KONICA MINOLTA

HEALTHCARE IT

Exa® PACS/RIS

Feature Summary

Billing Setup Menu

500-000665A

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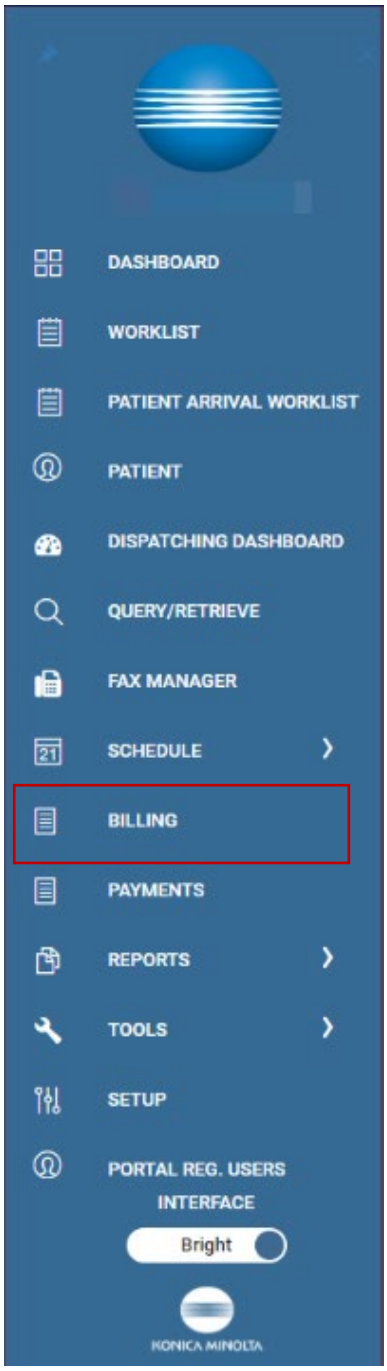
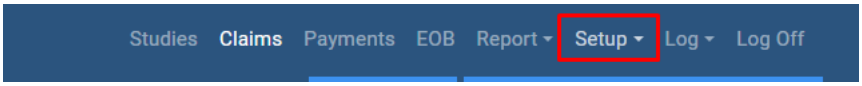
Introduction to the Billing Setup menu

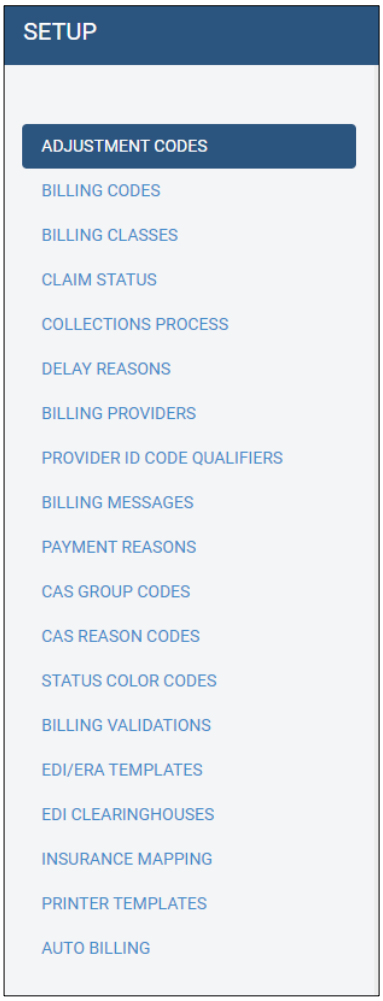
To open the Setup menu, select **Billing** > **Setup**.

Select Burger > Billing...



