Billing FAQs

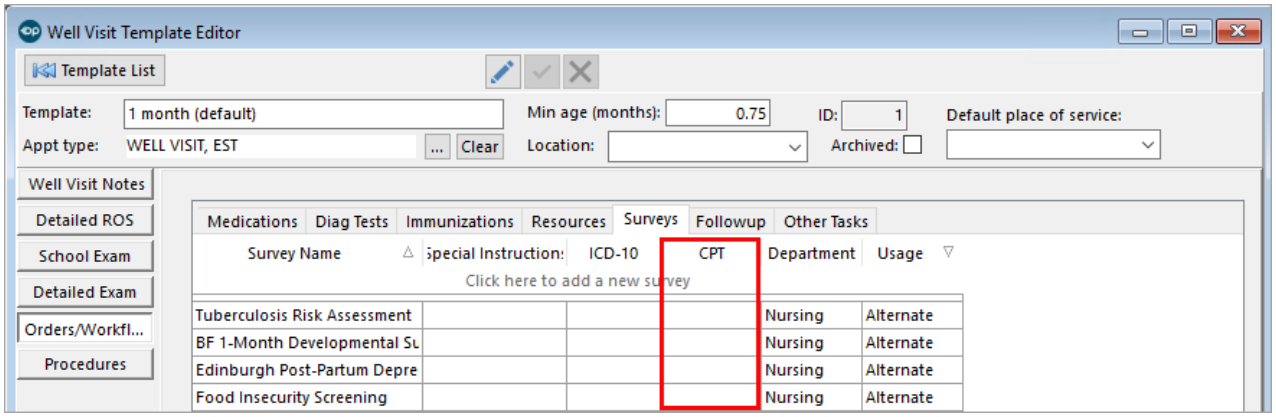
Last Modified on 07/21/2023 10:45 am EDT

Why are there duplicate charges for Surveys and Labs on superbills?

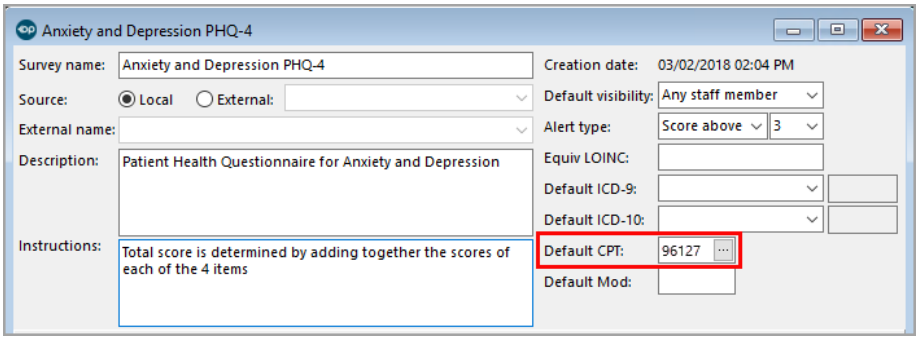
Duplicate charges typically occur for Surveys and Diagnostic Tests because a CPT code has been associated with the item in the Order/Workflow tab in the Encounter or Well Visit Templates. To avoid these duplicate charges, it is recommended to associate the CPT code in the respective setup area of OP for Surveys and Diagnostic Tests and **not in the template**. Within Encounter Templates, only Procedures should have CPT codes associated. Further, no E/M Codes should be attached to Encounter Templates.

Tip: Applying a Procedure Template more than once will cause duplicate CPT codes to appear under Coding within the template. Remember to remove any duplicate codes prior to saving the Note. Saving the Note will cause these duplicates to automatically push to the superbill.

1. Review your templates to see if a CPT code has been associated with a Survey or Diagnostic Test in the template.
    a. Navigate to **Clinical tab > Encounter Templates or Well Visit Templates**and select a template.
    b. Click the **Orders/Workflow** tab.
    c. Click the **Surveys** tab, and confirm that the CPT field is blank.
    d. Click the **Other Tasks** tab, and confirm there are no CPT codes associated with Diagnostic Tests**Note**: While Diagnostic Tests are typically tasked from the Diag tests tab and not the Other Tasks tab, it is still recommended to check Other Tasks for CPT codes that may be causing duplicate charges.

