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SmartDoctor® Automated Patient Care System

by
Intelligent Medical Systems, Inc.
of Alpine, Texas
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USER MANUAL

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CHAPTER 1 Basic concepts of using the SmartDoctor® system.

The SmartDoctor® Automated Patient Care System is a comprehensive computer software tool to be used by physicians, nurses, managers, and the general office staff to provide efficient, comprehensive, and safe patient care. The system covers all aspects of patient care in a typical medical office practice. This includes, appointing patients to the clinic, recording their arrival, nursing intake, provider notes, prescription writing, procedure notes, ordering and reviewing laboratory data, immunization checks, provider charges, care plans, management functions, etc. In addition, the system has a complete accounts receivable system, including electronic billing. Further, the system has many features to make daily tasks much simpler than they would otherwise be, including facilitated personal note taking, a clinic bulletin board, and an on-line phone book to keep track of all phone numbers for the entire staff.

There are two basic concepts to grasp in use of the SmartDoctor® system. First is, that of the Family file system and Patient file system. Second is the form of data entry, single valued entries versus multi-valued entries.

Nomenclature.

In this document, any items enclosed in "<>" brackets represent the key strokes or data to be entered. Screen text will be shown in **bold**.

IMS will be used to indicate Intelligent Medical Systems, Inc, of Alpine, TX

All screen shots have fictitious names, addresses, phone numbers, etc.

Family and Patient file systems.

Starting with the concepts for the Family and Patient file systems, patients are assigned to family units or head of household (HOH) units. This increases the overall efficiency and reduces errors by only having to enter the basic family information such as address and family insurances one time, rather than repeating it for each family member. The patient file contains only the unique information of the patient and a pointer to the family file. The family file indicates the head of household or responsible party, which can be either the husband, or wife, or possibly a third party agency.

The family file contains the basic information about the family. The head household is the person to whom the bills will be mailed. The family file includes the address, contact phone numbers, primary clinic physician, any notes about the family situation, and insurance policies that would cover multiple family members. Insurance policies for a single individual such as Medicare or Medicaid, and those policies written only for the patient, should only be listed in the patient file. When insurance policies are listed for selection, insurance policies from the patient file will be displayed first, followed by any insurance policies in the family file which can possibly apply to this individual also.

To create a new family and patient in the system, first enter the family information. In addition to the above mentioned information, this would include the social security number and workplace for both the head of household and spouse. You may add notes regarding the family as well as information you want to show up at the time of sign-in and exit billing.

The patient file contains unique patient information: relationship to the head of household, sex, birth date, social security number, activity status, type of residence, marital status, etc. This file also contains insurance policies that apply only to this individual.

Since patients are grouped into family units, all billing is addressed to the head of household in the family ledger files. This method simplifies the task of knowing who to bill for a given individual, and also shows overall family ledger status.

If the head of household is a patient, then there also needs to be a patient file for this individual. This is not duplicating any data entry since only information not entered in the family file is needed. When going into the patient file to add a patient, you will first be prompted to put in a cross-reference term to find the family file to be associated with this patient. Next you will be asked: "**Is Patient also Head of Household?**" If you answer “yes”, then all the pertinent information will be pulled from the family file. Finally, complete the specific information needed for this individual.

Concepts of data entry.

There are two forms of data entry, single valued prompts and the multi-valued prompts. The single valued prompts can only have one data element in them. They are generally preceded with a prompt number and description. Examples of this would be sex, date of birth, social security, etc. Generally, when populating single valued prompts when the system is in the "add mode" (as indicated at the right hand side of screens title bar), you will be stepped through each of the single valued prompts. When you complete filling in the single valued prompts, you will automatically be placed in the "change mode" (as seen on the title bar), and be prompted to go back and make corrections by the specific Prompt number, All the prompts, or to just Fill in blank prompts. The multi-valued prompts will start with a line number, and will scroll down the screen to list or enter as many values as are needed. When in a multi-valued prompt the “Line” heading will be highlighted for that prompt. An example of a multi-valued prompt would be multiple phone numbers. There can be none, one, or many. Generally to modify the multi-valued prompts you: (A)dd to the lines, (C)hange a multi-valued line, or (D)elete a multi-valued item. You can also use the up arrow key to go back through fields and lines of a multi-valued prompt, while still in a prompt line.

If you go from one type of prompt such as single valued prompts, to the multi-valued prompts, you can go back up to the first type of prompts by typing <u> (for up) at the change prompt.

When you add a line of text to the LINES section of the data entry screen, just press <Enter>, the cursor will move to the next line and add a new line number. If you do not want to add any more lines, press <F1>. See the Line Notes prompts at the bottom of the screen if you want to make any changes or corrections before you exit. (See "Using the Line Prompts" below for further information.)

MAKING CORRECTIONS:

If you try to erase a line and receive a message that "**a response is required**", then you can only alter it. You may want to retype it (type over text), or use the backspace or space bar to erase parts of it. If you don't have enough information to fill in a line that requires a response, try typing <F2> or <?>." to bring up the help screen. To move from the end of a line to the beginning of the same line quickly, press the down-arrow and then the up-arrow. You may use the left and right arrows for moving forward and back on a line. After making a correction, always arrow over to the end of the line (if you are not already there), or hit the <End> key (if using a PC) before pressing the <enter>

key. Otherwise you will only enter the part of the line that is before the cursor.

USING THE SINGLE-VALUED PROMPTS:

To make corrections to a single valued prompt, enter the prompt #. After you have made a correction on that field, arrow over to the end of the field and press <Enter>. Pressing <Enter> at the end of the field, enters the correction and returns the cursor to the Change prompt below. Hitting the <enter> key before reaching the end of the field, will truncate the field data to the cursor position. To make corrections to more than one prompt, enter "A" (for all). You may move down the single valued prompts by pressing <enter> at the beginning of each field. To Fill in any prompts, enter "F" (Fill). The cursor will then move to the first blank prompt. You may press <Enter> to move to the next blank prompt. Enter <F1> or type <end> (not the End key on a PC) to end filling in prompts. You then either exit the prompts or will be stopped at a required prompt.

USING THE "LINE" PROMPTS:

To add a line (in multi-valued prompts), type <A> (add) and press <Enter>. A line number will appear before each new line of text you type. Press <F1> to end the numbering. To make a change on a particular Line, at the change prompt at the bottom of the screen, enter <C> (change) and then the line number. To insert something between lines, enter <I> (insert) and the line number above which you want to insert the text. For example, to insert text between Lines 2 and 3, enter <I> and then <3>. To bring any line up to the top of the viewing area, enter <L> (list) and then the line number you would want to scroll to. To restore the original order, enter <L> by itself. Enter <D> to Delete a Line of Text. Specify by entering the line number, and then answer the prompts.

NAVIGATING THE "LINE" PROMPTS:

To move around quickly when the Line (multi-valued) prompt is presented with many lines (as in the Family Ledger), or more than one screen full, the following short cut methods are provided. You can enter <lb> at the change prompt for “list bottom”. This will scroll you down to the last line. You can also enter <sb> to “select bottom”, which will have the same effect of scrolling down to the last line and then selecting it, with it's line number. You can also use the “page up”, “page down”, “up arrow”, and “down arrow” keys to navigate the multi-value prompt. Once you see the line you want to work on, enter that line number.

ENTERING DATES

In general, dates can be entered in one of several formats: 0603, 060304, 06032004, 06/03, 06/03/04, 06/03/2004, <TODAY> (upper or lower case) will be replaced with today's date. If the year is left off, it is assumed by the system to be the current year. If the century is left off, it is assumed to be the current century (2000) if the number is between 00 and 10. It is assumed to be in the past century if the number is 11 through 99. Of course, you can enter the century explicitly. You will want to do this if the patient was born in the 1800's such as 1899 for a patient who is 105 in 2004. You will also need to add the century for a person born between 1900 and 1910 (or 2000 will be assumed for the century).

ENTERING PHONE NUMBERS

Phone numbers can be entered in a 7 digit or 10 digit form, to represent phone numbers without or with area codes respectively. You can enter the numbers with or without the dashes “-”. The entries without dashes will be converted automatically to numbers with the dashes added.

ENTERING SOCIAL SECURITY NUMBERS

Social security numbers (often abbreviated as SSN) contain 9 digits. These 9 digits can be entered without dashes, and dashes will be automatically placed. If you elect to enter these with dashes,

they must be in the form of: xxx-xx-xxxx.

A WORD ON SELECTION RANGES

When specifying ranges that span both numbers and characters, or that span both upper and lower case characters, you need to know the sorting order that will be used. The sorting system sorts with the standard ASCII code system order sequence, as follows: space * 0 1 2 3 4 5 6 7 8 9 0 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z a b c d e f g h i j k l m n o p q r s t u v w x y z. There are many additional characters not listed here (a total of 127 ASCII characters), since they would normally not be used in the procedure charges coding system. Therefore if you wanted to select from 99212 through a Medicare Pap smear of G0101, you need to list the number as the starting range, and the G code in the ending range.

In addition, most range prompts can also take and/or will default the following terms: “FIRST”, “LAST”, “ALL”, “TODAY”. However, they do need to be used in the appropriate context. For example, entering <TODAY> in a name field, would not result in a good search.

REPORTS AND OUPUT

In general, you will be given an option at the bottom of the screen after a selection menu for the form of the output you want as follows:

```
Enter (S)creen, (P)rinter, (B)oth, (F)ile, or (O)ther printer :  S
F1=End/Exit-1   F5=Business Printer  F6=Main Prntr  F7=lab printer
```

The default will generally be “S” for screen. Each clinic has its own standard printers that can be selected by using the appropriate F-Key. Further the output can be directed to a specific file or other printer. This will vary significantly depending on how your clinic is set up, and HIPAA restriction. Talk to your system administrator if you want to use these other output options.

CONTROL CHARACTERS, MAIL, AND GENERAL COMMANDS

1. $ or # Problem:

If you ever see $ or # sign on the screen waiting for data entry, hit <Ctrl> <d>. This rarely happens when a program does not shut down properly.

2. To get to the **Interoffice mail** program - go to the Quick Menu (F4) and then select **Mail**

You will then be given a selection seen below:

```
Welcome to the Unix mail system
For a short summary of mail commands, type help or ?

Do you wish to:
     1) Send mail
     2) Read new mail
     3) Read old mail
Enter your choice
```

To send mail - press <1>

You will then be asked whom do you wish to send mail. Type in the initials of the person and press enter. You will then be asked the Subject. Type it in, and press enter. At the next line, type in your text. When finished, to end the message and send, enter a blank line and press <Ctrl> <d>.

To read mail - press <2>

At the “**&**” prompt, type the number of the message you want to read or <t> to get the next

message. Then press <enter> to read the message. If you read a message and then do not delete it, it will automatically go to Old Mail.

To read Old mail - press <3>

At the "**&**" prompt, type the number of the message you want to read, or just type <t> to get the next message. Then press <enter> to read the message.

Simple Commands for the Mail:
t - to type it
d - to delete
q - to quit

3. Terminal or PC Lock-up Problem:
While using a Terminal input device, the screen hangs up. That is, will not respond to any keystroke or action.
Discussion: This problem is often a result of hitting the(control) <Ctrl> key instead of the shift key while hitting the letter s. The <Ctrl> <s> combination is a basic system command that tells the system to stop transmitting to the terminal. The screen will stay frozen until the <Ctrl> <q> command is given, the system command to continue to transmit.
Correction of problem: While holding the control <Crtl> key down, hit the letter <q>.

On PCs using a terminal emulator or a client application, the system may appear not to be responding, because the screen is not active. Check to see that the window is active by looking at the top bar. It should be blue if it is active. If it is gray, then click anywhere on the window to make it active.

When using a PC with a terminal emulator or a client application, be sure to exit the program before closing the window. That is, end-out or <F1> back to the point that you are presented with a new login prompt. Closing the window prior to doing this can result in a locked record or incomplete posting to an associated file, both of which will cause problems for you later.

4. Unwanted message or garbage on screen. If the screen doesn't look normal, you can redraw the screen on the Wyse 150 terminal by hitting the <Ctrl>and <n> keys at the same time. On the PC use the <Ctrl> and <l> (letter L, not number 1) at the same time. If garbage or junk is still on the screen, type "end" and hit the <enter> key until out of the screen.

5. To print any screen - press <Ctrl> <r> and then press <P> for printer. Once you get the notice that a print job has been queued, then press <Ctrl> <l> (letter L) to redraw the screen on the PC, or <Ctrl> <n> on the terminal.

7. If you are working on a screen with single and multi-values, and you need to move up on the screen, at the prompt sign type <u> and press <enter>. It will move you up a section.

8. Simple commands for Wyse Terminals:

<Ctrl> + <e> - will move you to the end of the line. You can use the <End> key on a PC.

<Ctrl> + <b> - will move you backward on a line without erasing characters. You can use the arrow keys on a PC.

<Ctrl> + <f> - will move you forward on a line without erasing characters. You can use the arrow

keys on a PC.

<Ctrl> + <p> - will let you insert (or put) characters without overwriting. You can use the <Insert> key on a PC.

If the F Keys are not working use these instead:
<F1> is equal to <end>
<F2> is equal to <?>
<F8> is equal to <top> - is defined as exit without save - it is the same as top

When picking from a list - you can use the following commands if you do not want to page through the list:
LB goes to the bottom of the list.
SB selects the bottom of the list.

LOGIN AND PASSWORDS

Is the Terminal On?
Look for a small green light at the base of the screen. If this light is on, the terminal is on. You cannot tell just by looking at the screen if the terminal is on or off, because it may appear dark in either case. If the green light is on and the screen is dark it is only "napping", so press the Shift key to "wake it up." But if the light is off, you know that the terminal needs to be turned on to bring it to life. Merely press the on/off button (or toggle) on the terminal. See the instruction manual if you are uncertain of its location.

Logging in for the First Time: Before you can do any work on the terminal, you must introduce yourself. Turn on the computer and press the return key a couple of times untill you see the "**login**" prompt. You will need a login name and a password. The login name may be the user's (your) name. The password should be provided by your systems administrator. Type the login name at the "login" prompt and press Enter. When you see the "**password**" prompt, enter your password. Use only lowercase letters for login entries.

Password Security Precautions: You should memorize your password instead of writing it down, for security reasons. Whenever you type in your password, type it carefully. You will not be able to see what you have typed, as it will not appear on the screen. If it is incorrect, you will be asked to log in again. When you enter the password correctly, the date and time of your last (successful or unsuccessful) logins will be displayed. If these times do not match your actions, consult your administrator. He may want to change your password if someone has tried to log into your account.

Why Can't I Log In?
If you cannot log in, it is possible that the "lifetime" given your password has expired. Your systems administrator will need to give you a new password. There may be a limit on the number of unsuccessful logins you are allowed at your terminal or for your account. Your systems administrator will need to give you a new password or reopen your account before you can log in again. Tell your systems administrator immediately if you feel you have entered your logins correctly, since this might indicate that the system has been tampered with. This system will only recognize lower case letters in your login entries. Be sure your Caps Lock key is not on. If everything you type is in capital letters (and your Caps Lock key is not on) try switching the computer on and then off again. If you forget your password, ask your administrator to change it.

Changing Your Password:
The first time you log in your password will be "password," but you should change this password immediately after you log in. It should be a password only you know. Open the "Quick Menu" by pressing F4. In the "Quick Menu" off the “Family & Patient File Maint.” screen (Front Office Menu), Select #14 and press <Enter>. In the "Quick Menu" off the “Doctor Main Menu”, Select #11 and press <Enter>. Type in your old password at the prompt. On SCO Unix Systems, you will be given a choice of picking your own password or having the computer create one for you. To pick your own password, press <Enter> for the default (or enter the number "1"). Then just enter the new password. On Linux systems you will just type in your new password after the next prompt. You will then be prompted to repeat your entry. If you type your password incorrectly when changing it, the password program will terminate and the computer may log you out. Log in again, if necessary, and restart the password program.

Rules for Password Security: Choosing & Using your Password
1. Never give anyone your password. This is YOUR password. If someone gets your password they could log into the system as you and make changes for which you will become responsible.
2. Passwords should never be written, spoken, sent over electronic mail or shared with anyone.
3. Never reuse a password.
4. Never enter your password when someone is watching your fingers.
5. Do not use words spelled backwards.
6. Do not use a password that is easy to guess.
7. A combination of upper and lower case letters, numbers, and special characters is best.
For example: <Golf-Movie> or <this4Me>. Even better, do not used words in dictionary.

Expiration of Your Password: Your systems administrator may have set a date by which your password expires. If your password has expired, you will have to obtain a new one. The administrator decides whether or not you can change password for yourself.

Logging out: To log out, return to your Main Menu and then press the <F1> key (End/Exit), which will automatically log you out of the system. In the event there is a system problem, you may see a "$" prompt or a "#" prompt. If this happens you should log out as follows to prevent damaging system files: Type "exit," and press <Return>. Alternately, you may use the quick log out, <CTRL> <d>. Hold down the CTRL key and press <d>. The "login:" prompt should reappear on your screen after you have logged out.

F-KEYS

To move to different areas of the system quickly, you can use the function keys (F-Keys) at the bottom of the screen. The main advantage of using the F-Keys is that with a single key stroke you can quickly branch to other areas of the system, get the information (or record information), and then quickly return to where you started. The F-Keys at the bottom of the screen will change depending on where you are in the system. In this way logical branching can be set in relation to what you are working on. Screen specific F-Keys will be explained in the specific screens.

The general F-Keys available from most screens are: F1=Exit, F2=Help, F4=QMenu, F5=Cal.

F1-Key: Hitting the <F1> key is the equivalent of typing the word "end". To the Appgen® run-time engine this means end input to single valued or multi-valued prompts. So if there were 10 single-valued prompts on a screen, and while entering on any of these prompts you hit the <F1> key, you

would skip that prompt and all others listed in the group of prompts. You would then be presented with the change prompt at the bottom of the screen or exited from that screen to the prior screen. If you were on the main starting menu after login, then you would exit that screen and be brought back to a login screen. If one or more of the prompts is a required prompt, these prompt will not be skipped, and processing will stop here for a data entry.

F2-Key: Hitting the <F2> key is equivalent to typing the <?> key. To the Appgen® run-time engine, this means present any help messages associated with that prompt. Most data entry fields will have context sensitive help available for you. So if you are not sure of what information is needed in a specific field, simply hit the <F2> key or enter <?>, and any context sensitive help that is available will be presented to you. Occasionally, where the data entry choices are limited, a defaulted "?" will be seen in the data field. All you have to do here is hit the enter key and the context sensitive help will pop-up. Of course, if you know which limited character set you want to enter, you may just enter it and avoid picking from the pop-up list.

F4-Key: Hitting the <F4> key is equivalent to typing the <ctrl+w> keys. The Quick Menu (QM) is slightly different depending on whether your start screen is the main office screen, the main provider screen, or the main system screen. This will allow you to quickly branch to another area in the system and then return automatically to the place that you called it from. Each QM screen available is show below in Figures 1 through 4, being called from anywhere within one of those main screens.

F5-Key: Hitting the <F5> key is equivalent to typing the <ctrl+d> keys. This brings up the calendar function as seen in Figure 4. When the calendar screen first pops up, it is in the month mode. You can right or left arrow to move through the adjacent months. Then to come back to today's date, just enter <t>.

To go to the year version of this screen (Figure 5) just enter <y>, and you will see the yearly format. Move around as above on the monthly screen.

Hit the <F1> from any of these screens to close the calendar function.

OTHER QUICK MENU OPTIONS

In the three Quick Menus above, from the Family (Front Office) screens, the Provider (Doctor Menu) screens, and the System (System Information Files) screens, there are up to 16 items to select from to perform specific functions. Many of these have been discussed above. Many others are simply ways to reach other main menu items without having to go back through the screen to get to these. For example, from the QuickMenu you can temporarily branch to the Booking menu, the Family menu, Insurance menu, etc. Other options branch to previously mentioned menus, but

Quick Menu from Family File screen:

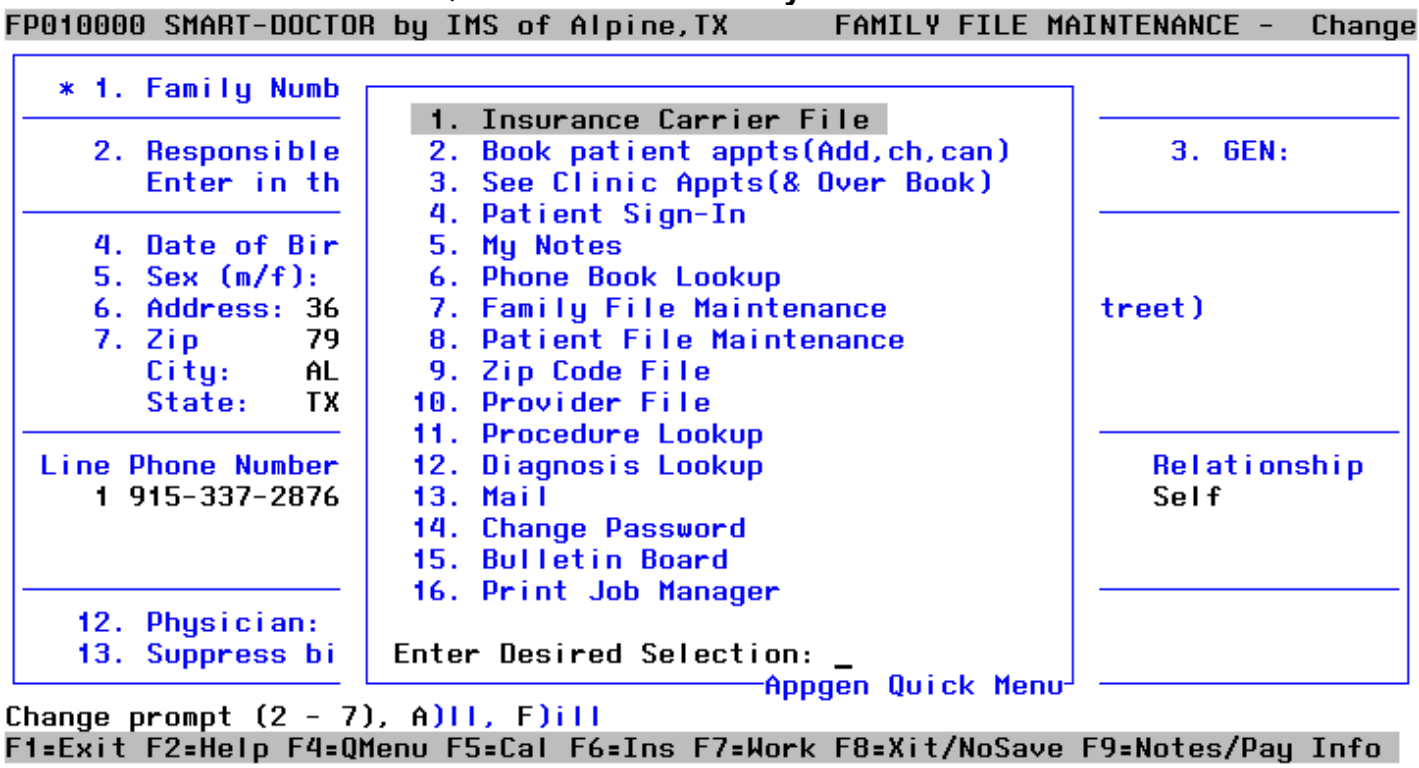


Figure 1 *Quick Menu of the Family File Maintenance screen.*

Quick Menu from Provider Main screen:

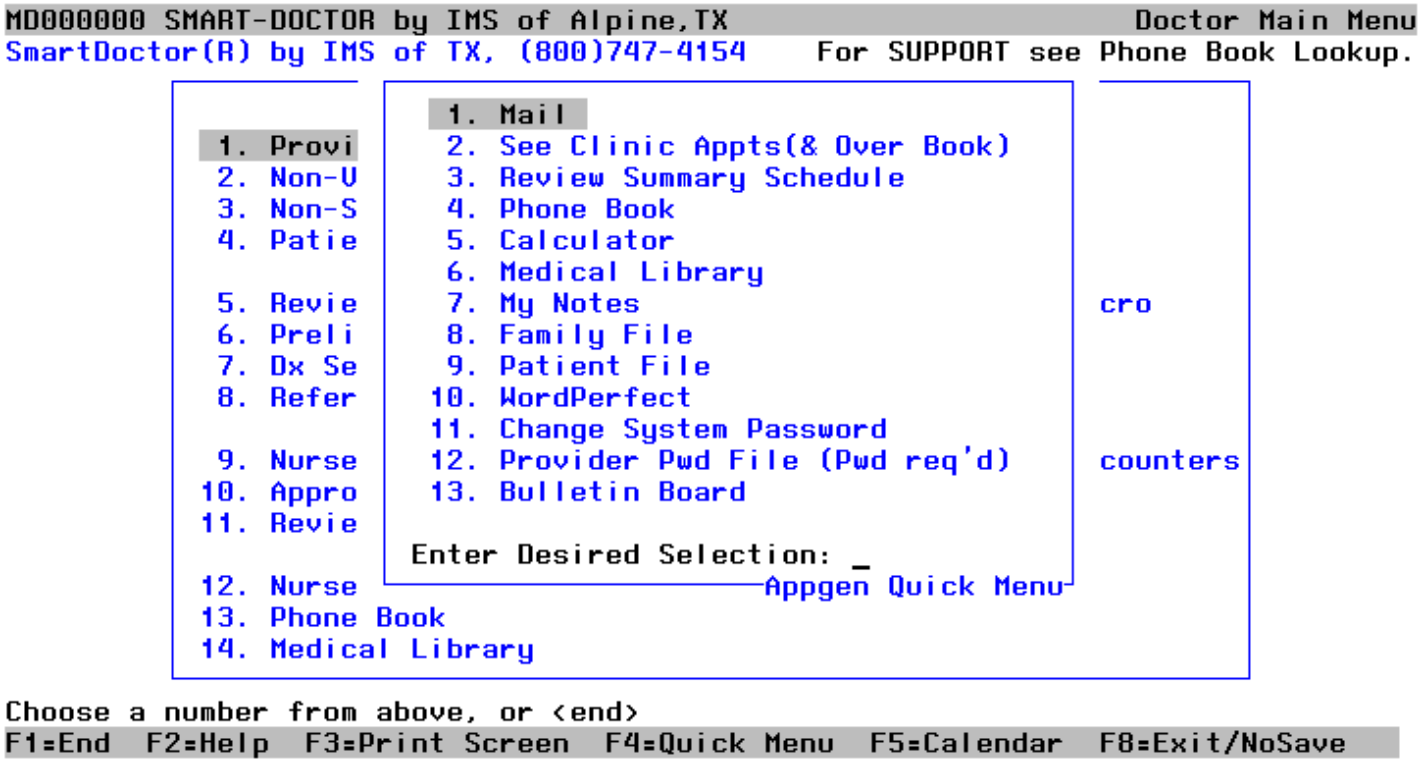


Figure 2 *Quick Menu of the Doctor Main Menu.*

Quick Menu from System Main screen:

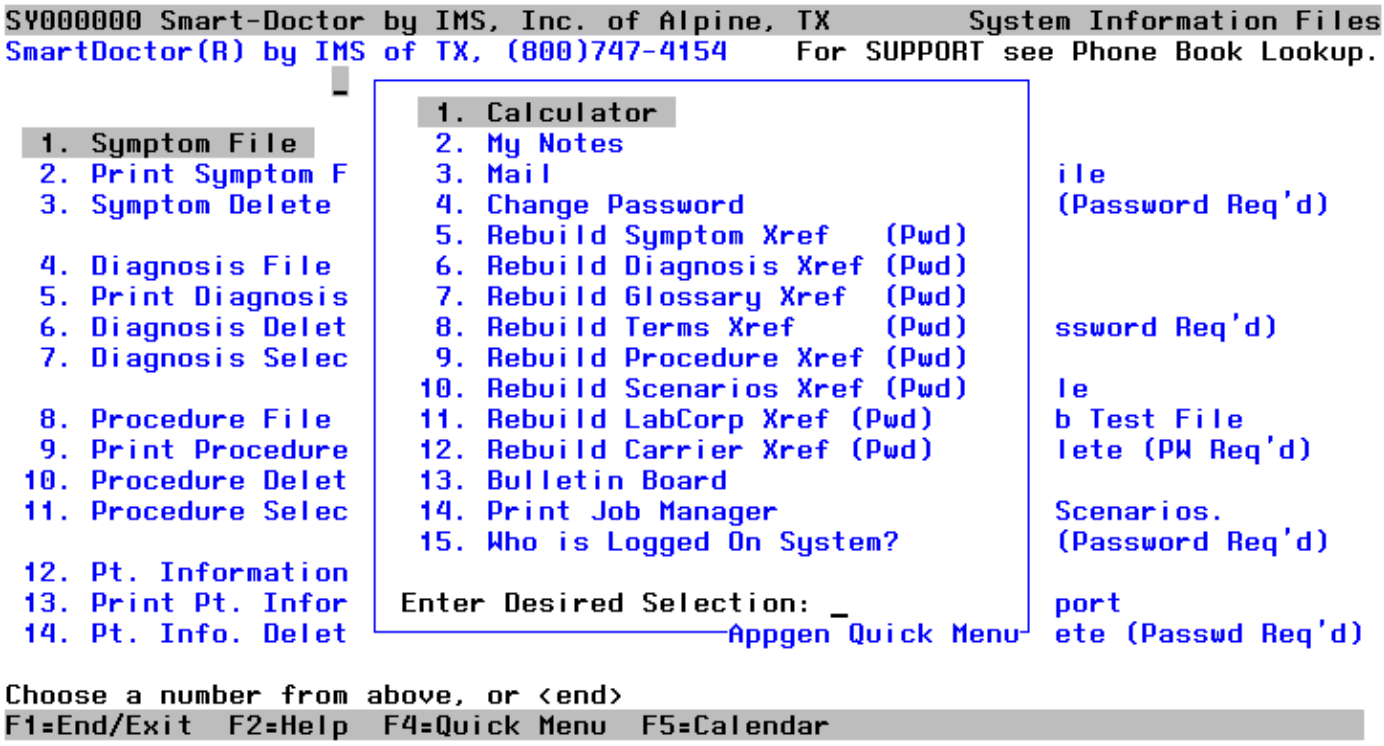


Figure 3 *Quick Menu of the System Information Files screen.*

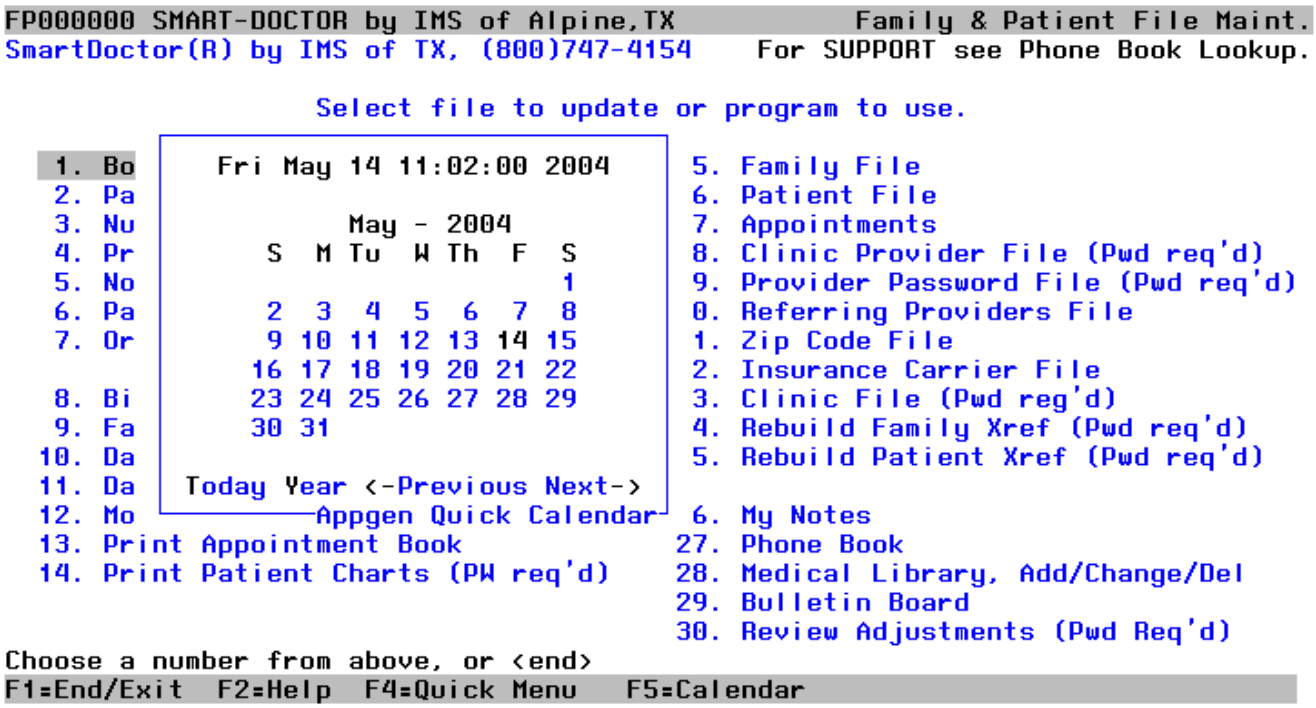


Figure 4 *Calendar Pop-Up in Month Mode.*

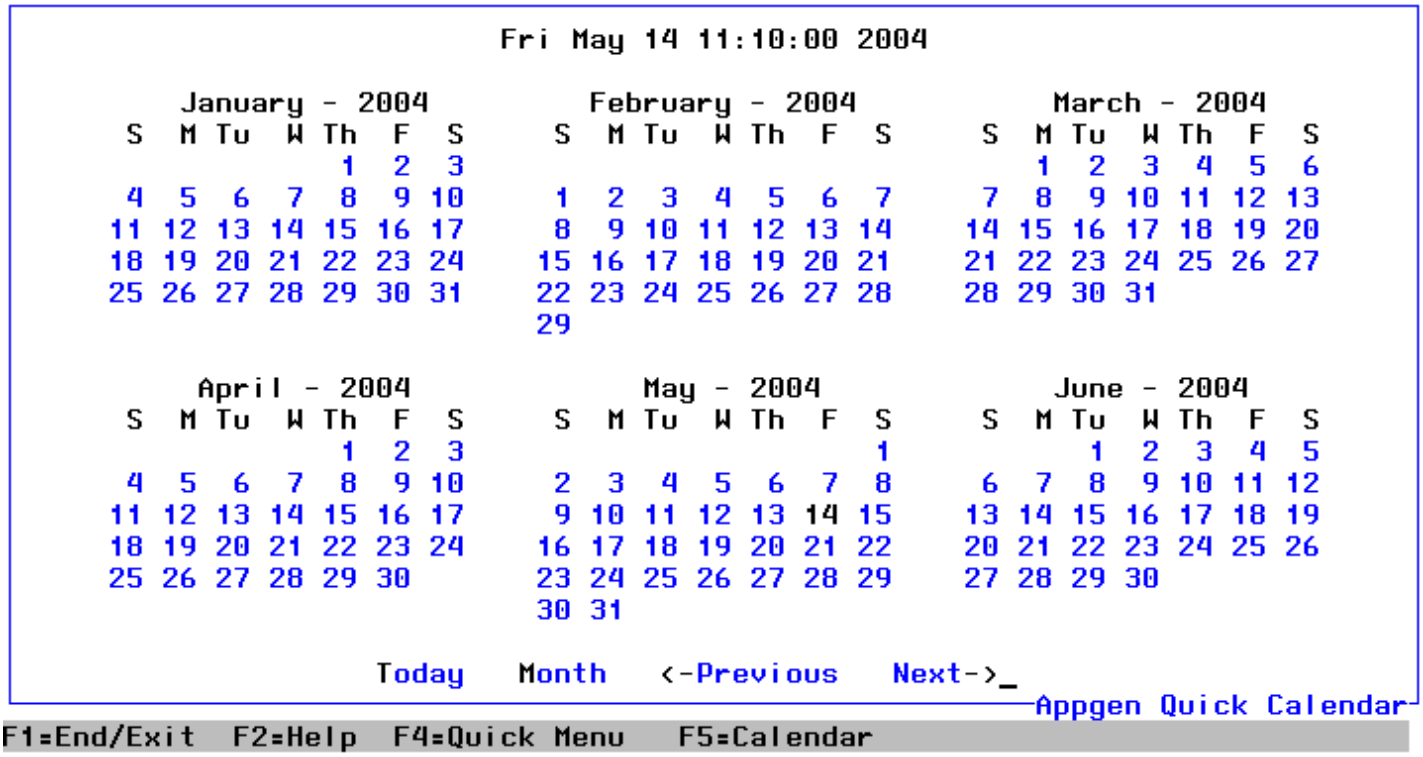


Figure 5 Calendar Pop-Up in Year Mode.

in a lookup mode only, such as the Phone Book Lookup, and Procedure Lookup, etc. The Rebuild selections are to rebuild the specific cross-reference files indicated. See the section on Rebuild Family XREF for general instruction and precautions. The only selections from these Quick menu selections not otherwise discussed are: branching to word processing or other programs, use of the Calculator, Print Job Manager, and Who is Logged On System?, which is discussed below.

BRANCHING TO OTHER PROGRAMS

The system has the ability to branch to other programs on the server such as word processing. For example, we show a branch to “WordPerfect” on the Provider Quick menu in Figure 2. To implement branches such as this, the appropriate software must be installed on the server by IMS. Have your system administrator call IMS if this option is desired.

CALCULATOR

This branch can be selected from the Provider and System Quick Menu screens. The calculator is the Unix/Linux “bc” calculator. This is a scientific calculator that is very powerful. It can actually have programs written in it. However, we will show you how to use it in its most basic form. Upon selecting the calculator from the Quick menu, the following screen will be seen:

```
Welcome to bc calculator

To exit calculator enter <Ctrl d>


_
```

Below are shown two calculations. The first calculation is done to determine what 20% of the fee of $83.24 will be. The result is $16.65, if you round off the number. In this case we entered 83.24 for the amount, used the “*” (accepted math symbol for multiplication) for multiply, and then hit the <enter> key. The result is displayed on the next line.

In the second example, we divided a child's weight in lbs by 2.2 to convert it to kilograms. Then multiplied it by 25mg/kg. Finally divided it by 3 for three times a day dosing, and hit the <enter> key. The result rounded would be 189 mg per dose.

```
Welcome to bc calculator

To exit calculator enter <Ctrl d>


83.24*.2
16.648

50/2.2*25/3
189.39393939393939393933
```

The basic operators are + - * / for add, subtract, multiply, and divide. The multiply and division will be done before adding and subtracting. To get the results you want, it is always a good idea to place the addition and subtraction in parenthesis "()" to get the results you want. Otherwise, do not mix the add, subtract, multiply, and divide on the same line.

For example:

2+1*10 results in 12.
(2+1)*10 results in 30.
2+1 results in 3.
3*10 results in 30.

When done with the calculator, simply hit the <Ctrl> + <d> keys. You will then be returned to the Quick Menu.

WHO IS LOGGED ON THE SYSTEM?

This function is available from the System Information Files screen via the Quick Menu. Upon selecting this item, a screen similar to that shown in Figure 6 below, will be presented.

```
Users Logged On System are Listed Below:

 11:44am  up 168 days, 19:28,  2 users,  load average: 0.00, 0.00, 0.00
User     Tty       Login@   Idle   JCPU   PCPU  What
sjj      ttyp1    10:16am      -      1      -  w
jhd5     ttyp2    11:44am      -      -      -  Menu MD000000 Secret SMART-DOCTO


- Press <return> to continue _
```

Figure 6 Who is Logged On.

It is suggested that the system administrator check that everyone is logged off the system at the end of the day. We have set all systems to automatically kick anyone off the system after two hours of idle time, unless your clinic requested a different time limit. It is important for system security and system maintenance that all users be logged off the system when not actively using the system. Further, it is a HIPAA requirement that users log off when not using the system to preserve privacy and security of patient data.

In Figure 6 above, you can see that two "User"(s) are logged on, sjj and jhd5. The "Tty" column tells

you the terminal they were logged in on; the “login@” column tells you when they logged in; and the “Idle” column tells you how long the terminal has been idle (in this case, not idle). When done, hit the <enter> (return key), and you will be returned to the Quick Menu.

PRINT JOB MANAGER

The Print Job Manager can be reached from the QuickMenu by hitting the <F4> from most front office screens. The format of the print job manager will change depending on the operating system you are using. The clinic managers will be shown how to control the print jobs by the system administrator.

The first thing to do if a print job is running and you want to stop it is turn off the printer (or set it to off-line). Once printing has stopped, you will have time to be sure you are deleting the correct print job. Once the print job is cleared you can turn on the printer again. If the printer starts printing information you deleted, just turn the printer on and off a few times until the buffer of information that was already in transit to the printer has been consumed (every time the printer is turned on, it will fill its buffers with any information being transferred.).

PHONE BOOK

One of the first things you will want to do to make life easier is enter all the phone numbers you need in the systems phone book. This listing will include names, addresses, phone numbers, and any other information you think is pertinent. The Phone Book is listed on the Main Menu as well as in the Quick Menu.

If you just want to look up an address, phone number, or to check to see whether it has ever been entered in the phone book, you should press <F4>. This gives you the Quick Menu. Select "**Phone Book Lookup**" (#6), and press <Enter> to go to the phone book look-up screen.

At the first prompt (# 1), enter part of the description (part of name, company, city, etc.) of the phone number you want. If there is more than one entry with the same cross-reference information, a pop-up window will present the choices from which you can select. In the following example, Figure 7, <amb> was entered to find an ambulance company.

To add a new address to the phone book, go to the Main Menu and select "**Phone Book**" (#27). Then press <Enter>. The screen you see is only to be used for adding or changing addresses and information.

Setting Up the Phone Book

A number is assigned to each address you add. This is a permanent number for reference only. If you decide to eliminate an address, however, the related number will not be eliminated. So, the next address you type will be assigned the next consecutive number. When you accept a new number (as seen in Figure 9 below), you will see the following message, "**This record is not on file FP-PHONE_BOOK. Create a new one?**" Answer with <y> to add a new record.

Next, a pop-up screen, as seen in Figure 10, will ask if you want to add a referring provider.

If you answer yes, then you are taken to the referring provider screen as seen in Figure 11. Hit the <F7> key to start a new referring provider record.

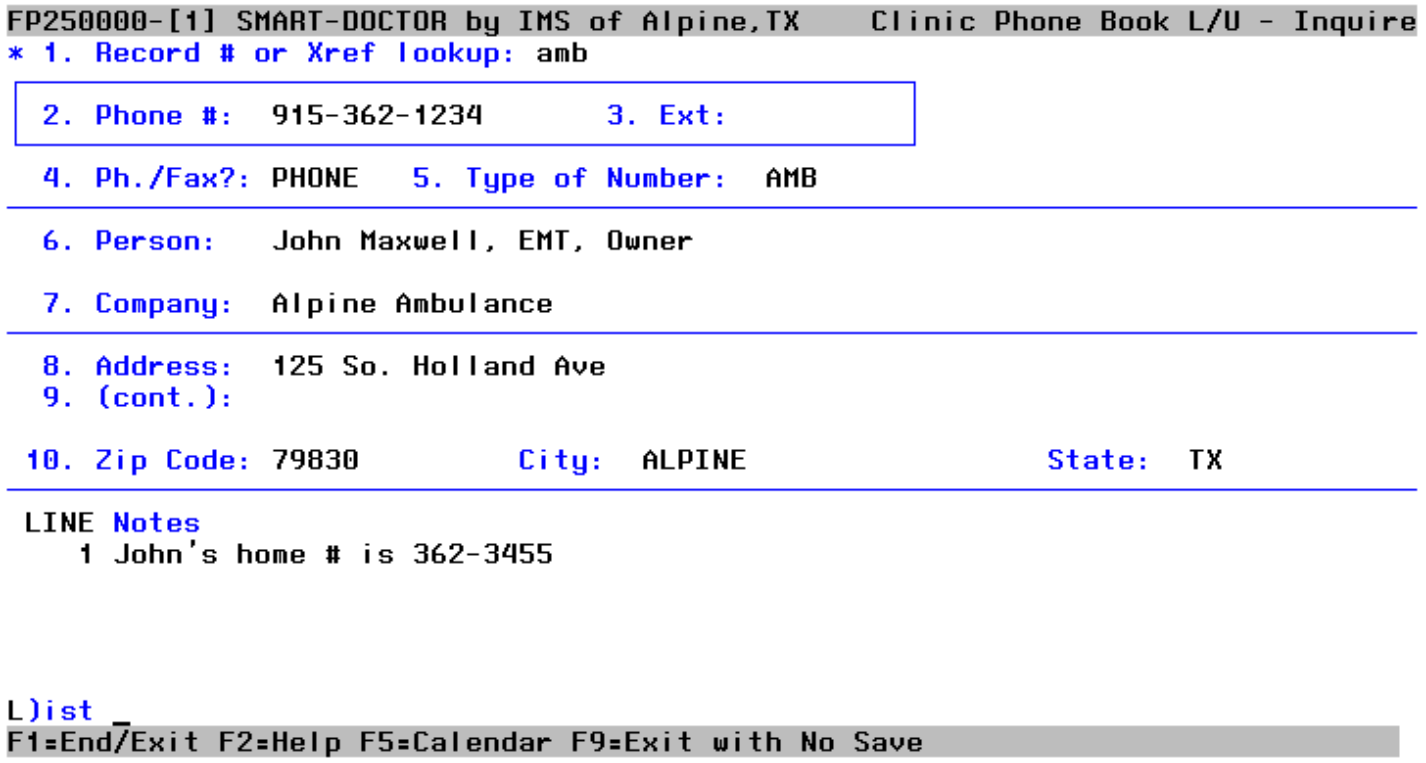


Figure 7 *Phone Book Lookup—Inquire Mode*

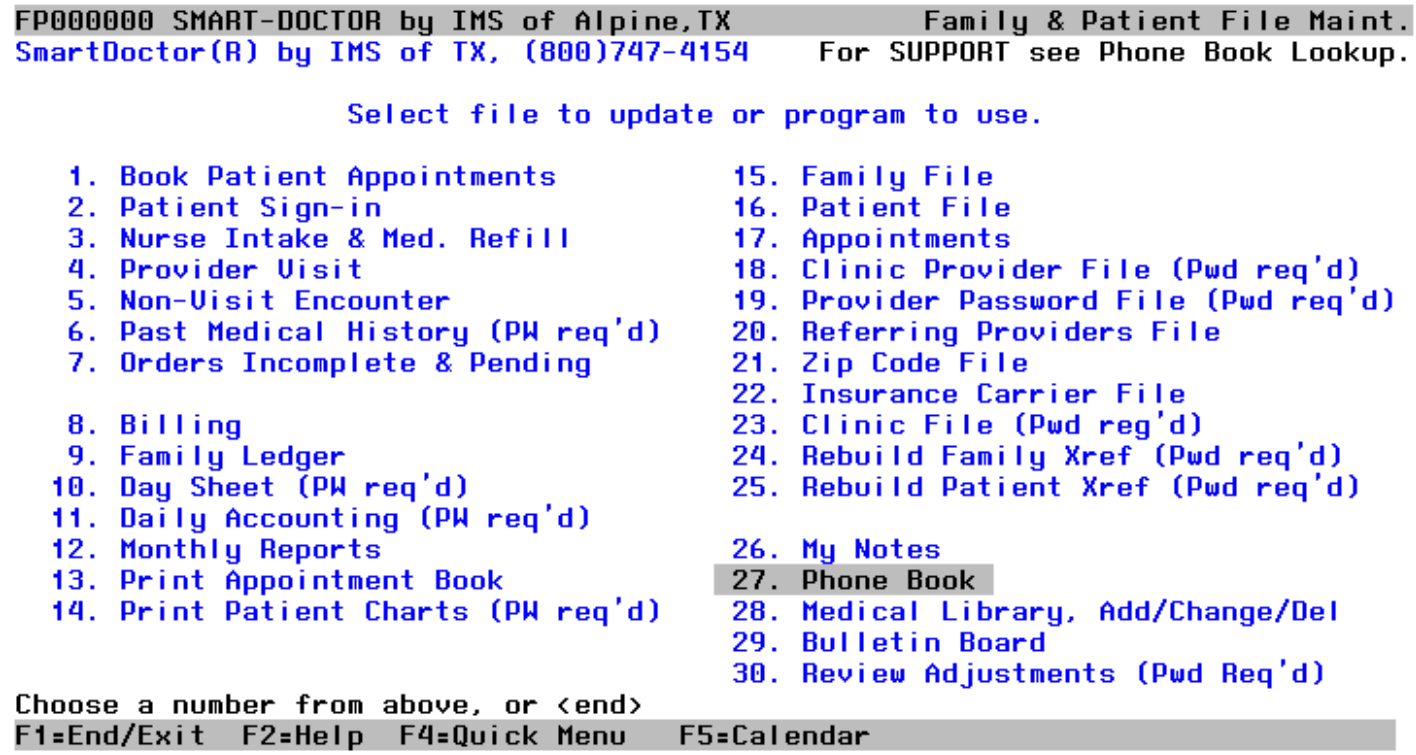


Figure 8 *Selecting to Add to Phone Book*

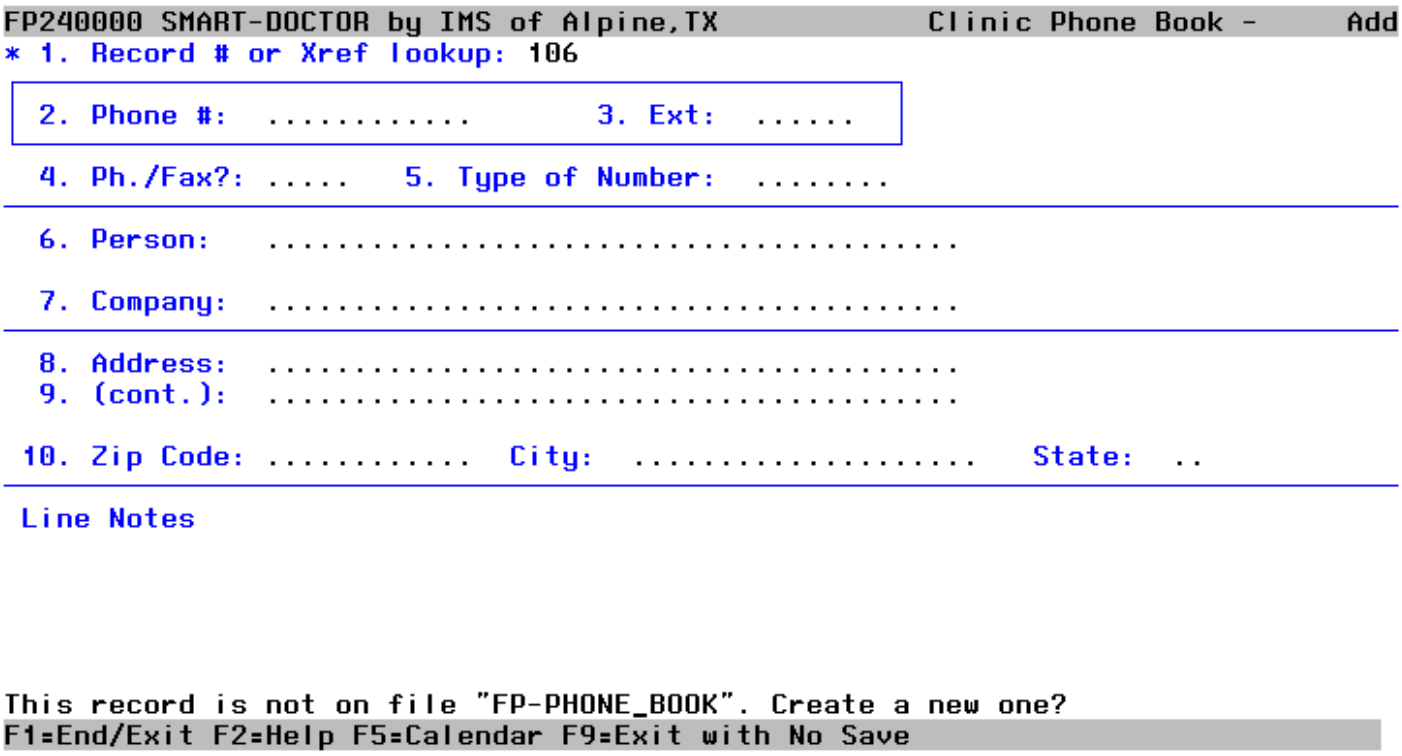


Figure 9 Initial Phone Book Add Screen

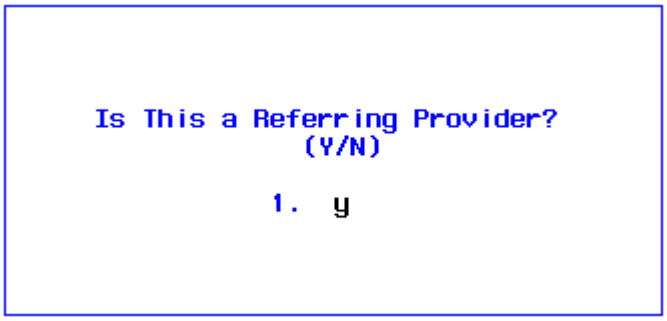


Figure 10 Add Referring Provider Option

Then enter the UPIN number and the rest of the information requested. Upon entering the zip code in prompt #8, the city and state will be filled in for you with information from the zip code file, discussed below. Prompts # 10 and 11 on this screen will give you choices from a pop-up screen, just highlight the selection you want and hit <enter>. The pop-up for prompts # 10 and 11 can be added to in the TERMS file under keys, "SY-SPECIALTY" and "SY-DEGREE", respectively. When complete, a new record appears. Hit <F1> and this will return you to the phone book file. In the phone book, just hit the <Enter> key in each field and the value from the referring provider file will be placed in that field.

If just entering a new phone number, type in the information requested on the entry screen, as seen in Figure 12. After you type in the phone number, you will need to indicate whether you will be making contact by FAX or phone. Press Enter if it is by phone (or type in your choice). For "Type of Number", you need to indicate the type of profession involved, i.e., hosp, fire, doctor, lab, etc. If

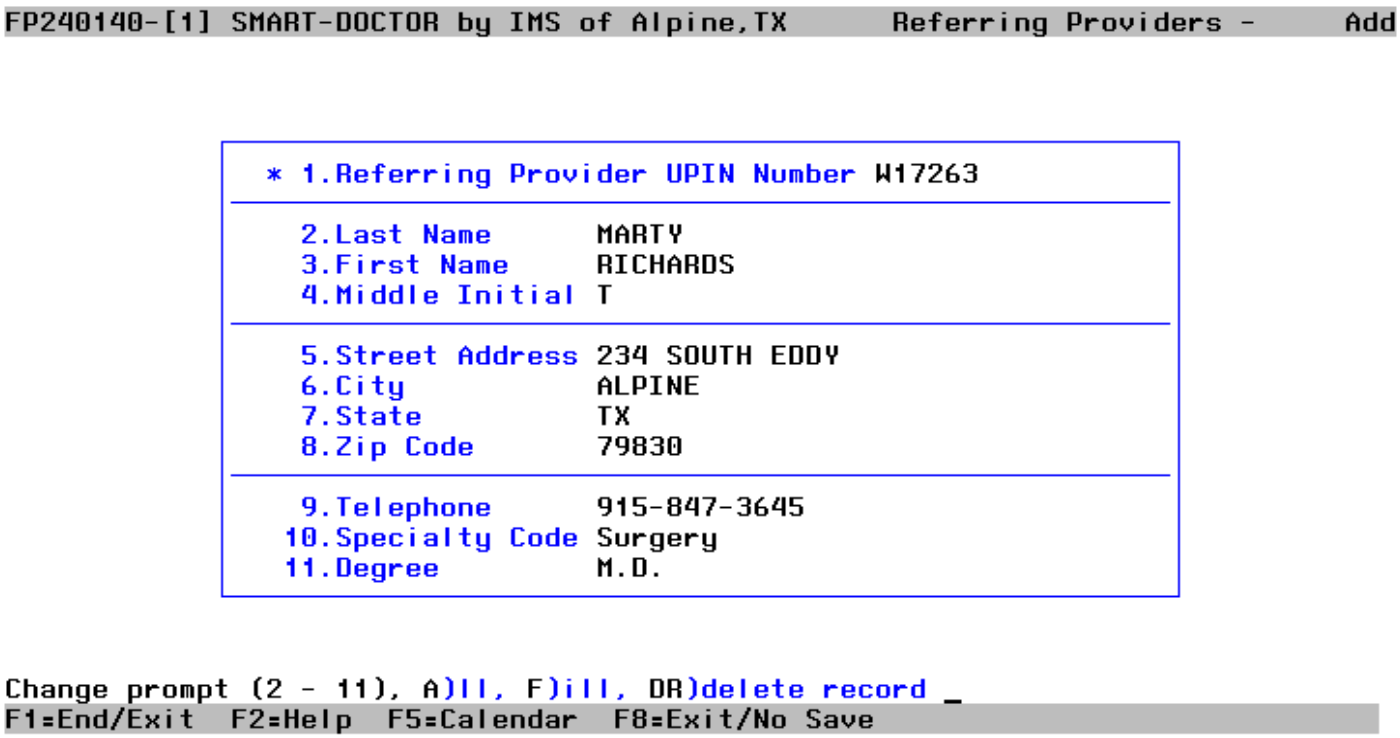


Figure 11 Adding Referring Provider Information.

you do not have a "contact" person, type in "unknown" or "---." You may want to get that information later. Most of the time you will only need one line for the street address, though two are provided. If you know the zip code, you may type it in and the rest of the line will be filled in automatically if it is listed in the zip code file. If you don't know the zip code, press <Enter> to see a list of towns and their zip codes. Press <Enter> to activate the Line Note section when you have completed the address information. Here, you may type notes, comments, instructions, or other information that you would like to have available for contacting this company (such as cell phone number, alternate numbers, etc.). <F1> out of this screen when it is completed.

MY NOTES

This file is for your personal notes (see Figure 13), so the content is not limited. Today's date will be entered on each line automatically. However, you may over-type with any date you wish.

As in all the Line sections, you are allowed to make any changes, additions, or corrections (see "Using Line Prompts"). Only you can see these notes, or anyone knowing your login name and password. So don't give anyone your login or password!

Bulletin Board File

This file is similar to the My Notes file with the exception that this is used for public notes (Figure 14). Everyone in the clinic will be able to read these notes. Most clinics use this as a public bulletin board. You can keep track of supplies that are needed, place announcements about meetings, etc. Also, you can add suggestions for your support personnel, such as, ideas for changes to the system or additional drugs that need to be added to the system. Notify your support staff if you have placed any messages on this bulletin board for them. They do not routinely check this bulletin board.

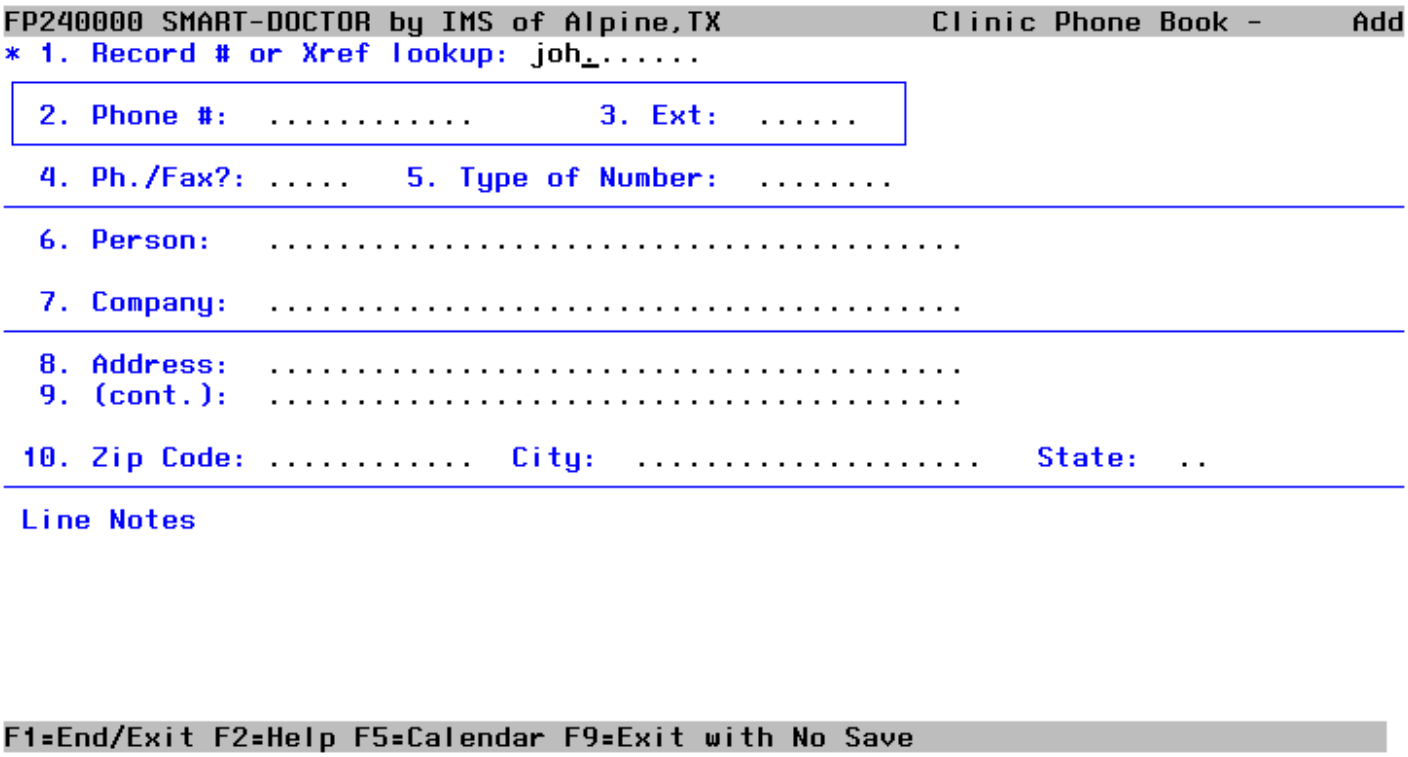


Figure 12 *Clinic Phone Book Add screen*

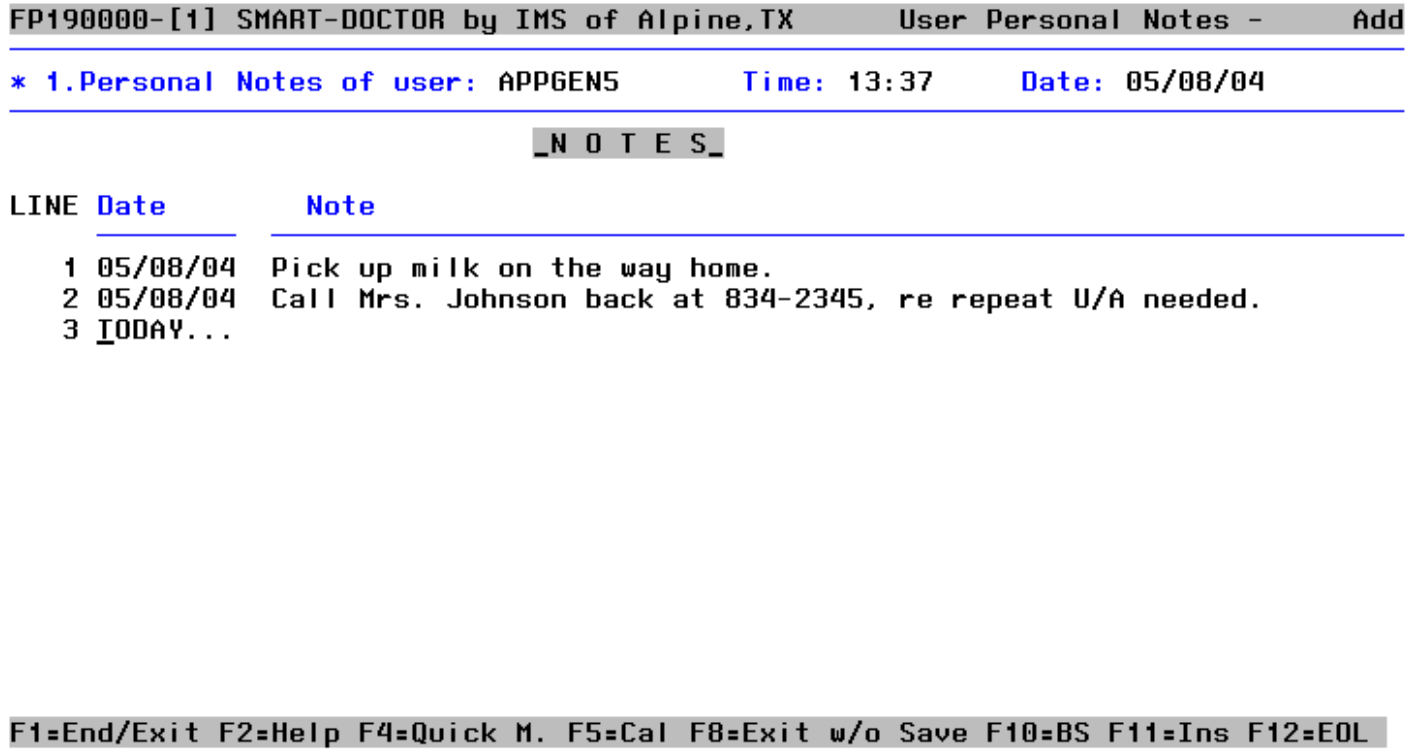


Figure 13 *Personal Notes screen*

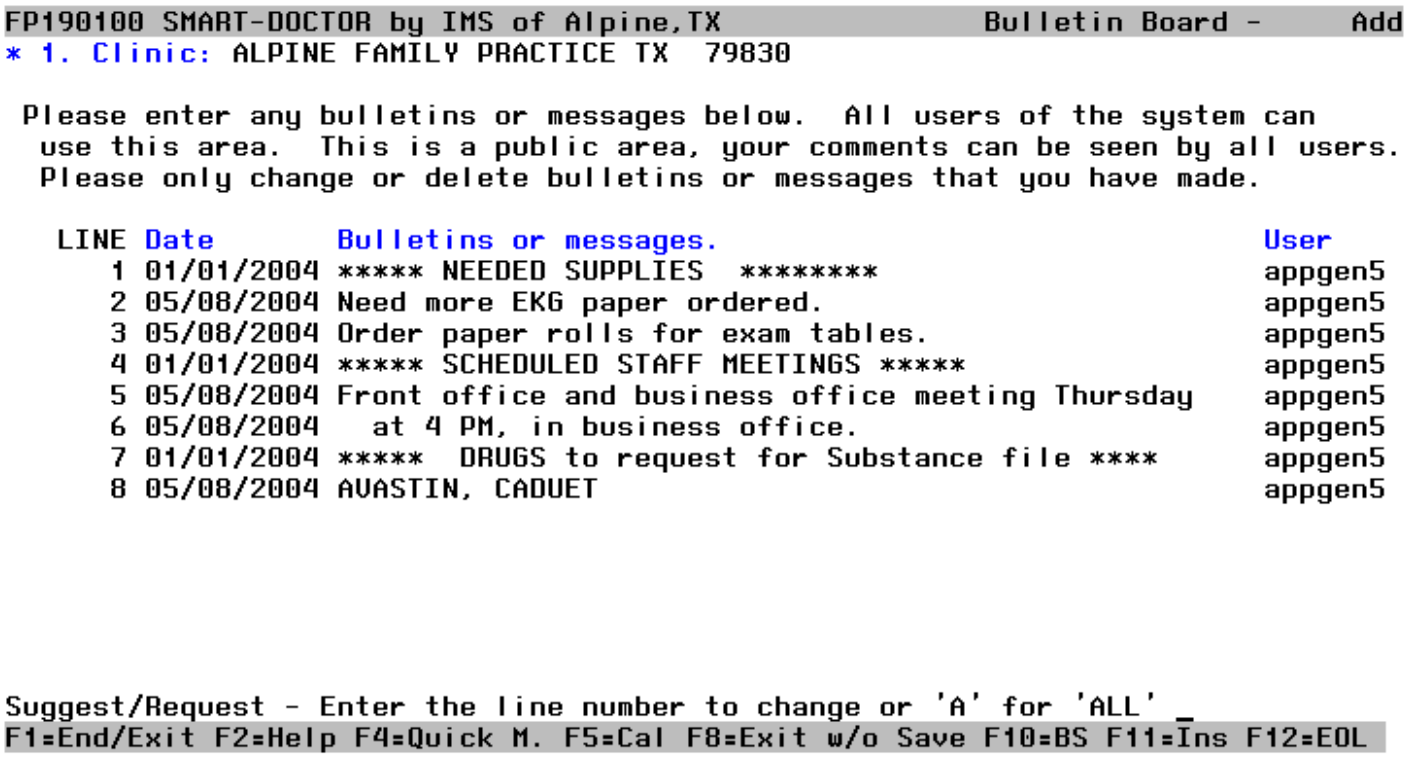


Figure 14 *Bulletin Board screen.*

THE ZIP CODE FILE

You may get to the Zip Code file off the main front office screen or from the Quick Menu pop-up screen. You will then be placed in the ZIP Code Maintenance menu screen.

MAKING ADDITIONS TO THE ZIP CODE FILE

To add zip codes, select #1 in the Zip Code Maintenance menu. Enter the zip code number on the Add screen (5 or 9 digits--no dashes or spaces). Then enter the name of the city. Enter the two-letter state abbreviation at the "State Code:" prompt. You will not be allowed to add a zip code already listed. If you want to take a look at the list anyway, answer "Y" to the "Review?" prompt. The address you have just filled in will not be on the list yet. So, you still have a chance to make changes once you "end" this screen (type <end> or press <F1>). The change prompt on the Zip Code Add screen allows changes on lines 2 through 5 only. So if you have typed the zip code wrong, no changes are allowed. Fortunately, you have the alternative of deleting the whole thing (by hitting the <F8> to exit with no save), if you catch your error before you exit the screen. You may always just start over again!

MAKING CHANGES IN THE ZIP CODE FILE

Select #2 and enter a password to bring up the Zip Code File Change screen. Enter the zip code # to identify the record to be changed. Make the necessary changes using the Change prompt at the bottom of the screen. The zip code number cannot be changed or deleted at this point, nor can you delete the entire record. You may want to review the zip code listing again before you exit to a new screen. If not, enter the default.

PRINT/REVIEW ZIP CODE FILE

Select #3 in the Zip Code File to see the zip codes listed for a particular state or for all the states. If you enter a state code (i.e., postal abbreviation), you will see a listing of zip codes that are on file for cities in that state. If you enter the word "All," you will see the entire list of zip codes.

CLINIC PROVIDER FILE

The Clinic Provider File, menu item number 18 on the Main Menu, contains identification information on each provider working at the clinic. It also has information relating to the provider's medical specialty, medical licenses, provider numbers issued by various agencies, length of affiliation with the clinic, the group or clinic for billing, etc.

MODIFYING INFORMATION IN THE PROVIDER FILE

Select menu item #1 in the Clinic Provider File menu screen to see the Clinic Provider Change screen (Figure 15). In prompt #1, "**Prov. Initials:**", hit enter to see the list of providers from the pop-up screen. Arrow down to the provider you want to see or modify, and hit <enter> to select this provider. Then add or change information as needed, as seen in Figure 16. Use the <F2> help key to get information on what is expected for each field.

The "**Degree:**" field (prompt # 7) is set by IMS and cannot be changed by the user. This field specifies the user's privileges in the system. The actual degree to be listed after the providers name, if not that specified, will be listed in the block next to that prompt labeled "chg_to:".

In prompt #11 "**Taxonomy Code**:", leave blank unless you are certain of your code. Putting in the wrong number will result in denied claims. However, leaving it blank will be accepted at this time (this will probably change over time as the HIPAA regulations are modified).

In prompt #12 " **Tax ID #**:", enter the federally assigned Tax Identification Number of the billing provider. This can be either the Employer Number or the SSN of this provider.

Prompt # 13 "**Type:**", relates to the type of tax ID # entered in prompt #12. Hitting the <F2> key will bring up the help screen with the limited choices. The choices will be "E" for Employer Identification Number, "S" for Social Security Number, and "X" for Corporate name.

Prompt #14, "**Start Date**", is the date the provider started working at the clinic. This must include the month, day, and year, but you may approximate the date using "01" for the day started. If the provider is still working at the clinic, press <enter> to skip to the next prompt.

Prompt #15, "**Leave:**" date, only populate this field if the provider will no longer will work in the clinic.

Prompt # 16, "**Group Number:**", enter "0" if this provider is part of the primary clinic or group. If there are multiple groups at this facility, other than the primary clinic, then add group numbers that correspond to the clinic number for that group. The group number will be used for this provider to pull information for billing from the clinic file of the same number.

Prompt # 17 "**# days Chronic:**", is the default number of days this provider wants for a chronic type of prescription. If the provider generally would prescribe a 90 day supply of medication for chronic type medications, such as thyroid medications, then indicate 90 here.

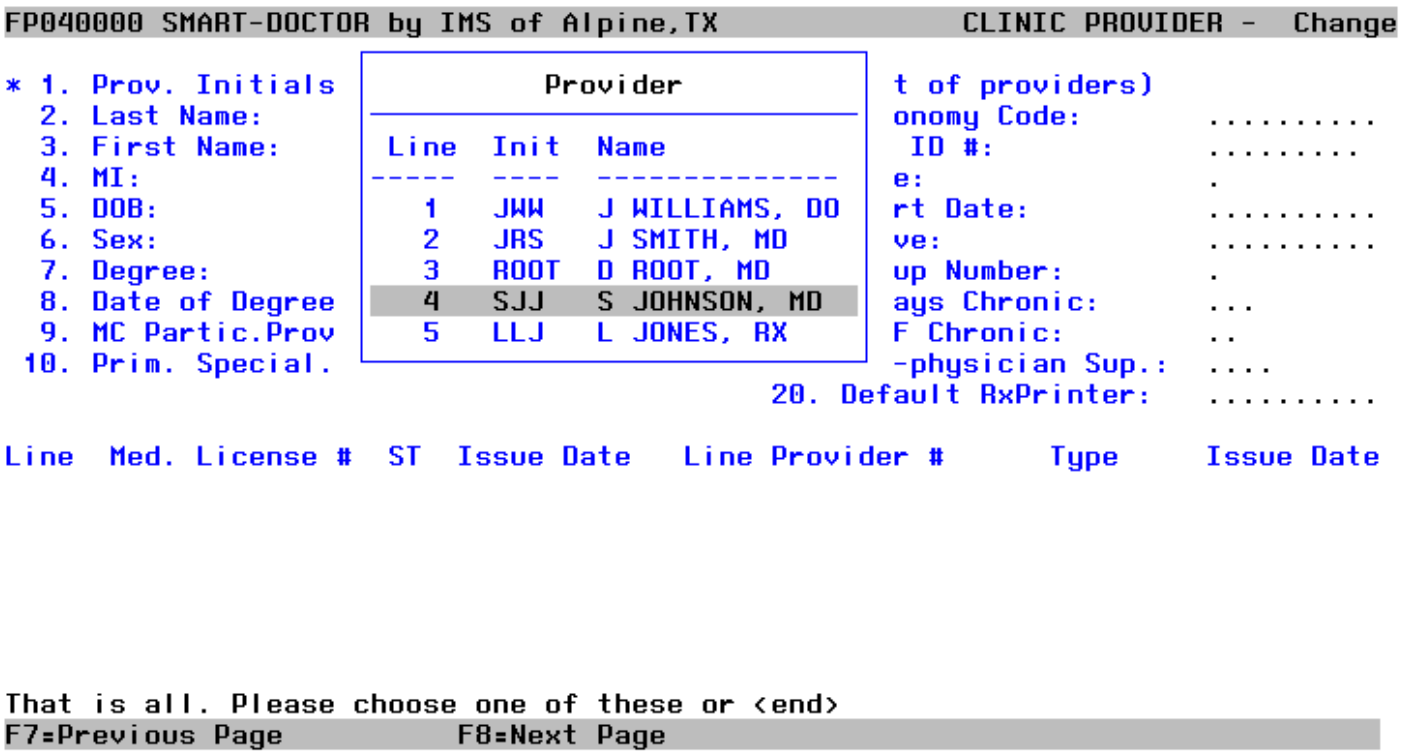


Figure 15 *Select the Clinic Provider for changes.*

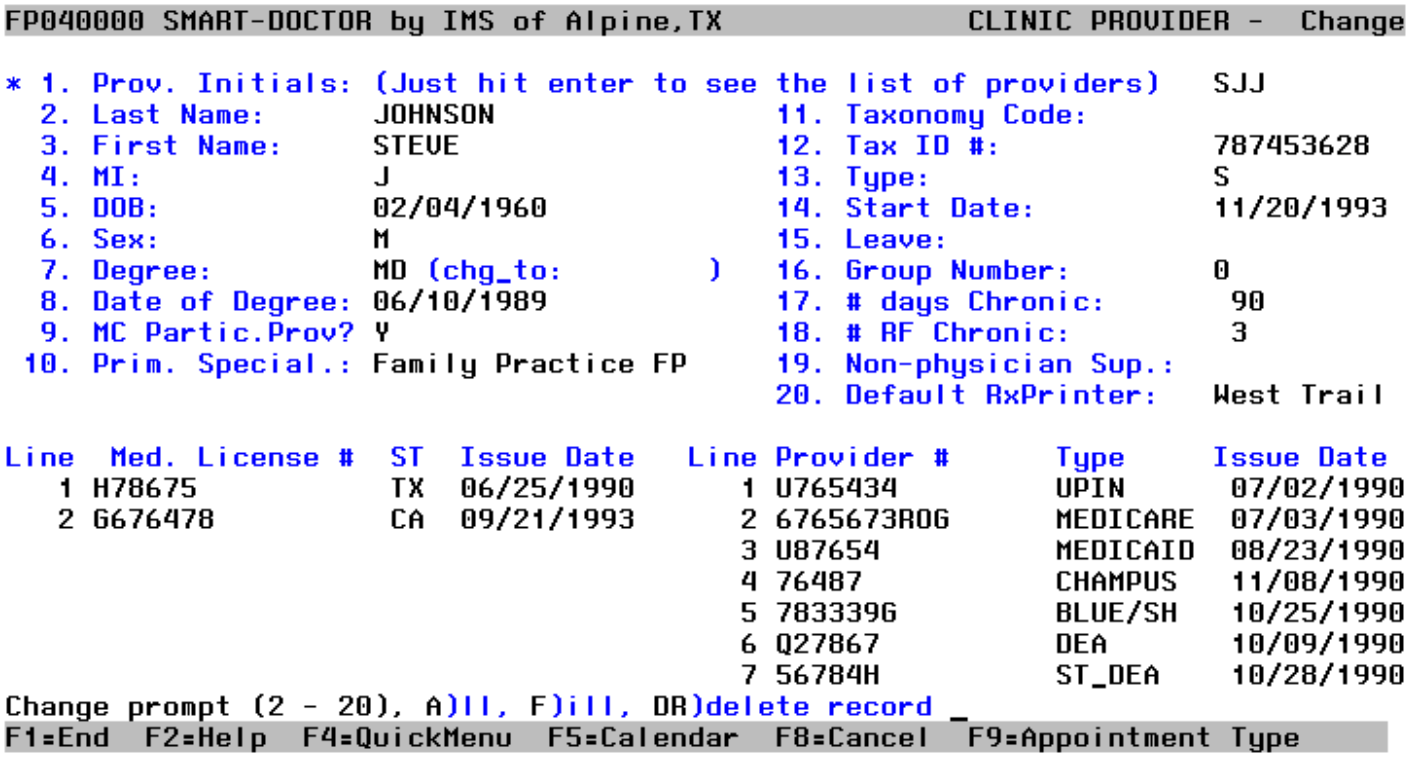


Figure 16 *Clinic Provider Change screen.*

Prompt # 18 " **# RF Chronic:**", is the default number of refills this provider wants for these chronic medications. Typically, this is 3.

Prompt # 19, "**Non-physician Sup.:**", if the provider type in the "**Degree**" field is NP, PA, or any non-billing provider type, then you will be allowed to pick the supervising provider from the pop-up list of providers in that prompt. Of course, you will not be able to pick a provider not entered into the provider file yet.

Prompt # 20, "**Default RxPrinter**:", a pop-up list will be presented of available prescription printers that can be used. Pick the one that would be best for this provider in general. The provider will be able to choose other available prescription printers, at the time of prescription writing. The available prescription printers are listed in the TERMS file under the key "ADM-RXPRINTERS. Only system administrators should edit that record.

Entering the medical license information.
After passing prompts 2-20, you can add to or modify the lower left hand corner multi-value prompt for medical license information. When you fill in the LINE section of the multi-value, you must enter the medical license information (left side of screen) first. Then enter the postal abbreviation for the state where the license was issued (for example, TX for Texas), followed by the date issued. Repeat this process for each license the provider has. Once you have entered this information correctly, press <F1> to end the numbering and press <enter> to continue on to the next Line section.

Entering provider numbers.
These can be state and federal drug license numbers, insurance carrier ID numbers, or state nursing board numbers. Enter any provider or license number issued by state or federal agencies, or insurance companies first. Next, under "Type", pick the appropriate provider number from the list presented (issuing agency or company). The available list of provider numbers are listed in the TERMS file under the key "ADM-PROV-NUM".

Provider Appointment Types.
To set or see the provider appointment types and times press <F9> (Appointment Types "pop-up" screen) to establish the provider's appointment types as seen in Figure 17.

Prompt #1, "**Blocking Factor (min. per slot):**" on this screen is for block time (blocking factor) for this provider. From the associated pop-up screen pick the base block time for this provider. These times go from 1 minute to 90 minutes. Typically, this is 15 minutes.

Next on the lower half of the screen is a multi-valued prompt for the different appointment types. For example, School Physical, Wound Check, Counseling, etc., and the number of time slots required for each of these appointment types. The system will then multiply the number of slots assigned by the blocking factor to come up with the "Actual Time", or minutes for this type of appointment for this provider. This allows you to specify different amounts of time based on provider preference for the same appointment type.

The pop-up screen for the appointment types can be modified. You can add any appointment type you like via the system TERMS file under the ADM-APPT_TYPE key. You must follow the format of the previously added terms. You should use capital letters. The last character of the 8 characters must be an "M","F", or "B", for male, female, or both sexes, respectively. Be sure to always have at least one appointment type for each sex, or one for both ("B"). This prevents getting stuck in the error loop by trying to make an appointment for a patient of one sex, and not having a corresponding "M", "F", or "B".

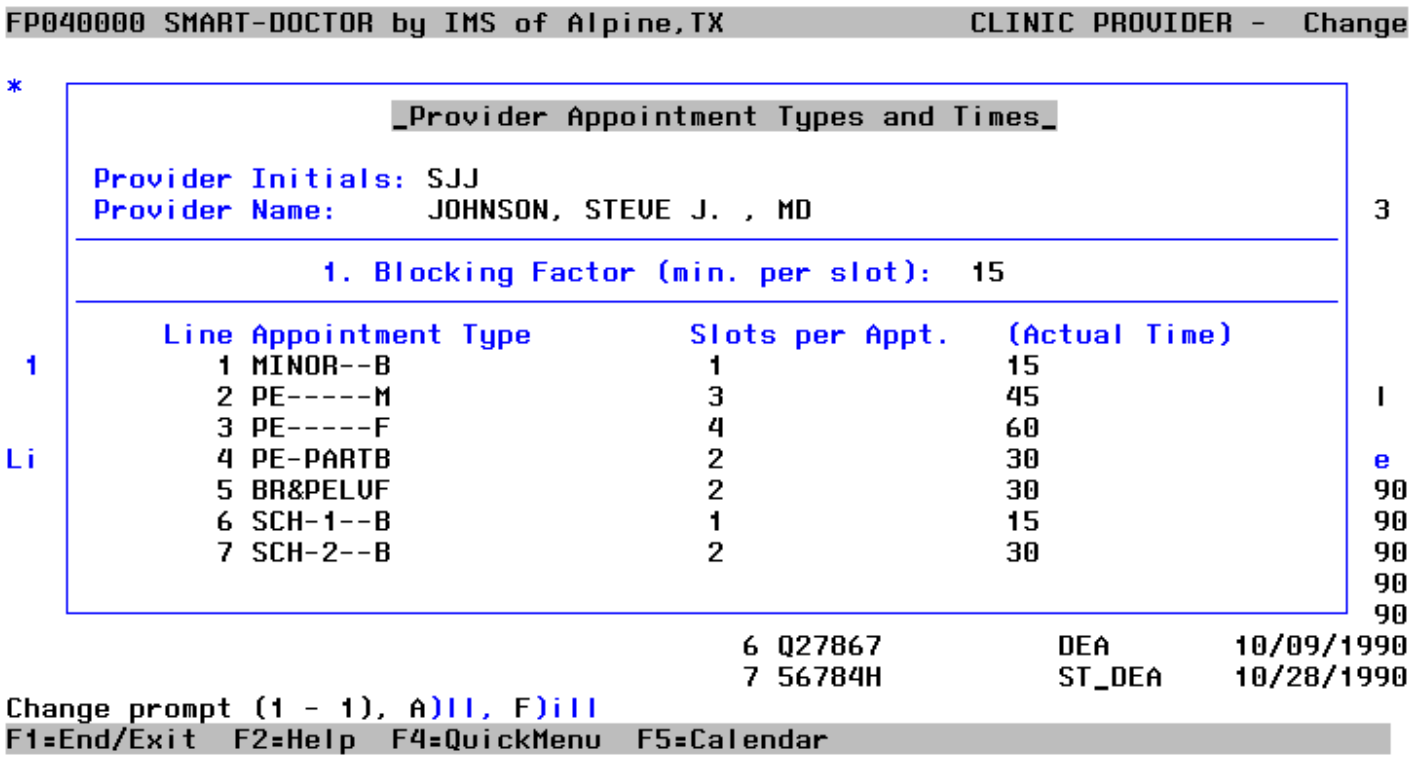


Figure 17 *Clinic Provider Appointment Types.*

PRINT PROVIDER LIST

Select #2 from the Clinic Provider menu screen to view or print the provider listing by professional degree and specialty.

CLINIC FILE

The Clinic File, #23 on the Main Office Menu, is where all basic information about the place of service is entered. The "0" (zero) clinic is the primary clinic for a typical installation. All the information requested should be filled in if available. Additionally, a "clinic" for each place of service should be listed for sites where services are rendered. These additional clinics should only have the clinic name and address entered, since the remaining information only pertains to a clinic which generates bills. If this is a multiple group practice, you must enter the equivalent of the "0" (zero) clinic information for each group. The clinic number will become that of the group number. This group number then must be entered in the provider file to link this information with that provider.

TO ADD A CLINIC:

Each clinic (or site where services are preformed) must be assigned a new number before you enter the clinic name and information. The primary clinic is always assigned the number "0" which is the default at the first prompt. Press <enter> and type the name of the primary clinic (as seen in Figure 18).

If you are adding an additional clinic (or site of service), hit the <F4> key, “New Clinic Number”, to get a new number for each clinic you add. Then enter the clinic name, street address, and the zip code. If you don't know the zip code, press <F7> to make a selection from the zip code list. The rest of the address will be filled in automatically.

To see all the clinics currently listed in the system, hit the <F3> key, "**See All Clinics**".

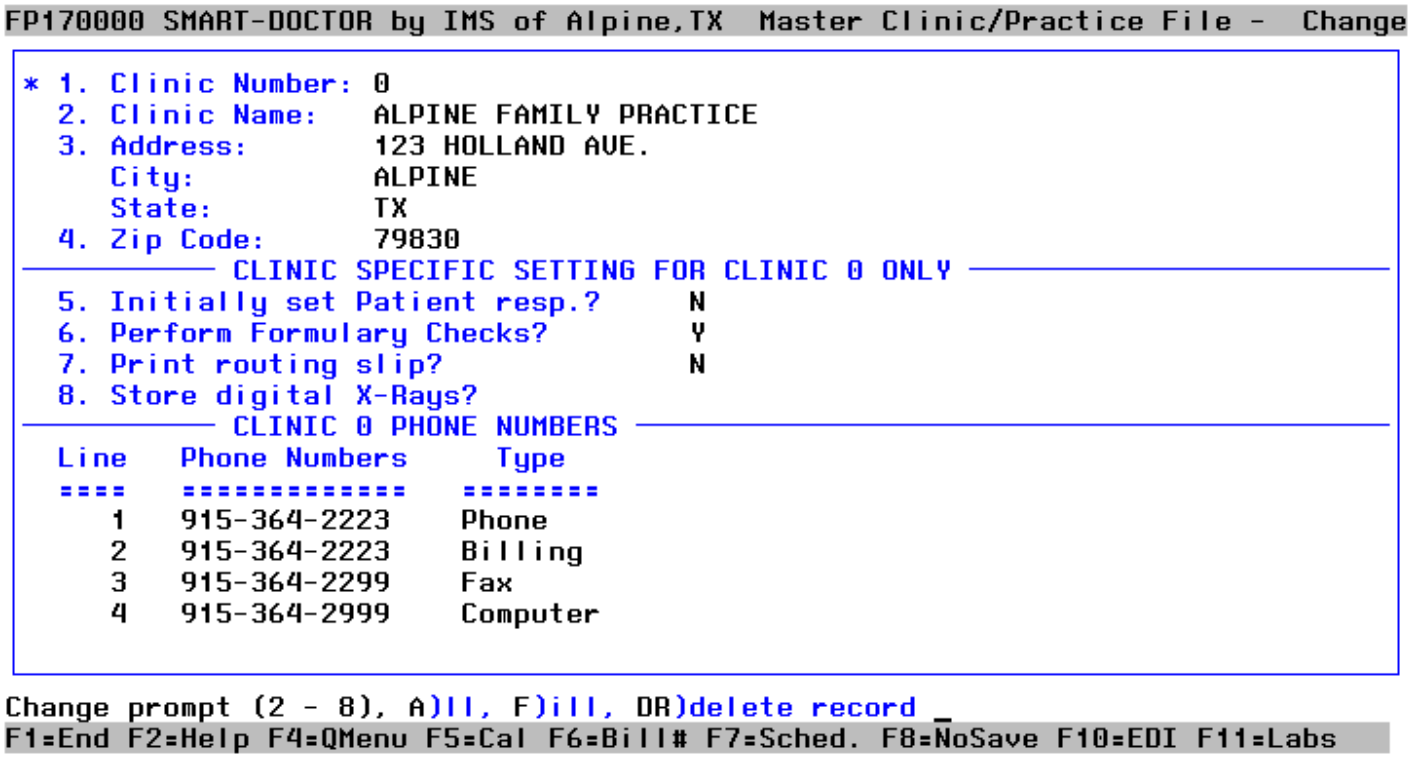


Figure 18 *Setting Up Primary Clinic Record*

Prompt #5 , "**Initially set Patient resp.?**", enter <Y>es if you wish to change the default responsibility to patient instead of insurance. If left blank or <N>o, then the insurance company is assumed to be responsible until changed in charge item document.

Prompt #6, "**Perform Formulary Checks?**", enter <Y>es if you want formulary checks done when prescribing drugs. If left blank or set to <N>o, then no formulary checks will be done.

Prompt #7, "**Print routing slip?**", set this to <Y>es if you use routing slips (not recommended) and have a printer dedicated for this purpose. The "printrte" shell script will need to be modified as needed by your software vendor to indicate the printer to use.

Prompt #8, "**Store digital X-Rays?**", set to <Y>es if you take In-House X-Rays and store the data for viewing on-line. Otherwise, leave it blank or enter <N>o.

To make any changes, use the Change prompt, then continue on to the LINE section. Enter the phone number(s) of the clinic (just numbers--no spaces or dashes in between). Then press <F2> to select the "Type" you need to enter, or enter "Phone," "Fax," “Billing” (required for electronic billing), or "Computer." Press <F1> to end entering these multi-valued items. Use the Change prompt to make any corrections before continuing on.

TO VIEW OR CHANGE CLINIC INFORMATION:

To view or change the primary clinic information, accept the default at the first prompt. To view or change any other clinic information, enter the clinic number or the first three characters of the clinic name, address, or city. You may move through the change prompts to the section you want to change by pressing the return key in order to "continue on." In the LINE section, if you need to change the "Type" but not the "Phone Number," press <enter> to skip past the phone number. (See

"Using the LINE Prompts" for further information.) Press <F3> to see a list of the clinics on file. This list includes name, city, and state only.

TO VIEW OR CHANGE CLINIC BILLING INFORMATION:

To view or change billing information hit the <F6> key, "Bill#", from the main clinic screen to go to the billing information screen, Figure 19.

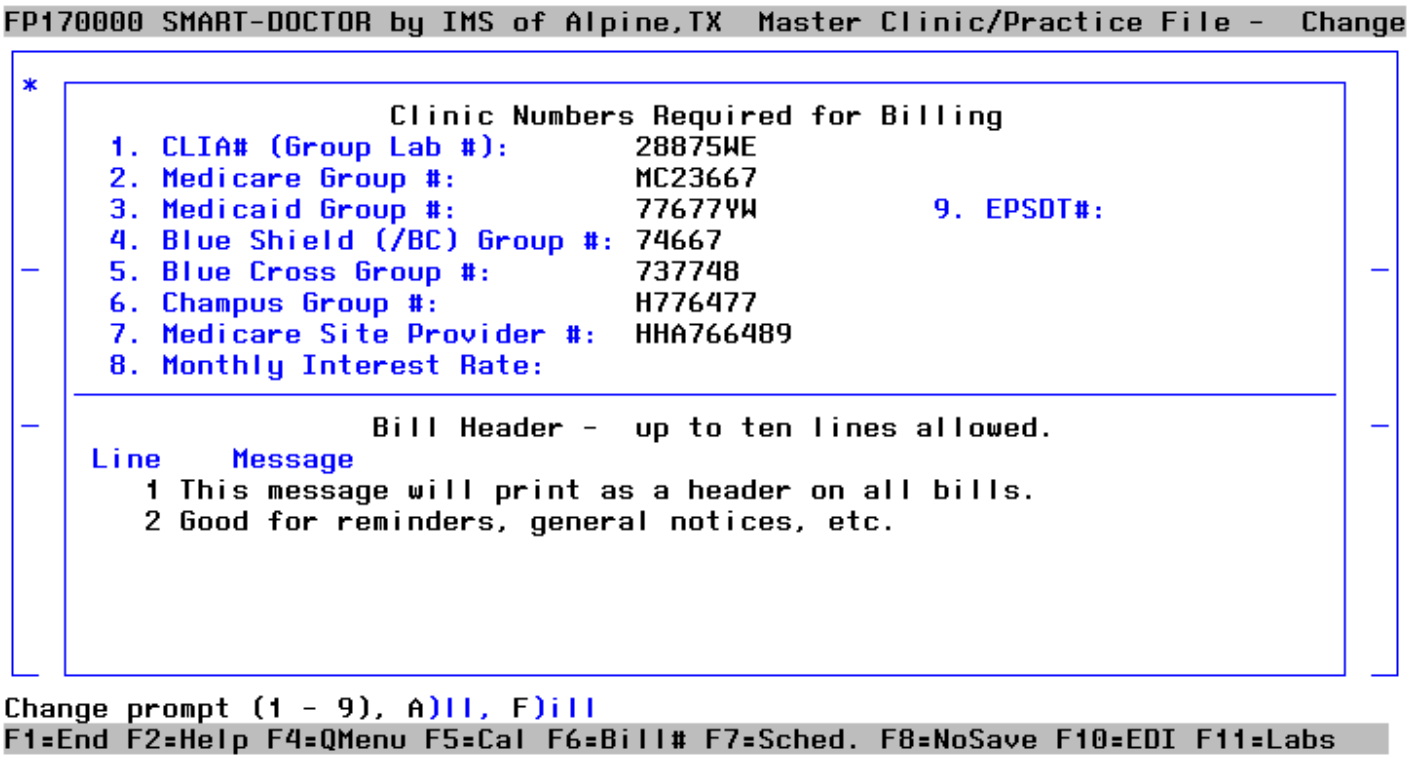


Figure 19 *Billing Information for Clinic*

Prompts 1-9 are for "**Clinic Numbers Required for Billing**" or group billing numbers. If you have questions about these prompts, hit the <F2> help key while in that prompt for any additional information that may help you. Prompt #8, "**Monthly Interest Rate:**", on this screen is for the monthly interest rate to be charged for past due balances. This is only for clinics that want to charge interest. Please notify patients in advance if you plan to do this. This interest will not be calculated monthly if IMS has not been notified by the clinic to activate the monthly interest posting program. In addition, no interest will be posted to the family ledger if the interest field is left blank, the charge item has not be changed to reflect the balance is due from the patient and not the insurance company, or the date of patient responsibility is not over one month.

BILLING HEADER INFORMATION:

The lower half of the billing information screen contains a multi-valued field for entering up to ten lines of text for the monthly bill header. This header is placed below the family name and address and can be left blank, or used to give general notice to ALL families that are billed. This is often used to notify patients of pending vacations, office hours changes, seasonal greetings, requesting credit card information, etc.

EDI INFORMATION SCREEN:

The <F10> key is to enter EDI information for this clinic and is generally only used by IMS. You will not need to go to this screen unless specifically asked to do so by IMS.

LAB INFORMATION:

The <F11> key is to enter lab information in the "LAB INFORMATION SCREEN", Figure 20.

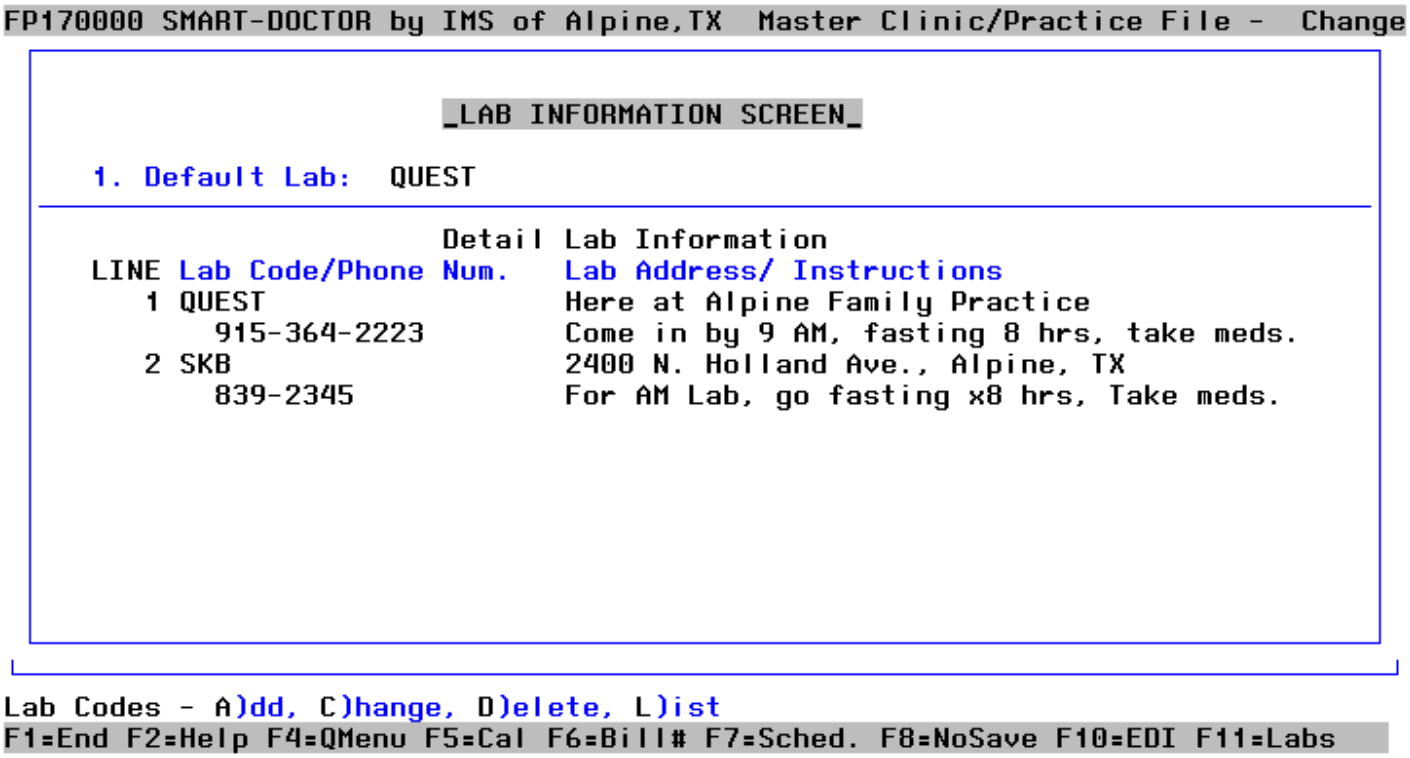


Figure 20 *Lab Information screen.*

Prompt #1, "**Default Lab:**", is for the default lab. On entering prompt #1 you will be presented with a pop-up screen to pick the default lab. The available list of labs are listed in the TERMS file under the key "ADM-LABS". These can be modified by request to IMS. Simply highlight the lab to be the default lab and hit the <enter> key.

Below this is a multi-valued prompt to give lab information that will be printed out on any lab requests that are printed and not automated (request not interfaced electronically with a lab). In adding to the list, you will first be presented with a pop-up from which to select a lab. Next you will enter the lab's address (where the patient is to go, not the billing address), followed by the lab's phone number, and, last, any special instruction for patients going to this lab. If the same lab is entered more than once, delete the incorrect entry. If it is listed more than once, only the information in the first listing for that lab will be used.

DEFAULT CLINIC SCHEDULE:

The <F7> key, "Sched.", will take you to the default clinic schedule screen, Figure 21. Here you have five single value prompts to fill out. By filling these out before you start to make up clinic schedules, you can save a significant amount of time.

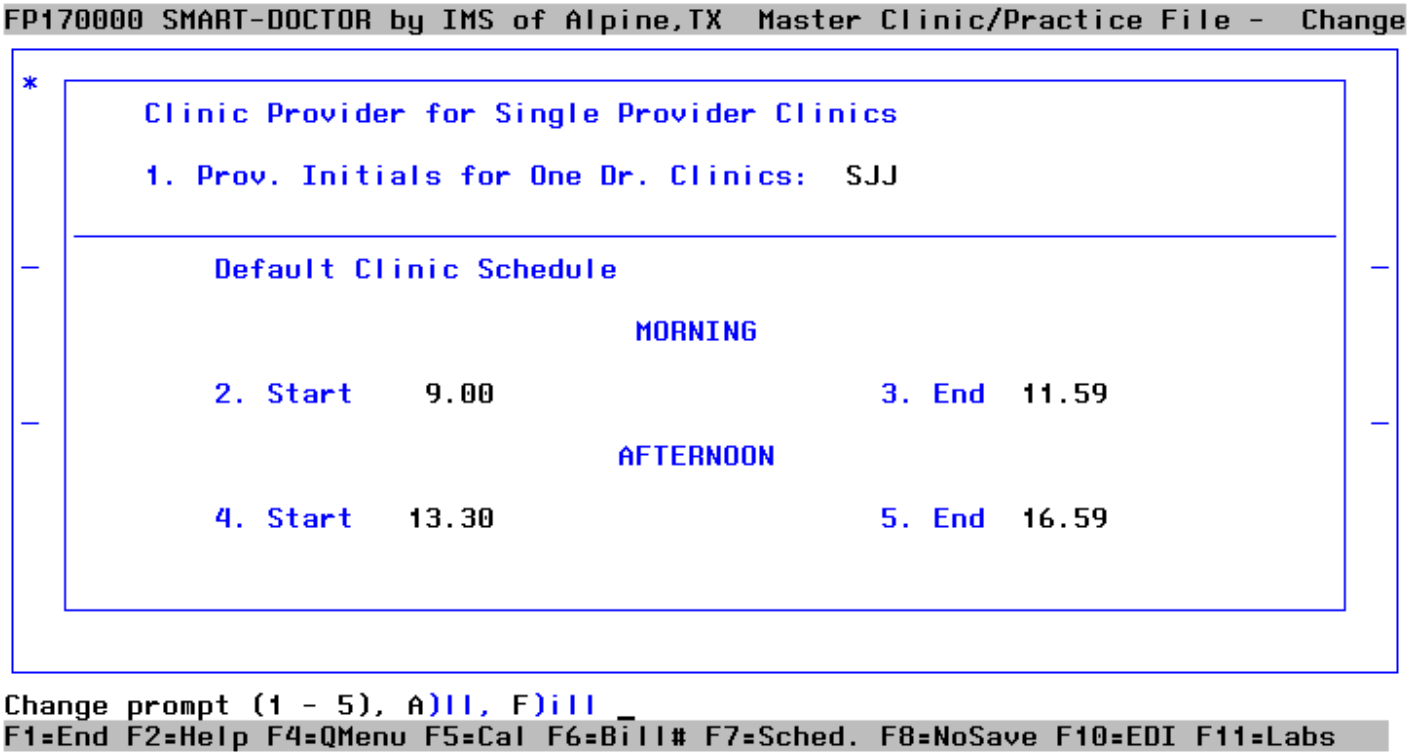


Figure 21 *Default Clinic Schedule screen.*

Prompt #1, "**Prov. Initials for One Dr. Clinics:**", is where you will select the initials from a pop-up of clinic providers. This will be the default doctor the system uses. This can be changed at any time since it is just a default value.

Prompt #2 through #5, are starting and stopping times for each contiguous block of appointments for the default clinic schedule. These times should coincide with the block times of the individual providers. For further information on how to enter the times, hit the <F2> for help at each prompt.

FAMILY FILE MAINTENANCE

From the main menu, go to prompt #15 "**Family File**". You will be presented with the initial "FAMILY FILE MAINTENANCE" screen, Figure 22.

Here you are given a number of choices starting with "**Inquire about Head of Household**". This choice should always be used before adding a family to check if a family is already in the system. It is much easier to check before adding a new family each time you think you need to, rather than have to deal with all the problems that will arise if you enter a family more than once. Please, check first!

DELETE A FAMILY

If you did not follow the advice given above, and added a family only to find out later this family was already in the system, you will need to delete one of the entries. Deleting a family is a serious matter and should not be done without the consultation of the clinic manager. Since the family ledger and all family charges are attached to the family file, it must be determined which is the best one to delete. Generally, the one that will need the least amount of work in recharging the correct family account for charges posted against the bad family account.

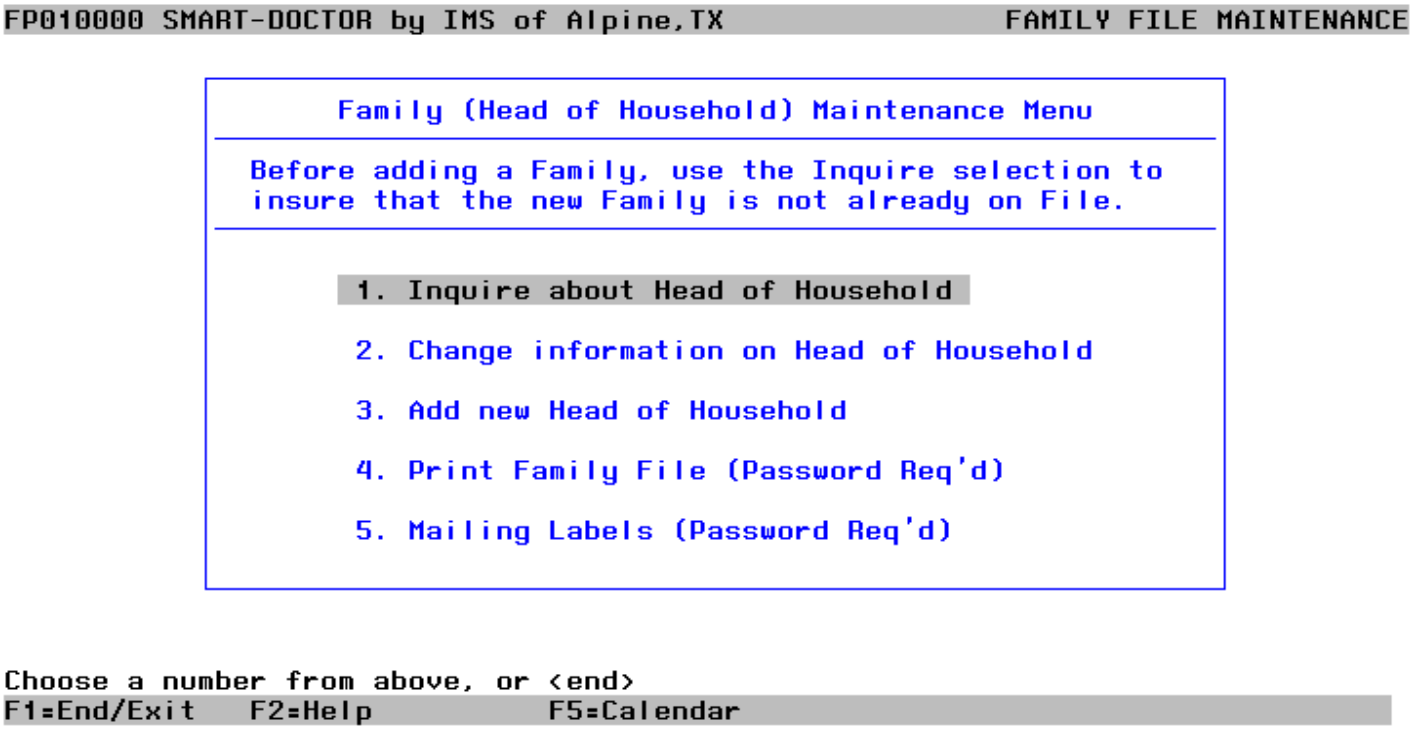


Figure 22 *Family File Maintenance Menu*

To add an additional backup mechanism, we use a very specific way to inactivate or delete a family. Once the family to be deleted is determined with agreement by the office manager, simply insert the following term before the family name with no spaces between it and the family name: <xdelete>. For example, if it was found that there were two John Bonners, you would change one of them from: BONNER, JOHN J., to: XDELETEBONNER, JOHN J. In this way, we can always find out what was in the deleted record by looking up the family with this new name. Further, it would be possible to restore the original record by simply setting the name back to the original.

Then, proceed to move the charges to the correct family, and reverse the charges on the bad account so that all charge balances are 0 (zero).

ADDING A NEW FAMILY

Select menu item #3, "**Add new Head of Household**", Figure 22.

Prompt #1, "**Family Number:**", the system will default for you the next family number available. (You can also enter a unique number of your own, but this is not recommended, since the system will not automatically give you the next number in that sequence.) If you try to enter a number already in the system, you will be told: "**This record is already on file FP-FAMILY. <Return> to continue.**". Accept the new number by hitting the <enter> key.

The screen seen in Figure 23, is where new family data is entered.

Prompt #2, "**Responsible party:**", enter Responsible party (Head of Household), mother, father, or legal guardian who has financial responsibility. Start with the Last name followed with a comma. Then add a space followed by the First name. Then add a space and follow with the Middle name, or initial, followed by a period. You can also add aliases or a maiden name after this. Only the last name, the first name, and middle initial will be used in billing. However, all names are available for cross-reference lookup. This is the name to which all family bills will be sent. This individual should

have the group insurance policy for the family.

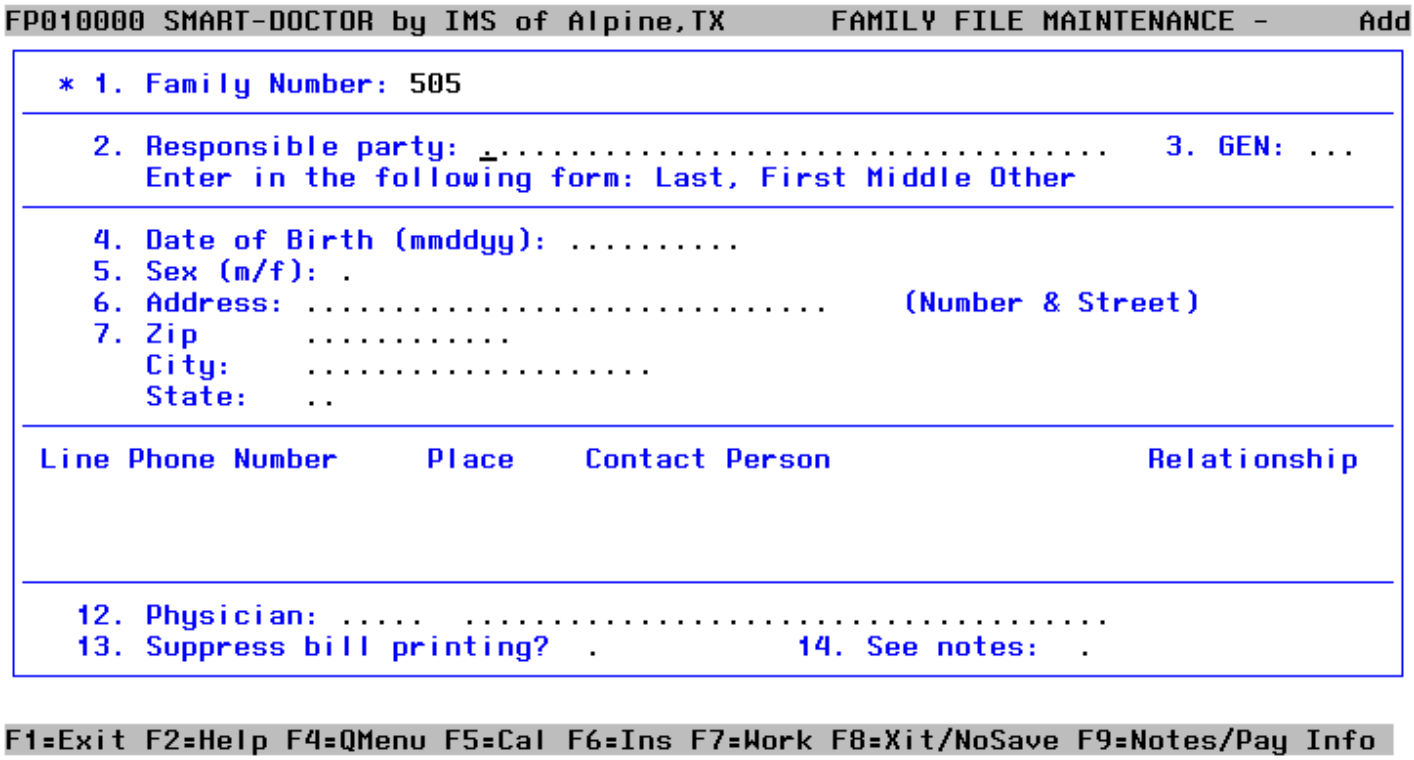


Figure 23 Entering New Family Data

Prompt #3, "**GEN:**", is for generation. This can be left blank, or you may use one of the terms allowed by insurance carriers. The terms that are allowed can be selected from the <F2>, help key pop-up. The help key lists the following choices: I for First generation, II for Second generation, III for Third generation, IV for Fourth generation, SR for Senior, and JR for Junior.

Prompt #4, "**Date of Birth (mmddyy):**", enter the date of birth of the Head of Household (responsible party). Enter in either of the following formats: mmddyy or mm/dd/yy. For dates in a different century, enter in the MM/DD/YYYY format. e.g. 11231898 or 11/23/1898.

Prompt #5, "**Sex (m/f):**", enter sex of head of household, either m or f.

Prompt #6, "**Address:**", enter in form: No. Street, Apt., such as "123 Any Street, Apt. #4".

Prompt #7, "**Zip**", enter the Zip Code. For a list of Zip Codes, press <enter> on a blank field. The city and state will be filled in for you automatically once you have entered or selected a zip code. If the zip code you need does not exist in your current database, you can add it immediately via the Quick Menu <F4>. From the Quick Menu you can select to go to the Zip Code file maintenance to enter this information. It will then become immediately available for your use in completing the address.

The Phone Number multi-value prompt is next. Here you will enter any phone number you want to store for the family. You will add the Phone Number, Place, Contact Person, and Relationship. The phone number can be in the form : xxx-xxxx or xxxxxxx. To enter area code, the form can be: xxx-xxx-xxxx or xxxxxxxxxx. When you move to the "**Place**" field, a "?" will be presented as the default. Since the <?> and the <F2> key mean go to the help screen, by hitting <enter> you will be taken to

the help screen for valid choices. Just pick one of these choices which fits best. In the "**Contact Person** " field, enter the name of the individual to be contacted at this number. In the "**Relationship**", again, hit the <enter> key at the "?" to be taken to the help screen to select a valid choice.

Prompt #12, "**Physician:**", enter the family physician's initials or hit <enter> to accept the default physician's initials. The default initials come from the clinic file's default physician for a single provider clinic. Alternatively, type in the initials of the provider who will be the primary provider for this family, or type in part of the name of the provider. If more than one provider is found on the cross-reference lookup, then a pop-up screen will be presented. Arrow up or down to the provider you want and hit the <enter> key to accept this provider.

Prompt # 13, "**Suppress bill printing?**", hit the <enter> key to accept the default of <N>o, or enter <Y>es to suppress bill printing. If suppressed, then a bill will not be prepared for this family (HOH) when the monthly bills are prepared. This might be appropriate for a contracted family care plan, such as for an HMO or capitated program, or for a family which you do not want to bill at this time.

Prompt No. 14, "**See notes:**", hit the <enter> key to accept the default of <N>o, or enter <Y>es to set the flag to show the "See Notes" message on all provider screens. This alerts the provider that they should review the family notes prior to seeing this family member. This can be done by hitting the <F9> as described below.

Figure 24 is an example of previously entered family data.

AUTOMATIC ADD SCREENS and F-KEYS SCREENS

During the add mode the system will automatically take you to the next logical screen for adding family information. In the change mode, you will get to these screens by using the F keys described below.

Employment Information: Head of Household, <F7> Screen

This screen, Figure 25, can also be called from the primary Family File Screen by hitting the <F7> key. Then select the Work Information For: Head of Household.

Prompt # 1, "**Social Security Number:**", enter the social security number in the form xxx-xx-xxxx or xxxxxxxxx.

Prompt # 2, "**Employment Status:**", an pop-up screen will present you with valid choices to select from.

Prompt # 3, "**Employer:**", enter name of employer. If unemployed enter <UNEMPLOYED> in this field.

Prompt # 4, "**Address:**", enter employer's address, No., Street, Suite.

Prompt # 5, "**Zip:**", enter the zip code in the same manner as in prompt #7 of the primary family file screen above.

Prompt # 6, "**Phone:,** enter Emp. phone number in form xxx-xxx-xxxx or xxxxxxxxxx, with or without the area code.

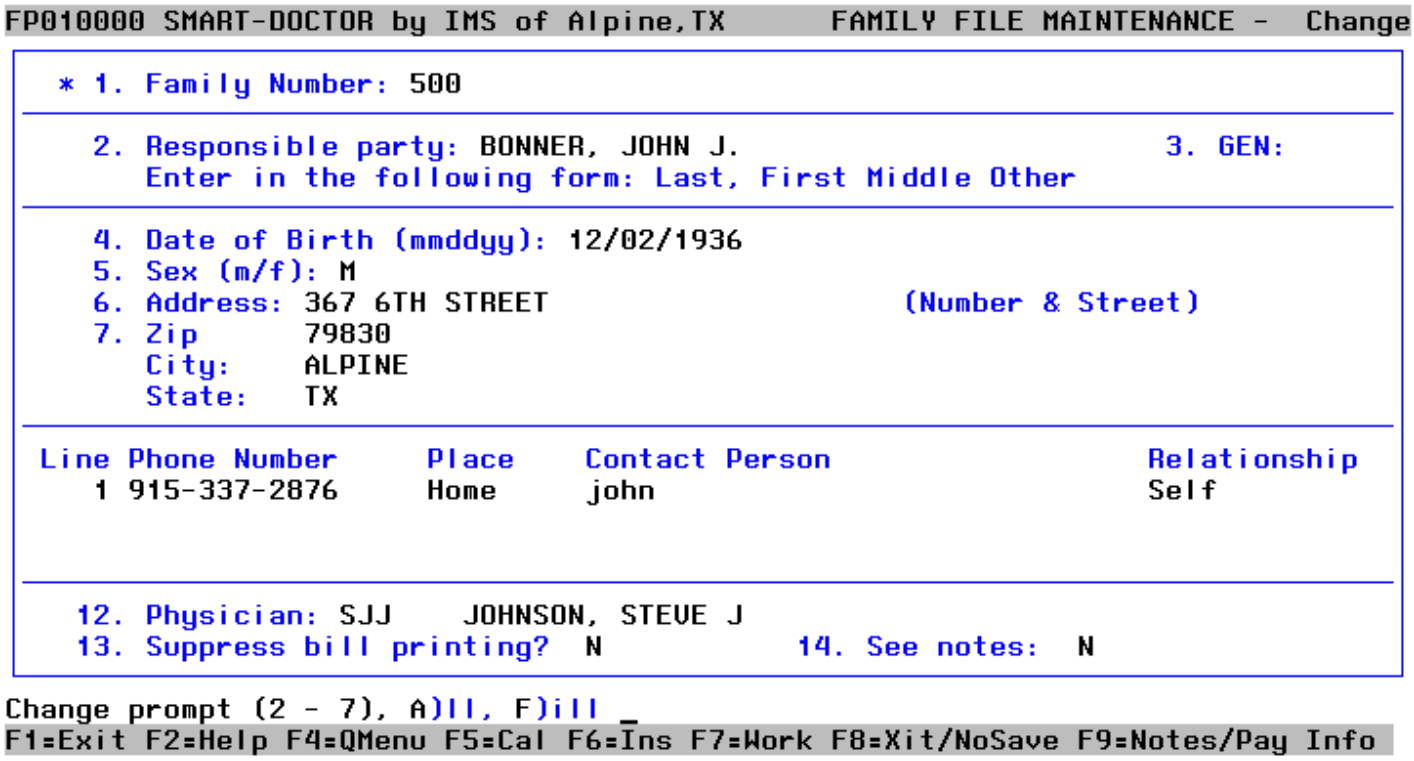


Figure 24 *Completed HOH screen.*

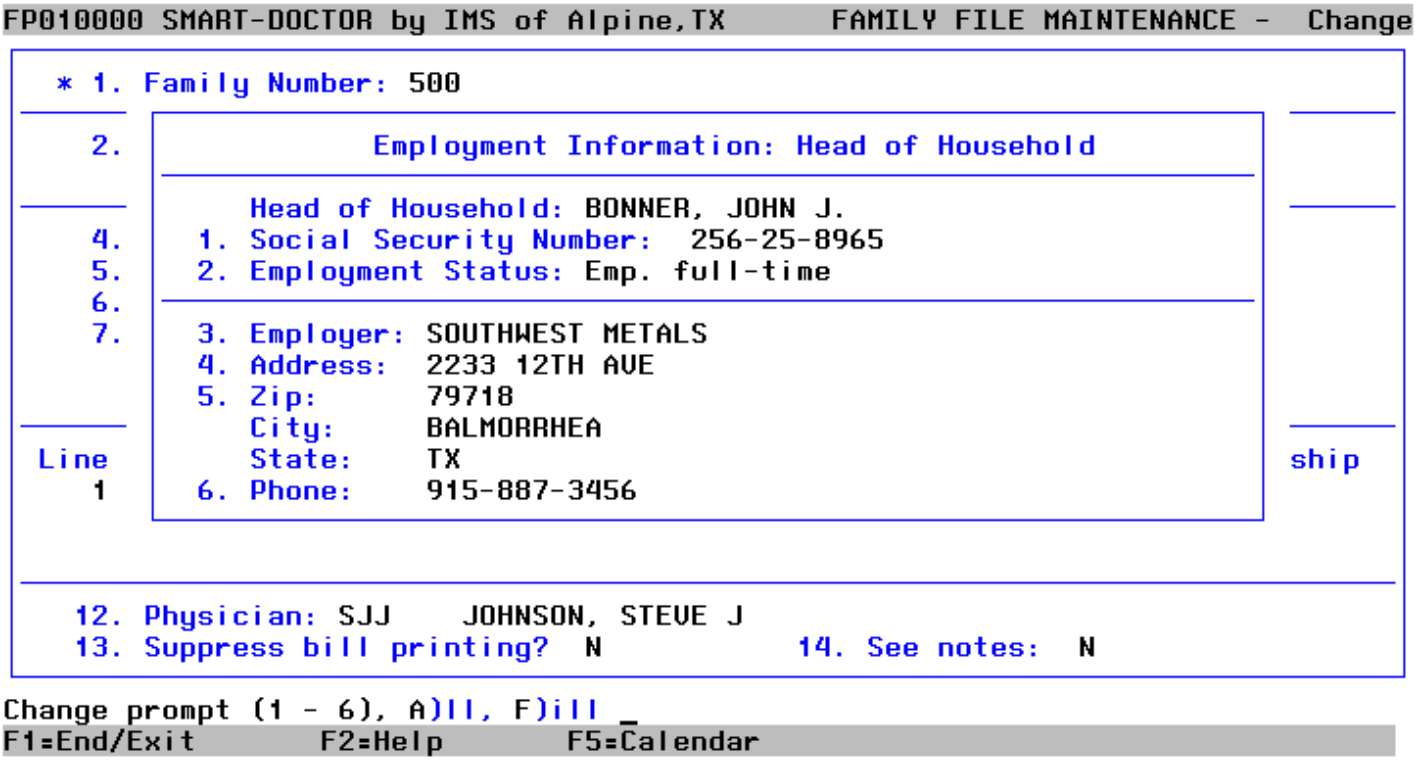


Figure 25 *Work Information screen for HOH.*

Employment Information: Spouse of HOH, <F7> Screen

This screen can also be called from the primary Family File Screen by hitting the <F7> key. Then selecting the Work Information For: Spouse.

If no information is to be added here, just repeatedly hit the "end" <F1> key to end input and go to the next prompt. If you have information available to add here, then complete the entry as described immediately above for Head of Household. There are three additional prompts on this screen, as seen in Figure 26.

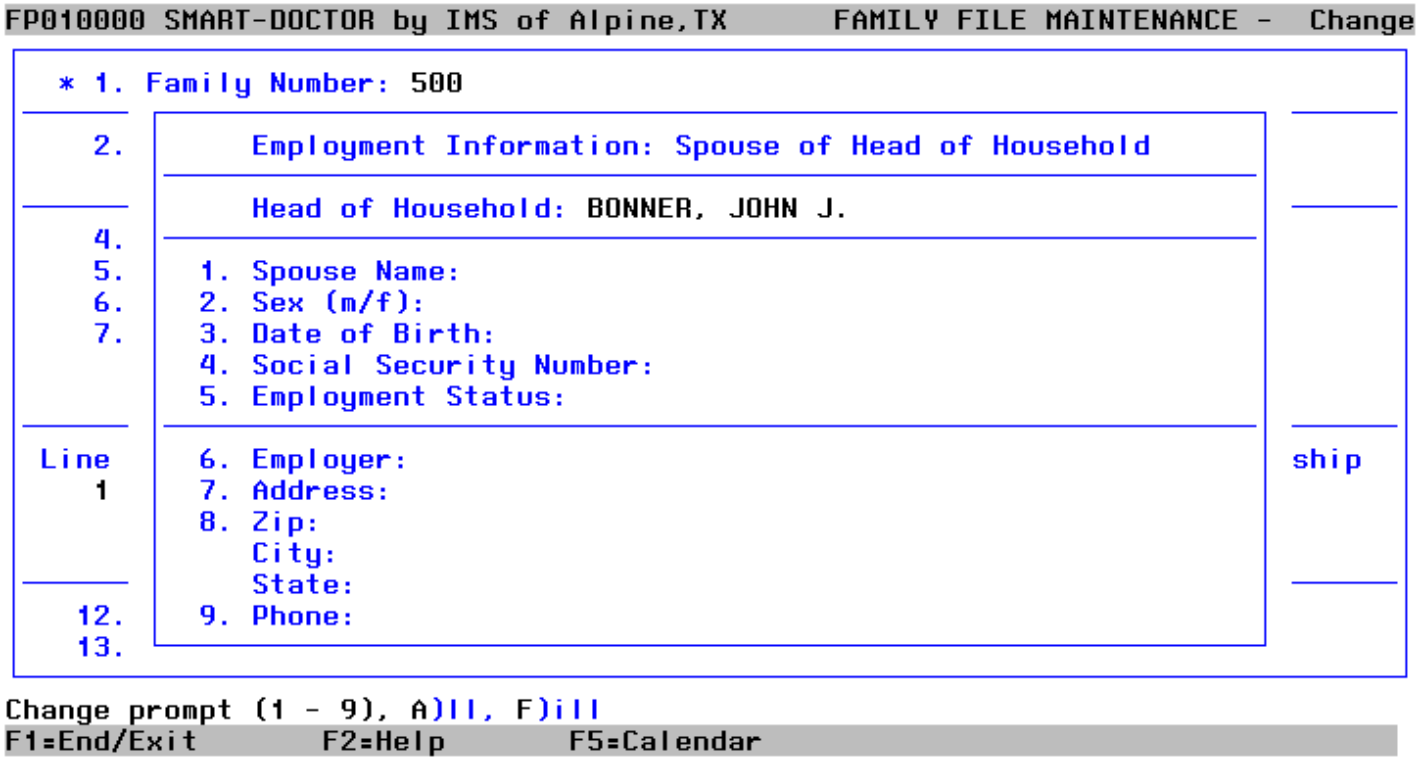


Figure 26 *Spouse Work Information screen.*

Prompt # 1, "**Spouse Name:**", enter the Spouse name here in the form: Last, First Middle Maiden Alias Alias. If widowed (spouse Deceased) indicate by entering <DECEASED> in front of name.

Prompt # 2, "**Sex (m/f):**", enter sex in the form: M,F or m,f.

Prompt # 3, " **Date of Birth:**", enter the date of birth of Spouse. Enter in one of the following formats; mmddyy or mm/dd/yy. For prior centuries, enter the year in the four digit form: yyyy.

FAMILY INSURANCE FILE, <F6> Screen

This screen, Figure 27, can also be called from the primary Family File Screen by hitting the <F6> key.

This screen is for entering the family insurance information. This insurance applies to one or more individuals in the family, but is not for individual only insurance's such as Medicare or Medicaid. These individual insurances must be placed in the Patient File under the insurance screen. The data entry is the same as described below, with the only difference being that the insurance only applies to one individual. On selection screens for insurance policies to bill, the individual insurances will be presented first, followed by the family policies. Generally the individual policy should be billed first, and then the family policy.

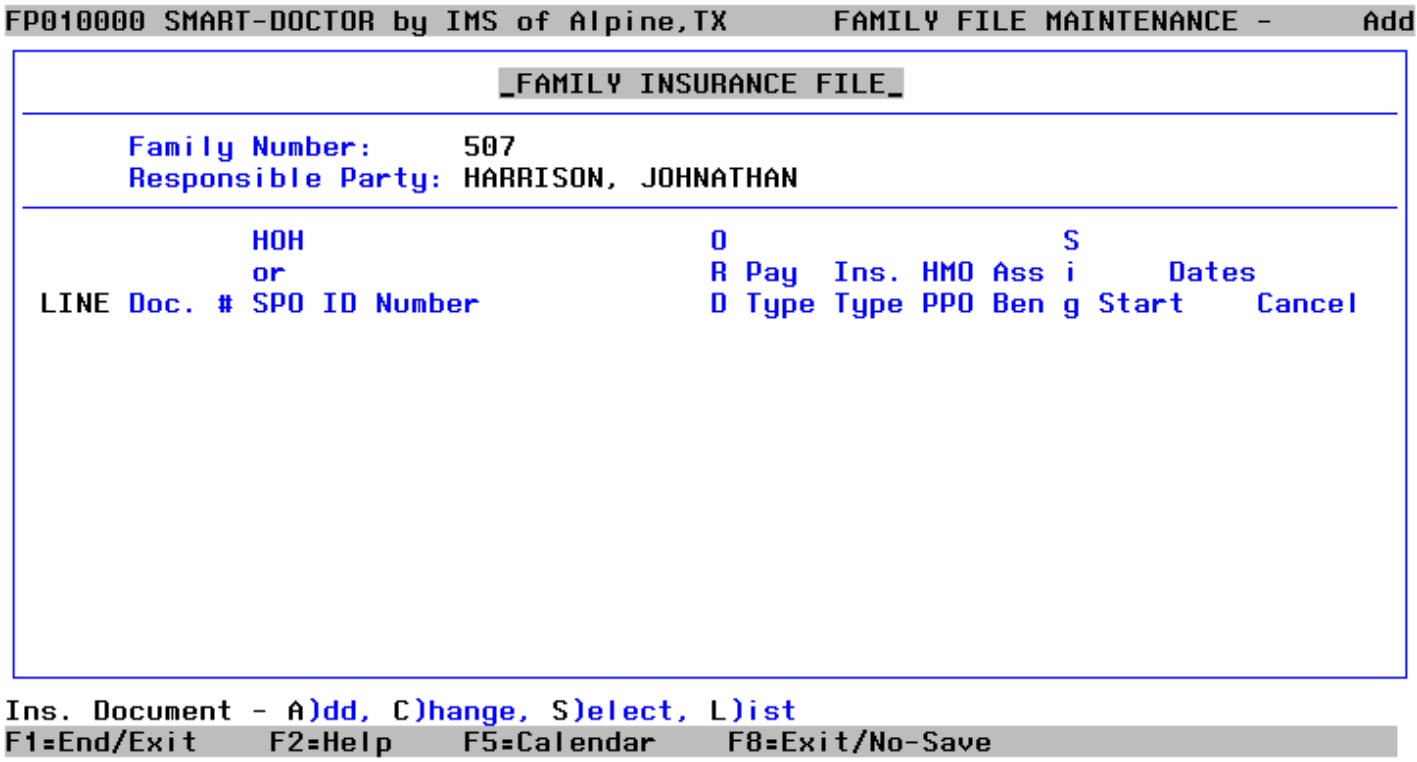


Figure 27 *Family Insurance screen.*

To add a policy, enter <a> at the Ins. Document change prompt. You will then be placed on a multi-value "Line", Figure 28, with next defaulted insurance document number that is available. Hit <enter> to accept this number. This will take you to the insurance document screen, Figure 29 (Insurance Document File -- Add, Screen).

Prompt # 2, "**Ins. Type:**", here a default of "?" is show. By hitting the <enter> key you can see the allowable choices. You can also get to this by hitting the <F2> "Help" key for context specific help.

Only HOH or SPO can be used in the family insurance screen since all individual insurance types must be placed in the patient file. If you select IND, you will be given an error message and then can select the appropriate entry.

The Figure 30 is an example of previously entered insurance data.

Prompt #3, "**Emp. Name:**", this prompt is used if this is an insurance for workman's compensation. Since this is a family insurance that applies to more than one individual, you will not be allowed to enter anything in this field. This same screen is used in the patient file. In that situation, you would be able to enter the name of the company the individual works for.

Prompt #4, "**Supplemental to the primary insurance?**", if this is a supplemental insurance to the family's primary insurance enter <Y> for Yes. Otherwise, answer <N> for No.

Prompt #5, "**Insured ID Number:**", enter the Insurance ID number as it appears on the insurance card. If there is no insurance, then enter <x> (or None) to indicate no ins.

Prompt #6, "**Carrier ID(or Unique xref):**", enter the 5 digit national designation for this company. If not known, enter at least 3 characters of the Company name for a listing of companies with those

letters. Enter <none> if without insurance. This will be replaced by 999999. Once this insurance document is added, you cannot change the Carrier ID Number.

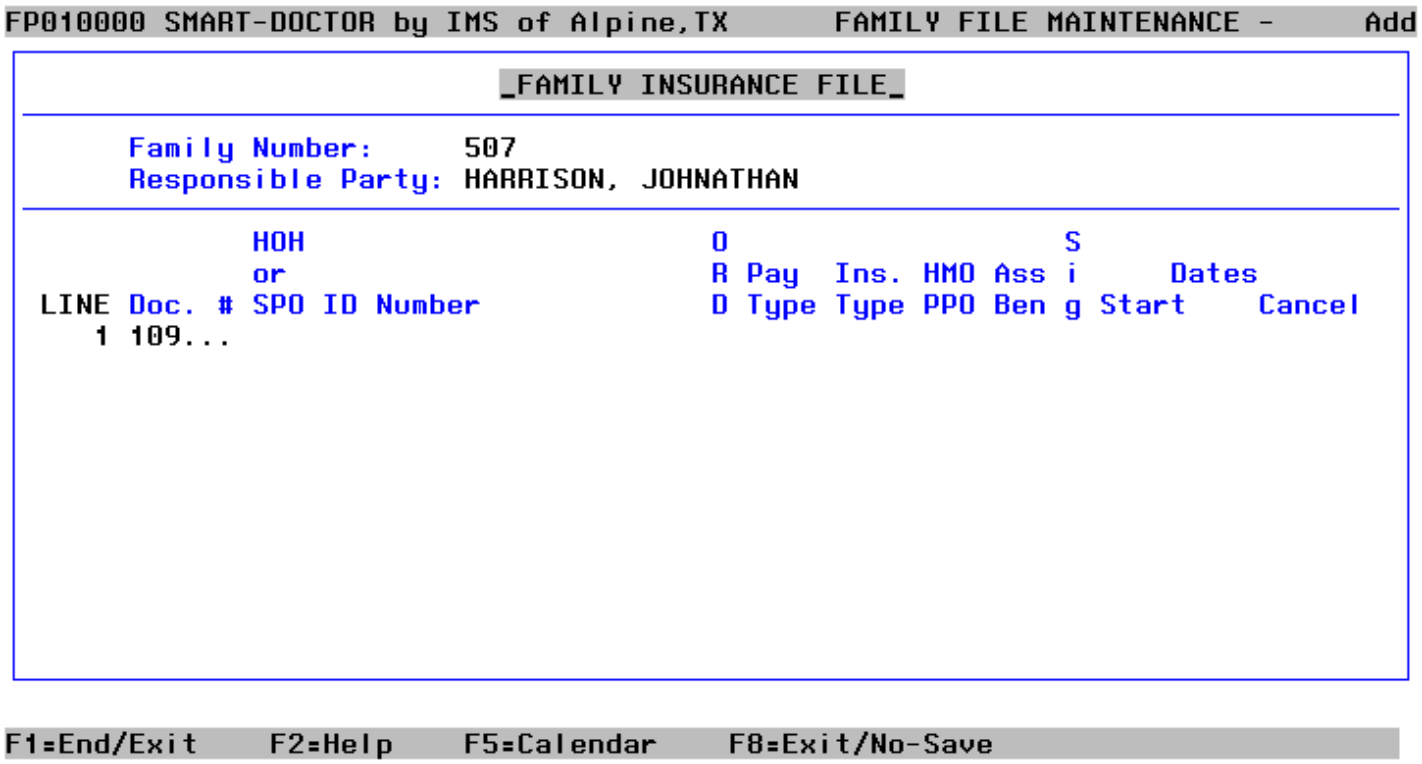


Figure 28 *Family Insurance Documents screen*

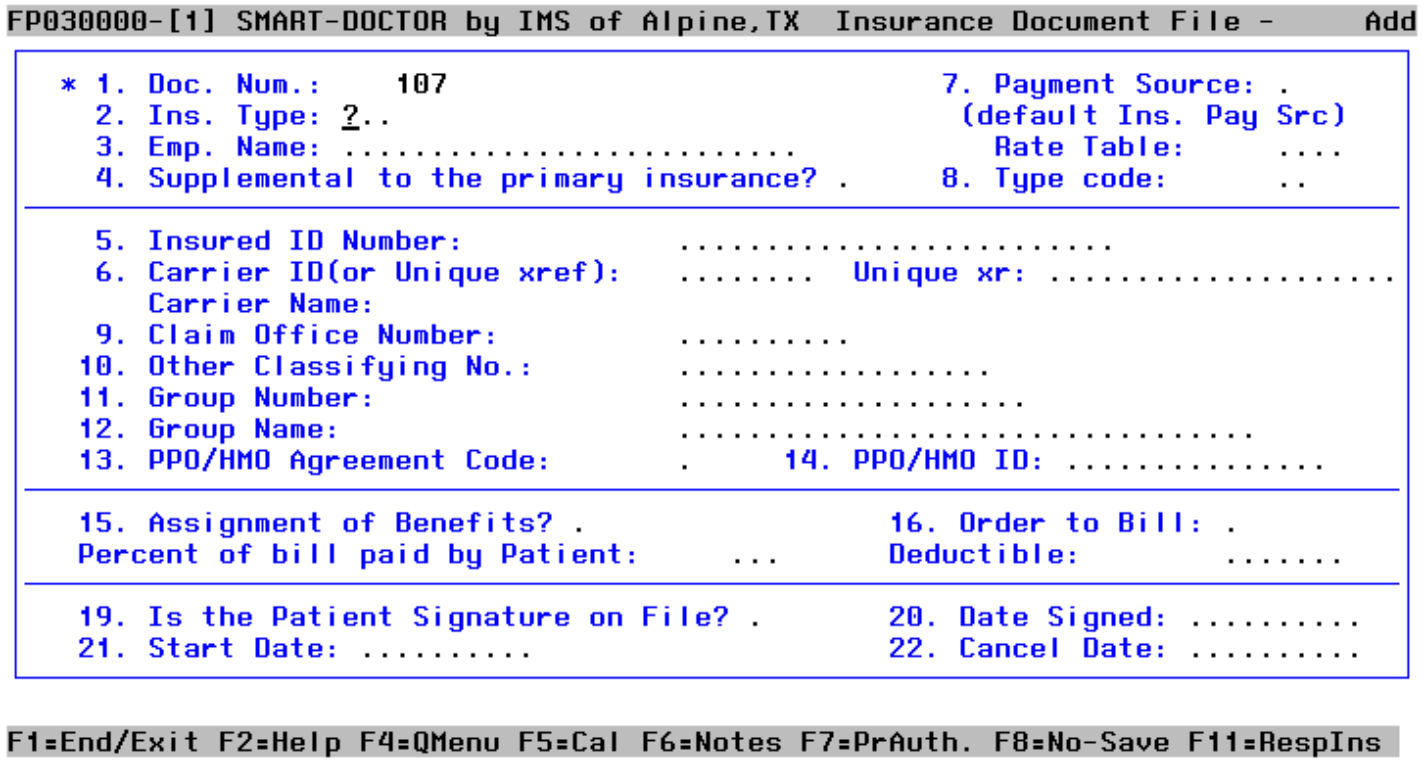


Figure 29 *Insurance Document screen*

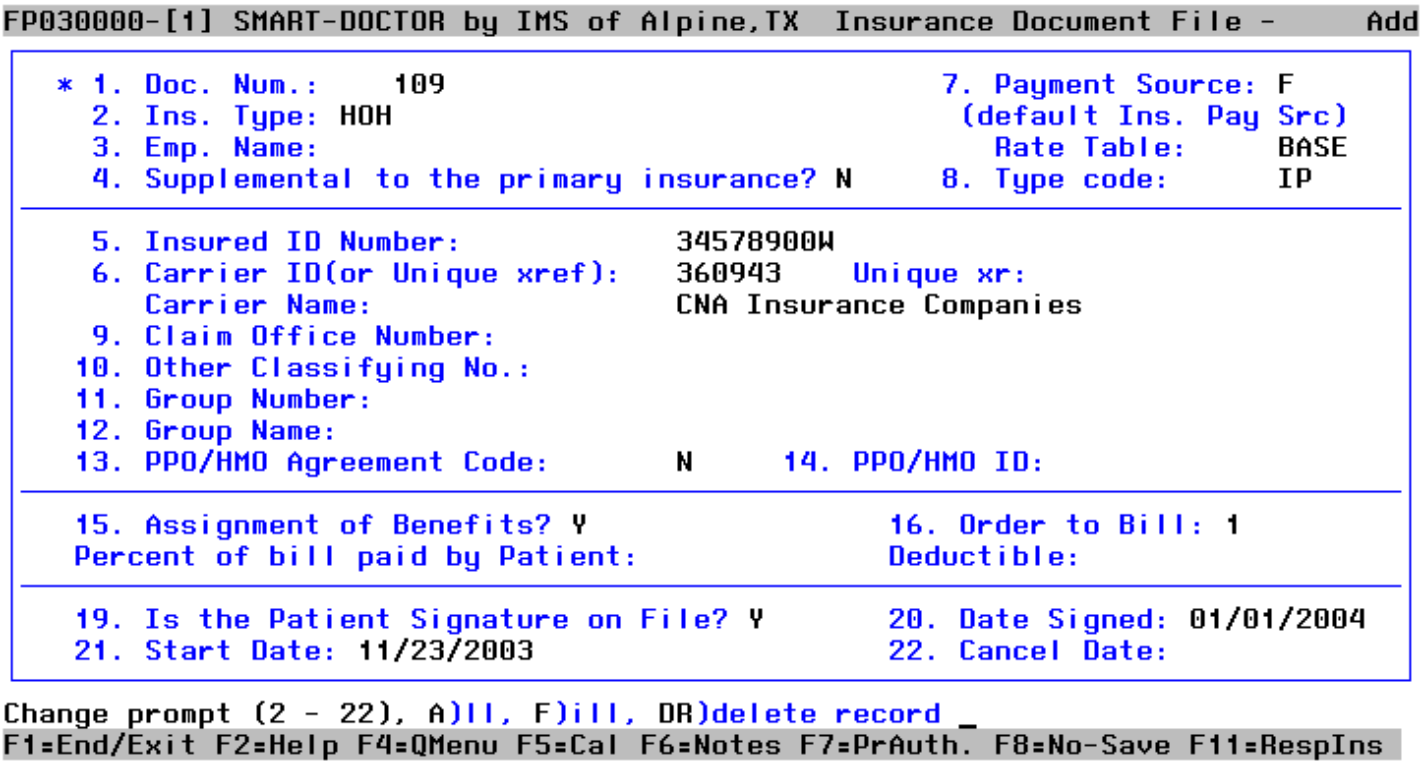


Figure 30 Completed Insurance Document.

Prompt #7, "**Payment Source:**", if a selected Insurance Carrier already has a Payer Type selected, the Insurance Document will accept this type and not give the user the option to change it. This is the preferred method to reduce billing errors. See "INSURANCE CARRIER MAINTENANCE FILE" below (Following Figure 60) for details. Otherwise select from the choices given.

If payment type "F" for other is selected, then a screen will pop-up for Prompt #8 "**Type code:**", the following table will be presented:

Table	Description
MG	Medigap Policy
SP	Supplemental Policy
IP	Individual Policy
PP	Personal Payment (Cash - No Insurance)
GP	Group Policy
LT	Litigation
AP	Auto Insurance Policy
LD	Long Term Policy
OT	Other
MP	MEDICARE PRIMARY
12	Working Aged Benefic/Spouse w/Empl Grp Health Plan
13	ESRD Benefic. in 12 Mos. Coor with Emp. Health Plan
14	No Fault Ins. Auto or other
15	Worker's Compensation
16	PHS or Other Federal Agency
41	Black Lung
42	VA
43	Disabled Benefic. under 65 with LGHP
47	Any Liability Insurance

All the above NUMBER codes are ONLY to be used when Medicare is the Secondary payer and the Source of Pay code is "C" for Medicare.

Prompts #9 through #12 are optional, and are to be added if this information is available on the patient's insurance card.

Prompt #9, "**Claim Office Number:**", enter the claim office number to identify the specific payor location responsible for processing this claim. The number should be on the patients insurance card. For MEDICAID use NONE if there is no claim office # for your state. For MEDICARE, use NONE.
For Champus use the appropriate code for the region below:

SER - Southeast region.
MAR - Mid-Atlantic Region.
WTR - Western Region.
NTR - Northern Region.
SCR - South Central Region.
CRI - California Project
CMN - Catchment Area Management Pro. Navy, SC
CMF - Catchment Area Management Pro. Air Force, TX

Prompt #10, "**Other Classifying No.:**", an optional entry.

Prompt #11, "**Group Number:**", if there is a Group/Plan #, enter it here. Otherwise skip.
(Skip by hitting the <enter> key while line is blank).

Prompt #12, "**Group Name**:", enter Group/Plan name here. If their is no entry for this field, just hit <enter> with a blank line to skip this field.

Prompt #13, "**PPO/HMO Agreement Code:**", either accept the default of "N", or choose one of the following:

Table	Description
Y	Process claim under PPO/HMO agreement.
I	Process claim under CHAMPUS Internal agreement.
E	Process claim under CHAMPUS External agreement.
N	Claim is Not a PPO or HMO claim.
C	Process claim under CHAMPUS "CAM Charleston" agreement.
G	Process claim under CHAMPUS Army CAM Demonstration.
H	Process claim under CHAMPUS Navy CAM Demonstration.
J	Process claim under CHAMPUS Air Force CAM Demonstration.
O	Process claim under CHAMPUS MCSP PPO Agreement.
P	Process claim under CHAPMUS MCSP Prime agreement.
T	Process claim under CHAMPUS TRICARE MCSP Extra agreement.
U	Process claim under CHAMPUS TRICARE MCSP HMO agreement.
X	Process claim under CHAMPUS Cooperative Care Claim.

Prompt #14, "**PPO/HMO ID:**", if prompt #13 is indicated as "Y", then you enter the PPO/HMO Organization number here. (Not the patient insurance # or patient #.)

Prompt #15, "**Assignment of Benefits?**", (this is a required field) answer <Y> Yes to this prompt if you will accept assignment of benefits

Prompt #16, "**Order to Bill:**", choose one of the following from the help screen:

Table	Description
1	Bill this company first.
2	Bill this company second.
3	Bill this company third.
0	Order of billing varies.
W	Work Comp. billing.
C	Cancelled policy.

The next two fields, "**Percent of bill paid by Patient:**" and "**Deductible:**" are automatically filled in from the insurance carrier file.

Prompt #19, "**Is the Patient Signature on File?**", (or guardians signature) on file for this insurance policy. Answer yes or no (<y> or <n>). You MUST keep a hard copy of this signature in the patient file for EACH policy (or have a image of it in the patient's image file). Each insurance must have its own release form. This is very important for Medicare, Medigap, Medicaid, etc. Be sure the document on file indicates that the patient or guardian (indicate relationship) authorizes release of medical information necessary to process claim. It also should authorize payment to physician when physician accepts assignment. This signature usually would go in item 12 on the HCFA-1500 for Medicare and other commercial insurance, and in item 13 for Medigap (or both if both apply).

Prompt #20, "**Date Signed:**", should be the date the form was signed, or the last date it was revised or extended. Enter in the format: mmddyy or mm/dd/yy.

Prompt #21, "**Start Date:**", enter the date the insurance coverage started. If unsure, but you know it is valid for the current period, then enter an approximate date based on the information given to you. You can go back and change this later once you have the correct information.

Prompt #22, "**Cancel Date:**", enter the date the insurance policy was canceled (i.e. the last day the policy was in effect). You will not be able to do primary billing of office visits with the cancelled insurance that occur after this date. You will be able to bill secondary bills after this date, however, the date of service should be before this date or you will get a rejection.

FAMILY INSURANCE FILE Screen F Keys

The <F6> key will take you to the family insurance notes section, Figure 31. In this multi-value prompt, you may add any notes that you need regarding the carrier and family.

The <F7> key will take you to the prior authorization (PrAuth.) screen, Figure 32.

This screen should NOT be used for a family insurance since prior authorizations are always for a specific individual. If you decide to use this anyway, be careful that the prior authorization is specific enough that it could only be for one individual in the family, for example, a vasectomy on an adult male. Otherwise, it would be safer to place this insurance in the individual file, where the prior authorization will be specific to that individual.

The multi-valued prompts on this screen contain all prior authorizations by this carrier. When adding, enter the procedure number or part of the procedure description for a cross-reference lookup. Do Not use 6 digit procedure codes that were added by your clinic to indicate special charging for the standard 5 digit codes. The system will only use the first 5 digits for prior

authorizations.

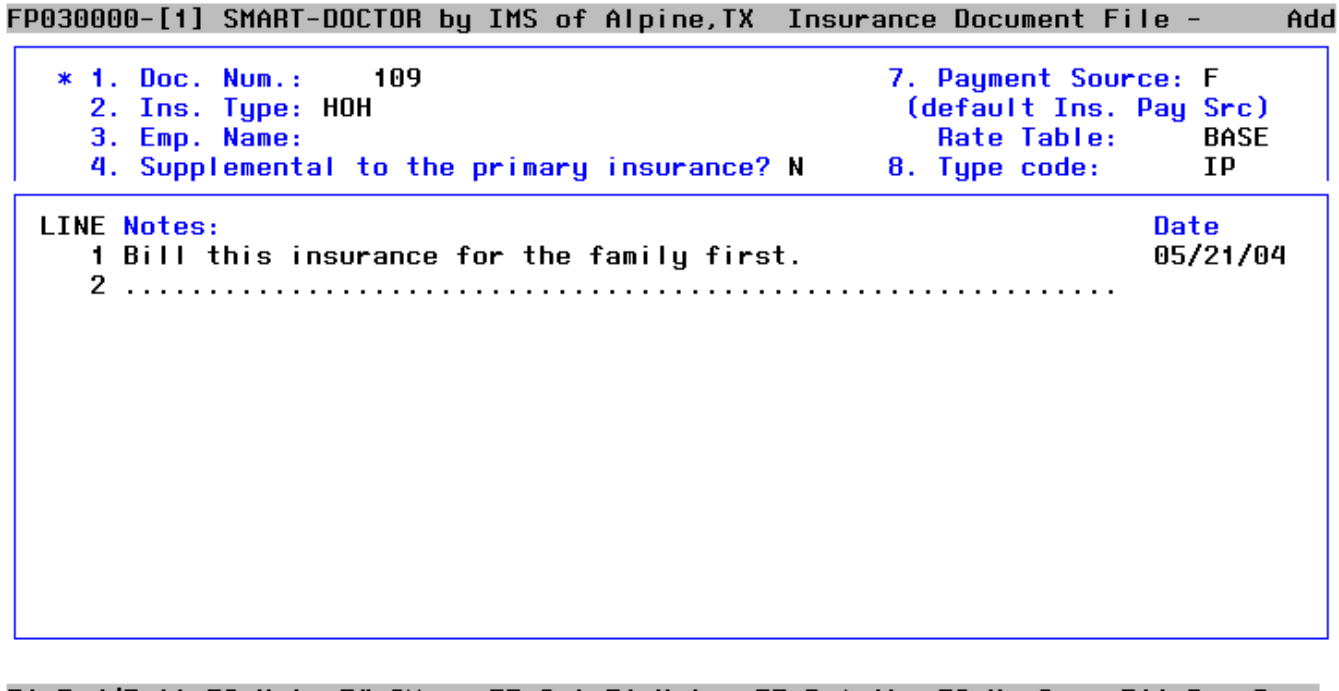


Figure 31 Insurance Documents Notes screen

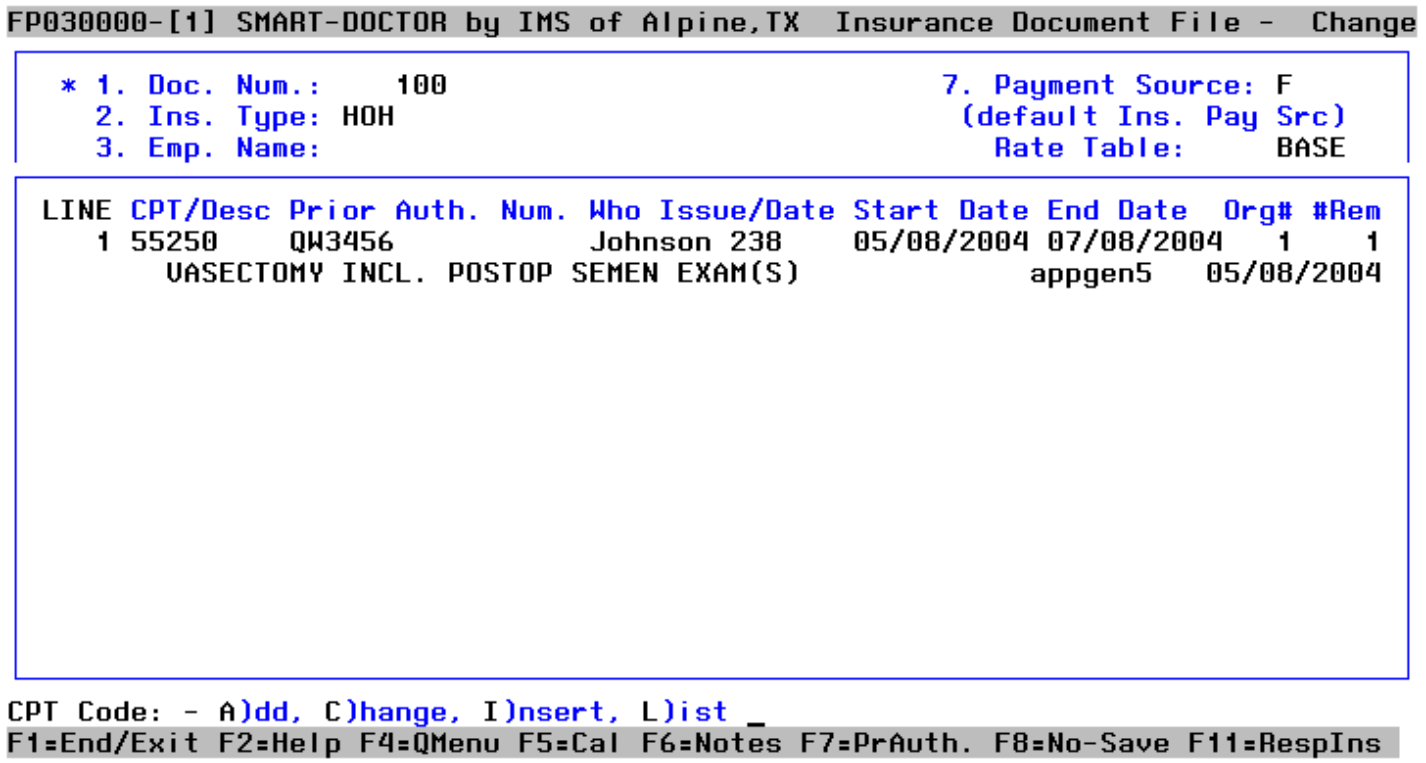


Figure 32 Prior Authorization screen

The <F11> key, "**RespIns**". Use the <F11> key to go to the Responsible Party screen, Figure 33, if the person who is responsible for this insurance is not the HOH.

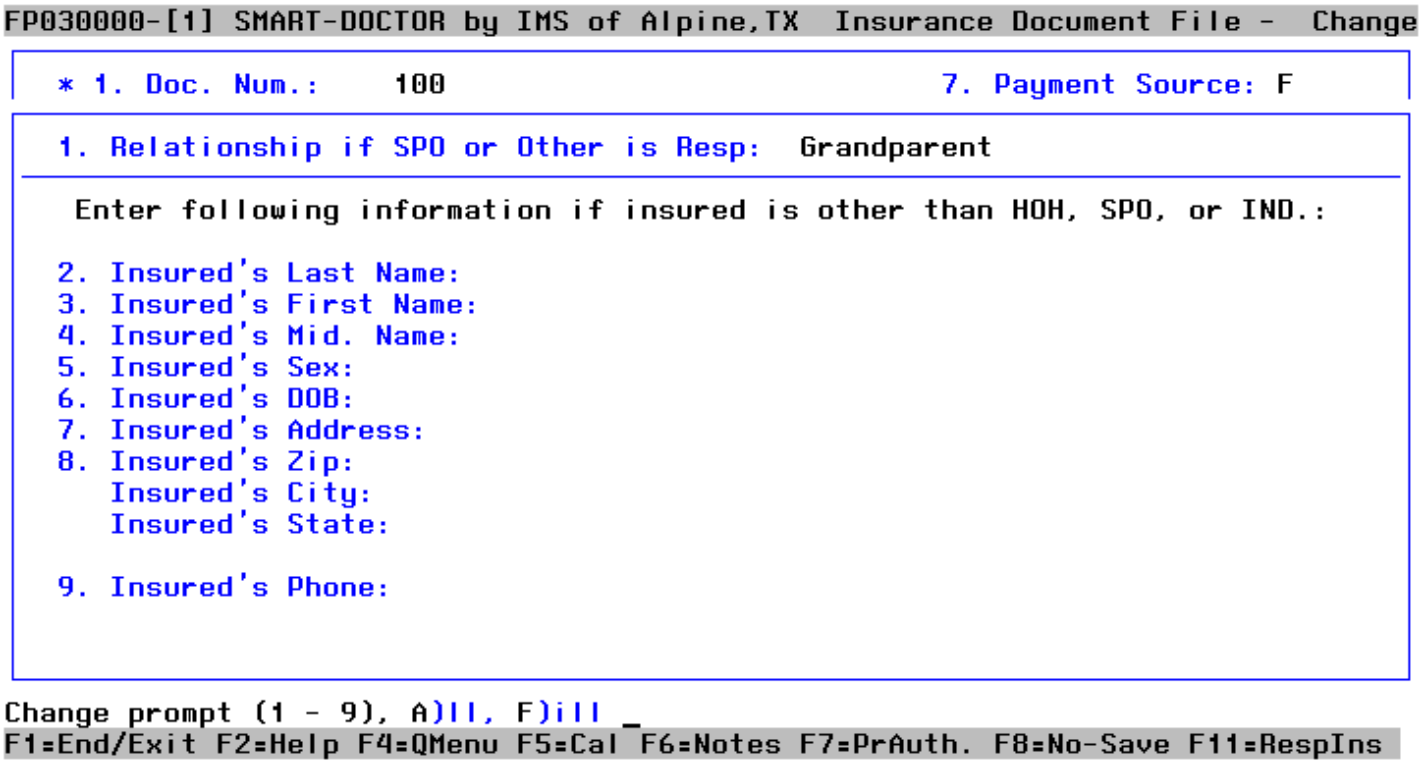


Figure 33 *Responsible Party screen*

On this screen, if the other responsible is "**SPO**" (spouse), then enter this in prompt #1 and exit the screen by using the <F1> key. If it is HOH, do not use this screen since this is assumed. If however, this is another individual or agency, then select the appropriate relationship from the pop-up table, and then enter the remaining information. Be aware, that once anything is placed in the "**Last Name**" field, the information on this screen will be used with this insurance document regardless if it is complete or not.

An example of this type of insurance is generally in the individual file of a child, in which the child's natural parent has an insurance policy on the child. The child however is living with one natural parent and a step-parent, or the current HOH.

GENERAL FAMILY NOTES AND PAYMENT INFORMATION <F9> KEY (Notes/Pay Info)
This screen (Figure 34) is called from the primary Family File Screen by hitting the <F9> key.

The top half of the screen is for general family notes. This could be additional contact information or other general family information. Notes regarding specific services rendered should go in the Notes section of the Family Ledger in the Transaction file of the specific transaction. The Message area of the Family ledger is where you should keep notes of what you have told the HOH about payment of the charges. These messages can also be printed on the monthly statements from that screen by setting the dates to print.

The bottom half of the screen is for messages that you want to pop-up automatically at the time of sign-in and billing.

PRINT FAMILY FILE
From the family menu (Figure 22) select menu item #4, "**Print Family File**", to print Family file sorted by Family name. The selection screen shown in Figure 35 will be presented.

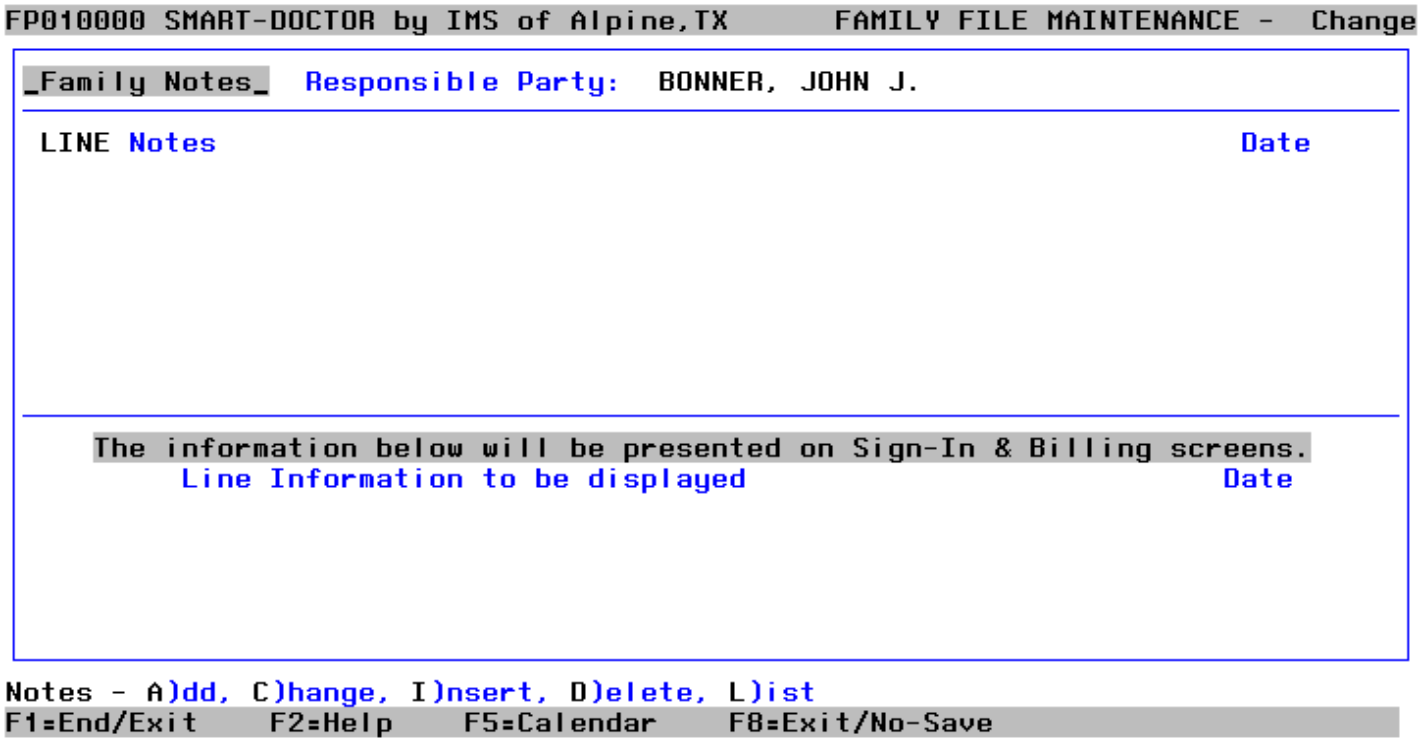


Figure 34 *Family Notes and Payment Information screen.*

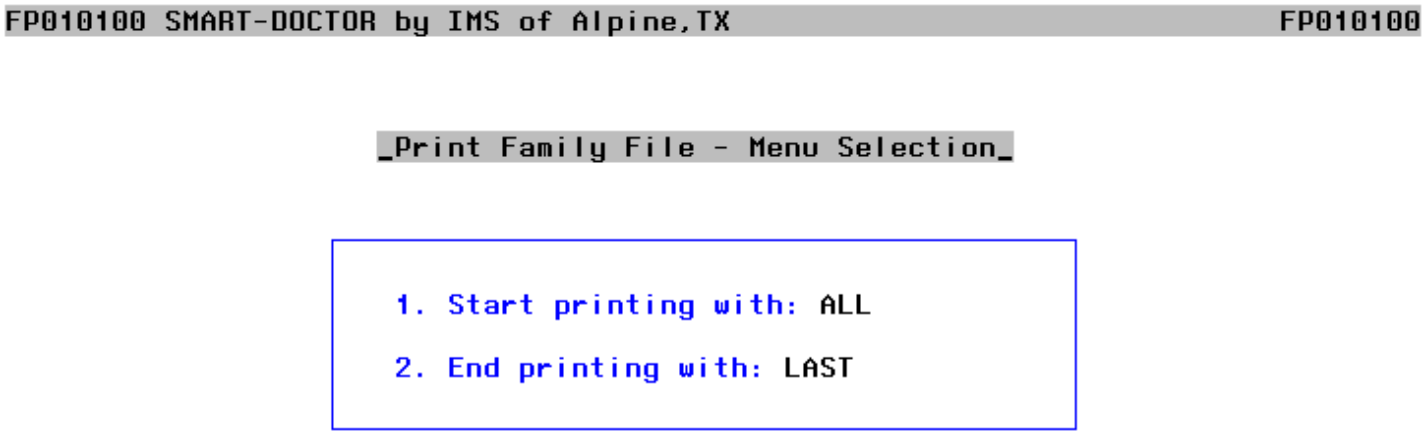


Figure 35 *Family Print Selection screen.*

Prompt #1, "**Start printing with:**", accept the default of "**ALL**" by hitting the <enter> key, or enter the first letter of the family names you want to start with. You can also start with a specific family name if you wish. Please review "A WORD ON SELECTION RANGES" in the beginning of this manual to understand how selections work. For example, if you just wanted to get the Bonner family, you would enter "BONNER" in prompt #1, and BONNERz in prompt #2.

Prompt#2, "**End printing with:**", accept the default of "**LAST**", or the ending letter or name as indicated above. An example of the output, with only 4 families in the system, is shown in Figure 36.

MAILING LABELS for FAMILY FILE

From the family menu (Figure 22) select menu item #5, "**Mailing Labels**", to print Family mailing labels. The selection screen and logic is the same as in "PRINT FAMILY FILE" above. An example of the output, with only 4 families in the system, is as shown in Figure 37.

```
FP010100              SMART-DOCTOR by IMS of Alpine,TX              Page    1
                                  FAMILY FILE              17:37:02 16 Jun 2004

Responsible Party                    Gen DOB      Sex Family Num  SSN
==================================== === ======== === ==========  ===========
BONNER, JOHN J.                          12/02/36 M   500         256-25-8965
COOPER, DAVID S.                         10/25/61 M   501         256-45-8845
FOSTER, EMMA J.                          01/20/21 F   502         258-25-8225
JACKSON, JOHN                            10/23/69 M   503         836-45-7565
```

Figure 36 *Example of Family File Printout.*

```
FP010101              SMART-DOCTOR by IMS of Alpine,TX              Page    1
                        FAMILY FILE - Mailing Labels.     17:46:43 16 Jun 2004

Responsible Party
==================================
BONNER, JOHN J.
367 6TH STREET
ALPINE               TX  79830

COOPER, DAVID S.
34 WEST ADAMS
BALMORRHEA           TX  79718

FOSTER, EMMA J.
HC 67, BOX 33D
BALMORRHEA           TX  79718

JACKSON, JOHN
2323 ELM STREET
ALPINE               TX  79830
```

Figure 37 *Example of Mailing Label Printout.*

PATIENT FILE MAINTENANCE

From the main menu (FP000000) select the " **Patient File**", prompt #16. You will be presented with the initial " PATIENT FILE MAINTENANCE" screen, as seen in Figure 38. Here you are given a number of choices starting with "**Inquire about Patient**". This choice should always be used before adding a patient to check to see if a patient is already in the system.

In the Inquire mode: Enter a patient number or at least three letters of the last name and optionally two or more letters of other names separated by a space. Also, you can look up a patient by SSN, enter it without any "-" (hyphens) between the three number sets (i.e. 123456789 not 123-45-6789).

It is much easier to check before adding a new patient, rather than have to deal with all the problems that will arise if you enter a patient more than once. Please, check first!

DELETE A PATIENT

If you did not follow the advice given above, and end up with two or more entries for the same patient, then follow the procedure similar to that described under the heading “DELETE A FAMILY”

in the family file maintenance screen. However, in this case, instead of transferring charges, you must transfer clinical information. Clinical information can only be changed by someone who is designated as a provider.

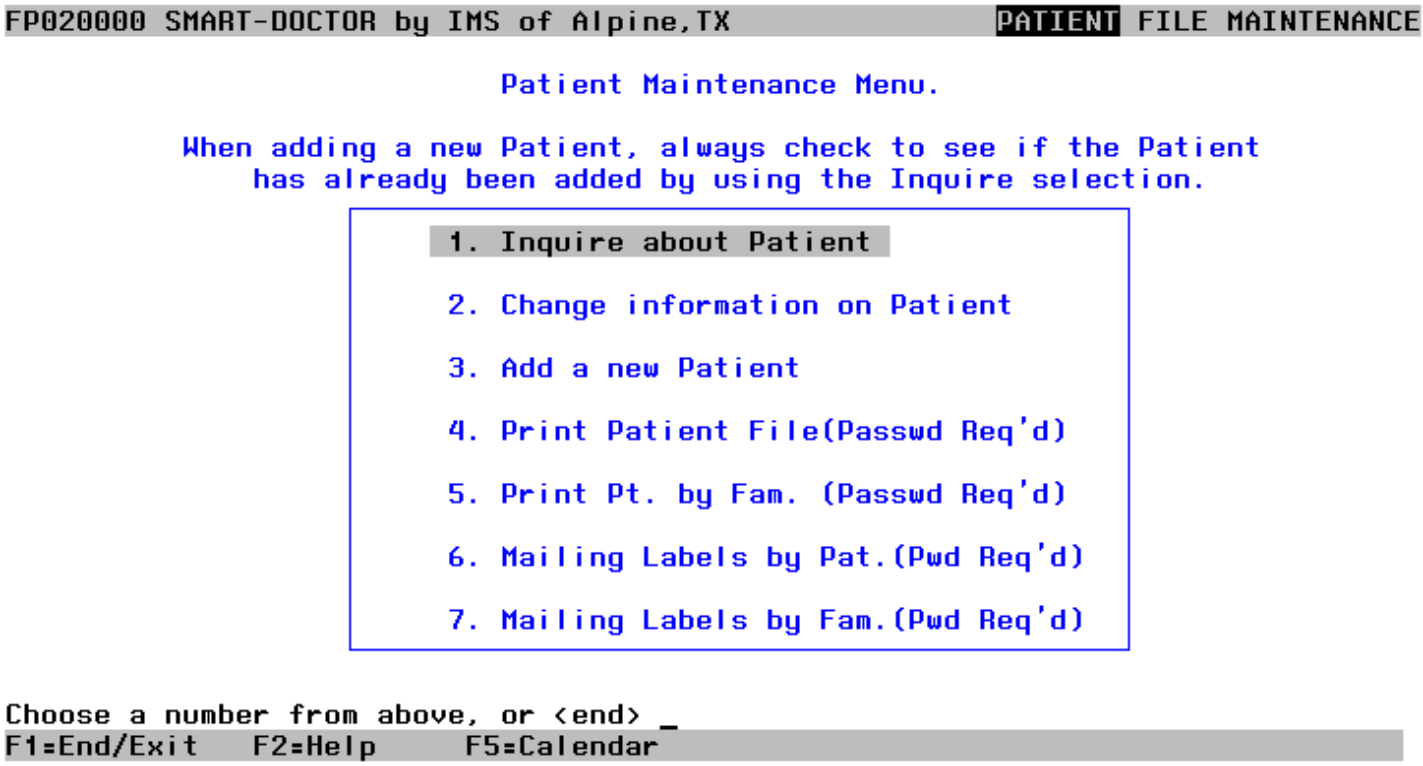


Figure 38 *Patient Maintenance screen.*

ADDING A NEW PATIENT

Select menu item #3, "**Add a new Patient** ", Figure 39.

Prompt #1, "**Patient Number:**", the system will default for you the next patient number available. (You can also enter a unique number of your own, but this is not recommended, since the system will not automatically give you the next number in that sequence.) If you try to enter a number already in the system, you will be told: "**This record is already on file FP-PATIENT. <Return> to continue.**". Accept the new number by hitting the <enter> key, and proceed as indicated below.

Prompt #4, "**Family number(or Xref):**", is the next prompt to be filled in and not prompt #2. The reason for this is to be able to copy information about an individual who is the HOH from the family file. This reduces typing as well as errors in copying that information. Therefore, the only information that you will be putting in the patient file is unique to that file. You are not doing any additional work. You now have two options:

1) enter the family number, or
2) enter a partial family name for a cross-reference list from which to choose.

Prompt #5, "**Is Patient also Head of Household?**" is the next prompt that you are presented with. Answer with <y> or <n>. If <y> was entered, then the information from the family file for the HOH will be copied into the remaining prompts from 2 through 9. If any of this information needs to be changed in the future for the HOH, it must be changed in the family file, and then the prompts of the individual file refreshed by going back into the patient record. If <n> is entered, then you will be taken through remaining prompts discussed below.

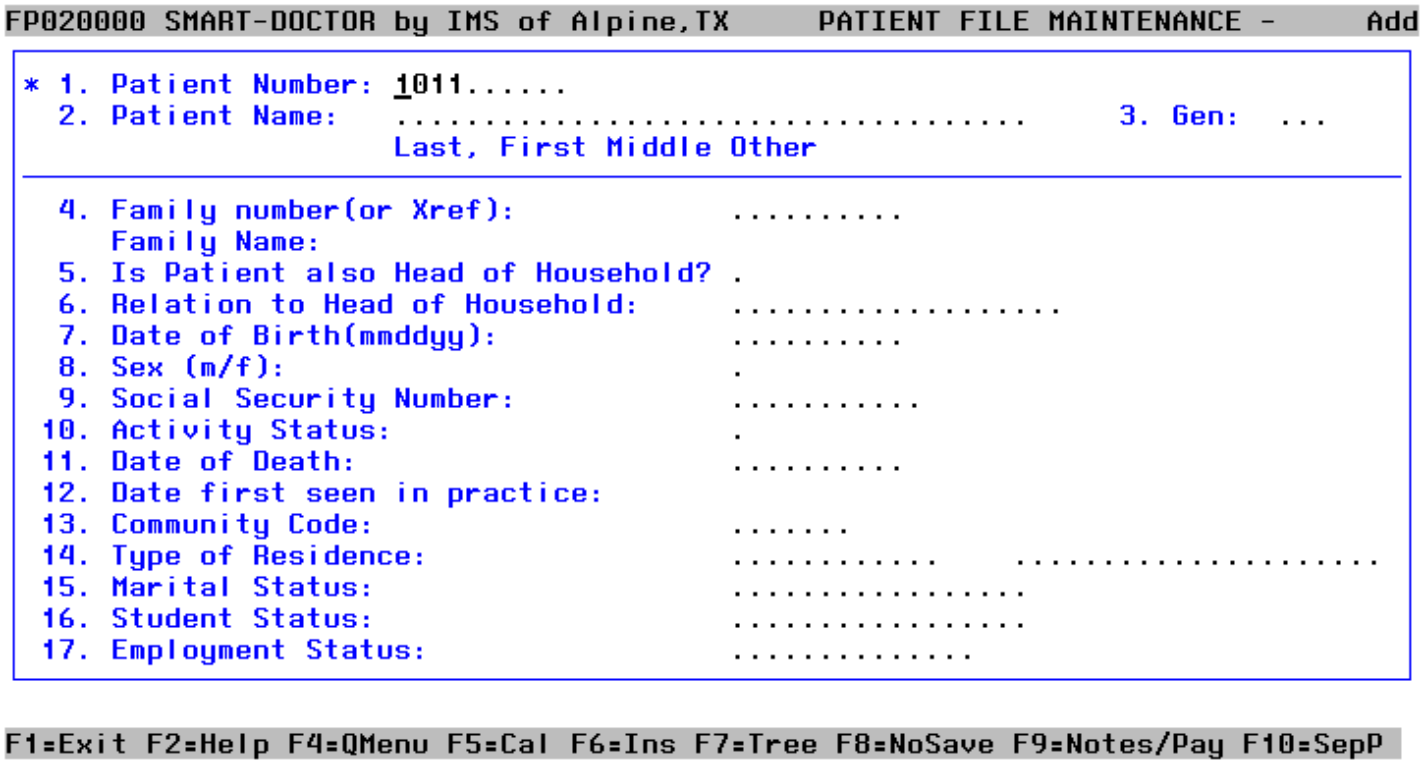


Figure 39 *Patient Add screen.*

Prompt #2, "**Patient Name:**", enter the patient name. Start with the Last name followed by a comma. Then add a space followed by the First name. Then add a space followed by the Middle name or initial followed by a period. Finally, add other names in the space allowed you think may be useful in looking up the patient, such as the maiden name or alias.

Prompt #3, "**Gen:**", is for generation. This can be left blank, or you may use one of the descriptions allowed by insurance carriers which are presented to you in the help key: I for First generation, II for Second generation, III for Third generation, IV for Fourth generation, SR for Senior, and JR for Junior.

Prompt #6, "**Relation to Head of Household:**", select a relationship type from the pop-up screen presented. These are defined by the insurance industry.

Prompt #7, "**Date of Birth (mmddyy):**", enter the date of birth. Enter in either of the following formats: mmddyy or mm/dd/yy. For dates in a different century, enter in the MM/DD/YYYY format, e.g. 11231898 or 11/23/1898.

Prompt #8, "**Sex (m/f):**", enter sex of the patient, either m or f.

Prompt #9, "**Social Security Number:**", enter in the from 123456789 or 123-45-6789.

Prompt #10, "**Activity Status:**", choose one of the following:

Table	Description
A	Active
I	Inactive
D	Deceased

R Reference(not a regular pt., incl. for genetic history only)

Prompt #11, "**Date of Death:"**, will only be able to be entered if "**Activity Status:**" is indicated as "D" for Deceased.

Prompt #12, "**Date first seen in practice:**", you have two options: 1) leave it blank (the SmartDoctor® system will then put the date of the visit when the patient first signs in). 2) enter the date of the patient's first visit. This is important for billing. If the patient is a previously seen patient, put in the date first seen in the practice. If you are unsure of that date, be sure to put in a date before today's date if you want to consider this patient an established patient for billing purposes. If the date is left blank, and the provider sees the patient, the system will then assume that this is a new patient and indicate a higher charge (new patient charge) for this first visit.

It is not necessary to put in the year in the date field if you want to use the current year. For example, if you enter 0101, the system will convert this to 01/01/2004.

Prompt #13, "**Community Code:**", this field can be used to indicate the patient's home community for those insurers who require this information. For the Indian Health Service, the first 3 digits are for the Community, the next 2 digits are for the County, and the last 2 digits are for the state.

Prompts #14 through #17, Type of Residence, Marital Status, Student Status, and Employment Status are all pop-up selections. Pick the appropriate selection for this patient. These selections have generally been set by the insurance industry, however their order can be changed in the TERMS file under the appropriate key. This is generally done by the system administrator.

See the completed patient Add screen in Figure 40.

AUTOMATIC ADD SCREENS and F-KEY SCREENS

During the add mode the system will automatically take you to the next logical screen for adding patient information. In the change mode, you will get to these screens by using the F keys described below.

PATIENT INSURANCE FILE, <F6> Screen

This is the first automatic screen and is similar to the insurance screen in the Family File. The one exception is that only "IND" (individual) can be selected for the insurance type. Insurances placed here should only be for this patient. Insurances for more than one individual should go in the Family File (HOH). For more information on completing the insurance document see "*FAMILY INSURANCE FILE, <F6> Screen"* , in the family file maintenance section.

FAMILY TREE, <F7> Screen

This screen is for entering blood relatives of this patient for purposes of genetic counseling. The data entered here is optional. This screen, shown in Figure 41, is used to enter the family blood relatives which may be patients from more than one family file, but are in the system.

PRINT PATIENT FILE

The printing pf the Patient file is identical in the selection method to family file printing above. There are 4 options here (Figure 38):

#4. **Print Patient File**
#5. **Print Pt. by Fam.**
#6. **Mailing Labels by Pat.**

#7 **Mailing Labels by Fam.**

The sample output of each of these is presented in Figures 42 through 45.

```
FP020000 SMART-DOCTOR by IMS of Alpine,TX     PATIENT FILE MAINTENANCE -  Change

* 1. Patient Number: 1001
  2. Patient Name:   BONNER, JOHN J.                          3. Gen:
                     Last, First Middle Other
-------------------------------------------------------------------------------
  4. Family number(or Xref):              500
     Family Name:                         BONNER, JOHN J.
  5. Is Patient also Head of Household?   Y
  6. Relation to Head of Household:       Self
  7. Date of Birth(mmddyy):               12/02/1931
  8. Sex (m/f):                           M
  9. Social Security Number:              256-25-8965
 10. Activity Status:                     A
 11. Date of Death:
 12. Date first seen in practice:         04/15/1998
 13. Community Code:
 14. Type of Residence:                   Alone
 15. Marital Status:                      Divorced
 16. Student Status:                      Not a student
 17. Employment Status:                   Emp. full-time

Change prompt (2 - 17), A)ll, F)ill _
F1=Exit F2=Help F4=QMenu F5=Cal F6=Ins F7=Tree F8=NoSave F9=Notes/Pay F10=SepP
```

Figure 40 *Completed Patient Add screen.*

```
FP020000 SMART-DOCTOR by IMS of Alpine,TX     PATIENT FILE MAINTENANCE -     Add

* 1
  2      F a m i l y   T r e e
---
         List only direct blood relatives, DO NOT list adopted
  4            siblings, or adoptive or foster parents.
---
  5
  6    LINE Relation    Patient Number of Relative    See Patient File?
  7         --------    --------------------------    -----------------
  8       1   ?
  9
 10

 Choose one:
 1  PGF      Paternal Grand Father
 2  PGM      Paternal Grand Mother
 3  MGF      Maternal Grand Father
 4  MGM      Maternal Grand Mother
 5  F        Father
                                                      Appgen Quick Help
Please choose one of these, press <return> to continue, or <end> _
F7=Previous Page          F8=Next Page
```

Figure 41 *Blood Relative Linkage screen*

```
FP020100                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                                Patient File                 17:59:41 16 Jun 2004

Patient Name (Last, First MI. AKA)   Gen. Sex  DOB       Patient Num Family Num
==================================== ==== ===  ========  =========== ==========
BONNER, JOHN J.                           M    12/02/31  1001        500
BONNER, MARY K.                           F    08/24/62  1006        500
COOPER, DAVID S                           M    10/25/61  1005        501
COOPER, JANE T.                           F    03/12/90  1004        501
COOPER, MARY K.                           F    07/12/60  1003        501
FOSTER, EMMA J                            F    01/20/21  1002        502
JACKSON, JOHN                             M    10/23/69  1007        503
JACKSON, MARY                             F    11/22/60  1009        503
```

Figure 42 *Patient File Printout.*

```
FP020200                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                                Patient File                 18:01:56 16 Jun 2004

Patient Name (Last, First MI. AKA)   Gen. Sex  DOB       Patient Num Family Num
==================================== ==== ===  ========  =========== ==========
BONNER, JOHN J.                           M    12/02/31  1001        500
BONNER, MARY K.                           F    08/24/62  1006
COOPER, DAVID S                           M    10/25/61  1005        501
COOPER, JANE T.                           F    03/12/90  1004
COOPER, MARY K.                           F    07/12/60  1003
FOSTER, EMMA J                            F    01/20/21  1002        502
JACKSON, JOHN                             M    10/23/69  1007        503
JACKSON, MARY                             F    11/22/60  1009
```

Figure 43 *Patient file Printout by Family*

```
FP020101                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                           Mailing labels by patient.        18:04:32 16 Jun 2004

Patient Name (Last, First MI. AKA)   Gen. Sex  DOB       Patient Num Family Num
==================================== ==== ===  ========  =========== ==========
BONNER, JOHN J.                           M    12/02/31  1001        500
367 6TH STREET
ALPINE                TX  79830

BONNER, MARY K.                           F    08/24/62  1006        500
367 6TH STREET
ALPINE                TX  79830

COOPER, DAVID S                           M    10/25/61  1005        501
34 WEST ADAMS
BALMORRHEA            TX  79718

COOPER, JANE T.                           F    03/12/90  1004        501
34 WEST ADAMS
BALMORRHEA            TX  79718

COOPER, MARY K.                           F    07/12/60  1003        501
Press <return> to continue, or <end> _
```

Figure 44 *Mailing Labels by Patient*

```
FP020201                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                    Mailing labels for patients by family. 18:06:03 16 Jun 2004

Patient Name (Last, First MI. AKA)   Gen. Sex  DOB       Patient Num Family Num
================================== ==== ===  ========  =========== ==========
BONNER, JOHN J.                           M    12/02/31  1001        500
367 6TH STREET
ALPINE               TX  79830

BONNER, MARY K.                           F    08/24/62  1006
COOPER, DAVID S                           M    10/25/61  1005        501
34 WEST ADAMS
BALMORRHEA           TX  79718

COOPER, JANE T.                           F    03/12/90  1004
COOPER, MARY K.                           F    07/12/60  1003
FOSTER, EMMA J                            F    01/20/21  1002        502
HC 67, BOX 33D
BALMORRHEA           TX  79718

JACKSON, JOHN                             M    10/23/69  1007        503
2323 ELM STREET
Press <return> to continue, or <end>
```

Figure 45 *Mailing Labels by Family, Printout.*

APPOINTMENT SCHEDULING MENU

From the main menu (FP000000) select the "**Appointments**", prompt #17. The Appointment Scheduling Menu, as seen in Figure 46, will then be presented.

```
FP060000 SMART-DOCTOR by IMS of Alpine,TX          Appointment Scheduling Menu

                        File Maintenance

                    1. Temp. Provider Schedule

                    2. Print Temp. Provider Schedule (S/P)

                    3. Create Appointment Schedules

                    4. Print Appointment Schedule


                    5. Review Appointment Schedule

                    6. See Clinic Appts (Over-Book & Cancel clinic)

                    7. Book patient appts (Add, Change, Cancel)

Choose a number from above, or <end>
F1=End/Exit    F2=Help    F5=Calendar
```

Figure 46 *Appointment Scheduling Menu.*

SCHEDULING CONCEPTS

Before getting started with describing how to go about setting up the schedule you want, we should first look at modern concepts of appointment scheduling. The information presented here comes from papers and lectures of L. Gordon Moore, M.D., who has been a leader in the Idealized Design of Clinical Office Practice initiative, which is sponsored by the Institute for Healthcare Improvement. There are two main concepts two scheduling that will enable an office to run more efficiently and with less stress: 1. Open Assess Scheduling, and 2. Real-time scheduling. These concepts are summarized as follows:

a. Set limits on accepting new patients. In a typical practice, there should be 60% of the appointments open in the upcoming 30 days.

b. In any given day, 0.75% of your active patients can be expected to call for an appointment that day. So in a practice with 2,000 active patients, you can expect to get calls for 15 appointments for that day (2,000 x 0.0075). Therefore, leave 15 open appointment slots. This is just an estimate, you can come up with better number by logging the number of patients that call each day of the week for an appointment that day. Then set the average number as the number of open slots that can not be booked before that day of the week. Mondays, Friday afternoons, and days after holidays generally have the highest requests for same day appointments.

c. Set up the schedule based on actual times for patient care, including phone calls, chart completion, correspondence required for patients, and prescription refills. To do this, review a week of patient visits. Get the actual arrival and departure time of the care provider (doctors, nurse practitioner, physician assistant, etc.), for each clinic day. Subtract hours spent for lunch and scheduled meetings. What you want to derive is the actual amount of time required to see the average patient, including time spent on other practice needs at the same time.

An example would be a doctor that arrives at 9 am, leaves for lunch at noon, returns at 1:30 pm, and actually leaves the clinic at 6:30 pm. During this time, the doctor sees an average of 20 patients. Since the total time in clinic is 8 hours, and the number of patients seen is 20, the average time needed to see a patient is 24 minutes. Therefore you should be booking patients at an average of 24 minutes. Then schedule the doctor till 6 pm, and you should be done at that time. This means, however, that you should book at least one to two patients less per day. If the doctor really wants to stop at 5 pm, then you can only schedule 16 patients that day.

In using the SmartDoctor® system, this could be done using a blocking factor for slots of 10 minutes each. Then scheduling 3 slots (30 minutes) for new problems, 2 slots (20 minutes) for minor or recurring problems, and 1 slot (10 minutes) for a wound check or suture removal. An alternative to this is to set all appointments to 25 minutes each. The patient flow will average out as the day goes on.

The amount of time spent on juggling the schedule, asking nurses and doctors about fitting patients in, and time spent on the phone can be reduce by about a factor of 9.

Too many practices cause problems and become inefficient because of anxiety over not seeing enough patients. They keep on accepting new patients to fill any empty slots. This results in having to try to work in established patients on a recurring basis. Established patients find they cannot get an appointment for 2 to 3 weeks or more, and rarely can be seen as soon as they want. Once they find another clinic with more availability to see them, they will leave your practice, no matter how good you think you are. You are left with is seeing a higher percentage of new patients. This is inefficient from several standpoints. First, it is much easier and faster to see an established

patients than a new one. There is much paper work involved for your office to set up this new patient. You do not know if they are good at paying bills and keeping appointments. You have to learn how to bill their insurance carriers. You need to get their past records and enter this information into your records. A well established practice may only see a couple of new patients per week. If your doctors occasionally have 15 minutes without a patient, they can catch up on other things that should be done before the end of the day, and leave on time.

TEMPORARY PROVIDER SCHEDULE

First you must set up a temporary schedule. This should be reviewed by the provider before you actually create the schedule.

You will need to set up a schedule of hours for each provider for each day. It is recommended that you schedule two months in advance because some appointments are made at least that far ahead. You will not be able to make an appointment for a patient on a day the provider hasn't been scheduled to see patients. Since most providers seldom change their time slots or standard office hours, setting up this schedule is generally more repetitious than time consuming.

A default clinic schedule as well as a default doctor can be set in the clinic file as discussed under "Clinic File". If the default doctor is correct, just accept this. Alternatively, you can type in the initials or part of the name of the provider for whom you want to make a schedule. Next, hit the <enter> key to accept the default clinic times, or over type with time times you want. Use the <F2> key to help you define any hours that are different than these. You need to be aware of the provider's block-time, because this must agree with the hours you enter. If you need to retype a line (before you enter it), press the up arrow. If you do not want to add any more time blocks, press <F1>. Check for accuracy and make any changes necessary using the prompts at the bottom of the screen. Then hit the <F1> key to go to a new screen or back to the Appointment Scheduling Menu. If you do not want to make a clinic schedule for the defaulted date, hit the <F8> key to exit with no save, instead of the <F1> (end/exit) key. If you do the latter, it will be saved "as is", even with blank appointment times. An example of a completed appointment schedule is seen in Figure 47.

PRINT PROVIDER SCHEDULE

Next, you should print the provider schedule which incorporates the provider's hours previously assigned. This schedule is tentative and must be approved by the appropriate provider. After you get it approved, you may record it into the system or "create" the schedule. To print the "tentative" provider schedule, select #2. On the selection screen, identify the provider, or enter "all" if there are other provider's schedules that you want to see or that need to be approved. Indicate the dates of the schedules to be printed, i.e. "start" date and "ending" date. You may want to print this schedule to the screen before printing to the printer, or you may select "B" for both. You will need a hard copy for the provider to approve.

