Release 16.22.0 - November 16, 2026

t Modified on 11/13/2026 5:30 pm EST

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

Highlights

New Features	Enhancements
New: "Payer Agreements Needing Attention" Timeline Item	Updated CollaborateMD Logos Throughout the Application
New Options: Show the Procedure Code on Statements and HSA/FSA Receipts	Improvement: Universal Import Now Uses the Patient's Default Office When the File Has No Office
	New Report Field: First Visit Date
	First Pass Claim Count Gadget Now Refreshing Daily

New features

New: "Payer Agreements Needing Attention" Timeline Item

uccessful payer enrollment enables providers to submit claims electronically and receive electronic emittance advice. Approximately half of enrollment denials occur because a required step was not ompleted on time, despite our clearinghouse partner sending reminder emails.

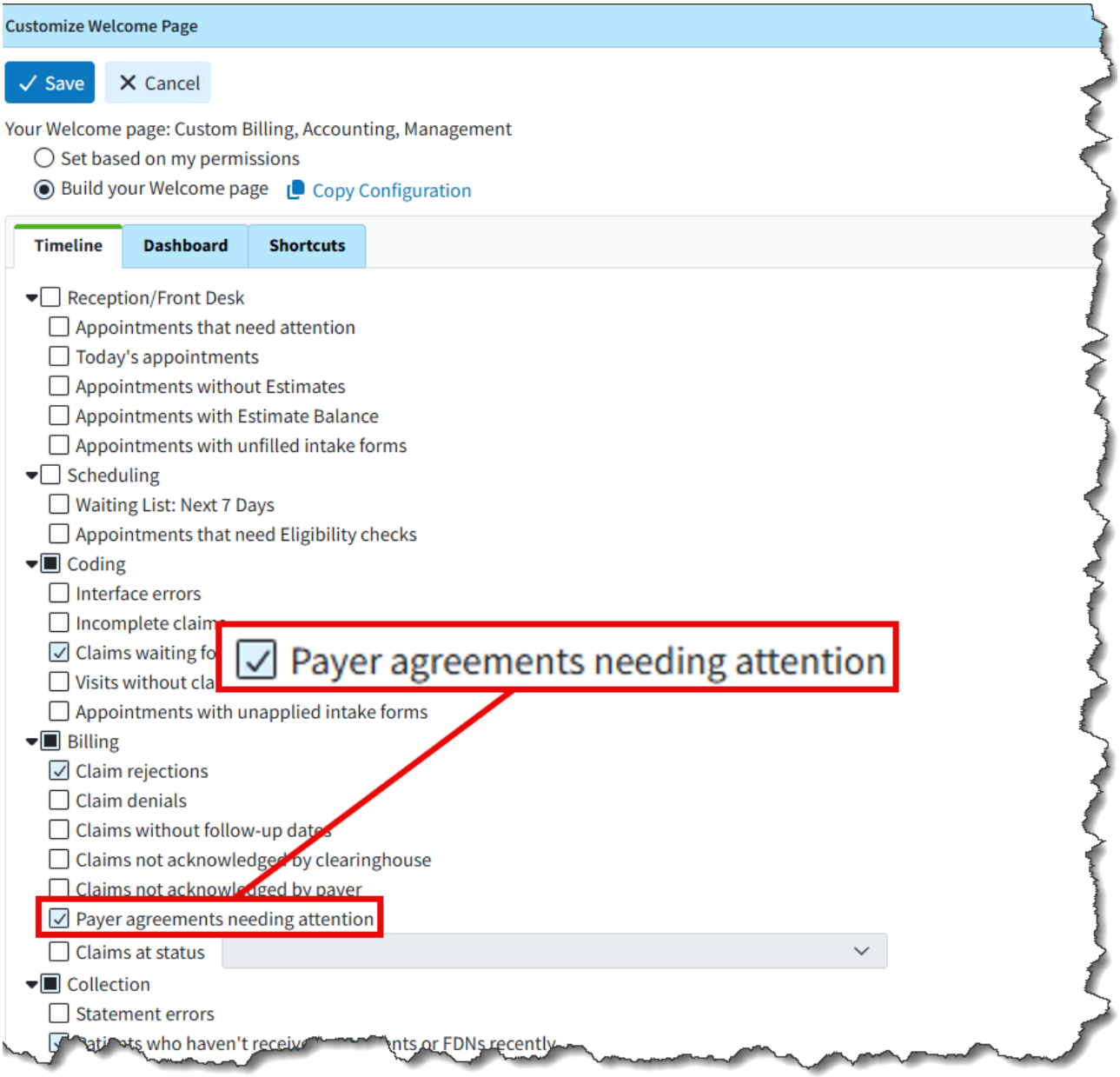
n this release, we added a new timeline item called **Agreements Needing Attention**. This option notifies ou when payer agreements (enrollments) are waiting for you to do something. It shows one line for each **ubmitter and NPI** combination that has agreements needing action. For example:

