medisoft™

Medisoft Network Professional
Medisoft Advanced
Medisoft

User Manual

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Version 14

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Software registration required

You must register your Medisoft program. Full instructions on how to register are part of the installation instructions you printed out prior to installing the program.

Proof of ownership

KEEP YOUR SERIALIZED SOFTWARE, even if damaged or obsolete. It is your proof of ownership.

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Preface

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Chapter 1

Setting up the Practice

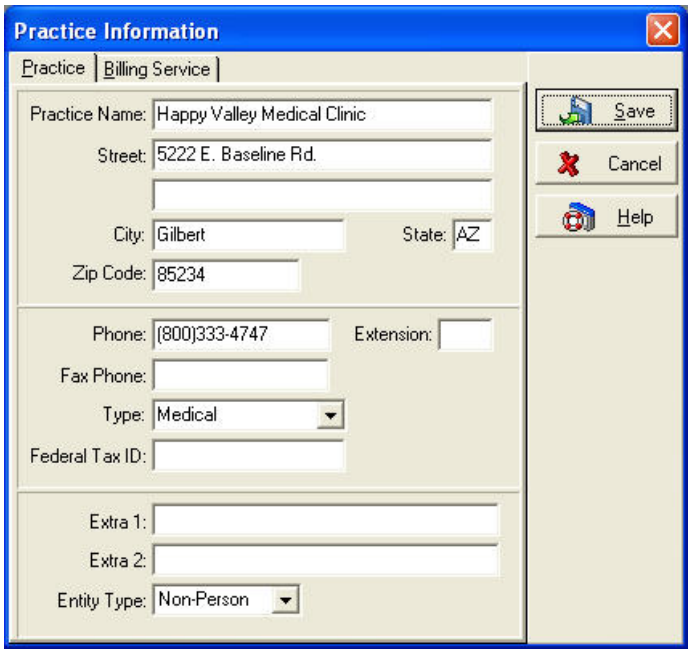
When you first open the Medisoft program after installation, you are required to create a new data set (if this is the first time you have ever installed Medisoft) or convert previous Medisoft or MS-DOS data.

If you have been using Medisoft Version 5.5x or 5.6x and above and have just installed Version 14, a message displays stating that data must be converted before you can access the program. If you have not already performed a backup on your existing data, perform a backup now. Then click **OK** to perform the automatic conversion.

If you work with multiple practices, each will have to be converted.

For more conversion information, see Appendix C, page 157.

If you choose to create a new data set, the **Create a New Set of Data** window is displayed. Fill in the practice name. When you click **Create**, the **Practice Information** window is displayed, at which time you need to enter all the practice information requested.



The information in report headings comes from this **Practice Information** window.

Billing Services

In recent years, with electronic submission becoming more important and the complexity of insurance claims processing increasing, there has been a growing number of billing services. Smaller office or home-based businesses now handle insurance billing for healthcare practices.

If you are a billing service, enter your client's information in the Practice tab. Enter your information in the Billing Service tab. If you want to use the Medisoft program to keep track of your own accounts receivables, a separate database can be set up with each client listed as a patient. Separate procedure codes can be created to cover the various services of your billing service.

Setting up Multiple Practices

It is not necessary to install the program for each new practice. To set up multiple practices, go to the **File** menu and select **New Practice**. When the first practice is set up in the Medisoft program, the program assumes there is only one practice and establishes a default directory for the data for that practice. Each time you set up an additional data set with totally unrelated patients and procedure files, you must create a different

subdirectory. In the **Create A New Set Of Data** window, enter the additional practice name and change the data path. This establishes a completely separate database for the new practice.

Once you have set up additional practices, you can move easily from one to another by going to the **File** menu, selecting **Open Practice**, and choosing the practice you want from the list presented.

Practice Type

The practice **Type** field is a drop-down list. Click on the arrow to view the entry options, i.e., Medical, Chiropractic, and Anesthesia. Each option controls special fields within the program.

Medical: This is the general setting for all healthcare groups except Chiropractic and Anesthesiology.

Chiropractic: Choosing Chiropractic activates the **Level of Subluxation** field in the diagnosis section of the patient case file. When set as Medical or Anesthesia, this field is not available.

Anesthesia: The Anesthesia choice adds a **Minutes** field in the **Transaction Entry** window for entering charges in transaction billing functions.

Chapter 2

Medisoft at a Glance

Once the program is open, your can get a good look at the main program window. The top bar on the window is the Title bar and it displays the name of the active program and contains Minimize, Maximize, and Close buttons on the right side.

Menu Bar

Just below the Title bar is the Menu bar, which shows categories of activities available in the program. Click on various headings, such as **File**, **Edit**, **Activities**, **Lists**, **Reports**, **Tools**, **Window**, **Services**, and **Help**, and each opens a submenu with a list of all the activity options available in that category.

File Menu

The **File** menu contains options for managing your database files and access to them.

Edit Menu

The functions of the **Edit** menu are **Cut**, **Copy**, **Paste**, and **Delete**. These deal primarily with the handling of text.

Activities Menu

This is the center of much of the daily routine of the practice.

Lists Menu

This menu provides access to the various list windows available in the program.

Reports Menu

Reports within Medisoft are accessible through the **Reports** menu. You can also access the Custom Report List and the Report Designer through this menu.

Tools Menu

The options available in this menu help you access peripheral programs and information to assist in the management of your practice.

Window Menu

This menu contains options that control the display of windows in the program.

Services Menu

The Services menu contains a link to OnCallData for electronic prescriptions. Call your local Value-Added Reseller or call your Medisoft sales representative at (800) 333-4747 for information concerning OnCallData.

Help Menu

The **Help** menu contains access to information on how to use the program, as well as how to register.

Toolbar

Below the menu bar is the toolbar with an assortment of speed buttons (or icons) that are shortcuts to accessing options within the program.

Select the option you want by clicking the appropriate speed button. That function of the program opens in a full data entry window.

The toolbar can be customized to your liking. Change the order of the buttons in the toolbar or hide them so they don't show at all. Create a new toolbar with only the buttons or file names that you want. In addition, you can move the toolbar to the top, bottom, or either side of the screen or return it to its original position and layout.

F1 Look up Toolbar Customizing.

Shortcut Bar

At the bottom of the screen, above the Status bar, is a shortcut bar that describes the available shortcut function keys available in the active window. This bar may also be referred to as the "function help bar."

Chapter 3

General Practice Setup

Open Practice, New Practice

To change practices or create a new practice database, go to the **File** menu and select the appropriate option.

To open an existing database, go to the **File** menu and select **Open Practice**. Choose the practice you want to open and click **OK**.

To create a new database, follow the same procedure as described in the Setting Up the Practice section, page 1.

Backup Data, View Backups, Restore Backups

Information concerning backups is contained in the online Help. Go to the **File** menu in your Medisoft program, select any backup-related topic, and then press **F1**.

F1 Look up Backup, View Backup, or Restore.

Program Date

You can change the program date for back dating a large number of transactions. This affects all dates in the program except the Date Created setting, which always reflects the System date.

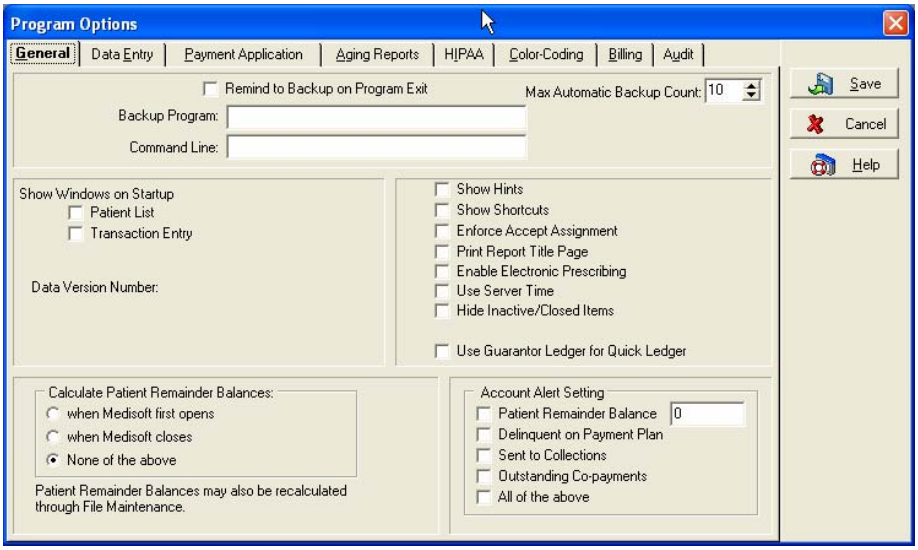
Program Options

Go to the **File** menu and select **Program Options**. There are a number of tabs within **Program Options**, several available only with Medisoft Advanced and Medisoft Network Professional. Each is described below.

General Tab

Backing Up Data

The General tab deals with backups, which are an essential part of maintaining a computer-generated billing program, and with general default settings.



We recommend that data files be backed up every day, with a program of rotating backup disks so you can restore lost data to the most recent date before the files were damaged or corrupted. If you are working with multiple practices, each practice should have its own set of backup files. Doing your backups within the Medisoft program is a dependable method.

When you perform a backup, you are only backing up the data files for the practice currently open. If you work with several practice databases, you must open each practice and perform a backup to preserve those files.

F1 Look up Backup, View Backup, or Restore.

Hide Inactive/Closed Items

Accessed from the General tab on the Program Options window or by right-clicking a list, the Hide Inactive/Closed Items option provides quick filtering options for data display for inactive or closed items. Users can apply a setting on the Program Options tab and as needed, override this setting by right-clicking as needed to view or hide data in a list.

The default setting for this option is not enabled; users can selectively override this setting to enable the feature as needed or permanently change the default setting and then also, as needed, override this setting.

Users can apply these settings to these lists:

Billing Codes	Insurance Carriers	Procedure Codes
Diagnosis Codes	Providers	Patients
Cases `	Referring Providers	Security Accounts

When users selects the right-click menu option of Show Inactive Records to override the setting on the Program Option window, a red X appears next to all inactive items in the list. It is very easy for users to distinguish what codes have been marked as inactive by noting the red " X " as the graphic indicator in front of the inactive code. The right-click menu also provides an option to Hide Inactive Records.

Note: The option that is initially displayed depends on the current setting on the Program Options window. If the feature is enabled on the window, then the right-click menu initially displays the Show Inactive Records option; if the feature is disabled on the Program Options window, then the right-click menu initially displays the Hide Inactive Records option.

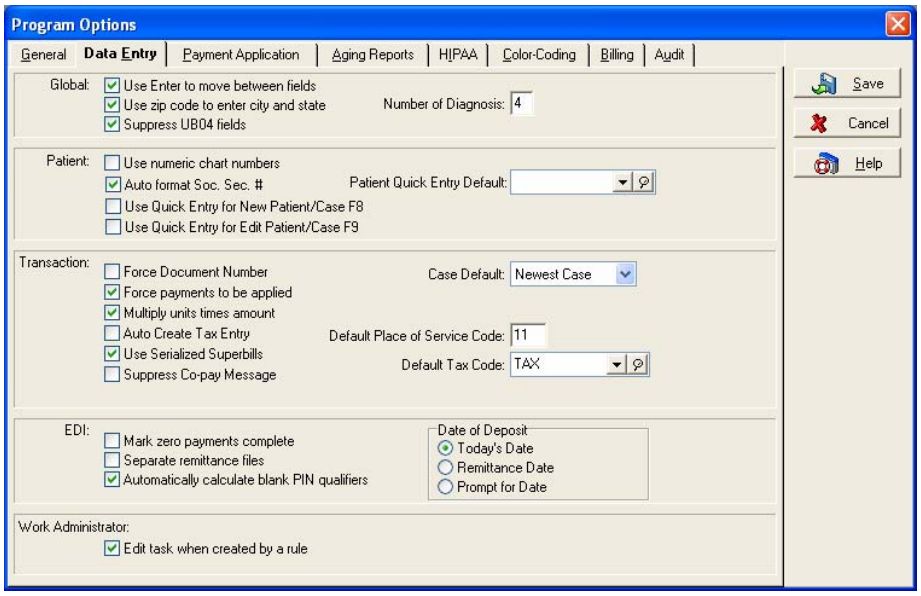
■ Default Choices

You have the option to show the **Patient List** and/or **Transaction Entry** windows on startup by placing a check mark next to either or both options here. You can indicate whether you want to show shortcuts and/or hints, or **Enforce Accept Assignment**. You have the option to calculate patient remainder balances upon opening or closing the program. You can set account alerts that appear in the Transaction Entry, Deposit List, and Appointment windows that tell you when a patient has a certain remainder balance, is delinquent on a payment plan, or is in collections. In Medisoft Advanced and Medisoft Network Professional, you can indicate whether to print a title page for every report. Network Professional includes an option to synchronize your computer time with the time on the network server.

F1 Look up Program Options-General Tab.

Data Entry Tab

The Data Entry tab gives you lots of options for various sections of the program.



In the **Global** section, you can indicate whether to use **ENTER** as a toggle to move between fields, to force payments to be applied, and to multiply unit times amount. Using the zip code to enter city and state information can save a lot of time. When the **Suppress UB04 Fields** check box is selected, UB-04 fields do not appear throughout the program. If you do not process UB-04 claims, check the box. If you do process UB-04 claims, uncheck the box so that all the fields you need to populate the claim form will be available. For more information on UB-04 functionality in Medisoft:

F1 Look up UB-04.

In the **Patient** section, you can choose to use numeric Chart numbers (the default is to use an alphanumeric code) and/or have the program automatically hyphenate Social Security Numbers. The **Patient Quick Entry Defaul**t list and the **Use Quick Entry for New Patient/Case F8** and **Use Quick Entry for Edit Patient/Case F9** check boxes provide setting options for the Patient Quick feature, which provides a custom method for creating records. For more information on the Patient Quick Entry feature in Medisoft:

F1 Look up Patient Quick Entry.

Choices in the **Transaction** section primarily affect **Transaction Entry**. Selecting **Force Document Number** displays a **Document** field in the **Transaction Entry** window. If you click **Force payments to be applied**, the program makes you apply every payment before exiting **Transaction Entry**. If you choose to **Multiply units times amount**, the program automatically adjusts the cost of the procedure based on number of units. If

you click **Auto Create Tax Entry**, the program automatically adds tax to any selected procedure code that has been marked taxable and create a separate line item in **Transaction Entry**. Be sure you have created and selected a **Default Tax Code**.

Select the **Suppress Co-pay Message** option to suppress the co-pay collection message on the Transaction Entry for cases that require a co-pay.

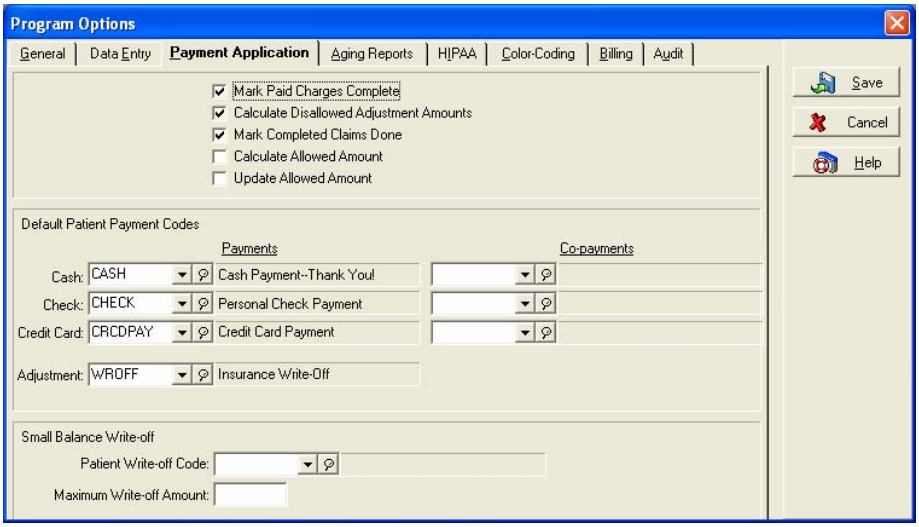
The **Case Default** field determines which case is selected in **Transaction Entry**. The default is **Last Case Used**, but you can change this to **Newest Case** or **Oldest Case**.

There is also a field where you can set the default Place of Service Code. The default in this field is 11. When there is an occasional change of location, simply type the new code to override the default entry.

F1 Look up Program Options-Data Entry Tab.

Payment Application Tab (Advanced and above)

In the Payment Application tab, you can establish default settings that affect the payment application function.



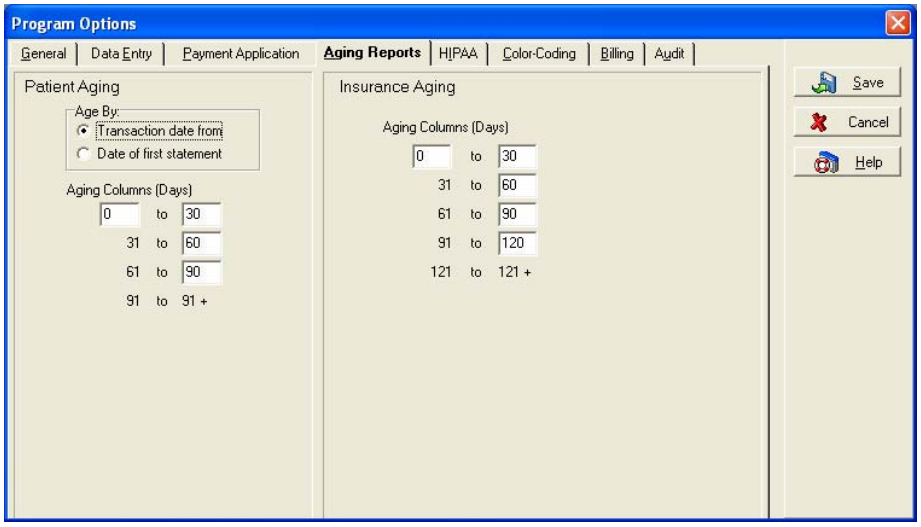
If you choose to accept the default settings, any amount applied to a charge is automatically marked as paid by that particular payee, the allowed amount is automatically calculated, and the difference between the calculated allowed amount and the practice charge is offset in the **Adjustment** column. In addition, any claim that has received payment from all responsible payers is automatically marked "Done."

In the lower half of the window, select default billing codes to be applied when using this feature.

F1 Look up Program Options-Payment Application Tab.

Aging Reports Tab

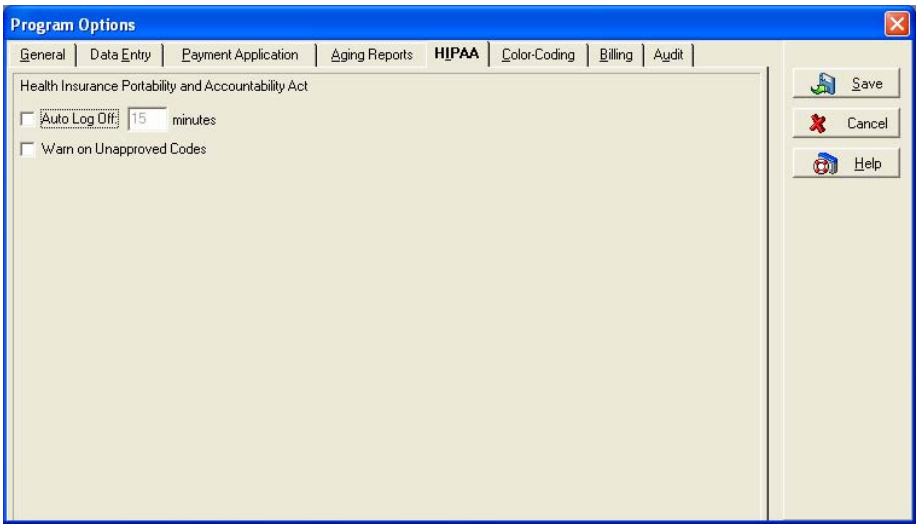
The Aging Reports tab lets you alter the starting date for patient aging reports and to redefine aging columns for both patient and insurance aging reports.



F1 Look up Program Options-Aging Reports Tab.

HIPAA Tab

The HIPAA tab offers features designed to help protect patient information from unauthorized access.



The **Auto Log Off** check box is designed to protect your data files from unauthorized tampering. Click the check box and then enter a number of minutes (up to 59) in the data box. If you click this box and have not utilized the Security Setup feature in the program, a message pops up telling you that security has to be set up before the backup will function. Click OK to clear the message. See Security Setup for information on setting up security for the program.

With Auto Log Off activated, any time the program remains unused for the amount of time designated, it minimizes to a User Login window which requires reentry of the user's password in order to access the program again. You can also click Close Program to turn the program off completely.

When the **Warn on Unapproved Codes** check box is checked, the program alerts you if a code entered or selected is non-HIPAA compliant. This warning pops up every time you save transactions and the program finds a code that has not been marked HIPAA compliant.

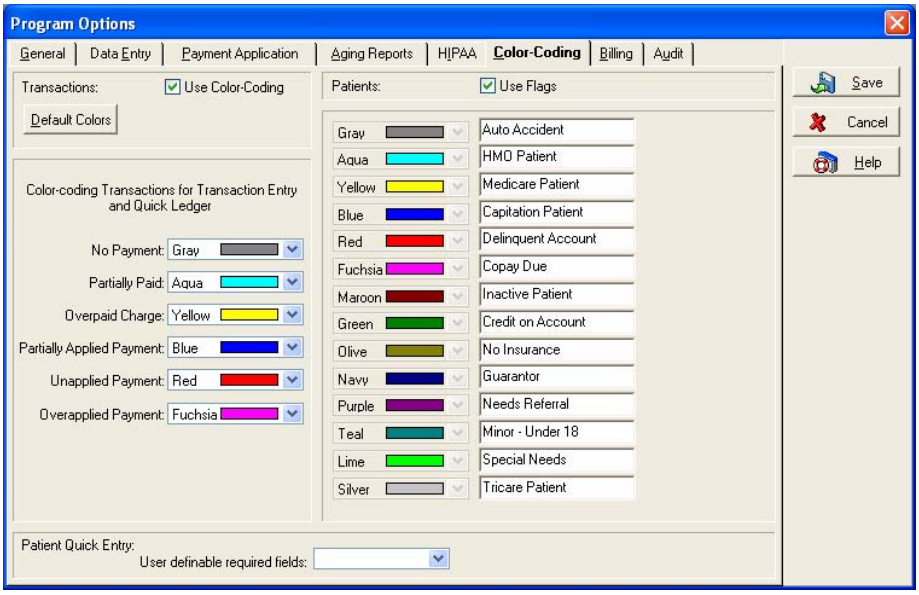
To mark an existing code compliant, you need to edit each code entered in the program, determine its HIPAA compliance and then click the HIPAA Approved box (in both **Procedure Code** and **Diagnosis Code** edit windows).

Another option is to use a program such as Codes on Disk. This program imports current CPT and/or ICD-9 codes with all HIPAA-compliant codes marked. See your local Value-Added Reseller or contact NDCHealth directly at (800) 333-4747.

Color-Coding Tab (Advanced and above)

Transactions

If you want to use color coding for transactions in **Transaction Entry** and **Quick Ledger**, click the **Use Color Coding** box.



Select colors for each of six types of transactions: **Unsaved**, **No Payment**, **Partially Paid**, **Overpaid Charge**, **Unapplied Payment**, and **Overapplied Payment**. These colors appear in both windows, letting you know at a glance the status of the transaction.

Patients

This feature, called patient flagging, lets you color code patient records to alert you to various situations when viewing the records the **Patient List**, **Transaction Entry**, **Quick Ledger**, and **Deposit List** windows of Medisoft and the **New Appointment** window in Office Hours (when integrated with Medisoft).

The patient flag colors in the **Program Options** window are fixed and cannot be edited. In the box to the right of a color box, assign your own description to that flag color. To activate the edit boxes, click **Use Flags**.

Patient flags are connected to patient records in the Other Information tab of the **Patient/Guarantor** window as you edit or set up a new patient record.

F1 Look up Program Options-Color Coding Tab.

Billing Tab (Advanced and above)

■ Claims Manager

These check boxes control settings for the Claims Manager feature. For more information on using Claims Manager with Medisoft:

F1 Look up Claims Manager Overview.

The **Delete transmission and claim batch information after X days** check box and field controls when the application deletes the transmission and batch related information that appears on the Claims Manager Transmission History report. This field defaults to 60 days.

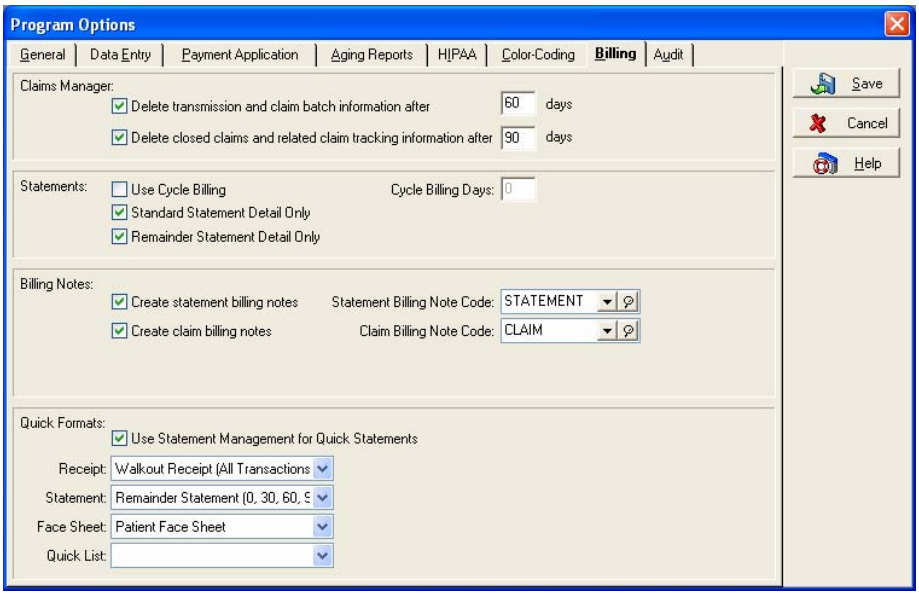
The **Delete closed claims and related claim tracking information after X days** check box and field controls when the application deletes closed claims and other claim related information like the change log and change detail information. This field defaults to 90 days.

■ Statements

Options in the **Statements** section deal with billing cycles. If you want to use billing cycles when sending statements, click **Use Cycle Billing**. See page 96 for more information.

F1 Look up Cycle Billing.

If you choose to use cycle billing, be sure to enter a cycle billing days interval (e.g., every 30 days).



■ Billing Notes

When **Create statement billing notes** is activated, a note is added to statements when printed. Be sure to select a default note in the **Statement Billing Note Code** field.

When **Create claim billing notes** is activated, a Comment transaction line is added in both **Transaction Entry** and **Quick Ledger** whenever a claim is billed. The note includes the carrier name, date billed, claim number, and the name of the provider associated with the claim. Be sure to select a default **Claim Billing Note Code**.

F1 Look up Program Options-Billing Tab.

■ Quick Formats

If the **Use Statement Management for Quick Statements** check box is checked, then the Quick Format options for Statements are the Statement Management statements; otherwise, the list would include the Report option statement formats. Any place that a Quick Statement prints would need to print the appropriate statement type: regular statements or Statement Management statements

The **Receipt** format option is tied to the **Quick Receipt** button in **Transaction Entry**. Select a default quick receipt format here, and that receipt is automatically printed when you click the **Quick Receipt** button in **Transaction Entry**.

You can select a default **Statement** format, which gives you one-button printing of a statement from **Quick Ledger**. When you click **Quick Statement** from either of these windows, the default statement is automatically printed for the selected patient record. If you do not specify a default format here, the first time you click **Quick Statement** from **Quick Ledger**, you are required to select a format.

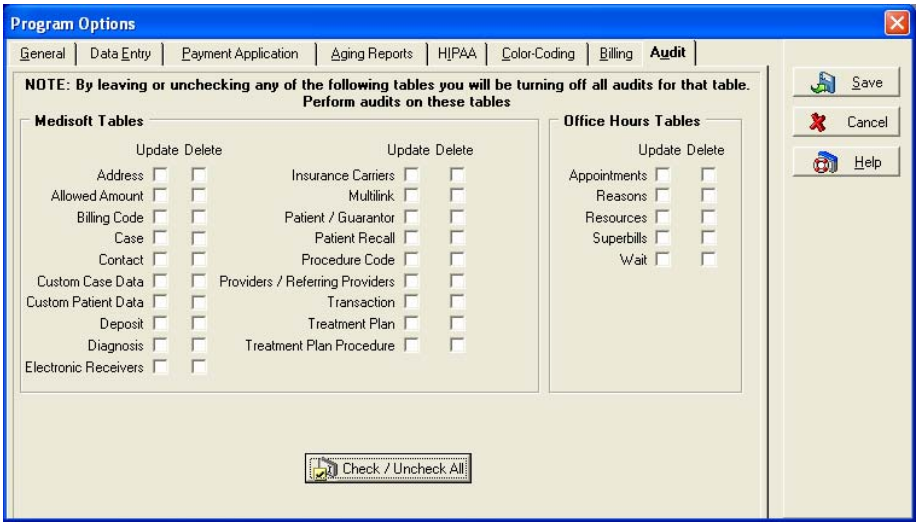
You can print a **Face Sheet** directly from the patient **Case** window. To set a default form, click the down arrow in the **Face Sheet** field and select one of the options. The selected default form prints each time you click **Face Sheet** in the patient **Case** window.

The **Quick List** provides report options for selecting a default list report for the **Quick List** on the **Patient Quick Entry** window. You can print a quick list directly from the **Patient Quick Entry** window each time you click **Quick List** in the **Patient Quick Entry** window.

F1 Look up Program Options-Billing Tab.

Audit Tab

The Audit tab lists all tables available in the database. The tables you choose here become those tables available in the Audit Generator when preparing the Data Audit Report. If you deselect MultiLink here, it will not be available in the Audit Generator.



F1 Look up Program Options-Audit Tab and Audit Report Generator.

Security Setup

Medisoft Standard Security

Basic security in Medisoft is practice based with each practice having various users and groups. Multiple practices require security setup for each database. Set up security when nobody else is using the program. After you set up security, close and open the practice to apply the changes.

Security in Medisoft Advanced and Medisoft Network Professional allows restricted levels of access to those areas of the program that the security supervisor designates. The supervisor has unlimited access and full control of security, while other users are restricted to varying degrees. See Permissions. You can also manage password settings, such as how frequently a user must change the password. Once at least one Level 1 user has been entered, you can add more names, edit entries, or delete entries as necessary. See Login/Password Management.

In Medisoft Basic, you can define a user as an Administrator, which grants the user access to the Security Setup window and the ability to create users. If you are creating an administrator, make sure that you select the Administrator check box. The first user needs to be designated the Administrator.

If desired, Level One users can also set up and apply the Global Login feature. The Global Login function provides an extra layer of security and added convenience for users that access multiple practices and applications. For more information see Global Login Overview.

Through the Security Setup window, you are also able to assign users to groups. Grouping users by job function or security level can help you easily assign tasks or send messages to a number of people at once.

F1 Look up Medisoft Standard Security.

Global Login

Topic is for Medisoft Advanced and Medisoft Network Professional only.

The Global Login features works with standard Medisoft security to provide a path that determines what practices users can access. The feature utilizes standard security and permissions that determine what users can access or do in individual practices but then provides a method for users to logon once and then access all practices associated with the global user—essentially, once the feature is set up, a single user may access multiple practices without having to login to each dataset separately.

Users apply standard security in practices and create users within the practice. A practice without security applied to it (no users) can be associated with any global users. If a practice has users created in it, these users are the only users that can have a global login

associated with them. That is, if standard security exists in a practice, then these users are the only potential global login users—in this case a standard user must exist in the practice before a global user can be created. If a practice has no security applied, then any global users can be associated with the practice.

Global login users are machine-specific and only users with a standard security of Level 1 can enable this feature and create users. Level 1 users can then create a global login user and make this global login user a Global Login Administrator. Global Login Administrators create other users, map these users to practices, change their or users passwords, and determine whether the new users are also Global Login Administrators or Global Login users with login expiration dates. What this means in a multiple PC environment is that the Global Login PC machine practice is enforced. In other words if user Smith is a Global Login user connected to Practice A on machine A, Smith cannot login to Practice A on machine B at the same time. Smith, however, could login to Practice A from machine B as another Global Login User if an account exists.

When setup, global login users default to the last practice accessed, but can select a different practice if the global login user is associated with that practice.

F1 Look up Global Login Overview.

Login/Password Management

In Login/Password Management, the supervisor sets the requirements and application of login rights and password usage. For example, you can set the length of valid passwords, the valid time frame in which a password can be used before it has to be changed, how long a user has to wait before reusing a password, etc.

F1 Look up Login/Password Management.

Permissions (Advanced and above)

The Permissions feature provides five levels of access to the program. The Security Supervisor, who has unlimited access and full control of security, can assign or remove rights for any level of security, with one exception. Level 1 access cannot be removed from any of the three options listed in the **Security** window settings for the Supervisor. Lower level access can be added, but the Supervisor must retain rights to these options.

Level 1 is for unlimited access and is designed to be used exclusively by the Supervisor or administrator to restrict access to the program. Levels 2, 3, 4, and 5 can be user-defined with the Supervisor deciding what fits in what level and assigning users accordingly. Generally, the higher the level number, the less rights are assigned to it. Add or remove check marks for level access by clicking the appropriate check box for each process displayed with each listed window name.

If a task is attempted by a user who does not have rights to that task, based on the security level assigned, a warning dialog box is displayed stating that the user does not have the authority to perform the requested task.

Once the security feature is used, the **File** menu contains an additional option, **Log In As Another User**.

File Maintenance

The program puts you in the driver's seat by giving you the ability to rebuild indexes, pack data, recalculate patient balances, and purge data. The tools to perform each procedure are contained within separate tabs.

☞ Each of these file management functions carries the warning that it can take a **long time** to process. Keep that in mind when planning your file maintenance activities.

Rebuild Indexes

The Rebuild Indexes tab provides options to rebuild data indexes and lists the files available for rebuilding. Clicking **All Files** includes them all.

Pack Data

Select the Pack Data tab to choose the data files from which you want to remove deleted data. Here again, you can choose one particular set of files or click **All Files** to include them all.

Purge Data

The decision to purge data files should be done only after careful consideration. Data removed cannot be reinstated unless you have a previous backup disk containing the information. You have a choice of purging appointment fields, closed cases, and claims data files. In any case, select the cutoff date to which you want to clear data. All data in the selected file before and including the date specified is deleted.

Recalculate Balances

On occasion, account balances or applied amounts may appear to be miscalculated. This option recalculates the selected types of balances.

> **Note:** An individual patient's account balance can be recalculated in the **Transaction Entry** window by clicking the **Account Total** amount. Click **OK** in the **Transaction Entry** window and the program begins the process.

To recalculate all account balances, click the **Recalculate Balances** check box. To recalculate all unapplied amounts, click the **Recalculate Unapplied Amount** check box.

Click the **Recalculate Patient Remainder Balances** to recalculate all patient remainder balances.

F1 Look up File Maintenance.

Tutorial Practice

To practice setting up security, you can perform the following steps using the tutorial database provided with this program.

User Setup

1. Go to the **File** menu and select **Security Setup**. This opens the **Security Setup** window:
2. Click **New** to open the **User Entry** window.
3. In the Medisoft original program, we recommend that the first user be designated the Administrator. Click the **Administrator** box in the middle of the window. Then you can add more names, edit entries, or delete entries as necessary.

   In Medisoft Advanced and Medisoft Network Professional, after one Level 1 person has been entered, you can add more names, edit entries, or delete entries as necessary.
4. In **Login Name**, enter **Supervisor** as the login name.
5. In **Full Name**, enter **I M Boss** as the user's full name.
6. In **Password**, enter **Adam812** as the password.
7. Reenter the password in **Reconfirm**.
8. If you are using Medisoft original, click the **Administrator** box (if this is the first record you are setting up).

   If you are using Medisoft Advanced or Medisoft Network Professional, be sure the **Access Level** is **1**.
9. Skip the **Expire Date** field for now.
10. Open the Question tab.
11. In **Select a question or type in your own**, choose **What is your pet's name**.
12. In **Answer**, type **Ginger**.
13. Reenter **Ginger** in the **Reconfirm** field.
14. Click **Save**.

Repeat these steps for a second user only this time, the user won't have the **Administrator** box checked (Medisoft original).

15. Click **Close** to close the **Security Setup** window.
16. If a message pops up reminding you that users must relog into the program before the changes take effect, click **OK** to clear this message.

Group Setup

1. Go to the **File** menu and select **Security Setup**. This opens the **Security Setup** window.
2. Click the **Group** tab.
3. Click **New** to open the **Security Group** window.
4. In **Group ID**, enter **DCTRS**.
5. Enter **Doctors** in the **Group Name** field.
6. Enter **All doctors and physicians assistants** in the **Description** field.
7. Click **Save**.
8. In the **Security Setup** window, click the **User** tab.
9. Select the user information for **I. M. Boss**.
10. Click **Edit**.
11. Select the **Group** tab.
12. Click the check-box next to the **DCTRS** group.
13. Click **Save**.
14. Repeat these steps to create another group and to assign a user to that group.
15. Click **Close** to exit the **Security Setup** window.

Permissions

If you are using Medisoft Advanced or Medisoft Network Professional, logged in as Supervisor, you can create/revise the rights of each level of security. Be sure you are still in the Tutorial database when you perform the following steps. Today we'll just change the settings for Credit Card functions.

1. Go to the **File** menu and select **Permissions**.
2. Select **Activities**. In the **Process** section, give Level 2 and 3 users the rights to Billing Charges by clicking in those boxes.

