Med✚Suite

1402 SE 47th Strees
Suite 4
Cape Coral, FL 33904

http://www.medsuite.net

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MedSuite

Med-Suite

Version 7.0

MedSuite

President

...Philip Warenik

Vice President of Operations

...Sherri Warenik

Development Team

...Cameron Cole
...Timothy Dibble
...Laura Parker

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1   Introduction

MedSuite is both the name of a company and of a product. When this document refers to "MedSuite", it is almost always referring to the MedSuite product. If the context in which the reference to MedSuite is unclear whether the document refers to the company or the product, the document will clearly indicate to which entity it is referring. The section of this document called MedSuite - The On Demand Model introduces two ideas; one is On Demand Software and the other is an Application Service Provider or ASP. MedSuite, the company, can be thought of as an ASP. MedSuite, the product, is and is sometimes referred to in this document as an On Demand Software.

- MedSuite - The On Demand Software Model
- MedSuite - The Product

1.1   MedSuite - The On Demand Software Model

A revolution in the use of shared computing resources that uses the internet as a wide-area network is underway. Most readers are familiar with using the internet to "surf-the-web" or send email. On Demand software is a business application like an accounting system or a medical practice management system that is used over the internet. The server-side of the application (databases, business rules, etc.) is hosted in a separate location from the end-users of the application. The client-side of the application (user-input) may access the application from virtually any place that has an internet connection. With On Demand software, the internet is used as a transport layer to send data back and forth between client and server. The data resides on the server-side. All of the processing of data, such as generating claims and statements, producing reports, etc. is also done on the server-side.

A company that "hosts" or offers On Demand software is often referred to as an Application Service Provider or ASP. The ASP handles backups, application software updates and upgrades, hardware maintenance, operating system upgrades, and all of the other tasks that can make having a system in your office a burden. During the internet bubble of the late 1990's, the first generation of ASPs acquired somewhat of a bad reputation that was not totally undeserved. Many of these ASPs were offering legacy "turn-key" applications which used the internet as the transport layer. These legacy applications were based on older technology that were using operating systems like Citrix or Microsoft's Windows Terminal Server to extend the life-span of their aging applications. In addition, many of these first generation ASPs were venture capital funded internet start-ups simply trying to cash in on the internet bubble. Only in rare cases were these ASPs using new technology designed for the internet.

Most turn-key practice management software products are licensed on a "per-seat" basis where the client pays for each user (or seat) that will access the product. In the On Demand Software Model, the client is usually charged transaction fees (sometimes referred to as "per-click" fees) for the use of the On Demand software as opposed to the large up-front costs and long-term commitments associated with the "turn-key" application model. Almost all of the first generation of ASP's were existing companies that historically sold turn-key systems. Their expense structure, the so-called "burn rate", was not built around the concept of pay-as-you-go transaction fees. They needed the cash infusion that occurs when a turn-key system is sold. This first generation of APS's were destined to perish simply due to the fact that their funding mechanism would not last long enough for their monthly transaction fee revenues to catch up to their monthly burn-rate. In addition, if one of these first generation ASP's was a public company, they had to have the cash infusion that occurs when a turn-key system is sold to satisfy the demands of investors and Wall Street analysts. "Wall Street" would not accept a reduction in revenue for two to three years while the ASP built up their recurring monthly revenue stream.

MedSuite's software is licensed on a transaction fee basis. These transactions include Anesthesia Cases, Encounters, Electronic Claims, and Electronic Remittances. Client license fees are solely based upon the client's actual volumes of these transactions. We believe that the transaction based pricing model creates an environment in which benefits both the client and MedSuite. We have to earn our client's business every day.

1.2   MedSuite - The Product

The principals that developed MedSuite have over 75 years of combined experience in the development, marketing, implementation, and support of medical practice management information systems. The bulk of that time was spent serving the needs of anesthesia practices and billing services. When we began to design the MedSuite product, we believed that there was a need for a new software product that could address the requirements of large multi-practice and multi-specialty billing organizations. Many large practices, particularly hospital-based physician practices such as anesthesia practices, tend to handle their own internal billing as though they were a billing service.

We felt that the problem with most medical practice management applications was that they simply were not designed for the large billing organization. We felt that these products were designed for a single practice, but are often used in large billing organizations. These products generally maintain each practice in a separate database. As a result, much of the setup information maintained by these products is duplicated and maintained for each practice. This may seem like a trivial issue to an organization managing a practice or two or three. However, something as simple as updating CPT and ICD9 codes every year for 20 or 25 practices can become a monumental problem fro a large billing organization.

While this may appear to be a statement of the obvious, multi-practice billing organizations tend to use the same coding structure(s) across their client base. They use the same insurance codes, payment codes, adjustment codes, billing messages, etc. We wanted to provide this capability while only requiring the maintenance of one set of codes for the entire billing service where possible. Why make the billing service maintain a complete set of billing messages for each of their clients when a single set will be sufficient?

We determined that the best approach towards solving this problem would be to implement a structure in which all of the practices for a billing organization are maintained in a single database and that each billing organization (MedSuite customer) would be maintained in a separate database. This approach provides the ability to "share" some of the setup information between practices within a billing organization. Since MedSuite had plans to develop On Demand Software and to become an ASP, this approach also offers the added benefit of physically segregating and securing the data of one billing organization from that of another. We felt (and still do today) that this physical separation is preferable to simply separating the data for these organizations by using a company code of some sort within a single database.

In effect, the billing organization is the client of MedSuite and may be a billing service, MSO, or physician practice. Nevertheless, the billing organization will use the same coding system(s) for each of their clients or practices. This model works quite well in billing services and MSOs. In the past decade, we have seen many physician practices merge into ever larger practices. We have also seen physician practices "spin-off" their billing office as a separate billing service both to spread some of the cost of billing onto other outside practices as well as to seek additional income opportunities for the physicians in the practice. So while a physician practice client might not need the multi-practice capabilities of MedSuite at first, having this capability available at the "flip-of-a-switch" can be a huge benefit.

2   Technology

MedSuite uses the ASTA communication architecture for Windows-based applications. The architecture of the MedSuite's On Demand Software is enabled by two fundamental technologies that we believe make the MedSuite's On Demand Software different from other enterprise medical billing and practice management applications.

N-Tier

What exactly do we mean when we talk about n-tier (or multi-tier) applications? An n-tier application is simply one which has the capacity to run on multiple physical machines. The ancestor of n-tier application technology is the client/server application technology where there is delineation between the client and the database server that is most likely located on a server machine on a local area network. These applications are commonly called "fat client", as most of the business logic for the application lies on the client side.

The evolution of n-tier was spurred by the realization that performance, scalability, deployment, sharing of functionality and application maintenance could be significantly enhanced by dividing application functionality into any number of separate tiers. This allowed applications to be developed where each key part of the business logic could be encapsulated in its own process. This provided the ability to deliver real "thin clients", as most of the applications functionality could be stripped out of the client to be located appropriately on a server or other machine visible to the client. Thus, the 'n' in n-tier simply denotes an undefined number of tiers. The most common manifestation of the n-tier paradigm is the 3-tier model. This entails the following logic:

- User interface functionality is located in the client application
- The majority of business logic is located in the middle tier (sometimes called an application server)
- The data is located within a database which is managed by a DBMS

While the above example is a very simple explanation of the paradigm, it is adequate to explain the concept – in reality; some program functionality may be shared between tiers.

So what is happening in each of these three tiers? The client application manages the user's interaction with your system. It includes all of the screens and dialogs that allow the user to interact with your program. The application server (or middle tier) includes the actual business logic – this tier provides the main functionality. The middle tier (as its name suggests) manages and controls all interaction between users and the database tier. Finally, the DBMS/database tier includes your actual data and the processes required to manage that data.

Scalability

Scalability is a significant issue with n-tier systems. When we developed MedSuite, one of the issues we wanted to address was that we wanted to ensure that server resources are properly managed. MedSuite optimizes resource usage based on expected client utilization levels. Servers can automatically expand available connection resources without user intervention to cover peak usage requirements without the need for programmer intervention.

Deployment

MedSuite is easy to deploy. MedSuite uses TCP/IP for the transport of messages between tiers, requiring no additional communication protocol and no component registration. There is no need for

COM/DCOM or other such technologies. MedSuite also provides the ability to automatically update client applications to the most recent version. The server keeps track of the most recent version of each client application. At login, if the server detects that the client is running an older version of the client application, then the server will stream the latest version back to the client.

Security

MedSuite utilizes high performance encryption and access control methodologies to its servers. It uses certificate based encryption, unique session keys, firewalling, message switching and logging. It provides unparalleled protection for your servers and your data.

Internet/ASTA

The World Wide Web ("WWW" or "the web"), and the servers and browsers that make it work, are fantastic and highly useful pieces of technology. But like all tools, the web has appropriate and inappropriate uses. Whether you entrust your business to a technology like the web or a technology like ASTA is a question of appropriate use.

The following table contrasts browser-based applications and the MedSuite's On Demand Software:

	Browser-Based	**MedSuite On Demand**
Appropriate Use	Lightweight Applications. Web is ill-suited for data driven, enterprise-wide business applications	Heavyweight Application. Specifically designed to be a data-driven, enterprise-wide business application
Protocol	HTTP - Stateless and therefore connectionless; Cannot "push" data to a client	Maintains state and connection; Can "push" data to clients
Interface	HTML - Appears to be rich, but is actually lacking in both features and development tools.	Rich feature-set built with state of the art development tools.
Java / Active-X / etc.	Deployment is problematic and complex. Often lose platform independence offered by browser	Not necessary

Appropriate Use

We believe that the classic web architecture - a light browser, a protocol like HTTP, and a server – is the best way to handle many lightweight applications. A website is an example of an appropriate use of this technology – the web is great for presenting read only data. Even though the technology used by the MedSuite's On Demand Software can (and does) perform this task, it is handled well by the WWW and is the better choice for publishing static pages of information. But while the WWW is good for simple data, we feel that it is a poor choice for implementing complex applications, even with Java or ActiveX. The web seems particularly ill-suited for data-driven, enterprise-wide, business applications.

Protocol

The problem with the web is fundamental to it's architecture and manifests itself the protocol called HTTP and the fact that this protocol is stateless. A "stateless protocol" is one where the connection is not maintained. Put simply, the web can't "push". Clients can ask the server for information, but the server cannot send information to the clients that clients did not specifically ask for. For instance, a customer might trade stocks using a browser on the Internet. But the brokerage notifies the

customer that their stock trade has occurred by sending email. This is the result of an architecture built on a stateless protocol; the server cannot update the browser. While this is not a critical problem for a casual surfer, it is unacceptable in a business environment.

Interface

The second problem with the web is the limitations of Hyper Text Markup Language (HTML). At first, it appears that the web has a rich interface - look at all the rich text, images, video and even audio! These media can be readily delivered in business applications. They simply haven't been. Why? Probably because most businesses are more concerned with basic commerce than entertainment. Hopefully, as a result of the web, "regular" applications will become more lively without sacrificing their usefulness. But despite the varied media riches, HTML is not practical for business tasks. HTML has inadequate database support and interface tools.

Java / Active-X

Java, ActiveX and other embedded browser-based technologies have their own problems. Essentially, once program code other than the browser is deployed on the client, you are faced with significant deployment problems. In addition, the platform independence promised by the browser-based application is lost with Active-X technology in particular, but also to some degree with Java and other technologies.

The MedSuite's On Demand Software

The MedSuite's On Demand Software was designed from the ground up to be use an N-Tier architecture. This isn't an academic issue, it's a very practical one. At MedSuite, we wanted to take the best features of the web and balance them against the needs of medical practice administrators and executives. We wanted to take the best features of the web and then add the capabilities that are critical to practice administrators and executives. We wanted to purposefully avoid the "bleeding edge" pitfalls of other technologies. We wanted to deliver a thin client application that can be centrally controlled, installed, and upgraded. We wanted the business rules of the application to be maintained at a central server. We wanted to use a proven near-universal technology standard like TCP/IP and minimize the bandwidth requirements of the application. We wanted to develop an application with a small "footprint" that would run well on older inexpensive PCs even over a dial-up line.

We believe that the MedSuite's On Demand Software meets all of these goals and more!

3   Getting Started

In this section, we review information that is both helpful and necessary in getting started using the MedSuite's On Demand Software. This information includes:

- Application Terminology   Learn and review basic application terminology as it relates to accounts, patients, subscribers, plans, etc.
- User Interface   Learn and review basic user interface terminology, how to use the mouse and the keyboard, understand the names and functions of visual components, and recognize visual cues.
- Setup Concerns   Discussion of some setup issues that you should review before you start
- Setup Sequence   Discussion of the proper sequence of loading support table data so that you don't run into "blind alleys" during the setup process.

3.1   Application Terminology

The following is a list of terms that you may find useful when reviewing this document:

▼ **Company**

Both billing services and large practices usually use the same insurance codes, payment codes, adjustment codes, billing messages, etc. across their client practices. We wanted MedSuite to provide this capability while only requiring the maintenance of one set of codes for the entire billing service, where possible. Why make the billing service maintain a complete set of billing messages or payment code for each of their clients when a single set will be sufficient? These requirements led us to define the concept of a Company.

The data for each company is maintained in a separate database. This not only allows certain codes to be maintained and shared at the company level, but it also provides the added benefit of physically segregating and securing the data of one company (billing service) from that another, rather than simply separating the data by using a client code of some sort.

▼   **Practice**

The primary objective of MedSuite is to satisfy the practice management requirements of complex physician organizations. We reasoned that if MedSuite can satisfy the practice management requirements of a complex physician organization, then a simpler organization such as a solo physician in practice or a small group of physicians in practice should be easily satisfied as well. Let's examine a fairly complicated physician organization:

Assume that there is a group of physicians who call themselves Anesthesia Associates of America. These physicians may provide services in multiple hospitals and/or surgical centers. They may provide services for patients in need of anesthesia services, chronic pain management services, and critical care services. They may be legally organized together in one or more partnerships, professional associations, or professional corporations. From a legal and tax position, they may function as separate individuals. They may call themselves "Anesthesia Associates of America" in order to appear to the outside world as a single entity. They may be multiple legal entities that are divided on physician lines, facility lines, or type of service lines. The number of ways to divide such an organization is at least equal to the number of physicians in the organization.

We are not really concerned with all of that. We are only concerned with two fundamental questions:

- Who are the physicians that comprise the group of physicians that call themselves Anesthesia Associates of America?
- How are the services provided by the physicians who call themselves Anesthesia Associates of America allocated to the separate legal entities that operate under the umbrella organization Anesthesia Associates of America?

In MedSuite's nomenclature, the term "practice" performs two functions. First, it allows us to define the organization called Anesthesia Associates of America as a reporting "roll-up". Second, and perhaps more importantly, is allows us to greatly reduce the replication of data and ease the maintenance chores within this organization.

▼ **Division**

A division represents an entity that is formed for the purpose of providing medical services to

patients and billing for these medical services to patients and their insurance carriers. Simply put, in our definition above, a division is a legal entity that has a Tax ID number, files Federal and State income tax returns, receives 1099's from insurance carriers, owns assets including bank accounts and real property, etc. In short, it is a "business".

In MedSuite's nomenclature, the term "division" performs two functions. First, it allows us to define the legal entity called Anesthesia Associates of America as a reporting "roll-up". More importantly, is allows us to separate the financial data of different legal entities that may be operating as a single "practice" but which are actually different businesses whose funds cannot and should not be co mingled.

In the practice example provided previously, Anesthesia Associates of America may be set up as one or more divisions. All of the services provided by the physicians that comprise the **practice** Anesthesia Associates of America may be provided by a single legal entity (i.e. **division**) called Anesthesia Associates of America. Conversely, the services provided by these physicians may be allocated to several legal entities (i.e. **divisions**) by type of service and called the Anesthesia Division, Chronic Pain Management Division, and Critical Care Division. However, the services provided by these physicians could be allocated to several legal entities (i. e. **divisions**) by the location in which the service was performed and called the Hospital A Division, Hospital B Division, etc. Practically any reason one can imagine may be used to define the division. The important fact is that a "practice" may and often does consist of several legal entities. Our goal is to accommodate this requirement without putting too many unnecessary restrictions in place.

▼ Physician

A physician is a person who is licensed to practice medicine by the state in which he is practicing. A physician is a member of a practice but performs services under the legal umbrella of a division. Since both the physician and the division are living, legal entities, identifying numbers may be assigned to either the physician or to the physician within a division. If in our Anesthesia Associates of America example the anesthesia services, chronic pain services, and critical care services were billed under separate divisions, each physician would have a personal social security number, a UPIN, and a state license number. In addition, in order to bill certain carriers under the division, a physician may also need a number assigned by the carrier for each division. Examples of this include Medicare numbers, Medicaid numbers, etc. Physician is a standard sort and control-break function in the software.

▼ Assistant

An individual who is licensed or certified to assist a physician in the practice of medicine. An assistant may be a Physicians Assistant, Nurse Practitioner, Certified Registered Nurse Anesthetist, Anesthesia Assistant, etc.

▼ Facility

Hospital-based specialties such as anesthesiology lend themselves well to the concept of a "facility". Under MedSuite's nomenclature, a facility is simply the physical address where a service was performed. Generally, a facility may be thought of as a "hospital". However, a hospital may be spread across a large campus with a number of physical locations. A facility may provide services that are performed in a number of HCFA/CMS Places of Service. Facility is a standard sort and control-break function in the software.

▼ Location

The place of service (HCFA/CMS) where the service was rendered. May be the same or a different street

address as the facility.

▼ O/R Suite

Frequently, the contract between the hospital and the anesthesia practice providing anesthesia services calls for the anesthesia practice to cover a defined number of "rooms" or O/R Suites. These suites are often not fully utilized. In turn, this requires that more anesthesiologists will be required to provide anesthesia for the number of surgical cases performed. Analysis reporting by suite is often required to convince hospital administrators that the staffing model is inefficient and places an unreasonable financial burden on the anesthesiology department.

▼ Patient

A patient is the person to whom the physician is providing medical services. The patient exists at the practice-level and may have multiple sets of active insurance thereby eliminating the need to have multiple "patients" representing the same person.

▼ Account

The person or entity who is legally and/or financially responsible for the patient.

▼ Subscriber

A subscriber is the person who is holds the insurance under which medical services provided to the patient will be billed. The subscriber and the patient may be one and the same person or they may have some relationship such as spouse, parent and child, or something else altogether. The subscriber and the account may be one and the same person or they may have a some relationship such as spouse, parent and child, or no relationship at all. A subscriber exists at the practice-level.

▼ Carrier

A carrier is an insurance company, health maintenance organization, self-insured corporation, or healthcare intermediary. Under our definition, a carrier is effectively a reporting entity. The definition of schedules of benefits, fees, claims processing functions, etc. does NOT take place at the carrier level. These functions are defined at the plan level. A carrier may have multiple plans.

▼ Plan

The plan is the place where the detail that supports the definition of contract parameters, calculation of billed and allowed fees, and the submission of claims is defined.

▼ Policy

A policy is the "intersection" of a plan, a patient and a subscriber. A policy also maintains other information such as the policy type, policy number, group number, eligibility dates, etc.

3.2   User Interface

Since the MedSuite's On Demand Software was designed to be used in large practice settings, particularly multi-specialty practices and billing services, we paid great attention to the need of these organizations to quickly and efficiently enter the data necessary to operate and analyze their businesses.

Applications with a graphical user interface or GUI (pronounced "gooey") often are unreasonably dependent on the use of the mouse for data entry. By that we mean that some functions can only be performed by removing your hand from the keyboard, grasping and moving the mouse to the appropriate location on the screen, and then left-clicking, right-clicking, double-clicking, dragging-and-dropping, etc. The very nature of GUIs means that you will be presented with a variety of buttons, grids, tabs, lookups, widgets, and gadgets (collectively known as "components") that are all begging you to 'click me'. MedSuite has all of that.

MedSuite has been designed for large billing organizations in which efficient "heads-down" data entry is a major concern. The mouse usage required by many GUI applications results in tremendous data entry inefficiencies. MedSuite has been built with the ability to allow the user to "drive" the application almost completely without resorting to the mouse. In the section Using the Keyboard, key sequences and shortcuts that will help the user resist the temptation to use the mouse are addressed. We ask the reader to learn how to use the keyboard. There really are only a few things to remember. Drive the application, don't let it drive you.

The User Interface subjects discussed in this section include:

- Terminology   Learn and review basic user interface terminology
- Using the Mouse   Learn and review terminology as it regards the use of the mouse
- Using the Keyboard   Learn and review terminology and keystrokes that will be helpful in using MedSuite to its fullest potential
- Visual Components   Learn and review terminology as it regards the visual components of the user interface
- Visual Cues   Learn and review the visual cues provided by the user interface and what they mean.

3.2.1   Terminology

The following table provides a list of the basic user interface terminology that is used throughout this document:

Term	What Does it Mean
Component	Any 'object' including menus, buttons, text fields, grids, and many others.
Icon	An icon is a small image that represents a function. They are normally used on button, menus, and special field types. The image should give you a graphical representation of what you should expect its underlying component to do when you click on the icon. An example of an icon is the check mark that appears on the Ok Button. It seems to say "everything is ok".
Form	A form is any panel with a caption bar and one or more components. It may also be referred to as a 'window'.
Modal Form	A form is said to be modal when the user must close the form by selecting either the OK button or the Cancel button on the form before any other action(s) in the application can take place.
Focus	The component that is currently 'active' is said to have focus. This means that the next action that the user performs with the mouse or keyboard (a keystroke for example) will occur on the component with the focus. This is not to imply that the action taken by the user will actually do anything to the component. For example, pressing the letter 'a' while a button has focus will not likely invoke any action by the button. However, entering the letter 'a' in a text field will enter the letter 'a' into the field. Some actions such as moving the mouse pointer over a different component will cause the focus to move to the component 'under' the mouse pointer. A component can receive the focus by: • Tabbing to the component • Pressing enter and having the program move focus to the next component on the form • Clicking the mouse on a different component • Setting the focus to a component programmatically
Tab Order	The "sequence" of fields on the form or window. The focus will go to the next component in the Tab Order when Tab is pressed. It will go to the previous component in the Tab

	Order when Shif+Tab is pressed.
Enabled	A component may be visible on the form but not enabled. If a component is disabled: • It will be greyed-out • Data cannot be keyed into it • It cannot have the focus • It is not in the Tab Order (cannot be tabbed to)
Context	Frequently, a component, form, or application will behave differently depending on how a function is accessed. For example, word processors behave very differently when a document has been opened as opposed to when there is no open document. In the "open document" mode or context, functions that edit, copy, paste, cut, and delete text are available. These functions are not available when the word processor is running but no document is open.
Wizard	A set of forms that steps the user through a complicated function.

3.2.2   Using the Mouse

The following table provides a list of the mouse usage terminology that is used throughout this document:

Action	How to Do It	What Does it Do
Click	Click once on the 'left' mouse button. We use the term 'left' loosely here. Control Panel lets you configure a mouse as either right- or left-handed (and reverse the buttons). If the mouse is configured as right-handed, the left mouse button will perform a 'click'. If the mouse is configured as left-handed, the right mouse button will perform a 'click'.	Selects the 'default action' of virtually every 'gadget' available on a form including menus, buttons, lookup fields, date fields, grids, radio buttons, check boxes, list boxes, drop-down lists, etc.
Double-Click	Click twice (quickly) on the 'left' mouse button. See 'Click' above for a discussion on the left and right mouse buttons.	Selects the 'default action' (OK or Edit) on the selected item in a search list or lookup list.
Right-Click	Click once on the 'right' mouse button. See 'Click' above for a discussion on left and right.	Cut/Copy/Paste in text fields Add/Remove Columns in certain grids Activate Popup Menu in certain grids
Drag-and-Drop	Left-Click and while still holding down the mouse button, drag the mouse to the location where you want to drop.	Select Report Sorting Options

	Release the mouse button when you are at the location where you want to drop.	

3.2.3   Using the Keyboard
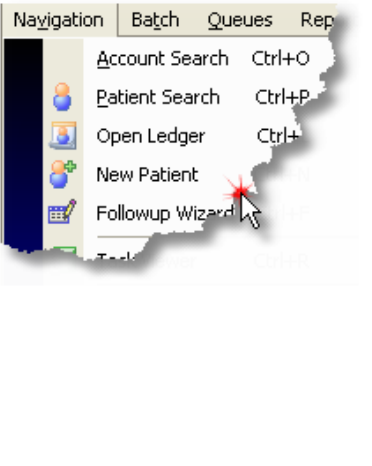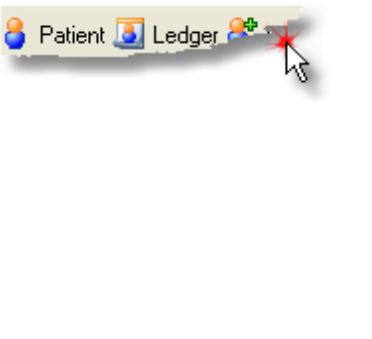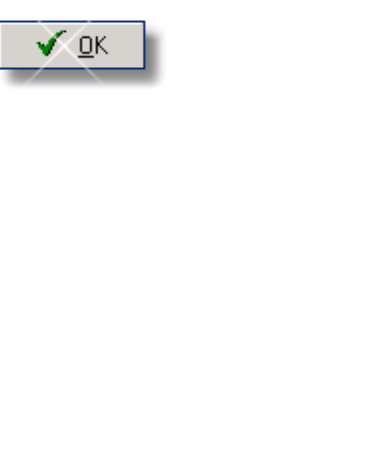
The following table provides a list of the keyboard usage terminology and keystroke or keystroke combinations that are used throughout this document:

Key	How To Do It	What Does It Do?
Space bar	Press the SpaceBar	If the control that has the focus is a control that accepts mouse clicks (such as a radio button, a check box, or a button) the Spacebar will "click" on the control as if the mouse were clicked. In a grid control, Spacebar will behave as if the selected row had been double-clicked by the mouse. If the control that has the focus is a text field, the Spacebar will erase the field (if it is selected or add a space to the field.
Tab	Press Tab	The focus will move to the next control in the tab order (generally left to right and top to bottom) on the form or window.
Shift+Tab	Hold down the Shift Key and press Tab	The cursor or focus will move to the previous control in the tab order (generally right to left and bottom to top) on the form or window.
Alt+Letter	Hold Down the Alt Key and press the Letter	Some functions have been programmed with shortcut keys that are activated by holding the Alt key and pressing the key indicated on the menu or other control. The shortcut will "click" on the menu or control in question. The menus or controls that operate using the Alt+Letter key sequence contain an underline under the letter that activates the 'click'.
Ctrl+Letter	Hold Down the Ctrl Key and press the Letter	Some functions have been programmed with shortcut keys that are activated by holding the Ctrl key and pressing the key indicated on the menu or Navigation Bar. The shortcut will "click" on the menu or button in

		question.
Ctrl+Tab	Hold Down the Ctrl Key and press Tab	The [focus](#) will move to the next tab in a [tabbed dialog](#).
Ctrl+Shift+Tab	Hold Down the Ctrl and Shift Keys and press Tab	The [focus](#) will move to the previous tab in a [tabbed dialog](#).
F4 & F5 Keys	Select the F4 or F5 function keys above the numbers on the keyboard	The [focus](#) will move to the next field labled with purple font in the New Patient demographic screen allowing the user to jump to fields labeled with purple font on the screen.

3.2.4   Visual Components

Graphical User Interface or GUI, (pronounced "gooey") terminology will be tossed about in the Help resources of the MedSuite On Demand Software. It is important that the you understand this terminology. We will first talk about the visual components of the GUI and then discuss the actions that may be taken on those components.
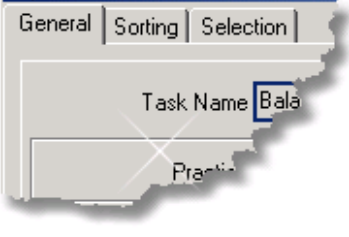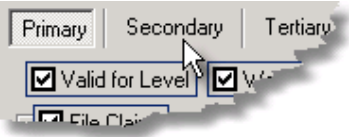
Component	Name	Description
	Menu	All functions in MedSuite's On Demand Software are available in the Menu system. Menus operate in much the same way as they do in any other GUI application. A menu may be activated by: • Clicking on it with the mouse • Pressing the applicable Alt+Letter keys • Pressing F10 and navigating through the menus using the arrow keys • Pressing the Applicable Ctrl+Letter keys
	Toolbar	The most commonly used functions of MedSuite's On Demand Software are available from the Toolbar. Toolbars operate in much the same way as they do in any other GUI application. A toolbar may be activated by: • Clicking on it with the mouse • Pressing the Applicable Ctrl+Letter keys
	Button	Buttons allow the user to Add, Edit, Delete, Search, Save, Cancel and many other functions. Buttons generally use speed-keys (of the Alt-Letter variety) The letter used to select a button in underlined on in the buttons description or caption. Buttons may be 'pressed' by: • Clicking on the button with the mouse • Pressing the applicable Alt+Letter keys • Pressing Spacebar when the button has focus

	Practice Selector	MedSuite's On Demand Software is a multi-practice environment. The user selects a company when logging in to the software. The user should select a 'current' practice to use within the company. The currrent practice may be changed to another practice within the company at any time.
Practice Meyer Anesthesiology Assoc.P.C		
	Text Field	Non-required text entry fields are outlined with a blue border.
	Text Field - Required	Required text entry fields are outlined with a green border.
Female	Lookup Field	Lookup fields are specialized text entry fields. These fields perform 'lookups' on other dictionaries. Lookup fields are indicated by the binoculars superimposed over a table or spreadsheet icon at the end of the field. If entered, the lookup field forces the user to select a valid dictionary entry. The lookup function may be invoked by: • Typing in the lookup value of the dictionary • Pressing F9 and searching the dictionary • Clicking the binoculars icon searching the dictionary
613-Administrative Servi	Lookup Field - Required	Lookup fields may be required entry fields. Required lookup fields are outlined with a green border.
09/28/1979 □□□ << < December, 2002 > >> Sun Mon Tue Wed Thu Fri Sat 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 ✓ OK ✗ Cancel	Date Field	Date fields are specialized text entry fields. These fields perform date lookups. If information is entered, it must be in the form of a valid date in MM/DD/YYYY format. The date field automatically handes the slashes in the date. Date fields are indicated by the calendar icon at the end of the field. Date fields may be entered by: • Keying in the date • Clicking on the calendar icon and selecting the date from the displayed month-at-a-glance calendar

		• Pressing F9 and selecting the date from the displayed month-at-a-glance calendar
		A two digit year may be entered by the user. If the date entered has a two digit year, the year will be resolved to a four digit year as follows:
		• If the year is greater than the current year and less than or equal to 99, it will default to 19xx.
		• If the year is less than or equal to the current year and greater than or equal to 00, it will default to 20xx.
		• Dates with years less than 1900 can be entered with a four digit year.
11:25	Time Field	Time fields are specialized text entry fields. These fields perform time lookups. If information is entered, it must be in the form of a valid time in HH:MM format (24hr clock). The time field automatically handles the colon in the time. Time fields are indicated by the scroll arrows icon at the end of the field. Times may be entered by:
		• Keying in the the time
		• Selecting either the hour or minute portion of the time (by suing the mouse or arrow keys and 'scrolling' the hour or minute up or down using the scroll button.
$676.00	Calculator Field	Calculator fields are specialized text entry fields and are indicated by the calculator icon at the end of the field. These fields allow the user to enter numeric digits into the field either by keying the digits into the field or by invoking a calculator, peforming the calculations, and "pasting" the results into the text entry field. The calculator may be invoked by:
		• Clicking on the calculator icon with the mouse
		• Pressing F9 from within the calculator field
		The results of the calculation are then pasted into the amount portion of the

		field.
Employment	Radio Button	The radio button indicates true/false values. Radio buttons are always used in groups of two or more. The radio button 'group' is always surrounded by a box that is indicated by a dark-grey border and optionally a caption or description. Only one radio button in a group can have a "true" value at any given time. When one radio button is toggled "on" or "true", the rest of the radio buttons in the group are automatically toggled "off" or "false". Therefore radio buttons are used in "OR" situation (A or B or C). Radio buttons may be 'toggled' on by: • Clicking on the desired radio button with the mouse • Pressing the spacebar when the desired radio button has the focus
Emergency	CheckBox	The checkbox indicates true/false values. Unlike the radio button, each checkbox is operated independently of other checkboxes and of radio buttons as well. Therefore checkboxes are used in "AND/OR" situation (A and/or B and/or C). Checkboxes may be 'toggled' on by: • Clicking on the desired checkbox with the mouse • Pressing the spacebar when the desired checkbox has the focus
Regular	Drop-Down List	The drop-down list field is used to allow the user to select from a list of specific values. MedSuite generally uses the Lookup Field rather than drop-down lists. This is due to the fact that Lookup Fields are more flexible the drop-down lists. There are a number of instances where drop-down lists are appropriate and are used. Values in a drop-down list may be selected by:

		• Typing in a unique portion of a value of the list and selecting the value • Clicking on the list and clicking on one of the items with the mouse • Pressing the up/down arrows to select the desired item.
Lookup ▲ Addre 21ST Century Insurance Group 613-Administrative Services 21 A & I Benefit Plan Administrat A.U.L.R.M.S. Aaa Insurance CO Acacia Life Insu	Data Grid	The Data Grid is used to enter and display data. A data grid is difficult to use for data entry purposes, but provides an display and formatting capabilities. As a result, MedSuite uses the grid for display purposes only. An item in a grid is 'selected' by: • Clicking on a field in a row of the grid with the mouse • Using the up and down arrow keys when the grid has the focus When selected, a grid row will be displayed as white text on a blue background. Any grid may be sorted by clicking with the mouse on the column to be sorted. An arrow in the column heading indicates if the sort is ascending or descending. Some grids are customizable, allowing the user to add or remove the displayable columns by right-clicking on the grid and using the pop-up menu. In addition, these customizable grids also allow the user to modify the sequence in which the columns appear in the grid by clicking and dragging the column(s) into the desired order.
☐ 36489-CVP - CVP ☐ 36620-Arterial Line - Arteria ☐ 99241-Pre-Admit H&P C	CheckList	The CheckList is a list of checkboxes. Items in the list may be toggled on and off by: • Clicking on then with the mouse • Scrolling to them (when the grid has the focus) using the up and down arrow keys and pressing the spacebar on the desired item.

General | Sorting | Selection | Task Name [Bala Prac	Tabbed Dialog	Tabbed Dialogs contain items related to a specific function that generally fit into logical categories and will not fit on a single form or window.
Primary | Secondary | Tertiary ☑ Valid for Level ☑ V ☑ File Clai	Tabs w/in Tabbed Dialog	In a few instances, MedSuite's On Demand Software has a tabbed dialog within a tabbed dialog. Sometimes, there is just no avoiding this problem. The tabs-within-tabs is indicated by what appears to be buttons separated by a short vertical line. These 'buttons' are, in fact, a specialized tab.

3.2.5   Visual Cues

Many of the Visual Components of MedSuite's On Demand Software also provide cues to the user. These cues include:

Cue Type	Cue Description
Border	Normal text fields, lookups, checkboxes, and radio buttons have a blue border around them. Required fields have a green border.
Fields Labeled with Purple Font	Fields that are labeled with purple font are "jump" fields that utilize the F4 & F5 function keys on the keyboard. These function keys enable the cursor to skip certain fields in New Patient Demographics to speed the manual entry of new patients. F4 will move the cursor forward to the next field labeled with purple font on the screen, and F5 will move the cursor backward to the previous field labeled with purple font.
Background - White	The component with the focus has a white background and a bold blue or green border. All other components have a grey background and a non-bold blue or green border.
Background - Yellow	Most of the data input fields are "proper-cased". By this we mean the text entered in upper or lower case will be converted to the proper case. Fields that will proper case have a white background. Some fields are intentionally not proper-cased. These have a yellow background. An example of this may be Lookup fields in which the user may want to enter some sort of code. Frequently these codes simply belong in the uppercase.
Background - Red	If a required field is not entered the form edits will cause the field to be displayed with a red background.
Fly-Over Highlight	The border on the component that the mouse is 'hovering' over 'lights-up' with a bold blue or green border.

3.3   Setup Concerns

There are several concepts that the administrator should consider before setting up a new company or practice in MedSuite. If these concepts are not fully digested and understood before beginning the setup process, the administrator may find themselves facing the choice of re-doing the setup or suffering with self-imposed usability and/or reporting issues.

- Will codes or abbreviations be entered into Lookup fields?
- How does MedSuite handle deleted dictionary items?

3.3.1   Lookups, Names and Descriptions

Support tables or dictionaries fall into one of two primary classes. They are either a "description-only" table containing only a description field or they are a "keyed" table containing a key or ID field, a lookup field, and an "active" flag. Keyed-tables may also contain a name field, a practice identifier, and possibly other fields as well. Since description-only tables consist only of a description and have no practice identifier, by definition, they exist at the company-level. However, keyed-tables may exist at the company-level, the practice-level, or the division-level.

MedSuite performs lookups by using a special class of grid called the Lookup Search List. This grid looks like any other grid. However, it is tied to the lookup field component. The Lookup Search List has a text field on the form called "Search For". If the lookup field is "looking for" a table that contains a description only, the Lookup Search List "filters" the description field (since there are no other fields) for descriptions that match the value entered in the Search For field. If the lookup field is "looking for" a table that contains a key or ID field and a lookup field, the Lookup Search List "filters" the lookup field and name field (if one exists) for the value entered in the Search For field. If nothing is entered in the Search For field, then nothing is "filtered-out" of the search.

This then raises the issue of how text should be entered into the Lookup, Name, or Description field so that the search will be returned accurately and appropriately. Should a code/description methodology be used? Should descriptions only be used? Should some sort of abbreviation nomenclature be used? For example, since there are so many Referring Physicians, we may want to search for them by their last name and first name (Smith, Mary). You would expect to have a large number of Plans as well. You may want to search for Plans by some sort of abbreviation of the name (Medicare, Aetna-Atlanta, Blue-POS, etc.). Finally something that has a defined list of values such as Places of Service might lead you to set them up by the codes (21-I/P Hospital, etc.) or some other mnemonic that will save time such as IP for In-Patient or OP for Out-Patient.

This help document does not propose to answer these questions for you. We merely hope to raise them so that you can think about what will work best for you. The main issue that you should be concerned with is that what you put into the Lookup, Name, and Description will be what MedSuite will search for when you are entering data. The fewer characters that are used to make a lookup unique, the faster the correct one will be found. On the flip side, if you define the lookups with too many non-unique characters you will slow down data entry.

3.3.2   Deleted Dictionary Entries

When you wish to delete a dictionary entry, If the dictionary is a description-only table, the software will physically delete the entry. If the dictionary is a keyed-table, the software will flag the entry as deleted. The reason that description-only table items may be physically deleted and the keyed-table items must be flagged as deleted is technical in nature, but it needs to be discussed anyway.

Dictionaries do not live in a vacuum. They exist in order that higher-level dictionaries or even master-level tables may be built with accurate data. For example, the Sex Dictionary Table and the Specialty Dictionary Table are used by the Staff Dictionary Table. The Sex table is a description-only table containing "Male", "Female", and "Unknown". The Sex field in the Staff table contains the **value** "Male", "Female", "Unknown", or null (if no Sex was entered/selected). If we later go back and delete the "Unknown" entry from the Sex table, the Staff table will still contain the **values** in the Sex field.

