# Release 16.21.0 - November 2, 2026

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**New features** | **Enhancements**| **Resolutions**

## Highlights

**New Features**
New Feature: View Past Claim Submissions And Reorganized Print Menu
New: Eligibility Billing Alerts in Claim Review
New: E-Statements & Payment Portal Communications to Guarantor
New: Separate Minimum Amounts for Paper and Electronic Statements

**Enhancements**
Statements, Estimates, and Payment Plans Now Appear Separately in the Payment Portal
Improvement: Standard "Select All" Checkbox Is Back in Batch Statements
New Report Field: First Visit Date
Payment Automations Now Follow the Order You Set

# New features

## New Feature: View Past Claim Submissions And Reorganized Print Menu

illers working rejections, denials, and appeals need to know what the payer actually received. Before, you ould print the claim or preview the electronic claim as it is now, but not as it was sent. If the claim had beer dited since, those views no longer matched the submission.

With this release, you can now see exactly what was sent to the payer for any past claim submission. This eature is available in **Claim Tracker** and the **Claim** section, and it adds two ways to look at a past ubmission:

- **View Electronic Claim:** the claim exactly as it went to the payer, for any claim sent electronically. This is the best choice if you're comfortable reading electronic claims.
- **View Claim Form:** the **CMS-1500** or **UB-04** form, as the clearinghouse interpreted the electronic clair This is the best choice if you're more familiar with paper claims. It preserves the patient name, each charge, and the amounts, codes, and units that were sent.

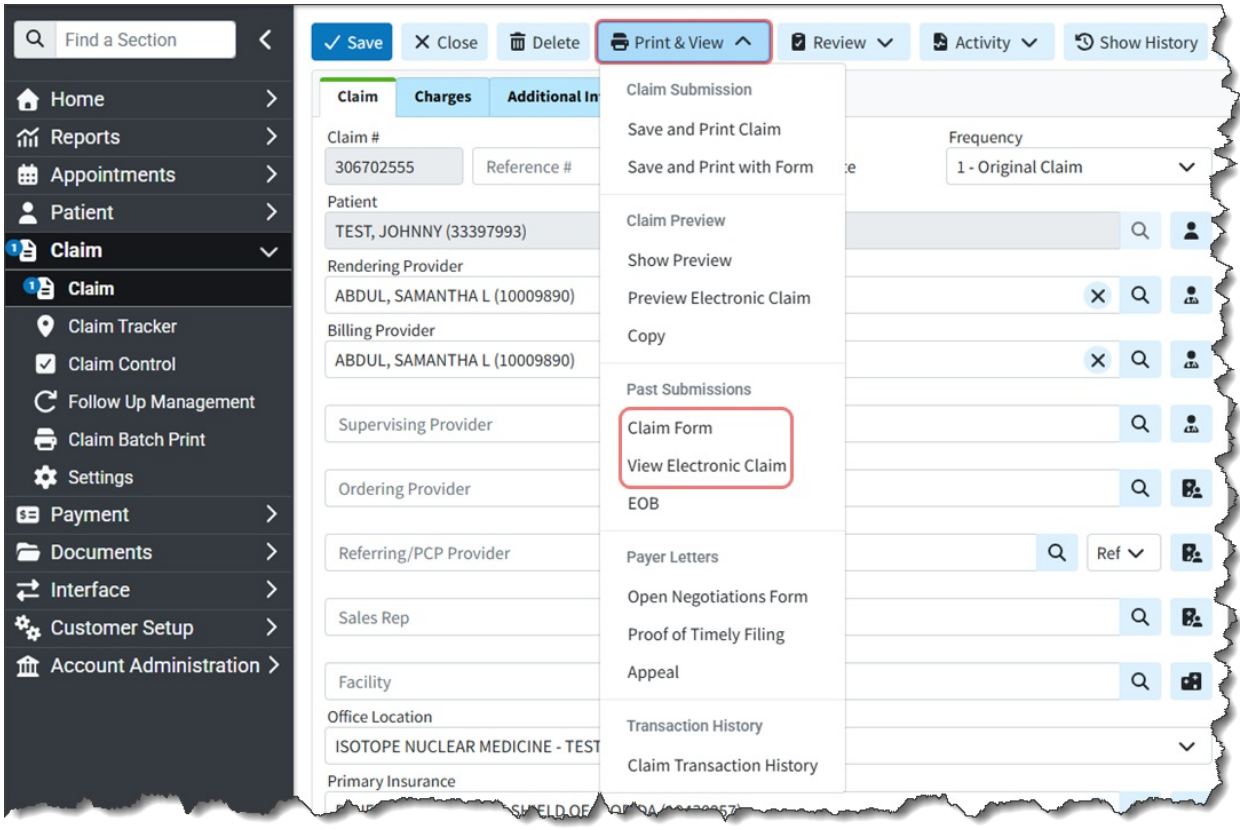
oth show the claim as it was when it was submitted so if you changed the claim afterward or resubmitted , you still see what the payer originally received. This means that you can check what a payer received efore you appeal or dispute a decision, and use it to support your case.

