HIPAA Security and Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects health insurance coverage for workers and their families when they change or lose employment. It includes the Privacy Rule (enacted April 14, 2003) that established regulations for the use and disclosure of Protected Health Information (PHI), the Security Rule (enacted April 25, 2005), that addressed electronic PHI (e-PHI), and established the requirements to protect the confidentiality, integrity and availability of PHI created, maintained and transmitted in electronic format, and Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) that strengthened the HIPAA regulations.

HIPAA is intended to:

- Provide better access to health insurance.
- Limit fraud and abuse.
- Reduce the administrative costs of providing health care.
- Standardize the content and format of electronic health care transactions and promote their use.
- Ensure privacy and security of paper PHI and e-PHI.

Under HIPAA users are to:

- Utilize unique user IDs and passwords for each login.
- Only share PHI with co-workers who have a need to know and the appropriate access.
- Discuss PHI in private areas, not in public areas or in telephone conversations that can be easily overheard by others.
- Keep and protect written and electronic health information from the eyes of others who do not need the information in order to perform their assigned jobs.
- Ensure that casual visitors cannot access areas in which clinical or billing information is kept.
- Know when a person’s PHI can be shared without the person’s permission, and when written or oral permission is required.
- Ensure that all policies and procedures for safeguarding the confidentiality of PHI or other sensitive material are followed.
- Investigate and report to the appropriate Compliance Officer or designee any incident where the acquisition, access, use or disclosure of PHI is in a manner not permitted, or which compromises the security or privacy of PHI.
- Properly dispose of printed PHI and delete e-PHI.
- Access PHI on company owned equipment in secure locations and not in public settings such as malls and libraries.

Users are responsible for the preservation, privacy, and security of data in their possession. While using the application, the user has access to data that contains PHI and must be guarded and disposed of appropriately if downloaded by the user. As covered entities (or vendors operating on behalf of a covered entity), any inappropriate use or disclosure of PHI must be handled as prescribed in the federal regulations above.
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REIMBURSEMENT

Add New Request

Add New Request creates a new reimbursement request for an individual client of a facility. The function is a multi-step process that begins with swiping or entering a client's ID. The system uses the ID to determine the client's eligibility and the provider who will pay the claim. After entering the relevant information for a claim—escort, one way/roundtrip—the client electronically signs the claim and it is submitted for approval by either a supervisor or the facility administrator.

The following information is specified:

- CIN
- Date*
- Access A Ride request
- Escort
- One way or roundtrip
- Cash or Metrocard payment (specified for both if client had an escort)

* The date is always set to the current date and cannot be changed. Requests for dates other than the current date must be submitted through either Batch Mode Entry or File Upload.
**Instructions**

1. Select facility.
2. Swipe the client's card or type the CIN.
3. Click the Next button. The travel entry fields display with the client's information at the top and a system message indicating the paying provider.
4. Select the appropriate values for the travel. Note that a row for Escort displays under Payment Details when selecting Yes for Escort Required.
5. Click Continue. The travel details listing displays.
6. Verify the information is correct. Click Back to change any incorrect entries.
7. Click Manual Issuance or Activate Signature Pad to acknowledge the information.
   a. If selecting Manual Issuance, a comment must be entered and the signature collected by having the client physically sign a sheet of paper.
   b. If selecting Activate Signature Pad, the client must sign the request using the electronic signature pad.

The page refreshes and displays the successful submission message: The request is now pending approval by a supervisor or the facility administrator.

8. Click Add Another Request to create a new request for the selected facility or Select new Location to create request for a different facility.
Approve Requests

Approve Requests provides supervisor and facility administrators with the ability to approve or deny reimbursement requests. The requests may be approved individually or multiple groups. There is also the ability to filter (separate) the requests into various types.

A list of the months containing outstanding requests is displayed under each facility. A supervisor or facility administrator clicks on a month to view and process the individual claims.

The detailed breakdown for a month shows one or more pages of individual requests. For each request has the following fields:

- Client name
- Reimbursement Type
- CIN
- DOB
- Service Date
- Disability/Access-a-Ride
- Roundtrip
- Carfare
- Escort/Age (age is either < 65 or > 65, and is only applicable when Escort = Y)
- Submitter Name
- Request Date

Above the grid is a breakdown of the individual requests types and the number of requests for each type. In addition, the display may be limited to displaying a single type of request by selecting a type from the Filter By drop-down.

