NextGen: PM Contract Library

User Manual

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NextGen PM Contract Library

Common Uses for Contracts

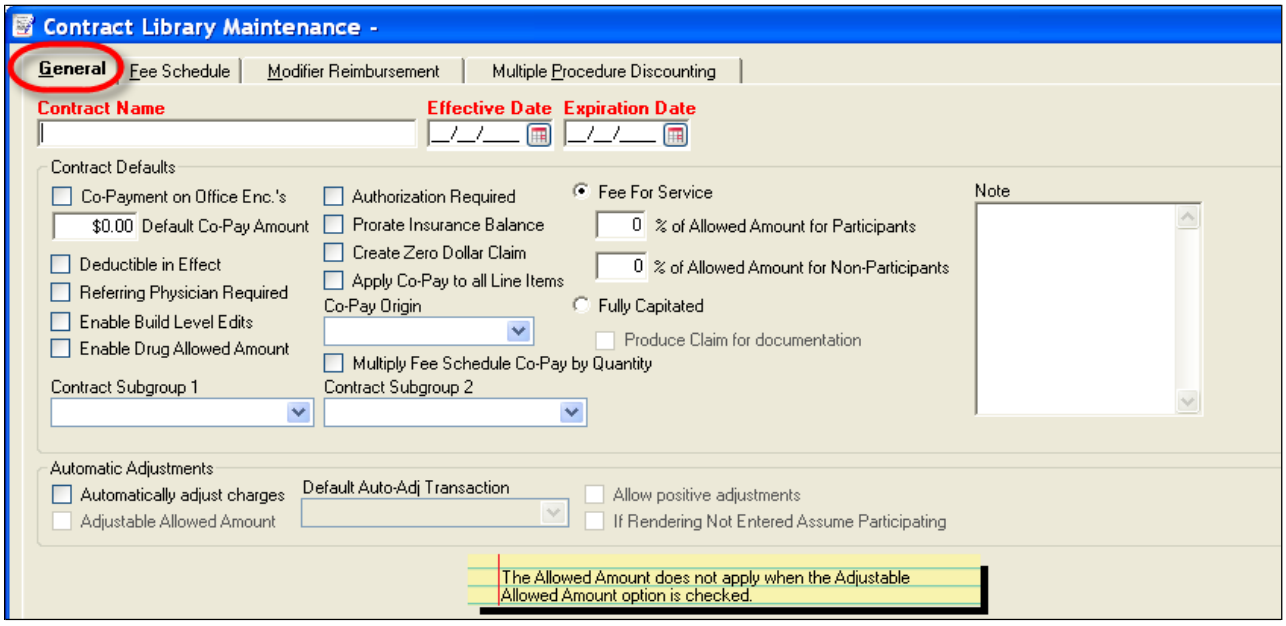
- Streamline payment entry by defaulting the payer's allowed, payment and adjustment amounts.
- Automatically adjust charges during charge posting so that A/R reflects expected reimbursement.
- Track expected vs. actual reimbursement with the Contractual Analysis Report.
- Define requirements for specific CPT4 codes. For example: authorization required, referring provider required, co-pay amount, diagnosis code required, modifier required, etc.

Note: *The information entered within a contract applies only when the contracted payer is the primary insurance on the encounter.*

File Maintenance

File Maintenance>Libraries>Contract

General Tab



- Contract Name
  - Enter a name for the contract.
- Effective/Expiration Dates
  - The dates entered are used in determining whether or not to apply the contracts rules to a particular date of service for the patient. The contracts Fee Schedule

tab also has effective and expiration dates specified for each CPT4 code. Those dates must fall within the effective/expiration dates defined here.

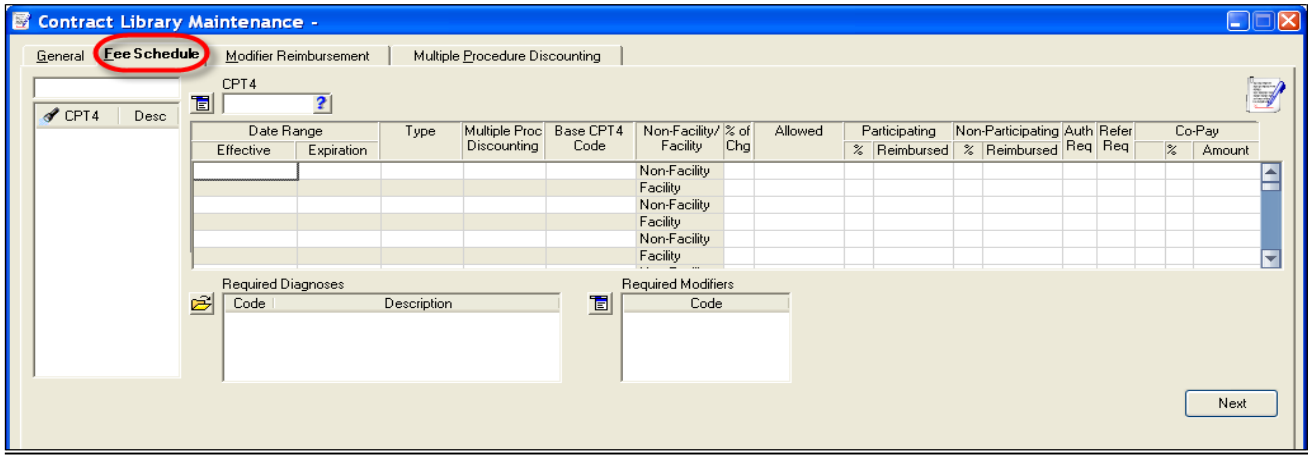
- Co-Payment on Office Enc's (Encounters)
  - Displays the following prompt to users when the Co-Payment field is left blank on the Insurance Maintenance Window: "*The copay field is a required entry for this contract. Are you sure you want to leave this screen? Yes/No*."
- Default Co-Pay Amount
  - Defaults the amount indicated into the Co-Pay Amount field on the Insurance Maintenance window. This can be used if <u>all</u> patients that have an insurance associated to this contract have the same co-pay amount.
  - Note: This feature only works if the "enable practice payer specific information" option in Practice Preferences is <u>not</u> selected.
- Deductible in Effect
  - Displays the following prompt to users when the Deductible field is left blank on the Insurance Maintenance Window: "*The deductible field is a required entry for this contract. Are you sure you want to leave this screen? Yes/No*."
- Referring Physician Required
  - Displays the following contract edit alert to users on the Charge Posting window for any CPOT4 code entered: "*Referring Physician is required for this procedure*."
- Enable Build Level Edits
  - Generates a claim edit failure on the Claim Production Status Report during the billing process and stops a claim from being created if an encounter is missing any of the criteria defined within the contract.
- Enable Drug Allowed Amounts
  - Enables allowed amounts for each CPT4 code to be entered with three decimal places on the contract's Fee Schedule tab. ($0.000)
- Contract Subgroup 1 and 2
  - A contract can be linked to one or two Contract Subgroupings which are defined in File Maintenance/Master Lists and used to associate providers and contracts together. Providers linked to the same subgroup(s) in the Providers table can easily be assigned or unassigned as participating providers for the contract.
- Authorization Required
  - Displays the following contract edit alert to users on the Charge Posting window for any CPT4 code entered: "*Authorization is required for this procedure*."
- Prorate Insurance Balance
  - Charge balances on an encounter will be prorated in the Balance Control window between the primary and secondary insurances (or between the primary insurance and the patient if no secondary insurance exits). The prorated amount is based on the fee for service percentage defined in the contract's fee schedule.
  - Note: the "prorate insurance balance" option must also be selected for the Payer on the Practice tab>Libraries sub-tab.
- Create Zero Dollar Claim
  - Enables $0.00 charges to be included and billed on insurance claim forms. Unless this option is selected, the application does not normally include $0.00 charges on claims.
- Apply Co-Pay to All Line Items
  - Enables multiple charges on a single encounter to have a co-pay applied if the Co-Pay Amount or Co-Pay % has been defined for each CPT4 code in the contract's fee schedule. Unless this option is selected, the application applies a

co-payment only to the first charge entered on an encounter, regardless of the CPT4 code entered.

- Co-Pay Origin
  - Determines if the Co-Pay% indicated in the contract's fee schedule should be based on the *Allowed Amount* or the *Reimbursed Amount* defined for each CPT4 code.
  - Note: The "Co-Pay percent calc" option within the Payers table in File Maintenance must also be selected.
- Multiply Fee Schedule Co-Pay by Quantity
  - The co-pay amount indicated for a CPT4 code on the Fee Schedule tab of the contract will be multiplied by the quantity entered during charge posting.
- Fee for Service
  - Defaults "FFS" into the Type field for each CPT4 code added to the contract's fee schedule.
- % of Allowed Amount for Participants/Non-Participants
  - The percentage defined here will be multiplied by the price from the SIM Library for any CPT4 code not defined in the contract's fee schedule. The multiplied value will default onto the Payment Entry window as the expected payment amount.
- Fully Capitated/Produce Claim for Documentation
  - Charges for CPT4 codes not defined in the contract's fee schedule will be adjusted to a balance of $0.00 on the Payment Entry window. The adjustment amount is equal to the price from the SIM Library. The adjustment code used is the Default Adjustment code from the Payers table.
  - Also defaults "Capitated" into the Type field for each CPT4 code added to the contract's fee schedule.
- Automatically Adjust Charges
  - Charges will be adjusted at the time of entry on the Charge Posting window. The adjustment amount is calculated as the difference between the price from the SIM Library and the allowed amount from the contract's fee schedule. [*Charge – Allowed = Adjustment*]
- Adjustable Allowed Amount
  - Charges will be adjusted at the time of entry on the Charge Posting window. The adjustment amount is calculated as the difference between the price from the SIM Library and the reimbursed amount from the contract's fee schedule plus the patient's co-pay amount. [*Charge – (Reimbursed + Co-Pay) = Adjustment*]
- Default Auto-Adj Transaction
  - Required entry if the "Automatically Adjust Charges" option is selected. Enter the third party adjustment Transaction Code to be used when charges are adjusted at the time of entry on the Charge Posting window.
- Allow Positive Adjustments
  - Charges will be adjusted at the time of entry on the Charge Posting window. If the price from the SIM Library is less than the allowed amount from the contract's fee schedule, a positive adjustment will be added to bring the balance of the charge up to the allowed amount.
- If rendering Not Entered Assume Participating
  - If the Rendering field is left blank on the Encounter Maintenance window (and therefore is also left blank on the Charge Posting window) the system will

assume that the “no rendering” is a participating provider and the adjustment amount will be calculated accordingly.

Fee Schedule Tab



- CPT4
  - Enter the CPT4 code to be added to the fee schedule.
- Effective Date
  - Enter the date the allowed amount takes effect for the CPT4 code. The default is from the Effective Date defined on the contract’s General Tab and can be overridden.
- Expiration Date
  - Enter the date the allowed amount ends being in effect for the CPT4 code. The default is the Expiration Date defined on the contract’s General Tab and can be overridden.
- Type
  - Enter the FFS (Fee for Service) for the CPT4 code. The default is FFS or Capitated depending on which option was selected on the contract’s General tab.
  - Note: If Capitated is selected, the CPT4 will be adjusted during Payment Entry. The adjustment amount is equal to the Reimbursed amount defined for the CPT4 in the contract. The adjustment code used is the Default Adjustment code form the Payer’s table.
- Multiple Proc Discounting
  - Select the appropriate option for the CPT4 code.
    - No: The allowed amount for the CPT4 will not be reduced.
    - Multiple Surg: The allowed amount for the CPT4 code will be reduced based on the order/sequence of the charge on the encounter. The allowed amount is reduced to the percentage defined on the Multiple Procedure Discounting tab.
    - Endoscopy: The allowed amount for the CPT4 code will be reduced. The allowed amount is reduced to the difference between the allowed defined for the CPT4 and the allowed defined for the “Base CPT4 Code.”
- Base CPT4 Code
  - Select the “Base Code” for the endoscopy CPT4 Code.