...Setup



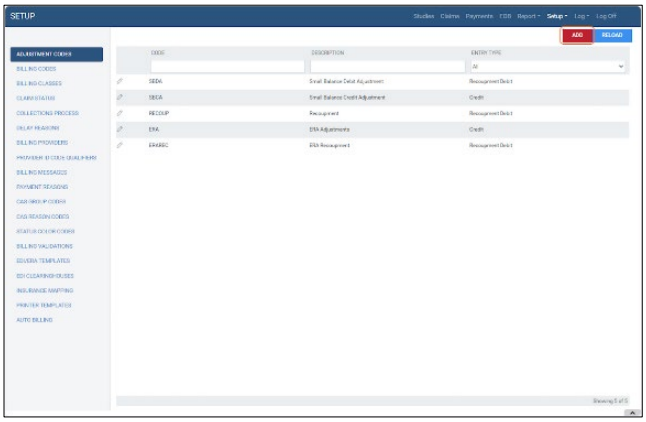


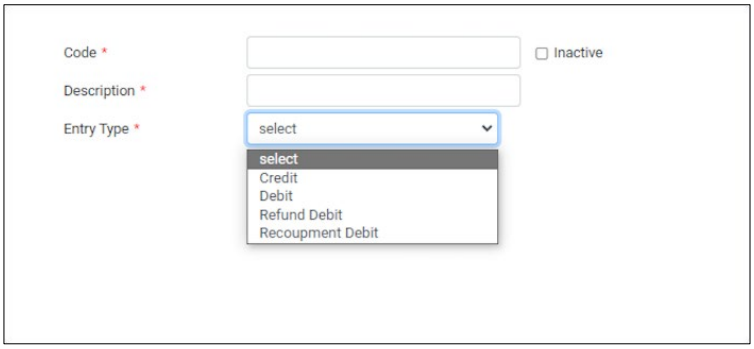
This document describes the items on the Setup menu.

Adjustment codes

Adjustment codes are used by healthcare providers, insurers, and clearinghouses to explain why a claim or service line was adjusted, rejected, or denied. Codes appear on the claim level adjustment. Exa Billing comes with some adjustment codes, but you can add more as needed. To add a code:

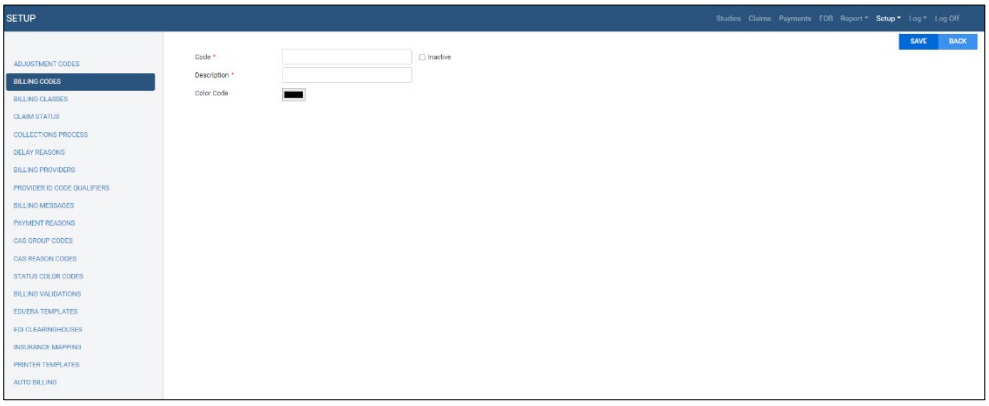
Each code needs a description and an entry type.
Code = Adjustment code nickname/acronym
Description = Name of the adjustment code
Entry Type = Type of adjustment the code will be used for





Billing codes and billing classes

You can apply user-specific billing codes and classes to claims to categorize them for easier follow-up and organization. You can also apply colors to claims by class or code.