Requests can be individually selected using the checkboxes next to each request or all requests can be selected using the Check all function. Clicking either Approve Requests or Disapprove Requests displays the Confirm action page that displays only the selected claim(s) with either the Approve Requests or Disapprove Requests button. After selecting the action, the display updates with a success message and presents the option to return to approvals by location or by month.

Instructions

1. Select month under the appropriate facility. The individual requests for the month display.
2. Select one or more of the displayed requests or use the By Filter function to limit the displayed requests.
3. Click Approve Requests or Disapprove Requests. The confirm action page displays with only the selected requests and the applicable Approve/Disapprove button.
4. Click the Approve or Disapprove button to confirm the action. The action page updates with the action success message and displays the Go Back to Pending Approvals by Month and Locations button.
5. Click the appropriate button to continue processing requests.
Batch Mode Entry

Batch Mode Entry provides the ability to enter up to 25 reimbursement requests in a single submission for a selected facility.

It is essentially the same as doing a series of individual Add New Requests with two major differences:

- All CINs must manually entered. There is no ability to swipe cards.
- The date of service may be any date rather the current date.

The requests are arranged in a 25 row grid with each row having fields for:

- CIN
- Service Date
- Escort Required
- Access-a-Ride
- Round Trip
- Payment Mode
  - Client
  - Escort

![Figure 2: Batch Mode Entry](image-url)
The system processes only rows that contain a CIN. In those rows, all fields must be filled to be valid. Note that the Escort field under Payment Mode is ignored if the Escort Required value is No.

After submission, the function displays the submitted request. The user may continue using the function by either selecting a new facility or adding a new batch mode entry.

Instructions
1. Select the location from the location grid.
2. For each batch entry, fill out all fields. The Escort field under Payment Mode is ignored if Escort Required is set to No.

   **Note:** Selecting the Service Date for the first batch entry defaults all entries to that date. However, the date may be overridden for each succeeding batch entry.

3. Click Save to submit the batch entries. The Request Submitted Successfully page displays.
4. Click Select New Location to submit batch entries for a different location or Add New Request to submit a new set of batch entries for the same location.
Change Facility

Change Facility sets the target facility for functions and reports. The selection is made from a list of the available facilities.

![Figure 4: Change Facility](image)
File Upload

File Upload allows multiple requests to be submitted for a selected location by uploading them in a spreadsheet.

![File Upload](image)

**Figure 5: File Upload**

The system supplies a downloadable template for the submission that can be populated and uploaded, or users may create one from scratch as long as it matches the column layout of the template and is in .xls format. The template has seven columns that match the seven parameters entered when using the Add New Request or Batch Mode Entry functions.

<table>
<thead>
<tr>
<th>Column</th>
<th>Format or value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Date (MM/DD/YYYY)</td>
<td>mm/dd/yyyy</td>
</tr>
<tr>
<td>Medicaid CIN</td>
<td>xxxxxxxxxx</td>
</tr>
<tr>
<td>Escort (Y/N)</td>
<td>Y or N (Yes or No)</td>
</tr>
<tr>
<td>Access-A-Ride (Y/N)</td>
<td>Y or N (Yes or No)</td>
</tr>
<tr>
<td>RoundTrip (Y/N)</td>
<td>Y or N (Yes or No)</td>
</tr>
<tr>
<td>Pay Client (C/M)</td>
<td>C or M (Cash or Metrocard)</td>
</tr>
<tr>
<td>Pay Escort (C/M)</td>
<td>C or M (Cash or Metrocard—Must always be specified)</td>
</tr>
</tbody>
</table>

**Figure 6: File Upload Spreadsheet Template**

Each row in the template is one reimbursement and every entry must be a specific format or value.

For example, a claim on November 18, 2013 for CIN ZZ12345X with no escort, Access-a-Ride, a roundtrip, and a Metrocard for the client would be entered as

![Sample Entry in File Upload Template](image)

**Figure 8: Sample Entry in File Upload Template**

**NOTE**: Even though there is no escort (Escort cell = N), the Pay Escort cell must contain a value.
**Instructions**

*First time usage including template download.*

1. Select the location from the location grid.
2. Click the Template link to download the File Upload spreadsheet template. The web browser prompts to open or save the template.

**Steps 3 and 4 are performed offline in a spreadsheet application.**

3. After opening the template in a spreadsheet application, enter the appropriate values for each claim in a separate row. Refer to the table above for the proper field formats and values.
4. Save the spreadsheet.