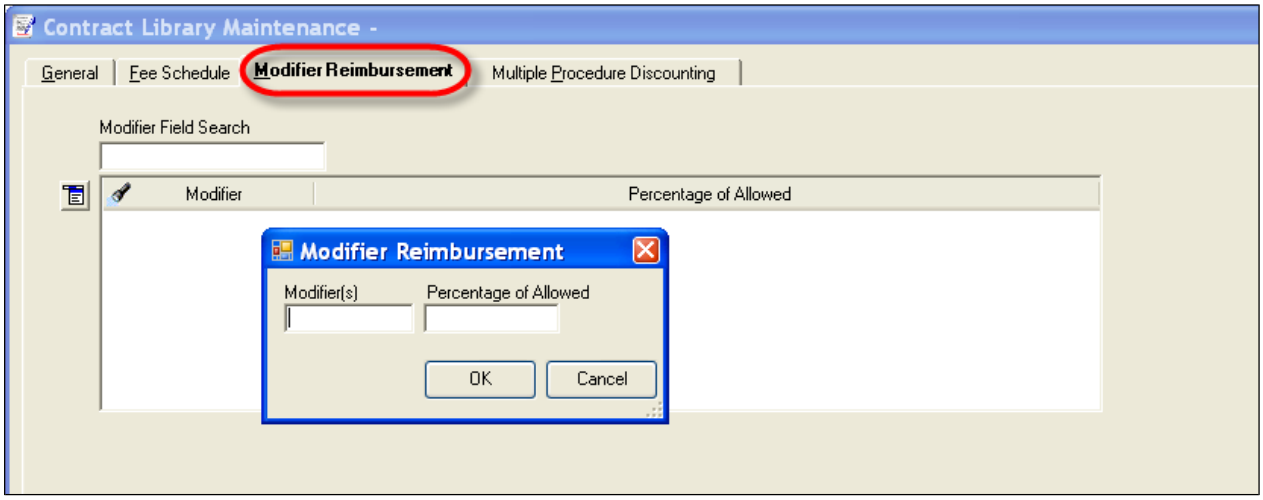
    - Note: This field is required if “Endoscopy” was selected in the “Multiple Proc Discounting” field.
- Non-Facility/Facility
    - Allows for difference in allowed and reimbursed amounts depending on where a service is performed. (E.G. Office=Non-Facility and Inpatient Hospital = Facility)
- % of Chg
    - Select this column (green check) if the allowed amount for the CPT4 code is to be a percentage of the charge amount from the SIM Library.
    - Note: when this column is selected, the Allowed field becomes a % amount, not a $ amount and the Participating/Non-Participating Reimbursed fields become unavailable.
- Non-Facility Allowed
    - Enter the non-facility allowed amount for the CPT4 code. An adjustment will be made to the charge if the non-facility price from the SIM Library and the non-facility allowed amount from the contract’s fee schedule are not the same.
    - Note: The charge will be adjusted at the time of entry on the Charge Posting window if the “Automatically Adjust Charges” option is selected on the contract’s General tab. Otherwise, the charge will be adjusted during Payment Entry.
- Participating %
    - Enter the percentage of the allowed amount that is expected as reimbursement for a participating provider. The Participating Reimbursed amount will be calculated form the percentage entered.
- Participating Reimbursed
    - Enter the reimbursement amount that is expected for a participating provider. The Participating % will be calculated from the amount entered.
- Non-Participating %:
    - Enter the percentage of the allowed amount that is expected as reimbursement for a non-participating provider. The Non-Participating Reimbursed amount will default to $0.00 as an entry is not required in both fields.
- Non-Participating Reimbursed
    - Enter the reimbursement amount that is expected for a non-participating provider. The Non-Participating % will default to $0.00 as an entry is not required in both fields.
- Auth Req
    - Select this option if an authorization is required for the CPT4 code. The following contract edit alert will display to users on the Charge Posting window: “*Authorization is required for this procedure*.”
    - Note: This will override the “Authorization Required” option setting on the General tab.
- Refer Req
    - Select this option if a referring physician is required for the CPT4 code. The following contract edit alert will display to users on the Charge Posting window: “*Referring Physician is required for this procedure*.”
    - Note: this will override the “Referring Physician Required” option setting on the General tab.
- Co-Pay √
    - Select this option if a co-payment should be applied to the CPT4 code. The co-pay applied will be the amount defined in the Default Co-Pay Amount field on the contract’s General tab. If no co-pay amount is defined on the contract’s General tab, the co-pay

applied will be the amount entered in the Co-Pay Amount field on the patient's Insurance Maintenance window.

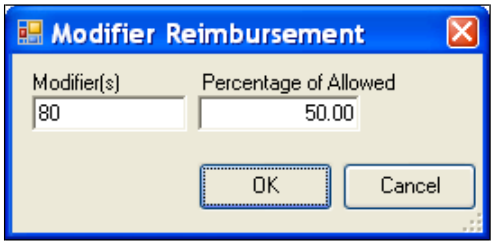
- Co-Pay %
  - If the co-payment to be applied to the CPT4 code should be calculated as a percentage of the allowed amount defined in the contract's fee schedule, enter the percentage here.
  - Note: This percentage co-payment will override both the "default Co-Pay Amount" defined on the contract's General tab and the Co-Pay Amount defined on the patient's Insurance Maintenance window.
- Co-Pay Amount
  - If the co-payment to be applied to the CPT4 code should be a specific dollar amount, enter the amount here.
  - Note: This co-payment amount will override both the "default Co-Pay Amount" defined on the contract's General tab and the Co-Pay Amount defined on the patient's Insurance Maintenance window.
- Required Diagnoses
  - If the payer requires that a specific diagnosis code be associated to this CPT4 code, add the ICD9(s) here. The following contract edit alert displays to users on the Charge Posting window if a required ICD9 code is not entered.
  - "*Warning: The contract requires the primary diagnosis code to be one of the following diagnosis code(s): code1, code2, code3, etc*."
- Required Modifiers
  - If the payer requires that a specific modifier be associated to this CPT4 code, add the modifier(s) here. The following contract edit alert displays to users on the Charge Posting window if a required modifier is not entered: "*Warning: according to the contract the following modifier code(s) are required for this procedure: code1, code2, code3, etc.*"

Modifier Reimbursement Tab

This tab can be used if the payer reduces the allowed amount defined for CPT4 codes on the Fee Schedule tab to a certain percentage when a specific modifier or modifier combination is used on the charge.

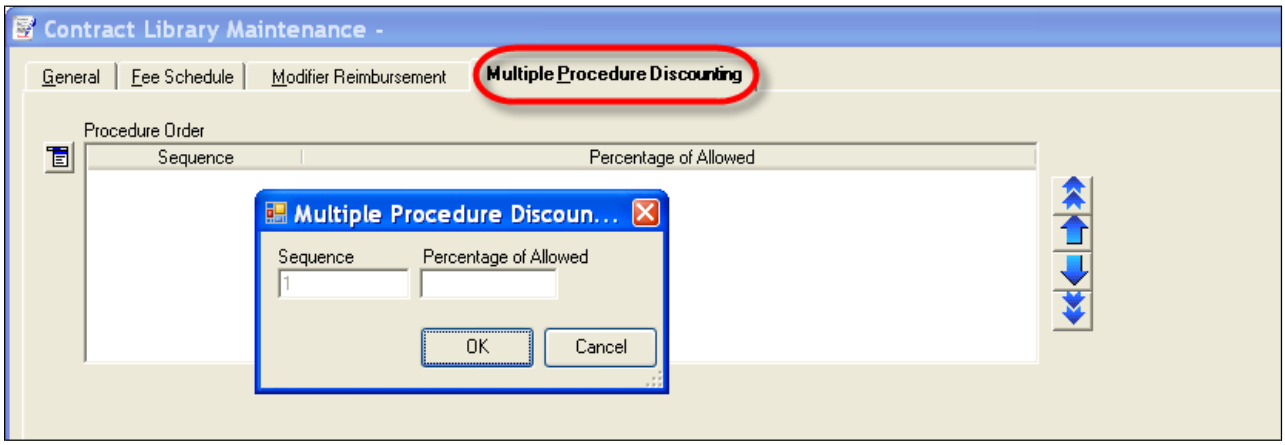


- Modifier(s)
  - Enter a specific modifier or modifier combination.
- Percentage of Allowed
  - Enter the percentage the allowed amount should be reduced to when the specified modifier or modifier combination is used on a charge.
  - Example: Modifier 80 (Assistant Surgeon) will reduce the allowed amount to 50%.

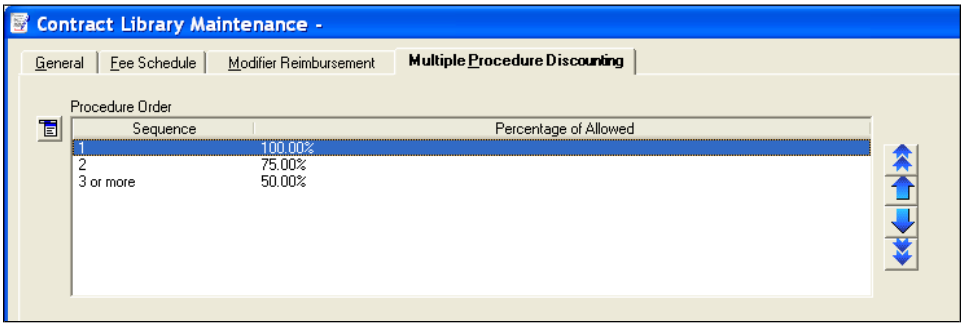


Multiple Procedure Discounting Tab

This tab can be used if the payer reduces the allowed amount defined for CPT4 codes on the Fee Schedule tab to a certain percentage when those codes are setup as a "Multiple Surg." The allowed amount is reduced based on the charge order/sequence on the encounter.

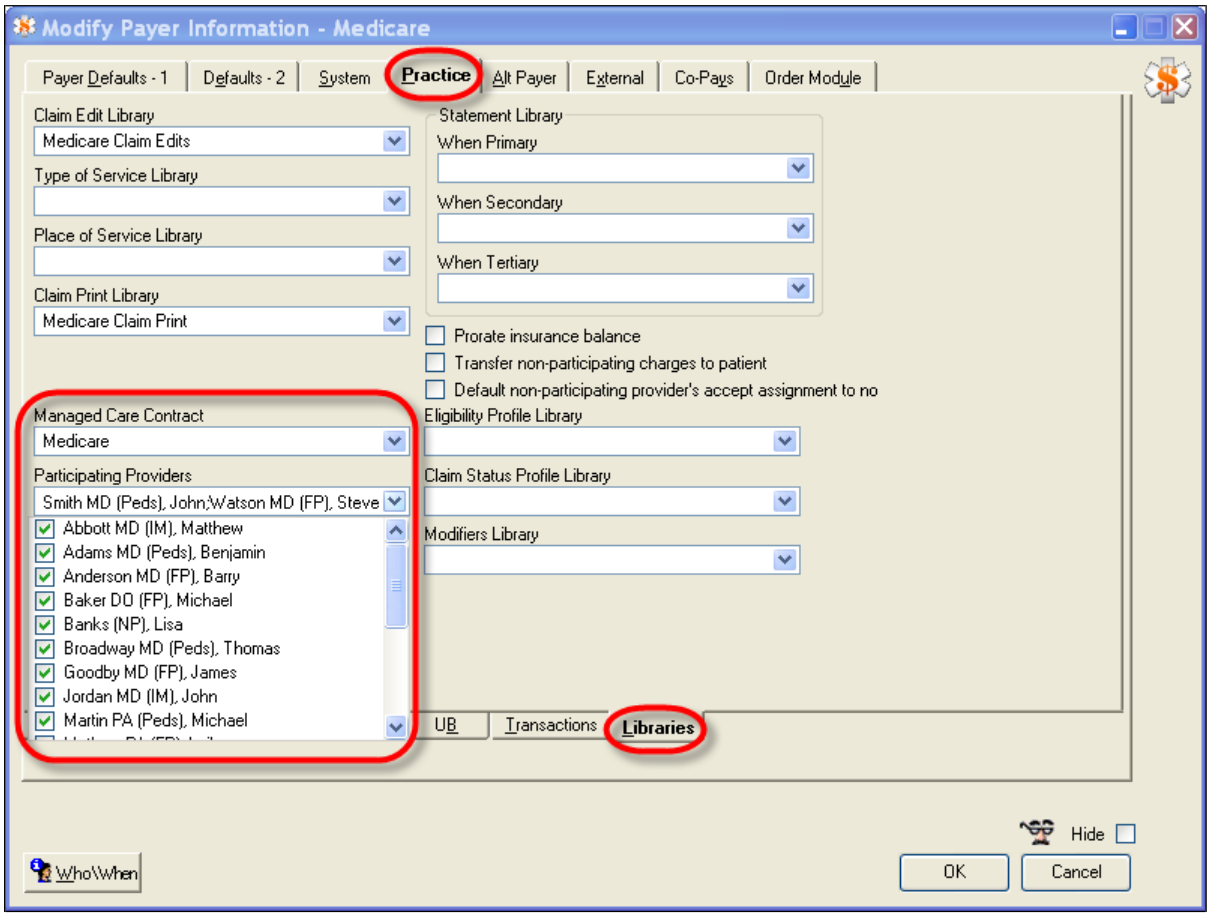


- Sequence
  - Defaults a number as follows and cannot be changed:
    First entry = 1
    Second entry = 2
    Etc.
- Percentage of Allowed
  - Enter the percentage the allowed amount should be reduced to when the charge falls into the defined order/sequence on the encounter. Example:
    First charge: The allowed amount will remain at 100%
    Second charge: The allowed amount will be reduced to 75%
    Third charge: The allowed amount will be reduced to 50%