⚠ Please note that an electronic claim has more places to send information than a paper claim, so there isn't an exact one-to-one match between the two. For example, an electronic claim can carry several CLIA numbers, and it can carry separate operating, ordering, referring, and PCP providers. The paper form can't show all of that. If you need the full detail of what was sent electronically, use **View**

**Electronic Claim.**

We also added an update to the **Claim** section, where the **Print** button is now **Print and View**. It brings together everything that was in the Print menu, the new past submission options, and the electronic claim review that used to be in the **More** menu, so all previews are in one place. The menu is grouped like this:

- **Claim Submissions:** Print Claim, Print Claim with Form
- **Claim Preview:** Show Preview, Preview Electronic Claim
- **Past Submissions:** Claim Form, View Electronic Claim, EOB
- **Payer Letters:** Open Negotiation, Proof of Timely Filing, Appeal
- **Transaction History:** Claim Transaction History



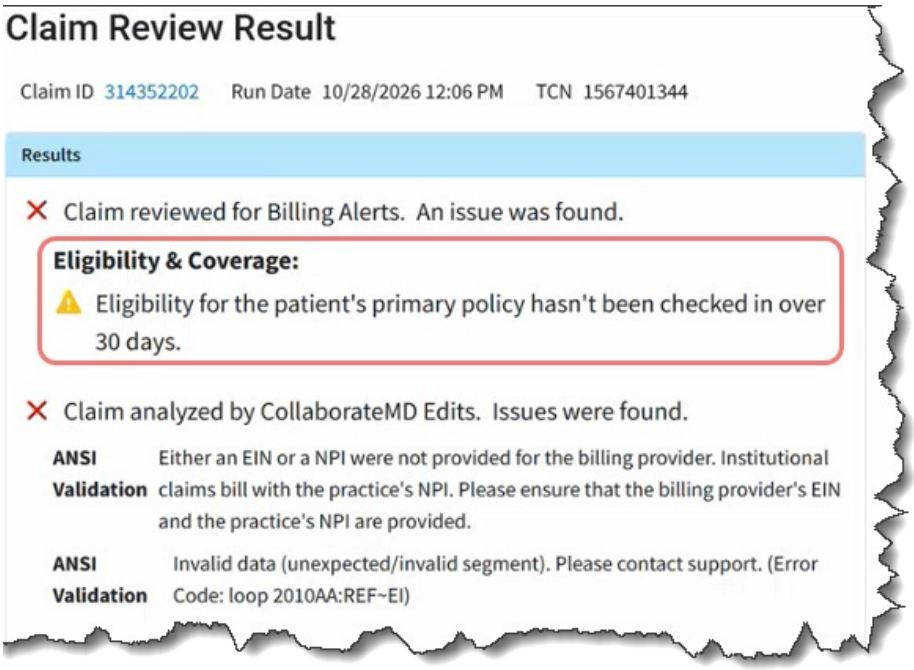

For more information, please visit our Print & View Options Help Article.

## New: Eligibility Billing Alerts in Claim Review

Most practices and billing services have a process for verifying benefits, but things can still slip through the cracks. This is especially true as more eligibility checks happen automatically, for example when a patient is created through an EHR integration, and nobody looks at the result.

With this release, the Claim Review results now include an **Eligibility Coverage** section. It shows errors and warnings when something may be wrong with a patient's insurance eligibility, so you can fix it before the claim goes out. It checks every policy on the claim and runs wherever Claim Review runs, including the Claim screen, Claim Control, and the WebAPI. Claims that may have an eligibility problem are flagged before

ubmission, so you can check coverage or update the policy and avoid a likely denial.

