

# 2026 Release Notes

Modified on 06/22/2026 10:03 am EDT

## Release 16.11.0 - June 8, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

#### New Features

Bulk Claim Status Updates Now Available in Follow Up Management  
Ability To Search Multiple Statuses At Once From Claim Control

#### Enhancements

Statement Batch Printing By Last Seen Date  
Improved Eligibility Labeling  
New Interface Setting To Use CMDs Situational & Default Modifiers  
Taxonomy Specialty Can Now Be Overridden Independently in Payer Records

## New features

### Bulk Claim Status Updates Now Available in Follow Up Management

Previously, when managing claims from the "Follow-up Management" screen, bulk actions were limited to adding notes and setting follow-up dates. The next logical step would be to allow users to update claim statuses in bulk when adding notes or adjusting follow-up dates after contacting a payer.

In this release, we added a new "Update Status" button to the follow up management table that allows you to change the claim status for all selected claims in a single action – making it easier to keep your workflow moving after contacting a payer.

Alerts	Claim #	Balance	Patient Name	DOS	Last Note	Claim Follow Up Date	Current Payer
<input type="checkbox"/>	284263949	\$208.00	HILDBRAND, MANDERVILLE	12/26/2025		05/13/2026	AETNA
<input checked="" type="checkbox"/>	286003648	\$700.00	JUDD, KYLE	01/15/2026	test1	05/07/2026	1199 NATIONAL
<input type="checkbox"/>	282935833	\$102.00				05/07/2026	AMERICHON (MEDICAID)
<input type="checkbox"/>	198081586	\$711.00	NEASON, RAJA	01/03/2023		05/07/2026	HEALTHFIRST
<input type="checkbox"/>	266237284	\$194.02	TESTENSTEIN, TESTY	06/10/2025		05/07/2026	SOUTH CAROLINA

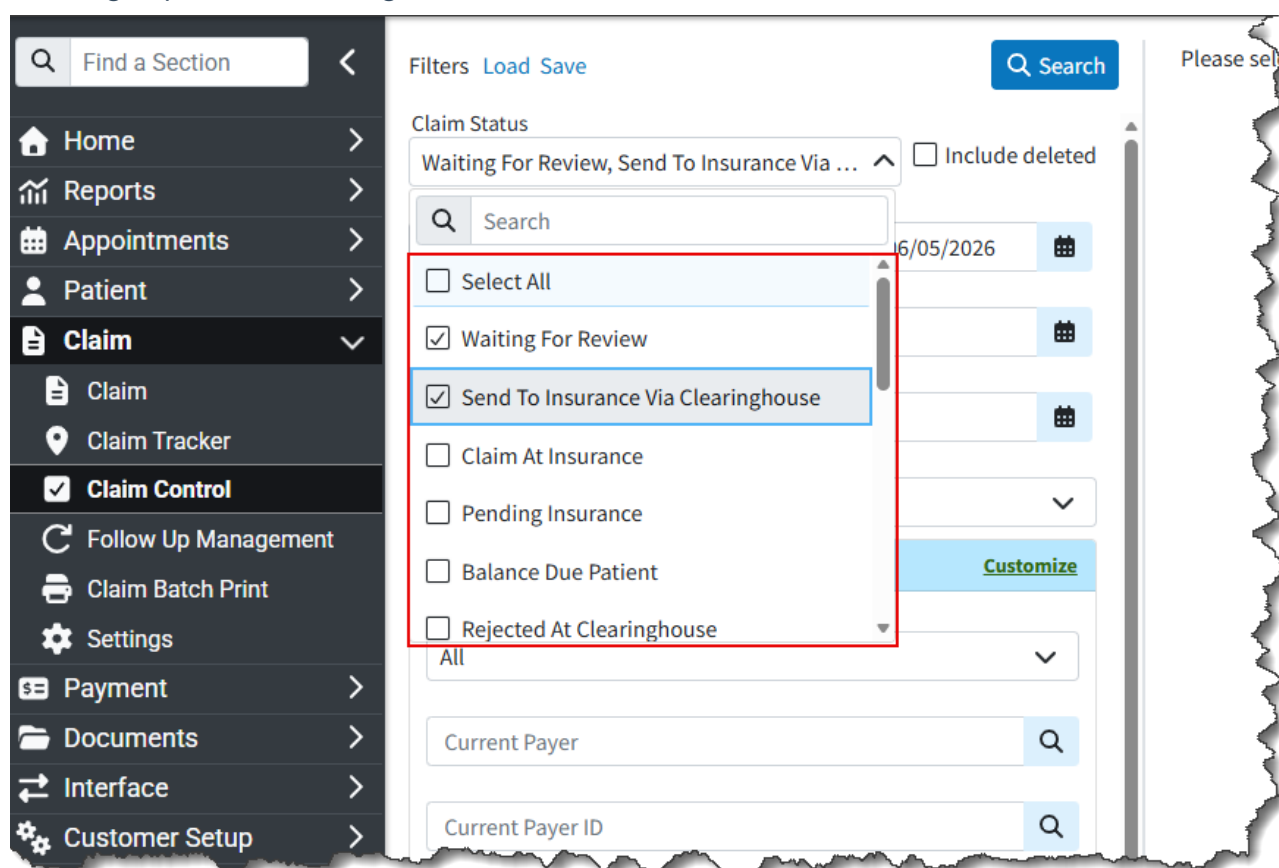
**Note:** You can also update a claim's status and add a note directly from the **Check Claim Status** button. However, these options will only appear when the real-time status check returns results – if no results are found, the update and note options will not be available, as they are tied to the outcome of the status check.

For more info on how to update claim statuses from the Follow Up Management screen, visit our [Update Claim Status From F/U Management Help Article](#).

## Ability To Search Multiple Statuses At Once From Claim Control

Previously, searching for claims in Claim Control was limited to one status at a time, meaning you had to run separate searches to find claims across different statuses.

With this release, you can now select multiple claim statuses at once when searching in Claim Control. For example, you can search for all claims that are "Pending" and "In Progress" simultaneously, rather than running individual searches for each status. This makes it faster and easier to identify and bulk update a broader group of claims in a single search.



**Note:** When searching with multiple statuses selected, the date range for the claim's date of service or entry date is limited to a maximum of one year.

For more information on selecting multiple claim statuses in Claim Control, visit our [Update Claim Status Help Article](#).

## New Automatic Multi-Payer ERA Splitting

Some payers now use third-party companies to handle their ERA processing. These third-party processors

often manage ERAs for multiple payers, which can result in a single ERA file containing checks from more than one payer. Previously, CMD could only handle one payer per ERA file, which could cause issues when a single ERA contained checks from multiple payers.

With this release, ERA files containing multiple payers will automatically be split into separate ERA files upon receipt. This means that when you go to apply payments, the system will automatically associate the correct payer with each check — no manual corrections needed.

**Note:** This will affect all new files received from the clearinghouse and all files uploaded after the release.

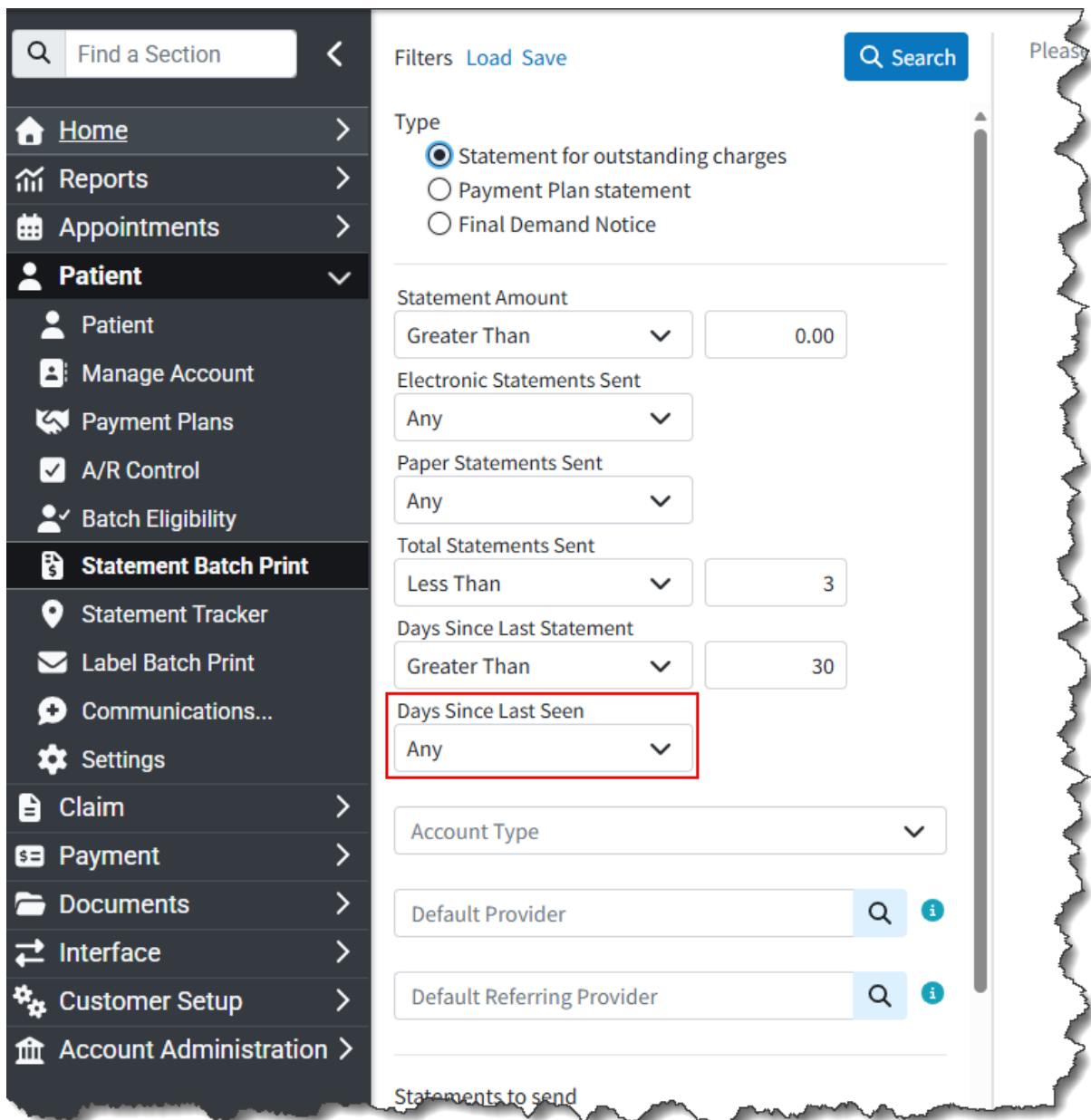
## Enhancements

### Statement Batch Printing By Last Seen Date

When a patient is admitted to a facility, offices typically submit multiple interim claims to the payer while the patient is still receiving care. During this time, sending the patient a billing statement is often premature and can create a poor experience.

To address this, we previously added a Last Seen Date filter to Statement Automation, allowing you to hold statements until a patient has been discharged. With this release, we've brought that same capability to the **Statement Batch Print** screen.

You can now filter by **Days Since Last Seen** when batch printing statements, ensuring that statements are not sent to patients who are still admitted to a hospital or facility.



Visit our [Batch Print Statements For Outstanding Charges Help Article](#) for more information.

## Improved Eligibility Labeling

We've improved the way eligibility responses display certain payer and provider information. Previously, details such as the IPA payer, HMO payer, contracted service provider, and service facility were returned in the eligibility response without clear labels, making it difficult to identify and use that information effectively.

With this release, these fields are now properly labeled in the eligibility response, so you can quickly identify the relevant information and use it with confidence.

## New Interface Setting To Use CMDs Situational & Default Modifiers

Previously, we introduced the ability for API customers to use CMD's internal default and situational modifiers, which offer more robust modifier management than what most EHR systems provide natively.

