QUADAX, INCORPORATED
RESPONSE TO
REQUEST FOR QUOTATION

WEH11111

CLEARINGHOUSE SERVICES
FOR ELECTRONIC CLAIMS SUBMISSION
FOR WELCH COMMUNITY HOSPITAL

APRIL 2011

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State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

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ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
*313145144 440-788-2122
QUADAX INC
3690 ORANGE PL #270

BEACHWOOD OH 44122

SHIP TO
HEALTH AND HUMAN RESOURCES
WELCH COMMUNITY HOSPITAL

454 MCDOWELL STREET
WELCH, WV
24801 304-436-8710

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
3/25/2011				

BID OPENING DATE: 04/28/2011 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

OPEN-END BLANKET CONTRACT

****

PLEASE NOTE: A MANDATORY PRE-BID MEETING WILL TAKE PLACE ON 4/13/2011 @ 10:00 AM AT THE HOSPITAL.

****

YR 946-10

1

TO PROVIDE REMOTE DATA PROCESSING FOR WELCH

THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES IS REQUESTING MONETARY QUOTATIONS TO PROVIDE ALL APPLICATION SOFTWARE, INSTALLATION, SUPPORT, AND ANY-THING INCIDENTAL TO PROVIDE A FULLY INTEGRATED CLEARINGHOUSE SERVICE FOR ELECTRONIC CLAIMS SUBMISSION TO ALL MAJOR INSURANCE CARRIERS, PARTICIPATING PAYERS, SERVICED BY WELCH COMMUNITY HOSPITAL LOCATED AT 454 MCDOWELL STREET, WELCH, WV 24801, PER THE ATTACHED DETAILED SPECIFICATIONS.

A MANDATORY VENDOR PREBID MEETING WILL BE HELD ON 4/13/2011 @ 10:00 A.M. AT ADMINISTRATIVE CONFERENCE ROOM AT WELCH COMMUNITY HOSPITAL. FAILURETO ATTEND THIS MANDATORY PREBID CONFERENCE WILL RESULT IN BID REJECTION. ONE INDIVIDUAL CANNOT REPRESENT MORE THAN ONE VENDOR.

3/30/11

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

E James J. McCauley TELEPHONE 440.777.6300 DATE 4-20-2011

ice President FEIN 34-1127026 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

GENERAL TERMS & CONDITIONS
REQUEST FOR QUOTATION (RFQ) AND REQUEST FOR PROPOSAL (RFP)

1. Awards will be made in the best interest of the State of West Virginia.

2. The State may accept or reject in part, or in whole, any bid.

3. Prior to any award, the apparent successful vendor must be properly registered with the Purchasing Divi and have paid the required $125 fee.

4. All services performed or goods delivered under State Purchase Order/Contracts are to be continued for term of the Purchase Order/Contracts, contingent upon funds being appropriated by the Legislature or other being made available. In the event funds are not appropriated or otherwise available for these services or g this Purchase Order/Contract becomes void and of no effect after June 30.

5. Payment may only be made after the delivery and acceptance of goods or services.

6. Interest may be paid for late payment in accordance with the ***West Virginia Code***.

7. Vendor preference will be granted upon written request in accordance with the ***West Virginia Code***.

8. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

9. The Director of Purchasing may cancel any Purchase Order/Contract upon 30 days written notice to the seller.

10. The laws of the State of West Virginia and the ***Legislative Rules*** of the Purchasing Division shall govern purchasing process.

11. Any reference to automatic renewal is hereby deleted. The Contract may be renewed only upon mutual wr agreement of the parties.

12. BANKRUPTCY: In the event the vendor/contractor files for bankruptcy protection, the State may de this contract null and void, and terminate such contract without further order.

13. HIPAA BUSINESS ASSOCIATE ADDENDUM: The West Virginia State Government HIPAA Business Asso Addendum (BAA), approved by the Attorney General, is available online at **www.state.wv.us/admin/purchase/vrc/hipaa** and is hereby made part of the agreement. Provided that the Agency meets the definition of a Cover E (45 CFR §160.103) and will be disclosing Protected Health Information (45 CFR §160.103) to the vendor.

14. CONFIDENTIALITY: The vendor agrees that he or she will not disclose to anyone, directly or indirectly, any personally identifiable information or other confidential information gained from the agency, unless the individual wh the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the agen policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Inform Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/noticeConfidentiality

15. LICENSING: Vendors must be licensed and in good standing in accordance with any and all state and local laws requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secr of State's Office, the West Virginia Tax Department, and the West Virginia Insurance Commission. The vendor m provide all necessary releases to obtain information to enable the director or spending unit verify that the vendor is licensed and in good standing with the above entities.

16. ANTITRUST: In submitting a bid to any agency for the State of West Virginia, the bidder offers and agrees if the bid is accepted the bidder will convey, sell, assign or transfer to the State of West Virginia all rights, title and int in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the Sta West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or serv purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the tim purchasing agency tenders the initial payment to the bidder.

I certify that this bid is made without prior understanding, agreement, or connection with any corporation, firm, lim liability company, partnership, or person or entity submitting a bid for the same material, supplies, equipmen services and is in all respects fair and without collusion or Fraud. I further certify that I am authorized to the certification on behalf of the bidder or this bid.

INSTRUCTIONS TO BIDDERS

1. Use the quotation forms provided by the Purchasing Division. Complete all sections of the quotation form.

2. Items offered must be in compliance with the specifications. Any deviation from the specifications must be cle indicated by the bidder. Alternates offered by the bidder as **EQUAL** to the specifications must be cle defined. A bidder offering an alternate should attach complete specifications and literature to the bid. Purchasing Division may waive minor deviations to specifications.

3. Unit prices shall prevail in case of discrepancy. All quotations are considered F.O.B. destination unless altern shipping terms are clearly identified in the quotation.

4. All quotations must be delivered by the bidder to the office listed below prior to the date and time of the opening. Failure of the bidder to deliver the quotations on time will result in bid disqualifications: Department of Administration, Purchasing Division, 2019 Washington Street East, P.O. Box 50130, Charleston, WV 25305-0130

5. Communication during the solicitation, bid, evaluation or award periods, except through the Purchasing Divis is strictly prohibited (W.Va. C.S.R. §148-1-6.6).

State of West Virginia
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2019 Washington Street East
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VENDOR
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EXHIBIT 3

LIFE OF CONTRACT: THIS CONTRACT BECOMES EFFECTIVE ON AWARD..... AND EXTENDS FOR A PERIOD OF ONE (1) YEAR OR UNTIL SUCH "REASONABLE TIME" THEREAFTER AS IS NECESSARY TO OBTAIN A NEW CONTRACT OR RENEW THE ORIGINAL CONTRACT. THE "REASONABLE TIME" PERIOD SHALL NOT EXCEED TWELVE (12) MONTHS. DURING THIS "REASONABL TIME" THE VENDOR MAY TERMINATE THIS CONTRACT FOR ANY REASON UPON GIVING THE DIRECTOR OF PURCHASING 30 DAYS WRITTEN NOTICE.

UNLESS SPECIFIC PROVISIONS ARE STIPULATED ELSEWHERE IN THIS CONTRACT DOCUMENT, THE TERMS, CONDITIONS AND PRICING SET HEREIN ARE FIRM FOR THE LIFE OF THE CONTRACT.

RENEWAL: THIS CONTRACT MAY BE RENEWED UPON THE MUTUAL WRITTEN CONSENT OF THE SPENDING UNIT AND VENDOR, SUBMITTED TO THE DIRECTOR OF PURCHASING THIRTY (30) DAYS PRIOR TO THE EXPIRATION DATE. SUCH RENEWAL SHALL BE IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT AND SHALL BE LIMITED TO TWO (2) ONE (1) YEAR PERIODS.

CANCELLATION: THE DIRECTOR OF PURCHASING RESERVES THE RIGHT TO CANCEL THIS CONTRACT IMMEDIATELY UPON WRITTEN NOTICE TO THE VENDOR IF THE COMMODITIES AND/OR SERVICES SUPPLIED ARE OF AN INFERIOR QUALITY OR DO NOT CONFORM TO THE SPECIFICATIONS OF THE BID AND CONTRACT HEREIN.

OPEN MARKET CLAUSE: THE DIRECTOR OF PURCHASING MAY

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

	TELEPHONE	DATE
James F McCauley	440-777-6300	April 20, 2011
President	FEIN 34-1127024	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

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AUTHORIZE A SPENDING UNIT TO PURCHASE ON THE OPEN MARKET, WITHOUT THE FILING OF A REQUISITION OR COST ESTIMATE, ITEMS SPECIFIED ON THIS CONTRACT FOR IMMEDIATE DELIVERY IN EMERGENCIES DUE TO UNFORESEEN CAUSES (INCLUDING BUT NOT LIMITED TO DELAYS IN TRANSPORTATION OR AN UNANTICIPATED INCREASE IN THE VOLUME OF WORK.)

QUANTITIES: QUANTITIES LISTED IN THE REQUISITION ARE APPROXIMATIONS ONLY, BASED ON ESTIMATES SUPPLIED BY THE STATE SPENDING UNIT. IT IS UNDERSTOOD AND AGREED THAT THE CONTRACT SHALL COVER THE QUANTITIES ACTUALLY ORDERED FOR DELIVERY DURING THE TERM OF THE CONTRACT, WHETHER MORE OR LESS THAN THE QUANTITIES SHOWN.

ORDERING PROCEDURE: SPENDING UNIT(S) SHALL ISSUE A WRITTEN STATE CONTRACT ORDER (FORM NUMBER WV-39) TO THE VENDOR FOR COMMODITIES COVERED BY THIS CONTRACT. THE ORIGINAL COPY OF THE WV-39 SHALL BE MAILED TO THE VENDOR AS AUTHORIZATION FOR SHIPMENT, A SECOND COPY MAILED TO THE PURCHASING DIVISION, AND A THIRD COPY RETAINED BY THE SPENDING UNIT.

BANKRUPTCY: IN THE EVENT THE VENDOR/CONTRACTOR FILES FOR BANKRUPTCY PROTECTION, THIS CONTRACT IS AUTOMATICALLY NULL AND VOID, AND IS TERMINATED WITHOUT FURTHER ORDER.

THE TERMS AND CONDITIONS CONTAINED IN THIS CONTRACT SHALL SUPERSEDE ANY AND ALL SUBSEQUENT TERMS AND CONDITIONS WHICH MAY APPEAR ON ANY ATTACHED PRINTED DOCUMENTS SUCH AS PRICE LISTS, ORDER FORMS, SALES AGREEMENTS OR MAINTENANCE AGREEMENTS, INCLUDING ANY ELECTRONIC MEDIUM SUCH AS CD-ROM.

REV. 04/11/2001

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

James F McCauley	TELEPHONE 440-777-6300	DATE April 20, 2011
e President	FEIN 34-1127026	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

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INQUIRIES:
WRITTEN QUESTIONS SHALL BE ACCEPTED THROUGH CLOSE OF BUSINESS ON 4/14/2011. QUESTIONS MAY BE SENT VIA USPS, FAX, COURIER OR E-MAIL. IN ORDER TO ASSURE NO VENDOR RECEIVES AN UNFAIR ADVANTAGE, NO SUBSTANTIVE QUESTIONS WILL BE ANSWERED ORALLY. IF POSSIBLE, E-MAIL QUESTIONS ARE PREFERRED. ADDRESS INQUIRIES TO:

ROBERTA WAGNER
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON STREET, EAST
CHARLESTON, WV 25311

FAX: 304-558-4115
E-MAIL: ROBERTA.A.WAGNER@WV.GOV

PURCHASING CARD ACCEPTANCE: THE STATE OF WEST VIRGINI CURRENTLY UTILIZES A VISA PURCHASING CARD PROGRAM WHICH IS ISSUED THROUGH A BANK. THE SUCCESSFUL VENDOR MUST ACCEPT THE STATE OF WEST VIRGINIA VISA PURCHASING CARD FOR PAYMENT OF ALL ORDERS PLACED BY ANY STATE AGENCY AS A CONDITION OF AWARD.

REV 07/16/2007

VENDOR PREFERENCE CERTIFICATE

CERTIFICATION AND APPLICATION* IS HEREBY MADE FOR MANDATORY PRE-BID

A MANDATORY PRE-BID WILL BE HELD ON 4/13/2011 AT 10:00

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

	TELEPHONE	DATE
James F McCauley	440-777-6300	April 20, 2011
Vice President	FEIN 34-1127026	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

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AM IN ADMINSTRATIVE CONFERENCE ROOM AT THE HOSP. ALL INTERESTED PARTIES ARE REQUIRED TO ATTEND THIS MEETING. FAILURE TO ATTEND THE MANDATORY PRE-BID SHALL RESULT IN DISQUALIFICATION OF THE BID. NO ONE PERSON MAY REPRESENT MORE THAN ONE BIDDER.

AN ATTENDANCE SHEET WILL BE MADE AVAILABLE FOR ALL POTENTIAL BIDDERS TO COMPLETE. THIS WILL SERVE AS THE OFFICIAL DOCUMENT VERIFYING ATTENDANCE AT THE MANDATORY PRE-BID. FAILURE TO PROVIDE YOUR COMPANY AND REPRESENTATIVE NAME ON THE ATTENDANCE SHEET WILL RESULT IN DISQUALIFICATION OF THE BID. THE STATE WILL NOT ACCEPT ANY OTHER DOCUMENTATION TO VERIFY ATTENDANCE. THE BIDDER IS RESPONSIBLE FOR ENSURING THEY HAVE COMPLETED THE INFORMATION REQUIRED ON THE ATTENDANCE SHEET. THE PURCHASING DIVISION AND THE STATE AGENCY WILL NOT ASSUME ANY RESPONSIBILITY FOR A BIDDER-S FAILURE TO COMPLETE THE PRE-BID ATTENDANCE SHEET. IN ADDITION, WE REQUEST THAT ALL POTENTIAL BIDDERS INCLUDE THEIR E-MAIL ADDRESS AND FAX NUMBER.

ALL POTENTIAL BIDDERS ARE REQUESTED TO ARRIVE PRIOR TO THE STARTING TIME FOR THE PRE-BID. BIDDERS WHO ARRIVE LATE, BUT PRIOR TO THE DISMISSAL OF THE TECHNICAL PORTION OF THE PRE-BID WILL BE PERMITTED TO SIGN IN. BIDDERS WHO ARRIVE AFTER CONCLUSION OF THE TECHNICAL PORTION OF THE PRE-BID, BUT DURING ANY SUBSEQUENT PART OF THE PRE-BID WILL NOT BE PERMITTED TO SIGN THE ATTENDANCE SHEET.

NOTICE

A SIGNED BID MUST BE SUBMITTED TO:

DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
James F McCauley	440-777-6300	April 20, 2011
Vice President	FEIN 34-1127026	ADDRESS CHANGES TO BE NOTED ABOVE

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3/25/2011				

BIDDING DATE: 04/28/2011 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO	ITEM NUMBER	UNIT PRICE	AMOUNT

BUILDING 15
2019 WASHINGTON STREET, EAST
CHARLESTON, WV 25305-0130

PLEASE NOTE: A CONVENIENCE COPY WOULD BE APPRECIATED.

THE BID SHOULD CONTAIN THIS INFORMATION ON THE FACE OF THE ENVELOPE OR THE BID MAY NOT BE CONSIDERED:

SEALED BID

BUYER:----------RW/FILE 22----------

RFQ. NO.:----------WEH11111----------

BID OPENING DATE:----------04/28/2011----------

BID OPENING TIME:----------1:30 PM----------

PLEASE NOTE: A CONVENIENCE COPY WOULD BE APPRECIATED.