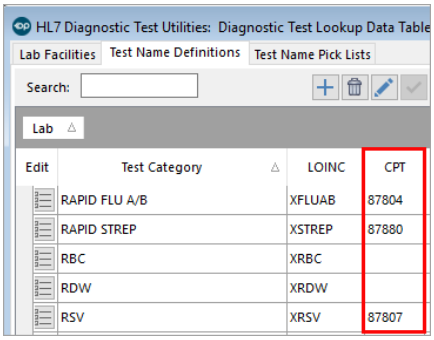


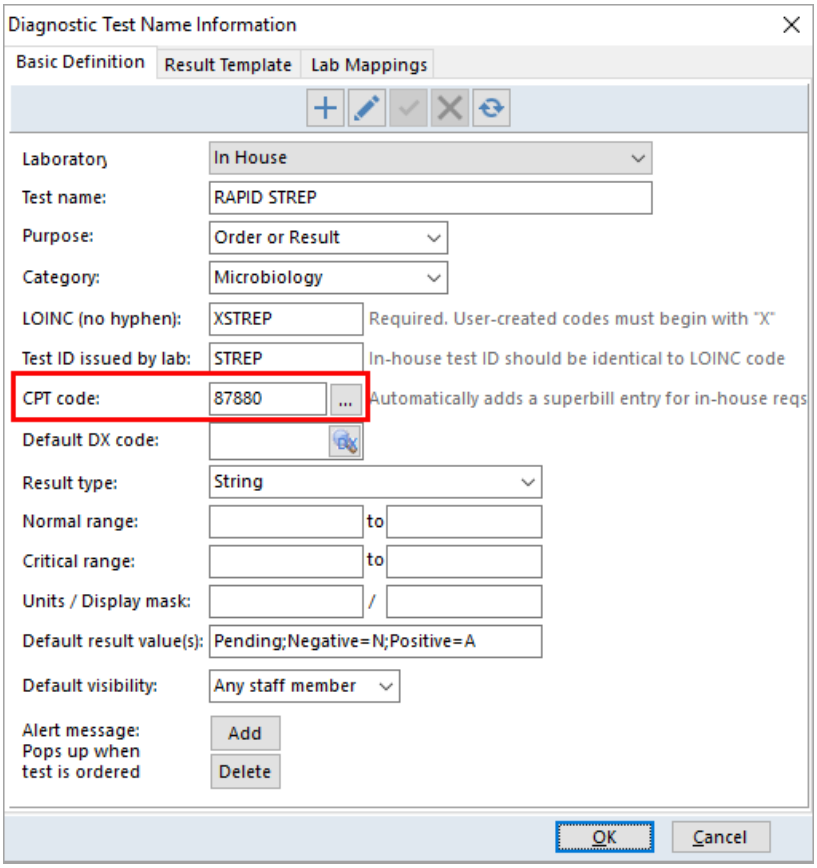
2. Review Survey setup by navigating to**Clinical tab > More button (Customize group) > Surveys** Once you open the Survey, you'll associate the CPT Code by entering it or selecting it in the **Default CPT** field.



3. Review Diagnostic Test setup by navigating to**Clinical tab > More button (Customize group) > Diagnostic Tests** Once you open the Test, you'll associate the CPT Code by entering it or selecting it in the **CPT code** field.

Tip: Rather than open up each Test to confirm the CPT code is associated, you can easily review the list of Tests to which Tests do not have a CPT code already associated.





How do I make collection fee automatically bill with lab?

You can utilize the Blocked and Substitute feature in OP so that each time the a test such as glucose or hgbA1c is ordered, it will add the collection code. You have the option of setting this up for individual payers or for all payers.

How do I change a diagnosis code after a note is finalized?

You cannot go back and add the diagnosis directly to the note, but you can create an addendum to indicate that you have changed the diagnosis.

To rebill the claim with a correct ICD code, edit the archived transaction by adding the new ICD on the Basic Info tab associated with appropriate CPT codes and then re-queue the claim. Add a claim note so that you know what has been done.

How do I see all charges for day's visit when in note?

If you are in an encounter, you do not have to close out of the note. Click on the Superbill button that is on the top toolbar, and it will show you what codes have been already added to the visit for a diagnostic test or an immunization. Once a diagnostic test or immunization has been documented the code will automatically be sent to the superbill, so if they are appearing in your summary there will be a charge on the superbill.

Another way to view all the charges for a visit is to go to the Schedule > Tracking and check Billing Reconciliation. From here, highlight the visit and you will see all charges associated with the visit.

On the Coding tab of the visit, you will only see codes that have been added directly to the Coding tab, such as the E&M code or a procedure code. Codes that have been added to the Procedure tab of a template will also appear on the coding tab.

How do I add more than 4 diagnosis codes to a claim?

You are able to add 4 diagnoses per CPT code with a total of 12 per claim. This is per 5010 guidelines. You are able to add as many diagnoses as you want to the note itself.

You also have the option to document and bill for a separate visit with the appropriate codes if you are seeing a patient for a well visit, and providing care for a separate identifiable service.

How do I run my statements?

How do I put a patient in collections for bad debt?

While there is currently not a Collections module in OP, you can still set the patient's status to indicate their financial standing with the practice. To change a patient's status to In Collection:

1. Navigate to the patient's chart.
2. Click **Basic Information**.

3. Use the Status drop-down to select **In Collection**.
4. Click the **Save** button.

You may also consider adding a Billing Note or a Misc. Note to the chart.

How do I post a patient adjustment?

To post a patient adjustment, follow the steps below:

1. Navigate to the **Patient Chart**.
2. Click **Payments** in the window navigation panel.
3. Click the **New Payment** button.
4. Ensure you are in the **Patient** tab (indicated with a pink background).
5. Select **AD Adjustment Only** from the Pay Method drop-down menu.
6. Enter the **Adjustment Amount** in the Adjustment column for the appropriate procedure code.
7. Select an **Adjustment Reason** in the Adj Reason column for the same procedure code.
8. Click the **Save + Close** button.

How do I post patient balances and credits to OP from prior system?

To post patient balances to OP from a prior (legacy) system, follow the steps below:

1. Navigate to the patient's chart.
2. Click **Charges** in the Window Navigation Panel.
3. Click the **New Claim** button. The Add/Edit Charges window is displayed.
4. Click the **SP** button in the Payer(s) section of the window to clear the patient's insurance for the claim.
5. Select the **Rendering Provider**.
6. In the Diagnosis section of the window, search for and select a 'balance forward' diagnosis or another miscellaneous/administrative diagnosis code.
7. In the Add CPT field, search for and select **BEGBAL** (or another CPT code set up by the practice).
8. In the Unit Chart and Charge amount fields, enter the **amount** of the patient's balance to be moved to OP.
9. Click **Save**. If you click **Save + Queue**, the claim will be added to the transmit queue and will have to be removed.