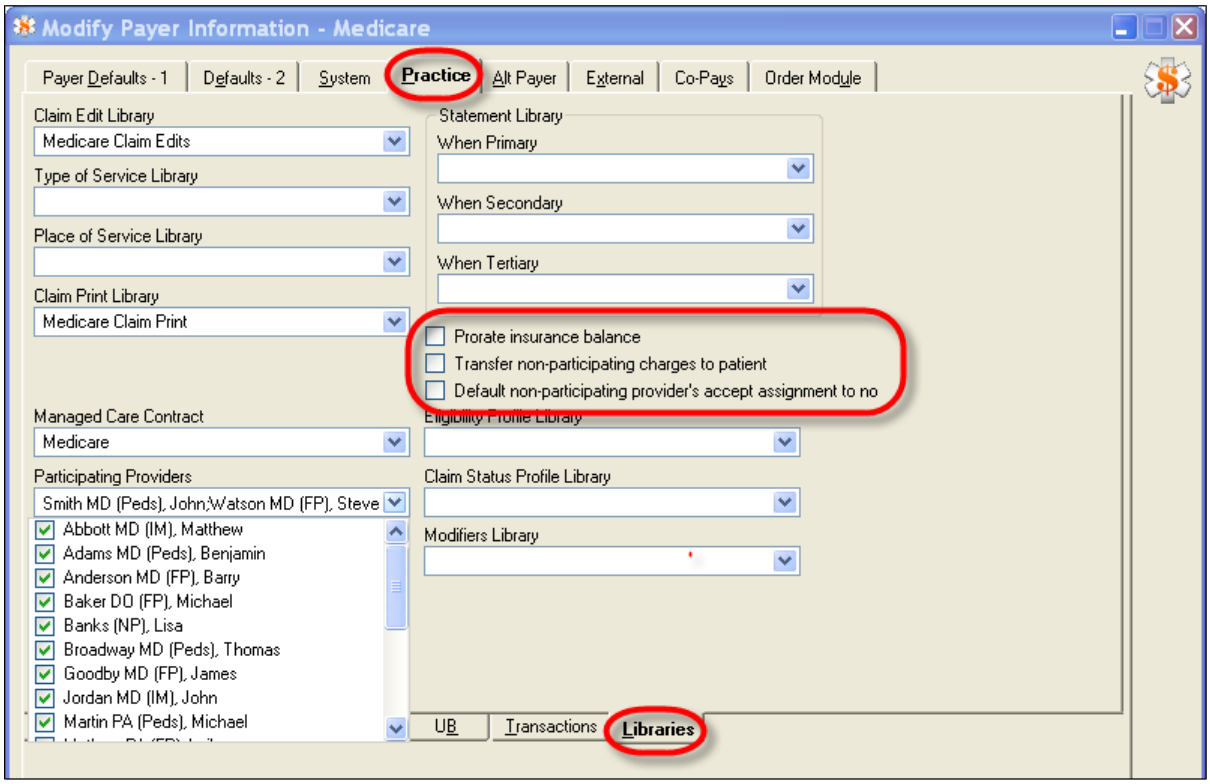
Link to Contract to Payer(s) and Providers

The contract is attached to the appropriate payer(s) on the Practice tab>Libraries sub-tab and the rendering providers that participate with the payer's contract are selected.



- Managed Care Contract
  - Select the contract for the payer.
- Participating Providers
  - Select the rendering providers that participate with the payer's contract. Providers that are not selected are considered non-participating providers.

The following fields display only if a Managed Care Contract has been selected for the payer.



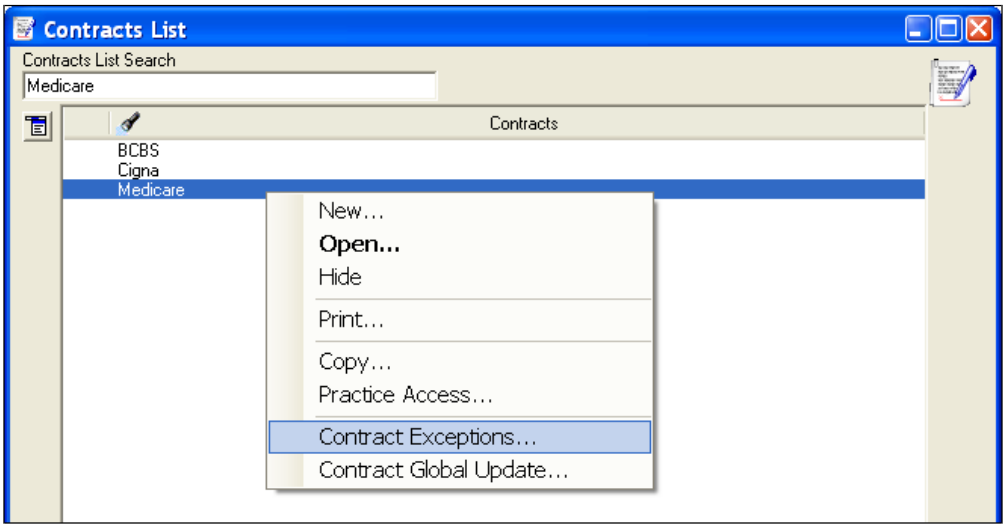
- Prorate Insurance Balance
  - Select this check-box if charge balances on an encounter are to be prorated in the Balance Control window between primary and secondary insurances (or between the primary insurance and the patient if no secondary insurance exists). The prorated amount is based on the fee for service percentage defined in the contract's fee schedule.
  - Note: *The "Prorate insurance balance" option must also be selected on the Contract>General tab and on the Payer>Practice tab>Libraries sub-tab.*
- Default Non-Participating Provider's Accept Assignment to No
  - Select this check-box to set the "Assignment of Benefits" to No for the encounter when a non-participating provider is selected as rendering. Assignment of Benefits is found on the Chart>Encounters tab>Insurance sub-tab>Verification section.

Contract Exceptions

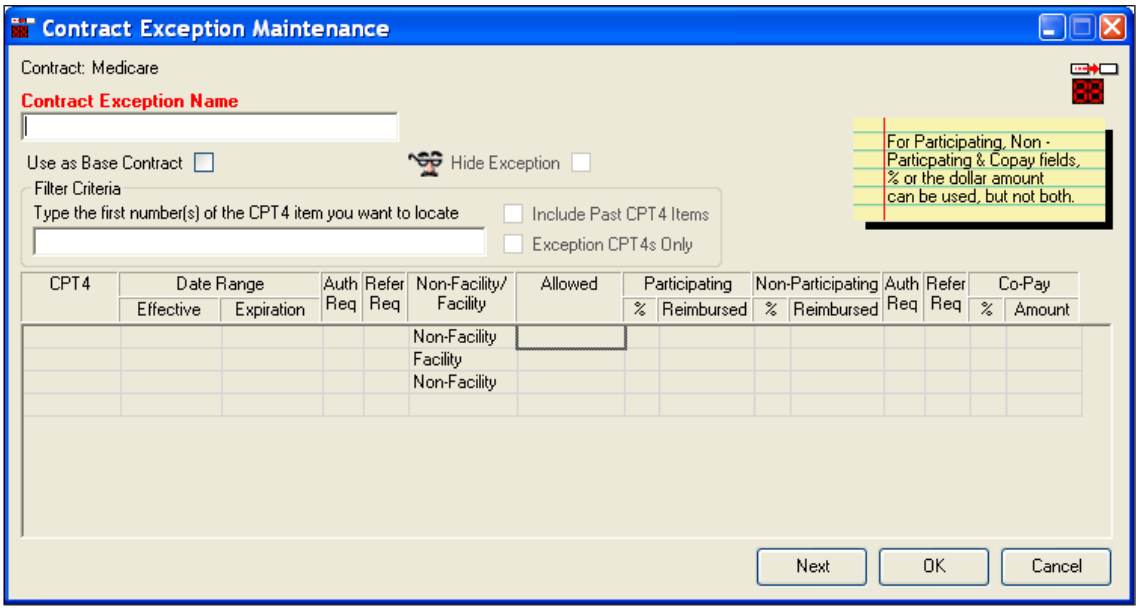
Contract Exceptions allow differences from the standard contract for allowed amounts, reimbursed amounts, etc. to be defined. The differences can be based on any of the following:

	Example
Provider	Dr. Jones
Provider/Location	Dr. Jones at Westminster Office
Provider/Location/Payer	

- Create a Contract Exception
  - Right-click on the contract and select Contract Exceptions from the menu.

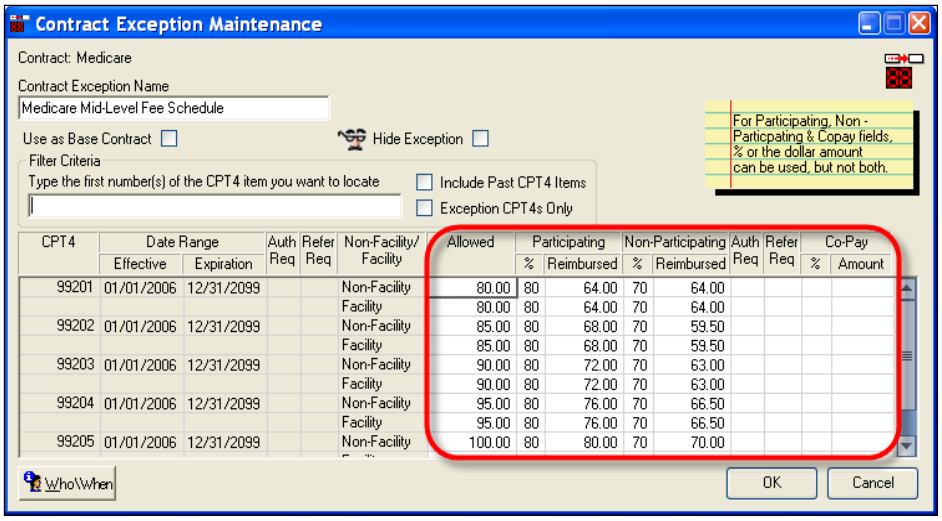


  - The Contract Exception Maintenance window displays.



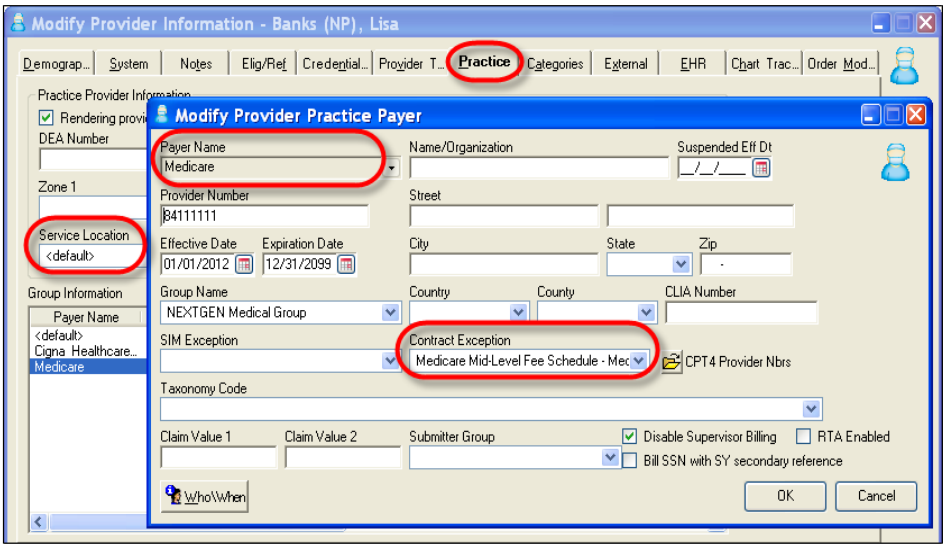
  - Contract Exception Name
    - Enter a name for the exception being defined.
  - Type the First Number(s) of the CPT4 Item you want to Locate
    - Enter the first few digits of the CPT4(s) that you need to have exception parameters defined.
  - CPT4 / Effective / Expiration / Auth Req / Refer Req
    - These parameters default from the original contract setup and cannot be modified.
  - Non-Facility / Facility

- Define the following exception parameters for each CPT4 code as needed:
  - Allowed
  - Participating % and Reimbursed
  - Non-Participating % and Reimbursed
  - Authorization Required
  - Referring Provider Required
  - Co-Pay % and Amount
- Example: Medicare Contract Exception for Mid-Level Providers



Link to Contract Exception to Provider(s)

Once a Contract Exceptions has been created, it is linked to the appropriate rendering providers in the Providers table > Practice tab > Group Information section. In the below example, the Mid-Level Contract Exception is being linked to Lisa Banks, NP at all locations for Medicare.

