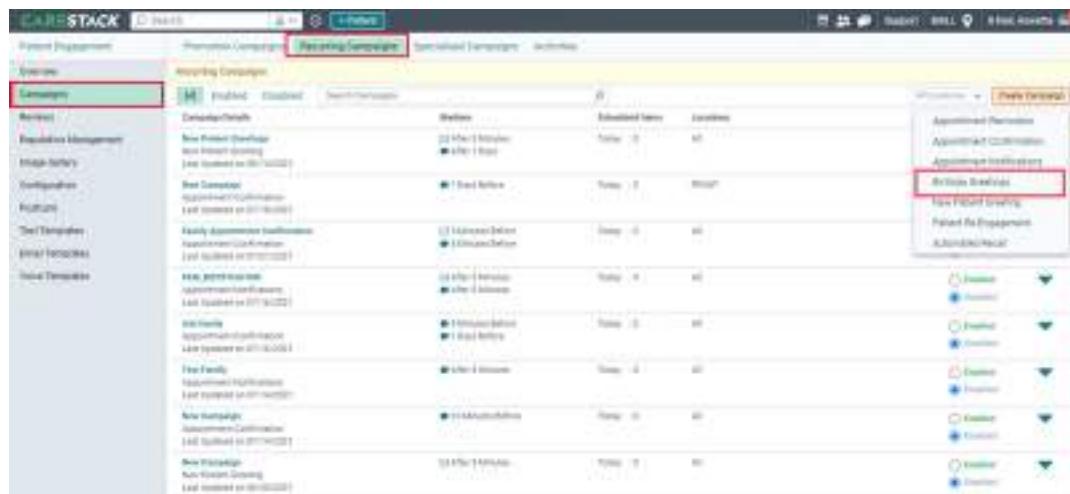
- Click **Save** to hold your promotion and continue to work on it. Your campaign will be visible in the All section on the Recurring Campaigns page.
- Click **Save and Enable** to enable it to run.
- You can even **Cancel** the campaign and the system will discard all the changes made.

## Birthday Greetings

Wouldn't the patient be happy if they see that you remember their birthday! Of course they will be. Who doesn't love Birthday Wishes?

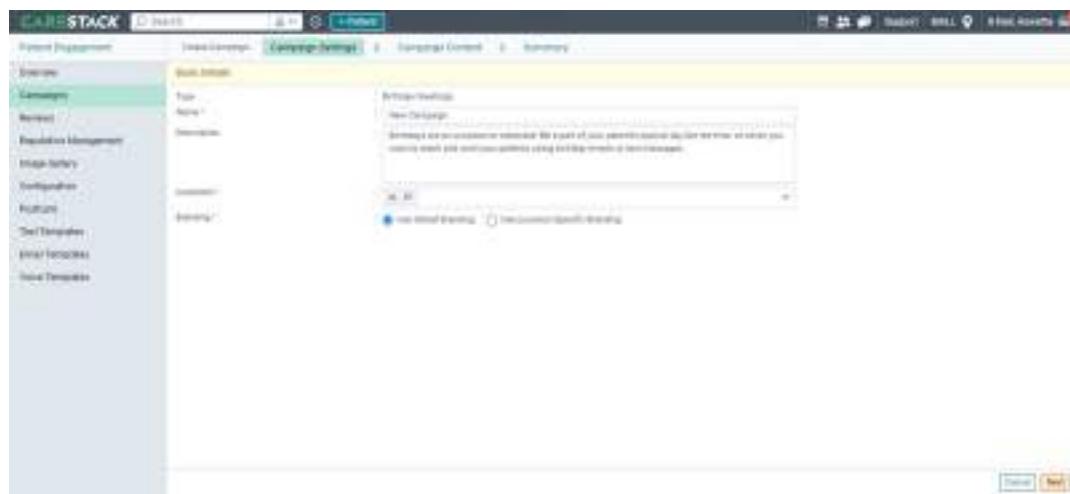
CareStack helps you wish patients' birthday, even if you forget them. This is the purpose of Birthday Greetings.

To create a Birthday Greeting you have to navigate to **System menu > Patient Engagement > Campaigns > Recurring Campaigns > Create Campaign > Birthday Greeting**



## Campaign Settings

Just like we did in New Patient Greetings, fill all the necessary fields in this page. All the fields would be filled with default values and you can make changes if you would like to.

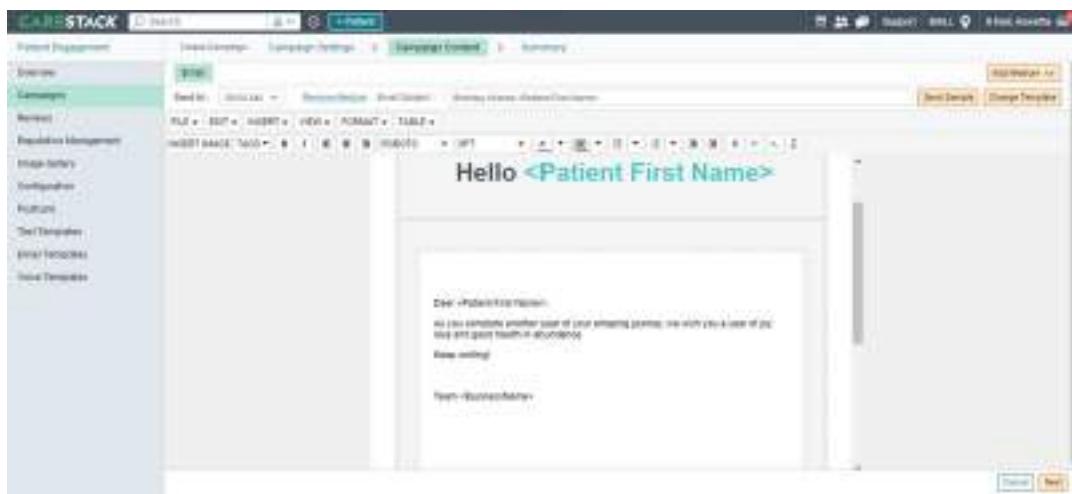


When you click '**Next**', it will take you to the Campaign Content page.

## Campaign Content

Here, on the landing page of the Campaign Content, you will have the opportunity to choose the email template. Once you select the templates, you would be taken to the page where you can make changes to the existing template.

- You can set the time at which you want the wishes to be sent to the patient on the day of their Birthday.
- Also you have to set the Email Subject. This field would already have a defaulted value there.
- You can add and remove medium if you wish to from this page.



## Summary

On the Summary tab, we would be able to see details of the campaign. You can verify the details and make changes if required.

- Click **Save** to hold your promotion and continue to work on it. Your campaign will be visible in the All section on the Recurring Campaigns page.
- Click **Save and Enable** to enable it to run.
- You can even **Cancel** the campaign and the system will discard all the changes made.

# Recall Campaign

Written by Aswathy B Nair | Last published at: August 16, 2021

Bringing patients back to your office is important for them and for the practice. Patients need regular treatments to maintain their health, and you need the steady stream of patient visits. Recalls are generally used for this purpose.

Recall campaigns are reminders sent to the patient regarding their recalls. Let's see how we can create a recall Campaign.

You can add a new Recall campaign by going into **System Menu > Patient Engagement > Campaigns > Recurring Campaigns > Create Campaign > Automated Recalls**.

## Campaign Settings

When you select Automated Recall from Create Campaign, you would be taken to the Campaign Settings page. In this page, you would have to fill the Basic details.

- **Type:** This field will be already filled with the campaign type. In this case, it will be Automated Recall.
- **Name:** You can give a easily identifiable name to your campaign. This field have the default name as New Campaign.
- **Description:** CareStack always gives the perfect description there. But you can always give the description according to your choice.
- **Locations:** You have to choose the default location of the patients for whom the campaign should go. By default it would be set to All locations
- **Branding:** Decide whether to use your Account details (Global Branding) or Location details (Location Specific Branding) -- this will be used to draw the correct office name, logo, phone number, and so on. By default it would be set to use Global Branding.

Once you fill all the details in this tab, you can click Next which will take you to the next tab.

## Campaign Content

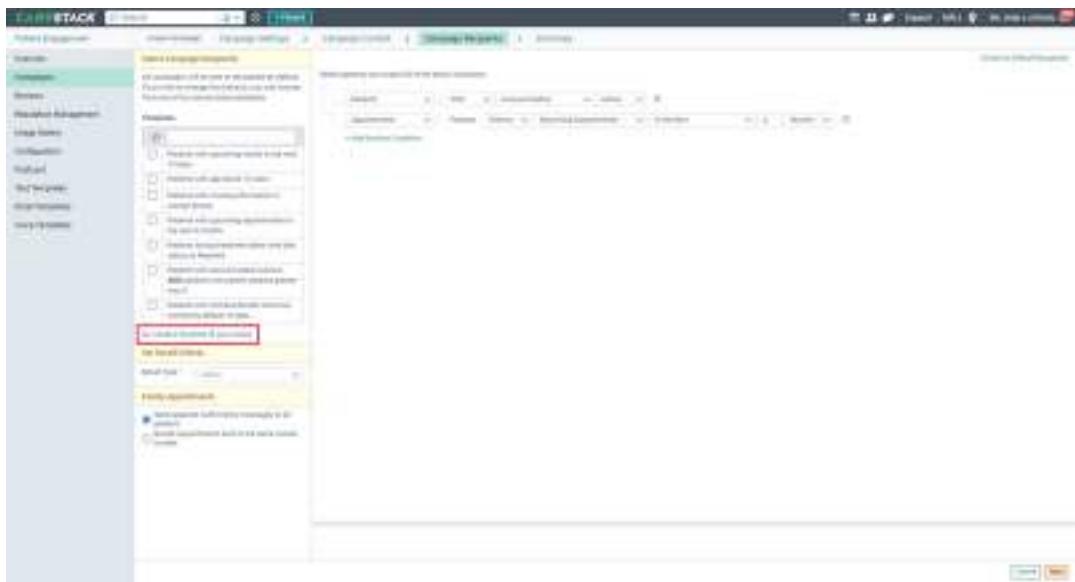
You would be able to set the content for your campaign from this page. You could either use email templates available or you could create an new template by choosing the **Blank Template**. You could also click on "**Upload HTML**" at the top-right to browse for an HTML template saved on your computer. When you select the template, you will be taken to the page where you will be able to edit the contents of the template.

- You can decide whether you want the campaign to be sent before or after the campaign. On the same page, you will be able to set the number of days before or after the Recall due date to trigger the campaign.
- Also, you have to set the Email Subject on this page.

Are you wondering if you can use only email templates? No way, you can have them sent as text as well. You just need to click on **Add Medium** on top right and it will give you an option to add other mediums. You also have an option to remove a medium. If you click on **Remove Medium**, you will have the option to choose the medium from the start. Once you choose all the templates and set the time by which you want the campaign to get triggered, you can click **Next**.

## Campaign Recipients

On this tab, you can set for whom the campaign should be triggered. There are certain existing templates from which you can select or you can create a list of patients or template of your choice by clicking on '**create template of your choice**' just below the existing templates. On clicking 'create a template', you would get the option to set the conditions just like when we generate a patient list.



### Set Recall Criteria

You can select the recalls for which you want the campaign to be sent. This can be chosen from the dropdown list in Recall Type. This Recall type is actually reflected from those set under *System menu > Practice settings > Codes > Recalls*.

We can choose patients with specific recall codes or patients that have overdue recalls in the next 3 months. This can be completely configured according to the practice's criteria.

### Family Appointments

You can choose to send the campaigns either to each patient in a family account separately or merge the appointment details of all the campaigns sent to a single phone number.

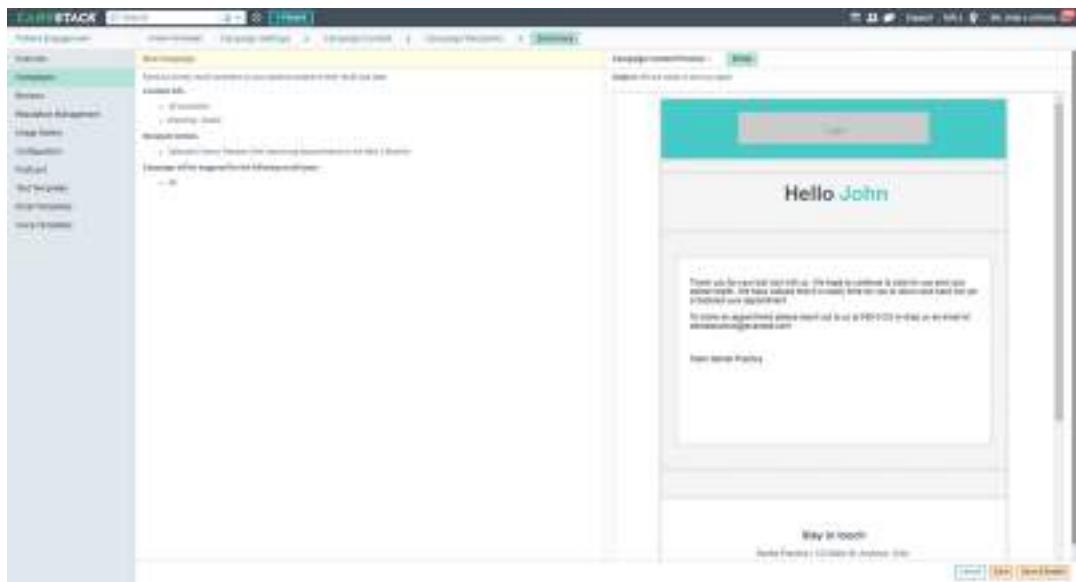
Note:

- It would club together all the messages sent to 1 particular phone number on the same day.
- If this option is enabled, it would append an appointment list to the template.
- If confirmed, all the appointments mentioned in the message would be confirmed.
- If one particular number has only 1 appointment, then the Appointment block should not be added to the template.

Once all the fields are filled with the desired criteria, you can click Next.

### Summary

Here you would be able to see all the information that we have entered regarding the campaign. This is the best place where you can check all the details that you have entered before you could save and enable the campaign.



- Click **Save** to hold your promotion and continue to work on it. Your campaign will be visible in the All section on the Recurring Campaigns page.
- Click **Save and Enable** to enable it to run.
- You can even **Cancel** the campaign and the system will discard all the changes made.

# Patient Re-Engagement Campaign

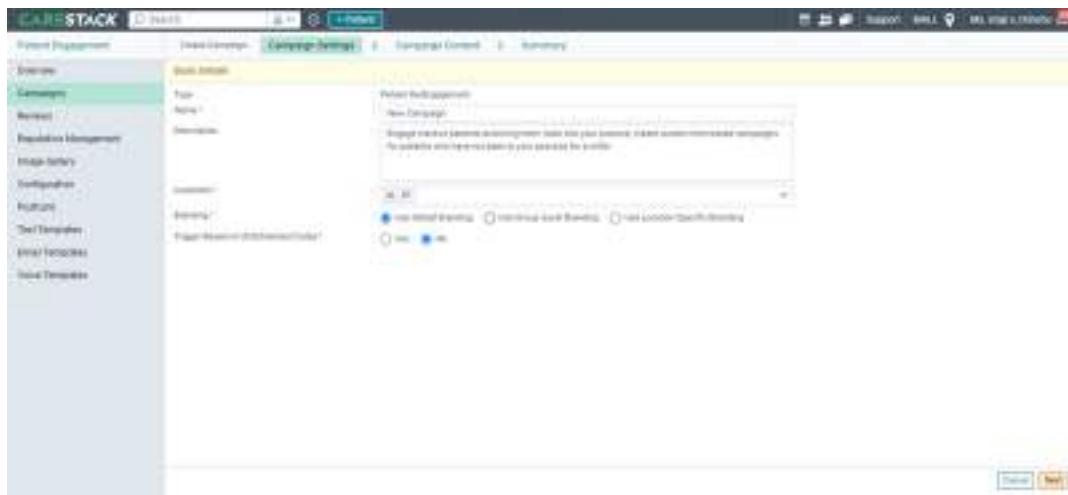
Written by Aswathy B Nair | Last published at: August 16, 2021

Bringing back inactive patients is very important for a practice. Inorder to engage the inactive patients, we can set up Patient Re-Engagement Campaigns.These campaigns are sent to patients after a specified time after their last checked out appointment.

You can add a Patient Re-Engagement campaign by going into **System Menu > Patient Engagement > Campaigns > Recurring Campaigns > Create Campaign > Patient Re-Engagement**.

When you select Patient Re-Engagement from Create Campaign, you would be take to the Campaign Settings page. In this page, you would have to fill the Basic details.

## Campaign Settings



- **Type:** This field will be already filled with the campaign type. In this case, it will be Patient Re-Engagement.
- **Name:** You can give a easily identifiable name to your campaign. This field have the default name as New Campaign.
- **Description:** CareStack always gives the perfect description there. But you can always give the description according to your choice.
- **Locations:** You have to choose the default location of the patients for whom the campaign should go. By default it would be set to All locations
- **Branding:** Decide whether to use your Account details (Global Branding) or Location details (Location Specific Branding) -- this will be used to draw the correct office name, logo, phone number, and so on. By default it would be set to use Global Branding.
- **Trigger based on Unscheduled codes:** If you want to trigger the campaign based on the unscheduled code, then you can click Yes and if you want to trigger the campaign even if there are no unscheduled codes, then you can select No.

Once you fill all the details in this tab, you can click **Next** which will take you to the next tab.

## Campaign Content

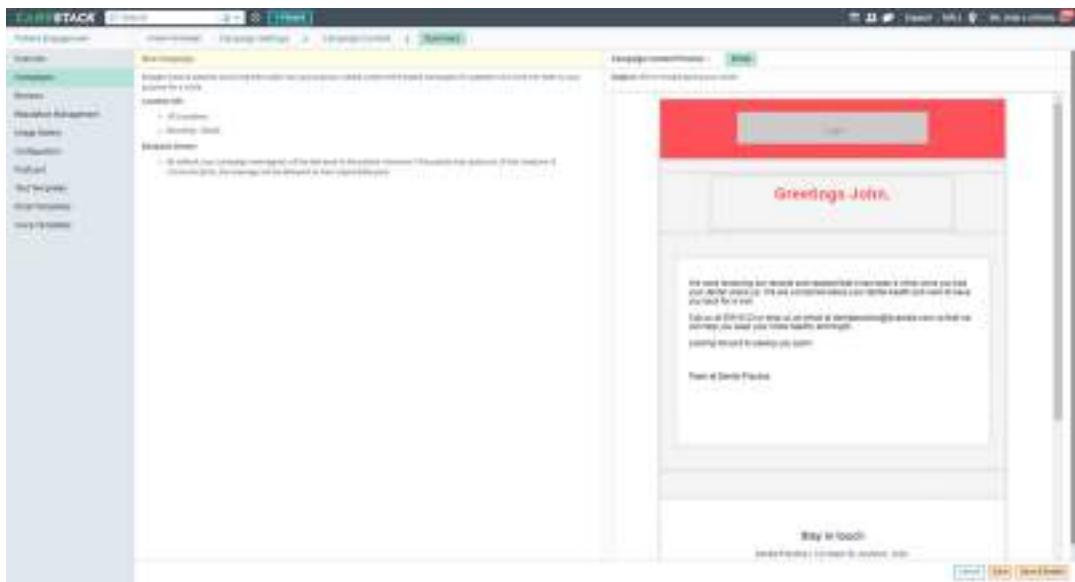
You would be able to set the content for your campaign from this page. You could either use email templates available or you could create an new template by choosing the **Blank Template**. You could also click on "**Upload HTML**" at the top-right to browse for an HTML template saved on your computer. When you select the template, you will be taken to the page where you will be able to edit the contents of the template.

- How many months after the last appointment would you like to trigger the campaign? You can set that here, when you want to trigger the campaign, as in the number of months after the last appointment.

Do you want the campaign to be sent in any medium other than email? You just need to click **Add Medium** on top right and it will give you an option to add other mediums. You also have an option to remove a medium. If you click on **Remove Medium**, you will have the option to choose the medium from the start. Once you choose all the templates and set the time by which you want the campaign to get triggered, you can click **Next**.

## Summary

Here you would be able to see all the information that we have entered regarding the campaign. This is the best place where you can check all the details that you have entered before you could save and enable the campaign.



- Click **Save** to hold your campaign and continue to work on it. Your campaign will be visible in the All section on the Recurring Campaigns page.
- Click **Save and Enable** to enable it to run.
- You can even **Cancel** the campaign and the system will discard all the changes made.

# Reputation Management

Written by Sarah Abraham | Last published at: August 16, 2021

## Overview

Reputation management allows the user to collect reviews and user feedback that helps better the overall dental experience.

## Setting up Reputation Management

Reputation management can be set up by navigating to Patient Engagement > Reputation Management.



Under setup tab, the user can choose to select the mediums for review. We currently provide Google, Yelp, Facebook reviews along with Carestack reviews.

The practice can choose the branding that would suit their business. Global branding allows the reviewers to see the account details whereas group branding provides the flexibility to cluster the different locations under one brand. The practice can also choose to brand at a location level.

## Automatic Review Requests



We have an option to send manual requests as well as automatic requests for review to patients. To set automatic requests the option '*Send review requests automatically after every appointment*' should be set to 'Yes'.

If this has been done, the user has to choose locations for which automatic review requests has to be sent. We do provide the functionality to send both email and text. Text can be enabled only upon a service request from the client.

For locations that have automatic requests set up, every time an appointment is checked out, a review email or text is sent to the patient. The template of the mail sent is similar to the one shown in above image.

The user also has an option to choose the time period after which the review has to be sent. By default this is 5 minutes. So the review is sent to the patients 5 minutes after the appointment is checked out.

Here we have to note only those patients with notifications enabled will receive the request.

## Manual Requests

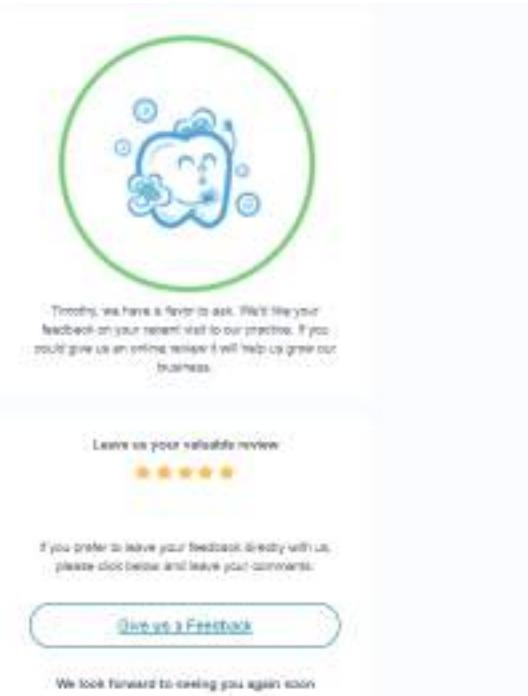
The locations that aren't chosen for automatic requests can be used for manual requests. In this case, the locations which are chosen for manual requests will have a new option namely , 'Send manual requests' in the appointment context menu.



Upon choosing this option, immediately a mail or text is sent to the patient.

## Review

The user will receive either a mail or a text. The format of the mail is similar to the one shown below



Clicking on 'Give us a feedback', the user is taken to Carestack review page. Here the user can submit a review as well as leave their comments as feedback.

**Leave a Review**

We want to provide the best possible care for all our patients and want to hear how we are doing. Can you please take just a minute to provide us with some feedback to help us be the best we can be? Please note that your review, if approved, may appear publicly on our website, Facebook page, or other websites designed for reviews.

**Overall Rating \***

★★★★★      5.0 Excellent

**Review \***

Excellent. Easy to use

The application helps me make my daily workflow easy and provides a seamless experience for my clients!

**SUBMIT**

## Dashboard

All Carestack reviews that are provided by the patients would be listed on the dashboard. The current location of the user would be selected by default and the user can further choose any location or all locations from the filter.

Name	Date	Rating	Location	Customer Review
Ronald Timothy	07/01/2021	★★★★★	Minot, ND	Great application User friendly
Ronald Timothy	07/01/2021	★★★★★	Minot, ND	Easy to use User friendly
Ronald Timothy	07/01/2021	★★★★★	Minot, ND	Great application User friendly
Ronald Timothy	07/01/2021	★★★★★	Minot, ND	Easy to use User friendly
Mike Allen	06/21/2021	★★★★★	AAA Medical Center	Mike User friendly
Ronald Timothy	06/21/2021	★★★★★	AAA Medical Center	Excellent User friendly
Ronald Timothy	06/21/2021	★★★★★	AAA Medical Center	Great User friendly

Also, the user is provided details like the total number of review, Aggregate rating and a breakup of the review according to the rating as well as the rating distribution.

The user also has the option to sort the entries either by Latest first, oldest first, highest or lowest level rating.

Also to view the entire comments, the user can click the 'View Details' option.

**Customer Review**

**Ronald Timothy** ★★★★★ 5

Excellent. Easy to use.  
The application helps me make my daily workflow easy and provides a seamless experience for my clients!



# Campaign Dashboard

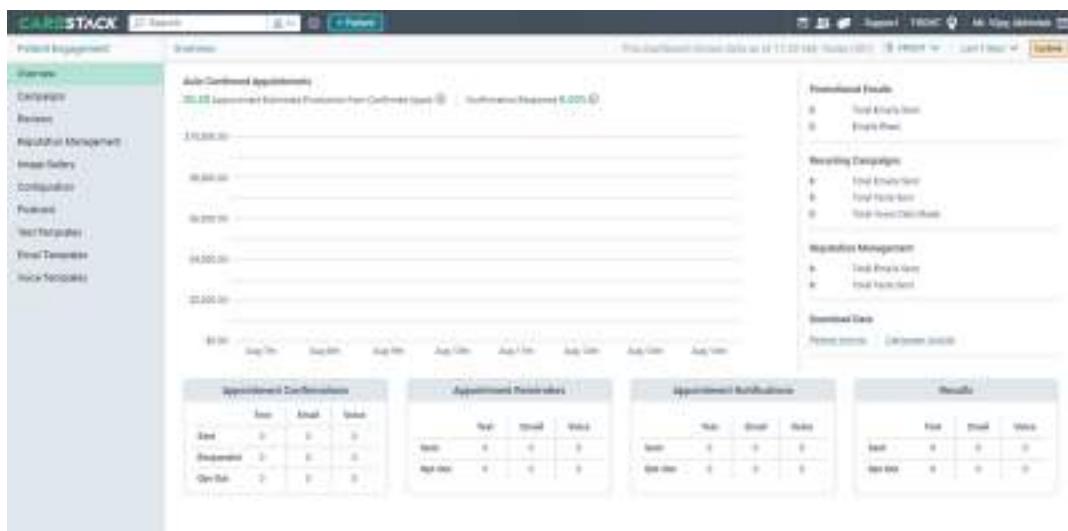
Written by Abhishek Vijay | Last published at: August 15, 2021

The heart of the patient engagement workflows of CareStack, the Dashboard. Here is where all the campaigns, their content, their set up, and the status of delivery of the same are all housed.

The dashboard provides a summarized data around patient engagement campaigns so that the user can quickly evaluate the effectiveness of the campaigns and access detailed information if needed.

We can navigate to the Patient Engagement Dashboard by navigating to the same through the System Menu.

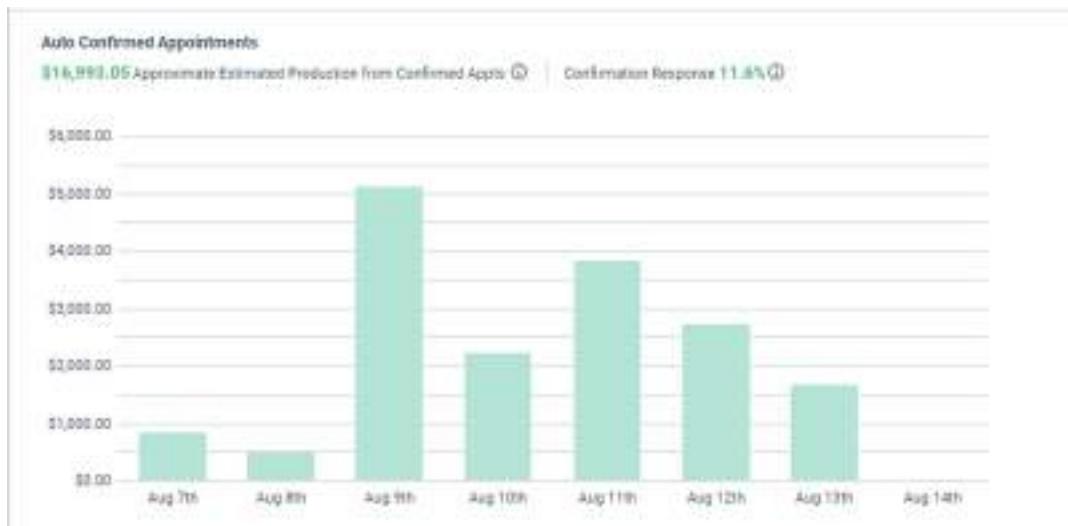
**System Menu > Operations > Patient Engagement**



As you can see above, there are multiple sections, campaigns, and functions over here. Let's go through them one by one.

## Overview

The overview is the first screen that greets us when we navigate towards the Patient Engagement section through system menu.



The overview presents us with a graphical representation of the confirmed appointments via the campaigns sent. It also gives us the approximated production expected from those appointments, and the confirmation response percentage.

Towards the right of this screen, we have the ability to set and view the data displayed on the dashboard according to a date-range and location combination that we can select from a drop-down menu.

We also have an 'update' button to the right of these drop-downs, and on clicking it data should be displayed for the corresponding combination of location and date. The update button can be disabled if there is no location selected from the drop-down.

By default, the user is navigated to the view with location set as the default location of the user, and date range as "last 7 days". The max number of locations that we can select at a time will be 30.

The date range drop-down should have these options:

- Yesterday
- Last 7 Days
- Last 14 Days
- Last 30 Days
- Week to Date (This can be deactivated on "Monday")
- Month to Date (This can be deactivated on the '1st' of every month)
- Last 60 Days
- Last 90 Days

On the right, we have 3 sections, that has the details about the emails and texts sent as campaigns. The sections are Promotional Emails, Recurring Campaigns and Reputation Management.



You also have an option to download the data about the patient activity and the campaign activity as well.

At the bottom, we have the details about the main four campaigns that we have, **Appointment Confirmations**, **Appointment Reminders**, **Appointment Notifications**, and **Recalls**.

From this tabular representation, you can get an idea about the modes of communication sent, responded, and in some cases, opted out by the patient, at a glance.

Appointment Confirmations			Appointment Reminders			Appointment Notifications			Recalls		
	Text	Email		Text	Email		Text	Email		Text	Email
Sent	0	0	0	200	100	100	0	0	0	0	0
Responded	0	0	0	0	0	0	0	0	0	0	0
Opt-Out	0	0	0	0	0	0	0	0	0	0	0

The data represented would be T-1, that means the data being displayed is a day behind, showing the count till yesterday end.

# Templates

Written by Abhishek Vijay | Last published at: August 16, 2021

You might have noticed by now that the content inside an active campaign is mostly pre-filled on a client's site. How and where is all this change made, and how can it all be altered?

Similar to creating a template for texts and memo, we have the option to create templates for Texts, Emails and Voice models to be used inside a campaign. Once these templates are created, we can simply add them with a click into a campaign.

Let's now have a look at the workflow to create each template.

# Text Templates

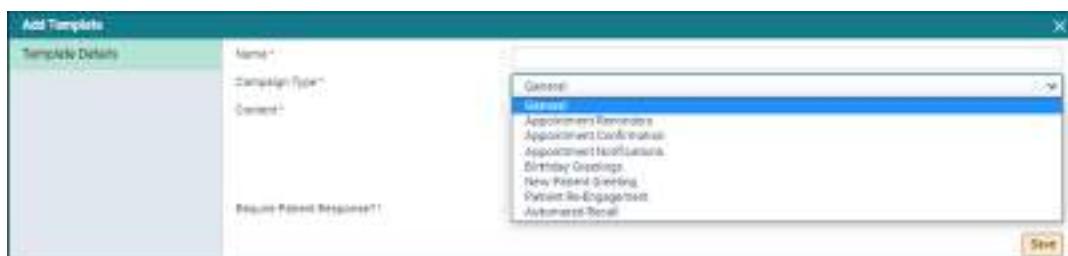
To send an alert to a patient via a text, CareStack has the ability to add pre-set templates into the campaigns. The text templates can be newly added, edited and even deleted as per the wish of the practice.

## Adding a Template

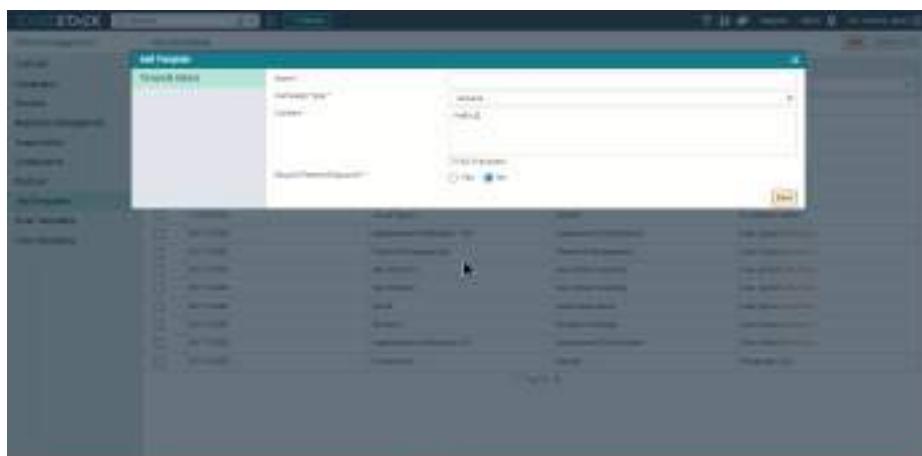
To add a text template, we may simply select the add option present at the top right. Upon adding a new template, we can notice a few fields as well that require data to be entered. Let's have a detailed look at the same.

- **Name:** The name to be set to the template to make it stand out.

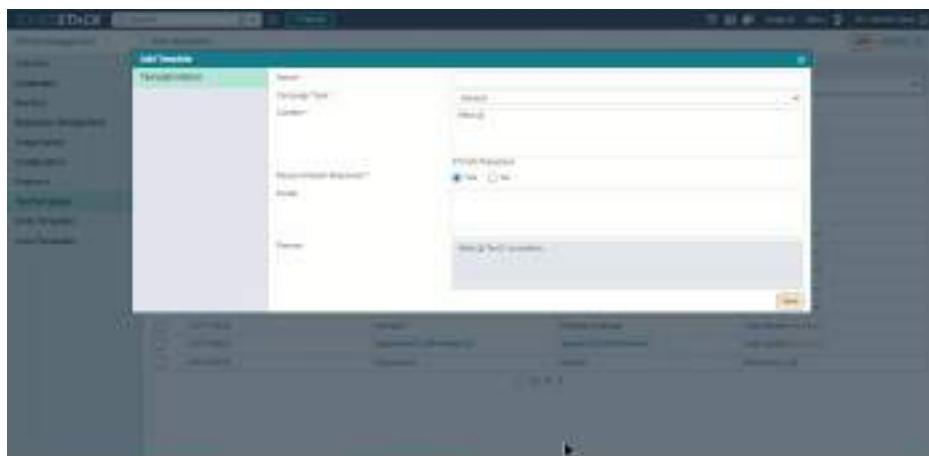
- **Campaign Type:** We have the ability to create templates tailor-made for certain campaigns. The Campaign Types option has several entries in a drop down list that can be selected as per our need. The General template can be used in any campaign as such, and the rest of the type of templates can be used in their specific campaigns. The options available in the list are:



- General
  - Appointment Reminders:
  - Appointment Confirmations:
  - Appointment Notifications:
  - Birthday Greetings:
  - New Patient Greeting
  - Patient Re-Engagement
  - Automated Recall
- **Content:** Here is where we can specify the content that is required inside the campaigns. The corresponding patient and account and location data can be added as a quick link, by using the "@" symbol.
  - **Require Patient Response:** Here we can specify whether we are expecting a patient response upon the receipt of the campaign text. Usually this is employed in the case of Appointment Confirmation campaigns or Curbside Check-In. Once the option has been set as Yes, the corresponding fields of Footer and Preview would be visible.



- **Footer:** Here is where we can enter in the text which would show up as the footer text of the content that we've entered just before.



- **Preview:** The content that we've entered in to the previous fields will be shown as a preview in this field.

## Editing a template

To edit an existing template, we can just click on the template field to bring up the edit option, and once we click on edit, we can make the necessary changes as well.

## Deleting a template

To delete a template, we have to select the checkbox corresponding to the required template and then under the Actions tab at the far right, you would have the option to delete.

## Email Templates

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Creating, editing and deleting an email template is very similar to that of a text template. Here we have the added option of adding pictures, links, buttons to be assigned to an action or even tables.



Moreover, we have the option to import HTML documents directly into our templates, with the Upload HTML button at the top right.

The procedure to adding an email template is very similar to that of the text template, with the exception of the ability to add external media content into the template.

To edit or delete an existing email, the procedure is again similar to that of the text templates.

## Voice Templates

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CareStack has the added advantage of adding templates as voice models, which serve a similar purpose to that of the text and email templates, but in an audio form. The client would receive a call from the practice, and the audio transcription of our text input is being read out.

Embedded content from <https://www.loom.com/embed/30acadab38f34ca08be6d69218b26407>

The creation process is similar to the process for text and email templates. The text that is entered into the template would be transcribed into an audio form that is sent to the patient as an audio file. We also have an option to add a separate message to be read aloud in case the call is missed and goes to voicemail.



Similarly the procedure to edit and delete the template is possible by clicking into field and clicking edit as well as selecting the template and selecting the delete option under Actions respectfully.

# Deposit Slip Report

Written by Athul V Suresh | Last published at: October 07, 2022

## Overview

The Deposit slip report is used to track all payment transactions. This report is used to reconcile the total amounts collected for the different types of payment deposits received. It shows a record of receipt entries that have payment categories as Cash, Card, and check. It will help the practice determine how much money has been deposited in their bank.

The report shows real-time data. The report can be generated by either payment category or payment type. The Deposit slip shows a consolidation of the payments deposited through the selected payment category or payment type(as selected in the view) to your practice and lists out the count, patient amount, insurance amount, collection agency amounts, and total collection received. It also has a totals row for the consolidation across the different payment categories/ types. The deposit slip shows separate entries for each receipt that is added in the practice within the selected date range.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Date As\*

Decide whether to include receipts in the report that has payment date/transaction date within the selected date range. Only receipts with the transaction date within the selected date range will appear when the date as option is set to the transaction date. Only receipts with the payment date within the selected date range will appear when the date as option is set to the payment date. By default, the payment date is selected.

### View by\*

Select this option to choose to view your report either by payment category or payment type. When you choose to view this report by payment category/payment type you will be able to see all receipts that have been added under each payment category/payment type under a consolidated view and the details pertaining to each individual receipt.

### Date Range\*

Deposit slip report is dated by transaction date or payment date as selected in Date as filter. The date range can be selected for a maximum of 1 month. By default, the date range will be for the current day.

### Location\*

Select a location or locations to focus the report on the receipts in the selected location(s). By default, the location will be the user's default location.

### Payment category

Select this option to focus your report on the payment category. the payment categories that are considered for this report are Care Credit, Cash, Check, Credit/Debit card, and direct transfer. By default, Cash and Check are selected.

### Payment type

Select this option to focus your report on the payment types in your practice Only payment types with categories set as Care Credit, Cash, Check, Credit/Debit card, and direct transfer will be available for the report.

### Payment entity

Select this option to focus your report on the payment entity of the receipts, either patient, insurance, collection agency or all of them. Depending on the options you choose you will be able to see further criteria options to choose the patient, carrier, collection agency.

### Patient

Choose to focus the report based on the selected patients.

### Carrier

Choose whether to focus your report on only the selected carrier(s).

### Collection Agency

Choose whether to focus your report on only the selected collection agency(s).

## Columns\*

Choose the columns you wish to see in this report. By default, all the columns will be selected.

# Sorting

The default sorting for Deposit Slip report is by transaction date (asc). Sorting is possible on payment date, deposit date, amount, and unapplied columns as well.

# Results

**View by payment category:**

**View by payment type:**

The deposit slip report has two sections- the first is the consolidated totals and the next section is the detailed receipt section. The results columns shown in this report include:

## Consolidated Section

## Payment Category

The category of payment, whether it was made via Cash, Credit Card, Check, and so on.

## Payment Type

The payment method of the receipt like the type of credits card accepted in the practice and other payment sources with payment category as mentioned above.

## Count

The number of payments made on the selected date range via this payment category/ payment type.

#### Patient

The total dollar amount received from patient payments on the selected date range via this payment category/ type.

#### Insurance

The total dollar amount received from insurance payments on the selected date range via this payment category/ type.

#### Collection Agency

The total dollar amount received from collection payments on the selected date range via this payment category/ type.

#### Total

The total dollar amount received from patients, insurance carriers, and collection agency on the selected date range via this payment category/ type.

### Detailed Receipt Section

#### Payment Entity

The type of payment accepted whether it was a patient payment, insurance payment, or a payment made by a collection agency.

#### Payment Date

The date on which the payment was accepted according to the Payment Date specified on the receipt.

#### Transaction Date

The date on which the payment was deposited according to your system records.

#### Deposit date

The date the insurance payment was deposited by your office.

#### Source

The source of the payment, whether the payment was made by the specified insurance carrier, collection agency, or patient.

#### Receipt #

The system-assigned number used to identify the payment that has been entered into the system. Click this hyperlink to be taken to the receipt details.

#### Location

The location pertaining to the payment that has been deposited.

#### Payment Category

The category of payment, whether it was made via Cash, Credit Card, Check, and so on.

#### Payment Type

The method of payment, whether the payment was made via Visa, Master Card, Cash, Check, and so on.

#### Reference Number

The reference number entered by your office staff member while accepting the payment.

#### Amount

The total dollar amount of the payment made.

#### Unapplied

The dollar amount that remains unapplied on the payment receipt after any credits have been posted from the receipt.

#### Last Updated By

The name of the user that last updated/ edited the receipt.

### Permissions

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Permissions for the Deposit Slip report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Deposit Slip Report. Only users with **Generate Deposit Slip Report** permission set as Yes will be able to generate the report.

The screenshot shows a software application window titled "Project > Reporting Functions". On the left, there is a sidebar with several tabs: "Home", "Reports", "Dashboards", "Metrics", "Requirements", "Search", "Timeline", and "Comments". The "Reports" tab is highlighted with a green background. Below the sidebar, there is a search bar labeled "Search" and a "Report Type" dropdown set to "General Reports".

The main content area displays a table with columns for "Report Name", "Type", and "Status". The table lists various report types, each with a blue circular icon, a white square icon, and a green square icon. One row, "General Test Coverage Report", is highlighted with a red background.

Report Name	Type	Status
General Test Coverage Report	●	□
General Daily Test Report	●	□
General Test Overview Report	●	□
General Test Coverage by User Report	●	□
General Application Test Coverage Report	●	□
General Test Coverage Report	●	□
General Test Coverage by Test Case Report	●	□
General Test Coverage by Test Suite Report	●	□
General Test Coverage by Test Plan Report	●	□
General Requirements Report	●	□
General Metrics Report	●	□
General Test Coverage Report	●	□
General Requirements Report	●	□
General Metrics Report	●	□
General Test Coverage Report	●	□

# Daily Journal Report

Written by Athul V Suresh | Last published at: September 28, 2021

## Overview

The Daily journal report is used to see the daily productions and collections. The report can be used to see compare the codes that have been completed for the day and receipts that have been added for the day.

The report gives the user a comprehensive idea of the daily transactions and diverts the attention to potential areas that the practice loses money on. The report shows real-time data in two views- summary view and detail view.

All dates are based on the transaction date. The summary view shows the consolidated total production and collection for the date range selected. It also shows the payment summary which shows the unapplied payments within the selected date range, the applied payments in the selected date range, and the applied payments in the selected date range from receipts that were added prior to the selected date range. The user can also see the total applied payments from the payment summary. You also have the flexibility to see the daily collection and production grouped by either provider or location. The detailed view gives the patient level drill down on each action the user performs.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the daily journal summary view report, your filter options include:

#### **Group By\***

Decide whether to group your report results by Provider or Location. The location specified will be the treatment location for the completed codes and the receipt location for all the receipts that have been added to the system. By default, Provider will be selected.

#### **Date Range\***

Select this option to focus your report on transactions and completed codes made within your selected date range. The date range can be selected for a maximum of 3 months. By default, the date range will be for the current day.

#### **Provider**

Select this option to focus your report based on the selected treatment provider(s).

#### **Location\***

Select this option to generate your report data based on transactions and completed codes made at the selected location(s). By default, the location will be the user's default location.

### Detail view

For the daily journal Detail view report, your filter options include:

#### **Date Range\***

Select this option to focus your report on transactions and completed codes made within your selected date range. The date range can be selected for a maximum of 3 months. By default, the date range will be for the current day.

#### **Provider**

Select this option to focus your report based on the selected treatment provider(s).

#### **Location\***

Select this option to generate your report data based on transactions and completed codes made at the selected location(s). By default, the location will be the user's default location.

#### **Action**

Select this option to choose the action of the transaction done (whether a code was completed or deleted, or the fee was updated, a payment was made or the receipt refunded, and so on).

#### **User**

Select this option to focus your report to display only on the transactions or completed codes or both, made by the selected user.

#### Patient flag

Choose to focus the report based on the patients with the selected patient flags.

#### Patient

Choose to focus the report based on the selected patients.

#### Group By\*

Choose to group by location, provider or patient. By default, 'None' is selected.

#### Group By Action and Show total check box

Click on this check box to show the total UCR fee, Gross production, Insurance amount, Patient amount, Unapplied amount grouped by each action.

#### Columns\*

Choose the columns you wish to see in this report. By default, 10 of the most relevant columns will be selected.

## Sorting

The default sorting for Daily Journal report is by transaction date (asc). Sorting is possible on DOS, Deposit date, UCR Fee, Gross Production (Trans. Date), Ins Amt, Pat Amt, and Action columns as well

## Results

### Summary View

Category	UCR Fee	Gross	Ins. Amt	Total Amt
Completed Codes				
Completed Codes	\$0.00	\$1,102.28	\$0.00	\$1,102.28
Fee Updates	\$0.00	\$0.00	\$0.00	\$0.00
Production	\$0.00	\$0.00	\$0.00	\$0.00
Production Adjustments	\$0.00	\$48.00	\$0.00	\$48.00
Migrated Production	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>\$1,150.28</b>	<b>\$0.00</b>	<b>\$1,150.28</b>
Refunds	\$0.00	\$0.00	\$0.00	\$0.00
Closed Patients	\$0.00	\$0.00	\$0.00	\$0.00
Revised Income	\$0.00	\$0.00	\$0.00	\$0.00
Refunds	\$0.00	\$0.00	\$0.00	\$0.00
Net Production	\$0.00	\$0.00	\$0.00	\$0.00
Revenue RPT Re-Edit	\$0.00	\$0.00	\$0.00	\$0.00
Deletion Adjustments	\$0.00	(-\$0.00)	\$0.00	(-\$0.00)
Over Payment Recovery	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>(-\$0.00)</b>	<b>\$0.00</b>	<b>\$0.00</b>

The report provides information in column form grouped by either provider or location.

The first section of the summary view contains the consolidated total of all productions and collections of all the selected locations. The first section shows the **UCR fee**, **Pat. amount** and **Ins. Amount** and **Total Amount** of the following.

**Completed codes-** The codes that have been completed in the selected date range in the selected location.

**Fee updates-** The fee updates that have been made for the completed codes. If the total fee is an update made in the selected date range is less than the total estimated fee then the amount will be displayed in red color inside closed brackets.

**Deleted Codes-** The dollar amount of balances removed when these procedure codes were deleted out of the system. The amount will be displayed in red color inside closed brackets.

**Production Adjustments-** The dollar amount of production adjustments made against an outstanding balance, either to increase or decrease the amount of production generated. If the total Adjustment is a negative amount then the amount will be displayed in red color inside closed brackets.

**Migrated production-** The total migrated production from the practice's previous software.

**Total (Net Production)-** The dollar amount of production generated plus/minus any production adjustments made.

The next section inside the consolidated grid shows the net collections from receipts in the selected date range

**Receipts**- The dollar amount of payments that have been accepted and entered into the system.

**Deleted Receipts**- The dollar amount of payment receipts that have been deleted out of the system. The amount will be displayed in red color inside closed brackets to indicate a negative transaction.

**Receipt Updates**- The total dollar amount involved in receipts that were updated, in the instance that the payment amount on an insurance receipt is updated (for example, the receipt was made for \$100, but then the receipt was updated to reflect a payment of \$120). If the total receipt update is a negative amount then the amount will be displayed in red color inside closed brackets.

**Refunds**- The dollar amount of payments that have been refunded to the payer. The amount will be displayed in red color inside closed brackets to indicate a negative transaction.

**NSF Receipts**- The dollar amount of payment receipts that have been marked as Non-Sufficient Funds. The amount will be displayed in red color inside closed brackets. Even if the NSF is reversed the amount in the check that was marked as NSF will still be displayed here.

**Reverse NSF Receipts**- The total dollar amount involved in receipts that were reversed due to nonsufficient funds.

**Collection Adjustments**- The dollar amount of collection adjustments made against an outstanding balance, either to increase or decrease the receivable. If the total Adjustment made is a negative amount then the amount will be displayed in red color inside closed brackets.

**Over Payment Recovery**- The dollar amount involved in overpayment recovery from insurance receipts.

**Total (Net Collection)**- The dollar amount of receivables collected after any collection adjustments made.

**Transaction charges**- The transaction charges associated with payment types like care credit.

**Total**- The total dollar amount of the transaction charges.

**Payment summary**- The payment summary sections inside the consolidated total show the applied payments and unapplied credits in the selected date range.

**Unapplied Payments (current)**- The unapplied payments from receipts added within the selected date range.

**Applied Payments (Current)**- The credits applied to codes from receipts added within the selected date range.

**Applied Payments (Prior)**- The credits that have been applied to codes from receipts that have been added before the selected Date Range.

**Total Applied payments**- The total applied payments in the selected date range.

The next sections inside the summary view are Grouped by provider or location depending on the group by option the user selects.

If the user chooses to group by provider then the section after the consolidated total will be the net productions and collections mentioned above for each provider. For each section of the provider, the net collection and production will be shown for each location and the provider total.

If the user chooses to group by location then after the consolidated total, the net production and collection will be shown for each location. For each section of the location, the net collection and production will be shown for each provider.

## Detailed View.

The screenshot displays a software application window titled "CARESTACK". The menu bar includes "File", "Edit", "View", "Print", "Search", "Help", and "Logout". The main area shows a grid of transaction details. The columns include: Transaction ID, Transaction Date, Transaction Type, Transaction Description, Location, Status, Provider, Unit of Measure, Gross Production (\$), Net Collection (\$), and Net Production (\$). The data shows various transactions for different providers and locations, with some values in red indicating negative amounts. A legend at the bottom right defines the colors for the columns.