PLEASE PROVIDE A FAX NUMBER IN CASE IT IS NECESSARY TO CONTACT YOU REGARDING YOUR BID:

440-777-2330

CONTACT PERSON (PLEASE PRINT CLEARLY):

JAMES F. McCAULEY

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

	TELEPHONE	DATE
James F McCauley	440-777-6300	April 20, 2011
Vice President	FEIN 34-1127024	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

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BID OPENING DATE: 04/28/2011 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	****** THIS IS THE END OF RFQ WEH11111 ****** TOTAL:					$10,250.00

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE James J McCauley TELEPHONE 440-777-6300 DATE April 20, 2011

TITLE President FEIN 34-1127026 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

RFQ Cost Sheet WEH11111

Item #	Quantity	Description	Unit Cost	Total Cost
1	1 Job Installation Fee	Installation of application software for fully-integrated clearinghouse. Provide, install, and support all software applications for a 100% turnkey installation.	(Not Applicable) $ 0.00	$ 0.00
2	12 ea. Monthly fees	Application software, install, support, and anything incidental to provide a fully integrated clearinghouse service. Technical support Monday through Friday, 8:00 a.m. to 4:00 p.m. EST, except on Federal and West Virginia State holidays. Emergency service to be provided.	Included	$ 0.00
3	4000 each estimated # of claims per month	Fully integrated clearinghouse service Average monthly claim submission 3000-4500 claims	$ 0.40 per claim	$ 1,600.00
4	500 each estimated # of claims per month	Automated real-time insurance eligibility and benefit verification Average monthly claim verification – 500 claims	$ 0.20 per transaction	$ 100.00
5	15,000 each estimated # of claims per month	Remote statement processing, technical support and anything incidental for statement outsourcing – cycle statements Average monthly statement outsourcing – 15,000 claims	$ 0.57 per statement	$ 8,550.00
6	150 each estimated # of address corrections per month	Address correction service Average monthly claims 100-200	Included in statement processing fee	$ 0.00
7	1 job Annual Fee	Enhancements, routine releases to software	Included; no additional charge	$ 0.00
		GRAND TOTAL (without Remittance or other Optional services)		**$ 10,250.00**
Additional Services, Optional				
8	OPTIONAL	Remittance Payers - $60.00 per payer per month Each Payer/Payer Plan for which Quadax has to individually retrieve the ERA is considered one Remittance Payer or Remitter. Welch Community Hospital currently receiving ERA for 4 Remittance Payers (WV Medicare, WV Medicaid, WV Blue Cross, WV Blue Shield)	$ 60.00	$ 240.00 (Optional)
9	12 each Monthly Fees	Payer Reports on the Web (ASP Portal)	Fees Waived	$0.00
11	OPTIONAL	Claim Status transactions	$ 0.20 per transaction	(Optional)
12	OPTIONAL	Custom Programming QUADAX may program client-specific edits and inbound claim data conversions, as requested by the Client in writing, which allow the Client to better manage the claim submission process. Requests for these edits and conversions will be completed at a cost of one hundred dollars ($100.00) per hour, per edit/conversion programmed. This rate will NOT apply to special custom programming projects other than client-specific edits and claim data conversions. Custom development projects, including but not limited to special reporting, data conversions, remittance formats, imaging formats, and posting or comment records, will be individually quoted.	Optional	(Optional)
13	OPTIONAL	Healthcare Authority Reporting: $ 0.40 per claim, charged as used, no minimum	$ 0.40 per claim	(Optional)

14	OPTIONAL	Hardcopy Claims Print and Mail Service: $ 0.53 per claim, charged as used, no minimum	$ 0.53 per claim	(Optional)
15	OPTIONAL	Secondary Claim & EOB Hardcopy Print and Mail Service: $ 0.63 per claim/EOB, charged as used, no minimum	$ 0.63 per claim/EOB	(Optional)

Contract will be awarded to the successful bidder based on all costs combined.

ESTIMATES USED FOR EVALUATION PURPOSES ONLY. ACTUAL NUMBER OF CLAIMS WILL BE PAID ACCORDING TO ACTUAL CLAIMS PROCESSED.

RFQ No. WEH11111

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

st Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its ical subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the dor or prospective vendor is a debtor and the debt owed is an amount greater than one thousand dollars in the regate.

FINITIONS:
bt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its tical subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation mium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its tical subdivisions, including any interest or additional penalties accrued thereon.

btor" means any individual, corporation, partnership, association, limited liability company or any other form or siness association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county mmission; municipality; county board of education; any instrumentality established by a county or municipality; any parate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any blic body charged by law with the performance of a government function or whose jurisdiction is coextensive with one more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, sociation, limited liability company or any other form or business association or other entity whatsoever, related to any ndor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest h the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other nsideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent the total contract amount.

CEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the tter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in fault of any of the provisions of such plan or agreement.

nder penalty of law for false swearing (***West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and knowledges the information in this affidavit and is in compliance with the requirements as stated.

ITNESS THE FOLLOWING SIGNATURE

endor's Name: QUADAX, INC.

uthorized Signature: James F McCauley Date: 4-20-2011

tate of OHIO

ounty of Cuyahoga, to-wit:

aken, subscribed, and sworn to before me this 20th day of April, 20 11.

y Commission expires 6/22, 20 14.

FFIX SEAL HERE

NOTARY PUBLIC Janet Grisler

JANET CRISLER
NOTARY PUBLIC, STATE OF OHIO
Recorded in Cuyahoga County
My Comm. Expires June 22, 2014

9/08

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

(NOT APPLICABLE)

ication and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to ruction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) rence for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in rdance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing on will make the determination of the Resident Vendor Preference, if applicable.

Application is made for 2.5% resident vendor preference for the reason checked:
Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

Application is made for 2.5% resident vendor preference for the reason checked:
Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

Application is made for 2.5% resident vendor preference for the reason checked:
Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

Application is made for 5% resident vendor preference for the reason checked:
Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:
Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:
Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

der understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the uirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty inst such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency educted from any unpaid balance on the contract or purchase order.

submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and horizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information med by the Tax Commissioner to be confidential.

der penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true d accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate anges during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: Quadax, Inc. Signed: James F McCauley

Date: 4.20.2011 Title: Vice President

heck any combination of preference consideration(s) indicated above, which you are entitled to receive.

ATTACHMENT
P.O.# WEH 11111

This agreement constitutes the entire agreement between the parties, and there are no other terms and conditions applicable to the licenses granted hereunder.

Agreed

James J McCauley 4.20.2011
Signature Date

Vice President
Title

Quadax, Inc.
Company Name

Signature Date

Title

Agency/Division

AGREEMENT ADDENDUM

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event of conflict between this addendum and the agreement, this addendum shall control:

DISPUTES - Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.

HOLD HARMLESS - Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.

GOVERNING LAW - The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.

TAXES - Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.

PAYMENT - Any references to prepayment are deleted. Payment will be in arrears.

INTEREST - Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.

RECOUPMENT - Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.

FISCAL YEAR FUNDING - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.

STATUTE OF LIMITATION - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.

SIMILAR SERVICES - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.

ATTORNEY FEES - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.

ASSIGNMENT - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.

LIMITATION OF LIABILITY - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.

RIGHT TO TERMINATE - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay Vendor for services rendered or goods received prior to the effective date of termination.

TERMINATION CHARGES - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.

RENEWAL - Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.

INSURANCE - Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.

RIGHT TO NOTICE - Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.

ACCELERATION - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.

CONFIDENTIALITY: -Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.

AMENDMENTS - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

CCEPTED BY:

TATE OF WEST VIRGINIA

pending Unit: _____

Signed: _____

Title: _____

Date: _____

VENDOR

Company Name: QuadAx, Inc.

Signed: James F McCauley

Title: Vice President

Date: 4.20.2011

SPECIFICATIONS TABLE

SPEC #	SPEC DESCRIPTION	RESPONSE	DETAIL
1. GENERAL INFORMATION			
1.1	Quotation sought for provision of all application software, install, support, and anything incidental to provide a fully integrated clearinghouse service for electronic claims submission to all major insurance carriers, participating payers, serviced by Welch Community Hospital. Bidder shall state if real-time insurance eligibility and benefit verification is available electronically and additional fee, if applicable.	QUOTATION PROVIDED; REAL-TIME ELIGIBILITY AVAILABLE	Please see cost sheet for fees; Please see Specifications Narrative Section 1.1 for further information.
1.1.1	Quotation sought for provision of remote statement processing, technical support, and anything incidental to statement processing for Patient Accounts, Welch Community Hospital. Bidder shall state if address correction service is available, and additional fee, if applicable.	QUOTATION PROVIDED; ADDRESS CORRECTION SERVICE IS AVAILABLE	Please see cost sheet for fees; Please see Specifications Narrative Section 1.1.1 for further information.
1.1.2	Contract shall be an open end contract to begin upon award and continue for a period of one (1) year with the option of two (2), one- (1-) year renewals.	AGREED	
1.2	All claim submissions and statement processing will be in compliance with HIPAA, federal and state regulations, and industry standards. During the contract period, payment may be withheld if services rendered are not in full compliance.	AGREED	Please see Specifications Narrative Section 1.2 for further information.
1.3	All data transmitted to clearinghouse for electronic claims submission or remote statement processing shall be the property of the hospital at all times and shall be acknowledged by the bidder upon acceptance of a contract to be the property of the hospital.	AGREED	
1.4	The words "will," "must," and "shall" listed herein this document are mandatory requirements.	AGREED	
2. BIDDER REQUIREMENTS			
2.1	Qualified bidders, being familiar with and understanding the bidding documents and also being familiar with all billing conditions affecting the project hereby propose to furnish all application software, support, and anything incidental to perform all testing and installation in accordance with the bidding documents within the time set forth below.	AGREED	
2.2	Bidder is responsible to verify all required software and hardware and limitations prior to bidding, and to notify the WV Dept. of Health & Human Resources in writing of conditions detrimental to proper and timely completion of the installation.	AGREED	
2.3	In the event of changes in the Federal and/or State-mandated regulatory billing standards, and/or payer-	AGREED	Please see Specifications

	required changes to format, the bidder shall make mandated regulatory changes to the software including but not limited to operating parameters or network settings. The bidder shall provide all enhancements, routine releases to the software. Associated fees, if applicable, shall be quoted with this bid.		Narrative Section 2.3 for further information.
2.4	Bidder shall identify, provide, and install any additional hardware and software required to make the clearinghouse and remote statement processing operational at the hospital within this bid.	AGREED	All hardware and software components required are already in place and operational.

SPEC #	SPEC DESCRIPTION	RESPONSE	DETAIL
3. SCOPE OF WORK			
3.1	Minor deviations from the stated specification not listed as mandatory (must, shall, or will) are acceptable to facilitate a competitive bidding atmosphere provided the intent of the Request for Quotation or the effectiveness of the system is not compromised.	AGREED	
3.2	Successful Bidder shall act as a clearinghouse for electronic claims submission to all major insurance carriers, including but not limited to: Medicare, Medicaid, Blue Cross, ChampVA, UMWA, and all other commercial insurance carriers.	AGREED	Please see Specifications Narrative Section 3.2 for further information.
3.3	Successful Bidder shall act as a remote statement processor for printing, sorting, folding, stuffing, and first-class mailing of monthly patient statements.	AGREED	
3.4	Successful bidder shall provide, install, and support all software applications for this project for a 100% turnkey installation. Installation, training, and support shall be provided by a technician certified in the use and installation of the system provided or by software manufacturers' approved service representatives.	AGREED	Please see Specifications Narrative Section 3.4 for further information.
3.4.1	Bidders will provide a minimum of three (3) references from clients to whom they have successfully provided a similar or same system and services specified, in the past five (5) years.	PROVIDED	Please see Specifications Narrative Section 3.4.1 for list.
3.5	Successful Bidder shall provide standard technical support Monday through Friday, 8:00 a.m. to 4:00 p.m. EST, except on Federal and WV State holidays. Emergency service to resolve a condition that causes the billing department to be inoperable, or application software to be inoperable, shall be provided.	AGREED	Please see Specifications Narrative Section 3.5 for further information.
3.5.1	Standard technical telephone support shall be provided to solve operational or technical problems.	AGREED	Please see Specifications Narrative Section 3.5.1 for further information.
3.5.2	Standard technical support response from support personnel shall be provided within two (2) hours of service request.	AGREED	Please see Specifications Narrative Section 3.5.2 for further

			information.
3.5.3	Standard technical support for loading of application software release updates and operating system updates shall be provided.	AGREED	Please see Specifications Narrative Section 3.5.3 for further information.
3.6	Clearinghouse service will process all automated transactions from delivering UB04 and CMS1500 claims to the proper destination into the specific format required by the health plan payers to reporting back to the sender on any warnings, errors, and claim adjudication messages.	AGREED	Please see Specifications Narrative Section 3.6 for further information.
3.7	Successful bidder shall provide the hospital on-line viewing, customized statement options, ability to demand reprinting of prior statements and reporting to sender on processed claims.	AGREED	Please see Specifications Narrative Section 3.7 for further information.
3.8	Successful bidder will provide all technical and software training for up to 18 WCH employees after installation and quarterly thereafter for the duration of the contract. Successful bidder shall work with current software vendor, Keane, and Patient Accounting Manager on the set-up and testing of the system.	AGREED	Please refer to Specifications Narrative Section 3.8 for further information.

SPEC #	SPEC DESCRIPTION	RESPONSE	DETAIL

4. INSPECTION

4.1	Successful bidder shall be familiar with current hardware and software applications governing this installation during pre-bid inspection to determine conditions and extent of software and hardware required. No allowance shall be made subsequently on behalf of the successful bidder for any error or negligence on their part in connection with this requirement.	AGREED	
4.2	Successful bidder shall receive approval of test claims from all insurance providers prior to actual live transmissions.	REQUIREMENT NOT APPLICABLE AS QUADAX HAS COMPLETED ALL TESTING & RECEIVED APPROVAL FOR ALL WV PAYERS	Please see Specifications Narrative Section 4.2 for further information.

5. COORDINATION OF WORK

5.1	Successful bidder shall coordinate the installation and testing with the Patient Accounting Manager and Keane representative.	AGREED	
5.2	Successful bidder shall provide the Patient Accounting Manager with a time schedule for completed installation and testing.	NOT APPLICABLE	System is already in live production use; no installation necessary.

SPEC #	SPEC DESCRIPTION	RESPONSE	DETAIL

6. WARRANTY

6.1	Successful bidder warrants the performance of the system and/or service they provide according to specifications, for the entire term of this contract, to include any renewals or extensions.	AGREED	Please see Specifications Narrative Section 6.1 for further information.
6.2	Successful bidder shall guarantee all electronically-submitted UB04 and CMS1500 transactions will be delivered to the proper destination into the specific format required by the health plan payers in conformance with the contract documents. Not conforming to these requirements may be considered inferior and payment may be withheld.	AGREED	Please see Specifications Narrative Section 6.2 for further information.
6.3	Successful bidder shall guarantee 48-hour turnaround time for patient statement processing. Not conforming to these requirements may be considered inferior and payment may be withheld.	AGREED, FOR WEEKLY FILE SUBMISSION	Please see Specifications Narrative Section 6.3 for further information.
6.4	Successful bidder shall guarantee reporting to the Patient Accounting Department on any warnings, errors, and claim adjudication messages as well as accepted claim reporting. Not conforming to these requirements may be considered inferior and payment may be withheld.	AGREED	Please see Specifications Narrative Section 6.4 for further information.