- *2 Payer Agreements require your action to complete. Agreements not actioned will be denied. NPI: 0123456789 / Submitter: 1234567*

licking a line opens **Agreement Lookup** for that submitter and NPI, so you can finish the steps. If no greements need action, the item shows as complete.

⚠ The item shows by default for users in the **Management** and **Billing** roles who have the **Payer Agreements** permission. If you've set up a custom Welcome Timeline, the item is added automatically for users who have that permission

lacing it on the timeline keeps it visible within your workflow, allowing you to quickly identify and address greements requiring immediate action.



or more information, please visit ourCustomize Your Timeline Help Article.

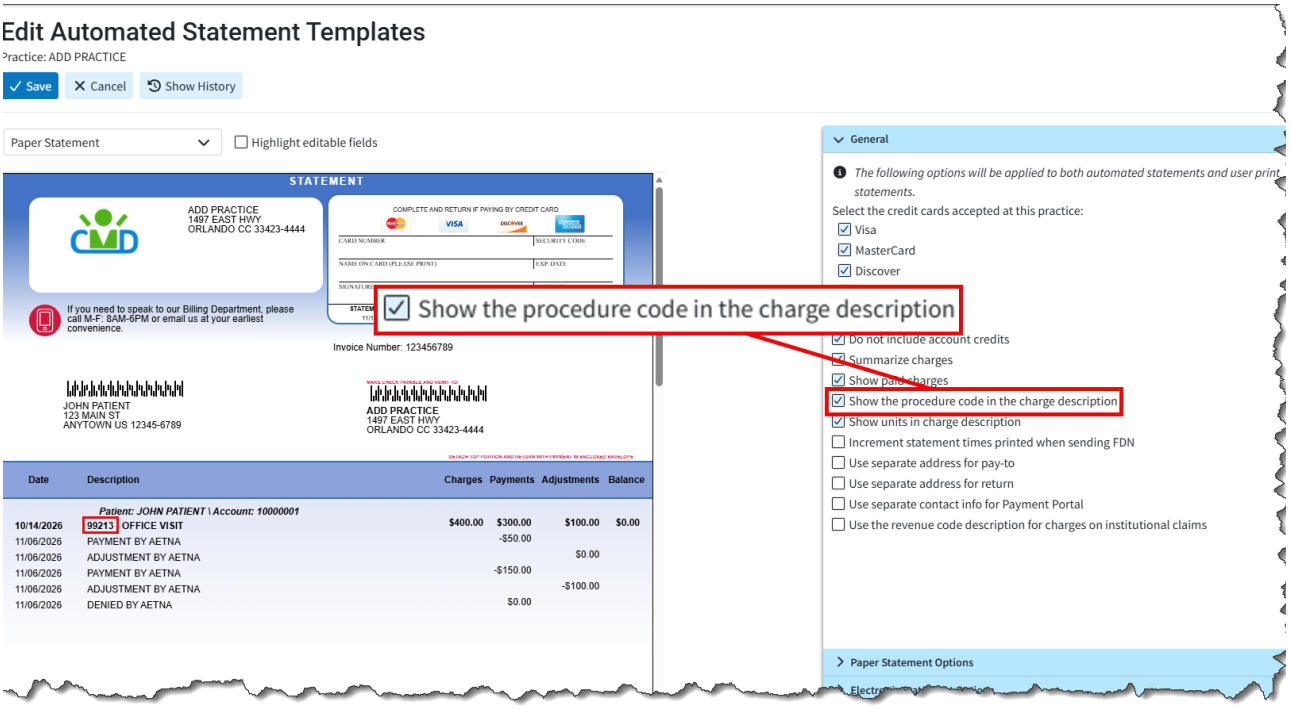
lew Options: Show the Procedure Code on Statements and HSA/FSA Receipts

lany states require procedure codes on patient statements. Some HSA/FSA processors also require these odes on receipts for documentation purposes. Previously, adding a code to a statement required manually ntering both the code and its description into each item within the code list—a time-consuming process fo ractices with extensive inventories.