However, the Specialty table is a keyed-table. It contains Key, Lookup, Name, Code, and other fields. The Specialty field in the Staff table contains the **key** to the Specialty table, not the Lookup or Name values. If an item were to be physically deleted from the Specialty table, any Staff item where that Specialty **key** was used would now be "pointing to" a Specialty item that no longer exists. Referential integrity is the term for the process used to ensure that this sort of problem does not occur. Lack of referential integrity would create all sorts of havoc in any system. Therefore, to prevent this problem, when we want to delete an item from a keyed table, we simply flag it as deleted. If an item is flagged as deleted, it cannot be selected from a lookup field but it is still available for reporting purposes.

3.4 Setup Sequence

The data that supports companies and practices in MedSuite's database is maintained in a number of tables. A specific table may be said to be either company-specific in that the data is used for all practices in a company, or the table may be said to be practice-specific in that the data is used for a single practice in the company.

Before you can use MedSuite's On Demand Software to enter patients and visits and begin billing, the company-specific and practice-specific tables that support this process will need to be loaded. This section covers the both the tables that need to be loaded and the sequence in which these tables need to be loaded. The sequencing of the data load is important since you may find yourself attempting to enter information only to be forced to stop because you are missing other supporting information. This type of problem is avoided by knowing and understanding the "data dependencies" of the software.

For example, before you enter any names or addresses in any of the company-specific or practice-specific tables, you should have created all of the information you will need in the supporting Postal Codes, Titles, Degrees, and Generations tables. Otherwise, you may create a Referral without a Postal Code or without a Title. Then you will have to go back later and correct all of the Referrals that you entered.

When a company becomes a MedSuite client, a database will be set up for that company. This database will already contain information in the company-specific database tables. This information comes from the MedSuite "StarterSet" and is the information that we at MedSuite think you need to get started. This StarterSet information is simply MedSuite's ideas on what the Company-Level tables ought to contain but is yours to do with as you please. These tables may be kept intact, deleted and replaced, or expanded upon.

There are two important pieces of information in this section of the document. First, you have been given a list of MedSuite support tables and what they are used for. Secondly, you have been given the sequence in which these tables should be built so that you will not be constantly forced to stop and address data dependency issues.

The tables should be examined and built in the following sequence:

- Company-Level Standard Code Sets
- Company-Level Client Specific Tables
- Practice-Level Tables

3.4.1 Company-Level Standard Code Sets

Some of the database tables in MedSuite represent a standard list of codes or descriptions. These standard code sets may be an industry-standard code set such as the ASA Codes or the Modifier Codes, or they may be something that are more or less self-evident such as the list of Gender or Sex Codes (Female, Male, or Unknown). Therefore, the Standard Code Sets can be thought of as either code sets defined by some outside entity such as HCFA/CMS, the American Medical Association (AMA), the American National Standards Institute (ANSI) or other such organization.

Coding Tables

       * Indicates tables that have special logic tied to values and should not be modified

ASA Codes	American Society of Anesthesiologists coding system

		including codes, descriptions and base units.
Procedure Codes		Current Procedural Terminology (CPT) coding system including codes and descriptions
Diagnosis Codes		International Classification of Diseases (ICD) coding system including codes and description
Procedure/ASA X-Walk		Cross-reference of valid combinations of CPT and ASA codes
Procedure/Diagnosis X-Walk		Cross-reference of valid combinations of CPT and ICD codes

Demographics Support Tables

* Indicates tables that have special logic tied to values and should not be modified

Degrees		Higher education degree (MD, CRNA, DO, etc.). File maintained by MedSuite.
Employment Status	*	Full-Time, Part-Time, Retired, etc. File maintained by MedSuite.
Gender	*	Female, Male, Unknown. File maintained by MedSuite.
Generations		Jr, Sr, III, etc. File maintained by MedSuite.
Marital Status	*	Single, Married, Widowed, etc. File maintained by MedSuite.
Relationships to Patient		Relationship of a patient to an account or a subscriber. File maintained by MedSuite.
Student Status	*	Full-Time Student, Part-Time Student, Not a Student, etc. File maintained by MedSuite.
Titles		Mr, Ms, Mrs, etc. File maintained by MedSuite.

Insurance Tables

* Indicates tables that have special logic tied to values and should not be modified

Carrier Types		Carrier grouping for reporting purposes
Carriers		All Carriers in the US.
Claim Edit Indicator	*	Claim type indicator (C-Medicare, D-Medicaid, etc.) File maintained by MedSuite.
Claim Payment Source	*	Claim type indicator (C-Medicare, D-Medicaid, etc.) File maintained by MedSuite.
Payer Types	*	Type of Payor or Plan (Medicare, Medicaid, etc.) File maintained by MedSuite.

Visit Support Tables

* Indicates tables that have special logic tied to values and should not be modified

Medical Directions		Indicates number of concurrent anesthesia cases. File maintained by MedSuite.
Modifiers		HCPCS Modifiers. File maintained by MedSuite.
Service Place		HCFA/CMS Place of Service. File maintained by MedSuite.
Service Type		HCFA/CMS Type of Service. File maintained by MedSuite.

Specialty		HCFA/CMS Provider Specialty Code. File maintained by MedSuite.
Taxonomy Class		HCFA/CMS Provider Taxonomy Class. File maintained by MedSuite.
Taxonomy Type		HCFA/CMS Provider Taxonomy Type. File maintained by MedSuite.
Visit Type	*	Anesthesia or Front Office. Other visit types may be added.

3.4.2   Company-Level Client Specific Tables

Administration Tables

Practice Types	Type of Practice for reporting purposes
Practices	Practice Information...General Tab Only
Division Types	Type of Division for reporting purposes
Company	Company User Password setup parameters
User Types	Type of User for reporting purposes
User Groups	User Group (Manager, Data Entry, Collection, etc.). Security functions are tied to the User Group
Users	User name, address, login, password, email, etc.

Coding Tables

Diagnosis Category	Grouping of diagnosis codes (neoplasms, infections, etc.) for reporting purposes
Diagnosis Type	Additional grouping of diagnosis codes used for reporting purposes
Diagnosis Sub-Type	Additional grouping of diagnosis codes used for reporting purposes
Procedure Category	Grouping of procedure codes (neurological, orthopedic, etc.) for reporting purposes
Procedure Type	Additional grouping of procedure codes used for reporting purposes
Procedure Sub-Type	Additional grouping of procedure codes used for reporting purposes

Demographics Tables

Account Classes	Billing control information and reporting purposes
Account Types	Reporting purposes

Billing Tables

Billing Messages	Special billing message codes that may be tied to an account
Payment/Adjustment Types	Payment/Adjustment Types to be used in Payment Entry and for reporting

Insurance Tables

Network Types	Reporting purposes

Visit Tables

* Indicates tables that have special logic tied to values and should not be modified

Anesthesia Types		Anesthesia type description (General, Epidural, etc.) and modifier. Used in visit entry and reporting.
Referral Types		Reporting purposes
Staff Types		Type of Staff (Physician, Anesthetist, Physicians Assistant, etc.). Reporting purposes
Facility Types	*	HCFA/CMS Facility Type. Reporting purposes.

Other Tables

* Indicates tables that have special logic tied to values and should not be modified

Charge Card Types		Visa, MasterCard, American Express, etc.
Collector Groups		Collection accounts may be assigned to a group of in-house collectors or pre-collectors (Medicare, Medicaid, Self-Pay, etc.).
Contact Types		Contacts may be used in several places in MedSuite. If they are used, a contacts type is used to indicate what type of contact (Plan, Employer, Referral, etc.) to the practice a person is.
Followup Action Classes		Groups of Followup Action Codes (Contacts, Billing, Financial, etc.)
Followup Action Codes		Categorize the Actions and specify if the system should perform some special function when an Action is performed.
Followup Actions		Specific Action to occur on a claim or account within the Followup Queue (Called - No Answer, Called - Left Message, etc.)
Followup Queue Definitions		Define what & when something is put into the Followup Queue.
Payment Exception Type		Payment Exception Type that will be used for Payment Reasons that are indicated to appear on the Payment Exception Report.
Payment Methods	*	Cash, Check, Credit Card, EFT, etc. File maintained by MedSuite.
Payment Reason		Payment Reason Codes supported by HCFA/CMS

3.4.3 Practice-Level Tables

Demographics Tables

Contacts	Contacts at Plans, Employers and Referring Physicians Offices
Employers	Employers

Insurance Tables

Anesthesia Preferences	Anesthesia setup (Bill for Age, Bill for Emergency, Bill for Physical Status, etc). that may be tied and shared among plans.
Anesthesia Time Preferences	Anesthesia Time setup (Minutes per unit, Minute caps, unit caps, etc.) that may be tied and shared among plans.
Claim Formats - Paper	Mapping of a paper claim that may be shared among plans
EMC Claim Formats	Electronic claim definition for practice (Submitter Number, Tax Id, etc)
Fee Schedules	Definition of procedures and fees for a plan
Networks	HMO/PPO Network
Plan Types	User-defined breakdown (Medicare, Medicaid, etc.) for reporting
Plans	Contract provisions for billing patients with insurance
Rate Structures	Definition of anesthesia rates per unit for a plan
EMC Claim Format Plans	Electronic claim definition for a plan (Provider IDs ,etc.)

Visit Tables

Facility Groups	Facility (Hospital, Surgical Center, etc.) chain for reporting
Facilities	Hospital, Surgical Center, etc.
Locations	Location within Facility (Place of Service)
O/R Suites	O/R Suite within Facility
Referral Groups	Referring physicians may be grouped into their respective practices for reporting purposes
Referrals	Referring physicians, Attending Physicians, Surgeons, etc.
Staff Groups	Staff members of the practice may be grouped into other entities (Stockholders, Non-Stockholders, etc.) for reporting purposes.
Staff	Individual Staff members (Physicians, Anesthetists, etc.) of the practice.

Other Tables

Agency	Collection Agencies
Followup Actions	Followup Action Codes used by the practice and the followup time period that next action
Followup Criteria	How and When accounts or claims are to be sent to the Followup Queue

Form Letters	Form Letters may be defined with mail merge fields

Practice Master Tables

Practices	Remainder of the practice information
Divisions	Divisions of the practice
Division / Facility X-Ref	Valid Facilities for the Division

Proprietary and Confidential

4   MedSuite for Everyone

This section addresses the basic login, data entry, and daily functions of MedSuite including:

- MedSuite Basics   Learn and review the basics functions of logging in, system security, and selecting and changing practices.
- Dashboard   Learn and review the functionality of the Dashboard, the main screen of MedSuite
- Tool Bar   Learn and review the functions accessible from the Tool Bar
- Navigation Menu   Learn and review the functions accessible from the Navigation Menu
- Batch Menu   Learn and review the functions accessible from the Batch Menu
- Queues   Learn and review the functions accessible from the Queues Menu

The workflow processed by billing organizations is typically in the form of documents of one kind or another. These documents include Hospital Admitting Records, Anesthesia Records, Super-Bills, etc. In order to function as efficiently as possible, a billing organization will attempt to limit the number of times that each document is "touched" by their employees. Usually, the entry of the data from one document is dependent upon the entry of another document. For example, if you don't enter charges, you won't generate any claims and therefore won't receive any payments. The event that initiates this entire process is the receipt of a charge record (Anesthesia Record, Super-Bill, etc.). However, before the charges can be entered, the patient must be entered. It is at this point where organizations may differ as to the order in which these events occur. Some organizations have someone enter all of the demographics and then that person or typically someone else will enter all of the charges. We call this the demo-demo/charge-charge organization. Other organizations enter their demographics and charges for each patient simultaneously. We call this the demo-charge/demo-charge organization.

Neither approach is right or wrong. Sometimes economies of scale dictate the demo-demo doesn't work well because there isn't sufficient volume to keep two people busy. In other cases, there is information on the Anesthesia Record or Super-Bill that is demographic in nature, it is not available on the Admitting Record, and the decision to perform demo-charge is an acknowledgment that the charge entry people will have to update the demographics anyway; so they might as well enter the entire demographic.

Naturally, MedSuite provides a facility to implement whichever approach that the organization wants to implement. The Navigation Menu provides the Demo-Charge/Demo-Charge approach while the Batch Menu provides the Demo-Demo/Charge-Charge approach. Of course there are any number of reasons why one would want to open a Patient's Demographics or their Ledger from the Navigation Menu that have nothing to do with entering new charges. In addition, there are a number of functions on the Batch Menu that have nothing whatsoever to do with entering Demographics, Charges, or Payments, but nevertheless they are Daily "batch-type" functions. However, as a rule-of-thumb Demo-Charge/Demo-Charge is done through the Navigation Menu whereas Demo-Demo/Charge-Charge is done through the Batch Menu.

The Queues Menu provides a the means of accessing the primary Followup functions of MedSuite. These functions include the Followup Manager, Collection Selection and Turnover, Collection Letters, and the Refund Manager and Refund Listing.

4.1 The Basics

Logging in to MedSuite

Before you can do anything in MedSuite, you will have to login. The first time a user logs into MedSuite the system will prompt the user for their password and prompt them to re-type the password for verification. The MedSuite Login form requires that you enter a valid company name, user name and password.

Company	The company name is required for two reasons:
	• MedSuite must be told which database the user is attempting to log in to
	• MedSuite must validate that the user name and password entered allows access to the company requested
User Name	The user name is the Login Name name assigned to the user by the system administrator. This Login Name may be the user's name, initials, or nickname assigned to the user. It must be unique within the company.
Password	The password is set up by the user the first time the user logs in and must be updated based on what is setup in the Company by the System Administrator. See your System Administrator to obtain details on the password setup requirements for your Company.

Access is granted to the various functions in MedSuite by granting access to the function in question to a User Group and then assigning Users to the group. All of this should already be setup for you by your system administrator. If it is not, you may successfully log in to MedSuite, but you may not have been granted access to do anything other than exit the software.

Selecting and Changing Practices

Once you have successfully logged-in, you must select a "current" practice from the practice selector. Once you have selected a practice and until you select a different practice, everything that you do within MedSuite will occur "within" within the selected practice.

There are two ways to change the "current" practice that you have selected:

Practice Selector	The user may select a new practice via the practice selector. Since MedSuite is a multi-practice application, the user must select a practice to work in by clicking on the practice selector before doing any work. The 'current' practice may be changed at any time the user is not in a modal form. Changing the current practice does not change the practice in any function that is already open.

The practice selector will display the practice name in the color settings defined for the practice in Practice Maintenance.

Account Search   If you are not sure what practice a patient "belongs to", you can enter the search criteria for the patient and click the checkbox "Show Patients from All Practices". The list of patients meeting the search criteria will be displayed. The first column of the grid will display the practice name in the color settings defined for the practice in Practice Maintenance. If you select a patient in a practice other than your currently selected practice, MedSuite will ask you if you want to open the selected patient in the patient's practice or if you want to copy the patient's demographics to the currently selected practice.

4.2   Dashboard

The main screen that you see when you log into MedSuite is called the Dashboard.

The first time you log in, you will see your open Payment and Visit batches in the top left portion of the screen. You may double-click on a batch to go to that Batch List. On the top right, you'll see your last 10 tasks in the Task Viewer, along with a View Task button and Refresh Task button. You may double-click on a task to view it or use the View Task button. After running a new task, it will be displayed at the top of the list, and you may simply click the View Task button to see it.

The bottom portion of the screen displays "Ticklers".

The display in the top portion of the screen may be modified. In User Maintenance, there is a tab for Dashboard Setup. By default, all users are set to display the last 10 tasks and their payment/visit batches. The other option will display a chart. Currently, it is a chart of the AR for the active practice for the last 5 days. You may display 2 of the 3 options. Your system administrator can make these changes for you.

A "slider bar" in the middle of the screen allows the top and bottom portions to be expanded or shrunken. Move the mouse to the middle of the screen until it forms cross-hairs. Then click and drag the slider bar up or down to display more of the Tickler portion of the screen or more of the top portion of the screen.

As you open patient ledgers, payment screens, etc., color-coded tabs corresponding to the practice colors will be displayed at the bottom of the screen for each window that you have opened. You may click on the different tabs to go to the different screens, or use the CTRL+PageUp or CTRL+PageDown functions to move between them. Click on the Dashboard tab to go back to the main screen, or use the keyboard shortcut CTRL+D.

Each of the tabbed screens has a CLOSE button at the bottom right. Clicking it will close that screen. The keyboard shortcut to Close is CTRL+E (as in Exit). Learning the shortcut keys will enable you to navigate the screens faster than utilizing the mouse alone.

4.3   Toolbar

After you logon to MedSuite, you will be on the main screen of MedSuite, called the "Dashboard." You will see a Tab on the bottom left of the screen and that the Tab is titled Dashboard. You will also see a toolbar running across the top of this screen and below the menu bar. This Toolbar is one of the primary means of accessing the most common functions of MedSuite. The functions available on the Toolbar are contained in a series of buttons that include the functions on the following list. Since each of these functions is defined in great detail in their respective topics of this document, it would be redundant to define them here as well. Each of these buttons on the Toolbar may be accessed with a keyboard shortcut as noted below. We strongly encourage you to become familiar with the keyboard shortcuts as they will save you a great deal of time navigating the system instead of using the mouse to navigate.

Patient	Search for an existing patient or account or create a new patient	CTRL+P
Ledger	The user may search for a patient or an account and go directly to that patient's or account's ledger.	CTRL+L
New	Create a new patient / account	CTRL+N
Visit	Add, change, and delete unposted visits via Batch Visit Entry	CTRL+T
Payment	Add, change, and delete unposted payments via Batch Payment Entry	CTRL+Y
Tasks	Invokes the Task Viewer that allows the user to see tasks (generally reports) that have been submitted. The Viewer displays the status of pending and running tasks and allows the user to display the output of completed tasks.	CTRL+R
Imaging	Scan and/or maintain document images	CTRL+I
Wizard	Access the Followup Wizard	CTRL+F
Followup	Access the Followup Queue	CTRL+Q
Refund	Add, change, and delete Refund Requests.	CTRL+P
Web	Access the built-in Web Browser	CTRL+W
E-Mail	Access the built-in e-mail client	CTRL+M
Help	Access On-Line Help	CTRL+H

You may display this list of the keyboard shortcuts that can be invoked via the CTRL key by pressing and holding the CTRL key for 2 seconds. A list of the keyboard shortcuts will be displayed. From the list, enter the letter corresponding to the function you need, and it will come up.

4.4   Navigation Menu

After you logon to MedSuite, you will notice a menu running across the top of the screen. One of the sub-menus in this menu is the Navigation menu, which is one of the primary means accessing the most common functions of MedSuite.

Menu	**Description of Function**
Account Search	An existing account may be opened
Patient Search	An existing patient may be opened
Open Ledger	The Ledger for an existing patient or account will be displayed.
New Patient	Create a new patient
Followup Wizard	The Followup Wizard will be invoked
Task Viewer	Invokes the Task Viewer that allows the user to see tasks (generally reports) that have been submitted. The Viewer displays the status of pending and running tasks and allows the user to display the output of completed tasks.
Contact Manager	The Contact Manager will be invoked
Day Book	The Day Book will be invoked
Spreadsheet	The built-in Spreadsheet will be invoked
Word Processor	The built-in Word Processor will be invoked
Practice Graphs	Displays graphs for the Practice Balances, Followup Queues, and Practice Accounts Receivable.
Web Browser	The built-in Web Browser will be invoked
E-Mail	The built-in E-Mail Client will be invoked
Exit	Exit MedSuite

4.4.1   Account Search

MedSuite presents the user with a tabbed dialog that searches for an account by a variety of different criteria. Once an account has been selected, the user is presented with the demographics in account context.

The Enhanced Search List option from Practice Setup is implemented in Account Search. If the Enhanced Search List option is "on", the search will retrieve the most recent Visit Date, the sum of all Visit Balances for the Account and the Division from the oldest Visit with and open balance. In addition, if an account has a Visit in Collections, the item in the Account Search List will be displayed in Red.

Optionally, the ability to select only Accounts with balances is available as well. The check-box labeled " Display Zero Balance Accounts" gets its initial value from Practice Setup. Theuser may override this value (include or exclude) on any given search.

> **Note: Running a search using Enhanced Search List or excluding Zero Balance Accounts is**
>
> **slightly slower than the non-Enhanced Search List and including all accounts. The**
>
> **reason for this is that the Enhanced Search is more complicated and performs additional**
>
> **sub-queries that are not otherwise necessary.**

Quick Search	The user may key in a data value that will be used to search a variety of fields for matching accounts that will be displayed in the grid on the Search tab.
Advanced Search	The user may tell the search which fields to search in rather than let the Quick Search decide which fields to search. Matching accounts will be displayed in the grid on the Search tab.
Search Type	The Search may be told to retrieve accounts meeting the search criteria.
Display Zero Balance Accounts	This check-box defaults from the Practice Setup option and controls whether accounts with zero balances are retrieved by the search or not. **Accounts that have no charges are not considered "zero-balance" accounts and will always be returned by the search.**
Display last Year Only	The Search will only retrieve accounts entered in the past year.
Show Patients from All Practices	The search may be told to search within the current practice (as indicated by the practice selector) or it may be told to search across all practices. **If an account is selected from a practice other than the current practice, the user will be asked if they wish to open the account and change the current practice.**
Message Line	A message will be displayed indicating how many accounts meet the search criteria entered.
Search Button	(Re)Executes the search based on the Quick Search or Advanced Search criteria entered.
New Button	Executes the New Patient Wizard.

Ok Button   Opens the account currently selected in the Search grid.

Cancel Button   Closes the Account Lookup dialog without selecting a patient or account.

4.4.1.1   Quick Search

The Quick Search tab displays examples of how different fields types searched via the Quick Search field. The fields that may be searched by the Quick Search are:

Last	Patients and accounts with last name starting with the value entered will be retrieved.
Last, First	Patients and accounts with last name starting with the value entered before the comma and first names or nick names starting with the value entered after the comma will be retrieved.
Dash ('-')	Patients and accounts with phone numbers or social security numbers matching the value entered will be retrieved.
Slash('/')	Patients and accounts with birth dates matching the value entered will be retrieved. Partial birth dates may be entered.
Numeric	Patients, accounts, or policies with chart number, account number, or policy number matching the value entered will be retrieved.

4.4.1.2   Advanced Search

The Advanced Search form allows the user to search in a specific field to find an existing account. For example, a policy number may have dashes or slashes in it. The Advanced Search allows the user to tell the search routine to 'search the policy number for this value' rather than allowing the search routine to search the phone number and social security number for the value.

The Advanced Search fields are:

- Last Name
- First Name
- Address
- Birth Date
- Home Phone Number
- Work Phone Number
- Social Security Number
- Claim Number
- Ticket Number
- Reference No (Emdeon)
- Patient Number
- Chart Number
- Medical Record Number
- Policy Number

4.4.1.3   Account Context

An account is "opened" when the user searches for and selects an **account.** The, so called, account context consists of a tabbed dialog containing three (3) tabs:

- Account
- Billing
- Patient List

4.4.1.3.1 Account

The Account Tabs are only displayed while in the account context

Account Control

Patient Relationship to the Account	The Patient Relationship is use to control what if anything needs to be entered for the account on this form. If the relationship is 'self', then the patient **is** the account. The patient (and therefore the account) information was just entered on the New Patient form. If the relationship is not 'self', then the account can be: • Entered • Imported from the Patient and Modified • Selected from a Previously Exisiting Account When a new patient is being added, the relationship defaults to "Self". If, at the time of data entry, the patient is less than 18 years old, you will receive a message telling you to verify the patients relationship to the account holder.
Import Patient Information	If the patient information is imported, all of the data fields on the form will be populated from the New Patient form. The user should new override the fields that need to be changed. For example, if the account is the patient's spouse and the patient date is imported, then the user will need to change the accounts first name, date of birth, social security number, sex, etc. However, all of the rest of the information is 'clean' and 'correct'.
Select Account	If the account is also the account holder form another patient, then the Account Lookup will be presented and the user can select an account from a list of previously entered accounts.

Patient Numbers

Patient No	Number assigned to the patient by the practice. This number may be system generated from a 'seed' number in Practice Maintenance.
Chart No	Chart Number.
Soc Sec No	Social Security Number
Med Rec No	Medical Record Number from the hospital

Name

Title	Title (Mr, Ms, Mrs, etc.)
Salutation	Indicates how letters to the patient will be addressed (Dear Salutation....) Values are: • Title & Last Name • First Name • Nickname
First/M/Last	Name entered in First, Middle and Last sequence
Nickname	NickName. Will default from patient fiest name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, Phd, etc.)

Personal Contact Information

Address	Address consisting of: • Street Address • Street Address (Add'l) • City • State • Postal Code The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Country	A foreign country may be entered if needed. The cursor will, by default, skip this field. To enter a country, Shift+Tab to back up to the field to enter the country. NOTE: Canadian mail is addressed like US Mail: City, State (Province Code) and Postal Code. Therefore, it is entered into MedSuite with the Postal Code, City, Province (AB for Alberta, ON for Ontario, etc). and then Canada can be typed into the Country field.
Home	Home telehone number.
Fax	Fax telephone number
Work	Work telephone number
Other	Other telephone number
Mobile	Mobile telephone number
Pager	Pager telephone number
E-Mail	E-Mail address

Personal Details

Birth	Date of Birth. See date field definition for use of two/four digit years.
Death	Date of Death. See date field definition for use of two/four digit years.
Sex	Sex (Male, Female, Unknown)
Marital Status	Marital Status (Married, Single, Widowed, etc.)

Employment

Practice Maintenance allows the system to be configured to allow entry of the Employer Lookup or Employer Name/Description or both.

Some practices will define employers in a separate Employee Maintenance function and use the Employer Lookup. This allows the Primary Insurance Plan to be pulled through from the Employer as a default. Other practices will find that this capability does not gain them much and will simply want to key in both the Employer Name/Description and the Primary Insurance Plan.

Employer (Lookup Field)	Employer can be selected from Employer lookup.
Employer (Text Field)	Employer Name can be keyed in
ID	ID assigned to employee by the Employer may be entered
Status	Employment Status (Full-Time, Part-Time, Retired, etc.)
Date	Date Status was changed (employment date if employed, retirement date if retired, etc.)
Occupation	Occupation name/description

Buttons

Memo	An account memo may be entered
Imaging	A image may be scanned and attached to this account
Save	Save changes to the database
Cancel	Close the form and do not save the changes (if any)

4.4.1.3.2 Billing

The Account Billing Tab is only displayed while in the account context

Account Class	The Account Class must be selected from the Account Class Lookup. A default value for the Account Class may be defined in Practice Maintenance.
Account Type	The Account Type is an optional field that is used for reporting and selection purposes
Payment Plan Amt	Overrides the practice-level Minimum Payment Amount for this account. This allows monthly payments to be negotiated and tracked as minimum payments that are different from the practice minimum.
Claims Suspended	All claims may be suspended for the account until such time as the suspend is removed.

Finance Charges

Waive Finance Charges	Indicates if Finance Charges should be waived on this particular account, if the Practice and Account Classes are set up to assess Finance Charges.

Orig Fin Chrg Date	Date that the first finance charge was issued to the account holder
Last Fin Chrg Date	Date that the most recent finance charge was issued to the account holder
Next Fin Chrg Date	Date that the next finance charge is due to be issued to the account holder if no payment is made.

Collections

In Collections	Indicates if the account is in a collection status.
Number of Collection Letters Sent	Indicates how many Collection Letters have been sent to the account
Collector Group	Indicates if there is a Collector Group assign to 'work' this account
Agency	Indicates the Collection Agency assigned to this account if it currently is in a collection status or if it goes into a collection status in the future

Statement

Stmt Suspended	All statements for the account may be suspended until such time as the suspend is removed. If an account is suspended:

- Statement Billing will stop being issued
- Dunning Levels will not advance
- Account Followup will cease
- Collections activities will cease

When the suspend is removed from the account, the user will be asked if they want the billing cycle to restart the billing cycle. If the user indicates that he wants the billing cycle to be restarted:

- Statement Billing will commence
- Account Followup will commence
- Collections activities will commence
- Dunning Level by set to zero
- First Statement Date will be reset
- Last Statement Date will be reset
- Next Statement Date will be set to the current date

If the user indicates that he does not want the billing cycle to be restarted:

- Statement Billing will commence
- Account Followup will commence
- Collections activities will commence
- Dunning Levels will advance from the Last Level

Returned Mail	Indicates if the practice has gotten returned mail from billing the account. In other words, since the address is bad or incorrect and the statements are not getting to the account holder, there is no point in continuing to be bill the account until such time as a current address is entered.

First Statement Date	Date that the first statement was issued to the account holder
Last Statement Date	Date that the most recent statement was issued to the account holder
Next Statement	Date that the next statement is due to be issued to the account holder
Dunning Level	Delinquency level that the next statement will be issued at. The Dunning Message associated with this level is defined in Practice Setup.
Billing Message	Special Billing Message that will appear on the statement for this account holder.
Billing Message is Recurring	Indicates if the Billing Message is a one-time or recurring message
Override Billing Message	Free-Form Text Billing Message that will override the Billing Message or the Practice-level Dunning Message. Up to four lines of 60-characters of text per line may be entered.

Buttons

Memo	An account memo may be entered
Imaging	A image may be scanned and attached to this account
Save	Save changes to the database
Cancel	Close the form and do not save the changes (if any)

4.4.1.3.3 PatientList

Patient List

Patient Name	Names of patients for which the account is the responsible party

The Patient List has an Edit button below it. If this button is clicked, the software will ask you if you want to open the patient. If you click Yes, the patient will be opened in the Patient Context.

Buttons

Memo	A patient memo may be entered
Imaging	A image may be scanned and attached to this patient
Save	Save changes to the database
Cancel	Close the form and do not save the changes (if any)

4.4.2   Patient Search

MedSuite presents the user with a tabbed dialog that searches for a patient by a variety of different criteria. Once a patient has been selected, the user is presented with the demographics in patient context.

The Enhanced Search List option from Practice Setup is implemented in Patient Search. If the Enhanced Search List option is "on", the search will retrieve the oldest Visit Date with a balance or if there are no Visits with balances, it will pull the most recent Visit Date, the sum of all Visit Balances for the Patient, and the Division from the oldest Visit with and open balance. In addition, if a patient has a Visit in Collections, the item in the Patient Search List will be displayed in Red.

Optionally, the ability to select only Patients with balances is available as well. The check-box labeled " Display Zero Balance Accounts" gets its initial value from Practice Setup. The user may override this value (include or exclude) on any given search.

Note: Running a search using Enhanced Search List or excluding Zero Balance Accounts is
slightly slower than the non-Enhanced Search List and including all accounts. The
reason for this is that the Enhanced Search is more complicated and performs additional
sub-queries that are not otherwise necessary.

Quick Search	The user may key in a data value that will be used to search a variety of fields for matching patients that will be displayed in the grid on the Search tab.
Advanced Search	The user may tell the search which fields to search in rather than let the Quick Search decide which fields to search. Matching patients will be displayed in the grid on the Search tab.
Display Zero Balance Accounts	This check-box defaults from the Practice Setup option and controls whether accounts with zero balances are retrieved by the search or not. **Patients that have no charges are not considered "zero-balance" patients and will always be returned by the search.**
Search Type	The Search may be told to retrieve patients meeting the search criteria.
Display Last Year Only	The Search will only retrieve patients added in the past year.
Show Patients from All Practices	The search may be told to search within the current practice (as indicated by the practice selector) or it may be told to search across all practices. **If a patient is selected (double-click or Ok Button) from a practice other than the current practice, the user will be asked if they wish to open the patient and change the current practice.** **If the user clicks on the Copy Wizard button, the Copy Wizard dialog will be presented. The user can copy the**

	patient from the currently selected practice or from a different practice as a new patient in the currently selected practice.
Message Line	A message will be displayed indicating how many patients meet the search criteria entered.
Copy Wizard	Invokes the Copy Wizard dialog that allows the user to copy a patient from the currently selected practice or from a different practice as a new patient in the currently selected practice.
Search Button	(Re)Executes the search based on the Quick Search or Advanced Search criteria entered.
New Button	Executes the New Patient Wizard.
Ok Button	Opens the patient currently selected in the Search grid.
Cancel Button	Closes the Patient Lookup dialog without selecting a patient

4.4.2.1   Quick Search

The Quick Search tab displays examples of how different fields types searched via the Quick Search field. The fields that may be searched by the Quick Search are:

Last	Patients and accounts with last name starting with the value entered will be retrieved.
Last, First	Patients and accounts with last name starting with the value entered before the comma and first names or nick names starting with the value entered after the comma will be retrieved.
Dash ('-')	Patients and accounts with phone numbers or social security numbers matching the value entered will be retrieved.
Slash('/')	Patients and accounts with birth dates matching the value entered will be retrieved. Partial birth dates may be entered.
Numeric	Patients, accounts, or policies with chart number, account number, or policy number matching the value entered will be retrieved.

4.4.2.2   Advanced Search

The Advanced Search form allows the user to search in a specific field to find an existing patient. For example, a policy number may have dashes or slashes in it. The Advanced Search allows the user to tell the search routine to 'search the policy number for this value' rather than allowing the search routine to search the phone number and social security number for the value.

The Advanced Search fields are:

- Last Name
- First Name
- Address
- Birth Date
- Home Phone Number
- Work Phone Number

- Social Security Number
- Patient Number
- Chart Number
- Medical Record Number
- Policy Number
- Claim Number

4.4.2.3   Patient Context

The Patient context is displayed when the user opens a **patient** and consists of a tabbed dialog containing nine (9) tabs:

- Patient
- Additional
- Insurance
- Primary Care
- Account Management
- Ledger
- Visits
- Payments
- Imaging

4.4.2.3.1 Patient

The Patient Tab is only displayed while in the patient context

Patient Numbers

Patient No	Number assigned to the patient by the practice. This number may be system generated from a 'seed' number in Practice Maintenance.
Chart No	Chart Number.
Soc Sec No	Social Security Number
Med Rec No	Medical Record Number from the hospital

Name

Title	Title (Mr, Ms, Mrs, etc.)

Salutation	Indicates how letters to the patient will be addressed (Dear Salutation....)
	  Values are:
	    • Title & Last Name
	    • First Name
	    • Nickname

First/M/Last	Name entered in First, Middle and Last sequence
Nickname	NickName. Will default from patient fiest name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, Phd, etc.)

Personal Contact Information

Address	Address consisting of:
	    • Street Address
	    • Street Address (Add'l)
	    • City
	    • State

- Postal Code (Required Field)

	The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Country	A foreign country may be entered if needed. The cursor will, by default, skip this field. To enter a country, Shift+Tab to back up to the field to enter the country.
	NOTE: Canadian mail is addressed like US Mail: Zip Code, City & State in US would be the Canadian Postal Code (L7L6M-7), the Canadian Province (Burlington) & Canadian Code (ON for Ontario). In the Country field in MedSuite you would enter Canada. Therefore, it is entered into MedSuite with the Postal Code, Province and Province Code (AB for Alberta, ON for Ontario, etc). and then Canada can be typed into the Country field.
Home	Home telehone number.
Fax	Fax telephone number
Work	Work telephone number
Other	Other telephone number
Mobile	Mobile telephone number
Pager	Pager telephone number
E-Mail	E-Mail address

Personal Details

Birth	Date of Birth. See date field definition for use of two/four digit years.
Death	Date of Death. See date field definition for use of two/four digit years.
Sex	Sex (Male, Female, Unknown)
Marital Status	Marital Status (Married, Single, Widowed, etc.)

Employment

Practice Maintenance allows the system to be configured to allow entry of the Employer Lookup or Employer Name/Description or both.
Some practices will define employers in a separate Employee Maintenance function and use the Employer Lookup. This allows the Primary Insurance Plan to be pulled through from the Employer as a default. Other practices will find that this capability does not gain them much and will simply want to key in both the Employer Name/Description and the Primary Insurance Plan.

Employer (Lookup Field)	Employer can be selected from Employer lookup.
Employer (Text Field)	Employer Name can be keyed in
ID	ID assigned to employee by the Employer may be entered
Status	Employment Status (Full-Time, Part-Time, Retired, etc.)
Date	Date Status was changed (employment date if employed, retirement date if retired, etc.)
Occupation	Occupation name/description

Buttons

Memo	A patient memo may be entered
Imaging	A image may be scanned and attached to this patient
Ok	Save changes to the database
Cancel	Close the form and do not save the changes (if any)

4.4.2.3.2 Additional

Emergency Information

Name	Emergency Contact Name
Pt Rel	Patients Relationship to the Emergency Contact
Phone	Emergency Contact telephone number

Student Information

School	School attended by patient
Phone	Telephone number of school
Status	Student Status (Full-Time, Part-Time, etc.)

Patient Defaults

Physician	Physician to default into Visits for the Patient
Referring	Referring Physician to default into Visits for the Patient
Surgeon	Surgeon to default into Visits for the Patient
Facility	Facility to default into Visits for the Patient
Hosp From	Beginning date of hospitalization
Hosp Thru	Ending date of hospitalization
Injury/Illness	Date of Injury or Illness

Additional Patient Numbers

Drivers License	Patients drivers license number

Buttons

Memo	A patient memo may be entered
Imaging	A image may be scanned and attached to this patient
Ok	Save changes to the database
Cancel	Close the form and do not save the changes (if any)

4.4.2.3.3 Insurance

Insurance Tab

Insurance Information

The Insurance information grid contains a list of the insurance plans available to the patient and is listed in the sequence in which the insurance is applied.

Plan	Name of the Insurance Plan
Subscriber	Subscribers Name
Effective Date	Effective date of the insurance coverage
Expiration Date	Expiration date of the insurance coverage
Up Button	Moves the selected insurance up to the previous coverage level
Down Button	Moves the selected insurance down to the next coverage level
New Button	Adds new insurance coverage to the patient
Edit Button	Edits the selected insurance coverage
Expire Button	Displays a pop-up menu that allows the user to expire the insurance on the effective date thereby not having the coverage at all or expiring the coverage on the current date thereby terminating coverage.

Subscriber (View Only) Information

Name	Subscribers Name from the coverage selected in the Insurance Information grid.
Soc Sec No	Subscribers social security number from the coverage selected in the Insurance Information grid.
Pt Rel	Patient's relationship to the subscriber from the coverage selected in the Insurance Information grid.
Policy No	Policy number from the coverage selected in the Insurance Information grid.
Group Name	Group name from the coverage selected in the Insurance Information grid.
Group No	Group number from the coverage selected in the Insurance Information grid.
Pre-Auth No	Pre-authorization number assigned by the insurance carrier

The prior authorization number may be maintained in two different locations; one is in the Insurance Demographic and the other is on the Visit - HCFA Tab. Please check with your system administrator to determine where you should be maintaining this value.

Claim Office (View Only) Information

Address	Address consisting of:
	• Street Address
	• Street Address (Add'l)

- City
- State
- Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Country	A province and/or foreign country may be entered if needed.
Phone	Home telephone number.
Fax	Fax telephone number
Other	Other telephone number

Billing Control

Wait for Payment	Indicates if, during the billing cycle, whether the carrier/plan will wait at the current level for payment from the carrier before proceeding to the next level. A value of 'Default' indicates that the plan defaults will be used. The user may override the plan defaults with "Yes" or "No".

