

Expired Claims

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Introduction to the Expired Claims Connect Report

The **Expired Claims** Connect Report identifies claims that have reached an expired status within a defined workflow. It is used to help billing teams review and manage claims that have stalled, allowing staff to take appropriate action based on category, priority, and financial class filters.

Parameters

When running the Expired Claims Connect Report, users can filter results using the following parameters:

Parameter	Description
Category	Multi-select dropdown that filters claims by their assigned workflow category (e.g., Appeal, Bundled Test, Claim Submission Delayed, Clinic Review, Coding, Collection, Collections Balance, Cross Over, Incorrect Payer, Info Requested from Office, Legal, Open – Electronic LIS, Open – Electronic Superbill, Payment Arrangement, Pending Collection, Predetermination, RCM Coding Review, RCM Review, Ready to Send, Ready to Send Statement, Refund, Rejected, Return Mail, Reversed Payment, Sent).
Priority	Multi-select dropdown that filters claims by priority level. Options are 1 , 2 , and 3 .
Financial Class	Single-select dropdown that filters claims by their financial class (e.g., commercial insurance, Medicare, Medicaid, self-pay).
Provider List	Multi-select dropdown that filters claims by rendering provider.
Location	Multi-select dropdown that filters claims by service location.

Priority Logic

The **Priority** level on each claim is automatically determined based on the relationship between the current date and the claim's **Calculated Follow-up** date, as follows:

Priority	Condition
Priority 3	The current date is <i>before</i> the follow-up date (the follow-up has not yet been reached).
Priority 2	The current date and the follow-up date are fewer than 3 days apart (i.e., within 2 days of each other).
Priority 1	There is <i>no</i> follow-up date set, <i>or</i> the current date is more than 2 days past the follow-up date.

Follow-up Date Calculation Logic

The **Calculated Follow-up** date is calculated based on the claim's current status. The system evaluates the claim status and applies the following rules in order:

Condition (Claim Status)	Follow-up Date Calculation
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Condition (Claim Status)	Follow-up Date Calculation
Claim status is "Sent, x" or is "Cross Over"	Add 30 days after the date the claim was last changed (or the claim date if no change date exists). Example calculation; 01/01/2026 + 30 = 01/31/2026
Claim status is "Ready to Send x" , "In process - x" , or "Closed - Electronic x"	Add 3 days after the date the claim was last changed (or the claim date if no change date exists). Example calculation; 01/01/2026 + 3 = 01/04/2026
Claim status is "Ready to Send x" , "Predetermination" , "In Progress" , "Hold" , "Documentation Needed" or "Appeal"	The follow-up date from the last comment on the claim. If no follow-up date is recorded, the date the last comment was entered is used instead.
All other claim statuses	The date the claim was last changed (or the claim date if no change date exists).

Note: These rules are evaluated in the order listed above. The first matching condition determines the follow-up date.

Report Display Fields

The Expired Claims Connect Report displays the following columns for each claim returned by the selected parameters:

Field	Description
Priority	The priority level assigned to the claim (1, 2, or 3), indicating urgency for follow-up.
Claim Status	The current status of the claim within the billing workflow.
Claim ID	The unique identifier assigned to the claim in OfficeEMR.
Chart	The patient chart number associated with the claim.
DOS	The Date of Service for the claim.
Patient	The name of the patient associated with the claim.
Charges	The total charges billed on the claim.
Balance	The remaining balance owed on the claim.
Claim Level	Indicates whether the claim is at the primary, secondary, or patient responsibility level.
Primary Class	The financial class of the primary payer on the claim.
Primary Payer	The name of the primary insurance payer responsible for the claim.
Secondary Class	The financial class of the secondary payer, if applicable.
Secondary Payer	The name of the secondary insurance payer, if applicable.
Comment Date	The date of the most recent comment or note added to the claim.
Comment Follow-up	The scheduled follow-up date noted in the claim comments.
Comment Text	The text of the most recent comment or note added to the claim.
Changed	The date the claim record was last modified.
Rendering Provider	The rendering provider on the claim.
Service Location	The service location on the claim.