Transaction ID	Transaction Date	Transaction Type	Transaction Description	Location	Status	Provider	Unit of Measure	Gross Production (\$)	Net Collection (\$)	Net Production (\$)
00-10001	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10002	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10003	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10004	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10005	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10006	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10007	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10008	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10009	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10010	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10011	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10012	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10013	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10014	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10015	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10016	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10017	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10018	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10019	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10020	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10021	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10022	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10023	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10024	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10025	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10026	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10027	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10028	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10029	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10030	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10031	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10032	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10033	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10034	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10035	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10036	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10037	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10038	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10039	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10040	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10041	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10042	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10043	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10044	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10045	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10046	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10047	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10048	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10049	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10050	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10051	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10052	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10053	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10054	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10055	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10056	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10057	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10058	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10059	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10060	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10061	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10062	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10063	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10064	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10065	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10066	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10067	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10068	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10069	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10070	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10071	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10072	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10073	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10074	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10075	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10076	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10077	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10078	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10079	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10080	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10081	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10082	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10083	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10084	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10085	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10086	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10087	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10088	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10089	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10090	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00	100.00	100.00
00-10091	08/10/2021	Normal	Normal Transaction	Office	Active	John Doe	Units	100.00		

**Transaction Date**

The date the code was marked as completed in the system or the date the receipt was added to the system.

**Patient Name**

The name of the patient to which the transaction applies, whether it was a completed code, refund, deleted receipt, or so on.

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the ledger of the patient's profile.

**D.O.S**

The date on which the patient was seen by their treatment provider for the completion of these services.

**Deposit date**

Date of deposit of insurance check.

**Code Description**

The procedure code name along with its description.

**Tooth/Area**

The Tooth/Area on which the procedure code was done.

**Surface**

The surface of the tooth to which the procedure code applies.

**Location**

The treatment location for the listed procedure code or receipt.

**Provider**

The treatment provider applicable to the listed procedure code or receipt.

**UCR Fee**

Your office's standard fee for this procedure code according to your practice settings.

**Gross Production (Trans. Date)**

The dollar amount pertaining to the transaction completed, or the total fee of the procedure code at the time of check-out.

**Insurance Amount**

The insurance payable at the time of code completion.

**Patient Amount**

The patient payable at the time of code completion.

**Action**

The action of the transaction done (whether a code was completed or deleted, or the fee was updated, a payment was made or the receipt refunded, and so on)

**Payment Method**

The method of payment accepted or refunded, whether it was made via Visa, Master Card, Cash, Check, and so on.

**Carrier**

The insurance carrier to which the payment, refund, or adjustment applies.

**Receipt #**

The system-assigned number is used to identify the payment that has been entered into the system.

## Unapplied

The dollar amount on a receipt remains to be applied towards any outstanding charges.

## User's Name

The name of the user that completed the transaction in the system.

If the show total check box is applied then the detailed view report will be grouped into sections depending on the actions. The report will have entries grouped by actions like completed codes receipt addition receipt deletion and so on.

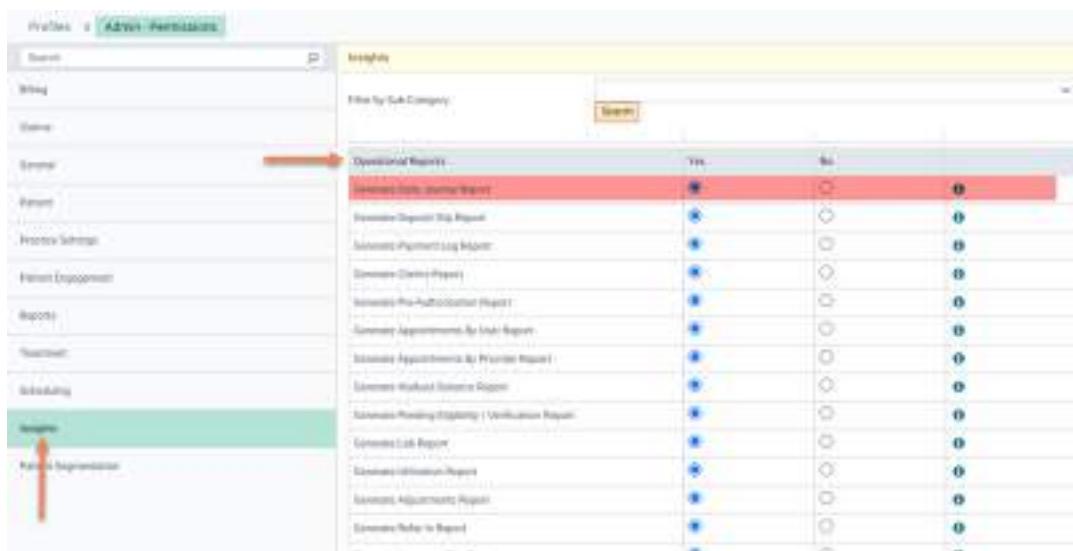
## Use Case

The report can be used to get a detailed idea of all transactions that happen in the practice. The ability to see the transactions that happen grouped by each action helps the practice to have a clear idea of the productions and collections in the practice.

The daily journal report is also a useful tool to map the daily provider production. This helps the practice determine the exact revenue produced from each provider.

## Permissions

Permissions for the Daily Journal report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Daily Journal Report. Only users with **Generate Daily Journal Report** permission set as Yes will be able to generate the report.



# Claims Report

Written by Athul V Suresh | Last published at: August 23, 2021

## Overview

Claims report is used to track the claims that have been generated in the practice. This report lets the user know the claims that require attention, the claims that have been sent out and are yet to hear back from the carrier, the claims that have been rejected, and so on.

The Claims Report can be used to view the expected insurance production from each carrier for the claims sent out, the claim status outstanding balance, and so on. This report shows real-time data and is available in two views- Summary and Detail view.

The summary view shows the total outstanding dollar amount and number of all claims that have remained unpaid in different aging buckets. The users have the flexibility to group the report by either carrier or claim status and allows them to see outstanding amount by each carrier or in each claim status like acknowledged (payor), finalized(payor), On Hold, and so on. Moreover, the user can also choose if the aging buckets should be based on the submitted date or the DOS of the claim. The detail view shows the drill-down information of each claim including details like claim ID, patient ID, the carrier, plan, estimate fee, insurance paid amount, outstanding fee, and so on.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the Claims Summary View report, your filter options include:

#### Group by\*

Select this option to group your report on either Carrier or claim status. When you choose to group by carrier the report is based on each carrier and the total outstanding dollar amount for claims sent to each carrier is divided into aging buckets. Similarly, when you choose to group by claim status the report is based on claim status and the total outstanding dollar amount for claims in each status is divided into aging buckets.

#### Carriers list\*

This filter is only available when you group by carrier. Choose to view your report on either the top 10 carriers or all of the carriers in your practice. The default will be the top 10 carriers

#### Date As\*

Decide whether to date your report results by Aging Days or Creation Date of the claim. If you choose to date as Aging date then all claims other than the ones in closed status and voided status will be considered and their outstanding amount grouped into corresponding aging buckets. If you choose to date as Created date then you will have to choose the date range. Only claims that are created within the date range selected will be considered for the report.

#### Aging based\*

Select this option to choose the aging bucket calculation based on the date of submission of the claim or the DOS of the claim.

#### Aging Days

Select this option to choose whether to generate data based on claims that have been aging within the last 30 days, 31-60 days, 61-90 days, 91-120 days, or over 120 days.

#### Date range

If generating this report based on the creation date, select the intended date range. Select a maximum of up to 6 months.

#### Location\*

Select this option to focus the report on the claim's location. The default location will be the user's default location.

#### Claim Status

Select this option to focus your report on generated claims currently in the selected status(es).

#### **Claim Flag**

Select this option to focus your report on generated claims with the selected claim flags.

#### **Plan Types**

Select this option to focus your report data based on the claims with selected type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

#### **Carrier**

Select this option to focus your report on only the claims with the selected carrier(s).

#### **Provider**

Select this option to focus your report on only the selected Billing provider(s).

#### **Outstanding Amount >=\***

Focus the report on unpaid claims billed out for an amount that is greater than or equal to the dollar amount you specify here.

### **Detail View**

For the claims Detail View report, your filter options include:

#### **Date As\***

Decide whether to date your report results by Aging Days or Creation Date of the claim. If you choose to date as Aging date then all claims other than the ones in closed status and voided status will be considered and their outstanding amount grouped into corresponding aging buckets. If you choose to date as Created date then you will have to choose the date range. Only claims that are created within the date range selected will be considered for the report.

#### **Aging based\***

This field is only available when Aging Days is selected for the Date as filter. Select this option to choose the aging bucket calculation based on the date of submission of the claim or the DOS of the claim.

#### **Location\***

Select this option to focus the report on claims generated at the selected location(s).

#### **Claim Status**

Select this option to focus your report on generated claims currently in the selected status(es).

#### **Claim Flag**

Select this option to focus your report on generated claims with the selected claim flags.

#### **Plan Types**

Select this option to focus your report data based on the claims with the selected type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

#### **Carrier**

Select this option to focus your report on only the claims with the selected carrier(s).

#### **Provider**

Select this option to focus your report on only the selected treatment provider(s).

#### **Outstanding Amount >=\***

Focus the report on unpaid claims billed out for an amount that is greater than or equal to the dollar amount you specify here.

#### **Columns\***

Choose the columns you wish to see in this report. By default, all the columns will be selected.

## Sorting

The Claims report can be sorted by First submitted date, Last submitted date, DOS, Billed Amount, Insurance amount, Insurance paid, outstanding amount, last updated date.

## Results

### Summary view

The report shows information in column form grouped by carrier or claim status as selected. It also shows the consolidated values of each location selected on top if more than 1 location is selected. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

The screenshot shows a software interface titled "Claims Report Summary". The main area is a grid table with columns for Carrier, Status, and various monetary amounts. The grid includes rows for "All Carriers", "All Locations", and specific carriers like "Cigna", "Aetna", "HealthCare USA", etc. The columns include "0-30(#)", "61-90(#)", "91-120(#)", "Outstanding", "Insurance Paid", and "Billed Amount". The interface has a top navigation bar with icons for Home, Reports, and other system functions.

Carrier Report Summary - All Locations   All Providers   All Current   All Class Totals   All Claims/Pages   All Aging Dates   All File Types   Consolidating						
Carrier	0-30(#)	61-90(#)	91-120(#)	Outstanding	Insurance Paid	Billed Amount
All	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Aetna	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Cigna	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
HealthCare USA	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
All Carriers	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Carrier	0-30(#)	61-90(#)	91-120(#)	Outstanding	Insurance Paid	Billed Amount
Blue Cross Blue Shield of Michigan	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Blue Cross Blue Shield of North Carolina	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
HealthCare USA	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Aetna	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Cigna	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
HealthCare USA	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
All Carriers	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Carrier	0-30(#)	61-90(#)	91-120(#)	Outstanding	Insurance Paid	Billed Amount
Aetna	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
Cigna	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
HealthCare USA	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271
All Carriers	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271	\$10,138,271

The results columns shown in this report include:

### Location

The location the claim was created.

### Carrier

The insurance carrier to which the claim was submitted.

### Status

The current status of the claim, whether it has been Acknowledged by the carrier, Rejected, Partially Paid, and so on.

### 0-30(#)

The outstanding dollar amount of claims that have remained unpaid for 30 days or less (along with the total number of these claims). Click this hyperlink to view a Detail Report listing these claims and their details.

### 31-60(#)

The outstanding dollar amount of claims that have remained unpaid for at least 31 to 60 days (along with the total number of these claims). Click this hyperlink to view a Detail Report listing these claims and their details.

### 61-90(#)

The outstanding dollar amount of claims that have remained unpaid for at least 61 to 90 days (along with the total number of these claims). Click this hyperlink to view a Detail Report listing these claims and their details.

### 91-120(#)

The outstanding dollar amount of claims that have remained unpaid for at least 91 to 120 days (along with the total number of these claims). Click this hyperlink to view a Detail Report listing these claims and their details.

## **Over 120(#)**

The outstanding dollar amount of claims that have remained unpaid for more than 120 days (along with the total number of these claims). Click this hyperlink to view a Detail Report listing these claims and their details.

## **Grand Total(#)**

The total outstanding dollar amount of all claims that have remained unpaid (along with the total number of these claims). Click this hyperlink to view a Detail Report listing these claims and their details.

The report also has a totals row "**Grand Total**" that shows the total outstanding dollar amount of all claims that have remained unpaid (along with the total number of these claims) in each bucket.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these claims and their details.

## **Detail view**

Claims Report Details - 2 Locations - All Insurance - All Services - All Claim Types - Outstanding Amount > 120 Aging Days - Total 144 Aging Days - Aging Days/ Aging Days Inc - Insurance Info								
Location	First Submitted Date	Last Submitted Date	D.O.C.	Claim Aging Days	Insurance Aging Days	Patient Name	Patient ID	D.O.B.
West	2010-01-01	2010-01-01	2010-01-01	Over 120	144	John Doe	1234567890	1970-01-01
East	2010-01-01	2010-01-01	2010-01-01	Over 120	144	Jane Doe	1234567891	1970-01-01
South	2010-01-01	2010-01-01	2010-01-01	Over 120	144	Mike Smith	1234567892	1970-01-01
North	2010-01-01	2010-01-01	2010-01-01	Over 120	144	Sarah Johnson	1234567893	1970-01-01
Mid	2010-01-01	2010-01-01	2010-01-01	Over 120	144	David Williams	1234567894	1970-01-01

The result in the Claims detail view report include :

### **Location**

The treatment location for which the insurance claim was generated

### **First Submitted Date**

The date the claim was submitted to the insurance carrier.

### **Last Submitted Date**

The date the claim was last resubmitted to the insurance carrier.

### **D.O.S**

D.O.S of the claim is the date in which the patient was seen by their treatment provider for the completion of these services. if there are procedure codes with more than 1 DOS then the DOS of the first procedure code is taken.

### **Claim aging Days**

The number of days this claim has remained unpaid.

### **Claim ID**

The system assigned number used to identify the unique claim that has been generated. Click this hyperlink to view the insurance claim details.

### **Patient Name**

The name of the patient to which this claim pertains.

### **Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the Claims page of the patient's profile.

**D.O.B**

The patient's date of birth according to the information specified on their patient profile.

**Subscriber**

The name of the subscriber listed on this patient's insurance plan.

**Subscriber ID / SSN**

The subscriber's ID or social security number is used to identify the subscriber and their coverage.

**Service Type**

The type of dental services provided to this patient.

**Billed Amount**

The dollar amount billed to insurance based on the total UCR fees of the procedure codes included on the claim.

**Insurance Amount**

The expected insurance receivable for the procedure codes included on the claim.

**Insurance Paid**

The amount the insurance carrier has paid towards this claim so far.

**Paid Date**

The date the insurance payment has been applied toward the claim.

**Outstanding Amount**

The dollar amount that remains unpaid on this claim.

**Claim Status**

The current status of the claim, whether it has been Acknowledged by the carrier, Rejected, Partially Paid, and so on.

**Mode**

The mode in which the claim was submitted, whether it was electronically or by paper.

**Claim Order**

The order of the claim, whether it was the primary claim submitted to the primary dental insurance, primary medical, secondary dental, and so on.

**Provider**

The treatment provider pertaining to the procedures included on the insurance claim.

**Provider TIN / NPI**

The treatment provider's unique identifier number used to distinguish the eligible clinician.

**Carrier**

The insurance carrier to which the claim was submitted.

**Carrier ID**

The carrier identifier number used to route an electronic claim to the correct destination (i.e. insurance carrier).

**Phone Number**

The phone number used to reach the insurance carrier (as entered in the insurance details in your practice settings).

**Group Number**

The group number used to identify this patient's insurance plan.

#### Plan Name

The name of the plan under which this patient has insurance coverage.

#### Plan Type

The type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

#### Remarks

The most recent remarks that have been included on the claim.

#### Last Updated On

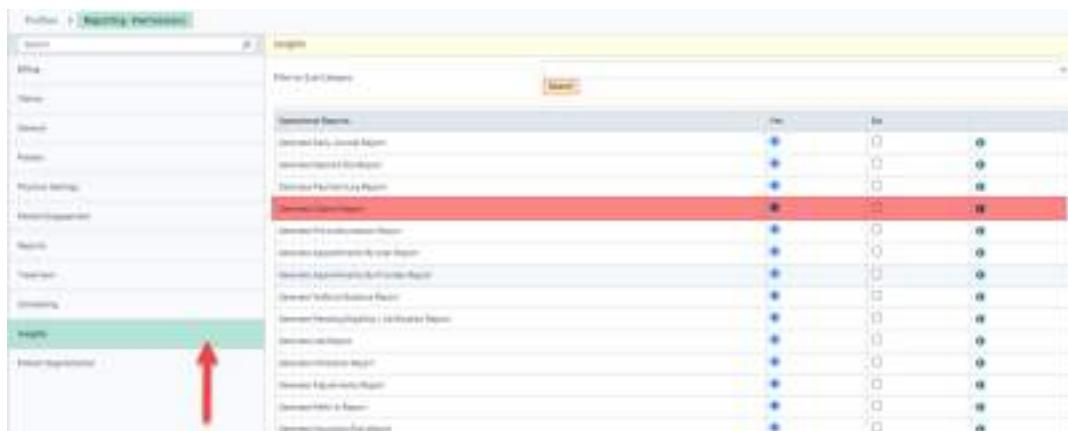
The date the claim has been last updated.

#### Last Updated By

The user that last updated the claim.

## Permissions

Permissions for the Claims report will be in System Menu -> Practice Settings -> Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Claims Report. Only users with **Generate Claims Report** permission set as Yes will be able to generate the report.





# Refer Out Report

Written by Athul V Suresh | Last published at: September 28, 2021

## Overview

The Refer out report is used to track the patients that were referred out in the selected time frame. This will let the practice keep track of all the referred out patients. The report shows real-time data in a single view.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Date Range\*

Generate Refer Out data based on your selected date range. Select a maximum of up to 6 months. By default, the date range will be for the current day.

### Location\*

Select this option to focus the report on patients that were Referred-Out from the selected location(s). By default, the location will be the user's default location.

### Referred By

Select this option to focus the report on Refer-Outs generated by the selected in-house provider(s).

### Referral To

Select this option to focus your report on Refer-Outs made to the selected recipient.

### Referral Provider

Select this option to focus your report on Refer-Outs made to the selected referral provider(s).

### Referred to Specialty

Select this option to focus your report based on the specialty of the referral provider.

### Patient Flag

Select this option to focus the report only on patients that have the selected patient flag associated with their profile. Leave the option All to find ReferOuts for all patients, regardless of their flags.

### Patient

Select this option to focus the report only on the selected patients.

### Columns\*

Choose the columns you wish to see in this report. By default, all the columns will be selected.

## Sorting

The default sorting for Refer Out report is by referral date(desc). Sorting is possible on Last Visit, Exp. Visit and Next Visit columns as well.

## Results

The report gives the drill-down of each refer out.

The screenshot shows a software application window titled "CARISTACK". The main area displays a grid of patient information. The columns include: Patient ID, Referrer Name, Referrer Specialty, Referral Date, Referral Location, Referee Name, Referee Specialty, Last Visit Date, Exp. Visit Date, and Next Visit Date. The data grid contains approximately 15 rows of patient records.

Patient ID	Referrer Name	Referrer Specialty	Referral Date	Referral Location	Referee Name	Referee Specialty	Last Visit Date	Exp. Visit Date	Next Visit Date
123456789	Dr. Smith	Primary Care	2023-01-01	Office	Patient A	Primary Care	2023-01-01	2023-01-15	2023-02-01
987654321	Dr. Jones	OB/GYN	2023-01-02	Office	Patient B	OB/GYN	2023-01-02	2023-01-16	2023-02-02
543210987	Dr. Lee	Orthopedic	2023-01-03	Office	Patient C	Orthopedic	2023-01-03	2023-01-17	2023-02-03
321098765	Dr. White	Neurology	2023-01-04	Office	Patient D	Neurology	2023-01-04	2023-01-18	2023-02-04
765432109	Dr. Green	Urology	2023-01-05	Office	Patient E	Urology	2023-01-05	2023-01-19	2023-02-05
987654321	Dr. Brown	Cardiology	2023-01-06	Office	Patient F	Cardiology	2023-01-06	2023-01-20	2023-02-06
543210987	Dr. Miller	Endocrinology	2023-01-07	Office	Patient G	Endocrinology	2023-01-07	2023-01-21	2023-02-07
321098765	Dr. Wilson	Psychiatry	2023-01-08	Office	Patient H	Psychiatry	2023-01-08	2023-01-22	2023-02-08
765432109	Dr. Taylor	Orthopedic	2023-01-09	Office	Patient I	Orthopedic	2023-01-09	2023-01-23	2023-02-09
987654321	Dr. Johnson	Neurology	2023-01-10	Office	Patient J	Neurology	2023-01-10	2023-01-24	2023-02-10
543210987	Dr. Parker	Urology	2023-01-11	Office	Patient K	Urology	2023-01-11	2023-01-25	2023-02-11
321098765	Dr. Thompson	Cardiology	2023-01-12	Office	Patient L	Cardiology	2023-01-12	2023-01-26	2023-02-12
765432109	Dr. Campbell	Endocrinology	2023-01-13	Office	Patient M	Endocrinology	2023-01-13	2023-01-27	2023-02-13
987654321	Dr. Parker	Orthopedic	2023-01-14	Office	Patient N	Orthopedic	2023-01-14	2023-01-28	2023-02-14

The results columns shown in this report include:

#### Referred To

The recipient provider to which the patient was referred out.

#### Specialty

The specialty of the referral provider.

#### Referred By

The short name of the provider that has referred the patient out.

#### Referral Provider

The provider to which the patient was referred out .

#### Location

The short name of the Location from which the patient was referred out.

#### Patient ID

This is the system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the patient's record of referrals.

#### Patient Name

The name of the individual that was referred out.

#### Phone Number

The contact number of the individual referred out.

#### Referral Date

The date the patient was referred out.

#### Last Visit

The date of the patient's last visit to your office.

#### Exp. Visit

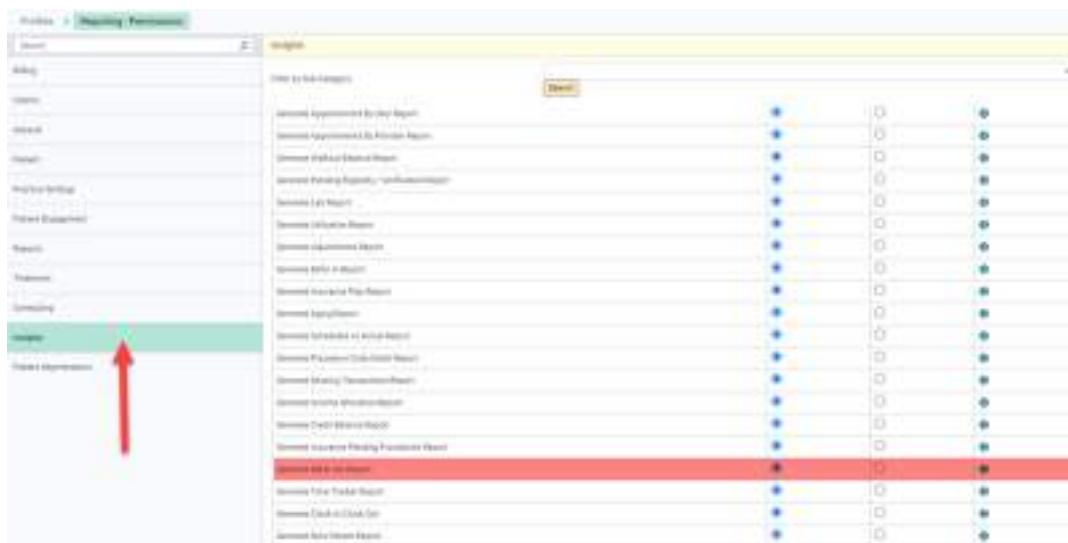
The date of expected visit from the patient recorded during the time of refer out.

#### Next Visit

The date of the patient's next visit to your office (if an appointment is scheduled).

## Permissions

Permissions for the Refer Out report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Refer Out Report. Only users with **Generate Refer Out Report** permission set as Yes will be able to generate the report.



# Appointments by Provider Report

Written by Aaqib Mohammed Sali | Last published at: August 22, 2021

## Overview

Appointment reports are intended to show both past and future trends of scheduling and opportunities for improvements. There are often production goals associated with scheduling, and appointments can be strategically placed in order to meet these goals.

The Appointments by Provider report can be used to find the count of appointments, appointment details, and production for each provider. This report shows real-time data and is available in two views- Summary and Detail view.

The summary view shows the total count of appointments and scheduled production either by appointment location or by appointment primary provider. The users have the flexibility to view the report by the appointment primary provider or by appointment location. The detail view shows the patient level drill-down of each appointment including details like patient's phone number, appointment date and time, operatory, appointment providers and duration, the scheduled production of the appointment, the patient estimate of scheduled production, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary View

For the Appointments by Provider Summary View report, your filter options include:

#### Group By\*

Appointment by Provider summary view report can be grouped by appointment provider or by appointment location.

#### Dates\*

Appointment by Provider report is dated by **appointment date**. The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

#### Location\*

Select a location or locations to focus the report on the **appointments in the selected location(s)**. By default, the location will be the user's default location.

#### Provider

Select a provider or providers to focus the report on appointments with the selected provider(s) as primary treatment provider.

#### Prod. Type

Choose to focus the report based on the selected Production Types.

#### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

#### Patient

Choose to focus the report based on the selected patients.

#### Exclude Inactive/ Duplicate Patients

Checkmark this option if you would like to exclude Inactive/Duplicate Patients from the report. By default, it will be checked.

## Detail View

For the Appointments by Provider Detail View report, your filter options include:

#### Dates\*

Appointment by Provider report is dated by **appointment date**. The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

**Location\***

Select a location or locations to focus the report on the **appointments in the selected location(s)**. By default, the location will be the user's default location.

**Appt. Type\***

Generate your report data based on the selected appointment types. You can choose to view the appointments booked by the user in the system or booked by the patient using the Online Booking feature or both.

**Provider**

Select a provider or providers to focus the report on appointments with the selected provider(s) as a primary treatment provider.

**Appt. Mode\***

Generate your report data based on the selected appointment modes. You can choose to view the appointments that are In-Office appointments or Tele-appointments or both.

**Prod. Type**

Choose to focus the report based on the selected Production Types.

**Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

**Patient**

Choose to focus the report based on the selected patients.

**Appt. Status**

Choose to focus the report based on the selected status of the appointment.

**Exclude Inactive/Duplicate Patients**

Checkmark this option if you would like to exclude Inactive/Duplicate Patients from the report. By default, it will be checked.

**Columns\***

Choose the columns you wish to see in this report. By default, all the columns excluding carrier and schedule patient prod will be selected.

## Sorting

The default sorting for Appointment by Provider report will be by Appt date (desc) and Appt time (asc). Sorting is possible on Operatory and Sched. Prod columns as well.

## Results

### Summary View Report

The report provides information in column form grouped by either primary appointment provider or appointment location as selected. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Appointments by Provider - All Locations - All Primary - Utilization Flags - All Patients - All Producers - Date: 01/01/2017 - 01/30/2017												
Location		CheckOut		Scheduled		Operatory		All Other		Other		
Location	Appt. D	Sched. Prod.	Appt. P	Sched. Prod.	Appt. F	Sched. Prod.	Appt. R	Other Prod.	Appt. H	Utiliz. Prod.	Appt. M	Other Prod.
All L.	0	\$0.00	10	\$1,124.00	0	\$0.00	0	\$0.00	0	\$0.00	11	\$1,124.00
General Room	0	\$0.00	10	\$1,124.00	0	\$0.00	0	\$0.00	0	\$0.00	11	\$1,124.00
Report/DRK - Non-Operatory	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00

Appointments by Provider - All Locations - All Primary - Utilization Flags - All Patients - All Producers - Date: 01/01/2017 - 01/30/2017												
Location		CheckOut		Scheduled		Operatory		All Other		Other		
Location	Appt. D	Sched. Prod.	Appt. P	Sched. Prod.	Appt. F	Sched. Prod.	Appt. R	Other Prod.	Appt. H	Utiliz. Prod.	Appt. M	Other Prod.
All L.	0	\$0.00	10	\$1,124.00	0	\$0.00	0	\$0.00	0	\$0.00	11	\$1,124.00
General Room	0	\$0.00	10	\$1,124.00	0	\$0.00	0	\$0.00	0	\$0.00	11	\$1,124.00
Report/DRK - Non-Operatory	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00

Appointments by Provider - All Locations - All Primary - Utilization Flags - All Patients - All Producers - Date: 01/01/2017 - 01/30/2017												
Location		CheckOut		Scheduled		Operatory		All Other		Other		
Location	Appt. D	Sched. Prod.	Appt. P	Sched. Prod.	Appt. F	Sched. Prod.	Appt. R	Other Prod.	Appt. H	Utiliz. Prod.	Appt. M	Other Prod.
All L.	0	\$0.00	10	\$1,124.00	0	\$0.00	0	\$0.00	0	\$0.00	-1	\$1,124.00
General Room	0	\$0.00	10	\$1,124.00	0	\$0.00	0	\$0.00	0	\$0.00	-1	\$1,124.00
Report/DRK - Non-Operatory	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00

The results columns shown in this report include:

**Location**

The location for which the appointment was scheduled.

**Provider**

The practice primary treatment provider who is a part of appointments in the selected date range.

**Checked Out**

The number of appointments with this provider/location combination that are in the Checked-Out status (along with the dollar amount produced by the treatment included in these appointments).

#### **Scheduled**

The number of appointments with this provider/location combination that are in the Scheduled status (along with the dollar amount produced by the treatment included in these appointments).

#### **Cancelled**

The number of appointments with this provider/location combination that are in the Cancelled status (along with the dollar amount produced by the treatment included in these appointments).

#### **No Show**

The number of appointments with this provider/location combination that are in the No show status (along with the dollar amount produced by the treatment included in these appointments).

#### **Other**

The number of appointments with this provider/location combination that are in a status other than the ones specified here (along with the dollar amount produced by the treatment included in these appointments).

#### **All**

The total number of appointments with this provider/location combination (along with the dollar amount produced by the treatment included in these appointments).

The report also has a totals row "**Grand Total**" that shows the consolidated totals of number and scheduled production of appointments in each status group under each grouping selected.

The blue colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these appointments and their details.

### **Detail View Report**

The results columns shown in this report include:

#### **Appt. Date**

The date for which the appointment was scheduled to take place.

#### **Appt. Time**

The time for which the appointment was scheduled to take place.

#### **Patient Name**

The name of the patient scheduled to be seen in the appointment.

#### **Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the Appointments page of the patient's profile.

#### **DOB**

The patient's date of birth according to the information specified on their patient profile.

#### **Phone No**

The patient's phone number.

#### **Location**

The location for which the appointment was scheduled.

#### **Prov. 1**

The primary treatment provider of the appointment.

#### **Prov. 1 Time**

The amount of time the primary treatment provider is projected to spend with the patient during this appointment.

## **Prov. 2**

The secondary treatment provider of the appointment.

## **Prov. 2 Time**

The amount of time the secondary treatment provider is projected to spend with the patient during this appointment.

## **Prov. 3**

The tertiary treatment provider of the appointment.

## **Prov. 3 Time**

The amount of time the tertiary treatment provider is projected to spend with the patient during this appointment.

## **Carrier**

The primary carrier of the patient.

## **Appt. Mode**

This column indicates if the appointment is an in-office or tele-appointment.

## **Online Appt**

This column indicates whether the appointment was scheduled by the patient using the Online Booking feature.

## **Operatory**

The operatory for which the appointment was scheduled to take place.

## **Prod. Type**

The type of production to be generated by this appointment.

## **Appt. Status**

The current status of the appointment, whether it has been Confirmed, Rescheduled, Checked Out, and so on.

## **Sched. Patient Prod**

The dollar amount scheduled to be produced by the treatment(s) that is payable by the patient included in this appointment.

## **Sched Prod**

The dollar amount scheduled to be produced by the treatment(s) included in this appointment.

## **Notes**

Any notes that have been included in the appointment details.

## **Use Cases**

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Appointment reports are intended to show both past and future trends of scheduling and opportunities for improvements.

- To see the count of appointments
  - for each provider
  - in each location
  - that were no-show or cancelled
- To see the scheduled production
  - for each provider
  - in each location
- To see the appointment details and patient information for the day.
- To see the future appointment scheduling for a provider or location.

## Special Cases

- **Appointment With Multiple Provider Tagged**

The report will list a single appointment under the primary providers in the summary view if the appointment is tagged to three providers. In the detailed view if the selected provider is the Prov 1/ Prov 2/ Prov 3 of an appointment, then it will be shown in the report.

- Appointment In Cancelled or No-Show Status

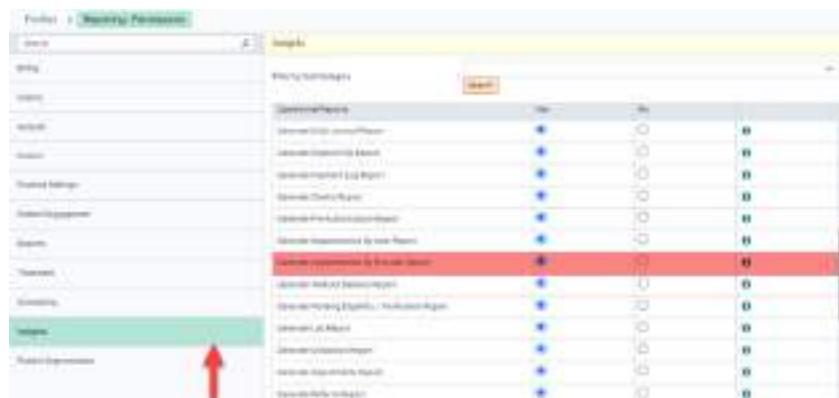
Appointments in cancelled or no-show status are shown in the appointment by provider report. But if it is moved to the reschedule queue, it will still be shown with the same previous status of the appointment. But when rescheduled the appointment status will be changed to scheduled.

- Deleted Appointments

Deleted appointments will not be shown in the appointments by provider report.

## Permissions

Permissions for the Appointments by Provider report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Appointments by Provider Report. Only users with **Generate Appointments by Provider Report** permission set as Yes will be able to generate the report.



# Payment Reconciliation Report

Written by Athul V Suresh | Last published at: August 23, 2021

## Overview

The Payment Reconciliation report is used to make the reconciliation of all payment receipts added to the practice. It can be used to view the receipts added in the selected locations from patient insurance and collection agency and deletion of receipts. The report shows the applied payments within the selected date range, all adjustment transactions, reversals, refunds, Adj off's, and Transfers.

All the refunds, receipt deletions, Adj-off will be in red color inside brackets to indicate a negative transaction. The report pulls real-time data in a single view. The report is based on the transaction date of the actions performed.

The report is grouped into sections based on the actions and has a totals row for each section. The actions are receipt addition, applied payments, adjustments, provider adjustments, refunds, Adj off, and transfers. The report will give the user a drill down off transactions associated with the action, the patients, carrier, or collection agency associated with the action. The report also shows codes the payments have been applied, the DOS of the code, the treatment provider, treatment location, and so on.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

For the Payment Reconciliation report, your filter options include:

### Date range\*

The payment reconciliation report is based on the transaction date. Choose the date range to focus your report on the selected date range. The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

### Trans. Location\*

Choose this option to focus your report on the transaction location.

### Trans. User

Choose this option to focus your report on the transactions made by the selected User. If no users are selected, the default will be all users.

### Action

Choose this option to focus your report on specific actions. If no actions are selected by default all actions will be selected.

### Payment location

Choose this filter to focus your report on the location the receipt(s) has been added.

### Receipt user

Choose this option to focus your report on users that updated the receipt.

### Payment type

Choose this option to focus your report on the selected payment types.

### Payment category

Choose this option to focus your report on the payment category of the receipt like cash, check, direct transfer, and so on.

### Paying entity

Choose this option to focus your report on payment entities like patient, insurance, or collection agency.

### Adjustment code

Choose this option to focus your report on the selected Adjustment codes.

### Provider Adjustment

Choose this report to focus your report on the selected provider adjustments.

### Amount\*

Focus the report on transactions for an amount that is "less than" "greater than" "equal to" (and so on) than the dollar amount you specify here. By default, not equal to \$0 is selected.

#### Columns\*

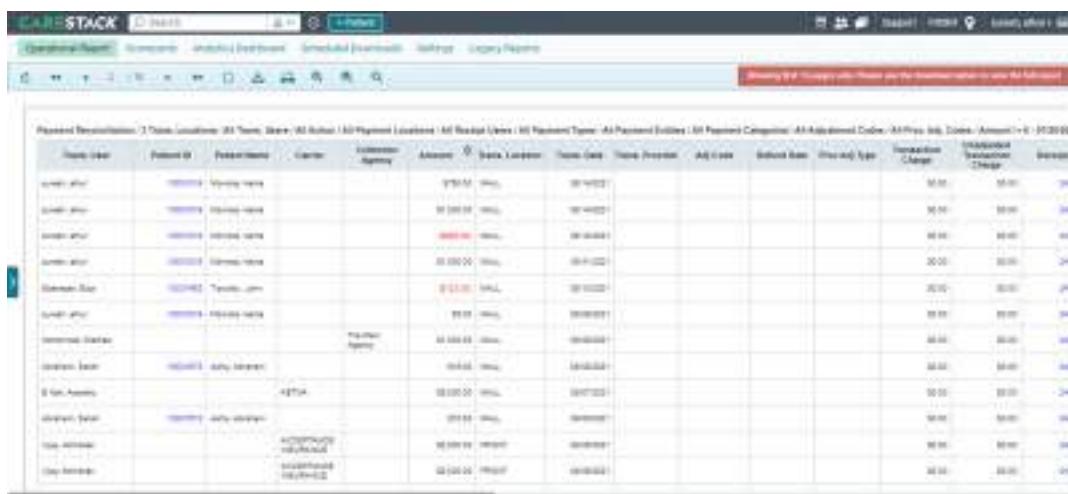
Choose the columns you wish to see in this report. By default, all the columns will be selected.

## Sorting

The default sorting in the payment reconciliation report is by transaction date. The user can also sort by amount, patient Gross production, and insurance gross production.

## Results

The report provides information in column form grouped by the above-mentioned actions and has a totals row for each group. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.



The screenshot shows a software application window titled 'CARESTACK' with a toolbar at the top. Below the toolbar is a menu bar with options like 'General Report', 'Reconcile', 'Unreconciled Dashboard', 'Scheduled Payments', 'Refund', and 'Delete Payment'. The main area displays a grid of data. At the top of the grid, there is a complex query string: 'Patient Reconciliation / (3 Date Conditions / All Terms, Status - All Refund / All Payment Locations / All Receipt Types / All Payment Types / All Payment Entities / All Payment Categories / All Adjustment Codes / All Phys. Inv. Codes - Amount > 0 - [10/20/00]'. The grid itself has several columns: 'Trans. User', 'Patient ID', 'Description', 'Carrier', 'Collection Agency', 'Amount', 'Date', 'Receipt Number', 'Adj. Class', 'Refund Reason', 'Receipt Type', 'Individual Insurance Charge', 'Individual Deduction Charge', and 'Balance'. The data in the grid consists of multiple rows of transaction details.

Trans. User	Patient ID	Description	Carrier	Collection Agency	Amount	Date	Receipt Number	Adj. Class	Refund Reason	Receipt Type	Individual Insurance Charge	Individual Deduction Charge	Balance
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100001				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100002				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100003				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100004				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100005				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100006				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100007				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100008				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100009				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100010				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100011				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100012				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100013				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100014				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100015				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100016				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100017				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100018				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100019				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100020				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100021				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100022				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100023				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100024				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100025				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100026				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100027				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100028				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100029				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100030				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100031				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100032				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100033				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100034				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100035				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100036				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100037				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100038				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100039				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100040				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100041				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100042				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100043				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100044				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100045				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100046				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100047				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100048				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100049				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100050				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100051				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100052				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100053				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100054				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100055				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100056				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100057				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100058				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100059				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100060				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100061				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100062				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100063				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100064				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100065				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100066				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100067				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100068				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100069				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100070				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100071				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100072				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100073				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100074				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100075				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100076				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100077				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100078				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100079				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100080				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100081				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100082				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100083				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100084				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100085				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100086				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100087				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100088				50.00	50.00	
Customer-Account	1000010	Primary name			\$100.00	10/10/2000	10100089		</				

**Trans. Provider**

The provider associated with the transactions like Applied Payments, Adjustments, and so on.

**Adj. Code**

Adjustment code associated with the adjustment transaction. The adj code applied only during adding a receipt will show up in the report.

**Refund Date**

Refund date associated with the refund transaction.

**Prov Adj Type**

Type of provider adjustment associated with Provider adjustment transaction.

**Transaction charge**

The transaction charge associated with payment types like care credit.

**Unadjusted transaction charge**

The total amount of unadjusted transaction charge.

**Receipt#**

The receipt ID of the receipt in context. On clicking the receipt ID the user is taken to the patient's ledger or insurance payment page depending on the payment entity of the receipt.

**Paying entity**

The entity against whom the receipt in context is addressed. (Patient, Insurance, Coll. Agency)

**Paying entity name**

The name of the entity against whom the receipt in context is addressed.

**Payment category**

The payment category of the receipt like cash, check, direct transfer, and so on .

**Payment type**

The payment type of the receipt.

**Payment date**

The payment date of the receipt. This is the actual date the patient paid the practice.

**Receipt Add Trans. Date**

The date on which the payment was recorded in CareStack.

**Receipt type**

This column shows whether the receipt type is Regular payment or Advance payment.

**Payment Location**

The location in which the receipt was added or simply the payment location of the receipt.

**Receipt user**

The user who added the receipt on which the transaction action was done.

**Claim ID**

The Claim ID of the claim that was used to post payments from the insurance receipt.

## Code

The code against which the transaction was done.

## DOS

The DOS of the code against which the transaction was done.

## Tx. Provider

The treatment provider of the code against which the action is made.

## Tx. location

The treatment location of the code against which the action is made.

## Pat. Gross Production

The dollar value of the patient balance of the code against which the transaction was made.

## Ins. Gross Production

The dollar value of the insurance balance of the code against which the transaction was made.

## Special Case

The transaction location and payment location and treatment location denote where the receipt was added, where the payment was added, and where the treatment was completed. These locations may or may not be the same for all entries in the report.

- In case of receipt addition, the transaction location and payment location will be the same.
- In the case of applied payments, if the receipt added is in a different location than the treatment location then the transaction location and payment location will be different.

## Permissions

Permissions for the Payment Reconciliation Report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Payment Reconciliation Report. Only users with **Generate Payment Reconciliation Report** permission set as Yes will be able to generate the report.

Profile : 1 Admin - Permissions	
User	Search
String	
Name	
Gender	
Address	
Practice Settings	
Patient Engagement	
Records	
Transfers	
Scheduling	
Insights	
Patient Registration	

A screenshot of the 'Admin - Permissions' page in a software application. The 'Insights' section is highlighted with a green background. A red arrow points from the 'Patient Registration' section down to the 'Generate Payment Reconciliation Report' permission row. The 'Generate Payment Reconciliation Report' row is also highlighted with a red background. The table has two columns: 'Name' and 'Search'. The 'Search' column contains icons for search, refresh, and other functions.



# Income Allocation Report

Written by Mathew Kandirickal | Last published at: August 27, 2021

## Overview

The Income Allocation report details provider performance measured in terms of Opening Balances and Closing Balances, Production and Collection Amounts/Adjustments, as well as Outstanding Credits within the selected time frame.

The Income Allocation Report is based on Transaction Date and shows real-time data. The report is available in five different views - Income Allocation, Net Production, Net Applied Payments, Allocated Advance Payments, and Adjustments views.

The Income Allocation view shows the high-level grouping for all the production. It shows the Opening, Closing Balances, Gross Production, Production adjustments, Net Production, Applied payments, Collection adjustments, Net applied grouped by either location or provider. The Net Production view shows the information of how each code contributes to the production, the patient and insurance split, etc, and the patient and insurance production adjustments. The Net Applied Payments can be used to track the payment that has been applied to the code and also shows the estimate of the code. It shows the patient payments and insurance payments and collection adjustment applied to codes and also includes the reversals if any. The allocated advance payments view allows the user to see the payments which have been applied from advance receipts and shows the treatment information to which the payment is applied and receipt information of the advance receipt. The Adjustments view gives detail on the patient and insurance adjustments made between the selected date range.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria is important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Income Allocation View

For the Income Allocation View, the filter options include:

#### Group By\*

Decide whether to group the report results by Provider or Location. By default, the Provider will be selected.

#### Date Range\*

Income Allocation report is dated by Transaction date. Focus the report on transactions made within your selected date range. By default, the current date will be selected.

#### Location\*

Focus the report on transactions completed at the selected location(s). By default, the user's default location will be selected.

#### Provider Type\*

Generate the report data based on the type of provider (dentists, hygienists, or both). By default, All is selected.

#### Provider

Choose whether to focus the report on the selected treatment provider(s).

#### Patient Flag

Choose whether to focus the report based on patients with the selected patient flag(s).

#### Exclude Inactive Providers

Checkmark this option to exclude inactive providers from the report.

#### Single Group Per Page

Checkmark this option to separate each group of generated data onto its own page (whether grouped by provider or location, each will be individualized into separate pages of the report).

## Net Production View

For the Net Production View, the filter options include:

### Date Range\*

Income Allocation report is dated by Transaction date. Focus the report on transactions made within the selected date range. By default, the current date will be selected.

### Location\*

Focus the report on transactions completed at the selected location(s). By default, the user's default location will be selected.

### Provider

Choose whether to focus the report on the selected treatment provider(s).

### Patient Flag

Choose whether to focus the report based on patients with the selected patient flag(s)

### Code

Choose the procedure codes to be included.

### Exclude Inactive Providers

Checkmark this option to exclude production from the inactive providers in the report.

## Net Applied Payments View

For the Net Applied Payments View, the filter options include:

### Date Range\*

Income Allocation report is dated by Transaction date. Focus the report on applied payment transactions made within the selected date range. By default, the current date will be selected.

### Location\*

Focus the report on transactions completed at the selected location(s). By default, the user's default location will be selected.

### Provider

Choose whether to focus the report on the selected treatment provider(s).

### Patient Flag

Choose whether to focus the report based on patients with the selected patient flag(s).

### Code

Choose the procedure codes to be included.

### Exclude Inactive Providers

Checkmark this option to exclude inactive providers from the report.

## Allocated Advance Payments

For the Allocated Advance Payments View, the filter options include:

### Date Range\*

Income Allocation report is dated by Transaction date. Focus the report on transactions made within the selected date range. By default, the current date will be selected.

### Receipt Location\*

This is used to filter out applied payments and reversals that come from advance patient receipts from the selected location as the receipt location. By default, the user's default location will be selected.

#### **Receipt Provider**

This is used to filter out advance receipts added against a particular provider.

#### **Treatment Location**

This is used to filter out applied payments that are made on the selected locations.

#### **Treatment Provider**

This is used to filter out applied payments posted against a particular provider.

#### **Code**

Choose to filter out codes against which applied payments were made.

#### **Patient Flag**

Choose patient flags to filter out applied payments made against patients with selected flags.

#### **Exclude Inactive Providers**

Checkmark this option to exclude inactive providers in the report.

### **Adjustments View**

For the Adjustments View, the filter options include:

#### **Date Range\***

Income Allocation report is dated by Transaction date. Focus the report on transactions made within the selected date range. By default, the current date will be selected.

#### **Location\***

Focus the report on transactions completed at the selected location(s). By default, the user's default location will be selected.

#### **Provider**

Choose whether to focus the report on the selected treatment provider(s).

#### **Patient Flag**

Choose whether to focus the report based on patients with the selected patient flag(s).

#### **Adjustment Category**

Choose the adjustment category from Production or Collection.

#### **Exclude Inactive Providers**

Checkmark this option to exclude inactive providers in the report.

### **Results**

#### **Income Allocation View**

The report provides information in column form grouped by either provider or location as selected. The report also has a consolidation of the income allocation values across all the selected providers and locations at the end of the report. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Income Allocation Report (Location : PAU) / Provider / Provider Types - All / All Patient Flags : RTRW/OSCH - 30/10/2019										
Provider : Dr. Rajesh Patel (PAU199)										
Location	Opening Balance	Gross Production (Trans. Dated)	(+) Prod Adj	(-) Prod Adj	Net Production (Trans. Dated)	Applied Payments (Trans. Dated)	(+) Coll. Adj	(-) Coll. Adj	Net Applied Payments (Trans. Dated)	Closing Balance
PAU1	\$11.00	\$07.00	\$0.00	\$0.00	\$07.00	\$0.00	\$0.00	\$0.00	\$0.00	\$11.00
Total UCR		\$0.00				Johnson Payments				\$0.00
Gross Production (Trans. Dated)		\$07.00				Allocated Advance Payments				\$0.00
Production Adjustments		\$0.00				Applied Payments (Trans. Dated)				\$0.00
Net Production (Trans. Dated)		\$07.00				Collection Adjustments				\$0.00
Revised Production		\$0.00				Net Applied Payments (Trans. Dated)				\$0.00
						Income Reduction				\$0.00

The results columns shown in this report include:

#### Provider

The treatment provider to which these transactions apply.

#### Location

The treatment location to which these procedures and transactions apply.

#### Opening Balance

The opening balance of outstanding charges that remained to be collected going into this selected time period.

#### Gross Production

The dollar amount of production generated from procedures completed by this provider at this location.

#### ( + ) Production Adjustment

The dollar amount of positive adjustments made against this provider's production generated at this location.

#### ( - ) Production Adjustment

The dollar amount of negative adjustments made against this provider's production generated at this location.

#### Net Production

The dollar amount of production generated by this provider at this location, including any production adjustments made.

#### Applied Payments

The dollar amount of payments that have been applied towards these balances.

#### ( + ) Collection Adjustment

The dollar amount of positive adjustments made against this provider's expected receivables at this location.

#### ( - ) Collection Adjustment

The dollar amount of negative adjustments made against this provider's expected receivables at this location.

#### Net Applied Payments

The dollar amount of payments applied towards these balances after any collection adjustments made.

#### Closing Balance

The remaining balance to be collected for this provider at this location after production generated and receivables collected during this time period.

#### Total UCR

The total UCR of procedure codes checked out transactionally in the selected date range.

#### Gross Production

The total dollar amount of production generated during this time period according to the procedure fees at the time of code completion.

#### **Production Adjustments**

The total dollar amount of production adjustments completed during this time period.

#### **Net Production**

The total dollar amount of production generated during this time period including any production adjustments made.

#### **Migrated Production**

The total production brought in by the MSB codes.

#### **Advance Payments**

The total dollar amount of advance payments collected during this time period.

#### **Allocated Advance Payments**

The total dollar amount allocated from the advance receipts added in the selected date range.

#### **Applied Payments**

The total dollar amount of payments applied against the outstanding balances during this time period.

#### **Collection Adjustments**

The total dollar amount of collection adjustments made against patient and insurance receivables during this time period.

#### **Net Applied Payments**

The total dollar amount of payments applied during this time period after any collection adjustments made.

#### **Income Reduction**

The total dollar amount of income reduction payment type added against the provider

### **Net Production View**

The net production view lists out all the procedure codes completed and the production adjustments made in the selected date range. This view has three sections- the first section shows the completed procedure codes completed with a totals column that shows the consolidated UCR, Contractual adjustment, Pat amount, Ins amount, and Production. The second section shows the patient adjustments and the third section shows the insurance adjustments. Both these sections also have a totals column showing the total patient and insurance adjustments made. The end of the report shows the Grand Total- Gross production, Grand Total- Production adjustments, and Grand Total- Net production.