To post patient credits to OP from a prior (legacy) system, follow the steps below:

1. Navigate to the patient's chart.
2. Click **Credits** in the Window Navigation Panel.
3. Click the **New Credit** button.
4. From the Pay Method drop-down, select **Transfer (general)**. Selecting this method prevents the credit from looking like new revenue.
5. In the Patient Credit Amount field, enter the **amount** of the credit from the prior system.
6. Click **Save**. The credit is now available in OP for allocation to a patient balance.

Can I daysheet if I am not done with charges from day before?

Yes, you can daysheet even if you are not done with charges from previous day. The importance of running a daysheet is to lock in the payments and prevent them from being deleted. If a payment is deleted/voided prior to posting the daysheet, it will not show in the audit log, reports, or the Patient's Account. As for charges, you are able to run reports based on the DOS, therefore you will still be able to filter for them regardless of what daysheet(s) they were posted on.

How do I align HCFA form?

Due to various printer setup and configurations, you may find that when printed, HCFAs are misaligned. To correct this, try some of the following options as they apply in the Print Settings window:

- Select **Actual Size** instead of **Shrink to Fit** or **Fit to Width**
- Change the **Custom Fit Percentage** to a different value (for example, change from 100% to 102%)

How do I process and reconcile Instamed Portal payments?

How do I correct charges if I clicked cancel while posting and now charges show as posted?

1. Navigate to the **Charges** section in the Patient Chart.
2. Select the charge(s) in the Posted Charges section of the window.
3. Click the **Edit** button and make the necessary change(s).
4. Click **Save** or **Save + Queue**.

If I void payment taken at front desk and applied during charge entry, where does the money go?

If a payment is voided prior to daysheeting then it is deleted from OP. There is no record of the payment as it will not be reflected in the audit log or in the patient's account.

If a payment is voided after it was posted on a daysheet then the money will be moved to the credits tab. All actions will be listed in the audit log, on reports, and on the patients claim history.

How do I adjust off a balance at same time as posting copay in charge window?

To adjust off a patient balance while in the payment window, click in the adjustment field and enter the amount to be adjusted.

Note: You will also need to enter your adjustment reason at this time

How do I post an ERA that has payments that belong to OP and to legacy system?

If you have recently gone live with OP, you may receive ERAs that contain claim payments for claims in your former billing system (also known as legacy system). Only the payments that belong to OP claims can be posted in OP.

This means that the ERA will appear that it does not balance. For more information on reviewing an out of balance payment, click here.

What do my claim status categories mean?

The claim categories group your claims according to the last claim phase the claim went through. For example, after your claim has been transmitted, it will have a Q2 category, indicating "Transmitted."

Note: The categories rarely have to be manually changed.

The other category changes occur when either an OP user makes a change with the claim, or a response is received from the clearinghouse or payer. For example, if a claim is transmitted, it will be a Q2 category and then when the clearinghouse has accepted the claim and forwarded it to the payer, the category will automatically change from a Q2 to an A1, indicating "Accepted for Adjudication."

To learn more about how the claim status categories are defined, **click here**.

How do I move a payment posted to the wrong account?

When a payment has been posted to an incorrect account, you'll first want to determine if the payment has been archived. Archived transactions (or ones that appear on a daysheet) appear in black text, while current transactions appear in blue text. The steps below are also determined by the source of the payment (Patient or Insurance).

Correcting a Current Payment Posting (Patient or Insurance)

1. Click the **Account** button.
2. Navigate to the account that has the incorrect posting.
3. Click the **Claims** tab.
4. Expand the date of service to see the payment posting.
5. Highlight the payment (and associated adjustment and patient responsibility if applicable).
6. Click the **Void** button located at the top of the window.
7. Navigate to the correct Account, and post the payment as you normally would.

Correcting an Archived Patient Payment Posting

1. Click the **Account** button.
2. Navigate to the account that has the incorrect posting.
3. Click the **Claims** tab.
4. Void the incorrectly posted payment (this will create a credit on the patient's account) and adjustment.
5. Click the **Credits** tab.
6. Click the **+Refund** button.
7. Select **Refund Method: Refund Transfer**.
8. Enter the amount being moved from the Patient.
9. Enter a **Note** if desired.
10. Click the **Save / Post** button.
11. Navigate to the account where the money belongs.
12. Click on the **Credits** tab.
13. Click the **+Credit** button.
14. Select **Pay Method: Transfer General**.
15. Enter the amount being credited to the account.
16. Enter a **Note** if desired.
17. Click the **Save / Post** button.

Correcting an Archived Insurance Payment Posting

Follow the 12 steps above. Then, perform the following:

1. Select **Pay Method: Insurance Transfer**.
2. In the Debit Patient field, search for and select the patient who currently holds the credit.
3. Enter the transfer amount to the right of the patient's name.
4. Enter a Note (if desired).
5. Click the **Save / Post** button.

How can I mark stuck clearinghouse files as reviewed?