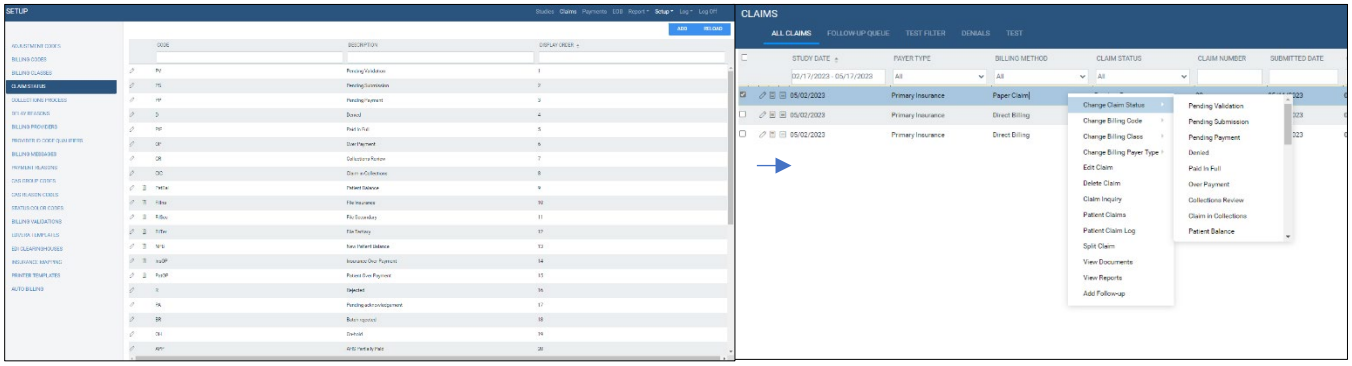
This is an optional feature.

Claims status

Claims statuses denote the different stages of processing and reimbursement of claims. You can add, remove, and inactivate claim statuses depending on the claim and claim scenarios.

Some codes come standard with Exa Billing, such as:

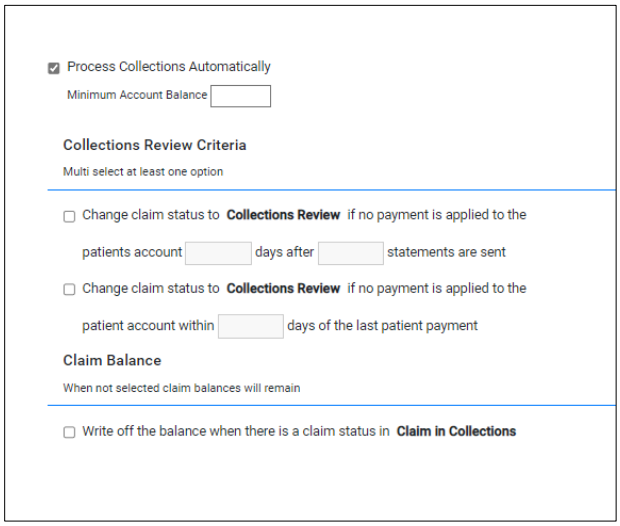
- Pending Validation: Claims must meet specific parameters set before billing
- Pending Submission: The claim was successfully validated and is waiting to be sent to the payer.
- Pending Payment: Default status once the claim is submitted. This status will automatically update when the payment is received.
- Paid in Full: Claim has a 0 balance.
- Denied
- Overpayments
- Collections Review
- Claims in Collections



You can view statuses by right-clicking a claim

Collections

You can use the Collections feature to automatically send patient-responsible claims to collections based