Vith this release, you can now show the procedure code at the start of each charge's description on patient **tatements** and on **HSA/FSA receipts** (CPT or revenue code, depending on what the charge uses).

or Statements

, new checkbox option has been added to the General options side panel within the Enhanced and utomated statement templates. When editing a statement template, selecting "Show the procedure code the charge description" will include the procedure code followed by the description.

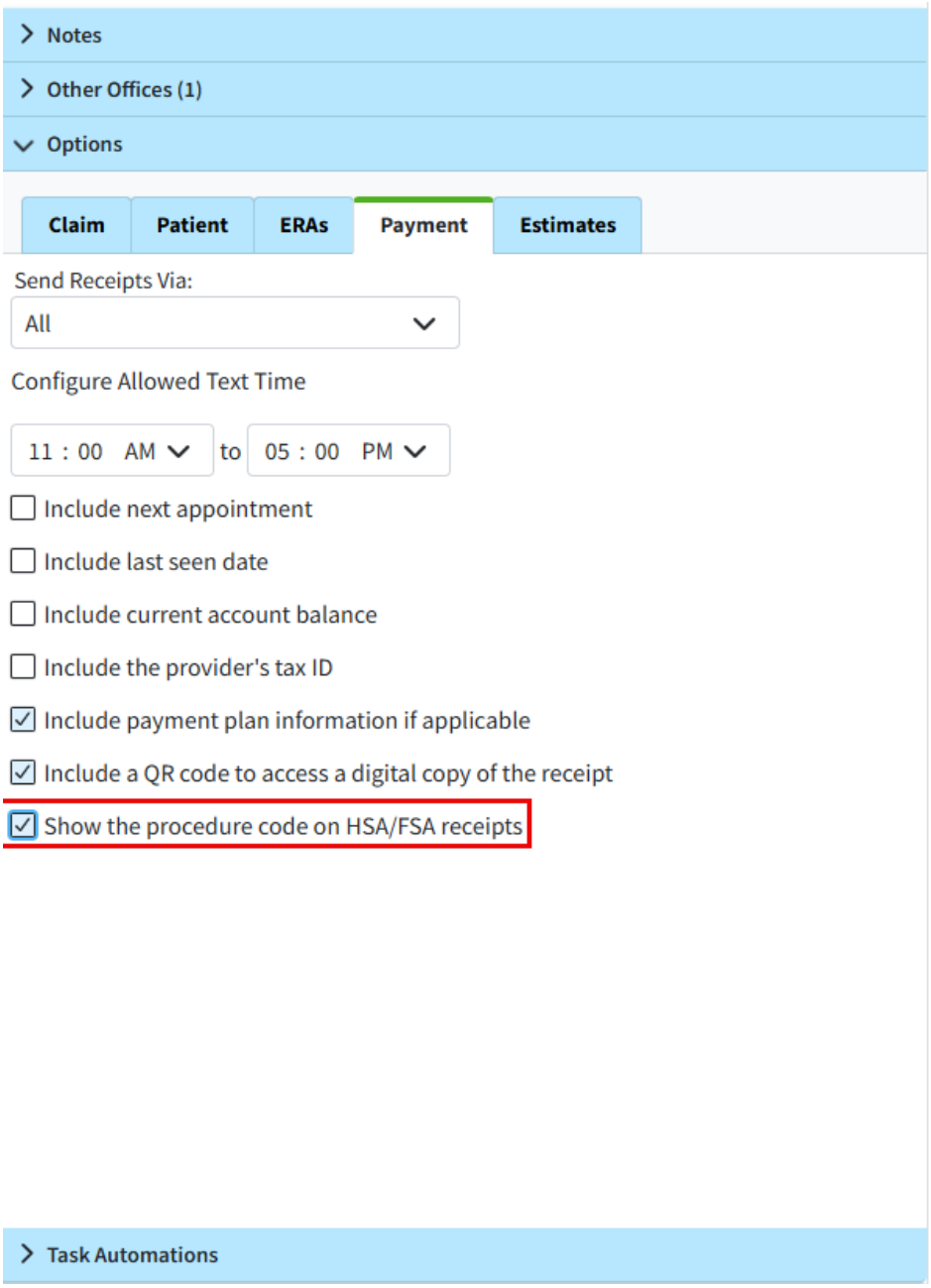


⚠ Please note that this applies only to Automated and Enhanced Statements.

or more information, please visit our Configure Automated Patient Statement Template or the Configure lser Print Statement Settings Help Articles.

or Receipts

, new checkbox, "Show the procedure code on HSA/FSA receipts," has been added to the Practice section nder Options → Payment. When selected, the procedure code will be included on all HSA/FSA receipts.



or more information, please visit our[Practice Payment Defaults](#) Help Article.