7. LICENSE

7.1	Successful bidder shall secure and provide adequate user license required for the hospital billing staff.	AGREED	
7.2	Hospital understands and agrees that it is being granted access to use the software owned and developed by the Service Provider and that the amounts paid by the hospital to the Provider pursuant to a contract agreement are not intended to and do not fully reimburse Provider for the full expense of developing the software. Hospital agrees that access to the software does not include the right to reproduce, publish, or license any part of the software for use by an unrelated third party. Hospital consents that the entire right and title to the software is and shall remain with the Provider.	AGREED	

8. PAYMENT SCHEDULE

8.1	Successful bidder may begin to submit monthly invoices to Welch Community Hospital when the installation is completed in its entirety and testing accepted by insurance carriers and approved by Welch Community Hospital.	AGREED	Please see Specifications Narrative Section 8.1 for further information.
8.2	Welch Community Hospital reserves the right to refuse payment in the event the completed install and testing is not in accordance with Federal and State regulations, or, if the invoice amount is not within the agreed terms of the contract.	AGREED	

SPEC #	SPEC DESCRIPTION	RESPONSE	DETAIL
9. TERM OF WORK			
9.1	All software installation and claim transmission testing shall be complete and approved within thirty (30) calendar days, after receipt of the approved purchase order.	AGREED	System is already operational at WCH and claim transmissions are live.
10. DELAYS AND EXTENSION OF TIME			
10.1	If the successful bidder is delayed at any time in the progress of the installation and claim transmission testing, then the contract time may be extended at the discretion of Welch Community Hospital and only by written approval of the hospital, Department of Administration, Purchasing Division, and approved to form by the State Attorney General's office.	AGREED	
11. DAMAGES			
11.1	Any damaged occurring to the hospital patient accounting claim information resulting from the successful bidder's act of gross negligence and/or willful misconduct will result in such claim at law or in equity that may be brought against the successful bidder or any of its employees and to pay the amount of any judgment that may be entered against the successful bidder or its employees, or the amount of any reasonable settlement of any such claims.	AGREED	Please see Specifications Narrative Section 11.1 for further information.
12. SCHEDULE OF BID RESPONSES			
12.1	Successful bidders shall bid a one-time installation set-up fee as well as a unit cost per transaction for all the work under all the terms and conditions as described herein.	AGREED	System already operational at WCH; no installation necessary. Unit costs appear on cost sheet.
12.2	Successful bidder shall provide warranty information for the annual term of the contract upon acceptance of the system after installation. Successful bidder shall also provide warranty information upon renewal of each successive term.	AGREED	Please see Specifications Narrative Section 6.1 for further information.
12.3	Successful bidder must be a registered bidder with the WV State Purchasing Division and the Secretary of State's Offices, and any other entity that is required by West Virginia State Code including but not limited to section 21-11-2.	QUADAX IS A REGISTERED BIDDER	
12.4	Contract will be awarded to the successful bidder based on the grand total of all costs combined.	UNDERSTOOD	
13. WARRANTY (GUARANTEE)			
13.1	The Vendor shall warrant to the facility all materials and equipment will be new, and that all work will be of good quality, free from faults and defects in conformance with the	AGREED	

	contract documents. All work not conforming to these requirements may be considered defective.		
13.2	All materials and/or equipment shall be of current year production of manufacturer and manufactured for commercial usage. Used, reconditioned or remanufactured equipment is not acceptable.	AGREED	
13.3	Insurance Requirements: The vendor, as an independent contractor, is solely liable for the acts and omissions of its employees and agents. The vendor shall provide proof of insurance at the time the contract is awarded. The vendor shall maintain and furnish proof of coverage of liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the vendor, its agents and employees in the following amounts: (a) For bodily injury (including death): $500,000.00 per person, to a minimum of $1,000,000.00 per occurrence. (b) For property damage and professional liability: a minimum of $1,000,000.00 per occurrence. (c) Vendor will furnish a copy of certificate of workers' compensation coverage.	AGREED	Proof of insurance can be provided at time of contract award.

SPECIFICATIONS NARRATIVE

1. GENERAL INFORMATION

1.1 Quadax is pleased to currently be providing Welch Community Hospital (WCH) the total Quadax EDI package, which is not simply a software solution, but rather encompasses our exemplary support, exceptional reliability of product and processes, and extensive knowledge and West Virginia healthcare business experience. Xpeditor, the premier healthcare EDI processing engine throughout the region, facilitates a fully-integrated clearinghouse service for electronic claims submission, remittance management, eligibility transaction processing, full reporting, and more.

Quadax exchanges ANSI (the HIPAA-mandated standard) transactions with all major insurance carriers throughout the region and most across the country. Through Xpeditor, WCH is currently submitting claims to Medicare, Medicaid, Blue Cross, Blue Shield, CHAMPUS, and numerous commercial payers.

Real-time eligibility and benefit verification are available; the fee for the real-time transaction appears on the Cost Sheet. Quadax has developed several approaches to the use of the eligibility transaction to bring value to our clients, including both real-time, individual transactions and batch transactions. The fee per transaction is the same whether the verification requests are submitted individually or in batch.

--- Inside Xpeditor, the "Eligibility" button on the Selector screen toolbar initiates a real-time eligibility check either from scratch - with patient data entered directly into the form - or based on a claim in the active Selector, in which case the appropriate data will be scraped to complete the form. From the Selector, you can perform transactions one-by-one or a whole set of them at a time. Tracking for these transactions will be maintained within Xpeditor.

--- A stand-alone eligibility application available from the ASP Portal permits easy access to individuals outside the Patient Accounting Department, for example in Patient Registration. Eligibility inquiries generated through this application are processed in real-time.

--- A batch of eligibility requests may be generated from a flat file that contains the required data elements. Reports are returned to the client with detail and summary of the responses returned. As this is performed completely outside of Xpeditor, tracking and history for each transaction will not be stored in Xpeditor.

--- A batch of eligibility requests may also be initiated by the submission of an ANSI 270 from the Hospital Information System (HIS), with the response, the ANSI 271, returned to the HIS for display within that system. No tracking or history will be stored within Xpeditor. This option requires special configuration.

1.1.1 Quadax Statement Processing service provides the client with the following address correction edits:

- CASS address certification
- Delivery Point Validation (DPV)
- Locatable Address Correction (LACS)
- National Change of Address 48-month (NCOA48)

These services are bundled into the per-statement fee indicated on the Cost Sheet.

1.2 Quadax, Incorporated, a Covered Entity according to HIPAA regulations, is committed to full HIPAA compliance in every aspect of our business operation. Quadax likewise considers compliance with all Federal, State, and industry regulations to be essential to our operation, our service to our customers, and our integrity as a corporation. The Quadax Compliance Statement states:

Quadax considers compliance to be a process rather than a task that can be marked completed. We work on compliance every day, monitoring new regulatory requirements, establishing internal policies, educating our

employees, enforcing standards, and implementing enhancements to our software systems. Compliance takes the focus and commitment of the entire organization and is ingrained in our culture. Our compliance plan encourages the prevention, detection, and resolution of any conduct that is in violation of state or federal regulations.

The Quadax Corporate Compliance Officer is Catherine Sicker. She is responsible for planning, development, and oversight of HIPAA-mandated and OIG-recommended compliance guidelines. Our Corporate Security Official is Gene Calai.

Quadax has demonstrated its HIPAA and regulatory compliance through attainment of full accreditation by the Electronic Healthcare Network Accreditation Commission for three successive accreditation cycles, and Claredi certification of ANSI transactions. Quadax has also successfully been subject to audit according to SAS-70 standards. An announcement of our 2010 EHNAC Accreditation is included in the Appendix to this document.

2. BIDDER REQUIREMENTS

2.3 Quadax software engineers are continually engaged in research and development to enhance the Xpeditor system, both to comply with regulatory/payer requirements as well as to improve efficiency for our customers. One example of an enhancement to the Xpeditor system was the recent programming implemented to comply with Change Request 5647 issued by Centers for Medicare & Medicaid Services, which began to require that hospitals, IRFs, and LTCHs submit "no pay" bills to their Medicare contractor for the Medicare Advantage beneficiaries they treat. In order to ensure that our clients could comply with this Federal mandate, Quadax programmers added significant functionality to Xpeditor, our flagship EDI processing engine.

This feature ("No Pay" claim creation) functions in two distinct, but related, modes: Ongoing and Historical. In the Ongoing mode, the Communicator Module automatically generates a "no pay" claim for current Medicare claims that are selected based on user-defined criteria. The Historical mode utilizes a separate, stand-alone screen that allows the user to pull claims based on user-defined criteria from History. Per the CMS mandate, users are able to report claims as far back as October 1, 2006. Xpeditor automatically add a Condition Code "04" to a "No Pay" claim when it is created in order to comply with CMS' mandate. The bottom portion of the Setup Screen allows the user to modify/update information as well. After a "No Pay" claim has been created, in either Ongoing or Historical mode, it is placed in the Selector screen with the status "W: MEDICARE NO PAY" so that users may review the "No Pay" claim for all proper information.

Another example of Xpeditor's evolution to keep pace with regulatory requirements is the implementation of ANSI 5010, which necessitates not only updated back-end transmission adjustments but also changes to screens within Xpeditor (to account for new data elements) and new edit routines. Implementation of the ANSI 5010 standard paves the way for the adoption of ICD-10, required for dates of service/discharge on and after October 1, 2013, for which Quadax will also be ready.

Quarterly upgrades to the Xpeditor system are issued at no additional charge, and are automatically implemented by means of Xpeditor's "Update Module" that executes updates according to a scheduled routine, generally during the overnight hours so that billing productivity is not impacted.

3. SCOPE OF WORK

3.2 Getting claims to payers "clean" – error-free – improves and accelerates your reimbursement, giving you value where you need it most: right at the bottom line. Xpeditor's edits, or validation rules, are applied through both batch (at initial download) and interactive processing, and include:

- Standard edits for ANSI requirements
- Standard edits for payer billing requirements
- Custom edits programmed by Quadax staff according to client-specific instructions

- Custom edits or rules programmed by authorized Xpeditor users through the XpressBiller interface

The function of reviewing edit routines for compliance with payer requirements is fulfilled at Quadax by the Edits and Documentation Group in concert with the UB Edit Group and the Insurance Committee. The UB Edit Group and the Insurance Committee each comprise a cross-section of representatives from throughout our organization with diverse, complimentary expertise which fosters well-informed discussions and decision-making. Payer and industry news is brought to the table by the members assigned to each area. Client requests may also be evaluated in this forum, if there appears to be a conflict with a requirement, or if it appears that a client-specific edit request has potential value for all of our hospital clients.

Edits are implemented by our programming staff, and the Edits and Documentation Group gathers documentation and posts it in the Quadax Knowledge Base. From the ASP Portal (the secure client area of the Quadax web site), clients may access a complete, searchable list of all Xpeditor edits. Each edit is linked to detail on the Quadax Knowledge Base, and supporting documentation is noted or linked.

Ongoing monitoring of the effectiveness of Xpeditor edits takes place through the analysis of a weekly report, automatically generated and sent to several key individuals within EDI Services, that identifies the percentage of claims rejected by payers, thus revealing a "mismatch" between Xpeditor edits and payer front-end or adjudication edits.

Xpeditor edits are updated through an automated process which occurs each Tuesday night. Edit and Code Table Update Reports, which document standard edit changes, additions, or deletions, are likewise provided each week. Revisions to standard edits, necessitated by changes to payer or regulatory requirements, are made on a regular basis, so that Xpeditor edits are continually kept up to date based on the best information we are able to obtain. Those edits that are "hard-coded" into the application are updated every two weeks; edits that are driven by tables of data are updated every week. Confirmation of custom edit or data conversion request fulfillment is done on an individual basis as soon as the programming has been completed. Approximately 90% of all custom edit revisions or custom edit requests are completed within 24 to 48 hours of receipt from customer. The remaining 10% are edit requests that are unclear and require further explanation, or those which require more extensive testing in unique situations prior to live implementation.

The Tracking system, Xpeditor's audit trail function, is one of its most useful features. Xpeditor logs every event in the life cycle of a claim, permanently attaching the complete audit trail to the claim, even in the History database following transmission or deletion from the active database. The Tracking record will detail information about all of these, and other, milestones:

- A claim's creation (with a hyperlink to the original file from which it was converted)
- A claim's batch conversion
- Any custom conversions or XpressBiller rules applied, identified by reference number for further auditing ability
- Errors found on the claim
- Each instance a claim is viewed, and by whom
- Each instance a claim is saved, and by whom
- Each instance a claim is printed
- Any additions, changes, or deletions of any data on the claim, identifying the user
- Duplicate or spawned claims, with links to the new documents
- Changes made to a claim through a Global script
- The claim's release or deletion from the active database
- The claim's acceptance at the Quadax clearinghouse
- The claim's acceptance or rejection at the payer (for most payers), including a link to the new document if the claim was rejected

- The remittance received for the claim, for some payers, if enabled, including a link to the EOB

Tracking records may also be added to a claim's life cycle to document special events concerning the claim that may happen outside of Xpeditor. The detail of the documentation associated with each claim in its Tracking permits a wide range of reporting options. Through the browser interface, the Tracking records may be viewed according to the user's preference: fully itemized events, collapsed to summary, or key events only.

Xpeditor's automated workflow processes enable optimal efficiency; Workflow Statuses are assigned to claims through batch processing upon import based on what, if any, intervention is required prior to the claim's release to the payer of record. Workflow Statuses may be customized and applied based on client-defined scenarios. The "View" or Worklist presented to each biller is customizable such that the workload is logically divided and distributed according to the Workflow Status applied to each claim.

Quadax transmits claims electronically to hundreds of payers. Welch Community Hospital currently submits claims through Xpeditor to Medicare, Medicaid, Blue Cross, Blue Shield, CHAMPUS, and numerous commercial payers. At regular service visits by the account representative assigned to WCH, analysis of the hospital's payer matching matrix is performed to ensure that all claims that can be transmitted electronically are being processed accordingly.

3.4 The Xpeditor system is already fully implemented at Welch Community Hospital; no further installation is required.

3.4.1 West Virginia Hospital References for whom Quadax successfully provides similar/same services:

- Charleston Area Medical Center Memorial Hospital | Jay Richmond: 304-388-6250
- Stonewall Jackson Memorial Hospital | Dodie Arbogast: 304-269-8050
- Minnie Hamilton Hospital | Liz Farrell: 304-354-9244 ext. 110
- Monongalia General Hospital | Linda Dugan: 304-285-2690
- Pleasant Valley Hospital | Tammy Midkiff: 304-675-4340 ext. 2053
- St. Mary's Medical Center | Mike Keeney: 304-526-1022
- Pocahontas Memorial Hospital | Wanessa Cassell: 304-799-7400 ext. 228

Patient Statement Reference

- Welch Community Hospital | Johnny Brant: 304- 436 - 8683

Selected other West Virginia Hospitals for whom Quadax provides similar services, used at varying levels:

- Braxton County Hospital
- Broaddus Hospital
- Camden-Clark Hospital
- Davis Hospital
- Fairmont General Hospital
- Grafton City Hospital
- Highland Hospital
- St. Joseph Hospital
- Thomas Memorial Hospital
- Webster County Hospital
- West Virginia University Hospitals
- Jefferson Memorial Hospital
- Montgomery General Hospital
- Ohio Valley Medical Center
- Preston Memorial Hospital
- Reynolds Memorial Hospital
- Roane General Hospital
- United Hospital Center
- Weirton Medical Center

In addition to the fine institutions listed above, Quadax processes electronic transactions for more than sixty physician practices and clinics located in West Virginia.

3.5 The first line of support for Quadax clients is the EDI Client Support Center (CSC), staffed by representatives ready to take your phone call or electronically submitted support event logged to the ASP Portal. The CSC staff is available **Monday through Friday, 6 a.m. to 5 p.m. EST**. The CSC may be reached toll-free: 866-422-8079, or by a local call to 440.979.4090. CSC reps will personally address issues whenever possible, or will route an event to another area of the support structure when they can't, so that the solution is prepared by the best-qualified personnel in the timeliest fashion. Support events may also be logged on the ASP Portal, the secure client area of the Quadax web site, and those events are routed immediately to queues managed by the CSC.

Please see Section 3.5.2, below, for detail regarding emergency service for event resolution.

3.5.1 Please see Section 3.5, above, Section 3.5.2, below, and the support leaflet titled "What's in a Name" included in the Appendix to this document.