3. Click **Close**.

Login/Password Management

1. Go to the **File** menu and select **Login/Password Management**.
2. Enter **30** in the **Renewal Interval** field. This way, a password must be replaced every 30 days.
3. In **Reuse Period**, enter **90** as the number of days before a password can be reused.
4. Enter **6** as the minimum character requirement for a valid password.
5. Enter **25** as the maximum number of characters for a valid password. .
6. Click the **Require Alphanumeric** check box. You may notice that the password for the Supervisor already complies with these settings.
7. Enter **5** as the maximum number of failed login attempts before a user is locked out of the program.
8. In **Account disable period**, enter **5** as the length of time a user's account is on hold when the maximum number of attempts has been exceeded.
9. Click **Save**.
10. Close the program and open it again. This applies all the security changes you just set up.
11. When you reenter the program, the **User Login** box appears asking you to enter your login name and password. Enter **Supervisor** and **Adam812**.

Chapter 4

Setting Up the Practice

Here is a recommended sequence for setup that helps you get off to a great start.

1. Procedure codes and MultiLinks.
2. Diagnosis codes.
3. Provider records.
4. Insurance carrier records and their ID numbers.
5. Address information.
6. EDI receiver records.
7. Referring provider records.
8. Billing codes.
9. Contact List.

Procedure, Payment, and Adjustment Codes

Procedure codes are used to communicate procedure information between patient, provider, and third-party payers. These codes can be accessed by going to the **Lists** menu and selecting **Procedure/Payment/Adjustment Codes**, or by clicking the CPT icon.

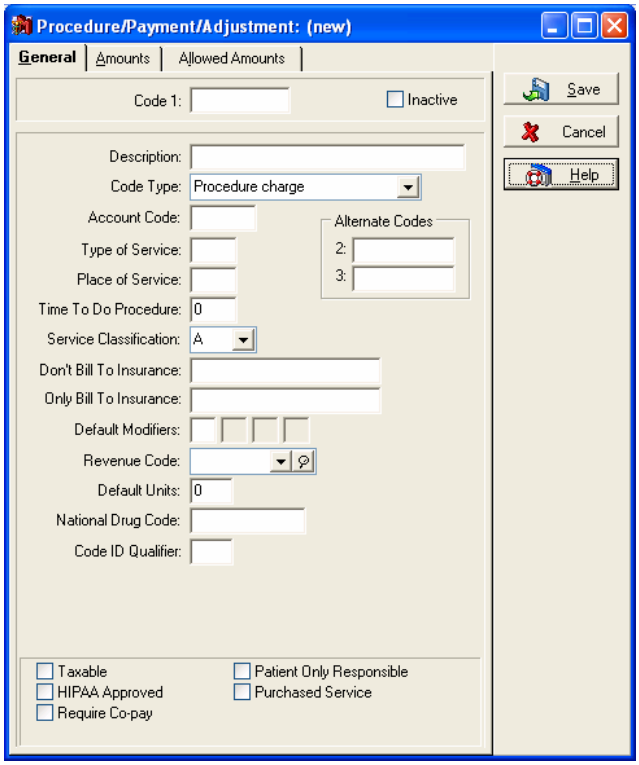
The **Procedure/Payment/Adjustment List** window shows what codes have been set up. At the top of the window, there are two fields to help you find a procedure code: **Search for** and **Field**. **Field** defaults to **Type** but can be changed to **Code 1** or **Description**. If you are not sure of the complete code, description, or type, enter the first few letters or numbers in the **Search for** field. As you type, the list automatically filters to display records that match. At the bottom of the window are choices for setting up a new code, editing a code, or deleting a code. If the code you need is not shown in the list, click **New** or press **F8**.

F1 Look up Procedure/Payment/Adjustment Entry.

New Procedure Codes and Accounting Codes

General Tab

In this area, you can enter a new code number, description, and type. Valid code types can be seen by clicking on the drop-down **Code Type** list.



Accounting Codes can be any configuration of letters or numbers you want to assign to each accounting function, e.g., cash, checks, etc. Procedure codes are used for recording charges for services rendered, and Accounting Codes show the payment and adjustment side of the entry process. These categories are broken down into codes for specific purposes.

Valid codes that have unique functions within the program are:

Adjustment	Deductible
Billing Charge	Inside Lab Charge
Cash Co-payment	Insurance Adjustment
Cash Payment	Insurance Payment
Check Co-payment	Insurance Withhold Adjustment

Check Payment	Outside Lab Charge
Comment	Procedure Charge
Credit Card Co-payment	Product Charge
Credit Card Payment	Tax

Also indicated in this window are the type of service, place of service, time to perform the procedure, whether to allow the code to print on insurance forms, Alternate Codes and, if applicable, whether only the patient is responsible. There is also a check box to indicate if the code is inactive.

Modifiers help pinpoint the exact procedure performed. If needed for claim filing, add modifiers. The **HIPAA Approved** field indicates whether the code is HIPAA approved. The **Revenue Code** is used with the UB92 claim form. You can adjust the number of units associated with this code in the **Default Units** field. If the code is used only with a service that the practice purchased (usually from a lab), click this check box.

F1 Look up Procedure/Payment/Adjustment Entry-General Tab.

Amounts Tab

The Amounts tab is linked with **Case** information, Account tab, **Price Code** field. Medisoft Advanced and Medisoft Network Professional allow 26 charge amounts for each code entered in the program. The applicable charge amount is selected in the Account tab of each patient's **Case** window.

F1 Look up Procedure/Payment/Adjustment Entry-Amounts Tab.

Allowed Amounts Tab (Advanced and above)

The Allowed Amounts tab keeps track of how much each carrier pays for a particular code. The program calculates the allowed amount based on the amount paid, any applicable deductible, and the service classification. This amount is used in calculating the patient portion of any transaction entered in **Transaction Entry**.

F1 Look up Procedure/Payment/Adjustment Entry-Allowed Amounts Tab.

MultiLink Codes

MultiLinks are groups of procedure codes combined under one access code. They are for procedures that are normally performed at the same time, e.g., for a physical exam, a routine set of treatments, etc.

The advantages to using MultiLinks include a reduction of time during data entry. If you can create several transactions with the entry of a single code name or number, there is an obvious time saving. MultiLinks also reduce omission errors. You won't forget codes that should be included if they are included in a MultiLink. When you use the MultiLink code, all the codes in the group are entered.

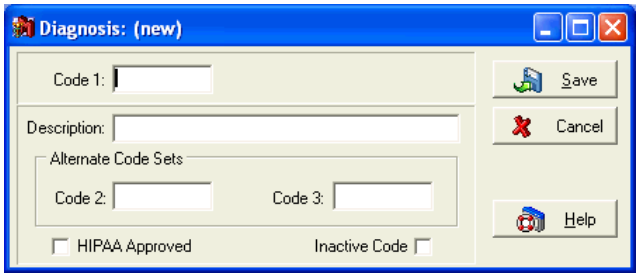
Enter the MultiLinks function by going to the **Lists** menu and selecting **MultiLink Codes**. The list displays all available procedure codes, adjustment codes, and payment codes. You can also set up a new MultiLink or edit or delete an existing MultiLink code.

F1 Look up MultiLink Entry.

Diagnosis Codes

Diagnosis codes represent the reason a service is provided. In effect, the procedure code tells what the doctor did and the diagnosis code tells what the doctor found.

As with other list functions, the diagnosis code setup is accessed by going to the **Lists** menu and selecting **Diagnosis Codes** or by clicking the Diagnosis Code List speed button. At this point you can review codes in the list or search for one you do not see. Clicking **New** (**F8**)or **Edit** (**F9**)opens up a window where you can create a new code or edit an existing one.

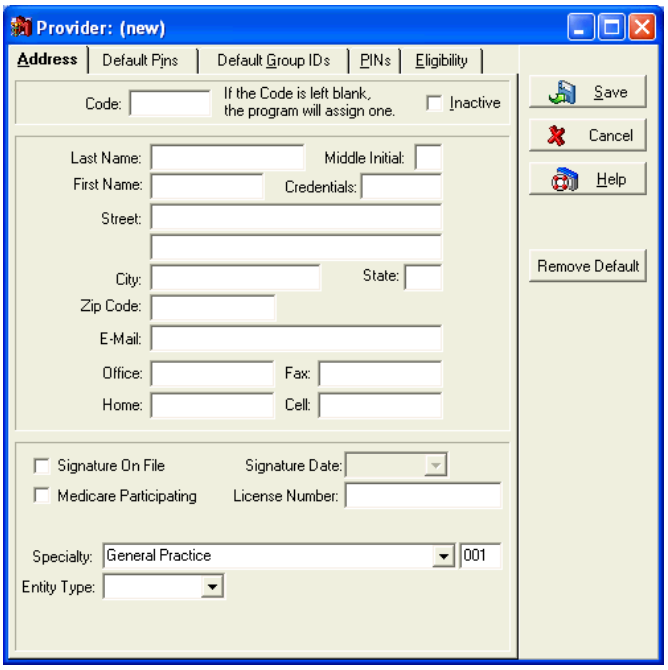


The **Diagnosis: (new)** window displays fields for the code number and description. You also have the option of entering **Alternate Code Sets**. These can be used later for entering codes for different carriers but for the same diagnosis.

F1 Look up Diagnosis Entry.

Provider Records

The **Provider List** is accessed by going to the **Lists** menu and selecting **Providers** or by clicking the Provider List speed button. Specific provider information is accessed by clicking **Edit** or pressing **F9**, and the **Provider: (new)** setup window is accessed by clicking **New** or pressing **F8**.



Address Tab

Provider **Code** numbers are assigned to more than the doctors. Every member of the staff should be set up as a provider and receive a provider Code number.

Provider and staff member Code numbers are utilized in **Transaction Entry** to identify the author when a Patient note is generated. The only provider Code number that is printed on a claim form or transmitted electronically is that of the physician assigned to the patient. All others are for in-house monitoring and accounting.

F1 Look up Provider Entry-Address Tab.

Default Pins and Default Group IDs Tabs

PIN and ID numbers assigned by Medicare, Medicaid, TRICARE, Blue Cross/Blue Shield and other commercial carriers are recorded in the Default PINs and Default Group IDs tabs.

F1 Look up Provider Entry-Default Pins Tab and Provider Entry-Default Group IDs Tab.

PINs Tab

The PIN matrix is contained in the PINs tab. This contains all of the provider's PINs assigned by the various carriers. This is the same table as that contained in the **Insurance Carrier** record.

F1 Look up Provider Entry-PINs Tab.

Eligibility Tab

This tab is where you set up the provider to perform eligibility verification.

F1 Look up Provider Entry-Eligibility Tab.

Provider Class Records

Use this window to enter classes or groups for providers in your practice. Grouping providers into classes is helpful when sending claims or statements electronically. Go to the **Lists** menu and select **Provider**. Select **Class** from the drop-down menu. To create a new class of providers, click **New** or press **F8**. To edit a class, click **Edit** or press **F9**. The **Provider Class List** window appears. Enter an **ID**, **Name**, **Description**, and **National ID** (group NPI number) for the class. Provider classes are assigned to specific providers in the **Providers Entry** window, Default Group IDs tab.

F1 Look up Provider Class Entry.

Insurance Carrier Records

Setting up the insurance carriers correctly is essential to getting claims paid in a timely manner. Go to the **Lists** menu and select **Insurance**. Select **Carriers** from the drop-down menu or click the Insurance Carrier speed button.

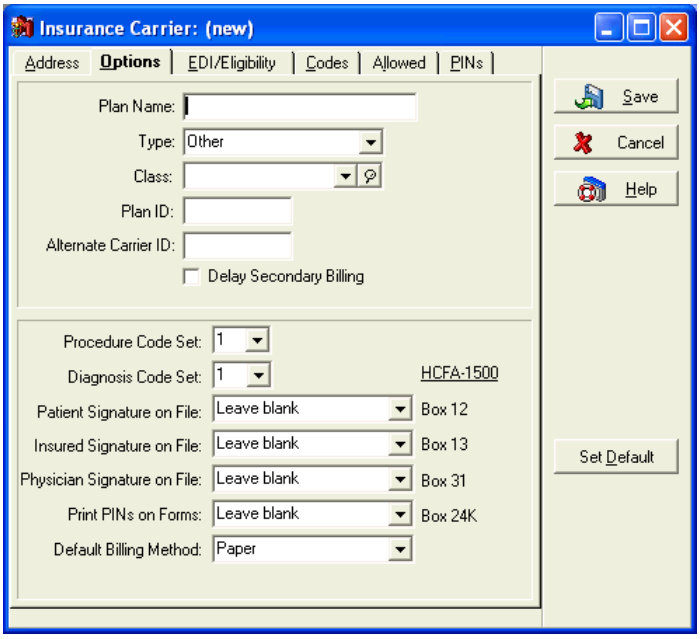
Address Tab

The information contained in the Address tab is standard and includes the **Practice ID** code.

F1 Look up Insurance Carrier Entry-Address Tab.

Options Tab

The Options tab provides fields for more specific information, including plan name and type.



This is where you designate insurance classes, indicate the **Procedure** and **Diagnosis Code Set** that are used by this carrier, select options in the various **Signature on File** fields, and specify the **Default Billing Method**. The various **Signature on File** fields are provided to determine what prints in Boxes 12, 13, 31, and 24K of the CMS- or HCFA-1500 claim form.

F1 Look up Insurance Carrier Entry-Options Tab.

EDI/Eligibility Tab

In the EDI/Eligibility tab, be sure to enter the **EDI Receiver** if you are planning to submit electronic claims. If the EDI receiver you want is not in the list, you can add it "on the fly" by pressing **F8**. After you have signed up with a receiver for your electronic claims, that receiver assigns your **EDI Payor ID** and **EDI Sub ID** numbers and any other necessary numbers or codes.

F1 Look up Insurance Carrier Entry-EDI/Eligibility Tab.

Codes Tab

In the Codes tab, you can enter default payment and adjustment codes for applying payments from this insurance company.

F1 Look up Insurance Carrier Entry-Codes Tab

Allowed Tab (Advanced and above)

This tab contains a listing of allowed amounts paid by the selected carrier for each of the procedure codes contained in the program. Enter these amounts by hand or let the program gather the information from insurance payments entered in the program.

F1 Look up Insurance Carrier Entry-Allowed Tab.

PINs Tab

The PINs tab contains a listing of all PINs assigned by the selected carrier to each provider contained in the program.

F1 Look up Insurance Carrier Entry-PINs Tab.

Insurance Class Records

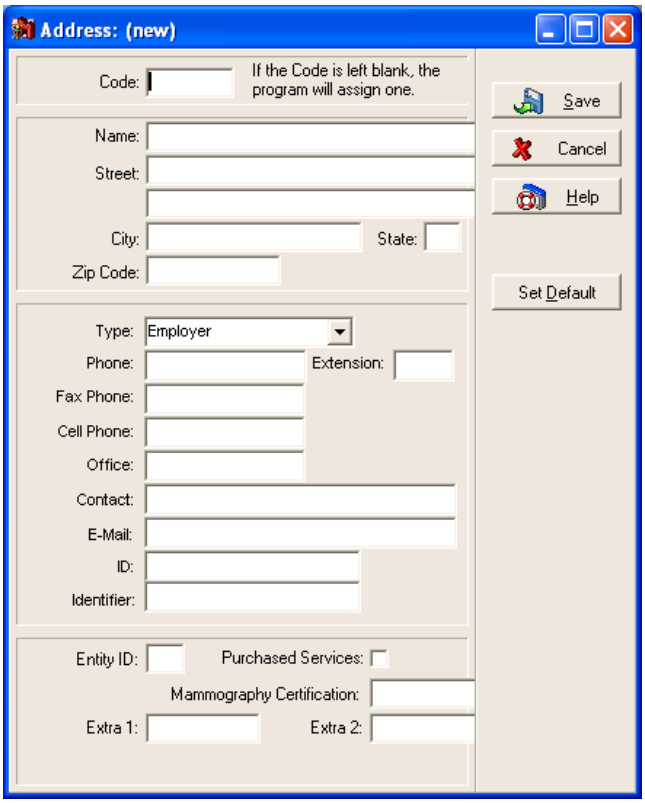
Use this window to create insurance classes, such as Blue Shield or Medicare. Use these classes to group insurance carriers for easier reporting. Go to the **Lists** menu and select **Insurance**. Select **Classes** from the drop-down menu. To create a new insurance class, click **New** or press **F8**. To edit a class, click **Edit** or press **F9**. The **Insurance Class List** window appears. Enter an **ID**, **Name**, and **Description** for the class. Insurance classes are assigned in the **Insurance Carrier Entry** window, Options tab.

F1 Look up Insurance Class Entry.

Address Records

The Address file is your address book within the computer. It keeps the names, addresses, and phone numbers (with extensions) of important outside contacts, such as referring physicians, attorneys, employers, referral sources, etc. The Address file should include all important contact persons whose phone, fax, cell, and e-mail numbers the practice needs at any time in the future.

Go to the **Lists** menu and select **Addresses** or click the Address List icon.



When you click **New** or press **F8**, the program automatically assigns an address code based upon the **Name** field. The address code is not assigned until all information is entered and saved. Use **Search for** and **Field** to look up the address code of existing records.

The addresses maintained in the program are classified by "type" assigned to facilitate ease of selection in a drop-down list. These types include: **Attorney**, **Employer**, **Facility** (Hospital, Rest Home, etc.), **Laboratory**, **Miscellaneous**, and **Referral Source**. Correct types are required to ensure the CMS- or HCFA-1500 form prints correctly.

F1 Look up Address Entry.

EDI Receiver Records

EDI receiver records are used when sending claims or statements electronically. To get started with electronic claim or statement submission, contact your local Value-Added Reseller or call Medisoft directly at (800) 689-4550 and request the enrollment package.

Optional direct claims software is available to send claims directly to selected carriers throughout the country. Most of these are set up on a state or regional basis and handle Medicare, Medicaid, Blue Cross/Blue Shield, and often commercial claims. There is a cost for each of these programs, but, in most cases, there is no charge for claims filed. Information on other available EDI modules can be obtained by calling your local Value-Added Reseller or Medisoft directly at (800) 689-4550.

F1 Look up EDI Receiver Entry.

Referring Provider Records

Many patient visits are the result of a referral from another provider. When a patient is referred to your practice, you must record the Unique Physician Identification Number (UPIN). The referring provider name prints in Box 17 of the CMS- or HCFA-1500 claim form, and the UPIN prints in Box 17a.

Go to the **Lists** menu and select **Referring Providers**. To enter a new referring provider record, press **F8** or click **New**.

Address Tab

The Address tab takes the basic information, plus specialty data and the license number. It allows space for you to indicate whether this doctor is a Medicare participating healthcare provider.

Default PINs Tab

The Default PINs tab displays UPIN and other identification numbers and information. If a practice is performing internal lab work and/or X-rays, the attending provider is also the referring provider. To get paid for this service, the attending provider must also be set up in the Referring Provider file and assigned to the patient.

F1 Look up Referring Provider Entry.

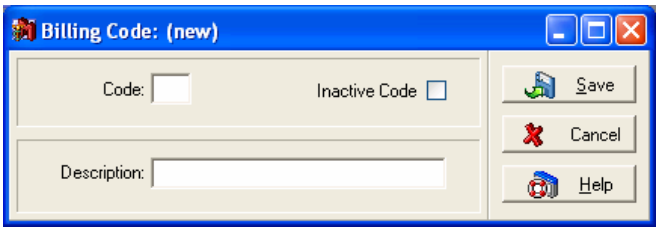
PINs Tab

Depending on the type of claims you file, you could have separate PINs from each insurance for this referring provider. The PINs tab provides a PIN matrix where you can store these additional PINs. If you send electronic claims, you are also required to enter qualifiers to the PINs, if applicable. These qualifier codes indicate the type of PIN. Refer to the implementation guide for you insurance carrier if you are not sure which qualifier to use. This is not provided by Medisoft but by your carrier.

F1 Look up Referring Provider Entry.

Billing Code List

A Billing Code is a user-defined two-character alphanumeric code. Billing Codes can be effective in sorting and grouping patient records. Go to the **Lists** menu and select **Billing Codes**.



The **Billing Code List** window lets you review and edit the codes contained in the program and create new ones. If you want to use a code you have not previously entered, click **New** or press **F8** and the window for a code and description appears.

A billing code range is a filter available in most reports printed in Medisoft.

F1 Look up Billing Code Entry.

Contact List (Advanced and above)

The **Contact List** contains a ready reference of people with whom you have had contact during the course of business. The **Contact** window has space where you can add notes concerning your conversations to help you keep track of what was discussed and any conclusions or information shared during the conversation. For more information on the use of this feature, see the Help files.

F1 Look up Contact Entry.

Tutorial Practice

To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided with this program.

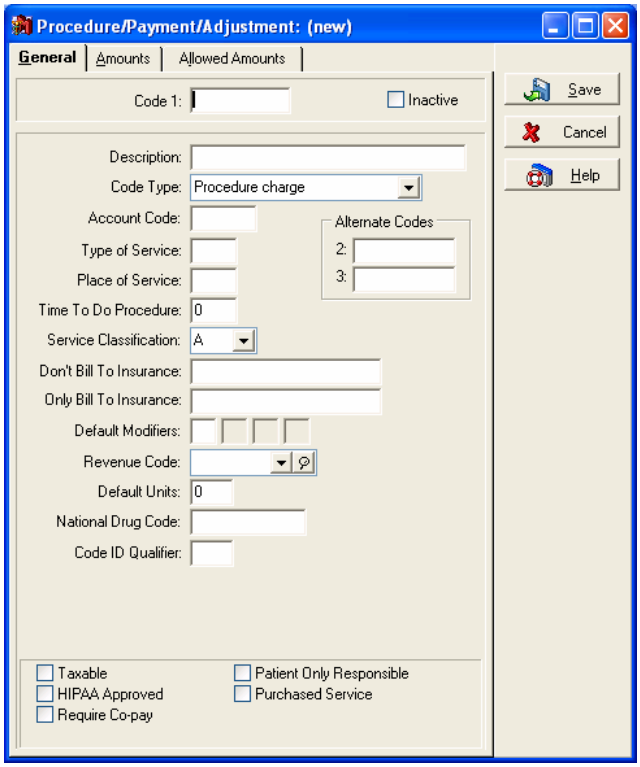
Opening the Practice Record

Going to the **File** menu and selecting **Open Practice**.

The sample data set up in this tutorial is under the practice name Medical Group (Tutorial Data). Highlight that name and click **OK**. If this practice name does not appear, click the **Add Tutorial** button. Then select the practice and click **OK**. The practice name appears in the Title bar of the main Medisoft window.

Creating a New Procedure Code

Click the Procedure Code List speed button. In the **Procedure/Payment/Adjustment List**, click **New**.



In the General tab, enter **XYZ** in the **Code 1** field, and then enter **Test Code** in the **Description** field. Select **Procedure charge** in the **Code Type** field.

The **Account Code** is an internal code for in-house bookkeeping. It can be any configuration of letters or numbers you want to assign to each accounting function, i.e., cash, checks, etc. Enter **OVSP** (for Office Visit-School Patient).

Leave **Type of Service** empty. Enter **11** as the **Place of Service**, and leave **Time to do Procedure** empty.

Leave the **Service Classification** field alone. It defaults to **A.**.

Leave the **Alternate Codes** fields alone.

Click the **Taxable** box to mark this code as needing tax charges added to it.

Click the **Patient Only Responsible** box.

No other fields in this window are applicable, so skip them.

Open the Amounts tab and enter **50** in field **A** as the amount you want charged for this procedure.

Enter **20** in the **Cost of Service/Product** field and **50** in the **Medicare Allowed Amount** field. Click **Save**

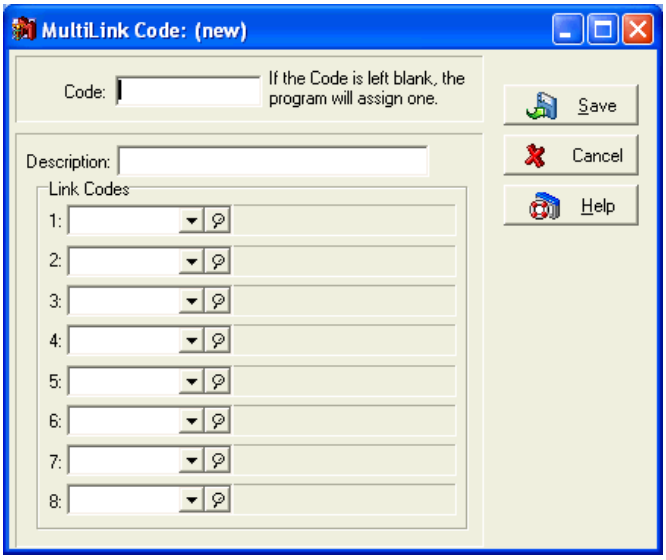
Editing Procedure Codes

You need to edit a couple of the procedure codes in the program. If the **Procedure/Payment/Adjustment List** window is not already open, click the Procedure Code List speed button. In the **Search for** field, enter **99214**. (Be sure the **Field** is set to **Code 1**.) Click **Edit**. Open the Amounts tab. In field **A**, enter 75. Click **Save**.

In the **Search for** field, enter **82954**. Click **Edit**. Open the Amounts tab and enter **12.50** in the **A** field. Click **Save**. Click **Close**.

Creating a MultiLink Code

Go to the **Lists** menu and select **MultiLink Codes**. Click **New**.

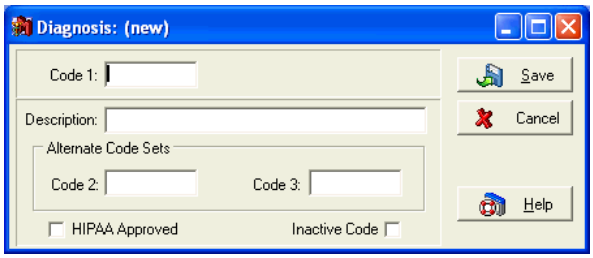


In the **MultiLink Code: (new)** window, enter **SCHOOLPHYS** in the **Code** field. Enter a description in the **Description** field, such as **Physical, School**. In **Link Codes 1**,

enter **80050**, the general health screen panel; in **Link Codes 2**, enter **81000**, a routine urinalysis; in **Link Codes 3**, enter **93000**, an EKG; and in **Link Codes 4**, enter **99241**, office consultation. When you have selected all of the procedures you want linked, click **Save**. Click **Close**.

Creating a New Diagnosis Code

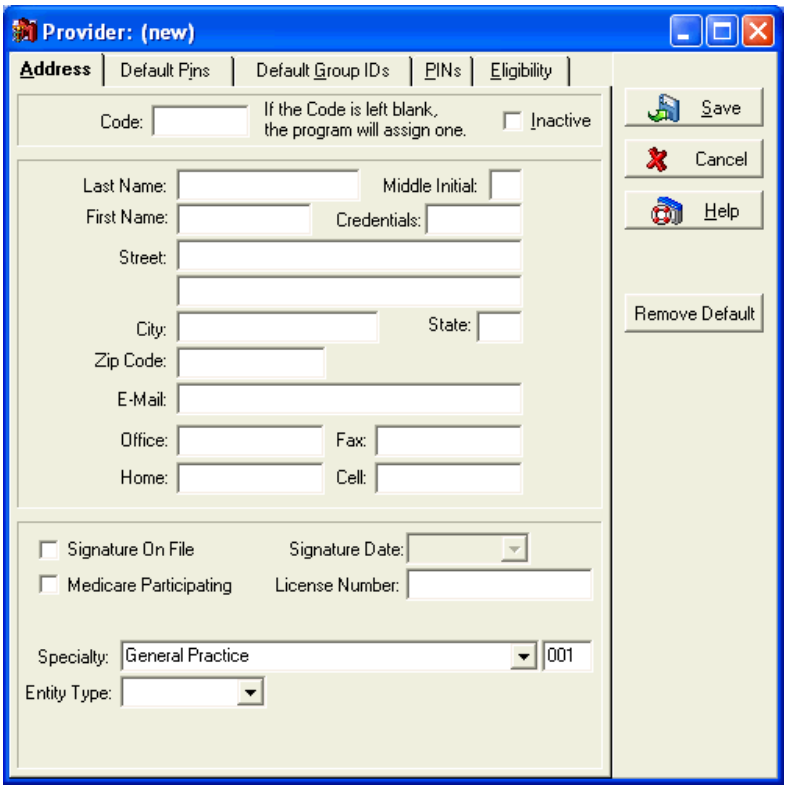
Click the Diagnosis Code List speed button. Click **New**.



Enter **TEST** in the **Code 1** field. In the **Description** field, enter **Test Diagnosis Code**. Click **Save**. Click **Close**.

Setting up a New Provider Record

Click the Provider List speed button. In the **Provider List** window, click **New**.



Skip the **Code** field. Enter the following information:

Name: I. M. Urdoc

Credentials: MD

Address: 1 Healthy Avenue, Stressfree, IA 68888

Office number: (123) 443-2584 (123-4HEALTH). There are no additional numbers, so leave those fields blank.

This provider is a Medicare participating provider. Click the **Signature on File** check box, then select or enter 4/3/89 as the **Signature Date**. Click the **Medicare Participating** check box. Enter Dr. Urdoc's **License Number** as **ZYX1111110**. His practice specialty is General Practice.

In the Default PINs tab, enter **102938475** in the **SSN/Federal Tax ID** field, choose **Federal Tax ID Indicator**, and then enter **22222222** in the **Medicare** field.
No other information is available right now for Dr. Urdoc.

When you have entered all the information, click **Save**. Click **Close**.

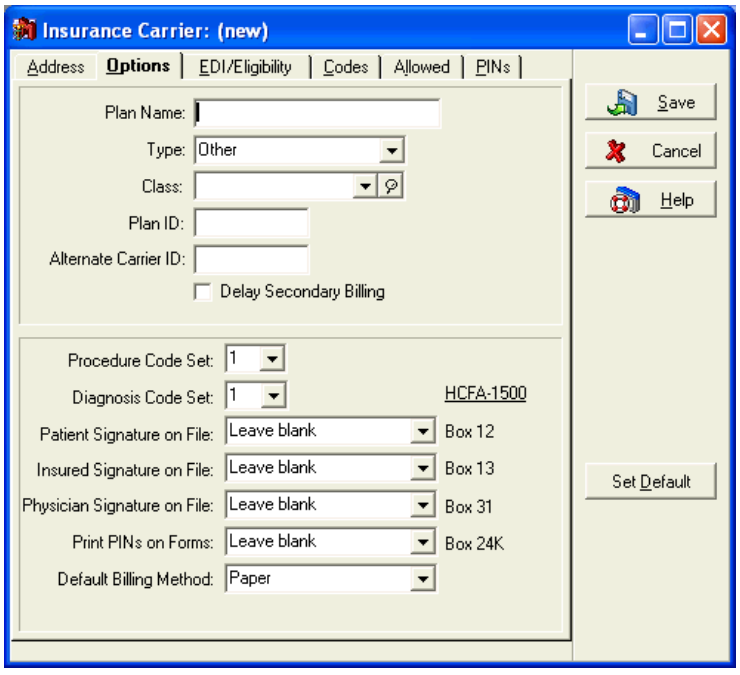
Setting Up a New Insurance Carrier Record

Click the Insurance Carrier List speed button. Click **New**.

Skip the **Code** field. Enter the following information:

In the **Name** field, enter **A1 Insurance Partners**. In the other appropriate fields, enter PO Box 11223, Hartford, CT 01234.

Open the **Options** tab.



Enter **Best Choice** in the **Plan Name** field. Enter **HMO** in the **Type** field. Leave the **Procedure Code Set** and **Diagnosis Code Set** fields alone for now.

What you select in the various **Signature on File** fields determines what prints in Boxes 12, 13, 31, and 24K of the CMS- or HCFA-1500 form. For now, select **Signature on File** in each of them. Select **Provider Name and PIN** in the **Print PINs on Forms** by clicking the box and selecting that option. Leave the **Default Billing Method** as **Paper**.

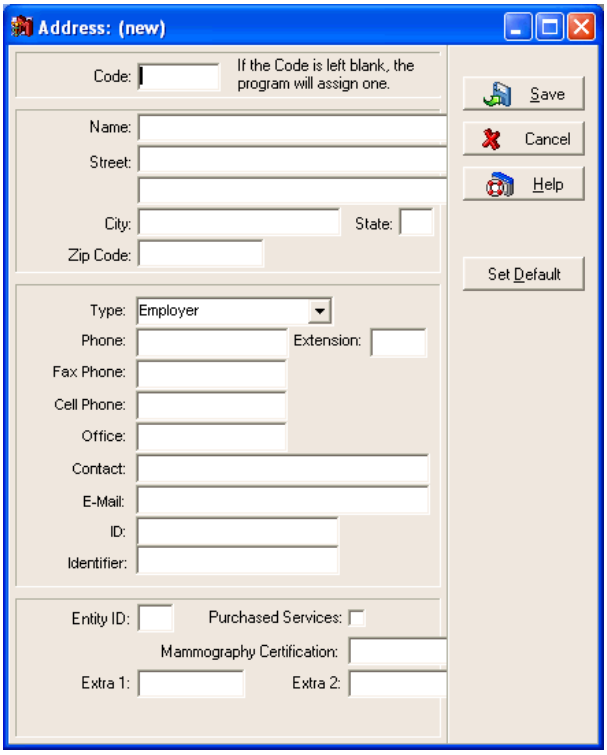
Open the EDI/Eligibility tab. We aren't dealing with electronic claims, so skip the top section of the window. In the respective default payment application code fields, select **INSPAY**, **APWROFF**, **MCWH**, **DEDUC**, and **TAKEBACK**. Click **Save**. Highlight

A1 Insurance Partners, and click **Edit**. (A new insurance record must be saved before the last two tabs are accessible.)

Open the PINs tab. For IM Urdoc, enter **1122334**. When finished, click **Save**. Click **Close**.

Creating a New Address Record

Click the Address List speed button to open the **Address List** window. Click **New**.



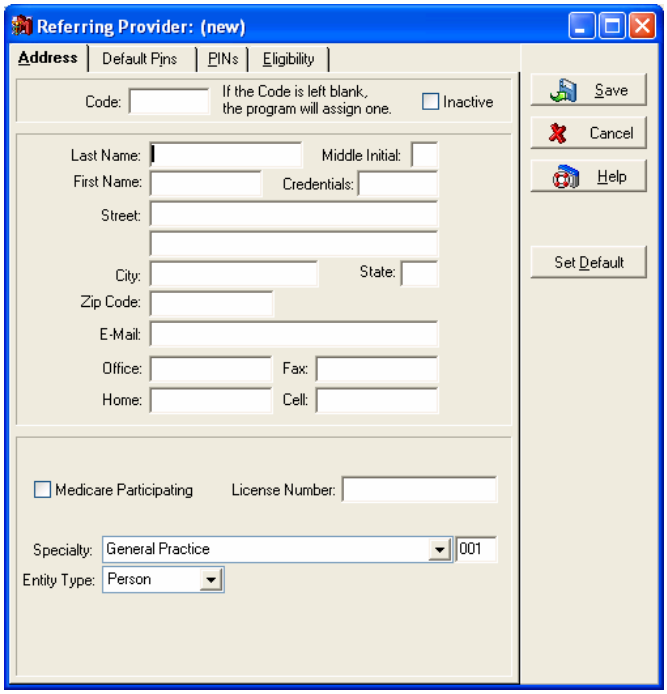
Leave the **Code** field blank this time and let the program automatically assign one based on the **Name** field. The code is not assigned until all information is entered and saved.

In the name and address fields, enter **Pizza Hut**, **1234 Fifth Avenue**, **Anywhere, IA 85000**, **1234567890** (this is the phone number). In **Fax Phone**, enter **1234567899**. Be sure the **Type** field reflects **Employer**.

The contact for this entry is **Murray** and in the **ID** field, enter **Hawaiian, 3-Cheese**. The **ID, Extra 1,** and **Extra 2** fields are used for any other information you may want to enter to identify this entry. When finished, click **Save**. Click **Close**.

Setting Up a Referring Provider Record

Click the Referring Provider List speed button. Click **New**.



Create a record for Frank N. Stein, MD; 1 Spooky Drive, Transylvania, IA 85004; enter **fnstein@mdsx.com** in **E-Mail** address, **4800981234** in the **Office** phone, **4800981233** as the **Fax**, **6026789123** as the **Home** phone number, and **4805432109** as the **Cell Phone** number. Dr Stein is a Medicare participating physician, his License Number is **5551212900**, and his specialty is **Gastroenterology**.

Open the Default Pins tab. Dr. Stein's Federal Tax ID is **23YXO444** (be sure to choose **Federal Tax ID Indicator**), and his UPIN is **2X3XC12**. That's all the information needed right now. When information is entered in both tabs, click **Save**. Click **Close**.

Chapter 5

Patient Record Setup

Patient List

Set Up

One of the most important functions in getting your practice computerized is entering patient data. Go to the **Lists** menu and select **Patients/Guarantors and Cases** or click the Patient List speed button. You can search for an existing patient's record by entering the first few letters of his or her last name in the **Search for** field.

If you want the **Patient List** window to open automatically each time you open the program, go to **Program Options** and click **Patient List** in the **Show Windows on Startup** section of the General tab.

Clicking **New** or pressing **F8** opens an entry window to set up a new patient. Each of the data windows during setup lets you edit, change, or delete the information contained in window. The importance of entering correct information into the patient data files cannot be overemphasized. From setting up the chart numbers to entering percentage amounts for insurance claims, the effect of data entry is far reaching.

It is especially important to set up the guarantor when doing insurance billing.

F1 Look up Patient/Guarantor Entry.

Setting Up the Chart Number

Every patient or guarantor must have a chart number and be set up in the database before transactions can be entered.