With this release, this setting is now available for **Practice Fusion** and **Elation Health** interfaces. Users of these integrations can enable and configure this option directly from the **Interface Settings** screen.

Set modifiers based on the modifiers received from the Interface? Even if this is set to Yes, default and situational modifiers will be used if they are not received from the Interface.

Yes  No

**Note:** Even if the setting is configured to use modifiers from the interface, default and situational CMD modifiers will still apply if none are received.

## Taxonomy Specialty Can Now Be Overridden Independently in Payer Records

When configuring a Payer record, you have always had the option to override the Tax ID, NPI, address, and taxonomy specialty using the **Use Alternate Practice Information** checkbox. However, if you only needed to override the taxonomy specialty, the system previously required you to also override the NPI, Tax ID, and name – even if no changes to those fields were needed.

With this release, you can now override the taxonomy specialty on its own and save the record without being required to populate any other override fields.

### Alternate Practice Information

On electronic claims, the below address will override the

Pay-To Address (Loop 2010AB)  Main Address (Loop 2010AA)

Name

Address

City  State  ZIP Code

Tax ID  NPI

**Taxonomy Specialty**

103GC0700X   Behavioral Health & Social Service Providers : Clinica...

## Resolutions

## Updated: ERA Search Now Limited to a One-Year Date Range

To ensure system stability and optimal performance, ERA searches are now limited to a maximum date range of one year when searching by report date. Searches without a specified date range are no longer supported.

Previously, selecting "All" dates while searching by check number required the system to scan every ERA file ever received, which could place significant load on the database and impact overall system performance. This change is necessary to maintain a reliable experience for all users.

### What this means for you:

- If you were previously using "All" as your date range, switching to "Last 12 Months" should allow you to locate most ERAs you are looking for.
- If you are searching for an older ERA, we recommend narrowing your date range to a short window – such as one week – around the expected check date to quickly locate the file.

## Fixed: Residual Balances on Completed Payment Plans Now Handled Correctly

When a patient is on a payment plan and a payer processes a claim resulting in a higher patient responsibility than originally anticipated, a remaining balance can sometimes be left on the charges associated with the payment plan – even after the payment plan itself has been paid in full.

Previously, once a payment plan was completed, any charges with a remaining balance would no longer appear on patient statements and could not have payments applied to them, since they were still tied to the closed payment plan. As a workaround, many customers were manually deleting the completed payment plan to free up those charges.

With this release, this issue has been resolved. Once a payment plan is paid in full, any associated charges with a remaining balance will automatically become available again – appearing on statements and accepting payments as expected. No manual intervention or deletion of the payment plan is required.

## Universal Import Resolutions

We've made two updates to the Universal Import feature in this release:

- **Claim Reference # Import** – You can now map and import the Claims Reference Number field, expanding the data available for import.
- **Preview Screen Fix** – The preview screen now correctly displays all fields from your import file, even if the sample patient record does not have a value for a particular field. Previously, fields without a value for the sample patient were not shown, which made it difficult to verify your field mappings before completing the import.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security

vulnerabilities.

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## Release 16.10.0 - May 26, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

#### New Features

Alternate Eligibility Payer ID  
Universal Import Updates

#### Enhancements

Claim Status Service Information Now Displayed  
New Alerts Column in Claim Control  
New Alerts Side Panel in Follow Up Management  
Charge Panel Limit Increased

## New features

### Alternate Eligibility Payer ID

Some HMO payers (specifically Independent Physician Associations, or IPAs, in California) have a specific network payer ID that provides claim services, while the regular payer ID is used for Eligibility. Users have previously requested that we update our system to add a separate connection for Eligibility when the main clearinghouse connection doesn't support Eligibility. In this release, a new checkbox has been added to the patient insurance policy section, allowing users to verify eligibility through an alternative payer. When selected, an additional field appears, enabling users to search for and designate a separate payer. This option is available only when the primary payer does not support eligibility verification.

## Edit Policy

Insured Party Payer Info

Priority: Primary  Policy Type: Other

Payer: ADVANCED MEDICAL DOCTORS OF CA (13451014)

Check eligibility using a different payer ID

Member ID: 65163512 Group ID:

Copay: 25.00 Co-Insurance %: 0 Deductible: 0.00 Out of Pocket Max: 0.00

Effective Date:  Termination Date:

For more info on how to set up a different payer ID for eligibility, visit our [Add Insured or Payer Policy Help Article](#).

## Universal Import Updates

This release introduces more enhancements to the Universal Import feature to improve data matching accuracy, and reduce manual preparation across various import scenarios. These updates include:

- Anesthesia Support:** Previously, customers were required to manually enter start and stop times for each anesthesia claim during the import process. This will now happen automatically while processing Universal Import files. The system now identifies start and stop times, calculates the duration of anesthesia, and automatically applies the appropriate units and pricing based on those minutes.
- Fix Import Data Option:** When importing a file, users may receive a warning indicating insufficient information to create patients or claims. The system provides details specifying the requirements needed in the file to resolve these errors. This required the file to be updated and re-uploaded, even if the only change involved a field shared by all patients or claims, such as provider, date of service, or diagnosis. This release introduces a "Fix" button, allowing you to enter missing information directly during the import process. You no longer need to modify and re-import files; you can now update data for all patients or claims directly within the system at the time of import. Please note that this method is only suitable when the missing information is the same across all records, such as a shared diagnosis procedure code, or date of service. If the missing information varies, you must update the import file accordingly before uploading. This approach applies only when the data is identical for all items imported from the claim.

## Universal Import: Review

● If any data does not import correctly, please adjust column names in the imported file and try again

▲ This file doesn't have enough information to create complete claims. Only patient information will be imported. See Data

Fix

Patient	Provider	Facility	Charges	Unmatched Columns
Header from File		CMD Field		Value from File
SSN				SSN
Patient Last Name				Last Name
Patient First Name				First Name
DOB				Birth Date
Gender				Gender
Address Line 1				Address Line 1
City				City
State				State
Zip Code				ZIP Code
94513				
<b>Insurance #1</b>				
Header from File		CMD Field		Value from File
Insured Last Name				Insured Last Name
Insured First Name				Insured First Name
Insured Address Line 1				Insured Address Line 1
Insured City				Insured City
Insured State				Insured State
Insured Zip Code				Insured ZIP Code
Reneberg				
Alan				
14 CINDY PLACE				
Brentwood				
CA				
94513				

Import Back Cancel

For more information on using the Fix option, visit our [Importing CSV, Excel, TSV, or Pipe-Delimited Files Help Article](#).

## Enhancements

### Claim Status Service Information Now Displayed

Previously, electronic claim status responses displayed claim-level payment information but omitted certain charge-level details provided by the payer. Consequently, data such as service line payment amounts were not captured, requiring users to contact the payer directly for this information. In this release, the system will automatically pull in the paid amount for each service line, provided the payer supplies this information. Access to this data will save customers time by eliminating the need to contact the payer for status updates.

### New Alerts Column in Claim Control

A new "Alerts" optional column has been added to the Claim Control table, allowing users to view alerts while reviewing claims prior to submission. This column is hidden by default and mirrors the functionality in Follow-Up Management, displaying a clickable yellow bell icon when alerts are present. Clicking the icon displays the claim alert pop-up.

Claim #	Alerts	DOS	Patient	Primary Payer	Review Status	To
287775573		02/03/2026	KEYS, ALICIA	UNITED HEALTHCARE	✔ No Issues Fo...	02/0
287935059		02/05/2026	MUNIZ, JOSEPH	AMERICOHOICE OF NEW YORK INC. (MEDICAID NY)	✔ No Issues Fo...	02/0
291585791	🔔	03/12/2026	TEST, JOHNNY	BLUE CROSS AND BLUE SHIELD OF FLORIDA	❌ Error Detected	03/1
291588187	🔔	03/12/2026	TEST, JOHNNY	BLUE CROSS AND BLUE SHIELD OF FLORIDA	❌ Error Detected	03/1

## New Alerts Side Panel in Follow Up Management

This release introduces alert visibility when viewing individual claims within Follow Up Management. Previously, alerts were only accessible via the main table's yellow bell icon. Users can now view or add alerts directly within the side panel, enabling immediate issue identification during claim processing.

Find a Section

- Home
- Reports
- Appointments
- Patient
- Claim
  - Claim
  - Claim Tracker
  - Claim Control
  - Follow Up Management
  - Claim Batch Print
  - Settings
- Payment
- Documents
- Interface
- Customer Setup
- Account Administration

Save
Close
Claim Status
Print
Activity
More

Editing follow up information for Claim #284263949

Follow Up Date: 05/13/2026    Set all charges to: NO CHANGE

Follow Up Notes

+ Add Note

Reference Information

Expected Payment Info

Open Negotiations

Patient Notes 1

Tasks

EOB Info

**Alerts 1**

+ Add Alert

Test

Created by davidacosta on 05/04/2026

Patient: HILDIBRAND, MANDERVILLE

Show On: Patient, Claim, Appointment, Payment

Visit our [View/Add Alerts From Follow Up Help Article](#) for more information.

## Charge Panel Limit Increased

Previously, our charge panels were limited to five-character codes, restricting the system to 999 panels. In this release, we have increased the code limit to 10 characters to support a larger volume of panels, allowing customers to create an unlimited number of charge panels per account.

### Charge Panels

Title

TEST CHARGE PANEL

Code

CP00123456

Type

Professional ▾

Description

Code	POS	TOS	Modifier Options	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Price	Units
	Q	Q	Code Defaults ▾	Q	Q	Q	Q	Code Default ▾	

## New Report Field: # of Public Follow Up Notes

Previously, it was possible to retrieve the number of claim notes but not follow-up notes. This release introduces a new report field, "# Number of Public Follow-Up Notes" allowing users to see the number of public claim follow up notes in reports. This release also renames the existing "# Number of Notes" field to "# Number of Claim Notes."

Title

Category ▾ +

**Report Fields**

Search for fields

# OF ▾

Claim Data
 

- # Number of Claim Notes
- # Number of Public Follow-Up Notes**

ERA Data
 

-

**Columns**

## Resolutions

## Denials and Unpaid Reasons Reports Slowness When Using Remittance Received date

Resolved an issue causing slowness in "Denials and Unpaid Reasons" reports when using the Remittance Received date filter. This fix significantly improves the performance of the remittance received report filter for customers.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.9.0 - May 11, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

#### New Features

Even More Universal Import Updates

#### Enhancements

New Referring Provider Column in Claim Control

## New features

### Even More Universal Import Updates!

This release introduces further enhancements to the Universal Import feature, continuing to streamline the mapping of imported columns to CollaborateMD fields. Key updates include:

- **Recognizing institutional claims:** Previously, customers were required to include a claim type column in their imports to specify institutional claims. This necessitated manual intervention, as EHR exports typically lack this information. This release introduces support for importing institutional claims by automatically identifying them through specific data fields. Fields such as *Revenue Code*, *Value Code*, *Admit Type*, and *Condition Code* are now used to recognize institutional claims, eliminating the need for adding a manual claim type column.
- **Better Provider Name matching:** We have improved our provider name matching. Provider names often appear in a single column, sometimes accompanied by IDs or credentials. In this release, the system has been updated to ignore these extraneous details to accurately identify the first and last names for searching. While the system now effectively parses these columns, we still recommend maintaining a separate provider NPI column whenever possible.