3.5.2 As outlined in the support leaflet included in the Appendix to this document, Quadax support personnel prioritize all reported support events and actively work toward resolution of those events as quickly as possible, by order of priority. When responding to Priority One events (A Priority One event is one in which Xpeditor is down or failing to the extent that critical work cannot be done and there is no immediate workaround solution; Xpeditor is not functional and there is a critical impact to your business operation.), Quadax will immediately assign the necessary personnel to resolve the problem, and will then provide continuous attention and resources, including escalation to higher levels of authority, with assistance from you as required, until the problem is resolved. Our goal is to resolve within 2 business hours.

3.5.3 Updates to software are implemented on a quarterly basis; updates to codes, medical necessity policy rules, etc., are implemented on a weekly basis, and hard-coded edits are implemented every other week. Each of these updates occurs automatically; intervention by WCH staff is generally not required. Notice of the specific codes, edits, and other updates to be applied is sent by e-mail to all registered users and also posted on the secure ASP Portal for reference. All updates are performed through the automated Update Module, which is scheduled to run on each client system at a time that will not impede the client's workflow, since the Update Module must retain exclusive access to the system while it applies modifications; generally this occurs during the overnight hours. In the event that the Update Module fails to complete its update routine and release exclusive access by 4:00 a.m., a support event is automatically logged to the Quadax Help Desk so that the Technical Support team can intervene as soon as they arrive at 6:00 a.m. Please see the EDI *Policies in Practice* document titled "Automated System Updates" in the Appendix to this document for further information.

3.6 Quadax currently transmits data to payers in the ANSI 4010 format, and is undertaking the transition to ANSI 5010 as payers are prepared to receive the new format. The Xpeditor user interface displays the claim data in a user-friendly claim form appearance, UB04 and CMS1500, with additional screens for data elements that are part of the ANSI specifications but not included on the standard paper forms.

Because Xpeditor doesn't stop with transmitting claims, but rather closes the loop by bringing payer response, and remittance data, if you receive electronic remittance through Quadax, back into the life cycle of claims in the Xpeditor database, Xpeditor is able to detect payer rejections and denials and process those according to the parameters set by your facility.

Claims rejected at the payer front end, often due to patient ineligibility, prompt Xpeditor to add the appropriate record to that original claim's Tracking in the History archive, and create a new iteration of that claim, added to the active database with the workflow status of "W: Payer Rejected." The reason code and description the

payer included on the front-end response report will be included in the claim's error grid. The Tracking records for both the original and the newly created claim will be linked, such that there is easy audit trail of what transpired.

Claims (or individual charges) denied during the payer's adjudication process, and identified as such on the electronic remittance advice, can be displayed on a remittance report of all denied claims. Using the information on this report, those denials may be captured and worked appropriately.

3.7 Historical online statement viewing and demand printing is available and currently operational through a secure web-based Portal. Quadax is providing ten named licenses for WCH users to access the Portal. Twelve-month rolling access to statements is available through the Portal for viewing and demand printing.

3.8 Installation, set-up, and testing of the system have already been accomplished, as the Xpeditor system is currently in production use at Welch Community Hospital.

Training as needed is a regular feature of the service visits conducted by the Quadax account representative assigned to WCH and will continue throughout the duration of the engagement.

4. INSPECTION

4.2 Quadax is an approved EDI Vendor for all major insurance payers in West Virginia and, and such, is not required to test with each payer in order to submit claims. Further, the Xpeditor system is currently in live production use at Welch Community Hospital; therefore, no additional testing is required.

6. WARRANTY

6.1 Quadax warrants that it is the exclusive owner, of Xpeditor, the Xpeditor User Manual, and all associated materials ("Deliverables") provided to Client, all modifications, additions, derivatives and enhancements thereof, all copies thereof, and all rights therein. The Deliverables do not and will not, infringe or violate any intellectual property rights (copyright, trademark, trade secret or patent) or other proprietary rights of any party. For so long as Client has performed its obligations under agreement with Quadax, Client shall not, with the passage of time, lose the right to use some or all of the Deliverables. There is no action, suit, claim, investigation or proceeding pending, or, to the best of Quadax's knowledge, threatened against, by or affecting Quadax or the Deliverables, that, if adversely decided, would adversely affect (i) Quadax's ability to enter into or perform under a service agreement with Quadax; or (ii) Client's use of the Deliverables.

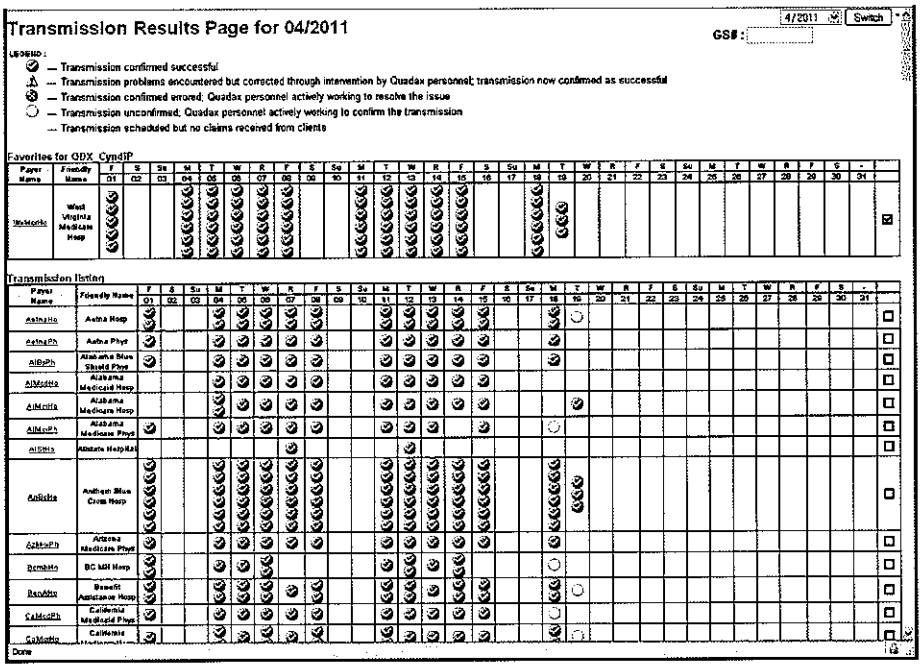
Quadax represents and warrants to Client that Xpeditor, when operated as recommended in the Xpeditor Documentation, will perform substantially as described in the current edition of the Documentation.

Quadax makes no representations or warranties as to the **benefit** from the use of its services and products. The liability of Quadax for errors and omissions shall be limited to their correction or revision at Quadax's expense. Quadax shall have no liability for incidental, special or consequential damages.

6.2 Quadax provides its customers tools with which to monitor the status of their claims and thereby to hold Quadax accountable; these include Tracking records, the Transmission Results system, and payer reports.

The Transmission Results System, available through the ASP Portal (the secure client area of the Quadax web site), gives clients a behind-the-scenes view of all transmission activity of the EDI Clearinghouse. At a glance, thanks to an intuitive scheme of symbols, you can verify the successful transmission of claim data to all third parties with whom we transact. You can save certain payers as "favorites" so that the payers most important to your operations appear at the top of the grid. Clicking on an indicator symbol on the grid takes you to a page with details

about the transmission, with a link to the ANSI response received. As you can see in the image below, multiple transmissions per day are indicated by multiple results symbols.



From the ASP Portal, clients may access Payer Reports on the Web, which are, quite simply, the payers' own reports in their own formats. This data is returned to us as response reports, front-end reject or acceptance reports, etc., and from those reports Quadax extracts claim data to return to your Xpeditor database for the creation of Tracking records to be added to claims in History, as well as the generation of new claims when an original has been rejected. We also parse those payer reports by provider so that we can return each organization's portion to its Payer Reports folder. Thus, you are equipped to answer any objections a payer may have regarding the receipt of claim data; they generally cannot argue with a report in their own format!

Please refer to Section 3.2 for a discussion of Tracking records applied to every claim.

6.3 Quadax shall guarantee a forty-eight (48) hour turnaround time on the processing of a weekly patient statements file. Should the hospital wish to submit daily or semi-weekly data files for patient statement processing, hospital personnel must discuss requirements and expectations with Quadax; the 48-hour guarantee may not be valid under such circumstances.

6.4 Xpeditor applies validation rules, or "edits" to every claim passing through the system, flagging potential errors where found, then adding claims with errors to workflow for intervention by the billing staff. A discussion of Xpeditor edits appears in Section 3.2.

Claims rejected at the payer front end, often due to patient ineligibility, prompt Xpeditor to add the appropriate record to that original claim's Tracking in the History archive, and create a new iteration of that claim, added to the active database with the workflow status of "W: Payer Rejected." The reason code and description the payer included on the front-end response report will be included in the claim's error grid. The Tracking records for both the original and the newly created claim will be linked, such that there is easy audit trail of what transpired.

Xpeditor reporting is comprehensive, with several report options to keep Welch Community Hospital informed about all claims processed, including claims accepted at the clearinghouse level and at the payer front-end system. For more information about reporting in Xpeditor, please see the Xpeditor User Guide Reporting Chapter excerpted and included in the Appendix to this document.

8. PAYMENT SCHEDULE

8.1 Quadax will submit an invoice to Client for Electronic Data Interchange and other agreed-upon services on a monthly basis, based on the rates and charges identified on the cost sheet section of this document. Payment for each monthly invoice is due in full from Client when invoice is received by the Client and shall be considered delinquent thirty (30) days following invoicing. Quadax must be notified in writing of any charge that is disputed by Client. Quadax reserves the right to suspend processing of transactions for the Client if any undisputed balance owing is delinquent more than thirty (30) days. Such processing may, at the sole discretion of Quadax, remain suspended until all balances owed by the Client are paid in full.

11. DAMAGES

11.1 Intellectual Property Indemnification. At Quadax's expense, Quadax shall indemnify, defend and hold Client harmless from and against any claim enforceable in the United States that the Xpeditor product/system infringes a patent, copyright, trademark or other intellectual property right by defending against such claim and paying all amounts that a court finally awards or that Quadax agrees to in settlement of such claim. Quadax shall also reimburse Client for all reasonable expenses incurred by Client at Quadax's request in defense of any such action(s). To qualify for such defense and payment, Client must: (i) give Quadax prompt written notice of such claim; and (ii) fully cooperate with Quadax in, the defense and all related negotiations subject to the Ohio Attorney General's statutory authority to appoint legal counsel and approve settlements proposed by Quadax, which authority will not be unreasonably withheld. Quadax's obligation under this Section is conditional upon Client's agreement that, if the operation of the Xpeditor becomes, or in Quadax's opinion is likely to become, the subject of an infringement claim, then Client shall permit Quadax, at Quadax's expense, either to procure the right for Client to continue to use such items or to replace or modify them so that they become non-infringing and retain substantially comparable function. Quadax shall have no obligation with respect to any claim based on (i) Client's use of the Xpeditor in violation of this Agreement. This Section states Quadax's entire obligation to Client regarding intellectual property right infringement.

Mutual Indemnification. Quadax shall indemnify, defend, save and hold harmless the Client, its employees, agents, officers, directors, affiliated entities, and representatives (individually and/or collectively, "Representatives") from and against any and all third-party claims, suits, actions, investigations, proceedings, liability, loss, damage, or demands, and all related costs, penalties, interest, or expenses (including reasonable attorneys' fees) at all levels of litigation which may be sustained or incurred by Client at any time (i) by reason of Quadax's gross negligence or willful action or omission in the performance or failure to perform its obligations set out in this Agreement, and as set forth in Section 7.1; or (ii) as a result of Quadax's violation of federal, state or local civil and/or criminal statutes, laws or regulations.

Client shall indemnify, defend, save and hold harmless Quadax, its employees, agents, officers, directors, affiliated entities, and representatives (individually and/or collectively, "Representatives") from and against any and all third-party claims, suits, actions, investigations, proceedings, liability, loss, damage, or demands, and all related costs, penalties, interest, or expenses (including reasonable attorneys' fees) at all levels of litigation which may be sustained or incurred by Quadax at any time (i) by reason of Quadax's gross negligence or willful action or omission in the performance or failure to perform its obligations set out in this Agreement, and as set forth in Section 7.1; or (ii) as a result of Client's violation of federal, state or local civil and/or criminal statutes, laws or regulations.

If any event occurs giving rise to a claim for indemnification hereunder, the party against whom indemnification is sought shall be entitled to prompt written notice thereof from the other party hereto (including a full disclosure of all facts and circumstances giving rise to the claim of indemnification); and such party shall have the right, at its option, to designate its own legal counsel, at its own expense, for the defense of such claims.

APPENDIX

QUADAX
INCORPORATED

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www.quadax.com

Quadax, Incorporated Again Achieves EHNAC Healthcare Network Accreditation

Accreditation ensures adherence to health data processing standards and compliance with security infrastructure and integrity requirements

CLEVELAND, OH – June 17, 2010 – Quadax, Inc., a regional leader in the delivery of clearinghouse and revenue cycle management solutions, announced today it has again achieved full accreditation with the Healthcare Network Accreditation Program (HNAP) from the Electronic Healthcare Network Accreditation Commission (EHNAC). EHNAC's HNAP accreditation recognizes excellence in health data processing and transactions, and ensures compliance with industry-established standards and HIPAA regulations.

Through the consultative review process, EHNAC evaluated Quadax in areas of privacy measures, systems availability and security infrastructure. In addition, EHNAC reviewed the organization's process of managing and transferring protected health information and determined that the organization meets or exceeds all EHNAC criteria and industry standards. Through completion of the rigorous accreditation process, the organization demonstrates to its constituents, adherence to strict standards and participation in the comprehensive, objective evaluation of its business.

"With recent changes in legislation and compliance requirements, this is a crucial time for healthcare networks to ensure that they're adhering to the latest standards in privacy, security and confidentiality," noted Lee Barrett, executive director of EHNAC. "In order to earn EHNAC HNAP accreditation, healthcare networks are required to demonstrate excellence and a commitment to ensuring the security and privacy of health data processing and transactions for their customers. Quadax joins this select group of HNAP-accredited organizations."

Quadax fulfills its mission of improving the financial performance of healthcare organizations by creating revenue cycle efficiencies with Xpeditor Xtensions: a powerful suite of tools for claims management, remittance management, denials management, automated claim status, eligibility verification, and audit (including RAC) management. Quadax clients enjoy the attentive support of Quadax representatives who work with them to identify problems and to continually optimize business office processes for exceptional outcomes.

It is this drive toward continual improvement that motivates Quadax to seek EHNAC accreditation. "Every two years, we at Quadax undergo a review of our company and operating processes by our peers," says Tom Kish, CEO of Quadax EDI Services. "The EHNAC Certification represents recognition from the industry that Quadax is an exemplary vendor of electronic healthcare transactions. We are proud of that distinction and proud of the people of Quadax who have earned this award. We are earnestly engaged and diligent about being the best clearinghouse in our business. We continue to strive to represent the standard by which our industry is measured. The EHNAC Certification justifies to us that we are succeeding."

About Quadax

Quadax has invested in the improvement of healthcare EDI and revenue cycle management since its founding in 1973. A privately-held corporation, Quadax is well-positioned to remain flexible and agile in a continually evolving industry. More information about Quadax can be found on the company's web site: http://www.quadax.com.

About EHNAC

The Electronic Healthcare Network Accreditation Commission (EHNAC) is a voluntary, self-governing standards development organization (SDO) established to develop standard criteria and accredit organizations that electronically exchange healthcare data. These entities include electronic health networks, payers, financial services firms, health information exchanges and e-prescribing solution providers.

EHNAC was founded in 1993 and is a tax-exempt 501(c)(6) nonprofit organization. Guided by peer evaluation, the EHNAC accreditation process promotes quality service, innovation, cooperation and open competition in healthcare. To learn more, visit www.ehnac.org or contact info@ehnac.org.