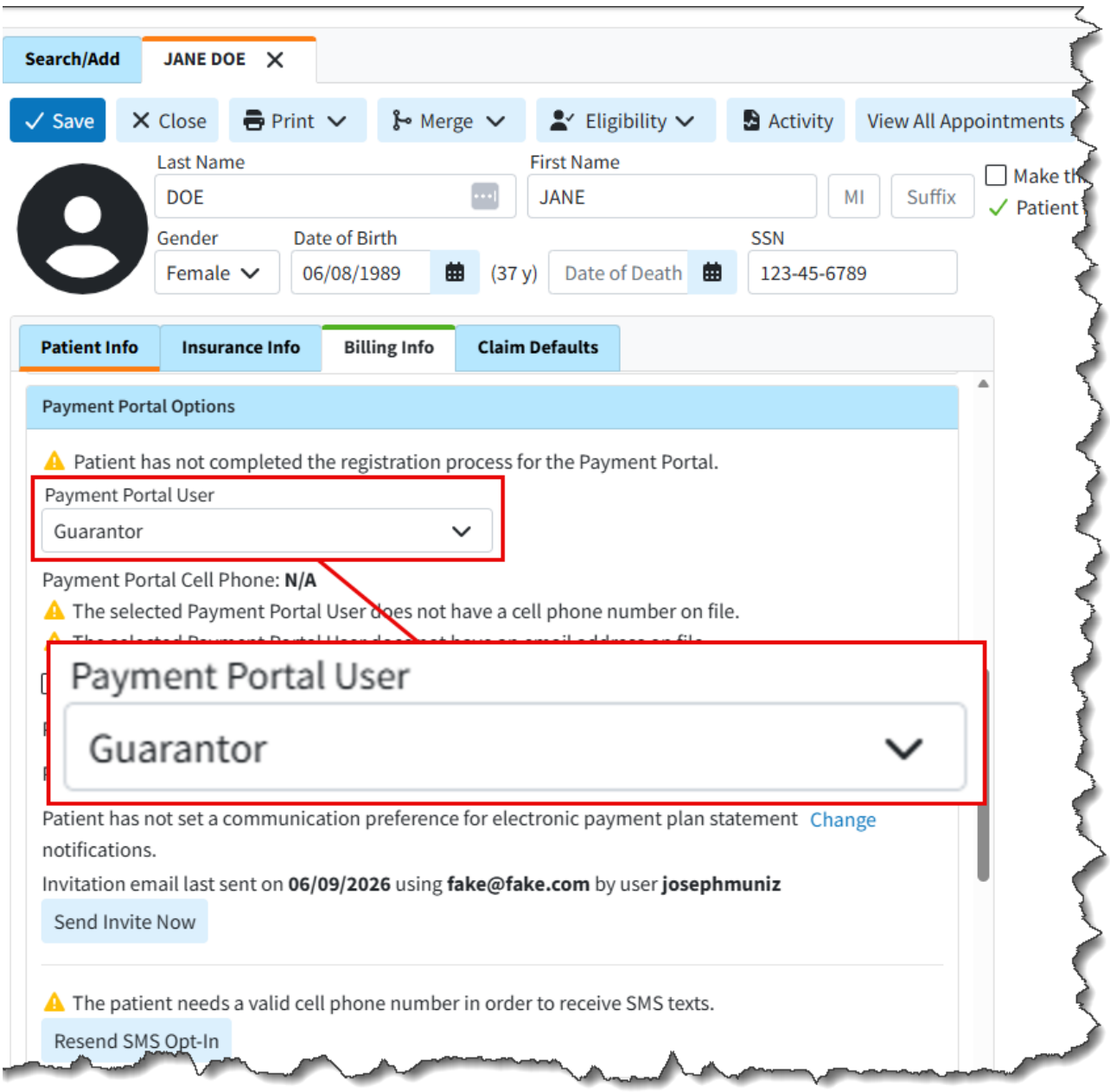



⚠ Please note that if eligibility is turned off for your account, the Eligibility Coverage section will not appear on your claim review results.

## lew: E-Statements & Payment Portal Communications to Guarantor

Intil now, all E-Statement and Payment Portal communications went to the patient's own cell phone and mail. But there are scenarios where they should go to a Guarantor instead. For example, a 17-year-old ight have their own email in the system while a parent is the guarantor and should get all the payment essages.

Vith this release, you can now choose who the Payment Portal user is. A new**Payment Portal User** ropdown has been added to the **Patient** section, under **Billing Info → Payment Portal Options**. This allows ou to select a different person (such as the Guarantor) as the user. CMD then uses that person's email ddress and cell phone number for Payment Portal communications. This includes the Payment Portal nvite, receipts, and statement notifications.