Income Monitor - Net Production / Location - WMA / MSB Procedure / MSB Patient Flags - 01/01/2021 - 06/19/2021 / All Codes								
Procedure								
Transaction Date	Patient Name	Code - Description	U.S.D.	UCR	Contr. Adj.	Pat. Amt.	Ins. Amt.	Production
01/01/2021	REV. Doc/DRG001 1350417146	20100 - Limited Prosthetic Services	01/01/2021	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
01/01/2021	DALELLIE, ROBERTA (Report) (350417146)	20100 - Comprehensive Exam-Early	01/01/2021	\$11.00	\$11.00	\$11.00	\$11.00	\$11.00
01/01/2021	DALELLIE, ROBERTA (Report) (350417146)	20100 - Screening (P.A. Patient)	01/01/2021	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00
01/01/2021	DALELLIE, ROBERTA (Report) (350417146)	20100 - Screening (P.A. Patient)	01/01/2021	\$1.00	\$1.00	\$41.00	\$12.00	\$43.00
01/01/2021	DALELLIE, ROBERTA (Report) (350417146)	20100 - Screening (P.A. Patient)	01/01/2021	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00
		20100 - Screening (P.A.)						

The results columns shown in this report include:

#### **Transaction Date**

The date the transaction was completed in the system.

#### **Patient Name**

The name of the patient that was seen for treatment.

**Code - Description**

The procedure code that was completed for this patient, along with its description.

**D.O.S**

The date on which the patient was seen by their treatment provider for the completion of these services.

**UCR**

The office's standard fee for this procedure code according to the practice settings.

**Contractual Adjustment**

The contractual adjustment made to the payable according to the difference between the office's standard fee for this procedure and what the insurance carrier has agreed to pay.

**Patient Amount**

The expected patient receivable.

**Insurance Amount**

The expected insurance receivable.

**Production**

The dollar amount of production generated from completing this treatment.

**Adj.Code - Desc.(Action)**

The adjustment code used to adjust the resulting balance for treatment completed (along with the description and action of the adjustment code).

**User's Name**

The user that completed the transaction in the system.

**Carrier**

The name of the insurance carrier for which an adjustment was made.

## Net Applied Payments View

The net applied payment view consists of patient payments that are applied, insurance payments that are applied grouped by each carrier, the reversals of payments applied, collection patient adjustments, and collection insurance adjustments. Each of these sections and groupings has the totals shown and shows the consolidated Grand Total - Applied Payments, Grand Total - Reversals, Grand Total - Collection Adjustments, Grand Total - Net Applied Payment at the end of the report.

Income Allocation - Net Applied Payments / Location - WA12 / All Patients / All Patient Flags - 03/01/2021 - 06/19/2021 / All Codes							
Patient Payments							
Trans. Date	Patient Name	Code - Description	Billing	Hipr#	User's Name	Net Total	Applied Payment (From Date)
06/19/2021	John Doe Normal Payee/ (35041983)	011001 - Computerized Bill - Non-Billable	00100001	200000	No ap. carried	0.00	0.00
06/19/2021	John Doe Normal Payee/ (35041983)	01101 - Bill	00100001	200000	No ap. carried	0.00	0.00
06/19/2021	John Doe Normal Payee/ (35041983)	10201 - Income - General Foreign Body, Subacute Two Cmp	00100001	200000	No ap. carried	60.00	60.00
06/19/2021	John Doe Normal Payee/ (35041983)	01101 - Screening (if Present)	00100001	200000	No ap. carried	240.00	240.00
06/19/2021	John Doe Normal Payee/ (35041983)	01101 - Screening (if Present)	00100001	200000	Unknown Auth	240.00	240.00

The results columns shown in this report include:

**Transaction Date**

The date the transaction was completed in the system.

**Patient Name**

The name of the patient that was seen for treatment.

## **Code - Description**

The procedure code that was completed for this patient, along with its description.

## **D.O.S.**

The date on which the patient was seen by their treatment provider for the completion of these services.

## **Receipt #**

The system-assigned number used to identify the payment that has been entered into the system.

## **User's Name**

The user that completed the transaction in the system.

## **Patient Balance**

The patient balance at the time of checkout.

## **Applied Payment**

The dollar amount that has been paid towards this balance.

## **Plan**

The plan which is associated with the patient.

## **Claim ID**

The identifier of the claim or claim number.

## **Ins Amount**

The expected insurance receivable.

## **Carrier/Collection Agency**

The carrier or collection agency in the context.

## **Adj Code Desc**

The adjustment code used to adjust the resulting balance for treatment completed (along with the description and action of the adjustment code).

## **Allocated Advance Payments View**

The allocated advance payments view shows the payments that are applied from the advance receipts from the selected locations in the selected date range. The applied payments allocated from the advance receipts are shown as positive, while its reversals appear negative. This differs from the primary report. The view also has a total that shows the total applied payments that are allocated from the advance receipts which were added in the selected date range.

Invoice Allocation - Allocated Advance Payments - 1) Receipt Locations - 2) Receipt Provider - 3) Treatment Locations - All Treatment Providers - All Receipt Flags / All Codes - 01/01/2021 - 06/10/2021														
For clarity in this table results, applied payments (payments from advance receipts) are shown as positive, while its reversals (receipts) are negative. This differs from the primary report.														
Transaction Date	Patient ID	Patient Name	Receipt Location	Receipt Provider	Treatment Location	Treatment Provider	Applied Receipt (Total)	Pricing/Reason	User	Label Group	Batch ID	Printed	File Date	Line
2021-06-10	1234567890	John Doe	Examination Center	Provider 1	Treatment Center	Provider 2	1000.00	Normal	Admin	Emergency Room Visit	1234567890	Yes	2021-06-10	1

The results columns shown in this report include:

## **Transaction Date**

The date the transaction was completed in the system.

## **Patient Id**

The Identifier of the patient that was seen for treatment.

## **Patient Name**

The name of the patient that was seen for treatment.

#### **Receipt Location**

The receipt location of the advance receipt in context.

#### **Receipt Provider**

The receipt provider of the advance receipt in context.

#### **Treatment Location**

Treatment location of the code.

#### **Treatment Provider**

Treatment provider of the code.

#### **Applied Payment**

The amount applied against the code from the advance receipt.

#### **Paying Patient**

Mentions the name of the patient who is paying the amount.

#### **Code**

Mentions the treatment procedure in context.

#### **Code Desc**

The procedure code completed for this patient, along with its description.

#### **Date of Service**

The date on which the patient was seen by their treatment provider for the completion of these services.

#### **Patient Amount**

The expected patient receivable.

#### **Insurance Amount**

The expected insurance receivable.

#### **Receipt #**

The system-assigned number used to identify the payment that has been entered into the system.

#### **User's Name**

The user that completed the transaction in the system.

### **Adjustments View**

The adjustments view consists of two sections- patient side production/ collection (as selected) adjustments and insurance production/ collection (as selected) adjustments. Each of these sections and has the totals shown and shows the consolidated Grand Total - Production/ Collection (as selected) Adjustments at the end of the report.

Patient Adjustments						
Trans Date	Patient Name	Code	R.O.S.	Adj Code - Description	User's Name	Amount
08/12/2021	David Lee	20100	08/12/2021	ICD9 - ICD OFF - One Charge/Previous Deduction Filled	DR - David	(80.00)
08/12/2021	David Lee	20100	08/12/2021	ICD9 - ICD OFF - Treatment incomplete/One Off Patient	DR - David	(80.00)
Grand Total - Production Adjustments						\$160.00

The results columns shown in this report include:

#### **Transaction Date**

The date the transaction was completed in the system.

#### **Patient Name**

The name of the patient that was seen for treatment.

#### **Code**

The procedure code completed for this patient, against which an adjustment was made.

#### **D.O.S.**

The date on which the patient was seen by their treatment provider for the completion of these services.

#### **Adj. Code - Desc. (Action)**

The adjustment code used to adjust the resulting balance for treatment completed (along with the description and action of the adjustment code).

#### **User's Name**

The user that completed the transaction in the system.

#### **Amount**

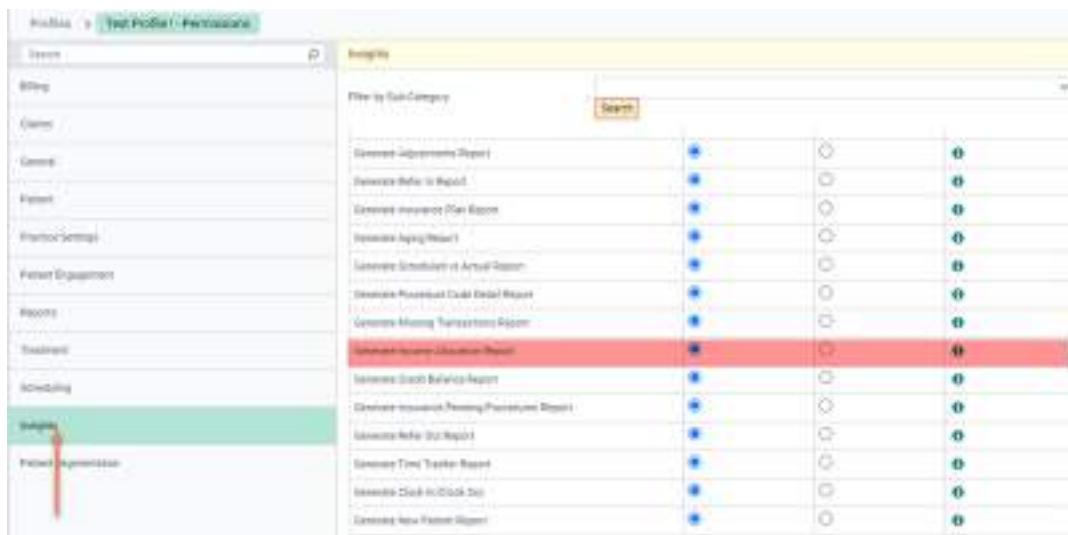
The dollar amount of the adjustment completed.

#### **Carrier**

The name of the insurance carrier for which an adjustment was made.

## Permissions

Permissions for the Income Allocation report will be in System Menu -> Practice Settings -> Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Income Allocation Report. Only users with **Generate Income Allocation Report** permission set as Yes will be able to generate the report.



# Walkout Balance Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

This report is intended to be used daily as a measurement of what is being allowed to walk out the door with respect to patient financial responsibility. This report can be used to see how much the patient owes the practice at the end of day.

This report shows real-time data and has two views- summary view and detail view. The summary view shows the total starting balance and ending balance for each selected location by transaction date. Transaction date is the date on which the user entered the transaction in the system. It may or may not be different from the actual DOS/payment date. The detail view shows the walkout details of each patient who was seen on the selected date range and includes details like their unapplied credits, total patient responsibility, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary View

For the walkout balance Summary View report, your filter options include:

#### Date Range\*

Walkout Balance report is dated by Transaction date. Focus your report based on balances created in the specific date range. Select a maximum of up to 1 year.

#### Location\*

Select location(s) to focus your report based on balances created in the selected Locations.

### Detail View

For the walkout balance Detail View report, your filter options include:

#### Date Range\*

Walkout Balance report is dated by Transaction date. Focus your report based on balances created in the specific date range. Select a maximum of up to 1 year.

#### Location\*

Select location(s) to focus your report based on balances created in the selected Locations.

#### Patient flag

Choose to focus the report based on the patients with the selected patient flags.

#### Patient

Choose to focus the report based on the selected patients.

#### Columns\*

Choose the columns you wish to see in this report. By default, all the columns will be selected.

## Sorting

The default sorting for the Walkout Balance report will be by Trans date (asc). Sorting is possible on Total Patient Resp, Starting Balance, Ending Balance, Unapplied Credits, Last paid amount, and last paid date columns as well.

## Results

### Summary View Report

The report provides information in column form for each date of transaction and the starting balance for the day and ending balance for the day. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

The screenshot shows the CARESTACK software interface with the title "Walkout Balance - Summary | Location - FRONT - 07/07/2021 - 08/06/2021". The report table has columns: Trans. Date, Starting Balance, and Ending Balance. The data shows a sequence of transactions from July 14, 2021, to August 10, 2021, with a final balance of \$899.00.

Trans. Date	Starting Balance	Ending Balance
07/14/2021	\$1,452.00	\$1,112.00
07/16/2021	\$171.00	\$171.00
07/16/2021	\$205.00	\$0.00
07/26/2021	\$1,848.00	\$1,140.00
07/26/2021	\$118.00	\$100.00
07/26/2021	\$128.00	\$100.00
07/27/2021	\$12.00	\$12.00
07/28/2021	\$208.00	\$208.00
07/29/2021	\$208.00	\$208.00
07/31/2021	\$208.00	\$208.00
08/10/2021	\$899.00	\$899.00

The results columns shown in this report include:

#### Trans. date

The date on which the patient's treatment was marked as complete in the system. It may or may not be the same as the DOS of the treatment.

#### Starting balance

The balance the patient has on their account after the completion of their treatment. It is the fees of code minus any adjustments made and payments applied on the same date for the code.

#### Ending Balance

The outstanding amount from the balance the patient walked out with. It is fees for the code minus any patient payment applied to the balance.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing each patient that walked out with or without a balance.

## Detail View Report

The screenshot shows the CARESTACK software interface with the title "Walkout Balance - Detail | Location - FRONT - All Patients - All Walkout Flags - 07/07/2021 - 08/06/2021". The report table lists patients with their names, Patient ID, Trans. Date, Location, Total Patient Resp., Starting Balance, Ending Balance, Unsettled Credit, Last Visit Amount, Last Visit Date, and Last Visit To. The data includes multiple entries for患者 (Patient Name), Patient ID, Trans. Date, Location, Total Patient Resp., Starting Balance, Ending Balance, Unsettled Credit, Last Visit Amount, Last Visit Date, and Last Visit To.

Patient Name	Patient ID	Trans. Date	Location	Total Patient Resp.	Starting Balance	Ending Balance	Unsettled Credit	Last Visit Amount	Last Visit Date	Last Visit To
患者 (Patient Name)	PID-001	07/14/2021 14:00:00	FRONT	\$0.00	\$1,452.00	\$1,112.00	\$0.00	\$8,000.00	\$1,112.00	07/07/2021 14:00:00
患者 (Patient Name)	PID-002	07/14/2021 14:00:00	FRONT	\$0.00	\$112.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-003	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-004	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-005	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-006	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-007	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-008	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-009	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-010	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-011	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-012	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-013	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-014	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-015	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-016	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-017	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-018	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-019	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-020	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-021	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-022	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-023	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-024	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-025	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-026	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-027	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-028	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-029	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-030	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-031	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-032	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-033	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-034	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-035	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-036	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-037	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-038	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-039	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-040	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-041	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-042	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-043	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-044	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-045	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-046	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-047	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-048	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-049	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-050	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-051	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-052	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-053	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-054	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-055	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-056	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-057	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-058	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-059	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-060	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-061	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-062	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-063	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-064	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-065	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-066	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-067	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-068	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-069	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-070	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-071	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-072	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-073	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-074	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-075	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-076	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-077	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-078	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-079	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-080	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-081	07/14/2021 14:00:00	FRONT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
患者 (Patient Name)	PID-082	07/14/2021 14:00:00	FRONT	\$0.00	\$0.					

#### **Trans Date**

The date on which the patient's treatment was marked as complete in the system.

#### **Location**

The location in which the patient's treatment was completed.

#### **Total Patient Resp**

The total patient payable for services completed on this date.

#### **Starting balance**

The balance the patient has on their account after the completion of their treatment. It is the fees of code minus any adjustments and payments applied on the same date for the code.

#### **Ending Balance**

The outstanding amount from the balance the patient walked out with. It is fees for the code minus any patient payment applied to the balance.

#### **Unapplied Credits**

The monetary credits the patient has available on their account if any.

#### **Last Paid Amount**

The last dollar amount the patient has paid to your office.

#### **Last Paid Date**

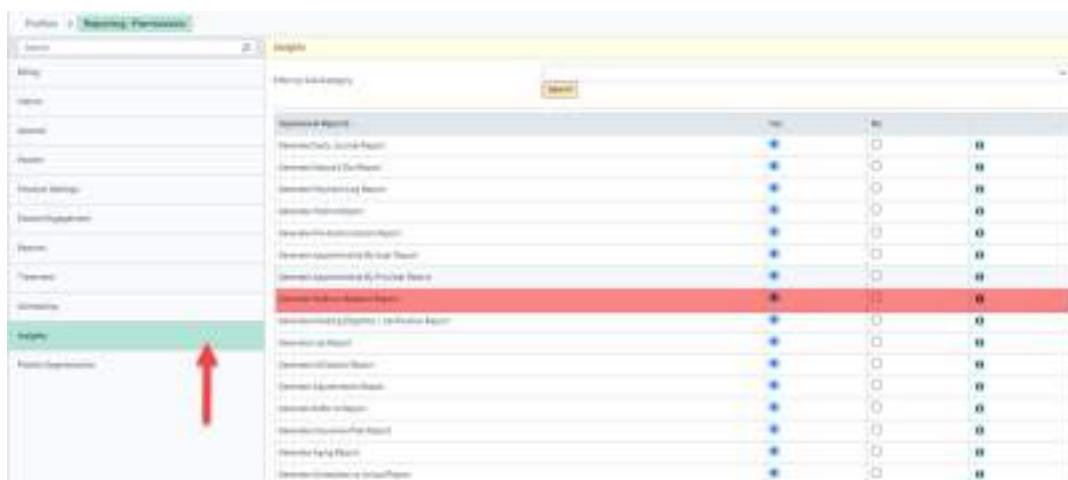
The last date a payment was made by the patient.

#### **Last Paid To**

The user who entered the receipt for the last payment that was made by the patient.

## **Permissions**

Permissions for the Walkout Balance report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Walkout Balance Report. Only users with **Walkout Balance Report** permission set as Yes will be able to generate the report.



# Pending Eligibility/Verification Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

The pending eligibility/verification report is intended to view patients with upcoming appointments whose insurance plan or eligibility needs to be verified. The report can be used to review upcoming appointments with patients' insurance either in draft or eligibility pending status.

This report shows real-time data. The report shows separate entries for primary, secondary, and tertiary insurances that the patient has.

The data captured is according to the date range specified. Only the appointments between the date that has insurance either in draft or eligibility pending status will be displayed. It will also show insurances that did not have had their insurance eligibility last completed before the specified number of days. There is only a single view for this report but it includes all the necessary information.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Date Range\*

The pending eligibility report is dated by appointment date. Select the date range to focus your report on patients with an upcoming appointment that falls within the selected date range, and have had their insurance eligibility last completed before the number of days specified in the Days Since Last Eligibility filter. The date range can be selected for a maximum of 3 months. The default date range is 2 days from the date of generation.

### Location\*

Select the location(s) to focus your report on patients with the selected appointment location(s). The default location will be the default location of the user.

### Provider

Select provider(s) to focus your report based on patients with the selected primary appointment provider(s).

### Insurance Status\*

Select insurance status to focus your report on patient insurance that is either pending verification, pending eligibility, or choose to include all. By default, All will be selected.

### Insurance Type\*

Select insurance type to focus your report only on dental insurance, medical insurance, or choose to include both. By default, All will be selected.

### Carrier

Select carrier to focus your report only on the selected carrier(s).

### Insurance Hierarchy

Select Insurance Hierarchy to focus your report only on primary dental insurances, primary medical insurances, secondary dental insurances, or so on.

### Patient Flag

Select patient flags to focus the report based on the patients with the selected patient flags.

### Patient

Select patient to focus the report based on the selected patients.

### Days Since Last Eligibility

Choose whether to focus your report on patients with an insurance plan that last had eligibility completed within the last 30 days, 31-60 days, 61-90 days, 90+ days, or select Days Greater Than to specify a custom number of days.

### Days Greater Than\*

Generate your report based on insurance plans that have been pending eligibility or verification for a number of days greater than the number specified here. This filter is available only when the Days Greater Than is selected in the Days Since Last Eligibility filter.

### Exclude Draft Insurances

Checkmark this option if you would like to exclude drafted insurance plans that have yet been added and verified.

#### Columns\*

Choose the columns you wish to see in this report. By default, all the columns excluding appt notes will be selected.

## Sorting

The default sorting in the Pending eligibility/verification report will be by Appt date (desc) and Appt time (asc). Sorting is also possible on the last eligibility done on column.

## Results

Patient Name	Patient ID	Subscriber Name	Subscriber ID	Last Name	Appt Date	Appt Time	Scheduled Provider
John Doe	123456789	John Doe, Inc.	123456789	John Doe	2023-09-01	13:00-14:00	Dr. Smith
Mary Smith	987654321	Mary Smith, Inc.	987654321	Mary Smith	2023-09-01	14:00-15:00	Dr. Jones
Bob Johnson	111111111	Bob Johnson, Inc.	111111111	Bob Johnson	2023-09-01	15:00-16:00	Dr. Smith
Mike Johnson	222222222	Mike Johnson, Inc.	222222222	Mike Johnson	2023-09-01	16:00-17:00	Dr. Jones
Samuel Johnson	333333333	Samuel Johnson, Inc.	333333333	Samuel Johnson	2023-09-01	17:00-18:00	Dr. Smith
David Johnson	444444444	David Johnson, Inc.	444444444	David Johnson	2023-09-01	18:00-19:00	Dr. Jones
Emily Johnson	555555555	Emily Johnson, Inc.	555555555	Emily Johnson	2023-09-01	19:00-20:00	Dr. Smith
Frank Johnson	666666666	Frank Johnson, Inc.	666666666	Frank Johnson	2023-09-01	20:00-21:00	Dr. Jones
Grace Johnson	777777777	Grace Johnson, Inc.	777777777	Grace Johnson	2023-09-01	21:00-22:00	Dr. Smith
Henry Johnson	888888888	Henry Johnson, Inc.	888888888	Henry Johnson	2023-09-01	22:00-23:00	Dr. Jones
Jane Johnson	999999999	Jane Johnson, Inc.	999999999	Jane Johnson	2023-09-01	23:00-24:00	Dr. Smith
John Doe	123456789	John Doe, Inc.	123456789	John Doe	2023-09-02	08:00-09:00	Dr. Smith
Mary Smith	987654321	Mary Smith, Inc.	987654321	Mary Smith	2023-09-02	09:00-10:00	Dr. Jones
Bob Johnson	111111111	Bob Johnson, Inc.	111111111	Bob Johnson	2023-09-02	10:00-11:00	Dr. Smith
Mike Johnson	222222222	Mike Johnson, Inc.	222222222	Mike Johnson	2023-09-02	11:00-12:00	Dr. Jones
Samuel Johnson	333333333	Samuel Johnson, Inc.	333333333	Samuel Johnson	2023-09-02	12:00-13:00	Dr. Smith
David Johnson	444444444	David Johnson, Inc.	444444444	David Johnson	2023-09-02	13:00-14:00	Dr. Jones
Emily Johnson	555555555	Emily Johnson, Inc.	555555555	Emily Johnson	2023-09-02	14:00-15:00	Dr. Smith
Frank Johnson	666666666	Frank Johnson, Inc.	666666666	Frank Johnson	2023-09-02	15:00-16:00	Dr. Jones
Grace Johnson	777777777	Grace Johnson, Inc.	777777777	Grace Johnson	2023-09-02	16:00-17:00	Dr. Smith
Henry Johnson	888888888	Henry Johnson, Inc.	888888888	Henry Johnson	2023-09-02	17:00-18:00	Dr. Jones
Jane Johnson	999999999	Jane Johnson, Inc.	999999999	Jane Johnson	2023-09-02	18:00-19:00	Dr. Smith
John Doe	123456789	John Doe, Inc.	123456789	John Doe	2023-09-03	08:00-09:00	Dr. Smith

The results columns shown in this report include:

#### Patient Name

The patient who has an appointment on the specified date.

#### Patient ID

The system-assigned number used to identify this patient and their records. Click on this hyperlink to be taken to this patient's insurance page.

#### Patient D.O.B

The patient's date of birth according to the information included in their patient profile.

#### Subscriber Name

The name of the subscriber listed on this patient's insurance plan.

#### Subscriber ID / SSN

The subscriber's ID or social security number is used to identify the subscriber and their coverage.

#### Subscriber D.O.B

The subscriber's date of birth is used to identify the subscriber and their coverage.

#### Appointment Date

The date of the patient's next appointment.

#### Appointment Time

The time of day in which the patient's next appointment is scheduled.

#### Appt Notes

Any notes that have been included in the appointment details.

#### Location

The location in which the patient's next appointment is scheduled.

#### Location Tax ID

The tax ID of the location in which the patient's next appointment is scheduled.

#### Scheduled Provider

The Primary appointment provider pertaining to the patient's next scheduled appointment.

#### **Scheduled Provider NPI**

The HIPAA-assigned National Provider Identifier number pertaining to the primary treatment provider of the patient's scheduled appointment.

#### **Default Provider**

The patient's default treatment provider.

#### **Default Provider NPI**

The unique National Provider Identifier (NPI) of the patient's default treatment provider.

#### **Carrier**

The carrier pertaining to this patient's insurance plan.

#### **Carrier Phone No**

The phone number used to reach the insurance carrier (as entered in insurance details in your practice settings).

#### **Carrier Website**

The website used to reach the insurance carrier (as entered in insurance details in your practice settings).

#### **Insurance Type**

The type of insurance coverage, whether it is dental or medical.

#### **Plan Name**

The name of the patient's insurance plan as it is entered in your practice settings.

#### **Plan Type**

The type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

#### **Group #**

The group number of this patient's insurance plan.

#### **Hierarchy**

The hierarchy of this patient's insurance plan, whether it is their primary dental insurance, primary medical, secondary dental, and so on.

#### **Status**

The current status of this patient's insurance plan, whether it is pending verification or pending eligibility.

#### **Last Verified On**

The date on which the insurance plan was verified.

#### **Last Verified By**

The user who last verified this insurance plan.

#### **Last Eligibility Done On**

The date on which eligibility was last completed for this patient's insurance plan.

#### **Last Eligibility Done By**

By The user who last completed eligibility for this patient's plan.

## **Use Cases**

---

This report is used to view patients with an upcoming appointment whose insurance plan or eligibility needs to be verified. The practice can use the report to distinguish the patient's eligibility in draft and eligibility pending status.

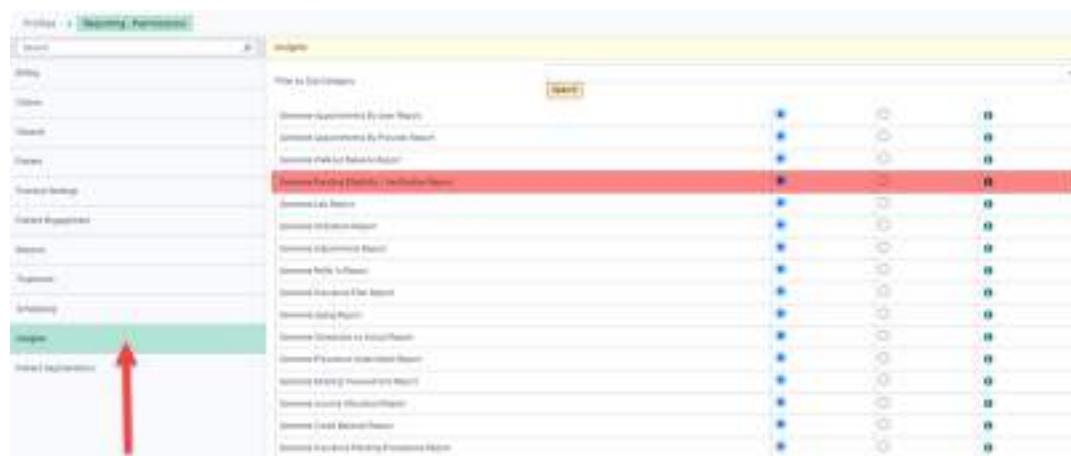
The practice can get an idea of all patients they need to verify the insurance before their next appointment. This will help the practice to streamline their workflow and be ready to bill the insurance and patient accordingly instead of completing treatment and hoping the insurance will pay for the code.

## **Special Cases**

- 
1. If Patients have insurance with an effective date in the future then those insurances will still have an entry in the report.
  2. Patients with inactive insurances also will have entries in the report.
  3. Patients with Terminated insurance will not have an entry in the report.

## **Permissions**

Permissions for the Pending eligibility/verification report will be in System Menu ->Practice Settings ->Administration -> Profiles ->Manage Permissions ->Insights ->Under Operational Reports ->Generate Pending eligibility/ verification Report. Only users with **Generate Pending eligibility/ verification** permission set as Yes will be able to generate the report.



# Clock In / Clock Out Report

Written by Roshni R | Last published at: August 22, 2021

## Overview

This report is used to track user time clock data and provides time-based pay details. The Clock In/ Clock Out report can be used to find the total number of hours the user clocked in and the payment details based on those hours. This report shows real-time data.

The Clock In/ Clock Out report shows the clock in/ clock out date and time, the total hours the user clocked in, the pay rate per hour for normal hours and for overtime hours, the pay for normal and overtime pay, and gross pay for the user.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Dates\*

Clock In/ Clock Out report is dated by **action date**. You can generate your report data based on time clock actions completed within the selected date range. The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

### Location\*

Select a location or locations to focus the report based on **time clock actions for the selected location(s)**. By default, the location will be the logged in user's default location.

### User\*

Select a user(s) to focus the report on time clock data based on the selected user(s).

## Sorting

The default sorting for Clock In/ Clock Out report will be by Date (asc) and Clock In time (asc).

## Results

The report provides information in column form grouped by each user selected. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Clock In/Clock Out - 2 Locations   2 Users - 04/26/2021 - 05/09/2021										
Break Overview										
User	Clock In	Clock Out	Location	Total Hours	Normal Pay Rate/Hr	Normal Pay	Overtime Pay Rate/Hr	Overtime Pay	Gross Pay	Notes
0000-00001	0:00:00	01:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	1:00:00	02:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	02:00:00	03:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	03:00:00	04:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	04:00:00	05:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	05:00:00	06:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	06:00:00	07:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	07:00:00	08:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	08:00:00	09:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	09:00:00	10:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	10:00:00	11:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
0000-00001	11:00:00	12:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
Total:										
Employee Info										
Date	Clock In	Clock Out	Location	Total Hours	Normal Pay Rate/Hr	Normal Pay	Overtime Pay Rate/Hr	Overtime Pay	Gross Pay	Notes
00-00-2021	0:00:00	01:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	01:00:00	02:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	02:00:00	03:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	03:00:00	04:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	04:00:00	05:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	05:00:00	06:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	06:00:00	07:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	07:00:00	08:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	08:00:00	09:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
00-00-2021	09:00:00	10:00:00	000001	1.00	\$100.00	\$100.00	\$100.00	\$100.00	\$200.00	
Total:										

The results columns shown in this report include:

### Date

The date pertaining to the day the user has clocked in or out.

### Clock IN

The time of day the user was clocked in.

### Clock OUT

The time of day the user was clocked out.

#### **Location**

The location at which the user was clocked in or out.

#### **Total Hours**

The calculated number of hours the user was clocked in before later clocking out.

#### **Normal Pay Rate/ Hr**

The Normal Pay Rate for this user per hour (as specified in their User Setup). Click this hyperlink to be taken to this user's setup.

#### **Normal Pay**

The calculated dollar amount of Normal Pay for this time entry (according to the specified Normal Pay Rate and Total Hours clocked-in for this time entry).

#### **Overtime Pay Rate/ Hr**

The Overtime Pay Rate for this user per hour (as specified in their User Setup). Click this hyperlink to be taken to this user's setup.

#### **Overtime Pay**

The calculated dollar amount of Overtime Pay for this time entry (according to the specified Overtime Pay Rate and Total Overtime Hours clocked for this time entry).

#### **Gross Pay**

The gross dollar amount of pay calculated for this time entry including Normal Pay and Overtime Pay.

#### **Notes**

The notes if added when the time clock entry was added or edited would be shown here.

#### **Totals**

The Totals are provided for the total number of hours worked and the total calculated dollar amount of Normal Pay, Overtime Pay, and Gross Pay (respectively) for all time entries this user-generated within the specified date range.

## **Use Cases**

---

The Clock In/ Clock Out reports are used to track user time clock data and provide time-based pay details. This report can be used to find

- Time entries of when the user is clocked in or out
- Total working hours of a user
- Total Normal hours of a user
- Total Overtime hours of a user
- Total gross pay of a user

## **Special Cases**

---

1. The report will list all clock in or out entries even if the clock in or clock out time was not entered. If any of the clock in or clock out time or both is missing, the total hours will be 0.
2. If the Normal Pay rate or Overtime Pay rate is edited in User Setup, the edited values will be used for dates after the edit. For the previous dates, the previous values of rates would be used for the calculations.

## **Permissions**

---

Permissions for the Clock In/Clock Out report will be in System Menu ->Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Clock In/Clock Out Report. Only users with **Generate Clock In/Clock Out Report** permission set as Yes will be able to generate the report.

Profile > Reporting Permissions

Module	Actions	Reports
Billing		
Care		
General		
Patient		
Practice Definitions		
Patient Employment		
Receivables		
Timeliness		
Scheduling		
Metrics		
Metrics		
Patients (Reporting)		

# Lab Case Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

The Lab Case report shows all the lab cases that are linked to an appointment. This report is used to identify the patients that have pending lab cases, allowing you to track cases that are due or overdue. This report shows real-time data.

The Lab Case report shows the patient details, the appointment details of the linked appointment, the sent date, due date, received date, and lab cost. The user has the flexibility to group the lab cases by lab, location, or provider. The total number of lab cases and the total cost of all the lab cases under each individual group will also be shown in the report.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

For the Lab Case report, your filter options include:

### Date As\*

Choose whether to run this report by the following options :

- Created Date: The date when the Lab case was added/created.
- Appointment Date: The date of the appointment to which the lab is linked is/was scheduled.
- Sent Date: The date the lab case was sent to the dental lab.
- Due Date: The date the lab case was projected to be due.
- Received Date: The date the lab case was received back.

### Date Range\*

Choose a date range to focus the report on lab cases with an appointment date falling within the selected date range, or lab cases that have been created/ sent/ due/ received within the selected date range. The date range can be selected for a maximum of up to 1 year. By default, the date range will be for the current day.

### Provider

Select a provider or providers to focus the report on lab cases associated with the selected providers.

### Location\*

Select a location or locations to focus the report on lab cases associated with appointments in the selected appointment location(s). By default, the user's default location will be selected.

### Lab

Choose to focus the report on lab cases associated with the selected lab(s) .

### Group By

Choose whether to group the report results by Labs, Location or Provider.

### Include Notes

Choose whether to include the lab notes in the report.

### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

### Patient

Choose to focus the report based on the selected patients.

## Sorting

The default sorting for the Lab Case report will be by Appt date (desc) and Appt time (asc). Sorting is possible on Created Date, Lab Cost, Due Date, and Received Date columns as well.

## Results

The report provides information in column form grouped by Lab or Location or Provider as selected. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Lab Case   Date Rpt - Created Date (S) Locations / All Providers / All Labs / Group By - Lab / All Patient Flags / All Patients - 12/05/2018 - 06/05/2019														
Lab : Standard														
Patient Name	Patient ID	Created Date	Appt. Date	Appt. Time	Location	Provider	Prod. Type	Lab Cost	Appt. Status	Sent Date	Due Date	Received Date	Reference No.	Notes
Karen Johnson	1405047	10/26/2017	08/18/2017	07:30 AM - 08:00 AM	FROST	ACEDAM		\$185.00	Scheduled	08/18/2017	08/18/2017	08/20/2017	1405047	Appt
Jean O'Neil	1405048	10/26/2017	10/26/2017	09:00 AM - 09:45 AM	MILL	FIGLIOTI	PCP-Affinity	\$0.00	Scheduled		10/26/2017			
<b>Total:</b>								<b>\$185.00</b>						
<b>Total Cases:</b>														
Lab : Standard														
Patient Name	Patient ID	Created Date	Appt. Date	Appt. Time	Location	Provider	Prod. Type	Lab Cost	Appt. Status	Sent Date	Due Date	Received Date	Reference No.	Notes
Paul D'Amelio	1405049	08/11/2017	08/11/2017	11:00 AM - 12:00 PM	FROST	WATSON	Refugee	\$100.00	Scheduled			08/11/2017		
Hank Torn	1405050	08/14/2017	08/19/2017	09:00 AM - 09:45 AM	FROST	WATSON		\$2.00	Confirmed	08/19/2017	08/19/2017			
John Neary	1405051	08/16/2017	08/18/2017	08:00 AM - 08:30 AM	FROST	WATSON	Emergency	\$0.00	Scheduled	08/18/2017	08/18/2017	08/18/2017		
Jean O'Neil	1405052	10/26/2017	10/26/2017	10:00 AM - 10:45 AM	FROST	WOODMAN	PCP-Affinity	\$0.00	Scheduled		10/26/2017			
Angele Andrade	1405053	08/18/2017	12/05/2017	10:00 AM - 11:00 AM	MILL	ORLANDO	Emergency	\$22.00	Scheduled	08/18/2017	08/18/2017	08/18/2017	321321321	202131321
<b>Total:</b>								<b>\$22.00</b>						
<b>Total Cases:</b>														

The results columns shown in this report include:

### Patient Name

The name of the patient scheduled to be seen in the appointment.

### Patient ID

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the Appointments page of the patient's profile.

### Created Date

The date on which the lab case was created in the system.

### Appt. Date

The date of the patient's appointment associated with this lab case.

### Appt. Time

The time for which the associated appointment is/was scheduled.

### Lab

The dental lab to which the lab case was sent.

### Location

The location of the associated appointment.

### Provider

The treatment provider of the Lab case.

### Prod. Type

The type of production to be generated from the associated appointment.

### Lab Cost

The estimated or actual cost of this lab case.

### Tooth #

The tooth numbers if any associated with the lab case.

### Tooth Shade

The tooth shade associated with the lab case.

### Appt. Status

The current status of the patient's appointment associated with this lab case. **Sent Date:** The date the lab case was sent to the dental lab.

### Due Date

The date the lab case was projected to be due.

### Received Date

The date the lab case was received back.

#### Reference No.

The reference number of the lab case.

#### Notes

Any notes that have been included in the lab case.

## Use Cases

The Lab Case report is used to identify the patients that have pending lab cases, allowing you to track cases that are due or overdue. You can use the Lab Case report,

To track the lab cases that were created on the date range

- that are associated with appointments on the date range
- that are sent on the date range
- that are due for the date range
- that were received on the date range

To track the total lab cases and lab cost against

- each dental lab
- each location
- each provider

## Special Cases

1. The report shows lab cases that are linked with an appointment. If no appointment is linked with a lab case, this lab case won't show up on the report.

## Permissions

Permissions for the Lab Case report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights ->Under Operational Reports ->Generate Lab Report. Only users with **Generate Lab Report** permission set as Yes will be able to generate the report.

Operational Reports	Yes	No	Generate
Generate Daily Journal Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Deposit Slip Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Payment Log Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Claims Report	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Pre-Auth Requests Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Appointments By User Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Appointments by Provider Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Treatment Plan Report	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Pending Capacity / Verification Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Generate Lab Report</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Utilization Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate Treatment Plan Report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

# Appointments by User Report

Written by Abhishek Vijay | Last published at: August 22, 2021

## Overview

Appointment reports are intended to show both past and future trends of scheduling and opportunities for improvements. There are often production goals associated with scheduling, and appointments can be strategically placed in order to meet these goals.

The Appointments by User report can be used to find the count of appointments, appointment details, and production for appointments that were created by each user. This report shows real-time data and is available in two views - Summary and Detail view.

The summary view shows the total count of appointments that were created, scheduled production, and average scheduled production either by appointment location or by user who created the appointment. The users have the flexibility to view the report by the user who created the appointment or by appointment location.

The detail view shows the patient level drill-down of each appointment including details like scheduled date, patient's phone number, appointment date and time, operatory, appointment providers and duration, the scheduled production of the appointment, the patient estimate of scheduled production, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary View

For the Appointments by User Summary View report, your filter options include:

#### Group By\*

Appointment by User summary view report can be grouped by user that created the appointment or by appointment location.

#### Dates\*

Appointment by User report is dated by scheduled date (appointment creation date). The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

#### User\*

Select a user(s) to focus the report on appointments that were created by the selected user(s).

#### Location

Select a location or locations to focus the report on the appointments in the selected location(s). By default, the location will be the user's default location.

#### Prod. Type

Choose to focus the report based on the selected Production Types.

#### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

#### Patient

Choose to focus the report based on the selected patients.

#### Exclude Inactive/Duplicate Patients

Checkmark this option if you would like to exclude Inactive/Duplicate Patients from the report. By default, it will be checked.

## Detail View

For the Appointments by User Detail View report, your filter options include:

#### Dates\*

The appointment by User report is dated by scheduled date (appointment creation date). The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

#### Appt. Type\*

Generate your report data based on the selected appointment types. You can choose to view the appointments booked by the user in the system or booked by the patient using the Online Booking feature or both.

#### User\*

Select a user(s) to focus the report on appointments that were created by the selected user(s).

#### Location

Select a location or locations to focus the report on the appointments in the selected location(s). By default, the location will be the user's default location.

#### Appt. Mode\*

Generate your report data based on the selected appointment modes. You can choose to view the appointments that are In-Office appointments or Tele-appointments or both.

#### Prod. Type

Choose to focus the report based on the selected Production Types.

#### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

#### Patient

Choose to focus the report based on the selected patients.

#### Appt. Status

Choose to focus the report based on the selected status of appointment.

#### Exclude Inactive/Duplicate Patients

Checkmark this option if you would like to exclude Inactive/Duplicate Patients from the report. By default, it will be checked.

#### Columns\*

Choose the columns you wish to see in this report. By default, all the columns excluding carrier and sched patient prod will be selected.

## Sorting

---

The default sorting for Appointment by User report will be by Appt date (desc) and Appt time (asc). Sorting is possible on Operatory and Sched. Prod and Sched. Date columns as well.

## Results

### Summary View Report

---

The report provides information in column form grouped by either the user that created the appointment or the appointment location as selected. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Shaji, chenchu

Location	Appt. Count	Sched. Production	Avg. Sched. Production
FRONT	<a href="#">5</a>	\$35.00	\$7.00
MALL	<a href="#">2</a>	\$0.00	\$0.00
<b>Grand Total:</b>	<a href="#">7</a>	<b>\$35.00</b>	<b>\$7.00</b>

Support #82, Case Stack

Location	Appt. Count	Sched. Production	Avg. Sched. Production
MALL	<a href="#">4</a>	\$1,081.00	\$270.25
<b>Grand Total:</b>	<a href="#">4</a>	<b>\$1,081.00</b>	<b>\$270.25</b>

The results columns shown in this report include:

**Location**

The location at which the appointment was scheduled.

**User Name**

The user that created the appointment in the system.

**Appt Count**

The number of appointments this user has scheduled for this location during the selected time frame.

**Sched. Production**

The dollar amount scheduled to be produced by the treatment included in this appointment.

**Avg. Sched. Production**

The average dollar amount scheduled to be produced by these appointments. This is calculated by dividing the amount of scheduled production by the number of appointments scheduled.

The report also has a totals row "**Grand Total**" that shows the consolidated totals of number, scheduled production, and avg scheduled production of appointments for each grouping (user/ location) selected.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these appointments and their details.

**Detail View Report**

User's Name	Sched. Date (C)	Appt. Date	Appt. Time	Patient Name	Patient ID	S.I.D.	Payer Number	Location	Poss. 1	Poss. 1 Time	Poss. 2	Poss. 2 Time
Kumar@H2	<a href="#">05/22/2021</a>	<a href="#">05/22/2021</a>	11:00 AM-12:00 PM	<a href="#">S100 ABC</a>	<a href="#">10012345</a>	<a href="#">00101010</a>		MALL	<a href="#">CHITK</a>	11:00		
Kumar@H2	<a href="#">05/23/2021</a>	<a href="#">05/23/2021</a>	08:30 AM-10:45 AM	<a href="#">S100 ABC</a>	<a href="#">10012345</a>	<a href="#">00101010</a>		MALL	<a href="#">CHITK</a>	08:30		
Kumar@H2	<a href="#">05/23/2021</a>	<a href="#">05/23/2021</a>	11:00 PM-11:00 PM	<a href="#">White Right</a>	<a href="#">10012345</a>	<a href="#">00101010</a>	<a href="#">00011111</a>	MALL	<a href="#">YOGI</a>	11		
Kumar@H2	<a href="#">05/20/2021</a>	<a href="#">05/20/2021</a>	08:30 PM-09:00 PM	<a href="#">Re: Test</a>	<a href="#">10012345</a>	<a href="#">00101010</a>	<a href="#">00011111</a>	MALL	<a href="#">CHITK</a>	08		

The results columns shown in this report include:

**User's Name**

The user that created the appointment in the system.

**Sched. Date**

The date the appointment was created in the system.

**Appt. Date**

The date on which the appointment was scheduled to take place.

**Appt. Time**

The time for which the appointment was scheduled to take place.

**Patient Name**

The name of the patient scheduled to be seen in the appointment.

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the Appointments page of the patient's profile.

**DOB**

The patient's date of birth according to the information specified on their patient profile.

**Phone No**

The patient's phone number.

**Location**

The location for which the appointment was scheduled.

**Prov. 1**

The primary treatment provider of the appointment.

**Prov. 1 Time**

The amount of time the primary treatment provider is projected to spend with the patient during this appointment.

**Prov. 2**

The secondary treatment provider of the appointment.

**Prov. 2 Time**

The amount of time the secondary treatment provider is projected to spend with the patient during this appointment.

**Prov. 3**

The tertiary treatment provider of the appointment.

**Prov. 3 Time**

The amount of time the tertiary treatment provider is projected to spend with the patient during this appointment.

**Carrier**

The primary carrier of the patient.

**Appt. Mode**

This column indicates if the appointment is an in-office or tele-appointment.

**Online Appt**

This column indicates whether the appointment was scheduled by the patient using the Online Booking feature.

**Operatory**

The operatory for which the appointment was scheduled to take place.

**Prod. Type**

The type of production to be generated by this appointment.

**Appt. Status**

The current status of the appointment, whether it has been Confirmed, Rescheduled, Checked Out, and so on.

#### **Sched. Patient Prod**

The dollar amount scheduled to be produced by the treatment(s) that is payable by the patient included in this appointment.

#### **Sched Prod**

The dollar amount scheduled to be produced by the treatment(s) included in this appointment.

#### **Notes**

Any notes that have been included in the appointment details.

## **Use Cases**

---

Appointment reports are intended to show both past and future trends of scheduling and opportunities for improvements.

- To see the count of appointments:
  - that were created by each user
  - in each location
- To see the total scheduled production:
  - that were created by each user
  - in each location
- To see the average scheduled production:
  - that were created by each user
  - in each location
- To see the appointment details and patient information that were created on the day.

## **Special Cases**

---

1. The report will list all appointments that were created. This means appointments in the Cancelled or No show status will also be counted as an appointment against that user.
2. Once a cancelled or No show appointment is rescheduled, that appointment will still be counted against the user but the appointment status will be rescheduled and the rescheduled appointment will be shown as another appointment entry against the user who rescheduled the appointment.
3. Deleted appointments will not be shown in the appointments by user report.

## **Permissions**

---

Permissions for the Appointments by User report will be in System Menu ->Practice Settings ->Administration ->Profiles ->Manage Permissions ->Insights ->Under Operational Reports ->Generate Appointments by User Report. Only users with Generate Appointments by User Report permission set as Yes will be able to generate the report.

Reporting - Permissions			
Module	Category	Filter by Sub-Category	Action
Billing	General	Generate Reports	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Claims	General	Generate Log Reports	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Paid	General	Generate Payment Log Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Process Payments	General	Generate Normal Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Patient Dispositions	General	Generate Pre-Submitted Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rebills	General	Generate Appointments By User Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Patients	General	Generate Appointments By Provider Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Prescribing	General	Generate Refillable Scripts Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Inspections	General	Generate Pending Requests / Verification Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Inspections	General	Generate Lab Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Inspections	General	Generate Utilization Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Inspections	General	Generate Adjustment Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Inspections	General	Generate Refund Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

# Adjustments Report

Written by Abhishek Vijay | Last published at: August 22, 2021

## Overview

Adjustment report is used to verify whether debit and credit adjustments have been posted correctly against the relevant procedure code balances. Adjustment reports are also used to identify trends of common adjustments so processes can be implemented to avoid them in the future.

The Adjustments report is based on Transaction Date and shows real-time data. The Adjustment report is available in two views- Summary and Detail view.

The summary view shows the total count and amount of the production adjustments and the collection adjustments made in each location and how each specific production/collection adjustment code has contributed to the adjustment as well. This view also shows the total count and amount of adjustment made against insurance adjustments and patient adjustments. The detail view gives detailed information on each adjustment made including details like patient name, adjustment type, adjustment code, action, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria is important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary View

For the Adjustment Summary View Report, your filter options include:

#### Date Range\*

Adjustments report is dated by transaction date. The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day.

#### Location\*

Select a location or locations to focus the report on the treatment location of the procedure codes (to which the adjustments have been made against) . By default, the location will be the user's default location.

#### Provider

Choose a provider or providers to focus the report on adjustments made against treatment completed by the selected provider(s).

#### Adjustment Type\*

Select the Adjustment type to focus the report on collection adjustments, production adjustments, or both. By default, All will be selected.

#### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

#### Patient

Choose to focus the report based on the selected patients.

#### Adj.Amt\*

Specify whether to generate data based on Adjustment codes with a total adjustment amount of "less than", "greater than", "equal to" (and so on) than the specified dollar amount (including both patient and insurance amounts). By default, not equal to \$0 will be selected.

## Detail View

For the Adjustment Detail View Report, your filter options include:

#### Date Range\*

Adjustments report is dated by transaction date. The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day.

#### **Location\***

Select a location or locations to focus the report on the treatment location of the procedure codes (to which the adjustments have been made against). By default, the location will be the user's default location.

#### **Provider**

Choose a provider or providers to focus the report on adjustments made against treatment completed by the selected provider(s).

#### **Adjustment Against\***

Select the Adjustment Against to focus the report on adjustments made against patient balances, insurance balances, or both. By default, All will be selected.

#### **Adjustment Type\***

Select the Adjustment type to focus the report on collection adjustments, production adjustments, or both. By default, All will be selected

#### **Adjustment Code**

Choose to focus your report on the selected adjustment code(s).

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Patient**

Choose to focus the report based on the selected patients.

#### **User**

Choose to focus your report on adjustments made by the selected user(s). By default, the current user will be selected.

#### **Adj.Amt\***

Specify whether to generate data based on Adjustment codes with a total adjustment amount of "less than", "greater than", "equal to" (and so on) than the specified dollar amount (including both patient and insurance amounts). By default, not equal to \$0 is selected.

#### **Columns\***

Choose the columns you wish to see in this report. By default, all the columns will be selected.

## **Sorting**

---

Sorting is possible on Trans. Date, D.O.S, Location, Adj.Code, Action, and User Name columns.

## **Results**

---

### **Summary View Report**

The report provides information in column form grouped by treatment location as selected. It shows the consolidated values of all locations on top as well. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

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Adjustment Type	Adjustment Code	Description	Insurance Adjustments		Patient Adjustments		Grand Total	
			Count	Amount	Count	Amount	Count	Amount
Collection Adjustments	PBA	Remaining insurance balance carried to patient loan to improve insurance payment	2	\$71.00	1	(\$11.00)	1	\$60.00
	Total		2	\$71.00	1	(\$11.00)	1	\$60.00
Production Adjustments	A2000	A2100 - Depth Adjustment	0	\$0.00	1	(\$0.40)	1	(\$0.40)
	A2011	A2100 - Ins Agreement	2	(\$15.00)	0	\$0.00	2	(\$15.00)
	A2012	A2100 - Treatment Improvement	0	\$0.00	1	(\$11.00)	1	(\$11.00)
	A2020	A2100 - Charge Adjustment	0	\$0.00	1	\$0.00	1	\$0.00
	A2031	A2100 - Ins Agreement	0	\$0.00	0	\$0.00	0	\$0.00
	A2051	A2100 - Reserve Balance	0	\$0.00	0	\$0.00	0	\$0.00
	A2070	A2100 - Payer + DRG	0	\$0.00	1	\$2.00	1	\$2.00
Total			0	(\$16.00)	1	\$14.00	1	(\$1.00)
Last Month Total			0	\$10.00	0	(\$0.40)	0	(\$0.40)

The results columns shown in this report include:

### **Adjustment Type**

The type of adjustment made, whether it was a collection adjustment or production adjustment.