**The remaining steps are performed online in the PTAR system.**

5. Click Browse. The Choose File to Upload dialog displays.
6. Navigate to the location containing the updated template.
7. Select the template and click Open. The dialog closes and the upload field displays the selected template.
8. Click Upload File. The file successfully accepted message displays.

*Template populated and ready for upload.*

1. Select the location from the location grid.
2. Click Browse. The Choose File to Upload dialog displays.
3. Navigate to the location containing the populated template.
4. Select the template and click Open. The dialog closes and the upload field displays the selected template.
5. Click Upload File. The file successfully accepted message displays.
Mark Service Month as Complete

Mark Service Month as Complete ends the ability for new reimbursements claims to be added for a selected month. It can be thought of as closing the books for that month.

| Facility Name: | MIS TEST |
| Facility Address: | 15 Metritech, Brooklyn, NY, 11201 |

<table>
<thead>
<tr>
<th>Service Month</th>
<th>Total Claims</th>
<th>Total Claims Amount</th>
<th>Issued Claims / Amount</th>
<th>Denied Claims / Amount</th>
<th>Pending Claims / Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2013</td>
<td>186</td>
<td>$930.09</td>
<td>1 / $5.00</td>
<td>24 / $40.00</td>
<td>151 / $885.00</td>
</tr>
<tr>
<td>November 2013</td>
<td>464</td>
<td>$2,195.00</td>
<td>16 / $85.00</td>
<td>103 / $80.00</td>
<td>349 / $1,890.00</td>
</tr>
<tr>
<td>October 2013</td>
<td>158</td>
<td>$875.09</td>
<td>14 / $105.00</td>
<td>23 / $130.00</td>
<td>121 / $640.00</td>
</tr>
<tr>
<td>August 2013</td>
<td>183</td>
<td>$590.09</td>
<td>14 / $77.50</td>
<td>83 / $82.50</td>
<td>86 / $430.00</td>
</tr>
<tr>
<td>June 2013</td>
<td>69</td>
<td>$160.09</td>
<td>6 / $30.00</td>
<td>49 / $65.00</td>
<td>14 / $70.00</td>
</tr>
<tr>
<td>May 2013</td>
<td>139</td>
<td>$370.85</td>
<td>1 / $2.50</td>
<td>91 / $133.35</td>
<td>47 / $235.00</td>
</tr>
<tr>
<td>April 2013</td>
<td>96</td>
<td>$440.09</td>
<td>1 / $10.00</td>
<td>49 / $122.50</td>
<td>46 / $307.50</td>
</tr>
<tr>
<td>March 2013</td>
<td>333</td>
<td>$1,625.00</td>
<td>2 / $15.00</td>
<td>114 / $366.00</td>
<td>217 / $1,225.00</td>
</tr>
<tr>
<td>February 2013</td>
<td>854</td>
<td>$3,712.10</td>
<td>11 / $63.90</td>
<td>275 / $884.10</td>
<td>518 / $2,765.00</td>
</tr>
<tr>
<td>January 2002</td>
<td>65</td>
<td>$425.00</td>
<td>0 / $0.00</td>
<td>15 / $75.00</td>
<td>70 / $350.00</td>
</tr>
<tr>
<td>January 2001</td>
<td>34</td>
<td>$170.00</td>
<td>0 / $0.00</td>
<td>6 / $39.00</td>
<td>28 / $140.00</td>
</tr>
</tbody>
</table>

Note: * Service Month can not be mark as complete until all Pending Requests are processed and approved.
* Before Closing the Service Month, please make sure all claims for the Service Month are entered in PTAR.

Figure 9: Mark Service Month as Complete

The Mark Service Month as Complete grid displays seven fields:

- Service Month
- Total Claims
- Total Claims Amount
- Issued Claims/Amount
- Denied Claims/Amount
- Pending Claims/Amount

The three claims/amount fields are click-thrus that lead to summary and detailed listings of their respective claim types. The type of claim summary is indicated by the shading under its name.

| Facility Name: | MIS TEST |
| Facility Address: | 15 Metritech, Brooklyn, NY, 11201 |

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Total No. of Claims</th>
<th>Total Amount</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending Facility Approval</td>
<td>148</td>
<td>$870.00</td>
<td>VIEW</td>
</tr>
<tr>
<td>Pending Batch Processing</td>
<td>3</td>
<td>$15.00</td>
<td>VIEW</td>
</tr>
<tr>
<td>Pending Issuance</td>
<td>1</td>
<td>$0.00</td>
<td>VIEW</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Month</th>
<th>Total Claims</th>
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<td>349 / $1,890.00</td>
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<td>69</td>
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<td>0 / $0.00</td>
<td>6 / $39.00</td>
<td>28 / $140.00</td>
</tr>
</tbody>
</table>

Note: * Service Month can not be mark as complete until all Pending Requests are processed and approved.
* Before Closing the Service Month, please make sure all claims for the Service Month are entered in PTAR.