If using the program's default automatic settings, each chart number consists of eight alphanumeric characters. If you leave the **Chart Number** field blank, the program automatically assigns a unique chart number. If you want, you can change the default settings and have the program automatically assign numeric chart numbers. Go to **Program Options**, open the Data Entry tab, and click **Use numeric chart numbers** in the **Patient** section.

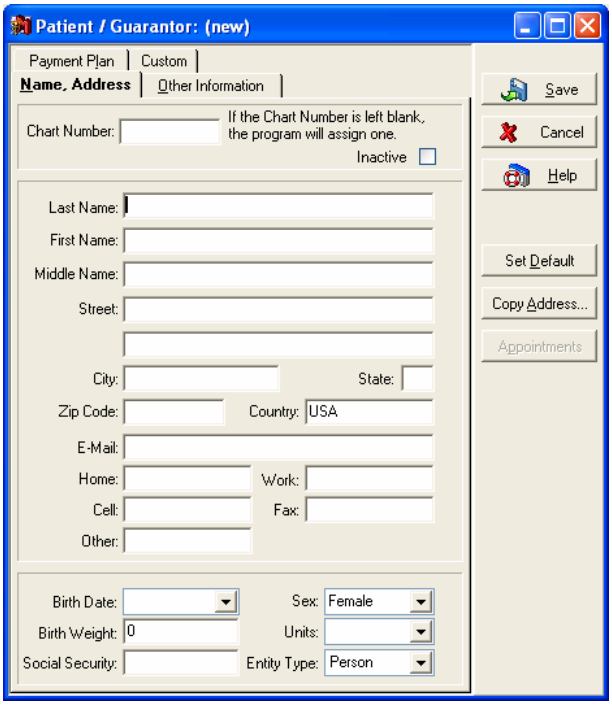
If you want to establish your own patient chart numbering system, type a number or code as soon as you enter the new patient window. There is no need for corresponding numbers within a family; the number sequence has little bearing on grouping of

patients. Each patient is set up individually in the program and individual bills are prepared for each guarantor. It is important to understand that once assigned, the Chart Number cannot be changed. To correct a wrong chart number, you'd have to delete the entire patient record and create a new one with the proper chart number. All other data in the patient record can be modified.

F1 Look up Chart Number.

New Patient Setup Window

Clicking **New Patient** or pressing **F8** lets you set up a new patient record in the program.



Enter all known or necessary information. When entering an address, the focus moves from the **Street** fields directly to the **Zip Code** field. The program has a feature that saves city, state, and zip code information in a table. Once you enter a zip code with its associated city and state, the next time you enter the zip code, the **City** and **State** fields are filled in automatically, saving you time when entering new records.

In the Medisoft Advanced and Medisoft Network Professional programs, you can establish default information, applied to all new patient records. Enter that information

which is generally the same for all of your patients, and then click **Set Default**. To remove your new default settings, hold down **CTRL** and the button name changes to **Remove Default**.

When you enter a Social Security Number, the program checks through the patient records for any duplications. If a number you enter is a duplicate, the program displays the name and chart number of the patient first showing that Social Security Number.

Do not include spaces or hyphens as you enter dates or phone numbers. If you want the program to automatically hyphenate Social Security Numbers, go to **Program Options**, open the Data Entry tab, and click **Auto format Soc. Sec. #** in the **Patient** area. Then enter Social Security Numbers without hyphens.

The Other Information tab contains fields for additional information relevant to the patient record, such as the assigned provider, identification codes, and emergency contact numbers. If you have chosen to use patient flagging (Advanced and above), the **Flag** field lets you choose which flag to associate with the patient record, including **None** if you want to disable the feature after assigning a flag.

F1 Look up Patient/Guarantor Entry-Other Information Tab and Program Options – Color Coding Tab (Advanced and above).

If the patient's employer record has been set up in the Address file, this data is available in the Other Information tab. Clicking the arrow or magnifying glass icon to the right of the **Employer** field displays a list of those employer records already stored in the program. If the employer record you need is not available, press **F8** for the new employer setup.

F1 Look up Patient/Guarantor Entry and Patient List.

Patient Quick Entry Overview

(Available with Medisoft Advanced and Network Pro)

The Patient Quick Entry feature provides another way to create patient records. This method involves more initial setup but offers benefits for practices that want to streamline and customize data entry. This feature provides a customized interface for patient entry. Using this feature allows you to set up a method for entering patient data that reflects your work environment, which simplifies data entry and increase efficiency. Patient and case data is easily added to existing records or you can quickly create new records from one window without clicking multiple tabs.

This feature lets you select which fields from the Patient and Case windows are included on a Patient Quick Entry template. Templates are the basic building block of this

feature. You can create and customize as many as needed and then when using the Patient Quick Entry feature, you can select which template to build or edit a record from. When building templates, you cannot remove required system fields, but can create as many templates as needed to reflect your office workflow and job duties. And, you can on an ad-hoc basis add or remove fields on a template from the Patient Quick Entry window.

For more information and complete instructions for setting up and using this feature, see:

F1 Look up Patient Quick Entry Overview, Using the Patient Quick Entry Feature.

Custom Patient Designer (Advanced and above)

A practice may need information that is not already gathered in the accounting package. Medisoft lets you design a custom tab in the **Patient/Guarantor** window for gathering this data. It could be eye color, hair color, emergency contact information, and so on. Go to the **Tools** menu and select **Design Custom Patient Data**.

If there is information in the Patient/Guarantor window that you do not need or if you want to add additional fields, go to the **Tools** menu and select **Design Custom Patient Data**. The **Custom Patient Designer** window opens.

☞ Installing this feature replaces any existing fields in the window.

Within the large blank area on the right, add whatever fields you want to gather the extra data. Similar to the Report Designer function (see Chapter 13, page 119), you have tools with which to define the fields, place Text or Data fields in the window in whatever order you desire, and create shapes to frame, divide or accent the fields or sections within the window. There is an Add New Data Field speed button that lets you specify the type of data the fields contain (Alphanumeric, Date, or True/False) and then establish the field names. Click a field type speed button, and then click in the window to place the field. Each field, when created, can be adjusted as to size, alignment, and position.

Multiple custom patient tabs can be designed in a database, and you can access them by opening the appropriate tab in the **Patient/Guarantor** window.

F1 Look up Custom Patient Designer.

Setting up a Case

Transactions within the program are generally case-based. A case is a grouping of procedures or transactions generally sharing a common treatment, facility or insurance carrier. You can set up as many new cases as needed.

Each new case that is set up needs to contain the patient's pertinent information. If you click **New Case** or press **F8** with the case list selected, only the Guarantor designation is copied to the new case. To save time, click **Copy Case** to copy all the current case information, and then revise those portions of the data that are different for the new case.

You definitely want to open a new case if the treatment comes under a different insurance carrier. Suppose you are treating a diabetic patient regularly and he is injured on the job. His visits regarding the work-related injury should be kept in a Workers' Compensation case, totally separate from the regular visits, for legal and reporting reasons. The ideal situation is to have a case for each different malady from which the patient suffers. Then you can pull up groupings of case visits to help you evaluate the patient's overall health status. By pulling a case that contains all diabetic treatments, one for high blood pressure, one for angina, and one for cancer, you get a better picture of the full range of health problems.

If a patient comes for a onetime treatment, you can create a transaction for that treatment without creating an entirely new case. Just select different diagnosis codes in **Transaction Entry** when creating the transaction.

Existing case numbers are found in the **Patient List** window through which you set up new cases. Case numbers set by the program are sequential and not one of the numbers is repeated within the program in a single data set.

An existing case can be edited or reviewed through the **Patient List** window or accessed from any **Case** fields in the program by pressing **F9**. The patient **Case** window contains tabs that display fields necessary to complete an insurance claim form.

In Medisoft Advanced and Medisoft Network Professional, you can limit the tabs that are displayed. If a tab is not applicable to your practice or if you would prefer not to have it visible, right-click the tabs. In the list that appears, click each tab you don't want displayed. That tab no longer appears in the **Case** window. To add tabs that are not visible, right-click the tabs and click the tab you want displayed to remove the check mark.

The Personal tab establishes the patient and his or her guarantor information, marital and student status, and employment.

F1 Look up Case – Personal Tab.

The Account tab displays the provider, referral, and attorney information set up in the Address file. It also covers billing and price codes and information on visit authorization, including the number of visits.

F1 Look up Case – Account Tab.

The Diagnosis tab allows for entry of up to four default or permanent diagnosis codes for this case, plus entry for allergy and EDI notes. Information in the **Allergies and**

Notes section is displayed in **Transaction Entry** and the **New Appointment Entry** window of Office Hours when a Chart number is selected.

F1 Look up Case – Diagnosis Tab.

The Condition tab allows for entry of information pertinent to the illness, pregnancy, or injury and tracking of symptoms. It also includes dates relative to the condition, plus Workers' Compensation information.

F1 Look up Case – Condition Tab.

The Miscellaneous tab contains supplemental information features like lab work charges, whether the lab is in-house or outside, **Referral** and **Prescription Dates**, **Local Use A** and **Local Use B** fields, case **Indicator** code, and prior authorization. It also provides space for recording information concerning a primary care provider outside your practice.

F1 Look up Case – Miscellaneous Tab

The Policy 1, 2, and 3 tabs let you connect up to three insurance carriers to the patient record, including policy and group numbers, and **Insurance Coverage Percents by Service Classification** (how much the carrier pays for certain types of procedures). The service percentage classification is tied to each procedure code.

F1 Look up Procedure/Payment/Adjustment Entry.

A **Deductible Met** check box is provided in the Policy 1 tab. When the patient meets his or her deductible obligation for the year, click this box and the status is displayed in the patient account detail of the **Transaction Entry** window.

The three tabs have the same layout, except Policy 1 asks about **Capitated Plan** and **Co-Pay Amount** and has the **Deductible Met** check box; Policy 2 asks if this is a **Crossover Plan**; and Policy 3 can be set up for tertiary or third-party involvement.

F1 Look up Case – Policy 1, 2, and 3 Tabs

The Medicaid and TRICARE tab includes fields for all submission numbers, reference, and data for each carrier. It also includes branch of service information.

Within the Medicaid and Tricare tab are **EPSDT** and **Family Planning** indicators, required submission numbers, and reference data for the case. It also includes service information for TRICARE claims.

The Multimedia tab (Network Professional only) allows you to add bitmaps, video, or sound to your patient records.

F1 Look up Case – Multimedia Tab and Multimedia Entry.

The Comment tab (Advanced and above) is provided for the entry of notes to be printed on statements.

F1 Look up Case – Comment Tab.

This EDI tab is where you enter information for electronic claims specific to this case. If applicable to the claims for this case, enter values in the fields.

F1 Look up Case – EDI Tab.

Custom Case Designer (Network Professional only)

As well as creating custom patient tabs, you can create custom case tabs in the **Custom Case Designer**. Information in these tabs might be vital signs, immunization records, etc. Go to the **Tools** menu and select **Design Custom Case Data**.

Within the large blank area, add whatever fields you want to gather for extra data. Similar to the Report Designer function (see Chapter 13, page 119), you have tools with which to define the fields, place Text or Data fields in the window in whatever order you desire, and create shapes to frame, divide or accent the fields or sections within the window. There is an Add New Data Field speed button that lets you specify the type of data the fields contain (Alphanumeric, Date, or True/False) and establish the field names. Click a field type speed button, and then click in the window to place the field. Each field, when created, can be adjusted as to size, alignment, and position.

Multiple custom case tabs can be designed in a database, and you can access them by clicking on the appropriate tab in the patient **Case** window.

F1 Look up Custom Case Designer and Format/Design Reports.

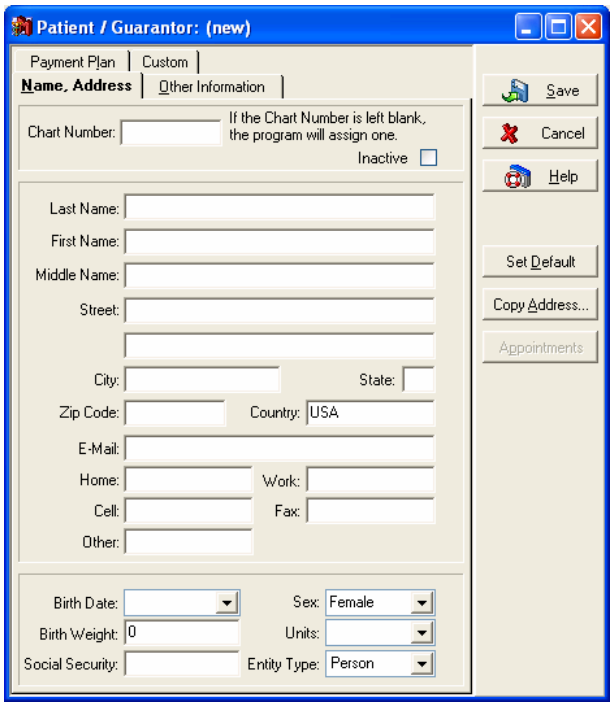
Tutorial Practice

To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided with this program.

Entering Patient and Case Records

Setting Up a New Patient Record

Click the Patient List speed button to open the **Patient List** window. Click **New Patient**.



The **Patient/Guarantor:** (**new**) window opens on the Name, Address tab. **Chart Number** is the first field. Skip this field and let the program create a unique chart number.

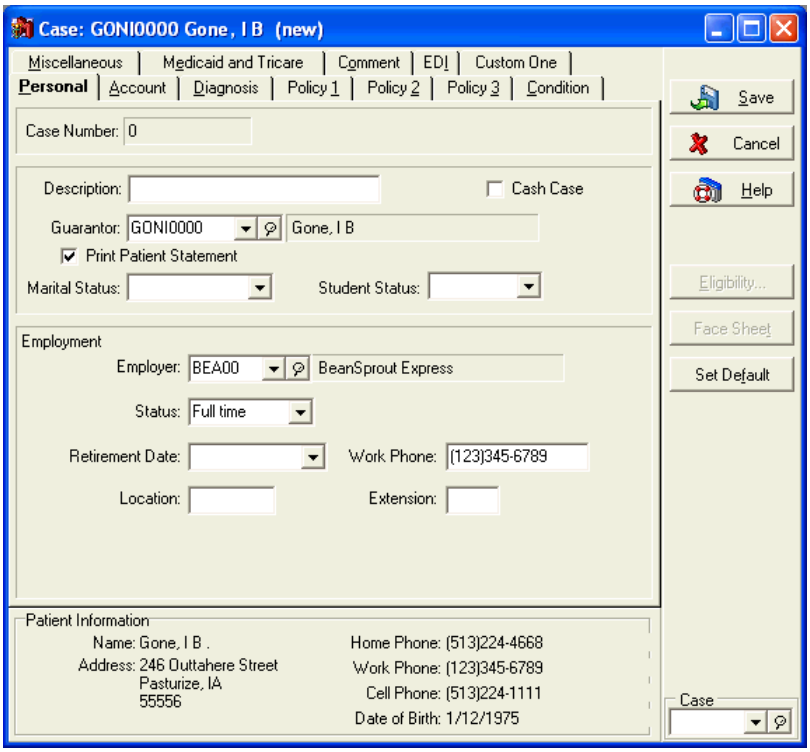
Create a record with the following information: Name: I.B. Gone; address: 246 Outtahere Street, Pasturize, IA 55556; e-mail address: ibgone@wahoo.com; home phone number: (513) 224-4668 (remember to not enter parentheses or hyphens in phone numbers); work number: (123) 345-6789; cell phone: (513) 224-1111; fax number: (513) 531-9766; birth date: 1/12/1975; sex: Male; Social Security Number: 012-34-5678.

Open the Other Information tab. In the **Type** field, be sure **Patient** is selected. Assign J. D. Mallard as the provider, click **Signature on File** and enter the signature date of **9/15/2004**.

In the **Employer** field, select Bean Sprout Express. Mr. Gone's status is **Full time**. When finished, click **Save**. Click **Close**.

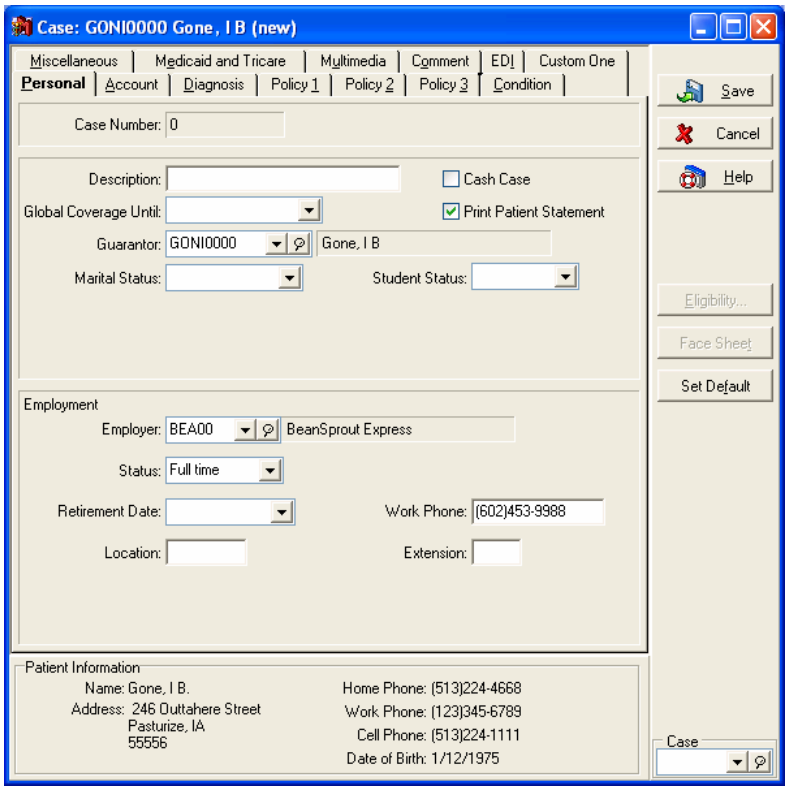
Opening a New Case

Open the **Patient/Guarantor List** window by clicking the Patient List speed button. Highlight I.B. Gone in the left section of the window. Then choose the **Case** radio button at the top right of the window. Click **New Case**.



Enter **Back pain** as the description of this case. Change **Marital Status** to **Single**. All the other information is taken from the patient record.

Open the Account tab.

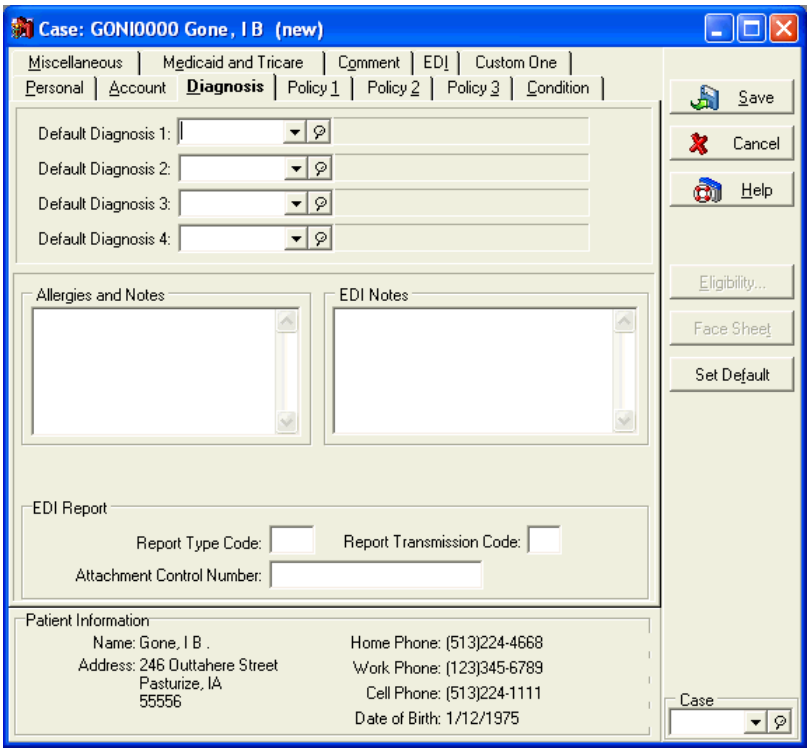


In the **Assigned Provider** field, enter IMU (for I.M. Urdoc). In **Referring Provider**, select Frank N. Stein.

Let's say Mr. Gone was referred by your stellar Yellow Pages ad. In **Referral Source**, select **Yellow Page Ad**.

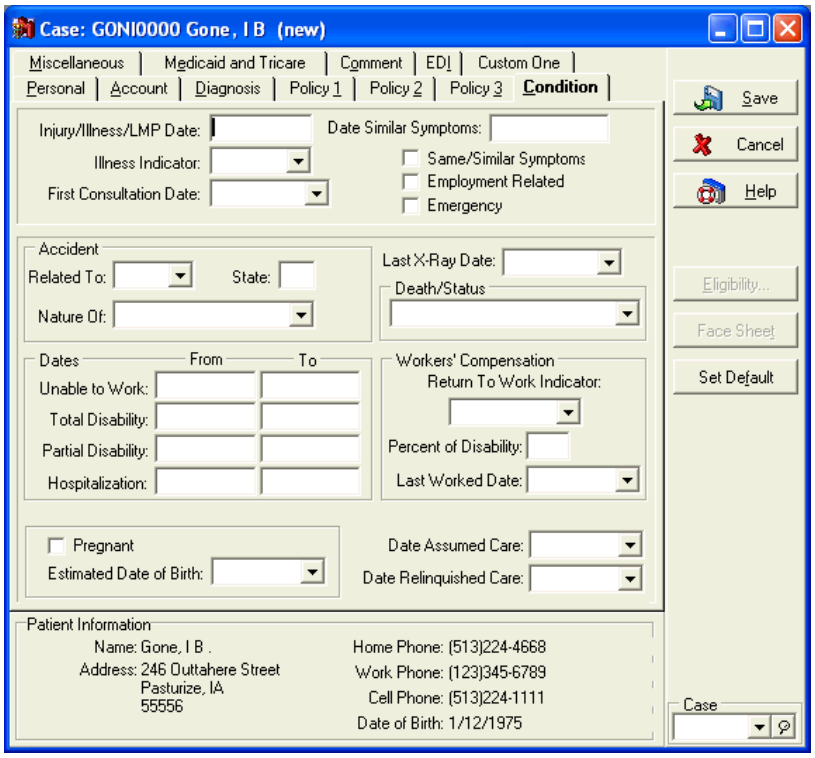
You've already received information from Mr. Gone's insurance carrier and you know that treatment is authorized through October 2006. Enter 10/31/2007 in the **Treatment Authorized Through** field. In **Authorization Number** enter **6489211**, in **Authorized Number of Visits** enter **12**, and in the **ID** field, enter **A**.

Open the Diagnosis tab.



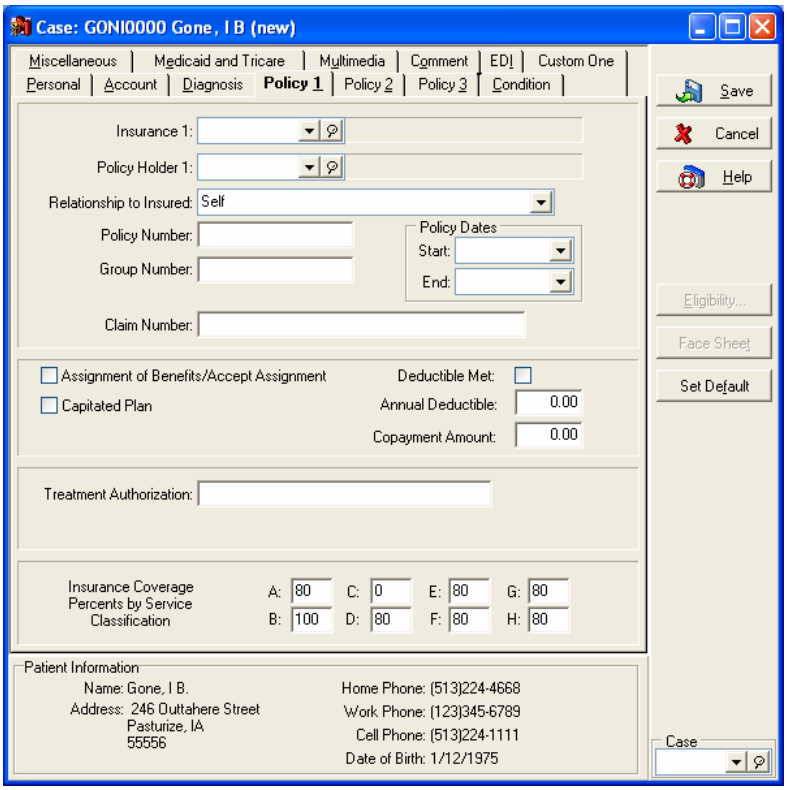
In **Default Diagnosis 1**, enter 724.2, and in **Default Diagnosis 2** enter 847.2. Mr. Gone has informed you that he is allergic to Codeine, so enter that in the **Allergies and Notes** field.

Open the Condition tab.



The reported injury date was September 15, 2002, the **Illness Indicator** is **Injury**, and the first consultation date was September 21, 2002. There have been no similar symptoms. This was related to an auto accident, so select **Auto** in **Accident Related To**. Mr. Gone lives in Iowa but was visiting people in Arizona when the accident happened, so indicate **AZ** as the **State**. In **Nature Of**, select **Injured during recreation**. No other fields are important for this case so leave them blank.

Open the Policy 1 tab.



In **Insurance 1**, select **A1 Insurance Partners**. Mr. Gone's **Policy Number** is **9782XYZ**, and his **Group Number** is **98KEY**. The Policy **Start** date is **October 1, 1998** and the **End** date is **October 31, 2007**. Click **Assignment of Benefits/Accept Assignment**. Leave the default information in the rest of the fields in this tab.

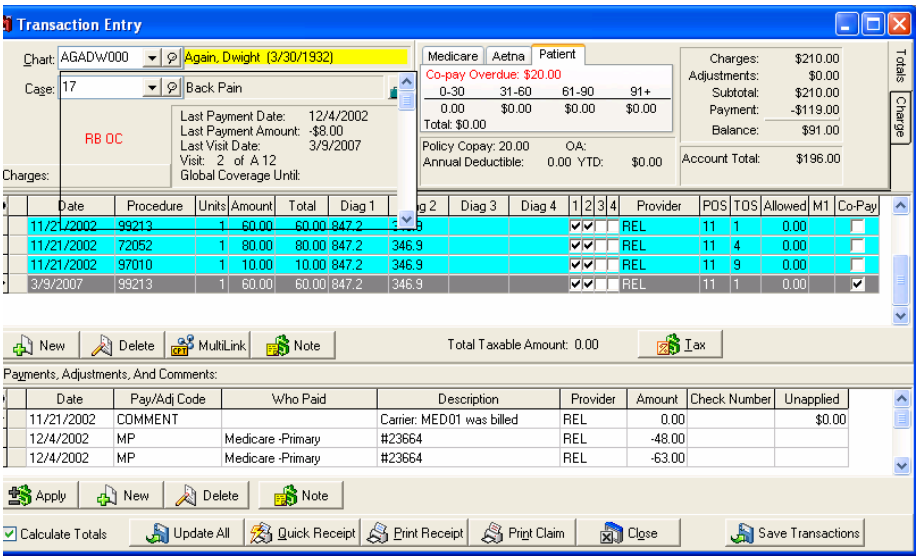
Mr. Gone has a secondary insurance policy. Open the Policy 2 tab. Select **Aetna** as his secondary coverage, Policy Number **00034526Z**, and the Group Number is **888B**. Policy Start and End dates are **October 1, 1999** and **September 30, 2008**, respectively. Click **Assignment of Benefits/Accept Assignment**. Your carrier assigns a Claim Number; in our case let's use **283-8765D**.

No fields in the Medicaid and Tricare or Multimedia (Advanced and above) tabs are necessary for Mr. Gone, so skip these tabs. Click **Save** when finished.

Chapter 6

Transaction Entry

The **Transaction Entry** window is designed for easy transaction entry and to display as much information with as few clicks or keystrokes as possible. Not only do you record all patient visits and their charges, you also enter payments and adjustments that may be added to the ledger.



Medisoft is an Open Item Accounting program, meaning that transactions entered are marked when paid but remain on the active ledger as long as the case is active. There is no clearing of the ledger and bringing up a total to start a new month, as with a balance forward program.

Transaction entry is generally case-based. Transactions are entered into the patient ledger grouped by case number. You can have a case for each transaction or for each diagnosis type.

F1 Look up Transaction Entry.

Start with a Chart Number

From the **Activities** menu select **Enter Transactions** or click the Transaction Entry speed button. Within **Transaction Entry**, two numbers are of prime importance: the chart number and the case number.

Enter the chart number or click the **Chart** field and select the chart number from the drop-down list. You also have the option of entering the superbill number or selecting the superbill number from the drop-down list in the **Superbill** field. If the patient record has not yet been set up, press **F8** to bring up the **Patient/Guarantor:** (**new**) window. See Chapter 5 for setting up a patient record, page 43.

When you press **TAB** or **ENTER**, a case number is selected in the **Case** field (if one is available). By default, the most recently opened case is opened. You can change the default in the **Program Options** window, Data Entry tab, **Case Default** field, see page 9.

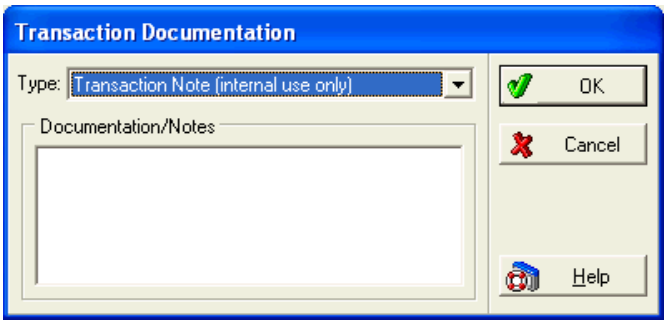
If you want to create a new case, the shortcut to bring up the **Case** window is **F8**. Another method of selecting a specific case is to click the speed button to the right of the **Case** description field to open the **Select Case by Transaction Date** window.

F1 Look up Select Case by Transaction Date.

A document number is automatically assigned by the program and is used for reference and filtering purposes, whether the field is displayed in the **Transaction Entry** window or not. You can replace this number with your own if you want.

If you use superbills, you can enter a superbill Serial Number in this field to help keep track of the superbill. To use superbill numbers in **Transaction Entry**, open **Program Options** and click both **Force Document Number** and **Use Serialized Superbills** in the Data Entry tab.

Sometimes there is a need to provide more documentation about a transaction. This can be done in a special **Transaction Documentation** window activated by pressing **F5** or clicking **Note** in the **Charges** section of the **Transaction Entry** window.

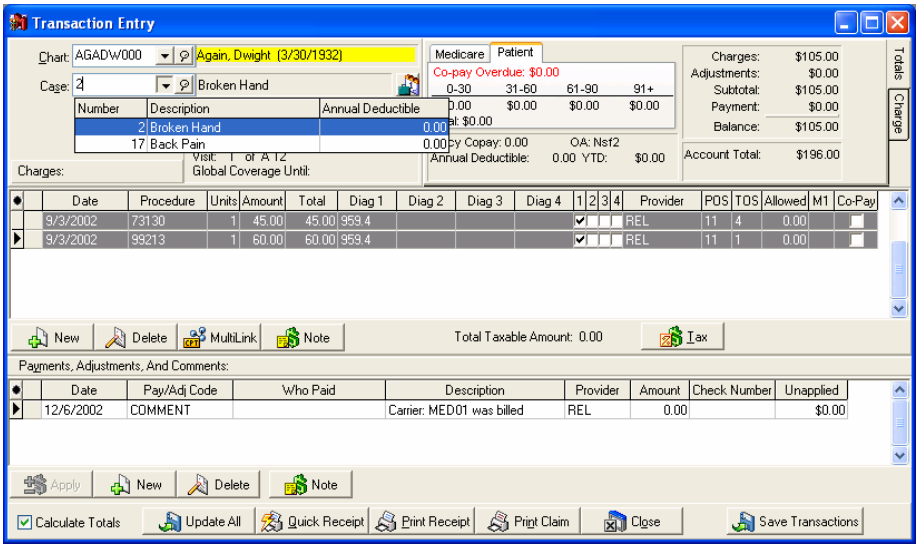


There are various transaction documentation types available, e.g., **Diagnostic Report**, **Ambulance Certification**, etc., and they can be viewed in the **Quick Ledger**.

F1 Look up Transaction Documentation.

Entering a Charge in Transaction Entry

Once you have selected patient chart and case number in the **Transaction Entry** window, click **New** or click in any column of the **Charges** section.



The current date is automatically entered. If you are entering transactions from earlier dates, insert the correct date of the entries with which you are working. If you have a number of transactions from a different date, you can change the program date by clicking the date in the lower right corner of the program window and selecting a new date. Be sure to change the date back to the current date when finished.

The Transaction Entry window displays on a tabbed panel the current insurance carriers assigned to the patient's case along with the aging columns. The aging columns' appearance is dictated by setting on the Program Options tab.

Enter information in the **Procedure** column and any other information that is necessary to complete this charge transaction.

To create a second charge transaction, click the down arrow key or click **New**.

Entering a Payment or Adjustment in Transaction Entry

After selecting patient chart and case numbers in the **Transaction Entry** window, you can enter a payment by clicking **New** in the **Payments, Adjustments, and Comments** section of the window.

The current date is inserted in the **Date** field. Select the **Pay/Adj Code**, and then enter **Who Paid**, a **Description**, and the **Amount**. If the payment is being made by check, the check number can be entered in the **Description** field.

Apply Payments or Adjustments to Charges

We recommend that you apply all payments and adjustments to charges. Failure to do so results in other parts of the program not functioning properly, i.e., remainder billing and the delay secondary billing feature (Advanced and above), to name only two. In addition, some report results will be incomplete or inaccurate.

You can distribute a payment or an adjustment to a specific charge or charges by clicking **Apply**. The **Apply Payment to Charges** or **Apply Adjustment to Charges** window opens (depending on whether you are applying a charge or an adjustment) and lets you direct that payment or adjustment to the proper charge or charges.

Besides displaying the source of the payment or adjustment and the patient's name, the **Apply Payment to Charges** or **Apply Adjustment to Charges** window also displays the number of charges in this case. The upper right corner displays the unapplied amount entered in the payment.

Once the entry is complete and verified, click **Close** to return to **Transaction Entry**. You can then click **Print Receipt** (which gives the patient a Walkout Receipt before leaving the office), click **Print Claim** (which prepares entries that have not yet been submitted on an insurance claim and sends them to print), or click **Close** to exit the window.

F1 Look up Apply Payment to Charges or Apply Adjustment to Charges.

Unprocessed Transactions

The **Unprocessed Charges** window provides an interface between an Electronic Medical Records (EMR) service and Medisoft via Communications Manager.

This window provides controls to with edit and post financial transactions imported from an EMR service and Medisoft.

Transactions imported into Medisoft from an EMR service through **Communications Manager** are held as Unprocessed Charges until they can be processed by a Medisoft user.

From **Activities** menu select **Unprocessed Transaction** and then select **Unprocessed EMR Charges**. The **Unprocessed Charges** window appears with a list of transactions that have yet to be posted.

The columns in the list correspond to information from EMR application Columns such as billing, providers, diagnosis codes, and procedure codes should be reflected in the same manner as found in your practice management software.

F1 Unprocessed Transactions Overview.

Patient Treatment Plans (Network Professional only)

When a patient has a choice of options for the treatment he or she can receive, a treatment plan can be prepared which sets out the different treatments offered and the cost of each plan.

F1 Look up Treatment Plan List.

Print Receipts, Create Claims

Once a transaction has been entered and saved, the transaction can be displayed in the **Transaction Entry** window. By sliding the scroll bar at the bottom of the window, a full summary of the transaction is revealed.

You can now print a receipt for the patient, file a claim, or close the window.

F1 Look up Create Claims.

Billing Charges (Advanced and above)

This feature lets you apply billing charges to accounts that are past due.

Before you can use this feature, you must set up at least one billing charge type of procedure code. Do this through the **Procedure/Payment/Adjustment List** and **Procedure/Payment/Adjustment: (new)** windows. Fill in the **Code 1** and **Description**

fields. Be sure to select **Billing charge** in the **Code Type** field. Add whatever other information you want and save the code. Create as many billing charge codes as you need.

If desired, you can use billing codes (which are used to categorize patient records) and indicator codes in applying billing charges. Be sure these codes are set up if you want to use them.

Go to the **Activities** menu and select **Billing Charges**. Use the range limitations to select the records to which you want to apply the billing charges. The **Charges Creation Date** is the date that appears in the ledger with the billing charges. This can be whatever date you choose (but the transactions created still show on the current day's activity reports).

Fill out all the requested information, then click **Start**. New transactions are added to each patient record that fits the criteria you selected.

F1 Look up Billing Charges and Procedure/Payment/Adjustment Entry.

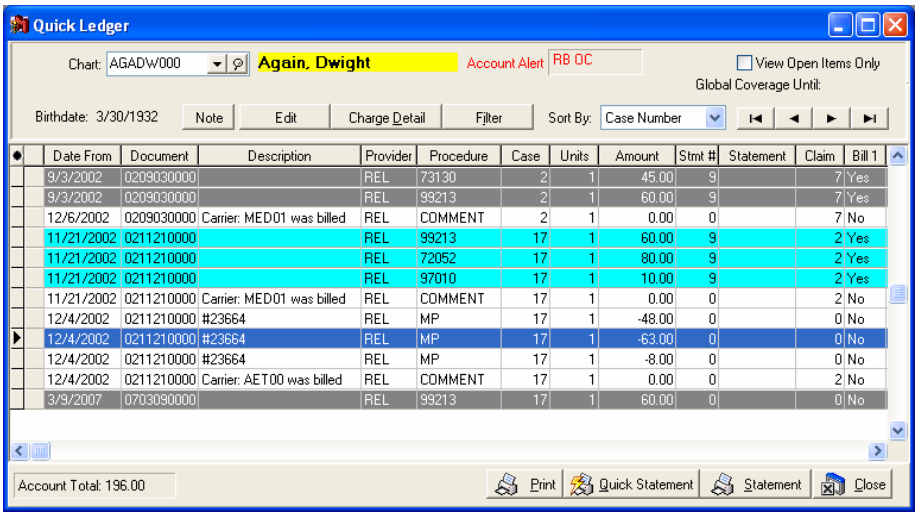
Quick Ledger (Advanced and above)

The **Quick Ledger** in Medisoft gives a quick reference for transaction and other information in the patient's account. There are two types of Quick Ledgers in Medisoft: the **Patient Ledger** and the **Guarantor Ledger**.