QUADAX
EDI SERVICES

VHAT'S IN A NAME?

illiam Shakespeare has suggested that a name doesn't n all that much, since *"that which we call a rose by any r name would smell as sweet."* Well, we hate to argue the Bard, but we think that some names are pretty im- ant—for example, ours: **EDI Services**. By our name should know that ***service isn't just something we do, who we are.***

dax has a firm foundation in the healthcare EDI busi- , built on developing and adapting new technologies to t the unique needs of this industry. We've built a premier thcare transaction processing engine—Xpeditor. We've loped other valuable tools to benefit our clients, such ie Transmission Results system. But we don't want to you software, even if it is the best around. We want to ower you to meet your revenue, compliance, and pro- ivity goals, and give you extra value along the way.

purpose of this leaflet is to give you an overview of how service organization works to meet that goal, what you expect from us throughout our relationship with you, and t this relationship requires of you, the client.

ayers win games, teams win championships."
ill Taylor

take a team approach to customer support because we ve that the depth afforded by a multi-tiered support struc- enables us to offer unparalleled service to our clients. in EDI Services, specialized teams permit the greatest feration and maturation of knowledge and experience. iple specialties can be represented on a team, assuring ed viewpoints and experience to draw on as solutions developed. And, teams provide the greatest coverage sible to our client base. Although one representative will lesignated as the primary relationship manager for each ount, clients never need feel abandoned when that pri- y rep is away from the office. In this way, there are no nds of isolation. Information is not isolated to discon- ted individuals, nor is any client isolated to one individual t of contact.

eral teams comprise EDI Services, and ultimately each nese has a role to play in supporting your account:

- Sales & Marketing
- Client Set-Up
- Xpeditor Implementation Team (XIT)
- Service
- Client Support Center (CSC)
- EDI Tech Support
- Transmissions Auditing
- Edits & Documentation Group (EDG)

Xpeditor Enterprise clients will first have contact with XIT soon after the contract is executed in order to set up the Kick-Off Meeting. From there, XIT works through a finely-tuned set of protocols to work through all of the steps to a successful implementation, including workflow analysis, training, parallel testing, etc. The XIT includes Workflow Analysts, Workflow Leaders, Technical Analysts, Technical Leaders, and a Remit Leader, all under the direction of the XIT Project Manager.

The goal of XIT is to achieve live use of Xpeditor ('go-live') as smoothly, effectively, and efficiently as possible. While the Remit Leader will remain engaged to appropriately implement all remittance-related processes, go-live serves as the segue (or 'hand-off') from account management by XIT to account management by Service.

The Xpeditor Implementation Team (XIT) brings value to current and new clients alike: current clients can be assured that their support won't evaporate whenever a new client needs to be brought up, and new clients enjoy the expertise of a team devoted to new implementations.

A hospital in Michigan told us, "This has been one of the smoothest implementations I've ever experienced!"

A hospital in Pennsylvania so appreciated the XIT Workflow Rep that worked closely with their staff during Implementation that they awarded her a "You Make a Difference" award, "for the wonderful job that [she has] done for us during our electronic claims conversion! [She] made it painless!!"

In most instances, one or more Service Representatives will have partnered with the Xpeditor Implementation Team to bring up your account, often while training your staff. But those Service faces are likewise part of a team that includes Territory Coordinators, Junior and Senior Representatives,

Service Managers, Regional Account Managers, the Senior Service Manager, and the VP/COO of EDI Services. When hand-off from XIT to Service takes place at go-live, this team works together with the CSC, EDG, Tech, and all the rest to provide comprehensive support by fulfilling certain responsibilities.

"The price of greatness is responsibility."
—Winston Churchill

The responsibilities of our Service staff include:

- On-going product training and education
- On-going client support / event resolution
- Researching, reporting, and resolving billing edit changes and conflicts
- Assisting client to take best advantage of Xpeditor's efficiencies
- Assisting to align Xpeditor to meet client's workflow objectives
- Maintaining relationship
- Serving as client advocate to Quadax
- Serving as Quadax advocate to client

These responsibilities are fulfilled by:

- Maintaining an active/current Help Desk log
- Scheduling and conducting on-site client visits at regular intervals
- Reporting on every client visit, with analysis of objective fulfillment & need for follow-up
- Participation in on-going product training through Regional User Group meetings, the Annual Xpeditor Enterprise User Conference, and other training opportunities as they arise
- Serving on the Quadax Insurance Committee and/or the UB Edit Group
- Facilitating communication with other Quadax teams on behalf of client
- Communicating with clients regarding corporate updates
- Maintaining integrity with service protocols and internal procedures
- Integrating the CSC as effective first contact for customer support
- Engaging in on-going product and industry education to stay current with all developments

That's a lot of responsibility. In a partnership, however, such as the relationship between Quadax and each of our clients, there is responsibility on both sides. Our teams can often only function properly in their roles when certain roles are fulfilled at the client organization. Three critical roles are that of the Billing Lead, the Administrator, and the IT Lead, each with important responsibilities of their own:

The Billing Lead may be a manager, supervisor, or team leader, but should be a power user with security clearance and authority to document and confirm custom programming requests, configure new users, establish views and determine appropriate workflow, monitor daily reports, etc.

The Administrator (and a backup) primarily monitors the Xpeditor Director PC and server(s), acting as liaison between the business office and the facility's IT staff with regard to file loading issues and communication (transmiss issues, etc.

The IT Lead and backup will typically be persons of aut ity on the client IT staff, serving technical capacity to sup the IT environment, involving SQL, servers, firewalls, ren connectivity, etc., within which your Xpeditor Enterprise tem is running.

We depend on these individuals, in particular, to log deta support events in a timely fashion when help is requi monitor payer reports, review and distribute informa coming from Quadax about software and industry chan and review Xpeditor reports in order to detect irregular before they become real problems. In that way, we can v together, as partners, to achieve optimal performanc your Xpeditor system and optimal revenue cycle results

"The customer doesn't expect everything will g right all the time; the big test is what you do wh things go wrong." —Sir Colin Marshall

When you do encounter a difficulty with Xpeditor, your line of support is the EDI Client Support Center (C Since an important part of a Service Representative's sponsibility is to be on-site with clients regularly, they will always be at their desk to take your call—but the CSC r will. CSC representatives are available Monday through day, 6 a.m. to 5 p.m. EST/EDT. **The CSC may be reac toll free, 866-422-8079, or by a local call to 440-9 4090**. Support events may also be logged online, thro the secure Portal, and those online events are automatic sent to the CSC. Log into the Portal at www.quadax.com/user.

CSC reps will personally address issues whenever possible, or will route an event to another area of the support structure when they can't, so that the solution is prepared by the best-qualified personnel in the timeliest fashion.

Quadax has developed our own customer relationship management package we call simply the "Help Desk" application. This package mits not only routing and tracking of support events, but reporting and automatic escalation, so there are no bl holes. Each support event is prioritized according to severity of its impact on the client's daily processes; this mits the appropriate allocation of resources to resolve ery event within a timeframe that meets or beats the g we have set for ourselves. The prioritization of events enables the automatic escalation of events according to fined parameters. Event priorities and corresponding es lation procedures are as follows:

Priority One—Xpeditor is down or failing to the extent critical work cannot be done and there is no immediate w around solution. Xpeditor is not functional and there critical impact to your business operation.

Quadax will immediately assign the necessary personne

solve the problem, and will then provide continuous attention and resources, with assistance from you as required, til the problem is resolved. Our goal is to resolve within 2 siness hours.

ould a Priority One event remain unresolved 1 hour after t report, it is automatically escalated to the next level of thority; further escalation occurs at the third hour and sixth ur and then e-mails continue to be generated to the high- authorities every 12 hours until the event is closed.

survey of Priority One events for a recent month revealed at 81% of these were corrected in 1 hours or less, and only % required longer than 2 hours to resolve; however, we not place a guarantee or warranty on the time that will be quired to correct a software problem.

iority Two—Xpeditor's operation is significantly degraded d substantial aspects of your claims-processing business eration are severely impacted.

adax will immediately assign the necessary personnel to solve the problem, and will then provide priority attention d resources, with assistance from you as required, until problem is resolved. Our goal is to resolve within 4 business hours.

ould a Priority Two event remain unresolved 2 hours after t report, it is automatically escalated to the next level of thority; further escalation occurs at the fourth hour and ain at the eighth hour; e-mails continue to be generated ery 12 hours until the event is closed.

survey of Priority Two events for a recent month revealed at 87% of these were corrected in 2 hours or less; however, we do not place a guarantee or warranty on the time at will be required to resolve a support event.

iority Three—Xpeditor's operational performance is impaired while most other aspects of your claims-processing siness operations remain functional.

adax will commit resources during normal business hours restore service to satisfactory levels, with assistance from u as required. Our goal is to resolve within 1 business y.

ould a Priority Three event remain unresolved four hours ter first report, it is automatically escalated to the next level of authority; further escalation occurs at the eighth hour; mails continue to be generated every 12 hours until the event is closed.

Priority Four—Your call is a request for information or assistance related to Quadax EDI product capabilities, or general assistance in resolving EDI-related billing or coding issues. There is minimal impact on your business operation.

Quadax will commit the appropriate resources during normal business hours in order to address your request, with assistance from you as necessary. Our goal is to resolve promptly, based on current CSC workload. There are no automated escalation procedures for Priority Four events.

Please note that if problems originate from incorrect use of Xpeditor or from a computer equipment malfunction which results in database errors which may require assistance by Quadax for correction, we will generally provide such assistance; however, depending on the efforts to be expended, Quadax reserves the right to assess fees for the associated consulting time. Incorrect use of Xpeditor is defined as data processing procedures not in conformity with such procedures as described in the Xpeditor User Guide and Release Notes as updated from time to time by Quadax. If the problems originate in a client's computer network or in software not covered by this Agreement or result from modifications to Xpeditor made by any one other than Quadax, our responsibility shall be limited to providing assistance and advice to enable you, our client to determine appropriate remedial action that you must take or delegate to professionals other than Quadax personnel to resolve such problems.

Are we there yet? While our support personnel are working on your event, you can see up-to-the-minute information on the current status of your event and what progress has been made by viewing the "Personal Support" folder on your ASP Portal home page. You can even add a comment to report additional information that may be helpful to reach resolution.

Who, What, Where, When, Why? It is imperative, in fact, that we have every piece of information necessary to resolve a support event, and our support staff relies on you to provide all the information that you can so we can serve you effectively. Events that must be left open because a client has not provided critical data needed are just as frustrating to us as they are to clients. Please help us help you!

Hand me the remote... Another way that you, the client, facilitate our customer service to you is through the remote access to your Xpeditor system that you have enabled for our support representatives. As noted in the EDI Policy Paper titled *Remote Support*, "The connection providing access to the client desktop must be secured such that it satisfies the requirements of HIPAA as well as the organizational information technology policies of the client and Quadax. Speed, functionality, and ease of use are also important considerations." The preferred methodology for enabling the remote desktop connection is GoToMyPC® which provides fast, secure access for optimal issue identification and resolution. (Please request and review *Policies in Practice: Remote Support* for further information.) When connect-

"I am writing to express my appreciation for your timely response to my situation. You not only helped me resolve that problem but you took time to answer my questions and instruct me, patiently I might add, in how to use the Xpeditor program. It is comforting to know that help is available from Quadax and that such courteous people are there to assist when these problems occur. Usually in these situations tension is high and it's easy to get frustrated. But your calm manner and knowledge made the problem much easier to fix."

(actual e-mail from an Ohio client, July 2007)

ing to your Xpeditor system, Quadax reps use the Quadax Connection Manager (QCM) to log the reason for access; the user name, date, time of entry and time of departure are also logged and reported on the Quadax Connection History report on the ASP Portal for complete accountability.

Eureka! When resolution has been reached, a member of our support team will contact the person who logged the event. We'll file the event as closed when you're satisfied with the solution. In the event we cannot reach the person who logged the event, we'll follow the 3-2-3 rule before closing an event: we'll attempt to contact 3 people in your organization, by 2 different means, 3 times.

"If the only tool you have is a hammer, you tend to see every problem as a nail." —Abraham Maslow

Because we know that every problem is *not* the same, we've equipped our support reps with an array of tools to get to the bottom of nearly any type of problem you may be experiencing in the most effective way. In the interest of transparency to clients and empowering them to reach peak efficiency, we make many of those same tools available to our customers, as well. Just a few examples are:

Xpeditor User Guide—while the printed copies you receive during training will go out of date with subsequent software releases, an electronic copy of the latest version of the User Guide is always available on your home page of the Portal.

Transmission Results System—use this intuitive, interactive tool to view the results of every file transmitted from our clearinghouse to every payer, for every single day. Drill down to see details about the file and each action associated with the transmission. If problems were encountered during transmission, the details page will note every step taken by our transmission auditors to correct the problem.

Service bulletins and alerts are e-mailed to affected clients, and are also posted on the Portal.

Xpeditor Errors Report—this helpful resource identifies every error that could be raised on your claims in Xpeditor, and links to the documentation supporting the edit that raised the error in the Quadax Knowledge Base. You can search the entire Errors Report by clicking on the link from your Portal home page, or you can go directly to the Knowledge Base from a specific error within Xpeditor.

Additional Fees

Quadax offers the broadest support available for the lowest cost—in most cases, at no additional charge. However, some special services do carry associated fees. You should check the terms of your Service Agreement and talk wit Quadax Sales Executive or Regional Account Manager potential fees associated with these and other custo services:

- History Load (from prior EDI vendor product)
- Custom remit posting records
- "Comment" and similar custom records for HIS/PMS
- ANSI 837 "wrap"
- Custom report programming
- Training outside normal parameters
- Consulting services
- Stand-alone eligibility system
- Custom system integrations
- Custom edits and incoming claim data conversions the Implementation period window
- Other custom programming

"Assumptions are the termites of relationsl —Henry Winkler

When it comes to our business, we like to speak of th ***tionship*** between Quadax and our clients, and that's word we use lightly. Like any good relationship, the Qu client partnership requires communication and comm to thrive.

It's true—assumptions can be dangerous; open comm tion is the first key to the strength of our relationship wit our client. We have developed several channels to ke lines of communication open; please take advantage o these, as well as every opportunity to give us feedback

- Regular visits &/or conference calls with Service staff
- Client Access & Notification System (CANS)-generated alerts to notify you of important news and potential iss
- News items posted on the ASP Portal
- Connections, the monthly newsletter with highlights of Edit Group and Insurance Committee meetings
- EDI Policy papers, published on the ASP Portal
- Codetable Update Reports & Release notes
- Quarterly Software Release webinars
- Regional User Group Meetings & the annual Xpeditor prise User Conference
- Satisfaction surveys
- Quarterly Quadax newsletter, published on our web sit
- Discussion Forums on the Portal

Finally, any relationship requires commitment. We've our commitment to you in our corporate mission state ***The mission of Quadax Incorporated is to improv financial performance of organizations in the healt industry by creating efficiencies in their revenue with innovative strategies, products, and services on superior technologies, delivering relational s with integrity and dedication.***

And we stand behind that commitment in everything we

QUADAX
INCORPORATED
www.quadax.com

AUTOMATED SYSTEM UPDATES

PRINCIPLE

Xpeditor is a dynamic, complex system designed to meet the needs of a dynamic, complex industry. In order to accommodate the variety of regulations and coverage rules, as well as evolving medical and billing practices encountered in the delivery of healthcare in the United States today, it is vital that the Xpeditor system installed on the client network be constantly updated.

When designing a methodology for keeping Xpeditor current, two options were available: one reliant on human intervention, the other on automated processes. Unfortunately, update routines that depend on an individual often suffer delay or omission based on that person's availability. By instead relying on an automated process, updates are applied on schedule at all client sites, and the update may occur unattended, after hours, so that normal daily operations are not impaired.