CREATE SCHEDULE

You must "create" the schedule by answering the prompts given in the Create Schedule screen. This will record the schedule into the system and create the actual "appointment book" for making appointments. There are only three prompts in this screen. You should (1)identify the provider or accept "All", (2) enter the start date, i.e. the first date that you have scheduled for the provider or providers (or use the default if it is today's date), and (3) enter the ending date by accepting the default. If you haven't yet received approval for all the temporary provider schedules, you may enter the date of the "latest dated" approved schedules. You will be returned to the Appointments menu automatically.

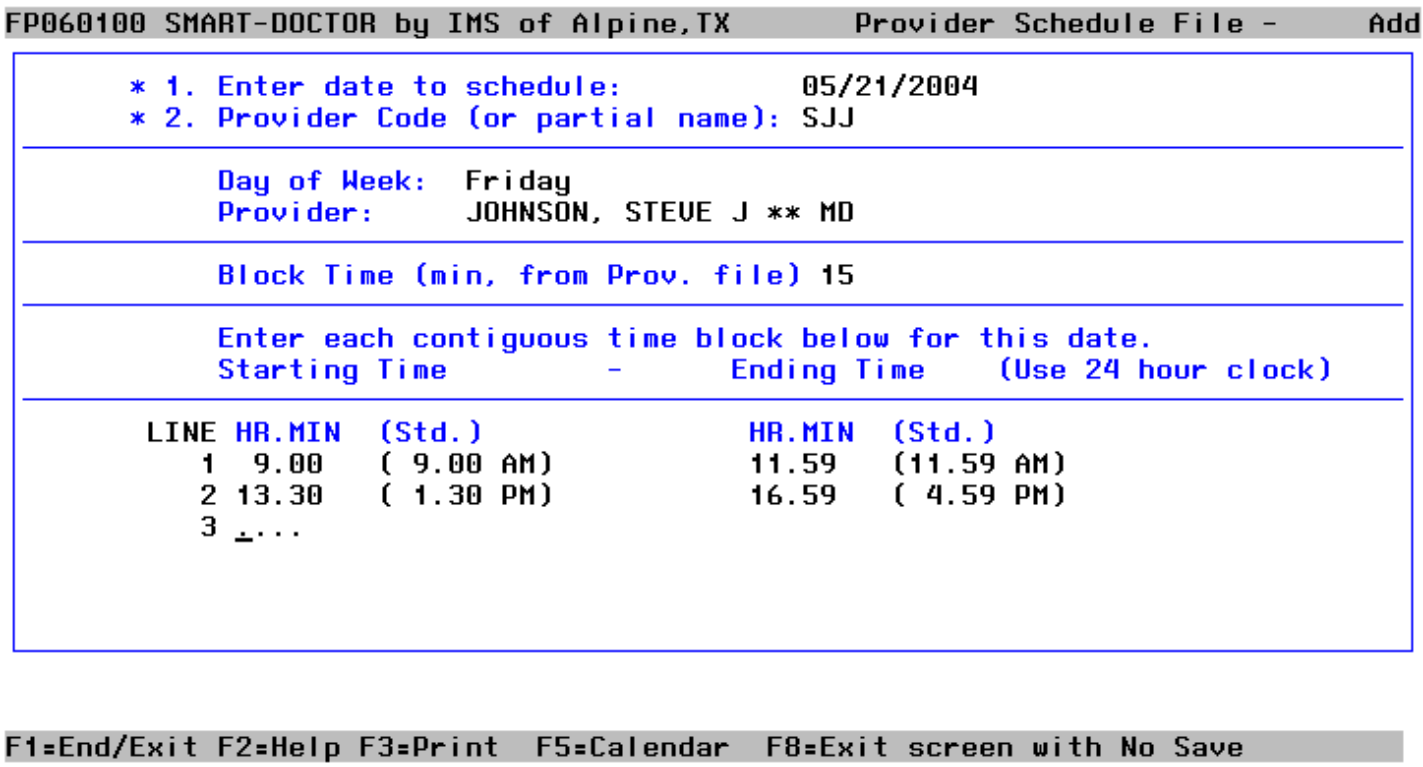


Figure 47 Provider Schedule screen.

PRINT SCHEDULE

The final schedule or work load summary should be of help in planning the staffing of nurses and other clinic personnel. This schedule is broken down by date to show the clinic load each day, i.e. the number and % of slots already booked for the doctors in clinic on the days scheduled. To print this schedule, select #4 and answer the next three prompts on the Summary Appointment Schedule screen. Select a printing option or enter the default (S) for printing to the screen. If you print it on the screen, since there is only one day listed to a screen, you will need to page down or hit the <enter> key for each succeeding day to see the entire schedule. (You may view the schedule again by entering "Y" at the "Reprocess Summary Schedule" prompt). When you print it to the printer, the entire summary will be condensed into one document.

REVIEW APPOINTMENT SCHEDULE

Selection #5 "**Review Appointment Schedule**" presents appointment information in a format which is valuable when arranging patient appointments. It lists each provider followed by the days he will be seeing patients, the number of slots already booked for appointments and the number of slots still available. This is similar to "Print Appointment Schedule", but cannot be printed.

Selection #6 "**See Clinic Appts (Over-Book & Cancel clinic)**". This menu is broken down into three mini menus (see Figure 48): 1) The first mini-menu item is designed to view or inquire about appointment booking, 2) the second is to add special message at the top of the appointment schedule, add overbook slots, or add or change room numbers, and 3) the third is to delete appointment booking (cancel clinic). The screens look the same, see Figure 49, however the mode changes from "Inquire" in the "See Bookings" selection to "Change" in the "Add Rm#, Over-Book Slot or Message" selection, and finally to "Delete" in the "Cancel Clinic" selection.

Selection #1 "**See Bookings**," to get information about a provider's bookings (patient schedule) for the day you designate. Enter the date and identify the provider on the Appointment Booking Inquire screen to see the appointment list. See Figure 49.

Selection #2 "**Add Rm#, Over-Book Slot or Message**", to add/change room numbers, add an over-book slot, or add a header message to the appointment schedule.

On the Appointment Booking Change screen, enter the date of the clinic schedule that you want to change, and identify the provider.

To add or change the "**Special Message:**" header, go to prompt #3. See Figure 50.

To add or change the room number in the multi-valued prompt on the lower half of the screen, go into the change mode for the line number you want to change. See Figure 51.

SEE CLINIC APPOINTMENTS (OVERBOOK, CANCEL)

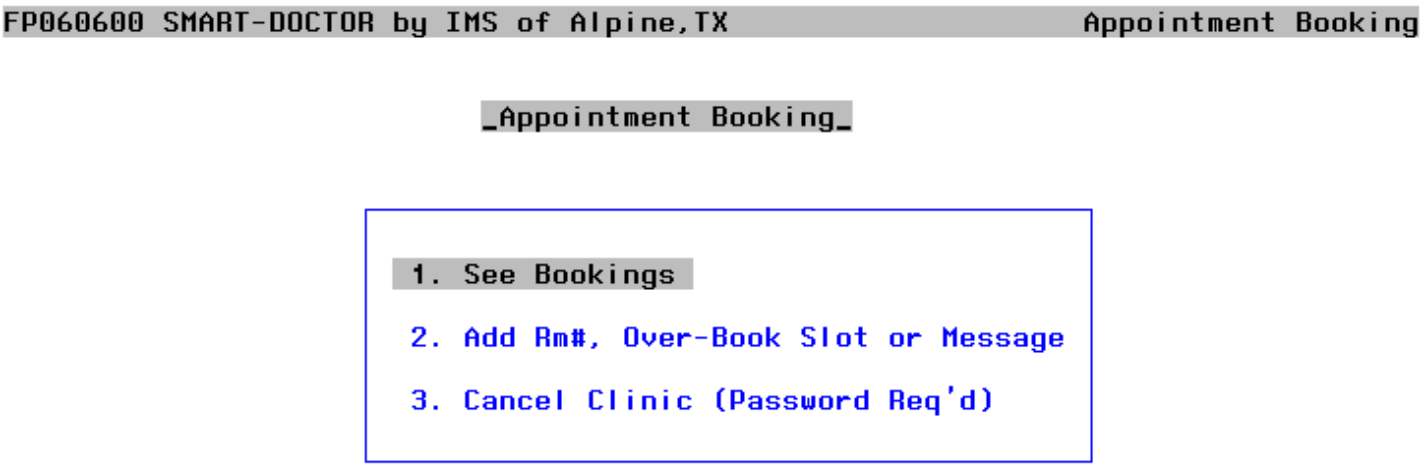


Figure 48 Appointment Booking Menu screen.

To insert an "over-book" slot, go to "Time Slot" prompts at the bottom of the screen and select "I" to insert. Indicate the line number before which you wish to add the new appointment and enter the new time. You may not enter any of the times already booked, but only the times in between. If you are working in a patient between 9:00 and 9:15 you may assign any time between 9.00 and 9.15, such as 9.01, 9.02, ... 9.14, etc. Once you have added the appointment to the provider's record, you may add it to the patient's appointment record. A new slot will be available. See Figure 51.

Selection #3 "**Cancel Clinic**" only after you have cancelled the patients. To cancel a clinic on a particular date, you will first need to cancel each patient's individual appointment on that day. Select #1 Booking to see the Appointment Booking Inquire screen. Enter the date of the clinic to be cancelled and identify the provider. Note the number of patients scheduled. To cancel an appointment for one of these patients you must go to the Booking Appointments Add screen. To do

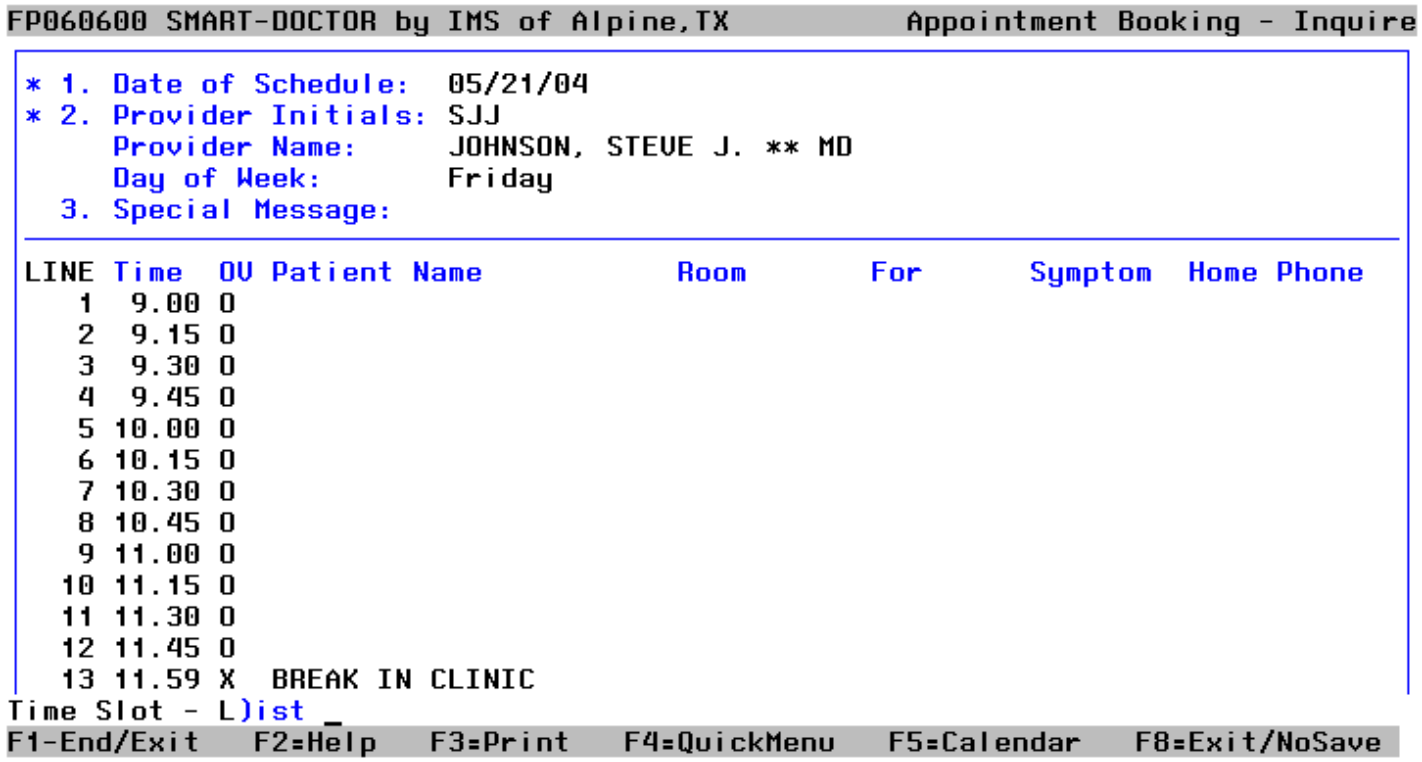


Figure 49 *Appointment Booking screen.*

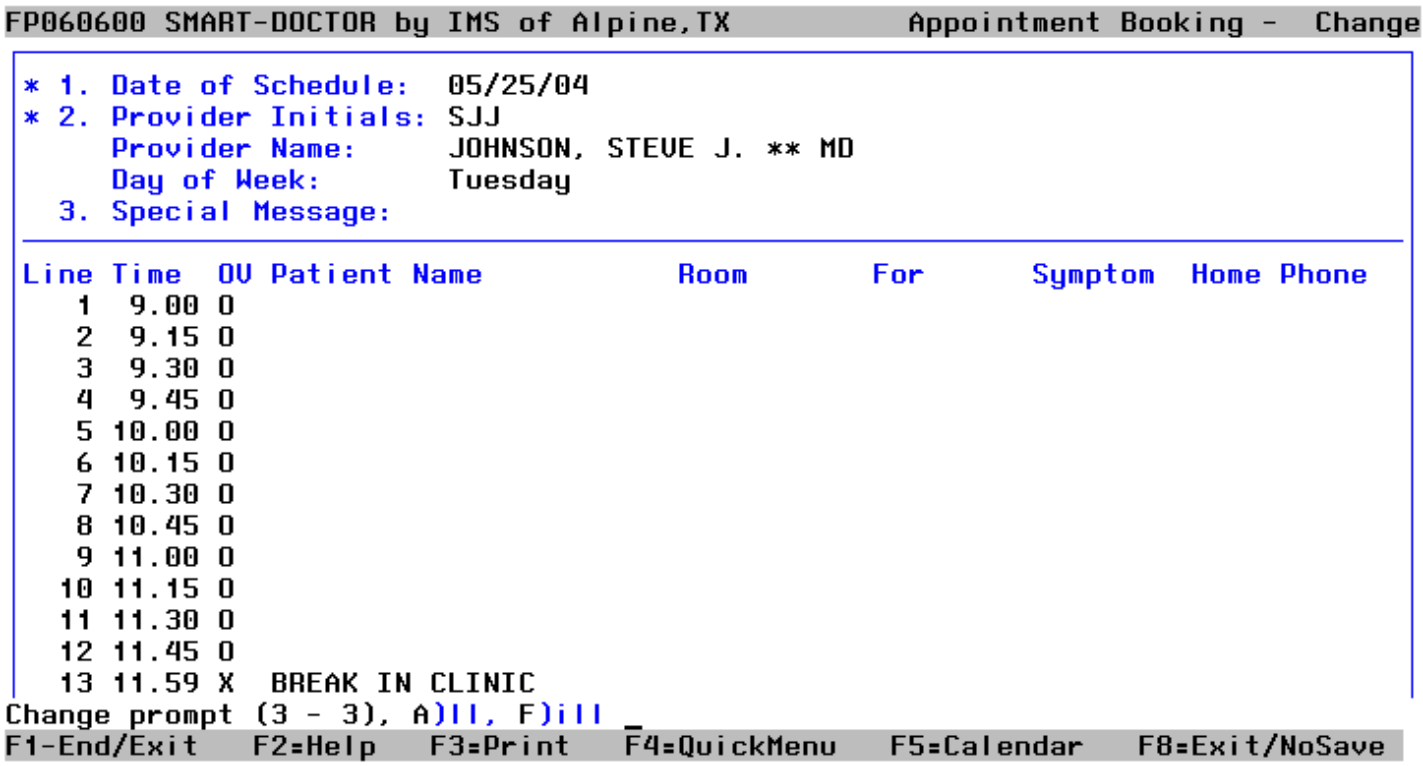


Figure 50 *Change Appointment schedule Display Message.*

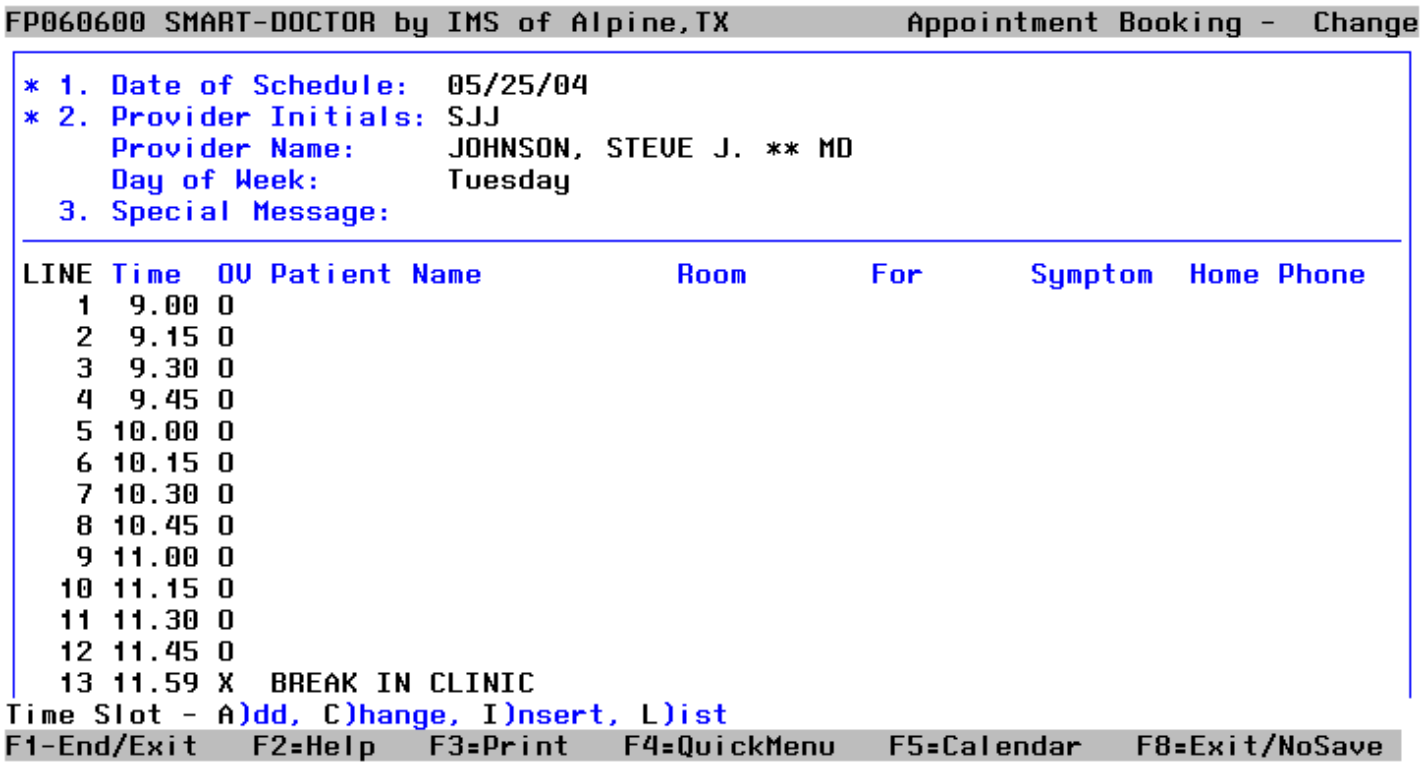


Figure 51 Change Appointment Schedule Room Number.

this, press Ctrl W (or <F4>) to get a Quick menu, and select #2 "**Book patient appts(Add,ch,can)**". Identify the patient, skip the "**Check Family File?**" prompt (enter <n>), and enter the cancellation on a new line. Be sure you have the right Line # entered in the cancel column. You will get a pop-up to confirm that you are cancelling the correct appointment. Hit the <enter> key to accept the default of yes, if this is correct, or enter <n> if this is incorrect. Then, <F1> back to the Appointment Booking Inquire screen to select another patient (unless you have a photographic memory), and repeat the procedure. When the last patient is cancelled, you may select #3 to cancel the Clinic. Enter the password to get into the Appointment Booking Delete screen. Enter the date and provider information, and answer the prompt confirming that this is indeed the right record to delete.

The last prompt on the prior menu screen #7, "**Book patient appts (Add, Change, Cancel)**", is the same as the first menu item on the main office screen "**Book Patient Appointments.**" The description of which follows.

BOOK PATIENT APPOINTMENTS

From the main office menu select prompt #1 "**Book Patient Appointments**". This will take you to the "Booking Appointments" screen. This screen can also be reached while working in other areas by hitting the <F4> key for Quick Menu. On the Quick Menu screen this is choice #2 --"Book patient appts(Add,ch,can)".

In prompt #1, on the "**Booking Appointments**" screen (see Figure 52), enter at least three letters of the last name and optionally two letters or more of other names separated by a space. You can also find a patient by entering the patient number or Social Security Number (SSN) without dashes. If you enter a name that is not on file, you will receive a message "**not found in cross-reference.**" If this is a new patient, you will need to add the patient to the Patient File (#16 on the Main Menu) before you can make an appointment. The first appointment on the Patient Appointment Record

will be entered at LINE 1 of the multi-valued field. All subsequent appointments, cancellations and referrals will be listed on succeeding lines as they are made.

You will first be asked if you want to review the family file information. Answering <y> or hitting <enter> will result in you going to the Family file in the "Inquire" mode. If you want to bypass this since you have already reviewed this, enter <n>.

The next prompt (Prompt #2), in the Booking Appointments screen is for daytime phone numbers. Either enter the number, or hit <enter> to go by this prompt (on existing patients you will be dropped to the change prompt area). This number will NOT be added to the family file. That file should be used for all other phone numbers.

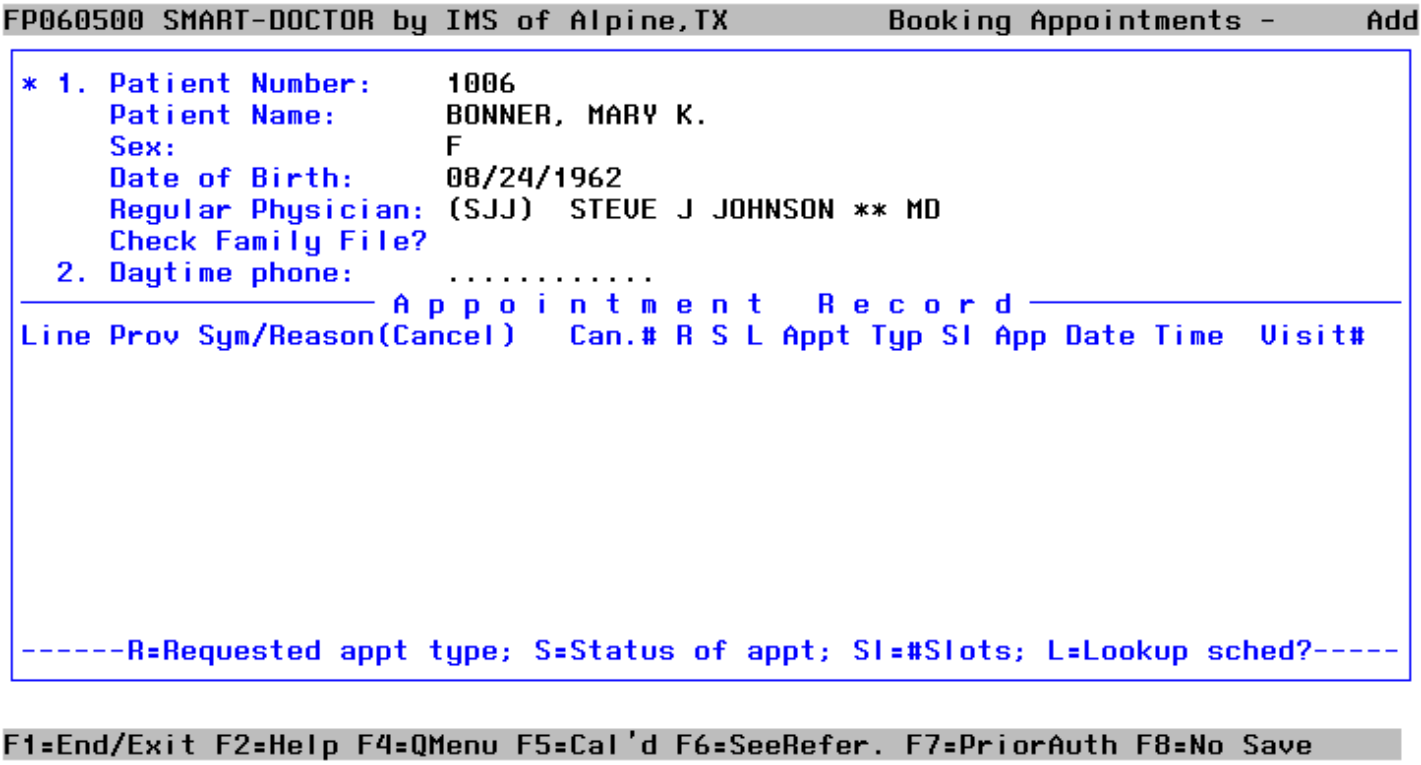


Figure 52 Booking a Patient Appointment.

After you pass prompt #2, you will be at the multi-valued prompt for adding an appointment. If you are in the Add mode, just start entering the appointment. In the change mode, to add an appointment to the Appointment Record, type <A> (for Add), and a new number will appear on the left margin followed by the initials of the patient's Provider (doctor). If you need to schedule a different provider to see the patient, enter his/her initials (or part of name) instead of the defaulted Family file doctor.

In the "**Sym/Reas (Cancel)**" field, enter the reason for the appointment. The reason for the appointment which will most often be the symptom for which the patient is seeing the doctor (you should be able to select a symptom from the symptom list which coincides best with the patient's complaint, i.e. cold, allergy, headache, etc.). You only need to type part of the symptom or reason since this field is cross-referenced with the Symptoms File, which contains all the terms your clinic wishes to use (and can be changed by your clinic).

However, if the patient was referred to the clinic by another doctor, you need only type <Ref> or

<Referral> as the reason for the visit. A "pop-up" screen will then request the Diagnosis code and the Name of the referring doctor. The F1 key will return you to the Patient Appointment Record after you have entered this information.

The "**Can. #**" field. Cancellations of appointments are recorded in the Patient Appointment Record in the same manner as the appointments. Type "A" (for add), press <Enter>, and then type <Cancel> in the Symp/Reas(Cancel) field. To identify the appointment that was cancelled, type in the line number(#) of the appointment to be cancelled. A prompt will then ask you to indicate whether the patient cancelled or if it was a clinic cancellation. Highlight your choice and press <Enter>. To be sure you are not making a mistake, the system will prompt you to verify that you want this appointment cancelled for this patient. Just hit the <enter> key (or <return> key) to indicate yes, or enter y. To void this cancellation enter <n> for no.

The "**R**" field is for " Requested appt type". Hit the help key <F2> for a list of possible terms, "R" will be defaulted for routine. A regular appointment is recorded as an "R", automatically, after you type in the reason for the appointment. However, you may change this to fit the circumstances. Insert an <M> (mandatory) if the doctor considers it mandatory that the appointment be kept. Insert an <N> (for no problem) if the reason for the appt. is a school physical, etc. And a <C> (for cancelled) will automatically appear whenever you enter a cancellation in the "Sym/Reason(Cancel)" field.

The "**S**" field is for Appointment Status. After you enter the reason for the appointment, this will be set to a "P" to indicate the patient visit is pending. The system changes this field automatically. See Figure 53.

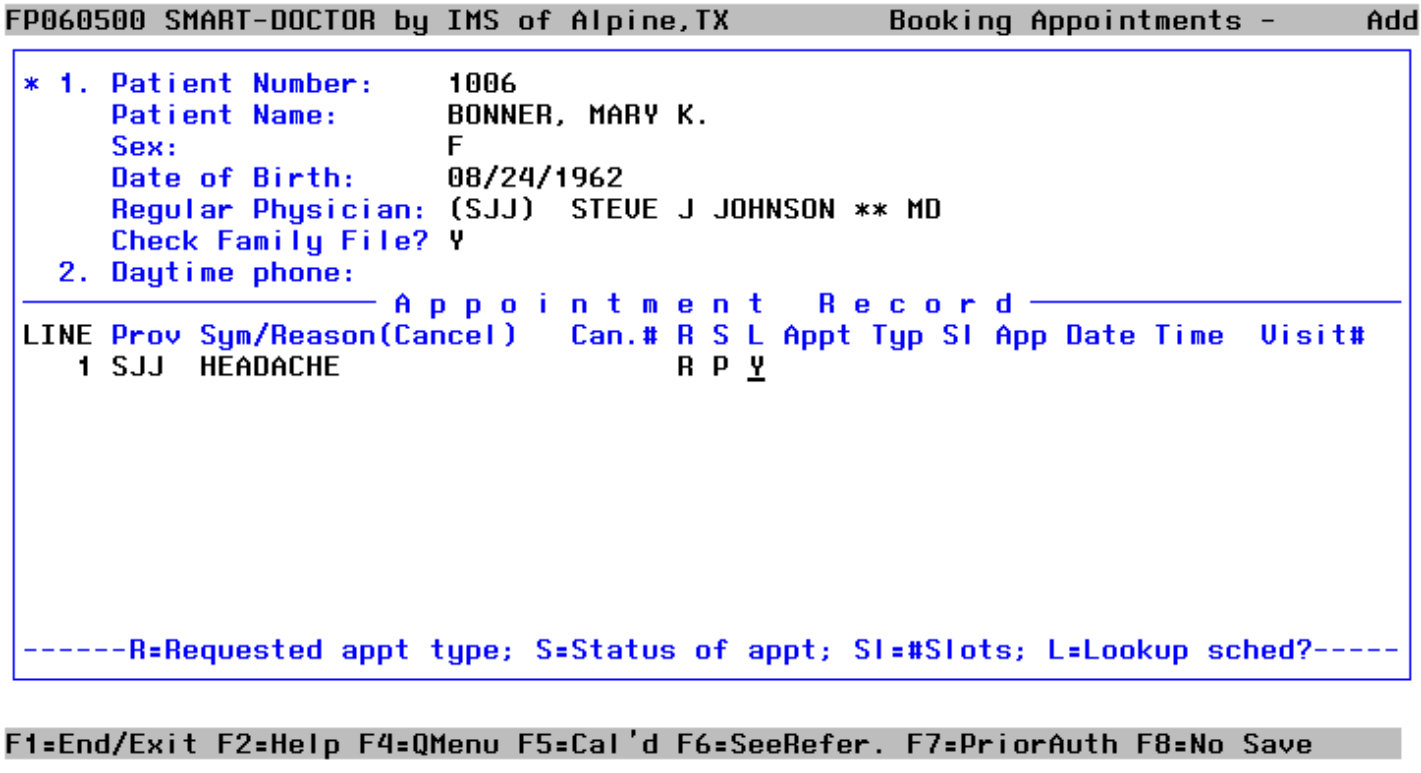


Figure 53 An Appointment Line in the Patient Appointment Schedule.

The "**L**" field is where you specify how to look for a provider's appointments. Enter <Y> (the default) to choose a date from the providers entire schedule. If you only want to look at the providers schedule for the current day, enter <N> for "now". Or you can enter <S> to select from a list of all

providers' schedules (if you pick a different providers schedule, the "Prov" field will change to that provider upon a screen refresh). The default is set to <Y>. Press <Enter> to accept the <Y> (yes) prompt if you want to see how many slots have already been booked on this provider's schedule (see Figure 54). Then, highlight the date for the appointment and hit <Enter>.

In the "**Appt**" field, an "Appointment Types" pop-up screen (see Figure 55) will list the types of appointments available. Highlight the type of appointment the patient requires and press <Enter>. If you pick an appointment type of the wrong sex, you will get a warning message to that effect and will be forced to pick an appropriate appointment type for the patient's sex.

Next, the appointment schedule for that day opens and you select time slot, as seen in Figure 56. At this point, you have the last opportunity to up-arrow, back through the prompts on this line before you select the appointment time, completing the appointment. If you up-arrow all the way back to the first field on this line and hit the <F1> key, it will cancel this line. Then you may then start again or quit.

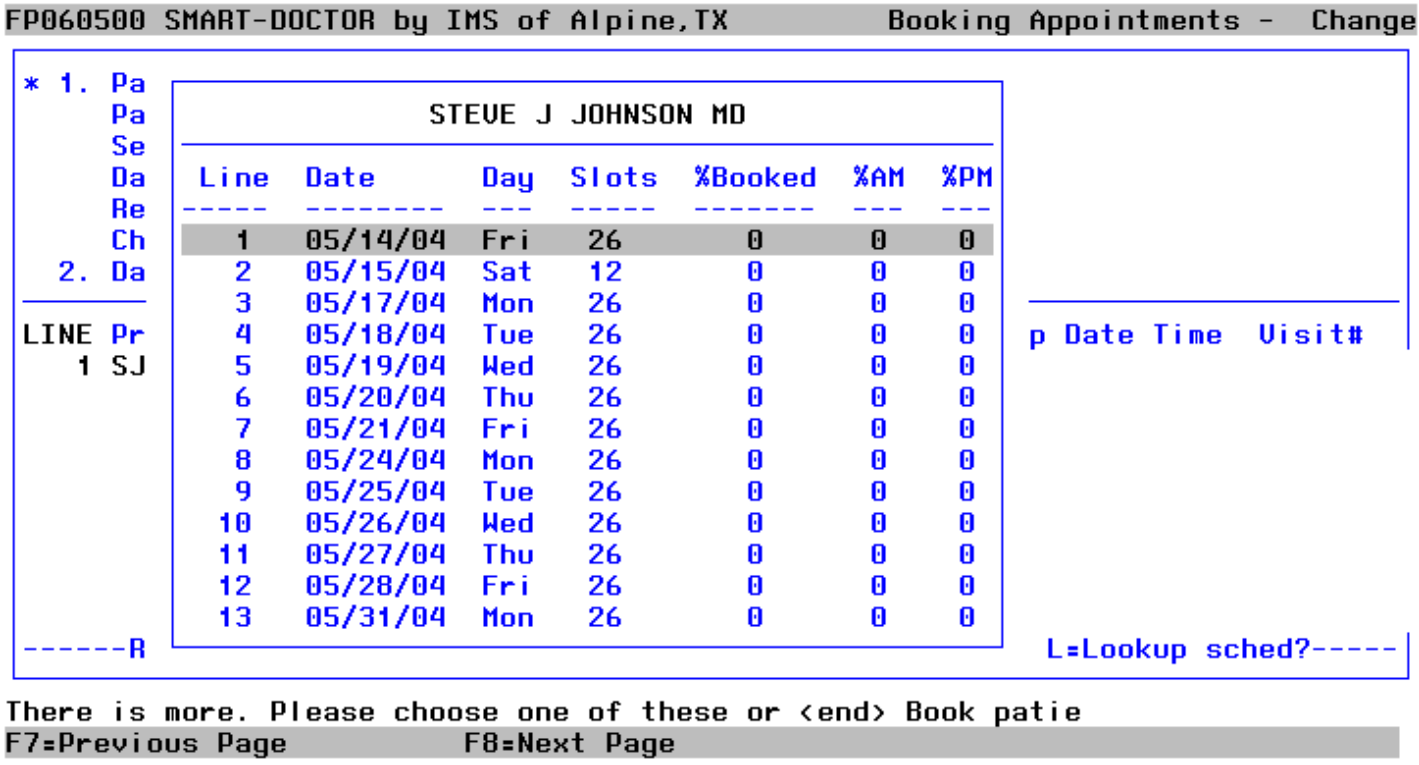


Figure 54 *Select Date for Appointment.*

The appointment type you designated and the number of slots required for the visit will be recorded on the appointment record. You may now enter another appointment or hit the <F1> key to end adding appointments for this patient. The completed appointment screen is seen in Figure 57.

You may get a warning that this appointment may need a prior authorization. This is a result of the system looking at the reason for the appointment in the Symptom file and finding it is flagged for possible prior authorization request. If this is flagged, then the system checks to see if any insurances the patient has have prior authorizations indicated. If both conditions are true, then a flashing message is displayed: " **Please check for need of Prior Authorization** ". As you then move to the next field you will get a pop-up window asking, " **Should this appointment be placed in the file indicating that Prior Authorization is required?**" If you want to be reminded to get this

prior authorization before the appointment, answer yes. You can check to see if this was already

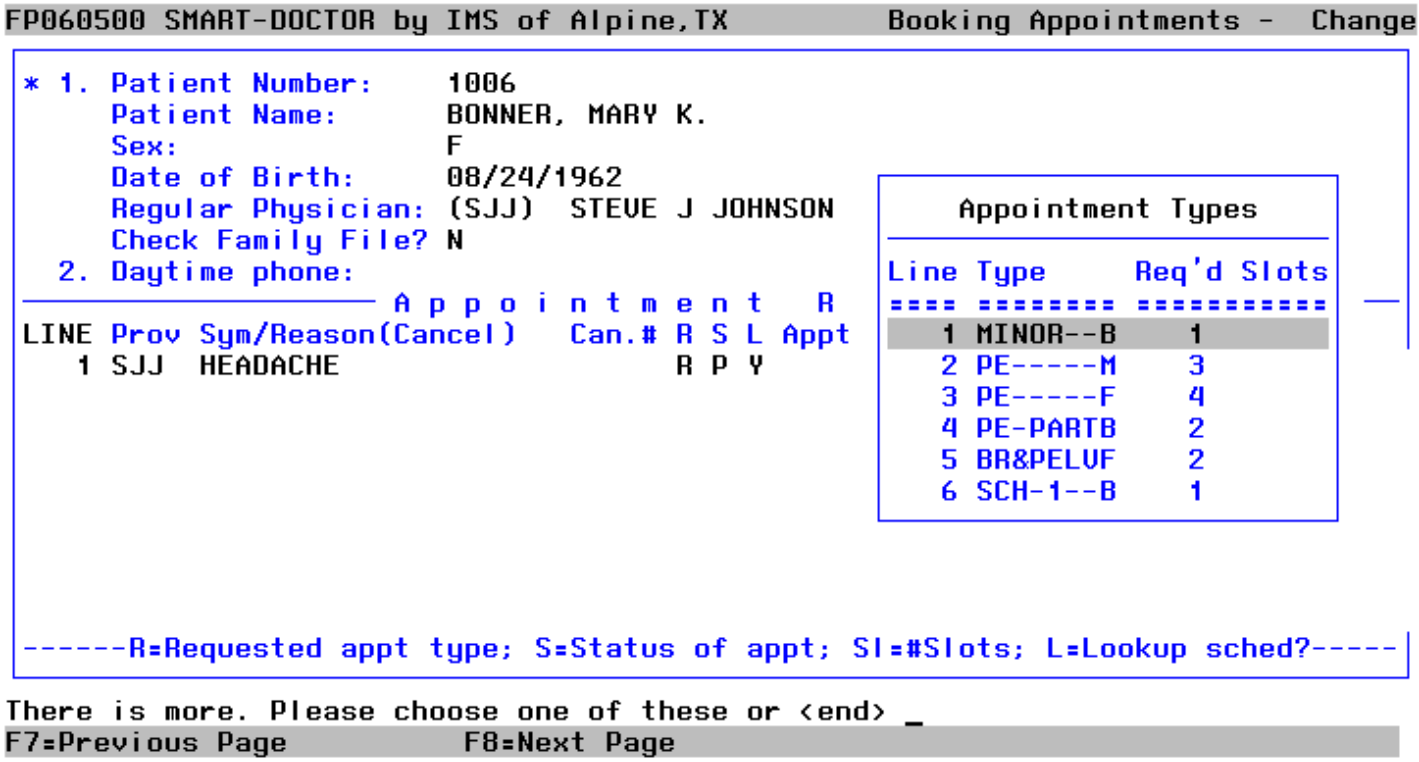


Figure 55 *Select Appointment Type*

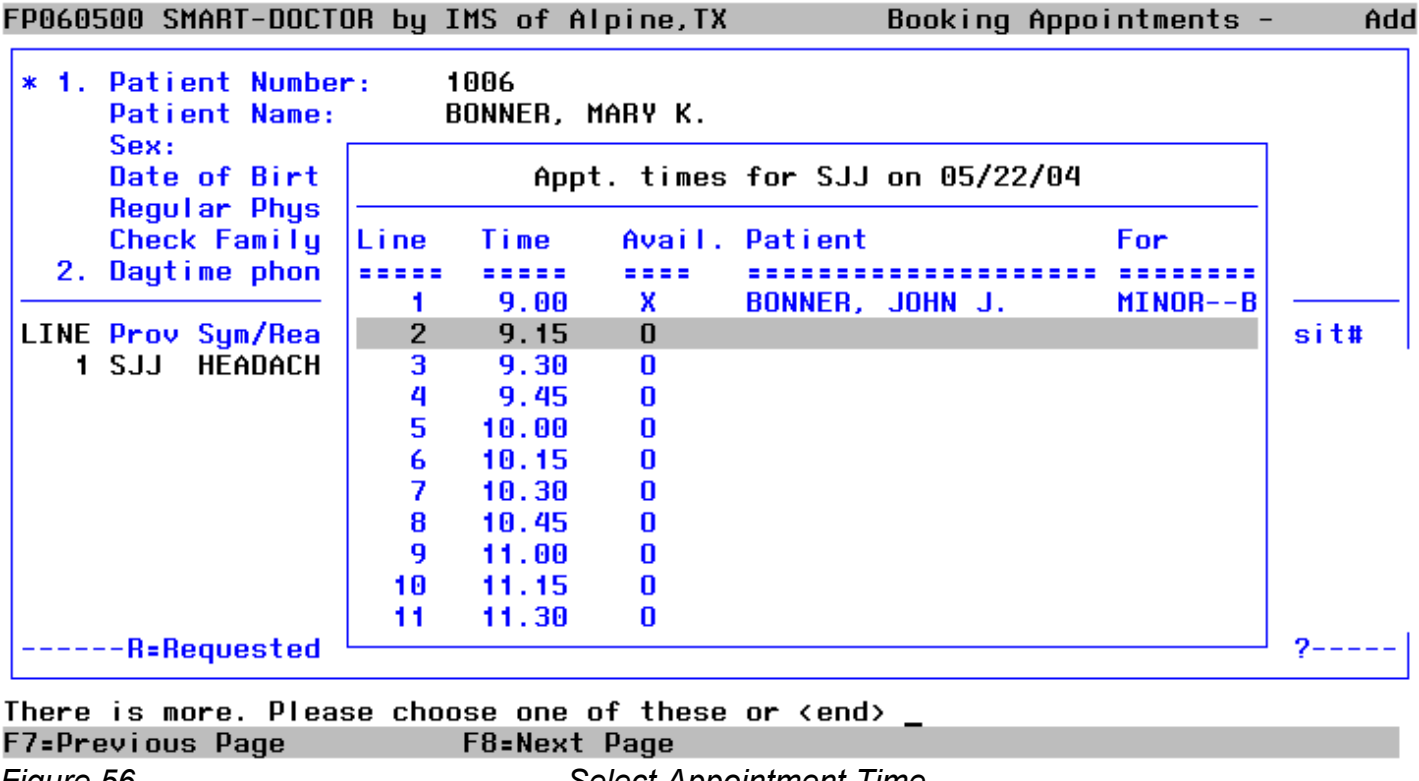


Figure 56 *Select Appointment Time.*

obtained for this patient by hitting the <F7> key which will take you the patient prior authorization screen, where all prior authorizations are listed. The example shown in Figure 58 is for a different

patient.

Appointment security screen, F12.
The system employs several different methods to track when and who made significant additions or modifications to the system data. In the case of the appointment screen, you can find out who added each line in the appointment record multi-valued prompt by hitting the “hidden” F12 key for security auditing. This will open up the “SECURITY SCREEN” (as seen in Figure 60), after prompting for a security password. Figure 59 is an example of a longer appointment list for John Bonner. Figure 60 shows the security screen presented after hitting the hidden F12 key and giving the security password.

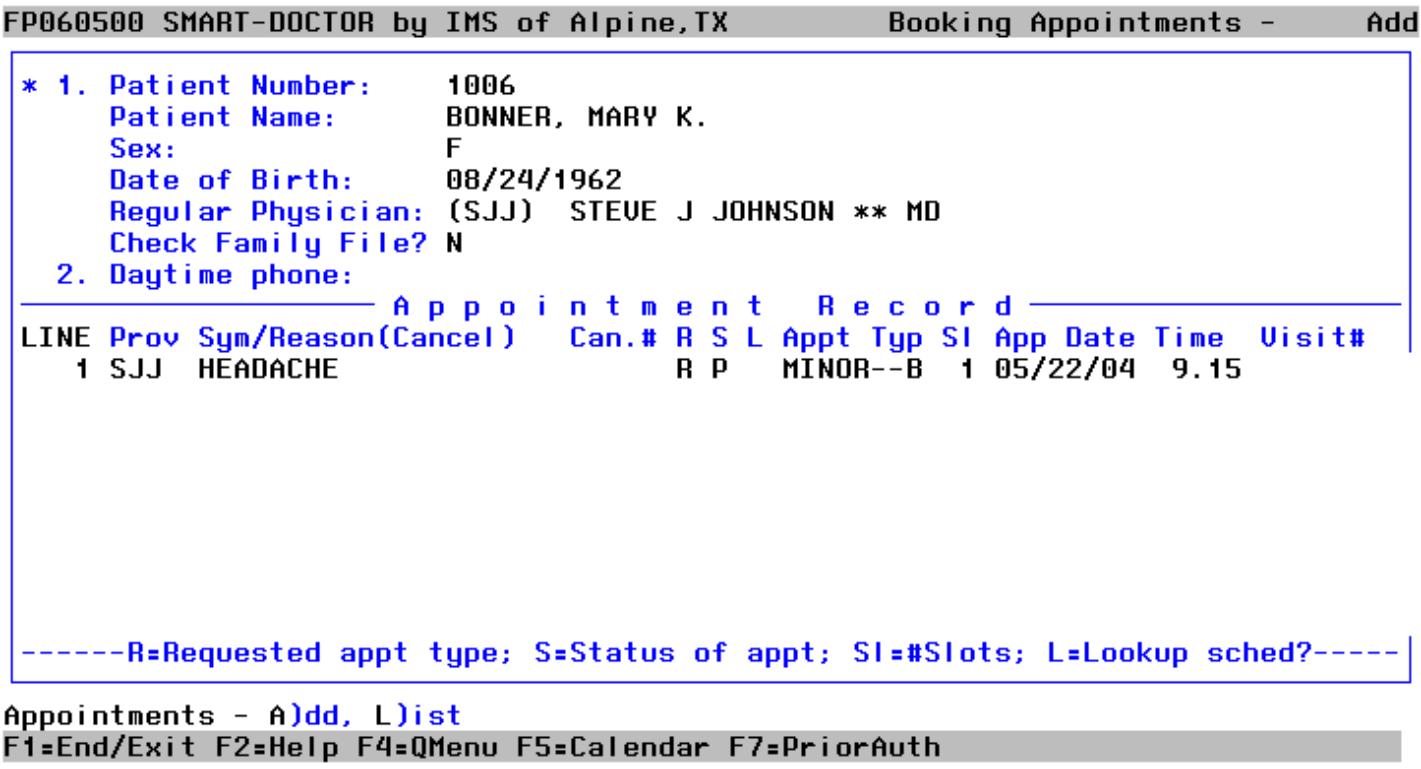


Figure 57 Completed Appointment Screen.

INSURANCE CARRIER MAINTENANCE FILE

This is an important file that keeps all insurance company information. From the main front office menu select menu item #22, **Insurance Carrier File**. You will be taken to a sub-menu from which you can choose to: 1) “Add or Change” or 2) “Print File”. On selecting #1, the "**Carrier Maintenance File**" will open, as seen in Figure 61. Enter at least 3 characters of the name of the carrier you want. If it is not the only one with those characters, a list to choose from will pop-up. Pick the carrier you want to review or change information for. In the example seen in Figure 61, "blu" was entered, and the carrier comes up.

You can make additions or corrections to each insurance company record to keep it up to date. That is, except for the ID #. All the insurance companies have an ID # of their own which is permanent and cannot be changed.
If you are adding an insurance company, you may have to call the company to get the number if you are not using the Texas Health information Network (THIN). Once added, you can look up that carrier again by entering the first few letters of the company's name. You can download the current

THIN Participating Professional Payer List at http://www.thinedi.com/pdf/prof_payer.pdf, which is

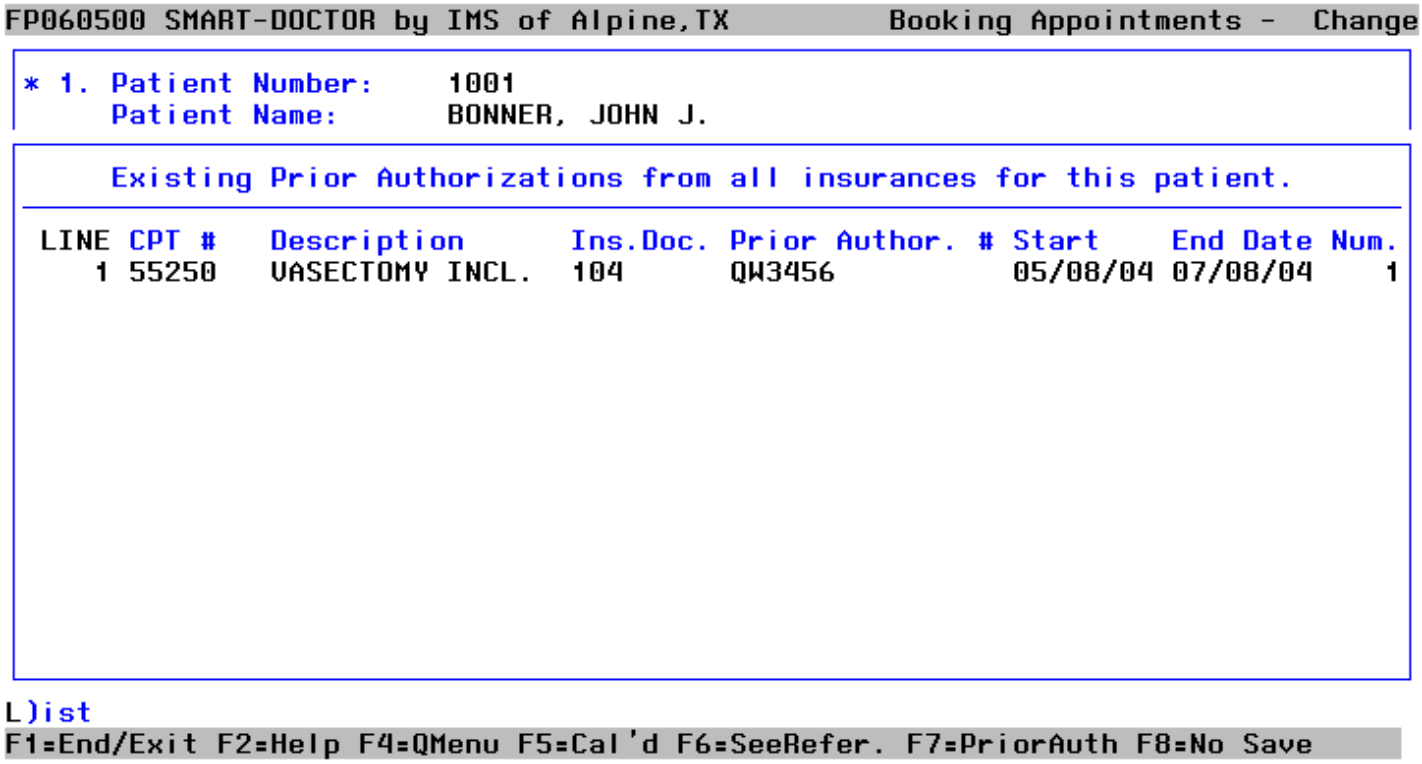


Figure 58 *A Patient's Prior Authorization screen.*

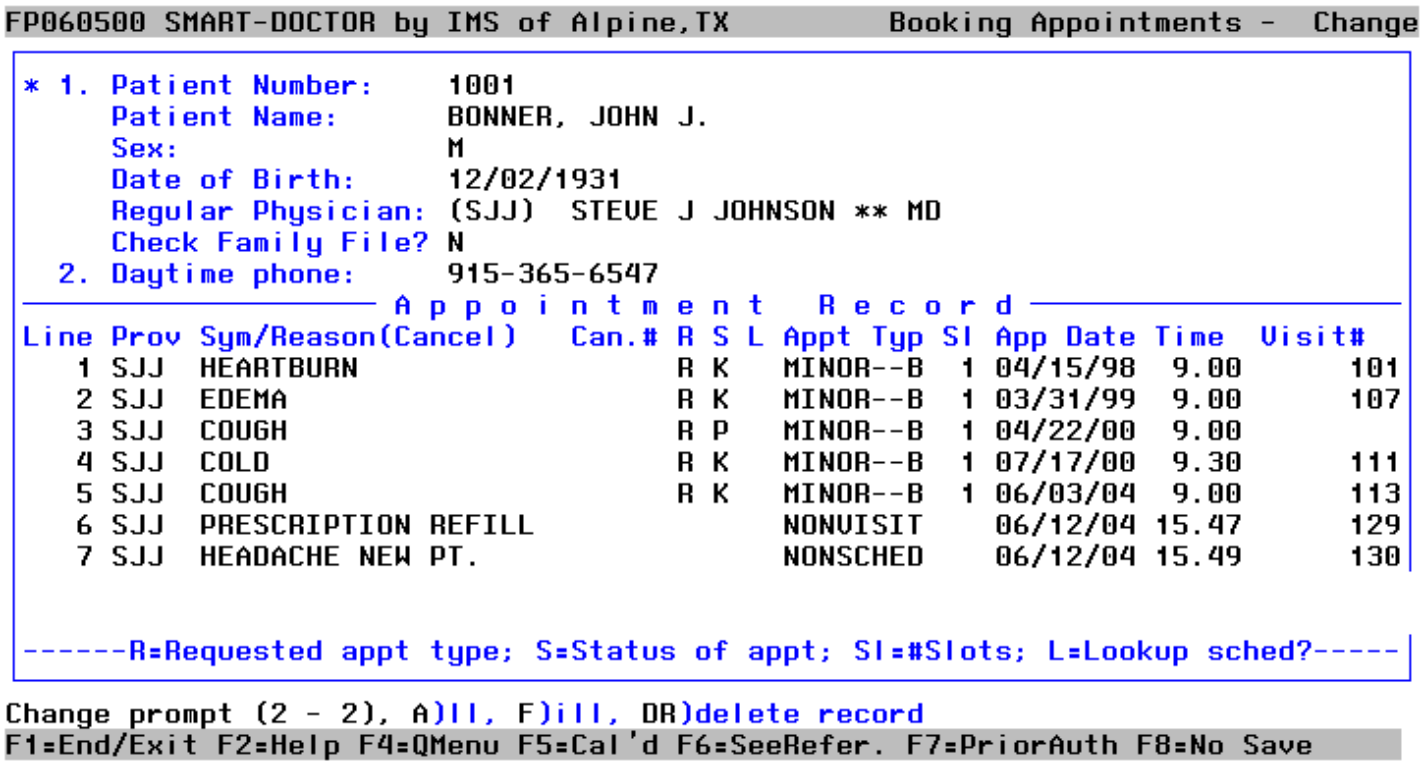


Figure 59 *List of Appointments Made.*

```
                          _SECURITY SCREEN_

LINE User            Terminal    Date      Time      Mode
   1 sjj             ty08        04/15/98  19:39      A
   2 appgen4         ty08        03/31/99  19:35      A
   3 root            typ2        04/22/00  09:39      A
   4 sjj             typ2        07/17/00  15:36      A
   5 sjj             typ3        06/03/04  11:53      A
   6 SJJ             typ1        06/12/04  15:47      A
   7 sjj             typ1        06/12/04  15:49      A
```

Figure 60 *Security Screen for Appointments.*

```
SY310100 SMART-DOCTOR by IMS of Alpine,TX     Carrier Maintenance File -  Change
* 1. Enter Insurance Carrier ID #:  84980
      (To add, enter ID#.  To change or inquire, enter # or partial name.)

  2. Carrier Name:  BLUE CROSS AND BLUE SHIELD OF TEXAS, INC.
  3. Unique ID:
  4. Address-1:     BOX 660044
  5. Address-2:

  6. ZIP Code:      79830         City:  ALPINE                 State:  TX

  7. Phone #:       800-451-0287
  8. Bill Elect.:   Y
  9. Receiver:      84980
 10. Formulary:     ALL
 11. Payer Type:    G
 12. Lab:           LABCORP              13. Opt. LabCorp Code: ORGH
 Line Notes on carrier:
    1 for claims corrections mail to bcbs box 655488 dallas tx 75265-5488
    2 nashville bcbs 18006762583
    3 healthselect claims or benefits 1800 252 8039
    4 bluecard cust serv  888 922 2391
Change prompt (2 - 13), A)ll, F)ill, DR)delete record
F1=End F2=Help F4=QMenu F5=Cal F6=Billing #'s F7=PriorAuth F8=No-Save F9=CoPay
```

Figure 61 *Insurance Carrier screen.*

updated frequently. You can also call your THIN representative to ask about a carrier's number or request that a carrier be added. If you add a carrier number that is not on the list, then please place a <+> sign in front of the alphanumeric value you add. This will prevent any confusion with existing carriers or numbers to be added by THIN.

If adding a new carrier to the file, enter the carriers national number (as discussed above) and press <enter>. If this number is not listed in the cross-reference file, you should press <enter> again to continue on.

Prompt #2, "**Carrier Name:**", Enter the name of the carrier. For example; TRAVELERS,

BLUE CROSS, or BLUE CROSS/BLUE SHEILD OF TEXAS, etc.

Prompt #3, "**Unique ID:**", add a unique ID term here to help you look up this specific carrier's information in the future. This is extremely useful when there is more than one type of policy offered by a specific carrier. An example of this are carriers that offer cafeteria plans. The carrier's primary national ID number is the same, but the coverage can vary significantly in regard to: Percent Paid by Patient, Deductible for Year, Basic Co-Pay per Visit, Maximum Pay per Visit, CPTs Excluded from Discount, and Other Payment restrictions. To distinguish between these different version of policies by the same company, simply add another record to the carrier file with the same carrier id number, but with an additional single character appended. Now, by typing in the unique ID, you will be able to locate the specific type of policy that company offers quickly.

Prompt #4, "**Address-1:**", enter the first line of the carrier's address.

Prompt #5, "**Address-2:**", enter the second line of the carrier's address if needed. If the second line not needed, leave it blank.

Prompt #6, "**ZIP Code:"**, enter ZIP code. If not known, just press enter for a selection list. The city and state will be filled in automatically from data entered in the zip code file previously.

Prompt #7, "**Phone #:**", enter the phone number with or without dashes, and with or without area code.

Prompt #8, "**Bill Elect.:**", indicate <y> if this insurance is to be billed electronically. You will then be asked to select the proper Receiver Type, as seen in Figure 62.

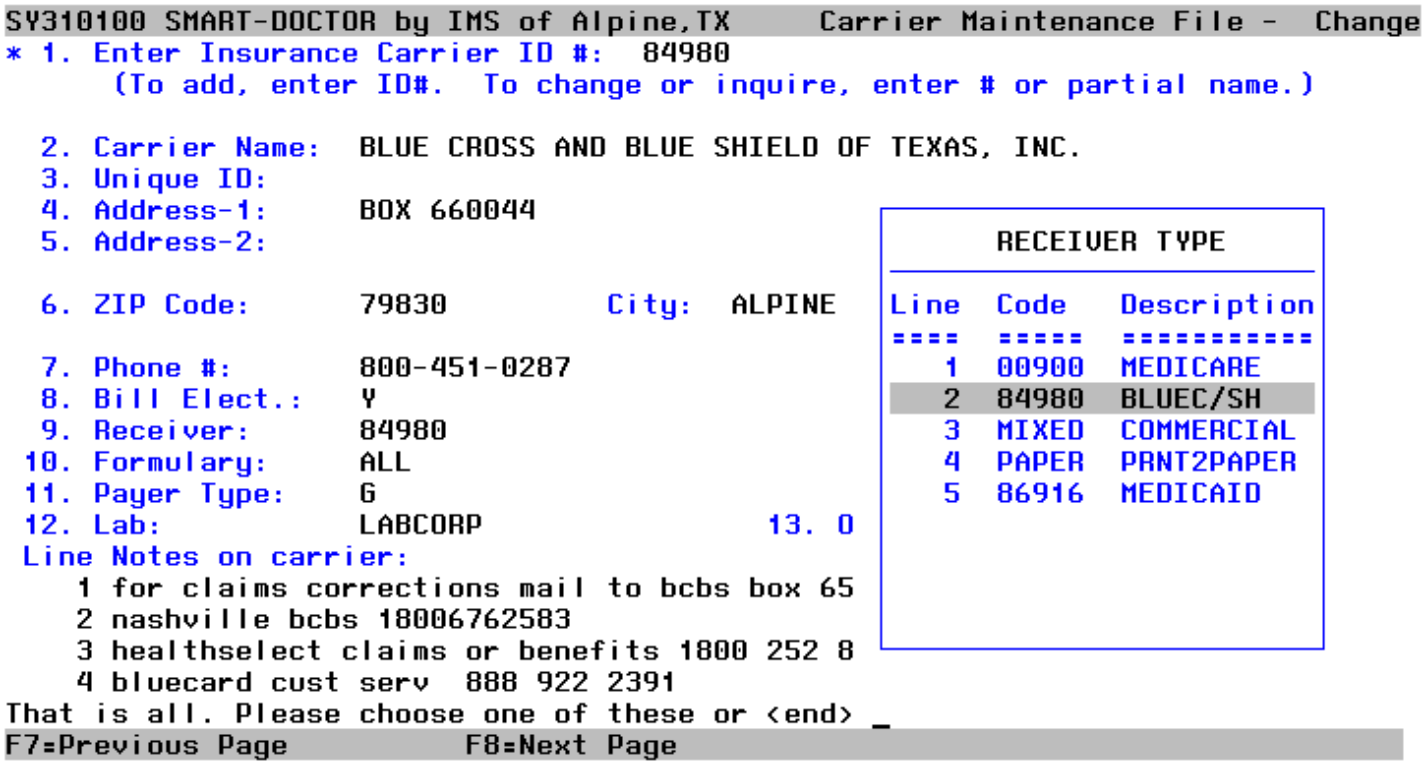


Figure 62 *Specifying Receiver Type.*

Or, indicate <n> if this is to be billed with the HCFA-1500 paper claim form.

Prompt #10, "**Formulary:**", Select one formulary term from the pop-up, or enter a space to delete the term. See Figure 63.

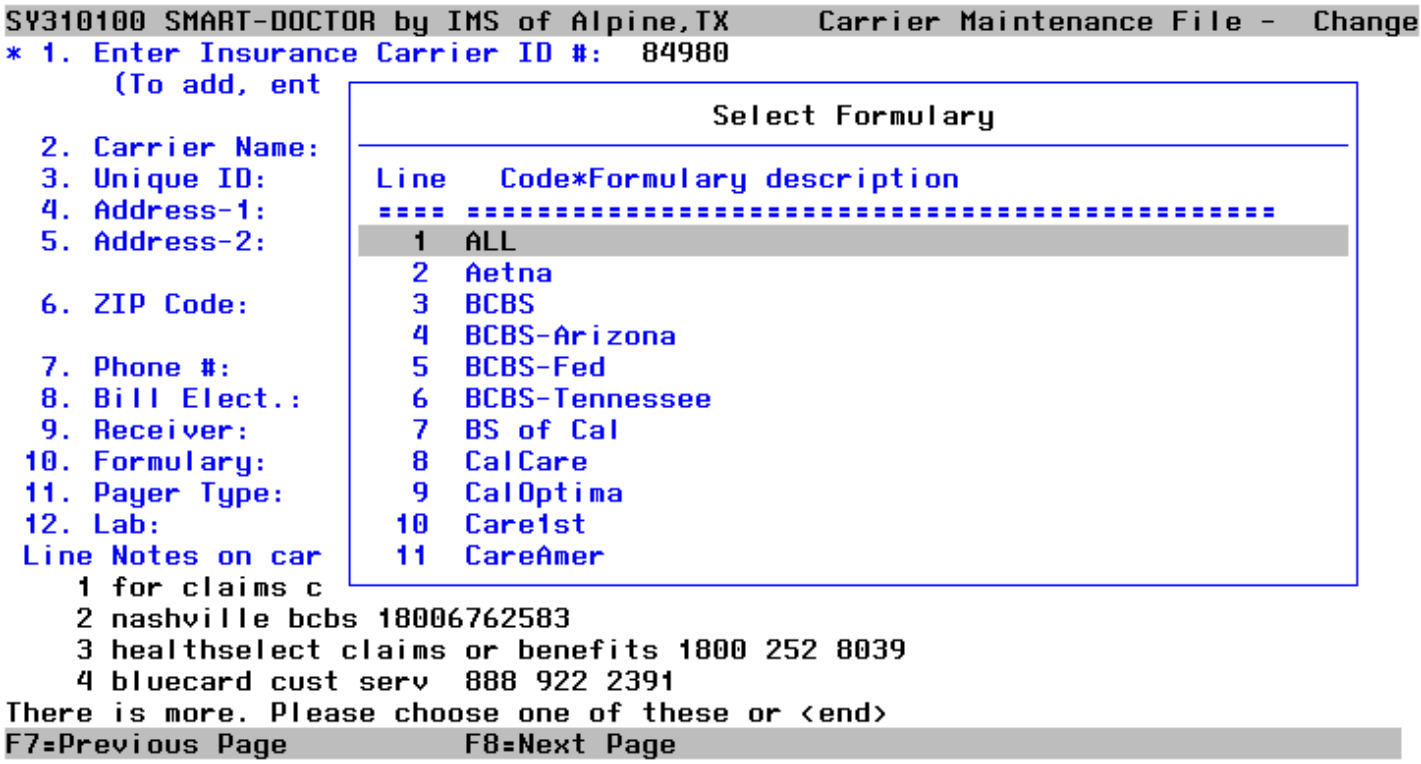


Figure 63 *Select Formulary Carrier Requires.*

Prompt #11, "**Payer Type:**", is an automatic pop-up screen from which you must select a payer type. The payer types have been specifically set up for your system/location, as seen in Figure 64.

The Payer Type selected should be the type recognized by the claim receiver for billing to the selected Insurance Carrier Number (prompt 1). Clinics should try to input the correct Payer Type for every Insurance Carrier to ensure proper electronic billing. If the Insurance carrier selected for an insurance document already has a Payer Type set, the Insurance Document will accept this type and not give the user the option to change it.

Prompt #12, "**Lab:**", will give you an automatic pop-up screen, as seen in Figure 65, from which you can select a lab used by the carrier if the carrier requires you to use a specific lab. If no lab is required by the carrier, then hit the <F1> key to leave this field blank.

Prompt # 13, "**Opt. LabCorp Code:**", if "LABCORP" is selected in the preceding prompt, then a specific pop-up screen will be seen based on the name of this carrier as seen in Figure 66. In this case all the LabCorp carriers with the first three characters of the insurance carrier name "blu" will be presented.

For non- "LABCORP" labs, this field can be left blank or filled in as needed.

"**LINE NOTES ON CARRIER PROMPT**", enter any carrier specific notes you need here.

F-KEY SCREENS

BILLING #'S <F6> SCREEN

Specific billing information for this carrier should be entered on the Carrier Specific Billing Information screen as needed, as seen in Figure 67.

```
SY310100 SMART-DOCTOR by IMS of Alpine,TX     Carrier Maintenance File -  Change
* 1. Enter Insurance Carrier ID #:  84980
      (To add, enter ID#.                                    r partial name.)

                          Payer Types
  2. Carrier Name:  BLUE C  ------------------------------   NC.
  3. Unique ID:              Line  Type  Carrier
  4. Address-1:     BOX 66   -----  ----  --------
  5. Address-2:               1     C     MEDICARE
                              2     G     BLUEC/SH
  6. ZIP Code:      79830     3     D     MEDICAID              State:  TX
                              4     F     OTHER
  7. Phone #:       800-45    5     A     Self Pay
  8. Bill Elect.:   Y
  9. Receiver:      84980
 10. Formulary:     ALL
 11. Payer Type:    G
 12. Lab:           LABCOR                                   p Code: ORGH
 Line Notes on carrier:
    1 for claims correctio                                  s tx 75265-5488
    2 nashville bcbs 18006
    3 healthselect claims
    4 bluecard cust serv  888 922 2391
That is all. Please choose one of these or <end>
F7=Previous Page          F8=Next Page
```

Figure 64 *Select Payer Type.*

```
SY310100 SMART-DOCTOR by IMS of Alpine,TX     Carrier Maintenance File -  Change
* 1. Enter Insurance Carrier ID #:  84980
      (To add, enter ID#.                                    r partial name.)

                       Lab Used by Carrier
  2. Carrier Name:  BLUE C  ------------------------------   NC.
  3. Unique ID:              Line   Lab
  4. Address-1:     BOX 66   -----  --------
  5. Address-2:               1     LABCORP
                              2     SKB
  6. ZIP Code:      79830     3     QUEST                 State:  TX
                              4     DAMON
  7. Phone #:       800-45
  8. Bill Elect.:   Y
  9. Receiver:      84980
 10. Formulary:     ALL
 11. Payer Type:    G
 12. Lab:                                                   p Code:
 Line Notes on carrier:
    1 for claims correctio                                  s tx 75265-5488
    2 nashville bcbs 18006
    3 healthselect claims
    4 bluecard cust serv  888 922 2391
That is all. Please choose one of these or <end> _
F7=Previous Page          F8=Next Page
```

Figure 65 *Selecting Lab Required by Carrier.*

```
SY310100 SMART-DOCTOR by IMS of Alpine,TX     Carrier Maintenance File -  Change
* 1. Enter Insurance Carrier ID #:  84980
      (To add, enter ID#.  To change or inquire, enter # or partial name.)

  2. Carrier Name:  BLUE CROSS AND BLUE SHIELD OF TEXAS, INC.
  3
  4    1  BBCG      BC/BS BLUE CHOICE GOLD
  5    2  ORGH      BC/BS HMO BLUE OF W TX
       3  BST       BC/BS OF TEXAS - BLUE CHOICE
  6    4  OBHNE     BLUE CROSS HMO OF N.E. TX                          TX
       5  TBL       BLUE LINC **TULSA**
  7    6  DHMO      HMO BLUE MEDICAID
  8    7  CNCH      HMO BLUE TEXAS-COMMERCIAL
  9    8  ONCH      HMO BLUE TEXAS-COMMERCIAL
 10    9  DRGH      MEDICAID HMO BLUE/STAR
 11   10  MSB       SENIOR BLUE HMO
 12
 Li                                                                  88

    4 bluecard cust serv  888 922 2391
That is all. Please choose one of these or <end> _
F7=Previous Page          F8=Next Page
```

Figure 66 *LabCorp Carrier Code screen.*

```
SY310100 SMART-DOCTOR by IMS of Alpine,TX     Carrier Maintenance File -  Change
*
                  _Carrier Specific Billing Information_

  1. Provider Signature on File Y/N:

                          EDI Information
  2. Clearinghouse:              THIN
  3. EDI Other Data Field #2:
  4. EDI Other Data Field #3:
    (Prompts 2, 3, and 4, can only be modified by the EDI administrator.)

                     HCFA 1500--Field Print Options
 Use the following fields to override the standard paper print defaults.
  Pick the provider number type code presented below for each field to
  replace the standard default.
  5. HCFA-1500 Field 23:                  10. HCFA-1500 Box 24C :
  6. HCFA-1500 Field 24K:                 11. HCFA-1500 Field 32:
  7. HCFA-1500 Field 31:                  12. HCFA-1500 Fld 24A :
  8. HCFA-1500 PIN# F'ld 33a:
  9. HCFA-1500 GRP# F'ld 33b

Change prompt (1 - 12), A)ll, F)ill
F1=End F2=Help F4=QMenu F5=Cal F6=Billing #'s F7=PriorAuth F8=No-Save F9=CoPay
```

Figure 67 *Carrier Specific Billing Information.*

Prompt #1, “**Provider Signature on File Y/N:**”, is the provider signature on file for this specific

carrier? You must answer (Y)es or (N)o.

Prompts 2, 3, and 4, can only be modified by the EDI administrator.

Prompts #5-12, are to be used to override the standard paper print defaults required by this specific carrier. In the pop-up boxes described below, just hit <F1> if you do not wish any of the choices presented and the field will be left blank. The data normally output in that field on the HCFA-1500 form will not be changed.

Prompt #5, "**HCFA-1500 Field 23:**", the pop-up for field #23 can be replaced with one of the provider numbers, as seen in Figure 68. Provider number types are found in the "ADM-PROV-NUM" record in the TERMS file. This record can only be modified by IMS personnel to prevent billing errors.

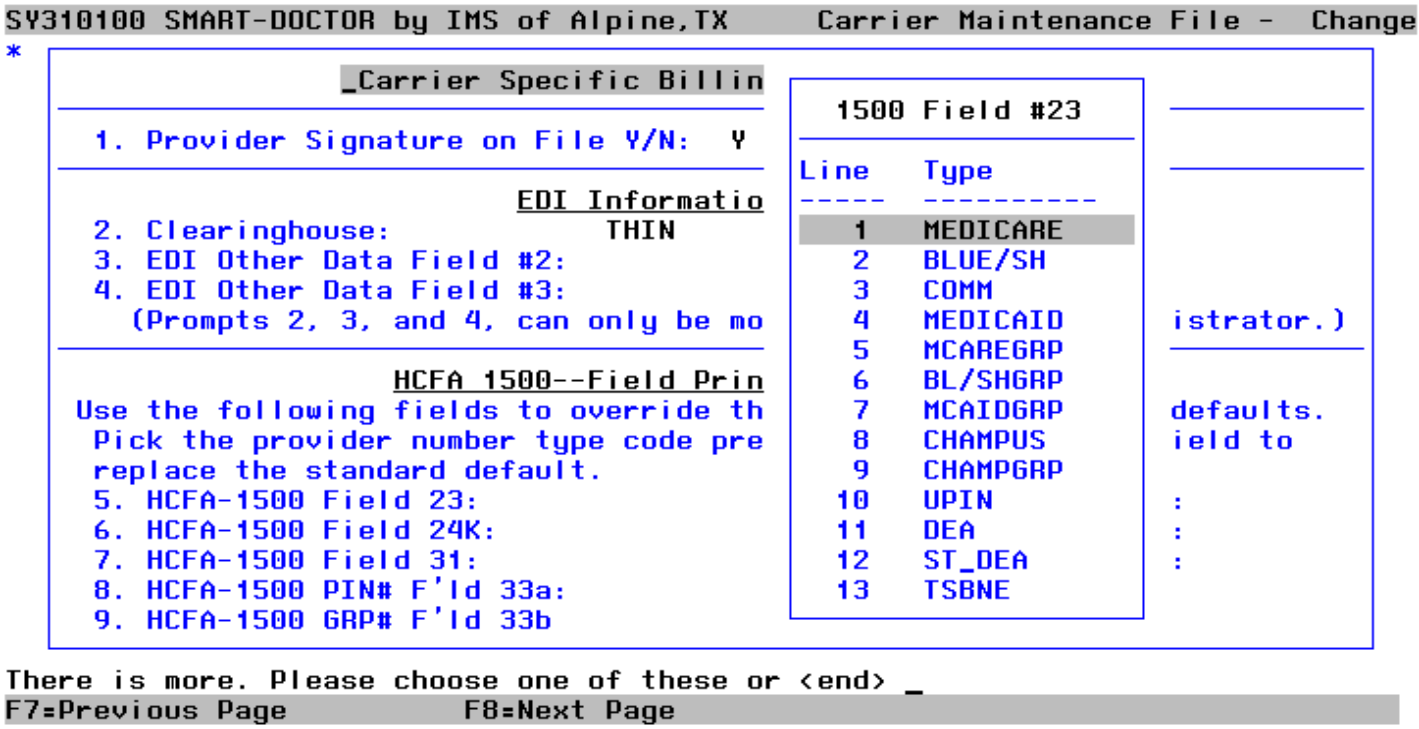


Figure 68 *Provider Numbers Selection screen.*

If you make this change, be sure the the corresponding provider number type is listed in each provider's file for whom you will be billing to this carrier.

Prompt #6, "**HCFA-1500 Field 24K:**", is similar to prompt #5, with the exception that this information will be placed on each line of 24K.

Prompt #7, "**HCFA-1500 Field 31:**", is similar to prompt #5, with the exception that this information will be placed in box 31.

Prompt #8, "**HCFA-1500 PIN# F'ld 33a:**", is similar to prompt #5, with the exception that this information will be placed in box 33a.

Prompt #9, "**HCFA-1500 GRP# F'ld 33b**", is similar to prompt #5, with the exception that this information will be placed in box 33b.

Prompt #10, "**HCFA-1500 Box 24C :**", if you would like the Type of Service (box 24C) to be filled on the HCFA form when printing claims for this carrier, enter a "Y". Otherwise, leave blank or set to "N".

Prompt #11, "**HCFA-1500 Field 32:**", enter a "Y", to put the facility address in Field 32 of the HCFA-1500. Leave blank or set to "N" to put "SAME" in the facility address.

Prompt #12, "**HCFA-1500 Fld 24A :**", set as 'Y' to populate the "To" date fields in Box 24A.

PRIORAUTH SCREEN <F7> KEY

To enter prior authorizations required by this carrier, hit the <F6> key. The screen seen in Figure 69 will be used to enter this information.

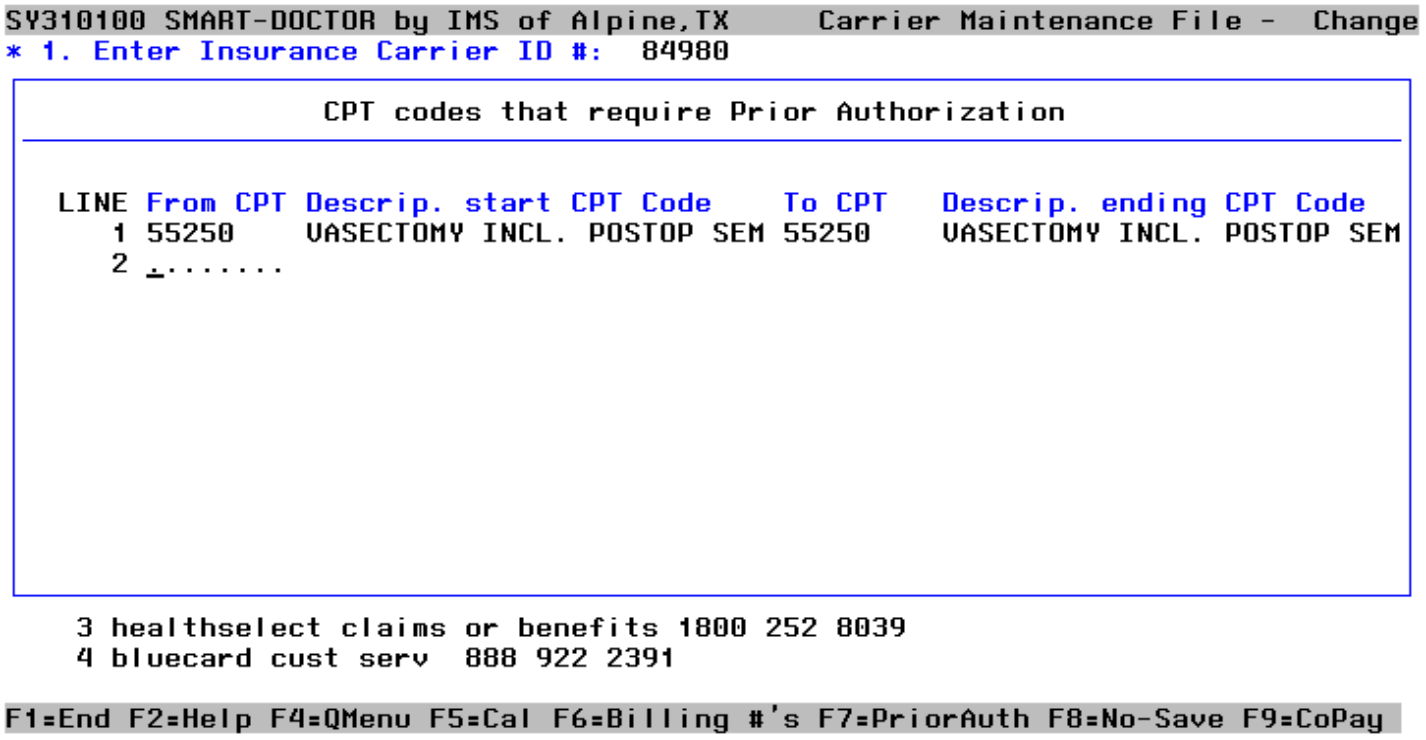


Figure 69 Entering Carrier Required Prior Authorizations.

In this example, "vase" was entered in field #1 of the multi-value which has the system check the cross-reference file for a procedure type. Number 55250 was selected. The system then defaulted the same number in the "To CPT" field. Hitting <enter> had the system take this as the ending value also. A range of CPTs could also be specified. For example, if you wanted, you could also list a range of surgeries, a range of lab tests, or any other procedures.

On billing, the system will check to see if the specified insurance carrier requires prior authorization for the procedure being billed. If it does, the system will then check the individual's patient file for approved prior authorization for this procedure. If it exists, then it will check for dates allowed and number allowed. If all checks are valid, then the system will use this prior authorization number in billing and debit the patient file for one procedure of this type. If no valid prior authorization exists, then the bill will be suspended and placed in the file of bills requiring prior authorization before billing. This will be discussed further in the billing screens.

CO-PAY SCREEN <F9> SCREEN

To enter information on payments required by the patient for this carrier, hit the <F9>key to get to the screen in Figure 70.

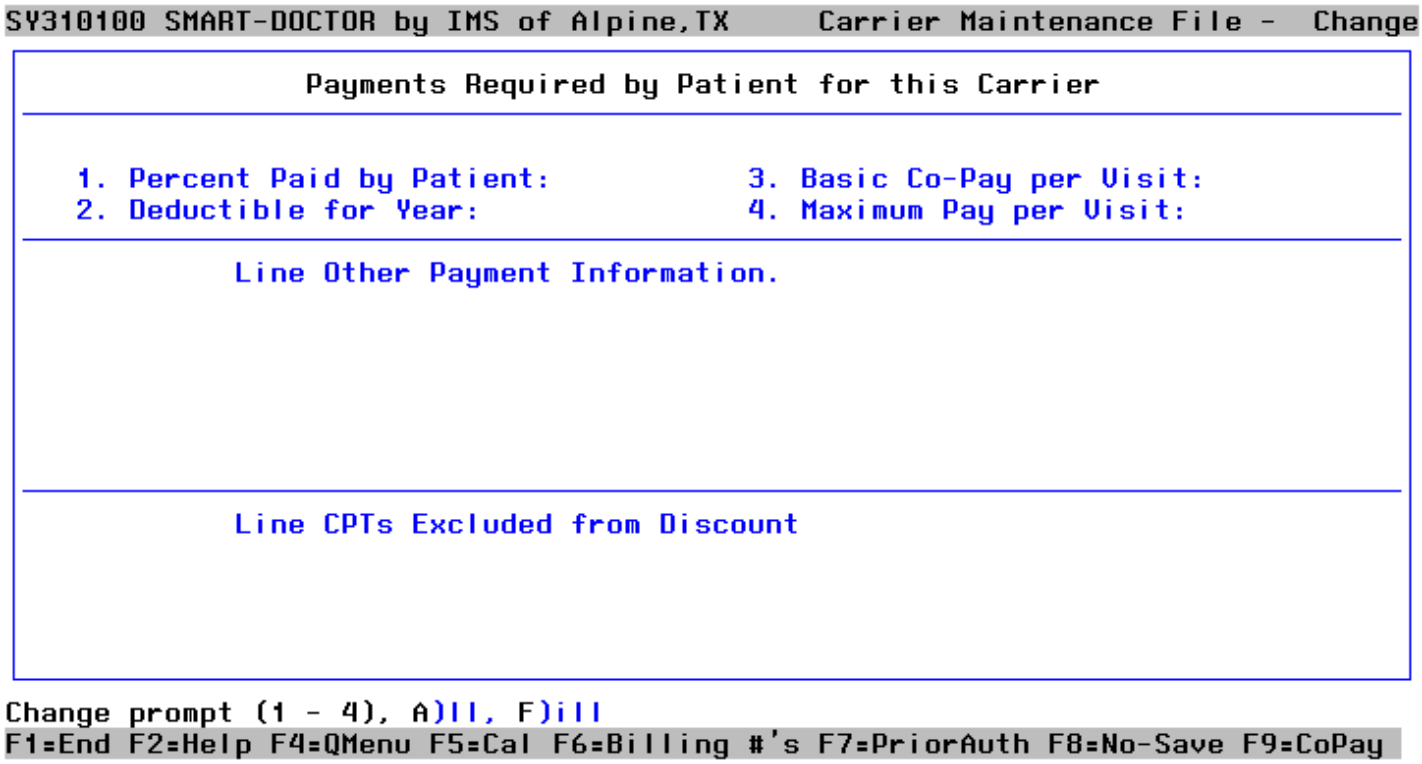


Figure 70 *Payment Required by Carrier.*

Prompt #1, "**Percent Paid by Patient:**", enter the percent to be paid by the patient, or patient's responsible party. Twenty percent should be entered as 20. The percent should be a whole number from 0 to 100.

Prompt #2, "**Deductible for Year:**", enter the deductible amount the patient must pay each year before the insurance carrier must start to pay. For example: Medicare is $100.00. Some patients may have very high deductibles, $10,000 or more.

Prompt #3, "**Basic Co-Pay per Visit:**", this is where you should enter required payment at the time of the visit. This is generally the amount the insurer asks each patient to make at each visit, before or at the time of the visit, the purpose being to discourage overuse. Typically this is $5.00, $10.00, $25.00, etc.

Prompt #4, "**Maximum Pay per Visit:**", some insurers, for some types of practices, have a maximum amount that they will pay for any given visit or procedure. Therefore regardless of the percent paid by the carrier, the amount the carrier pays is limited to this maximum amount. The balance is due from the patient.

Line Prompt--"**Other Payment Information.**", enter other information that is unique to this carrier. This information should only be that which will be of assistance to the sign-in clerk and the biller.

Line Prompt--"**CPT codes Excluded from Discount**", enter the specific CPT and/or other procedure codes that will not be paid for by the carrier. These are generally cash items, such as

equipment, crutches, and non-covered procedures. Enter the actual CPT code or other KEY from the procedure file, one per line, left adjusted. For example,

Line	CPTs Excluded from Discount
1	55250
2	55400

PRINT INSURANCE CARRIERS

Select #22, "**Insurance Carrier File**" from the Main Menu. Then select menu item #2, "**Print File**", to print up the list of insurance carriers' names and ID numbers on file. Choose one of the printing options, or enter the default if you want it printed to the screen.

SNF (SKILLED NURSING FACILITY) RESIDENT BILLING

You can ensuring proper Medicare billing for SNF residents in two steps:

1.) Sites must have a clinic record, in the "Clinic File" (Prompt 23 off the main menu), for each SNF where the the doctor may see a patient. In that clinic record, the SNF's Medicare Site Provider Number must be entered in Prompt 7 on the <F6> "Bill#" screen, as seen in Figure 71.

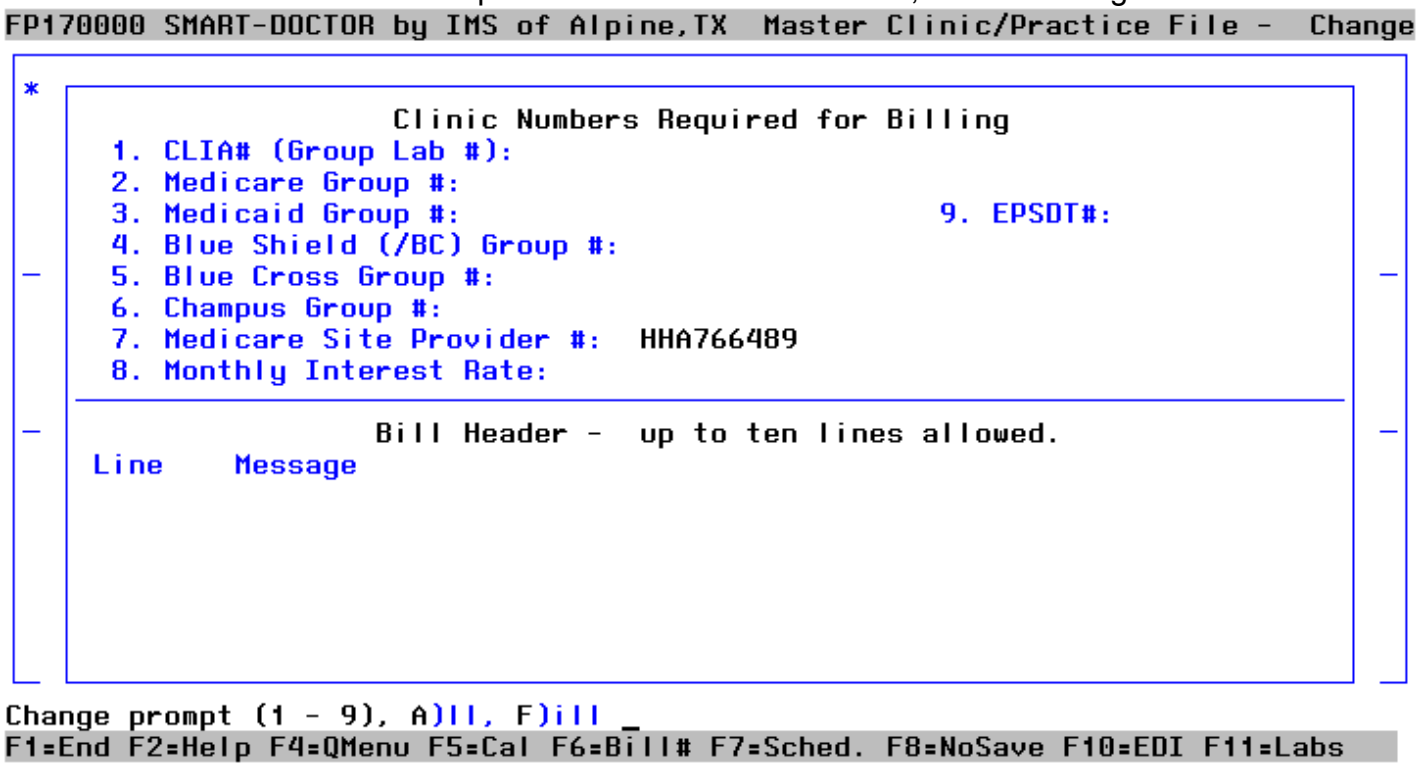


Figure 71 Entering the Medicare Facility Number.

2.) For all SNF resident patients, the patient file must indicate "N.H. Skilled" in prompt 14, "**Type of Residence**". Upon selecting this item, a list of clinics will pop up. Select the SNF that the patient resides.

With both steps completed, HCFA forms will put the SNF number in the appropriate box, 23 or 32.

MEDICAL LIBRARY

This file is a collection of medical information that the physician needs to have available for instant referral. It may include data from guidelines, medical journals, conferences, or merely past experience. Your provider may specify the types of information needed to store here, such as drugs, diseases, x-ray, lab, finance, or any other subjects of interest. As part of the support services from IMS, many commonly used guidelines, reference information, and ACLS protocols are kept up to date for your doctors automatically.

To enter or change information, access the “Medical Library“ from the main front office screen or the doctor main menu screens. To just reference the medical library, access this file from the front office or provider QuickMenu, the <F4> key. From the front office menu, you would select menu item #28 “**Medical Library, Add/Change/Del**”. From the doctor main menu, you would select menu item #14, “**Medical Library**”. In both cases, you would be placed in these screens for adding, changing, or looking up information. As in the “Phone Book”, these add and change screens should only be used for that purpose (adding and changing information), and not for routine inquiries. For routine inquiries, use the QuickMenu, <F4> key, since you cannot change or delete information accidentally from this “Inquire Only” screen. Figure 72 shows the medical library screen in the add mode:

```
FP270000 SMART-DOCTOR by IMS of Alpine,TX              Medical Library -     Add
* 1. Record # or Xref lookup: 102          2. Date entered/changed: ........
  4. Type of Information: ........

  5. Title: ........................................
  6. Keys:  ..........................................................

 Line Document text:




This record is not on file "FP-MED_LIBRARY". Create a new one?
F1=End/Exit   F2=Help   F5=Calendar   F8=Exit/No Save   F9=List
```

Figure 72 *Medical Library Add screen.*

Prompt #1,”**Record # or Xref lookup:**”, hit the <enter> key to accept the system number for a new document number, or enter a partial description of the type of document you are looking for. For example, for fungal nail infection <nai> or <inf na> or <nai fu> may be entered. For all drugs, enter <drug>, etc. If this is a new record key, enter <y> at the “**Create a new one?**”, at the bottom of the screen.

Prompt #2, “**Date entered/changed:**”, enter the date of adding or changing the record, or hit

<enter> to accept the default of “TODAY”.

Prompt #4, “**Type of Information:**”, hit <enter> at the defaulted “?”, to bring up a help screen with the following possible choices:

drug	- Drugs
disease	- Diseases
x-ray	- Radiology
lab	- Laboratory
finance	- Financial
other	- Other

Prompt #5, “**Title:**”, enter the title or subject of the article.

Prompt #6, “**Keys:**”. The title you entered above in prompt #5 will automatically be filled in here. All titles should be condensed, if possible, by omitting any words not pertinent to a cross-reference, such as "and", "or", "of", “the", etc. You may list other descriptive key words if the title is brief or not easily associated. You are permitted nine words for cross-reference at the “**Keys**” prompt (separated by spaces only--no commas). Any of the words you record in the “**Keys**” prompt will bring up the article the next time you want to retrieve it.

Next is the multi-value prompt “Document text:”, enter the article information, or other information here. You may type lines or paragraphs in the Lines section, but you will have to hit <enter> on each line you type before you can begin a new line (unlike your word processor). If you type a complete sentence on a line, press <enter> after the period. If you have to continue a sentence onto the next line, you will press <enter> after the cursor moves to the left margin of the next line. Each line will be numbered automatically for easy reference.

You can cut and paste entire documents in this prompt. To have this work properly, the margins of the document you will cut and paste from must be 74 characters or less per line. If the text you are trying to cut and paste is wider than this, you will only get the first 74 characters and everything after that will be lost. Figure 73 is an example of cutting and pasting from an article on treating head lice.

To quickly lookup information, the provider, from the “Doctor Main Menu”, can hit the <F4> key and select “**Medical Library**”. The screen presented will look just like the first add mode screen above with the exception of indicating “Inquire” on the right header bar. No changes or additions can be made on this screen. You can type in a partial description of the information you want to find (as described above in this section), or hit the <F9> key to get a list of documents available as seen in Figure 74.

Please note, that the sort starts with upper case letters first. To avoid mixed sorts (ABC.. followed by abc..), always title your additions in upper case letters. See “A WORD ON SELECTION RANGES” for more information on sorting.

PRINT APPOINTMENT BOOK

The main front office screen, menu item #13, “**Print Appointment Book**”, will print the appointment book for the range of dates you choose. The selection screen is as seen in Figure 75:

Prompt #1, “**From:**”, enter the starting date of the appointment book pages you want to print.

```
FP270000 SMART-DOCTOR by IMS of Alpine,TX              Medical Library -  Change
* 1. Record # or Xref lookup: hea li        2. Date entered/changed: 06/16/04
  4. Type of Information: OTHER

  5. Title: Pediculosis and scabies
  6. Keys:  PEDICULOSIS AND SCABIES HEAD LICE

 LINE Document text:
    1 Topical Agents. In the United States, several topical agents
    2 are available for the treatment of head lice infestation.
    3 All over-the-counter agents approved by the U.S. Food and
    4 Drug Administration (FDA) belong to the pyrethrum group of
    5 insecticides (pyrethroids). Both 4 percent piperonyl
    6 butoxide0.33 percent pyrethrins (e.g., Rid, Pronto) and 1
    7 percent permethrin (Nix) are safe and effective. Experts
    8 consider permethrin the treatment of choice.
    9 The pyrethrum insecticides are pregnancy category B drugs.
   10 Their safety in breastfeeding is unknown.
   11 prescription.6 It is highly effective in the treatment of
   12 resistant head lice infestation in the United States.
   13 Because of its odor, flammability, and potential for causing
   14 respiratory depression if ingested, malathion is considered
Document text - Enter the line number to change or 'A' for 'ALL'
F1=End/Exit   F2=Help   F5=Calendar   F8=Exit/No Save   F9=List
```

Figure 73 *Pasting into the Medical Library.*

```
                    Med. Library Titles

Line Select one of the following Titles
==== ================================================
   1  ACLS
   2  Asthma
   3  Calculate Creatinine Clearance
   4  Childhood Immuniation Schedule
   5  Classification of NSAIDS
   6  GOLD COPD Stages and Treatment
   7  High Blood Pressure Guidelines
   8  Hypercholesterolemia
   9  International Prostate Symptom Score
  10  Metabolic Syndrome
  11  Migraine Headache
```

Figure 74 *Medical Library List.*

Prompt #2, "**To:**", enter the ending date of the appointment book pages you want to print.

Prompt #3, "**Provider**", enter the provider initials of the appointment book pages you want to print, or accept the default of "**ALL**" to get all providers. The resulting screen output of the report will appear as seen in Figure 76.

Of course, you can also request this report to be sent to the printer or to a file as usual.

```
FP060604 SMART-DOCTOR by IMS of Alpine,TX                Print Appointment Book
```

```
   Print Appointment Book

   1. From:     06/03/04

   2. To:       06/03/04

   3. Provider: SJJ
```

Figure 75 *Print Appointment Book Selection screen.*

```
FP060604                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                              Appointment Book             11:04:28 18 Jun 2004

      Date: 06/03/04        Provider: SJJ

Time  OV Patient Name          Symptom       Appt Typ Home Phone   Day/Work Ph.
----- -- --------------------- ------------- -------- ------------ ------------
900   B  BONNER, JOHN J.       COUGH         MINOR--B 915-337-2876 915-365-6547
915   H  FOSTER, EMMA J        F/U HYPERTENS MINOR--B 915-736-6377
930   O
945   X  COOPER, MARY K.       ABDOMINAL PAI PE-PARTB 913-278-7646 915-234-7484
1000  X    same as above       ABDOMINAL PAI PE-PARTB 913-278-7646 915-234-7484
1015  X  COOPER, JANE T.       SORE THROAT   MINOR--B 913-278-7646 915-234-7484
1030  O
1045  O
1100  O
1115  O
1130  O
1145  O
1159  X  BREAK IN CLINIC
1330  O
1345  O
Press <return> to continue, or <end> _
```

Figure 76 *Printout of Appointment Schedule.*

PRINT PATIENT CHARTS

From the main front office screen, menu item #14, "**Print Patient Charts**", will print the portions of the patient chart that is needed. The selection screen is as seen in Figure 77.

Prompt #1, "**Patient Number:**", enter the patient number, or if unknown, enter at least 3 characters of the patient's name for a cross-reference lookup. Once the patient is selected, at the "Change prompt", enter either <2> to "**Print the Patient's Active Problems, Medications, and Past medical History**", <3> to "**Print a Visit Encounter**", or hit the <F1> key to end and exit.

Prompt #2, "**Print Active Problems, Medications and PMHx?**", enter <y> or <return> if you wish to print the Patient's Medical History, <n> otherwise. If you enter "y" here, then the screen seen in Figure 78 will pop-up, and the Past Medical History will print. The special confidential information screen will not be printed. Only the provider can see this, and this must be on-line. The patient's Medical History will print from the clinics main printer. Now just follow the instruction at the bottom of the screen and hit the <enter> key.

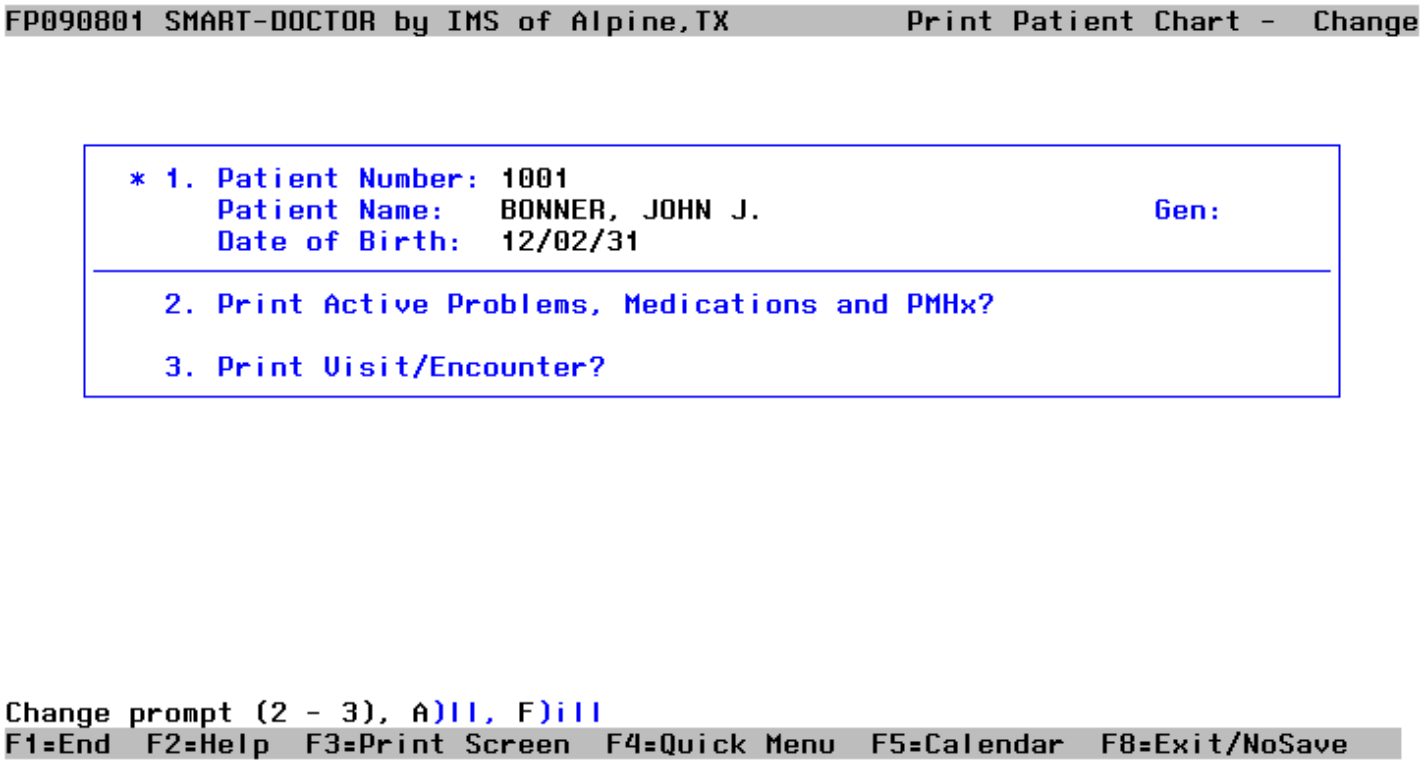


Figure 77 *Print Patient Chart screen.*

Prompt #3, "**Print Visit/Encounter?**", enter <y> or <enter> if you wish to print a visit review. Enter <n> if you do not. The selection screen shown in Figure 79 will then be presented, showing all the patient's visits or encounters in the system:

In Figure 79, we have highlighted the visit we wish to printout. Upon hitting the <enter> key, the screen in Figure 80 is presented as the complete visit note prints from the clinic's main printer.

Then, by hitting the <enter> key, you will be brought back to the main "Print Patient Chart" menu. Here you may make another selection or hit the <F1> to "end" or exit.

PROVIDER PASSWORD FILE

The provider password file is for modification of the provider's "sign out" password. This is similar to the login password in concept, but it is only for "providers" to indicate signature of their note. For primary front office users that are also providers, they can maintain their sign out passwords by use of this menu selection #19, "**Provider Password File**". For providers that log on to the "Doctor Main Menu", this same menu item is reached from the "QuickMenu" <F4> key (item # 12 "**Provider Pwd File**"). The maintenance screen is as seen in Figure 81.

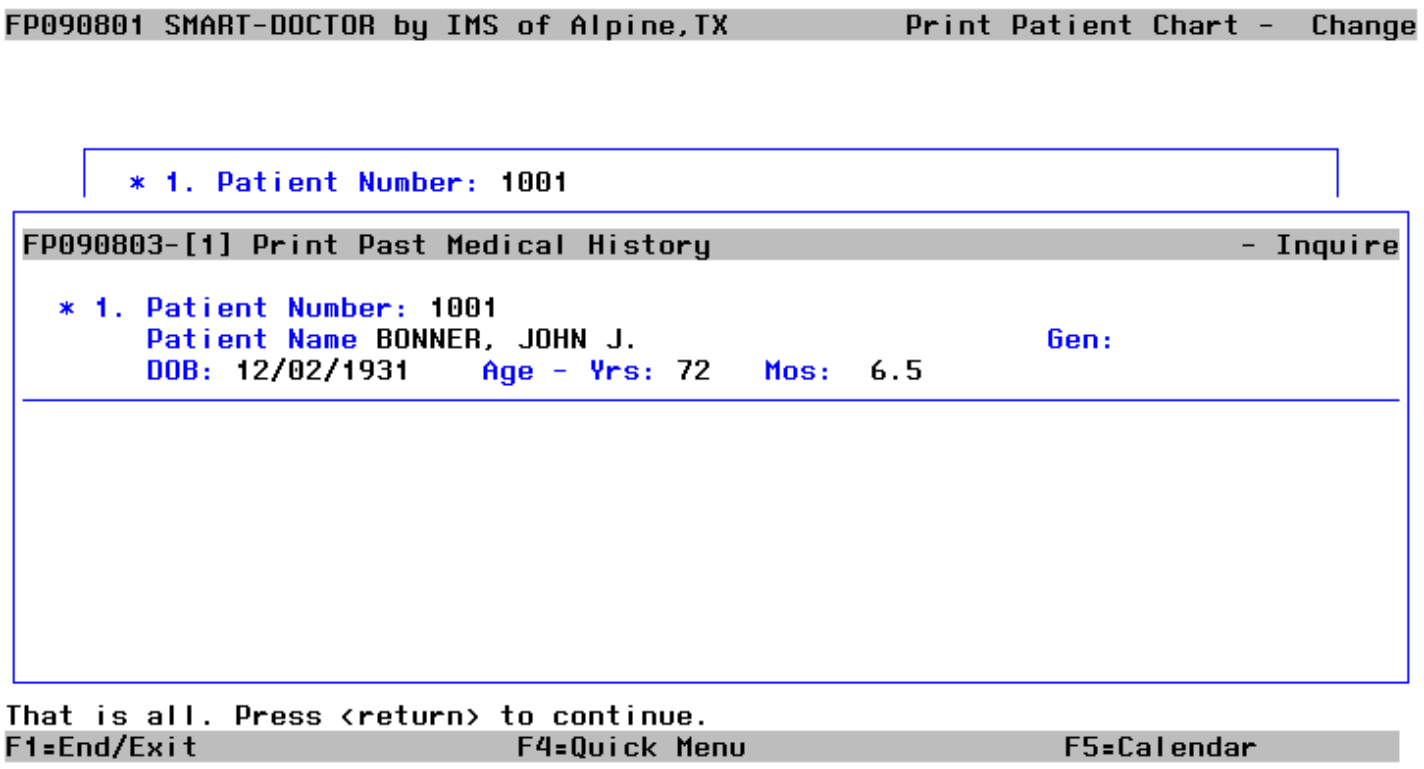


Figure 78 *Printing the Patient's Past Medical History.*

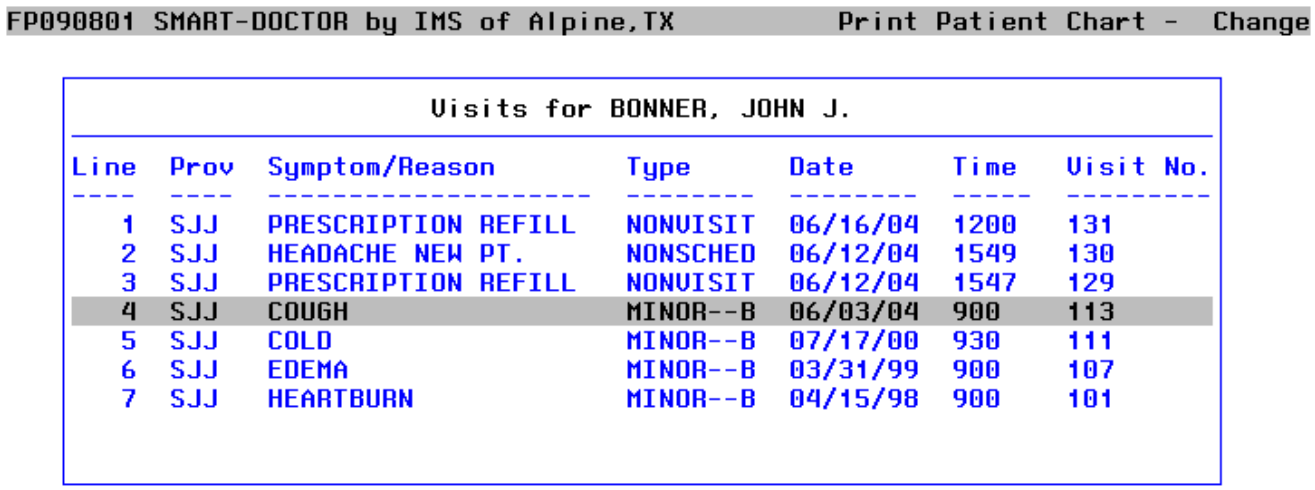


Figure 79 *Selecting Encounter Note to Print.*

Prompt #1, "**Enter new signature password:**", Enter 3 to 10 characters for a new password. This can be any combination of standard keyboard characters. Ex: <HarryX9> or <tennis now> or <joe-sig> or <mary-789*> or <##jones>, etc. The password must be unique. If you get a response that the entry already exists, choose another password for your signature. As you leave Prompt #1 and enter prompt #2, the first prompt will go blank. This is done in the rare case that you may not have noticed someone watching what you are doing, or your being called away before completing the screen.

Prompt #2, "**Enter old signature password:**", enter your old signature password. If this is the first time you are setting your password, enter "password", this first time only.

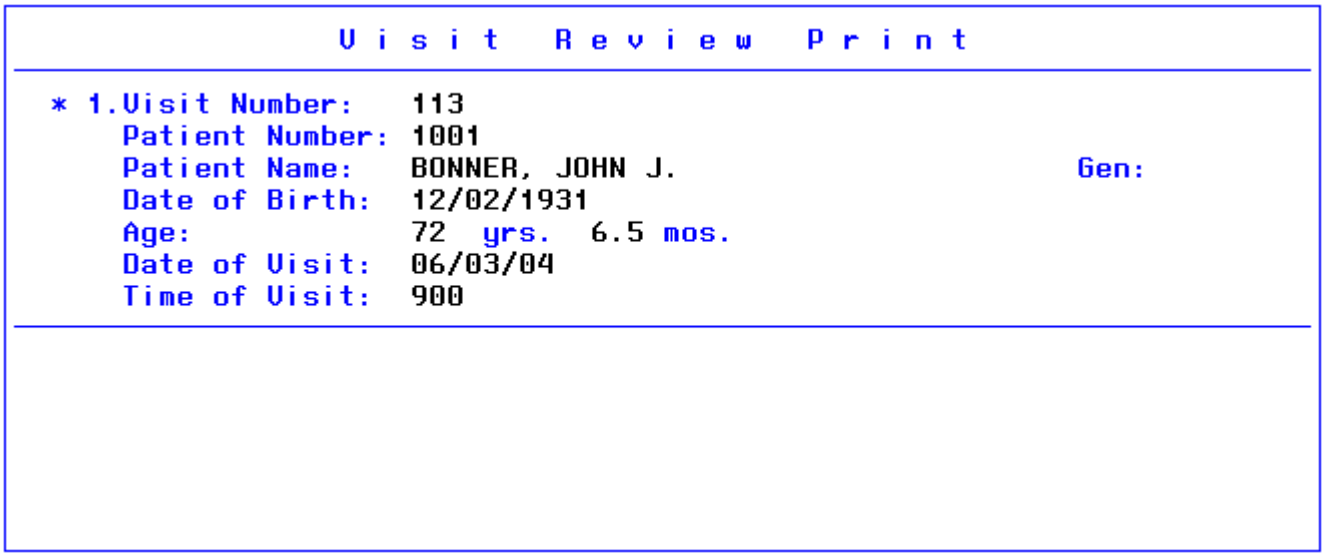


Figure 80 *Printing the Selected Encounter Note.*

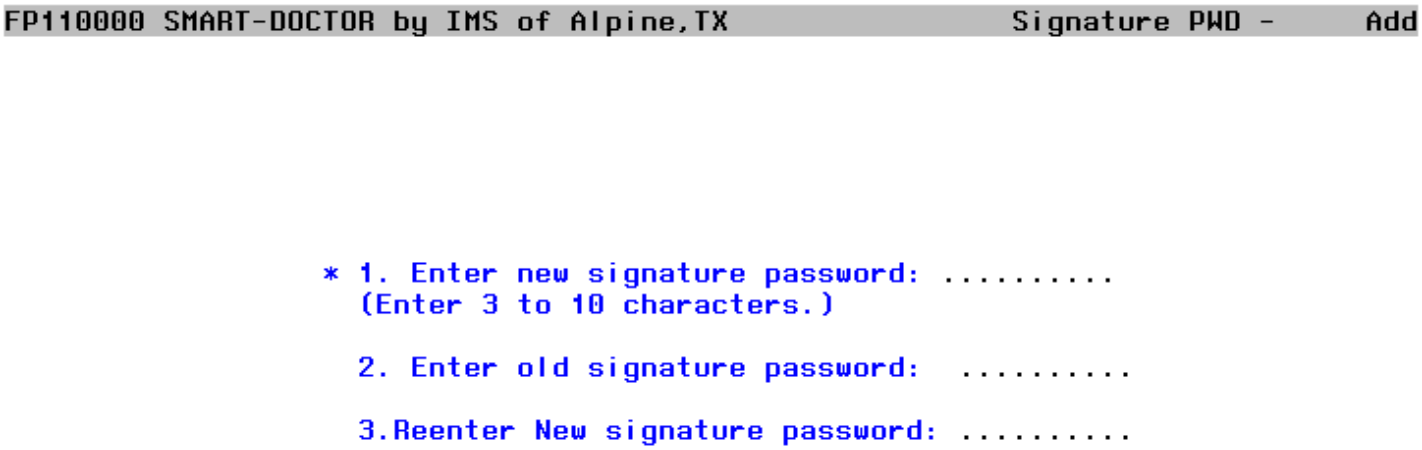


Figure 81 *Sign-Out Password Change screen.*

Before initializing or changing your sign out password, be sure your provider profile is set up as you wish. For example if your name has not been added in that file, your signature will show up something like " , , MD". If correcting a spelling or changing to a married name, do this first in the provider file before you change your signature password. The system pulls the information to use as your signature block from your existing provider file.

Prompt #3, "**Reenter New signature password:**", reenter the new password. If you enter the new password incorrectly, you will be prompted to reenter or quit.

Once complete, the system will prompt you to exit by hitting the "F1" key twice.

REBUILD FAMILY XREF

Menu item #24 off the main office screen, "**Rebuild Family Xref**"; is to rebuild the Family cross-reference file. Only choose this selection when the system will not be used for at least one hour. It takes a long time to rebuild a large Family file. Further, if anyone is using the Family file at this time,

the cross-reference file may be corrupted. On the selection screen, there is only one prompt. At prompt #1, press <enter> to continue or <F1> to end. Then, wait while the cross-reference is rebuilt. Stopping the process part way through will definitely corrupt the cross-reference file. Rebuilding the cross-reference may be desirable periodically if the cross-reference list is significantly out of alphabetical order.

REBUILD PATIENT XREF

Menu item #25 off the main office screen, "**Rebuild Patient Xref**"; is to rebuild the Patient cross-reference file. Only choose this selection when the system will not be used for at least one hour. It takes a long time to rebuild a large Patient file. Further, if anyone is using the Patient file at this time, the cross-reference file may be corrupted. On the selection screen there is only one prompt. At prompt #1, press <enter> to continue or <F1> to end. Then, wait while the cross-reference is rebuilt. Stopping the process part way through, will definitely corrupt the cross-reference file. Rebuilding the cross-reference may be desirable periodically if the cross-reference list is significantly out of alphabetical order.

CHAPTER 2 ACCOUNTING

FAMILY LEDGER

The “Family Ledger” is accessed from the main front office menu at menu item #9. Upon selecting this menu item, you will be presented with the screen shown in Figure 82.

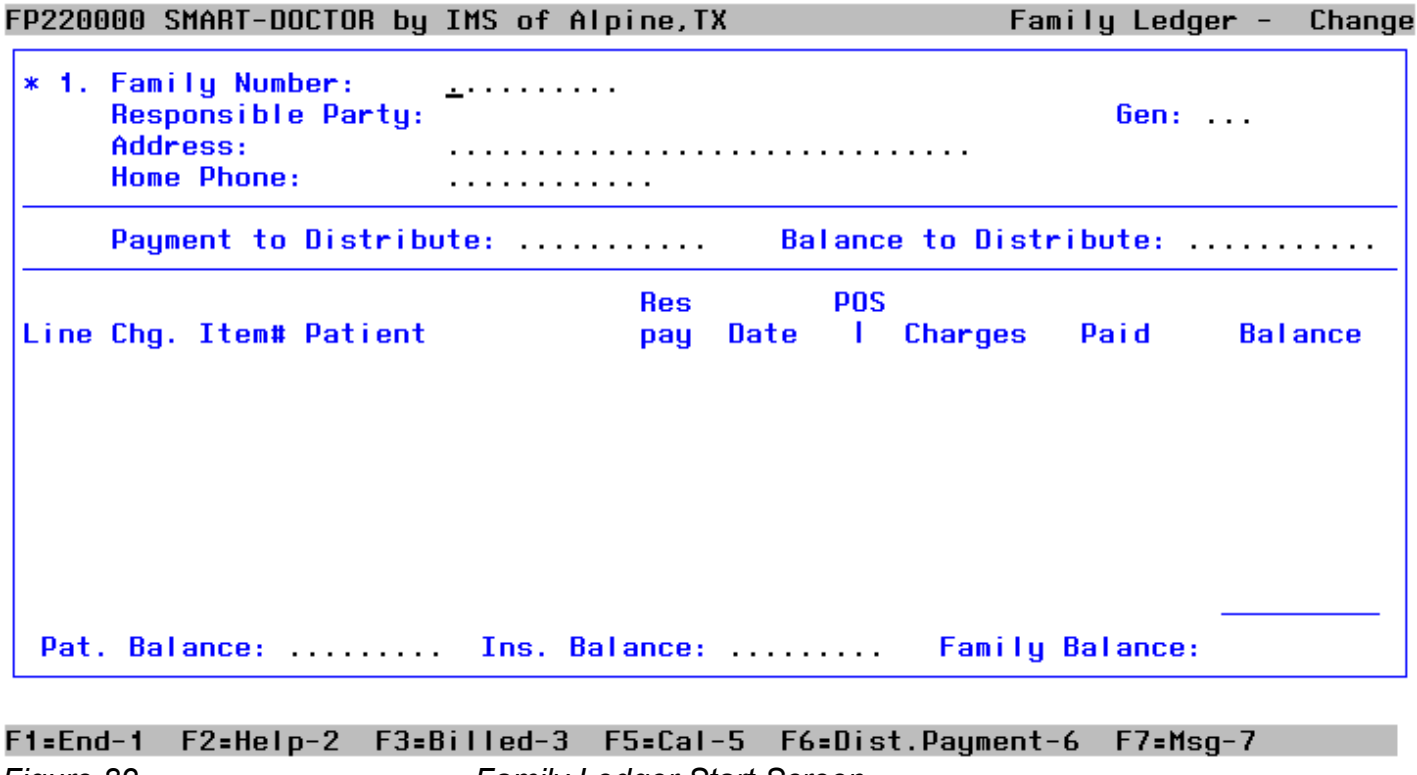


Figure 82 *Family Ledger Start Screen*

Prompt #1, “**Family Number:**”, enter the Family Number if known. If not enter at least 3 characters of either the family name or the name of a member of the family. The following actions will then occur:

A) A search of the patient records is performed.
  a) If a match to your input is found, then a list of these patients is presented.
    i) If the list contains the name of a family member, choose it. You will then see the Family Ledger.
    ii) If not, press <F1> to exit this list. Go to item B) in this help message.
  b) If no match is found in the patient records, then
B) A search of the family file is then performed.
  a) If a match is found, then a list of these families is presented.
    i) If the list contains the name of a desired family member, choose it. You will then see the Family Ledger.
    ii) If not, press <F1>. You will be re-prompted for additional inputs.
  b) If no match is found in the Family records, you will be re-prompted for additional inputs.

Once selected the screen will appear as seen in Figure 83:

In Figure 83 you will notice the Family Ledger (HOH) has charges for all the family members. This is much more efficient than keeping all individuals separate. The bill is sent to the HOH only. However, bills can be produced by insurance carrier so that problems will not arise with insurances such as Workmen's Compensation carriers. Further, on mailing statements only one bill needs to be sent to the HOH, saving a significant amount of time and money spent on postage.

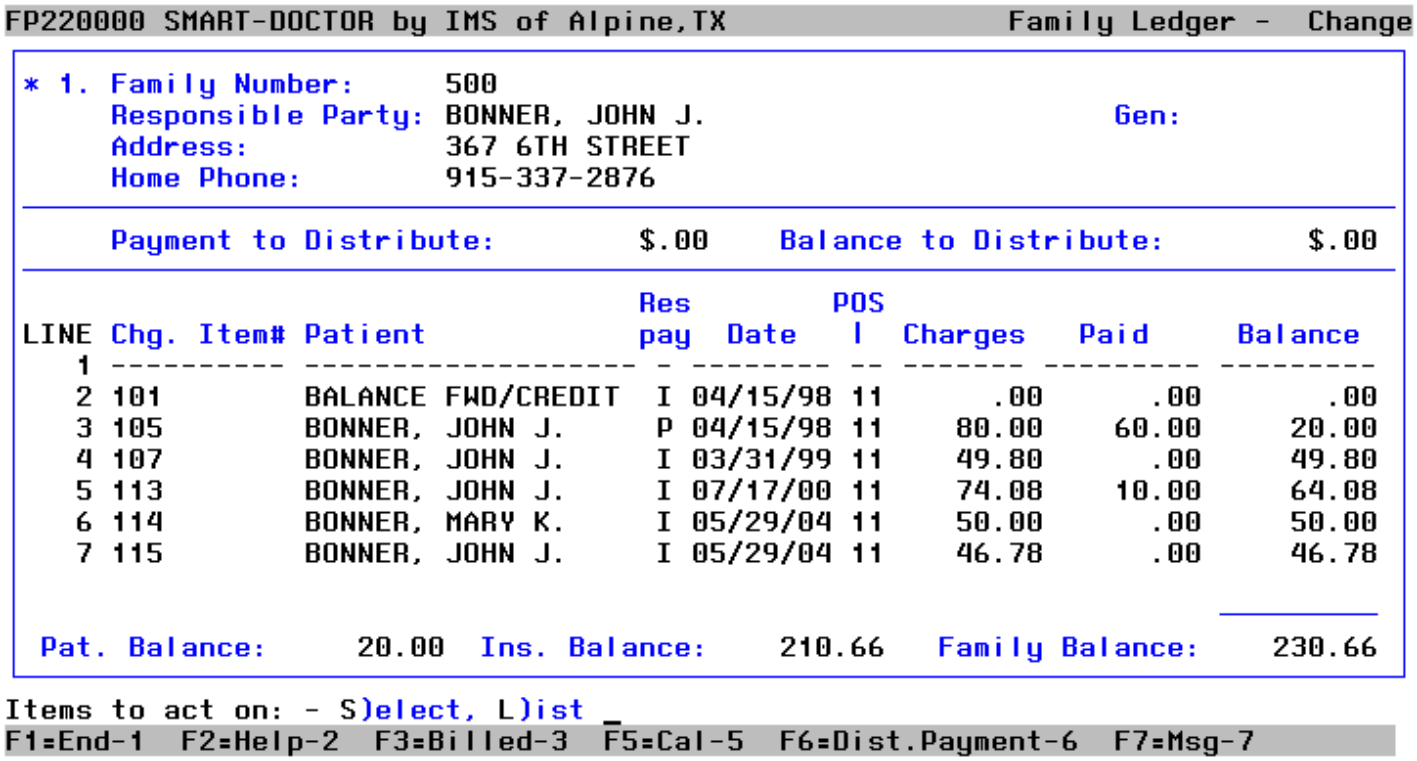


Figure 83 *Family Ledger*

On this screen, you can see all charges in a chronological order. If you want to see the last entries when there are many charges posted over time, you can quickly go to the bottom of the list by entering <lb> at the change prompt (at the blinking cursor at the bottom of the screen next to, "**Items to act on: - S)elect, L)ist**"). The "lb" stands for "list bottom". Also, you can select the last item posted to the family ledger by entering <sb> at this same location. The "sb" stands for "select bottom".

At a quick glance, you can see the family balance at the bottom of the screen. This is broken out as, "Pat. Balance", "Ins. Balance", and the (total) "Family Balance".

F-KEY SCREENS (specific to Family Ledger)

BILLED <F3> SCREEN

Hitting the <F3> key will open up the "Bills" screen as seen in Figure 84.
On this screen the top half of the screen shows when bills were printed and who the user was that requested them to be printed. This is a multi-value prompt. To see all the lines, you may have to page or arrow down. You can also use the <lb> command at the change prompt to list the bottom row. The bottom half of the screen has 3 additional prompts.

Prompt #4, "**Print Family Bill Now ?**:", enter <y> to print family bill now.

Prompt #5, "**Print Family Bill Later ?:**", enter <y> to place family bill in a file for group printing.

Prompt #6, "**Print Family Receipt ?:**", entering a "Y", will create a "Family Receipt." The receipt displays all charges for this day, and any previous charges in which the patient is responsible and the balance is non-zero.

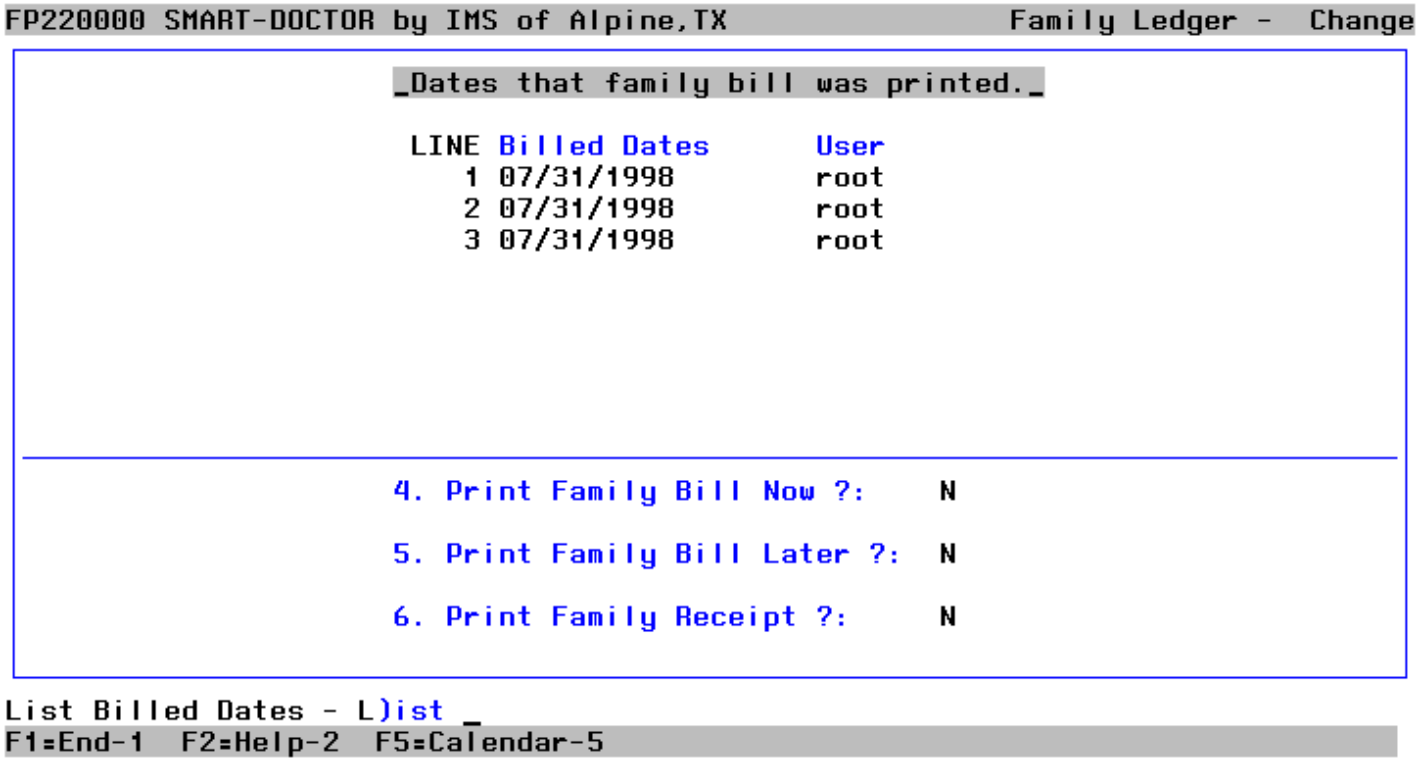


Figure 84 *Family Ledger Billing Screen*

DIST.PAYMENT <F6> SCREEN

Hitting the <F6> key will open up the "Dist.Payment" screen, Figure 85 below. Please note that before going to this screen the primary Family Ledger screen, Figure 83, shows the "**Payment to Distribute:**" to be "$.00" and the "**Balance to Distribute:**" to be "**$.00**". Distributing a payment starts with determining the type of distribution you want to make, as indicated on the first of the distribute payment screens seen in Figure 85.

At prompt #1 on this screen, enter the type of distribution you want to make. Enter <S> to select an individual item for general payment. Enter <I> to distribute Insurance payments by dates. Enter <P> to distribute "Patient/Resp. Party" payments by dates. Enter <C> to choose a number of items to which you want to distribute "Patient/Resp. Party" payments. In all the examples below, we will use an example of posting $5.00. *Upon choosing "S",* you will be taken to the "Distribution of Funds screen, Figure 86 below.

Prompt #1, "**Payment to Distribute:**", enter the amount you wish to distribute to the Charge Items on the main screen. In this case we entered $5.00.

Prompt #2, "**Payment from:**", enter the source of the payment (patient, insurance, etc.) Just hit enter to accept the default of: "Paid-Pt./Resp.Party".

Prompt # 3, "**Method of Payment:**", a pop-up screen is presented as shown in Figure 87 below. This screen shows the different payment types available at this clinic. These can be changed for your site by having the system administrator modify the information for this pop-up screen in the TERMS file record "ADM-PAY_TYPE". Highlight the one you want, or enter its line number and hit <enter>.

Prompt #4, "**Check/CC Number:**", enter the check or credit card number. If you choose "Cash" from the prior selection screen, the value of "--" will be placed in the field, and it will be skipped.

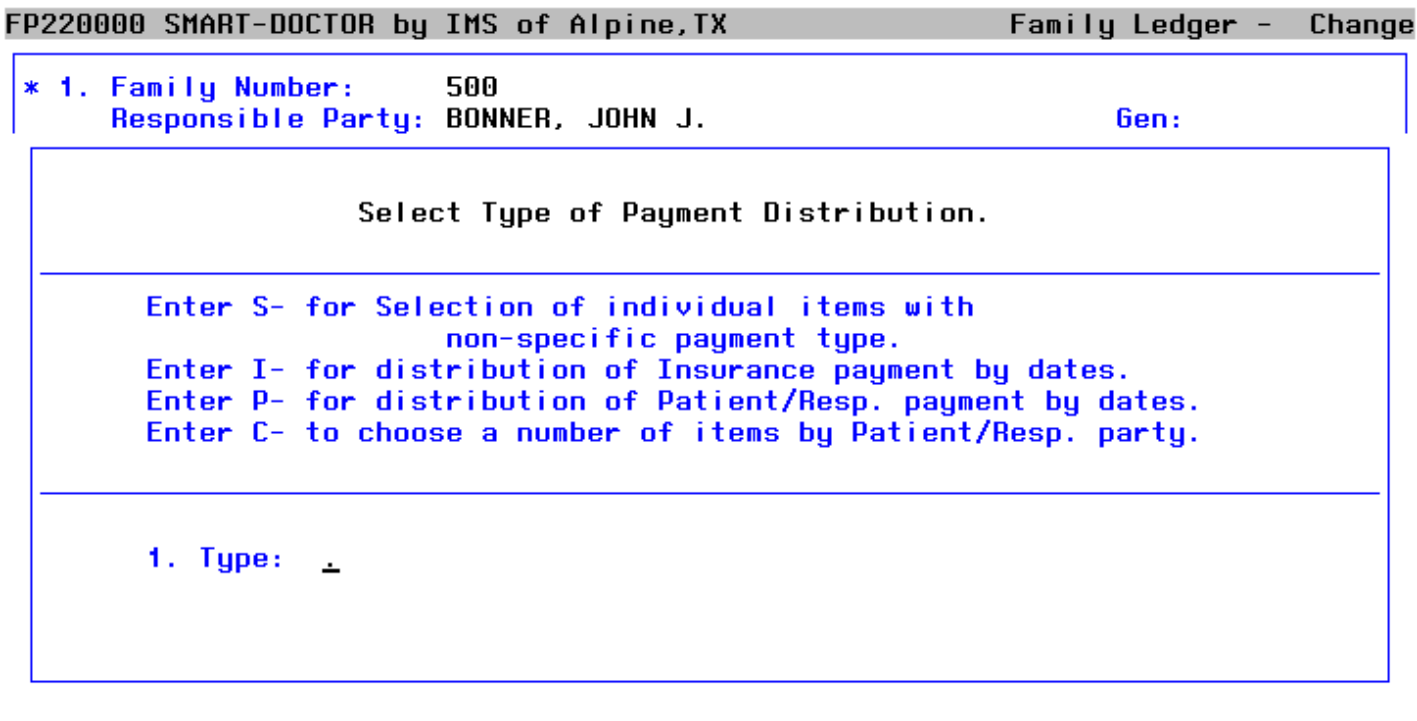


Figure 85 *Payment Distribution*

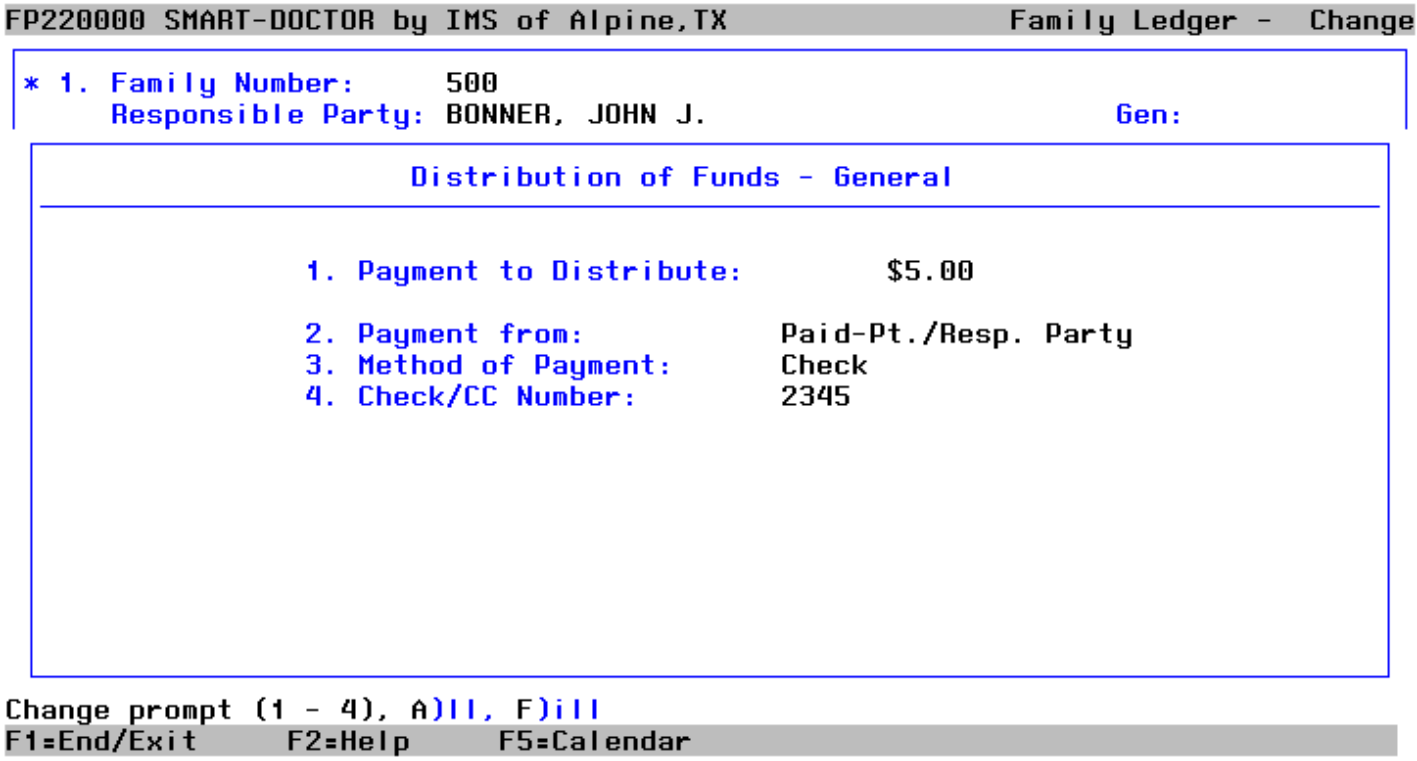


Figure 86 *Distribution of Funds*

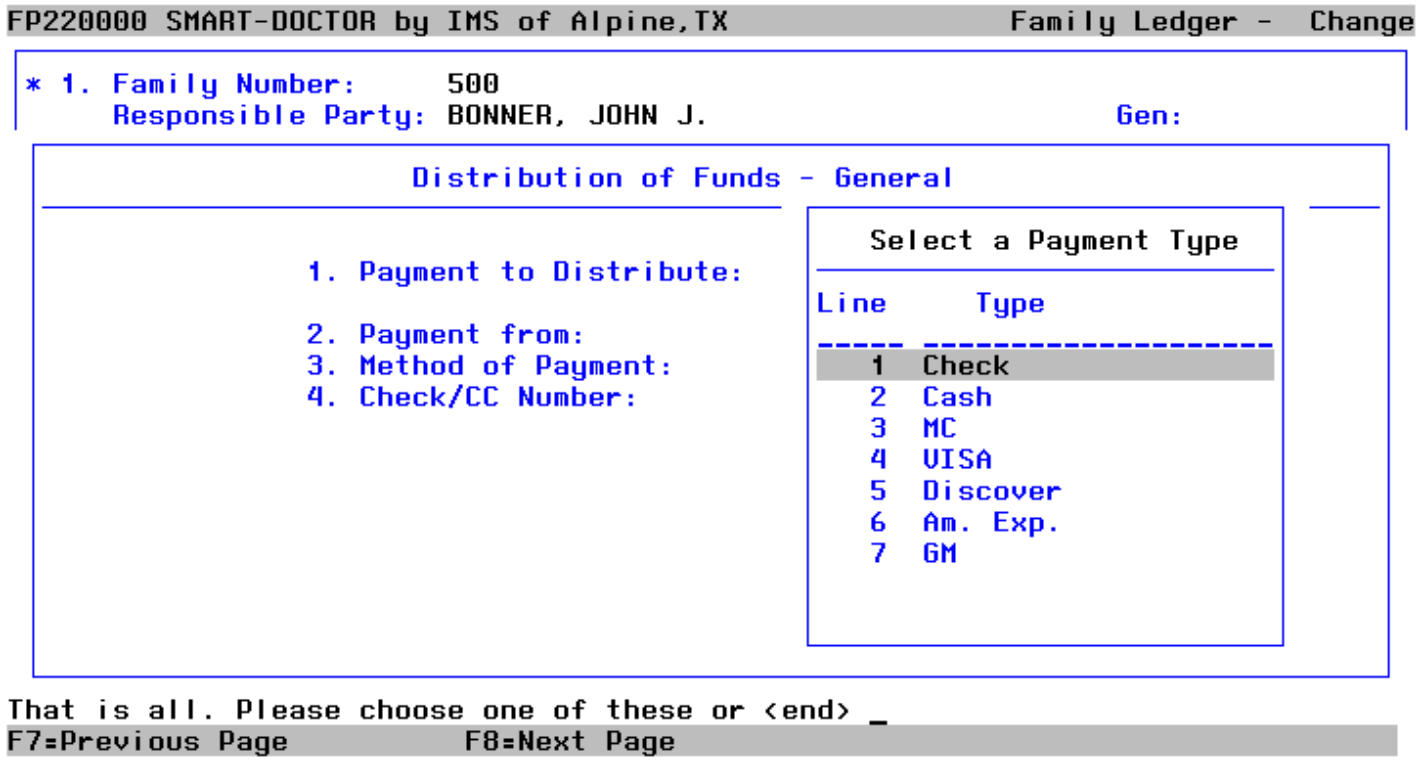


Figure 87 *Select Payment Type, Pop-Up*

Any time you need to make corrections, indicate at the change prompt which prompt you want to go back to, or you can select “A” for all. If you do not catch your error until after you get into the charge item screen, hit <F1> to “end” back to the primary family ledger screen and start again.

You will then be taken to the prior screen. Hit enter, not changing your previous selection. Then hit <enter> again to get back to the primary Family Ledger screen. Now from this screen, you will see a prompt at the bottom of the screen (just above the F-Keys line) instructing you as follows: “Items to act on: - Enter the line number to select”. Enter the line number of the charge you want to distribute part or all of the amount you indicated for payment. You can also use the multi-value shortcuts to move around in these items, <lb>, <sb>, page up, page down, arrow up, and arrow down, as discussed previously under “*NAVIGATING THE "LINE" PROMPTS:”.* Then distribute the payment as described below in “*CHARGE ITEM DISTRIBUTION*”.

Upon choosing “i”, you will be taken to the insurance carrier screen seen in Figure 88 below.

Since you have chosen payment distribution by an insurance carrier, the system will present you with the carriers that have been billed for charges in the Family Ledger. This is done to save you typing and reduce errors. Also, since the text entered will be consistent, a future search that may be wanted will be more accurate. Pick the appropriate carrier that is making payment.

The system will now find all charges, in the date range specified, for that carrier. You will then be presented with these in a serial fashion. To skip an item, hit <F1> to “end” input on this particular charge and go on to the next one selected, if there are any more.

An example of choosing the “P” type of distribution was already described in the “Primary Billing” section of this manual. Please refer to that section for an example of completion of the remainder of the prompt items.

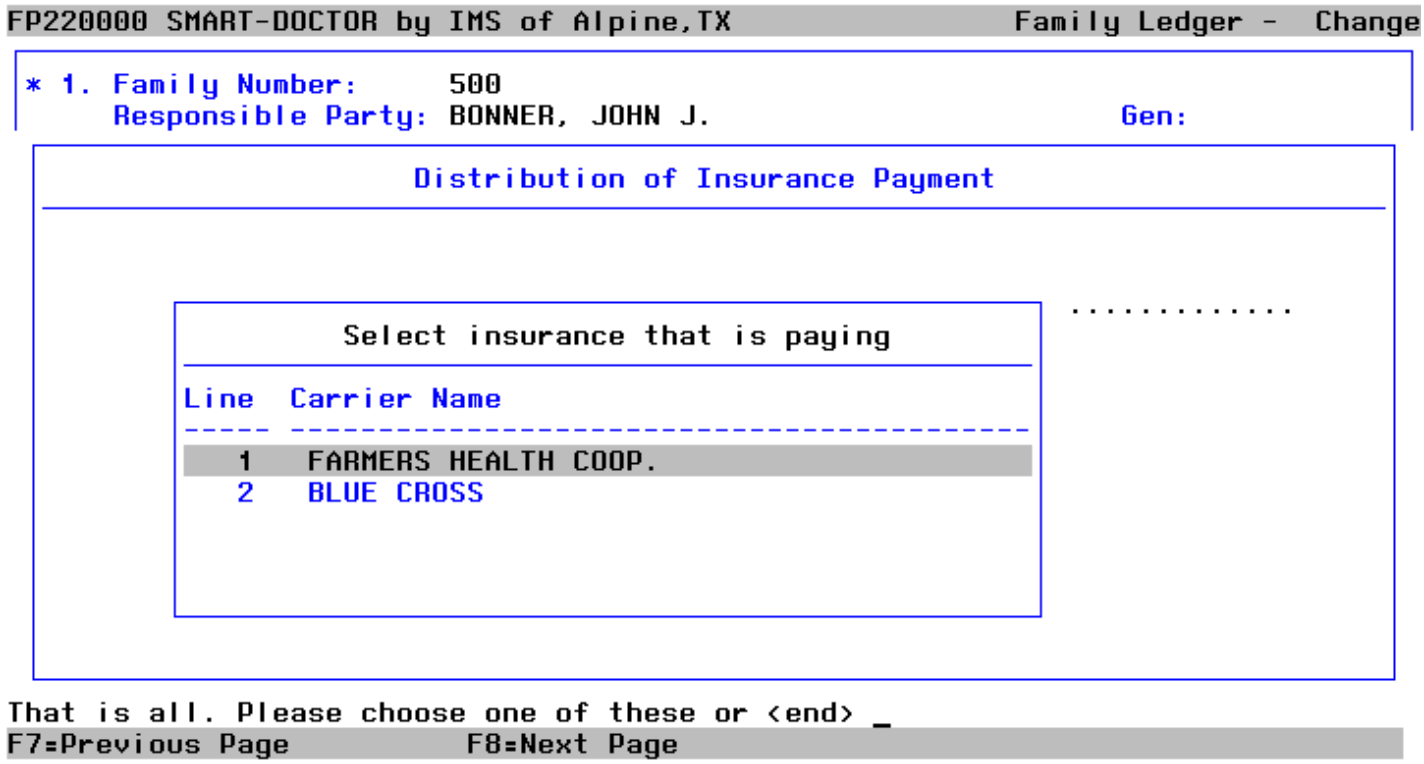


Figure 88 *Select Insurance carrier, Pop-Up*

Upon choosing "C", you will be taken to the screen shown in Figure 89 below.

Prompt #1, "**Pt./Resp. Paying**:", will default "Paid-Pt./Resp. Party" to indicate the the payment was made by the patient or the responsible party (HOH). This can be over-typed as needed to indicate the correct source of payment. Please keep the terms used consistent, so that others in the clinic know what you mean. Also, this will aid in any future database searches.

Prompt #2, "**Amount to Dist.**", enter the amount you wish to distribute to the Charge Items on the main screen. In this case, we entered $5.00.

Prompt # 3, "**Method of Payment:**", a pop-up screen is presented as shown in the "s" type distribution in Figure 87.

Next a screen will open, showing all the charge items as shown in Figure 90.

In the screen shown in Figure 90, you can select one or more charge items to be processed one-by-one. Hit enter at each line number you want to select. An asterisk, "*", will be placed at the beginning of each line selected. In the above example, the last two charge items were selected. To un-select any item, arrow back to that line number and hit the <enter> key again to remove the asterisk. Also, you can use the "F5" range function key which will allow you to indicate the first line and then scroll to the last line. The "F6" clear function key will clear any selections made.

CHARGE ITEM DISTRIBUTION

Once the charge item(s) have been selected, you will post the payments as follows. In the following screen, Figure 91, hit the <enter> key in prompt #1 to accept the defaulted charge item number presented. Then to distribute part or all of the amount to distribute, enter <a> (Add) at the change prompt to enter a transaction line.

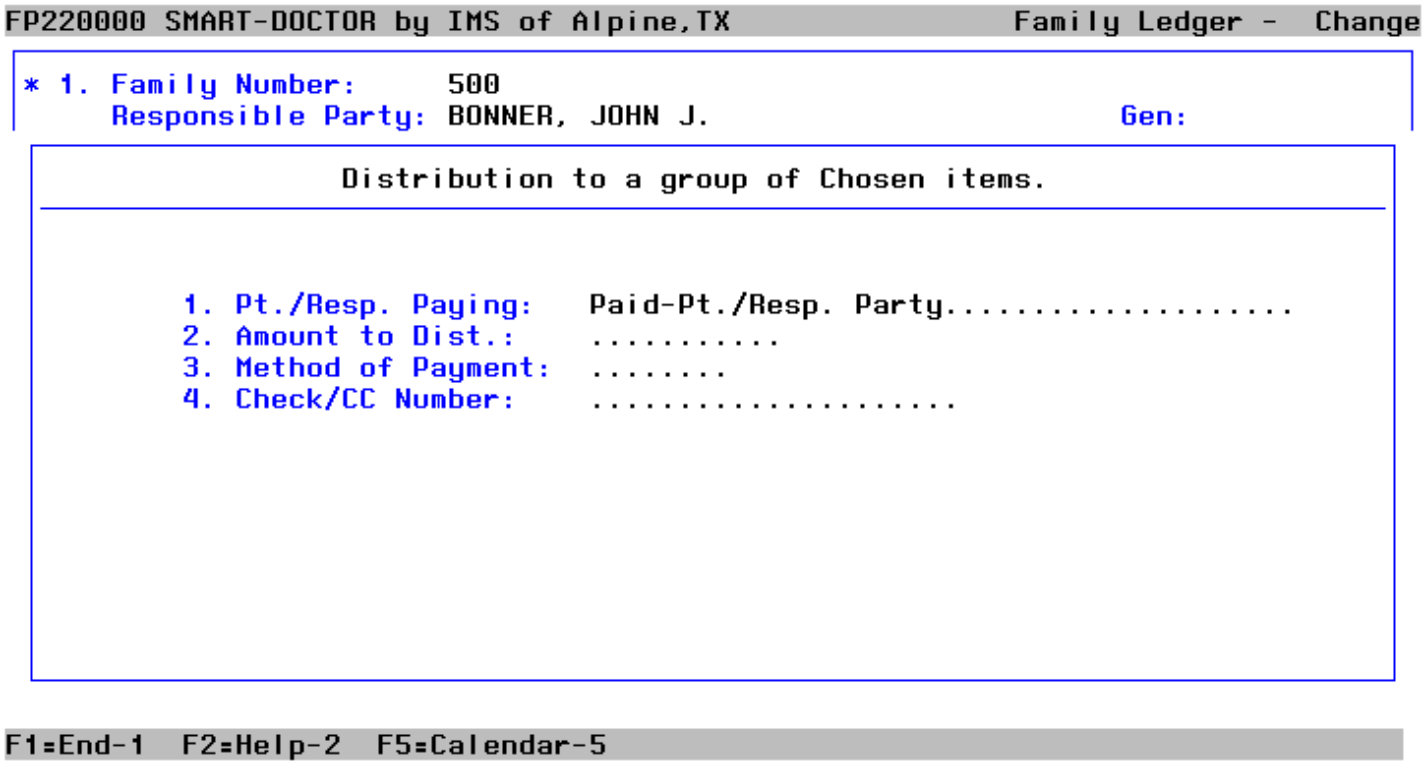


Figure 89 *Distribution to a Group of Charges.*

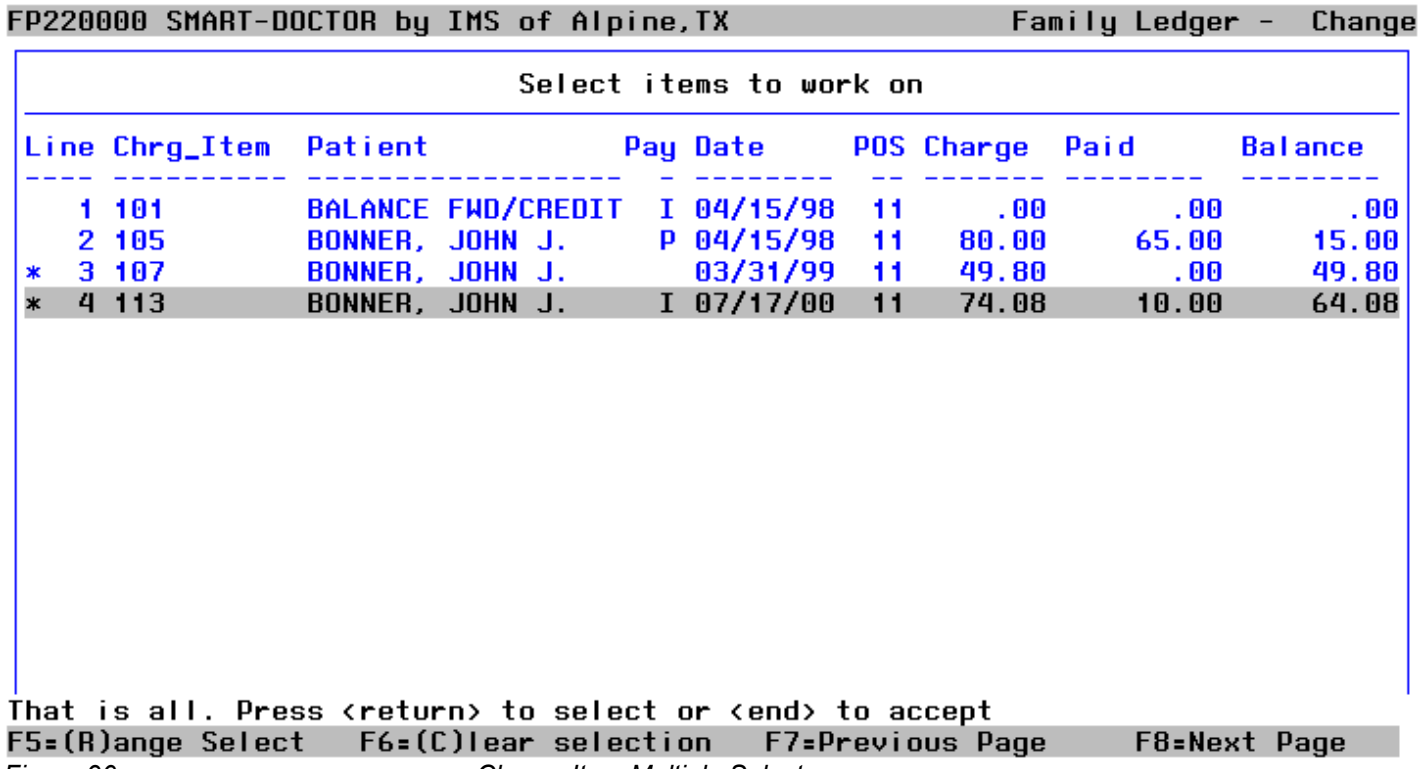


Figure 90 *Charge Item Multiple Select*

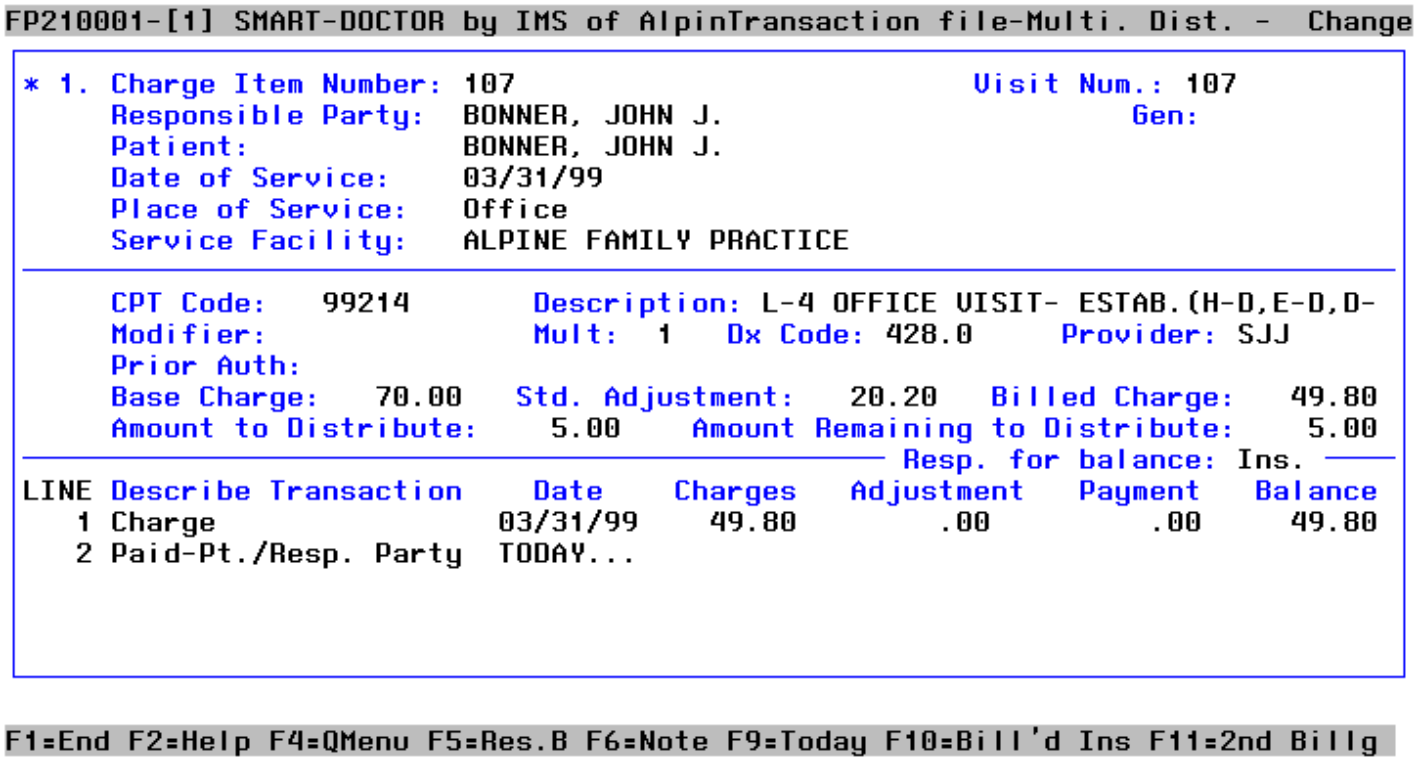


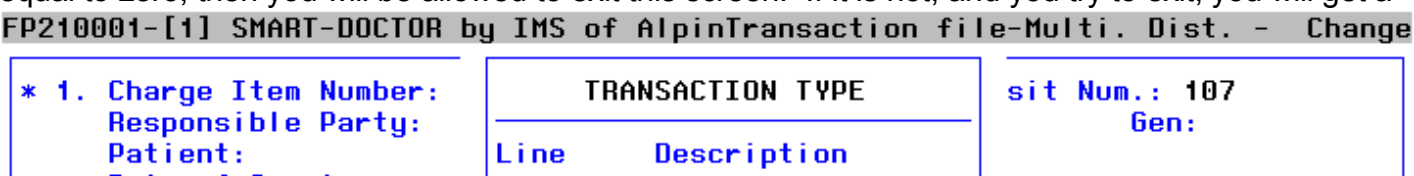
Figure 91 *Charge Item Distribution*

Line 2 in Figure 91 is opened with the previously entered value of the “Pt./Resp. Paying:” in the “**Describe Transaction**” field. If you want to change this, hit the <up arrow> key, and over type the information. Next, accept “TODAY” in the “**Date**” field by hitting <enter>. Generally, you would then hit <enter> at the “**Charges**” field and the “**Adjustment**” fields to take the default of zero (.00). Then, in the “**Payment**” field, enter the amount of the “**Amount Remaining to Distribute:**” amount you want to disperse to this charge item. If you try to disperse more than the $5.00 remaining to distribute, you will be stopped and informed that “There is only $5.00 remaining to distribute”. Upon entering the $5.00, you will see the distributed amount, the balanced reduce appropriately, and the “Amount Remaining to Distribute:” drop to “.00”. You will also be presented with a pop-up screen for any adjustments you may want to make on the next line. All of these above actions are shown in Figure 92 below.

The pop-up screen shown in Figure 92 can be changed by the system administrator or clinic manager in the TERMS file record of “ADM-TRANSACTION”. In that record, you can enter the most common terms you want to see in the “Describe Transaction” field of the next line. Although you can make additional charges and adjustments all on one line, it is better to do this on separate lines for clarity. You can over-type or free text the “Describe Transaction” field, but it is best to use consistent terms so that others working with the charge items know what you mean. Also this will aid in searches for specific transaction types.

If you do not want to make any further entries on this charge item at this time, hit the <F1> key to “end” and to close the pop-up screen. Hit <F1> again if you do not want to make any further additions to this charge item. Next, you will be presented with the next selection if you indicated more than one charge item to distribute funds.

If you do not wish to work on the next charge item hit <F1> to “end” input. Then <F1> back to the main Family Ledger screen. Here you will see all the changes made. If the “Balance to Distribute:” is equal to zero, then you will be allowed to exit this screen. If it is not, and you try to exit, you will get a



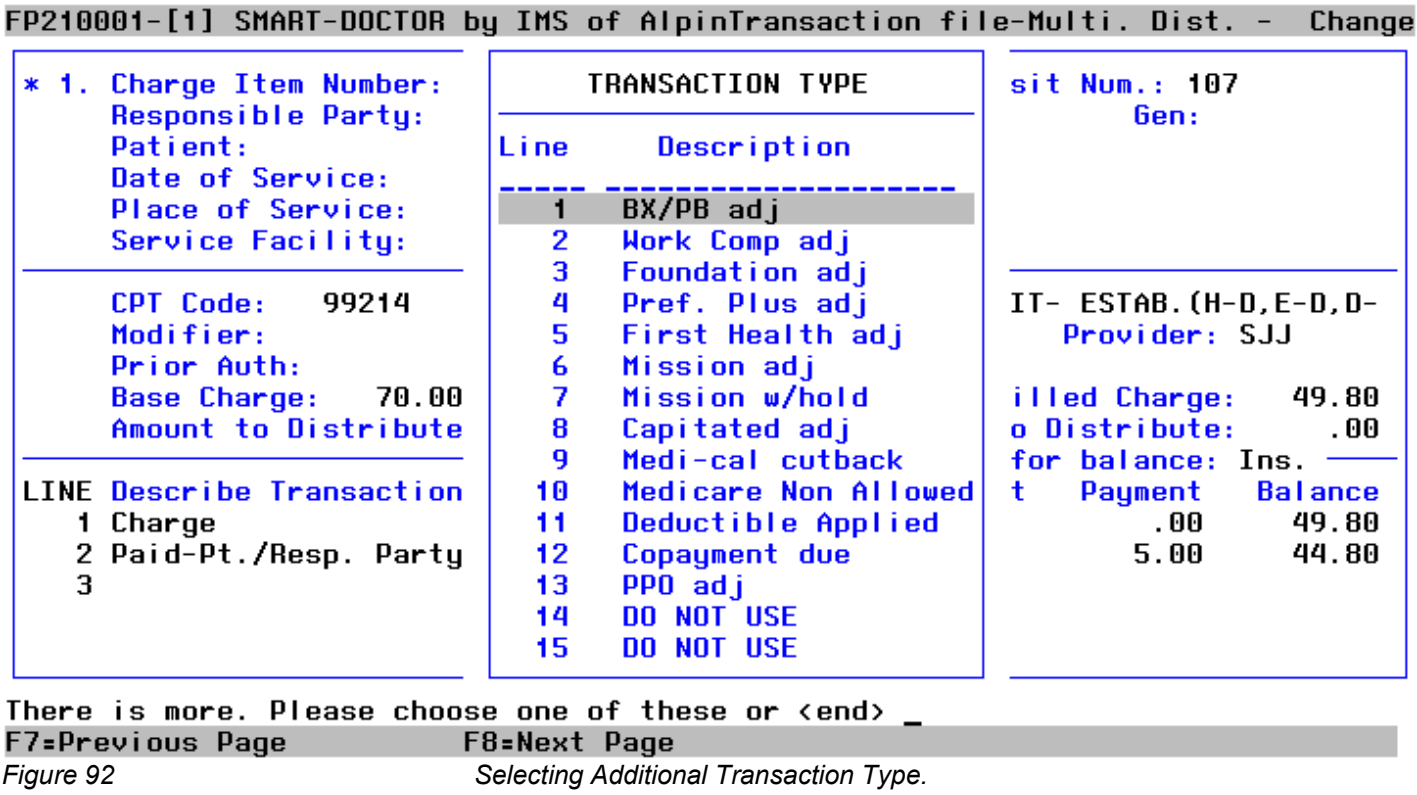


Figure 92 *Selecting Additional Transaction Type.*

"**Failed Validation**" error and will be presented with possible causes and ways to correct the error.

CORRECTING ERRORS.

To correct errors, simply pick a transaction term that is appropriate (don't forget you can add any standard terms you wish to the pop-up selection screen as discussed above). For the transaction term, you could also hit the <F1> key at the pop-up box, to place you on a blank transaction field where you can place a free text entry, for example <correct adj. Ln #3>. Then, correct one error at a time. That is, one per line, so it is clear what you are doing. The screen image of this example is shown in Figure 93 below.

As discussed at the end of this section, you can hit the <F12> to see the hidden security screen, to see who made each transaction and when.

Msg. <F7> Screen.

The "Message" (Msg) screen, Figure 94, is used to tract and give information to the HOH regarding problems with payments on the HOH account.

Prompt #1, "**Suppress Dunning Message (y/n)?**", enter <y> to suppress dunning messages. Leave blank or enter <n> to allow dunning messages. The dunning messages for greater than 30, 60, or 90 days can be modified by the system administrator, clinic manager, or billing manager. These changes are made to the "ADM-BILL-OVER30", "ADM-BILL-OVER60", "ADM-BILL-OVER90" records in the TERMS file.

In the multi-valued prompt for "Messages", the first field is for the message. The second and third fields are start and stop dates to show the message on the monthly HOH bill. The messages, as well as the dunning messages, and any general clinic messages are inserted into the HOH bill. The HOH bill is generated via the "Monthly Reports"screen by choosing menu item #2, "Bill w/DX & CPT w/Pt.

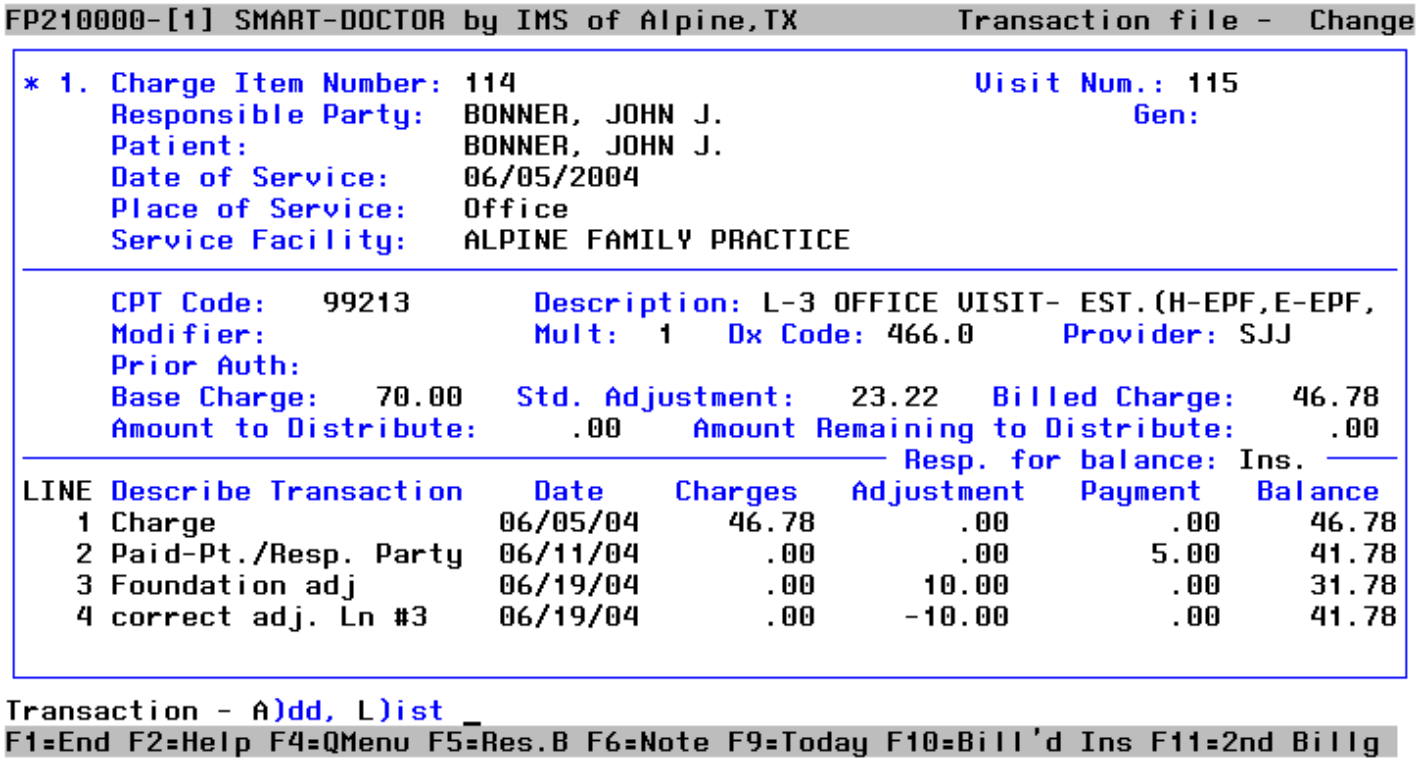


Figure 93 *Example of Charge Item Correction.*

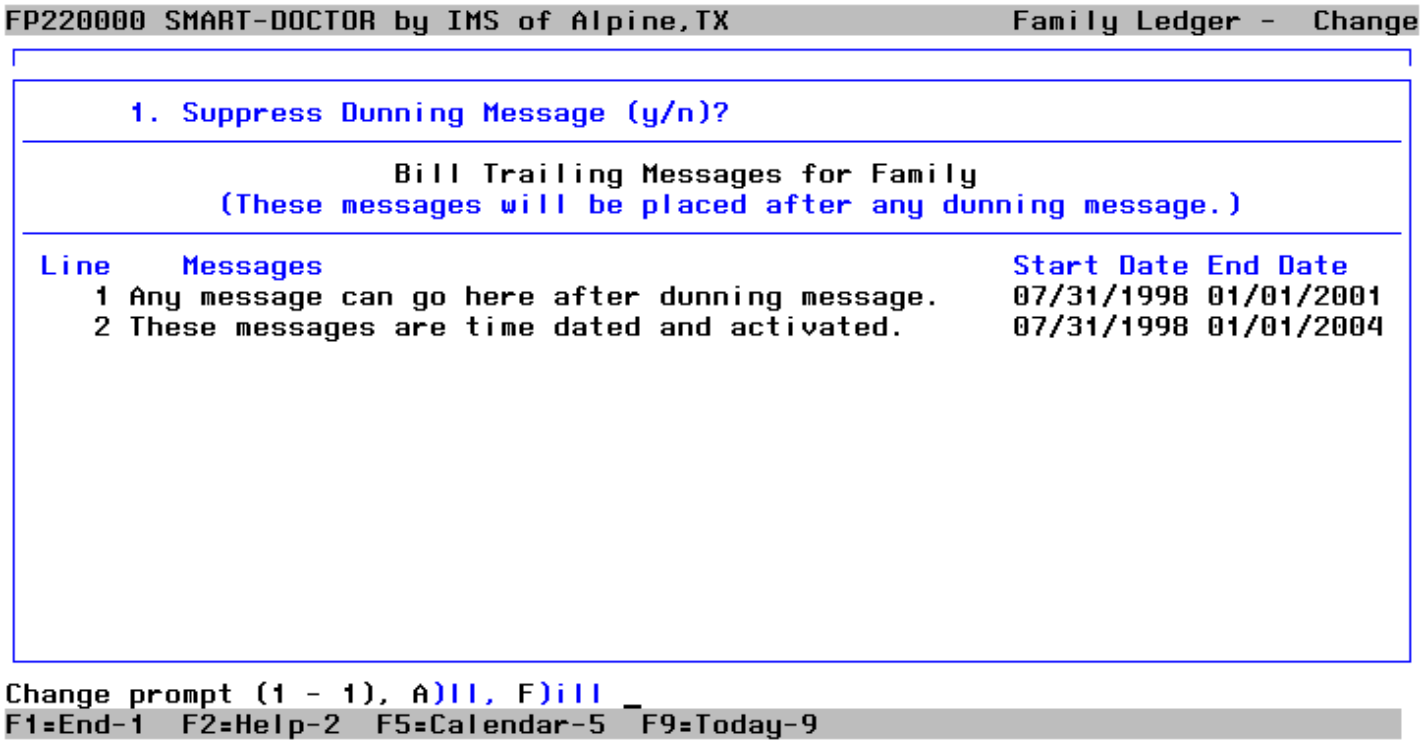


Figure 94 *Family Billing Messages Screen.*

Resp.>0". The other 4 types of "Patient Statements" will not have this information.

DAY SHEET

The main office menu item #10, "**Day Sheet (PW req'd)**", will take you to the Day Sheet, Figure 95, which shows all transactions for that date.

Prompt #1, "**Date of Posting:**", will default today's date. You can also enter prior dates if you wish to review those dates. In the above screen will be listed all transactions for a given day. If any of the listed items need to be reviewed, enter the appropriate line number to select the transaction to review. The transaction screen as shown in Figure 96 will be presented. All the pertinent information about that specific transaction is presented along with the security information showing the user, date, time, and terminal used.

DAILY ACCOUNTING

Menu item # 11, "**Daily Accounting (PW req'd)**", off the front office menu will take you to the screen seen in Figure 97, where you can perform several daily tasks.

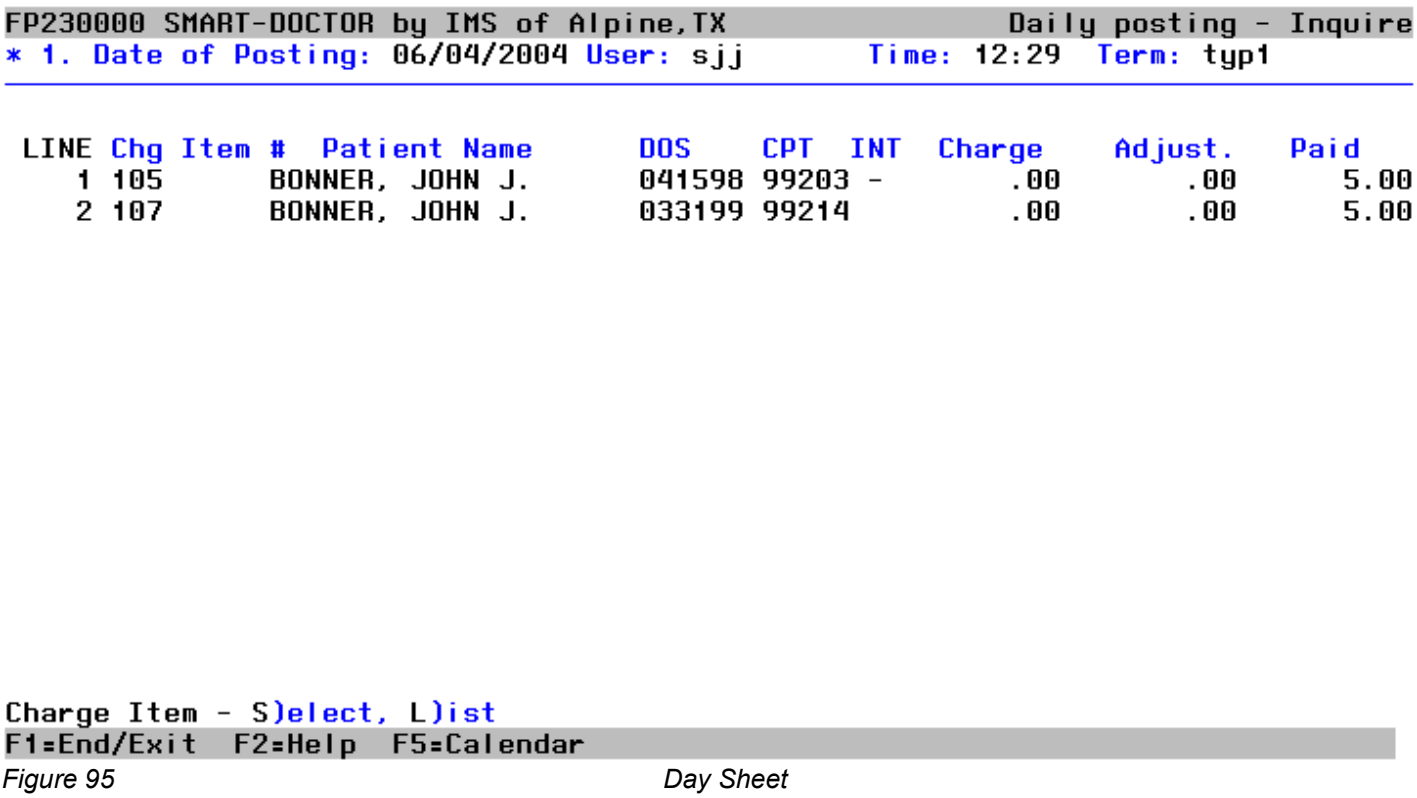


Figure 95 *Day Sheet*

Generally, only menu items #2 through #4, which are all reports, are used regularly. Menu item #1 is only used if there has been a posting error. This would be indicated in the "Daily Admin" menu item from the "Billing" screen. The "Daily System Monitor" would indicate that the posting was "Bad", as discussed in that section.

The first of these reports is seen in Figure 98, the report of the Day Sheet.

Each of these reports gives you several options for output as listed on the bottom of the screen. This can be seen in Figure 98, above. You can hit <enter> to accept "s" for screen which will present the report to you on the screen, <p> for the default printer, <b> to send it to both the screen and the default printer, <f> to a file, <o> to specify another printer, and any printers listed as F-Keys.

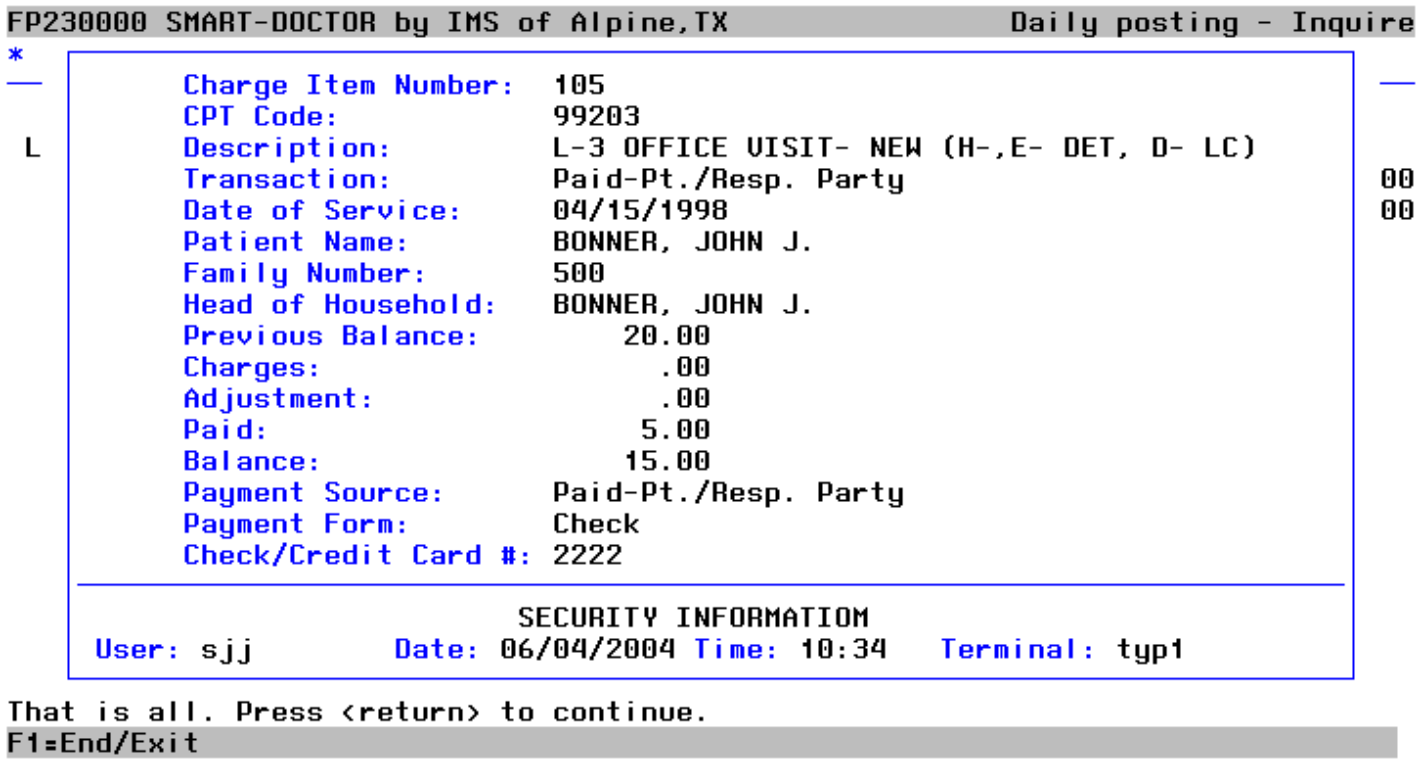


Figure 96 *Transaction Screen*

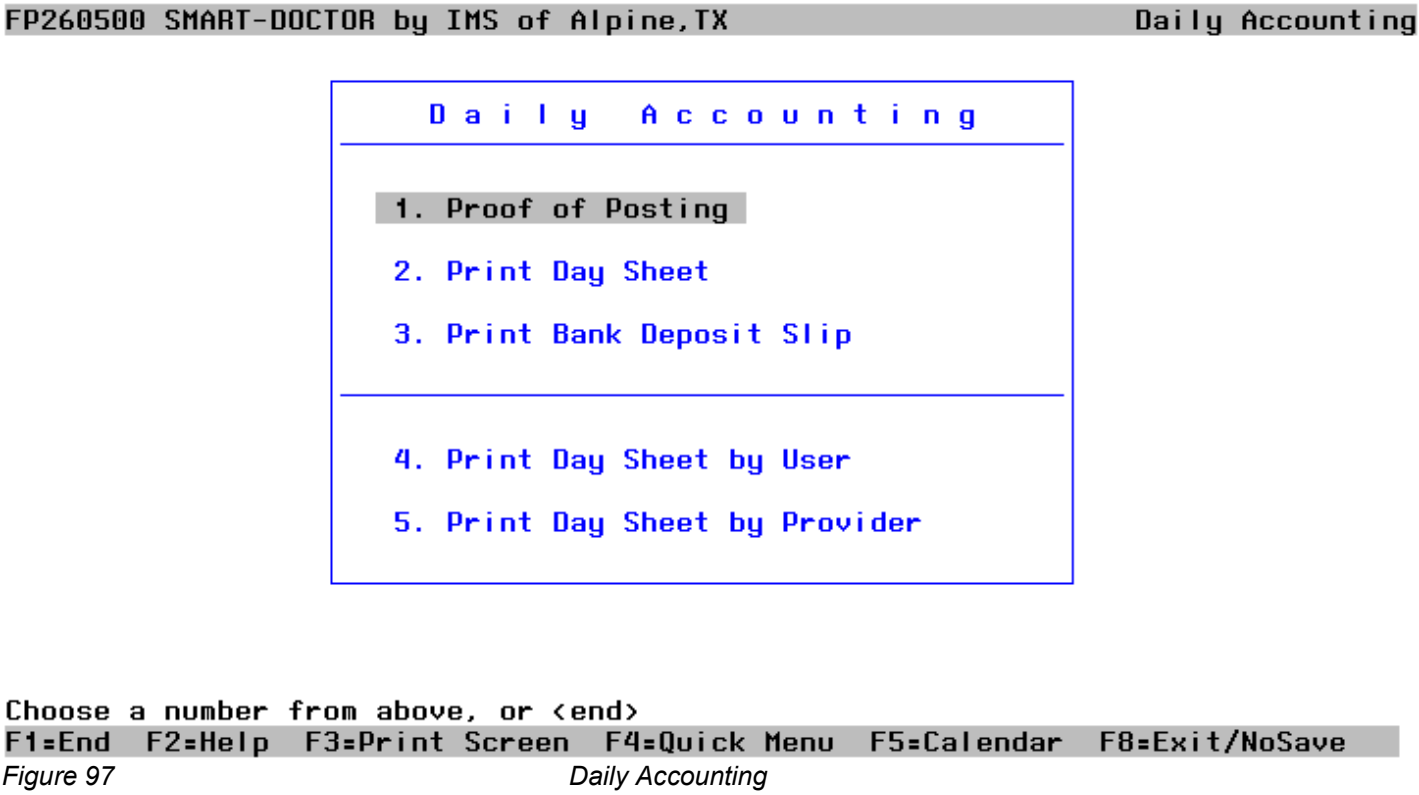


Figure 97 *Daily Accounting*

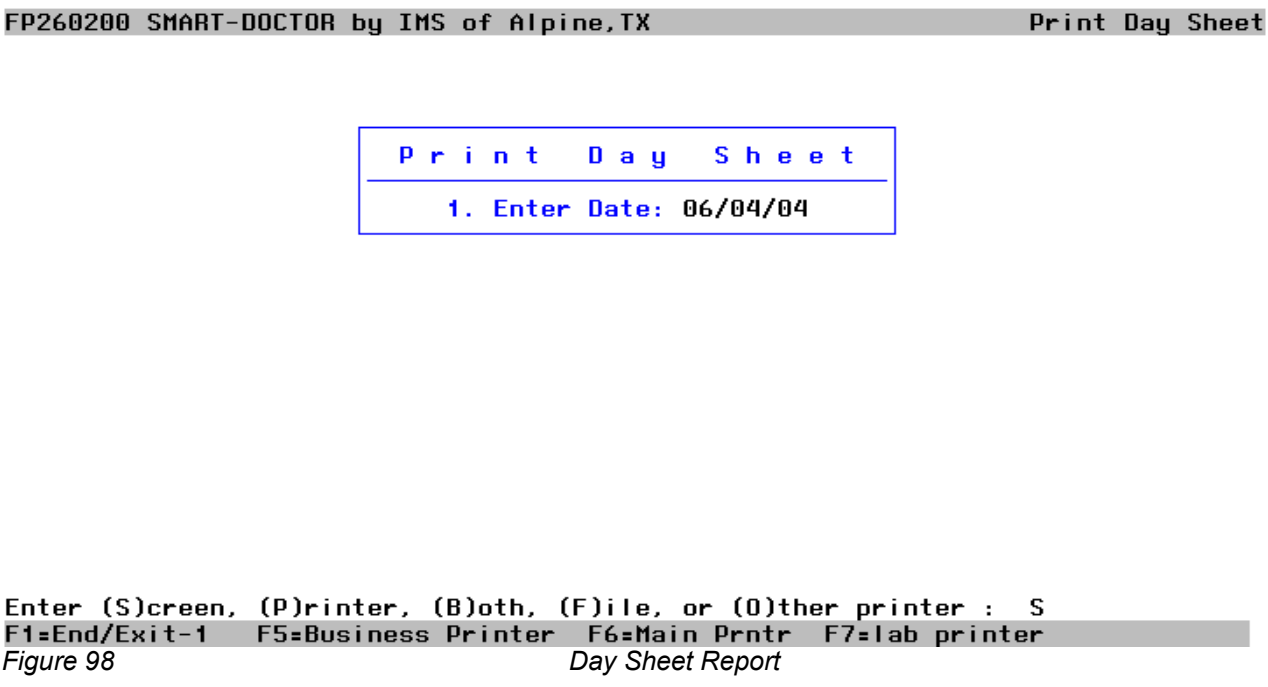


Figure 98 *Day Sheet Report*

Below, Figure 99, is an example of this specific report as shown on the screen. The other reports work in a similar manner. Menu item #3 prints the bank deposit slip. Menu item #4 prints the day sheet by user. Menu item #5 prints the day sheet by provider.

REVIEW ADJUSTMENTS

To review adjustments select menu item #30, "**Review Adjustments (Pwd Req'd)**", off the main front office menu. You will then be presented with the selection screen seen in Figure 100 below.

Prompt #1, **"Provider:"**, enter provider initials or <ALL> to select all providers.

Prompt #2, "**DOS from:**", Enter date of service in the following form: 0201, 020104, 02012004, 02/01, 02/01/04, 02/01/2004, or enter <FIRST> to start with the first date of service in the system.

Prompt #3, "**DOS to:**", enter as in prompt number 2, or enter <LAST> to select through the last date of service.

Prompt #4, "**CPT Code:**", accept the default of <ALL>, or enter the CPT Code in the form: 99212, or 10060*.

Prompt #5, "**Ins. Co.:**", accept the default of <ALL> for the insurance company, or enter a partial description of the insurance company to select from a list.