The **Patient Ledger** displays transaction information and account totals for individual patients. The Patient Ledger is the default ledger in Medisoft.

The **Guarantor Ledger** provides the same information as the Patient Ledger but allows you to view guarantor totals as well. In the **Program Options**, **General** tab, you can select Guarantor Ledger as your default ledger.

To get quick and easy access to a patient's ledger from almost anywhere in the program, press **F7** or click the Quick Ledger speed button.



While no new transactions can be made in the ledger itself, it is possible to edit and print the ledger and gain valuable detail on patient accounts.

You can change responsibility for a selected transaction in the **Quick Ledger** window. Right-click a transaction to change its responsibility between insurance carriers or from an insurance to the patient. This feature lets you skip entering the zero-dollar insurance payment to indicate that no payment is coming from the insurance carrier.

F1 Look up Changing Responsibility in Quick Ledger.

The **Quick Ledger** detail window is very similar to the **Transaction Entry** window. Use the horizontal scroll bar to reveal additional data fields. A navigation bar lets you move quickly through the list of transactions. Three buttons open additional data fields.

Click **Edit** or press **F9** to open a panel very similar to the transaction panel in the **Transaction Entry** window where charges, payments and adjustments can be reviewed and edited, as needed. Notes can be added through the **Transaction Documentation** window. Click **Payment Detail** to display all payments/adjustments made toward a specific charge. Click **Filter** to search which transaction data to display. Real power comes with using multiple filters. Navigation buttons in the **Payment/Adjustment Detail** window are for selecting other entries in the **Quick Ledger** to review without having to exit the **Payment/Adjustment Detail** window first.

If you click **Quick Statement**, you print statements from the **Reports** menu. If you click **Statement**, you print statements from **Statement Management**.

F1 Look up Quick Ledger, Payment/Adjustment Detail, and Transaction Filter.

Quick Balance (Advanced and above)

Quick Balance is a quick summary of all remainder charge totals contained within the program for a selected guarantor record. It can be displayed at just about any time while working in the Medisoft program by clicking the Quick Balance speed button or pressing **F11**.

If the record selected is a guarantor's record, the **Quick Balance** window displays each patient for whom the guarantor is responsible and the total qualifying remainder charges for each. If the record selected is not a guarantor's record, a listing of all the selected patient's guarantors is displayed. Choose a guarantor to see the quick balance.

If you click **Print** in **Quick Balance**, you print statements from the **Reports** menu.

F1 Look up Quick Balance.

Tutorial Practice

To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided.

Transaction Entry

To begin, go to the **Activities** menu and select **Enter Transactions** or click the Transaction Entry speed button.

For this exercise, enter **GON** in the **Chart** field to pull up Mr. Gone's chart. Press **ENTER**. His most recent case opens and a number appears in the **Document** field. If this field does not appear and you want to see it, go to **Program Options**, open the Data Entry tab, and click **Force Document Number**. Return to the **Transaction Entry** window.

To create a new transaction, click any column in the **Charges** section or click **New**. Any information contained in the case **Allergies and Notes** box is popped up for your view. Click **OK** to clear this message and continue.

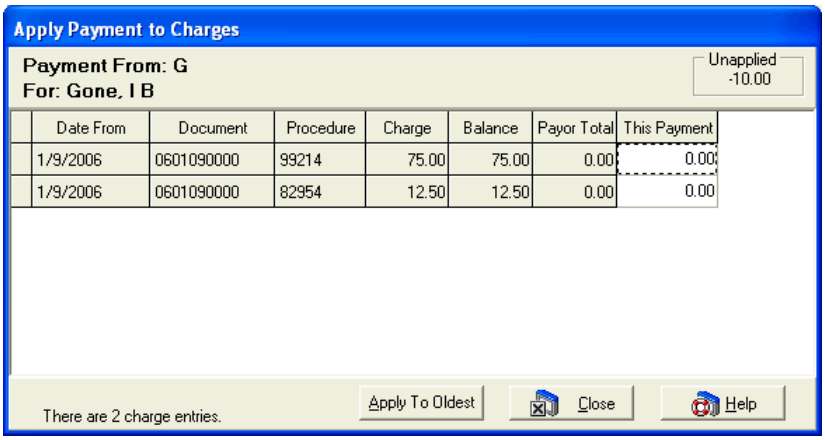
Enter **99214** (Office visit) in the **Procedure** column. Press **ENTER**. All available information concerning that procedure code is automatically entered in the appropriate column. The charge shows $75 for the visit.

To create a second charge transaction, press the down arrow or click **New**. Now enter a second procedure code for this visit, **82954** (Glucose Test). Note that the **Amount** field shows $12.50.

Mr. Gone is making a payment of $10 on the account. Click any column in the **Payments, Adjustments, and Comments** section, and then enter the procedure code for

a cash co-payment (**COPAY10**). In **Who Paid**, select Mr. Gone. In the **Description** field, enter **Co-payment**. Notice that -10 is entered in the **Amount** field. Click **Apply**.

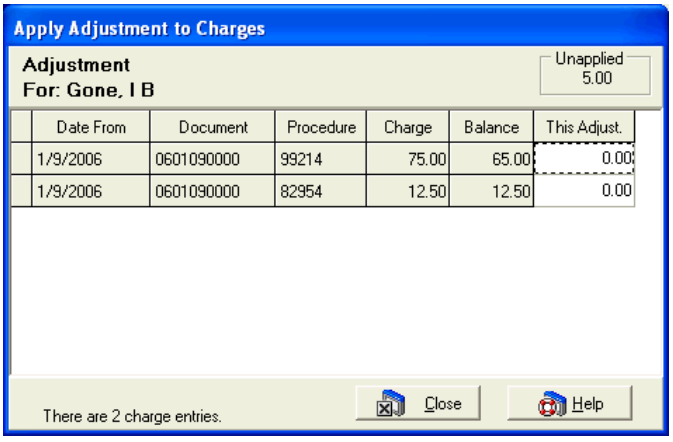
The **Apply Payment to Charges** window shows each of the charge entries that have been made and a white column marked **This Payment**.



With the $10 to apply, select the charge that is $75.00, click in the **This Payment** column of that transaction, and enter **10**. Click **Close**.

You need to make an adjustment, so click **New** in the **Payments, Adjustments, and Comments** section of **Transaction Entry**. Enter the adjustment code **CACSYDISC**, in the **Pay/Adj Code** field, **Courtesy Discount** in the **Description** column, and **5** as the adjustment amount. Click **Apply**.

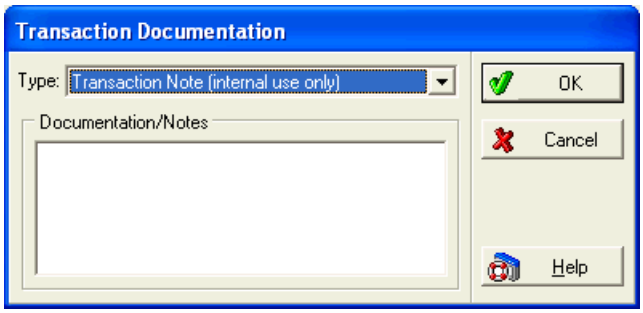
The **Apply Adjustment to Charges** window is similar to the **Apply Payments to Charges** window.



Locate the $65 balance and enter **5** in the **This Adjust** column. Click **Close** to return to the **Transaction Entry** window.

Transaction Documentation

You need to add a note to the first transaction. Locate that transaction in the **Charges** area and click **Note** in that same area. (You can add a note to either a charge transaction or a payment/adjustment transaction.)



The default **Type** is **Transaction Note (internal use only)**. Enter the following in the **Documentation/Notes** area of this window: **Follow up with the carrier on this charge**.

Press the **ENTER** key and then press **CTRL +T** to enter a date and time stamp in the note. Click **OK**. Click **Save Transactions**. In the column to the right of the selected transaction there is a small icon, which indicates that a note has been added. This indicator is also displayed in the **Quick Ledger** window next to this transaction.

Click **Close** to close the **Transaction Entry** window.

Chapter 7

Claim Management

This chapter explains briefly how to manage claims within the **Claim Management** window and includes creating, editing, printing/reprinting, and listing claims, as well as changing claim status.

The Claim Manager's Job

To help you better understand the function of claim management, let's use a shipping analogy. Whereas Cases are containers filled with claims for specific diagnoses, claim management is the process by which the cases are checked, sorted and delivered. In other words, claim management is the process of making sure all shipments are correct, ready to be sent and shipped to the right companies (insurance carriers).

The Claim Manager (the person performing claim management) checks the claims, makes sure the boxes are properly marked, and sends them on their way. She determines whether the shipment goes by truck (paper claims) or by air (electronic claims). When a box is returned (rejected claim), the Claim Manager makes whatever changes are necessary (with help from the EOB or Audit/Edit Report) and ships the box again (resubmits the claim).

Someone else sees and treats the patients. Another person enters data from the superbill to begin the billing process. Once all the data has been entered, it must go through the Claim Manager's office before being sent to an insurance carrier.

The Claim Manager focuses on three principal areas, not necessarily sequential: review, batch, and final review.

Watchdog: The Claim Manager is, first of all, the watchdog of the claims. She checks each claim and verifies the numbers. She has the authority to edit the claim and make needed changes. If she sees that a claim should go to a different carrier than indicated, or if the EDI receiver information is incomplete, she corrects the record. She has access to all three carriers, primary, secondary, and tertiary. She checks the billing date and how the claim is to be sent, either by paper or electronically. And then she can indicate the status of the claim. There is a place where she can add any special instructions that need to go with the claim.

Batch 'em up! The function of creating claims serves to group claims that are headed to the same destination. The Claim Manager gathers and sorts by range of dates or chart numbers. Transactions can be selected that match by primary carrier, Billing Code, case

indicator, or location. Random Billing Code numbers can be selected. The Claim Manager can also indicate a minimum dollar amount for creating the claims, eliminating claims too small to be worth billing.

Reviewer: The Claim Manager has at her fingertips a **List Only** button that lets her retrieve claims that match a certain criteria that she has determined. The **List Only Claims That Match** window is a "show me" window that lets the Claim Manager review all that is in the program. The claims that come before her can be given a final check for accuracy and completeness. She can select specific or all carriers to review. She can group all electronic media claims.

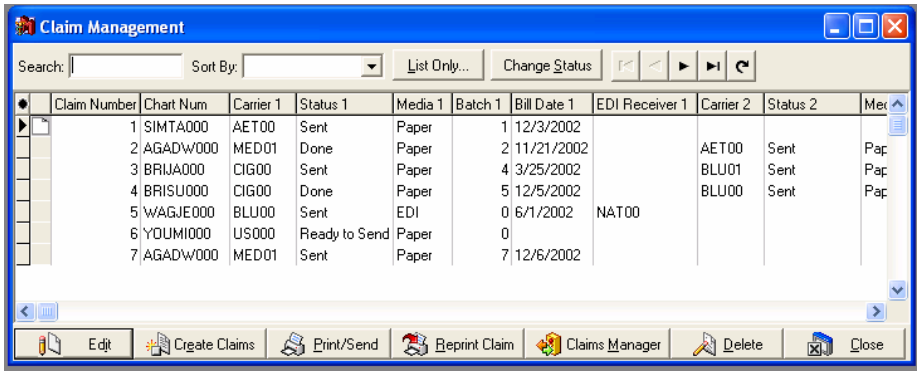
Besides these three focus areas, the Claim Manager also has responsibility to mark claims that are paid and those that are rejected.

Marking paid claims: The date of submission in the **Claim Management** window indicates when the claims were shipped or transmitted. Claims are marked under the designation of "Sent" and the date is automatically inserted. The claims stay in **Claim Management** marked as "Sent" until they are manually changed in the **Claim** edit window as having been received and dispatched by the carrier. When a payment is received, use the EOB to enter all payments through transaction entry. If selected in **Program Options** (Payment Application tab, **Mark Completed Claims Done** field), the status for paid claims is automatically changed to "Done."

Handling rejected claims: When a paper claim is rejected for payment by the insurance carrier, change the payment status in the **Claim Management** window from "Sent" to "Rejected."

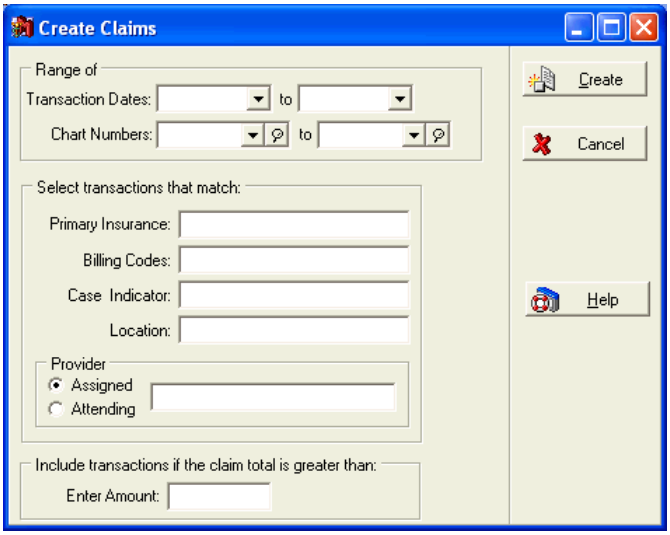
Now put yourself in the picture. Picture yourself as the Claim Manager. The tools by which you get the job done are found in **Claim Management**.

To perform any claim management functions, go to the **Activities** menu and select **Claim Management**, or click the Claim Management speed button.



Creating Claims

It is in the creating claims operation that a claim is finally prepared for submission.



Preparation can involve a single claim or a batch. Claims are gathered by range of dates and/or chart numbers. The selection of claims to be created can be further narrowed by specifying detail in the **Select transactions that match**, **Provider**, and **Include transactions if the sum is greater than** fields.

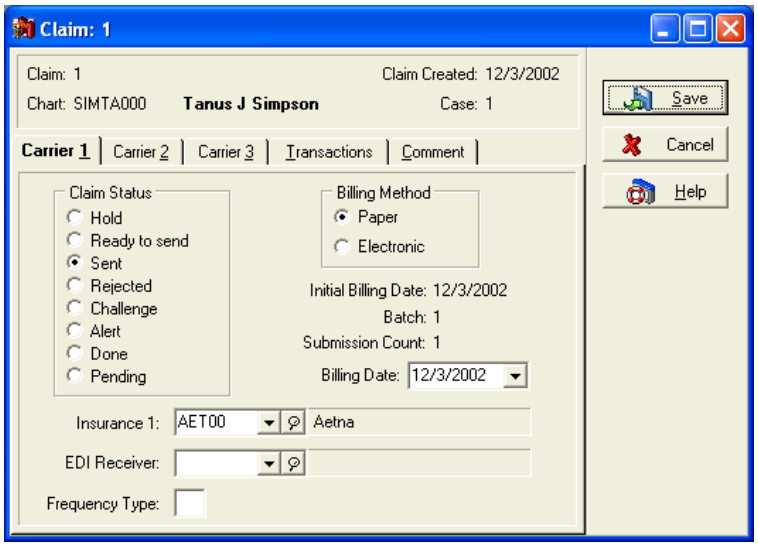
F1 Look up Create Claims.

Editing Claims

This function within the program is the watch dog area where you can verify and edit the claims that are ready to be submitted for payment. It is a safety net where problems can be solved, and information entered in a transaction can be overridden if necessary. An override in the **Claim** edit window changes that claim submission, but does not affect the default database.

As the claim comes up for final verification, it may be determined that a change needs to be made, such as a different carrier or EDI receiver.

By highlighting a specific claim and clicking **Edit** or pressing **F9**, the **Claim** edit window appears with the claim details and information concerning all assigned insurance carriers and their pertinent data.



The detail also indicates submission method assigned to the claim (paper or electronic), as well as the claim status. Claim status options include: **Hold**, **Ready to send**, **Sent**, **Rejected**, **Challenge**, **Alert**, **Done**, or **Pending**. The status of the claim can be changed at this point.

Any time a claim is sent, a batch number is assigned. That number shows in the **Batch** data box in the center of the window of the claim you are reviewing. If a claim needs to be resubmitted, the batch number coincides with the number shown in the **Claim Management** window and the one you use to designate those claims that need to be resubmitted.

The Transactions tab reveals a listing of all transactions applied to the selected claim. You can split, add, or remove qualifying transactions in this tab. The Comment tab provides an empty box in which to place whatever comments you feel are necessary concerning this claim and/or any transactions relating to it. If you have Medisoft Advanced or Medisoft Network Professional, these notes are represented by a note icon in the **Claim Management** window. Double-click the icon to view or edit the note.

F1 Look up Edit Claim.

Printing Claims

Once claims are created, you can print them by clicking **Print/Send**. Indicate whether you are sending the claims on paper or electronically, then apply filters to select only those claims you want to send.

F1 Look up Print/Send Claims.

Troubleshooting Insurance Claims

Claim Form Not Centered

If your insurance claims are printing just a little off center, this can be fixed by entering the Report Designer (**Reports** menu, **Design Custom Reports and Bills**). Open the insurance form you use for printing claims. Go to the **File** menu and select **Report Properties**. In the **Form Offset** area of the window, adjust the form as necessary from the top and/or left margins. The form is moved in increments of one hundredth of an inch. When the form is adjusted, save the form, exit the Report Designer, and reprint your claim.

For more detailed information, go to the Knowledge Base (www.medisoft.com/kb).

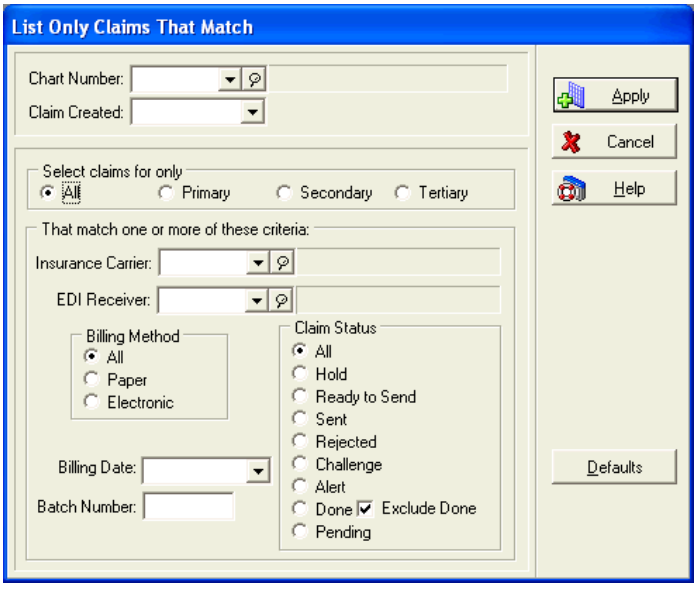
Reprinting Claims

If necessary, you can reprint claims without regard to their status. To reprint an entire batch, the status must be changed for the batch.

F1 Look up Reprinting Claims.

Listing Claims

The **Claim Management** window has a claims viewing feature that lets you retrieve claims that match a set of criteria that you define. Click **List Only**.



In the **List Only Claims that Match** window, use one or more of the options to limit the claims you want to appear in the window.

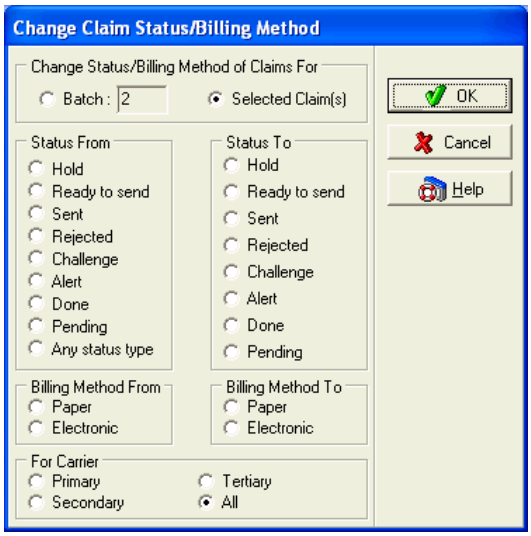
F1 Look up List Only Claims that Match.

Changing Claim Status

In the **Claim Management** window, all submitted claims are automatically marked Sent with an indication of the method of submission. There may be occasions when you need to change this status.

Entire Batch

If the status of an entire batch needs to be changed, you can change all the claims at once. Highlight one of the claims and note the number listed in the **Batch 1** column in the **Claim Management** window. Click **Change Status**. The **Change Claim Status/Billing Method** window is opened.



Choose the **Batch** radio button and enter the batch number from the **Batch 1** column in the **Claim Management** window. Then choose the appropriate radio buttons in the **Status From** and **Status To** sections. All claims with that batch number have the status changed when you click **OK**.

Selecting Multiple Claims

When only one or a few claims within the same batch or claims from multiple batches need a status change, hold down the **CTRL** key and click each claim that needs the

status changed. Note that the selected claims do not need to have the same claim status to begin with, but they are all changed to the same status. Click **Edit**.

In the **Change Claim Status/Billing Method** window, choose the **Selected Claim(s)** radio button, then choose the appropriate radio buttons in the **Status From** and **Status To** sections. If you have chosen claims with varying statuses, choose **Any status type** in the **Status From** section. When finished, click **OK**.

F1 Look up Change Claim Status/Billing Method and Marking Claims.

Sending Claims to a File

The HCFA11 program takes data and puts it in an MS-DOS text file in CMS or HCFA format. The program prints only the Group ID Number in Box 11.

☞ Only the standard CMS or HCFA form can be used with this feature.

Now you can follow the instructions given in your third-party program to access this claim file.

F1 Look up Sending Claims to a File.

Tutorial Practice

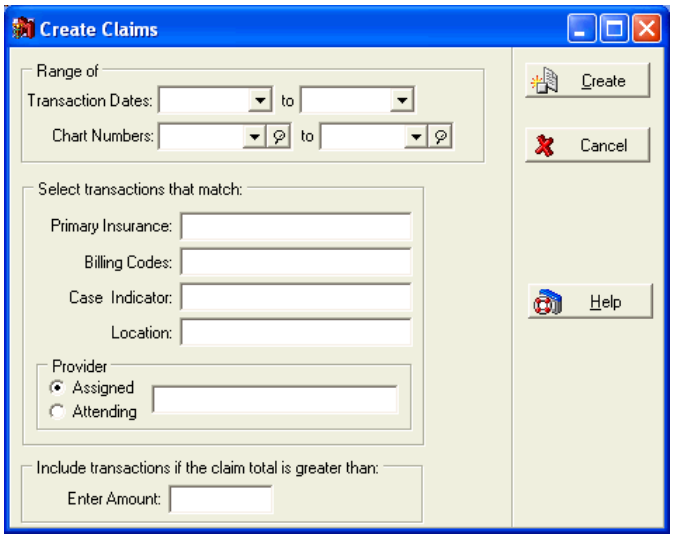
To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided with this program.

Claim Management

To perform any claim management functions, click the Claim Management speed button to open **Claim Management**. Be sure you are using the tutorial database for these exercises.

Creating Claims

Click **Create Claims** in the **Claim Management** window.



Since we created two charge transactions for I.B. Gone in the Transaction Entry portion of this tutorial, let's create the claim for these charges. Click the first **Chart Numbers** range field and type **GON** to set GONI0000 in the first **Chart Numbers** field. Repeat this process in the second **Chart Numbers** field.

Click **Create**. When you return to the **Claim Management** window, change the **Sort By** field to **Chart Number** and type **GON** in the **Search** field. A new claim has been created for GONI0000.

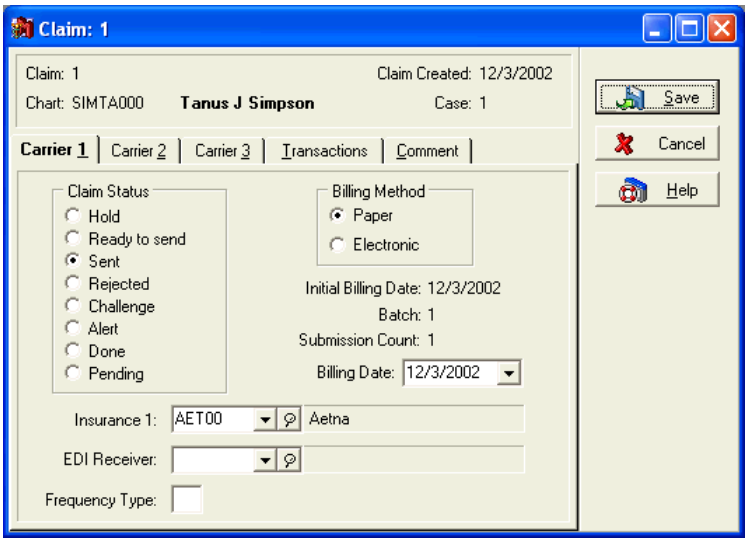
☞ The claim number may not match that shown in figures below.

Editing Claims

To edit the claim, highlight the GONI0000 claim and then click **Edit** or press **F9** to open the **Claim** editing window.

Open the Comment tab. Type the following message: **Notify attorney when claim is paid by primary carrier**. Press **ENTER** and then press **CTRL+T** to enter a date/time stamp.

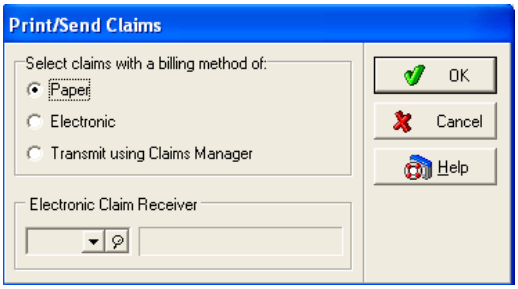
The two transactions we created in **Transaction Entry** are now part of one claim. Suppose you find out that they have to be sent separately (for whatever reason). Open the Transactions tab.



This tab shows that both transactions are included in the selected claim. To split the claim, highlight the second transaction, procedure code 82954, and click **Split**. Click **Yes** to split the claim. The second transaction is removed from the claim. Click **Save**. When **Claim Management** is reopened, a second claim has been created and displays below the original claim.

Sending Claims

Once the claims are ready to go, in the **Claim Management** window, click **Print/Send** to open the **Print/Send Claims** window.



We are dealing only with paper claims in this tutorial, so leave the setting at **Paper** and click **OK**. The **Open Report** window opens so you can select the claim form on which to send the claim. For now, highlight **HCFA-1500 (Primary)** and click **OK**.

The **Print Report Where?** window pops up for you to indicate whether you want to preview the claim before printing or just send the claim directly to the printer. For now, leave the setting on **Preview the report on the screen** and click **Start**.

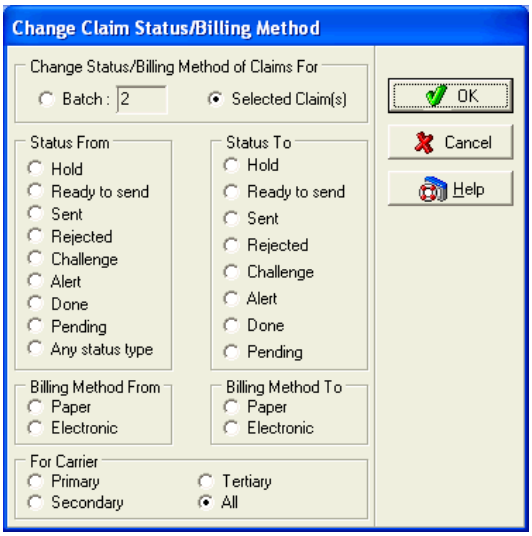
The program assembles the information and then displays the **Data Selection Questions** window. In each of the **Chart Number Range** fields, enter **GON** and press **TAB** to print only Mr. Gone's claims. Click **OK**.

The claim is displayed in the **Preview Report** window. If you have preprinted CMS- or HCFA-1500 claim forms, put a couple in your printer. Click the Print Report speed button. Answer whatever questions you may need in the **Print** window, and then click **OK**.

Click **Close** in the **Preview Report** window. You may briefly see an **Update Billing Status** window and then are returned to **Claim Management** and the claim for Mr. Gone is printed. The claim status has been automatically changed to Sent, a batch number assigned, and the current date entered in the **Bill Date 1** column for both claims.

Changing Claim Status

Through **Claim Management**, all submitted claims are automatically marked **Sent** with an indication of the method of submission. The status needs to be changed when the claim is paid completely or if a claim is rejected or put on hold or pending for some reason. Time has passed since you printed and sent the claims for I.B. Gone and you've received a rejection notice from the carrier. You've already corrected the errors and are ready to resend the claims. To locate Mr. Gone's claims, we'll use a different portion of the program. Click **List Only** and type **GON** in the **Chart Number** field and press **TAB**. Click **Apply**. In **Claim Management**, make note of the batch number and click **Change Status**.



Choose the **Batch** radio button and make sure the batch number in the box matches that shown in **Claim Management**.

☞ Since we used the **List Only Claims that Match** window to locate the claims, the batch number is automatically entered in the **Change Claim Status/Billing Method** window.

In the **Status From** section, choose **Sent**. In the **Status To** section, choose **Ready to Send**. Click **OK**.

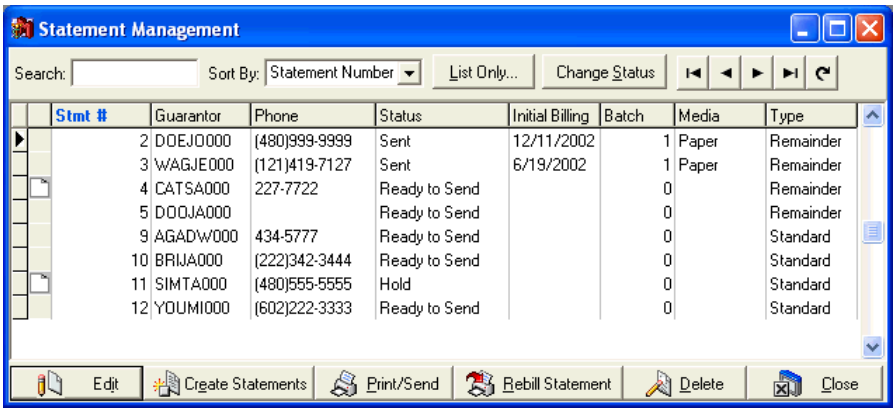
You are now ready to send the claims for I.B. Gone again.

Chapter 8

Statement Management (Advanced and above)

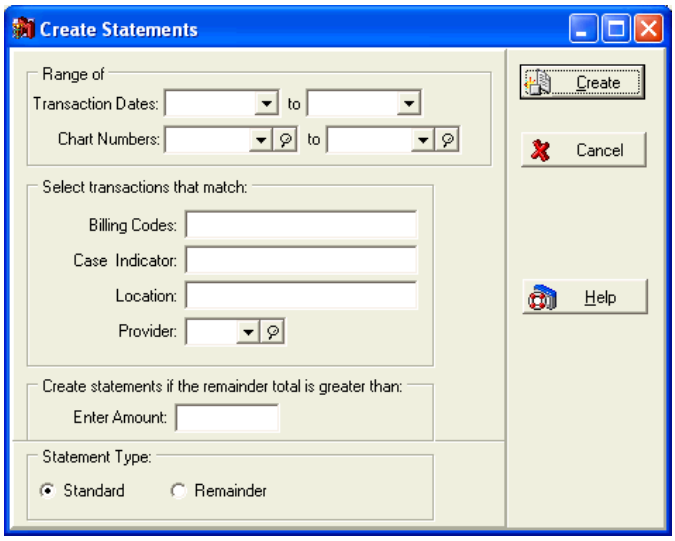
This chapter explains briefly how to manage statements within the **Statement Management** window and includes creating, editing, printing/reprinting, and listing statements, as well as changing statement status.

To perform any statement management functions, go to the **Activities** menu and select **Statement Management** or click the Statement Management speed button.



Creating Statements

Click **Create Statements** to gather available transactions onto a statement.

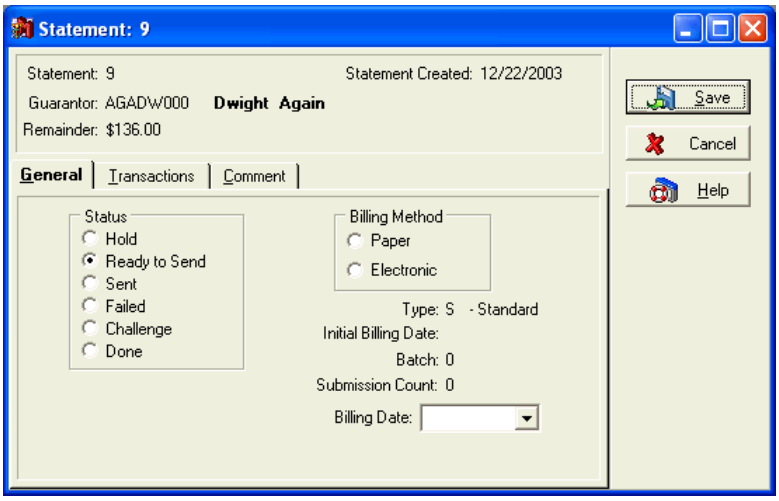


You can create a single statement or an entire batch. Enter ranges of transaction dates and/or chart numbers to control which statements are created. Also, you can further limit the statements created by entering information in the **Select transactions that match**, **Include statements if the remainder total is greater than**, and **Statement Type** areas of the window.

F1 Look up Create Statements.

Editing Statements

Highlight a specific statement and click **Edit** or press **F9** to edit a statement. You can modify general statement information, the transactions that appear on the statement, and any comments attached to the statement. When you make changes in the **Statement** edit window, you modify only that statement and do not affect the defaults for other statements.



The detail also indicates submission method assigned to the statement (paper or electronic), as well as the statement status. Statement status options include: **Hold**, **Ready to send**, **Sent**, **Failed**, **Challenge** or **Done**. You can also see the statement type, initial billing date, batch number, submission count, and most current billing date.

Any time a statement is sent, the program assigns the statement a batch number. That number shows in the **Batch** field. The program also updates the submission count, the number of times the statement has been sent, and the billing date.

The Transactions tab shows all the transactions that appear on the statement. You can split, add to, or remove transactions from statements in this tab. The Comment tab provides an empty box in which to place whatever comments you feel are necessary concerning this statement and/or any transactions relating to it. If you add a note here, an icon is displayed next to the statement in **Statement Management**. You can double-click the note to view or edit the note.

F1 Look up Edit Statement.

Converting Statements

To make it easier to use Statement Management, you can now easily convert old statements into Statement Management statements in the format's report properties. This is done through the **Design Custom Reports and Bills** option in the **Reports Menu**.

F1 Look up Converting a Statement Format to a Statement Management Format.

Printing Statements

Once statements are created, click **Print/Send** to process them. Indicate whether you are sending the statements on paper or electronically. If you are sending statements electronically, specify the format for the statements. Then apply filters to select only those statements you want to send.

F1 Look up Print/Send Statements.

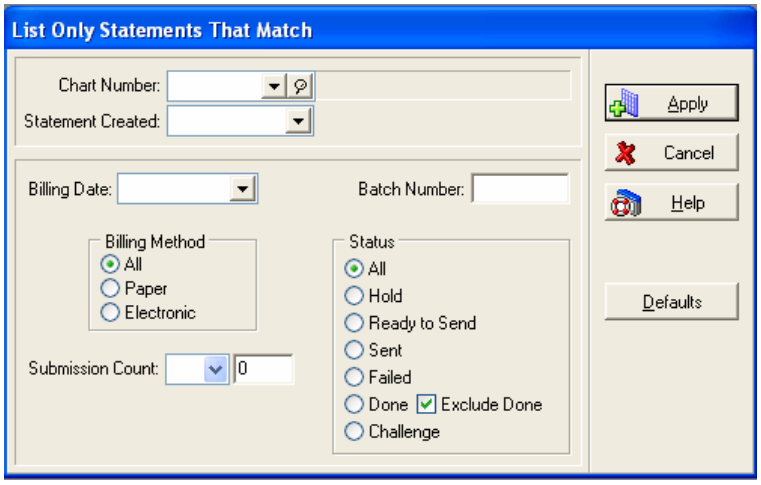
Reprinting Statements

If necessary, you can reprint statements without regard to their status. To reprint an entire batch, the status must be changed for the batch.

F1 Look up Reprinting Statements.

Listing Statements

Click **List Only** to view only those statements that match a set of criteria that you define.



In the **List Only Statements that Match** window, use one or more of the options to limit the statements you want to appear in the window.

F1 Look up List Only Statements that Match.

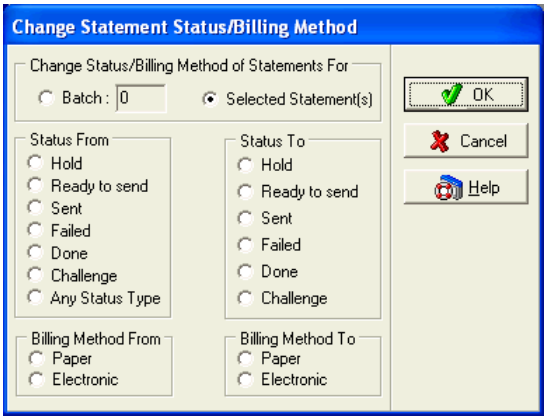
Changing Statement Status

In the **Statement Management** window, all submitted statements are automatically marked **Sent** with an indication of the method of submission. There may be occasions when you need to change this status.