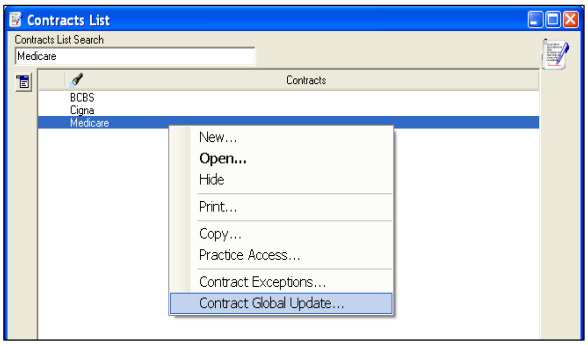


Contract Global Update

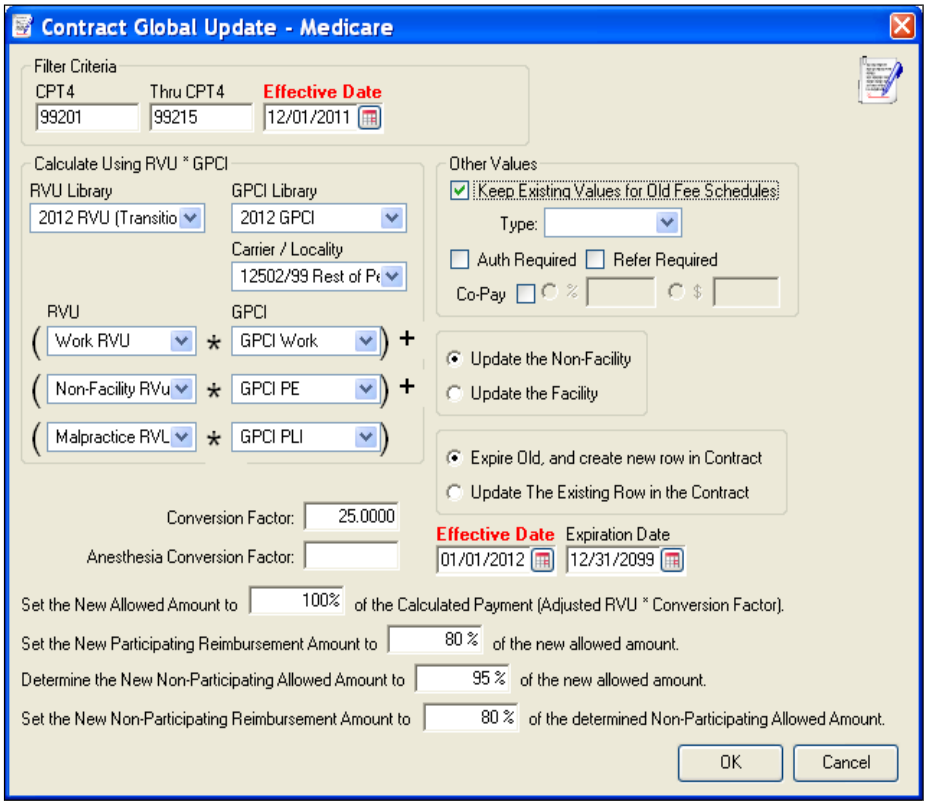
The Contract Global Update is a utility that can be used to update the Non-Facility / Facility allowed amounts and reimbursement amounts within an existing contract. The utility uses the RVU Library and GPCI Codes Library (optional) in the calculation of the new allowed/reimbursement amounts.

The utility can be access by right-clicking on the contract and selecting Contract Global Update from the menu.

- Access Contract Global Update
  - Right-click on the contract and select Contract Global Update from the menu.



  - The Contract Global Update window displays.



- Filter Criteria
  - CPT4
    - Starting CPT4 code in the contract to be updated with new fees.
  - Thru CPT4
    - Ending CPT4 code in the contract to be updated with new fees.
  - Effective Date
    - Enter an Effective Date for the selected CPT4 codes.
    - Note: Only CPT4 codes in effect on the date specified will be updated.
- Calculate Using RVU*GPCI
  - RVU Library
    - Select the RVU Library to be used in the fee update calculate.
  - GPCI Library
    - Select the GPCI Library to be used in the fee update calculation, if applicable.
  - Carrier/Locality
    - Select the Carrier/Locality from the GPCI Library to be used in the fee update calculation, if applicable.
  - RVU/GPCI Calculation
    - Create the fee update calculation to be used.
  - Conversion Factor
    - The conversion factor entered here will be multiplied by the total from the calculation defined above.
  - Anesthesia Conversion Factor
    - The anesthesia conversion factor entered here, if applicable, will be multiplied by the total from the calculation defined above.
  - Set the New Allowed Amount to (n) 5 of the Calculated Payment
    - The percentage entered here will be multiplied by the total form the calculation defined above. This will become the *new allowed amount* in the contract for the selected CPT4 codes.
  - Set the New Participating Reimbursement to (n) % of the New Allowed Amount
    - The percentage entered here will be multiple by the *new allowed amount*. This will become the expected reimbursement amount in the contract for participating providers for the selected CPT4 codes.
  - Determine the New Non-Participating Allowed Amount to (n) % of the New Allowed Amount
    - The percentage entered here will be multiple by the *new allowed amount*. This will become the allowed amount for non-participating providers for the selected CPT4 codes.
  - Set the New Non-Participating Reimbursement Amount to (n) % of the Determined Non-Participating Allowed Amounts
    - The percentage entered here will be multiple by the *non-participating allowed amount.* This will become the expected reimbursement amount in the contract for non-participating providers for the selected CPT4 codes.
- Other Values
  - Keep Existing Values for Old Fee Schedule
    - Select this check-box to retain the current settings on the Fee Schedule tab in the contract for the selected CPT4 codes. The settings include:
      - Auth Req — Authorization Required
      - Refer Req — Referring Provider Required
      - √ — Co-Pay Indicator

        - Co-Pay % Co-Pay Percentage
        - Co-Pay Amount Co-Pay Dollar Amount
    - Do not select this check-box if it desired to change the current setting on the Fee Schedule tab in the contract for the selected codes. The settings that can be changed include:
        - Type
            - Select FFS (Fee for Service) or Capitated.
        - Auth Required
            - Select this check-box to activate Auth Req for the selected codes.
        - Referral Required
            - Select this check-box to activate Refer Req for the selected codes.
        - CoPay
            - Select this check-box to activate the Co-Pay Indicator (√) for the selected codes.

              %: If the co-pay for the selected codes should be a percentage of the allowed amount, enter the percentage here.

              $: If the co-pay for the selected codes should be a specific dollar amount, enter the amount here.
- Update the Non Facility
    - Select this option to update the Non-Facility fee row in the contract for the selected codes.
- Update the Facility
    - Select this option to update the Facility fee row in the contract for the codes selected.
- Expire Old, and Create New Row in Contract
    - Select this option to expire the existing fee row and create a new fee row for the selected codes.
- Update the Existing Row in the Contract
    - Select this option to update the existing fee row for the selected codes.
- Effective Date
    - Enter the Effective Date for the fee row.
- Expiration Date
    - Enter the Expiration Date for the fee row.

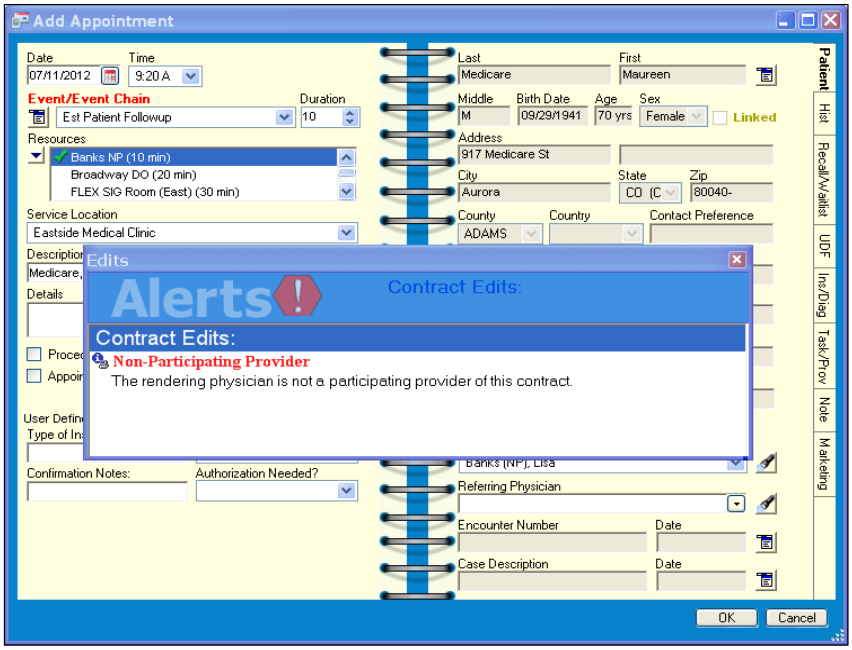
Contract Functionality in EPM

The examples on the following pages are intended to illustrate some of the options available in the setup of a Contract and how those options work from an end user's perspective in EPM.

Example 1: Non-Participating Provider Alert

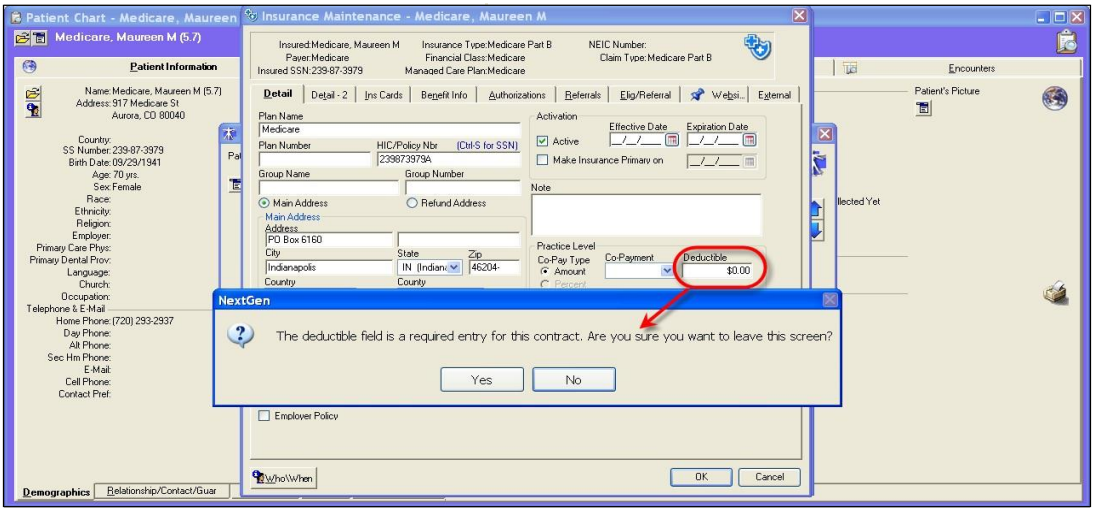
- Lisa Banks, NP is not selected as a participating provider for the Medicare contract in the Payers table > Practice tab > Libraries sub-tab.

- An appointment is created for a Medicare patient with Lisa Banks, NP.
- A contract edits alert displays on the Add Appointment window.
- Note: The contract edit alert also displays when selecting Medicare as the primary insurance on the encounter during check-in and when posting charges.



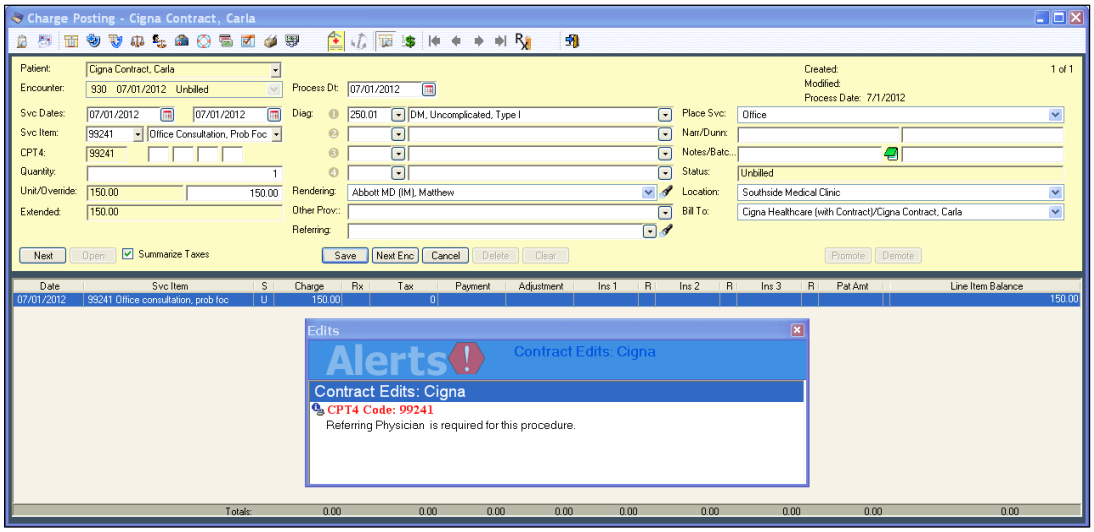
Example 2: Deductible in Effect Prompt

- The Deductible in Effect option is selected in the Medicare contract > General tab.
- Medicare insurance is entered for a patient and the Deductible field is left blank ($0.00) on the Insurance Maintenance window.
- A contract prompt displays when user clicks OK to save the insurance information.



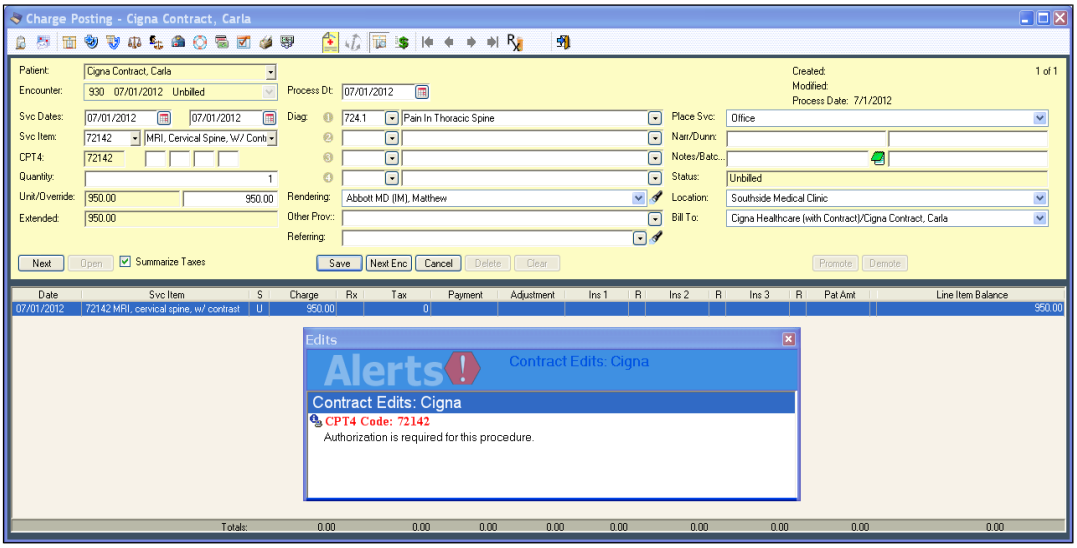
Example 3: Referring Physician Required Alert

- The Ref Req option is selected in the Cigna contract > Fee Schedule tab for CPT4 code 99241 (Office Consult).
- An encounter is created with Cigna as primary insurance.
- The Referring provider field was left blank on the Encounter Maintenance window.
- A contract edits alert displays on the Charge Posting window for 99241.
- Note: The contract edit alert will not display if a referring provider is entered on the encounter prior to posting charges.