The typical resulting screen will be presented starting with the first Charge Item Number defaulted for you. If no number is presented, then no charge items were found meeting the criteria you input above. To see the information, hit <enter> at prompt #1 with a defaulted Charge Item Number. Figure 101, below, is an example of an adjustment that was found.

```
FP260200                  SMART-DOCTOR by IMS of Alpine,TX                Page    1
                                    Day Sheet                 13:49:13  4 Jun 2004

                                Day Sheet for 06/04/04

                  Accounts Receivable at Start of Day:            .00
                  Accounts Receivable at End of Day:              .00

 Pt. Name    Prev Bal    Charges Adjustmnt Amnt Cash Amnt Chk  Amnt CC   Balance
 ---------- --------- --------- --------- --------- --------- --------- ---------
 J.BONNER       20.00       .00       .00       .00      5.00       .00     15.00
 J.BONNER       49.80       .00       .00       .00      5.00       .00     44.80
                       --------- --------- --------- --------- ---------
                Totals:       .00       .00       .00     10.00       .00

 The report is complete. <Return> to continue.
```

Figure 99 *Day Sheet*

```
FP210003 SMART-DOCTOR by IMS of Alpine,TX                  Selection of adj <>0

    1. Provider: ALL

    2. DOS from: FIRST

    3. DOS to:   LAST

    4. CPT Code: ALL

    5. Ins. Co.: ALL

Any Change ? _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 100 *Review Adjustments Selections Screen*

In this example, this charge item contains a $10.00 adjustment in the adjustment field of the multi-value. To see the security screen, hit the <F12> key. This screen, as seen in Figure 102 below, will show you the User , Date, Time, and Terminal for each line in the transaction multi-value prompt.

Information on this transaction could have also been seen in the Day Sheet screens discussed

previously (Figure 99). This information could also be reviewed from the Family Ledger. The advantage of this method of review, is that a manager can more easily concentrate on looking at all adjustments of a selected type at one time, without having to go to the individual Day sheet or Family Ledger.

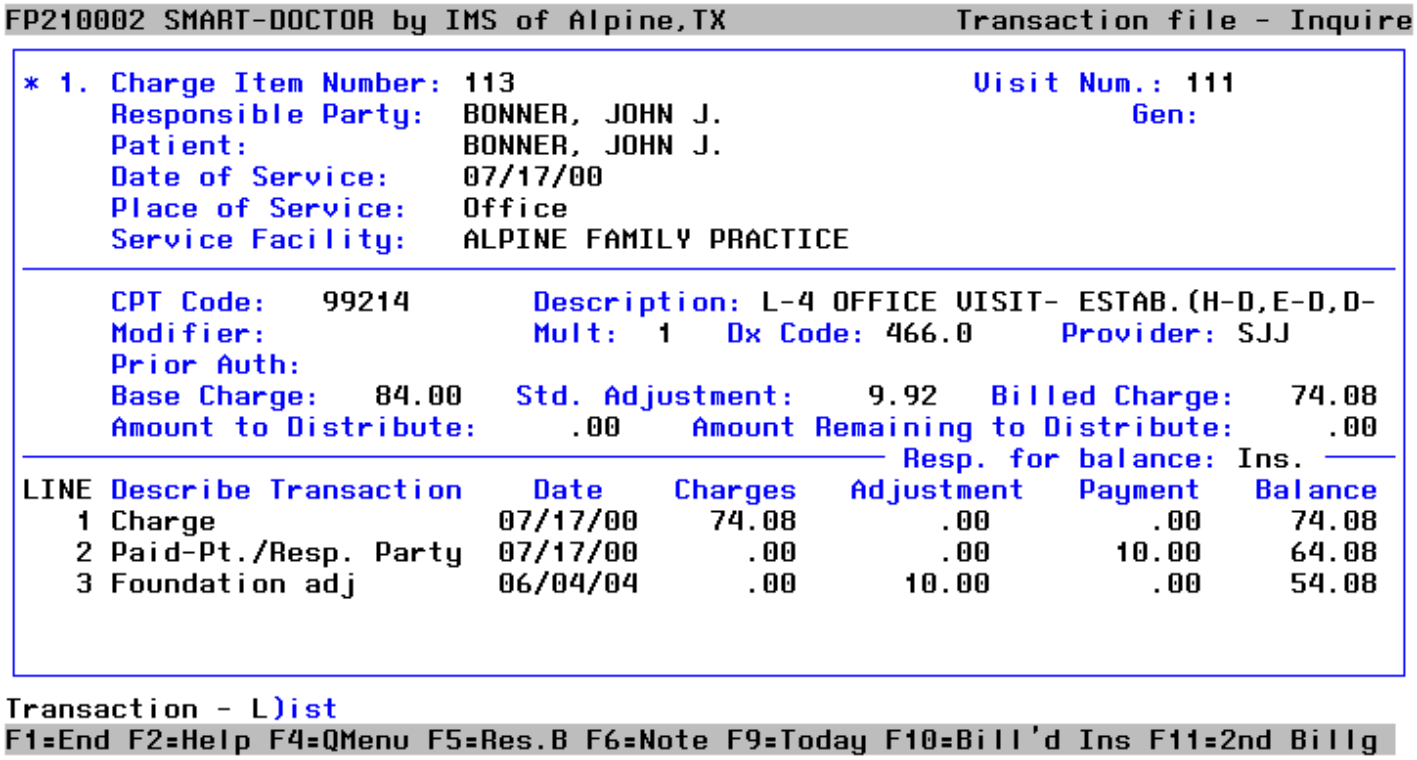


Figure 101 *Adjustment found in Transaction File*

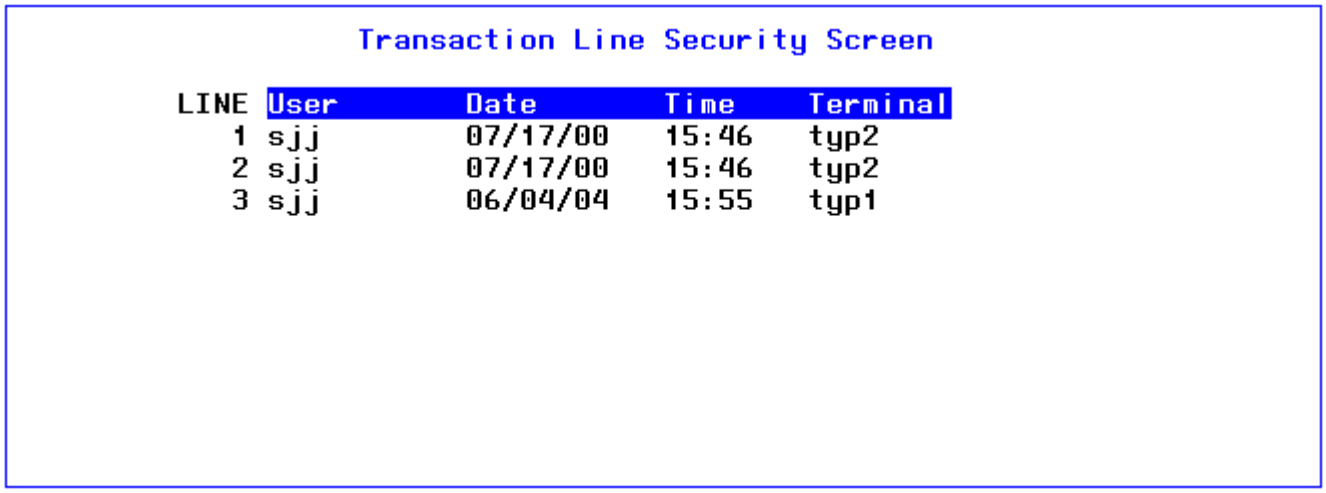


Figure 102 *Transaction Security Screen*

CHAPTER 3 BILLING

The billing screens are reached from the main menu via menu item #8. This screen present you with numerous tools to process office visit bills, out of office bills (including hospitals and nursing homes), bills of office visits not billed at the time of the visit, and many other functions as will be described in Figure 103 below.

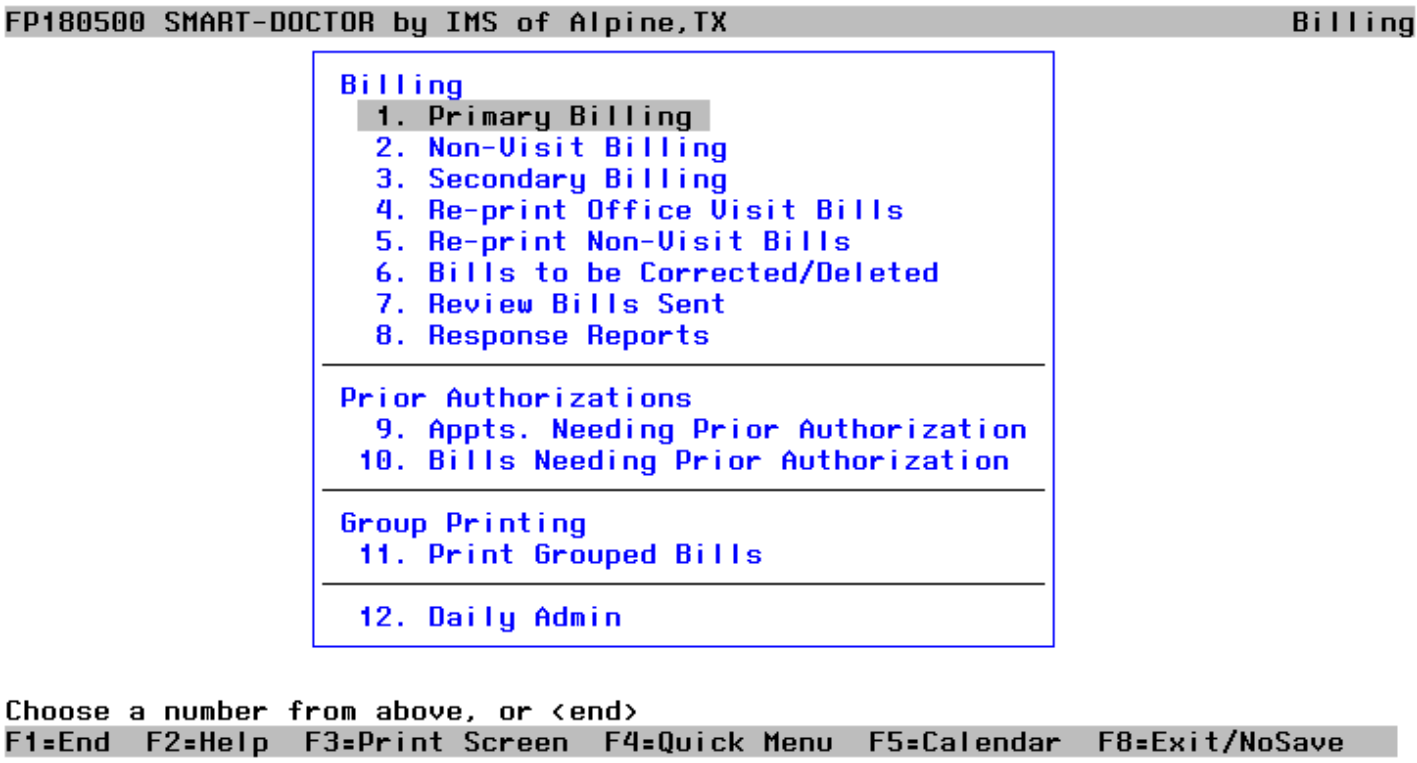


Figure 103 *Billing Menu*

PRIMARY BILLING SCREENS

Select menu item #1 above to go into the primary billing screen. This screen, Figure 104, will display ALL of the bills not yet processed at the time you open the screen. This screen might reflect the situation after the first two patients of the day have been seen and are exiting. These bills are in reverse chronological order, so the most recent bill is at the top. This would be the last patient seen by the doctor, generally. Any bills from prior days will remain here until billed, or specifically deleted via other screens requiring passwords to access.

Enter the line number of the bill you want to process, and hit the <enter> key. The billing screen seen in Figure 105 below, will now open.

Prompt #2, "**Is this the correct Patient & Family?**", is the name of the person shown above this question the Responsible Party, Head of Household, legal guardian, or the adult listed as the patient? Answer yes <y> or <n>. If there is no insurance company or a balance is due after insurance has paid, this person will be billed. All actions on the account will be reported to this person.

Next the insurance screen, Figure 106, will automatically open showing all available insurances for the patient. The patient's individual insurances will be shown first, followed by any HOH family insurances. If the patient was see in the clinic, and had the insurance for the visit selected at sign-in, the insurance

```
FP180506 SMART-DOCTOR by IMS of Alpine,TXFront End for Primary Billing -  Change

* 1. Terminal: typ1       User: sjj          Time: 18:21      Date: 05/22/2004

                              Primary Billing
  LINE Patient Name          Time    Prov     Date Of Service   LAB/ENC
     1 BONNER, MARY K.        9.15   SJJ      05/22/2004        ENC
     2 BONNER, JOHN J.        9.00   SJJ      05/22/2004        ENC

Choose a bill. - S)elect _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 104 *Primary Billing screen.*

```
FP180000-[1] SMART-DOCTOR by IMS of Alpine,TX     Office Exit and Bill -     Add

  * 1. Originally Scheduled Provider        SJJ
       Visit Number: 113
  ------------------------------------------------------------------------------
       Patient Name:   BONNER, JOHN J.                                Sex: M
       Patient Number: 1001
       Date of Birth:  12/02/1931 Age: 72  yrs.   5.7 mos.
  ------------------------------------------------------------------------------
       Responsible Party:       BONNER, JOHN J.
       Relationship to Patient: Self
       Family Number:           500
    2. Is this the correct Patient & Family? _
  ------------------------------------------------------------------------------
       Total charges for today's visit is:     ..........
       Total payment needed for today's visit: ..........
  ------------------------------------------------------------------------------
    3. How would the patient like to pay? ..........

F1=End/Exit F2=Help F4=QMenu F5=Cal F7=Charges F8=Xit/NoSv F9=VisRev F10=InsDc
```

Figure 105 *Starting Billing screen.*

the insurance previously selected will be shown in line #1 of the lower half of the screen for the insurance policy to be billed. Initially you will be in the multi-value prompt at the top half of the screen. You are place here in case you want to look at the other insurance policies, to see if one of them would be more appropriate. You would do this by entering the appropriate line number.

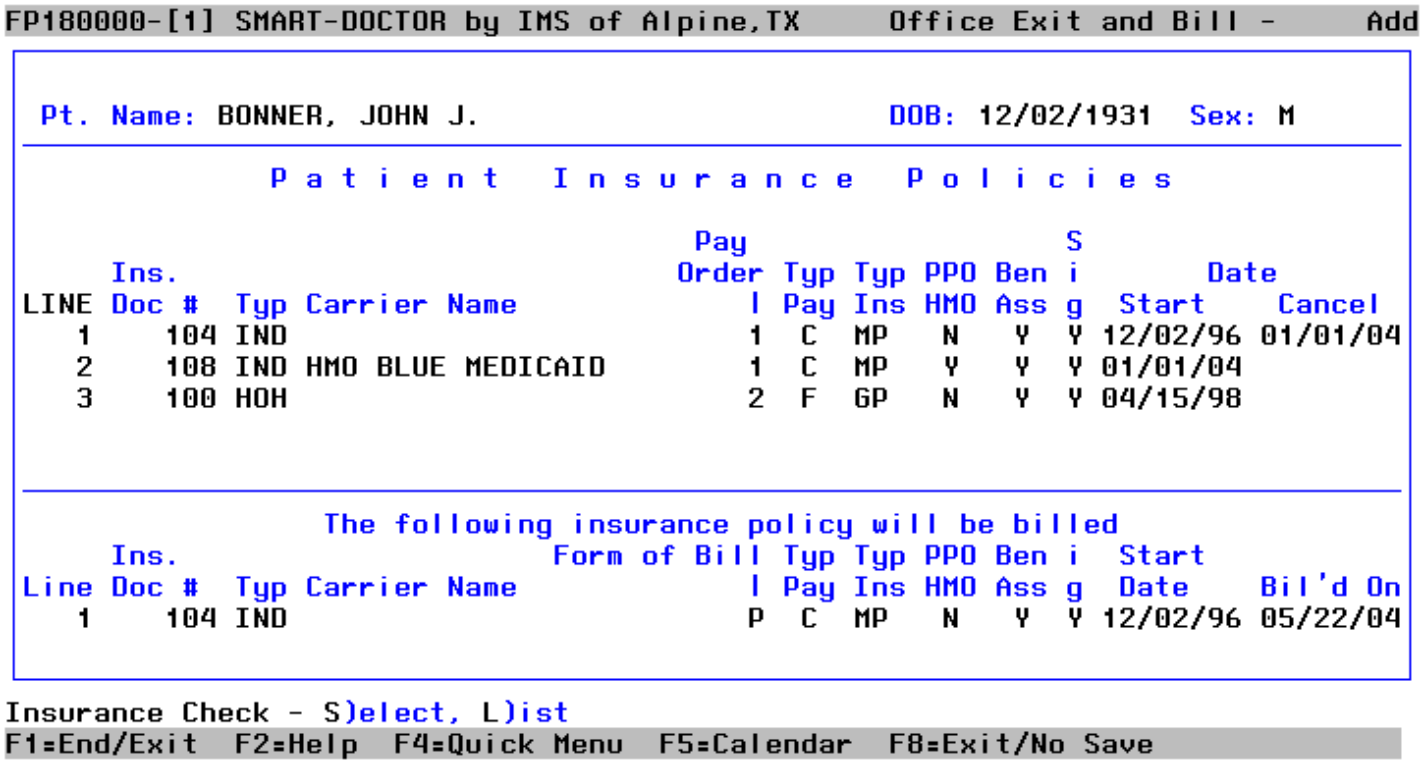


Figure 106 *Insurance screen.*

This section allows you to select an insurance policy, to see the insurance policy information, before selecting it for billing. If you do not enter a number and just hit <enter>, then you will be moved to the bottom half of the screen in a multi-value prompt. Here you will be able to indicate C(hange) to change the to another carrier if you want before the bill is processed. If you just hit <enter> then this carrier will be used for billing. You may change this at any time before reaching the “Pay Now or Bill” screen by using the F10 key to go to the insurance screen again.

You are next automatically taken to the referring provider and visit information screen as seen in Figure 107.

Prompt #1, “**Provider to bill to:**”, will be skipped if the provider of the service was a provider that can legally bill (MD, DO, DC, etc.). For other providers such as PAs, working under a physicians supervision, you will be stopped at prompt #1 with the defaulted value of the supervising physician taken from the provider file for this individual (prompt # 19, for Non-physician's Sup.:). If this is correct just hit <enter>, if not, type part of the name of the supervising physician at that time, and pick the appropriate physician if more than one choice is given.

Prompt #2, “**Are billing Prov. & referring the same:**”, if this appointment was scheduled as a referral, and a referring physician was indicated, then this will be defaulted for you. If this wasn't initially indicated as a referral, and the provider was a physician, then a “Y” is defaulted to indicate, that they are the same (which is the most common case). Medicare and some other carriers requires you to specify the referring physician, even if the provider the patient came to see initially, is the same provider, i.e., not a referral. If it is the same provider, just hit <enter> to keep this as yes. If the referring provider is different from that presented, you will be able to enter part of the referring providers name, and then select from the choices presented. These providers can be clinic providers or referring provider's listed in the referring provider file discussed previously.

If this is a standard office visit, then just hitting the <F1> key here will drop you through the remaining prompt items, placing default values where appropriate.

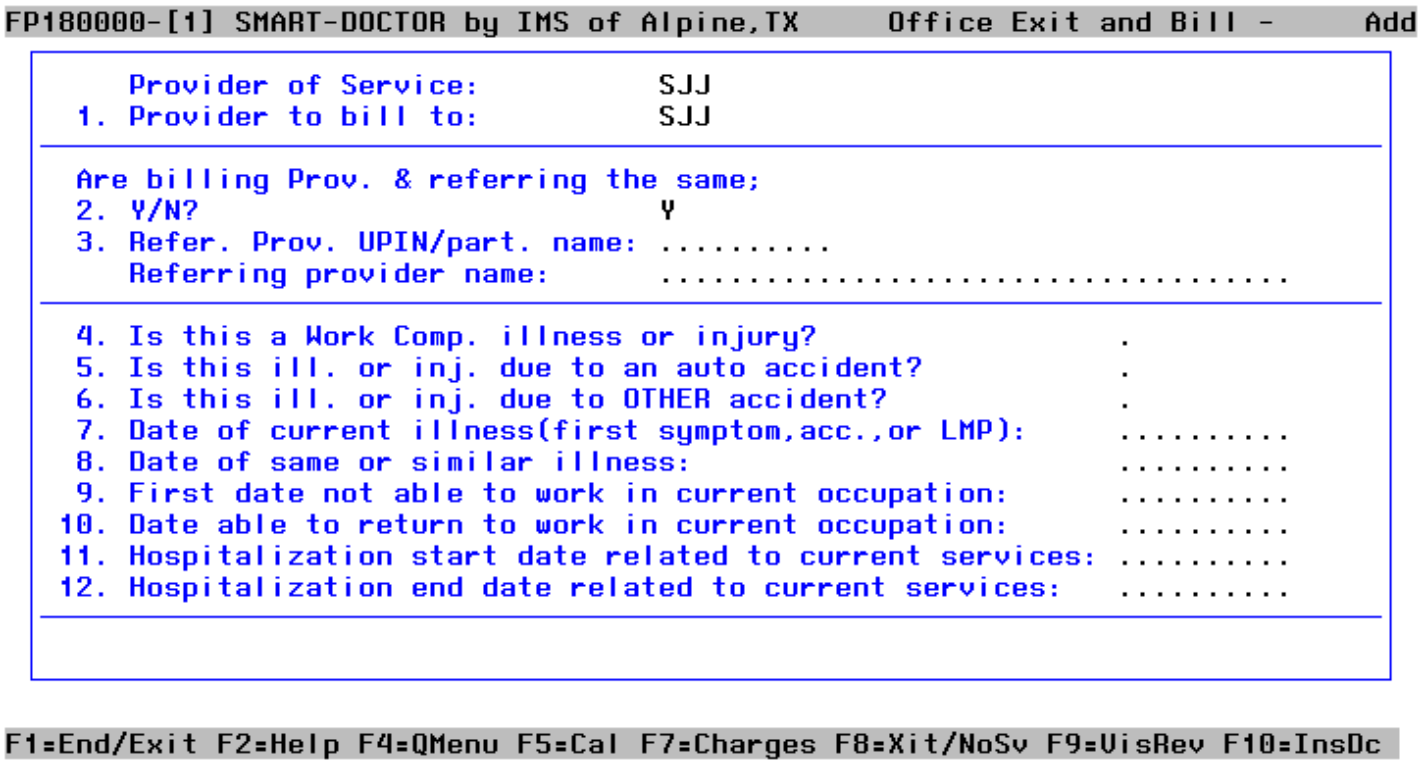


Figure 107 Referring Provider and Visit Information screen.

On the remaining prompts 4 through 12, you can take the default values, or enter the appropriate information. The <F2> can be used at each prompt to get context specific help. Prompts 4 through 6 have a logic check so that you do not make mutually exclusive choices. Basically what is being asked here, is someone else possibly responsible for the bill.

The next screen that pops-up is the charges screen, as seen in Figure 108. Here the charges entered by the provider and the system (InHouse lab, automated lab, and InHouse X-Rays) are listed in the top half of the screen. The base fee as well as the standard adjustment and final fee are shown. The standard adjustment is the contracted (or reduced amount) for this carrier, to be distinguished from a write-off. The fees for all CPT and other procedure codes are defined in the Procedure file, described elsewhere in this manual. The only thing that can be done on the top half of the screen is change the modifier by going to that line in the change mode, or deleting the charge entirely.

By hitting the <F9> key while in this area of the screen, a list of acceptable modifiers will be presented, as seen in Figure 109.

Scroll to the modifier you want and hit <enter>. A star “*” will be placed next to that item. Do the same for up to 4 selections. Delete the previous selection by going back to it and hitting <enter> again. When satisfied you have specified the modifiers you want, hit the <F1> key to accept them. Also, you can hit <F1> without starring any selections to get a blank field.

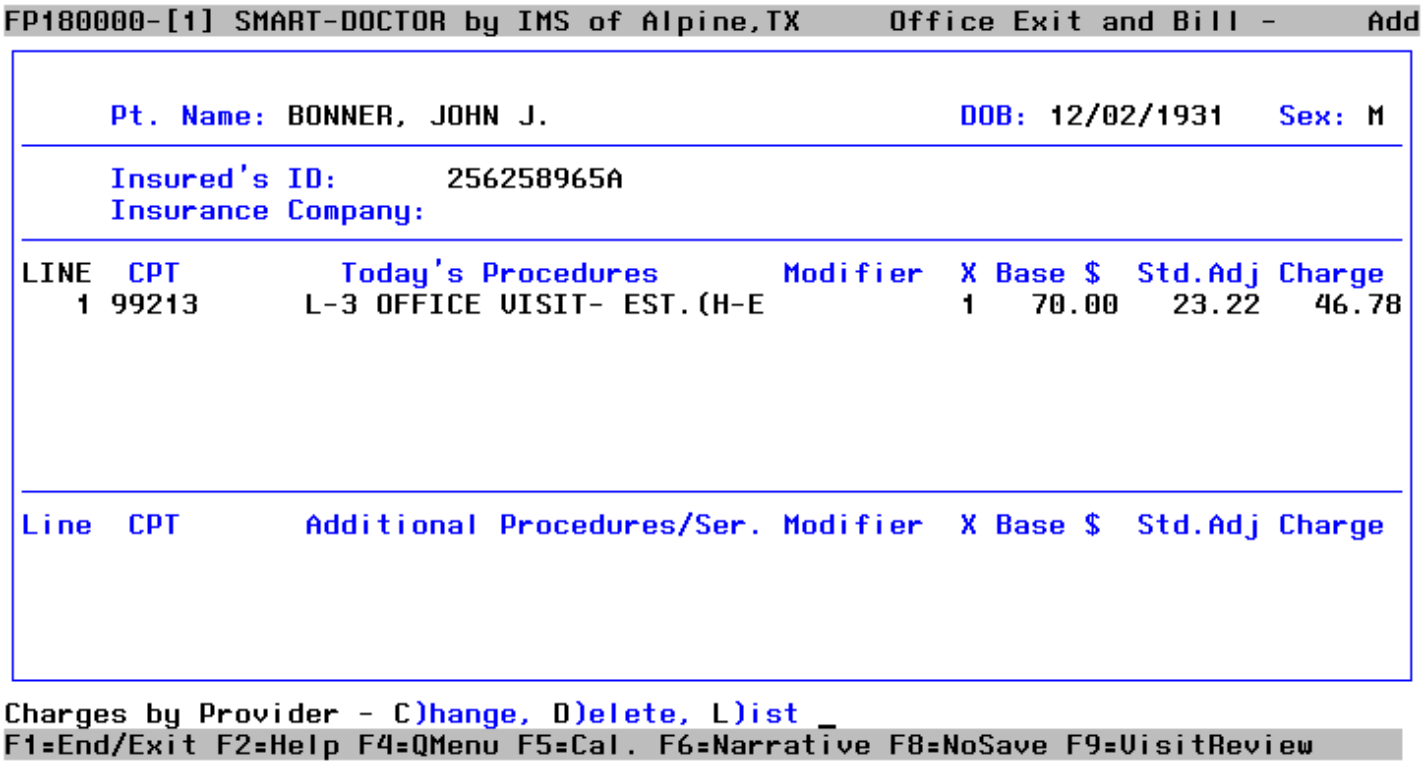


Figure 108 *Provider Charges and System Charges.*

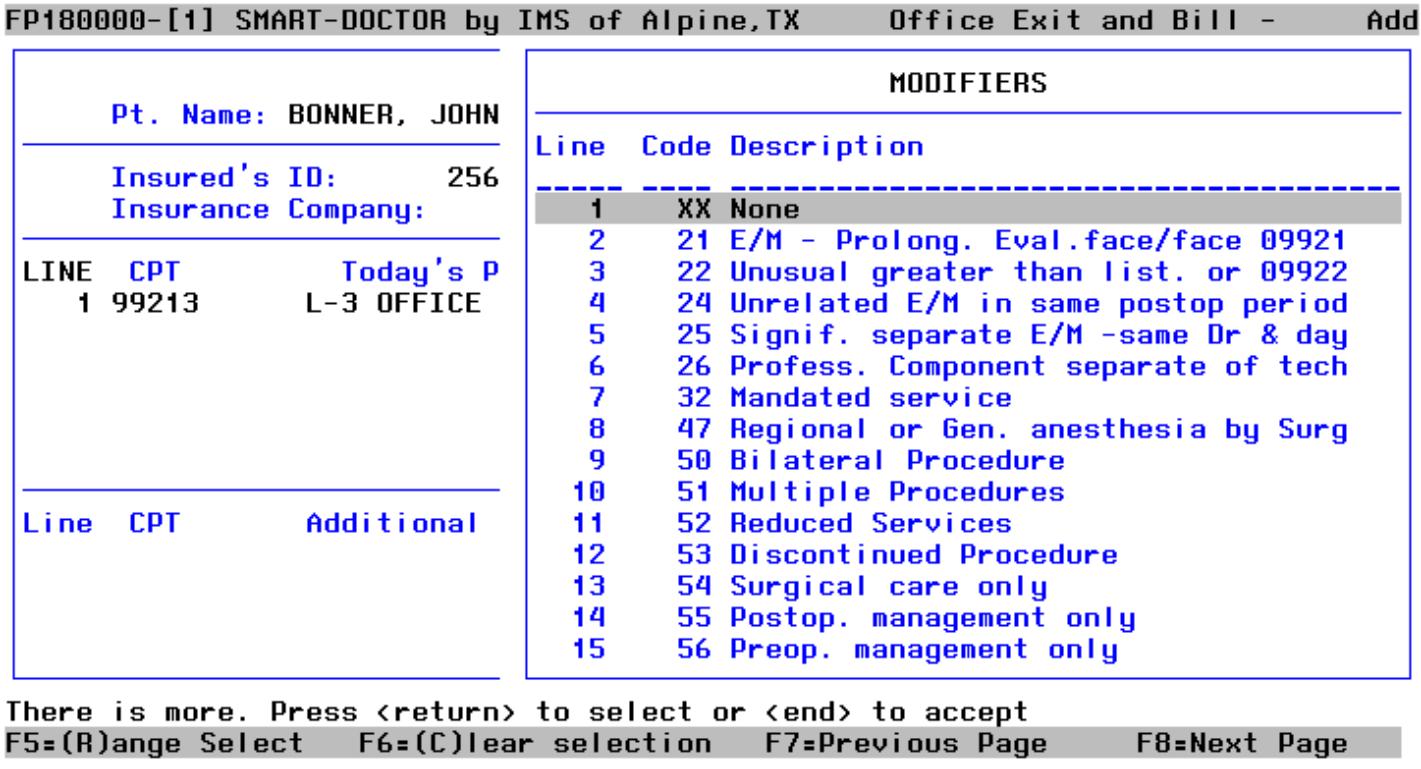


Figure 109 *Adding Modifiers to Provider Charges.*

In the bottom half of the screen, additional procedure charges can be entered.

Adding or changing additional charges, besides the charges indicated by the provider, is done after

exiting the multi-value prompt on the top half of the screen. If you need to get back to the top half of the screen to change modifiers or delete a charge, you can do so by entering a “u” for up, at the change prompt for the multi-value at the bottom half of the screen.

Both the provider placed charges on the top half of the screen and the additional charges added on the bottom half of the screen are checked for age and sex appropriateness, as well as Medicare Correct Coding Initiative (CCI) checks. You will be prompted to select again, or asked to add a modifier.

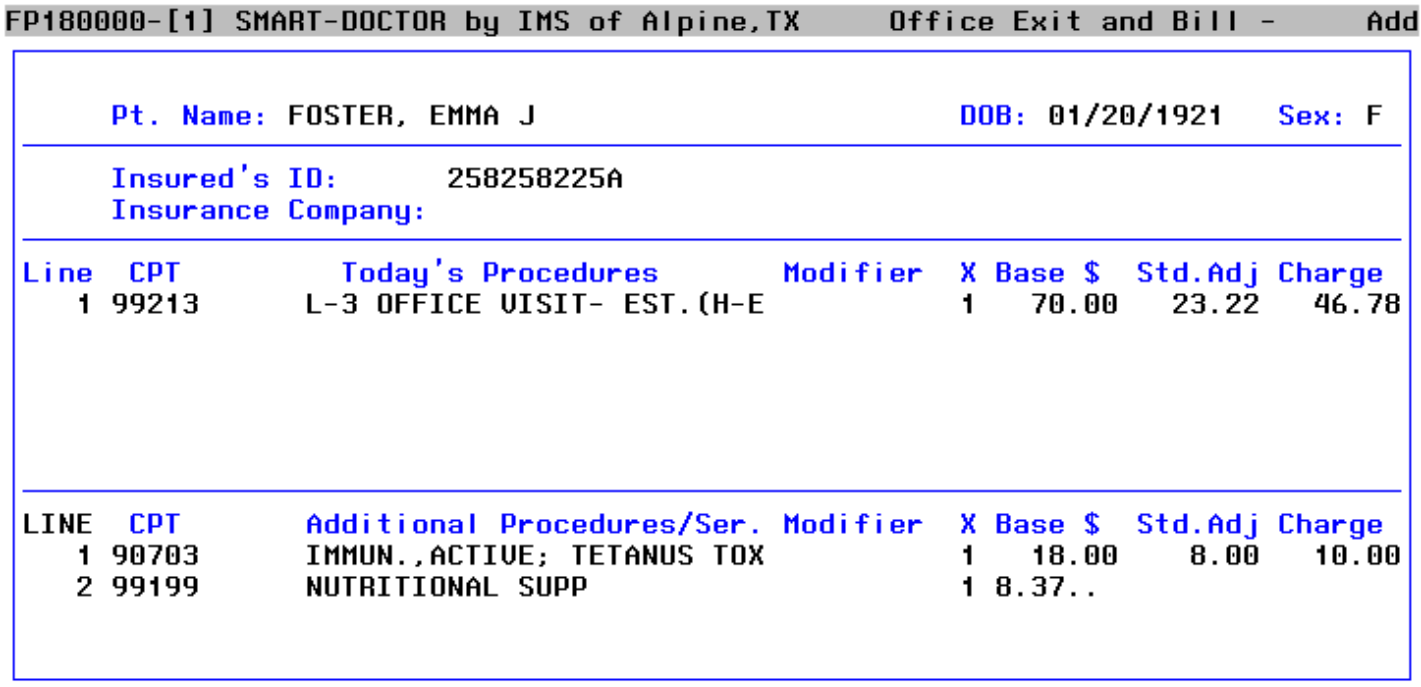


Figure 110 *Adding Additional Charges.*

In the example seen in Figure 110 above, the first additional charge for a tetanus toxoid immunization was added as an after thought, after the provider completed the note and charges. Note that all charges can be added simply by entering part of the description of the procedure or CPT code. In this case “teta “ was entered, and then the proper code was picked from the selection list. All the checks noted above will be done as the codes are added. The fees and adjustments are pulled from the Procedure file. It is a better practice to enter part of the description rather than the actual code number. Since codes are deleted every year, and IMS deletes the cross-reference of these deleted codes, you will not inadvertently enter a deleted code. If you just enter the code number you have memorized, and do not see that it is described as a deleted code, then it will be billed and probably rejected.

The “X” field just before the base fee field is to indicate the number of units to charge. The default is “1”, which would be correct for most situations.

In a second example, a special type of charge is being added as a nutritional supplement. The “99199” is a non-existent CPT code number. This is the only code in the system in which you can enter the fee as you wish, under the base fee field. This was done for those practices that sell nutritional supplements of varying prices. In general, this should be done as a stand alone bill, and not part of a

bill sent to a carrier (generally a non-visit bill). All carriers will reject any such charges.

NARRATIVE <F6> SCREEN

Hitting the <F6> will bring you to the narrative screen, as seen in Figure 111. Go to this screen if you know that the primary procedure needs a narrative to be sent with the claim.

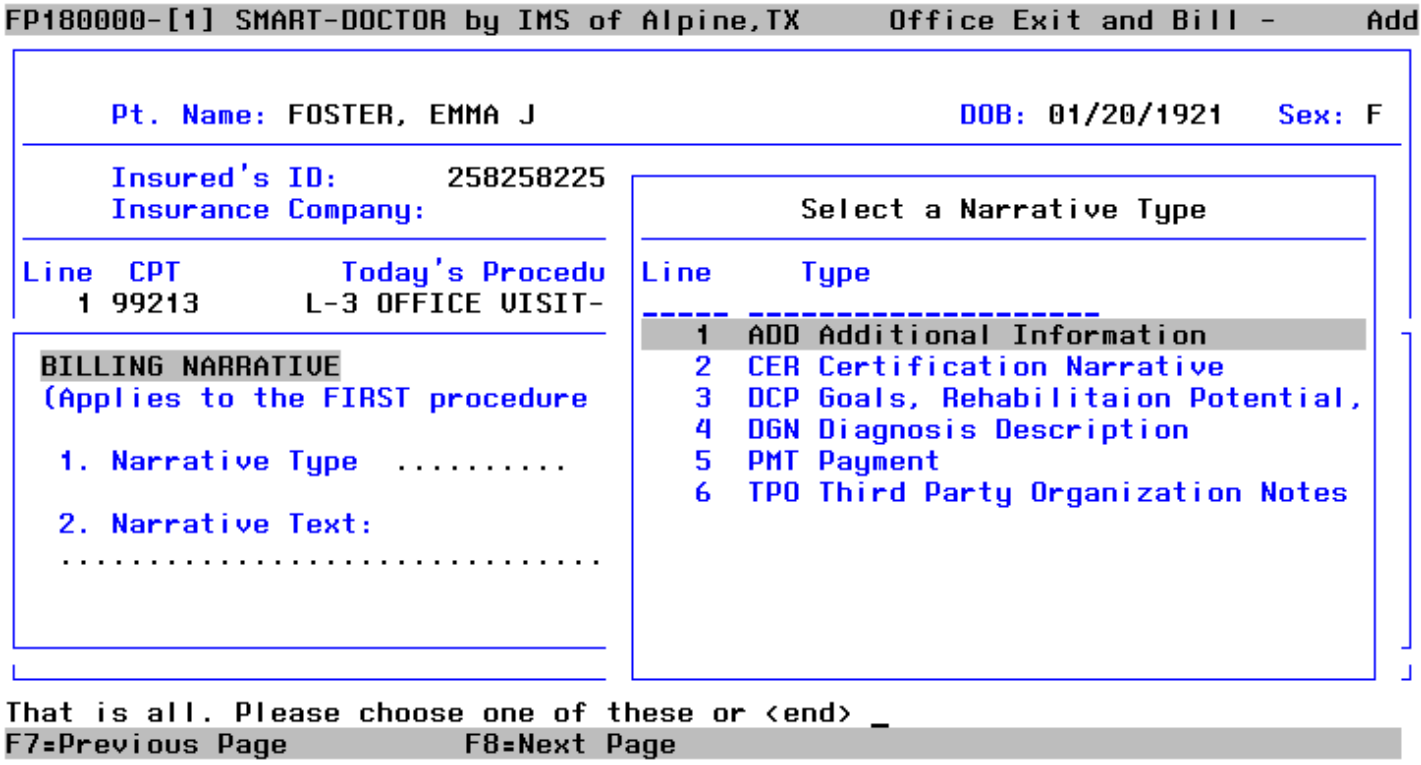


Figure 111 *Selecting Narrative Type.*

When the narrative screen first pops-up, you will be asked to select from one of the permitted types of narrative reports. Once this is done you will be able to enter one line of text to send with the claim, as shown in Figure112.

The narrative will apply only to the first procedure listed. If you have multiple charges to enter, and they each need a narrative, then enter each additional procedure as a non-visit bill, and delete those from this bill.

VISIT REVIEW <F9> SCREEN

The visit review screen shown below in Figure 113, is the one time that the billing personnel can see the visit record. They can only view the visit they are currently billing, and are in the inquire mode so that the record cannot be altered. This screen allows the billing personnel to review the visit for additional charges. Confidential, provider only information, is not displayed.

AUTOMATIC EXIT SCREENS

The first exit screen for a Medicare carrier is shown in Figure 114 below. This screen shows the Medicare discount and the total fee due.

```
FP180000-[1] SMART-DOCTOR by IMS of Alpine,TX     Office Exit and Bill -     Add

     Pt. Name: FOSTER, EMMA J                          DOB: 01/20/1921   Sex: F

     Insured's ID:       258258225A
     Insurance Company:

Line  CPT          Today's Procedures        Modifier  X Base $  Std.Adj Charge
   1 99213      L-3 OFFICE VISIT- EST.(H-E              1   70.00   23.22   46.78

 BILLING NARRATIVE
 (Applies to the FIRST procedure listed ONLY.)

  1. Narrative Type  ADD

  2. Narrative Text:
  Needed re-evaluation early due to poorly controlled blood pressure._.......

F1=End/Exit F2=Help F4=QMenu F5=Cal. F6=Narrative F8=NoSave F9=VisitReview
```

Figure 112 *Completed Narrative Billing Note.*

```
FP090805-[2] SMART-DOCTOR by IMS of Alpine,TX Visit Review for Billing - Inquire
 * 1.Visit Number: 117
     Patient Name: FOSTER, EMMA J                          Gen:
     Age:          83  yrs.  4.0 mos.
LINE ---------------- Visit Review (scroll to see all) ----------------------
   1 Patient's Date of Birth:   01/20/21
   2 Reason for Appointment:    F/U HYPERTENSION
   3 Reason for Visit:          F/U HYPERTENSION
   4 Date of Visit:             05/23/04
   5 Time of Visit:             9:15
   6 Patient indicated visit is not urgent
   7                      *****  Vital Signs  *****
   8 Recorded By: STEVE J. JOHNSON, MD
   9 LMP:
  10 Temp. (F):          Systolic BP:   140     Weight:       124 lbs  oz
  11 Heart Rate:   80    Diastolic BP:  90      Ht. in.:      64.0
  12 Respirations: 16    Head Cir. cm.:         Ht/Wt Ratio:  -5 % off Norm
  13                                            BMI:          21.3
  14 Nursing Subjective:
  15   Feeling well, taking meds.
  16            *****  Subjective Patient Information  *****
  17 Visit is F/U; status is Baseline
History - L)ist _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 113 *Visit Review for Billing.*

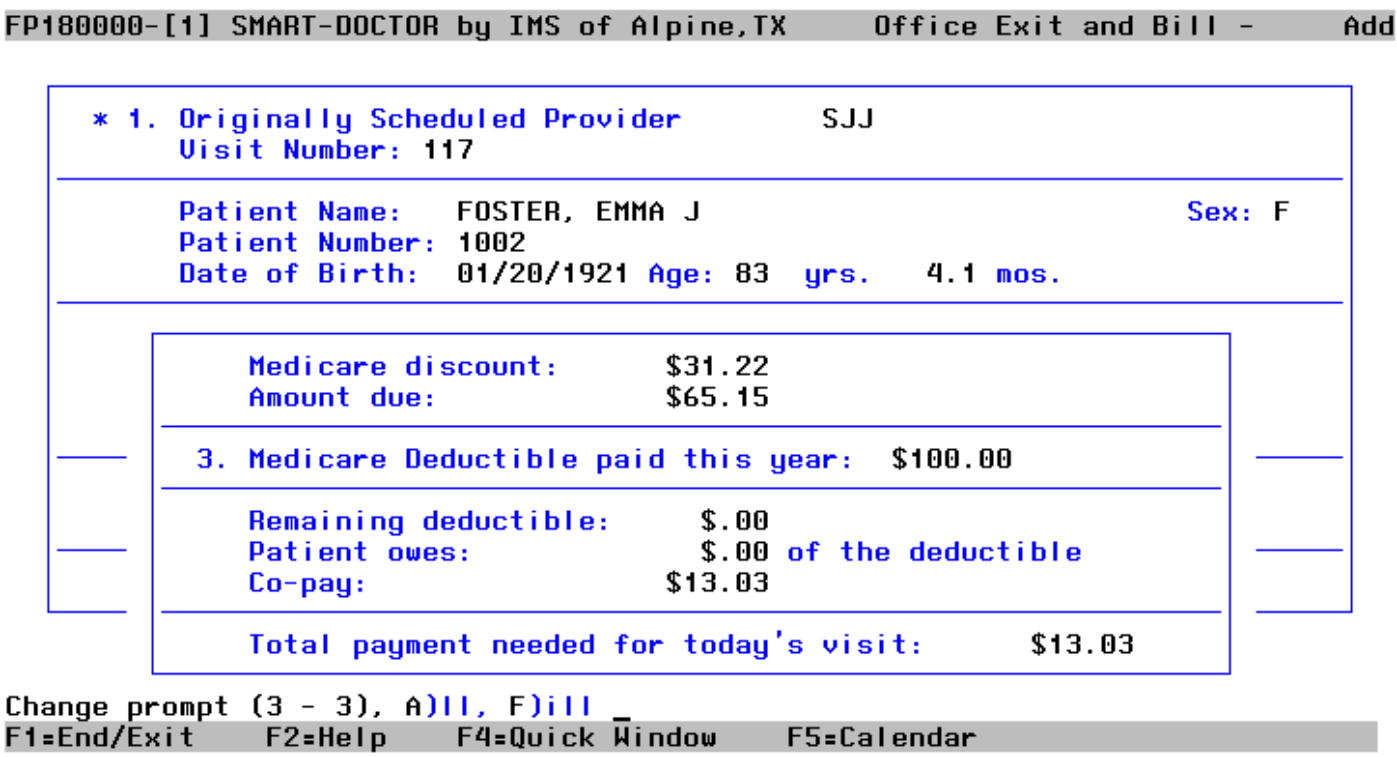


Figure 114 *Medicare Payment Exit screen.*

Prompt #3, "**Medicare Deductible paid this year:**", is where the billing clerk would enter what the patient thinks they paid so far this year. If they paid over $100.00, then you can just enter $100.00, since this is the standard amount they are required to pay by Medicare this year.

The system will then calculate what the patient owes at this time on these charges. A good way to handle things at this time is to tell the patient that their portion of the Medicare charges is ("the amount needed for today's visit"). How would you like to pay for this? At this time the patient may offer to pay, or may ask you to bill them after Medicare has paid. This will allow you to be able to answer the questions on the next automatic exit screen.

The first exit screen for a non-Medicare carrier is different from the Medicare screen as seen in Figure 115. This screen shows carrier specific payment requirements. The standard adjustment if any is shown first, followed by the amount due, the percent to be paid by the patient, any basic visit co-pay required, and the deductible for this policy per year.

Prompt #1, "**Deductible paid this year:**", is where you will enter the amount that the patient thinks they have paid this year on this policy.

The area of the screen for "Carrier Specific Instructions", is information from this carriers file with any other specific instructions, relating to payments or restrictions on this policy. These are informational only and cannot be changed here.

Prompt #2, "**Add Additional Required Amounts**:", can be used to add additional amounts based on the Carrier Specific Instructions. Or, this prompt can be used to add negative amounts to eliminate a co-pay amount based on this information.

None of these calculations will affect the basic charges, but is only an on-line assistant to help you tell

the patient what they should pay today.

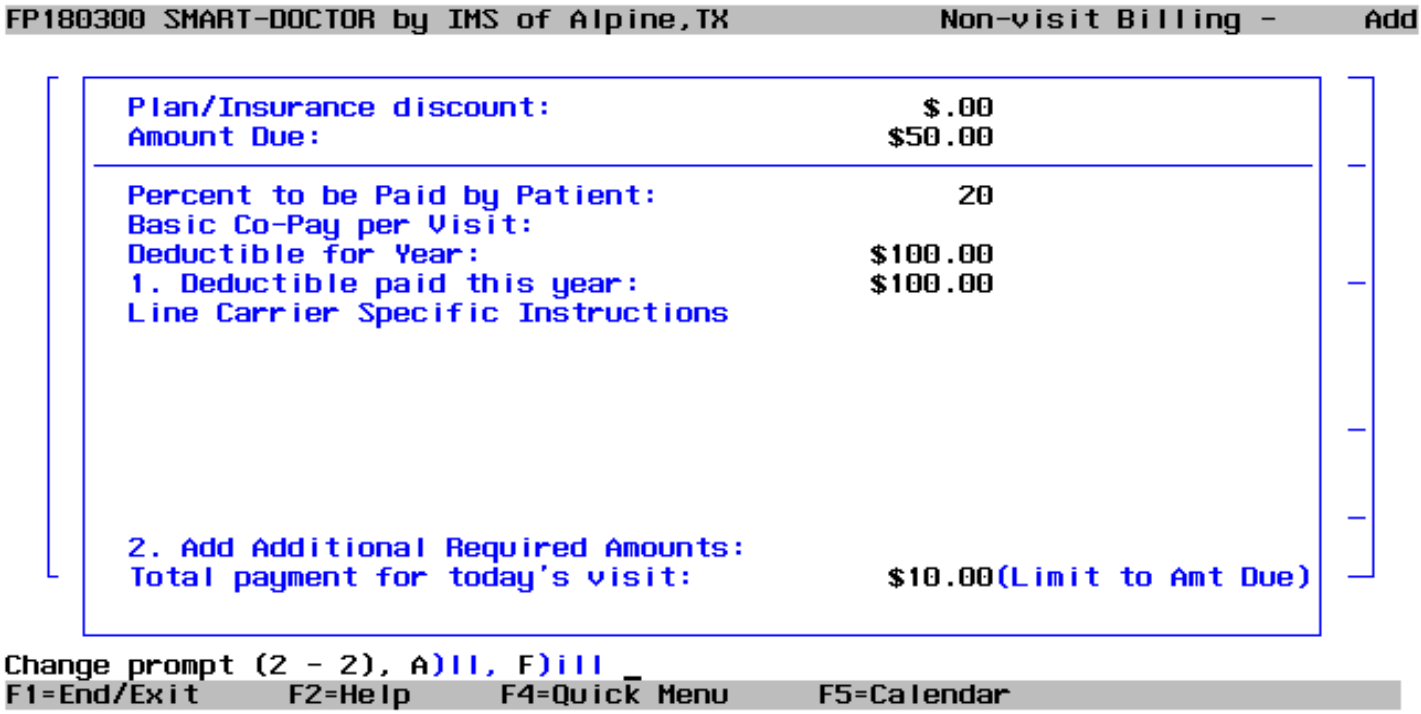


Figure 115 *Standard Carrier Exit Payment screen.*

At this point you will choose one of the two options presented in payment form exit screen shown in Figure 116.

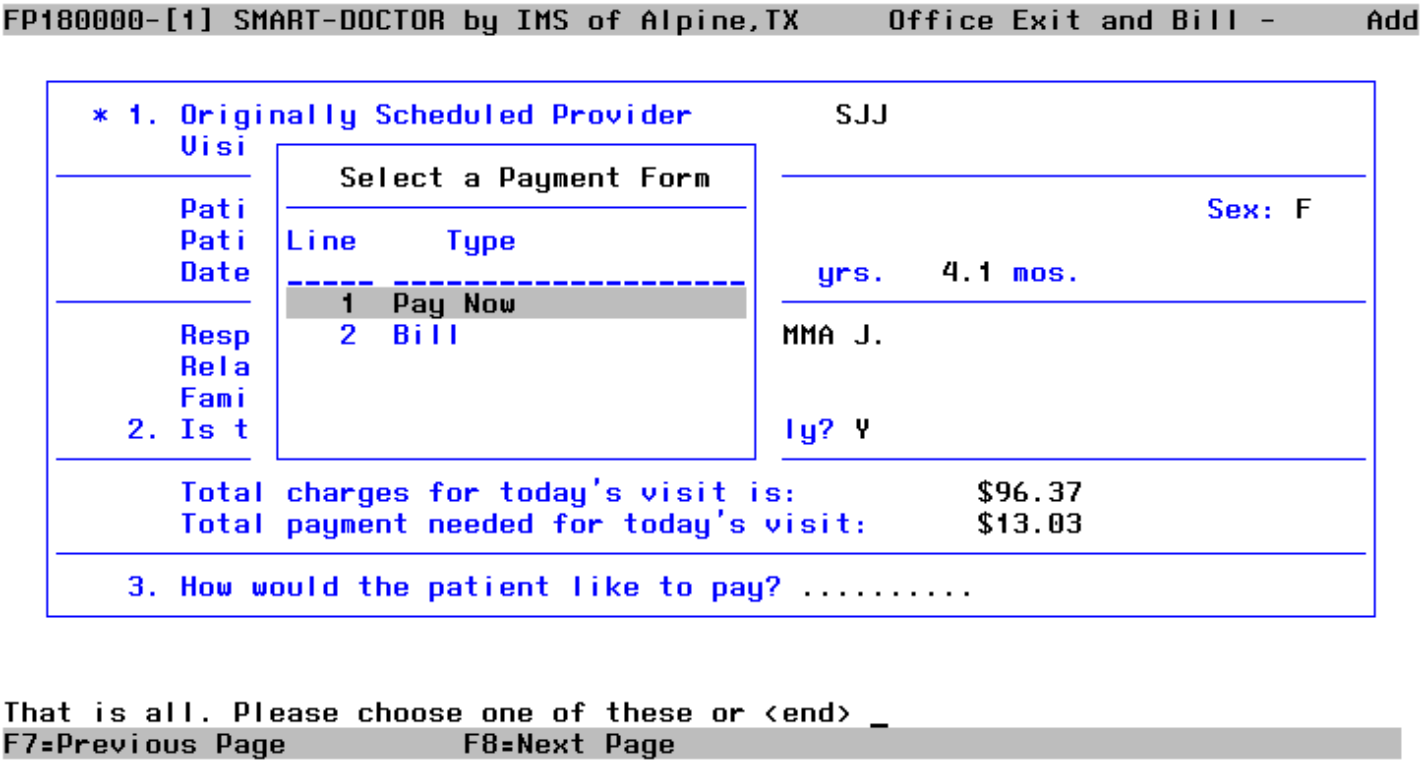


Figure 116 *Select Payment Type.*

AUTOMATIC EXIT BILLING SCREEN FOR PAY NOW OPTION. If the patient elects to pay now, the following payment screens, starting with Figure 117, will be presented. After these screens, the normal exit process will continue (starting at Figure 124).

```
FP220000-[2] SMART-DOCTOR by IMS of Alpine,TX          Family Ledger -  Change

* 1. Family Number:      502
     Responsible Party: FOSTER, EMMA J.                        Gen:
     Address:           HC 67, BOX 33D
     Home Phone:        915-736-6377

     Payment to Distribute:          $.00    Balance to Distribute:          $.00

                                      Res        POS
LINE Chg. Item# Patient               pay  Date    |  Charges    Paid      Balance
   1 ---------- -------------------- - -------- -- ------- --------- ---------
   2 103        BALANCE FWD/CREDIT   I 04/15/98 11      .00       .00        .00
   3 106        FOSTER, EMMA J       I 04/15/98 11    43.31       .00      43.31
   4 110        FOSTER, EMMA J       I 03/31/99 11    78.20       .00      78.20
   5 114        FOSTER, EMMA J       I 05/23/04 11    46.78       .00      46.78
   6 115        FOSTER, EMMA J       I 05/23/04 11    10.00       .00      10.00
   7 116        FOSTER, EMMA J       I 05/23/04 11     8.37       .00       8.37

                                                                          ________
 Pat. Balance:          .00  Ins. Balance:     186.66   Family Balance:     186.66

Items to act on: - S)elect, L)ist _
F1=End-1  F2=Help-2  F3=Billed-3  F5=Cal-5  F6=Dist.Payment-6  F7=Msg-7
```

Figure 117 *Family Ledger screen.*

You have been taken to the Family Ledger to make a payment. The Family Ledger will be discussed further in the Accounts Receivable section. In the current exit example a payment of $10.00 will be posted to the initial charge. This is done by hitting the <F6> key for Distribution of Payments.

The screen shown in Figure 118, allows you to choose how you want to distribute the payment. In this case only the “P” type for for “distribution of Patient/Resp. Payment by dates”, will be shown. The other options will be discussed further in the Accounts Receivable section. Once the type of payment distribution is indicated the appropriate screen will open, as shown in Figure 119 (for this example), below.

Prompt #1, “**Pt./Resp. Paying:**”, (in Figure 119) will be defaulted for you based on your previous choice. This can be over typed if you wish, but it is generally better to leave it as the default or to use some standard text description, should there every be a need to search for all transactions of a specific type (and avoids spelling errors).

Prompt #2, “**Amount to Dist.:**”, enter the amount of money that needs to be distributed. In this example, $10.00 will be used.

Prompt #3, “**Date from:**”, you can hit the <F9> key listed on the bottom of the screen for “Today's” date. This will restrict charges brought up for possible distribution of funds for this starting date to the ending date below. So, to just select today's charges, both should be today's date. Or, enter the first date of service that you want to distribute part or all of this money.

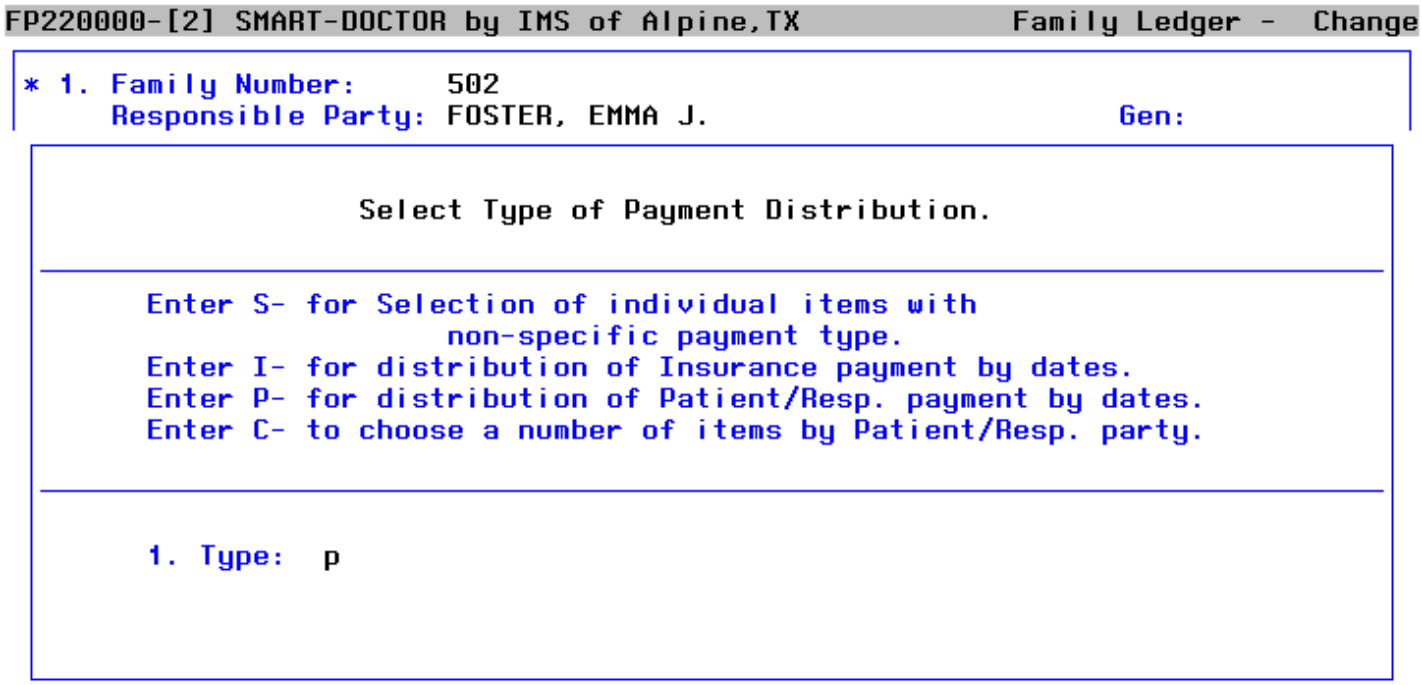


Figure 118 *Select Type of Distribution.*

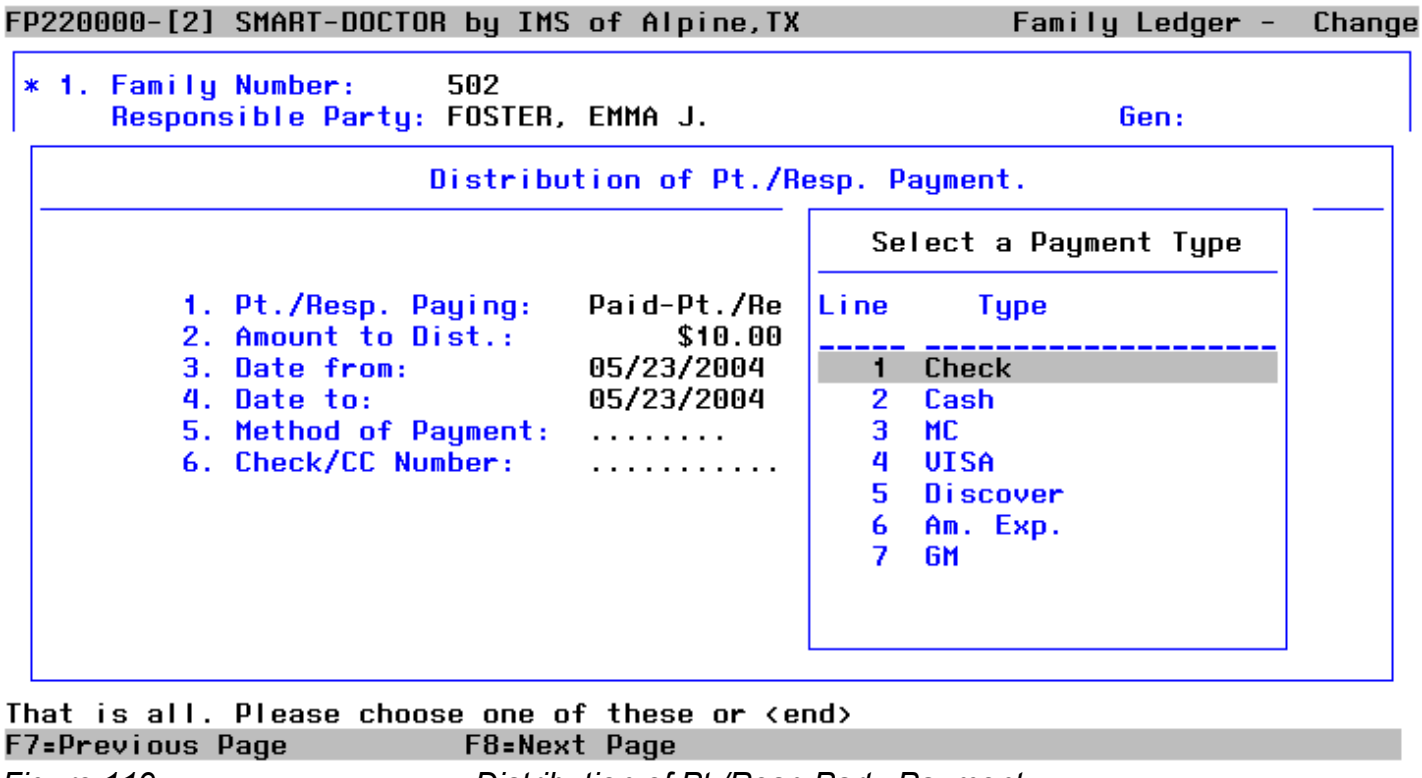


Figure 119 *Distribution of Pt./Resp Party Payment.*

Prompt #4, **Date to:**", will default the date from prompt #3. You can over type this if you wish if prompt #3 was other than today's date. Or, enter the last date of service that you want to distribute part or all of this money.

Prompt #5, "**Method of Payment:**", will have a pop-up screen with the method of payments defined for your clinic. Select the type of payment. These payment types are specified in the Terms file under the "ADM-PAY_TYPE" key. These will be changed for you by IMS at your request. Another standard type in addition to "Check" and "Cash", is "Other", which is not shown here. Most sites use the Check, Cash, or pick a Credit card company. We have added the "Other" category for sites for "Other" types of payments, such as direct deposit. This will be reflected in the report of "Chg, Adj, Pay, by Provider", menu item #17 of the Reports Menu.

Prompt #6, "**Check/CC Number:**", if you choose other than cash, enter the check or credit card number as per your clinic policy. Selecting Cash, will cause this field to display "--", since there is no number to record.

You will next be taken to the transaction file, as seen in Figure 120, where all transaction on the charge item will take place. The charge items that can be acted upon, based on your date selection, will be presented one at a time. If the transaction item is the one you want to apply payments to, then hit <A> at the change prompt to start adding to the the multi-value prompt. Otherwise, hit the <F1> key to end input on this item and go to the next one (if there are any more).

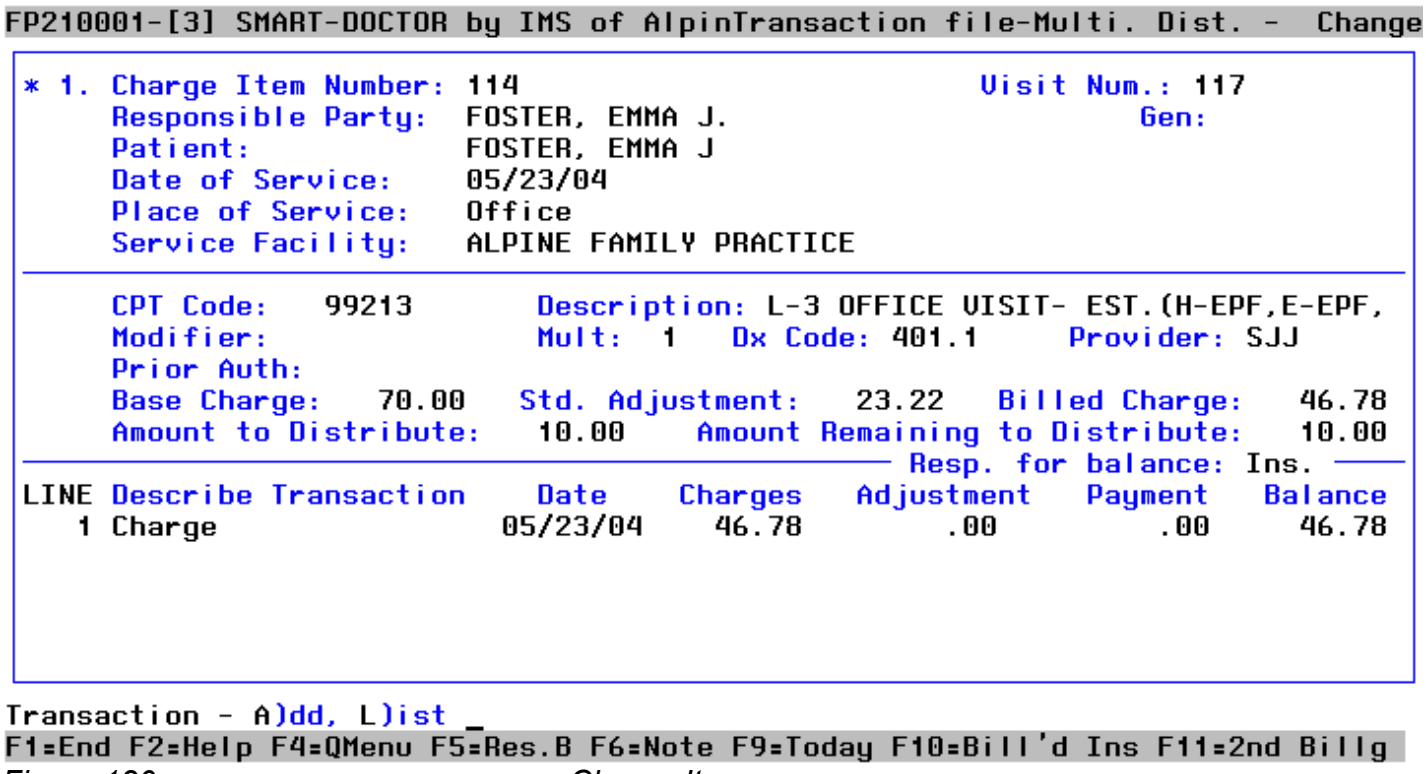


Figure 120 Charge Item screen.

The next screen, as shown in Figure 121, shows the automatic step after a line was added and a payment of $10.00 was made. Please note that the above screen shows an "Amount Remaining to Distribute:" to be "10.00". Compare this to the next screens, as shown in Figures 121 and 122, after the payment has been posted.

Once the amount has been posted, a pop-up screen is presented (Figure 121) in which you may select one of these descriptions to be defaulted in the first field of the next multi-value line. If you do not want to make any changes or adjustments, just hit the <F1> key to end input.

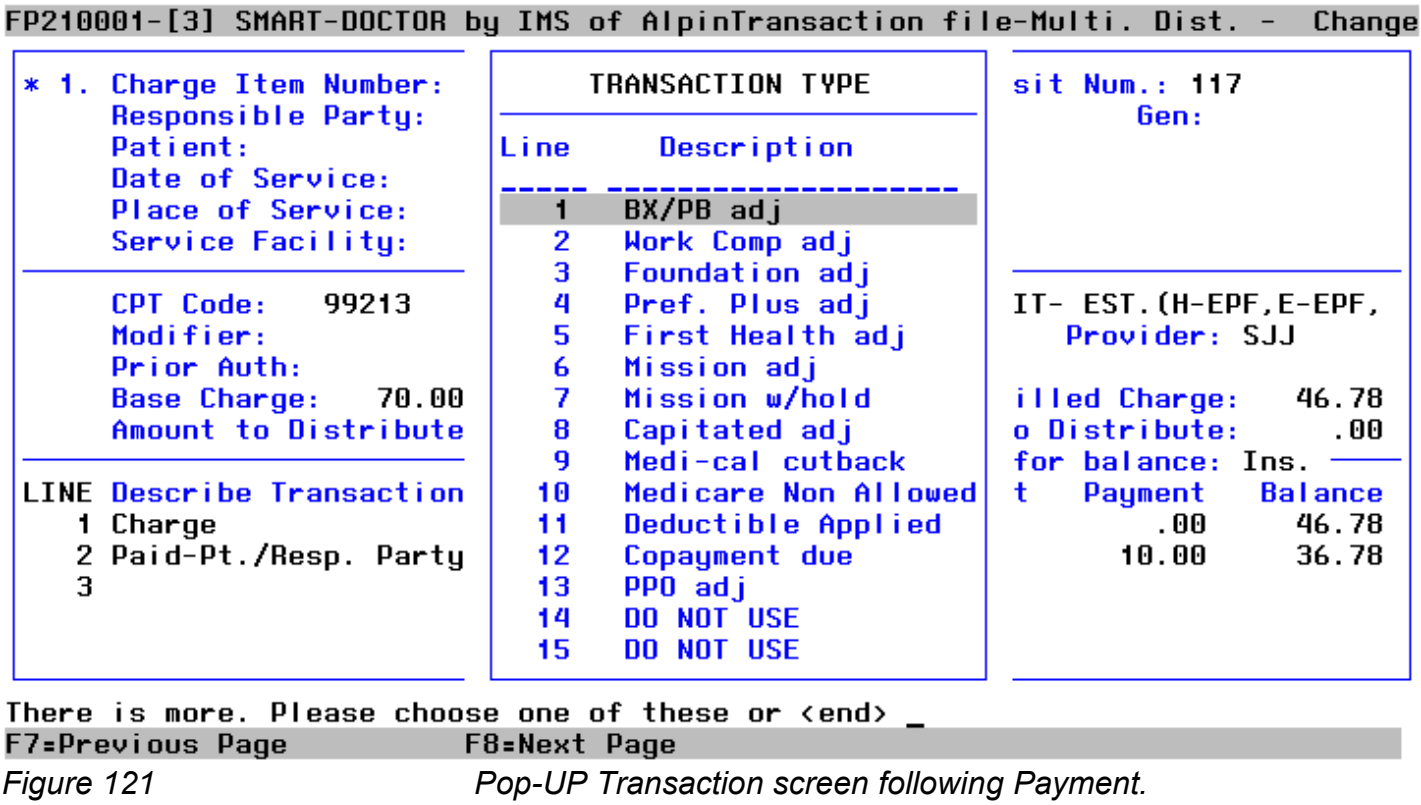


Figure 121 *Pop-UP Transaction screen following Payment.*

The following screen, Figure 122, shows the results of the actions taken above, assuming the <F1> key was hit, to not add any transactions such as adjustment on the line following the payment line.

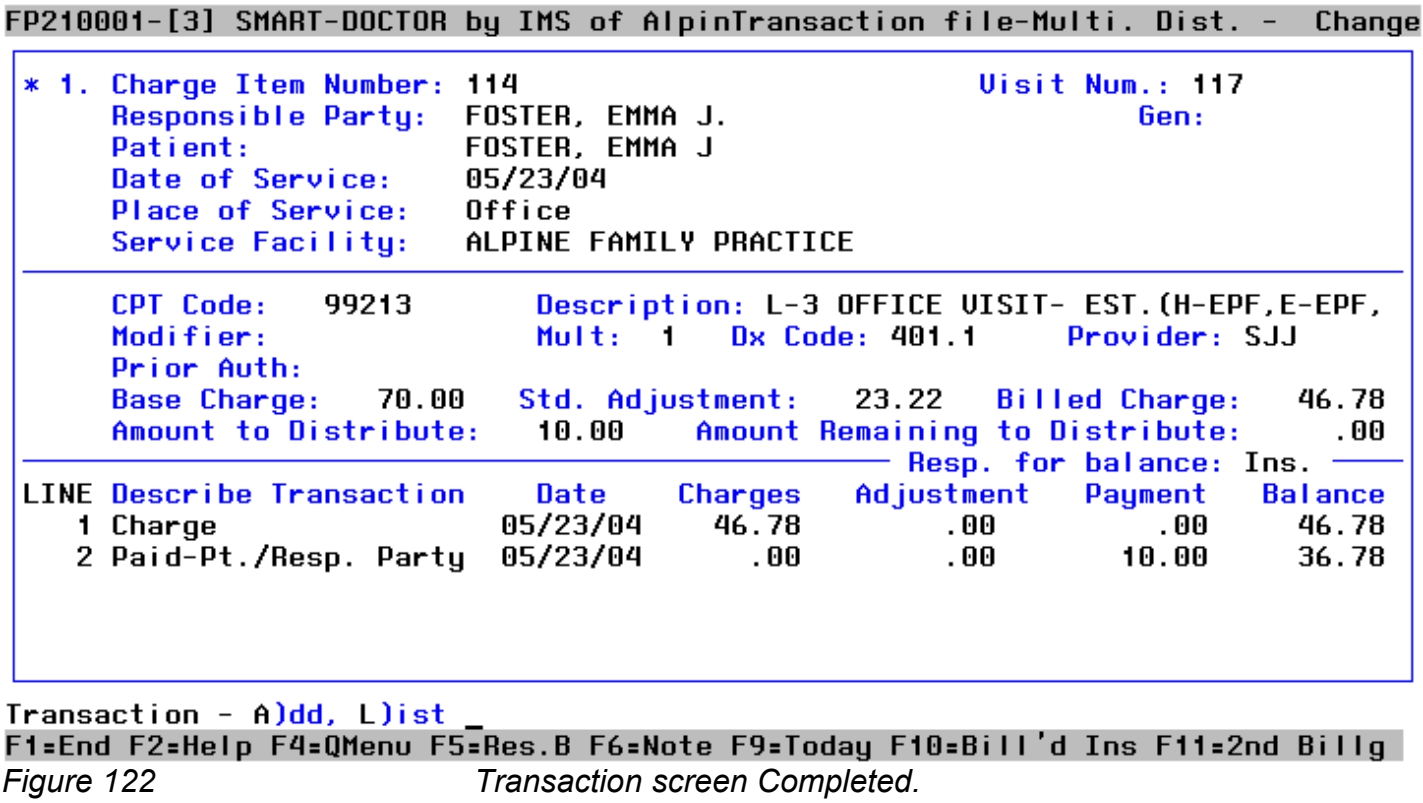


Figure 122 *Transaction screen Completed.*

Any other transactions for this date range will be presented next. To skip these, if there are any, just

hit the <F1> key to skip (end). On return to the main Family Ledger screen, the results of these actions are shown, with the Family Balance reflecting these changes, as seen in Figure 123.

```
FP220000-[2] SMART-DOCTOR by IMS of Alpine,TX          Family Ledger -  Change

* 1. Family Number:      502
     Responsible Party: FOSTER, EMMA J.                      Gen:
     Address:           HC 67, BOX 33D
     Home Phone:        915-736-6377

     Payment to Distribute:      $10.00    Balance to Distribute:        $.00

                                      Res        POS
LINE Chg. Item# Patient               pay  Date    |  Charges   Paid      Balance
   1 ---------- -------------------- - -------- -- ------- --------- ---------
   2 103        BALANCE FWD/CREDIT   I 04/15/98 11      .00       .00        .00
   3 106        FOSTER, EMMA J       I 04/15/98 11    43.31       .00      43.31
   4 110        FOSTER, EMMA J       I 03/31/99 11    78.20       .00      78.20
   5 114        FOSTER, EMMA J       I 05/23/04 11    46.78     10.00      36.78
   6 115        FOSTER, EMMA J       I 05/23/04 11    10.00       .00      10.00
   7 116        FOSTER, EMMA J       I 05/23/04 11     8.37       .00       8.37

 Pat. Balance:        .00  Ins. Balance:     176.66   Family Balance:     176.66

Items to act on: - Enter the line number to select
F1=End-1  F2=Help-2  F3=Billed-3  F5=Cal-5  F6=Dist.Payment-6  F7=Msg-7
```

Figure 123 *Family Ledger After Payment Posted.*

Next you will be taken back to the automatic exit screens.

AUTOMATIC EXIT SCREENS (continued).

Prior to going to the final exit screen you may be taken to one or more optional screens for order processing, referrals, appointment follow-ups, etc. The number of optional screens depends on the provider's orders. All orders not processed as requested at time of exit are automatically stored for later processing in the “Orders Incomplete & Pending” screens from main menu item # 7.

OPTIONAL SCREEN FOR: NON-AUTOMATED OUTSIDE LAB PROCESSING. See Figure 124 below. From this screen you would hit the <F9> key to print information for the patient. This will print a lab requisition sheet with all necessary information. Specific information on each lab is contained in the “LAB INFORMATION SCREEN” of the clinic file as discussed in the Clinic File section.

OPTIONAL SCREEN FOR: DX SERVICE – TAKEOFF. See Figure 125 below. To indicate order placed, at the change prompt indicate the line number of the order being processed. The system then will indicate the date and time the order was placed by you.

OPTIONAL SCREEN FOR: PROVIDER REFERRAL – TAKEOFF See Figure 126 below. The first line of this multi-value prompt, shows the name or site of the provider to whom the referral is to be made. Also it shows the when the referral is to take place, and for what diagnosis. The second line is to record the appointment scheduled. To get to this line, indicate the line number you need to work with at the change prompt. While on this second indented line, you will enter the date and time of the appointment. The system will add your user login and the time this line item was completed by you.

You will then be stopped and asked if you want to print out the referral form. The answer, generally, should be yes. The referral form, similar to the example shown in Figure 127 below, will then be printed for you to give to the patient.

The form contains the following information:
1. Patient name, Patient Number, and DOB.
2. The Health Care Provider to whom the patient is being referred, including:
   Name, Address, Phone Number, Appointment Date, and Time of Appointment.
3. The reason for referral.
4. The referring providers comments regarding the referral.
5. The referring providers name, UPIN number, and date of referral.
6. The patient's Active Medical Problem List.
7. The patient's Chronic Medications and Acute Medications of the Past 12 Months.
8. The patient's Past Medical History, including:
   Past Medical Problems, Past Surgeries and Procedures, Allergies, Immunizations, Reproductive History for Females, Family Medical History with age of onset and relation, Hospitalizations including duration of stay and admit date.

If the referral is not completed, then this referral will be stored for later processing in the “Orders Incomplete & Pending” screens from main menu item # 7.

```
FP160116-[2] SMART-DOCTOR by IMS of AlpiPending Labwork - Exit Billing -  Change

* 1. Patient Number:    1002
     Patient Name:      FOSTER, EMMA J
     Sex:               F
     Date of Birth:     01/20/1921
     Provider:          STEVE J. JOHNSON, MD

                        _Scheduled Patient Lab Work_

LINE Lab Work:                  When     Reason                    Status
   1 CBC WITH DIFFERENTIAL/P    05/23/04 401.1                     REQUISITION

SPECIMEN=Send pt. back to have specimen drawn before leaving.
OVERDUE=Send pt. to have specimen drawn, or have dr. or rn. cancel lab.
REQUISITION=Print out requisition for this outside labwork.
SCHEDULED=Print out reminder for patient to come in for labwork.

Lab Test Name - L)ist
F1=End/Exit  F2=Help  F4=QMenu  F5=Cal  F8=Exit/NoSave  F9=Print Pt. Info
```

Figure 124 Order for Non-Automated Outside Lab Work.

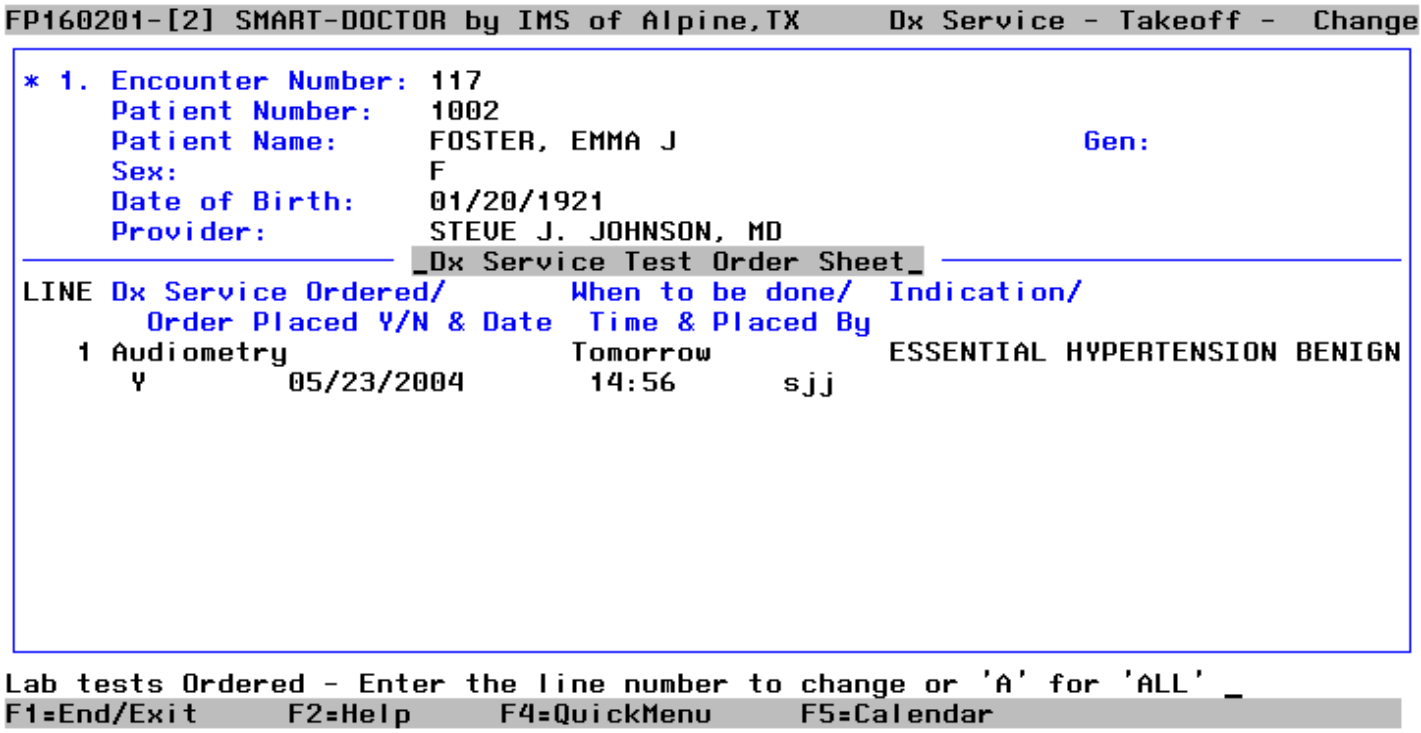


Figure 125 *Orders for Diagnostic Services.*

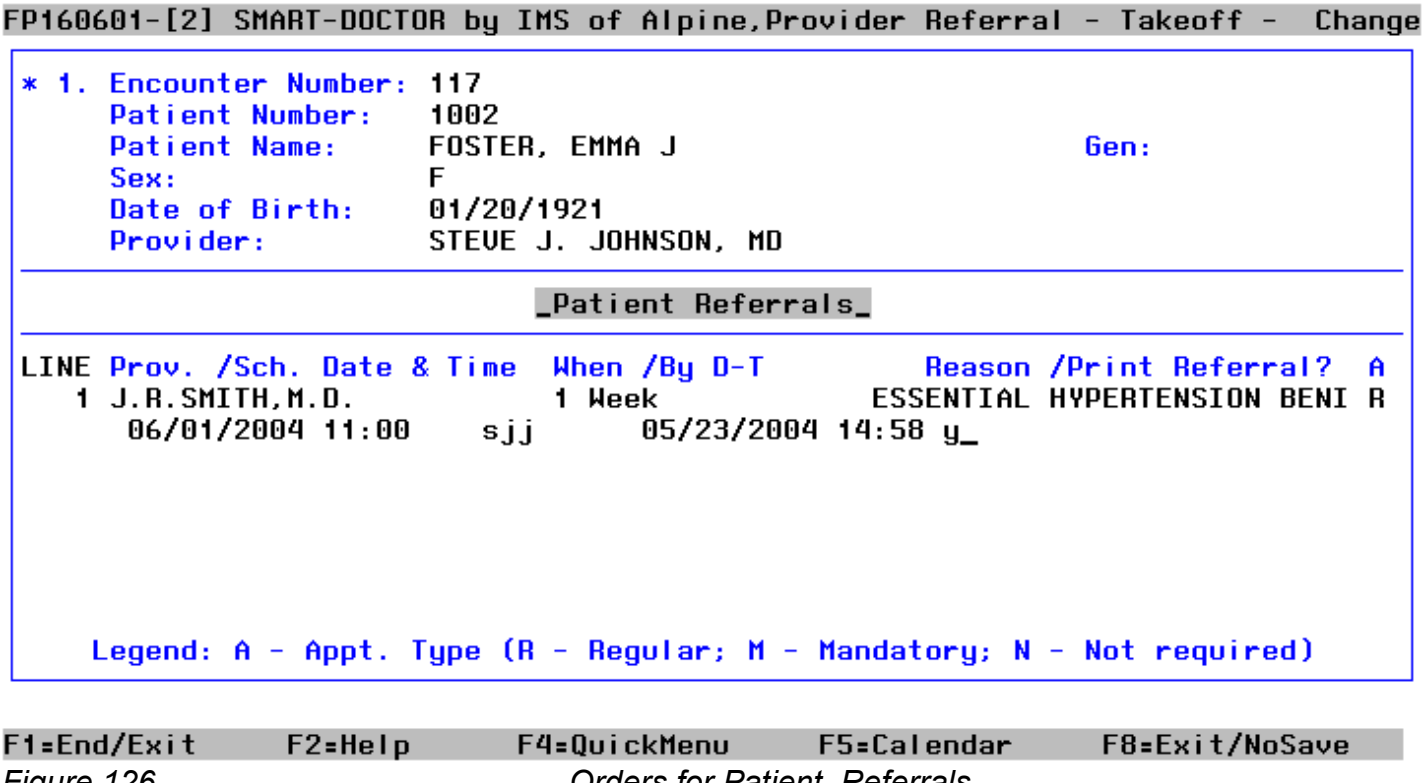


Figure 126 *Orders for Patient Referrals.*

FOSTER, EMMA J Patient No.: 1002 DOB: 01/20/21

Referral To: J.R.SMITH,M.D.
Address: 1112 12TH STREET ALPINE TX 79830
Phone: 915-876-2536
Appt. Date: 05/24/2004 Appt. Time: 4:00

Reason For Referral: ESSENTIAL HYPERTENSION BENIGN
Comment: Please eval and Rx
Referring Provider: STEVE J. JOHNSON, MD
Referring Provider UPIN: U765434 Date of Referral: 05/24/2004

Following is this patient's Active Medical Problems, Medications, and Past Medical History.

***** ACTIVE MEDICAL PROBLEMS *****

*DX CODE	Description	Onset	#Vs	Recorded
401.1	ESSENTIAL HYPERTENSION BENIGN	04/15/98	5	05/24/04
238.2	NEOPLASM OF SKIN - OF UNCERT. BEHAV.	04/15/98	1	04/15/98

****** CHRONIC MEDICATIONS AND ACUTE MED'S OF PAST 12 MONTHS ******

*Substance	Brand Name	Dose	Amount	Freq.	Dis.	Nur	# Rfls	Last Rx
ATENOLOL	TENORMIN	25	1 Tab	q day	60	Y	1	033199

***** PAST MEDICAL HISTORY *****

*DX CODE	PAST MEDICAL PROBLEMS	Onset
562.10	DIVERTICULOSIS OF COLON	07/07/96
401.1	ESSENTIAL HYPERTENSION BENIGN	01/01/81

*CPT CODE	PAST SURGERIES AND PROCEDURES	Date
58150A	TOTAL ABD HYSTERECTOMY W BILAT SAL OOP	01/01/71

*ALLERGIC TO	COMPOUND CLASS	Reaction
ERYTHROMYCIN DELAYED/REL*Or	MACROLIDE	MINOR

*TYPE OF IMMUNIZATION	Date
Flu	10/01/96
Flu	10/01/95
Pneumo	01/01/94

*REPRODUCTIVE HISTORY:	Gravida	Para	Ab
	3	3	0

*FAMILY DX	Desc. of Blood Relative Condition	Onset Age	Relation
250.00	DIABETES MELLITUS NIDDM CONTROLLED	60	M
162.9	MALIG. NEOPLASM BRONCHUS & LUNG, UNSP *	70	F

*HOSP DX	Hospitalization For:	# Days	Adm Date
626.2	EXCESSIVE OR FREQUENT MENSTRUATION	3	01/01/71

*** End of Referral Request ***

Figure 127 *Example Patient Referral Form.*

OPTIONAL SCREEN FOR: SCHEDULE PROCEDURES – TAKEOFF. See Figure 128 below. On this screen, you select the order you want to work with at the change prompt. Once you have scheduled the patient procedure via the <F4> QuickMenu, indicate <Y> in the first field of the second half of the multi-value line. The system will place the current date, time, and user. If you do not indicate that the order has been placed, then this order will be stored for later processing in the "Orders Incomplete & Pending" screens from main menu item # 7.

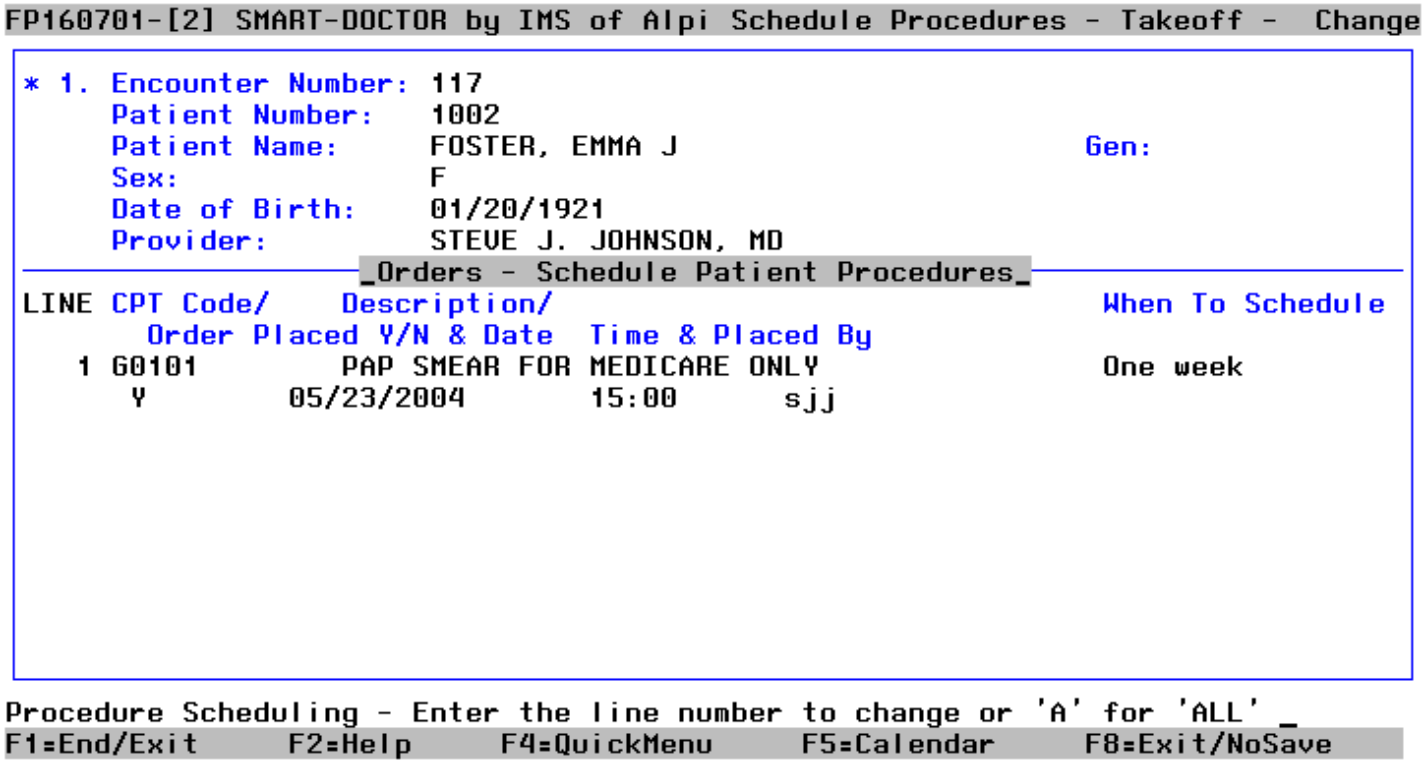


Figure 128 *Orders to Schedule Patient Procedures.*

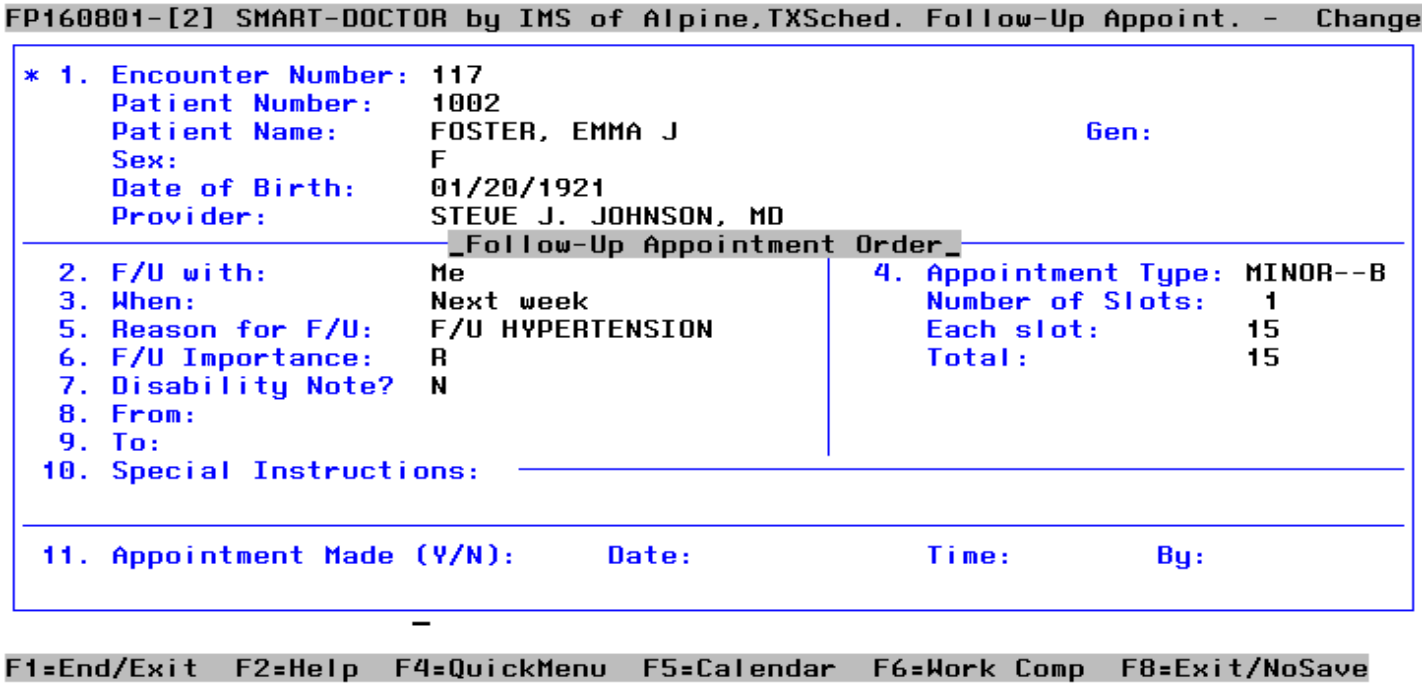


Figure 129 *Orders for Follow-Up Appointments.*

OPTIONAL SCREEN FOR: SCHEDULE FOLLOW-UP APPOINTMENTS. See Figure 129 above. Information through prompt #10 is completed for you by the system, based on the providers order. Once you have made the follow-up appointment (via the QuickMenu), choose prompt #11 from the change prompt to record the date of the appointment.

If you do not indicate that the appointment has been made as described above, then this order will be stored for later processing in the “Orders Incomplete & Pending” screens from main menu item # 7.

OPTIONAL SCREEN FOR: PATIENT INSTRUCTIONS – TAKEOFF. See Figure 130 below. All those patient information documents requested by the provider for you to hand out on patient exit will be presented to you. As you hand out these documents, go to the change prompt and indicate which line item you need to update as given. You indicate the document has been given by placing <y> in the first field of the second half of the multi-value prompt. The system will then place the user and the time done.

If you do not indicate that the materials have been handed out, then this order will be stored for later processing in the “Orders Incomplete & Pending” screens from main menu item # 7.

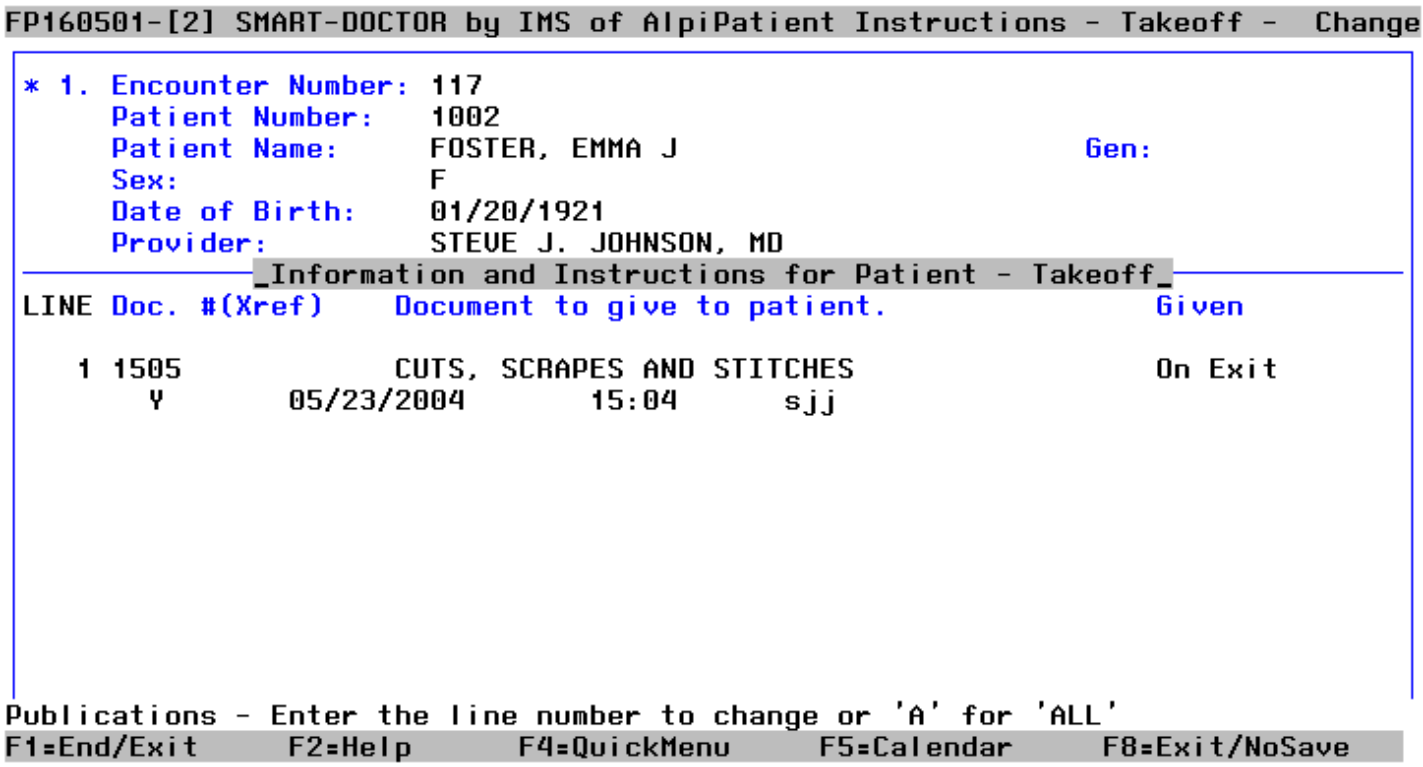


Figure 130 Orders for Patient Instructions and Information Handouts.

FINAL EXIT SCREEN--AUTOMATIC EXIT PROMPTS. See Figure 131 below.

First prompt:
Print Active Problems, Medications, and PMHx? (<enter>=Yes/n=No). Hit <enter> or enter <y> to print the Active Problems, Medications, and PMHx (Past Medical History) list. Enter <n> to skip printing.

Second prompt:
Print the Visit Review? (<enter>=Yes/n=No). Hit <enter> or <y> to print the Visit Review, or hit <n> to skip printing.

Third prompt:
This will either say: "**The Bill will be Sent Electronically**" if the insurance carrier file for this carrier is indicated to be sent electronically, or "**Print the Bill? (<enter>=Yes/n=No)**" if it is not. If the latter, hit <enter> or enter <y> to print the Bill, or hit <n> to skip printing.

The second half of this screen will indicate if the system found a problem with required authorizations. If it is found that a procedure code (CPT, HCPCS, or other) is indicated to require a prior authorization in the insurance carrier file, and no valid prior authorization is found in the patient file for this procedure, then the bill will be suspended and placed in the file of "Bills Needing Prior Authorization". This suspended list of bills can then be processed later by going to prompt #10 (with the same title) on the "Billing" screen. This prevents bills being sent that will be automatically refused by the insurance carrier.

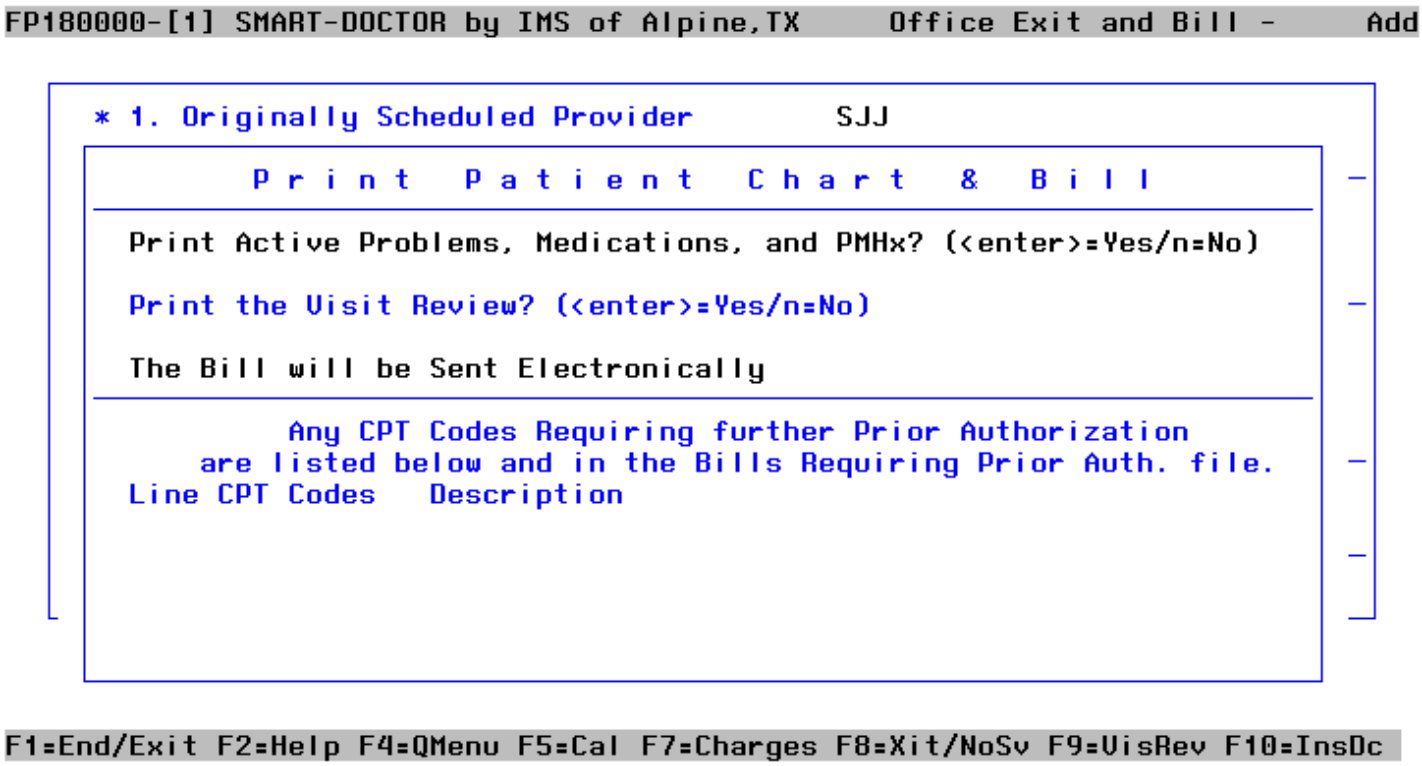


Figure 131 Final Billing Exit screen.

NON-VISIT BILLING SCREEN

Select menu item #2, "**Non-Visit Billing**", from the main billing screen. This will bring up the Non-Visit billing screen as seen in Figure 132 below.

Here, you first enter part of the patient's name to do a cross-reference lookup. The screen then changes (as shown in Figure 133 below) showing the bill number and defaults the family provider's initials.

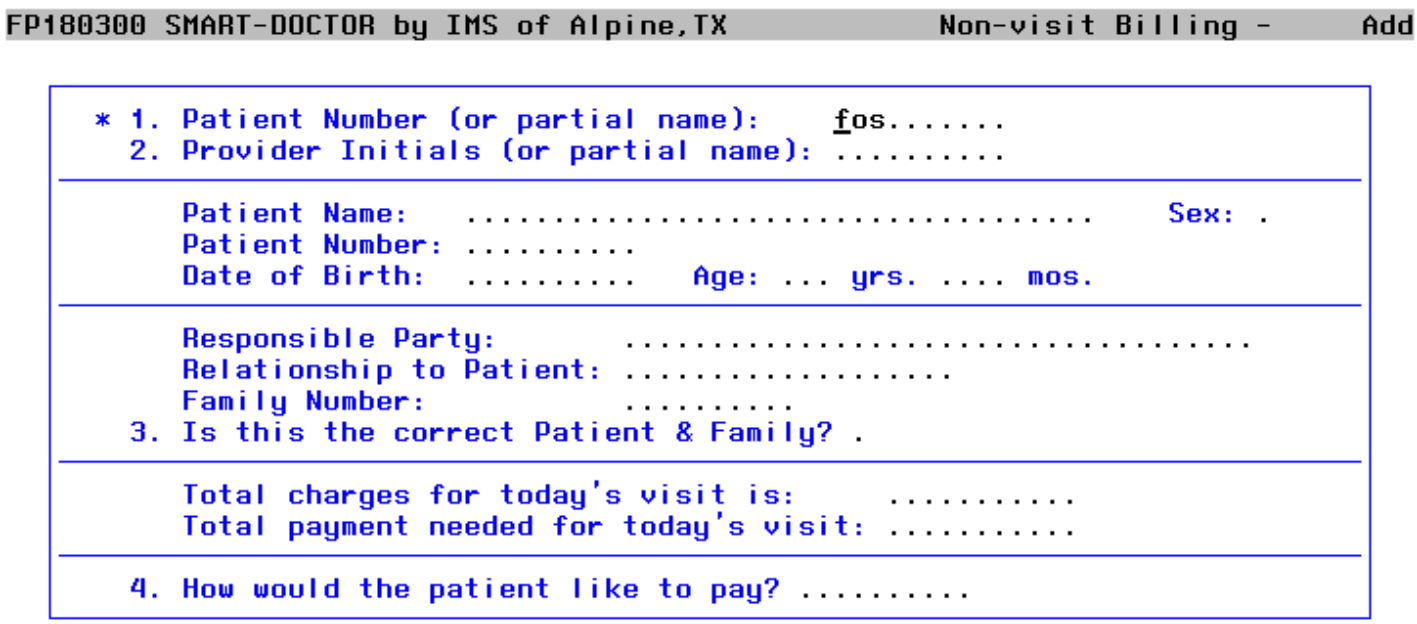


Figure 132 Initial Non-Visit Billing screen.

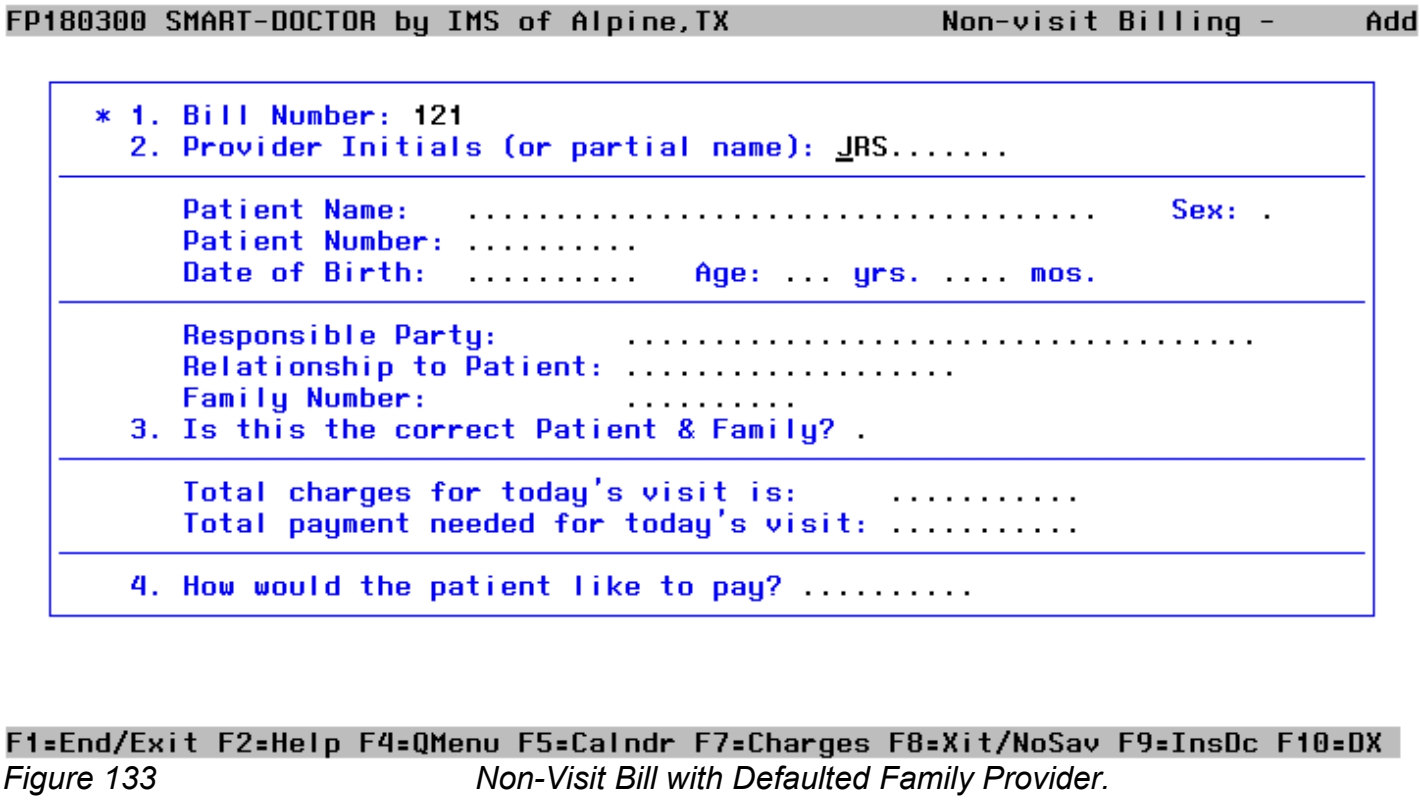


Figure 133 Non-Visit Bill with Defaulted Family Provider.

If this is the correct provider, just hit <enter>. Otherwise enter the initials of the provider that provided the service, or part of that provider's name for a cross-reference lookup. In the example below (Figure 134) when “john” is entered you get the following Pop-Up selection screen.

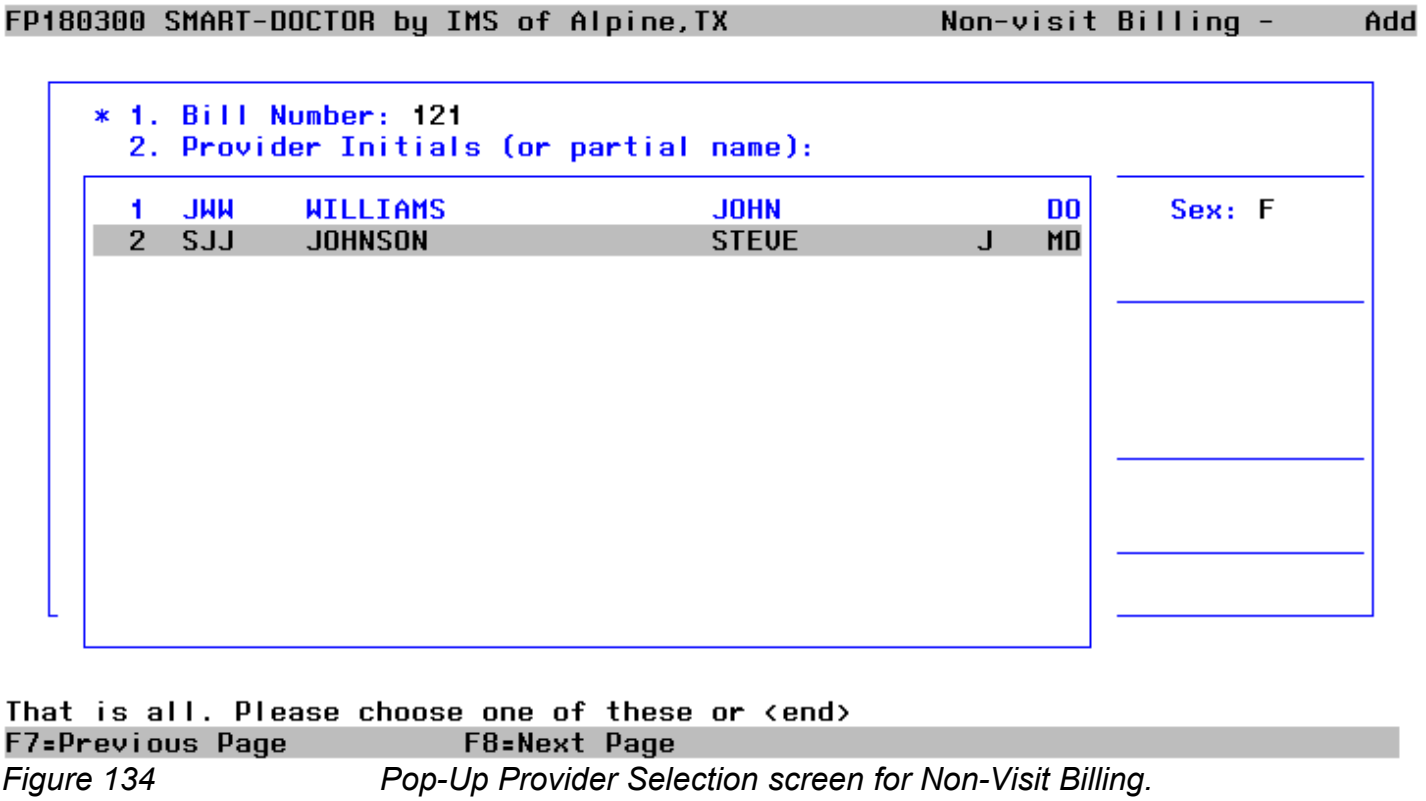


Figure 134 *Pop-Up Provider Selection screen for Non-Visit Billing.*

Upon selecting line #2 ,the provider's initials are placed in prompt #2, and you are next stopped at prompt #3 (see Figure 135). Here you are asked if this is the correct family associated with this patient for billing purposes. If it is, answer <y>, and you will then proceed to theinsurance selection screen as in the Primary Billing screens.

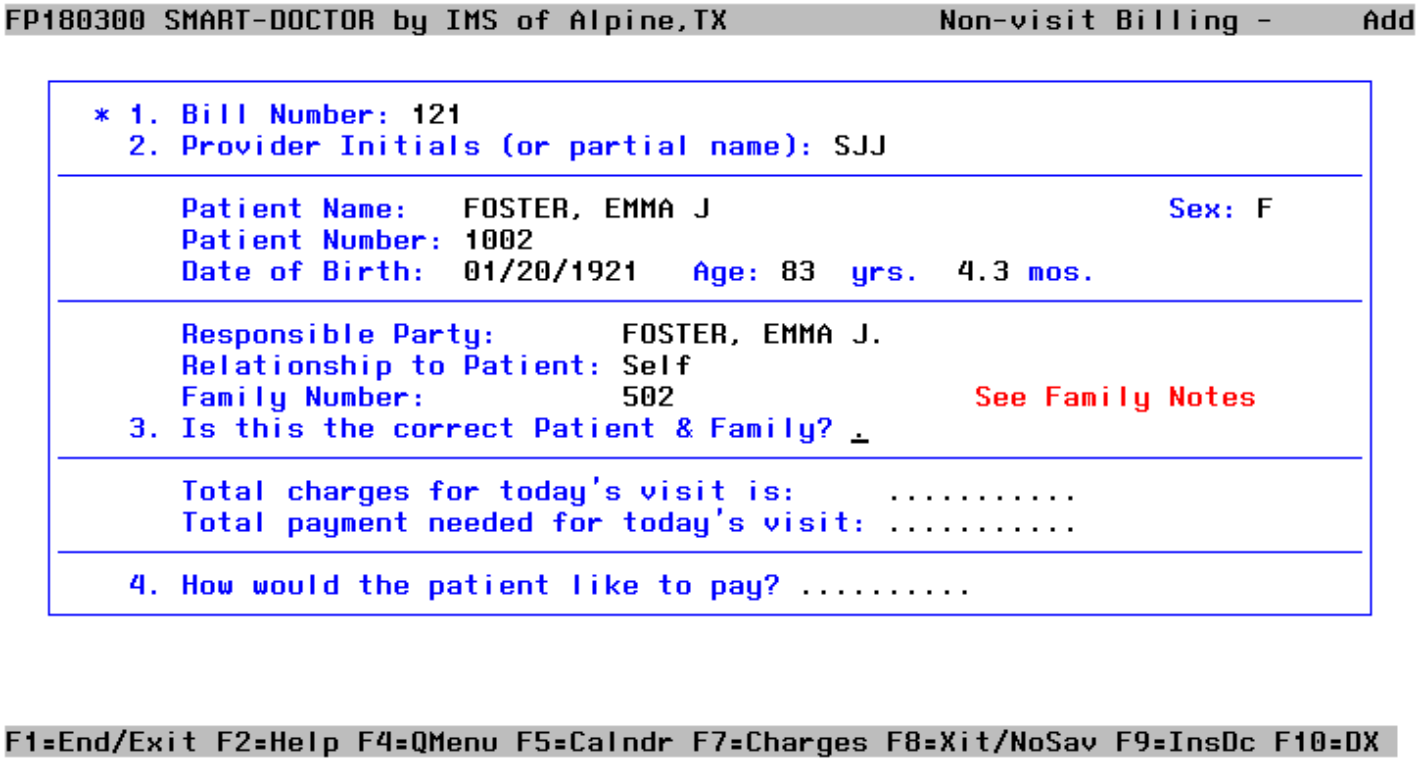


Figure 135 *Verify Correct Family for Non-Visit Bill.*

You will notice in this example that “See Family Notes” is in red (and flashing when on-line). If you know what this is about, you do not need to investigate, otherwise hit the <F4> key to go to the QuickMenu to access the Family file and review the family notes.

In the next screen (Figure 136) you will be able to enter up to four (4) diagnosis codes for billing. Always make the most significant diagnosis the first one. Start by entering part of the diagnosis description or shortcut description, as shown below.

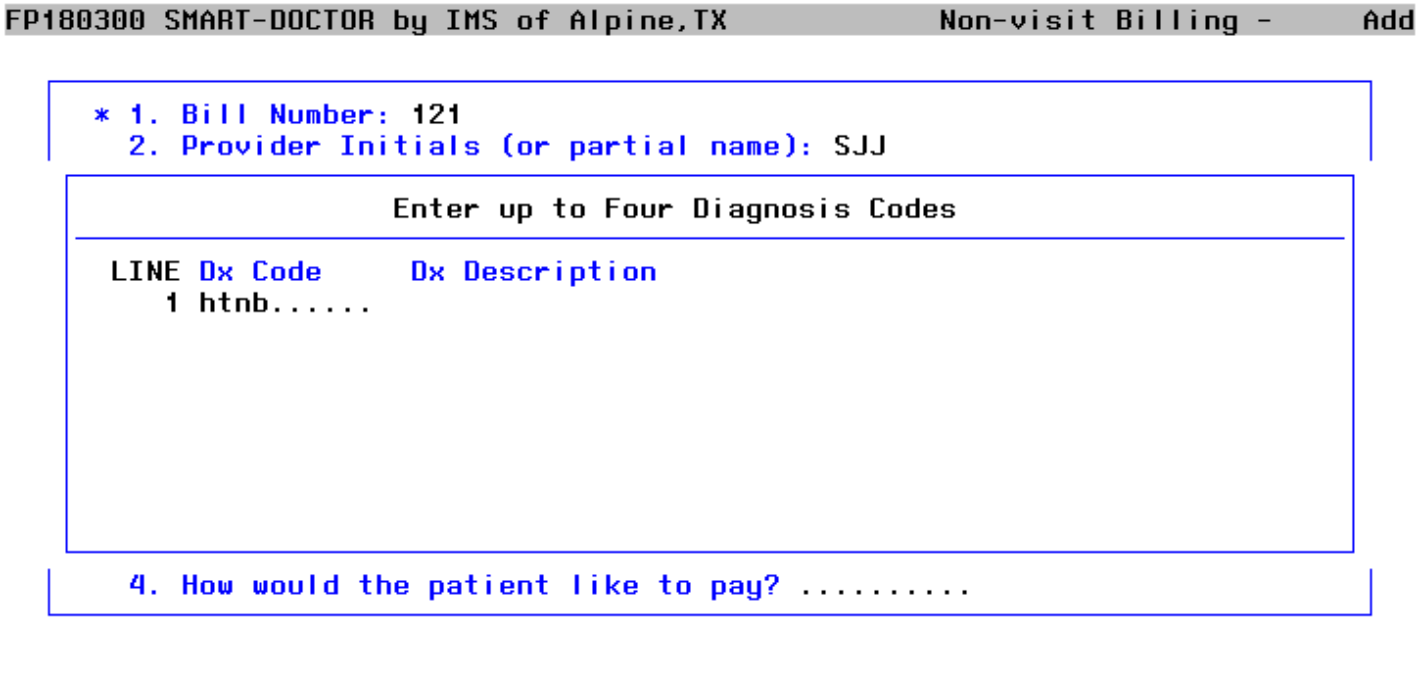


Figure 136 Entering Non-Visit Billing Diagnoses.

Entering “htnb”, resulted in a “direct hit” on Essential Hypertension Benign, as shown in Figure 137 below. On the following line we entered “dm” for diabetes, and get a cross-reference lookup as shown in Figure 138 below.

In this case simply highlight the diagnosis you want (or enter the line number) and hit <enter> to select. Please note that all diagnoses presented for selection are to the highest level of specificity and are checked for age and sex appropriateness. If a diagnosis is selected that is inappropriate, based on the patient's age or sex, one of the following messages will be presented at the bottom of the screen:

Diagnosis is not possible for this patient's age, return to continue

OR

This Dx not possible for pt. Sex, return to continue

You will then be forced to select again or end input.

Once the diagnoses have been entered, you will be placed at the change prompt where you will be able to Add, Change, Delete, or Insert diagnoses. In the screen shown in Figure 139 below we, have added the diagnosis for appendicitis.

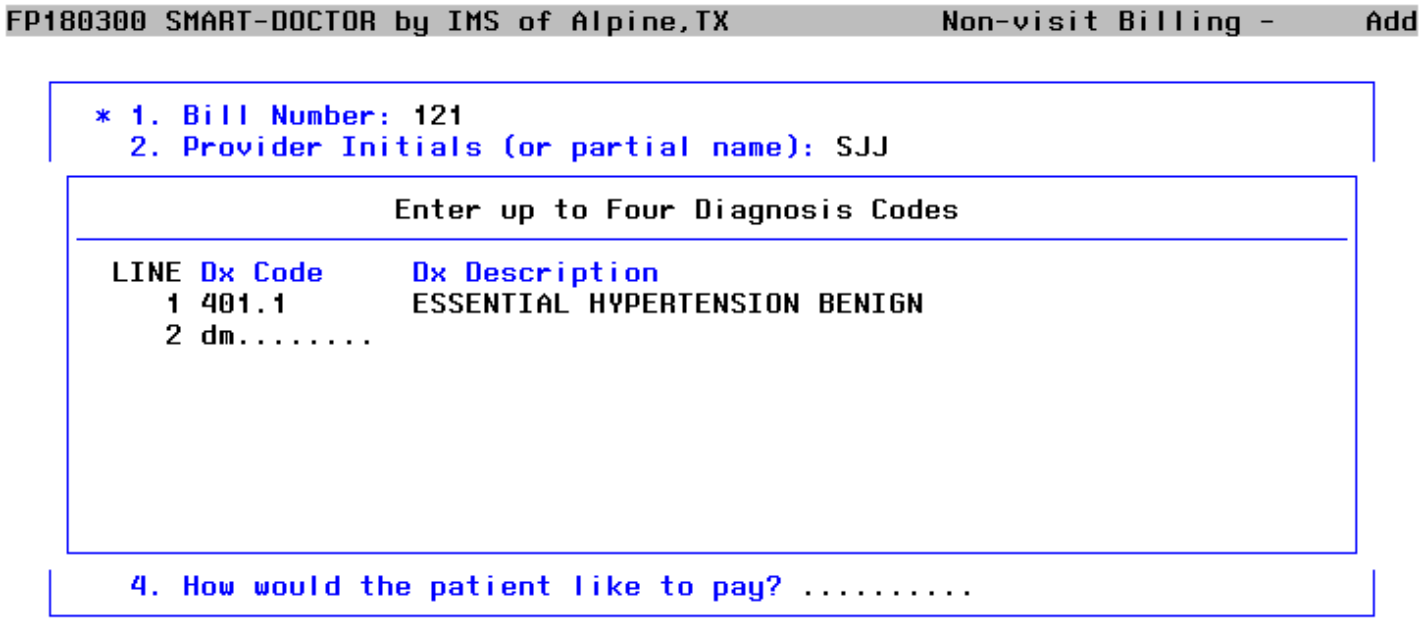


Figure 137 Entering a Partial Description for Diagnosis Lookup.

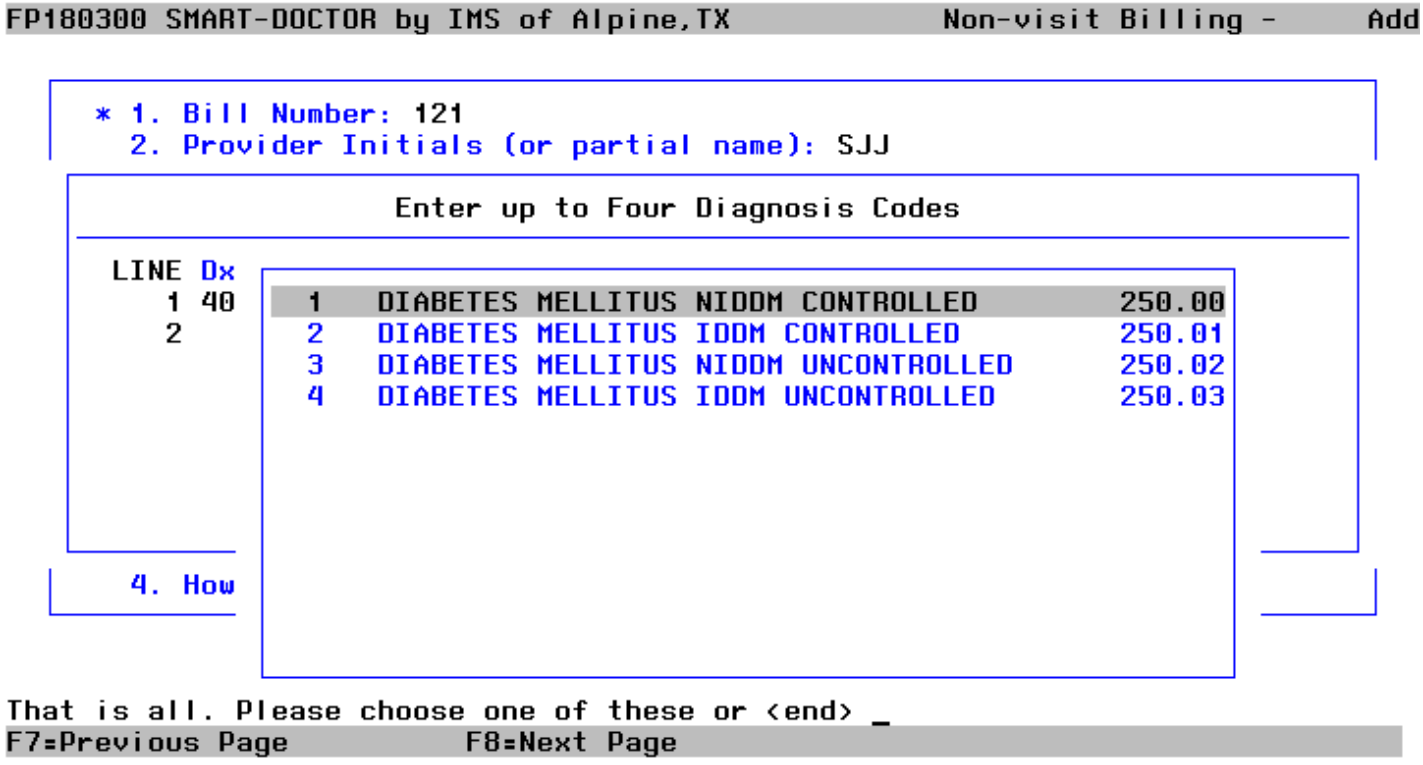


Figure 138 Selecting a Diagnosis.

You will notice that the Non-Visit billing screens do not have the “F9-VisRev” screen to review the associated visit. This is because there is no associated visit note to review, by definition, in a Non

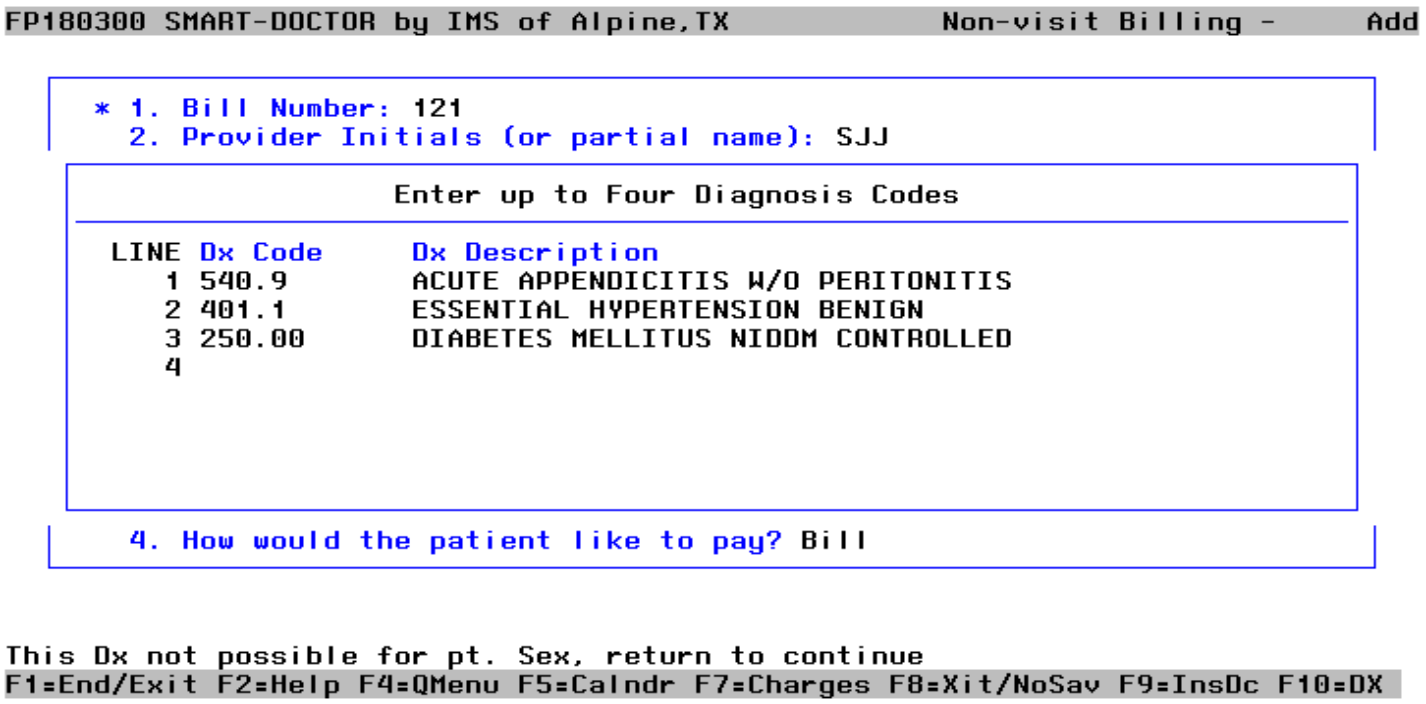


Figure 139 Completed Diagnoses screen for Non_Visit Billing.

-Visit" bill. This type of bill is generally used for a hospital procedure such as an appendectomy, where the provider documents the procedure in the hospital records, to which you generally do not have access. The Non-Visit Billing can also be used for office visits in the rare case that the note was never completed. The Non-Visit Bill is also used for charging for a service or supply not billed at the time of the visit, or that was independent of the visit. Further, Non-Visit Billing can also be used for nursing home or emergency room charges, that were not entered via the Non-Scheduled Provider Visit system.

However, there are two additional F-Keys, "F7=Charges" and "F10=DX". These two keys are for going back to the Charges screen or the Diagnosis screen if you realize that you need to add something are make a correction before completing the bill.

The next screen you are automatically taken to is the "Patient charges" screen, as seen in Figure 140. In this screen, you enter part of the description of the procedure in the first field of the multi-value line. You will then either get a direct hit, or a selection screen from which to choose the proper procedure to be billed.

Once the charge is picked, you will taken to the specific charge window, as seen in Figure 141. In this case, we have picked the procedure code for Appendectomy. Now you must go through prompts #1 through #5.

Prompt #1, "**Dx Code:**" As seen in Figure 141 below, a selection screen pops up with the diagnoses you previously entered. If you do not find the diagnosis needed in the list of this pop-up, then select one of these temporarily. Then, after completing the remaining prompts on this screen, use the "F10=DX" key mentioned above to insert the diagnosis. Come back to this screen again by going to this item on the Patient Charges screen in the Change mode and replace with the correct diagnosis.

Prompt #2, "**Date of Service:**", hit <enter> to take the default of today's date, or enter at least the

month and date.

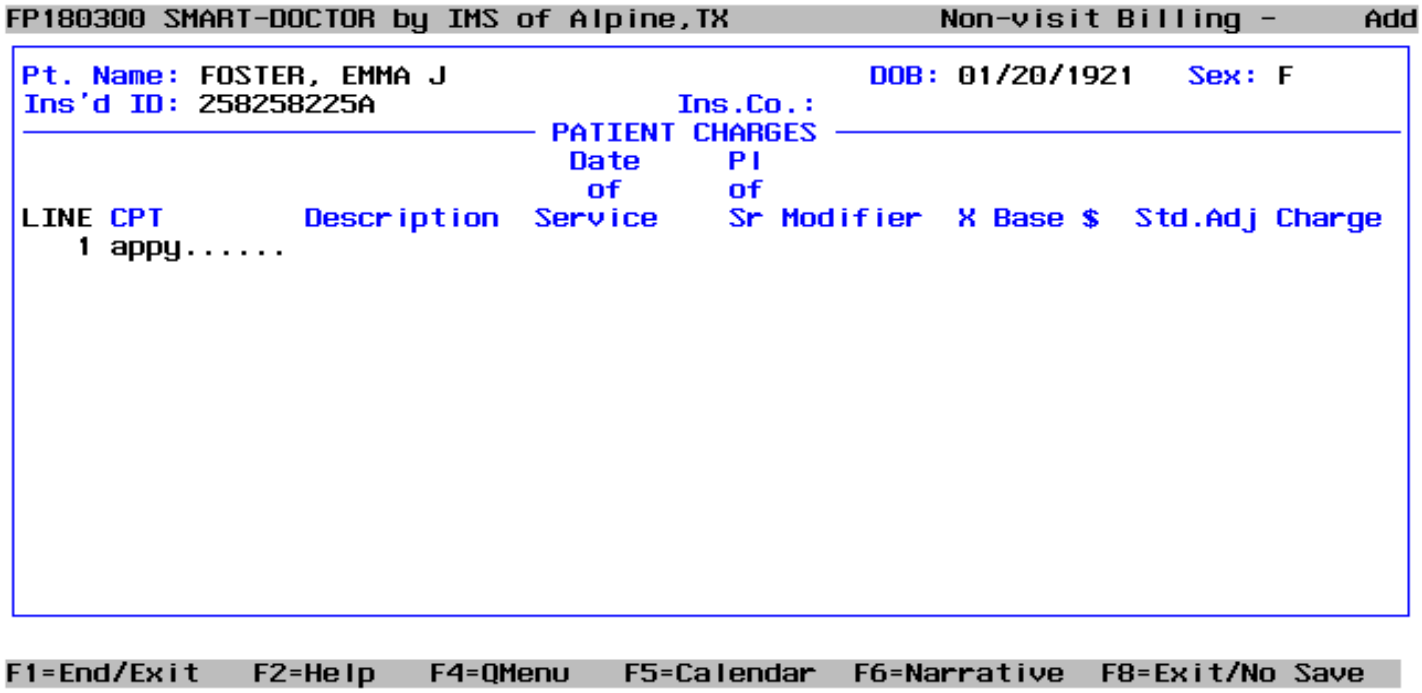


Figure 140 *Adding Charges to Non-Visit Billing.*

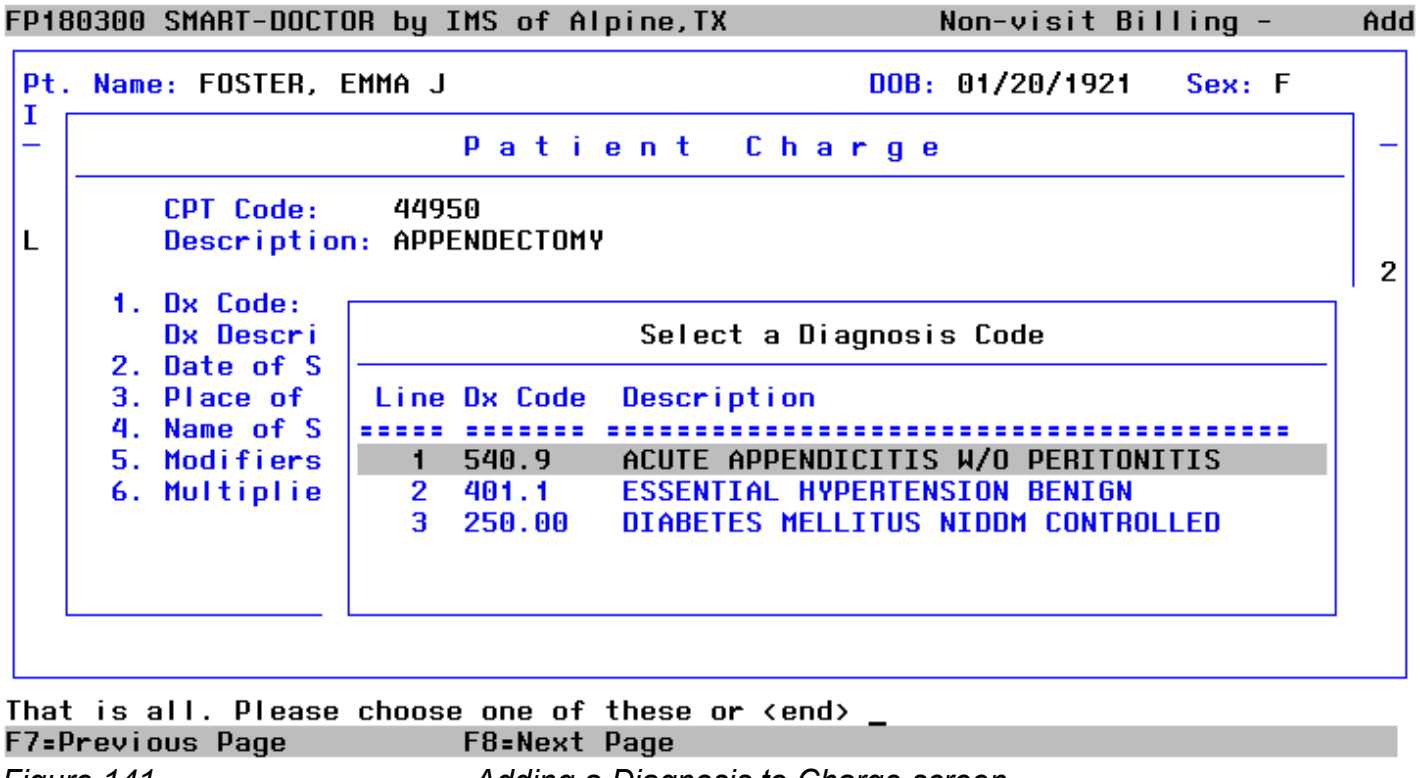


Figure 141 *Adding a Diagnosis to Charge screen.*

Prompt #3, "**Place of Service:**", here you must select from the "Place of service" pop-up screen (Page down or arrow down to see all of the choices.), as seen in Figure 142 below.

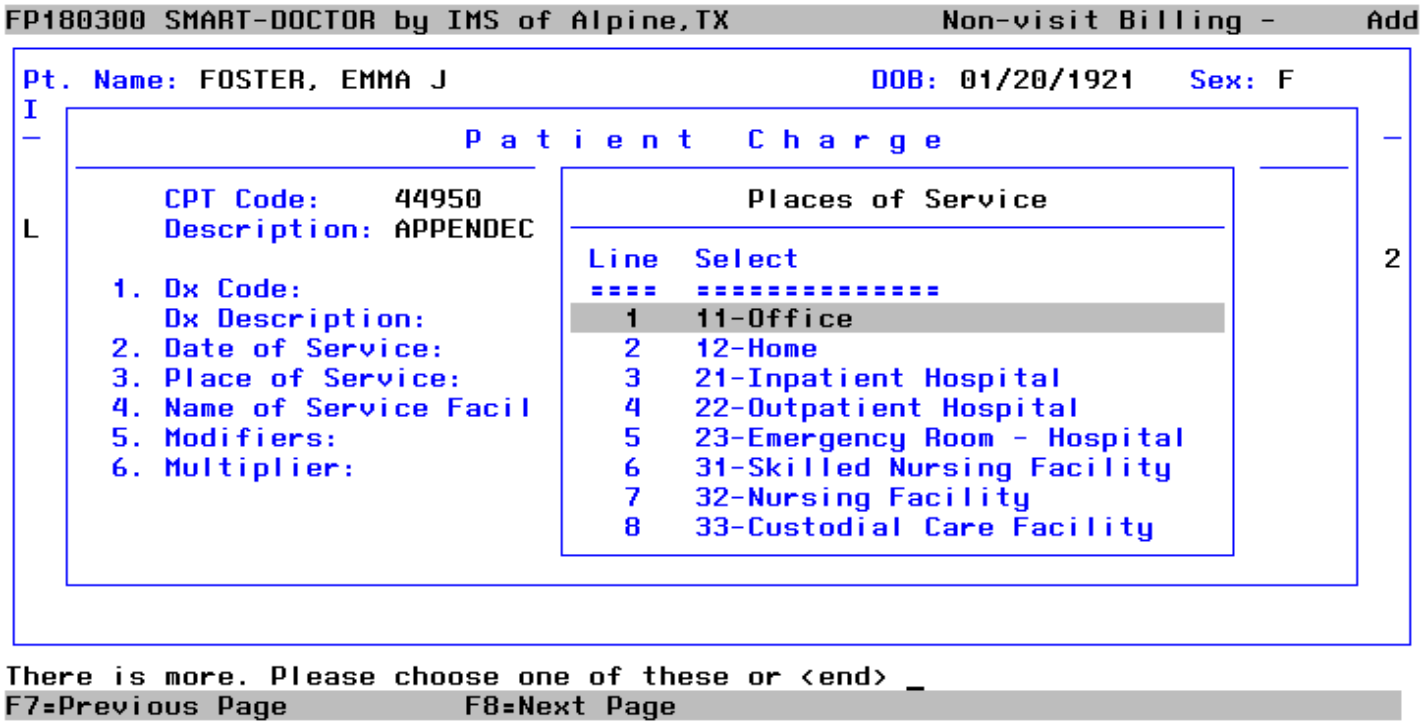


Figure 142 *Place of Services screen for Non-Visit Billing.*

Prompt #4, "**Name of Service Facility:**", is another pop-up window, as seen in Figure 143, with the places of service available for you to select from based on the clinics listed in your clinic file. Please note that the clinic file also is used for hospitals, nursing homes, and any other facility where care may be rendered.

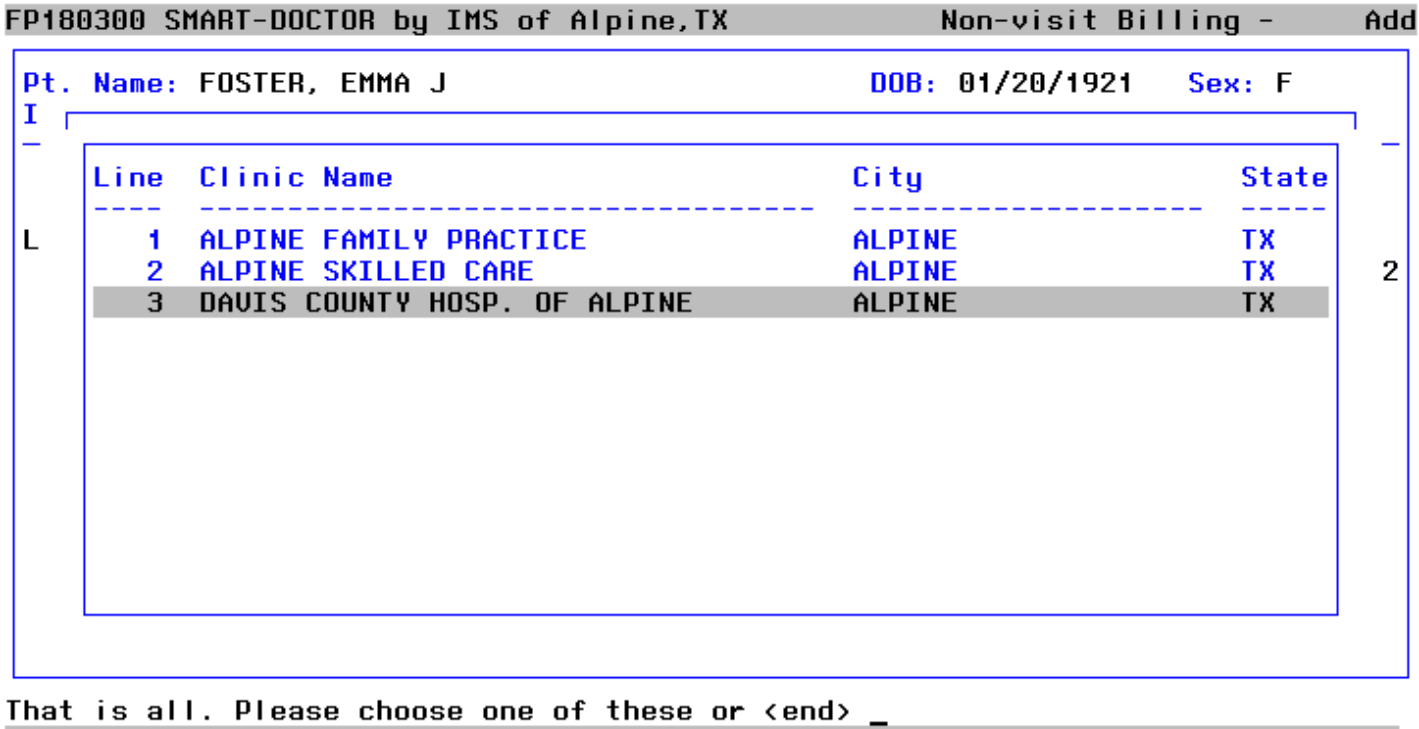


Figure 143 *Selecting Service Facility for Non-Visit Billing.*

Prompt #5, "**Modifiers:"**, here you may enter up to four, two digit, modifiers manually. You can also hit the <F9> key "F9=See and Select Modifiers", to get a pop-up with all modifiers listed, from which you can select up to four. An example of this is seen below in Figure 144.

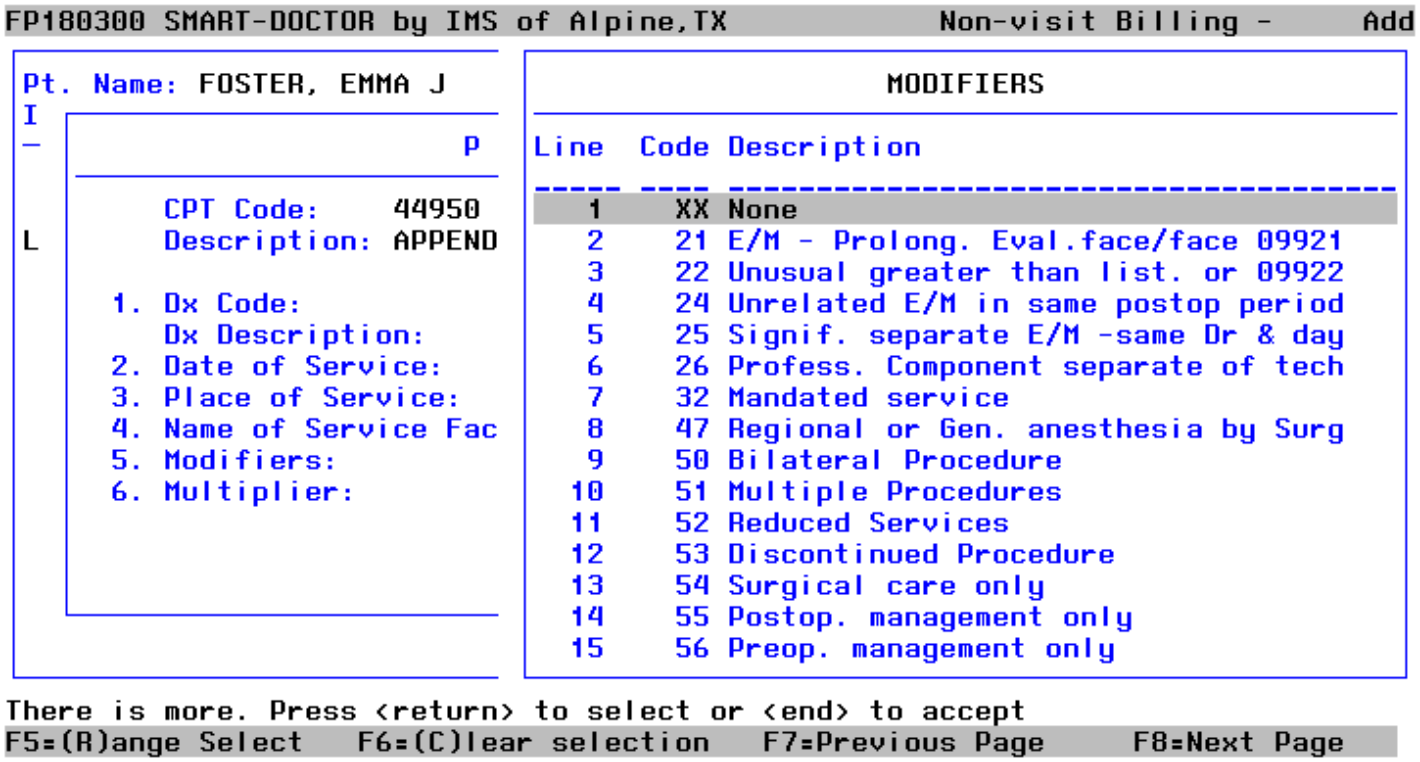


Figure 144 Selecting Modifiers for Non-Visit Billing.

To select from this multi-select pop-up, press <return> to select (a star "*" will be placed or removed) or <end> to accept the starred selections.

Prompt #6, "**Multiplier:**", hit <enter> to take the default of one (1), or enter the number of times this procedure was done. A number greater than one may be appropriate when the provider repeats a procedure multiple times as in Acne surgery with multiple lesions.

The screen shown in Figure 145 comes up next, showing the completed charge item line for the first procedure. Now additional charges can be added to this bill if appropriate (in this example, this charge generally would be submitted by itself). In a missed office visit, being billed as a Non-Visit bill, it might include other charges for lab test and supplies, etc.

The "**F6=Narrative**" screen is the same as the primary billing discussed earlier.

Exiting from the Non-Visit Billing screen is the same as in the Primary Billing, except there are no Optional Exit Screens of orders to process, since there is no associated visit note.

SECONDARY BILLING SCREEN

Select menu item #3, "**Secondary Billing**", from the main billing screen. Enter in part of the patient's name in the screen shown in Figure 146 below. Then a selection list will appear if not a direct hit. Once the proper patient is selected, a pop-up screen showing prior bills will be shown, as seen in Figure 147.

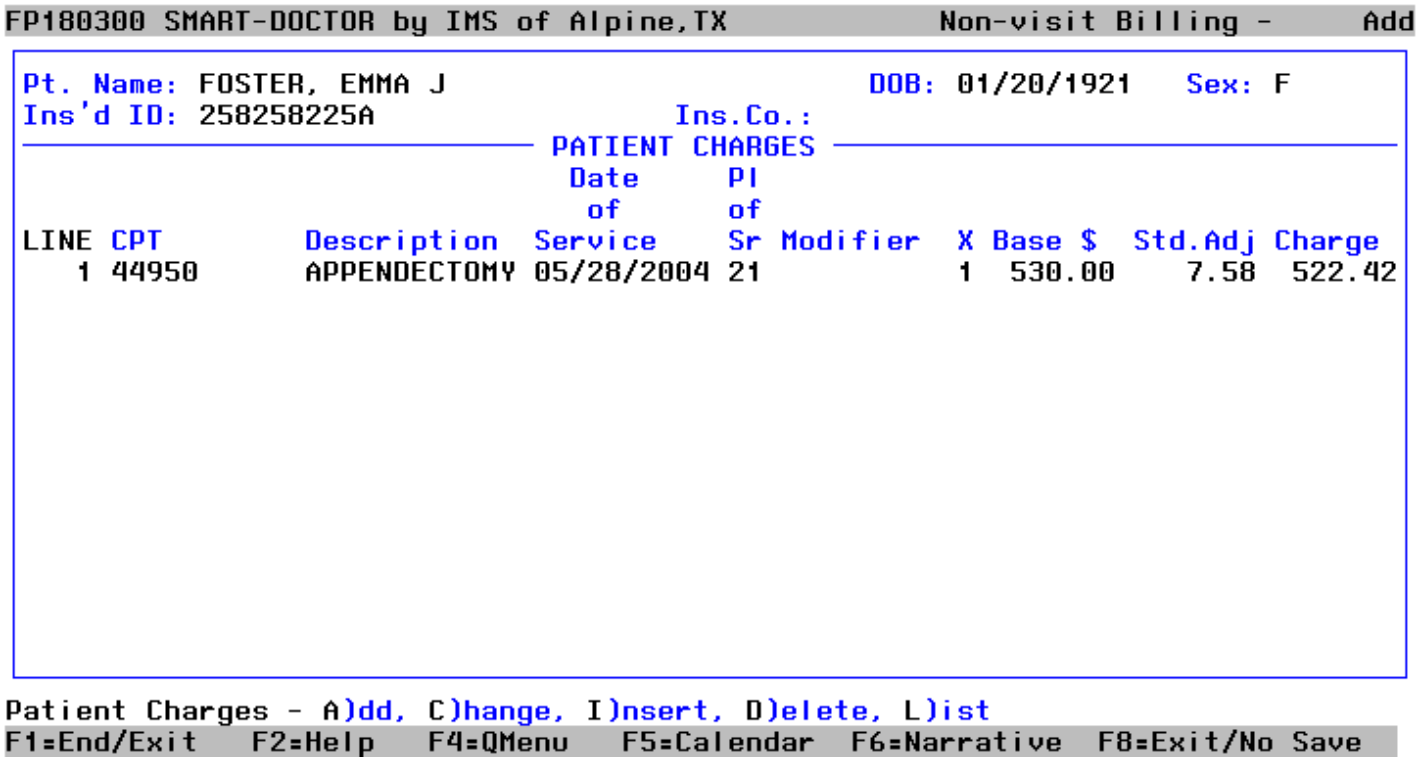


Figure 145 *Completed Charge Item Line for Non-Visit Billing.*

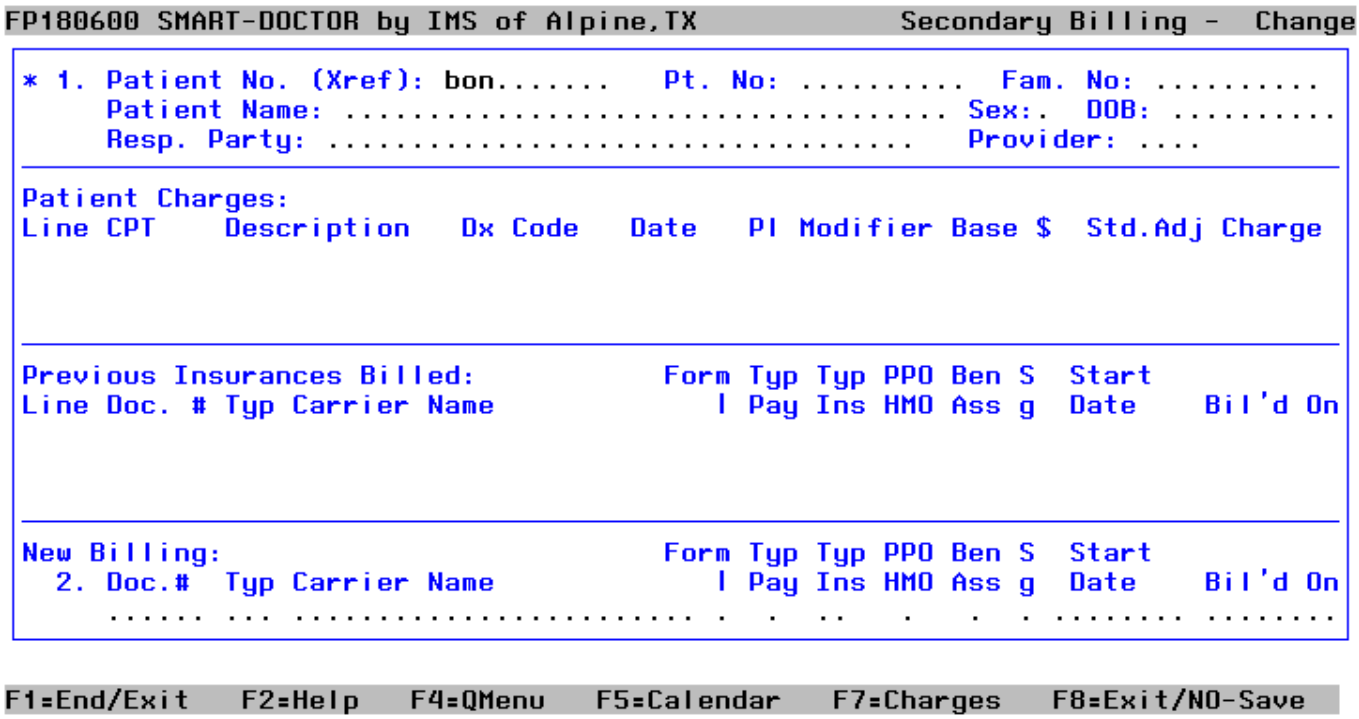


Figure 146 *Select Patient for Secondary Billing.*

Now select the bill you would like to bill secondarily or resubmit. These are called “Unit Bills”, and may each contain one or more charges each. They can represent “Primary Bills” from Office Visits, or Non-Visit encounters, or Non-Visit bills. They each represent a specific patient encounter. Once selected, the screen seen in Figure 148 is presented.

```
FP180600 SMART-DOCTOR by IMS of Alpine,TX          Secondary Billing -  Change

                          Bills for BONNER, JOHN J.

Line Bill No.  Prov Date     Time  CPT Code  Description
---- --------- ---- -------- ----- --------- --------------------------------
   1 111       SJJ  07/17/00 15:45 99214     L-4 OFFICE VISIT- ESTAB.(H-D,E-D
   2 107       SJJ  03/31/99 20:47 99214     L-4 OFFICE VISIT- ESTAB.(H-D,E-D
   3 101       SJJ  04/15/98 20:19 99203     L-3 OFFICE VISIT- NEW (H-,E- DET

New Billing:                              Form Typ Typ PPO Ben S  Start
  2. Doc.#  Typ Carrier Name                 | Pay Ins HMO Ass g  Date    Bil'd On
     ...... ... ......................... .  .  ..   .   .  . ........ ........

That is all. Please choose one of these or <end> _
F7=Previous Page          F8=Next Page
```

Figure 147 *Selection of Prior Bill for Secondary Billing.*

```
FP180600 SMART-DOCTOR by IMS of Alpine,TX          Secondary Billing -  Change

* 1.    Bill Number:     111          Pt. No: 1001        Fam. No: 500
     Patient Name: BONNER, JOHN J.                    Sex:M  DOB: 12/02/1931
     Resp. Party: BONNER, JOHN J.                     Provider: SJJ

Patient Charges:
LINE CPT    Description   Dx Code   Date    Pl Modifier Base $  Std.Adj Charge
   1 99214  L-4 OFFICE VI 466.0    07/17/00 11            84.00    9.92   74.08

Previous Insurances Billed:               Form Typ Typ PPO Ben S  Start
Line Doc. # Typ Carrier Name                 | Pay Ins HMO Ass g  Date    Bil'd On
   1    104 IND BLUE CROSS                   P  C  MP   N   Y  Y 12/02/96 07/17/00

New Billing:                              Form Typ Typ PPO Ben S  Start
  2. Doc.#  Typ Carrier Name                 | Pay Ins HMO Ass g  Date    Bil'd On

Patient Charges - C)hange, L)ist
F1=End/Exit   F2=Help   F4=QMenu   F5=Calendar   F7=Charges   F8=Exit/NO-Save
```

Figure 148a *Secondary Billing Screen.*

This screen has 4 sections. The first section gives the patient and responsible party, as well as the provider of the service. The second section, "**Patient Charges**", lists one or more charges associated with that encounter. This section is a multi-valued change prompt so that you can make changes, but to the modifier field only. Upon selecting a charge in this second section (which you may or may not

want to do), the following screen (Figure 148) will open to allow a change or addition of a modifier.

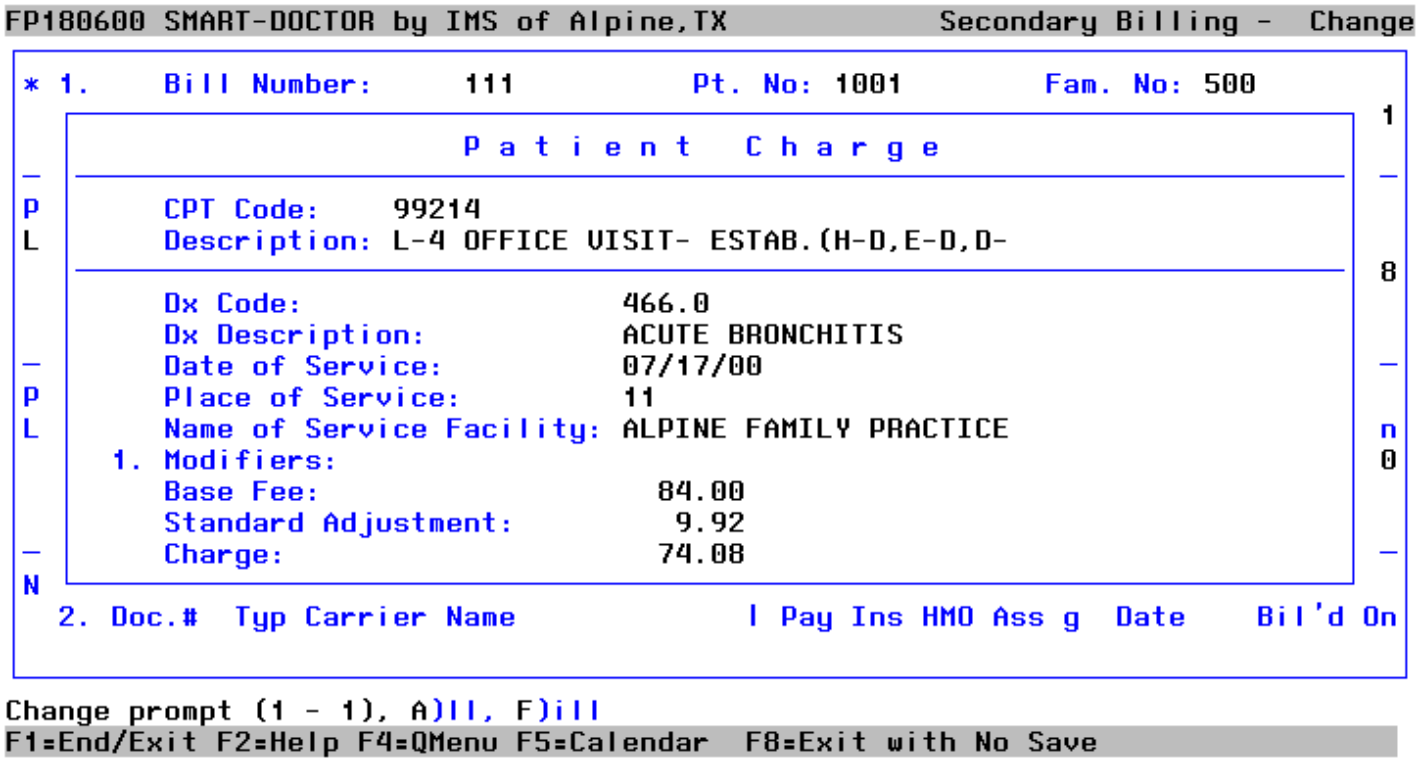


Figure 148 *Changing Modifier for Secondary Billing.*

Going into prompt #1 in this screen will allow a change or addition to the modifier. In this example we added modifier “24” for “Unrelated E/M in same postop period” which results in the change seen in Figure 149, which now shows the modifier “24” that was selected.

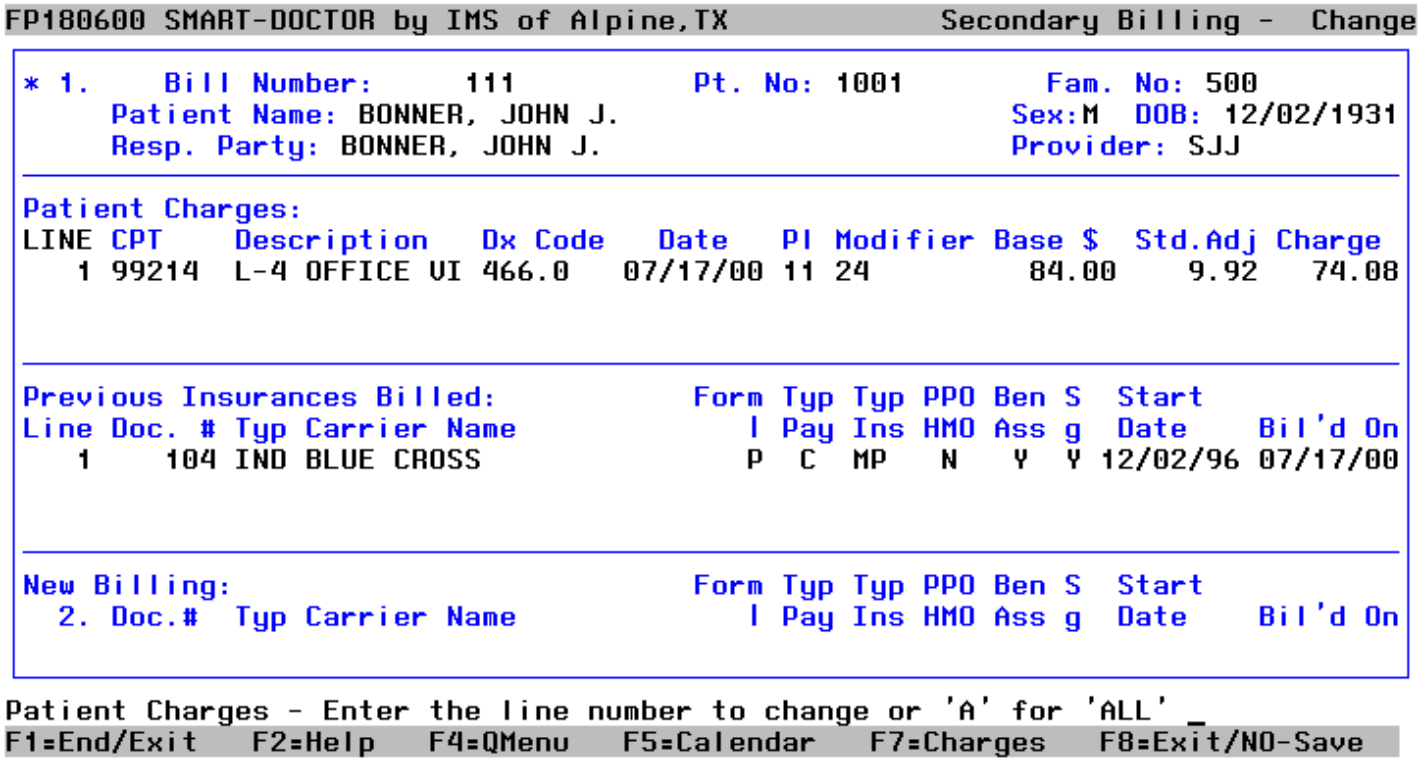


Figure 149 *Modifier Change for Secondary Billing.*

Next we go to the third section of this screen, "**Previous Insurances Billed:**". Here (Figure 149) we can look at the insurance document that was billed by selecting the appropriate line number, if more than one is listed. This is the same as looking at these insurance documents in the billing screens.

Finally, we get to section four, "**New Billing:**", which is a one value, multi-valued prompt. At the change prompt in this section, enter <2> to bring up the selection screen for all insurances available for this patient and family. You will then be presented with the following pop-up screen (Figure 150) to select the appropriate insurance to bill. The individual insurance type documents are always presented first, followed by any group insurances from the family file.

```
FP180600 SMART-DOCTOR by IMS of Alpine,TX          Secondary Billing -  Change

* 1.    Bill Number:     111          Pt. No: 1001        Fam. No: 500

                        Choose an insurance policy

Line Doc #  Typ Carrier Name           O Pay Ins HMO Ass  Start      Cancel
---- ------ --- ---------------------- - --- --- --- --- ---------- ----------
   1    104 IND                       1  C   MP   N   Y  12/02/1996 01/01/2004
   2    108 IND HMO BLUE MEDICAID     1  C   MP   Y   Y  01/01/2004
   3    100 HOH AETNA SAFEWAY GROUP   2  F   GP   N   Y  04/15/1998

New Billing:                          Form Typ Typ PPO Ben S  Start
  2. Doc.#  Typ Carrier Name             I Pay Ins HMO Ass g  Date    Bil'd On

That is all. Please choose one of these or <end> _
F7=Previous Page          F8=Next Page
```

Figure 150 *Selecting Insurance for Secondary Billing.*

After the proper insurance is indicated, a pop-up screen (Figure 151) is presented asking if the bill should be printed now. All secondary billing is done via paper. Medigap approved secondary policies are automatically billed via the carriers if the initial bill is sent electronically.

If you were to go back into these screens again to re-bill, you will see that the prior billing is documented, as is seen below in Figure 152.

RE-PRINT OFFICE VISIT BILLS SCREEN

Select menu item #4, **Re-print Office Visit Bills**, from the main billing screen. The screen shown in Figure153 will be presented. If you enter a bill for reprinting which has not been processed, as done in this example, then you will get a warning message at the bottom of the screen telling you that the bill for that visit number "has not yet been processed" yet. If you go to the primary billing screen, you will see it there waiting to be processed.

If you select a bill that has been processed, the bill will be printed as soon as you enter the line number.

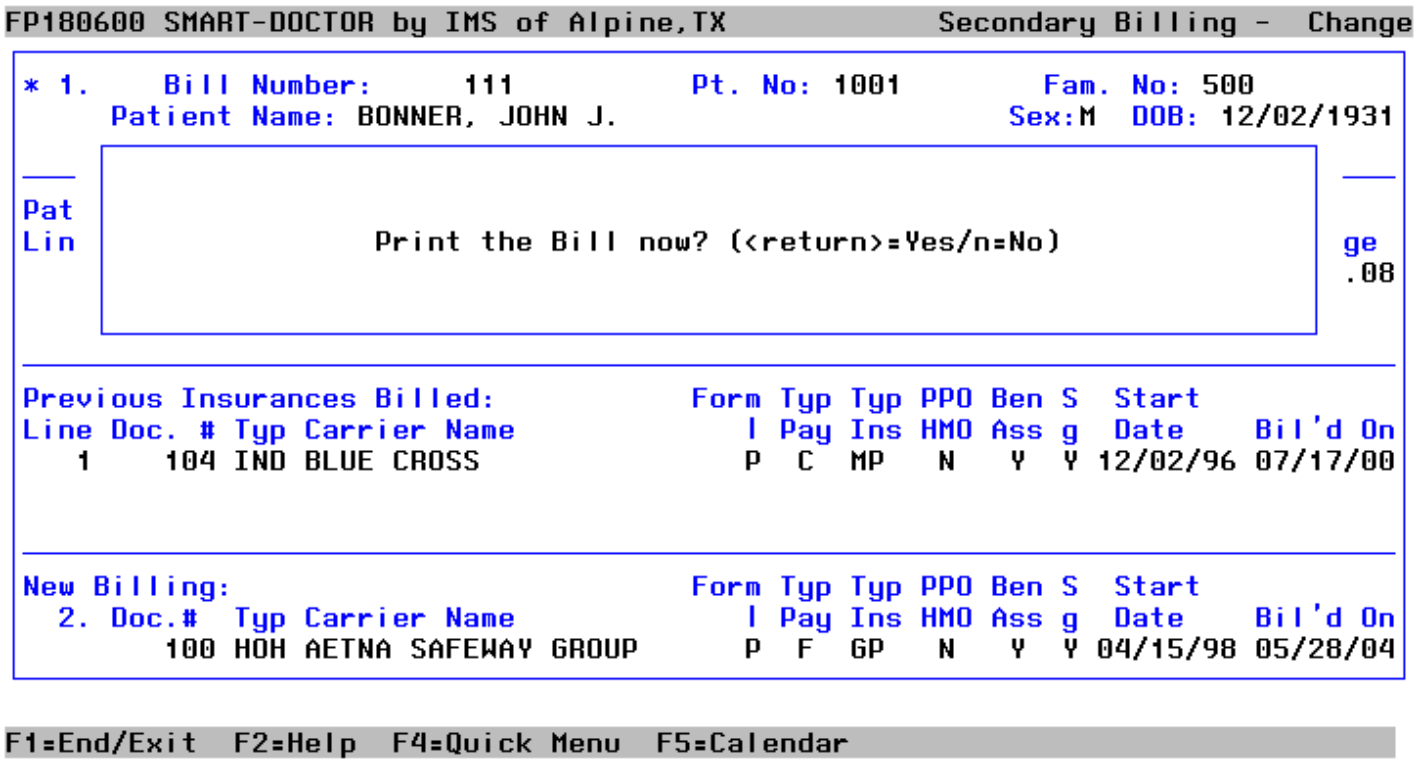


Figure 151 *Printing Secondary Billing.*

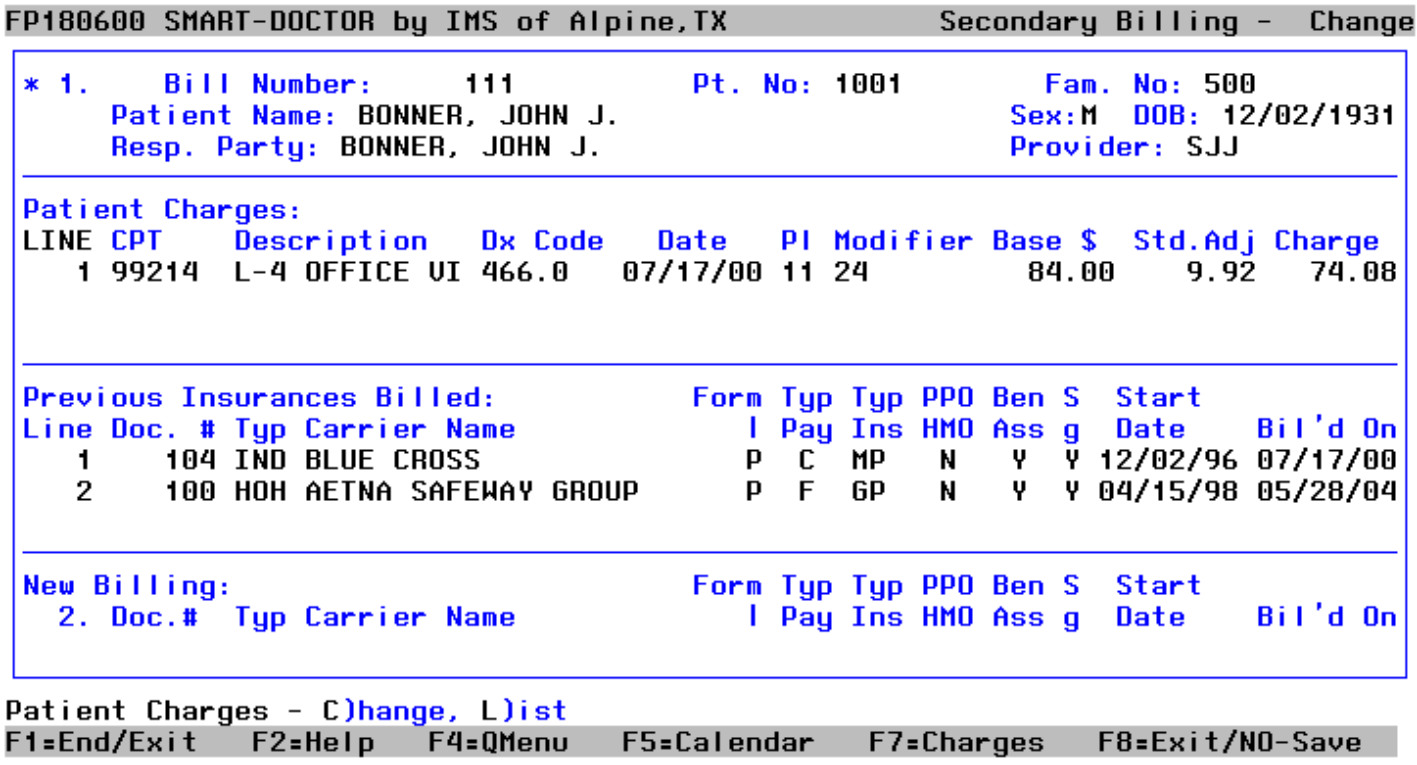


Figure 152 *Review of Added Secondary Billing.*

```
FP180200 SMART-DOCTOR by IMS of Alpine,TX   Re-print Office Visit Bill - Inquire

* 1. Patient Number (or partial patient name): bon
     Patient Name: BONNER, JOHN J.                              Gen:
     DOB: 12/02/1931    Age - Yrs: 72   Mos:  5.8

                Select the Visit whose bill you wish to print

                                                                    Visit
LINE Prov  Symptom/Reason          R   S    Type      Date      Time   Number
   1 SJJ   HEADACHE                R   K    MINOR--B  05/22/04   9.00  113
   2 SJJ   COLD                    R   K    MINOR--B  07/17/00   9.30  111
   3 SJJ   EDEMA                   R   K    MINOR--B  03/31/99   9.00  107
   4 SJJ   HEARTBURN               R   K    MINOR--B  04/15/98   9.00  101

 The bill for Visit No. 113 has not yet been processed, return to continue _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 153 *Selecting a Bill for Reprinting.*

RE-PRINT NON-VISIT BILLS SCREEN

Select menu item #5, "**Re-print Non-Visit Bills**", from the main billing screen. The screen seen in Figure 154 will be presented:

```
FP180400 SMART-DOCTOR by IMS of Alpine,TX     Re-print Non-Visit Bills - Inquire

* 1. Patient Number (or partial patient name): bon jo
     Patient Name: BONNER, JOHN J.                              Gen:
     DOB: 12/02/1931    Age - Yrs: 72   Mos:  5.8

                Select the Bill you wish to re-print

LINE Bill No.  Prv   Date     Time  CPT Code   Description
   1 126       SJJ  05/28/04 18:33 99213      L-3 OFFICE VISIT- EST.(H-EPF,E-EPF,

Encounters - S)elect, L)ist
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 154 *Select Non-Visit Bill to Reprint.*

Simply enter the line number of the visit to print, and it will be printed immediately.

BILLS TO BE CORRECTED/DELETED SCREEN

Select menu item #6, "**Bills to be Corrected/Deleted**", from the main billing screen. The screen in Figure 155 will be presented.

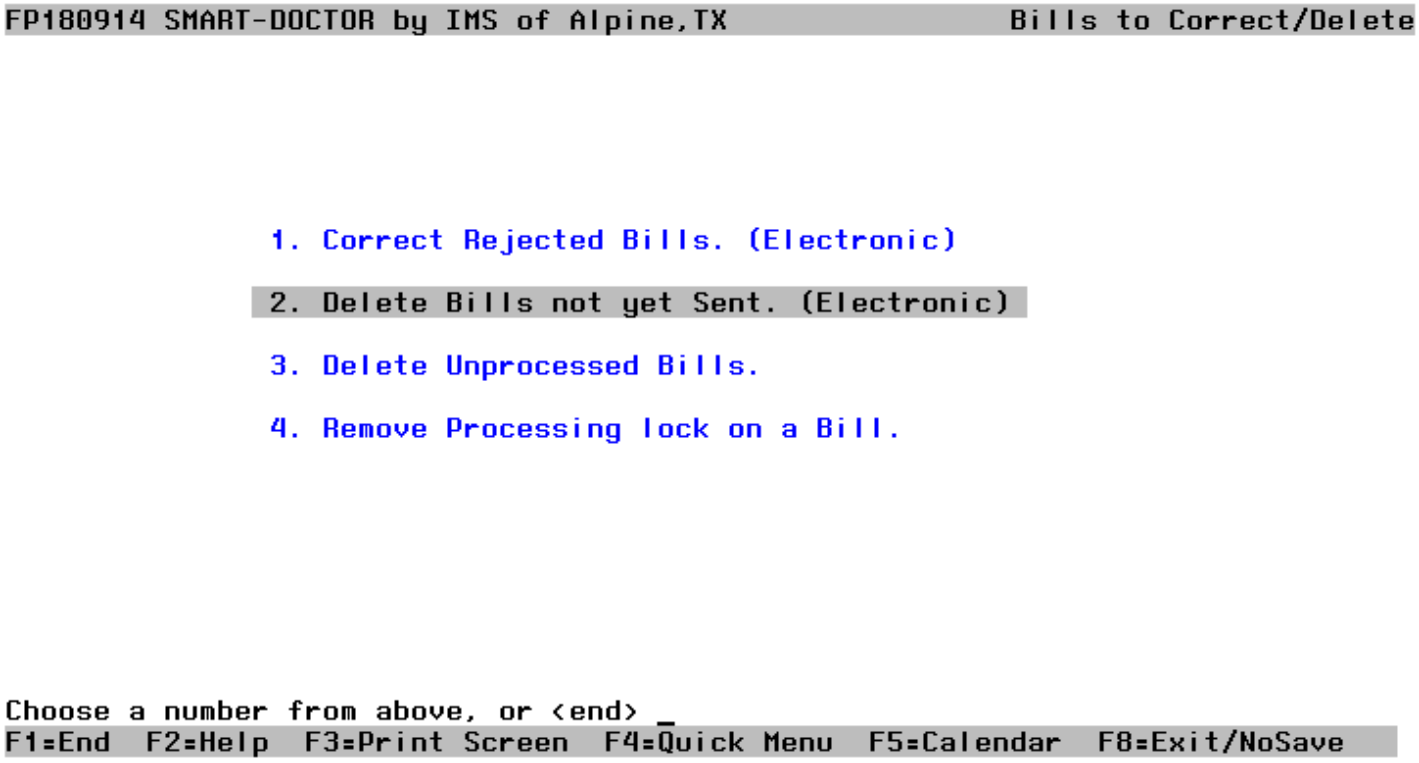


Figure 155 Selecting Bills to be Corrected or Deleted, Not Yet Sent.

On selection of Menu item #1, "**Correct Rejected Bills. (Electronic)**", you will be taken to the screen shown in Figure 156.

In prompt #1, you will either have a defaulted number for the "**Unit_BILL Number:**", or no number in this prompt's input field. If you see a number, then there is a Unit_Bill to be corrected. To see the errors and make corrections to this bill, just hit <enter>.

If there is no number, then there are no Unit_Bills that need correction. Just hit <F1> to "end" and return to the prior screen.

In the above example, after hitting the <enter> key, you are presented with the Unit_Bill information, and the preprocessing error report. In this case a single error was found: "Policy ID blank on Insurance Document.". If their was more than one error, they would all be presented on this screen, so that you can fix all the errors at one time, and then reprocess the bill automatically.

To correct the errors, you can use the F-Keys to navigate through the supporting documents that need correction. Besides the general "F4" or QuickMenu key, there are 4 F-keys that will take you to the indicated area and return you back to this same screen when you have made the corrections.

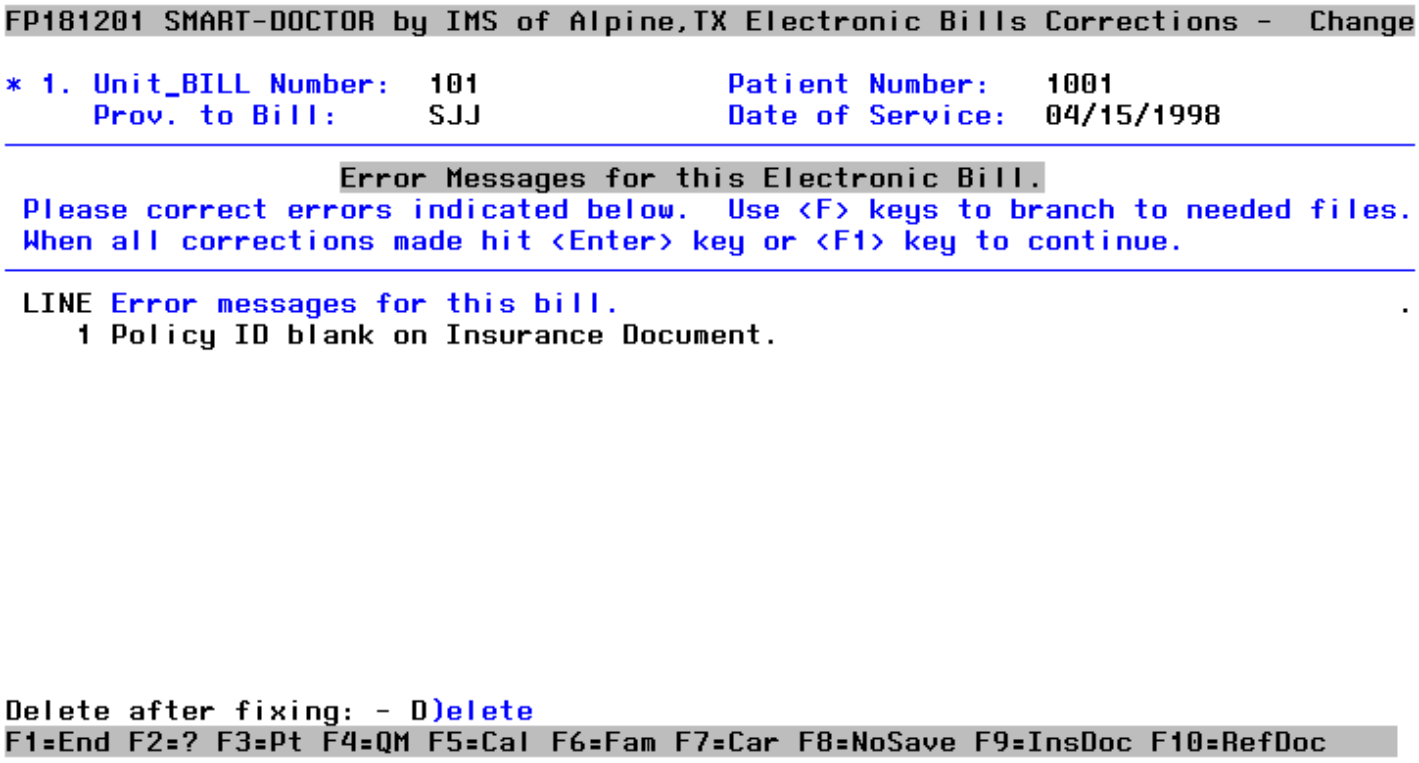


Figure 156 Correcting Electronic Billing Errors.

Specifically:
F6=Fam: Will take you to the family file for this patient.
F7=Car: Will take you to the carrier file used in this Unit_Bill.
F9=InsDoc: Will take you to the insurance document referenced for this Unit_Bill.
F10=RefDoc: Will take you to the referring provider file.

In this example, you would hit the <F9> key to go to the insurance document in question, add in the policy ID number, and return. On return, hit <F1> to "end" input and get the next screen seen in Figure 157.

If you answer <y> to the first question (in Figure 157) on the pop-up screen, then the system will reprocess this Unit_Bill to be sent electronically. It will then delete this record from the errors file and bring you to the next Unit_Bill requiring correction, if any. The bill will be reprocessed before being sent out electronically the next day. If you haven't made all the required corrections, you will be presented with the Unit_Bill again the next day.

If you answer <n> to the first question above, you will be placed at the second question in the pop-up above, "**Delete this record without reprocessing:**". If you answer <n>, then the record will be left here for later processing. If you answer <y>, then you will be presented with the following pop-up screen question:

"**You are about to delete this reminder record without posting an Electronic Bill or printing a Bill. Do you still want to DELETE(y/n)?**"

Answering <y> will delete this bill. Answering <n> will leave this bill for the next time you come back to correct Unit_Bills. If you really want to delete this bill answer <y>. If you delete this bill, it will not affect the charges in the Family Ledger. So if this is not sent, you should at least send this bill out from the

family ledger as a secondary billing, or no bill will ever be sent to the insurance carrier. Or, correct the charges off the Family Ledger if these charges were an error.

```
FP181201 SMART-DOCTOR by IMS of Alpine,TX Electronic Bills Corrections -  Change

* 1. Unit_BILL Number:  101              Patient Number:   1001
     Prov. to Bill:    SJJ              Date of Service:  04/15/1998

                    Error Messages for this Electronic Bill.
 Please correct errors indicated below.  Use <F> keys to branch to needed files.
 When al

 Line Er
    1 Po
          1. Reprocess Elec. Bill and delete this record:  .
          2. Delete this record without reprocessing:      .

F1=End F2=? F3=Pt F4=QM F5=Cal F6=Fam F7=Car F8=NoSave F9=InsDoc F10=RefDoc
```

Figure 157 Delete or Reprocess Electronic Bill with Error.

On selection of Menu item #2 from "Bills to Correct/Delete" menu screen above (Figure 155), "**Delete Bills not yet Sent. (Electronic)**", you will be taken to the following screen (Figure 158) after being asked for a management password to allow access to this area.

```
FP180917 SMART-DOCTOR by IMS of Alpine,TX     Electronic Bill Deletion -  Change

* 1. Terminal: typ4       User: sjj          Time: 16:59      Date: 06/02/2004

                          Electronic Bills
  LINE Patient Name          Prov      Date Of Service    Time Billed
     1 BONNER, MARY K.       SJJ       05/29/2004         16:28
     2 BONNER, JOHN J.       SJJ       05/29/2004         16:29
     3 BONNER, JOHN J.       SJJ       06/02/2004         14:19
     4 BONNER, JOHN J.       SJJ       06/02/2004         14:22
     5 BONNER, JOHN J.       SJJ       06/02/2004         14:24
     6 BONNER, JOHN J.       SJJ       06/02/2004         15:26

Choose a bill. - S)elect _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 158 Selecting Electronic Bill to be Deleted.

At the selection prompt, enter the line number of the bill you want to delete before it can be processed for electronic transmission. You will then be presented with the following pop-up (Figure 159):

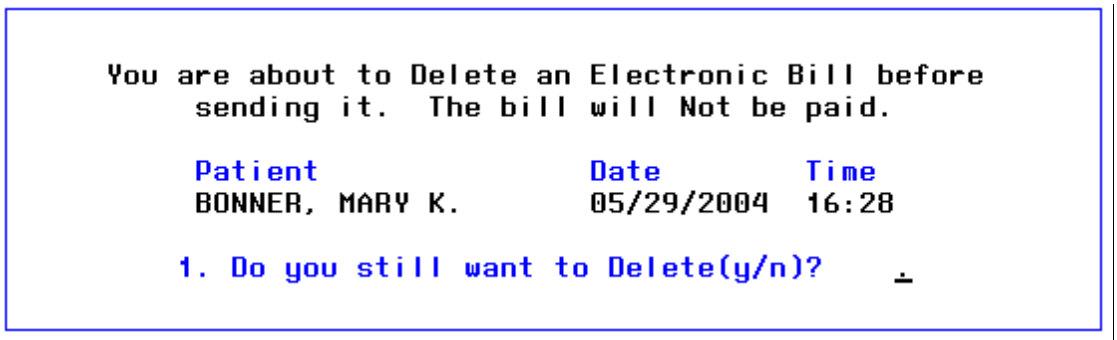


Figure 159 Verify Electronic Bill Before Sending.

If you really want to delete this bill answer <y>. If you delete this bill, it will not affect the charges in the Family Ledger. So if this is not sent, you should at least send this bill out from the family ledger as a secondary billing, or no bill will ever be sent to the insurance carrier. Or correct the charges off the Family Ledger if these charges were an error.

On selection of Menu item #3 from "Bills to Correct/Delete" menu screen above (Figure 155), the "**Delete Unprocessed Bills.**", you will be taken to the screen shown in Figure 160, after being asked for a management password to allow access to this area.

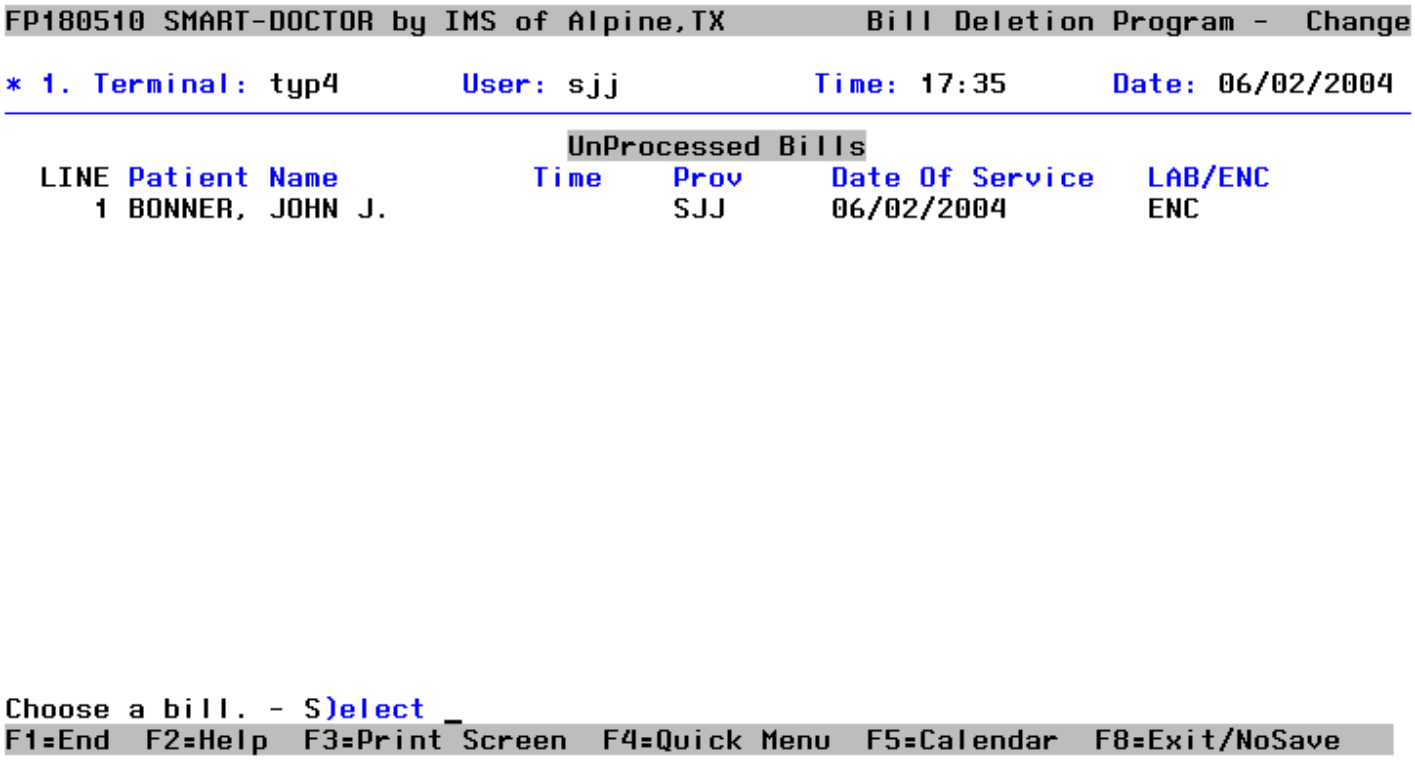


Figure 160 Delete UnProcessed Bills.