Statements sent electronically through Statements Processing get a report that marks each statement as either accepted or rejected.

Entire Batch

If the status of an entire batch needs to be changed, you can change all the statements at once. Highlight one of the statements and note the number listed in the **Batch** column in the **Statement Management** window. Click **Change Status**. The **Change Statement Status/Billing Method** window is opened.



Choose the **Batch** radio button and enter the batch number from the **Batch** column in the **Statement Management** window. Then choose the appropriate radio buttons in the **Status From** and **Status To** sections. All statements with that batch number have the status changed when you click **OK**.

Selecting Multiple Statements

When only one or a few statements within the same batch or statements from multiple batches need a status change, hold down the **CTRL** key and click each statement that needs the status changed. Note that the selected statements do not need to have the same status to begin with, but they are all changed to the same status. Click **Edit**.

In the **Change Statement Status/Billing Method** window, choose the **Selected Statement(s)** radio button, then choose the appropriate radio buttons in the **Status**

From and **Status To** sections. If you have chosen statements with varying statuses, choose **Any Status Type** in the **Status From** section. When finished, click **OK**.

F1 Look up Change Statement Status/Billing Method and Marking Statements.

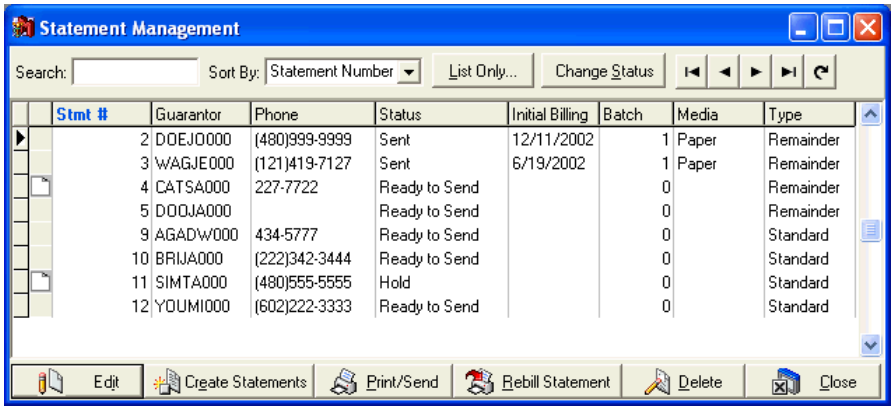
Tutorial Practice

To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided with this program.

Statement Management

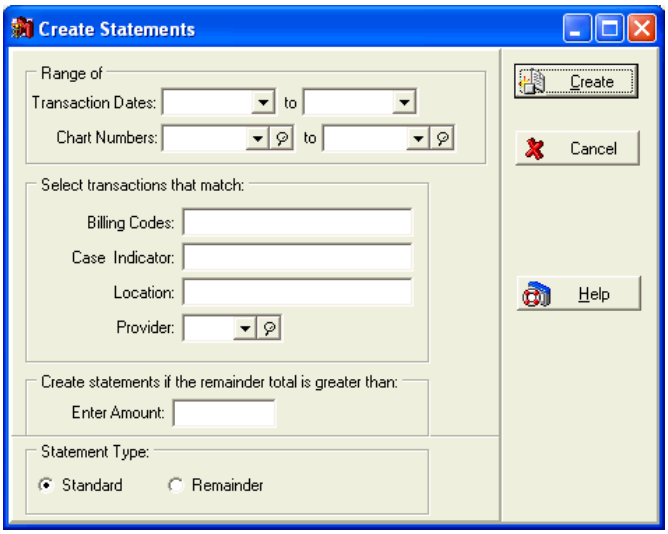
To perform any statement management functions, click the Statement Management speed button to open **Statement Management**.

Be sure you are using the tutorial database for these exercises.



Creating Statements

Click **Create Statements** in the **Statement Management** window to open the **Create Statements** window.



Since we created two charge transactions for I.B. Gone in the Transaction Entry portion of this tutorial, let's create the statement for these charges. Click the first **Chart Numbers** range field and type **GON** to set GONI0000 in the first **Chart Numbers** field. Repeat this process in the second **Chart Numbers** field.

Click **Create**. When you return to the **Statement Management** window, type **GON** in the **Search** field. A new statement has been created for GONI0000. Click **OK**.

☞ The statement number may not match that shown in figures below.

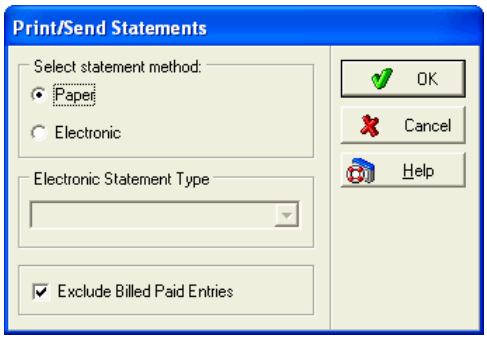
Editing Statements

To edit the statement, highlight the GONI0000 statement and then click **Edit** or press **F9** to open the **Statement** editing window.

Open the Comment tab. Type the following message: **Notify attorney when statement paid**. Press **ENTER** and then press **CTRL** + **T** to set a date/time code. Click **Save**.

Sending Statements

Once the statements are ready to go, in the **Statement Management** window, click **Print/Send** to open the **Print/Send Statements** window.



We are only dealing with paper statements in this tutorial, so leave the setting at **Paper** and click **OK**. The **Open Report** window opens so you can select the statement form on which to send the statement. For now, highlight **NEW Patient Statement (30, 60, 90)** and click **OK**.

The **Print Report Where?** window pops up to indicate whether you want to preview the statement before printing or just send the statement directly to the printer. For now, leave the setting on **Preview** and click **Start**.

The program assembles the information and then displays the **Data Selection Questions** window. In each of the **Chart Number Range** fields, enter **GON** and press **TAB** to print only Mr. Gone's statements. Click **OK**.

The statement is displayed in the **Preview Report** window. Click the Print Report speed button. Answer whatever questions you may need in the **Print** window, and then click **OK**.

Click **Close** in the **Preview Report** window. You may briefly see an **Update Billing Status** window and then are returned to **Statement Management** and the statement for Mr. Gone is printed. The statement status has been automatically changed to **Sent**, a batch number assigned, and the current date entered in the **Bill Date** column for both statements.

Troubleshooting Statement Printing

Patient Remainder Statements (Advanced and above)

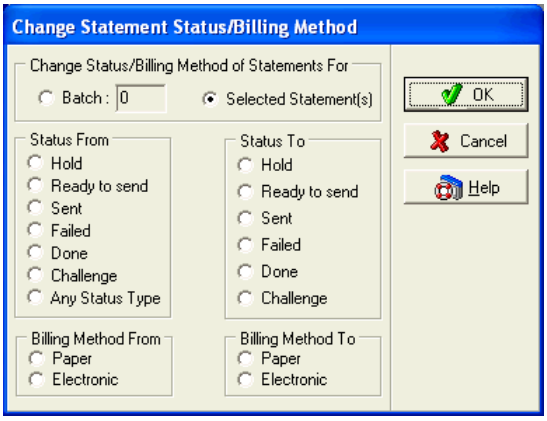
If you are having trouble printing patient remainder statements, check to be sure the following items have been performed:

1. The patient has insurance coverage other than Medicare. This is indicated in the patient **Case** window, Policy 1 tab, **Insurance 1** field (also Policy 2 and Policy 3 tabs if there is secondary and/or tertiary coverage).

2. A charge has been posted in the patient case.
3. A claim has been created.
4. An insurance payment or adjustment has been posted, applied, and marked as Complete to the account for each applicable carrier.

Changing Statement Status

Through **Statement Management**, all submitted statements are automatically marked **Sent** with an indication of the method of submission. The status needs to be changed when the statement is paid completely or for some other reason. Time has passed since you printed and sent the statements for I.B. Gone and you've received a correction notice from the patient. You've already corrected the errors and are ready to resend the statements. To locate Mr. Gone's statements, we'll use a different portion of the program. Click **List Only** and type **GON** in the **Chart Number** field and press **TAB**. Click **Apply**. In **Statement Management**, highlight the statement and click **Change Status**.



Choose the **Batch** radio button and make sure the batch number in the box matches that shown in **Statement Management**.

☞ Since we used the **List Only Statements that Match** window to locate the statements, the batch number is automatically entered in the **Change Statement Status/Billing Method** window.

In the **Status From** section, choose **Sent**. In the **Status To** section, choose **Ready to Send**. Click **OK**.

You are now ready to send the statements for I.B. Gone again.

Click **Close** to close the **Statement Management** window.

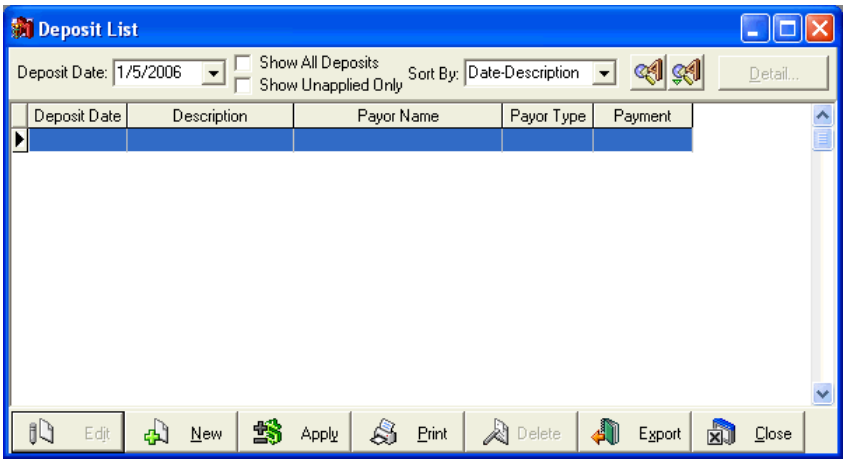
Chapter 9

Deposit/Payment Application (Medisoft Advanced and above)

This feature makes creating a deposit list and applying payments, especially EOB payments from insurance carriers, an easy process. In many ways, it is a more convenient place to apply payments than **Transaction Entry** because you enter one deposit, then distribute the payment to as many cases as necessary, then click one button and all the transactions are created at one time. If necessary, within the same window, open a different patient record and continue distributing payments.

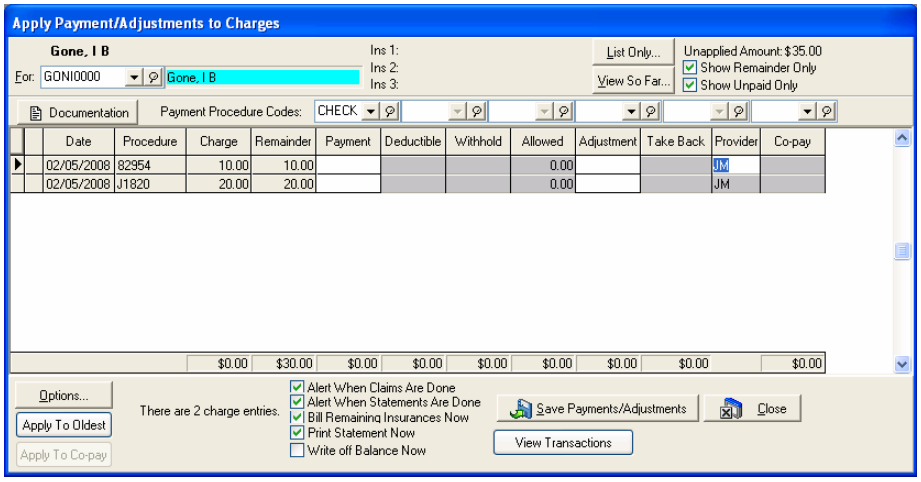
F1 Look up Deposit Entry, Apply Payment/Adjustments to Charges, and Program Options.

Click the Enter Deposit/Payment speed button or go to the **Activities** menu and select **Enter Deposits/Payments** to open the **Deposit List** window.



In this window, you can select a payment to apply, edit a payment, or create a new payment. The deposit date does not have to be the current date (but the transactions entered still appear on the current day's activity reports).

When you highlight a payment and click **Apply**, the **Apply Payment/Adjustments to Charges** window is opened.



In this window, select the patient chart number (if you've chosen an insurance payment) and apply the portion of the payment to the applicable charge(s). When finished, click **Save Payments/Adjustments** to create the transactions.

If you check **Print Statement Now** and click **Save Payments/Adjustments**, you print statements from **Statement Management**.

Then, if you need to apply payments from the same deposit to another patient record, select the next patient chart number and continue making payment applications. This window is also tied to the Payment Application tab of **Program Options**. Unless deactivated, all payment applications are automatically checked as paid in full by the payer, allowed amounts are calculated on all charges, and any charges over the calculated allowed amounts are automatically entered in the **Adjustment** field.

Be sure to click **Save Payments/Adjustments** before closing this window or transactions cannot be created.

The payment application feature is designed specifically to closely match the format of an EOB. When you receive an EOB with a payment from an insurance carrier, open the **Deposit List** window, create the total amount deposit, and then apply the payment to the cases as specified in the EOB.

EOB Payments

Part of the payment structure to a healthcare office from an insurance carrier involves a check and an "Explanation of Benefits." Widely known throughout the industry as the

EOB, it lists claims for which payment is being made and, in some cases, an explanation of what is not being paid and why.

Not every insurance claim that is filed with a carrier is paid in full. It may be that payment is 80 percent of the claim or it may be 50 percent. Other times a claim may be totally or partially disallowed. The EOB explains in these cases. Normally the part that is not paid by the carrier is picked up by a secondary carrier or charged back to the patient.

When an EOB is received, a transaction must be entered to offset the charges. This is done by creating a deposit in the **Deposit List** window. If the EOB check covers several charges, distributing a payment to specific charges can be handled by clicking **Apply**. The window lets you select the patient records and claims to be paid and designate how much goes to each.

F1 Look up EOB Payments/Managed Care/Capitation Payments.

Managed Care

One of the important sources of patients and income in many practices has begun to be managed care organizations. In each instance, the HMO or PPO provides a list of patients who have selected your practice as their primary care provider. Payment is made to your practice on a per-patient basis, regardless of whether the patient ever visits the office. When a patient does come in for treatment, he or she pays a set co-pay amount.

The co-pay is charged only by the primary care facility or the facility to which the patient is referred by the primary care facility. After a patient's visit to the doctor's office, a claim is filed and sent to the carrier. When the EOB is returned, there is seldom a payment included, since payment is made under the capitation program for managed care organizations.

F1 Look up EOB Payments/Managed Care/Capitation Payments.

Capitation Payment

The basis for capitation payments is to provide healthcare for a fixed cost, irrespective of the amount of service required by each individual patient. This is done in connection with the managed healthcare services such as HMOs and PPOs. There is no direct relationship between the capitation payment received by the practice and the number of patients covered by the plan who actually visit the practice for treatment. Capitation payments are not posted to patient accounts but are entered in the **Deposit List** window. If it is necessary to zero out a patient account, create a zero deposit for the carrier. For each patient covered by the capitation payment who has an outstanding balance, zero out the account by entering the remainder in the **Adjustment** field. When

it is applied, the payment shows as zero and the patient's balance shows as a write off in the **Adjustment** field in the **Transaction Entry** window.

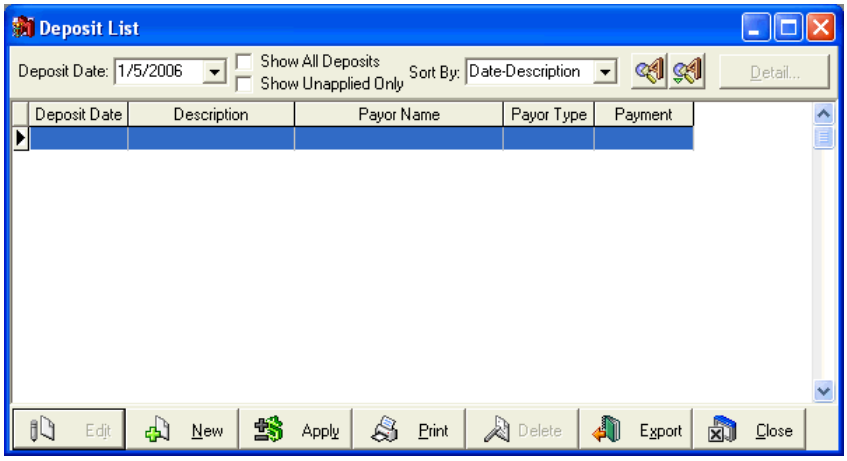
F1 Look up EOB Payments/Managed Care/Capitation Payments.

Tutorial Practice

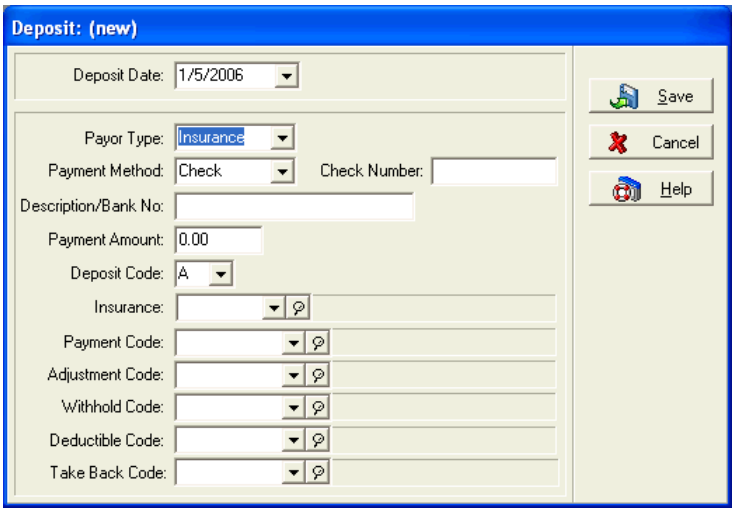
To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided with this program.

Creating a New Deposit

Click the Enter Deposits and Apply Payments speed button.



Click **New**.

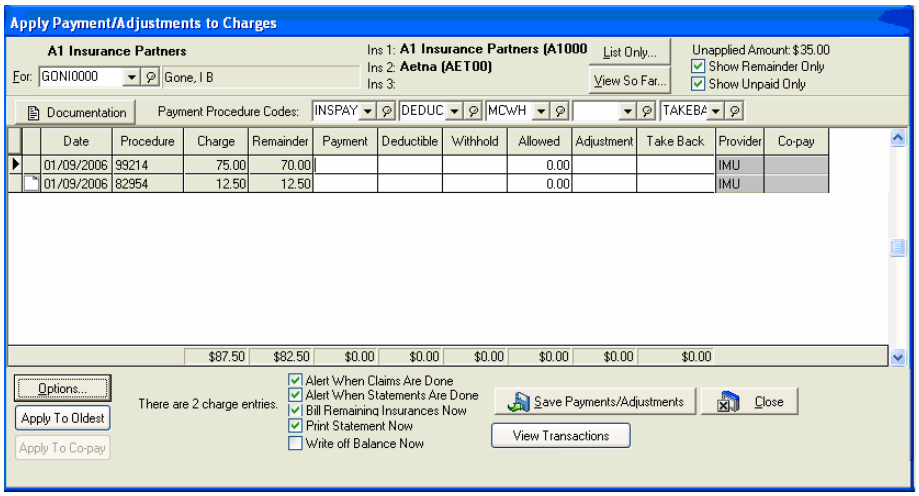


The payer is A1 Insurance Partners, so be sure the **Payor Type** is **Insurance**. A1 Insurance Partners conveniently paid $35 by check No. 5237; enter the check number in the **Check Number** field. The bank is American Southwest Savings. Enter the amount in the **Payment Amount** field.

In the **Insurance** field, select **A1 Insurance Partners**. Since you already set default codes when you set up the record for A1 Insurance Partners, the remaining fields are automatically filled. Click **Save**.

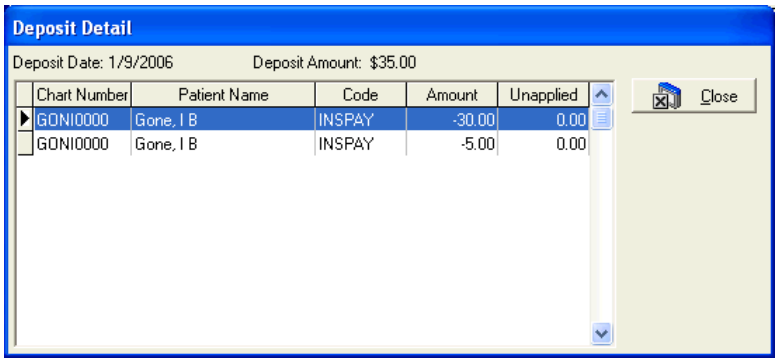
In the **Deposit List** window, be sure this new deposit is selected, and then click **Apply**.

The **Apply Payments/Adjustments to Charges** window is opened. In the **For** field, type **GON** and press **Enter** to call up I.B. Gone's chart number.



Locate the $75 charge, click the **Payment** column of that record, and enter **30**. In the box below (part of the $12.50 charge record), enter **5**. Click **Save Payments. Adjustments** and then **Close**. A message is displayed letting you know that both claims will be marked "Done" for the primary carrier. (This is based on a selection made in **Program Options**.) If the **Print Statement Now** box is checked, the **Open Report** window is opened to select a statement form. Print it if you'd like, or click **Cancel**.

To review what you just did, click **Detail** in the **Deposit List** window.



The **Deposit Detail** window shows which transactions were affected and what was applied. This window is only for reviewing the details of a deposit. You cannot edit any transaction in this window. Click **Close** after reviewing the details.

Click **Close** again to close the **Deposit List** window. If you return to the **Transaction Entry** window, a new entry has been created in the **Payments, Adjustments, And Comments** section—this insurance carrier payment.

Chapter 10

Collections and Revenue Management

Collection List

The collection list is a central place where you can manage accounts that are in collections. Ticklers or collection reminders are displayed as collection list items. Go to the **Activities** menu and select **Collection List**.

Note: Security must be activated before this feature can be used.

What appears in the collection list depends on the user login. The program displays the collection list item for the current user, unless the user has administrative access. Administrators can choose to view all or selected users' collection list items.

To enter items in the collection list, click **New** while in the collection list. Fill in the necessary information.

F1 Look up Collection List.

Add Collection List Items

The option to add collection items through reports is no longer an option. However, you can add collection items with the new **Add Items** option in the Collection List. This feature lets you create tickler items based on criteria you enter in the **Add Collection List Items** window.

F1 Look up Add Collection List Items.

Patient Payment Plans

To help patients make consistent payments on their accounts, create payment plans. You can create as many plans as necessary to accommodate your patients. Go to the **Lists** menu and select **Patient Payment Plan**.

Once you create a plan, open the **Patient/Guarantor** window, Payment Plan tab, and assign the plan to the patient's record. The particulars for the plan appear in fields in this tab.

The program records and tracks the scheduled date for the next payment and the amount to be applied. If the patient follows the payment plan (e.g., the patient pays the

required amount by the required date), this account is not included when you process collection letters. If the patient does not follow the payment plan, the account is included when you process collection letters.

F1 Look up Patient Payment Plan Entry.

Collection Letters

Once you put a patient-responsible account in collections, you can create collection letters to follow up with the patient.

To print collection letters, go to the **Reports** menu, select **Collection Reports**, and then select **Patient Collection Letters**. You must print the Collection Letter Report before you print collection letters.

In the **Data Selection Question** window, click the **Exclude items that follow Payment Plan** check box to activate **Generate Collection Letters** box. Check the **Generate Collection Letters** box.

F1 Look up Collection Letters and Collection Letter Report.

Customizing Collection Letters

Customize the collection letter format through the Collection Letter Wizard. Go to the **Tools** menu and select **Collection Letter Wizard**.

The things you can customize are the name and address, contact phone number, and sender's name. Make your selections and click either **OK** or **Preview**.

Access the new format through the **Custom Report List**. New formats are named WzCollections **date** (using the date on which the format was revised). If you create several new formats in a single day, you can distinguish them by the order in which you created them. Click **Show File Names** to reveal the format file names. This shows the file names (which are mrcol[#], numbered sequentially), type and date and time last modified.

F1 Open the Collection Letter Wizard and then look up Collection Letter Selection.

Revenue

Billing Cycles

The cycle billing feature lets you print statements every certain number of days. If you want to print statements every 30 days, you can set up a billing cycle of that length. First you set up the billing cycle in **Program Options**, Billing tab. Then you process the

statements through **Statement Management**. The other ways of printing statements do not offer this feature.

F1 Look up Cycle Billing.

Claim Rejection Messages

Claim rejection messages let you enter rejection messages from an EOB and print them on patient statements. You connect the message to a transaction in the **Rejection** field when applying deposits from the insurance company. To create claim rejection messages, go to the **Lists** menu and select **Claim Rejection Messages**.

F1 Look up Claim Rejection Message Entry.

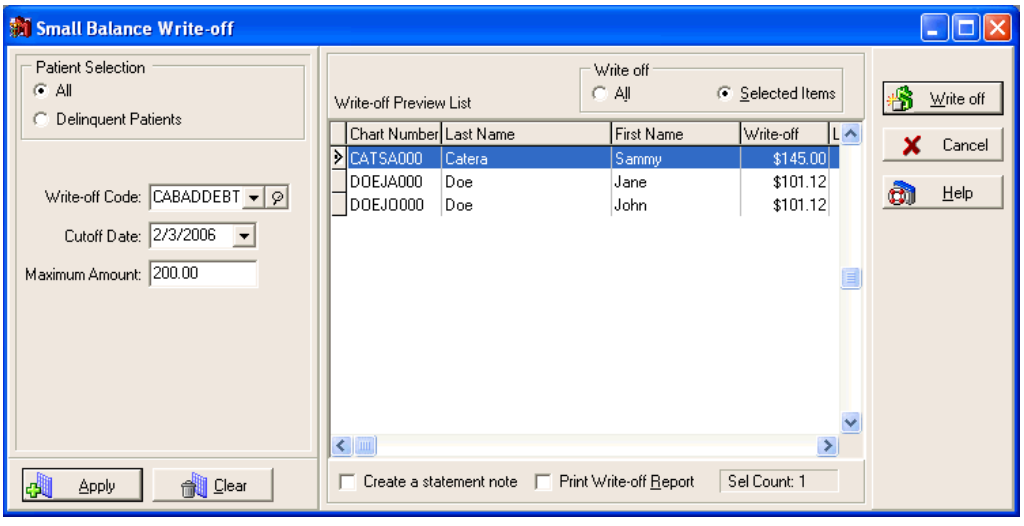
Small Balance Write-off

This feature lets you automatically write off remainder balances of a certain amount. The balance written off is the patient remainder balance. You can write off small remainder balances as a batch in the **Small Balance Write-off** window or for one patient at a time in the **Apply Charges/Adjustments to Payments** window.

F1 Look up Small Balance Write-off Overview.

Writing off a Balance

To access the **Small Balance Write-off** window, select **Small Balance Write-off** from the **Activities** menu.



The window is divided into two sections. In the first section, select criteria for the type of remainder balances you want to write-off and click apply. In the second section, a list of the patients who meet the criteria appears in the **Write-off Preview List**. The default is set to write off all records in the list. You can select individual records to write off by clicking on the record. Multiple records can be selected by pressing the **CTRL** key and clicking the record. Click **Write off** to write off the selected remainder balances.

When the program writes off the remainder balances it updates a number of other features. Write-off entries are created and applied to all patient responsible charges associated with the selected patient. The program also updates the associated **Collection List** items, refreshing balances and marking zero balances as deleted. After a remainder balance write off, statements are changed to the status of **Done** and a note is added to the write-off entries.

F1 Look up Small Balance Write-off.

Tutorial Practice

To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided with this program.

> **Note:** Be sure that you have activated security in your Medisoft program. Collections and Revenue will not work unless you have applied security.

Creating Collection List Items

1. Go to the **Activities** menu and select **Collection List**.
2. Click **New**.
3. In the Tickler tab, enter **Contact Attorney**.
4. Choose the **Patient** radio button.
5. In the **Chart Number** field, start typing **Gone** to call up I B Gone.
6. Choose Mr. Gone also in the **Guarantor** and **Responsible Party** fields.
7. Choose the person to whom you want to assign this tickler. The names you see are those entered in the **Security Setup** window. If no names appear, you must set up Security first. See Chapter 3.
8. Choose **Open** as the status of the item.
9. By default, the follow-up date is today's date. Leave that date for now.
10. Click **Save**.

11. Let's create an insurance-responsible tickler also, so you can see the difference between the two. Click **New**.
12. In the Tickler tab, enter **Call insurance**.
13. Select **Insurance**.
14. In the **Chart Number** field, start typing **Gone** to call up I B Gone. Press **TAB**.
15. Choose Mr. Gone also in the **Guarantor** field.
16. Choose **AI Insurance Partners** in the **Responsible Party** field.
17. Choose the person to whom you want to assign this tickler.
18. Choose **Open** as the status of the item.
19. By default, the follow-up date is today's date. Leave that date for now.
20. Click **Save**.

Adding a Collection List Item

1. Go to the **Activities** menu and select **Add Collection List Item**.
2. Choose the **Claims** radio button.
3. Click the **Primary** radio button in the **Carriers** field.
4. Click the **Rejected** radio button.
5. Select **Aetna** for the first **Insurances** field and **A1 Insurance Partners** in the second **Insurances** field.
6. Enter **2** in the **Add item if submission count is great than** field.
7. Assign the item to **I M Boss.**
8. Check the **Add Billing Comment to Office Notes** check box.
9. Click **Add Items.**
10. Click **No**.

Patient Payment Plans

1. Go to the **Lists** menu and select **Patient Payment Plan**.
2. Click **New**.
3. In the **Code** field, enter **A**.
4. In **Description** enter 15/30 (signifying a plan to pay $15 dollars every 30 days).

5. In **First Payment Due**, enter **5** to have payments due on the 5th of every month.
6. In **Due Every … days** enter **30**.
7. Enter **15** in the **Amount Due** field.
8. Click **Save**.
9. Close the **Patient Payment Plan List** window.
10. Go to the **Lists** menu and select **Patients/Guarantors and Cases**.
11. Find IB Gone's record, highlight it, and click **Edit Patient**.
12. Open the Payment Plan tab.
13. In **Payment Code** select plan **A**.
14. Click **Save**. Click **Close**.

Mr. Gone is now assigned to a payment plan. If he makes payment of the correct amount and in the prescribed time, he will not be receiving collection letters from your practice.

Collection Letters

1. Go to the **Reports** menu and select **Collection Reports**, then **Patient Collection Letters**.
2. Click **Start** in the **Print Report Where?** window.
3. In the **Collection Letter Report: Data Selection Questions** window, skip the range fields and click **Exclude items that follow Payment Plan**.
4. Click **Generate Collection Letters**. This also activates and enables the **Add To Collection Tracer** field. Keep this field clicked. Then click **OK**.
5. Preview the report, and then click **Close** (unless you really want to print it first).
6. When asked if you want to print collection letters, click **Yes**.
7. Select the **Collection Letter** format (or any customized format available) and click **OK**.
8. Click **Start** to preview the letters.
9. Review the letters and print them.
10. When you open an account in **Transaction Entry**, **Quick Ledger**, **Quick Balance**, or an **Appointment** window, the words "Account alert" appear near the patient's name to indicate that the account is in collections.

Customizing Collection Letters

1. Go to the **Tools** menu and select **Collection Letter Wizard**.
2. Choose the **Third-Party Address** radio button. The **Third-Party Billing Information** section opens at the bottom of the window.
3. In the other fields enter **Happy Valley Associates**, **9825 W. Baseline Road, Suite 263**, **Gilbert, AZ 85234**, **480-111-2222**.
4. In **Sender Name** choose **Provider**.
5. Click **Preview**.
6. After previewing the sample letter, click **Create**. A little box appears in the middle of the window stating that the format is being updated. Then a confirmation box displays. Click **OK**. The wizard closes.
7. A new collection letter format has been created. You will see it the next time you create collection letters. It is called WzCollections **date**. For example, if today's date were December 3, 2004 and I customized the format today, the format would be called "WzCollections120304."

   Note: If you create multiple customized versions of the collection letter format, you might want to keep a list somewhere noting the date and a note concerning what was customized.

Writing off Small-Balances

1. Go to the **Activities** menu and select **Small Balance Write-off**.
2. Leave the radio button set to **All** in the **Patient Selection** field.
3. Select **CABADDEBT** in the **Write-off Code** field.
4. Enter **1/12/06** in the **Cutoff Date** field.
5. Enter **150.00** in the Maximum Amount field.
6. Click **Apply**.
7. Select **Selected Items** in the **Write off** field.
8. Hold down **CTRL** and click the patient record for **Sammy Catera** and **James Doogan**.
9. Click **Write off**.
10. Click **Close**.

Chapter 11

Electronic Services

Electronic Claims Processing

Medisoft offers the ability to file electronically. Electronic submission through Electronic Claims Processing is a separate procedure and requires enrollment. To get started with electronic claim submission, contact your local Value-Added Reseller or call Medisoft directly at (800) 689-4550 and request the enrollment package.

Optional direct claims software is available to send claims directly to selected carriers throughout the country. Most of these are set up on a state or regional basis and handle Medicare, Medicaid, Blue Cross/Blue Shield, and often commercial claims. There is a cost for each of these programs, but, in most cases, there is no charge for claims filed. Information on other available EDI modules can be obtained by calling your local Value-Added Reseller or Medisoft directly at (800) 689-4550.

Statement Processing

You can send statements electronically through Statement Processing, the clearinghouse which is set up to process Medisoft electronic statements. Statements sent electronically through Statement Processing get an instant response report that tells what information was sent.

F1 Look up Sending Statements Electronically.

Customizing Statements

Statement Processing lets you choose alternate formats for both paper (Advanced and above) and electronic statements through the Statement Wizard. Go to the **Tools** menu and select **Statement Wizard**.

F1 Look up Statement Selection in the Statement Wizard Help file.

Eligibility Verification

The Eligibility Verification feature lets you check a patient's insurance coverage online. This is a fee-based service for which you must enroll. Contact the Medisoft sales

department at (800) 333-4747 for information on pricing. You must have broadband internet service to make eligibility verification inquiries.

Eligibility Verification Setup

To set up Medisoft for eligibility requests, you must enter information in the **Provider**, **Insurance Carrier**, **Patient**, and **Case** windows. Manage your eligibility enrollment from the Services Menu by selecting **Eligibility Verification** and then selecting **Manage Enrollment**.

F1 Look up Eligibility Verification Overview

■ Provider

Fields in the **Provider** window must be populated for each provider whose patients you are verifying electronically. On the Default Pins tab, enter information in the **Tax ID** field. On the Eligibility tab, enter information in the **Allow Eligibility Verification** and **Eligibility Enrollment IDs** fields.

F1 Look up Provider Entry

■ Insurance Carriers

The **Eligibility Payer** field on the EDI/Eligibility tab must be populated for each insurance company.

F1 Look up Insurance Carrier Entry – EDI/Eligibility Tab

■ Patients

Fields in the **Patient / Guarantor** window must be populated for each patient. On the Name, Address tab, enter information in the following fields: **Last Name**, **First Name**, **Date of Birth**, **Gender**, and **Social Security Number**. On the Other Information tab, enter information in the **Assigned Provider** field.

F1 Look up Patient/Guarantor Entry

■ Cases

Fields in the **Case** window must be populated for each patient. On the Policy 1, Policy 2, and Policy 3 tabs, enter information in the following fields: **Insurance**, **Policy Holder**, **Relationship to Insured**, and **Policy Number**. On the Account tab, enter information in the **Assigned Provider** field.

F1 Look up Case Entry.

Eligibility Verification Results

The **Eligibility Verification Results** screen is where you perform many eligibility verification activities. Go to the **Activities** menu and select **Eligibility Verification**. From the speed menu, select **View Results**. The **Eligibility Verification Results** window opens. Records only appear in the Eligibility Verification Results window after you have made an eligibility verification inquiry. You can redo an eligibility inquiry at any time by highlighting the inquiry and clicking **Verify**.

F1 Look up Eligibility Verification Results.

Chapter 12

Reports

Printing Reports

Reports are generated through the **Reports** menu. In Medisoft, you can view or preview a report before printing or exporting it. For example, you could preview a Patient Aging report before printing it to make sure that you have selected the most appropriate data criteria. Or users could conduct a search for certain details before printing. After previewing users can export or print the report.

F1 Look up Reports and Printing Reports.

Available Reports

Not only does the program build an accounts receivable file and handle statements, insurance claims, and electronic billing, it also provides a variety of reports that can give you a better understanding of the day-to-day workings of your practice.

Among the reports generated within the program are Day Sheets, Analysis Reports, Aging Reports, Productivity Reports (Advanced and above), Activity Reports (Advanced and above), Audit Reports (Advanced and above), Patient Ledger Report, and Guarantor Quick Balance List (Network Professional only).

You can print a title page that shows all the filters used in preparing the report.

F1 Look up Program Options.

Day Sheets

Day Sheets are available in three reports. The Patient Day Sheet lists each patient's name, showing all transactions and a summary of activities for the day. The Procedure Day Sheet breaks down by procedure code the activities of the day, summarizing patients treated for each procedure. The Payment Day Sheet shows the payments made on the requested day and the charges to which the payments are applied.

F1 Look up Patient Day Sheet, Procedure Day Sheet, and Payment Day Sheet.

