

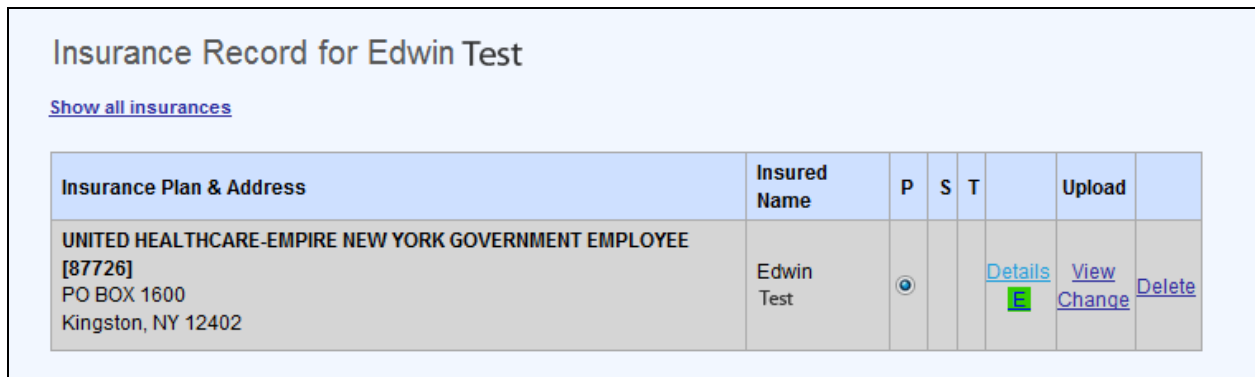


To: All WRS Users  
From: WRS Development Team  
Date: 02/10/12  
Re: System Update to Waiting Room Solutions

The WRS Development Team will be performing a software update to the Waiting Room Solutions System on or about February 10, 2012. This release will include the following:

**Eligibility Information for Patient Co-Pay and Deductible Amounts**  [\(Click to View Video Release Note 1\)](#)

Eligibility-checked co-pay and deductible amounts are now displayed on the **Patient Management>Insurance Tab** and **Patient Account** screen. This information is presented as supplied through the WRS Automated Eligibility Checking Service (via Gateway EDI) and the patient’s insurance company.



The screenshot shows a web interface titled "Insurance Record for Edwin Test". Below the title is a link "Show all insurances". A table displays insurance information for Edwin Test. The table has columns for "Insurance Plan & Address", "Insured Name", "P", "S", "T", and "Upload". The "Insurance Plan & Address" column contains "UNITED HEALTHCARE-EMPIRE NEW YORK GOVERNMENT EMPLOYEE [87726] PO BOX 1600 Kingston, NY 12402". The "Insured Name" column contains "Edwin Test". The "P" column has a radio button. The "S" and "T" columns are empty. The "Upload" column contains links for "Details", "View Change", and "Delete".

Insurance Plan & Address	Insured Name	P	S	T	Upload
UNITED HEALTHCARE-EMPIRE NEW YORK GOVERNMENT EMPLOYEE [87726] PO BOX 1600 Kingston, NY 12402	Edwin Test	<input checked="" type="radio"/>			<a href="#">Details</a> <a href="#">View Change</a> <a href="#">Delete</a>

Figure 1: Manage Patients>Insurance


*Note: This functionality is only applicable for WRS clients using the Automated Eligibility Checking Service through Gateway EDI.*

*The information supplied by the Automatic Eligibility Checking Service is matched between the patient’s insurance information and the practice/provider NPI number as supplied by the practice during the initial practice clearinghouse setup process (i.e. if the provider is in-network for a particular insurance, then in-network details are automatically displayed here).*

The **Patient Management>Insurance Tab>Details** now displays two columns. The first column, **User Defined**, displays the co-pay and deductible information as entered by the practice. The second column, **Eligibility Details**, displays the deductible and co-pay information as presented by the Automated Eligibility Checking Service via Gateway EDI.