Figure 10: Mark Service Month As Complete Summary View (Pending Claims)
The Mark Service Month as Complete function requires all pending claims to be processed as issued or denied before a month can be closed. As well, care should be taken before using Mark Service Month as Complete to ensure that all claims have been entered because once a month is closed, those claims cannot be processed.

For months that have no pending claims, clicking the Service Month field performs the function and marks that month as complete.
View Reimbursement History

View Reimbursement History presents a month-by-month summary of the reimbursement claims for a facility. Two parameters control the report:

- Calendar year
- Last x months where x = 12, 9, 6 or 3 months

Changing either of the parameters automatically refreshes the page with the selected information.

For each month, two sets of information are presented—Processing and Claims. The status information is a combination of facility administrator and DOH processing milestones:

- Did the Facility Administrator close the Medical Service Month?
- Date Closed
- DOH Medicaid Approved Date
- DOH Finance Processed Date
- Voucher No.

The claims information includes the claim submission type, totals and summaries for issued, denied and pending claims:

- Type
- Total Claims
- Total Claims Amount
- Issued Claims/Amount
- Denied Claims/Amount
- Pending Claims/Amount

Figure 11: View Reimbursement History
The three claims/amount fields are click-thrus that lead to summary and detailed listings of their respective claim types. The type of claim summary is indicated by the shading under its name.

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>MIS TEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Address:</td>
<td>15 Metro tech, Brooklyn, NY, 11291</td>
</tr>
</tbody>
</table>

Please select a Year: 2013  Display Last 6 Months

### December 2013

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Claims</th>
<th>Total Claims Amount</th>
<th>Issued Claims/Amount</th>
<th>Denied Claims/Amount</th>
<th>Pending Claims/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online</td>
<td>170</td>
<td>$930.00</td>
<td>1 / $5.00</td>
<td>19 / $40.00</td>
<td>151 / $385.00</td>
</tr>
</tbody>
</table>

#### Claim Type Details
- Disapproved Claims: 1 / $10.00 (VIEW)
- Incomplete Claims: 16 / $30.00 (VIEW)
- Client Ineligible: 1 / $0.00 (VIEW)

### November 2013

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Claims</th>
<th>Total Claims Amount</th>
<th>Issued Claims/Amount</th>
<th>Denied Claims/Amount</th>
<th>Pending Claims/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online</td>
<td>414</td>
<td>$2.165.00</td>
<td>15 / $85.00</td>
<td>63 / $590.00</td>
<td>345 / $1,990.00</td>
</tr>
</tbody>
</table>

### October 2013

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Claims</th>
<th>Total Claims Amount</th>
<th>Issued Claims/Amount</th>
<th>Denied Claims/Amount</th>
<th>Pending Claims/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online</td>
<td>136</td>
<td>$746.00</td>
<td>14 / $106.00</td>
<td>0 / 50.00</td>
<td>121 / $540.00</td>
</tr>
</tbody>
</table>

### September 2013

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Claims</th>
<th>Total Claims Amount</th>
<th>Issued Claims/Amount</th>
<th>Denied Claims/Amount</th>
<th>Pending Claims/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online</td>
<td>10</td>
<td>$40.00</td>
<td>2 / $10.00</td>
<td>0 / $30.00</td>
<td>0 / $0.00</td>
</tr>
</tbody>
</table>

### August 2013

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Claims</th>
<th>Total Claims Amount</th>
<th>Issued Claims/Amount</th>
<th>Denied Claims/Amount</th>
<th>Pending Claims/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online</td>
<td>141</td>
<td>$586.00</td>
<td>14 / $57.50</td>
<td>41 / $72.50</td>
<td>66 / $42.00</td>
</tr>
</tbody>
</table>

### July 2013

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Claims</th>
<th>Total Claims Amount</th>
<th>Issued Claims/Amount</th>
<th>Denied Claims/Amount</th>
<th>Pending Claims/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online</td>
<td>59</td>
<td>$196.00</td>
<td>17 / $107.50</td>
<td>41 / $72.50</td>
<td>0 / $0.00</td>
</tr>
</tbody>
</table>

**Legend:**
- *Pending Processing By DOH / Batch Mode is not included in the Total Claims and Total Claims Amount

**Figure 12: View Reimbursement History Single Summary View (Denied Claims)**
Multiple months can display summaries including showing different claim types.