Analysis Reports

■ Billing/Payment Status Report (Advanced and above)

One of the most powerful tools in Medisoft, the Billing/Payment Status Report provides a thumbnail sketch of the current billing and payment status of each claim. The report shows what has been billed and not billed, what is delayed for some reason, if the carrier is not responsible or has refused the claim, or if the claim is paid in full. An asterisk (*) next to an amount indicates that entity has paid all it is going to pay and the balance, if any, should go to the next responsible payer.

F1 Look up Billing/Payment Status Report.

■ Insurance Payment Comparison (Network Professional only)

The Insurance Payment Comparison report compares the payment records of all carriers in the practice.

F1 Look up Insurance Payment Comparison.

■ Practice Analysis

This report summarizes the activity of a specified period (e.g., a month), listing each procedure performed, the number of times it was performed, and the total dollar amount generated by each procedure. It shows the average charge, includes any costs involved with that procedure, and calculates the net monetary effect on the practice's income.

F1 Look up Practice Analysis.

■ Insurance Analysis (Advanced and above)

This report summarizes all claims filed by category (Primary, Secondary, and Tertiary). Claims totals are shown for charges and insurance payments in both dollar amount and percentage.

F1 Look up Insurance Analysis.

■ Referring Provider Report (Advanced and above)

It is good to keep track of the source of your patients. The Referring Provider Report shows which patients were referred by other practices and the percentage each referral contributes to the overall referred income of the practice, as of the date of that report. The report also includes the UPIN of the referring provider. By blanking out the **Referring Provider** range in the **Data Selection Questions** window, a report can be generated showing what percentage of the entire practice has been referred.

F1 Look up Referring Provider Report.

■ Referral Source Report (Advanced and above)

This is another report for tracking the source of patients who come to the practice. For the report to work, however, all referral sources must be entered in the Address Book. A source can be an attorney, a hospital, friends, other patients, or even the Yellow Pages. Most new patient application forms include the inquiry "How did you hear about us?" The Referral Source Report assembles the patient list by source (other than provider) and shows how much revenue comes from each source, allowing the practice to identify those sources that send profitable referrals and/or limit those that are costly or nonproductive.

F1 Look up Referral Source Report.

■ Facility Report (Network Professional only)

This report tracks patients who are seen at different facilities. Like referral sources, all the facilities records are created in the **Address List** window. The Facility Report assembles the patient list by facility and shows how much revenue comes from each facility, helping you identify which generates the most money.

F1 Look up Facility Report.

■ Unapplied Payment/Adjustment Report (Advanced and above)

This report shows any payment or adjustment that has an unapplied amount and where the transaction can be found.

F1 Look up Unapplied Payment/Adjustment Report.

■ Unapplied Deposit Report (Advanced and above)

The Unapplied Deposit Report shows all deposits that have an unapplied amount.

F1 Look up Unapplied Deposit Report.

■ Co-Payment Report (Advanced and above)

The Co-Payment Report shows all patients who have co-payment transactions. It shows the amount of the required co-payment, how much was applied, and what was left unapplied. If a patient does not have any co-payment transactions, he or she is not included in the report.

F1 Look up Co-Payment Report.

■ Outstanding Co-Payment Report (Advanced and above)

This topic is for Medisoft Advanced and Network Professional programs.

This report shows all patients who have outstanding co-payment transactions. The report shows the Co-payment amount expected, the actual amount paid, and the amount due. If a patient has no outstanding co-payment transactions, he or she is not included in the report.

F1 Look up Outstanding Co-Payment Report.

■ Global Coverage Report

The Global Coverage Report displays the patients who fall under global coverage during a certain time frame. The report detail includes information on the patients, the date the coverage expires, and the total that would have been billed if global coverage did not apply. For more information on using and implementing the Global Coverage feature:

F1 Look up Global Coverage Overview.

F1 Look up Global Coverage Report.

Aging Reports

■ Patient Aging

One of the important tools in collections is the patient aging report. This can be printed showing the age of each unpaid transaction for patients. Default aging criteria is based upon the number of days between the creation of the transaction or claim and the date of the report you are generating. The columns break down the amounts due that are 30, 60, and 90+ days old. Aging is from actual date of the transaction, so it reflects the true age of the account. The aging criteria and columns can be altered in **Program Options**. This report includes all unapplied amounts in the totals. The Date filter has been removed as it would return invalid values.

F1 Look up Patient Aging.

■ Patient Remainder Aging (Network Professional only)

This report has the same format as the Patient Aging, but there is a key difference in how it works. A charge does not show up on Patient Remainder Aging until all insurance responsibility has been marked complete.

F1 Look up Patient Remainder Aging Report.

■ Patient Remainder Aging Detail (Network Professional only)

This report has the same criteria as Patient Remainder Aging Detail; however, it also lists each insurance company on the patient's account and the date the insurance payment was marked complete.

F1 Look up Patient Remainder Aging Detail.

■ Patient Aging Applied Payment

This report differs from the Patient Aging Report in that it contains only applied amounts in the totals and it has a Date filter. In earlier Version 9 releases, this report was called the Patient Aging Report but has now been renamed Patient Aging Applied Payment Report.

F1 Look up Patient Aging Applied Payment Report.

■ Insurance Aging

These reports (Primary, Secondary, and Tertiary) tracks aging of claims filed with insurance carriers.

F1 Look up Insurance Aging.

Production Reports (Network Professional only)

■ Production by Provider, Procedure, and Insurance

These reports give incoming revenue information for each provider, procedure, or insurance carrier, respectively.

F1 Look up Production by... Reports.

Activity Reports (Network Professional only)

■ Daily/Monthly Activity Report

This report presents financial activity based on the date range selected. The report displays the total number and the total amounts of the charges, payments, and adjustments entered during a date range. The report also details the net effect of the financial information entered on the Accounts Receivable balance for the day/month.

■ Activity Summary by Provider, Procedure, and Insurance

Activity reports break down financial activity by day or month. The summary reports summarize financial information entered for each provider, procedure, or insurance carrier, respectively.

F1 Look up Activity Reports.

Collection Reports (Advanced and above)

■ Patient Collection Report

The Patient Collection Report contains information based on statements marked **Sent** in the **Statement Management** window, showing what has not been paid, statement date, etc.

F1 Look up Patient Collection Report.

■ Insurance Collection Reports

The Insurance Collection Reports are identical in layout, but each reflects the selected insurance level—primary, secondary, or tertiary. This report also shows the claim data, what amount is outstanding, etc.

F1 Look up Insurance Collection Report.

■ Patient Collection Letters

The Collection Letter Report is printed in preparation of collection letters. It contains information from the collection list and is used to help evaluate collections. To access this report, go to the **Reports** menu, select **Collection Reports**, and then **Patient Collection Letters**.

F1 Look up Collection Letter Report.

■ Collection Tracer Report

The Collection Tracer Report reports how many collection letters have been sent and when. Each time collection letters are printed, the program, by default, keeps track of each letter sent.

F1 Look up Collection Tracer Report.

Audit Reports

■ Audit Generator

The Audit Generator helps create a Data Audit Report that contains only the information you want included in the report. The tables available in the Audit Generator are governed by choices made in the Audit tab of the **Program Options** window and whether a table has been edited. You choose which tables, fields, users, and activities are included in the template. This report is intended as a protection for the practice to keep track of changes made and, if desired, by whom.

Some PHI (personal health information) will be included in the Data Audit Report no matter what selections are made or excluded in the **Program Options** window or the Audit Generator.

Note: This report does not support printing a report title page even if the **Print Report Title Page** option was set in the **Program Options** window.

F1 Look up Audit Generator.

■ Login/Logout Report

This report tracks user login/logout activity in the program.

F1 Look up Login/Logout Report.

■ Security Permissions Report (Advanced and above)

This report lists permissions by security level, and shows which users are assigned to which level.

F1 Look up Security Permissions Report.

■ Productivity by User (Network Professional only)

This report tracks user activity in the program.

F1 Look up Productivity by User Report.

Patient Ledger

This report reflects the account status of each patient. Charges are shown until a payment is entered to remove a specific procedure paid. You may include all patient accounts or select a few. The patient ledger is similar to a ledger card in a manual accounting program. Since the Medisoft program is a true Open Item Accounting program, it can show all or part of the financial activity for a patient, including the current balance and what procedures have not been paid. Past activity in the account

includes a listing of all transactions, indicating those that have been paid. The report marks those transactions that have been paid and the amounts.

F1 Look up Patient Ledger.

Guarantor Quick Balance List (Network Professional only)

This report lists the guarantor quick balances that appear in the Quick Balance feature. These balances are the guarantor remainder balances, so if there are charges that the insurance company has not paid on yet, then they are not reflected in this report.

F1 Look up Guarantor Quick Balance List.

Standard Patient Lists

The Patient by Diagnosis, Patient by Procedure, and Patient by Insurance Claim reports provides users a means to sort data in meaningful chunks for analysis and reporting purposes.

F1 Look up Patient by Diagnosis Report.

F1 Look up Patient by Procedure Report.

F1 Look up Patient by Insurance Claim Report.

Claims Manager Reports

The purpose of the Transmission History report is to give the user an idea of when transmissions occurred between Medisoft and Claims Manager. This report will help users troubleshoot integration issues between Claims Manager and Medisoft.

The purpose of the Process Change Results Report is to show what information was updated in Medisoft after you made changes to claims in Claims Manager. This report is broken down into two levels: Log and Detail.

F1 Look up Transmission History Report or Process Change Results Report.

Custom Report List

Design capabilities in the program let you generate a variety of custom reports to meet the needs of your practice. To access the customized reports, go to the **Reports** menu and select **Custom Report List**. When you create a customized report, it is included in the Custom Report List.

There are numerous reports already formatted that are included in the program and can be accessed. These include: Address List, Billing Code List, Birthday Card, Birthday Labels, Claim List, Diagnosis Code List, EDI Receiver List, HCFA-1500 Forms,

Insurance Carrier List, Insurance Payment Tracer (Claim Mgmt), Laser HCFA-1500 forms, Patient Birthday List, Patient Face Sheet, Patient List, Patient Recall Labels, Patient Recall List, Patient Statements, Pre-Printed Statement, Primary Claim Detail, Primary Claim Labels, Primary Claim Summary, Procedure Code List, Provider/Staff List, Referring Provider List, Remainder Statements, Remainder Statement Troubleshooter Report, Sample Statement with Image, Sample Statement with Logo, Secondary Claim Labels, Security Permissions Grid, Superbill, Tertiary Claim Labels, Transaction List, Unbilled Transactions, and Walkout Receipts.

In Medisoft Advanced and Medisoft Network Professional, there are two statement types: Statement and Statement Management. If you are modifying a statement, make sure you are modifying one with the correct type. You can only print Statement report formats from the **Reports** menu and Statement Management report formats from **Statement Management**

F1 Look up Modifying an Existing Report.

Load Saved Reports

This option allows you to reopen reports that were prepared earlier and have been saved.

F1 Look up Load Saved Reports.

Add/Copy User Reports

This option allows you to share reports by adding reports to your database that may have been prepared by another practice or copying reports to disk for use by another practice or for disk storage. Go to the **Tools** menu and select **Add/Copy User Reports**.

F1 Look up Add Reports and Copy Selected Reports To.

Receive/Send Reports Through Medisoft Terminal

Within Medisoft, the Medisoft Terminal option can be used to send or receive reports by connecting to various bulletin boards using a modem. The BBS (Bulletin Board Service) is set up through Medisoft Terminal. See Appendix F, Medisoft Terminal, page 175.

F1 Look up Medisoft Terminal.

Report Procedures

Printing a Report

To print a report, complete the following steps:

1. On the **Reports** menu select the report to be run. The **Data Selection Questions** window opens.
2. On the **Data Selection Questions** window enter and select appropriate criteria.
3. If needed, select the **Print Setup** button to select another printer other than the system default.
4. Click the **Print** button.

Exporting a Report

In Medisoft, you are able to export a report into another format. For example, you could export a Patient Aging report to an Excel spreadsheet. To export a report, complete the following steps:

1. On the **Reports** menu select the report to be exported. The **Data Selection Questions** window opens.
2. On the **Data Selection Questions** window enter and select the appropriate criteria and click the **Export** button. The **Export** window appears.
3. On the **Export** window select a file format for exporting and a destination. Click **OK**. The **Export Options** window appears.
4. On the **Export Options** window select an appropriate page range and enter criteria if needed. Click the **OK** button. The **Choose export file** window appears.
5. On the **Choose** export file window confirm file name and destination or make needed changes and click **the** Save button. The report is exported.

Previewing a Report

In Medisoft, you can view or preview a report before printing or exporting it. For example, you could preview a Patient Aging report before printing it to make sure that you have selected the most appropriate data criteria. After previewing users can export or print the report.

1. On the **Reports** menu select the report to be run. The Da**ta Selection Questions** window opens.
2. On the **Data Selection Questions** window enter and select appropriate criteria.
3. Click the **Preview** button. The **Report** appears in the **Report Preview** window.
4. The **Report Preview** window displays the contents of the report most recently generated from the **Data Selection Questions** window. Use the controls in the **Report Preview** window to view or search for details. Controls include:

- **Print** - Used to print the report on the default system printer using the user specified criteria.
- **Export** - Used to export reports in various file formats including MS Word, MS Excel, or PDF.
- **Refresh** - Used to refresh page so that the most current information is displayed.

- **Toggle Group Tree** - Used to change the display space of the window and move to a specific element in a displayed report such as a chart number, insurance, etc.
- **Zoom** - Used to increase or decrease the viewing size of the report.
- **Navigate** - Used to navigate or browse through the various pages of a multi-page report and features jumping to the first or last page, moving to the previous or next page, or specifying a particular page to view.
- **Stop Loading** - Used to stop a report from loading.
- **Search Text** - Used to perform a case-insensitive text search within the report currently being viewed.
- **Help** - Used to open the access the Help file.

Searching for a Specific Detail in a Report

Once you have generated a report, you can use the Search tool to find specific information in the report. To search for data, complete the following steps:

1. On the **Reports** menu select the report to be run. The **Data Selection Questions** window opens.
2. On the **Data Selection Questions** window enter and select appropriate criteria.
3. Click the **Preview** button. The **Report** appears in the **Report Preview** window.
4. On the **Report Preview** window click the **Search** Text button. The **Search** window appears.
5. On the **Find What** field enter the appropriate search criteria and click the **Find Next** button. The search executes.

Chapter 13

Medisoft Report Designer

Report Designer

One of the most exciting features of Medisoft is the Report Designer, adding flexibility in the creation of reports to best serve your practice or business needs. Using the Report Designer and the existing set of reports, you can generate custom reports tailored to meet specific needs.

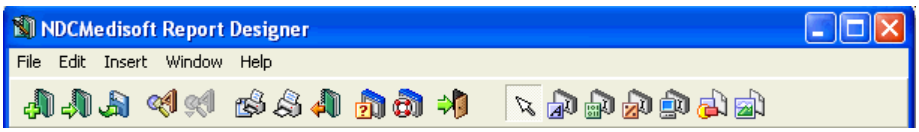
Report forms in this section are categorized into several "styles." Each style defines basic report characteristics, i.e., List, Label, Ledger, Walkout Receipt, Insurance Form, Statement, and Statement Management.

To create custom reports, go to the **Reports** menu and select **Design Custom Reports and Bills**.

F1 Look up Report Designer and Format/Design Reports.

Report Designer Menu Bar

The Menu bar for the Report Designer is very similar to the Menu bar of Medisoft.



It lists **File**, **Edit**, **Insert**, **Window**, and **Help** menus.

The **File** menu is where most of the functions begin. The **Edit** menu features the usual **Cut**, **Copy**, **Paste**, and **Delete** options, plus **Find Field** and **Find Again**.

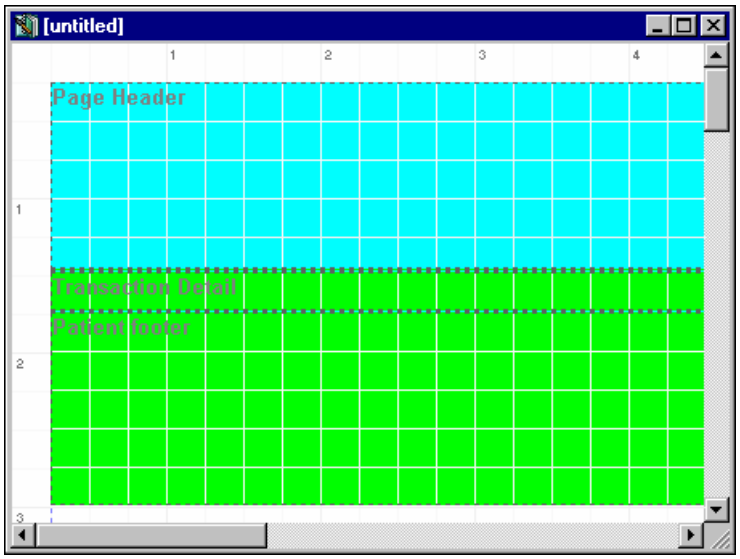
The **Insert** menu contains a variety of the field types that can be used to create your report. The field types are **Text Field**, **Data Field**, **Calculated Field**, **System Data**, **Shapes**, and **Images**). The field types are also conveniently placed as speed buttons on the right side of the toolbar, giving quick and easy access.

Toolbar

Besides the New, Open, Save, Preview, Print, and Exit speed buttons, there are Find and Find Again buttons, as well as a Hints button that lets you toggle on or off the Help that appears throughout the program. On the right side of the toolbar are the field type speed buttons.

The Format Grid

For illustration purposes, go to the **File** menu and select **New Report**. Click **Next**. Choose **Patient** and click **Next**. Click **Create**. The format grid, which is the basis for the layout of the report (excluding insurance and statement forms), generally contains three "bands" to help in its organization.



The Page Header band is where basic identifying information should be placed, such as the report title, page number and date. Header information appears at the top of every page printed.

The Transaction Detail band, or the body of a report, contains the main information of the report and differs from page to page.

The Patient Footer band contains those fields that typically appear at the bottom of the every report. For example, in a patient list, you might expect to see a page number, a date, or maybe the total number of records.

F1 Look up Report Properties-Bands Tab.

Report Properties

One of the creative features of the Report Designer is the ability to break up the report into sections or bands. Go to the **File** menu and select **Report Properties**. You can adjust band height, set data filters and determine the overall general size and margin settings. You can also enter the title, paper size, orientation, and position. One important feature is **Form Offset**. This permits the form to be adjusted even fractions of an inch so it fits exactly the prescribed form. You can also affect the order in which the documents are printed by using the **Sort By** feature.

F1 Look up Report Properties.

Field Properties

Standard Properties

Each field type has the following options:

Alignment: Options are Left, Center, or Right, which align the box to report margins. There is also an option to Align to Band. Used in conjunction with one of the other alignment designations, it applies the alignment to the **height of the band**.

Size: You can specify in the **Properties** window an exact height and/or width in increments of pixels (which are the smallest graphic unit that can be displayed on your screen).

Matching Alignment and Size: You can match the size or alignment of any field or group of fields to another.

Position: Specify an exact position on the page in relation to the top and left edges of the report, again in increments of pixels.

Transparent Background: This option eliminates the white area around data in the various fields when the report is printed, showing the data directly over any background color.

Font: One of the variations you can introduce is changing the font. As you go through the font list in the **Font** window, a sample of how a highlighted type face looks is shown in the sample box.

Background Color: You can change the background color for each field. These colors are printed with the report if you have a color printer.

Handles: When a field is selected, it displays black handles. The handles allow the field to be resized, shaped and moved by dragging the handles with the mouse.

Multiple Fields: If you hold down the **SHIFT** key and click on any field speed button, you can drop multiple fields by placing your pointer on the format grid and clicking.

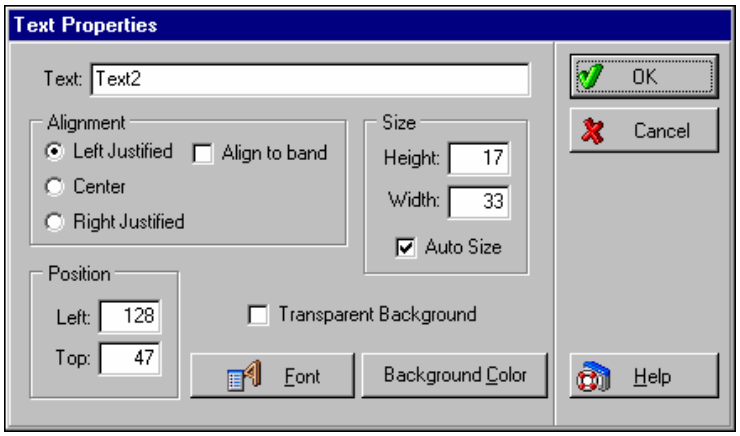
Use the arrow key on the toolbar to release the multiple lock or click on another speed button. You can also use the **SHIFT** key to select multiple fields to size or align all at once.

Other: You have the choice to show the ruler, snap to the grid or designate the grid size. "Snap to the grid" means the field adheres to the grid lines and does not float when you click it.

F1 Look up Format/Design Reports.

Text Field Properties

 A Text field is used to enter static text, or text that you want to print the same way every time, such as the word "Signature" next to a blank line. A Text field does not retrieve stored information from program database files. It prints on the form in the position you specify, and what you type is what prints. This is contrasted with the Data field, which pulls data from your program data files.



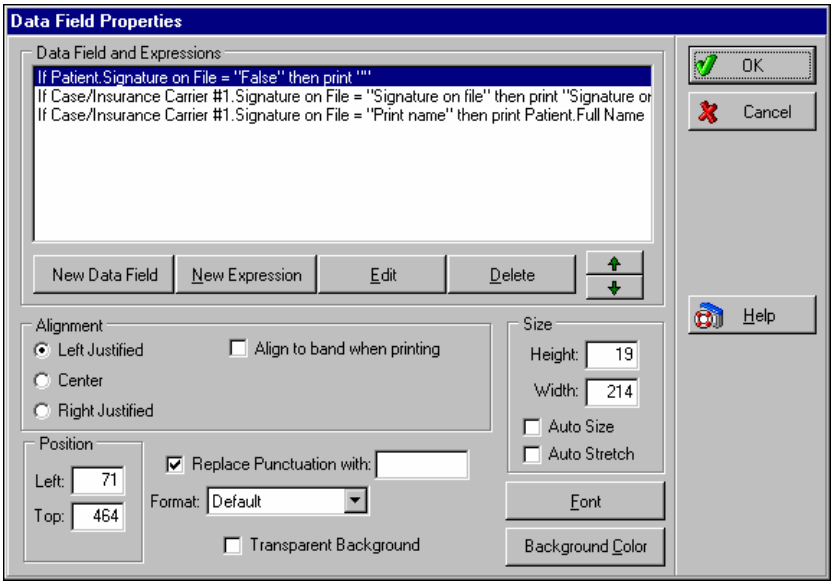
Insert a Text field by clicking the **Text** speed button on the toolbar, then clicking the report grid. A field labeled "Text1" is displayed and each time you add a text field, the number advances — Text2, Text3, etc.

F1 Look up Text Field Properties.

Data Field Properties

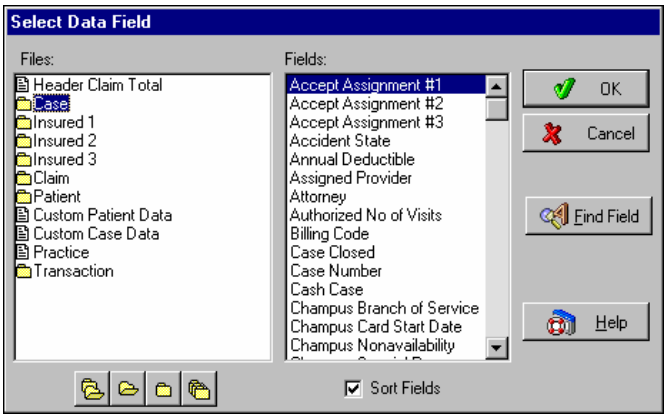
 A Data field allows complete control in retrieving data from your program data files (Case, Insured, Claim, etc.) through the use of expressions.

Click the Data Field button on the toolbar and then click on the grid to place a Data field on the form. To set the properties of the field, double-click on the field (or right-click and select **Properties**). The **Data Field Properties** window appears.

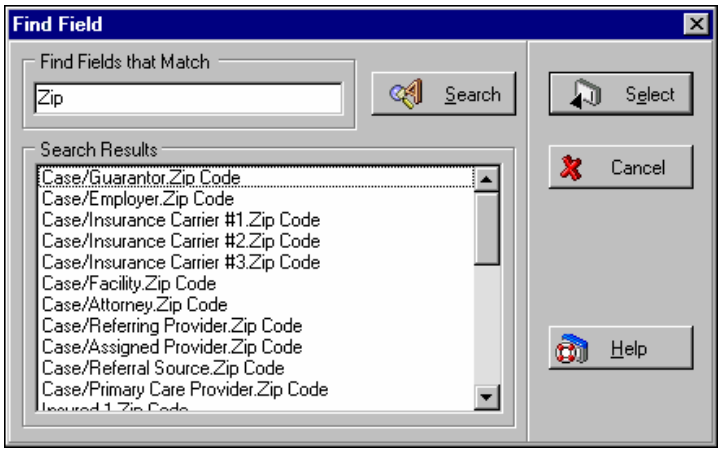


The **Data Field Properties** window lists any expressions that have already been created.

To create an expression, click **New Data Field**, select a field from the list and click **Save** or press **F3**.



If you do not see the field you want, either scroll through the **Fields** list box or click **Find Field**. The **Find Field** window is displayed.



In the **Find Fields that Match** area, type a word or two of description and you usually get a list in **Search Results** to select the field you want.

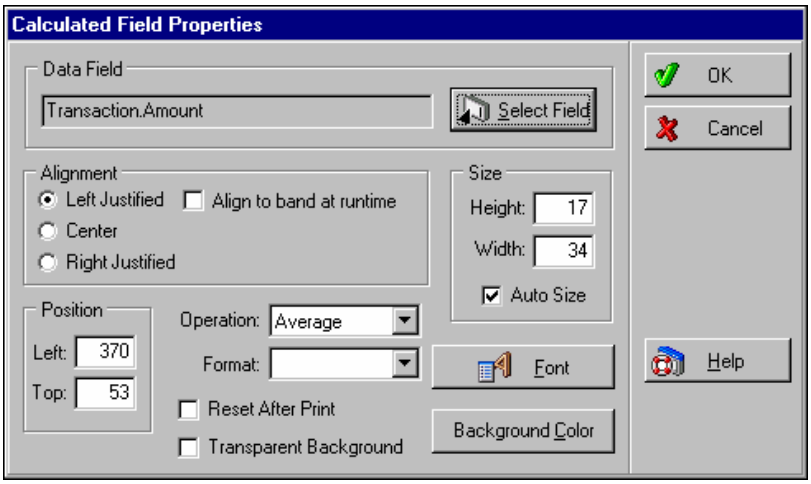
F1 Look up Data Field Properties and Find Field.

Calculated Field Properties

A Calculated field works with the same files and data selections as a Data field, but also lets you specify financial operations, how the numbers are formatted, and whether the layout bands are reset at the time of printing.

☞ This field type has no effect on statements, which present a special situation.

Data entered in a Calculated field can generate the transaction and calculates costs and charges. The **Calculated Field Properties** window has three fields for financial accounting.

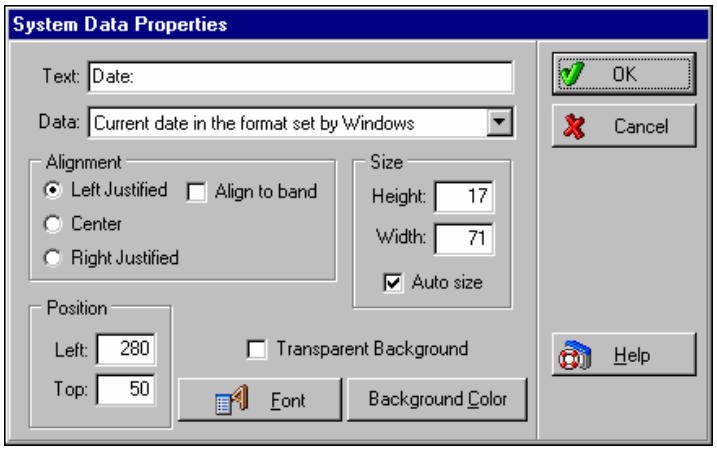


The **Calculated** field permits averaging, count, maximum, minimum, and sum functions. There are numerous options for the **Format** field. The **Reset After Print** field can be used to reset the calculations after printing. This resets the field to zero.

F1 Look up Calculated Field Properties.

System Data Field Properties

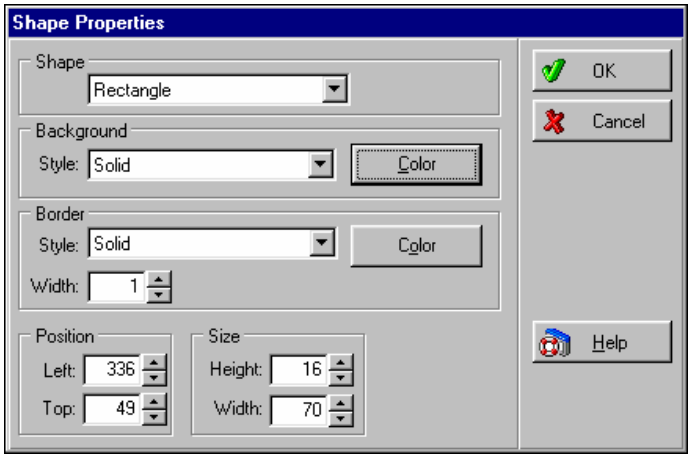
A System Data field lets you insert data into your report that is tracked by your computer system, such as the date or current page number. Data possibilities, such as **Total number of Records to be Printed on Report**, **Current date in the format set by Windows**, **Current Page Number,** and **Report Title**, among others, make System fields an invaluable asset to creating that "finishing touch" to a report.



F1 Look up System Data Properties.

Shape Field Properties

The Shapes feature lets you add color, shapes, different background styles, and borders with inserted text. Shapes and colors can add greatly to the appearance of reports and creative possibilities are almost limitless. In the Shapes category, you can choose from rectangle, circle, horizontal line, vertical line, right and left lines, and top and bottom lines. Backgrounds can be solid, cross, diagonal cross, backward diagonal lines, horizontal lines, forward diagonal lines, vertical lines, and clear.



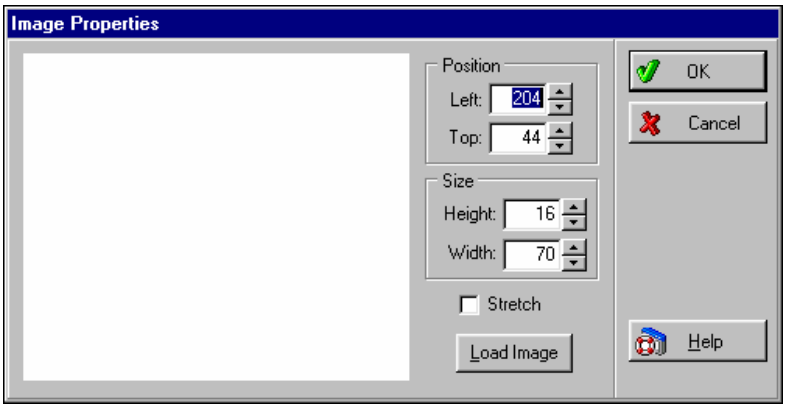
Choices for border style are clear, solid, dash, dot, dash-dot, dash-dot-dot, and inside frame. Colors can be basic or custom, and within custom you can designate hue, sat, lum (which is set for brightness), plus basic color mixes.

F1 Look up Shape Field Properties.

Images Field Properties

 The Images feature permits you to add bitmaps, sound, and videos to patient records in the program.

Add images to your reports, such as a company logo or picture of the office building.



F1 Look up Image Properties.

Data Fields and Expressions

Of the field types available in the Report Designer, the Data field is the only type that allows for expressions to be defined.

An **expression** is a formula or equation that lets you introduce variables to determine the end result. A **conditional expression** is a formula or equation that contains at least one "if" clause which must be met to get the desired result. In effect, expressions give you an easy formatting method to get the exact data desired to display in the field.

Click **New Expression**. The **Select Data Field** window is displayed. Select a file on the left-hand side of the window and an abundant list of fields available is displayed in the **Fields** list on the right. The files from which you may choose are Case, Insured, Claim, Custom Data, Patient, Practice, and Transaction.

F1 Look up Data Field Expressions and Conditional Expressions.

Tutorial Practice

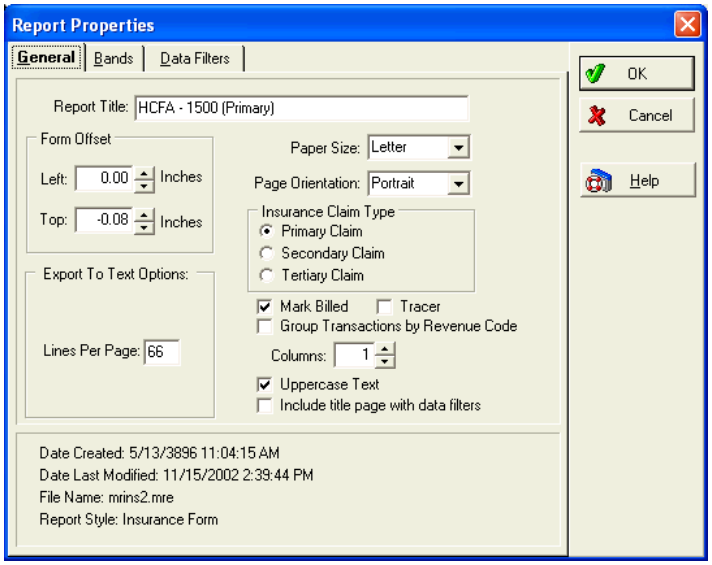
To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided.

Repositioning the CMS- or HCFA-1500 form

Let's say your paper claims are printing with text shifted too far to the right and below the spaces provided in the pre-printed CMS- or HCFA-1500 forms.

Go to the **Reports** menu and select **Design Custom Reports and Bills**. Click the Open speed button (the book with the arrow pointing to it) and select **HCFA - 1500 (Primary)**. Click **OK**.

Go to the **File** menu and select **Report Properties**.



It's probably better to make one adjustment at a time, so in the **Form Offset** section, and change **Left** to **.05**. Click **OK**. You need to print the form to see if it is adjusted enough. Click the Print speed button. The **Save Report As...** window is displayed. Since you are revising a standard form, give this form a different name, until you know it is correct. In the **Report Title** box, enter **CMS - 1500 1**.

You need to use a name that you can remember, but you can't replace the original form. If you use the same name as the original form, the list shows two forms with the same name and it may be difficult to remember which is the form you've revised.

The program informs you that claims and statements printed through the Report Designer are not marked as billed. This is generally a good thing. Click **OK**.

In the **Data Selection Questions** window, select a single claim number in the **Claim Number Range** so only one page prints. Click **OK**.

Use the **Claim Number Range** and not the **Chart Number** range because there must be an available claim before the form prints from the Report Designer.

Click **OK** in the **Print** window. We made a great adjustment and the right/left adjustment is perfect.

Now repeat the process, opening the **Report Properties** window. This time, enter **.6** in the **Top** field. Click **OK**.

Again print the form and check to see if the alignment is OK.

Unfortunately, aligning the CMS- or HCFA-1500 form is a trial-and-error process. You may have to make a number of adjustments to get the printing just right. When you do get the adjustments right, save the form and close the Report Designer. Use this revised form each time you print paper claims.

If you are short on CSM- or HCFA forms, you can print the report on plain paper. Place the test paper on top of a pre-printed form and hold them up to the light to see if the text is lined up properly.

How To Revise an Existing Report

You decide that you want the Zip Code included on your patient lists. In the Report Designer, click the Open speed button. Locate **Patient List** and click **OK**.

First you need to add the column heading and you have to make a little space for it. Move the **Phone** heading a little to the right by clicking and dragging the field. (This is the heading in the blue band, not the one in the green band.)

Click the Text Field speed button in the toolbar and then click the cursor in the space between **CityLine** and **Phone**. Double-click this new text field to open the **Text Properties** window. In the **Text** field, enter **Zip Code**. Click **Font** and, in **Font style**, click **Bold**. Click **OK**. Click **OK** again. To be sure the heading is aligned properly, hold down the **Shift** key and click **CityLine**, **Zip Code**, and **Phone**. Right-click over one of the selected fields and select **Align Fields** in the Speed menu.

In the **Alignment** window, choose **Bottoms** and click **OK**. You're halfway there!

In order to align the **Phone** heading and the **Phone 1** field (in the green band), right-click **Phone** and select **Properties**. In the **Text Properties** window, locate and make note of the value in the **Position Left** field. Click **OK**. Now, right-click over the **Phone**

1 field and enter the same value in the **Position Left** field of this window. Click **OK**. The **Phone** heading and **Phone 1** field are now aligned.

Next you need to enter the Zip Code field in the document–you need to insert a Data Field in the green band. Click the Data Field speed button, and then click the green band below the **Zip Code** heading.

Double-click this new field to open the **Data Field Properties** window. Click **New Data Field**. In the **Select Data Field** window, the **Patient** file should automatically be selected. Be sure it is. In the **Fields** section, scroll down until you see **Zip Code**. Select **Zip Code** and click **OK**. Click **OK** again.

To make sure the two Zip Code fields are aligned, right-click over the heading and make note of the value in the **Left** position field. Then right-click over the Zip Code field (green band) and enter the same number in the corresponding field of this window.

To save, you must rename the form. Go to the **File** menu and select **Save As**. In the **Report Title** box, enter **Patient List w/Zip** and click **OK**. Close the Report Designer.

To test your new report form, go to the **Reports** menu and select **Patient List w/Zip**.

How To Create a New Report

Choose a report style on which to base a completely new form.

Format the report by going to the **File** menu and selecting **Report Properties**. Establish the report name, margins, size of bands and filter the source data needed to provide the information for the report.