	User Defined	Eligibility Details
Copay <input type="checkbox"/> Apply To All Copays	\$ 15.00	20.00
Specialist Copay	\$ 15.00	
Walk-in Copay	\$ 15.00	
In Patient Copay	\$ 15.00	
ER Copay	\$ 15.00	
Mental Health Copay	\$ 15.00	
Vision Copay	\$ 15.00	
Individual Deductible	\$ 0.00	1000.00
Family Deductible	\$ 0.00	
Individual Out of Pocket	\$ 0.00	3000.00
Family Out of Pocket	\$ 0.00	
Copay <input type="checkbox"/> Apply To All Copays	\$ 15.00	
Specialist Copay	\$ 15.00	
Walk-in Copay	\$ 15.00	
In Patient Copay	\$ 15.00	
ER Copay	\$ 15.00	
Mental Health Copay	\$ 15.00	
Vision Copay	\$ 15.00	

**Figure 2: Manage Patients>Insurance>Details**

If there is a discrepancy between these two amounts, the **User Defined** amount will be highlighted in **yellow**. The practice can then press the **ARROW**  icon to update to the amount supplied by the insurance company during Automated Eligibility Checking. Clicking **Update Insurance**, at the bottom of the page, will save these changes to the patient's record.

	User Defined	Eligibility Details
Copay <input type="checkbox"/> Apply To All Copays	\$ 15.00	20.00

**Figure 3: Manage Patients>Insurance>Details>Arrow Icon to Update**

Patient co-pay and deductible amounts from the Automated Eligibility Checking Service are also shown on the **Patient Account Screen**.

**Patient Claims and Bill**

Patient:

Automatic Patient Statements:

---

**Post Payment / Co-Payment To Account** | **Patient Insurance Info**

Payment Amount:

Payment Type:  **Eligibility Mismatch**

Co-Payment Amount To Be Charged:

Apply To Claim #:

Charge Patient for Miscellaneous Fee

---

**Patient Insurance Info**

UNITED HEALTHCARE-EMPIRE NEW YORK GOVERNMENT EMPLOYEE

	User Defined	Eligibility Details
Copay:	\$20.00	\$20.00
Walk In Copay:	\$20.00	\$0.00
In Patient Copay:	\$20.00	\$0.00
ER Copay:	\$20.00	\$0.00
Mental Health Copay:	\$20.00	\$0.00
Vision Copay:	\$20.00	\$0.00
Specialist Copay:	\$20.00	\$0.00
Individual Deductible:	\$0.00	\$1000.00
Family Deductible:	\$0.00	\$0.00
Individual Out of Pocket:	\$0.00	\$3000.00
Family Out of Pocket:	\$0.00	\$0.00

---

**Patient Account History**

	AMOUNT CHARGED	AMOUNT ADJUSTED	AMOUNT PAID	AMOUNT OWED

Figure 4: Patient Account Screen>User Defined and Eligibility Details

If **Eligibility Details** and **User Defined** information does not match, then an **Eligibility Mismatch** error message will be displayed. Insurance information can then be updated (as described above) on the **Patient Management>Insurance Tab**. Note that the **User Defined** amounts can also be left as entered, if desired by the practice.

**Post Payment / Co-Payment To Account**

Payment Amount:

Payment Type:  **Eligibility Mismatch**

Figure 5: Patient Account Screen>User Defined and Eligibility Details> Eligibility Mismatch

Once the information has been updated on the **Patient Management>Insurance Tab**, the error message will be removed.

Patient: Edwin Test

Automatic Patient Statements:

Payment Amount:

Payment Type: Cash

Co-Payment Amount To Be Charged:  20.00

Apply To Claim #: 212789 10/05/09

Post Payment

Charge Patient for Miscellaneous Fee

Patient Insurance Info: UNITED HEALTHCARE-EMPIRE NEW YORK GOVERNMENT EMPLOYEE

	User Defined	Eligibility Details
Copay:	\$20.00	\$20.00
Walk In Copay:	\$15.00	\$0.00
In Patient Copay:	\$15.00	\$0.00
ER Copay:	\$15.00	\$0.00
Mental Health Copay:	\$15.00	\$0.00
Vision Copay:	\$15.00	\$0.00
Specialist Copay:	\$15.00	\$0.00
Individual Deductible:	\$1000.00	\$1000.00
Family Deductible:	\$0.00	\$0.00
Individual Out of Pocket:	\$3000.00	\$3000.00
Family Out of Pocket:	\$0.00	\$0.00