⚠ Please note:

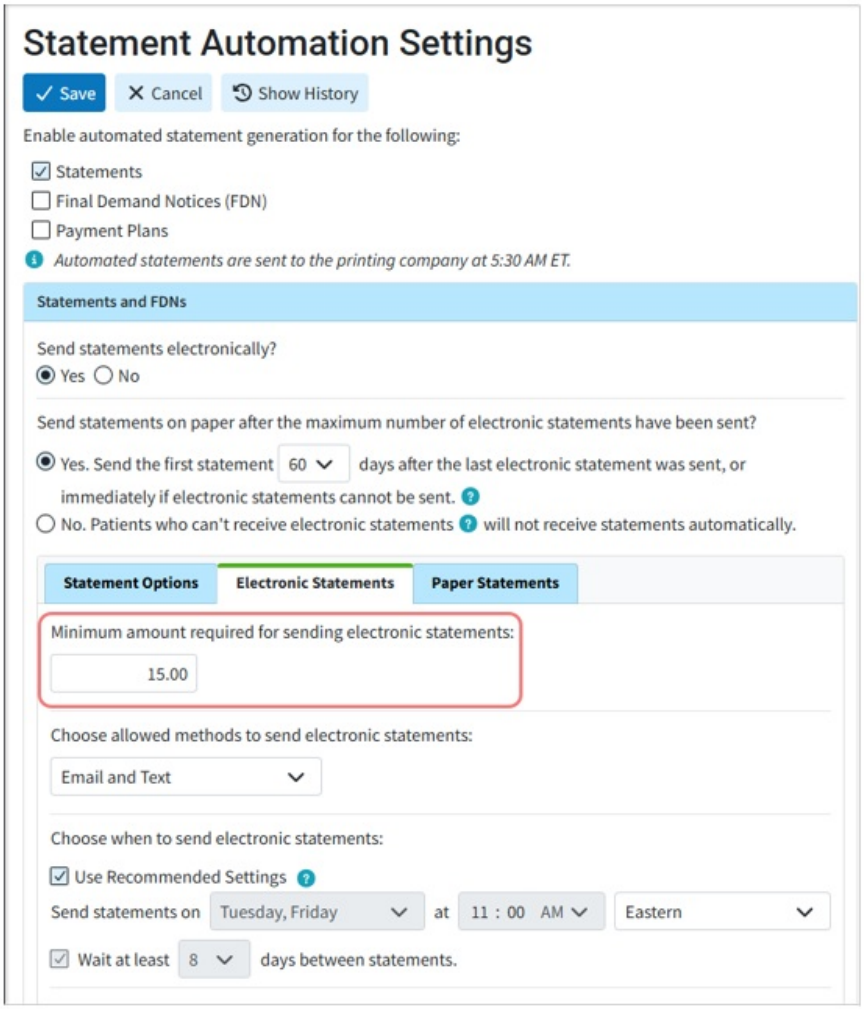
- **The email only updates automatically for new registrations.** If a patient is already registered with the Payment Portal, switching the Payment Portal user to the guarantor will **not** change the email on file. That email was set when the patient registered, and CMD doesn't update it automatically. To send Payment Portal email to the guarantor, use the **change email** option to update it yourself. The email changes automatically only when the patient hasn't registered yet.
- **Changing the user changes the cell phone number.** This includes switching a registered patient to the guarantor. Text message opt-ins belong to a specific phone number, so the guarantor's number needs its own opt-in, even if the patient's number has already opted in. Until the guarantor opts in, text messages won't reach them.

or more information, please visit our Change Payment Portal User Help Article.

## New Option: Separate Minimum Amounts for Paper and Electronic Statements

Previously a single field controlled the minimum amount for statements regardless if they were paper or electronic statements. Some practices want to have an option to send electronic statements for smaller balances than they would paper statements. Others require a high minimum payment in the Payment Portal, so they want a higher minimum for electronic statements. With this release, automated statements now have a separate minimum amount for **paper** and **electronic** statements. Since before, one minimum applied to both, we deployed the following changes:

- The existing minimum amount has moved to the **Paper Statements** tab.
- A new minimum amount field was added to the **Electronic Statements** tab.
- The **Statement Options** tab now has a note that the minimum can be set separately on each of those tabs.




For more information, please visit our Statement Automation Settings Help Article.