Enhancements

Updated CollaborateMD Logos Throughout the Application

We've updated CollaborateMD to our new logos, so you get a consistent, modern look everywhere you and our patients see us. You'll find the new logo in these places:

- **Login and lock screens**
- **The application header**

- **Co-branding**, where your logo appears with “Powered by CollaborateMD”
- **Excel report exports**
- **Invoices**
- **WebAPI documentation**
- **The Payment Portal**

Old Logo



New Logo

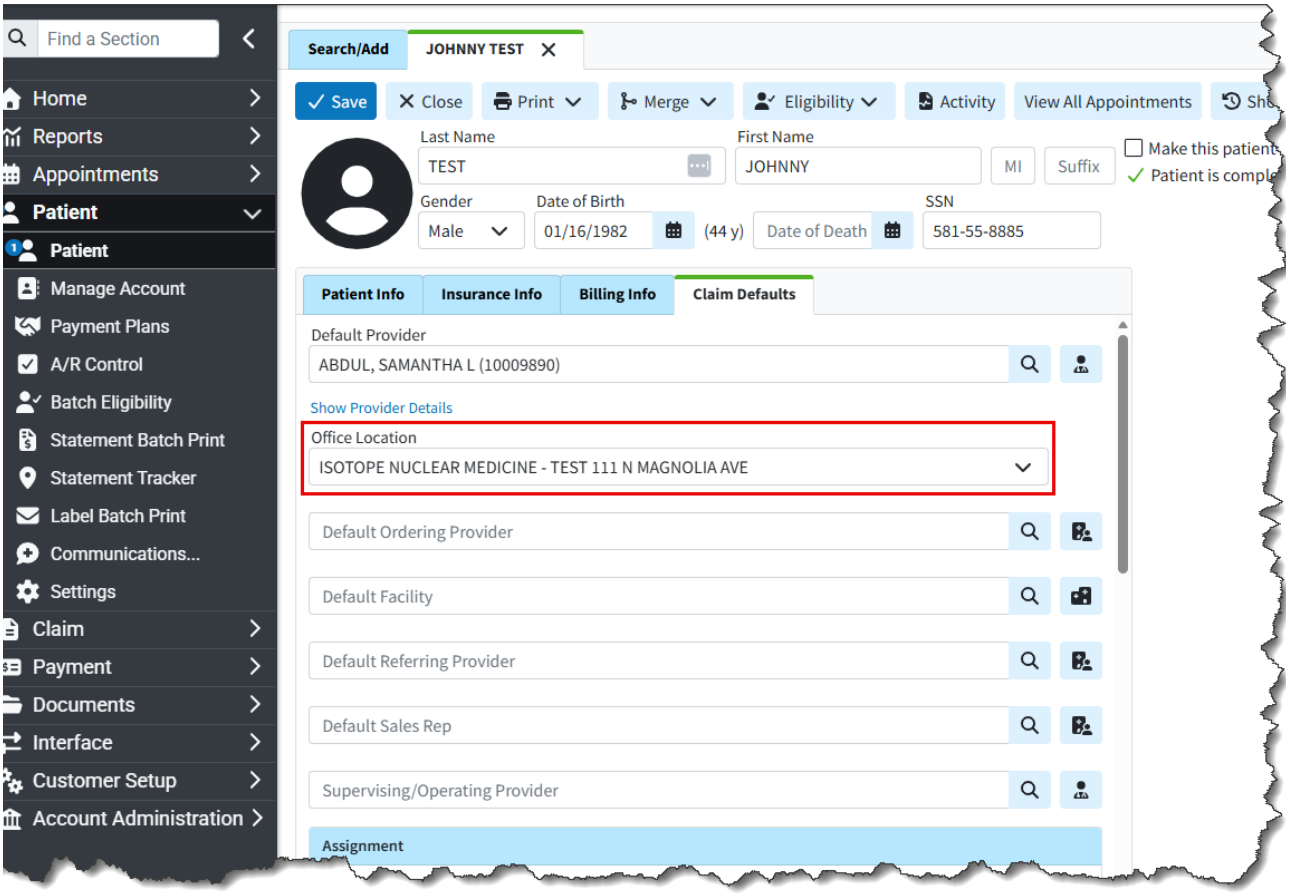


⚠ Please note that this is a visual change only. Nothing about how CMD works has changed. If you show your own logo in CMD, it stays as you set it.