## **Adjustment Code**

The adjustment code used to adjust the resulting balance for treatment completed. These codes are defined by the practice and set up in your Practice Settings.

### Description

The description of the adjustment code used to adjust the balance.

### **Insurance Adjustments**

The adjustments made against insurance balances. (This includes the number of the adjustments made and the total dollar amount of these adjustments made against an insurance balance within the selected date range.)

### Patient Adjustments

The adjustments made against patient balances. (This includes the number of the adjustments made and the total dollar amount of these adjustments made against a patient balance within the selected date range.)

### **Grand Total**

The total number of the adjustments made and the total dollar amount of the adjustments made against both patient and insurance balances within the selected date range.

The report also has a totals row “**Location Total**” that shows the total counts of insurance and patient adjustments for this location, along with the total dollar amount of insurance and patient adjustments for this location.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these adjustments and their details.

## Detail View Report

The results columns shown in this report include:

**Adjustment Type**

The type of adjustment made, whether it was a collection adjustment or production adjustment

**Adjustment Against**

Denotes whether the adjustment was against a patient balance or an insurance balance.

**Transaction Date**

The date the adjustment was made in the system.

**Patient Name**

The name of the patient that was seen for treatment (in which an adjustment was made against the resulting balance).

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to this patient's ledger.

**D.O.S**

The date on which the patient was seen by their treatment provider for the completion of the services against which the adjustment was made.

**Carrier**

The carrier of the patient's insurance plan for which the adjustment was made (if applicable).

**Code**

The procedure code in which the adjustment was made against its balance.

**Provider**

The short name identifying the patient's treatment provider.

**Location**

The location where the treatment was completed.

**Adj Code**

The adjustment code used to adjust the resulting balance for treatment completed.

**Description**

The description of the adjustment code used to adjust the balance.

**Action**

The action of the adjustment code used to adjust the balance (whether it was to deduct a portion of the balance, transfer the balance to the patient, and so on).

**Amount**

The dollar amount that was adjusted in this transaction. The amount of any adjustment made will be shown within brackets in red color and the amount of any adjustment that has been reversed will be shown in black color.

**User's Name**

The user that completed the adjustment in the system.

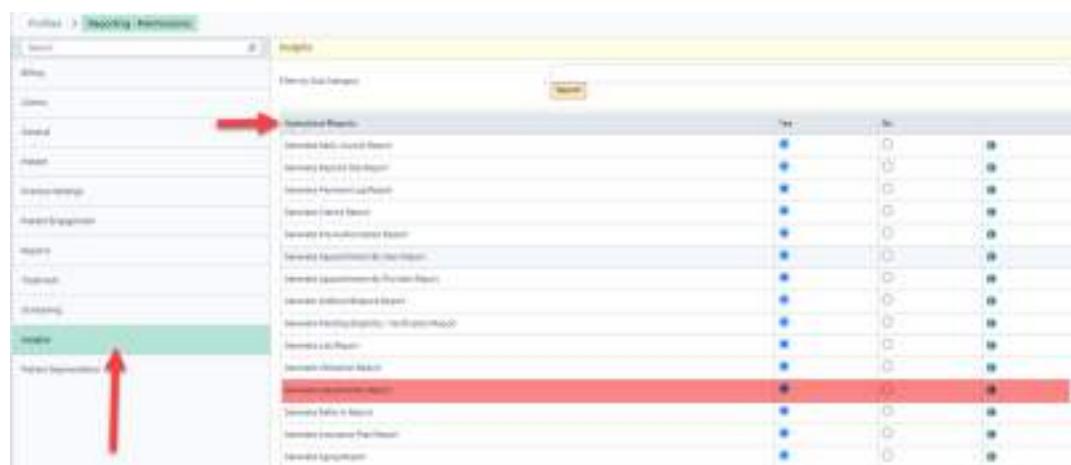
**Remarks**

Any remarks the user left regarding the transaction (if applicable).

## Permissions

---

Permissions for the Adjustments report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Adjustments Report. Only users with Generate Adjustments Report permission set as Yes will be able to generate the report.



# Refer In Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

This report is used to track the referral sources, as well as the production generated and receivables collected from patients that were created or had their first date of service in the selected time frame.

This report shows real time data and is available in two views- Summary and Detail view.

Users could group the results based on Location, Referral source or Referral Category to see the referred patients.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields*

Setting the filter criteria is important for building your report. It allows you to focus exactly on the information you need without having to wade through the information you don't.

### Summary View

For the Refer In report, your filter options include:

#### **Group By\***

The Summary View of the Refer In Report can be grouped by Location (Treatment Location for First DOS logic/Default Location for Created Date logic), Referral Category, and Referral source.

#### **Date Criteria\***

Users could choose to see referred patients based on the date of their first completed service, First DOS, or by the date in which these patient records were created in the system.

#### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the Date Criteria selection.

#### **Referral Category**

The referral sources are grouped into categories as Internal Provider(lists the practice providers), External Provider(lists the referral providers added in the system), Patient and Other Referral Sources(groups all the custom referral sources).

#### **Location\***

Based on the date criteria selection the filter lists the patient's first treatment location/default location. Up to 5 locations could be selected for onscreen report generation.

#### **Practice Provider**

This lists the internal practice providers and shows results based on the patients referred by each practice provider in the selected time range.

#### **Specialty**

This filter helps to filter out internal providers based on specialty.

#### **Referral Provider**

This lists the external referral providers and shows results based on the patients referred by each external provider in the selected time range.

#### **Referral Patient**

This lists the patients in the system and shows results based on the patients that referred in these new patients into the practice.

## **Other Referral Sources**

This lists all the custom-added referral sources in the system.

### **Referred Patient Flag**

This helps to filter out referred patients based on the selected patient flags.

## **Detail View**

For the Refer In Detail View report, your filter options include:

### **Date Criteria\***

Users could choose to see referred patients based on the date of their first completed service, First DOS, or by the date in which these patient records were created in the system.

### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the Date Criteria selection.

### **Referral Category**

The referral category of the referred-in patient; whether they were referred by an internal or external provider, another patient, or some other referral source.

### **Location\***

Based on the date criteria selection the filter lists the patient's first treatment location/default location. Up to 5 locations could be selected for onscreen report generation.

### **Practice Provider**

This lists the internal practice providers and shows results based on the patients referred by each practice provider in the selected time range.

### **Specialty**

This filter helps to filter out internal providers based on specialty.

### **Referral Provider**

This lists the external referral providers and shows results based on the patients referred by each external provider in the selected time range.

### **Referral Patient**

This lists the patients in the system and shows results based on the patients that referred in these new patients into the practice.

## **Other Referral Sources**

This lists all the custom-added referral sources in the system.

### **Referred Patient Flag**

This helps to filter out referred patients based on the selected patient flags.

### **Columns\***

This helps users to choose the relevant columns to be listed in the detailed view. Users could now select the necessary columns and print the report as per the need.

## **Sorting**

---

The default sorting for Refer In report will be by Date of Service (Asc) for past date and Appt date (asc) for future dates. Created Date, First DOS, Last Visit, Gross Production (DOS).

## **Results**

---

### **Summary View Report**

The report provides information that could be pivoted based on Location, Referral Category and Referral Source.

The first screenshot shows a summary row with columns for Location, Referral Category, Referral Source, and Gross Production(DOS). The second screenshot shows a detailed view of the data with rows for individual patients and columns for various demographic and production details.

The results appear based on the pivots and the order of pivots selected.

**In the image, the pivot is by Location first, followed by referral category and then referral source.**

The result columns shown in this report include:

#### **Location**

In the First DOS mode, this shows the treatment location in which the referred patient had the first DOS. In the Created date mode, it shows the default location of the patient.

#### **Referral Category**

The referral sources are grouped into categories as Internal Provider(lists the practice providers), External Provider(lists the referral providers added in the system), Patient and Other Referral Sources(groups all the custom referral sources).

#### **Referral Source**

It shows the referral source that referred the patient.

#### **Address**

This shows the address of the referred patient.

#### **Email**

This shows the email id of the referred patient.

#### **Phone**

This shows the phone number of the referred patient.

#### **Mobile**

This shows the mobile number of the referred patient.

#### **Specialty**

It shows the specialty of the internal provider who referred the patient.

#### **Patients**

It shows the count of referred patients having the same location, referral source, or referral category. On clicking this field the users are navigated to a detailed list of referred patients belonging to that pivot group.

#### **Gross Production(DOS)**

This shows the total lifetime production made by the patient.

#### **Prod/Pat**

This represents the average production made based on the referred patient pivot group.

## Detail View Report

Referrals by Referrer											Address	
Patient ID	Patient Name	Created Date	First DOS	Last DOS	Gross Production(DOS)	Location	Referral Category	Material Source	Phone Number	Street	Address	
123456789	Clarke, Jason	01/01/2021			1000	Other ReferralSource	HealthFair	1800-123-4567	clarkej@healthfair.com	12345	12345, Somewhere, Thornton, CO, 80233	
123456789	Patel, Utsav	02/01/2021			1000	Other ReferralSource	Forrest			12345	12345, Somewhere, Thornton, CO, 80233	
123456789	Wong, David	03/01/2021			1000	Other ReferralSource	Digital Health			12345	12345, Somewhere, Thornton, CO, 80233	

The result columns shown in this report include:

### Patient ID

The system-assigned number used to identify this patient and their records. On clicking the ID, the user is navigated to the patient's overview page.

### Patient Name

The name of the referred patient who had the first DOS or created date in the selected time range.

### Created Date

The date on which the patient record was created in the system.

### First DOS

The date on which the patient completed the first DOS.

### Last DOS

The date on which the patient completed their last DOS as of the current day.

### Gross Production(DOS)

The total lifetime production made by the referred patient to the practice.

### Location

For First DOS logic this represents the treatment location of the first visit and for created date logic, it represents the default location of the patient.

### Referral Category

The referral sources are grouped into categories as Internal Provider(lists the practice providers), External Provider(lists the referral providers added in the system), Patient and Other Referral Sources(groups all the custom referral sources).

### Referral Source

It shows the referral source that referred the patient.

### Phone No

The patient's phone number.

### Email

This shows the email id of the referred patient.

### Address

The address of the new patient in context.

## Use Cases

This report helps to find the following details of every new patient:

- This report is used to track the referral sources of the patient who visited the practice.
- This report helps to track the production that the referred patient brought in. This could be seen grouped by referral source.

## Permissions

Permissions for the Refer In report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Refer In Report. Only users with **Generate Refer In Report** permission set as Yes will be able to generate the report.

The screenshot shows a software interface titled "Reporting Permissions". On the left, there is a sidebar with categories: Billing, Claims, General, Patient, Practice-Specific, Patient-Registration, Reports, Treatment, Unbilling, Insights, and Patient-Registration. The "Insights" category is highlighted with a green background and has a red arrow pointing down to it from the bottom of the sidebar. The main area is titled "Insights" and contains a table with rows of permissions. The table has columns for "Filter by SubCategory", "Search", and three checkboxes: "Yes", "No", and "Not Set". One row, "Generate Refer In Report", is highlighted with a red background and has all three checkboxes checked ("Yes", "No", and "Not Set"). Other rows include "Generate-Account-Balance-Report", "Generate-Individual-Balance-Report", "Generate-Payment-Digitizer-Verification-Report", "Generate-Lab-Report", "Generate-Off-Campus-Report", "Generate-Subscriptions-Report", "Generate-Refer-In-Report", "Generate-Invoiced-Print-Report", "Generate-Aging-Report", "Generate-Statement-of-Accrual-Report", "Generate-Procedure-Extra-Detail-Report", and "Generate-Showing-Transactions-Report".

Filter by SubCategory	Search	Yes	No	Not Set
Generate-Account-Balance-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Individual-Balance-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Payment-Digitizer-Verification-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Lab-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Off-Campus-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Subscriptions-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Generate-Refer-In-Report</b>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Invoiced-Print-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Aging-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Statement-of-Accrual-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Procedure-Extra-Detail-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Generate-Showing-Transactions-Report		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

# New Patient Report

Written by Abhishek Vijay | Last published at: August 23, 2021

## Overview

The new patient report provides insights about the new patients that visit the practice or are scheduled to visit the practice, with a future appointment on their schedule. For past dates, users could group the report based on provider and location to get a list of patients and the production contributed by these new patients that visited each provider/location. For future days, users could check the new patients and their scheduled production for an upcoming appointment, thereby allowing practices to keep track of the prospective new patients that are incoming.

This report shows real time data and is available in two views - Summary and Detail view.

### New Patient Code Configuration

Practices could configure codes that they would complete during any new patient's visit as new patient codes through a service request. The 2 modes include:

1. any code logic- This means a new patient visit is marked/identified by the patient completing any code, as the very first code completion in the account.
2. specific code- This means a new patient visit is marked/identified by the patient completing specific code(s) and any other code completion would not be considered as a first new patient visit.

#### For Past Dates:

The summary view shows the total count of new patients, their first visit production and shows if those new patients, that visited in the past, have a future appointment (Scheduled Patients) or not (Unscheduled Patients). The users have the flexibility to view the report by the Treatment Provider or by Treatment Location based on the first DOS against which the new patient visit is marked. The detail view shows the patient level drill-down of each new patient including details like patient details, RP details, referral source, first and next appointment details.

#### For Future Dates:

The summary view shows the total count of new patients that are scheduled for a future appointment and the scheduled production. The users have the flexibility to view the report by the Primary Appointment Provider or by the Appointment Location. The detail view shows the patient level drill-down of each new patient including details like patient details, RP details, referral source, first and next appointment details.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria is important for building your report. It allows you to focus exactly on the information you need without having to wade through the information you don't.

### Summary View

For the New Patient report, your filter options include:

#### Group By\*

The Summary view of the New Patient Report can be grouped by the Treatment Provider/Treatment Location (for past days) or by Primary Appointment Provider/Appointment Location (for future dates).

#### Date Type\*

Users could choose to see new patients that visited the practice on a past day or could see prospective new patients scheduled for a future date. For the past date, the report is dated by the Date of Service (DOS) and filters new patients with their first DOS in the selected date range, in the past. For the future date, the report is dated by the Appointment Date and filters prospective new patients who have their first visit scheduled based on their appointment in future. This is irrespective of the New Patient Code Configuration.

#### Dates\*

The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day. This works based on the Date Type selection.

#### Location\*

For past dates- Select a location or locations to focus the report based on the treatment location of the new patients, in the selected locations.

For future dates- Select a location or locations to focus the report based on the appointment location of the prospective new patients, in the selected locations.

#### **Provider**

For past dates- Select a provider or providers to focus the report with the selected provider(s) as the treatment provider.

For future dates- Select a provider or providers to focus the report on new patient appointments with the selected provider(s) as primary appointment provider.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Patient**

Choose to focus the report based on the selected patients.

### **Detail View**

For the New Patient Detail View report, your filter options include:

#### **Date Type\***

Users could choose to see new patients that visited the practice on a past day or could see prospective new patients scheduled for a future date. For the past date, the report is dated by the Date of Service (DOS) and filters new patients with their first DOS in the selected date range, in the past. For the future date, the report is dated by the Appointment Date and filters prospective new patients who have their first visit scheduled based on their appointment in future. This is irrespective of the New Patient Code Configuration.

#### **Dates\***

The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day. This works based on the Date Type selection.

#### **Location\***

For past dates- Select a location or locations to focus the report based on the treatment location of the new patients, in the selected locations.

For future dates- Select a location or locations to focus the report based on the appointment location of the prospective new patients, in the selected locations.

#### **Provider**

For past dates- Select a provider or providers to focus the report with the selected provider(s) as the treatment provider.

For future dates- Select a provider or providers to focus the report on new patient appointments with the selected provider(s) as primary appointment provider.

#### **Patient Type**

This helps to filter out patients based on their patient type, i.e, General and Ortho.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Patient**

Choose to focus the report based on the selected patients.

#### **Columns\***

This helps users to choose the relevant columns to be listed in the detailed view. Users could now select the necessary columns and print the report as per the need.

### **Sorting**

---

The default sorting for the New Patient report will be by Date of Service (Asc) for past date and Appt date (asc) for future dates.

# Results

## Summary View Report

The report provides information grouped either by Provider or Location, based on selection. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.



New Patient Summary / Locations : All Providers : All Patient Flags : All Patients : 08/01/2011 - 08/01/2011					
Consolidated Total:					
Patient Type	Sched Pat	Unsched Pat	Total Pat	First Visit Prod.	Next Appt. Sched. Prod.
General	0	0	0	\$1,081.00	\$0.00
<b>Grand Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$1,081.00</b>	<b>\$0.00</b>

Location Detail First Visit(HCPCS)					
Patient Type	Sched Pat	Unsched Pat	Total Pat	First Visit Prod.	Next Appt. Sched. Prod.
General	0	0	0	\$1,081.00	\$0.00
<b>Grand Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$1,081.00</b>	<b>\$0.00</b>

Location Detail Next Month(HCPCS)					
Patient Type	Sched Pat	Unsched Pat	Total Pat	First Visit Prod.	Next Appt. Sched. Prod.
General	0	0	0	\$1,081.00	\$0.00
<b>Grand Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$1,081.00</b>	<b>\$0.00</b>

A consolidated total at the top of the report shows the total of new patients spread across each location or provider. The grouping of results is based on 'Group By' selection.

**In the image, it is grouped by Location.**

The result columns shown in this report include:

### Patient Type

Lists patients based on the patient type as General and Ortho.

### Sched Pat

This shows, out of the total new patients that were seen in the selected location/provider, how many of the patients have a scheduled future appointment (with respect to the current date).

### Unsched Pat

This shows, out of the total new patients that were seen in the selected location/provider, how many of the patients do not have a scheduled future appointment (with respect to the current date). Since all the new patients in the future date type are based on the new patient appointment, this count would be zero for the future date.

### Total Pat

The number of new patients based on the selected filters.

### First Visit Production

This shows the total production of the new patient's first visit. Since patients appearing in this report are yet to have their first visit for future dates, this value would be zero for future date type.

### Next Appt. Sched. Prod

This shows the total production linked to the very next appointment scheduled for the new patient, in the future.

## Detail View Report

*(Past Date)*

Key Financial Measures (US\$'000) as of December 31, 2018											
Period	Revenue	Net Income	EPS	EBITDA	EBIT	Net Cash Flow	Capital Expenditure	Dividends Paid	Free Cash Flow	Interest Coverage	Debt-to-Equity Ratio
Year-to-Date	\$1,234,567	\$234,567	\$0.56	\$345,678	\$123,456	\$123,456	\$123,456	\$123,456	\$123,456	4.5x	1.2x
Q4	\$312,345	\$56,789	\$0.15	\$87,654	\$31,234	\$31,234	\$31,234	\$31,234	\$31,234	4.5x	1.2x
Q3	\$312,345	\$56,789	\$0.15	\$87,654	\$31,234	\$31,234	\$31,234	\$31,234	\$31,234	4.5x	1.2x
Q2	\$312,345	\$56,789	\$0.15	\$87,654	\$31,234	\$31,234	\$31,234	\$31,234	\$31,234	4.5x	1.2x
Q1	\$312,345	\$56,789	\$0.15	\$87,654	\$31,234	\$31,234	\$31,234	\$31,234	\$31,234	4.5x	1.2x

*(Future Date)*

The result columns shown in this report include:

**Patient ID**

The system-assigned number used to identify this patient and their records. On clicking the ID, the user is navigated to the patient's overview page.

**Patient Name**

The name of the new patient seen(past logic) or scheduled for a visit(future).

### Patient Type

The type of new patient profile- this could be General or Ortho.

## Address

### The address of the new patient in context

**Phone No**

The patient's phone number

## **Responsible Party**

The name of the responsible party of the new patient. If the patient is self-responsible, it shows his/her name

## Location

The treatment location of the past visit or the appointment location of the new patient's future appointment

Provider

The treatment provider of the past visit or the primary appointment provider of the new patient's future appointment

#### **Referral Sources**

Represents the referral source of the new patient who visited the practice.

### **First Rate of Melt**

This is the first DOS of the new patient based on the New patient code configuration. For future dates, this field would be blank because the prospective new patient is yet to visit the practice.

First Visit Record

The total production created due to the first new patient visit. For future dates, this field would be blank because the prospective new patient is yet to visit the practice.

#### Prod. Type of First Appt

The production type of the appointment in which the new patient visit was made. For cases where new patient codes are completed without the code being linked to an appointment, this would be blank. For future dates, this field would be blank because the prospective new patient is yet to visit the practice.

#### Last Date of Visit

The latest DOS in which the patient visited the practice for a checkout. This could be the checked-out date due to any code completion.

#### Next Appt. Date

The appointment date of the very next scheduled appointment.

#### Next Appt. Status

The appointment status of the very next scheduled appointment.

#### Next Appt. Sched. Prod

The total scheduled production from codes, added in the very next scheduled appointment.

#### Next Appt. Prod. Type

The production type of the very next scheduled appointment.

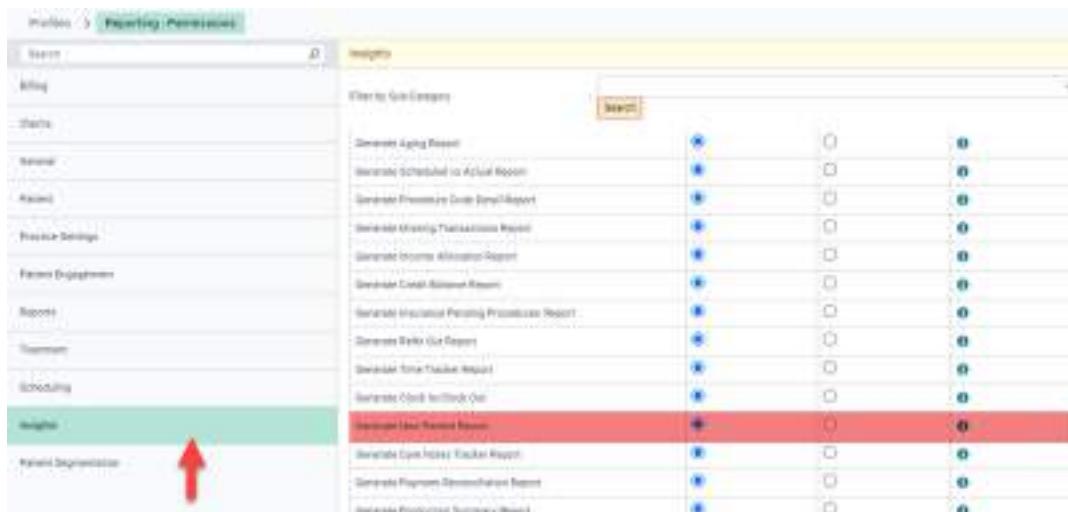
## Use Cases

This report helps to find the following details of every new patient:

- Count of new patient visits/ scheduled visits
- First visit production created
- Prospective new patient production scheduled
- Referral source of each new patient
- The next scheduled appointment of the new patient

## Permissions

Permissions for the New Patient report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate New Patient Report. Only users with Generate New Patient Report permission set as Yes will be able to generate the report.





# Procedures Report

Written by Abhishek Vijay | Last published at: August 23, 2021

## Overview

This report is used to view procedure code statuses and other details like number of unscheduled/ scheduled codes, the fee details associated with the code, etc. This report can be used to track the list of unscheduled/ scheduled codes and can also be used to track the list of codes that was changed to a code status on the selected time range. This report shows real-time data and is available in two views- Summary View and Detail View.

The Procedures report summary view shows the number of all codes that had a status change in the selected date range against their current status. The summary view shows the number of codes that are in each code status grouped under three groups - Scheduled (linked) to an appointment, Unscheduled, and Grand total (sum of scheduled and unscheduled).

The detail view shows the details of each code like the patient name the code is added to, the Tx provider, Tx location, the schedule status, appt date if scheduled, and fee details.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary View

For the Procedures Summary View report, your filter options include:

#### Dates\*

The procedures report is dated by status change date. Select a date range to focus your report on procedure codes that have had their status changed within the selected date range. The date range can be selected for a maximum of 3 months. By default, the date range will be for the current day.

#### Location\*

Select a location or locations to focus the report on the codes with treatment location in the selected location(s). By default, the location will be the user's default location.

#### Provider Type\*

Select a provider type to focus your report on the treatment provider type of the code. You can choose between Dentist, Hygienist, in-house, or All. By default, All is selected.

#### Provider

Select a provider or providers to focus the report on procedure codes with the selected provider(s) as treatment provider.

#### Status Last Changed To

Select statuses to focus your report-based procedure codes that last had the selected status(es) within the selected date range, whether it was previously in the Proposed, Accepted, Scheduled statuses or so on.

#### Current Status

Select statuses to focus your report based on procedure codes with the selected status(es) as the current status, whether the status is now Accepted, Scheduled, Rejected, or so on.

#### Code

Select codes to focus your report based on the selected procedure codes.

#### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

## Patient

Choose to focus the report based on the selected patients.

### UCR\*

Specify whether to generate data based on procedure codes that have a UCR fee "less than" "greater than" "equal to" (and so on) than your specified dollar amount. By default, greater than or equal to \$0 is selected.

### Total Est.\*

Specify whether to generate data based on procedure codes with a total estimated production of "less than" "greater than" "equal to" (and so on) than your specified dollar amount (including both patient and insurance amounts). By default, greater than or equal to \$0 is selected.

## Detail View

For the Procedures Detail View report, your filter options include:

### Dates\*

The procedures report is dated by status change date. Select a date range to focus your report on procedure codes that have had their status changed within the selected date range. The date range can be selected for a maximum of 3 months. By default, the date range will be for the current day.

### Location\*

Select a location or locations to focus the report on the codes with treatment location in the selected location(s). By default, the location will be the user's default location.

### Provider Type\*

Select a provider type to focus your report on the treatment provider type of the code. You can choose between Dentist, Hygienist, in-house, or All. By default, All is selected.

### Provider

Select a provider or providers to focus the report on procedure codes with the selected provider(s) as treatment provider.

### Status Last Changed To

Select statuses to focus your report-based procedure codes that last had the selected status(es) within the selected date range, whether it was previously in the Proposed, Accepted, Scheduled statuses or so on.

### Current Status

Select statuses to focus your report based on procedure codes with the selected status(es) as the current status, whether the status is now Accepted, Scheduled, Rejected, or so on.

### Scheduled Status\*

Select status to focus your report based on procedure codes that are scheduled (linked) or unscheduled to an appointment. By default, All is selected.

### Code

Select codes to focus your report based on the selected procedure codes.

### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

## Patient

Choose to focus the report based on the selected patients.

### UCR\*

Specify whether to generate data based on procedure codes that have a UCR fee "less than" "greater than" "equal to" (and so on) than your specified dollar amount. By default, greater than or equal to \$0 is selected.

### Total Est.\*

Specify whether to generate data based on procedure codes with a total estimated production of "less than" "greater than" "equal to" (and so on) than your specified dollar amount (including both patient and insurance amounts). By default, greater than or equal to \$0 is selected.

## Sorting

The default sorting for the Procedures report will be by Status Change Date (desc). Sorting is possible on Status Change Date, Appt Date, UCR Fee, Est Pat, Est Ins, and Est. Fee columns as well.

## Results

### Summary View Report

The report provides information in column form grouped by each location selected. The first group would be consolidated total if more than one location is selected and there are codes in at least two locations. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

The screenshot displays two tables of data from a 'Summary View Report'. The top table is titled 'Procedure Status' and has columns for 'Current Status', '#Procedures', 'UCR', 'Total Est.', 'Unscheduled', 'Scheduled', 'Est. Pat', 'Est. Ins', and 'Grand Total'. The bottom table is titled 'Detail' and has similar columns. Both tables include rows for 'All Codes', 'Unscheduled', 'Scheduled', and 'Grand Total'. The 'Grand Total' row for the top table is highlighted in yellow. The 'Unscheduled' and 'Scheduled' rows for the bottom table are also highlighted in yellow. The 'Detail' table shows detailed breakdowns for each status category.

Procedure Status									
Current Status	#Procedures	UCR	Total Est.	Unscheduled	Scheduled	Est. Pat	Est. Ins	Grand Total	
All Codes	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Unscheduled	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Scheduled	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
None	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Planned	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Completed	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
<b>Total</b>	<b>0</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>0</b>	<b>0</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>
Detail									
Current Status	#Procedures	UCR	Total Est.	Unscheduled	Scheduled	Est. Pat	Est. Ins	Grand Total	
All Codes	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Unscheduled	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Scheduled	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
None	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Planned	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
Completed	0	\$0.00	\$0.00	0	0	\$0.00	\$0.00	0	\$0.00
<b>Total</b>	<b>0</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>0</b>	<b>0</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>

The results columns shown in this report include:

#### Current Status

The current status of the procedure code.

#### #Procedures

The number of procedure codes in this status.

#### #Patients

The number of patients that have this procedure codes in this status in their treatment plan.

#### UCR

The UCR amount calculated from these procedure codes based on your office's standard fees.

#### Total Est.

The total receivable estimated for procedure codes in this status.

The Scheduled column includes the procedure codes that are linked to an appointment. The Unscheduled column includes the procedures codes that are not linked to any appointment.

The Grand Total column includes all procedure codes (codes that are scheduled and unscheduled). The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these appointments and their details.

### Detail View Report

Procedure Status Overview - All Codes   Previous Types: All   All Patients: All   All Current Status: All Current Status   All Codes   Individual Status - All   All Patients Page   All Patients   All Rows   Total Rows: 0   Last Run: 09/09/2024 - 09:59:39 AM													
Patient Name	Patient ID	Code Description	Current Status	Status Last Changed To	Status Change Date	Schedule Status	Provider	Location	Appt. Date	UCR Fee	Est. Pat	Est. Ins	Est. Prod
Smith, John, Jr.	11111111	12345 - Frown Face	In Progress	In Progress	2024-09-01	Scheduled	Dr. Smith	Office	2024-09-01	\$125.00	100.00	100.00	
Johnson, Jennifer	22222222	56789 - Frown Face	In Progress	In Progress	2024-09-01	Scheduled	Dr. Johnson	Office	2024-09-01	\$125.00	100.00	100.00	
Doe, David	33333333	98765 - Frown Face	In Progress	In Progress	2024-09-01	Scheduled	Dr. Doe	Office	2024-09-01	\$125.00	100.00	100.00	
(1) Patient	11111111	12345 - Angry Eye	In Progress	In Progress	2024-09-01	Unscheduled	None	None	2024-09-01	\$125.00	100.00	100.00	
(2) Patient	22222222	56789 - Current Cold	In Progress	In Progress	2024-09-01	Unscheduled	None	None	2024-09-01	\$125.00	100.00	100.00	
(3) Patient	33333333	98765 - Frowny Face	In Progress	In Progress	2024-09-01	Scheduled	None	None	2024-09-01	\$125.00	100.00	100.00	

The results columns shown in this report include:

#### Patient Name

The name of the patient that has this procedure code in their treatment plan.

#### Patient ID

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the advanced planner page of the patient.

#### Code- Description

The name of the procedure code and its description.

#### Current Status

The current status of the procedure code.

#### Status Last Changed To

The last status the procedure code was changed to within the selected time range.

#### Status Change Date

The date the code status was changed.

#### Schedule Status

This column indicates whether this code is linked to an appointment-scheduled or if not linked to an appointment- unscheduled.

#### Provider

The treatment provider of the listed procedure code.

#### Location

The treatment provider of the listed procedure code.

#### Appt. Date

The date the treatment is or was scheduled.

#### UCR Fee

The office's standard fee for this procedure code according to your practice settings.

#### Est. Pat

The estimated patient receivable.

#### Est. Ins

The estimated insurance receivable.

#### Est. Fee

The estimated total production for this procedure code.

## Use Cases

Procedures reports are intended to show procedure codes that have had a status change in the selected time range. This report can be used

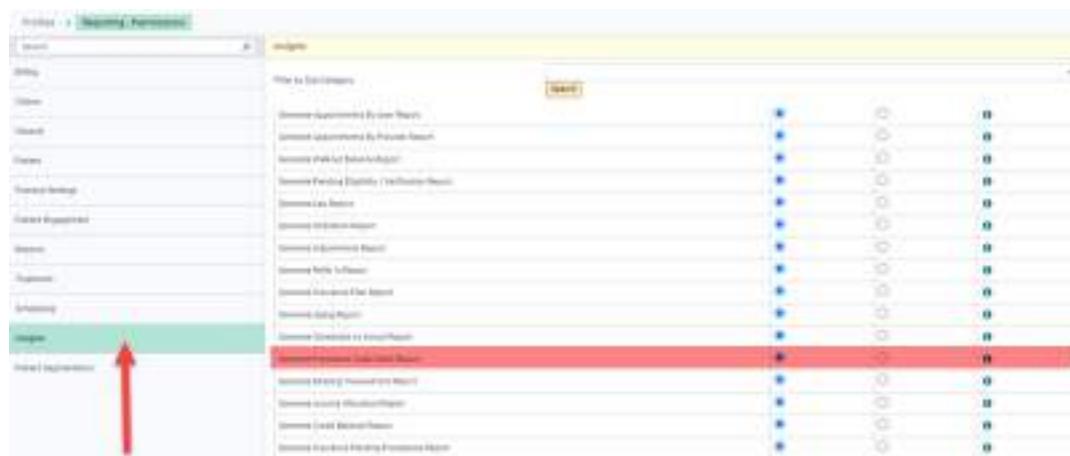
- To see the number of codes
    - that had a status change in the selected date range and their current status.
    - that had a status change in the selected date range and their schedule status.
  - To see the codes that had a status change in the selected date range and that are charged above UCR.
  - To see all the codes that had a status change on any given day.
  - To see the fee, provider, location, schedule status and appt details for the codes.

## Special Cases

1. The procedures report shows procedure codes if they had a status change in the given date range.
  2. If there was multiple status changes that happened in the selected date range, the last status it was changed to in the date range and that status change date will be shown in the report.
  3. The summary view shows the current status of the procedure codes which had a status change in the selected date range. If the procedure code did not have a status change in the selected date range, that code will not be shown in this report.

## Permissions

Permissions for the Procedures report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Procedure Code Detail Report. Only users with **Generate Procedure Code Detail Report** permission set as Yes will be able to generate the report.



# Credit Balance Report

Written by Aaqib Mohammed Sali | Last published at: August 22, 2021

## Credit Balance Report

The Credit Balance Report is used to find the unapplied credits in the practice. This report can be used to identify all patients with remaining credit amounts and have outstanding balances.

This report shows real-time data. The Credit Balance report is available in two views- Summary and Detail view.

The Summary view shows the total Unapplied Credits for each location selected is shown with the aging of credits in each aging bucket. The Detail view shows the Total Unapplied Credit amount of each patient of the selected filter and gives more information like Patient's name, Responsible Party's Name, Advance Payments, Account Outstanding, etc.

### Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria is important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

#### Summary View:

For the Credit Balance Summary View Report, your filter options include:

##### **Day\***

This report is dated by the Transaction date of the receipt. By default, the date will be for the current day. The report will show the aging of credits that have been added until the specified day.

##### **Group Credits By\***

Choose whether to Group Credits By 'Receipt Location' (set as default) and 'Default Location'. When the selection is the default location, all credits from receipts added in different locations would be grouped under the default location and shown. Only one entry would be created corresponding to the patient and the aging of credits would be put in each bucket in that single entry. When the selection is receipt location, it would show the unapplied credits added from each receipt location as a separate entry.

##### **Location\***

Focus the report on receipts added from the selected locations if group by receipt location is chosen or focus the report on generated at the selected location(s).

##### **Aging Bucket\***

Choose whether to generate data based on credit that has been aging. You can choose the Aging Bucket as either Till 120 or Till 180. By default, the Aging Bucket will be the Till 120.

##### **Ind Outst.\***

Filter the report by the patients that have the individual net balance outstanding, regardless of the entire account's balance. Specify whether to generate data based on Individual Outstanding amount of "less than" "greater than" "equal to" (and so on) than your specified dollar amount. By default, greater than equal to \$0 is selected.

##### **Patient Unapplied\***

Filter the report by the patients that have the individual patient unapplied, regardless of the entire account's unapplied. Specify whether to generate data based on Patient Unapplied with a total amount of "less than" "greater than" "equal to" (and so on) than your specified dollar amount. By default, greater than \$0 is selected.

#### Detail View:

For the Credit Balance Detail View Report, your filter options include:

##### **Day\***

This report is dated by the Transaction date of the receipt. By default, the date will be for the current day. The report will show the aging of credits that have been added until the specified day.

##### **Group Credits By\***

Choose whether to Group Credits By 'Receipt Location' (set as default) and 'Default Location'. When the selection is the default location, all credits from receipts added in different locations would be grouped under the default location and shown. Only one entry would be created corresponding to the patient and the aging of credits would be put in each bucket in that single entry. When the selection is receipt location, it would show the unapplied credits added from each receipt location as a separate entry.

#### Location\*

Focus the report on receipts added from the selected locations if group by receipt location is chosen or focus the report on generated at the selected location(s).

#### Aging Bucket\*

Choose whether to generate data based on credit that has been aging. You can choose the Aging Bucket as either Till 120 or Till 180. By default, the Aging Bucket will be the Till 120.

#### Patient Flag

Select a Patient Flag or flag to focus the report only on patients that have the patient flag associated with the profile. These flags are determined and customized by each practice. Leave the option All to find credit balances for all patients, regardless of their flags.

#### Patient Type\*

Leave this option as All to include all types of patients in the report or choose either the Orthodontic or General type to narrow the report to one patient type. By default, the Patient Type will be the All.

#### Patient

Search for and select a patient or patients to focus the report only on the balances for a specific patient or patient(s).

#### Responsible Party

Search for and select a responsible party to focus the report only on the balances for a specific responsible party or party(s).

#### Ind Outst.\*

Filter the report by the patients that have the individual net balance outstanding, regardless of the entire account's balance. Specify whether to generate data based on Individual Outstanding amount of "less than" "greater than" "equal to" (and so on) than your specified dollar amount. By default, greater than equal to \$0 is selected.

#### Account Outstanding\*

Type a dollar value to represent the lowest amount of outstanding account balance you want to be included in the report. Leave the amount as \$0.00 to include all balances. Specify whether to generate data based on Account Outstanding amount of "less than" "greater than" "equal to" (and so on) than your specified dollar amount. By default, greater than equal to \$0 is selected.

#### Patient Unapplied\*

Filter the report by the patients that have the individual patient unapplied, regardless of the entire account's unapplied. Specify whether to generate data based on Patient Unapplied with a total amount of "less than" "greater than" "equal to" (and so on) than your specified dollar amount. By default, greater than \$0 is selected.

#### Columns\*

Choose the columns you wish to see in this report. By default, all the columns will be selected.

## Sorting

The default sorting for the Credit Balance report will be by Total Unapplied Credits.

## Results

### Summary View Report

The report provides information in column form grouped by location as selected. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

(Aging Bucket - Till 120)

Credit Balance Summary / Total Unapplied Credits						
Location	0-99	100-999	1000-9999	10K-120K	Over 120K	Total Unapplied Credits
TOTAL	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
PAEDIATRIC	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
ORTHODONTIC	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

(Aging Bucket - Till 180)

Credit Balance Assessment - Unapplied Patient Unapplied Credits by Location									
Category	0-30	31-60	61-90	91-120	121-150	151-180	Total	Unapplied Credits	Responsible Party
0-30	\$1,200.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,200.00	\$1,200.00	Location 1
31-60	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Location 2
61-90	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Location 3
91-120	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Location 4
Total	\$1,200.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,200.00	\$1,200.00	

The results columns shown in this report include:

#### Location

Selected Location as per the selection you made in Group Credits by. The blue-colored entries are links to the detailed view of the corresponding Location entry. Click the hyperlinks to view a Detail Report listing all the credits and their details.

#### 0-30

The dollar amount of unapplied credits that have remained unapplied for 30 days or less.

#### 31-60

The dollar amount of unapplied credits that have remained unapplied for at least 31 to 60 days

#### 61-90

The dollar amount of unapplied credits that have remained unapplied for at least 61 to 90 days

#### 91-120

The dollar amount of unapplied credits that have remained unapplied for at least 91 to 120 days

#### 121-150

The dollar amount of unapplied credits that have remained unapplied for at least 121 to 150 days

#### 151-180

The dollar amount of unapplied credits that have remained unapplied for at least 151 to 180 days

#### Total Patient Unapplied Credits

The total of all unapplied credits remaining for all Patients on the selected Location.

The report also has a totals row "Total" that shows the consolidated total dollar amount of unapplied credits in each aging bucket and the total unapplied credits over all of the locations selected.

#### Detail View Report

Patient Unapplied Credit Detail Report									
Patient ID	Patient Name	DOB	Gender	SSN	Responsible Party	Resp Party ID	Indiv Outst	Location	Balance Due
PAT1	John Doe	1985-01-01	M	123-45-6789	John Doe	1234567890	\$0.00	Location 1	\$0.00
PAT2	Jane Doe	1985-01-01	F	123-45-6789	Jane Doe	1234567890	\$0.00	Location 2	\$0.00
PAT3	John Smith	1985-01-01	M	123-45-6789	John Smith	1234567890	\$0.00	Location 3	\$0.00
PAT4	Jane Smith	1985-01-01	F	123-45-6789	Jane Smith	1234567890	\$0.00	Location 4	\$0.00
PAT5	John Johnson	1985-01-01	M	123-45-6789	John Johnson	1234567890	\$0.00	Location 5	\$0.00
PAT6	Jane Johnson	1985-01-01	F	123-45-6789	Jane Johnson	1234567890	\$0.00	Location 6	\$0.00
PAT7	John Williams	1985-01-01	M	123-45-6789	John Williams	1234567890	\$0.00	Location 7	\$0.00
PAT8	Jane Williams	1985-01-01	F	123-45-6789	Jane Williams	1234567890	\$0.00	Location 8	\$0.00
PAT9	John Brown	1985-01-01	M	123-45-6789	John Brown	1234567890	\$0.00	Location 9	\$0.00
PAT10	Jane Brown	1985-01-01	F	123-45-6789	Jane Brown	1234567890	\$0.00	Location 10	\$0.00
PAT11	John Green	1985-01-01	M	123-45-6789	John Green	1234567890	\$0.00	Location 11	\$0.00
PAT12	Jane Green	1985-01-01	F	123-45-6789	Jane Green	1234567890	\$0.00	Location 12	\$0.00
PAT13	John White	1985-01-01	M	123-45-6789	John White	1234567890	\$0.00	Location 13	\$0.00
PAT14	Jane White	1985-01-01	F	123-45-6789	Jane White	1234567890	\$0.00	Location 14	\$0.00
PAT15	John Black	1985-01-01	M	123-45-6789	John Black	1234567890	\$0.00	Location 15	\$0.00
PAT16	Jane Black	1985-01-01	F	123-45-6789	Jane Black	1234567890	\$0.00	Location 16	\$0.00
PAT17	John Lee	1985-01-01	M	123-45-6789	John Lee	1234567890	\$0.00	Location 17	\$0.00
PAT18	Jane Lee	1985-01-01	F	123-45-6789	Jane Lee	1234567890	\$0.00	Location 18	\$0.00
PAT19	John Clark	1985-01-01	M	123-45-6789	John Clark	1234567890	\$0.00	Location 19	\$0.00
PAT20	Jane Clark	1985-01-01	F	123-45-6789	Jane Clark	1234567890	\$0.00	Location 20	\$0.00
PAT21	John Taylor	1985-01-01	M	123-45-6789	John Taylor	1234567890	\$0.00	Location 21	\$0.00
PAT22	Jane Taylor	1985-01-01	F	123-45-6789	Jane Taylor	1234567890	\$0.00	Location 22	\$0.00
PAT23	John Davis	1985-01-01	M	123-45-6789	John Davis	1234567890	\$0.00	Location 23	\$0.00
PAT24	Jane Davis	1985-01-01	F	123-45-6789	Jane Davis	1234567890	\$0.00	Location 24	\$0.00
PAT25	John Wilson	1985-01-01	M	123-45-6789	John Wilson	1234567890	\$0.00	Location 25	\$0.00
PAT26	Jane Wilson	1985-01-01	F	123-45-6789	Jane Wilson	1234567890	\$0.00	Location 26	\$0.00
PAT27	John Jones	1985-01-01	M	123-45-6789	John Jones	1234567890	\$0.00	Location 27	\$0.00
PAT28	Jane Jones	1985-01-01	F	123-45-6789	Jane Jones	1234567890	\$0.00	Location 28	\$0.00
PAT29	John Smith	1985-01-01	M	123-45-6789	John Smith	1234567890	\$0.00	Location 29	\$0.00
PAT30	Jane Smith	1985-01-01	F	123-45-6789	Jane Smith	1234567890	\$0.00	Location 30	\$0.00
PAT31	John Williams	1985-01-01	M	123-45-6789	John Williams	1234567890	\$0.00	Location 31	\$0.00
PAT32	Jane Williams	1985-01-01	F	123-45-6789	Jane Williams	1234567890	\$0.00	Location 32	\$0.00
PAT33	John Brown	1985-01-01	M	123-45-6789	John Brown	1234567890	\$0.00	Location 33	\$0.00
PAT34	Jane Brown	1985-01-01	F	123-45-6789	Jane Brown	1234567890	\$0.00	Location 34	\$0.00
PAT35	John Green	1985-01-01	M	123-45-6789	John Green	1234567890	\$0.00	Location 35	\$0.00
PAT36	Jane Green	1985-01-01	F	123-45-6789	Jane Green	1234567890	\$0.00	Location 36	\$0.00
PAT37	John White	1985-01-01	M	123-45-6789	John White	1234567890	\$0.00	Location 37	\$0.00
PAT38	Jane White	1985-01-01	F	123-45-6789	Jane White	1234567890	\$0.00	Location 38	\$0.00
PAT39	John Black	1985-01-01	M	123-45-6789	John Black	1234567890	\$0.00	Location 39	\$0.00
PAT40	Jane Black	1985-01-01	F	123-45-6789	Jane Black	1234567890	\$0.00	Location 40	\$0.00
PAT41	John Lee	1985-01-01	M	123-45-6789	John Lee	1234567890	\$0.00	Location 41	\$0.00
PAT42	Jane Lee	1985-01-01	F	123-45-6789	Jane Lee	1234567890	\$0.00	Location 42	\$0.00
PAT43	John Clark	1985-01-01	M	123-45-6789	John Clark	1234567890	\$0.00	Location 43	\$0.00
PAT44	Jane Clark	1985-01-01	F	123-45-6789	Jane Clark	1234567890	\$0.00	Location 44	\$0.00
PAT45	John Taylor	1985-01-01	M	123-45-6789	John Taylor	1234567890	\$0.00	Location 45	\$0.00
PAT46	Jane Taylor	1985-01-01	F	123-45-6789	Jane Taylor	1234567890	\$0.00	Location 46	\$0.00
PAT47	John Davis	1985-01-01	M	123-45-6789	John Davis	1234567890	\$0.00	Location 47	\$0.00
PAT48	Jane Davis	1985-01-01	F	123-45-6789	Jane Davis	1234567890	\$0.00	Location 48	\$0.00
PAT49	John Wilson	1985-01-01	M	123-45-6789	John Wilson	1234567890	\$0.00	Location 49	\$0.00
PAT50	Jane Wilson	1985-01-01	F	123-45-6789	Jane Wilson	1234567890	\$0.00	Location 50	\$0.00
PAT51	John Smith	1985-01-01	M	123-45-6789	John Smith	1234567890	\$0.00	Location 51	\$0.00
PAT52	Jane Smith	1985-01-01	F	123-45-6789	Jane Smith	1234567890	\$0.00	Location 52	\$0.00
PAT53	John Williams	1985-01-01	M	123-45-6789	John Williams	1234567890	\$0.00	Location 53	\$0.00
PAT54	Jane Williams	1985-01-01	F	123-45-6789	Jane Williams	1234567890	\$0.00	Location 54	\$0.00
PAT55	John Brown	1985-01-01	M	123-45-6789	John Brown	1234567890	\$0.00	Location 55	\$0.00
PAT56	Jane Brown	1985-01-01	F	123-45-6789	Jane Brown	1234567890	\$0.00	Location 56	\$0.00
PAT57	John Lee	1985-01-01	M	123-45-6789	John Lee	1234567890	\$0.00	Location 57	\$0.00
PAT58	Jane Lee	1985-01-01	F	123-45-6789	Jane Lee	1234567890	\$0.00	Location 58	\$0.00
PAT59	John Clark	1985-01-01	M	123-45-6789	John Clark	1234567890	\$0.00	Location 59	\$0.00
PAT60	Jane Clark	1985-01-01	F	123-45-6789	Jane Clark	1234567890	\$0.00	Location 60	\$0.00
PAT61	John Taylor	1985-01-01	M	123-45-6789	John Taylor	1234567890	\$0.00	Location 61	\$0.00
PAT62	Jane Taylor	1985-01-01	F	123-45-6789	Jane Taylor	1234567890	\$0.00	Location 62	\$0.00
PAT63	John Davis	1985-01-01	M	123-45-6789	John Davis	1234567890	\$0.00	Location 63	\$0.00
PAT64	Jane Davis	1985-01-01	F	123-45-6789	Jane Davis	1234567890	\$0.00	Location 64	\$0.00
PAT65	John Wilson	1985-01-01	M	123-45-6789	John Wilson	1234567890	\$0.00	Location 65	\$0.00
PAT66	Jane Wilson	1985-01-01	F	123-45-6789	Jane Wilson	1234567890	\$0.00	Location 66	\$0.00
PAT67	John Smith	1985-01-01	M	123-45-6789	John Smith	1234567890	\$0.00	Location 67	\$0.00
PAT68	Jane Smith	1985-01-01	F	123-45-6789	Jane Smith	1234567890	\$0.00	Location 68	\$0.00
PAT69	John Williams	1985-01-01	M	123-45-6789	John Williams	1234567890	\$0.00	Location 69	\$0.00
PAT70	Jane Williams	1985-01-01	F	123-45-6789	Jane Williams	1234567890	\$0.00	Location 70	\$0.00
PAT71	John Brown	1985-01-01	M	123-45-6789	John Brown	1234567890	\$0.00	Location 71	\$0.00
PAT72	Jane Brown	1985-01-01	F	123-45-6789	Jane Brown	1234567890	\$0.00	Location 72	\$0.00
PAT73	John Lee	1985-01-01	M	123-45-6789	John Lee	1234567890	\$0.00	Location 73	\$0.00
PAT74	Jane Lee	1985-01-01	F	123-45-6789	Jane Lee	1234567890	\$0.00	Location 74	\$0.00
PAT75	John Clark	1985-01-01	M	123-45-6789	John Clark	1234567890	\$0.00	Location 75	\$0.00
PAT76	Jane Clark	1985-01-01	F	123-45-6789	Jane Clark	1234567890	\$0.00	Location 76	\$0.00
PAT77	John Taylor	1985-01-01	M	123-45-6789	John Taylor	1234567890	\$0.00	Location 77	\$0.00
PAT78	Jane Taylor	1985-01-01	F	123-45-6789	Jane Taylor	1234567890	\$0.00	Location 78	\$0.00
PAT79	John Davis	1985-01-01	M	123-45-6789	John Davis	1234567890	\$0.00	Location 79	\$0.00
PAT80	Jane Davis	1985-01-01	F	123-45-6789	Jane Davis	1234567890	\$0.00	Location 80	\$0.00
PAT81	John Wilson	1985-01-01	M	123-45-6789	John Wilson	1234567890	\$0.00	Location 81	\$0.00
PAT82	Jane Wilson	1985-01-01	F	123-45-6789	Jane Wilson	1234567890	\$0.00	Location 82	\$0.00
PAT83	John Smith	1985-01-01	M	123-45-6789	John Smith	1234567890	\$0.00	Location 83	\$0.00
PAT84	Jane Smith	1985-01-01	F	123-45-6789	Jane Smith	123			

### **31-60**

The outstanding dollar amount of unapplied credits that have remained unapplied for at least 31 to 60 days

### **61-90**

The outstanding dollar amount of unapplied credits that have remained unapplied for at least 61 to 90 days

### **91-120**

The outstanding dollar amount of unapplied credits that have remained unapplied for at least 91 to 120 days

### **121-150**

The outstanding dollar amount of unapplied credits that have remained unapplied for at least 121 to 150 days

### **151-180**

The outstanding dollar amount of unapplied credits that have remained unapplied for at least 151 to 180 days

### **Total Unapplied Credits**

The dollar value of the total of all credits for the particular patient under the responsible party. These credits have not been applied against any outstanding balance for the patient.