View Insurance Card | Upload New Insurance Card

Figure 6: Patient Account Screen>User Defined and Eligibility Details> Eligibility Mismatch (Removed)

### Addition of Tertiary Insurance (Click to View Video Release Note 2)

The ability to handle a Tertiary insurance workflow has been added to the WRS System. This new functionality allows practices to designate **Primary**, **Secondary** and **Tertiary** insurance plans for any patient. The practice can then transfer, bill, post and report on this tertiary insurance within their WRS workflow.

The ability to add a tertiary Insurance has been added to **Patient Management>Insurance**. Practice users can specify the **Primary (P)**, **Secondary (S)** and **Tertiary (T)** insurance packages for a patient record.

Insurance Record for Patti Test

[Show all insurances](#)

Insurance Plan & Address	Insured Name	P	S	T		Upload	
Medicare B [13202]	patti test	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<a href="#">Details</a> <a href="#">E</a>	<a href="#">Upload</a>	<a href="#">Delete</a>
AETNA [60054] PO BOX 981106 EL PASO, TX 79998	patti test	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<a href="#">Details</a> <a href="#">E</a>	<a href="#">Upload</a>	<a href="#">Delete</a>
AARP MEDICARE [87726] PO BOX 31362 SALT LAKE CITY, UT 84131-0362	patti test	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<a href="#">Details</a> <a href="#">E</a>	<a href="#">Upload</a>	<a href="#">Delete</a>

Figure 7: Patient Management>Insurance

Once the tertiary insurance has been added, the user selects the “P” “S” and “T” radio boxes to designate the **Primary**, **Secondary** and **Tertiary** insurances for the patient.

P	S	T
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Figure 8: Patient Management>Insurance>”P”, “S”, “T”

Tertiary insurance has also been added to the **Post Payment Screen**. Balances can be transferred to the tertiary Insurance, as applicable.


**Post Payments to Charges**

**Post Payment (Claim #1343965)**

Claim ID: 1343965   [New Claim](#)   [Rebill](#)   [Bill Secondary](#)   [Bill Tertiary](#)   [View/Print Claim](#)   [Claim History](#)   [Patient Statement](#)   [Account History](#)   [Billing Summary](#)

---

**Patient:**



**TEST, PATTI**  
update  
MIDDLETOWN, NY 10940  
342-1234

**Primary:**  
New York Medicare  
MEDICARE B-NY  
11111111111111111111  
PO BOX 6178  
INDIANAPOLIS, IN 462066178  
(877) 869-6504