mprovement: Universal Import Now Uses the Patient’s Default Office When th ile Has No Office

Universal import files often contain only the data exported by the EHR, frequently omitting the office ocation. Previously, the system defaulted such claims to the practice’s main office when no office was on th le. This resulted in inaccurate location data for patients seen elsewhere, requiring manual correction.

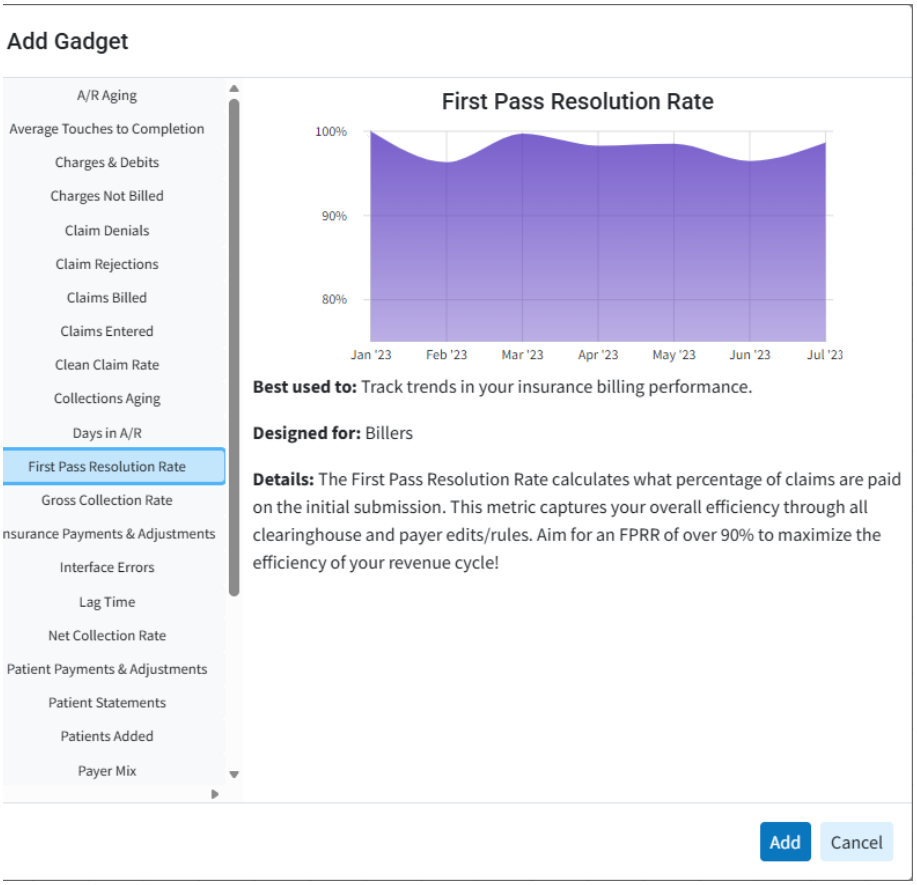
With this release, when a Universal Import file doesn’t include an office location, CMD now uses the atient’s default office for the claim.



irst Pass Claim Count Gadget Now Refreshing Daily

Re-releasing): Our "First Pass Resolution Rate" dashboard gadget had not been refreshing on a daily basis ue to performance issues. With the recent move of Data Snapshots and reporting queries to a Read Replic atabase, additional capacity became available in our nightly database processing, allowing gadget refresh mes to be moved earlier.

With this release, the First Pass Resolution Rate (Claim Count) gadget will now update daily, giving you mo urrent data each time you view it.



Resolutions

Resolved Issue: Insurance Transfer Amount Report Field Not Returning Insurance Transfers

Resolved an issue where, the Insurance Transfer Amount report field didn't work as intended. It looked for the source of an applied account credit in a way that never matched, because CMD always records the source of a transfer as 1. A single applied account credit can draw on several account credits, which can come from different payers, so CMD doesn't record one source for it. As a result, the field didn't pick up you insurance transfers.

