

# Release 15.20.0 - October 13, 2025

Updated Modified on 10/10/2025 1:42 pm EDT

## New features | Enhancements

### Highlights

New Features	Enhancements
New Payment Automations	Remove All Option for Claim/Patient Not Found
New Statement Automation Option to Send Based on Days Since Last Seen	ERA Errors
New Admitting Diagnosis Default	Refund Reversals Removed from Statements
	New Automatic TCN Prefix (For ERA Splits)

### New features

#### New Payment Automations Feature

In this release, we added an exciting feature that allows users to build powerful custom automations to prevent manual work for ERAs. They can be configured to perform actions automatically based on the remittance codes received from the payer. These automations replace our existing "Remittance Actions" and significantly enhance the feature by expanding the criteria that payment automations can detect and improving the actions that automation rules can perform.

Our new Payment automations allow you to automatically mark payments as denials and move adjustments so they do not affect the balance. You can also create your own rules and criteria for moving adjustments, control how adjustments are applied, set specific status buckets where claims need to go, or even create and assign automatic tasks based on a remittance code.

Please note that this feature is available to all customers that use our ERA feature. Visit our [Payment Automations Demo](#) for an interactive, step-by-step demonstration on its use, or refer to our [Payment Automations Help Articles](#) for more information.

Find a Section	Payment Automations					
Home	<a href="#">Edit</a> <a href="#">+ New Automation</a> <input type="checkbox"/> Show inactive automations					
Reports	Name	Remittance Codes	Adjustment Method	Processing	Additional Actions	Created By
Appointments	109 - CO - Contractual Obligation	109	Don't apply	Process the payment as a total denial		Collaboration
Patient	QA218 - Automobile Medical	QA218	Apply according to the payer's instructions	Forward to the next insurance		Collaboration
Claim	100 - Medicaid	100	Apply according to the payer's instructions	Write off the charge's remaining balance		Collaboration
Payment	23 - Forward Converted Remittance Action	23	Apply according to the payer's instructions	Write off the charge's remaining balance		Collaboration
Documents	N545 - Forward Converted Remittance Action	N545	Apply according to the payer's instructions	Set a specific status		Collaboration
Interface	N545 - Commercial Insurance Company	N545	Apply according to the payer's instructions	Set a specific status		Collaboration
Customer Setup	197 - Forward Converted Remittance Action	197	Don't apply	Process the payment as a total denial		Collaboration
Practices	16 - CO - Contractual Obligation	16	Don't apply	Process the payment as a total denial		Collaboration
Providers	N545 Medicare	N545	Apply according to the payer's instructions	Set a specific status	<ul style="list-style-type: none"> <li>Assign Task to joetest1</li> </ul>	Collaboration
Facilities	Apply As Adjustment	142, 227, 274	Apply as an insurance adjustment	Write off the charge's remaining balance		Collaboration
Referring Providers	Deny claims with denial remittance codes	10, 107, 108 ... +160 more	Apply as an unpaid amount (due patient/next insurance)	Process the payment as a partial denial		Collaboration
Payers	Forward claims based on remittance code	MA07, MA18, N367 ... +1 more	Apply according to the payer's instructions	Forward to the next insurance		Collaboration
Payer Agreements	Do not apply secondary adjustments	1, 100, 101 ... +128 more	Don't apply	Process according to the payer's instructions	<ul style="list-style-type: none"> <li>Add Issue: Adjustments from the secondary payer were not applied.</li> </ul>	Collaboration
Collection Agencies	Default Automation	All Remittance Codes	Apply according to the payer's instructions	Process according to the payer's instructions		Collaboration
Codes...						
Alert Control						
Statements						
Superbills						
Labels						
Customization...						
Settings						
Account Administration						

## New Statement Automation Option to Send Based on Days Since Last Seen

For some institutional claim workflows, a patient may be admitted to the hospital for a period during which the provider sends multiple "interim" claims while the patient is still admitted. These claims may be paid in part or in full, but the patient's account may still show a "Balance Due Patient" even before discharge. Many practices and hospitals prefer not to send statements until after a patient has been discharged.

In this release, we added a new option to Statement Automation to restrict patient statements until a specified number of days have passed since the patient's last visit. This setting, located under "Statement Options," allows users to set a hold on statements for 1 to 99 days based on the patient's last visit date. This new option is turned off by default and is included with our Statement Automation feature. For more information on enabling this feature visit our [Statement Options Help Article](#).

## Statement Automation Settings

✓ Save

✕ Cancel

🕒 Show History

Enable automated statement generation for the following:

- ☒ Statements
- ☒ Final Demand Notices (FDN)
- ☒ Payment Plans

*Automated statements are sent to the printing company at 5:30 AM ET.*

### Statements and FDNs

Send statements electronically?

☒ Yes ☐ No

Send statements on paper after the maximum number of electronic statements have been sent?

- ☒ Yes. Send the first statement  days after the last electronic statement was sent, or immediately if electronic statements cannot be sent. [?](#)
- ☐ No. Patients who can't receive electronic statements [?](#) will not receive statements automatically.

### Statement Options

#### Electronic Statements

#### Paper Statements

Minimum amount required for sending Statements and FDNs:

☐ Wait to send statements until  days since the patient's last visit. [?](#)

Automatically send FDN to patient after the maximum number of statements (both electronic and paper) have been sent?

☐ Yes ☒ No

Prevent statements from being sent to patients with any outstanding account credit(s) set to due insurance?