![Figure 13: View Reimbursement History Showing Multiple Summary Views](image)

Clicking VIEW for a claim type displays the detail view of its individual claims.

![Figure 14: View Reimbursement History Detail View (Issued Claims)](image)
For large individual claim listings, the Filter By fields—CIN, Medical Service Date, and Request Type can limit the number of displayed claims. The filters can be specified individually (e.g., all claims on a particular date) or combined (e.g., Incomplete claims on a particular date).

![Figure 15: View Reimbursement Filter By Fields](image)

A 14 claim listing

![Figure 16: View Reimbursement Claims Detail Listing (Unfiltered)](image)
can be filtered to a three claim listing. In this case, Medical Service Date is the filter.

Figure 17: View Reimbursement Claims Detail Listing (Filtered by Medical Service Date)

**Instructions**

1. Select the calendar year from the Year drop-down. The Reimbursement History grid updates to the selected year.
2. Select the number of months to display. The grid updates to display the selected number of months.
3. Click the applicable claims/amount field for a month to display the claims by type summary. This may be repeated for different months simultaneously.
4. Click VIEW for a claim type to view the individual claims for that type.
5. Optionally use one or more of the fields in the Filter By section to limit the claims shown.
REPORTS

Hospital Expense Report
The Hospital Expense report provides summary and detail views of hospital expense claims for a facility.

The initial summary view displays the total number and dollar amount of claims for every month on record. The view stretches over multiple pages beginning with the most recent month.

The two summary two fields:

- Total Hospital Expense Reimbursement
- Total Amount

present the number of the claims and total amount for each month.

Figure 18: Hospital Expense Report
The View PDF button displays the complete set of individual hospital expense claims for a selected month. The reports are PDFs showing each individual expense incurred in a given month.

1. Click the View PDF button for a month to view its individual hospital expense claims. The report PDF displays.
2. Print and/or save the PDF.
Issuance Details Report

The Issuance Details report lists the individual claims issued for a period of up to 31 days. The claims may be viewed as a complete listing of every claim for the period, or broken down by one or more of the Group, Location and Issued by (PTAR user or role) parameters.

The report has three sections:

- **Report Parameters**—Date range, group, location and issued by
- **Issuance Summary**—summary of the issued claims
- **Date**—detailed listing by date of the individual claims

The Issuance Details report has many options for viewing issued claims for a selected period:

- All claims
- All claims for a specific facility
- All claims for a specific location
- All claims issued by a specific user or a user role (Data Entry, Cashier, Supervisor, Facility Administrator)
- Any combination of facility, location and user or user role

One thing to keep in mind is that because the output is a PDF, reports can be stored for offline use. It may be worthwhile to create a folder structure on a drive or utilize a document repository to hold a set of reports that are produced on a regular schedule.
**Instructions**

1. Set the Start Date and the End Date using their respective calendar controls. The maximum range is 31 days.
2. Select the group from the Group drop-down or use the ALL default.
3. Select the location from the Location drop-down or use the ALL default.
4. Select the user or role from the Issued By drop-down or use the ALL default.
5. Click Submit to generate the report based on the selected parameters. The report PDF displays.
**Issuance Summary Report**

The Issuance Summary report lists a summary of the claims issued on either a by date or by group basis for a period of up to 31 days. The claims may be viewed as a complete summary of every claim for the period, or a summary of the claims broken down by one or more of the Group, Location and Issued by (PTAR user or role) parameters.

