

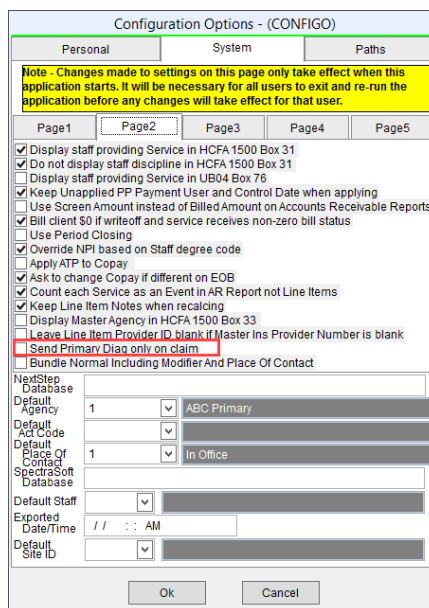
Configuration for Diagnoses on Claims

Last Modified on 01/17/2022 8:54 am EST

About

The **Send Primary Diag only on claim** setting located in the Billing Engine's Configuration Options (**Maintenance and Setup > Configuration Options > System tab > Page 2 tab**) determines how diagnoses are passed to claims. This checkbox is a system-wide setting and impacts how diagnoses are sent out on all claims.

- **(Default)** If the **Send Primary Diag only on claim** checkbox *is not* selected: All diagnosis codes from a client chart come over from the Clinical site. The system reorders the diagnosis code in the Primary DX field in Clinical to the front on the Service or Line Item when generating an 837 file.
- If the **Send Primary Diag only on claim** checkbox *is* selected: The only diagnosis to go out on a claim is the one that was selected as the Primary DX within Clinical.



Configuration Options - (CONFIGO)

Personal System Paths

Note - Changes made to settings on this page only take effect when this application starts. It will be necessary for all users to exit and re-run the application before any changes will take effect for that user.

Page1 Page2 Page3 Page4 Page5

Display staff providing Service in HCFA 1500 Box 31
 Do not display staff discipline in HCFA 1500 Box 31
 Display staff providing Service in UB04 Box 76
 Keep Unapplied PP Payment User and Control Date when applying
 Use Screen Amount instead of Billed Amount on Accounts Receivable Reports
 Bill client \$0 if writeoff and service receives non-zero bill status
 Use Period Closing
 Override NPI based on Staff degree code
 Apply ATP to Copay
 Ask to change Copay if different on EOB
 Count each Service as an Event in AR Report not Line Items
 Keep Line Item Notes when recalcing
 Display Master Agency in HCFA 1500 Box 33
 Leave Line Item Provider ID blank if Master Ins Provider Number is blank
 Send Primary Diag only on claim
 Bundle Normal Including Modifier And Place Of Contact

NextStep Database
 Default Agency 1 ABC Primary
 Default Act Code
 Default Place Of Contact 1 In Office
 SpectraSoft Database
 Default Staff
 Exported Date/Time // : : AM
 Default Site ID

OK Cancel

Tip: If additional control is needed over which diagnoses pass to claims, an override can be applied on the HIPAA 5010 Transfer Form when generating an 837 claim file to send all four diagnoses on each Line Item instead of populating from the client's chart. To apply this override:

1. Navigate to the HIPAA 5010 Transfer Form: **Navigation Menu > 837 Form**.
2. Fill out the HIPAA 5010 Transfer Form as you would to prepare a claim file by following the steps in **Create and Send Electronic Claim Files**.
3. Select the **Only use Diagnoses from Line Item** checkbox to override the current selection in Configuration Options.



SS HIPAA 5010 Transfer Form - (HIP5010F)

Transaction Set: 837 Professional Format Type: 15 HIPAA 837 Medicaid 10/11

Start Date: // Stop Date: // Only use Diagnoses from Line Item

Billing Group: [dropdown] [redacted]

Contact Employee: [dropdown] [redacted]

Agency ID: [dropdown] [redacted]

Procedure Code: [dropdown] [redacted]

Modifier: [text]

Activity Code ID: [dropdown] [redacted]

Case No.: [text] [redacted]

Staff: [dropdown] [redacted]

Insurance ID: [dropdown] [redacted]

Transaction Set Control #: [text] Claim Frequency Code: [dropdown] [redacted]

Add Carriage Return After Segments Update Billing Status Only

Don't Include Secondary Claims Override Invoice Date Override: // Send As Test Claim Remove "--"

Billing NPI (2010AA) [redacted]

Subscriber ID: [redacted] Case Number: [redacted]

Client Name: [redacted]

Event Date / Time: [redacted]

Control Date / Time: [redacted] Employee / Contractor ID: [redacted] Staff ID: [redacted]

Staff Name: [redacted]

[Start] [Exit]