At the selection prompt, enter the line number of the bill you want to delete that has not yet been processed from the "Primary Billing" screen. You will then be presented with the pop-up screen in Figure 161.

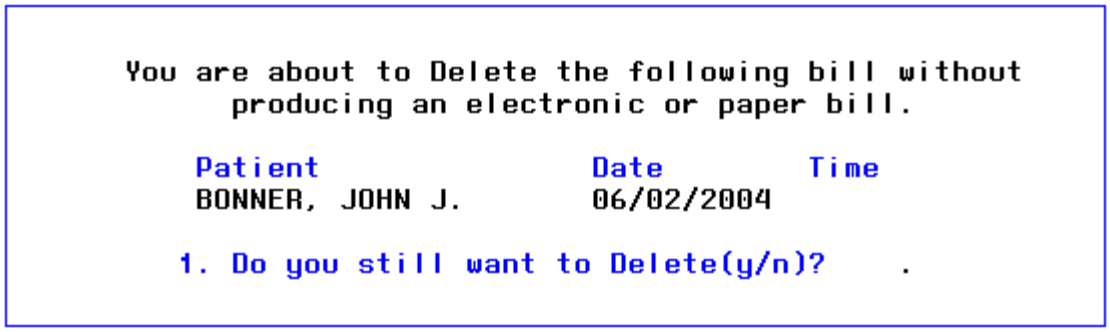


Figure 161 Delete Unprocessed Bill.

If you answer <y>, this Unit_Bill will be deleted and no charges will be entered in the Family Ledger, nor will any bills be sent out. In this case, you must capture any charges by entering them by way of the Non-Visiting billing screens.

On selection of Menu item #4 from "Bills to Correct/Delete" menu screen above (Figure 155), the "**Remove Processing lock on a Bill.**", you will be taken to the screen shown in Figure 162, after being asked for a management password to allow access to this area.

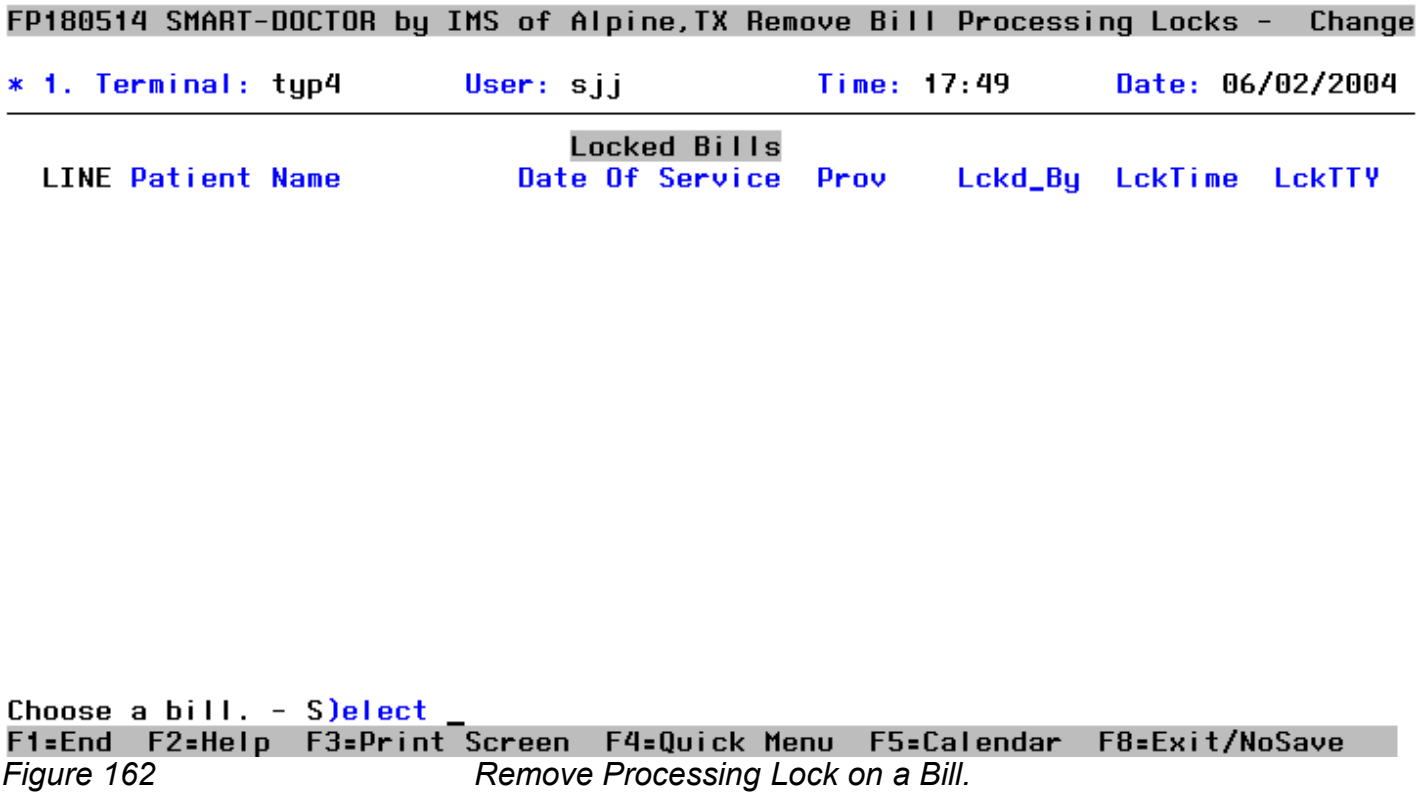


Figure 162 Remove Processing Lock on a Bill.

In the above screen (Figure 162), any bills that are being processed will have the patient's name replaced with the word "Pending". If this continues to stay here on repeated returns over time, then this is probably a bill that hasn't completed processing. On the Primary Billing screen it may indicate billed, but remain there on subsequent entries to that screen, which indicates a locked record. This can happen if in the process of working on a primary bill, the client PC that you are using crashes, gets turned off, or you close the client session without completing the screens and coming back to a login

prompt.

Review Bills Sent

Select menu item #7, "**Review Bills Sent**", from the main billing screen. The screen in Figure 163 will be presented.

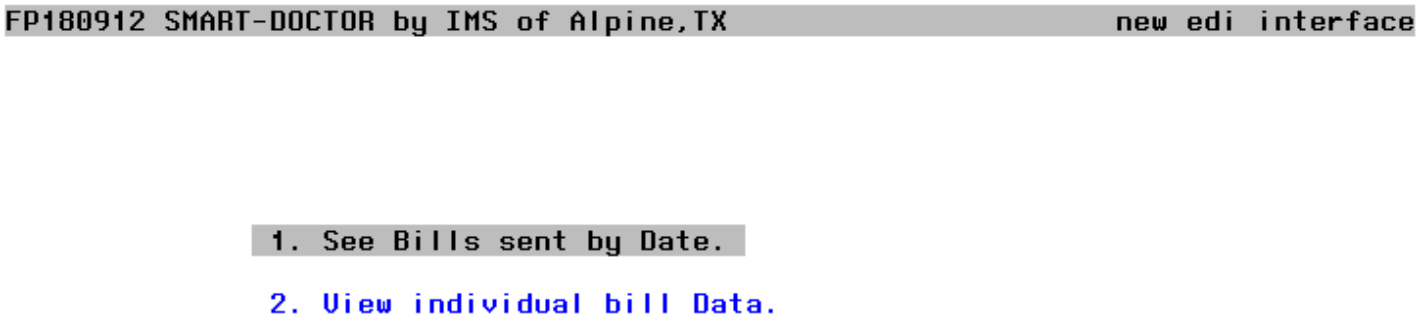


Figure 163 *Review Bills Sent Electronically.*

On selection of Menu item #1, "**See Bills sent by Date.**", you will be taken to the following screen shown in Figure 164.

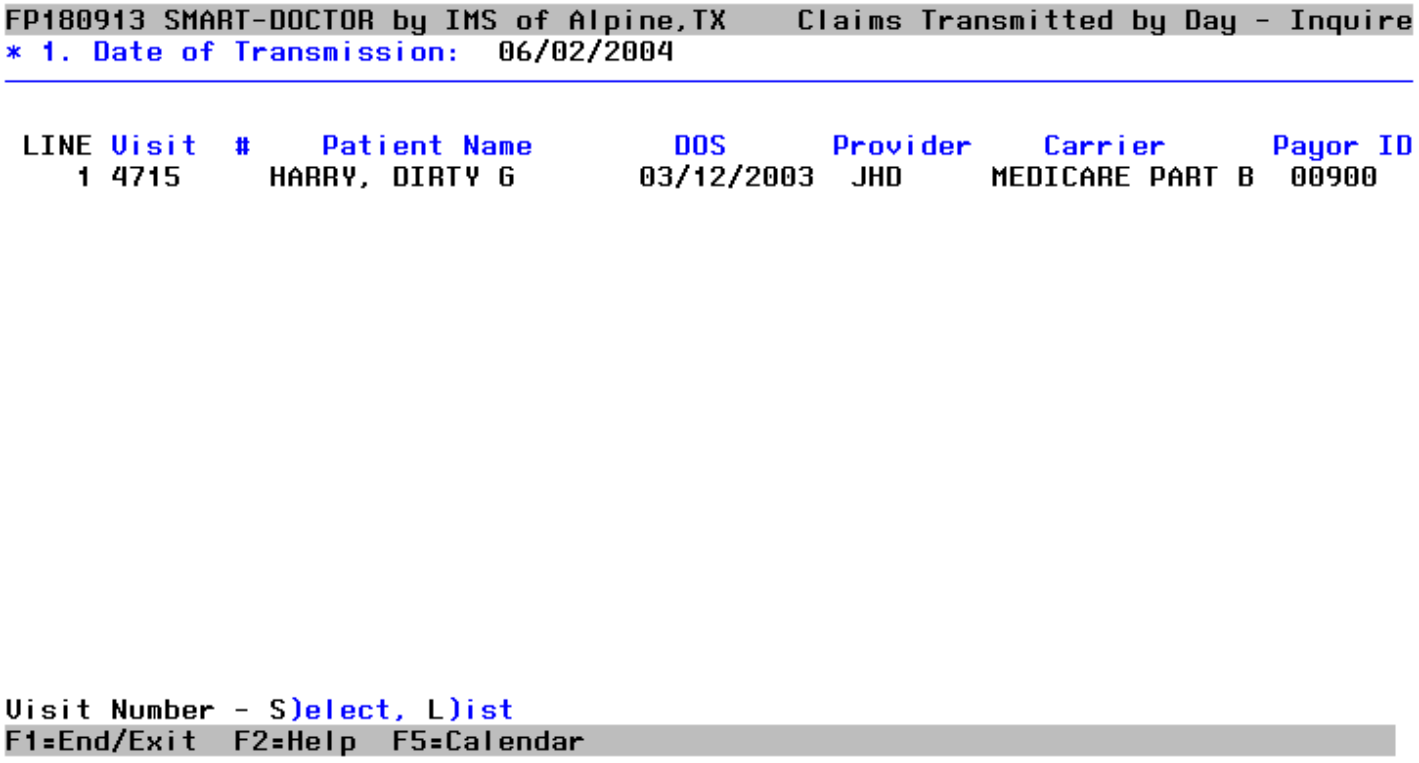


Figure 154 *Review Bills Sent Electronically.*

Prompt #1, "**Date of Transmission:**", enter a date to bring up a list of electronic bills sent on that date.

Electronic bills are sent out the day after they are billed. Any bills listed would have been billed out the day before or previously. The automated program which sends the bills "believes" the bills to have been sent if they are on the list. Your response report or remittance from the payer is the only guarantee the claim was received.

At the Multi-value change prompt: "**Visit Number**", select a bill by its Line Item number. This will take you to that bill's claim data. There, you can find a bill's File ID and other such information, as seen in Figure 165 below:

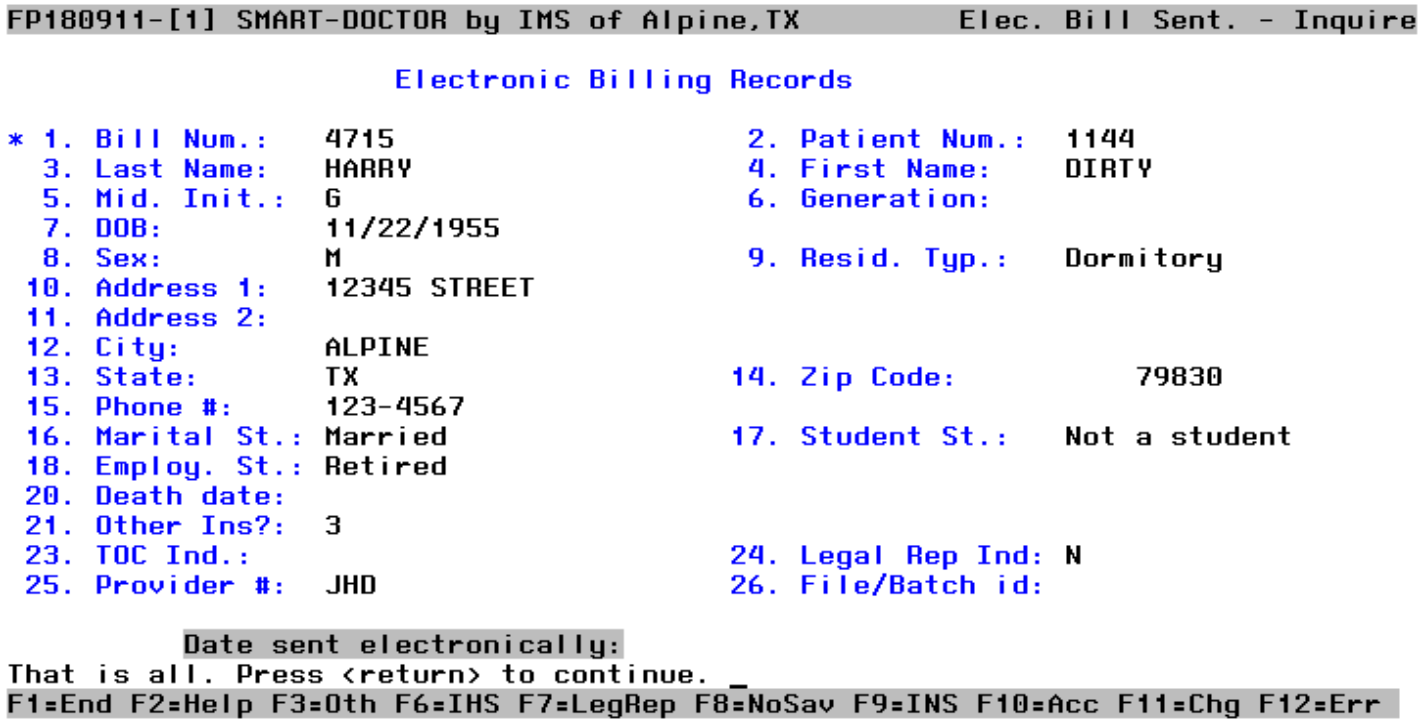


Figure 165 Record of Electronic Bill Transmitted.

Just above the F-Keys listed on the bottom of this screen, is the "**Date sent electronically:**" This will be populated by the system once sent electronically. The F-keys on the bottom of the screen can be used to look at the different components of information sent with this bill.

F3, Additional Billing Information, eg Referring Provider, employer name
F6, Indian Health Service Information
F7, Information on Legal Representative if other than the Patient
F9, Insurance Information
F10, Accident Information
F11, Charges and diagnoses
F12, Will take you to any reported errors by the carrier, once the response report is received from that carrier.

On selection of Menu item #2 (Figure 163), **"View individual bill Data."** , you will be taken to the screen shown in Figure 166 below.

Selection menu item #1, "**Date bill sent electronically**", enter the date the bill was sent electronically (usually the day after it was billed.) You may also enter the default, "ALL", to select on all electronic bills sent.

Selection menu item #2, "**Patient Number**", enter the patient number to select bills for that patient. "ALL" will include all bills.

Selection menu item #3, "**File/Batch ID**", enter a File/Batch ID to review the bills sent under that ID. "ALL" will include all bills. The resulting screen, as seen in Figure 167, will be presented repeatedly for all bills selected. To stop reviewing bills, hit the <F1> key to "end".

```
FP180910 SMART-DOCTOR by IMS of Alpine,TX      Review bills sent electronically.




          1. Date bill sent electronically: ALL

          2. Patient Number:                ALL

          3. File / Batch ID:               ALL
```

Figure 166 *Select Bill Individual Bills Sent Electronically.*

```
FP180911 SMART-DOCTOR by IMS of Alpine,TX            Elec. Bill Sent. - Inquire

                      Electronic Billing Records

* 1. Bill Num.:    4715                    2. Patient Num.:   1144
  3. Last Name:    HARRY                   4. First Name:     DIRTY
  5. Mid. Init.:   G                       6. Generation:
  7. DOB:          11/22/1955
  8. Sex:          M                       9. Resid. Typ.:    Dormitory
 10. Address 1:    12345 STREET
 11. Address 2:
 12. City:         ALPINE
 13. State:        TX                     14. Zip Code:           79830
 15. Phone #:      123-4567
 16. Marital St.:  Married                17. Student St.:   Not a student
 18. Employ. St.:  Retired
 20. Death date:
 21. Other Ins?:   3
 23. TOC Ind.:                            24. Legal Rep Ind: N
 25. Provider #:   JHD                    26. File/Batch id:

          Date sent electronically:
That is all. Press <return> to continue.
F1=End F2=Help F3=Oth F6=IHS F7=LegRep F8=NoSav F9=INS F10=Acc F11=Chg F12=Err
```

Figure 167 *Individual Bill Sent Electronically.*

Prompt #1, "**Bill Num.:**", if you know the Bill/Visit number you are looking for, you can enter it here. Otherwise, you can accept the defaulted bill number which will be in the set of bills you selected. As you come out of a selected bill, the next selected bill in the set will be made available for review.

When a bill number is entered, the prompts on the screen will be populated with that bills details. The main screen is primarily patient demographic data. You will find the File/Batch ID at the bottom, right hand side of the screen, prompt 26. The following informational screens are also

available through F-Keys:

F3 - Additional Billing Information, eg Referring Provider, employer name
F6 - Indian Health Service Information
F7 - Information on Legal Representative if other than the Patient
F9 - Insurance Information
F10 - Accident Information
F11 - Charges and diagnoses
F12 - Electronic response error messages

Response Reports

Select menu item #8, "**Response Reports**", from the main billing screen (Figure 103). The screen in Figure 168 will be presented:

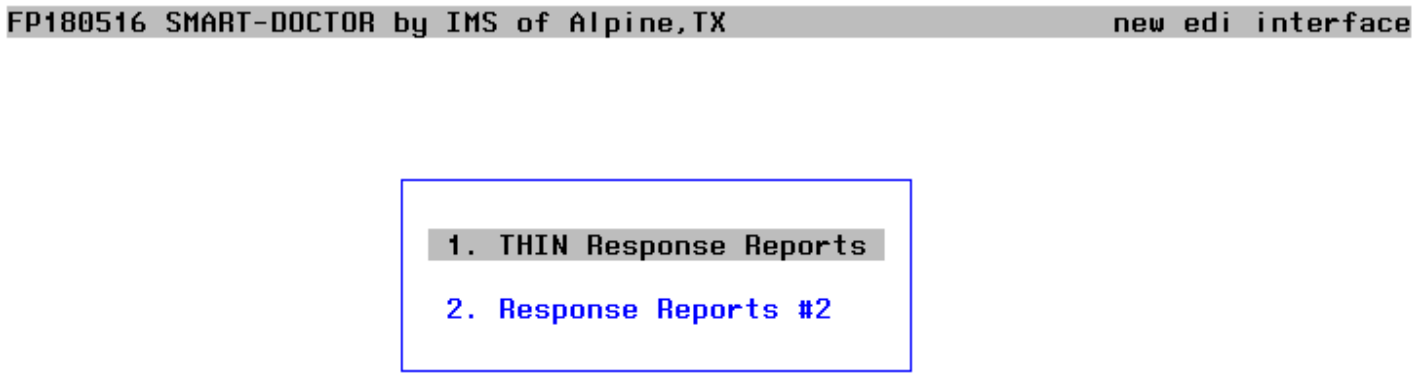


Figure 168 *Response Reports Selection Menu.*

The selection of Menu item #1, "**THIN Response Reports**", will allow you select and view Response Reports uploaded into SmartDoctor® system from THIN. The sub selection menu is shown in Figure 169 below.

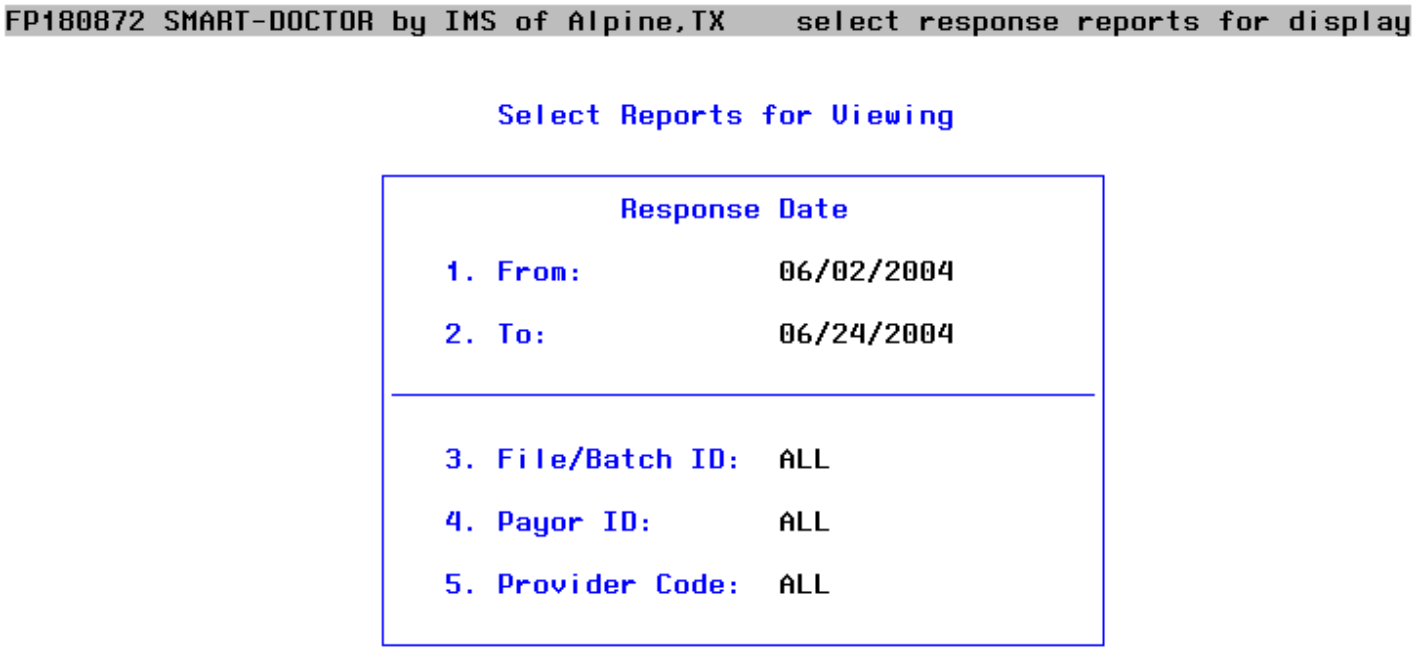


Figure 169 *Response Report Selection Menu.*

Menu selection item #1, "**From:**", enter the beginning date for report date range selection, or accept "TODAY" as default to only look at today's reports.

Menu selection item #2, "**To:**", enter the ending date for report date range selection, or accept "TODAY" as default.

Menu selection item #3, "**File/Batch**", enter the File/Batch ID of a claim file to select all reports reporting on that file. A claim's associated File/Batch ID may be referenced in the "View Individual Bill Data" program found on the "Review Bills Sent" menu. The default, "ALL," may be entered to select on all File/Batch IDs.

Menu selection item #4, "**Payor ID:**", enter the Payer/Carrier ID of an insurance carrier to select only reports for that carrier, or accept the default, "ALL," to select reports for all carriers. The Payer/Carrier ID is the key (prompt 1) to that insurance carrier's record in the "Carrier File," prompt 22 off the Patient and Family Main Screen.

Menu selection item #5, "**Provider Code:**", enter the Provider ID of a clinic provider to select only reports for that provider, or accept the default, "ALL," to select on all providers reports.

An example of the screen presented as a result of this selection is seen in Figure 170, below.

```
FP180873 SMART-DOCTOR by IMS of Alpine,TX          Display THIN RSPs -  Change

  * 1. Response Date:  06/02/2004          * 2. File/Batch ID:  100001
    (Date Report Downloaded from THIN)     * 3. Payor ID:       00900

LINE test
   1 rEDI-link Blue - Claim Acceptance Response
   2 ~~
   3 Response Date: 2000/12/20 Response Type: INITIAL  Response Time: 11:57:33
   4 ~~
   5 SENDER: XCLR00        THIN - CLEARINGHOUSE
   6 PAYOR: C00900        MEDICARE 'B' - TEXAS              Format: NSF
   7 ~~
   8 SUBMITTER    ID: 123456          FILE ID: 100001       Status: ACCEPTED/P
   9 Total  Claims:       5          Charges:       $343.16
  10 Claim Rejects:       0          Charges:         $0.00
  11 ------------------------------------------------------------------------
  12 PROVIDER     ID: 123456          BATCH ID: 100001 0001  Status: ACCEPTED/P
  13 Total  Claims:       5          Charges:       $343.16
  14 Claim Rejects:       0          Charges:         $0.00
  15 END OF REPORT
  16 ~~
L)ist _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 170 Viewing THIN Response Report.

If there were reports found within the selected set, their access information will be defaulted in prompts 1-3. The user need only hit the <enter> key at each prompt to accept the default key for the selected response report. When a valid response report key (date of download, File/Batch ID, and Payer ID) has been entered, the system will display this response report. Pg Up, Pg Down, and the up and down arrow keys can be employed to view reports which continue off the screen. Among the common F-Keys available, F3 is also available to print the screen image.

After a report has been viewed, the user may hit the <enter> key or the <F1> key to come out of the record and bring the next report in the selection set up for viewing.

The selection of Menu item #2 (Figure 168), "**Response Reports #2**", will allow you to view Response Reports from other payers by date of download. The screen seen in Figure 171 will be presented.

```
Welcome to the E-Response directory

Please Select a ClearingHouse:
    1) MEDICARE
    2) BLUESHIELD
    3) BLUECROSS
    4) Exit
Enter your choice _
```

Figure 171 Select ClearingHouse

Please select a ClearingHouse by entering the number for the ClearingHouse/Payer from which you would like to view reports. Otherwise, you may enter the number next to "Exit" to exit the program.

You will then be presented with the screen seen in Figure 172 to see the reports.

```
Welcome to the E-Response directory

Do you wish to:
     1) View Reports
     2) Print Reports
     3) Exit
Enter your choice _
```

Figure 172 Select to See or Print Reports.

Then enter <1> to view reports, enter <2> to print reports, or enter <3> to exit.

You will next be prompted as follows:

Enter date of Response Reports in MM/DD/CCYY:

Upon entering <06/04/2004>, and <enter>, you will be prompted as follows:

Response Reports downloaded on 06/04/2004

1) mail.643.13303
2) mail.651.13303

Enter number to View, or q, to quit to Main Menu:

When the selection screens have been completed, a list of reports in your selection set will be displayed (as seen above). Enter the number of the report on the list to select it. Enter <q> to quit to the main menu. These reports are displayed in the form they are received. No editing has been done on the downloaded file. Some reports come in an 132 character format. The PowerTerm®

client software can be set to a 132 character display if necessary. Upon entering <1> (above), the following report is displayed (Figure 173):

```
 H88RRR03                                NATIONAL HERITAGE INSURANCE COMPANY                                PAGE  305
                                            PROFESSIONAL EMC PROGRAM
PRODUCTION                                    MEDICARE-B EMC INPUT
                                            PROVIDER SUMMARY REPORT

                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: RLPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           RLPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004
                                          TOTAL              CLAIMS             CLAIMS             ERROR              DELETE
            PROVIDER #                    CLAIMS            ACCEPTED           DELETED             RATE               RATE
           -------------                 --------           --------           --------           -------            -------
              ZXX29338Z                      8                  8                  0                0 %                0 %
 H88RRR04                                NATIONAL HERITAGE INSURANCE COMPANY                                PAGE    1
                                            PROFESSIONAL EMC PROGRAM
PRODUCTION                                    MEDICARE-B EMC INPUT
                                          BATCH DETAIL CONTROL LISTING
                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: RLPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           RLPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004

 EMC PROVIDER : ZXX29338Z     BATCH NUMBER : 1
  PROV          REFERENCE       REC TYPE  DTL   FIELD IN          FIELD          ERR          MESSAGE           ERROR
  NUM            NUMBER                   NUM    ERROR           CONTENTS        NUM                          SEVERITY
---------- ------------------ ---------- --- ------------ -------------------- ---- ------------------------ -------------
 EMC PROVIDER : ZXX29338Z     BATCH STATUS : ACCEPTED
     TOTAL CLAIMS RECEIVED     :                2
     TOTAL CLAIMS ACCEPTED     :                2
     TOTAL CLAIMS DELETED      :                0
     TOTAL CLAIMS WITH ERRORS  :                0
     TOTAL CHARGES ACCEPTED    : $        208.98



 ZXX29338Z                                NATIONAL HERITAGE INSURANCE COMPANY                                PAGE    2
                                            PROFESSIONAL EMC PROGRAM
PRODUCTION                                    MEDICARE-B EMC INPUT
                                          BATCH DETAIL CONTROL LISTING
                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: RLPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           RLPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004
                                                             TOTALS FOR THIS FILE    000500435
     TOTAL CLAIMS RECEIVED     :                2
     TOTAL CLAIMS ACCEPTED     :                2
     TOTAL CLAIMS DELETED      :                0
     TOTAL CLAIMS WITH ERRORS  :                0
     TOTAL BATCHES RECEIVED    :                1
     TOTAL BATCHES ACCEPTED    :                1
     TOTAL BATCHES DELETED     :                0
     FILE TOTAL CHARGED        : $        208.98

 EMC PROVIDER : ZXX29338Z     BATCH NUMBER : 1
  PROV          REFERENCE       REC TYPE  DTL   FIELD IN          FIELD          ERR          MESSAGE           ERROR
  NUM            NUMBER                   NUM    ERROR           CONTENTS        NUM                          SEVERITY
---------- ------------------ ---------- --- ------------ -------------------- ---- ------------------------ -------------
 EMC PROVIDER : ZXX29338Z     BATCH STATUS : ACCEPTED
     TOTAL CLAIMS RECEIVED     :                3
     TOTAL CLAIMS ACCEPTED     :                3
     TOTAL CLAIMS DELETED      :                0
     TOTAL CLAIMS WITH ERRORS  :                0
     TOTAL CHARGES ACCEPTED    : $        411.81


 H88RRR04                                 NATIONAL HERITAGE INSURANCE COMPANY                                PAGE    4
                                            PROFESSIONAL EMC PROGRAM
PRODUCTION                                    MEDICARE-B EMC INPUT
                                          BATCH DETAIL CONTROL LISTING
                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: RLPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           RLPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004
                                                             TOTALS FOR THIS FILE    000500436
     TOTAL CLAIMS RECEIVED     :                3
     TOTAL CLAIMS ACCEPTED     :                3
     TOTAL CLAIMS DELETED      :                0
     TOTAL CLAIMS WITH ERRORS  :                0
     TOTAL BATCHES RECEIVED    :                1
     TOTAL BATCHES ACCEPTED    :                1
     TOTAL BATCHES DELETED     :                0
     FILE TOTAL CHARGED        : $        411.81
```

```
 H88RRR04                                  NATIONAL HERITAGE INSURANCE COMPANY                                  PAGE     5
                                                PROFESSIONAL EMC PROGRAM
PRODUCTION                                        MEDICARE-B EMC INPUT
                                                BATCH DETAIL CONTROL LISTING
                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: ALPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           ALPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004
 EMC PROVIDER : ZXX29338Z    BATCH NUMBER : 1
  PROV          REFERENCE        REC TYPE  D/L   FIELD IN          FIELD          ERR          MESSAGE            ERROR
  NUM            NUMBER                    NUM   ERROR            CONTENTS       NUM                             SEVERITY
---------- ------------------- ---------- --- ---------- -------------------- ---- ------------------------ ------------
 EMC PROVIDER : ZXX29338Z     BATCH STATUS : ACCEPTED
     TOTAL CLAIMS RECEIVED    :                3
     TOTAL CLAIMS ACCEPTED    :                3
     TOTAL CLAIMS DELETED     :                0
     TOTAL CLAIMS WITH ERRORS :                0
     TOTAL CHARGES ACCEPTED   : $         314.00


     TOTAL CLAIMS WITH ERRORS :                0
     TOTAL BATCHES RECEIVED   :                1
     TOTAL BATCHES ACCEPTED   :                1
     TOTAL BATCHES DELETED    :                0
     FILE TOTAL CHARGED       : $         314.00


 H88RRR04                                  NATIONAL HERITAGE INSURANCE COMPANY                                  PAGE     6
                                                PROFESSIONAL EMC PROGRAM
PRODUCTION                                        MEDICARE-B EMC INPUT
                                                BATCH DETAIL CONTROL LISTING
                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: ALPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           ALPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004
                                                             TOTALS FOR THIS FILE    000500437
     TOTAL CLAIMS RECEIVED    :                3
     TOTAL CLAIMS ACCEPTED    :                3
     TOTAL CLAIMS DELETED     :                0


     TOTAL CLAIMS WITH ERRORS :                0
     TOTAL BATCHES RECEIVED   :                1
     TOTAL BATCHES ACCEPTED   :                1
     TOTAL BATCHES DELETED    :                0
     FILE TOTAL CHARGED       : $         314.00


 H88RRR04                                  NATIONAL HERITAGE INSURANCE COMPANY                                  PAGE     7
                                                PROFESSIONAL EMC PROGRAM
PRODUCTION                                        MEDICARE-B EMC INPUT
                                                BATCH DETAIL CONTROL LISTING
                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: ALPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           ALPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004
                                                           TOTALS FOR THIS SUBMITTER
     TOTAL CLAIMS RECEIVED    :                8
     TOTAL CLAIMS ACCEPTED    :                8
     TOTAL CLAIMS DELETED     :                0
     TOTAL CLAIMS WITH ERRORS :                0
     TOTAL BATCHES RECEIVED   :                3
     TOTAL BATCHES ACCEPTED   :                3
     TOTAL BATCHES DELETED    :                0

     TOTAL FILES RECEIVED     :                3
     TOTAL FILES ACCEPTED     :                3
     TOTAL FILES DELETED      :                0
     SUBMITTER TOTAL CHARGED  : $         934.79
```

Figure 173 *Sample Response Report.*

The above report shows that there were 3 batches of charges sent in 3 files, with a total of 8 claims. There were no rejections.

```
 H88RRR04                                  NATIONAL HERITAGE INSURANCE COMPANY                                  PAGE     1
                                                PROFESSIONAL EMC PROGRAM
PRODUCTION                                        MEDICARE-B EMC INPUT
                                                SUMMARY OF ERROR MESSAGES
                                SUBMITTER ID: BXB32038B      SUBMITTER NAME: ALPINE PRACTICE GROUP
                                                             ADDRESS:        1233 S. 110TH STREET
                                                             CITY:           ALPINE
                                                             STATE/ZIP:      TX  79830
                                                           PROCESS DATE: 05/28/2004
     PROVIDER #                                              MESSAGE                                    OCCURRENCES
     ----------                                  ------------------------                               -----------
```

Figure 174 *Response Reports Cont.*

The last page above is the summary of errors, in this case none.

To page through this report, just hit the <enter> key.
To go up, hit the <-> “minus” key followed by <enter>. To quit looking at the report, hit <q> to quit.

Upon entering <2> above, the second report is shown. This is the transmission report, is seen below in Figure 175.

Report for BXB32038B, submission id: p6447154.323342 (200406020316.3)

Initial transmission successful. For a more complete review of your transmission and final acceptance, please review your 997 functional acknowledgment(s) in your CABBS mailbox the next business day.

GS-GE segment: 837 version 004010X098A1: Claim(s) counted : 3

Total number of 837 claim(s) received this transmit : 3
(EOF):

Figure 175 Transmission Report.

After reviewing the reports, hit <q> to quit and go back to the previous screen. Once finished reviewing all reports, enter the number next to “Exit” on the “Select a ClearingHouse” screen to exit.

APPOINTMENTS NEEDING PRIOR AUTHORIZATION

Select menu item #9 , “**Appts. Needing Prior Authorization**”, from the main billing screen (Figure 103). The screen seen in Figure 176 will be presented.

```
FP181001 SMART-DOCTOR by IMS of Alpine,TX     Before appt. Prior Auth. -  Change

 * 1. Sequence Number: 100.....                    Patient Number:
      Patient Name:    ..................................   Gen:  ...
      Date of Birth:   .........                             Sex:  .
      Family Number:   .........
      Resp. Party:     ..................................
      Patient is:      ..............
------------------------ Appointment or Procedure Scheduled ------------------------
      Prov. Init.:     ....          Symptom/Reason:  ...................
      Date Scheduled:  .........     Time:            .....
-------------------------------- Prior Authorization --------------------------------
   2. Ins. Doc. #:     ......        Ins. Co. Num:  ........
      Ins. Co. Name:   ....................................
      Ins. Co. Phone:  ............
 Line CPT/Desc Prior Auth. Num. Who Issued/ext Start Date End Date  Org# #Rem

F1=End/Exit  F2=Help  F4=QuickMenu  F5=Calendar  F8=Exit-NoSave
```

Figure 176 Appointments Needing Prior Authorization.

If any prior authorization appeared to be needed during an appointment scheduling, and you indicated you wanted a reminder to get a prior authorization, then a record will be waiting in the file for completion. If there are no records requiring a prior authorization, then prompt #1, "**Sequence Number:**", will be blank.

If a "Sequence Number" is shown, then by simply hitting the <enter> key the screen will be populated with the needed information, as well as a pop-up of any individual insurance companies, as shown in Figure 177 below.

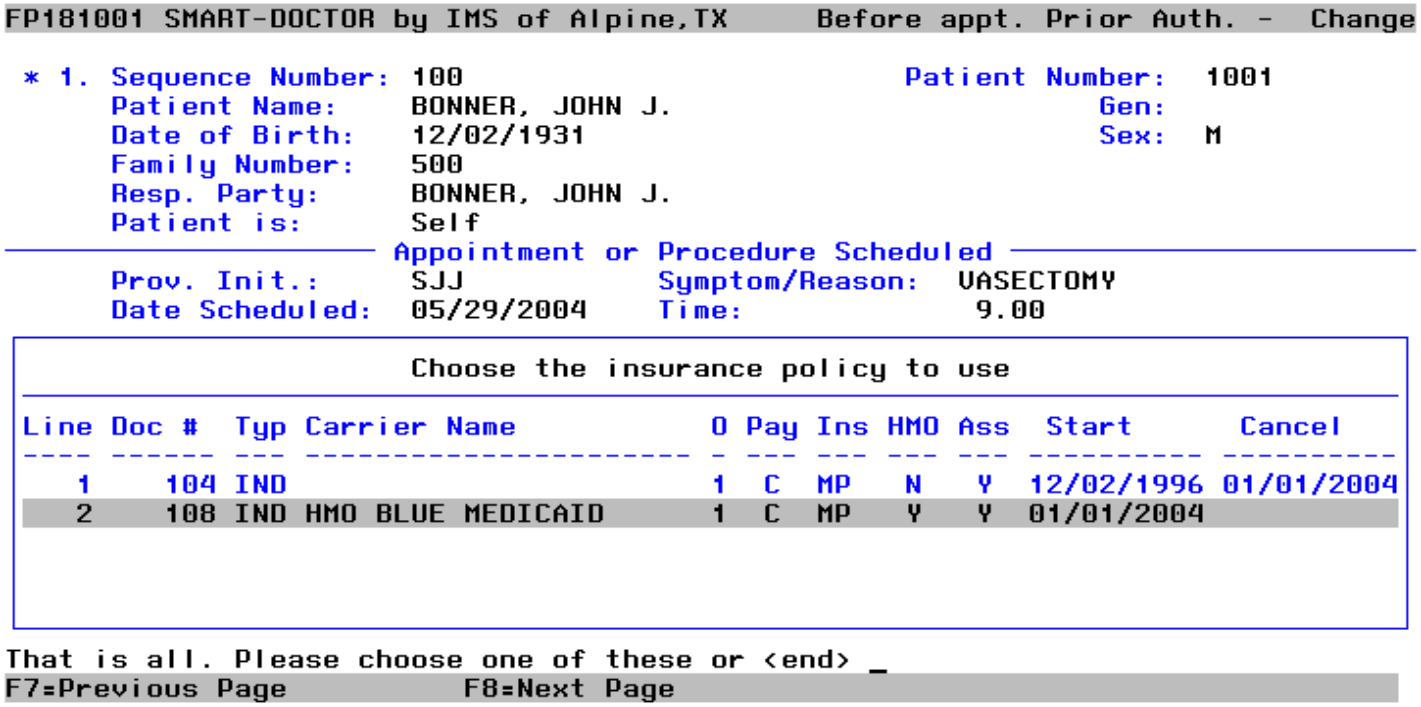


Figure 177 *Choosing Insurance for Prior Authorization.*

Choose the appropriate insurance carrier from those presented. Then the screen shown in Figure 178, with additional information for contacting the insurance carrier, will be presented.

With the insurance carrier name and phone number now presented in prompt #2, you can call the insurance carrier to obtain the remaining information needed in the subsequent multi-valued prompt. In the first field of that prompt, you can enter a partial description of the procedure needed based on the information in the "Symptom/Reason" prompt. A cross-reference lookup will be done for you, so you do not need to know the procedure number ahead of time. Then enter the Prior Authorization Number, Who Issued with an extension number if appropriate, the date the procedure can first be performed, the last date the procedure can be performed, the original number of times the procedure is authorized, and the remaining number to be preformed.

Next a pop-up screen is presented asking the following two questions:

1. **Post to file and delete this record?** .
2. **Delete this record without posting?**

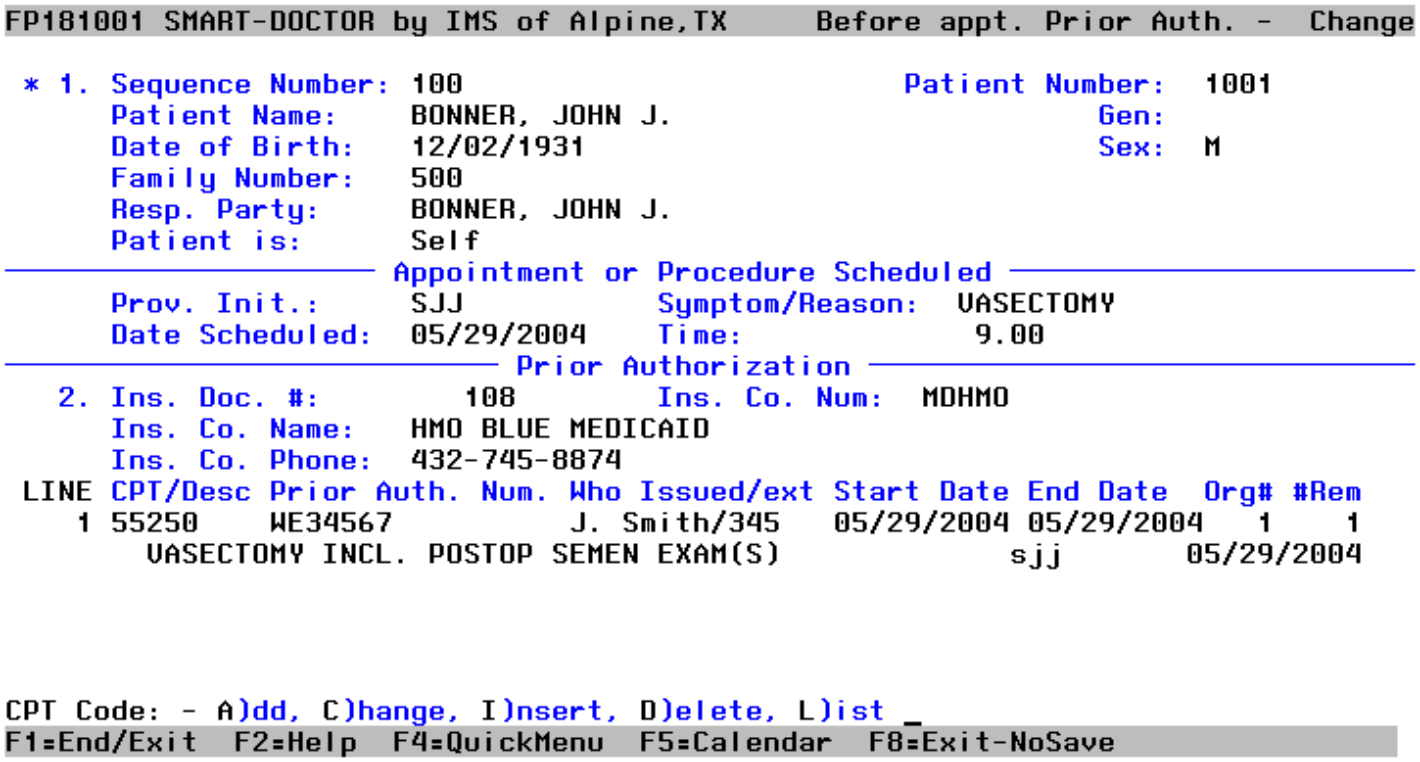


Figure 178 Entering Prior Authorization Information.

For the first prompt, enter <y> if you want to post the Prior Authorization information to the patient's insurance document file and delete this record. Enter <n> if you are not finished or you do not want to post the information at this time.

If you answer <y> at the first prompt, the second prompt will be skipped since the record will automatically be posted and deleted. If you answer <n> at the first prompt, you will then be placed at the second prompt. At the second prompt, if you indicate <y> to "**Delete this record without posting?**", then a subsequent screen will pop-up with the following warning:

You are about to delete this reminder record without posting a Prior Authorization to the Insurance Doc.

1. Do you still want to DELETE(y/n)? .

If you want to delete this record because you do not need a prior authorization, then answer <y>. Else, if you want to leave this reminder in the file and exit, answer <n>.

This information will be place in the individual's prior authorization section of the associated insurance document on normal exit from this screen. The result of posting the above prior authorization is shown below (in Figure 179) in the patient's insurance document.

BILLS NEEDING PRIOR AUTHORIZATION

Select menu item #10, "**Bills Needing Prior Authorization**", from the main billing screen (Figure 103). You will then be placed in a screen that is identical and processed in the same way as in prompt #9, "Appts. Needing Prior Authorization", above (Figure 179). However, this queuing is a result of the billing process when a required prior authorization is not found at the time of billing. The bill is suspended and placed in this queue for later processing, once the prior authorization has been

obtained. Once the prior authorization information is completed, the system will ask you if want to process the bill and delete this record, similar to the preceding section.

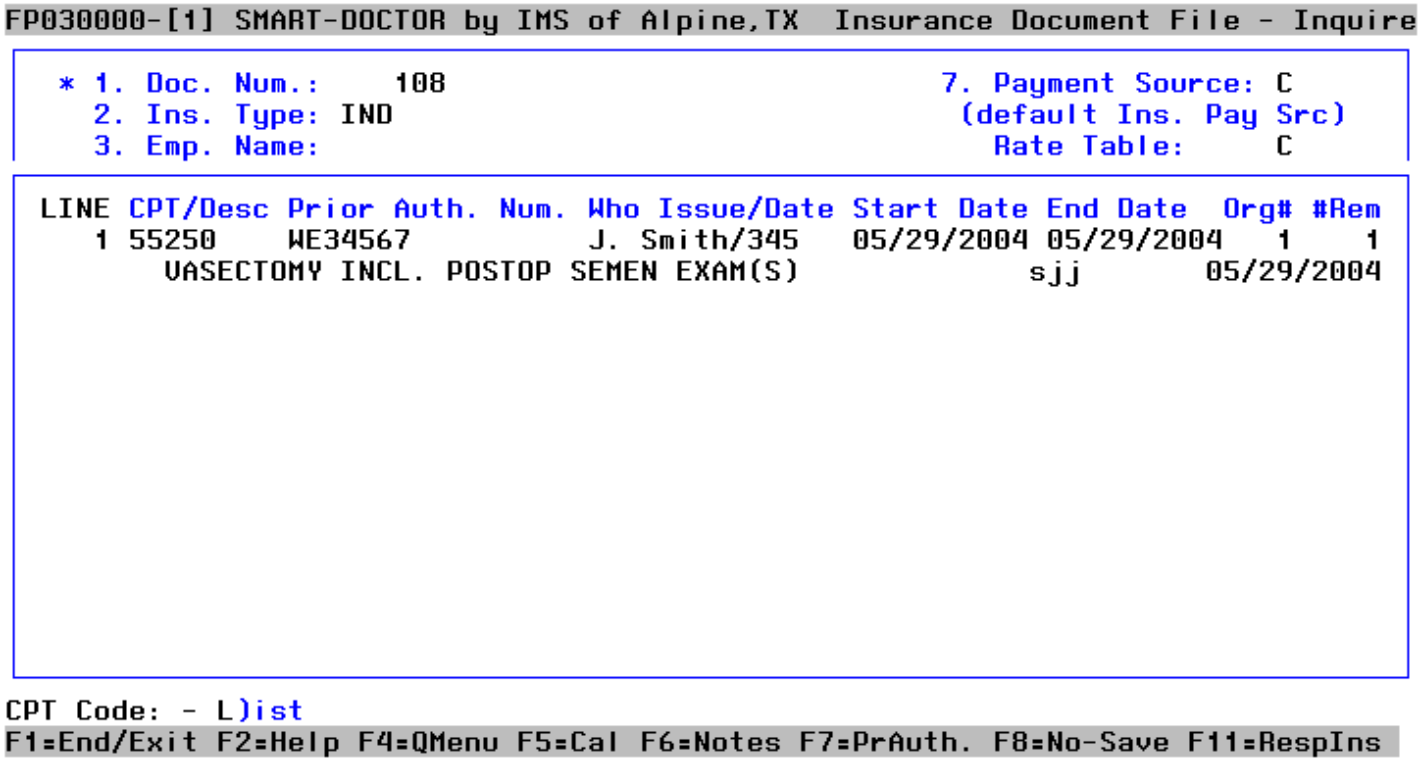


Figure 179 Completing the Prior Authorization Request.

PRINT GROUPED BILLS

Select menu item #11, "**Print Grouped Bills**", from the main billing screen (Figure 103).

A screen will be presented titled: "Group Billing Report". At the bottom of the screen will be the standard screen print options:

Enter (S)creen, (P)rinter, (B)oth, (F)ile, or (O)ther printer : S

Enter <p> to print the bills.

DAILY ADMIN

Select menu item #12, "**Daily Admin**", from the main billing screen (Figure 103).

The following screen shown in Figure 180 will be presented.

Meaning of "Daily System Monitor" screen information:

Backup

Good, indicates that a verified back-up was performed successfully. You must take a copy of the backup media off site for storage. This will insure that you have a good backup copy of all your data should the building burn down, or if someone steals the

server.

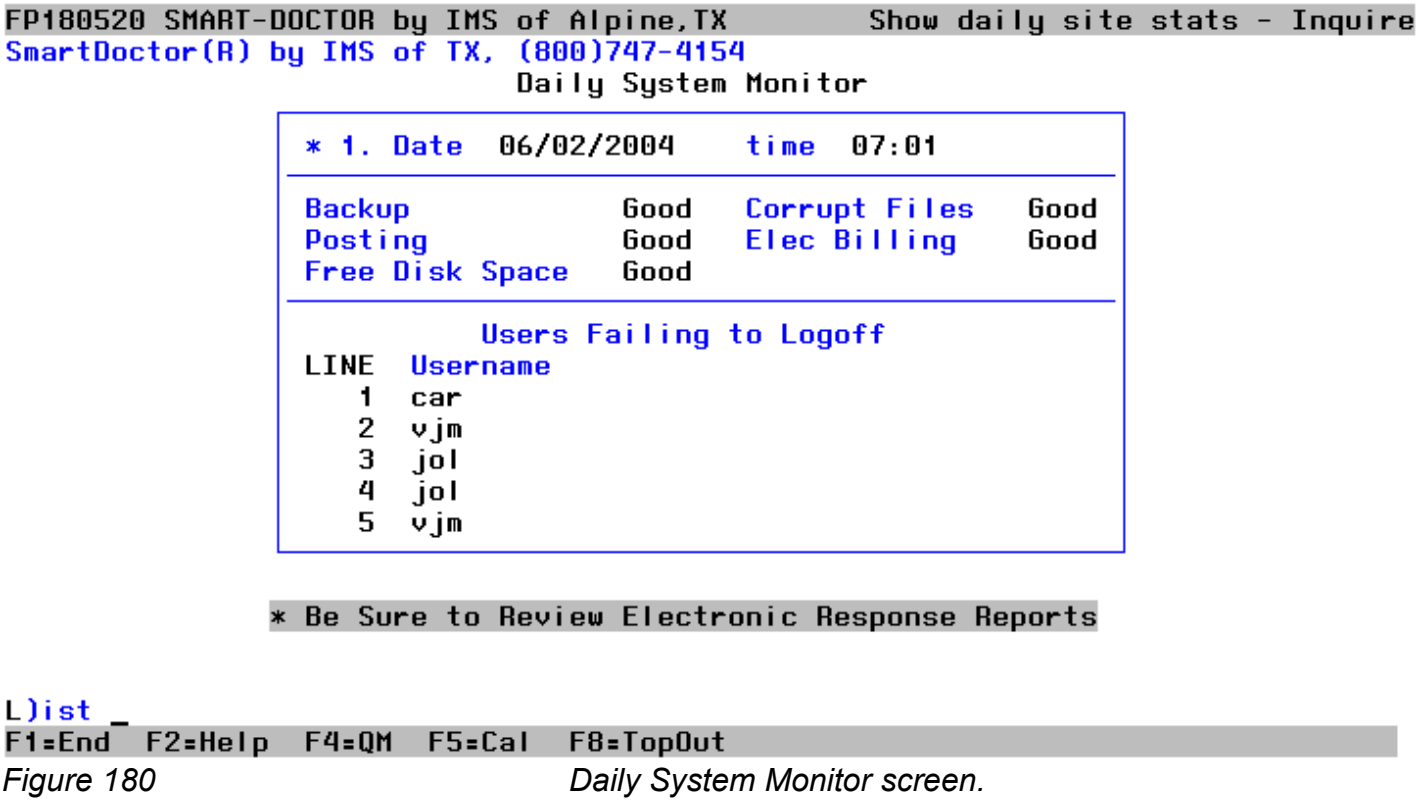


Figure 180 *Daily System Monitor screen.*

Bad, indicates that the backup has failed. Check the the media was in the backup device and that it was not set on write-protect. If no apparent cause is found, call your hardware support personnel, system administrator, or IMS immediately.

Posting

Good, indicates that an integrity check of all accounting information from the beginning of time was done, and was successful. This check involves comparing all items in the Family Ledger to that of the Charge Item file and the DailyPost file. This makes sure that not only todays data is intact and balances, but all the data from system initialization. Other systems are not as comprehensive, so that previous data may be damaged and will not be discovered until the old information is reviewed. This cannot happen with the SmartDoctor® system.

Bad, indicates a failure. This is most commonly caused by the system being down or turned off at the scheduled time that this checking is to take place. If this is the case, as in a one day power outage, then you can correct this easily. Go to the main front office menu and select menu item #11, "**Daily Accounting**". Then on the "Daily Accounting" menu select #1, "**Proof of Posting**". For the proof of posting date, enter a date at least two days before the day of failure. If this is successful, repeat this again for each subsequent date through yesterday's date. All users should be off the system while doing this. If proof of posting fails again, call IMS.

Free Disk Space

Good, indicates that there is greater than 20 percent free disk space. This is satisfactory

for normal system performance.

Bad, indicates less than 20 percent free disk space. System performance may start to suffer. Call your system administrator, or hardware support person, to have this corrected within the next week.

Corrupt Files

Good, indicates that all the system data files are in good order with no data corruption.

Bad, indicates that one or more data files are corrupted. **THIS IS AN EMERGENCY.** Call IMS immediately. Stop using the system if possible. The most common case for this is failing hardware.

Elec Billing

Good, means that the bills pending electronic transmission were processed and sent successfully.

Bad, means the bills pending electronic transmission were not sent. Check that the modem or network connections are intact and working. Be sure, if using a modem that the phone line is connected. Be sure that this phone number can make long distance calls. The best way to check the phone line is to connect a standard phone to the line going to the modem and make a long distance call.

The problem can also be caused by the carrier or THIN not being able to accept files because of a system problem on there side. However, any file not sent on a given day will be held and sent again the next day with any other new files to send. If the problem persists for more than one day call IMS.

Users Failing to Log Off

This is a multi-valued listing of all users that have not logged off the system at the time of file integrity checking. This checking is generally done during early morning hours, before 6 AM. Users generally should not be logged on at these times. Being logged on during this time may prevent file tuning. The administrator will also get a separate mail message regarding this problem. You should check with these users to ask why they haven't logged off, or why they were on the system at these hours.

This problem may also rarely exist with a hung process that was not terminated properly, such as turning off a PC on the network that was in an open document. The system is set to kick off all idle users after a clinic-determined amount of time. Therefore, all persistently logged on users should be investigated. Call your system administrator or IMS.

CHAPTER 4 MANAGE PATIENT CARE

PATIENT SIGN-IN

When a patient arrives at the clinic, you must first sign that patient in. To do so, select menu item #2, "**Patient Sign-in**", from the clinic front office screen (Family & Patient File Maint.). You will be taken to the screen shown in Figure 181 below.

Prompt #1, "**Visit Number:**", will have the next visit number defaulted for you. You must except this number by hitting <enter> to continue.

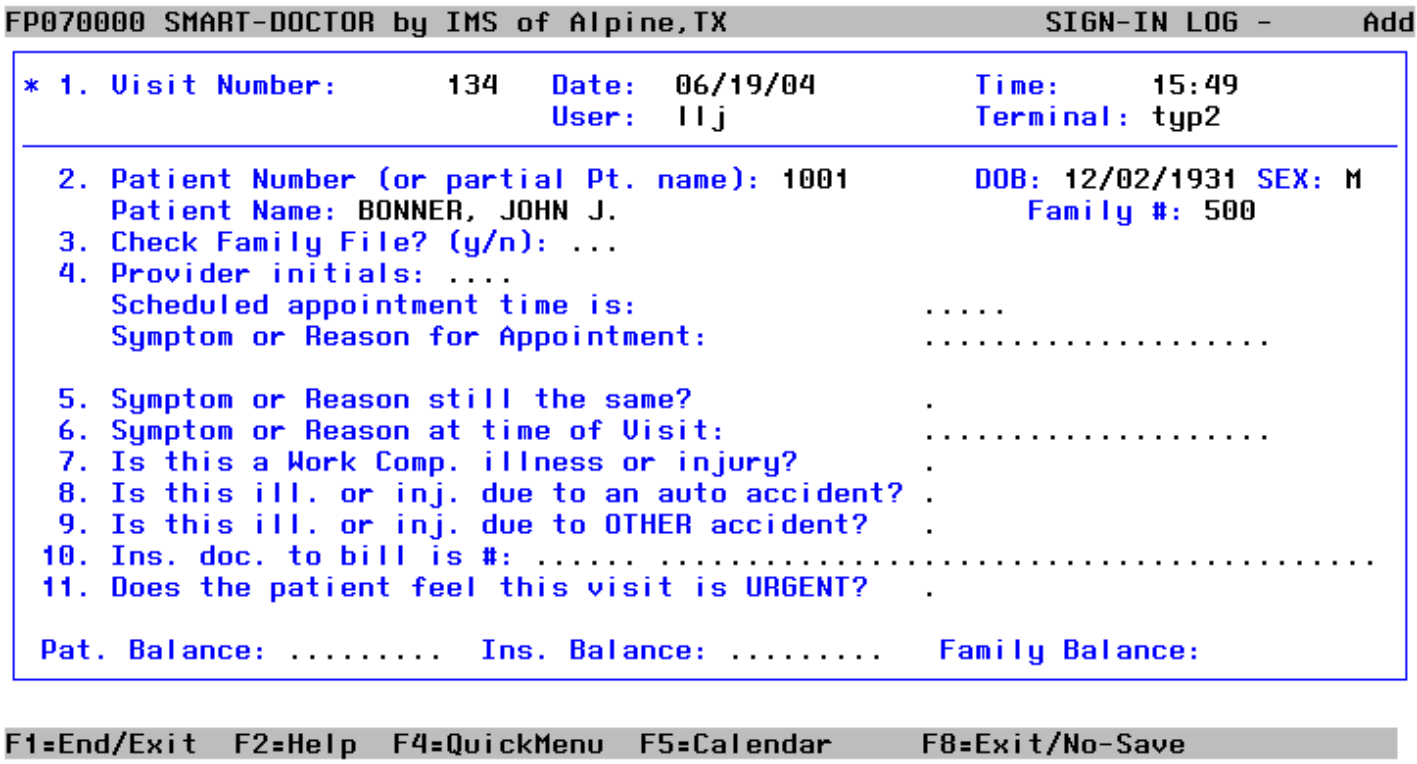


Figure 181 *Patient Sign-In.*

Prompt #2, "**Patient Number (or partial Pt. Name):**", enter the patient number, or at least three letters of the first or last name. You can narrow the search by giving more letters of the name, or giving at least two additional letters of another name.

Prompt #3, "**Check Family File? (y/n):**", if you want to review the Family file. i.e. check address, phone numbers, etc., hit <enter>, or enter <Y>. To avoid seeing this information (because you are sure it is current), enter <N>. If you hit <enter> or <y>, you will be taken immediately to this patient's family file and the "FAMILY FILE MAINTENANCE" screen. Here you will be in the inquire mode, so that you do not accidentally make changes to that file. If you find the information is incorrect, then you can correct it by hitting the <F4> key for the QuickMenu. Then then go to the Family file in the change mode.

Prompt #4, "**Provider initials:**", enter the providers initials or at least three letters of the provider name for a selection list.

Prompt #5, "**Symptom or Reason still the same?**". Ask the patient if the reason for the visit is the same as initially scheduled, as indicated next to the heading "**Symptom or Reason for**

Appointment:". If it is, then answer <y>es. If the current problem the patient wants evaluated is different, then answer <n>o.

Prompt #6, "**Symptom or Reason at time of Visit:**". If you entered "yes" at prompt #5, then this will be defaulted to the initial "Symptom or Reason for Appointment". If you answered "no", then enter the symptom or at least three letters of the symptom to get a cross-reference lookup to select from.

Prompt #7, "**Is this a Work Comp. illness or injury?**", enter <y> if worker comp. related. Otherwise, accept the default of "N".

Prompt #8, "**Is this ill. or inj. due to an auto accident?**", if this illness or injury was due to an auto accident enter <y>. Otherwise, accept the default of "N".

Prompt #9, "**Is this ill. or inj. due to OTHER accident?**", enter <y>. Otherwise, accept the default of "N".

Prompt #10, "**Ins. doc. to bill is #:**". When you get to this prompt, the insurance selection screen will pop open automatically, as shown in Figure 182 below.

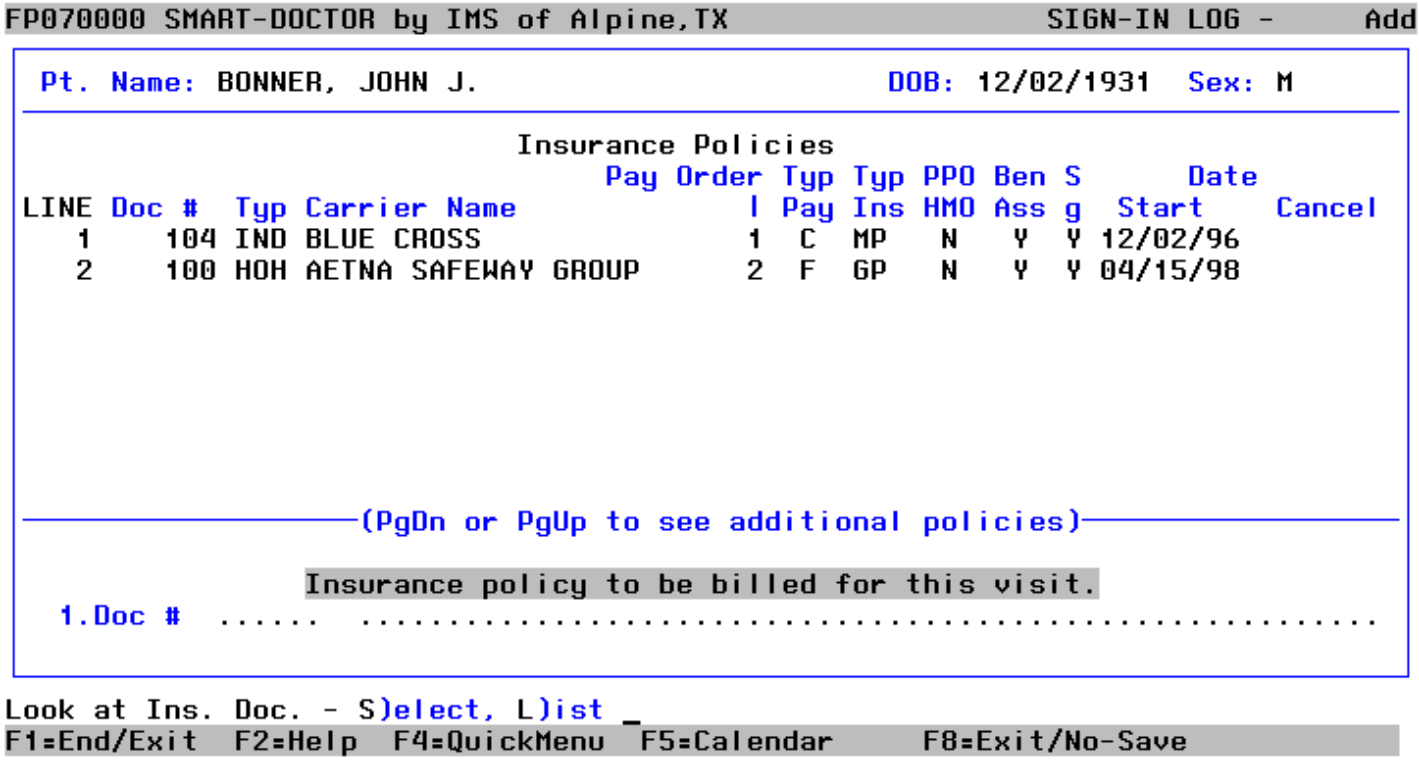


Figure 182 View Insurance Policies Available for this Patient.

You are initially placed at the change prompt "Look at Ins. Doc", for the top half of the screen. The multi-valued prompt here shows all the patients possible insurances, starting with the individual insurances, followed by any HOH insurances. To see more information on any of these, enter the line number at the prompt and hit enter. The insurance document screen for this document will be presented. Once you are ready to go on an select one of these for billing, hit the <enter> key to bring you to the second half of the screen and prompt #1, "**Doc.**". This prompt automatically opens up the insurance selection screen, as seen in Figure 183.

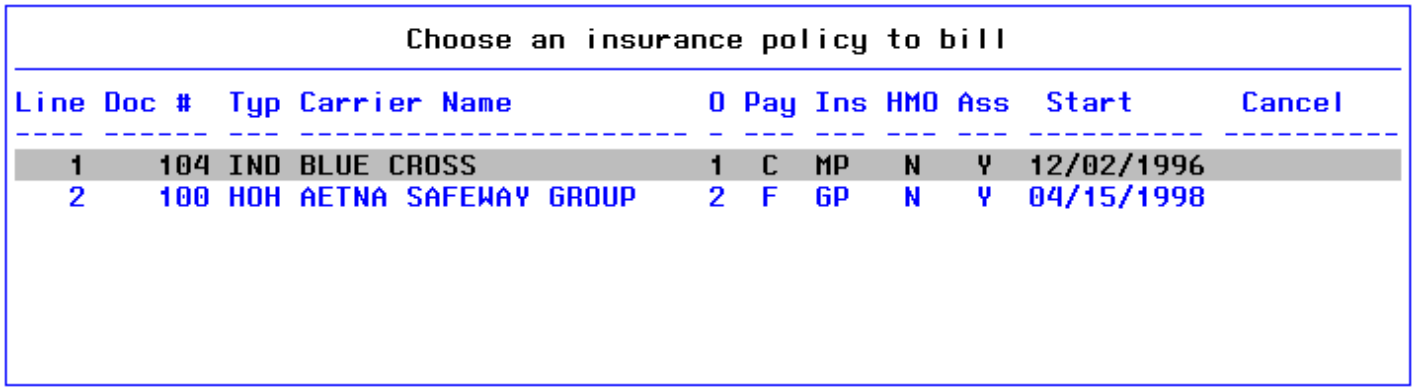


Figure 183 *Choose Insurance to Bill.*

Use the up and down arrows or enter the line number of the insurance document that will be used for this visit and hit <enter>. In this case we chose the first one and now our screen appears as shown in Figure 184.

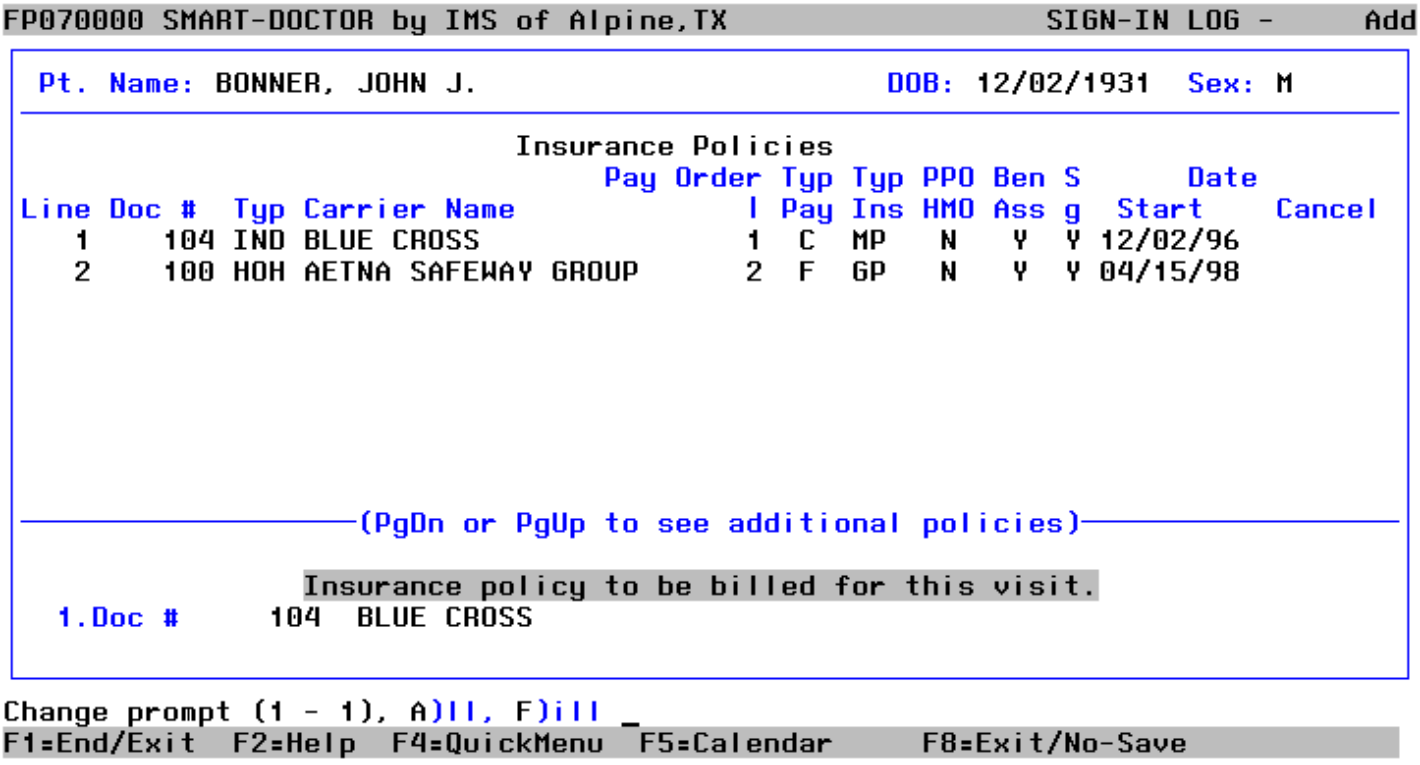


Figure 184 *Insurance Policy for Billing Selected.*

You will then be at the "**change prompt**". If you need to change the insurance policy enter <1> or <a>, to get back to the selection screen, otherwise hit <enter>. You will then be returned to the primary Sign-in screen with the selected insurance document number and insurance company showing to the right of prompt #10, as shown in Figure 185..

At this time, if the insurance company selected requires prior authorizations for any procedures, a warning message will be shown flashing at the bottom of the screen with the message "**Please check for need of Prior Authorization**". You can check the insurance carrier file to see what prior

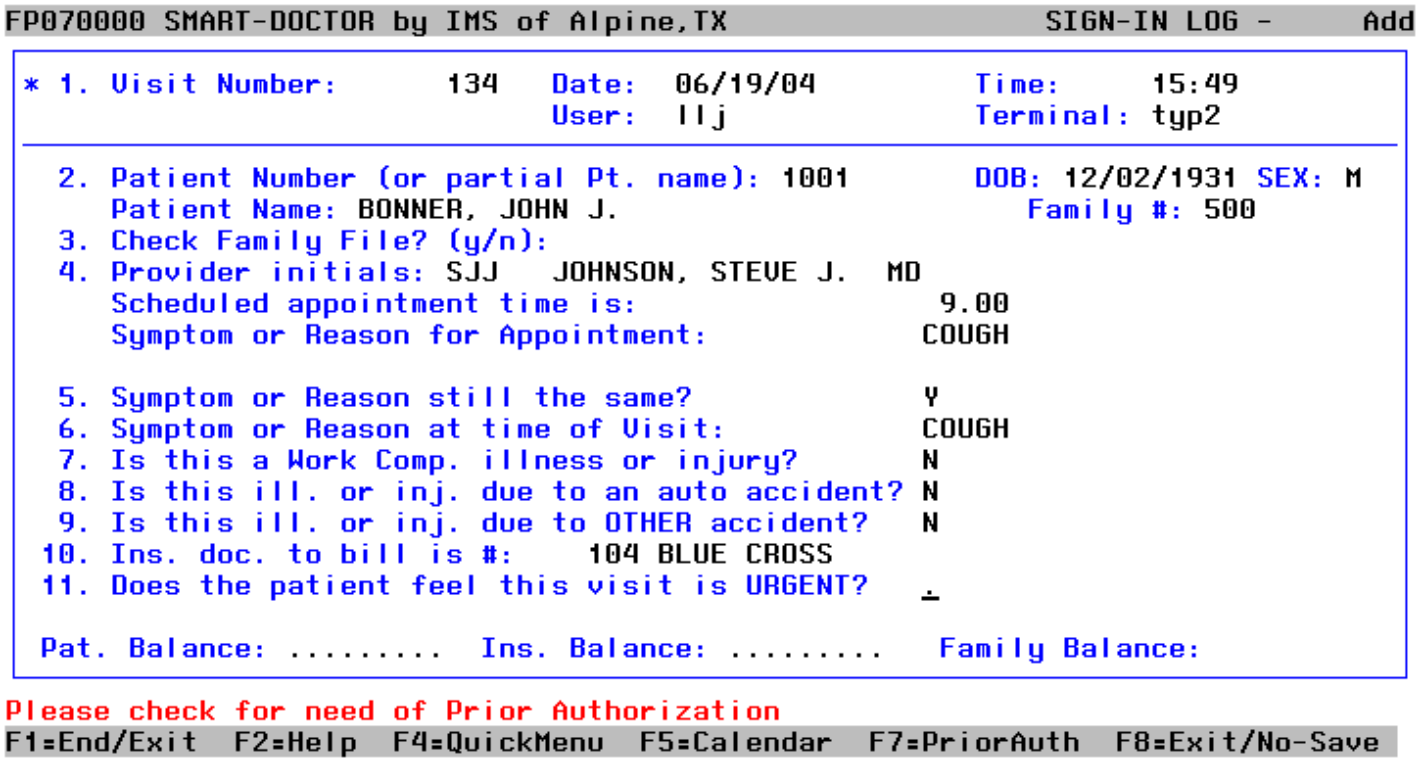


Figure 185 *Sign-in screen with Insurance Selected.*

authorizations are required by this carrier by using the QuickMenu <F4> key. Then, the Insurance Carrier File prompt to check out the carrier requirements. Otherwise, if this message is not shown, or you feel this type of visit (i.e. A cough evaluation.) would not need a prior authorization, then go on to the next prompt.

Prompt #11, "**Does the patient feel this visit is URGENT?**". Ask the patient if he/she feels this problem to be evaluated or treated is URGENT. If the answer is "yes", then enter <y>es. If not, enter <n>o. If you place a "y" at this prompt, a flashing URGENT sign will start flashing on your screen. You will also be asked to notify the nurse that the patient thinks this visit is urgent. This flashing sign will also be on the nurse's screen and the provider's screen. If the answer was "n", then a steady message stating, "Notify the Nurse: the patient is here.", will be shown.

Next a pop-up window, as shown in Figure 186, will show information from the insurance carrier file regarding: Percent Paid by Patient, Deductible for Year, Basic Co-Pay per Visit, and any special payment requirements for this carrier. Also, presented below this will be additional patient and family specific payment information from the patient and family file that your office requested to be shown on Sign-In & Billing screens.

Also now displayed is the balance due that is the patient's responsibility , the insurance carrier's responsibility, and the combined amount.

The <F7> key, "PriorAuth". This key allows you to bring up the patient's prior authorization screen from the Patient file, if you would like to see if any prior authorizations exist.

The <F8> key, "Exit/No-Save". This key will allow you to cancel everything you did up to this point on this screen.

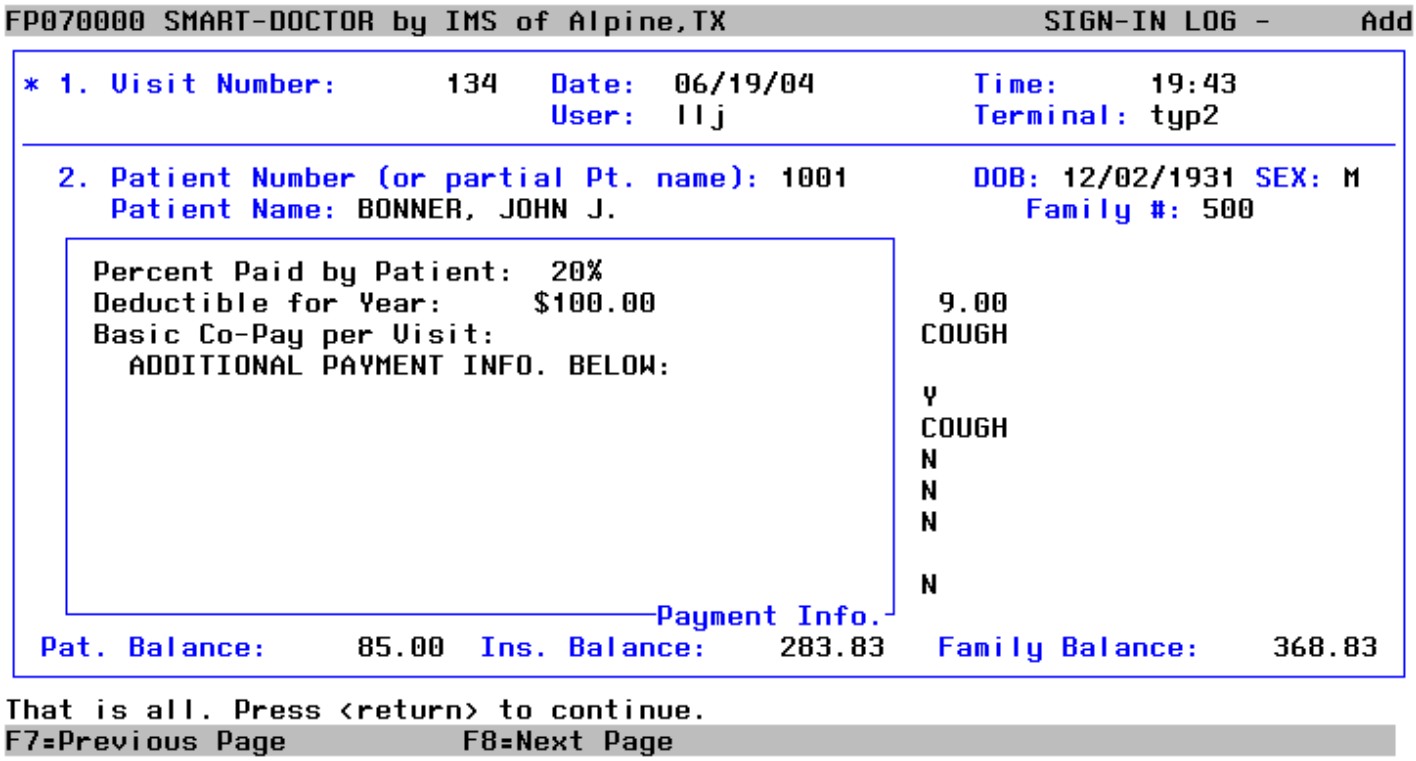


Figure 186 *Window Showing Payment Information.*

ENCOUNTER NOTES AND USER CLASSES

Any contact, communication, comment, note, message, or action taken regarding a patient is documented via an encounter note. There are three types of encounters: “Non-Visit Encounter”, “Provider Visit”, and “Non-Scheduled Provider Visit”. The “Non-Visit Encounter” type can be made by one of three classes of users: Clerical (or Administrative), Nursing, and Prescribing Providers (or Doctors). The “Provider Visit”, and “Non-Scheduled Provider Visit” types can only be made by Nursing, and Prescribing Providers. Depending on the user class, different functions are allowed on the same screens. In addition, certain functions may not show up as an options to choose depending on the provider class. For example, in the “Non-Visit Encounter”, the “Clerical” class will not be presented with the opportunity to refill medications or the review the chart. The Nurse class will be able to refill prescriptions approved by the doctor, but is otherwise unable to refill or write prescriptions. The Nurse, however, may review the chart. The Prescribing Provider class has full privileges.

The sign-out is also different depending on user class. For the clerical user, they just indicate that they want to exit the note. The system will track the users actions. However, for the nursing and prescribing provider classes, once they indicate they want to exit, they will be presented with a sign-out screen. To sign-out they must use their sign-out password. This acts as a signature stamp to authenticate the note and actions taken.

NON-VISIT ENCOUNTER, CLERICAL USER

From the main front office screen (Family & Patient File Maint.), select menu item #5, “**Non-Visit Encounter**”. This selection allows the clerical staff to enter Non-Visit encounter information, such

as a patient phone call, or notes for the chart. These communication's can be filed in the chart, or forwarded on to the nurse or provider. For nursing and prescribing providers, the above information can be entered, as well as to access the regular provider parts of the chart. Examples of use by these classes of providers will be shown later in the Nursing and Provider sections of this manual. On selecting this menu item, the screen shown in Figure 187 will be presented.

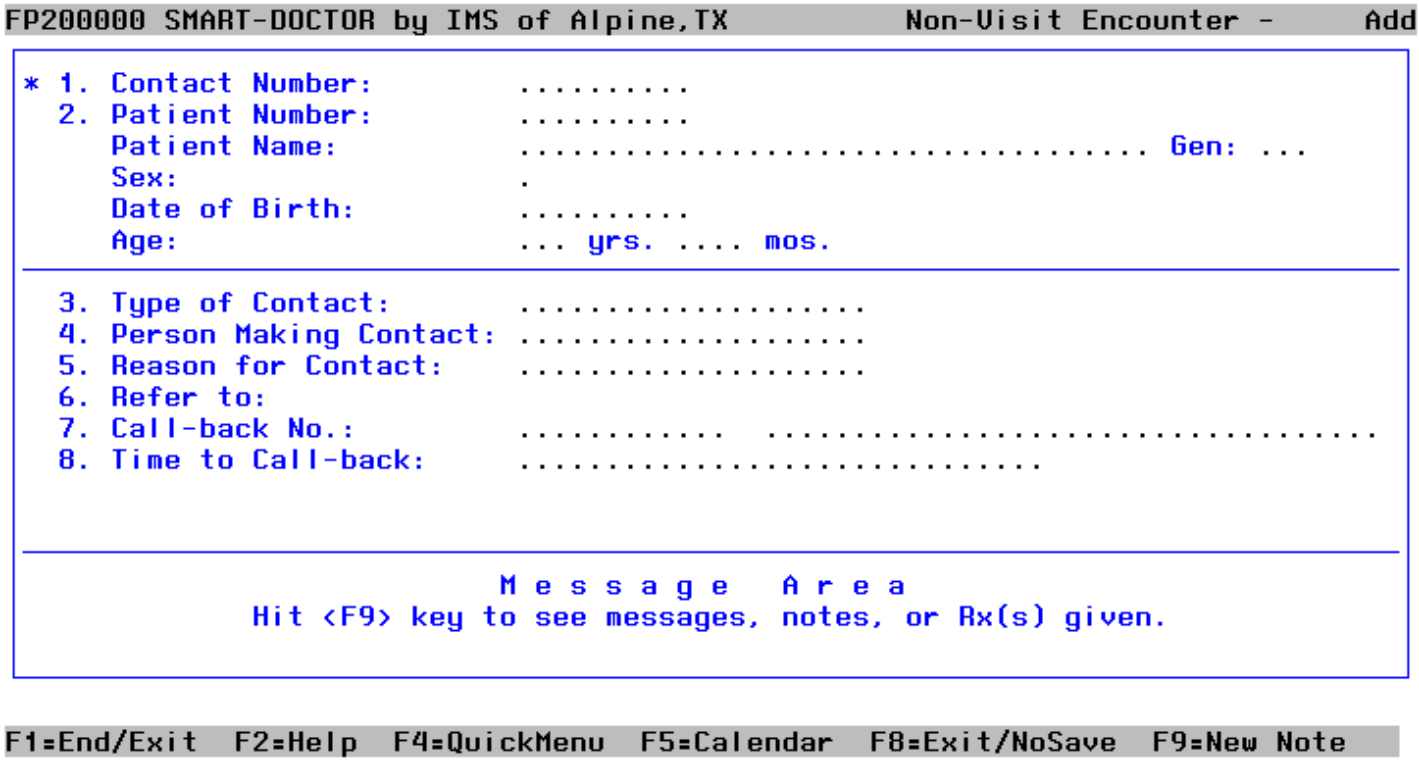


Figure 187 Non-Visit Encounter screen.

Prompt #1, "**Contact Number:**", hit the "**New Note**"-<F9> key to get the next patient encounter number. This is a system provided number that cannot be changed.

Prompt #2, "**Patient Number:**", enter at least 3 characters of the patient's name for a cross-reference search, or the patient's number. You will next be presented with a pop-up window asking "**Is this the correct PATIENT? (<ret>=Yes/n=No)**". If you answer <n>, then you will be kicked out of this note and presented with a new "Non-Visit Encounter" screen. If you answer <y>, the pop-up window will change to that shown in Figure 188, with the additional question of "**Is this the correct Address and Phone number?**". If you answer <n>, then you will be taken to the family maintenance sub-menu screen for this family, to change the family address information. Upon return you can proceed with the non-visit encounter note as shown below. If you answer yes, you will proceed directly with the note as indicated below, see Figure 189 below..

You will note the patient's information is placed at the top of the screen. You will now be taken through a set of pop-up selection screens to help you document the following information about the contact with the patient: "Type of Contact", "Person Making Contact", and "Reason for Contact". These selections will fill in prompts 3, 4, and 5 for you. The selection options presented can be changed for your clinic. If you would like these changed, have your clinic manager contact IMS. These selection lists are in the TERMS file with the following three corresponding records: "CONTACT-TYPE", "CONTACT-INDIV", "CONTACT-REASON".

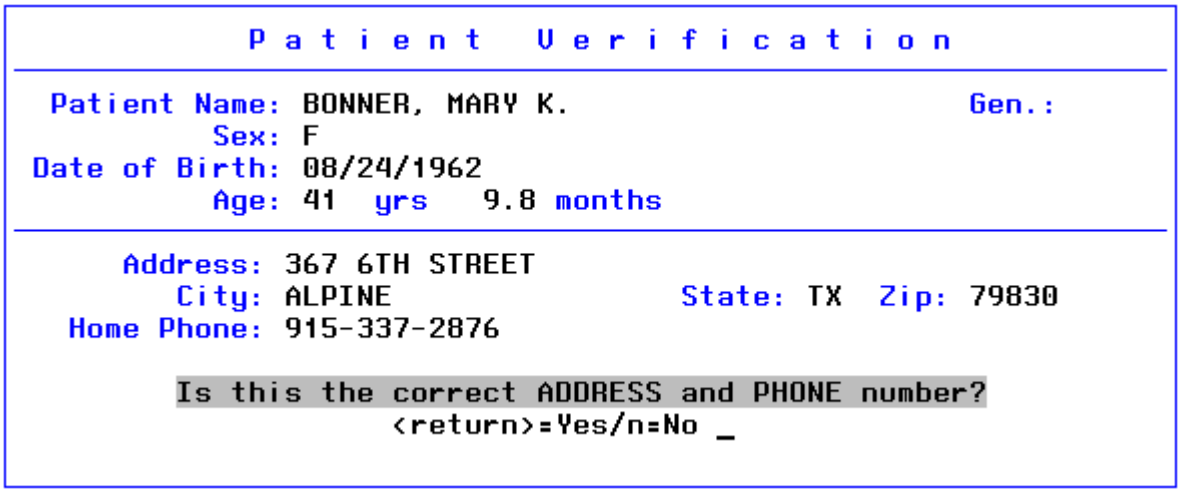


Figure 188 Verify Correct Patient and Address window.

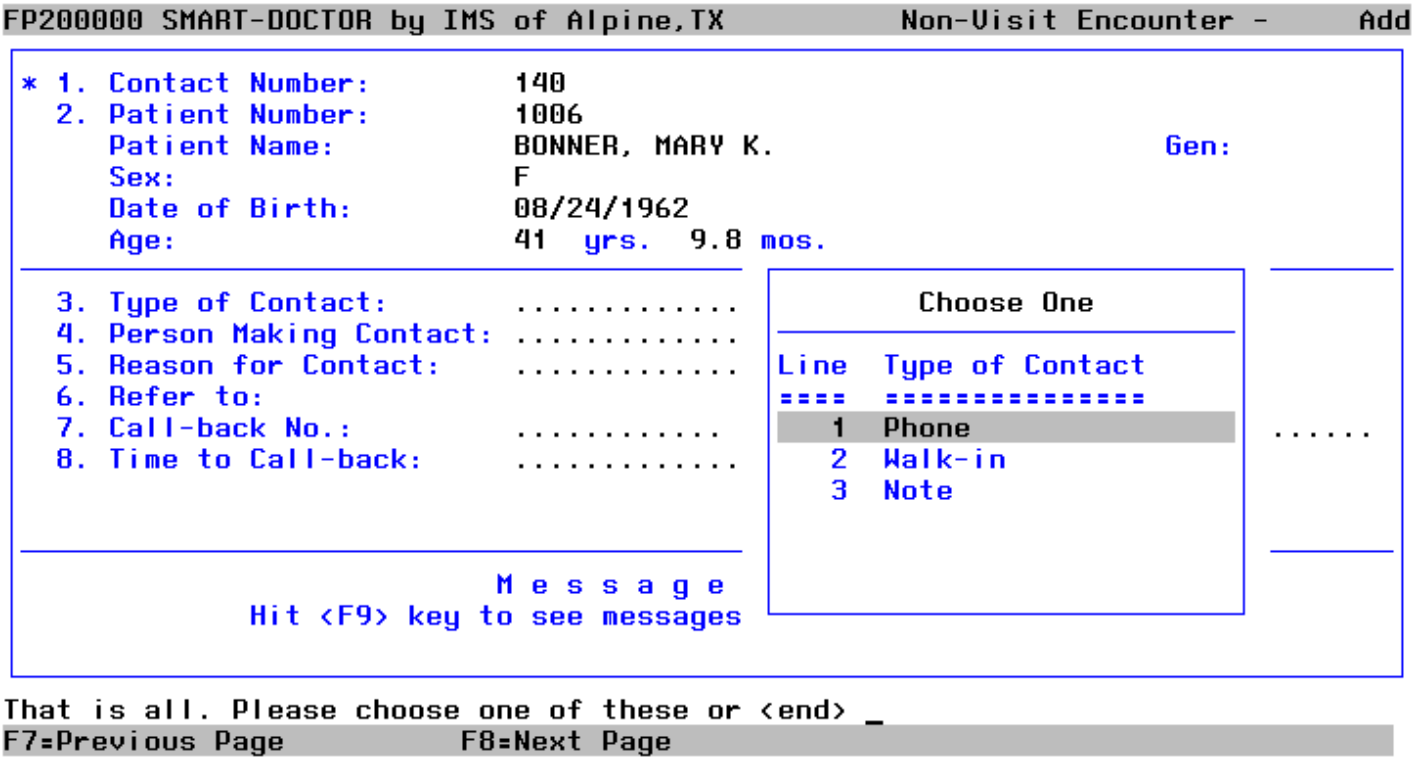


Figure 189 Non-Visit window for Type of Contact.

Prompt #6, "**Refer to:**", if you hit the <enter> key here, the system will default "**Note for File**". You should only use "Note for File" if you want to document something that needs no further attention, for example, to document that you called the patient to remind her of a blood test she needs to repeat in the AM. This note will not be referred on to anyone else. Any note that needs to be referred on to the nurse or doctor should be sent specifically to that person. You can enter either the providers initials, part of the providers name (for a provider cross-reference look up), or hit the <F10> key-"PLst" to bring up the provider selection window shown in Figure 190.

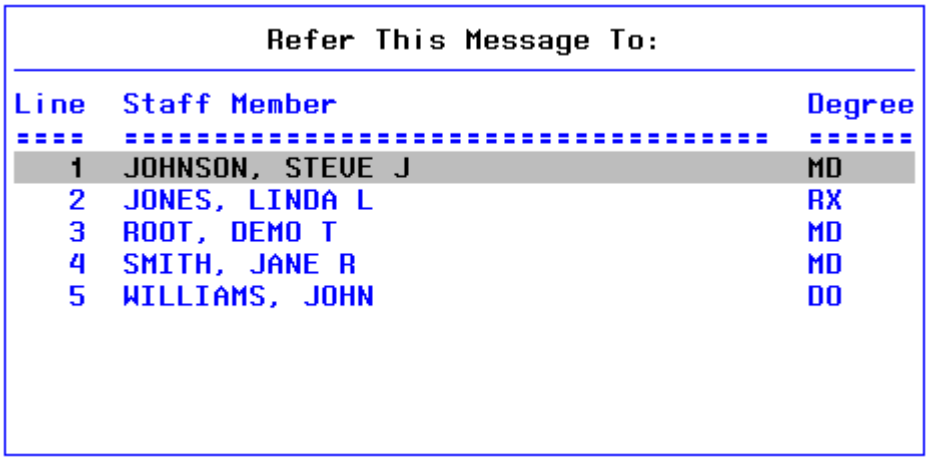


Figure 190 Provider Selection window.

To summarize, your options are:

1. Press <return> for a note directed to the Patient's file.
2. Press F10 for a complete list of Providers.
3. Enter a partial name for a cross-reference search.
   If this search fails, then the Provider list will be displayed from which you can choose.

The following screen (Figure 191) shows the result of selecting the provider, and then entering the optional call back phone number and time to call back.

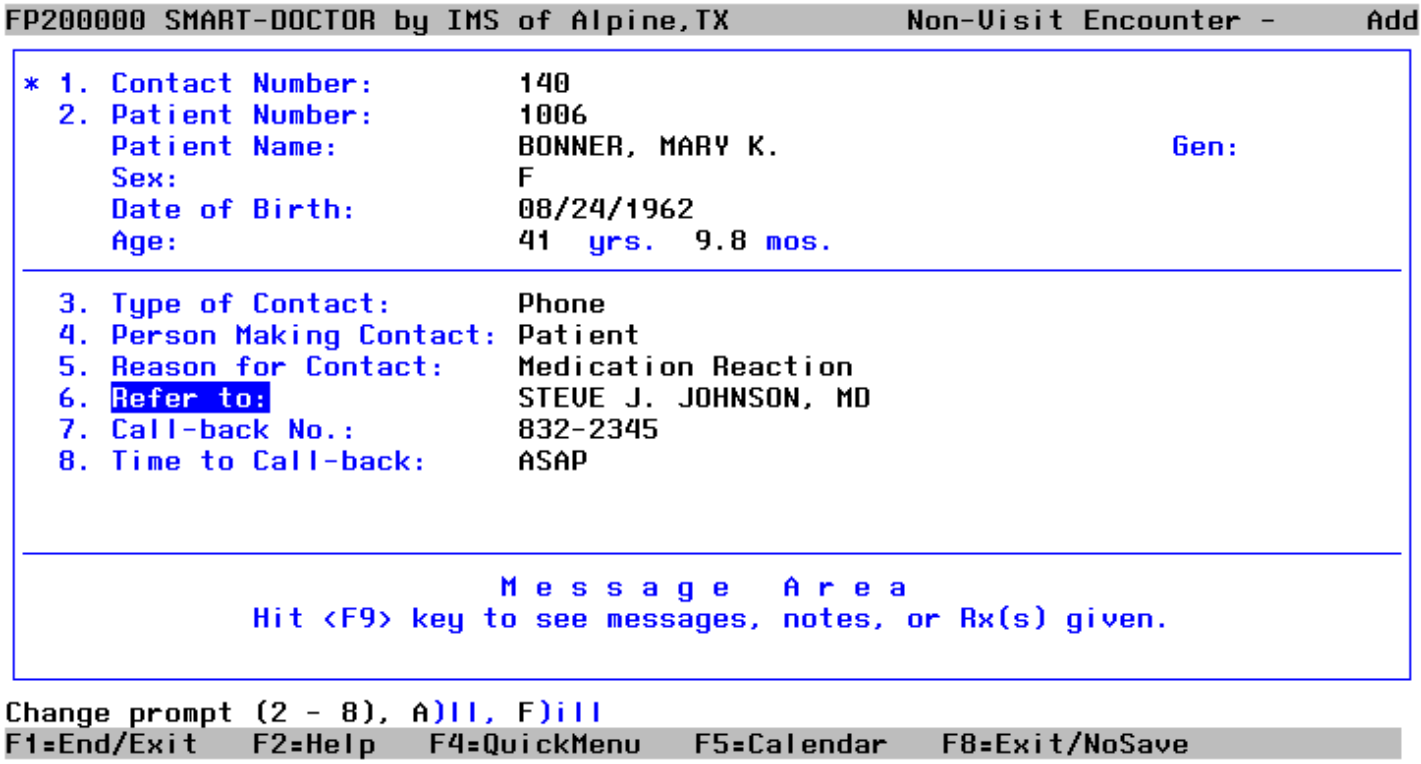


Figure 191 *Completed Non-Visit Note Information.*

Now hit the <F9> key to enter the “Message” as seen in Figure 192.

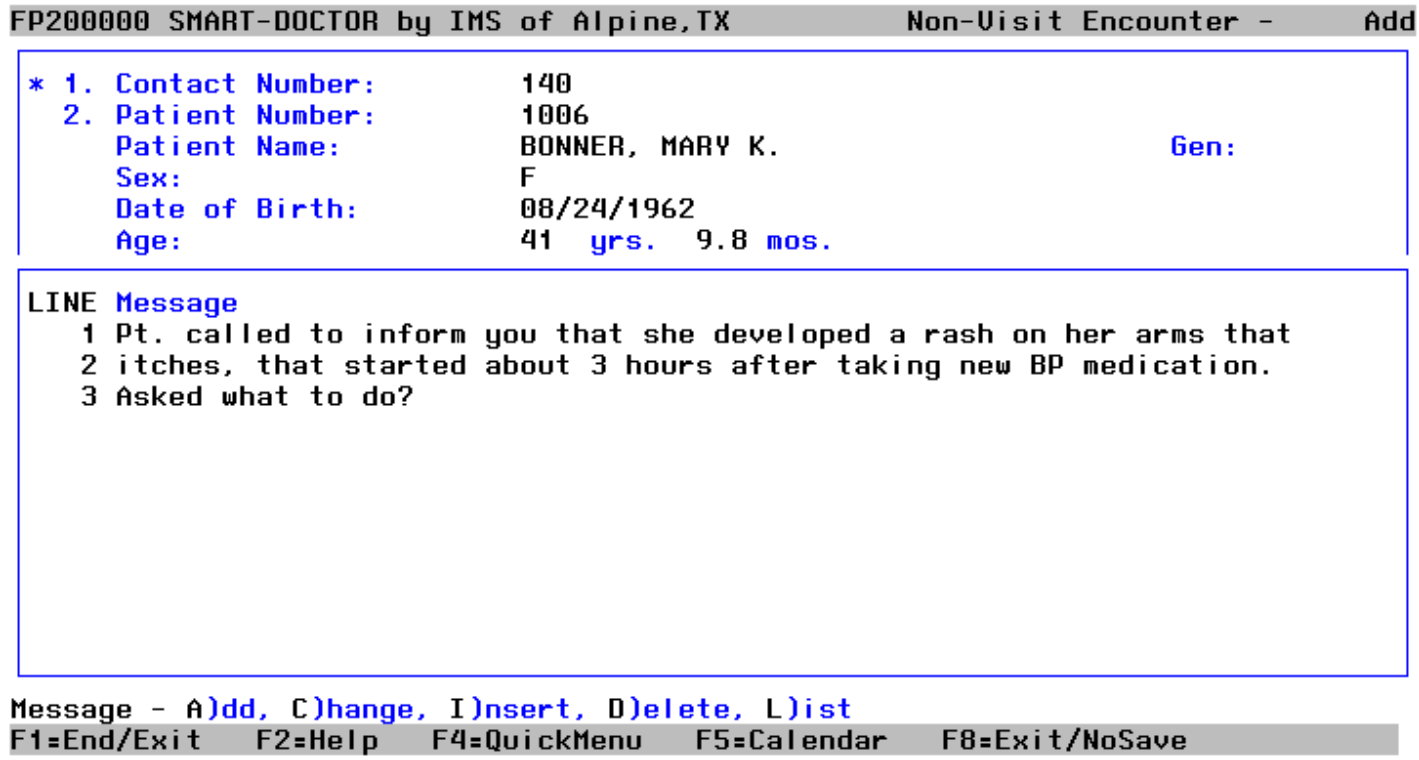


Figure 192 *Non-Visit Note Message screen.*

If you are finished, hit the <F1> key to return to the prior screen. You can return here any time before you exit this contact note by hitting the <F9> key again. Once complete, from the contact note screen, hit <F1> to end and exit the note. You will then be presented with the exit screen as seen in Figure 193.

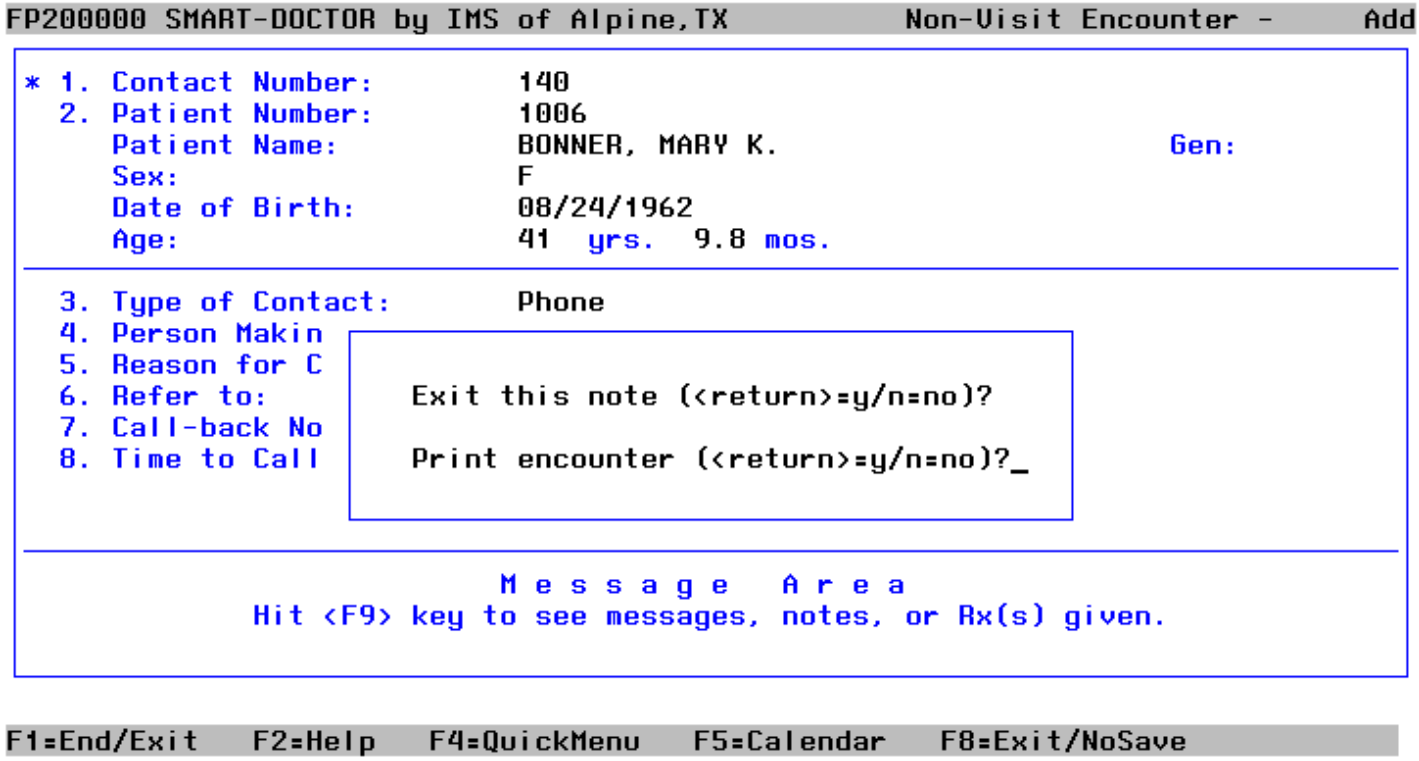


Figure 193 *Exit of Non-Visit Encounter Note.*

You will be presented with each question above sequentially. Hitting <enter> or <y> will get you to the next prompt regarding printing of this note. Answer appropriately.

The note will then be sent either to the chart or to the provider, depending on what you indicated in prompt #6 (Refer to:).

PAST MEDICAL HISTORY

From the front office menu screen (Family & Patient File Maint.), menu item #6, "**Past Medical History**", will allow clerical entry of the patient's past medical history. This screen can be used by all user classes. However, it requires a specific user password given only to those authorized to enter and see this type of data. Upon selecting this menu option, the screen seen in Figure 194 will be presented.

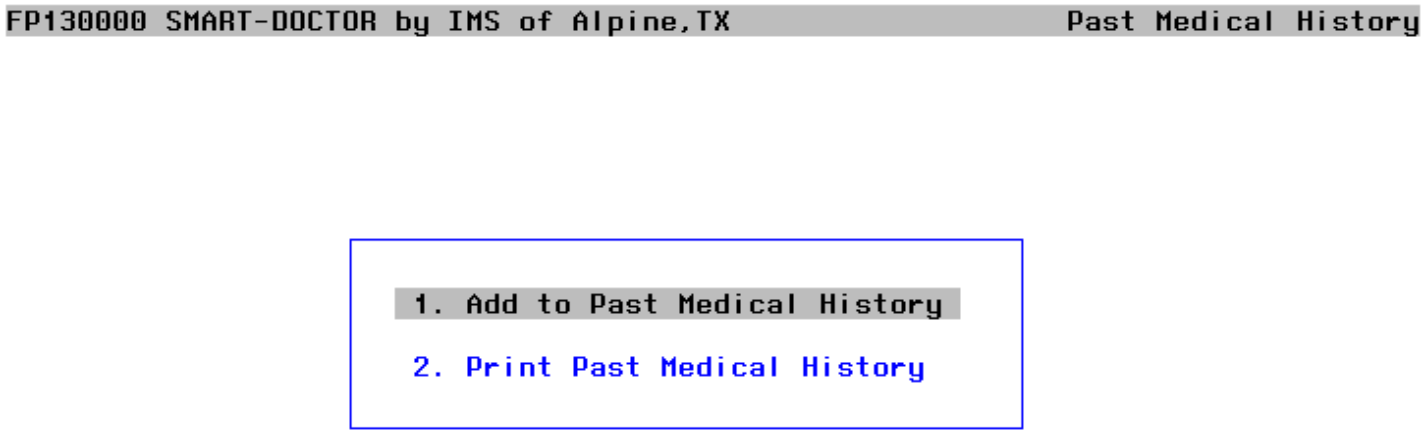


Figure 194 *Initial Past Medical History screen for Front Office.*

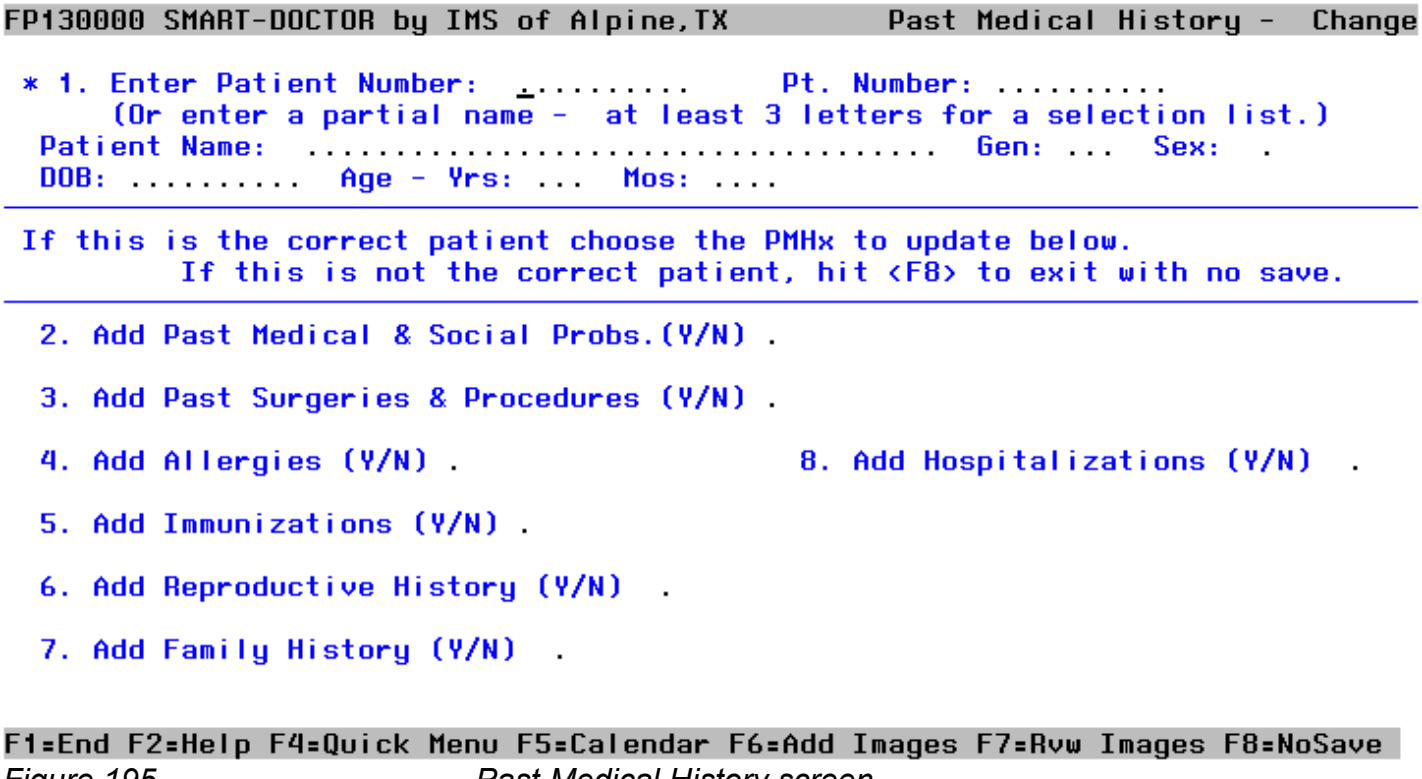


Figure 195 *Past Medical History screen.*

Picking selection #1, "**Add to Past Medical History**", will then bring you to the screen shown in Figure 195.

Prompt #1, "**Enter Patient Number:**", enter the patient's number or at least three letters of the patient's name for a cross-reference lookup. The patient information will then be populated. Once you are sure you have the correct patient, you can proceed to enter the Past Medical History using the screen shown in Figure 196. If this is not the correct patient, then hit the <F8> key-"**NoSave**", to exit without saving any changes to the record.

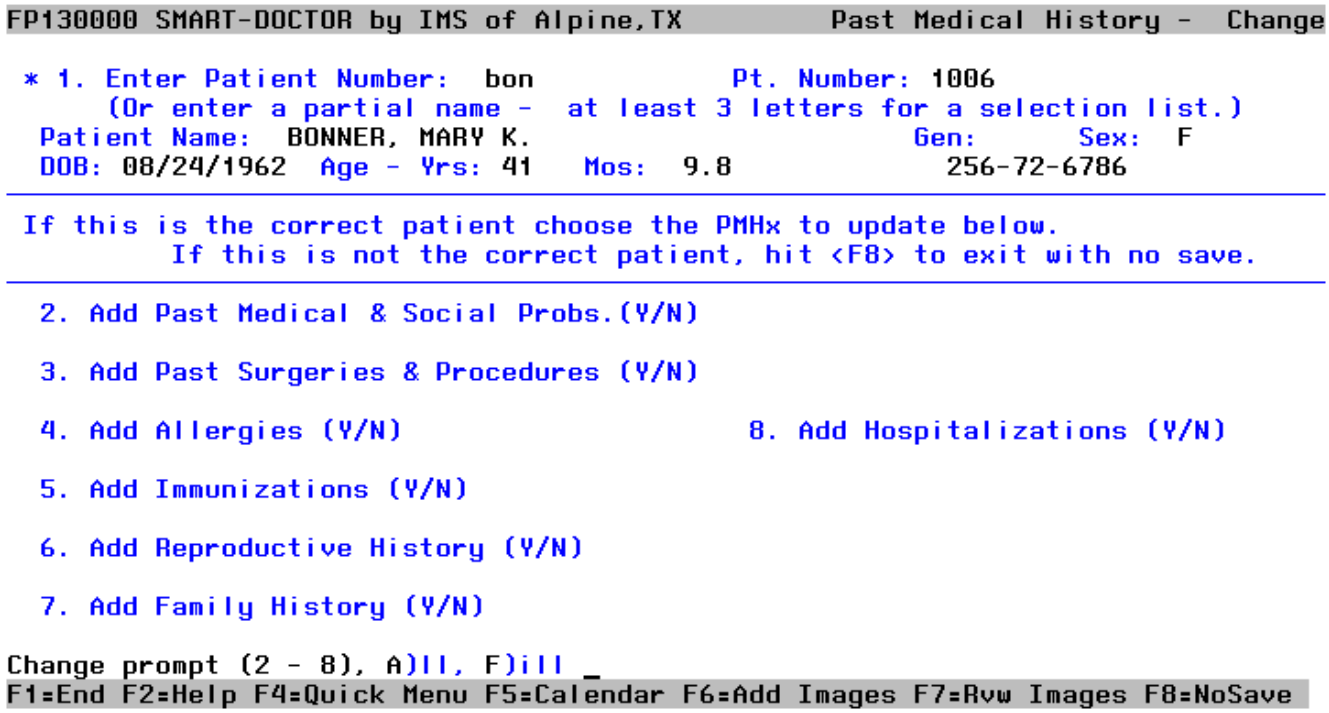


Figure 196 Past Medical History screen with Patient Selected.

At the change Prompt, enter the number of the corresponding area you want to work on, or hit <a> (for ALL) to be taken through each area sequentially. ALL changes to ADD screens for all Past Medical History section below are done by adding. This includes deleting an entry. How to delete an entry will be shown later.

*PROMPT #2, "***ADD PAST MEDICAL & SOCIAL PROBS.(Y/N)***"*, enter <y> + <enter> to add or review past medical problems. The screen shown in Figure 197 will be presented.

You will be at the change prompt of the multi-valued prompt to add past diagnoses for this patient. Hit <a> to add a diagnosis to the past medical history.

After hitting the <a> for add, you will be placed in the first field of this multi-valued prompt. Here you should enter part of the description of the diagnosis you want. It is best to find the the diagnosis code by the cross-reference method rather than entering a diagnosis code number. This is because, as codes get changed, deleted, or modified by the organizations responsible for them. The old code numbers may no longer be correct. By looking the code up with the cross-reference system, you will be presented with all the current codes. See the System's file section of this manual for methods to speed up cross-reference searches. As an example, if we entered "htn" for hypertension, the selection list pop-up window shown in Figure 198 is seen.

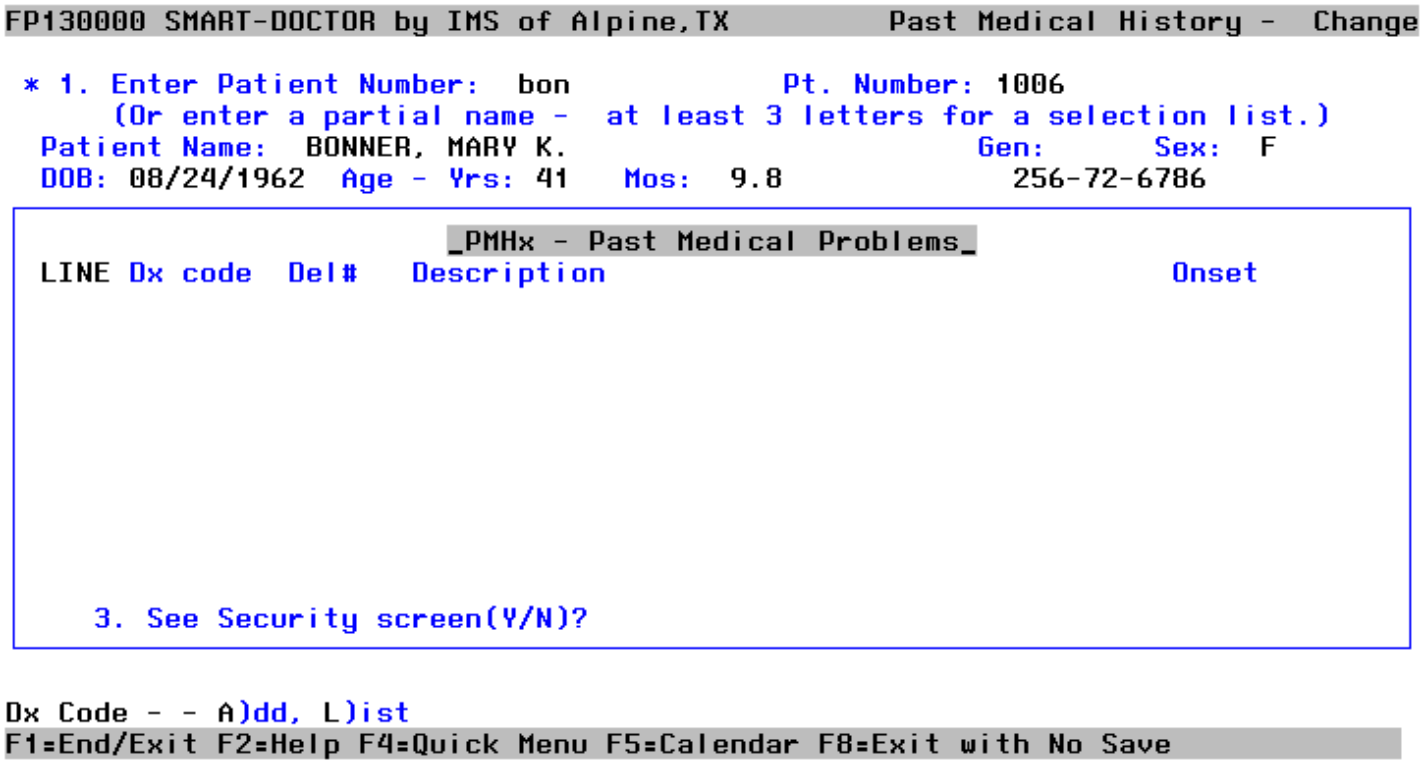


Figure 197 *Adding to Past Medical Problems.*

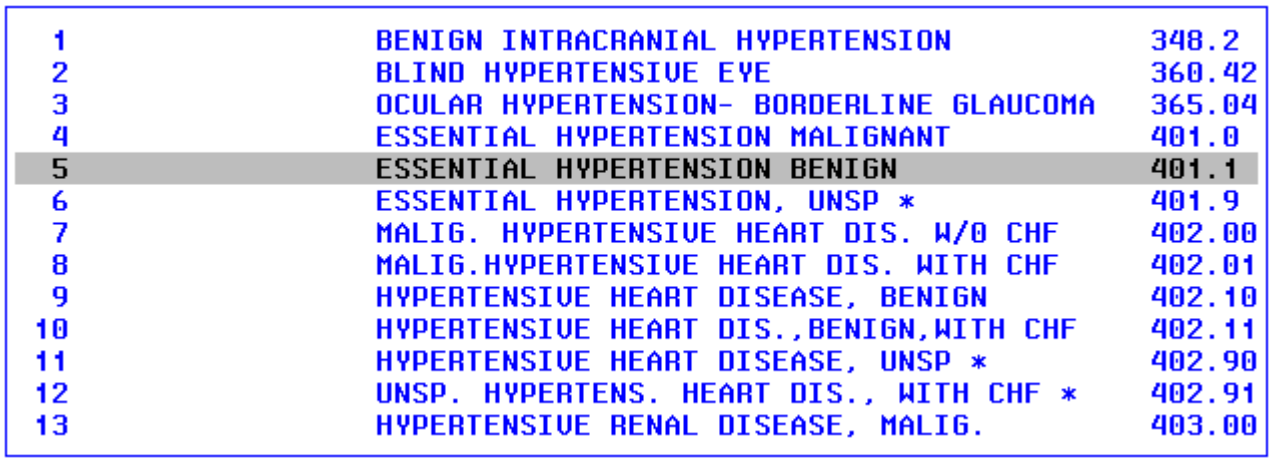


Figure 198 *Diagnosis Selection List.*

In this case, we selected code 401.1. A short cut to this specific code could have been defined as “htnb”, for “Hypertension Benign”, which would have resulted in a direct “hit”. Again, see the systems file discussion later in this manual. In the screen shown in Figure 199 below, the results of this selection and a second cross-reference lookup using “ref es” for “reflux esophagitis”, is presented.

The system checks for appropriateness of the diagnosis for sex and age. If the sex is not possible, you will be blocked from accepting it and will get the following warning:

This Dx not possible for pt. Sex, return to continue

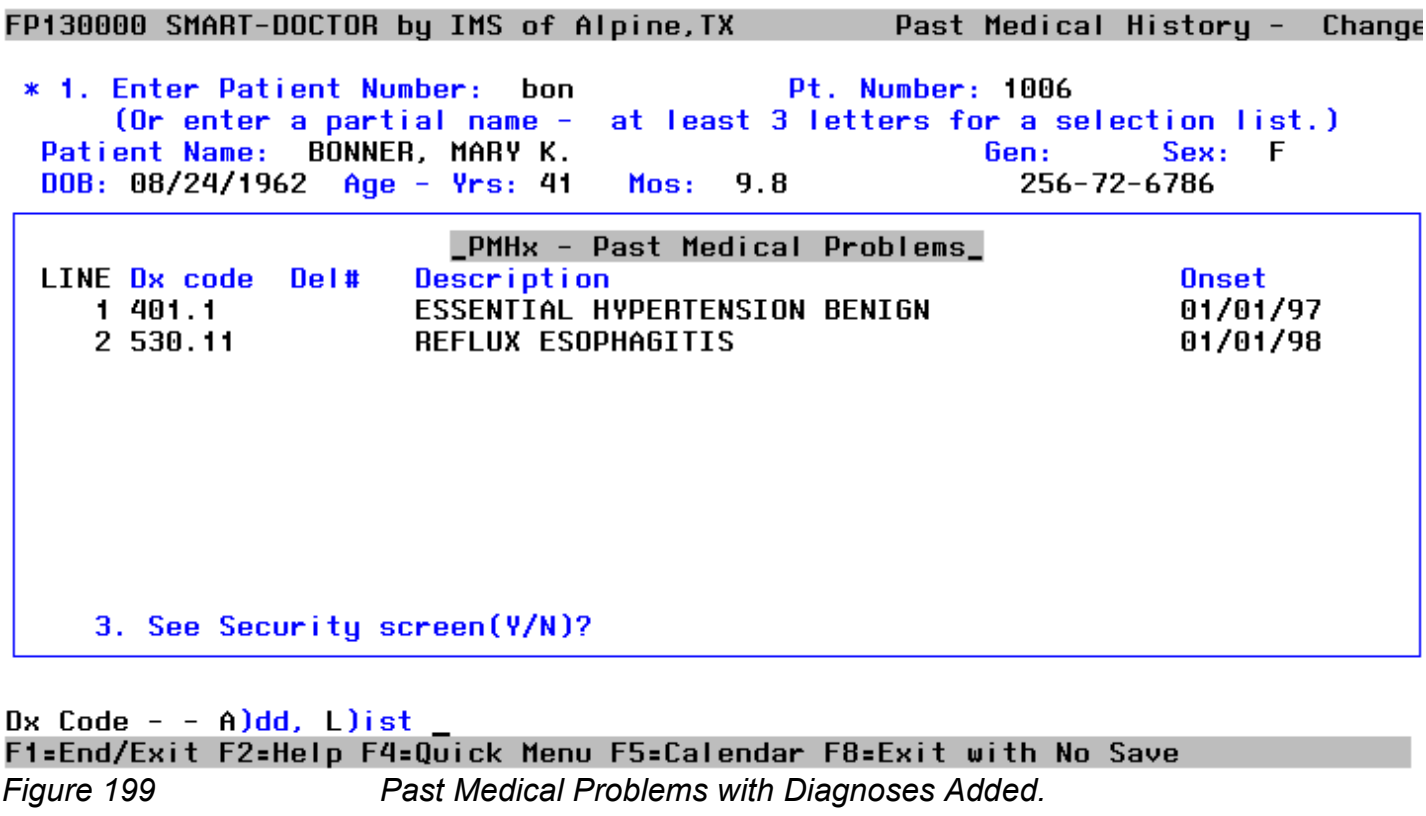


Figure 199 Past Medical Problems with Diagnoses Added.

If the age is not appropriate for the date you gave (the original date the diagnosis was established), then you will be blocked from accepting it and will get the following warning:

Onset not possible for this pt's age on that date, return to continue

When you are finished adding diagnoses, hit the <F1> to "end" input. If you get stuck in the last field, because you cannot specify a good date, then you can always enter <top> to top out of a record without saving. This is equivalent to the <F8> key on most screens.

ADDING A DATE

In adding date information to the patient's file, if the exact date is not know, the use the following method to enter the approximate date: If the month is not known, use 01/01 for the month and day. Otherwise use the approximate day and year. In the above example, the dates of "01/01/97" and "01/01/98", would most likely represent the approximate, rather than the actual date. In the example given below for past surgeries, the date is the actual date of the procedure.

DELETING A CODE

The method to delete in this section, can also be applied to the following sections, and the system in general. To delete a clinical entry, ADD a "DELETE" in the add field (or in the case of appointments, a "CANCEL").

Upon entering delete in the first add field, you will be placed in the "Del #" field (skipped normally with regular adding). Here, you enter the Number of the line containing the diagnosis you want to cancel. The resulting screen is shown in Figure 200.

However, after leaving this screen and coming back to it again, it refreshes with all current the information. Please note the changes in line #2, in the refreshed screen seen in Figure 201 below, in comparison to the prior screen shown in Figure 200.

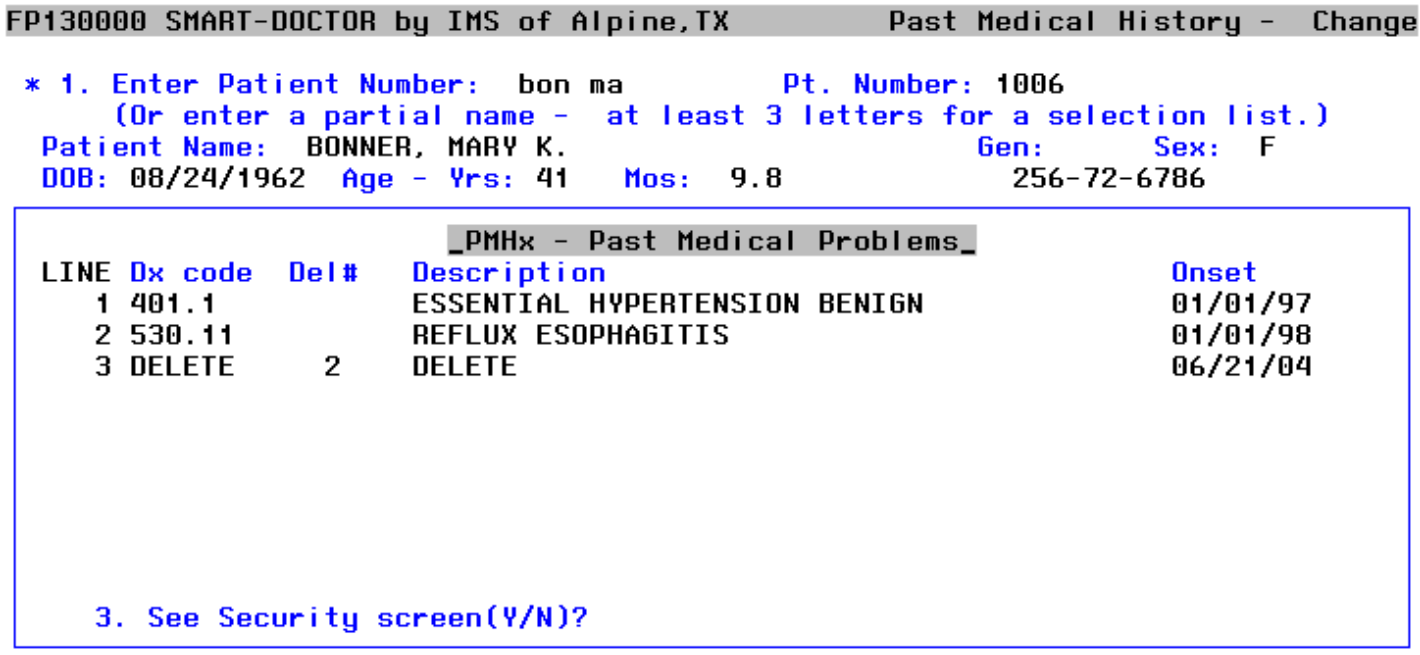


Figure 200 *Past Medical Problems screen with Deleted Code.*

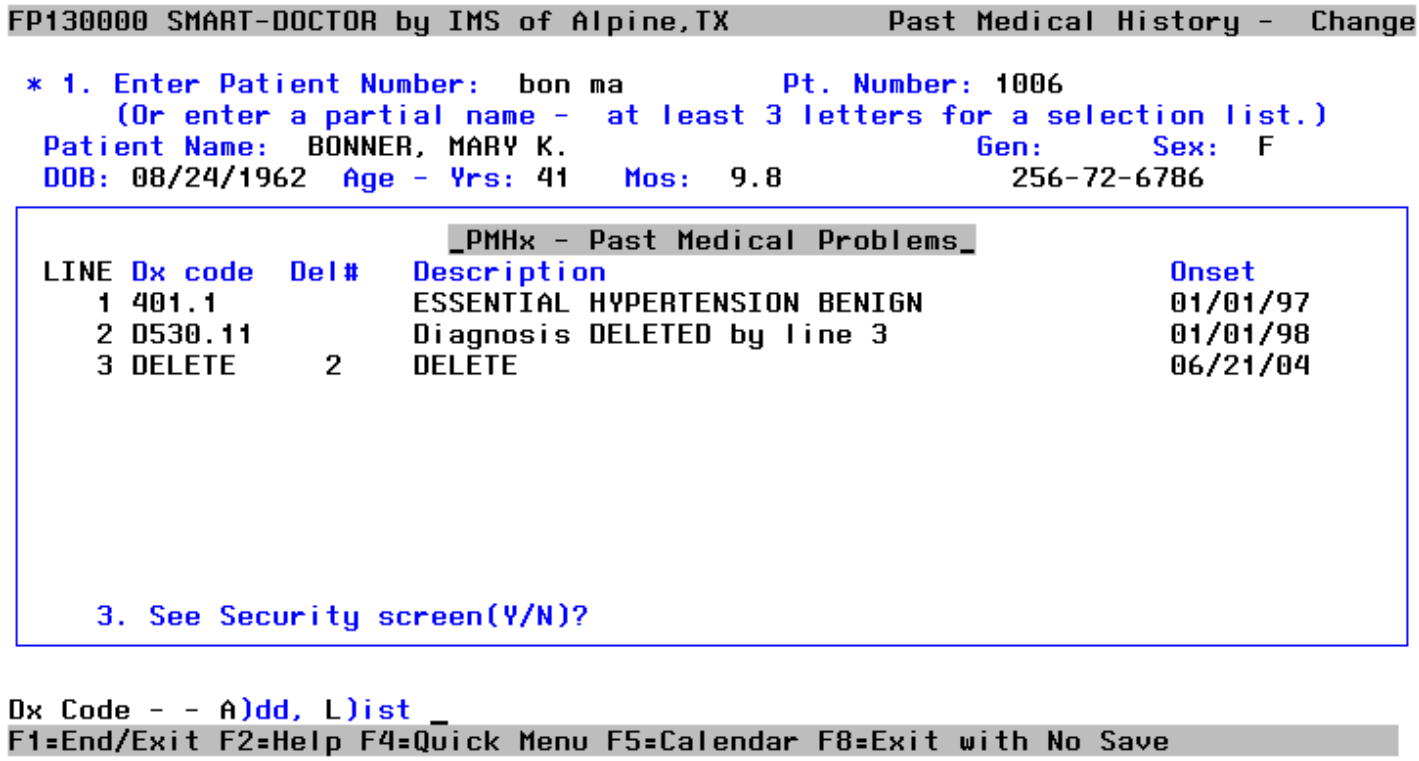


Figure 201 *Past Medical History screen with Updated Information.*

In this way, information entered in the past is never lost. This information will always stay in the add screens. However, in the review screens that will be seen below, the deleted information will not be shown to avoid confusion and clutter.

If you would like to see who entered the information previously, go on to prompt #3, "**See Security screen(Y/N)?**", and enter <y>. The security screen seen in Figure 202 will be presented, showing the user, date, and time of entry for each line added:

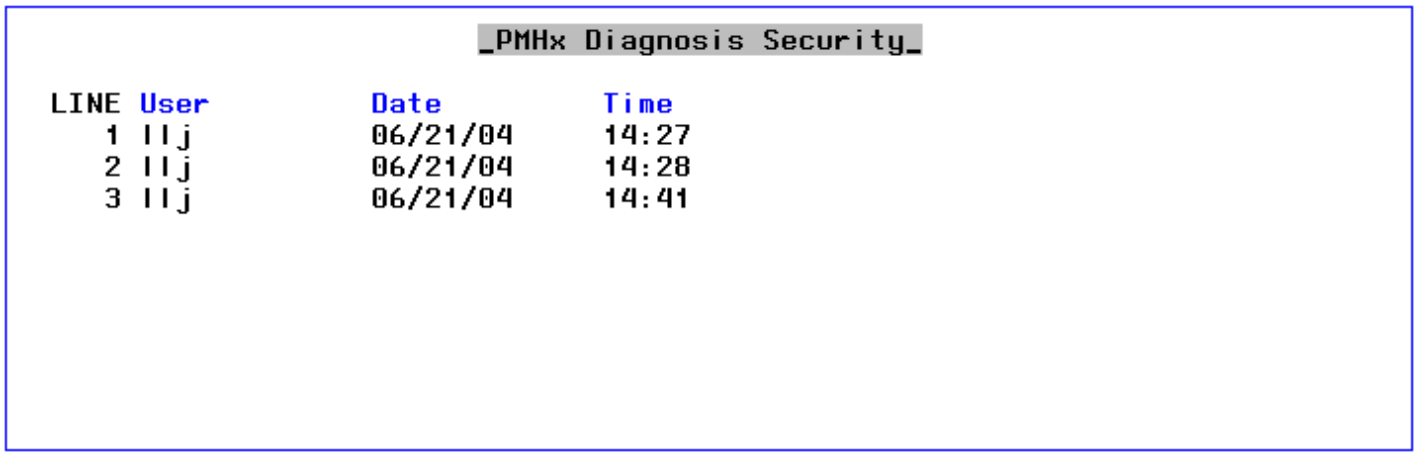


Figure 202 *Past Medical history Security screen.*

You can now tell who added each code, and who deleted any code, if any were deleted.

*PROMPT #3, "***ADD PAST SURGERIES & PROCEDURES (Y/N)***"*, enter <y> + <enter> to add or review past Procedures (Surgeries). In the following example (Figure 203), a surgical procedure has already been added, in the same manner as in the diagnosis screen above:

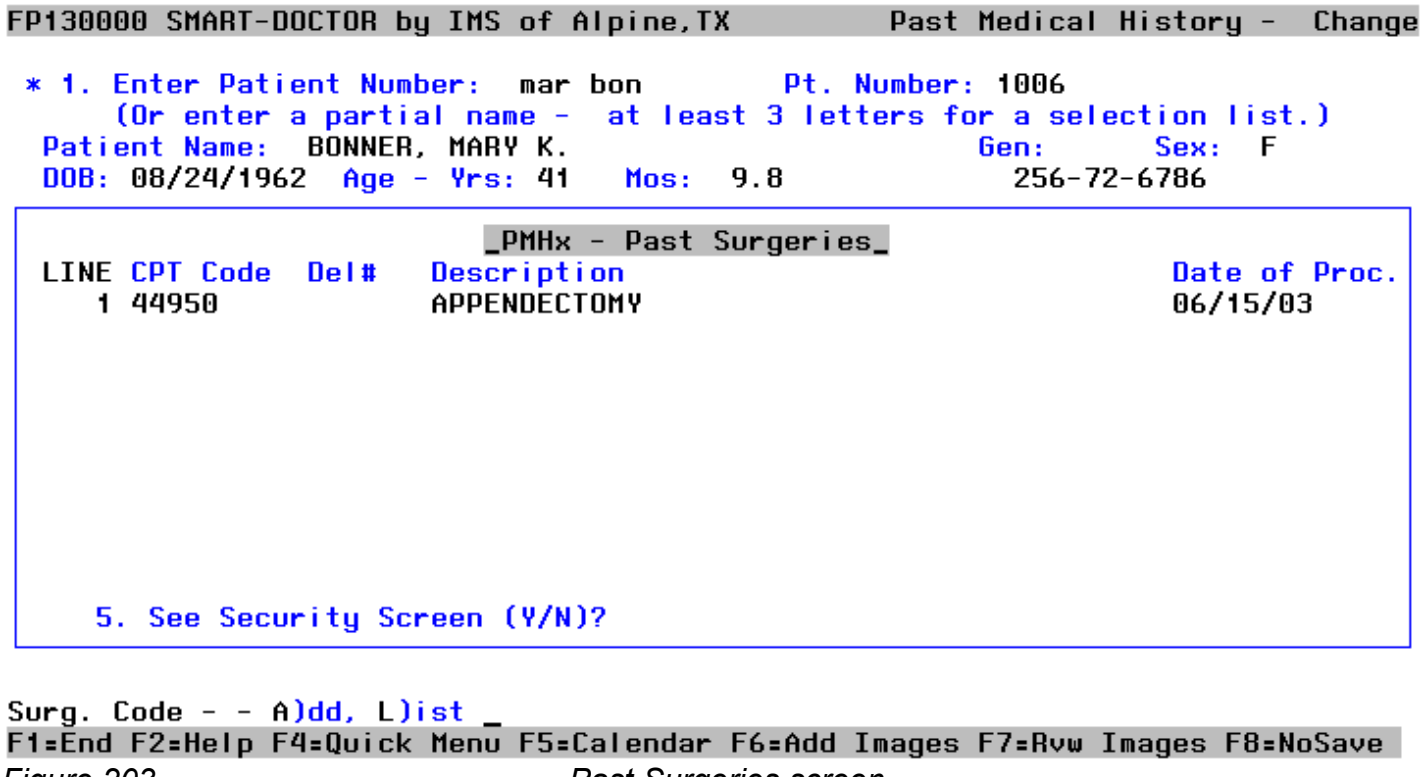


Figure 203 *Past Surgeries screen.*

*PROMPT #4, "***Add Allergies (Y/N)***"*, enter <y> + <enter> to add or see past Allergies. In the

following example, seen in Figure 204, an allergy has already been added in the same manner as done in the "ADD PAST MEDICAL & SOCIAL PROBS*" discussed* above.

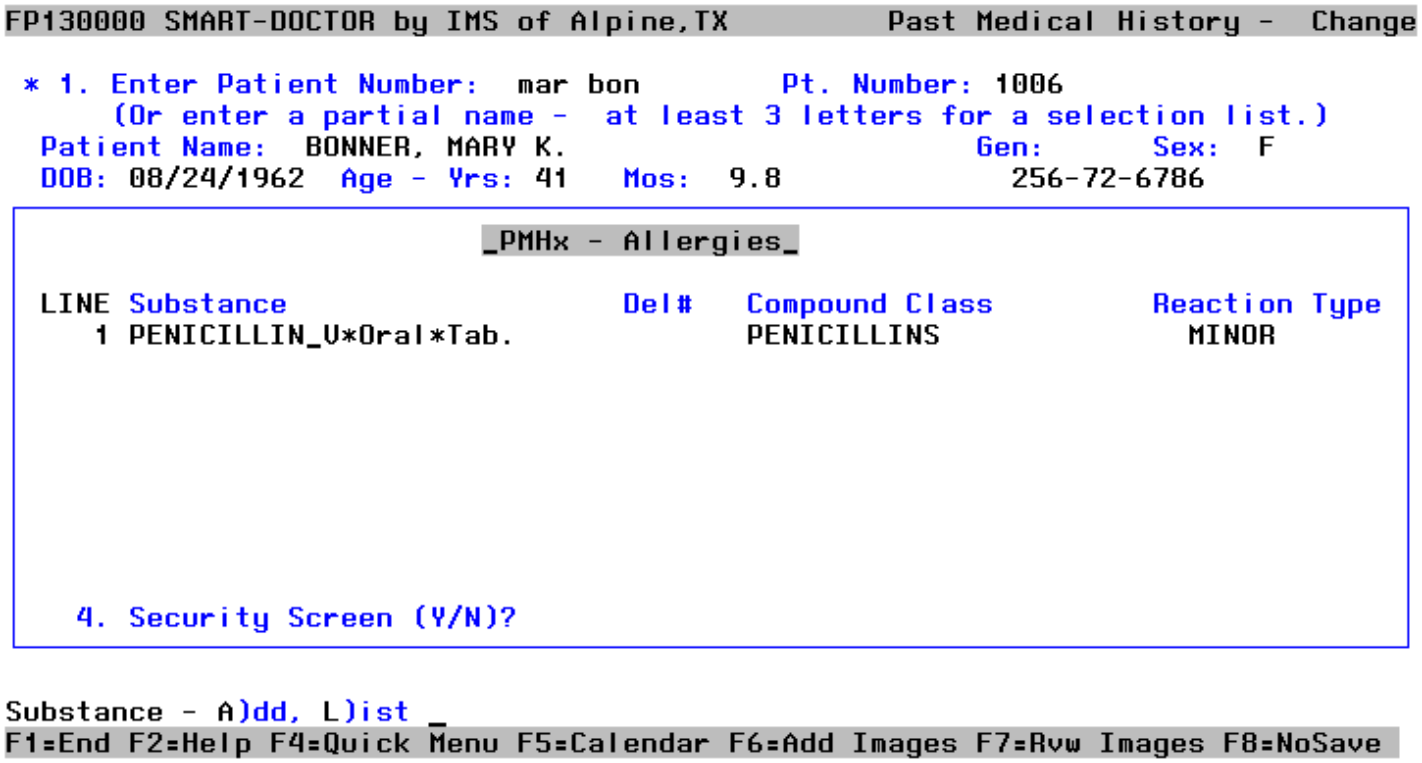


Figure 204 *Adding Allergies to Past Medical History.*

Allergic reactions in the SmartDoctor® system are defined as two distinct types: Minor and Major. "MINOR" means: Nausea with little or no vomiting, or local swelling, or rash, all without fever. "MAJOR" means: Systemic, or severe, or anaphylactic, or with shortness of breath, or with Cardiac problems.

To enter an allergic reaction, enter the product or substance producing a problem. Often the product the patient has a reaction to may be a combination of two or more substances. The system will only look at the first compound of any given product as the compound class causing the reaction. So you must check with the doctor before, to be sure you know which is the correct compound to list as the allergy. For example, if a patient takes Tylenol with codeine product and develops severe constipation, the most likely cause is the codeine and not the Tylenol (acetaminophen) component. In the example below, we entered "tyl cod" in the Substance field. We are then presented with the cross-reference selection window seen in Figure 205.

Upon selecting line # 2 in Figure 205, the allergy screen is populated as shown in Figure 206. At this point you can see listed under the "**Compound Class**" field, the partial list of compounds the product contains. In this case, "OPIOIDS ACETAMINOPHE". Only the **first** compound listed will be stored in the system. This can be seen on exiting and then coming back to this screen (screen refresh), as seen in Figure 207. Only Opioids is listed under Compound Class.

Once you select a substance you must pick a reaction type as discussed above. However, if at this time you realize that this is not the substance or the compound class you want, you will not be able to backup or up arrow. If you try, you will get the following message:
"**You cannot go back at this point. <Return> to continue.**"

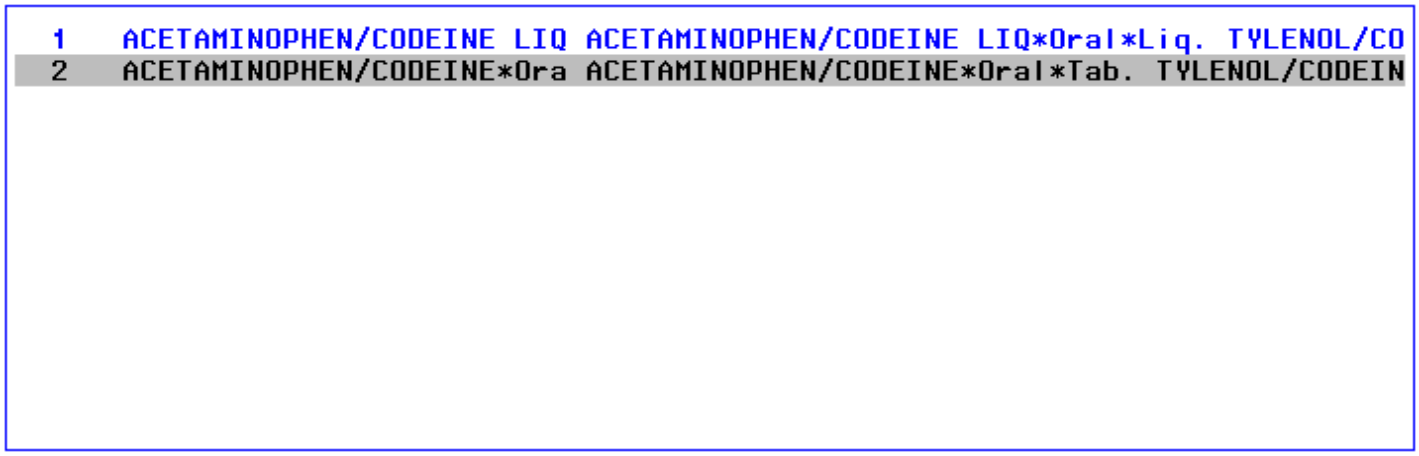


Figure 205 Selecting Substance Causing Allergy.

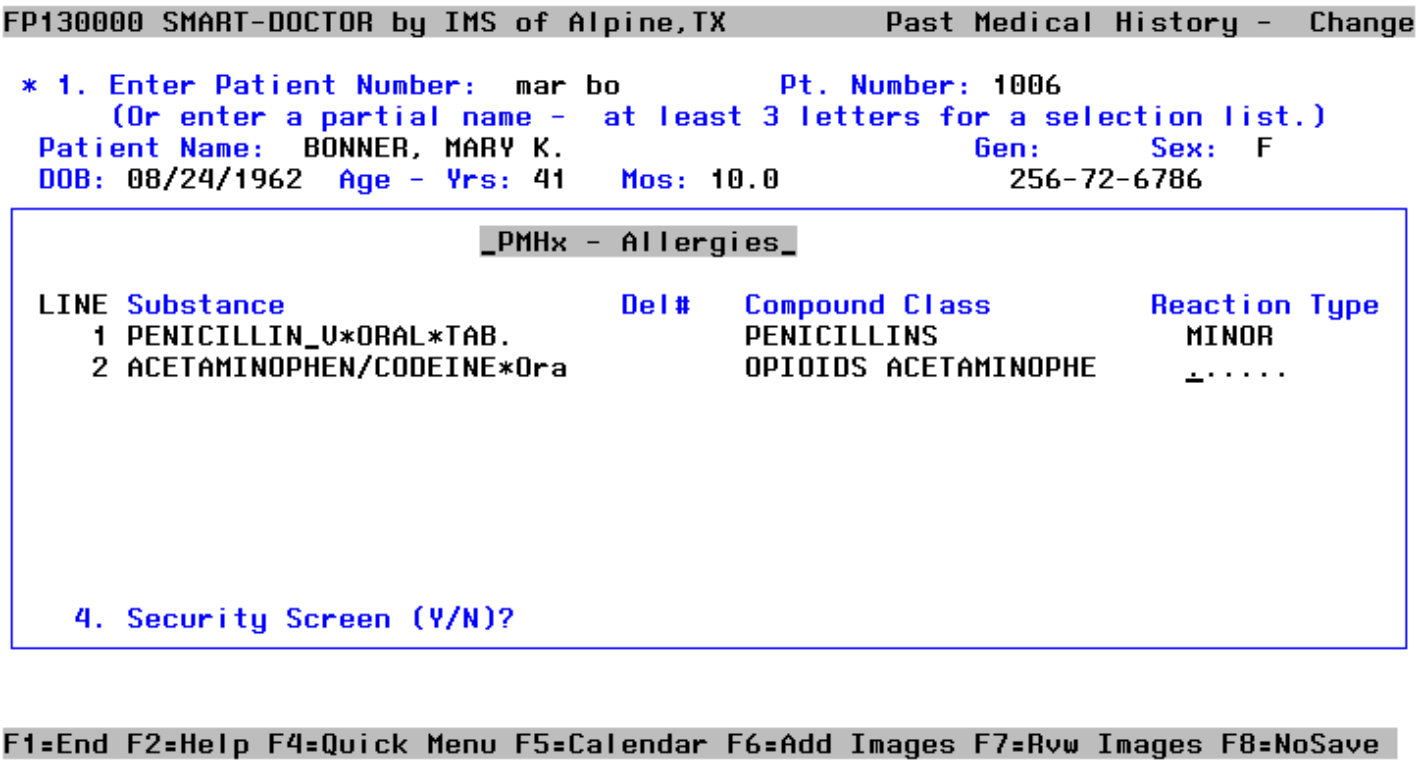


Figure 206 Selecting Reaction Type.

The choices you have here are to hit the <F8> key to exit or enter <top> to top out (exit) or except this entry, and then add a “delete” following this to delete the entry as in “ *ADD PAST MEDICAL & SOCIAL PROBS” above.*

If your doctor tells you that the allergy was due to the acetaminophen component, them you would need to add Tylenol or acetaminophen by itself, and not Tylenol with codeine as the substance.

*PROMPT #5, “***Add Immunizations (Y/N)***”*, enter <y> + <enter> to add or see “Immunizations*”*. In the following example (Figure 208), an allergy has already been added, in the same manner as in the “*ADD PAST MEDICAL & SOCIAL PROBS”* screen above.

```
FP130000 SMART-DOCTOR by IMS of Alpine,TX          Past Medical History -  Change

 * 1. Enter Patient Number:  mar bo          Pt. Number: 1006
      (Or enter a partial name -  at least 3 letters for a selection list.)
  Patient Name:  BONNER, MARY K.                          Gen:      Sex:  F
  DOB: 08/24/1962  Age - Yrs: 41   Mos: 10.0              256-72-6786

                          _PMHx - Allergies_

 LINE Substance                      Del#   Compound Class          Reaction Type
    1 PENICILLIN_V*ORAL*TAB.                PENICILLINS               MINOR
    2 ACETAMINOPHEN/CODEINE*ORA             OPIOIDS                   MINOR




   4. Security Screen (Y/N)?
```

Figure 207 *Allergy screen After Refresh.*

```
FP130000 SMART-DOCTOR by IMS of Alpine,TX          Past Medical History -  Change

 * 1. Enter Patient Number:  mar bo          Pt. Number: 1006
      (Or enter a partial name -  at least 3 letters for a selection list.)
  Patient Name:  BONNER, MARY K.                          Gen:      Sex:  F
  DOB: 08/24/1962  Age - Yrs: 41   Mos: 10.0              256-72-6786

                        _PMHx - Immunizations_

 LINE Type of Immunization   Del#   Date of Immunization
    1 (Enter to see list)...




    4. See Security Screen (Y/N)?
```

Figure 208 *Adding Immunizations.*

Hit the <enter> key as indicated to see a list of possible immunizations. This list is defined in the TERMS file in the “ADM-IMMUNE” record. Talk to your system administrator to make changes to this list. An example of the pop-up selection window is shown in Figure 209.

The immunization followed by “*REFUSED” is to be used to indicate that the patient was asked to get the immunization as recommended, however, the patient refused. This avoids having the provider being asked about the patient's failure to have this immunization documented in the chart during cyclic time periods for this immunization. For example, if we choose “Flu” from this pop-up

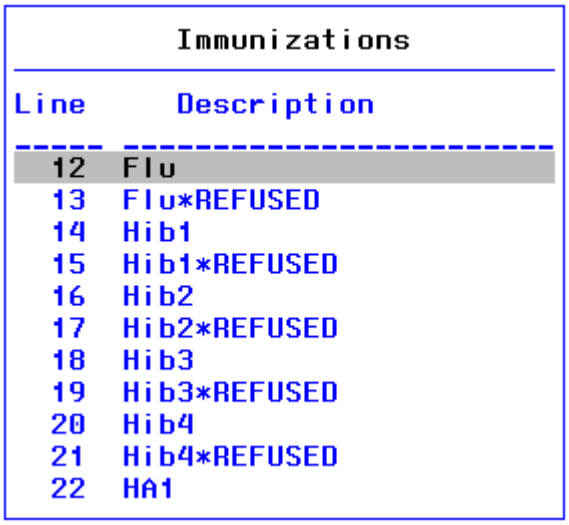


Figure 209 Immunization Selection.

window, then the the provider will not be prompted again during this period if today's date is indicated. This would also be the case if we picked “Flu*REFUSED”. To see other immunization that are available to select by using the “page up” or “page down” keys, in addition to the up and down arrow keys. The example of picking “Flu” and entering a date (or accepting the default of today's date) results in the screen shown in Figure 210.

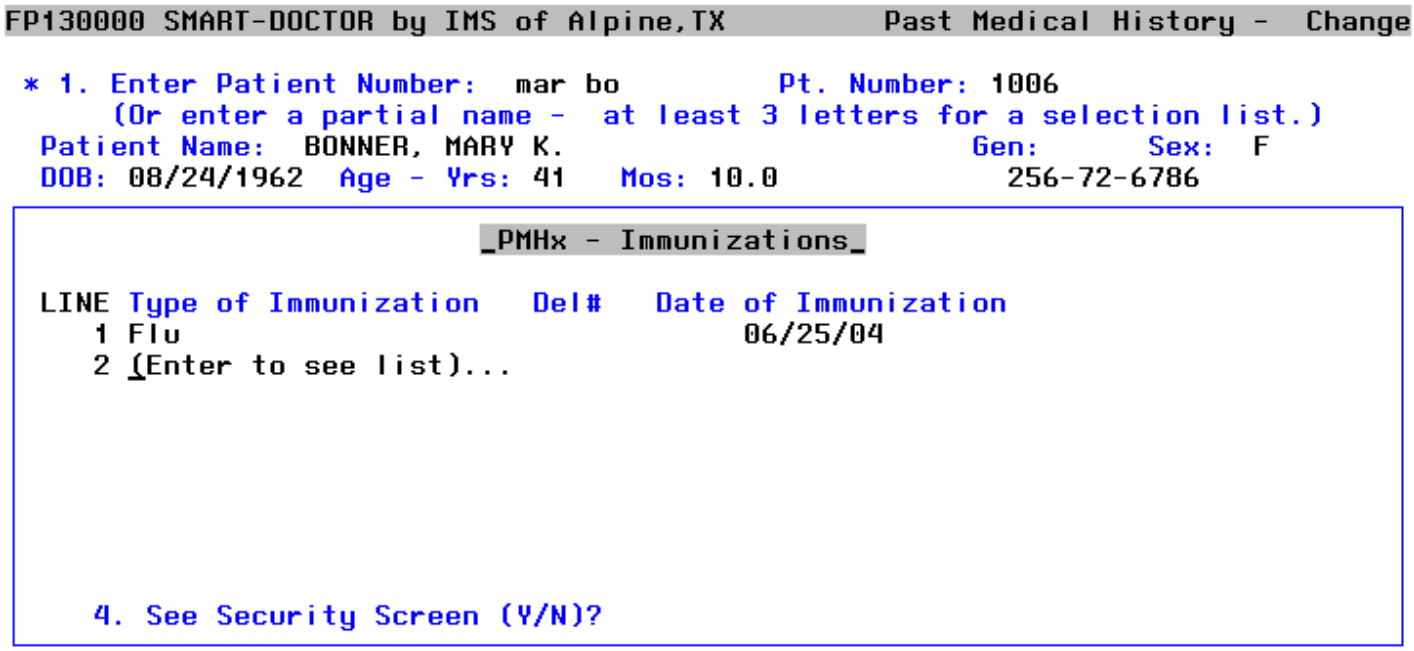


Figure 210 Immunization Added.

When finished entering immunizations, hit the <F1> key to “end” or exit.

*PROMPT #6, “***Add Reproductive History (Y/N)***”*, enter <y> + <enter> to add or see the patient's reproductive history. You will only be allowed into this screen for female patients. In the example seen in Figure 211, the prior reproductive history can be seen. On attempting to add an updated reproductive history, the system will force you to delete the prior multi-value line that is still active, since it would be illogical to have two reproductive histories on the same patient. You will be given a warning as seen on the bottom of the following screen if this is attempted.

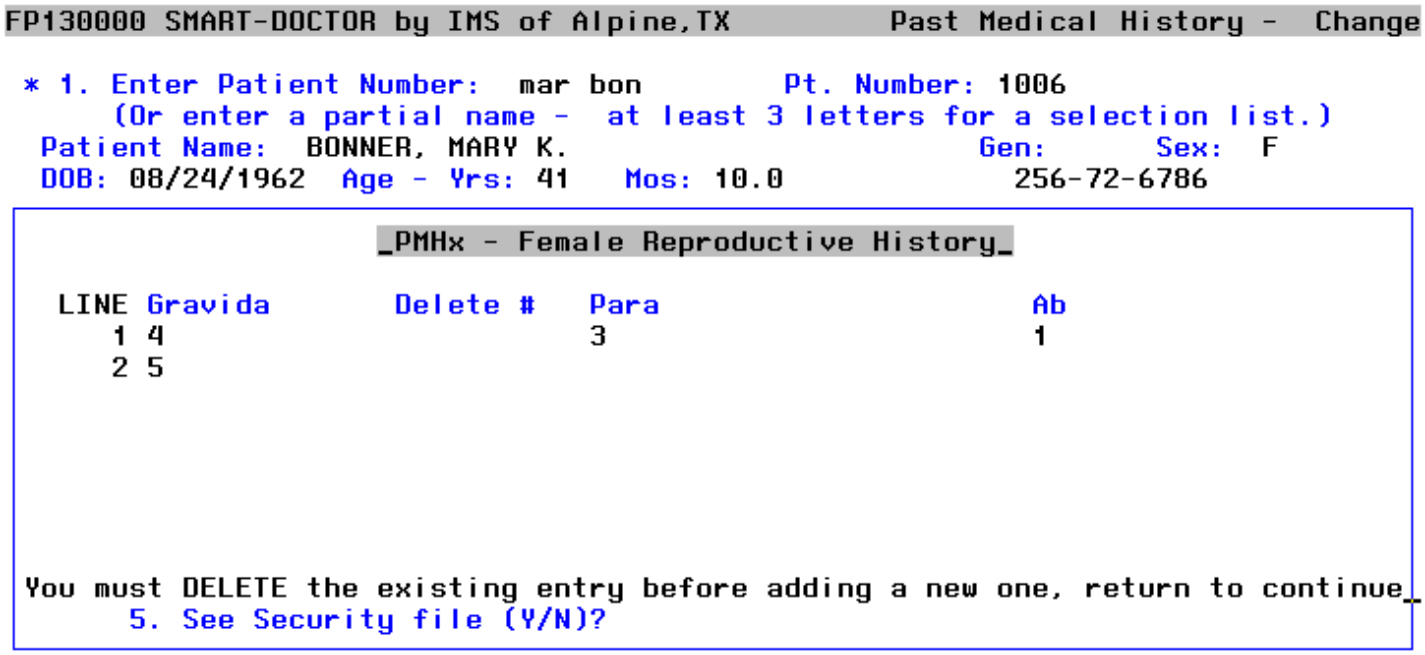


Figure 211 *Reproductive History, Adding.*

The following screen shows the result of the proper way to update this information:

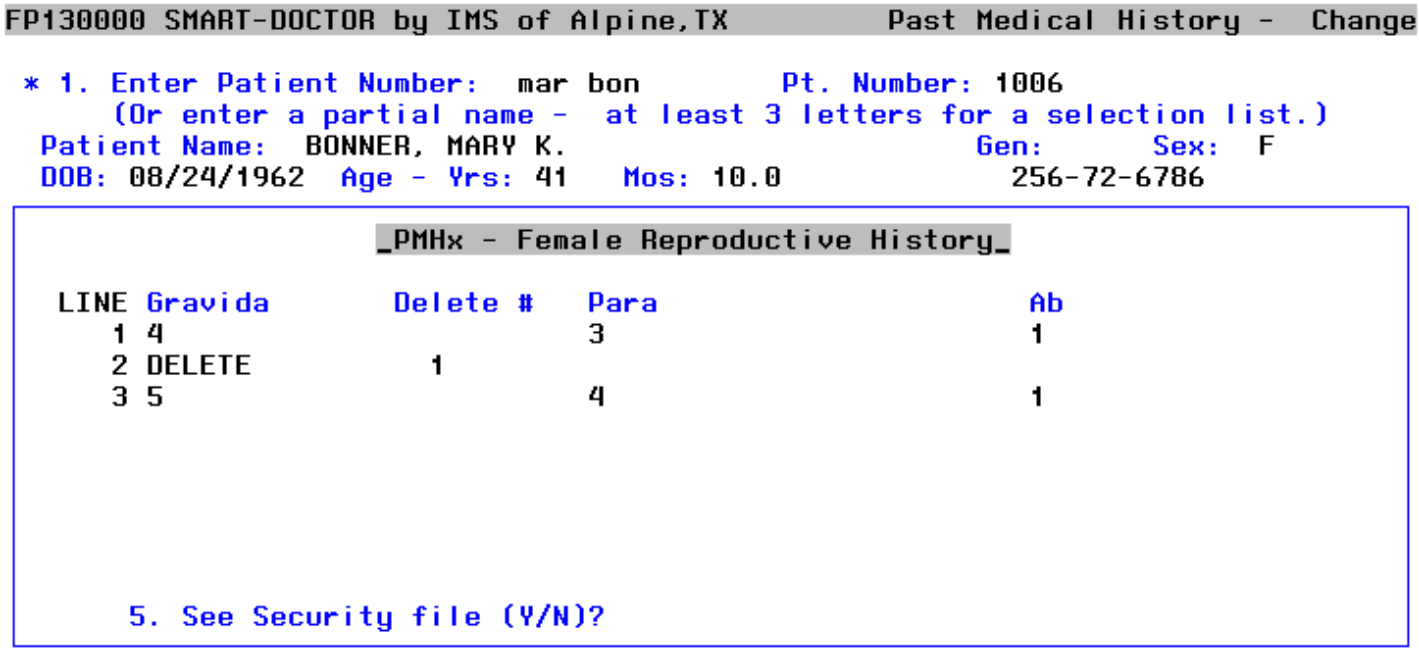


Figure 212 *Reproductive History Completed.*

If the selection of Gravida, Para, and Ab, appear to be illogical, you will get the following message:

Value of G,P,or Ab may be incorrect -delete if needed, return to continue

Make any needed corrections and continue.

*PROMPT #7, "***Add Family History (Y/N)***"*, enter <y> + <enter> to add or see Family History . In the following example (Figure 213), an Family History has already been added, in the same manner as in the "*ADD PAST MEDICAL & SOCIAL PROBS"* screen above.

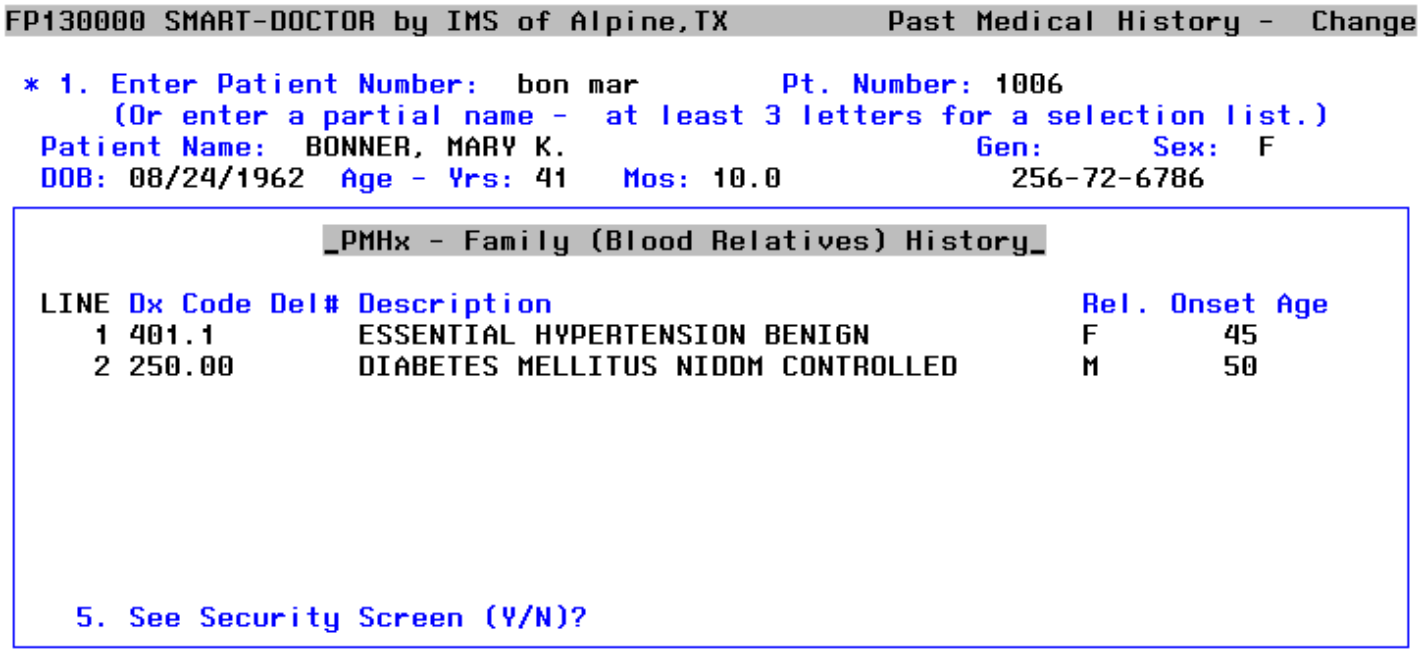


Figure 213 *Family History.*

In the “Rel” field, you can hit <F2> help key to see the list of possible relationships used by the system. Of course, these only have meanings for blood relatives. The system list of blood relatives is as follows:

Rel. Abbr.	Relationship
PGF	Paternal Grand Father
PGM	Paternal Grand Mother
MGF	Maternal Grand Father
MGM	Maternal Grand Mother
F	Father
M	Mother
B	Brother
S	Sister
PU	Paternal Uncle
PA	Paternal Aunt
MU	Maternal Uncle
MA	Maternal Aunt
SON	Son
D	Daughter

In the “Onset Age” field, enter the appropriate age that this condition developed in the patients blood relative.

*PROMPT #8, “***Add Hospitalizations (Y/N)”**, enter <y> + <enter> to add or see the patient's hospitalization history . In the following example (Figure 214), an Hospitalization History has already been added, in the same manner as in the “*ADD PAST MEDICAL & SOCIAL PROBS”* screen above.

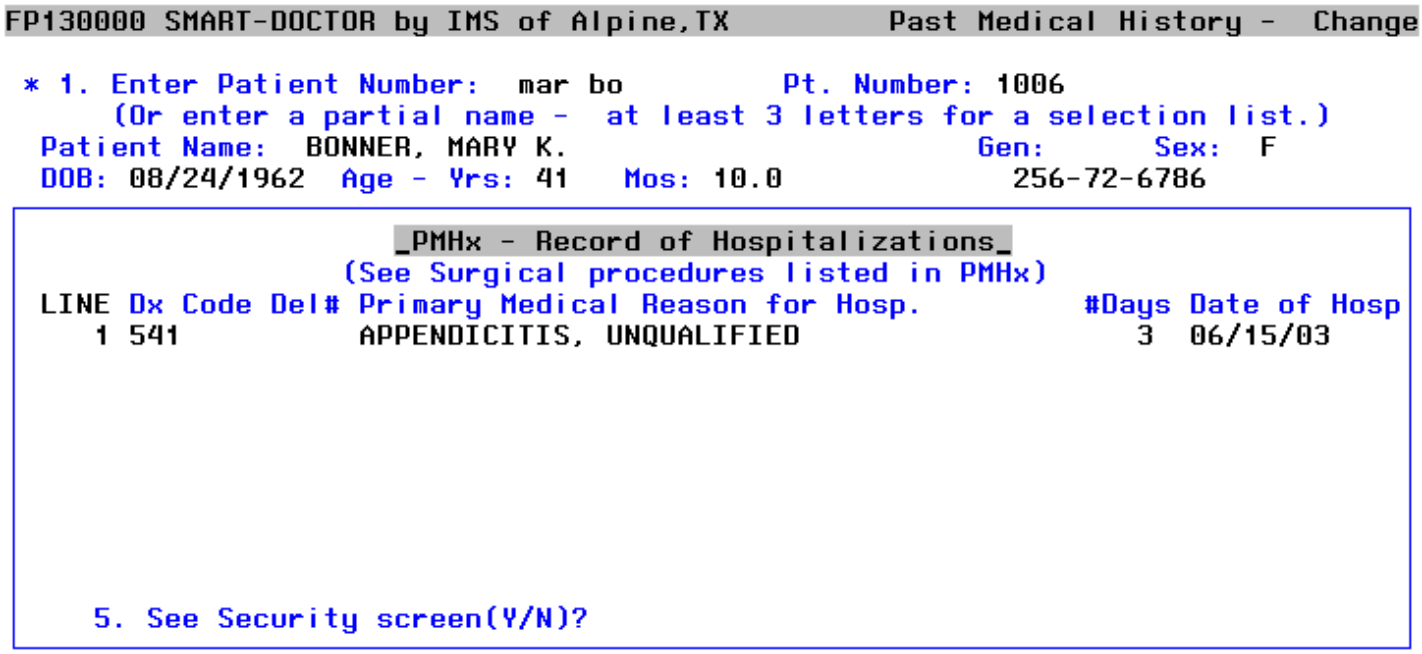


Figure 214 Past Hospitalizations.

Correct errors by use of the “DELETE” diagnosis method discussed in the section on “DELETING A CODE” earlier in this section.

Even admissions for surgical procedures that are listed under the “Past Surgeries & Procedures” section have an associated diagnosis for admission. As in this example, the procedure was appendectomy (documented in the Surgeries section of the past medical history) for the diagnosis, of “appendicitis”.

In the days field, indicate the approximate number of days the patient was hospitalized for tis diagnosis. This often indicates how serious a condition was, as well as possible complications that might still arise from this condition. For example, in the case of appendicitis above, it was probably a pretty standard case. However, if the hospitalization was for 30 days, then you know there were complications, and the probability for adhesions, and late complications from this hospitalization are much higher.

Special F-keys
To allow selected front office personal to enter images into the patient's record, the add images and review images screens are presented via the F6 and F7 keys.

The <F6> key, “Add Images”
Hitting the <F6> will open the add images screen seen in Figure 215. After entering <a> at the multi-value change prompt, the “**Image Types**” window will pop-up as seen in this figure. Select the image type you want to enter. Then at the “**Description**” field, enter a description of the image you are adding. Next enter the date and time of the image (not the current time and date) as seen below.

You will then be asked; **Is this a new Image?**

Upon answering <y>, you will get the pop-up window seen in Figure 216. After saving the image to the name and path given, answer <y> to prompt #2.

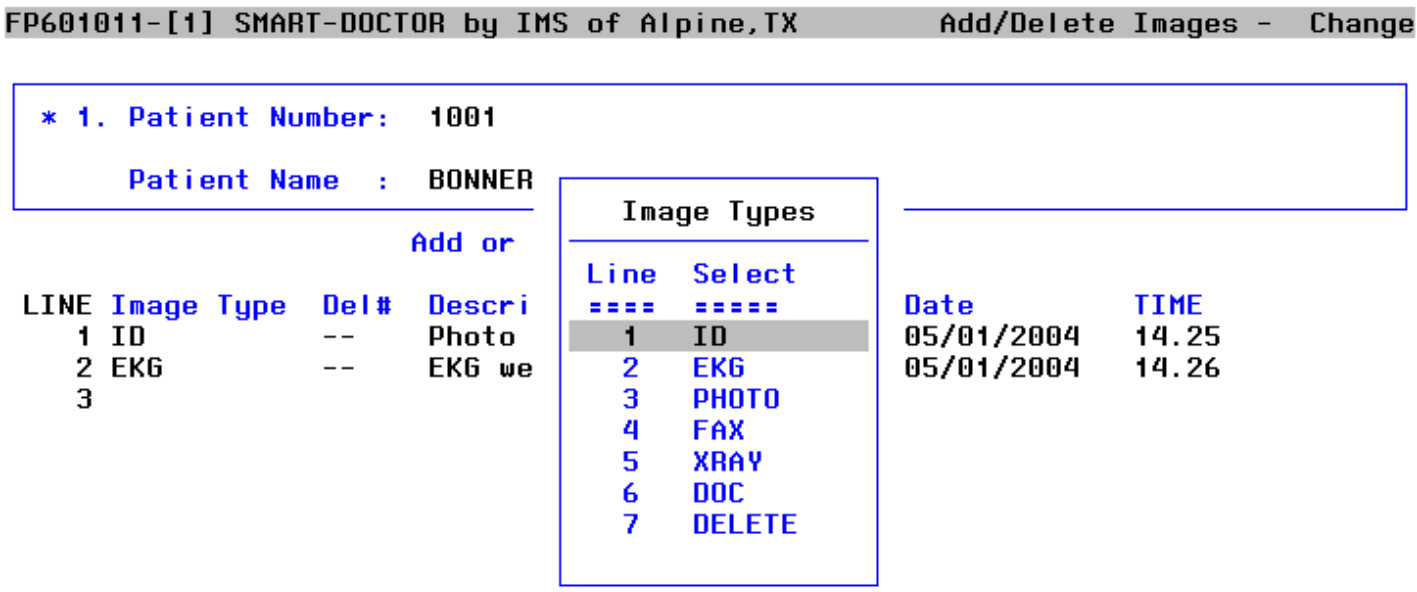


Figure 215 *Add Images screen.*

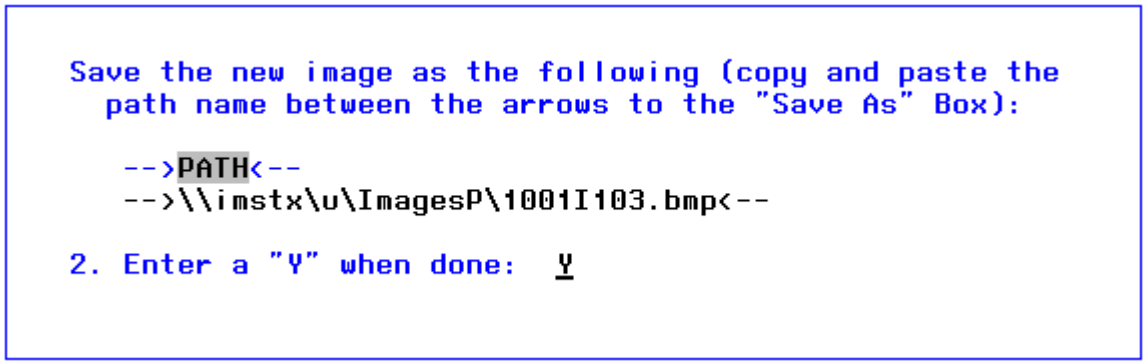


Figure 216 *Image Path and Name to Store.*

You should the check that the image you saved actually was stored properly, and that the system is working correctly. You will get next be presented with the reminder screen shown in Figure 217.

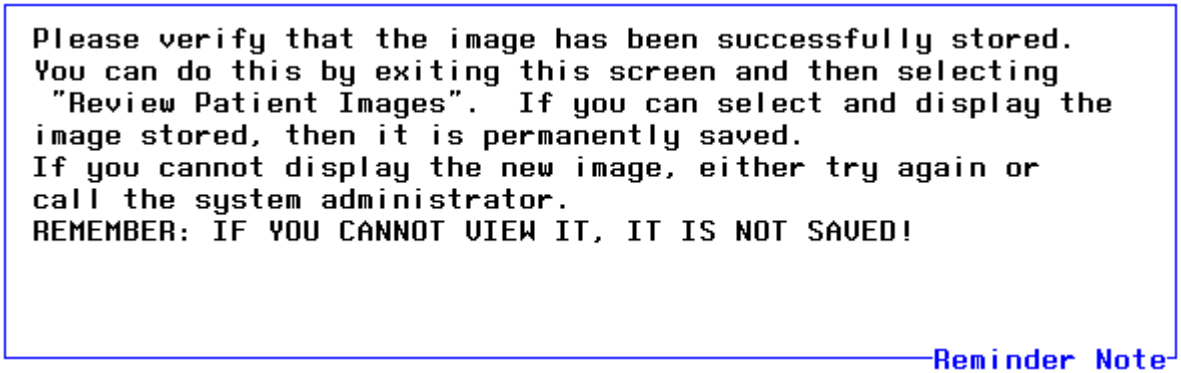


Figure 217 *Reminder to Check Image window.*

The completed add images screen can be seen in Figure 218 below.

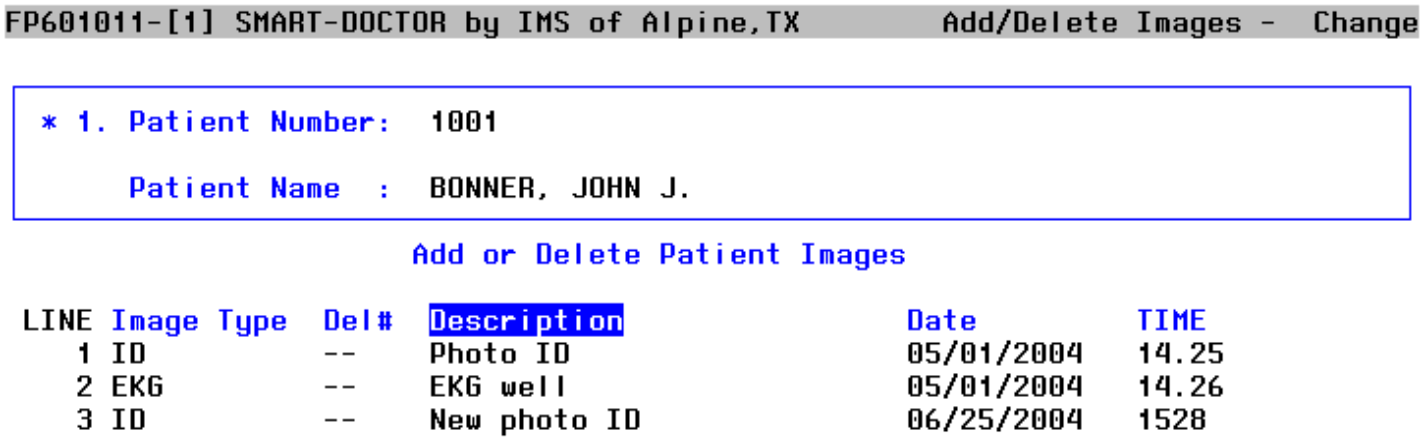


Figure 218 *Complete Add Images screen.*

The <F7> key, "Rvw Images"

The review images screen will identical to that of the add images screen seen in Figure 218, with the exception being that the change prompt only allows for selection of an image to view (no ability to add). Upon selecting the line number of the image you want displayed, the image will be presented to you.

ORDERS INCOMPLETE & PENDING

From the front office menu screen (Family & Patient File Maint.), menu item #7, "**Orders Incomplete & Pending**", will allow the user to check on Incomplete or Pending Orders. This sub menu screen can be used by all user classes, however, it is generally used by the front office staff that generally interact with patients regarding scheduling appointments. It is also used by lab, X-Ray, and nursing, to process pending orders. The sub menu as seen in Figure 219, will allow you to go to the specific type of pending order you want to process or review.

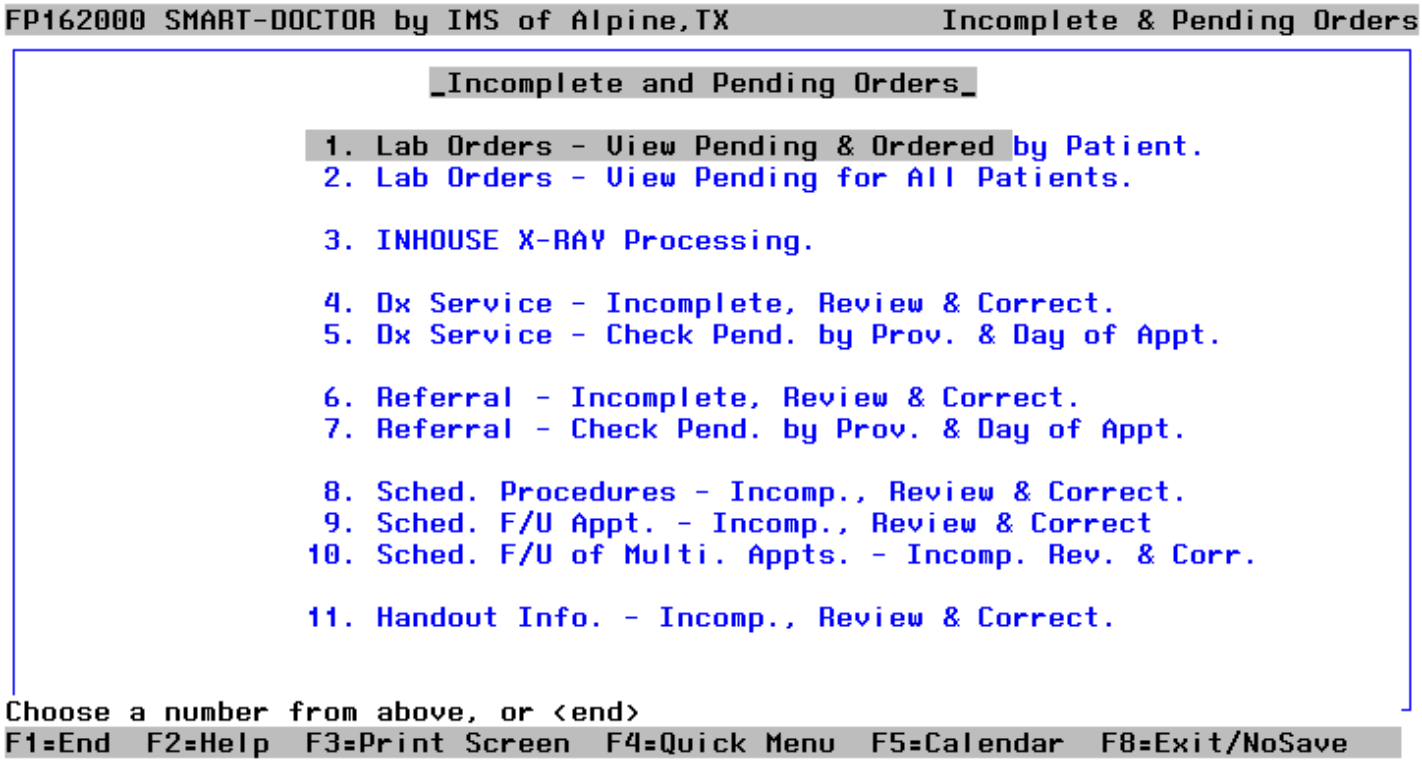


Figure 219 *Incomplete and Pending Orders Sub Menu.*

Selecting Menu item #1, "**Lab Orders - View Pending & Ordered by Patient.**", choose this item to View Status of Lab Orders, by patient. This selection is used most often to answer a patients questions as to whether a lab result has come back. It is also useful to reprint outside lab requisitions. Upon selecting this item the following Lab Order Maintenance screen, as seen in Figure 220, is presented:

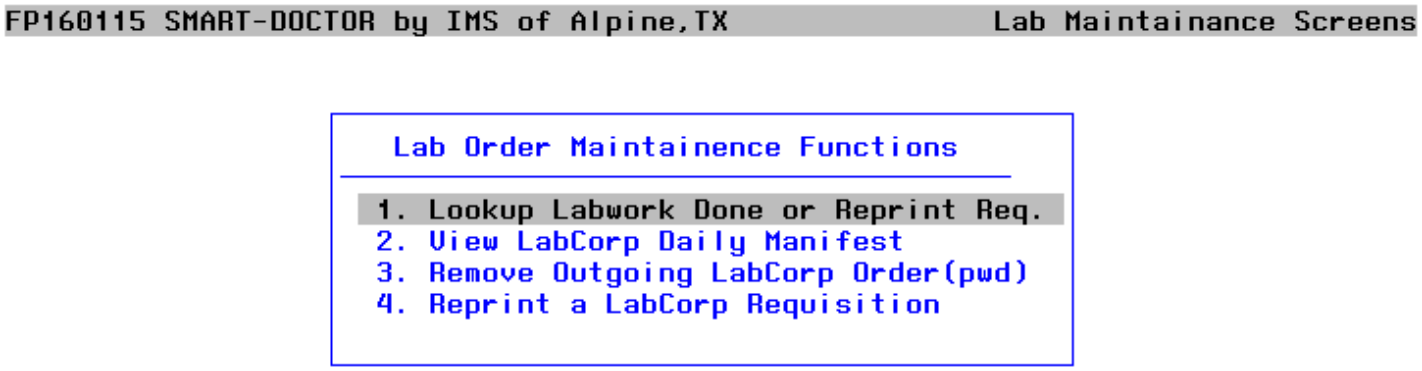


Figure 220 *Lab Order Maintenance screen.*

Upon selecting item #1, "**Lookup Lab work Done or Reprint Req.**", the "Patient Lab Results Status" screen will be shown as seen in Figure 221. At prompt #1, "**Patient Number:**",enter part of the patient's name (for cross-reference lookup) or enter the patient's number. After selecting the patient, the following screen will be seen, with any lab pending. If your are immediately returned to prompt #1, with the name field now blank, then there are no labs pending for that patient.

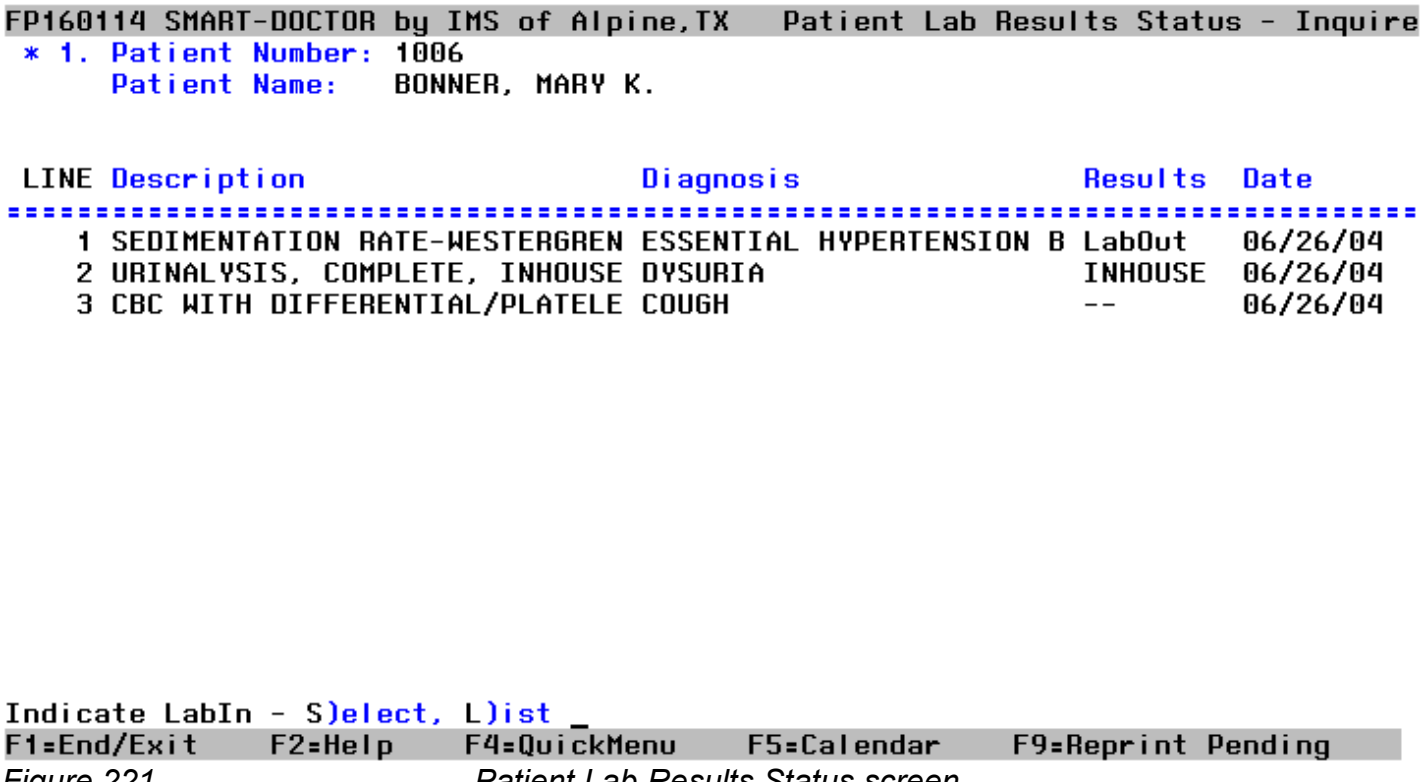


Figure 221 *Patient Lab Results Status screen.*

There are three possible lab types, all of which are shown above. 1) Standard External Labs, 2) INHOUSE Labs, and 3) Interfaced Outside Labs. Below is discussion of each the three types of lab, and how to use the screens associated with each.

External labs that are not interfaced with the SmartDoctor® system (not automated), for other than ordering, printing the requisition slips, and tracking. In line #1 above, this is a lab test that was sent out by giving the patient a printed lab requisition for a non-interfaced lab. The patient may go to another site (lab) to have the lab drawn, or may have the lab this drawn at your clinic, but in either case, there is no direct interface between the SmartDoctor® system and the lab. The requisition is in a paper form, and the result come back in a paper form. In this case the values in the result field will say “LabOut” or “LabIn”.

Once the lab test comes back, you may indicate this by selecting this line item, and then answering <y> to the prompt: “Indicate this lab is IN, Y/N:”, at the bottom of the screen as shown below in Figure 222.

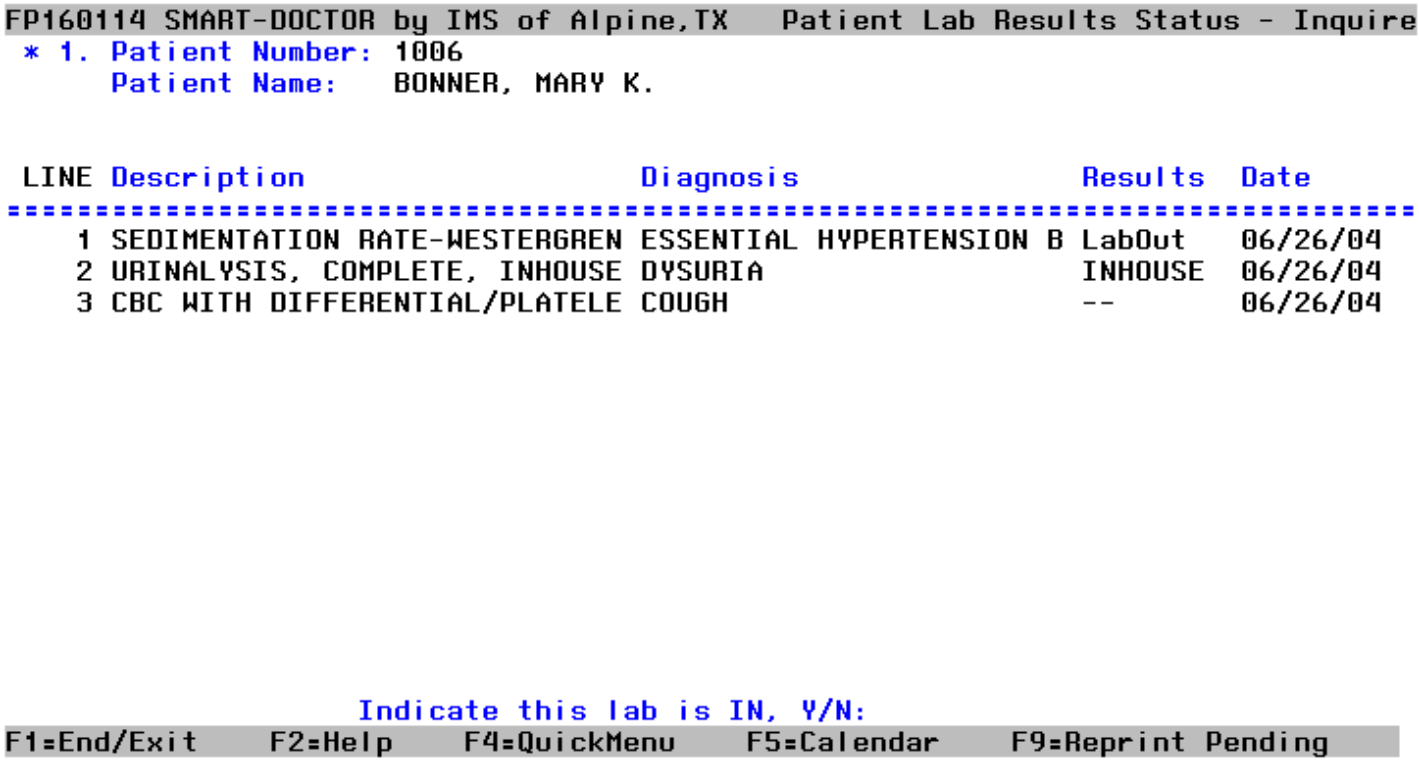


Figure 222 Selecting External Lab to Indicate Returned.

The results of answering “yes”, changes the value in the results field to “LabIn” as is seen in Figure 223 below.

f you have another non-interfaced lab to indicate has returned, then enter that line number at the prompt shown above. However, if you enter 1,2, or 3, at this time in the above screen, you will get no response (other than to return you to that selection prompt above). The reason for this is that, Line #1 has already been indicated as “LabIn”, and nothing else can be done with that line. Line #2 is an INHOUSE lab. This must be process through the nursing screen, menu item #3, “**Nurse Intake & Med. Refill**”, off the main front office menu. The results field will change as a result of actions taken on processing that lab. The results field will then be populated with an indication of this being normal or abnormal. Line #3 is an interfaced lab that will indicate “NORMAL”, ABNORMAL, or “--” once processed and results are pending.

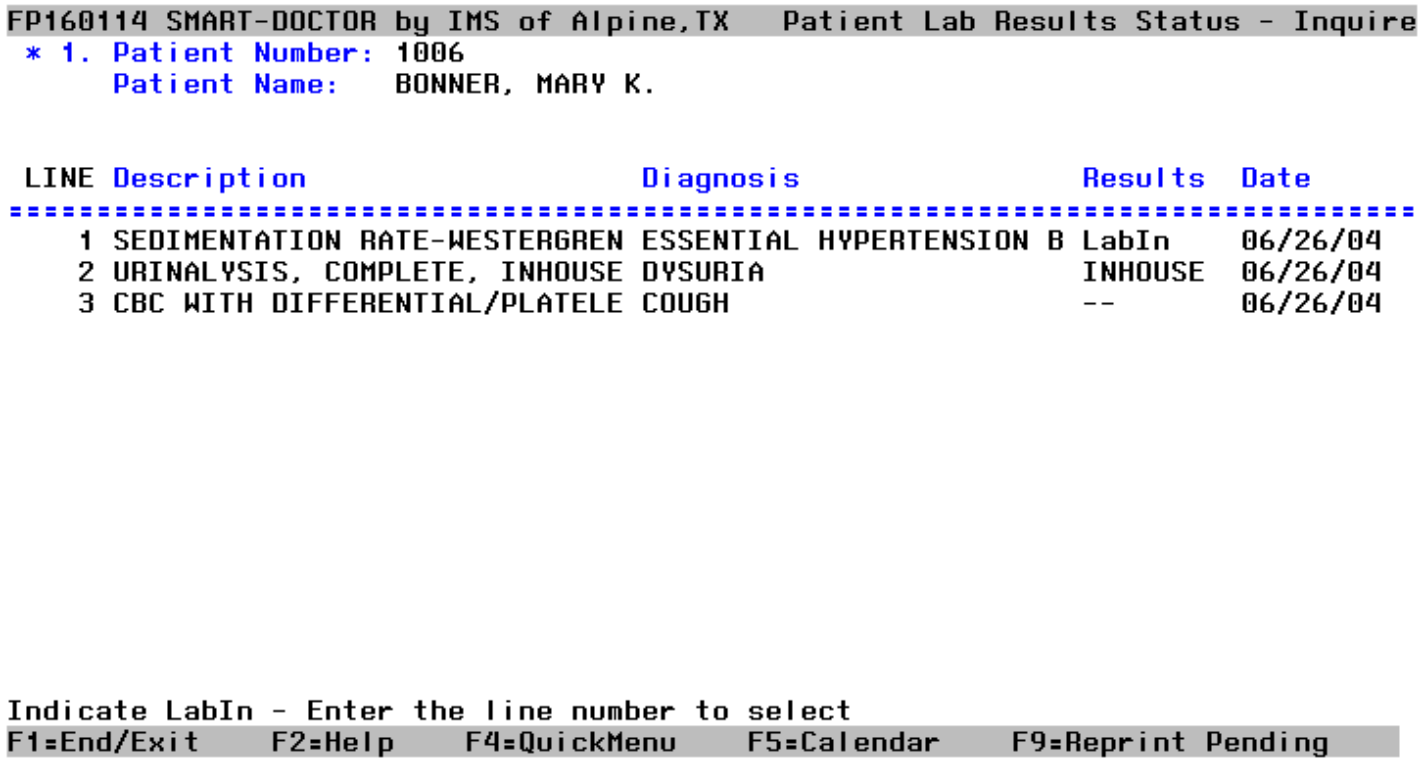


Figure 223 *External Lab Indicated as IN.*

INHOUSE labs. In line #2, this is an example of an "INHOUSE" lab that is pending completion. In this case it is a Urinalysis. The "INHOUSE" indicates that this has not been processed yet. Had it been processed, it would be indicated as "Normal" or "Abnormal". This must be process through the nursing screen, menu item #3, "**Nurse Intake & Med. Refill**", off the main front office menu. Then in that sub menu, selecting menu item #5, "**Collect/Process Doctor Ordered Labwork**".

Interfaced lab results. In line #3, is an example of an interfaced lab order that is pending processing. The double dash (--) indicates that the test have been ordered, but no results are available yet.

The <F9> key, "Reprint Pending"
The "F9" key is to reprint pending labs that are not "INHOUSE labs", or "Interfaced labs". Upon hitting the <F9> key the screen seen in Figure 224 will be presented for this patient's labs.

The first two labs listed are to be processed as an Interfaced Lab, and as an INHOUSE lab, respectively. Therefore there is no requisition to be reprinted. You are just made aware that these test have been ordered and are still pending. How overdue they are can be seen by comparing the "When" date, to the current date. Upon hitting the <F9> key, "Print Pt. Info", on this screen, you will be presented with the multiple select list shown in Figure 225:

In this multiple selection screen, you can arrow up and down to highlight a line you want to select. Then while on that line, hit the <enter> (or <return>) key to select an item. Hitting the <enter> key again on that same line will un-select it. To indicate that a line is selected, an asterisk (*) will be placed at the beginning of the line. Once you have selected the requisitions that you want printed again, hit the <F1> key (end), to accept your selection(s). Upon hitting the <F1> key, the requisition seen in Figure 226 is reprinted for this outside lab.