With the report formatted, you can begin placing fields on the grid. Make the necessary additions and/or changes to complete your form, then save and exit Report Designer. The new report appears in the Custom Report List.

As you become familiar with the workings of Report Designer, formatting and designing become easier.

Chapter 14

Office Hours

Introduction

Office Hours is an appointment scheduling program that helps keep track of appointments for your practice. It is automatically installed with Medisoft (unless you chose not to have it included when you performed the installation).

If you purchased Office Hours Professional, the features of this program are clearly marked throughout this chapter.

Starting Office Hours

If you are working in Medisoft, click the Appointment Book speed button or go to the **Activities** menu and select **Appointment Book**.

Accessing Office Hours from Other Programs

You can access Office Hours at the same time as you are working in other Windows-based programs. Open Office Hours at the beginning of each day and then minimize it. Press **ALT** + **TAB** at the same time to activate Office Hours, perform the desired scheduling tasks, and then minimize it to return to your previous task.

Office Hours Setup

There are several portions of the program that need to be set up before you can start scheduling.

First, set up provider records. If you are booking appointments for lab work or therapy, each of those technicians should have a provider number and schedule and so should each office member whose schedule is included in the Office Hours program.

Second, create your resource records. You can include all treatment apparatuses in this list, as well as consultation and treatment rooms, so that you do not double book a room or equipment.

Third, establish the number of booking columns you want.

Fourth, clarify program options, such as establishing appointment length, creating whatever views you need for viewing multiple columns at once, and deciding how much information you want displayed in your appointment blocks in the appointment grid.

Fifth, set up breaks and recurring breaks, to show lunch hour, set coffee-type breaks, seminars, etc.

Setting up Provider Records

Office Hours must have at least one provider record set up in order to run. If no provider record is set up, Office Hours automatically prompts you to do so. If you want, you can let the program assign the **Code** for the provider or you can enter a five-character code yourself.

Enter the provider's name and pertinent information. PIN and ID numbers assigned by governmental carriers and other commercial carriers are recorded in the Default Pins tab of the **Provider:** (**new**) setup window, as well as the Group Number and UPIN, when needed.

F1 Look up Provider Entry.

Setting up Patient Records

This can be done in either Medisoft or Office Hours. Click the Patient List speed button and click **New Patient** or press **F8** to display the **Patient/Guarantor:** (**new**) window. You can create a chart number yourself (eight alphanumeric characters) or let the program create one. Enter information in as many of the fields as necessary in both tabs. When finished, click **Save**. Repeat this process for each patient who visits your practice.

F1 Look up Patient Entry.

Setting up Case Records

This can be done in either Medisoft or Office Hours. Click the Patient List speed button and then choose the **Case** radio button in the top-right corner of the window. Then click **New Case** or press **F8** to display the **Case: Patient Name** (**new**) window. Enter information in as many of the fields as necessary. When finished, click **Save**. Repeat this process for each case you want to enter.

☞ In the **Case** window, you cannot press **F8** or **F9** to access records available from lookup fields, such as **Facility** or **Attorney**. The **F8** and **F9** keys are only available in the **Case** window from within Medisoft itself.

F1 Look up Case Entry.

Setting up Resource Records

The **Resource List** is a tool to help you manage the scheduling of rooms and equipment in the office. To create the list, click the Resource List speed button or go to the **Lists** menu and select **Resource List.** In the **Resource List** window, click **New** or press **F8**.

Create a code for the resource or let the program create one based on the description. Enter a description (e.g., Room 1, Treadmill, etc.) and click **Save**. Repeat this process until all rooms and/or equipment are contained in the list.

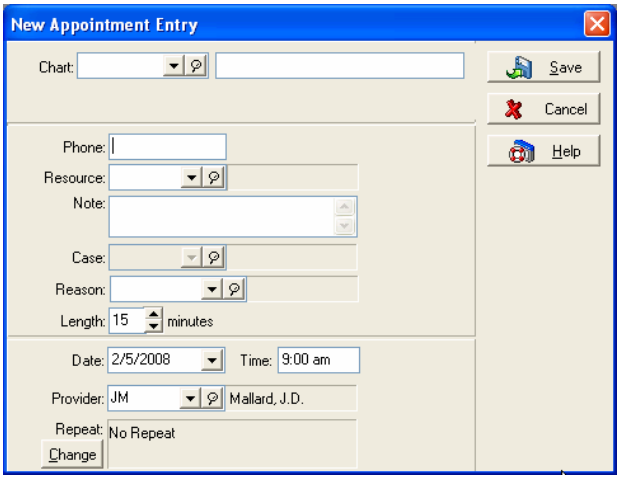
F1 Look up Resource Entry.

Setting an Appointment

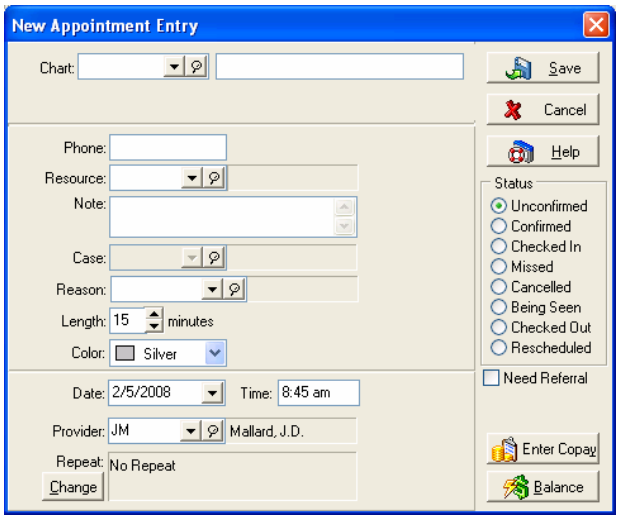
To set an appointment in Office Hours, first select the provider for whom you are scheduling. The provider box at the top right of the toolbar has a drop-down box arrow. Select the provider you need, or press **F8** to set up a new provider record. In any Multi View (Office Hours Professional), select the provider by clicking in the appropriate provider's column.

Select the date on which the appointment is to be set. You can use the **Day**, **Week**, **Month**, and **Year** selection arrows below the calendar to locate the correct date, or use the Go to Date feature.

Next, in the appointment grid, double-click a time slot, which is highlighted with a heavy line border. You can also click the New Appointment speed button; right-click in the time slot and select **New Appointments** press **F8**; or go to the **Lists** menu and select **Appointment List** and then click **New** to open the **New Appointment Entry** window.



Office Hours Original



Office Hours Professional

Enter or select the chart number of the person for whom the appointment is being set. If the person's information has been entered in the program, the name and phone number are automatically entered and the patient's last case is reflected in the **Case** field.

Assign a resource. If the resource or room you need is not in the list, press **F8** to create a new resource record. The **Notes** field lets you include a reminder message regarding the patient's need or condition. Enter an appointment reason in the **Reason** field. If necessary, change the **Length**, **Date**, and **Time** fields here. You can also change the appointment color. If there is a need for repeat visits, click **Change** in the **Repeat** section. See the following **Repeating Appointments** section.

F1 Look up New Appointment Entry.

Repeating Appointments

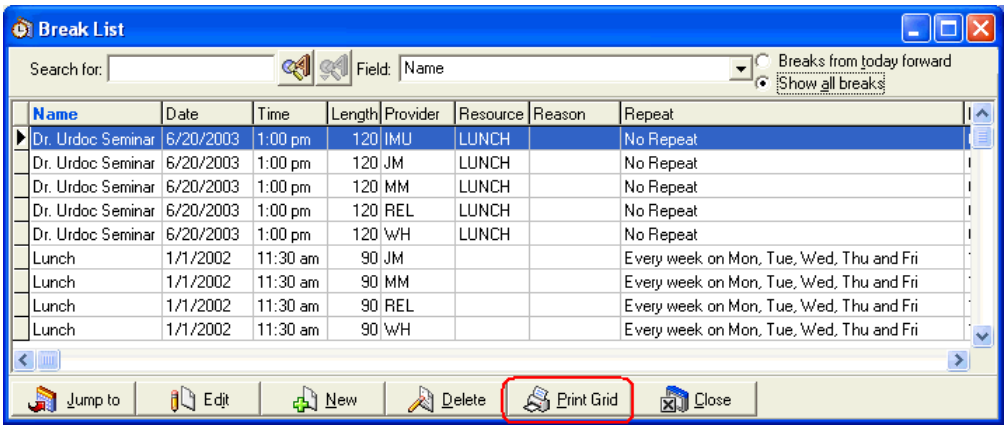
When a patient needs to make regular return visits, set up repeat appointments through the **New Appointment Entry** or **Edit Appointment** window. Click **Change** in the **Repeat** section at the bottom of the window. The **Repeat Change** window that opens is the same window that appears when creating repeating breaks. See the **Setting Up Repeating Breaks** section for instructions, page 136.

F1 Look up Repeat Change.

Entering Breaks

You can enter breaks into the appointment schedule as reminders that the time slots are committed. Some breaks are a one-time occurrence, like a vacation or a seminar. Others are regularly scheduled times for each month or week.

There are several ways to access the **New Break Entry** window. The quickest way is to click the Break Entry speed button. You can also click **New** or press **F8** in the **Break List** window.



To create a break, give it a name, a date, and enter the time that the break starts. Using the up and down arrows, enter the length of time in minutes. The display color of the break should be contrasting to the regular daily appointment schedule (the default is gray).

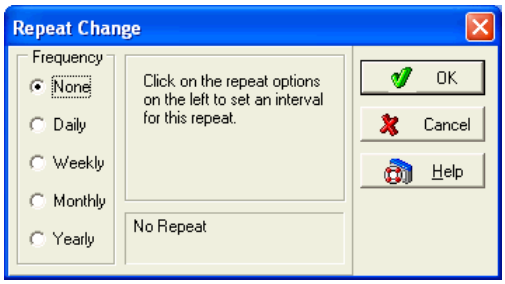
Indicate whether the break should display in all columns on the appointment grid. If not, click the **All Columns** box to uncheck it, and then mark those columns to be affected. Three radio buttons at the bottom of the window let you apply the break to the **Current** provider (the one whose schedule is on the window), **Some**, or **All** providers.

The Print Grid feature is available with Office Hours Professional.

F1 Look up New Break Entry.

Setting Up Repeating Breaks

In the **New Break Entry** window is a field marked **Repeat**, with a **Change** button. Clicking **Change** opens the **Repeat Change** window where you can establish the **Frequency** of the break.



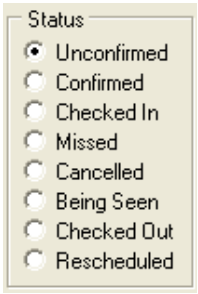
Choosing any of the radio buttons (except **None**) displays different data entry boxes in the middle of the window that give you the repeat options for each frequency. Also, a written summary of the selected frequency appears in the bottom middle area of the box.

It is important to note that when you set up a break using the **Monthly** frequency, the date highlighted on the main calendar affects the day or date that is entered in the break note.

Moving/Deleting Appointments

Changing Appointment Status (Office Hours Professional)

There are multiple options for marking the status of an appointment.



The default is **Unconfirmed**. When any change in status occurs, edit the appointment or right-click on the appointment and choose the appropriate radio button. If you choose **Cancelled**, the appointment is removed from the grid display. Any other status is reflected by a small icon in the upper right corner of the appointment in the grid.

Moving an Appointment

If you want to move the appointment to another day or time, click the appointment and press **CTRL + X** (or go to the **Edit** menu and select **Cut**). Move the cursor to the new day and/or time slot, and either press **CTRL + V** or select **Paste** in the **Edit** menu. If you want to move the appointment to another time slot showing on the appointment grid (whether the same provider or not), click the appointment, hold the left mouse button down and drag the cursor to the desired time slot. Release the mouse button.

Deleting an Appointment

There are multiple ways to delete or remove an appointment: click the appointment slot on the appointment grid and press **DELETE**, highlight the appointment in the **Appointment List** and click **Delete**, or right-click on the appointment (either in the **Appointment List** window or on the appointment grid) and select **Delete** or **Delete item**, respectively. You can also edit the appointment and change the status to **Cancelled**.

F1 Look up Moving/Deleting an Appointment.

Patient Recall (Office Hours Professional Integrated)

The program includes a complete patient recall system with a recall appointment list to assist in contacting patients to schedule appointment dates and times or to make reminder phone calls. This feature is available through both the Medisoft and Office Hours programs.

F1 Look up Patient Recall.

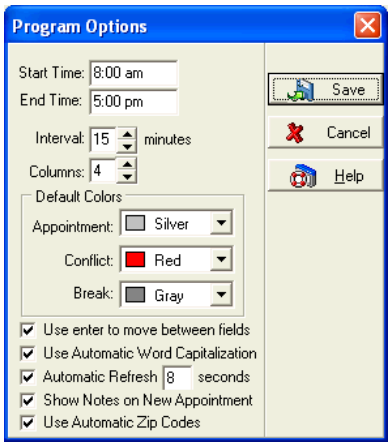
Multiple Booking Columns

If you want to multi-book appointments (that is, schedule more than one patient in the same time slot), simply right-click on the column heading in the appointment grid and the Speed menu gives you a choice of **Add Column** or **Delete Column**. If you add a column, the **Add Column** window has a horizontal scroll bar that lets you indicate the provider for whom you are adding a column. The number of columns determines how many appointments can be booked in one time slot for one provider. There is really no limit as to how many columns can be set up on the appointment grid. You can also edit the column display by selecting **Edit Column** in the Speed menu. Changes are made in the **Change Column** window.

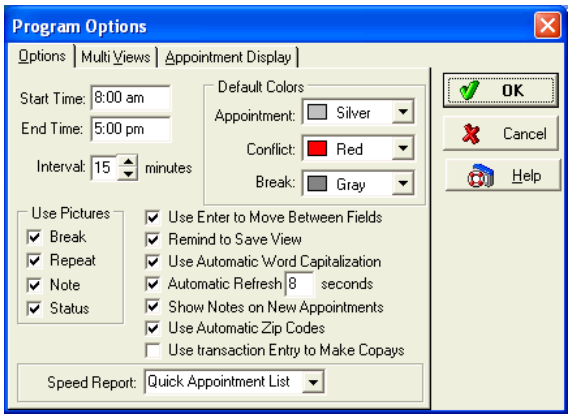
Program Options

Appointment Length

Set the starting and ending appointment times for the practice. Enter the **Starting Time** and **Ending Time**, breaking it down by hour and minutes. Standard appointment **Intervals** can be established by scrolling with the up and down arrows.



Office Hours Original



Office Hours Professional

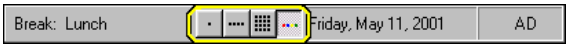
You can also set colors to distinguish appointments, breaks, and conflicts (Office Hours Professional). Make decisions concerning all the other default settings in this tab.

Designate one of the reports in the **Speed Report** box (Office Hours Professional) and it automatically prints when you click the Print speed button.

Views (Office Hours Professional)

One of the most important features of the Office Hours Professional program is the variety of ways you can display appointments/breaks in the appointment grid.

At the bottom of the main Office Hours window, in the Status bar, there are four View boxes, with different configurations of dot patterns. These give quick access to the same functions available through the **View** menu on the Menu bar. These correspond to Single Provider View, Week View, Month View, or any combination Multi View.



- ### Day View

  The Day View shows a single provider's appointments for a selected day. If multiple columns are set up, all columns are displayed. To display another provider's schedule, make a new selection in the provider box in the toolbar. This view does not show columns for resources, but columns can be added or removed as necessary in this view.

- ### Week View

  The Week View also shows only one provider's schedule, but with one column for each day of the week. If you have multiple appointments scheduled, the time slot shows the color for scheduling conflicts. You can size the columns to see all the appointments/breaks scheduled by placing the cursor on the right column heading boundary line until it takes the shape of a double-sided arrow, and then drag the boundary line right or left to increase or decrease the size of the column. Columns can be added or removed as necessary in this view.

- ### Month View

  The Month View shows up to 31 days, with the boxes colored where appointments have been scheduled. This is a single-provider view. The value of this view is that you can get a good overall view of which days are free for appointments or other scheduled items. Columns cannot be added or removed in the Month View.

- ### Multi View/Multiple Provider/Resource View

  The Multi View, or Multiple Provider/Resource View, is the most flexible. The program provides one Multi View setup, which automatically includes all providers and all resources, each with its own column. You can create as many Multi Views as you need in the Multi Views tab of **Program Options.**

The open data entry field lists all Multi Views that have been set up. This is where you can group providers and/or resources (rooms or facilities scheduled for appointments) in any combination desired, or modify or delete existing multiple view setups. Click **New** to set up a new Multi View (select a view and click **Edit** to make changes).

In the **New View** window, assign a name for the new view. For the first column, indicate the type (Provider or Resource), the **Code** (provider number or resource code), then the width of the column (in pixels). Set up each column you want in the view and click **Close** when finished.

If you want to add a column between columns that have already been created, place your cursor where you want the new column and click **Insert**.

These views can be also edited or reverted to default views through the **View** menu.

Appointment Display (Office Hours Professional)

In the Appointment Display tab of **Program Options**, you can specify up to five rows of information to display in the grid for an appointment. Be aware that the length of the appointment determines how much data is actually displayed on the grid. An appointment must be at least 75 minutes long to display five rows of information.

F1 Look up Program Options.

Security Setup

If you are using Office Hours in connection with Medisoft, the security settings established in Medisoft are applied to Office Hours as well. However, you can make changes from within Office Hours if needed.

You can be logged in to the program on only one computer at a time. If you are logged in on one computer and try to log in on another, a message pops up. You have to log out of the first computer before you can log in on another computer.

F1 Look up Security Setup.

Reports in Office Hours

If you select one of the following reports in the **Speed Report** box in **Program Options** (Options tab), that report prints automatically when you click the Print speed button (Office Hours Professional).

Appointment List

Probably the most important report printed in Office Hours is the Appointment Schedule, a listing of all the day's scheduled events. Generally, printing this report is the first order of business. Print the list and be sure you are ready to meet the day.

F1 Look up Printing the Appointment List.

Appointment Status (Advanced and above)

The Appointment Status report displays a list of appointments showing their statuses.

F1 Look up Appointment Status Report.

Printing Superbills

If you use Office Hours integrated with any version of Medisoft, you can print superbills for the day through Office Hours. Go to the **Reports** menu and select **Print Superbills**.

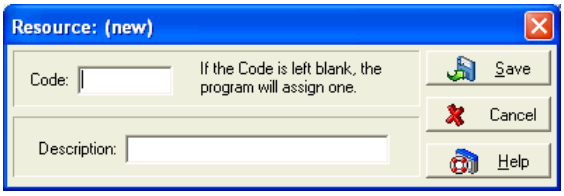
F1 Look up Printing the Superbill.

Tutorial Practice

To review the procedures outlined in this chapter, you can perform the following steps using the tutorial database provided with this program.

Entering Resources

Go to the **Lists** menu and select **Resource List**. Click **New**.

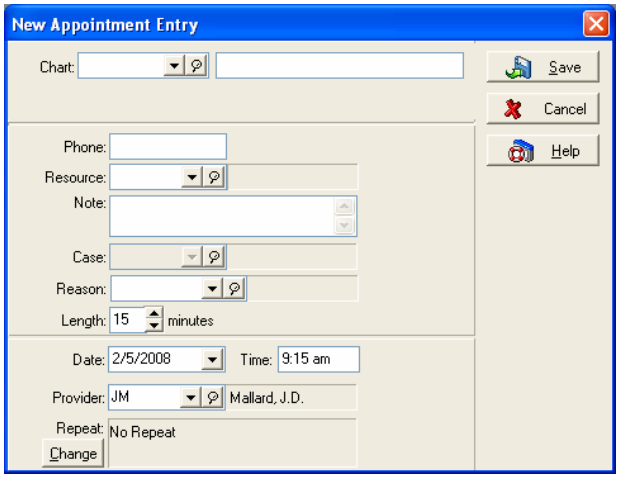


Leave the **Code** field blank. In the **Description** field enter **Treadmill**. Click **Save**. Click **Close**.

Entering Appointments

I.B. Gone (remember him?) calls and needs to see Dr. Urdoc today. Dr. Urdoc actually has an opening at 11:30 am. In all views except Monthly (Advanced and above) and Multi View (Advanced and above), select Dr. Urdoc in the provider box to the right of

the Exit speed button in the toolbar. In any Multi View, be sure to locate Dr. Urdoc's appointment column. You see that the 11:30 time slot is open for Dr. Urdoc so double-click it to open the **New Appointment Entry** window.



Office Hours Original

In the **Chart** field, enter **GON** to locate I.B. Gone's chart number. Press **ENTER**. In **Resource**, enter **T** to help locate the treadmill resource. Highlight the correct resource and press **ENTER**.

In the **Note** field, enter the following information: **Emergency physical for work.**

The **Case** defaults to Mr. Gone's most recently opened case. In the **Reason** field, although we have not yet created reasons of our own, we can select one from the database. Click the down arrow and select **Routine Checkup**.

The date and time have already been selected, so click **Save**. See that Mr. Gone's name appears in the 11:30 am slot. Also notice that it is fuchsia in color (which is the color assigned to the Routine Checkup reason). A recap of the appointment and Mr. Gone's information is also displayed to the left of the Appointment Grid.

Repeating Appointments

Dr. Urdoc wants to follow up on Mr. Gone's treadmill results and asks you to make two more appointments, a month apart. Since 11:30 am is a good time for Mr. Gone, double-click the existing appointment.

In the bottom left corner of the **Edit Appointment** window, click **Change** to open the **Repeat Change** window. Choose **Monthly**. In the **End on:** field, click the down arrow

to show the calendar. Click the right arrow twice (for two months). Then click **OK**. Click **Save**.

Setting Breaks

Click the Break Entry speed button. In the **Name** field, enter **Dr. Urdoc Seminar**.

The meeting is scheduled for two hours on June 21, starting at 1:00 pm. In the **Date** field, enter **6/20/2003**. For **Time**, type in **1:00 p**. In **Length** type **120**. In **Resource** enter **L** for the Lunch room. Give it an aqua color, using the down arrow to display the color choices. Click the **All Columns** box to be sure everyone participates. Under **Provider**, choose **All**. Click **Save**. To double-check, click the appropriate **Month** and **Day** buttons to locate June 21, 2003. If necessary, use the scroll bar to show the seminar.

To return to today's calendar, click the Go to Today speed button.

Creating Reason Codes

Go to the **Lists** menu and select **Reasons List**. Click **New** to open the **Appointment Reason Entry** window.

Leave the **Code** field blank. In the **Description** field, enter **Sports Accident.**

The default appointment length is 15 minutes. Change this number to 30. In the **Default Appointment Color** field, the drop-down arrow lets you select a color that fills the appointment space on the schedule grid. Choose red for this emergency accident response. In **Default Template Color** (Advanced and above), select **Light Red**. Click **Save**.

Creating Templates (Office Hours Professional)

Go to the **Lists** menu and select **Templates List**. Click **New**.

In one of the six **Template Reasons** fields, use the drop-down arrow to enter **NEW** in the **Code** field. In the **Description** field describe the template's use as **See New Patients**. Using the drop-down arrows, select Dr. Urdoc as the **Provider**, and the **Resource** is Exam Room 2.

Click the arrow on the **Date** field to display the calendar and highlight the designated date. Use the arrows on either side of the month name to change to an earlier or later month, if necessary. Type **10:00 a** in the **Time** field. Set the **Length** to 120. The search arrow on the **Color** field lets you select light yellow as the color for the template on the appointment grid.

You want to use this template every day, so click **Change** to display the **Repeat Change** window. Choose the **Weekly** frequency, enter the number 1, and click the boxes for

Tuesday and **Thursday**. Leave the **End on** field blank at this time. Your entry is confirmed with the message, "Every week on Tue and Thu."

Creating Multi Views (Office Hours Professional)

Dr. Urdoc works only with therapy patients and uses Exam Room 2 for consultations. Let's create a view where you can see all of these schedules at the same time.

To create a multi view, go to the **File** menu and select **Program Options**. Open the Multi Views tab. Click **New**.

Name the new view **Dr. Urdoc** and press **TAB**. In the **Type** field, click the box and select **Provider**. In the **Code** field, locate and highlight Dr. Urdoc's name. Leave the **Width** at its default setting. Click **Insert Column**.

In the next line, select the **Resource** type. Press **TAB**. Locate Exam Room 2 and highlight it. Press **TAB**. Change the **Width** column to 50. Click **Insert Column** to create a new line. Again select **Resource**. This time locate and select **Therapy**. Click **Close**. Click **OK**.

Using the Wait List (Office Hours Professional)

Mr. Gone has seen the doctor for his injury but he needs a return visit in a week. With the full appointment schedule, the surest way to work him in is to put him on the Wait List. Go to the **View** menu and click **Wait List**. Click **New**.

Type in **GONI** to select the Chart number. Click **Save**.

To begin the search for his next appointment, highlight his record and click **Find** to open the **Find Open Time** window.

Mr. Gone is out of school at 2 p.m. but has choir practice on Tuesday and Thursday. He needs a 15 minute appointment so enter a **Start Time** of **2:30 p** and an **End Time** of **5:00 p**. Click **Monday**, **Wednesday**, and **Friday**. Click **Search** and let it go. In a few moments, if the program finds a match, a **Confirm** window pops up: "Open time slot found. Do you want to set the appointment?" If the first time slot it presents is not satisfactory, click **Retry** and let it search further. Or click **Yes** and schedule the appointment.

Chapter 15

Work Administrator

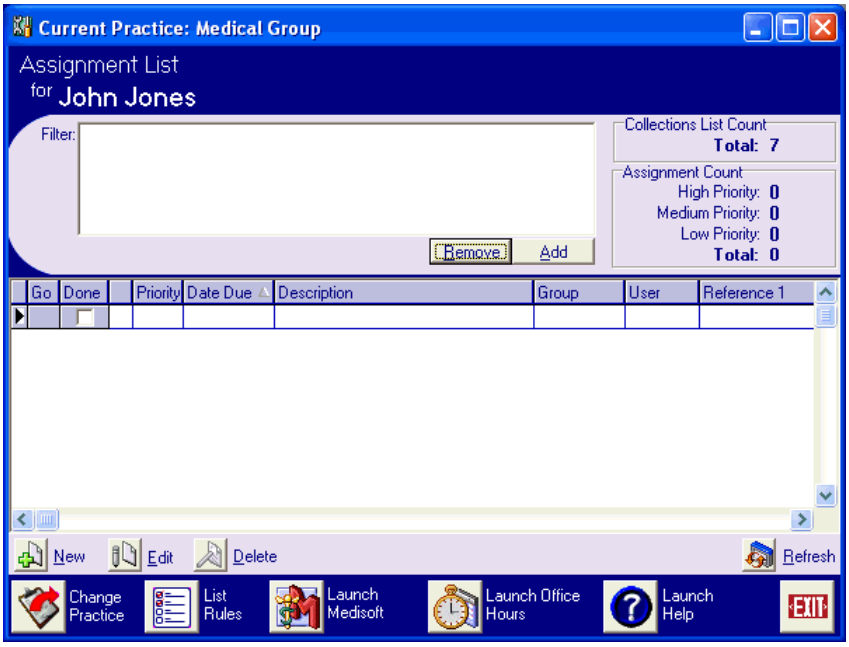
Introduction

This program lets staff streamline their work process. You can use this feature to organize tasks for users and user groups. It lets you add tasks manually and set up rules that automatically add tasks when certain conditions are met.

To open Work Administrator, go to the **Activities** menu and select **Launch Work Administrator** or click the Launch Work Administrator icon in the toolbar.

Assignment List

The Assignment list is the main window for the Work Administrator. This window lets you view the tasks assigned to Medisoft users.

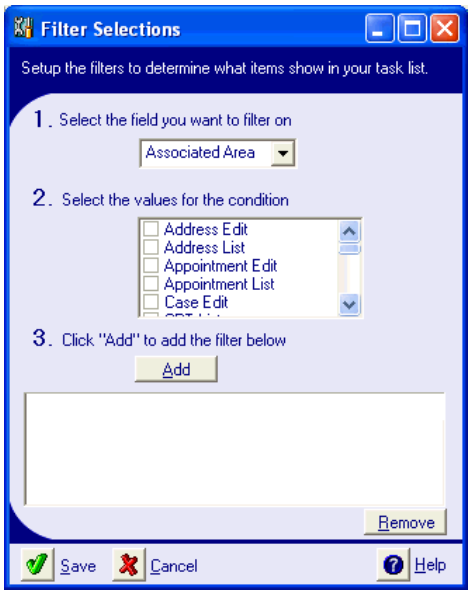


F1 Look up Assignment List.

Filters

The default for the Assignment List window is to display the tasks assigned to the user currently logged in to Medisoft. Data filters can be added to determine which tasks show on the Assignment List.

To add a data filter, click **Add** in the **Filters** section of the Assignment List. The Filter Selections window opens.



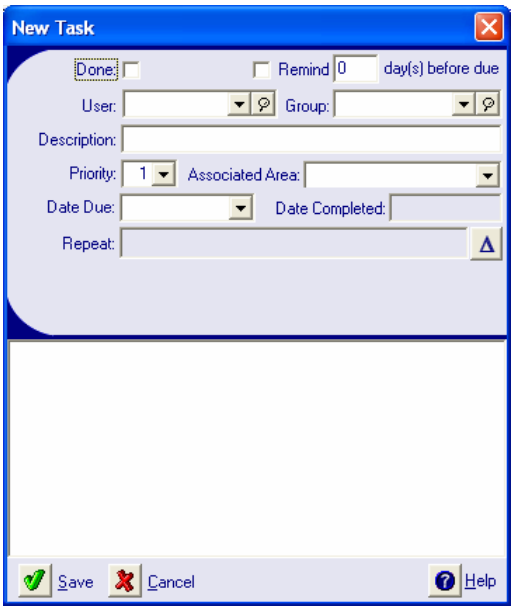
Select the field and values for the filter. Click **Add** and the new filter will appear in the text box at the bottom of the window. Click **Save** to apply the filter to the Assignment List.

F1 Look up Filter Selections.

Tasks

This window lets you enter tasks in the Assignment List and assign them to a specific user or group of users. Users can check the Assignment List throughout the workday to view the tasks they should complete. Depending on a user's permission level, he or she may not be allowed to create or edit tasks.

To create a task, click **New** in the **Assignment List** or select **Add New Task** from the **Activities** menu. To modify an existing task, click **Edit**. The Task window opens.

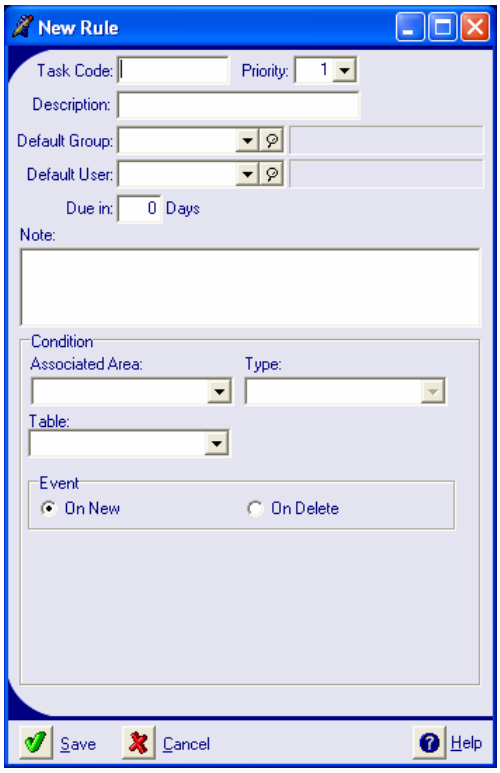


Select the user to whom you would like to assign the task by clicking the down arrow in the **User** field and selecting the appropriate user. If you would like to assign a task to a group of users, rather than a single user, select the group name from the drop-down menu in the **Group** field. Enter information in the remaining fields as necessary. Click **Save** and the task appears in the Assignment List of the appropriate users.

F1 Look up Tasks.

Rules

Work Administrator allows you to create rules so that a task is automatically added to the Assignment List each time a particular scenario is created. Existing rules are displayed in the **Task Rules List** accessed by clicking the **List Rules** button in the **Assignment List**. To add or modify a rule, click **New** or **Edit** in the **Task Rules List**. The **Rule** window appears.



This window allows you to add or edit rules so that common tasks are automatically created. The top portion of the window lets you create a type of task and specify instructions. The Condition portion of the window lets you determine when the task above is created. For example, you office may need to check eligibility for each patient who needs a referral. You can create a rule that automatically adds this task after entering a new appointment.

Depending on the type of task you want to create, the fields displayed in the **Rule** window change. Enter information in the appropriate fields and click **Save** to apply the rule.

F1 Look up Rules.

Appendix A

Where to Find Help with Medisoft

Support Options

Technical help for learning and working with Medisoft is available in the following options: (1) **F1** key or **Help** buttons access online information while within the program; (2) accessing the Medisoft web site; (3) training options; (4) local Value-Added Resellers; and (5) Medisoft telephone technical support. Medisoft support is unable to provide training on the telephone.

Using Online Help

No matter where you are in your Medisoft program, help is close at hand. If you don't understand what is wanted, or how data should be entered, press **F1**, click **Help** (if available), or click the Help speed button, and data files are opened. Specific information and examples of how data should be entered is displayed in the Help window.

In addition, you can go to the **Help** menu and select **Table of Contents**. Highlighting any option in the Contents list opens the related help data fields.

Regardless of which of these entry points you utilize, you open the same Help files. Access the files in the manner most convenient to you.

Medisoft Web Site

The Knowledge Base is a searchable online database containing technical information relevant to the use of all Medisoft and related products. If you are working in a Medisoft program, access is made easy by going to the **Help** menu and selecting **Medisoft on the Web** or at the following web site:

http://www.medisoft.com/kb.

When accessed, you can search for information concerning all Medisoft products or any particular product. We try to maintain the most current technical information in the Knowledge Base. For instructions on how to use the Knowledge Base, click **Help** on the left side of the Knowledge Base page.

Training Options

There are various training options available. Contact your sales representative at (800) 333-4747 or a local Value-Added Reseller for information concerning these options.

Local Value-Added Resellers

There are local Value-Added Resellers of Medisoft in your market area who are knowledgeable and efficient in selling, installing, troubleshooting, and supporting your Medisoft program. You can contact a Medisoft sales representative for the name of a qualified Value-Added Reseller in your area to give you hands-on help.

Technical Support

Call Toll-Free (800) 334-4006. Get help directly from Technical Support services! Support is available to answer questions and assist in troubleshooting problems.

Support answers questions related to the operation of Medisoft software in a physician's office or a billing service. Support technicians are unable to assist with network configuration, computer hardware problems, training on how to do medical billing, or aligning your CMS or HCFA forms. Support does provide software assistance to any customer, no matter where the program was purchased.

Support is unable to provide training or file repair over the telephone.

When You Call Support

You'll get faster service if you have these items ready when you call Support:

- Your Medisoft customer number. This is found on the upper right corner of the invoice or packing slip that came with your Medisoft program.
- The Serial Number and registration information for your Medisoft software.
- A complete description of your problem or question, including the complete text of any error messages.
- Have a current support contract already in place or be ready with credit card information to set one up.
- It is usually necessary for you to be able to work on your computer while you are talking to the technical support staff, so be sure your phone is close to the computer.

Service Hours

Remember, Arizona doesn't change to daylight saving time. Year around support is available from 6:00 AM until 5:00 PM, Monday through Friday, Mountain Standard Time.

Updates and Changes

Go to the **Help** menu and select **Online Updates**. Any free update available is downloaded to your system.

F1 Look up Online Updates.

Tips and Shortcuts on the Internet

There's a wealth of information on the Medisoft web page on the Internet. The web site address is **www.medisoft.com**.

Appendix B

New Features in Medisoft 14

There are many new features in this version to help you to manage your practice. Some of the highlights are listed below.

UB-04 Support

- Version 14 adds UB-04 claims support. If you need to process these types of claims, you can easily enable UB-04 specific fields in the application on the Program Options, Data Entry tab. Version 14 also provides UB-04 claim processing. Once you have entered data in the UB-04 fields for a patient, you can enter transactions and then create and print UB-04 claims. You will enter transactions and create UB-04 claims as you would for other insurance claims. You will also print the UB-04 claims the same except for the report format you choose when printing. For more information on this feature:

  F1 Lookup UB-04 Claims Overview

Custom Date Entry for ERA Posting

- Version 14 now supports a quick method for a entering a custom remittance date. The Program Options window, Data Entry tab now provides a new option that you can select so that you are prompted to enter a remittance date after selecting a file to post. For more information on selecting this feature:

  F1 Lookup Program Options, Data Entry Tab

Global Days

- The Global Coverage feature lets you enter multiple charges for follow up visits after a surgery. When you enter a Global Surgical Procedure for a patient in Transaction Entry, all transactions entered during the global coverage period will default to a zero-dollar amount and will not be included on claims. Once the global coverage period expires, the charges default back to the standard amount. For more information on this feature:

  F1 Lookup Global Coverage Overview

Patient Quick Entry (Available with Medisoft Advanced and Network Pro)

- Version 14 now offers a customized interface for patient entry. Using this feature allows you to set up a method for entering patient data that reflects your work environment, which simplifies data entry and increase efficiency. Patient and case data is easily added to existing records or you can quickly create new records from one window without clicking multiple tabs. Using this feature involves setting up templates which contain fields from the Patient and Case windows. You can create and customize as many as needed and then when using the Patient Quick Entry feature, you can select which template to build or edit a record from. For more information on this feature:

  F1 Lookup Patient Quick Entry Overview or Using the Patient Quick Entry Feature

Dashboard (Available with Medisoft Advanced and Network Pro)

- Version 14 introduces the Dashboard feature. This new feature provides a quick method to monitor key data points such as the number of appointments, outstanding claims, etc. along with one-click access to application functions all in one window. Once setup is complete and you have created at least one profile (a basic grouping of data categories and selected settings), you can view the displayed data on the Dashboard window and if needed, click links on the window to further examine the data in greater detail. For more information on this feature:

  F1 Lookup Medisoft Dashboard Overview or Using the Dashboard

PowerTools Enhancement

- Version 14 adds the Power Tools utility to Medisoft Utilities. PowerTools is also enhanced and now provides a new feature to modify individual procedure codes in a single practice.