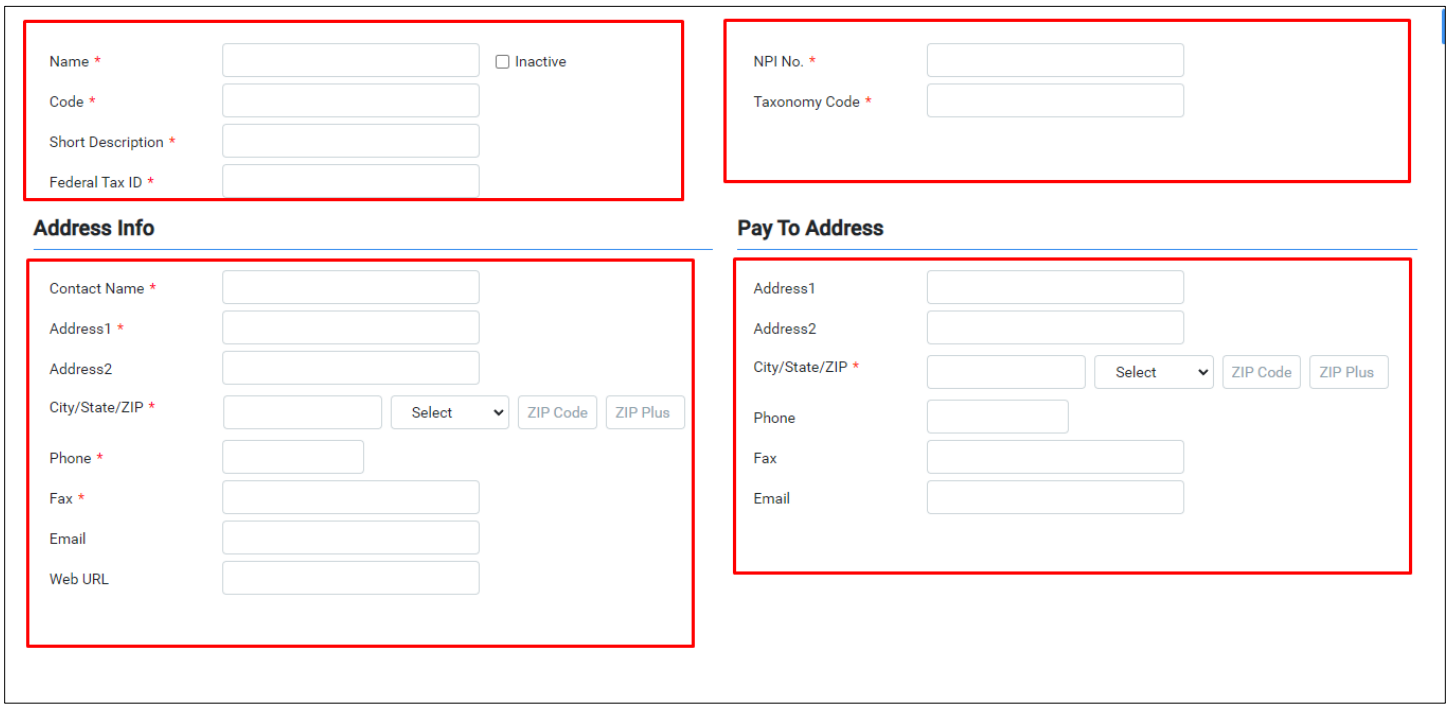
on specified parameters. You can modify how the statement is sent, and select to automatically write off claims when in collections.

Delay reason codes

Delay reason codes provide information to both healthcare providers and insurance companies as to why claims submitted to an insurance company were delayed or denied.

Billing providers

A *billing provider* (or *rendering provider* or *billing entity*) is a healthcare professional or organization submitting the reimbursement claim to the insurance company or payer.



This screen corresponds to box 33 on the CMS 1500 claim form

Box 1 (upper-left)

- Enter the name of the billing provider
- The code is an internal nickname or acronym given to each provider
- Short description can be the same as the name
- Federal Tax ID is a 9-digit number

Box 2 (upper-right)

- NPI number
- Taxonomy

Box 3 (lower-left)

- Basic contact information for the site

Box 4 (lower-right)

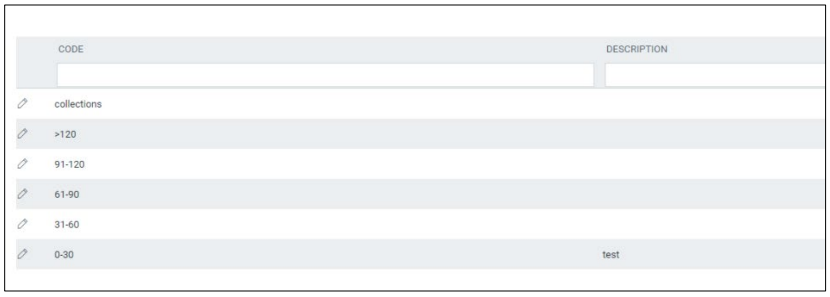
- A Pay To Address specifies where to send payments for the provider (if different than the address entered in Box 3, i.e., PO Box or Lock Box)