```
FP160116-[1] SMART-DOCTOR by IMS of AlpiPending Labwork - Exit Billing -  Change

* 1. Patient Number:    1006
     Patient Name:      BONNER, MARY K.
     Sex:               F
     Date of Birth:     08/24/1962
     Provider:          STEVE J. JOHNSON, MD

                    _Scheduled Patient Lab Work_

LINE Lab Work:                  When     Reason                 Status
   1 CBC WITH DIFFERENTIAL/P    06/26/04 786.2                  OVERDUE
   2 URINALYSIS, COMPLETE, I    06/26/04 788.1                  OVERDUE
   3 SEDIMENTATION RATE-WEST    06/26/04 401.1                  REQUISITION


SPECIMEN=Send pt. back to have specimen drawn before leaving.
OVERDUE=Send pt. to have specimen drawn, or have dr. or rn. cancel lab.
REQUISITION=Print out requisition for this outside labwork.
SCHEDULED=Print out reminder for patient to come in for labwork.

Lab Test Name - L)ist _
F1=End/Exit  F2=Help  F4=QMenu  F5=Cal  F8=Exit/NoSave  F9=Print Pt. Info
```

Figure 224 *Request Lab Requisition Reprint.*

```
                    Select lab items to print

Line Lab Test                  Scheduled  Laboratory   Status
---- ------------------------- ---------  ----------   -----------
   1 CBC WITH DIFFERENTIAL/P    06/26/04  LABCORP      OVERDUE
   2 URINALYSIS, COMPLETE, I    06/26/04  INHOUSE      OVERDUE
*  3 SEDIMENTATION RATE-WEST    06/26/04  SKB          REQUISITION
```

Figure 225 *Multiple Select for Requisition Reprints.*

Had you also selected the INHOUSE and Interfaced labs that are indicated that are overdue, the additional page would be printed for this patient as seen in Figure 227. This might be necessary in the case that the patient left the clinic before having the tests done. You could mail this to the patient and have them come back for the needed labwork.

Upon selecting item #2, "**View LabCorp Daily Manifest**" from the Lab Maintenance Screen sub-menu, you will be presented with the screen seen in Figure 228. The manifest is the listing of lab tests sent to the interfaced lab and billing status by date.

In prompt #1, enter the date of the manifest for labs sent on that date. Be aware, that putting in

Outside Labwork Requisition

ALPINE FAMILY PRACTICE
123 HOLLAND AVE.
ALPINE, TX 79830

Patient Number: 1006
Patient Name: BONNER, MARY K.
Patient Sex: F
Date of Birth: 08/24/62

The following labs are scheduled at the outside provider indicated. Please contact them at the number below to schedule testing.

Lab	Date Ord.	Laboratory	Diagnosis
SEDIMENTATION RATE-WEST	06/26/04	SKB	401.1

Testing Facility: 2400 N. Holland Ave., Alpine, TX

Contact Number: 839-2345

Additional Information: For AM Lab, go fasting x8 hrs, Take meds.

_____

_____

_____
STEVE J. JOHNSON, MD

Figure 226 Requisition Reprint for External Lab.

Patient Pending Labwork

ALPINE FAMILY PRACTICE
123 HOLLAND AVE.
ALPINE, TX 79830

Patient Number: 1006
Patient Name: BONNER, MARY K.
Patient Sex: F
Date of Birth: 08/24/62

The following scheduled labs have not been collected. Please make arrangements with the office to have your samples collected.

Lab	Date Scheduled	Laboratory
CBC WITH DIFFERENTIAL/P	06/26/04	LABCORP
URINALYSIS, COMPLETE, I	06/26/04	INHOUSE

Figure 227 Reprint Reminder for INHOUSE and Interfaced Labs.

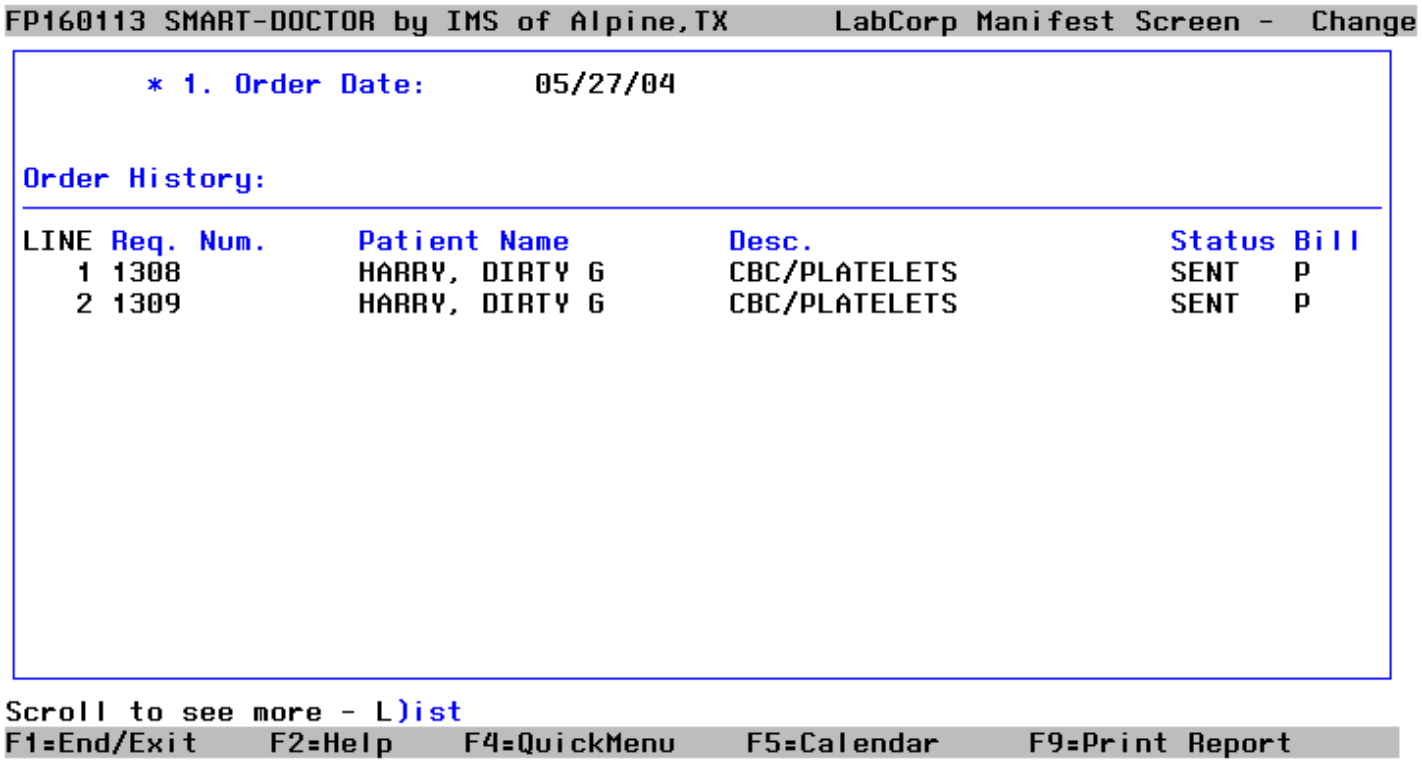


Figure 228 *Interfaced Lab Manifest by Date.*

todays date may result in a blank screen as above since this manifest is only generated at the time a batch of test are sent electronically by the SmartDoctor® system to the interfaced lab system. In most clinics the is done at the end of the day after lab pickup. However, at large clinics with multiple pickups per day, all the test sent that day will be listed. This report is used most often on a later date to check correlation of tests your clinic is being billed for from the lab. And to check that they were billed.

In this example, Dirty Harry, had two CBC's drawn and processed the same day. (Probably checking serially for blood loss after a gun fight.) To print the manifest hit the <F9> key “Print Report”, to print a report similar to the that seen in Figure 229.

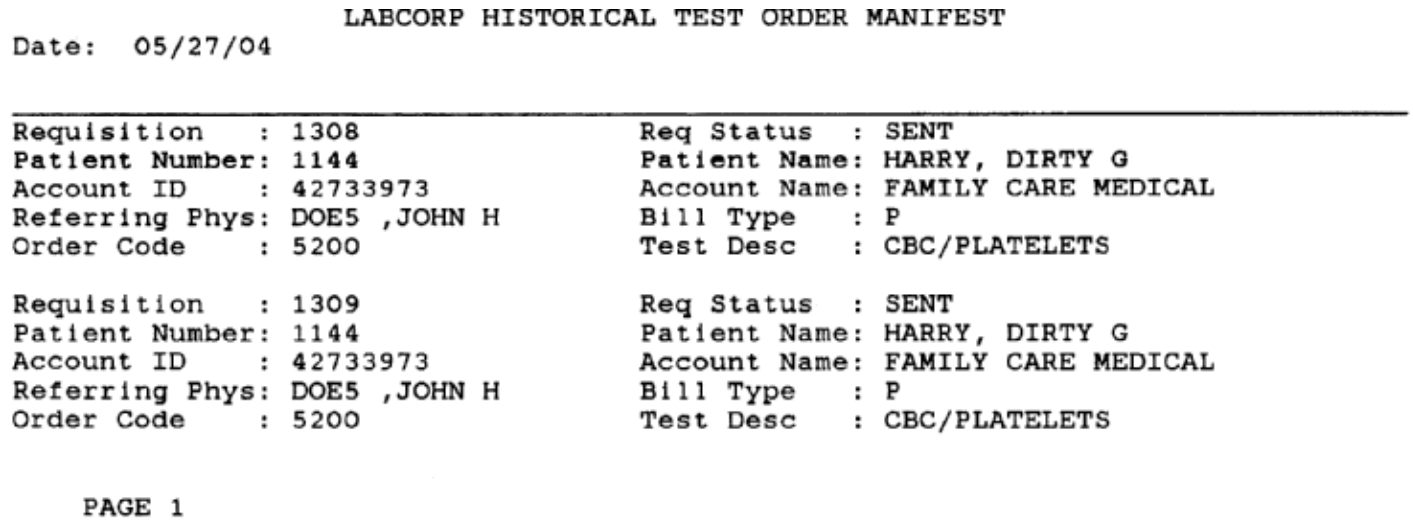


Figure 229 *Interfaced Lab Manifest Report.*

Other interfaced labs such as Quest, could also be listed here. This depends on the number of labs with bidirectional interfaces that your clinic uses.

Upon selecting menu item #3, "**Remove Outgoing LabCorp Order**", (or other labs that your site uses), the screen seen in Figure 230 is presented. Here we have already selected the patient for prompt #1 below, with the standard cross-reference lookup method.

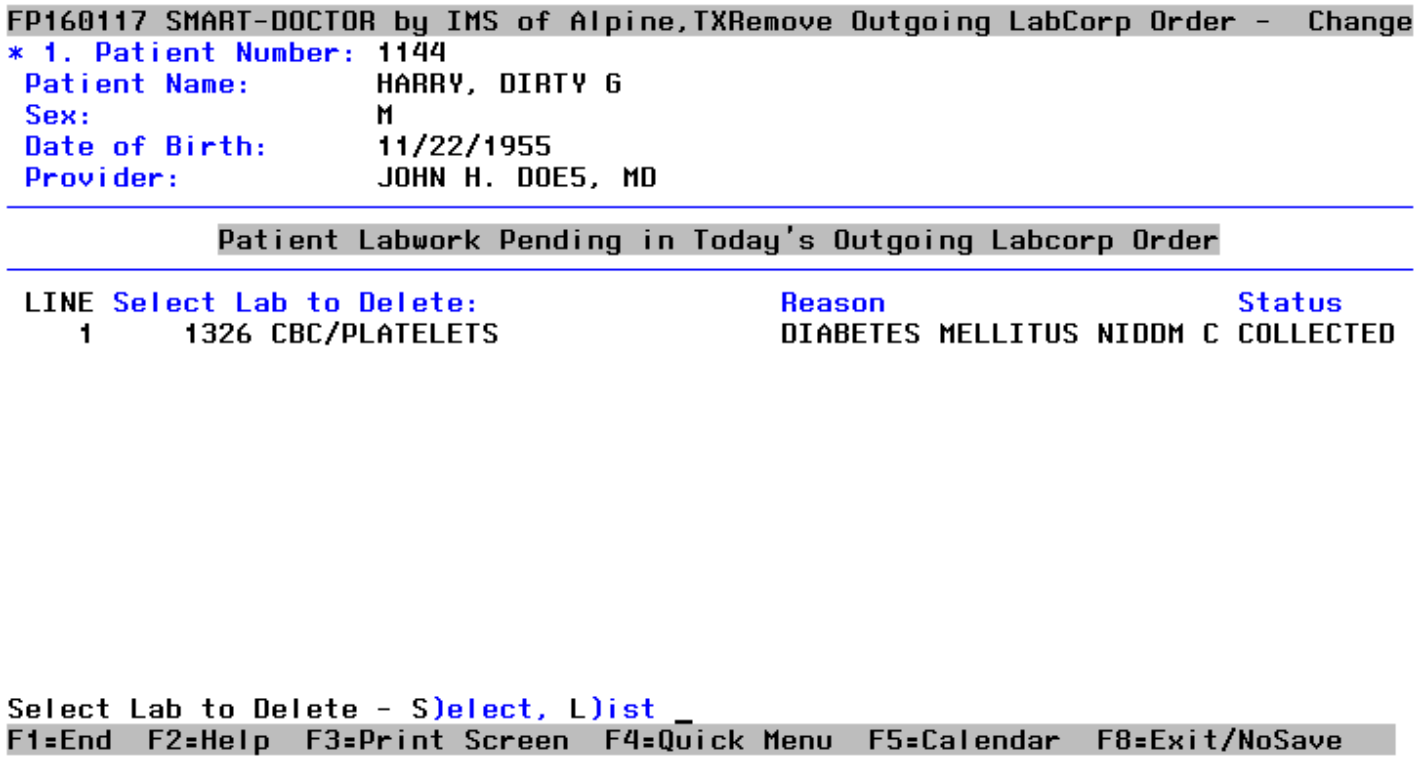


Figure 230 *Removing Interfaced Lab Order.*

Upon selecting line #1, the pop-up window seen in Figure 231 is presented.

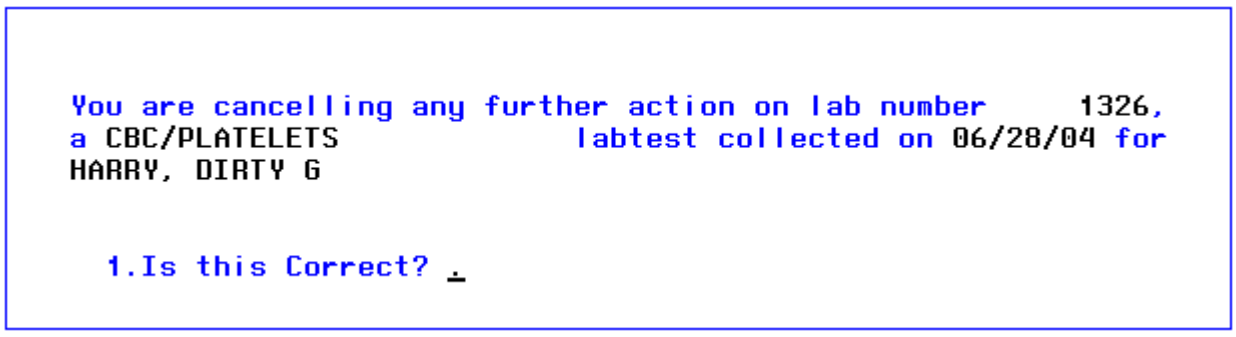


Figure 231 *Verify Cancel of Interfaced Lab.*

If you enter <y> here, the request will be deleted from the batched requests pending transmission to the lab. Be sure to delete the sample and any printed requisitions the are associated with this cancellation from the labs daily shipment.

Upon selecting menu item #4, "**Reprint a LabCorp Requisition**", the following screen (Figure 232) will be presented. Again, we have entered the patient's name in prompt #1 already.

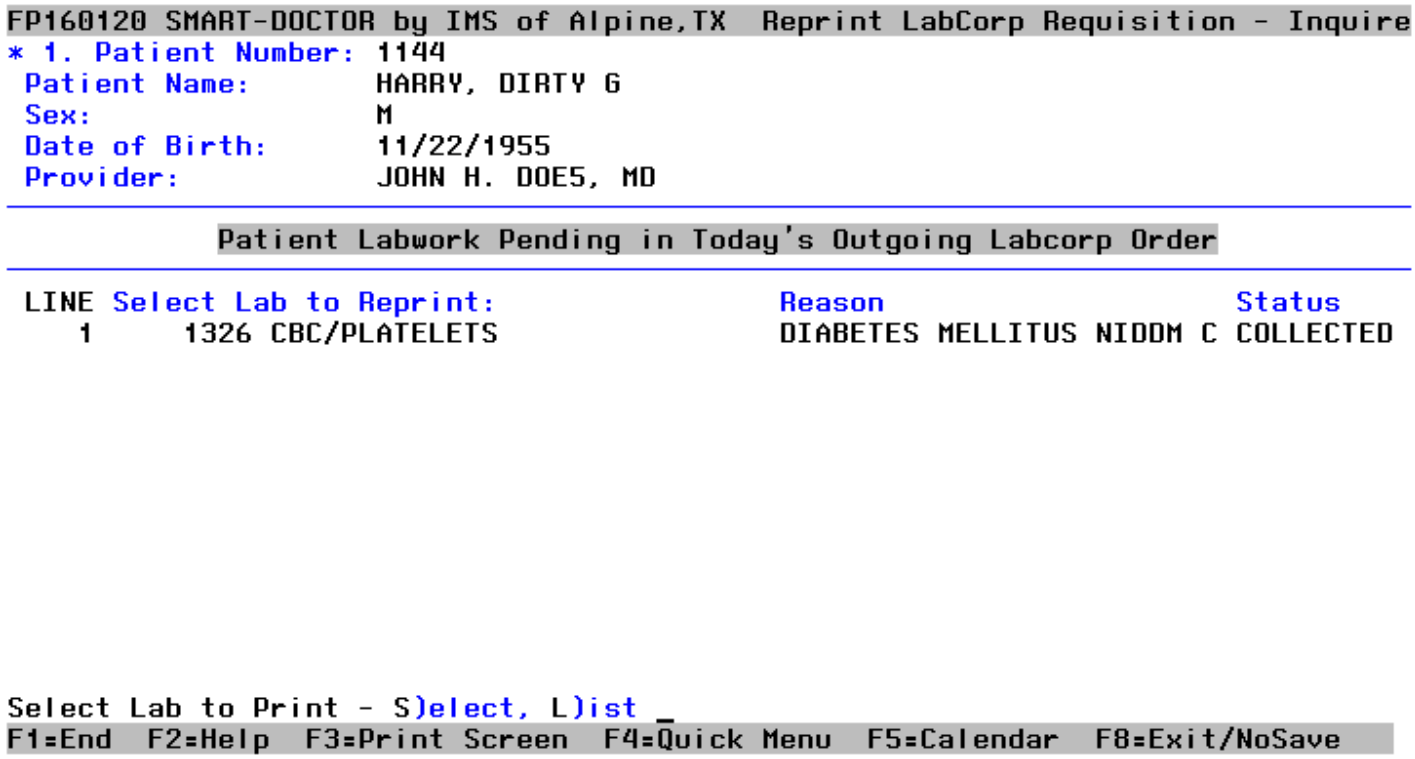


Figure 232 Reprinting Interfaced Lab Requisition.

Upon selecting line #1, the requisition seen in Figure 233 is reprinted:

BACK TO: Incomplete & Pending Orders Menu

Selecting Menu item #2, "**Lab Orders - View Pending for All Patients.**", choose this menu item to find all labs ordered but not in yet. The screen shown will be similar to that of Figure 234, but without any data except for the patient number in prompt #1, "**Patient Number:**". This number is defaulted from the list of patients with orders still pending completion. Just hit the <enter> key to accept this patient number, and you will be taken to the populated screen seen in Figure 234.

The <F9> key, "Reprint Pending"
The "F9" key is to reprint pending labs that are not "INHOUSE labs", or "Interfaced labs". This functions exactly the same as screen FP160114 as shown above under "Lookup Lab work Done or Reprint Req.", described previously.

Upon hitting the <enter> key or the <F1> key to end, you will be taken to the next patient found to have lab orders pending. Once you are presented a screen with no patient number defaulted in prompt #1, "Patient Number:", then the list of patients with pending labs has been exhausted. At this point hit the <F1> key to "end" input.

Selecting menu item #3, "**INHOUSE X-RAY Processing**", choose this menu item to perform or review INHOUSE X-RAY Processing. You will then be presented with the following sub menu shown in Figure 235 for INHOUSE X-RAY Processing, Review, and Readings. This menu item is for x-ray techs., radiologists, or physicians reading or reviewing patient x-rays.

Selecting sub menu item #1, "**Process pending INHOUSE X-RAY requests**",will take you to the shown in Figure 236. This screen is for use by the X-Ray technician.

```
QUEST DIAGNOSTICS REQUISITION                                    DATE RECORD
PRINTED: 06/28/04

Order Number: 1325

Client Account Number: 52324          Client:       FAMILY CARE MEDICAL
                                                    17812 MORO ROAD
                                                    ALPINE, TX 79830
                                                    (408)663-3926

Social Security: 314159233            Patient Name: HARRY, DIRTY G
                                                    12345 STREET
                                                    ALPINE, TX 79830

Sex:                M                 Date of Birth:   11/22/1955
Date Collected:     06/28/2004        Time Collected:  10:20    Fasting: N
Chart/Pt ID:        1144              Reqstng Physcn:  DOE5, JOHN
Room/Location:                     STAT: N Ph (408)663-3926 Fx (915)364-2299
Clncl Comment Test 1:
Clncl Comment Test 2:

Pt. Home Phone#:       123-4567       Pt. Work Phone #:     234-5678

*******************************************************************************
Insurance Information:


Relation to Insrd: Self
Insurance Carrier: MEDICAID TEXAS NHIC
Address 1:         12545 RIATA VISTA CIRCLE
Address 2:         SUITE 420
City, State Zip:   ALPINE, TX  79830
Insured:           HARRY, DIRTY G
Insured ID:        19238909A
Group:             Wal2343

BILL TO:     [] Account     [] Patient     [*] Other
*******************************************************************************

Tests
==========

Unit Code Tests                                    Diagn  UC Information
========= ======================================== ====== ====================
10400     CREATININE CLEARANCE                     401.1  Vol mL:  1600
                                                          Ht In:   72
                                                          Wt lbs:  180
                                                          #Hr Col: 24
5200      CBC/PLATELETS                            250.00
```

Figure 233 *Reprint of Interfaced lab requisition.*

Here the terminal you are logged in on is displayed in prompt #1. Just hit the <enter> key as you are instructed in this prompt to accept this and proceed. All this means is that the system will pull the information needed and present it to you in this screen, on this terminal. If there are no X-Rays to process you will get the following message at the bottom of the screen: "**This record is not on file "FP-XRAY_TMP**". When there are X-Rays to be processed a screen similar to the that shown in Figure 236 will be displayed:

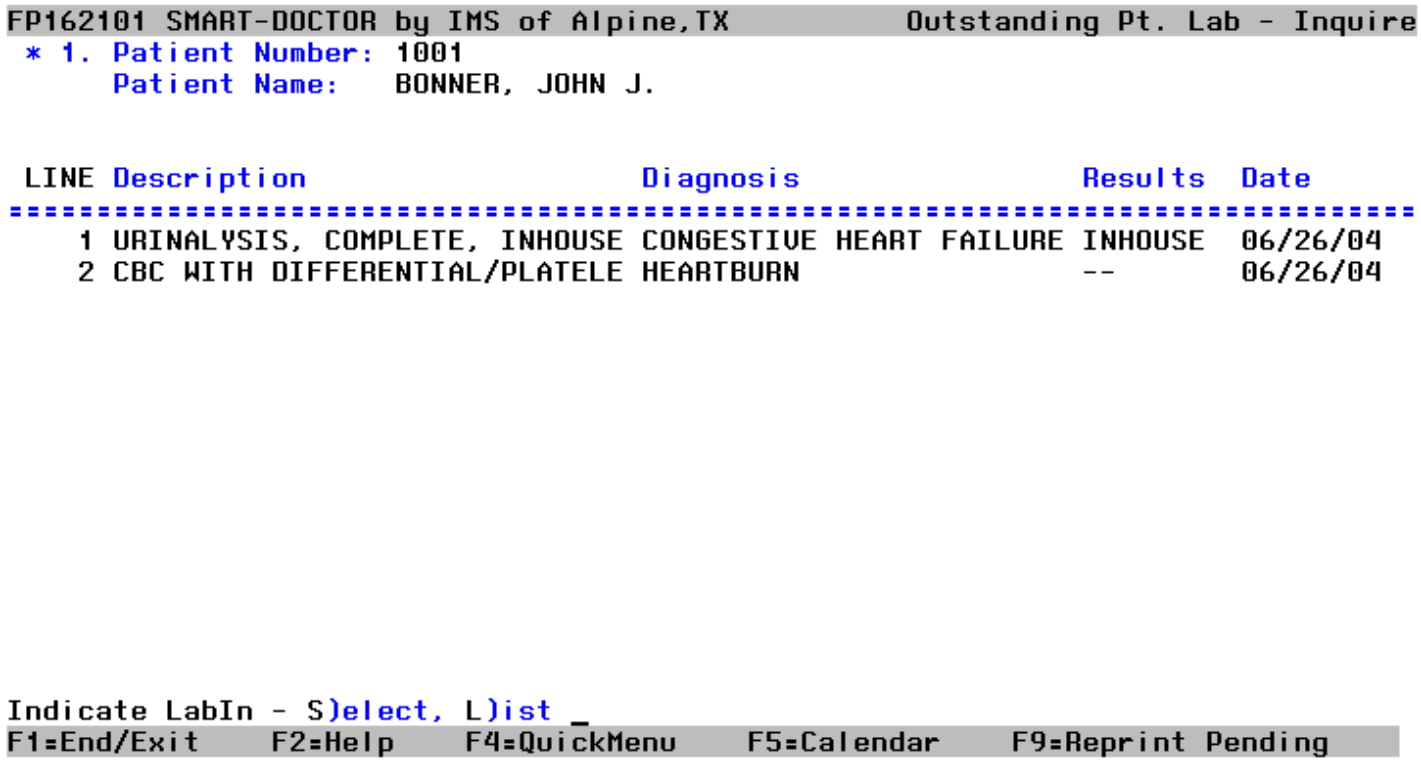


Figure 234 *Outstanding Lab Review.*

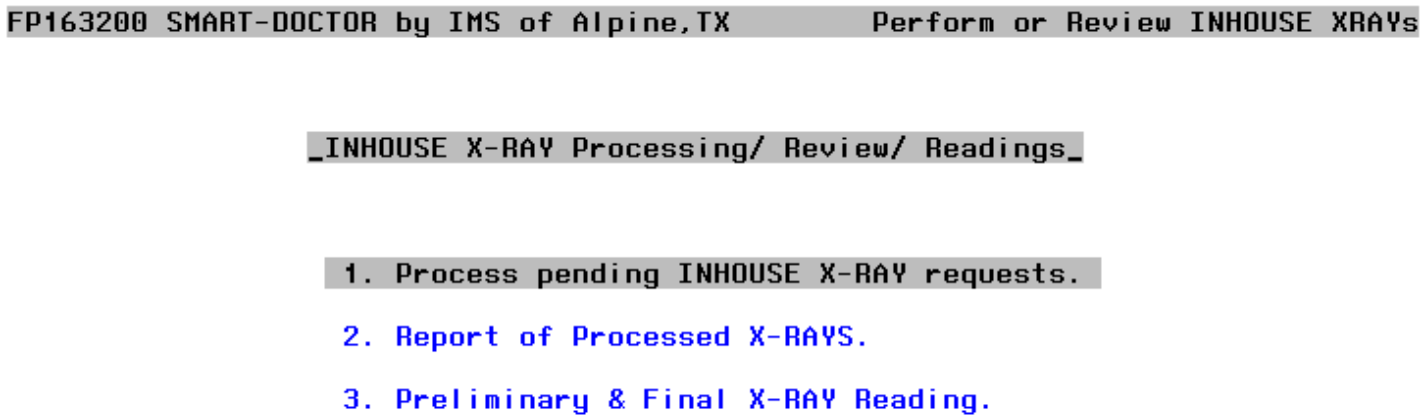


Figure 235 *Menu for INHOUSE XRAY Processing.*

In this screen the X-Ray tech. can see the x-rays ordered, in double multi-valued lines. On the header line are descriptors of what is below. The descriptor followed by a forward slash (“/”), is what is on the first line in that field, and after the forward slash is descriptor of what will be on the second line of that field. Therefore in line item #1 (In Figure 236), you can see the following information: the underlined order number, the underlined patient name, the patients date of birth, sex, and scheduled date. On the second half of multi-value line #1 is: the CPT or other charge code for the procedure, the procedure name, the diagnosis for which the test is being performed, the ordering provider, and finally the priority of the test. In this case it is showing “ROUT” for routine.

If line #1 is selected (by entering <1> and hitting <enter>), you will be presented with the screen seen in Figure 237.

```
FP163212 SMART-DOCTOR by IMS of Alpine,TX    INHOUSE XRAY TAKEOFF LIST - Inquire

 * 1. Terminal   typ3    (Hit enter.)     _Exit to Menu to Refresh Screen_

 LINE Seq#/CPT     Patient Name/Test Desc.                DOB/Dx  Sex/P Sch. Date
    1 100006       COOPER, MARY K.                        07/12/1960F   07/02/200
       74020 X-RAY,ABD,COMPLETE;INCL.DECUB.&/OR ERECT ABDOMINAL PAIN L SJJ  ROUT
    2 100003       BONNER, MARY K.                        08/24/1962F   06/26/200
       71021 RADIOLOGIC EXAM, CHEST, 2 VIEWS, FRONTAL ACUTE BRONCHITIS SJJ  ROUT

Select Order - S)elect, L)ist
F1=End/Exit  F2=Help  F4=QuickMenu  F5-Calendar  F8=Exit/NoSave
```

Figure 236 *XRAY Technician Order Takeoff screen.*

```
FP163213-[1] SMART-DOCTOR by IMS of Alpine,TX-RAY Processing & Reading -  Change

* 1. Sequence #: 100006        Patient name:  COOPER, MARY K.
     DOB:        07/12/1960     Pt. Number:    1003              Sex:  F
     Sch. Date:  07/02/2004     Priority:      ROUTINE    Pregnancy Precautions

Procedure #:  74020   Procedure Desc.:  X-RAY,ABD,COMPLETE;INCL.DECUB.&/OR ERECT
Diagnosis #:  789.04  Diagnosis Desc.:  ABDOMINAL PAIN LEFT LOWER QUADRANT
Ordered by:   SJJ     Date Ordered:  07/02/2004  Time Ordered:  13:15

  2. Shielding used(y/n)?     3. Type:
    (enter for list)         _Describe each exposure below._
Line Film         kVp   mA    Sec  Comments                              Image#

        Total exposures taken:     0
Change prompt (2 - 3), A)ll, F)ill, DR)delete record _
F1=End/Exit  F2=Help  F4=QuickMenu  F5-Calendar  F8=Exit/NoSave
```

Figure 237 *XRAY Processing screen.*

The top section of the screen shows the patient identification, the priority, and a warning about possible pregnancy if the patient is female, and is between the ages of 11 to 59 years old.

At the change prompt hit <a> for all, which will take you through prompts #2 & 3.

Prompt #2, "**Shielding used(y/n)?**", Answer <y> or <n>.

Prompt #3, "**Type:**", this is a free text field to enter the specific type of shielding used, if any. This field will be skipped if you answered "N" to prompt #2.

You will now be at the multi-value change prompt at the bottom of the screen as follows:

Exposure - A)dd, C)hange, I)nsert, D)elete, L)ist

Enter <a> to add an exposure record.

The system will take you to the first multi-value line for exposures, and automatically pop open a window as shown in Figure 238 below to select the film to be used. This may list one or more film types, including digital exposures.

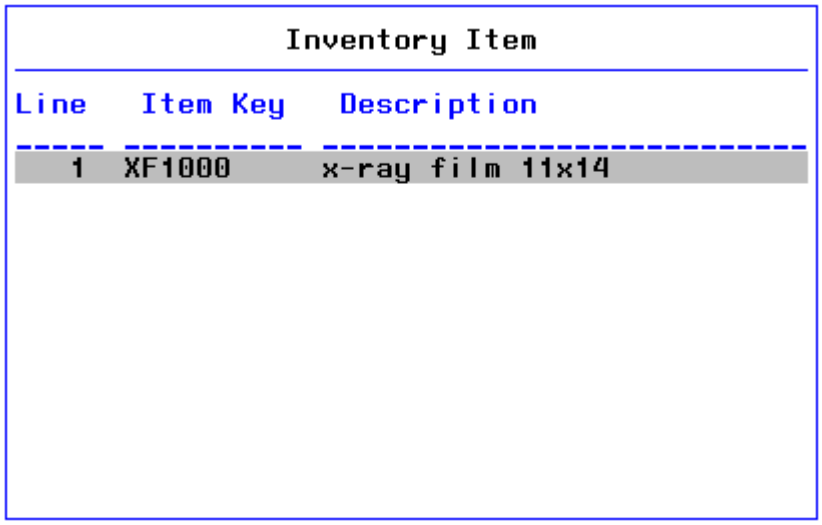


Figure 238 Select Film Type and Size to be Used.

In this case only one film type is shown. The film types that pop-up comes from the the procedure file. As will be discussed in the Procedure file section, each procedure may have X-Ray film or digital exposures placed in it's Inventory information section. The choices that are allowed there are defined in the TERMS file under in the "ADM-INVENTORY" record.

Field #2, "**kVp**", Kilo volts potential. Enter the voltage used here.

Field #3, "**mA**", Mili amps. Enter the current used here.

Field #4, "**Sec**", seconds. Enter the time used here.

Field #5, "**Comments**". Enter any comments here.

Field #6, "**Image#**", image number for digital x-rays. You will ONLY be taken to this field if the clinic file has the prompt #8, "**Store digital X-Rays?**", is set to "Y". If it is set to "N", then this field will be skipped. However, if it is set to "Y", then the following screen (Figure 239) will pop-up upon reaching this last field on the multi-value line for Exposures.

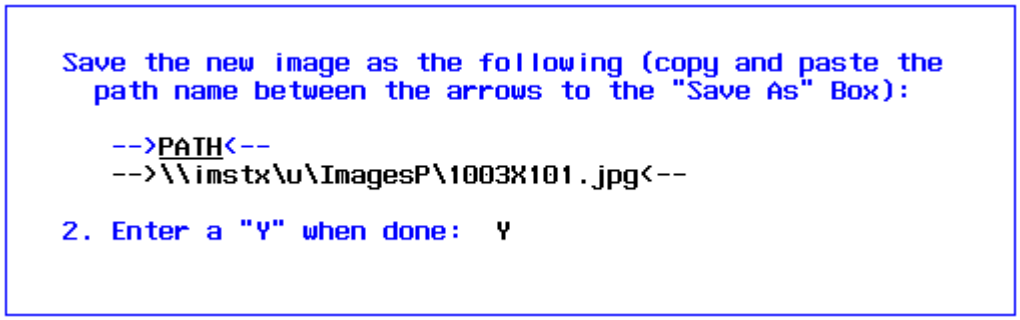


Figure 239 Path and Image Number to Store Digital XRAY.

At this point, you need to cut and past the “PATH” shown between the arrows on the screen. In this case this would be “\\imstx\u\ImagesP\1003X101.jpg”. The first part of this path is setup in your systems file for you when your clinic is first set up. The extension for the executable program to call up this image is set in the TERMS file under in the “ADM-IMAGE-TYPES" record. This will be set up by your system administrator.

Once you have saved the image, you will be at prompt #2 on this screen. Answer “Y” once the image is saved. Next you will be presented with the following reminder pop-up window (Figure 240)
:

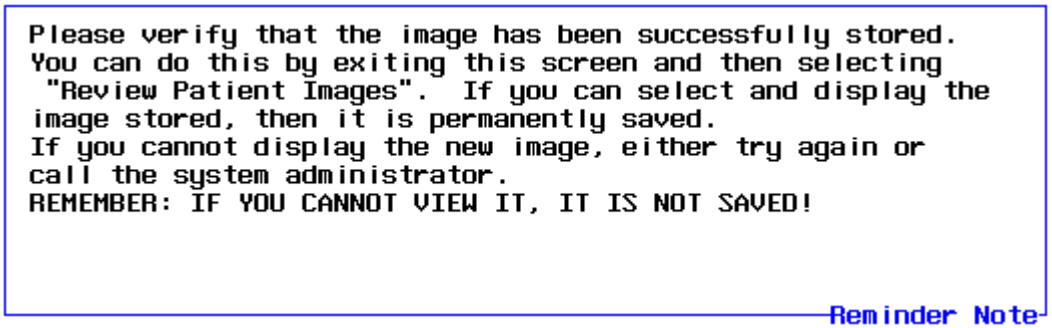


Figure 240 Reminder to Check Stored XRAY Image.

The sample screen shown in Figure 241 will now show the X-Ray image numbers assigned.

If there are no further exposures to record, just hit the <enter> key or <F1> key. You will then be asked “**Exit this X-Ray procedure (<return>=y/n=no)?**”. Enter <enter>, or <y> to exit and save.

You will then be asked to “**Enter your Signature PW**:”. Upon successfully doing this, the system will indicate this X-Ray order to have been process. It's status will be changed to “TAKEN”.

Selecting sub menu item #2, “**Report of Processed X-RAYS.**”, from the sub-menu screen for “Perform or Review INHOUSE XRAYs”, will present you with a selection screen asking for the first and last processing date that you want to review.

A sample Report of Processed X-Rays is shown in Figure 242.

Selecting sub menu item #3, “**Preliminary & Final X-RAY Reading.**”, from the “Perform or Review INHOUSE XRAYs” menu screen, is for used by the Radiologist or the primary clinic doctor to do preliminary and/or final X-ray readings that are pending. On selecting this item, the screen shown in Figure 243 will be presented showing the pending reading list.

```
FP163213-[1] SMART-DOCTOR by IMS of Alpine,TX-RAY Processing & Reading -  Change

* 1. Sequence #: 100001        Patient name:  COOPER, MARY K.
     DOB:       07/12/1960    Pt. Number:    1003              Sex:  F
     Sch. Date: 07/10/2004    Priority:      ROUTINE    Pregnancy Precautions

Procedure #:  74020   Procedure Desc.:  X-RAY,ABD,COMPLETE;INCL.DECUB.&/OR ERECT
Diagnosis #:  789.07  Diagnosis Desc.:  ABDOMINAL PAIN GENERALIZED
Ordered by:   SJJ     Date Ordered:  07/10/2004  Time Ordered:  15:08

  2. Shielding used(y/n)?  N  3. Type:
    (enter for list)          _Describe each exposure below._
LINE Film          kVp   mA    Sec  Comments                              Image#
   1 XF1000         80   400    .05 SUPINE                                101
   2 XF1000         80   400    .05 ERECT                                 102

        Total exposures taken:    2
Exposure - A)dd, C)hange, I)nsert, D)elete, L)ist _
F1=End/Exit  F2=Help  F4=QuickMenu  F5-Calendar  F8=Exit/NoSave
```

Figure 241 *Completed XRAY Processing screen.*

```
FP163214                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                             Review X-RAY Processing        12:10:04 11 Oct 2004

Starting Processing date:  10/11/2004 Ending Processing Date:  LAST

Sequence #  Patient Name                          Pt. #       Ord Date   By Prov
100007      COOPER, MARY K.                      1003        10/11/04   SJJ

    CPT      X-Ray Description                            Date Sch   Priority
    74020    X-RAY,ABD,COMPLETE;INCL.DECUB.&/OR ERECT     10/11/04   ROUTINE

    Dx Code  Dx Description                               Date Perf  By Code  Time
    789.07   ABDOMINAL PAIN GENERALIZED                   10/11/04   sjj      12:07

        Sex  DOB       Shield    Type of Shielding
        F    07/12/60    Y       Pelvic/Ovaries

        ** EXPOSURE INFORMATION
        Inventory    kVp    MA  Time  Exposure Comments
        XF1000        80   400    .5  SUPINE

        XF1000       80   400    .5  ERECT
        Performed by:
        LINDA L. JONES, RX
```

Figure 242 *Sample Printout of XRAY Processing Report.*

The clinic doctor can also reach this screen from the doctor main menu via menu item #6, "**Preliminary & Final InHouse X-RAY Reading.**" The selection screen for processing is similar to that of processing the X-Ray orders above. The top of the screen seen in Figure 243 below.

```
FP163222 SMART-DOCTOR by IMS of Alpine,TX     Preliminary Reading List - Inquire

 * 1. Terminal   typ4    (Hit enter.)     _Exit to Menu to Refresh Screen_

 LINE Seq#/CPT     Patient Name/Test Desc.                  DOB/Dx  Sex/P Sch. Date
    1 100001       COOPER, MARY K.                          07/12/1960F  07/10/2004
       74020 X-RAY,ABD,COMPLETE;INCL.DECUB.&/OR ERECT ABDOMINAL PAIN G SJJ ROUT
```

Figure 243 *Pending XRAY Reading List.*

Simply select the item to process, and the screen seen in Figure 244 will be presented for the line selected.

```
FP163223-[1] SMART-DOCTOR by IMS of AlpinPreliminary or Final Reading. -  Change

 * 1. Sequence #: 100007        Patient name:  COOPER, MARY K.
      DOB:        07/12/1960     Pt. Number:    1003              Sex:  F
      Sch. Date:  10/11/2004     Priority:      ROUTINE

Procedure #:   74020   Procedure Desc.:  X-RAY,ABD,COMPLETE;INCL.DECUB.&/OR ERECT
Diagnosis #:   789.07  Diagnosis Desc.:  ABDOMINAL PAIN GENERALIZED
Ordered by:    SJJ     Date Ordered:  10/11/2004  Time Ordered:  11:51

 Shielding used(y/n)?      Y  ype:      Pelvic/Ovaries
    (enter for list)        _Describe each exposure below._
LINE Film          kVp    mA  Time(S)  Comments
   1 XF1000         80    400      .5  SUPINE
   2 XF1000         80    400      .5  ERECT

Total exposures taken:    2      Taken by:  STEVE J. JOHNSON, MD
L)ist _
F1=End/Exit  F2=Help  F4=QuickMenu  F5-Calendar  F8=Exit/NoSave  F9=Reading
```

Figure 244 *XRAY Selected for Reading.*

The doctor would review the information and then hit the <F9> key for “Reading”. The doctor would then enter their preliminary or final reading as seen Figure 245. In this example, the preliminary and final readings are the same and there is no disagreement. If the final reading is abnormal and the readings are indicated as not agreeing, or the readings are incomplete, then on return to the selections screen the a message window will pop-up as shown in Figure 246.

BACK TO: Incomplete & Pending Orders Menu for Prompts #4 through #11

Here we will discuss prompts #4 through #11 on this sub-menu screen (Figure 219). These specific orders can only be placed during a “Provider Visit”, or a “Non-Scheduled Provider Visit”. These menu items are only populated after the bill has been processed. Prompts #4, #6, and #8 through #11 will only contain orders that were not taken-off at the time of billing, or were incompletely taken off. These prompts will be presented for incomplete orders, in the same manner as described in the billing sections “automatic exit screens”.

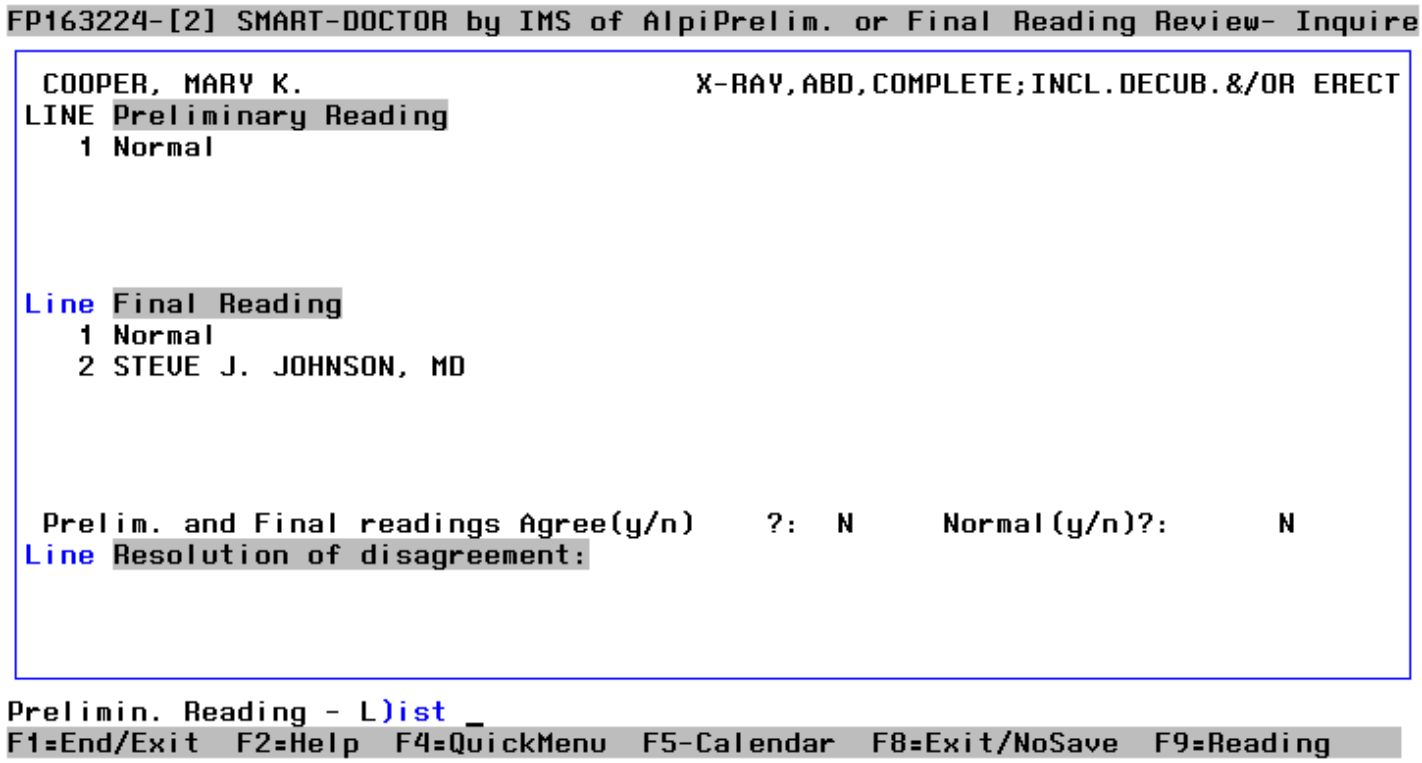


Figure 245 *Physician Entering Final XRAY Reading.*

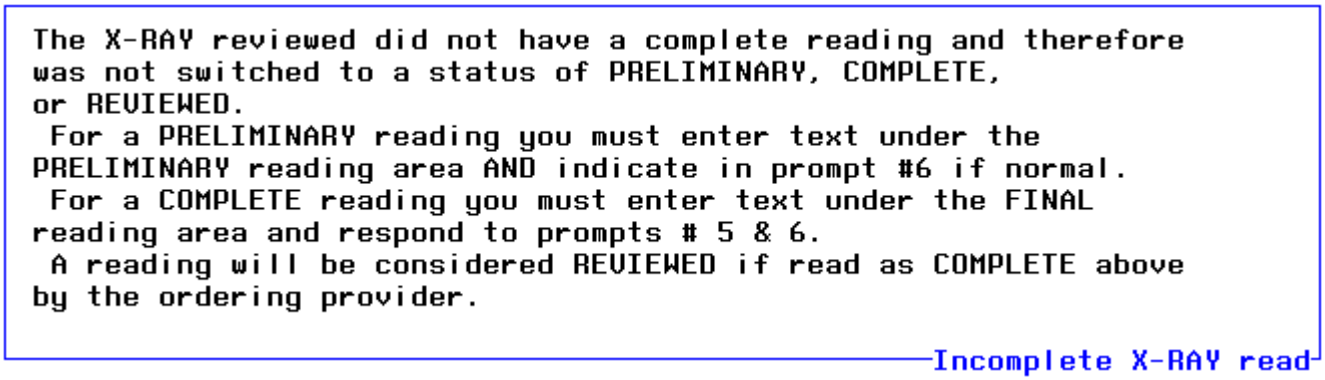


Figure 246 *Warning of Incomplete XRAY Reading.*

Prompts #5 and #7 are to allow nursing to see what Dx Service and Referrals were ordered for a doctor's patients for a future date. The nurse would generally check one day before for all scheduled Dx Services and Referrals, to be sure the reports are in before the doctor sees the patient.
On selecting either one of these prompts, a screen similar the selection screen seen in Figure 247 will pop-up.

In prompt #1, "**Enter Date of Appointment:**", enter the date in the future of the doctor's schedule you want to check.

In Prompt #2, "**Prov. Initials:**", enter the initials of the provider, or part of the doctors name for a cross-reference lookup.

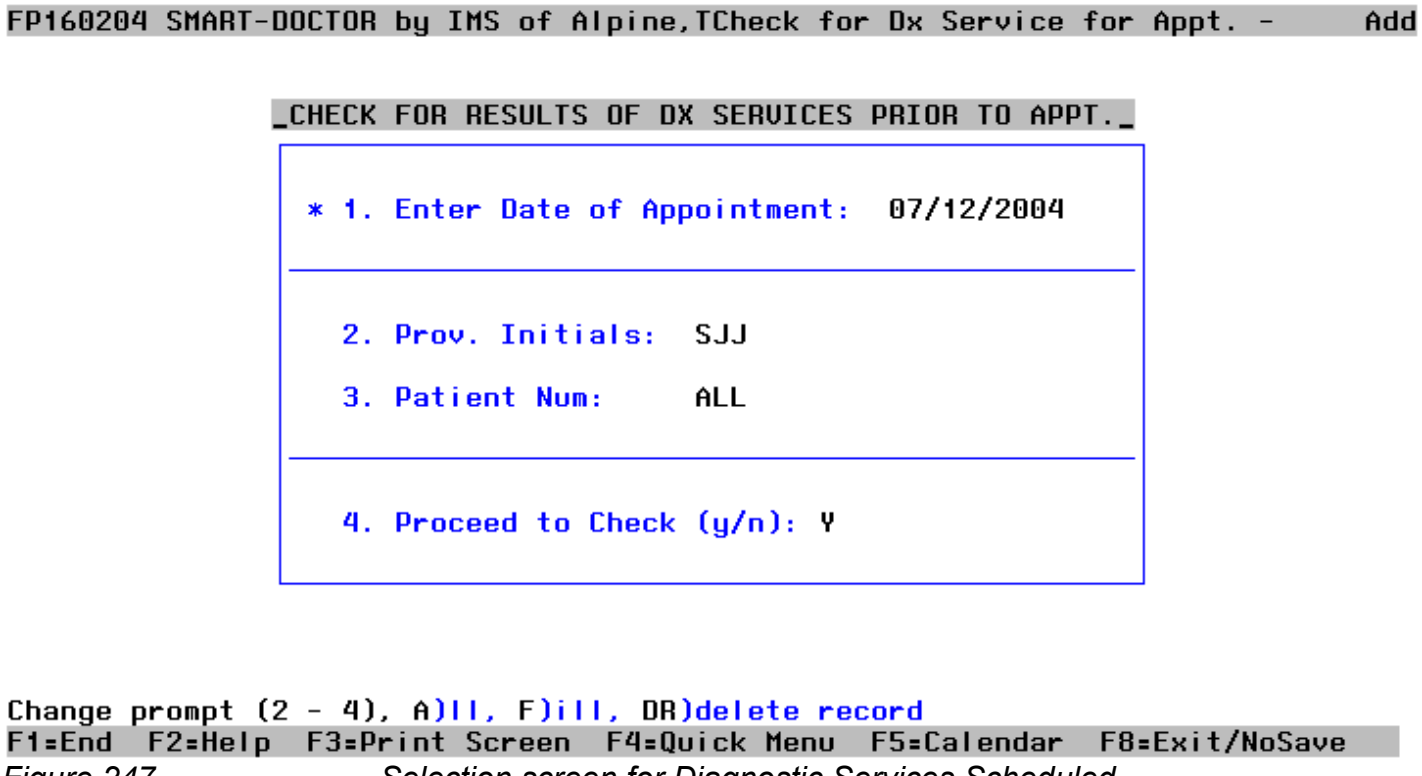


Figure 247 Selection screen for Diagnostic Services Scheduled.

In Prompt #3,. "**Patient Num:**", accept the default of "ALL" to see all patients with orders that should be back for that doctor on that date, or enter the patient number or part of the patient name for a cross-reference lookup.

In Prompt #4. "**Proceed to Check (y/n):**", enter <y> when you are ready to start reviewing the patients with orders due. Again, these prompts will be presented for orders, in the same manner as described in the billing sections "automatic exit screens". The only difference is that you see a defaulted encounter number of the order when it was placed. Simply hit the <enter> key and you will be presented with the order. A typical screen is shown in Figure 248 below.

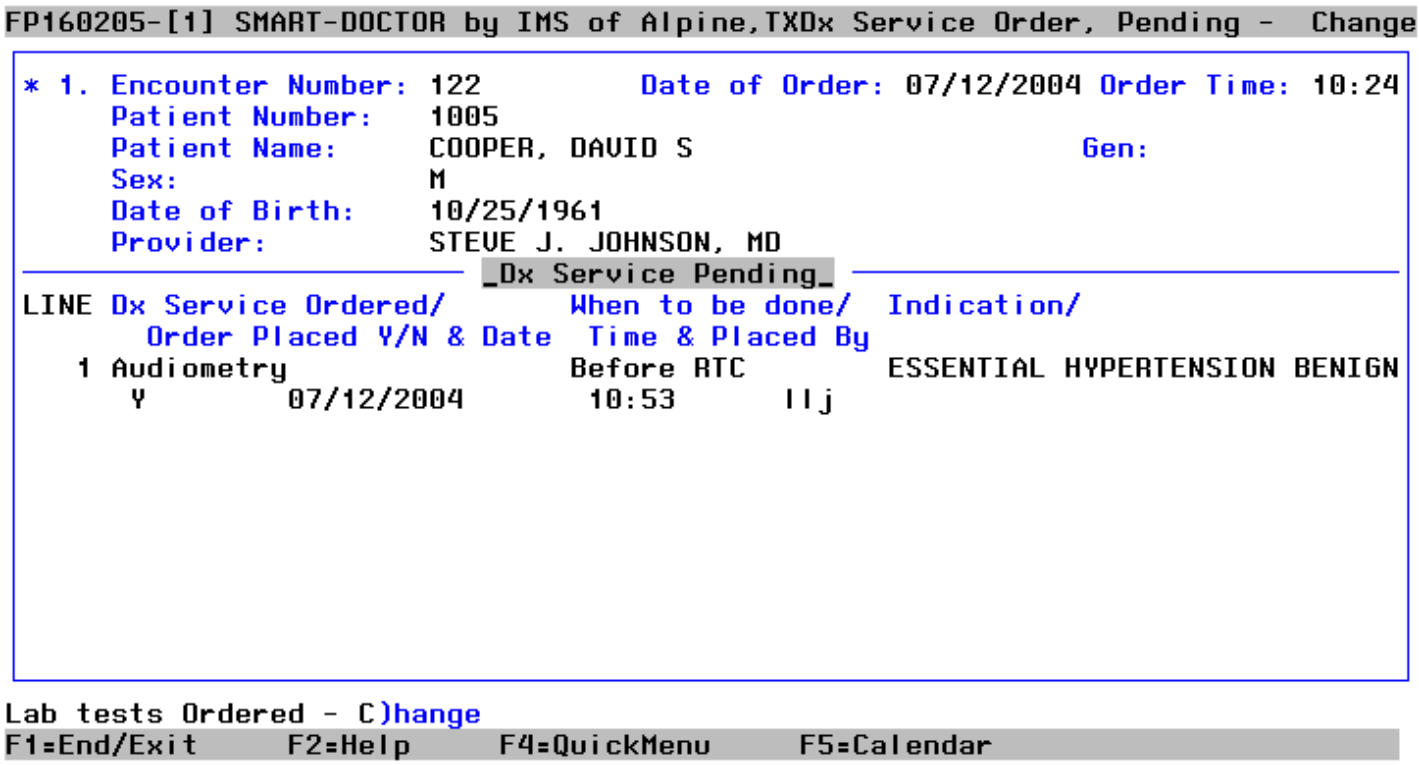


Figure 248 *Viewing a Schedule Diagnostic Service.*

CHAPTER 5 COMMUNICATION LOOPS

The SmartDoctor® system has a special mechanism for office and clinical staff to communicate information regarding specific patients. We refer to this as “Communication Loops”.
Most offices that are not automated, exchange information about a patient by moving charts around. At hospital, this problem is even worse because of the many different departments that need to have access to the records, the added administrative documentation, and the physical size for the facility. At least in a doctors office, the area to search for a chart is only as large as the office itself. In a typical doctor's office, the doctor's desk will have three stacks of charts on it:

1. Charts with questions or information from the patient, nurse, front office personnel, other doctors, or yourself, regarding that patient's care for your review.
2. Charts with refill requests that need your approval.
3. Charts with prescriptions that have been refilled (previously indicated OK to fill), for your review.

In the SmartDoctor® system, we eliminate the need to move charts around, and provide a much more efficient way of handling the tasks indicated above. This is done by way of “communication loops”, using the Non-Visit encounter note, or the Refill note, as the starting point of the communication

The chart representation of these “communication loops” is shown below:

	Starting with:	Who	To whom	Next Action or Process
1.	Non-Visit Encounter note.	Clerical	Note for file	File.
2.	Non-Visit Encounter note.	Clerical	Nurse	Place in nurse queue.
3.	Non-Visit Encounter note.	Clerical	Provider	Place in doctor queue.
4.	Refill Request of Pre-approved medication.	Nurse	Provider	Queued for review, by doctor.
5.	Refill Request of Non-approved medication or Controlled Substance	Nurse	Provider	Queued for Approval, by doctor.
6.	Non-Visit Encounter note.	Nurse	Note for file.	File.
7.	Non-Visit Encounter note.	Nurse	Nurse	Place in nurse queue.
8.	Non-Visit Encounter note.	Nurse	Provider	Place in doctor queue.
9.	Non-Visit Encounter note.	Doctor	Note for file	File.
10.	Non-Visit Encounter note.	Doctor	Nurse	Place in nurse queue.
11.	Non-Visit Encounter note.	Doctor	Doctor	Place in doctor queue.

12.	Doctor queued Non-Visit note	Doctor	Nurse automatic	Place in nurse queue.
13.	Doctor queued prescription approval, or action to take.	Doctor	Nurse automatic	Place in nurse queue.
14.	Doctor queued refill review.	Doctor	File	Review refills, file.
15.	Nurse queued Non-Visit note, or one time refill approval.	Nurse	File	One time medication refill, take action, and file.

Please note, anytime a Non-Visit encounter note is directed to a doctor (# 12 above), whether it be from a clerk, a nurse, another doctor, or the doctor, the note will always be placed in the nurse queue (# 15 above) for review and any final action.

To see the general description of the Non-Visit encounter notes, see the Patient Processing section of this manual, where you will see the clerical use of this encounter type. To see the nursing and doctor use of these “communication loops”, look in those respective sections of this manual.

Warning: Be sure to have included in your office policy manual a written list of who in your office is authorized to refill regular prescriptions and prescriptions for controlled substances. State laws vary regarding on how you must do this. In Texas, the Texas Controlled Substances Act (Texas Health and Safety Code, Title 6, Section 481.073) says you must keep a written designation in your medical office of each person that you’ve approved to phone in controlled substance prescriptions to pharmacies. In the SmartDoctor® system, only users designated as RX or higher, may refill a prescription (a user type is designated in prompt **#**7, “**Degree:**” in the provider record.). All controlled substance refills must also be pre-approved each time by a doctor prior, to the system allowing an RX user to refill a controlled substance.

CHAPTER 6 NURSING

Nursing personnel logging on to the system will be placed in either the “Family & Patient File Maintenance” menu (Front office menu), or in the “Doctor Main Menu”. Typical nursing personnel are given the designation as “RN” for those who are registered nurses and “RX” for those doing nursing work or medical assistant (work such as doing patient intake, vitals signs, and refilling prescriptions with the doctors approval). The decision as to which starting menu screen is used is made by the clinic administrator. Nursing personnel that do procedures (ex. suture removal, EKGs, etc.), specific patient teaching or do doctor directed treatments, may be more appropriately placed in the “Doctor Main Menu” as the starting screen. Since they will be listed as providers, they may have their own appointment schedules for the functions described above (or even to schedule lab draws and immunizations). Nursing personnel that mainly take vital signs, do doctor approved refills, make appointments, and do other front office functions would be better placed in the “Family & Patient File Maintenance” menu.

From the “Family & Patient File Maintenance” menu, select menu item #3, “**Nurse Intake & Med. Refill**”. From the “Doctor Main Menu”, select menu item #12, “**Nurse Intake**”. You will then be taken to the screen shown in Figure 249 below.

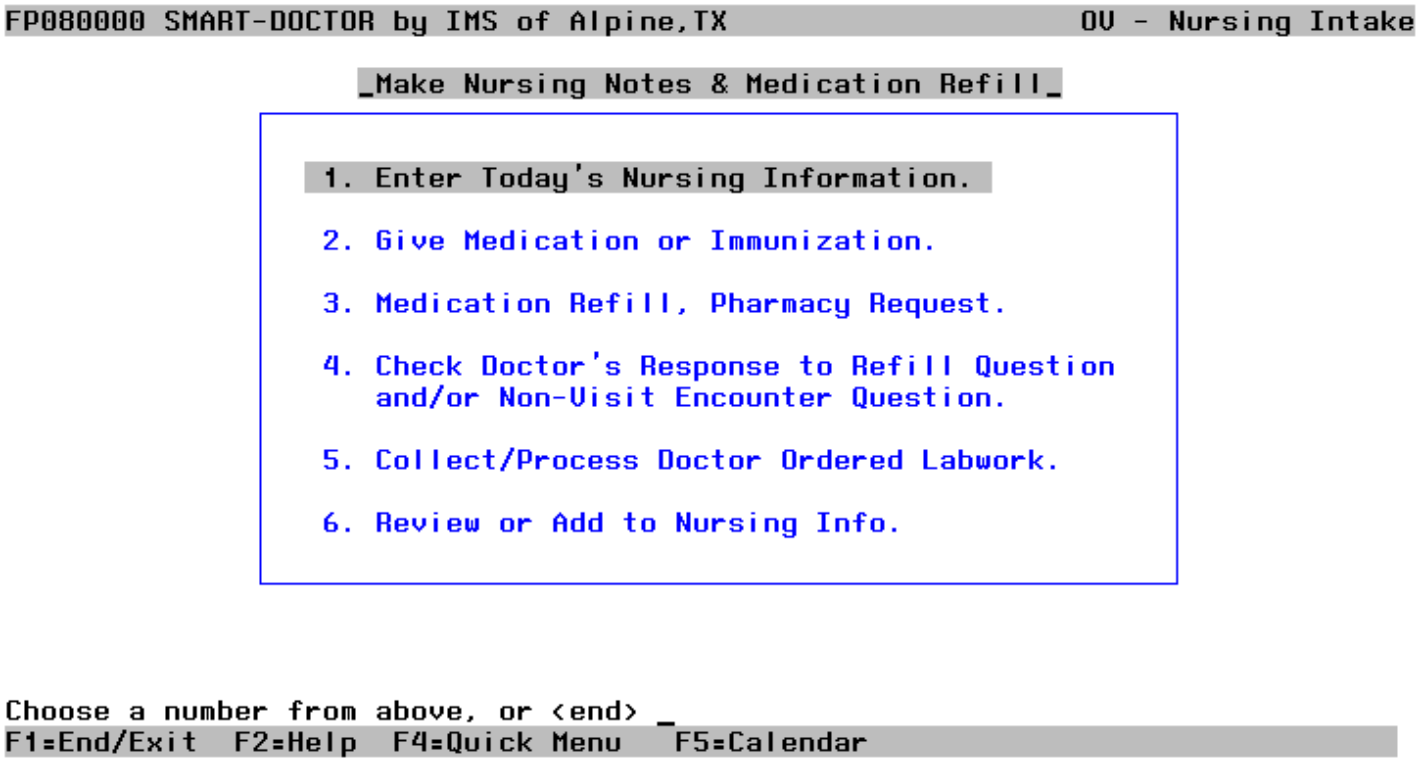


Figure 249 *Nursing Sub Menu screen.*

MENU ITEM #1, “ENTER TODAY'S NURSING INFORMATION.”, should be selected to enter information on a patient about to be seen by the doctor. Generally a nurse works with one or two doctors. Each doctor would be using two or more rooms to see and treat patients. When a nurse knows a doctor is ready to see patients, and a room is open, the nurse would open the doctors schedule for that day to see which patients have signed in and are ready for intake, as seen in Figure 250 below.

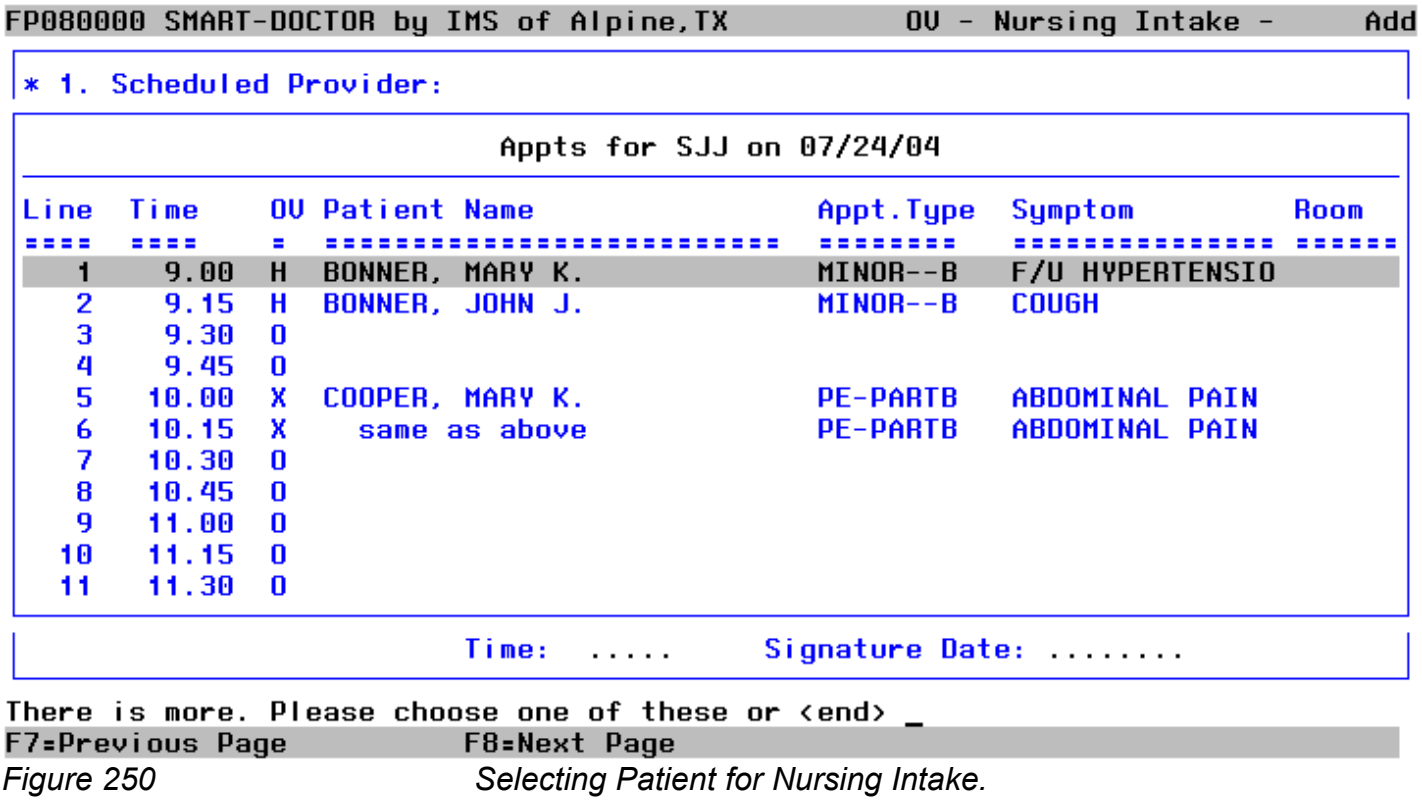


Figure 250 Selecting Patient for Nursing Intake.

On this screen, the nurse can quickly see by looking at the “OV” that the Bonners have arrived in the clinic, 9.30 and 9.45 are open, and that Cooper is scheduled but not here yet. The letters possible in the “OV” column and their meanings are as follows:

O	Open appointment slots.
X	Booked appointment slots.
H	The patient is Here, has signed in and is ready to be seen.
N	The Nurse has done the intake and the patient is ready for the doctor.
P	The Provider is seeing the patient.
C	The provider has Completed seeing the patient, and the patient is ready for checkout and billing.
B	The patient has been checked out and been Billed.

This makes it extremely easy to see the patient's progress through the clinic.

You do not have to select patients in the given order. For example if the Bonners want the husband seen first, just arrow down to that line number (or enter that line number), and hit <enter>. Upon selecting the second patient, the screen in Figure 251 is presented.

You are shown the patients demographics, his photo (public domain photo of senator Rockefeller), and are asked if this is the correct patient at the bottom of the screen. No image will be shown if there is no photo ID in this patient's images file. The program displaying the image can be the viewing program provided with your digital camera, or a a common available one like the MS Paint viewer shown above. You should close this image after you compare it to the patient (in the standard Windows manner-- click on “X” or hit <ALT + F4>.

Next, answer the question. “**Is this the correct Patient?**” If you answer <n>, then you are

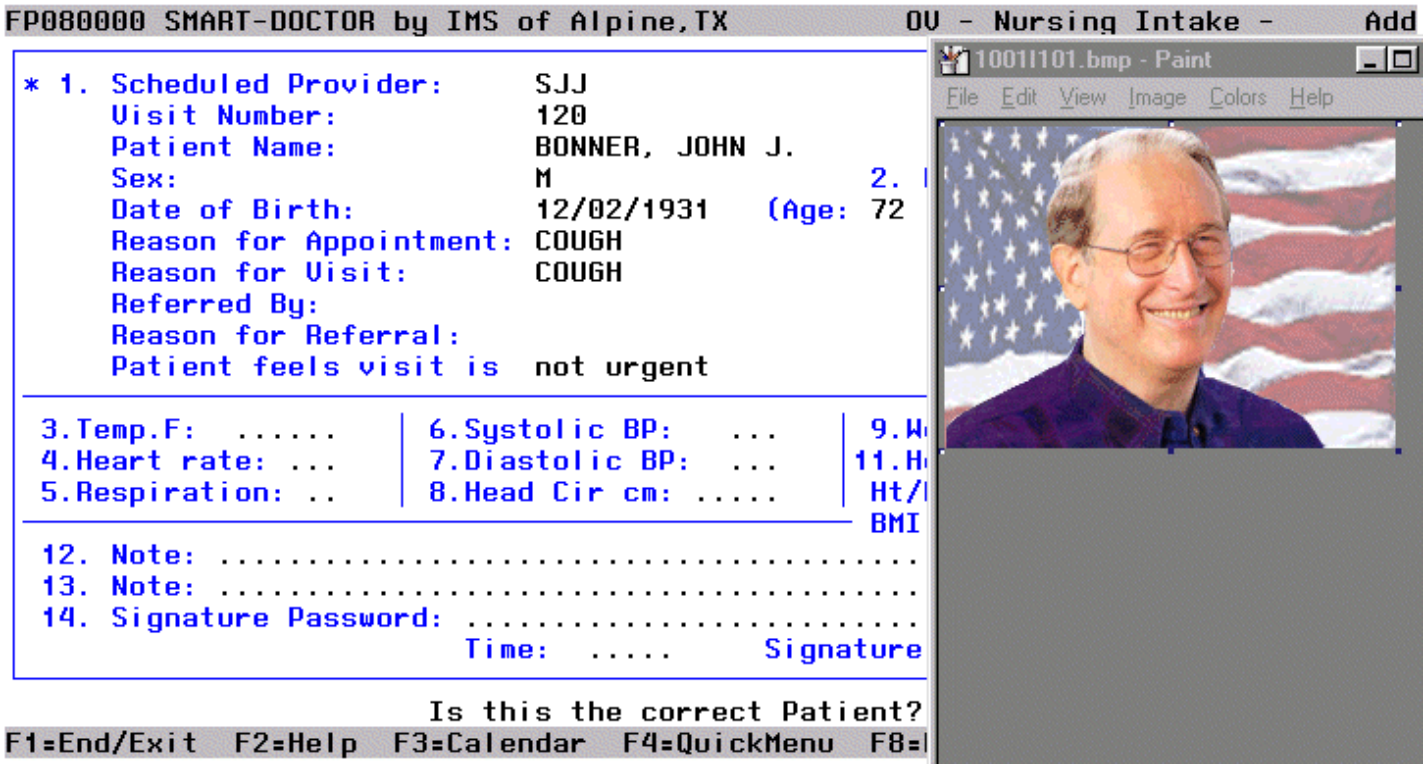


Figure 251 *Nurse Intake, Verify Patient ID.*

exited to the prior menu to select again. If you answer <y>, then you are presented with the next pop-up window as seen in Figure 252.

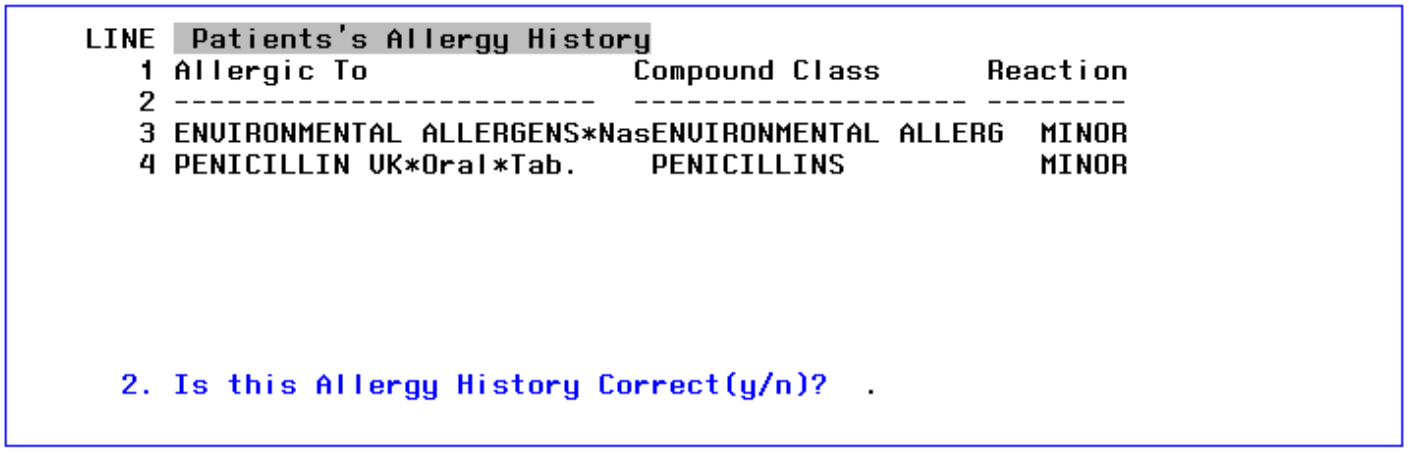


Figure 252 *Nurse Intake, Checking Allergies.*

You are shown a list of allergies in a multi-value prompt that can only be listed or scrolled. Scroll up and down until all are seen. In this case, there are only two allergies listed. Just hit <enter> here to go on to the next prompt.

Prompt #2, "**Is this Allergy History Correct(y/n)?**", answer <y> if this is correct. If you answer <n>, you will be taken to the general "Past Medical History" screen (Figure 196), discussed in the Manage Patient Care chapter of this manual. In in the "Past Medical History" screen, select prompt #4, "**Add Allergies (Y/N):**". Enter <y>, and proceed to enter the additional allergies (Figure 204).

Upon returning to the prior screen, answer <y> to prompt #2.

BACK TO THE INTAKE SCREEN.
You will next be presented with the screen shown in Figure 253. In this example screen, we already entered all the information in all the prompts up to the final sign out prompt.

```
FP080000 SMART-DOCTOR by IMS of Alpine,TX          OV - Nursing Intake -     Add

* 1. Scheduled Provider:      SJJ
     Visit Number:            119
     Patient Name:            BONNER, JOHN J.
     Sex:                     M                    2. LMP:
     Date of Birth:           12/02/1931   (Age: 72  yrs.  7.8 mos.)
     Reason for Appointment: COUGH
     Reason for Visit:        COUGH
     Referred By:
     Reason for Referral:
     Patient feels visit is  not urgent

 3.Temp.F:    101.1*  | 6.Systolic BP:   190** | 9.Weight lbs: 235* 10.oz:
 4.Heart rate: 110*   | 7.Diastolic BP:   86    |11.Height:     70.0   in.
 5.Respiration: 20*   | 8.Head Cir cm:         | Ht/Wt Ratio:   48** % off Norm
                                                | BMI:          33.7**

 12. Note: Coughing up a lot of yellow sputum, > tbs. day.
 13. Note: Took Tylenol 3 hours ago.
 14. Signature Password: _.....................................
                         Time:  .....     Signature Date: ........

F1=End F2=Help F3=Cal F4=QMenu F5=Sub. F8=NoSave F9=PMHxRv F10=PtSch F11=ChtRv
```

Figure 253 *Nurse Intake screen.*

Prompt #2, "**LMP:**", if the patient is a female and over the age of 9 years old, then you will be taken through this prompt. You can skip the prompt or enter the date of the LMP, but you cannot put a date in the future.

A WORD ABOUT ABNORMAL FLAGS.
Abnormal flags consist of one or two flashing, red asterisks, following the abnormal value. Rather than talking about standard deviations, or other abnormal parameters, IMS has established the following criteria: If the abnormal flag has one asterisk "*", then this is not normal and you should be aware of this and take appropriate action. If there is a double, flashing, red asterisk "**", then this is significantly abnormal. In this case, we suggest you or the doctor make note of this in the documentation, and indicate what action was taken in the plan, if it is not self evident in the note. All vital sign parameter flags are set by age and sex. For example, a heart rate of 140 would be normal in a three day old baby, and therefore no flags. It would cause two asterisks to be displayed in this patient.

Prompts #3 through #13. Enter the information indicated below, hit <enter> to skip a prompt, or hit <F1> ("end" input) to skip the rest of the prompts

Prompt #3, "**Temp.F:**", enter the patient temperature in degrees Fahrenheit. This field is expecting a decimal point, with a maximum of four characters. If you enter 101 without a decimal point or a zero as a fourth character, then you will get the following error message:

"The acceptable range is 800 to 1139. Press <return> to continue."
This looks funny, but actually means 80.0 to 113.9, since a single decimal point is assumed. So to enter 101 degrees, enter <101.>, or <101.0>, or <1010>. A temperature of 98.0 degrees should be entered as <98.>, or <98.6>, or <986>.

Prompt #4, "**Heart rate:**", enter the heart rate in beats per minute.

Prompt #5, "**Respiration:**", enter in breaths per minute.

Prompt #6, "**Systolic BP:**", enter in mm Hg.

Prompt #7, "**Diastolic BP:**", enter in mm Hg. If these two values of blood pressure are reversed, the system will prompt you to make a correction.

Prompt #8, "**Head Cir cm:**", this generally used in pediatrics only, and used for proper growth checks.

Prompt #9, "**Weight lbs:**", enter weight in lbs.

Prompt #10, "**oz:**", enter the weight in ounces over the full pound in prompt #9. For example, if the weight was 235 and one-half pounds, you would place 235 in prompt #9 and 8 in prompt #10 (for 8 ounces).

Prompt #11, "**Height:**", enter the height in inches. The system is expecting a single decimal point as in prompt #3 above. So 70 inches could be entered as <70.>, or <70.0>, or <700>.

The "**Ht/Wt Ratio:**" and the "**BMI:**", will be displayed once the height and weight data is entered.

Prompts #12 and #13, are to enter free text data. This information is generally the patient complaint or reason for visit. Sometimes this is called the nurse intake note.

Prior to signing out, the nurse has the ability to branch to the "Sub." <F5> (take subjective history), "PMHxRv" <F9> (Past Medical History), "PtSch" <F10> (Patient waiting time in clinic), and "ChtRv" <F11> (the ability to do a complete chart review if needed).

Prompt # 14, "**Signature Password:**", all provider notes require a signature password prior to exit. This password should be different form your sign-in password. The signature password acts as your signature and should be treated as such. Once you enter a valid signature password, the bottom of the screens appearance will change to the format shown in Figure 254.

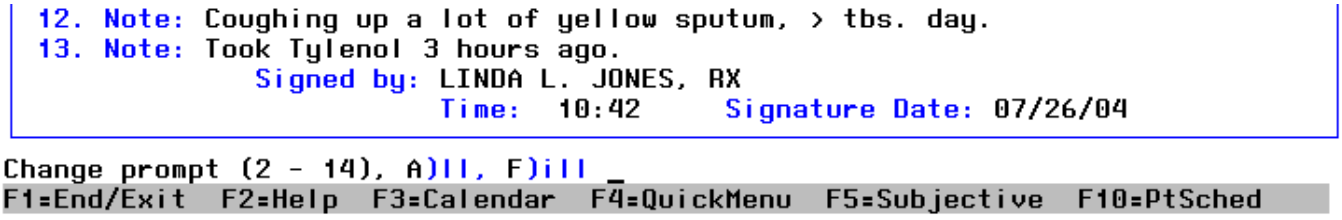


Figure 254 *Nurse Intake, Signature Block Completed.*

The signature will be indicated by replacing your sign-out password with your title block, and the time and date of signature will be noted.

MENU ITEM #2, "GIVE MEDICATION OR IMMUNIZATION.", choose this selection to administer medications or immunizations ordered by the doctor. Generally in the clinic situation described above, the nurse is working closely with the doctor. The doctor will generally just let the nurse know as the doctor leaves the room that the patient needs an injection. The nurse would then select this menu item to see what injections were ordered. The nurse would be presented with the screen shown in Figure 255.

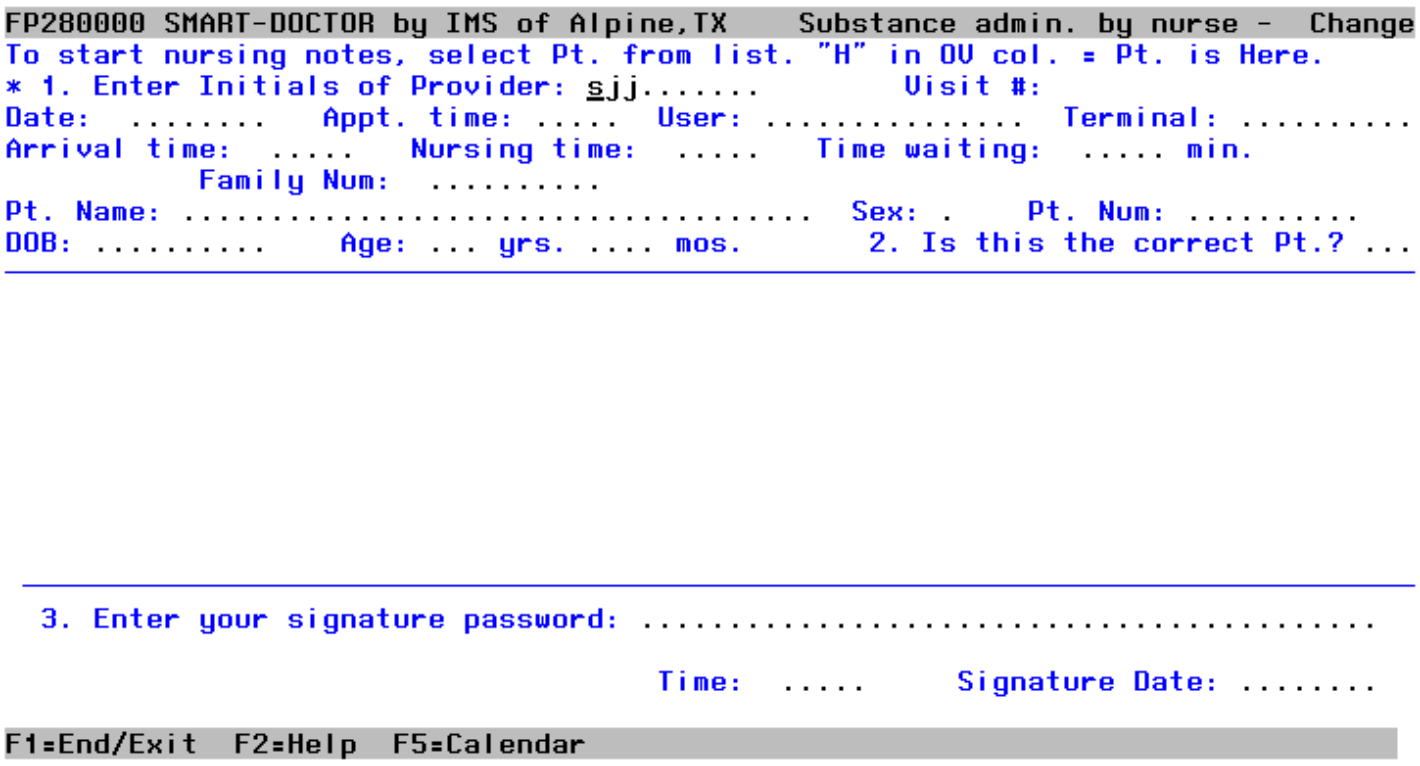


Figure 255 Substance Administration, Selecting Patient.

Upon indicating the doctor the nurse is working with, the nurse will get a listing of that doctor's clinic schedule, as seen in Figure 256. You will see the patient the physician currently is seeing indicated in the "OV" column as "P" for provider. If the provider has finished seeing the patient, then this will be a "C" for completed visit. If the bill has been generated, this will be changed to a "B" for billed.

Upon selecting the appropriate patient, you will see the screen filled out as shown in Figure 257. At the change prompt, enter <a> for all, which will then take you through prompts #2 and #3.

Prompt #2, "**Is this the correct Pt.?**", enter <y> if this is the correct patient. If this is not the correct patient, answer yes anyway. This will get you to the next screen where you can exit using the <F8> key, "Exit/NoSave", to exit without saving. However, you will then need to sign-out as usual.

After answering <y> above, you will be taken to the "Therapeutic Injection or Immun." screen as seen in Figure 258. Here, you will see listed the medications and/or immunizations the doctor has requested you to perform.

Enter the line number of the medication or immunization you are about to give. You will then see the "Medication Book" screen as seen in Figure 259.

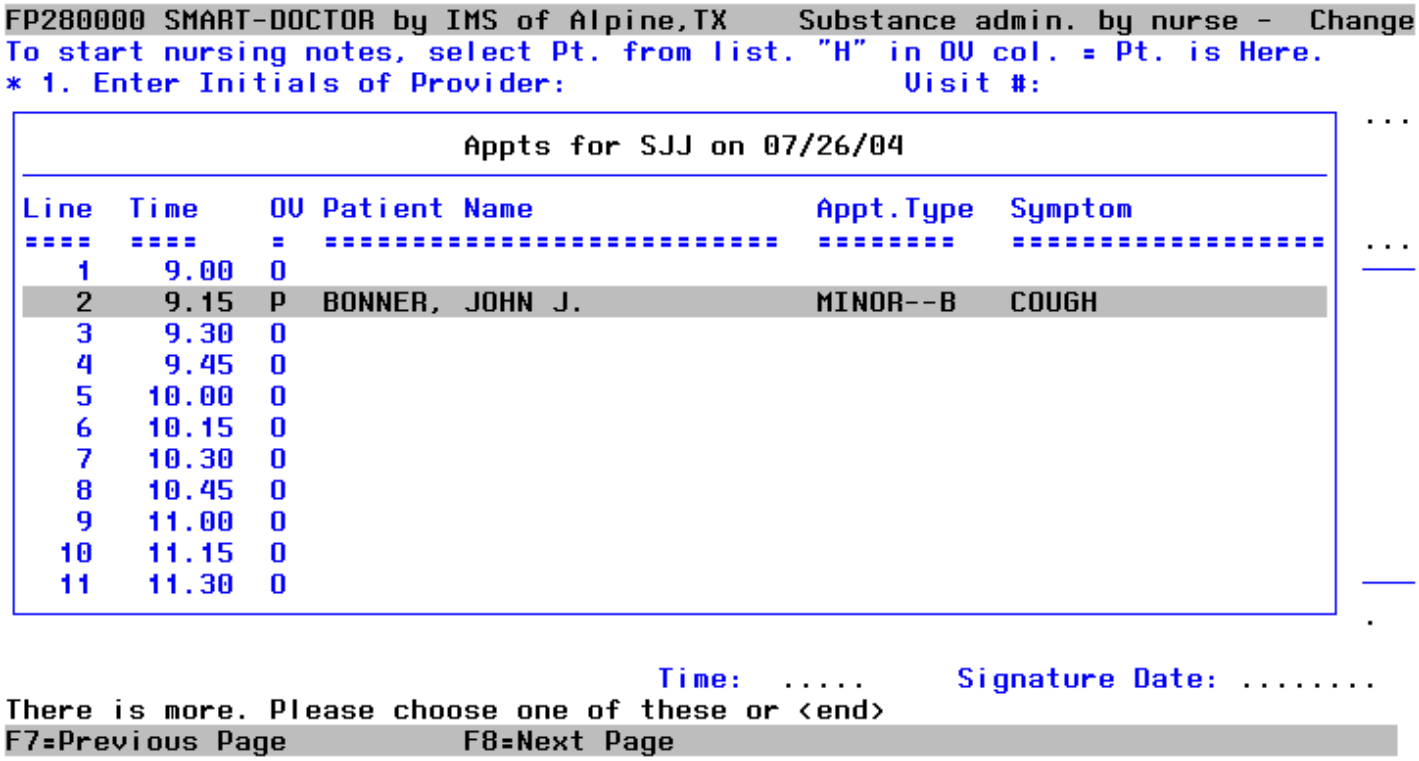


Figure 256 *Select Patient for Substance Administration.*

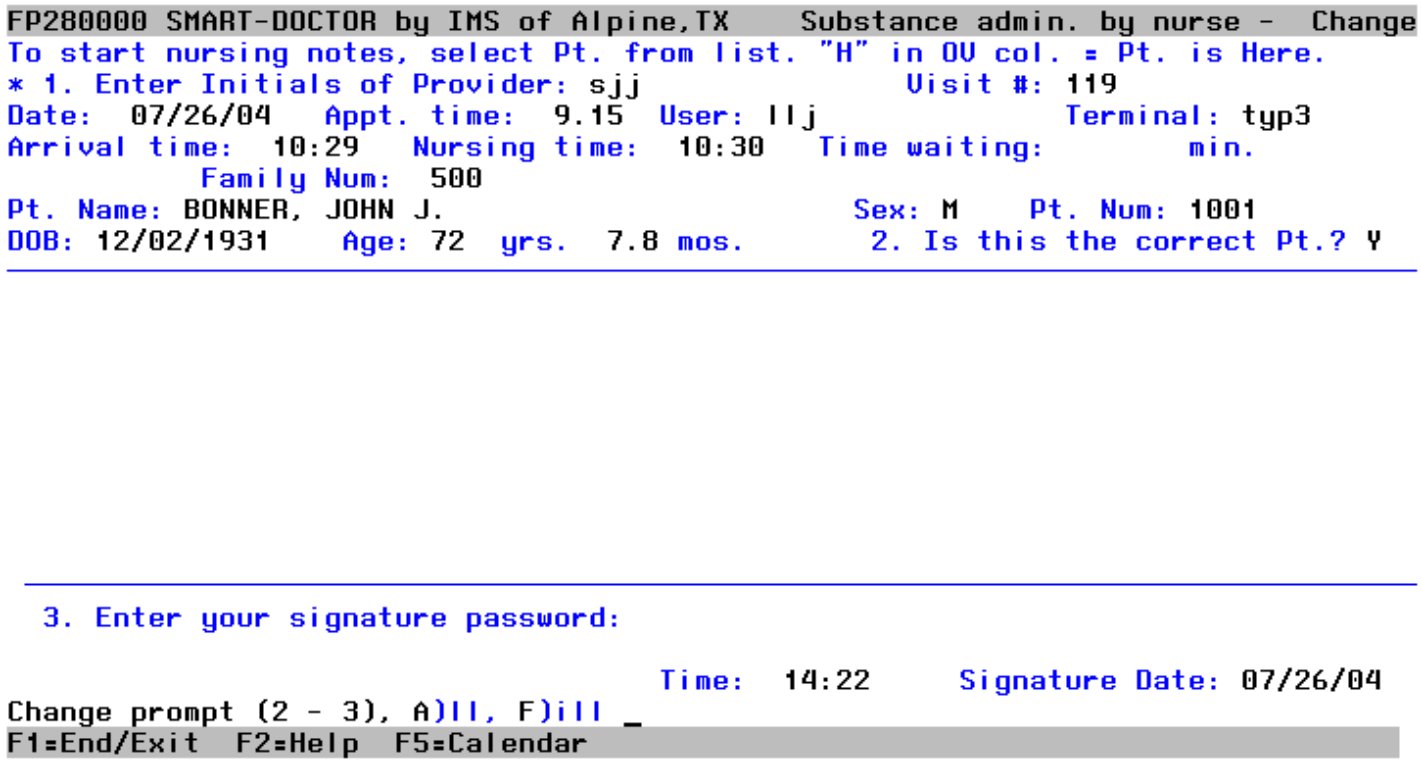


Figure 257 *Substance Administration screen.*

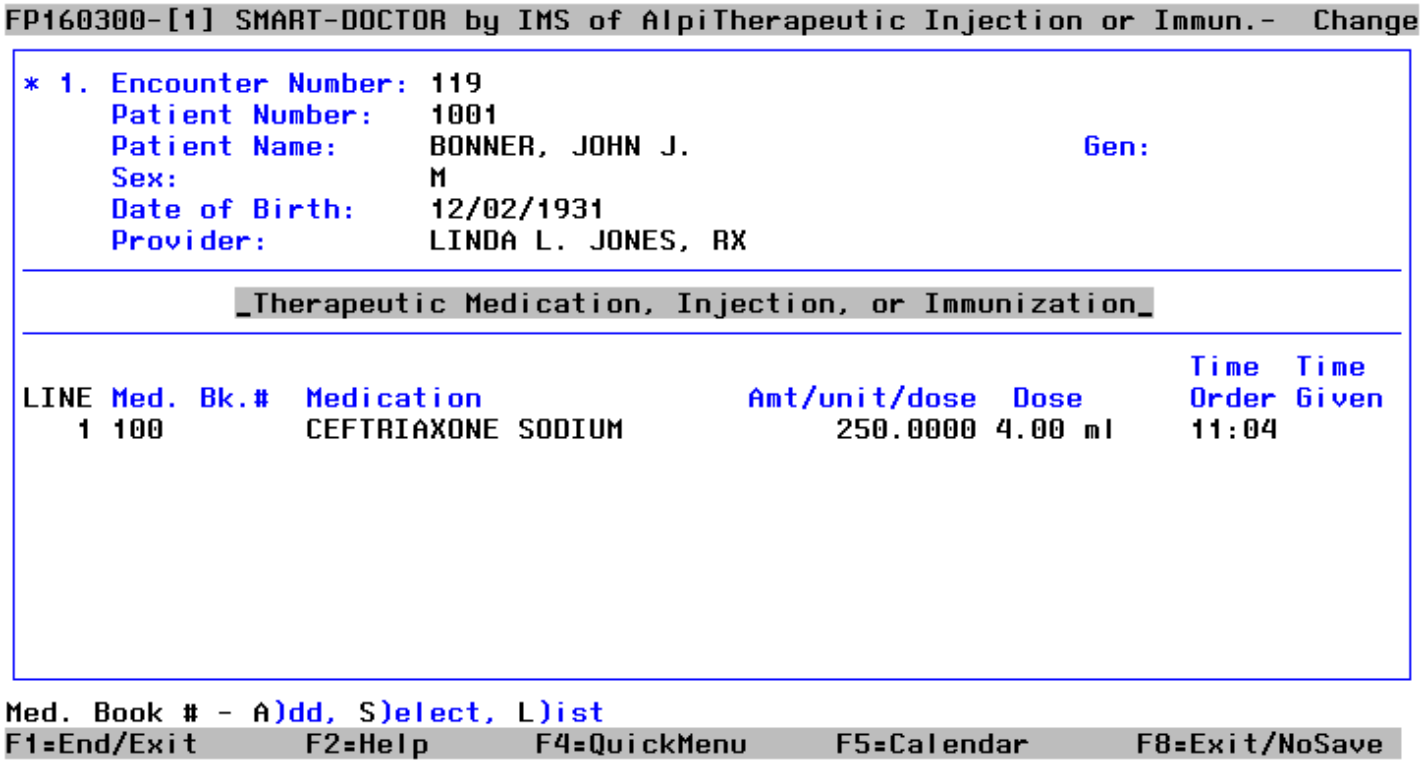


Figure 258 *Theraputic Medication, Injection, Immunization screen.*

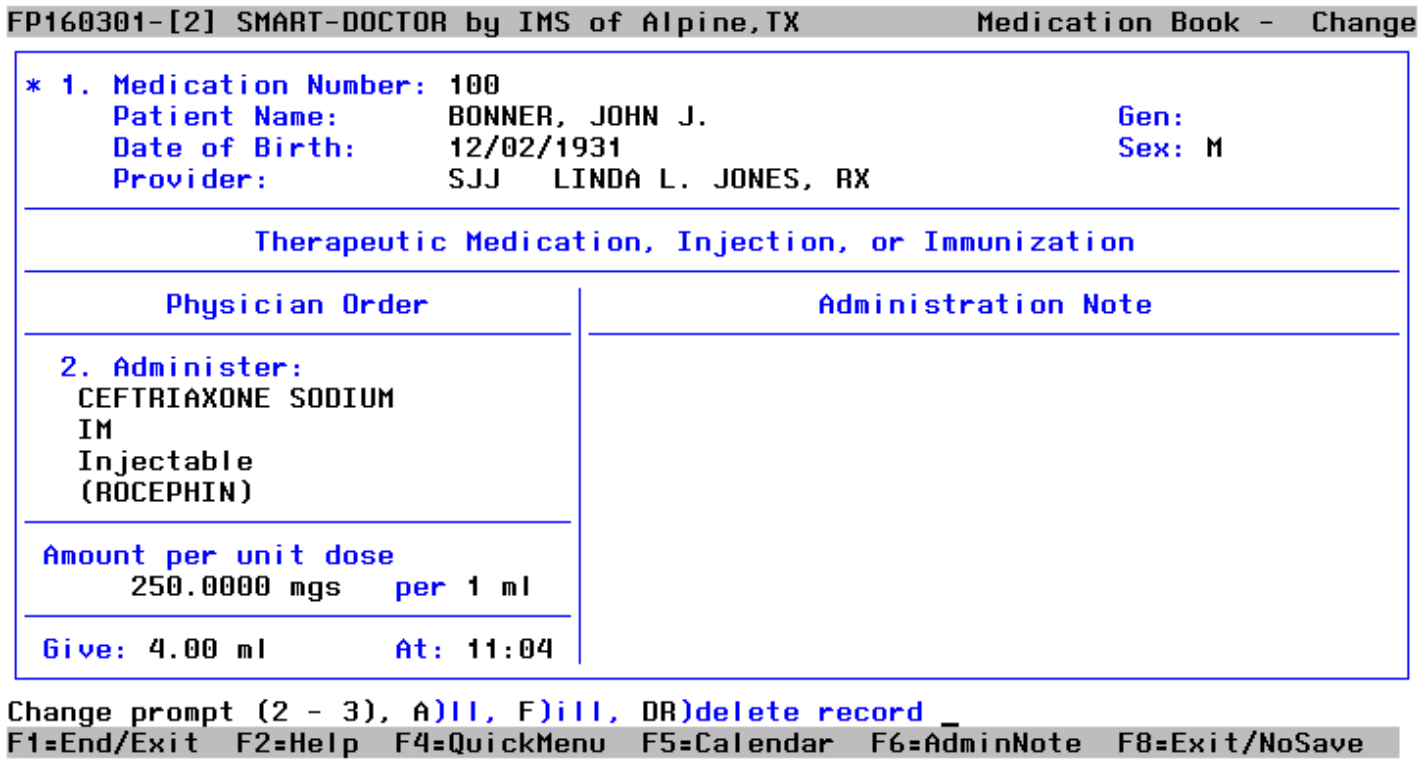


Figure 259 *Medication Administration Book.*

On this screen, hit the <F6> key, “AdminNote”, to document administration of the medication or immunization. An administration window will pop-up on the right hand side of the screen as seen in Figure 260. At the change prompt, enter <a>, to be taken through each prompt. Then, select the

multi-valued Administration note to document any additional information you wish.

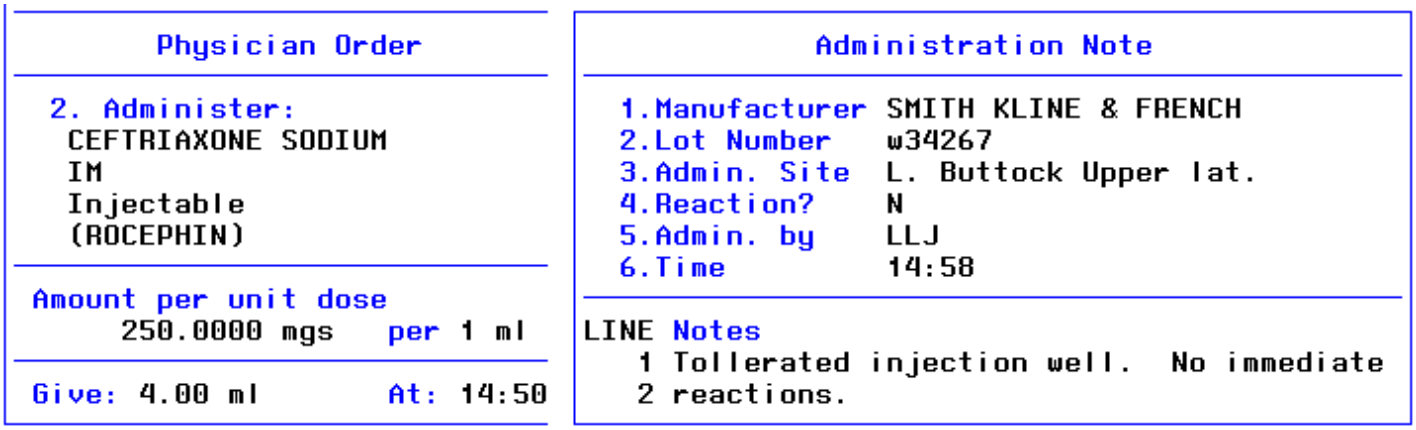


Figure 260 Substance Administration Note.

Administration Pop-Up window.
Prompt #1, "**Manufacturer**", enter part of the manufacturer's name. The system will locate the name from all manufacturers listed in the system with the standard cross-reference look-up. In this case, we entered "skf". The system found "SMITH KLINE & FRENCH", and entered it for us.

Prompt #2, "**Lot Number**", enter the lot number located on the medication packaging.

Prompt # 3, "**Admin. Site**", you will get a pop-up selection list as seen Figure 261.

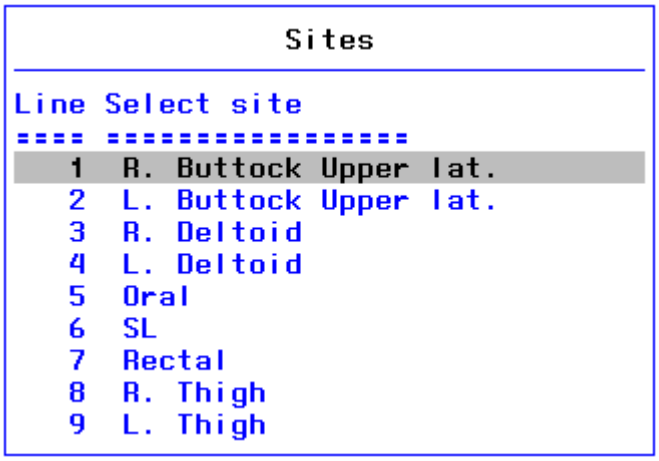


Figure 261 Administration Site Selection List.

You can page up and down through this list. Select the appropriate route of administration. The terms presented in the pop-up window come from the TERMS file record of "SUB-SITE". You can have your system administrator make changes to the selectable descriptions to make it more appropriate for your practice.

Prompt # 4, "**Reaction?**", if there was a significant reaction such as rapid local swelling, hives, itching, or worse, indicate <y> for yes. Then, make the appropriate entries in the patient's allergy file in the past medical history. If there was no reaction, enter <n> for no.

Prompt #5, "**Admin. By**", enter your user ID.

Prompt #6, "**Time**", the time will be automatically placed for you by the system.

"Notes", multi-valued prompt, enter any notes you wish to make regarding this medication administration. You can type as many free text lines as you wish.

The note will appear in the record as shown in the example seen in Figure 262, which is taken from a portion of the chart review function of the system.

```
69 Medication Ordered                      Medication Given
70 ------------------------------------ ----------------------------------
71 Substance: CEFTRIAXONE SODIUM           Manuf: SMITH KLINE & FRENCH
72 Route: IM                               Lot #: w34267
73 Form: Injectable                        Site:  R. Buttock Upper lat.
74 Dose:      250.0000 mgs per 1 ml        Reaction?  N
75 Give: 4.00 ml                           Admin. by: LLJ
76 Time Ordered: 14:50                     Time:      14:58
77                         Administration Notes:
78                              Tollerated injection well.  No immediate
79                              reactions.
```

Figure 262 Medication Chart Note Review.

If the medication is to be given to a pediatric patient (defined in this system as anyone under 17 years old) and a weight has not been entered, then you will be presented with a new screen to enter the child's weight.

MENU ITEM #3, "MEDICATION REFILL, PHARMACY REQUEST.", choose this selection to refill

```
FP200010 SMART-DOCTOR by IMS of Alpine,TX     Pharmacy Refill Request. -     Add
 * 1. Contact Number:          _.........
   2. Patient Number:          .........
      Patient Name:            ..................................... Gen: ...
      Sex:                     .
      Date of Birth:           .........
      Age:                     ... yrs. .... mos.
   3. Type of Contact:              ....................
   4. Person Making Contact:        ....................
   5. Reason for Contact:           ....................
   6. Refill and/or Dr Referral:
   7. Phone Book L/U for Pharm:     .........
      Pharmacy Name:
      Call-back No.:                ............
                          M e s s a g e   A r e a
               Hit <F9> key to see messages, notes, or Rx(s) given.
F1=End/Exit  F2=Help  F4=QuickMenu  F5=Calendar  F8=Exit/NoSave  F9=New Note
```

Figure 263 Pharmacy Refill Request.

medications. This selection is specific for pharmacy requests for refills. Generally, a pharmacy will call the doctor's office for a prescription refill. This call will be passed to the nursing staff approved to do refills. The nurse will then go to the nursing screen and select this menu item. Upon choosing this menu item, the screen in Figure 263 will be seen

To start this refill request, hit the <F9> key for "**New Note**". The next contact number (visit number) will be placed for you in prompt #1. Hit the <enter> key to accept this value

Prompt #2, "**Patient Number:**", enter either the Patient Number, or, for a cross-reference search, at least 3 characters of the patient's name.

Once selected, you will be asked to verify this is the correct patient, and correct family address. Once you have verified that this information is correct, you will automatically be placed at prompt #6. Prompts #3, #4, and #5, will be defaulted with the values seen in Figure 264.

Prompt #6, "**Refill and/or Dr Referral:**", will be defaulted with "Note for File". Generally you would just hit the <enter> key to accept this. However, if you want this to be placed in the doctor queue for review, then indicate the doctor. You may hit the <F10> key "Plst" to get a list of providers, and then select the appropriate doctor.

Prompt #7, "**Phone Book L/U for Pharm:**", hit <enter> to take the cross-reference lookup value of "Pharm". This will give you a listing of all pharmacies in your phone book file. Once the pharmacy is selected, the pharmacy name and phone number will be displayed in the next two automatic fill prompts, as seen in Figure 264 below.

```
FP200010 SMART-DOCTOR by IMS of Alpine,TX     Pharmacy Refill Request. -     Add

* 1. Contact Number:          120
  2. Patient Number:          1006
     Patient Name:            BONNER, MARY K.                        Gen:
     Sex:                     F
     Date of Birth:           08/24/1962
     Age:                     41  yrs. 11.2 mos.

  3. Type of Contact:              Phone or Walk-In
  4. Person Making Contact:        Pharmacist or Patient
  5. Reason for Contact:           Prescription Refill
  6. Refill and/or Dr Referral:    Note for File
  7. Phone Book L/U for Pharm:     103
     Pharmacy Name:                Prescription Shop of Alpine
     Call-back No.:                362-7223

                          M e s s a g e   A r e a
                Hit <F9> key to see messages, notes, or Rx(s) given.

Change prompt (2 - 7), A)ll, F)ill
F1=End F2=Help F4=QMen F5=Cal F6=NewRx or Refill F8=Xit/NoSve F9=Msg F11=ChtRv
```

Figure 264 *Prescription Refill screen.*

At this point, you would normally hit the <F6> key, "NewRx or Refill", to refill the prescription. Only a doctor type provider may enter a new prescription, You can only due refills as a nurse. Further, the

only refills you can do are those that are flagged as “Y” in the “**Nurs Rfls**” column. If a nurse attempts to refill a medication indicated as “N” in the “**Nurs Rfls**” column, you will be presented with the pop-up window seen in Figure 265.

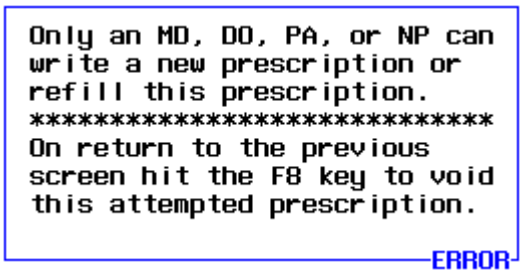


Figure 265 Refill Error Message.

After you hit the <enter> key to continue, you will be presented with the pop-up window seen in Figure 266.

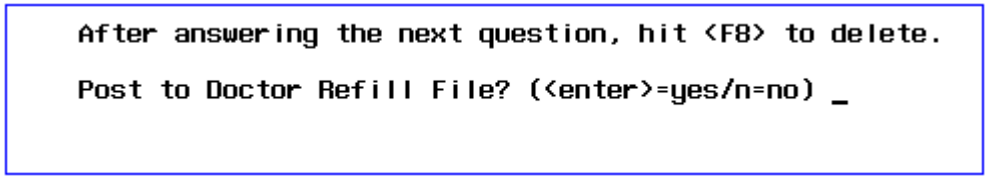


Figure 266 Post to Controlled Substance Refill Request.

Hit the <enter> key to post this to the doctor prescription approval screens. That the doctor will access this through the “Approve Refills Not Allowed by Nursing” selection from the doctor's main menu. This is part of the “Communication Loops” system discussed in that section. If you do not want to post this for the doctor, simply enter <n>.

NEWRX OR REFILL <F6> SCREEN

Upon hitting the <F6> key, the screen shown in Figure 267 will be presented. This is the standard prescription writing screen, however, nursing staff will only be permitted to refill prescriptions pre-approved by the doctor.

Prompt #2, “**Drug Name:**”, is defaulted with “Only Refills allowed”. Just hit the <enter> key to continue to do a refill. This is the equivalent of hitting the <F9> key for “Refill Rx”. You will be automatically placed in the insurance selection screen to identify the patient's insurance carrier. Select the carrier as shown in the billing section of this manual. This is done because many insurance companies have formulary restrictions. Having the insurance carrier formulary (provided directly from the carrier, or from information provided to you from the carrier) will allow the system to check for formulary restrictions.

Upon hitting <enter> on the highlighted multi-value line #1, the window in Figure 268 will pop-up. Hit the <enter> key to answer “y”, and proceed with the selected substance.

If the patient is female, in a reproductive age range, and the drug is a class “C”, “D”, or “X” drug, then the window in Figure 269 will pop-up. If the patient is not present or not the one that called in, you could have the pharmacist ask the question, or you could call the patient. You may also just want to refer this to the doctor instead. If you answer “n” by hitting <enter>, then you will proceed to the next check screen.

```
FP160000-[1] SMART-DOCTOR by IMS of Alpine,TX      Prescription Writer -      Add

* 1. Prescription Number: 114
     Patient Name:        BONNER, MARY K.                          Gen:
     Date of Birth:       08/24/1962                               Sex: F
     Provider:            LINDA L. JONES, RX

  2. Drug Name:                              Route: .......... Form: ..........

          Choose CHRONIC or PAST YR Rx to refill or press F1 to exit

                                                          Nurs Rfls     # of  Last
Line Substance     Dose   per      Amount     Freqency    Dis. | 1st Rx Rfls  Rx
   1 TENORMIN      25     tab      1 Tab      q day       90   Y 080104 0     080104
   2 TYLENOL/CODEI 30     tab      1 Tab      q 4 hrs     42   N 080104 0     080104

| 12. Generic or Brand Drug (g/b): ....                                       |
That is all. Please choose one of these or <end> _
F7=Previous Page          F8=Next Page
```

Figure 267 *Refill screen for Nursing.*

```
Brand Name: TENORMIN

Proceed with this substance? (n=No/<enter>=Yes)
```

Figure 268 *Verify Correct Brand Name.*

```
                Possible Pregnancy Risk

Is patient pregnant or considering? (y=Yes/<enter>=No)
```

Figure 269 *Pregnancy Precaution for this Substance.*

If the patient is female, in a reproductive age range, and the drug is "Allowed with caution" or "Not Allowed" with breast feeding, then the window seen in Figure 270 will pop-up:

```
                Possible Breast Feeding Risk

     Is this patient breast feeding? (y=Yes/<enter>=No)
```

Figure 270 *Breast Feeding Precaution for this Substance.*

If the patient is not present or not the one that called in, you could have the pharmacist ask the question, or you could call the patient. You may also just want to refer this to the doctor instead. If you answer “n” by hitting <enter>, then you will be returned to the prescription screen with the selected substance for refill. You will be stopped at prompt number six.

Prompt #6, “**Dispense:**”, hit enter to accept the defaulted amount that was on the last prescription. Or you may enter a different amount.

Prompt #7, “**Refills:”**, hit enter to accept the defaulted number of refills that was on the last prescription. Or you may enter a different number of refills.

Prompt #8, “**Until:**”, hit enter to accept the defaulted value dependent on the provider's preferences, or enter a different date.

The screen seen in Figure 271 will then be displayed.

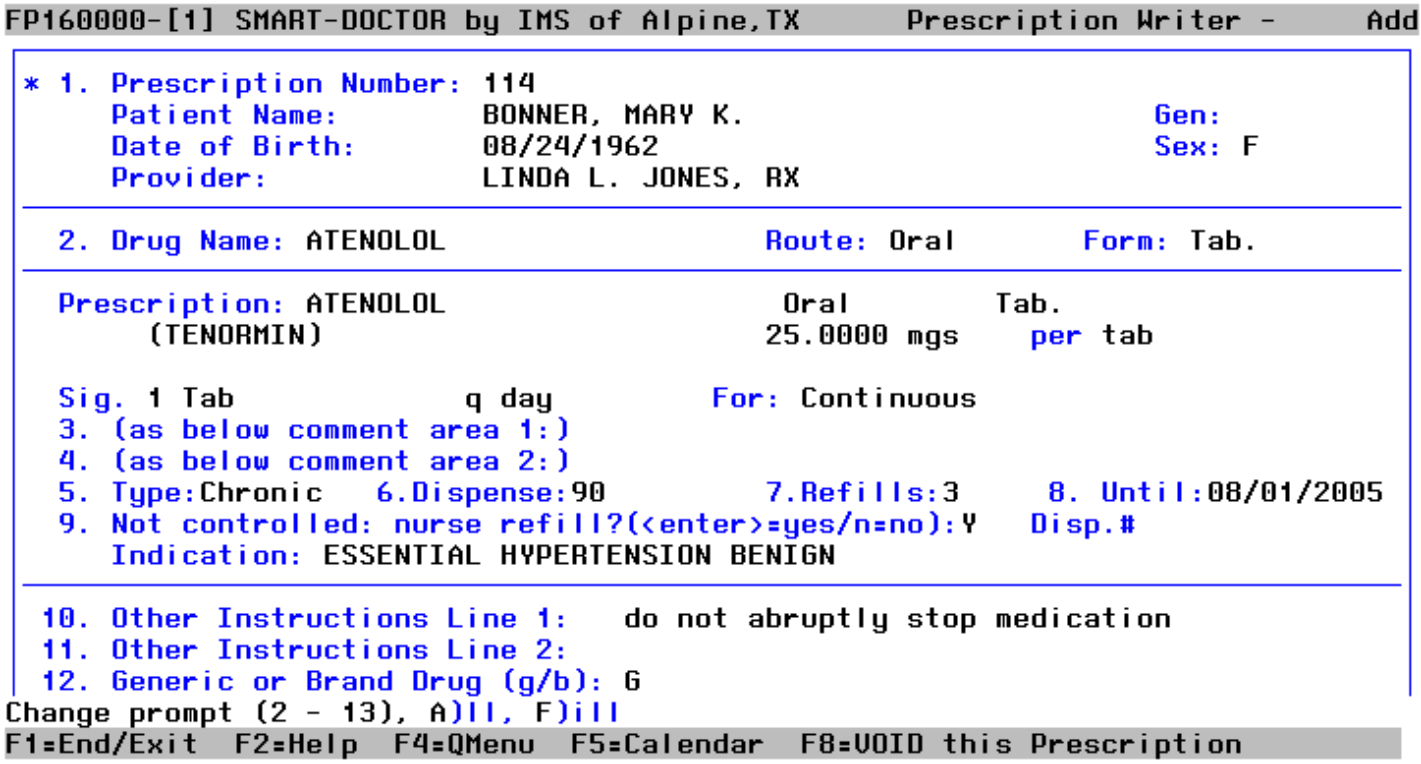


Figure 271 Completed Nursing Refill screen.

The remaining information was defaulted from the original prescription.

On return to the primary “Pharmacy Refill Request.” screen and hitting the <F9> key, “Msg”, to see the message screen, the first eight lines of the “Message” multi-value were placed by the system. Lines 9 and 10 were added to give you an example of adding a note to the message screen. This screen is seen Figure 272 below.

Upon exiting, once the note is complete and you agree to accept all liability of using the system, enter your signature password which indicates your electronic signature. Once you enter your signature password, the screen will show your name, the date, and time of refill, as seen in Figure 273 below.

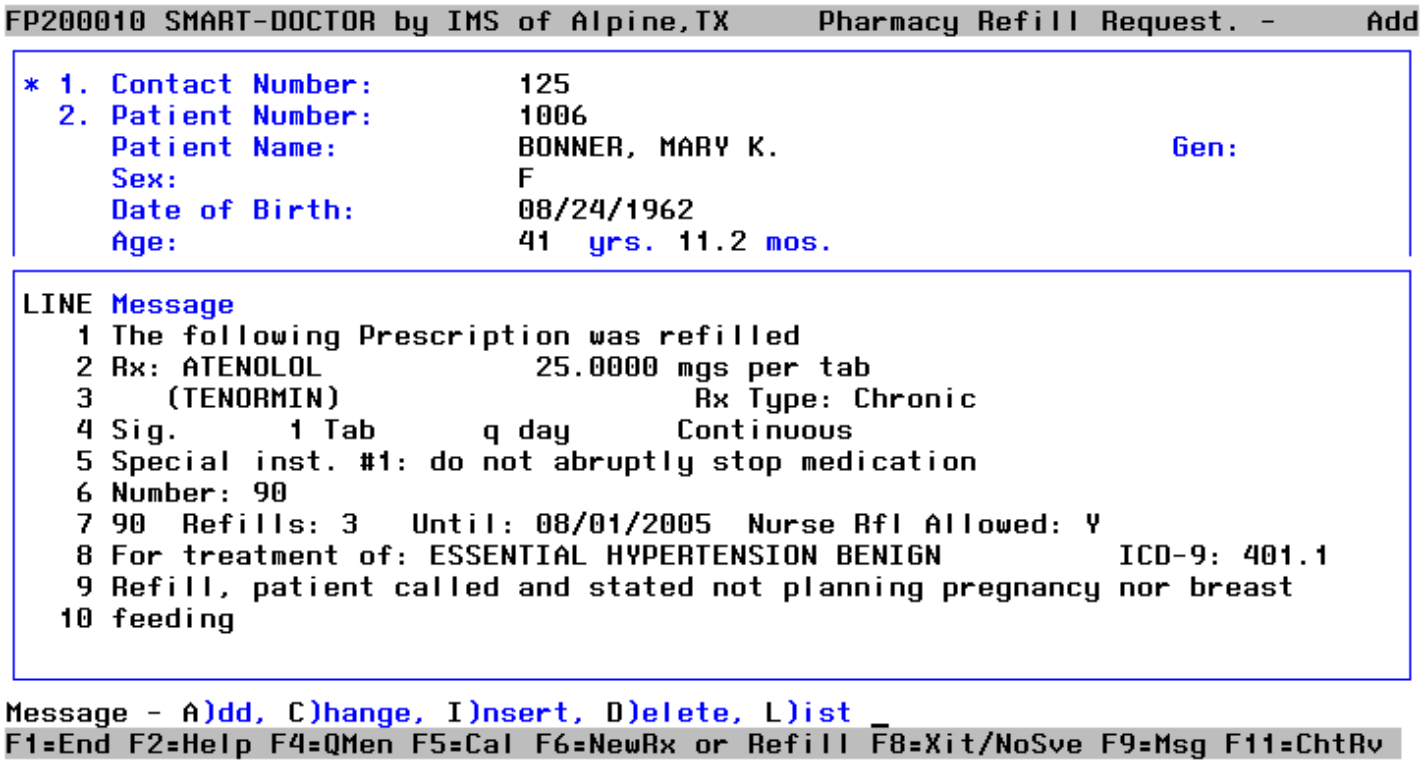


Figure 272 *Pharmacy Refill Request Message screen.*

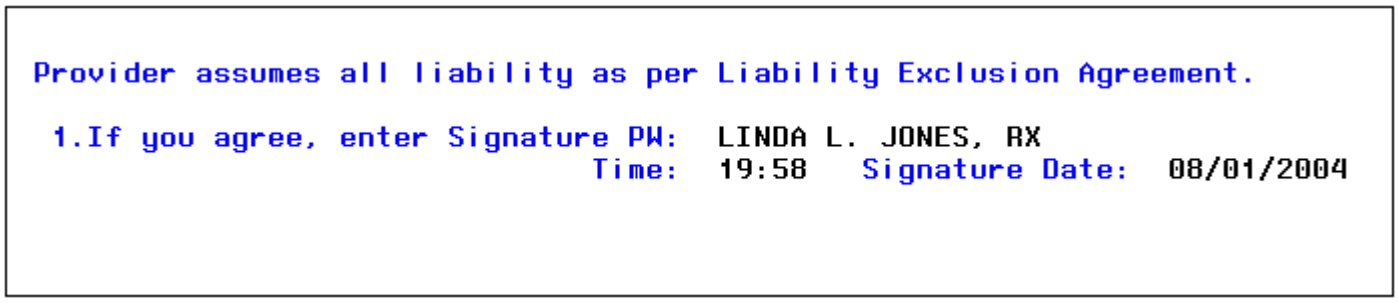


Figure 273 *Completed Nurse Signature screen.*

MENU ITEM #4, "CHECK DOCTOR'S RESPONSE TO REFILL QUESTION AND/OR NON-VISIT ENCOUNTER QUESTION.", choose this selection to see the doctor's response to a nursing question regarding a refill sent to the doctor, to see a one time OK for restricted refill, for a Non-Visit Encounter referred to a nurse or yourself, or to see a Non-visit Encounter that was referred to a doctor for action that may now require some action on your part. This is part of the "Communication Loops" of the SmartDoctor® system described fully in the "Communication Loops" section of this manual.

Upon choosing this selection, the "Review of Doctor's response" screen will come up as seen in Figure 274. Indicate which provider's Non-Visit Encounter notes need to be processed, including any specifically to you. In a large clinic, you should indicated the providers for which you are responsible or your own initials. For a small clinic, or a single doctor office, you can accept the default of "ALL".

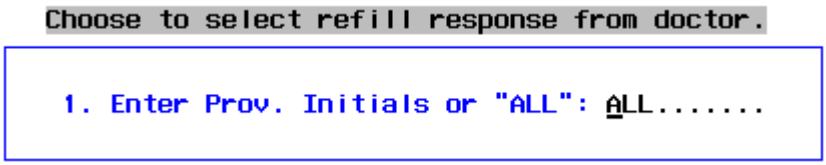


Figure 274 Select Provider Responses to Review.

Example #1, response from doctor regarding a controlled substance refill that you had forwarded on to the doctor for approval.

In the example seen in Figure 275 below, the default value was accepted, and prompt#1 was automatically filled with the next Non-Visit encounter in the queue (in this case # 129).

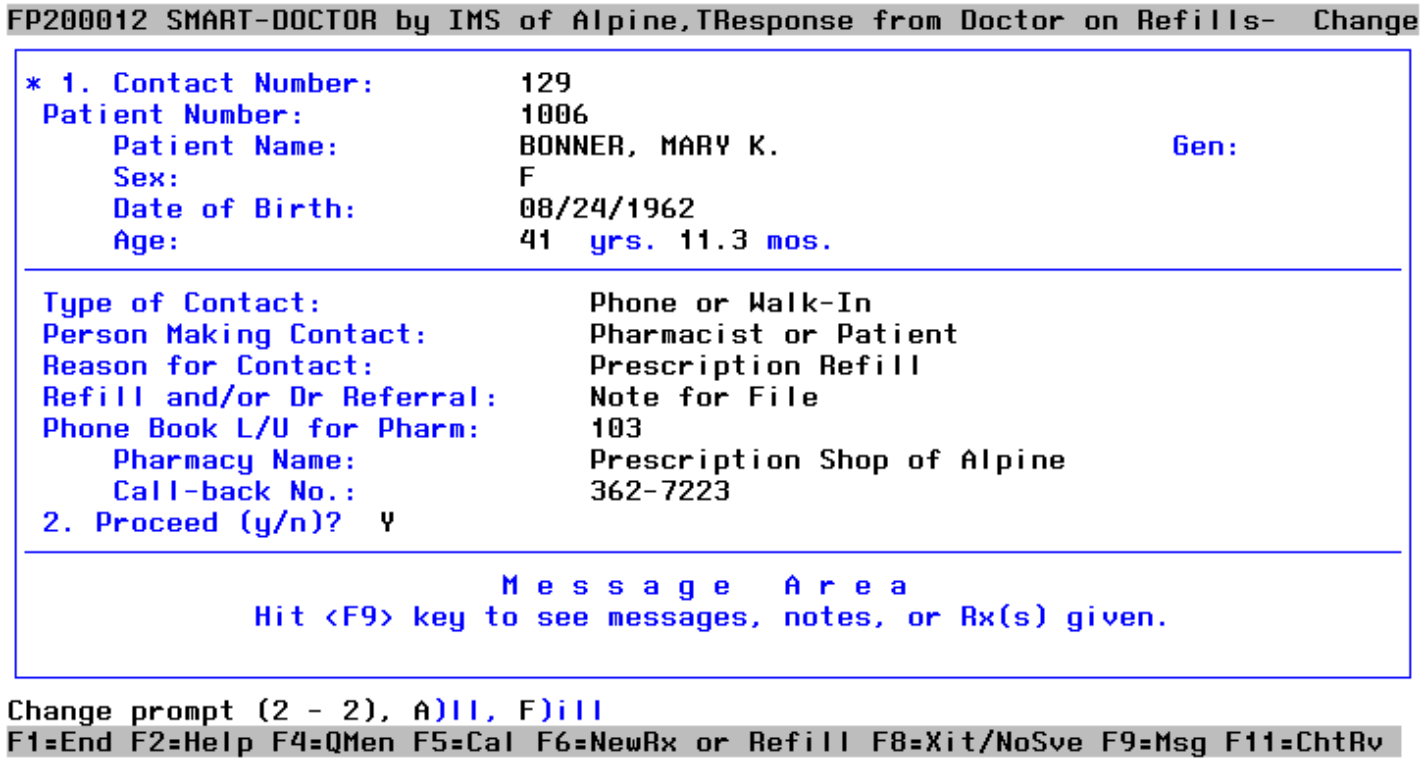


Figure 275 Doctors Response to Controlled Substance Refill request.

Here you see that the reason for contact was for a prescription refill to the Prescription Shop of Alpine. Upon hitting the <F9> “Msg” key, you see the doctors authorization for a one time refill:

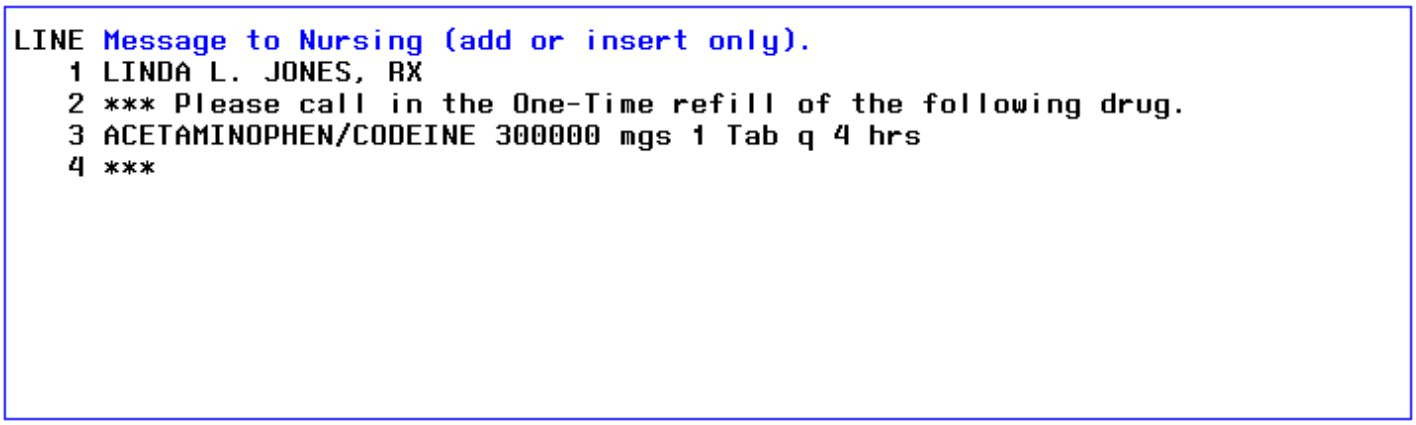


Figure 276 Doctor Response in Message screen.

You can see that the doctor has given you permission for a one time refill for this controlled substance. Upon hitting the <F6> key, you are allowed through the refill screen one time, to refill this prescription.

If you exit the message screen and then return so that it is refreshed, you will see that the refilled prescription information has been recorded here, as seen in Figure 277 below.

```
 5 The following Prescription was refilled
 6 Rx: ACETAMINOPHEN/CODEINE            30.0000 mgs per tab
 7    (TYLENOL/CODEINE)                    Rx Type: Acute
 8 Sig.      1 Tab      q 4 hrs      7 days
 9 Number: 42
10 42  Refills: 0   Until: 08/05/2004  Nurse Rfl Allowed: N
11 For treatment of: LUMBAGO (LOW BACK PAIN)           ICD-9: 724.2
12 The following Prescription was refilled
13 Rx: ACETAMINOPHEN/CODEINE            30.0000 mgs per tab
14    (TYLENOL/CODEINE)                    Rx Type: Acute
15 Sig.      1 Tab      q 4 hrs      7 days
16 Number: 42
17 42  Refills: 0   Until: 08/05/2004  Nurse Rfl Allowed: N
18 For treatment of: LUMBAGO (LOW BACK PAIN)           ICD-9: 724.2
```

Figure 277 Completed Message screen after Refill.

You now can add any information you need, or exit the Non-Visit encounter in the standard manner as discussed previously in this section.

Example #2, response from the doctor regarding a Non-Visit encounter sent to the doctor by either the clerical or nursing staff.

As part of the “Communication Loops” system, any Non-visit encounter note forwarded on to the doctor for action or attention is always placed back in the nurse queue for the nurse to review. The doctor may ask the nurse to have the patient come in, take an action, or simply be aware of the interaction and exit the note. In the following example, the doctor received a message via the queued Non-Visit encounter from the doctor's menu. After the doctor responded, this was queued for the nurse. Upon the nurse selecting this, as in the prior example, the nurse gets a screen similar to that shown in Figure 278 below.

Upon hitting the <F9> “Msg” key, the message screen seen in Figure 279 is seen.

The nurse can now call the patient, schedule the appointment, and schedule any needed tests. On completion, the nurse exits the note as shown previously.

If you were to review this note after the nurse signed out, the message area would appear as shown in Figure 280 below. Here you can see the entire exchange with both the doctor signature indicator and then the nursing note followed by the nursing signature indicator.

MENU ITEM #5, “COLLECT/PROCESS DOCTOR ORDERED LABWORK.”, choose this selection to process ordered, Interfaced lab and InHouse tests requested from providers. If you choose this menu item and there are no test pending, as seen in figure 208a below, then you are all caught up for the day. Otherwise, you will see a screen similar to that shown in Figure 280b.

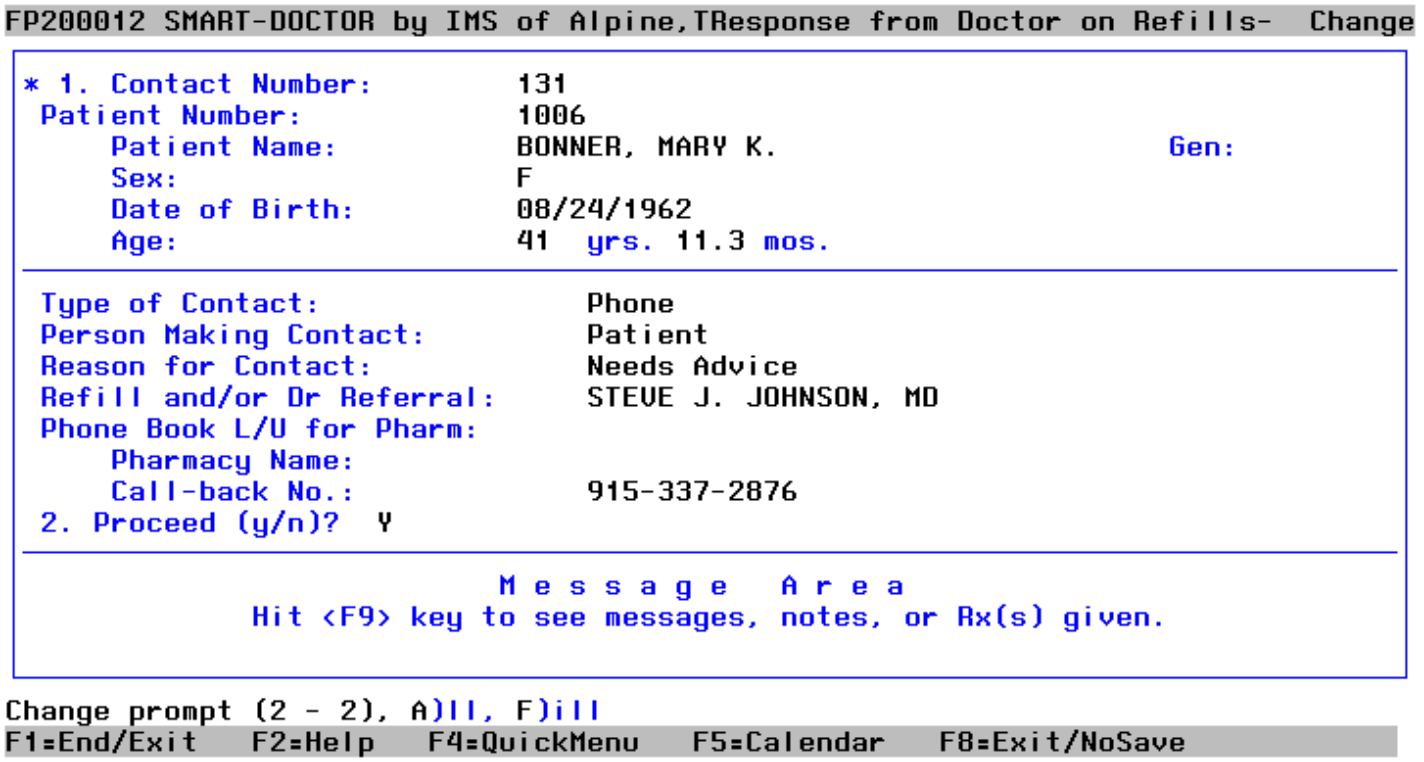


Figure 278 Doctor's Response on Refills.

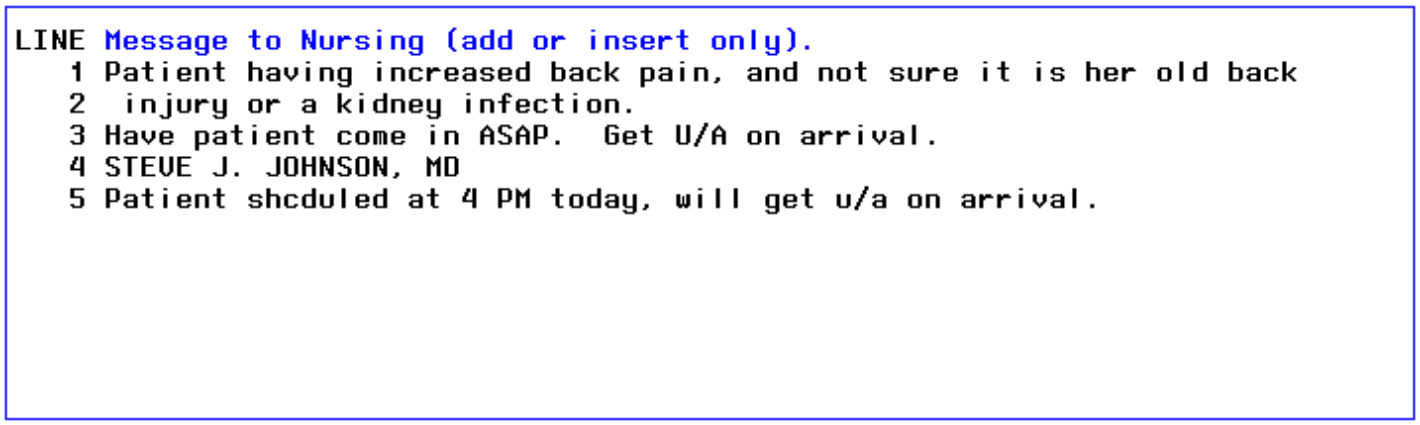


Figure 279 Message screen for Doctor's Refill Response.

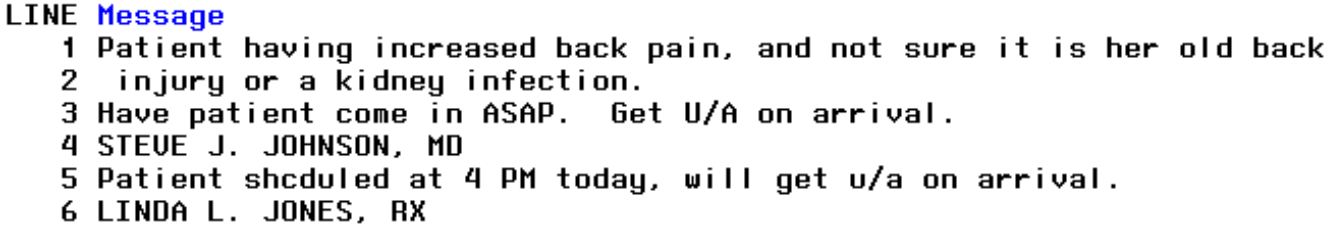


Figure 280 Completed Message Note in Response to Doctor.

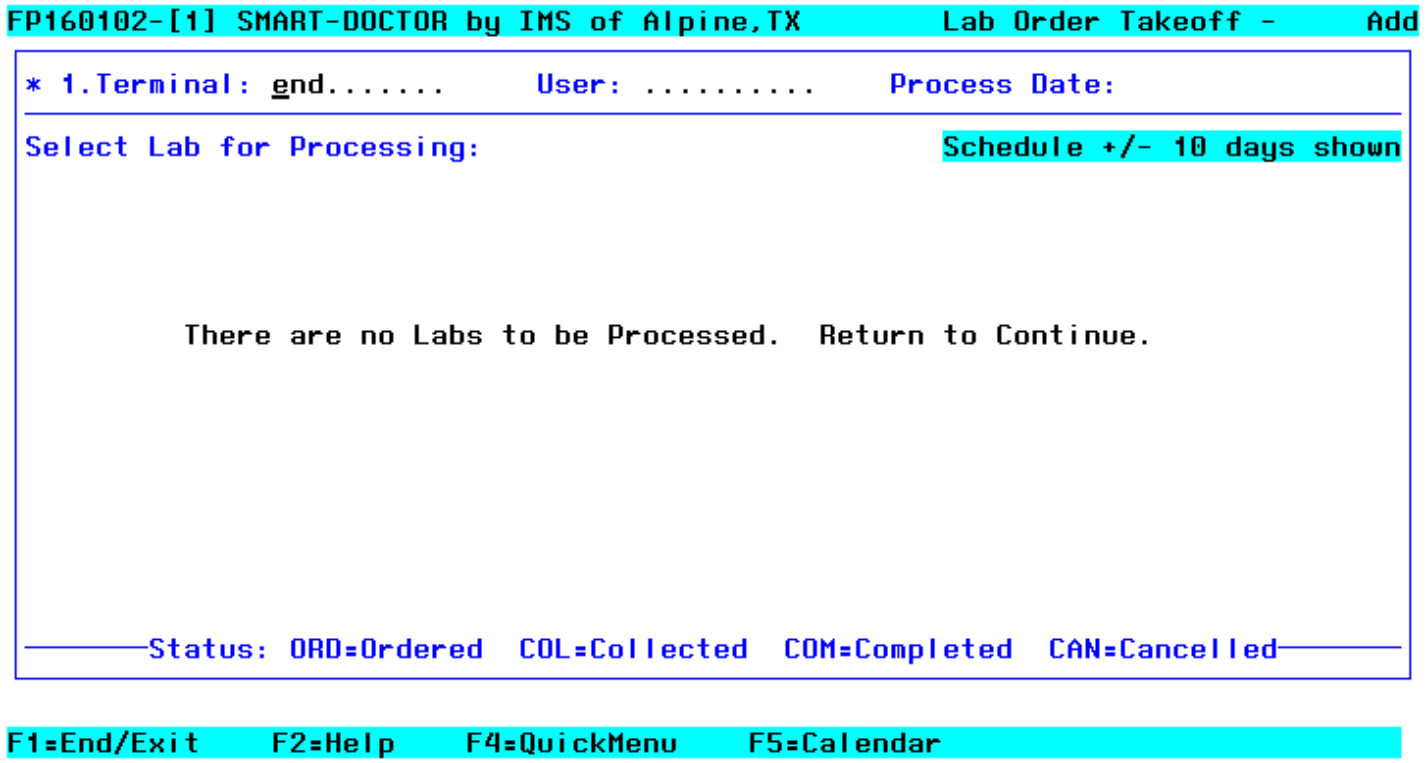


Figure 280a *Lab Order Takeoff screen with No Orders Pending.*

Examples of Interfaced lab processing.

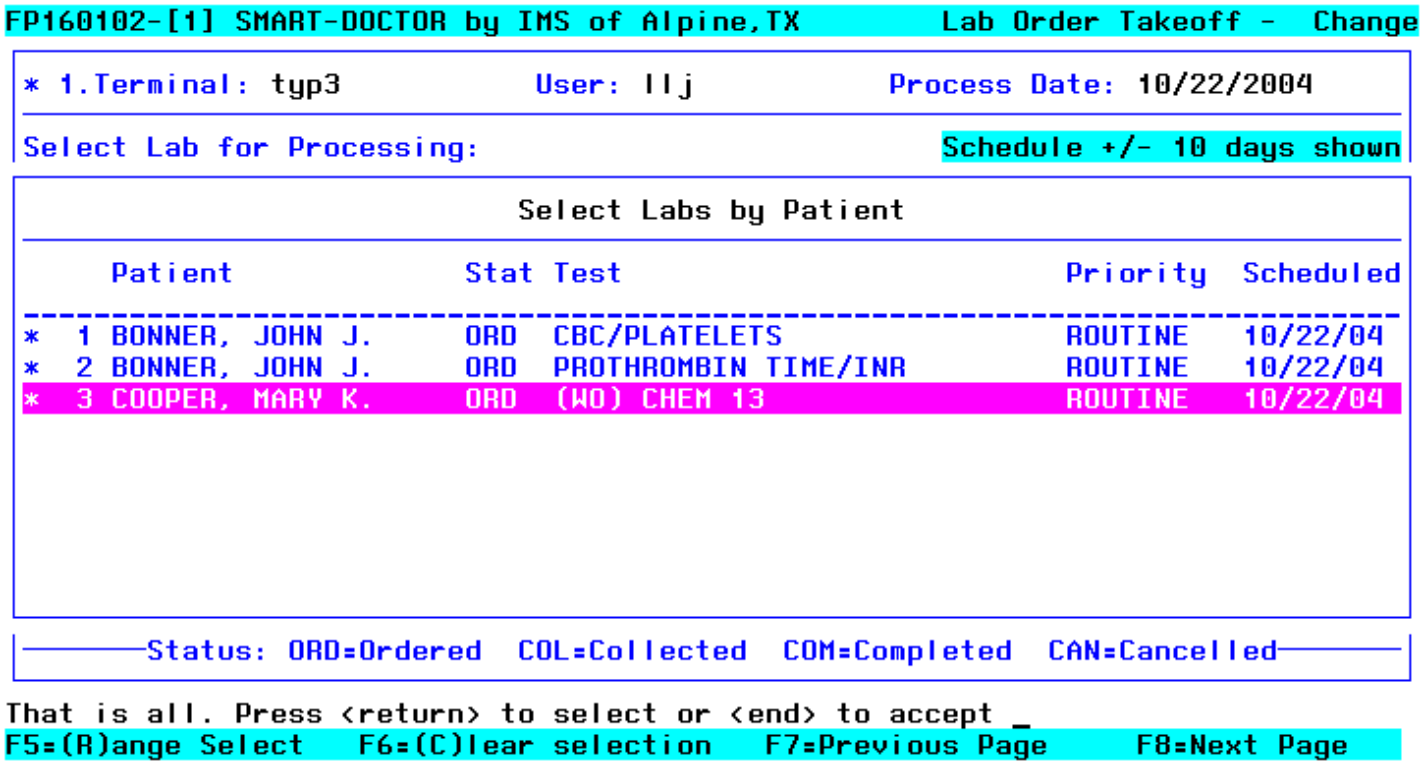


Figure 280b *Lab Takeoff screen with Pending Orders.*

This is a multiple select screen. In this screen, by hitting <enter>, an asterisk is placed in front of the selected items. Once selected (or unselected by hitting <enter> again), hit <F1> to accept the

selections. In this case, we intentionally mixed patients in the selection, which is incorrect. If you do this, then you will get the error message on the bottom of the screen as follows:

You have selected work on more than one patient!!, return to continue

Upon hitting <enter>, you will be return to the selection screen to choose again.

Since these are all Interfaced labs (not InHouse), then you only want to select labs for the same patient to place on the requisition form at this time. If you select these individually, then a separate requisition will be generated for each. Generally, CBC's and various chemistry tests are placed on a single requisition for a single patient. However, you may want to place certain tests such as PAP smears on separate requisitions, as instructed by your interfaced lab provider.

Upon selecting the first two line items shown in Figure 280b above, you will be taken through the individual lab order screen for each test. Below (Figure 280c) is an example for going through the first selected line item, the CBC/Platelets lab test for John Bonner.

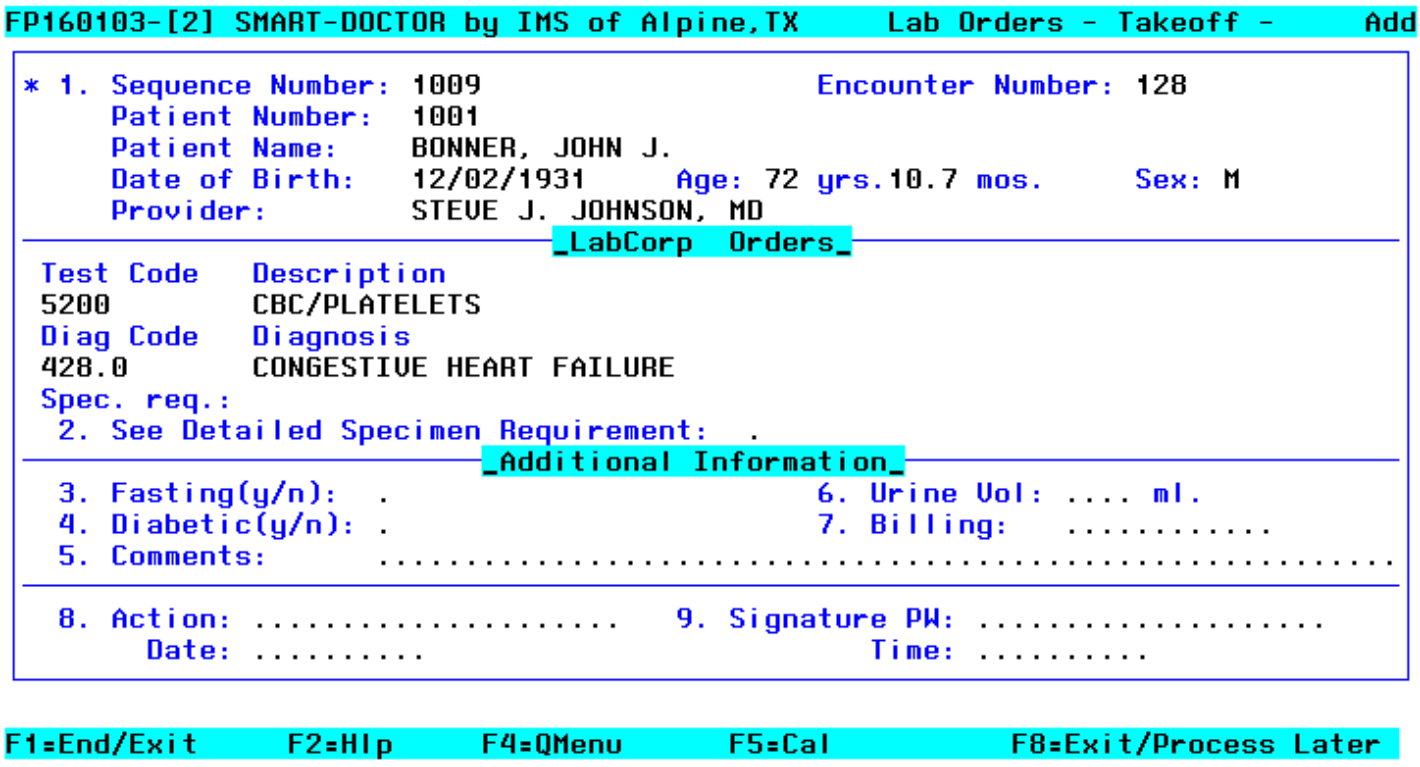


Figure 280c *Performing Specimen Collection.*

Prompt #2, "**See Detailed Specimen Requirements:**", enter <y> here if you wish to see any detailed specimen requirements specified by your interfaced lab provider. If you go to this screen and no details are listed, then none were given by your interfaced lab provider.

Prompt #3, "**Fasting(y/n):**", enter <y> or <n> as is appropriate.

Prompt #4, "**Diabetic(y/n):**", enter <y> or <n> as is appropriate.

Prompt #5, "**Comments:**", upon arriving at this prompt, you may be taken automatically to required information screens determined by your interfaced lab. For example, certain labs have specific

information they want completed for PAP smears, blood lead levels in children, Alpha Fetal Protein levels, etc. Other labs may not require any special information for the same tests.

Prompt #6, "**Urine Vol:**", this prompt will be skipped unless the test requested is a urine specimen with a required urine volume as specified by the interfaced lab.

Prompt #7, "**Billing:**", this prompt will automatically pop-up a window as shown in Figure 280d below.

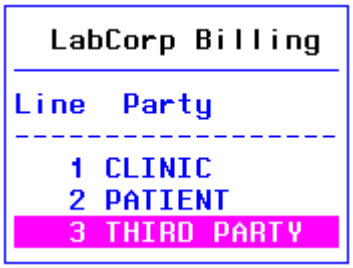


Figure 280d Party.

Selecting "CLINIC" will result in adding a charge to the patient's bill for the clinic. Selecting "PATIENT" will inform the lab to bill the patient. No charge to the patient by the clinic will be made. The patient's billing information will then be provided to the lab on the requisition. Selecting "THIRD PARTY" will inform the lab to bill the patient's insurance carrier. No charge to the patient by the clinic will be made. The patient's insurance carrier information will then be provided to the lab on the requisition.

Prompt #8, "**Action:**", this prompt will automatically pop-up a window as shown in Figure 280e below.

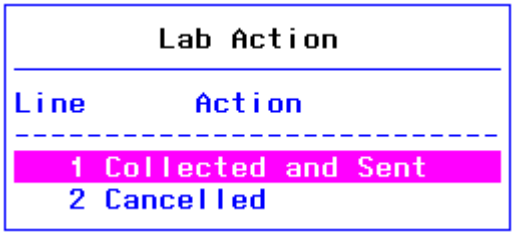


Figure 280e Select Lab Action.

Prompt #9, "**Signature PW:**", enter your signature password here to sign off the order. The completed screen is shown in Figure 280f below.

Examples of InHouse lab processing.

Below is a screen (Figure 280g) showing the selection of an InHouse lab test to be processed. The provider can order a number of InHouse lab tests to be done by the lab or nursing staff. All of these tests, except a Complete U/A, can be fully completed and placed in the patient's file for review by the provider. However, the Complete U/A gets completed in two parts when performed by nursing. First nursing will do the dip stick (chemistry) part of the test. Following this, the test results are queued for the doctor to complete the microscopic portion of the test.

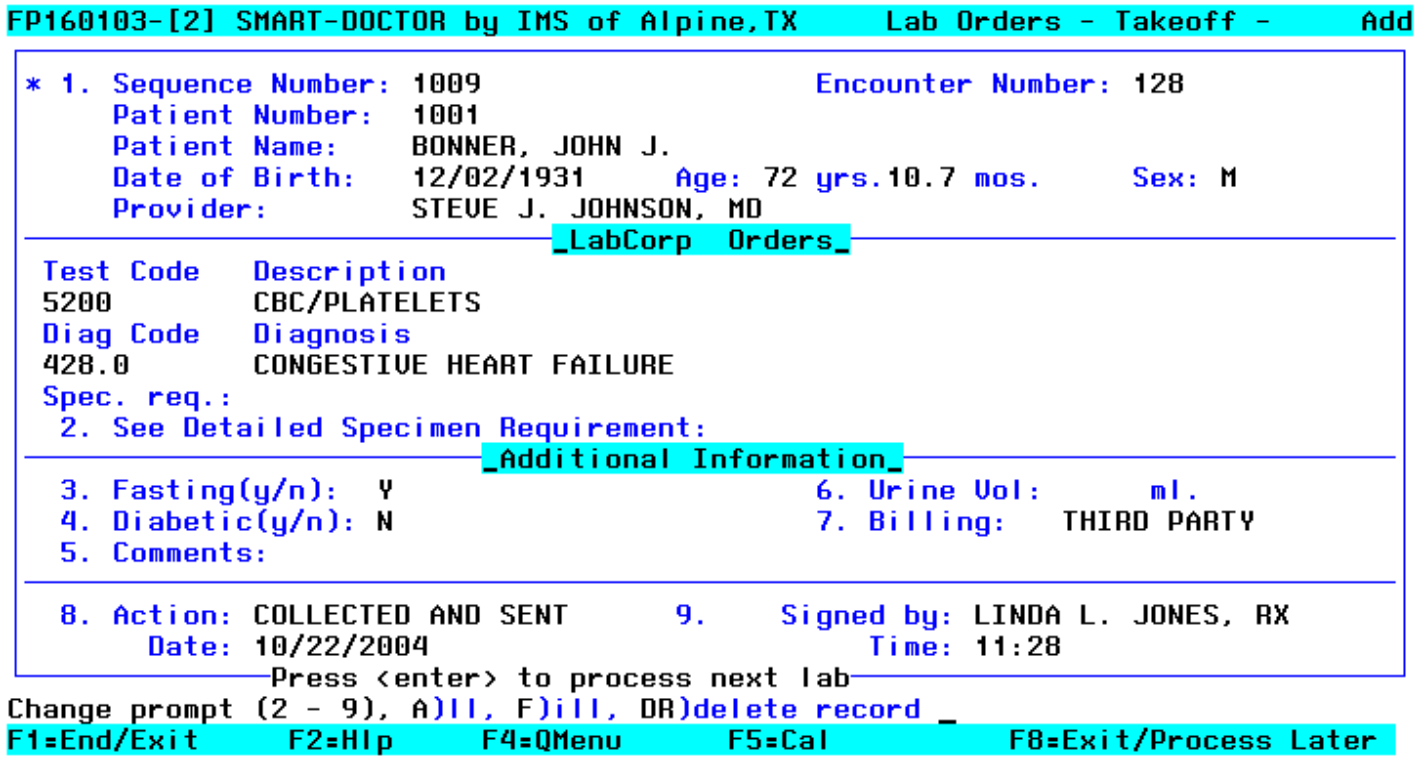


Figure 280f *Completed Lab Order Takeoff screen.*

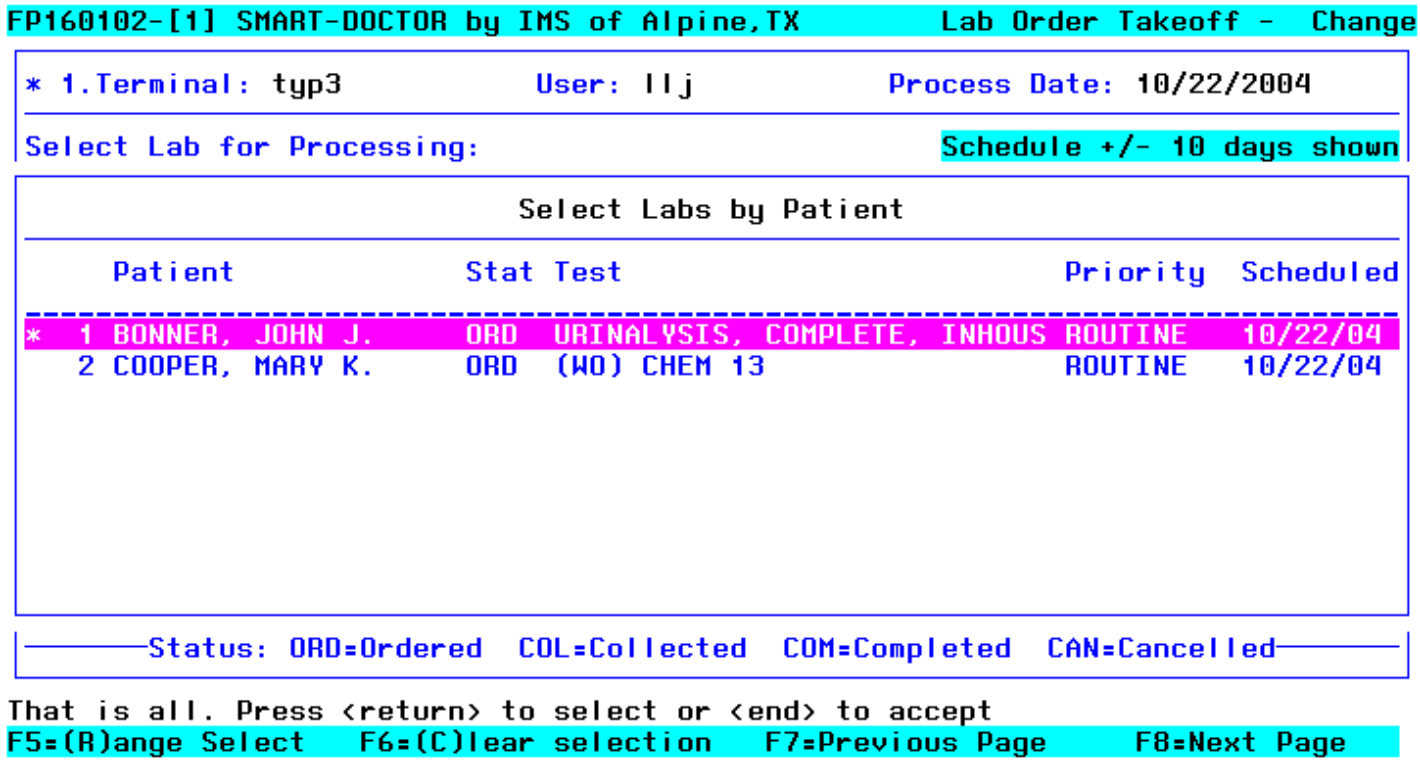


Figure 280g *InHouse Lab Takeoff.*

Upon selecting an InHouse lab test, you will be taken to the specific InHouse lab processing screen. Figure 280h below shows the completion of the nursing/lab component of the InHouse Complete U/A.

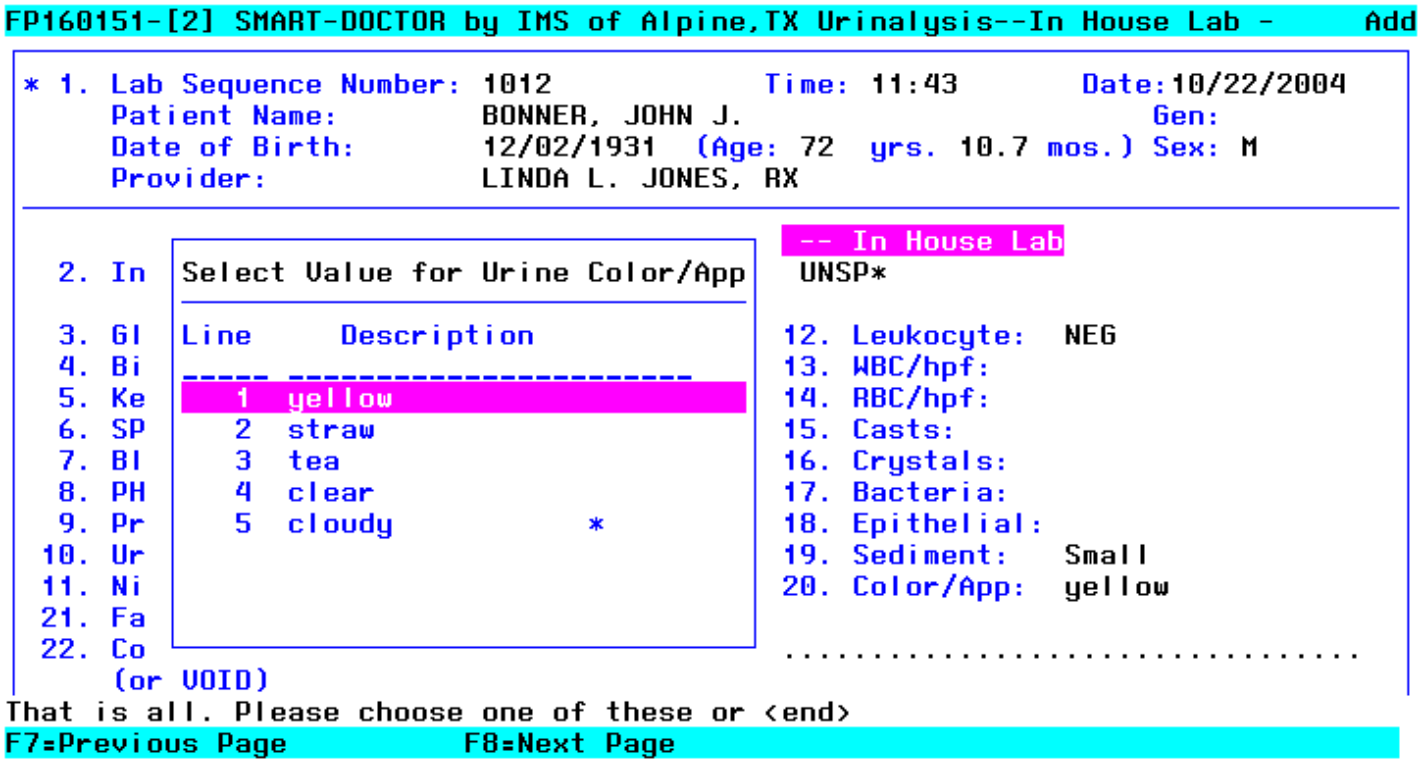


Figure 280h *Completed Nursing Component of U/A.*

Once the nurse or lab technician completes the chemistry part of the U/A, they enter their signature password to sign the report. This will then get queued for the doctor to complete the microscopic portion of the test.

Other InHouse lab tests can be completed fully by the nursing/lab personnel, and placed in a queue for the doctors review.

MENU ITEM #6, "REVIEW OR ADD TO NURSING INFO.", choose this selection to add to, inquire, or correct a previously entered nursing note for today. Upon selecting this menu item, a selection sub menu will be presented as seen in Figure 281.

Selection #1, "**Add Addendum to Nursing Intake Info.**", will allow you to add or change information to the prior intake. You will only be allowed to select notes in which an initial nursing note was done, and only before the doctor has seen the patient. Once the doctor has seen the patient, you will not be allowed to make any modification to the note. In the example shown in Figure 282, you will see that this nursing note has been assigned an addendum letter to distinguish it from the original. The original is never destroyed or changed.

In the example above, once you answer <y> to prompt #2, you can keep the prior values entered simply by hitting the <enter> key as you go through each field, or you can enter different information where needed. In this note, you will see at the top of the screen this is addendum "C", and in prompt #13 a note was added.

Selection #2, "**Inquire about Nursing Intake Info.**", allows you to see the most recent nursing note by selecting as was done above. However, no modifications are allowed.

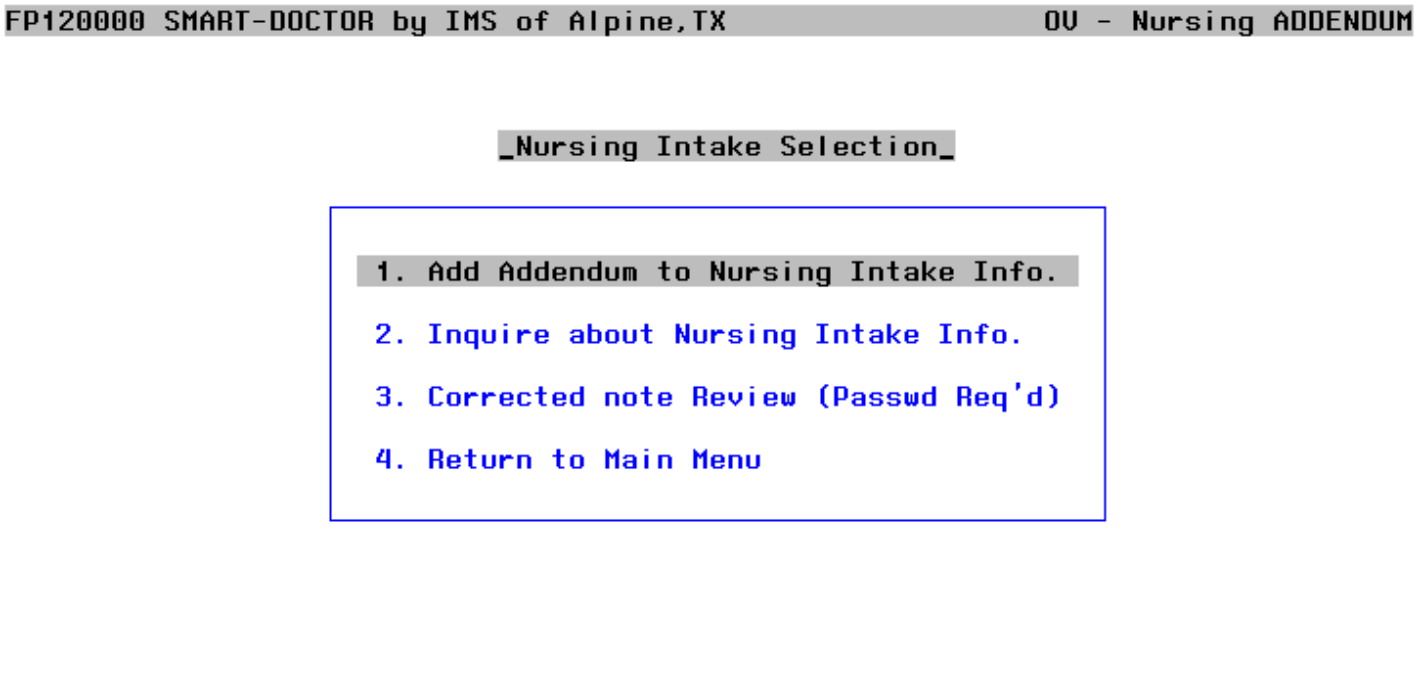


Figure 281 *Selection Sub Menu for Nursing Notes.*

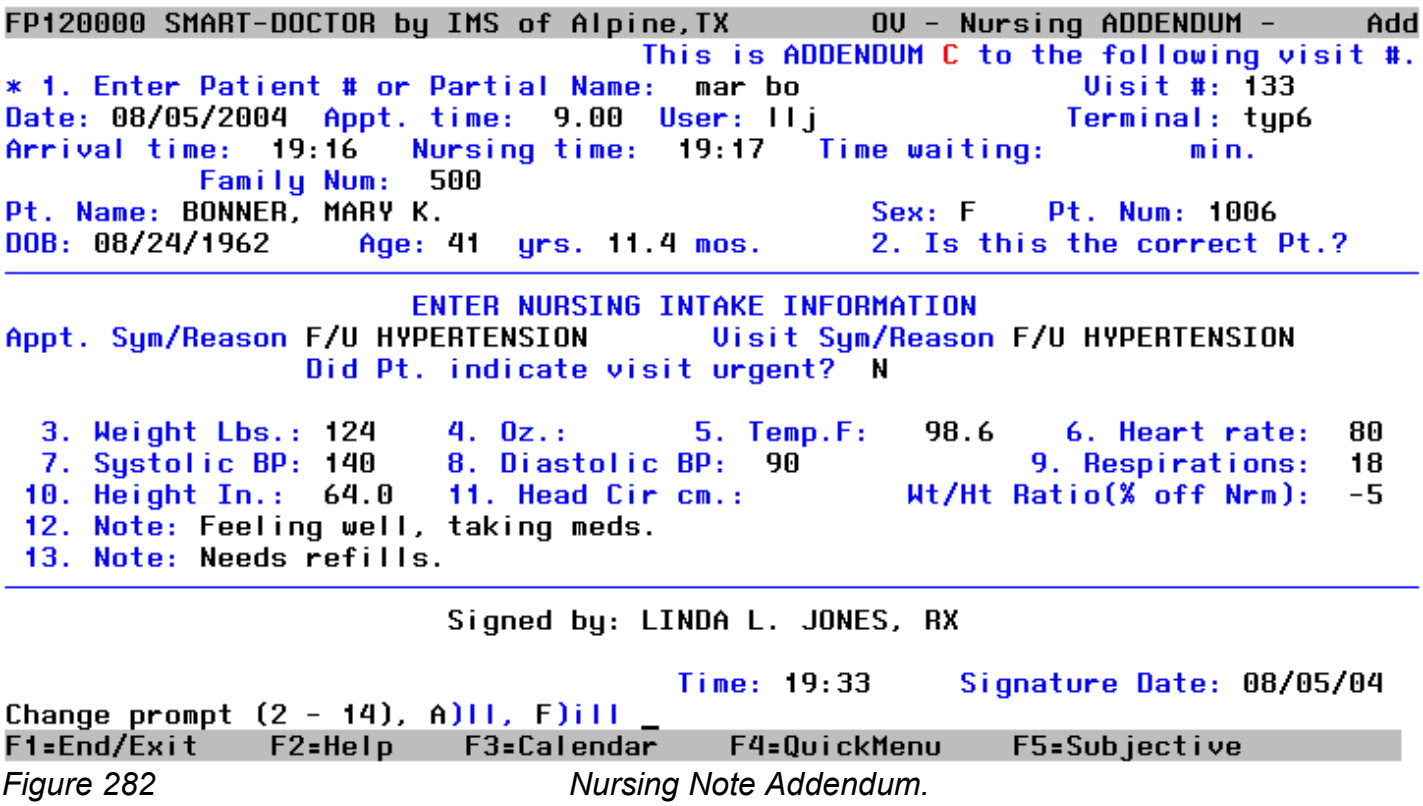


Figure 282 *Nursing Note Addendum.*

Selection #3, “**Corrected note Review**”, allows you to see any of the nursing notes or any of the addendum's. When the doctor sees the patient, only the last addendum of the nursing note is shown. In this way, the doctor gets to see the correct information, but allows for audit of all the nursing notes and any changes made.

Selection #4, “**Return to Main Menu**”, returns you to the main menu. If you hit the <F1> key instead, it will return you to the prior nursing menu.

CHAPTER 7 PROVIDER

All physician providers and physician-like providers (DCs, NPs, PAs, etc.) will generally be placed in the “Doctor Main Menu” screen upon logging into the system. Nursing personnel are generally started in the “Family & Patient File Maint.” screen, but may also be started in this screen at the discretion of the clinic. Some nursing staff that primarily do procedures or counseling may be more logically started in this screen. As providers, they can have appointment schedules just like physicians, and document there treatments and procedures in a similar manner. This is especially true in the case of billable encounters such as diabetic counseling, suture removal, physical therapies, etc.

The doctor main menu screen is shown in Figure 283 below.

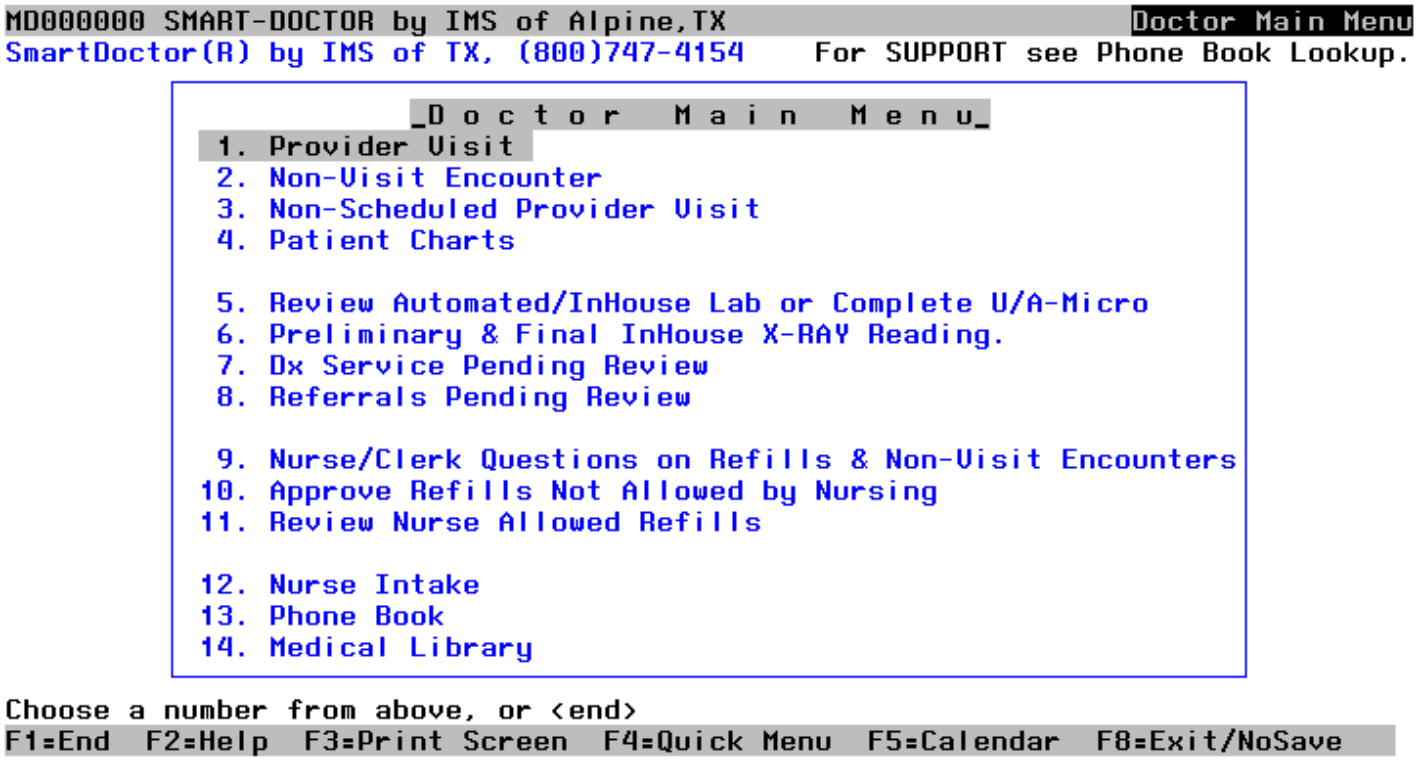


Figure 283 *Doctor (Provider) Main Menu.*

For the <F4> “Quick Menu” screen, please see the “Basic” section of this manual for a full description of the functions available from the doctor screen.

MENU ITEM #1, “PROVIDER VISIT”, should be selected to see your current appointment schedule for the day. You can also see the appointment schedule of other providers, in the case where you may be asked to cover for other providers that are behind in their schedule, or are unavailable to see their scheduled patients. Upon selecting this menu item, you will be placed in the screen shown in Figure 284 below.

Prompt #1, “**Scheduled Provider:**”, your initials will be defaulted for the scheduled provider. Just hit the <enter> key to see your current appointment schedule for the day. Also, as mentioned previously, you may enter the initials of another provider for whom you have been asked to see his or her patients because they are not available. Regardless of who's scheduled is picked, your

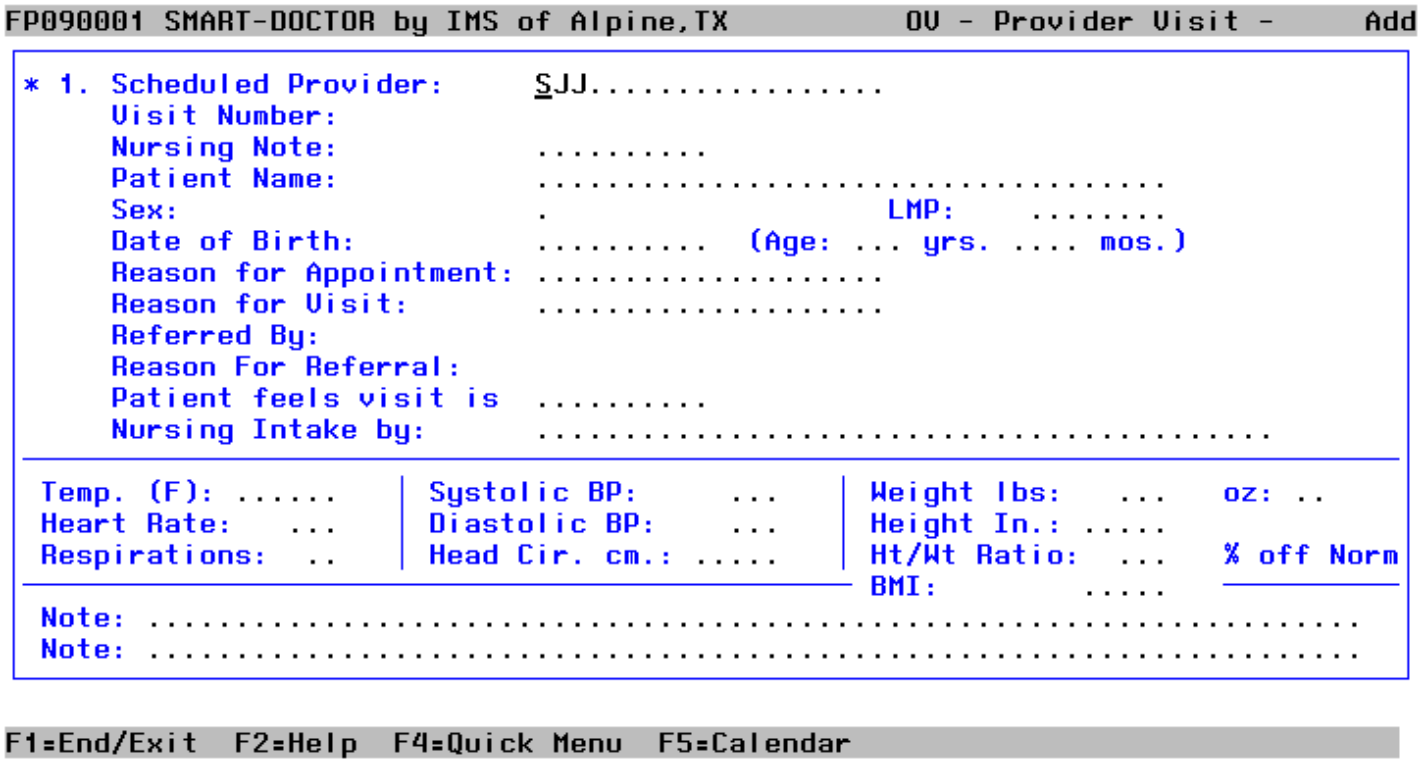


Figure 284 *Initial Provider Visit screen.*

initials (log-in name) will be associated with this encounter, and not that of the original scheduled provider. Once the initials of the “scheduled” provider's clinic have been entered, the schedule for that provider will be shown as in Figure 285.

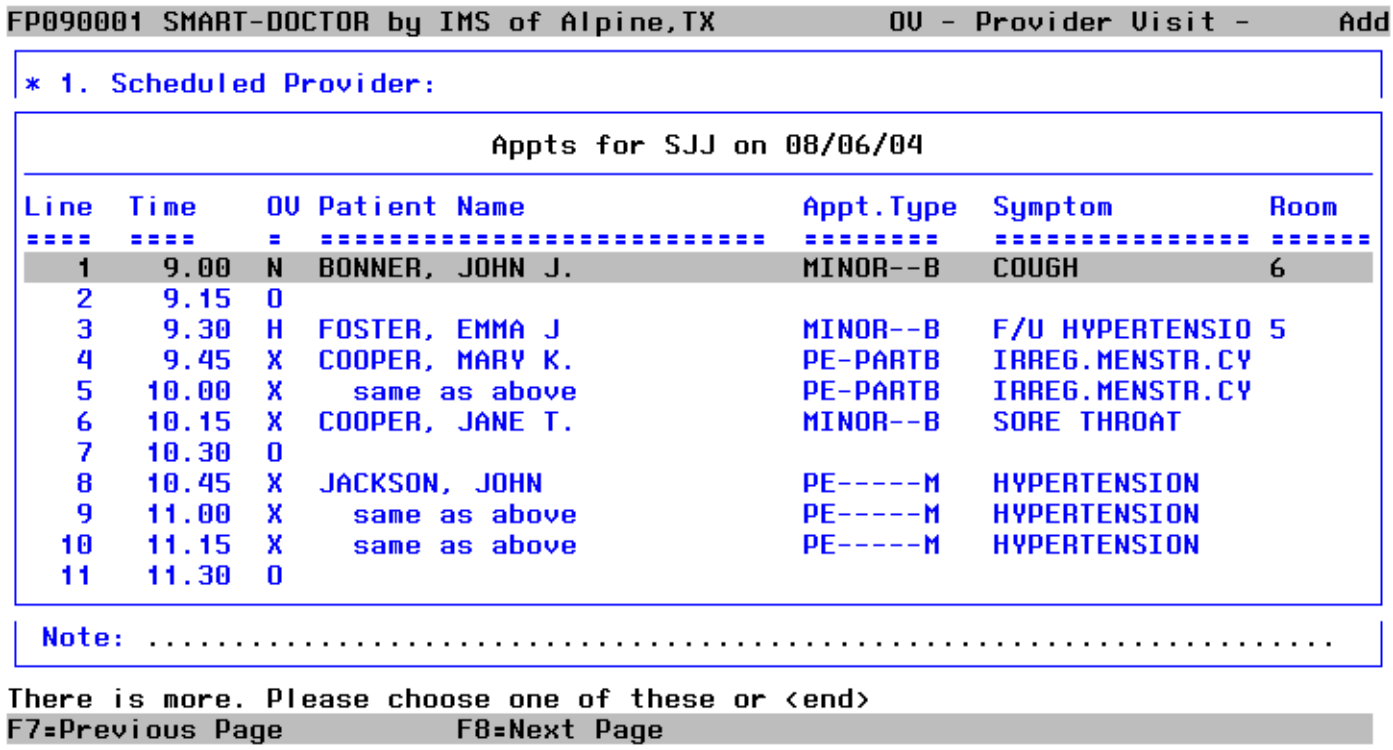


Figure 285 *Patient Selection screen.*

On this screen, the provider can quickly see by looking at the “OV” that John Bonner has arrived, been seen by the nurse, and is in room #6. The 9.15, 10.30, and 11.30 slots are open, and Emma Foster is here and in room # 5. Further, you can see that Mary Cooper has a double slot appointment at 9.45, Jane Cooper has a single slot appointment at 10.15. John Jackson has a triple slot appointment for a complete physical. The letters possible in the “OV” column and their meanings are as follows:

O	Open appointment slots.
X	Booked appointment slots.
H	The patient is Here, has signed in and is ready to be seen.
N	The Nurse has done the intake and the patient is ready for the doctor.
P	The Provider is seeing the patient.
C	The provider has Completed seeing the patient, and the patient is ready for checkout and billing.
B	The patient has been checked out and been Billed.

This makes it extremely easy to see the patient's progress through the clinic. Since the appointment schedule like the rest of the system, is designed as a “real-time system”. Every time you enter this screen your clinic schedule will be current. No more problems of having a paper list of your appointments for the day, that is incorrect every time a new appointment is made or canceled. Further, you know what the patient's progress through the clinic is, as well as what room they are in.

You do not have to select patients in the given order. The only requirement is that you select a patient that is indicated to have been seen by the nurse in th “OV” column with an “N”. If you want to see a patient before a nurse has done the nurse intake, you may do this yourself by choosing menu item # 12, “**Nurse Intake**“, from the “Doctor Main Menu”.

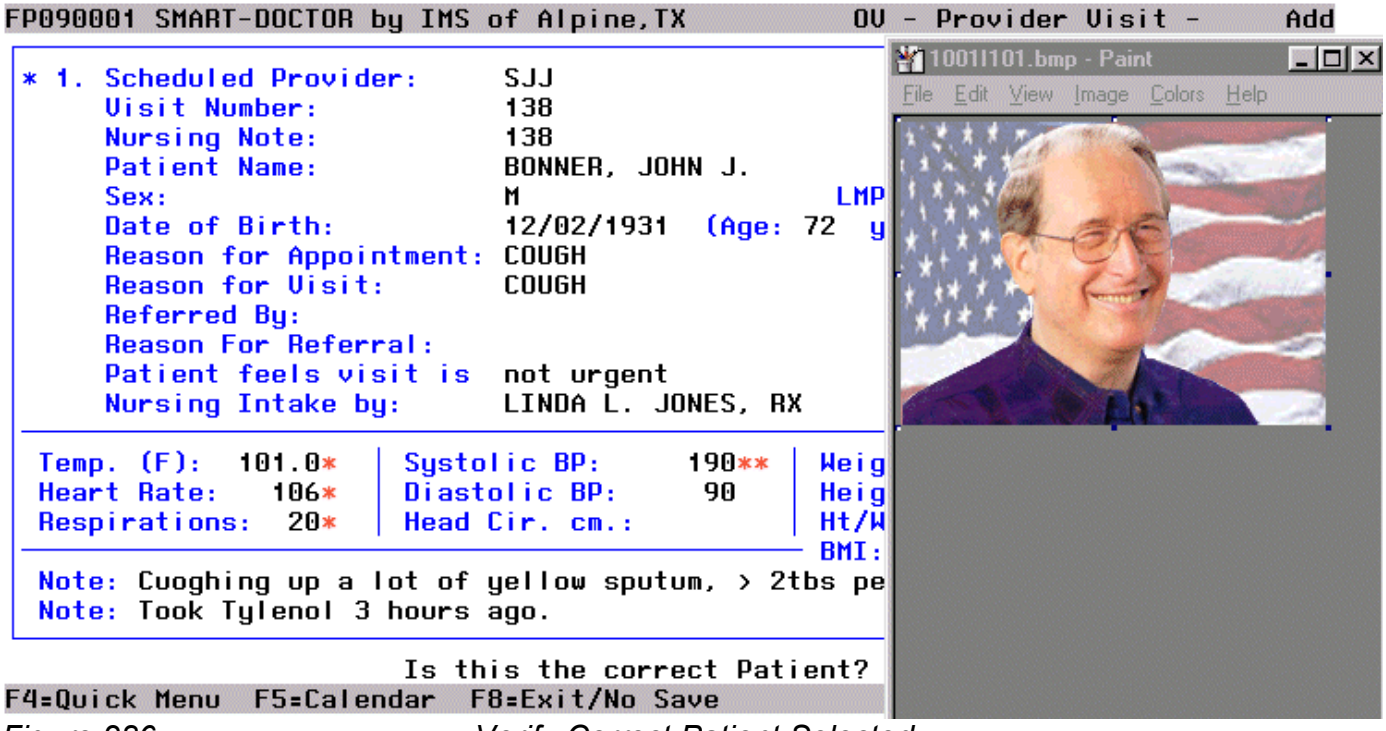


Figure 286 *Verify Correct Patient Selected.*

Upon hitting the <enter> key on the highlighted multi-value line of the appointment schedule, you will be placed in the screen shown in Figure 286 above. In this screen you can see the patient's name, DOB, age in years, and an ID photo if available. (The system can store photo IDs as well as other photos and images with appropriate equipment.)

Once you are certain that this is the correct patient, close the image window by clicking on the “X” box in the upper right hand corner of the image screen, or hit the <ALT + F4> key combination to close this window. You will then see the full “Provider Visit” orientation screen as seen in Figure 287 below.

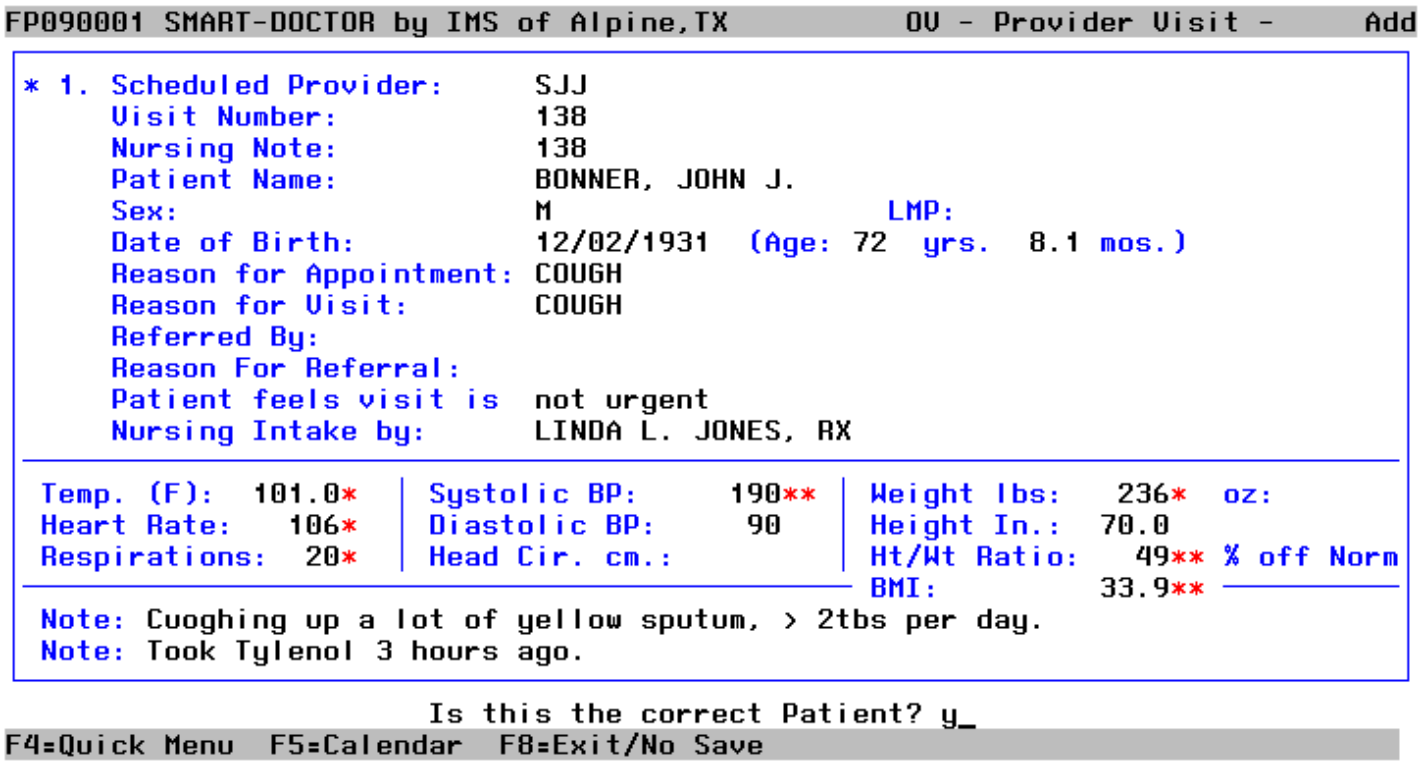


Figure 287 *Provider Visit Orientation screen.*

In this screen, you can see all the patient demographics, the reason for appointment, and final reason for this visit at the time of signing in. The reason for visit can change. For example, the patient may have made an appointment for a screening exam, but on arrival, wants to be evaluated instead for a new acute problem.

You will also see if this was a referral and by who, the patient opinion on sign-in as to whether the patient felt this problem or visit is an emergency. In this case the patient indicated that the visit was “**not urgent**”. If the patient had indicated at time of sign-in that this was an urgent problem, then the sign-in clerk would have the following message appear: “**Notify Nurse and Provider: patient feels visit is**“, followed by a red, flashing “**URGENT**”. On this provider visit screen you would see a red, flashing “**URGENT**”.

Next, you would review the patient's vital signs. Abnormal flags consist of one or two asterisks, “*”, in flashing red following the abnormal value. Rather than talking about standard deviations, or other abnormal parameters, IMS has established the following criteria: 1.) If the abnormal flag has one asterisk “*”, then this is not normal and you should be aware of this and take appropriate action. 2.) If there is a double flashing red asterisk “**”, then this is significantly abnormal. The provider should

make note of this in the documentation, and indicate what action was taken in the plan, if it is not self evident in the note. All vital sign parameter flags are set by age and sex. For example, a heart rate of 140 would be normal in a three day old baby, and therefore no flags.. It would cause two asterisks to be displayed in this patient.

Then, answer the prompt at the bottom of the screen, "**Is this the correct Patient?**". If you answer "N", then the screen will be cleared and you will be returned to the first "Provider Visit" screen. If you answer "Y", you will then be taken through a number of screens to orient you to the patient recent and past medical history. The first review screen is "Review of last Visit's Plans", as seen in Figure 288 below:

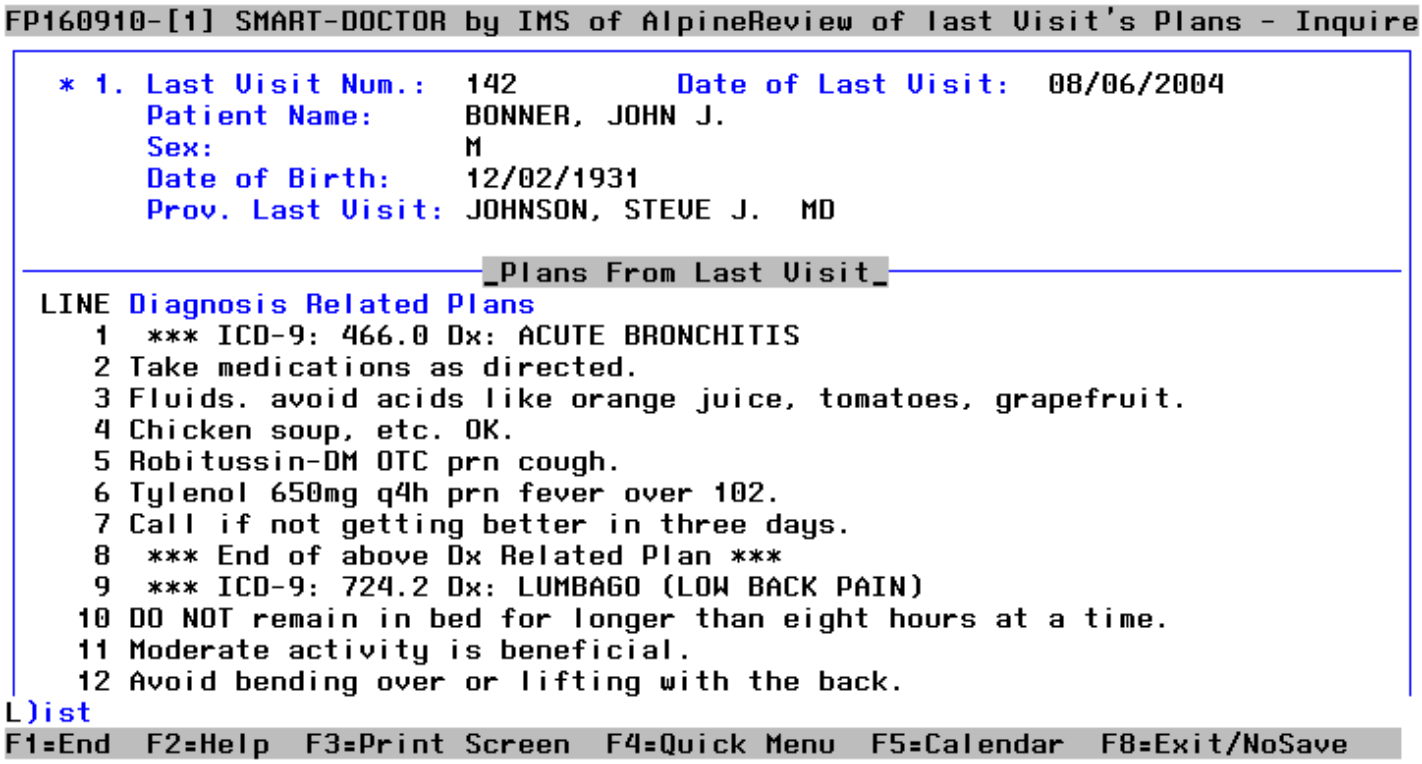


Figure 288 Review of Last Visit's Plans.

This gives you the opportunity to show the patient that you are up on their most recent care. It also allows you to see if the last problem was resolved, and if the patient followed your plan. You would page or arrow down on this screen to see the remainder of the back plan. The end of the plan is always indicated by the last line containing the following statement: "***** End of above Dx Related Plan *****".

The next automatic review screen is the patient's "Active Medical Problems", as seen in Figure 289 below. Here, you will see all medical problems that have ever been entered in this system as an active problem. The SmartDoctor® system specifically does not use the concept of acute and chronic, or major and minor problems, since these definitions are arbitrary and frequently change. For example, a urinary tract infection may be considered minor or chronic. However, if a patient comes in 10 times in one year for the problem, then this is a significant problem and you should be aware of it. The SmartDoctor® system logic handles this by placing the most recent problem at the top of the listing, and list the remaining problems in reverse chronological order, based on last date recored. Further, the system displays the first time the patient was seen for this problem, the number of times seen for this problem, and the last time seen for this problem. Therefore, a visit for

```
FP090300-[1] Review Active Medical Problems                        - Inquire

LINE Patient's Active Medical Problems  (scroll to see all)
==== ============================================================================
   1 Dx Code  Description                                 Onset     #Vs Recorded
   2 -------  ----------------------------------------  --------  --- --------
   3 V70.9    UNSP GENERAL MEDICAL EXAM *                08/06/04  1   08/06/04
   4 466.0    ACUTE BRONCHITIS                           07/17/00  1   07/17/00
   5 428.0    CONGESTIVE HEART FAILURE                   03/31/99  1   03/31/99
   6 530.81   ESOPHAGEAL REFLUX                          04/15/98  1   04/15/98
   7 787.1    HEARTBURN                                  04/15/98  1   04/15/98
```

Figure 289 *Active Medical Problem List.*

strep throat ten years ago will be at the bottom of the list. You will note that the screen is in the inquire mode, so no changes can be made here. This is just information to quickly reorient you to this patient. Hit the <enter> key to go on to the next screen.

The next review screen is all the patient's chronic medications, and all medications indicated at time of writing to be an acute medication for the last year. This is also presented as an inquire screen that you can scroll through, or page up and down through, as is seen Figure 290 below.

