Real Time Adjudication (RTA)
Overview

The RTA feature helps simplify and enhance the efficiency of the claim submission process by providing the ability to receive preliminary payment information from the payer at the time of visit or charge entry. This will help identify if a claim will be accepted or denied, the amount the payer will be paying, the patient’s coinsurance and more, making it easy to track and work claims efficiently.

This process is first implemented for United Healthcare and additional payers will be added in the future.

Overview of the current process for claims submission:

1. Visits/Charges are entered into CareTracker
2. Scrubbed by ClaimsManager for edits
3. Visits/Charges placed on Hold for any ClaimsManager edits
4. Visits/Charges on Hold are fixed
5. Charge Batch(es) are posted
6. Claims Generated
7. Claims Submitted to the payer

With the RTA feature, you can by-pass the time required for posting batches and generating of claims, and receive an instant response on payment information when a visit or charge is entered. This will help the office staff identify the amount the payer will pay, identify portions that are co-payments or deductibles, and collect the portion the patient is responsible for at the time of the office visit.

The RTA feature will be set up by payer and it can be set up by each CareTracker group (for multi-group practices). If RTA is active for a group, the RTA button will display when the user saves a visit or a charge. If the specific plan is not eligible, then the RTA button will be disabled and the user will not be able to select it as an option.

The RTA feature is available via the Visit and the Charges application.

It is very important to have a batch open before using the RTA feature. This helps identify transactions linked to the batch, date of each transaction and the operator who entered it into the system.
Creating a Batch

1. Click **Batch** on the Name Bar. The Operator Encounter Batch Control dialog box displays.

2. Click **Create Batch**. The Batch Master dialog box displays.

![Figure: Operator Encounter Batch Control](image)

3. By default, the **Batch Name** box displays a batch identification name. The name consists of your user name followed by the current date. However, you can edit the batch name if necessary to identify the types of financial transactions associated with the batch. For example, "copayment5132008." Do not use symbols when editing the name.

   **Setting up a batch helps identify a group of charges or payments and helps run reports to balance against the actual charges or payments entered. It is highly recommended that each person entering a financial transaction into CareTracker create a batch on a daily basis for audit and tracking purposes. You can also share a batch with co-workers or set up password overrides to prevent sharing a batch with others.**

   To set up and activate password overrides, log a To Do to the Support Department.

4. By default, the **Group Id** displays the name of your group.

5. By default, the **Primary Operator Id** displays your user name.

6. In the **Fiscal Period** list, click the period to post financial transactions. The list only displays fiscal periods that are currently open.

   **To open a fiscal period, click the Admin module and then click the Open/Close Period link under the A/R section.**

7. By default, the **Fiscal Year** displays the current financial year set up for your company.

   **Entering information for steps 8 through 11 helps to ensure that you post all payments and/or charges into CareTracker correctly and prevents from posting a batch until the monies match the data entered.**
8. (Optional) In the **Hash Patient Ids** box, enter the sum of all patient CareTracker ID numbers pertaining to the charges associated with the batch. This is to ensure that a charge is entered for all patients.

9. (Optional) In the **Hash Cpt** box, enter the sum of all CPT codes pertaining to the charges associated with the batch. This is to ensure that a charge is entered for all procedures.

10. (Optional) In the **Total Chgs** box, enter the sum of all charges that are associated with the batch.

11. (Optional) In the **Total Pmts** box, enter the sum of check(s) that are associated with the batch.

12. (Optional) In the **Batch Deposit** list, select the deposit ID to link to a deposit number, if using the Batch Deposit application.

![Batch Master](image)

**Figure: Batch Master**

13. Click **Save**. The Edit-Operator Batch Encounter Control dialog box displays with the new batch information.

   **If more than one fiscal period is open, a message prompts alerting you to ensure that the correct period is set for the batch.**

   **It is important to set up a Hold Batch Control in order to separate held charges from other charges that you can post. It is highly recommended to create ONLY ONE hold batch for the practice. The Hold Control Batch does not display in the Open Batches application, and hence, it is never posted. If a Hold Batch Control is not set up when a charge is put on hold, CareTracker automatically creates a hold batch enabling you to post held charges.**
To Create a Hold Batch Control:

I. Click **Add** next to the **Hold Batch Control** list. The Hold Batch Master dialog box displays.

II. By default, the **Batch Name** box displays an identification name for the batch. The name contains the operator name, create date of the hold batch and the term "HOLD". Enter a different name if necessary.