HIPAA Info Tab

In order to file Medicare Secondary claims electronically, Medicare needs to know the "reason" why Medicare is the secondary insurance rather than the primary insurance.

Secondary Ins Code	Select the Medicare Secondary "Reason" Code from the supplied list

Buttons

Memo	A patient memo may be entered
Imaging	A image may be scanned and attached to this patient
Ok	Save changes to the database
Cancel	Close the form and do not save the changes (if any)

4.4.2.3.4 Primary Care

Primary Care Physicians

Primary PCP	First Primary Care Physician
Secondary PCP	Second Primary Care Physician

Ongoing Diagnosis

Diagnosis 1	First Ongoing diagnosis
Diagnosis 2	Second Ongoing diagnosis
Diagnosis 3	Third Ongoing diagnosis

Diagnosis 4   Fourth Ongoing diagnosis

Ongoing Details

First Visit	Date of first visit
Last Visit	Date of most recent visit
Admit Date	Date of admission to the hospital
Discharge Date	Date of discharge from the hospital
Part Disab From	Beginning date of partial disability
Part Disab Thru	Ending date of partial disability
Total Disab From	Beginning date of total disability
Total Disab Thru	Ending date of total disability
Onset Date	Date of onset of illness or date of injury
Return to Work	Date patient is able to return to work

Buttons

Memo	A patient memo may be entered
Imaging	A image may be scanned and attached to this patient
Ok	Save changes to the database
Cancel	Close the form and do not save the changes (if any)

4.4.2.3.5 Account Management

Account List

Account Name	Name of Account that patient may be billed under
Patient Relationship to Account	Patient's relationship to the account (Relationships Table)
	The Relationships Table contains relationships in both "directions" from the patient. There are both child relationships and parent relationships. The key to not confusing this issue is that it is the relationship of the patient TO the account, NOT the account to the patient.
Default Account	The default account will be used (by default) in New Visit but may be overridden to a different account available to the patient.

Account List - Buttons

Refresh	Refreshes the List
New	Create a new account
Edit	Edit the selected account
Set Default	Set the selected account as the default account for the patient. This will be the default account in Visit Entry.

Buttons

Memo   A patient memo may be entered
Imaging   A image may be scanned and attached to this patient
Ok   Save changes to the database
Cancel   Close the form and do not save the changes (if any)

4.4.2.3.6 Patient Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree

A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.

The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

- Patient - Images indexed to the patient (Action = Patient)
- Visits - Images indexed to visits (Action = Visit-New)
- Payments - Images indexed to visits (Action = Payment Insurance -
  New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
  entity from the list above

Refresh   Refreshes the Image Tree
View   Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.
	In effect, the image is placed in an Imaging Station in a "ready to be processed" state.
	Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

4.4.2.4   Visits

MedSuite provides two different modes for visit entry:

[Single](#)	Open a patient or an account and access the Visits List by clicking on the Visits Tab of the Patient Chart
[Batch](#)	Select Visits from the Toolbar or from the Batch Menu

This section concerns itself with the Single Visit Entry mode.

4.4.2.4.1   Visit List

The Visit List consists of two sections. The first section is a list of visits for the Open Record. The second section displays details about a selected visit in the list.

There are a few important things that you need to bear in mind. Since an account may have financial responsibility for multiple patients, like Demographics, the Visit List supports both a Patient context and an Account context. In the Account context, the user must select a patient to enter a new visit. In the Patient context, the user may have to select an account to enter a new visit.

Visit List

Date	Date of Visit
Type	Type of Visit
Division	Division for which the physician performed the services
Physician	Physician who performed the services
Facility	Facility in which the services were performed
Charges	Charges for the Visit
Payments	Payments applied to the Visit
Adjustments	Adjustments applied to the Visit
Balance	Balance remaining on the Visit
Patient Name	Patient Name

Visit List Buttons

New	A new Visit may be created
Edit	An existing (unposted) Visit may be edited. Posted Visits may only be viewed.
Delete	An existing (unposted) Visit may be deleted. Posted Visits may only be viewed.

Visit Details (Read Only)

Certain details about a Visit are available for viewing on the Visit List Tab. This information falls into several categories including Batch Information, Coverage Information, Charges, and Visit Totals.

Batch Information

Batch No   Batch Number that the Visit was entered under
Dt Release   Date the Batch is Release For (due to be Posted)
Bill Date   Date the Visit was billed
Claim Number   Claim number that the Visit was billed under
User   Name of User who entered the Visit

Charge List

Date   Charge service date
Charges / Procedure Charge procedure description

Coverage Information

Account   Name of Account who is financially responsible for the Visit
Pat Rel   Relationship of patient to the account
Class   Account Class of the Account who is financially responsible for the Visit
Stmt Suspended   Indicates if Statements have been suspended for the Account who is financially responsible for the Visit
Returned Mail   Indicates if Returned Mail has been received for the Account who is financially responsible for the Visit
In Collections   Indicates if the Account who is financially responsible for the Visit is in a Collection status.

Calculations

Charges   Total charges for the Visit
Payments   Total Payments for the Visit
Adjustments   Total Adjustments for the Visit
Balance   Total Balance remaining for the Visit

4.4.2.4.2 Visit

Division	In MedSuite, a Visit exists at the Division-level. So you must select a division under which the Visit will be billed.
Visit Type	Select the Type of Visit (Anesthesia or User-Defined)
	Once a visit is posted, the Visit Type may be changed from one non-"Anesthesia" visit type to another but not from "Anesthesia" or something other than "Anesthesia" or something other than "Anesthesia" to "Anesthesia".
Visit Date	Enter the Visit Date
Copay Amt	Amount of the Co-Payment entered with the Visit
Copay Remit	Remit Date of the Co-Payment entered with the Visit.
Batch No	Select/Create a Batch for the Visit
Date Release	The release date of the batch is displayed.

Co-Payments are maintained on a separate batch from the Visit's batch. Co-Payment batches need to be released for payment posting in the same manner that any other payment batch needs to be released. A Co-Payment batch cannot be released prior to the Visit batch that the Co-Payment was applied against.

Account / Responsible Party

Select the account who is financially responsible for the visit must be selected. The <u>default account</u> will be initially selected, but any account attached to a patient may be selected.

(Name)	Select the name of the account who is financially responsible for the visit. The <u>default account</u> will be initially selected.
Group Name	Blank
Address	The account's address is displayed
Class	Account Class of the Account who is financially responsible for the Visit
Stmt Suspended	Indicates if Statements have been suspended for the Account who is financially responsible for the Visit
Returned Mail	Indicates if Returned Mail has been received for the Account who is financially responsible for the Visit
In Collections	Indicates if the Account who is financially responsible for the Visit is in a Collection status.

Claim Control

Override File Insurance	The "normal" insurance filing process can be overridden and claims may be forced to paper or may not be filed.
(Blank)	Allows the user to select the type of insurance override processing

Policy Sequence

The coverage type is used to select a set of insurance policies by the type of coverage or policy. The policies in effect at the time of the date of service (visit date) are displayed in the list. The policies are displayed in the sequence set by the user in the Insurance Demographics. If the sequence needs to be changed, the user to change it in Insurance Demographics.

Coverage Type	Select the Coverage Type required for this visit. This will help you select from multiple effective insurance coverage's that have been entered in Demographics.
Hold Claim Days	The number of days that claims for the primary insurance plan are to be held is displayed. This value may be overridden.
Carrier	Displays the carrier name
Plan	Displays the plan name
Subscriber	Displays the subscriber name
Effective Date	Displays the policy effective date
Expiration Date	Displays the policy expiration date

4.4.2.4.3 Visit Detail

In Front-Office context, the Visit presents a Tabs w/in Tabbed Dialog. There is a group of data entry fields on the top portion of the screen that is concerned with capturing information that applies to the entire visit. Th bottom portion of the screen is a tabbed dialog that captures:

- Diagnoses
- Quick-Picks

Visit Details

Visit Type	Displays Visit Type from the main Visit form
Physician	Enter/Select the Physician performing the services on the visit
Assistant	Enter/Select the Assistant performing the services on the visit
Facility	Enter/Select the Facility in which the procedure was performed
Location	Enter/Select the Location (Place of Service) in which the procedure was performed
PCP	Enter/Select the Primary Care Provider for the patient on the visit

4.4.2.4.3.1 Diagnoses

You may enter up to four(4) diagnoses for a visit. They should be entered in descending order of importance from primary diagnosis to last diagnosis.

(Diagnosis)	Enter/Select the diagnoses
(Description)	The diagnosis description is displayed
Related	Indicate any diagnoses related to the procedures to be entered. You may edit these on the Charges Tab to tie specific procedures to diagnosis combinations.

4.4.2.4.3.2 Quick Picks

Many times, certain routine procedures such as monitoring lines, and Evaluation and Management procedures are used quite frequently. The Quick Picks tab allows the user to select from a list of these procedures and bill them along with the rest of the procedures on the Visit. These procedures are defined for each Practice in Practice Setup on the Quick Picks tab.

4.4.2.4.4 Anesthesia

The Visit, in Anesthesia Context presents a <u>Tabs w/in Tabbed Dialog</u>. There is a group of data entry
fields on the top portion of the screen that is concerned with capturing information that applies to the
entire visit. The bottom portion of the screen is a tabbed dialog that captures:

- <u>Procedures</u>
- <u>Diagnoses</u>
- <u>Case Times</u>
- <u>Risk Factors</u>
- <u>Quick-Picks</u>
- <u>PQRI</u>

Anesthesia Main

Visit Type	Displays Visit Type from the main Visit form
Visit Date	Displays Visit Date (Service Date) from the main Visit form
Anesthesiologist	Enter of select the first Anesthesiologist on the visit
Anesthetist	Enter or select the first Anesthetist on the visit
Surgeon	Enter or select the Surgeon on the visit
Facility	Enter or select the Facility in which the procedure was performed
Location	Enter or select the Location (Place of Service) in which the procedure was performed
PCP	Enter/Select the Primary Care Provider for the patient on the visit
OR Suite	Enter or select the O/R Suite in which the procedure was performed
Anes Type	Enter or select the anesthesia type which was used for the procedure

4.4.2.4.4.1 Procedures

Primary Surgical Procedure

Svc Date	Service Date for the primary surgical procedure.
Procedure	Enter/Select the primary surgical procedure code.
ASA	If the primary surgical procedure crosswalks to more than one ASA procedure code, select the appropriate ASA code from the list. Selection of an ASA procedure code will set the base units value.
OR Suite	Indicates the OR Suite in which the primary procedure was performed.
Anes Type	Indicates the Type of Anesthesia for the primary procedure performed.
Modifiers	Enter/Select up to four modifiers. Some modifiers are automatically handled by MedSuite. Setting the Medical Direction may set one of the modifiers to a medical direction modifier used by the plan. In addition, anesthesia types may be setup such that modifiers are set for certain anesthesia types (monitored anesthesia care) practice-wide or for a specific plan.
Base Units	Base units will be retrieved from the ASA Procedures table for the ASA code selected. Several methods exist which can be used to override the base units:

- Override by Plan and ASA Code
- Override by Medical Direction (Directing 5-9 Anesthetists)
- Manual Override

Modify	If base units are overridden manually, check the Base Unit Modify checkbox. This will prevent the anesthesia charge calculation from performing its normal base unit processing. In effect, you are telling the calculation to use the base units entered.
Medical Direction	The Medical Direction will default as specified in the Division setup for the division that has been entered on the visit. This will be used to calculate the fee. Medical directions are tied to the anesthesia conversion factor (rate per unit). You should not normally need to change what is defaulted into this field. However, you may force the calculation to use a different medical direction and conversion factor. There is also a Medical Direction Override that is tied to procedure codes for primary procedures, only when they are entered in conjunction with a secondary procedure. NOTE: If a primary and secondary procedure are entered on a visit the Medical Direction is calculated on the secondary procedure and the primary procedure takes on that Medical Direction if there is no Medical Direction override setup on the procedure code. If the Medical Direction Override is setup on the procedure code it follows the Medical Direction Override.
File Insurance	Indicates if the File Insurance indicator will be overridden for the Primary Procedure.

Secondary Surgical Procedure

Procedure	Enter/Select the secondary surgical procedure. This secondary billable procedure was designed for OB Cases, Epidural to C-section procedures, so the user could enter the 2 procedures on one Visit screen and bill for both.
Svc Date	Service Date for the secondary surgical procedure. If you have a case that spans midnight please enter the second time segment starting the following day. (i.e. Labor epidural Start date 03/01/05, Start Time 15:00 and Stop Time 02:00 AM. C-section is entered as a secondary procedure and the second time segment should be keyed – Start Date 03/02/2005, Start Time 02:00 AM to 03:00 AM.)
ASA	If the primary surgical procedure crosswalks to more than one ASA procedure code, select the appropriate ASA code from the list. Selection of an ASA procedure code will set the base units value.
OR Suite	Indicates the OR Suite in which the secondary procedure was performed.
Anes Type	Indicates the Type of Anesthesia for the secondary procedure performed.
Modifiers	Enter/Select up to four modifiers. Some modifiers are automatically handled by MedSuite. Setting the Medical Direction may set one of the modifiers to a medical direction modifier used by the plan. In addition, anesthesia types may be setup such that modifiers are set for certain anesthesia types (monitored anesthesia care) practice-wide or for a specific plan.
Base Units	Base units will be retrieved from the ASA Procedures table for the ASA

code selected. Several methods exist which can be used to override the
base units:

- Override by Plan and ASA Code
- Override by Medical Direction (Directing 5-9 Anesthetists)
- Manual Override

Modify
: If base units are overridden manually, check the Base Unit Modify checkbox. This will prevent the anesthesia charge calculation from performing its normal base unit processing. In effect, you are telling the calculation to use the base units entered.

File Insurance
: Indicates if the File Insurance indicator will be overridden for the Primary Procedure.

Additional Procedures 1-4

You may enter up to four(4) additional surgical procedures for a visit. MedSuite will automatically bill the procedure with the highest base unit value. This is frequently used when a multiple procedures are performed through the same incision such as an Appendectomy and a Hysterectomy.

(Procedure)
: Enter/Select the additional surgical procedure(s)

ASA
: If the additional surgical procedure xwalks to more than one ASA procedure code, select the appropriate ASA code from the list. Selection of an ASA procedure code will set the base units value.

Base
: Base units will be retrieved from the ASA Procedures table for the ASA code selected. Base units may be overridden by:

- Plan and ASA Code
- Manual Override

Modify
: If base units are overridden manually, check the Modify checkbox. This will prevent the anesthesia charge calculation from performing its normal base unit processing. In effect, you are telling the calculation to use the base units entered.

4.4.2.4.4.2 Diagnoses

You may enter up to four(4) diagnoses for a visit. They should be entered in descending order of importance from primary diagnosis to last diagnosis.

(Diagnosis)
: Enter/Select the diagnoses. Press F8 to access the [Procedure/ Diagnosis X-Walk](#).

(Description)
: The diagnosis description is displayed

Related
: Indicate if the diagnosis is related to the surgical procedure.

Related Diagnoses

Primary Procedure
: The primary procedure description is displayed along with a set of check-boxes that allow the procedure to be tied to any of the four

diagnosis codes entered.

Secondary Procedure	The secondary procedure description is displayed along with a set of check-boxes that allow the procedure to be tied to any of the four diagnosis codes entered.
Add'l Procedure 1	Additional Procedure 1 description is displayed along with a set of check-boxes that allow the procedure to be tied to any of the four diagnosis codes entered.
Add'l Procedure 2	Additional Procedure 2 description is displayed along with a set of check-boxes that allow the procedure to be tied to any of the four diagnosis codes entered.
Add'l Procedure 3	Additional Procedure 3 description is displayed along with a set of check-boxes that allow the procedure to be tied to any of the four diagnosis codes entered.
Add'l Procedure 4	Additional Procedure 4 description is displayed along with a set of check-boxes that allow the procedure to be tied to any of the four diagnosis codes entered.

4.4.2.4.4.3 Case Times

You may enter an unlimited number of time segments for both anesthesiologists and anesthetists on a visit. Each time segment may have a different anesthesiologist or a different anesthetist. Time calculations are based on these split times. However, there must be an anesthesiologist "of record" and an anesthetist "of record" which are the anesthesiologist and anesthetist to be billed. The Anesthesia Tab of Practice Setup tells visit entry which of the anesthesiologists and anesthetist entered are to be the anesthesiologist and anesthetist of record based on:

- First on the Case
- Last on the Case
- Longest Time on the Case

When a new visit is being created, the user is prompted to enter the first anesthesiologist time segment defaulting the time segment anesthesiologist from the anesthesiologist on the main anesthesia tab. After this time segment is accepted, the first anesthetist time segment is automatically calculated defaulting the time segment anesthetist from the anesthetist on the main anesthesia tab.

The case times will default from the main visit wizard screen but if you have visits containing multiple start and stop times (one Anesthesiologist or CRNA relieving another) you would need to enter those on the Case Times tab. Select New and enter in the start & stop time of the Anesthesiologist or Assistant the case is being turned over to. Case times should start when the time segment before it ends. When entering hand off's make the start and stop times for the two time segments the same. Make sure that the procedure entered corresponds in the Procedure drop down primary/secondary.

If you have a case that spans midnight please enter the second time segment starting the following day. (i.e. Labor epidural Start date 03/01/05, Start Time 15:00 and Stop Time 02:00 AM. C-section is entered as a secondary procedure and the second time segment should be keyed – Start Date 03/02/2005, Start Time 02:00 AM to 03:00 AM.)

Anesthesiologist Case Times

Anesthesiologist	Enter/Select the anesthesiologist
Surg Proc	Enter/Select to indicate if the case time segment is tied to the primary or the secondary procedure.
Start Time	Enter the time (24hr clock) the anesthesiologist started. Case times may be required input fields.
Stop Time	Enter the time (24hr clock) the anesthesiologist stopped Case times may be required input fields.
Minutes	The total time in minutes is calculated and displayed
HHMM	The total time in hours and minutes is calculated and displayed
Hold	Indicates if the time segment is considered time in the holding area

Anesthesiologist Case Times - Buttons

New	Enter a new time segment for the anesthesiologist
Edit	Edit the selected time segment for the anesthesiologist
Delete	Delete the selected time segment for the anesthesiologist

Anesthetist Case Times

Anesthetist	Enter/Select the anesthetist
Surg Proc	Enter/Select to indicate if the case time segment is tied to the primary or the secondary procedure.
Start Time	Enter the time (24hr clock) the anesthetist started. Case times may be required input fields.
Stop Time	Enter the time (24hr clock) the anesthetist stopped. Case times may be required input fields.
Minutes	The total time in minutes is calculated and displayed
HHMM	The total time in hours and minutes is calculated and displayed
Hold	Indicates if the time segment is considered time in the holding area

Anesthetist Case Times - Buttons

New	Enter a new time segment for the anesthetist
Edit	Edit the selected time segment for the anesthetist
Delete	Delete the selected time segment for the anesthetist

4.4.2.4.4.4 Risk Factors

Certain risk factors also play a role in the calculation of anesthesia charges. The patients physical status is on of these factors. The Anesthesia Preference attached to each plan defines how many units and what modifiers may be assigned depending on the physical status selected on the Visit. In addition, other risk factors tied to the patients age, emergency conditions, or anesthesia technique used may come into play as well.

Physical Status

Select the physical status that applies to the patient:

- P1 - Normal
- P2 - Mild Systemic Disease
- P3 - Severe Systemic Disease
- P4 - Life Threatening Disease
- P5 - Moribund
- P6 - Organ Donor

Complicating Factors

Select all complicating factors that apply to the patient:

- 99100 - Anesthesia Complicated by Extreme Age
- 99116 - Anesthesia Complicated by Total Body Hypothermia
- 99135 - Anesthesia Complicated by Total Body Hypothermia
- 99140 - Anesthesia Complicated by Emergency Conditions

99100 - Extreme Age cannot be set by the user. Extreme age is determined by the minimum and maximum ages defined on the Anesthesia Preference.

4.4.2.4.4.5 Quick Picks

Many times, certain routine procedures such as monitoring lines, and Evaluation and Management procedures are used quite frequently. The Quick Picks tab allows the user to select from a list of these procedures and bill them along with the rest of the procedures on the Visit. These procedures are defined for each Practice in Practice Setup on the Quick Picks tab. The Quick Pick file contains a Visit Type so based on what type of Visit is entered (anesthesia, chronic pain management, acute pain management etc..) only Quick Picks for that Visit Type will display for the user to select. If the Visit Type is left blank on a Quick Pick the Quick Pick will apply to all Visit Types.

4.4.2.4.4.6 PQRI

This tab is read only and contains the PQRI details for the Visit.

Measure	The measure number
Procedure	The anesthesia or monitoring line procedure billed
M1	modifier 1 billed with the anesthesia or monitoring line procedure
Provider	The name of the provider
PQRI CPT	PQRI CPT Code.Example - 4048F: Antibiotic Ordered/Given
PQRI M1	PQRI Modifier for the PQRI CPT Code. FOr example, 4048F-1P

The buttons on the PQRI Tab function in the following manner:

Check PQRI	Perform validation of the procedure codes entered on the case and determines which of the codes are eligible for which PQRI Measures and then prompts the user through selecting valid responses.
New	Manually add a new PQRI response
Edit	Manually edit a PQRI response
Delete	Manually delete a PQRI response

4.4.2.4.5 Charges

The Charges Tab of Visit Entry displays a list of charges to be billed on the Visit. If the visit is an anesthesia visit, there will be one or more charges in the Charges for Visit list that are created as a direct result of the anesthesia charge calculation. The user may add or remove charges from the list. However, the charge(s) created from the Anesthesia tab may not be removed.

Visit Type	Displays Visit Type from the main Visit form
Begin Date	Displays Visit Date (Service Date) from the main Visit form
End Date	Enter of select the first Anesthesiologist on the visit

Charges for Visit

From Date	Displays charge begin service date
Procedure	Displays charge procedure description
Modifiers	Displays charge modifiers
Charges	Displays charge amount
Anes	Indicates (with a checkbox) if the charge was created from the anesthesia procedures tab
Staff Type	Indicates if the charge if for the doctor (anesthesiologist) or nurse (anesthetist)
Modified	Indicates in the user has overridden the charge amount in the Sow Calc form.

Charges for Visit - Buttons

Recalc	Performs recalculation of the charges
Show Calc	Displays the Show Calc screen for the selected charge
Legend	Displays Charges Legend form. Legend indicates the charges with olive green background in the Anes column are anesthesia charges. Charges with a blue background in the Modified column have been modified by the user.
New	Enter a new charge
Edit	Edit the selected charge
Delete	Delete the selected charge

Procedure

From Date	Displays charge begin service date
Thru Date	Displays charge ending service date
Procedure	Displays charge procedure description
Modifiers	Displays charge modifiers
Quantity	Displays charge quantity
Fee	Displays the Fee per Quantity
Charges	Displays the charge amount (Quantity * Fee)
Allowed	Displays the charge allowed amount
EPSDT	Indicates if charge is the result of Early Pregnancy Screening and Detection Testing program
Family Plan	Indicates if charge is the result of Family Planning program
Emergency	Indicates if charge is the result of a Emergency condition
COB	Indicates if Coordination of Benefits is in effect for the charge
Base Units	Displays the Base Units associated with the ASA Code
ASA Code	Displays the ASA Code tied to the procedure
Physician	Displays physician/anesthesiologist lookup
Assistant	Displays assistant/anesthetist lookup
File Ins	Indicates how/if the File Insurance flag is overridden for the procedure

Location	Displays location lookup
Place Svc	Displays place of service lookup
Type Svc	Displays type of service lookup
Diag1 - Diag 3	Displays the diagnosis codes, descriptions, and related to indicators of the first three diagnoses on the case.

4.4.2.4.6 HCFAs

The HCFA's Tab of Visit Entry accepts HCFA-1500 Insurance Form information to be billed on the Visit.

Visit Type	Displays Visit Type from the main Visit form
Visit Date	Displays Visit Date (Service Date) from the main Visit form

Condition Related To (Box 10)

Not Applicable	Will check the Not Applicable option of Box 10 on the HCFA-1500
Employment	Will check the Employment option of Box 10 on the HCFA-1500
Auto Accident	Will check the Auto Accident option of Box 10 on the HCFA-1500
State	Enter the Auto Accident State Code to be printed in Box 10 on the HCFA-1500
Other Accident	Will check the Other Accident option of Box 10 on the HCFA-1500

Reserved form Local User (Box 10d)

(Text)	Enter applicable text that is required by a carrier in Box 10d on the HCFA-1500

Release Information/Date (Box 12)

Authorized Signature	Indicates that an authorized signature to approve release of information to the carrier is on file
Date	Authorized signature date for Box 12 of the HCFA-1500

Benefits Assigned (Box 13)

Authorized Signature	Indicates that an authorized signature to approve assignment of benefits to the physician is on file

Current (Box 14)

Illness	Will check the Illness option of Box 14 on the HCFA-1500
Injury	Will check the Injury option of Box 14 on the HCFA-1500
LMP	Will check the LMP option of Box 14 on the HCFA-1500
Date	Enter print the date entered as the date of the current Injury, Illness, or LMP on the HCFA-1500

Similar Illness (Box 15)

Date	Prints the date of any similar illness in Box 15 on the HCFA-1500

Unable to Work (Box 16)

From	Will print the date entered in the Unable to Work From Date in Box 16 on the HCFA-1500

Thru | Will print the date entered in this field in the Unable to Work Thru Date in Box 16 on the HCFA-1500

Hosp Dates (Box 18)

From | Will print the date entered in this field in the Hospitalization From Date in Box 18 on the HCFA-1500

Thru | Will print the date entered in this field in the Hospitalization Thru Date in Box 18 on the HCFA-1500

Local Use (Box 19)

(Text) | Enter applicable text that is required by a carrier in Box 19 on the HCFA-1500

Outside Lab (Box 20)

Lab Used | Will check the Outside Lab Used option in Box 20 on the HCFA-1500

Amount | Will print the amount entered into this field in the Outside Lab Amount field in Box 20 on the HCFA-1500

Prior Auth No (Box 23)

(Text) | Enter the number to be printed as the Prior Authorization Number in Box 23 on the HCFA-1500.

The prior authorization number may be maintained in two different locations; one is in the Insurance Demographic and the other is on the Visit - HCFA Tab. Please check with your system administrator to determine where you should be maintaining this value.

Claim Delay Reason Code

(Text) | Select the reason to be report on on paper and electronic claims for NY MCD when there is a delay in reporting the claim.

EClaim Attachment - Additional Paperwork

This table allows you to define paperwork attachments that will be reported on electronic claims in the PWK (Paperwork) segment. This feature does NOT send these attachments electronically. However, it will allow you to send "notice" that an attachment is to be forwarded separately from the claim and how the attachment will be sent.

Patient Policy | Select the policy (primary, secondary, etc.) that the PWK segment will be sent to..

Report Type Code | Select the type of attachment that will be sent. This list is defined in the ANSI claim specification.

Transaction Code | Select how the attachment will be sent (Mail, e-Mail, or Fax). This list is defined in the ANSI claim specification.

Identification Code | Enter a number or code that uniquely defines the attachment,. Some payers provide pre-numbered blank forms to use while others rely on the

provider to define the attachment number. This code will help the payer identify which claim an inbound attachment belongs with when it is received.

4.4.2.4.7 Visit Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

	• Patient - Images indexed to the patient (Action = Patient)
	• Visits - Images indexed to visits (Action = Visit-New)
	• Payments - Images indexed to visits (Action = Payment Insurance -
	  New or Payment Self - New)
	• Claims - Images indexed to claims (Action = Claim Followup)
	• Miscellaneous - Images indexed via Manual Indexing to some other
	  entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.

In effect, the image is placed in an Imaging Station in a "ready to be processed" state.

Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

4.4.2.5 Payments

MedSuite's payment system is designed in three tiers:

Payment	The Payment tier represents a check or an Explanation of Benefits (EOB). This tier only contains information specific to a check or EOB. It does not contain any information that identifies claims, subscribers, patients, etc.
Payment Distribution	The Payment Distribution tier represents a payment or adjustment on a claim or on an account. This tier contains information specific to a claim or account. Multiple Payment Distributions may exist for a Payment as would be the case on a bulk insurance payment such as a Medicare EOB.
Payment Distribution to Charges	The Payment Distribution to Charges tier represents the distribution of payment and adjustment amounts to individual charge line items. Multiple Payment Distributions to Charges may exist for a Payment Distribution.

MedSuite provides two different contexts for payment entry:

Single	Open a patient or an account and access the Payments List by using the Navigation bar or the Record Menu.
Batch	Select Payments from the Financials/Followup Section of the Navigation Bar or from the Financials/Followup sub-menu of the Navigation Menu

Within each Payment Entry mode, MedSuite provides several styles of payments:

Self	Self Payments are payments received from patients or accounts are applied in the Self Style. Self Style is available in both Single and Batch Payment Entry modes.
Insurance	Insurance Payments received from an insurance carrier are sometimes paid in a format that contains one claim per Explanation of Benefits (EOB). Insurance Style is available in both Single and Batch Payment Entry modes.
Bulk	Insurance carriers often pays multiple claims on a single EOB. This is referred to as a Bulk Payment. MedSuite contains check "balancing" logic that allows the user to track and balance Bulk Payments to the EOB. Since Bulk Payments usually contain payments for multiple patients and Single Payment Entry mode is only accessible when you are "inside" an account or patient, Bulk Style Payments are not available on Single Payment Entry mode. Bulk Style is only available in Batch Payment Entry mode.

4.4.2.5.1 Payment List

Existing Payments are presented in a list consisting of a grid that contains a summary group for the payment that may be "drilled-into" by clicking on the "plus" sign. The summary group contains the Payment Document (Check or EOB) Number, the date the Payment was entered into MedSuite, and the amount paid.

Payments List

The Payments List contains about the Payment. Some of this information is actually on the Payment Distribution tier. Since the Payment only contains document number and amount information, the Payment Distribution information is both necessary and useful when we are trying to find a specific Payment in a list of Payments. The Payment List contains the following information:

Doc No	Check or EOB number
Date Entered	Date the payment was entered
Visit Date	First Visit Date the payment was applied
Claim No	Physician who performed the services
Amount Paid	Facility in which the services were performed
Plan	Charges for the Visit
Patient	Payments applied to the Visit
Account	Adjustments applied to the Visit
Subscriber	Balance remaining on the Visit

Payments List Buttons

1-Self	A new Self Payment may be created. Please refer to the Batch Payment Entry Mode section for a detailed definition of the Self Payment Entry Style
2-Ins	A new Insurance Payment may be created. Please refer to the Batch Payment Entry Mode section for a detailed definition of the Self Payment Entry Style
Edit	An existing (unposted) Payment may be edited. Posted Payments may only be viewed. The screen(s) presented are dictated by the style (Self/ Ins) in which the payment was originally entered. **Although you cannot add a Bulk Style Payment in Single Payment mode, you may edit a Bulk Style Payment in Single Payment mode and you will be placed into the Bulk Style Payment function.**
Delete	An existing (unposted) Payment may be deleted. Posted Payments may only be viewed.

4.4.3   Open Ledger

The Ledger is accessed via the standard patient and account search routines and consists of several different "views" of the data on file for a patient or an account. These different views are displayed in the different tabs, and operate in a "context" mode. Certain options are available from some views but not in others. Where applicable, these options are identified. The views in the different tabs are:

Charge/Payment View	Presents Visit and Payment information in a "drill-down" metaphor from Visit to Charges to Payment Distributions on each Charge.
Activity View	Presents Visit, Claim, and Payment information as well as billing information and memos, sequenced in Posted Date Order.
Billing View	Presents Billing information by Patient by Billing item (Claim and/or Statement).
Memo	Presents Patient Memos. New Memos may be added.
Followup History	Presents Followup History by Account and/or Claim in date/time sequence.
Conversion Ledgers	Presents print image of ledgers from legacy system in a scrollable field.
Change History	Presents messages recording changes of important information on an account such as changes in Account Class, Account Type, Suspend, Return Mail, Visit edits, demographic changes (edits and inserts) etc.
Access History	Presents a record of user access on this patient in date/time sequence.
Imaging	Presents a "tree" list of images indexed to the patient.

Options

Clicking the options button or right-clicking a row in the grid causes a pop up menu to be presented that provides different functionality depending on the "current" view. Some options are available on certain views/ledger tabs, while other options are not. Some options are available depending on whether the currently selected row in the ledger view is a visit, charge, payment, adjustment, claim, statement, or form letter. See the link to the specific function for more information about that function.

Function	Chrg/ Pymnt	Activity	Billing	Memo	Follow	Conv	Chng Hist	Description
Expand All	Y			Y	Y		Y	Expand All drill-down groups
Collapse All	Y			Y	Y		Y	Collapse All drill-down groups
Jump to Visit	1	1						Jump to Visit Entry for the selected Visit
Jump to Payment	2	2						Jump to Payment Entry for the selected Payment
Jump to Account Billing	Y	Y						Jump to the Account Holder's Billing Tab of the demographics.
View Charge	1	1						View the selected charge
View Claim		3	3					View the selected claim. Claim may then be printed immediately.
Batch Reprint			3					Reprint the claim in the next production run.

				Description
Followup Action			3, 4	Enter a Followup Action against the Claim or Statement.
Refile			3	Refile the claim in the next production run.
Release Unposted			3	Release the claim for the next production run
Remove from Collection	1			Removes a Visit from Collections that has already been turned-over
View Bill		4	4	View the selected patient statement.
Request Statement	Y	Y	Y	Request a special statement via the Close-Out
Demand Statement	6	6	6	Print a Demand Statement
ResetBillingwindow	Y	Y		Reset the insurance level of a Visit and restart the billing at that insurance level
Restart Self Billing			Y	Restart Self-Pay Billing on the Billing View
Reverse	1	1		Reverse the selected Visit.
Send Form Letter	1	1	7	Request that a Form Letter be created for processing, either immediately or in the next Closeout.
View Form Letter		5		View a previously generated form letter
Print Ledger View	Y	Y	Y	Prints the current Ledger View
Print Ledger Report	Y	Y	Y	Prints a Report of account/patient detail for the selected ledger.

Notes:

1 - Available option if a row representing a charge is selected

2 - Available option if a row representing a payment is selected

3 - Available option is a row representing a claim is selected

4 - Available option if a row representing a statement is selected

5 - Available option if a row representing a form letter is selected

6 - Demand Statements will print a Visit is selected from the Detail or Activity Views and will print the entire

account if selected from the Billing View.

7 - Certain edits take place when requesting a form letter so that a letter that contain merge fields that are visit or charge

based as division, provider, referring, procedure, date-of-service, etc. cannot be requested when a patient statement item is

selected. Patient Statements are not tied to a specific visit or charge. The edit occurs on a letter-by-letter basis. Claims

are, by definition, visit and charged based and do not have this problem.

4.4.3.1   Ledger Tabs

The views in the different tabs are:

Charge/Payment View	Presents Visit and Payment information in a "drill-down" metaphor from Visit to Charges to Payment Distributions on each Charge.
Activity View	Presents Visit, Claim, and Payment information as well as billing information and memos, sequenced in Posted Date Order.
Billing View	Presents Billing information by Patient by Billing item (Claim and/or Statement).
Memo	Presents Patient Memos. New Memos may be added.
Aging	Presents aging of patient and insurance balances at 0-30 days, 31-60 days, 61-90 days and over 90 days.
Followup History	Presents Followup History by Account and/or Claim in date/time sequence.
Conversion Ledgers	Presents print image of ledgers from legacy system in a scrollable field.
Change History	Presents a log recording the changes of important information on an account such as changes in Account Class, Account Type, Suspend, Return Mail, etc. In addition it tracks and logs the changes made to both patient and account demographics such as policy number, date of birth, or address changes. The system also tracks and logs the changes to a charge when editing an already posted Visit, like on a diagnosis, date of service, ICD9 code, modifier, location etc.
Access History	Presents a record of Access History for when different functions in MedSuite are accessed such as opening a Patient or Account Ledger, opening an Account or Patient Demographic, opening a Visit, opening a Payment, opening the Follow-up Queue, opening the Collection Turnover queue, opening the Refund Manager and opening Imaging.
Imaging	Presents a "tree" list of images that have been indexed to the patient, the patients' visits, patients' payments, etc.

Buttons

Options	Displays a "pop-up" menu with all available Ledger Options, some of which are dependent upon the Tab that is displayed. For example, a claim cannot be refiled from the Memo View.
Memo	A patient memo may be entered
Refresh	Refreshes the Ledger Data. A function performed in a different tab such as adding a payment, will not be reflected in a already open Ledger until the Refresh button is pressed.
Open Demo	Depending on the "mode" of the Ledger, this button opens the Patient or Account Demographic tab-set.
Open Billing	Opens the Account Billing Tab for the Patient or Account.

4.4.3.1.1 Charge/Payment View

Charge/Payment View "drills-down" from the Visit to individual Charges to Payment Distributions on each Charge.

Charge/Payment View List

Svc Date	On Charges, this is the service date of the charge, which is usually the same as the Visit Date. It could differ if charges from different dates of service were entered on the same Visit. On Payments/Adjustments, this field displays the Remit date.
Act Date	Posted Date of the Charge, Payment, or Adjustment.
User	Name/Initials of User who entered the activity.
Physician	Physician entered on the Visit. Blank on payments and adjustments.
Facility	Facility entered on the Visit. Blank on payments and adjustments.
Code	Procedure code for charges or the literal "Payment" on payments and "Adjustment" adjustments
Description	On charges, this is the Procedure Description. On Insurance payments and adjustments it will display first the name of the plan of the claim to which the pay/adj was posted, followed by the Payment Type or Adjustment Type that was used when it was keyed. On Self payments and adjustments, it will display "SELF" followed by the Payment Type or Adjustment Type that was used when it was keyed.
Bill No.	Claim Number that the Insurance payment or adjustment was posted against. Followed by "H" if the payment/adjustment was flagged as Held when it was posted. Followed by "D" if the payment/adjust was flagged as Disputed when it was posted. Displays 0 on a Self payment/adjustment.
Amount	Amount of the Charge, Payment, or Adjustment. Charges and Payments are shown in Black. Adjustments are shown in Green.
Open	Open balance on the Visit

Column widths can be changed by dragging the vertical borders of the columns.   Drop-down arrows at the top of each column allow the ledger to be filtered to show specific information only. A legend explains the different colors that might be displayed in the different tabs in the Ledger.

4.4.3.1.2 Activity View

The Activity View presents all data associated with a patient in chronological order. The data types displayed are charges, payments, adjustments, claims, statements, and memos.

MedSuite allows the user to bill multiple patients under a single accounts. As a result, when the Ledger is accessed in Account "mode", the list in the Activity View may display data for multiple patients. The data for each patient is separated under a patient "grouper". However, since Statements are sent to an Account, the Statements are "repeated" for each patient. In some cases, this may appear somewhat strange. For example is Patient1 for Account1 had a service date of 06/01/2006 and Patient2 for Account1 had a service date of 08/01/2006, there will likely be statements that only included balances

from Patient1, statements that included balances from both Patient1 and Patient2 and statements that included balances from only Patient2. In order to accommodate this "issue", MedSuite reports all statements for all patients under the account, even though that statement may have "occurred" prior to the service date.