Provider ID code qualifiers

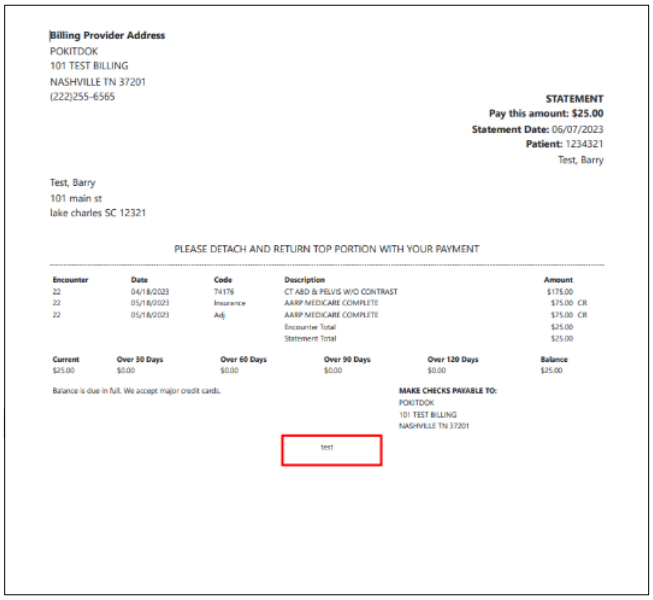
A 2-digit provider ID code qualifier is a code used in electronic transactions, particularly in healthcare-related transactions, to indicate the type or format of the identification number used for a provider.

Billing messages

Billing messages appear on the patient statement and can be entered into each of the fields below.

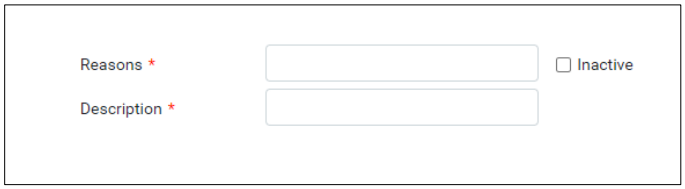


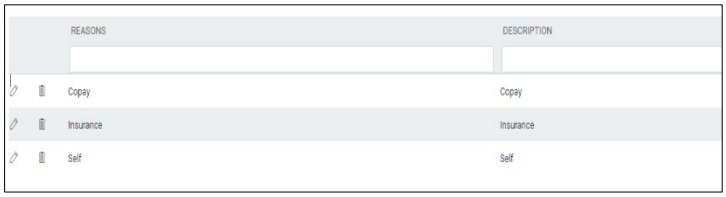
Example:



Payment reasons

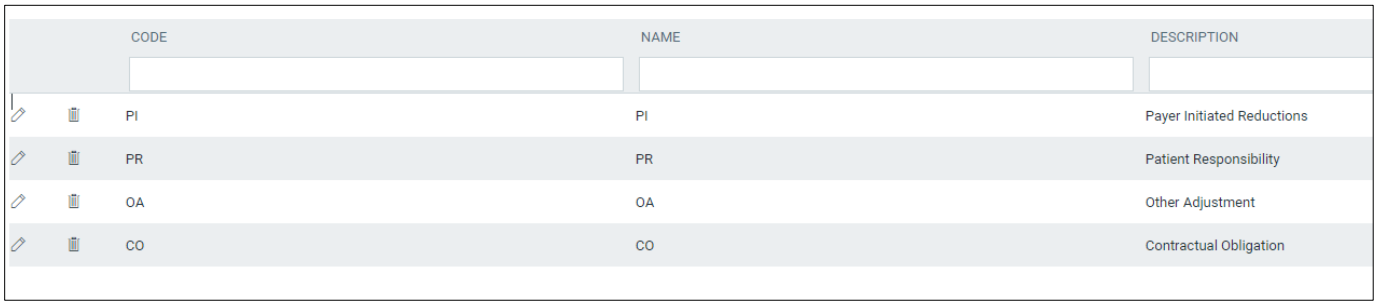
Payment reasons help identify the type of payment on the claim.