The report has three sections, two of which are the same for the by date and by group options

- **Report Parameters**—Date range, group, location and issued by
- **Issuance Summary**—summary of the issued claims

The third section varies based on the By Dates or By Group option

- **By Dates**—claims broken down by the issuance summary types

---

### ISSUANCE SUMMARY REPORT

**Print Date:** 12/1/2013

<table>
<thead>
<tr>
<th>MIS TEST</th>
<th>15 Metrotech Brooklyn, NY 11201</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date:</td>
<td>11/20/2013</td>
</tr>
<tr>
<td>End Date:</td>
<td>12/01/2013</td>
</tr>
<tr>
<td>Group Name:</td>
<td>ALL</td>
</tr>
<tr>
<td>Location Name:</td>
<td>ALL</td>
</tr>
<tr>
<td>Issued By:</td>
<td>ALL</td>
</tr>
<tr>
<td>Report Type:</td>
<td>Totals By Date</td>
</tr>
</tbody>
</table>

#### ISSUANCE SUMMARY:

<table>
<thead>
<tr>
<th></th>
<th>Metrocard Total / Amount</th>
<th>Cash Total / Amount</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid (Fee-For-Service) Issuances</td>
<td>$5.00</td>
<td>$0.00</td>
<td>$5.00</td>
</tr>
<tr>
<td>Total Hospital Expense Issuances</td>
<td>$40.00</td>
<td>$0.00</td>
<td>$40.00</td>
</tr>
<tr>
<td>Total</td>
<td>$45.00</td>
<td>$0.00</td>
<td>$45.00</td>
</tr>
</tbody>
</table>

**DATE:** 11/20/2013

**Group Name:** MIS Group 1

**Location Name:** MIS LOCATION 1

Total Medicaid (Fee-For-Service) Issuances:

- Number of Cards $5.00: 1
- Total Metrocards / Amount: 1
- Total: 1

Total Hospital Expense Issuances:

- Number of Cards $5.00: 2
- Total Metrocards / Amount: 2
- Total: 2

**DATE:** 11/21/2013

**Group Name:** MIS Group 1

**Location Name:** MIS TEST 2

Total Hospital Expense Issuances:

- Number of Cards $5.00: 4
- Total Metrocards / Amount: 4
- Total: 4

---

Figure 20: Issuance Summary Report by Date
• **By Group**— summary of the types

#### ISSUANCE SUMMARY REPORT

**Print Date: 12/10/2013**

**MIS TEST**

15 Metrotech Brooklyn, NY 11201

<table>
<thead>
<tr>
<th>Start Date:</th>
<th>11/20/2013</th>
<th>End Date:</th>
<th>12/01/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Name:</td>
<td>ALL</td>
<td>Location Name:</td>
<td>ALL</td>
</tr>
<tr>
<td>Issued By:</td>
<td>ALL</td>
<td>Report Type:</td>
<td>Totals By Group</td>
</tr>
</tbody>
</table>

**ISSUANCE SUMMARY:**

<table>
<thead>
<tr>
<th>Metrocard Total Amount</th>
<th>Cash Total Amount</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid (Fee-For-Service) Issuances:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Cards @$6.00</td>
<td>2</td>
<td>$12.00</td>
</tr>
<tr>
<td>Total Metrocards / Amount:</td>
<td>2</td>
<td>$12.00</td>
</tr>
<tr>
<td>Total:</td>
<td>2</td>
<td>$12.00</td>
</tr>
<tr>
<td>Total Hospital Expense Issuances:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Cards @$4.00</td>
<td>5</td>
<td>$20.00</td>
</tr>
<tr>
<td>Total Metrocards / Amount:</td>
<td>5</td>
<td>$20.00</td>
</tr>
<tr>
<td>Total:</td>
<td>5</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

**Group Name: MIS Group 1**

**Location Name: MIS LOCATION 1**

Total Hospital Expense Issuances:

<table>
<thead>
<tr>
<th>Metrocard Total Amount</th>
<th>Cash Total Amount</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid (Fee-For-Service) Issuances:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Cards @$6.00</td>
<td>1</td>
<td>$6.00</td>
</tr>
<tr>
<td>Total Metrocards / Amount:</td>
<td>1</td>
<td>$6.00</td>
</tr>
<tr>
<td>Total:</td>
<td>1</td>
<td>$6.00</td>
</tr>
</tbody>
</table>

**Location Name: MIS LOCATION 1**

Total For Location MIS LOCATION 1: Metrocard Amount: $15.00  Cash Amount: $0.00  Total(s): 3

**Location Name: MIS TEST 2**

Total Hospital Expense Issuances:

<table>
<thead>
<tr>
<th>Metrocard Total Amount</th>
<th>Cash Total Amount</th>
<th>Total Amount</th>
</tr>
</thead>
</table>
| Total For Location MIS TEST 2: Metrocard Amount: $20.00  Cash Amount: $0.00  Total(s): 6