**Secondary:**  
AETNA 1  
AETNA  
11111111111111111111  
PO BOX 981106  
EL PASO, TX 79998  
(800) 282-5366

**Tertiary:**  
AARP HEALTHCARE OPTIONS  
AARP  
PO BOX 13999  
PHILADELPHIA, PA 191870216  
(800) 282-5366

**Rendering Provider:**  
GORDON, LAWRENCE

**Claim Status:**  
Pre Clearinghouse Submission

**Patient Billing Status:**  
Patient Not Billed

**Primary Billing Status:**  
Billed

**Secondary Billing Status:**  
Billed

**Tertiary Billing Status:**  
Tertiary Not Billed

---

Reason	Procedure	Date Of Service	Amount Charged	Amount Adjusted	Amount Paid	Amount Owed	Owed By
<b>Procedure</b>	99213	02/08/12	\$150.00	\$-100.00	\$20.00	\$30.00	New York Medicare
Available Funds	Payment Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount
2/8   \$380.00   Ck #: 123	\$	Co-Pay	-\$ 0.00	Co-Insurance	-\$ 0.00	Contractual	-\$ 0.00
<b>Reason</b>	<b>Procedure</b>	<b>Date Of Service</b>	<b>Amount Charged</b>	<b>Amount Adjusted</b>	<b>Amount Paid</b>	<b>Amount Owed</b>	<b>Owed By</b>
<b>Deductible</b>	99213	02/08/12	\$100.00	\$0.00	\$10.00	\$90.00	AETNA 1
Available Funds	Payment Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount
2/8   \$10.00   Ck #: 123	\$ 10.00	Co-Pay	-\$ 0.00	Co-Insurance	-\$ 0.00	Contractual	-\$ 0.00
			<b>Amount Charged</b>	<b>Amount Adjusted</b>	<b>Amount Paid</b>	<b>Amount Owed</b>	
<b>Totals</b>			\$250.00	\$-100.00	\$20.00	\$130.00	

[Submit](#)   [Reset](#)

Figure 9: Post Payment>Balance Transfer

A claim can be generated for the tertiary insurance plan by clicking on **Bill Tertiary** on the **Post Payments Screen**.

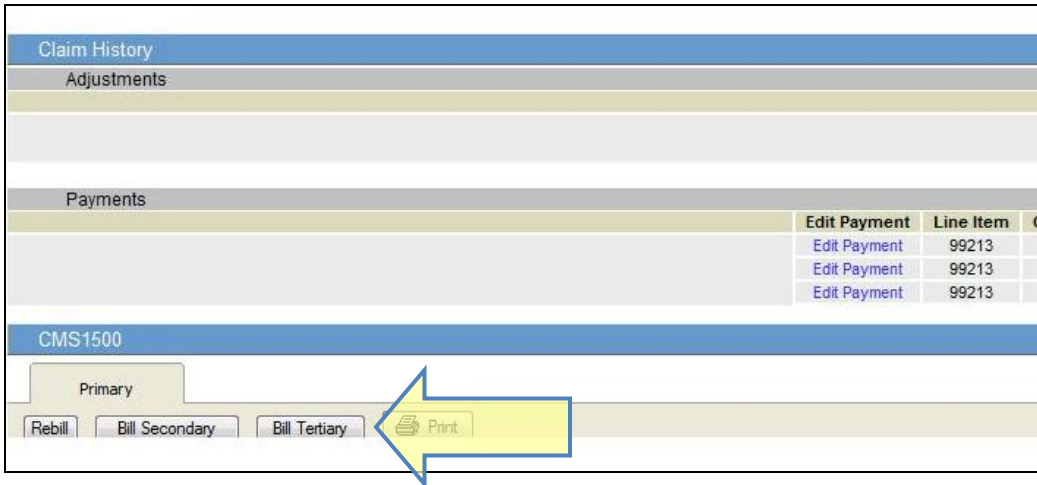



Figure 10: Post Payment>Bill Tertiary

Payments from tertiary insurances can now be entered on the **Post Payments Screen**. Note that once the screen refreshes, the payment will be available to be posted to line item amount owed by the tertiary.

Post Payments to Charges

**Post Payment (Claim #1343965)**

Claim ID: 1343965 [New Claim](#) [Rebill](#) [Bill Secondary](#) [Bill Tertiary](#) [View/Print Claim](#) [Claim History](#) [Patient Statement](#) [Account History](#) [Billing Summary](#)

**Patient:**  
  
**TEST, PATTI**  
 update  
 MIDDLETOWN, NY 10940  
 342-1234

**Primary:**  
 New York Medicare  
 MEDICARE B-NY  
 1111111111111111  
 PO BOX 6178  
 INDIANAPOLIS, IN 462066178  
 (877) 869-6504