## Run Reports in the Background

Running a report in the application has required an open network connection for the whole run. For some

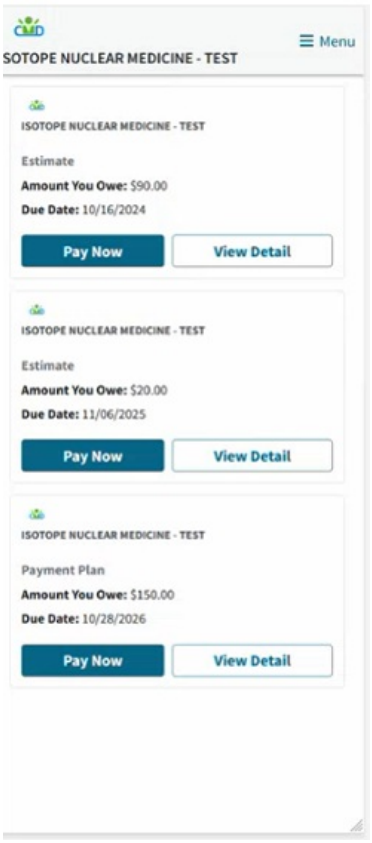
sers, especially those far from our servers, that connection can be interrupted along the way. The nterruption can be retried silently, and because reports take a long time and each user can run only one eport at a time, they would see an error saying they were already running the report. Meanwhile, the riginal report kept running and its results were never used.

With this release, reports run in the CMD application can now run in the background. CMD saves the esults, and you retrieve them when the report is done, so you don't need to keep an open connection while runs. This means that if If your connection drops while a report is running, you won't get an "already unning this report" error, and the work isn't wasted.

# Enhancements

## mprovement: Statements, Estimates, and Payment Plans Now Appear Separately in the Payment Portal

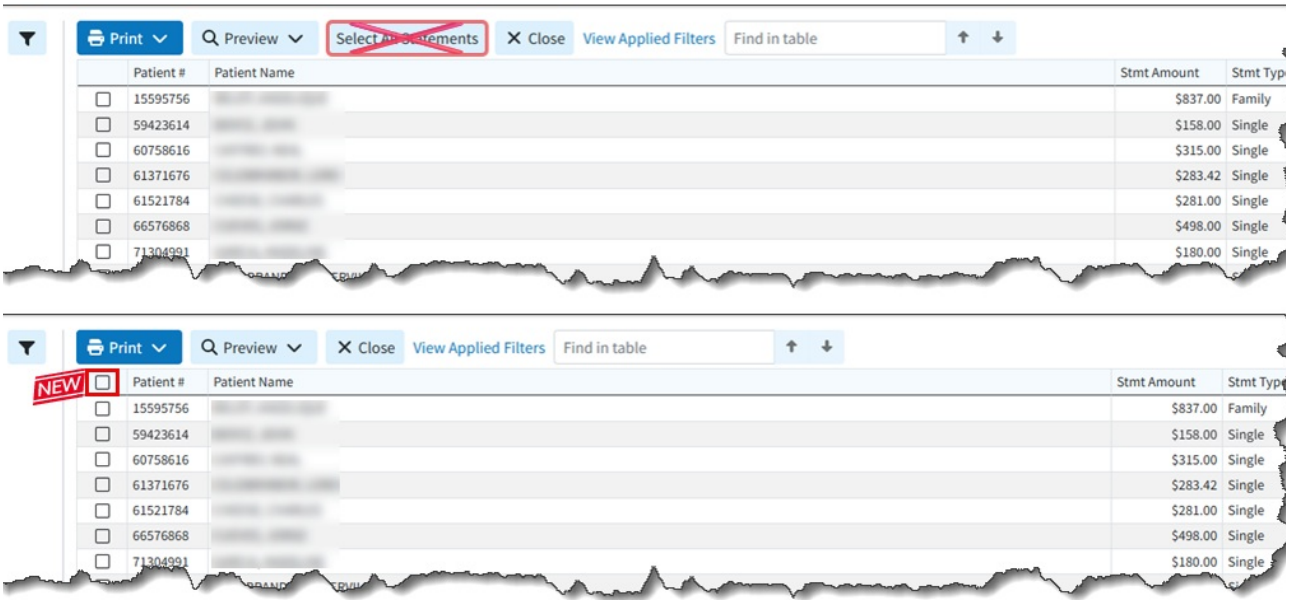
efore, everything a patient owed was combined on one page. A patient with an estimate and a payment lan had to scroll through the whole page to work out which was which. With this release, and as part of ou ngoing e-statement improvements, a patient's electronic statements will now be split into separate tatements in the Payment Portal. For example, if you create a payment plan for a patient, it appears as its wn statement. It no longer sits alongside their other balances. With this cleaner layout, patients can find hat they owe, and click through an upcoming estimate, or their payment plan without sorting through the thers.