```
FP090600-[1] SMART-DOCTOR by IMS of Alpine,TX  Chronic Medication List - Inquire
                _CHRONIC MEDICATIONS & ACUTE MED'S of PAST YR._
* 1.Patient Number: 1001          DOB: 12/02/1931   Age - Yrs: 72   Mos:  8.1
    Patient Name: BONNER, JOHN J.                          Gen:
 (To see full details, special inst., acute and
   sample meds, and deleted meds, see Add Medications.)   Nurs        No.
                                                          Rfls First  of   Last
      Substance      Dose   per    Amount      Freq.   Disp | Rx     Rfls
 LINE ------------------------------------------------------------------------
    1 CLONIDINE      .1000  tab    1 Tab       bid      120  Y 071700 0    071700
    2   CATAPRES     mgs    --
    3                       Do not suddenly stop medication without
    4                       talking to doctor.  BP may rise rapidly.
    5 FUROSEMIDE     40     tab    1 Tab       q day    60   Y 033199 0    033199
    6   lasix        mgs    --
    7 POTASSIUM CHLO 10     cap    1 Capsule   q am     60   Y 033199 0    033199
    8   Micro-K      meq    --
    9 CISAPRIDE      10     tab    1 Tab       tid ac,qh240  N 041598 0    041598
   10   propulsid    mgs    --


L)ist
F1=End/Exit   F4=QuickMenu   F5=Calendar
```

Figure 290 *Chronic and Acute Medications of the Past Year.*

Just hit <enter> when finished reviewing.

The next automatic review screen (see Figure 291) is for past medical history, including allergies and immunizations, as follows:

Past Medical Problems: shows the diagnosis code, followed by the text description of the diagnosis, followed by the date of onset.

Past Surgeries and Procedures: shows the procedure code, followed by the text description, followed by the date of the procedure.

Allergy History: lists the substance the patient reacted to, as well as the compound class in this substance the patient reacted to.

Immunization History: listing of the immunization type followed by the date of immunization.

Family History: listing of the medical diagnosis code, followed by a text description, age of onset, and blood relationship.

Hospitalizations: listing of all hospitalizations by discharge diagnosis, text description of the diagnosis, the number of days in the hospital, and the date of admission. Knowing the number of days in a hospital adds significant information since it gives you an idea of the severity of a specific condition. For example, a hospital stay of 3 days for appendicitis would probably indicate a normal course. However, if the hospital stay was 30 days, then you would expect something like a ruptured appendix with peritonitis. This would significantly increase the chance of future problems. It would stimulate you to ask more questions about that hospitalization, like, “were you on a ventilator?”, etc.

To understand date approximations used in this system when a patient only knows an approximate date, see the “Past Medical History” section of patient information processing of this manual, under the heading of “Adding a Date”.

You are then brought back to the provider “Orientation Screen” and asked if you want to “Preload with a Scenario?”. This screen is shown in Figure 292 below.

SCENARIOS

Normally at this point, you may want to discuss the other areas just reviewed with the patient. You would review the current problem with the patient, and do the appropriate physical exam. Following this, you should have a good idea of the type of problem you are dealing with. In a medical practice, 90% or more of the problems seen have been seen before. To enable you to document these recurrent conditions, the SmartDoctor® system uses a documentation shortcut called “Scenarios”. A “scenario” contains the subjective, objective, assessment and plan for a given problem. The only things a “scenario” doesn't contain are the review of systems, social history, and prescription for this condition. As should be apparent, these last items are unique to an individual, and are not appropriate for a generalized “scenario”. Please see the “Scenarios” section of the “Systems Files” division of this manual for more information on how to make, copy, or modify a “scenario” for your own use. The “Scenarios” feature should help you more easily enter clinical information and can reduce the time of full visit documentation down to as little as 35 seconds. Try beating that with dictation!

When you select a “scenario”, you can later, prior to exiting the note, modify any component of the

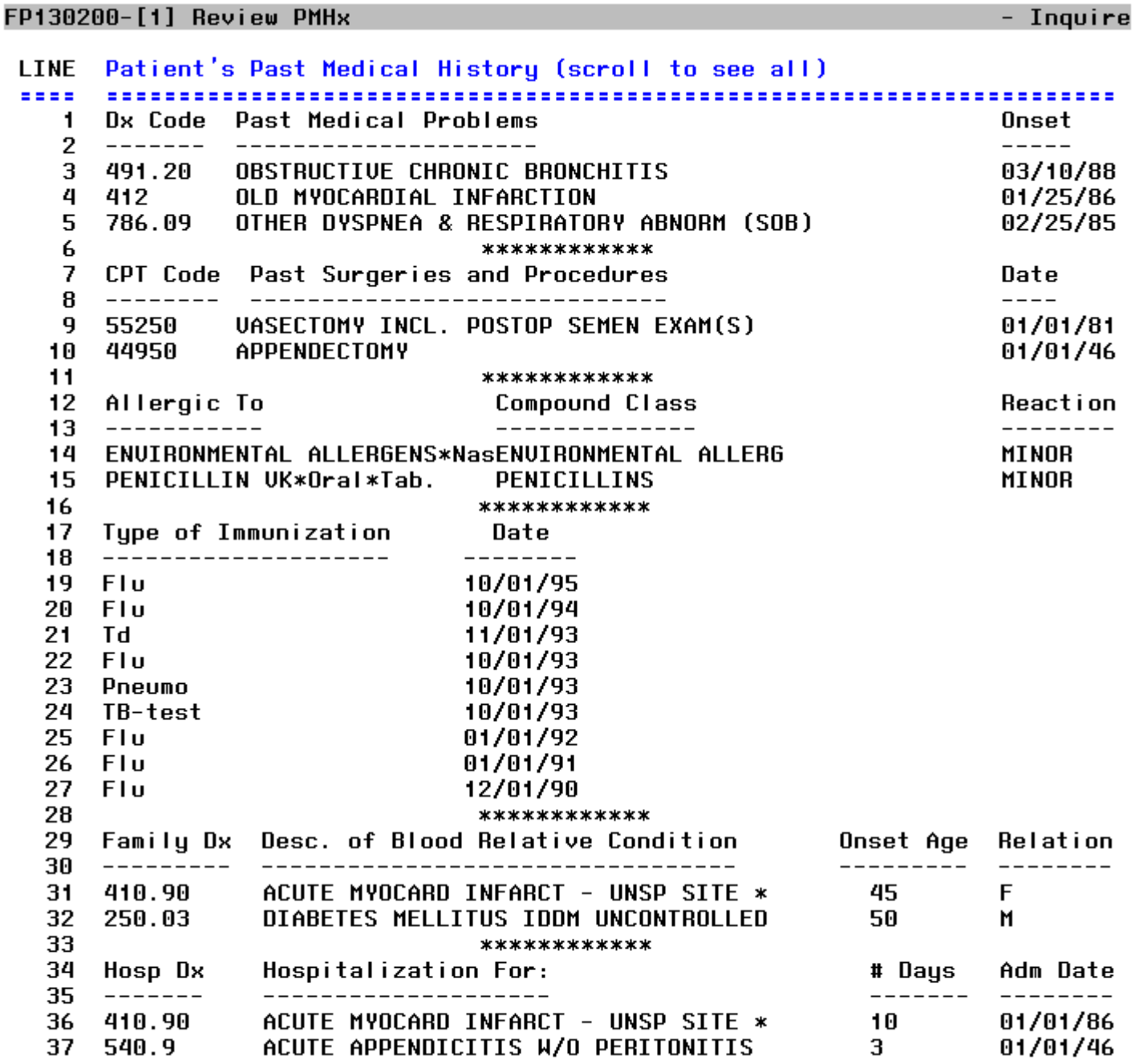


Figure 291 *Patient's Past Medical History.*

scenario through the normal documentation functions to be described below.

In the following example (Figure 292), we will answer “Y” to this last prompt, “Preload with a Scenario?”, and get a pop-up window as seen in Figure 293.

Here, we entered “acu br” for acute bronchitis, which is what was felt to be the most appropriate diagnosis after the review, additional history, and physical exam. You could also hit the <F9> key, “List Scenarios”, to get a sorted list of scenarios from which you can choose. However, in this case, after entering the partial description above, we get the pop-up selection window seen in Figure 294.

```
FP090001 SMART-DOCTOR by IMS of Alpine,TX          OV - Provider Visit -      Add

* 1. Scheduled Provider:      SJJ
     Visit Number:            144
     Nursing Note:            144
     Patient Name:            BONNER, JOHN J.
     Sex:                     M                        LMP:
     Date of Birth:           12/02/1931  (Age: 72  yrs.  8.2 mos.)
     Reason for Appointment:  COUGH
     Reason for Visit:        COUGH
     Referred By:
     Reason For Referral:
     Patient feels visit is   not urgent
     Nursing Intake by:       LINDA L. JONES, RX

 Temp. (F):  101.0*  | Systolic BP:     190**  | Weight lbs:   236*  oz:
 Heart Rate:   106*  | Diastolic BP:     80    | Height In.:  70.0
 Respirations:  20*  | Head Cir. cm.:          | Ht/Wt Ratio:   49** % off Norm
                                                 BMI:          33.9**
 Note: Coughing up a lot of yellow sputum, > 2 tbs. per day.
 Note: Took Tylenol 3 hours ago.

                          Preload with a Scenario?_
F4=Quick Menu  F5=Calendar  F8=Exit/No Save
```

Figure 292 *Preload with Scenario Question.*

```
                    Choose a Scenario to use.

   1.Scenario Name ( or Xref):
     acu br_.........................................

   2. Use this Scenario?:  .



  (Note: Nursing subjective will not be overwritten if it exits.)
```

Figure 293 *Selecting a Scenario.*

Upon selecting line #1, we get the confirmation screen seen in Figure 295.

Please note the information on the lower half of the screen shown in Figure 295. Since the system allows the nurse to take the subjective information for the doctor as part of the nursing notes (for clinics that normally operate that way), it would be inappropriate to overwrite any subjective information input by the nurse, with that from a generalized scenario. Therefore, if the nurse has taken any part of the subjective history, then the subjective history of the “scenario” will not be copied into the current record. Please note that the subjective history is separate and distinct from the nurse intake note, which is the equivalent to the patient's presenting complaint.

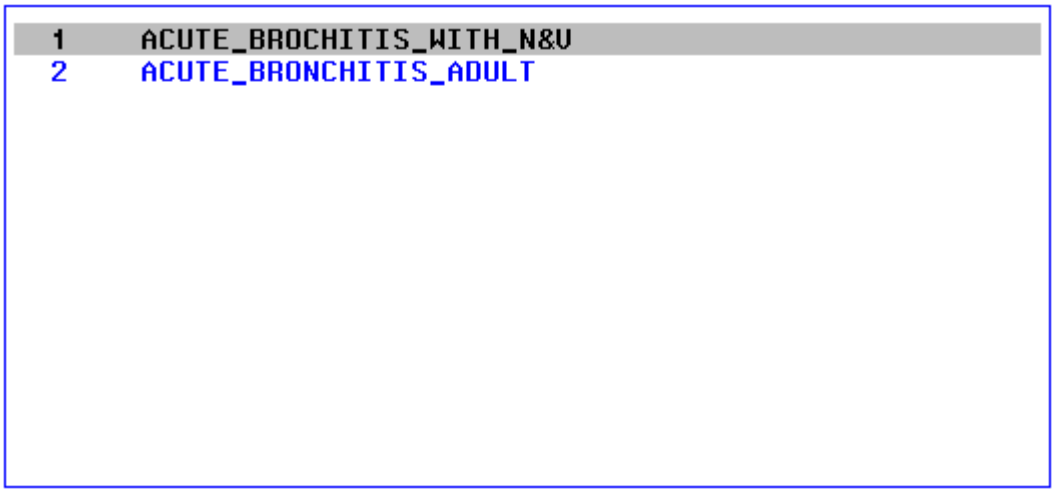


Figure 294 Scenario Cross-reference Selection screen.

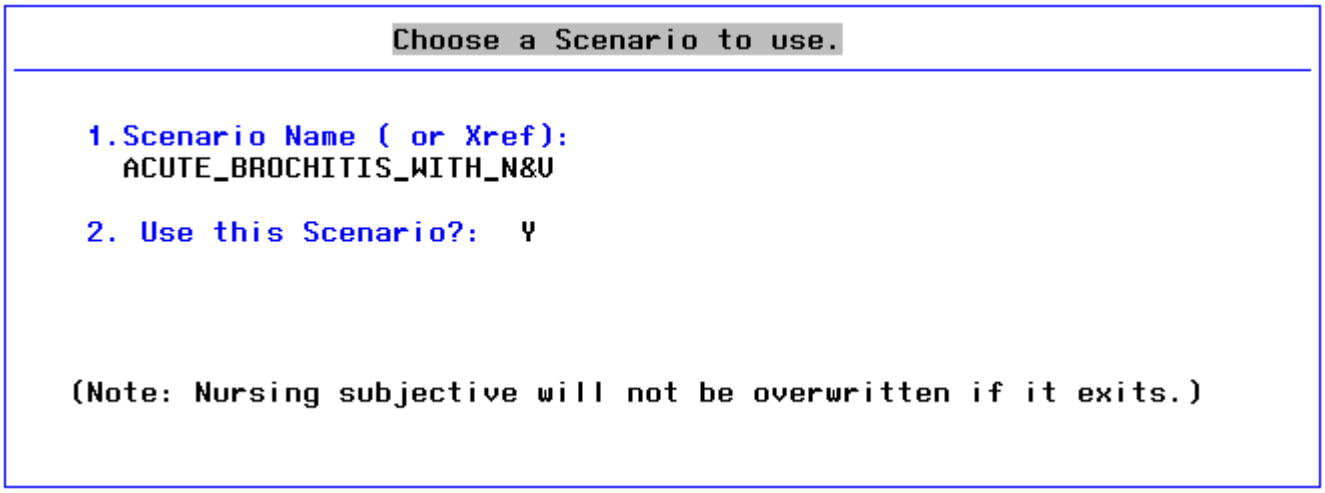


Figure 295 Scenario Selection Confirmation screen.

Once selected, you will immediately taken through a “Visit Review” (similar to the example shown in Figure 296) to show you what the note would look like if you exited at this time.

Upon completing review and hitting <enter>, you are returned to the provider “Orientation Screen” from which you can now branch to any part of the note or chart. The F-Keys at the bottom of the screen will quickly take you to the areas you want to go with one keystroke. The central F-Keys, F5, F6, F7, and F8 are for your “SOAP” note access, as can be seen on the sample “Orientation Screen” seen below in Figure 297.

QUICK OVERVIEW OF THE F-KEY FUNCTIONS ON THIS SCREEN.

You will note that the “Provider Visit” screens do not have the F1 key to “End (input)” or “Exit”. This was done to avoid exiting the note by accident, when returning from other screens, by using the F1 key once too many times. To exit, you must do this explicitly by hitting the <F12>, “**SgnOut**”, to signout.

F2,”**Help**”, will bring up a screen with a brief description of all the F-Keys on this screen.

```
FP090800-[1] SMART-DOCTOR by IMS of Alpine,TX                Visit Review - Inquire
 * 1.Visit Number: 144
     Patient Name: BONNER, JOHN J.                          Gen:
     Age:          72  yrs.  8.1 mos.
LINE ------------------ Visit Review (scroll to see all) ------------------------
   1 Patient's Date of Birth:   12/02/31
   2 Reason for Appointment:    COUGH
   3 Reason for Visit:          COUGH
   4 Date of Visit:             08/07/04
   5 Time of Visit:             9:00
   6 Patient indicated visit is not urgent
   7                      *****  Vital Signs  *****
   8 Recorded By: LINDA L. JONES, RX
   9 Temp. (F): 101.0*   Systolic BP:   190**   Weight:       236* lbs  oz
  10 Heart Rate:   106*  Diastolic BP:  80      Ht. in.:      70.0
  11 Respirations: 20*   Head Cir. cm.:         Ht/Wt Ratio:  49** % off Norm
  12                                            BMI:          33.9**
  13 Nursing Subjective:
  14   Coughing up a lot of yellow sputum, > 2 tbs. per day.
  15   Took Tylenol 3 hours ago.
  16            *****  Subjective Patient Information  *****
  17 Visit is New.
  18 Onset: 2 days
  19 Problem Number 1
  20  *Symptom/Quality/Reason*
  21   Pos. for, yellow sputum.
  22   Pos. for, cough -sputum > 2tbs.
  23   Pos. for, fever.
  24   Pos. for, nausea & vomiting.
  25   free
  26  *Body Area/System*
  27   Respiratory.
  28   Generalized.
  29  *Modifying Factors*
  30   Better with, resting.
  31  *Duration: Number of day(s), 2.
  32  *Timing: Const..
  33  *Severity: Minor - Self Limited(perm. impair. unlikely).
  34            *****  Objective Patient Information  *****
  35 *General Appearance:
  36          Normal
  37 *Ears:
  38          Normal
  39 *Nose & Sinuses:
  40   Nares:
  41    Bilat., serous drainage.
  42   Nasal Septum/Turbinates:
  43    Bilat., edematous.
  44   Maxillary Sinuses:
  45    Normal.
  46   Frontal Sinuses:
  47    Normal.
  48 *Mouth, Pharynx, Neck, Thyroid, Head:
  49   Mouth:
  50    Normal.
  51   Pharynx:
```

```
52    erythematous, pharynx.
53   Neck:
54    Normal.
55 *Lungs (Ausc, Percus, Palp, Effort):
56   Respiratory Effort:
57    Coughing.
58   Auscultation of Lungs:
59    Bilat., rhonchi.
60   Percussion of Lungs:
61    Normal.
62 *Lymph (neck, axilla, groin, other):
63   Neck Nodes:
64    Normal.
65 *Heart, VJD, & Ped. Edema:
66          Normal
67                      *****  Assessment  *****
68 466.0        ACUTE BRONCHITIS
69                     *****  Provider Plan  *****
70 Diagnosis Related Plans
71 ------------------------------------
72 Plan For: ACUTE BRONCHITIS
73 Take medications as directed.
74 Fluids. avoid acids like orange juice, tomatoes, grapefruit.
75 Chicken soup, etc. OK.
76 Robitussin-DM OTC prn cough.
77 Tylenol 650mg q4h prn fever over 102.
78 Call if not getting better in three days.
79 Provider: STEVE J. JOHNSON, MD
```

Figure 296 *Visit Review.*

```
FP090001 SMART-DOCTOR by IMS of Alpine,TX          OV - Provider Visit -     Add

* 1. Scheduled Provider:     SJJ
     Visit Number:           144
     Nursing Note:           144
     Patient Name:           BONNER, JOHN J.
     Sex:                    M                    LMP:
     Date of Birth:          12/02/1931  (Age: 72  yrs.  8.2 mos.)
     Reason for Appointment: COUGH
     Reason for Visit:       COUGH
     Referred By:
     Reason For Referral:
     Patient feels visit is  not urgent
     Nursing Intake by:      LINDA L. JONES, RX

 Temp. (F):  101.0*  | Systolic BP:     190** | Weight lbs:   236*  oz:
 Heart Rate:   106*  | Diastolic BP:     80   | Height In.:  70.0
 Respirations:  20*  | Head Cir. cm.:         | Ht/Wt Ratio:   49** % off Norm
                                                BMI:          33.9**
 Note: Coughing up a lot of yellow sputum, > 2 tbs. per day.
 Note: Took Tylenol 3 hours ago.

F2=Help F3=Scen F4=QM F5=S F6=O F7=A F8=P F9=VS F10=PtScd F11=ChtRv F12=SgnOut
```

Figure 297 *Provider Orientation screen.*

F3, “**Scen**”, will allow you to overlay additional scenarios over the current note without overwriting anything previously entered.

F4, “**QM**”, will bring up the Quick Menu screen as discussed in the “Basics” division of the manual.

F5, “**S**”, will bring you to the “Subjective” screens.

F6, “**O**”, will bring you to the “Objective” screens.

F7, “**A**”, will bring you to the “Assessment” screen.

F8, “**P**”, will bring you to the “Plan” screens.

F9, “**VS**”, will take you to the additional Vital Signs screen.

F10, “**PtScd**”, will take you first to the patient's insurance selection screens to change or see the insurance carrier to be billed. Hitting the F10 key again will show you the patient waiting times for this visit.

F11, “**ChtRv**”, will allow you to see any part of the patient chart including lab and images.

F12, “**SgnOut**”, will allow you to exit this note, taking you through a note review, immunization reminders, and assisted charge documentation.

We will now proceed to describe each of these branches with the exception of the simple F2 help screen, which is self explanatory, and the F4 key which is discussed in the “Basics” division of this manual.

Scenarios: <F3> “Scen” Screen.

You can hit the <F3> key to add the first or additional scenarios on top of the first scenario, or the documentation you have already done. Upon hilting the <F3> key, the window shown in Figure 298

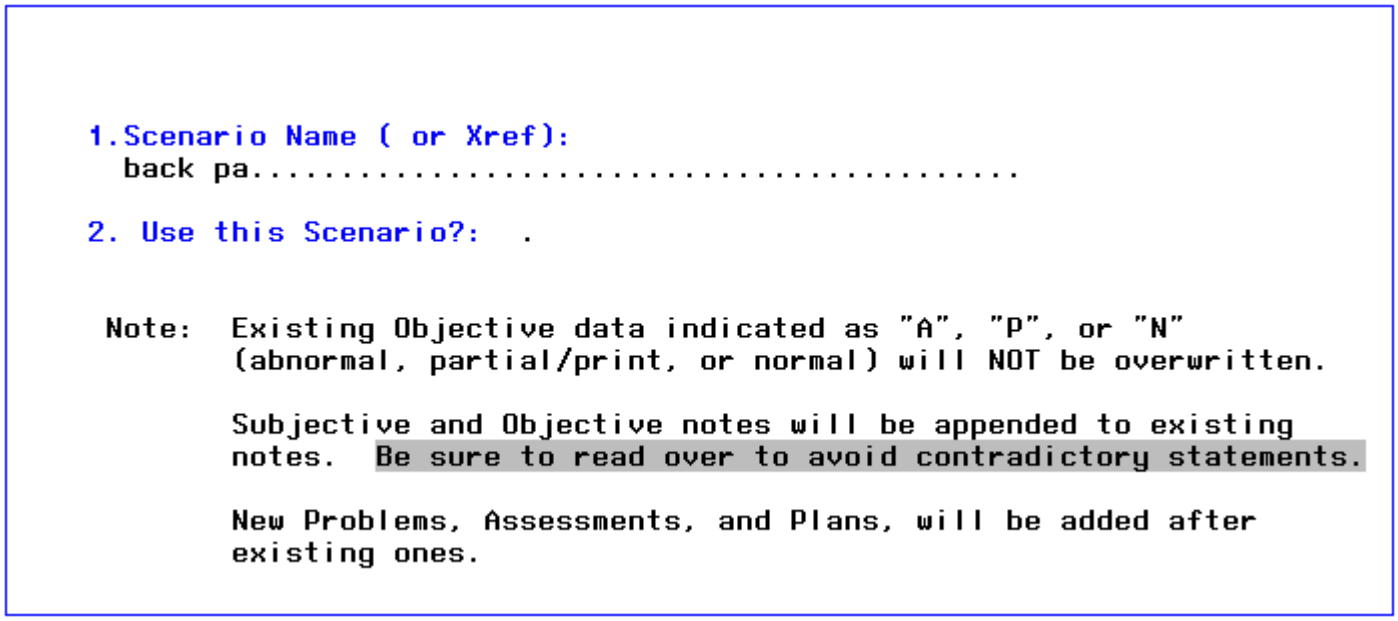


Figure 298 *Additional Scenario window.*

will be presented.

In this case we are entering a partial description of back pain. Here we are simulating that during the subsequent history and exam we noted a back pain complaint. After selecting the “Back Pain” “scenario” from the subsequent pop-up selection list, we see the window shown in Figure 299. Please read over the explanatory note on the bottom half of the screen.

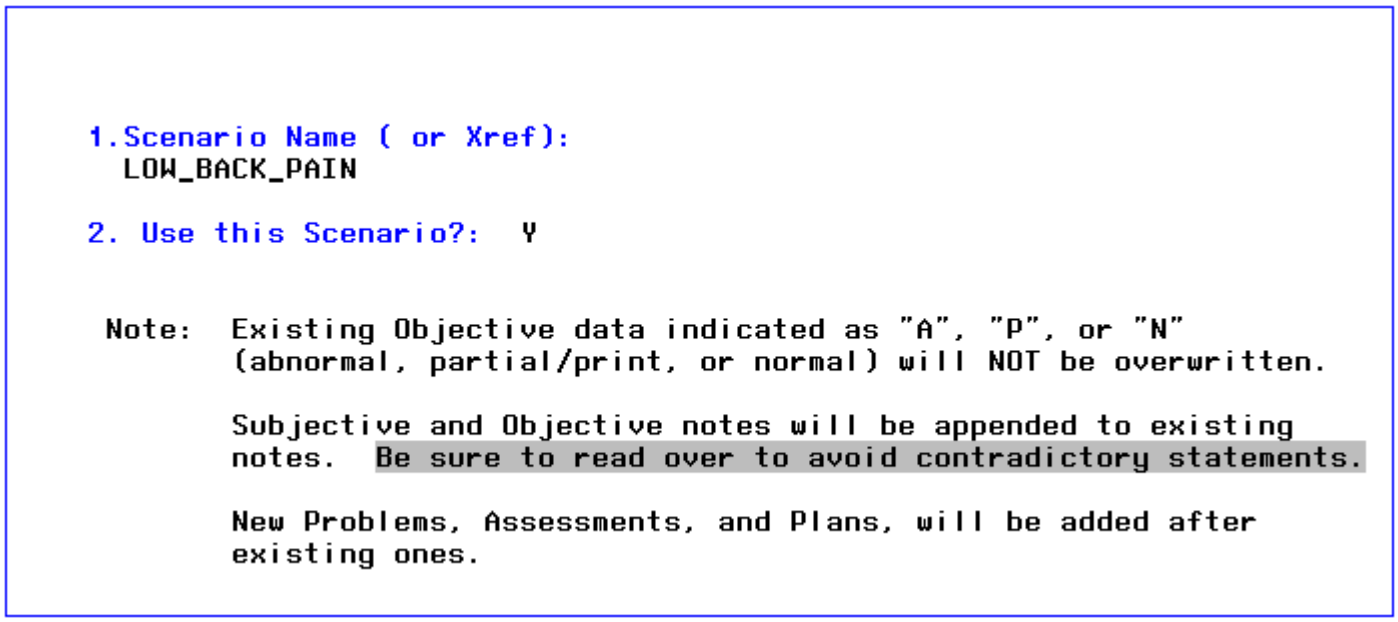


Figure 299 *Verifing Additional Scenario Selection.*

Subjective: <F5> “S” Screen.

Upon hitting the <F5> key, the “Subjective” screen is displayed, as shown in Figure 300.

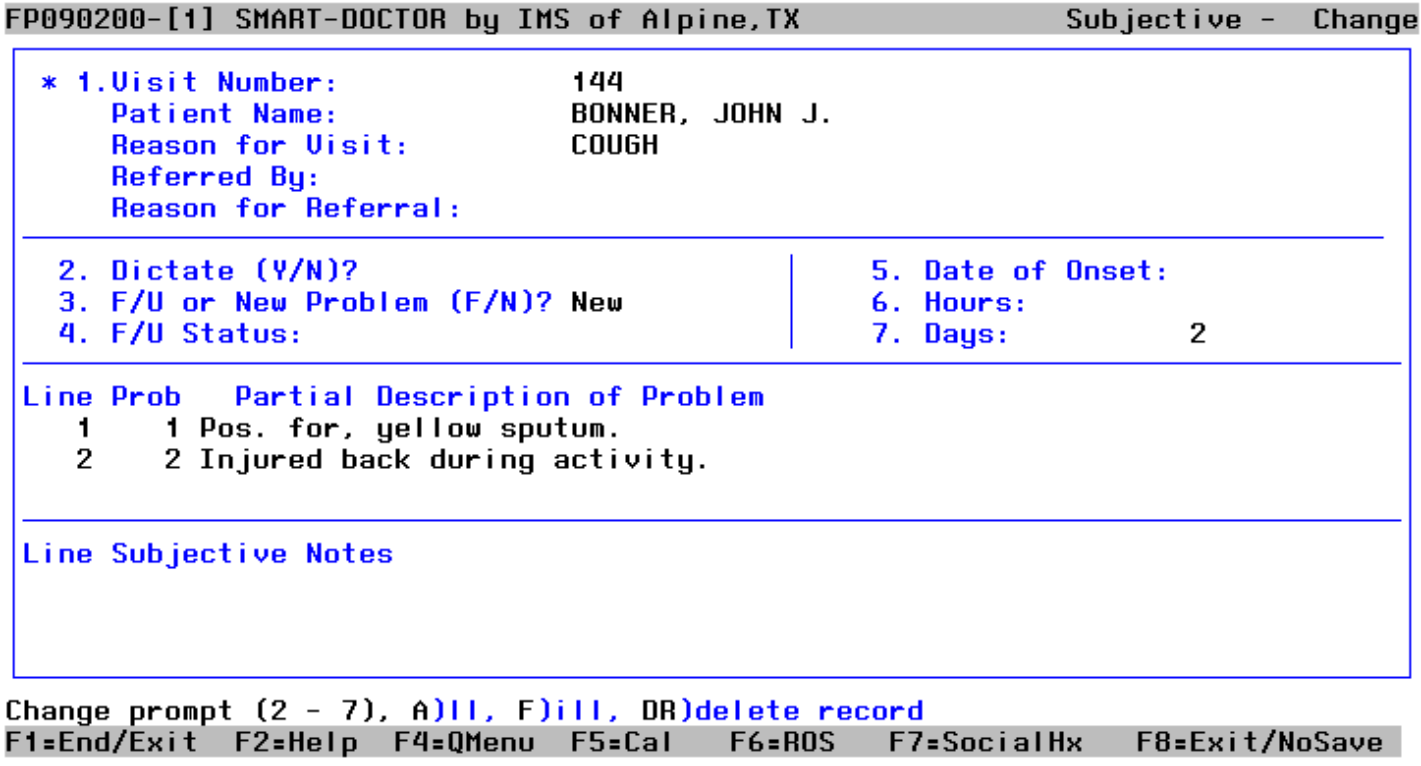


Figure 300 *Subjective Notes screen.*

Prompt #2, "**Dictate (Y/N)?**", select either "N" or "Y" from the pop-up selection box. Hitting the <enter> key will give you the default of "N". No dictation is the preferred way to used the system. In general it is less accurate and more expensive to dictate. The time it takes to dictate and then review the note is significantly longer than using the "Scenarios" method. However, in rare instances, it may be appropriate to dictate a note (as might be the case for psychiatric notes). In this case, dictate the visit number and all the demographics from the "orientation" screen. You can use the "SOAP" F-keys as an outline for the notes structure. Once dictated, the note can be added to the patient's file via the document images screens via a Visit encounter note or a Non-Visit encounter note.

Prompt #3, "**F/U or New Problem (F/N)?**", select either "New" or "F/U" from the pop-up selection box. The default will be "New" if you hit the <enter> on the first selection listed, which is set to "New". "New" should be only used for new onset or acute problems. "F/U" should be used for conditions that have been treated by you or an equivalent member of the doctor staff (i.e., not a consultant in your group). Setting this flag will affect billing charges recommended, so it is important to be correct.

Prompt #4, "**F/U Status:**", will be skipped if prompt #3 is set to "New". If prompt #3 is set to "F/U", then you will be presented with a choice of "Improved", "Baseline", or "Worse". Pick the appropriate response.

Prompt #5, "**Date of Onset:**", if you wish to enter a date, do so in form mm/dd/yy or mmddyy.

Prompt #6, "**Hours:**", enter the number of hours since onset of symptoms. If greater than 72 hrs. use the next field to enter in days.

Prompt #7, "**Days:**", enter the number of days since onset of symptoms.

Problem Number Multi-value: In the third section of this screen are the problems identified with this visit. In the above example, we see two problems. The "**Partial Description of Problem**" is taken from the first line of the subjective detail information screen. Each problem number has it's own associated detailed subjective screen. To add a problem, simply enter <a> at the multi-value prompt for "Prob. #". You could also enter the number of the existing problem number to review, add, or modify. Since in this example we have used the "acute bronchitis" scenario, we will enter a <1>, and look at the detailed subjective screen.

Problem Specific Subjective Record

Figure 301 shows the starting screen of the problem specific subjective note. The specific sections list items used by Medicare to audit and evaluate your E/M coding. All such audited screen prompts on all screens in the provider visits with an asterisk ("*") following the title are Medicare specific areas used in E/M coding. Other prompt headings without an asterisk were added by IMS for completeness.

In this screen a pop-up window displays the subjective types available to select from. This selection list comes from the TERMS file record "SUB-NOTES".

Discussion of Subjective Types:

You have a choice of subject pop-ups to choose from, as well as the ability to add more of your own choosing. When you first go into the subjective screen you will have a pop-up giving you a choice of subjective term set to use. You can change the set of subjective terms

used at any time by hitting the F6 key and picking another set to use. The "DEFAULT" type of subjective information is obtained from the following TERMS file records HX-QUALITY, HX-BODY_AREA, HX-CONTEXT, HX-MODIFY, HX-LASTS, HX-TIMING, HX-SEVERE, HX-ASSOC. These can all be modified by the clinic administrator with IMS assistance. The default selection contain the largest number of subjective terms. The system has the ability to add as many more disease specific terms as you want. This is done via the TERMS file using the SUB-NOTES record. This contains additional symptom specific partial keys which need to be appended to any of the following terms to make a new unique key to be used in place of the DEFAULT keys above: “QUALITY-”, “AREASYS-”, “CONTEXT-”, “MODIFY-”, “LASTS-”, “TIMING-”, “SEVERE-”, and “ASSOC-”. The SUB-NOTES key should always have the first term of the Terms Description equal to "DEFAULT", and the second term equal to"FREE_TEXT". Following this you may add any other symptom partial keys you wish.

As an example, we have added HTN as the third term description. The length of the appended term is restricted to a maximum of 12 characters. For each new symptom specific subjective set you wish to make, you must make up a corresponding symptom specific full key. For HTN, this should be: QUALITY-HTN, AREASYS-HTN, CONTEXT-HTN, MODIFY-HTN,LASTS-HTN, TIMING-HTN, SEVERE-HTN, and ASSOC-HTN. You do not need to add all eight subjective areas, since any omitted will use the default settings. See QUALITY-HTN as an example.

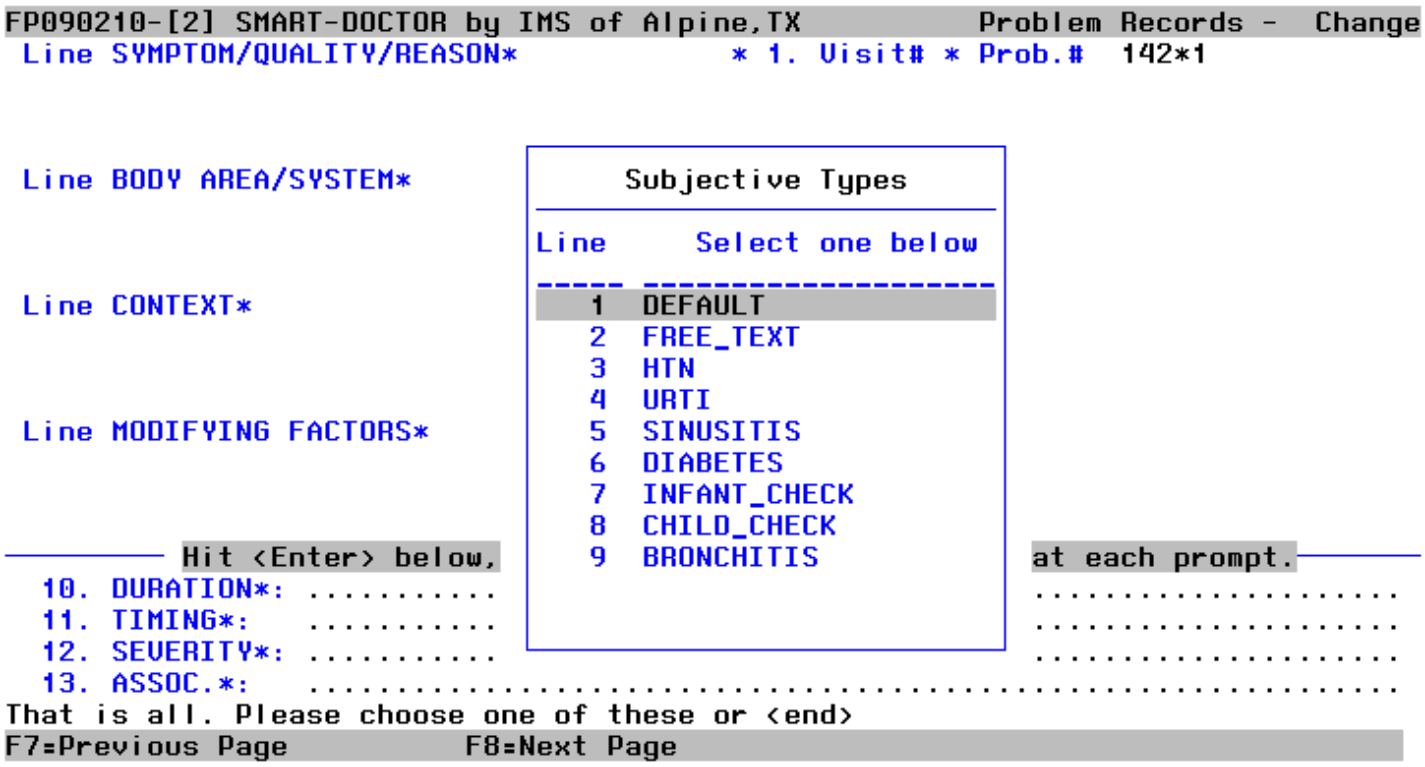


Figure 301 *Selecting Subjective type for Problem.*

Upon hitting <enter>, the “DEFAULT” of subjective terms will be used. You can also select another type listed here. Hitting <F1> to “end” selection will leave the prior subject type setting.
In this case, we just wanted to see what was documented before so we hit the <F1> key to “end” selection. The screen shown in Figure 302 shows the “scenario” information placed earlier.

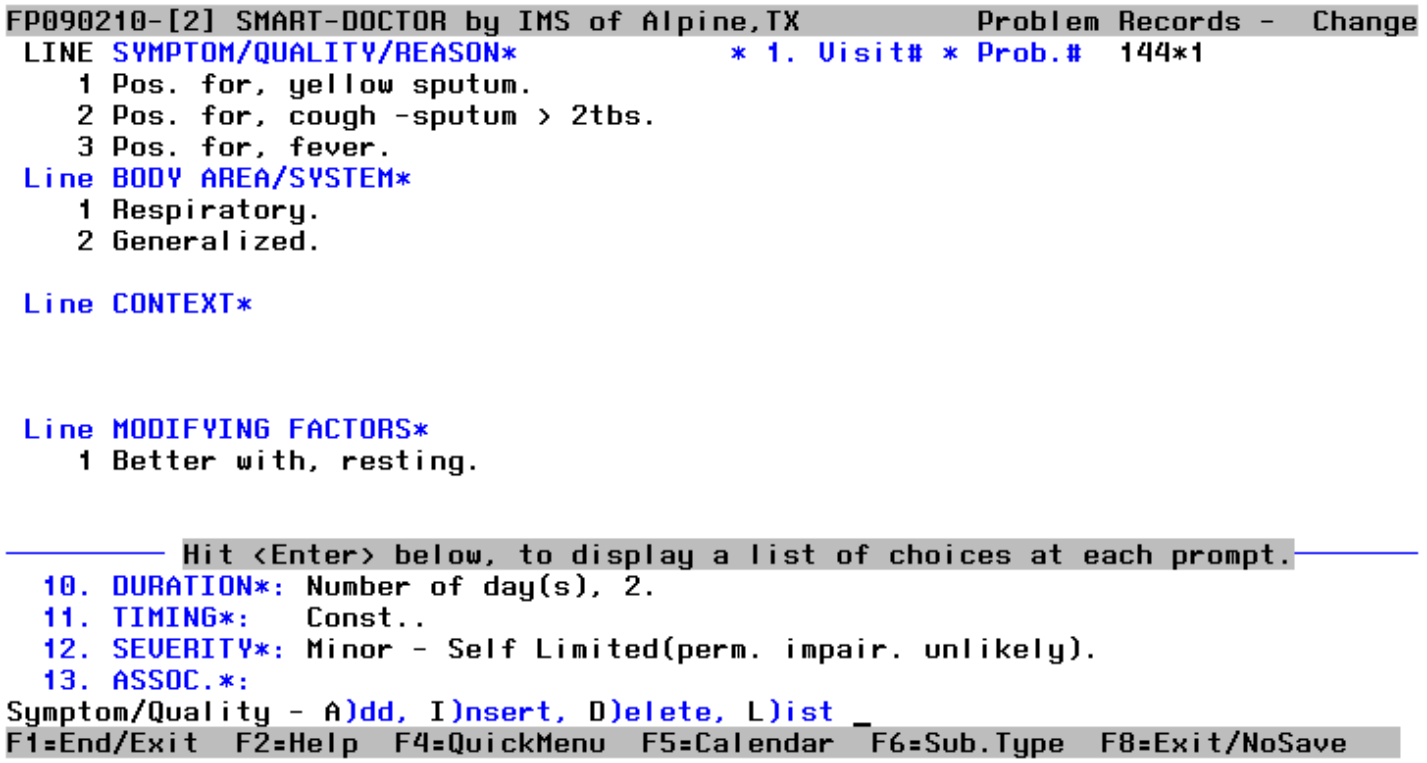


Figure 302 Problem screen Populated with Scenario Information.

As an example of using this system, we will add a statement that the patient had no chest pain associated with these Quality symptoms. Since the symptom is bronchitis, we changed the "Subjective Type" to "BRONCHITIS", by hitting the <F6>, "Sub.Type" key, an selecting

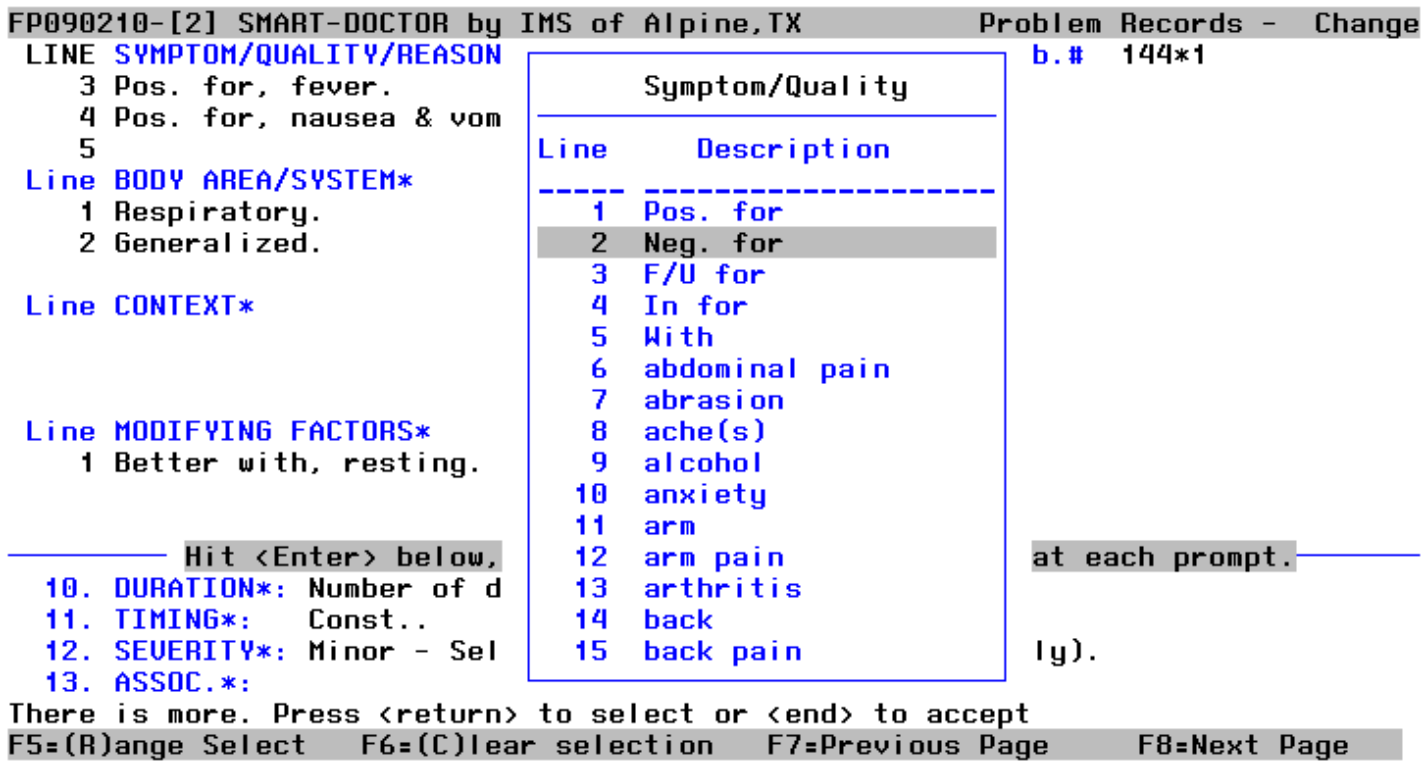


Figure 303 Entering Symptom Terms Using Bronchitis List.

"BRONCHITIS". Next, at the "Symptom/Quality" change prompt, enter <a> to add. The screen now appears as shown in Figure 303.

You should notice several things on this screen. First, the multi-value prompt, "**SYMPTOM/QUALITY/REASON**", has been scrolled down to open line #5. If you see all the lines filled between the prompts, you should scroll down in these prompts to be sure you have seen all the information. Second, the number of lines you can have in each multi-valued prompt on this screen is unlimited. Third, the pop-up selection box is now specific to bronchitis terms. Here we have highlighted "Neg for". This is a multi-select prompt that has more than the 15 terms presented. You can tell this by looking above the bottom bar where you will see the message "**There is more. Press <return> to select or <end> to accept**". Upon pressing <enter> (or <return>), an asterisk will be placed next to each choice. To un-select, highlight that line again and hit <enter> again. The asterisk will be removed, indicating the line is unselected. Once you are through selecting the terms you wish, hit the <F1> key to "end" selection. The system will then take the selected terms from the top of the list down and construct a pseudo sentence. Then, if finished, hit <F1> without selecting when the next line opens and the pop-up multi-selection box is presented. The screen shown in Figure 304 shows the result of selecting "Neg. for" and "chest pain" for line #5:

```
FP090210-[2] SMART-DOCTOR by IMS of Alpine,TX          Problem Records -  Change
 LINE SYMPTOM/QUALITY/REASON*            * 1. Visit# * Prob.#  144*1
    4 Pos. for, nausea & vomiting.
    5 Neg. for, chest pain.

 Line BODY AREA/SYSTEM*
    1 Respiratory.
    2 Generalized.

 Line CONTEXT*



 Line MODIFYING FACTORS*
    1 Better with, resting.


--------- Hit <Enter> below, to display a list of choices at each prompt.---------
  10. DURATION*: Number of day(s), 2.
  11. TIMING*:   Const..
  12. SEVERITY*: Minor - Self Limited(perm. impair. unlikely).
  13. ASSOC.*:
Symptom/Quality - A)dd, I)nsert, D)elete, L)ist _
F1=End/Exit  F2=Help  F4=QuickMenu  F5=Calendar  F6=Sub.Type  F8=Exit/NoSave
```

Figure 304 *Result of Adding Selected Terms.*

The remaining Multi-value prompts on this screen act in the same manner.

The final single value prompts #10 through #13 are slightly different. Upon selecting to go into each of these prompts, you first hit <enter> as indicated just above these prompts. You will then be presented with a multi-select pop-up as on the upper half of the screen. However, the number of items selected must be done logically. We are trying to save you typing time and get consistency of terminology by presenting these pop-ups. In prompts #11 & #12, only select one term. Selecting more for these two prompts would be illogical since they are mutually exclusive terms. Prompt #13 can have multiple selections as can #10.

Upon completing this screen, you will be returned to the main subjective screen.

At the bottom of the subjective screen is the "**Subjective Notes**" multi-value prompt (see Figure 300). This is to be used to enter any information to difficult to enter into the standard subjective screens. This is completely "free text" and unlimited in the number of lines you can enter. This may be a place to document that you had a prolonged discussion related to this patient's anxious depression after losing his wife. Note the discussion lasted 45 minutes. Should you be audited, you can show the amount of time you spent in counseling this patient. The standard E/M evaluator and this system cannot analyze this type of information to come up with a suggested E/M code. So, just document your work here.

Review of Systems <F6> "ROS" screen from main Subjective screen.

Upon hitting this F-key, the screen seen in Figure305 is presented.

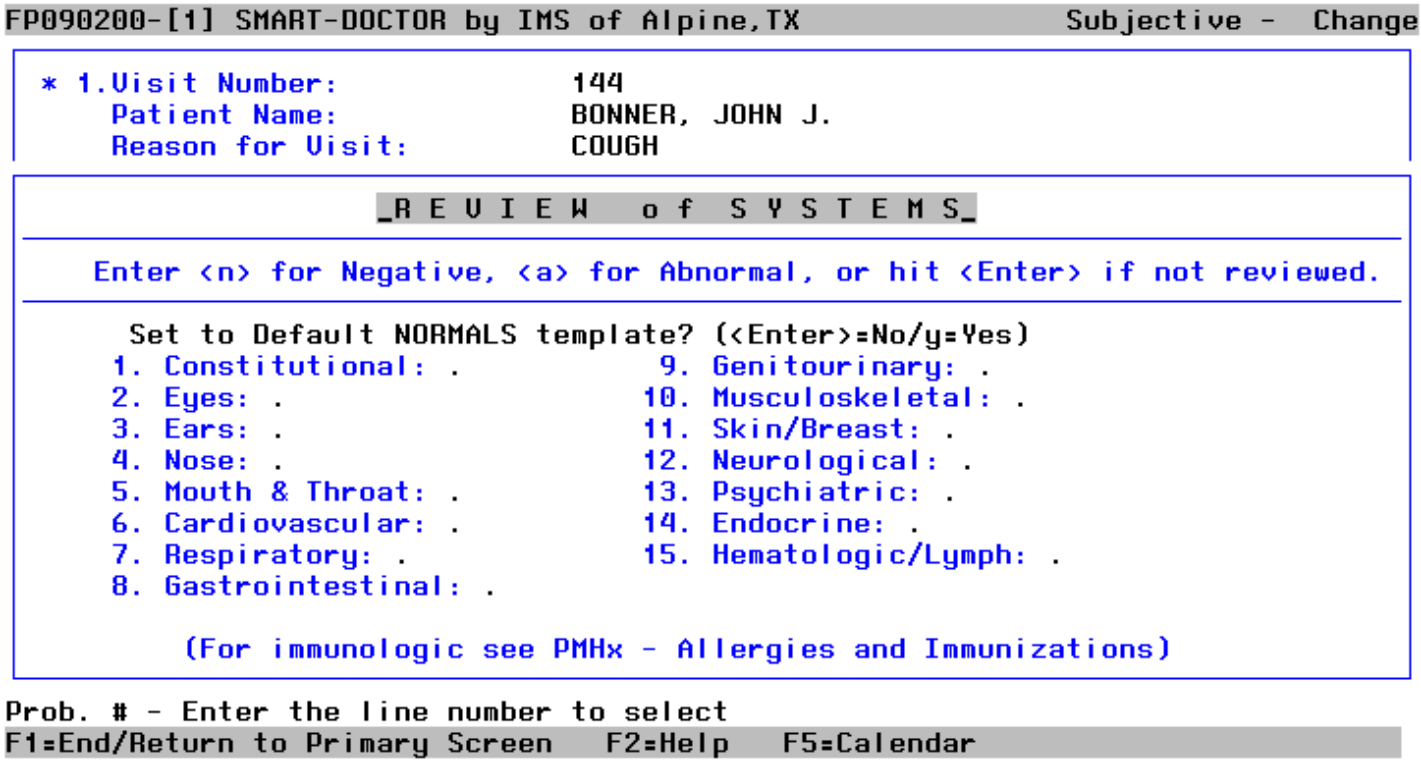


Figure 305 *Review of Systems screen.*

Every time you enter this screen, you will have the option to set all these ROS terms to normal. The default response of <enter> is "No". Hitting <F1> at this point will also result in not setting these prompts to "N" for normal. If you enter <y>, them all prompts will be set to "N" for normal. Once past this, you will see the following change prompt:

"**Change prompt (1 - 15), A)ll, F)ill**"

This works in the standard manner as described in the "Basics" section of this manual. As you are going through these, follow the instructions just above these prompt items to "Enter <n> for Negative, <a> for Abnormal, or hit <Enter> if not reviewed." Also, if a value has been set in one of these prompts to "n" or "a", you can either over type it with the opposite letter, or enter a space

followed by <enter> to clear it completely. The prompt logic works the same for each of these prompts. Entering an "n" will cause this to show up on chart review as "Normal". It will not show up at all if blank.

Upon entering "a" for abnormal in prompt #7, "**Respiratory**", you will be placed in the screen shown in Figure 306.

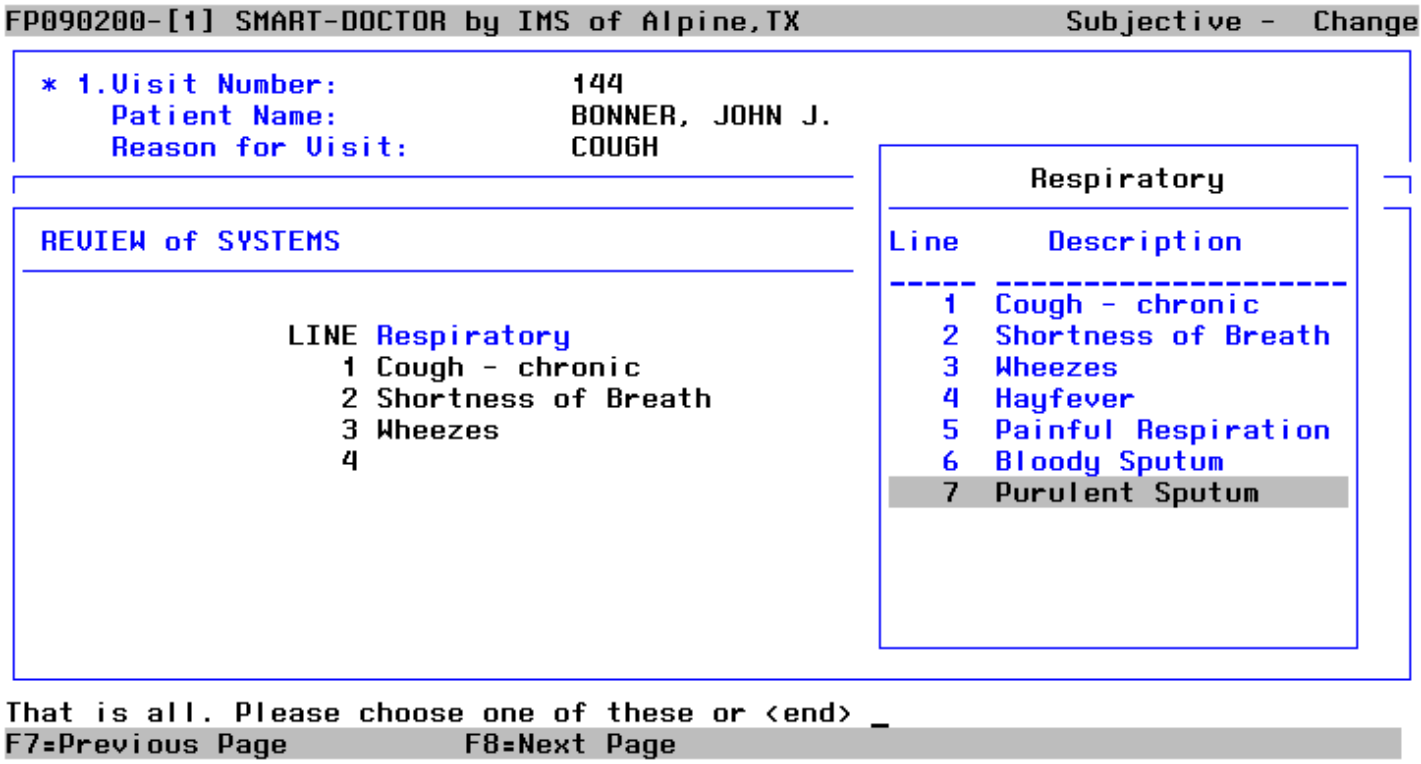


Figure 306 *Selecting Respiratory ROS Terms.*

In this multi-valued prompt, as each line is added the pop-up single selection box will be presented to select from. Again, do this in a logical way. If you happen to select an item twice in the list, delete the unneeded line number. After selecting this last item on the list, we hit the <F1> to "end" input. You will then be at the change prompt on this screen to "A)dd, I)nsert, D)elete, L)ist". Once complete, hit the <F1> to "end" input and return to the prior screen.

The terms that are presented in these pop-up selection screens can be changed by the clinic, with assistance from IMS. The record keys for these terms all start with "ROS-", with the appropriate ROS area attached such as, "ROS-RESPIRATORY".

If we did a "Chart Review" now, and selected "Review Current Visit", we would see the following information in the ROS section:

```
52 Review of Systems
53 -----------------
54 Respiratory:       Cough - chronic
55                    Shortness of Breath
56                    Wheezes
57                    Purulent Sputum
```

Social History <F7> "SocialHx" screen from main Subjective screen.
Upon hitting this F-key, the screen shown in Figure 307 is presented.

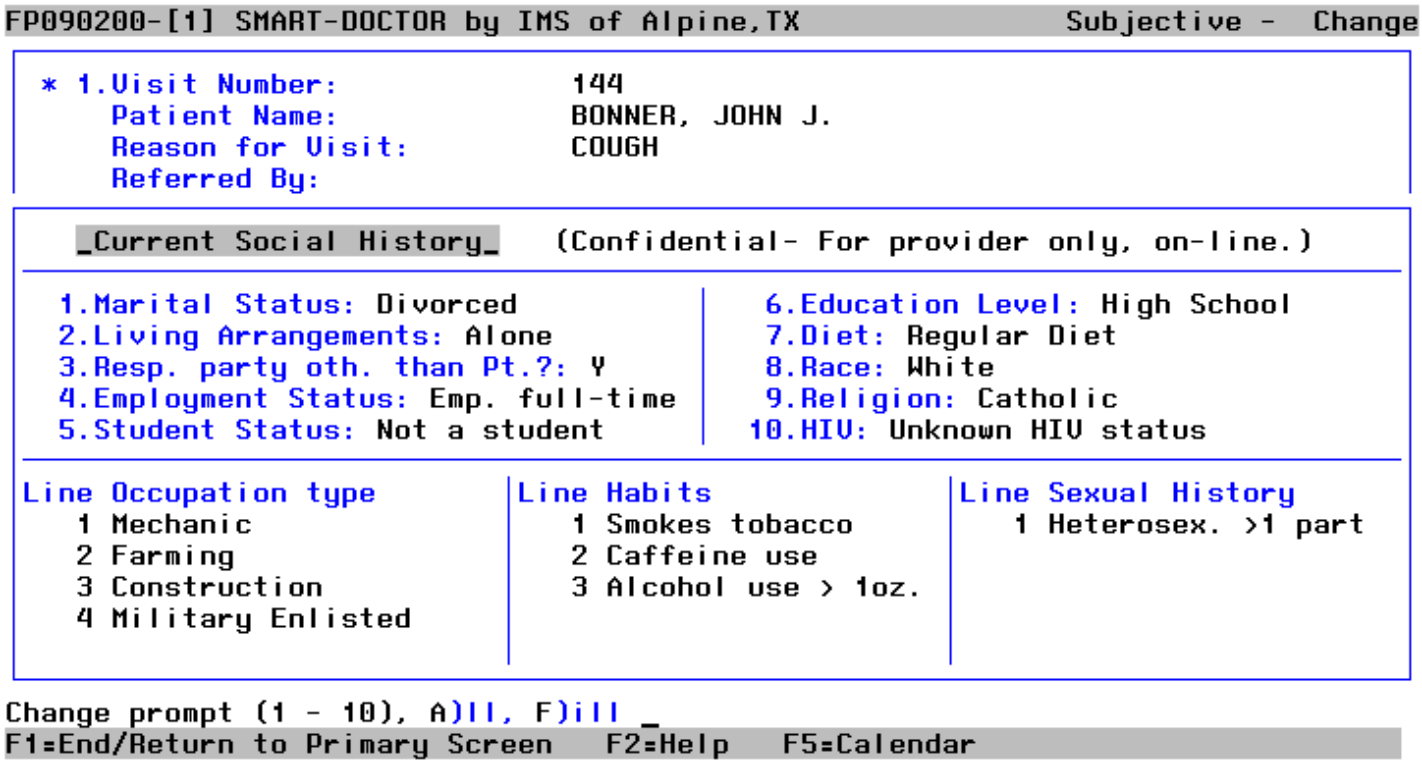


Figure 307 *Provider Only, Social History screen.*

This screen can only be seen by providers, and only on-line. This information is never printed on any reports or chart printouts. Further to view these screens a visit must be scheduled, or you must be a provider that is allowed to use the “Doctor Main Menu” and use the the “Non-Scheduled Provider Visit”.

Prompts #1 through #5 are common to the patient's “Patient File” record. Changing data in either screen will affect the other, and will be seen on a screen refresh. Prompts #1through #10 are all single value prompts. Each of these are associated with single selection pop-up screens. The three multi-valued prompts on the lower half of the screen “Occupation type”, “Habits”, and “Sexual History”, also have the same type of association to the single selection pop-up screens. The terms presented in these single selection pop-up screens are maintained in the TERMS file with record keys starting with “HX-”. Appended to these are terms taken from the prompts above. For example, the “Habits” record key is “HX-HABITS”. These can be changed by the clinic administrator with assistance from IMS.

The logic to be used for the order of items listed in the multi-valued prompts on this screen (“Occupation type”, “Habits”, and “Sexual History”) should be the most recent at the top, or line #1. Therefore, under “Occupation”, this patient was first in the military, then in construction, then farming, and now is working as a mechanic. His habits are all those listed. His sexual history shows only “Heterosex. >1 part”. If the sexual history changes, it would be appropriate to leave the older information and to insert the new information into prompt #1. For example, the patient's wife died, and he is no longer sexually active.

From the “Orientation Screen” again.

Objective: <F6> “O” Screen.

Upon hitting the <F6>, “**O**” key, you will be taken to the screen seen in Figure 308 below.

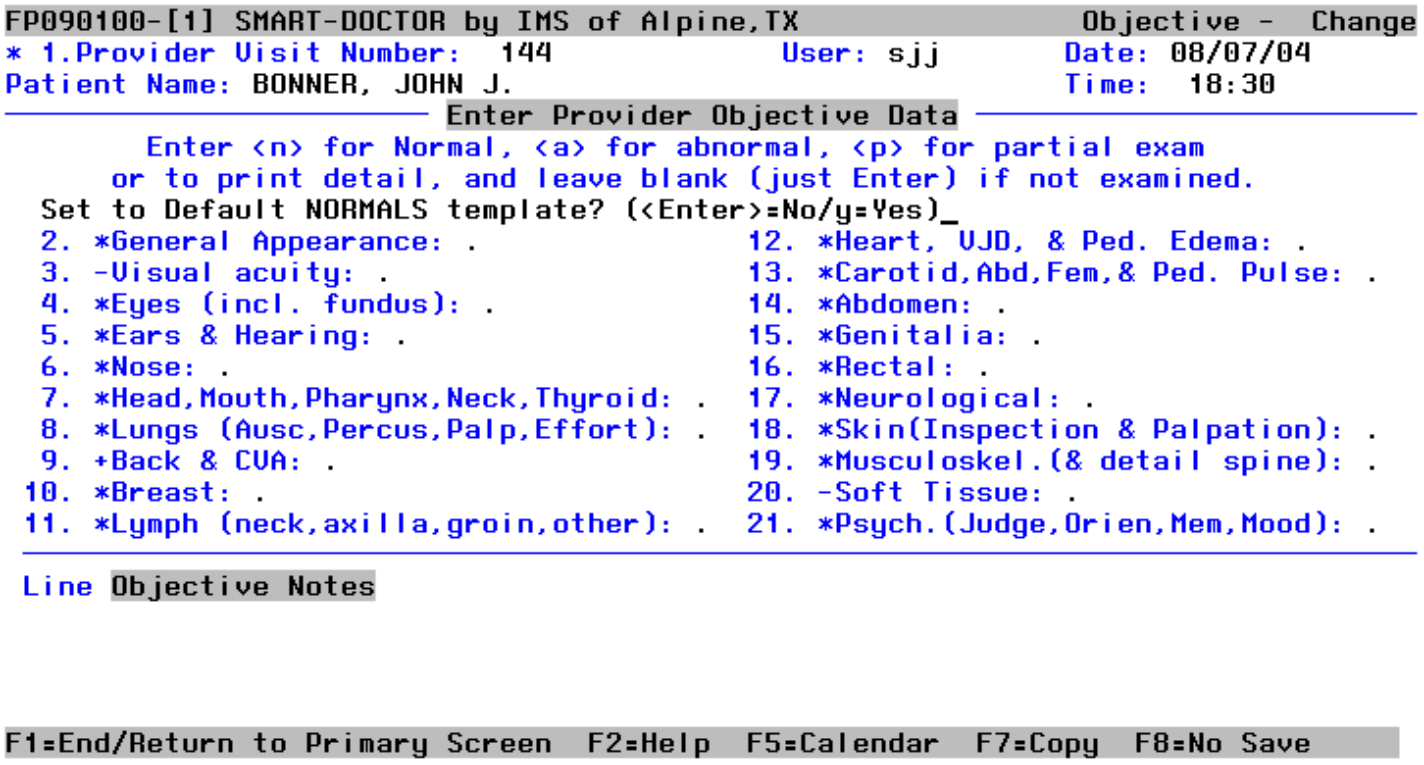


Figure 308 Objective screen.

Every time you go into this screen you will be presented with the following screen prompt:

"**Set to Default NORMALS template? (<Enter>=No/y=Yes)**"

If you didn't indicate a scenario earlier, you are doing a fresh documentation, and most of the exam you have done is normal, you may want to enter <y> here. If you do so, the selection pop-up window seen in Figure 309 below will appear.

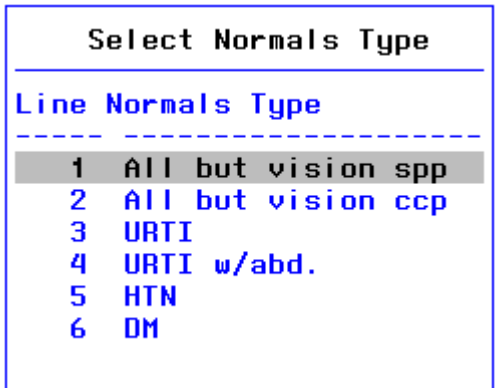


Figure 309 Select Default

These choices and their meanings are defined in the TERMS file under the record key of "ADM-NL-MAIN". These can be changed by the clinic administrator with the assistance of IMS. In this example, two doctors have different things they examine during a physical exam and, therefore, would like to set those items they examine to normal. Also, only certain items my be checked and found to be normal for disease specific exams. Having selected one of these will set the items you

specified to normal. However, from the change prompt you can go back and modify any of these if they are not normal.

In the following screen (Figure 210) is seen the current example. We hit <enter> (or <F1>) so as not to change what was set by the two scenarios we chose earlier.

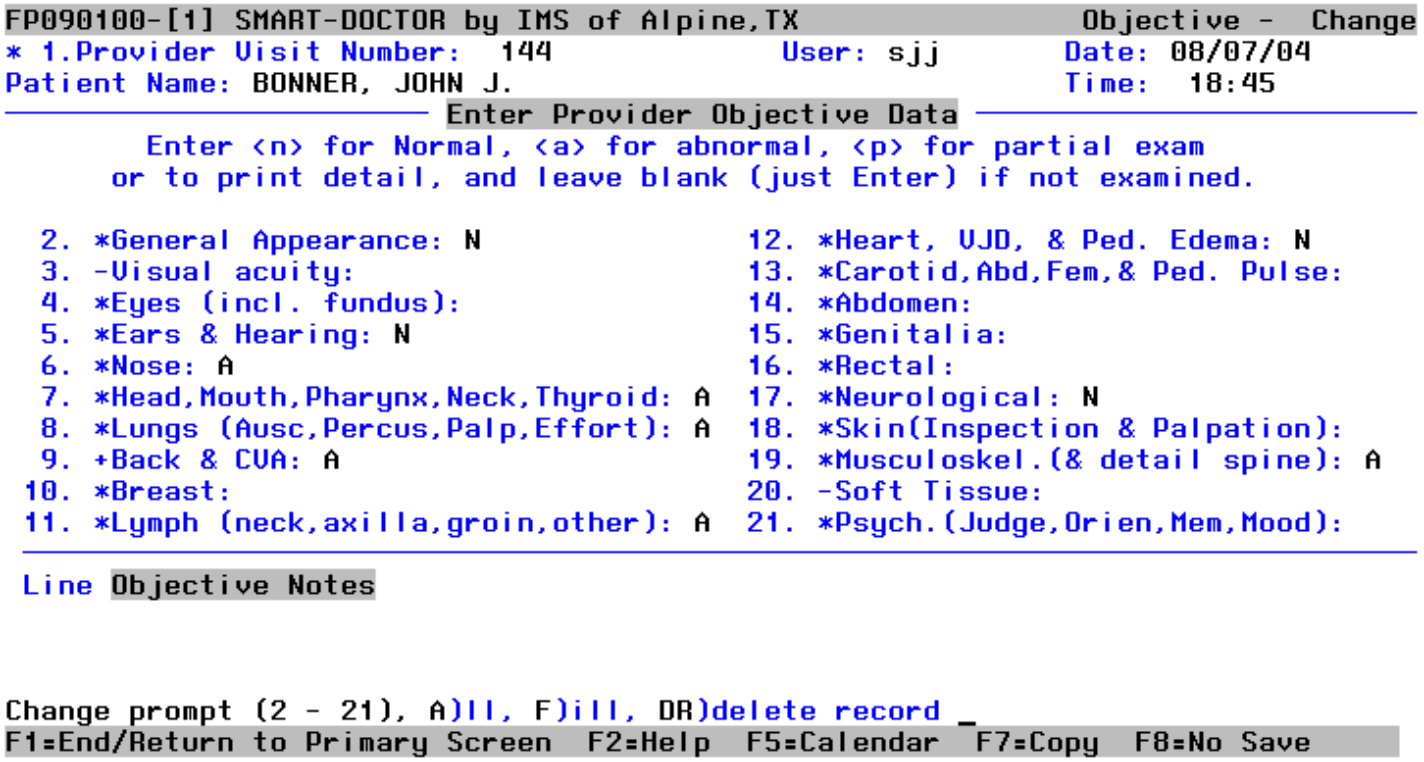


Figure 310 Objective screen with Normals & Abnormals Set.

This screen is similar to the subjective screen. On the top portion, you can go to specific prompts for assisted documentation, and the last multi-valued prompt for “Objective Notes” is unlimited free text. The “Objective Notes” should be reserved for documentation that is too difficult to document with the templated information provided.

The general flags set in these prompts determine if a sub-screen is open for more detailed information. As indicated just above the prompts, “Enter <n> for Normal, <a> for abnormal, <p> for partial exam or to print detail, and leave blank (just Enter) if not examined” In some cases, a carrier may request to see all the actual components of an exam rather than accepting that the entire organ system was examined and found to be normal. Also, sometimes only part of an organ system is examined. These are the cases when you should use the “P” indicator for a partial exam or to list out (and print if the record is printed) what was examined. For example, for osteopathic manipulation, it is necessary to document each spinal level examined, as well as major joints, for reimbursement.

Prompts 2 through #21 work in generally the same way. One of the major differences is that there is no free text option. Free text is only available in the “Objective note” discussed above. However, there are two general types. First, is a series of multi-valued prompts similar to the “Subjective Problem Record” discussed above. The second is similar, but has a multiple column input. Both will be discussed below.

First is an example of the multi-valued screen prompt that has only one field that is derived from a multi-select pop-up list. For this example, we will use the prompt #8 ,"***Lungs (Ausc,Percus,Palp,Effort):**". Upon selecting this item from the change prompt and entering <a>, the screen seen in Figure 311 will open.

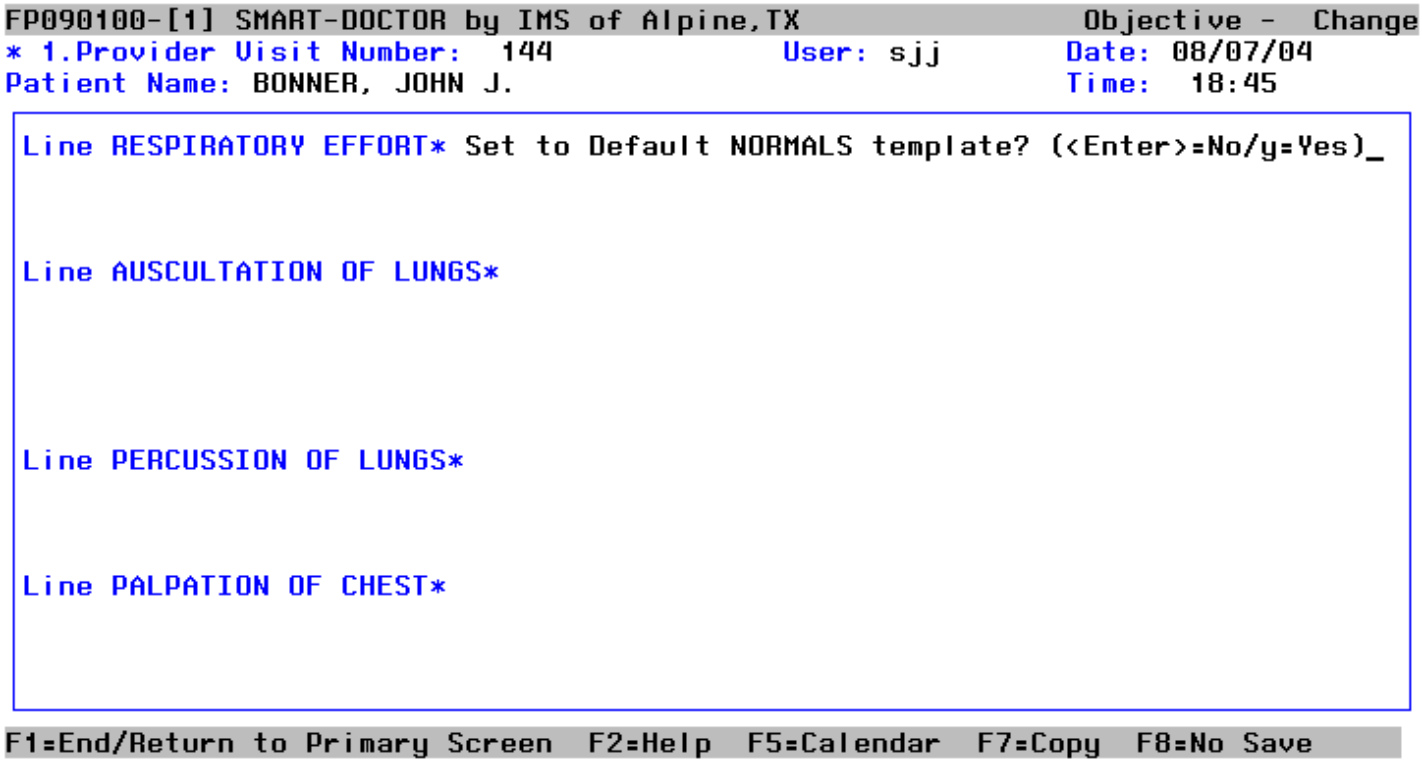


Figure 311 Lung Examination screen.

The default "NORMALS" option is similar to the ROS option discussed earlier. If <y> is entered, then all multi-values are set to "Normal". To add to one of these multi-valued prompts after the first is set to "Normal" requires you to first delete the "Normal" line.

In this example, we will hit <enter> (for "No") to preserve what was defaulted into all these prompts as a result of the "scenarios" chosen. The screen then will appear as seen in Figure 312 below.

We will hit <enter> to skip to the second multi-value prompt "**AUSCULTATION OF LUNGS***". Again as mention in the subjective notes section, the prompts with an asterisk are evaluated for E/M coding. Those not so flagged were added for completeness.

Notice that "**LINE**" (in Figure 312) of the second multi-valued prompt is highlighted and in capital letters, and, at the bottom of the screen (above the bottom bar), the multi-valued change prompt indicates "**Auscultation Lungs**" which corresponds to the highlighted line. Here, we will add an additional note as seen Figure 313 below.

Here (Figure 313), we have done a multi-select on "**Bilat.**" and "**wheezes**". Hitting <F1> once to end the selection and once to end multi-value input for this prompt. We then see the resulting screen shown in Figure 314 below, with a new pseudo sentence indicating "**Bilat., wheezes.**".

To exit this screen without entering any further information, simply <F1> through the remaining prompts.

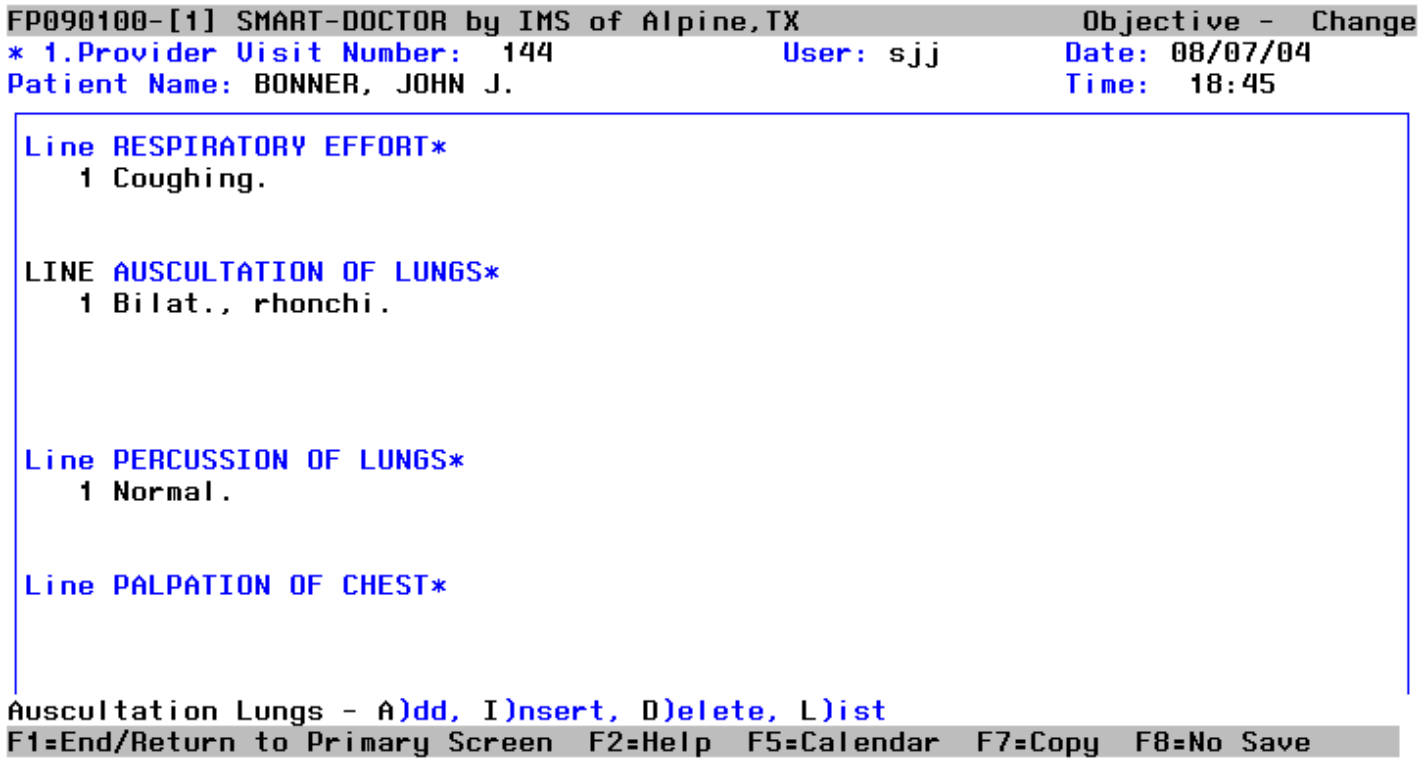


Figure 312 *Lung Exam with Scenario Settings.*

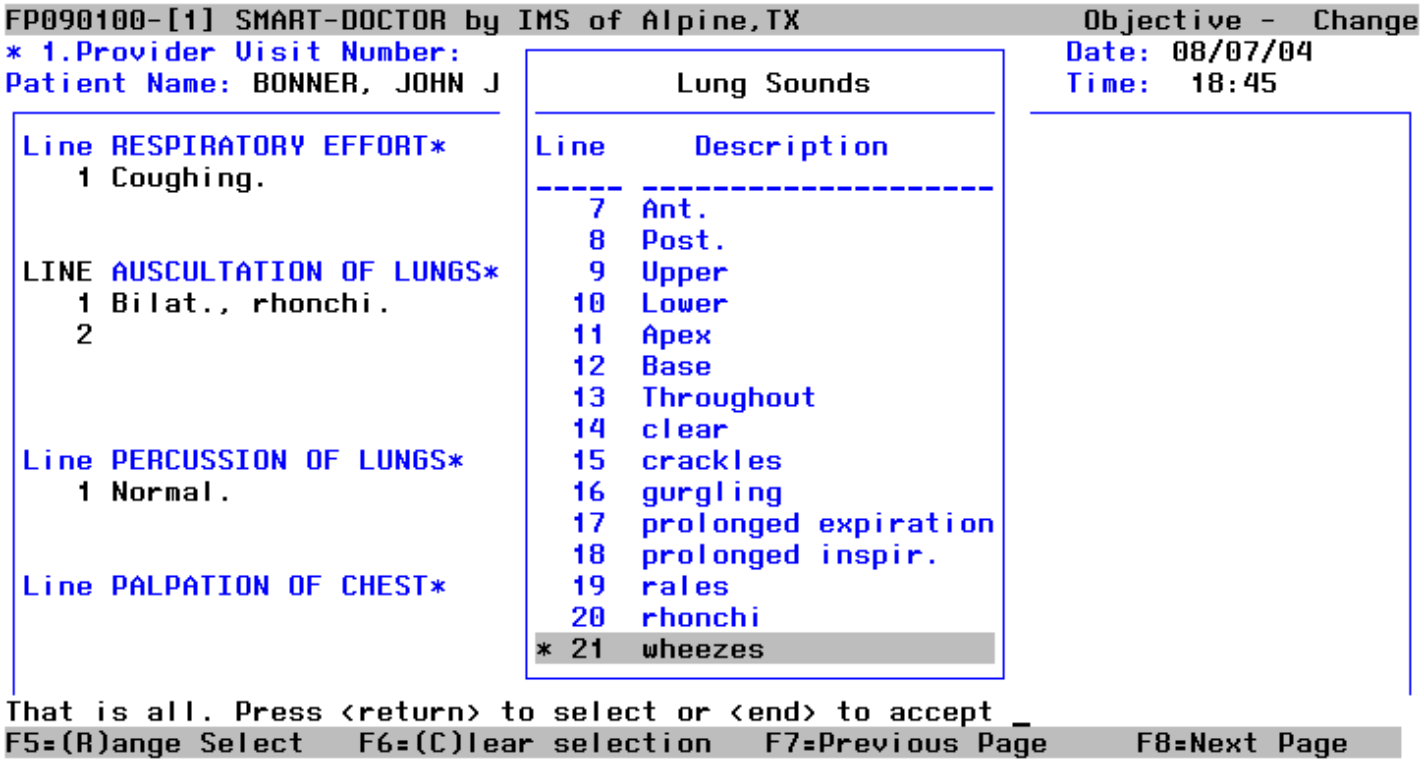


Figure 313 *Selecting Lung Sounds.*

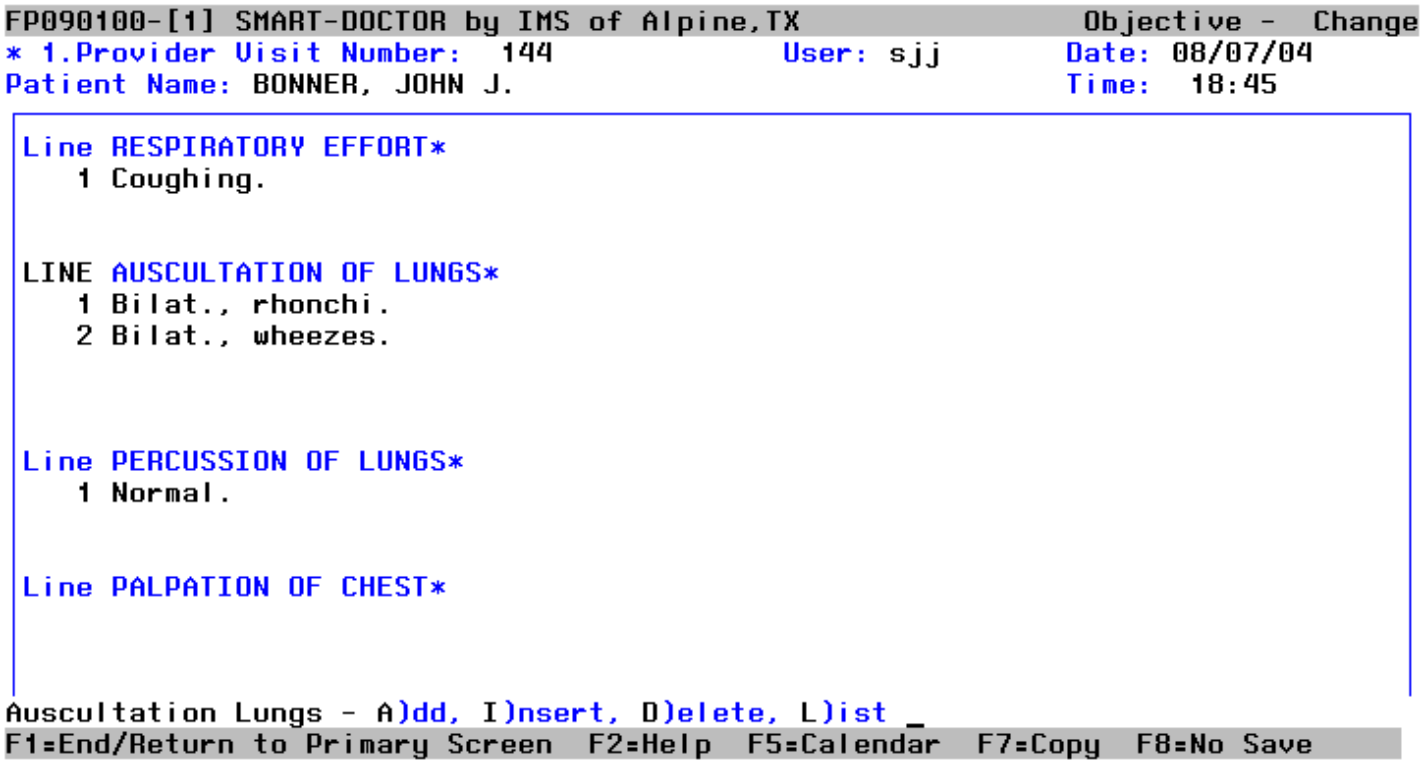


Figure 314 *Lung Sounds Completed.*

The second example is that of a multi-valued screen prompt that has multiple column input. The input for each column is derived from a multi-select pop-up list. For this example, we will use prompt #12, "***Heart, VJD, & Ped. Edema:**". Upon selecting this item from the change prompt and entering <p> for a partial exam, the screen seen in Figure 315 will open.

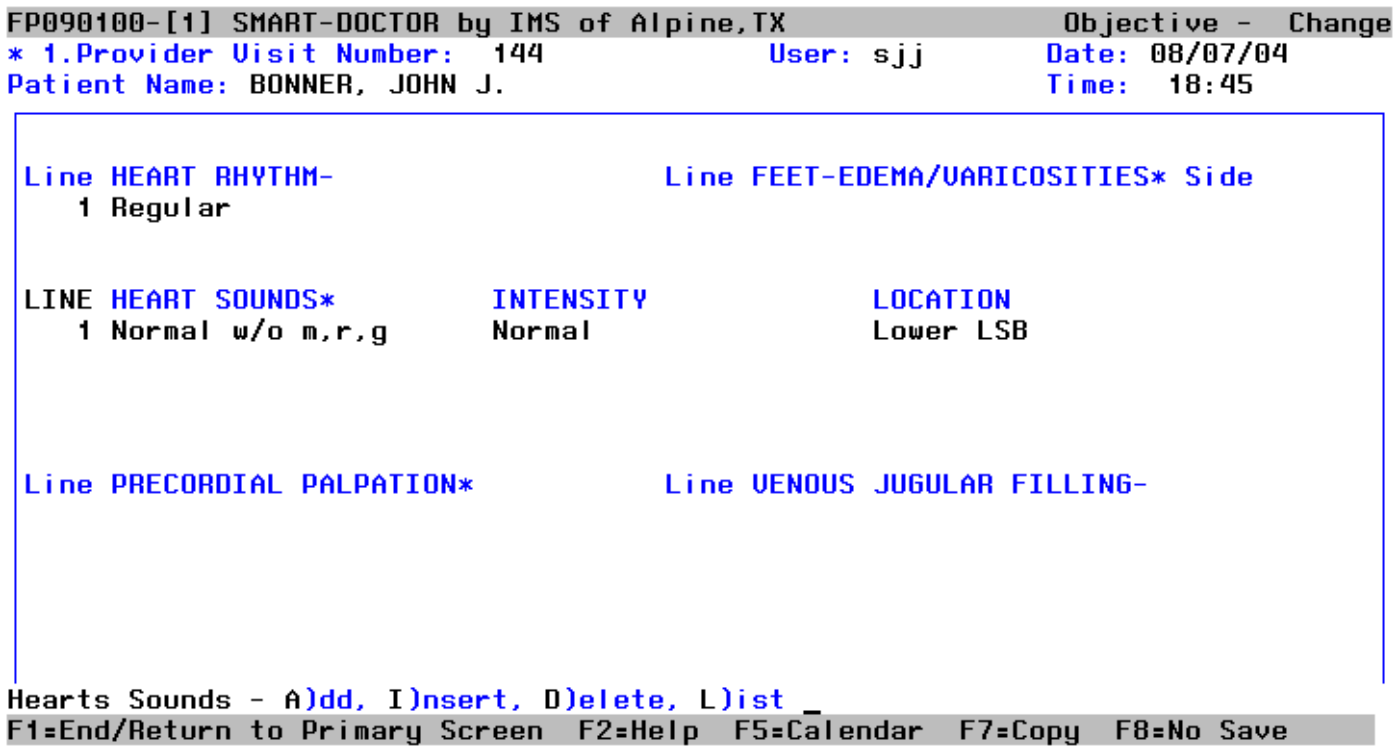


Figure 315 *Heart Exam screen.*

In this partial exam, only the Heart Rhythm and Heart sound were were done. Here we will add a murmur to "**Heart Sounds***". You will see as each field is entered a single selection window pops-up, the "**Heart Sounds**" selection first, as seen in Figure 316.

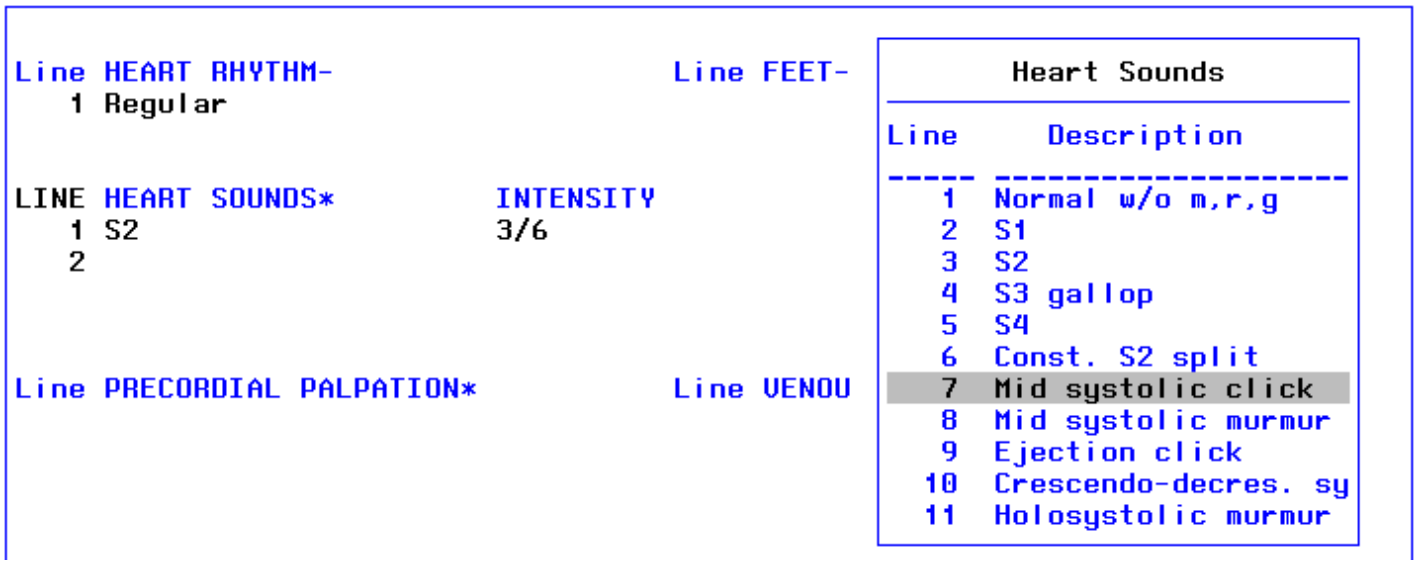


Figure 316 *Heart Sounds Selection.*

Heart sounds intensity selection is next as seen in Figure 317 below.

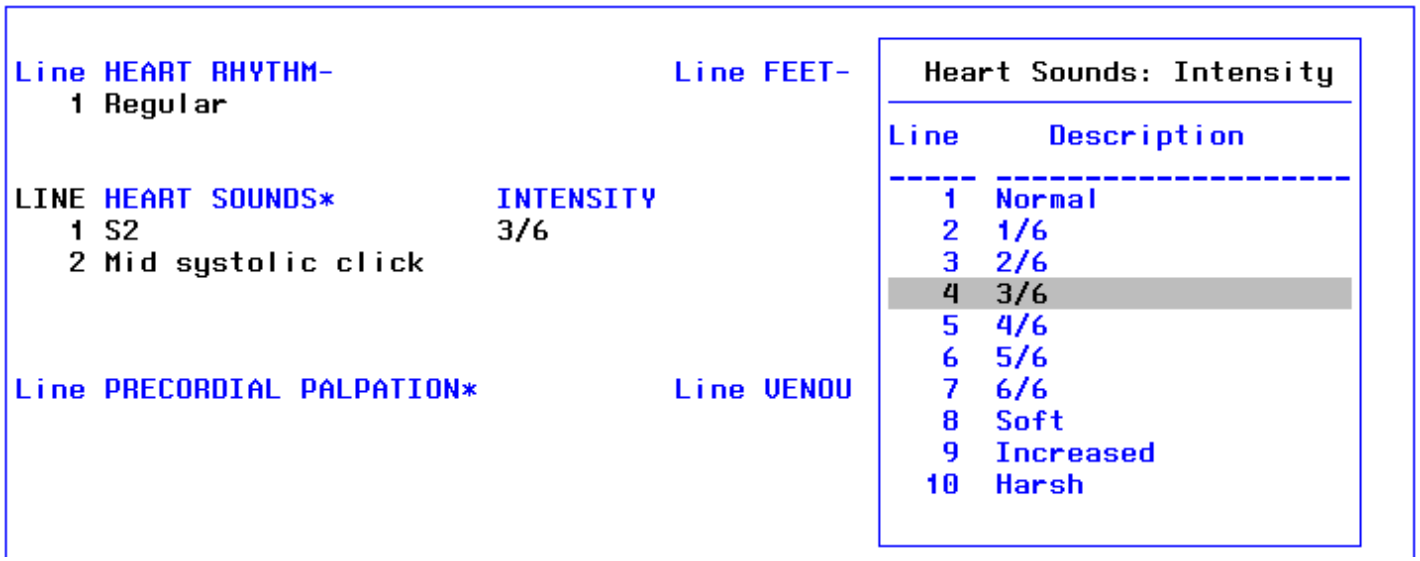


Figure 317 *Heart Sounds, Intensity.*

Location of heart sounds selection is next as seen in Figure 318.

Resulting screen after the changes made above can be seen in Figure 319.

Hit the <F1> key repeatedly to skip remaining prompts, and return to main "Objective" screen.

*Objective Copy <F7>, "**Copy**" screen.* Hit <F7> "**Copy**" to copy an objective exam from a prior visit. This may be extremely useful for a patient with a complicated and abnormal physical exam. Rather

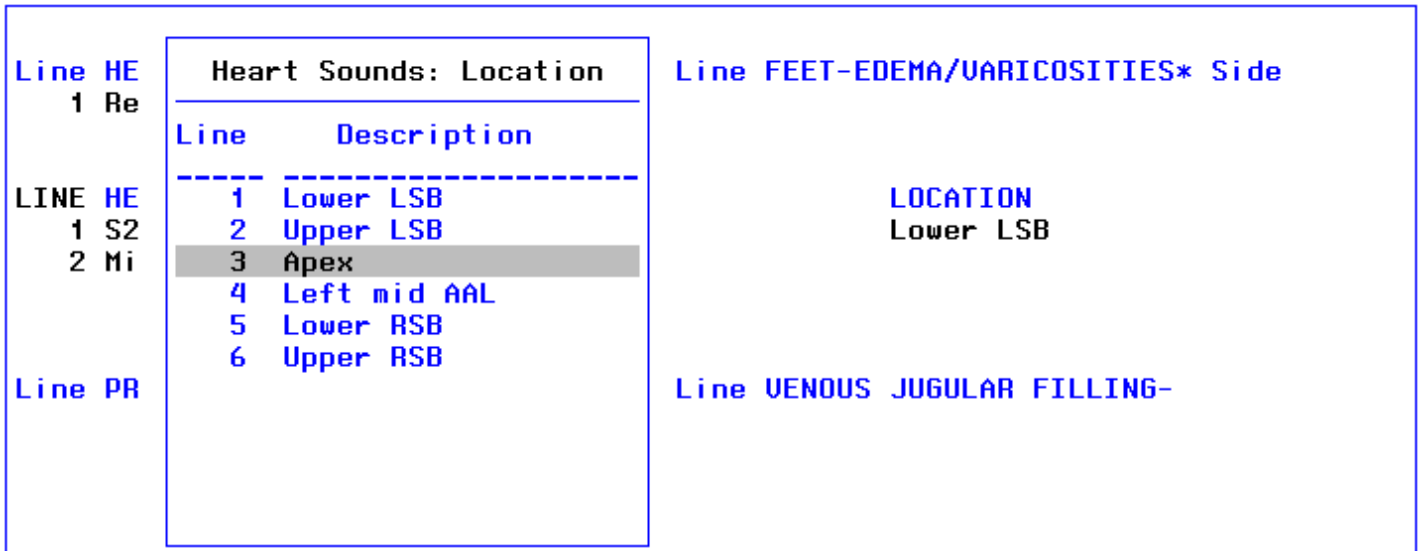


Figure 318 *Heart Sounds, Location.*

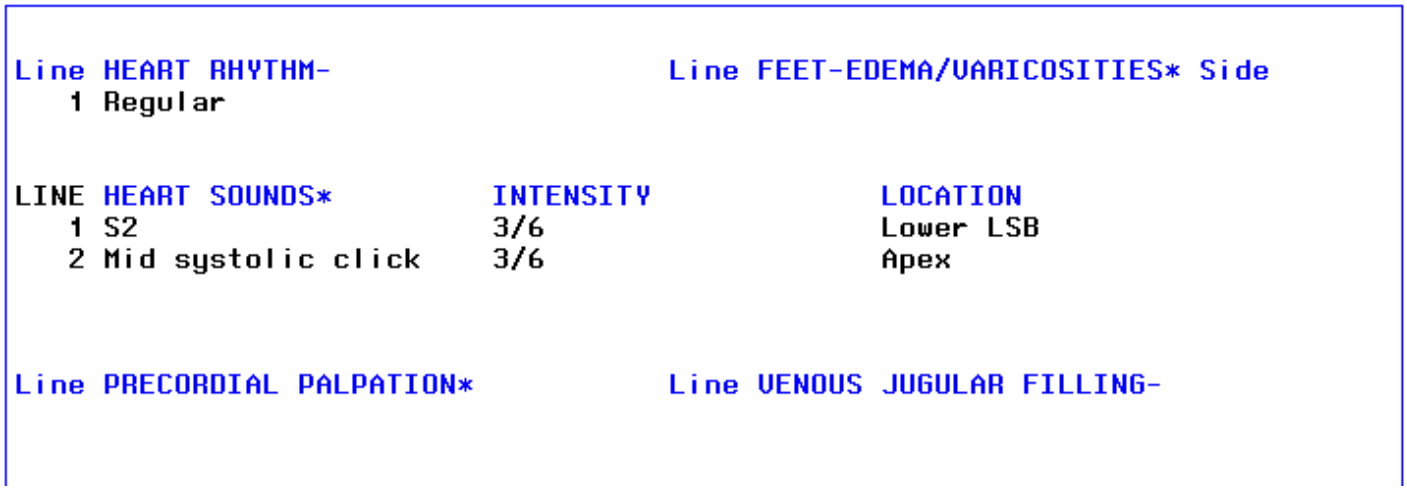


Figure 319 *Heart Sounds Revised.*

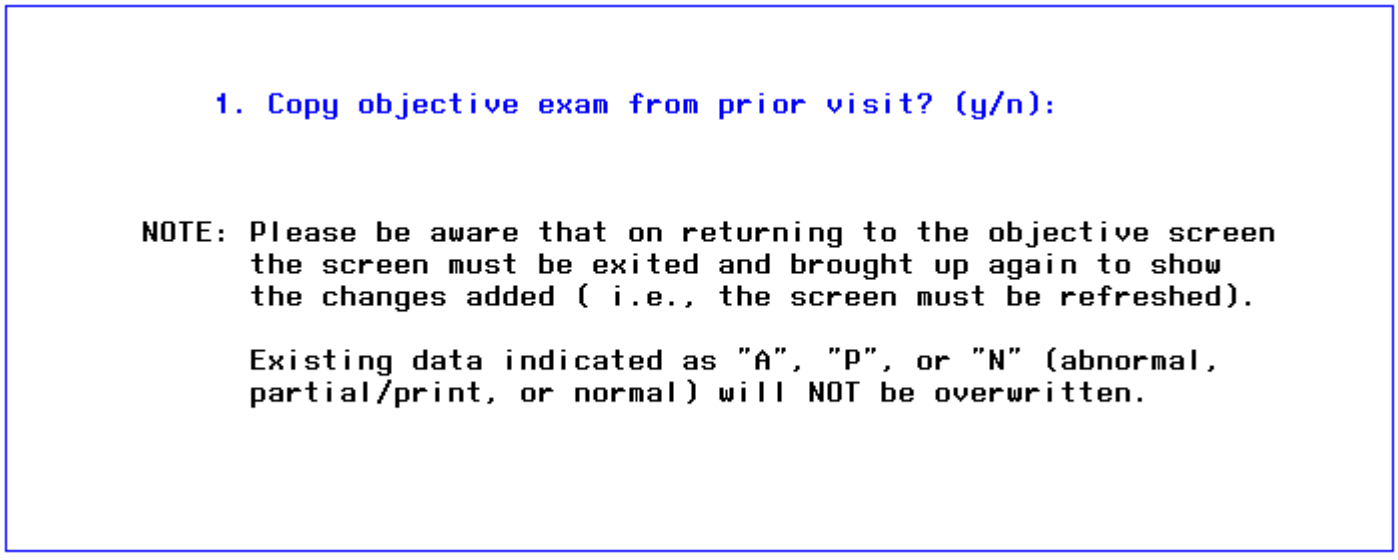


Figure 320 *Copy Objective Exam window.*

than re-document the entire exam, you can copy it in from a prior visit note. Then modify the exam for the current changes. Upon hitting the <F7> "**Copy**" key, you open the pop-up window shown in Figure 320.

At the change prompt on this screen, enter <1> to go to prompt #1. Here, enter <y> to start the objective note copy. Review the note on the bottom half of the window shown above (Figure 320). Having read this note, it should be apparent that you cannot copy over existing information. So, unless you have not done any documentation on the "Objective" screens, you must be sure that objective area you want to copy into from a prior note is blank. For example, if you wanted to copy a detailed back exam from a prior visit, before hitting the <F7>--Copy key, you should go to prompt #19, "***Musculoskel.(& detail spine):**", and enter a <space> key to blank the field and get rid of the "**A**" currently there (as seen in Figure 310). Of course, you can go back and do this now if you forgot. The next screen presented (Figure 321) will let you select the prior visit encounter you want to copy the objective data from.

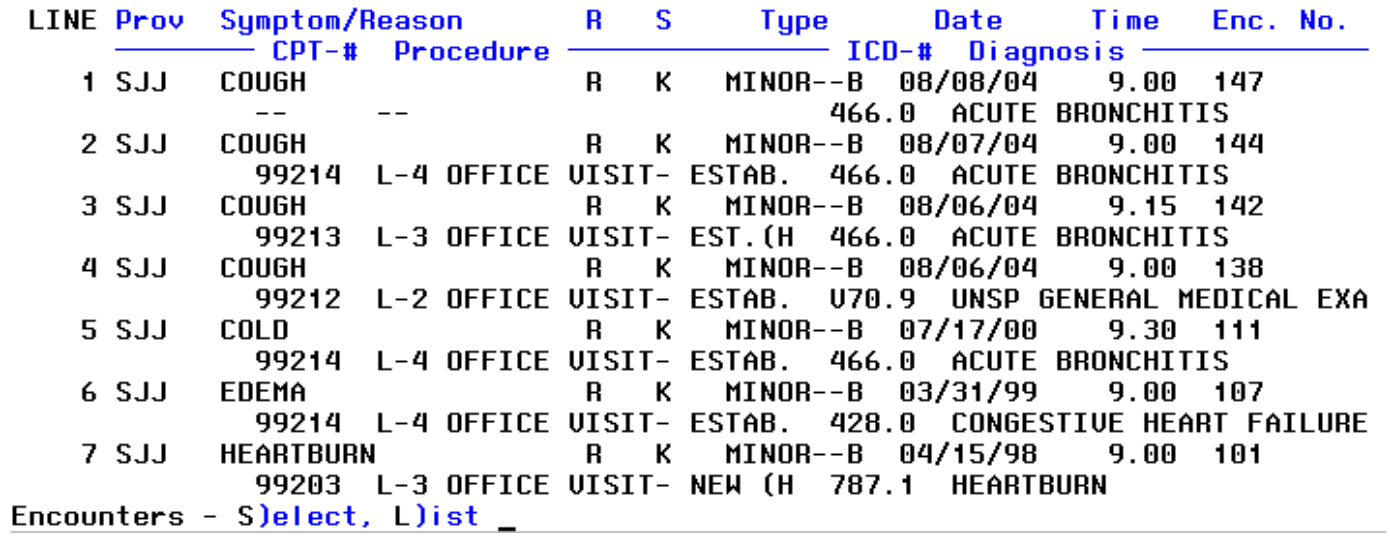


Figure 321 Selecting Prior Visit Note to Copy Objective Exam.

Line #1 on the above screen is the current visit. So, you would enter the line number other visits to copy. You can page down through this list to find the appropriate visit objective data to copy. Once copied, you will see the following message come up just above the bottom bar on the screen:

"**Data copied, F1 back to Objective screen, return to continue**"

Hit <F1> as indicated. You can copy from as many prior visits as you want. Just remember, only those prompts that are blank on the main objective screen will have prior visit data copied in.

From the "Orientation Screen" again.

Assessment: <F7> "A" Screen.

Upon hitting the <F7> "A" key the screen shown in Figure 322 will come up.

You see listed here the two assessments from the selected two scenarios. The first was selected after the initial chart review, and the second later. You can now add, insert, delete, and list (page through) diagnoses. There are several important points to make regarding assessments that

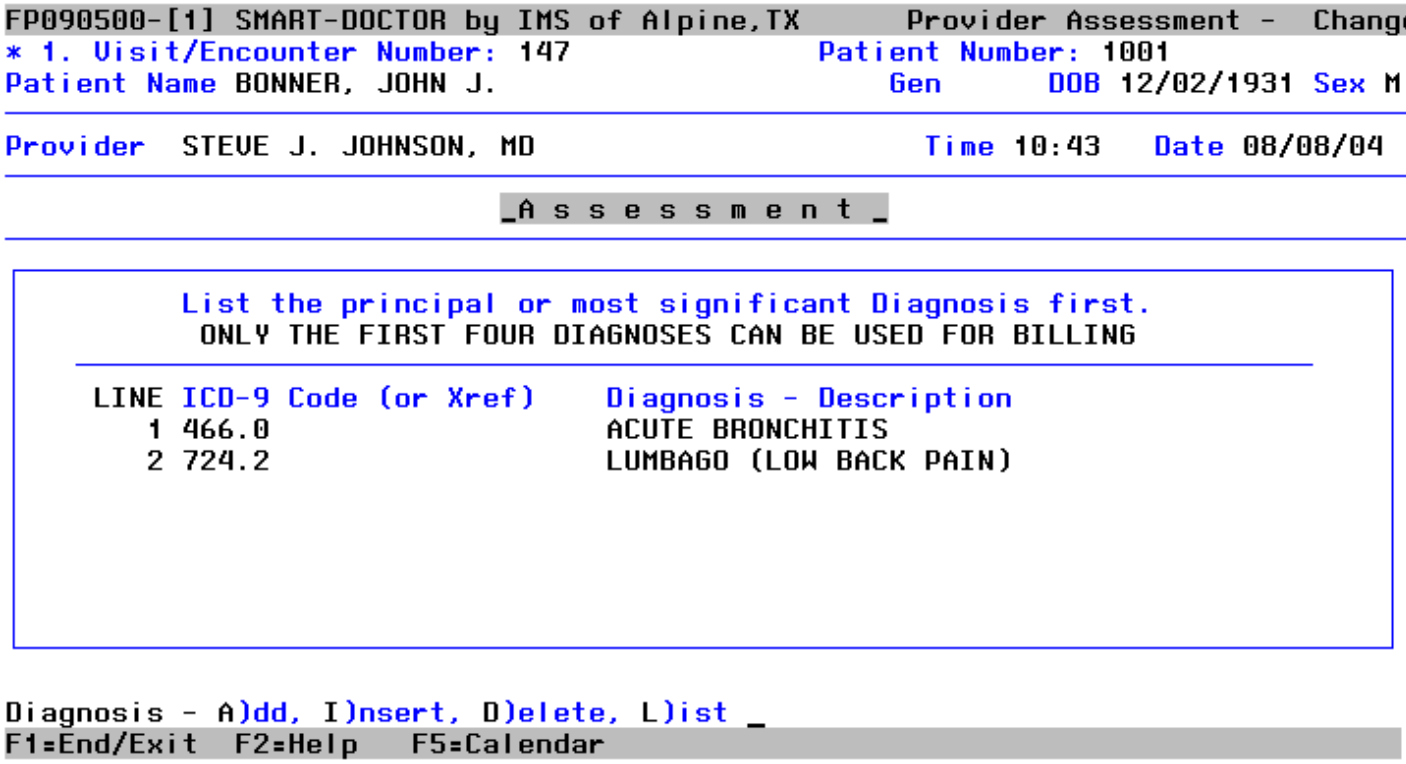


Figure 322 *Assessment screen.*

will significantly affect the validity of your billing:

1. Always list the most significant and medically complex reason for the visit first.
2. Only the first four diagnoses can be used for billing. Listing more will allow the system to document these other problems in the problem list. They will not show on a printed billing form since there is only room for four diagnoses.
3. If you are going to do a procedure, list the diagnosis on this screen before going to the procedure screen. The procedure screen only allows you to select a diagnosis from assessments already noted on this screen, to be sure the procedure charge will not be rejected because the proper diagnosis was not listed in the assessment list.
4. In the add mode (as will be shown below in Figure 324), always try to select from a previous diagnosis entered for this patient in the past. This will help to keep the patient's active problem list more concise. For example, if you previously used a more precise diagnosis to describe a problem such as “530.81 ESOPHAGEAL REFLUX”, it would be better to select this from the patient's active problem list rather than to enter “heartburn” and end up selecting “787.1 HEARTBURN”. In addition, it will save you time.

Upon hitting <a>, you will be placed in the add mode as seen below in Figure 323. Please note the new F-Key to “**Select from Active Medical Problems**”. Hitting <F9> here results in the pop-up window seen in Figure 324 to select from.

Upon selecting line #5 (in Figure 324) and then hitting the <F1> key to end adding diagnoses, we get the assessment screen shown in Figure 325.

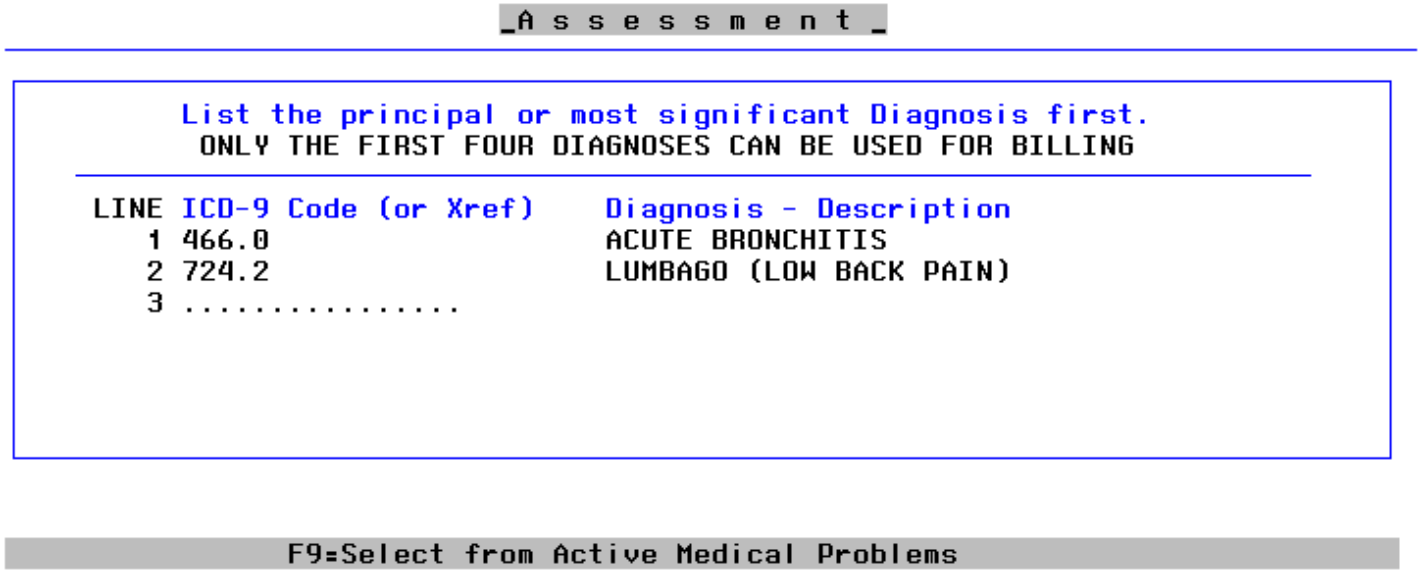


Figure 323 *Adding to Assessment screen.*

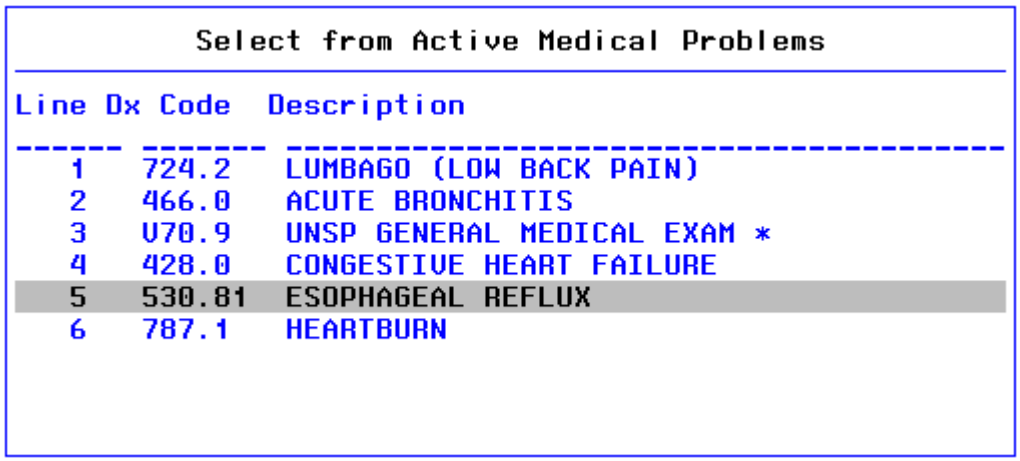


Figure 324 *Selecting from Active Medical Problems.*

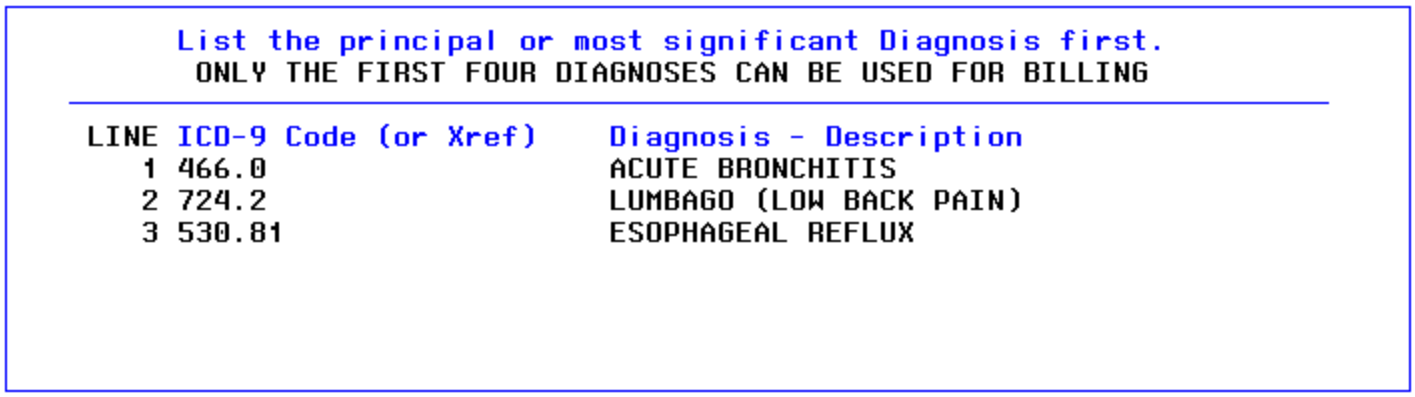


Figure 325 *Final Assessment screen.*

From the “Orientation Screen” again.

Plan: <F8> “P” Screen.

Upon hitting the <F8> ”**P**” key the screen shown in Figure 326 will come up.

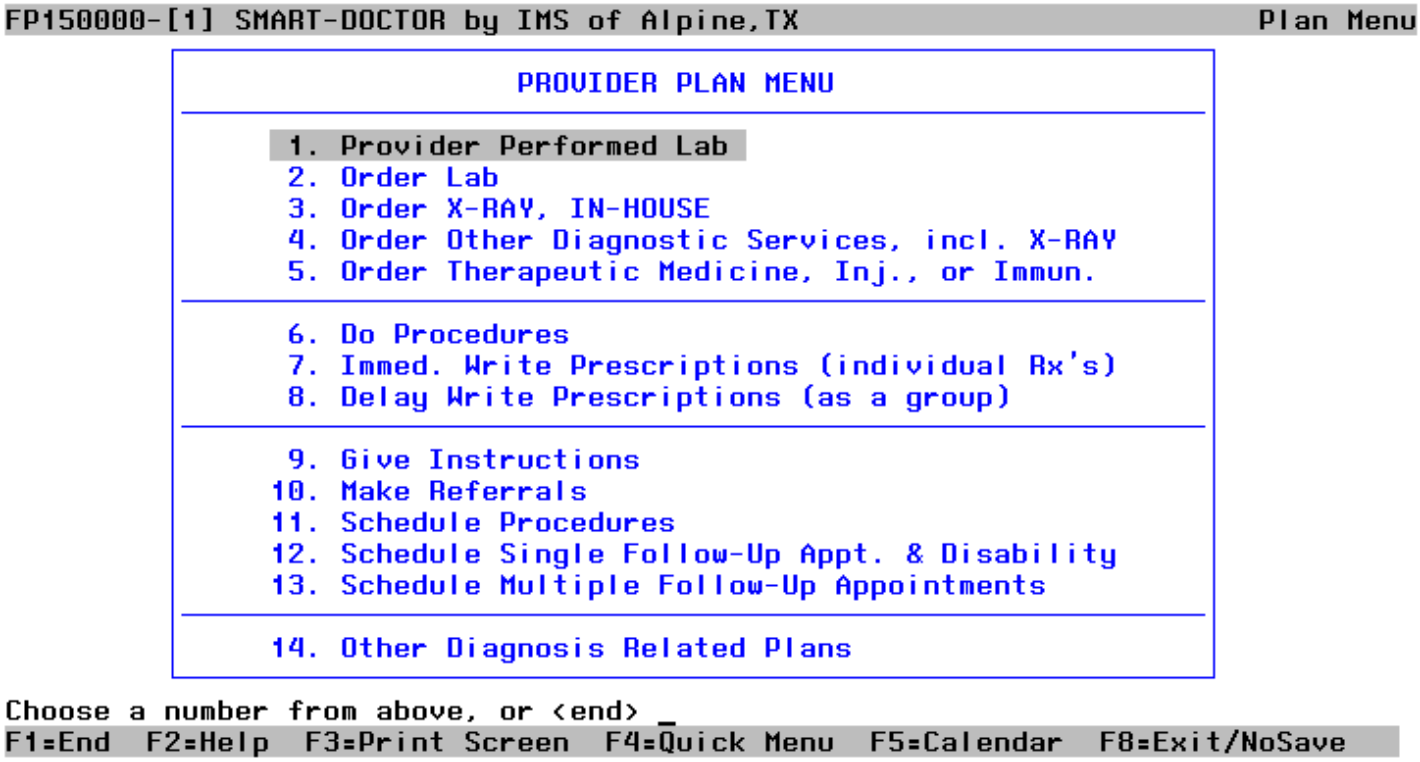


Figure 326 *Provider Plan Menu.*

For completeness in this manual, we will now go through each of these menu selections. At least one example of each menu item will be shown. However, it is extremely unlikely that you would ever use all of these menu selections in any one visit.

Menu selection #1, “Provider Performed Lab”.

Upon selecting this menu item, you will be placed in the following screen:

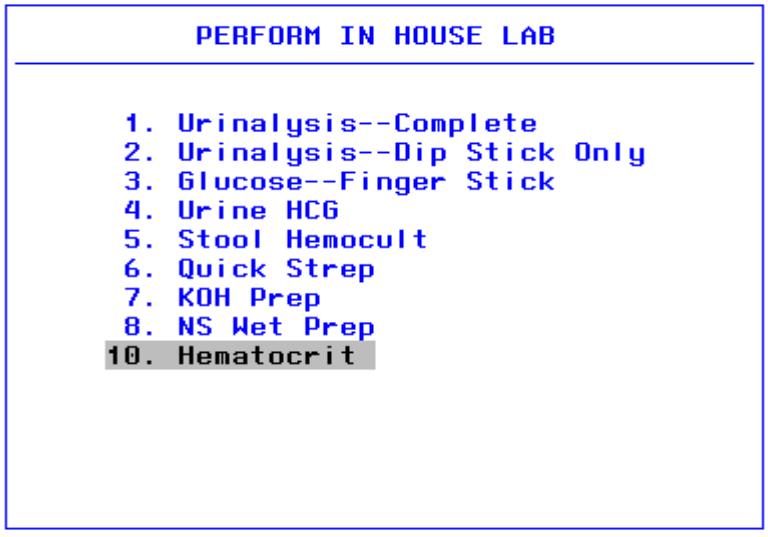


Figure 327 *IN House Lab Menu.*

Here, we highlighted and selected item #10. We get the following input screen.

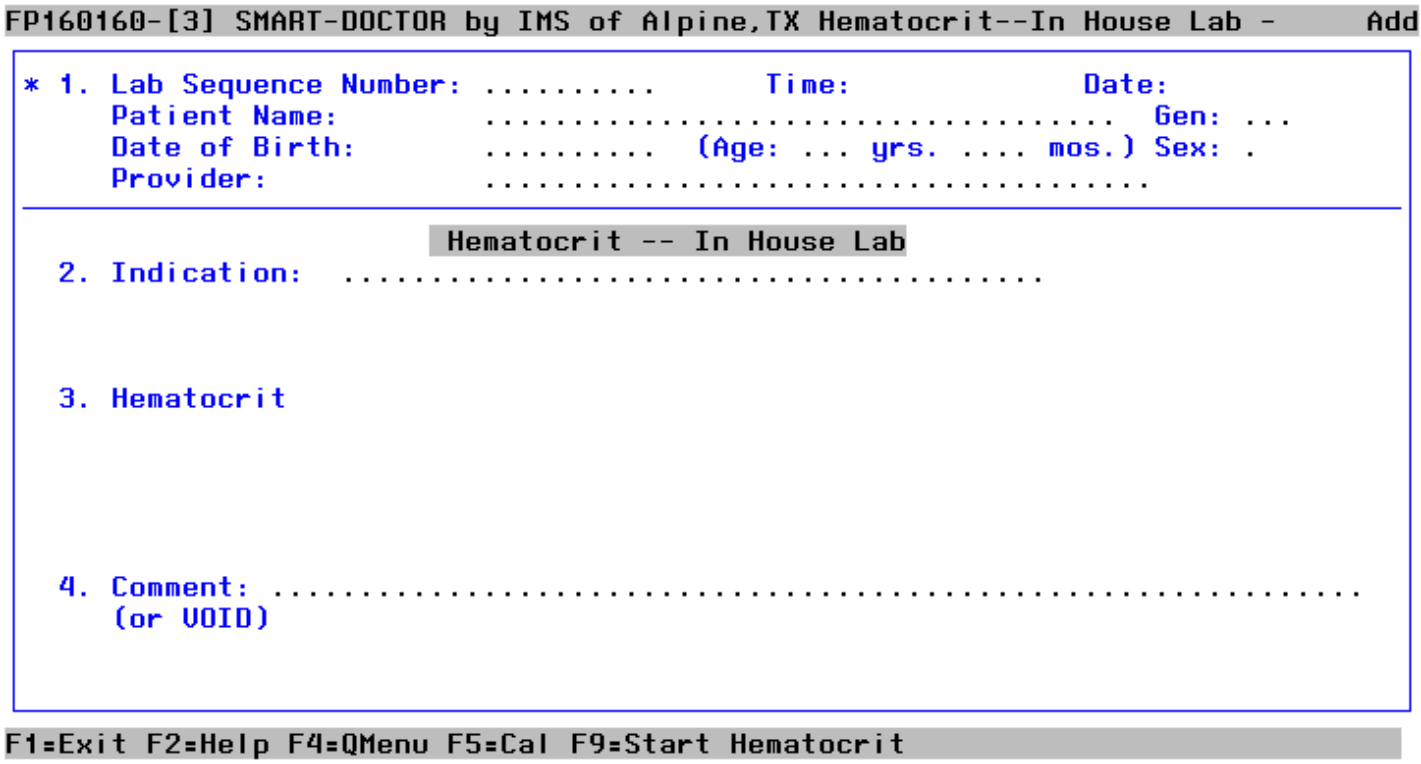


Figure 328 *Starting Hematocrit screen.*

On these type of screens for inhouse labs performed by the provider, you will hit <F9> to get a new lab number and start documentation. Once documentation is complete, the screen appears as below (Figure 329) with the standard warning flags as discussed previously:

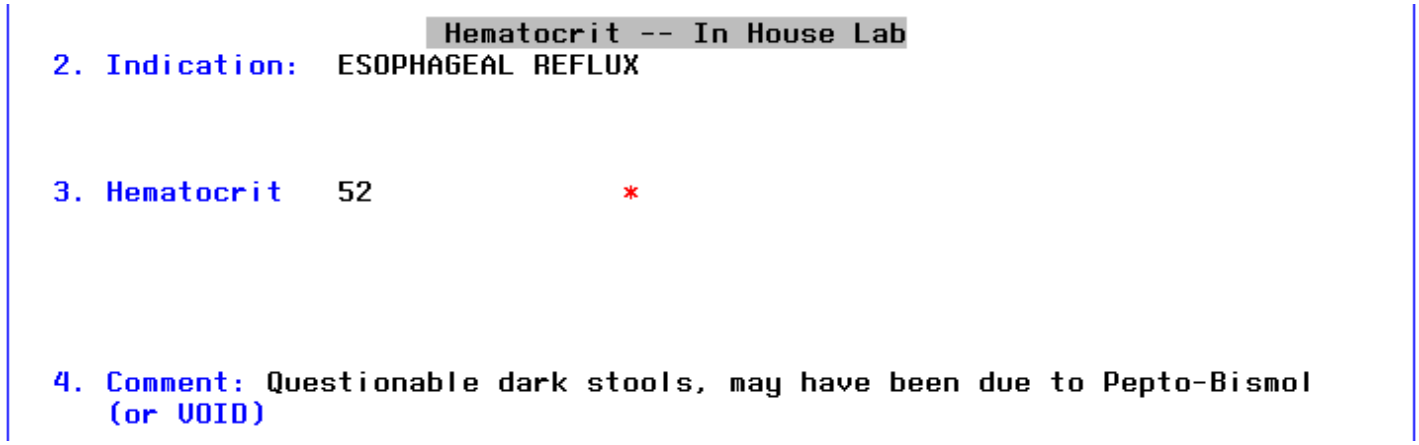


Figure 329 *Completed Hematocrit Data Entry.*

To void the above lab test, you would type “VOID” or hit the <F8> ”**VOID**” key, while in prompt #4.

The provider could have also ordered this inhouse lab to be done by the nursing staff via the “Lab Order” screen. In this case, the inhouse Hematocrit would have been placed in the nurse's queue to perform. (The “Collect/Process Doctor Ordered Labwork.” menu selection on the nursing screen.)

Menu selection #2, "Order Lab".
To order lab tests to be done, either "InHouse" or outside lab, you would select this menu item. Upon selecting this item, you will get a screen similar to that shown in Figure 330 below.

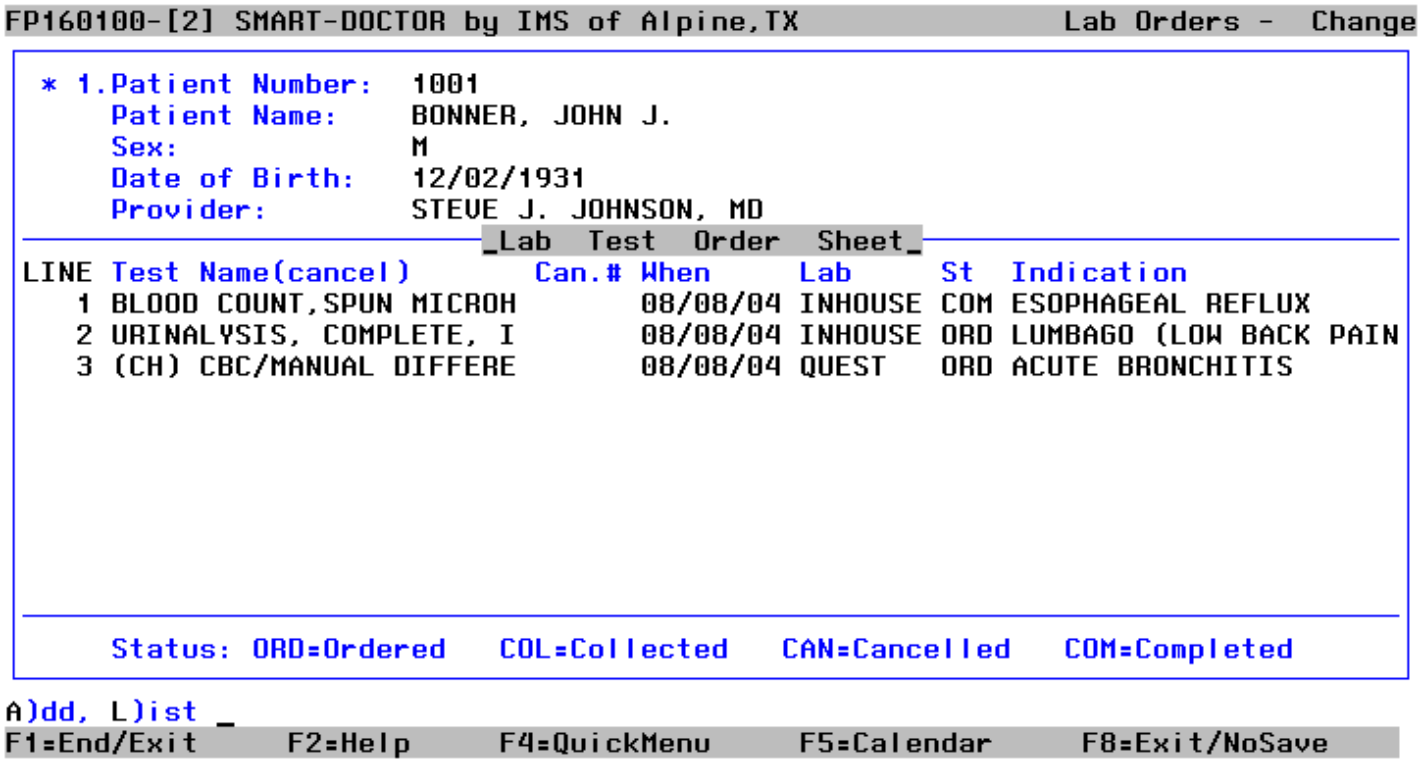


Figure 330 *Lab Test Order screen.*

On this screen, you will see the historical record of all lab tests ordered on this patient in chronological order. Any new test ordered will be placed at the bottom of the list. This will allow you to see any recent tests ordered and help avoid making the mistake of ordering a lab test that was done recently and not necessary to repeat again at this time.

As seen above, the most recent Hematocrit that was done InHouse by the doctor is seen. Also note that an InHouse lab was ordered via this screen on line #2. In the case of the first InHouse lab, you can see in the "**St**" (status) column the first item is "**COM**" (Completed), and the second item is still in the "**ORD**" (Ordered) status. This second order has been queued for nursing staff to do. This in turn will be queued for the provider to do the microscopic portion of this test.

The third test has been queued for an outside lab. If this is an automated test that will be draw inhouse, then this will be queued for nursing staff to draw, and a requisition will be produced. The automated lab result will then be automatically posted to the chart for your review. If there is an outside lab that is not automated and will will be drawn elsewhere, just an outside requisition slip will be produced on patient exit.

Menu selection #3, "Order X-RAY, INHOUSE".
To order an InHouse X-Ray, you would select this menu item. Upon selection you will see the following screen (Figure 331). We already entered "chest" in line #1 and got the pop-up window to confirm the order as shown below:

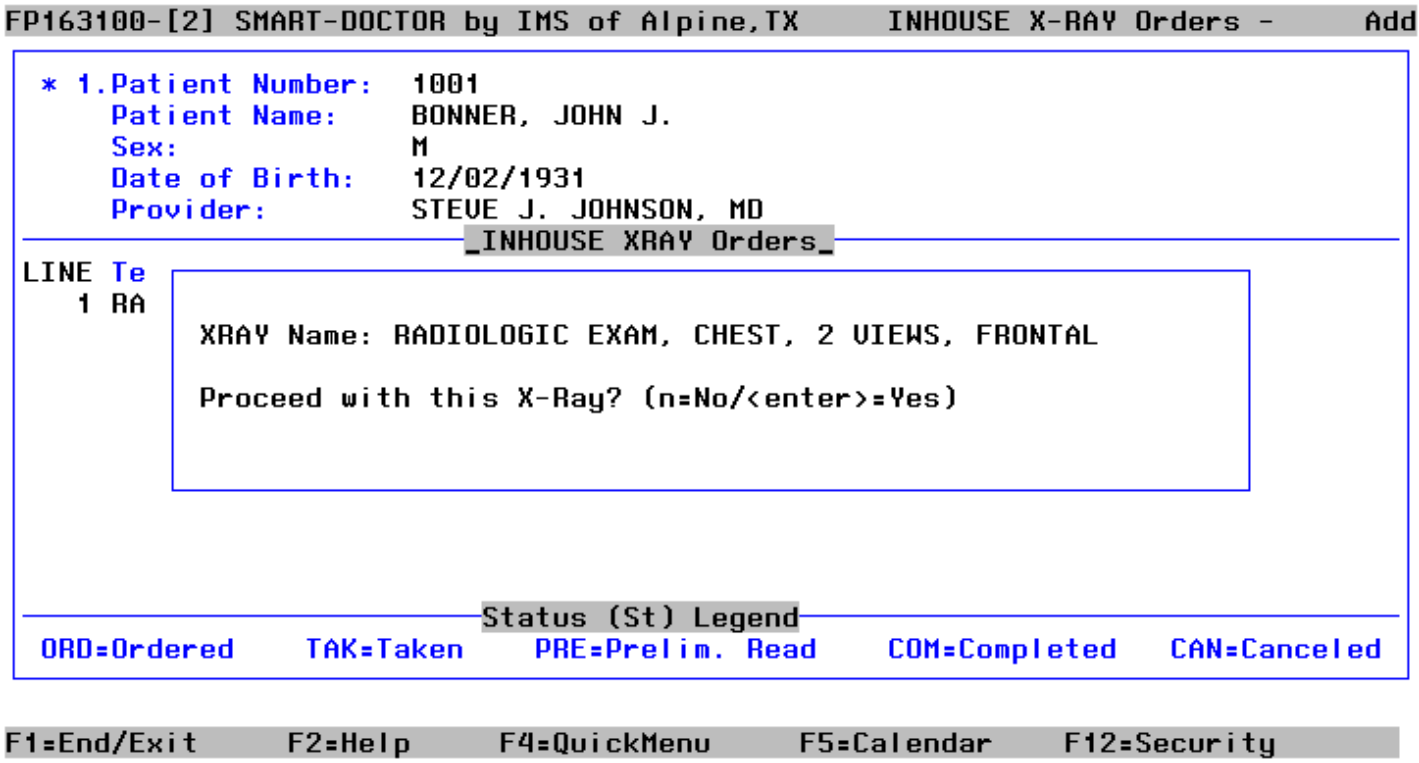


Figure 331 *InHouse X-Ray Order screen.*

Hit <enter> if this is correct. Next, you will get a pop-up that shows different selections for when to have the x-ray done. Subsequently, you'll get a pop-up to pick a diagnosis from the assessment list you had previously input. When done, the screen will appear as shown in Figure 332 below.

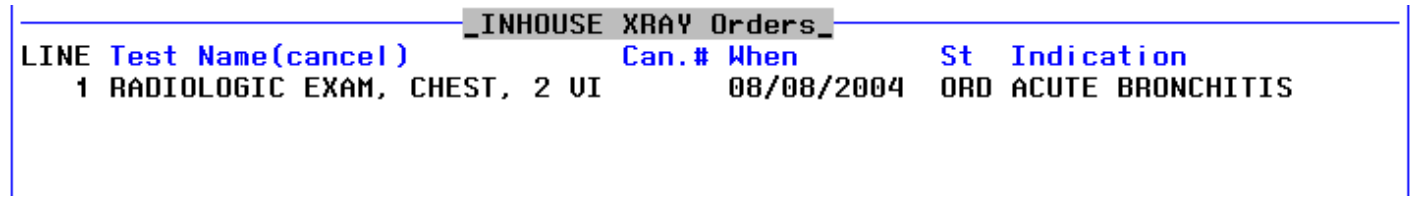


Figure 332 *InHouse X-Ray Order Added.*

This inhouse x-ray will then be queued for the x-ray technician to perform. Once performed, the provider can either do the pulmonary or final reading from the chart review screen during this visit note, or from the “Preliminary & Final InHouse X-RAY Reading” option from the doctor main menu.

Menu selection #4, “Order Other Diagnostic Services, incl. X-RAY”.
Upon selecting this menu selection, you'll get the diagnostic services screen (Figure 333). In prompt #1, the encounter number will be defaulted for you. Hit <enter> to accept. In the multi-value change prompt at the bottom of the screen, enter <a> to add. You'll will then see the following screen presented with a pop-up window indicating the diagnostic services that you can order. This pop-up window is defined in the terms file in the “LAB-DIAGNOSTIC” record. Your clinic administrator can modify this list as necessary with the assistance of IMS.

Once you have selected the diagnostic test, you will get another pop-up window for you to select when the test is to be done. Following this, you'll get a final pop-up to indicate which diagnosis from the assessment list to associative with this test. The resulting screen will appear as shown in Figure 334.

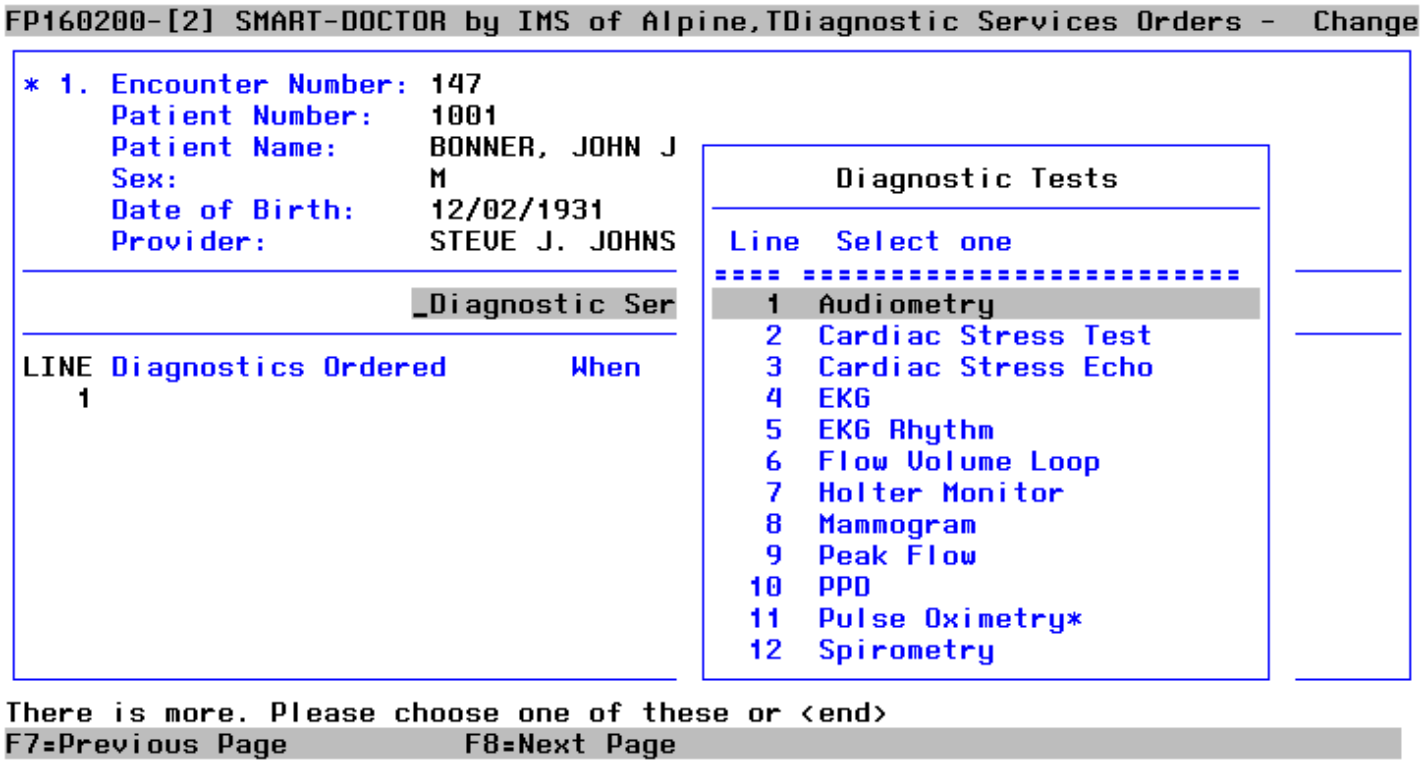


Figure 333 *Select Diagnostic Test to Order.*

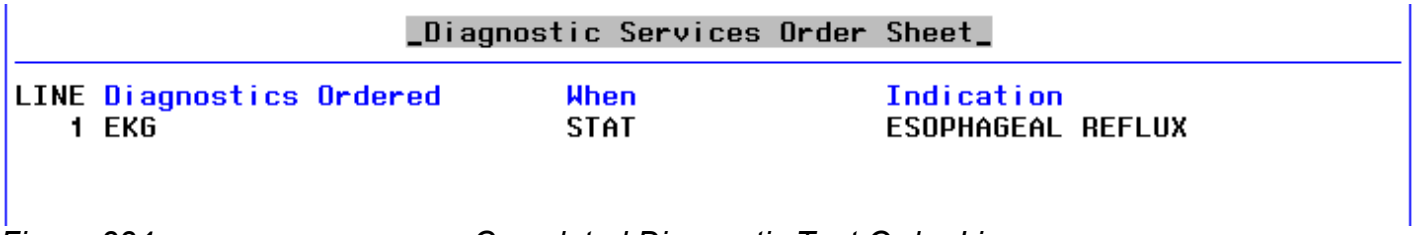


Figure 334 *Completed Diagnostic Test Order Line.*

Menu selection #5, "Order Therapeutic Medicine, Inj., or Immun."
Upon choosing this item, the screen shown in Figure 335 will be presented. Hit <enter> and accept the defaulted encounter number.

On the multi-value prompt under medication book #, hit <enter> to accept the next defaulted medication book number. Doing this will take you to the next medication administration screen, as seen Figure 336.

In prompts #2, enter a partial description of the substances you want to administer. For this example, "roc" was entered. Following this you'll get the next pop-up window (Figure 337) to pick the appropriate substance.

We will pick line item No. 2 for an injectable form of "**ROCEPHIN**". Next, a window will pop open has seen in Figure 338 for the dosage form and cost information.

Upon selecting the dosage form (with some medications there can be a number of selections here), you'll be placed in the window seen in Figure 339 to indicate the amount.

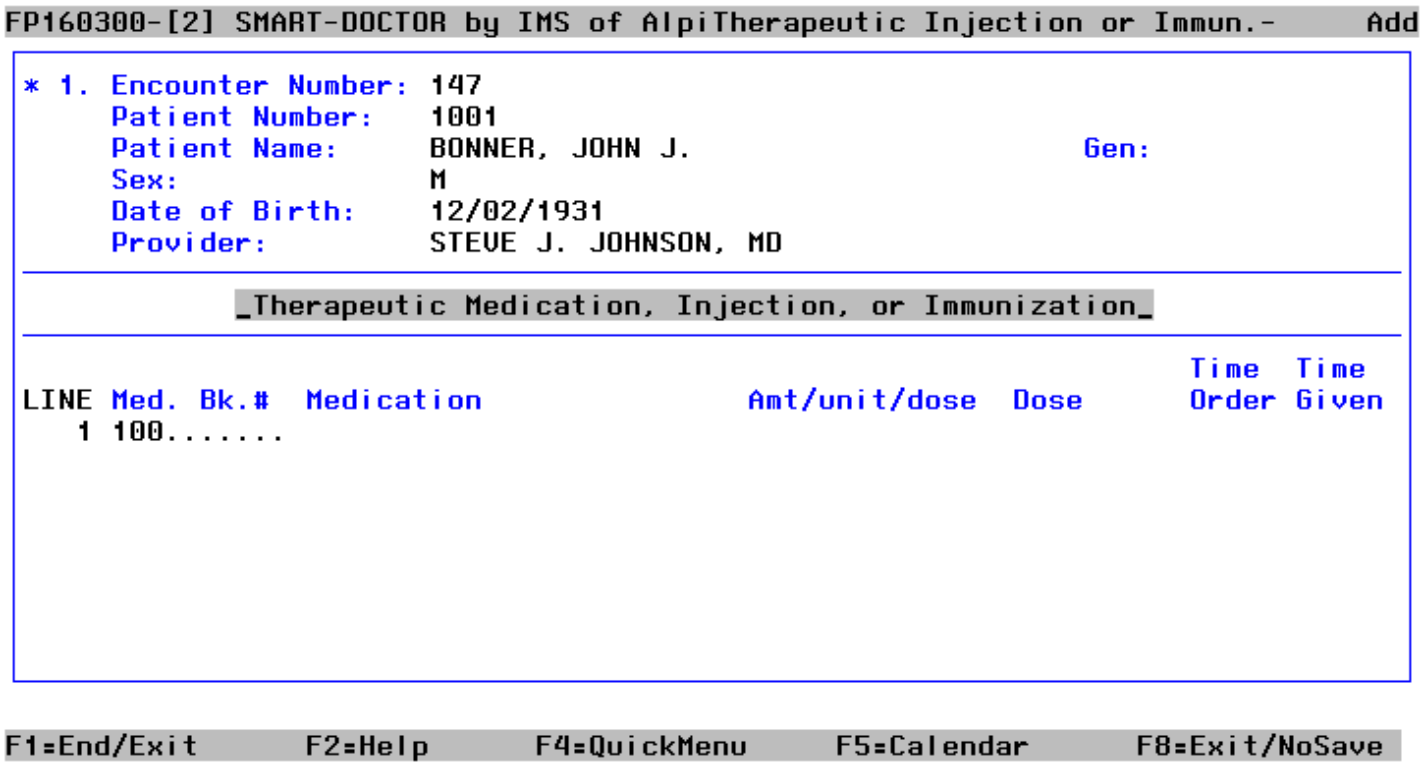


Figure 335 *Order Medication Administration.*

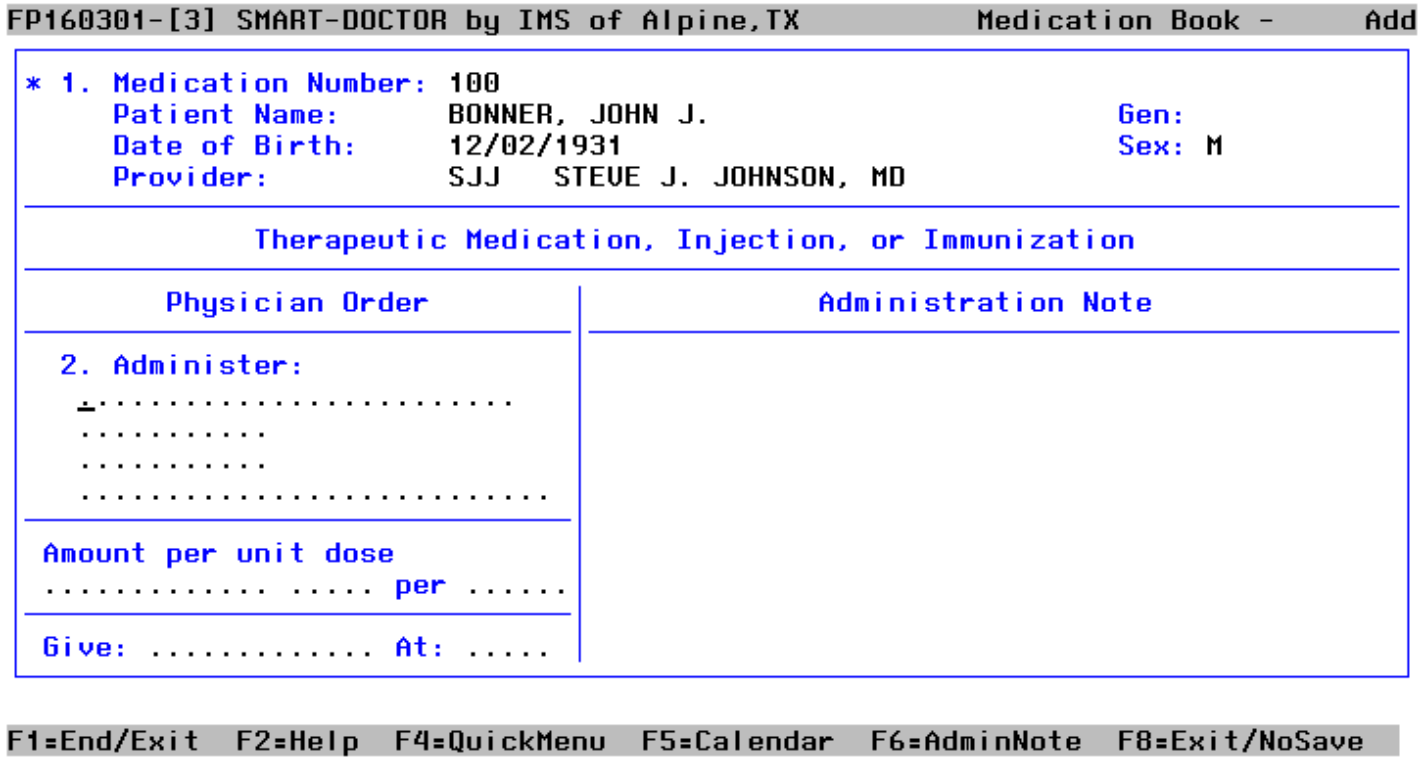


Figure 336 *Entering Medication to Administer.*

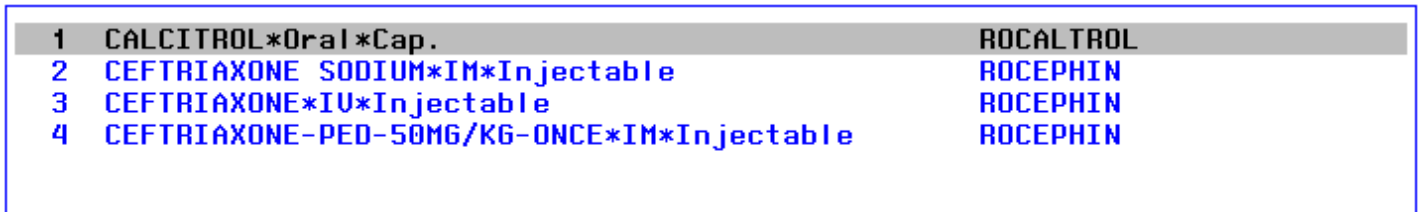


Figure 337 *Selecting Substance to Administer.*

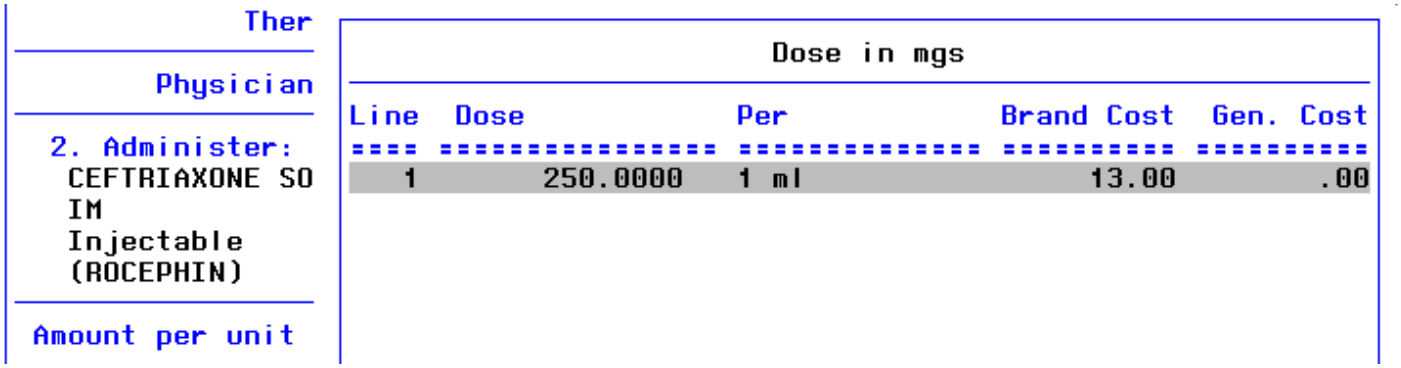


Figure 338 *Selecting Dosage Form.*

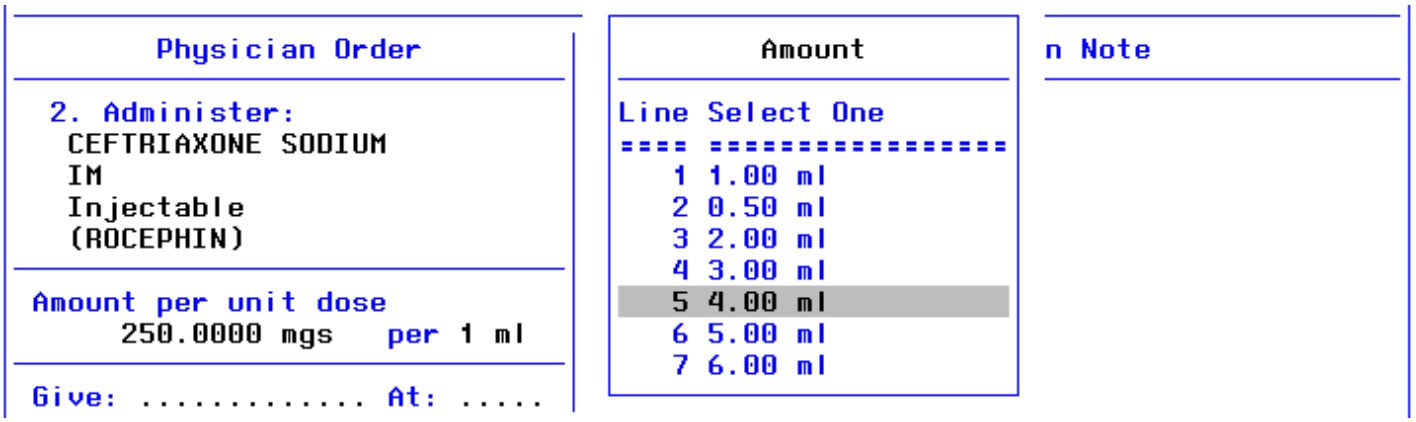


Figure 339 *Selecting Amount of Medication.*

After selecting the amount, the final administration screen will be seen as shown in Figure 340.

At this point, the provider can notify the nurse that administration of a medication is needed. The nurse can then check for of the queued medications to be given from the nurses screen, menu item #2 "**Give Medication or Immunization**". Please see the nursing section of this manual for administration of medications and immunizations ordered by the provider. The provider on returning to the screen after administration can see the administration information. Also, the provider can hit <F6> "**AdminNote**" to administer the medication and document this, as explained in the nursing section of this manual.

Upon returning from this screen by hitting <F1> to "end", the provider is returned to the "Therapeutic Injection or Immun." screen seen in Figure 341. Here, you can see the effect of the medication order.

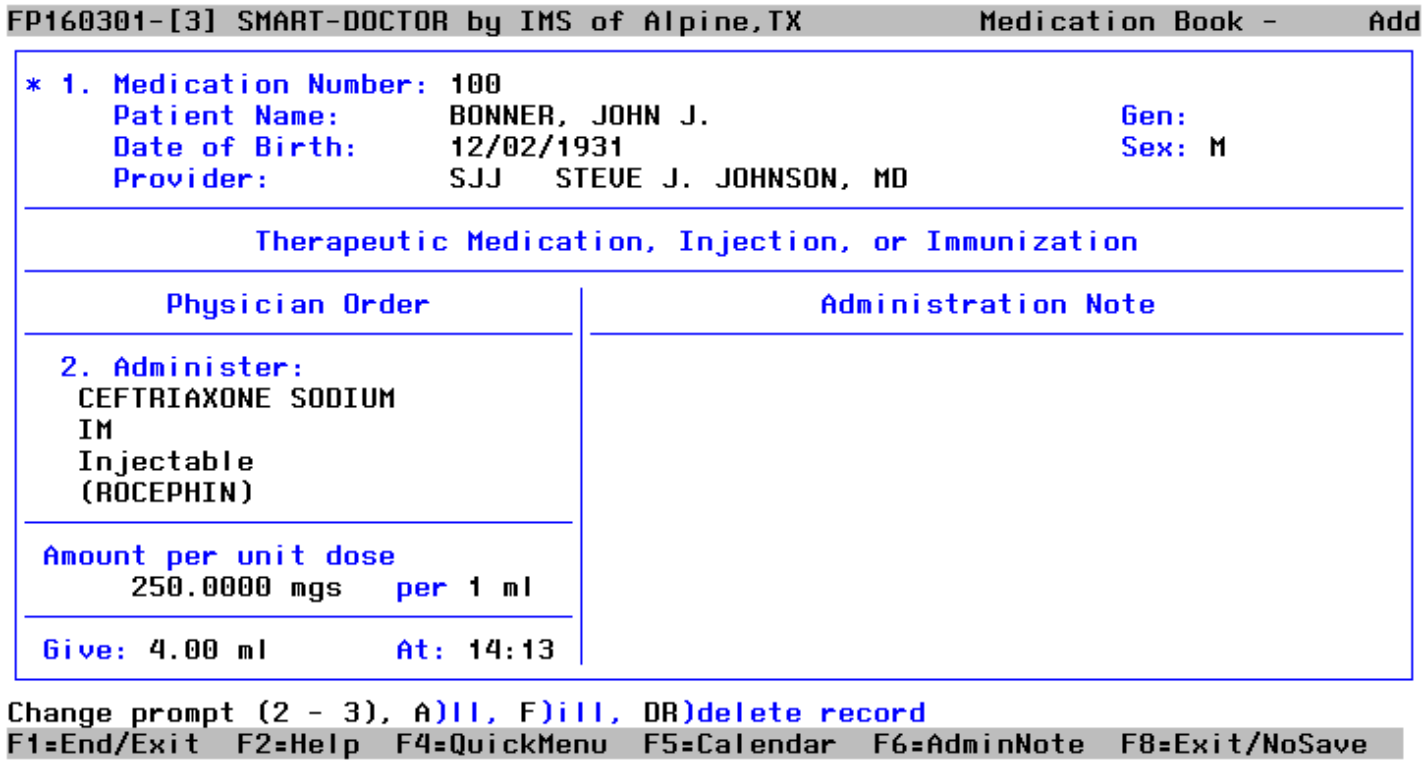


Figure 340 *Final Medication Administration Order screen.*

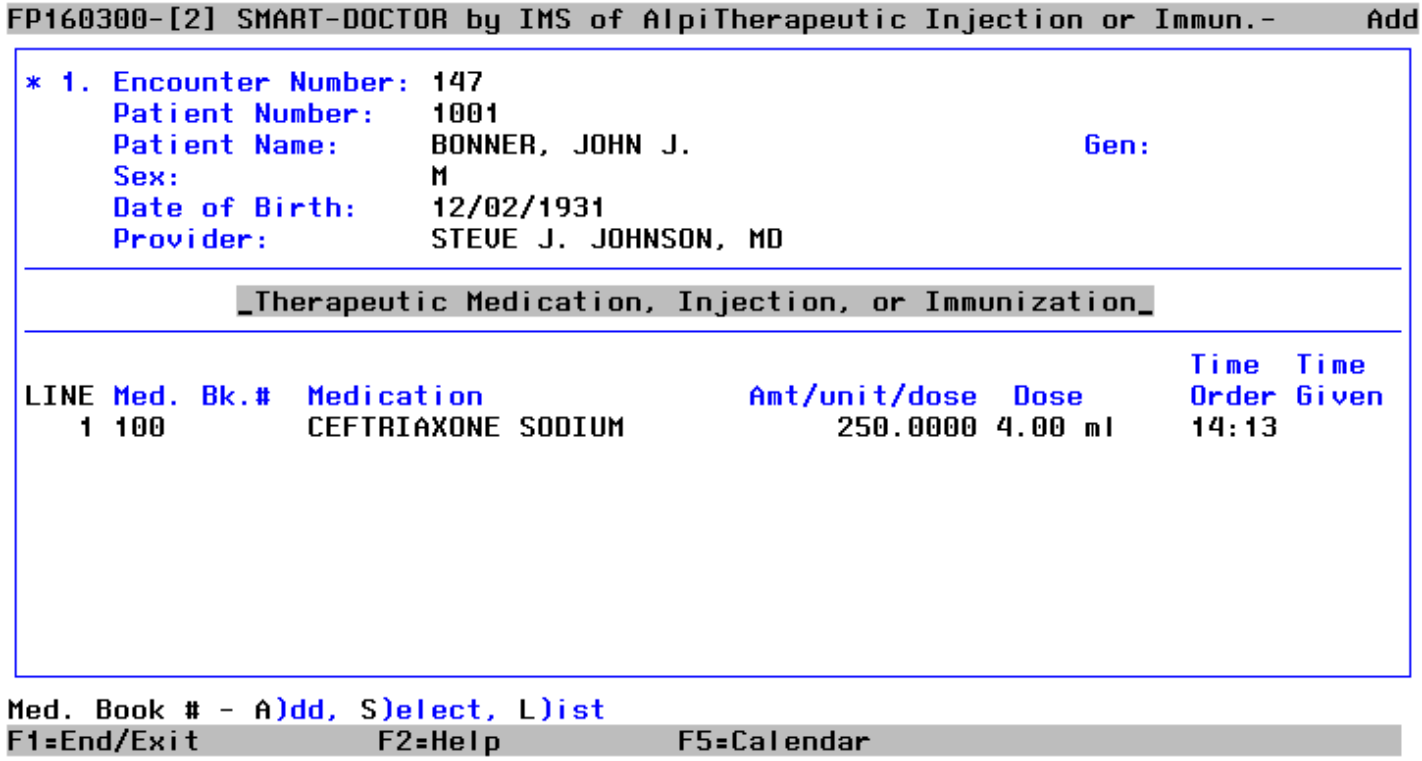


Figure 341 *Completed Medication Order.*

You will note the drug given, the amount given, and the time of the order. The time given column will be filled in when the drug has been administered by the nurse. In this way, the doctor can easily checked to see if the medication has been given and when.

Menu selection #6, "Do Procedures".
Upon selecting this menu item and accepting the default encounter number, we get the following screen (Figure 342) with a defaulted procedure number. If you wish to proceed, just hit <enter> to accept this procedure number.

```
FP160400-[2] SMART-DOCTOR by IMS of Alpine,TX          Procedure Book -  Change

* 1. Encounter Number: 147
     Patient Number:   1001
     Patient Name:     BONNER, JOHN J.                          Gen:
     Sex:              M
     Date of Birth:    12/02/1931
     Provider:         STEVE J. JOHNSON, MD

                              _P R O C E D U R E S_

LINE Proc.Bk.#    Procedure                          Indication
   1 100.....

F1=End/Exit     F2=Help     F4=QuickMenu     F5=Calendar     F8=Exit/NoSave
```

Figure 342 *Starting Procedure Note.*

After accepting the above procedure number, you'll be presented with the following screen (Figure 343).

```
     1. Is this a (S)tandard or (D)efined Procedure?   S
```

Figure 343 *Selectiong the Type of Procedure Note.*

There are currently two types of procedure notes that can be done. The first type is called a standard procedure note, from the original form of procedure notes, when the system was initially developed. This is still used today, but is not the preferred method. The preferred method of doing a procedure note would be the defined procedure note. The defined procedure note is described in the systems section of this manual. There, you can define the elements of the procedure note, the note itself, as well as the variables allowed in each defined field.

Below (Figure 344) is an example of the standard procedure note in which the key to the note is defined in the Terms file record, "PROC-NOTES". This record lists the keys which are terms file records. These records contain the narrative notes to be associated with these keys. All the variable fields are defined for the pop-up screens in the TERMS file. The keys for these variable lists in the TERMS file are as follows: "PROC-AGENT" for Types of Agent, "PROC-ANES" for Types

of anesthesia, “PROC-CLOSURE” for Type of closure material, “PROC-CONDITION” for Patient condition after proc., and “PROC-TRAYSIZE” for Surgical tray size. The remaining variables are free text.

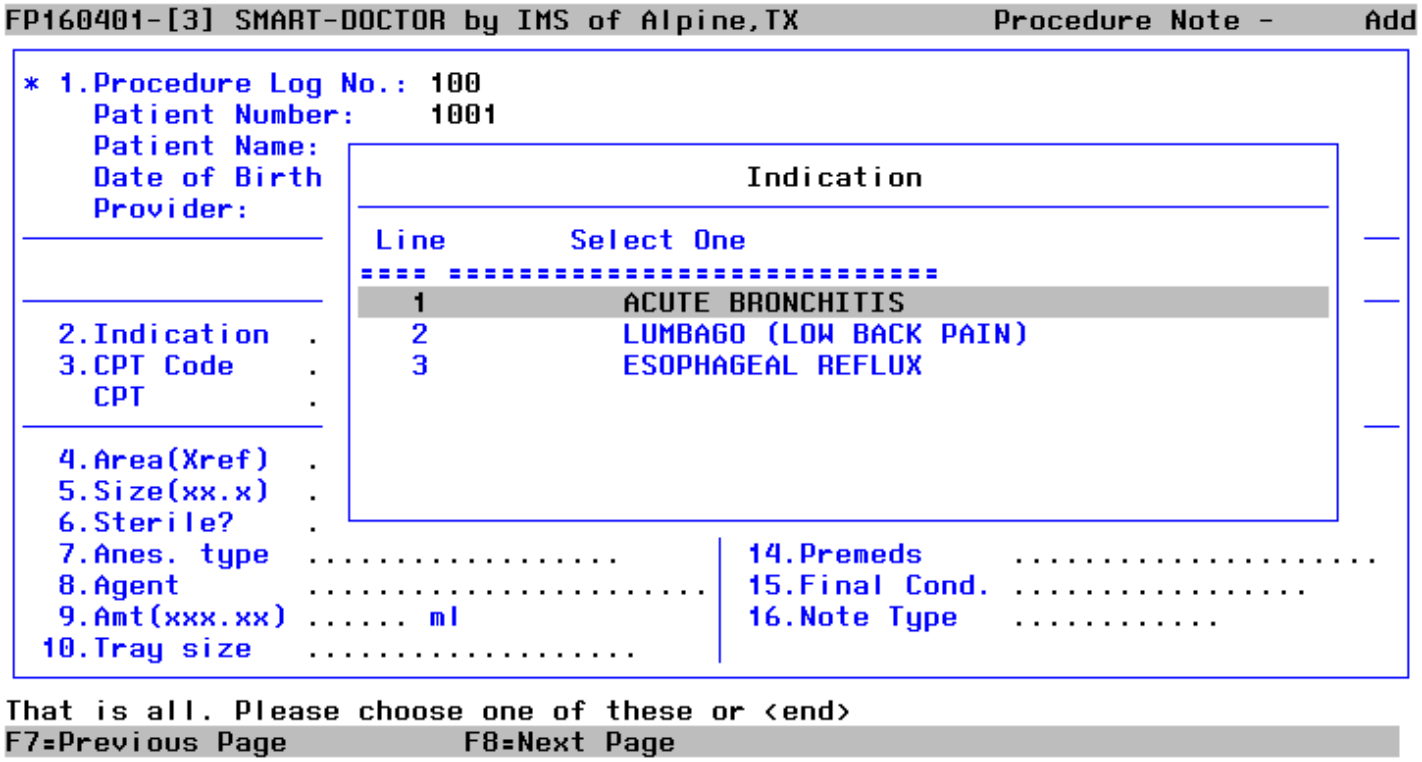


Figure 344 *Standard Procedure Note.*

Initially, you're presented with the pop-up screen containing the assessments you already assigned to this visit from the <F7> Assessments screen. Therefore, it will save you time if you list the diagnosis or indication for this procedure before documenting a procedure. After the diagnosis has been selected, you will be required to enter a cross-reference for an appropriate CPT to bill. In this example, we will put “inhal” in the cross-reference to find an appropriate CPT code for inducing a sputum. This is shown on the following screen (Figure 345).

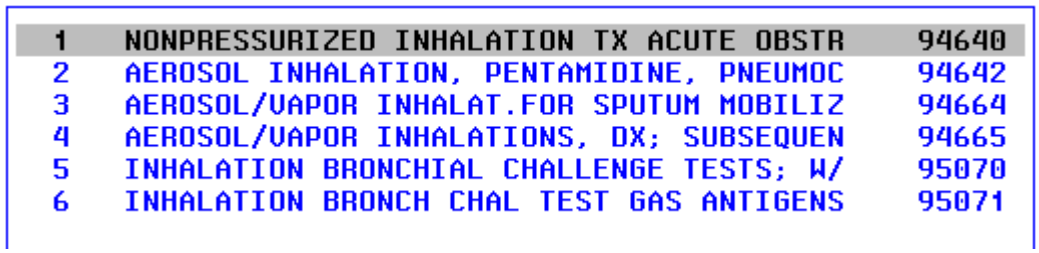


Figure 345 *Selecting Procedure Code.*

In the example above, we picked a procedure that would fit with one of our diagnoses from the assessment screen. In this case, there wasn't a pre-defined note for induction of sputum, so we selected “**Free-Text**” from the pop-up window in prompt #16 (see Figure 346). We next put in the narrative part of the note at the top of the screen. This is all free text. This free text note could have easily been placed in the terms file with a key of induced sputum (“INDUCEDSPUTUM”, 13 or less characters and no spaces required) and selected as the note type in prompt #16. Upon selection, this note would have populated the narrative field. You could have then modified the

narrative note as

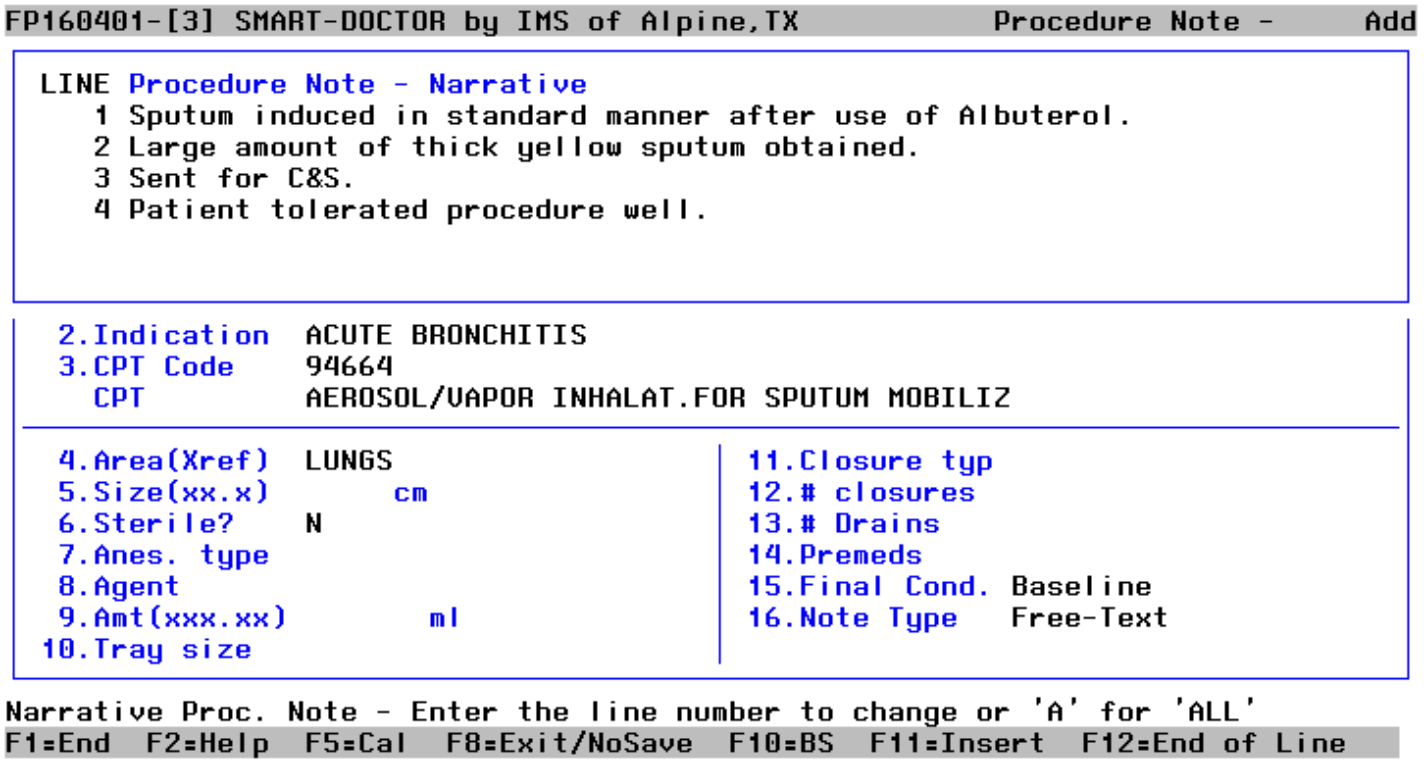


Figure 346 Completed Standard Procedure Note.

needed via the change prompt. The other prompts in the screen that had pop-ups associate with them were skipped by pressing F1 to skip without selection. In prompt #4 for area, the "**LUNGS**" term was a cross-reference lookup from the glossary file. This file contains cross-references for anatomical terms (discussed in the Systems section of this manual). In this case, we typed "lun" for the cross-reference lookup, and selected "LUNGS" as seen above.

The advantage of using the "Standard Procedure" note is that it is already set up, and is well designed for typical minor surgical procedures. The pop-up screens are easily modifiable with the assistance of IMS. The disadvantage is that you have to go through all the prompts whether you need them or not. Further, you cannot add additional prompts if you need them. Also, there is no ability to crosscheck whether the note picked is appropriate for the procedure code indicated, nor is checking for sex or age contraindications done. To remedy this problem, the "Defined Procedure" note was developed, as discussed in the systems files section of this manual. The screen works in a similar fashion, with the exception that as the procedure code is selected, editing for age and sex appropriateness is done, and a specific note is tied to that procedure code. In addition, the number of variable prompts can be specified from 1 to 14, and the types of pop-ups and variables can be defined for each individual variable prompt.

On exiting the procedure note, you'll be brought back to the initial Procedure Book screen (Figure 342) where all the procedures for this visit are listed. If you are to do another procedure, simply hit <enter> on the next line to accept the new procedure book number. The process will start over again. If there are no further procedures to enter, use <F1> repeatedly to end out of the add mode and exit to the prior Plan screen.

Menu selection #7, "Immed. Write Prescriptions (individual Rx's)". & Menu selection #8, "Delay Write Prescriptions (as a group)"

The function of these two menu selections are identical, with the exception of how the prescription is presented. The difference being the "Immediate Write" single prescriptions, versus the delayed Grouped prescriptions, produced at the end of the visit note.

Use <F7> to write an individual prescription. (This can be printed, faxed, or electronically sent to the pharmacy if they are set up to accept it in this way.). This selection is most appropriate when a prescription should be written, and signed individually. A good example of this would be a class 3 controlled substance such as Tylenol with ½ grain of codeine. Pharmacists do not want to see this mixed with Legend drugs such as Lasix, etc.

The example below is for a single prescription for immediate output. However, other than as discussed above, the Grouped prescription writing system logic is identical.

Doing a prescription refill has already been documented in the nursing section of this manual. The only difference here is that if the provider is classified as a doctor (that is, MD, DO, ND, DC, NP, PA –the last 3 with limitations depending on state laws), a new prescription may be written. Therefore, in the example below we will only show how to write a new prescription. Upon selecting to write a new prescription, the following screen will be presented to you. Hit <F9>, as indicated on the bottom bar of the screen, to start a new prescription.

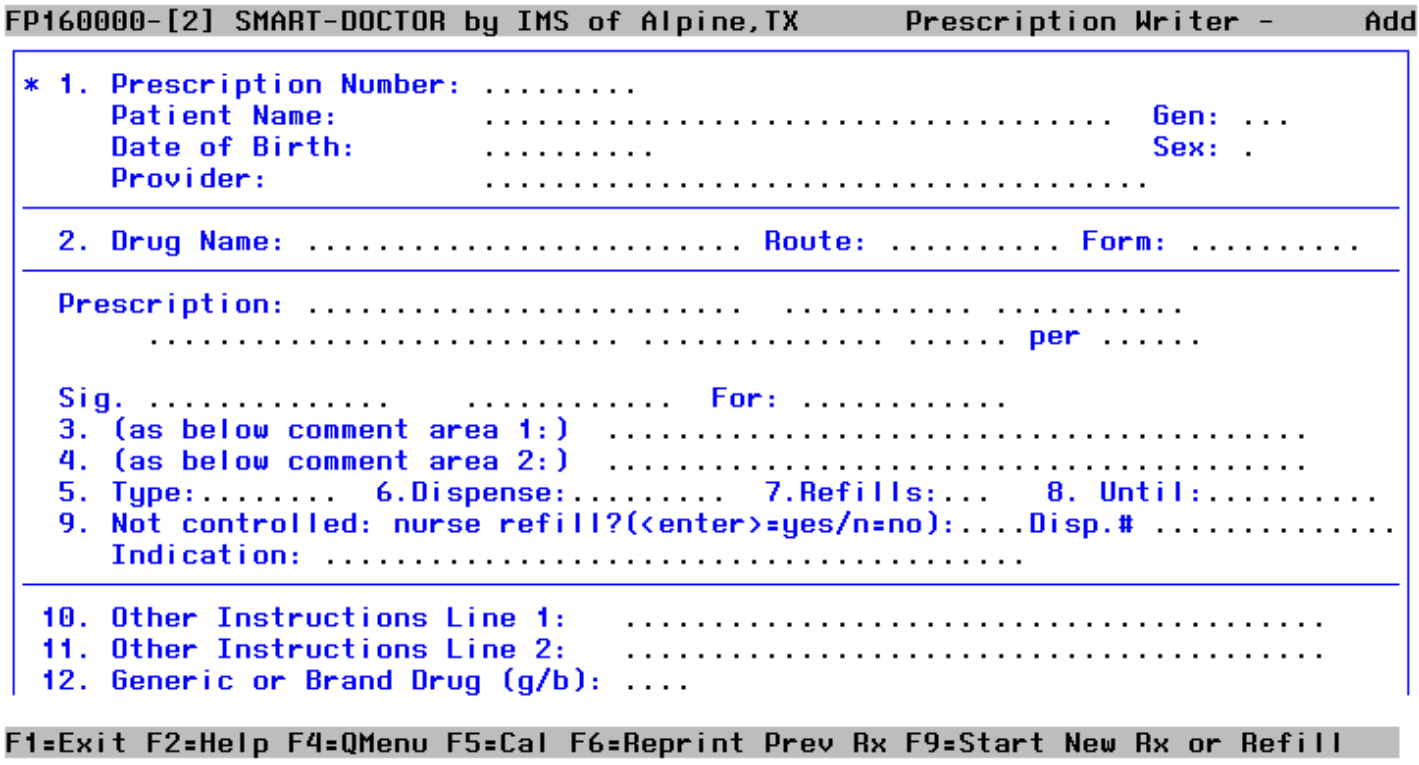


Figure 347 Initial Prescription Writer screen.

After hitting <F9> the screen will be represented. However, this time the patient information will be presented, and the bottom bar will have changed as shown in Figure 348 below.

You will note in the bottom bar that the F-Keys have changed. There is an <F3> "**Dx/Rx**" key to look up what other physicians have used for a specific diagnosis, an <F8> "**VOID**" to void a

prescription anywhere during writing a prescription prior to finalizing it, and <F9> "**Refill Rx**" to indicate refill in prompt #2 in place of a drug name cross-reference.

The <F8> key is self-explanatory. When you enter <F8> in a field which it is accepted, you

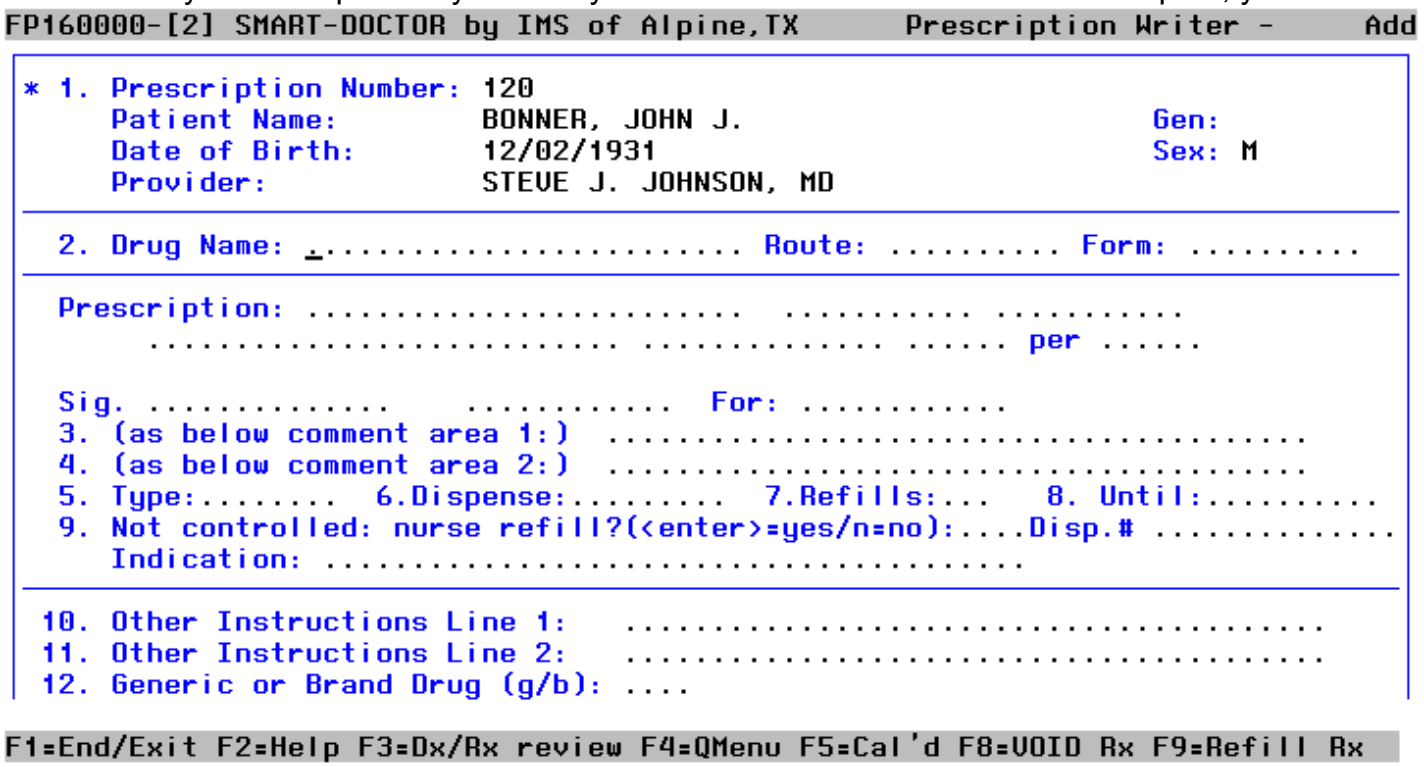


Figure 348 *New Prescription Started.*

will be given a pop-up window to ask if you want to void this prescription. If you indicate "yes" to void this prescription, you will then be asked to hit <F1> to complete the void process. The <F9> refill key works identically to that discuss in the nursing section of this manual, with the exception that doctors, as defined above, have the ability to refill controlled substances.

Following (Figure 349) will be a demonstration of using the <F3> "**Dx/Rx**" key to look up drugs used for acute bronchitis by other providers. We will then attempt to use this in prompt #2 to show you an absolute drug contra-indication. We have set up this example with a drug that has subsequently been pulled from the market because of the bad interaction it can cause with certain other drugs. In this case, even though the drug had been recalled, we want to leave it in the patient's medication list until we talk to the patient to be sure they have discarded the drug. Once the patient confirms that they have discarded the drug, then, and only then, should you delete the drug from the patient's medication list. Patients have a tendency when they have developed an illness or recurrence of illness, that they will pull old medicines out of the medicine cabinet and start using them again. If you are not aware of this potential problem, a lethal drug interaction could occur, as is the potential with the two drugs we will see here.

Upon hitting the <F3> key above, the screen shown in Figure 349 will be presented. In prompt #1, we entered "acu br" for acute bronchitis. A cross-reference pop-up box presented, and we selected acute bronchitis as indicated.

From this screen, it appears that by "**BIAXIN**" would be a good choice. Therefore we will enter part of the drug name, "bia" in prompt #2 for a cross-reference lookup, and we get the cross-reference

pop-up box as seen Figure 350 below.

