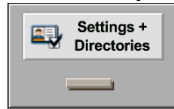**ICANotes Billing Training Guide**
Electronic Billing and Claims Submission

I. Configuring ICANotes for Electronic Billing:

The following Sections **A**, **B** and **C** list all fields that must be filled out in ICANotes in order for a claim to be "ready" to send to the clearinghouse electronically.

A. Settings + Directories (must be completed by a *Group Administrator*)

1. Navigate to [Settings + Directories] from the Chart Room.

2. Click on the [Show] button at the bottom of the page so that all required billing fields in Settings + Directories are highlighted in yellow for you.

[Show] Fields used by electronic billing   Required Optional

3. Navigate to the blue 'Group Level Settings & Directories' tab to fill out information your entire practice will use.

Group Level Settings & Directories

4. Click on the Sites/Letterheads tab to set up each location where services are rendered.   Use the [+ New] button to set up a new site.
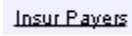
5. For each site, make sure to fill out all yellow fields under each of these three tabs:

Facility Info	Letterhead	Electronic Billing

6. Next, click on the Service/Mod Codes tab. Here you will set up a short list of all the procedure codes you bill for. Use the ▼ arrow to select a code from our Full List of codes or type in your own code in the text field. Use the ✏ icon to edit a custom code you have typed in. Use the red ✗ icon to delete a code from your short list.

00000 non-billable	▼	00000		✗
00022 Probation Non Billable	▼	11999	✏	✗
12345 no show	▼	0905	✏	✗

7. On the right you can also set up a list of modifier codes that you use for billing. Simply type a modifier code in the next available space on the list. Use the red ✗ icon to delete a modifier from this list.

8. After your short list is created, move on to the Insur Payers tab. Here you will set up another short list of the Insurance Payers you work with.

9. Use the [+ New] button to set up a new insurance payer. Make sure to populate all yellow fields with information then use the [□ Save] button to save the insurance payer to your short list. This list will appear on the demographics page for each patient so you can quickly select an insurance company and the selected information will populate without you having to manually type it in each time. To edit an existing insurance payer, simply click on the payer in the list to the left so the name is highlighted in blue (see below). Make sure to use the [□ Save] button to save your changes.

10. Now that you have set up all fields pertinent to billing under 'Group Level Settings & Directories' it is time to set up information for each clinician. Click on the green

Specific to Individual tab.

11. You will need to follow steps 12 through 16 to configure ICANotes for each clinician in your group. Click on a clinician's name in the list on the left so it is highlighted in blue.

42) **Joy Test4**
    User Name: joytest4

12. On the **Personal Info** tab, fill out all yellow fields.

13. Next, click on the **Billing Rates & Payer Rules** tab. Here you will link each procedure code this clinician bills for to the billing rate for that service.

NOTE: If a modifier is required in order to pull the billing rate, you may list the modifier(s) in the orange column(s). Typically you bill out the same rate regardless of insurance carrier, so you may leave this column blank. If different insurance carriers require different modifiers, feel free to link the insurance carrier to the code. If this is the case, you will need to create two lines of the same procedure code, one for the specific carrier and the other left blank for all other carriers *(see example above)*.

14. If the same billing rates are shared among certain clinicians, you may use the [Copy] button to copy the billing rates you set up, click on another clinician's name from the list on the left and use the [Paste] button to paste in the billing rates for that clinician. Repeat as needed.

15. Click on the [Provider Payer Rules] tab to see if these rules are needed for the clinician.

Payer Rule(s) (for joytest4)

Leave Insurance Payer blank to define the default rule.

Insurance Payer		Rendering Taxonomy	Billing Taxonomy	Code	Modifier Bill Under Supervisor		
Aetna	X		2222222222	HF			X
Medicare	X		3333333333	HO			X
BCBS	X		4444444444	MO			X
							X

NOTE: Here you can set up a default **Taxonomy Code**, if needed. You can also set up default **modifiers** per insurance carrier. For example, if BCBS of South Carolina requires an "MO" modifier attached to each code rendered by this clinician, you can set that up here. If done, the modifier will automatically populate into the clinician's note so the clinician does not have to remember to select the modifier each time. Here is also where you can specify a '**Bill Under Supervisor**' for a clinician who is billing under another clinician's name and information.

16. You have finished setting up all pertinent billing fields in Settings + Directories. Click on the [Chart Room] button and let's look at some other required fields for billing.

B. Patient Demographics

1. Navigate to a patient chart from the [Settings + Directories] drawer and find your patient by typing in his/her name or selecting the filing cabinet and clicking on his/her name in the list.