## mprovement: Standard “Select All” Checkbox Is Back in Batch Statements

o prevent out-of-memory errors when printing large volumes of statements, we had previously limited th umber of selectable items within statement batch print. If you select more than 1,000 statements for rinting or previewing, a warning will notify you that only the first 1,000 will be processed. After printing, ne system automatically deselects those 1,000 statements, allowing you to repeat the process for the nex et.

As part of that enhancement, we had also replaced the header checkbox with a "Select All Statements" utton at the top of the screen. But after some customer feedback, we realized that that was an unfamiliar vay to select statements for customers, so with this release, the batch statements screen now has the tandard **Select All** checkbox in the table header again. The separate**Select All Statements** button at the to f the screen is gone. This update keeps the 1000 statements safeguard but puts back the familiar checkbo which works the same way it does in Claim Control).

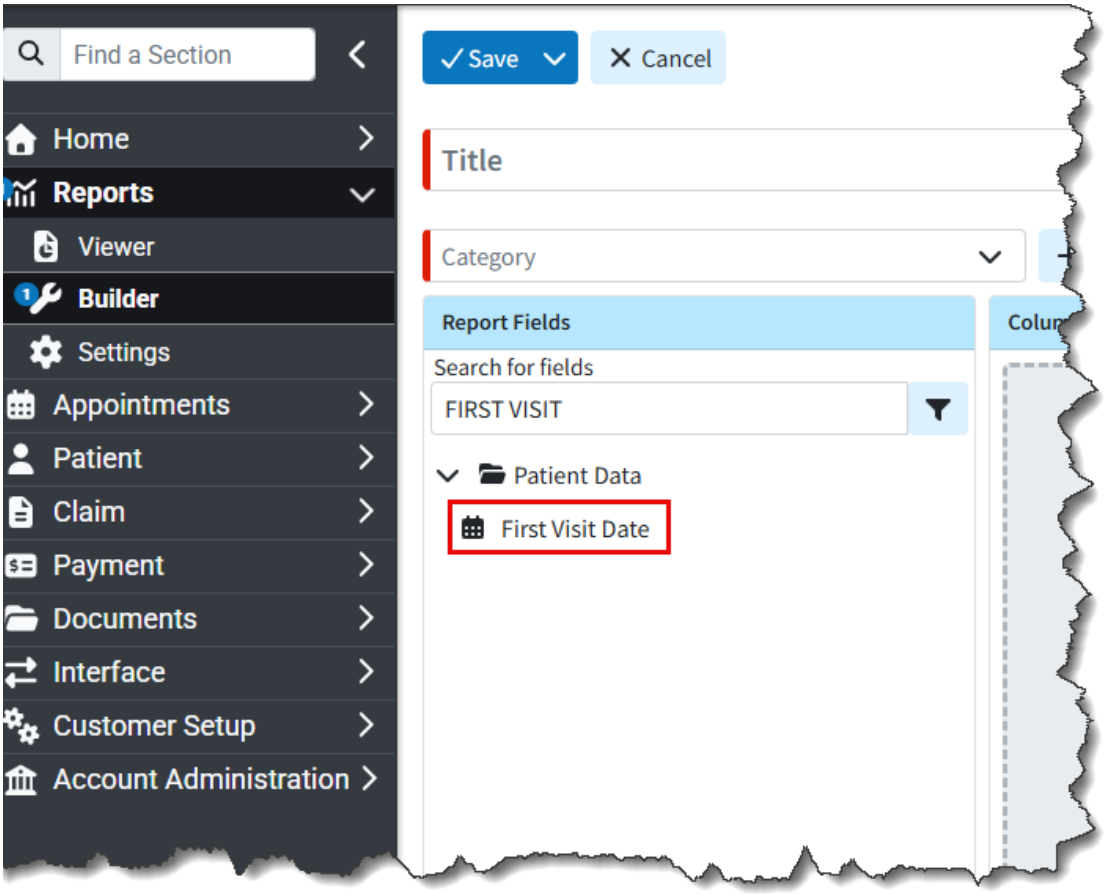



'isit our Batch Print Statements Help Article for more information.

## Jew Report Field: First Visit Date

ome practices treat patients over a long period for one reason, such as an inpatient psychiatric stay or 'eatment for an injury. Until now, there was no easy way to report on when a patient first came in.