```
FP161000-[3] SMART-DOCTOR by IMS of Alpine,TX          Drug Selection - Inquire

                        _Drug Prescription Experience_

 * 1. Enter Diagnosis/ICD-9 Code: acu br

      Drugs for Dx Class:          ACUTE BRONCHITIS
      ICD-9 Class:                 466
                                                    Only Drugs over 1% Listed
LINE Drugs used for this Class  Brand Name                Percentage  Total Rx's
   1 CLARITHROMYCIN             BIAXIN                       20         150
   2 ALBUTEROL                  Proventil                    11          80
   3 AZITHROMYCIN DIHYDRATE     Zithromax                     7          56
   4 GUAIFENESIN/HYDROCODONE    codiclear DH                  5          37
   5 BENZONATATE                tessalon perles               5          37
   6 GUAIFENESIN/PSEUDOEPHED    Entex PSE                     4          29
   7 PHENERGAN WITH CODEINE     --                            4          34
   8 GUAIFENESIN/PHENYLPROPAN   entex LA                      3          26
   9 AMOXICILLIN                amoxil                        3          23
  10 ERYTHROMYCIN DELAYED/REL   ery-tab                       2          19
  11 LEVOFLOXACIN               Levaquin                      2          20

List drugs. - L)ist
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 349 *Drug Prescription Experience screen.*

```
  1  CLARITHROMYCIN*Oral*Susp.                    BIAXIN
  2  CLARITHROMYCIN*Oral*Tab.                     BIAXIN
  3  CLARITHROMYCIN_EXT_REL*Oral*Tab.             BIAXIN XL
```

Figure 350 *Drug Selection screen.*

Upon selecting the highlighted line,we are shown the generic drug name in prompt #2, and shown the brand-name in the pop-up box, where we are asked to confirm that we want to proceed with this substance. Hitting <enter> key to proceed, we get the following "**ABSOLUTE compound contra-indication**" pop-up as shown in Figure 351.

In this example, it is found that "BIAXIN", a "MACROLIDE" antibiotic, has an "ABSOLUTE compound contra-indication" with "CISAPRIDE", brand name "Propulsid", a gastrointestinal mobility drug. Patients could develop extremely rapid, and even fatal, cardiac arrhythmias. Warnings were put out for a long time, however these interactions continued. Therefore "Propulsid" was pulled from the market.

If for some reason the physician is absolutely sure that they want to prescribe a drug that has absolute contraindications, they can do so in a pseudo manual way. You can entered the drug name in prompt #2 followed by "-*". The system will then not be able to find this drug and will ask you if you want to prescribe it with limited assistance. You will be informed that no drug interactions will be performed.

We will now proceed to show you an acceptable prescription, using the antibiotic "Keflex".

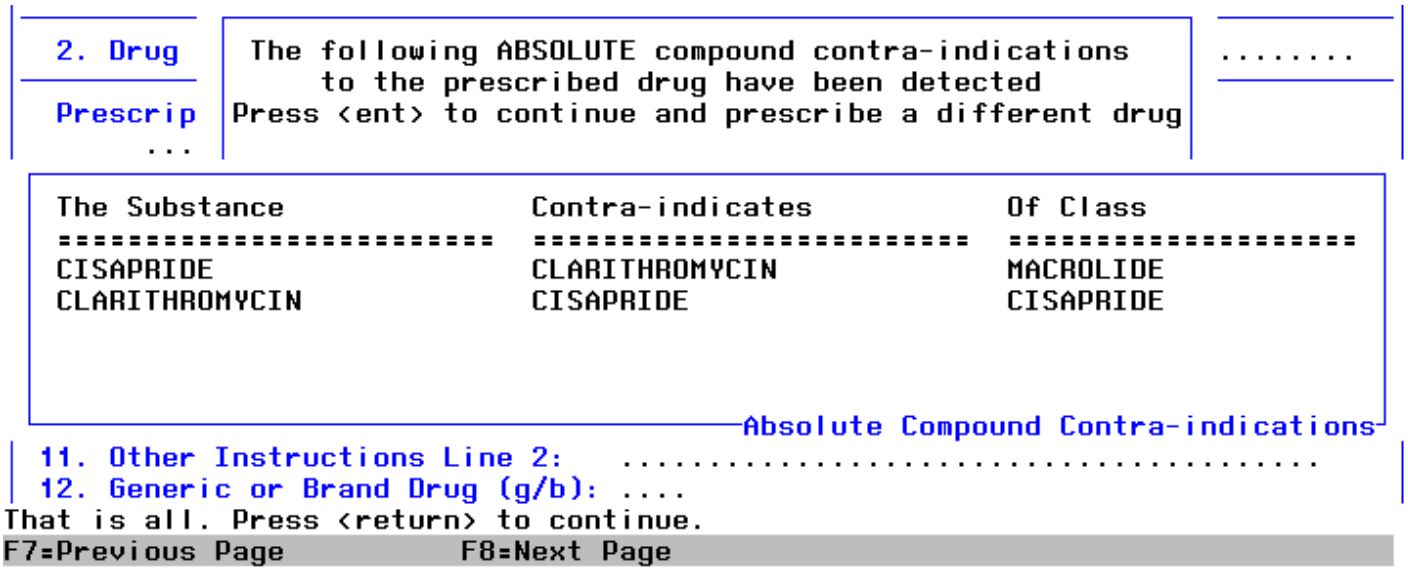


Figure 351 *Absolute Compound Contra-Indication.*

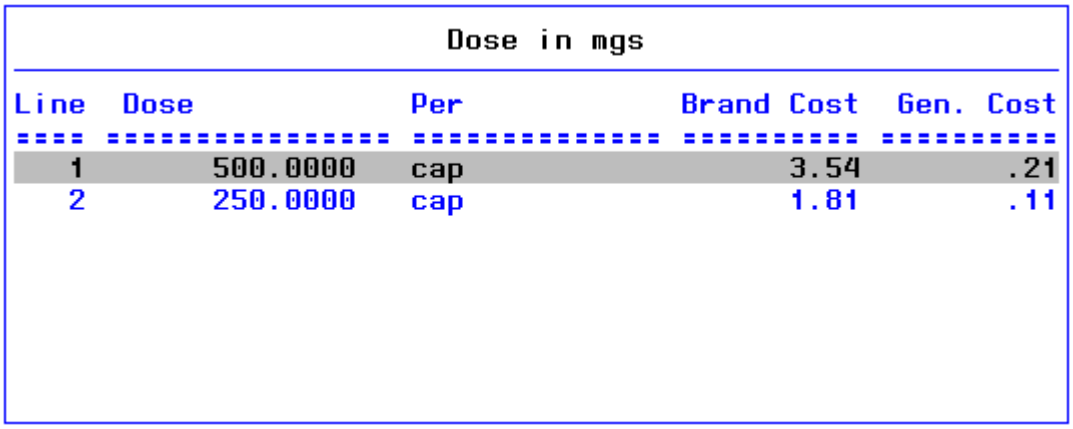


Figure 352 *Selecting Dosage Form.*

In the above pop-up window (Figure 352) after Keflex has been selected, you'll see the available dosages forms, followed by the brand, and generic costs for a typical days dosage. The dosing order is based on clinical judgment. The dosage most likely to be used will be listed first, followed by all other dosages. For example, had this been “Premarin” the 0.625 mg dosage would be listed first, with all other dosages (both above and below this amount) listed subsequently. The purpose here is to make it easy for a doctor to fill a typical prescription by just hitting <enter> as each box pops-up.

Pop-up selection boxes will be presented for you as you go through each of the prompt items. The order of selection is set as indicated above to reduce your need to scroll up and down. However, at the bottom of each selection box, other than the dosage box, you will see an ”**as below**” listed last. If you select this in any of the prompts, then the system will automatically stop you at prompts #3 & #4. This gives you two lines to fill in any specific directions on how to take medication. When you get to prompt #5, you will see a pop-up box asking you if this prescription is chronic, acute, or a sample prescription. If it is a chronic medication, the system will look at the provider file to find the number days the provider wants defaulted for a a chronic prescription. Also, it will look at the

default number of times per year the chronic prescription can be refilled. Based on that information the system will calculate the quantity required to dispense and indicate the number of refills. If this information is not in the provider file, then these responses will have to be filled manually. You can always over write these defaulted values. If you indicated a sample, then you will be taken to a new screen to document the information needed as well as the "Sig", number dispensed, lot number, etc.

Next you'll be stopped at prompt #9 for nurse refill allowed. This is generally defaulted as "yes". This will automatically be changed to "no" for controlled substances. If it is a controlled substance, the number will be shown in text format next to dispense number. At the indication box, you will be prompted to pick from one of the assessments you had entered earlier in this note. Therefore, it is important to list all the problems you are evaluating including refills in the assessment. Prompts 10 and 11 are generally defaulted by the system with the generic warnings that are felt to be clinically appropriate. You can override these defaulted instructions by going into the prompt and entering a space followed by the <enter> key. This will delete the line. Finally you'll be presented with the choice of generic or brand drug. The default is for generic. After completing this typical prescription the screen appears as seen in Figure 353 below.

```
FP160000-[2] SMART-DOCTOR by IMS of Alpine,TX      Prescription Writer -      Add

* 1. Prescription Number: 121
     Patient Name:        BONNER, JOHN J.                          Gen:
     Date of Birth:       12/02/1931                               Sex: M
     Provider:            STEVE J. JOHNSON, MD

  2. Drug Name: CEPHALEXIN                  Route: Oral       Form: Cap.

  Prescription: CEPHALEXIN                    Oral        Cap.
       (KEFLEX)                             500.0000 mgs    per cap

  Sig. 1 Capsule          q 6 hrs        For: 10 days
  3. (as below comment area 1:)
  4. (as below comment area 2:)
  5. Type:Acute     6.Dispense:40         7.Refills:0     8. Until:08/08/2004
  9. Not controlled: nurse refill?(<enter>=yes/n=no):Y   Disp.#
     Indication: ACUTE BRONCHITIS

 10. Other Instructions Line 1:
 11. Other Instructions Line 2:
 12. Generic or Brand Drug (g/b): G
Change prompt (2 - 13), A)ll, F)ill _
F1=End/Exit  F2=Help  F4=QMenu  F5=Calendar  F8=VOID this Prescription
```

Figure 353 Completed Prescription screen.

If you selected Prompt # 7, "**Immed. Write Prescriptions (individual Rx's)**" to write this prescription, then you will get the following prompt in a small pop-up window:

Print Prescription Now? (<enter>=yes/n=no)

If you hit <enter> for "yes" and your clinic has more than one prescription printer, then you will get a pop-up screen to select the prescription printer to use. If your site is set up for faxing to the pharmacy or electronic transfer to the pharmacy, then you will be prompted appropriately.

If instead, you selected Prompt # 8, "**Delay Write Prescriptions (as a group)**" to write this prescription, then you will get the following prompt in a small pop-up window:

Add Prescriptions to Print? (<enter>=yes/n=no)

If you hit <enter> for "yes", then the prescription will be placed in a queue for later printing or transmission with other "delayed print" prescriptions. You will be asked on exiting this note if you want to print (or transmit) the group of prescriptions that have been queued.

Menu selection #9, "Give Instructions".

Use this menu item to document information materials that had been handed out by the provider to the patient, or are to be handed out when the patient exits. Upon selecting this menu item, hit <enter> in prompt #1 to accept the default "Encounter Number". The following screen will be presented (Figure 354):

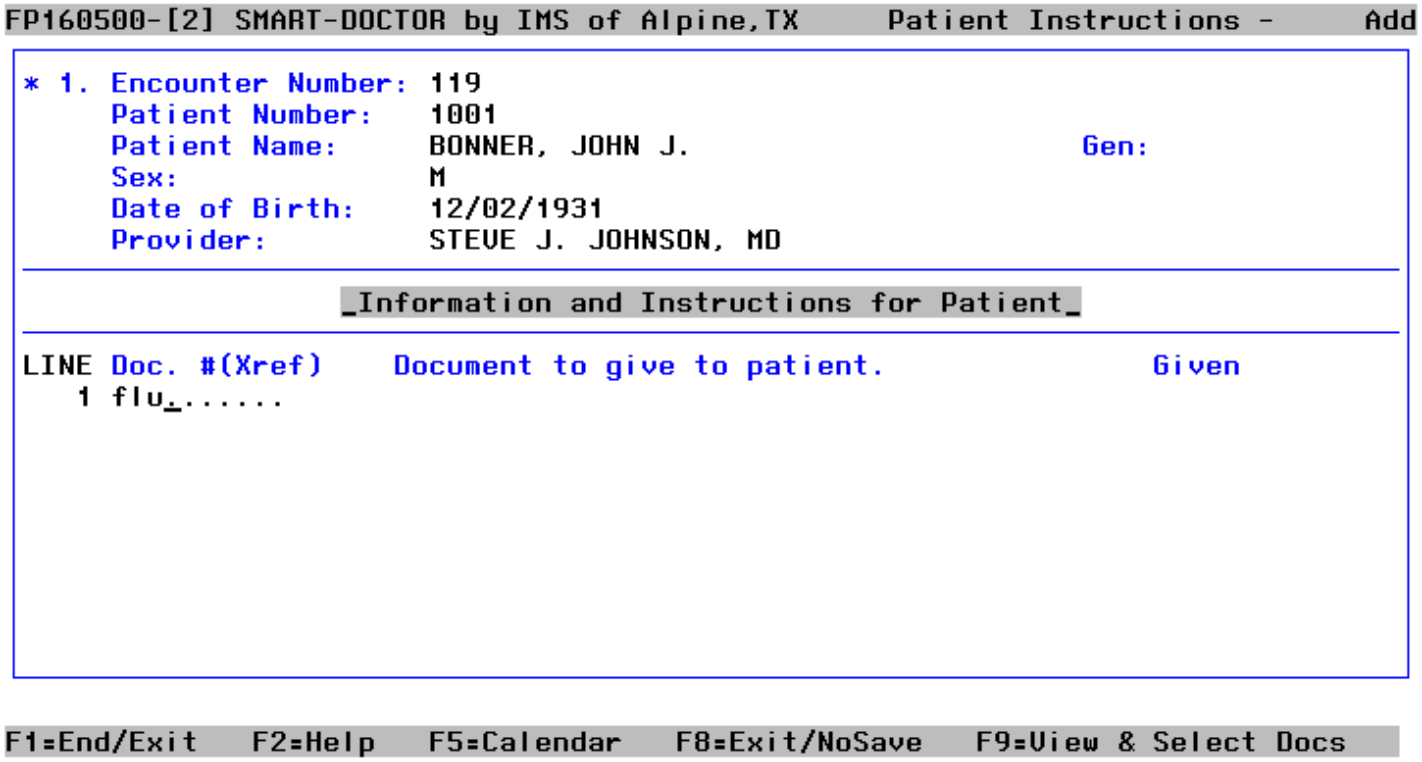


Figure 354 *Orders for Patient Instructions.*

In the multi-value line for "**Doc. #(Xref)**", enter part of the description of the document or materials you want to give to the patient. The standard cross-reference lookup will then be used to find the title in the information file. The selected document will be listed with its title in the second field, "Document to give to patient." Next, a pop-up screen will be presented to indicate whether this is to

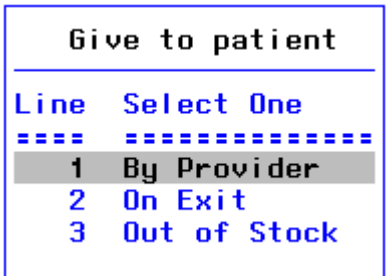


Figure 355 Give by.

be given to the patient by the provider, the clerk on exit, or that it is out of stock and queue it for later delivery to the patient, as seen in Figure 355.

Once indicated to be handed out by the provider or by the clerk on exit, you will be placed on the next line to specify additional information to hand out. If no more handouts are desired, hit the <F1> key to "end" input. The screen showing the selection and method of handouts is seen in Figure 356 below.

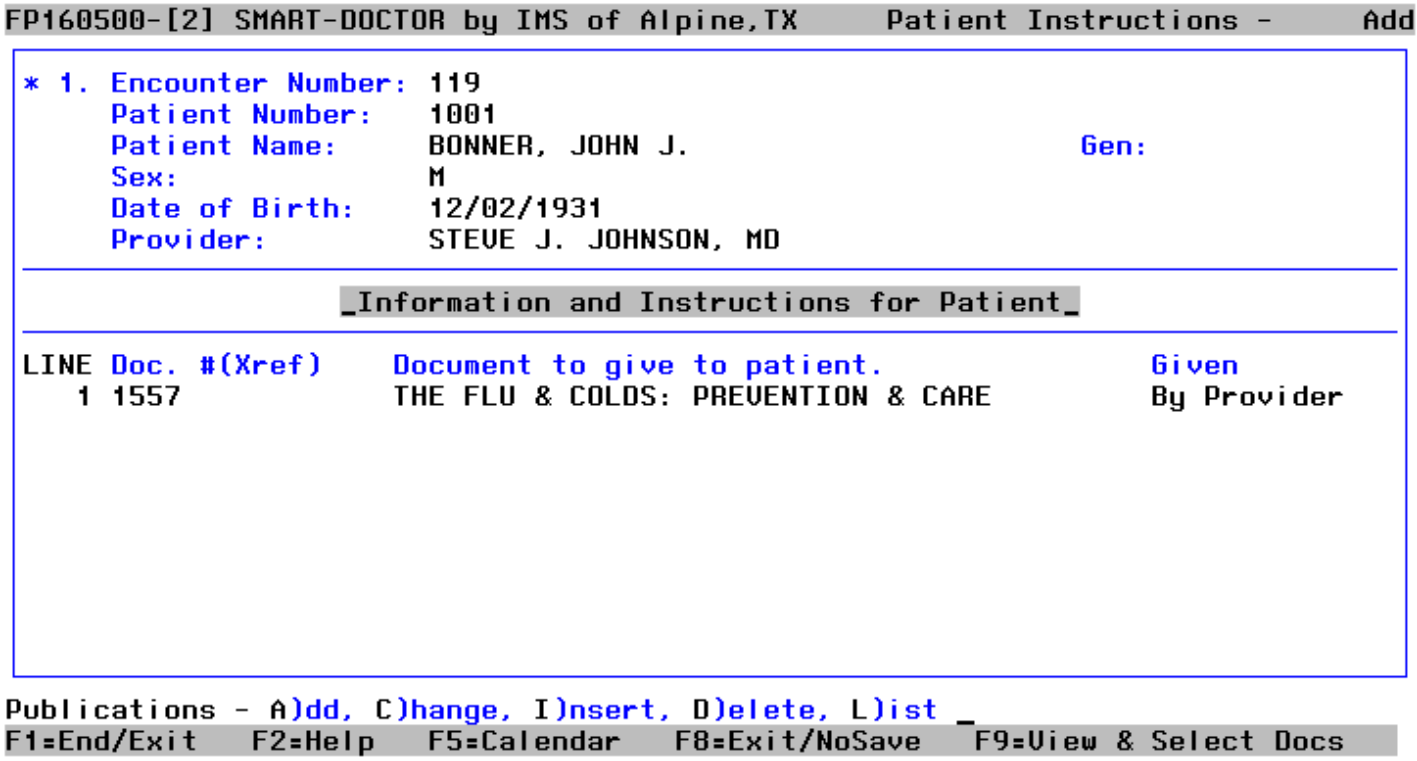


Figure 356 Final Orders for Patient Instructions.

Items contained in the information file are defined in the systems section of this manual under prompt #12. "**Pt. Information File**", from the "Systems Information File" screen.

Menu selection #10, "Make Referrals".
Select this menu item to make referrals. In prompt #1 of this new screen, hit the <enter> key to accept the defaulted "Encounter Number". The following referral screen seen in Figure 357 below.

Upon opening this screen and accepting the default encounter number, you will be placed in line #1 of the multi-value for the provider to whom you want to refer this patient. You can enter part of the provider's name, and/or city, and/or specialty, for a cross-reference lookup in the referring provider

file. Or, you can use the “F9” key on this screen to select from a list of providers,

Provider List *<F9> key*, will bring up a list of referring providers in the system from which you can select. Alternatively you can do a cross-reference search by entering in the “**Provider**” field part of the providers name. The selection screen is shown in Figure 358 for the name “**smith**”, entered on the first multi-valued prompt line of Figure 357.

Next you will get to select when to have the referral as seen in Figure 359 below.

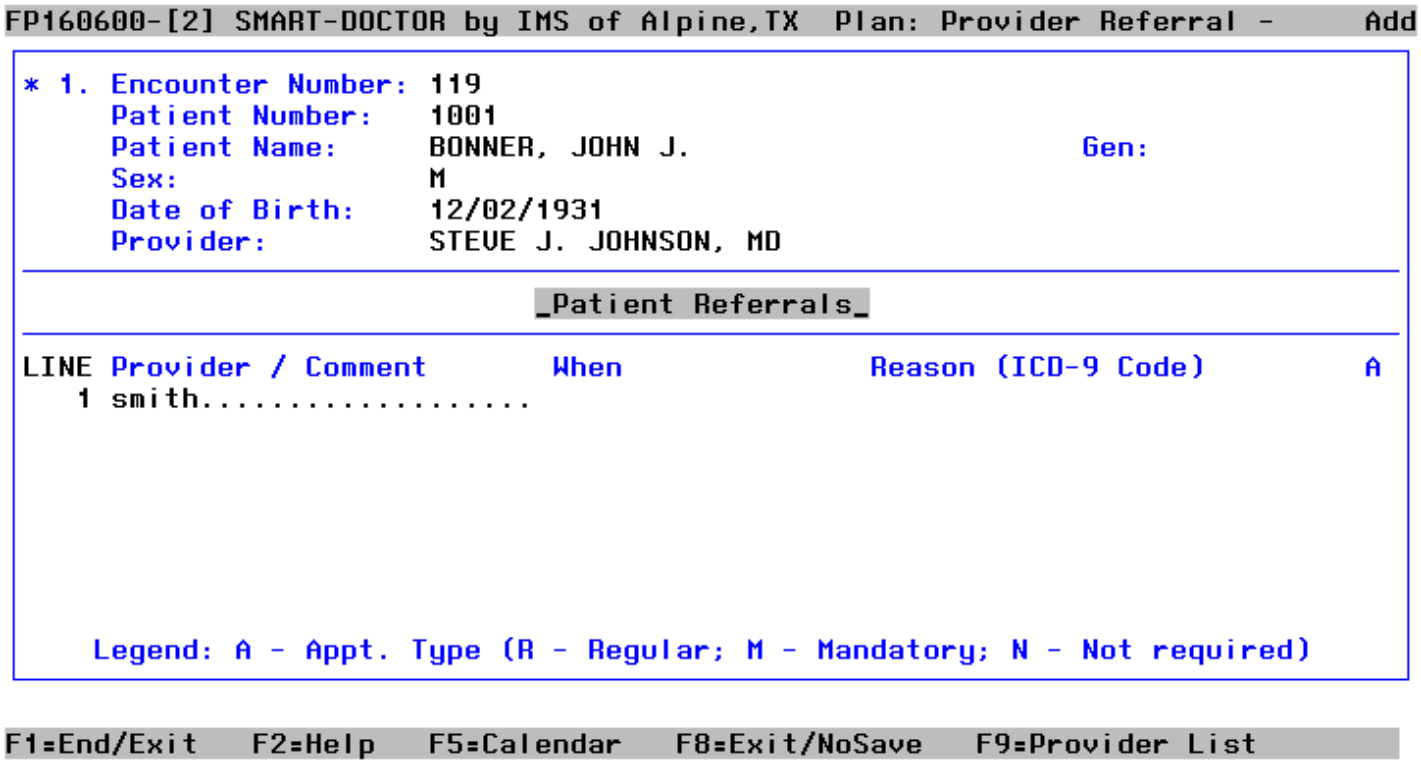


Figure 357 *Ordering Referrals*

Figure 358 *Cross-Reference Lookup for Referral.*

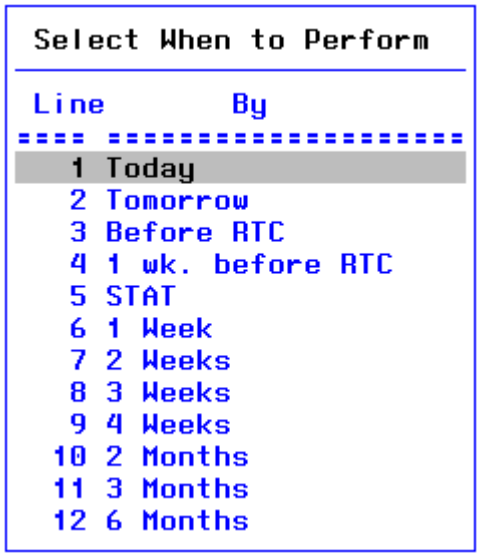


Figure 359 Selecting When.

You can page down through this screen for additional choices. The pop-up is defined in the TERMS file record “LAB-WHEN”, and can be changed by the system administrator with the assistance of IMS.

In “Reason (ICD-9 Code)” field, enter the ICD-9 code using the standard cross-reference lookup for assessments.

In the field labeled “**A**” for appointment type, enter as follows:

R for Regular Appt.:	Routine visit, minor illness, S/R, etc.
M Mandatory Appt.:	Abnormal test, serious prob, neoplasm, etc.
N No Appt. Req'd:	Screening PE, school PE, etc.; no med prob.

The second line of the multi-value is for your comments to the referral provider. This is a free-text entry. These comments will be printed on the referral sheet.

The resulting screen is seen in Figure 360 below:

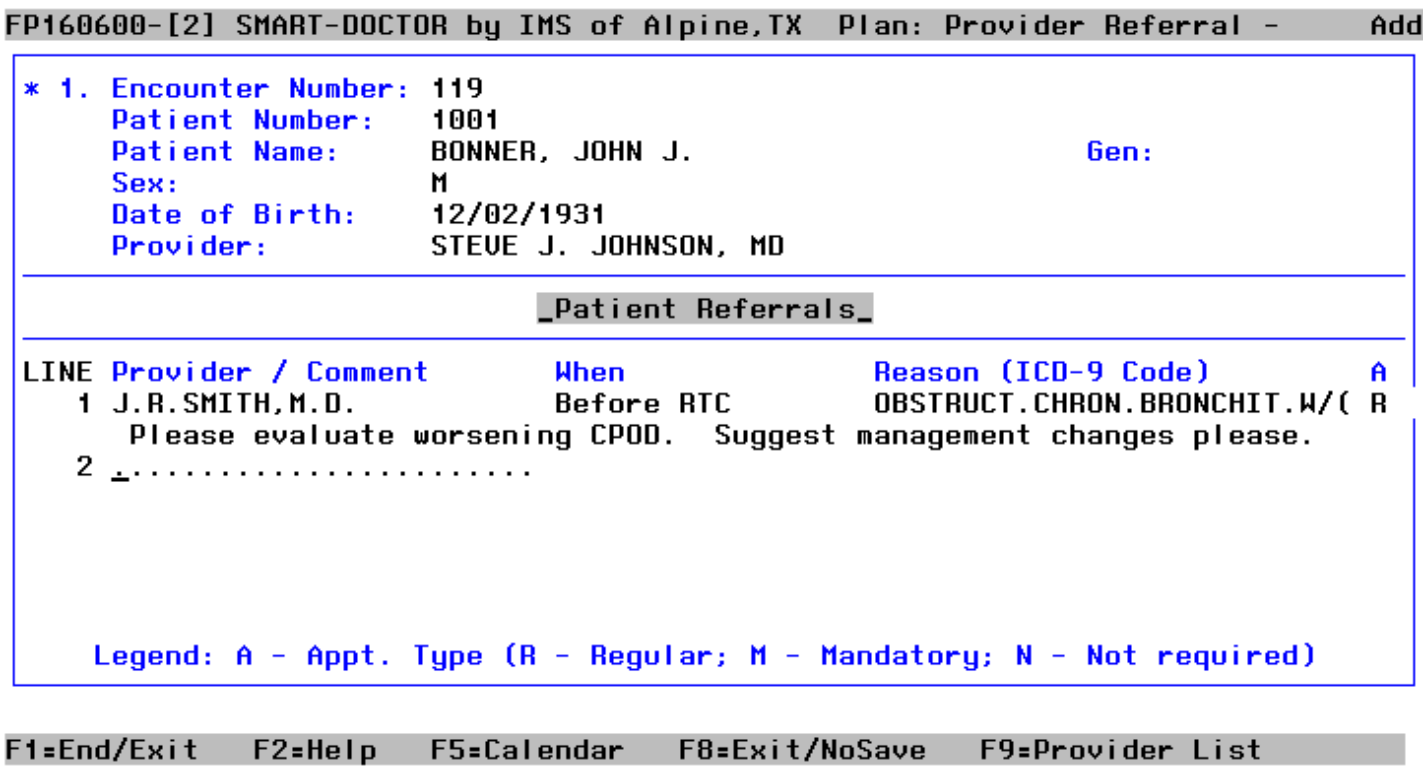


Figure 360 Completed Referral Order Line.

If a second referral is to be done, repeat in the same manner as on line #1, otherwise hit the <F1> key to “end” input.

Menu selection #11, “Schedule Procedures”.
Select this menu item to schedule one or more procedures. In prompt #1 of this new screen, hit <enter> to accept the defaulted “Encounter Number”. The following “Schedule Procedures” screen will be seen (Figure 361):

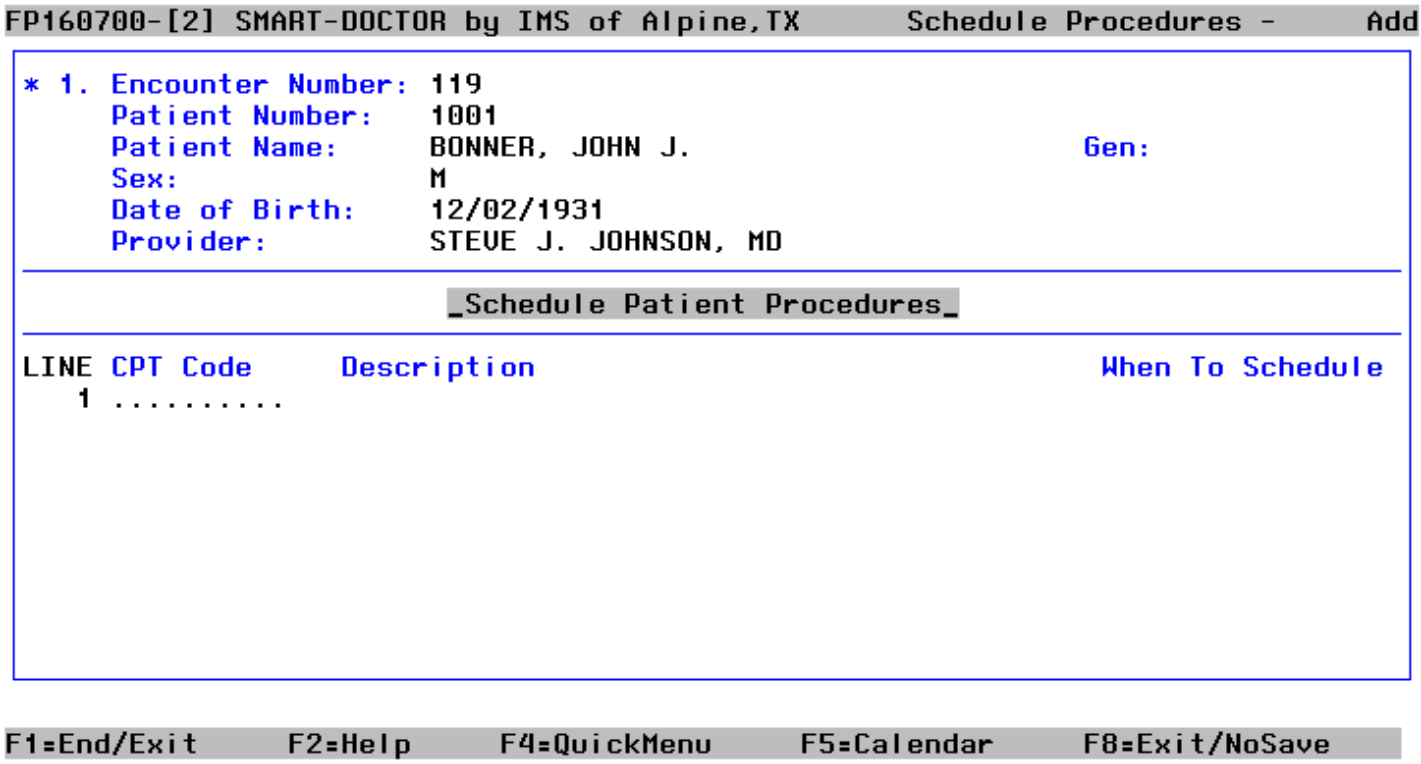


Figure 361 Initial Schedule Procedures screen.

In the multi-value line for scheduling procedures, indicate in the "**CPT Code**" field a partial description of the procedure for a cross-reference lookup, or enter the actual CPT code. The description of the procedure will be shown in the "**Description**" field automatically.

Next you will get the pop-up shown in Figure 362 where you will select when you want this procedure scheduled.

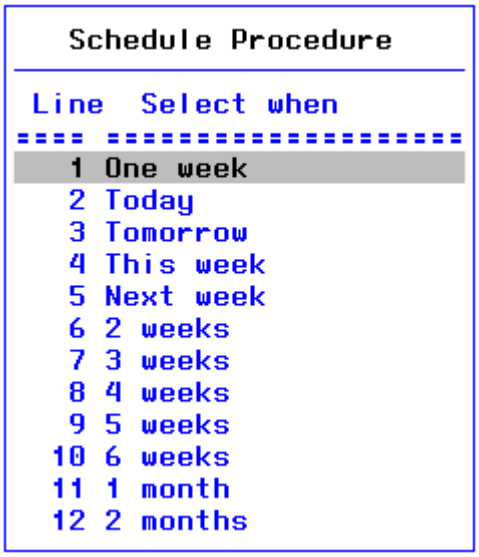


Figure 362 Procedure When.

You can page down through this screen for additional choices. The pop-up is defined in the TERMS file record "PLAN-SCHED_PRO", and can be changed by the system administrator with the assistance of IMS.

The resulting screen is seen in Figure 363 below.

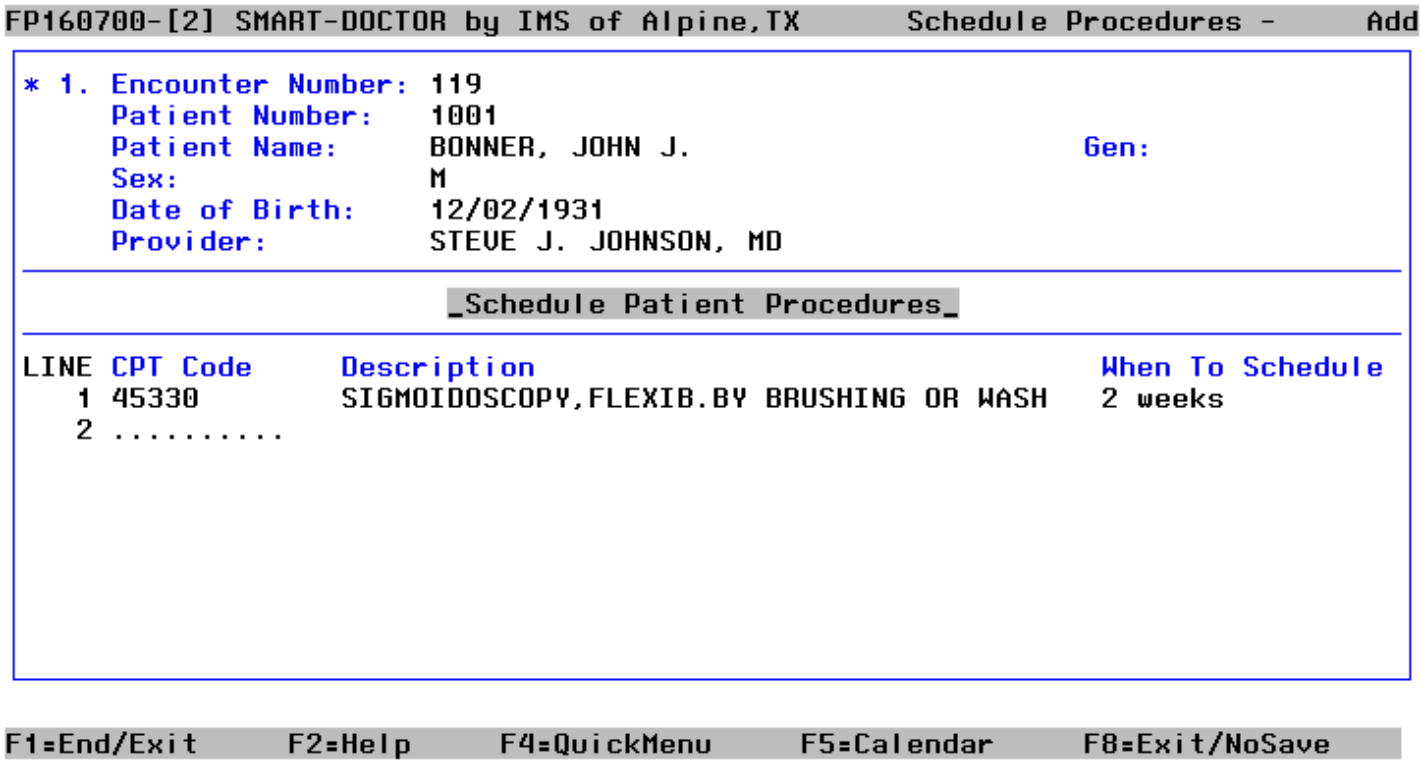


Figure 363 Completed Procedure Schedule Line.

In this example, a Flexible Sigmoidoscopy is to be scheduled in two weeks. If another procedure is to be scheduled, just continue in the same manner on line #2. Otherwise, hit the <F1> key to "end" input. Procedures indicated for scheduling on this screen will be queued for the patient exiting process.

Menu selection #12, "Schedule Single Follow-Up Appt. & Disability"
Select this menu item to schedule a single follow-up appointment and disability note. In prompt #1 of this new screen, hit <enter> to accept the defaulted "Encounter Number". The Follow-Up Appointment screen can be seen in Figure 364 below.

Prompt#2, "**F/U with:**", will bring up a pop-up selection window for the person in the clinic to make an appointment with. Selecting "Me" will result in indicating an appointment for yourself. This pop-up selection list is maintained in the TERMS file record "PLAN-WHO". All the selections, other than the first, can be changed by the clinic administrator with the help of IMS.

Prompt #3, "**When:**", will bring up the pop-up seen in Figure 365 below. This pop-up selection list is maintained in the TERMS file record "PLAN-SCHED_APPT". All the selections, other than the first, can be change by the clinic administrator with the help of IMS.

You can page down (or scroll down) to see additional choices in Figure 365.

Prompt #4, "**Appointment Type:**", will be skipped unless the entry in prompt#2 is set to "Me". If prompt #2 "F/U with:" was set to "Me", then your appointment schedule will be shown. You can then select the appointment type and length you desire. Your specific appointment types will appear similar to that shown in Figure 366 below:

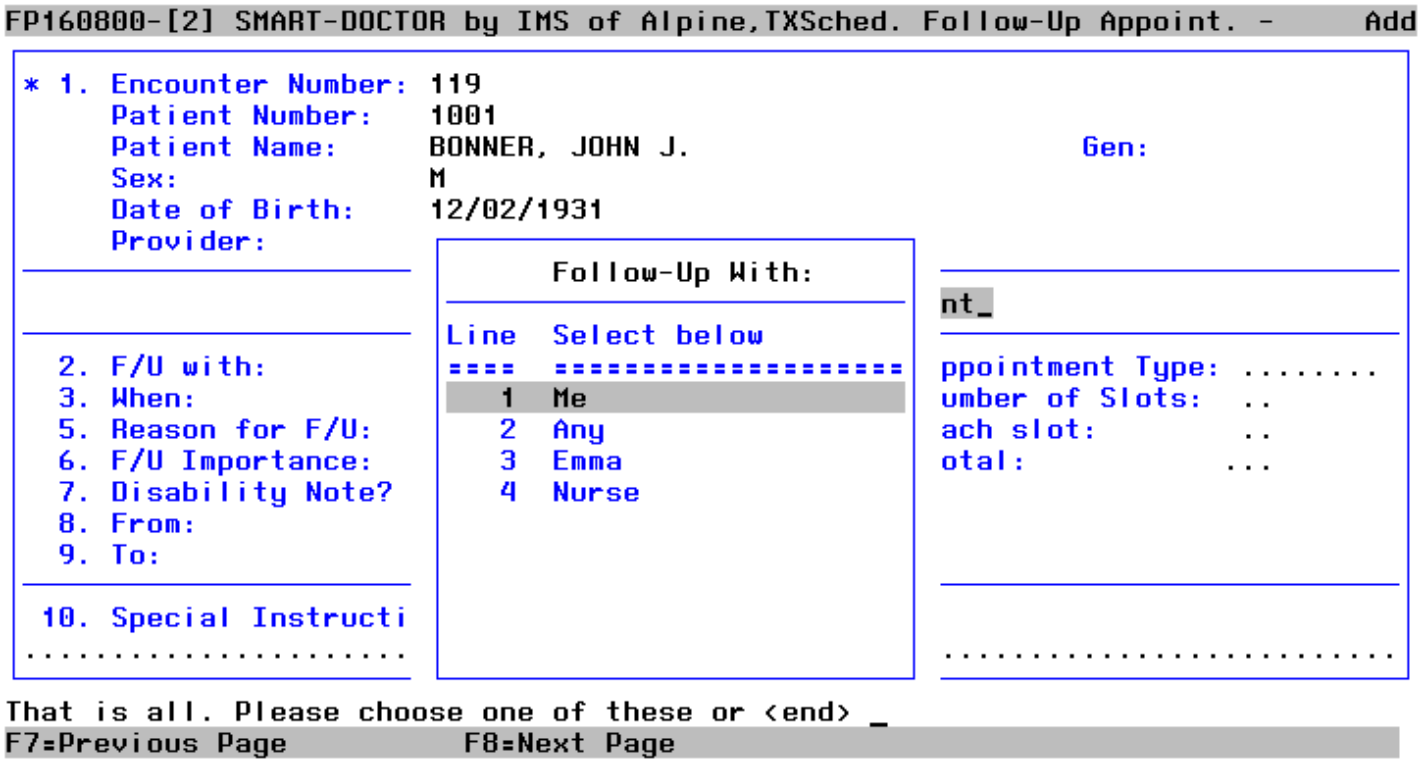


Figure 364 Schedule F/U/ Appointment.

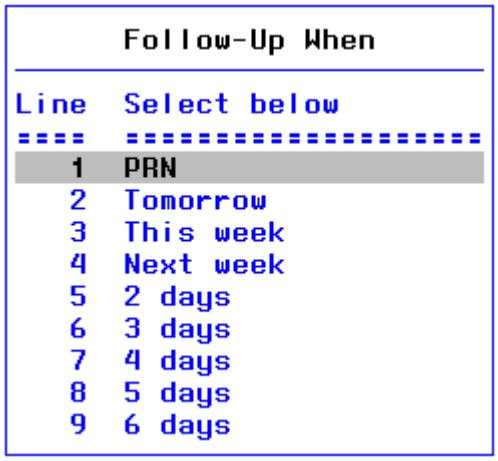


Figure 365 Select When

These appointment types are set in the Clinic Provider File as discussed in the basics section of this manual.

Prompt #5, "**Reason for F/U:**", is for a symptom or reason for visit. This works exactly the same as in the appointment scheduling section of this manual. It is a cross-reference lookup of the symptom file.

Prompt #6, "**F/U Importance:**", is to indicate the significance of the appointment to be made. The "?" mark is defaulted. By hitting <enter>, the "?" is entered and triggers the standard help screen to pop-up for this prompt. (You can do the same by hitting <F2> which is the equivalent of the "?" or help key in this system.). The help key will display the following:

R	-Regular F/U:	Routine visit, Minor illness, S/R, etc.
M	-Mandatory F/U:	Abnormal test, serious prob, neoplasm, etc.
N	-No F/U Req'd:	Screening PE, School PE, etc.; No med. Prob.

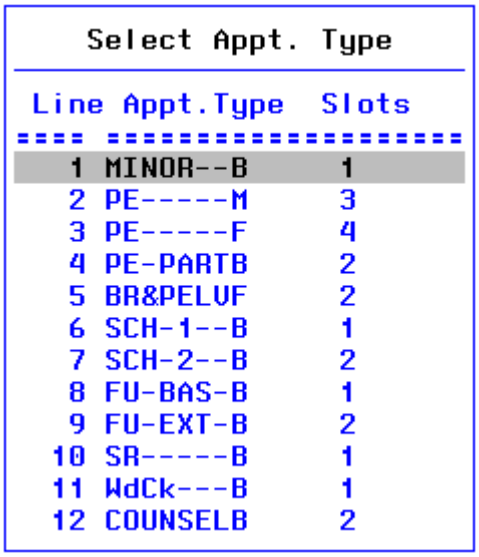


Figure 366 Appt. Type.

The purpose of indicating the "F/U Importance", is so that you can lookup all appointments due of this specific type that have not been made. A report of this nature can be made from selection #8, "Patient Appointments Due", off the reports screen. These appointments that have been queued but not made yet can also be found in the "Incomplete and Pending Orders" screen off the main office menu.

Prompt #7, "**Disability Note?**", enter <y> if the patient needs a "Disability Note" from the provider. The defaulted value is "**n**". Hit the <enter> key to accept this if you wish. If this prompt is set to "**N**", then prompts #8 and #9 will be skipped.

Prompt #8, "**From:**", if prompt #7 is set to "**Y**", then you will be placed in this prompt. Enter the appropriate date.

Prompt #9, "**To:**", if prompt #7 is set to "Y", then you will be placed in this prompt. Enter the appropriate date.

Prompt #10, "**Special Instructions:**", enter any special instructions or comments.

Work Comp <F6> screen. Hit the <F6> key to indicate this as a workmen's compensation case. Upon doing so, you will be presented with the following question in a pop-up box:

Do you wish to place this visit under Work. Comp.?
<return>=Yes/n=No

Entering <n> will bring you back to the original screen. Hitting <enter> or entering <y> will cause the "Workmen's Compensation" disability screen shown in Figure ** to pop-up.

Workmen's Compensation disability screen, Figure 367.

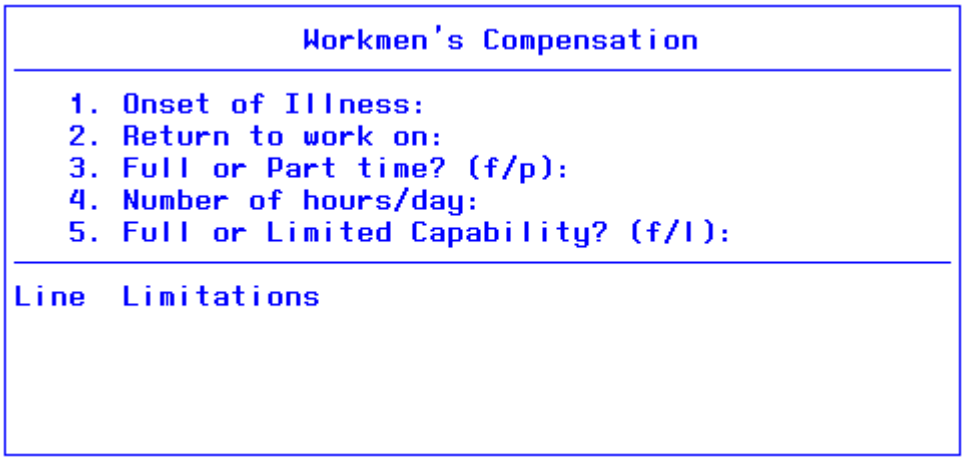


Figure 367 Disability screen.

Prompt #1, "**Onset of Illness:**", enter the date of onset of the patient's condition, or accident date.

Prompt #2, "**Return to work on:**", enter the date on which the patient is allowed to return to work.

Prompt #3, "**Full or Part time? (f/p):**", enter as follows:

F	Full Time:	Patient can return to work full-time
P	Part Time:	Patient is able to work only part-time

Prompt #4, "**Number of hours/day:**", this prompt is skipped if prompt #3 is set to "F". If prompt #3 is set to "P", then you should enter in this field the maximum number of hours/day the patient is allowed to work.

Prompt #5, "**Full or Limited Capability? (f/l):**", enter as follows:

F	Full:	the patient is allowed to work at full capability
L	Limited:	the patient has limits on his/her work capability

"**Limitations**" multi-value line. This prompt is skipped if prompt #5 is set to "**F**". If prompt #5 is set to "**L**" and you enter <a> at the"**Limitations**" change prompt, then you will be presented with a pop-up selection window to help you select the appropriate terms for each line added. The typical selection window for this prompt is seen in Figure 368 below.

You can page up and down (scroll) to see additional choices.

This pop-up selection list is maintained in the TERMS file record "LIM-WORKCOMP". All the selections can be changed by the clinic administrator with the help of IMS.

A resulting, typical Workmen's Compensation" disability screen will appear as seen in Figure 369 below.

The final Follow-Up Appointment and Disability screen appears as in Figure 370 below.

Had this visit originally been indicated as a workman's compensation visit, then the system would prompt the provider to fill out the screen for disability and follow-up appointments, had the

```
        Limitations on Physical Activity

Line  Limitation
----  ------------------------------
   9    no standing
  10    no standing over 1 hr
  11    no standing over 4 hrs
  12    no walking
  13    no walking over 100 yds
  14    no walking over 1 mile
```

Figure 368 Limitations Selection.

```
                  Workmen's Compensation

   1. Onset of Illness:                    08/20/2004
   2. Return to work on:                   08/30/2004
   3. Full or Part time? (f/p):            P
   4. Number of hours/day:                  6
   5. Full or Limited Capability? (f/l): L

LINE  Limitations
   1  no lifting over 10 lbs
   2  no standing over 1 hr
```

Figure 369 Completed limitation screen.

```
FP160800-[2] SMART-DOCTOR by IMS of Alpine,TXSched. Follow-Up Appoint. -  Change

* 1. Encounter Number: 119
     Patient Number:   1001
     Patient Name:     BONNER, JOHN J.                    Gen:
     Sex:              M
     Date of Birth:    12/02/1931
     Provider:         STEVE J. JOHNSON, MD

                       _Schedule Follow-Up Appointment_

  2. F/U with:         Me                  4. Appointment Type: MINOR--B
  3. When:             Next week              Number of Slots:   1
  5. Reason for F/U:   COUGH                  Each slot:         15 min
  6. F/U Importance:   R                      Total:             15 min
  7. Disability Note?  Y
  8. From:             08/20/2004
  9. To:               08/30/2004

 10. Special Instructions:
Come in AM, after your first breathing treatment of the day.

Change prompt (2 - 10), A)ll, F)ill, DR)delete record _
F1=End/Exit  F2=Help  F4=QuickMenu  F5=Calendar  F6=Work Comp  F8=Exit/NoSave
```

Figure 370 Completed F/U Appointment Order.

provider not done so by the time of exiting.

Menu selection #13, "Schedule Multiple Follow-Up Appointments".
Selecting this menu item allows the provider to schedule multiple follow-up appointments. In prompt #1 of this new screen, hit <enter> to accept the defaulted "Encounter Number". The Schedule Multiple Follow-Up Appointments screen screen can be seen in Figure 371 below.

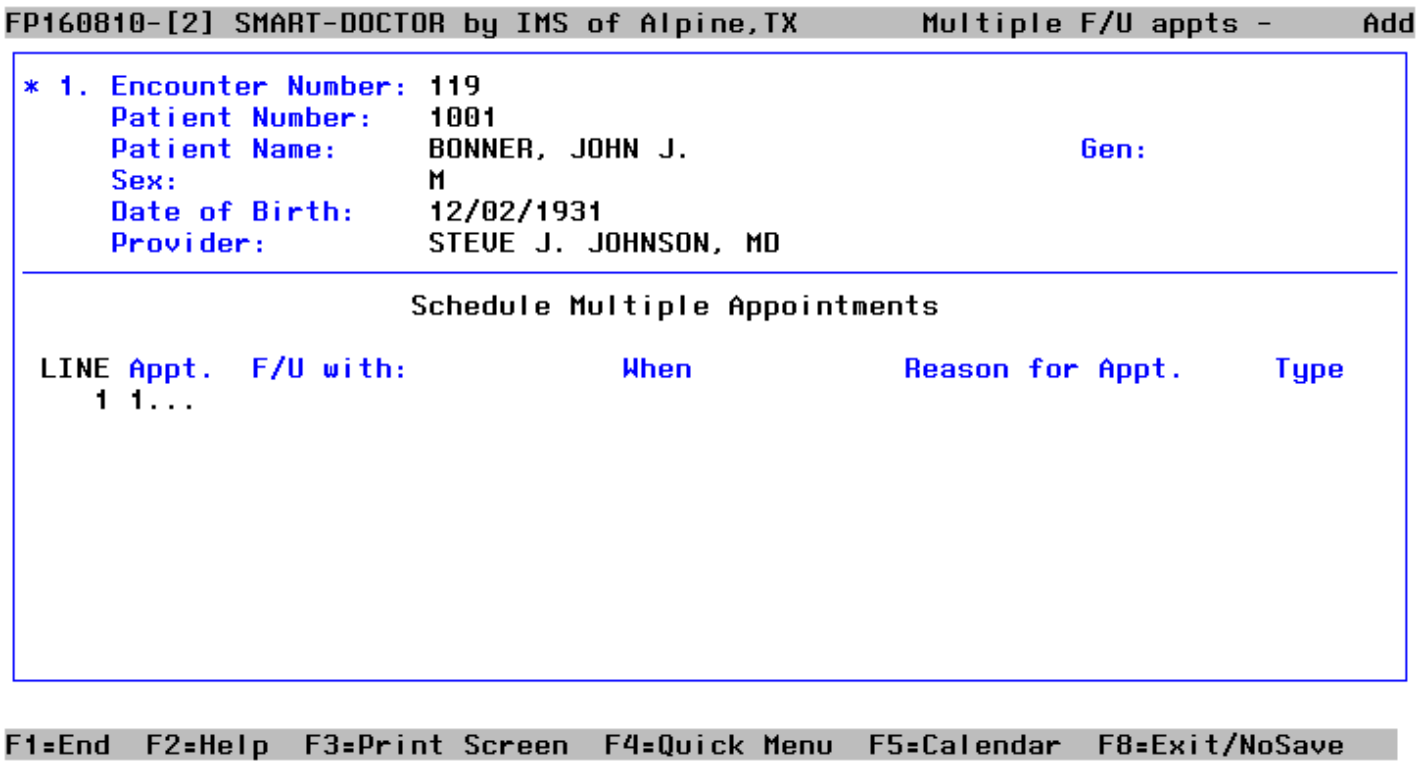


Figure 371 Order Multiple F/U Appointments.

On entry, you will be placed in multi-value line #1. Here, hit <enter> to accept the default in the "Appt." number field. This functions in an identical manner to the single appointment screen described in menu selection #12, "**Schedule Single Follow-Up Appt. & Disability**" above, with the exception that the "F6" key for a workman's compensation disability note does not function. (You must use menu selection #12 as discussed above for the disability note.) Upon returning to the primary screen, you can accept the default on the second line to make additional appointments as needed. In this example, in the final screen prior to exit, Figure 372 below, you will see that we have made two appointments. To review these appointments in detail, select that appointment number at the "Appt. #" change prompt.

Menu selection #14, "Other Diagnosis Related Plans"
Select this menu item to indicate plans related to a specific diagnosis indicated on the "F7" assessment screen from the providers orientation screen. In prompt #1 of this new screen, hit <enter> to accept the defaulted "Encounter Number". The "Other Diagnosis Related Plans" screen can be seen in Figure 373 below.

If you want to modify or see one of the existing plans, just enter the line number to select it. You will be placed in that plan screen to review or modify the plan. At the "**Plan for DX**" change prompt, you could enter <a> to add an additional plan. Upon doing so you will be placed on the next multi-value

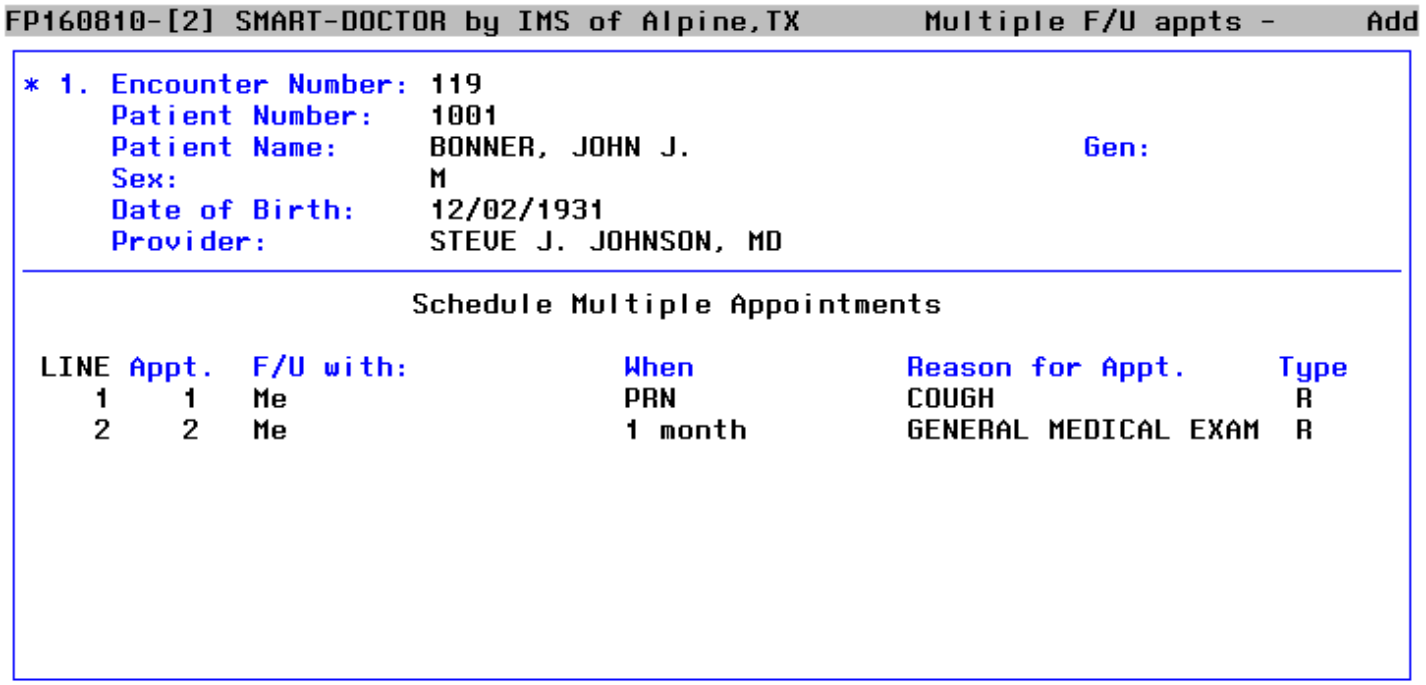


Figure 372 *Mutiple Appointment Orders.*

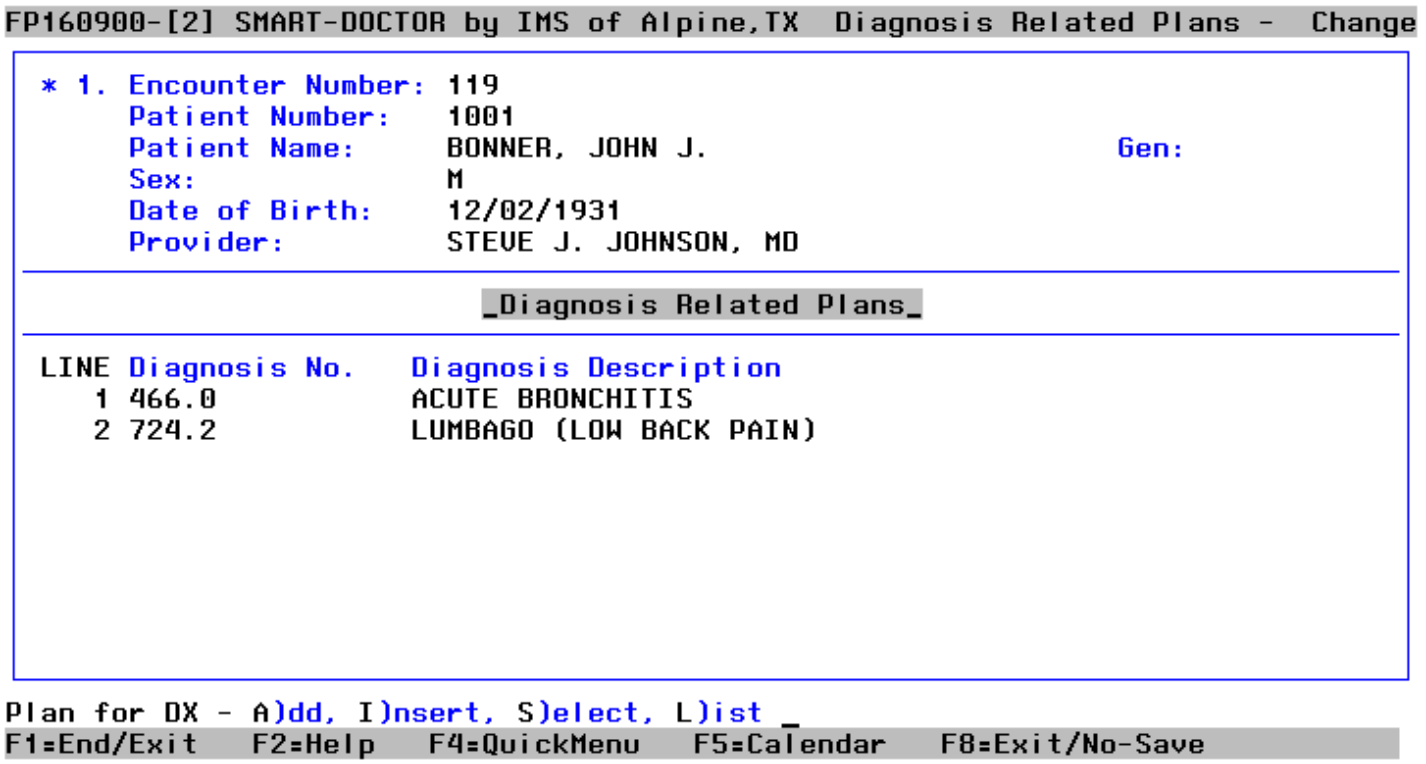


Figure 373 *Diagnosis Related Plans.*

line with "**Press <ent>...**" defaulted for you. Hit <enter> to get a pop-up that shows the diagnoses entered on the assessment screen prior to this point as seen in Figure 374 for this example.

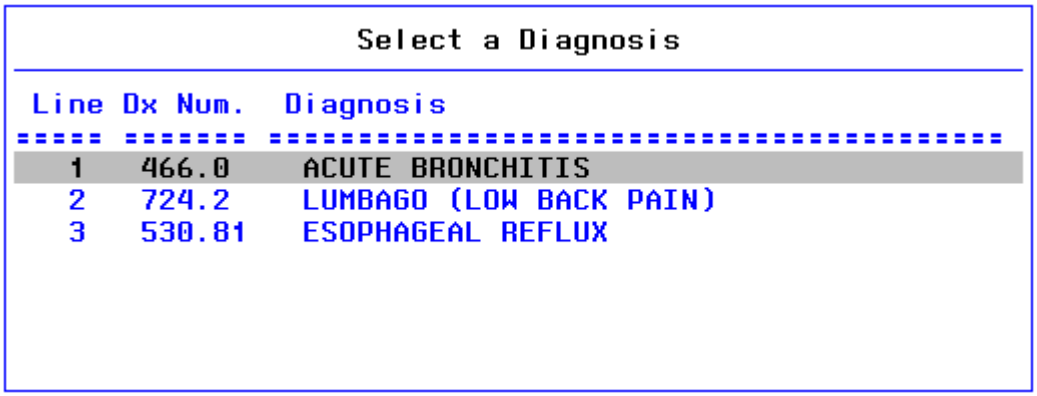


Figure 374 Select Plan Diagnosis.

If you select one of the diagnoses already showing on the plan screen, you will be told that the record is already on file. If you select a diagnosis that has not yet been listed in the diagnostic related plans menu screen, then, upon selecting this diagnosis, you will be brought into a new screen which will give you the "**Plan Narrative**" multi-value prompt as seen in Figure 375.

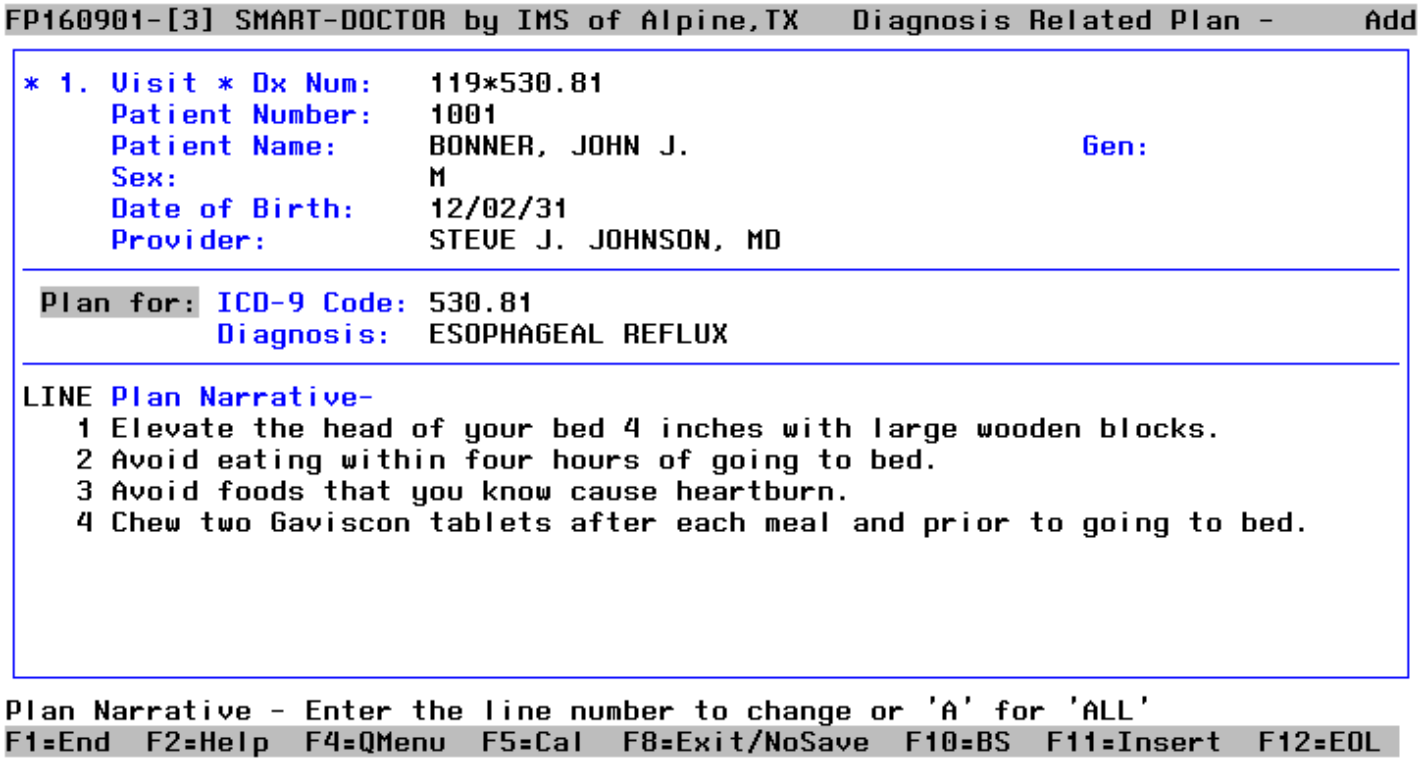


Figure 375 Diagnosis Related Plan.

In this example, we added a plan for "ESOPHAGEAL REFLUX". You can enter as many lines of text as you wish. Upon completing your text entry, hit <F1> to exit back to the prior screens. The resulting "Diagnosis Related Plans" screen is seen in Figure 376.

Chart Review <F11>, "ChtRv" screen.

From the provider visit orientation screen, you can select to review as well as add information to any part of the chart (other than existing notes). Upon hitting <F11>, the "Chart Review" screen will be seen as shown in Figure 377, and Figure 378, upon paging down.

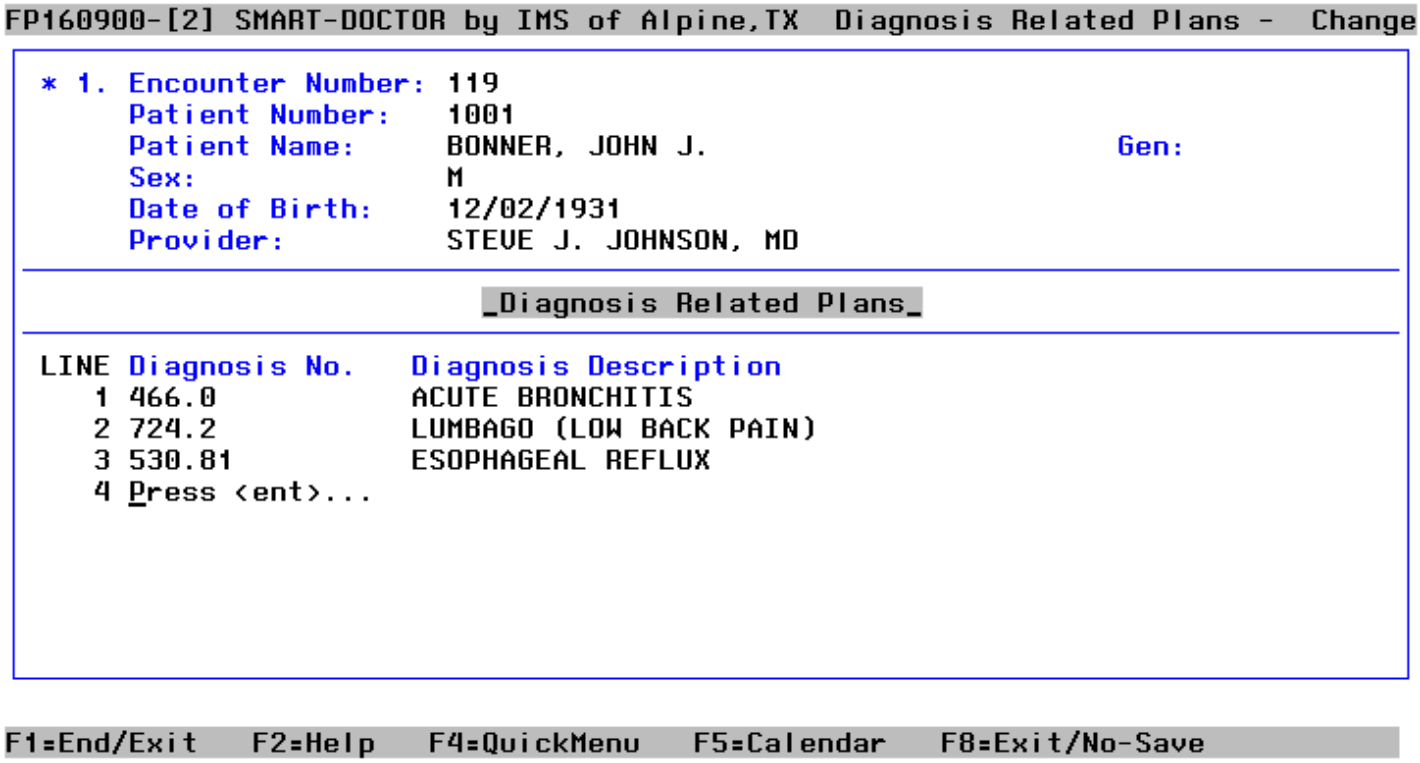


Figure 376 Revised Diagnosis Related Plans screen.

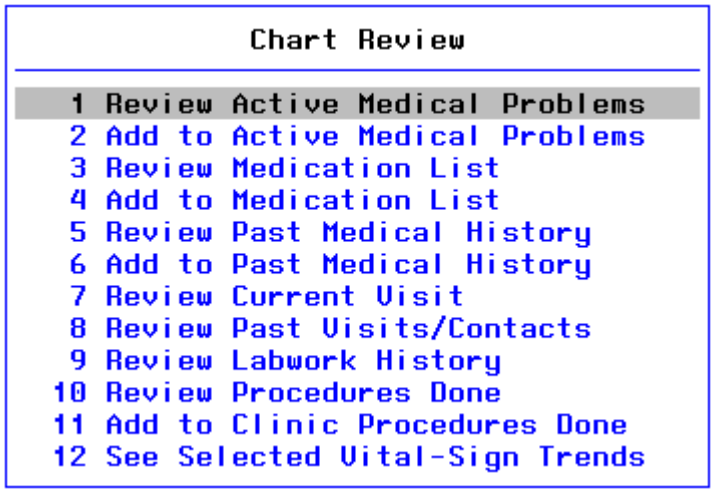


Figure 377 Chart Review Selection.

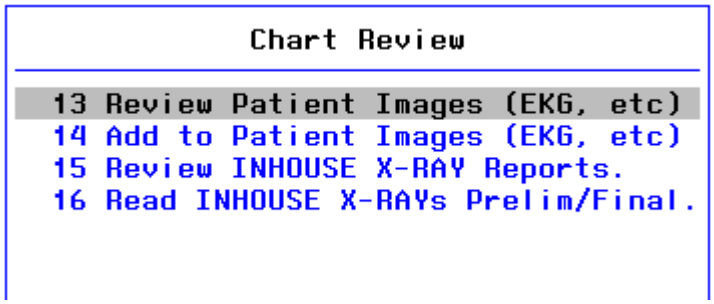


Figure 378 Chart Review Selection, Cont.

Review Active Medical Problems selection.
Upon selecting this item, you will be placed in the "Review Active Medical Problems" screen. This is the same screen presented in the automatic review screens at the beginning of the provider encounter note as is seen in Figure 289 above. It is fully discussed in that section.

Add to Active Medical Problems selection.
Upon selecting this item, you will be placed in the "Active Problem List" screen. The Active Medical Problems are added to automatically every time the provider exits the "Provider Visit" or "Non-Scheduled Provider Visit" encounter note. The format is different from the review screen, since each time a problem is added it gets it's own multi-value line. The line shows the diagnosis code, description, and indication if this came from a provider visit as indicated with a "**P**", or blank if this was added by way of a non-visit encounter. The last two columns indicate the date of onset and the date recorded, respectively. An example of this screen is shown in Figure 379.

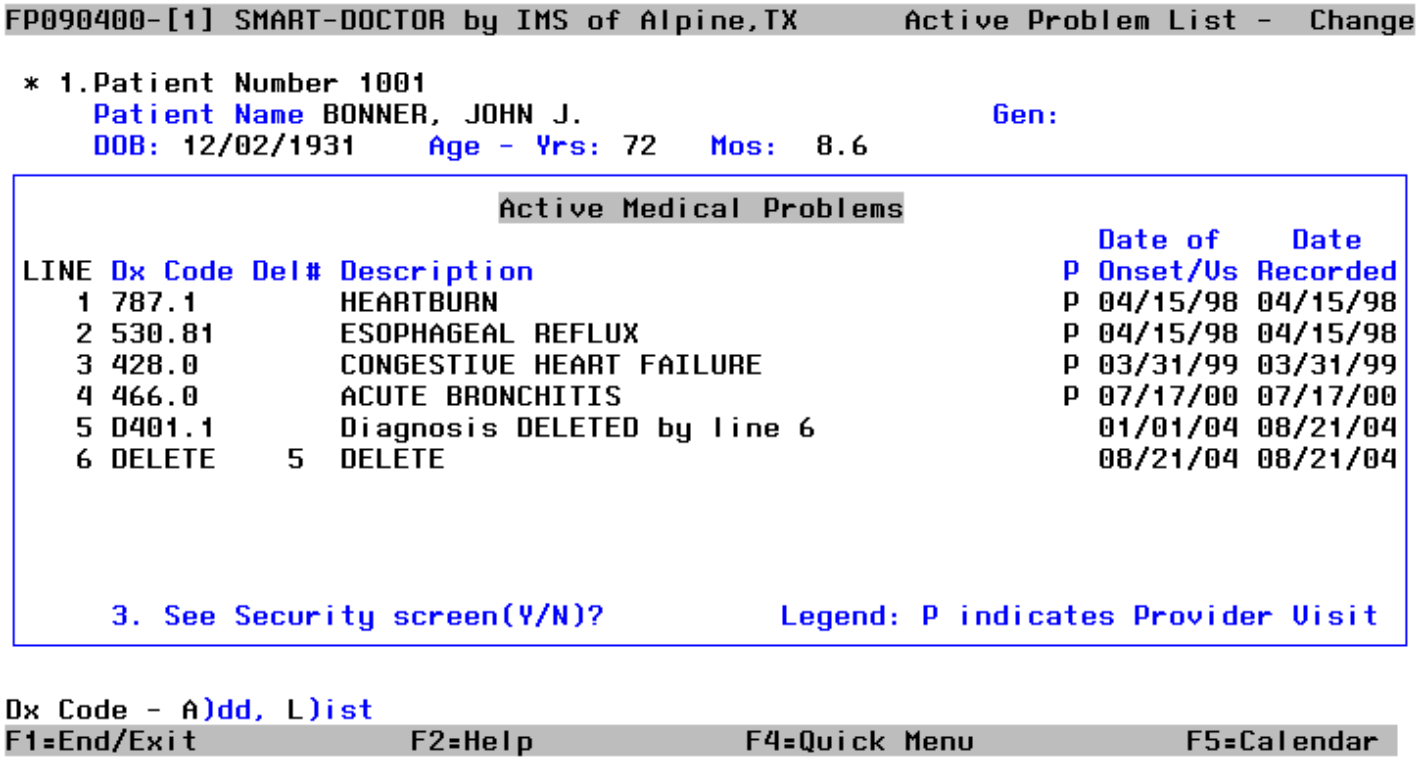


Figure 379 Adding to Active Problem List.

In this example, you can see that each diagnosis is entered on a separate line. If in the diagnosis field you added heartburn again, it would be a separate line with its own date of onset and date recorded. This is a different than the review screen, in that in the review screen we want to see a

cleaned up list of active medical problems. We do not want to see the detail of each time it was recorded, nor those that were deleted because they were in error. In the example shown in Figure 379, a diagnosis of hypertension (ICD code number 401.1) had been added. Upon the provider's realization that this was an error, the provider can delete this by entering the word "delete" in the “Dx Code” field. You will then be stopped in the “Del #” field to enter the line number that you want to delete. You'll note in the example shown that once deleted there's a capital “D” placed in front of the code number. The original code that was entered previously is not destroyed, as well as the detail of which line deleted this specific diagnosis code. Upon bringing up the security screen from prompt #3, you can see who entered each diagnosis and who deleted each diagnosis by checking the corresponding line number on the security screen, has seen in Figure 380.

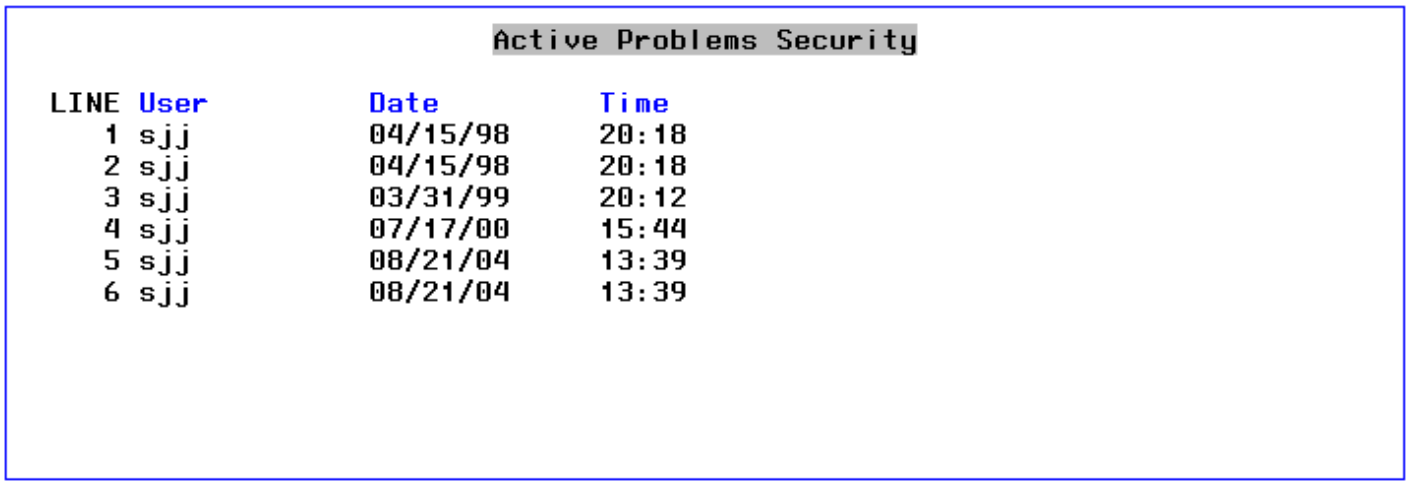


Figure 380 *Add Problem Security screen.*

On the “Security” screen you can see who and when each entry was made on the primary screen.

Review Medication List selection.
Upon selecting this item, you will be placed in the “CHRONIC MEDICATIONS & ACUTE MED'S of PAST YR.” screen. This is the same as the screen presented in the automatic review screens, at the beginning of the provider encounter note, Figure 290 above.

Add to Medication List selection.
This screen appears similar to the review screen with the exception that now the “per”, “Disp”, and “Nurs Rfls” columns are missing. Also, “**Del No.**”, “**TYP**”, and “**Dltd by Line**” columns have been

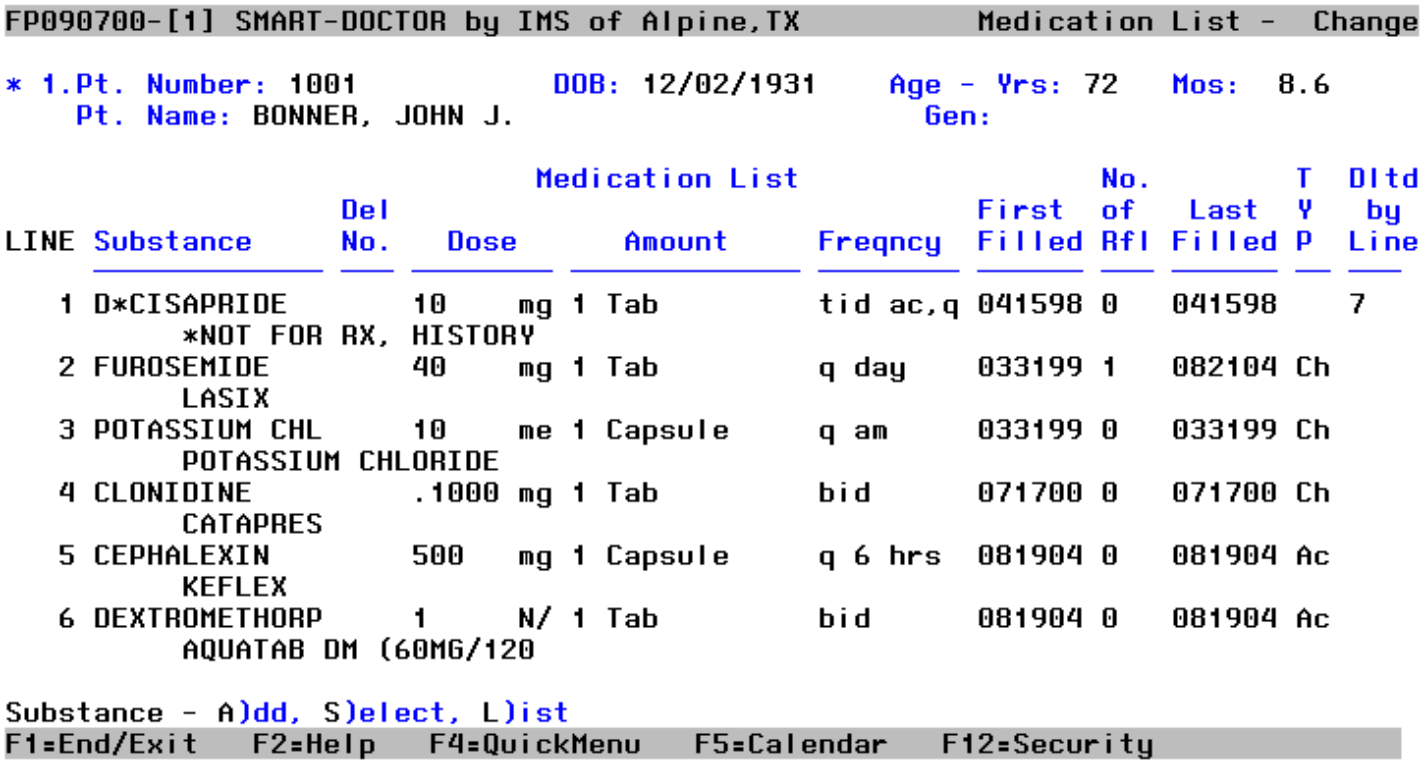


Figure 381 Medication Add screen.

added. See Figure 381.

Deleting a medication from the list is done in a manner similar that in the “Active Medical Problem List” section above, in that you add a “DELETE” in the first field (“Substance”). Then, you enter the line number you wish to delete. In Figure 381 you can see an example of a deleted drug. In the example on line #1, you will see a “**D***”, in front of the original substance name. You will also note in the “**Dltd by Line**” column the line number of the line that deleted this substance. In this case, this was line #7. You can review the security screen as in the example of the “Active Medical Problem List” above. On the security screen, you'll be able to see who deleted the substance and when.

In line #2 of this example you can see the drug FUROSEMIDE (Lasix) indicated as having one refill in the “**No. of Rfl**” column. The “**TYP**” column is indicated as chronic. The type column can have three descriptors, “**Ac**” for acute, “**Ch**” for chronic, and “**Sa**” for sample.

To see details on this prescription and refills at the “**Substance**” change prompt, enter the line number to select. An example of the resulting screen can be seen in Figure 382.

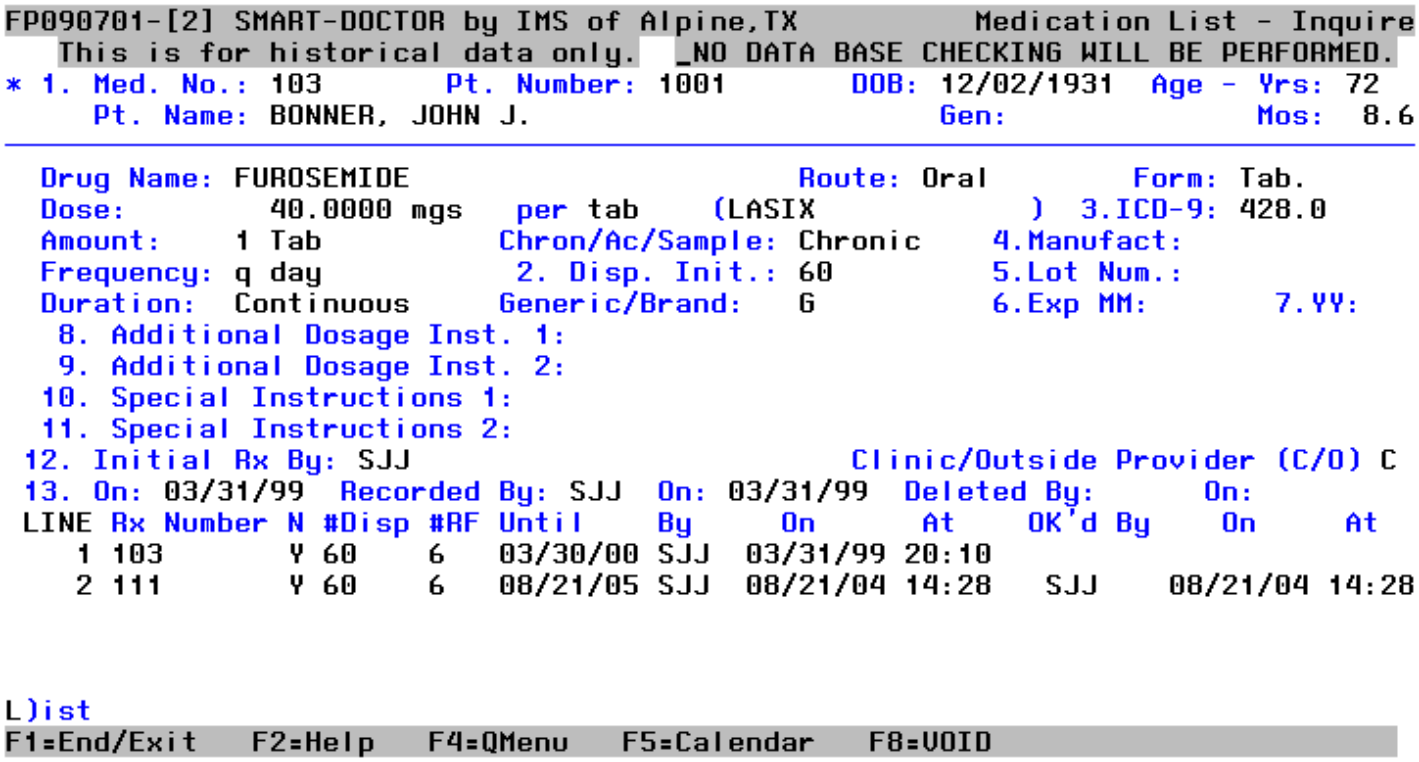


Figure 382 *Medication List Review.*

In this screen, you can see the detail of who and when the prescription was filled and refilled. If the medication was written by a doctor, then the "**OK'd by**" column does not get populated. If refilled by a nurse, the the "**OK'd by**" field will be filled in when the doctor indicates approval.

Adding an "historical" substance brings up the screen shown in Figure 382 above in the "**Add**" mode rather than the "**Inquire**" mode shown in that Figure. (The Figure will not be shown again to save space.) As you go through the add screen for each of the prompts shown above, pop-up selection windows appear which are the same used in the prescription writer. However, at the top of this screen it states "**This is for historical data only. _NO DATA BASE CHECKING WILL BE PERFORMED**". Since these may be substances provided by outside doctors, they would not have had the benefits of the SmartDoctor® prescription writer and this patients database files for contraindication problems. All we are doing here is adding this historical data to the prescription writer system. However, on using the standard prescription writer from the provider screens, these substances will be checked for contraindications with newly prescribed or refilled substances.

Review Past Medical History selection.
Upon selecting this item, you will be placed in the "Review PMHx" screen. This is the same as the screen presented in the automatic review screens at the beginning of the provider encounter note as is seen in Figure 291 above. It is fully discussed in that section.

Add to Past Medical History selection.
Adding or deleting information in the patients "Past Medical History" screen is fully described in the Patient Processing section of this manual under the title "Past Medical History".

Review Current Visit selection.
Upon selecting this item, you will be placed in the "Visit Review" screen. This is the same as the screen presented in the automatic review screens at the beginning of the provider encounter note

as is seen in Figure 296 above. It is fully discussed in that section. However, as the visit progresses the information displayed will change. If at anytime during the documentation of the current visit you want to review the current note, this is the way to do it. It avoids having to go back to each subsection of the note with the "**SOAP**" keys. Everything documented up untill selecting this option will be shown.

Review Past Visits/Contacts selection.
Selecting this option will allow you to look at all prior "Provider Visit" notes, "Non-Visit Encounter" notes, and "Non-Scheduled Provider Visit" notes. It is an extremely fast way to find and review prior notes. In the screen presented in Figure 383 below you'll see listed all the patient's prior visit

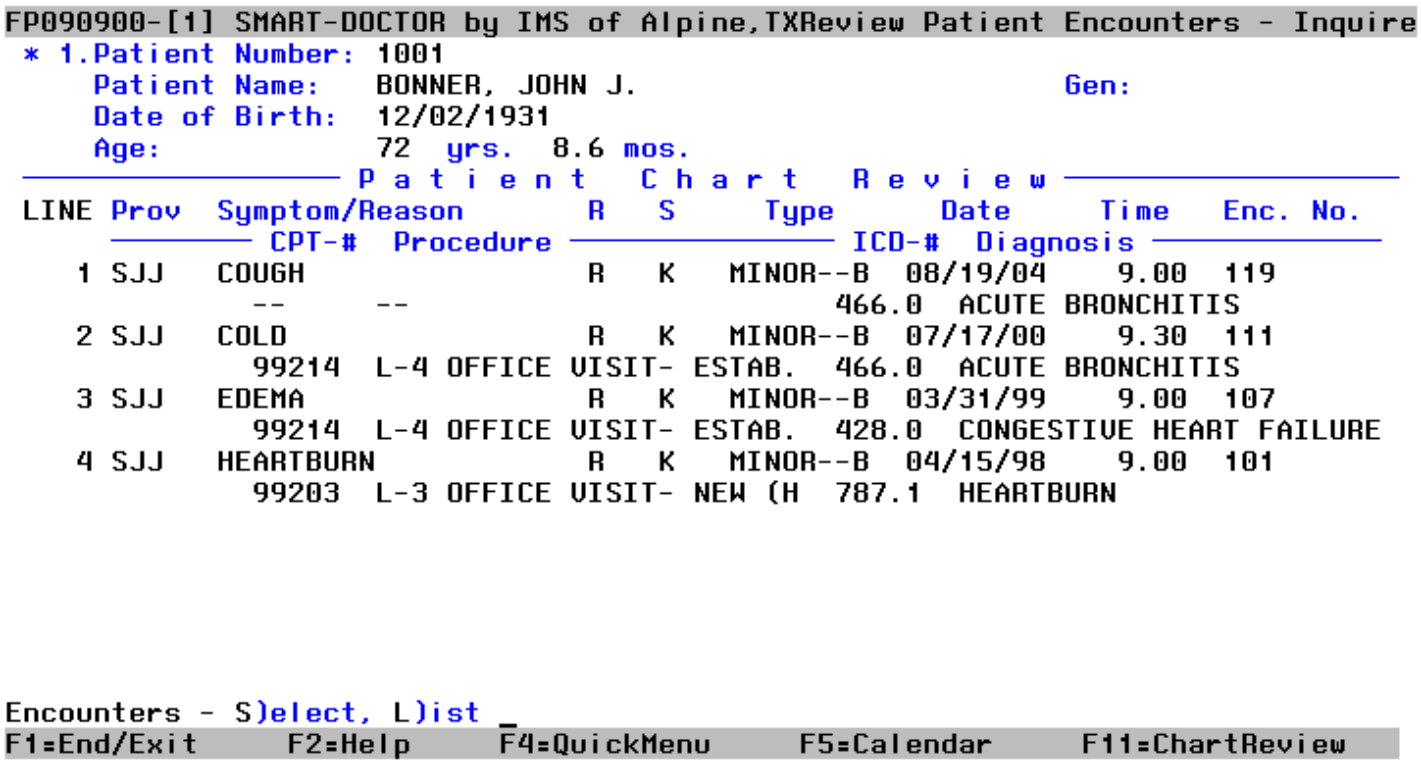


Figure 383 Select Past Encounter to Review.
contacts.

At the "Encounters" change prompt, enter the line number of the visit you would like to review. Line #1 is the current visit. You can tell this by the date, time, and the fact that there is no procedure charge indicated. Upon selecting one of these lines, you'll be taken through the visit review just like the beginning of this provider note, as described above.

Review Labwork History selection.
Upon selecting this menu item, you will be taken into the "Patient Lab History" screen. An example of the screen is shown in Figure 384 below. At the "Indicate Reviewed" change prompt, enter the line number of the lab test you would like to review. In this case, the first test, a Serum Glucose, was indicated as abnormal. Upon selecting this test, you will be taken to that lab screen to show you the blood glucose value. In this case, the reviewed column shows an "**R**" to indicate that this was reviewed previously. Tests done by the provider, as in the case of an "In-House" test such as this, will be indicated as reviewed, since the provider performed the test. Tests that have not been reviewed by the provider will have a "**-**" symbol in the reviewed column. After reviewing a test, the provider can indicate the test has been reviewed. In the case of the second lab test presented in

this example, this is an outside lab that has not returned yet. When the actual lab comes back, this can be indicated as “In” and reviewed either from this screen or from the doctor main menu. Please see the section on lab tests in the patient processing section of this manual for more information on lab test processing. Also, see the information on ordering lab tests presented earlier in this section of the manual.

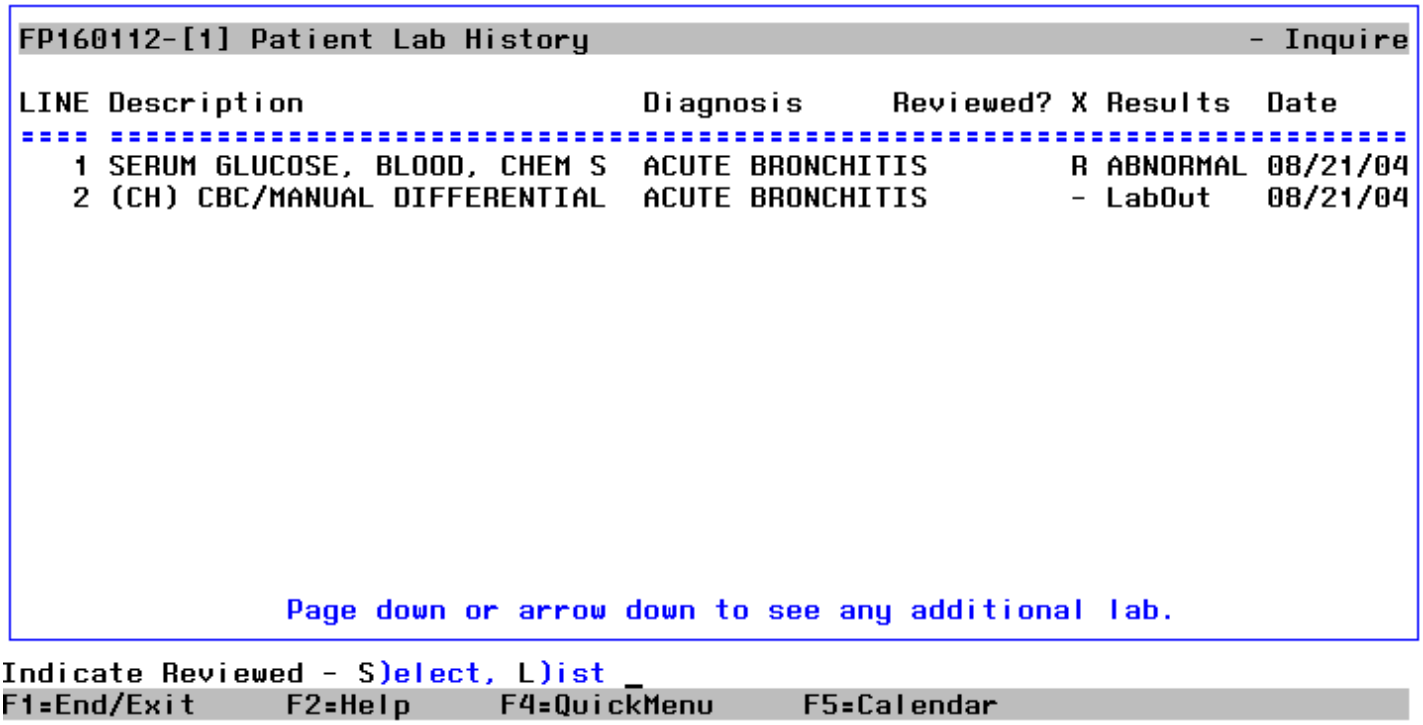


Figure 384 *Patient Lab History Review screen.*

Review Procedures Done selection.

Upon selecting this menu item, you'll be placed in the “Review Procedures by Clinic” screen. The screen seen in Figure 385 below shows the procedures that have been documented by this clinic.

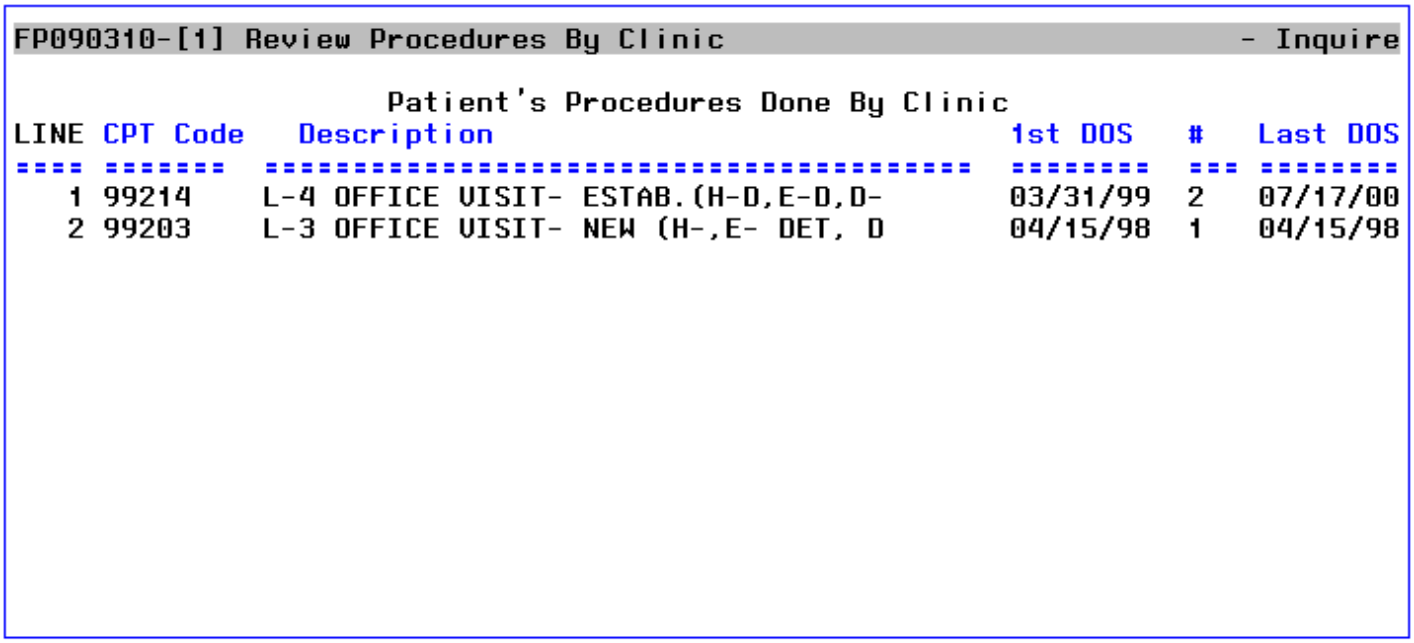


Figure 385 *Review Clinic Procedures.*

All procedures indicated by the provider on the exit screen will be documented in this file. On this inquire screen, you can see the initial procedure code, the description of the procedure, the day of service first of the procedure, the number of procedures performed, and the date of service the last time this procedure was performed.

Add to Clinic Procedures Done selection.
Select this menu item if you want to document procedures done in the past or that have not been captured through the standard procedure charge mechanism, for example, if you have done a complete physical on a female patient which included a pelvic exam. However, you just charged for a complete medical exam, then you may want to indicate that this procedure had been done. This would be useful when making reports of procedures that are overdue. If you are looking for the specific procedure “Pap Smear” in female patients that do not have this procedure indicated in your selection criteria, you would get the patient flagged in the overdue procedure report inappropriately. Of course, if you are sending out the “Pap Smear” routinely with the lab portion, then this would not be needed. However, tests done by other clinics could also be noted here for you to keep track of health care maintenance procedures done. The “add procedure” screen is shown in Figure 386 below.

In in the multi-value change prompt **"CPT code"**, enter <a> to add. You'll be placed in the multi-value line in the “**CPT code**“ field. Here, enter the partial description of the procedure that was done, or the actual CPT code if known. In the “**P**” column, a “**P**” indicates this was documented from the provider's exit billing screen. If “**O**”, this was documented in this add screen, and could have been done in this clinic or another clinic. The security screen works in the same manner as the “Add to Active Medical Problems”, described earlier in this manual.

See Selected Vital-Sign Trends selection.
Upon selecting this menu item, you will be placed in the “Review Vital Signs--Inquire” screen. Here, you will be able to scroll up and down through the list of vital signs taken. An example of the screen is shown in Figure 387.

```
FP090410-[1] SMART-DOCTOR by IMS of Alpine,TX   Clinic Procedures Done -  Change

 * 1.Patient Number 1001
     Patient Name BONNER, JOHN J.                              Gen:
     DOB: 12/02/1931    Age - Yrs: 72   Mos:  8.6

                          Clinic Procedures Done
                                                          Date of      Date
LINE CPTcode Del# Description                           P Service    Recorded
   1 99203    --  L-3 OFFICE VISIT- NEW (H-,E- DET, D  P 04/15/1998 04/15/1998
   2 99214    --  L-4 OFFICE VISIT- ESTAB.(H-D,E-D,D-  P 03/31/1999 03/31/1999
   3 99214    --  L-4 OFFICE VISIT- ESTAB.(H-D,E-D,D-  P 07/17/2000 07/17/2000

     3. See Security screen(Y/N)?          Legend: P= Provider Off. Visit Bill

Cpt Code - A)dd, L)ist _
F1=End/Exit            F2=Help            F4=Quick Menu            F5=Calendar
```

Figure 386 *Add Clinic Procedure Not Documented.*

```
FP091000-[1] SMART-DOCTOR by IMS of Alpine,TX      Review Vital Signs - Inquire

 * 1. Patient Number: 1001
      Patient Name:   BONNER, JOHN J.

                        _History of Selected Vital Signs_
 LINE Date       Temp     HR    Resp SBP   DBP   WT#   Oz Ht.in   H/W   Head cm
    1 04/15/1998  98.8   100*  20*  160*   80   220*      70.0    39**
    2 03/31/1999  98.2   100*  20*  160*   90   235*
    3 07/17/2000 102.0*  120**

L)ist
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 387 *Review of Vital Signs.*

All abnormals are flagged as indicated in the basics section of the manual. These are the initial vital signs taken by the nurse at the onset of the visit. Intra-office visit vital signs are only documented within the note itself and may be found by reviewing the specific note.

Review Patient Images (EKG, etc) and Add to Patient Images (EKG, etc) selections.
Upon selecting one of these menu items, you would proceed as described in the "Manage Patient Care" section of this manual, discussing adding and reviewing images. Images can be added by the provider or may be delayed and entered by the nursing staff at a later time. These images can be added though the Non-Visit encounter screen by a provider or by the clinic staff through the front office screen, as discussed in the "Manage Patient Care" section.

In displaying images, it is important to note that you may have multiple images up at the same time so that you can make comparisons. Any type of image can be stored and viewed, including photos, EKGs, Faxes, X-ray, and Sonograms (all standard formats including DICOM). Have your clinic administrator set these capabilities up for you with assistance from IMS.

Review INHOUSE X-RAY Reports and Read INHOUSE X-RAYs Prelim/Final selections.
Upon selecting one of these menu items, you would proceed as described in the "Manage Patient Care" section of this manual, discussing X-RAY images. The initial image would be added by the X-Ray technician as a result of an X-ray order queued by you or another provider. Once the X-Ray has been taken, it can then be read by the doctor from the "**Preliminary & Final InHouse X-RAY Reading**" menu item. The doctor can do the preliminary or final readings depending on how your clinic functions. Images can be added by the provider or may be delayed and entered by the nursing staff at a later time. These images can be added though the Non-Visit encounter screen by a provider or by the clinic staff through the front office screen, as discussed in the "Manage Patient Care" section.

The Non-Visit encounter Chart Review pop-up has three additional selections. They are "**Order Patient Labwork**", "**In House Labwork**", and "**Order INHOUSE X-RAY**". It does not have "Review Current Visit". The three additional choices allow the provider to order or do tests that are done in the "Visit" encounter screens from the "Plan" menu. The missing "Review Current Visit", does not apply to a "Non-Visit" encounter.

Sign Out: <F12> "SgnOut" Screen.
When ready to sign out, hit the <F12> key. You will be presented with the following prompt:

Do you want to proceed with Sign-Out (y/n)?

Upon answering <y>, you will be taken through the an automatic review of the note to this point. This will help prevent omissions and prepare you for the charges section of the sign-out screen. You can page up & down, as well as arrow up & down to review the note. Once satisfied, either hit <F1> or <enter> to move on to the sign-out screen.

On the way to the sign-out screen, the system will do an automatic check of the patient's immunization status. Any needed immunizations will be presented to you. You can then decide if you want to go back to your encounter note and take an action, or just proceed on to the sign-out screen. An example of an "Immunization Due" note is shown in Figure 388.

Hit <enter> to pass these reminders, one at time. Once these are reviewed and cleared, you will be in the sign-out screen, as seen in Figure 389. On entry to the sign-out screen, you will be placed in the first line of the multi-value for "**CPT codes**". Any procedures that have been done via the "PROVIDER PLAN MENU" "Do Procedures" menu item will be placed here on the first pass to this screen. However, it is important to note that this is only done on the first pass to the screen. If you exit the sign-out screen without signing out and return to the provider's orientation screen, then on

subsequent returned to the sign-out screen, no additional population of the "**CPT codes**" multi-value will be done automatically. This is done intentionally to prevent duplications and errors.

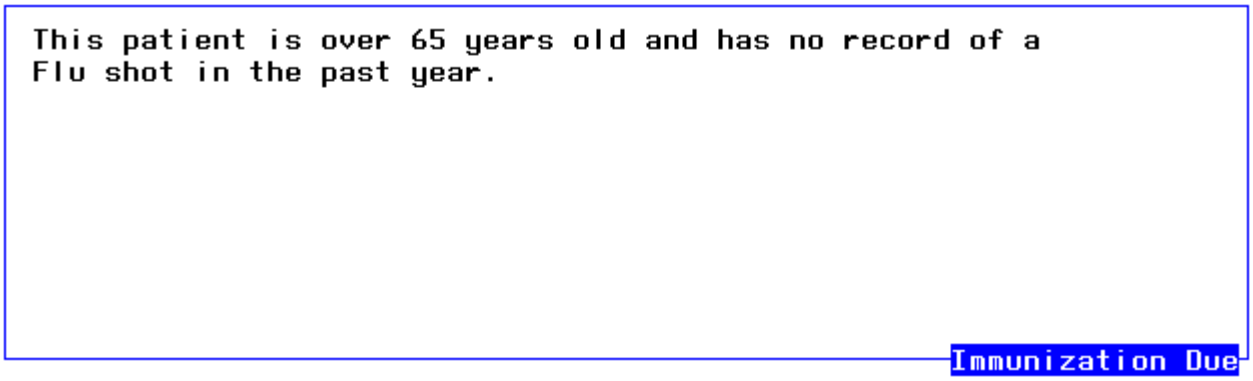


Figure 388 *Immunization Due, Exit Pop-up window.*

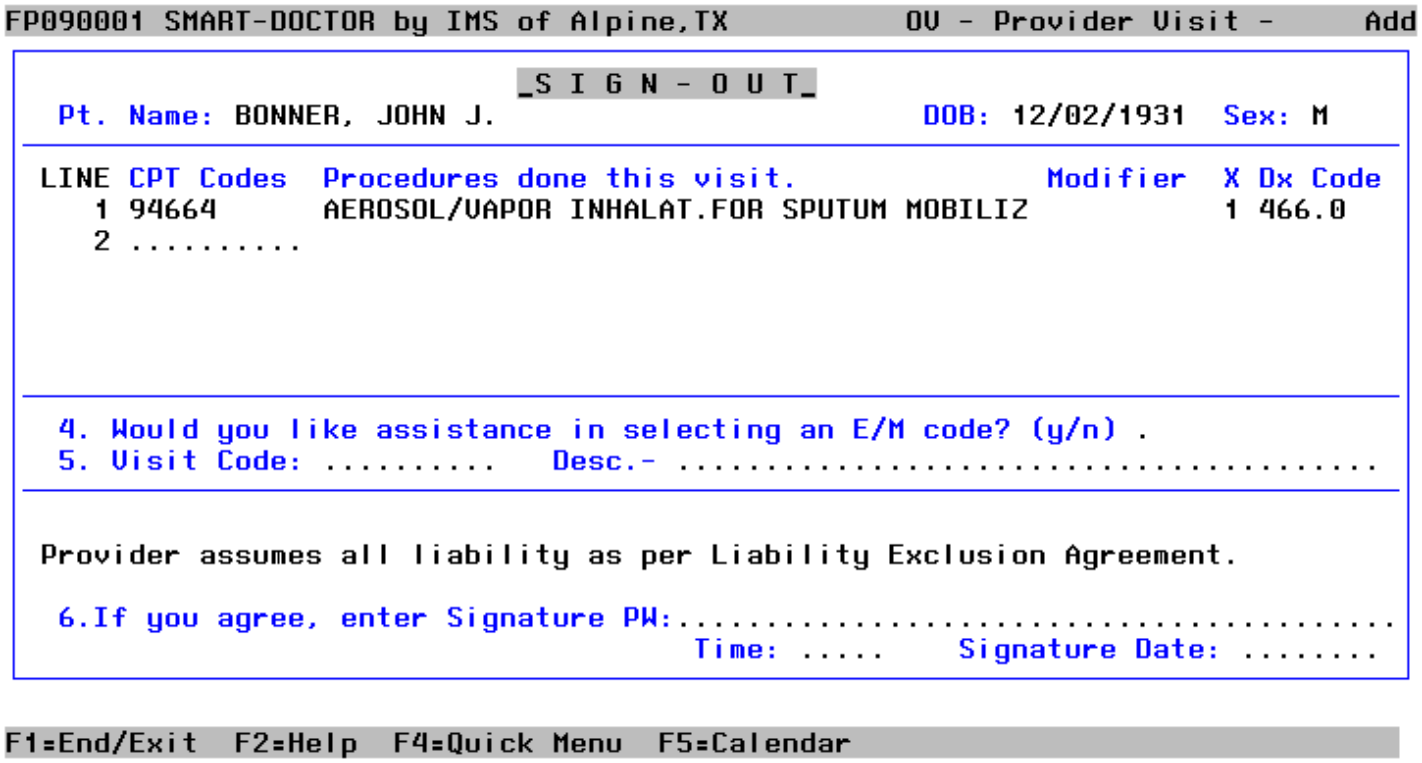


Figure 389 *Provider Visit Sign-Out screen.*

Being able to add procedure charges here allows the provider more control in being sure that services provided are captured for billing. For example, if the provider knows that he/she gave the patient a sling, cervical collar, or did a test that is not automatically billed by the system, this could be documented here and the charge captured.

On entering a value in the CPT codes multi-value prompt, you can just add a partial description of the procedure for the standard cross-reference lookup. You could also enter the actual procedure code in this field. The description of the procedure will be listed in the next field. When adding or changing a procedure, you will next be taken to the modifier field. You will notice that when you are in this field, there is a "**See and Select Modifiers**", <F9> key, present on the bottom bar. Upon hitting <F9>, a pop-up screen as is shown in Figure 390 is presented.

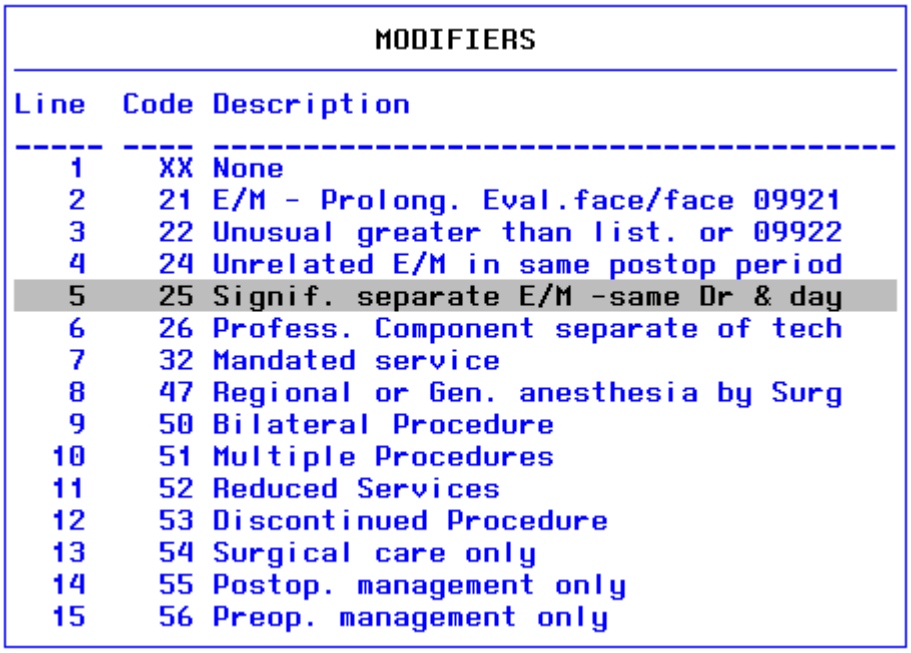


Figure 390 Modifier Selection window.

You can page or arrow up & down through this list of 69 modifiers to select up to 4 modifiers. In this case, we would just hit <enter> on line five to indicate a “Significant separate E/M code with the same doctor, on the same day”. Then, hit <F1> to select this or up to 4 choices from this menu. Next we will be stopped in the "X" field to indicate the number of times this was performed. In this case you accept the default of 1. Upon getting to the last field on this line "**DX code**", you will see a pop-up of the “Assessment” screen. Select one assessment to associative to this procedure.

Prompt #4, "**Would you like assistance in selecting an E/M code? (y/n)**", enter <y> if you would like assistance in selecting an E/M code. Upon answering yes, you will see the E/M coding assistance screen open, as seen in Figure 391.

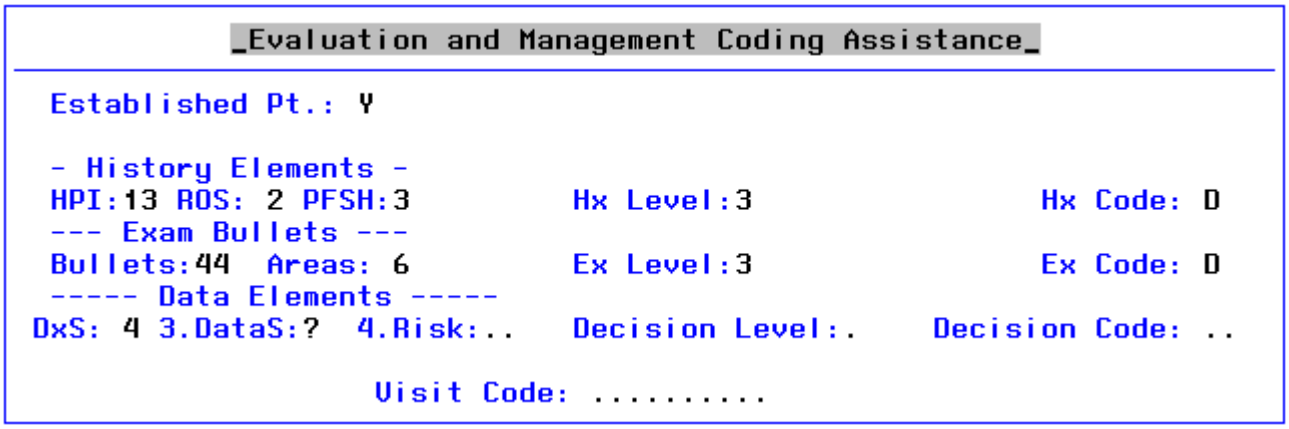


Figure 391 Evaluation and Management Coding Assistance screen.

On this screen you can see all the elements that the SmartDoctor® program uses to come up with a recommended E/M code. The first element evaluated is whether this is an established patient not. In this case, it is an established patient. You can see we have done an extensive history in this example. It includes many “**HPI**“(history of present illness) elements, a review of systems, and family and social history items. The HPI elements come from counting the lines in the subjective

screen. The review of systems comes from counting the basic review on startup of the note, and the added review of system elements. The Past Family and Social History (PFSH) comes from looking at the social history screen and basic review on startup. Using Medicare's 1998 guidelines for coding, this is a history level of 3, or a history code of "Detailed". In the exam area, 44 of Medicare's bullet items were examined, in a total of 6 body areas as defined by Medicare. This resulted in a level 3 exam, or a code of "Detailed". The "**DxS**" stands for the number of diagnoses points given. In this case, a new problem with three problems total is a value of four.

You will automatically be placed at prompt #3, "**DataS:**", for the number of data sources reviewed. At this prompt, a "**?**" has been defaulted. By hitting <enter> here, you will open up a help screen as shown in Figure 392.

Figure 392 *Data Reviewed Score, Help window.*

In this example, line #2 was picked since we reviewed 1 additional set of data.

You will next be placed at prompt #4, "**Risk:**", for risk level. A "**?**" is defaulted here also, to facilitate going to the help screen. By hitting <enter>, you will be taken to the help screen for information from Medicare on deciding the risk value. This is presented in Figure 393.

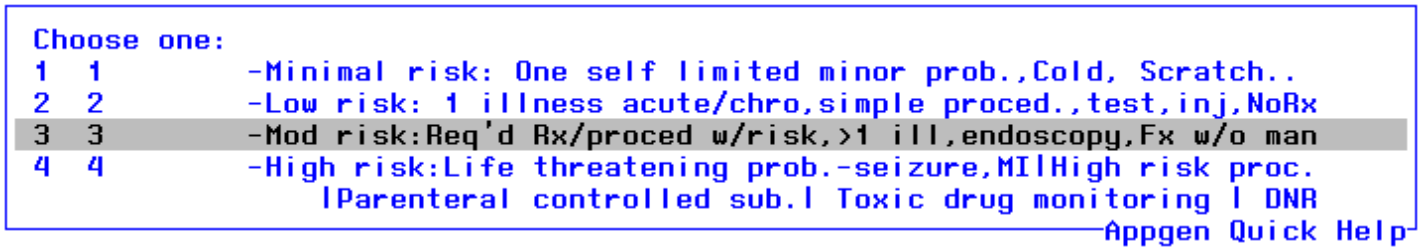


Figure 393 *Risk Level Score, Help window.*

You'll note that writing a required prescription is a risk level of three. Writing a prescription of Tylenol for a child on "Medicaid" would not be a "Required" prescription. This is merely administrative. A "Required" prescription would be any substance that can only be dispensed by a pharmacist with a prescription. These are called "Legend" and "Controlled" drugs. They involve more risk than over-the-counter medications.

After using the system for a while, you will be able to enter the appropriate values in prompts #3 & #4 without looking at the help screens. Simply enter the value you want, and hit <enter> at each prompt.

After completing prompts #3 & #4, the system will come up with a recommended E/M code for you, as shown in Figure 394.

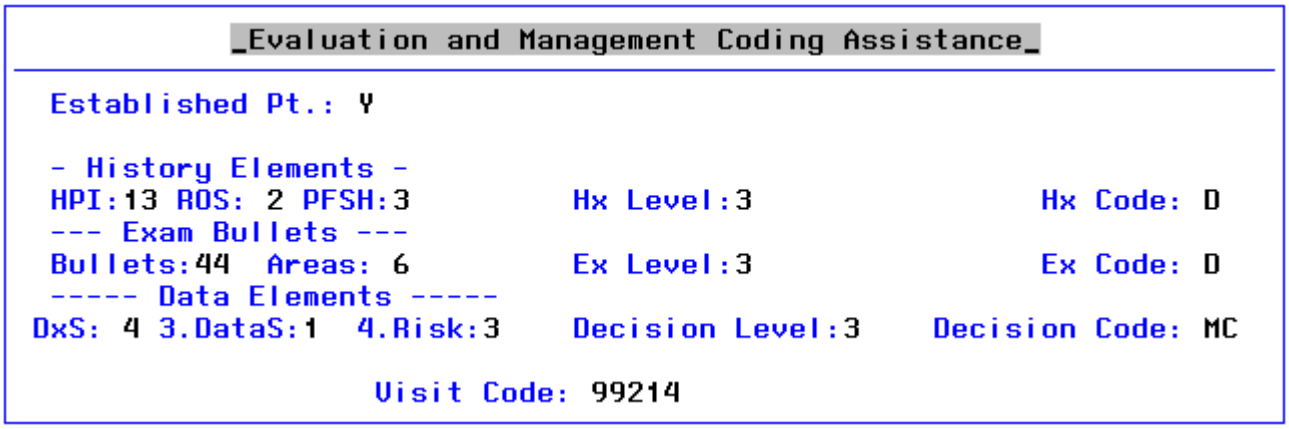


Figure 394 *Completed E/M Coding Assist screen.*

Upon hitting <enter>, this "**Visit Code**" value will be returned to the prior screen in prompt #5. The description of this code will be placed next to it. The sign-out screen will now appear as seen in Figure 395.

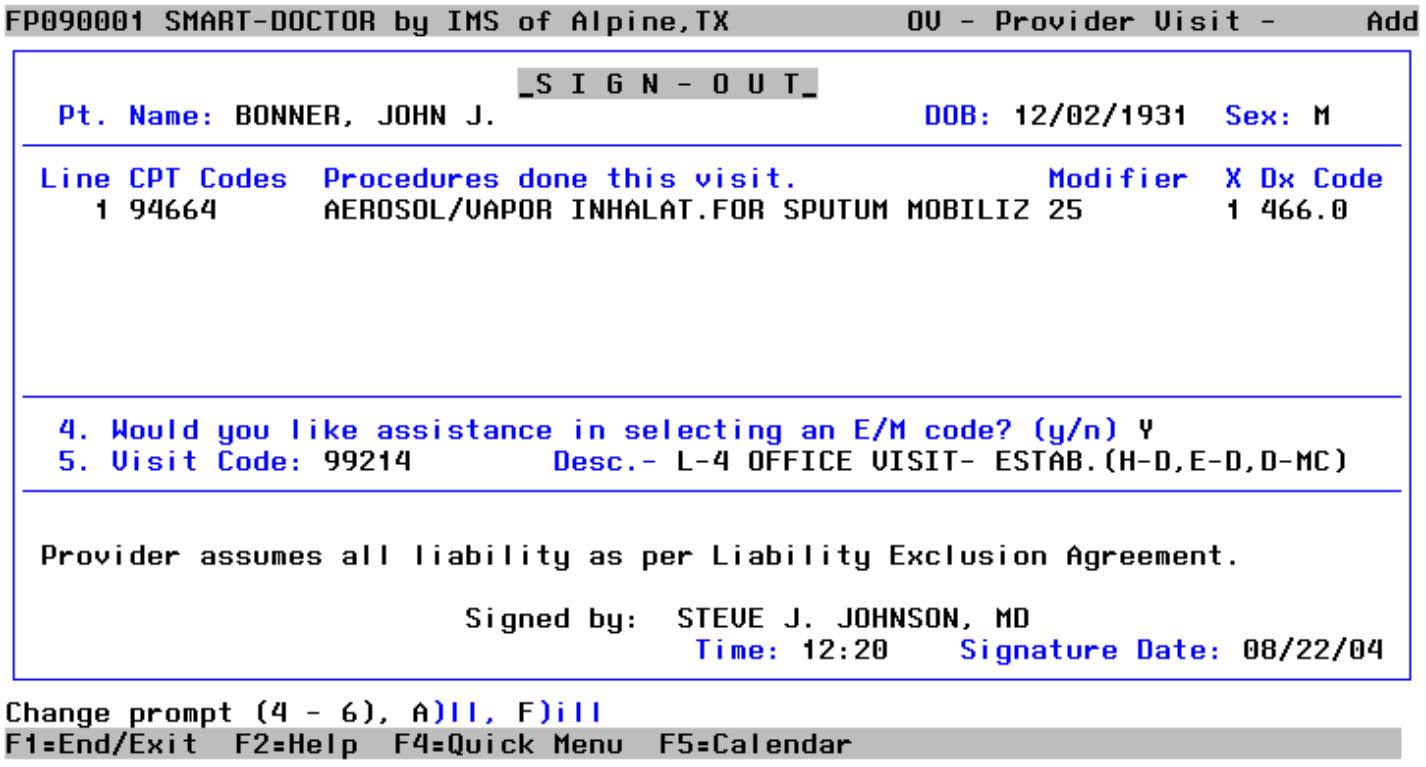


Figure 395 *Completed Provider Visit Sign-Out screen.*

Finally, you will be placed at prompt #6 for your signature password, to indicate your acknowledgment of the "Liability" notice, and sign-off on your chart notes and charges. Here, you type in your secondary signature password. Once successfully entered, it will be replaced by your name, degree, time, and date.

At this point, hitting <enter> or <F1> will return you to the starting "Provider Visit" screen. Here, hitting <enter> would bring you into the provider schedule for another patient selection. Generally, you would hit <F1> to "end" out and exit back to the doctors main menu.

MENU ITEM #2, "NON-VISIT ENCOUNTER", is the same as discussed in the section on "Manage Patient Care". There are several differences based on user class. A doctor class user can refill prescriptions, write new prescriptions, and access the chart review. The nursing class user can refill prescriptions and access the chart review. Both the nursing class user and the doctor class user are required to use their secondary password to sign-off on a chart before exiting. They are also prompted on exiting whether they want to print the note. Printing of the note will depend on how your clinic is operating.

MENU ITEM #3, "NON-SCHEDULED PROVIDER VISIT", is identical to the "**Provider Visit**" of menu item #1, with two significant exceptions. First, no appointment is required. This can be a visit that was done in the office as a walk-in with no appointment scheduled, or could be a nursing home visit, hospital visit, emergency room visit, etc. This requires, however, that the user indicate the location on the intake screen, as well as take the initial vital signs, and answer the question about the patient's perception of the "urgency of the visit". The initial screen appears as shown in Figure 396.

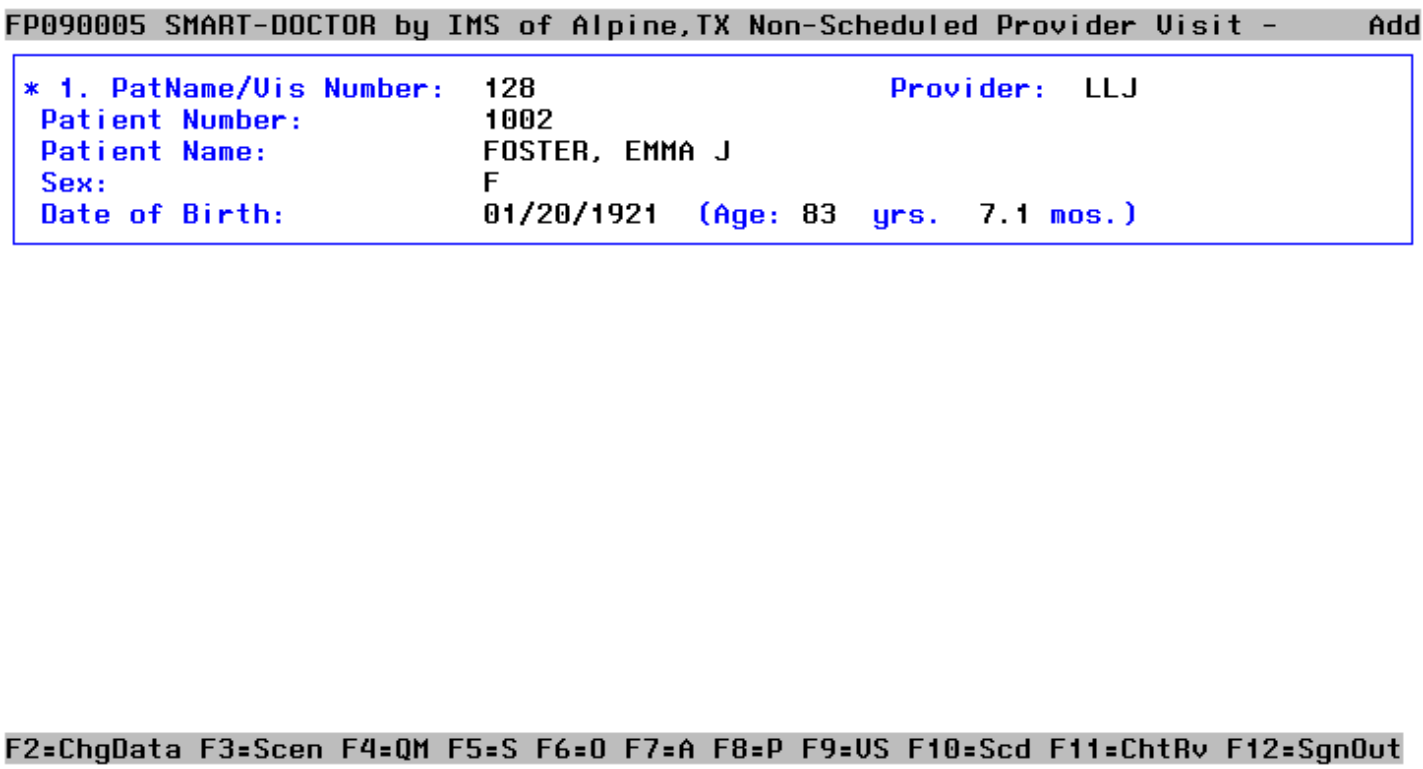


Figure 396 Initial Non-Scheduled Provider Visit screen.

In prompt #1, "**PatName/Vis Number:**", enter part of the patient's name for the standard cross-reference lookup. Once selected, you will immediately be brought to the intake screen. This screen is shown in Figure 397.

In this screen, you will fill in the needed information in the same manner as described for the nursing intake screen. You will note that in prompts #4, #5, #6, #7, and #8 had been filled in for you before in the "**Provider Visit**". However, in the case of the "**Non-Scheduled Provider Visit**", you will need to fill these all in yourself. For prompt #4, "**Place of Service:**", you will be given a pop-up to select the place of service. Examples of these are office, home, inpatient hospital, outpatient hospital, emergency room, skilled nursing facility, etc. In prompt #5, "**Name of Facility:**", you will be

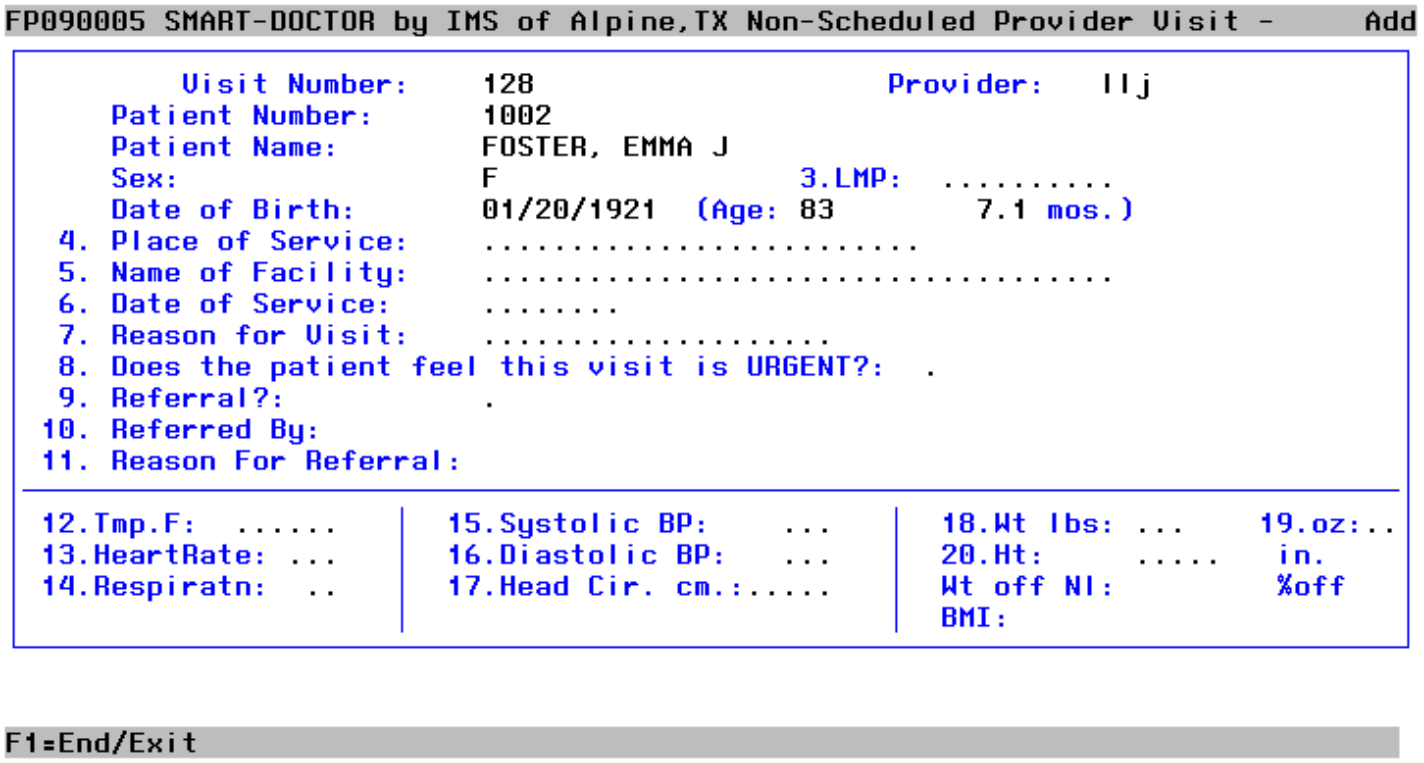


Figure 397 Non-Scheduled Provider Visit Intake screen.

given a pop-up to select the facility used, that your clinic has predefined. In prompt #6, "**Date of Service**", today's date will be defaulted for you. You can over type for a prior date if necessary. In prompt #7, "**Reason for Visit:**", the reason for visit given in the abbreviated form, as on appointment scheduling (comes from the symptom file). Examples of reasons to visit can be cough, headache, follow-up of a problem, medical exam, etc.. Prompt #8, "**Does the Patient feel this visit is URGENT**", is the patient's interpretation as to whether they feel is urgent, not yours. Fill in the referral prompts if this patient was referred to you for this encounter. You will next be able to do the standard nursing vital signs, and then proceed on to the standard provider note screens as described previously in this section of the manual. You can return to this screen anytime during the visit. You do this by hitting the <F2>, "**ChgData**" key from the provider's orientation screen.

Exiting the "Non-Scheduled Provider Visit" note is identical to exiting the standard provider a note, discussed above, with the exception that the "**Category of Service**" is to be chosen from a pop-up screen. The exit screen with pop-up presented for selecting the category of service type, is shown in Figure 398.

Based on the "Category of Service", the system will use the standard E/M algorithm's to pick the appropriate E/M code.

The remainder of the doctor main menu items have been discussed previously in other sections of this manual.

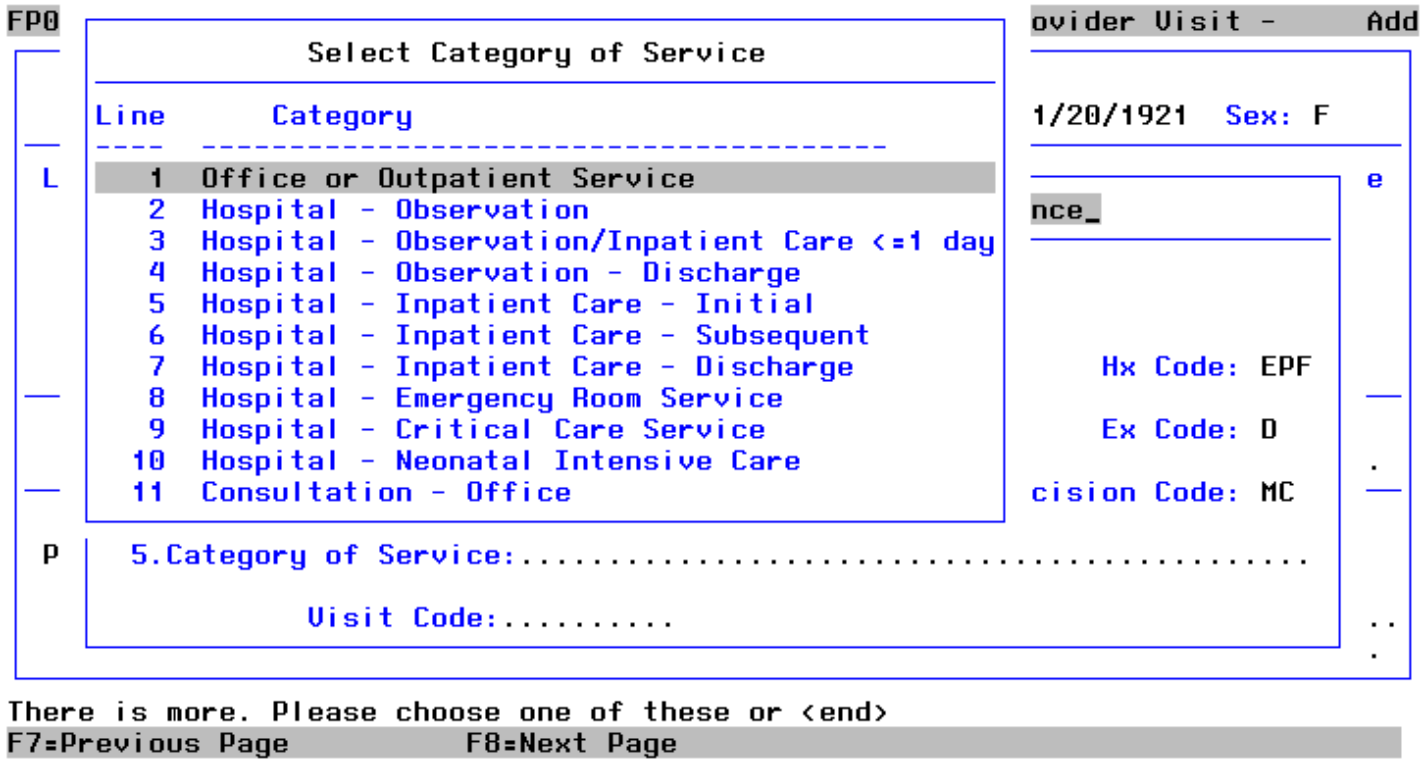
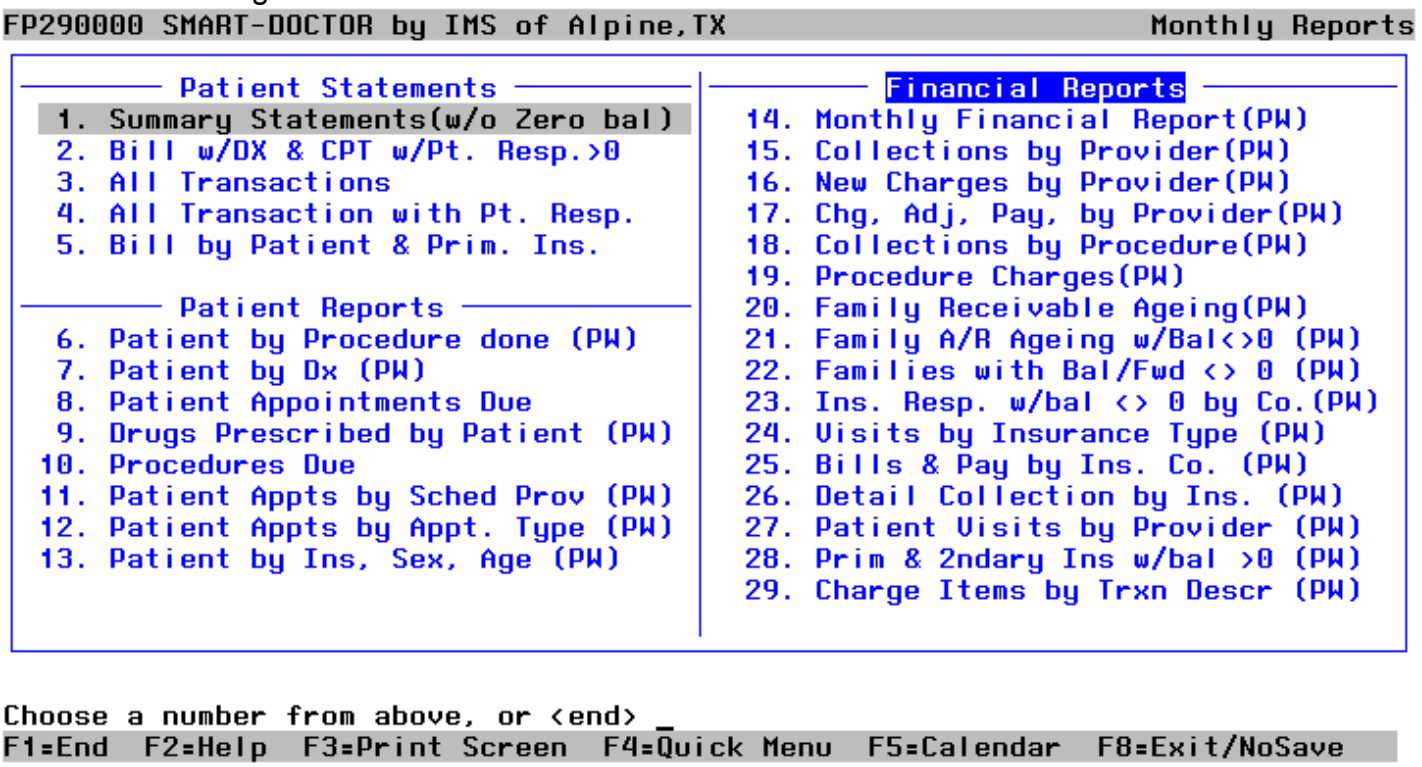


Figure 398 *Selection of Category of Service.*

CHAPTER 8 MONTHLY REPORTS

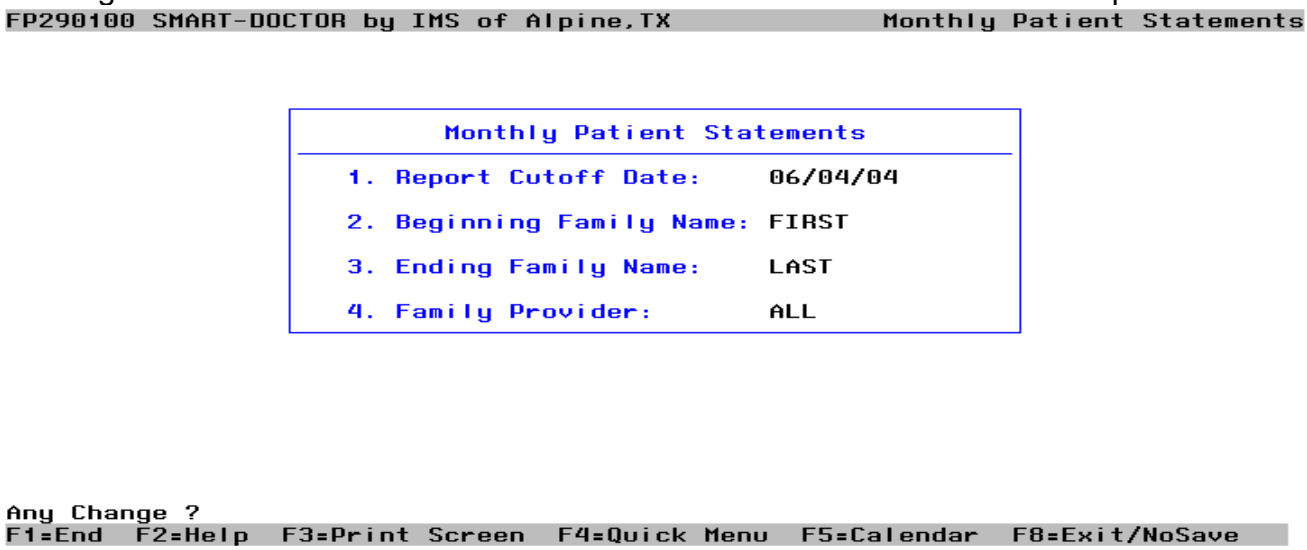
From the front office menu, select menu item # 12 to go to the Monthly Reports screen. This screen has three basic sections: Patient Statements, Patient Reports, and Financial Reports, as shown below in Figure 399:



PATIENT STATEMENTS

This section has 5 reports. The primary report used for monthly billing to the HOH is menu selection #2, "**Bill w/DX & CPT w/Pt. Resp.>0**". All the other reports in this section are used to look at billing information from the family ledger and charge item files in different, but useful ways.

Menu selection #1, "**Summary Statements(w/o Zero bal)**", this Patient Statement contains only those Charge Items which have a non-zero balance. The selection screen for this report is as follows:



Selection prompt #1, "**Report Cutoff Date:**", enter the cutoff date for this detailed report. All open items before and on this date will be printed. Any invoices or checks after this date will not appear on the report.

Selection prompt #2, "**Beginning Family Name:**", enter the first family name in the range of patient names that you wish to appear on this list. For example, start with an actual family name like "Bonner" or more simply "B". To get all the b's and c's, enter "B" for the starting and "D" for the ending. Now you will get families that include Bonner and Cooper, the two families in our example files. This is shown below in Figures 401 and 402.

Selection prompt #3, "**Ending Family Name:**", see Selection prompt #2 above. Enter the last patient name in the range of patient names that you wish to appear on this list.

Selection prompt #4, "**Family Provider:**", enter the Provider's user name to select family records by. Else, accept the default "ALL" to select all Providers' family records.

The standard report Selection prompt for report output will be presented. Below are screen shots of the report for two sample families:

```
FP290100                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                    Summary Statements with non-zero balances.       - 4 Jun 2004

Responsibility for payment is indicated under column labeled "Rsp".

ALPINE FAMILY PRACTICE                  BONNER, JOHN J.
123 HOLLAND AVE.                        367 6TH STREET
ALPINE                TX 79830          ALPINE                      TX 79830
Call 915-364-2223 for billing questions.


================================================================================
Date     Patient Name    Purpose Of Visit    Rsp Charge  Adjstmt Payment Balance
-------- --------------- ------------------- --- ------- ------- ------- -------
04/15/98  JOHN J.        L-3 OFFICE VISIT- N Pat   80.00     .00   65.00   15.00
03/31/99  JOHN J.        L-4 OFFICE VISIT- E Ins   49.80     .00    5.00   44.80
07/17/00  JOHN J.        L-4 OFFICE VISIT- E Ins   74.08   10.00   10.00   54.08
                                                 ------- ------- ------- -------
                                Family Totals:   203.88   10.00   80.00  113.88


Press <return> to continue, or <end>
```

Figure 401 *Non-Zero Balance Report, Page 1.*

Menu selection #2, "**Bill w/DX & CPT w/Pt. Resp.>0**", choose this selection to print Family bills with Dx & CPT information. Only bills with patient responsibility and a balance not equal to 0 will be printed. Balances not equal to 0 with responsibility set to insurance will not be shown in this report. This report is the basic report used for monthly billings. This selection method avoids sending bills to HOH when the only balance pending is from the insurance company. This saves employee time and mailing costs.

The selection screen for this menu item is shown below in Figure 403.

```
FP290100                SMART-DOCTOR by IMS of Alpine,TX                Page    2
                    Summary Statements with non-zero balances.       - 4 Jun 2004

Responsibility for payment is indicated under column labeled "Rsp".

ALPINE FAMILY PRACTICE                  COOPER, DAVID S.
123 HOLLAND AVE.                        34 WEST ADAMS
ALPINE                TX 79830          BALMORRHEA                    TX 79718
Call 915-364-2223 for billing questions.


================================================================================
Date     Patient Name    Purpose Of Visit    Rsp Charge  Adjstmt Payment Balance
-------- --------------- ------------------- --- ------- ------- ------- -------
03/31/99  MARY K.        L-4 OFFICE VISIT- E Ins   70.00     .00     .00   70.00
03/31/99  JANE T.        L-4 OFFICE VISIT- E Ins   70.00     .00     .00   70.00
                                                 ------- ------- ------- -------
                                    Family Totals:  140.00     .00     .00  140.00
                                                 ------- ------- ------- -------


Reprocess Monthly Patient Statements ? - Y)es, N)o, E)nd N
```

Figure 402 *Non-Zero Balance Report, Page 2.*

```
FP290703 SMART-DOCTOR by IMS of Alpine,TX    Bill with DX,CPT, w/bal <>0  &Ptpay
```

Family Statement w/balance not zero.	
1. Report Cutoff Date:	06/04/04
2. Clinic Number:	0
3. Family Provider:	ALL
4. Beginning Family Name:	FIRST
5. Ending Family Name:	LAST

```
Any Change ?
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 403 *Report Selection screen.*

Selection prompt #1, "**Report Cutoff Date:**", enter the cutoff date for this detailed report. All open items before and on this date will be printed. Any invoices or checks after this date will not appear on the report.

Selection prompt #2, "**Clinic Number:**", this number is defaulted to "0" if there is only one group represented at this site. If more than one group is present then you enter the number of the group (which correlates to the clinic number) for this billing. The TERMS file contains the record of the groups allowed at this site in the record "ADM-SITE-CLINICS". The first field in the Term Descriptions gives the number of groups that can be billed at this site. The second and subsequent multi-value fields (which should agree in total number to the value of the first field, on the first line) indicate the clinic number and group name. Only those clinic numbers listed here can be sent as group or clinic specific bills. Only charges for the clinic number entered will be billed.

Selection prompt #3, "**Family Provider:**", enter the Provider you wish to select family records by. Else, accept the default "ALL" to select all Providers' families. For MultiGroup Clinics, "ALL" selects only providers in the selected (Selection prompt 2) clinic. Any providers selected in this prompt must also belong to the selected clinic from prompt 2.

Selection prompt #4, "**Beginning Family Name:**", enter the first family name in the range of patient names that you wish to appear on this list. For example, start with an actual family name like "Bonner" or more simply "B". To get all the b's and c's, enter "B" for the starting and "D" for the ending. Now you will get families that include Bonner and Cooper, the two families in our example files. A sample of one such bill generated for this report option is shown in Figures 404 and 405, with a screen output option rather than printed.

Selection prompt #5, "**Ending Family Name:**", see Selection prompt #4 above. Enter the last patient name in the range of patient names that you wish to appear on this list.

An of the selection screen output for our sample file is as follows:

```
FP290704                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                              Monthly Statement.            18:32:19  4 Jun 2004

Family Number: 500

ALPINE FAMILY PRACTICE                  BONNER, JOHN J.
123 HOLLAND AVE.                        367 6TH STREET
ALPINE, TX  79830                       ALPINE, TX  79830
For questions about billing
         call: 915-364-2223

    This message will print as a header on all bills.
    Good for reminders, general notices, etc.

Charge #   Description of Charge or Activity                 Charges   Payments
========== ================================================ & Debits  & Credits
101        BALANCE FWD/CREDIT  Date: 04/15/98
           .............BALANCE DUE from INSURANCE =
105        Pt: BONNER, JOHN J. Prov: JOHNSON MD
           CPT: 99203 L-3 OFFICE VISIT- NEW (H-,E- DET, D
           Dx: 787.1 HEARTBURN
           SERVICE DATE: 04/15/98  Place code: 11
Press <return> to continue, or <end>
```

This number is taken from the Clinic file's "Billing" phone #.

This heading is taken from the header information as indicated in the Clinic file under the "F6-Bill#" screen. Up to ten lines can be added. Greetings, general messages, and this even can be used to get credit card numbers and authorizations (signatures).

Figure 404 Monthly Statement, screen 1.

```
FP290704                SMART-DOCTOR by IMS of Alpine,TX              Page    2
                              Monthly Statement.          18:32:19  4 Jun 2004

          Date: 04/15/98 Action: Charge                          80.00
          Date: 07/31/98 Action: FARMERS HEALTH COOP.                    60.00
          Date: 06/04/04 Action: Paid-Pt./Resp. Party                     5.00
          **************BALANCE DUE from PATIENT =   15.00

THIS ACCOUNT IS SEVERELY PAST DUE. IF WE DO NOT HEAR FROM
YOU WITHIN 10 DAYS THIS ACCOUNT MAY BE TURNED OVER TO OUR
COLLECTION AGENCY.
PROMPT PAYMENT IS GREATLY APPRECIATED.   THANK YOU


Period in days    0 - 30   31 - 60   61 - 90   91 ----> Balance
--------------- --------- --------- --------- --------- ---------
Combined Due                                     113.88    113.88
Insurance Due                                     98.88     98.88
Patient Due                                       15.00     15.00



Reprocess Billing Report ? - Y)es, N)o, E)nd N
```

These dunning messages will be placed in the bill automatically for bills with patient responsibility of over 30, 60, and 90 days respectively. These three message can be found in the TERMS file with the cross reference of “dunn”.

Time dated messages from the Family Ledger will be placed here if the bill date falls between the message start and end dates. (See the patient example below.)

Figure 405 Monthly Statement, screen 2.

The next page is a Sample of a “Monthly Billing Explanation Sheet for Patients” (you are welcome to use or modify this example for your patients).

The following is an example of our standard monthly bill for amounts that are your personal responsibility. All the charges are shown for days where you have one or more charges that have been determined to be your responsibility. The insurance carrier, if any, has made any payments or denied payments. Any charges on the same day that you have charges that are your responsibility are shown so that you can see all the charges of a specific day. Those charges that are your responsibility are indicated as:

"****************BALANCE DUE from PATIENT =** " followed by the amount.

Charges that are still the responsibility of the insurance carrier are indicated as:

"**.....BALANCE DUE from INSURANCE =** " followed by the amount.

You may have other charges that have been paid on other days or that are still pending response from the insurance carrier from other days. If you need a statement showing all charges on your account for all time periods, please ask the billing clerk. A sample Monthly Billing statement is shown is attached.

Sample Monthly Statement.

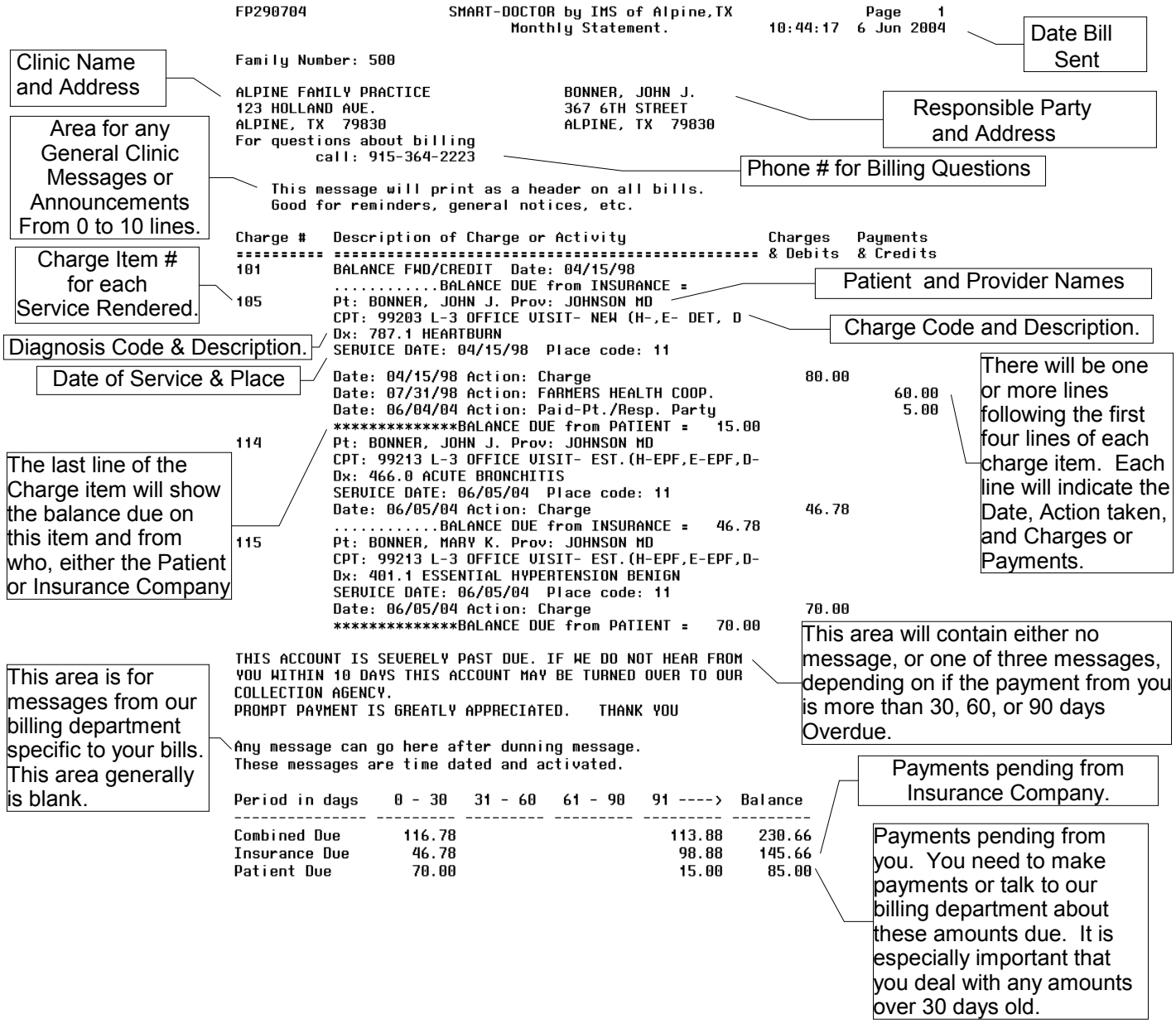


Figure 406 Example of Monthly Family Statement.

Menu selection #3, "**All Transactions**", This selection provides a listing of all transactions on this family account. The selection screen is the same as Menu selection #1 above. A sample of the screen output for the default selections is as follows (Figures 407 & 408):

```
FP290701                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                      Patient Statement -All Transactions  16:05:47  6 Jun 2004

Responsibility for payment is indicated under column labeled "R".
  (I=Billed to Insurance. P=Patient to pay.)


ALPINE FAMILY PRACTICE                BONNER, JOHN J.
123 HOLLAND AVE.                      367 6TH STREET
ALPINE              TX 79830          ALPINE                    TX 79830
Call 915-364-2223 for billing questions.



================================================================================
Chg. Patient  Purpose Of Visit Tns.Date    Transaction R Charge  Adjstmt Payment
---- -------- ---------------- -------- ------------- - ------- ------- -------
   2  JOHN J. L-3 OFFICE VISIT 04/15/98 Charge        P   80.00     .00     .00
      JOHN J. L-3 OFFICE VISIT 07/31/98 FARMERS HEALTH P     .00     .00   60.00
      JOHN J. L-3 OFFICE VISIT 06/04/04 Paid-Pt./Resp. P     .00     .00    5.00
   3  JOHN J. L-4 OFFICE VISIT 03/31/99 Charge        I   49.80     .00     .00
      JOHN J. L-4 OFFICE VISIT 06/04/04 Paid-Pt./Resp. I     .00     .00    5.00
Press <return> to continue, or <end> _
```

Figure 407 *Listing of All transactions, screen 1.*

The second screen for this Family is:

```
FP290701                SMART-DOCTOR by IMS of Alpine,TX                Page    2
                      Patient Statement -All Transactions  16:05:47  6 Jun 2004

Responsibility for payment is indicated under column labeled "R".
  (I=Billed to Insurance. P=Patient to pay.)

   4  JOHN J. L-4 OFFICE VISIT 07/17/00 Charge        I   74.08     .00     .00
      JOHN J. L-4 OFFICE VISIT 07/17/00 Paid-Pt./Resp. I     .00     .00   10.00
      JOHN J. L-4 OFFICE VISIT 06/04/04 Foundation adj I     .00   10.00     .00
   5  JOHN J. L-3 OFFICE VISIT 06/05/04 Charge        I   46.78     .00     .00
   6  MARY K. L-3 OFFICE VISIT 06/05/04 Charge        P   70.00     .00     .00
                                                      ------- ------- -------
                              Family Total             320.66   10.00   80.00




Press <return> to continue, or <end>
```

Figure 408 *Listing of All Transaction, screen 2.*

End of example.

Menu selection #4, "**All Transaction with Pt. Resp.**", This selection shows all transactions on this family account when there is at least one item that the patient is responsible to pay for. The selection screen is the same as Menu selection #1 above. A sample of the screen output for the default selections is as follows (Figures 409 & 410):

```
FP290702                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                      All Transactions w/Pt. Responsible.  16:14:16  6 Jun 2004

Responsibility for payment is indicated under column labeled "R".
  (I=Billed to Insurance. P=Patient to pay.)


ALPINE FAMILY PRACTICE                  BONNER, JOHN J.
123 HOLLAND AVE.                        367 6TH STREET
ALPINE                TX 79830          ALPINE                      TX 79830
Call 915-364-2223 for billing questions.



================================================================================
Chg. Patient  Purpose Of Visit Tns.Date    Transaction R Charge  Adjstmt Payment
---- -------- ---------------- -------- -------------- - ------- ------- -------
   2  JOHN J. L-3 OFFICE VISIT 04/15/98 Charge         P   80.00     .00     .00
      JOHN J. L-3 OFFICE VISIT 07/31/98 FARMERS HEALTH P     .00     .00   60.00
      JOHN J. L-3 OFFICE VISIT 06/04/04 Paid-Pt./Resp. P     .00     .00    5.00
   3  JOHN J. L-4 OFFICE VISIT 03/31/99 Charge         I   49.80     .00     .00
      JOHN J. L-4 OFFICE VISIT 06/04/04 Paid-Pt./Resp. I     .00     .00    5.00
Press <return> to continue, or <end> _
```

Figure 409 All Transaction w/Pt. Resp., screen 1.

The second screen for this report is:

```
FP290702                SMART-DOCTOR by IMS of Alpine,TX                Page    2
                      All Transactions w/Pt. Responsible.  16:14:16  6 Jun 2004

Responsibility for payment is indicated under column labeled "R".
  (I=Billed to Insurance. P=Patient to pay.)

   4  JOHN J. L-4 OFFICE VISIT 07/17/00 Charge         I   74.08     .00     .00
      JOHN J. L-4 OFFICE VISIT 07/17/00 Paid-Pt./Resp. I     .00     .00   10.00
      JOHN J. L-4 OFFICE VISIT 06/04/04 Foundation adj I     .00   10.00     .00
   5  JOHN J. L-3 OFFICE VISIT 06/05/04 Charge         I   46.78     .00     .00
   6  MARY K. L-3 OFFICE VISIT 06/05/04 Charge         P   70.00     .00     .00
                                                       ------- ------- -------
                              Family Total              320.66   10.00   80.00
                                                       ------- ------- -------


Reprocess All Transactions w/Pt. Responsible. ? - Y)es, N)o, E)nd N
```

Figure 410 All Transaction w/Pt. Resp., screen 2.

End of example.

Menu selection #5, "**Bill by Patient & Prim. Ins."**, Choose this item to print a bill for a patient that was billed to a specific insurance company. This insurance company must be the primary (or first) insurance company that was billed. The first screen allows you to "Select Patient and Insurance Company for Bill Print." This report is generally used to bill Workmen's Compensation, when a summary report of all charges is requested. As seen below in Figure 411:

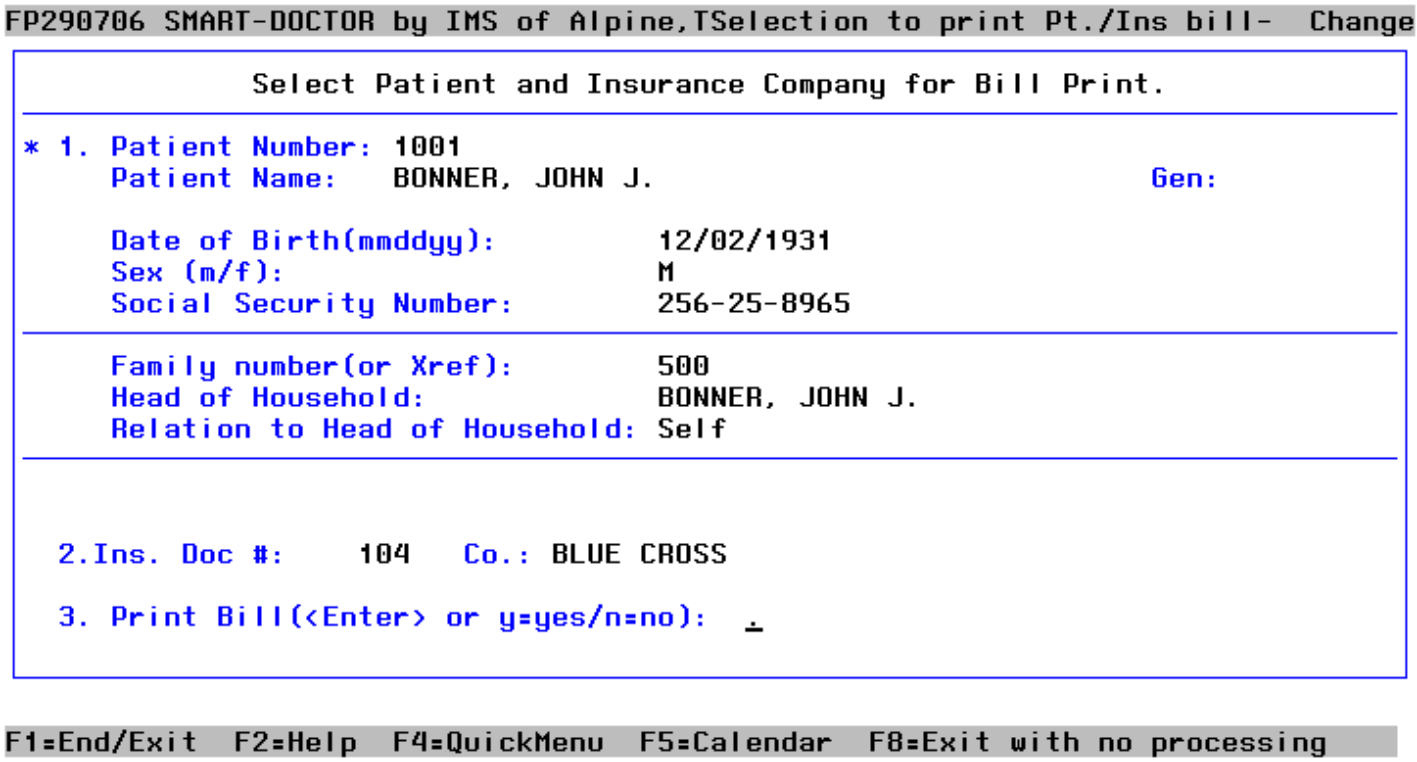


Figure 411 *Patient Bills by Insurance Carrier.*

Selection prompt #1, "**Patient Number:**", enter a patient number or at least three letters of the last name and, optionally, two letters of other names separated by a space. To Exit without lookup, hit <F1>.

Selection prompt #2, "**Ins. Doc #:**", go into this change prompt by hitting <2> or <a> for all. A pop-up of the insurance carrier information selection screen will be seen as in the billing screens. Select in the same manner as in the billing screens.

Selection prompt #3, "**Print Bill(<Enter> or y=yes/n=no):**", answer yes to print a monthly statement for this patient (not the entire family) pertaining to this carrier only.

A sample screen output for this report is seen below in Figure 412, 413, and 414.

```
FP290708              SMART-DOCTOR by IMS of Alpine,TX              Page    1
                    Monthly Statement for Past Due Amounts 16:40:48  6 Jun 2004

Family Number: 500
                                      BLUE CROSS
ALPINE FAMILY PRACTICE                BONNER, JOHN J.
123 HOLLAND AVE.                      367 6TH STREET
ALPINE, TX  79830                     ALPINE, TX  79830
For questions about billing
         call: 915-364-2223

    This message will print as a header on all bills.
    Good for reminders, general notices, etc.

Charge #   Description of Charge or Activity                Charges   Payments
========== ================================================ & Debits  & Credits
107        Pt: BONNER, JOHN J. Prov: JOHNSON MD
           CPT: 99214 L-4 OFFICE VISIT- ESTAB.(H-D,E-D,D-
           Dx: 428.0 CONGESTIVE HEART FAILURE, UNSP*
           SERVICE DATE: 03/31/99  Place code: 11
           Date: 03/31/99 Action: Charge                        49.80
           Date: 06/04/04 Action: Paid-Pt./Resp. Party                    5.00
Press <return> to continue, or <end> _
```

Second screen shot:

```
FP290708              SMART-DOCTOR by IMS of Alpine,TX              Page    2
                    Monthly Statement for Past Due Amounts 16:40:48  6 Jun 2004

           .............BALANCE DUE from INSURANCE =   44.80
113        Pt: BONNER, JOHN J. Prov: JOHNSON MD
           CPT: 99214 L-4 OFFICE VISIT- ESTAB.(H-D,E-D,D-
           Dx: 466.0 ACUTE BRONCHITIS
           SERVICE DATE: 07/17/00  Place code: 11
           Date: 07/17/00 Action: Charge                        74.08
           Date: 07/17/00 Action: Paid-Pt./Resp. Party                   10.00
           Date: 06/04/04 Action: Foundation adj                         10.00
           .............BALANCE DUE from INSURANCE =   54.08
114        Pt: BONNER, JOHN J. Prov: JOHNSON MD
           CPT: 99213 L-3 OFFICE VISIT- EST.(H-EPF,E-EPF,D-
           Dx: 466.0 ACUTE BRONCHITIS
           SERVICE DATE: 06/05/04  Place code: 11
           Date: 06/05/04 Action: Charge                        46.78
           .............BALANCE DUE from INSURANCE =   46.78


    Any message can go here after dunning message.
    These messages are time dated and activated.
    Press <return> to continue, or <end>
```

Third Screen shot:

```
FP290708              SMART-DOCTOR by IMS of Alpine,TX              Page    3
                    Monthly Statement for Past Due Amounts 16:40:48  6 Jun 2004


Period in days    0 - 30   31 - 60   61 - 90   91 ----> Balance
--------------- --------- --------- --------- --------- ---------
Combined Due        46.78                         98.88    145.66
Insurance Due       46.78                         98.88    145.66
Patient Due
```

Figures 412, 413, and 414 are shown above. Together they make up one report.

PATIENT REPORTS

This section has eight reports. All these reports are patient centric, and are used to help manage care of the patients.

Menu selection #6, "**Patient by Procedure done (PW)**", choose this selection to print a report of patients that had a specific procedure done. The selection screen for this menu item is as follows, with all defaults selected (Figure 415):

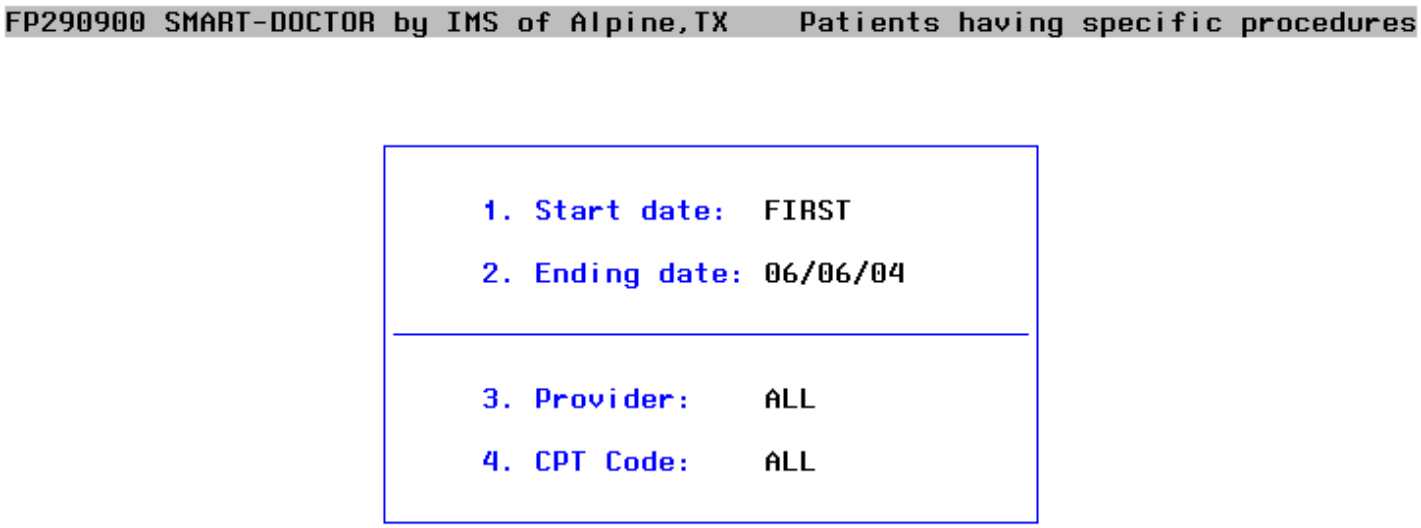


Figure 415 Selection for Pt. Procedures Report.

Selection prompt #1, "**Start date:**", enter the starting date. Procedures done on that date, up to the "Ending date" of Selection prompt #2 will be shown.

Selection prompt #2, "**Ending date:**", enter the ending date. Procedures done from the "Starting date" up to the "Ending date" will be shown.

Selection prompt #3, "**Provider:**", enter the provider initials for a specific provider, or <all> for all providers.

Selection prompt #4, "**CPT Code:**", enter specific CPT Code. i.e. 10040, or <all> for all procedures.

A sample screen output for this report is seen below in Figure 416:

```
FP290900                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                      Patients having specific procedures  17:55:52  6 Jun 2004

                        For dates : FIRST to 06/06/04
CPT Code  Patient Name                              Pt. Num.    Prov.    DOS
========  ====================================      ==========  =====  ========
99201     COOPER, JANE T.                           1004        SJJ    04/15/98
99202     FOSTER, EMMA J                            1002        SJJ    04/15/98
99202     JACKSON, JOHN                             1007        ROOT   04/21/00
99203     BONNER, JOHN J.                           1001        SJJ    04/15/98
99213     BONNER, JOHN J.                           1001        SJJ    06/05/04
99213     BONNER, MARY K.                           1006        SJJ    06/05/04
99214     BONNER, JOHN J.                           1001        SJJ    03/31/99
99214     BONNER, JOHN J.                           1001        SJJ    07/17/00
99214     COOPER, JANE T.                           1004        SJJ    03/31/99
99214     COOPER, MARY K.                           1003        SJJ    03/31/99
99215     FOSTER, EMMA J                            1002        SJJ    03/31/99


Enter (S)creen, (P)rinter, (B)oth, (F)ile, or (O)ther printer :  S
F1=End/Exit-1   F5=Business Printer  F6=Main Prntr  F7=lab printer
```

Figure 416 *Patient Procedure Report.*

Menu selection #7, "**Patient by Dx**", Choose this selection to look up patient by a specific diagnosis or range of diagnoses. The selection screen for this menu item is as follows, with all defaults selected:

```
FP290910 SMART-DOCTOR by IMS of Alpine,TX     Patient by Dx (Active,PHX, & Hosp)


                        Find Patients by Diagnosis
                (search for Dx in Active Problem List, PMH, and Hosp. Dx)
          ┌──────────────────────────────────────────────┐
          │                                              │
          │   1. Starting Diagnosis Number: 401.0        │
          │   2. Ending Diagnosis Number:   401.99       │
          │                                              │
          │   3. Starting DOB: FIRST                     │
          │   4. Ending DOB:   LAST                      │
          │                                              │
          │   5. Sex: ALL                                │
          │                                              │
          └──────────────────────────────────────────────┘


Any Change ?
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 417 *Patient Diagnosis Report Selection.*

Selection prompt #1, "**Starting Diagnosis Number:**", enter the starting diagnosis number you want in the search. Diagnoses from that code number through that entered in "Ending Diagnosis Number:", Selection prompt #2, will be shown.

Selection prompt #2, "**Ending Diagnosis Number:**", enter the ending diagnosis number you want in the search. Diagnoses in the range of Selection prompt #1 through Selection prompt #2 will be searched for and shown. In the example selection screen above, all diagnoses for hypertension are being searched.

Selection prompt #3, "**Starting DOB:**", enter the starting DOB so as to give you a starting age range, or accept the default of "FIRST", for the oldest patient.

Selection prompt #4, "**Ending DOB:**", enter ending DOB, or accept the default of "LAST" for the youngest patient.

Selection prompt #5, "**Sex:**", enter <m> for male, <f> for female, or accept the default of "ALL".

A sample screen output for this report is seen below in Figure 418:

```
FP290910                  SMART-DOCTOR by IMS of Alpine,TX                Page    1
                        Patient by Dx (Active,PHX, & Hosp)   11:15:08  7 Jun 2004

                         For Dx 401.00 to 401.99
                         For DOBs FIRST to LAST
                         For Sex: ALL

Patient Name                          Pt. Num.   DOB        Sex Active PMHx Hosp
===================================== ========== ========== === ====== ==== ====
FOSTER, EMMA J                        1002       01/20/1921  F   X      X    -




Reprocess Patient by Dx (Active,PHX, & Hosp) ? - Y)es, N)o, E)nd N
```

Figure 418 *Report of Patients by Diagnosis.*

In the above screen, the selection criteria is displayed in the first three lines after the heading. Next, all patients will be shown who meet these criteria. In this example only one match was found. The right hand three columns indicate where the diagnoses were found, i.e. in the "**Active**" problem list, in the "**PMHx**" (past medical history), or in the past "**Hosp**" records.

Menu selection #8, "**Patient Appointments Due"**, choose this selection to print a list of patients due for a follow-up appointment by dates and categories. The selection screen for this menu item is as shown in Figure 419 below.

Selection prompt #1, "**Reason for F/U:**", accept the default of "ALL", or enter a specific reason. Since it is very possible to miss the specific reason indicated for the appointment (can be thousands, including misspellings), it is best to accept the default of "ALL".

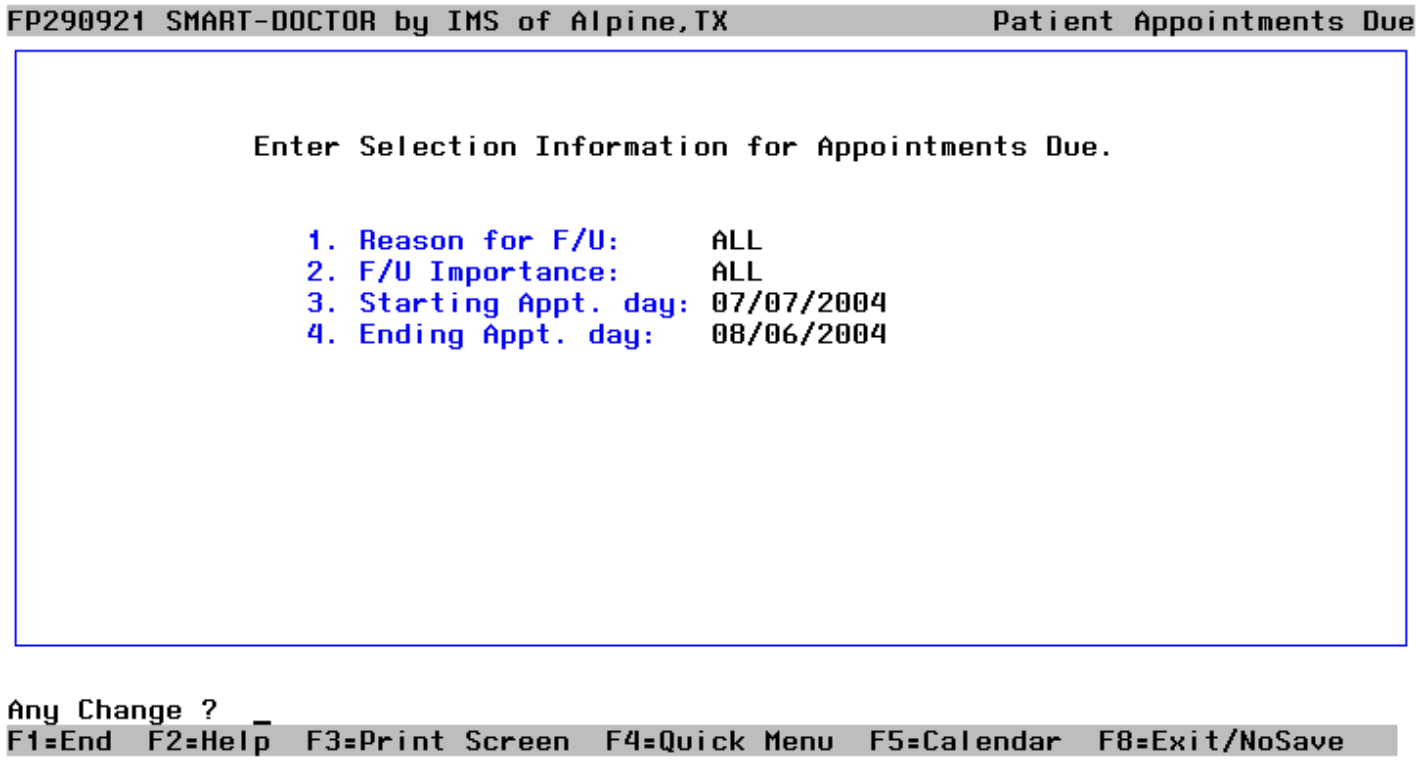


Figure 419 Selection for Appointments due.

Selection prompt #2, "**F/U Importance:**", hitting <enter> at the defaulted "?", will give you a list of acceptable choices as follows: R -Regular F/U: Routine visit, Minor illness, S/R, etc.; M -Mandatory F/U: abnormal test, serious prob, neoplasm, etc.; N -No F/U Req'd: Screening PE, school PE, etc.; No Med. Prob.; or ALL -All Reasons.

Selection prompt #3, "**Starting Appt. day:**", the system will default a date one month in advance. You can over type this with another date if you wish.

Selection prompt #4, "**Ending Appt. day:**", the system will default a date two months in advance. You can over type this with another date if you wish.

A sample screen output for this report is seen in Figure 420 below.

Menu selection #9, "**Drugs Prescribed by Patient**", choose this selection to find patients using a specific drug. The selection screen for this menu item is as shown in Figure 421.

Selection prompt #1, "**Enter starting drug name:**", enter the starting part of the generic name or all of the generic name. For example: amo, or amoxicillin, or amoxicillin cla. You must enter at least three letters. In this example, we entered "cisapride" the generic name of "Propulsid" that was pulled off the market several years ago.

Selection prompt #2, "**Enter ending drug name:**", accept the default of the first selection with "Z" appended, or enter an ending drug.

Selection prompt #3, "**Enter starting DOB:**", enter starting date of birth to select patients, or accept "FIRST" to start with oldest the patient.