☒ Yes ☐ No

## Jew Admitting Diagnosis Default

We previously added a new "Institutional" Default Codes tab within the patient's Claim Defaults section, allowing users to set default Principal Diagnosis, POA, Other Diagnosis, CPT Codes, or Value Codes to be added to any new institutional claim for the patient. We then added the admitting diagnosis default in release 15.18 but immediately reverted it to fix a bug. In this release, we re-launching the "Admitting Diagnosis" as a patient claim default for institutional claims. When the default admitting diagnosis is set and the user has enabled the claim setting to "automatically apply the patient's default diagnosis codes on new claims," the admitting diagnosis will automatically be set on new claims created for that patient. For more information on default codes, visit our [Configure Patient Claim Defaults Help Article](#).

The screenshot shows a medical software interface for a patient named JOHNNY TEST. The interface includes a sidebar with navigation options like Home, Reports, Appointments, Patient, Manage Account, Payment Plans, A/R Control, Batch Eligibility, Statement Batch Print, Statement Tracker, Label Batch Print, Communications..., Settings, Claim, Payment, Documents, Interface, Customer Setup, and Account Administration. The main area displays patient information (Last Name: TEST, First Name: JOHNNY, Gender: Male, Date of Birth: 01/16/1982, SSN: 581-55-8885) and tabs for Patient Info, Insurance Info, Billing Info, and Claim Defaults. Under the Claim Defaults tab, there are sections for Default Codes, Professional, and Institutional. The Professional section has a Principal Diagnosis and an Admitting Diagnosis field. The Institutional section has an Admitting Diagnosis field. Red circles highlight the Admitting Diagnosis input fields in both the Professional and Institutional tabs.

## Enhancements

### Remove All Option for Claim/Patient Not Found ERA Errors

When posting ERAs, particularly for new customers, the ERA may have a large number of "Claim Not Found" issues if the ERA has claims that were sent from different systems. Some of these ERAs are huge, meaning that it can take an hour just to mark all of these payments as removed.

In this release, we added a **"Remove All"** option next to the "Unresolved Errors" displayed at the top of the ERA screen. When unresolved errors of the type "the claim or patient for this payment was not found" are present, the system will display the "Remove All" button. Clicking this button will remove all such errors simultaneously instead of having to remove them one by one. Please note that this option will only be visible if two or more of these errors ("the claim or patient for this payment was not found") exist. All other error types must be resolved individually. Visit our [ERA Errors, Warnings, Informational Messages & Alerts](#) Help Article for more information on errors and warnings.

Remove All

## Refund Reversals Removed from Statements

Whenever an insurance adjudicates a claim multiple times (e.g., paying, adjusting, and then issuing a refund/reversal), it creates a longer, confusing statement for patients. To enhance the patient experience and reduce clutter, we are removing all refunds/reversals from enhanced, automated, and electronic statements (payment portal). The system will now automatically detect reversed payments and adjustments. When this occurs, the original payment and adjustment, along with any associated information lines, will be excluded from the statement.

## New Automatic TCN Prefix (For ERA Splits)

Previously, the TCN Prefix field in the Practice section was used by ePS when an ERA Split was necessary. This was not ideal because a Practice can be associated with multiple Providers (and therefore multiple submitters), which required significant extra work (e.g., creating multiple practices) and could lead to error

In this release, we added a new "TCN Prefix" field within the "Internal Use" area of the "Provider" section. This field will show the Practice TCN Prefix (if one exists), otherwise, a system-generated prefix will be created. We will automatically send this submitter-specific TCN prefix for submitters who lack a Practice-level TCN Prefix when an ERA split is required. This means that when entering an ERA split, ePS will look up that submitter in CMD and copy the TCN Prefix. The system-generated prefix will be consistent for all providers sharing the same Submitter ID.

Find a Section

- Home
- Reports
- Appointments
- Patient
- Claim
- Payment
- Documents
- Interface
- Customer Setup
  - Practices
  - Providers
  - Facilities
  - Referring Providers
  - Payers
  - Payer Agreements
  - Collection Agencies
  - Codes...
  - Alert Control
  - Statements
  - Superbills
  - Labels
  - Customization...
  - Settings

Save Close Configure Eligibility Register Submitter Show History

Bill claims under  
SELF

Check eligibility under  
ABDUL, SAMANTHA L (10009890)

Use which ID number? Social Security # (SSN)  
Social Security# (SSN) 555-55-5555 Change

Bill as  
Individual

☒ Bill professional claims (CMS-1500) TEST

☒ Bill institutional claims (CMS-1450) TEST

Internal Use

Submitter #

Submitter Request has NOT been sent electronically for this provider.  
Clearinghouse: eProvider Solutions  
ePS Registration Date: Mar 11, 2021

TCN Prefix

☐ Use Submitter's TCN Prefix in an ePS ERA split  
(the Practice TCN Prefix will not be used)

Contact Information

Home Phone Cell Phone

Fax # Pager #

## Display Follow Up Note Count on Claim Side-Tab Header

We added a "Follow-Up Note Count" indicator to the side-tab header within the claim's "Follow-Up Activity" side panel. This indicator mirrors the existing functionality on the top-level side-tab header for Patient Notes, "Tasks," and "Alerts" when viewing a claim.

- Claim Summary
- Estimate
- Patient Notes
- Follow Up Activity 2
- Alerts
- Tasks
- Documents
- Payment