Example 4: Authorization Required Alert

- The Auth Req option is selected in the Cigna contract > Fee Schedule tab for CPT4 code 72142 (MRI Cervical Spine).
- A valid authorization is not entered for Cigna prior to the encounter being created.
- An encounter is created with Cigna as primary insurance.
- A contract edits alert displays on the Charge Posting window for 72142.
- Note: The contract edit alert will not display if a valid authorization is entered prior to posting charges.

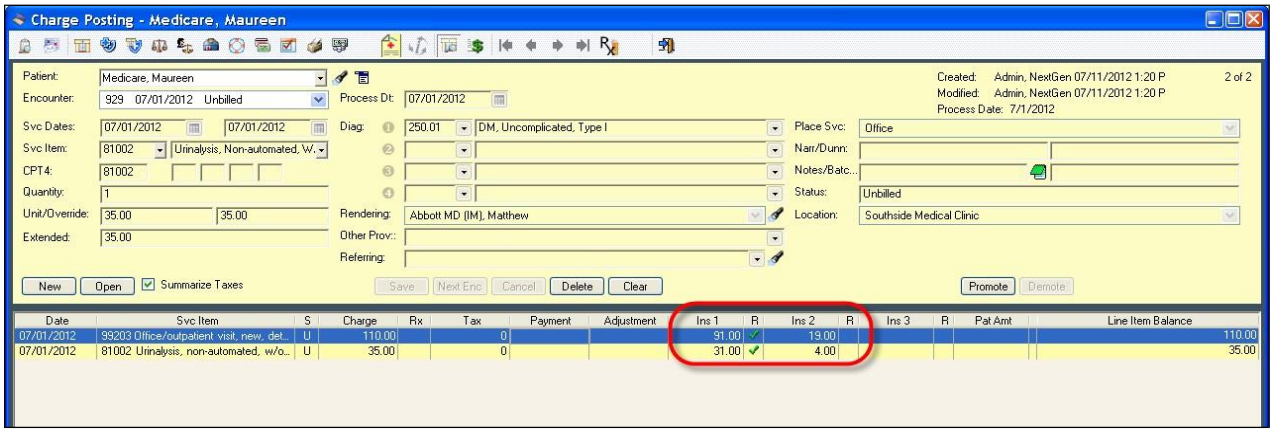


Example 5: Prorate Insurance Balance (80% / 20%)

- The Prorate Insurance Balance option is selected in the Medicare contract > General tab.
- The Prorate Insurance Balance option is selected in the Medicare payer > Practice tab > Libraries sub-tab.
- The contract's allowed amounts are defined as follows:

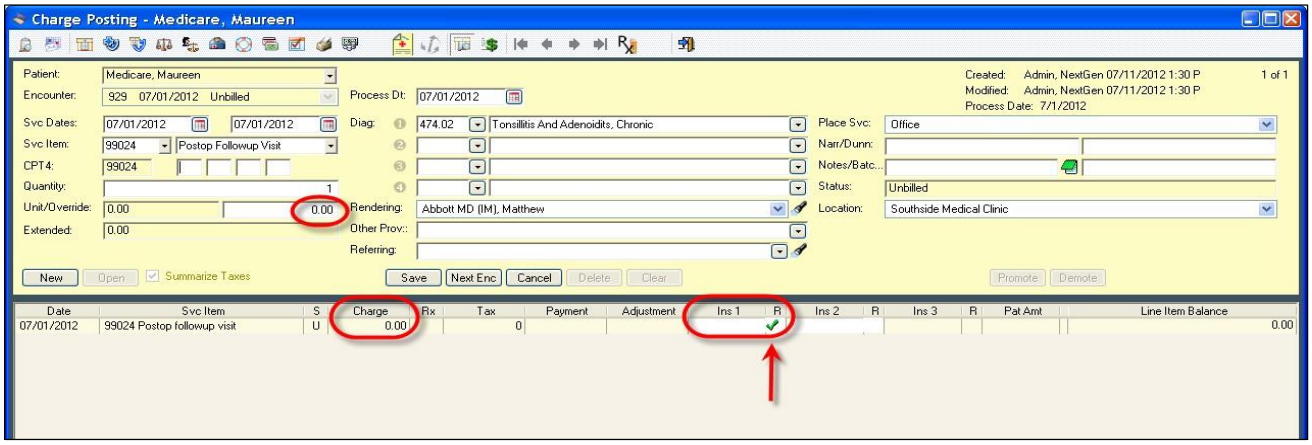
  99203 = $95.00 with 80% expected reimbursement
  81002 = $20.00 with 80% expected reimbursement

- An encounter is created with Medicare as primary and AARP as secondary.
- 20% of Medicare's allowed amounts are prorated to Ins2 on the Charge Posting window.
- Note: If there is no secondary insurance on the encounter, 20% of allowed amounts are prorated to Pat Amt.



Example 6: Create Zero Dollar Claim

- The Create Zero Dollar Claim option is selected in the Medicare contract > General tab.
- An encounter is created with Medicare as primary insurance.
- A 99024 (Post Op Followup) charge is entered for $0.00.
- The charge is flagged to be released (R) and sent on a claim for to Ins1 (Medicare).

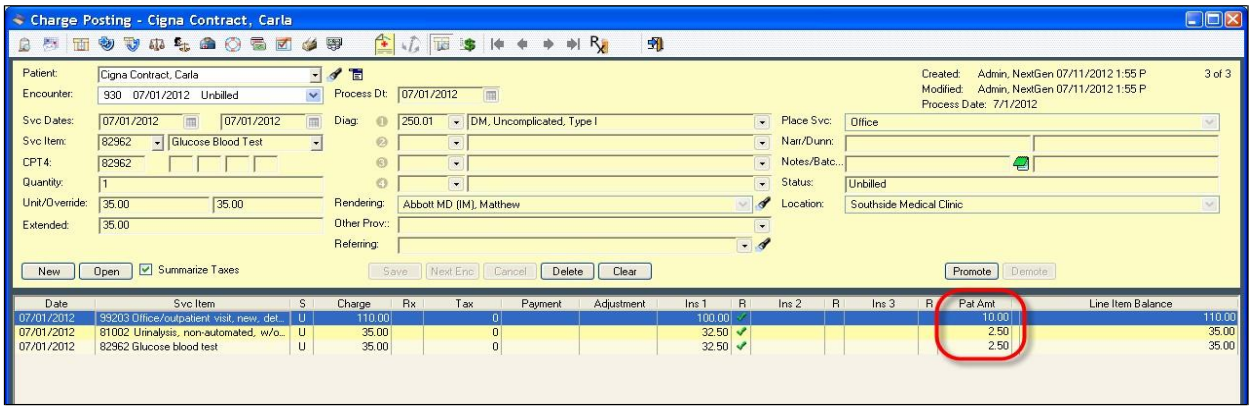


Example 7: Apply Co-Pay to All Line Items (90% / 10%)

- The Apply Co-Pay to All Line Items option is selected in the Cigna contract > General tab.
- The contract's allowed amounts are defined as follows:

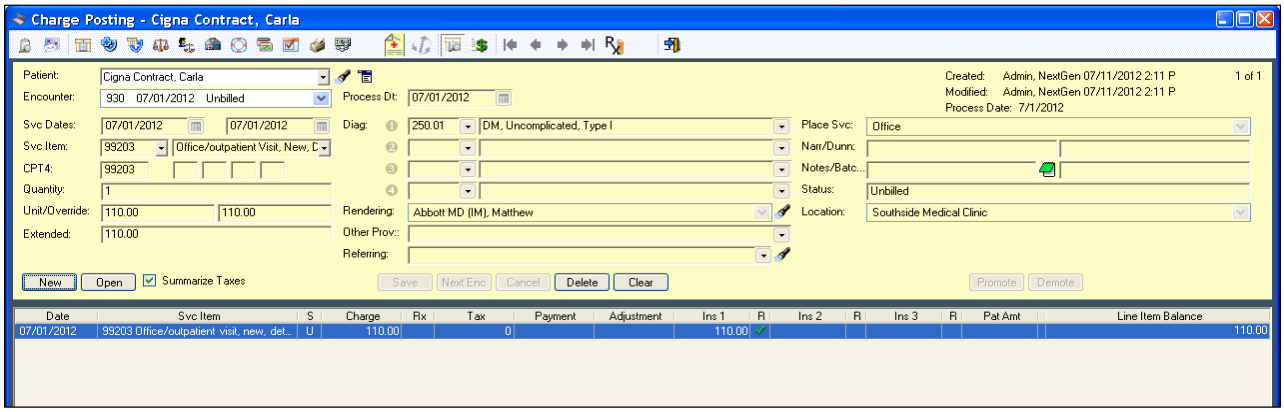
  99203 = $100.00 with 10% co-pay
  81002 = $25.00 with 10% co-pay
  82962 = $25.00 with 10% co-pay

- An encounter is created with Cigna as primary insurance.
- The 10% of Cigna's allowed amount is automatically moved to the patient (Pat Amt) as the co-pay for each charge on the Charge Posting window.



Example 8: Automatically Adjust Charges = Turned Off

- The Automatically Adjust Charges option is not selected in the Cigna contract > General tab.
- The SIM Library price for a 99203 is $110.00.
- The contract's allowed amount for 99203 is $100.00.
- An encounter is created with Cigna as primary insurance.
- A 99203 charge is entered on the encounter in the Charge Posting window.
- The encounter is billed.

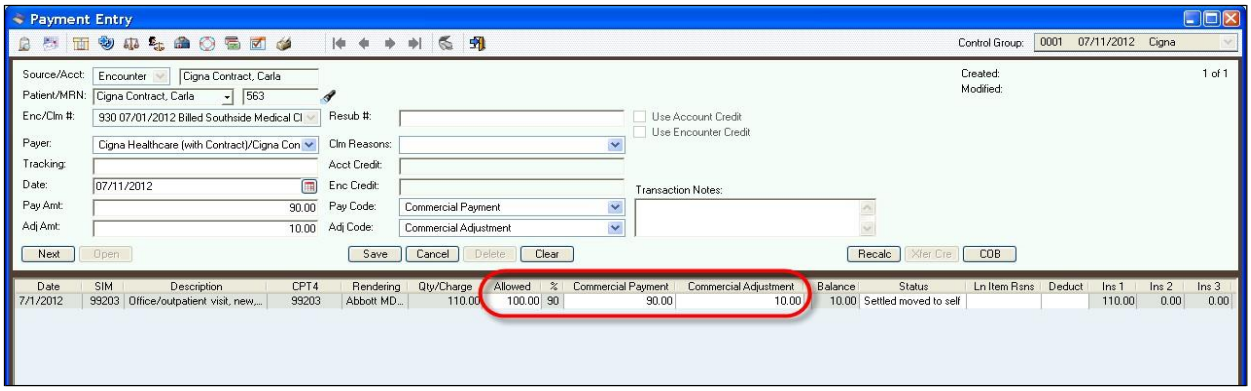


- The contract's allowed amount of $100.00 defaults into the Payment Entry window.
- The contract's reimbursed amount of $90.00 defaults into the Payment Entry window.

[Allowed X 90% = Payment] [$100.00 X 90% = $90.00]

- The contract's adjusted amount of $10.00 defaults into the Payment Entry window.