The same issue exists for Memos tied to the account. MedSuite has no way of "knowing" if a Memo is relevant to all patients or only one, or possibly two of the three patients for an account. As a result, all Memos tied to the account are displayed for all patients. Again, some of these Memos could "occur" prior to the service date. The simplest way to avoid unnecessary "problems" in this area is to attach Memos that are patient-specific to a specific patient and to attach those Memos that are account-specific to the account.

4.4.3.1.3 Billing View

Presents billing information by Patient by Billing item (Claim and/or Statement)

Billing View List

Enter	Date the Bill (Claim or Statement) was created
Submit	Date the Bill (Claim or Statement) was filed. Delays may be due to pending Provider IDs (credentialling problems) or Claim Hold Days set on the visit.
Visit	Date of the Visit that a claim was generated for
Billed To	Who was the Claim (Plan) or Statement (Account) billed to
Billing No	Billing number
Output	Electronic / Paper / Test Indicator

Type	Indicates the "reason" that a Claim was generated:
	  Visit Entry
	  Payment Posted
	  Rebill
	  Auto Refile
	  User Refile
	or the "reason" that a Statement was generated:
	  Visit Entry (No Insurance)
	  Payment Posted
	  Rebill
	  Requested
	  Dunning

Status	Open, Closed, Paid, Denied, Held
Billed	Total charges for the claim or statement
Paid	Total paid on the claim or statement
Adj	Total adjusted on the claim or statement

Miscellaneous

Group By Patient	MedSuite allows the user to bill multiple patients under a single accounts. As a result, when the Ledger is accessed in Account "mode", the list in the Billing View may display claims for multiple patients. The "Group by Patient" indicator allows the user to separate claims for the various patients under a patient "grouper". Since Statements are sent to an Account, the Statements are "separated" into a separate group for the account.

4.4.3.1.4 Memo

Presents Patient memos, Account Memos, Visit Memos, Payment Notes and Follow-up History Comments. Memos may be Permanent Alerts or One-Time Alerts and are color-coded to indicate their status. Payment Notes are also color-coded, but cannot be edited or deleted like a memo can.

Memo View List

Date Entered	Date the Memo was created
User	User who created the memo
Description	Memo text

4.4.3.1.5 Aging

Presents amounts due from insurance and patient and then totals both in aging increments of 0 (current) 30, 60, and 90+ days. Aging is from the date the charge(s) was/were posted to MedSuite (the release date on the Charge Batch) to the current date. This view also shows "Unposted" amounts for visits that have been entered but not "posted" to the system through the closeout.

Aging View List

Amount due Ins	Cumulative amount due at the insurance level in the corresponding aging bucket. Current (0-30), 31-60, 61-90, and 91+.
Amount due Pat	Cumulative amount due at the self or patient level in the corresponding aging bucket. Current (0-30), 31-60, 61-90, and 91+.
Total	Cumulative total due for both the insurance and patient due amounts in the corresponding aging bucket. Current (0-30), 31-60, 61-90, and 91+.

4.4.3.1.6 Followup History

The Followup History tab presents Followup History activity. As you begin using the Followup Queue to work your accounts, the Followup History tab in the patient and account ledgers will be updated with the actions that are taking place with the Followup Queue. The date and time of the action are displayed, along with the user name and any comments they may have entered. The Action Data field will display the name of the Form Letter that was requested if the action is linked to an action code with a process type of Correspondence. It will display the amount promised is the action is linked to an action code with a process type of Promise. The default sort for the Followup History is by entered date with the oldest entered date first. If you would like to sort this differently, click on the column heading and the system will sort by the heading you select. For example if you want to view the Followup History by the next followup date, simply click on the column heading and it will sort in date order by the next followup date.

One of the important fields to note here is the *next* followup date. This will be of use if users are ever wondering why a particular account is not showing in the Followup Queue. If it has a future followup date, then it is not displayed until that date. Therefore, it is possible to have accounts listed on the Self Delinquency Report that are not currently being displayed in the Followup Queue.

Followup History View List

Entered	Date the followup action occurred
Next Followup	Next followup date resulting from the followup action that was performed
User Name	Name of user performing the followup action
Action	Name of the action that was performed
Action Data	Name of the Form Letter that was requested if the action is linked to an action code with a process type of Correspondence. Amount promised if the action is linked to an action code with a process type of Promise.
Comment	Comment entered during followup activity. This will display as a comment box in the lower part of the screen with a scroll bar on the right hand side so the entire comment can be viewed if it is lengthy. Followup History comments are also displayed in the Ledger Memo view as read-only items.

Options

Display Full Description	Allows the user to "toggle" between displaying the first line of the comments and "wrapping" the comments so that all of the comment text is displayed.

4.4.3.1.7 Change History

The Change History tab presents a log recording the changes of important information on an account such as changes in Account Class, Account Type, Suspend, Return Mail, etc. In addition it tracks and logs the changes made to both patient and account demographics such as date of birth or address changes and changes to insurance information such as updated policy or group numbers, changes to effective or termination dates, and the addition of new insurance plans. The system also logs the changes to a charge when editing an already posted Visit, such as a diagnosis code, date of service, ICD9 code, modifier, location, etc.

Change History View List

Date Changed	Date the change occurred.
User Name	Name of user initiating the action.
Type	Indicate whether the action was an Update or an Insert. Insert means a new entry such as a new insurance plan. An update is an edit or change to existing entry, or if a field was previously blank and has been filled in, such as the addition of an apartment number in the Address2 field that may have been previously blank.
Item Changed	Indicates where the change occurred (Patient, Account, Visit, Policy) and the Name of the field or item changed (Returned Mail Flag, Suspend Statement, ICD9 code, Date of Service, SSN, Modifier, etc.)
Old Value	Value of item before the change. Blank if the field was previously blank.
New Value	Value of item after the change.

4.4.3.1.8 Access History

The Access History tab presents a record of user access on this patient into functions such as a Patient or Account Ledger, Account or Patient Demographics, Visits, or Payments etc. More detail about access can be obtained by the Administrator via the Access Log Report.

Access History View List

User Name	Name of the user initiating the access.
User Type	The User Type of the User as defined in User Maintenance.
Access Type	Name of the function that was accessed (Patient Ledger, Patient Demographic, Visit, etc.)
Date Entered	The date when the access occurred.
Time Entered	The time when the access occurred.

NOTE: For system performance reasons, the local MedSuite client software does not send every access event from the client to the server every time one occurs. Instead, access events are sent after a user has performed 25 events, or logged out of MedSuite, or gone to a patient Ledger tab and selected the Access History tab. If any of those 3 things occur, MedSuite will send the local access log to the server so that the access events can be reported on the Access Log or on the Access History tab of the patient ledger.

4.4.3.1.9 Ledger Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.

The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

- Patient - Images indexed to the patient (Action = Patient)
- Visits - Images indexed to visits (Action = Visit-New)
- Payments - Images indexed to visits (Action = Payment Insurance -
  New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
  entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image

Un-Index   Displays the <u>Move Images to Imaging Station</u> screen. You should enter/
                            select the Imaging Station that you want the document moved to. When
                            you press Ok on the Move Images screen, the selected image is
                            removed from the Image Tree and any indexes on the image are removed
                            from the image.

                            In effect, the image is placed in an Imaging Station in a "ready to be
                            processed" state.

                            Un-Index can be used any time that an image is index to the wrong
                            entity. Although it may be used on Patients, Visits, Payments, or
                            Claims, this is not typical. The Workflow will generally create these
                            entities so it is unlikely that they will be incorrectly indexed.

4.4.3.2   Ledger Options

Clicking the Options button or right-clicking a row in the grid causes a pop up menu to be presented that
provides different functionality depending on the "current" view. Some options are available on certain
views/ledger tabs, while other options are not. Some options are available depending on whether the
currently selected row in the ledger view is a visit, charge, payment, adjustment, claim, statement, or form
letter. See the functions for more information about that function.

4.4.3.2.1 Demand Statement

A Demand Statement is an itemized statement to the account holder that will print a paper statement
immediately, as opposed to going through the next Closeout and being processed with all the other
statements (as a batch to be printed or sent electronically).

From the Ledger, a Demand Statement may be printed from the Charge/Payment, Activity, or Billing
Views by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of
the screen.   The Demand Statement option will be available if the currently selected row in the Charge/
Payment or Activity View is a Visit or a Charge, or if the current view is the Billing View.

After selecting the Demand Statement option, a box is displayed with several options:

Chgs, Pmts, and Adjs on the Visit   This option is only available if the currently selected row in
Selected   the Charge/Payment or Activity View is a Visit or a Charge.
                                           The Statement will print activity for the selected visit only.
Chgs, Pmts, and Adjs on Visits within   The Statement will print charge, payment, and adjustment
the Selected Date Range   activity for all visits that occur during the date range specified
                                           in the Activity Date Range below.
All Activity within the Selected Date   The Statement will print all activity for all visits that occur
Range   during the date range specified in the Activity Date Range
                                           below. This will include claim and account billing activities as
                                           well.
Beginning Date   Beginning date of the Demand Statement activity date range.
Ending Date   Ending date of the Demand Statement activity date range.

4.4.3.2.2 Remove From Collection

The Remove From Collection option may be used to remove an account from collections that has already been turned-over. From the Ledger, this option is available from the Charge/Payment View if a visit has been turned over to collections and is displaying in red, by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen.

After selecting the Remove From Collection option, the visit will no longer display in red in the ledger. However, this does not change the Account Class, or remove a Collection Agency Code, or reverse a collection adjustment, or remove the "In Collections" flag from the Account Billing Tab. If necessary, the user should perform these functions. The Account Class, Collection Agency, and In Collections flag may all be change on the Account Billing Tab.

4.4.3.2.3 Request Statement

A Request Statement is a statement to the account holder that will be generated in the next Closeout when statements are selected. It will be processed with all the other statements and be included with them in the batch to be printed or sent electronically.

From the Ledger, a Request Statement may be selected from the Charge/Payment, Activity, or Billing Views by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen.

After selecting the Request Statement option, a box displays allowing you to select a Billing Message, indicate whether it will be recurring, or enter an Override Billing Message option to print a free-form message on the statement. (You should not use both; if anything is entered in the Override Billing Message, the selected Billing Message will not be used). Either of these will override the Dunning Message. If both options are left blank, the current Dunning Message will be printed on the statement. A statement billing record will be added and displayed in the Billing View showing that a statement has been requested. It will display in light-blue ("unposted") until it is processed by the next Closeout when statements are selected.

4.4.3.2.4 Reset Billing

Reset Billing will restart the billing at a specific insurance level if selected while on a visit with insurance, or restart the Self-pay billing if selected while on a Self Bill in the Billing View.

If you change or add an insurance plan, you need to reset the billing so the system will recognize the new plan and generate a new claim. The old claim "billing record" will be closed. Since the reset billing will be a new claim the aging will restart if there were previous claims open. Important: The Reset Billing option resets the ENTIRE visit, not a particular charge(s) on a visit.

From the Ledger, Reset Billing may be performed from the Charge/Payment, Activity, or Billing Views by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen. You may also Reset Billing from the Follow-up Wizard.

Reset Billing - Insurance
Once you select the Reset Billing option, select the **Coverage Type**: Regular, Workers Comp, No-fault Auto or Other. As noted on the screen, if necessary, you may change the coverage type here. However, please note that charges will NOT be recalculated with new billed or allowed Fee Schedules, Rate

Structures, Units, Quantities, etc. If you wish to update these fields, you must Reverse, Reissue, and Re-post the Visit using the appropriate Coverage Type. Reset Billing will, however, update the Medical Direction modifiers to the ones required by the new plan, or remove the modifiers from the MD and CRNA modifiers if the new plan does not use Medical Direction modifiers. Reset Billing will remove the visit from Collection Turnover (if it is in Collection Turnover).

A red message is displayed in the Reset Billing screen beside the **"Force Refile To"** field alerting the user that leaving the field BLANK will allow the system will file the new claim according to the Patient Insurance Setup. The user should only utilize the Force Refile To field if OVERRIDING the plan setup. For example, if a plan is set to file claims electronically but you need to attach additional documentation to have the claim paid, select PAPER in the "Force Refile To" drop down. In most instances the user should leave this field blank to file the claim according to the plan setup.

Select the insurance plan to reset the billing on and then choose OK. The Billing View of the ledger will display a new claim billing record in light blue as un-posted. This means the new claim will generate in the nightly closeout.

4.4.3.2.5 Reset Billing - Line Item

Insurance Payment Entry is the principal means for performing line-item refiles. However, it is likely that some miss-paid line-items will not be refiled by the payment entry staff like they ought to be. Therefore, another way of performing a Line-Item Refile needs to be available. Reset Ins - Line Item will restart the billing at a specific insurance level for specific line items.

The old claim "billing record" will be closed. Since the reset billing will be a new claim the aging will restart if there were previous claims open. Important: The Reset Ins Billing - Line Item option resets particular charge(s) on a visit.

Once you select the Reset Ins Billing - Line Item option, select the **Coverage Type**: Regular, Workers Comp, No-fault Auto or Other. As noted on the screen, if necessary, you may change the coverage type here. However, please note that charges will NOT be recalculated with new billed or allowed Fee Schedules, Rate Structures, Units, Quantities, etc. If you wish to update these fields, you must Reverse, Reissue, and Re-post the Visit using the appropriate Coverage Type. Reset Billing will, however, update the Medical Direction modifiers to the ones required by the new plan, or remove the modifiers from the MD and CRNA modifiers if the new plan does not use Medical Direction modifiers. Reset Billing will remove the visit from Collection Turnover (if it is in Collection Turnover).

A red message is displayed in the Reset Billing screen beside the **"Force Refile To"** field alerting the user that leaving the field BLANK will allow the system will file the new claim according to the Patient Insurance Setup. The user should only utilize the Force Refile To field if OVERRIDING the plan setup. For example, if a plan is set to file claims electronically but you need to attach additional documentation to have the claim paid, select PAPER in the "Force Refile To" drop down. In most instances the user should leave this field blank to file the claim according to the plan setup.

Select the insurance plan to reset the billing on for each charge and then choose OK. The Billing View of the ledger will display a new claim billing record in light blue as un-posted. This means the new claim will generate in the nightly closeout.

4.4.3.2.6 Reset Billing - Self

Reset Billing - Self
If the Reset Billing option is selected while the cursor is on a Self Bill in the Billing View, a Reset Self Billing will be performed on the account. The Self Pay balance will restart the aging process from the date of the Reset. The Dunning will be reset to the first dunning message, and the Collection Letter counter

will be reset as well. The Billing View of the ledger will display a new Self billing record in light blue as un-posted. This means the statement will generate in the nightly closeout.

4.4.3.2.7 Reverse Visit

Reverse Visit is used when you need to make corrections to a visit, such as a physician, start/top time, facility, or CPT code. Reversing a Visit is also often necessary if insurance information has been changed on an account, and the new plan bills differently than the old plan (split MD & CRNA billing), or if the contracted allowed amounts are different. For example, if a plan is switched from Medicare that bills an MD and separate CRNA charge, to a Commercial plan that bills one charge with no contracted allowed amounts, the visit should be reversed and "re-issued." The Reverse Visit Wizard is tool that will allow you to reverse a visit and immediately re-issue the visit to make corrections, without having to key the entire visit from scratch.

The Reverse Visit option will reverse an entire visit, not just an individual charge on a visit, and any payments or adjustments that have been posted on that visit to date. You can Reverse Visit and Reissue Visit if you need to make any corrections, such as the physician, CPT code, facility, or if the insurance plan has changed. If the visit had been entered on the wrong patient, you may just Reverse Visit and *not* Re-issue in that case. The reversed visit will show in a coral color in the ledger, and will "undo" the Visit and any payments or adjustments posted to that visit. The payments will need to be re-posted normally to the new visit when it is re-issued correctly.

To Reverse a Visit, make sure the mouse has selected the Visit to be reversed by pointing and clicking on the line of the ledger for the *visit* (visits display in light-green in the ledger, blue if the visit is selected as above). If the mouse cursor is on a *VISIT* line when you right-click, you will have an option to Reverse Visit. From the Ledger, Reverse Visit may be performed from the Charge/Payment or Activity Views by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen. Selecting Reverse Visit will invoke the Reversal Wizard. A warning will display: "You are about to reverse a visit. All charges, payments and adjustments will be reversed and payments must be reapplied to a new visit. A reversal cannot be undone. Please verify this is what you want to do." If you would like to reverse the visit and re-issue with corrections select Yes. If you would like to reverse but *not* re-issue a new visit, select No. If you select Yes, the system will prompt you for a Batch to put the new visit in. Select the Batch or create a new batch for the new visit. Select Finish.

If the Visit has any payments applied to any of the charges, a payment batch must also be selected. The total of the payments applied that are to be reversed will be written to the payment batch as a Bulk Payment with no claim distributions. This is true whether the reversed payments were originally bulk, insurance, or self pay. MedSuite uses the bulk payment as a "place-holder" or "tickler" so that the user will be reminded to re-apply the reversed payments.

Now the ledger will display the original visit, the reversal, and any payments/adjustments for that visit in a coral color, and a new light blue "unposted" visit if you re-issued the visit. Edit the unposted visit and make the necessary changes by right-clicking on the new visit, and selecting the option Jump to Visit. Note that if the insurance plan has been changed, you will need to *recalculate* the charges on the reissued visit. After making the necessary changes or recalculating the charges, you do not need to do anything else (like refile or reset billing). The new visit will post in the nightly closeout and a new claim will be generated.

When a Visit is reversed, any open claims for the original visit are *closed*, unlike a single charge reversal, which leaves the original claim open.

4.4.3.2.8 Reverse Charge

Reverse Charge allows you to reverse a single charge on a visit, instead of having to reverse the entire visit in order to remove one of the charges on the visit.   For example, you may use the Reverse Charge option if you need to un-do a single charge from a visit with multiple charges, such as an Age or Emergency charge, or a line or other modifier charge, or a post-op pain charge on a visit.

From the Ledger, Visit or Charge Reversals may be performed from the Charge/Payment or Activity Views by either *right-clicking* to invoke the pop-up menu, or selecting the *Options* button at the bottom of the screen.

To reverse a single charge, make sure the mouse has selected the individual charge to be reversed by pointing and clicking on the charge (charges display yellow in the ledger). If the mouse is on a *CHARGE* line when you right-click to invoke the pop-up menu, you will have an option to Reverse Charge. After selecting the option to Reverse Charge, a Warning will be displayed, and you will be asked if you want to reverse the selected charge. After selecting Yes, the Charge will be reversed, as well as any Payments and Adjustments that had been posted to the Charge. Please note that a Reversal cannot be undone after you have selected Yes.

If the charge to be reversed has any payments applied to it, a payment batch must also be selected. The total of the payments applied that are to be reversed will be written to the payment batch as a Bulk Payment with no claim distributions. This is true whether the reversed payments were originally bulk, insurance, or self pay. MedSuite uses the bulk payment as a "place-holder" or "tickler" so that the user will be reminded to re-apply the reversed payments.

Another box will be displayed to remind you that if you would like a new, corrected claim to be produced, you will need to Reset Billing. The original claim will remain *open* unless you reset billing to create a new, corrected claim. If you do not need to file a corrected claim, you do not have to reset the billing; the original claims remains open and payments can be posted to it.

After the Reverse Charge is complete, the reversed charge/payments/adjustments visit will show in a coral color in the ledger.

A visit with a Physician and a separate system-created CRNA charge will not allow either of those charges to be reversed individually. If you need to reverse either the MD or CRNA charge, the entire visit will need to be reversed. In addition, "Secondary Procedures" may not be reversed (such as the C-Section following a Labor Epidural, if it was entered using the Primary/Secondary Procedure function in Visit Entry). If a Visit only has one Charge, the entire Visit must be reversed; you may not use the Reverse Charge option in that case.

4.4.3.2.9 View Bill

The View Bill option allows you to view a previously generated statement on an account.

From the Ledger, this option is available from the Activity or Billing View by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen.   The View Bill option will be available when the currently selected row in the Activity or Billing View is a statement billing record.

After selecting the View Bill option, the statement will be displayed on the screen for viewing.

4.4.3.2.10 View Claim

The View Claim option allows you to view a previously generated claim. From the Ledger, this option is available from the Activity or Billing View by either right-clicking to invoke the pop-up menu, or selecting

the Options button at the bottom of the screen.   The View Claim option will be available when the currently selected row in the Activity or Billing View is a claim billing record. Both electronic and paper claims may be viewed; electronic claims will be displayed in a HCFA paper claim format.

After selecting the View Claim option, the claim will be sent to the View Claim/Stmt tab in the Task Viewer, where it may be viewed or reprinted. No notation is made in the account that the claim has been viewed and/or reprinted.

Reprinting will reprint the original claim, exactly as it was originally. It will have the original file date and data (so if there was an incorrect policy number on the claim before, which has since been corrected, a reprinted claim will still print the incorrect policy number.) A reprint will not close the original claim or restart the aging. No notation is made in the account that the claim has been viewed and/or reprinted.

4.4.3.2.11 Batch Reprint

The Batch Reprint option allows you to reprint a previously generated claim. The claim will be generated in the next Closeout where claims are selected. Reprinting will reprint the original claim, exactly as it was originally. It will have the original file date and data (so if there was an incorrect policy number on the claim before, which has since been corrected, a reprinted claim will still print the incorrect policy number.) A reprint will not close the original claim or restart the aging.

From the Ledger, the Batch Reprint option is available from the Activity or Billing View by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen. This option will be available when the currently selected row in the Activity or Billing View is a claim billing record.

The Billing View of the ledger will display the Re-printed claim in light blue as un-posted. This means the claim will generate in the nightly closeout.

Note regarding MEDIGAP claims: Medigap claims are not generated for printing via the Batch Reprint function. To print a Medigap claim, you should use the View Claim option, then print. Claims that are designated as Medigap claims do not get printed by the system in a Closeout.

4.4.3.2.12 Edit Claim

The Edit Claim option allows you to view the data that makes up a claim. The MedSuite Support Department may use this option to diagnosis claim issues or problems.   From the Ledger, this option is available from the Activity or Billing View by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen.   The Edit Claim option will be available when the currently selected row in the Activity or Billing View is a claim billing record.

After selecting the Edit Claim option, a window will be displayed showing the claim Header information. A drop-down box at the top allows different parts of the claim to be displayed, such as Patient Header, Insurance Header, Detail, Detail Place, etc.

4.4.3.2.13 Refile

Refile should be used when anything is updated on a visit or an existing plan. Example: if the policy number or group number were entered incorrectly and you need to submit a corrected claim, you could use a refile. The re-file would print out the new data with the current date on the claim. However, the claim will be aged from the original submission date. If you have added a new plan code you should NOT Refile to the new plan; in this case use Reset Billing or if the plan bills differently, Reverse.

From the Ledger, Refile may be performed from the Billing View on an open claim by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen. Users can also perform refiles through the [Followup Wizard](#). Once the Refile is requested the system will ask if the claim should be refiled with the current insurance. After selecting Yes, the system will then prompt the user to tell it how to file the claim. If a user leaves the "Force Refile To" field BLANK the system will file the claim as it was originally filed regardless of the paper/electronic setting on the plan setup. A user should only utilize the "Force Refile To" field if OVERRIDING the claim filing for something other than what was originally filed. For example, if a claim originally filed electronically but it needed to be refiled paper to attach additional documentation, the user would select PAPER in the "Force Refile To" drop down. This will cause the claim to file paper. If the user left the "Force Refile To" option BLANK it would file electronically because that is the way it originally filed. In most instances you should leave this field blank to file the claim the same way if filed originally.

The Billing View of the ledger will display the Refiled claim in light blue as un-posted. This means the claim will generate in the nightly closeout.

4.4.3.2.14 Release Unposted

The Release Unposted option is available in the Billing View of the ledger. This feature may be used when Claim Hold Days have been set on a visit, but you wish to release the claim sooner than was originally specified via the Claim Hold Days. In the Billing View of the Ledger in the Submit Date column, the Submit Date will display the date the claim is due to be released, based on the number of days that was entered in Claim Hold Days during Visit Entry. The claim the claim will display as light blue (unposted) in the Billing View and will not be filed until the Submit Date has been reached. In the Activity View, the claim will show with a WAIT beside it to indicate that it is waiting to be filed.

The Release Unposted option may be performed from the Billing View on an unposted claim by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen. Release Unposted will change the submit date to the current date, but the claim will continue to show as "unposted" (light blue) until the next closeout is performed, at which time the claim will be released and will generate. The Released Unposted option is only available when there is a claim with Claim Hold Days set on it; otherwise, it displays in light grey on the Option button or the pop-up menu and may not be used.

4.4.3.2.15 Send Form Letter

The Send Form Letter option allows you to generate a letter for a patient either immediately or in the next Closeout. From the Ledger, the Send Form Letter option may be selected from the Charge/Payment, Activity, or Billing Views by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen.   The Send Form Letter option will be available if the currently selected row in the Charge/Payment or Activity View is a Visit or a Charge, or if the current view is the Billing View.

After selecting the Send Form Letter option, the Submit Form Letter window is displayed. Select the Form Letter you wish to send, and whether the processing should Create the Document Now, or Create the Document in the Closeout.

If you select Create Document Now, the letter will be created and displayed on the screen immediately in the Word Processor. You may then proceed to print the letter. If you select Create Document in Closeout, the letter will be created during the next Closeout process. You will see a Mail Merge task and a Document Listing in the Closeout reports. The Mail Merge task contains the letters that have been requested that need to be printed. The Document Listing is a report showing all the different letters and the accounts getting each letter.

After the letter has been generated (which may be after the next Closeout is run) the Activity view of the

ledger will display the date the letter was generated, the name of the letter, the user who requested it, and the addressee (which could be the account holder, patient, insurance plan, etc).   The View Form Letter option can now be used to view the letter.

4.4.3.2.16 View Form Letter

The View Form Letter option allows you to view a previously generated form letter. From the Ledger, this option is available from the Activity View by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen.   The View Form Letter option will be available when the currently selected row in the Activity View is a Form Letter.

After selecting the View Form Letter option, the Word Processor will display the form letter for viewing.

4.4.3.2.17 Print Ledger View

The Print Ledger View option prints a hard-copy of the current view of the Ledger, and is available from either the Charge/Payment, Activity, or Billing Views. This option is invoked by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen. After selecting the Print Ledger View option, a printer dialog box is displayed for you to specify where you would like it to print, the number of copies, etc. The printout of the ledger will go straight to the printer dialog box instead of being sent to the Task Viewer.

4.4.3.2.18 Print Ledger Report

The Print Ledger Report option prints a hard-copy of account/patient detail for the selected Ledger, and is available from either the Charge/Payment, Activity, or Billing Views. This option is invoked by either right-clicking to invoke the pop-up menu, or selecting the Options button at the bottom of the screen.

After selecting the Print Ledger Report option, a box is displayed with several options:

Chgs, Pmts, and Adjs on the Visit Selected	This option is only available if the currently selected row in the Charge/Payment or Activity View is a Visit or a Charge. The Report will print activity for the selected visit only.
Chgs, Pmts, and Adjs on Visits within the Selected Date Range	The Report will print charge, payment, and adjustment activity for all visits that occur during the date range specified in the Activity Date Range below.
All Activity within the Selected Date Range	The Report will all print activity for all visits that occur during the date range specified in the Activity Date Range below. This will include claim and account billing activities as well.
Demographic Ledgers Only	The Report will print Account and Patient Demographic information only.
Include Unposted Transactions on Demographic Ledgers	This option is only available if the Demographic Ledgers Only option has been selected.
Beginning Date	Beginning date of the Ledger Report activity date range.
Ending Date	Ending date of the Ledger Report activity date range.

4.4.4   New Patient

The New Patient function presents the user with a wizard that steps the user through the creation of a patient, then of an account, and finally of the insurance.

The New Patient wizard consists of the following steps:

- New Patient
- New Account
- New Insurance

Green fields are required fields.   **Blue fields** are optional fields.   **Purple font** indicates a Jump field. Use the F4 key to jump from one jump field to the next jump field.   F5 to jump back to a previous jump field.
Underscored letter – Use ALT + the underscored letter and the system will perform the function. (ATL+N = NEW)
Binocular Icon – Indicates that this is a searchable field.   Use the F9 function key for the keyboard shortcut!

Movement from Patient to Account to Insurance (and back) is accomplished by the use of the Next and Back buttons.   The New Insurance form will be 'looped' for each plan (up to three) entered in the New Patient Form.   If no plans are entered in the New Patient Form, the New Account form will be considered the last form in the wizard.   Depending on how you initiated the New Patient form, the OK button will behave in one of two ways on the final form in the wizard.   If you selected New Patient from the Navigation Menu or the Tool Bar, the OK button will open the newly created patient chart and provide access to several additional tabs of patient information.   If you select Batch Demographics and added the patient from the Batch Demographics List, the OK button will save the newly created patient and open another New Patient form.   This is primarily how the Demo-Charge/Demo-Charge or Demo-Demo/Charge-Charge scenario discussed previously is implemented.

Patient Numbers

Patient No	Number assigned to the patient by the practice. This number may be system generated from a 'seed' number in Practice Maintenance.
Chart No	Chart Number.
Soc Sec No	Social Security Number
Med Rec No	Medical Record Number from the hospital

Name

Title	Title (Mr, Ms, Mrs, etc.)
Salutation	Indicates how letters to the patient will be addressed (Dear Salutation....) Values are: - Title & Last Name - First Name - Nickname
First/M/Last	Name entered in First, Middle and Last sequence
Nickname	NickName. Will default from patient fiest name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, Phd, etc.)

Personal Contact Information

Address	Address consisting of: - Street Address - Street Address (Add'l) - City - State - Postal Code (Required Field)

<table>
<tr><td></td><td>The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.</td></tr>
<tr><td>Country</td><td>A foreign country may be entered if needed. The cursor will, by default, skip this field. To enter a country, Shift+Tab to back up to the field to enter the country.
NOTE: Canadian mail is addressed like US Mail: Zip Code, City & State in US would be the Canadian Postal Code (L7L6M-7), the Canadian Province (Burlington) & Canadian Code (ON for Ontario). In the Country field in MedSuite you would enter Canada. Therefore, it is entered into MedSuite with the Postal Code, Province and Province Code (AB for Alberta, ON for Ontario, etc). and then Canada can be typed into the Country field.</td></tr>
<tr><td>Home</td><td>Home telehone number.</td></tr>
<tr><td>Fax</td><td>Fax telephone number</td></tr>
<tr><td>Work</td><td>Work telephone number</td></tr>
<tr><td>Other</td><td>Other telephone number</td></tr>
<tr><td>Mobile</td><td>Mobile telephone number</td></tr>
<tr><td>Pager</td><td>Pager telephone number</td></tr>
<tr><td>E-Mail</td><td>E-Mail address</td></tr>
</table>

Personal Details

<table>
<tr><td>Birth</td><td>Date of Birth. See date field definition for use of two/four digit years.</td></tr>
<tr><td>Death</td><td>Date of Death. See date field definition for use of two/four digit years.</td></tr>
<tr><td>Sex</td><td>Sex (Male, Female, Unknown)</td></tr>
<tr><td>Marital Status</td><td>Marital Status (Married, Single, Widowed, etc.)</td></tr>
</table>

Employment

Practice Maintenance allows the system to be configured to allow entry of the Employer Lookup or Employer Name/Description or both.
Some practices will define employers in a separate Employee Maintenance function and use the Employer Lookup. This allows the Primary Insurance Plan to be pulled through from the Employer as a default. Other practices will find that this capability does not gain them much and will simply want to key in both the Employer Name/Description and the Primary Insurance Plan.

<table>
<tr><td>Employer (Lookup Field)</td><td>Employer can be selected from Employer lookup.</td></tr>
<tr><td>Employer (Text Field)</td><td>Employer Name can be keyed in</td></tr>
<tr><td>ID</td><td>ID assigned to employee by the Employer may be entered</td></tr>
<tr><td>Status</td><td>Employment Status (Full-Time, Part-Time, Retired, etc.)</td></tr>
<tr><td>Date</td><td>Date Status was changed (employment date if employed, retirement date if retired, etc.)</td></tr>
<tr><td>Occupation</td><td>Occupation name/description</td></tr>
</table>

Insurance

Plan	The primary, secondary and tertiary insurance plans may be entered
Subscriber	The subscriber may be described as either the patient, the account, or some other person. **This does not define the HCFA/CMS Patient Relationship to the Insured,** but it does allow us to define if the subscriber can be 'picked-up' from the New Patient form or the New Account form, or needs to be entered separately.
Policy No	Policy Number
Group No	Group Number

Buttons

Next	Go to the next step (New Account) in the wizard.
Cancel	Close the form and do not save the changes (if any).

4.4.4.1 New Account

The New Account form allows the user to enter information about the person or entity who is the account holder as well as some billing control information about the account holder.

Account Control

Patient Relationship to the Account	The Patient Relationship is use to control what if anything needs to be entered for the account on this form. If the relationship is 'self', then the patient **is** the account. The patient (and therefore the account) information was just entered on the New Patient form. If the relationship is not 'self', then the account can be: • Entered • Imported from the Patient and Modified • Selected from a Previously Exisiting Account When a new patient is being added, the relationship defaults to "Self". If, at the time of data entry, the patient is less than 18 years old, you will receive a message telling you to verify the patients relationship to the account holder.
Import Patient Information	If the patient information is imported, all of the data fields on the form will be populated from the New Patient form. The user should new override the fields that need to be changed. For example, if the account is the patient's spouse and the patient date is imported, then the user will need to change the accounts first name, date of birth, social security number, sex, etc. However, all of the rest of the information is 'clean' and 'correct'.
Select Account	If the account is also the account holder form another patient, then the Account Lookup will be presented and the user can select an account from a list of previously entered accounts.

Patient Numbers

Patient No	Number assigned to the patient by the practice. This number may be system generated from a 'seed' number in Practice Maintenance.
Chart No	Chart Number.
Soc Sec No	Social Security Number
Med Rec No	Medical Record Number from the hospital

Name

Title   Title (Mr, Ms, Mrs, etc.)
Salutation   Indicates how letters to the patient will be addressed (Dear Salutation....)
 Values are:
- Title & Last Name
- First Name
- Nickname

First/M/Last   Name entered in First, Middle and Last sequence
Nickname   NickName. Will default from patient fiest name
Generation   Generation (Jr., Sr., etc.)
Degree   Degree (MD, CRNA, Phd, etc.)

Personal Contact Information

Address   Address consisting of:
- Street Address
- Street Address (Add'l)
- City
- State
- Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Country   A foreign country may be entered if needed. The cursor will, by default, skip this field. To enter a country, Shift+Tab to back up to the field to enter the country.
NOTE: Canadian mail is addressed like US Mail: City, State (Province Code) and Postal Code. Therefore, it is entered into MedSuite with the Postal Code, City, Province (AB for Alberta, ON for Ontario, etc). and then Canada can be typed into the Country field.

Home   Home telehone number.
Fax   Fax telephone number
Work   Work telephone number
Other   Other telephone number
Mobile   Mobile telephone number
Pager   Pager telephone number
E-Mail   E-Mail address

Personal Details

Birth	Date of Birth. See date field definition for use of two/four digit years.
Death	Date of Death. See date field definition for use of two/four digit years.
Sex	Sex (Male, Female, Unknown)
Marital Status	Marital Status (Married, Single, Widowed, etc.)

Employment

Practice Maintenance allows the system to be configured to allow entry of the Employer Lookup or Employer Name/Description or both.
Some practices will define employers in a separate Employee Maintenance function and use the Employer Lookup. This allows the Primary Insurance Plan to be pulled through from the Employer as a default. Other practices will find that this capability does not gain them much and will simply want to key in both the Employer Name/Description and the Primary Insurance Plan.

Employer (Lookup Field)	Employer can be selected from Employer lookup.
Employer (Text Field)	Employer Name can be keyed in
ID	ID assigned to employee by the Employer may be entered
Status	Employment Status (Full-Time, Part-Time, Retired, etc.)
Date	Date Status was changed (employment date if employed, retirement date if retired, etc.)
Occupation	Occupation name/description

Account Class	The Account Class must be selected from the Account Class Lookup. A default value for the Account Class may be defined in Practice Maintenance.
Account Type	The Account Type is an optional field that is used for reporting and selection purposes
Payment Plan Amt	Overrides the practice-level Minimum Payment Amount for this account. This allows monthly payments to be negotiated and tracked as minimum payments that are different from the practice minimum.
Claims Suspended	All claims may be suspended for the account until such time as the suspend is removed.

Finance Charges

Waive Finance Charges	Indicates if Finance Charges should be waived on this particular account, if the Practice and Account Classes are set up to assess Finance Charges.
Orig Fin Chrg Date	Date that the first finance charge was issued to the account holder

Last Fin Chrg Date	Date that the most recent finance charge was issued to the account holder
Next Fin Chrg Date	Date that the next finance charge is due to be issued to the account holder if no payment is made.

Collections

In Collections	Indicates if the account is in a collection status.
Number of Collection Letters Sent	Indicates how many Collection Letters have been sent to the account
Collector Group	Indicates if there is a Collector Group assign to 'work' this account
Agency	Indicates the Collection Agency assigned to this account if it currently is in a collection status or if it goes into a collection status in the future

Statement

Stmt Suspended	All statements for the account may be suspended until such time as the suspend is removed. If an account is suspended:

- Statement Billing will stop being issued
- Dunning Levels will not advance
- Account Followup will cease
- Collections activities will cease

When the suspend is removed from the account, the user will be asked if they want the billing cycle to restart the billing cycle. If the user indicates that he wants the billing cycle to be restarted:

- Statement Billing will commence
- Account Followup will commence
- Collections activities will commence
- Dunning Level by set to zero
- First Statement Date will be reset
- Last Statement Date will be reset
- Next Statement Date will be set to the current date

If the user indicates that he does not want the billing cycle to be restarted:

- Statement Billing will commence
- Account Followup will commence
- Collections activities will commence
- Dunning Levels will advance from the Last Level

Returned Mail	Indicates if the practice has gotten returned mail from billing the account. In other words, since the address is bad or incorrect and the statements are not getting to the account holder, there is no point in continuing to be bill the account until such time as a current address is entered.
First Statement Date	Date that the first statement was issued to the account holder

Last Statement Date	Date that the most recent statement was issued to the account holder
Next Statement	Date that the next statement is due to be issued to the account holder
Dunning Level	Delinquency level that the next statement will be issued at. The Dunning Message associated with this level is defined in Practice Setup.
Billing Message	Special Billing Message that will appear on the statement for this account holder.
Billing Message is Recurring	Indicates if the Billing Message is a one-time or recurring message
Override Billing Message	Free-Form Text Billing Message that will override the Billing Message or the Practice-level Dunning Message. Up to four lines of 60-characters of text per line may be entered.

Buttons - New Patient Mode

[Back](#)	Go to the previous step ([New Patient](#)) in the wizard.
[Next](#)	Go to the next step ([Insurance](#)) in the wizard.
New Patient	Complete the New Patient Wizard, "Loops" back and re-runs the Patient Wizard allowing you to add another New Patient.
Ok	Complete the New Patient wizard and opens the patient in 'Edit' mode
Cancel	Close the form and do not save the changes (if any).