- **Support for Different Modifiers for each charge:** The system has been updated to support distinct modifiers for individual charges. Previously, the system incorrectly consolidated all modifiers into a single list and applied it to every charge. This release ensures that imported files correctly match specific modifiers to their respective charges. Additionally, the system now treats "NA" or "N/A" values as blanks when multiple modifier codes are present.
- **Support for State's Full Name:** We have updated our address matching to support both full state names and two-digit abbreviations. The system now correctly processes EMR files regardless of whether the state is provided as a full name (e.g., Florida) or an abbreviation (e.g., FL).
- **Better Recognition of columns with duplicate or invalid values** We have updated the system to improve handling of multiple potential matches, such as when both rendering and provider NPIs are submitted. The system now clearly distinguishes between matched and unmatched entries. Previously, if one field matched, the other was omitted, which often caused confusion regarding the data imported.
- **Improvement when combining multiple rows into one claim:** Previously, the system consolidated rows for the same patient based solely on claim or appointment IDs. This often incorrectly merged records involving different providers or payers. Because distinct providers indicate separate services these records must remain on individual claims. This update improves logic to prevent the improper combination of claims.
- **Excel formatting now used for number columns:** When exporting member IDs starting with zeros to Excel, the application often removes the leading zeros, resulting in incorrect IDs and claim denials. In this release, we updated the Excel formatting for numeric columns to preserve leading zeros.
- **Support for Importing Patient's Marital Code:** Resolved an issue where patient marital status failed to import during data retrieval for meaningful use or other tracking purposes. This release ensures the information is now correctly imported.

Universal Import: Review



If any data does not import correctly, please adjust column names in the imported file and try again

Patient	Provider	Facility	Payer	Charges	Unmatched Columns
<b>Charge #1</b>					
Header from File		CMD Field		Value from File	
DOS		Date of Service		01/26/2026	
EDOS		End Date of Service		01/26/2026	
Unit		Units		1.0	
Fee		Unit Price		60	
POS		Place of Service		20	
ICD1, ICD2, ICD3, ICD4		Diagnosis Code(s)		Z20.822	
Code		CPT Code(s)		87426	
M1		Modifiers		QW	

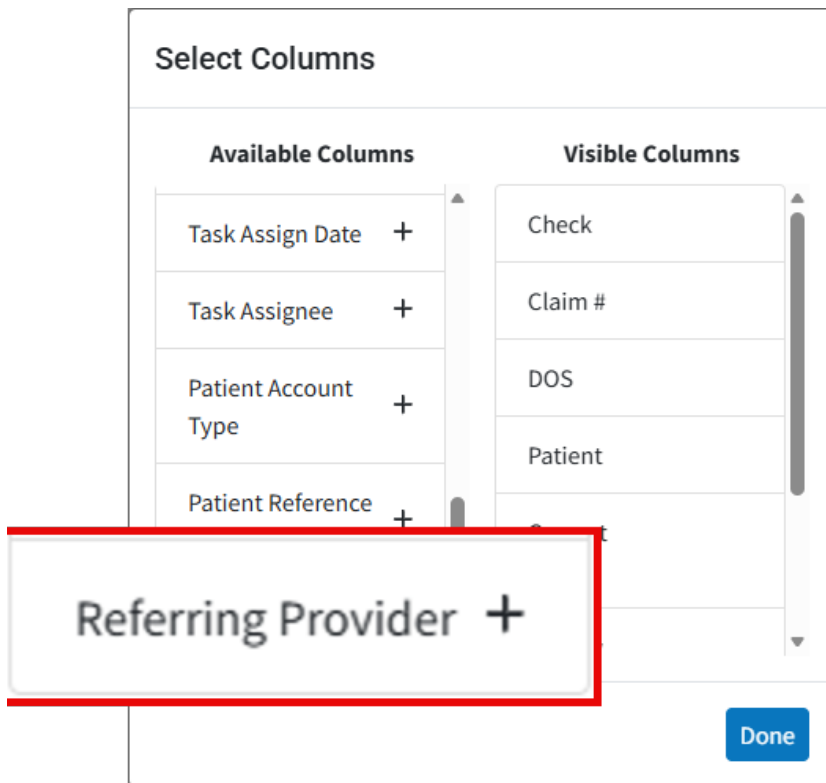
Import Back Cancel

Continue checking our release notes for further Universal Import updates and enhancements coming soon

## Enhancements

### New Referring Provider Column in Claim Control

When reviewing claims, users often need to verify referring provider information, particularly for services or payers where the referring provider is always required. Previously, when working claims from the Claim Control screen, users had to open each individual claim to ensure this information was present and accurate. To improve this workflow, we have added the referring provider as an optional column (hidden by default) in Claim Control. This column allows users to identify and quickly access claims missing a referring provider for correction.



### GPI Onboarding Now Automatically Checks Status of In-Progress Applications

Previously, the status of in-progress GPI applications (and their credentials) was only checked when users manually accessed the In-App Payment Processing section. As this process was often overlooked, we have updated the system to automatically check for pending applications upon login. This ensures that credentials and merchant details are retrieved promptly, allowing users to begin processing payments without delay.

## Resolutions

### Ability to Run Patient Eligibility When a Patient Record is Locked

Previously, if a user opened a patient record already locked by another user, they could view the information but were unable to check eligibility. As saving the record is not required to perform this action, this update allows users to run eligibility checks even when a patient record is locked (in use) by another user.

## Practice Fusion Issues Fixed

We resolved an issue with payment tracking for Practice Fusion where, Practice Fusion payments were incorrectly consolidated onto a single receipt despite occurring at different times. We have updated the system to generate a separate receipt for each Practice Fusion payment, ensuring they can be printed individually in CMD.

We also implemented reliability improvements to resolve a duplication issue where Practice Fusion sent redundant claim copies.

## Scrolling Issues in Safari

We have resolved scrolling issues in Safari where headers would disappear when viewing large tables. The headers now remain correctly positioned. Mac users who previously switched browsers due to this issue may now return to Safari, as functionality has been restored.

## Intelligent Claim Rejection: "Marked as Fixed" Issue

We resolved an issue where marking claim rejections as "fixed" did not consistently update their status. Previously, claims remained visible in search results for unresolved issues due to underlying errors that were not properly cleared. This update ensures that all claim issues are fully marked as resolved upon confirmation.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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Release 16.8.0 - April 27, 2026

## Highlights

### New Features

More Universal Import Updates

### Enhancements

New GPI Onboarding Tooltips

Revenue Code-Specific Taxonomy Codes

## New features

### More Universal Import Updates

This release introduces further enhancements and updates to the Universal Import feature, streamlining the process of mapping imported columns to CollaborateMD fields. The system now supports importing addresses consolidated into a single column by automatically recognizing individual address components (street, city, zip, etc.). Additionally, we have added support for importing multiple insurance policies from a single column to accommodate various export formats. **Please note that we still recommend keeping address fields such as street, city, state, and zip code in individual columns whenever possible.**

This release includes updates to ignore "N/A" fields in columns, eliminating the need for manual removal prior to upload. We have also improved payer name matching, allowing files to be uploaded without editing names containing extra parentheses or special characters. Additionally, refinements to the AI prompt will minimize unexpected errors during file imports.

#### Universal Import

If any data does not import correctly, please adjust column names in the imported file and try again

Patient	Provider	Facility	Payer	Claim	Charges	Unmatched Columns
Charge #1						
Date of Service (SDOS): 08/26/2025						
End Date of Service (EDOS): 08/26/2025						
Units (Unit): 1.0						
Unit Price (Fee): 60						
Place of Service (POS): 20						
Diag (ICD1, ICD2, ICD3, ICD4): Z20.822						
CPT Code(s) (Code): 87426						
Modifiers (M1): QW						

Show header information

Import Back Cancel

Continue checking our release notes for further Universal Import updates and enhancements coming soon

## Enhancements

### New GPI Onboarding Tooltips

Several sections of the GPI In-App Payments application have caused customer issues; for example, entering incorrect placeholders for average transaction amounts has led to application delays or denials. In this release, new tooltips have been added to the merchant details screen during GPI onboarding to clarify these fields. Hovering over these fields now displays a tooltip explaining the required information. Tooltips have been added to fields such as types of goods, services, annual volume, average sale price, and sales channels, to assist customers in completing the required information.

### Revenue Code-Specific Taxonomy Codes

Vermont Medicaid requires specific taxonomy codes for certain behavioral health institutional claims, depending on the revenue code used. To comply with these billing guidelines, a new "Taxonomy Code Override" field has been added to the Revenue Code section within the Claim Defaults tab. This allows users to assign specific taxonomy codes to individual revenue codes.

**Please note that this feature requires a feature flag. If you require access to per-revenue code taxonomy overrides, please request it via a support case.**

## Resolutions

### Claim Control Incorrect Warning

Some users previously encountered warnings in Claim Control when a claim contained charges with multiple statuses. Because the system's ability to update these statuses depended on the things like the processing order, the behavior was inconsistent and confusing.

In this release, we resolved this issue so that Claim Control now correctly processes charges regardless of their individual statuses within a claim.

## Incorrect Warning for "Forgot Password" option

We resolved an issue where entering a previously used password during the "Forgot Your Password" process incorrectly triggered an error message that your account was closed. The system now correctly displays an error message indicating that a new password must be used, consistent with the 12-month password history policy.

## New Institutional Claim Edit: TOB 86x

We have added a new institutional claim edit for bill type 86. These inpatient claims generally do not involve a hospital admission; therefore, by default, we do not transmit admitting diagnoses or related admission fields. If customers using bill type 86X experience rejections or denials due to missing admission information, they may request this edit via support. We can then enable their payer to ensure the admitting diagnosis is included when the bill type begins with 86.

## Custom Edits (Aptarro) Issue

We resolved an issue regarding custom edits at Aptarro where certain submitter IDs were missing from our system despite being previously established. All affected submitters have been corrected, and we have implemented measures to prevent submitters from being inadvertently removed in the future.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.7.0 - April 14, 2026



## Highlights

### New Features

New Total and Selected Patient Counts in Claim Control

### Enhancements

Payment Automations UI Update  
Universal Import UI Update

## New features

### New Total and Selected Patient Counts in Claim Control

We previously added the total and selected charges & claims to the bottom of the Claim Control results screen. In this release, we added "Total Patients" and "Selected Patients" counts to the Claim Control results screen. These fields display the total number of unique patients and, when claims are selected, the number of unique patients within that selection.