### **Advanced Payments**

The total dollar amount of advance payments collected. It would calculate the sum of all advance payment receipts and show it against the patient entry.

### **Acct OutSt**

The dollar value of the outstanding account balance for all the patients under the responsible party.

### **Acct Unapplied Credits**

The dollar value of the total of all credits for all the patients under the responsible party. These credits have not been applied against any outstanding balance for any patients.

### **Last Paid Date**

This column shows the date of the most recent patient payment transaction made.

### **Last Paid Amount**

This column shows the amount of the most recent patient payment transaction made.

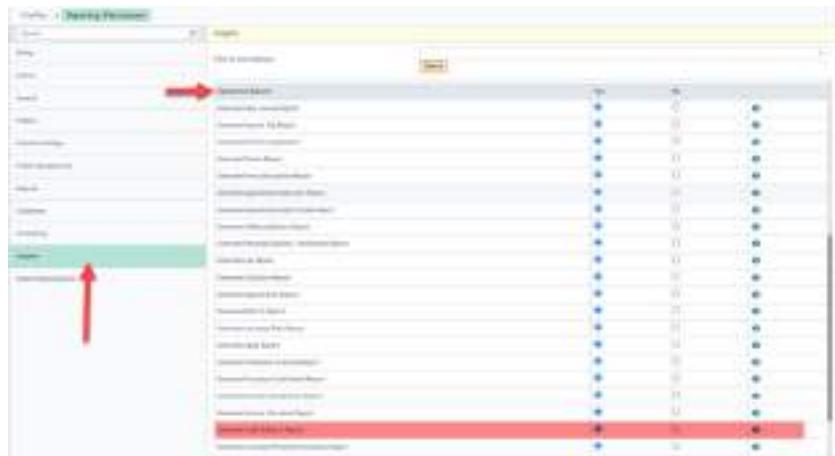
## **Special Cases**

1. When the Group By default location is selected: All unapplied credits from receipts added in different locations would be grouped under the patient's default location. Only one entry would be created corresponding to the patient and the aging of credits would be put in each bucket in that single entry.

2. When the Group By receipt location is selected: If a patient has receipts added from multiple locations then, for each receipt location an entry would be shown in the report. So the patient would have more than one entry.

## **Permissions**

Permissions for the Credit Balance report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Credit Balance Report. Only users with **Generate Credit Balance Report** permission set as Yes will be able to generate the report.



# Aging Report

Written by Aaqib Mohammed Sali | Last published at: August 22, 2021

## Overview

Aging report is used to identify the patients with outstanding amounts and track the pending payable the practice has to receive from both the patient and insurance. It also shows the Net A/R the practice needs to collect.

This report shows data from the data warehouse which means it shows data as of 11:59 PM yesterday, local time. The Aging report is available in two views- Summary and Detail view.

The summary view shows the insurance aging and patient aging and the total aging amount in different aging buckets and also shows the contracted balance and the total outstanding. The users have the flexibility to group and view the report by the treatment provider or by treatment location and this enables the user to see the outstanding amount that needs to be collected for the services against each provider or each location. Moreover, the summary view also shows the consolidated total so that you can see the aging consolidated across the practice providers and locations. The detail view shows the detailed information on the aging including the patient name, DOS of the associated aging entry, unapplied credits, carrier, the different aging bucket values, total outstanding, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria is important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary View:

For the Aging Summary View Report, your filter options include:

#### Group By\*

Aging summary view report can be grouped by treatment location or by the treatment provider.

#### Day\*

Select the date till which the aging needs to be shown. By default, the date will be for the current date.

#### Aging Bucket\*

Choose whether to generate data based on aging till 120 days or aging till 180 days. By default, Till 120 will be selected.

#### Aging Type\*

Choose whether to generate the report based on Insurance aging or Patient aging or both. By default, all will be selected.

#### Location\*

Select a location or locations to focus the report on the treatment location(s). By default, the location will be the user's default location.

#### Patient Flag

Choose whether to focus your report based on patients with the selected patient flag(s).

#### Provider

Choose whether to focus your report on the selected treatment provider(s).

#### Specialty

Choose whether to focus your report on providers who have the selected specialty.

#### Exclude Inactive Providers

Checkmark this option if you would like to exclude Inactive Providers from the report. By default, it will be checked.

## Detail View

For the Aging Detail View Report, your filter options include:

#### Day\*

Select the date till which the aging needs to be calculated. By default, the date will be for the current date.

#### Aging Bucket\*

Choose whether to generate data based on aging till 120 days or aging till 180 days. By default, Till 120 will be selected.

**Aging Type\***

Choose whether to generate the report based on Insurance aging or Patient aging or both. By default, all will be selected.

**Location\***

Select a location or locations to focus the report on the treatment location(s). By default, the location will be the user's default location.

## Patient Flag

Choose whether to focus your report based on patients with the selected patient flag(s).

## Provider

Choose whether to focus your report on the selected treatment provider(s).

## Specialty

Choose whether to focus your report on providers who have the selected specialty.

#### **Exclude Inactive Providers**

Checkmark this option if you would like to exclude Inactive Providers from the report.

### Columns\*

Choose the columns you wish to see in this report. By default, all the columns will be selected.

## Sorting

Sorting is possible on Patient Id, Unapplied credits, Trans. Date, D.O.S, Aging buckets, Contracted balance, and Total outstanding columns.

## Results

## Summary View Report

The report provides information in column form grouped by treatment location or the treatment provider (as selected). It shows the consolidated total of patient aging and insurance aging along with the aging buckets, total outstanding balance, Net A/R across all locations or providers on top as well. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Customer Demographic Analysis									
	Age Group	Gender	Income Level	Education Level	Employment Status	Geographic Region	Product Line	Total Sales	Net Profit
Demographic Data	18-25	Male	Low	High School	Employed	North America	Electronics	\$1000.00	\$200.00
	18-25	Female	Low	High School	Employed	North America	Electronics	\$1000.00	\$200.00
	26-35	Male	Medium	College	Employed	Europe	Software	\$1500.00	\$300.00
	26-35	Female	Medium	College	Employed	Europe	Software	\$1500.00	\$300.00
Demographic Data (Cont.)	36-45	Male	High	Postgraduate	Employed	Asia-Pacific	Hardware	\$2000.00	\$400.00
	36-45	Female	High	Postgraduate	Employed	Asia-Pacific	Hardware	\$2000.00	\$400.00
	46-55	Male	Very High	Postgraduate	Employed	South America	Software	\$2500.00	\$500.00
	46-55	Female	Very High	Postgraduate	Employed	South America	Software	\$2500.00	\$500.00
Demographic Data (Cont.)	56-65	Male	Very High	Postgraduate	Retired	Africa	Hardware	\$3000.00	\$600.00
	56-65	Female	Very High	Postgraduate	Retired	Africa	Hardware	\$3000.00	\$600.00
	66-75	Male	Very High	Postgraduate	Retired	Africa	Hardware	\$3500.00	\$700.00
	66-75	Female	Very High	Postgraduate	Retired	Africa	Hardware	\$3500.00	\$700.00
Demographic Data (Cont.)	76+	Male	Very High	Postgraduate	Retired	Africa	Hardware	\$4000.00	\$800.00
	76+	Female	Very High	Postgraduate	Retired	Africa	Hardware	\$4000.00	\$800.00
	76+	Male	Very High	Postgraduate	Retired	Africa	Software	\$4500.00	\$900.00
	76+	Female	Very High	Postgraduate	Retired	Africa	Software	\$4500.00	\$900.00

The results columns shown in this report include:

### Aging Type

The type of aging; whether it is insurance or patient aging.

0-30

The outstanding dollar amount that has remained unpaid for 30 days or less.

31-60

The outstanding dollar amount that has remained unpaid for at least 31 to 60 days.



## **Carrier**

The name of the insurance carrier associated with the insurance aging. When the patient aging is chosen as the aging type, this field would be blank.

## Provider

The treatment provider who completed the services to which these aging apply.

0-30

The outstanding dollar amount that has remained unpaid for 30 days or less.

31-60

The outstanding dollar amount that has remained unpaid for at least 31 to 60 days.

61-90

The outstanding dollar amount that has remained unpaid for at least 61 to 90 days.

91-120

The outstanding dollar amount that has remained unpaid for at least 91 to 120 days.

121-150

The outstanding dollar amount that has remained unpaid for at least 121 to 150 days. This field is shown only when the aging bucket Till 180 is selected.

151-180

The outstanding dollar amount that has remained unpaid for at least 151 to 180 days. This field is shown only when the aging bucket Till 180 is selected.

Over 120

The outstanding dollar amount that has remained unpaid for more than 120 days. This field is shown only when the aging bucket Till 120 is selected.

Over 180

The outstanding dollar amount that has remained unpaid for more than 180 days. This field is shown only when the aging bucket Till 180 is selected.

#### **Contracted Balance**

Contracted balance is the balance amount the patient has to pay from the contracted amount.

### Total Outstanding

The total dollar amount that remained unpaid till the date selected.

## Permissions

Permissions for the Aging report will be in System Menu ->Practice Settings ->Administration ->Profiles ->Manage Permissions ->Insights ->Under Operational Reports ->Generate Aging Report. Only users with **Generate Aging Report** permission set as Yes will be able to generate the report.



# Scheduled vs Actual Production Report

Written by Aaqib Mohammed Sali | Last published at: August 23, 2021

## Overview

The Scheduled vs Actual Production report is used to analyze scheduling and production trends, identify areas of improvement, as well as track any remaining codes that were scheduled and not yet completed. It also identifies areas of opportunity. If a column or provider is being underutilized, you can identify this and schedule more for this provider.

The Scheduled vs Actual Production report shows both the Scheduled Production and the Actual Production along with the percentage of Scheduled Production converted into Actual Production. This report shows real-time data and has a pivot structure. This means you can group it by one column and then drill down to the next grouping and reach into more drilled down information. The user has the flexibility to group the report by location and/or provider.

The Scheduled production values will not have any changes for a day, it will be frozen in the morning at 5.00 am for the day, whereas the actual production is a real-time value and it will show the dollar amount of the codes when it is completed, that is when it is being added to actual production.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria is important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Group by\*

Choose to focus on whether to group your report results based on treatment location and/or treatment provider. Please note that the report results will display in the order that the data variables are selected. By default, Location, Provider is selected.

### Date range\*

Choose to focus the report on treatment that was scheduled and/or completed on a day that falls within the selected date range. The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day.

### Location

Choose to focus the report on production scheduled for or charged out at the selected location(s). By default, the location will be the user's default location.

### Provider

Choose to focus whether to generate production data for only the selected provider(s).

## Results

The report provides information in column form grouped by location as selected.

Location	Provider	Date Range	Scheduled Production	Actual Production	% Complete
North America	Provider A	2021-08-01 to 2021-08-31	\$1,234,567	\$1,123,456	90%
North America	Provider B	2021-08-01 to 2021-08-31	\$890,000	\$800,000	90%
North America	Provider C	2021-08-01 to 2021-08-31	\$567,890	\$500,000	90%
North America	Provider D	2021-08-01 to 2021-08-31	\$345,678	\$300,000	90%
North America	Provider E	2021-08-01 to 2021-08-31	\$213,456	\$180,000	90%
North America	Provider F	2021-08-01 to 2021-08-31	\$123,456	\$100,000	90%
North America	Provider G	2021-08-01 to 2021-08-31	\$76,543	\$60,000	90%
North America	Provider H	2021-08-01 to 2021-08-31	\$45,678	\$35,000	90%
North America	Provider I	2021-08-01 to 2021-08-31	\$23,456	\$15,000	90%
North America	Provider J	2021-08-01 to 2021-08-31	\$12,345	\$10,000	90%
North America	Provider K	2021-08-01 to 2021-08-31	\$6,789	\$5,000	90%
North America	Provider L	2021-08-01 to 2021-08-31	\$3,456	\$2,000	90%
North America	Provider M	2021-08-01 to 2021-08-31	\$1,234	\$1,000	90%
North America	Provider N	2021-08-01 to 2021-08-31	\$678	\$500	90%
North America	Provider O	2021-08-01 to 2021-08-31	\$345	\$300	90%
North America	Provider P	2021-08-01 to 2021-08-31	\$176	\$150	90%
North America	Provider Q	2021-08-01 to 2021-08-31	\$88	\$80	90%
North America	Provider R	2021-08-01 to 2021-08-31	\$44	\$40	90%
North America	Provider S	2021-08-01 to 2021-08-31	\$22	\$20	90%
North America	Provider T	2021-08-01 to 2021-08-31	\$11	\$10	90%
North America	Provider U	2021-08-01 to 2021-08-31	\$5.5	\$5	90%
North America	Provider V	2021-08-01 to 2021-08-31	\$2.75	\$2.5	90%
North America	Provider W	2021-08-01 to 2021-08-31	\$1.375	\$1.25	90%
North America	Provider X	2021-08-01 to 2021-08-31	\$0.6875	\$0.625	90%
North America	Provider Y	2021-08-01 to 2021-08-31	\$0.34375	\$0.3125	90%
North America	Provider Z	2021-08-01 to 2021-08-31	\$0.171875	\$0.15625	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
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North America	Total		\$1,234,567	\$1,123,456	90%
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North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
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North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
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North America	Total		\$1,234,567	\$1,123,456	90%
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North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.60	90%
North America	Min		\$11.00	\$10.00	90%
North America	Max		\$1,234,567.00	\$1,123,456.00	90%
North America	Total		\$1,234,567	\$1,123,456	90%
North America	Avg		\$123,456.70	\$112,345.6	

The location in which the treatment was scheduled or completed.

#### Provider

The treatment provider of the scheduled or completed treatment.

#### Date

The date on which the treatment was scheduled in the system.

#### Sched. Prod

The total dollar amount of production scheduled for the given date. This amount is calculated by totaling all treatments added to appointments.

#### Actual Production (Gross Production (DOS))

The total dollar amount of production completed on the given date. The amount is calculated from the charges of the completed codes, both those that were planned inside the appointment and those completed without an appointment.

#### Percentage

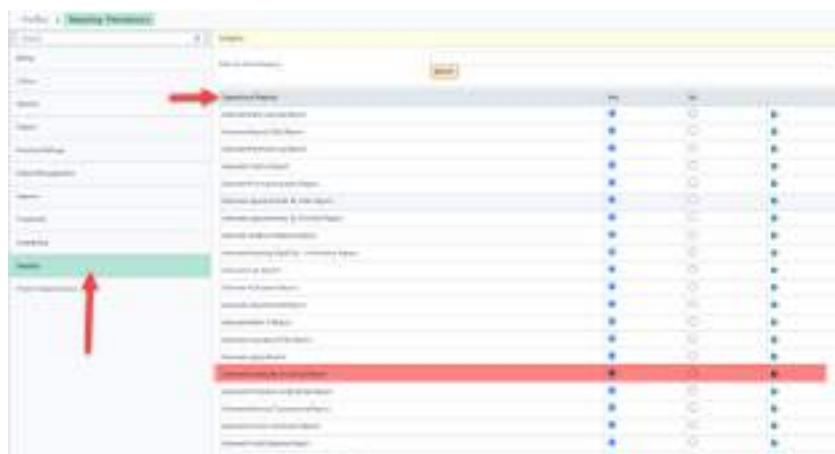
The percentage of Scheduled Production converted into Actual Production.

## Special Cases

1. When a code is scheduled with a treatment provider, let's say A, the scheduled production for that provider A would be the scheduled amount of dollars for that code and if the code gets completed with the same treatment provider, his scheduled production amount will be transferred to his actual production.
2. When a code is scheduled with a treatment provider, let's say A, the scheduled production for that provider A would be the scheduled amount of dollars for that code and if the code gets completed with the different treatment provider, let's say B, the scheduled production amount of the provider A will be transferred to the actual production of provider B.

## Permissions

Permissions for the Scheduled vs Actual report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Scheduled vs Actual Report. Only users with **Generate Scheduled vs Actual Report** permission set as Yes will be able to generate the report.



# Care Notes Tracker Report

Written by Elza Ebenezer | Last published at: September 28, 2021

## Overview

The Care Notes Tracker report is used to track the clinical care notes added to patient chart. This report can be run at the end of the day to see if the provider has missed out on adding care notes against the codes completed on that day and can be used to track the status of care notes added.

This report shows real-time data and shows the care notes in three ways- care notes added against codes, care notes added against codes and unlinked carenotes (care notes added to the patient chart and not linked to codes or conditions). The report has the ability to shows all the completed codes with DOS on the selected date range, the code details and shows the status of the care notes added against these codes and shows blank status if no care note was added against these codes.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

For the Care Notes Tracker report, your filter options include:

### **Care Notes For\***

This filter allows you to view the care notes added against codes, conditions, or look at unlinked care notes added to patient. For codes, the report will show all codes added in the patient's chart and shows the corresponding care note information if any care note is linked to the code. For conditions, the report will show conditions with care notes linked to it. For unlinked, the report will show any care note that is not linked to codes or conditions. By default, Codes will be selected.

### **Date As\***

The care notes tracker report is dated based on the Care Notes For option selected. For codes, the Date As options include Date of Service, Added Date or by Care Note Date. For conditions, the Date As options include Added Date or Care Note Date. For unlinked, this filter is not available and the date considered would be by Care Note Date. The Date of Service would be the date the code is completed. The Added Date would be the date the code/condition is added to the patient chart. The Care Note Date is the date specified in the care note.

### **Date range\***

The care notes tracker report is dated by the selection on Date As filter. The date range can be selected for a maximum of 3 months. By default, the date range will be for the current day.

### **Location As\***

For codes, the Location As options include Tx location and Care Note Location. For conditions, the Location As options include condition location and Care Note Location . For unlinked, this filter is not available and the location considered would be by Care Note location.

### **Location\***

Select a location or locations to focus the report on the codes, conditions or care notes in the selected location(s). By default, the location will be the user's default location.

### **Tx Provider**

Select a provider or providers to focus the report on the selected tx provider(s), This filter is available only when care notes for codes is selected.

### **Appt Provider**

Select a provider or providers to focus the report on the codes linked to appointment with selected appt provider(s). This filter is available only when care notes for codes is selected. This filter is available only when care notes for codes is selected.

### **Cn Provider**

Select a provider or providers to focus the report on the selected condition provider(s), This filter is available only when care notes for conditions is selected.

Care Note Provider

Select a provider or providers to focus the report on the selected care note provider(s).

## Care Note Status

Select a location or locations to focus the report on the selected care note status(s). If no care note is added, then the status will be blank.

### Show completed codes only

Select this checkbox to filter and show only completed codes and the care notes against them in this report. This filter is available only when care notes for codes is selected.

# Sorting

The default sorting for the Care notes tracker report is by column selected in Date As filter. Sorting is also possible in all date columns and patient Name.

## Results

The report shows information in column form. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Data Analysis - Core Business - Product Line A - Product Line B - Product Line C - Product Line D - Product Line E - Product Line F - Product Line G - Product Line H - Product Line I - Product Line J - Product Line K - Product Line L - Product Line M - Product Line N - Product Line O - Product Line P - Product Line Q - Product Line R - Product Line S - Product Line T - Product Line U - Product Line V - Product Line W - Product Line X - Product Line Y - Product Line Z																			
Product ID	Product Name	Category	Sub-Category	Color	Size	Material	Weight (kg)	Stock Status	Supplier	Order ID	Order Date	Shipped Date	Delivery Status	Customer ID	Customer Name	Address	City	State	Zip Code
P001-A1	Laptop Model X	Electronics	Computers	Black	15.6"	Plastic	2.5	In Stock	Supplier A	ORD-2023-001	2023-01-01	2023-01-05	Delivered	C001-A	John Doe	123 Main St	New York	NY	10001
P002-B1	Smartphone Model Y	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier B	ORD-2023-002	2023-01-02	2023-01-06	Delivered	C002-B	Jane Smith	456 Elm St	Los Angeles	CA	90001
P003-C1	Smartphone Model Z	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier C	ORD-2023-003	2023-01-03	2023-01-07	Delivered	C003-C	David Johnson	789 Oak St	Chicago	IL	60601
P004-D1	Smartphone Model A	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier D	ORD-2023-004	2023-01-04	2023-01-08	Delivered	C004-D	Sarah Lee	123 Main St	Seattle	WA	98101
P005-E1	Smartphone Model B	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier E	ORD-2023-005	2023-01-05	2023-01-09	Delivered	C005-E	Michael Chen	456 Elm St	Los Angeles	CA	90001
P006-F1	Smartphone Model C	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier F	ORD-2023-006	2023-01-06	2023-01-10	Delivered	C006-F	Amy Green	789 Oak St	Chicago	IL	60601
P007-G1	Smartphone Model D	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier G	ORD-2023-007	2023-01-07	2023-01-11	Delivered	C007-G	Emily Blue	123 Main St	Seattle	WA	98101
P008-H1	Smartphone Model E	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier H	ORD-2023-008	2023-01-08	2023-01-12	Delivered	C008-H	James Red	456 Elm St	Los Angeles	CA	90001
P009-I1	Smartphone Model F	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier I	ORD-2023-009	2023-01-09	2023-01-13	Delivered	C009-I	Olivia Green	789 Oak St	Chicago	IL	60601
P010-J1	Smartphone Model G	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier J	ORD-2023-010	2023-01-10	2023-01-14	Delivered	C010-J	Lucas Blue	123 Main St	Seattle	WA	98101
P011-K1	Smartphone Model H	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier K	ORD-2023-011	2023-01-11	2023-01-15	Delivered	C011-K	Mia Red	456 Elm St	Los Angeles	CA	90001
P012-L1	Smartphone Model I	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier L	ORD-2023-012	2023-01-12	2023-01-16	Delivered	C012-L	Natalie Green	789 Oak St	Chicago	IL	60601
P013-M1	Smartphone Model J	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier M	ORD-2023-013	2023-01-13	2023-01-17	Delivered	C013-M	Isabella Blue	123 Main St	Seattle	WA	98101
P014-N1	Smartphone Model K	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier N	ORD-2023-014	2023-01-14	2023-01-18	Delivered	C014-N	Charlotte Red	456 Elm St	Los Angeles	CA	90001
P015-O1	Smartphone Model L	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier O	ORD-2023-015	2023-01-15	2023-01-19	Delivered	C015-O	Penelope Green	789 Oak St	Chicago	IL	60601
P016-P1	Smartphone Model M	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier P	ORD-2023-016	2023-01-16	2023-01-20	Delivered	C016-P	Scarlett Blue	123 Main St	Seattle	WA	98101
P017-Q1	Smartphone Model N	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier Q	ORD-2023-017	2023-01-17	2023-01-21	Delivered	C017-Q	Madison Red	456 Elm St	Los Angeles	CA	90001
P018-R1	Smartphone Model O	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier R	ORD-2023-018	2023-01-18	2023-01-22	Delivered	C018-R	Charlotte Green	789 Oak St	Chicago	IL	60601
P019-S1	Smartphone Model P	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier S	ORD-2023-019	2023-01-19	2023-01-23	Delivered	C019-S	Penelope Blue	123 Main St	Seattle	WA	98101
P020-T1	Smartphone Model Q	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier T	ORD-2023-020	2023-01-20	2023-01-24	Delivered	C020-T	Scarlett Green	456 Elm St	Los Angeles	CA	90001
P021-U1	Smartphone Model R	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier U	ORD-2023-021	2023-01-21	2023-01-25	Delivered	C021-U	Charlotte Blue	789 Oak St	Chicago	IL	60601
P022-V1	Smartphone Model S	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier V	ORD-2023-022	2023-01-22	2023-01-26	Delivered	C022-V	Penelope Red	123 Main St	Seattle	WA	98101
P023-W1	Smartphone Model T	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier W	ORD-2023-023	2023-01-23	2023-01-27	Delivered	C023-W	Scarlett Green	456 Elm St	Los Angeles	CA	90001
P024-X1	Smartphone Model U	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier X	ORD-2023-024	2023-01-24	2023-01-28	Delivered	C024-X	Charlotte Blue	789 Oak St	Chicago	IL	60601
P025-Y1	Smartphone Model V	Electronics	Smartphones	Black	6.5"	Glass	0.5	In Stock	Supplier Y	ORD-2023-025	2023-01-25	2023-01-29	Delivered	C025-Y	Penelope Red	123 Main St	Seattle	WA	98101
P026-Z1	Smartphone Model W	Electronics	Smartphones	White	6.5"	Glass	0.5	In Stock	Supplier Z	ORD-2023-026	2023-01-26	2023-01-30	Delivered	C026-Z	Scarlett Green	456 Elm St	Los Angeles	CA	90001

The results columns shown in this report include:

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the clinical page of the patient's profile.

**Patient Name**

The name of the patient who has code, condition or care note added.

## Code

The procedure codes that was added or completed against which the care note, if any, is added. This column is present only when Care Notes For codes is selected.

## Conditions

The condition that was added against which the care note is added. This column is present only when Care Notes For condition is selected.

DOS

The DOS of the procedure code.

**Added Date**

The date on which the code or condition is added to the patient chart. This column is present only when Care Notes For codes or condition is selected.

**Tx. Location/ Cn. Location**

The treatment location of the procedure code/ condition.

**Tx. Provider/ Cn. Provider**

The treatment provider of the procedure code/ condition.

## **Appt Date**

The appt date of the appointment if the procedure code was linked to an appt.

## **Appt Provider**

The primary appt provider of the appointment if the procedure code was linked to an appt.

## **Code Status**

The status of the procedure code.

## **Template**

The name of the care note template that was added.

## **Note Date**

The date specified in the linked care note .

## **Note Provider**

The short name of the provider who is listed in the linked care note.

## **Assignee**

The name of the user who is listed as the assignee in the linked care note.

## **Note Location**

The location listed in the linked care note.

## **Status**

The status of the care note added. This could be To Be Started, To Be Completed, To Be Reviewed, Finalized and Deleted. If no care note is added, it will be blank.

## **Merged**

The status of the care note added. This could be Draft or Finalized. If no care note is added, it will be blank.

# **Permissions**

Permissions for the Care Notes Tracker report will be in System Menu -> Practice Settings -> Administration ->Profiles ->Manage Permissions ->Insights ->Under Operational Reports ->Generate Care Notes Tracker Report. Only users with **Generate Care Notes Tracker Report** permission set as Yes will be able to generate the report.

Module	Action	Permissions
Billing	Generate Aging Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Actual vs Actual Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Procedure Code Detail Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Missing Transactions Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Income Allocation Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Credit Balance Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Insurance Pending Procedure Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Staff Call Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Time Tracker Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Check In/Check Out	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Home Patient Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Care Notes Tracker Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Payment Reconciliation Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Billing	Generate Production Summary Report	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

# Insurance Pending Procedures Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

The Insurance Pending Procedures report provides a list of completed procedure codes that are not being billed to insurance, completed procedures that have not been submitted on a claim yet, as well as completed services with mismatched insurances.

This report shows real-time data. The report has two views- Summary and Detail view. The summary view shows the total count of the Completed Services Not Billed to Insurance, count of completed services with Pending Claim Creation, and count of completed services with mismatched insurances along with their Total UCR Fee and the Gross Production. The detail view shows the patient level details for these codes along with their Patient id, DOS, Insurance Status, Claim carrier, Treatment provider, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the Insurance Pending Procedures Summary View Report, your filter options include:

#### Condition

Select whether to generate data based on completed services that match one or more of the following conditions:

- Completed services not billed to insurance
- Completed services pending claim creation
- Completed services with an insurance mismatch: The insurance is considered mismatched if the patient's insurance hierarchy has been changed while they still have an active claim out. For instance, if the primary claim was already sent out to the patient's primary insurance (Cigna), but then the patient's primary insurance plan was changed to something else (Aetna).

#### Date Range\*

Choose to focus the report on services completed (DOS of code) within the selected date range. The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

#### Location\*

Choose to focus the report on codes with tx location in the selected locations. By default, the location will be the user's default location.

#### Provider

Choose whether to focus your report based on the selected treatment provider(s).

#### Carrier

Choose whether to focus your report only on the selected carrier(s).

#### Insurance Plan

Choose whether to generate data based on the selected insurance plan(s).

#### Code

Choose whether to focus your report based on the selected procedure code(s).

#### Patient Flag

Choose whether to focus your report based on patients with the selected patient flag(s).

#### Patient

Choose to focus the report based on the selected patients.

#### **Exclude Do Not Bill to Insurance Codes**

Checkmark this option if you would like to exclude procedure codes with the billing order 'N' (do not bill to insurance).

#### **Exclude Ortho Codes Attached to Payment Plans**

Checkmark this option if you would like to exclude ortho codes that are attached to Payment Plans.

### **Detail View**

For the Insurance Pending Procedures Detail View Report, your filter options include:

#### **Condition**

Select whether to generate data based on completed services that match one or more of the following conditions:

- Completed services not billed to insurance
- Completed services pending claim creation
- Completed services with an insurance mismatch: The insurance is considered mismatched if the patient's insurance hierarchy has been changed while they still have an active claim out. For instance, if the primary claim was already sent out to the patient's primary insurance (Cigna), but then the patient's primary insurance plan was changed to something else (Aetna).

#### **Date Range\***

Choose to focus the report on services completed within the selected date range. The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

#### **Location\***

Choose to focus the report on codes with tx location in the selected locations. By default, the location will be the user's default location.

#### **Provider**

Choose whether to focus your report based on the selected treatment provider(s)

#### **Carrier**

Choose whether to focus your report only on the selected carrier(s)

#### **Insurance Plan**

Choose whether to generate data based on the selected insurance plan(s)

#### **Code**

Choose whether to focus on the selected procedure code(s).

#### **Patient Flag**

Choose whether to focus your report based on patients with the selected patient flag(s)

#### **Patient**

Choose to focus the report based on the selected patients.

#### **Exclude Do Not Bill to Insurance Codes**

Checkmark this option if you would like to exclude procedure codes with the billing order 'N' (do not bill to insurance).

#### **Exclude Ortho Codes Attached to Payment Plans**

Checkmark this option if you would like to exclude ortho codes that are attached to Payment Plans.

### **Sorting**

---

The default sorting for the Insurance Pending Procedures report will be by UCR fee in each condition grouping.

Sorting is possible on D.O.S, UCR Fee, and Gross Production columns as well.

## Results

## Summary view

The report provides information in column form. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Condition	UCB Fee	gross Profit(\$000)	# Procedures
Completed Services Not Billed to Insurance	\$11,290.00	\$6,877.00	11
Completed Services with Insurance mismatch	\$388.00	\$217.62	8
Completed Services with Pending Claim Creation	\$6,895.00	\$4,351.00	14
<b>Grand Total</b>	<b>\$18,633.00</b>	<b>\$13,445.62</b>	<b>33</b>

The results columns shown in this report include:

## Conditions

This column states whether the generated data pertains to completed codes that either was not billed to insurance, that is pending claim creation or has an insurance mismatch. The insurance is considered mismatched if the patient's insurance hierarchy has been changed while they still have an active claim out. For instance, if the primary claim was already sent out to the patient's primary insurance (Cigna), but then the patient's primary insurance plan was changed to something else (Aetna).

UCR Fee

The total UCR calculated from these procedure codes based on the office's standard fees (according to your practice settings).

## Gross Production (DOS)

The total dollar amount of production generated according to the patient and insurance payables at the time of code completion.

## #Procedures

The total number of procedure codes with the listed condition completed within the selected time frame.

The report also has a totals row “**Grand Total**” that shows the consolidated totals of UCR fee, Gross Production, and #procedures.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these codes and their details.

## Detail view

Insurance Pending Processes - Detailed View															
General Services Act Billing by Insurance															
Patient ID	Patient	Date	SSN	Provider	Inv Type	Inv Status	SD	Claim Type	Claim Status	Carrier	Plan	Claim Number	ICB# Type	Open	Open Pending Action
1000111	Jane Doe	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00
1000111	Jane Doe	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00
1000111	Jane Doe	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00
1000111	Jane Doe	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00
1000111	Jane Doe	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00
1000111	Jane Doe	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00
General Services Act Pending Cases Details															
Patient ID	Patient	Date	SSN	Provider	Inv Type	Inv Status	SD	Claim Type	Claim Status	Carrier	Plan	Claim Number	ICB# Type	Open	Open Pending Action
1000001	General	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00
General Services Act Pending Cases Details															
Patient ID	Patient	Date	SSN	Provider	Inv Type	Inv Status	SD	Claim Type	Claim Status	Carrier	Plan	Claim Number	ICB# Type	Open	Open Pending Action
1000001	General	01/01/2021	12345	General	Initial	Open	N	SG	Open	HCFA	HCFA	1234567890	HCFA	\$0.00	\$0.00

The results columns shown in this report include:

**Patient Id**

The patient that has had this procedure code completed. Click this hyperlink to be taken to the Completed Procedures section of the patient's profile

## Patient

The name of the patient that has had the service completed.

Code

The procedure code that was completed for this patient.

D.O.S

The date on which the patient was seen by their treatment provider for the completion of these services.

## Provider

The treatment provider that completed these services for the patient.

**Ins. Type**

The type of insurance coverage, whether it is dental or medical. If a patient has medical insurance and dental insurance, the dental has higher priority over medical.

### **Ins. status**

The status of this patient's insurance plan, whether it is currently active, pending verification, or has been terminated.

B.O

The billing order of the procedure code.

**Claim Type**

The type of insurance claim, whether it is a dental claim or medical.

### Claim Status

The current status of the claim if any attached for these services, whether it has been Accepted, Rejected, Resubmitted, and so on.

Carrier

The carrier pertaining to this patient's insurance plan

Plan

The name of the patient's insurance plan as it is entered in your practice settings

### **Claim Carrier**

The insurance carrier to which the claim was submitted

UCB Eee

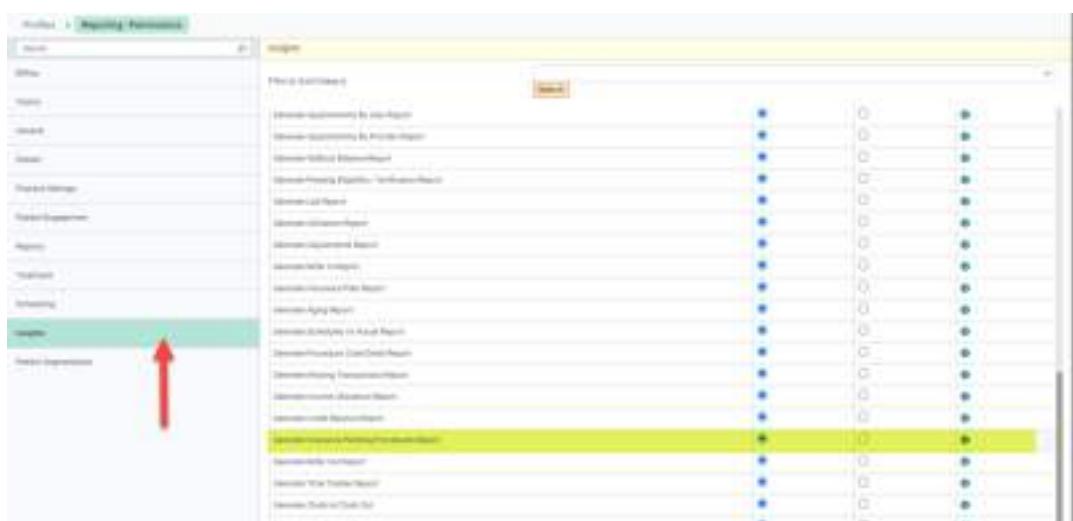
The total UCR calculated from these procedure codes based on the office's standard fees (according to your practice settings).

### Gross Production (ROS)

The total dollar amount of production generated according to the patient and insurance payables at the time of code completion.

## Permissions

Permissions for the Insurance Pending Procedures report will be in System Menu -> Practice Settings ->Administration ->Profiles ->Manage Permissions ->Insights ->Under Operational Reports ->Generate Insurance Pending Procedures Report. Only users with **Generate Insurance Pending Procedures Report** permission set as Yes will be able to generate the report.



# Insurance Plan Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

The Insurance Plan report lists the number of patients or insurance holders associated with a particular insurance plan.

This report shows real-time data. The Insurance plan report is available in two views- Plans and Patient view. The Plans view shows the total number of patients added against each plan including the details like Plan type, Carrier, Number of Patients with Active Ins, etc. The Patient view shows patient-level information and details like Patient's name, Plan name, Subscriber Name, Effective Date, Active Date, Hierarchy, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Plan view

For the Insurance Plan Plan View Report, your filter options include:

#### **Location\***

Select a location or locations to focus the report only on insurance patients associated with the selected default location(s). By default, the location will be the user's default location.

#### **Insurance Type\***

Choose whether to display only dental insurance, medical insurance, or both. By default, All is selected.

#### **Plan Type**

Choose whether to generate the report for only a certain type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

#### **Carrier**

Choose whether to generate data based on the selected insurance carrier(s).

#### **Employer**

Choose whether to generate data based on insurances associated with the selected employer(s).

#### **Insurance Plan**

Choose whether to generate data based on the selected insurance plan(s).

#### **Plan Status\***

Choose whether to focus your report on patient insurance that is either verified, pending verification, or choose to include all. By default, All is selected.

### Patients view

For the Insurance Plan Patient View Report, your filter options include:

#### **Location\***

Select a location or locations to focus the report only on insurance patients associated with the selected default location(s). By default, the location will be the user's default location.

#### **Insurance Type\***

Choose whether to display only dental insurance, medical insurance, or both. By default, All is selected.

## Plan Types

Choose whether to generate data for only a certain type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

## Carrier

Choose whether to generate data based on the selected insurance carrier(s).

## Employer

Choose whether to generate data based on insurances associated with the selected employer(s).

## Plan Status\*

Choose whether to focus your report on patient insurance that is either verified, pending verification, or choose to include all. By default, All is selected.

## Insurance Plan

Choose whether to generate data based on the selected insurance plan(s).

## Insurance Status

Choose whether to generate data based on the selected insurance plan(s) status, whether it is Active, Draft, Inactive, Pending Verification, and so on.

## Columns\*

Choose the columns you wish to see in this report. By default, all columns except Insurance Type, Plan Type, Carrier, Employer, Address, and Phone Number will be selected.

## Sorting

The default sorting for the Insurance Plan report is by the Plan Used By column.

Sorting is also possible on the Plans view by # Patients with Active Ins and possible on Patients view by Eff. Date, Term. Date, Act. Date, Family Max Remaining, Individual Max Remaining, Family Deductible Remaining, Individual Deductible Remaining, Individual Ortho Max Remaining, Individual Ortho Deductible Remaining columns as well.

## Results

### Plan view

The report provides information in column form. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Plan	Insurance Type	Plan Type	Carrier	Employer	Plan Used By	0	# Patients with Active Ins	0	Plan Status
CHARTERED DENTAL INC 101886	Dental	PPO	AETNA	HERZOG COMMERCIAL INSURANCE CO INC		0	0	0	Verifed
10010000000000000000	Dental	PPO	AETNA			0	0	0	Verifed
ORTHO MEDICAL INC 044501	Dental	Co-Pay	AMERICAN DENTAL SERVICES			0	0	0	Verifed
WWE - WEA 1001 101 001254211	Dental	PPO	AMERICAN DENTAL SERVICES			0	0	0	Verifed
BURLINGTON COUNTY SCHOOLS 21274000000000000000	Hospital	Hospital	BLUE CROSS BLUE SHIELD OF NEW JERSEY	BURLINGTON COUNTY SCHOOLS DISTRICT		0	0	0	Verifed
HHS/HMO 2000 0007400 (Ins. No. 0021440001)	Dental	PPO	AMERICAN DENTAL	CROSSCOUNTRY MORTGAGE INC		0	0	0	Verifed
00000000000000000000	Dental	PPO	AMERICAN	HHS/HMO 2000 0007400 (Ins. No. 0021440001)		0	0	0	Verifed
RENTEX INC 10000000000000000000	Hospital	Hospital	AMERICAN FEDERAL INSURANCE COMPANY (AFC)	RENTEX INC		0	0	0	Verifed
PATHOLOGY CENTER 10000000000000000000	Hospital	Hospital	AMERICAN	PATHOLOGY CENTER		0	0	0	Verifed
FLORIDA HOSPITALS 10000000000000000000	Hospital	Hospital	AMERICAN	FLORIDA HOSPITALS GROUP INC		0	0	0	Verifed
AMERICAN 10000000000000000000	Dental	Hospital	AETNA			0	0	0	Verifed
AMERICAN 10000000000000000000	Dental	Hospital	AETNA	AMERICAN DENTAL SERVICES LLC		0	0	0	Verifed
AMERICAN 10000000000000000000	Dental	Hospital	AETNA	AMERICAN DENTAL SERVICES LLC		0	0	0	Verifed

The results columns shown in this report include:

### Plan

The name of the patient's insurance plan as it is entered in your practice settings. Click this hyperlink to be taken to this insurance plan's details in your practice settings.

### Insurance Type

The type of insurance coverage, whether it is dental or medical.

### **Plan Type**

The type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

Carrier

The carrier associated with the listed insurance plan.

## **Employer**

The employer associated with the listed insurance plan.

#### **Plan used by**

The number of patients that have this insurance plan associated with their profile according to your selected filters. Click this hyperlink to view a Detail Report listing these patients.

### #Patients with Active Ins

The number of patients that have this insurance plan marked as verified on their profile

## Plan Status

The current status of this insurance plan, whether it is verified or pending verification

## Patients view

The results columns shown in this report include:

## **Plan Name**

The name of the patient's insurance plan as it is entered in your practice settings. Click this hyperlink to be taken to this insurance plan's details in your practice settings.

### **Insurance Type**

The type of insurance coverage, whether it is dental or medical.

**Plan Type**

The type of insurance plan, whether it is PPO, Medicaid, Co-Pay, and so on.

Carrier

The carrier associated with the listed insurance plan.

**Employer**

The employer associated with the listed insurance plan.

## Plan Status

The current status of this patient's insurance plan, whether it is verified or pending verification.

**Patient Name**

The name of the Patient associated with the insurance plan.

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the Overview page of the patient's profile.

## Location

The default location of the patient associated with the insurance plan.

#### **Address**

The address associated with this insurance carrier.

#### **Phone Number**

The phone number associated with this insurance carrier.

#### **Relationship to Subscriber**

The patient's relationship to the subscriber listed on their insurance plan, whether they are the spouse, the dependent child, the subscriber themselves, or so on.

#### **Subscriber Name**

The name of the subscriber listed on this patient's insurance plan. Click this hyperlink to be taken to the subscriber's insurance page.

#### **Subscriber ID / SSN**

The subscriber's ID or social security number used to identify the subscriber and their coverage.

#### **Eff. Date**

The date the insurance went into effect according to the information provided in the insurance details.

#### **Term. Date**

The date the insurance was set to be marked as terminated.

#### **Act. Date**

The date the insurance was marked as active in the system.

#### **Insurance Status**

The status of this patient's insurance plan, whether it is currently active, pending verification, or has been terminated

#### **Hierarchy**

The hierarchy of this patient's insurance plan, whether it is their primary dental insurance, primary medical, secondary dental, and so on.

#### **Family Max Remaining**

The dollar amount of the family maximum remaining in the Benefits section of the Subscriber's Insurance plan.

#### **Individual Max Remaining**

The dollar amount of the individual maximum remaining which is in the Benefits section of the Insurance plan of the patient.

#### **Family Deductible Remaining**

The dollar amount of the family deductible remaining in the Benefits section of the Subscriber's Insurance plan.

#### **Individual Deductible Remaining**

The dollar amount of the individual deductible remaining which is in the Benefits section of the Insurance plan of the patient.

#### **Individual Ortho Max Remaining**

The dollar amount of the individual ortho maximum remaining which is in the Benefits section of the Insurance plan of the patient.

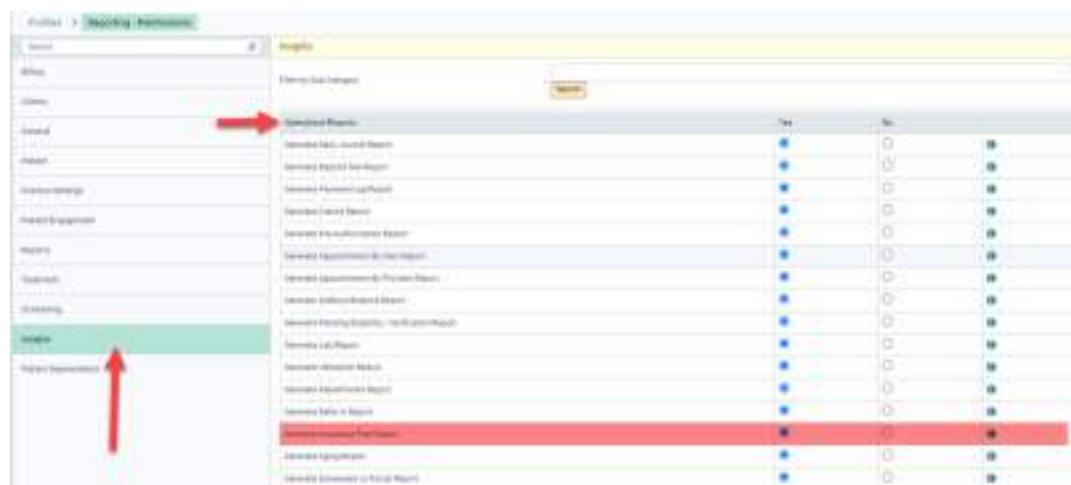
#### **Individual Ortho Deductible Remaining**

The dollar amount of the Individual Ortho deductible remaining which is in the Benefits section of the Insurance plan of the patient.

## **Permissions**

---

Permissions for the Insurance Plan report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Insurance Plan Report. Only users with **Generate Insurance Plan Report** permission set as Yes will be able to generate the report.



# Missing Transactions Report

Written by Roshni R | Last published at: August 22, 2021

## Overview

This report is used to find procedure codes that were missed during the checkout process. This report shows all past appointments with at least one non-completed code and checked-out appointments with no codes associated in the selected date range.

This report shows real-time data. This report shows the appointments for two scenarios:

- 1) Appointment with Status "Checked Out" with no codes completed
- 2) Appointment is scheduled but all treatment codes linked to the appointment are not in "completed" status.

The report shows appointment details like appointment location and time, operator, the scheduled production of the appointment, provider, location, No. of codes linked to the appointment, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Date range(Max 6 months)\*

Missing Transactions report is dated by **appointment date**. The date range can be selected for a maximum of 6 months. By default, the date range will be for the current day.

### Location\*

Select a location or locations to focus the report on the **appointments in the selected location(s)**. By default, the location will be the user's default location.

### Provider

Select a provider or providers to focus the report on appointments with the selected provider(s) as primary appointment provider.

### Prod. Type

Choose to focus the report based on the selected Production Types.

### Appt Status

Choose to focus the report based on the selected status of appointment.

### Patient Flag

Choose to focus the report based on the patients with the selected patient flags.

### Patient

Choose to focus the report based on the selected patients.

## Sorting

The default sorting for the Missing Transactions report will be by Appt date (desc) and Appt time (asc). Sorting is possible on Sched. Prod and No. of Codes columns as well.

## Results

The screenshot shows a software interface for a 'Missing Transactions' report. At the top, there are several tabs: 'Operational Report', 'Encounters', 'Analysis Dashboard', 'Unbilled Encounters', and 'Legacy Reports'. Below the tabs is a toolbar with icons for search, refresh, and other functions. The main area is a grid table with the following columns and data:

Missing Transactions (0-00000000-0000-0000-0000-000000000000 / All Providers / All Prod. Status / All Production Type / All Patient Flags / 1 Prod=of - 01/01/2021 - 01/01/2021)									
Appt. Date	Appt. Time	Patient Name	Patient ID	Provider	Location	Schedule	Prod. Type	Service	Sched. Prod. ▾
01/01/2021 - 00:00:00-00:00:00 AM		Transient-Max	100000111111	DRILL	HILL	Office - HILL	Appt	Normal	Unscheduled
01/01/2021 - 00:00:00-00:00:00 AM		Transient-Max	100000111111	ULTRAV	HILL	Office - DRILL	Visa-Paper	Cleanse	Unscheduled
01/01/2021 - 00:00:00-00:00:00 AM		Transient-Max	100000111111	CBD	HILL	Office - HILL	Adult-Psy	Complaint	Scheduled
01/01/2021 - 00:00:00-00:00:00 AM		Transient-Max	100000111111	ALIVE	HILL	Office - DRILL	Emergency	Self-Message	Scheduled
01/01/2021 - 00:00:00-00:00:00 AM		Transient-Max	100000111111	VINYL	HILL	Office - DRILL	Emergency	Self-Ref	Scheduled

The results columns shown in this report include:

#### **Appt. Date**

The date for which the appointment was scheduled to take place.

#### **Appt. Time**

The time for which the appointment was scheduled to take place.

#### **Patient Name**

The name of the patient scheduled to be seen in the appointment.

#### **Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the Appointments page of the patient's profile.

#### **Provider**

The primary treatment provider of the appointment

#### **Location**

The treatment location for the patient's appointment.

#### **Operatory**

The operatory for which the appointment was scheduled.

#### **Prod. Type**

The type of production set for this appointment.

#### **Status**

The current status of the appointment.