Buttons - Batch Demographics Mode

[Back](#)	Go to the previous step ([New Patient](#)) in the wizard.
[Next](#)	Go to the next step ([Insurance](#)) in the wizard.
New Visit	Completes the New Patient, enters New Visit mode, and (when the Visit is completed) "loops" back and re-runs the Patient Wizard allowing you to add another New Patient.
Visit Wizard	Completes the New Patient, enters the Anesthesia Visit Wizard mode, and (when completed with the Visit) "loops" back and re-runs the Patient Wizard allowing you to add another New Patient.
Ok	Completes the New Patient, and "loops" back and re-runs the Patient Wizard allowing you to add another New Patient.
Cancel	Close the form and do not save the changes (if any).

4.4.4.2 New Insurance

The New Insurance form allows the user to enter information about the insurance plan and policy and the person who is the subscriber. The New Insurance form will be 'looped' for each plan (up to three) entered in the New Patient Form. On the last loop, the Finish button will be [enabled](#) and the New Account wizard will be complete.

Patient Plan

Patient Plan	Allows the user to select a different plan from that entered in the New Patient form.
Carrier	If a plan has been defined as a generic plan, the user is required to enter a carrier for the plan on the Insurance form. This permits electronic claims to be sent for generic plans.

Claim Filing Office

Description	The Patient Relationship allows use to control what if anything needs to be entered for the account on this form. If the relationship is 'self', then the patient is the account and we just got through entering all of the patient information on the New Patient form. If the relationship is not 'self', then the account can be:

- Entered
- Imported from the Patient and Modified
- Selected from a Previously Exisiting Account

Address	Claim filing address consisting of:

- Street (or P.O. Box) Address
- Street (or P.O. Box) Address (Add'l)
- City
- State
- Postal Code

The tab order will skip from Street (or P.O. Box) Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Country	A foreign country may be entered if needed.
Phone	Carrier/Plan main telelphone number
Fax	Carrier/Plan fax telephone number
Phone Other	Carrier/Plan other telephone number

Details

Eff Date	Effective date of the subscriber's insurance coverage for this plan
Exp Date	Expiration date of the subscriber's insurance coverage for this plan
Policy No	Policy number assigned by the carrier/plan to the subscriber's coverage
Group Name	Group Name (for Group Plans)
Group Number	Group Number assign by the carrier/plan to the group (for group plans
HCFA 10D	Special information to go into Box 10d - Local Use on the HCFA-1500
Medigap Number	Number assigned by the Medicare intermediary to this carrier/plan. This need only be entered if the plan is secondary to Medicare and the practices wants to send the secondary claims as Medigap

Pre-Auth Number	Enter the Pre-Authorization Number assigned to the patient/visit by the insurance carrier.
	The prior authorization number may be maintained in tw odifferent locations; one is in the Insurance Demographic and the other is on the Visit - HCFA Tab. Please check with your system administrator to determine where you should be maintaining this value.
Coverage	Drop-down list of types of insurance coverage. Coverage types allows a patient to have multiple types of current and effective insurance coverage to exist. Coverage types include: • Regular • Workmen's Compensation • No-Fault Auto • Other

Billing Control

Wait for Payment	Indicates if, during the billing cycle, whether the carrier/plan will wait at the current level for payment from the carrier before proceeding to the next level. Default will use the plan's Wait for Payment settings.

Subscriber Information

Pt Rel	The Patient Relationship to the Subscriber allows the user to control what if anything needs to be entered for the subscriber on this form. If the relationship is 'self', then the patient is the subscriber and since we have already entered all of the patient information on the New Patient form we don't need to enter anything for the subscriber. If the relationship is not 'self', then the subscriber can be: • Entered • Imported from the Patient and Modified • Selected from a Previously Exisiting Subscriber
Import Patient Information	If the patient information is imported, all of the data fields on the form will be populated from the New Patient form. The user should new override the fields that need to be changed. For example, if the account is the patient's spouse and the patient date is imported, then the user will need to change the accounts first name, date of birth, social security number, sex, etc. However, all of the rest of the information is 'clean' and 'correct'.
Select Subscriber	If the account is also the account holder form another patient, then the Subscriber Lookup (effectively the same as the Account Lookup) will be presented and the user can select a subscriber from a list of previously entered subscribers.

Subscriber

Title	Title (Mr, Ms, Mrs, etc.)
Salutation	Indicates how letters to the patient will be addressed (Dear Salutation....)

      Values are:
- Title & Last Name
- First Name
- Nickname

First/M/Last	Name entered in First, Middle and Last sequence
Nickname	NickName. Will default from patient fiest name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, Phd, etc.)
Address	Address consisting of:

- Street Address
- Street Address (Add'l)
- City
- State
- Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Country	A foreign country may be entered if needed.
Home	Home telephone number
Fax	Fax telephone number
Work	Work telephone number
Ext	Work telephone extension
Other	Other telephone number
Mobile	Mobile telephone number
Pager	Pager telephone number
Birth	Date of birth. See date field definition for use of two/four digit years.
Death	Date of death. See date field definition for use of two/four digit years.
Sex	Sex (Male, Female, Unknown)
Marital	Marital Status (Married, Single, Widowed, etc.)

HIPAA Info

Secondary Ins Code	If Medicare is secondary, this field indicates why Medicare is secondary. The allowable values are "hard-coded" and conform to ANSI requirements for the field SBR05 - Insurance Type Code.

If this field is not entered on an MSP claim, the MSP Reason Code will default to '12 - Working Aged Beneficiary or Spouse with Employer Group Health Plan".

Plan Setup allows the user to create User-Defined Fields that may be used when the Plan is used in Insurance Demographics. Any of the User-Defined Fields may be made a required input field by setting the "required" flag in the Plan setup for the UDF.

Buttons

[Back](#)	Go to the previous step ([New Account](#)) in the wizard.
[Next](#)	Go to the next step ([Insurance](#)) in the wizard.
New Visit	Completes the New Patient, enters New Visit mode, and (when completed with the Visit) "loops" back and re-runs the Patient Wizard allowing you to add another New Patient. Visit
Visit Wizard	Completes the New Patient, enters the Anesthesia Visit Wizard mode, and (when completed with the Visit) "loops" back and re-runs the Patient Wizard allowing you to add another New Patient.
Ok	Complete the New Patient wizard and opens the patient in 'Edit' mode
Cancel	Close the form and do not save the changes (if any).

Note: If a user has entered a visit

4.4.5 Followup Wizard

The Followup Wizard organizes a number of functions that are available via the Ledger onto a single easy-to-use screen. This function can be used when a Followup function needs to be performed and the user has no need to view the Ledger prior to performing the followup function. If the user needs to view the Ledger, it will be faster to perform these functions via the Ledger. If the Ledger does not need to be viewed, then it will be faster to perform these functions via the Followup Wizard. The following functions are available on the Followup Wizard:

View or Reprint a Claim Now	Enter a claim number and view the claim immediately in the Task Viewer. Then claim may then be printed if necessary. For more information on Viewing/Reprinting claims, please see View Claim.
Reprint a Claim in the Next Close-Out	Enter a claim number and the claim will be reprinted in the next Close-Out. For more information, please see Batch Reprint.
Refile a Claim in the Next Close-Out	Enter a claim number and the claim will be refiled in the next Close-Out. For more information on Refiling Claims, please see Refile Claim.
Reset the Insurance on a Visit	Enter a patient number and then select a Visit that should have the insurance reset. Note that the visits displayed are posted visits only, and visits that are not in collections. The Reset Billing window is displayed.
View or Reprint a Statement Now	Enter a patient number and view the latest statement immediately in the Task Viewer. The statement may then be printed if necessary.
Request a Statement for the Next Close-Out	Enter a patient number and a "request statement" will be issued for the next Close-Out. For more information on Requesting a Statement, please see Request Statement.
Reset the Billing on an Account	Enter an account number and a Reset - Self billing will be performed on the account. For more information on Refiling Claims, please see Reset Billing - Self.

4.4.6 Task Viewer

Almost all of MedSuite's data intensive functions are processed by submitting tasks to a Task Server. The Task Viewer allows the user to see which tasks are waiting for processing and which tasks have been completed. The completed tasks are displayed in a"drill-down" grid that is grouped by practice. A row representing each task is inserted into the grid as the task is completed. Rows with a yellow background indicate that the Task had no output. Tasks that have a white background have not been retrieved and Tasks that have a green background have been retrieved and viewed by a user. Tasks may be retrieved by double-clicking on the task or by selecting the task and clicking on the Retrieve button. To make the viewing of Task Files and Data Cubes less memory intensive the system will load the file in chunks of 500K. There is a progress window that will display Running and shows the progress of the file as it's loading.

Tasks that created printed output, may be previewed on the screen. The Print Preview window allows the

user to print the task. The subsequently displayed Print Dialog allows the user to "print" to a file of a location, name, and type specified by the user. Tasks that created data cubes may also be previewed on the screen as well. A data cube Export Wizard allows the user to export data cubes may in a wide variety of file formats.

For each type of Task there is a time limit to which it is available for viewing from the Task Viewer. Below is a list of Task Reports and the length of time each report is available for viewing in the Task Viewer.

Any Task Reports that generate Errors are available for 3 Days.
Any No Output Tasks that are generate are on a short delete cycle of 5 days.
Any Viewed Claims or Statements are available for 7 Days.
Any Non-Batch Charge Worksheet/Journals are available for 10 Days.
Any Non-Batch Payment Worksheet/Journals are available for 10 Days.
Any Non-Batch Concurrent Case Audit Reports are available for 10 Days.
Any Close Out or Batch Reports are available for 30 Days.
Any EDI Reports are available for 60 Days.
All of the other reports in MedSuite are available for viewing for 15 Days.

4.4.7   Contact Manager

The MedSuite Contact Manager is a way to organize and store contacts within the MedSuite system.

4.4.8   Day Book

The Day Book is a feature that allows a user to setup appointments for meetings or things to do outside of account follow-up, on a calendar. Once an appointment is set on the calendar a pop-up box will display. The user can choose to Dismiss, Snooze or Open the reminder and re-schedule. MedSuite must be active for this to work.

4.4.9   Spreadsheet

Creating Spreadsheet Folders and Spreadsheets

MedSuite has a spreadsheet application that is found under Navigation / Spreadsheet. Many offices use the spreadsheets to hold their Billing Logs or A/R Logs. Each company should start out with January – December Billing Logs. If you have additional practices or need to create a new folder and spreadsheets for the New Year, please utilize these instructions!

Creating a New Folder

To create a new Folder where the spreadsheets will be contained, select the New Folder button and in the Create Folder window, select if you want the spreadsheet to be held at the Company level, Practice level or at the User level. For example if Anesthesia Billing Company is the company and North Pole Anesthesia was the Practice, the user should choose North Pole Anesthesia to have a spreadsheet for that specific practice. If a user would like a spreadsheet just for them they would choose their user name instead of the Practice Name. Once the user selects where they want the new Folder created they should type in the Folder name and select OK to accept. The new folder should appear.

Creating a New Spreadsheet

To create the spreadsheet inside the folder, Right click on the folder and select New Document. A blank spreadsheet will display. Create the spreadsheet.

Inserting a New Page into an Existing Spreadsheet

To create other sheets inside the spreadsheet select Insert and Sheet. To name the sheet double-click on the tab name Sheet2 and type in the name (i.e. Second Sheet)

Copying Information from One Spreadsheet to Another

To copy information from one sheet to another, highlight the cell and hold down the Shift key on the keyboard. Use the arrow keys or page down to select the cells that should be copied. If a user chooses to select data to be copied with the mouse, by clicking on the cell they want copied and dragging it across a row and down a column, it is a good idea to have the spreadsheet window fully Maximized.

Once the information is selected or highlighted, select Edit and Copy on the Spreadsheet menu. Click on the tab at the bottom, which is the other spreadsheet the selected information should be copied to. In this example it was Second Sheet. Position your cursor in cell A1 and select Edit then Paste. The familiar windows shortcuts to do this work here as well. Once the information is selected or highlighted, use the Ctrl key on the keyboard plus the letter C on the keyboard to Copy. Go to the other sheet and position your cursor in cell A1 and use the Ctrl key on the keyboard plus the letter V on the keyboard and paste.

4.4.10 Word Processor

Enter topic text here.
4.4.11 Practice Graphs

The Practice Graphs in MedSuite provide visual depictions or "snapshots" of several indicators for a practice. Many practices refer to these as Dashboard Indicators because they help gauge how a practice is doing. For a billing company, it provides a quick view of how a particular practice within the company is doing.

The top left section displays the Practice Balance for all practices in the company and the A/R Days, also called the Days in AR.

, the accounts receivable for a selected practice, all Followup Queues for the selected practice with the number of entries in the selected queue and lastly, graphs the number of entries for individually selected queues.

There are four graphs that display. The first graph is for the Practice Balance, which displays the balance for each practice in a Company. The second graph, to the right of Practice Balance, is the accounts receivable for the practice selected. By clicking on a bar in the graph Practice Balance graph that practice's accounts receivable will display in the graph with the practice name above it. The third graph, below the Practice balance graph, is each Followup Queue within the selected practice on the Practice Balance graph. If you select a particular Followup queue, by clicking on a bar, the fourth graph displays the progress of that individual queue by graphing the number of entries in the queue selected.

The security setting for this option is found in the User Group on the Other Security tab.

4.4.12   Web Browser

Enter topic text here.

4.4.13   EMail

Enter topic text here.

4.5   Batch Menu

The Batch Menu provides access to all of the Batching functions of MedSuite including:

- Demographics

  The Demographics function of the Batch menu invokes the Batch mode of Demographic Entry. The screen will display all demographics a user has entered that day, and they may be accessed from this screen for editing. Users may choose to enter all demographics at once and then enter charges later, or they may enter a demographic and charge for a patient all together.

- Visits

  The Visits function of the Batch Menu invokes the batch context of Visits.

- Visit Worksheet/Journal

  The user can print a worksheet of visits entered to "balance" their batch

- Concurrent Case Audit

  The Concurrent Case Audit calculates the number of concurrent cases and recalculates visits and sets modifiers according to plan requirements.

- Payments

  The Payments function of the Batch Menu invokes the batch context of Payments.

- Payment Worksheet/ Journal

  The user can print a worksheet of payments entered to "balance" their batch

- Closeout

  The nightly production process is submitted for processing

- Batch Claim Reprint

  A batch of claims can be reprinted en masse

- Batch Claim Refile

  A batch of claims can be refiled en masse

- Transmit to PerSe

  Claims and Statements can be submitted to PerSe

- Retrieve Elec Statements

  Electronic statements not submitted to PerSe can be retrieved by the user for transmission to another third-party.

- File Imports

  This functionality is not currently in use.

- System Imaging

  Invoke the System Imaging application.

4.5.1   Demographics

As discussed previously, many organizations enter their demographics in batches; the so called Demo-Demo/Charge-Charge scenario. Additionally, offices who wish to use the so called Demo-Charge/Demo-Charge scenario may also use this screen. After registering a patient, the New Visit or Visit Wizard buttons will take the user to Visit Entry.

Demographics Entered Today by (User Name)

Name	Name of the Patient Added
Patient No	Patient Number of the Patient Added
Account Class	Account Class of the Account Holder for the Patient Added

Buttons

Open Patient	Used to open the demographics of the selected Patient on the Batch Demographics list
Refresh	Refreshes the list of patients for the user
New	Invokes the New Patient Wizard
Search	Invokes the Patient Search function to allow users to search for a patient before registering. If the patient already exists, users may choose to not enter a new demographic. If the patient is not found, the user may then

select New to invoke the New Patient Wizard

4.5.2　Visits

Visit Context

MedSuite provides two different modes for visit entry:

Single	Open a patient or an account and access the Visits List by clicking on the Visits Tab of the Patient Chart
Batch	Select Visits from the Toolbar or from the Batch Menu

This section concerns itself with the Batch Payment Entry context. There is a sub-context or style within visit entry that we need to understand as well. There are two "new" buttons on the Visits on Current Batch grid: New and Wizard. The fundamental distinction between these styles is that by clicking the "New" button the "full" Visit Entry tabbed dialog will be used for Visit Entry, whereas by clicking on the "Wizard" button, the Visit Wizard will be used for Visit Entry.

4.5.2.1　Visit Batches

The Batch context of Visit entry consists of two sections. The first section is a list of open Batches of Visits. The second section displays a list of Visits attached to the selected Batch.

Batch List

Batch No	Number assigned to the batch by the user
Router No	Sequentially assigned number within a batch
Date Release	Date the batch is to be release for processing and posting.
Date Entered	Date the batch was entered into MedSuite
Batch Type	VISIT
User	Name of user who created (and presumably) entered the batch
Description	Description assigned by the user to the batch

You may be prevented from setting the Date Release on a Batch under the following conditions:

- There are visits in the Batch, with the Service Date displayed in maroon, that have not been processed by the Concurrency program.

- There are visits in the Batch, with the Service Date displayed in Red, that the Concurrency program identified as having certain error conditions and the Practice Setup - Anesthesia Tab has been configured to prevent batches with concurrency errors to be released.

Visit List Buttons

Imaging	Invokes the Image Tree display for the Visit Batch
Refresh	Refreshes the Visit List
New	Create a new batch

Edit	Edits the selected batch
Delete	Deletes the selected batch

Visits on Current Batch

Certain details about a Visit may be viewed in this grid. In addition, Visits may be created, edited, or deleted from this grid. See the Visits section of this document for detailed information about the Visit form.

The color of (Service) Date in the list may be displayed as black, maroon, or red.

Maroon
Indicates a Visit that has a Medical Direction value of 'S-System Calculated'. The batch must be processed by the concurrency program which will assign a numeric value to the Medical Direction of every Visit before the Batch can be released.

Red
Indicates a Visit that has a Concurrency Error on it. The visit was processed by the Concurrency Program, but an error condition was discovered that may prevent the release of the batch to posting. Concurrency Errors are displayed in Red regardless of whether or not the Practice Setup - Anesthesia Tab is configured to to prevent batches with concurrency errors to be released

Black
Indicates a Visit that does not have Concurrency Error on it, nor does it have a Medical Direction with a value of 'S-System Calculated'.

Date	Visit (service) date
Patient	Patient name
Type	Visit type (Anesthesia / Front-Office)
Division	Division selected for the Visit when the Visit was created
Plan	Patient's primary insurance plan for the Visit
Facility	Facility in which the service for the Visit were performed
Physician	Physician/Anesthesiologist who performed the services on the Visit
Refr/Surg	Referring Provider (non-Anesthesia Visit) or Surgeon (Anesthesia Visit) on the Visit
Charges	Total charges on the Visit

Visits on Current Batch - Buttons

Open Patient	Opens the Patient for the selected Visit.
Imaging	Displays Images indexed to the Visit
Wizard	Create a new Visit Using the Visit Wizard
New	Create a new Visit
Wizard	Create a new Visit Using the Visit Wizard
Edit	Edit the selected Visit
Delete	Delete the selected Visit. This will only function on unposted Visits.

4.5.2.2 Visit Wizard

The Visit Wizard allows you to quickly enter anesthesia cases on a single screen. There are several features available in the "full" version of Anesthesia Visit Entry that are not available in this Wizard. These functions include the following:

- Entry of Primary and Secondary Surgical Procedures
- Entry of Additional Procedures (Billed with Modifier 51)
- Entry of Discontinuous (Multiple Start and Stop) Times
- Entry of Additional Procedures such as Post-Op Pain

That being the case, you may still enter a Visit that requires one of the above options via the Visit Wizard. When the Wizard is complete, you will be placed in the "full" version of Anesthesia Visit Entry and may perform any additional functions that you require. We believe that the Visit Wizard allows you to enter in excess of 75% or your anesthesia visits on a single screen.

Billing Information

Select the account who is financially responsible for the visit must be selected. The default account will be initially selected, but any account attached to a patient may be selected.

Account	Select the name of the account who is financially responsible for the visit. The default account will be initially selected.
Class	Account Class of the Account who is financially responsible for the Visit
File Insurance	Indicates how (or if) claims should be filed for the Visit • Use Plan Default • File Claim - Paper Only • Do Not File Claim
Coverage Type	Select the Coverage Type required for this visit. This will help you select from multiple effective insurance coverages that have been entered in Demographics.
Hold Claim Days	The number of days that claims for the primary insurance plan are to be held is displayed. This value may be overridden.

Miscellaneous

Displays information about the patient and the insurance coverages that the patient has.

Patient Name	Patient's Name
Patient Age	Patient's age as of the Visit Date
Policy 1	Displays the insurance carrier name for policy level 1
Policy 2	Displays the insurance carrier name for policy level 2
Policy 3	Displays the insurance carrier name for policy level 3
Balance	Displays Balance of the account
Bal Age	Displays age of the oldest open Visit on the account

Details

Division	Enter/Select the Division for which the Visit is being entered. **The Division is how Visits are tied to Divisions and their Tax IDs**

Visit Type	Displays the Visit Type. The Visit Wizard is only used for Anesthesia.
Visit Date	Enter/Select the Visit Date (Service Date).
Anesthesiologist	Enter/Select the first Anesthesiologist on the visit
Anesthetist	Enter/Select the first Anesthetist on the visit
Surgeon	Enter/Select the Surgeon on the visit
PCP	Enter/Select the Primary Care Provider
Facility	Enter/Select the Facility in which the procedure was performed
Location	Enter/Select the Location (Place of Service) in which the procedure was performed
OR Suite	Enter/Select the O/R Suite in which the procedure was performed
Anes Type	Enter/Select the anesthesia type which was used for the procedure
Physical Status	Enter/Select the physical status of the patient.
99140-Emergency Conditions	Select this check box if Emergency Conditions are present

Procedure

Procedure	Enter/Select the primary surgical procedure
ASA	If the primary surgical procedure crosswalks to more than one ASA procedure code, select the appropriate ASA code from the list. Selection of an ASA procedure code will set the base units value.
Modifiers	Enter/Select up to four modifiers. Some modifiers are automatically handled by MedSuite. Setting the Medical Direction may set one of the modifiers to a medical direction modifier used by the plan. In addition, anesthesia types may be setup such that modifiers are set for certain anesthesia types (monitored anesthesia care) practice-wide or for a specific plan.
Base Units	Base units will be retrieved from the ASA Procedures table for the ASA code selected. Several methods exist which can be used to override the base units: • Override by Plan and ASA Code • Override by Medical Direction (Directing 5-9 Anesthetists) • Manual Override
Modify	If base units are overridden manually, check the Base Unit Modify checkbox. This will prevent the anesthesia charge calculation from performing its normal base unit processing. In effect, you are telling the calculation to use the base units entered. If base units are manually overridden, changes that are applied to the MD will also be applied to the CRNA where appropriate.
Case Times	Enter the beginning and ending case times (military time). Case times may be required input fields.
HH:MM	Displays the time entered in the Case Times fields in hours and minutes
Minutes	Displays the time entered in the Case Times fields in minutes
Medical Direction	Enter/Select the Medical Direction that will be used to calculate the fee. Medical directions are tied to the anesthesia conversion factor (rate per unit). Medical direction defaults to 'S-System Calculated'. You should not normally need to change this. However, you may force the calculation to use a different medical direction and conversion factor.

Diagnoses

You may enter up to four(4) diagnoses for a visit. They should be entered in descending order of importance from primary diagnosis to last diagnosis.

(Diagnosis)	Enter/Select the diagnoses
(Description)	The diagnosis description is displayed
Related	Indicate if the diagnosis is related to the surgical procedure.

PQRI

If the plan, procedure and patient's age qualify them for PQRI, you will be prompted to select the appropriate codes for each measure after entering the Diagnoses and selecting **Ok**. Use the Up and Down arrow keys on the keyboard to navigate the list and the Tab key to select the code to be applied. See Modify a PQRI Measure for additional details on how to set up the codes.

4.5.3   Visit Worksheet/Journal

Visits are typically entered in "batches." A batch of visits may be for a date of service, or for a physician for a date of service, or some other batching methodology. However, once the visits are entered, the batch should be reviewed for data entry errors and should be "balanced." This involves checking a report of the visits in the batch against the original documents for the visits. The process ensures that all visits are entered, that all procedures are entered, and that all modifiers (age, emergency, etc.) are entered.

The Visit Worksheet/Journal request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Sequence By	Indicates the sequence to print details on the report (within primary sorts):
	• Entry Order

• Patient Name

Show Anesthesia Times	If checked, this option prints all the individual MDs and CRNAs and all of their time segments on a case, in addition to the case start and stop time. This will allow review of all providers, handoffs, and discontinuous time segments that may have been entered on each visit. If unchecked, only the case start and stop time will print on the report.
Report CRNA Charges in Hash Totals	Indicates whether the CPT and ASA Hash for a CRNA Charge should be accumulated into the Visit, Batch, and Report Hash Totals. When balancing batches, if the insurance is not known at the time the "tape" is being run, the user cannot determine if a CRNA Charge will be created and therefore what the hash total will be.
Un-Posted	Indicates that the Worksheet is to be run against unposted visits for a batch or all batches
Batch No	Batch number (blank for all) to run for unposted visits
Released Batches Only	When running the report in Un-Posted mode, you may select only batches that have been released for posting.
Include Unposted Reversals	When running the report in Un-Posted mode, you may select unposted reversals.
Posted Date	Indicates that the Worksheet is to be run against posted visits for a posted date range
From Date	When running the report in Posted Date mode, enter the beginning date of the posted date range
Thru Date	When running the report in Posted Date mode, enter the ending date of the posted date range
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	indicates that the report should be scheduled to run at a future time
Schedule Task	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

4.5.4 Concurrent Case Audit

In order to properly bill for the medical direction of anesthetists by anesthesiologists, HCFA (CMS) and other carrier requirements dictate that certain limits be imposed. One of these limits is that an anesthesiologist can medically direct no more than four anesthetists. If an anesthetist is a resident or student nurse anesthetist, these regulations limit medical direction to two anesthetists. Frequently, a special modifier indicating that medical direction took place is placed on the anesthesia charge and reported to the carrier. Sometimes this modifier indicates to the carrier how many cases were being medically directed.

If more than four anesthetists are performing concurrently under the direction of an anesthesiologist, the anesthetists are considered supervised rather than medically directed and the anesthesiologist is considered to be supervising rather than medically directing. When an anesthesiologist is supervising, the payment for the anesthesiologists services change from base plus time to three (3) total units. In addition, the penalties for fraudulently billing Medicare are quite serious. It is therefore critical to know accurately how many cases were being performed concurrently under the direction of an anesthesiologist.

The Concurrent Case Audit counts concurrent cases by anesthesiologist and date of service. It determines the appropriate modifier for each plan or carrier, it performs and necessary anesthesia charges recalculations, and it performs several data audits. These audits include:

Audit Type	Audit Description	Error/ Warning
Physician	An anesthesiologist is personally performing more than one case simultaneously.	Error
	An anesthesiologist is personally performing one case and medically directing another case simultaneously.	Error
	An anesthesiologist is medically directing more than 4 cases simultaneously (supervising).	Warning
Assistants	An anesthetist is personally performing and or is medically directed/supervised on more than one case simultaneously.	Error
	An anesthesiologist is directing/supervising more than two cases simultaneously and one or more of those cases involves a Student Nurse Anesthetist.	Error
Surgeons	A surgeon is performing two cases simultaneously. This audit is optional and if used is a warning due to the fact the surgery time (s) and anesthesia time(s) for the case are not always equal. A surgeon may have actually started another case with a different anesthesiologist when the patient for the previous case is still under the care of the previous anesthesiologist and the case (for anesthesia purposes) has not "ended".	Warning
Facilities	An anesthesiologist is directing/supervising cases in more than one facility simultaneously. This audit is optional as the "facility" as defined in MedSuite may not directly correspond to a physically separate building. In some cases it may be a physically separate building, making medical direction an impossibility.	Warning
Locations	An anesthesiologist is directing/supervising cases in more than one location simultaneously. This audit is optional as the "location" as defined in MedSuite	Warning

	may not directly correspond to a physically separate building. In some cases it may be a physically separate building, making medical direction an impossibility.	
O/R Suites	An anesthesiologist is directing/supervising cases in more than one O/R Suite simultaneously. This audit is optional as the "OR Suite" as defined in MedSuite may not directly correspond to a physically separate suite or the suite may not be entered causing many cases to be performed in the same (blank) suite.	Warning

The Concurrent Case Audit request form contains the following information:

Task Name	Task Name displayed in the Task Viewer. Defaults to Concurrent Case Audit.
Generate Report	The Concurrent Case Audit can be performed with or without generating a report. The concurrent case calculation may be made, charges recalculated, modifiers updated without generating a report.
Report Only - Do not update Visits	Checking this option will prevent visits from calculating in concurrency. In addition, the Medical Direction will not be updated on the visits. This will merely print the report, but modifiers and medical direction will NOT be updated on the visits.
Report Errors Only	Checking this option will cause the Concurrency Report to print only those cases that have errors or warnings.
Batch	Indicates that the Worksheet is to be run against unposted visits for a particular batch
Batch No	Batch number to run for unposted visits
Date	Indicates that the Worksheet is to be run against all posted and unposted visits for a service date range
From Date	Begin date of date range
Thru Date	Ending date of date range
Perform Audit On:	Indicates that optional audits may be performed on::

- Physicians
- Assistants
- Surgeons
- Facilities
- Locations
- O/R Suites

These will default to the settings in the Anesthesia tab of the Practice setup unless none are specified there. If no audits are specified in the Practice Setup, they will default here to Physicians and Assistants.

Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Task Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

4.5.5   Payments

MedSuite's payment system is designed in three tiers:

Payment	The Payment tier represents a check or an Explanation of Benefits (EOB). This tier only contains information specific to a check or EOB. It does not contain any information that identifies claims, subscribers, patients, etc.
Payment Distribution	The Payment Distribution tier represents a payment or adjustment on a claim or on an account. This tier contains information specific to a claim or account. Multiple Payment Distributions may exist for a Payment as would be the case on a bulk insurance payment such as a Medicare EOB.
Payment Distribution to Charges	The Payment Distribution to Charges tier represents the distribution of payment and adjustment amounts to individual charge line items. Multiple Payment Distributions to Charges may exist for a Payment Distribution.

Payment Context

MedSuite provides two different contexts for payment entry:

Single	Open a patient or an account and access the Payments List by using the Navigation bar or the Record Menu.
Batch	Select Payments from the Financials/Followup Section of the Navigation Bar or from the Financials/Followup sub-menu of the Navigation Menu

This section concerns itself with the Batch Payment Entry context. There is a sub-context or style within payment entry that we need to understand as well. There are three "new" buttons on the Payments on Current Batch grid: Self, Ins, and Bulk..

The fundamental distinction between these styles is that Self Payment entry requires that the user post payments against and an account whereas the Ins and Bulk styles requires that the user posts payments against a claim.

Context	Applied To	Style	Payment Distribution Behavior
Single	Account or Patient	Self	The payment is applied to the account or patient that the user currently has "open".
	Claim	Ins	A claim search is performed when New Payment is selected. Therefore, we are searching for a claim for the patient or account

that the user has "open"

Batch	Patient or Account	N/A	Bulk Style is not available within Single Context
		Self	An account search is performed when New Payment is selected. Therefore, we are searching for any account meeting the search criteria
	Claim	Ins	A claim search is performed when New Payment is selected. Therefore, we are searching for any claim meeting the search criteria
	Claim	Bulk	A claim search is performed when New Payment is selected. Therefore, we are searching for any claim meeting the search criteria

Payment Entry Styles

Self	Self Payments are payments received from patients or accounts are applied in the Self Style. Self Style is available in both Single and Batch Payment Entry modes.
Insurance	Insurance Payments received from an insurance carrier are sometimes paid in a format that contains one claim per Explanation of Benefits (EOB). Insurance Style is available in both Single and Batch Payment Entry modes.
Bulk	Insurance carriers often pays multiple claims on a single EOB. This is referred to as a Bulk Payment. MedSuite contains check "balancing" logic that allows the user to track and balance Bulk Payments to the EOB. Since Bulk Payments usually contain payments for multiple patients and Single Payment Entry mode is only accessible when you are "inside" an account or patient, Bulk Style Payments are not available on Single Payment Entry mode. Bulk Style is only available in Batch Payment Entry mode.

User Setup contains limit control information so that a specific user may be limited to a maximum amount that may be entered as Self Payments, Self Adjustments, Insurance Payments, or Insurance Adjustments.

4.5.5.1   Payment Batches

The Batch Payment entry consists of two section. The first section allows the user to select from or add to a list of unposted Payment Batches. The second section displays a list of Payments attached to the selected Batch.

Batch List

Batch No	Number assigned to the batch by the user
Router No	Sequentially assigned number within a batch
Remit Date	Date the payment was deposited into the bank. A warning will be issued if this is entered as a future date.
Date Release	Date the batch is to be release for processing and posting.
Date Entered	Date the batch was entered into MedSuite
Batch Type	PAYMENT
User	Name of user who created (and presumably) entered the batch
Description	Description assigned by the user to the batch

Batch List Buttons

Imaging	Invokes the Image Tree display for the payment batch.
Refresh	Refreshes the batch list
New	Create a new batch
Edit	Edit the selected batch
Delete	Delete the selected batch

If a Batch has been released, you may not add payments to or delete payments from the batch. You may "edit" payments in the Batch. However, the Ok and Cancel buttons will not be available in the Payment Distribution Screen.

Payments on Current Batch

Certain details about a Payment may be viewed in this grid. In addition, Payments may be created, edited, or deleted from this grid.

Document No	Check or EOB number
Patient Name	Name of patient to which the payment was applied
Account	Name of the account to which the payment was applied
Amount Paid	Payment amount applied
Amount Adj	Adjustment amount applied

Payments on Current Batch - Buttons

Ledger	Jump to Patient Ledger on Reversed Bulk Payment

When a Visit or Charge is Reversed that has payments on it, the payments are written to a payment batch (selected by the user) as an unapplied Bulk Payment that is basically a "tickler" to remind you to reapply the payments after the charges are posted. The

unapplied Bulk Payment "knows" which patient the payments are for and allows you to Jump directly to the Ledger.

1-Self	Create a new Self Payment
2-Ins	Create a new Insurance Payment
3-Bulk	Create a new Bulk Insurance Payment
Edit	Edit the selected Payment

If you Edit the "drill-down" for a Bulk Payment, you will be presented with a form that requires that you pick a distribution of the bulk payment.

When a Visit or Charge is Reversed that has payments on it, the payments are written to a payment batch (selected by the user) as an unapplied Bulk Payment that is basically a "tickler" to remind you to reapply the payments after the charges are posted. The unapplied Bulk Payment is not expected to have any distributions on it and the edit button is disabled.

Delete	Delete the selected Payment. This will only function on unposted Payments.

If you Delete the "drill-down" for a Bulk Payment, you will be presented with a window that asks you to confirm that you want to delete all of the claims on a Bulk Payment. Make sure that is what you want. It takes a lot of time to re-enter a Bulk Payment.

4.5.5.2 Payments - Self

The Self Payments form consists of three sections. In the first section, the Document/Check Information corresponds to the Payment tier. The Account information corresponds to the Payment Distributions tier. The second section allows the user to enter Payment Distributions to Charges. The final section allows the user to enter Payment Notes and Special Billing Messages.

The Payment Document/Check Information captured in MedSuite contains the following information:

Batch No	Enter/Select the Batch to which the payment was applied. This defaults to the batch selected in the Payment Batch List
Remit Date	Date the payment was deposited into the bank. A warning will be issued if this is entered as a future date.
Account No	Enter or Search (F9) for the account that is making the Self Payment.
	You may enter an account number or name in the Account No field. If a single entry is found that matches the information entered, the Account information will be retrieved. If not match is found or if more that one match is found, you will be automatically taken to the Account Search window that will present a list of matching account entries.
Pmt Method	Enter/Select the Payment Method (Check, EFT, Cash, etc)
Charge Card	Enter/Select the credit card type (VISA, MC, Amex, etc.) user-defined
Doc./Check No	Enter the Document or check number
Pmt Type	Enter/Select the Payment Type
Adj Type 1	Enter/Select the primary Adjustment Type

Adj Type 2   Enter/Select the secondary [Adjustment Type](#)

Automatic Payment Distribution

MedSuite is a line-item posting system. Payments must be applied to individual line items. Self Payment rarely, if ever, come in with the payment broken-down by line-item. On accounts with a large number of open line-items, Self Payment Posting can become quite tedious. To streamline this process, you may enter the total payment, total primary adjustment and total secondary adjustment and click on the Auto Distrib button (or press Alt-A). The totals entered will be distributed to the line-items in oldest to newest order until there is no more money to distribute. If there is money left to distribute (all line-items are at a zero balance), the first line-item will be set to a credit balance.

Payment	Total payment amount
Adjust 1	Total adjustment 1 amount
Adjust 2	Total adjustment 2 amount
Auto Distrib	Click this button to auto distribute the totals above to the line items

Payment Distributions to Line-Items

All charges at the self pay level (insurance has already paid) will be displayed. If no line-items are displayed in the grid, you may click the Show All button on the bottom of the screen to display all line-items on the account regardless of whether or not they are at the self-pay level or not.

Date	Service date is displayed
CPT	Procedure code is displayed.
	This field is highlighted Yellow if the Charge is in Collection Turnover
	This field is highlighted Red if the Charge has been previously written-off to Collections
Bill	Charge amount billed is displayed
Payment	Enter the charge amount paid
Adj 1	Enter the charge amount primary adjustment
Adj 2	Enter the charge amount secondary adjustment
Open	The open balance of the charge is displayed

Payment Notes
You may enter a free-form payment note regarding the payment that will display in the account ledger. The note will be displayed in the Activity View of the ledger and on the Memo tab of the ledger with a blank date as there may be multiple dates of service on a singe payment note. If you select Print Payment Note on Statement, the note will not only go in the ledger but show on the patients statement as well.

Print Payment Note on Statement	Indicates if the note typed in the box should be printed on a statement.
Note	Text of the note to be added to the account ledger. If "Print Payment Note on Statement" is checked the note typed will also print on the statement.

Special Bill Message

Sometimes, you want to convey information to the account holder or patient. This can be done via the [Special Billing Message](#). The message can be a "canned" of pre-defined message or it may be free-format text. The Account Billing Tab will be updated with the selected/entered message and the recurring flag.

(Blank)	Enter/Select the "canned" special billing message that will be set on the account.
Recurring	Indicates if the message is recurring or a one-time message.
Message	Text of the message. Up to four lines of 60-characters of text per line may be entered.

Buttons

Show All	Shows all charges on the account regardless of whether they are at the self-pay level or not.
Suspense	You may suspend claims or statements for the account and add a memo indicating why this was done. The Suspend Claims and/or Suspend Statement flags on the Account Billing Tab will be updated.
View	You may select this button to view the account demographics or ledger.
Imaging	Displays images attached to the payment.
Finish	Saves the payment as entered and closes the Self Payment form putting you back on the Batch List screen.
Ok	Saves the payment as entered.
Cancel	Cancels the payment changes made and closes the Self Payment form

4.5.5.3   Payments - Insurance

The Insurance Payments form consists of three sections. In the first section, the Document/Check Information corresponds to the [Payment](#) tier. The Account information corresponds to the [Payment Distributions](#) tier. The second section allows the user to enter [Payment Distributions to Charges](#). The final section allows the user to enter Payment Notes and Special Billing Messages.