**Secondary:**  
 AETNA 1  
 AETNA  
 1111111111111111  
 PO BOX 981106  
 EL PASO, TX 79998  
 (800) 282-5366

**Tertiary:**  
 AARP HEALTHCARE OPTIONS  
 AARP  
 PO BOX 13999  
 PHILADELPHIA, PA 191870216  
 (800) 282-5366

**Rendering Provider:**  
 GORDON, LAWRENCE

**Claim Status:**  
 Pre Clearinghouse Submission

**Patient Billing Status:**  
 Patient Not Billed

**Primary Billing Status:**  
 Billed

**Secondary Billing Status:**  
 Billed

**Tertiary Billing Status:**  
 Tertiary Not Billed

Reason	Procedure	Date Of Service	Amount Charged	Amount Adjusted	Amount Paid	Amount Owed	Owed By
<b>Procedure</b>	99213	02/08/12	\$150.00	\$-100.00	\$20.00	\$30.00	New York Medicare
Available Funds	Payment Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount
2/8   \$380.00   Ck #: 123	\$	Co-Pay	-\$ 0.00	Co-Insurance	-\$ 0.00	Contractual	-\$ 0.00
<b>Deductible</b>	99213	02/08/12	\$100.00	\$0.00	\$10.00	\$90.00	AETNA 1
Available Funds	Payment Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount	Adjustment Type	Adj Amount
2/8   \$10.00   Ck #: 123	\$ 10.00	Co-Pay	-\$ 0.00	Co-Insurance	-\$ 0.00	Contractual	-\$ 0.00
<b>Totals</b>			\$250.00	\$-100.00	\$20.00	\$130.00	

[Submit](#) [Reset](#)

Figure 11: Post Payment>Post Payment to Tertiary

The ability to search for claims billed to tertiary insurance has been added. **Claim Status: Billed Tertiary** is now shown on the **View Claims Screen**. Selecting this option will include all claims designated as tertiary.

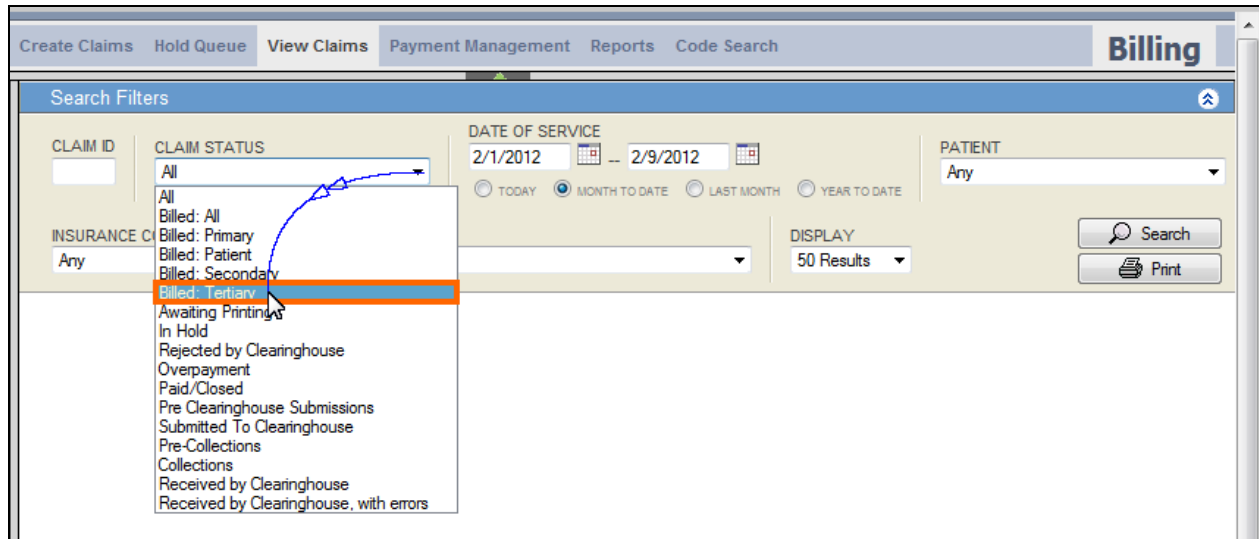


Figure 12: Billing>View Claims>Billed: Tertiary

**Billing Activity** and **Trend Reports** now reflect tertiary insurance payments, adjustments and charges.

**Print Filters?**

DATE: 12/01/2011 - 12/31/2011    SUPERVISING PROVIDER:    RENDERING PROVIDER: All    INSURANCE COMPANY:    HCPC CODE(S):    LOCATION: ENT SPECIALT