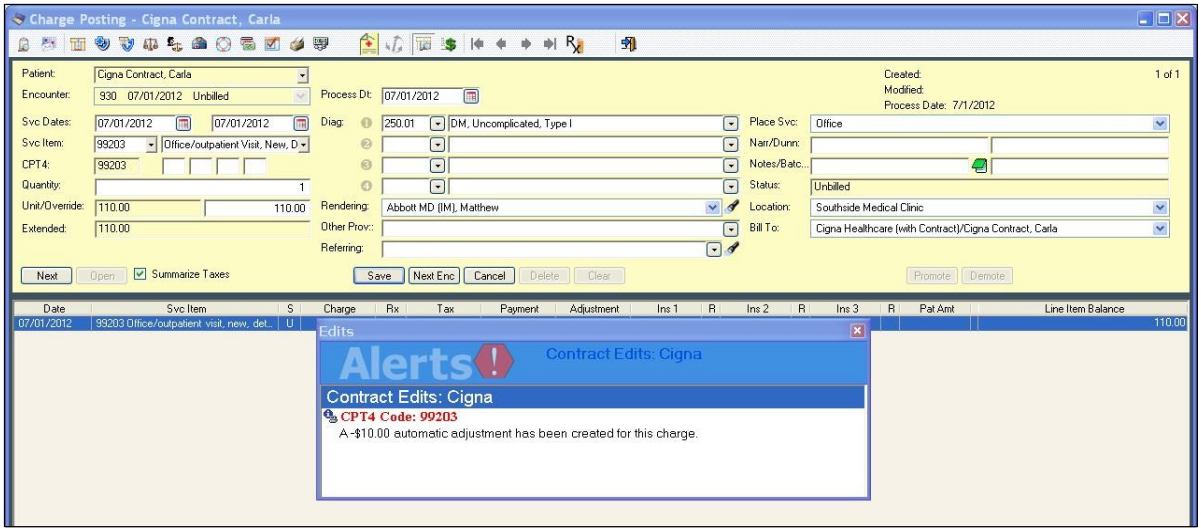
[Charge – Allowed = Adjustment] [$110.00 - $100.00 = $10.00]



Example 9: Automatically Adjust Charges = Turned On

- The Automatically Adjust Charges option is selected in the Cigna Contract > General tab.
- The SIM Library price for a 99203 is $110.00.
- The contract's allowed amount for 99203 is $100.00.
- An encounter is created with Cigna as primary insurance.
- A 99203 charge is entered on the encounter in the Charge Posting window.
- A contract edits alert displays on the Charge Posting window for the 99203 indicating a $10.00 adjustment has been created.

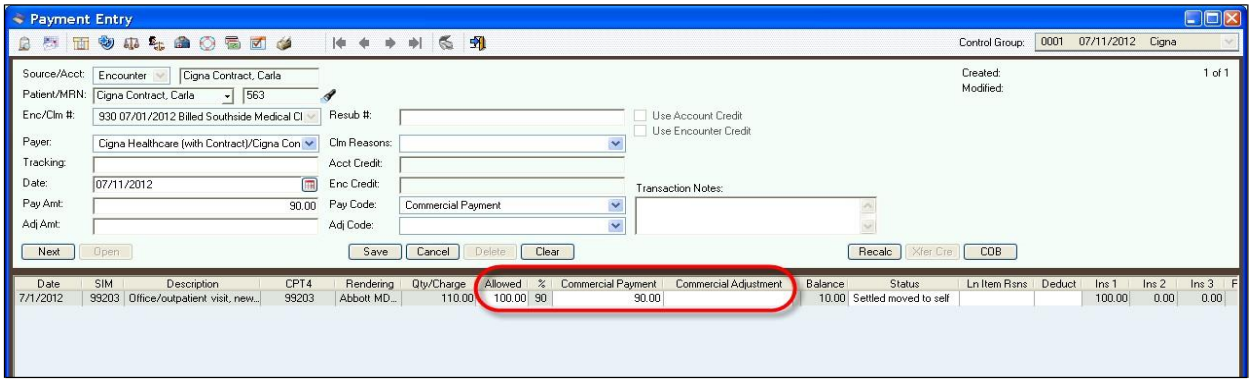
[Charge – Allowed = Adjustment] [$110.00 - $100.00 = $10.00]



- The contract's allowed amount of $100.00 defaults into the Payment Entry window.
- The contract's reimbursed amount of $90.00 defaults into the Payment Entry window.

[Allowed X 90% = Payment] [$100.00 X 90% = $90.00]

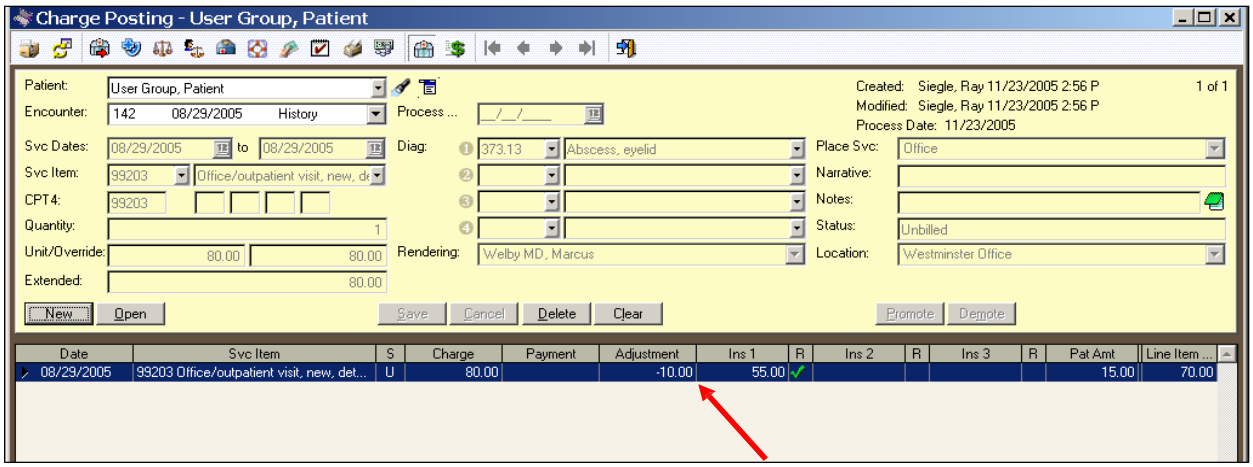
- The contract's adjustment amount of $10.00 does not default into the Payment Entry window because it occurred at het time of Charge Posting.



Example 10: Adjustable Allowed Amount

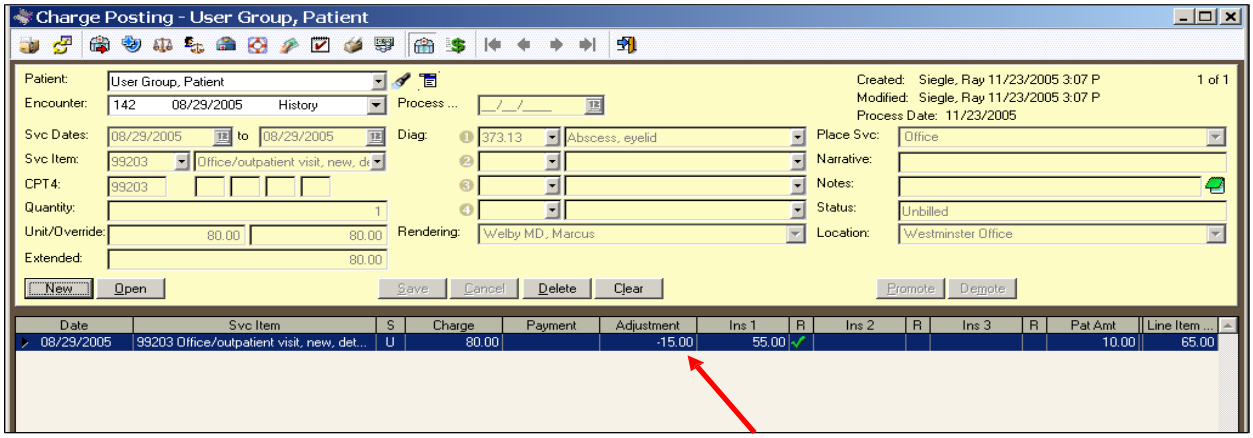
- The Automatically Adjust Charges and Adjustable Allowed Amount options are selected in the Aetna contract > General tab.
- The Sim Library price for a 99203 is $80.00.
- The contract's reimbursed amount of 99203 is $55.00.
- An encounter is created with Aetna as primary insurance for a patient with a co-pay of $15.00.
- A 99203 charge is entered on the encounter in the Charge Posting window.
- The contract edits alert displays on the Charge Posting window for the 99203 indicating a $10.00 adjustment has been created.

[Charge – (Reimbursed + Co-Pay) = Adjustment] [$80.00 – ($55.00 + $15.00) = $10.00]



- An encounter is created with Aetna as primary insurance for another patient with a co-pay of $10.00.
- A 99203 charge is entered on the encounter in the Charge Posting window.
- A contract edits alert displays on the Charge Posting window for the 99203 indicating a $15.00 adjustment has been created.

[Charge – (Reimbursed + Co-Pay) = Adjustment] [$80.00 – ($55.00 + $10.00) = $15.00]



Example 11: Allow Positive Adjustments

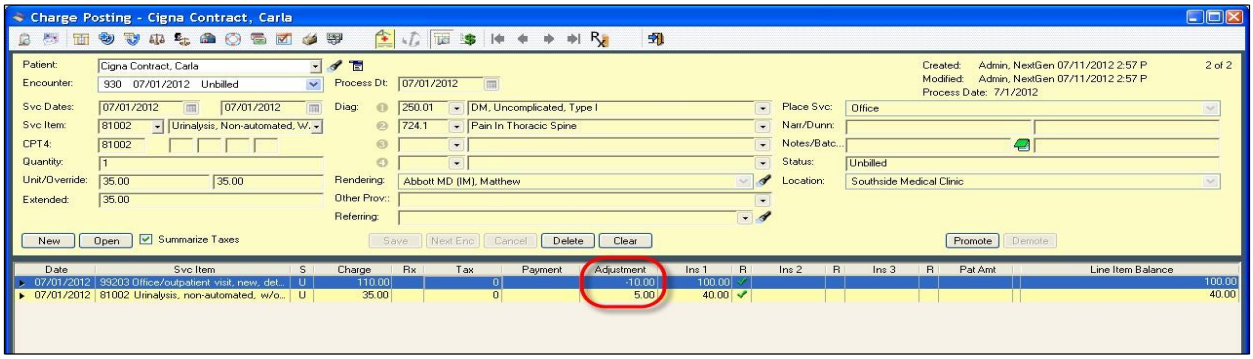
- The Automatically Adjust Charges and Allow Positive Adjustments options are selected in the Cigna contract > General tab.
- SIM Library prices are defined as follows:

  99203 = $110.00
  81002 = $35.00

- Contract allowed amounts are defined as follows:

  99203 = $100.00
  81002 = $40.00 Note: The allowed amount is greater than the charge amount

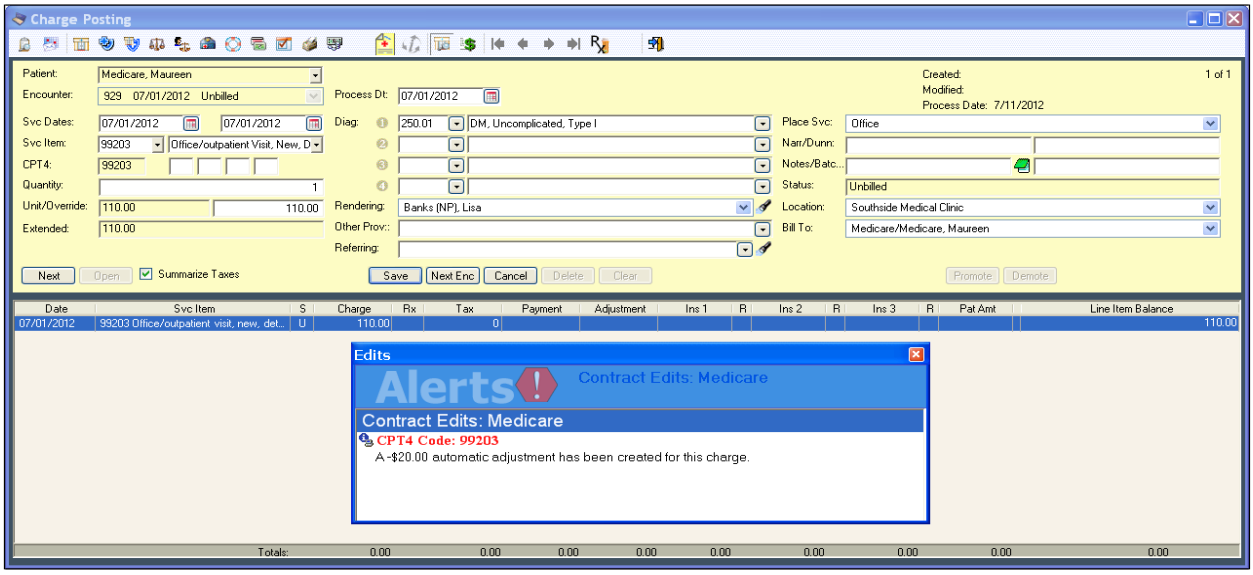
- An encounter is created with Cigna as primary insurance.
- Both the 99203 and 81002 charges are entered on the encounter in the Charge Posting window.
- A contract edits alerts display on the Charge Posting window indicating a $-10.00 adjustment (negative) has been created for the 99203 and a $5.00 adjustment (positive) has been created for the 81002.



Example 12: Contract Exception for Mid-Level Providers

- The Automatically Adjust Charges options is selected in the Medicare contract > General tab.
- The SIM Library price for a 99203 is $110.00.
- The Medicare contract's allowed amount for 99203 is $95.00.
- The Medicare contract exceptions allowed amount for 99203 is $90.00 for Mid-Level Providers.
- AN encounter is created with Lisa Banks, NP as rendering and Medicare as primary insurance.
- A 99203 charge is entered on the encounter in the Charge Posting window.
- A contract edits alert displays on the Charge Posting window for 99203 indicating a $20.00 adjustment has been created.