An additional advantage associated with automated updates is the elimination of CD-ROM or other media delivery as well as instruction regarding the actions necessary to complete the update. A disadvantage associated with any automated process is that occasional system anomalies will prevent that process from concluding properly. When this occurs during an Xpeditor automatic update, the system remains unavailable until corrective action can be taken. Despite this risk, Quadax strongly believes that the benefits, including speed, regularity, and the high degree of complexity accommodated by the automated process outweigh the potential negative outcomes.

PROCESS

The first critical step in the process of automatic updates is the proper setup of the 'Scheduled Task' on the Director PC (the machine which controls the separate functions involved in an Xpeditor installation). The settings within the Scheduled Task are dependent upon the login used, the password(s) involved, the connectivity of the PC to the network, its accessibility to the SQL databases, and the properties of the Date/Time function on the machine. A discrepancy in any of these particular items will prevent the Update Module from functioning as expected.

There are 12 Tasks that the Update Module undertakes, some of which can involve multiple iterations:

Task 1: Gain Exclusive Access

- This step assures that no users are still attached to the Xpeditor database so that files are not locked or actions are skipped due to sharing violations. Any users logged into Xpeditor when the update module initiates will be notified by means of a pop-up window that they have 2 minutes (120 seconds) to exit the application before the session is automatically terminated.

Task 2: Applying User Edits

- This step overwrites a file named ClientDLL.DLL with a newly retrieved file that contains client-requested custom converts or edits coded by Quadax personnel. This mechanism is the means by which clients can realize the effect of a custom request being implemented in a 24-48 hour timeframe.

Task 3: Deleting Backup Logs

- Xpeditor creates a record of various actions into "log files" as different processes run throughout the day. The update module routinely removes older logs to conserve hard drive space.

Task 4: Resetting Locked Claims

- When a user opens a claim, the Current Status of the claim is set to a value of "L: Locked by" so that only one person at a time can be accessing the claim. Occasionally, a user can abruptly exit the application while inside a claim, and when this occurs, the claim remains in the L status. Update module will analyze any claims that remain in this status, while exclusive access is set, and will restore these particular claims to a value of W: Client Workflow, such that they are not hidden from views or inaccessible to another biller.

Task 5: Applying SQL Updates

- Quadax occasionally generates scripts which are then used to update data within databases, allowing records to be added or changed. This is most useful for setting up default database records for programs.

Task 6: Applying EditCodes.UPG

- This step involves multiple tables, including by not limited to CPT, HCPC, and Diagnosis Codes; Provider Numbers, Edits, CCIs, modifiers, and zip codes. There are 48 tables in total, some of which can be updated daily, others occur on a weekly basis. This is the most time-consuming step in the process, and the one with the highest failure rate, primarily due to the items listed in the *barriers* section at the end of this paper.

Task 7: Applying Other Updates

- This step applies updates to files with extensions of EXE, DLL, INI, RPT, and/or PDF which are located within the QAServ folder and are used in conjunction with the Xpeditor application.

Task 8: Removing Exclusive Access

- This step removes the "lock" that prohibits a user from opening the application. Although the update module is still completing, users are able to open, modify, edit, and save claim data without disrupting the process. It is the failure of this Task which generally alerts users to a problem with the automatic update. When Tasks 2 through 7 fail to complete logically, Exclusive Access is not removed, keeping users locked out of Xpeditor until or unless corrective action can be initiated.

Task 9: Applying Alter SQL Statements

- The use of SQL in the database design allows for fields to be increased or decreased and added or deleted in a dynamic way. This step enables these changes to be accomplished without having to "wipe and rebuild" entire database structures.

Task 10: Remit Maintenance

- The step performs a purge of remittance files through the user-defined remittance settings found under the remittance screen menu.

Task 11: Copying Files to Proper Folder

- Similar to Task 7, this step copies any new or undefined file extensions that are included in an update.

Task 12: Clean Up Directories

- This step deletes files older than:

30 days in the FixPrograms, PatchedFiles, and Ufile folders
90 days in the LOGS and BACKUP folder
180 days in the RESPONSEFILES folder
365 days in the PRTFILES folder

Barriers to successful conclusion

The Update process, including all of the above-listed tasks, is generally scheduled to perform Sunday through Thursday nights. Automated updates are not applied on Friday or Saturday nights, since Quadax Support is unavailable on weekends and therefore a process error resulting in failure to release exclusive access would remain unresolved until Monday morning.

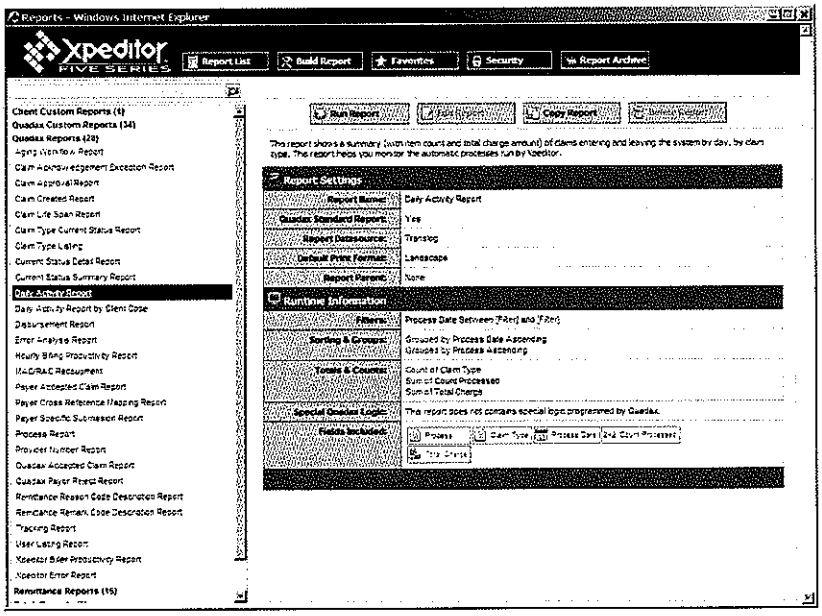
There are a number of factors that can cause the Update Module to fail; among them:

- Network connection loss
- Exclusive tasks running on the Director or SQL Server machine(s)
- Power loss
- Windows™ locking a file
- SQL timeout
- SQL Deadlock

Because of these, and other items that can impact the update process, it is vital that the client's IS/IT and Network Administrator be actively engaged in the setup and control of this particular application, the correct operation of which is so critical to successful healthcare transaction processing through Xpeditor.

CHAPTER 5: REPORTING

Xpeditor's reporting capabilities allow you to manage your business processes, not just transmit claims. Both standard and custom reports provide a thorough historical record and archive of claims processed, offering accountability in all aspects of claim reporting. To access the Xpeditor Reports window, click the Menu icon on the Transaction Manager Toolbar, and select "Report Menu":



The left side of the Reports window lists all the available reports categorized by report type. Report categories can be collapsed (to show only the heading) or expanded (to list all reports beneath the heading). To expand a collapsed category, click anywhere on the bold face heading. You may filter/search for reports by entering a report name or partial name into the textbox above the reports list and either click the search button ( ) or press the the ENTER key.

The right portion of the window is the report description pane, which provides detailed information about the selected report, including a brief summary of the report.

Denial Management Reports are available only if the Denial Managment Xtension product has been purchased.

Quadax Custom Reports include reports that have been specially coded for your organization, and are the result of a custom programming request.

The Report Window Menu

The top section of the Reports window houses the Reports window menu.The Report window menu allows users to utilize several report-related features. To access a desired feature, click the associated button:

- **Report List**—Click this button to return to the Report window "home" from any of the other Report features and/or display the current list of reports.
- **Build Report**—This feature allows users to build their own reports. For information on how to create an Xpeditor report, refer to the "Building a Report" section of this Chapter.
- **Favorites**—Click this button to access the list of user-defined favorite reports For more information about this feature, refer to the "Client Favorites Reports" section of this Chapter.

- **Security**—This button will access the Reports Security Grid, which allows users to define which reports can be viewed based on individual user security levels. For more information about the security feature, refer to the "Security" section of this Chapter.
- **Report Archive**—Click this button to open the Report Archive, which displays a log of viewed reports. For more information about the Report Archive, refer to the "Report Archive" section of this Chapter.

The Report Toolbar

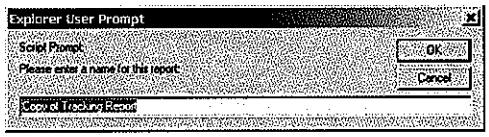
To view and manage individual reports, use the Report Toolbar located above the report description pane. The Toolbar allows you to **Run** a report, **Edit** an existing Client Favorite report, **Copy** a report, and **Delete** a report.

Dates entered in the Run Report pane will automatically default to a MM/DD/YYYY format.

Click the **Run Report** button to view the currently selected report. For more information about running a report, refer to the "Running Reports" section of this Chapter.

The **Edit Report** button allows the user to modify the parameters of the selected report. Refer to the "Editing Reports" section of this Chapter for details on how to edit a report.

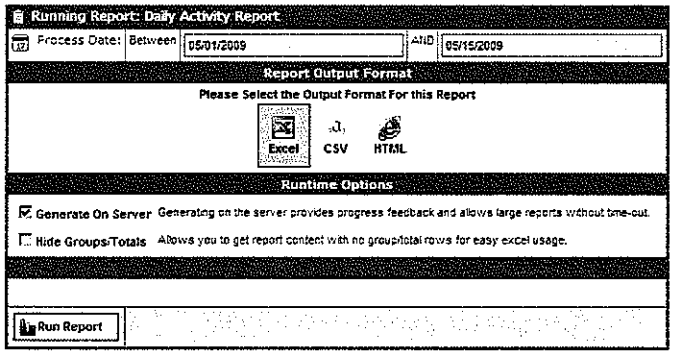
To copy a report, select the report to copy and click the **Copy Report** button. A confirmation message will appear requesting the user type in a new name for the copied report. If a report name is not supplied, the new report name will default to "Copy of" followed by the original report name. For example, if you select the Tracking Report and copy it, the default report name will be "Copy of Tracking Report" . The selected report will be placed under the Client Custom Reports heading.



To delete a Client Favorite, Client Custom, or a Copy of a report, select the report from the Report Menu and click the **Delete Report** button. A confirmation window will appear. Click "OK" to delete the report or "Cancel" to return to the Xpeditor Reports window.

Running Reports

To run a report, click the name of the report you wish to view from the Report Menu, then click the "Run Report" button. The "Run Report" pane will open and prompt the user to enter associated report filter criteria, if applicable. For example, you may be prompted to enter the Process Dates (i.e. From and Through Dates) for a particular report, as in the example on the next page:

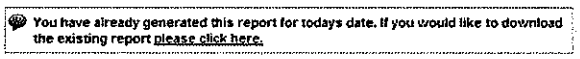


In addition to the report parameters, users have the option to select from three different report output formats:

- **an Excel document**—the most common and user-friendly format (Refer to the Microsoft® Excel Help screen for more information about how to navigate and mange Excel reports.)
- **a CSV (comma delimited) file**—this is a standard datafile that contains no formatting; it is most commonly used for incorporation into databases or for large data dumps.
- **an HTML web page**—allows the report to be viewed immediately within Xpeditor or saved as an .html file to be viewed later in a web browser.

The "Generate on Server" Runtime Option allows large reports to be generated "in the background" while a user continues to use Xpeditor. It prevents reports from "timing out" (i.e. stops the report from being generated) and interrupting an Xpeditor session. Select this option to run reports faster. This option is selected by default.

Once the criteria have been entered, click the "Run Report" button at the bottom of the Run Report pane. If the same report has already been run that day, a warning message will appear instructing the user to download the report from the Report Archive:



Once the report has been compiled, click the "Download Report" link to view the report.

A File Download window will open, prompting the user to choose to either view the report or save the report to the local workstation for viewing later. Click the "Open" button to view the report in the selected format, or the "Save" button to save the report.

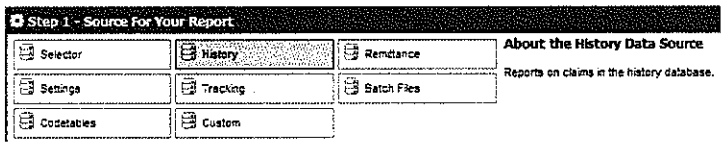
Building Reports

One of the most powerful features of the Xpeditor Reports window, is the ability to create custom reports. This gives users the ability to create a virtually unlimited variety of reports to document, review, and manage Xpeditor claims.

Click the Build icon to open the Build Custom Report window. Similar to creating Global Scripts, there are seven steps involved in creating a custom Xpeditor report.

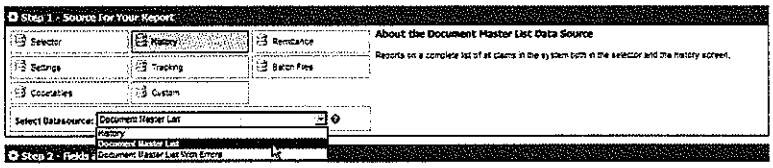
STEP 1

The first step in building a report is to select the Database from which the data will be pulled. Click the radio button associated with the desired database to make your selection. There are eight databases from which to choose:



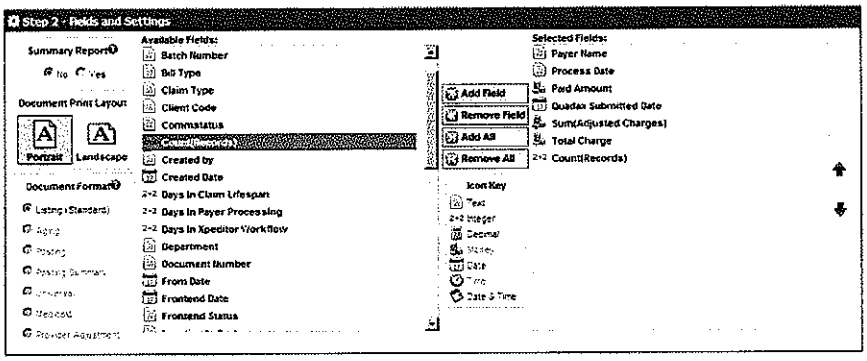
1. **Selector (Transaction Manager)** —This database allow reports to be run on those claims currently in the selector. Examples of reports that run off Trans are 'Error Analysis' and 'Current Status Summary'.
2. **History**—Allows reports to be run based on certain claim information pulled from the History databases.
3. **Remittance**—Permits users to create reports based on data pull from the remittance database.
4. **Settings**—Lists each Claim Type to which a particular payer name has been mapped, as well as the payer names to which Xpeditor will default.
5. **Tracking**—Permits reports to be run based on the Tracking messages of claims. Claims will be pulled from both the Transaction Manager and History databases. Batch reports run off Tracking.
6. **Batch Files**—Allows reports to be based on a batch log from a specific week, starting from the date of the previous Sunday.
7. **Codetables**—Allows reports to be based on select Quadax codetables (e.g. the Errors codetable database) selected from the drop-down menu. Provides a snapshot of the age of claims pulled from the active Transaction Manager database.
8. **Custom**—This option lets the user pull specified information from the Transaction Manager database. For example, selecting Error Analysis with Details Data Source Reports on errors currently in the active Selector with access to detail line information.

After the database source has been selected, choose the desired datasource associated with that database from the "Select Datasource" drop-down menu. This feature allows users to select the type of information to be pulled from the slected database. Each database has its own unique set of datasource options from which to choose. A brief summary of each option will appear to the right of the database icons when selected.



STEP 2

This step allows you to select the field(s) that will be displayed on the finished report. The list of fields from which to choose changes and depends upon the database selected in Step 1. To choose a field to be included in the report, highlight (click) the desired field from the list of Available Field names on the left and click the "Add Field" button. The field will move to the list on the right side under "Selected Fields". To remove a selected field, highlight the desired field from the Selected Field list on the right and click the "Remove Field" button. Click the "Add All" button to select and move all Available Fields into the Selected Fields box. Click the "Remove All" button to remove all the Selected Fields.