The Payment Document/Check Information captured in MedSuite contains the following information:

Batch No	Enter/Select the Batch to which the payment was applied. This defaults to the batch selected in the Payment Batch List
Remit Date	Date the payment was deposited into the bank. A warning will be issued if this is entered as a future date.
Claim No	Enter or Search (F9) for the claim that is making the Insurance Payment.
	You may enter a claim number or patient name in the Claim No

field. If a single entry is found that matches the information entered, the Claim information will be retrieved. If not match is found or if more that one match is found, you will be automatically taken to the Pick Distribution (Claim Search) form that will present a list of matching account entries.

Division	The Division associated with the claim is displayed
Pmt Method	Enter/Select the Payment Method (Check, EFT, Cash, etc)
Charge Card	Enter/Select the credit card type (VISA, MC, Amex, etc.) user-defined
Doc./Check No	Enter the Document or check number
Pmt Type	Enter/Select the Payment Type

This field may default from the payment calculation setups on the Plan Details Tab. If it is not setup on the Plan, then it must be manually entered in order to key in a payment amount.

Adj Type 1	Enter/Select the primary Adjustment Type

This field may default from the payment calculation setups on the Plan Details Tab. If it is not setup on the Plan, then it must be manually entered in order to key in a primary adjustment amount.

Adj Type 2	Enter/Select the secondary Adjustment Type

This field may default from the payment calculation setups on the Plan Details Tab. If it is not setup on the Plan, then it must be manually entered in order to key in a secondary adjustment amount.

Reason 1	Enter/Select the first Payment Reason
Reason 2	Enter/Select the second Payment Reason
Reason 3	Enter/Select the third Payment Reason

Co-Payments / Co-Insurance

Co-Payment and Co-Insurance information may be added to the Payment Distribution. This data is informational only and will display in the Activity View of the Ledger.

Copay $	Enter the Co-Payment amount
Co-Ins $	Enter the Co-Insurance amount
Co-Ins %	Enter the Co-Insurance percent (typically carrier-side)

Automatic Payment Distribution

MedSuite is a line-item posting system. Payments must be applied to individual line items. Insurance payments generally provide line-item posting information. However, sometimes this information is not provided. In these cases, the insurance payment must be manually split to post to the individual line items and this process can be quite tedious. To streamline this process, you may enter the total approved, total deductible, total payment, total primary adjustment and total secondary adjustment and click on the Auto Distrib button (or press Alt-A). The totals entered will be distributed to the line-items on the claim as a percentage of the each line item's billed amount out of the total billed amount.

Approved	Total approved amount.

	Disabled if the Plan Details Tab Approved amount indicates that it is Not Used; otherwise it is enabled
Deduct	Total deductible amount
	Disabled if the Plan Details Tab Deductible amount indicates that it is Not Used; otherwise it is enabled
Payment	Total payment amount
	Disabled if the Pmt Type on this form is blank; otherwise it is enabled
Adjust 1	Total adjustment 1 amount
	Disabled if the Adj Type 1 on this form is blank; otherwise it is enabled
Adjust 2	Total adjustment 2 amount
	Disabled if the Adj Type 2 on this form is blank; otherwise it is enabled
Auto Distrib	Click this button to auto distribute the totals above to the line items

Payment Distributions to Line-Items

All charges for the claim will be displayed in the grid. The fields below marked with an asterisk (*) may be automatically calculated of defaulted from the Plan Setup. If the user hits the Alt-5 the screen will hide the (Date and CPT fields) and display the (ASA, Units, and Minutes fields).

Date	Service date is displayed
CPT	Procedure code is displayed
Bill	Charge amount billed is displayed
M1	Charge Modifier 1 is displayed
Allow	The line-item amount allowed is displayed
Open	The line-item amount open is displayed
Approved*	Enter the line-item amount approved
Deduct*	Enter the line-item amount deduct
Payment*	Enter the line-item amount paid
Adj1*	Enter the line-item amount primary adjustment
Adj2*	Enter the line-item amount secondary adjustment
Status	The line-item payment status may be selected from the drop-down list displayed. The values available for selection in this field are defined as follows:

- Blank - Attempt to go through the Payment Status Defaults described below

- Paid - The balance will drop to the "next" level of insurance. If no insurance exists after the current level, any balance remaining will drop to Self Pay.

- Denied - The balance will drop to the "next" level of insurance. If no insurance exists after the current level, any balance remaining will drop to Self Pay.

- Disputed - The balance will drop to the "next" level of insurance. If no insurance exists after the current level, any balance remaining will drop to Self Pay.

  A new billing record for the amount in dispute will be created with the original claim number.

  Use of the "Disputed" status combined with a contractual write-off in Adj1 that you agree with and a disputed write-off in Adj2 that you do not agree with will allow you to create a patient statement that matches the payer's EOB.

- Held - The balance is held (open) at the current level

- Self - The Claim is paid or denied and the user wants to skip any remaining levels of insurance and have the billing proceed to the self-pay level

- Refile - The balance will be held (open) at the current level and will be refiled to the payer

  A new claim for the amount refiled will be created with the original claim number.

Payment Status Defaults

Zero/Credit Balance Defaults
MedSuite may automatically select one of the Default Payment Status values from [Practice Setup - Claims](#) Tab as follows:

- Zero Balance - The charge is paid in-full and the status will default to the practice setup. It is often useful to set the default to "Self" in this situation.
- Credit Balance - The charge is overpaid and the status will default to the practice setup. It is often useful to set the default to "Held" or "Self".

Paid/Denied Defaults
Assuming that the Zero Balance or Credit Balance defaults either were not invoked or were blank in Practice Setup, MedSuite may automatically select one of the values from the drop-down list as follows:

- Paid - If the Payment column is not equal to $0.00
- Denied - If the Payment column is equal to $0.00

Payment Reason Defaults
Other values are automatically selected by entering [Payment Reason Codes](#) that have been configured to set the line-item payment status:

- Held   - Held at the current claim level

- Denied - The claim is denied and proceeds to the next billing level displayed

Refile Secondary Claim	Forces a refile of the secondary claim (if one has already been created). This is used primarily in Medigap situations where the Medigap claim was created by MedSuite, but Medicare failed to send the claim to the Medigap Carrier.

Payment Notes

You may enter a free-form payment note regarding the payment that will display in the account ledger. The note will show in the Activity View and Memo tab of the ledger with the Visit Date of the claim that the payment note was applied to. If you select
Print Payment Note on Statement, the note will not only go in the ledger but show on the patients statement as well.

Print Payment Note on Statement	Indicates if the note typed in the box should be printed on a statement.
Note	Text of the note to be added to the account ledger. If "Print Payment Note on Statement" is checked the note typed will also print on the statement.

Special Bill Message

Sometimes, you want to convey information to the account holder or patient. This can be done via the Special Billing Message. The message can be a "canned" of pre-defined message or it may be free-format text. The Account Billing Tab will be updated with the selected/entered message and the recurring flag.

(Blank)	Enter/Select the "canned" special billing message that will be set on the account.
Recurring	Indicates if the message is recurring or a one-time message
Message	Text of the message. Up to four lines of 60-characters of text per line may be entered.

Buttons

Sec Info	When Medicare is secondary (MSP), You must enter information about the adjudication of the primary claim in order to file the MSP claim electronically
Suspense	You may suspend claims or statements for the account and add a memo indicating why this was done. The Suspend Claims and/or Suspend Statement flags on the Account Billing Tab will be updated
View	You may select this button to view the account demographics or ledger
Imaging	Displays images indexed to the payment.
Ok	Saves the payment as entered
Cancel	Cancels the payment changes made and closes the Insurance Payment form

4.5.5.4   Payments - Bulk Insurance

he Bulk Insurance Payments form consists of three sections. In the first section, the Document/Check Information corresponds to the [Payment](#) tier. The Account information corresponds to the [Payment Distributions](#) tier. The second section allows the user to enter [Payment Distributions to Charges](#). The final section allows the user to enter Payment Notes and Special Billing Messages.

The Payment Document/Check Information captured in MedSuite contains the following information:

Batch No	Enter/Select the Batch to which the payment was applied. This defaults to the batch selected in the Payment Batch List
Remit Date	Date the payment was deposited into the bank. A warning will be issued if this is entered as a future date.
Claim No	Enter or Search (F9) for the claim that is making the Insurance Payment.
	You may enter a claim number or patient name in the Claim No field. If a single entry is found that matches the information entered, the Claim information will be retrieved. If not match is found or if more that one match is found, you will be automatically taken to the Pick Distribution (Claim Search) form that will present a list of matching account entries.
Division	The Division associated with the claim is displayed
Pmt Method	Enter/Select the Payment Method (Check, EFT, Cash, etc)
Charge Card	Enter/Select the credit card type (VISA, MC, Amex, etc.) user-defined
Doc./Check No	Enter the Document or check number
Pmt Type	Enter/Select the [Payment Type](#)
	This field may default from the payment calculation setups on the [Plan Details Tab](#). If it is not setup on the Plan, then it must be manually entered in order to key in a payment amount.
Adj Type 1	Enter/Select the primary [Adjustment Type](#)
	This field may default from the payment calculation setups on the [Plan Details Tab](#). If it is not setup on the Plan, then it must be manually entered in order to key in a primary adjustment amount.
Adj Type 2	Enter/Select the secondary [Adjustment Type](#)
	This field may default from the payment calculation setups on the [Plan Details Tab](#). If it is not setup on the Plan, then it must be manually entered in order to key in a secondary adjustment amount.
Reason 1	Enter/Select the first [Payment Reason](#)
Reason 2	Enter/Select the second [Payment Reason](#)
Reason 3	Enter/Select the third [Payment Reason](#)

Co-Payments / Co-Insurance

Co-Payment and Co-Insurance information may be added to the Payment Distribution. This data is informational only and will display in the Activity View of the Ledger.

Copay $	Enter the Co-Payment amount
Co-Ins $	Enter the Co-Insurance amount
Co-Ins %	Enter the Co-Insurance percent (typically carrier-side)

Automatic Payment Distribution

MedSuite is a line-item posting system. Payments must be applied to individual line items. Insurance payments generally provide line-item posting information. However, sometimes this information is not provided. In these cases, the insurance payment must be manually split to post to the individual line items and this process can be quite tedious. To streamline this process, you may enter the total approved, total deductible, total payment, total primary adjustment and total secondary adjustment and click on the Auto Distrib button (or press Alt-A). The totals entered will be distributed to the line-items on the claim as a percentage of the each line item's billed amount out of the total billed amount.

Approved	Total approved amount.
	Disabled if the Plan Details Tab Approved amount indicates that it is Not Used; otherwise it is enabled
Deduct	Total deductible amount
	Disabled if the Plan Details Tab Deductible amount indicates that it is Not Used; otherwise it is enabled
Payment	Total payment amount
	Disabled if the Pmt Type on this form is blank; otherwise it is enabled
Adjust1	Total adjustment 1 amount
	Disabled if the Adj Type 1 on this form is blank; otherwise it is enabled
Adjust2	Total adjustment 2 amount
	Disabled if the Adj Type 2 on this form is blank; otherwise it is enabled
Auto Distrib	Click this button to auto distribute the totals above to the line items

Payment Distributions to Line-Items

All charges for the claim will be displayed in the grid. The fields below marked with an asterisk (*) may be automatically calculated of defaulted from the Plan Setup.

| Date | Service date is displayed |
| CPT | Procedure code is displayed |

Bill	Charge amount billed is displayed
M1	Charge Modifier 1 is displayed
Allow	The line-item amount allowed is displayed
Open	The line-item amount open is displayed
Approved*	Enter the line-item amount approved
Deduct*	Enter the line-item amount deduct
Payment*	Enter the line-item amount paid
Adj1*	Enter the line-item amount primary adjustment
Adj2*	Enter the line-item amount secondary adjustment
Status	The line-item payment status may be selected from the drop-down list displayed. The values available for selection in this field are defined as follows:

- Blank - Attempt to go through the Payment Status Defaults described below

- Paid - The balance will drop to the "next" level of insurance. If no insurance exists after the current level, any balance remaining will drop to Self Pay.

- Denied - The balance will drop to the "next" level of insurance. If no insurance exists after the current level, any balance remaining will drop to Self Pay.

- Disputed - The balance will drop to the "next" level of insurance. If no insurance exists after the current level, any balance remaining will drop to Self Pay.

   A new billing record for the amount in dispute will be created with the original claim number.

   Use of the "Disputed" status combined with a contractual write-off in Adj1 that you agree with and a disputed write-off in Adj2 that you do not agree with will allow you to create a patient statement that matches the payer's EOB.

- Held - The balance is held (open) at the current level

- Self - The Claim is paid or denied and the user wants to skip any remaining levels of insurance and have the billing proceed to the self-pay level

- Refile - The balance will be held (open) at the current level and will be refiled to the payer

A new claim for the amount refiled will be created with the original claim number.

Payment Status Defaults

Zero/Credit Balance Defaults
MedSuite may automatically select one of the Default Payment

Status values from Practice Setup - Claims Tab as follows:

- Zero Balance - The charge is paid in-full and the status will default to the practice setup. It is often useful to set the default to "Self" in this situation.
- Credit Balance - The charge is overpaid and the status will default to the practice setup. It is often useful to set the default to "Held" or "Self".

Paid/Denied Defaults

Assuming that the Zero Balance or Credit Balance defaults either were not invoked or were blank in Practice Setup, MedSuite may automatically select one of the values from the drop-down list as follows:

- Paid - If the Payment column is not equal to $0.00
- Denied - If the Payment column is equal to $0.00

Payment Reason Defaults

Other values are automatically selected by entering Payment Reason Codes that have been configured to set the line-item payment status:

- Held   - Held at the current claim level
- Denied - The claim is denied and proceeds to the next billing level displayed

Refile Secondary Claim	Forces a refile of the secondary claim (if one has already been created). This is used primarily in Medigap situations where the Medigap claim was created by MedSuite, but Medicare failed to send the claim to the Medigap Carrier.

Payment Notes

You may enter a free-form payment note regarding the payment that will display in the account ledger. The note will show in the Activity View and Memo tab of the ledger with the Visit Date of the claim that the payment note was applied to. If you select Print Payment Note on Statement, the note will not only go in the ledger but show on the patients statement as well.

Print Payment Note on Statement	Indicates if the note typed in the box should be printed on a statement.
Note	Text of the note to be added to the account ledger. If "Print Payment Note on Statement" is checked the note typed will also print on the statement.

Special Bill Message

Sometimes, you want to convey information to the account holder or patient. This can be done via the Special Billing Message. The message can be a "canned" of pre-defined message or it may be free-

format text. The Account Billing Tab will be updated with the selected/entered message and the recurring flag.

(Blank)	Enter/Select the "canned" special billing message that will be set on the account.
Recurring	Indicates if the message is recurring or a one-time message
Message	Text of the message. U to four lines of 60-characters of text per line may be entered.

Buttons

Sec Info	When Medicare is secondary (MSP), You must enter information about the adjudication of the primary claim in order to file the MSP claim electronically
Suspense	You may suspend claims or statements for the account and add a memo indicating why this was done. The Suspend Claims and/or Suspend Statement flags on the Account Billing Tab will be updated
View	You may select this button to view the account demographics or ledger
Imaging	Displays images indexed to the payment.
Ok	Saves the payment as entered
Cancel	Cancels the payment changes made and closes the Insurance Payment form

4.5.5.4.1 Payment Distribution List

The Payment Distribution List allows the user to select add a new Payment Distribution or to edit or delete and existing Payment Distribution and contains the following information:

Visit Date	Date of Visit
Billing No	Billing (Claim) number
Patient	Patient name
Account	Account name
Subscriber	Subscriber name
Plan	Plan name
Paid	Payments applied
Ellipsis Icon	Edit Payment Distribution and Payment Distribution to Charges
Delete Icon	Delete Payment Distribution and Payment Distribution to Charges

Payment Distribution List Buttons

New	Add Bulk Payment Distribution and Payment Distribution to Charges
	If you are using Image Workflow with a Bulk EOB, a previously indexed Bulk EOB will be displayed.
Edit	Edit Bulk Payment Distribution and Payment Distribution to Charges

> **If you are using Image Workflow with a Bulk EOB, a previously indexed redacted or "clipped" EOB will be displayed.**

Delete   Delete Bulk Payment Distribution and Payment Distribution to Charges.

> **The delete from the Distribution List only deletes the selected claim.**

4.5.5.4.2 Payments - EOB Image

The Bulk Payment EOB Image screen presents the contents of a Bulk EOB image and a series of controls and buttons that allow you to control and manipulate the image. In a Windows environment, the window or form with "the focus" is the window where keystrokes are directed. This form is generally the "front" or top-most form on your desktop.

When using Bulk EOB Workflow, you will be dealing with two windows; one with the image of the Bulk EOB and the other is Bulk Payment Entry. You will need to control the image window without "changing" windows or clicking on the image. The "P" on the Print button of the EOB Image window below is underlined, so you would expect that Alt-P will "click" the Print button. You would be correct if the EOB Image window below has the focus. However, you are keying a new Bulk Payment; therefore, the New Bulk Payment window has the focus and the Alt-P will do whatever (if anything) Alt-P does in New Bulk Payment.

This problem is resolved by a series of keystrokes that allow you to manipulate the image from a data window without losing focus in the data window. You can rotate the image, zoom in or out, or pan left, right, up, or down without leaving the data input window.

Keystroke	Description	Notes
Alt-Ctrl-Up	Pan Image Up	Up Arrow
Alt-Ctrl-Down	Pan Image Down	Down Arrow
Alt-Ctrl-Left	Pan Image Left	Left Arrow
Alt-Ctrl-Right	Pan Image Right	Right Arrow
Alt-Ctrl-+	Zoom-In	Alt-Ctrl-Plus
Alt-Ctrl--	Zoom-Out	Alt-Ctrl-Minus
Alt-Ctrl-Home	Toggle Windows	Toggle focus between Imaging Window and main
window of MedSuite		
Alt-Ctrl-PgUp	Previous Image	Display previous image in Image List
Alt-Ctrl-PgDn	Next Image	Display next image in Image List
Alt-Ctrl-*	Rotate Right	Asterisk on ten-key pad. Rotate image 90-degree to
right		
Alt-Ctrl-/	Rotate Left	Divide on ten-key pad. Rotate image 90-degree to left

Description   The description assigned to the image by MedSuite is displayed.
Toolbar   MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In   Zooms-In (enlarges) the image
Zoom-Out   Zooms-Out (reduces) the image

Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Redaction (Clipping)	The following buttons allow the user to redact or "clip" portions of the Bulk EOB into an EOB for a single claim. The EOB Header, Footer, and Detail Area can be "clipped" and pasted together for form a separate EOB that is indexed to a claim.

Header	By pressing the Header button you press and hold the right button of the mouse to drag a box around the header portion of the Bulk EOB and release the button to select the area of the EOB to redact or "clip". If you have properly selected the redacted area, a red box will be drawn around the area selected.
Footer	By pressing the Footer button you press and hold the right button of the mouse to drag a box around the footer portion of the Bulk EOB and release the button to select the area of the EOB to redact or "clip". If you have properly selected the redacted area, a red box will be drawn around the area selected.
Line 1	By pressing the Line 1 button you press and hold the right button of the mouse to drag a box around the detail portion of the Bulk EOB and release the button to select the area of the EOB to redact or "clip". If you have properly selected the redacted area, a green box will be drawn around the area selected.
Line 2	By pressing the Line 2 button you press and hold the right button of the mouse to drag a box around the second detail portion of the Bulk EOB and release the button to select the area of the EOB to redact or "clip". If you have properly selected the redacted area, a green box will be drawn around the area selected. **Line2 should only be used when a claim spans pages of a Bulk EOB**
Join Img	Join Img joins the Header, Line1, Line2, and Footer selections into a single redacted EOB image that is then displayed.
Clear	Clears the Header, Line1, Line2, and Footer selections.

Page Control There are several controls that allow you to page through a multi-page EOB.

Page Up Go to the previous page of a multi-page EOB
Page Down Go to the next page of a multi-page EOB
Go to Page Go to a specific page of a multi-page EOB.

Annotation Area

This area will display a text box along with any special controls that were selected in the Imaging Type setup. The text and selection boxes entered here are saved with the image. Several of the annotation fields are mutually exclusive. Charge Tickets don't have remit dates and Demographics don't have procedure codes. Although all of the available annotation fields will never be displayed on a single Imaging Type, they will all be documented here.

You will notice that the field "groups" are highlighted with purple text. This indicates that those group boxes may be "jumped-to" during data input. F4 will jump forward to the next purple field, and F5 will jump backward to the previous purple.

Annotation The first several lines of the keyed annotation are displayed.
Payment Method Enter/Select the Payment Method for an EOB.
Date Remit Enter/Select the Remit Date for an EOB.
Document Number Enter/Select the Document Number for an EOB.

Buttons

A series of buttons are displayed across the bottom of the screen and are used as follows:

Print Prints the selected image

4.5.6 Payment Worksheet

Payments are typically entered in "batches". A batch of payments may be for a date from a lock box, or for an EOB, or for all self-pay payments from the lock box, or some other batching methodology. However, once the payments are entered, the batch needs to be "balanced". This involves checking a report of the payments in the batch against the original documents for the payments and ensuring that the total payments and total adjustments balance between the report and the original documents. This process ensures that all payments and adjustments are entered, that they will balance to the bank deposit.

The Payment Worksheet request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Sequence By	Indicates the sequence to print details on the report (within primary sorts): • Entry Order • Patient Name
Include Interest Payments and Adjustments Only	Selects only those payments and adjustments that are flagged as Interest codes on Payment Types or Adjustment Types Setup.
Un-Posted	Indicates that the Worksheet is to be run against unposted payments for a batch or all batches
Batch No	Batch number (blank for all) to run for unposted payments
Released Batches Only	When running the report in Un-Posted mode, you may select only batches that have been released for posting.
Include Unposted Reversals	When running the report in Un-Posted mode, you may select unposted reversals.
Posted Date	Indicates that the Worksheet is to be run against posted visits for a posted date range
From Date	When running the report in Posted Date mode, enter the beginning date of the posted date range
Thru Date	When running the report in Posted Date mode, enter the ending date of the posted date range
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	indicates that the report should be scheduled to run at a future time
Schedule Button	invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the

second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

4.5.7   Close Out

MedSuite uses the concept of a Close Out to perform all of the daily production functions required to properly operate the system. The Close Out form is submitted to the Task Manager with indicators set to run or not run each of the production functions.

The Close Out request form contains the following information:

Task Name	Task Name displayed in the Task Viewer
Report Results to User	User Name whose Task Viewer will receive the output of the Close Out
Concurrency	Indicates that the Concurrent Case Audit will be rerun in the Close Out to get a final report for all batches and all anesthesiologists
Post Visits	Indicates that all released batches of visits will be posted
Post Payments	Indicates that all released batches of payments will be posted
Process Remittance	Indicates that any unprocessed electronic remittance files should be processed and create unreleased payment batches, enter the payments and adjustments to the patient claims and generate remittance reports.
Claim Print	Indicates that all selected paper claims be formatted for subsequent printing
Electronic Claims	Indicates that all selected electronic claims be formatted for electronic submission
Auto Refile Claims	Indicates that all claims not paid or denied should be refiled as defined by the plan definition for each plan
Statement Print	Indicates that all selected paper statements be formatted for subsequent printing
Electronic Statements	Indicates that all selected electronic statements be formatted for subsequent submission
Balance Sheet	Indicates that the Balance Sheet should be run for the posted activity
Create Collection Followup	Indicates that all claims and all accounts that meet the Followup Queue Definitions for a practice be sent to the Followup Queue.
Mail Merge	Indicates that all requested form letters be formatted for subsequent printing
Run Now	Indicates the report should be run immediately
Schedule	Indicates the report should be scheduled to run at a future time
Schedule Task Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow

	button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

4.5.8   EDI Claims

4.5.8.1   EDI Management

MedSuite enables the user to view generated EDI files as PDFs. This allows users to search the files for specific patients, claims or account numbers. This page also allows a user to download files in their originally generated format via the "Get" functionality to support re-submission.

The following controls are available on the EDI Management page:

From Date	Use the calendar to select a date or enter a date by typing in the field.
To Date	Use the calendar to select a date or enter a date by typing in the field.
Practice	Limit the displayed files to a specific practice.
Type	Limit the files to a specific file type.
Refresh Button	Refreshes the list of files.

The EDI Management page contains a grid with the following information:

Practice	The name of the Practice the file was generated for.
Processor	The type of processor used to create the file
Type	The type of file, i.e. Statement or 835
Status	The status of the file
Created	The date the file was created
Time	The time the file was created
View	View the file as a PDF
Get	Download the file as a zipped file locally

4.5.8.2   Batch Claim Reprint

MedSuite allows the user to reprint an entire batch of claims. This function is especially useful when bringing up a new practice and claims are being "tweaked" for specific carrier requirements. This function may also be used if a batch of claims has been lost and needs to be reprinted.

The Batch Reprint form contains a grid with the following information:

Date Claim Filed	Date that the original claim(s) were created
Claim Format Name	Format Name
Claim Number From	Claim number beginning range
Claim Number To	Claim number ending range
Detailed Count	Number of claims to print

The following buttons are available in the Batch Reprint function:

Refresh Button	Refreshes the list of batches that may be reprinted.
Print Button	Prints the selected batch
Close Button	Closes the form

4.5.8.3   Batch Claim Refile

MedSuite allows the user to refile claims that meet a set of user-specified selection criteria:

Task Name	Task Name displayed in the Task Viewer
Refile by Submission	Select Paper, Electronic, or All to be refiled
Refile for Claim Format	Enter/Select the Claim Format to be refiled (optional)
Division	Enter/Select the Division to be refiled (optional)
Carrier	Enter/Select the Carrier to be refiled (optional)
Plan	Enter/Select the Plan to be refiled (optional)
Staff	Enter/Select the Staff member to be refiled (optional)
Date of Service	Enter the beginning and ending dates of service to be refiled.
Claim Filing Date	Enter the beginning and ending claim filing dates to be refiled.
Close and Refile Items in Follow-up	Select this option if you want claims that are in the Follow-up Manager to be closed and refiled.
Force Refile To	If you Refile by Submission, you can force the refiled claims to go to:

- Paper
- Electronic/Paper (Based on Carrier)
- Test (Paper and Eletronic)
- Test(Electronic)

Patient Policy Level	Refiles may be limited to specific levels of insurance policies:

- All Levels
- Primary Policies
- Secondary Policies
- Tertiary Policies
- Non-Primary Policies

4.5.8.4   Transmit to EDI Portal

This function is used by clients who do not utilize PerSe/RelayHealth as their electronic claims clearinghouse. This process sends electronic claims files that were created during the MedSuite Closeout process to the client's FTP site so that they can transmit the files to their claims vendor. In addition, it will move ERA (electronic remittance advice) files from the client's FTP site to the proper location on the MedSuite servers so the ERA files can be processed during the next closeout. This process is a "global" process; it performs the transfer of files for ALL practices within the database at once, and does not have to be performed individually for each practice. After a scheduled closeout, this process runs automatically to move the newly created claims files, and to move over any ERA files from the FTP site. However, using this separate menu item, clients can run the process "on demand," or schedule it to run at another time (besides the one that runs automatically after a scheduled closeout). For instance, an office may want to schedule an EDI Portal transmission to run just prior to the nightly scheduled closeouts so that any ERA files they've placed on their FTP site throughout the day will be processed during that night's closeout.

After running the Transmit to EDI Portal, reports are placed in the Task Viewer under the CLOSEOUT tab, under the "blank" practice since the transmission is for all practices.

Task Name	Task Name displayed in the Task Viewer
Schedule	Indicates in the report should be scheduled to run at a future time
Schedule Task Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

4.5.8.5   Transmit to PerSe

This function transmits electronic claims and statement files to PerSe via FTP.

Task Name	Task Name displayed in the Task Viewer
Transmission Type	Indicates what is to be sent/retrieved from PerSe
*Full	Claims and Statements will be sent and message files will be retrieved
*Messages Only	No claims or statements will be sent. Message files will be retrieved
*Production	Indicates that a production transmission will be sent
*Test	Indicates that a test transmission will be sent
Run Now	Indicates in the report should be run immediately
Schedule	Indicates in the report should be scheduled to run at a future time
Schedule Task Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

4.5.8.6   Retrieve Electronic Statements

This function allows electronic statements to be retrieved by the user for transmission to another third-party.

Task Name	Task Name displayed in the Task Viewer
Transmission Type	Indicates the mode in which statements will be sent:
*Production	Indicates that a production transmission will be sent
*Test	Indicates that a test transmission will be sent
Run Now	Indicates in the report should be run immediately
Schedule	Indicates in the report should be scheduled to run at a future time
Schedule Task Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

4.6   Queues

The Queues Menu provides access to all of the "Queue" functions of MedSuite including:

- Followup Queue   Allows you to "filter" on delinquent accounts and/or claims and perform followup functions.
- Collection Selection   Allows you to select Visits that meet delinquency criteria
- Collection Turnover   Allows you to manage the Visits selected for collection in Collection Selection. You may also manually add Visits to Collection Turnover
- Collection Turnover Listing   Allows you to list the Visits in Collection Turnover. You may perform the actual Turnover and balance write-off.
- Collection Letters   Allows you to select Visits that meet delinquency criteria and send Collection Letters
- Refund Manager   Allows you to request Refunds to be sent
- Refund Listing   Allows you to List requested Refunds and (optionally) issue Refund Checks

4.6.1   Followup Queue

The Followup Queue in MedSuite provides a means of following-up on claims and accounts on the screen, virtually eliminating the need to run lengthy followup or delinquency reports. Followup "queues," built by criteria determined by each practice, allow "actions" to be taken on a claim or account, track those actions by user, and allow the user to set a future followup date at which point it will re-appear in its queue.

Through the use of the Followup Queue Definitions, practice managers determine if, when, and how an account or a claim will be sent to the Followup Queue. The followup workload in a practice is typically divided among several workers by type of followup (insurance or self-pay). Within insurance there is frequently a further breakdown into specific plans or plan types because workers who have expertise in Medicaid followup generally have contacts at Medicaid who can help speed things along. For larger practices, within self-pay a further breakdown is required simply due to the volume of followup accounts. MedSuite uses Followup Queues and Filters to accommodate both the insurance and the self-pay breakdowns.

Let's look at a brief example:

Let's assume that a practice has defined that a Blue Shield claim that has not been paid or denied within 30 days of the submission date should be sent to a Blue Shield Followup Queue. Furthermore, a Blue Shield claim has met this followup criteria and has been sent to the Blue Shield Queue. Finally, let's assume that someone called BFW (Blue Followup Worker) does the followup for Blue Shield.

Each day, BFW comes in to work and opens the Blue Shield Followup Queue. When the Queue is opened, all claims that are to be "worked" today (or days past that weren't worked) will be displayed on the screen. BFW then begins making phone calls, pulling ledgers, refiling claims, etc. As these actions are performed, they tell the Followup Queue how far to advance the Next Followup Date. For example, if the Blue Shield claim were to be refiled, then the Next Followup Date might be advanced fourteen days. If the carrier were called and said that the check was in the mail, then the Next Followup Date might be advanced five days. In either case, the actions performed are recorded in Followup History and the Next Followup Date is advanced according to a manager-defined guideline.

Five days into the future when BFW starts working the Blue Shield Queue again, the "check is in the mail" claim pops up on the list just like magic if it has still not been paid. In the event that in the

intervening five days, the claim was paid, then the claim will be closed and the claim will not appear in the Followup Queue for followup processing by BFW.

Followup actions are performed via the Followup Queue. Access the Followup Queue by clicking the Followup Button on the Dashboard Toolbar, or entering the short-cut key combination CTRL+Q, or by selecting Followup Queue from the Queues menu.

Press F9 or click the search on the Queue field to display a list of the Followup Queues. Select the Queue that you wish to view. Select the Filter button to go ahead and display the entire Queue without applying any filters to it.

4.6.1.1   Navigating the Followup Queue

Use the horizontal and vertical scroll bars to move around the Followup Queue grid to see all the data for each record, and to see more records that follow. The system displays the number of records contained in the Queue in the top right corner so that you have an idea as to what you're going to be looking at.

There are many ways to control how the Followup Queue grid is displayed.
- The grid will display a maximum of 100 accounts at a time. Use the Page drop down box to select the next set of accounts if the total number of records exceeds the 100 account maximum.
- Clicking at the top of any of the fields sorts the records in that order so that you can list them by Patient Number, alphabetically by name, or group by Acct Class, sort by patient birth day, phone #, etc.
- Fields may be rearranged by dragging columns to the left or right.
- Fields may be removed by using a right-click, then the Remove option. A list of all the fields will be displayed so you can proceed to remove the ones you do not wish to see. After removing fields, you may always use a right-click then the Add option to put them back.
- After rearranging or removing fields, the Default option will restore the fields to their original default setting. Right-click, then select the Default option. Changes that a user makes to a Self Queue display apply to all Self Queues that user opens up on their machine. Insurance Queues retain the last setup done for an Insurance Queue.

BUTTONS:
After clicking on a record to select it, the buttons at the bottom of the screen will allow different functions to be performed.

Search Invokes the Followup Search Wizard which allows Followup Queue data that has already been Filtered to be searched and further filtered by Patient Name, Patient Number or Billing (Claim) Number.

This feature functions like a filter within the main Followup Queue Filter. If the search does not return the desired results, you must Refilter the Followup Queue.

Export Invokes the Export Wizard which allows Followup Queue data to be exported to a text file, Excel file, Word file, etc. This feature might be used by managers wishing to run some additional data analysis or reports on the Queue data.

Open Demo: Opens the Patient Demographics for the selected record. Note that it opens a separate window that can be closed with the CTRL+E shortcut (E as in Exit).

Open Billing: Opens the Account Holders Billing Tab for the selected record. This allows quick access to change Acct Class or Types, Suspend/Un suspend statements, and set the Return Mail flag. Note that it opens a separate window that can be closed with the CTRL+E shortcut (E as in Exit). This button only displays in Self Queues.

Ledger: From a SELF Queue, this opens the Account Ledger for the selected account record. From an INSURANCE Queue, this opens the Patient Ledger for the selected claim record. Note that it opens a separate window that can be closed with the CTRL+E shortcut (E as in Exit).

Action: Displays the Followup Action dialogue box where you specify what action you are taking on the claim/account and the next followup date. This will be discussed in more detail later in

this manual.

History: Displays the Followup Activity box which lists followup actions that have previously taken place on this claim/account. Some other information is displayed as well, such as the Account Name, Address, and Phone #, and billing information such as bill dates and dunning level.

REFRESH QUEUE alert:

You may see an alert in the top right corner of your screen periodically. This is letting you know that additional entries should be displayed in your queue because the next followup date/time have been met. For example, you might call and get a busy signal, and set followup date/time for 2 hours in the future to try again. This will display in 2 hours to let you know that there is an entry out there whose followup date/time has passed, and you need to refilter to refresh the screen to display the entries that should now be followed up on.

Note: Self Queue displays records by VISIT, so you could see a patient listed more than once if there are multiple visits that have met the queue criteria.

4.6.1.2   Followup Filters

"Filters" may be applied to Followup Queues to limit the number of claims/accounts that are on display, to make working the Queues more manageable if they are very large.

After selecting the Queue you wish to work in, press F9 or click the search on the Filter field to display a list of the available Filters. Select the Filter that you wish to apply to the Queue.

To create a new filter, select New from the Followup Filter Search window.

Enter a Name for the Filter. If you've accessed the Filter Maintenance from a Self Queue, the Criteria Type will default to Self. If you've accessed the Filter Maintenance from an Insurance Queue, the Criteria Type will default to Insurance. Enter the filter criteria you'd like to use.

Examples of Filters could be ones that select portions of queues based on the last name alphabetically, Filters to display only primary or secondary and third level claims, Filters to display only Disputed claims, only paper or electronic claims, claims/accounts over a certain amount, Filters by Acct Class or Acct Type, etc.

A NOTE OF CAUTION if you are using Filters:

Filters limit the number of records that are displayed from within a queue. For example, a Medicare queue might have 200 claims in it, but after applying a filter to show only Primary claims, it might be limited to 180. Or, if you apply an A-L filter it will only show claims for patients with a last name starting with A-L. If you limit the queues with the use of filters, you will need to make sure that another appropriate filter is run to display any other claims you may wish to see, such as claims for patients with a last name starting with M-Z.

4.6.1.3   Queues and Multiple Users

Ideally, one user should access a queue at a time, or the queue should be filtered in such a way that users are accessing different claims/accounts within the queue. For example, in a Self Pay Over 60 queue, it could be filtered so that someone sees A-L accounts and someone else sees M-Z accounts so that they are not trying to work on the same queue entries simultaneously.

However, it is possible for multiple users to access a queue if so desired. After the queue has been opened by one user, any subsequent users who open it will receive a warning message alerting them that the queue is already open by someone else. This is merely a warning, and the user may continue on to use the queue.

If the warning is received, it is advised that the user refresh their displayed entries periodically by re-filtering. This will remove from their display the entries that the first user has worked and updated with a future followup date.

4.6.1.4   Actions within the Followup Queue

Once you are in a Queue you will take Action on claims/accounts within the queue. As discussed in the Navigating section previously, after selecting a record in the queue, you may view a ledger, go to demographics, account billing, and view the followup history. The ACTION button at the bottom of the screen will display the Followup Action dialogue box where you specify what action you are taking on the claim/account and the next followup date.

Choose the Action that you are taking.

The Form Letter field is only active when you've selected an Action that is linked to an Action Code that has a Process Type of Correspondence.

The Account Class field is only active when you've selected an Action that is linked to an Action Code that has a Process Type of Collection-Turnover.

The Promise Amount field is only active when you've selected a Self Pay record and an Action that is linked to an Action Code that has a Process Type of Promise.

If an Action is linked to an Action Code that has a Process Type of Other, the cursor will jump from the Action to the Next Action date and time fields.

The Next Action date will default to a future date and/or time if the Action is set up with a period to advance the Followup Date by. For example, the date/time may advance by 2 days or 14 days or 2 hours or 1 week. If the Action is NOT set up to advance the Followup Date, the current date will display.

You may override the date to any date sooner than the default, but you are limited on how far into the future you can override the default. The default override edits depend on the Period Type from Followup Action Setup.

    Period Type: Days, Hours or Minutes
        Override of default may be up to twice the Period or 5 Periods whichever is greater. For example if the followup period is 5 days, the Override limit will be 10 days which is twice the period but greater than 5 days. If the period is 2 days, the override limit will be 5 days which greater than twice the period of 2 days.

        If the Period is left blank or is zero, the Override limit will be 5 Periods.

    Period Type: Weeks or Months

Override of default may be up to twice the Period. For example if the followup period is 3 weeks, the Override limit will be 6 weeks which is twice the period.

If the Period is left blank or is zero, the Override limit will be 1 Period.

After selecting OK to save the action, you are returned to the Queue.

The queue entry you just worked will display in green. You may continue to take additional actions on it. To remove the green entries from your screen, simply Filter again.

4.6.1.4.1 Collection-Turnover

An Action may be created and used that is linked to an Action Code that has a Process Type of Collection Turnover. This is used in cases where a collector needs to manually add a visit to the Collection Turnover file. After selecting OK to save the action, the Collection Maintenance window is displayed.