**Total for Group MIS Group 1**

<table>
<thead>
<tr>
<th>Metrocard Total Amount</th>
<th>Cash Total Amount</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total:</td>
<td>3</td>
<td>$38.00</td>
</tr>
</tbody>
</table>

---

**Figure 21: Issuance Summary Report by Group**

The Issuance Summary report has many options for viewing issued claims for a selected period:

- All claims
- All claims for a specific facility
- All claims for a specific location
- All claims issued by a specific user or a user role (Data Entry, Cashier, Supervisor, Facility Administrator)
- Any combination of facility, location and user or user role

One thing to keep in mind is that because the output is a PDF, reports can be stored for offline use. It may be worthwhile to create a folder structure on a drive or utilize a document repository to hold a set of reports that are produced on a regular schedule.

**Instructions**

1. Set the Start Date and the End Date using their respective calendar controls. The maximum range is 31 days.
2. Select the group from the Group drop-down or use the ALL default.
3. Select the location from the Location drop-down or use the ALL default.
4. Select the user or role from the Issued By drop-down or use the ALL default.
5. Select the By Date or By Group option.
6. Click Submit to generate the report based on the selected parameters. The report PDF displays.
Managed Care Invoice
Managed Care Invoice is a combination report and invoice producer for claims involving managed care providers. The claims may be viewed on a facility or group basis. The invoices are PDFs that can be printed and sent to providers.

The report presents the number of claims and amount totals for each month having managed care claims. Selecting a month and the report type displays a summary of the claims based on the report type—facility or group.

The facility report type lists the claims and total amounts for each associated managed care provider.

![Managed Care Invoice Facility Report](image)

**Figure 22: Managed Care Invoice Facility Report**

The group report type lists the groups that have associated managed care providers. Click the plus icon to the left displays the managed care providers. At that point, the report types converge.

![Managed Care Invoice Group Report](image)

**Figure 23: Managed Care Invoice Group Report**
The View PDF function for each provider generates the invoice for the managed care claims.

**Figure 24: Managed Care Invoice**

**Instructions**

1. Select the month from the Managed Care Invoice grid.
2. Select the report type.
3. Click View Details. The facility or group report displays.
4. For a group report, click the + icon to the left of the group to display its managed care providers; for a facility report, the providers are immediately displayed.
5. Click the View PDF button to view the invoice for the selected managed care provider.
6. Print or save the PDF in preparation for sending to the managed care provider.
## Cashier's Issuance

<table>
<thead>
<tr>
<th>Cashier Issuance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name: MIS TEST</td>
</tr>
<tr>
<td>Facility Address: 15 Metrotech, Brooklyn, NY, 11201</td>
</tr>
</tbody>
</table>

### No Reimbursement Issued

<table>
<thead>
<tr>
<th>Select a Date Range:</th>
<th>Start Date:</th>
<th>End Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Location:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Submit  Clear
**Usage Report**

The Usage report lists the individual Issued, Denied or Pending claims for a period of up to 31 days. The claims may be viewed as a complete listing of every claim for the period, or broken down by one or more of the Group, Location, and Staff (PTAR user or role) parameters.

![Figure 25: Usage Report](image)

The Usage report has many options for viewing issued claims for a selected period:

- All claims
- All claims for a specific group
- All claims for a specific location
- All claims for a staff member
- Any combination of group, location and staff

**Instructions**

1. Set the Start Date and the End Date using their respective calendar controls. The maximum range is 31 days.
2. Select the group from the Group drop-down or use the ALL default.
3. Select the location from the Location drop-down or use the ALL default.
4. Select the user or role from the Staff drop-down or use the ALL default.
5. Select Issued, Denied or Pending from the Request/Claims drop-down.
6. Click Submit to generate the report based on the selected parameters. The report PDF displays.
SETTINGS

Update User Settings

Update User Settings contains personal and security information for users. It is the initial page that all users encounter in order to create a permanent password and set up the three required security questions. The information may be updated at any time.

Instructions

Update password.

1. Enter the updated password in New Password. The password must conform to the minimum requirements listed on the page.
2. Enter the updated password in Confirm Password.
3. Click Submit.

Update security question(s).

1. Select a new security question from the applicable drop-down.
2. Enter the answer in the corresponding Security Answer field.
3. Click Submit.