  [Charge – Allowed = Adjustment] [$1100.00 - $90.00 = $20.00]



Example 13: Allowed Amounts Reduced based on Modifiers and Multiple Procedures

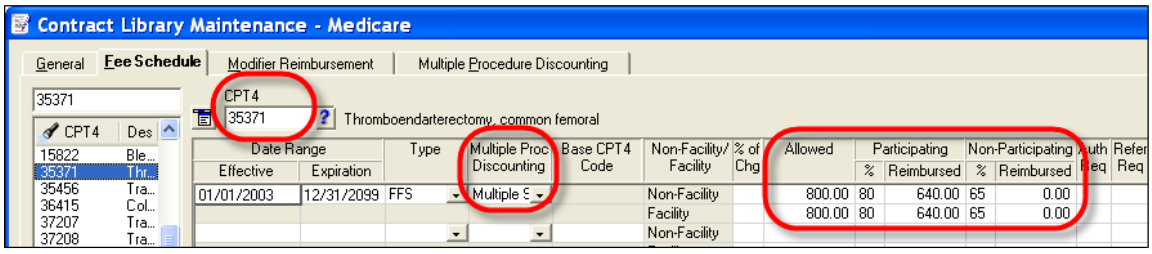
This example illustrates how the allowed amounts for surgical procedures can be reduced based on modifiers entered on the charges and the charge order/sequence when multiple procedures are performed.

- SIM Library prices are defined as follows:

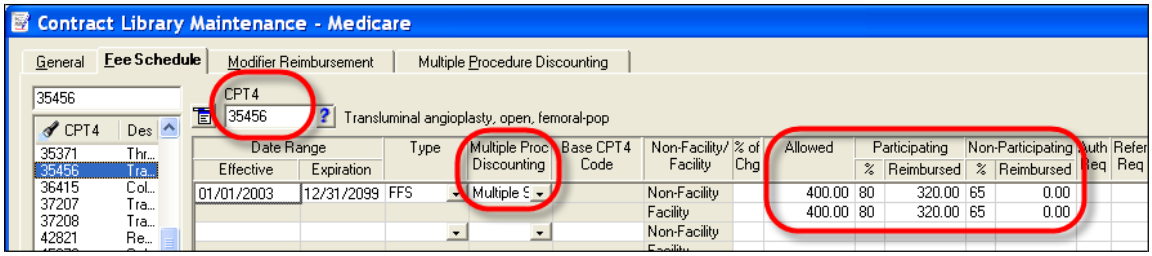
SIM/CPT4 Code	Price
35371	$1600
35456	$800
37207	$900
37208	$400

- The Medicare contract > Fee Schedule tab is setup for each of the above CPT4 codes as follows:

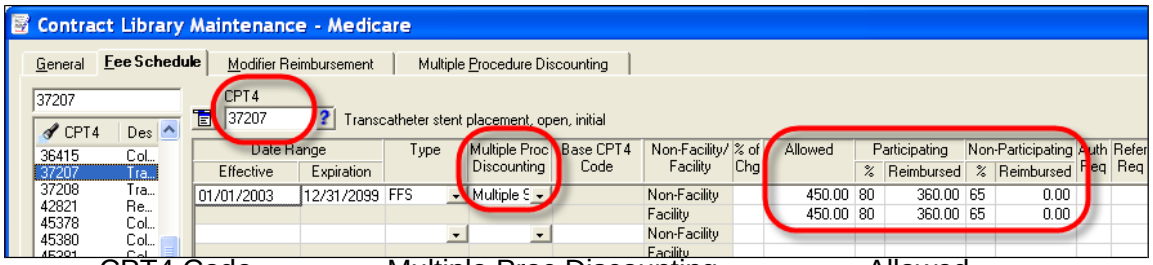
CPT4 Code	Multiple Proc Discounting	Allowed
35371	Multiple Surg (Yes)	$800



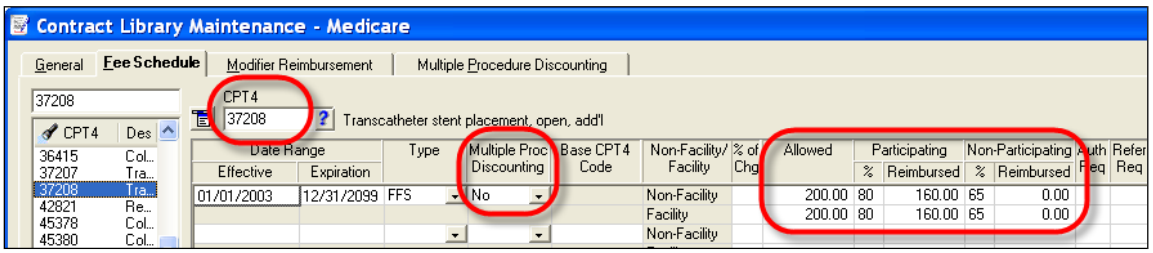
CPT4 Code	Multiple Proc Discounting	Allowed
35456	Multiple Surg (Yes)	$400



CPT4 Code	Multiple Proc Discounting	Allowed
37207	Multiple Surg (Yes)	$450



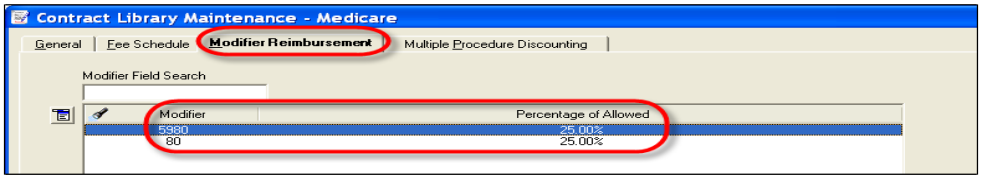
CPT4 Code	Multiple Proc Discounting	Allowed
37208	No	$200



- The Medicare contract > Modifier Reimbursement Tab is setup as follows:

  Modifier 59 (Distinct Procedure/Service) and/or Modifier 80 (Assist Surgeon) are defined to reduce the Allowed Amount to $25% of the amount defined in the contract's Fee Schedule tab.

Modifier	% of Allowed
5980	25%
80	25%

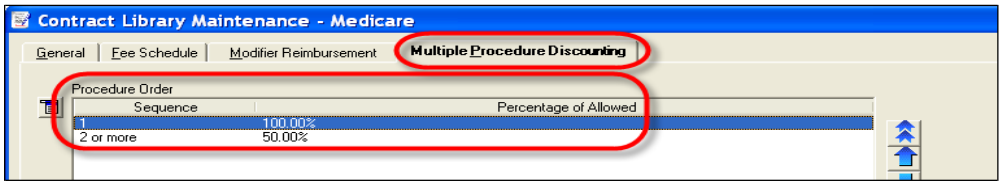


-

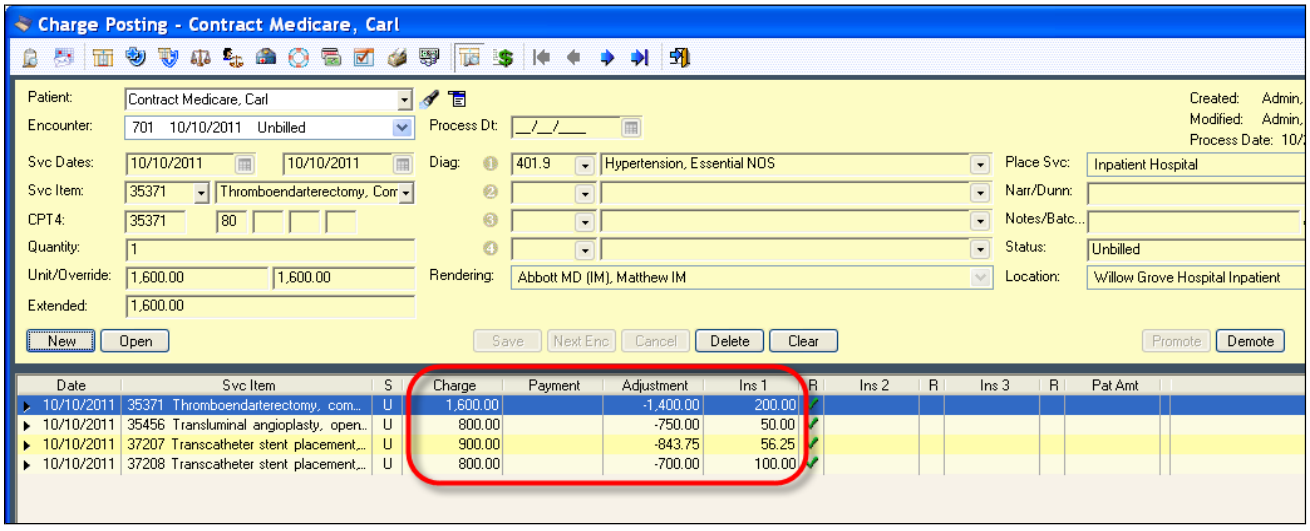
- The Medicare contract > Multiple Procedure Discounting tab is setup as follows:

  Multiple Procedure Discounting is defined to not reduce the Allowed Amount on the first procedure (100%) but reduce the allowed amounts on the second, third, etc. procedures (50%).

Sequence	% of Allowed
1	100%
2 or more	$50%



- Charge Posting and Contract Auto-Adjustments
  - Based on the above setup in the Medicare contract's Fee Schedule tab, Modifier Reimbursement tab, and Multiple Procedure Discounting tab, the Charge Posting screen below shows the allowed amount that was calculated for each charge and the resulting adjustment amount.



- Calculation of Allowed Amount

[Final Calculated Allowed = Contract Allowed – Contract Modifier Reduction – Contract Multiple Procedure Reduction]

- Calculation of Adjustment Amount

[Adjustment Amount = Charge – Final Calculated Allowed]

Charge Posting				Contract Library Calculated Allowed Amounts						
CPT4	Mod	Qty	Charge	Contract Allowed	Modifier Reduces Allowed to 25%	Multiple Procedure Discounting?	Multiple Procedure Discounting Allowed	Qty	Final Calculated Allowed	Adjustment
35371	80	1	$1600	$800	$200	Yes 100%	$200	1	$200	-$1400
35456	5980	1	$800	$400	$100	Yes 50%	$50	1	$50	-$750
37207	5980	1	$900	$450	$112.50	Yes 50%	$56.25	1	$56.25	-$843.75
37208	80	2	$800	$200	$50	No 100%	$50	2	$100	-$700

Reports

Reports > Accounts Receivable

Contractual Analysis Report

- Explanation of Columns
  - Cont Allwd Amount
    - Allowed amount defined in the contract for the CPT4 code.
  - Act Allwd Amt
    - Actual allowed amount from payer (EOB) entered during payment entry.
  - Diff Allwd Amt
    - Difference between the allowed amount defined in the contract for the CPT4 code and the actual allowed amount entered during payment entry.

    If $0.00: Contract allowed amount and payer allowed amount are the same.

    If > $0.00 or < $0.00: There is a discrepancy between contract and payer allowed amounts.

  - Cont Pay Amt
    - Payment amount defined in the EPM contract for the CPT4 code.
  - Act TP Pay Amt
    - Actual payment amount from payer (EOB) entered during payment entry.
  - Diff Pay Amt
    - Difference between the payment amount defined in the contract for the CPT4 code and the actual payment amount entered during payment entry.

    If $0.00: Contract reimbursed amount and payer reimbursed amount are the same.

    If > $0.00 or < $0.00: There is a discrepancy between contract and payer reimbursed amounts.

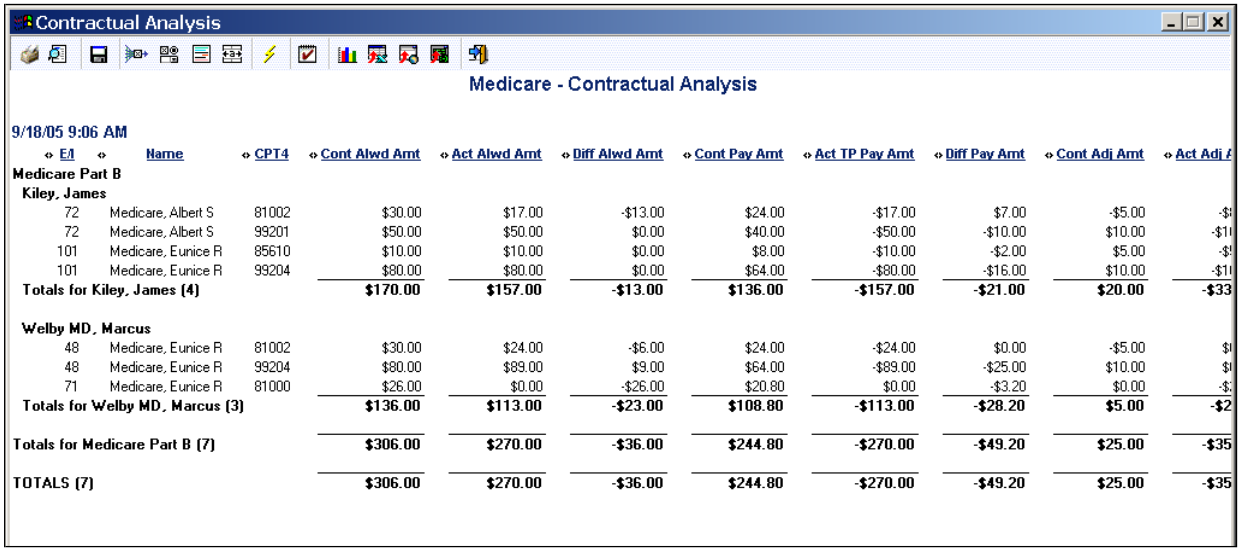
- Cont Adj Amt
  - Adjust amount defined in the EPM contract for the CPT4 code.
- Act Adj Amt
  - Actual adjustment amount from payer (EOB) entered during payment entry.
- Diff Adj Amt
  - Difference between the adjustment amount defined in the EPM contract for the CPT4 code and the actual adjustment amount entered during payment entry.

