

Release 16.20.0 - October 19, 2026

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

Highlights

New Features

Updated E-statement Experience: Cleaner, Easier-to-Read E-Statement in the Payment Portal

New Payer Option: Round Anesthesia Units Up to the Next Whole Unit

Enhancements

New Field: Account Type Now Shown in the Account & Claim Summary

Update: New "Admin Users" Can Now Add Practices by Default

New WebAPI Capabilities: Deposit Date on Payments and Claim Statuses by Name

New features

Updated E-statement Experience: Cleaner, Easier-to-Read E-Statement in the Payment Portal

In this release, we've redesigned our e-statement in the Payment Portal so patients can read and pay their statement more easily, especially on a phone. The new updates are:

- **More room for the statement:** We updated the header, footer, and sidebar so less of the screen goes to names, addresses, and blank space. Almost the whole screen on mobile can now be used for the statement itself.
- **A simpler charges table:** The table used to have four columns, and long descriptions ran onto several lines. On mobile it now has two columns: each charge, followed by a line for each payment. On desktop the table still has separate columns, so patients can see the amount and balance side by side.

We want patients to understand their statement at a glance. This release allows patients to get a more readable statement on any device, with less scrolling and less confusion over the table. A cleaner layout and an easier-to-scan table make it faster to see what they owe and why, which helps them pay with confidence.

The screenshot shows a mobile application interface for a medical bill. The title is 'ISOTOPE NUCLEAR MEDICINE - TEST'. There are two tabs: 'Summary' (selected) and 'Breakdown'. The 'Summary' tab displays the following information:

- Visit: 02/01/2024**
- ABDUL, SAMANTHA L - ISOTOPE NUCLEAR MEDICINE - ...**
- TRIM SKIN LESION** \$208.00
- 02/01/2024
- Admission 10/30/2024**
- ABDUL, SAMANTHA L - ISOTOPE NUCLEAR MEDICINE - ...**
- BEHAVIORAL HEALTH TREATMENTS/ SERVICES (ALSO SEE 09** \$200.00
- 10/30/2024
- Patient Payments** -\$40.00
- 11/26/2025
- Amount You Owe** \$368.00
- Provider: BEARD, BLACK**

Below this is a table with the following columns: Description, Charges, Payments / Adjustments, and Copay Due.

Description	Charges	Payments / Adjustments	Copay Due
11/06/2025	\$250.00	\$0.00	\$20.00
OFFICEOP VISIT EST			
PT KEY			
COMPONENTS			
PROB FOCUS HX			
PROB FOCUS EXAM			
STRTFWD MED			
DECISION			
TOTAL			\$20.00

At the bottom, there are two links: 'Print Estimate' and 'Estimate Disclaimer'.

New: Smarter Provider Adjustments

A provider adjustment is a payment that isn't tied to a specific claim. For example, a payer may have overpaid you \$250 earlier and now pays \$250 less on a later check, without an EOB that explains it. Despite the name, provider adjustments are payments. They adjust the amount of the check. These Provider adjustments have been usually hard to manage because they have no clear reason attached.

With this release, provider adjustments now show up in your reports next to the right provider, practice, office, or facility. You'll no longer see them grouped on a "No Provider" line. This makes it easier to reconcile checks and to see revenue by provider or location so your reports can attribute it correctly.

CMD will work out where an adjustment belongs in the following order:

1. **Linked to a claim:** If the adjustment is linked to a claim, it uses that claim's provider, practice, office location, and facility.
2. **Matched by NPI:** If it isn't linked to a claim, CMD tries to match the NPI on the adjustment to one of your providers, practices, or office locations, and fills in the related details. If the NPI matches an office location, the adjustment also gets that office's practice. If the match doesn't identify an office, CMD uses the practice's first office location. If it doesn't identify a provider, CMD uses the provider from the first claim for that practice and office.
3. **No NPI match:** If the NPI doesn't match anything, CMD uses the practice, provider, facility, and office from the first claim on the check.

 Please note that this applies to Provider Adjustments posted on or after Monday, October 19, 2026.

New Payer Option: Round Anesthesia Units Up to the Next Whole Unit

Anesthesia time is usually converted to units at 15 minutes per unit. For example, 15 minutes is 1 unit, and 22.5 minutes is 1.5 units. But some payers, such as workers' comp and other plans that don't follow Medicare rules, don't accept partial units and want them rounded up.

In this release, we've added a new option to a payer's billing options that rounds anesthesia time up to the next whole unit. This option lets you meet that requirement without editing each claim by hand. When the option to "**Round anesthesia units up to whole units**" is checked for a payer, anesthesia units will be rounded up to the next whole unit. The rounding happens when the claim is entered, including anesthesia minutes that arrive through an interface, claims imported with Universal Import, and claims typed in manually.