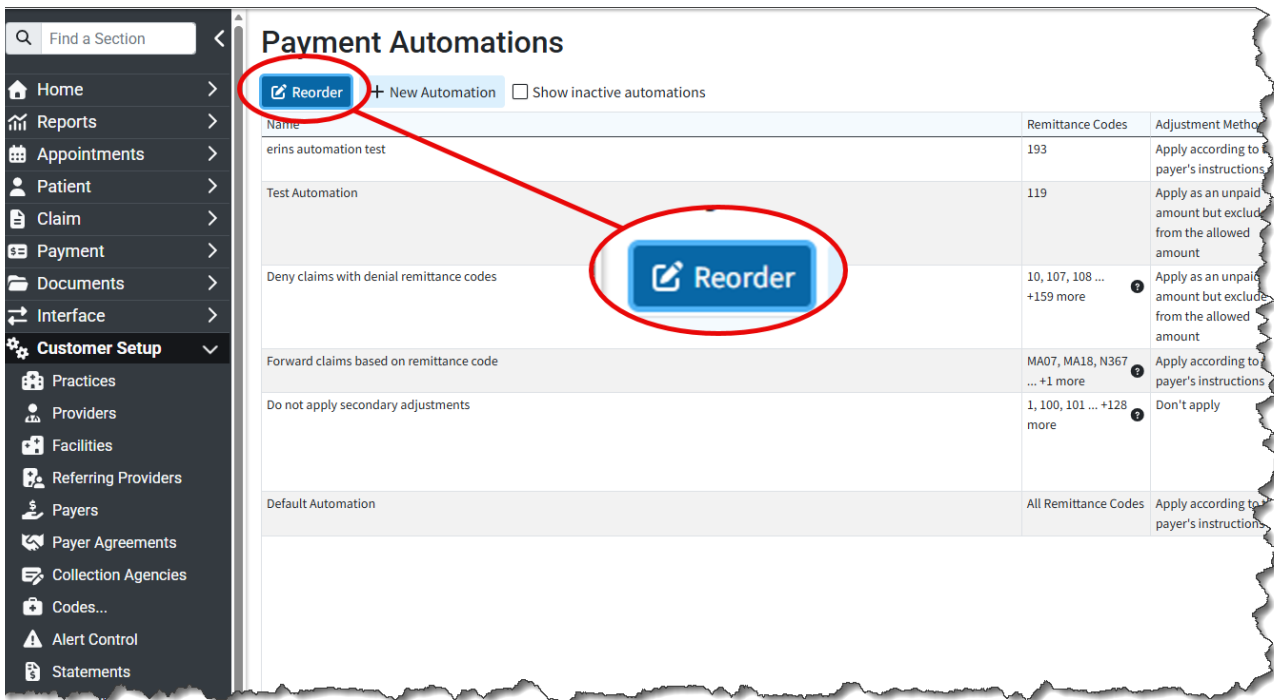
Claim #	DOS	Patient	Primary Payer	Review Status	To DOS	Claim Type
<input type="checkbox"/>	287775573	KEYS, ALICIA	UNITED HEALTHCARE	<span style="color: green;">●</span> No Issues Fo...	02/03/2026	Professional
<input type="checkbox"/>	287935059	MUNIZ, JOSEPH	AMERICHoice OF NEW YORK INC. (MEDICAID NY)	<span style="color: green;">●</span> No Issues Fo...	02/05/2026	Professional
<input checked="" type="checkbox"/>	291585791	TEST, JOHNNY	BLUE CROSS AND BLUE SHIELD OF FLORIDA	<span style="color: green;">●</span> No Issues Fo...	03/12/2026	Professional
<input checked="" type="checkbox"/>	291588187	TEST, JOHNNY	BLUE CROSS AND BLUE SHIELD OF FLORIDA	<span style="color: green;">●</span> No Issues Fo...	03/12/2026	Professional
<input checked="" type="checkbox"/>	293751412	TEST, JOHNNY	BLUE CROSS AND BLUE SHIELD OF FLORIDA	<span style="color: green;">●</span> No Issues Fo...	04/10/2026	Professional
<input checked="" type="checkbox"/>	293751413	MUNIZ, JOSEPH	AMERICHoice OF NEW YORK INC. (MEDICAID NY)	<span style="color: green;">●</span> No Issues Fo...	04/10/2026	Professional

**Total Claims:** 6 **Total Patients:** 3 **Total Charges:** \$844.00 | **Selected Claims:** 4 **Selected Patients:** 2 **Selected Charges:** \$576.00 Count: 1

## Enhancements

### Payment Automations UI Update

The "Edit" button previously located at the top of the payment automation screen was misleading. Rather than allowing users to modify specific automations, this button is used to reorder, activate, or deactivate them. To edit an individual automation, users must open the specific entry directly. To avoid confusion, in this release the "Edit" button within Payment Automations has been renamed "Reorder," as it is used to reorder, activate, or deactivate automations rather than edit them.



## Improved Deposit Date Reporting

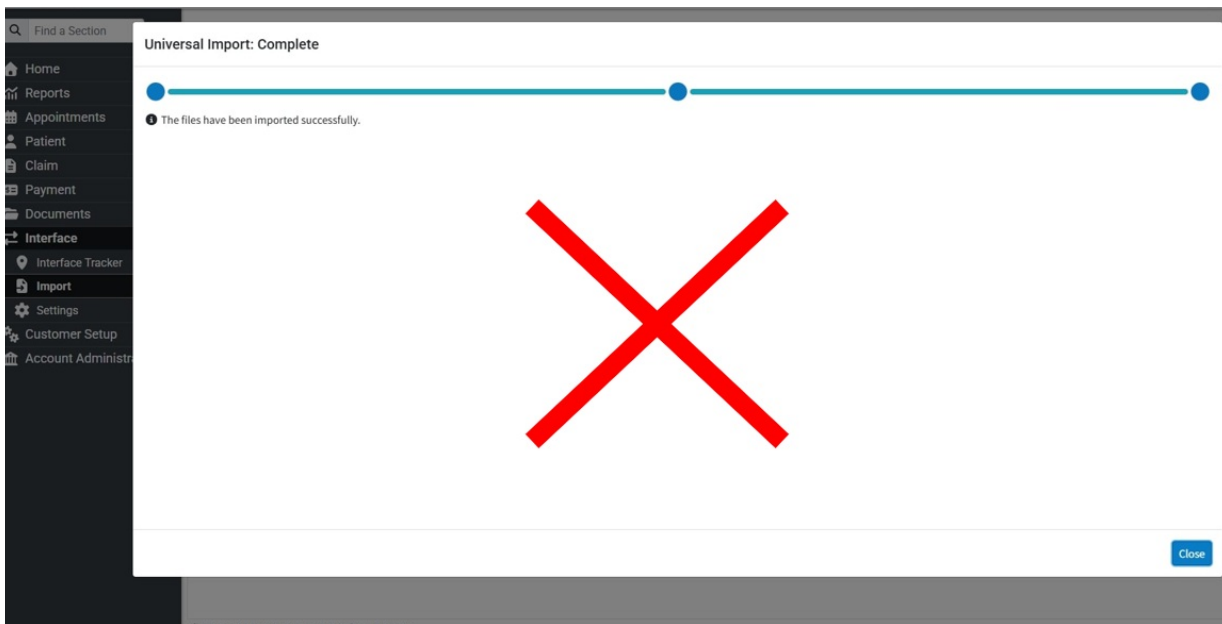
We have improved the performance of reports, such as the Daily Deposit Report, when filtering by deposit date. Previously, generating these reports for large accounts over extended periods was time-consuming. By adding an index to the Deposit Date field, we have matched the efficiency of reports filtered by receive date, significantly increasing processing speed and preventing timeouts.

## ERA Negative Adjustments

Previously, negative adjustments were not applied correctly to ERAs, resulting in inaccurate credits. This issue pertains to scenarios where a payer's payment and adjustment total exceeds the billed amount, adding a negative adjustment (not refunds/reversals). In this release, the system has been updated to correctly apply these negative adjustments for primary payers when claims are received with amounts intended to offset overpayments.

## Universal Import UI Update

We made a minor update to the universal import process. Previously, after reviewing the field matching in the review screen and then selecting "import" the dialog remained open, requiring users to manually close it to see the option to review the results. With this update, the dialog now closes automatically, removing an extra step and streamlining the workflow.



## Resolutions

### Electronic Statements Issue

We resolved an issue where setting up electronic statements when the patient was already receiving paper statements, would occasionally received both formats simultaneously, exceeding the established statement limit before an FDN. In this release, we updated the system so that enabling electronic statements for patients already receiving paper statements will not trigger electronic delivery for them. Electronic statements will now only be issued to patients who have not previously received paper statements. Once a patient pays and resets their balance, the process restarts: we will send electronic statements, followed by paper statements and the FDN.

### Incomplete Claims Won't Appear in Follow-Up Management

The claim follow-up screen previously allowed users to retrieve incomplete claims and update their status to options such as "Send to Insurance." The problem is that incomplete claims cannot be submitted to insurance, and our system would block these attempts, causing processing issues. Since follow-up management is intended use is to handle claims already submitted, we have updated the system to exclude incomplete claims from this view. Instead, Incomplete claims should be searched within Claim Control, using the Incomplete Claims report, or a customized welcome screen. Once identified, resolve the issues within the claim or patient sections to ensure successful submission.

### Interface Error With the Archive Insurance Option

We previously identified isolated interface errors that prevented claims from posting and patient records from updating. As a workaround, users were advised to temporarily disable the "archive patient insurance information" setting. This release resolves the issue, allowing users to re-enable this feature.

## Universal Import Updates

We have enhanced our universal import feature to better process provider and patient names. The system now more accurately parses names when first, middle, and last names are contained within a single column regardless of formatting variations. During import, the AI will now more effectively match these entries in our file to the corresponding fields in CMD.

## Invoice Email Update

Resolved an issue where users incorrectly received invoice emails after being reassigned from a custom permission to a "User Role" without the permission. The system had failed to clear the legacy permission, causing it to persist despite the role change not including it.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.6.0 - March 30, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

#### New Features

[Universal Import](#)

#### Enhancements

[New Rich Text Editor](#)

[New Automation for Value Code 80](#)

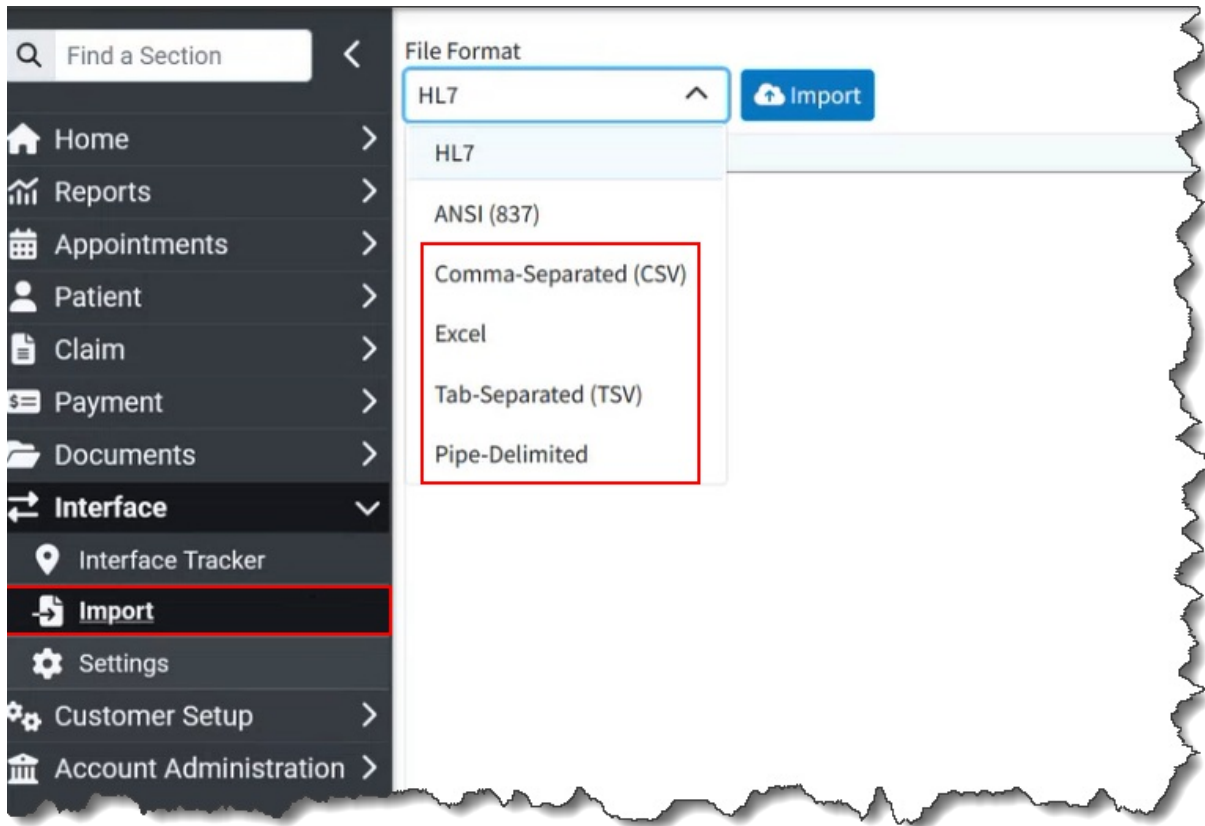
## New features

### Universal Import

This release introduces the beta version of CollaborateMD's Universal Import feature. Many Electronic Health Record (EHR) systems now include interfaces designed to export data, often in HL7 standard format, offering greater flexibility to their users. However, a common issue is that numerous EHRs lack interfaces for external systems. This deficiency creates substantial additional work for medical practices and billing services, as they are forced to manually input claims and patient data into CMD.