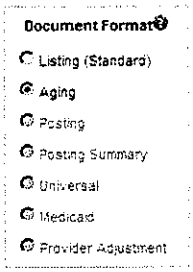


The order of the Selected Fields (i.e. how the fields will be displayed in the report) can be changed as well. Highlight (click) the desired Available Field and click either the up or down arrow immediately to the right of the Selected Fields box to move the field accordingly.

The "Summary Report" option allows users to create an abridged version of the report, displaying groupings and summary data (e.g. sub-totals) only. Detail information is still present on the report, they are simply hidden from view. To show the hidden detail lines, change the row height to "9" in Step 6 of the Report Builder window.

Users can also determine the layout of the report being created: either Portrait (the "standard" view) or Landscape (the "wide" view). Click the desired icon to make your selection.

The Document Format list allows users to select additional report style formats for the chosen report source, if available. Only one format style can be selected per report, and only active formats (i.e. formats that or not grayed out) can be chosen. In this case, the report can be created in either the Listing or Aging format because the Active Claims (Selector) datasource was chosen:



STEP 3

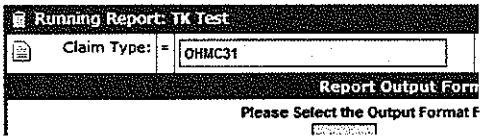
The report filter parameters are determined in this step. Filter parameters can be defined and implemented automatically by the user building the report, or by a user that will be running the report at a later time.

Three separate Filter criteria are permitted. Click the desired filter checkbox under the "Use" Column to activate that particular filter. From the first drop-down menu, select the field on which the report will filter. The choices available in this drop-down menu are based on the fields listed in the Selected Fields box in Step 2.

Next, choose the desired operator from the drop-down menu: equal to (=), greater than (>), less than (<), greater than or equal to (>=), less than or equal to (<=), Not Equal, Like, Not Like, Between, In List and Not In List. Click the textbox to the right of the operator and type in the desired value. If you choose the "between" operator, an additional textbox will appear so the beginning and ending range values can be entered.

Click the "Yes" checkbox under the "Prompt" columt to prompt the user to define (i.e. type in) the Filter parameters specified in this step when the report is run, instead of having the parameters automatically defaulted. In this example, a user will be prompted to define the Transaction Type by which the report will be filtered.

In this example, the user chose to filter the report for Ohio Medicare Inapatient claims (OHMC31 Claim Type).

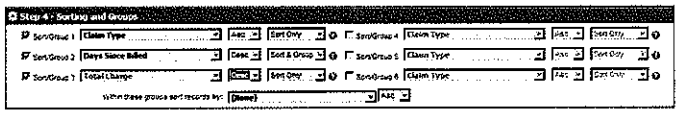


STEP 4

This step determines how report data will be grouped or sorted; for example, by Client Code or Claim Type. You can break down and display information in up to six different groupings, in sequential order. Similar to selecting the criteria for Step 3, first click the desired checkbox to active that particular group. From the drop-down menu, select the field that determines how the information will be grouped. The choices available in this drop-down menu are based on the Selected Field(s) chosen in Step 2.

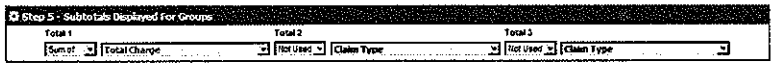
After selecting the grouping field(s), select "Asc" or "Desc" from the drop-down menu to determine if the information in that particular group will be sorted in ascending or descending order, respectively. You may further refine a Sort/Group based on the manner it is presented. From the drop-down menu, select either "Sort Only" to change the order in which records appear in the report, or "Sort & Group" to both change the order in which records appear and group the records together with the associated counts/totals.

Select a field from the "Within these groups sort records by" drop-down menu to define how the information *within each Group* will be organized. For example, if claim information is grouped by Transaction Type (UB, HCFA, and 6780), select "Claim Type" (if available) from the drop-down menu to sort each group in the report by Claim Type. Users also have the option to sort this option in asending or descending order.



Step 5

If desired, you may choose to provide the subtotal for a particular field for each group. The first drop-down menu gives you the option of reporting a Sum of (all records in a Group will be added up) or Count of (the number of records in a selected field) the field selected in the second drop-down menu. For example, you may want to provide a subtotal of the number of claims with an OHMD Claim Type (Count), or the subtotal of the dollar value for all UB claims (Sum). Next, select the field that will be subtotaled. Again, the choices available in this drop-down menu are based on the field(s) chosen in Step 2.

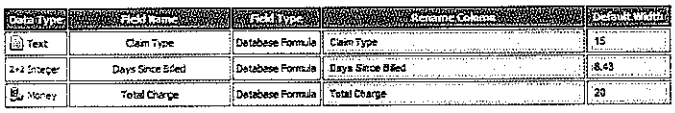


Step 6

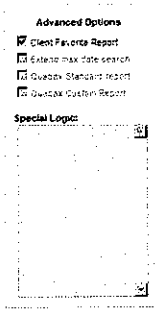
In this step, users determine any advanced reporting options that will be applied to the report. The right side contains a grid that displays information about each field selected in Step 2, including the type of data found in that field, the current name of the field, and the type of field. For example, if the data in a column is Money, the information in that column will be displayed in a dollar format (e.g. 515.76).The grid also permits users to format the headings and columns that will be displayed in the Excel report. Immediately after the Field Type column is the "Rename Column" field that allows the user to rename the column header. Simply click on the text box and type in the new column heading.

Data Type	Field Name	Field Type	Rename Column	Default Width
2+2 Integer	Days Since Billed	Database Formula	Days Elapsed	8.43

The "Default Width" field displays the current width of that particular field in the Excel report. Users may define the width of of a column by clicking on the text box and entering a new value. Excel documents use a pixel ratio of 1 to 12 to define column width. So a column formatted to be 20 units in Advanced Options, would equal a column 240 pixels wide in the report (12 x 20 = 240). The larger the Default Width number, the wider the report column. The default width of a column in Excel is 8.43. In this example, the Claim Type and Total Charge columns have been widened:



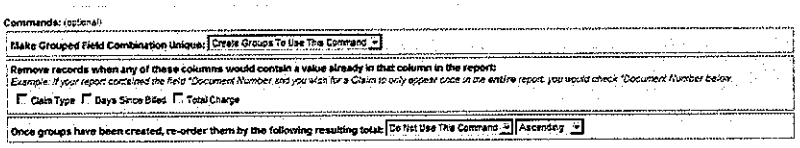
Data Type	Field Name	Field Type	Rename Column	Default Width
Text	Claim Type	Database Formula	Claim Type	15
2+2 Integer	Days Since Billed	Database Formula	Days Since Billed	8.43
Money	Total Charge	Database Formula	Total Charge	20



The left side allows users to set advanced reporting options. If you wish to add the report being created to the Favorites list, click the "Client Report Favorite" check box.

The remaining three Advanced Options along with unique report coding logic documented in the Special Logic text box is used primarily for information purposes only by Quadax select users with Security Level 9 access only.

The Commands feature below the Advanced Options settings allows users to define additional high-level report functions. To access the Commnds options, click the "Show" link.

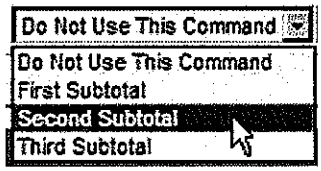


The Commands feature allows even greater control over report data, allowing for the elimination of repetative or unnecessary information. It can be used as a type of summary report, similar to the detail lines "roll up" feature, to display the first occurrence of selected field(s) only once in a report. For example, you could report a particular Payer Code only once per Client Code even if that Payer Code occurs multiple times in the report.

Currently, there is only one choice in the first Command option ("Create Groups To Use This Command"), so no action is required. The second option allows the user to select the fields that will be affected. The choices available will be the same as the fields selected in Step 2 of the report creation process. Click the associated check

box to select a field for inclusion. For example, if the report contained the "Document Number" field and you want a claim to appear only once in the *entire* report, you would click the "Document Number" check box for inclusion.

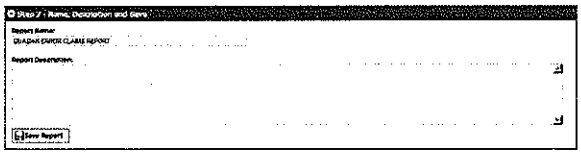
The last option permits a user to re-order information within a given group by the subtotal selected and establish the final level of grouping once the groups have been created. The three options available are: First, Second, and Third subtotals. By default, this Command option is not used (i.e. turned off). You can further refine the subtotal selected by sorting the group in ascending or descending order.



Step 7

The final step in building a report involves assigning a name/title to the report. To create a report name/title, click in the "Report Name" textbox, and type in the name. You may click on the "Description" textbox and type in additional information (e.g. notes, tips) about the report.

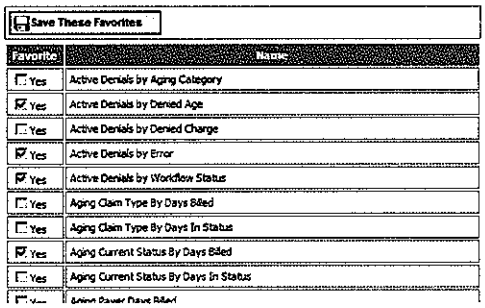
When all the report parameters have been established, click "Save Report" to save the report and add it to the Client Custom Reports section of the Report Menu.



Client Favorites Reports

The Report window menu features a "Favorites" tool that comes in handy for frequently-run reports that can be accessed quickly and easily. To access the "Favorites" tool, click the "Favorites" button located on the Report window menu.

The "Manage Favorite Reports" list will open, displaying all the Client Custom reports. Click the checkbox next to the report(s) you wish to add to the Client Favorites list. Choosing to add a report to this section copies the report, rather than moving it, so you may delete the Client Favorites version without losing the original version. Click the "Save These Favorites" button to save the slected reports.



Editing Reports

Users have the option to edit both Client Custom and Quadax standard reports. To edit a Client Custom report, simply click the "Edit" button. To edit a report other than a client custom report, you must first copy an existing report. First, select (click on) the desired report from the Report List, then click the "Copy Report" icon on the Report Toolbar. You will be prompted to name the new report and save it. Copied reports are automatically saved to the Client Custom Reports section of the Report List.

Next, select the copied report from the Report List and click the "Edit Report" button. The Report Builder window will open with the associated parameters for the selected report. You may then add, delete, and/or modify report criteria, as noted in the "Building Reports" section of this chapter. When all report parameters have been established, click "Save Report".

Standard Reports

Xpeditor comes with pre-defined, "standard" reports. These reports provide important information about your claims and can aid greatly in your claims management process. The parameters for each of standard report can be viewed and modified, allowing them to serve as the basis for a custom report. However, *Quadax Reports cannot be permanently modified or deleted.* Following is the list of standard reports:

The accuracy of report data may be compromise if a date range is not specified.

Quadax Reports

Biller Productivity Report—Gives you a snapshot of the work handled by each of your users, as well as by the Batch Processor, for the selected date or date range.

- The "Volume" column will record the number of claims worked for each claim type, for each user. A claim is counted once when it has been worked—a change is made and that change is saved. If the same claim is changed and saved multiple times by the same user within the date (or date range) selected, only one instance will be recorded.
- If the same claim is worked multiple times within the selected date or date range by multiple users, each user will be credited for having worked the claim (once).
- A subtotal of claim volume and total dollars will appear in bold for each user.

Claim Acknowledgement Exception Report—This is perhaps the most important report in this section; the Claim Acknowledgement Exception Report should be run every day to verify the transmission of your claims to the clearinghouse.

- The Claim Acknowledgement Exception Report looks for tracking records confirming acknowledgement of claim receipt by the Quadax clearinghouse, and reports on exceptions—those claims lacking an acknowledgement.
- The Report Parameters window allows you to select a date range: earliest date to view through most recent date to view. The dates Xpeditor uses to examine data for this report are the dates claims were released from your database.

NOTE: Since this report lists exceptions, the best report is an empty report. Should you find claims on your Claim Acknowledgement Report, phone the EDI Client Support Center for assistance.

Claim Approval Report—Lists all claims whose history records an acknowledgement from the Quadax clearinghouse.

- This report pulls from the history database, based on the tracking action "Quadax Approved."
- The report sorts by transaction type (HCFA or UB) and then by claim type, with subtotals of the number of claims and the total charges.
- The Parameters window will ask you to specify "Earliest date to view" and "Most recent date to view."

Claim Created Report—These reports generate a list of all claims for the selected time period that document a particular action.

- All reports pull data from the Tracking database.
- These reports sort primarily by document number.
- Claim information includes the action performed along with the date(s) a claim was printed. The reports also provide details about the action carried out on a claim.

Claim Life Span Report—Documents the number of days that comprise a claim's life cycle.

- Identifies total number of claims and differentiates between days spent in Xpeditor versus Payer Processing as well as Total Days.
- Organizes claims by Client Code and Claim Type.

Claim Type Current Status—This report lists all of the claims presently in the active database, categorized by status (Released, Miscellaneous, Workflow, etc.), with subtotals, dollar amounts and a grand total. Use this report to get a snapshot of the work to be done—or the work that has been accomplished.

- Both UB and HCFA claims will be included on this report, regardless of the View currently displayed when the report is generated.
- The report lists each Workflow status currently associated with any claims in the active database. If a Workflow status set up for your organization does not currently have any claims assigned to it, that Status will not be listed on the report.
- There are no parameters available by which to narrow the selection.

Claim Type Listing—Gives a list of all the claim types that are currently available within Xpeditor.

- The transaction type differentiates between HCFA, and UB. Within each Transaction type, the claim types appear in alphabetical order by Description.
- The column labeled "Claim Type" gives the Xpeditor claim type for each description; this is the claim type designation you will see on the Daily Activity Report and the Current Status Detail Report.
- The column labeled "QUICK_CLAIM_TYPE" refers to the way the claim type was identified within our legacy products, and is, therefore, helpful to those clients who have upgraded from a previous Quadax EDI package to Xpeditor.
- The "Payor Code" is necessary for claims going through the WebMD portal. Claims not going through the WebMD portal do not need to be labeled with that code, though there may be a code listed on this report.
- There are no options for narrowing the report or changing its sort order.
- To see a list of payer names and the claim types to which they've been mapped specific to your organization, generate the "Payer Name Cross Reference Mapping Report".

Current Status Detail Report—This report lists all of the claims presently in the active database, categorized by status (Released, Miscellaneous, Workflow, etc.),

with subtotals and grand total. Use this report to get a snapshot of the work to be done—or the work that has been accomplished.

- Both UB and HCFA claims will be included on this report, regardless of the View currently displayed when the report is generated.
- The report lists each Workflow status currently associated with any claims in the active database. If a Workflow status set up for your organization does not currently have any claims assigned to it, that Status will not be listed on the report.
- There are no parameters available by which to narrow the selection.

Current Status Summary Report—This report provides an overview of how many claims in the Selector are assigned each status code, and the dollar amounts those represent, without detail of individual claims.

- This report pulls from the entire active database—all claims contained within all views.
- HCFA and UB claims are listed separately, each with a subtotal for the number of claims and the dollars represented by the total charges on those claims.
- The report lists each Workflow status currently associated with any claims in the active database. If a Workflow status set up for your organization does not currently have any claims assigned to it, that status will not be listed on the report.

Daily Activity Report—Shows a summary of claims (with item count and total charge amount) entering and leaving the system by day and by claim type. This report helps you monitor the automatic processes run by Xpeditor.

- Claims shown as entering the system are those added by Print File or those manually pulled from History.
- Within each category, for each date selected, claims are categorized by claim type.
- "Transactions Sent to Quadax" are counted after Communicator has run, distributing the claims according to their Workflow status ("Release to Quadax" or "Delete/Archive").
- The Report Parameters window will ask you to select a processing date range, starting with the earliest date to view through most recent date to view.