> Clearinghouse Connection
 > Notes
 > Alerts
 > Tasks
 ✓ Billing Options

General Provider Patient ERA

Professional

Default POS

Default Claim Note

☐ Do NOT print the payer address on the top of the form
☐ Exclude patient payments from Box 29
☐ Print the license number in Box 31

☒ Round anesthesia units up to whole units

☐ 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

☐ Print ICD code for first diagnosis pointer in Box 24E
☐ Send minutes instead of units on anesthesia claims
☒ Round anesthesia units up to whole units
☐ Send anesthesia start/stop times in a line note.

Institutional

⚠ Please note:

- The rounding does **not** happen at the time of billing. The units on the claim are what goes out to the payer.
- The option doesn't affect secondary claims, so the primary and secondary claims won't carry different units.
- Claims entered before you turn the option on are not affected/changed.

or more information, please visit our [General Billing Options Help Article](#).

Enhancements

New Field: Account Type Now Shown in the Account & Claim Summary

Account types can sometimes affect how you bill and work with a patient. Some practices use custom account types to decide how payments are posted or how claims are billed. Showing the account type in the account summary puts that information in front of staff while they work, so they don't have to look it up.

With this release, the account summary side panel now includes an **Account Type** field. You'll see it in the Patient section, the Claim section, and anywhere else the account summary appears. If you use account types to guide your workflow, you can now see them wherever you're working on a patient or a claim, without opening a separate screen.

▼ Account Summary for JOHNNY TEST

Family Account Type:	Regular
Account Type:	Payment Plan
Patient Balance:	\$898.04
Last Patient Payment:	\$80.00 (04/09/2026)
Insurance Balance:	\$5,231.16
Last Insurance Payment:	\$300.00 (07/18/2025)
Collections Balance:	\$0.00
Due Payment Plan:	\$327.04
⚠ Overdue: \$327.04	
Primary Insurance:	BLUE CROSS AND BLUE SHIELD OF FLORIDA
Copay:	\$30.00
Last Statement:	\$998.04 (mailed on 01/06/2025)
Statements Mailed Count:	2
Electronic Statement Count:	0
Last Visit:	09/03/2026
Next Appointment:	Not Scheduled
Follow-Up Date:	
Recall Date:	
✓ Last Eligibility Check:	193 days ago

> Notes

> Appointments

> Alerts 1

> Tasks 1

> Documents / Forms

or more information, please visit our [Account Summary Help Article](#).

Update: New "Admin Users" Can Now Add Practices by Default

During onboarding, an auth rep or owner often hands setup over to an admin. Because new admins couldn't create a practice, the person who wanted to hand off the work had to step back in and do that part themselves. With this release, when you create a new admin user, they now get **Access, Modify, and Create** permissions for Practices by default. Before, new admins only had Access and Modify, so they couldn't add a new practice. This means that Admin users you create from now on can add practices without any extra permission changes.

⚠ Please note that **this does not change existing users**. No one's current permissions are affected, including admins who already exist. If you want an existing admin to be able to add practices, you can still give them "Create" access for the Practice permission manually.

Before

The 'Before' screenshot shows the 'Permissions' section with 'COLLABORATEMD' selected. Under 'Set custom permissions', the 'Practice' row is highlighted with a red box and shows 'Access and Modify' in the dropdown menu. Other permissions like 'Provider', 'Facility', 'Referring', 'Payer', 'Payer Agreements', 'Codes', and 'Inventory' are also listed with their respective permissions.

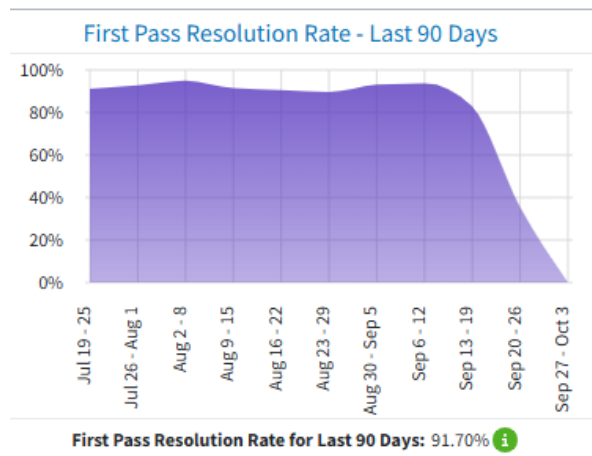
Now

The 'Now' screenshot shows the same 'Permissions' section, but the 'Practice' row is now set to 'Access, Modify, & Create' in the dropdown menu. A red arrow points from the 'Before' state to this state, indicating the change.

Visit our [Practices Help Article](#) for more information.

Improvement: Daily Updates for the First Pass Resolution Rate Gadget Are Coming Back

or the last several months, the First Pass Resolution Rate gadget on the welcome screen has only updated weekly because of performance issues. A weekly refresh means you could be looking at data that's several days old. This release adds the ability for the gadget to receive daily updates. Daily updates give you a more current view of how many claims are resolved on the first pass.