Clearinghouse files, such as payments and acknowledgements, can sometimes become "stuck" which causes subsequent files to not pull into OP. Stuck files are usually identified by either an ISC error message (such as when an Instamed portal payment file is stuck) or by a lack of files coming in (such as ERA payment and acknowledgements). There may also be instances where you do not want a specific file to pull into OP. In either of the above scenarios, you can follow the steps below to mark the stuck file as reviewed and resume file processing as normal:

1. Navigate to the Administrative Documents Repository: **Admin tab > Admin Documents**.
2. Select the Transaction type for the stuck file. Here are some examples:
   - 835 = ERA payments
   - 277, 997, 999 = Acknowledgments
   - PAY = Instamed portal payments (see Example below)
3. Click the **Search** button. All outstanding files are displayed with the stuck file at the top of the list.
4. Select the **Revd?** checkbox for the stuck file to mark it as reviewed.
5. Click the **Mark Reviewed** button.
6. Navigate to the Billing Center: **Billing tab > Billing Center** button.
7. Click the **Claims (A/R)** tab (if processing Instamed portal payments or Acknowledgement files) or the **Adjudications** tab (if processing ERA payment files).
8. Click the **Process** button. The files being held up by the stuck file are processed into OP.
9. Repeat this process until all files that have not been reviewed have been marked reviewed.

> **Example**: One reason Instamed portal payments become stuck is when the patient account number was incorrectly entered. Users should visit their Instamed account to review patient payments and enter them manually into OP if the account number was incorrectly entered. To review the files in OP:
>
> 1. Navigate to **Admin tab > Admin Documents**.
> 2. Select the Correspondent ID **IMD** and Transaction type **PAY**.
> 3. Follow the above remaining steps above.

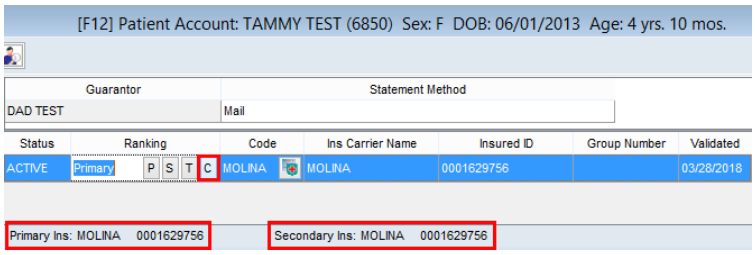
Why won't the insurance rank?

If you are unable to rank an insurance entry, it is likely that there is a space in the Subscriber ID number or Group Number. To remove the space, simply locate the space and use the backspace function on your keyboard to remove it.

> **Note**: If a claim has already been submitted under the ID or Group Number with the space, OP will not allow you to make any edits to that insurance record. You will need to recreate the insurance without the space and rank the new entry.

Why is the same insurance showing as Primary and Secondary?

If you have one insurance entry, but that insurance is showing as Primary and Secondary, then it is likely the the ranking was not cleared prior to switching the ranking. To avoid this, be sure to click the **C** in the ranking field to clear the existing ranking before selecting **P** for primary or **S** for Secondary.



Where does the CLIA number pull from?

CLIA numbers are often required to appear on claims where labs are being billed. Where the CLIA number pulls from depends on how the claim is being submitted.

- **For electronic claims (837)**: the CLIA number is pulled from the CLIA ID field located under**Practice Management tab > Practices/Locations > Locations tab** and appears in box 23. You will not see the CLIA number in the Add/Edit charges window, but it will transmit electronically on the claim.
- **For paper claims (CMS-1500)**: the CLIA number must be manually added to the claim in box 23.

1. In the Add/Edit charges window or the Edit Archived Claim Transactions window, navigate to the Other Items (1-27) tab.
2. Enter the CLIA number in the **Item 23: Referral #** field.
3. Click the **Save** button.
4. Print the claim.

Note: Box 23 is the most typical placement of this information. Depending upon the state in which you are billing, it may be required to record the CLIA number elsewhere on paper claims.

How can I make sure patients are included in my batch statements?

> **Path: Billing Tab > Billing Center button > Statements Tab > Bulk Stmts button**

Here are a few of the batch statement parameters you can check to ensure that your patients are included in your statement batches.

- When batching your statements, ensure that**Exclude if all sent >= XX times**is deselected or the number in the field is high enough to not effect the batching.
- Make sure the Minimum family balance is set appropriately.

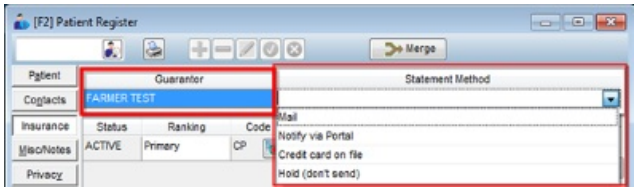
Example: If the minimum family balance is set to $20, and the family's balance is only $10, then that family will be excluded from the statement batch.

- Make sure the Days since last printed is set appropriately.

Example: If all patients should receive a statement regardless of when a previous statement was sent, enter -1.

Additionally, you will want to ensure that all patients have a Guarantor and Statement Method selected at the top of the Insurance tab in their Account or Register. To do this:

1. Navigate to the Patient Register: (**Path: Smart Toolbar > Register button**).
2. Select the Insurance tab.
3. Make sure that all patients have a Guarantor and Statement Method selected.



For more information on creating batch statements, click**here**.

How can I set up a payment plan in OP?

Currently, OP does not have a platform for creating or maintaining payment plans. Until a feature for this has been developed, practices may track patients they have put on a payment plan by editing the patients' statuses and making notes on the respective patient accounts. For more information on patient statuses, click **here**.

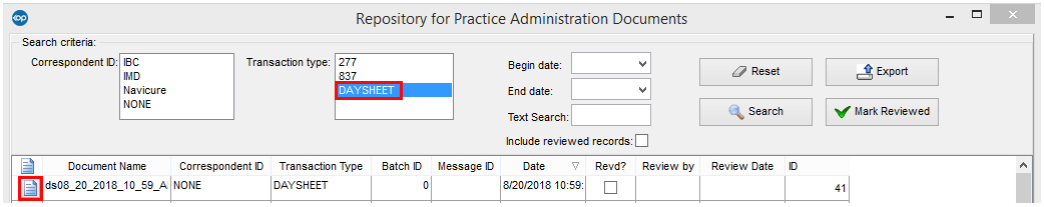
How can I view the Current Receipts by specific data?