  F1 Lookup PowerTools

Data Import/Export

- Version 14 adds two new utilities to Medisoft Utilities. The Export Data utility lets you export data from a Medisoft practice. You can pick and choose the tables and records that are exported. The utility then exports the data into an encrypted file that can be imported into another Medisoft practice. The Import Data Records utility lets you import data into a Medisoft practice. First you have to create an export file using the Export Data Records utility. Then you can import that file using the Import Data Records utility.

F1 Lookup Export Data Records or Import Data Records

Multi-Practice Data Conversion

- Version 14 adds the Global Convert utility to Medisoft Utilities. This new utility lets you select and convert multiple practices in the same root directory to the current Medisoft version at the same time.

F1 Lookup Global Convert

Scheduled File Maintenance

- Version 14 provides a simple method for scheduling file maintenance. You can now select a time and a interval for these features to run that best reflects your office's needs. For more information on this feature:

F1 Lookup Scheduling File Maintenance

Appendix C

Converting Data

Converting from Windows Version 5.5x or Higher to Windows Version 14

If you have been using Medisoft Version 5.5x or higher and have just installed Version 14, an automatic conversion is performed the first time a practice data set is opened in the new program.

Converting from Windows Version 5.4x or Lower to Windows Version 14

If you are converting from Medisoft Windows Version 5.4x or lower to Version 14, data must be converted before it can be accessed in the new program. Go to the **File** menu and select **Convert Data**. Choose **Convert Windows 5.x data**. Follow the prompts.

Multiple Practice Conversion Process

There are two ways to convert data. First, you can open a different practice through the **File** menu. The program will immediately perform a conversion. Second, you can go to the File menu and select **Convert Data**.

When you convert previous data choosing **Convert Data**, the program searches your physical hard drive for any MWDBLIST.ADT files. When found, the program lists all valid data directories in the **Medisoft File Conversion** window.

☞ A valid data directory is one that contains data.

Of the data sets listed in the **Medisoft File Conversion** window, select one at a time that you would like to have converted.

When you are finished converting the data sets, your original data directories remain unchanged except a CONVERT.LOG file (and possibly a DATABASE.CLI file) is created in each data directory that is upgraded. The program creates a new directory for each data set converted in the root data directory you specified when you installed your latest program. The first new data directory is automatically named DATA, the second is named DATA1, and each new data directory is named consecutively after that (e.g., DATA2, DATA3, etc.).

DO NOT RENAME THESE DATA FILES.

The program relies on this naming convention to function properly. To identify which practice files are contained in which data directory, use the **Open Practice** window, which contains the data path for the highlighted directory.

We recommend that you do not delete your old data directories until you know for certain that the newly converted data is complete. If you need more space on your computer, you can create a backup of the old data directories or just copy them onto storage disks, but keep them until you are certain the new program is working completely and properly.

Medisoft MS-DOS Users Converting to Windows

If you are a user of any Medisoft patient accounting program in the MS-DOS environment, your data files are converted to the Windows version.

The conversion process is designed to have no effect on your original MS-DOS files. However, before you begin installation of the new program, back up your current data files just to be safe.

■ What Doesn't Convert

Before you undertake the conversion of Medisoft MS-DOS data to the Medisoft Windows program, you need to know that there are several types of data or formats that do not convert, no matter which option you choose.

Any custom formatting you have done, including lists, statements, CMS or HCFA forms, receipts, and the custom data windows, does not convert. In addition, notes, superbills, billing notes, and custom printer setups do not convert.

Prior to conversion, you must complete all EDI batches in your MS-DOS program. In addition, the conversion does not apply payments to charges. There is no way for the conversion program to know how much of each check is applied to respective changes, so it is up to you to apply payments to charges. It is highly recommended that all payments be applied before performing a conversion of the data.

■ Converting MS-DOS to Windows

Medisoft data file conversion from MS-DOS to Windows is automated with a simple click of a button.

To start your conversion, go to the **File** menu (or press **ALT+F**) and select **Convert Data**.

The **Convert Medisoft Data** window, by clicking **Search for Data**, finds all MS-DOS Medisoft data files. This search may take a few minutes.

Each MS-DOS database found appears in a list and automatically marked for conversion. If you do not want to convert all data at one time, deselect those files you do not want to convert by clicking on the check box next to the data you don't want converted. Buttons marked **All** and **None** below the data field can aid in marking the files. When you click **Start Data Conversion**, you have three options: **Convert All Transactions**, **Convert Patient Balances**, and **Convert No Transactions**.

The Convert No Transactions option (which is recommended) converts all MS-DOS data except transaction detail and transaction histories. If selecting this option, you need to maintain two accounting systems until all patient balances in the earlier system are zeroed out. All new charges (and payments and adjustments for the new charges) should be recorded in the new Medisoft program for Windows program, and all payments and adjustments for existing transactions should be recorded in the MS-DOS program until all accounts are balanced.

The Convert Patient Balances option (not recommended) converts all MS-DOS data but treats transactions in a special manner. All transactions for each patient are compiled and converted into a single balance forward sum with no transaction detail. A BALFORWARD or CREDFORWAR transaction is created showing the amount owing or credited to the patient. Because no detail is converted, we do not recommend this type of conversion. It becomes very difficult to apply payments to old transactions.

The Convert All Transactions option (not recommended) converts all MS-DOS data and creates new cases as necessary.

Select the type of conversion you want and click **OK**. The **Conversion Progress** window is displayed.

The Convert No Transactions option converts only these files:

Address	Insurance
Appointment	Patient
Billing Code	Provider
EDI Receiver	Procedure/Diagnosis/MultiLink

The Convert Patient Balances option converts these files:

Address	Patient
Appointment	Provider
Billing Code	Transaction (lump sum only)
EDI Receiver	Procedure/Diagnosis/MultiLink
Insurance	

The Convert All Data process converts the following data files:

Address	Patient
Appointment	Provider

Billing Code	Transaction
EDI Receiver	Transaction History
Insurance	Procedure/Diagnosis/MultiLink

During the conversion process, the program checks billing dates on all transactions and places them in the **Claim Management** list format, as discussed in Chapter 7, page 67.

The conversion finishes on its own. If the data conversion encounters problems, a file named CONVERT.LOG is created in the data file directory which explains any problems.

Any problems or questions should be reported to or clarified through Technical Support. Call (800) 334-4006.

Bringing Over Account Detail from Another System

If you are converting data from an accounting system other than Medisoft, the data is not affected by the built-in automatic conversion. Because Medisoft is an Open Item Accounting system, to best take advantage of this capability, it is recommended that you recreate each transaction, with all of its detail, for every charge that is still outstanding.

The recommended course of action is as follows:

1. Be sure each patient with an outstanding balance is set up in the **Patient/ Guarantor:** (**new**) window. That puts all the patient information into the system for filling out the insurance claim forms.
2. After your patient accounts are set up, enter a transaction for each outstanding charge in **Transaction Entry**. The date on each transaction should be the date that service was rendered.

You can work from the ledger of each patient and enter data, item by item, until everything is current.

Again, it is noted that the manual reentry applies to data originating from a different accounting program. It could also apply if you do not want to put your MS-DOS data through the automatic conversion built into the Windows versions of Medisoft.

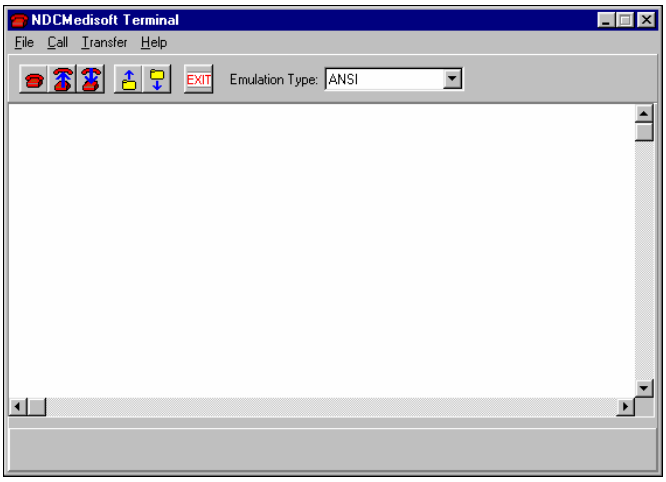
Appendix D

Medisoft Terminal

Receiving Reports from a BBS

Within the Medisoft program, the Medisoft Terminal feature can be used to send or receive reports by connecting to bulletin boards using a modem.

Go to the **Tools** menu and select **Medisoft Terminal.** The **Medisoft Terminal** window appears.



The window displays speed buttons or icons allowing you to dial, hang up, answer, and send or receive files. The Menu bar at the top of the window has corresponding functions to the speed buttons.

Dial:	**CTRL + D**	Hangup:	**CTRL + H**
Answer:	**CTRL + A**	Send File:	**CTRL + S**
Receive File:	**CTRL + R**		

The speed buttons are defined as follows:

 Dial

 Answer

 Hang up

 Send a file

 Receive a file

 Exit the program

The blank part of the window displays all modem activity (such as dialing).

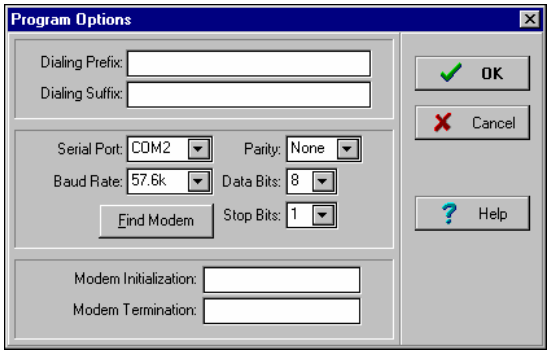
Before using Medisoft Terminal, parameters are defined in the **Dial** menu or the **Program Options** window of Medisoft Terminal. Go to the **File** menu and select **Program Options**.

Check the Knowledge Base (www.medisoft.com/kb), call your local Value-Added Reseller, or call Support at (800) 334-4006 for technical support, go to the **Call** menu and select **Dial.**

F1 Look up Medisoft Terminal.

Program Options

Go to the **File** menu and select **Program Options.** The **Program Options** window appears.



The window is divided into three groups. If you are using an in-house phone system, you may need to enter 9 or some other number in the **Dialing Prefix** field. You are always required to enter a 1 for dialing a long distance phone number. The **Dialing**

Suffix is used to dial any extra numbers after the telephone number, such as an extension.

In the next group are a series of scroll boxes for defining technical information about your modem. The **Serial Port** field has four selections: **COM1**, **COM2**, **COM3**, and **COM4**. In order to determine which Communications port your modem uses, click **Find Modem** and the **Modem Search/Test** window opens.

F1 Look up Modem Search/Check in the Medisoft Terminal help files.

The lower third of the window has two fields. **Modem Initialization** is normally left blank. If you have problems connecting with your EDI receiver or BBS and your modem manufacturer suggests a Modem Initialization String, enter the string here.

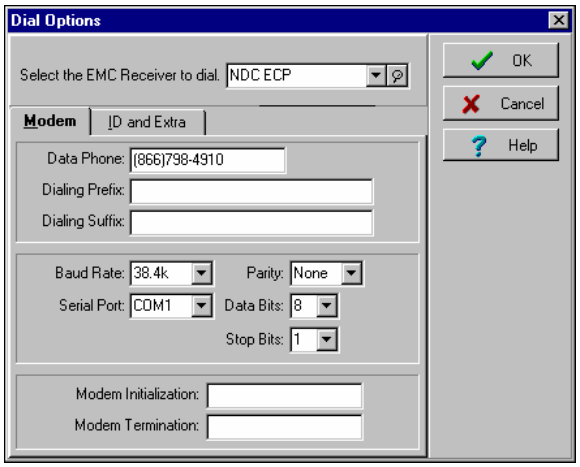
In **Modem Termination**, enter a character string to terminate the phone connection after the transmission has ended if your modem requires this. This field is usually left blank.

F1 Look up Program Options in the Medisoft Terminal Help file.

Dial Options

Go to the **Call** menu and select **Dial** to open the **Dial** window.

Select the EDI receiver to dial from the scroll box. After the EDI receiver is selected, the **Options** button becomes activated. Click it to open the **Dial Options** window.



Modem Tab

The Modem tab is divided into three groups. In the top group, enter the **Data Phone Number**. This is the number that the Terminal program dials when you are transmitting your claims.

Enter the data phone number assigned for your transmission. The program automatically enters the punctuation for you.

In the **Dialing Prefix** field, enter the prefix number, if any. If you are using an in-house phone system, you may need to enter a 9 or some other number to get an outside line, followed by one or two commas to create a pause during dialing. For dialing a long distance phone number, you always need to enter the number 1. The **Dialing Suffix** is used to dial any extra numbers after the telephone number, such as an extension.

In the next group are a series of scroll boxes for defining technical information about your modem. The **Serial Port** field has four selections: **COM1**, **COM2**, **COM3**, and **COM4**.

The **Baud Rate** is the speed at which your modem transmits data. The **Parity**, **Data Bits**, and **Stop Bits** fields are defaulted to **None**, **8**, and **1**, respectively, and usually do not need to be changed.

The lower third of the window has two fields. **Modem Initialization** is normally left blank. If you have problems connecting with your EDI receiver or BBS and your modem manufacturer suggests a Modem Initialization String, enter the string here.

In **Modem Termination**, enter a character string to terminate the phone connection after the transmission has ended, if your modem requires this. This field is usually left blank.

ID and Extra Tab

This tab displays information only. Any entries in these fields are already set up in the **EDI Receiver** window.

F1 Look up Dial Options in the Medisoft Terminal Help file.

Dialing a BBS

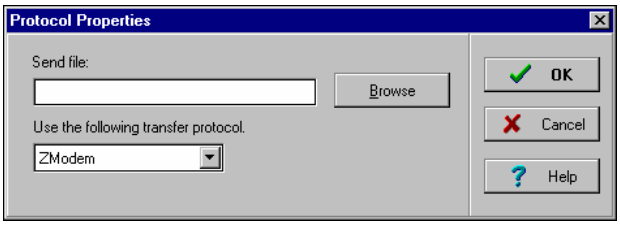
To dial a BBS, press **CTRL + D** to bring up the **Dial** window. See **Dial Options**, page 163, on the features and setup. Once the parameters have been specified, select your EDI receiver and click **OK** to initiate the dialing process. After clicking **OK**, the phone number, ATDT, and any prefix entered displays in the **Medisoft Terminal** window.

Since all BBS's are different, you need to follow the screen commands as they appear.

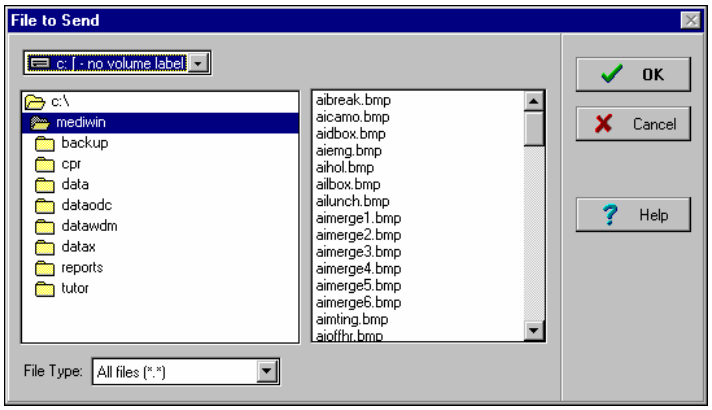
F1 Look up Dial in the Medisoft Terminal Help file.

Sending and Receiving Files

While you are logged on to the BBS, you may want to send or receive files. To do this while logged on, go to the **Transfer** menu and select **Send File**. The **Protocol Properties** window appears.



The window has two field selections: **Send file** and **Use the following transfer protocol**. If you know the name of the file and its location, enter it here. If you need to locate the file, click **Browse**. This opens the **File to Send** window.



The window is divided into two parts. On the left side, select the drive and/or subdirectory where the file(s) are located. On the right, select the actual file to send.

Click **OK** when done and the file is immediately downloaded.

In the **Send A File** window, select the protocol at which you want to send the file.

The selections are, in suggested order of use:

ZModem offers the best overall combination of speed, features and error tolerance. ZModem protocol has many options and should generally be used as the most versatile protocol of choice.

XModem is the simplest and possibly the slowest protocol. XModem uses blocks of 128 bytes and requires an acknowledgment (ACK) of each block. It uses only simple checksum for data integrity.

XModem-1K transfers larger blocks (1024- bytes) and uses a 16-bit cycle redundancy check. A larger block size can considerably increase the protocol speed because it cuts down on the amount of times the transmitter waits for an acknowledgment.

YModem is essentially the same as XModem with batch facilities added. This means that a single protocol session can transfer as many files as you can care to transmit. Another added feature allows the sender to provide the receiver with the name, size, and time stamp with the incoming file.

YModem-G has a "streaming" feature and operates in a similar manner to XModem-1K. But like YModem itself, YModem-G offers the advantages of batch transfers and file information.

☞ This protocol shouldn't be used unless you are using an error-correcting

modem with error control turned on.

Kermit allows file transfers in environments that other protocols can't handle. Examples of different environments would include those that transfer only seven data bits; links that can't handle control characters, computer systems that can't handle large blocks of data.

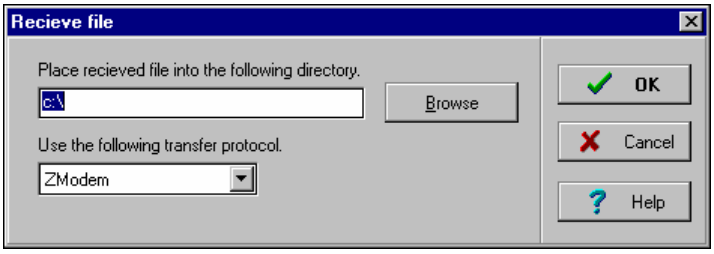
ASCII is a convenient way of transmitting a text file. Because ASCII follows no real protocol, it is difficult for the receiver to know when an ASCII transfer has completed. The ASCII protocol terminates on any of three conditions: when it receives or saves the file, a **CTRL** + **Z** character, when it times out waiting for more data, or when the user aborts.

BPlus protocol is a proprietary protocol designed and used exclusively by CompuServe.

F1 Look up Send A File and/or File Transfer Protocol in the Medisoft Terminal Help file.

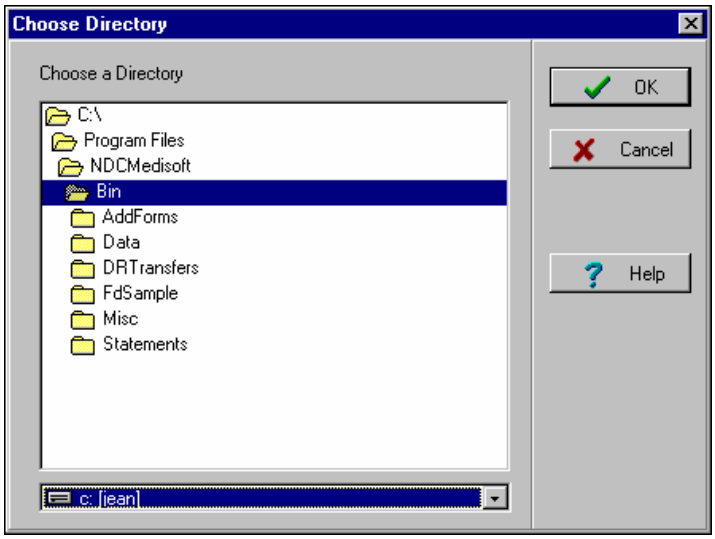
Receive File

To receive files while logged on to the BBS, go to the **Transfer** menu and select **Receive File**.



As with sending a file, enter the location and the protocol of where and how the file is to be received.

If you want to search on a location to download a file, click **Browse** and the **Choose Directory** window opens.



Select the proper transfer protocol by clicking on the **Transfer Protocol** field. For descriptions on what each protocol does, refer to the previous two pages.

F1 Look up Receive File in the Medisoft Terminal Help file.

Answering

When an outside source wants to connect with your computer (generally an individual), he or she would typically let you know that a connection will be attempted at such a time.

At the given time, when the phone rings and with Medisoft Terminal open, click the Answer speed button, or go to the **Call** menu and select **Answer** to make the connection through your modem.

Once the two computers are communicating, you can send or receive files. You can also communicate by typing on your keyboard. What you type shows up on the other user's screen, and vice versa.

Appendix E

Archiving Overview

Accessed from the **File** menu – Archive, Archiving provides a simple method for improving system performance and avoiding undue HIPAA compliance issues.

Note: Archiving functionality is available for Medisoft Network Professional.

Records can be archived instead of deleted, which increases system performance and lets the practice still access the records if necessary. This feature provides users a method to archive or, if necessary, restore archived records for items tied to that patient including cases, claims, statements, and appointments.

The archiving feature allows users with the appropriate permission level to archive and restore cases to the database. The archiving process is implemented via a series of dialog boxes that lead users through the process of archiving data, restoring data, or printing log or error reports on archived and restored records. Users can also print the archive data in reports.

Note: the advantage of archiving patients' cases is that patients remain in the system without the risk of deleting records to save space. Do not delete patients after archiving their cases since this could create a situation in which these cases are no longer accessible.

Medisoft Archive Wizard window

The Medisoft Archive Wizard window provides three options: the Archive Patient Case Records radio button, the Restore Patient Case Records radio button, and the Print Log Reports radio button. Next to the Archive Patient Case Records radio button is the Cutoff Date for Archive Patient Case Records drop-down list, which is enabled when the radio button is selected. The default date is one year prior to the current date.

Setting Up Archiving Permissions

Before utilizing the archiving feature, the system administrator should set up user access and create/revise rights in the Medisoft Security Permissions window. Also, if needed, the system administrator should set up any new users using the Security Setup window, accessed from the File menu.

The Medisoft Security Permissions window features two sections. The Window section shows the available modules. The Process section shows the access level. A checkmark under a level heading means users with that level of security have the ability to perform that task or have access to that portion of the application. The supervisor has full rights within this window to assign to or remove rights from any level of security.

Level 1 is for unlimited access and is designed to be used exclusively by the supervisor or administrator to restrict access to the program. Levels 2, 3, 4, and 5 can be user-defined – the supervisor decides the appropriate level and assigns users accordingly.

In most cases, archiving will only be assigned for level 1, or supervisor level.

To Set Up Archiving Permissions

1. On the **File** menu select **Permissions**. The **Medisoft Security Permissions** window opens.
2. In the **Window** section select **Archive Wizard** and in the **Process** section click the appropriate checkbox corresponding to the desired access level.
3. Click the **Reset Defaults** button and click the **Close** button.

Archiving Cases

The archiving process is implemented via a series of dialog boxes that lead users through the process of archiving data, restoring data, or viewing/printing/exporting log or error reports on archived and restored records.

To Access the Archiving Module and Archive a Case

1. On the **File** menu select the **Archive** command. The **Warning** window appears.
2. Option: if needed, click **Back up Data Now** (recommended) and follow the steps for data backup.
3. Click **Continue w/o Backup**. In some instances, the **Confirm** window appears. This window notes the total number of open cases (greater than ten) with a zero account balance.
4. Option: on the **Confirm** window click **No** to skip reviewing the open cases. The **Medisoft Archive Wizard** window appears. Skip Step Five and proceed to Step Six.

5. Option: on the **Confirm** window click **Yes** to review the open cases. The **Patient Case Search** window appears. As needed in the **Case Closed** column, select any cases to close or click **Select All** to select all the cases. Click **Save**. The **Medisoft Archive Wizard** window appears.
6. Choose the **Archive Patient Case Records** radio button and on the **Cutoff Date for Archive Patient Case Records** drop-down list next to the radio button, select an appropriate cutoff date.
7. Click **Next**. The **Select Patient Cases to Archive** window appears, which displays a list of all the patients who qualify for archiving based on the specified criteria.

   Note: A guarantor's chart will only be included in this window if all patients associated with this guarantor and their cases have had no transactions since the cutoff date for all cases and have a zero balance.
8. As needed in the **Selected** column, deselect any records not to be included in the archive or click **Unselect All** to deselect all the records displayed and then select any appropriate records.

   Note: If a patient who is a guarantor is selected, then all patients associated with the chart are also selected. If one of the patients associated with a guarantor's chart is deselected, then the guarantor's chart is also deselected.
9. Click **Next**. The **Warning** window appears.
10. On the **Warning** window click the **Yes** button. The **Archiving Data** window appears, and as patient records are archived, a dual progress bar displays the progress of the archiving process. When the archiving process completes, the **Confirm** window appears.
11. Option: click **No** on the **Confirm** window to exit the **Medisoft Archive Wizard** without printing the log report or click **Yes** to view the log report. The **Print Report Where** window appears. As needed, select printing or exporting options on the **Print Selection** panel and click **Start**.

Restoring Archived Cases

The archiving process is implemented via a series of dialog boxes that lead users through the process of archiving patient data, restoring patient data, or printing log or error reports on archived and restored records. Users can also print the archive data in reports.

To Access the Archiving Module and Restore a Record

1. On the **File** menu select **Archive**. The **Warning** window appears.
2. Option: if needed, click **Back up Data Now** (recommended) and follow the steps for data backup.
3. Click **Continue w/o Backup**. In some instances, the **Confirm** window appears. This window notes the total number of open cases (greater than ten) with a zero account balance.
4. Option: on the **Confirm** window click **No** to skip reviewing the open cases. The **Medisoft Archive Wizard** window appears. Skip Step Five and proceed to Step Six.
5. Option: on the **Confirm** window click **Yes** to review the open cases. The **Patient Case Search** window appears. As needed in the **Case Closed** column, select any cases to close or click **Select All** to select all the cases. Click **Save**. The **Medisoft Archive Wizard** window appears.
6. Choose **Restore Patient Case Records**.
7. Click **Next**. The **Select Patient Cases to Restore** window appears, which displays a list of all the patients who qualify for restoring based on the specified criteria.
8. As needed in the **Selected** column, check the records to restore or click **Select All** to select all the records displayed.

   Note: If you select a chart that is associated with an archived guarantor, then the guarantor's record is also selected. If you deselect a guarantor who has associated archived patients selected, they will be unselected.
9. Click **Next**. The **Warning** window appears.
10. On the **Warning** window click **Yes**. The **Restoring Data** window appears and as patient records are archived, a dual progress bar displays the progress of the restoring process. When the restoring process completes, the **Confirm** window appears.
11. Option: click **No** on the **Confirm** window to exit the **Medisoft Archive Wizard** without printing the log report or click **Yes** to view the log report. The **Print Report Where** window appears. As needed, select printing or exporting options on the **Print Selection** panel and click **Start**.

Printing Log Reports

The archiving process is implemented via a series of dialog boxes that lead users through the process of archiving patient data, restoring patient data, or printing log or error reports on archived and restored records. Users can also view or export log reports.

Use the Print Log Reports option to view, print, or export archiving log report batch files.

To Access the Archiving Module and Print a Log Report

1. On the **File** menu select **Archive**. The **Warning** window appears.
2. Click **Continue w/o Backup**. In some instances, the **Confirm** window appears. This window notes the total number of open cases (greater than ten) with a zero account balance.
3. Option: on the **Confirm** window click **No** to skip reviewing the open cases. The **Medisoft Archive Wizard** window appears. Skip Step Four and proceed to Step Five.
4. Option: on the **Confirm** window click **Yes** to review the open cases. The **Patient Case Search** window appears. As needed in the **Case Closed** column, select any cases to close or click **Select All** to select all the cases. Click **Save**. The **Medisoft Archive Wizard** window appears.
5. Choose **Print Log Report**.
6. Click **Next**. The **Select Archive Batches to Report** window appears, which displays a list of all batch reports.
7. As needed in the **Selected** column, check the batch log report records to archive or click **Select All** to select all the batch log report records displayed.
8. Click **Next**. The **Print Report Where** window appears. As needed, select viewing/preview, printing, or exporting options on the **Print Selection** panel and click **Start**.

Appendix F

Glossary

Many of the words in this list may be familiar, but a common understanding of their meanings is helpful.

Abort — To discontinue or stop the current function or process.

Accelerator key (hot key) — A shortcut key on the keyboard that can be pressed to perform a specific action. Usually the **ALT** key in combination with another key, but can also be a combination of the **CTRL** or **SHIFT** keys with another key. The underlined letter on menu items and field labels indicates an accelerator key that is available. Function keys are also considered accelerator keys. *See* Function keys.

Activate — To bring an application or document window to the foreground. If you are working in more than one application or more than one document with the active program, the active window is the window in which you are working.

Alphanumeric — Consisting of both letters and numbers and often other characters (such as a question mark).

Application menu — The main menu of the program; it is displayed in a horizontal format. Sometimes called *operations menu* or the *Menu bar*.

Backup — Act of saving some or all of the data on a backup disk. Backups are extremely important in the event of data loss, data damage or computer failure. Making regular and complete data backup copies can save countless hours of data reentry.

Bit map — Graphic image that fills appointment spaces illustrating and indicating breaks in scheduling. *See also* Pixel.

Boolean — A switching function that has two options, such as True/False or Yes/No.

Capitation — The payment made to doctors from managed healthcare services for those patients who select this primary care provider, regardless of whether they visit that provider or not.

Case — A grouping of claims usually with at least one thing in common, i.e., the same carrier, the same diagnosis, etc.

Case-based — A method of accounting that helps keep track of transactions of a common nature; transactions tied to a case.

Chart number — An eight-character control number to a patient's information.

Check box — A square box with associated text that represents a choice. When a user selects a choice, a check mark appears in the box to indicate that the choice is in effect.

Choose — To execute and complete a command. Some commands are executed when you select the menu command; others execute when you choose **OK** in a window or dialog box.

Clearinghouse — A company set up to process Medisoft insurance claims transmitted electronically, distributing those claims to various carriers.

Click — To place the mouse pointer at the desired location and then quickly press and release the left mouse button once.

Close button — The button in the top right-hand corner of an active window which, when clicked, ends an activity and removes that window from the display. Closing a program window clears the immediate screen in which you are working. *See also* Exit.

Close — The button in many windows that closes the active window but not the program.

CMS — Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration – HCFA).

Combo Box control — A combination edit control and list box control with a down arrow button control. The button control displays a drop-down list box so a selection can be made.

Conditional expression — An expression applied to Data fields in Report Designer that contains at least one "if" clause.

Control — A component of the user interface that allows the user to select choices or types of information, i.e., check box, entry field, radio button, etc.

Cursor — A movable object (such as the flashing underline or block) on your screen that indicates the position where keyboard input appears.

Cyclical billing — A method of equalizing cash flow by spreading billing processes through the month.

Date format (MMDDYY or MMDDCCYY [for Medicare forms]) — The format used to enter dates in Medisoft programs. The date is entered without punctuation, using two digits each for month, day and year.

Default — A preset value in a field.

Diagnosis code — One of the ICD-9 codes used to identify a patient's condition.

Dialog box — A moveable window containing controls that a user uses to provide information required to process a user request.

Double-click — To place the mouse pointer at the desired location and then quickly press and release the left mouse button twice.

Drag — To place the mouse pointer on an item and, holding down the left mouse button, move the pointer to the desired location and release the mouse button to set the item in the new place.

Drop-down menu — A menu that emerges in a downward direction from a point or line at or near the top of the window. The series of menu levels displayed underneath the main menu are drop-down menus.

Edit control — The most common type of control for entering text.

EOB Report — "Explanation of Benefits" report provided by the insurance carrier at the time a check is sent for payment of submitted claims.

Exit — An action that ends the active application and removes all windows associated with it. Usually press on the program Title bar. Many data screens also have **Exit** or **Cancel** buttons, as well as a **Close** button (*see* Close button).

Expression — A formula or equation that lets you introduce variables into Data fields in Report Designer.

Field — The space allowed in the window for entering data, usually labeled by a field name, e.g., *Code Name*.

Filter — A procedure that reads data from the keyboard, modifies the data, and displays it on the window; that is, you set parameters through the keyboard, the program searches the database for data that fits your parameters, and displays the result on the window.

Focus — The control or area of a window where user interaction is possible, where the data entry or action can occur or is occurring at a set point in time. A button that has the focus usually has a broken line box on the button. An edit control indicates that it has the focus by the blink caret (vertical cursor).

Folder — A container in which documents, program files, and other files are stored in the computer or on disk. Also referred to as a *directory*.

Format code — A character assigned to a data entry field that can be used in designing a report.

Function keys — Keys usually identified by the letter "F" followed by a number from 1 to 12 which provide shortcuts to accessing various parts of the program. Each key can have assigned functions in different software.

Graying — A visual cue that a choice is not available at that time; a menu item or control is displayed in a gray color instead of black.

Guarantor — A person who accepts responsibility for the payment of the patient's debt.

HCFA — *See* CMS.

Highlight — Contrasting color or reverse video (light letters on dark background) indicating selection of a menu option or field in a window.

Hint — Brief summary of function displayed in a small yellow balloon when the mouse cursor is placed on an icon in the toolbar or on a field in a window. Hints are also displayed in text form in the Status bar at the bottom of the application window. Also known as a *ToolTip*.

Hotspot — A point of reference in a window that provides additional information concerning the picture, word, or group of words on which the cursor is resting. To signify that a hotspot is present, the cursor becomes a hand. Click anywhere you see a hand. Text that is linked to a hotspot is displayed in green and underlined in one of two specific ways: Solid double underlining moves you to another topic or activates a particular macro; dotted underlining displays a brief definition.

Icon — *See* Speed button.

List box — A control that presents its data in a list format from which a user can make a choice. Normally a vertical roll bar appears on the right side of the list. Also known as a *scroll box*.

List window — A window unique to Medisoft programs which presents each record of the given data file in a list format. This window is also called the *browser* window, indicating that the data can easily be viewed and browsed through.

Managed care — Healthcare organizations that offer patients treatment to contracting providers and facilities for payment of a set co-pay amount. Services and co-pay amounts vary with the plan under which the patient registers.

Maximize — To expand the active window to fill the entire screen. The Maximize button is the middle of three buttons in the upper right corner of the Title bar.

Minimize — To reduce the program to a button on the Task bar. The Minimize button is the first of three buttons in the upper right corner of the Title bar.

Operation — A function in the program which may be selected from a menu.

Operations menu — The main list of options in a program. Also referred to as the *application menu* or *Menu bar*.

Pixel — Short for "picture element." The smallest graphic unit that can be displayed on your screen. All the images displayed on a computer screen are composed of pixels. *See also* Bit map.

Procedure code — A CPT code established by the American Medical Association consisting of up to ten characters which identify a service provided to a patient. A charge is assigned to each procedure and is included with the code data. Procedure codes are also used to record payments or adjustments to patient accounts.

Provider — Usually a doctor, but may also be an assistant or nurse who renders services.

Radio button — A circle with text beside it. Radio buttons are combined to show a user a fixed set of choices from which only one choice can be selected. The circle is partially filled when a choice is made.

Record pointer — The pointer on the left side of list windows that indicates the record selected.

Right-click — To position the mouse pointer in the desired location and then click the right mouse button. This action displays the Speed menu.

Select — To highlight or mark a section of text, menu name, command, dialog box option or graphical object with the keyboard or with mouse actions.

Shortcut — A quicker, more direct method of doing something than the ordinary procedure; usually keystrokes as opposed to using the mouse.

Speed button — An image or picture displayed on a window on which the user can click to select a particular function or software application. Also known as an *icon*.

Speed menu — The menu that displays when the right mouse button is pressed. This menu normally duplicates functions that can be initiated in other ways.

Statement — A summary of a financial account showing the balance due.

Status bar — The gray bar across the bottom of an applications window which displays data and information pertaining to the field in which a user is working.

Submenu — A menu related to and reached from a main menu.

Suboption — An option on a submenu.

Superbill — Checklist of procedures and diagnoses used to indicate the procedures that are performed during an office visit. Once completed by the doctor, it becomes the basis for transaction entry. Also known as a *Routing slip*.

System menu — A drop-down list that displays when the System menu icon is selected (the upper left square in a window). Usually contains items such as Restore, Move, Minimize, Maximize, Close, Switch To.

Task bar — The bar at the bottom of the screen that contains the Start button, as well as minimized buttons of any active program. In the Medisoft program, it also contains written hints concerning buttons and windows.

Tertiary — Of third rank, value or importance. In the Medisoft program, the patient's tertiary (third) insurance carrier can be an attorney, employer, or anyone else that needs a copy of insurance claims.

Title bar — The area at the top of each window that contains the window title and System menu icon. When appropriate, it also contains the Minimize, Maximize, and Close buttons.

Toggle — To switch between two options, such as showing hints or not showing hints.

Toolbar — The bar just below the Menu bar that usually contains speed buttons to perform specific functions in the program.

Transaction — Recording of both charge procedures and accounting procedures to depict accounting activities.

Validation — A process used to detect input data in order to determine whether they are inaccurate, incomplete or reasonable. The object (or set of functions) that actually performs the validation of the data is called the *validator.*

Walkout Receipt — A receipt issued to the patient at the time of payment specifying the procedures and related accounting codes for which he/she was treated.

Window — An area on your computer monitor screen surrounded by a box which contains information for temporary use. Windows may be used to display information or to enter data. They may include search information, help text, notes, etc.

Windows Operating System — A graphical user interface developed by Microsoft Corporation wherein action is controlled by movement with a mouse or by clicking on icons.

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