If $0.00: Contract adjustment amount and payer adjustment amount are the same.

If > $0.00 or < $0.00: There is a discrepancy between contract and payer adjustment amounts.

Contractual Analysis Report for Medicare Contract

Sorted by Rendering Provider



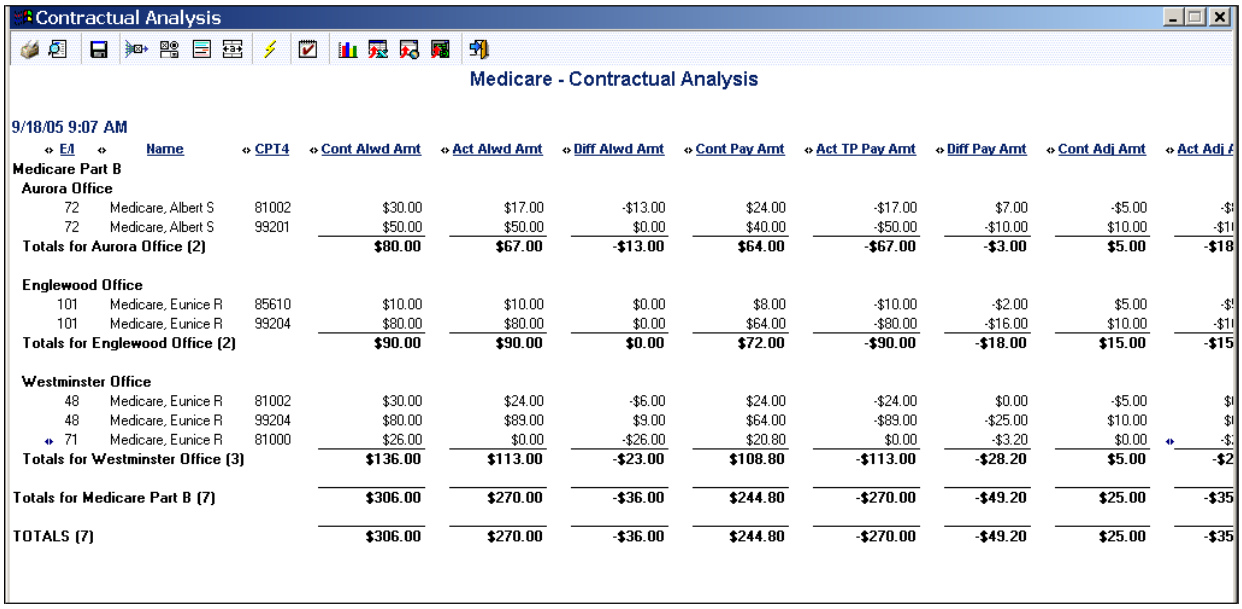
Contractual Analysis

Medicare - Contractual Analysis

9/18/05 9:06 AM

E/I	Name	CPT4	Cont Alwd Amt	Act Alwd Amt	Diff Alwd Amt	Cont Pay Amt	Act TP Pay Amt	Diff Pay Amt	Cont Adj Amt	Act Adj A
Medicare Part B										
Kiley, James										
72	Medicare, Albert S	81002	$30.00	$17.00	-$13.00	$24.00	-$17.00	$7.00	-$5.00	-$
72	Medicare, Albert S	99201	$50.00	$50.00	$0.00	$40.00	-$50.00	-$10.00	$10.00	-$1
101	Medicare, Eunice R	85610	$10.00	$10.00	$0.00	$8.00	-$10.00	-$2.00	$5.00	-$
101	Medicare, Eunice R	99204	$80.00	$80.00	$0.00	$64.00	-$80.00	-$16.00	$10.00	-$1
Totals for Kiley, James (4)			**$170.00**	**$157.00**	**-$13.00**	**$136.00**	**-$157.00**	**-$21.00**	**$20.00**	**-$33**
Welby MD, Marcus										
48	Medicare, Eunice R	81002	$30.00	$24.00	-$6.00	$24.00	-$24.00	$0.00	-$5.00	$
48	Medicare, Eunice R	99204	$80.00	$89.00	$9.00	$64.00	-$89.00	-$25.00	$10.00	$
71	Medicare, Eunice R	81000	$26.00	$0.00	-$26.00	$20.80	$0.00	-$3.20	$0.00	-$
Totals for Welby MD, Marcus (3)			**$136.00**	**$113.00**	**-$23.00**	**$108.80**	**-$113.00**	**-$28.20**	**$5.00**	**-$2**
Totals for Medicare Part B (7)			**$306.00**	**$270.00**	**-$36.00**	**$244.80**	**-$270.00**	**-$49.20**	**$25.00**	**-$35**
TOTALS (7)			**$306.00**	**$270.00**	**-$36.00**	**$244.80**	**-$270.00**	**-$49.20**	**$25.00**	**-$35**

Sorted by Service Location



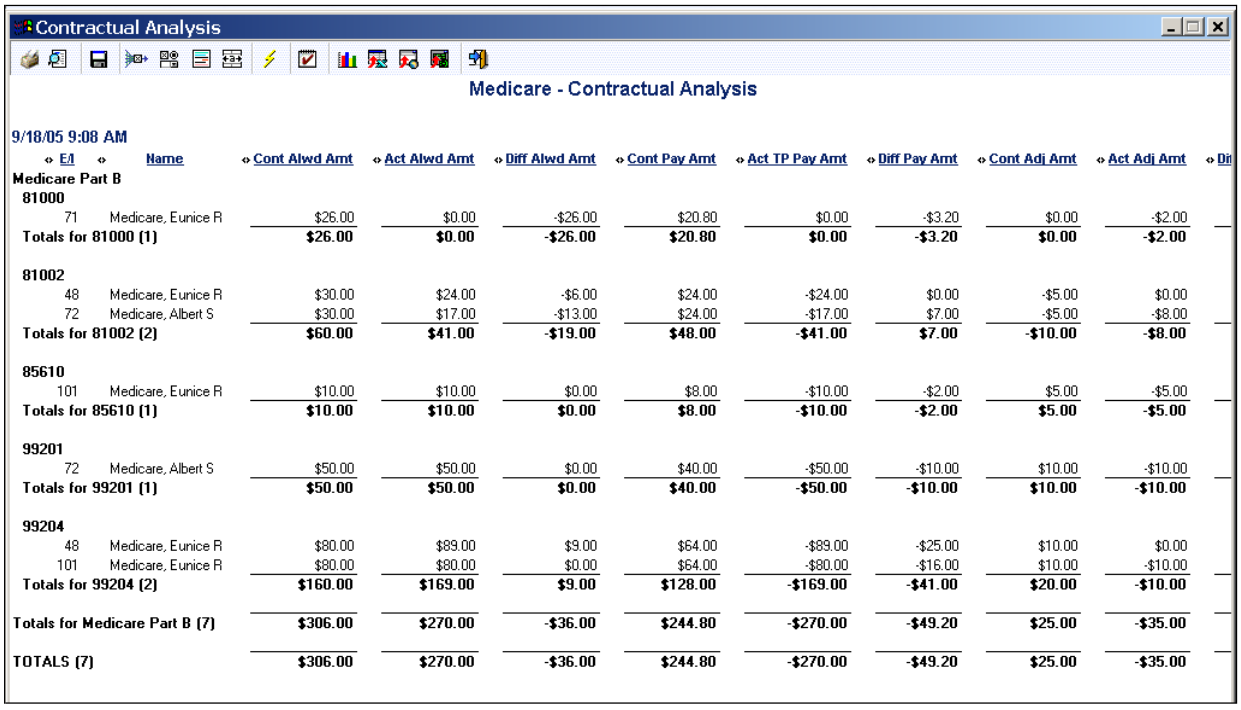
Contractual Analysis

Medicare - Contractual Analysis

9/18/05 9:07 AM

E/I	Name	CPT4	Cont Alwd Amt	Act Alwd Amt	Diff Alwd Amt	Cont Pay Amt	Act TP Pay Amt	Diff Pay Amt	Cont Adj Amt	Act Adj A
Medicare Part B										
Aurora Office										
72	Medicare, Albert S	81002	$30.00	$17.00	-$13.00	$24.00	-$17.00	$7.00	-$5.00	-$
72	Medicare, Albert S	99201	$50.00	$50.00	$0.00	$40.00	-$50.00	-$10.00	$10.00	-$1
Totals for Aurora Office (2)			**$80.00**	**$67.00**	**-$13.00**	**$64.00**	**-$67.00**	**-$3.00**	**$5.00**	**-$18**
Englewood Office										
101	Medicare, Eunice R	85610	$10.00	$10.00	$0.00	$8.00	-$10.00	-$2.00	$5.00	-$
101	Medicare, Eunice R	99204	$80.00	$80.00	$0.00	$64.00	-$80.00	-$16.00	$10.00	-$1
Totals for Englewood Office (2)			**$90.00**	**$90.00**	**$0.00**	**$72.00**	**-$90.00**	**-$18.00**	**$15.00**	**-$15**
Westminster Office										
48	Medicare, Eunice R	81002	$30.00	$24.00	-$6.00	$24.00	-$24.00	$0.00	-$5.00	$
48	Medicare, Eunice R	99204	$80.00	$89.00	$9.00	$64.00	-$89.00	-$25.00	$10.00	$
71	Medicare, Eunice R	81000	$26.00	$0.00	-$26.00	$20.80	$0.00	-$3.20	$0.00	-$
Totals for Westminster Office (3)			**$136.00**	**$113.00**	**-$23.00**	**$108.80**	**-$113.00**	**-$28.20**	**$5.00**	**-$2**
Totals for Medicare Part B (7)			**$306.00**	**$270.00**	**-$36.00**	**$244.80**	**-$270.00**	**-$49.20**	**$25.00**	**-$35**
TOTALS (7)			**$306.00**	**$270.00**	**-$36.00**	**$244.80**	**-$270.00**	**-$49.20**	**$25.00**	**-$35**

Sorted by CPT4 Code



Contractual Analysis

Medicare - Contractual Analysis

9/18/05 9:08 AM

E/I	Name	Cont Alwd Amt	Act Alwd Amt	Diff Alwd Amt	Cont Pay Amt	Act TP Pay Amt	Diff Pay Amt	Cont Adj Amt	Act Adj Amt	Di
Medicare Part B										
81000										
71	Medicare, Eunice R	$26.00	$0.00	-$26.00	$20.80	$0.00	-$3.20	$0.00	-$2.00	
Totals for 81000 (1)		**$26.00**	**$0.00**	**-$26.00**	**$20.80**	**$0.00**	**-$3.20**	**$0.00**	**-$2.00**	
81002										
48	Medicare, Eunice R	$30.00	$24.00	-$6.00	$24.00	-$24.00	$0.00	-$5.00	$0.00	
72	Medicare, Albert S	$30.00	$17.00	-$13.00	$24.00	-$17.00	$7.00	-$5.00	-$8.00	
Totals for 81002 (2)		**$60.00**	**$41.00**	**-$19.00**	**$48.00**	**-$41.00**	**$7.00**	**-$10.00**	**-$8.00**	
85610										
101	Medicare, Eunice R	$10.00	$10.00	$0.00	$8.00	-$10.00	-$2.00	$5.00	-$5.00	
Totals for 85610 (1)		**$10.00**	**$10.00**	**$0.00**	**$8.00**	**-$10.00**	**-$2.00**	**$5.00**	**-$5.00**	
99201										
72	Medicare, Albert S	$50.00	$50.00	$0.00	$40.00	-$50.00	-$10.00	$10.00	-$10.00	
Totals for 99201 (1)		**$50.00**	**$50.00**	**$0.00**	**$40.00**	**-$50.00**	**-$10.00**	**$10.00**	**-$10.00**	
99204										
48	Medicare, Eunice R	$80.00	$89.00	$9.00	$64.00	-$89.00	-$25.00	$10.00	$0.00	
101	Medicare, Eunice R	$80.00	$80.00	$0.00	$64.00	-$80.00	-$16.00	$10.00	-$10.00	
Totals for 99204 (2)		**$160.00**	**$169.00**	**$9.00**	**$128.00**	**-$169.00**	**-$41.00**	**$20.00**	**-$10.00**	
Totals for Medicare Part B (7)		**$306.00**	**$270.00**	**-$36.00**	**$244.80**	**-$270.00**	**-$49.20**	**$25.00**	**-$35.00**	
TOTALS (7)		**$306.00**	**$270.00**	**-$36.00**	**$244.80**	**-$270.00**	**-$49.20**	**$25.00**	**-$35.00**	