III. By default, the **Group Id** list displays the name of the group you are working.

IV. By default, the **Primary Operator Id** displays your user name. Select a different name from the list if necessary.

V. Click **Save**.

Setting up the provider, location, and transaction and service dates for a batch, automatically fills in the information when a charge is entered into CareTracker via the **Transactions** module. This makes the data entry process much more efficient and avoids redundant data entry. However, you can edit the information if necessary. In addition, the **Scheduling** module and the **Clinical Today** module displays information based on information set up in the **Resource** list. The Dashboard information is based on both the provider and resource set up in the batch. For example, the Admissions and To Do(s) application is based on the provider and the Appointments application is based on the resource.

14. In the **Provider** list, select the name of the billing provider associated with the batch.
The Admissions application accessed via the Dashboard and the Charges application in the Transactions module displays information based on the provider set up in the batch.

15. In the **Resource** list, select the servicing provider. In most instances, the billing provider and the resource is the same.

The Book application in the **Scheduling** module and the Appointment application in the **Clinical Today** module displays information based on the resource set up in the batch.

16. In the **Location** list, select the location associated with the batch.

The Admissions application accessed via the Dashboard and the Book application in the **Scheduling** module displays information based on the location set up in the batch.

17. By default, the **All Groups Default** list is set to **No**. Change the list to **Yes** if necessary. This displays patient financial information for the current group or all groups in the practice based on the setting selected. If **Yes** is clicked, you can only see the financial transactions for the groups that you have access to as an operator. This setting mostly benefits multi-group practices and also determines the default value in the Open Items application of the **Financial** module and Edit application of the **Transactions** module.

18. By default, the **Default Referral to Billing Provider** list is set to **No**. Change the list to **Yes** if there is no referring provider in the patient's demographics or if there is no active referral/authorization for the patient. This sets the billing provider as the referring provider and is important when primary care practices submit claims to Medicare. Medicare requires a referring provider on all claims.

19. By default, the **Show Alerts** list is set to **No**. Change the list to **Yes** if necessary. This determines the display of patient alerts associated with a patient when the patient is in context.

All Administrative, Front Office and Billing staff are highly recommended to set this field to **Yes**.

20. Enter the corresponding dates in the specific boxes in MM/DD/YYYY format or click to select the required date. The dates selected will default in the corresponding applications.

21. By default, the **Show Operator Name** list is set to **Yes**. Change the list to **No** if necessary. This setting determines if to display your operator name on the Name Bar when working in CareTracker.

22. Click **Save**. The batch information is saved.

24. Click **X** on the right hand corner to close the dialog box.
RTA via Visits

It is very important to have a batch open before using the RTA feature. This helps identify transactions linked to the batch, date of each transaction and the operator who entered it into the system.

1. Access the Visit application. The Visit application is accessible via the Scheduling or Clinical Today module.

2. Enter the CPT and ICD-9 codes and other information that pertain to the patient visit and click the Save tab.

3. If the Insurance Plan is entered in the patient’s demographics is eligible for RTA checks, the RTA button will be enabled for you to click.

The visit information entered will be scrubbed against ClaimsManager edits. Visits with ClaimsManager edits can be corrected, or held as a “Visit on Hold” to fix and submit later. Clean visits will be saved as a charge, moved from the service batch to the RTA batch and the claim will be created to be sent to the payer.

The RTA batch is created by the system in order to post the claim in real time. This avoids the delay of a claim being processed when the specific batch is not posted.
<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>MOD</th>
<th>ICD9</th>
<th>Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>427.9</td>
<td></td>
<td>Mnemonic: DLP. The claim line is a possible duplicate of Claim ID [173900006], Ext/Int Line ID [298029371], by the same Provider.</td>
</tr>
<tr>
<td>99213</td>
<td>427.9</td>
<td></td>
<td>Mnemonic: HCP. Procedure Code 99213 on this line will cause the typically allowed daily frequency of 1 to be exceeded by 2 for date of service 20090401.</td>
</tr>
</tbody>
</table>

Figure: ClaimsManager Edits
RTA via Charges

It is very important to have a batch open before using the RTA feature. This helps identify transactions linked to the batch, date of each transaction and the operator who entered it into the system.