Our Universal Interface Import allows users with an EMR/EHR that has not built an interface with us to import encounter, claim, and patient data from any external system. Customers can now upload CSV, Excel

TSV, and pipe-delimited files using our Interface Import section. This new feature uses AI-powered field mapping to automatically interpret the structure of CSV/Excel files from other systems and map them into CMD. This feature allows customers who do not use our WebAPI to automatically import claims, and patients from any EMR/EHR via a report or export from their software.



Customers can still manually import claims into our system in the HL7 format or from an 837 ANSI file into CollaborateMD.

For more information visit our [Universal Import Help Articles](#) or visit our [Universal Import Interactive Demo](#).

## Enhancements

### New Rich Text Editor

This release includes an update to our Rich Text Editor, used in sections such as alerts and messaging. Although the editor functions similarly, you will notice some changes to the toolbar's appearance and its items. Icons for bold, italics, underline, and insert link remain largely the same, while others, such as Font Color and Font Size, have a new look. The previous Text Color and Highlight Color icons were combined into one. The Indent, Insert Ordered List, Insert Unordered List, and Insert Table icons are now visible in the toolbar. This new editor reduces clutter and increases visibility directly from the toolbar.

## Creating alert for Provider

**Font**

**Font Size**

**Text & Fill Color**

**Lists, Indent & Tables**

**Display Options**

Global

- Show Alert in Patient Section
- Show Alert in Claim Section
- Show Alert in Appointment Section
- Show Alert in Payment Section

**Effective Date Range**

Alert Start Date

Alert End Date

**Done** **Cancel**

## New Automation for Value Code 80

We previously added the ability to default value codes at the payer and patient level for institutional claim as part of our claim workflow enhancements. Value codes are specific billing details on institutional claims. For example, value code 80, "Covered Days," represents the number of days covered by the bill. This value will vary per claim, so it should not be set as a default amount.

In this release, we added an automation for value code 80. When value code 80 is used, leaving the amount blank in the default value codes section for the payer or patient will change the value field to "number of days" instead of "dollar amount." Subsequently, when a claim is received via interface, the value code's amount will be automatically set based on the number of covered days.

> Clearinghouse Connection

> Notes

> Alerts

> Tasks

▼ Billing Options

**General**   **Provider**   **Patient**   **ERA**

Send patient address in Box 32 for Place of Service 12

Remove the insured's ID# from Box 1A

Print the following supplemental info in Box 24

Narrative Notes ▼

Print ICD code for first diagnosis pointer in Box 24E

Send minutes instead of units on anesthesia claims

Send anesthesia start/stop times in a line note.

**Institutional**

Print the following in Box 38

Print payer's address ▼

Print the following in Box 80

Print remarks ▼

Print referring physician in Box 76

Print Taxonomy Code in Box 76

Print Taxonomy Code in Box 81CC a

**Default Value Codes**

Code	Amount	Description	
80	# of days	Covered Days	X
	0.00		

## Resolutions

### ERA Reversal Matching Improvement

We resolved an issue that prevented some ERA reversals from applying correctly. The affected ERAs received a "we couldn't apply the reversal because there was no prior reversal to apply to" warning message. With this update, the system now looks at the previous payment to determine how the payment and adjustment should be posted. This ensures consistent application, allowing reversals to be matched appropriately.

### Corrected GPI Onboarding Issues

We fixed several issues with the GPI onboarding when setting up In-App Payment Processing. The 'Percentage of Processing Methods' field will now have improved validation to prevent progression with invalid or null information. Additionally, the "Title" field for the **Authorized Signer** will now be a dropdown

menu with allowed options, preventing errors, as GPI expects specific values.

## Intake Forms: Unmatched Forms Option Fixed

We corrected an issue with our Intake Forms' **Unmatched** forms feature. A previous release accidentally created a bug that prevented the option to fix unmatched intake forms from appearing when clicking on an "Unmatched" form. This has been corrected in this release and is working again.

## Incorrect Net Amount Issue

We resolved an issue where a net amount could be calculated incorrectly for patients. This issue prevented the charge-level allowed and net amounts from calculating correctly in the daily/monthly net charges report. Although this issue will be fixed going forward, existing patients may still have invalid values. If that's the case, opening and saving the patient will solve the issue.

## Multiple Universal Import Beta Fixes

Since releasing the Beta version of our Universal Import feature, we have updated and corrected some issues. First, we updated the Universal Import user interface to simplify the process and improve readability. We also updated how Universal Import files are read to better determine header and value rows. This means users do not need to remove blank or additional rows before the file header.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.5.0 - March 16, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

#### New Features

[New Plan Name Details Within the Eligibility Plan Number](#)

#### Enhancements

[ERA Name Mismatch Warning Will Now Ignore the Middle Name](#)

## New features

### Eligibility Will Now Show Extra Details Within the Plan Number

---

This item has been delayed due to a bug but will be released soon.

When an eligibility response is received, the "Plan Number" field, located under the "Subscriber/Plan Information" tab, previously displayed only the plan number. This number is the unique identifier assigned by the payer to a specific insurance plan, helping the customer distinguish which of the many available plans a patient has. It is used to identify the precise benefits, coverage, and cost-sharing amounts associated with the patient's policy.

Accurately identifying a patient's plan is important for any practice, but it is critical for California IPA plans. In California, Independent Physician Associations (IPAs) are often tied to specific medical groups and PCP networks. The plan number acts as a code to identify the exact health plan and managed care plan network which directly dictates patient benefits, PCP assignment, and required authorization procedures for services. When we receive an eligibility response message, it sometimes includes an additional segment with the name of the Group, Plan, or Network associated with the plan number.

In this release, when the eligibility response message includes an additional segment with the group, plan, or network name, we will now include the plan name when it is provided with the plan number in the response. This will assist practices that handle California IPAs by offering an additional reference point to minimize errors.

✓ Active Coverage

Subscriber/Plan Information	Eligibility/Benefit Details	Request ANSI	Response ANSI
Type	Insured or Subscriber		
Last Name	[REDACTED]		
First Name	[REDACTED]		
Member Identification Number	[REDACTED]		
Group Number	VHPCOMM ⚠		
Plan Number	7 [HSS COMMERCIAL PREFERRED - SCCIPA]		
Address	[REDACTED]		
City	[REDACTED]		
State	CA ⚠		
Zip	[REDACTED]		
Date of Birth	[REDACTED]		
Gender	[REDACTED]		
Plan	07/01/2018 - 12/31/2078		
Type	Payer		
Name	VALLEY HEALTH PLAN		

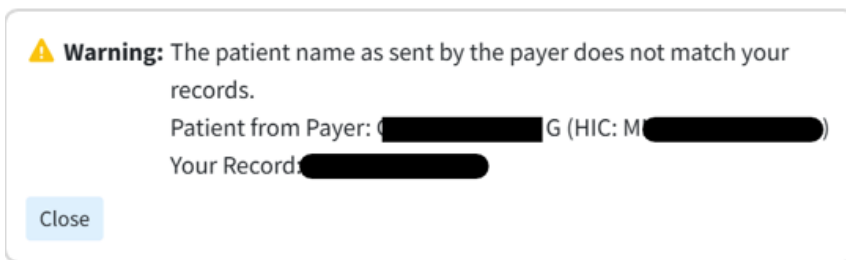
## Enhancements

ERA: Name Mismatch Warning Will Now Ignore The Middle Name

When reviewing an ERA, if a patient had a mismatched middle initial, the system would always display the "Name Mismatch" warning. This scenario could occur if the ERA and CMD records have a discrepancy in the middle initial, such as one record including it while the other does not, or if the initials themselves differ.

The purpose of this warning is to identify instances where the payer may have a completely different patient. A missing middle initial is not critical and was generating numerous warnings for correct patients due to unmatched or missing initials.

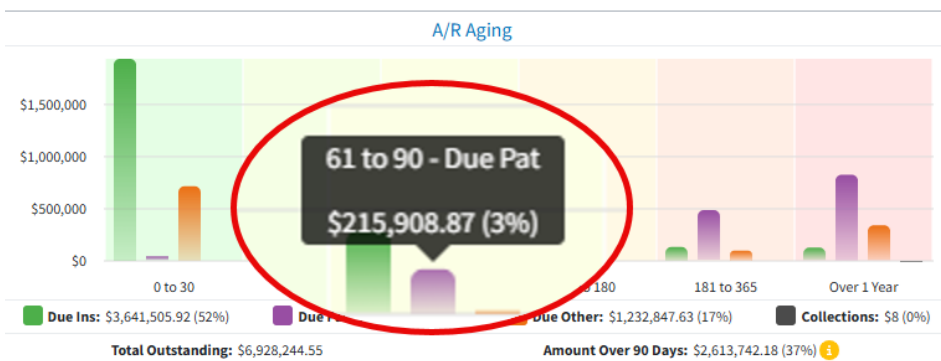
In this release, we updated this process to no longer show this warning based on the middle initial. Instead, it will only check if the first and last name do not match, regardless of whether the middle initial is present. This will reduce the time spent reviewing unnecessary warnings.



## Resolutions

### Missing Tooltip in Dashboards

A bug affecting the A/R Dashboards has been fixed. The bug, introduced in the last release, prevented the hover-over feature from displaying the amount represented by a bar or graph point. This functionality has been restored.



### Copy Configuration Issues Within Claim Scrubbing

When an authorized representative adds additional services, particularly for billing service customers, they can copy existing service configurations of certain services from one customer to another. This feature is crucial for billing services that frequently onboard new customers, as it significantly reduces data entry and setup times.

The problem was that the copy configuration feature was not working correctly for the "Claim Scrubbing" feature. When Copy Configuration was used for claim scrubbing, the selected specialty was not set up correctly, and the Aptarro submitters were not set up for the enabled customers.

In this release, we corrected this issue so that when the "Copy Configuration" option is used, the system copies and displays the selected specialty and registers the required submitters with Aptarro.

## Copy Configuration Issues Within Interface Automation Settings

We also corrected an issue where, the copy configuration option was not working for interface automation settings. This meant that when copying the configuration to other customers, applicable interface automation settings, within features such as address verification and eligibility, were not being copied over.

In this release, we resolved this so that if there are any interface automation options selected, they are also copied over as part of the process.

**Address Verification for Customer #10001911 - COLLABORATEMD**

*This service is included in your account's price plan*

Enable Address Verification

**Address Verification Settings**

Automatically scrub the following when changes are made:

Patient Address

Insured Address

Guarantor Address

Statement Recipient Address

Payer Address

Automatically scrub addresses when the above changes are made via Interface?

Yes  No

## Claim Tracker: Mark as Fixed Issue

We also corrected an issue stemming from our 16.3 release, where Claim Tracker inconsistently marked some rejections as fixed. When checking the claim-level checkbox next to a claim without expanding it in Claim Tracker, the row would remain checked, but the "Mark as Fixed" and "Task" options would remain grayed out or unavailable. This was causing issues by selecting (checking) "Mark as Fixed" at the claim level instead of the issue level.

## Global Period Alert Issue

The Global Period alert ensures the correct modifiers are used for post-surgery procedures. These procedure codes typically have a follow-up period during which charges for normal post-operative care are bundled into the global surgery fee. Therefore, when a claim is saved with a Date of Service (DOS) that falls within the global period of a code on a previous claim, the Global Period alert will appear to warn the user.

In this release, we fixed an issue where the global period alert was not appearing as expected under specific circumstances where, based on the modifier, it should have triggered the alert. We corrected the issue, and

The feature now activates when any relevant modifiers are used.