ı this release, we added a new First Visit Date report field within Patient Data. It shows the date of service f the patient's earliest claim, ignoring deleted claims. With First Visit Date, you can see how long a patient as been in treatment, which can help you compare treatment length with what you've been paid.

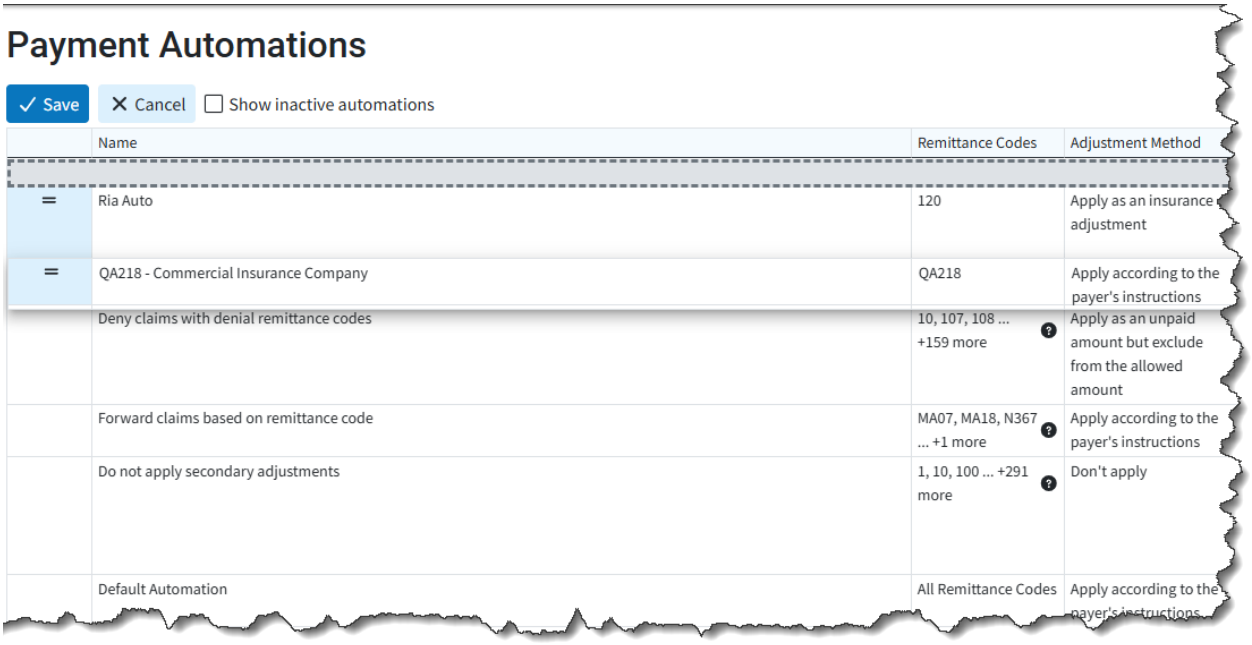



'isit our Patient Data Report Fields Help Article for more information.

## Jpdate: Payment Automations Now Follow the Order You Set

:MD used to check code types in a fixed order: remark codes first, then unpaid reason codes, then djustment reason codes. The order of your automations only mattered within each type. That was hard to redict. A remark code on a charge could override an automation you had placed higher in your list. To get ıe result you wanted, you had to turn off automations you still wanted to use.

Vith this release, when more than one Payment Automation applies to a charge, CMD now uses the top-ıost automation in your list that matches any of the charge's remark, unpaid reason, or adjustment reason odes. This means that you can now control which automation wins by reordering your list, and moving the utomation you want to apply first to the top.




## New WebAPI Capability: Update a Claim's Follow-Up Date Without Adding a Note

The WebAPI's **follow-up note** endpoint could already add a follow-up note and optionally change the follow-up date. This means that an integration could add a note and keep the current date since the date was optional, but it couldn't do the reverse (update the follow-up date without adding a new note).

With this release, the WebAPI now lets an integration update a claim's **follow-up date** without adding a note. By making the note now optional, a customers can push a claim's follow-up date out when the claim hasn't been worked yet, without adding a placeholder note.

## Improvement: Formatting Is Now Kept When You Paste Text Into CMD Editors

Staff often move information between messages, patient notes, and patient alerts. Previously, a list, such as a refund request with the date of service, office, provider, patient, amount, and reason, was flattened into one block of plain text when pasted, so people had to reformat it by hand.

This issue has been fixed in this release so users can copy a list or other basic formatted text from a CMD message and paste it into a patient note, patient alert, or another message without redoing the formatting.