Specify the Account Class that should be assigned to the account when it is turned over to collection. If the Account Type should be changed when it is turned over to collection, specify the Account Type to which the account should be changed. Specify the Agency to which it should be sent when it is turned over to collection. These fields will all be updated to these new values when the Collection Turnover process is run and the account is turned over. After selecting OK to save the action, you will be returned to the Queue.

After performing this action, the visit will display in yellow in the ledger to indicate that it is now in Collection Turnover. If a future Next Action date is entered, it will no longer display in the Collection Queue, and it will not display on the Next Action date either. Accounts that are in Collection Turnover do NOT display in the Queues; the assumption is that they have already been worked or are being dealt with via the Collection Turnover, and that they do not need to be worked or followed up on in the queue any longer. (Note: if the Next Action date is left as the current date, it will continue to display. We suggest that the Action set up to default the date by 1 day so that it will disappear).

4.6.1.4.2 Collector Group

An Action may be created and used that is linked to an Action Code that has a Process Type of Collector Group. This is used to set the Collector Group on the Account Billing Tab without having to navigate through MedSuite to that screen. The Collector Group is used by some clients to indicate internal or external collector or assignment of an item in a queue to a manager.

4.6.1.4.3 Correspondence

If you select an Action that is linked to an Action Code that has a Process Type of Correspondence, then the Form Letter field is required. As when you request to Send Form Letter from a ledger, you need to specify which letter you want to send. The form letter will be mail merged during the next Closeout (assuming that option is selected during the Closeout). The ledger will then display the letter that was sent and the user that sent the letter.

After selecting OK to save the action, you will be returned to the Queue. The queue entry you just worked will display in green. You may continue to take additional actions on it. To remove the green entries from your screen, simply Filter again.

4.6.1.4.4 Followup Wizard

Some Actions may be linked to an Action Code that have a Process Type of Followup Wizard, such as actions that involve requesting statements, refiling/reprinting claims, and resetting insurance billing.

After selecting OK to save the action, the Followup Wizard screen is displayed.

If you were working a self queue entry, only the Self-Pay options are available. If you were working on a claim, only the Insurance options are available. Select the option you want then select OK. Depending on the option, you may receive different additional pop-up boxes asking for the billing message you want on the statement, or whether you wish to force a claim refile to paper or electronic, etc. You may then receive a message that you have successfully queued a statement or claim, depending on the option selected.

After completing the Followup Wizard prompts, you will be returned to the Queue. The queue entry you just worked will display in green. You may continue to take additional actions on it. To remove the green entries from your screen, simply Filter again.

4.6.1.4.5 Promises - Self

If you select an entry from a Self Pay Queue and select an Action that is linked to an Action Code that has a Process Type of Promise, then the Promise Amount field is required. Enter the amount to be paid, and then the date the account should come back into the Queue if it is NOT paid.

After selecting OK to save the action, you will be returned to the Queue.

The system will monitor that account for the payment. If no payment is received by the date specified, it will incur a "broken" status and will redisplay in the Queue on the specified Followup Date (assuming the Queue is set up to include Broken Promise statuses). If a payment is posted that is greater than or equal to the promised amount, the account will not incur a broken status and will not come back into the queue unless it meets the queue criteria at some point.

Partial Payments on Self Promises

You may need a separate Queue for monitoring promises if patients make partial payments. A partial payment that is greater than the Minimum Payment amount will reset the aging on the account, even if it is not the amount that was promised. Therefore, it is possible that it may not show up in a Self Pay Queue if your queues are set up to only show delinquent accounts such as a minimum age of 45 or 60.

To ensure that you see any accounts where the promise is broken because only a partial payment is made, create a Self Pay Queue with NO max or minimum age, and specify Only Broken Promises. Refer back to the section on Self Queue Types for examples on how to set this up.

Claims/Accounts with a broken status display in red in the queue.

4.6.1.4.6 Promises - Insurance

If you select an entry from an Insurance Queue and select an Action that is linked to an Action Code that has a Process Type of Promise, enter the date the claim should come back into the Queue if it is NOT paid. Note that the Promise Amount field is NOT used on promises on claims.

After selecting OK to save the action, you will be returned to the Queue.

The system will monitor that claim for the payment. If no payment is received by the date specified, it will incur a "broken" status and will redisplay in the Queue on the specified Followup Date (assuming the Queue is set up to include Broken Promise statuses). If a payment is received or a denial is posted to

cause the claim to be closed, it will not come back into the queue.

4.6.2   Create Collection Followup

This utility allows a user to create the Followup queues for Insurance or Self independently or at the same time.

Create Collection Followup - Insurance	Run the utility to create the Insurance Followup Queue
Create Collection Followup - Self	Run the utility to create the Self Followup Queue
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

4.6.3   System Imaging

MedSuite's Imaging Workflow module supports two major features. The first feature is, as its name implies, to create a "workflow" so that scanned documents can be routed to various stations based on the type of document scanned so that data input may occur directly from the scanned documents. The second major feature is to provide ability to "index" a scanned document to some data whether that data represents a Patient, an Account, a Visit, a Payment, or some other data entity such as a Plan, a Fee Schedule, or a Staff Member.

Indexing

Any scanner designed to support a sheet feeder that rapidly scans multiple documents (and many that scan only one image at a time) assigns some unique identifier to an image as its file name or Document ID. This identifier is often in the format of DOC99999.TIF or IM999999.GIF where 99999 and 999999 represent some sequential number assigned to the image.

"Indexing" generally refers to linking either specific documents (by Document ID) or batches of documents (by some other criteria) to some recognizable search data in an automated manner. The whole purpose behind scanning documents is to make retrieval both possible and easier than searching for the paper document in a storage facility. If a practice or billing company would like to retrieve a scanned document at some point in the future, then Indexing the document to some recognizable search data is crucial.

Batch Indexing

Batch Indexing assigns "some recognizable search data" to a group or batch of documents. For example, a batch of Hospital Faces Sheets can be indexed by the hospital admit date or the patient's surgery date. With Batch Indexing, retrieval is basically a manual process. The user typically has to find the batch of images (by date in our example) and then display each image to determine if the displayed image is the image the user is searching for. If the images were not alphabetized before scanning, then on the average, the user will have to review one-half of the images before he finds the image that he wants. If the images are alphabetized prior to scanning, then the search process will be somewhat faster.

Document Indexing

If Batch Indexing can be thought of as indexing a group or batch of documents to some recognizable search data, then Document Indexing can be thought of as indexing specific documents to some

recognizable search data. Whereas Batch Indexing functions at the batch "level", Document Indexing functions at the document "level".

What we are really talking about when we refer to Document Indexing is having the "recognizable search data" that is tied to a document specific enough so that a single document or just a handful of documents can be retrieved. Let's look at an example:

> Let's assume that a patient had surgery on Jan 1, 2005. There are three paper documents associated with the service that the practice or billing wants to scan; a Hospital Face Sheet, an Anesthesia Record, and a Charge Ticket. Furthermore, let's also assume that we had enough detail on each document so that a specific document or a handful of documents could be retrieved by a search. Let's look at an example:

> We now have a database table called the Document Index Table. Each row of the table stores data such as the Patient Name, Medical Record Number, Social Security Number, Date of Service, Document ID, Document Type, and Document Date Scanned. After several months we have thousands of documents and thousands of corresponding rows in the Document Index Table. Let's assume we have also written a program that will take input like a Patient's Name, or Medical Record Number and retrieve the matching rows from the Document Index Table and the documents corresponding to those rows.

> Our document retrieval process has been drastically changed for the better. Rather than having to view tens or even a hundred documents or more to find the one or two that we need, we can now retrieve exactly those documents that are for a specific patient. Let's further assume that the search program was sophisticated enough to allow the user to search on multiple criteria such as Patient Name, Date of Service, and Document Type. Now the search result will be only the one or two documents meeting the search criteria.

> That was the easy part. Creating the rows in the Document Index Table is the hard part. There are a number of ways to create these rows and most of them are dependent upon how much access and control the people implementing the imaging system have over the billing software. In cases where there is no control whatsoever, Document Indexing may be a separate stand-alone data input process. This is time-consuming and prone to data input errors. Where there is some control of the billing software, Document Indexing is often a "screen-scraping" process in which a program "reads" the data input screen and inserts specific data from the screen into the Document Index Table. While this often works, it has its flaws. If patient's name was originally misspelled and later corrected after the image was indexed, will the change be populated to the Document Index Table? Unfortunately, the answer to this question is frequently "No".

We now usually get into a cost-justification discussion over Batch Indexing vs. Document Indexing. Batch Indexed documents are easier, faster, and cheaper to Index, but require more effort and are by far more expensive to retrieve. One the other hand, Document Indexed documents require more work and are more expensive to Index, but require little effort and expense to retrieve. Often, Batch Indexing is selected because it is less onerous to Index and the hope is that the practice or billing company won't have to retrieve too many documents.

Workflow

What if Indexing could occur as quickly and easily as Batch Indexing and document retrieval could occur as quickly and easily as Document Indexing? Image Workflow makes both of these possible. The idea behind Image Workflow is that, in many applications, a document isn't just scanned, indexed, and stored.   In some applications, like auto insurance claims, there are many types of documents such as accident reports, photos of the car, claim adjuster's worksheets, body shop estimates, etc. Some of these are just

supporting documentation while others are the documents that drive the process. At various points during the claims process, different people need access to these documents; some for review and approval, others to actually enter, adjudicate, and pay the claims. This is probably an extreme example, but it illustrates the point that in a workflow setting, documents need to be sent from one step in a process to the next. As the documents move from step-to-step, more and more data is captured along with the scanned documents until, eventually, the process is "completed" and the "case" is closed.

In an anesthesia billing office, some documents like a Hospital Face Sheet are data input, indexed, and closed in a single step for while others such as a Charge Ticket can go to coding, data input, batch verification and balancing, and then are closed. In MedSuite's Image Workflow, a specific document can be displayed on the screen while the data is input. The action of saving the data that has been input has been modified to save the data (Patient, Visit, etc.), index the document to the data, and pass the document on to the next step in the process.

Office Policies and Procedures

Anytime the volume of work to be input in an office exceeds the ability of one person to enter all of that work, the work must then be divided among multiple users for data input. Of course, there are many ways to divide the work for data input. Due to Concurrency issues, all of the anesthesia charges for a date of service for a physician need to be entered at the same time. If an anesthesia group works out of multiple facilities, the paper documents often arrive in the central billing office facility-by-facility, so some offices will divide the work by facility. Under the same scenario, others offices will accumulate all of the work for all facilities by date of service and then divide the work evenly among the available data entry staff.

Since the work to be entered is organized into multiple "batches", most billing systems, including MedSuite, allow the user to create a "logical batch" of charges or payments that represents the physical batch of work. These logical batches can capture information that allows the user to "balance" their batch of work. This generally involves making sure that all of the documents in the physical batch have been entered and entered correctly. Typically, the user will run an adding machine tape of the count of documents and a "hash total" of the CPT Codes to be entered. For a batch of payments, an adding machine tape of total payments and total adjustments will be run and compared to the total payments and total adjustments entered into the computer.

Obviously, office policies and procedures dictate how the total volume of work in the office is divided into physical and therefore logical batches. Someone in the office actually divides the work. We at MedSuite needed to make sure that we were not going to force a client into dividing the work before scanning just to accommodate the Image Workflow.

Prior to scanning, the user must separate documents by Document Type (Charges, EOBs, Face Sheets, etc). The documents can be further subdivided into smaller batches by criteria that make sense to the user. For example, charge tickets could be divided by facility and service date. EOBs could be divided by remittance date and insurance or self. Insurance EOBs could be further divided by bulk and non-bulk EOBs. What we do not want to do is to force a client into organizing their physical batches in a specific way. If a day's work is roughly divided into equal shares, then the same division of work can take place prior to scanning. If an anesthesia group works out of multiple facilities, and the paper documents arrive in the central billing office facility-by-facility, then the documents can be scanned by facility.

MedSuite accommodates these requirements by allowing the user to define "image types" and "image stations". When documents are scanned, the user assigns a specific image type and a station name, which is nothing more than a user-defined name for the first (or only) location to which the "batch" of documents will be sent. A batch of documents could be scanned into a station that several people use for source documents.

Among other things, the image type controls the level at which documents of that type will be indexed. For example, one office may want to index charge tickets by visit while another office wants to index by batch. One office may want to index hospital face sheets by patient while another office wants to index by batch (service date). There is no reason why MedSuite should not be capable of permitting these options.

What does change is that if indexing by patient or by visit is selected, then the user will key from the image. MedSuite will allow both the image and a data entry window (demographics, visits, payments) to be open simultaneously which facilitates data entry directly from the image. Demographic face sheets and anesthesia records/face sheets should be separated so that Demographics are keyed first, then visits are keyed separately.

If an office is indexing by batch, then the user will typically key from paper and scan the documents after-the-fact. Documents can be scanned into an already open station. For example, in a setting where several users are "sharing" a station, it is expected that new documents will be scanned into that station.

Imaging Workflow

Based on the previous discussion of Image Workflow and Office Policy and Procedures, it is clear that certain capabilities needed to be implemented in MedSuite in order to accommodate Image Workflow:

Imaging Stations

- Documents must be scanned to a "first" station, which may be the only station in the "workflow" for that image type. For example, charge documents may be scanned to "Coding".

- Multiple users should be able to pull documents from a single station. If two users attempt to pull the same image from a station at the same time, an error will be generated for the second user and optionally allow them to choose another image.

- The user must be able to transfer Images from one station to another. Charge documents should be capable of being transferred from "Coding" to "Visit Entry".

Indexing

- An image type must be capable of "knowing" the level at which indexing will be performed for that image. For example, a charge document should be indexed at the Visit level, while a Demographic document should be indexed at the Patient level.

  - Patient
  - Account
  - Visit
  - Payment
  - User-Defined Folder

Actions / Activities

- An imaging station's "action" must be capable of invoking a specific MedSuite function:

  - Patient
  - New Visit

- o Open Visit
- o New Payment - Bulk EOB
- o New Payment - Insurance
- o New Payment - Self
- o Open Payment – Insurance
- o Open Payment - Self
- o Follow-up Wizard – Claim Functions
- o Move to another station
- o No Action

> For example, a charge document should invoke the New Visit function, while a demographic document should invoke the Patient (Patient Search) function.

- Image Workflow must be capable of capturing and holding "data" for an image. For example, in a Coding Department, the codes are written on the Charge Documents. Since we are going "paperless", the codes need to be saved as data fields on the image itself. Since this data has already been keyed and saved on the image, it can be imported to the Visit or Payment screen at the time the Visit or Payment is keyed.

  - o Charge Document
    - Patient Name
    - Visit Type
    - Date of Service
    - CPT Code(s) – Multiple
    - ASA Code(s) – Multiple
    - ICD Code(s) – Multiple
    - Procedure Charge
    - Facility and Location

  - o Payment Document (EOB)
    - Payment Method (Check, EFT, etc)
    - Document Number
    - Remit Date

- An Electronic Remittance Advice (ERA) file should be processed so that an "image" is created for each claim in the file and indexed to the claim. Secondary claims will need this "image" as their EOB.

- Users are able to cut sections of a scanned EOB and attach them to individual insurance payments.

4.6.3.1   Imaging Workflow

The Imaging Workflow screen is a tabbed dialog that presents:

- Station - A list of the contents of a "station"
- Image - An image viewer to display any image in the station
- Search Images - An image search screen that allows the user to search for any document meeting the search criteria.

4.6.3.1.1 Imaging Workflow - Station Tab

There are four ways an image may be placed in a Station:

- The image is scanned into the Station
- The image is imported into the Station
- The image is moved into the Station
- The index of an image (a charge, payment, etc.) is deleted and the image is thus "un-indexed" and placed into the Station

The contents of the Station Tab is a grid which has a series of columns and horizontal and vertical scroll bars that are used to move around the grid to see all the data for each image, and to see more images that follow. There are ways to modify how the list of images is displayed which include:

- Clicking at the top of any of the fields sorts the images in that order so that you can list them by Patient Number, alphabetically by name, or group by Acct Class, sort by patient birthday, phone #, Service Date, Amount Billed, etc.
- Fields may be rearranged by dragging columns to the left or right. The system will retain the new column locations for each user.

Note: Images that have been flagged as having an "Error" are displayed in Red.

The fields and their descriptions are as follows:

Station	Press F9 or click the search on the Station field to display a list of the Stations. Select the Station that you wish to view. Alternatively, if you already know the name of the station, you may type it into the Station field. Select the Refresh button to display the Station contents.
Refresh	When the Refresh button is pressed, the grid will fill with all the records in the selected Station. The Refresh button acts on the entire list of images.
Filter	Pressing the Filter button will cause a form to appear that allows you to optionally select and "filter" the list of images based on the following criteria: Imaging Type Entered Date range (which is the date it was scanned), Image Date range (date entered on the image at the time it was scanned; usually the service date for demographic and charge images, or the remit date for payments) Description ranges Batch Type Batch Number If you select OK from this form, the system will only display the matching records for the selected station. Any filter that is applied to the Station Tab will be reflected in what is displayed on the Imaging Tab.

Display Images   This drop-down list allows you to select images that have been flagged with errors. Available options are:

- All Images – All images will be displayed.
- No Errors – Images flagged as errors will not be displayed.
- Only Errors – Only images flagged as errors will be displayed.

Note that images that have been flagged as having an "Error" are displayed in Red in the list.

The view applied on the Station Tab will be reflected in what is displayed on the Imaging Tab.

Image List

The fields in the Image List grid are the following:

Date Image   Date that was entered on the image at the time it was scanned into MedSuite. Usually the service date for demographic and charge images, or the remit date for payments.

Imaging Type   Imaging Type

Description   Image Description (ie. Demos000001). Images that have been annotated will display an asterisk (*) at the end of the description.

Station specific Annotations   Annotation values that have been defined for that station can be added to the grid by selecting the "Show in Grid" option for the annotation in Imaging Station maintenance.

Date Entered   Date the image was scanned into MedSuite

Batch No   Batch number the image was scanned into or indexed to

Incidents   A count of any incidents associated with the image.

Entered By   The MedSuite user ID of the person that added the image to the system.

Annotations   The number of annotations that have been added to the image.

Page Count   Indicates the number of pages contained in the image if it is a multi-page image.

Additional Functions

A series of buttons are displayed across the bottom of the screen and are used as follows:

View Image   Displays the highlighted image in the Image tab. An image can also be displayed by double-clicking on the image.

Merge   Use this option to combine two or more images in the station. Highlight

the desired images and select Merge. Note that the Page Count is updated after merging.

Split Use the option to split apart a multi-page image. Highlight the desired image and select Split. All of the pages that made up the multi-page image are now individual single page images.

Jump The Jump button is only available if an image has been indexed/linked to a demographic, charge, or payment and then is flagged as an Error. It is not available for images that have not yet been indexed.

For Images with errors that have been partially input, the user may "Jump" to the related data input function. For example, if a demographic was entered without a SSN, the user could "flag" the image as an "Error" and send it to the "DemoErrors" station. The user responsible for resolving "DemoErrors" would select the Image and "Jump" to demographic input, make any necessary corrections, and then remove the Error flag; at that point, the image will be permanently indexed to the patient demographic.

Print Prints the selected image(s). Note that you may select multiple images to print by using CTRL+CLICK to select them one-by-one, or SHIFT+CLICK to select a range.

Action Invokes the software function defined for the Imaging Station. For example, if the Imaging Station named as Demographic Entry and the Action assigned to that Station is "Patient", then the Patient function will be started when the Action button is clicked.

When the action has been completed, MedSuite will index the image to the entity (patient, visit, etc) and display the next image.

Index Clicking this button presents the Manual Indexing Form. Manual Indexing allows you to index documents that are not tied to the "conventional" entities such as Patient, Account, Visit, Payment or Claim. Documents that might require manual indexing might include provider (Staff) credentialling documents and managed care contracts (Plan, Rate Structure or Fee Schedule). In addition, the user may want to manually index certain documents, such as correspondence, that are tied to the "conventional" entities. Note that you may select multiple images to be indexed by using CTRL+CLICK to select them one-by-one, or SHIFT+CLICK to select a range.

Please refer to the section of this document that covers Manual Indexing for a detailed description of Manual Indexing.

Move Clicking this button presents the Move Image to Imaging Station box, and allows the user to select one or more records from the Images List and forward them onto another Station. Note that you may select multiple images to move by using CTRL+CLICK to select them one-by-one, or SHIFT+CLICK to select a range.

Images can be moved manually from one station to another. This is generally done when there is a problem with an image that requires action that is outside the ordinary. For example an image that is

illegible that needs to be re-scanned can be moved to station called "ReScan". Images with missing information could be moved to a station called "Researching". The reasons and stations that the user could manually move images to are virtually limitless.

Please refer to the section of this document that covers Moving Images to Stations for a detailed description of Moving Stations.

Delete
This allows the user to select one or more records in the Station to be deleted. This would be used when images are illegible, were scanned as the wrong type or some other serious error that would require re-scanning. Note that you may select multiple images to deleted by using CTRL+CLICK to select them one-by-one, or SHIFT+CLICK to select a range.

Scan
Images may be scanned into MedSuite. Please refer to the section of this document that covers scanning images for a detailed discussion of scanning.

Import
Previously scanned Images may be imported into MedSuite. Imaging conversions or images sent by another source may be imported into MedSuite and treated as though they were scanned by MedSuite. Please refer to the section of this document that covers importing images for a detailed discussion of importing.

4.6.3.1.1.1 Image Workflow - Manual Indexing

If you do not perform Image Workflow with automated Actions and Indexing, you can use Manual Indexing to index scanned images. You can select from a variety of entities to which the document may be indexed.

Index Type   Selects the type of entity that the document will be indexed to from the following:
- Patient
- Account
- Visit
- Payment
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure
- Document Folder

Index To   Enter/select the desired entity. For example, if you selected a Referral Index Type, then select the referring physician to which you are indexing the image. The image will be tied to that referring physician and may be viewed when that referring physician is edited.

4.6.3.1.1.2 Image Workflow - Move to Station

The Move Images to Imaging Station function allows the user to move an image from one station to another station. This would be used in a workflow to move an image to the next station in the workflow or when an "error handling" station has been created to communicate errors to account managers. In addition, the un-Index function requires that you move the image to a station so that the imaging process can be restarted.

Imaging Station

Enter/select the station to which you are moving the image.

4.6.3.1.1.3 Image Workflow - Scanning

When the Scan button on the Imaging Workflow List is pressed, the Scan Image form is presented. You can select from a variety of fields that will be tied to the scanned images. Based on the Imaging Type selected, images will be scanned to a specific Imaging Station for Workflow input. Although Imaging Types are associated with specific stations, the user does have the ability to override the default station and select another in it's place.

Practice
Displays the practice that the user has currently selected. Image will be scanned into this practice.

Date
You may enter/select the date represented by the images. For demographic and charge images, the date should generally be the service date. For payments, this date should be the remittance date.

Process Images
The Process Images drop-down list has two options:

"Create an image for each page"
Will create a separate image for each page contained in an imported file (or files). Example: If you have 3 files to import with 4 pages each, you will end up with 12 separate images.

"Create one multi-page image"
Will create one image with multiple pages for a file (or files) imported that contain multiple pages. Example: If you have 3 files to import with 4 pages each, you will end up with 1 image with 12 pages. *Note: Create one Multi-Page Image should be used on Bulk EOBs*.

Imaging Type
You must enter/select the type of image to be scanned.

Imaging Station
If the Imaging Type setup indicates that the images should be scanned to a Station, then the user may select the Station to which the images should be scanned. The default station the Image Type is associated will be displayed, but the user may override this and select another station if they wish.

Description
Enter the first portion of the description assigned to the image documents. MedSuite will append a sequential number after the description. For example, Hospital Demographics can be called DEMO and then MedSuite will assign 00001, 00002, etc to create unique document ID's DEMO00001, DEMO00002, etc..

Brightness
The Default Brightness assigned to the Imaging Type is displayed and may be overridden.

If certain images are typically scanned from a poor quality original such as the yellow copy of a carbon-less form, MedSuite can, by default, brighten those images to make them more legible. A higher number will brighten the image.

Threshold
The Default Threshold assigned to the Imaging Type is displayed and may be overridden.

MedSuite scans in black and white. The resolution (horizontal and vertical dots per inch) of a scanner dictates how many dots-per-inch an image is made up of. In black and white mode, each dot is "seen" as either white or black. Changing the threshold to a higher value will darken the "black" of an image.

Use Duplexing   If the scanner supports duplexing, the user may select this option to capture documents with text on both sides in one pass through the scanner.

Optional Scan Engine   Some scanners have TWAIN drivers that have problems communicating with MedSuite which can be resolved by using the Optional Scan Engine. This should only be used in cases where MedSuite Support has suggested turning this on.

4.6.3.1.1.4 Image Workflow - Importing

When you press the Import button on the Imaging Workflow List, the Import Image form is presented. You can select from a variety of fields that will be tied to the imported images. Based on the Imaging Type selected, images will be scanned to a specific Imaging Station for Workflow input. Although Imaging Types are associated with specific stations, the user does have the ability to override the default station and select another in it's place.

The Image Import facility works in very much the same way that Scan Image works with the following exceptions:

- Import Image does not support either the Brightness or the Threshold Options. The images should already be scanned. Changing Brightness or Threshold would be irrelevant.

- After pressing OK on the Import image window, Import Image invokes the standard Windows "File-Open" Dialog. The Images should already be scanned in a location accessible to you to perform the import. This will allow you to select the images to be imported into MedSuite.

Practice   Displays the practice that the user has currently selected. Image will be scanned into this practice.

Date   You may enter/select the date represented by the images. For demographic and charge images, the date should generally be the service date. For payments, this date should be the remittance date.

Process Images   The Process Images drop-down list has three options:

          "Create an image for each file imported."
             When importing image files, you will have the ability to multi-select files to import all at once from the same directory, instead of having to import each one individually. This option will create a separate image for each file imported. The image will have multiple pages if the imported file contains multiple pages, or just one page if the file contains one page. Example: If you have 3 files to import with 4 pages each, you will end up with 3 images, each with 4 pages.

          "Create an image for each page"
             Will create a separate image for each page contained in an imported file (or files). Example: If you have 3 files to import with 4 pages each, you will end up with 12 separate images.

          "Create one multi-page image"

Will create one image with multiple pages for a file (or files) imported that contain multiple pages. Example: If you have 3 files to import with 4 pages each, you will end up with 1 image with 12 pages.

Imaging Type   You must enter/select the type of image to be scanned.

Imaging Station   If the Imaging Type setup indicates that the images should be scanned to a Station, then the user should select the Station to which the images should be scanned.

Description   Enter the first portion of the description assigned to the image documents. MedSuite will append a sequential number after the description. For example, Hospital Demographics can be called DEMO and then MedSuite will assign 00001, 00002, etc to create unique document ID's DEMO00001, DEMO00002, etc..

4.6.3.1.1.5 Image Workflow - Error Handling

Let's take a look at error handling. One option is to Move an image to an "error handling" Station. Once the image is in an "error handling" Station, there are two possibilities. The first is that there were sufficient problems such that the Action selected (Patient, New Visit, etc) could not be completed and that a resulting entity (Patient, Visit, etc) was NOT added to MedSuite prior to Moving the image to the error handling Station. The second possibility is that the missing information was not a required field or the user "dummied-up" data to get past a required field edit. So the entity (Patient, Visit, etc) has been added to MedSuite, but needs to be edited and corrected.

In either case, the person whose job it is to resolve these issues or errors needs to get the missing information from the hospital, the surgeon, or the patient.

Depending on whether the patient was added to MedSuite or not, it will be handled one of two ways:

Option 1 – Entity Doesn't Exist in MedSuite

1.   Press the Action button.
2.   The Action will invoke the appropriate MedSuite software function and focus will be given to the data input window.
3.   You may zoom-in, zoom-out, or pan the image in any direction to more easily view the image and key the demo without changing to the image window or clicking on it.
4.   When entity (Patient, Visit, etc) is completed, click OK or Finish. The data input window will be closed, the image will be indexed and the Image Workflow List will automatically load the next image in the list into the Image Viewer.

Option 2 – Entity Exists with Incomplete or "Dummied-Up" Data

1.   Press the Jump button.
2.   The appropriate data input window will be opened automatically and focus will be given to the data input window. You may edit or correct the pertinent information.
3.   You may zoom-in, zoom-out, or pan the image in any direction to more easily view the image and key the demo without changing to the image window or clicking on it.

4.   When entity (Patient, Visit, etc) is completed, click OK or Finish. The data input window will be closed, the image will be indexed and the Image Workflow List will automatically load the next image in the list into the Image Viewer.

4.6.3.1.2 Imaging Workflow - Image Tab

The Image Tab screen presents the contents of an image and a series of controls and buttons that allow you to control and manipulate the image. In a Windows environment, the window or form with "the focus" is the window where keystrokes are directed. This form is generally the "front" or top-most form on your desktop.

In an imaging workflow scenario, you will often be dealing with two windows; one with the image and one that you are keying data into. You will need to control the image window without "changing" windows or clicking on the image. Assume that in addition to the Imaging Window below, you also have a "New Visit" window open and are keying a New Visit. The "P" on the Print button of the Imaging Window below is underlined, so you would expect that Alt-P will "click" the Print button. You would be correct if the Imaging Window below has the focus. However, in this example, we said that you are keying into New Visit; therefore, the New Visit window has the focus and the Alt-P will do whatever (if anything) Alt-P does in New Visit.

This problem is resolved by a series of keystrokes that allow you to manipulate the image from a data window without losing focus in the data window. You can rotate the image, zoom in or out, or pan left, right, up, or down without leaving the data input window.

Keystroke	Description	Notes
Alt-Ctrl-Up	Pan Image Up	Up Arrow
Alt-Ctrl-Down	Pan Image Down	Down Arrow
Alt-Ctrl-Left	Pan Image Left	Left Arrow
Alt-Ctrl-Right	Pan Image Right	Right Arrow
Alt-Ctrl-+	Zoom-In	Alt-Ctrl-Plus
Alt-Ctrl--	Zoom-Out	Alt-Ctrl-Minus
Alt-Ctrl-Home	Toggle Windows	Toggle focus between Imaging Window, Annotation window and main window of MedSuite
Alt-Ctrl-PgUp	Previous Image	Display previous image in Image List
Alt-Ctrl-PgDn	Next Image	Display next image in Image List
Alt-Ctrl-*	Rotate Right	Asterisk on ten-key pad. Rotate image 90-degree to right
Alt-Ctrl-/	Rotate Left	Divide on ten-key pad. Rotate image 90-degree to left

Gutter   The Gutter is the area of the screen on the left side of the window that displays all of the images in that station as defined on the Station tab. Each image has a description combined with a hyphen (-) and the number of pages in that image. The legend at the bottom of the gutter gives additional information about the image.

Merge   Beside each image description in the Gutter is a selection check box

which enables you to Merge specific images into a single multi-page image. Note that the number of pages at the end of the description will be updated after merging. In addition to the hot key combination of Alt-Ctrl-PgUp and Alt-Ctrl-PgDn, you may use the Up and Down arrow buttons or the drop down control to display a specific page in the document.

If an image has been mistakenly merged, it can be Split from the Station tab.

Toolbar   MedSuite's Imaging Workflow screen displays a toolbar that contains buttons that perform image manipulation.

Zoom-In   Zooms-In (enlarges) the image

Zoom-Out   Zooms-Out (reduces) the image

Rotate Left   Rotates the image 90-degrees to the left

Rotate Right   Rotates the image 90-degrees to the right

Actual Size   The image is displayed at its actual size. This is the default setting upon entering the imaging screens.

Fit Page   The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Fit Width   The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Print   Prints the selected image

Show/Hide Annotations   Selecting this button opens the Annotation window to allow data entry. This window will stay open when moving from one image to the next in the gutter; the image that is being annotated will be high-lighted to provide context. Users may add, edit and delete annotations on the image. Selecting New will reset the annotations and associate them with the image that is highlighted in the gutter. See below for a detailed description of Annotation Types available in MedSuite.

Error   The image may be flagged with an "Error" indicating that a problem has been found on the image. These problems may be situations of illegibility or inability to input data from the image. For example, if a SSN or date of birth is missing from a demographic or a procedure or

diagnosis code is missing from a charge record, they may be flagged as having an Error.

Error images are not considered completed by MedSuite. The data associated with an image (demographic, charge, or payment) may have been keyed and the image may be indexed to the data, but the image will remain in an "open" status and be available in a Station.

Annotation Types

Annotations are system defined fields that can be added to a particular image or group of images (images that have been **Merged**.) Some Annotations have a specific function within MedSuite and are intended to facilitate data entry and your efficiency within the system by populating fields in Visit entry or Payment entry from data entered in an Imaging station.

Auto - Patient	The Auto-Patient annotation will allow a user to open the patient lookup window, search and then select the patient they wish to associate with the image. If the selected Action within that station is Visit - New, then the Patient information will be automatically populated in Visit Entry. *Note: This should only be used on Charge images when going to Visit Entry. It is not intended for use on Payments, which should utilize the Account holder (Guarantor) and not the Patient.*
Checkbox	The Checkbox annotation allows a user to enter a value of True if selected or False if not selected.
Currency	The Currency annotation allows a user to enter a properly formatted dollar amount, e.g. $999.99.
Date	The Date annotation will allow the user to enter a properly formatted date, e. g. dd/mm/yyyy
Insurance Verification	The Insurance Verification annotation is a checkbox that allows a user to enter a value of True if selected or False if not selected.
Payment - Remit Date	The Payment - Remit Date annotation allows a user to enter a properly formatted date value. If the selected Action within that station is any of the Payment Entry options, then the Remit Date will be automatically populated in Payment Entry. You may only add 1 Remit Date per Imaging Station.
Payment - Document Number	The Payment - Document Number annotation allows a user to enter a numeric value. If the selected Action within that station is any of the Payment Entry options, then the Document Number will be automatically populated in Payment Entry. You may only add 1 Document Number per Imaging Station.
Payment - Method	The Payment - Method annotation allows a user to select a value of Cash, Check or Charge. If the selected Action within that station is any of the Payment Entry options, then the Payment - Method will be automatically

populated in Payment Entry. You may only add 1 Payment - Method per Imaging Station.

Phone
The Phone annotation will allow the user to enter a properly formatted phone number, e.g. (999) 999-9999.

Text
The Text annotation will allow the user to enter free-form alphanumeric text on the image.

Time
The Time annotation allows the user to enter a properly formatted value for hours and minutes, e.g. 13:00.

Visit - Diagnosis
The Visit - Diagnosis annotation allows the user to access the Diagnosis Code lookup window, select a code and add it to an image. If the selected Action within that station is Visit - New, then the Diagnosis information will be automatically populated in Visit Entry. You may add up to 4 Diagnosis codes per Imaging Station.

Visit - Facility/ Location
The Visit - Facility/Location annotation allows the user to access the lookup windows for Facility and Location, select the appropriate values and add them to the image. If the selected Action within that station is Visit - New, then the Facility/Location information will be automatically populated in Visit Entry. If you enter a value for Facility, you are required to enter a value for Location. Only 1 Facility/Location annotation may be added per Imaging Station.

Visit - Procedure Charge
The Visit - Procedure Charge annotation allows the user to access the Procedure Code lookup window, select a procedure and add it to an image. If the selected Action within that station is Visit - New, then the Procedure Charge information will be automatically populated in Visit Entry. You may add up to 20 Procedure Charge annotations per station, however, only a total of 20 procedures will be added during Visit Entry. Each Procedure Charge, Procedure/ASA and Quick Pick annotation counts against the 20 total limit.

Visit - Procedure Secondary
The Visit - Procedure Secondary annotation allows the user to access the Procedure Code lookup window, select a procedure and add it to an image. The Secondary Surgical Procedure is used when the procedure is to be billed and is not informational (not "floated"). An example would be Labor Epidural/C-section cases. If the selected Action within that station is Visit - New, then the Secondary Procedure information will automatically be populated in Visit Entry. The user will still be prompted to enter case times for this procedure before saving the visit. Only 1 Procedure Secondary annotation may be added per Imaging Station.

Visit - Procedure/ ASA
The Visit - Procedure/ASA annotation allows the user to access the Procedure Code and ASA lookup windows, select the appropriate values and add them to the image. If you enter a value for Procedure, ASA becomes a required field. These codes should only be used for anesthesia cases. If the selected Action within that station is Visit - New, then the Procedure/ASA information will be automatically populated in Visit Entry. The system will "float" the Procedure/ASA with the highest Base Unit Value to the "top" to be billed, and the other Procedure/ASAs will not be billed.

You may add up to 5 Procedure/ASA codes per Imaging Station, however, only a total of 20 procedures will be added during Visit Entry. Each Procedure Charge, Procedure/ASA and Quick Pick annotation counts against the 20 total limit.

Visit - Quick Pick
The Visit - Quick Pick annotation allows the user to access the Quick Pick lookup window and select from the codes that have been set-up for Practices that use Visit Types of Anesthesia or Blank. If the selected Action within that station is Visit - New, then the Quick Pick information will be automatically populated in Visit Entry. Only 1 Quick Pick annotation may be added per Imaging Station. Although the user may enter multiple Quick Picks in Imaging, only a total of 20 procedures will be added during Visit Entry. Each Procedure Charge, Procedure/ASA and Quick Pick annotation counts against the 20 total limit.

Visit - Service Date
The Visit - Service Date annotation allows the user to enter a Date of Service and add it to an image. If the selected Action within that station is Visit - New, then the Service Date information will be automatically populated in Visit Entry. You may only add 1 Service Date annotation per Imaging Station.

Visit - Visit Type
The Visit Type annotation allows a user to access the Visit Type lookup, select a value and add it to an image. If the selected Action within that station is Visit - New, then the Visit Type information will be automatically populated in Visit Entry. You may only add 1 Visit Type annotation per Imaging Station.

Buttons

A series of buttons are displayed across the top right side of the screen and are used as follows:

Action
Invokes the software function defined for the Imaging Station. For example, if the Imaging Station named as Demographic Entry and the Action assigned to that Station is "Patient", then the Patient function will be started when the Action button is clicked.

Index
Clicking this button presents the Manual Indexing Form. Manual Indexing allows you to index documents that are not tied to the "conventional" entities such of Patient, Account, Visit, Payment or Claim. Documents that might require manual indexing might include provider (Staff) credentialling documents and managed care contracts (Plan, Rate Structure or Fee Schedule). In addition, the user may want to manually index certain documents, such as correspondence, that are tied to the "conventional" entities.

Please refer to the section of this document that covers Manual Indexing for a detailed description of Manual Indexing.

Move
Clicking this button presents the Move Image to Imaging Station box, and allows the user to select one or more records from the Images List

and forward them onto another Station. Note that you may select multiple images to move by using CTRL+CLICK to select them one-by-one, or SHIFT+CLICK to select a range.

Images can be moved manually from one station to another. This is generally done when there is a problem with an image that requires action that is outside the ordinary. For example an image that is illegible that needs to be re-scanned can be moved to station called "ReScan". Images with missing information could be moved to a station called "Researching". The reasons and stations that the user could manually move images to are virtually limitless.