Show Charts:
[All] [Assigned to Me] [I am Principal]

[No Pending e-Rxs] [No e-Rx Renewals]
Enter Patient Name or ID or Phone

[Last Chart] [_____] 🔍 ↻

First Name   Last Name   DOB

A - C	N - Q
D - F	R - T
G - J	U - Z
K - M	See All Active Charts
	Inactive/Pending Charts

Click on the name to get the patient's chart.
Hover cursor over name for more details.

2. When the patient chart appears, click on the [Demographics] tab.

3. Fill out all yellow fields on the ⬚ Patient Information tab.

4. Click on the ⬚ Insurance Information tab and populate all yellow fields here as well.

5. To add new Insurance Coverage, use the ➕ New button.

*You will not be able to enter any coverage details until the 'New' button has been pressed.

6. Highlight your short list and use the ⬇ arrow to select an insurance payer from the list (see the green square above). If this patient has insurance which does not appear in your short list, you can select from the full list or key in the insurance carrier.

7. If you type in an insurance carrier or select one from the full list, you will need to populate all of the yellow insurance provider fields at the bottom. You can quickly add this insurance carrier into your short list using the ➕ **Add to Short List** button (see the purple square above).

8. After you have populated all demographics fields, especially the yellow fields required for billing, use the **Continue** button to leave the page.

C. Clinical Note: Encounter Information
A claim can be generated in the ICANotes Billing/Productivity Report as soon as the clinician begins a note.

The following fields **MUST** be entered in the clinician's note in order for a claim to be ready to submit.

1. An **accurate note date** based on the day the patient was seen. The note date will default to the date the clinician starts their note. If they need to back date the note they can do so by clicking on the date at the top and selecting the correct date from the calendar drop down.
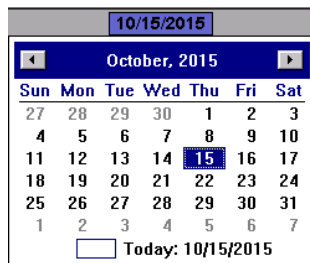
2. At least one active diagnosis. When a diagnosis code has been selected from the dropdown menu(s) correctly, it will turn a light green color. The diagnosis must also be listed as active under the 'Status' column on the far right to show on the claim file.
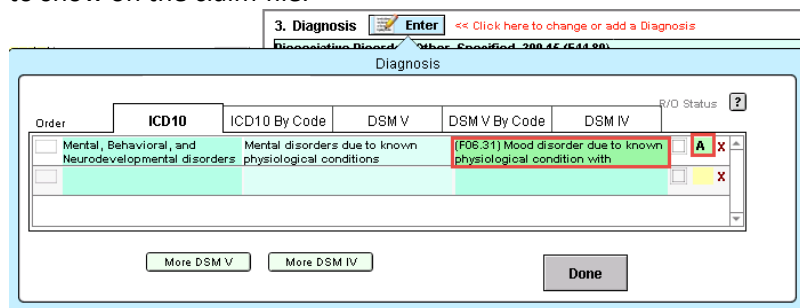
3. Finally, the clinician must code the note according to the services rendered.
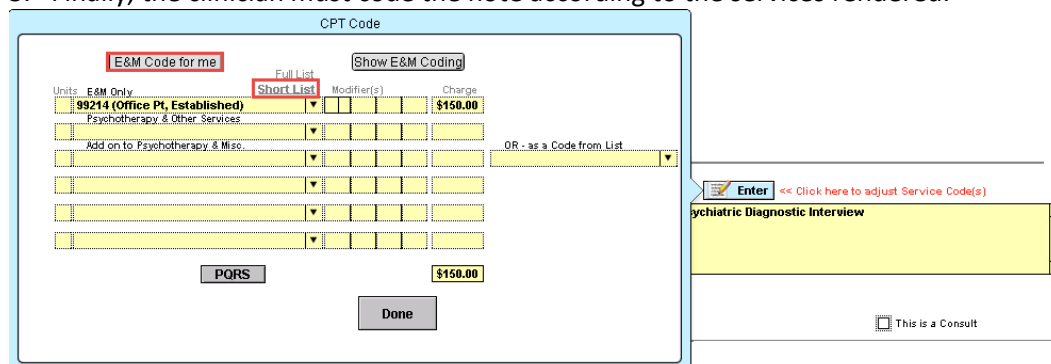
Prescribing clinicians wishing to arrive at an E&M code automatically can use the 'E&M Code for me' button. Otherwise the clinician will need to use the dropdown arrow and select the appropriate code(s) from the short list. Modifiers can also be selected to the right of the procedure code menu.
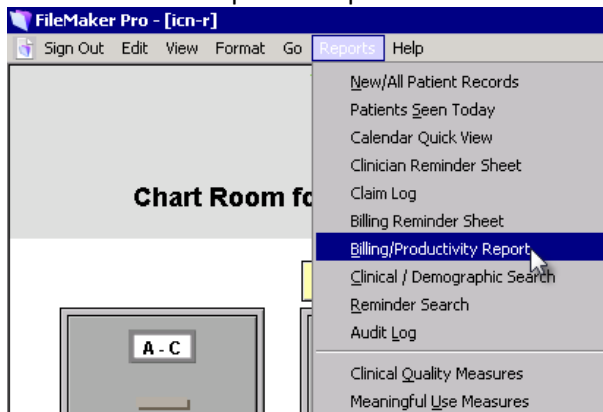
II. Running the Billing Report, Preparing and Submitting Claims Electronically

After you have set up all required fields in ICANotes and the clinicians are generating their notes for patient encounters, you are ready to begin preparing and submitting claims.