#### **Sched Prod**

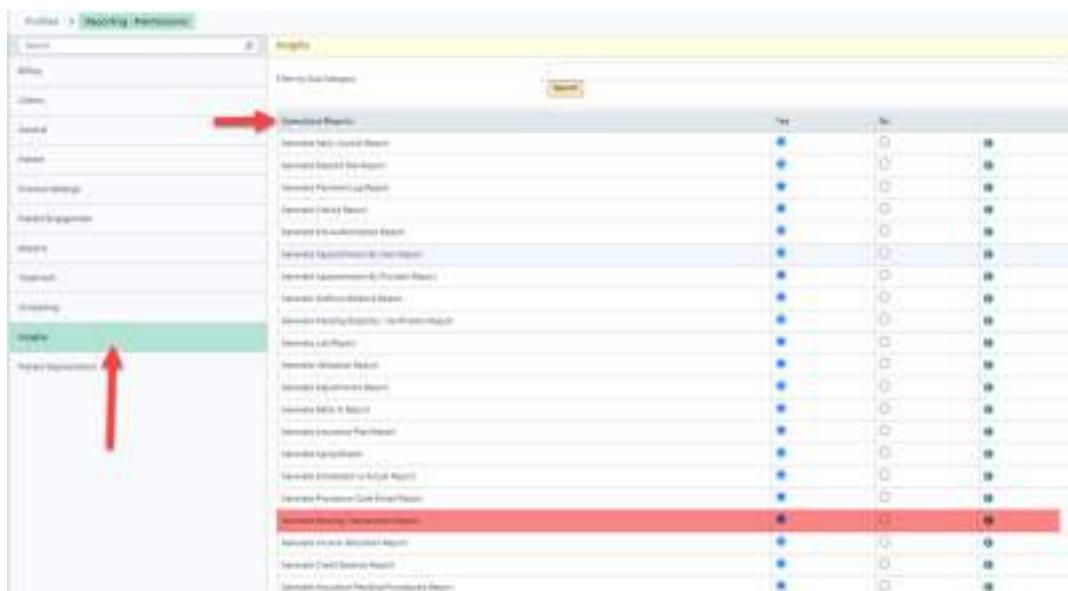
The dollar amount scheduled to be produced by the treatment(s) included in this appointment.

#### **No. Of Codes**

The total number of procedure codes linked to this appointment.

## **Permissions**

Permissions for the Missing Transactions report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Missing Transactions Report. Only users with **Generate Missing Transactions Report** permission set as Yes will be able to generate the report.



# Patient Time Tracker Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

The Patient Time Tracker report measures the amount of time the appointment itself has spent in each specified status. This report can be used to track the amount of time the patient spent in the waiting room or operatory (indicated by the appointment status used to signify this), or it can be used to track task productivity-based appointment status (such as the amount of time the appointment stayed in Left Voicemail status before the appointment was finally confirmed).

This report shows real-time data and has two views- Summary view and Detail view. The summary view shows the average amount of time all the appointments in the specified provider location combination have spent on each status. The detail view shows more of the appointment details and shows how each appointment contributes to the time spent on the specified statuses.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the Patient Time Tracker Summary View report, your filter options include:

#### Group By\*

Patient Time Tracker summary view report can be grouped by appointment provider or by appointment location. By default, location will be selected.

#### Date range\*

The report is dated by **appointment date**. Choose to focus the report on appointments that was scheduled on a day that falls within the selected date range. The date range can be selected for a maximum of 1 month. By default, the date range will be for the current day.

#### Location\*

Choose to focus to generate data based on appointments scheduled at the selected treatment location. By default, the location will be the user's default location.

#### Provider\*

Choose to focus the report on appointments scheduled with the selected appointment provider(s). Select a maximum of up to 10 providers.

#### Appt. Status\*

Choose to focus to generate data based on the specified appointment statuses. Select a maximum of up to 15 appointment statuses.

## Detail View

For the Patient Time Tracker Detail View report, your filter options include:

#### Date range\*

The report is dated by **appointment date**. Choose to focus the report on treatment that was scheduled on a day that falls within the selected date range. The date range can be selected for a maximum of 1 month. By default, the date range will be for the current day

#### Location\*

Choose to focus to generate data based on appointments scheduled at the selected treatment location. By default, the location will be the user's default location.

#### Provider\*

Choose to focus the report on appointments scheduled with the selected appointment provider(s). Select a maximum of up to 10 providers.

#### Appt. Status\*

Choose to focus to generate data based on the specified appointment statuses. Select a maximum of up to 15 appointment statuses.

## Sorting

The default sorting for the Patient Time Tracker report will be by Appt date (desc) and Appt time (asc).

## Results

### Summary view

Patient Time Tracker Summary / Location - MALL | 4 Providers | 4 Appointment Status - 08/08/2021 - 08/12/2021  
Celebration Dental , Mallory Circle(MALL)

Provider	Appt Time Mins	At Reception Mins (%)	Confirmed Mins (%)	In Operatory Mins (%)	Waiting for x-ray Mins (%)
ALTMAN	60	2(3.22 %)	247(77.08 %)	554(72.72 %)	-
BUSTI	60	-	-	-	-
Averages	55.33	2	247	554	-

The results columns shown in this report include:

#### Location

The location in which the patients were scheduled to receive treatment.

#### Provider

The treatment provider for which the appointments were scheduled.

#### Appointment Time mins

The total average duration (in minutes) for all appointments with this provider/location combination.

#### Time Spent in this Appointment Status (%)

These columns list the appointment statuses specified in the report generation criteria, along with the average time of selected appointment statuses (in minutes) with this provider/location combination and the calculated percentage relative to the total time spent in all selected statuses as a whole.

#### Averages

Calculated averages are listed for the average duration (in minutes) of all appointments in the selected statuses cumulatively (for appointments scheduled for this provider or this location, dependent upon how your report is grouped). Calculated averages are also provided for the average duration (in minutes) all appointments spent in each selected appointment status (for appointments scheduled for this provider or location, dependent upon how your report is grouped).

### Detail view

Patient Time Wasted Detail   Location - MALL   4 Providers   4 Appointment Status - 08/11/2021 - 08/11/2021										
Appt Date	Appt Time	Patient Name	Location	Procedure	Provider	At Reception Mins (%)	Confirmed Mins (%)	In Operatory Mins (%)	Waiting for x-ray Mins (%)	Total Time Spent Mins
08/11/2021	09:00 AM-10:00 AM	Tom Jerry (10001488)	MALL	Exams - R/200	BLAKE	-	-	554(90.90 %)	-	554
08/09/2021	10:30 AM-11:00 AM	Tom Jerry (10001488)	MALL	Exams - PERR	BLAKE	2(3.20 %)	247(86.24 %)	-	-	250
08/09/2021	10:30 AM-11:00 AM	Tom Jerry (10001488)	MALL	Exams - R/200	BLAKE	-	-	-	-	0

The results columns shown in this report include:

#### Appointment Date

The date the patient was scheduled to receive treatment.

#### Appointment Time

The time frame in which the patient was scheduled to be treated.

#### Patient Name

The name (and patient ID) of the patient that was seen by a treatment provider.

## Location

The location in which the patient was scheduled to receive treatment.

## Operatory

The operatory in which the patient was scheduled to be seen by a treatment provider.

## Provider

The treatment provider the patient was scheduled to see.

### Time Spent in this Appointment Status Mins.(%)

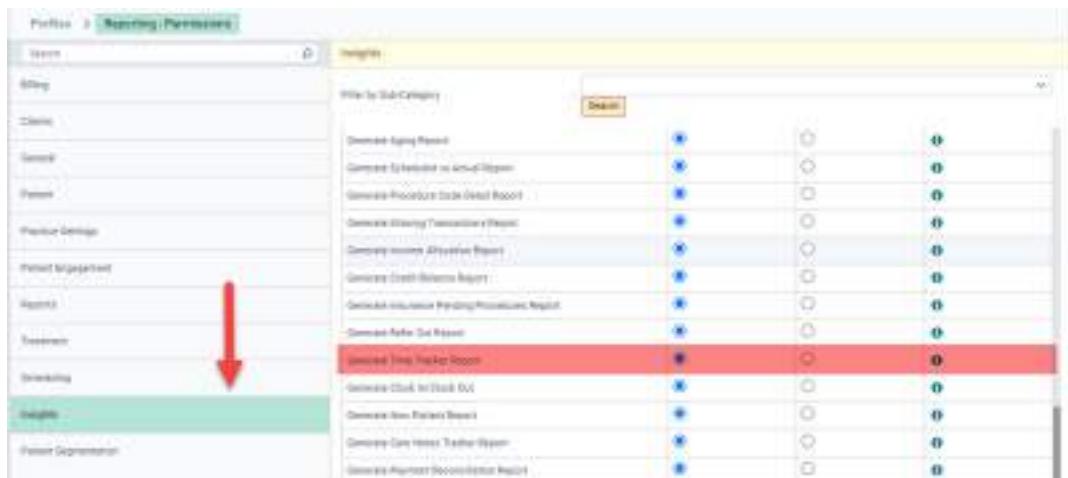
These columns list the appointment statuses specified in the report generation criteria, along with the total time of selected appointment statuses( in minutes) with this provider/location combination.

### Total Time Spent Mins.

This column states the total amount of time the patient spent in these appointment statuses (calculating time spent in all selected appointment statuses together).

## Permissions

Permissions for the Patient Time Tracker report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Time Tracker Report. Only users with **Generate Time Tracker Report** permission set as Yes will be able to generate the report.



# Pre Authorization Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

Pre-authorizations are used to confirm what percentage of procedure code fees the carrier will cover for the patient. With pre-authorization, you submit the treatment codes to the carrier and enquire and confirm what they will pay, instead of completing the treatment and then crossing your fingers and hoping they pay.

The pre-authorization report is used to track the status of the pre-authorization that has been created. It allows a user to confirm pre-auth has indeed been sent, monitor the status, and schedule patients for whom pre-auths have been approved.

This report shows real-time data and has two views- Summary view and Detail view. The summary view shows the total number of pre-auths created by their current statuses and total estimate fees for the created pre-auths grouped either by a treatment provider or treatment location. The detailed view gives the information regarding each Auth form including details like Created Date, Auth ID, Patient Name, Est. Fee, Est. Ins, Est. Pat, Auth Status, Sched. Status, Carrier Name, Plan Name, Submitted Date, Auth No, Subscriber Name, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the pre-authorization summary view report your filter options include:

#### Group By\*

Pre-authorization summary view report can be grouped by treatment provider or by treatment location.

#### Date Range\*

The pre-authorization report is dated by **created date**. The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day.

#### Location\*

Select a location or locations to focus the report on the **pre-authorizations in the selected location(s)**. By default, the location will be the user's default location.

#### Provider

Select a provider or providers to focus the report on pre-authorizations with the selected provider(s) as treatment provider.

#### Auth status

Select an Auth status to focus the report on.

### Detail View

For the pre-authorization Detail View report, your filter options include:

#### Date Range\*

The pre-authorization report is dated by **created date**. The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day.

#### Location\*

Select a location or locations to focus the report on the **pre-authorizations in the selected location(s)**. By default, the location will be the user's default location.

#### Provider

Select a provider or providers to focus the report on pre-authorizations with the selected provider(s) as treatment provider.

#### Auth status

Select an Auth status to focus the report on.

#### Sched. Status\*

Choose to focus the report on the scheduled status of the treatment on the authorization.

#### Columns\*

Choose the columns you wish to see in this report. By default, 14 most relevant columns are selected.

## Sorting

The default sorting of the Pre authorization report will be by auth ID. Sorting is also available on created date, submitted date, UCR fee, Est fee, Est. Ins, Est. pat, Actual. Ins, Actual. pat.

## Results

### Summary view

The report provides information in column form grouped by either treatment provider or treatment location as selected. It shows the consolidated values of all locations and providers on top as well. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Pre Authorization Summary / 2 Locations / All Providers / All Auth. Status / 10/06/2021 - 10/07/2021						
Consolidated Total	Not Scheduled			Scheduled		Grand Total
	Auth. Status	Count	Est. Fee	Count	Est. Fee	
Completed	0	\$0.00	0	\$0.00	0	\$0.00
Draft	0	\$0.00	0	\$0.00	0	\$0.00
Pending	0	\$0.00	0	\$0.00	0	\$0.00
Rejected	0	\$0.00	0	\$0.00	0	\$0.00
<b>Total</b>	<b>0</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>
Detailed Data: Active (10/06/2021)						
Active	Not Scheduled			Scheduled		Grand Total
	Auth. Status	Count	Est. Fee	Count	Est. Fee	
Completed	0	\$0.00	0	\$0.00	0	\$0.00
Draft	0	\$0.00	0	\$0.00	0	\$0.00
Pending	0	\$0.00	0	\$0.00	0	\$0.00
<b>Total</b>	<b>0</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>

The report shows the consolidated total number of auths created in the practice split into 2 categories based on the scheduled/unscheduled status of the code.

The results columns shown in this report include:

#### Auth Status

The current status of the pre-authorizations, whether it is in Draft status, Completed, Rejected, and so on.

#### Not Scheduled - Count

The number of authorizations created for codes that are not scheduled.

#### Not Scheduled - Est. Fee

The total estimated fees for all authorizations with no scheduled procedures included.

#### Scheduled - Count

The number of authorizations with at least one scheduled procedure code in this status.

#### Scheduled - Est. Fee

The total estimated fees for all authorizations with at least one scheduled procedure included.

#### Grand Total - Count

The grand total number of procedure codes included on authorizations in this status.

#### Grand Total - Est. Fee

The grand total of estimated fees of all procedure codes included on authorizations in this status.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these pre-auths and their details.

## Detail view

The results columns shown in this report include:

### **Created date**

Date of creation of the pre-authorization.

### **Submitted date**

The date on which the authorization was marked as submitted in the system.

### Auth ID

The system-assigned number used to identify the unique authorization that has been generated. Click this hyperlink to open this authorization request record.

**Auth No**

The number given to you by the insurance carrier used to identify the specific pre-authorization estimate that has been provided.

**Patient Name**

The name of the patient to which this pre-authorization pertains.

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to the Authorizations page of the patient's profile.

**DOB**

The patient's date of birth according to the information specified on their patient profile.

**Contact No**

The patient's phone number, provided here for convenient access for your workflow needs.

**Subscriber Name**

The name of the subscriber listed on this patient's insurance plan.

**Subscriber ID / SSN**

The subscriber's ID or social security number is used to identify the subscriber and their coverage.

UCR Fee

The total UCR fees calculated from these procedure codes on the auth are based on your office's standard fees (according to your practice settings).

**Est. Fee**

The estimated total receivable for the procedure codes on this preauthorization.

Est. Ins

The estimated insurance receivable for the treatment is included on this preauthorization.

#### **Est. Pat**

The estimated patient receivable for the treatment is included on this preauthorization.

#### **Authorization Status**

The current status of the pre-authorizations, whether it is in Draft status, Completed, Rejected, and so on.

#### **Actual Ins**

The estimated insurance payable as provided by the insurance carrier in the authorization response.

#### **Actual Pat**

The estimated patient payable as provided by the insurance carrier in the authorization response.

#### **Sched. Status**

The status of the treatment on the authorization, whether it has been scheduled yet or not.

#### **Mode**

The mode of the pre-authorization, whether your office has submitted it electronically or by paper.

#### **Location**

The location in which the authorization has been generated. It is the treatment location of the codes.

#### **Provider**

The treatment provider pertaining to the procedures included on the authorization.

#### **Provider TIN/ NPI**

The treatment provider's unique identifier number is used to distinguish the eligible clinician.

#### **Carrier Name**

The name of the insurance carrier to which this pre-authorization pertains.

#### **Carrier ID**

The carrier identifier number used to route an electronic claim to the correct destination (i.e. insurance carrier).

#### **Carrier Phone No**

The phone number used to reach the insurance carrier (as entered in insurance details in your practice settings).

#### **Plan Name**

The name of the patient's insurance plan pertaining to this treatment and pre-authorization request.

## **Use Cases**

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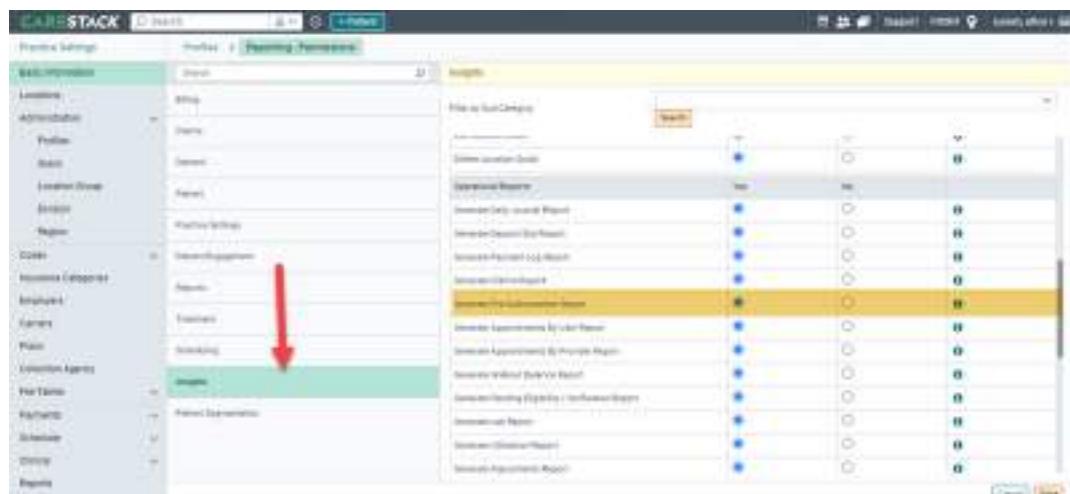
The Pre-authorization report is designed to help the practice keep track of the pre-authorizations created in the practice. The report can be used to see how many pre-authorizations are created for procedures that are yet to be scheduled or are created for codes that are scheduled. This will help the practice to plan their treatments and get an idea of actions that have to be taken on the procedure code.

The fee estimates for the production will also help the practice in determining the estimate from insurance for the treatments on the pre-auths.

## **Permissions**

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Permissions for the Pre Authorization report will be in System Menu -> Practice Settings -> Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Pre Authorization Report. Only users with **Generate Pre Authorization Report** permission set as Yes will be able to generate the report.



# Production Summary Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

The Production Summary report is intended to show the providers' overall production details with respect to different treatment locations. The report can be used to view each provider's Gross Production against the total number of procedures completed under each location. Users have the flexibility to group the report by the provider or by location to see the provider production summary or the location provider summary.

This report shows real-time data and is available in two views- Summary and Detail view. The summary view shows the total no of completed procedures, gross production, no. of appointments % of total production, etc, and shows the production summary for each provider or for each location as per the grouping. The detail view shows the patient level details along with the Code, Patient id, DOS, Patient and Insurance amount, etc that contributed to the production towards the provider and location.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the Production Summary Report Summary View, your filter options include:

#### Date As\*

Choose to focus the report with the selected Date as the Date Of Service or Transaction Date. By default, the date will be selected as Date Of Service. On choosing the date as DOS, filter out codes with DOS in the selected date range. On choosing the date as Trans. Date, filter out all code completions, fee updates, code deletions, with transaction date in the selected date range.

#### Date Range\*

Choose to focus the report within the selected date range. The date range can be selected for a maximum of 3 months. By default, the date range will be for the current day.

#### Group By\*

Production summary's summary view report can be grouped by treatment provider or by treatment location. This decides grouping the production by Location/Provider. By default, it will be set as Provider.

#### Treatment Location\*

Choose the locations in which the report data should be focused. By default, the location will be the user's default location.

#### Provider Type\*

Choose whether to focus your report based on the selected treatment provider type. The multi-select dropdown shows Dentist, Hygienist, and In-house provider as options. This helps to filter production, fee updates, deletions by the provider type of the provider. By default, all will be selected.

#### Treatment Provider

Choose whether to focus your report only on the selected provider(s). By default, all will be selected.

#### Exclude Inactive Providers

Checking this excludes inactive providers. By default, it would be checked.

#### Exclude Migrated Production

Checking this excludes production entries involving MSB codes. By default, it would be checked.

## Detail View

For the Production Summary Detail View Report, your filter options include:

#### **Date As\***

Choose to focus the report with the selected Date as the Date Of Service or Transaction Date. By default, the date will be selected as Date Of Service. On choosing the date as DOS, filter out codes with DOS in the selected date range. On choosing the date as Trans. Date, filter out all code completions, fee updates, code deletions, with transaction date in the selected date range.

#### **Date Range\***

Choose to focus the report within the selected date range. The date range can be selected for a maximum of 3 months. By default, the date range will be for the current day.

#### **Treatment Location\***

Choose the locations in which the report data should be focused. By default, the location will be the user's default location.

#### **Provider Type\***

Choose whether to focus your report based on the selected treatment provider type. The multi-select dropdown shows Dentist, Hygienist, and In-house provider as options. This helps to filter production, fee updates, deletions by the provider type of the provider. By default, all will be selected.

#### **Treatment Provider**

Choose whether to focus your report only on the selected provider(s). By default, all will be selected.

#### **Code**

Choose whether to filter out codes contributing to production. By default, all will be selected.

#### **Action**

If the date as selection is as Trans. Date, the possible actions in the dropdowns are Code completion, Code deletion, and Fee updates. This field is present if the date as selected is the trans date.

#### **Exclude Inactive Providers**

Checking this excludes inactive providers. By default, it would be checked.

#### **Exclude Migrated Production**

Checking this excludes production entries involving MSB codes. By default, it would be checked.

## **Sorting**

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The default sorting for the Production Summary report will be by the DOS (desc.) or trans. Date as per the Date As filter selected.

## **Results**

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### **Summary view**

The report provides information in column form grouped by treatment location or treatment provider as selected. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Production Summary - #Completed Procedures, No of Appointments, Avg Prod (\$), % of Total Production								
Location	#Completed Procedures	No. of Appointments	Avg Prod (\$)	% of Total Production	Avg Prod (\$)	% of Total Production	Avg Prod (\$)	% of Total Production
1-0001	22 00	0	0	0	0.00	0.00	0.00	0.00
Group Production - #Completed Procedures, No of Appointments, Avg Prod (\$), % of Total Production								
1-0001	22 00	0	0	0	0.00	0.00	0.00	0.00
Overall (DOS/Trans Date Range)								
1-0001	22 00	0	0	0	0.00	0.00	0.00	0.00
1-0002	22 00	0	0	0	0.00	0.00	0.00	0.00
Total Production - #Completed Procedures, No. of Appointments, Avg Prod (\$), % of Total Production								
1-0001	22 00	0	0	0	0.00	0.00	0.00	0.00
1-0002	22 00	0	0	0	0.00	0.00	0.00	0.00

The results columns shown in this report include:

#### Location/ Provider

If group by selection is location, the column title will be provider and show the contribution from each provider's split by location group.

If the group by selection is by provider, the column title will be location and show the contribution from each location split by provider group.

#### Gross Production

It would list the gross production made by each provider/location. There would be a total in the end to show the group aggregate value.

#### #Completed Procedures

In the DOS version, it represents the number of code completions with DOS in the selected date range. In the trans. date version, it represents the number of code completions that were checked out transactionally in the selected date range.

#### Patients Seen

The number of patients seen by the provider in the location across the selected date range.

#### No. of Appointments

This lists the number of appointments in the selected date range which are in the checked-out status. If the treatment provider has an appointment linked to that code, it is considered. The distinct appointment count for multiple codes completed in the same appointment is considered.

#### Avg Prod (\$) Per Code

This shows the Gross production/Codes completed based on DOS for DOS version and based on transactional code completions for Trans version.

#### Avg Prod (\$) Per Patient

This shows the Gross production/Patient seen completed.

#### Avg Prod (\$) Per Appt

This shows the Gross production/Number of checked-out appts.

#### % of Location/Provider Production

If the group by is by Provider, this column shows % of Provider Production, by taking each location production under that provider/total production in that grouping. If the group by is by Location, this shows % of Location Production, by taking each provider production under that location/total production in that grouping.

#### % of Total Production

If the group by is by Provider, this column shows % of Total Production, by taking each location production/consolidated total production. If the group by is by Location, this column shows % of Total Production, by taking each provider production/consolidated total production.

#### Distinct Patients Seen

In location grouping, it gives the distinct patient seen count across the selected date range, in that particular location(across all provs). In Provider Grouping, it gives the distinct patient seen count across the selected date range, by that treatment provider(across all locs).

### **Distinct Checked Out Appts**

In location grouping, it gives the total (active) checked-out appointments in the selected date range. In Provider Grouping, it gives the total (active) distinct checked-out appointments (each day) in which the provider is the treatment provider.

### **% of Dentist Production**

Column in Location grouping only. Total production made from providers with provider type as Dentist/total production.

## % of Hygiene Production

Column in Location grouping only. Total production made from providers with provider type as hygienist/total production.

### % of Inhouse Production

Column in Location grouping only. Total production made from providers with provider type as Inhouse Provider/total production.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing these productions and their details.

## Detail view

The results columns shown in this report include:

**D.O.S/ Transaction Date**

The column is named as D.O.S when date as selection is Date Of Service and it is named as Transaction Date when date as selection is Transaction Date.

## Action

This column is present if the date as selection is as Trans. Date and the possible actions applied against the code will be seen here as Code completion, Code deletion, and Fee updates.

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to this patient's overview.

**Patient Name**

The name of the patient that was seen for treatment.

## Code

The procedure code in which the code completion, deletion, updates were made against.

## **Code Description**

The description of the procedure code used.

### Tx. Location

The location where the treatment of the code was completed, deleted or fee update was made.

**Tx. Provider**

The treatment provider of the code when the action was made.

#### **Pat Amt**

Patient estimate of the code. If the action is Code Deletion or if the fee update is to a decreased amount then this entry would be in Red color. You can see the amount in Red Color within Red brackets like this **(\$10.00)**

#### **Ins Amt**

Insurance estimate of the code. If the action is Code Deletion or if the fee update is to a decreased amount then this entry would be in Red color.

#### **Total Amt**

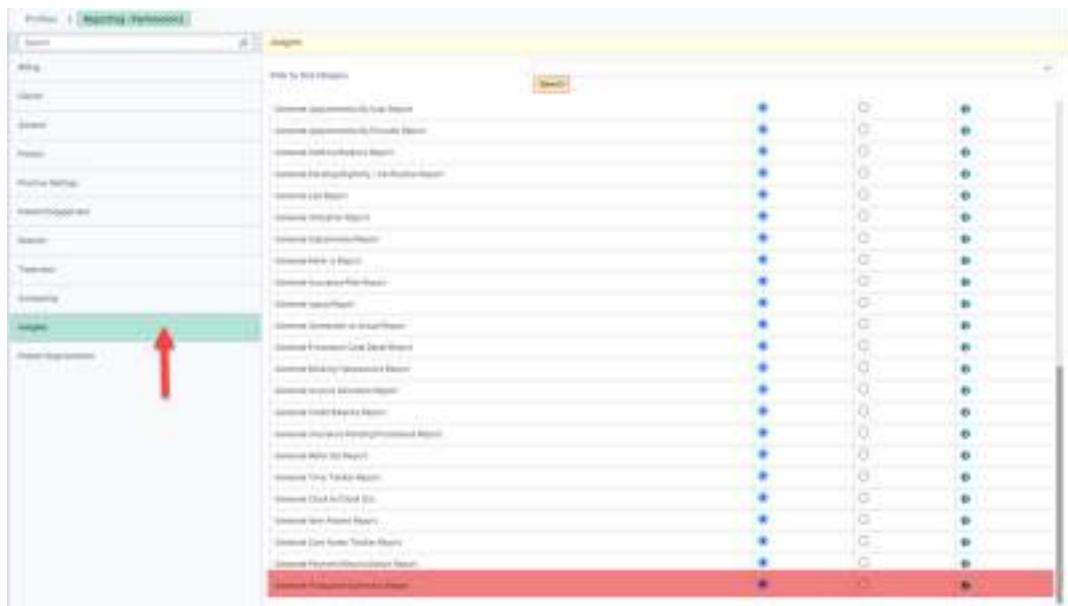
Sum of the total patient estimate and the insurance estimate of the code. If the action is Code Deletion or if the fee update is to a decreased amount then this entry would be in Red color.

#### **Last Modified User**

This shows the user who performed the action.

## Permissions

Permissions for the Production Summary report will be in System Menu -> Practice Settings ->Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Production Summary Report. Only users with **Generate Production Summary Report** permission set as Yes will be able to generate the report.



# Utilization Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

Utilization reports are typically used to monitor the frequency of diagnosis relative to peers or industry standards (for example the ratio of SRPs to Standard Prophy for hygienists). They are also used to assist in negotiating fees for insurance contracts (as it will show the highest volume of codes for which to focus), as well as average fee/reimbursement rates.

Utilization report is based on the Date of Service and shows real-time data. The Utilization report is available in two views- Summary and Detail view. The summary view has a pivot structure that allows you to group the information and drill down into further groupings.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the Utilization Summary View report, your filter options include:

#### Date of Service\*

Focus the report on procedure codes completed within the selected date range. The user can select a maximum of up to 1 year. By default, the date range will be for the current day.

#### Group By\*

Decide whether to group the report results based on Treatment Location, Treatment Provider, Treatment Provider Type, Primary Insurance Carrier, and/or Code. The report results will display in the order that the data variables are selected. By default, Code will be selected.

#### Treatment Location\*

Focus the report based on the location the codes were completed in. The user can select a maximum of up to 10 locations. By default, the location will be the user's default location.

#### Treatment Provider Type

Choose whether to focus your report on treatment completed by the selected provider type(s).

#### Treatment Provider

Choose whether to focus the report on treatment completed by the selected provider(s).

#### Primary Insurance Carrier

Choose whether to focus the report on procedure codes billed out to the selected insurance carrier(s).

#### Code

Choose whether to focus the report only on the selected procedure code(s)

#### Exclude Migrated Production

Checkbox this option to exclude migrated codes and their production.

## Detail View

For the Utilization Detail View report, your filter options include:

#### Date of Service\*

Focus the report on procedure codes completed within the selected date range. The user can select a maximum of up to 1 year.

#### Group By\*

Decide whether to group the report results based on Location, Treatment Provider, Treatment Provider Type, Carrier, and/or Code or you can choose no grouping. Unlike the summary view, only one of them can be selected. By default, Treatment Location is selected.

#### Treatment Location\*

Focus the report based on the location the codes were completed in. The user can select a maximum of up to 10 locations.

#### Treatment Provider Type

Choose whether to focus the report on Treatment Provider type from Dentist, Hygienist, In-house types.

#### Treatment Provider

Choose whether to focus the report on treatment completed by the selected provider(s).

#### Primary Insurance Carrier

Choose whether to focus the report on procedure codes billed out to the selected insurance carrier(s).

#### Code

Choose whether to focus the report only on the selected procedure code(s).

#### Columns\*

Choose the columns which the user wishes to see in this report. By default, all the columns except Def. Provider Short Name and Def. Hygienist Short Name will be selected.

## Sorting

The default sorting for the Utilization report will be by Date Of Service. Sorting is possible on Patient Name, UCR Fee, Patient Gross Production, Insurance Gross Production, Total Gross Production, Contractual Adj, Patient Applied Payment, Insurance Applied Payment, Applied Payment Columns as well.

## Results

### Summary view

The report provides information in column form. The report results will display in the order that the data variables in the *Group By* filter are selected. The user can drill through the options based on that order. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

Utilized Summary													
Numbered Rec.	Wk Rec'd	UCR	Patient Gross	Insur Gross	Contractual Adj	Patient Applied	Insur Applied	Applied Payment	Appl. Drt. Adj.	Appl. Drt. Reg.	Appl. Drt. Reg.	Appl. Drt. Reg.	
1002746	0	00000000	\$1,118,669.00	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002747	1	00000000	\$1,118,677.00	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002748	2	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002749	3	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002750	4	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002751	5	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002752	6	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002753	7	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002754	8	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002755	9	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002756	10	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002757	11	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002758	12	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002759	13	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002760	14	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002761	15	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002762	16	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002763	17	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002764	18	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002765	19	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002766	20	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002767	21	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002768	22	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002769	23	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002770	24	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002771	25	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002772	26	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002773	27	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002774	28	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002775	29	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002776	30	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002777	31	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002778	32	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002779	33	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002780	34	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002781	35	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002782	36	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002783	37	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002784	38	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002785	39	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002786	40	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002787	41	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002788	42	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002789	43	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002790	44	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002791	45	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002792	46	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002793	47	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002794	48	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002795	49	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002796	50	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002797	51	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002798	52	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002799	53	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002800	54	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002801	55	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,000	
1002802	56	0	\$1,091,000	\$1,091,000	\$1,091,000	\$1,091,0							



## Detail view

The results columns shown in this report include:

D.O.S

The Date Of Service of the code.

**Patient ID**

The system-assigned number used to identify this patient and their records. Click this hyperlink to be taken to this patient's completed procedures.

## Patient Name

The name of the patient that was seen for treatment.

## Code

The procedure code that has been completed.

### **Primary Insurance Carrier**

The carrier pertaining to this patient's primary insurance plan.

## Tx Provider Type

Shows the Treatment provider of the associated provider.

**Tx Provider Short Name**

Shows the Short name of the Tx provider.

## Tx Provider

Shows the name of the associated provider.

## Def Provider Short Name

Shows the short name of the default provider of the patient.

## Def Provider

Shows the name of the default provider of the patient.

**Def Hygienist Short Name**

Shows the short name of the default hygienist of the patient.

## Def Hygienist

Shows the name of the default hygienist of the patient.

**Tx Location Short Name**

Shows the short name of the treatment location.

### **Tx Location**

Shows the treatment location.

## **UCR Fee**

The total UCR fees calculated from these procedure codes based on your office's standard fees (according to your practice settings).

### **Pat. Gross Production (DOS)**

The total patient responsibility according to the patient payable at the time of code completion.

### **Ins Gross Production (DOS)**

The total insurance responsibility according to the insurance payable at the time of code completion.

## Total Gross Production (DOS)

The total expected receivable according to the patient and insurance payables at the time of code completion.

## Contractual Adj (DOS)

The contractual adjustment which is the difference between the office's standard fee and payable according to what the insurance carrier has agreed to pay.

### Patient Applied Paid (DOS)

The dollar amount the patients have paid toward the expected receivables.

**Insurance Applied Paid (DOS)**

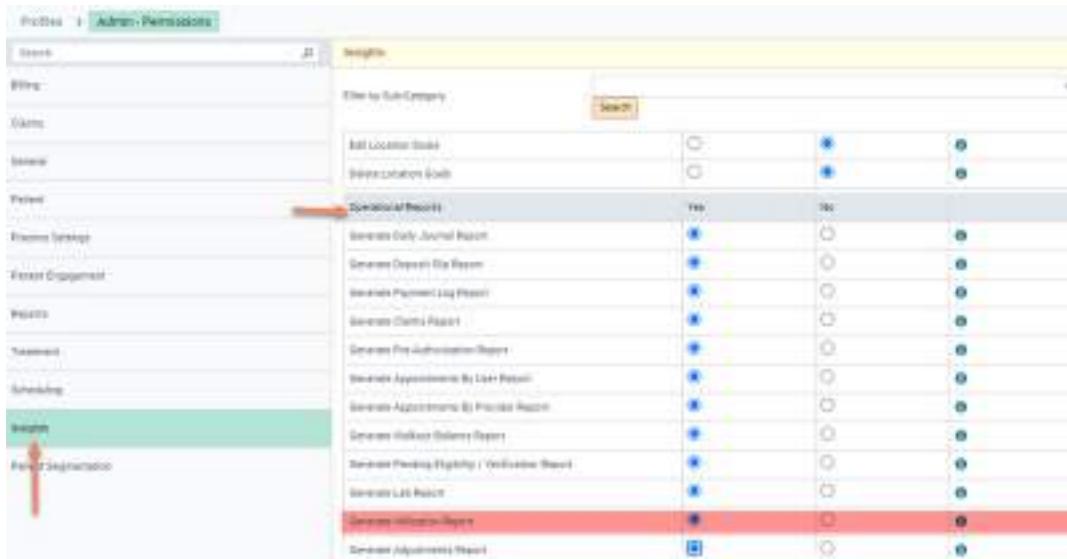
The average dollar amount insurance carriers have paid towards this procedure code, calculated by dividing the Total Insurance Paid by the Number of Codes.

## **Applied Payment (DOS)**

The total dollar amount that has been paid toward this procedure code's expected receivables, including both patient and insurance payments.

# Permissions

Permissions for the Utilization report will be in System Menu -> Practice Settings -> Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Utilization Report. Only users with **Generate Utilization Report** permission set as Yes will be able to generate the report.



# Payment Log Report

Written by Roshni R | Last published at: August 23, 2021

## Overview

The Payment Log report is used to balance and review revenue performance.

The Payment Log Report can be generated based on Transaction Date, Payment Date, or Deposit Date. This report shows real-time data. The Payment Log report is available in two views- Summary and Detail view.

The summary view shows the consolidation of actions, applied and unapplied amount for the particular location selected. Moreover, the summary view also shows the consolidated total so that you can see the actions, applied and unapplied amount consolidated across the selected locations. The detail view gives detailed information on each action including the type, transaction date, name, payment date, deposit date, amount, etc.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the Payment Log Summary View Report, your filter options include:

#### **View By\***

Payment Log summary view report can be viewed by Payment Category or by Payment Type. By default, the view will be for the payment category.

#### **Date As\***

Choose to run your report based on Transaction Date, Payment Date or Deposit Date. By default, the date will be the transaction date.

#### **Date Range\***

Choose to focus the report on payments dated within the selected date range (based on your choice of Transaction Date, Payment Date, or Deposit Date). Select a maximum of up to 1 month. By default, the date range will be for the current day.

#### **Location\***

Choose to focus your report based on payments entered at the selected location(s). By default, the location will be the user's default location.

#### **Action**

The action of the transaction done whether it was Patient Receipt Addition, Patient Receipt Deduction, Insurance Receipt Addition, Insurance Receipt Deduction, Collection Receipts, and so on. By default, all will be selected.

#### **Paying Entity\***

Choose to focus your report based on the paying entity you want to see, such as patient payments, insurance payments, or collection agency payments. By default, all will be selected.

#### **User**

Choose to focus your report based on the selected user(s) who performed the transaction.

## Detail View

For the Payment Log Detail View Report, your filter options include:

#### **Date As\***

Choose to run your report based on Transaction Date, Payment Date, or Deposit Date. By default, the date will be the transaction date.

#### **Date Range\***

Choose to focus the report on payments dated within the selected date range (based on your choice of Transaction Date, Payment Date, or Deposit Date). Select a maximum of up to 1 month. By default, the date range will be for the current day.

#### **Location\***

Choose to focus your report based on payments entered at the selected location(s). By default, the location will be the user's default location.

#### **Action**

The action of the transaction done whether it was Patient Receipt Addition, Patient Receipt Deduction, Insurance Receipt Addition, Insurance Receipt Deduction, Collection Receipts, and so on. By default, all will be selected.

#### **Payment Category**

The category of payment, whether it was made by cash, check, credit card, and so on.

#### **Payment Type**

Select this option to focus your report on the payment types in your practice. Only payment types with categories set as Care Credit, Cash, Check, Credit/Debit card, and direct transfer will be available for the report.

#### **Paying Entity\***

Choose to focus your report based on the paying entity you want to see, such as patient payments, insurance payments, or collection agency payments. By default, all will be selected

#### **User**

Choose to focus your report based on the selected user(s) who performed the transaction.

#### **Columns\***

Choose the columns you wish to see in this report. By default, all the columns will be selected.

## **Sorting**

---

The default sorting for the Payment log report will be by Trans. Date (asc). Sorting is possible on Trans. Date, Payment Date, Deposit Date, Amount, Applied and Unapplied columns as well.

## **Results**

---

### **Summary view**

The report provides information in column form grouped by treatment location as selected. It shows the consolidated values of all locations on top as well. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

N/A

	Applied	Unapplied	Amount
Patient Receipt Addition	\$76,00	\$72,000.00	\$92,000.00
CASH	\$76,00	\$0.00	\$76,00
WEEK	\$0.00	\$0.00	\$0.00
CREDIT/DEBIT CARD	\$0.00	\$0.00	\$0.00
Patient Receipt Deduction			(\$441.00)
CASH			(\$441.00)
Impact NSF			\$0.00
CHCK			\$0.00
Patient Adjustment			(\$1,221.00)
CARD CREDIT			(\$151.00)
CREDIT/DEBIT CARD			(\$1,001.00)
Insurance Receipt Addition	3241.00	\$0.000.00	\$3,181.00
CASH	\$612.00	\$0.00	\$6,000.00
CHCK	\$27.00	\$0.00	\$27.00
DIRECT TRANSFER	\$2,000.00	\$0.00	\$2,000.00
Collection Receipt	\$440.00	\$0.00	\$4,000.00
CASH	\$440.00	\$0.00	\$4,000.00
Impact Total	\$797.00	\$0.00	\$7,298.00

The columns in the Summary view include:

#### Applied

The dollar amount of payments that have already been applied towards an outstanding balance.

#### Unapplied

The dollar amount of payments that have yet to be applied towards an outstanding balance.

#### Amount

The total dollar amount of this payment type that has been accepted/deposited / entered/refunded / written-off (and so on) within the system during the selected time frame.

This view shows the **Applied**, **Unapplied**, and **Amount** of the following sections:

#### Patient Receipt Addition

This section lists the payment types that have been collected via patient payments within the selected date range -- along with the total dollar amount of this payment type that has been collected, the dollar amount that has already been applied towards a balance, and the remaining dollar amount that has yet to be applied towards any balance

#### Patient Receipt Deduction

This section lists the patient payment types that have had a refund completed in the system within the selected date range -- along with the total dollar amount of this payment type that has been refunded.

#### Patient NSF

This section lists the patient payment types that have been marked as Non Sufficient Funds in the system within the selected date range -- along with the total dollar amount of this payment type that has been written-off due to non-sufficient funds.

#### Patient Adjust-Off

This section lists the patient payment types that have had monetary credits adjusted-off in the system within the selected date range -- along with the total dollar amount of this payment type that has been adjusted-off.

#### Insurance Receipt Addition

This section lists the payment types that have been collected via insurance payments within the selected date range -- along with the total dollar amount of this payment type that has been collected, the dollar amount that has already been applied towards a balance, and the remaining dollar amount that has yet to be applied towards any balance.

#### Insurance Receipt Deduction

This section lists the insurance payment types that have had a refund completed in the system or had been transferred to patients within the selected date range (along with the total dollar amount of this payment type that has been refunded).

#### Collection Receipts

This section lists the payment types that have been collected via collection agency payments within the selected date range -- along with the total dollar amount of this payment type that has been collected, the dollar amount that has already been applied towards a balance, and the remaining dollar amount that has yet to be applied towards any balance.

The blue-colored entries are links to the detail view of the corresponding entry. Click the hyperlinks to view a Detail Report listing their details.

#### Detail view

The results columns shown in this report include:

## Type

The type of payment, whether it is a patient payment addition or deduction, insurance payment addition or deduction, or collection agency payment addition or deduction.

**Trans. Date**

The date on which the transaction was completed in the system.

Name \_\_\_\_\_

The name of the payer, whether it is a patient, insurance carrier, or collection agency.

**Payment Date**

The date the payment was made.

**Deposit Date**

The date the payment was deposited by your office.

Receipt#

The system-assigned number used to identify the payment that has been entered into the system. Click this hyperlink to be taken to this patient's ledger.

## Location

The location pertaining to the payment that has been deposited

### Payment Category

The category of payment, whether it was made by cash, check, credit card, and so on.

**Payment Type**

The type of payment accepted whether it was made via Visa, Master Card, Cash, Check, and so on.

Ref No

The reference number entered by your office staff member accepting the payment

## Amount

The total dollar amount of the payment made

## Annals

The dollar amount of the payment that has already been applied towards an outstanding balance.

## Unapplied

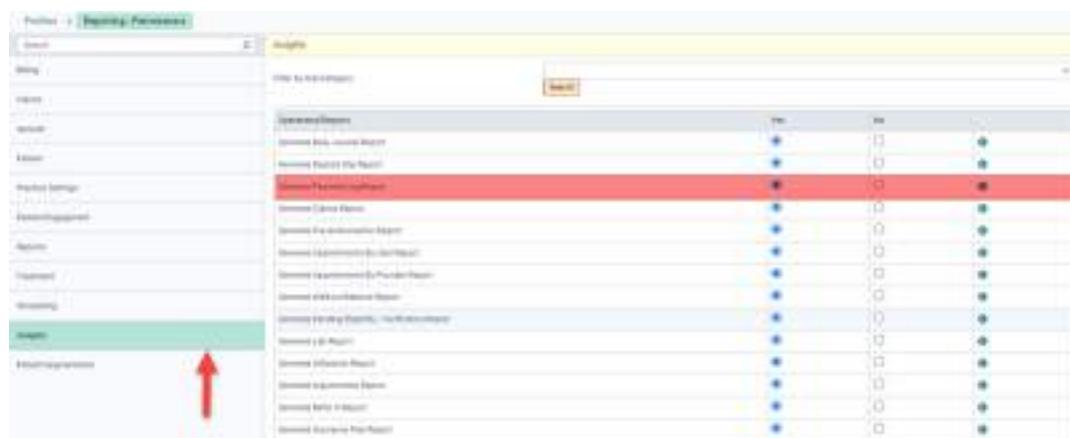
The dollar amount of the payment that has yet to be applied towards an outstanding balance.

### Usage Name

The name of the user that accepted the payment and entered it into the system

## Permissions

Permissions for the Payment Log report will be in System Menu -> Practice Settings -> Administration -> Profiles -> Manage Permissions -> Insights -> Under Operational Reports -> Generate Payment Log Report. Only users with **Generate Payment Log Report** permission set as Yes will be able to generate the report.



# Payment Log Beta Report

Written by Roshni R | Last published at: September 28, 2021

## Overview

Payment Log Beta report is used to balance and review revenue performance.

The Payment Log Beta Report can be generated based on Transaction Date or Payment Date and it shows real-time data. The Payment Log Beta report is available in four views- Summary view, Collection View, Transaction view, Receipt View.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Summary view

For the Payment Log Beta Summary View Report, your filter options include:

#### Date Range\*

Choose to focus the report on payments dated within the selected date range. Select a maximum of up to 3 months. By default, the date range will be for the current day.

#### Date As\*

Choose to focus the report on the date type to filter out the receipts based on Transaction Date & Payment Date. By default, the transaction date will be selected.

#### Receipt Location\*

Choose to focus the report on selecting the location filter so that the user can filter out receipts added to a specific location. By default, the user's default location will be selected.

#### Paying Entity\*

Choose to focus your report based on the paying entity you want to see, such as patient payments, insurance payments, or collection agency payments. By default, all will be selected.

#### User

Choose to focus your report based on the selected user(s). By default, all will be selected.

#### Group Collection By\*

Choose to focus the report to select the collection summary section group by. By default, the payment category should be selected. The dropdown will have the following options: Payment Category, Payment Type, Location, Payment Method, Payment Source, and None.

#### Show Collection By Paying Entity

Checkmark this option if you would like to include the paying entity in the report. By default, it will be checked.

### Collection View

For the Payment Log Beta Collection View Report, your filter options include:

#### Date Range\*

Choose to focus the report on payments dated within the selected date range. Select a maximum of up to 3 months. By default, the date range will be for the current day.

#### Date As\*

Choose to focus the report on the date type to filter out the receipts based on Transaction Date & Payment Date. By default, the transaction date will be selected.

**Receipt Location\***

Choose to focus the report on selecting the location filter so that the user can filter out receipts added to a specific location. By default, the user's default location will be selected.

**Paying Entity\***

Choose to focus your report based on the paying entity you want to see, such as patient payments, insurance payments, or collection agency payments. By default, all will be selected.

**Payment Category**

Choose to focus your report based on the category of payment, whether it was made by cash, check, credit card, and so on.

**Payment Type**

Choose to focus your report based on the type of payment accepted whether it was made via Visa, Master Card, Cash, Check, and so on.

**Payment Method**

Choose to focus the report based on the method of payment whether it was Regular, Advanced, Payment Plan, Patient Portal, Payment Portal, and Capitation.

**Payment Source**

Choose to focus the report based on the source of the payment whether it was Bluepay, Carestack Pay, Apex Payments, None or Not Applicable.

**Patient**

Choose to focus the report based on the selected patients.

**Carrier**

Choose whether to focus your report on only the selected carrier(s).

**Collection Agency**

Choose whether to focus your report on only the selected collection agency(s).

**User**

Choose to focus your report based on the selected user(s) who created the receipt.

**Receipt Action**

Choose to focus your report based on the receipt action whether it was Receipt Created, Receipt Updation, and Receipt Deletion.

**Columns\***

Choose the columns you wish to see in this report.

**Hide Patient Name**

Checkmark this option if you would like to hide the patient name from patient payments. By default, it will not be checked.

**Show Collection By Paying Entity**

Checkmark this option if you would like to include the paying entity in the report. By default, it will be checked.

**Group Collection by\***

Choose to focus the report to select the collection group by. By default, the payment category should be selected. The dropdown will have the following options: Payment Category, Payment Type, Location, Payment Method, Payment Source, and None.

**Show Receipts with Transaction Charges Only**

Checkmark this option if you would like to include the receipts with transaction charges. By default, it will be checked.

**Show Remarks**

Checkmark this option if you would like to show the remarks against each receipt (which has a remark). By default, it will be unchecked.

## Transaction View

For the Payment Log Beta Transaction View Report, your filter options include:

### Date Range \*

Choose to focus the report on payments dated within the selected date range. Select a maximum of up to 3 months. By default, the date range will be for the current day.

### Date As\*

Choose to focus the report on the date type to filter out the receipts based on Transaction Date & Payment Date. By default, the transaction date will be selected.

### Receipt Location\*

Choose to focus the report on selecting the location filter so that the user can filter out receipts added to a specific location. By default, the user's default location will be selected.

### Trans. Location

Choose to focus the report to select the location filter so that they can filter out specific transactions that happened at a specific location.

### Paying Entity\*

Choose to focus your report based on the paying entity you want to see, such as patient payments, insurance payments, or collection agency payments. By default, all will be selected.

### Transaction Action

Choose whether to generate the report based on the transaction action like Applied Payments, Refunds, Transfer Receipts, Adjust Off, Provider Adjustments, Overpayment Recovery, NSF.

### User

Choose to focus your report based on the selected user(s)

### Show Transaction By Paying Entity

Checkmark this option if you would like to include the paying entity in the report. By default, it will be checked.

## Receipt View

For the Payment Log Beta Receipt View Report, your filter options include:

### Receipt# \*

Choose to focus your report based on the entered receipt number/id.

### Show Transactions\*

Choose to focus your report to show the receipt transactions by Entire Transactions or by Transactions between a certain date range. By default, the date range will be for the current day when you select the option Transactions between

### Sort By\*

Choose to focus the report to sort the receipt by Transaction Date or by Amount. By default, the Transaction date will be selected.

## Sorting

---

Sorting is possible on Trans. Date, Receipt Of, Payment Date, Created User and Amount as well.

## Results

---

### Summary view

The report provides information in column form. Remember that you can use the tools in the top blue icon bar to move quickly through the pages or adjust the size.

The report has mainly 2 sections: Collection Summary and Transaction Summary.

### Collection Summary

The collection summary section would be grouped by Paying Entity (if the user selected the group by paying Entity). Under each paying entity group section, the grouping will be done based on the selection on the Group Collection By filter.

The collection summary has the following columns:

#### Collected

This would show the amount collected from receipts that were added in the specified date range.

#### Updated (Only for transaction date)

This would show the amount which was updated on the receipts during the specified date range.

#### Deleted (Only for transaction date)

This would show the dollar amount of receipts that were deleted during the specified date range.

#### Trans. Charge

This would show the amount of transaction charge that was collected from receipts that were added in the specified date range.

### Gross collection

This will show the gross collection split on each paying entity. If the user deselects any specific paying entity then that section will be hidden. This section will show the gross collection transaction date for each paying entity and the total.

### Transaction Summary

This section shows the overall utilization of the collected amount. The actions coming in this section will be Collection, Applied Payments, Refunds, Transfer Receipt, Adjustoff, Provider Adjustment, Overpayment Recovery, NSF, and Unapplied. If any of the Paying entity has value in any of these actions or else the action will be hidden.

In the tx. date logic, it will show values based on the transaction date of the action that happened. All the transactions will show the net i.e., the sum of all created/updated/deleted values.

In the payment date logic, it should be shown based on the actions that happened from the selected receipts.