If you want to change the view of the Current Receipts report, click a link below for further instruction.

- Filtering data
- Sorting data
- Grouping data
- Add, Remove or Reorder columns

How do I reprint a daysheet?

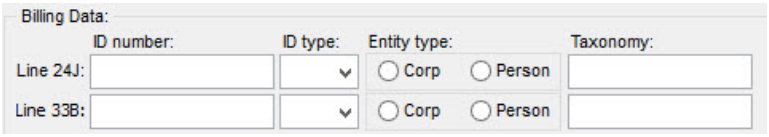
1. Navigate to **Admin tab > Admin Documents**. The Repository for Practice Administration Documents is displayed.
2. Select Transaction type: **Daysheet**.
3. *(Optional)* Enter a Begin and End Date range. This is the date that the daysheet was actually processed. It is not the date of the transactions contained in the daysheet.
4. Click the **Search** button. A list of processed daysheets is displayed.
5. *(Optional)* Click the **Date** column header to sort the data in ascending or descending order.
6. Click the document icon to the left of the Document Name to view and/or print the desired daysheet.



How do I bill under a Provider's Medicaid Assigned ID?

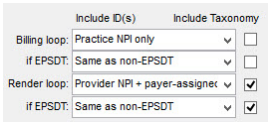
Medicaid insurances (and sometimes non-Medicaid insurances) commonly require the assigned Provider numbers to appear on claims. The placement of this number depends on the requirements for the state in which you are billing. To reflect that information in the OP software and ensure the payer-assigned ID number appears in the correct location, follow these steps:

1. Add the Provider's payer-assigned ID number to the Insurance Carrier Provider Information window.
    a. Click **Utilities** > **Manage Practice** > **Insurance Payers**. The Insurance Payers List will open.
    b. Expand the insurance who requires a payer-assigned ID number to be submitted on claims.
    c. Double-click the credentialed provider listed below the payer. The Insurance Carrier Provider Information window will open. For more information on adding credentialed providers to insurances, click **here**.
    d. Enter the payer-assigned ID number in either the Line 24J ID Number field or the Line 33B ID Number field. The ID type and Entity type should also be populated according to the type of number that has been entered in the ID number field.



    e. Click **Save**.

2. Set the Rendering or Billing Loop for the Insurance Carrier. The Loop will depend on where the Insurance Payer requires the payer-assigned number to appear on claims.
    a. If you have closed the Insurance Payers List, navigate back to it by clicking **Utilities** > **Manage Practice** > **Insurance Payers**.
    b. Select the payer that requires the assigned number.
    c. Click the **Edit Record** button. The Insurance Payer Details window will open.
    d. Click the **Claims/Routing** tab.
    e. Set the Billing loop (Line 33B) or Render loop (Line 24J) to **Provider NPI + payer assigned**.



    f. Click **Save**.

Why don't I see all of the CPT code charges that were in the visit's Coding tab?

Only one instance of each CPT code passes from the visit's Coding tab to the electronic superbill. This rule applies whether or not a CPT code was pulled in from an applied template and whether or not there is a modifier present on the second (or third etc.) code instance.

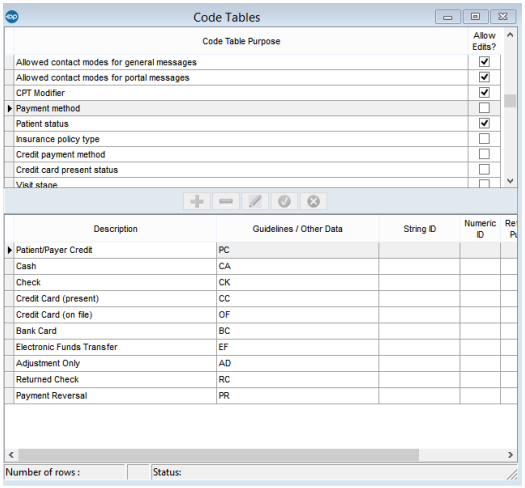
However, units of a CPT code may be changed on the Coding tab of a visit and will pass to the electronic superbill.

For example, if a provider adds the following CPT codes in the Coding tab (in this order): 99213, 94640, 94640-76, A7003, the only charges that will appear on the electronic superbill will be: 99213, 94640-76, and A7003. Please note, when a CPT code is entered twice, the most recent duplicate code entry (or second instance added) will be the one passed to the superbill.

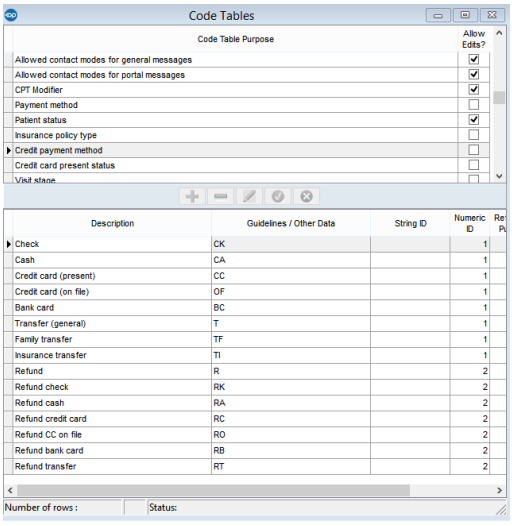
What do the codes for payment methods mean?