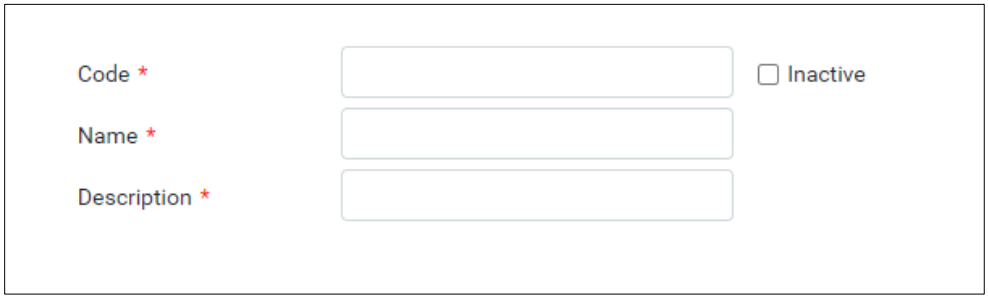


CAS group codes

Claim adjustment segment (CAS) group codes are two-digit alpha-character codes used by insurance companies to assign responsibility for adjustment amounts taken on a claim or service line.



You can add, remove, or inactivate CAS group codes.



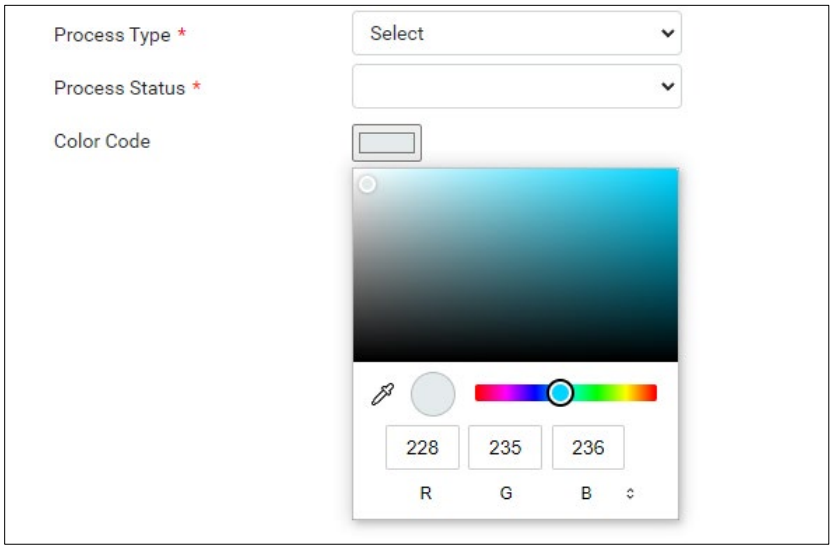
CAS reason codes (CARC)

Claim adjust reason codes pair with CAS group codes. CARC codes explain why there is a difference between the total billed amount and the paid amount.

You can add, delete, or inactivate CARC codes.