## Report Performance Improvements

A change was implemented in our report processor to significantly improve the performance of certain reports, depending on the filters used. Due to the nature of this change, it is difficult to predict which specific reports will experience performance improvements, but we should see better overall performance. It is important to note that this enhancement does not target a specific slow report. Instead, it addresses a pattern of report slowness issues observed within the application environment.

## 'Find a Time' Option Issue Within the Scheduler

We corrected an issue where the "Find a time" feature in the appointment scheduler did not consider appointment blocks. Appointment blocks are intended to prevent appointments from being scheduled within the blocked time. However, the "Find a time" feature was providing a list of available appointment slots that included times that should have been blocked.

This issue has been resolved in this release, ensuring that the appointment time-slot list provided via the "Find a time" option does not show appointment slots within blocks that disallow appointments.

The screenshot shows the appointment scheduler interface with the following elements:

- Buttons: Save, Cancel, Save & Send Forms
- Navigation tabs: Appointment, Patient, Payment
- Search bar: Patient
- Appointment Date: This field is required.
- Time: at [ : ] for [ 0 ] Minutes
- Length: 0 Minutes
- Find a time button (circled in red)
- Checkboxes:  Allow appointment to overbook with another appointment
- Appt Status: Scheduled
- Find a time button (circled in red)
- Appt Type: [ ]
- Resource: [001] STEPHEN KOZLOWSKI
- Facility: [ ]

## Updated Sending All Charges to Secondary Payer After a Payment

Previously, several changes and updates were implemented to ensure all charges are sent to the secondary payer after a primary payer payment. Although this is correct when there are other unpaid charges on a claim, it caused the system to send claims to the secondary payer even when all charges had been paid. In these scenarios, the secondary payer would have no action to take because the charges had already been paid by the primary. The secondary payer would then issue a \$0.00 payment, rendering the claim

submission inefficient.

In this release, we updated the system to ensure claims are not sent to the secondary payer if all charges are paid. This update will only send charges to the secondary payer if at least one charge has a balance greater than zero dollars (\$0.00).

## Family Statements: Printing Issue

When printing family statements, selecting "Family Statement" from the master account will generate a statement (Enhanced or Plain Text) for the entire family. However, if printing from a dependent's account with the "Family" option selected, only that dependent's statement will be printed.

In this release, we updated the system so that a family statement can now be printed from the dependent's account. This eliminates the need for users to switch to the master account to print a family statement.

## Fee Schedule: Round Prices Up to The Next Whole Dollar Option Not Working

In this release, we updated the option to round prices to the next whole dollar amount (available when updating prices), which was previously not working correctly. With this update, when selecting the "Round prices up to the next whole dollar amount" option, procedure prices will now be correctly rounded up.

The screenshot shows the 'Update Prices' interface. It has several sections: 'Use your ZIP code' with a text input field and a dropdown arrow; 'Enter the carrier and locality' with 'Carrier' and 'Locality' text input fields; 'Pricing Method' with radio buttons for 'Non-facility pricing' (selected), 'Include prices for codes that are not applicable for non-facility' (checkbox), and 'Facility pricing'; 'Adjust Prices' with radio buttons for 'Do not adjust the prices of the new Fee Schedule', 'Increase prices by' (0.00 %), 'Decrease prices by' (0.00 %), and 'Adjust prices to' (1.0000 times or 100.00 % of the selected prices); and a checkbox for 'Round prices up to the next whole dollar amount' which is highlighted with a red box. At the bottom, there are radio buttons for 'Set prices based on a Contract' and 'Set prices based on charges entered', and 'Update Prices' and 'Cancel' buttons.

## Copay Credits Applied to Incomplete Claims

When copays are configured to auto-apply to claims created via interfaces, they should never auto-apply to incomplete claims. We previously found some instances where this occurred, so in this release, we updated the process to prevent copay credits from being auto-applied to claims with an incomplete status.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.4.0 - March 2, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

#### New Features

Universal Import - BETA

#### Enhancements

New Option to Stop Showing the All-Inclusive Code Warning

## New features

### Universal Import Updated UI - BETA

Please be aware that the new universal import options are currently in BETA testing and will be available to all customers soon!

Our last release introduced the beta version of CollaborateMD's Universal Import feature, allowing users with an EMR/EHR that has not built an interface with us to import encounter, claim, and patient data from any external system. Customers can upload CSV, Excel, TSV, and pipe-delimited files using our Interface Import section. This new feature uses AI-powered field mapping to automatically interpret the structure of CSV/Excel files from other systems and map them into CMD. This allows customers who do not use our WebAPI to automatically import claims and patient data from any EMR/EHR via a report or export from their software.

In this release, we updated the Universal Import user interface to simplify the process and improve readability. We enhanced it by removing unnecessary fields and clutter, renaming file naming conventions, automating the matching of existing templates, and converting mapped preview data into a table. This facilitates scanning either the header or CMD field to ensure accurate field matching.

---

## Universal Import: Template Selection

---



Universal Import detected that you haven't imported a file that looks like this yet. You'll be able to use the below information to select this template the next time you import this kind of file.

EHR / Other System Name

Export / Report Name

Did you expect this file to match a template? Your EHR or other system may have changed its export format. [Show Other Templates](#)

---

[Next](#) [Cancel](#)

---

For more information visit our [Universal Import Help Article](#).

## Enhancements

### Claim: New Option to Stop Showing the All-Inclusive Code Warning

All-inclusive codes are common in Rural Health Clinics and Federally-Qualified Health Centers. In our system, entering a claim with an all-inclusive code triggers a warning. This notification indicates that an all-inclusive code has been selected and explains the impact on other charges. These charges will either not be billed or will be billed with a nominal amount, such as \$0.00 or \$0.01, depending on system configuration.

Because this all-inclusive code prevents users from editing other charges on the claim, the pop-up informs them that these are non-editable amounts. The problem is that this is inconvenient for some customers that work thousands of claims, when it happens for every claim.

To address this, a "Don't show this again" checkbox has been added to the All-Inclusive Code warning message in this release. Checking this box allows users to suppress the All-Inclusive Code warning dialog for the same user when editing or creating a new claim with an inclusive code.

**You have selected an all inclusive code.**  
 All other charges on the claim will be sent with an amount of \$0.00

Don't show me this again

OK

We also added a tooltip under the procedure description so that the information is still available without disrupting or prompting the user to close the warning.

Save Cancel Print Review Activity More

Claim Charges Additional Info Ambulance Info

ICD A ICD B  
 M25.561 M25.562 ICD C ICD D  
 ICD E ICD F ICD G ICD H  
 ICD I ICD J ICD K ICD L

**Charge Options**  
 Update patient ICD & Procedure Code defaults  
 Create a new charge panel from procedure(s)  
 Set all charges to  
 NO CHANGE

From	To	Procedure	POS	TOS	Mod 1	Mod 2	Mod 3	Mod 4	DX Pointers	Unit Price	Units		
02/19/2026	02/19/2026	80048	54	1					AB	50.00	1.00	50.00	SEND
02/19/2026	02/19/2026									0.00	1.00	0.00	DELE
02/19/2026	02/19/2026									0.00	1.00	0.00	SEND
										0.00	1.00	0.00	SEND

2 Charges

**Description:**  
 BASIC METABOLIC PANEL

**Note:**  
 This is an all-inclusive code. All other charges on the claim will be sent with an amount of \$0.00

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

## TCN Search Now Ignores the TCN Prefix

We recently added the submitter-level TCN Prefix feature to help the clearinghouse ensure that ERAs are routed correctly and to facilitate ERA splits.

This feature has been very helpful, but it could be inconvenient for some users depending on their workflow because if the full TCN, including the prefix, was copied from a payer report or EOB, users could not search for the correct claim or patient within the application. They would have to carefully copy the number while omitting the prefix, which could be difficult due to the small font on some reports.

In this release, the submitter-level TCN Prefix was updated so the system ignores it when searching by TCN in the claim, claim tracker, patient, insurance check, and ERA searches. This means that copying a TCN number from an EOB will no longer require partial selection for the search to function. This update allows the system to locate claims that include the prefix when copied.

## Resolutions

## WebAPI: Payer & Patient Default Value Codes Not Set on Claims

We have systematically implemented the ability to use more default codes from interface claims (such as value codes from revenue codes), but patient default codes and payer default value codes were still missing. In this release, we are adding both Patient and Payer default value codes. When a claim is received via the WebAPI, the system will now add the default value codes in the following priority order:

1. Value Codes from the interface message (if sent)
2. Payer Defaults
3. Patient Defaults
4. Revenue Code Defaults

At each priority step, the system will only add value codes that have not already been included. For example, if the interface message sends value code 16, and the patient defaults include value code 16 and value code 18, then the message's amount for value code 16 will be used, followed by the patient's amount for value code 18.

## Practice email address is automatically set as the "Reply-To" address for electronic statements

Previously, the practice email address was automatically set as the Reply-To address for electronic statements. Users were often unaware that the practice email was used as the default Reply-To email address when setting up their electronic statements, as this option is part of the electronic statement options. To prevent user error, we updated this release to default the Reply-To address to "No Reply," even when a practice email address is available. This will ensure that any Reply-To address set for electronic statements is added intentionally by the customer. Please note that existing configurations will not change. This applies only to electronic statement setups moving forward.

## ERA: Incorrect Claim Status

Resolved an ERA issue that caused a charge balance with no additional payers to display an incorrect claim status. It showed a "PAID" status instead of "BALANCE DUE PATIENT," despite an existing balance and no other payers.

## ERA & EOB: Incorrect allowed amount on refund/reversal

We corrected an issue within our ERA/EOBs causing an incorrect auto-calculation of the allowed amount on some refund/reversals.

## Universal Import: Support First and Last Names with Spaces

We corrected an issue within our universal import detected during testing where names containing spaces but no hyphens, apostrophes, or symbols (e.g., "De La Cruz," "Van Dyke," "Mary Jane") were not recognized correctly during import.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.3.0 - February 19, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