1. Click on the 'Reports' dropdown menu and select Billing/Productivity Report.

2. Fill in the appropriate fields to retrieve all of the claims you want to submit.
   a. Fill in the range of dates.
   b. Enter patient's name or patient ID. Leave blank for all patients.
   c. Enter specific billing/service code. Leave blank for all codes.
   d. Enter the site/location (multiple providers can be selected). Leave blank for all sites.
   e. Enter provider (multiple providers can be selected). Leave blank for all providers.
   f. Note types (select all that apply).
   g. Electronic billing options. Options for viewing claims based off of their status.
   h. Click 'Billing Report (expanded)' to run report.

3. The generated report will look similar to this one:

a. This blue box gives a summary of the report. This particular report contains 31 encounters.
b. There will be a claim status box for each claim on the report.
c. Edit demographics button.
d. Edit work areas button.
e. Check status again button.
f. Prep all claims button.
g. Submit all claims button.
h. Select button.
i. Prep selected claims button.
k. Submit selected claims button.

Claim status: Each entry in the report represents an encounter. Next to each entry is a status box.

When the **Not checked as of 10/15/2015 10:36:48 AM** status shows, click the **Check Status !** button to check the status.

When the **Not ready to submit eBill (click to see missing info)** status shows, click the status to see the missing information.

In this example, you can see we are missing the patient's phone number.

The program will tell you exactly what is missing ("Patient Phone") and where it is missing from ("Chart Face...Demographics").

When you have determined what information is missing and from where, you can use one of the shortcut buttons to quickly **Edit Demographics** or **Edit Work Areas** . These buttons will open up that area of the program so you can populate missing information.

After you have filled out all of the missing information, use the yellow `Check Status Again Last checked 10/30/2013 2:00:35 PM` button.   Your status should update accordingly.   If any additional information is missing, the program will tell you.   Otherwise, the status box should turn green.   Your goal is to get all claims 'Ready to Submit' so you can send them off to your clearinghouse in a single batch file.

When all claims are `Ready to submit eBill` use the `Prep Claims` button to prepare ALL claims in the report. Follow the prompts to prepare your claims accordingly.

After the claims are prepared, you will see the `Prepared 10/8/2015 (click to view) Status: Pending Primary with Secondary` status box next to each claim change.

Once prepared, use the `Submit Claim(s)` button to submit all prepared claims in a single batch file to your clearinghouse. You will see a confirmation window appear when you select this button.

The `Prepared 9/3/2015 (click to view) Status: Saved to File 9/3/2015 4:51:27 PM Primary with Secondary` status box tells you that this claim has been saved to the batch file and submitted to your clearinghouse on the exact date and time posted.

NOTE: If you only need to submit a few claims from the generated report, you may use the `SELECT` button to highlight each claim that you want to prepare and submit.   If this is the case, be sure to use `Prep SELECTED Claims` and `Submit SELECTED Claims` buttons to only prepare and submit the claims you have selected. See the screenshot below:

A few other items are displayed to the right of each encounter in the report. If you scroll to the right, you will see the following:

When you prep a claim, the program will simultaneously record the total charge for the service to Patient Accounts if it has not already been recorded.

If you are submitting claims as 837 files to your clearinghouse, this also allows the electronic remittance to match up to the original charge so auto-posting can work properly.

If you scroll even further to the right you will see the 'Claim History' log.

ICANotes keeps a log of all claim activity for each encounter. This includes preparing, submitting and even printing a claim to paper. This allows you to see the exact date and time a claim was submitted to the clearinghouse or printed to paper.

The claims that were electronically submitted will also contain a status indicated by the red arrow above.

To update the status at any time, you can press the refresh button indicated by the blue arrow above.

Note: You can Print HCFA 1500 forms from this billing report as well. Use the Print HCFA Forms button to print all encounters in your report to paper. You may also use the 'Select' button to pick claims and then use the Print SELECTED HCFA Forms button to only print selected claims to paper. You do not need to purchase HCFA 1500 forms if you are printing to a color printer. ICANotes will give you the option to print the red HCFA 1500 form in the background with all of the information populated.