Total Adjustments   
 Total Patient Transfers   
 Total Secondary Transfers   
 Total Tertiary Transfers   
 Transfer Back   
 Total Voids

Bad Debt     Balance Bill     Co-Insurance     Co-Insurance     Duplicate

Capitation     Co-Insurance     Co-Pay     Co-Pay     Global

Courtesy     Co-Pay     Deductible     Deductible     Void

Contractual     Deductible     Other     Other

Discount     Other

Interest

User Correction

Activity Report - annie test

Rendering Doctor	# Of Charges	Amount Charged	True Charges	Amount Posted This Period	Total Amount Posted	Total Adjustments	Total Patient Transfers	Total Secondary Transfers	Total Tertiary Transfers	Tran
WRS USER	277	\$31,327.49	\$26,041.95	\$-13,748.56	\$-13,903.92	\$-14,330.23	\$-2,214.37	\$-625.77	\$-2,214.37	
WRS USER	202	\$27,102.51	\$22,617.84	\$-11,614.19	\$-11,676.60	\$-13,037.77	\$-1,778.64	\$-509.50	\$-856.12	
WRS USER	20	\$531.35	\$130.00	\$-423.38	\$-423.38	\$-87.97	\$-20.00	\$0.00	\$-20.00	
WRS USER	12	\$1,513.51	\$1,342.59	\$-425.94	\$-425.94	\$-981.05	\$-102.41	\$0.00	\$-4531.64	
WRS USER	444	\$89,214.03	\$78,820.91	\$-31,115.03	\$-31,346.20	\$-51,300.43	\$-4,971.84	\$250.74	\$-123.45	
WRS USER	182	\$10,964.91	\$9,799.88	\$-2,790.33	\$-2,790.33	\$-7,918.60	\$-328.93	\$72.95	\$-45.37	
		\$160,653.80	\$138,753.17	\$-60,117.43	\$-60,566.37	\$-87,656.05	\$-9,416.19	\$-811.58	\$-8,9456.56	

Figure 13: Billing>Reports>Activity

**NDC Codes and Descriptions on the CMS 1500**  [\(Click to View Video Release Note 3\)](#)

**NDC Drug Code Descriptions** are automatically carried to the **CMS 1500 form** when an NDC Code is entered. If the NDC Description does not exist in the database, the user can input their own description by typing it between the square “[ ]” brackets. In addition, the user can modify the original, system-generated NDC Description by modifying information between the square “[ ]” brackets. The edited description will appear on the claim as modified.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
19. RESERVED FOR LOCAL USE			17b. NPI			20. OUTSIDE LAB? \$ CHARGES																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			22. MEDICAID RESUBMISSION CODE			23. PRIOR AUTHORIZATION NUMBER																							
1. 786.59			3.			ORIGINAL REF. NO.																							
2.			4.			24. A. DATE(S) OF SERVICE																							
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #		
N400002714001 [REOPRO 2 MG/ML VIAL]			ML			J0130			1			10.00			1			NPI											
02 10 2012 02 10 2012 11																													
1																													
2																													

Figure 14: Billing>View Claim>CMS 1500>NDC Description

The ability to remove **NDC Description** information has also been added. The user can click within the **NDC Description** information and delete this information to remove it from the claim.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
19. RESERVED FOR LOCAL USE			17b. NPI			20. OUTSIDE LAB? \$ CHARGES																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			22. MEDICAID RESUBMISSION CODE			23. PRIOR AUTHORIZATION NUMBER																							
1. 786.59			3.			ORIGINAL REF. NO.																							
2.			4.			24. A. DATE(S) OF SERVICE																							
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #		
N400002714001			ML			J0130			1			10.00			1			NPI											
02 10 2012 02 10 2012 11																													
1																													
2																													

Figure 14: Billing>View Claim>CMS 1500>NDC Description (removed)