Payment Log (Relax) - Summary View / Receipt Location - (All) / Paying Entity - All / All Users / Date As - Transaction Date / Group By - Payment Category - 08/01/2021 - 08/11/2021

Collection Summary (Transaction Date)

Paying Entity	Collected	Updated	Deleted	Trans. Charge
Patient Payment	\$16,465.16	\$0.00	(\$123.00)	\$0.00
CASH	\$7,425.16	\$0.00	\$0.00	\$0.00
CHECK	\$8,800.00	\$0.00	\$0.00	\$0.00
CREDIT/DEBIT CARD	\$0.00	\$0.00	(\$123.00)	\$0.00
Insurance Payment	\$8,082.00	\$0.00	\$0.00	\$0.00
CASH	\$8,800.00	\$0.00	\$0.00	\$0.00
CHECK	\$0.00	\$0.00	\$0.00	\$0.00
DIRECT TRANSFER	\$0.00	\$0.00	\$0.00	\$0.00
Collection Agency Payment	\$1,800.00	\$0.00	\$0.00	\$0.00
CASH	\$1,800.00	\$0.00	\$0.00	\$0.00

Paying Entity	Insurance	Collect. Agency	Total
Gross Collection (Transaction Date)	\$16,465.16	\$0.00	\$1,800.00

Transaction Summary (Transaction Date)

Paying Entity	Insurance	Collect. Agency	Total
Collection	\$16,345.16	\$0.00	\$1,800.00
Applied Payments	\$0.00	\$0.00	\$0.00
Refunds	\$0.00	\$0.00	\$0.00
Adjust Off	\$0.00	\$0.00	\$0.00
Unapplied	\$10,000.00	\$0.00	\$0.00

Generated On: 08/11/2021, 11:10 AM (UTC-05:00) Eastern Time (US & Canada)

### Collection View

Trans. Date	Receipt Of	Receipt #	Rcp. Location	Payment Date	Deposit Date	Payment Category	Payment Type	Payment Method	Payment Source	Ref No.	Created User	Amount	Trans. Charge	Advanced Rec. Provider	Income Reduction Provider	Spc. Cred. Adj. Code	Flexi Pay	Action
2023-09-01	Patient A	REC-001	Office	2023-09-01	2023-09-01	Cash	Cash	Regular	Bluepay	1234567890	John Doe	100.00	0.00	Provider B	Provider C	SPC-CR-001	Yes	Print
2023-09-02	Patient B	REC-002	Office	2023-09-02	2023-09-02	Credit Card	Credit Card	Advanced	Carestack Pay	9876543210	Jane Smith	200.00	10.00	Provider A	Provider D	SPC-CR-002	No	Print
2023-09-03	Patient C	REC-003	Office	2023-09-03	2023-09-03	Cash	Cash	Regular	Apex Payments	5432109876	Mike Johnson	150.00	0.00	Provider E	Provider F	SPC-CR-003	Yes	Print
2023-09-04	Patient D	REC-004	Office	2023-09-04	2023-09-04	Credit Card	Credit Card	Advanced	None	1234567890	Alice White	300.00	15.00	Provider G	Provider H	SPC-CR-004	No	Print
2023-09-05	Patient E	REC-005	Office	2023-09-05	2023-09-05	Cash	Cash	Regular	Not Applicable	9876543210	Bob Black	250.00	0.00	Provider I	Provider J	SPC-CR-005	No	Print

The results columns shown in this report include:

#### **Trans. Date**

The date on which the transaction was completed in the system.

#### **Receipt Of**

The name of the patient/carrier/collection agency for whom the receipt was added. This field will also have the patient ID for the patient payments. On checking hide patient name checkbox, for patient payments, only patient ID will be seen in this column.

#### **Receipt #**

The system-assigned number used to identify the payment that has been entered into the system. Click this hyperlink to be taken to the Receipt view.

#### **Rcp. Location**

The location pertaining to the payment that has been deposited.

#### **Payment Date**

The date the payment was made as mentioned in the receipt.

#### **Deposit Date**

The date the payment was deposited by your office.

#### **Payment Category**

The category of payment, whether it was made by cash, check, credit card, and so on.

#### **Payment Type**

The type of payment accepted whether it was made via Visa, Master Card, Cash, Check, and so on

#### **Payment Method**

The method of payment accepted whether it was Regular, Advanced, Payment Plan, Patient Portal, Payment Portal or Capitation

#### **Payment Source**

The source of the payment whether it was Bluepay, Carestack Pay, Apex Payments, None or Not Applicable.

#### **Ref No.**

The reference number entered by your office staff member accepting the payment.

#### **Created User**

The name of the user that created the receipt and entered it into the system.

#### **Amount**

The total dollar amount of the payment made.

#### **Trans. Charge**

The transaction charge amount charged on receipts if any.

#### **Advanced Rec. Provider**

The provider against which an advance receipt is tagged.

#### **Income Reduction Provider**

The provider against which an income reduction is tagged.

#### **Spc. Cred. Adj. Code**

If a receipt added with special credits payment type, then the adjustment code is mentioned here.

#### **Flexi Pay**

Shows yes if the receipt is a flexi pay payment.

#### **Action**

Action column will only appear when the date is selected as the transaction date and shows the transaction action.

In the transaction date logic: receipt deletions will have a red value in the Amount column. Also if any receipt updations are done then the corresponding value will be in Black color which will be shown in the entries.

► In the payment date logic: the receipt action column will be hidden and always show receipt creation entries.

If the patient section has any receipts with transaction charges then the transaction charge grand total should also be shown at the bottom.

## Transaction View

This view shows the details grouped by each transaction action for patient and insurance payments.

Each section should show the corresponding action based on the selected filters.

► In the transaction date filter, the transaction entries would show all transactions based on the selected date range.

In the payment date filter, the transaction entries would show all transactions with payment date based on the selected date range.

There is a total section at the bottom of all tables and after each grouped table.

The columns in the report include:

### Trans. Date

The date on which the transaction was completed in the system.

### Receipt #

The system-assigned number used to identify the payment that has been entered into the system. Click this hyperlink to be taken to the Receipt view.

### Rcp. Location

The location pertaining to the payment that has been deposited.

### D.O.S

The date on which the patient was seen by their treatment provider for the completion of the services to which the receipt is applied.

### Receipt Of

The name of the patient/carrier/collection agency for whom the receipt was added.

### Procedure Code

The procedure code name along with its description.

### Tx Provider

The treatment provider applicable to the listed procedure code or receipt.

### Tx Location

The treatment location for the listed procedure code or receipt.

### Amount

The amount that was involved in the transaction.

### Applied For

The patient to whom this receipt is applied.

### Claim ID#

The system assigned number used to identify the unique claim that has been generated.

### User's Name

The user who created the receipt

### Remarks

Any remarks added if any

### Refund Date

The date on which refund was made

### Refund Location

The location to which the refund is made

### Payment Type

The type of payment type which was made.

### Patient ID

The system-assigned number used to identify this patient and their records.

**Patient Name**

The name of the patient.

**Refund To**

Shows to whom the refund was made -patient or insurance

**Insurance Receipt Carrier**

The carrier pertaining to the insurance receipt

**Transfer Receipt#**

The system-assigned number used to identify the transfer payment that has been entered into the system.

**Transfer Receipt Location**

The location to which the credit has been transferred to.

**Receipt View**

Payment Log (Batch) - Recent Transactions - Receipt # - 249768 / Show Transactions - Transactions Between : Sort By - Transaction Date - 02/11/2021 - 02/20/2021

Receipt ID	Monica, Hania	Location	MAIL - Dependent Dental - Many Dentist	Paying Entity	Payer			
Receipt ID	249768	Payment Date	02/08/2021	Payment Source	None			
Total Amount	\$8.00	Created Date	02/08/2021	Payment Method	Refund			
Unapplied	\$8.00	Deposit Date		Remark				
User Name	sunith.afful	Ref ID						
Payment Category	CASH	Post Pay	No					
Payment Type	Cash							
Applied Payments								
Trans. Date	Applied For	Date Of Service	Procedure Code	Tx. Provider	Tx. Location			
02/08/2021	Monica, Hania	02/08/2021	00140	#2061H	MAIL	\$8.00	sunith.afful	
02/10/2021	Monica, Hania	02/08/2021	00140	#2061H	MAIL	\$8.00	sunith.afful	
Total						\$16.00		
Transaction Summary								
Receipt Amount								
Applied Payments								
Unapplied								

The report should have mainly 3 sections: Receipt Details, Transaction Details, and Transaction Summary.

**Receipt Details**

The user will be able to see the receipt details. The results columns shown in this report include:

**Receipt Of**

The name of the patient for whom the receipt was added.

**Receipt #**

The system-assigned number used to identify the payment that has been entered into the system. Click this hyperlink to be taken to the Receipt view.

**Total amount**

The total amount in the receipt

**Unapplied**

The unapplied credits available in the receipt

**User Name**

The name of the user that created the receipt and entered it into the system.

**Payment Category**

The category of payment, whether it was made by cash, check, credit card, and so on.

**Payment Type**

The type of payment accepted whether it was made via Visa, Master Card, Cash, Check, and so on

**Location**

The location where the receipt is added

**Payment Date**

The date the payment was made

**Created Date**

The date the receipt was made

**Deposit Date**

The date the payment was deposited by your office.

**Ref No.**

The reference number entered by your office staff member accepting the payment.

**FlexiPay**

Mentions is the receipt addition was flexi pay

**Paying Entity**

**If the payment was made by patient, insurance or collection agency**

**Payment Source**

The source of the payment whether it was Bluepay, Carestack Pay, Apex Payments, None or Not Applicable.

**Payment Method**

The method of payment accepted whether it was Regular, Advanced, Payment Plan, Patient Portal, Payment Portal or Capitation

**Remark**

Shows the remarks added to the receipt

The transaction detail section will list out all transactions (as selected in the show transaction filter) that was made on the receipt.

The transaction summary will show the summarized totals of all transaction action that was made on the receipt.

# Income Allocation Extended

Written by Roshni R | Last published at: August 30, 2021

## Overview

This report gives data points for measuring provider performance in terms of Opening and Closing Balances, Production and Collection Amounts, Adjustments, Advance Payments, and Income Reductions.

This report shows **real-time data** and has multiple views- Income Allocation, Gross Production, Applied Payments, Allocated Advance Payments, Adjustments, and Income Reduction.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Income Allocation view

For the Income Allocation view, your filter options include:

#### **Group By\***

The Income Allocation view of the report can be grouped by the Treatment Provider and/or Location. By default, the Location will be selected.

#### **Sort By**

Users could choose the sort criteria for the report which is to be generated. This report could be sorted based on provider/location Name, Gross Production or Applied Payments.

#### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date.

#### **Location \***

This helps to filter out transactions like production, applied payments, adjustments, advance receipts and income reduction receipts added at the selected locations.

#### **Provider Type \***

This helps to filter out transactions based on a particular provider type.

#### **Provider**

This helps to filter out transactions like production, applied payments, adjustments, advance receipts and income reduction receipts added against the selected providers.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

### Gross Production Summary view

For the Gross Production Summary View, your filter options include:

#### **Group By\***

The Gross Production view of the report can be grouped by the Treatment Provider or Location. By default, Location will be selected.

#### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of production created.

#### **Location \***

This helps to filter out production created at the selected treatment locations.

#### **Provider**

This helps to filter out production created by the selected treatment providers.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Code**

This helps to filter out production created from selected code in the chosen date range.

#### **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

### **Gross Production Detail view**

For the Gross Production Summary View, your filter options include:

#### **Date Range \***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of production created.

#### **Location \***

This helps to filter out production created at the selected treatment locations.

#### **Provider**

This helps to filter out production created by the selected treatment providers.

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Code**

This helps to filter out production created from selected code in the chosen date range.

#### **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

### **Applied Payment Summary view**

For the Applied Payment Summary View, your filter options include:

#### **Group By \***

The Applied Payment view of the report can be grouped by the Treatment Provider, Treatment Location, or Paying Entity.

#### **Date Range \***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

#### **Location \***

This helps to filter out payments applied at the selected treatment locations.

#### **Paying Entity**

This helps to filter out payments applied against completed codes from patient, insurance or collection agency receipt payments.

#### **Patient**

This helps to filter out payments applied against completed codes from patient receipts added against the selected patients.

#### **Carrier**

This helps to filter out payments applied against completed codes from insurance receipts from selected carriers.

#### **Collection Agency**

This helps to filter out payments applied against completed codes from collection agency receipts from selected collection agencies.

#### **Provider**

This helps to filter out payments applied against codes completed by the selected treatment providers.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Code**

This helps to filter out applied payments made against selected codes in the chosen date range.

#### **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

### **Applied Payment Detail view**

For the Applied Payment Summary View, your filter options include:

#### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

#### **Location \***

This helps to filter out payments applied at the selected treatment locations.

#### **Paying Entity**

This helps to filter out payments applied against completed codes from patient, insurance or collection agency receipt payments.

#### **Patient**

This helps to filter out payments applied against completed codes from patient receipts added against the selected patients.

#### **Carrier**

This helps to filter out payments applied against completed codes from insurance receipts from selected carriers.

#### **Collection Agency**

This helps to filter out payments applied against completed codes from collection agency receipts from selected collection agencies.

#### **Provider**

This helps to filter out payments applied against codes completed by the selected treatment providers.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

## **Code**

This helps to filter out applied payments made against selected code in the chosen date range.

## **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

## **Allocated Advance Payments Summary view**

For the Applied Payment Summary View, your filter options include:

### **Group By\***

The Applied Payment view of the report can be grouped by the Receipt Provider, Receipt Location.

### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

### **Receipt Location \***

This helps to filter out applied payments in the selected date range from advance receipts added at the selected receipt locations. This is like a subset of transactions in the applied payment view where only those payments from advance receipts are filtered. The date range filters applied payments from advance receipts and not advance receipt creation in the selected date range.

### **Receipt Provider**

This helps to filter out applied payments in the selected date range from advance receipts added against the selected providers. This is like a subset of transactions in the applied payment view where only those payments from advance receipts against the selected providers are filtered.

### **Treatment Location**

This helps to filter out payments applied at the selected treatment locations.

### **Treatment Provider**

This helps to filter out payments applied against codes completed by the selected treatment providers.

### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

## **Code**

This helps to filter out applied payments made against selected code from advance receipts, in the chosen date range.

## **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

## **Allocated Advance Payments Detail view**

For the Applied Payment Summary View, your filter options include:

### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

### **Receipt Location \***

This helps to filter out applied payments in the selected date range from advance receipts added at the selected receipt locations. This is like a subset of transactions in the applied payment view where only those payments from advance receipts are filtered. The date range filters applied payments from advance receipts and not advance receipt creation in the selected date range.

### **Receipt Provider**

This helps to filter out applied payments in the selected date range from advance receipts added against the selected providers. This is like a subset of transactions in the applied payment view where only those payments from advance receipts against the selected providers are filtered.

#### **Treatment Location**

This helps to filter out payments applied at the selected treatment locations.

#### **Treatment Provider**

This helps to filter out payments applied against codes completed by the selected treatment providers.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Code**

This helps to filter out applied payments made against selected code from advance receipts, in the chosen date range.

#### **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

### **Adjustments Summary view**

For the Adjustments Summary View, your filter options include:

#### **Group By\***

The Adjustments view of the report can be grouped by the Location, Provider, or Adjustment Type.

#### **Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

#### **Location \***

This helps to filter out adjustments done against treatment procedures completed in the selected locations.

#### **Provider**

This helps to filter out adjustments done against treatment procedures completed by the selected provider.

#### **Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

#### **Adjustment Type \***

This helps to filter out adjustments based on the type-Production or Collection.

#### **Adjustment Against \***

This helps to filter out adjustments as Insurance or Patient adjustments.

#### **Adjustment Code**

This helps to filter specific adjustment codes added in the chosen date range.

#### **Code**

This helps to filter out adjustments made against selected code in the chosen date range.

#### **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

### **Adjustments Detail view**

For the Adjustments Summary View, your filter options include:

**Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

**Location \***

This helps to filter out adjustments done against treatment procedures completed in the selected locations.

**Provider**

This helps to filter out adjustments done against treatment procedures completed by the selected provider.

**Patient Flag**

Choose to focus the report based on the patients with the selected patient flags.

**Adjustment Type \***

This helps to filter out adjustments based on the type-Production or Collection.

**Adjustment Against \***

This helps to filter out adjustments as Insurance or Patient adjustments.

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

**Adjustment Code**

This helps to filter specific adjustment codes added in the chosen date range.

**Code**

This helps to filter out adjustments made against selected code in the chosen date range.

**Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

## Income Reduction Summary view

For the Income Reduction Summary View, your filter options include:

**Group By\***

The Income Reduction view of the report can be grouped by the Location or Provider.

**Date Range\***

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

**Location \***

This helps to filter out income reduction receipts added in the selected locations.

**Provider**

This helps to filter out income reduction receipts against the selected provider.

**Patient**

This helps to filter income reduction receipts added against the selected patients.

The receipt additions are shown as positive and deletions as negative(which is opposite to that shown in the summary view)

**Exclude Inactive Providers**

**Exclude inactive providers** checkbox excludes transactions in the selected date range done by current inactive providers.

## Income Reduction Detail view

For the Income Reduction Summary View, your filter options include:

Date Range\*

The date range can be selected for a maximum of 1 year. By default, the date range will be for the current day. This works based on the transaction date of applied payments.

**Location \***

This helps to filter out income reduction receipts added in the selected locations.

## Provider

This helps to filter out income reduction receipts against the selected provider.

## Patient

This helps to filter income reduction receipts added against the selected patients.

The receipt additions are shown as positive and deletions as negative(which is opposite to that shown in the summary view).

### **Exclude Inactive Providers**

Exclude inactive providers checkbox excludes transactions in the selected date range done by current inactive providers.

## Results

## Income Allocation view

The report provides information in column form. The report results will display in the order that the data variables in the *Group By* filter are selected. The user can drill through the options based on that order.

Annual Performance Summary										
Category	Quarter	Actual Sales	Target Sales	Variance (\$)	YoY Growth (%)	Margin %	Days Sales Outstanding	Customer Acquisition Cost	Retention Rate	Net Profit Margin (%)
Grand Total	Q1-Q4	\$1,200,000	\$1,150,000	\$50,000	+5%	30%	45	\$100	85%	15%
Product A	Q1-Q4	\$450,000	\$420,000	\$30,000	+8%	28%	48	\$120	88%	16%
Product B	Q1-Q4	\$350,000	\$320,000	\$30,000	+7%	32%	42	\$110	86%	14%
Product C	Q1-Q4	\$300,000	\$280,000	\$20,000	+6%	35%	40	\$130	87%	15%
Product D	Q1-Q4	\$150,000	\$140,000	\$10,000	+5%	38%	43	\$140	89%	17%
Product E	Q1-Q4	\$100,000	\$90,000	\$10,000	+4%	40%	46	\$150	90%	18%
Product F	Q1-Q4	\$80,000	\$70,000	\$10,000	+3%	42%	49	\$160	91%	19%
Product G	Q1-Q4	\$50,000	\$40,000	\$10,000	+2%	45%	52	\$180	92%	20%
Product H	Q1-Q4	\$30,000	\$20,000	\$10,000	+1%	48%	55	\$200	93%	21%
Product I	Q1-Q4	\$20,000	\$15,000	\$5,000	+1%	50%	58	\$220	94%	22%
Product J	Q1-Q4	\$10,000	\$10,000	\$0	+1%	52%	60	\$240	95%	23%

You can drill down through the options as mentioned below:

The results columns shown in this report include:

## Location

Shows the treatment location against which the transaction was made.

## Provider









Receipt Location	Patient ID	Receipt Provider	Applied Amount	Treatment Date	Treatment Provider	Code	Date Rec'd	Total IT Service	Paid Bal	Paid B.R.	Receipt #	Receipt Date
Healthcare	123456789		\$2,000.00						\$2,000	\$2,000		
Healthcare	123456789		\$1,500.00						\$1,500	\$1,500		
Healthcare	123456789		\$1,500.00						\$1,500	\$1,500		
Healthcare	123456789		\$1,500.00						\$1,500	\$1,500		



The drill downs can be selected to view the allocated advance payment amount receipt location or receipt provider or both

Receipt Location	Receipt Provider	Name	Process ID	Payment Type	Applied Payment (Date)	Treatment Location	Treatment Provider
Healthcare	Dr. Smith MD	Dr. Smith MD	00001001	Normal	01/01/2023	Healthcare	Healthcare Inc.
Healthcare	Dr. Smith MD	Dr. Smith MD	00001001	Normal	01/01/2023	Healthcare	Healthcare Inc.
Healthcare	Dr. Smith MD	Dr. Smith MD	00001001	Normal	01/01/2023	Healthcare	Healthcare Inc.
Healthcare	Dr. Smith MD	Dr. Smith MD	00001001	Normal	01/01/2023	Healthcare	Healthcare Inc.

The result columns in the Summary view are

#### Receipt Location

The Receipt location of the adv receipt in context.

#### Receipt Provider

The Receipt Provider of the adv receipt in context.

#### Transaction Date

The date the transaction was completed in the system.

#### Patient Id

The Identifier of the patient that was seen for treatment.

#### Patient Name

The name of the patient that was seen for treatment.

#### Applied Payment

The amount applied against the code.

#### Treatment Location

Treatment location of the code.

#### Treatment Provider

Treatment provider of the code.

#### Paying Patient

Mentions the name of the patient who is paying the amount.

#### Code

Mentions the treatment procedure in context.

#### Code Desc

The procedure code completed for this patient, along with its description.

#### Date of Service

The date in which the patient was seen by their treatment provider for the completion of these services.

#### Patient Bal

The patient balance at time of checkout.

#### Insurance Bal

The insurance balance at time of checkout.

#### Receipt #

The system-assigned number used to identify the payment that has been entered into the system.

#### Receipt User

The user that completed the transaction in the system

## Allocated Advance Payments Detail view

The detailed view shows the patient level drill down of the allocated advance payment.





Identifier of the patient.

**Patient Name**

The name of the patient that was seen for treatment.

**Adj code**

The adjustment code that was made.

**Adj code Desc**

The adjustment code used to adjust the resulting balance for treatment completed (along with the description and action of the adjustment code).

**Adjustment type**

The adjustment type whether it was a production adjustment or collection adjustment.

**Adjustment Against**

Shows if the adjustment was made against the patient, insurance, all.

**Amount**

The dollar amount of the adjustment completed.

**Location**

Shows the tx. location against which the adjustment was made.

**Provider**

The treatment provider associated with the procedure code.

**Code**

The procedure code completed for this patient, against which an adjustment was made.

**Desc**

The description of the code.

**D.O.S.**

The date in which the patient was seen by their treatment provider for the completion of these services.

**User's Name**

The user that completed the transaction in the system.

**Remarks**

The remarks added while adding the adjustment.

## Income Reduction Summary view

In the income reduction summary view it only shows the receipts that have been added as payment type- Income reduction/provider payback.

Selecting the drill-downs will give the receipts for each location or provider or both.

The order of grouping would depend upon the group by option selected first. If the user selects provider and then location the report will be grouped accordingly the same is applicable if the user selected location and then provider. Income reduction numbers are shown as positive, while deleted income reductions appear negative. This differs from the primary report.

The results in this report include.

**Location**

The location the payment is added.

**Provider**

The provider associated with receipt.

**Trans Date**

Shows the date of receipt addition.

**Patient ID**

Identifier of the patient

**Patient Name**

Name of the patient.

**Payment Type**

Shows the payment type of the income reduction category

**Payment date**

The date the practice actually received the payment

**Amount**

Shows the receipt amount added as income reduction.

**Refunded**

Shows the amount refunded from the receipt as per the current day.

**Applied**

Shows the amount applied from the receipt as per the current day.

**Unapplied**

Shows the amount remaining as credits in the receipt as per the current day.

**Receipt#**

Shows the receipt id in context. It is click-through content and opens the patient's ledger in a new tab.

**Receipt User**

Shows the user who added the receipt.

## Income Reduction Detail view

The Income reduction detailed view shows the patient level drill-down of the income reduction receipts that have been added in the practice.

Transaction ID	Patient ID	Payment Method	Location	Provider	Payment Type	Payment Date	Amount	Refunded	Applied	Unapplied	Receipt ID	Receipt User
00-00-0000	1234567890	Newly Admitted	Emergency Room	John Doe, MD	Provider-Payback	01/01/2023	\$100.00	00.00	00.00	00.00	000001	John Doe
00-00-0001	1234567890	Initial Visit	Emergency Room	John Doe, MD	Provider-Payback	01/01/2023	\$100.00	00.00	00.00	00.00	000002	January 01, 2023
00-00-0002	1234567890	Initial Visit	Emergency Room	John Doe, MD	Provider-Payback	01/01/2023	\$100.00	00.00	00.00	00.00	000003	January 01, 2023
00-00-0003	1234567890	Initial Visit	Emergency Room	John Doe, MD	Provider-Payback	01/01/2023	\$100.00	00.00	00.00	00.00	000004	January 01, 2023
00-00-0004	1234567890	Initial Visit	Emergency Room	John Doe, MD	Provider-Payback	01/01/2023	\$100.00	00.00	00.00	00.00	000005	January 01, 2023
00-00-0005	1234567890	Initial Visit	Emergency Room	John Doe, MD	Provider-Payback	01/01/2023	\$100.00	00.00	00.00	00.00	000006	January 01, 2023

The results in this report include.

**Trans Date**

Shows the date of receipt addition.

**Patient ID**

Identifier of the patient

**Patient Name**

Name of the patient.

**Location**

The location the payment is added.

**Provider**

The provider associated with receipt.

**Pavment Type**

Shows the pavment type of the income reduction category.

**Pavment date**

The date the practice actually received the payment

**Amount**

Shows the receipt amount added as income reduction.

**Refunded**

Shows the amount refunded from the receipt as per the current day.

**Applied**

Shows the amount applied from the receipt as per the current day.

**Unapplied**

Shows the amount remaining as credits in the receipt as per the current day.

**Receipt#**

Shows the receipt id in context. It is a click through content, and opens the patient's ledger in a new tab.

**Receipt User**

Shows the user who added the receipt.

# KPI List

Written by Elza Ebenezer | Last published at: August 23, 2022

Area	KPI	Description	Trend	Remarks
Account's Receivable	Claim Pending Submission (\$)	The total dollar value of insurance production and insurance adjustment in claims that are pending submission.	Not Available	
	Claims Rejected (\$)	The total dollar value of insurance production and insurance adjustment in claims that are rejected.	Not Available	
	Inflated Ortho Aging	Total balance production amount of checked-out Ortho codes with a balance that are not on an Ortho plan.	Not Available	
	Insurance AR Days	The average number of days that it takes for a carrier to make payment on a claim. (based on first submitted date)	Available	
	Rejected Claims (Count)	Count of distinct claims that were rejected in the specified date range		Available in Scorecards only
	Rejection Ratio	The ratio of rejected claims to the number of claims submitted within a given date range		Available in Scorecards only
	Submitted Claims (Count)	Count of distinct claims that were submitted in the specified date range		Available in Scorecards only
	Unsubmitted Claims \$	Calculated as the insurance estimate of the claims that were created in the specified date range but are still pending submission		Available in Scorecards only
Appointments	Broken Appointments	The Total number of appointments, with appointment date in the selected date range, that are currently in the 'No Show', 'Cancelled' status.	Available	
	Broken Appointments Rate	Total number of appointments with appointment date in the selected date range, that are currently in the 'No Show', 'Cancelled' status/ (Total number of appts that are scheduled (any custom) + No show/Cancelled appt (excluding blocked appt) in the selected date range)	Available	
	Cancelled Appointments (Current)	The total number of appointments, with appointment date in the selected date range, that are currently in the 'Cancelled' status.  Exclusion: Blocked slots.	Available	
	Cancellations (Percentage)	Total percentage of appointments within a specified date range that are currently in 'Cancelled' status.		Available in Scorecards only
	Checked Out Appointments (Current)	The total number of appointments, with appointment date in the selected date range, that are currently in the 'Checked Out' status.	Available	
	Checked Out Production	The total dollar amount of production from appts that was checked out in the given date range and are currently in the checked-out status	Available	
	No Show Appointments (Current)	The total number of appointments, with appointment date in the selected date range, that are currently in the 'No Show' status.	Available	

Area	KPI	Description	Trend	Remarks
	No Show Rates (Percentage)	Percentage of "no show" appointments compared to total appointments in the selected date range.		Available in Scorecards only
	Procedures Not Linked to an Appointment	Count of completed procedures not linked to an appointment		Available in Scorecards only
	Rescheduled Appointments	The total number of appointments that were rescheduled in the selected date range. However, these appointments could currently be in any other status. This KPI enables users to check if the previously rescheduled appointments have been brought on schedule.  Exclusion: Blocked slots	Available	
	Rescheduled Appointments Rate	Percentage of rescheduled appointments of the total scheduled.	Available	
	Scheduled Appointments	Calculated as the count of appointments on the schedule in the selected date range.  Exclusion: No show, Cancel, Delete, Reschedule Appointments	Available	
	Scheduled Patients	The total number of patients having a scheduled appointment in the selected date range.  Exclusion: No show, Cancel, Delete, Reschedule Appointments	Available	
	Scheduled Production	Total production from codes linked to an appointment in the selected date range.  Exclusion: No show, Cancel, Delete, Reschedule Appointments	Available	
Clinical	Case Acceptance	Percentage of case acceptance out of the total cases presented in a given date range.	Not Available	Care Acceptance needs to be configured in the setting tab
Collection	Applied Insurance Payments (Trans. Date)	Calculated as the 'Total Insurance Applied' +/- collection adjustments based on the transaction date.  Inclusions: Income reduction, Transfer, and Special Credits.		Available in Scorecards only
	Applied Patient Payments (Trans. Date)	Calculated as the 'Total Patient Applied' +/- collection adjustments based on the transaction date.  Inclusions: Income reduction, Transfer, and Special Credits.		Available in Scorecards only
	Applied Payments (Trans. Date)	Calculated as the total applied payments based on the transaction date, in the selected date range.	Available	
	Collection Adjustment (TXN)	The total dollar amount of patient and insurance collection adjustments based on transaction date.	Not Available	
	Collection Adjustment Rate	A measurement of Collection Adjustments (transaction date) compared to Gross Collection (transaction date) over a specified period of time.	Not Available	

Area	KPI	Description	Trend	Remarks
	Collection Rate	A derived indicator that determines the overall performance of collection relative to net production over a period of time, calculated by transaction date.  (Net Collection (TXN) / Net Production (TXN))* 100	Available	
	Failed Payment Plan Transactions (#)	The number of tokenized transactions currently in failed status.	Not Available	
	Failed Payment Plan Transactions (\$)	The dollar amount of tokenized transactions currently in failed status.	Not Available	
	Gross Collection (Payment Date)	Calculated as the total money from Patient, Insurance, and Collection Agency receipts based on payment date.  Exclusion: Income Reduction, Transfer, and Special Credits.	Available	Drill Down by Location available
	Gross Collection (Trans. Date)	Calculated as the total money from Patient, Insurance, and Collection agency receipts, based on transaction date.  Exclusion: Income Reduction, Transfer and Special Credits in receipts.	Available	
	Gross Insurance Collection (Payment Date)	Calculated as the total money from Insurance receipts, based on the payment date specified on the receipt.  Exclusions: Refunds, Income Reduction, Transfer, and Special Credits in receipts.		Available in Scorecards only
	Gross Insurance Collection (Trans. Date)	Calculated as the total money from Insurance receipts, based on transaction date.  Exclusions: Income Reduction, Transfer, and Special Credits in receipts.	Available	
	Gross Patient Collection (Payment Date)	Calculated as the total money from patient receipts, based on the payment date specified on the receipt.  Exclusions: Refunds, Income Reduction, Transfer, and Special Credits in receipts.		Available in Scorecards only
	Gross Patient Collection (Trans. Date)	Calculated as the total money from Patient and Collection agency receipts based on transaction date.  Exclusions: Income Reduction, Transfer, and Special Credits in receipts.	Available	
	INS RECT XFER %	The percentage value of insurance receipt transfers to patient credit, within a specified date range. The value of receipt transfers compared to the insurance collection for the same time period. Ideally, this should be less than 1%.	Not Available	
	Insurance Collection Rate (TXN)	A derived indicator that determines the overall performance of insurance collection relative to net production over a period of time, calculated by transaction date.  (Net Insurance Collection (TXN) / Net Insurance Production (TXN))* 100	Available	
	Net Applied Insurance Payments (Trans. Date)	Calculated as the applied payments on insurance estimates +/- collection adjustments(insurance) based on transaction date.  Inclusions: Income reduction, Transfer, and Special Credits.	Available	

Area	KPI	Description	Trend	Remarks
	Net Applied Patient Payments (Trans. Date)	Calculated as the applied payments on patient estimates +/- collection adjustments(patient) based on transaction date.  Inclusions: Income reduction, Transfer, and Special Credits.	Available	
	Net Applied Payments (Trans. Date)	Calculated as the Applied Payments +/- Collection Adjustments based on transaction date.  Inclusions: Income reduction, Transfer, and Special Credits.	Available	
	Net Collection (Payment Date)	Calculated as the sum of money from Patient, Insurance, and Collection Agency receipts, based on payment date, +/- Collection Adjustments and Refunds with transaction date in the selected date range.  Exclusion: Income reduction, Transfer, and Special Credits.  Gross Collection (Payment Date) - Refunds +/- Collection Adjustments	Available	
	Net Collection (Trans. Date)	Calculated as the sum of money from Patient, insurance, and collection agency receipts+/- collection adjustments and refunds.  Exclusions: Income reduction, Transfer, and Special Credits.  Net Collection (Trans. Date)= Gross Collection (Trans. Date) +/- Collection Adjustments - Refunds.	Available	
	Net Insurance Collection (Payment Date)	Calculated as the Gross Insurance Collection (Payment Date) +/- Insurance Collection Adjustments  Inclusions: Refunds, Transfer in receipts		Available in Scorecards only
	Net Insurance Collection (Trans. Date)	Calculated as the sum of money from Insurance receipts +/- collection adjustments(insurance-based) and refunds.  Exclusions: Income reduction, Transfer, and Special Credits.  Net Insurance Collection (Trans. Date)= Gross Insurance Collection (Trans. Date) +/- Collection Adjustments - Refunds.	Available	
	Net Patient Collection (Payment Date)	Calculated as the Patient Gross Collection (payment Date) +/- Patient Collection Adjustments  Inclusions: Refunds, Transfer in receipts.		Available in Scorecards only
	Net Patient Collection (Trans. Date)	Calculated as the sum of money from Patient and Collection agency receipts +/- refunds and collection adjustments.  Exclusions: Income reduction, Transfer, and Special Credits.  Net Patient Collection (Trans. Date)= Gross Patient Collection (Trans. Date) +/- Collection Adjustments - Refunds.	Available	
	OTC Collection	Calculated as the total amount of patient payments collected at the time of service		Available in Scorecards only
	OTC Rate	The percentage of payments collected compared to the Collectable Balance of each appointment at the time of checkout. Collectable Balance is calculated to consider the Net Account Balance (Account Credits - Account Balance = Net Account Balance).	Available	

Area	KPI	Description	Trend	Remarks
	Pat Coll Pending Allocation	The total amount of pending unapplied patient collection where an account balance is due.	Not Available	
	Pat OverPayment	The total amount of unapplied account credits when the patient pays more than the balance due.	Not Available	
	Patient Collection Rate (TXN)	A derived indicator that determines the overall performance of patient collection relative to net production over a period of time, calculated by transaction date.  (Net Patient Collection (TXN) / Net Patient Production (TXN))* 100	Available	
	Same Day Allocation	Percentage of patient balance applied to procedures on the same transaction date as the procedure code completion.	Available	Drill down by Location and Provider
	Unapplied Adv Pmt	The total amount of unapplied credits from advanced payments.	Not Available	
	Unapplied Collection	Calculated as the sum of all unapplied money from all the receipts. The total reflects the current state and is not time-specific.	Not Available	
	Unapplied Ins Collection	Calculated as the sum of all unapplied money from insurance receipts. The total reflects the current state and is not time-specific.	Not Available	
	Unapplied Pat Collection	Calculated as the sum of all unapplied money from patient and collection agency receipts. The total reflects the current state and is not time-specific.	Not Available	
Front Desk	Accepted TX Scheduled \$	The dollar value of pending treatment added in accepted status that is linked to an appointment.	Available	
	Accepted TX Unscheduled \$	The dollar value of pending treatment added in accepted status without an appointment.	Available	
	Active Patients	Number of active patients in the system	Not Available	
	New Patient Production %	Calculated as the percentage of production from new patients, as compared to the gross production in the specified date range.	Available	
	New Patient Production(\$)	Calculated as the dollar value production from new patients, checked out within a specified date range.	Available	
	New Patient Seen	Calculated as the count of new patients checked out within a specified date range.	Available	
	New Patient Seen/Day	Calculated as the average number of new patients seen per day within a specified date range.	Available	
	Proposed TX Scheduled \$	The dollar value of pending treatment added in the proposed status that is linked to an appointment.	Available	
	Proposed TX Unscheduled \$	The dollar value of pending treatment added in proposed status without an appointment.	Available	
	Patients Seen (Location)	Unique count of patients seen per location		Available in Scorecards only

Area	KPI	Description	Trend	Remarks
	Recommended TX Scheduled \$	The dollar value of pending treatment added in recommended status that is linked to an appointment.	Available	
	Recommended TX Unscheduled \$	The dollar value of pending treatment added in recommended status without an appointment.	Available	
	Unscheduled Active Patients	Count of active patients that do not have a future appointment	Not Available	
	Walkout Retention %	The percentage of patients seen for a specified period that have a future appointment for a specific subset of codes. This KPI is most commonly used to measure the performance of the front desk in scheduling future hygiene appointments at the time of walkout. We'll need to specify a code filter for historical segmentation and a code filter for future appointments to see the efficiency in scheduling.	Available	Additional Setup Available
	Patient Attrition Rate	The percentage of patients that have been flagged as 'Inactive' within a specified date range, mostly due to a lack of activity, when compared to the active patients.	Available	
	Patient Reactivation Rate	The percentage of 'Active' patients that were previously flagged as 'Inactive' prior to the specified date range.	Available	
Production	Adjusted Insurance Production (Trans. Date)	Calculated as the net insurance production adjusted to remove inflated ortho production that was not set up using an ortho payment plan.	Available	
	Adjusted Patient Production (Trans. Date)	Calculated as the net patient production adjusted to remove inflated ortho production that was not set up using an ortho payment plan.	Available	
	Adjusted Production (Trans. Date)	Calculated as the net production adjusted to remove inflated ortho production that was not set up using an ortho payment plan.	Available	
	Average Daily Production (Location)	The average gross production checked out per working day within a specified time period where a working day is calculated based on the DOS of the completed charges.		Available in Scorecards only
	Average Daily Production (Provider)	The average gross provider production checked out per working day within a specified time period where a working day is calculated based on the DOS of the completed charges.		Available in Scorecards only
	Average Production Per Appointment	The average gross production checked out per appointment within a specified time period.		Available in Scorecards only
	Avg Prod Per Appt	Net Prod linked to completed appts (appt date)/ Total Completed Appts (appt date)	Available	
	Avg Prod Per Day	Net Prod (trans date)/ Working days. Working Days:- Total Days with min two completed appointments (by Appt Date)	Available	
	Gross Insurance Production (DOS)	The total dollar value of insurance payable of completed procedures, based on the date of service.  Exclusion: Migrated balances (MSB codes)	Available	

Area	KPI	Description	Trend	Remarks
	Gross Insurance Production (Trans. Date)	The total dollar value of insurance payable of completed procedures, based on transaction date of code completion. Exclusion: Migrated balances (MSB codes)	Available	
	Gross Patient Production (DOS)	The total dollar value of patient payable of completed procedures, based on the date of service. Exclusion: Migrated balances (MSB codes)	Available	
	Gross Patient Production (Trans. Date)	The total dollar value of patient payable of completed procedures, based on transaction date of code completion. Exclusion: Migrated balances (MSB codes)	Available	
	Gross Production (DOS)	Total dollar value from completed procedures based on the date of service. Exclusion: Migrated balances (MSB codes)	Available	Drill down available on all default filters
	Gross Production (Trans. Date)	Total dollar value from completed procedures based on transaction date of code completion. Exclusion: Migrated balances (MSB codes)	Available	
	Migrated Production (DOS)	Calculated as the total payable from Migrated Starting Balance codes with DOS in the given date range.		Available in Scorecards only
	Migrated Production (Trans. Date)	Calculated as the total payable from Migrated Starting Balance codes with transaction date in the given date range.		Available in Scorecards only
	Net Insurance Production (DOS)	Final dollar value after reducing production adjustments from insurance payable of completed procedures based on the date of service of codes in the selected date range.	Available	
	Net Insurance Production (Trans. Date)	Final dollar value after reducing production adjustments from insurance payable of completed procedures based on transactions in the selected date range.	Available	
	Net Patient Production (DOS)	Final dollar value after reducing production adjustments from patient payable of completed procedures based on the date of service of codes in the selected date range.	Available	
	Net Patient Production (Trans. Date)	Final dollar value after reducing production adjustments from patient payable of completed procedures based on transactions in the selected date range.	Available	
	Net Production (DOS)	Final dollar value after reducing production adjustments from Gross Production (DOS).	Available	
	Net Production (Trans. Date)	Final dollar value after reducing production adjustments from total payable of completed procedures based on transactions in the selected date range.	Available	
	Production Adjustment (TXN)	The total dollar amount of patient and insurance production adjustments based on transaction date.	Not Available	
	Production Adjustment Rate	A measurement of Production Adjustments (transaction date) compared to Gross Production (transaction date) over a specified period of time.	Not Available	
	UCR Total	Calculated as the sum of UCR of all completed procedures with DOS in the given date range		Available in Scorecards only

# Patient Lists

Written by Aaqib Mohammed Sali | Last published at: August 23, 2021

## Overview

Patient Lists is a list generator present within the Insights module. It is easily accessible from the main menu and it allows the users to save frequently used criteria as templates.

The uses of the generated lists include but are not limited to appointment reminders, appointment confirmations, payment reminders.

## Users

The users of patient lists are spread across different profiles. The ones that use it most frequently include front office staff for appointment reminders, confirmation, and verification as well as billing and insurance staff to keep track of outstanding payments and send payment reminders.

## Permissions

The permissions for patient lists are located within Patient segmentation in the Permissions screen. The related permissions are as follows:

### **View Patient Lists**

This permission provides you the ability to view and generate patient lists.

### **Add Patient List Templates**

This permission provides you the ability to add new patient lists templates.

### **Delete Patient List Templates**

This permission provides you the ability to delete patient list templates.

### **Export Patient List**

This permission provides you the ability to perform a quick export as well as an advanced export of the list

### **Send Text Message**

This permission provides you the ability to send text messages to patients in the list.

## Workflow

The patient lists options from the main menu takes the user to a general page with a list of saved patient list templates.

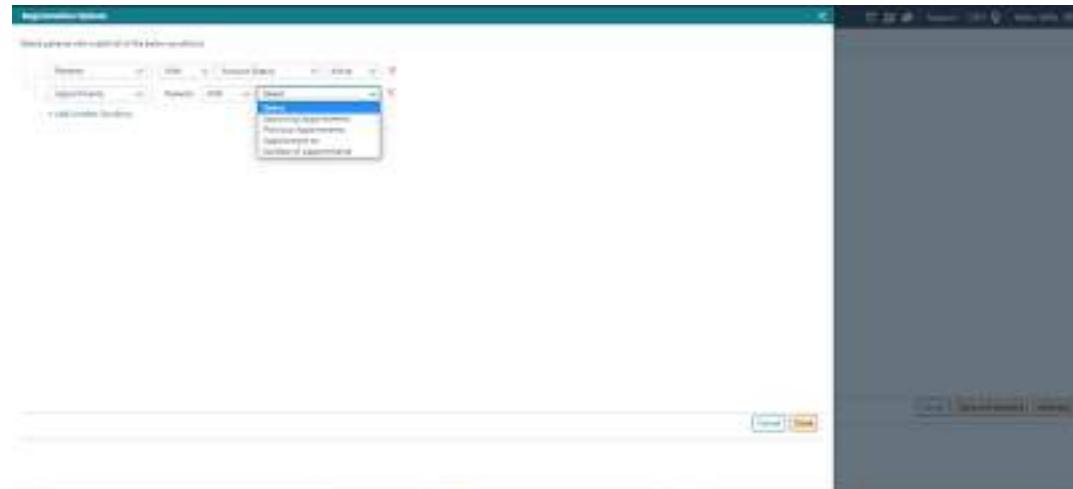


These templates may be viewed or modified or deleted from this screen. Similarly, there are options to generate a new list or view the scheduled downloads on the top right corner of the screen.

Clicking on the template name of a saved template will open a screen with pre-selected fields as was saved the last time the template was modified. Similarly, clicking on the “Generate New List” button will also take the user to the same screen.



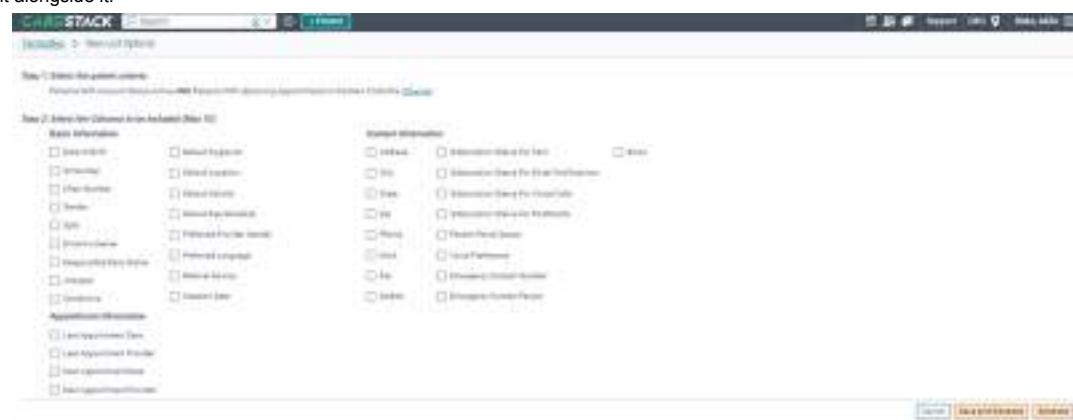
Clicking on the hyperlink listed under step up will open a slideout with options and sub-options like in a tree hierarchy. Different combinations of the options chosen by the user will be the criteria defined for the list to be generated.



The user may add any number of such filters and it will add to the existing combination using an “AND” operator further narrowing down the scope of the patients in the required list.

The filter for active patients are pre-filled on this slideout as a default filter but this may be removed by the user if required.

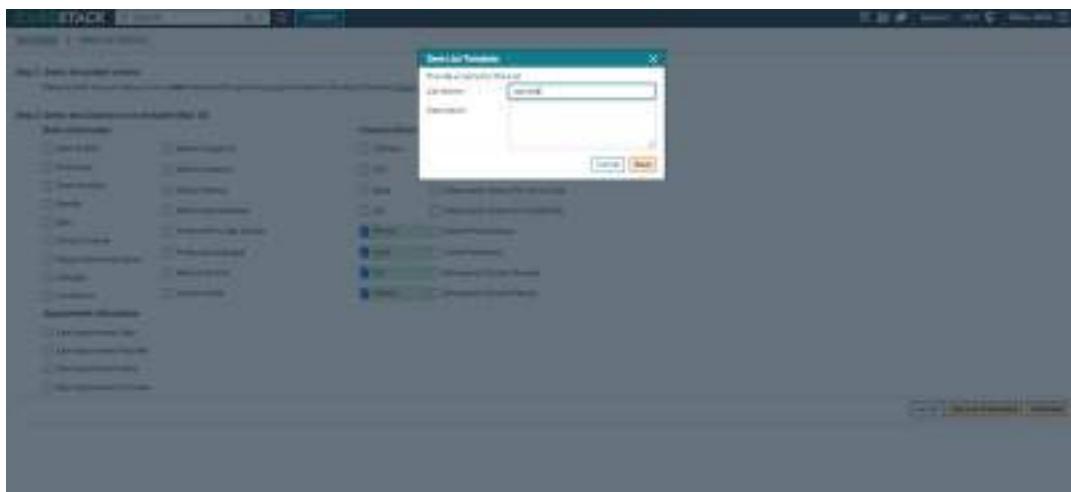
Once the criteria has been set, and user clicks on done, the slideout closes to reveal the previous screen. The selected criteria will be listed under step 1 and a link to edit the criteria will be present alongside it.



The next step would be to choose the required columns for the list. There are checkboxes related to Basic Information, Appointment Information and Contact Information of the patient. Checking the required checkboxes will allow the user to add those as columns to the list. A maximum of 10 columns can be selected per list.

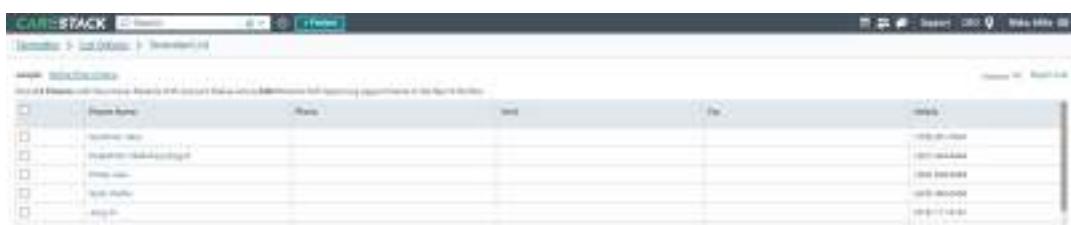
The user then has the option to simply generate the list as per the criteria and columns selected or the user may save the template for future use along with generating the list to avoid having to make each of these selections each time they have the same requirement.

On clicking the "Save and Generate" button, a dialog box appears for the user to provide a name and description for the saved list template.

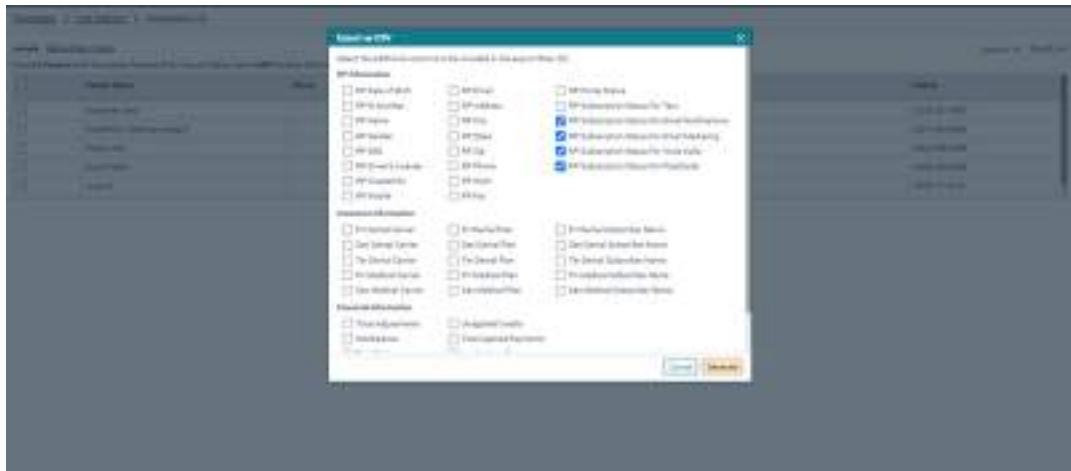


On providing a list name and clicking save, the template is saved and the list is generated. If the "Generate" button is clicked, then the dialog box is skipped and the template is not saved.