Improvement: Custom Payment Reports Can Now Include Insurance Check Data

Some practices need check-level details next to their payment details, such as which checks are committed and which still have money left to apply. Before, that information couldn't be combined with payment data in a custom report.

With this release, custom payment reports can now include **insurance check data** alongside individual payment information. For example, a custom Daily Deposit report can show whether each check has been **committed**, or whether an insurance check has an **unapplied amount**. Insurance check data is also now linked to credit data in custom reports. This means payments can be reported by **provider, practice, payer, and office**.

Please note that Insurance Check Data fields can only be added to your report by CollaborateMD.

New WebAPI Capabilities: Deposit Date on Payments and Claim Statuses by James

This release adds two improvements to the WebAPI for integration partners.

1. Deposit Date Now Supported on Payments

The WebAPI payment capability now accepts a **deposit date** in addition to the date the payment was received. For example, an integration can send the date a credit card payment settled as its deposit date. Many practices do their reporting by deposit date. The CMD application already tracks both dates, and the

VebAPI now matches it, so payments that arrive through an integration can be reported the same way.

. Claim Statuses Can Now Be Sent by Name

When an integration updates a claim's status, it can now send the **name** of the status as well as its identifier. Practices with hundreds of custom claim statuses previously had to look up the identifier for each one. Ending the name removes the need for that lookup.

We also added a new optional column (hidden by default) to the Custom Claim Status table for the status identifier for customers who use these identifiers and want a visual representation.

Select Columns

Available Columns	Visible Columns
Status ID +	Claim Status
	Due To
	Insurance
	Not-billed
	Restricted
	Created By

Done

Resolutions

Resolved Issue: ERA Interest Payments Not Linking to the Correct Claims

When an ERA included interest paid through a provider adjustment, CMD didn't always link the interest to the right claims. There were two problems:

- **Interest didn't match its claim.** The interest amount on the claim and the provider adjustment have opposite signs, so CMD often failed to match them and the interest wasn't linked to the correct claim.
- **Interest was spread by balance, not by actual interest.** When one interest adjustment covered the interest for many claims, CMD linked it to all of them and then, in most cases, applied the full amount to a single claim.

This issue has now been fixed and CMD now matches interest adjustments to claims correctly. It also uses each claim's actual interest amount to decide how much to apply to that claim, so each claim gets only its own interest. This makes it easier to reconcile interest against the ERA and to report on interest by claim.

Resolved Issue: Multiple Universal Import Resolutions

Corrected an issue where, in rare cases, saving a new claim co

Universal Import Removing Dashes and Other Characters from Procedure Codes

Universal Import removed dashes from procedure codes before matching them. A code like **99213-TELE** was read as **99213TELE**. Many practices add a dash-separated suffix to a code for reporting. That suffix isn't billed, but the code is its own entry in the practice's code library. Because the dash was removed, Universal Import couldn't match these codes to the ones in the library. Depending on the import, this could create a new, incorrect code or leave the charge uncreated.

This issue has been fixed. Universal Import now keeps dashes and other special characters in procedure codes, in line with what you can enter in the application. Codes with suffixes are matched to the correct code in your library.

Universal Import Setting a Blank Admission Hour to 12:00 AM

When you imported a claim with Universal Import and the **Admission Hour** column was blank or missing, CMD set the claim's admission hour to **12:00 AM - 1:00 AM** instead of leaving it empty. The claim then showed an admission time that wasn't in your file.

This issue has now been corrected. If your import file has no Admission Hour, the claim's Admission Hour stays blank.

Universal Import Not Reading the Procedure Code Column?

In some cases, Universal Import didn't read the procedure codes from your file, even though the file had a Procedure Code column. The import preview showed the column matched correctly and listed no errors. When you completed the import, it warned about a missing or invalid CPT code and didn't create the claim, because it found no valid charges.

This issue has been fixed. Universal Import now reads the procedure codes from the Procedure Code column, and claims are created with their charges.

Improvement: WebAPI Supervising Providers With a Space in the Name Are Now Matched

Previously, CMD matched supervising providers sent via the WebAPI as "Last, First" when no identifier or sequence number was included. If either name had a space, CMD couldn't match the provider, and Interfacetracker showed a warning that the supervising provider could not be matched.

With this release, when an integration sends a supervising provider in the XML and puts both names in the **LastName** field, such as "Last, First", CMD can match the provider even if one of the names contains a space.

Names like “John, Van Gogh” or “De LaGrange, Mike” now match.

Resolved Issue: Time Sent on Institutional Claims for Non-Inpatient Bill Types

For institutional claims with outpatient bill types such as 32x, CMD sent the admission time to the clearinghouse along with the admission date. Under UB-04 rules, only the admission date should be sent on these claims. Admission time applies to inpatient claims.

This issue has been fixed. For non-inpatient bill types, CMD now sends only the admission date. Admission time is sent only on inpatient claims.