Payment methods are codes used to indicate how a payment was managed. The codes and definitions are found in **Utilities > Manage Codes > Coded Values**. The Coded Values table will open. Scroll to locate the payment lists and definitions of:

- Payment Method



- Credit Payment Method

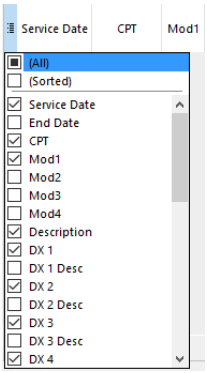


How do I suppress a Rendering Provider's NPI from a claim?

1. Navigate to the Insurance Payer list: **Billing tab > Payers**.
2. Select the **Insurance Payer**.
3. Click the **Edit** button to open the Insurance Payer Details window.
4. Click the **Claims/Routing** tab.
5. In the **Rendering Loop** field, use the drop-down to select **Suppress (don't include)**. The Rendering Provider's NPI will be suppressed from all claims for this payer.
6. Click **Save**.

How do I add more than one modifier to a CPT code?

1. In the **Add/Edit Charges** window, click the **Show/Hide/Move Columns** button . The list of available columns displays.



2. Select the checkbox(es) to include **Mod2**, **Mod3**, and/or **Mod4** to include the respective columns in the window.

Note: After adding the column(s) to the window, this can be saved as a preference by clicking the **Save Preference** button .

How do I process remit files that I downloaded from a website?

This content applies to users operating OP On-Premise only.

Once an 835 (or remit file) is downloaded from a website to the local computer, the file can be pasted into the OP > Claimnet folder. Once that is done, the user can navigate to the Adjudications tab of the Billing Center and click the **Process** button. If no files load, allow up to 15 minutes, and click the **Process** button again.

How do I add more than one NDC # to a Medication CPT code?

Only one NDC may be directly associated per CPT code in the CPT Code table. However, OP Aware rules can let you cleverly manage multiple NDCs for a single CPT code by using fake CPT aliases as placeholders.

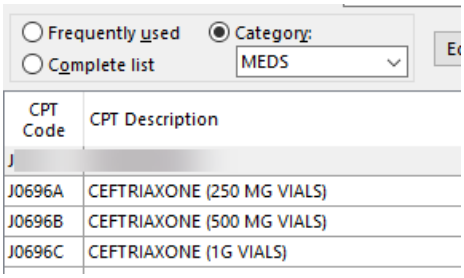
For example, a practice may stock three presentations of ceftriaxone (J0696), each with its own NDC number:

presentation	NDC (from vial)	11 digit padded NDC
250 mg vial	0409-7337-11	00409733711
500 mg vial	0409-7338-11	00409733811
1 g vial	0409-7332-11	00409733211

To minimize clicking and maximize automation, a practice might adopt this strategy:

Step one: Create three fake CPT aliases, one for each presentation

The practice adds new CPTs in the usual way and creates three aliases, one for each presentation, by appending a letter of the alphabet. For example, if a practice creates J0696A for 250 mg vials, J0696B for 500 mg vials, and J0696C for 1 g vials, and adds each to their Meds category, the result so far would look like this:

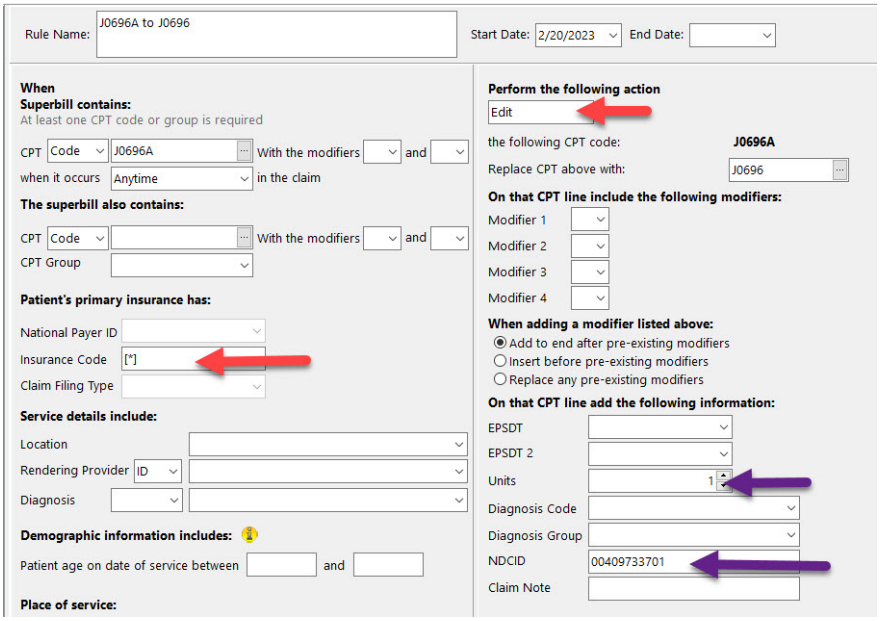


The practice need not associate NDC numbers with these vials in the CPT creation process.