# Resolutions

## Resolved Issue: Expected Reimbursement on Denials

Resolved an issue where, the Expected Revenue was being set from the payer's allowed amount even wher the claim had been denied. A denied claim then looked as if nothing more was expected, with $0.00 remaining even though in practice, you may still appeal the denial or fix and resubmit the claim and get paic Until the charge is written off, there is still money you expect to collect, so the number should show it.

With this release, when a claim is denied, CMD no longer uses the primary payer's allowed amount to work ut Expected Revenue. It now uses the contract amount for the procedure code if you have one. If there's r ontract amount, it uses the charge amount. (A denied claim no longer shows $0.00 expected , so A/R stay isible while you appeal.

## Resolved Issue: First Pass Resolution Rate Gadget Now Matches the First Pas Resolved Claims Report

Corrected an issue where the numbers in the**First Pass Resolution Rate** dashboard gadget didn't match the **irst Pass Resolved Claims** report. For the same month, the gadget could show a higher rate than the eport. Clicking a point on the graph also opened the report for only part of the month, such as the first veek, instead of the whole month.

Two causes were found:

- **Not only first submissions were counted.** A claim that wasn't resolved on the first pass could count as "not resolved" across several days or months.
- **Repeat submissions still counted as resolved.** Claims were counted as resolved on the first pass even if they had been submitted to the primary payer more than once.

This issue has been fixed, and the gadget now uses the same data as the report, so the two agree for the ame period.

## Resolved Issue: Claim Rejections Gadget Acceptance Rate Was Too High and Didn't Match Clean Claim Rate

The **Acceptance Rate** at the bottom of the **Claim Rejections** dashboard gadget was calculated from claim tatus messages, not from claim submissions. A single submission can have several status messages. For xample, the clearinghouse might accept a claim and the payer might then reject it. That claim counted as oth accepted and rejected, which inflated the Acceptance Rate. Customers who compared it to the **Clean laim Rate** gadget saw two different numbers for what should be nearly the same measurement.

This issue has now been fixed, and the Acceptance Rate now counts each claim submission once. A ubmission counts as rejected if it has at least one rejection, and the rate is the share of all submissions that were not rejected. It should now be very close to the Clean Claim Rate.

⚠ Please note that the two can still differ if you filter the Claim Rejections gadget to Clearinghouse or

Payer only.

## Resolved Admission Issue: Overdue Tasks Count Not Matching the Task Search Report or My Tasks

Resolved an issue where, the **Overdue Tasks** count on the dashboard Timeline could differ from the numbe of tasks in the other places you check it within the application. The number of overdue tasks from the meline could be different than the number from:

- The **Task Search** report, which opens when you click the Overdue Tasks Timeline item.
- **Home → Tasks → My Tasks**, when you filter by an end date of yesterday.

his issue has now been fixed, and the Overdue Tasks count on the Timeline now matches the Task Search eport and My Tasks.

## Resolved Issue: Claim Attachments Rejected Because the Provider NPI Didn't Match

Corrected an issue where, some claims submitted with an attachment were rejected by the clearinghouse with an "attachment's provider NPI did not match the claim's NPI" error. This was triggered by the fact that PS requires the NPI on the attachment to match the claim's rendering provider. With this release, claim ttachments will now send the claim's rendering provider NPI. If the claim has no rendering provider, the ttachment sends the billing provider NPI instead.

## Resolved Issue: Claims for Providers Without an NPI Rejected by UHC Medicaid

Corrected an issue where, professional claims for rendering providers without an NPI (atypical providers) were rejected by the clearinghouse when billed to UHC Medicaid. CMD sent the rendering provider with a lder ID type instead of the NPI type that current claim standards require. The rejection messages said the endering provider's ID type must be "XX" and that the rendering provider's NPI was missing.

low, when the rendering provider has no NPI, CMD no longer sends the invalid ID type and number. It ends the provider's **payer-specific ID** in a separate reference segment instead. This now happens even when the provider is set to bill as an individual, ensuring that claims for providers without an NPI are no onger rejected for an invalid rendering provider ID type.

## Resolved Admission Issue: Time Not Saved on Claims Created Through the WebAPI

Resolved an issue where, when an integration sent an admission time with a claim through the WebAPI, CMD left the claim's admission time blank instead of saving it. For example, a request with an admission me of 10:00 AM created a claim with no admission time. This ensures that claims created by your ntegration show the admission time you send. You no longer need to enter it by hand after the claim rrives.