#### New Features

Universal Import - BETA

#### Enhancements

New Option to Ignore Modifiers Received From The WebAPI

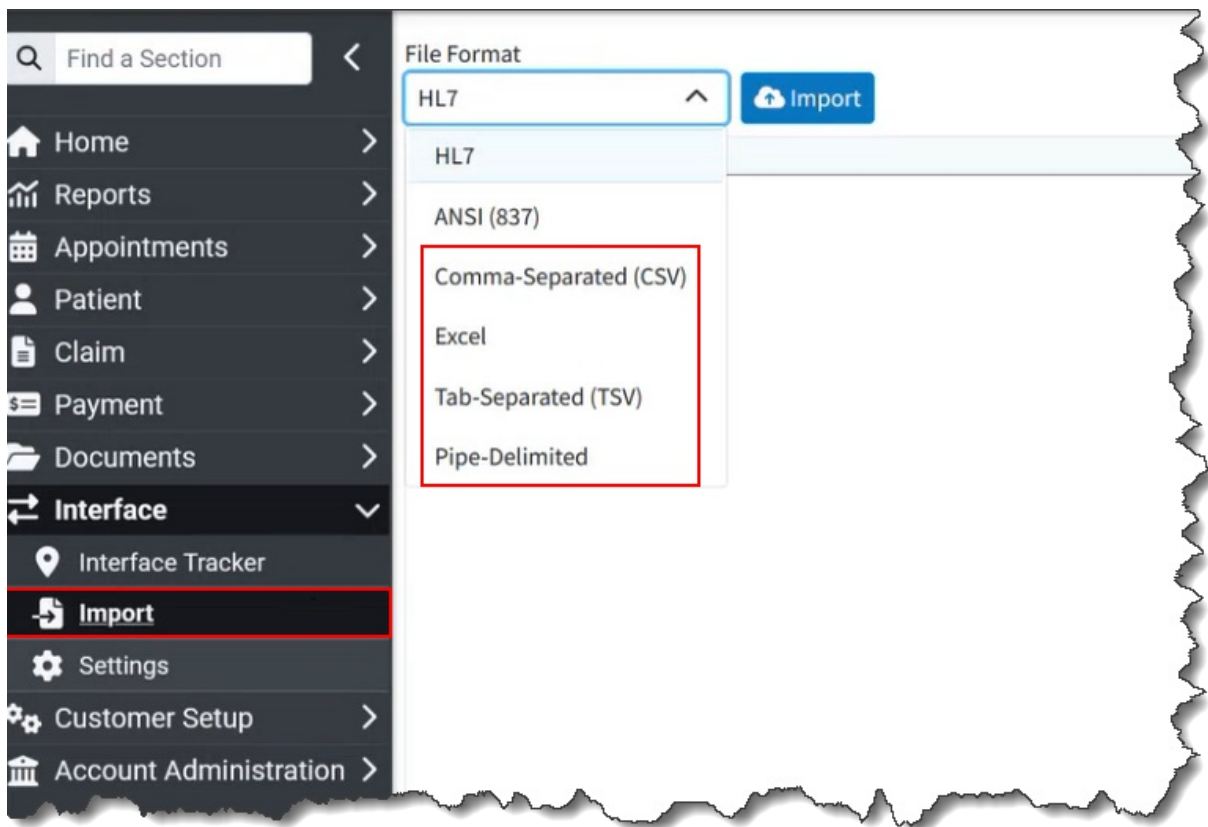
## New features

### Universal Import - BETA

**These new import options are currently in BETA testing and will be available to all customers soon!**

This release introduces the beta version of CollaborateMD's Universal Import feature. Many Electronic Health Record (EHR) systems now include interfaces designed to export data, often in HL7 standard format, offering greater flexibility to their users. However, a common issue is that numerous EHRs lack interfaces for external systems. This deficiency creates substantial additional work for medical practices and billing services, as they are forced to manually input claims and patient data into CMD.

Our Universal Interface Import allows users with an EMR/EHR that has not built an interface with us to import encounter, claim, and patient data from any external system. Customers can now upload CSV, Excel CSV, and pipe-delimited files using our Interface Import section. This new feature uses AI-powered field mapping to automatically interpret the structure of CSV/Excel files from other systems and map them into CMD. This feature allows customers who do not use our WebAPI to automatically import claims, and patients from any EMR/EHR via a report or export from their software.



Customers can also manually import claims into our system in the HL7 format or claims from an 837 ANSI file format into CollaborateMD.

For more information visit our [Universal Import Help Article](#).

## Enhancements

### New Option to Ignore Modifiers Received From The WebAPI

When configuring interfaces, we can currently set up the interface to ignore the price that comes over in the message and use our own pricing instead. This is necessary because CMD, as the billing system, houses the fee schedules and contracts. We also have many defaults & automations around modifiers (specifically situational modifiers), but those rules are not used if modifiers are received from your EMR. Some users do not want this since if the modifiers entered in the EMR are wrong, automations will not work.

In this release, we added new options to the Interface Settings screen (for WebAPI Interfaces) that allows you to ignore modifiers sent via the interface. The new setting "**Set modifiers based on the modifiers received from the Interface?**" will default to **Yes** to allow setting the modifiers based on the modifiers received from the interface (just like it does today). Even if this is set to Yes, default and situational modifiers will be used if they are not received from the Interface. When set to **No** it will ignore the modifiers sent from the interface.

### WEBAPI Interface Settings

Interface Status  
Active ▼

---

Allow interface to update existing patient information (address, insurance info, etc)?  
New patients will still be created as needed regardless of this setting.  
 Yes  No

---

Allow interface to archive patient insurance information? Insurance information will still be updated as needed regardless of this setting.  
 Yes  No

---

Set charge pricing based on unit price received in interface message? By default, the pricing information within the message is ignored and the charge amount is determined based on the pricing information in CollaborateMD (code default price or fee schedule price).  
 Yes  No

---

Set modifiers based on the modifiers received from the Interface? Even if this is set to Yes, default and situational modifiers will be used if they are not received from the Interface.  
 Yes  No

---

Specify the vendor associated to this WebAPI interface:  
Alex WebAPI ▼

For more information visit our [Configure Interface Settings Help Article](#).

## New Option To Get Current Claim Status Through The WebAPI

We previously introduced an API endpoint request that allows users to set the claim status. To allow API vendors to continue building on this capability, we added the ability to retrieve the current claim status. This will return an XML response that includes the Claim Status ID, Claim Location ID, and Claim Status Display value.

## Resolutions

### Report Performance Issue When Combining Results

We resolved an issue in our Report Viewer where reports, run for multiple customers with the "combine results" option selected, took longer to process compared to running the same report with separate result

## Mark as Fixed Issue in Claim Tracker

Corrected an issue within claim tracker where, when checking the Mark As Fixed checkbox on Intelligent Claim Rejection messages should also mark all of the hidden issues as fixed but instead was flagging issues as "Not Fixed."

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.2.0 - February 3, 2026

[New features](#) | [Resolutions](#)

### Highlights

**New Features**

[New Interface Automations](#)

## New features

### New Interface Automations

Our CollaborateMD interface provides a powerful bridge to automatically create patients, appointments, and claims in the CMD application via interface messages (ADT, SIU, DFT). Previously, after a patient appointment or claim was received & created via the interface, users still had to perform manual work such as checking eligibility, reviewing/scrubbing claims, or address verification. Powerful add-on features like Eligibility, Claim Scrubbing, and Address Verification had to be used either through a separate integration with our WebAPI (for Eligibility only) or manually in the application. In this release, these actions can now be automated to occur as soon as the claim, patient, or appointment is received. For more information visit our [Manage Interface Automations Help Article](#).

We added the following new automations that can be enabled and configured within the services section for Auth Reps:

#### Eligibility Interface Automation

We created 2 new eligibility settings to allow eligibility to be automatically checked when a patient, appointment, or claim is created via the interface:

- **Automatically check eligibility when an appointment or claim is created over an Interface?**

- Select **Yes** if you want an automatic eligibility check when creating an appointment or claim, from an SIU or DFT message received via the interface.

- **Automatically check eligibility when a patient is created or updated over an Interface?**

- Select **Yes** if you want an automatic eligibility check when creating a patient from an ADT message received via the interface.

Eligibility for Customer #10001911 - COLLABORATEMD

**i** This service is included in your account's price plan

Enable eligibility checking

**Eligibility Settings**

Automatically check eligibility when saving appointment?  
 Yes  No

Automatically check eligibility when an appointment or claim is created over an Interface?  
 Yes  No

Automatically check eligibility when a patient is created or updated over an Interface?  
 Yes  No

Limit automatic eligibility checking to:  
Once Every 30 Days

Show user an alert if they lack permissions to check eligibility when saving an appointment that otherwise would have run eligibility automatically?  
 Yes  No

**Save** Copy Configuration Cancel

For more information visit our [Manage Real-Time Eligibility Help Article](#).

### Claim Scrubbing Interface Automation

We created a new claim scrubbing setting to automatically review claims created via the interface:

- **Automatically review and scrub new claims as they are entered through an Interface?**

- Select **Yes** if you want to automatically scrub new claims created from a DFT message received via the interface.

## Claim Scrubbing for Customer #10001911 - COLLABORATEMD

*This service is included in your account's price plan*

Enable Claim Scrubbing

### Claim Scrubbing Settings

Specialty

Dermatology

Automatically scrub new claims as they are entered in through the claim section?

Yes  No

Automatically review and scrub new claims as they are entered through an interface?

Yes  No

Automatically scrub existing claims when coding changes are made?

Yes  No

Only perform automatic claim scrubbing for claims that contain more than one charge?

Yes  No

Exclude procedure codes marked as Retail or Other Medical from the code scrubbing process?

Yes  No

Save

Copy Configuration

Cancel

For more information visit our [Manage Claim Scrubbing Help Article](#).

## Address Verification Interface Automation

We created a new Address Verification setting to automatically scrub addresses when creating/editing a patient record via the interface:

- **Automatically scrub addresses when the above changes are made via Interface?**
  - Select **Yes** if you want to automatically scrub addresses (based on your pre-selected options) when creating or editing a patient record from an ADT/DFT message received via the interface.

## Address Verification for Customer #10001911 - COLLABORATEMD

*This service is included in your account's price plan*

Enable Address Verification

### Address Verification Settings

Automatically scrub the following when changes are made:

Patient Address

Insured Address

Guarantor Address

Statement Recipient Address

Payer Address

Automatically scrub addresses when the above changes are made via Interface?

Yes  No

Save

Copy Configuration

Cancel

For more information visit our [Manage Address Verification Help Article](#).

### Coming Soon - Patient Estimates Interface Automation

The ability to automatically generate patient estimates upon appointment or claim creation via the interface will be added soon!

## Resolutions

### Claim Control for Large Batches

We resolved an issue within Claim Control that could prevent users from changing the status of more than one thousand claims at once. This action would cause a "Maximum call stack size exceeded" console error when updating the claim status. With this new update, when a user updates claim statuses, it is performed in batches of 1,000 and pre-selects all the remaining claims that exceed 1000 after in initial claim status update. If more than 1,000 claims are selected for saving, a modal will appear stating: *"Only 1,000 claims can be saved at once. After the save is complete, the remaining X claims will be selected in the table and can then be saved."* Following the save, the selections in the table will be updated accordingly.

### Intelligent Claim Rejections Enabled by Default

The Intelligent Claim Rejection feature was enabled for most customers, but an issue prevented its automatic enablement for new submitters. This issue marked the submitter in CMD with the feature turned on without changing the submitter request sent to ePS. In this release, we corrected this issue to ensure that submitter registrations sent to ePS turns this feature flag on.

### Intelligent Claim Rejections Enabled by Default

In this release, we corrected some appointment reminder issues where some appointments were not sent and others had expired confirmation tokens. This issue was causing the confirm & cancel links in the appointment reminder to stop working after an additional reminder was sent to the patient.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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Release 16.1.0 - January 20, 2026

## Enhancements

### Highlights

#### Enhancements

New "To Date" Optional Column

New ERA Warning when Patient Name Doesn't Match

## Enhancements

### New "To Date" Optional Column

We have always displayed the "From" Date (Date of Service) as a column in our Claim Control, Claim Tracking, and Follow-Up Management tables. This represents the first date of service on the claim. Customers who treat patients for extended periods (especially those using Institutional claims) could not view the complete range of service dates in these tables. In this release, we added the "To" Date (representing the last date of service on the claim) as an optional, hidden-by-default column.

### Select Columns

Available Columns	Visible Columns
First Billed Date +	Check
Last Billed Date +	Claim #
Follow Up Date +	DOS
Patient # +	Patient
Billing Provider +	Primary Payer
To DOS +	Review Status

Done

### New ERA Warning when Patient Name Doesn't Match

A new ERA Warning has been implemented for instances where the patient's first or last name on the ERA (EraClaim.plast and EraClaim.pfirst) does not match the name recorded in our application. The warning

message, "Warning: The patient name as sent by the payer does not match your records," will alert users to this discrepancy.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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## Release 16.0.0 - January 5, 2026

### Enhancements

#### Highlights

##### Enhancements

New Referring Provider Note Report Field

New Optional Columns in Claim Control &

Follow Up Management

ERA Claim-level Payments Now Evenly Applied

## Enhancements

### New Referring Provider Note Report Field

In this release, we added a new report field for the Referring Provider's Note text field. This new report field (available under Referring Data) is useful for recording various information. For example, users can note the name of the facility a referring provider is from, allowing them to report on the number of lab samples received from each facility.