On the generated list page, the user has the option to export the list as a CSV file or the user may select the patients using checkboxes and send text messages using the Actions dropdown.



While exporting the list, the user may opt for additional columns that were not available in the initial set of options during generation.



Similarly, dynamic list generation has a limit of 1000 rows. If the criteria used for generation is such that the list contains more than 1000 rows, then only the top 1000 will be displayed and the entire list will be available on exporting. This will be indicated using a warning on top of the generated list.

**Patient list Criteria** will give a detailed explanation of the different options available to the user while setting the filter criteria for list generation.

# Intel Report

Written by Elza Ebenezer | Last published at: September 29, 2021

## Overview

The Intel Report is used as the client consultation platform which the Account Management & Client success team leads. With the Intel Report, the user can monitor prime KPIs and track how these KPIs perform as compared to the defined recommended rates.

The report shows data warehouse data, meaning the data till the last day. Intel report shows the KPI, its value, trend, and performance against the recommended rate.

## Criteria

*N.B. The filters with red asterisk signs are mandatory fields.*

Setting the filter criteria important for building your report. It allows you to focus on exactly the information you need without having to wade through the information you don't.

### Date Range\*

The date range that can be selected are YTD, QTD, MTD, WTD, Yesterday, Previous 6 Calendar Months, Previous 3 Calendar Months, and Previous Calendar Month. By default, MTD will be selected.

### KPI Trend\*

Choose to show the KPI trend by previous period or by previous year. By default, Previous period is selected.

## Results

The screenshot shows the 'Intel Report - BrightMedies Dental' page. At the top, there's a navigation bar with tabs like 'Operational Report', 'Insights', 'Analytics Dashboard', 'Intel Report' (which is active), 'Advanced Analytics', 'Dash', 'Settings', and 'Logout'. Below the navigation is a search bar and a date range selector. The main content area is titled 'Intel Report - BrightMedies Dental' and displays a table of KPIs. The table has columns: KPI, Value, Trend, and Performance. The KPIs listed are: Insurance Collection Rate (FY11), Patient Collection Rate (FY11), Total Paid Product (Total Sales), Net Revenue (Total Sales), Other Revenue Product (Party Total), and Net Insurance Product (Party Total). The 'Value' column shows numerical values for each KPI. The 'Trend' column uses icons to indicate whether the value has increased, decreased, or remained stable compared to the previous period or year. The 'Performance' column shows the recommended rate and the percentage difference from the KPI value.

KPI	Value	TREND	PERFORMANCE
Insurance Collection Rate (FY11)	\$1791.87K	↓ Decreased 10.4% from Previous Period	↓ 10.4% from Baseline Rate Recommended 20% vs 900%
Patient Collection Rate (FY11)	15.8%	↑ Up 1.80% from Previous Period	↑ 1.8% from Baseline Rate Recommended 20% vs 900%
Total Paid Product (Total Sales)	\$30.3K	↓ Decreased 10.4% from Previous Period	
Net Revenue (Total Sales)	\$30.3K	↓ Decreased 10.4% from Previous Period	
Other Revenue Product (Party Total)	\$4.57K	↓ Decreased 10.4% from Previous Period	
Net Insurance Product (Party Total)	\$4.34K	↓ Decreased 10.4% from Previous Period	

### KPI

The name of the KPI. The Intel report shows a total of 14 KPIs.

### Value

The value of the KPI in the specified date range.

### Trend

The trend of the KPI with the previous period/ previous year data. For KPIs with no trend option, this column would be blank.

### Performance

The performance of the KPI value compared with the defined recommended rates. The recommended rates are also shown in this column. If no recommended rate is defined, then this column would be empty.

## Permissions

The permissions for the Intel report will be in System Menu -> Practice Settings -> Administration -> Profiles -> Manage Permissions -> Insights -> Analytics Dashboard -> View Analytics Dashboard.

Section	Module	Actions
Billing		
Name		
Setting		
Print		
Practice Settings		
Patient Engagement		
Reports		
Therapy		
Scheduling		
<b>Insights</b>		
Demographic		
Fee by Sub-Category		
Advanced Analytics		
Find Similar Assessments		
Add Edit Single Document	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Update Single Assessment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Inventory Dashboard		
Find Similar Assessment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Find Similar Single Assessment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Service Settings		
Add Customer Credit Reasons	<input type="checkbox"/>	<input type="checkbox"/>
Edit Customer Credit Reasons	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Remove Customer Credit Reasons	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Index API Methods	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Add Edit API Methods	<input type="checkbox"/>	<input checked="" type="checkbox"/>
View Setting		
Find Location Group	<input type="checkbox"/>	<input type="checkbox"/>

# Callpop Integration

Written by Rahul Krishnan | Last published at: August 15, 2021

Callpop is a third party application which helps in the integration between practice management software like CareStack and existing phone system which enables the practice to communicate with patients seamlessly thereby enabling the practice to increase their profit margins as well as enrich the customer experience.

Callpop integrates with the CareStack software to launch a patient's profile the moment they call, eliminating the need to spell names or search through patient records. This awesome feature is included with your CareStack subscription at no additional charge.



## What is Callpop?

The first easy-to-use device that integrates your existing phones with CareStack.

### \* Keep Your Phones!

- Do you like your current phone system? Then keep it! What is new-phone anxiety or to switch to VoIP? Great! We've got it solution for you! Callpop lets you choose!

### \* 2-Way Texting

- Text from the office phone number from your computer
- Click Text

### \* Office / Front Desk Analytics

- Track patient arrival progress and make patient process improvements.
- Call pending time
- How patients talk vs. Existing patient calls
- How patient conversion rates



### \* Reviews

- Send Google & Facebook review requests with a custom message!
- Send Google review from your office to new patients before their first visit with a customizable welcome message!

### \* CallerID on Steroids

- Know important patient details... before you ever answer the phone
- Patient owned
- Patient appointments & history
- Personal information (Birthdays, anniversaries, etc.)
- All family members
- Additional communication tools



**The client will need the following information when beginning their Callpop setup:**

#### Identify their Phone Provider

■ Identify: **Landline or VOIP Landline:** Set-up will take place about 5 days after the initial call to Callpop. Additional set-up will need to be completed once they receive their Callpop device. The client may need:

- A photo of the Front and Back of the client's Desk Phone

A photo of their PBX – telephone room DMARC location

(multi-line Phone systems will require connection at their PBX)

They will also need an outlet in the telco closet.

■ **VOIP:** Set-up can be done over the phone, same day, with a Callpop lead.

*Once the Callpop setup is initiated, the final integration steps will need to be completed on the back-end by our Development team before the client can begin to use this feature with CareStack.*

## Definitions

**Telephony** – The working or use of telephones

■ **Private Branch Exchange (PBX)** – The telephone system which provides client service for multiple phone lines

**Demarcation Point (DMARC)** - In **telephony**, the demarcation point is the point at which the **public switched telephone network** ends and connects with the customer's **on-premises wiring**.

**Voice Over Internet Protocol (VOIP)** – Hardware and software that enables people to use the Internet to transmit phone calls.

# Qtrly Product Plan - Q3 2021

Written by Jay KV | Last published at: July 17, 2021

## Patient Services

### Major Features - Release 5.21

Text Chat Migration to Iris.

- I Introducing an all in one communication platform that can handle all the communication inside and outside the office.  
Build a platform which can be used to plug in all the non-core functionalities that can be driven separately.  
Build a complete communication log with the text and email history of patients  
Maintain this platform as independently as possible so that the practices do not miss out on communications even during down times.

#### Beta Release

As per the current plan, we will push for a beta by the end of the 5.21 Release. We will follow this up with the full rollout in 5.22.

### Patient Connect

- I Introducing a portal which can be used by the providers and the front office staff to access the patient details and appointment details.
- I A mobile friendly platform which can be used by the providers to quickly access their daily schedules.
- A portal that can run on any device and can double up as the kiosk which can be used in the front office, or at the patient's chair.  
By running our revamped patient portal in the background, cutdown cost on maintenance and additional development effort for kiosk.

#### Beta Release

The first round beta of patient connect is expected to be out in 5.20, we will have another beta in 5.21 and follow it up with the release in 5.22

### Patient Engagement Enhancements

- We are including different features in the Patient Engagement area to improve the usability and customisable of Patient Engagement campaigns.
- I There are around 10 enhancements that we have received as high priority enhancement requests from the customers which are lined up for this activity.
- I We will also be doing some cleanup and addressing some incoming enhancements that we have in curbside check in, to improve customizability.

### Document Sharing

- We finished the development for Document sharing in the first quarter of this year.
- We were not able to release the feature because of a dependency with an antivirus system.
- I While this is still in progress, we will be trying to push this out in the 3rd quarter to production.

### Forms Reminders and the Ability to fill forms without a login

- The percentage of Medical Hx forms filled by patients is below 20% as of now. Our goal is to bring this up to at least 50%.
- I Bring customisable campaigns in Patient Engagement that will trigger reminders to patients when they have pending forms in their account.
- I Bring the ability to complete patient forms without logging in to a patient portal. This will be a useful feature for paediatric practices, especially when a Responsible Party does not accompany the patients.

### Major Features - Release 5.22

#### Medical Hx forms Revamp

- I Introducing a lightweight form builder which is easy to maintain
- I Re-use the new form builder that we have brought in the office wizard.
- Eliminate all the complexities and rigidness within the configurations of medical hx forms, thereby increasing usability.
- Build a queryable system which will be useful for both us and the user to collect data around the responses of the Patients.

## Text Message FUP

As of now, we do not have control over the cost we spend on text messaging. On an average the cost we spend is showing a steady 15% increase monthly. We should devise a Fair Usage Policy and implement this across our customers to divide customers across different bands based on their usage.

Pre-loaded set of campaigns, template library for promotional campaigns, and intelligent template suggestions.

We should be able to make the patient engagement campaign system a true plug to play.

The practices spend a lot of time figuring out the ideal time settings for campaigns to run and this, along with configuring campaigns is a hectic job.

Also, there are occasions where practices configure campaigns with multiple mediums which involves a lot of cost for us.

- I With the increase in the number of text messages sent out per month, we are noticing very high filtering from the downstream carriers. This is mainly due to the practices using text templates to announce different offers and programs for the patients. The service providers usually filter out content like this and block the practice's numbers for further messages.

## Reputation Management - Social Media Integration

We have finished a major chunk of our reputation management feature. But, the feature is still in beta and is only used by less than 10 customers.

- I Social media integrations inside Rep management is something which is being asked by multiple customers.
- I Bringing in social media integrations to our reputation management will allow us to complete the first phase of reputation management and push it out to production.

## Online Appointments - Book multiple slots

For the paediatric practices out there, more than 50% of the incoming requests are family appointments.

- I Currently, we do not have the ability to book multiple appointment slots at once.
- I Bringing this ability will reduce the appointment booking time of the patients by at least 50%.

## Reporting & Analytics

[Roadmap View](#)



### Roadmap Items:

#### 5.21 Release

##### Aging Beta

The new Aging Report(Beta) gives users the flexibility to configure the aging logic, based on the practice requirements. This new report with enhanced features, has been found to be a gamechanger for practices wanting to calculate aging in Carestack, based on their definition. This also means that all the clients in Carestack are the target clients that would be impacted by the new report. While there seems to be considerable effort in building the new Aging Report, the report is expected to be released by 5.21. There is no specific release strategy for this new functionality.

##### Scorecard UX

The UI and UX rework on scorecards is aimed at providing a more usable easy experience while monitoring the relevant metrics on scorecards. This is released for all customers and is expected to be released by 5.21.

##### New KPIs

New KPIs relevant to be tracked by practises to stay on top of the charts are planned to be released by 5.21. This is released for all customers through a normal release strategy.

#### **KPI Drill Ins**

An enhanced drill in that provides the capability to view upto a patient level details on some of the existing dashboard KPIs. This is released for all customers through a normal release strategy, but would be impacting customers with the Custom Dashboard feature enabled. This is expected to be released by 5.21.

#### **Beta Reports Feedback**

With 5.21, all the old payment log and income allocation report in Insights would be decommissioned and removed. Users could use their corresponding enhanced beta reports as the main report to find data points they are interested in. This is targeted to impact all customers.

#### **Legacy Report Decommissioning**

Along with the decommissioning of legacy reports, we would be accommodating in the initial feedbacks in the Income Allocation and Payment Log Beta reports. This is targeted to impact all customers planned through a normal release strategy to be live by 5.21.

#### **Interactive Filters**

With the use of interactive filters in reports, users could look at only relevant data points rather than listing all filters that might not be in the context of the selection.

This framework change of providing advanced experience would impact all clients. This is planned to be released for all customers through a normal release strategy and is expected to be live by 5.21.

### **5.22 Release**

#### **Canned scorecards**

Canned scorecard is a high value analytics packaging that provides multiple templates like Health Summary, Production scorecards, etc, for practices to keep an eye on the performance and trends of these metrics. A location and provider level view of these metrics provide a holistic view of practice analytics. This is planned to be released for all customers through a normal release strategy. The initial version of it is expected to be released by 5.22 and the remaining versions are planned in the subsequent releases.

#### **New KPIs**

New KPIs relevant to be tracked by practises to stay on top of the charts are planned to be released by 5.22. This is released for all customers through a normal release strategy.

#### **Appointments by Provider Report(Enhancement)**

The appointments by provider report, in its current structure, shows inconsistent data. This is planned to be enhanced by fixing the inconsistencies and planned to provide additional functionalities. This is planned to be released for all customers through a normal release strategy and is expected to be live by 5.22.

#### **New Patient Report(Enhancement)**

The new patient report is found to have specific use cases that is how practices see the new patient report. The new mode and additional filtering options are expected to add value to all customers. This is planned to be released for all customers through a normal release strategy and is expected to be live by 5.22.

#### **Refer In Report(Enhancement)**

The current Refer In Report lacks the functionality to view the referred patients based on referral sources. Filtering based on referral source subcategory is what is achievable in the current report but the need to filter by referral source has been raised by multiple clients. There are additional pending enhancements like interactive filters and new data points that would be added to this enhanced report. This is planned to be released for all customers through a normal release strategy and is expected to be live by 5.22.

#### **Carenote Tracker Report**

The Carenote Tracker Report is planned to be enhanced with additional functionality that tracks all carenotes added in the system, be it against a code, condition or an unlinked carenote. This is planned to be released for all customers through a normal release strategy and is expected to be live by 5.22.

## **CLINICAL**

### **5.21**

## CareNote revamp

- Concatenating multiple incomplete care notes
- Care notes can be tagged to an appointment
- Assignee for CareNote
- Care Notes can be linked to a group of codes from practice settings

## Recalls

- Recalls based on production type
- Recall creation for new patient

## Treatment History

- I Ability to print treatment history with procedures and conditions.

## 5.22

## Referral Portal

- File sharing and note sharing between external and internal providers
- I Ability to edit referral provider
- I Ability to attach images as PNG/JPEG
- Attach perio chart

## SOTA Enhancements

- I Accessing SOTA Cloud from CareStack without clicking thumbnails.  
Refresh the image list when iFrame is closed.
- Intraoral camera and webcam support.

## 5.23

## Perio Enhancements

- I Enlarge perio numbers
- I Tooth specific selection
- Perio Chart Numeric Comparison in percentage
- Primary/permanent definition

## Quality Care

- Build Quality Care rules in practice settings.
- Display the rules on the patient's page

## Clinical Images

- Ability to upload images manually into PMS.
- Ability to manually tag uploaded images to a tooth number
- Ability to upload images from the clinical software
- I Ability to create date and bulk upload images.

## Front Office

### Appointment Booking and Cancellation

- I Consolidated work management experience with actionable insights and different layouts for long-term and short-term tasks for Front Office users.
  - Patient-related action items
  - Appointment related action items
- Assistance for Front Office users while booking appointments for an available slot for a patient
  - Show potential patients when looking for a slot.
  - Show availability of frequently used time slot
- I Appointment Rescheduling/Cancellation ability for the patient/responsible party.
  - The system identifies and lists potential patients who might book an appointment.
  - The user should be able to target the patients via email, text, and call
  - Improve the priority of the potential patient list based on the number of cancellations/no shows, A/R, insurance eligibility, etc.
- I The user should be able to view the details about the appointment in reschedule queue when booking another appointment
- I When rescheduling a patient appointment from the patient's all appointment page, I should be able to select a specific slot of a specific date.
- I As a user, I should be able to add a patient to the short call list without creating an appointment
  - As a user, I should be able to text/call a patient from the short call list or reschedule page.
- As a user, I should be able to send a patient in the short call list or reschedule list a link to book or reschedule an appointment

## Calendar

- I Have an option to view provider production at a monthly glance along with NP info.
- Identify an Appointment on Schedule with a box around it.
- Color change in appointment block when patients Check-in.

Hide Scheduled Production

# v5.22

## Key Features Upcoming in CS 5.22

Written by Aravind M | Last published at: October 01, 2021

## Key Features Upcoming in CS 5.22

Check out this list of features and enhancements coming in CS 5.22!

### Clinical

#### Code addition workflow UI changes

- Consolidated the addition of procedure codes, explosion codes, and conditions to a single button Code+.
- Ability to change the billing provider from the code addition slide-out.
- Ability to switch between normal mode and burst mode to save Care notes in draft status with and without prompts.

#### Advanced planner revamp

- Ability to present a tx plan to the patient and to mark the tx plan as presented.

Ability to visually differentiate if a Tx plan is in planned/accepted/completed/rejected status.

Ability to visually differentiate if a Tx plan has been presented or not.

- Ability to visually differentiate if a Tx plan has been scheduled or not.

Ability to view the Tx history of a Tx plan.

Ability to add notes specific to the Tx plan.

- Ability to tag a TX coordinator to the Tx plan.

Ability to add conditions corresponding to each Tx plan.

Ability to view odontogram from the Tx planner.

Ability to view insurance fee breakdown.

- Ability to view the Tx metrics which shows the percentage of unscheduled treatments.

A quick print option to print the Tx plan.

Ability to preview the Tx plan before presenting.

- Ability to send the Tx plan to the patient's portal.

#### Care note Enhancements

- Users can now link an appointment and an assignee to a care note.

- We have introduced the ability to add a recall by linking to a production type. Users can now create a recall and configure it to be triggered whenever an appointment with the linked production type is completed.
- Clinical Images have been made more accessible from the chart. SOTA Cloud has also been introduced. We have also introduced a new field to set up Practice Id while configuring SOTA when there is more than one practice in the instance.

#### Perio Chart Enhancements

- The ranges shown in the numeric comparison chart has been updated to follow ADA Standards

Users are given the ability to configure the way in which bleeding is marked on a Perio chart by choosing between marking on the current pocket which is probed or the previous pocket.

The perio chart numbers have been enlarged

#### Front Office

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Scheduler revamp - Introduced the global patient information slide out where a patient's information pertaining to Clinical , eligibility , financial, alerts, prescriptions, and documents are all accessible in a single slide-out for a user. The slide-out gets triggered when either one of the above-mentioned tabs is opened from the PMS. (**Beta Features**)

- Ability to view the patient's additional information in the appointment details tab whenever a patient is selected.

Ability to view the details of the family members from the appointment details tab.

Ability to view the patient's existing insurance details and its current status in the appointment details tab.

- Ability to add new insurance from the appointment details tab

- Ability to notify the user from the appointment details tab if the patient has any pending medical history form and documents to be completed.

Ability to key in multiple appointment notes and save the notes to the patient memo.

Ability to view the appointment history including all the status changes and the appointment note entries along with the proper date-time of occurrence and the user who is responsible for it.

Ability to switch to the Eligibility tab and view the patient's insurance eligibility details.

- Ability to switch to the financial tab which shows the patient's financial summary and make patient payments from there.

- Ability to switch to the clinical tab which shows the patient clinical information such as the last added prescription, recalls, lab cases, pending clinical notes, allergies & conditions, premedications, and medical history form details.

- Ability to switch to the patient alerts tab from the global slide out

Ability to switch to the prescriptions tab from the global slide out

Ability to switch to the documents tab from the global slide out

- Ability to view the patient memo slider from the global slide out.
- Ability to view the patient details, appointment details and add an appointment note from the appointment right-click menu.

Ability to view the secondary insurance information in the appointment hover.

Ability to view the patient's cancelation and no-show history when an appointment is canceled or marked as No Show.

- Ability to select and deselect the procedure codes to be retained in an appointment during cancelations and No Shows.

- Introduced a check-out confirmation modal to notify the user if there are non completed procedure codes linked to an appointment while checking out.

Introduced additional filters such as Same Day, This week, Next Week, Next month, +2M, +3M, +6M to filter out the search results inside the Find Slot

## Patient Services

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**Iris - Patient Chat** can now be accessed via Iris, with this users can now chat with both patients and other office users using a single application.

- Ability to select preset text templates to message patients.

Campaigns are now highlighted using a card in the conversation thread for better understandability.

- Users can easily identify if the patient has confirmed an appointment, by viewing the '*Responded*' flag inside the confirmation campaign cards.

Users can now access the Patient Memo of the respective patient while texting the patient, letting the user gather important patient memos and initiate conversations based on the previous Memos.

- Ability to configure (enable/disable) notifications inside Iris. Users can choose to enable or disable the browser push notification and the notification sounds for Patient Chat and Office Chat independently. Users can also choose between a variety of notification sounds, thus helping him/her differentiate between patient and office chat.

**Office Wizard(Revamp)** - Office Wizard has now been revamped and lets the users create forms and letters using much easier than before.

- The forms and letters can now be viewed as thumbnails on the Office Wizard page, letting the user edit/delete it from there.

- Users can now create preset components and save them inside the system, which can be reused, thereby not having to type the same component again and again while creating multiple forms and letters.

- Ability to trigger new forms/letters based on the last date of completion, thus saving a front office user's time and avoiding manual addition of forms against patients.
- Answers can be retained from the previous form, similar to the working of a Medical History Form, thus saving a patient's time of not having to fill the entire form multiple times.

Users can now choose between a wide variety of components while creating a form or letter.

Practice Users now have the ability to share documents with patients. The users can now share documents with their patients safely through a HIPAA-compliant medium via the Patient Portal.

Ability to print a patient's Treatment Plan from the Office Mode inside the Patient Connect.

## Reporting

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- Updated Care Notes Tracker report to track all care notes added to the system. With the new care notes tracker report, you can track care notes added to codes, conditions, and the unlinked care notes added to the patient chart. You can also track the codes which have no care notes added against them.

- Introduced 'Referred To' provider column in the refer-out report.

Introduced the Group By feature in the Daily Journal report. Daily Journal report can be grouped by location, provider, or patient.

- Introduced the patient ID column in Payment Log (Beta) and Daily Journal report.

Introduced 'Intel Report' used by the consulting team to track and monitor prime KPIs and assess how these KPIs are performing against the defined recommended rates.

Introduced new KPIs in Dashboards (for customers with the dashboard enabled), enabling users to view these new metrics visually. The new KPIs include Production Adjustment Rate, Collection Adjustment Rate, Patient Attrition Rate, Patient Reactivation Rate.

## RCM

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While opening a draft plan, except for the insurance account grid no other plan details are displayed inside it. But users can click on Update to update the plan and find the plan details.

BluePay transaction ID displayed on Patient Payment Details Modal and on Bluepay Transaction Grid.

# v5.23

Written by Aravind M | Last published at: December 03, 2021

## Key Features Upcoming in CS 5.23

Check out this list of features and enhancements coming in CS 5.23!

### Clinical

#### Perio Chart

Introduced the ability to draw on a perio chart

Introduced two new probing directions inside the perio and numeric chart

- Ability to mark bleeding on multiple teeth at a time.

The dentition shown in the perio chart will be based on the dentition in the dental chart.(Both the primary and permanent dentition will be considered in the perio chart)

- In the code addition slide out, when a code is selected from a range of selected codes, the tooth specific modal will be auto prompted for the rest of the codes.

#### Referrals

Ability to download the clinical images from the referral portal.

- Ability to download the referral letter from the referral portal.
- Introduced the ability to switch back to the previous stages of referring out workflow.

Ability to change the code type of an "Other" category code to either dental or medical.

- For tigerview users, multiple clinical images can be selected and opened to view at the same time.

#### Care Notes

Care notes are given a new UI and a slide-out is presented on adding a new note.

Users are allowed to merge multiple care notes.

- Care notes can now be linked to an assignee.

### Front Office

Introduced a practice level configuration to decide whether the blocked notes or the provider details need to be displayed first in the blocked tile.

- When a rescheduled appointment is booked, the codes linked to the rescheduled appointment will be displayed in the treatment summary. The same is applicable when scheduling a phase/plan directly from the advanced planner.

## Patient Services

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### Iris (Early Access)

- Practice users now have access to the patient's appointments, payments, labels, and treatment-related details while texting the patient. These details that are readily available can act as touchpoints to initiate conversations with the patients.
- **Preset Campaigns** - With the release of 5.23, **newly onboarded** practices will now have all the Recurring Campaigns pre-defined in their system. Providing a set of preset campaigns beforehand makes the work a lot easier for the Office Managers and they can send campaigns to their patients straightaway by simply enabling them.
- **Forms Reminders Emails** - Specialized Campaigns can now remind patients about their pending documents inside their Document Center. These emails can be customized to be sent days before an appointment or even days after a form was added, thus reducing the patient's long waiting time in the front office.
- Ability to delete Patient Flags from Practice Settings. Users can delete labels from the UI itself without having to reach out to Support and having it done by the engineering team, thus reducing the turnaround time.

### Reporting

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- Updated the appointment by provider report. The appointment by provider report now shows the appointment by the primary appointment provider. It also has the option to see the report by primary, secondary or tertiary providers. The report also shows the number of appointments that were rescheduled out of the broken appointments. Introduced the codes filter so that you will be able to filter the appointments with the selected codes.
  - Enhanced the payment log (beta) report to filter the report by deposit date and refund date. Also introduced the collection summary in the collection view of the report.
  - Introduced the production type recalls in the patient list
- Introduced new KPI in Dashboards (for customers with the dashboard enabled), enabling users to view these new metrics visually. The new KPI includes Patient Growth Rate.
- Introduced adjustment code filter in production and collection adjustment KPIs in the analytics dashboard.

### RCM

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#### Enhanced Statements feature

The new & enhanced Advanced Template. (*Beta*)

- To reduce wastage of pages, the statement has the pages optimized to accommodate the same.
- The user will be able to see the impact of each line entry on the Patient Balance.

The new Individual Patient statement feature provides more command over the statements generated from an individual patient context.

- All the statements for a patient can be seen under Billing > Statements.

Generate and take actions on Patient Statements like batch-generated statements.

Revamped UI for System Menu > Statements screen, with a single hub for Individual Patient statements & Batch generated statements. ()

Ability to void a single statement and other line level and bulk actions.

Exclusive practice setting for statements with more command over statement generation and template settings. (Template, Generation Criteria, Other Settings)

More configurability over the template that is to be sent to the patient.

#### **Ortho Cases Revamp (*Initially only for Beta clients*)**

Introduced two new workflows: Case level and Plan Level ortho cases.

Case level: current behavior where payment plans are created based on the case details. Here the ortho payment plans are dependent on the ortho case.

Plan level: New workflow where the user is given the flexibility to change the payment plan details irrespective of the case information.

Here the ortho payment plans are independent of the ortho case.

Account-level settings to toggle between the above two workflows.

■ Unified the procedure code checkout workflow.

UI changes for the creation of ortho case and plan.

New slideouts to add ortho case and plans:

Plans are created by default in draft status.

■ Ability to start a plan after updating plan details.

New statuses are introduced corresponding to cases and plans.

More flexibility in editing the case and plan details.

Users now have the ability to add multiple insurance payment plans under a case.

Users now have the ability to add secondary insurance to an insurance payment plan.

Users now have the ability to view the ortho payment schedule and ortho claim schedule along with creating the payment plans.

■ Users now have the ability to check out a code with \$0 under an insurance payment plan.

■ Users now have the ability to make the whole payment in a single payment as the total plan amount.

Users can now view the progress graph of a payment plan

Users now have the ability to select which all claims have to be generated and sent to the payor.

Initial claim: only the initial claim is sent.

## Initial claim and periodic claims

Users can now view a more detailed ortho payment schedule.

Each schedule status are differentiated with color variants.

Included two new columns - Paid and Adjustments, that show the whole payment and adjustments made against a generated code.

# v5.24

Written by Aravind M | Last published at: February 16, 2022

## Key Features Upcoming in CS 5.24

Check out this list of features and enhancements coming in CS 5.24!

### Clinical

Practices can now automate recall scheduling

- Ability to view the unscheduled/ overdue recall from the Dental chart, so that treatment coordinators can plan or take action accordingly
- Users can link additional codes to recalls, so that every time an appointment is booked through the new recall workflow, these codes will be automatically added to the appointment.
- With the new recall flow, we have brought the ability to automate scheduling of recalls. If the practice wishes to do so, every time a new recall is added, the user would be prompted an appointment slot to schedule the recall.
- Users can now link a care note to a previously completed code or a checked out Appointment
- Users can set a default imaging software for themselves and this would be opened every time they access the imaging slideout.

### Front Office

Scheduler revamp - Introduced the global patient information slide out where a patient's information pertaining to Appointments, Clinical, eligibility, financial, alerts, prescriptions, and documents are all accessible in a single slide-out for a user. The slide-out gets triggered when either one of the above-mentioned tabs is opened from the PMS.

- Ability to view the patient's additional information in the appointment details tab whenever a patient is selected.

- Ability to view the details of the family members from the appointment details tab.

Ability to view the patient's existing insurance details and its current status in the appointment details tab.

Ability to add new insurance from the appointment details tab

- Ability to notify the user from the appointment details tab if the patient has any pending medical history form and documents to be completed.

- Ability to key in multiple appointment notes and save the notes to the patient memo.

- Ability to view the appointment history including all the status changes and the appointment note entries along with the proper date-time of occurrence and the user who is responsible for it.

Ability to switch to the Eligibility tab and view the patient's insurance eligibility details.

Ability to switch to the financial tab which shows the patient's financial summary and make patient payments from there.

- Ability to switch to the clinical tab which shows the patient clinical information such as the last added prescription, recalls, lab cases, pending clinical notes, allergies & conditions, premedications, and medical history form details.

■ Ability to switch to the patient alerts tab from the global slide out

▼ Ability to switch to the prescriptions tab from the global slide out

Ability to switch to the documents tab from the global slide out

Ability to view the patient memo slider from the global slide out.

■ Ability to view the patient details, appointment details and add an appointment note from the appointment right-click menu.

▼ Ability to view the secondary insurance information in the appointment hover.

Ability to view the patient's cancellation and no-show history when an appointment is canceled or marked as No Show.

■ Ability to select and deselect the procedure codes to be retained in an appointment during cancellations and No Shows.

■ Introduced a check-out confirmation modal to notify the user if there are non-completed procedure codes linked to an appointment while checking out.

■ Introduced additional filters such as Same-Day, This week, Next Week, Next month, +2M, +3M,+6M to filter out the search results inside the Find Slot

Ability to copy previous appointment notes

▼ Users can now view the codes that were linked to a canceled appointment.

▲ Front Office Dashboard: Front Office Dashboard will provide bite-sized analytics to the front office users to take some core actions that will increase their day-to-day productivity which will have a bigger impact on the practice's profitability.

The landing page was revamped to show the Front Office dashboard with the Daily and Goals tab.

The Daily tab shows the day-wise overview of production, collection, and patient visits and lists the patient details of the appointments for the day.

▲ The Goals tab allows users to set production goals for providers for each month.

## Patient Services

### Book Appointments for multiple patients from the Online Scheduler

■ Patients can now book up to four appointments in one go from the Online Scheduling Portal. With this, appointments can now be booked by families all in one go.

■ **Medical History Form(Revamp)** - Medical History Form has now been revamped and lets the users configure the form in Practice Settings much easier than before.

▲ Users can now add questions to the Medical History Form using a wide range of question components.

Ability to trigger a follow-up question if the patient responds 'Yes' to a Medical Allergy or Condition. With this, the provider can collect relevant medical information pertaining to an allergy or condition before the patient's treatment.

Questionnaires can now be hidden from the patient. Practices can now choose to present either the Medical or the Dental questionnaire using a new 'Hide this Form' feature. This enables the practice in collecting only valid health information from their patients.

## Reporting

Introduced the Applied column in the Payment Log Beta report.

- Introduced the new Aging (Enhanced) report. The new aging enhanced report has two modes of aging computation: Original code completion and Balance creation. The new aging report comes with three views- Summary, Patient, and Detail view.

## RCM

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Implemented ADA 2019 claim form.

Users can now configure the Billing Dentist/Dental Entity at a Provider level, as this will allow them to cater for provider level credentials & billing.

Month logic in the waiting period of insurance plans is made to Calendar month.

- Enabled Apex for insurance, collections, and capitation payments.

Improvements in ERA:

Users can now trigger ERA auto-posting manually from UI.

- Introduced history for ERA auto-posting.

- Users can know the overall status of posting and paid as expected information along with their percentages.

The ins paid amount inside the claim is auto-populated from the value inside ERA whenever the user tries to add line-level ERA payment.

Users can now post the payments of 'Paid as expected' claim for a single line-level entry or in bulk using a single click.

- When the user clicks on 'Add Payment' inside an ERA, the fields inside this modal are auto-populated with values, and the ERA details are displayed inside the same.

# v5.26

Written by Aravind M | Last published at: July 04, 2022

## Key Features Upcoming in CS 5.26

Check out this list of features and enhancements coming in CS 5.26!

### Clinical

#### Multiple Cloud Imaging Software

Carestack now supports the use of SOTA, Tigerview, and Apteryx on a single account

Users can choose to switch between the softwares.

- Introduced the ability for users to select default imaging software at a location level.

When attaching images in the refer-out workflow, the images that are shown would be from the default imaging software.

#### Default Treating dentist (for claims)

- Replaced the term "default billing dentist" with "Treating Dentist".

Users can now assign a default treating dentist for every hygienist inside Practice settings > Administration > User.

#### Recalls

Introduced new permissions for viewing, adding, editing, and deleting recalls for patients.

Users with the existing permissions to do the above-mentioned actions would have the corresponding recall permissions enabled as default. Super admins can later disable these permissions if they wish to do so.

#### Fee Calculation

Fee calculation has taken into account AMB codes and deductible for Copay plans.

### Front Office

Appointments on the scheduler can now be customized to show different slot colors, margin colors, and border colors based on appointment status. Introduced Border colors. Users can now differentiate appointments based on the criteria for border color.

- Introduced a new appointment status group "In Office status".
- Users would now be able to print the Unscheduled procedures list.
- All Inactive appointment status and production types will be filtered out from legends in the scheduler.

Added a 'Go to scheduler quick link' in the appointments tab inside the global slide out.

Introduced new permissions for creating blocks in the scheduler as an extended part of the existing scheduler permissions.

Introduced branding for scheduler and routing slip print. Users can now choose whether they want an account or location-based branding.

- Ability to navigate 8 months forward from the quick navigation option in the scheduler.

Patient details can now be easily accessed from the reschedule queue without having to lose context by navigating to the patient page.

## Patient Services

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### Iris (Moving from Early Access to Full Rollout)

The entire campaign content can now be seen from Iris, giving users data on the appointment date and time and further information when the campaign was sent out.

### Inactive Patient Configuration (Beta - Bellano Dental only)

The Inactive Patient Configuration will be turned on for a selected customer. With this, users need not manually deactivate patients who haven't visited the practice for a long time. Instead, this can be done automatically by setting the time frame of the patient's last completed appointment and treatment's Date of Service.

The Patient Connect, Patient Portal and the Online Appointment Portal's URLs can now be bookmarked using the direct bookmark (star) in the browser. Practice users can now use these shortcuts to bookmark the Patient Connect URL which comes in handy while logging into Patient Connect daily.

The Patient Portal now has a **document upload** feature. With this new release, patients can upload and share the documents requested by the practice via the Patient Portal which is HIPAA compliant.

### Patient Connect - Kiosk Mode (Beta - selected customers only)

The kiosk mode of the Patient Connect has been revamped to a more intuitive patient-facing application that allows for a faster check-in process for a patient's appointment. Below listed are the key features.

Driving patient check-in via the kiosk through an intuitive wizard workflow.

Faster patient signatures with the new 'Quick Sign' feature.

- Automatic patient logout and redirect to the homepage after appointment check-in.

## Reporting

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- Introducing a new view of Unapplied Credits in the Aging (Enhanced) Report. Users can now drill into the unapplied credits and see the receipts contributing to these credits.

- Enhanced the Utilization report. Users can now filter the report by CDT code category and see the adjustments and net production and net collection details in the report.

Ability to filter the Applied view of the Income Allocation report and Income Allocation Beta report by payment type.

- Introduced the Missing Transactions KPI in the Intel report.

Introduced the current location and current provider checkbox in the analytics dashboard.

## RCM

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Electronic eligibility:

- Improved the Electronic Eligibility response view where users can see more information about Deductibles, Active Coverage, Maximums, Exclusion, and Limitations.

- Ability to easily navigate to different sections on eligibility response.
  - Ability to create credit/debit card payment type receipt without triggering payment gateway.
  - Ability to configure Account logo/custom logo which can be printed on new Advanced Statement template (Beta)
- Extending Bluepay transaction date range to provide the ability to see 30 days transaction history.  
Users will be able to update the payable of a completed code even when there is a claim raised against it.

# v5.27

Written by Aravind M | Last published at: July 04, 2022

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[Release Features 527.pdf](#)

# v5.28

Written by Aravind M | Last published at: October 03, 2022

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[Release Features 5\\_28.pdf](#)

# Patient Portal

Written by Akhila R | Last published at: July 28, 2021

## Overview

**Patient portals** are healthcare-related online platforms that allows patients to interact with their provider or practice , regarding their medical information and related business via the Internet. Patient portals benefit both patients and providers by increasing efficiency and productivity. Our patient portal is also a similar platform where patients are able to access medical records, make payments and complete forms via an email. They can access it from anywhere and everywhere!!!

## How to access patient portal?

If the patient wishes to receive patient portal emails, user will have to update the 'Enable Portal Notifications' checkbox in the new patient window(fig.1). After patient gets subscribed for 'Enable Portal Notifications', 'Check Patient Portal Status' button in patient overview will show that the patient portal is active.



fig. 1: Enable Portal Notification checkbox

User can send a patient portal email to patient by clicking 'Send Patient portal link' in overview. The email will contain a link to visit the portal, and on clicking the URL in mail patient is redirected to the patient portal login page where they can generate the one time authentication code. This figure shows both link in patient overview and a sample email that patient will receive in their device.



fig. 2 (a) : Send patient portal link in patient overview



fig.2 (b) : Example of a Patient portal email with URL

Also there is a generic link for each practice to navigate to an authentication page where patients can identify themselves after providing first name, last name and date of birth as shown below. The given steps shows how a patient can login to patient portal.

Step 1: In the authentication page patient can provide first name , last name and date of birth which are mandatory and then click next.( fig.3)

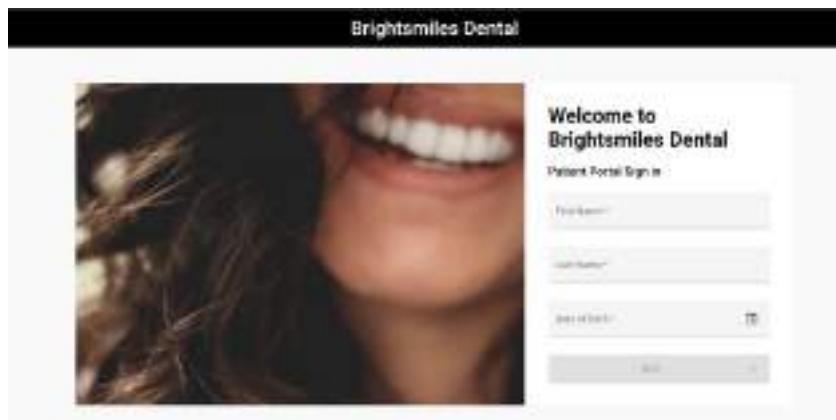


fig.3: Patient portal authentication page

Step 2: After giving the credentials patient should be able to generate an one time authentication code via email or text as per their choice. Patient can select a medium though which they would like to receive the OTP and can click 'GET VERIFICATION CODE' button.(fig.4)

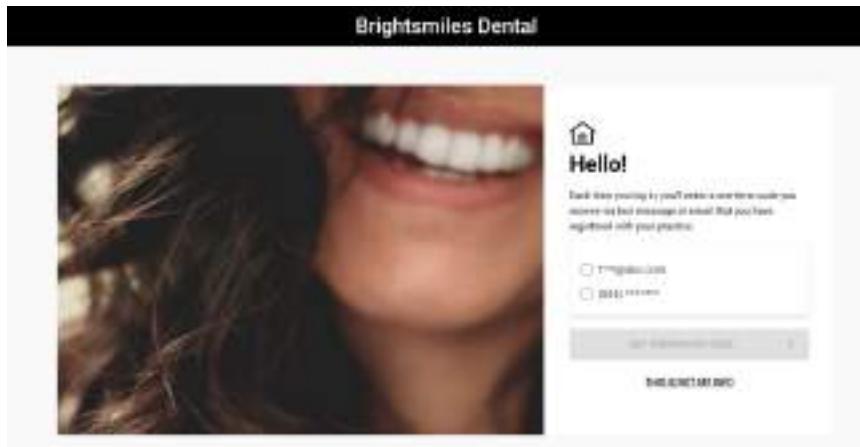


fig.4: Next page to select medium

Step 3: Patient can type OTP and then click proceed.

## What can patients do with Patient portal?

Patient portal should improve both patient care and provider workflow .It should be user friendly and at the same time should have a workflow that saves time and effort for staff and providers. The home page of portal comes with a welcome banner, consolidated payment data ,upcoming appointments , pending forms and treatment pending. There are some side tabs like forms, treatments, payments and appointments ( fig.4) .If the patient is a responsible party they can switch the context to another patient linked to the account by clicking 'Select Family Member'.



fig.4: Home page of Patient portal

### Patient portal tabs:

**Home:** A patient on logging in to portal lands on the home page by default . It contains 4 different sections as payments, upcoming appts, pending forms and treatment pending.

**Forms:** This section is titled pending forms and user can search any form from here. Incomplete forms of a patient will be listed in the home page. Once a form is completed, it is removed from the pending forms section.

**Treatments:** This section contains treatment plan, upcoming treatment and past treatment. The upcoming treatments shows upcoming treatments pertaining to the selected patient and past treatments show the completed ones.

**Payments:** Responsible party is able to see their saved payment details along with payment history and statement history. They can view and can make payments from here by clicking 'Pay now' button corresponding to each account member.

**Appointments:** It contains two different tabs as upcoming and past appointments. Upcoming appointments list all the appointments of patient for the a future date or for the same day. Patient can confirm their appointment from the portal by clicking 'Confirm Now' button. Past appointments lists the previous appointment of the patients.

**Documents:** Patient can upload documents from here by clicking 'Upload' button. There are two sections like 'Shared documents' and 'Uploaded by me'. There is an option to search documents and to sort the documents by Name as A-Z , Z-A and Date as Recent, Older.

**Account details:** Account details of responsible party and other members are shown here. Patients can edit their details , can add an account member and can add an insurance from this section.

# Iris

Written by Geo Thomas | Last published at: August 19, 2021

Iris is the hub that brings together User Chat, Group Chat, Patient Texting, and In-Office Patient Tracking capabilities into one interface. It has the ability to launch as a separate pop-out browser window, so that users can switch between the main browser instance (with the PMS tabs) and the Iris window using Alt + Tab (in Windows).

Iris can be launched only from within CareStack after the user has logged in. When they log out of CareStack, they will be logged out of Iris too. Unified chat search is for searching across users/profiles/locations.

The office chat can be accessed by clicking this icon.



It would have two options, one for text chat and the other for office chat.



## Office Chat

It is used for in-office communications.

### Statuses

By default, while logging in, the status would be **Active** and after logging out, it would be **Offline**. The other available statuses are **Busy** and **Away**. The user can choose any status based on their availability.



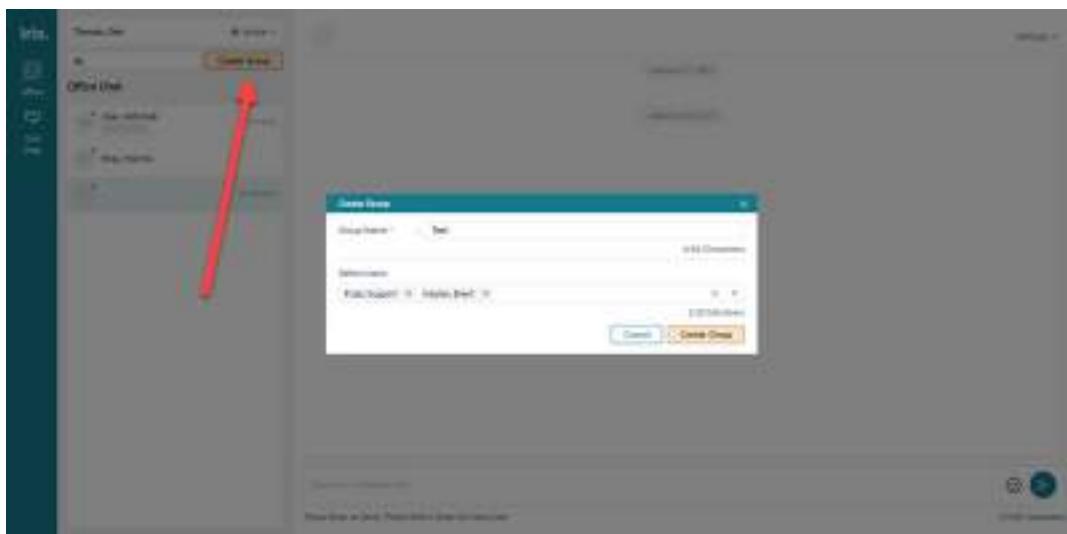
## Search

The search option allows the user to search for any other user in their practice.



## Chat Groups

Chat groups can be created by clicking Create Group. A maximum of 20 users can be added to a chat group.



## Settings

The settings button gives two options, to mute a chat and to mark a chat as unread.



## Alerts

While sending/receiving messages, IRIS produces a beep sound to alert the user. If desktop notifications are enabled in Chrome, a pop-up message would appear while receiving messages.

Embedded content from <https://www.loom.com/embed/517c56b5c53340df952dfb86077dbe5f>

## Text Chat

The text chat inside IRIS allows the user to send messages to patients. This is same as the text messaging feature inside CareStack.



The options available in IRIS text chat is same as that in the text messages in CareStack. That is, the user can search for any patient who has opted for text messages, can adjust the view of the chat as to show All messages, read messages or unread messages, can set the location for which the messages are to be shown, etc

Embedded content from <https://www.loom.com/embed/a9c04b54dcd64e30b5d0dae351088df8>

# Net Promoter Score (NPS)

Written by Nidhin John | Last published at: October 03, 2022

Net Promoter Score (NPS) is a customer loyalty and satisfaction measurement taken from asking customers how likely they are to recommend your product or service to others on a scale of 0-10. Depending on the score customers/ clients provide, they can be classified as Promoters, Passives and Detractors.

**Promoters:** Clients who give a score of 9 or 10. They represent a company's most enthusiastic and loyal customers: these people are likely to act as brand ambassadors, enhance a brand's reputation, and increase referral flows, helping fuel the company's growth.

**Passives:** Clients who give a score of 7 or 8. They are not actively recommending a brand, but are also unlikely to damage it with negative word of mouth. Although they are not included in the NPS calculation, passives are very close to being promoters (particularly when they give a score of 8), so it always makes strategic sense to spend time investigating what to do to win them over.

**Detractors:** Clients who give a score between 0 to 6. They are unlikely to recommend a company or product to others, probably won't stick around or repeat purchases, and—worse—could actively discourage potential customers away from a business.

## NPS calculation

NPS is calculated by subtracting the percentage of Detractors from the percentage of Promoters. Percentage of promoters can be calculated by dividing the number of clients who gave a score of 9 or 10 to the total number of clients who gave some rating. Similarly the percentage of detractors can also be calculated.

$$\boxed{\text{NPS} = \% \text{ of Promoters} - \% \text{ of Detractors}}$$

NPS can vary between -100 to +100. -100 is when all the clients are detractors, meaning, the score given by all clients are between 0 and 6. +100 is when all clients are promoters, meaning, the score given by all clients is either 9 or 10. Any score above zero is considered a good score.

## Why is NPS important?

NPS can be used as a predictor of business growth. When your company's NPS is high (or, at least, higher than the industry average), you know that you have a healthy relationship with customers who are likely to act as evangelists for the brand, fuel word of mouth, and generate a positive growth cycle.

NPS is a valuable metric on a strategic level, but by itself, the score is not enough to be useful or paint a complete picture. The overall NPS system is important because it allows businesses to:

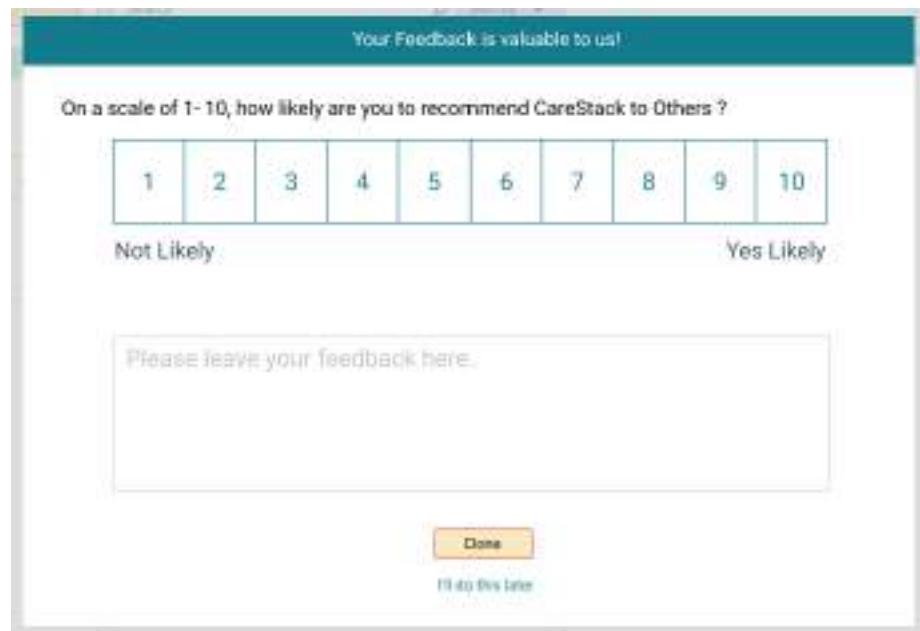
By asking customers why they've given a specific score, organizations of any size can understand what they're doing well and where they could be improving

Track and quantify a score over time, creating internal benchmarks

► Rally all employees around one mission-critical objective: earning more enthusiastic customers

## Current NPS workflow in CareStack

1. New practice onboard to CareStack
2. Each new CareStack user in a practice will get NPS feedback pop up after 60 days
3. After this NPS feedback is collected from all users every 90 days
4. If the user click "I will do it later" option, the pop up will appear each time the user log out
5. The data collected is stored in database
6. TOPS team share collected user feedback on a daily basis
7. NPS report is prepared on a monthly basis



The image shown above is the feedback modal users see while they log out. As per the current workflow two things can happen after a user give a score.

1. If the score is 8 or above, the user is directed to <https://carestack.com/refer-a-practice/>. Through this page a user can refer other practices to CareStack. If the user refer others to CareStack they are given vouchers and benefits.
2. If the score is below 8, the user will be redirected to the login page.