With this release, the field now checks the account credit that funded the transfer. If more than one credit was used, CMD uses the one with the largest amount. If several have the same amount, it uses the one entered first.

Resolved Issues: Universal Import Reliability

In this release, we resolved multiple universal import issues:

Adding a Blank Insured Party and Marking Patients and Claims Incomplete: Corrected a Universal Import issue where, if you imported claims for existing patients with Universal Import, and your file had insurance

etails such as an authorization number or the patient's relation to the insured but no payer, the import dded a new, blank insured party to each patient instead of using the insurance already on file. Because the ew insured party had no name, the import then marked every patient and claim from the file as incomplete

Using the Fee Schedule Price Instead of the Price in the File: Corrected a Universal Import issue where, the *Set charge pricing based on unit price received in interface message?* interface setting was not being respected nd Universal Import still used the price from the fee schedule for the charge (not the unit price in your nport file). Basically the import preview showed the file's price, but the claim that was created had the fee chedule price.

nport Failing With a Generic Warning and Creating Duplicates When Retried: Resolved a universal nport issue where, in some cases, an exception stopped a Universal Import partway through. You saw a eneric warning and stayed on the message preview screen, and nothing prevented you from clicking again ach retry started the import over, so repeated attempts could create duplicate import formats and uplicate patients and claims.

Resolved Issue: ERA Claims Not Matched When the Member ID Has Leading Zeros or the Last Name Is Formatted Differently

When an ERA doesn't send back the TCN, CMD matches each payment to a claim using patient details. One f the matches uses the member ID, last name, date of service, procedure code, and billed amount. It didn't work in two cases:

- **Member IDs that start with zeros.**
- **Payers that format the last name differently from how it's stored in CMD.**

n those cases the payment showed a ***Claim Not Found*** error, and you had to select each claim by hand. This elease resolves this issue and CMD now matches claims correctly.

Resolved Issue: Reference Numbers and Authorizations Lost When Combining Claims

Corrected an issue where, when you combined claims in Claim Control, the new combined claim didn't carr ver the Original Reference # or the authorization numbers and types from the claims you combined.

With this release, combining claims now copies the Original Ref. # fields and the authorization numbers to he new claim.

Resolved Issue: Units Running Outside the Box on Printed CMS-1500 Claims

Corrected an issue on a printed CMS-1500 claim where, since the units in Box 24G have room for three igits, when a charge had decimal units, such as 11.26, the number was too long and ran outside the box.

Units on the printed CMS-1500 are now shortened to fit the box and decimals that are removed are rounde o the nearest number:

- Units over 10: shown with one decimal place. For example, 10.23 prints as 10.2 and 10.56 prints as 10.6.

- Units over 100: shown as a whole number. For example, 115.3 prints as 115.
- Units of 10 or less: printed as before.

Resolved Issue: Wrong Taxonomy Code Sent for Providers Set to Bill as an Individual

Resolved an issue where, for a professional claim, when the rendering provider was set to Bill As an Individual, the claim's billing provider section carried the practice's taxonomy code, not the provider's individual taxonomy code. This issue has been fixed and professional claims for providers set to bill as an individual now send the individual taxonomy code. Institutional claims are not affected as they always use the practice's information.

Resolved Issue: "Refund to Original" Shown When Nothing Is Left to Refund

Corrected an issue in Manage Account where, if you had already refunded a merchant payment in full, the refund pop-over still showed the "*Refund to Original*" option, which sends the refund back to the original car through our payment processor, even though there was nothing left to refund and the option didn't apply.

This issue has been fixed and the *Refund to Original* option is no longer shown when there is nothing left to refund on the payment.

Resolved Issue: WebAPI Request Failing When a Patient Reference Number Is Too Long

Corrected an issue where, if an integration sent a patient reference number longer than 20 characters through the WebAPI, the request failed. CMD allows 20 characters in this field. The response was confusin since it said "*SUCCESS*" but gave the message "*Unexpected error trying to process claim review,*" so it looked as the request had worked when it hadn't been fully processed.

This issue has now been fixed. If a patient reference number is longer than 20 characters, CMD now ignores that value and processes the rest of the message normally. The patient or claim is then created without the reference number.