Report Fields	Columns
<input type="text" value="Search for fields"/> <ul style="list-style-type: none"> <li>A City</li> <li>A Credentials</li> <li>A Email</li> <li>A Fax #</li> <li>A First Name</li> <li>A Full Name</li> <li>A Full Name w/ ID</li> <li>A Home Phone</li> <li>A Inactive?</li> <li>A Last Name</li> <li>A Marketer</li> <li>A Medicaid ID</li> <li>A Medicare ID</li> <li>A Middle Initial</li> <li><b>A Note</b></li> <li>A NPI</li> <li>A Pager</li> </ul>	<input type="text" value="Referring Note"/>  <input type="button" value="Add Data Group"/> <b>Groups</b> <div style="border: 1px dashed gray; padding: 10px; text-align: center;">           Drag &amp; drop fields here to add report groups         </div>

## New Optional Columns in Claim Control & Follow Up Management

Some customers use the **Account Type** and **Reference #** fields in CMD to store information that does not fit elsewhere in the application. While integrating fields for workflows across different specialties would be ideal, many customer issues can be resolved by allowing them to view this information in various places. In this release, we added these two columns as optional (not visible by default) in both Follow Up Management and Claim Control.

### Select Columns

Available Columns	Visible Columns
Last Claim Status Check +	Checkbox
Insurance Payments +	Alerts
Patient Payments +	Claim #
<b>Patient Account Type +</b>	Patient Name
Patient Reference # +	DOS
	Current Payer

[Done](#)

## ERA Claim-level Payments are Now Evenly Applied

Some payers (particularly for institutional claims) send only a claim-level payment rather than line-item payments. Previously, our system applied these payments by distributing as much of the paid amount on each charge as possible, and then as much of the adjusted amount on each charge as possible, resulting in uneven claim application, and requiring users to manually correct the ERAs for institutional claims. With this release, these payments will now be applied evenly.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

## Release 16.12.0 - June 22, 2026

[New features](#) | [Enhancements](#) | [Resolutions](#)

### Highlights

## New Features

Last Payment Amount Fields Now Available in New Agreement Required Warning When Adding a Reports

## Enhancements

Payer

"Delete Credit" Renamed to "Unapply Credit" in Manage Account

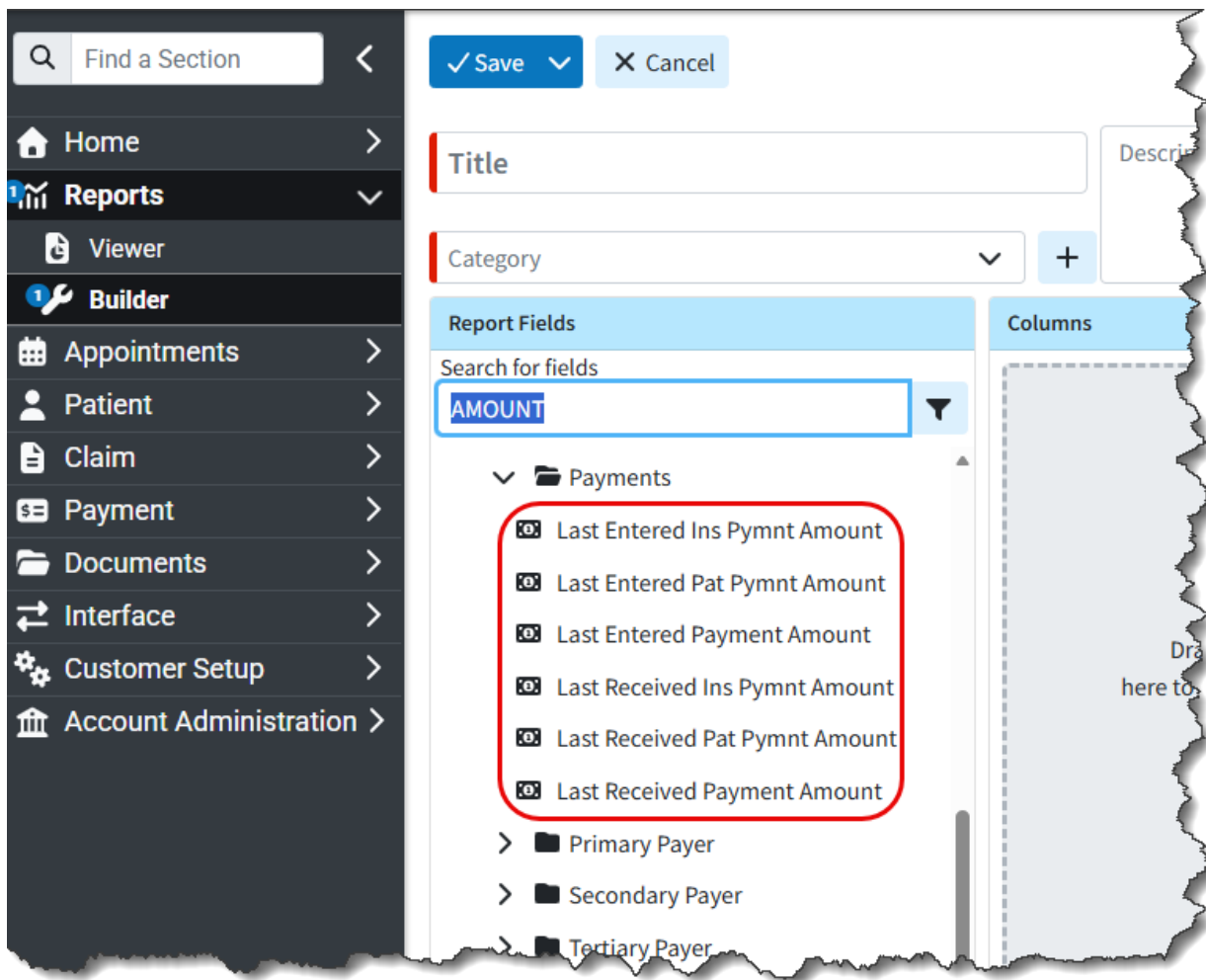
## New features

### Last Payment Amount Fields Now Available in Reports

Previously, charge-level reporting included fields for the date of the last payment received and the total amount of payments posted, but lacked the ability to report on the amount of the last payment itself.

In this release, we added six new charge-level report fields within the **Report Builder > Charge/Debit Data > Charges > Payments**, that complement the existing **Date of Last Payment** and **Total Payments Posted** fields, giving you a more detailed view of payment activity at the charge level:

- **Last Received Payment Amount** – Total of all payments received at the time of the last received payment.
- **Last Entered Payment Amount** – Total of all payments entered at the time of the last entered payment.
- **Last Entered Patient Payment Amount** – Total of all patient payments entered at the time of the last entered patient payment.
- **Last Received Patient Payment Amount** – Total of all patient payments received at the time of the last received patient payment.
- **Last Entered Insurance Payment Amount** – Total of all insurance payments entered at the time of the last entered insurance payment.
- **Last Received Insurance Payment Amount** – Total of all insurance payments received at the time of the last received insurance payment.



For more info on these report field descriptions, visit our [Payments Report Field Description Guide Help Article](#).

## Enhancements

### New Agreement Required Warning When Adding a Payer

Some payers require a signed agreement before professional or institutional claims can be submitted electronically. If claims are sent to the clearinghouse before this agreement is approved, they will be dropped to paper and mailed, resulting in additional charges.

To help prevent this, we have added a new warning that will appear when saving a payer that requires a claim submission agreement. The warning will notify you that:

- Claims cannot be sent electronically until the agreement has been completed and approved.
- Any claims submitted before the agreement is in place will be dropped to paper and mailed, incurring

additional charges.

Please note that claims cannot be sent electronically until the agreement is complete. **Any claims that you do send electronically will be sent on paper by the clearinghouse.**

To prevent paper claims from being printed, update the Payer's Clearinghouse Processing Mode to be **"Do not send claims to the clearinghouse for processing"**. Any other processing mode will cause the claims to be printed by the clearinghouse.

Once the agreement is in place, you can update the Processing Mode to "The clearinghouse will send the claims electronically" to submit all held claims.

[Save Anyway](#) [Cancel](#)

Visit our [Add New Electronic Payer Help Article](#) for more information.

## Improvement: "Delete Credit" Renamed to "Unapply Credit" in Manage Account

Previously, the **Delete Credit** option was used in all credit deletion scenarios within Manage Account, which could be misleading. When removing an applied account credit, the money is not actually deleted — it's returned to the Account Credit bucket to be applied elsewhere at a later time.

To better reflect what is actually happening, we have renamed this option to **Unapply Credit** when an applied account credit is selected. This distinction makes it clearer that selecting this option will not remove the funds from the account, but simply un-apply them so they can be applied to a different charge when needed.

Save     Close     Save & Re-Open     Activity     Create Task     Options

**JOSEPH MUNIZ (#37190993)**

**Patient Balance:** \$1,381.35    **Patient Credit:** \$479.45  
**Insurance Balance:** \$10,808.61    **Insurance Credit:** \$18.00

Transaction Listing    Find in table    ↑ ↓

DOS / Received Date	Procedure	Status / Memo
06/05/2026		
06/05/2026	00120	BALANCE DUE PATIENT
06/06/2024		APPLY ACCOUNT CREDIT - PATIENT PAYMENT - CREDIT CARD
02/05/2026		
02/05/2026	11055	SEND TO AMERICHoice OF NEW YORK INC. (MEDICAID NY) VI...
02/05/2026	11055	SEND TO AMERICHoice OF NEW YORK INC. (MEDICAID NY) VI...
02/05/2026	00148	COLLECTION
01/29/2026		
01/29/2026	11055	SEND TO AMERICHoice OF NEW YORK INC. (MEDICAID NY) VI...
01/29/2026		CREDIT - PATIENT COPAY - CASH
12/11/2025		
12/11/2025		HOICE OF NEW YORK INC. (MEDICAID NY)
01/29/2026		RICHoice OF NEW YORK INC. (MEDICAID NY)' (...)
06/12/2025		

Account Credit Listing    Find in table    ↑ ↓

DOS / Received Date	Status / Memo
Credits Due Patient	
Credits Due Insurance	

**Credit (Transaction 1975136528)**

Unapply Credit

**Credit (Transaction 1975136528)**

Unapply Credit

## More Universal Import Enhancements

We've made two additional updates to Universal Import in this release:

- Multiple Charges on a Single Line** – The import process now correctly handles multiple charges entered on a single line, ensuring that all associated dates, modifiers, units, and charge details are carried over accurately during the import.
- Improved Column Matching and Preview** – The import review screen now correctly displays all importable fields, even if a field is blank for the current row. This ensures all fields being imported are visible during review, preventing fields from appearing unmatched and providing a more accurate picture of your import before finalizing.

# Resolutions

## Fixed: CO-45 Adjustment Code and Amount Display Issue

We resolved an issue where adding a CO-45 code to the Adjustment Reasons on a payment row caused the code and amount to move to the unpaid reasons column, while the amount remained visible in the Adjusted column as well — resulting in the amount appearing in both columns simultaneously.

This release includes two specific fixes related to this behavior:

- **Adjustment Amount Handling** — When an adjustment amount is saved without a code and a code is subsequently added that triggers an automatic move to the unpaid column, the adjustment amount will now move consistently with the code. It will no longer appear in both the Adjusted and Unpaid columns at the same time.
- **Payment Automation Scope** — Payment automations tied to a specific adjustment code (such as code 96) will now only affect that specific code. Unless a code is configured to process as a total denial, it will remain in the correct column and will not inadvertently trigger column changes for other codes on the same row.

## Fixed: Source Claims Now Correctly Deleted When Combining Claims

We resolved an issue where combining claims in Claim Control would successfully create the new combined claim, but the original source claims were not being deleted as expected. With this release, combining claims will now correctly create the new claim and delete the original source claims in a single action.

## Improved: Denials Report Performance

We resolved a performance issue that was causing the Denials Report to run slowly, even when running it for a short date range like a single week. So, With this release, the Denials Report will now run significantly faster, even for larger date ranges.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

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