Step two: Create three new OP AWARE rules to convert each fake CPT alias back to J0696

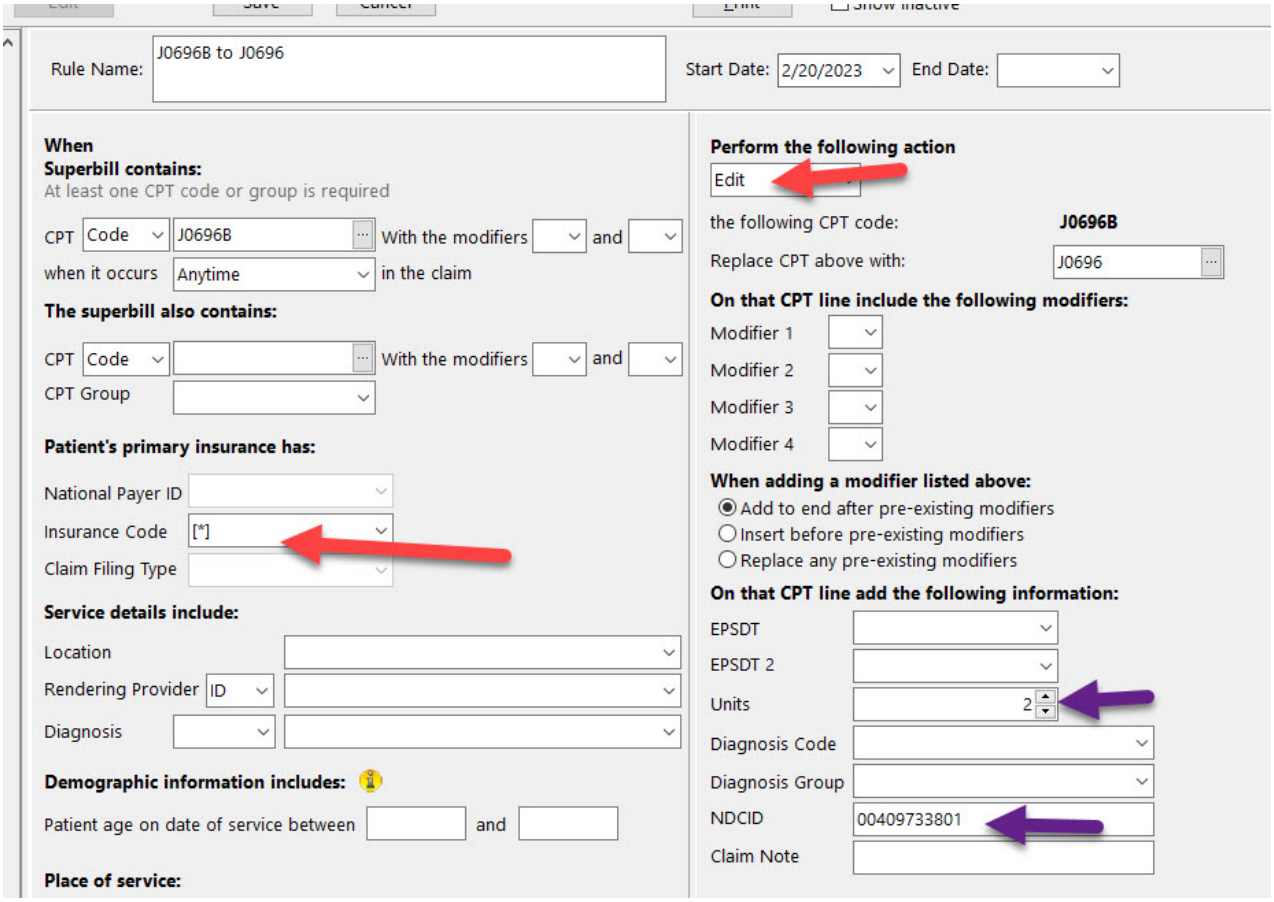
The practice can use OP AWARE's to automatically convert the aliases back to the proper CPT code -- and add the NDC and CPT units!

For example, here is a sample rule that takes a J0696A (representing a 250 mg vial) and replaces it with a J0696, with 1 unit and the proper NDC for the 250 mg vial:

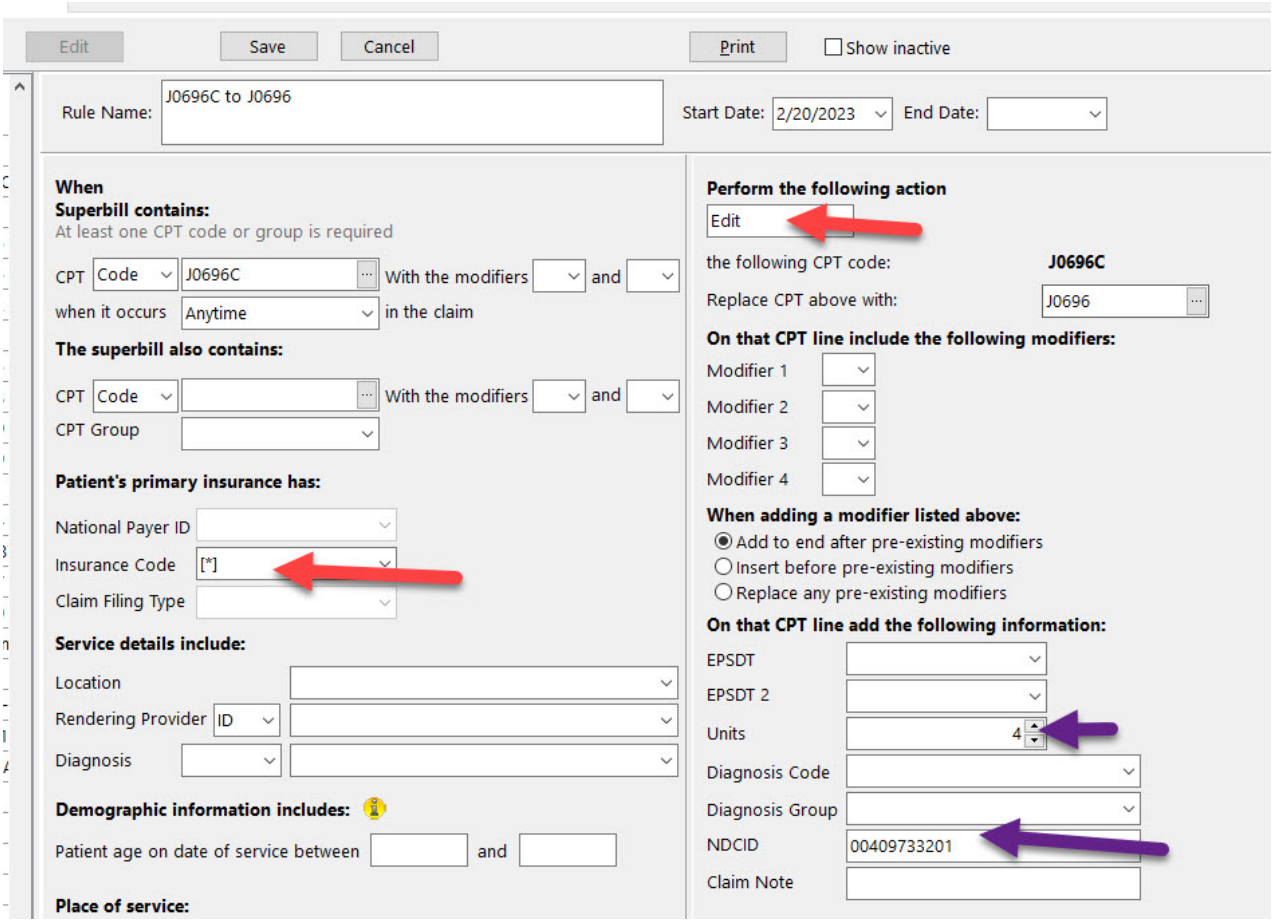


(The red arrows indicate fields that many users forget to set... don't forget to set the fields, or the rules won't fire!)

Similarly, here is a sample rule that converts J0696B to two units of J0696, with the appropriate NDC for the 500 mg vial:



Finally, here's a sample rule that converts J0696C to four units of J0696 with the NDC for a 1 g vial:

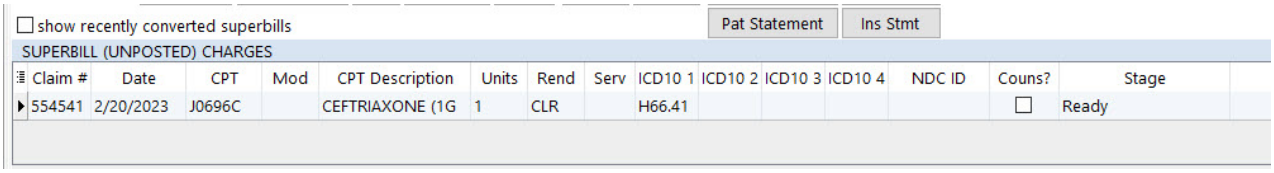


Converting the fake CPT aliases back to J0696 ensures that these fake CPT codes never go out on a claim. While you should only send proper AMA-compliant CPT and HCPCS codes out on claims, it is perfectly acceptable to use fake CPT aliases in your superbills as placeholders.

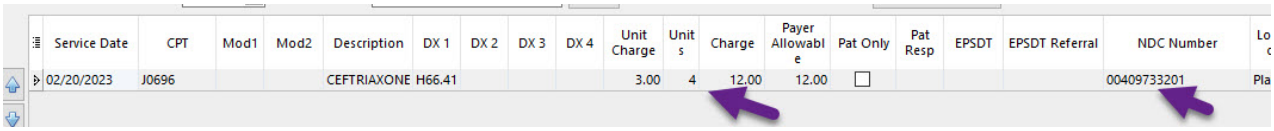
Step three: test your work

To ensure that you have set things up correct, do a sample claim for a Testpatient.**Note: you may need to totally restart OP (not just log out and in) for your fake CPT additions and new OP AWARE rules to fire properly.**

Before, in the superbill, J0696C is selected to represent 1 g ceftriaxone vial:



And after the charge is converted to a claim, note that now 4 units (since J0696 by definition is "per 250 mg") with the appropriate NDC for a 1 g vial.



Service Date	CPT	Mod1	Mod2	Description	DX 1	DX 2	DX 3	DX 4	Unit Charge	Units	Charge	Payer Allowable	Pat Only	Pat Resp	EPSDT	EPSDT Referral	NDC Number	Lo
02/20/2023	J0696			CEFTRIAXONE	H66.41				3.00	4	12.00	12.00	☐				00409733201	Pla

Please note: properly formatted NDCs not only contain an 11 digit NDC, **they also contain a unit of measure suffix (like ML1 or UN1)**. Unit of measure suffixes are required but are not shown in this example. You could either add them to your OP AWARE rules, or you could manually add them on the claim line if the volumes tend to vary a great deal.

What is a Rebook and how do I correct it on a claim?

A Rebook occurs when a user makes an edit to a claim that changes the status of the claim from *Archived* to *Current* and then voids a payment while it is current.

The only way to correct this transaction is to add an Insurance Credit. It is recommended to enter the credit with a Pay Method of Check and the Insurance Check number. This ensures that all payment entries are tied to the check number.