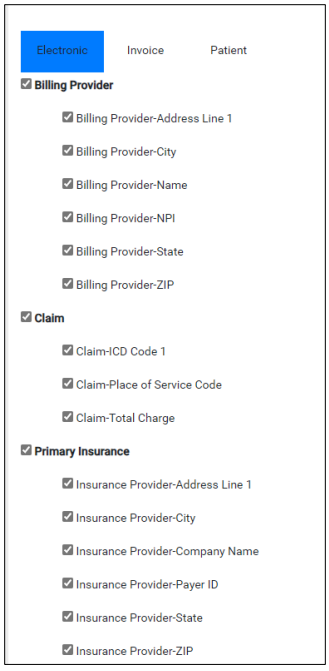
Status color codes

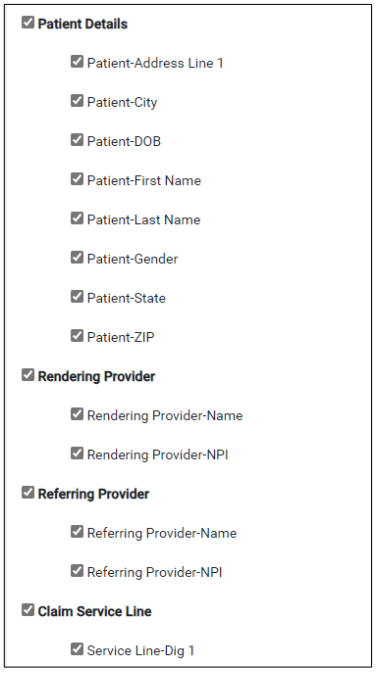
You can configure custom color codes for various processes in Exa Billing for increased organization and structure for claims, payments, and study types.

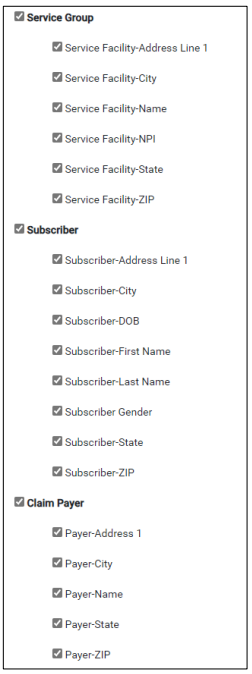


Billing validations

You can select which information on claims is validated for inclusion before submitting.

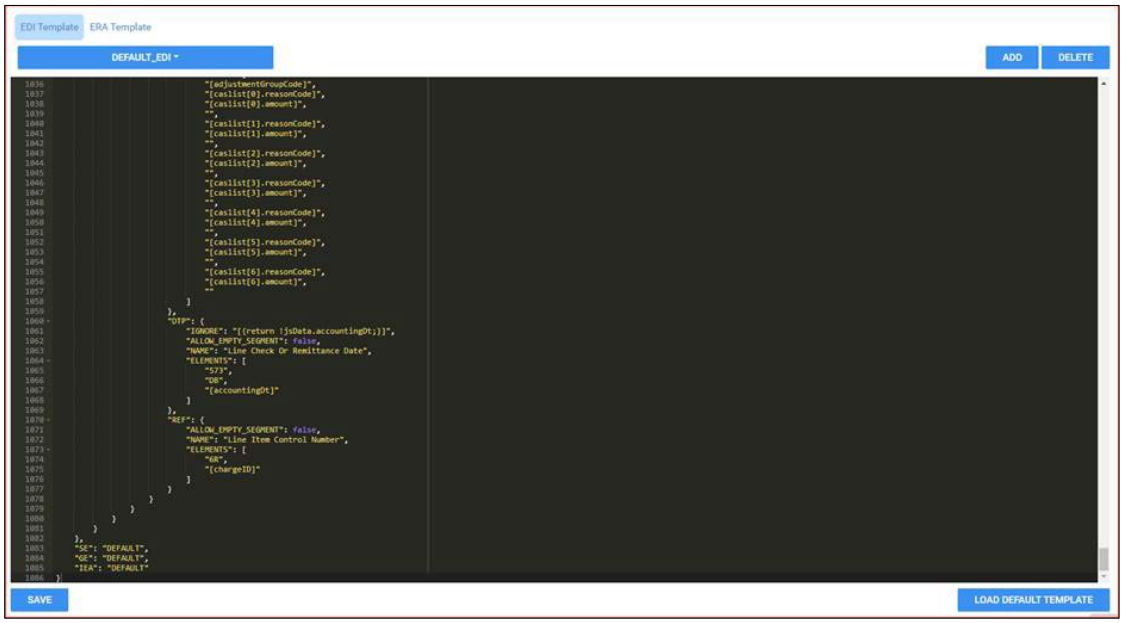






EDI/ERA templates

Exa Billing provides default EDI and ERA templates.