Daily Activity Report by Client Code—This report displays the same information as the Daily Activity Report broken down by specific Quadax Client Code(s).

Disbursement Report—Lists documents bound for each payer, grouped by the way they entered the database.

- The report pulls data from both the active and history databases.
- The report sorts by claim type, and counts the number of claims added by Print File, Duplicate Claim Process, History Claim Retrieval, ASP Pass, and all other methods by which claims have been added, including direct entry.
- Subtotals will reflect the count of documents bound for each payer, by method of entry and date added.
- The Parameters window will ask you to specify a single date for which to gather data. This is the date that the claims entered the system.

Error Analysis Report—Use this report to gain an understanding of what errors are routinely being found on your claims. With that information, you may find ways to avoid many of those same errors in the future by, for example, resolving a mapping issue related to your billing system claim file, or addressing a training issue.

- These reports pull from the entire active database—all claims contained within all views.

- Each report sorts by Error Message. For each error, the Detail report lists each claim that contains that error and the dollar amount represented by the total charge for that claim.
- The Drill-down report offers a summary for each error message, but you may drill into that line item to see the detail, if you wish. To drill down, move your cursor over an error description; the cursor will become a magnifying glass. Double-click to open the complete list of instances of that error. To return to the summary list, use the red "X" at the left corner of the report viewer toolbar at the top of your window.
- From either Error Analysis report, you may copy a Document Number, and then return to your Selector screen to paste that number into the Document Number Filter box. Click "Refresh" to locate the actual claim so that you may investigate further.
- It is important to remember, for both the Detail and the Drill-down reports, that if a claim contains several errors, the total charge for that claim will appear in each error category—thus apparently inflating the dollars represented as a grand total.

Hourly Billing Productivity—Provides a snapshot of the work handled by each user (biller), as well as the Batch Processor, for the selected date or date range.

- The "Count" column records the number of claims worked for each claim type, for each user. A claim is counted once when it has been worked—a change is made and that change is saved. If the same claim is changed and saved multiple times by the same user within the date (or date range) selected, only one instance will be recorded.
- If the same claim is worked multiple times within the selected date or date range by multiple users, each user will be credited for having worked the claim (once).
- A subtotal of claim volume and total dollars will appear in bold for each user.

MAC/RAC Recoupment Report—Provides valuable information related to remits and can be used to help assess potential RAC audit targets.

- Identifies all occurrences of Remark codes N102, N432 and N469 as well as all occurrences of RAC-specific Bill Type XXH within the specified date range.
- Provides information associated with the following fields: Patient Name, Patient Account Number, Check Date, Check Number, Provider Number, Total Charge, Medical Record Number, Admit Date, Discharge Date, Original Reference Number, Document Number, and the detail line to which the Remark code is related.

Payer Accepted Claim Report—Lists all the claims that contain tracking records indicating payer acceptance for a user-specified date range.

- The report sorts by Patient Account Number, differentiating UB from HCFA claims. Each group is then further broken down by specific claim type, such as OHMC61.
- Claim information includes the patient's first and last name and accompanying Xpeditor Document Number.
- The "Payer Date" column indicates the date that the tracking record was added to the claim, which is the date that Communicator was run.

Payer Cross Reference Mapping—This report displays a cross reference list of each Claim Type within Xpeditor to which you have mapped a particular payer name, specific to your organization, as well as the payer names to which Xpeditor will default.

- The "INFO" column displays the Emdeon Payer ID to which the associated payer name is linked.

- The "EDIT_IND" column indicates which additional edits, if any, will be applied to the associated payer name.
- The report also displays the user that matched the payer name.

Payer Reject Report—This report lists all the claims rejected by a payer during a user-specified date range

- The report sorts primarily by claim type, such as OHMC61. If applicable (as in the case of NACOxx), the group is then further broken down by payer.
- Claim information includes the patient account number, the patient's first and last name, the "from date," the number of claims, and the total charge for each claim.

Payer Specific Submission Report—This report lists all the claims submitted to a particular payer by day within a given date range, with the associated Total Charge dollar amount for each claim.

- Claim submissions are broken down by Quadax Client Code, then by Transactin Type (UB or HCFA).
- The "UPLOAD TIME" column indicates the date the claim was uploaded to the payer(s).
- The report Date Range (i.e. Upload Time) is limited to a maximum of 31 days.

Process Report—Documents the batch processes completed, by date and time.

- Each Communicator session will be detailed, with start and end time and status, e.g. "Worked" or "Crashed."
- For each print file, the file name and number of claims is given.
- "Ignored" claims are those for which the patient name and patient account number are blank, or those with X's for the 10 left-most characters of the Patient Account Number.

Provider Number Report—Lists all the provider numbers in your Xpeditor database for which Xpeditor will edit during claim processing.

- The "GROUP_CODE" column indicates if the associated Provider Number is flagged as a Group (G) or Individual (I) in the Quadax Provider Registration database.
- The column labeled "QUICK_CLAIM_TYPE" refers to the way the claim type was identified within our legacy products, and is, therefore, helpful to those clients who have upgraded from a previous Quadax EDI package to Xpeditor.

Quadax Accepted Claims Report—Lists all the claims containing a tracking record indicating acceptance by the Quadax clearinghouse for a user-specified date range.

- The report sorts by Patient Account Number, differentiating between UB and HCFA claims.
- Claim information includes the patient's first and last name, the payer name, and the total charge of the claim.
- The report also provides the date and time that the tracking record was added to the claim—this is the date that Communicator was run.

Remittance Reason Code Description—This report lists all ANSI Remittance Reasn Codes along with a brief explanation of each code.

Remittance Remark Code Description—This report lists all ANSI Remittance Remark Codes along with a brief explanation of each code.

Tracking Report—Will generate a list of all claims for the selected time period that document a particular tracking action. For instance, you may use this report to list all claims that have been printed.

- This report pulls from the history database, based on the tracking action specified.
- The report sorts by transaction type (HCFA or UB), and then by claim type, with subtotals of the number of claims and the total charges.
- A number of standard reports follow this model; for example, "Claim Created Report" and "Claim Printed Report."
- You must specify either a Tracking Action or a Tracking Description. See the chart on the next page for examples.

Tracking Actions and Descriptions ***(Note**: This may not be an exhaustive list.)*

Action	Description
Claim Created	Filter created claim from print file [filename] Starting line... [user name] entered this claim Created from Quadax Reject Claim Doc Num: xxxxxxxxxx [user name] retrieved this claim from history [user name] spawned this claim from Doc Num: xxxxxxxxxx [user name] duplicated this claim from Doc Num: xxxxxxxxxx ASP BATCH created an ASP. Doc Num xxxxxxxxxx
Claim Viewed	[user name] viewed this claim
Claim Edited	Batch process edited this claim Global change edited this claim
Saved Claim	[user name] saved this claim Current status switched to [status info]
Claim Released	Claim released and sent to Quadax
Claim Archived	Released claim archived into History
Quadax Approved	The claim has been accepted.
Quadax Reject	Claim rejected. New Doc Num xxxxxxxxxx
Payer Approved	The claim has been accepted.
Claim Printed	[user name] printed a UB92 claim form [user name] printed a HCFA1500 claim form
Secondary Claim Created	[user name] duplicated this claim. New Doc Num: xxxxxxxxxx [user name] spawned a new claim. Doc Num: xxxxxxxxxx
Remit Matched	Remittance Data Matched to this claim. Doc Num xxxxxxxxxx
Status Changed	[user name] changed the status of the claim to [status info]

User Listing—Lists all the active Xpeditor users registered for your facility.

- Details include user First and Last Name, Logon ID, and Security level.

Xpeditor Error Report—This report lists each of the errors that Xpeditor may raise on claims during the claim editing process. Errors are identified by Transaction Type (UB or HCFA), Error Code, Description, and the associated field to which the error is applied.

Remittance Reports

ASP Log Report—Lists all the Automatic Secondary Processing (ASP) claims created during a user-specified date range.

- Information includes the action performed along with the date an ASP claim was created. It also provides details about the action carried out on an ASP claim.

04 Denied Claim Status Report—This report shows detail level charge for each denied claim in the selected remittance file.

- This report is formatted in a similar fashion to the Medicaid paper remit.

Cashier Summary Report—This report displays summary information grouped by Provider Number, Check Number, and Bill Type for the selected remittance file.

Crossover Report—Lists all claims in the selected remittance file that have been electronically "crossed over" and is sorted by the Secondary Payer Name.

Denied Claims Report—Identifies claims in the selected remittance file that contain denials by a payer.

File Summary Report—This report provides a concise overview of claim information in a selected remittance file.

- Report information includes Provider Name, Provider Number, Check Date and Check Number.

Indicrect Medical Educ Report—This report displays the Indirect Medical Amount for each claim in the selected remittance file.

- Report information is summarized by Provider Number.

Interest Detail Report—Displays each claim that contains interest in the selected remittance file.

Non-Covered Charges Summary Report—This report shows claim level total charge information, much like the two line Summary EOB, for each claim in the selected remittance file.

- Displays summary information by Provider Number and Bill Type limited to claims with non-covered charges.

Posting Report—Provides detail-level charges for each claim in the selected remittance file as well as summary information by Provider Number and Bill Type.

Posting Summary Report—Displays claim-level total charge information, much like the two-line summary EOB for each claim in the selected remittance file and also displays summary information by Provider Number and Bill Type.

Provider Adjustment Report—This report lists the Provider Level Adjustments taken from the ANSI 835 returned by the payer.

Remit Report Medicaid Format—Shows detail-level charge(s) for each claim in the selected Medicaid remittance file.

- The report is formatted similar to the Medicaid paper remit.

Universal Remittance Report—Shows detail-level data for each claim in the selected remittance file and displays summary information by Check Number and Check Amount.

Zero Balance Report–Shows detail-level charge(s) for each zero-balance claim in the selected remittance file.

- The report is formatted similar to the Medicaid paper remit.

Batch Reports

Custom Conversion Report—Lists all the custom conversions that were applied to claims during a user-specified date range. Use this report to monitor the application of custom converts. To view a complete list of custom converts and edits you've requested, choose "Quadax-Custom Converts" from the list of Payer Reports on the Portal.

- The report sorts by the transaction type, the type of claim and the document number of those claims.
- For each document number, both Quadax standard conversions and User (Custom) conversions are listed.
- To jump to information about a particular document number, use the search function on the Report Viewer toolbar.
- The name identifying the custom convert on this report correlates to the "Logtrack" name appearing on the Quadax Custom Convert/Edit Request Documentation accessed via the Portal.

Error Log Report by Error—Identifies errors found by the Batch Processor, sorted within Client Code by Error Code.

- A list of the errors encountered in the specified date range is itemized by Error Number (Code) and Error Message for each Client Code with four columns of totals in two categories. The two categories of totals are Error Totals and Claim Totals.
- The two columns at the far right represent Claim Totals. First is a count of the number of claims found to contain the error. Next is the total dollar amount of those erred claims.
- The first category of totals reflects the number of times the error was encountered and a dollar total that aggregates the claim totals for each error instance. For example, a particular error may occur 4 times between 2 claims—twice on each claim. If the total charge for each claim is $200, the last two columns will record 2 claims, $400. The Error Totals/Total Charges columns will record 4 errors, $800. Subtotals (by client code) and the Grand Total are sums of the Total Charges for Error Totals.
- The report filter criteria requires you to specify the "Batch File to Use"; this is the date that the Batch Processor ran, performing the claim validation routine and adding claims to the active database.

Filtered Error Report—Similar to the Error Log Report by Error, this report identifies errors found by the Batch Processor filtered by Client Code.

- A list of the errors encountered in the specified date range is itemized by Error Number (Code) and Error Message for each Client Code.
- The column at the far right represents the dollar amount of the detail line associated with the error.
- The report filter criteria requires you to specify the "Batch File to Use"; this is the date that the Batch Processor ran, performing the claim validation routine and adding claims to the active database.

Error Analysis Report by Facility—Similar to the Filtered Error Report, this report identifies errors found by the Batch Processor filtered by Facility.

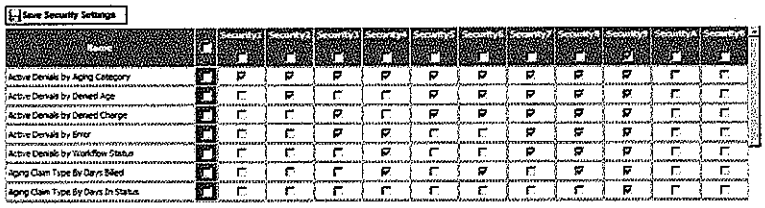
- A list of the errors encountered in the specified date range is itemized by Error Message for each Facility.
- The Total Charge column represents the total dollar amount of the errored claim.
- The report filter criteria requires you to specify the "Batch File to Use"; this is the date that the Batch Processor ran, performing the claim validation routine and adding claims to the active database.

Xpeditor Batch Processor Log Report—Gives an overview of the results of Batch Processing for a selected date range.

- The summary presents a total of claims for each Transaction Type (UB or HCFA), and within those totals, the associated Client Code and Claim Type as well as the number of claims Xpeditor recognized as clean (Released status), the number found to have errors (Workflow status) and the number deleted according to a custom rule, if applicable.
- The report also calculates the Rejection rate for each Claim Type: the percentage of claims that were placed in Workflow status for intervention. The report will show the rate rounded to the nearest whole value.
- The report filter criteria requires you to specify the "Batch File to Use"; this is the date that the Batch Processor ran, performing the claim validation routine and adding claims to the active database.

Report Security

The Report Security feature determines a user's access to Xpeditor Reports based on Xpeditor Security Level. Report Security levels range from 1 to 9 and A to Z (for a total of 35). Every user requires a Report Security level. To access the Report Security window, click the "Security" button on the Report window menu:



Only users with the appropriate Xpeditor security level can modify the Report Security settings.

Settings may be changed to accommodate the special needs of your business office. To make changes to a Report Security Level, simply click the checkbox associated with the desired function. Click the checkbox to activate the associated feature (a check will appear in the box); click it again to de-active it. When all selections have been made, click the "Save Security Settings" button at the top of the security grid. By default, all reports, including recently created/added reports, are available to all security levels.

Report Archive

The last feature on the Report window menu is the Report Archive, which allows users to view a list of previously run Xpeditor reports, including all History and Remit reports. Click the "Report Archive" button to access the list:

Download	User	Date	Report	Type
Download	JOEC	01/13/2010	Batch Processor Error Log Report By Error	.xls
Download	JOEC	01/13/2010	Daily Activity Report	.xls
Download	JOEC	01/13/2010	Error Analysis Report by Facility	.xls
Download	JOEC	01/13/2010	Process Report	.xls
Download	JOEC	01/13/2010	Trending Report	.xls
Download	QDX_ERICJ	01/13/2010	Payer Cross Reference Mapping Report	.xls
Download	QDX_LAURENP	01/13/2010	Process Report	.xls
Download	QDX_THOMK	01/13/2010	Aging Workflow Report	.xls
Download	QDX_THOMK	01/13/2010	Current Status Detail Report	.xls
Download	TOMTEST	01/13/2010	Aging Workflow Report	.xls
Download	TOMTEST	01/13/2010	Claim Type Listing	.xls

The archive also lists the user that created/ran the report, the date the report was originally created/run, and the format of the report. To view a previously crated/run report, simply click the associated blue "Download" link in the left-most column. The report will open in the specified file format.

The top section of the Report Archive is the filter tool, which allows users to search for previously created/run reports quickly and easily. Users may search archived reports based on a variety of filter criteria, including the report name, the report file type (format), the username of the person that originally created/ran the report, and a date or date range the report was orginally created/run. When the search criteria has been entered, click the "Search Archive" button to filter the results.