1. Access the Charge application by clicking Transaction module.
2. Enter the CPT and ICD-9 codes and other information that pertain to the patient visit and click the RTA. If the Insurance Plan is entered in the patient’s demographics is eligible for RTA checks, the RTA button will be enabled for you to click.

The charge information entered will be scrubbed against ClaimsManager edits. Visits with ClaimsManager edits can be corrected, or held as a Visit on Hold to fix and submit later. Clean visits will be saved as a charge, moved from the service batch to the RTA batch and the claim will be created to be sent to the payer.
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**Figure: ClaimsManager Edits**
Claim Process for RTA

Once a claim is submitted it can result in one of the following scenarios:

- If a claim results in an error during the submission process, it will indicate as being ineligible for RTA. Click Print to print the message if necessary.

- If the claim is identified as being eligible for RTA, but not paid, it would still be considered processed by the payer, and an acknowledgement will be sent so that you do not have to submit the claim.

- If the claim is denied, the denial reason will be sent via an electronic response. You must proceed with the existing denial/resubmittal process and post the denial. You can click Yes to post the denial or No to flag the claim as “Set to Deny” and move to the Claimswork list on the Dashboard to avoid posting the denial. Clicking Yes will automatically post the denial reason to the claim and be moved to the Denials application on the Dashboard until it is paid or adjusted. Denied claims cannot be resubmitted via RTA as it will be recognized as a duplicate claim and be denied again.

If reviewing all activity pertaining to a denied claim via the OI application, the batch will indicate R in front enabling you to quickly identify transactions that are RTA related.

- If the claim is eligible for RTA, a preliminary response will be returned by the payer. The results will be returned and displayed in a dialog box to you, real-time, after the charge is sent. This will include information such as coinsurance, patient responsibility and more.
Figure: Adjudication

Once the response is returned, if there is a patient responsible portion, you can do one of the following:

- Click **Statement Message** to add a message to the patient statement about the responsible portion. The Electronic Remittance Statement Message dialog box displays enabling you to select the message to attach to the statement.

  ![](Electronic Remittance Statement Message Default.png)

  **Figure: Electronic Remittance Statement Message**

- Click **No** to cancel the transfer and exit the transaction.

- Click **Yes** to transfer the amount to private pay or the patient’s other insurance and post the payment. If the patient does have additional insurances, a message prompts to confirm the transfer action. Once action confirmed and if transferring to private pay click **Yes** next to Take Payment. The RTA Payment Transfer dialog box displays enabling you to select the payment type, confirm the reference number, transaction date and payment amounts prior to clicking **Submit**.

  ![](RTA Payment Transfer.png)

  **Figure: RTA Payment Transfer**

  A message will display the status of the transaction enabling you to print the screen if necessary.
Table displaying payment transfer message details:

<table>
<thead>
<tr>
<th>Service Date</th>
<th>CPT</th>
<th>Charge</th>
<th>Allow</th>
<th>Payment</th>
<th>Adm</th>
<th>Ded</th>
<th>Co-Pay</th>
<th>Deductible</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2008</td>
<td>97124</td>
<td>105.00</td>
<td>105.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>Non-Covered charge (105.00) - 95</td>
</tr>
<tr>
<td>7/1/2008</td>
<td>99231</td>
<td>113.70</td>
<td>61.70</td>
<td>0.00</td>
<td>33.30</td>
<td>50.70</td>
<td>0.00</td>
<td>0.00</td>
<td>Deductible Amount (50.70) - 1</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>218.70</td>
<td>166.70</td>
<td>0.00</td>
<td>33.30</td>
<td>50.70</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

- Total Patient Responsibility: $50.70
- Previously transferred to patient: $0.00
- Remaining transfer to patient: $50.70
- Additional Insurance: United Healthcare PPO/POS/EPO, Lighthouse

The transfer of $50.70 to Private Pay was successful.

Payment Due: $61.30
Payment Taken: $112.00 (Cash/Check)

Total Payment Taken: $112.00

Figure: Payment Transfer Message