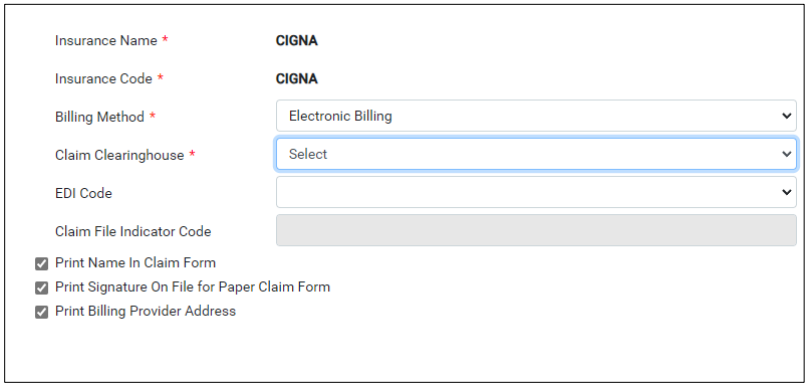


EDI clearinghouse

Exa Billing offers several options to submit electronic claims with EDI clearinghouses:

- Using an SFTP portal
- Downloading an 837 file from Exa Billing and upload it into a clearinghouse portal
- Downloading an 835 payment file

Insurance mapping

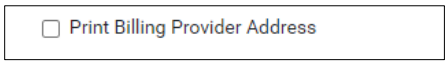


You can configure the billing method used by each insurance payer. Billing methods include:

- Direct Billing – Invoice
- Electronic Billing – Claims are submitted through EDI
- Paper Claim – Claims are submitted through a paper CMS1500 form
- Patient Payment – Patients receive their bills through the statement process

Another indicator listed on the screen is the EDI code.

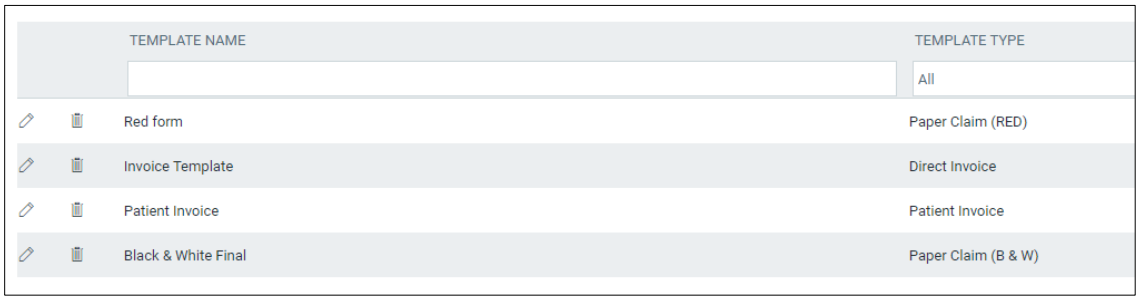
Definition	Equivalent Code submitted by EXA	Used?
Attorney	AT	
Automobile	AM	
Blue Cross	BL	Yes
Commercial	CI	Yes
HMO Medicare Risk	16	Yes
M DMERC	DMERC	No - DME
Medicaid	MC	Yes
Medicare	MB	
Railroad MC	MB	
Worker's Compensation	WC	
X Champus	CH	
Y Facility	YFAC	



The Print Billing Provider Address checkbox controls where claims are sent. If the user has a lock box or P.O. Box for their payments, clear the checkbox.

Printer templates

Printer templates are loaded into Exa Billing, and they can be customized to meet billing submission needs.



Auto-Billing

Auto-Billing allows you to automatically allow studies that are completed/closed (based on your internal workflows and criteria) that would normally fall in "ready to bill" to have a claim submitted. You can set up multiple auto-billing jobs based on criteria including study status, facility, modality, service code, insurance provider payer types, and insurance providers. You must enter a description for each auto-billing job you create. You also can identify what claim status you would like to use.