```
FP290921                  SMART-DOCTOR by IMS of Alpine,TX                Page    1
                              Patient Appointments Due        11:51:39  7 Jun 2004

For Dates 07/07/2004 Through 08/06/2004
================================================================================
Patient Number                          Follow-up with      Reason for Appt.
Patient Name                            Appt Type-Time      F/U Importance
Address
City, State, ZIP

1002                                    STEVE J. JOHNSON, MD F/U HYPERTENSION
FOSTER, EMMA J                          MINOR--B  .15        R
HC 67, BOX 33D
BALMORRHEA            TX  79718



Reprocess Patient Appointments Due ? - Y)es, N)o, E)nd N
```

Figure 420 Report of Patients with Appointments due.

```
FP290930 SMART-DOCTOR by IMS of Alpine,TX                Patients Prescribed Drug.


                    Enter selection criteria for patient drug look-up.

        1. Enter starting drug name: CISAPRIDE
        2. Enter ending drug name:   CISAPRIDEZ
        3. Enter starting DOB:       FIRST
        4. Enter ending DOB:         LAST
        5. Enter sex (m/f):          ALL


Any Change ? _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 421 Selection of Patients by Drug Prescribed.

Selection prompt #4, “**Enter ending DOB:**”, enter ending DOB or accept "LAST" to get from starting to youngest patient.

Selection prompt #5, “**Enter sex (m/f):**”, enter "m" for all male patients, "f" for all female patients

or accept "ALL" for both sexes.

A sample screen output for this report is seen in Figure 422 below.

```
FP290930                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                            Patients Prescribed Drug.       14:52:07  7 Jun 2004

  Starting Drug Name: CISAPRIDE           Ending Drug Name:  CISAPRIDEZ
======================================  ====================================
  Starting DOB:  FIRST          Ending DOB:  LAST          Sex: ALL
==============================  ========================  ============

Patient Name:                    Patient #: Date:       Drug Name:
================================ ========== ========== ========================
BONNER, JOHN J.                        1001 04/15/98   CISAPRIDE
```

```
Reprocess Patients Prescribed Drug. ? - Y)es, N)o, E)nd N
```

Figure 422 Report of Patients by Selected Drug.

Below the report header is listed the drug names searched, as well as DOB and sex selections. Following this is the list of patients (only one in this example) who were prescribed this drug, and the date prescribed. It is important to remember that patients often do not finish all their medications as indicated, and may still have old medications in their medicine cabinet. If a drug has been recalled, you should send a letter to all patients telling them to stop this drug if they are taking it, and to call your office for an alternative if needed. Also, tell them to discard any of this medication, if it was left over.

Menu selection #10, "**Procedures Due**", choose this selection to print a list of patients that are due for a procedure. The selection screen for this menu item is as seen in Figure 423 below.

Selection prompt #1, "**Procedure since:**", enter the date that you want to start looking from, i.e., the date after which the procedure should have been done. Or, take the default of one year ago.

Selection prompt #2, "**Starting Pt. age in Years:**", the default is "0", here we choose 65.

Selection prompt #3, "**Ending Pt. age in Years:**", the default is "150", or enter any ending age. Here, we accepted the default of 150.

Selection prompt #4, "**Patient Sex (m.f,b):**", the default is "B". You can also specify <m> or <f>. Here, we choose to enter "F".

Selection prompt #5, "**Starting CPT #:**", enter starting CPT number that has not been performed. This can be a single CPT number or the start of a range of numbers.

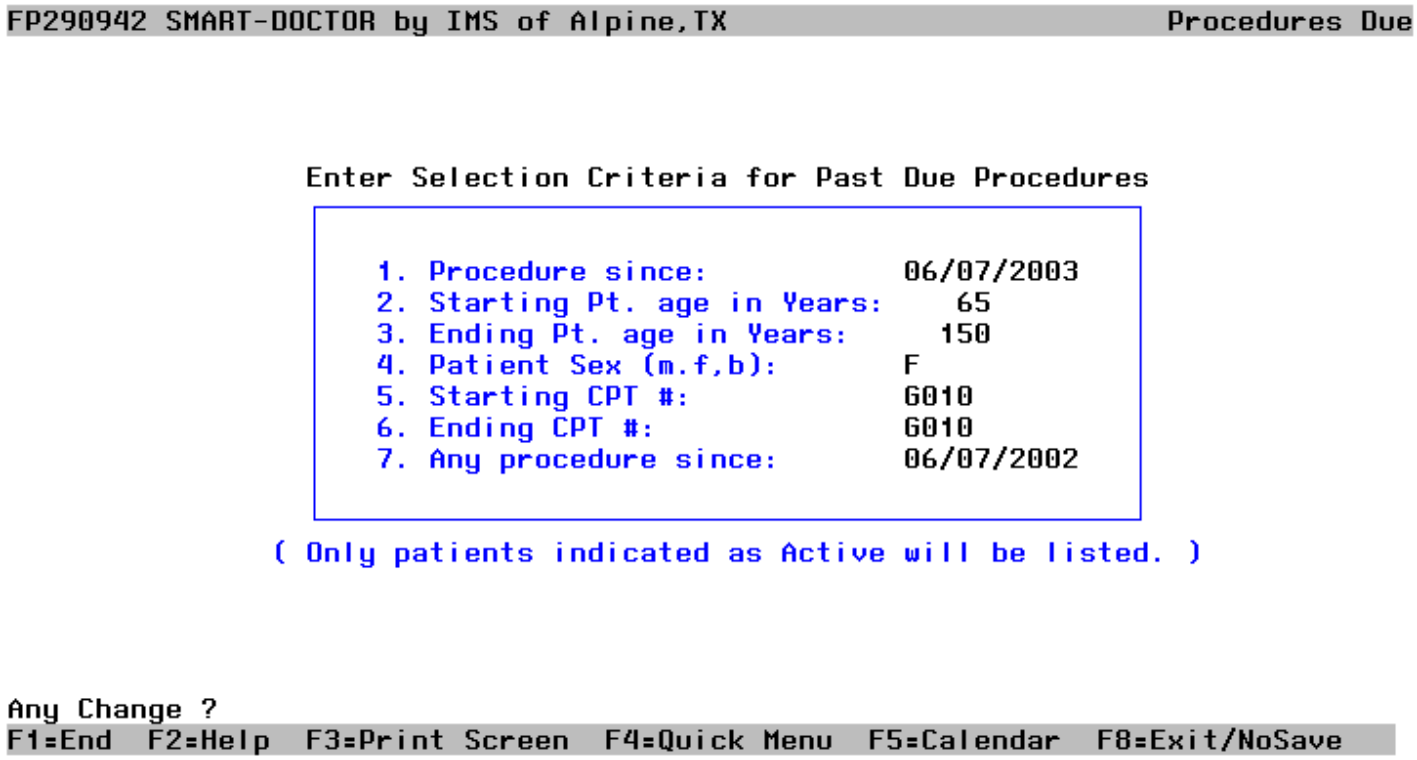


Figure 423 Selection for Past Due Procedures.

Selection prompt #6, "**Ending CPT #:**", enter ending CPT number that has not been performed. This can be the same as the starting number to select a single item. The ending CPT number must be equal to or greater than the starting number.

Selection prompt #7, "**Any procedure since:**", enter the date that this patient last had an office visit or other procedure that was billed by the system, or indicated in the system. This helps eliminate selecting patients that may have moved out of the area or are no longer being seen. The default is two years. Therefore, if no procedures have been documented in two years, the patient will not be considered active. Of course, you can change this to be a much longer time period if you wish. As noted on the selection screen, only patients indicated as Active will be listed.

A sample screen output for this report is seen below in Figure 424.

In this example, we were looking for an active patient who is female, over 65, has had some procedure done since 06/07/2002, and has not had the procedure G010 (a Medicare screening Pap smear) done in the last year. In this example only one patient was found.

Menu selection #11, "**Patient Appts by Sched Prov**", choose this selection to see appointment types for a Scheduled Provider. Included are counts of appts. kept, missed, mandatory missed, etc. The selection screen for this menu item is as shown in Figure 425.

Selection prompt #1, "**Start Date:**", enter starting appointment date, or enter <FIRST> to see from start of clinic.

Selection prompt #2, "**End Date:**", enter last appointment date to check, or enter <LAST> to get most recent appointment scheduled.

```
FP290943                  SMART-DOCTOR by IMS of Alpine,TX                Page    1
                              Procedures Due by Patient       15:27:16  7 Jun 2004

   Procedure(s) G010 to G010            Not done since 06/07/2003
   For patients between    65 and   150 yrs       Sex = F
   With some procedure done since 06/07/2002

   Patient Num.        Patient/Address
   ============        ==============
   1002                FOSTER, EMMA J
                       HC 67, BOX 33D
                       BALMORRHEA TX  79718




Reprocess Procedures Due by Patient ? - Y)es, N)o, E)nd N
```

Figure 424 *Report of Procedures Due by Patient.*

```
FP290332 SMART-DOCTOR by IMS of Alpine,TX                              FP290332

                Enter selection criteria for appointment types.

        1. Start Date:          FIRST

        2. End Date:            LAST

        3. Provider Initials:   ALL

        4. Status of Appt.:     ALL
           (P,K,C)

        5. Type of Appt.:       ALL
           (R,M,C,N)

        6. Pt. Number:          ALL

        7. Fam. Number:         ALL

Any Change ? _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 425 *Selection of Scheduled Patient Appointments.*

Selection prompt #3, "**Provider Initials**", enter provider initials or ALL to see all.

Selection prompt #4, "**Status of Appt.:**", enter <p> for appointment pending or not kept., <k> for appointment kept, <c> for appointment canceled, or <all> (the default).

Selection prompt #5, "**Type of Appt.:**", enter <r> for Regular appointment, <m> for Mandatory appointment, <c> for Canceled appointment, <n> for Not a required appointment, or <all> (the default).

Selection prompt #6, "**Pt. Number:**", enter a patient number or enter ALL.

Selection prompt #7, "**Fam. Number:**", enter a family number or enter ALL.

A sample screen output for this report is seen below in Figure 426.

```
FP290332                SMART-DOCTOR by IMS of Alpine,TX                Page    6
                  Selected Appt. types by SCHEDULED Provider5:19:20 10 Jun 2004

For dates: FIRST to: LAST

Provider  Appt. Date  Patient Number  Type  Status  Fam. Num.   Count  MOYR
========  ==========  ==============  ====  ======  ==========  =====  ======
SJJ       06/03/2004  1001            R     K       500         1      062004
SJJ       06/03/2004  1002            R     K       502         1      062004
SJJ       06/03/2004  1003            R     P       501         1      062004
SJJ       06/03/2004  1004            R     P       501         1      062004
                                                                -----
                                                  Sub-Total         4
                                                                -----
                                                  Total            18
```

Figure 426 *Report of Scheduled Appointments by Type.*

As can be seen in this last page for the example report, the appointments are output with month and year breaks in addition to indicating the scheduled provider. This report is mainly run to find families that are missing a lot of appointments so that you can counsel them on office policies regarding cancellations, rescheduling, and failed appointments.

Menu selection #12, "**Patient Appts by Appt. Type**", choose this selection to find patient appointments by type of appointment scheduled. The selection screen for this menu item is as shown in Figure 427.

Selection prompt #1, "**Start Date:**", enter last appointment date to check, or enter <LAST> to get most recent appointment scheduled.

Selection prompt #2, "**End Date:**", enter last appointment date to check, or enter <LAST> to get most recent appointment scheduled.

Selection prompt #3, "**Provider Initials:**", enter provider initials or <ALL> to see all.

Selection prompt #4, "**Status of Appt.:**", enter <p> for appointment pending or not kept, <k> for appointment kept, <c> for appointment canceled, or <all> (the default).

Selection prompt #5, "**Appt. Type**", enter appointment type as used in booking system. That is, to find all appts made for a female PE, enter PE-----F, etc.

```
FP290335 SMART-DOCTOR by IMS of Alpine,TX                    FP290335

          Enter selection criteria for appointment types.

          1. Start Date:          FIRST

          2. End Date:            LAST

          3. Provider Initials:   ALL

          4. Status of Appt.:     ALL
             (P,K,C)

          5. Appt. Type           ALL
             (PE-----B, SURGAC_F, etc.)

          6. Pt. Number:          ALL

Any Change ? _
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 427 *Selection of Patients by Appointment Type*

```
FP290335              SMART-DOCTOR by IMS of Alpine,TX              Page    6
                    Selected Appt. by Provider/Type/Status 15:30:29 10 Jun 2004

For dates: FIRST to: LAST            For Appt. Type: ALL

Prov Appt. Date Pat. Num.  Pat. Name           Appt Typ  Status Count  MOYR
==== ========== ========== ==================== ========  ====== =====  ======
SJJ  06/03/2004 1001       BONNER, JOHN J.      MINOR--B  K      1      062004
SJJ  06/03/2004 1002       FOSTER, EMMA J       MINOR--B  K      1      062004
SJJ  06/03/2004 1003       COOPER, MARY K.      PE-PARTB  P      1      062004
SJJ  06/03/2004 1004       COOPER, JANE T.      MINOR--B  P      1      062004
                                                                 -----
                                                Sub-Total            4
                                                                 -----
                                                Total               18
```

Figure 428 *Report of Patients by Appointment Type.*

Selection prompt #6, "**Pt. Number:**", enter a patient number or enter <ALL>.

A sample screen output for this report is seen above in Figure 428.

This report is mainly run to see which patients are missing or have appointments of a specific type, which may help relate how important it is to get hold of the patient for this problem or type of appointment.

Menu selection #13, "**Patient by Ins, Sex, Age**", choose this menu item to find patients by Insurance, Age, and/or Sex. The selection screen for this menu item is as seen in Figure 429.

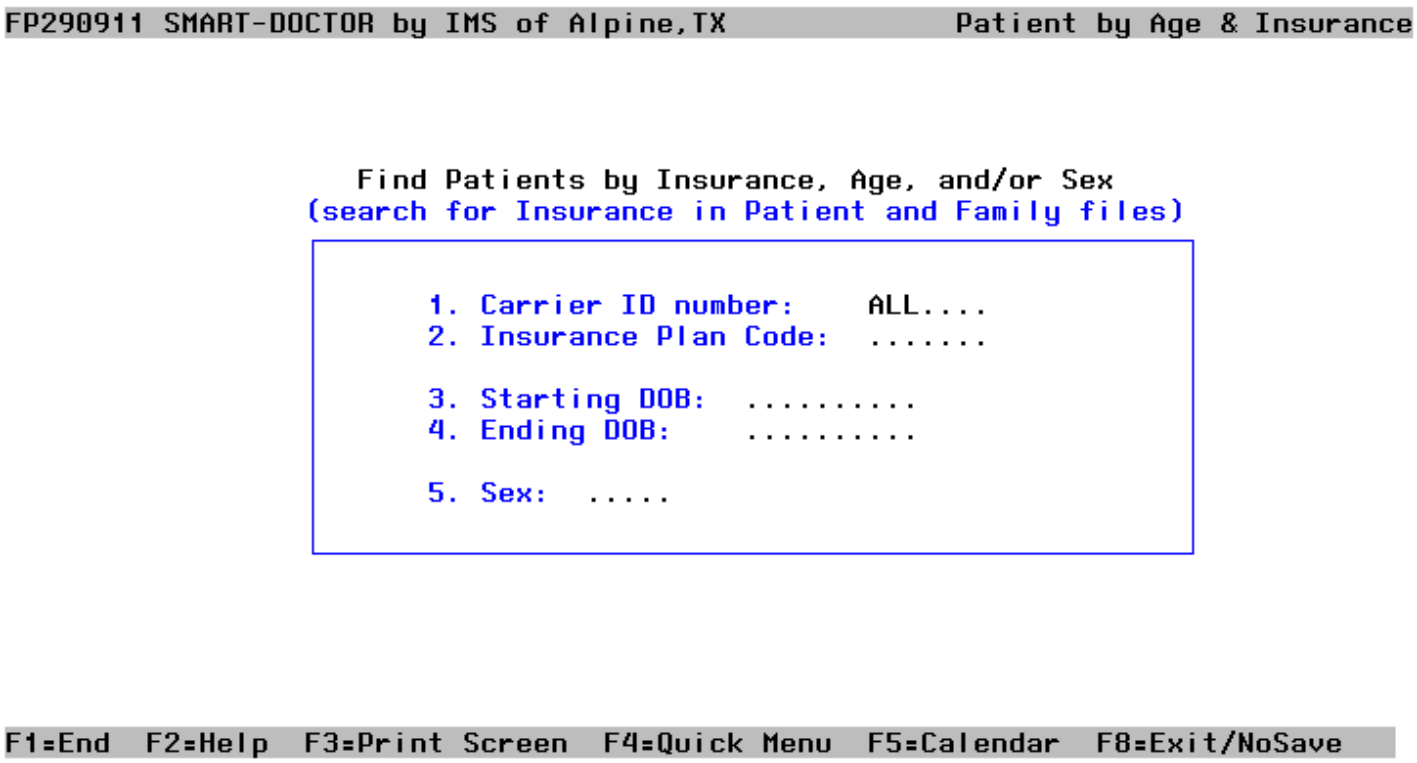


Figure 429 *Selection of Patients by Insurance Carrier.*

Selection prompt #1, "**Carrier ID number:**", accept or Enter <ALL> to select All carriers, or you may choose 1 carrier to select with. The carrier cross-reference will help you if you remember part of the name of the carrier.

Upon entering the second prompt, a pop-up a selection window appears as seen in Figure 430.

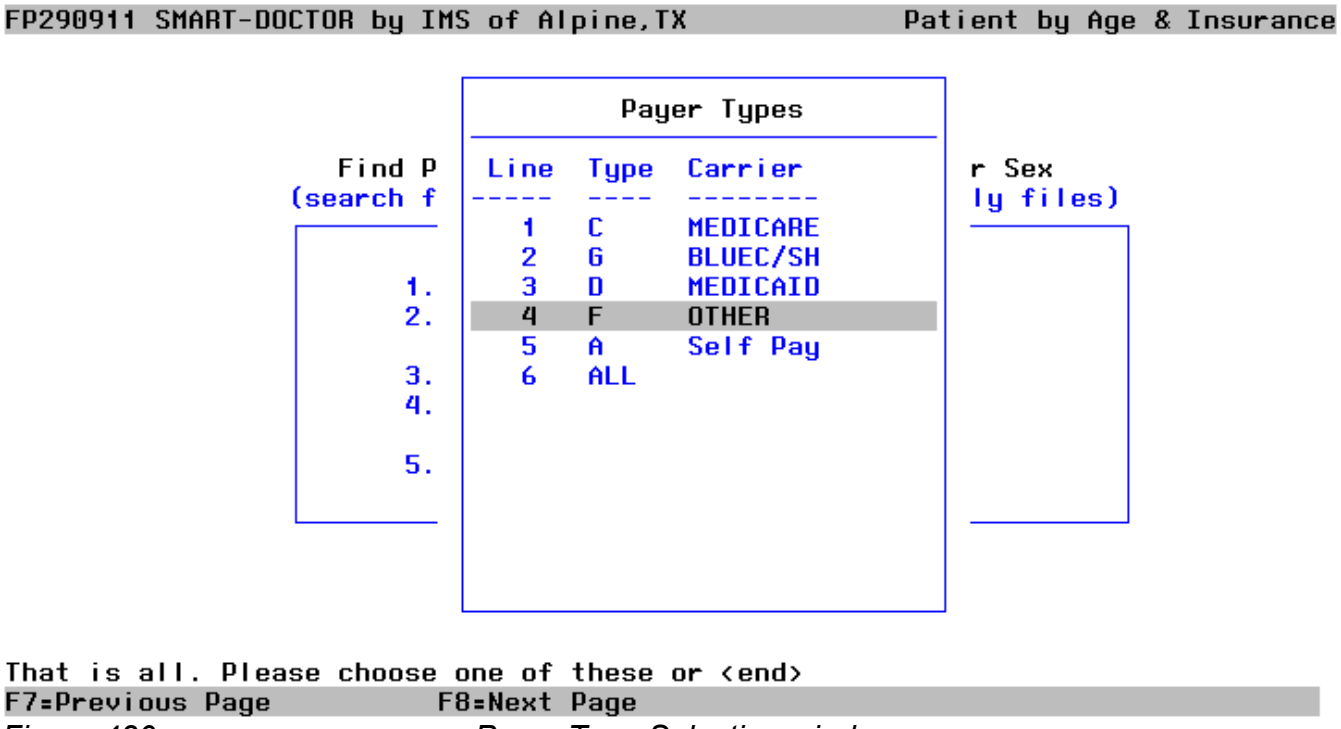


Figure 430 *Payer Type Selection window.*

Selection prompt #2, "**Insurance Plan Code:**", an automatic pop-up window, as shown in Figure 430, will help you select an appropriate plan code, or use "ALL".

Selection prompt #3, "**Starting DOB:**", enter a starting DOB range or accept the default of "FIRST".

Selection prompt #4, "**Ending DOB:**", enter a ending DOB range or accept the default of "LAST".

Selection prompt #5, "**Sex:**", accept the default of "all", or enter <m> for male or <f> for female.

A sample screen output for this report is seen in Figure 431.

```
FP290911                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                           Patient by Age & Insurance       16:13:51 10 Jun 2004

                        For Ins ALL to F
                        For DOBs FIRST to LAST
                        For Sex: ALL

Patient Name                  Pt Num  DOB        S F P Insurance ID or # of Dox
============================= ======= ========== = = = ======================
BONNER, JOHN J.               1001    12/02/1931 M Y - 264758764
BONNER, MARY K.               1006    08/24/1962 F Y Y 2 Insurance Documents
COOPER, DAVID S               1005    10/25/1961 M Y - 1234567
COOPER, JANE T.               1004    03/12/1990 F Y - 1234567
COOPER, MARY K.               1003    07/12/1960 F Y Y 2 Insurance Documents
JACKSON, JOHN                 1007    10/23/1969 M Y - 237389
JACKSON, MARY                 1009    11/22/1960 F Y - 237389
```

Figure 431 *Report of Patient by Insurance Carrier.*

In the above sample report, the patient's name, number, DOB, and sex are followed by three additional fields. The "**F**" and "**P**" columns indicate the insurance documents for these selection criteria were found in the Family or Patient insurance files, respectively. The last column will indicate the Insured ID Number if there is only one insurance document, or the number of insurance documents found if there is more than one.

FINANCIAL REPORTS

This section has 16 reports. All these reports are financial centric, and are used to help office manager and the billing manager keep track of income and accounts receivable.

Menu selection #14, "**Monthly Financial Report**", this is a report of all charges, adjustments, payments and balances for each day of the report period as well as totals of the above items for the period. The selection screen for this menu item is as shown in Figure 432 below.

Selection prompt #1, "**Posting Start Date:**", enter the start date of the report you want to see. Generally, this would be the beginning of a given month. In this example, we will show the beginning of June, 2004, through the 11th of the month. Normally, this would be the end of a month or time period.

Selection prompt #2, "**Posting End Date:**", enter the last date of the report, or accept the default of "TODAY", which will replaced with today's date. A sample screen output for this report is seen in Figure 433 below.

```
FP290200 SMART-DOCTOR by IMS of Alpine,TX                    Print Monthly Report

                    Monthly Financial Report
                  1. Posting Start Date: 06/01/2004
                  2. Posting End Date:   06/11/2004

Any Change ?
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 432 *Selection for monthly Financial Report.*

```
FP290200                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                            Monthly Financial Report        11:07:23 11 Jun 2004

                Monthly Financial Report: 06/01/2004 to  06/11/2004

Date       Charges     Adjstmnts   Amt Cash    Amt Check   Amt CC      Acc Rcvbl
---------- ---------   ---------   ---------   ---------   ---------   ---------
06/01/2004       .00         .00         .00         .00         .00    56412.89
06/02/2004     40.62         .00         .00         .00         .00    56453.51
06/03/2004       .00         .00         .00         .00         .00    56453.51
06/04/2004       .00         .00         .00         .00         .00    56453.51
06/05/2004       .00         .00         .00         .00         .00    56453.51
06/06/2004       .00         .00         .00         .00         .00    56453.51
06/07/2004       .00         .00         .00         .00         .00    56453.51
06/08/2004       .00         .00         .00         .00         .00    56453.51
06/09/2004       .00         .00         .00         .00         .00    56453.51
06/10/2004       .00         .00         .00         .00         .00    56453.51
06/11/2004     47.00        7.00         .00       10.00         .00    56483.51
           ---------   ---------   ---------   ---------   ---------
  Totals:      87.62        7.00         .00       10.00         .00
```

Figure 433 *Monthly Financial Report.*

Other than the first day of setting up the clinic, the right hand column, “Acc Rcvbl” (accounts receivable), should always have a non-zero number. If all of a sudden you see that the amount drops to 0.00, then the automatic system posting and integrity check failed. You should call IMS immediately. You are also notified of this failure in the “Daily Admin” report from the “Billing” screen.

Menu selection #15, "**Collections by Provider**", This report lists the charges, adjustments, and payments for each provider in the clinic. For the period selected, the sum of transactions for charges, adjustments, and payments is shown for each provider. The selection screen for this menu item is as seen in Figure 434 below.

```
FP290300 SMART-DOCTOR by IMS of Alpine,TX    Posting For Collections by Provider

                    Collections by Provider

                1. Posting Start Date: 06/01/2004

                2. Posting End Date:   06/11/2004

Any Change ?
F1=End  F2=Help  F3=Print Screen  F4=Quick Menu  F5=Calendar  F8=Exit/NoSave
```

Figure 434 *Selection of Collections by Provider.*

Selection prompt #1, "**Posting Start Date:**", enter the start date of the report you want to see. Generally, this would be the beginning of a given month. In this example, we will show the beginning of June, 2004, through the 11th of the month. Normally this would be the end of a month or time period.

Selection prompt #2, "**Posting End Date:**", enter the last day of the report, or accept the default of "TODAY", which be replaced with today's date.

A sample screen output for this report is seen in Figure 435.

```
FP290301                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                            Collections by Provider        11:29:20 11 Jun 2004

                    Collections for dates: 06/01/2004 to 06/11/2004

Prov  Provider Name                                 Billed     Adjstmnts  Payments
====  ========================================  =========  =========  =========
SJJ   STEVE J. JOHNSON, MD                         236.73      10.00      10.00
JRS   JANE R. SMITH, MD                             46.78        .00        .00
                                                 ---------  ---------  ---------
                                    Clinic Totals:  283.51      10.00      10.00
```

Figure 435 *Report of Collections by Provider.*

Please note that these are the amounts billed, adjusted, and paid during the selection period. These values are specified by the provider identified in the billing statements. These adjustments and payments may not be related to the charges billed, but reflect the activity of all the accounts receivable.

Menu selection #16, "**New Charges by Provider**", choose this selection to print new charges for the dates of service (DOS) selected. The listing includes the DOS, patient name, CPT code, base fee, standard adjustments (std. Adj.), charge applied and payments made to-date on each item. The selection screen for this menu item is as shown in Figure 436 below.

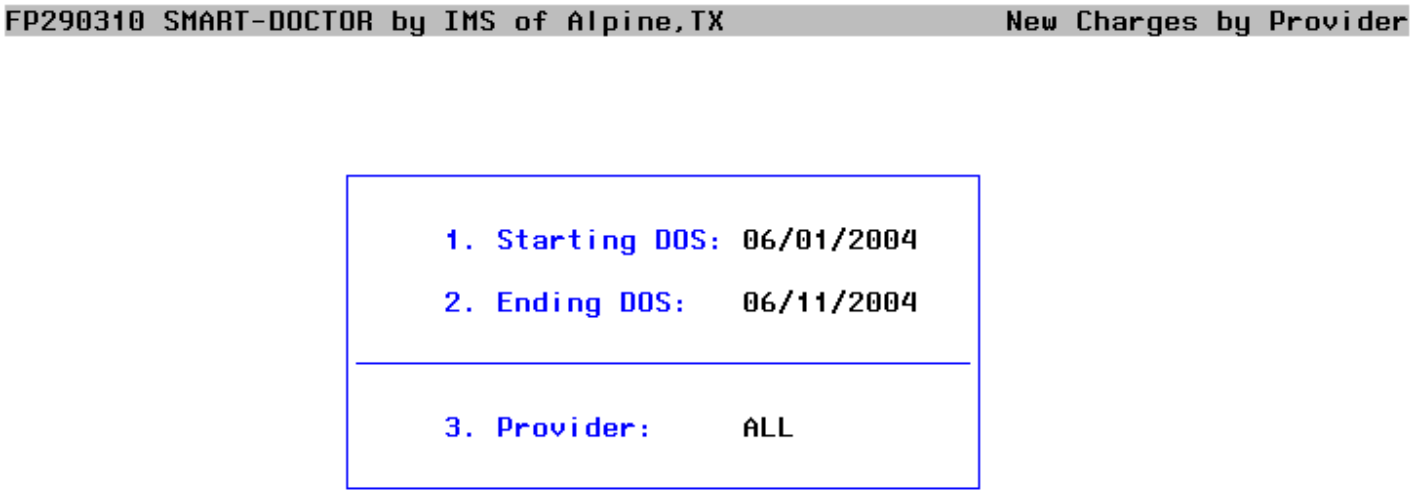


Figure 436 Selection for New charges by provider.

Selection prompt #1, "**Starting DOS:**", enter the starting date of service of the report you want to see. Generally this would be the beginning of a given month. In this example, we will show the beginning of June, 2004, through the 11th of the month. Normally this would be the end of a month or time period.

Selection prompt #2, "**Ending DOS:**", enter the last day of service of the report, or accept the default of "TODAY" which will be replaced this with today's date.

Selection prompt #3, "**Provider:**", enter the provider initials for a specific provider or <all> for all providers.

A sample screen output for this report is seen in Figure 437 below.

This report (seen in Figure 437) below, reflects the charges by the provider, grouped by provider, for the selected time period. The right 4 columns are related to these specific charges on those dates. Other than the "Std. Adj" (standard adjustment or contracted adjustment), charges and payments may vary in dates of action (such as bounced check fees, or payments made by the patient and insurance carrier on different dates).

```
FP290310                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                             New Charges by Provider          12:05:16 11 Jun 2004

       For dates of service:  06/01/2004  to  06/11/2004

Prov   DOS      Patient Name          CPT     Base Fee Std Adj   Charge    Payments
==== ======== ==================== ====== ======== ========  ========  ========
JRS  06/11/04 FOSTER, EMMA J        99213      70.00    23.22     46.78     10.00
                                              -------- --------  --------  --------
                    Sub-Total                    70.00    23.22     46.78     10.00

Prov   DOS      Patient Name          CPT     Base Fee Std Adj   Charge    Payments
==== ======== ==================== ====== ======== ========  ========  ========
SJJ  06/03/04 BONNER, JOHN J.       99214     109.00    35.83     73.17       .00
SJJ  06/05/04 BONNER, JOHN J.       99213      70.00    23.22     46.78       .00
SJJ  06/05/04 BONNER, MARY K.       99213      70.00      .00     70.00       .00
SJJ  06/07/04 FOSTER, EMMA J        99213      70.00    23.22     46.78       .00
                                              -------- --------  --------  --------
                    Sub-Total                   319.00    82.27    236.73       .00
                                              -------- --------  --------  --------
                    Total                       389.00   105.49    283.51     10.00
```

Figure 437 *New Charges by Provider.*

Menu selection #17, "**Chg, Adj, Pay, by Provider**", choose this selection to print a report showing Charges, adjustments, and form of payment by provider, for a given date range. The selection screen for this menu item is as in Figure 438 below. Only the top half of the screen is show to save space. The bottom half is typical of the prior screens.

```
FP290210 SMART-DOCTOR by IMS of Alpine,TX       Chg, Adj., Pay type, by Provider
```

```
          Chg., Adj., Payments by Provider

    1. Posting start date:   06/01/2004

    2. Posting End date:     06/11/2004
```

Figure 438 *Selection Charges by Provider.*

Selection prompt #1, "**Posting Start Date:**", enter the start date of the report you want to see. Generally, this would be the beginning of a given month. In this example, we will show the beginning of June, 2004, through the 11th of the month. Normally this would be the end of a month or time period.

Selection prompt #2, "**Posting End Date:**", enter the last day of the report, or accept the default of "TODAY" which will replaced this with today's date.

A sample screen output for this report is seen in Figure 439 below.

```
FP290211                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                        Chg., Adj., & Payment by Provider   12:23:36 11 Jun 2004

                    For the period: 06/01/2004   to 06/11/2004

Prov  Billed     Adjstmnts    Cash       Checks      CC/List     Other      Pay Total
==== ========== ========== ========= ========== ========== ========== ==========
SJJ       236.73      10.00       .00       15.00        .00        .00       15.00
JRS        46.78        .00     10.00         .00        .00        .00       10.00
     ---------- ---------- --------- ---------- ---------- ---------- ----------
           283.51      10.00     10.00       15.00        .00        .00       25.00
```

Figure 439 Report of Payments by Provider.

The above report shows charges grouped by provider for the selected time period. This reflects the amounts billed, adjusted, as well as method of payments for this time period. The adjustments, charges and payments were made during the selected time period, but may have been posted to a period prior to this. For example, if a charge or adjustment was placed today on a previous month's charge, that would be reflected in this time period, because this is the time period in which the action was taken.

To save space, the remaining screen shots for the reports section will only show the top part of the screen, which contains information that has changed from previous screens. The bottom half of the screens will be shown if the f-key selection changes.

Menu selection #18, "**Collections by Procedure**", this report lists the billings, adjustments, and payments associated with each procedure performed in the clinic. It is not a list of all procedures performed during the report period, but rather a list of the financial transactions performed during the report period. The selection screen for this menu item is as shown in Figure 440 below.

```
FP290400 SMART-DOCTOR by IMS of Alpine,TX        Posting for Coll. by Procedure

        Collections by Procedure
   ------------------------------------

     1. Report Start Date: 06/01/04

     2. Report End Date:   06/11/04

     3. CPT Start Code:    99213

     4. CPT End Code:      99214
```

Figure 440 Selection of Collection by Procedure.

Selection prompt #1, "**Report Start Date:**", enter the start date of the report you want to see. Generally, this would be the beginning of a given month. In this example, we will show the beginning of June, 2004, through the 11th of the month. Normally, this would the end of a month or time period.

Selection prompt #2, "**Report End Date:**", enter the last day of the report, or accept the default of "TODAY" which will be replaced with today's date.

Selection prompt #3, "**CPT Start Code:**", enter the first CPT or other code you would like to see listed in the selection of CPT codes, or accept the default of "FIRST" by hitting <enter>.

Selection prompt #4, "**CPT End Code:**", enter the last CPT or other code you would like to see listed in the selection of CPT codes, or accept the default of "LAST" by hitting <enter>.

Please see "A WORD ON SELECTION RANGES" in the "Basic" section of this manual.

A sample screen output for this report is shown in figure 441 below.

```
FP290401                  SMART-DOCTOR by IMS of Alpine,TX              Page    1
                                Procedure Report                 13:31:29 11 Jun 2004

                        Collections by Procedure: 06/01/04 to 06/11/04

CPT     CPT Description                  No.      Billed     Adjstmnts    Payments
======= ============================   =====    =========   =========    =========
99214   L-4 OFFICE VISIT- ESTAB.(H-D       2       146.34       10.00         5.00
99213   L-3 OFFICE VISIT- EST.(H-EPF       4       210.34         .00        15.00
                                         ------   ---------   ---------   ---------
                              Clinic Totals:       6       356.68       10.00        20.00
```

Figure 441 *Report of Collections by Procedure.*

Menu selection #19, "**Procedure Charges**", this is a report of all procedures actually performed during the report period, together with the Base Fee, Standard Adjustment, and Charge for that procedure. The selection screen for this menu item is as shown in Figure 442 below.

```
FP290500 SMART-DOCTOR by IMS of Alpine,TX                                FP290500

                          Procedure Charges

                    1. Report Start Date: 06/01/04

                    2. Report End Date:   06/11/04

                    3. Provider:          ALL
```

Figure 442 *Selection for Procedure Charges.*

Selection prompt #1, "**Report Start Date:**", enter the start date of the report you want to see. Generally this would be the beginning of a given month. In this example, we will show the beginning of June, 2004, through the 11th of the month. Normally, this would be the end of a month or time period.

Selection prompt #2, "**Report End Date:**", enter the last day of the report, or accept the default of "TODAY" which will be replaced with today's date.

Selection prompt #3, "**Provider:**", enter the provider initials for a specific provider, or <all> for all providers.

A sample screen output for this report is seen in Figure 443 below.

```
FP290500                  SMART-DOCTOR by IMS of Alpine,TX                  Page    1
                                Procedure Charges                 14:41:23 11 Jun 2004

                          For Dates 06/01/04 through 06/11/04

Prov  CPT     CPT Description                  MX  Base Chg   Std. Adj.  Billed
====  ======= ============================== ==  =========  =========  =========
JRS   99213   L-3 OFFICE VISIT- EST.(H-EPF,E  1       70.00      23.22      46.78
                                             ------ ---------- ---------- ----------
                    Sub Total by CPT          1       70.00      23.22      46.78

                                             ------ ---------- ---------- ----------
                    Sub Total by Prov.        1       70.00      23.22      46.78

Prov  CPT     CPT Description                  MX  Base Chg   Std. Adj.  Billed
====  ======= ============================== ==  =========  =========  =========
SJJ   99213   L-3 OFFICE VISIT- EST.(H-EPF,E  1       70.00      23.22      46.78
SJJ   99213   L-3 OFFICE VISIT- EST.(H-EPF,E  1       70.00        .00      70.00
SJJ   99213   L-3 OFFICE VISIT- EST.(H-EPF,E  1       70.00      23.22      46.78
                                             ------ ---------- ---------- ----------
                    Sub Total by CPT          3      210.00      46.44     163.56

SJJ   99214   L-4 OFFICE VISIT- ESTAB.(H-D,E  1      109.00      35.83      73.17
                                             ------ ---------- ---------- ----------
                    Sub Total by CPT          1      109.00      35.83      73.17

                                             ------ ---------- ---------- ----------
                    Sub Total by Prov.        4      319.00      82.27     236.73

                                             ------ ---------- ---------- ----------
                    Grand total               5      389.00     105.49     283.51
```

Figure 443 *Report of Procedure charges.*

The "**MX**" column stands for multiplier, for those charges that can be charged for each additional procedure of a like type, done at the same time.

Menu selection #20, "**Family Receivable Ageing**", this is an aged report, by Family, of the Family balance. This report can be produced for all providers or an individual provider. The selection screen for this menu item is as seen in Figure 444 below.

```
FP290600 SMART-DOCTOR by IMS of Alpine,TX                    Family Receivable Aging
```

```
        Family Receivable Ageing
 1. Beginning Family Name: FIRST
 2. Ending Family Name:    LAST
 3. Provider(s):           ALL
```

Figure 444 *Selection for family receivable ageing.*

Selection prompt #1, "**Beginning Family Name:**", enter the first Family name in the range of family names that you wish to appear on this list, or hit <enter> to accept the default of "FIRST".

Selection prompt #2, "**Ending Family Name:**", enter the last Family name in the range of family names that you wish to appear on this list, or hit <enter> to accept the default of "LAST".

Selection prompt #3, "**Provider:**", enter the provider initials for a specific provider, or <all> for all providers.

A sample screen output for this report is seen in Figure 445 below.

```
FP290600                  SMART-DOCTOR by IMS of Alpine,TX                Page    1
                               Family Receivable Aging          15:23:40 11 Jun 2004

          For Provider(s): ALL

Family No. Head of Household    0 - 30    31 - 60   61 - 90  91 ----->   Balance
---------- -------------------- --------- --------- --------- --------- ---------
500        BONNER, JOHN J.        184.95                       113.88    298.83
501        COOPER, DAVID S.                                    140.00    140.00
502        FOSTER, EMMA J.         83.56     73.17             121.51    278.24
503        JACKSON, JOHN                                        65.00     65.00
                                  --------- --------- --------- --------- ---------
                Clinic Totals:    268.51     73.17       .00     440.39    782.07
```

Figure 445 *Report of Family Receivable Ageing.*

Menu selection #21, "**Family A/R Ageing w/Bal<>0**", choose this report to print A/R ageing by Provider, or ALL, with bal <> 0, and indicate insurance and patient responsibility. The selection screen for this menu item is as shown in Figure 446 below.

```
FP290610 SMART-DOCTOR by IMS of Alpine,TX     Family Receivable Aging w/Bal. <>0
```

```
        Family Receivable Ageing
 1. Beginning Family Name: FIRST
 2. Ending Family Name:    LAST
 3. Provider(s):           ALL
```

Figure 446 *Selection for Family Receivable Ageing with Non-Zero Balance.*

Selection prompt #1, "**Beginning Family Name:**", enter the first Family name in the range of family names that you wish to appear on this list, or hit <enter> to accept the default of "FIRST".

Selection prompt #2, "**Ending Family Name:**", enter the last Family name in the range of family names that you wish to appear on this list, or hit <enter> to accept the default of "LAST".

Selection prompt #3, "**Provider:**", enter the provider initials for a specific provider, or <all> for all providers.

A sample screen output for this report is shown in Figure 447 below.

```
FP290610                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                      Family Receivable Aging w/Bal. <> 0  15:49:43 11 Jun 2004

         For Provider(s): ALL

Family No. Head of Household    0 - 30    31 - 60   61 - 90  91 ----->   Balance
---------- ------------------ --------- --------- --------- --------- ---------
500        BONNER, JOHN J.        184.95                       113.88    298.83
                  Ins.            114.95                        98.88    213.83
                  Pat.             70.00                        15.00     85.00
501        COOPER, DAVID S.                                     140.00    140.00
                  Ins.                                         140.00    140.00
                  Pat.
502        FOSTER, EMMA J.         83.56     73.17              121.51    278.24
                  Ins.            83.56     73.17              121.51    278.24
                  Pat.
503        JACKSON, JOHN                                         65.00     65.00
                  Ins.                                          65.00     65.00
                  Pat.
                               --------- --------- --------- --------- ---------
                Clinic Totals:    268.51     73.17       .00    440.39    782.07
                               --------- --------- --------- --------- ---------

                Ins. Totals:      198.51     73.17       .00    425.39    697.07
                               --------- --------- --------- --------- ---------
                Pat. Totals:       70.00       .00       .00     15.00     85.00
```

Figure 447 *Report of Family Receivable Ageing with Non-Zero Balance.*

Menu selection #22, "**Families with Bal/Fwd <> 0**", choose this item to print a list of families with balance forward amounts greater than 0. There is no selection screen for this menu item. The report is as seen in Figure 448 below.

```
FP290320                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                          Families with Bal. Fwd<>0       16:22:19 11 Jun 2004


Responsible Party                    Family Num.   Current Bal. Fwd/Credit
==================================== ===========   ======================
COOPER, DAVID S.                     501                        15.00
FOSTER, EMMA J.                      502                        20.00
                                                    ------------
                                      Grand Total               35.00
```

Figure 448 *Report of Families with Balance Forward Non-Zero.*

Menu selection #23, "**Ins. Resp. w/bal <> 0 by Co.**", choose this selection to print a report of adjustments and payments by insurance company. The selection screen for this menu item is as seen in Figure 449 below.

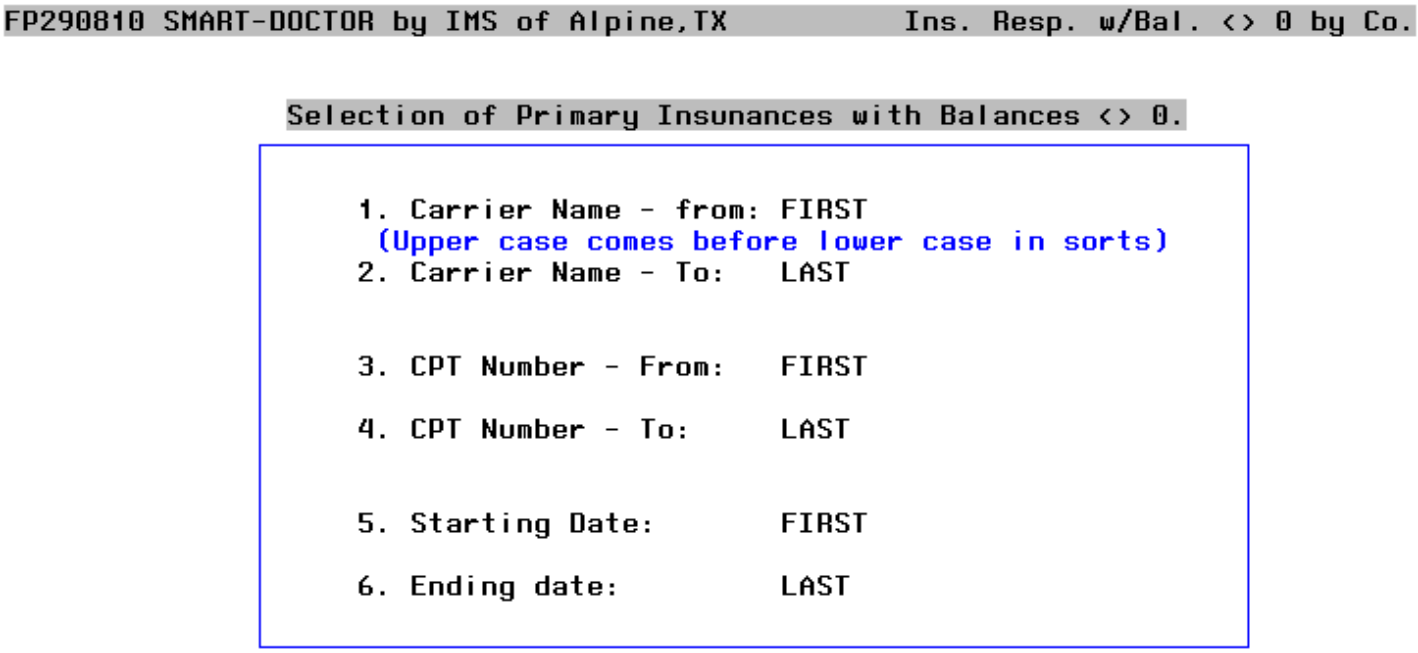


Figure 449 *Select Primary Insurances with Non-Zero Balances.*

Selection prompt #1, "**Carrier Name – from:**", to find all companies from Blue Cross to Coast Insurance, enter <Blu> in this line, and <Cx> in the next line. Starting with <blu> will miss all names starting with an upper case letter. (See "A WORD ON SELECTION RANGES" in the "Basics" section of this manual above.)

Selection prompt #2, "**Carrier Name – To:**", enter an ending insurance carrier name as mentioned above.

Selection prompt #3, "**CPT Number - From:**", enter the first CPT or other code you would like to see listed in the selection of CPT codes, or accept the default of "FIRST" by hitting <enter>.

Selection prompt #4, "**CPT Number - To:**", enter the last CPT or other code you would like to see listed in the selection of CPT codes, or accept the default of "LAST" by hitting <enter>.

Selection prompt #5, "**Starting Date:**", enter the start date of the report you want to see. Generally this would be the beginning of a given month in the past. Since it may take a month or more to get paid, a more meaningful report would be to indicate from the first time of billings or the beginning of the year. To accept the default of "First", hit <enter>.

Selection prompt #6, "**Ending date:**", enter the last date of the report. This would be best to be one month ago, as indicated above, to determine delinquency. You can also accept the default of "LAST" which will be replaced with today's date. A sample screen output for this report is seen Figure 450 below.

Menu selection #24, "**Visits by Insurance Type**", choose this report to display all visits by specific insurance company per provider. The selection screen for this menu item is as shown in Figure 451 below.

Selection prompt #1, "**Starting date:**", enter the start date of the report you want to see. Generally, this would be the beginning of a given month.

```
FP290810                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                          Ins. Resp. w/Bal. <> 0 by Co.     16:58:34 11 Jun 2004

                              For dates from FIRST to LAST

Insurance Company  Patient Name  Ins. ID #     DOS      CPT # Bill Chg  Balance
================== ============ =========== ======== ===== ========= =========
BLUE CROSS         BONNER, JOHN 256258965A  03/31/99 99214      49.80     44.80
BLUE CROSS         BONNER, JOHN 256258965A  07/17/00 99214      74.08     54.08
BLUE CROSS         BONNER, JOHN 256258965A  06/03/04 99214      73.17     73.17
BLUE CROSS         BONNER, JOHN 256258965A  06/05/04 99213      46.78     41.78
BLUE CROSS         COOPER, JANE 1234567     03/31/99 99214      70.00     70.00
BLUE CROSS         COOPER, MARY 2776645T    03/31/99 99214      70.00     70.00
BLUE CROSS         FOSTER, EMMA 258258225A  04/15/98 99202      43.31     43.31
BLUE CROSS         FOSTER, EMMA 258258225A  03/31/99 99215      78.20     78.20
BLUE CROSS         FOSTER, EMMA 258258225A  05/11/04 99214      73.17     73.17
BLUE CROSS         FOSTER, EMMA 258258225A  06/07/04 99213      46.78     46.78
BLUE CROSS         FOSTER, EMMA 258258225A  06/11/04 99213      46.78     36.78
                                                              --------- ---------
                                            Sub-Total          672.07    632.07

GREAT WEST HEALTH  JACKSON, JOHN 237389     04/21/00 99202      75.00     65.00
                                                              --------- ---------
                                            Sub-Total           75.00     65.00
                                                              --------- ---------
                                            Total              747.07    697.07
```

Figure 450 Report of Insurance Carriers with Non-Zero Balances.

```
FP291010 SMART-DOCTOR by IMS of Alpine,TX     Number of Office Visit by Provider
```

```
                    Select Date Range of Visits

        1. Starting date: 01/01/2000

        2. Ending date:   06/11/2004

        3. Provider(s):   all
        4. Provider(LU):  ALL
```

Figure 451 Selection for Visits by Insurance.

Selection prompt #2, "**Ending date:**", enter the last day of the report, or accept the default of "TODAY" which will be replaced with today's date.

Selection prompt #3, "**Provider(s):**", enter the specific provider, or hit <enter> to take the default of "all".

Selection prompt #4, "**Provider(LU):**", this is an automatic prompt to match both the upper and lower cases of the provider name, for backward compatibility. Just accept this default.

A sample screen output for this report is shown in Figure 452 below.

```
FP291011                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                           Provider Visits by Ins. Co.       19:40:27 11 Jun 2004

Provider(s): all              For the period: 01/01/00   to : 06/11/04

      Insurance Company                                    Num. Visits
      ========================================             ===========
      GREAT WEST HEALTH PLAN                                     1
      BLUE CROSS                                                 6
      FARMERS HEALTH COOP.                                       2
                                                           ---------
                                          Total                  9
```

Figure 452 *Report of Provider Visits by Insurance Carrier.*

Menu selection #25, "**Bills & Pay by Ins. Co.**", choose this item to produce a report of billings, adjustments, and payments by Insurance Company, for all or a given provider. The selection screen for this menu item is as shown in Figure 453 below.

```
FP291000 SMART-DOCTOR by IMS of Alpine,TX          Bills & Payments by Ins. Co.
```

```
Chg., Adj., Payments by Insurance
   1. Starting date: 01/01/2004
   2. Ending date:   06/12/2004
   3. Provider(s):   ALL
   4. CPT Code:      ALL
```

Figure 453 *Selections for Payments by Insurance Company.*

Selection prompt #1, "**Starting date:**", enter the start date of the report you want to see. Generally, this would be the beginning of a given month.

Selection prompt #2, "**Ending date:**", enter the last day of the report, or accept the default of "TODAY" which will be replaced with today's date.

Selection prompt #3, "**Provider(s):**", enter the specific provider, or hit <enter> to accept the default of "ALL".

Selection prompt #4, "**CPT Code:**", Enter CPT Code by code number. For example: 99212 or 10060*, or just hit <enter> to accept the default of ""ALL".

A sample screen output for this report is seen below in Figure 454.

Menu selection #26, "**Detail Collection by Ins.**", choose this report to see procedure charges, adjustments, and payments by Insurance Company. The selection screen for this menu item is as seen in Figure 455 below.

```
FP291001                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                          Bills & Payments by Ins. Co.      13:37:17 12 Jun 2004

                    For the period: 01/01/04     to 06/12/04
 Provider(s): ALL                                              CPT Code: ALL

Insurance Company             Std Chrge  Billed     Adjstmnts  Payments  Claims
============================= ========== ========== ========== ========= =======
BLUE CROSS                        428.00     286.68        .00     15.00       5
FARMERS HEALTH COOP.              140.00     140.00        .00       .00       2
                              ---------- ---------- ---------- --------- -------
                                  568.00     426.68        .00     15.00       7
```

Figure 454 *Report of Payments by Insurance Company.*

```
FP290311 SMART-DOCTOR by IMS of Alpine,TX       Detail Collections by Insurance
```

```
1. Ins. # start: 0
2. Ins. # end:   zz

3. Date start:   12/15/03
4. Date end:     06/12/04

5. CPT start:    00001
6. CPT end:      zz

7. Provider:     ALL
```

Figure 455 *Selection of Detail Collection by Insurance Company.*

Selection prompt #1, "**Ins. # start:**", enter the starting key to the insurance carrier record in the carrier file, or hit <enter> to accept the default of "0". You could also enter <first> to start with the first key in the carrier file. See "A WORD ON SELECTION RANGES" discussed earlier in this reports section of the manual. You can also narrow the range down to several or just one carrier. In the example above you could have just entered 28765, and used the same ending value, to get only this Blue Cross carrier.

Selection prompt #2, "**Ins. # end:**", this is similar to #1 above, with the exception that this is the ending value. You could enter <last> here to get the last key in the carrier file. You could accept the default of "999999999" by just hitting <enter>, however if your carrier file has any non numeric keys, they will be skipped. You could also enter <zz> to get the last key in the carrier file, assuming it contains all alphanumeric keys.

Selection prompt #3, "**Date start:**", the system will default a date of 180 prior to today's date. However, you can enter any starting date you wish. This defaulted starting date in combination with the defaulted ending date below will give you a selection of 180 to 90 days before today's date to look at. By this time, all payments from carriers in the list should be in. If not, you need to investigate further.

Selection prompt #4, "**Date end:**", enter the last date of the report, or accept the default of 90 days prior to today's date. You can also enter any date you wish including <today> to get today's date.

Selection prompt #5, "**CPT start:**", Enter CPT Code by code number. For example: 99212 or 10060*, or just hit <enter> to accept the default of "00001". You could also enter <first> to start with the first procedure code. Of course, you can enter a starting range of a specific code here and in the "CPT end" below to get information on only one procedure code.

Selection prompt #6, "**CPT end:**", Enter CPT Code by code number. For example: 99212 or 10060*, or just hit <enter> to accept the default of "99999x". However, this will miss any non-numeric codes. You can enter <zz> to get the last of an alpha numeric range, or enter <last> to get up to the last CPT code.

Selection prompt #7, "**Provider:**", enter the provider initials, or <all> to select all providers.

A sample screen output for this report is seen in Figure 456 below.

```
FP290311                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                         Detail Collections by Insurance    14:07:36 12 Jun 2004

                   For dates:  12/15/03  to  06/12/04

Ins Co #    DOS     Patient Name         CPT     Charge    Adjust.   Payments Prov
========  ======== ================== ======  ========  ========  ======== ====
28765     05/11/04 FOSTER, EMMA J      99214      73.17       .00       .00 JRS
BLUE CROSS
28765     06/03/04 BONNER, JOHN J.     99214      73.17       .00       .00 SJJ
BLUE CROSS
28765     06/05/04 BONNER, JOHN J.     99213      46.78       .00      5.00 SJJ
BLUE CROSS
28765     06/07/04 FOSTER, EMMA J      99213      46.78       .00       .00 SJJ
BLUE CROSS
28765     06/11/04 FOSTER, EMMA J      99213      46.78       .00     10.00 JRS
BLUE CROSS
8765      06/05/04 BONNER, MARY K.     99213      70.00       .00       .00 SJJ
AETNA SAFEWAY GROUP
8765      06/11/04 BONNER, MARY K.     99213      70.00       .00       .00 SJJ
AETNA SAFEWAY GROUP
                                                --------- --------- ---------
                                    Total         426.68       .00     15.00
```

Figure 456 Report of Detailed Collection by Insurance Company.

This report produces a two line output. The top line starts with the carrier key, followed by the DOS, Patient Name, CPT code, Charge, Adjustment, Payments, and Provider's initials. The second line contains the full carrier name as in the carrier file.

Menu selection #27, "**Patient Visits by Provider**", choose this selection to print the number of patients seen each month by a provider. The selection screen for this menu item is as shown in Figure 457 below.

Selection prompt #1, "**Starting date:**", enter the start date of the report you want to see. Generally, this would be the beginning of a given month. The default is the first day that the clinic started using the system.

```
FP290330 SMART-DOCTOR by IMS of Alpine,TX    Patients seen by provider per month
```

```
1. Starting Date:       06/01/2004

2. Provider Initials:   ALL

3. Provider lowercase:  all
```

Figure 457 *Selection of Patients Seen by Provider.*

Selection prompt #2, "**Provider Initials:**", enter the specific provider, or hit <enter> to take the default of "all".

Selection prompt #3, "**Provider lowercase:**", <enter> to accept the lower case version of selection #2. This is required to get all visits. When the provider is listed in upper case on the report, this indicates this was the result of a standard office visit. If it is listed as lower case, this indicates it was a Non-Scheduled Visit encounter.

A sample screen output for this report is seen in Figure 458 below.

```
FP290330                SMART-DOCTOR by IMS of Alpine,TX                Page    1
                      Patients seen by provider per month.  15:21:49 12 Jun 2004

Date:    User:           Patient Name:                          count  MOYR
======== ============== ====================================== =====  ======
06/03/04 sjj            BONNER, JOHN J.                        1      062004
06/05/04 SJJ            BONNER, JOHN J.                        1      062004
06/05/04 SJJ            BONNER, MARY K.                        1      062004
06/07/04 sjj            FOSTER, EMMA J                         1      062004
06/11/04 JRS            FOSTER, EMMA J                         1      062004
06/11/04 JRS            FOSTER, EMMA J                         1      062004
06/11/04 SJJ            BONNER, MARY K.                        1      062004
                                                               ----
                                        SubTotal                  7
                                                               ----
                                        Total                     7
```

Figure 458 *Report of Patients Seen by Provider.*

In the above example, only one month was selected. If the selection covered several months, or a whole year, there would be a page break for each month with visits recorded.

Menu selection #28, "**Prim & 2ndary Ins w/bal >0**", choose this selection to see all insurances billed for each charge for a given range of Dates of Service, with Insurance responsible and balance greater than 0. The selection screen for this menu item is as seen in Figure 459 beolw.

Selection prompt #1, "**Date of Service starting:**", enter the starting date you wish, or hit <enter> to take the system default of 360 days ago.

```
FP290820 SMART-DOCTOR by IMS of Alpine,TX          Prim & 2ndary Ins. w/Bal. > 0

   Select a range of dates of service to see
   all insurances billed, order of billing, and
   charges and balances due by insurance Co.

     1. Date of Service starting: 06/18/2003

     2. Date of Service ending:   06/12/2004
```

Figure 459 Selection of Primary & Secondary Billings with Balance.

Selection prompt #2, "**Date of Service ending:**", enter the ending date you wish, or hit <enter> to take the system default of 30 days ago. In the above example, a date of 06/12/04 was entered to capture our examples.

A sample screen output for this report is seen in Figure 460 below.

```
FP290830                SMART-DOCTOR by IMS of Alpine,TX              Page    1
                          All Ins. Billed with Bal. > 0     16:09:41 12 Jun 2004

Carrier                 Ord  Patient              DOS        Billed     Balance
======================  ===  ==================== ========== ========== ==========
BLUE CROSS              1    BONNER, JOHN J.      06/05/04        46.78      41.78
BLUE CROSS              1    FOSTER, EMMA J       06/07/04        46.78      46.78
COUNTRY LIFE INSURANC   2    FOSTER, EMMA J       06/07/04        46.78      46.78
BLUE CROSS              1    BONNER, JOHN J.      06/03/04        73.17      73.17
BLUE CROSS              1    FOSTER, EMMA J       06/11/04        46.78      36.78
BLUE CROSS              1    FOSTER, EMMA J       05/11/04        73.17      73.17
FARMERS HEALTH COOP.    1    BONNER, MARY K.      06/11/04        70.00      70.00
```

Figure 460 Report of Primary & Secondary Insurance Companies Billed with Balance.

In the above example, the "Ord" column indicates the order of insurances billed for a specific service. In the example of "FOSTER, EMMA", for the service provided on 06/07/04, you will see that the first bill was sent to BLUE CROSS. The second carrier billed for that claim was COUNTRY LIFE INSURANCE. All the other claims shown were only billed to the primary carrier.

Menu selection #29, "**Charge Items by Trxn Descr**", choose this selection to see all transactions with a specific phrase. Typically this is from the default pop-up box that is presented for adjustments or other standard transactions (as seen in the charge item screens). However, you can also search for a specific phrase not listed in those defaulted, i.e. free text. The selection screen for this menu item is as seen in Figure 461 below.

Selection prompt #1, "**From:**", enter the starting DOS you want to start looking from.

Selection prompt #2, "**To:**", enter the ending DOS you want to search through.

Selection prompt #3, "**Trnsxn Description:**", is where you enter the transaction term that was used in

the charge item transaction field. A pop-up box for the transaction type will be shown, as seen in Figure 462 below.

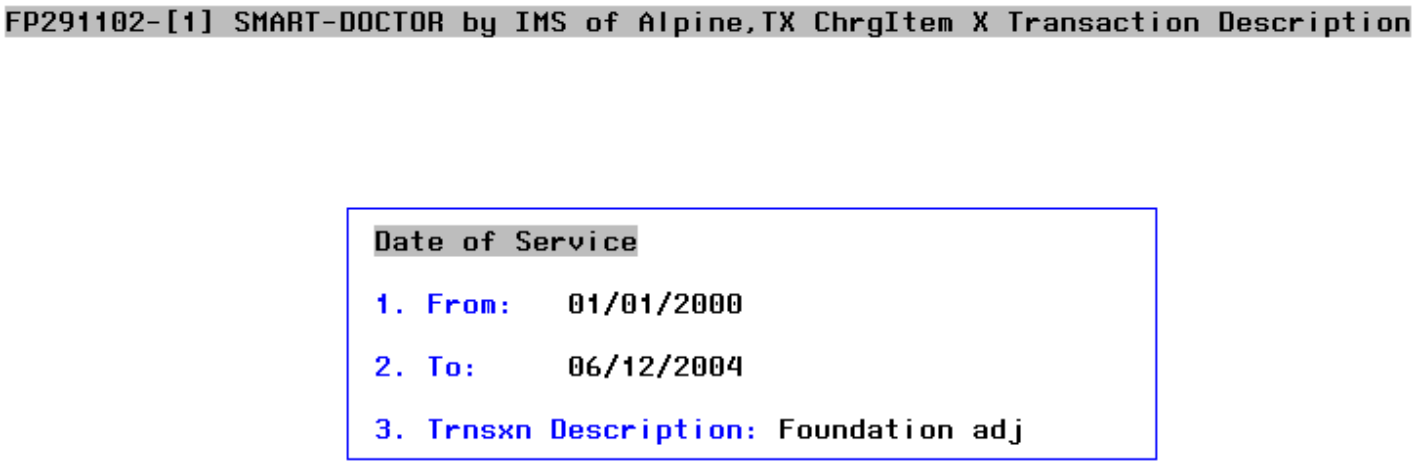


Figure 461 *Selection of Transaction Type.*

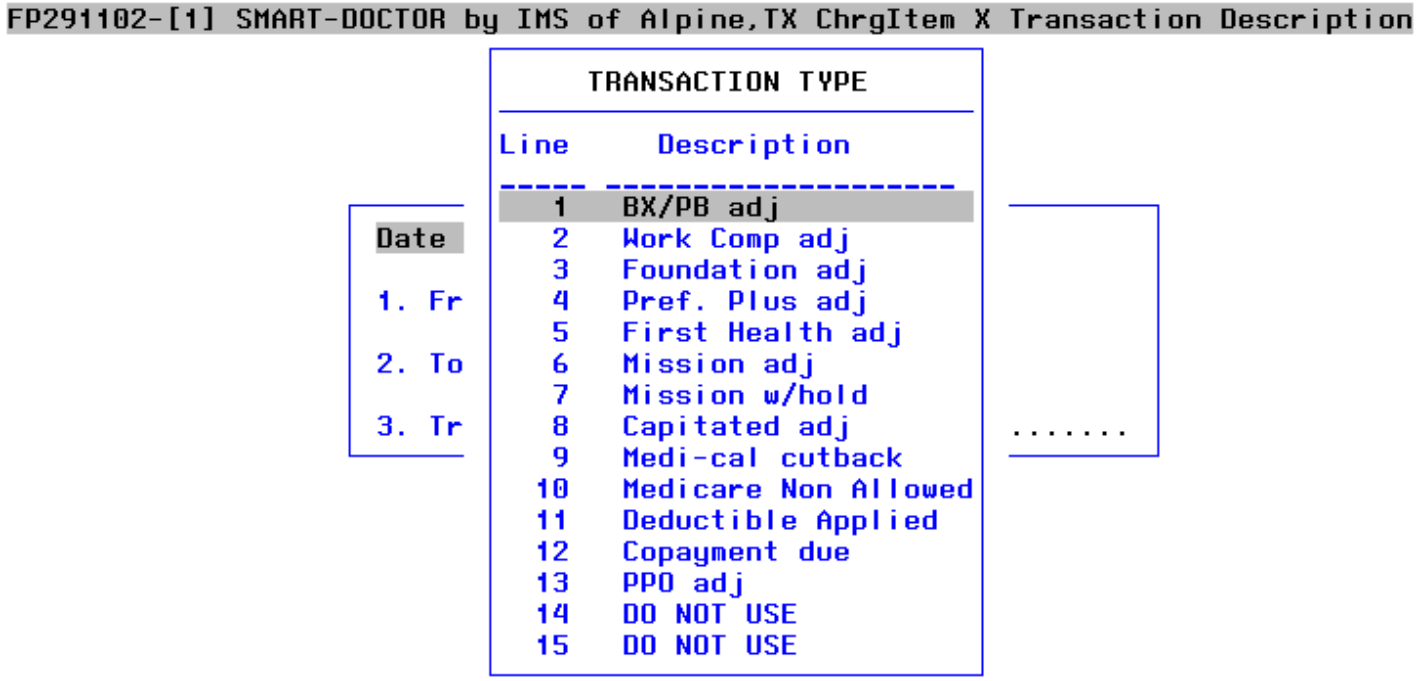


Figure 462 *Pop-Up Window to Select Transaction Type.*

You can bypass these choices by hitting <F1>. Then at the blank input line of prompt #3, enter the exact text you want to search for (case sensitive). It is always better to add any reoccurring terms used to the transaction pop-up window. This can be done in the TERMS file record “ADM-TRANSACTION”.

Under the main report header (as seen in Figure 463), the selection criteria are shown, the start and stop dates as well as the specific transaction term to be located. Only one item was found here. Additional items found would normally be listed sequentially below this. If we had entered <Charge>, we would see a list of all charge items for the given time period.

A sample screen output for this report is seen below:

```
FP291101                  SMART-DOCTOR by IMS of Alpine,TX                Page    1
                        Chg., Adj., & Paid by Trxn Dscrptn   16:49:25 12 Jun 2004

                                                              Txn Type
      For the period: 01/01/2000 to 06/12/2004                Foundation adj

Prov  Family #  ChrgItem #  DOS       Charge    Adjustmnts  Paid      Balance
==== ========== ========== ========= ========== ========== ========== ==========
SJJ         500         113  07/17/00      74.08      10.00      10.00      54.08
                                      ---------- ---------- ---------- ----------
                                           74.08      10.00      10.00      54.08
```

Figure 463 Report of Charge Items by Transaction Type.

CHAPTER 9 SYSTEM FILES

SYSTEM INFORMATION FILES MENU

The System Information Files main menu is shown below in Figure 464. Using the menu selections from this screen will allow you to customize the system to the needs of your particular clinic.

```
SY000000 Smart-Doctor by IMS, Inc. of Alpine, TX        System Information Files
SmartDoctor(R) by IMS of TX, (800)747-4154     For SUPPORT see Phone Book Lookup.
                    _SYSTEM INFORMATION -- FILE MAINTENANCE_

 1. Symptom File                          15. Glossary File
 2. Print Symptom File                    16. Print Glossary File
 3. Symptom Delete (Password Req'd)       17. Glossary Delete (Password Req'd)

 4. Diagnosis File                        18. Terms File
 5. Print Diagnosis File                  19. Print Terms File
 6. Diagnosis Delete (Password Req'd)     20. Terms Delete (Password Req'd)
 7. Diagnosis Selective Maintenance
                                          21. LabCorp Tests File
 8. Procedure File                        22. Print LabCorp Lab Test File
 9. Print Procedure File                  23. LabCorp Tests Delete (PW Req'd)
10. Procedure Delete (Password Req'd)
11. Procedure Selective Maintenance       24. Add or Maintain Scenarios.
                                          25. Scenario Delete (Password Req'd)
12. Pt. Information File
13. Print Pt. Information File            26. Add Procedure Report
14. Pt. Info. Delete (Password Req'd)     27. Proced. Rpt. Delete (Passwd Req'd)

Choose a number from above, or <end> _
F1=End/Exit  F2=Help  F4=Quick Menu  F5=Calendar
```

Figure 464 *Main System Information Files Menu.*

SYMPTOM FILE

MENU SELECTION #1, "SYMPTOM FILE", choose this menu item to add to or change information in the Symptoms File. The data in this file is used for making appointments only. This allows the user to enter part of the description of the symptom or reason for visit and get a selection list of terms that best match that entered. This allows for more consistent terminology and the same spelling of common terms. This will be useful in later queries into the database. The add/change screen for this file is as shown in Figure 465 below.

To change or modify an existing symptom or reason for visit, enter part of the description for a cross-reference lookup. In this example <dia> was entered. The cross-reference pop-up selection window is seen in Figure 466 below.

This pop-up screen displays the key to the record on the left and the cross-reference terms on the right. Upon picking "Diabetes", the screen shown in Figure 467 is displayed.

Prompts #2 through #4 can now be changed. In the "ADD" mode (entering a new term not found in the cross-reference lookup, or hitting <F1> in the pop-up screen), you will be able to enter a new symptom or reason for visit, as discussed below.

```
SY010000 Smart-Doctor by IMS, Inc. of Alpine, TX          Symptom File -     Add

                        _Add to, or Modify Symptom File_

* 1. Symptom/Reason for visit:  dia_.............

  2. ICD-9-CM code:             ......

         Following, list all other descriptions of this symptom.

  3. Alternate Descriptions:

     ..........................................................................

         When listing alternate descriptions, separate with a space.
         Do not use commas or periods.
           Example: blackout faint pass-out (for syncope).
-------------------------------------------------------------------------------
  Could evaluation or treatment of this symptom
    require prior authorization by an insurance company:

  4. Yes or no (y/n)?  .

F1=End/Exit  F2=Help  F3=Print  F5=Calendar  F8=Cancel  F10=End of Line
```

Figure 465 *Symptom File Add screen.*

```
  1  DIABETES                  DIABETES DM
  2  DIARRHEA                  DIARRHEA
  3  F/U DIABETES              F/U DIABETES DM FU
  4  GASTROENT./COLITIS        GASTROENT COLITIS COLON CONSTIPATION DIARRHEA R
  5  SWEATING                  SWEATING DIAPHORESIS
```

Figure 466 *Symptom File Cross-Reference Lookup window.*

Prompt #2, "**ICD-9-CM code:**", Enter the general ICD-9-CM code that best correlates to this symptom or reason. This is an optional field at this time. If you do not know an appropriate ICD-9 code number for this, enter <000>. At a later date this field may be used to trigger specific actions.

Prompt #3, "**Alternate Descriptions:**", enter the alternate descriptions that might be used to describe the same key symptom listed above.
i.e., Key=SYNCOPE, alternate=**SYNCOPE** FAINT PASSED OUT

ALWAYS include the key symptom listed above in the alternate description line. To help you with this, the key symptom is listed for you by the system as a default. Just hit the return key to accept this. You can arrow over or use the <F10> key to bring you to the end of the default symptom.

```
SY010000 Smart-Doctor by IMS, Inc. of Alpine, TX          Symptom File -  Change

                        _Add to, or Modify Symptom File_
```

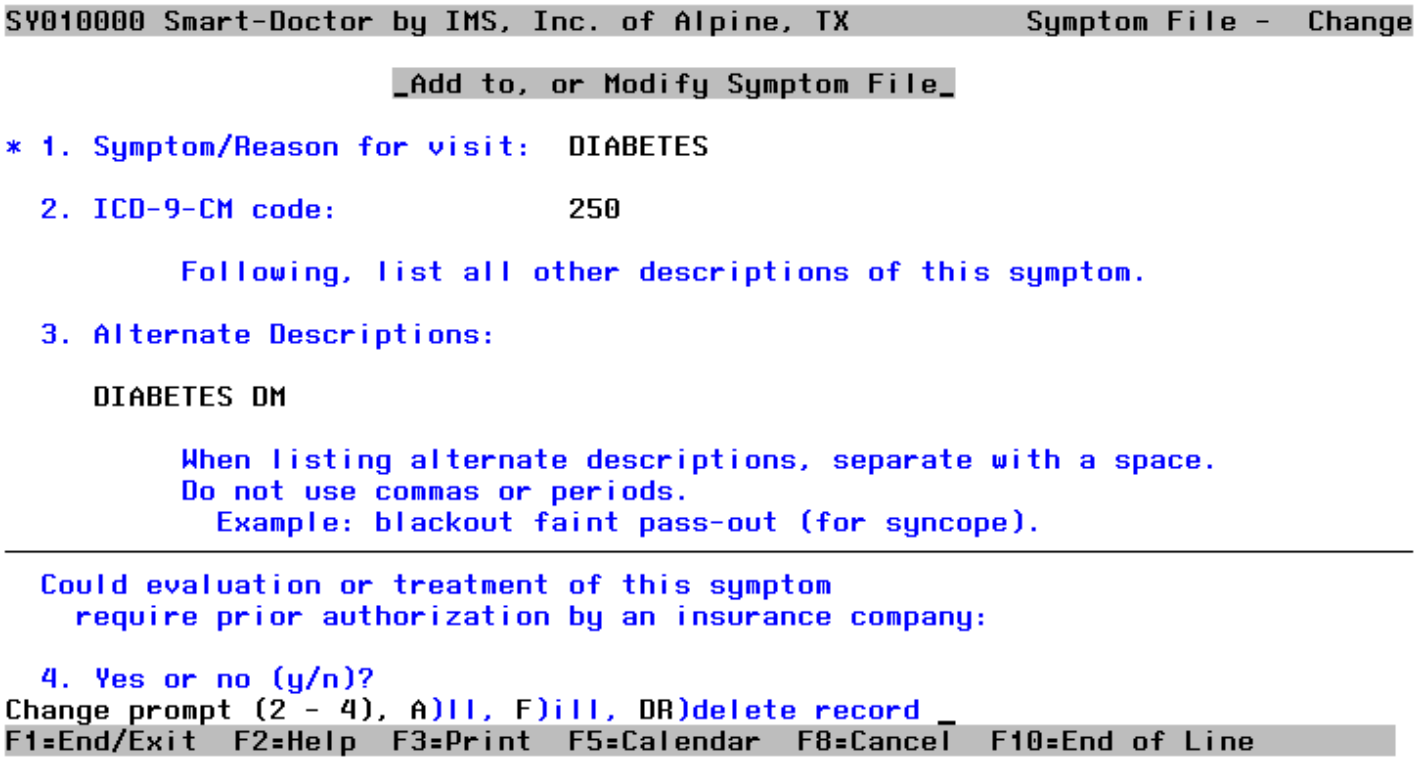


Figure 467 Symptom File screen in Change Mode.

Then add a space and alternate symptom descriptions separated by a space.

Prompt # 4, "**Yes or no (y/n)?**", to the following question: "Could evaluation or treatment of this symptom require prior authorization by an insurance company?" Enter <y> or <n>.

Answering this question as "(Y)es" will cause the following logic to be used when an appointment is made:

(1). If the symptom or reason for the visit could be required by any insurance company to have a prior authorization in place before service is rendered (this prompt set to "y");

AND
(2). One of the insurance companies in the patient's insurance file or in the HOH file has a requirement listed for any prior authorizations;

THEN
(3).A warning flag will be presented to the user of the possible need of a prior authorization before the patient is seen. The user can then lookup the policy to be used and determine if a prior authorization is needed. However, an experienced appointment clerk may be able to ignore this warning for visits known to never need a prior authorization. For example, a given company may require prior authorizations for sterilization or weight reduction surgery. However, only a few companies might require a prior authorization for a colonoscopy.

F8 key, "Cancel", prior to exiting the screen by hitting <F1> or <enter> upon leaving the last prompt, you can cancel everything you have added or changed. If you are in the "ADD" mode and hit the <F8> key, the record will not be entered in the system. In the "CHANGE" mode, all changes will be ignored.

MENU SELECTION #2, "PRINT SYMPTOM FILE".
Upon selecting this menu item, you will be placed in a selection screen to indicate the starting and ending selection criteria for the symptom/reason key. See "*A WORD ON SELECTION RANGES"*, in the Basic section. Upon completing selection, you will be presented at the bottom of the screen with the following choices: "Enter (S)creen, (P)rinter, (B)oth, (F)ile, or (O)ther printer : S". Generally you would just hit <enter> to see the report on the screen. If you enter <p>, the report will be sent to the default printer. For other options check with you system administrator.

An example of the first page of this report is as shown in Figure 468 below.

```
SY020000            Smart-Doctor by IMS, Inc. of Alpine, TX          Page    4
                                Symptom File              17:44:23 16 Jul 2004

Symptom / Alternate Description    ICD-9CM       Possible Prior Auth. Req'd
===============================    ======        ==========================
HICCOUGH                           401.0
  HICCOUGH

HICCUPS                            786           N
  HICCUPS HICCOUGH RESPIRATORY SPASM

HOARSENESS                         784.49
  HOARSENESS

HOLTER MONITOR                     hol           Y
  HOLTER MONITOR

HORMONE                            000000
  HORMONES PROBLEM FOLLICLES

HOSPITAL                           hos
  HOSPITAL CALL END
Press <return> to continue, or <end> _
```

Figure 468 Printout of Symptom File.

In the sample report above, there are several points to note. First, the key "HOLTER MONITOR" has the flag set for a possible prior authorization check. This is reasonable since some carriers may require this. Second, both "HICCCOUGH" and "HICUPS" are correct, just variations of spelling. However, since "HICCOUGH" is listed in the cross-reference of "HICCUPS", it would simplify things and would reduce errors in a search for one term verses another if you delete the "HICCOGH" key. How to do this follows.

MENU SELECTION #3, "SYMPTOM DELETE", choose this selection to delete a symptom key. Upon entering part of the key or cross-reference term for look up, you will see the screen shown in Figure 469 below.

You will see a prompt at the bottom of the screen asking you, "**Is this the right record ?**" Enter <y> to delete this key. Entering anything else will abort the delete operation. You will then be presented with a second prompt at the bottom of the screen; "**Please enter 'Y' to confirm delete**". Enter <y> to confirm you want to delete this record. Again, entering anything else will abort the delete operation.

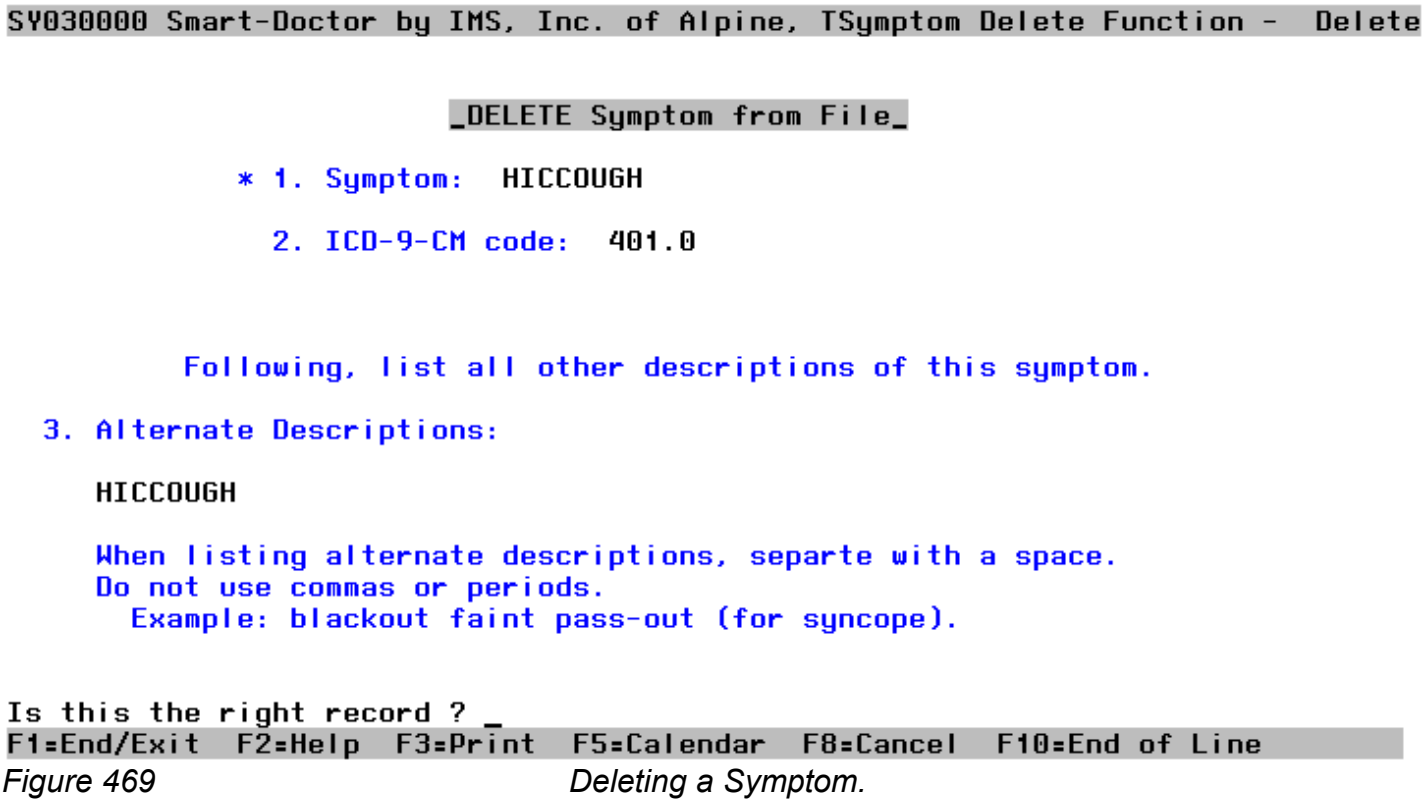


Figure 469 *Deleting a Symptom.*

DIAGNOSIS FILE

The diagnosis file maintenance is primarily used to modify the alternate descriptions for the primary ICD-9 diagnosis codes. The ICD-9 codes must come from the ICD-9 manual. All of the codes have been entered by Intelligent Medical Systems, Inc. The codes in the system are all to the highest level of specificity. Code numbers such as 250 for Diabetes Mellitus are non-billable and are not included. However, the higher level specificity codes of diabetes Mellitus such as 250.01 are included. The main use you will have for this file maintenance is the area of adding alternate terms or cross-references, to be able to quickly find the diagnosis code you want. The system can handle up to 30 cross-references for each diagnosis. These are broken up in two prompts, # 3 and # 4, "Alternate Descriptions" and "Other Descriptions", respectively.

Each diagnosis is further characterized by the possible sex and age range for each diagnosis, as is seen in prompts 5, 6, and 7.

CHOOSING DIAGNOSIS CODES AND DELETED CODES

Providers should be aware the Diagnosis codes with a "*" should only be chosen if a more specific code cannot be found. These codes may require further explanation to the insurance carrier at a later date. The notation of "(2)" means that this code should only be used for a secondary diagnosis. A primary diagnosis should be selected first. The secondary diagnosis codes are mainly in the "V" codes section of the ICD-9 coding manual. The deleted codes are still on your system for reference. However, you will not be able to find these deleted codes via the cross-reference feature since their cross-reference was changed to "DELETED_CODE". You can still look these up using the actual code number. DO NOT use this feature to bill any new charges.

MENU SELECTION #4, "DIAGNOSIS FILE", use this selection to add to or modify the Diagnosis File. The add/change screen for this file is as seen in Figure 470 below.

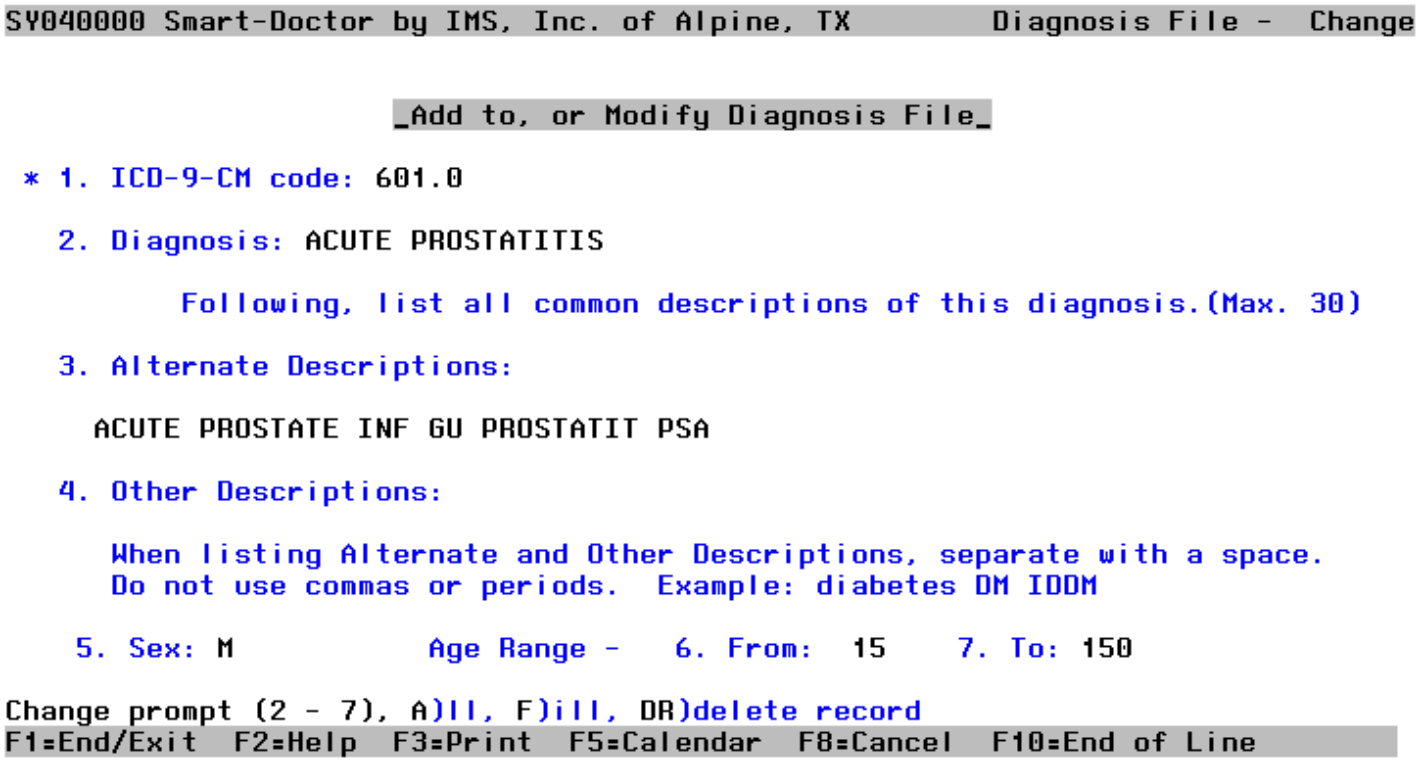


Figure 470 *Diagnosis File screen.*

The selection process here is the same as the Symptom file. This screen has two different features however. First, there is a second line (prompt #4) for other descriptions. As the software developed, the number of cross-references was expanded to 30. Adding this prompt allows for backward compatibility, while adding more flexibility. There is no difference between prompts #3 & #4. Just room to add up to 30 cross-references.

You will note in the alternate descriptions above, infection is truncated to “INF”. This was done for the prior version to allow for more cross-references to fit on one line. Now with two lines to use, this is not as important. However, for older ICD-9 codes and those that haven't changed, the original cross-reference data was truncated. You can now expand this if you wish to “infection”, since there are now two lines to use. However, if you entered “infection” to find this term in a cross-reference lookup, it would not be found. You must instead use “inf”. Therefore, until you customize the Diagnosis file to your preference, you should enter cross-reference lookup terms with no more than three letters. Don't forget, a cross-reference lookup must have at least three characters followed by sets of two or more characters. To narrow your search for this diagnosis, you might enter “acu pro inf”. This will reduce your choices to eight out of over 12,000 possible codes. Besides, it is less typing. However, fast typist may find this to be a problem at first (by typing more characters). You can customize the cross-reference to give you direct hits each time. Simply add a term to prompt #3 or #4 that would result in a unique cross-reference. For example, add “apix” to either prompts #3 or #4. Since there are no other keys with this Alternate or other description, you will get a direct hit. An example of an existing such code in your system is “htnb”, for Hypertension-benign, or code number 401.1.

MENU SELECTION #5, “PRINT DIAGNOSIS FILE”, choose this selection to view or print the Diagnosis file. Upon selecting this menu item, you will be placed in a selection screen to indicate the starting and ending selection criteria. In this case, you can accept the default of “ALL” or enter

the starting and ending ICD-9 code numbers (Not cross-reference terms). Upon completing selection, you will be presented at the bottom of the screen with the following choices: “Enter (S)creen, (P)rinter, (B)oth, (F)ile, or (O)ther printer : S”. Generally, you would just hit <enter> to see the report on the screen. If you enter <p>, the report will be sent to the default printer. For other options check with you system administrator.

An example of the first page of this report is as seen in Figure 471 below.

```
SY050000          Smart-Doctor by IMS, Inc. of Alpine, TX          Page    1
                              Diagnosis File          09:34:01 17 Jul 2004

Diagnosis/ Alternate Description          ICD-9CM   Sex  Min Age  Max Age
========================================  ======    ===  =======  =======
ESSENTIAL HYPERTENSION MALIGNANT          401.0     B    4        150
  ESSEN HYPERTENS MALIG HTN BP HIGH

ESSENTIAL HYPERTENSION BENIGN             401.1     B    0        150
  ESSEN HYPERTENS BENIGN HTN BP HTNB HIGH XHT

ESSENTIAL HYPERTENSION, UNSP *            401.9     B    0        150
  HYPERTENS HIGH BP ESSEN UNSP HTN

MALIG. HYPERTENSIVE HEART DIS. W/O CHF    402.00    B    0        150
  HYPERTENS HEART DIS MALIG HTN XHT

MALIG.HYPERTENSIVE HEART DIS. WITH CHF    402.01    B    0        150
  HYPERTENS HEART DIS MALIG CHF HTN FAIL

HYPERTENSIVE HEART DISEASE, BENIGN        402.10    B    0        150
  HYPERTENS HEART DIS HTN BENIGN
Press <return> to continue, or <end> _
```

Figure 471 Printout of Diagnosis File.

In the sample printout above, you can see the example discussed above for code number 401.1, with the unique cross-reference term of “htnb” to get a direct hit. The first line contains the actual ICD-9 description, followed by the code number, the sex (“B” for both), and minimum and maximum age limitations. On the second line are the cross-reference “Alternate Descriptions” terms. The “Other Descriptions” terms are not shown.

MENU SELECTION #6, “DIAGNOSIS DELETE”, works in the same manner as Menu Selection #3, “Symptom Delete”. See that section for a description of deleting a record.

MENU SELECTION #7, “DIAGNOSIS SELECTIVE MAINTENANCE”, choose this selection to select a range of diagnoses to modify. You are first presented with a selection screen to enter a starting number and ending number. You are then presented sequentially with the add/change diagnosis screen, starting with the first diagnosis number in the range you entered. Use this screen in the same manner as in menu selection #4, “**DIAGNOSIS FILE**”, above.

PROCEDURE FILE

The procedure file maintenance is similar to that of the diagnosis file maintenance. The procedure codes are based on the American Medical Association's CPT® manual. These codes are enhanced by Intelligent Medical Systems, Inc., but the basic code numbers and descriptions are the

property of the American Medical Association (see license agreements). The procedure codes also have "Alternate Descriptions" and "Other Descriptions" similar to the Diagnosis file, and are also characterize by sex and age range. For billing purposes, only the first five characters are used since this is all that is allowed for billing. However, to be more precise in describing a procedure, we allow an additional character (a sixth character) to be added to the procedure code. This added character will be deleted at time of billing.

MENU SELECTION #8, "PROCEDURE FILE", use this selection to add to or modify the Procedure File. The add/change screen for this file is as shown in Figure 472 below.

```
SY070000 Smart-Doctor by IMS, Inc. of Alpine, TX        Procedure File -  Change

                        _Add to, or Modify Procedure File_

* 1. Procedure Code:              58150B
  2. Standard Coding Modifiers:
  3. Procedure Name:              TOTAL ABD HYSTERECTOMY W RT. SAL OOPHOR

  Following, list all other common descriptions of this procedure. (Max. 30)
  When listing Alternate and Other descriptions, separate with a space.
  Example: Incision and drainage of abscess, Alternate add- I&D
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  4. Alternate Descriptions:

  HYSTERECTOMY RT SAL OOPHOR TAH SO RIGHT

  5. Other Descriptions:


  6. Sex: F             Age Range:     7. From:  13    8. To: 150

Change prompt (2 - 8), A)ll, F)ill, DR)delete record
F1=End/Exit F2=Help F3=Print F5=Cal F6=Billing F8=No-Save F9=Inventory F10=EOL
```

Figure 472 Procedure File screen.

To clarify the use of the Procedure File, a maximum of six characters are allowed for a code. Only the first five characters are used when sending a bill. This should be a valid procedure code. The sixth character is optional, specific to your site, and can be alphabetical or numeric. Billing errors will result if not used properly. The cross-reference (prompts 4 and 5 - Alternate and Other Descriptions - on the procedure screen) is the tool you would use to affect which codes are returned when entered in a live program. For example, if you would like more specific information in the patient record for a total abdominal hysterectomy, CPT code: 58150, you can create the extra codes 58150A, 58150B, and 58150C to distinguish between neither or both ovaries removed, R. ovary removed, or L. ovary removed, respectively. To have all these procedures returned by the cross-reference, you enter a mnemonic in the "Alternate Descriptions" or "Other Descriptions" prompt on the Procedure File screen. If you find it easy to remember a Total Abdominal Hysterectomy as a "TAH," you can enter "TAH" as your mnemonic on all the 58150 procedures. When entering procedures from the Doctor or Billing menu, you would only have to enter "tah" to be able to select from all 58150 procedures. If you enter the exact code as stored in the procedure file, e.g. 58150 or 58150A, the cross-reference will return only that code. You can be more specific when cross-referencing if you were to enter "left" in one of the cross-reference prompts for 58150C. Then for a total abdominal hysterectomy with the left ovary removed, you could then enter "tah left"

in the live program and cross-reference only the 58150C procedure. If you added a code with a particular modifier set, you can include that modifier in the cross-reference for quick selection similarly.

For orthopedics, a fractured left humerus could be coded as 23600L. This allows for a better description of the actual procedure done. Also the standard coding modifier should be added in the modifier prompt for left as LT, since only the 23600 and the modifier will be seen by the insurance company.

Because procedure codes are changed, deleted, and added every year, we do not recommend remembering procedures by their number. If you enter a deleted procedure number, and do not notice the that this is a deleted code, the bill will be rejected. The deleted codes are required to be on the system for reference when reviewing old information and billing. As stated previously, entering the exact code as stored in the procedure file will return that code only.

At the bottom of the primary screen is the *<F6> "Billing"* key, to go to the charges screen for this procedure as seen in Figure 473 below.

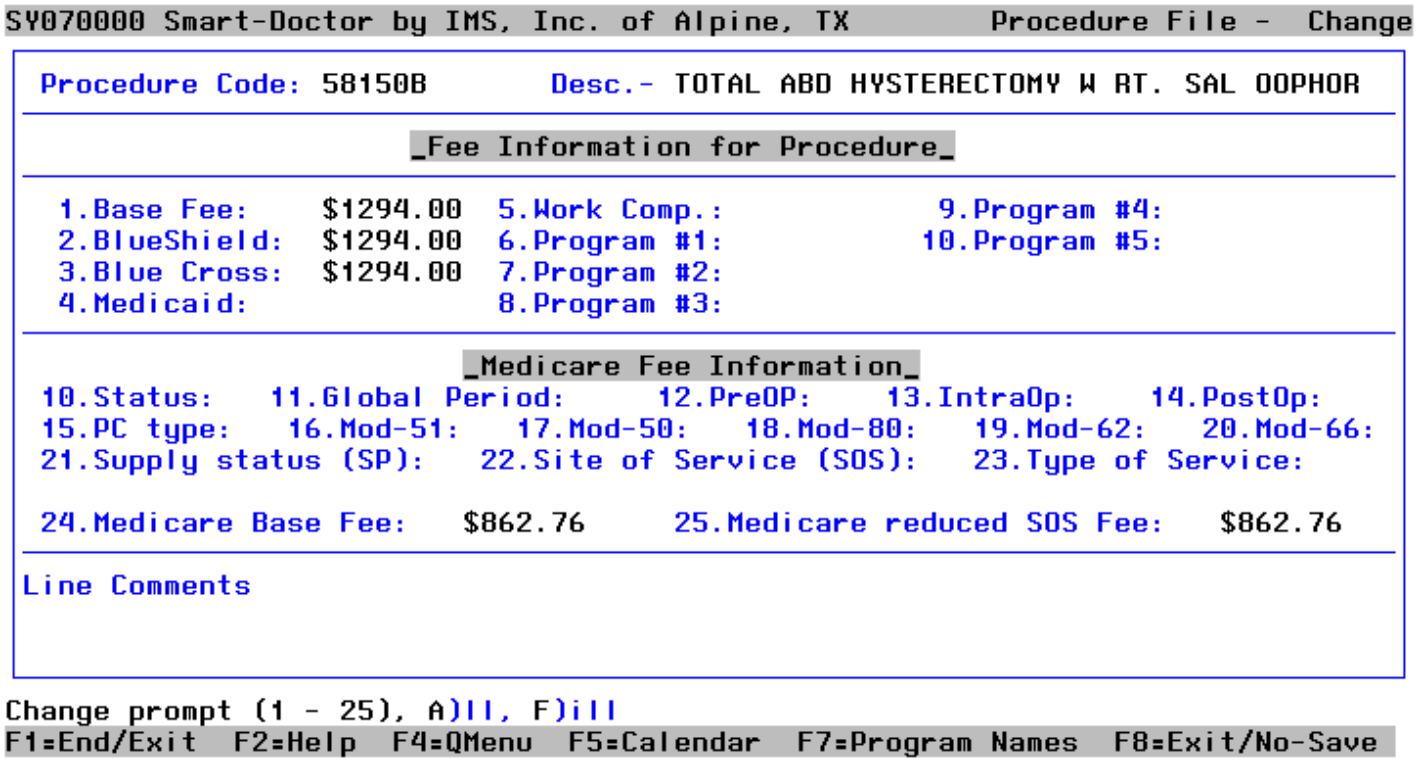

Figure 473 *Procedure File Fee screen.*

Prompt #1, "**Base Fee:**", is the base fee. All other fees should be equal to or less than this base fee. The system will prompt you if you try to put in a higher value. Ignore prompt items #10 to #23 at this time. This was added for future development of charges during the global period, and is not functional at this time. Prompts #24 & #25 are the Medicare fees for your geographical area that are loaded for you every January 1, by IMS as part of our support service to your site. However, in certain locations you may get notices of specific fee increases or decreases during the year. Your site is responsible to keep up on these mid-year changes.

The <F7> "Program Names" key, is to look up names of programs that your clinic has assigned to

unique billing plans. These program names can be modified in the TERMS file under the record key of “PROG-NAMES”. In actual practice, it is rare to use all or any of these since if the carrier is not one of the major carriers that are listed, or Medicare, you would use the defaulted base fee.

Back to the main procedure screen, *the <F9>, “Inventory” key*, is for entering X-RAY inventory items only at this time. This would only be applicable to your site if you do INHOUSE X-RAYs. In this case, a pop-up screen will be presented so that you can choose from inventory items defined in the TERMS file record “ADM-INVENTORY”. This TERMS record is defined as having the inventory item listed under Term descriptions, with columns 1-10 being the inventory item number, and its description in columns 20 to 45.

MENU SELECTION #9, “PRINT PROCEDURE FILE”,
The Procedure file printout not only shows the procedures in the file, but also compares the Medicare fee to the base fee. Please run this report for all procedures for which you bill, and make sure that the base fees are ALWAYS higher than the Medicare fees. It is a violation of the Medicare laws for you to charge Medicare an amount greater than your base fees (fees for non-insured).

The selection screen seen in Figure 474 is presented upon selecting this menu item.

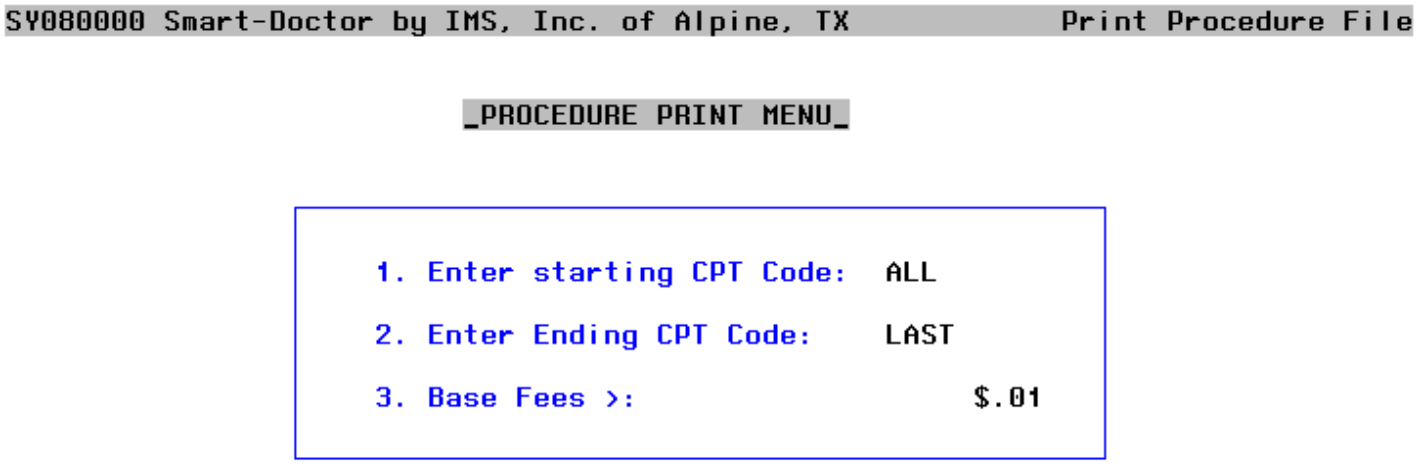

Figure 474 *Selection for Procedure File Printout.*

Enter the CPT code number range or accept the defaults of “ALL”. Prompt #3 on this screen, “Base Fees >:”, is to indicate the starting amount above which you want to review. This helps prevent looking at charges your clinic never uses, and therefore has not established a fee. There are over 8,300 procedures listed in the system, most of which your clinic would not use. A sample report is seen in in Figure 475 below.

This report finds a number of errors that must be corrected. Procedures numbers 11750, 11976, 12002, 12006, and 12032*, should all be raised to the Medicare base fee or higher. However, if your clinic actually wants to charge below the Medicare allowable, then reduce the Medicare amount to match.

SY080000 Smart-Doctor by IMS, Inc. of Alpine, TX Page 3
Procedure File 11:12:12 17 Jul 2004

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Procedure/ Alternate Description	Proc. Code	Modifers	Base Fee	Medicare
EXCIS.MALIG.LES(.5CM /<);FACIAL INC.EAR	11640		265.00	142.22
AVULS.OF NAIL PLATE,PART.OR COMPLETE	11730*		70.00	67.91
EVACUATION OF SUBUNGUAL HEMATOMA	11740		40.00	34.68
EXCIS. OF NAIL & MATRIX,PART.OR COMPLET	11750		88.00	132.51
WEDGE EXCIS. OF SKIN OF NAIL FOLD	11765		157.00	56.00
INJECT.,INTRALESIONAL;UP TO & INCL.7 LE	11900*		76.00	40.89
INSERT IMPLANTABLE CONTRACEPT. CAPSULES	11975		75.00	.00
REMOVAL,IMPLANTABLE CONTRACEPT. CAPSULE	11976		100.00	122.80
WOUND REPAIR,SIMPLE,(NOT FACE);<2.6 CM.	12001*		166.00	131.29
REPAIR SUPERFICIAL WOUND TRUNK	12002		134.00	142.30
WOUND REPAIR,SIMPLE,(NOT FACE); <7.6 CM	12002*		216.00	123.23
WOUND REPAIR,SIMPLE,(NOT FACE) <12.5 CM	12004*		287.00	165.16
WOUND REPAIR,SIMPLE,(NOT FACE) <30.1 CM	12006		250.00	268.56
WOUND REPAIR OTHER THAN FACE, >30.1 CM	12007		457.00	298.79
TREAT.OF WOUND DEHISCENCE W/PACKING	12021		140.00	133.49
LACER.INT-SCLP,AX,TK,EXT(NOT H&F)<7.6CM	12032*		150.92	178.37

Press <return> to continue, or <end>

Figure 475 Printout of Procedure File.

CHOOSING PROCEDURE CODES AND DELETED CODES

Providers should be aware that *before 2004,* procedure codes with a "*" indicated that this code could have an additional visit fee attached. However, as of 2004, the "*" indicator has been removed, and the additional charge (normally a new patient chart fee) is included in the basic charge. The "*" designation however has been left in our system for backward compatibility. No additional charges should be added to this fee, unless it is truly an additional billable service and the appropriate modifiers are added.

The deleted codes are still on your system for reference. However, you will not be able to find these deleted codes via the cross-reference feature since their cross-reference was changed to "DELETED_CODE". You can still look these up using the actual code number. DO NOT use this feature to bill any *new* charges.

MENU SELECTION #10, "PROCEDURE DELETE", works in a similar manner as that of Menu Selection #3, "**Symptom Delete**". See that section for a description of deleting a record.

MENU SELECTION #11, "PROCEDURE SELECTIVE MAINTENANCE",*works* in a similar manner as that of menu selection #7, "**DIAGNOSIS SELECTIVE MAINTENANCE**"

PATIENT INFORMATION FILE

The Patient Information file contains the list of Publications that your clinic can hand out to patients.

MENU SELECTION #12, "PT. INFORMATION FILE", choose this selection to Add to or Change the publications listed in the Patient Information file. The basic Add/Change screen for this file is as seen in Figure 476 below.

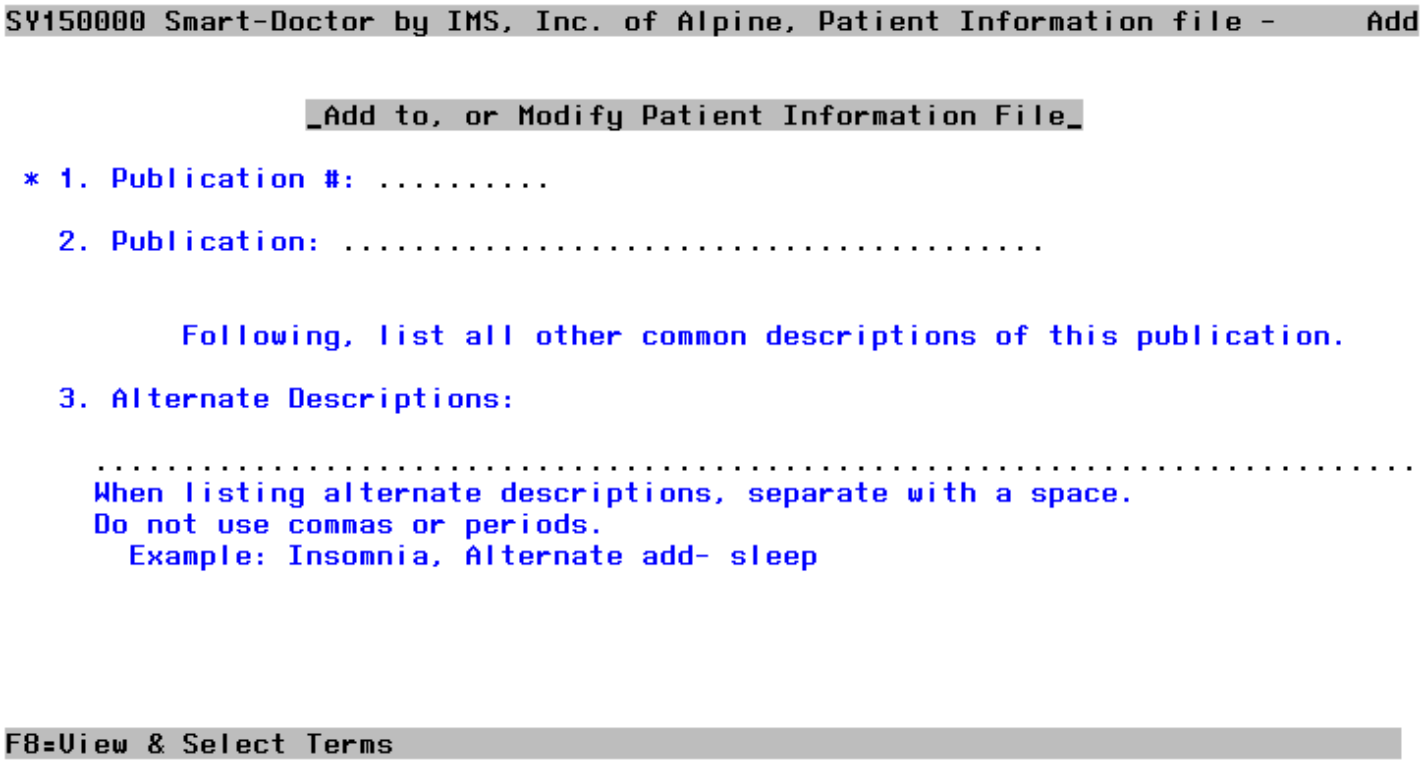


Figure 476 Patient Information Maintenance screen.

The <F8> key, "View & Select Terms", can be used to see or select a sorted list of publications already in the system, as seen in Figure 477 below.

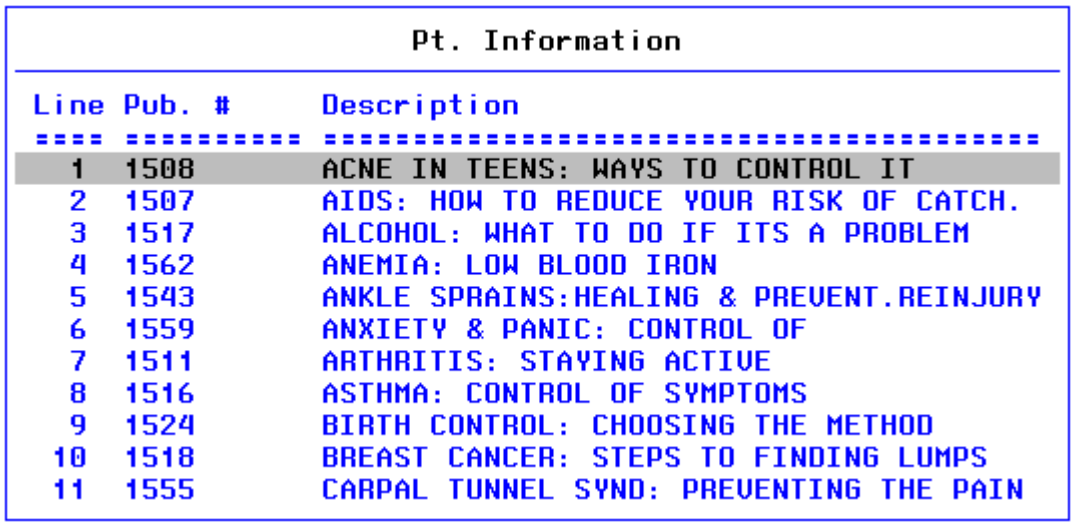


Figure 477 Selection List for Patient Information File.

The above listed publications are from a list of publications produced and sold by the American Academy of Family Physicians (AAFP). The series is titled "Health Notes from Your Family Doctor, and can be obtained by calling the AAFP at 1-800-944-0000 . To add publications from other organizations, or your own, follow the directions below.

Prompt #1, "**Publication #:**", enter a unique publication number on adding, or part of the description for a standard cross-reference lookup.

Prompt #2, "**Publication:**", enter the title of the publication here.

Prompt #3, "**Alternate Descriptions:**", enter the cross-reference terms to use to find this publication. It should contain the significant words of the title, in addition to other cross-reference terms. Avoid using "the", "of", etc. Separate terms with a space, and do not use commas or periods.

MENU SELECTION #13, "PRINT PT. INFORMATION FILE", choose this selection to print the patient information publications available at you clinic. The selection process is the same as that for menu selection #2, "**PRINT SYMPTOM FILE**", above. A sample of the screen output is shown in Figure 478 below.

```
SY150100            Smart-Doctor by IMS, Inc. of Alpine, TX          Page    1
                       Patient Information Material File  14:18:42 17 Jul 2004

Publication/ Alternate Description          Publication#
==========================================  ======
ACNE IN TEENS: WAYS TO CONTROL IT           1508
  ACNE CONTROL ADOLESCENTS

AIDS: HOW TO REDUCE YOUR RISK OF CATCH.     1507
  AIDS CATCHING HIV STD

ALCOHOL: WHAT TO DO IF ITS A PROBLEM        1517
  ALCOHOL ADDICTION PROBLEM

ANEMIA: LOW BLOOD IRON                      1562
  ANEMIA LOW BLOOD IRON

ANKLE SPRAINS:HEALING & PREVENT.REINJURY    1543
  ANKLE SPRAINS

ANXIETY & PANIC: CONTROL OF                 1559
  ANXIETY PANIC MENTAL HEALTH
Press <return> to continue, or <end>
```

Figure 478 Printout of Patient Information File.

MENU SELECTION #14, "PT. INFO. DELETE", follows the same logic as that of menu selection #3, "**SYMPTOM DELETE**"*, above.*

GLOSSARY FILE

The glossary file contains anatomical terms used in the system to describe the area of a procedure. This is used solely in the "Standard Procedure" type procedure, and not in the "Defined Procedure" type. This glossary system is left for backward compatibility for the standard procedure types. It is recommended that all new procedures added to the system be added to the "Defined Procedure" section discussed later.

MENU SELECTION #15, "GLOSSARY FILE", choose this selection to enter or modify glossary terms used in the "Standard Procedure" type procedure notes. In the screen seen in Figure 479 below, you can enter a new anatomical term or enter part of a term for cross-reference lookup.

Prompt #1, "**Enter Glossary Term:**", enter a unique new term or part of a term for cross-reference lookup. Figure 480 below is the cross-reference pop-up selection screen obtained by entering "bac".

```
SY130000 Smart-Doctor by IMS, Inc. of Alpine, TX        Glossary Terms -     Add

* 1. Enter Glossary Term:  _...................   ...................

  2. Enter Cross Reference:

.....................................................................................

  3. Is this Strictly an Anatomical term?  .

F1=End/Exit F2=Help F4=Quick Menu F5=Calendar F8=Cancel F10=End of Line
```

Figure 479 *Glossary File Maintenance screen.*

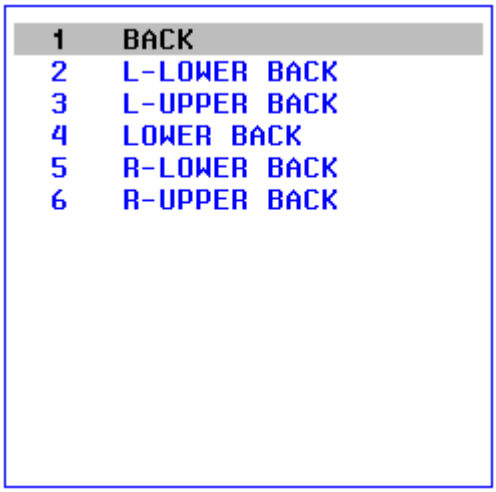


Figure 480 *Glossary Selection.*

Upon selecting item #2 above, the screen appears as seen in Figure 481 below.

```
* 1. Enter Glossary Term:  bac                          L-LOWER BACK

  2. Enter Cross Reference:

LOWER BACK L-

  3. Is this Strictly an Anatomical term?  Y
```

Figure 481 *Glossary screen After selection.*

Prompt #2, "**Enter cross-reference:**", enter cross-reference terms in the standard manner. That is, alternate descriptions, using significant terms and avoiding commas and periods. Leave one space between each cross-reference term.

Prompt #3, "**Is this Strictly an Anatomical term?**", answer <y> to this prompt. The case where <n> would apply has been eliminated by use of the TERMS file to be discussed later.

MENU SELECTION #16, "PRINT GLOSSARY FILE", choose this selection to print the glossary file. In the print selection screen enter the starting and ending glossary terms, or except the defaults of "FIRST" and "LAST", respectively.

A sample of the print screen output is as shown in Figure 482 below.

```
SY130100            Smart-Doctor by IMS, Inc. of Alpine, TX          Page    2
                                Glossary File             15:14:28 17 Jul 2004


 Glossary Term/Cross Reference
 =======================
AEROLA LEFT BREAST L-AREOLA

 AEROLA, RIGHT BREAST
AEROLA RIGHT BREAST R-AEROLA

 ANKLES
ANKLES

 ANT. 2/3 OF TONGUE
ANTER TWO-THIRDS 2/3 TONGUE

 ANT. ETHMOID SINUS
ANTERIOR ETHMOID SINUS

 ANT. NASAL CHAMBERS
ANTER NASAL CHAMB NOSE
Press <return> to continue, or <end> _
```

Figure 482 Printout of Glossary File.

MENU SELECTION #17, "GLOSSARY DELETE", follows the same logic as that of menu selection #3, "**SYMPTOM DELETE**"*, above.*

TERMS FILE

Most of the pop-up screens in the system come from the Terms file. The Terms file also contains patient management information, substance file information, immunizations, EDI information, and much more. These Terms are critical to system operation. The Terms file screens are used by administrators to modify and customize the way the system works for your specific clinic. It contains administrative terms (keys starting with ADM-), patient history terms (HX-), in-house lab terms (IHL-), outside lab terms (LAB-), physical exam terms (PE-), plan terms (PLAN-), procedure terms (PROC-), review of systems terms (ROS-), substance file terms (SUB-), X-Ray terms (XRAY-), as well as key terms for procedure notes, and subjective notes. Many of these terms can be changed by the clinic as needed without consultation with IMS. They should be changed only by administrative personnel at the office who understand the significance of making these changes, and understand

these changes affect ALL uses.

Certain terms, if changed without full understanding of the system, could cause billing problems, patient management problems, etc. To prevent this problem from arising, a significant number of terms are restricted from changes by clinic personnel, including administrators. To make changes to these terms you must call IMS. IMS programmers will make the changes for you.

Examples of changes your administrator can make are:

Description	Record Key
Types of Provider appointments	ADM-APPT_TYPE
Bill over due 30 dunning message	ADM-BILL-OVER30
exam abdomen hernia	PE-ABD_HERNIA

Example of changes IMS must make are:

immun error for flu	ADM-ERRFLU
Immunizations due	ADM-IMMUN_DUE
Labs for Carrier file	ADM-LABS
Amounts for tablets	SUB-AMT-TAB

Examples of how the basic screen acts for these two types of terms will be shown below in the explanation of screen data entry.

MENU SELECTION #18, "TERMS FILE", choose this selection to add to or change terms. The following screen allows you to add a new, unique record or lookup an existing record with the standard cross-reference system. In the following example, after entering <appoi ty> to do a cross-reference lookup for appointment type, the screen shown in Figure 483 is presented.

Prompt #1, "**Terms Key:**", enter a new unique key term here or a part of a description for cross-reference lookup.

Prompt #2, "**Description:**", are the cross-reference terms used to build the cross-reference.

Prompt #3, "**Max Length:**" is set by IMS for existing terms and should not be modified without consultation with IMS. The maximum length is often determined by the pop-up screen width, or by the way the program looks at the data in the subsequent multi-value "Term Descriptions" prompt. In the example above for appointment types, the description must be 8 characters long, and the eighth character must be a "B", "F", or "M" for both, female, or male, respectively.

Prompt #4, "**Record Key:**", determines if the lines in the multi-value "Term Descriptions" prompt, are defining record keys or not. In general this should be left as "n", for no. The only exception to this in the current system is in the Terms key "PROC-NOTES", which defines the subsequent keys of procedure notes for the "Standard Procedure" notes system. In general, the "Standard Procedure" system will be replace by the "Defined Procedure" notes system. The effect of this being set to "y" is that you will be given an error message if you enter any spaces in a "Term Descriptions" prompt line. Since record keys cannot contain spaces, it would not make sense to allow spaces in these lines.

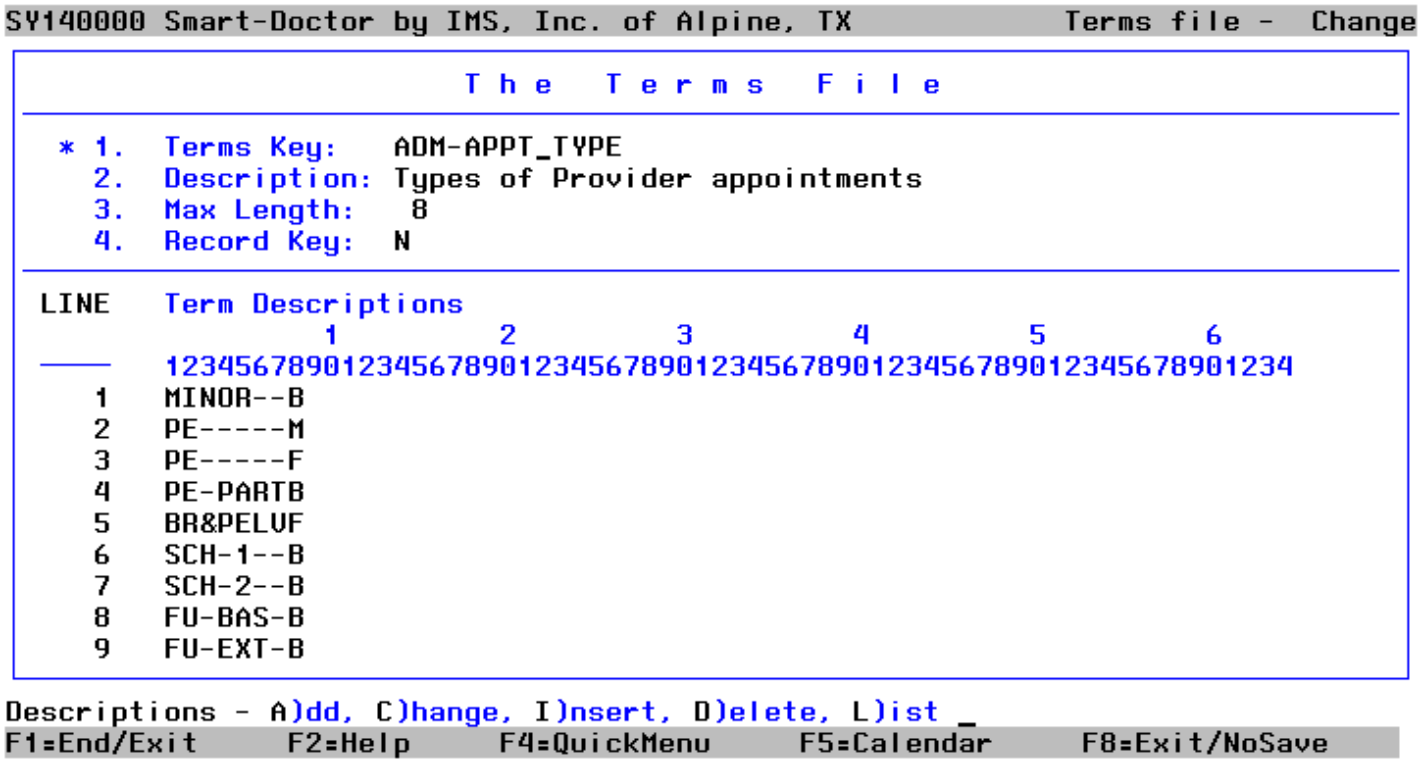


Figure 483 *Terms File Maintenance screen.*

Multi-Value “Term Descriptions” prompt, is where you will enter information of the appropriate type depending on where this information will be used.

The next screen (Figure 484) is an example of a dunning message that will be printed on a bill if it is over 30 days old but less than 60 days old:

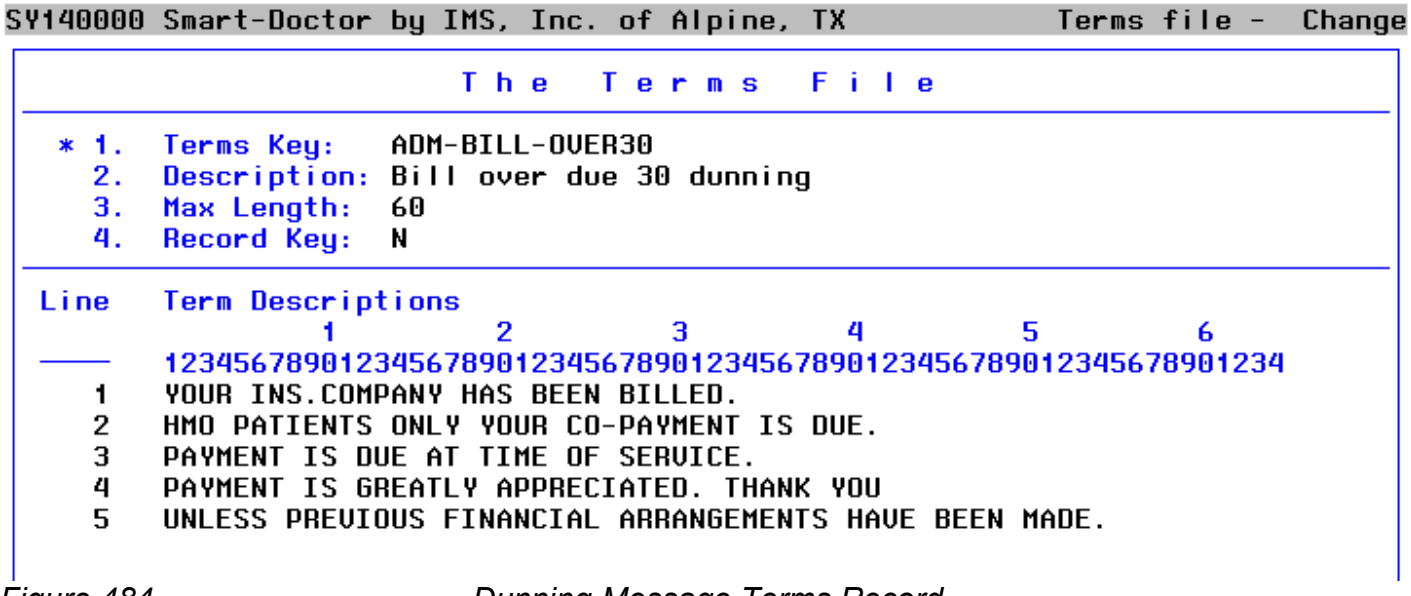


Figure 484 *Dunning Message Terms Record.*

In this case, you will note that the Max Length is 60, and that this is not a key to records. In the multi value prompt you can enter up to 60 characters per line. If you try to enter more than that, you will get the following warning at the bottom of the screen:

"The acceptable range is 0 to 60. Press <return> to continue."

And upon hitting <return>, the line will be blanked out.

The next example is a Terms record that only IMS programmers are allowed to change. You will note a red, flashing line at the upper right hand corner of the screen stating:

System Term, No Change Allowed

Following (Figure 485) is an example of an abbreviated immunization screen.

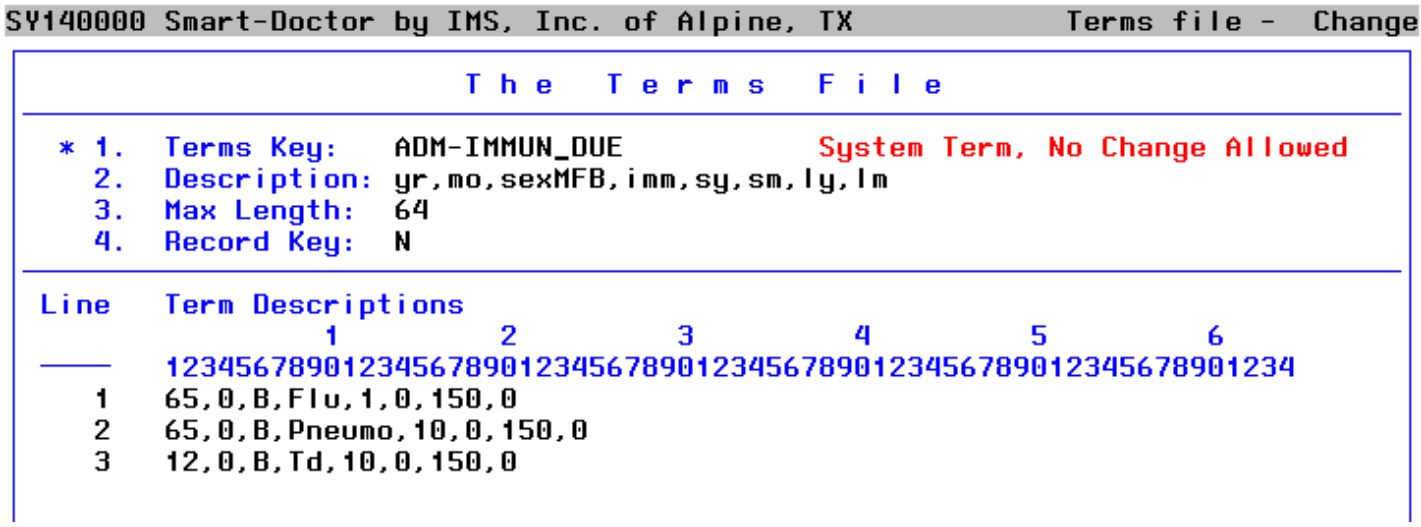


Figure 485 *Immunization Information Terms Record.*

As can be seen, these screens can get complicated. A description of this immunization Terms record and how it interacts with the system is described below.

FULL IMMUNIZATION CHECK CAPABILITY

The system has the ability to do full immunization checks for the immunizations shown below. However, your system has only been turned on for checking for the following immunizations at this time: Pneumovax starting at 65 and every ten years thereafter; Flu starting at 65 and every year thereafter; Td starting at 14 and every ten years thereafter. The remaining immunization checks will be turned on as you wish. However, turning them on before any immunizations are documented can lead to an excessive number of reminders for individuals under 22 years of age. The system is setup to stop checking for Hib after age 5; for DTP after age 7; for HA after age 11; and for HB, MMR, OPV/IPV, and Var after age 22. These can be changed at your discretion. You can see from the above, that for a five year old you could end up with approximately 18 reminders if none of these immunizations are documented as done, refused, or immune. The example of the full immunization check screen is seen in Figure 486 below.

Following is the explanation of the eight control fields in the Term Descriptions multi-value lines.

yr=	starting year.
mo=	starting month.
sexMFB=	sex, Male, Female, or Both sexes.
imm=	Immunization code.
sy=	years until immunization required again.
sm=	months until immunization required again.

ly= last year of are immunization required.
lm= last month of age immunization required.

```
SY140000 Smart-Doctor by IMS, Inc. of Alpine, TX          Terms file -  Change

                        T h e   T e r m s   F i l e

  * 1.  Terms Key:    ADM-IMMUN_DUEX          System Term, No Change Allowed
    2.  Description:  yr,mo,sexMFB,imm,sy,sm,ly,lm
    3.  Max Length:   64
    4.  Record Key:   N

Line    Term Descriptions
                1         2         3         4         5         6
------  1234567890123456789012345678901234567890123456789012345678901234
    1   65,0,B,Flu,1,0,150,0
    2   65,0,B,Pneumo,10,0,150,0
    3   0,2,B,DTP/AP1,150,0,7,0
    4   0,4,B,DTP/AP2,150,0,7,0
    5   0,6,B,DTP/AP3,150,0,7,0
    6   1,3,B,DTP/AP4,150,0,7,0
    7   5,0,B,DTP/AP5,150,0,7,0
    8   0,2,B,Hib1,150,0,5,0
    9   0,4,B,Hib2,150,0,5,0
```

On page down,

```
   10   0,6,B,Hib3,150,0,5,0
   11   1,3,B,Hib4,150,0,5,0
   12   1,0,B,HA1,150,0,11,0
   13   3,0,B,HA2,150,0,11,0
   14   0,2,B,HB1,150,0,22,0
   15   0,3,B,HB2,150,0,22,0
   16   0,10,B,HB3,150,0,22,0
   17   0,2,B,MMR1,150,0,22,0
   18   5,0,B,MMR2,150,0,22,0
```

On page down,

```
   19   0,2,B,O/IPV1,150,0,22,0
   20   0,4,B,O/IPV2,150,0,22,0
   21   0,10,B,O/IPV3,150,0,22,0
   22   5,0,B,O/IPV4,150,0,22,0
   23   1,0,B,Var1,150,0,22,0
   24   13,0,B,Var2,150,0,22,0
   25   12,0,B,Td,10,0,150,0
```

Figure 486 Example of Immunization Terms Record.

As you can see, making a mistake here could effect system function, and therefore access is restricted. However, it let's you see what can be changed.

MENU SELECTION #19, "PRINT TERMS FILE", choose this selection to print the Terms file. In the print selection screen enter the starting and ending Terms, or accept the defaults of "FIRST" and "LAST", respectively.

A sample of the print screen output is shown in Figure 487 below.

```
SY140100              Smart-Doctor by IMS, Inc. of Alpine, TX          Page    1
                              Printout of Terms file.       18:30:34 17 Jul 2004


Key Term              Descriptions
===================== ============================================================
PE-ABD_HERNIA         None
                      Midline
                      Incisional
                      R. Inguinal - direct
                      R. Inguinal - indir.
                      L. Inguinal - direct
                      L. Inguinal - indir.
                      Periumbilical
                      R. Abd. wall
                      L. Abd. wall
                      Diastasis recti

Key Term              Descriptions
===================== ============================================================
PE-ABD_LOC            Entire
                      Epigastric
Press <return> to continue, or <end>
```

Figure 487 Print screen of Terms File.

You may want to print physical exam Terms by selecting all those terms staring with “PE-”. Doctors can look these over and see if they want any additions or changes, so that they will be available to them when documenting a physical exam.

MENU SELECTION #20, “TERMS DELETE”, follows the same logic as that of menu selection #3, “SYMPTOM DELETE”, above. However, deleting a TERMS record may cause significant system problems if you do not understand exactly how the TERMS record is used in the system. As a general rule, do not delete any TERMS records, unless this is a TERMS record that you added yourself. Any other key TERMS that you think need to be deleted should be done with the assistance of IMS programmers.

LAB TEST FILE

The lab test file (LabCorp Tests File, at this time) is where all lab tests are listed. This includes both the automated outside labs, standard outside labs, and the inhouse labs.

MENU SELECTION #21, “LABCORP TESTS FILE” (currently LabCorp Test File), choose this selection to review or modify information on lab tests to be ordered. Upon selecting this item, the screen seen in Figure 488 will be presented.

Prompt #1, “**Test Code:**”, enter either the lab test number or partial test name for a cross-reference lookup. Upon entering <inhouse>, the following screen shown in Figure 489 will pop-up to choose from.

These are the InHouse lab tests, and are also tests the provider can perform. Upon selecting line #4, “**Urine HCG, InHouse**”, the screen looks as seen in 490.

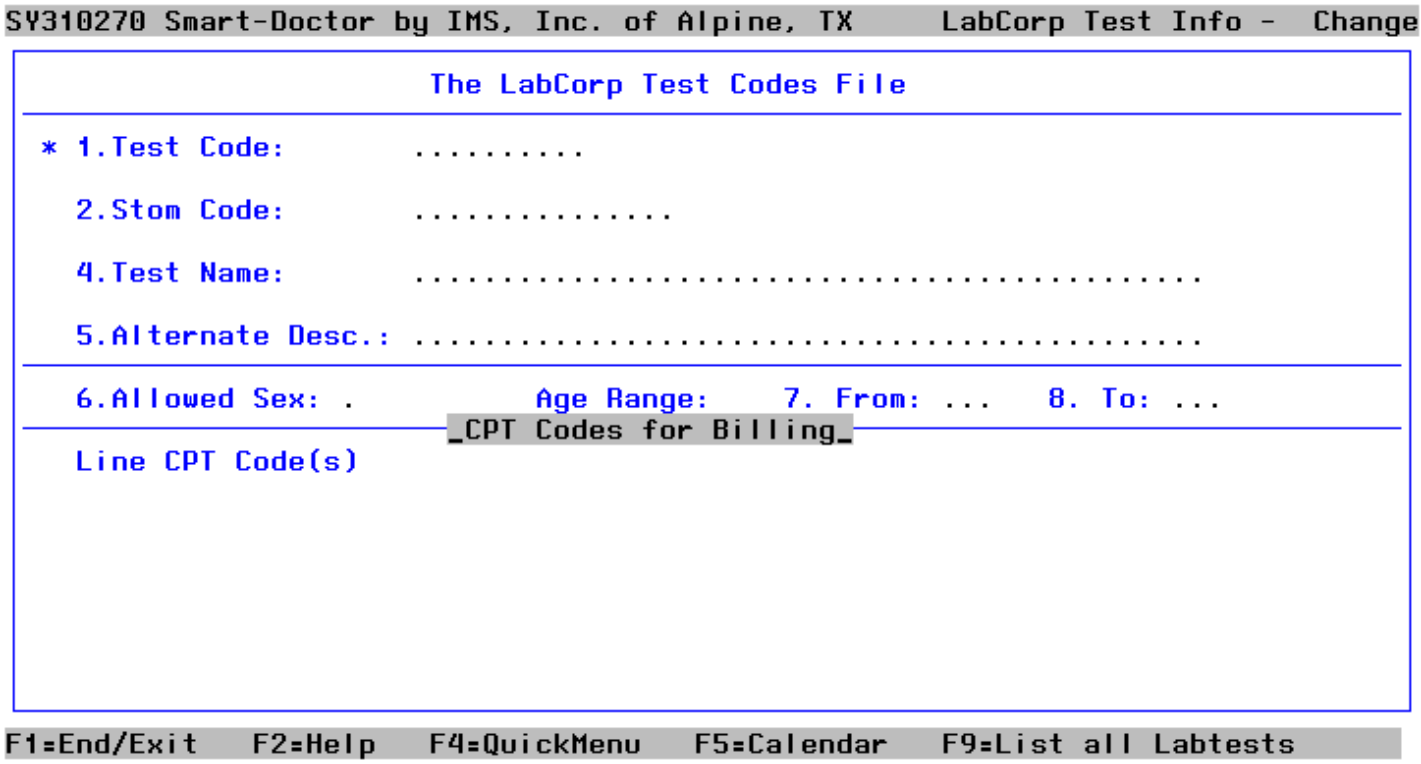


Figure 488 Lab Test Information File screen.

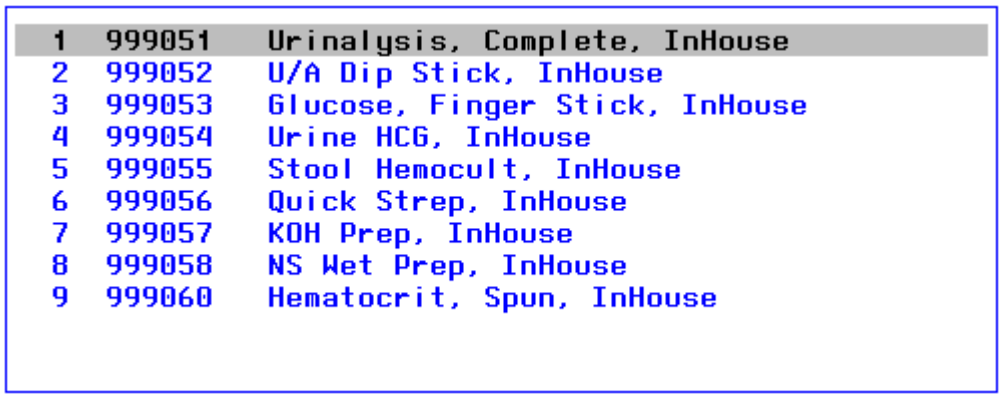


Figure 489 Cross-Reference Selection for Lab Tests.

Prompts #2 & #4, "**Stom Code**" & "**Test Name**". are set by the system and cannot be changed.

Prompt #5, "**Alternate Desc.:**", enter any other names used for this test, i.e., cross-reference terms.

Prompt # 6, "**Allowed Sex:**", if this test is restricted to a specific sex, as in this case of a pregnancy test, then indicate either <m> for male or <f> for female. If the test is applicable to either sex, then enter <b> for both, or leave blank (space).

Prompt #7, "**From:**", enter the starting age that this test would be applicable. If there is no minimum age, enter <0>.

Prompt #8, "**To:**", enter the ending age that this test would be applicable. If there is no maximum age enter <150>.

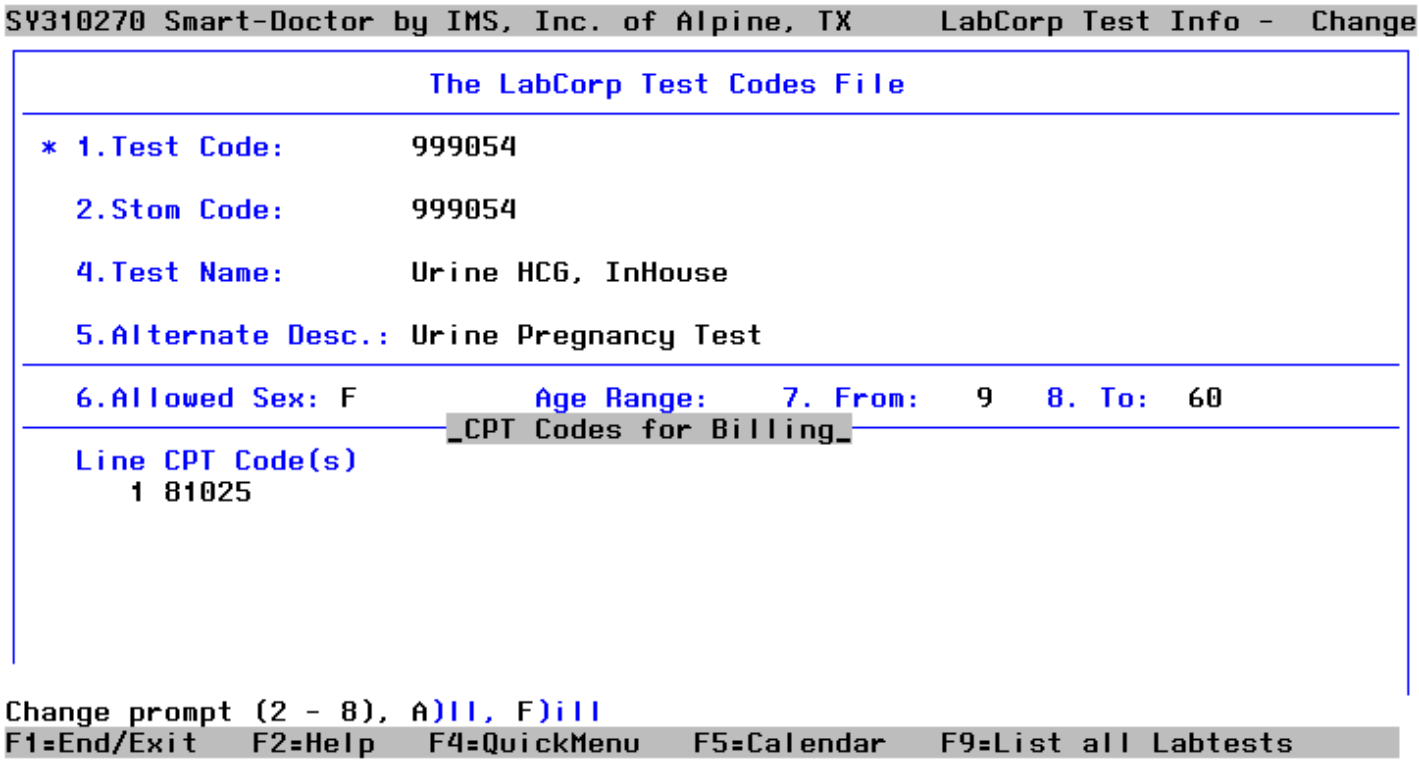


Figure 490 *Completed Test Code screen.*

After hitting <enter> at the at the change prompt, you will be taken to the bottom half of the screen for addition or modification of the multi-valued prompt for “Billing CPT's”, with the description header of “CPT Code(s)”. This is seen Figure 491 below.

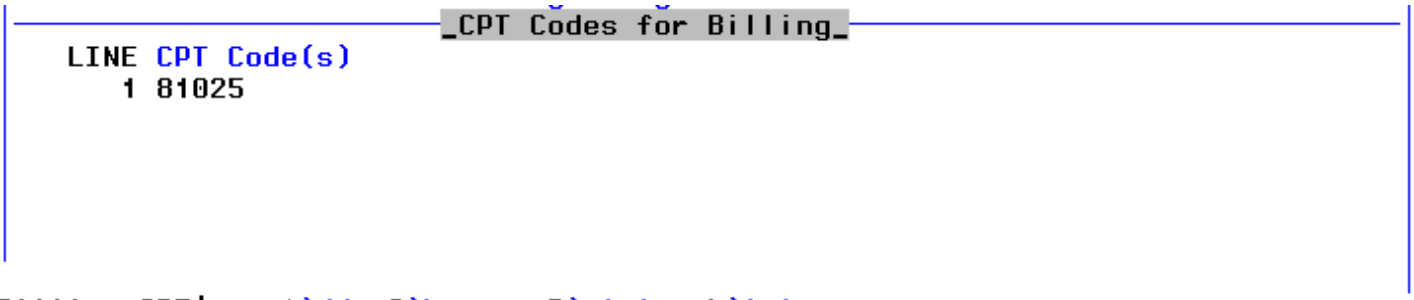


Figure 491 *Billing CPT Codes for Lab Test.*

“InHouse” labs are “hard coded” and making changes here will have no effect. However, for all other lab tests, the CPT codes listed here will be billed each time this lab test has been indicated to be billed to the clinic. Third party billing will be addressed by the lab doing the test, and will not be affected by any changes made here. The listing of more than one CPT code here (each CPT code must be on a separate line) may be appropriate for certain test panels where more than one billable test is indicated by ordering that panel.

The <F9> key, “List all Labtests”, can be used in prompt #1 to give you a listing of all the lab tests available in the system, from which you may select one.

MENU SELECTION #22, “Print Lab Test File” (currently LabCorp), choose this selection to print the Lab file. A sample of the screen output is shown in Figure 492 below.

```
SY310271            Smart-Doctor by IMS, Inc. of Alpine, TX          Page    6
                              LabCorp Tests File          13:57:52 23 Jul 2004


  Test Code: Stom Code:      Test Name:/CPT codes
  ========== ============== ============================================
  5201                      CBC/PLATELETS
                            85025
  5202                      CBC/RDW
                            85025
  5207                      CBC-NO INDICES
                            85025
  5219                      HLA B27
                            86812
  5232                      (FLOW) CBC
                            85025
  5300                      HEMATOLOGY
                            85060
  5500                      PLATELET COUNT
                            85049
  5560                      MALARIA SMEAR
                            87207
Press <return> to continue, or <end> _
```

Figure 492 Screen Print of Lab Test File.

MENU SELECTION #23, "LAB TESTS DELETE" (currently LabCorp Tests), follows the same logic as that of menu selection #3, "**SYMPTOM DELETE**"*,* above. However, deleting a Lab record will eliminate the ability to order a test from <u>any</u> lab. As a general rule, <u>do not delete any Lab records</u>. Any Labs records that you think need to be deleted should be done with the assistance of IMS programmers.

Scenarios FILE

A scenario is a synopsis of a patient encounter for a specific diagnosis, problem, or health exam. It may contain the subjective, objective, assessment, and plan related to that specific scenario. The Scenarios file contains all the scenarios available for your clinic providers to use in describing their interactions and observations with patients they see. These Scenarios can be called up from the Provider Visit or Non-Scheduled Provider Visit screens. Since many things in patient care are repetitive in nature for example, the common cold, hypertension, bronchitis, etc., you can document most of the provider visit in advance for a specific type of problem, diagnosis, or health exam. In the Scenarios file you can document the subjective, objective, assessment and plans in advance. Upon selecting a scenario, the scenario information is copied into the active visit note. Here, it can be modified using the standard provider screen tools. Prescriptions cannot be included in the scenarios since these are done interactively with the provider to allow for appropriate interaction checks.

MENU SELECTION #24, "ADD OR MAINTAIN SCENARIOS.", choose this selection to add or maintain Scenarios. Upon selecting this menu item you will be presented with the add screen. In the example below, we are adding the scenario for Flu. We will copy most of the scenario from an existing scenario for URTI, which is very similar. As in this example, clinic providers may elect to copy scenarios of another provider for a given problem and modify it slightly for their own use. All that is required is that the key be unique. This could easily be done by simply adding your initials to the key. To modify a scenario, simply find the scenario with the standard cross-reference lookup technique, and then modify as needed.

The screen for adding the new scenario described above is seen in Figure 493 below.

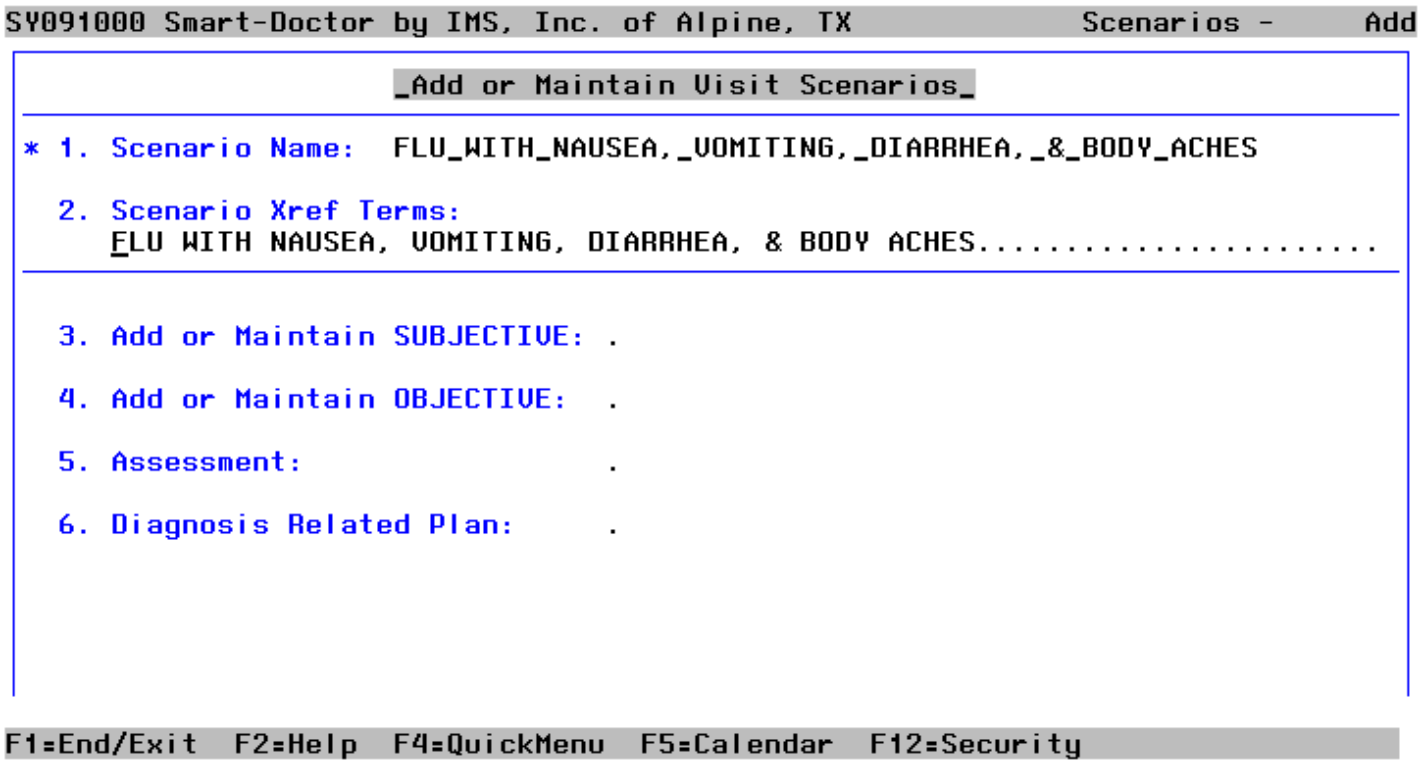


Figure 493 *Adding a New Scenario.*

Prompt #1, "**Scenario Name:**", enter a partial description for a cross-reference lookup, or enter a new key. In the example above, we entered the new key "flu with nausea, vomiting, diarrhea, & body aches". The system found that this key did not exist, converted the text to all upper case, and replaced the spaces with an underline character. Replacing the spaces with an underline character makes this into a valid key since no spaces are allowed in keys.

Prompt #2, "**Scenario Xref Terms:**", the system automatically places the original key entered in prompt #1 into this prompt, converting it to upper case. Since this is your cross-reference lookup, you can make this more efficient by eliminating insignificant terms and punctuation. In this case, we deleted insignificant terms to come up with a cross-reference of:

FLU NAUSEA VOMITING DIARRHEA BODY ACHES.

Next, the pop-up screen for copying will be seen as shown in Figure 494 below.

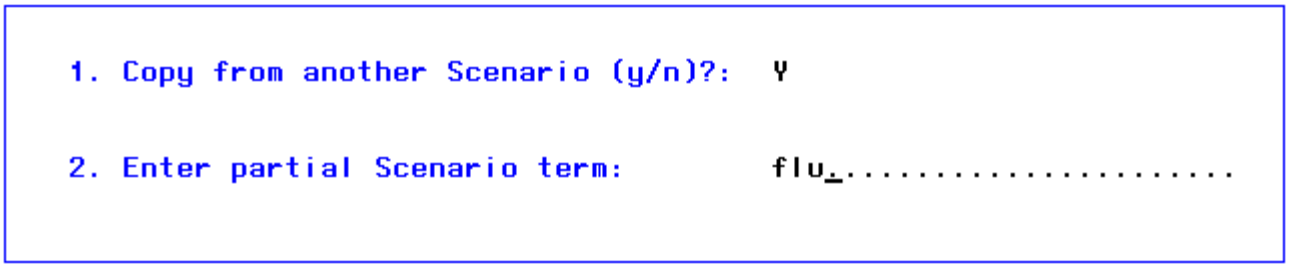


Figure 494 *Copy from Another Scenario.*

In this case we entered <flu> to copy another flu like scenario. The selection screen that came up is shown in Figure 495 below.

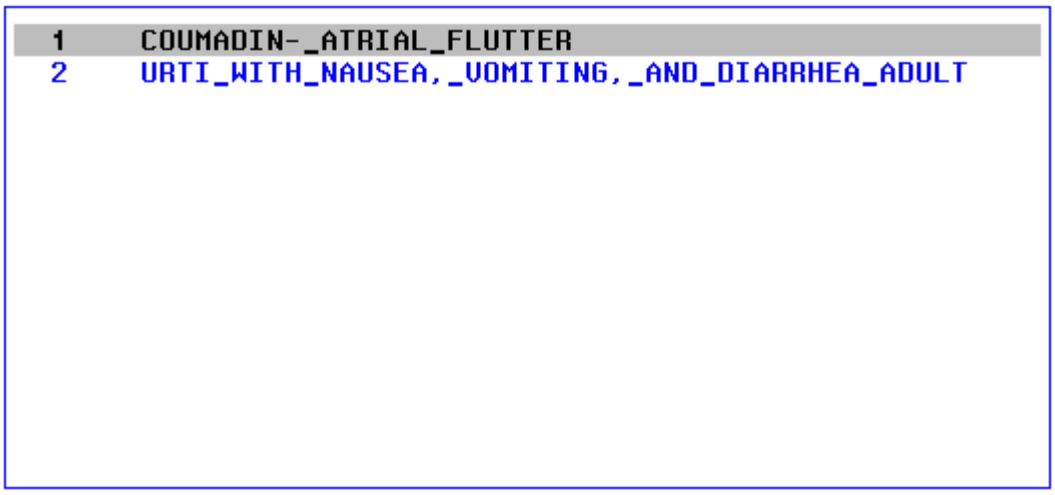


Figure 495 Selection screen for Existing Scenarios.

Upon picking line #2 above, we get the screen shown in Figure 496 below.

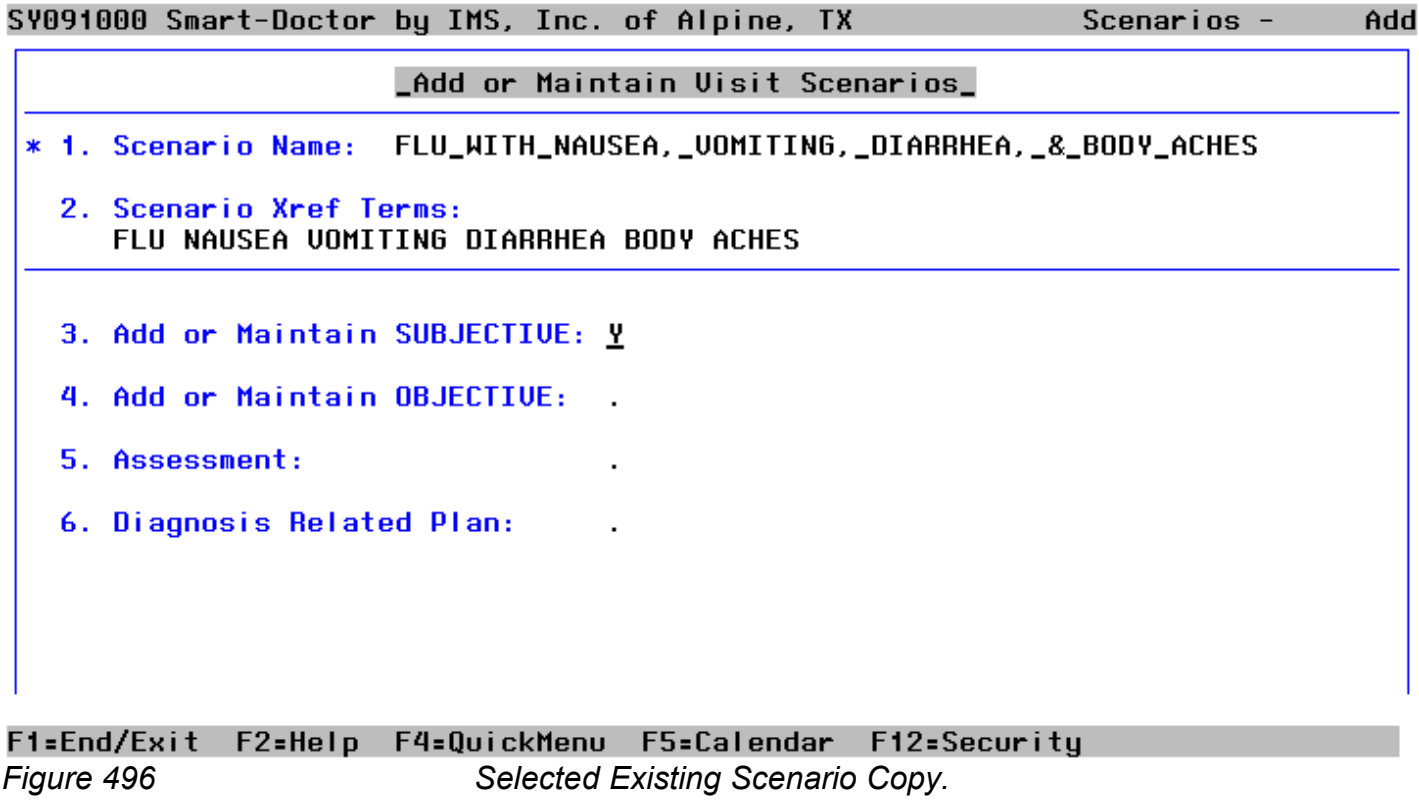
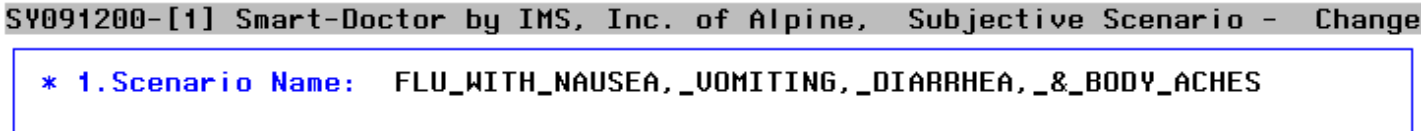


Figure 496 Selected Existing Scenario Copy.

Prompt #3, "**Add or Maintain SUBJECTIVE:**". This had been indicated as "y" in the copied scenario. By hitting <enter> here, you will be taken to the Subjective screen as seen in Figure 497 below.

This screen is similar to the standard subjective screen with several items changed or eliminated. The new scenario name is seen in prompt #1. Prompts #3, #4, #7, #21, and the multi-value prompt "**Subjective Notes**" have been copied from the referenced scenario. If these had not been copied, they would be blank. Enter <a> at the change prompt to go through each prompt, or enter the



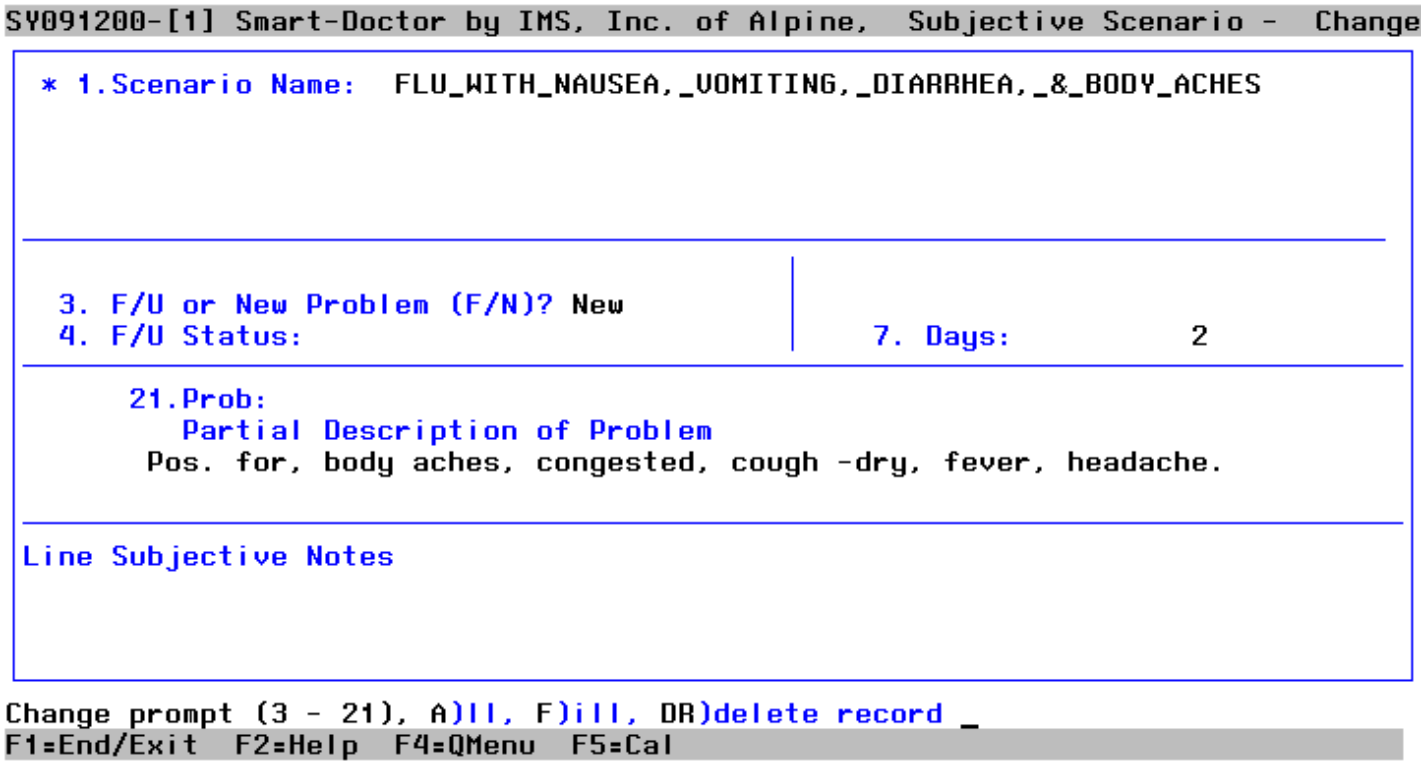


Figure 497 Scenarios Subjective screen.

specific number of the prompt that you wish to change. The screen acts just as described in the provider screen section of this manual.

Once the prompt items are completed, you will be taken to the multi-valued “Subjective Notes” prompt. Here you can accept, change, or add to what has been copied, if you elected to copy from another scenario.

You will note that there are no F-keys for ROS or Social Hx on this screen. These will be accessed at the time of the encounter on the provider screens.

Back to “**Add or Maintain Visit Scenarios**”:

Prompt #4, “**Add or Maintain OBJECTIVE:**”. Here, enter <y> to be taken to the same type of screen accessed via the provider visit for Objective data. If this is being copied, then the data from the copied scenario will have populated their corresponding prompts.

Prompt #5. “**Assessment:**”. The assessment screen is slightly different from that seen in the provider screens, as is seen in Figure 498 below.

Assessment screen Prompt #2, “**ICD-9 Code (or Xref):**”, acts in a way similar to looking up a diagnosis as using the cross-reference lookup system in the provider screens. You will note that only one diagnosis is allowed for each scenario. When in the provider visit, you will be able to add to, change, or delete this diagnosis as needed. The warning on the above screen is important to understand. You can reduce the chance of error if you identify this scenario in a way to make it clear if there is an age or sex restriction for a given scenario, for example, “BPH SYMPTOMS, IN ADULT MALE

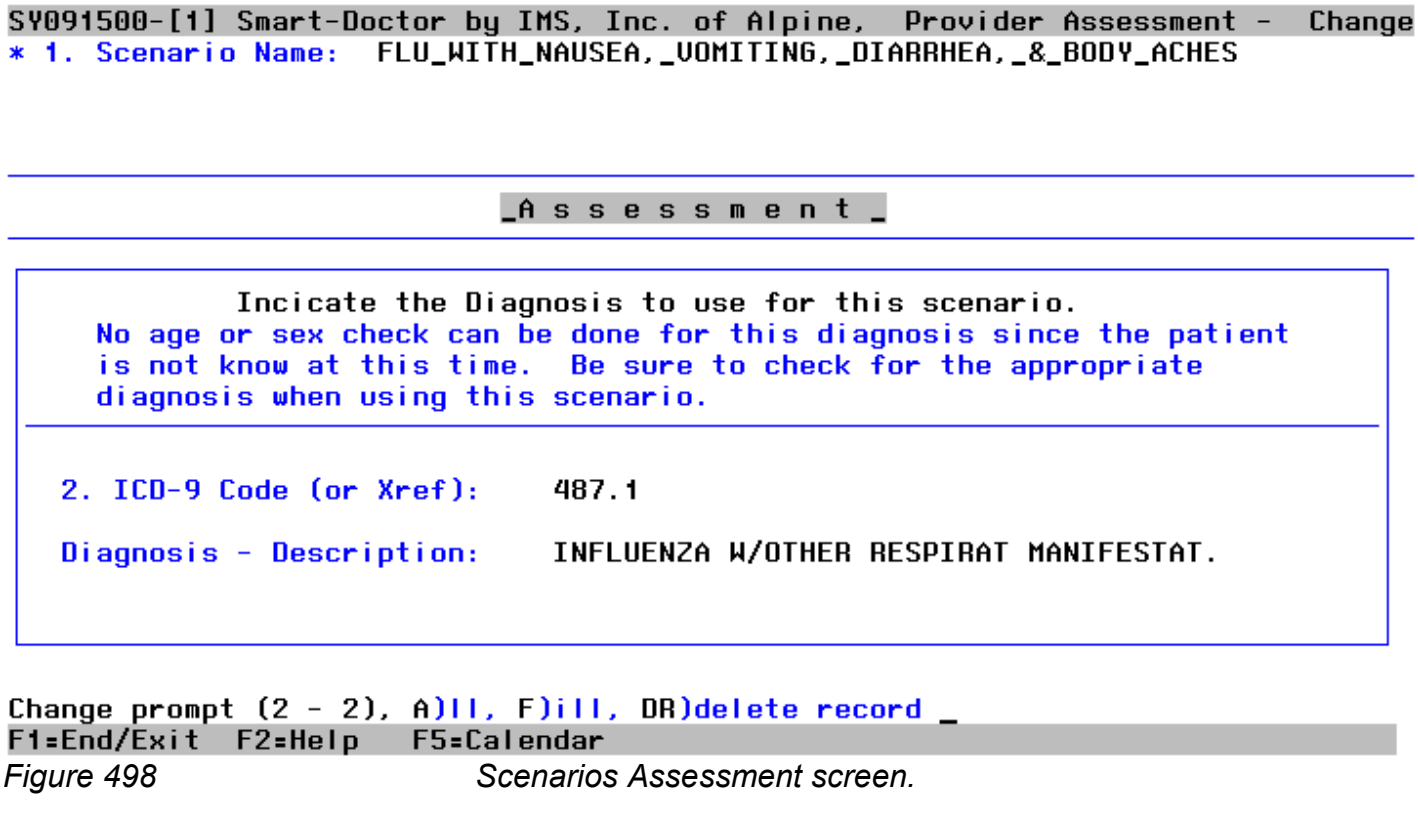


Figure 498 *Scenarios Assessment screen.*

Back to "**Add or Maintain Visit Scenarios**":

Prompt #6, "**Diagnosis Related Plan:**", upon accepting "y", or entering <y>, you will be taken to the modified plan screen seen in Figure 499 below.

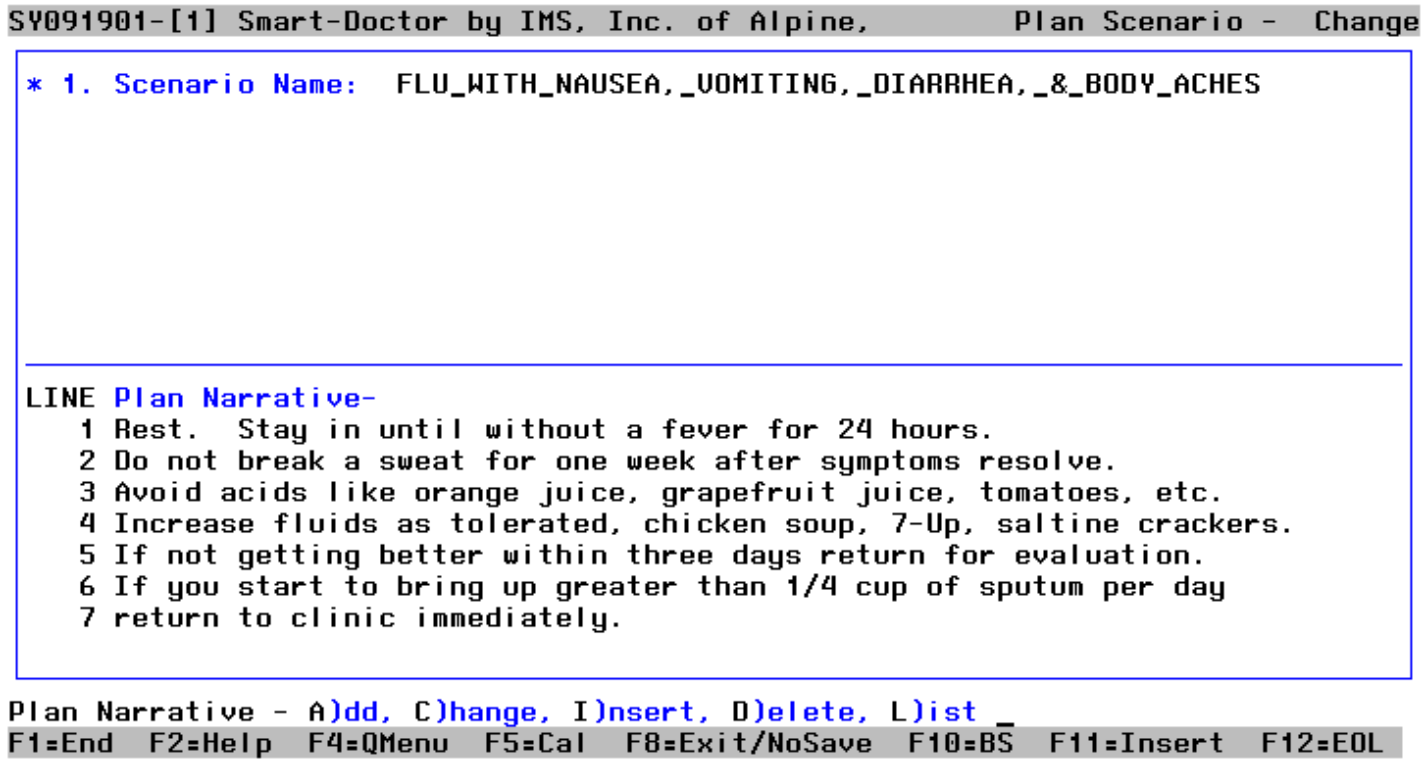


Figure 499 *Scenarios Plan screen.*

In this screen, you only have the ability to add a plan for this specific problem or exam. In the standard provider screens you can add additional plans as needed. Also, picking additional scenarios after the first will add the next appropriate plan note from the additional scenario.

Back to "**Add or Maintain Visit Scenarios**":

The <F12> Key, "Security", is used to see the security screen where you can see who entered or modified the scenario. The security screen is shown below in Figure 500.

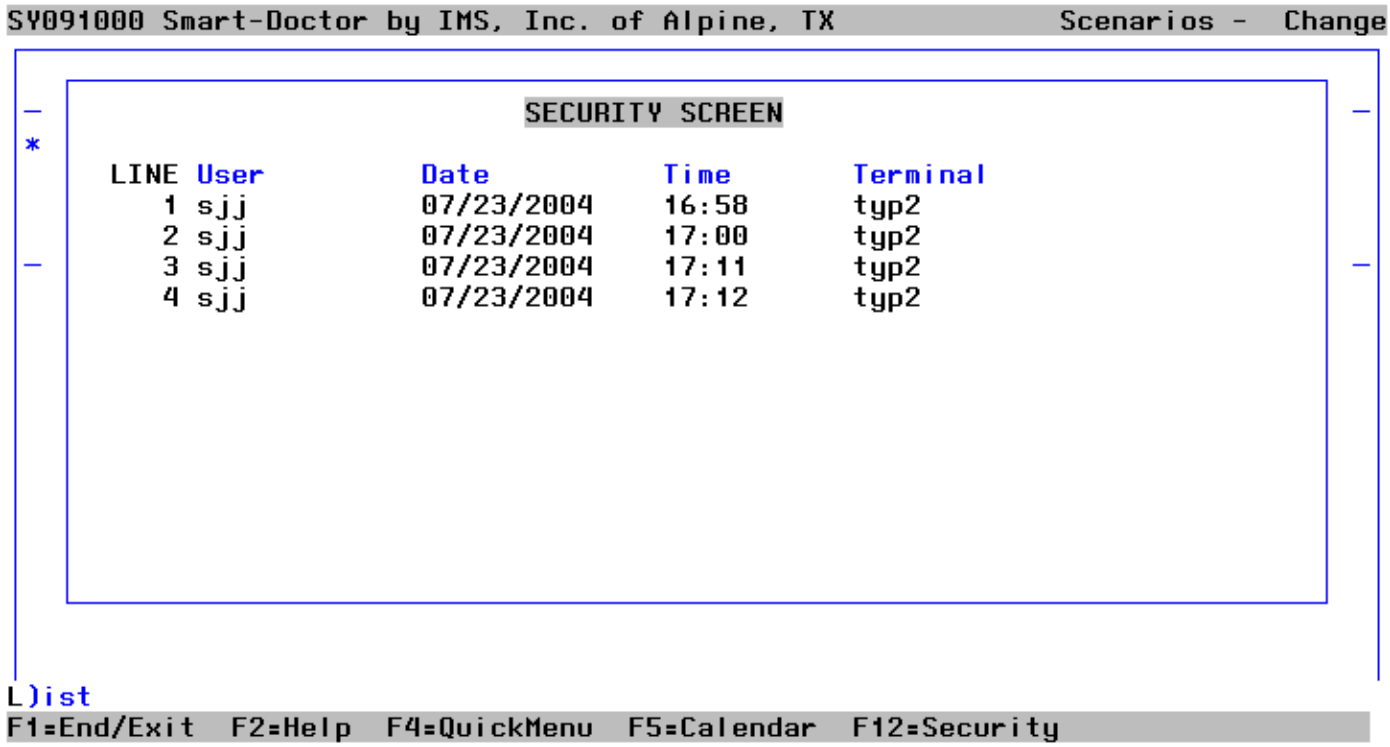


Figure 500 *Scenarios Security screen.*

The security screen above shows the user, date, time, and terminal or device used. Any review, changes, or additions will update this list. There is no way for the end user to delete or change this information.

MENU SELECTION #25, "SCENARIO DELETE", follows the same logic as that of menu selection #3, "**SYMPTOM DELETE**", above. If you think a scenario should be deleted, ask the system administrator to do this for you. The administrator can then check to be sure no one else is currently using this scenario before deleting it.

PROCEDURE REPORT FILE

The Procedure Report is used in the "Defined" procedures section of the provider procedure note. This is typically a minor surgery such as a skin biopsy, a procedure such as a sigmoidoscopy, or pap smear. Of course, major procedures can also be included here. The procedure note, as well as the defined variables in the TERMS file can give you the ability to define the procedure screen as you need, to add specific fields to fill in, as well as a note that can be modified. This is a significant enhancement over the standard procedure screen, in that you can not only specify the fill-in fields and control the input and pop-up screens, but that the procedure is tied to a specific CPT code with appropriate charges, and checks for age and sex appropriateness.

MENU SELECTION #26, "ADD PROCEDURE REPORT"

Choose this menu selection to add or modify the Defined Procedure Reports. Upon selecting this menu item, and entering <pap> in prompt #1, a selections screen pops-up. In that screen which comes from the Procedure files cross-reference lookup, we selected a Screening Pap Smear (HCPCS code number Q0091), for which a defined procedure report had already been done. The screen in Figure 501 will be displayed.

```
SY092000 Smart-Doctor by IMS, Inc. of Alpine, TX      Procedure Report -  Change

                    _Add to, or Modify Procedure Report File_

 * 1. CPT code:     Q0091         Desc.: SCREENING PAP SMEAR

    LINE Variable Name:     Terms File Name:
       1 EXT GEN            EXTGEN
       2 VAULT              VAULT
       3 CERVIX PRES        CERVIPRESENT
       4 CERVIX DC          CERVIXDC
       5 UTERINE POS        UTERINEPOS
       6 UTERINE SIZ        UTERINESIZE
       7 R ADNEXA SZ        ADNEXASZ
       8 L ADNEXA SZ        ADNEXASZ
       9 R ADNEX TEN        ADNEXTEND
      10 L ADNE TEN         ADNEXTEND

A)dd, C)hange, I)nsert, D)elete, L)ist
F1=End/Exit  F2=Help  F3=Print  F5=Calendar  F8=Cancel  F9=Note  F10=End Line
```

Figure 501 Defined Procedure screen.

Prompt #1, "**CPT code:**", enter the CPT-4 code of the Procedure Report you want to add or change. You can use the standard cross-reference to lookup. This specific procedure code (CPT or HCPCS) must already exist in the SY-PROCEDURE file. This is to insure that proper billing information is available. The above example shows a "SCREENING PAP SMEAR".

In the multi-valued prompt "Variable Name:" enter the variable name to be displayed next to this prompt number (same as line number). There can be up to 14 lines in this multi-valued prompt. This will result in up to 14 entry fields on the Defined Procedure screen.

In the second field of each line, "Terms File Name:", enter the name of the terms file record to be used in the pop-up selection list, or enter <FREE> for free text entry. Once the Terms record name has been set, go to the Terms file and add the appropriate terms for selection with this prompt. Limit the terms length to 20 characters so that it will fit on the screen.

Hit <F9>, "**Note**", to bring up the note screen seen in Figure 502 below. This is where you will enter the default note. The note can be modified by the provider in the procedure note.

```
LINE Procedure Note Text:
   1 Pap smear done in normal fashion using brush and spatula.
   2 Normal exam
```

Figure 502 Defined Procedure Default Note.

Obviously, you can write a much more extensive note. There is no limit on the number of lines you can have. Generally the note should consist of the constant parts of the note, with reference to the variables indicated on the first screen. For example, in a sigmoidoscopy note you could state " the scope was passed without problem to the distance indicated above".

The result of the above Defined Procedure note can be seen in the following example from the actual procedure screen seen in Figure 503 below.

```
FP160402-[3] SMART-DOCTOR by IMS of Alpine,TX          Procedure Note -     Add

* 1.Procedure Log No.: 104
    Patient Number:    1006
    Patient Name:      BONNER, MARY K.                          Gen:
    Date of Birth:     08/24/62                                 Sex: F
    Provider:          STEVE J. JOHNSON, MD

                       _P r o c e d u r e  N o t e_

  2.Indication  OTH.NONSPECIF ABNORM PAP SMEAR OF CERVIX
  3.CPT Code    Q0091
    CPT         SCREENING PAP SMEAR

  4.  EXT GEN      Normal          | 11. L ADNEXA SZ  Normal
  5.  VAULT        Normal          | 12. R ADNEX TEN  Non-tender
  6.  CERVIX PRES  Yes             | 13. L ADNE TEN   _.................
  7.  CERVIX DC    No Discahrge    | 14.              .................
  8.  UTERINE POS  Midline         | 15.              .................
  9.  UTERINE SIZ  Parous NI       | 16.              .................
 10.  R ADNEXA SZ  Normal          | 17.              .................

F1=End/Exit    F2=Help    F4=QMenu    F5=Cal    F8=Exit/NoSave    F9=Narrative
```

Figure 503 Example of Using Defined Procedure Note.

The number of Defined parameters or prompts following prompt #3, CPT code (or HCPCS code), is defined in the Procedure Report record. In this case, there were ten (10), as can be seen above. Each of these prompts had a TERMS file key associated with them. Therefore, there is a pop-up

screen for each of these as defined in the TERMS file key. For example, for prompt #13, the pop-up window is shown in Figure 504 below.

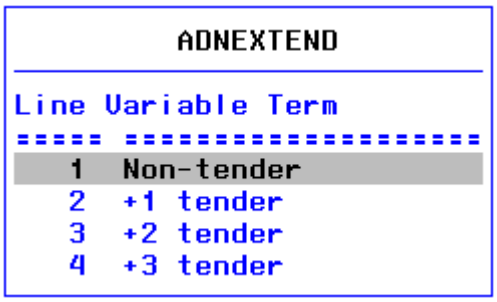


Figure 504
Pop-up for Defined Procedure.

You can page up or down to see a full list of options, and then pick the most appropriate. Had this prompt been indicated as “FREE” in the “Terms File Name:” field, then no pop-up window would be shown, and the prompt will take any free text you enter. It is suggested that you add something to the prompt to indicate that the entry field is free text rather than a pop-up from the Terms file. This could be done specifically as “Free Text Field”, or implied such as “L ADN Ten (FT)”.

The <F9> Key , “**Narrative**”, will bring up the defaulted narrative note as shown below in Figure 505.

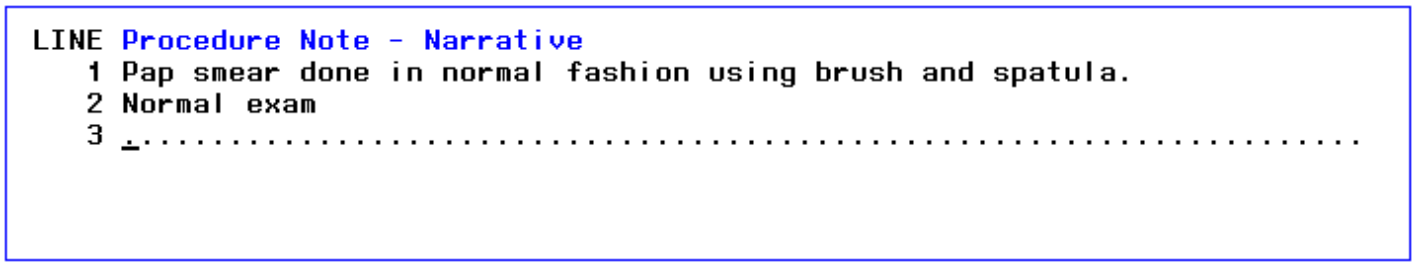


Figure 505 *Defined Procedure Note screen.*

You are placed on the next line of the narrative note where you can add notes. If you hit <F1> to “end”, then you will be placed at the change prompt. Here, you can add, change, or delete any lines in the note.

A chart review of this note after completion is as shown in Figure 506 below

MENU SELECTION #27, “PROCED. RPT. DELETE”, follows the same logic as that of menu selection #3, “**SYMPTOM DELETE**”, above. If you think a Procedure Report should be deleted, ask the system administrator to do this for you. The administrator can then check to be sure no one else is currently using this Procedure Report before deleting it.

```
17 Procedures Performed
18 ----------------------------
19 Indication OTH.NONSPECIF ABNORM PAP SMEAR OF CERVIX
20 CPT Code   Q0091
21 CPT        SCREENING PAP SMEAR
22 ------------------------------------------------------------------------
23   EXT GEN         Normal
24   VAULT           Normal
25   CERVIX PRES     Yes
26   CERVIX DC       No Discahrge
27   UTERINE POS     Midline
28   UTERINE SIZ     Parous NI
29   R ADNEXA SZ     Normal
30   L ADNEXA SZ     Normal
31   R ADNEX TEN     Non-tender
32   L ADNE TEN      Non-tender
33 Procedure Narrative
34   Pap smear done in normal fashion using brush and spatula.
35   Normal exam
36 Provider: STEVE J. JOHNSON, MD
```

Figure 506 Review of Defined Procedure Note.

CHAPTER 10 SUBSTANCE FILES

USING THE SUBSTANCE FILE FOR WRITING PRESCRIPTIONS.

Locating the substance you want quickly.
In addition to the standard cross-reference lookup ability of the system (based on the substance's generic or brand name), you can also look up a substance by category. Several terms have been added to the alternate description of many drugs in our system to make it easier to list and locate these drugs by category. The terms include allergy, antibiotic, antidepressant, asthma, BCP (birth control), BPH, cholesterol, diabetes, HTN, migraine, vaccine, and seizure. Also, if general drug categories (such as NSAID, opioid, ACE inhib, SSRI, beta block...) are entered, those substances in our file will be listed.

Pediatric and adult dosing.
Many drugs have had pediatric doses added. If a drug has "-ped" or a specific dose (frequently in mg/kg) or a maximum dose listed following the generic name, that dose is for peds (ie: amoxicillin-40mg/kg/d and propranolol-ha-max30mg/tid). While it appears that there are many more options in choosing a drug, in reality, the adult screen remains unchanged. Those treating only adults are able to choose a drug that has a pediatric dose and prescribe as they did before (i.e.: the adult screen for amoxicillin-45mg/kg/g-bid capsule is identical to amoxicillin-80mg/kg/d-tid capsule). Remembering that not all forms have the same strengths (i.e.: amoxicillin tablets are 500mg and 875mg while amoxicillin capsules are 250mg and 500mg), just choose the form you want -- capsule, tablet, chewable, suspension.

For those treating pediatric patients, choose the dose you want and the system will automatically prescribe the appropriate amount based on the patients weight. Since the dose of some drugs (i.e.: adderall) must be individualized for each patient, we provide one entry to allow you to enter the dose you want. For example, for adderall we have entered multiple peds doses. There is also one entry without a peds dose. In this case, the pediatric screen values for amount and frequency default to "**as below**", allowing you to enter the dose you want.

Dosages based on disease.
Medications often are prescribed in different dosage amounts based on the specific disease being treated. To make the defaults in the selection screens appropriate for a specific disease, the SmartDoctor® system shows the drug with the disease specific indication appended to the substance description. This can be seen in Figure 507 below.

In this case picking the highlighted line will result in appropriate dosing for a pediatric patient for otitis media, by simply accepting the defaulted dosages. Obviously, the dosing of this antibiotic is different for the 4 conditions noted, or they wouldn't exist here.

Disease contraindications.
Disease contraindications in the prescription system use the three digit categories of the ICD-9-CM. It would be impractical to have every possible code categorized. However, since the 3 digit code represents all codes of a higher specificity of that primary code this works well in almost all circumstances. For example, category 510, emphysema, contains a variety of forms of emphysema. However, for all practical purposes, diseases listed under the three digit category of 510 would function well regarding disease contraindications. Approximately 99.9 percent of the time using the three digit categories will work perfectly. However, any inaccuracy is on the

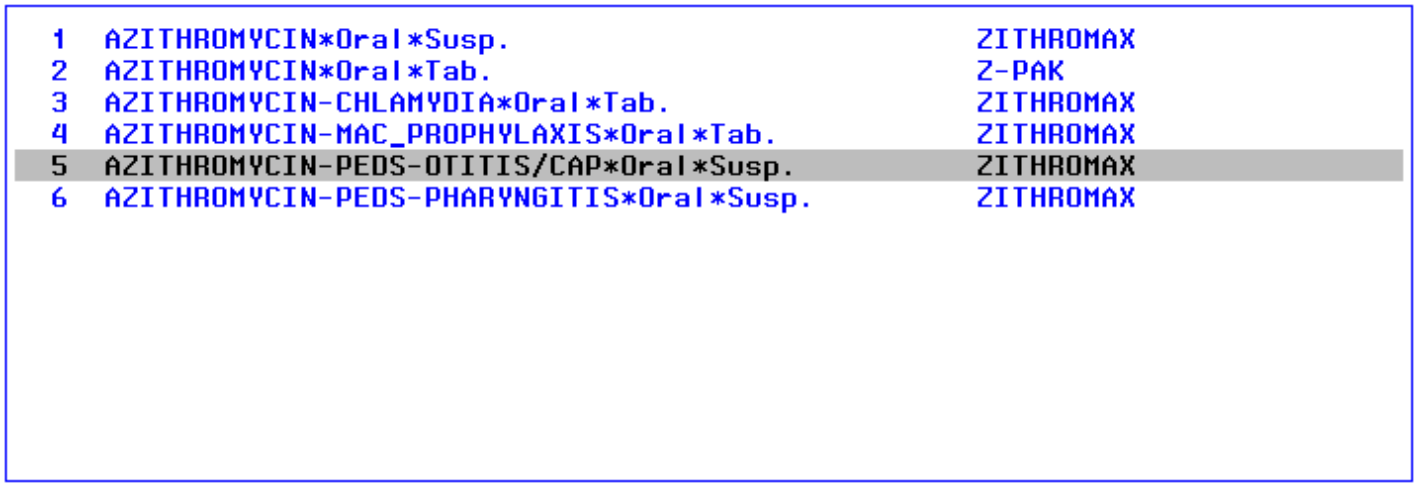


Figure 507 Dosage Based on Disease.

conservative side. For example, in the case of the three digit category No. 427 “Cardiac Dysrhythmias”. The system indicates that a beta blocker may have a “Relative Contraindication”. Although most of the conditions listed under that 3 digit code are tachycardias, and may appropriately be treated with a beta blocker, this is flagged because category No. 427.81 “Sinoatrial node dysfunction” which includes in its description “Sinus Bradycardia”. In this case it would be unlikely you would want to have the patient on a beta blocker.

Blocked/Deleted drugs.
As drug formulations change, such as the drug manufacturer reformulating Diovan from a capsule to a tablet, we need to stop prescribing the old formulation. Also, as new information about interactions change, we may need to reclassify drugs in the system. However, a patient may have indicated an allergy to one or more components of the old drug, and therefore, we must keep it in the database. To do this we removed the brand name and replaced it with "*NOT FOR RX, HISTORY ONLY".

Therefore, if you try to write Diovan by placing "dio" or "diovan", you will be presented with the correct choices. However, if you enter "valsartan" or part of this, you will see all the generic choices including those that were blocked. In place of the brand name you will see "*NOT FOR RX, HISTORY ONLY". If you try to prescribe this drug you will get an age limit restriction, because we set the minimum age to 99 and the maximum age to 1.

If you try to refill one of these old formulations, you will also get the same age restriction. We recommend you delete this drug from the patient's medication list and write a new prescription.

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