Please refer to the section of this document that covers Moving Images to Stations for a detailed description of Moving Stations.

Delete   Selecting this button will delete the image from MedSuite; if an image is deleted in error, use the various criteria on the Search tab to locate and **Move** it to the appropriate station.

4.6.3.1.3 Imaging Workflow - Search Images Tab

The contents of the Search results is a grid which has a series of columns and horizontal and vertical scroll bars that are used to move around the grid to see all the data for each image. There are ways to modify how the list of images is displayed which include:

- Clicking at the top of any of the columns sorts the images in that order so that you can list them by Patient Number, alphabetically by name, or group by Acct Class, sort by patient birthday, phone #, Service Date, Amount Billed, etc.
- Fields may be rearranged by dragging columns to the left or right. The system will retain the new column locations for each user.

Most of the columns found on the Station tab are also displayed in the Search tab, with the exception of Link Type. Link Type will display the MedSuite "object" that the image has been Indexed to, e.g. Visit, Claim or Company. Open Images will display in a separate window that will give the user the option to Print, view Annotations or Move the image to a Station among other things.

The search fields and their descriptions are as follows:

Img Type   Enter a specific type of image to search by.

Img Station   Enter a specific station to search by. If this option is selected, the results grid will also display the annotation values for the images.

Entered From / Thru   Enter/Select the date range that the image(s) were scanned or imported.

Image From / Thru   Enter/ Select the date range that was entered when the image(s) were scanned or imported.

Annotation   Enter a range of Annotation values (such as procedure codes 20550 - 20553) that were added to an image.

Desc From / Thru	Enter a range of description values (Demos000001 - Demos000099) that were generated by the MedSuite Imaging software.
Batch Type	Limit the search by Visit or Payment batch.
Batch No	Lookup or enter a batch number to limit the search.
Show Deleted	Select this option to show images that have been deleted. Opening a deleted image will allow you to **Move** it to the appropriate station.
Preview	Select this option to display a thumbnail view of the image beneath the search criteria.
Legend	The legend gives you additional information about the image based on the high light color that is displayed in the results grid.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

View Image	Displays the highlighted image in the Image tab. An image can also be displayed by double-clicking on the image.
Jump	The Jump button "jumps" to the data input / display screen associated with the image. If the image is a Hospital Face Sheet, then the Jump button will jump to Patient Demographics. If the image is a Charge Ticket, then the Jump button will jump to Visit Entry. If the image was not indexed to a data entity such as a patient, visit, provider, etc. or the image was scanned to a Folder, then "jump" simply displays the image.
Print	Prints the selected image.
Delete/UnDelete	Based on the current state of the image, the user can either Delete or UnDelete the image.

4.6.4   Collection Selection

Collection Selection allows you to select accounts that meet what you have defined as your collection criteria. Accounts that meet this criteria are placed into Collection Turnover where you can remove them (if you desire) and subsequently perform the actual Collection Turnover process.   Refer to the Tutorial on Collection Selection / Turnover for more information.

By using a combination of these criteria, you may send accounts that fall within one age/amount range to one agency and accounts that fall within a different range to another. For example, at 90 days send

accounts with a balance from $25.00 to $200.00 to agency 1 and accounts with a balance from $200.01 to $99999.99 to a different agency.

One of the items within Collection Selection that is sometimes confusing to users is that the Selection Tab on the form allows you to select by the account classes, account types and agencies that are already on an account. The Account Class, Account Type and Agency on the General Tab is what the Account will be changed to when the turnover is performed.

Collection Selection runs by **Visit** for "delinquent" Visits. If an account has more than one Visit that qualifies for collection, each Visit will be turned-over and (optionally) written-off.

Note: If the balance on a visit changes between the time that it is selected and the time that it is turned-over, MedSuite will write-off the balance on the visit, not the balance originally selected in Collection Selection.

A number of criteria will preclude an Visit from being selected for collection:

- Suspended for Statements
- Returned Mail
- In Collection Turnover (already)
- In Collections (previously turned-over to collections)
- Account balance is below the minimum billing amount for the practice

The Collection Selection request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Account Class	Enter/Select the Account Class that the accounts meeting the collection criteria will be **changed to** when they are turned-over.
Account Type	Enter/Select the Account Type that the accounts meeting the collection criteria will be **changed to** when they are turned-over.
Agency	Enter/Select the Agency that the accounts meeting the collection criteria will be **changed to** when they are turned-over.
Days No Payment	Accounts that have not made a payment in this number of days will be selected for collection.
Minimum Balance	Accounts with a balance of at least this amount will be selected for collection.
Maximum Balance	Accounts with a balance of not more than this amount will be selected for collection.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

4.6.5   Collection Turnover

The Collection Turnover screen can be used to manually request visits that need to be turned over to collections, or to delete visits that were automatically selected by the Collection Selection process that should not be turned over. Visits do not actually get "turned over" until the Collection Turnover process is run via the Collection Listing screen. The interim between the Collection Selection or manual turnover

request and the actual turnover is to be used by the practice manager to decide if a visit/account selected or requested for turnover should actually be turned-over. Requests for collection turnover may be deleted prior to the actual turnover process via this Collection Turnover screen. Refer to the Tutorial on Collection Selection / Turnover for more information.

Any visit that has been selected by Collection Selection and is therefore in collection turnover that is subsequently paid-off and reaches a zero balance will be automatically removed from collection turnover and will not be turned over to collection by the collection turnover process. In addition, any visit that has been selected by Collection Selection and is therefore in collection turnover that has a payment made on it where the payment meets the "Minimum Payment to Reset Dunning" and that is flagged to "Remove from Collection," will be automatically removed from collection turnover and will not be turned over to collection by the collection turnover process.

Several buttons at the bottom of the form allow the user to:

Quick Search	The user may key in a data value that will be used to search a variety of fields for matching accounts that will be displayed in the grid on the Search tab.
Message Line	A message will be displayed indicating how many accounts meet the search criteria entered.
Search Like Button	(Re)Executes the search based on the Quick Search criteria entered for items in Collection Turnover that are like the value entered in the Quick Search criteria. For example, it the Quick Search criteria is "SM", then any item in Collection Turnover with an Account Name beginning with "SM" are displayed in the list.
Search From Button	(Re)Executes the search based on the Quick Search criteria entered for items in Collection Turnover that are begin with the value entered in the Quick Search criteria as well as all higher values. For example, it the Quick Search criteria is "SM", then any item in Collection Turnover with an Account Name beginning with "SM" as well as those later in the alphabet are displayed in the list.
Ledger	The Account Ledger for the item selected in the list will be opened.
New Button	Creates an new Collection Turnover Request. Allows a visit to be added to Collection Turnover manually.
Edit Button	Opens the Collection Turnover Request currently selected in the Search grid.
Delete Button	Deletes the Collection Turnover Request currently selected in the search grid. Allows a visit to be deleted from Collection Turnover so that it is not turned over by the turnover process.
Cancel Button	Closes the Collection Turnover Request Lookup dialog without selecting a request

4.6.5.1   Quick Search

The Search Examples tab displays examples of how different fields types searched via the Quick Search field. The fields that may be searched by the Quick Search are:

Last	Patients, accounts, subscribers, or refunds with last name starting with the value entered will be retrieved.

Last, First   Patients, accounts, subscribers, or refunds with last name starting with
                            the value entered before the comma and first names or nick names
                            starting with the value entered after the comma will be retrieved.

Dash ('-')   Patients, accounts, subscribers, or refunds with phone numbers or
                            social security numbers matching the value entered will be retrieved.

Slash('/')   Patients, accounts, subscribers, or refunds with birth dates matching the
                            value entered will be retrieved. Partial birth dates may be entered.

Numeric   Patients, accounts, subscribers, or refunds or policies with chart
                            number, account number, or policy number matching the value entered
                            will be retrieved.

4.6.5.2   Collection Maintenance

Collection Maintenance allows the user to manually request visits to be turned over to collection.
Collection Turnovers are requested typically by lower level users. The requests are reviewed by a
manager and approved for subsequent turnover or deleted from the collection turnover.

Name   Name of the account holder
Select Button   Invoke Account Search to find the account holder
Select Button   Invoke the Visit Selector to select the visit to turn over to collection
Visit Date   The visit date of the selected visit is displayed
Procedure Desc   The procedure description of the selected visit is displayed
Account Class   Enter/Select the account class that the account will be changed TO after
                     collection turnover is completed
Account Type   Enter/Select the account type that the account will be changed TO after
                     collection turnover is completed
Agency   Enter/Select the Agency to which the account will be turned-over
User Name   Name of user selecting the collection turnover
Amount   Amount (account balance) to be turned over to collections
Date Requested   Date of the collection turnover request

4.6.6   Collection Turnover Listing

The Collection Listing is used both as a tool to view accounts selected/requested for Collection Turnover and to actually perform the Collection Turnover process.

One of the items within the Collection Turnover Listing that is sometimes confusing to users is that the Selection Tab on the form allows you to select by the account classes, account types and agencies that an account will be changed to when the turnover process is completed. This allows you to select just the accounts that are due to be turned-over to a specific agency. For this reason, this selection is different from all of the other selection tabs in MedSuite.

> **Note: If the balance on a visit changes between the time that it is selected and the time that it**
>
> **is turned-over, MedSuite will write-off the balance on the visit, not the balance originally**
>
> **selected in Collection Selection.**

The Collection Listing request form is a tabbed dialog that consists of a General tab and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
Collection Listing	Indicates that listing context is in effect.
Collection Turnover	Indicates that turnover context is in effect. Produces a (optional) list of accounts selected for turnover with (optional) cover sheets. Will (optionally) change the account class and (optionally) write-off the account balance.
Print Account Listing	Produces a list of accounts selected for turnover.
Print Cover Sheets	Produces cover sheets for accounts selected for turnover.
Print Account Ledgers	Produces Ledgers for accounts selected for turnover.
Change Account Class	In Turnover Context, will change the account class the Account Class, Account Type and Agency that was entered during Collection Selection.
Write-Off Balance	In Turnover Context, will write-off the account balance.
Write-Off Type	The write-off type that will be used to write-off the account balances turned-over to collections. The Bad Debt Type adjustment defined in practice maintenance is the default value for this field.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

4.6.7 Collection Letters

The Collection Letters function allows you to specify a specific letter that should be sent to a group of "delinquent" accounts or claims, and will produce a report listing the accounts or claims that meet the criteria entered by the user. The selected letters will be generated and merged during the next Closeout process.

The Collection Letters request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

A number of criteria will preclude an account from receiving a Collection Letter:

- Suspended for Statements
- Returned Mail
- In Collection Turnover
- In Collections (previously turned-over to collections)
- Account balance is below the minimum billing amount for the practice

Collection Letters are selected by **Visit** for "delinquent" Visits. If an account has more than one Visit that qualifies for a letter, the Visits will be "rolled-up" into a single letter.

General Tab

Task Name	Task Name displayed in the Task Viewer
Form Letter	Enter/Select the Form Letter to be sent as the collection letter.
Type	Delinquency Type to examine:

- Self - to send a letter to delinquent account-holders
- Claims - to send a letter out based on delinquent insurance claims

Letter Count	Enter/Select the number of previous collection letters that may have been sent to an account. Form example, you can elect to send only one letter and therefore you should select 0 - No previous Collection Letters so that the one letter may be sent and accounts that have received a previous letter will not receive a second letter.
Min Level	The minimum delinquency level to qualify for a collection letter when running for claims. Allowable values for claims are:

- Submitted - the Min Days will be counted from the claim submission date.
- Re-Submitted - the Min Days will be counted from the date the claim was refiled if it has been refiled, or from the claim submission date if it has not be refiled.

Min Days	Minimum days from the selected Minimum Level to qualify for a collection letter.
Max Days	Maximum days from the selected Minimum Level to qualify for a collection letter.
Claim Level	Indicates the insurance level to qualify for inclusion on Collection Letter selection when running for claims. Allowable values are:

- (Blank) All Levels

- Level 1
- Level 2
- Level 3

Held Claim	Indicate how or if you want held claims to qualify for inclusion when running Collection Letter selection for claims. Allowable values are:

- Include Held Claims
- Exclude Held Claims
- Held Claims Only

Disputed	Indicate how or if you want disputed claims to qualify for inclusion when running Collection Letter selection for claims. Allowable values are:

- Include Disputed Claims
- Exclude Disputed Claims
- Disputed Claims Only

Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates if the Collection Letter generation should be run immediately
Schedule	Indicates that the Collection Letter generation should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the Collection Letter run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while

holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.

Double-Click   Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

4.6.8   Refund Manager

All refund processing is performed via the Refund Manager.   Please see the Tutorial on Refunds for more information.

When a refund is initially requested, it is created in an "requested" status. Subsequently, the requested refunds are reviewed by a manager and approved for issue or not approved. Issued refunds are then paid periodically (weekly, monthly, etc.). Therefore, the Refund Manager allows you to search refunds so that they may be changed to the "next" status and advanced through the refund process. The user may In addition, several buttons at the bottom of the form allow the user to:

Quick Search	The user may key in a data value that will be used to search a variety of fields for matching Refunds that will be displayed in the grid on the Search tab.
Advanced Search	The user may tell the search which fields to search in rather than let the Quick Search decide which fields to search. Matching Refunds will be displayed in the grid on the Search tab.
Message Line	A message will be displayed indicating how many Refunds meet the search criteria entered.
Search Button	(Re)Executes the search based on the Quick Search or Advanced Search criteria entered.
New Button	Creates a new Refund Request.
Edit Button	Opens the Refund currently selected in the Search grid.
Delete Button	Deletes the Refund currently selected in the search grid.
Cancel Button	Closes the Refund Lookup dialog without selecting a Refund

4.6.8.1   Quick Search

The Search Examples tab displays examples of how different fields types searched via the Quick Search field. The fields that may be searched by the Quick Search are:

Last	Patients, accounts, subscribers, or refunds with last name starting with the value entered will be retrieved.
Last, First	Patients, accounts, subscribers, or refunds with last name starting with the value entered before the comma and first names or nick names starting with the value entered after the comma will be retrieved.
Dash ('-')	Patients, accounts, subscribers, or refunds with phone numbers or social security numbers matching the value entered will be retrieved.
Slash('/')	Patients, accounts, subscribers, or refunds with birth dates matching the value entered will be retrieved. Partial birth dates may be entered.

Numeric   Patients, accounts, subscribers, or refunds or policies with chart number, account number, or policy number matching the value entered will be retrieved.

4.6.8.2   Advanced Search

The Advanced Search form allows the user to search in a specific field to find an existing refund. For example, a policy number may have dashes or slashes in it. The Advanced Search allows the user to tell the search routine to 'search the policy number for this value' rather than allowing the search routine to search the phone number and social security number for the value.

The Advanced Search fields are:

- Last Name
- First Name
- Home Phone Number
- Work Phone Number
- Refund Number
- Policy Number

4.6.8.3 Refund Maintenance

Refund Maintenance allows the user to request refunds and then advance them through the process to payment. Refunds are requested typically by lower level users. The requests are review by a manager and approved for issue. Issued refunds are paid periodically (weekly, monthly, etc.).

Refund Number	Refund Number assigned by MedSuite
Issued To	Type of person/entity the Refund is to be issued to: • Account • Patient • Subscriber • Plan • Other
Issued To Name	Select the Search button to select the person or entity to whom the Refund is being issued. This is a required field. **The Issue To Name may be "keyed-in" if the Issued To (Type) above is "Plan" or "Other". Otherwise, the user must select the Issue To Name from the Account, Patient, or Subscriber Search.**
For Patient	When "Issued To" is a Patient, the "For Patient" field will default to the Patient selected in the "Issued To Name" field. When "Issued To" is an Account, the "For Patient" field will default to the Account Holder selected in the "Issued to Name" field if there is only one patient for that account holder. If there is more than one patient for that account holder, a drop down box appears on the "For Patient" field with all available Patients listed for that Account Holder. When "Issued To" is a Subscriber the system works the same as the Account. When Plan or Other are selected, select the "For Patient" Search button to select the patient for whom the Refund is being issued.
Address	Address consisting of: • Street Address • Street Address (Add'l) • City • State • Postal Code This is a required field. The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance
Country	A foreign country may be entered if needed.
Phone	Phone number of person/entity the Refund is to be issued to.
Phone Work	Work phone number of person/entity the Refund is to be issued to.
Amount	Request refund amount. This is a required field.
Division	Enter/Select the Division for which the Refund is being issued
Note	Note to appear on refund check
Status	Status of the Refund: • Requested • Issued • Paid • Revoked

Date Request   Date the Refund was requested
Date Issued   Date the Refund was set to issued status by the issuer.
Date Paid   Date the Refund Check was printed.
Date Revoked   Date the Refund was revoked or check was voided.

4.6.9   Refund Listing

The Refund Listing is used both as a tool to view Refunds and to actually issue the refunds and export a file to print the refund checks.

Task Name	Task Name displayed in the Task Viewer
Practice	Practice Name
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
Listing Only	Produces a listing of refund requests meeting the selection criteria below
Listing and Check Export	Produces a listing of refund requests meeting the selection criteria below. In addition, refund requests in an issued status (if selected) will be set to paid and exported into a file of the selected export type.
Export Type	Export File Type: • CSV - Comma Separated Value • IIF - Information Interchange Format (Quickbooks) • QIF - Quicken Interchange Format (Quicken)
Bank Account	Bank Account Name of checking account for Quickbooks IIF Format
Chart of Accounts	Account Name from Chart of Accounts that refunds should be recorded in for Quickbook IIF Format
Write-off Type	Enter the Write-off type (if known) or use the lookup to select from the Write-off types that have been set up for the company.
Requested	Select Refund Requests that are in a Requested Status and entered that status during the date range selected
Issued	Select Refund Requests that are in an Issued Status and entered that status during the date range selected
Paid	Select Refund Requests that are in a Paid Status and entered that status during the date range selected
Revoked	Select Refund Requests that are in a Revoked Status and entered that status during the date range selected
From Date	Beginning of date range to select
Thru Date	Ending of date range to select

5 MedSuite for Managers

One of the sub-menus in the MedSuite main menu is the Reporting menu which provides access to the reporting functions of MedSuite which include A/R Aging and Delinquency Reports, Payment and Reimbursement Reports, Production and Revenue Reports, and Data Cubes.

The functions available on the Reporting Menu include:

Menu	Description of Function
Account Listings	Invokes the form that requests the Account Listings task
Account Ledgers	Invokes the form that requests the Account Ledgers task
Accounts Receivable	Invokes the form that requests the Account Receivables report task
Balance Sheet	Invokes the form that requests the Balance Sheet report task
Claims Analysis Report	Invokes the form that requests the Claims Analysis Report task
Delinquency Report	Invokes the form that requests the Delinquency Report task
Deposit Summary Report	Invokes the form that requests the Deposit Summary Report task
Followup Report	Invokes the form that requests the Followup Report task
Finance Charges	Invokes the form that requests the Finance Charges Report task
Insurance Eligibility Check	Invokes the form that requests the Insurance Eligibility Report task
Mail Merge Document Listing	Invokes the form that requests the Mail Merge Document Listing task
O/R Utilization Report	Invokes the form that requests the O/R Utilization Report task
Over-Payment Report	Invokes the form that requests the Over-Payment Report task
Payment Exception Report	Invokes the form that requests the Payment Exception Report task
Payment Review Report	Invokes the form that requests the Payment Review Report task
Payment Summary Report	Invokes the form that requests the Payment Summary Report task
Production Reports	Invokes the form that requests the Production Reports task
Revenue Reports	Invokes the form that requests the Revenue Reports task
Report Card	Invokes the form that requests the Report Card task
Small Balance Write-Off	Invokes the form that requests the Small Balance Write-Off task
Summary Report	Invokes the form that requests the Summary Report task
Visit Detail Report	Invokes the form that requests the Visit Detail Report task
Data Cubes	Invokes the form that requests the Data Cubes task
Company Accounts Receivable Audit Report	Invokes the form that requests the Company Aging Report task
Company Billing Cube	Invokes the form that requests the Company Billing Cube task
User Productivity Report	Invokes the form that requests the User Productivity Report task
Annotation Production Report	Invokes the form that requests the Annotation Production task

Almost all MedSuite reports support the ability to save and retrieve Report Templates. Report Templates can be created, updated, and selected by pressing the Template button on the applicable report.

Report Templates

Almost all reports in MedSuite support report "templates". Report Templates allow you to save the screen settings on a report under a name of your choosing and then at a later date retrieve the Template so that the same settings can be applied to a subsequent report. The Report Templates screen is only accessable by pressing the Templates button on a Medsuite Report.

Saved Report Templates

Name	Name assigned to the Template by the user
Date Entered	Date that the Template was created
User Name	The name of the user who created the Template
Task Name	Task Name from the applicable report screen
Output	Indicates if report output is sent to a Report or to a Cube

Buttons

Show All Users	Indicates if Templates created by all Users should be displayed (default) or if only those Templates created by the current user should be displayed.
New	Creates a new Template using the screen options passed into the Report Template from the calling report.
Update	Updates an exisitng Template with the screen options passed into the Report Template from the calling report.
Delete	Deletes a Report Template.
Select	Selects a Report Template passing the saved screen options back to the calling report.
Cancel	Cancels and closes the Report Templates screen.

5.1   Account Listings

The user may want a list of accounts for a variety of reasons. The Account Listings Report may be run to include the following: All Accounts, Accounts Suspended for Claims, Accounts Suspended for Statements, Accounts with Held Statements, Returned Mail Accounts, Collection Accounts, Credit Balance Accounts and Possible Credit/Debit Offset Accounts. There is an option to Include Zero Balance Accounts when you run any of the selections listed above.

The Account Listing request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Include Zero Balance Accounts	Include/Exclude Accounts with zero balances.
All Accounts	Select All Accounts
Accounts Suspended for Claims	Select Accounts Suspended for Claims
Accounts Suspended for Statements	Select Accounts Suspended for Statements
Accounts with Held Statements	Select Accounts with Held Statements
Returned Mail Accounts	Select Returned Mail Accounts
Collection Accounts	Select Collection Accounts
Credit Balance	Select Accounts with Credit Balances
Possible Credit/Debit Offset Accounts	Select Accounts with offset debits and credits on an account. Example might be Visit 1 has a Credit but Visit 2 on the account may have an offsetting debit. This option would catch the Visit on the account that would need to be refunded even though the entire account is not a credit balance.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow

button.

| Drag-and-Drop | Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button. |
| Double-Click | Double-click on the item to be selected in the left-hand list. |

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.2   Account Ledgers

The Account Ledgers will produce a listing that is in the Adobe Portable Document format (PDF). This report contains at least one page per account, and is often quite large. As a result, it can take several hours to render a PDF and it is too large to download into the Task Viewer like other reports.

- **MedSuite recommends that when you request Account Ledgers to be printed, you schedule the Task for off-hours.**
- **When you have requested Account Ledgers, notify MedSuite support so that the output can be placed onto the MedSuite File Transfer Protocol (FTP) Server so that you can download the PDF via FTP.**

Task Name	Task Name displayed in the Task Viewer

Ledger Format	Select the format of Ledgers to Print:
	Full Account Activity
	    • Demographics
	    • Charges
	    • Payments
	    • Adjustments
	    • Comments / Notes
	Demographics Only
	    • Demographics

Include	Select what should be included:
	    • All Accounts
	    • Accounts with a balance
	    • Accounts with a zero balance

Use Account Range (Last Name)	This option is useful when working with a large number of accounts. You may select a range of accounts by patient last name, for example A through C, to break the report into more manageable sections.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Task	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

5.3   Accounts Receivable

At its core, MedSuite maintains the accounts receivable balance for all accounts. It is therefore necessary to periodically produce a report of the accounts receivable balances and the ages of the balances. The Accounts Receivable report may be requested for totals only, with patient detail only, or with charge detail. All of the detail level reports produce totals within the requested sort breaks. Therefore, if an Accounts Receivable report were run by Plan and Physician for totals only, the report produced would print an aged total for each plan and physician.

Accounts receivable may be requested by charge posted date or service date and payment posted date, remit (deposit) date, or entered date. The accounts receivable is generally run with an "as of" date. The default is "as of now". However, it is likely that the report will be generally run "as of" the end of the past month, past quarter, or past year.

The Accounts Receivable request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer.
Print Totals Only	Print totals only with breaks
Print Patient Detail	Print patient-by-patient totals with sort totals
Print Charge Detail	Print charge-by-charge totals with patient totals and sort totals
Report AR Balances for Pending Claims	Indicates whether the report should Include, Exclude, or report Only balances for accounts with claims that have not filed due to Pending provider ID numbers.
Charge Date Type	Charge Date to examine: • Service • Posted • Closeout • Entered • Accounting • Accounting - Previous • Accounting - Current
Charge Ending Date	Charges after this date will be ignored
Payment Date Type	Payment Date to examine: • Remit Date • Posted Date • Closeout Date • Entered Date • Accounting • Accounting - Previous • Accounting - Current
Payment Ending Date	Payments after this date will be ignored.
Age of Final Aging Column (Over XXX)	Configures the report to define the last two aging columns on the report. The first five columns will always report 0-30, 31-60, 61-90, 91-120, and 120-150. The last two columns will be reported as follows: • 180 - Report 151-180 and Over 180 • 360 - Report 151-360 and Over 360
Report Under Primary Plan	Report balances under the primary insurance plan (or Self) if the report is sorted by plan.
Report Under Current	Report balances under the current insurance plan (or Self) if the report is

Plan	sorted by plan.
Report Self Pay AR Balances	Indicates whether the report should Include, Exclude, or report Only self pay balances. Selecting the Include option will include any accounts at the self-pay level in the report. The Exclude option will not report any accounts without insurance, accounts with balances after insurance has paid, nor any accounts where the insurance is set to not wait for payment and the charges are at the self pay level. The Only option will report only balances at the self pay level, whether they had insurance or not.
Report Billed Amount	Aging totals are based on the charge amount and any payments or adjustments applied.
Report Allowed Amount	Aging totals are based on the expected (allowed) amount. Charges at the current level report the expected amount. Charges not at the current level report the charge amount less actual payments and adjustments.
Credit Balance Accounts	Indicates how credit balance accounts are handled on the report. Credit Balance Accounts can be Included in the report, Excluded from the report, or selected as the Only Accounts to be included in the report.
Cube Data	Indicates if report results should be output to a data cube.
Generate Standard Report	Indicates if report results should be output to a formatted report.
Run Now	Indicates in the report should be run immediately.
Schedule	Indicates that the report should be scheduled to run at a future time.
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.

Double-Click   Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.4   Balance Sheet

The Balance Sheet produces a report of the accounts receivable balances. However, it computes a beginning balance, reports charges, payments, and adjustments during the period of time requested and produces an ending balance. Since it is used to verify the integrity of the database, the balance sheet is always run by posted date which can never change.

The Balance Sheet request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Date	Date Type to examine: • Posted Date • Closeout Date • Accounting • Accounting - Previous • Accounting - Current
Begin Date	Beginning date of the "current" period on the report
End Date	Ending date of the "current" period on the report
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button   Click on item to be de-selected in the right-hand list and press the left-arrow button.

Drag-and-Drop   Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.

Double-Click   Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.5   CapitationWriteOff

The Capitation Write-Off Report produces a report and optionally generates Write-Offs for claims that should be written-off because the plans are capitated.

The Capitation Write-Off Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

Please note, that there is no capitation "flag" on the plan. The plans that are considered capitated and that will be written-off should be entered on the Selection Tab. At least one plan must be selected for write-off.

General Tab

Task Name	Task Name displayed in the Task Viewer
Age In Days	The number of days since the charge ha posted last payment or adjustment activity that must elapse before the Write-Off is taken. This will (hopefully) allow some recurring patient to return and drop additional balances that will be high enough to begin billing again.
Listing Only	Indicates that you want to generate only a listing of the accounts that "qualify" for the Capitation Write-Off.
Listing With Write-Off	Indicates that you want to generate a listing of the accounts that "qualify" for the Capitation Write-Off and perform the Write-off as well.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button   Click on item to be de-selected in the right-hand list and press the left-arrow button.

Drag-and-Drop   Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.

Double-Click   Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.6   Claims Analysis Report

The Claims Analysis Report produces a report of the "output" counts, amounts and percentages of claims filed for a given time period. The report will list the claims that meet the criteria entered by the user.

The Claims Analysis Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Min Level	The minimum claim level to qualify for inclusion on the report. Allowable values are:

- Submitted
- Re-Submitted

Min Days	Minimum days from the selected Minimum Claim Level for inclusion on the report.
Max Days	Maximum days from the selected Minimum Claim Level for inclusion on the report.
Claim Level	The insurance level to qualify for inclusion on the report. Allowable values are:

- (Blank) All Levels
- Level 1
- Level 2
- Level 3

Cube Data	Indicates if report results should be output to a data cube.
Generate Standard Report	Indicates if report results should be output to a formatted report.
Run Now	Indicates in the report should be run immediately.
Schedule	Indicates that the report should be scheduled to run at a future time.
Schedule Task	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

TIP: When running the Claims Analysis Report the default sort on the Sorting tab is Plan. The report lists the Count, Amount and Percentages of claims into two categories - Original Claims and Refiled Claims. These are broken down further by Primary claims and Non-Primary claims. The Output column shows if the claims were filed Electronic, Paper or were Medigap claims.

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.

Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.7   Delinquency Report

The Delinquency Report produces a report of the "delinquent" accounts or claims. The report will list the accounts or claims that meet the criteria entered by the user. If the providers have been setup with Individual or Group numbers assigned by Division in **Staff Maintenance** , the Delinquency Report will show the providers Group and/or Individual number at the division level. This apply's to both Data Cubes and Standard reports.

The Delinquency Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.
General Tab

Task Name	Task Name displayed in the Task Viewer
Type	Delinquency Type to examine:

- Self - to list delinquent accounts with self pay balances only
- Claims - to list insurance claims

Min Level	The minimum delinquency level to qualify for inclusion on the report when running for claims. Allowable values are:

- Submitted - the Min Days will be counted from the claim submission date.
- Re-Submitted - the Min Days will be counted from the date the claim was refiled if it has been refiled, or from the claim submission date if it has not be refiled.

Min Days	Minimum days from the selected Minimum Level (Claims) or last Payment Date (Self) for inclusion on the report
Max Days	Maximum days from the selected Minimum Level (Claims) or Last Payment Date (Self) for inclusion on the report
Claim Level	The insurance level to qualify for inclusion on the report when running for Claims. Allowable values are:

- (Blank) All Levels
- Level 1
- Level 2
- Level 3

Sort By Amount	Indicates if additional sorting will be performed based on the amount outstanding for the type of report:

Claims
- No Sort
- Amount Billed
- Claim Balance

Self
- No Sort
- Account Balance

| Held Claims | Indicate how or if you want to report Held Claims when running for claims. Allowable values are: |

- Include Held Claims
- Exclude Held Claims
- Held Claims Only

| Disputed Claims | Indicate how or if you want to report Disputed Claims when running for claims. Allowable values are: |

- Include Disputed Claims
- Exclude Disputed Claims
- Disputed Claims Only

| Pending Claims | Indicate how or if you want to report Pending Claims when running for claims. Allowable values are: |

- Include Pending Claims
- Exclude Pending Claims
- Pending Claims Only

| In Collection | Indicate how or if you want to report Visits already turned-over to Collections when running for Self. Allowable values are: |

- (Blank) Include
- Exclude

| In Turnover | Indicate how or if you want to report Visit in Collection Turnover but not yet turned-over when running for Self. Allowable values are: |

- (Blank) Include
- Exclude

| Include Medigap with Unpaid Primary Claims | Secondary Medigap Claims are created when the primary claim is created. This potentially causes some aging problems among these claims. This field indicates if Medigap Claims will be reported when the primary claim is created (include) or held until the primary claim is paid or denied (do not include). |

Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

TIP: When running the Delinquency Report for Claims, the output of the last claim that was filed will be shown on the report. This is because when a refile is done, the system closes the original claim or billing record and opens a new billing record for the re-filed claim. The Claims Delinquency Report only addresses open claims or billing records. For example if a claim filed originally Electronic and then Auto

Re-filed Paper, the Claims Delinquency Report would show PAPER in the Output column.

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.8   Deposit Summary Report

The Deposit Summary Report reports on payment-based revenue data. The report shows the patient number, service date, patient name, policy number, payments, adjustments and the date and transaction description for the revenue reported. The report can sort and break on virtually any field available in MedSuite. Therefore, the variety of reports that can be produced from this single report program is astounding.

The report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
Date Type	Payment Charge Date to examine: • Remit • Posted • Accounting • Accounting - Previous • Accounting - Current Payment selection is based on date range only. The payments selected do not necessarily have anything to do with the charges selected.
From Date	Beginning date of the (remit or posted) date range
Thru Date	Beginning date of the (remit or posted) date range

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.9   Followup Report

The Followup Report on the Reporting menu is used to track actions that take place within the Followup Queue to analyze productivity. It may be run for a specific date range and may be run either with summary counts or with detail, which will list the specific accounts that had actions on them. When the Detail option is selected, it will show the date/time that each action was performed.

By using the available Sorting options, you may break down the activity by User, Action, Account Class, Patient, Account, etc. When sorting by Patient or Account with the Details option, it will list the patients/ accounts alphabetically and the actions taken on them during the date range specified.

The Selection options will allow you to narrow down the data contained on the report by selecting certain Account Classes, Actions, Action Codes or Action Classes, etc. This could be helpful if you only wanted a list of accounts that had a Promise Action Class used on them.

The Followup Report prints Followup History information in two different formats. The "Counts" format prints counts of Followup History Action Codes. The "Details" format prints Followup History transaction detail with counts and subtotals. To get a list of accounts worked by each user, use the Details option and Sort By User. To get just a summary of how many of each action each user has performed, use the Counts option and Sort By User and then Action.

Experiment with the report options to see the different ways that this report might be utilized in your office.

The Followup Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
From Date	The beginning date for Followup History selection
Thru Date	The ending date for Followup History selection
Format	Counts or Details - The "Counts" format prints counts of Followup History Action Codes. The "Details" format prints Followup History transaction detail with counts and subtotals.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Task Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.10   Finance Charges

The Finance Charges Report produces a report and optionally generates Finance Charges for accounts with delinquent self-pay balances. These are generally accounts that have had no payment for a given number of days.

The Finance Charges Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Age In Days	The number of days since the original bill or last payment that must elapse before the Finance Charge is added. This defaults from the Statement Tab of the Practice Maintenance screen, where it also specifies whether this is the number of days from the original bill or from the last payment date.
Monthly Rate (%)	The percentage that will be used in calculating the Finance Charge. The delinquent self pay balance will be multiplied by this percentage to arrive at the finance charge. Example: delinquent balance of $324 at 1.5% is a finance charge of 4.86. This defaults from the Statement Tab of the Practice Maintenance screen.
Minimum Finance Charge	If a Minimum Amount was specified in the Statement Tab of Practice Setup, it will be displayed here. If the calculated Finance Charge is less than the specified minimum, the system will use the minimum amount instead.
Listing Only	Indicates that you want to generate only a listing of the accounts that "qualify" for the Finance Charges.
Listing and Create Charges	Indicates that you want to generate a listing of the accounts that "qualify" for the Finance Charges and add the charges to the accounts as well.
Compounding Calculation	Indicates if finance charges will be calculated with compounded interest. If interest is to be compounded, visit balances for previous finance charges will be included in the finance charge calculation. If interest is not to be compounded, the visit balances for previous finance charges will be excluded.
Cube Data	Indicates if report results should be output to a data cube.
Generate Standard Report	Indicates if report results should be output to a formatted report.
Run Now	Indicates in the report should be run immediately.
Schedule	Indicates that the report should be scheduled to run at a future time.
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.11   Insurance Eligibility Check

The Insurance Eligibility Check is a custom report that produces a list of patient information for the purposes of verifying insurance eligibility. There are no Sorting or Selecting options as this report is demographic in nature and does not report Visit information except for the First Visit Date which must be entered in the patient demographic on the Primary Care tab where the First Visit Date field is located. The system selects Plan Names based on the Prior Authorization option in the carrier file being checked.

The Insurance Eligibility Check contains one tab, the General tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Entered From	Beginning entered date of the period on the report
Entered Thru	Ending entered date of the period on the report
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

5.12   Mail Merge Document Listing

The user may want a list of Mail Merged Documents. The listing may be run for all documents or a specific document, all users or a specific user, and for a user-defined date range.

The Mail Merge Document Listing request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Letter (Blank for All)	Select all letters or a specific letter
User (Blank for All)	Select letters requested by all users or a specific user
Begin Date	Beginning Close-Out Date of letters to select
Ending Date	Ending Close-Out Date of letters to select
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.13 O/R Census Report

The O/R Census Report performs O/R Suite utilization calculations in terms of the number of ongoing cases in a facility over the course of the day. The time interval examined (or number of time segments per day) can be broken down into 6, 10, 15, or 30 minute intervals. The report can be run by either the maximum or the average number of cases per interval over the date range selected.

The report sorts and breaks on facility as other sorts will just tend to "water-down" the results. The purpose of the report is to examine average and maximum case load by facility to help determine staff coverage needs. Sorting be plan, procedure, etc. isn't relevant to the purpose of the report.

The O/R Census Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer.
Format	Report format to be printed: • Average • Maximum
Interval (Minutes)	Select the period or interval size (cases per X minutes) to examine.
Undefined O/R Suites	Indicate how or if "Undefined" O/R Suites should be reported. Allowable values are: • Include • Exclude • Only
Date Type	Charge Date to examine: • Service • Posted • Closeout • Entered • Accounting • Accounting - Previous • Accounting - Current
From Date	Beginning date of the (posted or service) date range.
Thru Date	Ending date of the (posted or service) date range.
Days of the Week to Include / Exclude	Select the days of the weeks to examine. Defaults are to include weekdays and exclude weekends.
Holidays	Enter any Holidays that fall within the report date range. If you use Report Templates, you can save all Holidays for the year and retrieve them on future runs of this report.
Cube Data	Indicates if report results should be output to a data cube.
Generate Standard Report	Indicates if report results should be output to a formatted report.
Run Now	Indicates in the report should be run immediately.
Schedule	Indicates that the report should be scheduled to run at a future time.
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s).

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.14   O/R Utilization Report

The O/R Utilization Report performs utilization calculations of cases performed compared to total time available in an O/R Suite. Utilization calculation is performed using only the time spent in the O/R during the user-defined "Work-Day." Actual case time may begin before the beginning of the "Work-Day" or end after the ending of the "Work-Day."   In addition, dates defined as "Holidays" are also excluded from the utilization calculation. The "Working Hours" and "Holidays" that are entered on this report screen are default values. The Working Hours and Holidays may be defined by Facility and by O/R Suite.

The "priority" sequence of Working Hours and Holidays is to first use the values from this screen then, if the O/R Suite Utilization Report Override (in Facility Setup) is "On", use the values in Facility Setup. Finally, if the O/R Suite Utilization Facility Override (in O/R Suite Setup) is "On", use the values in O/R Suite Setup.

The report can sort and break on virtually any field available in MedSuite. However, this particular tends to break down when sorted by fields that are not directly related to the Facility and O/R Suite. For example, if this report is broken by physician, you will generally receive only a partial picture of O/R Utilization.

This report can be printed in three different formats:

- Summary   Report prints summary totals only with Gantt Charts of cases that occurred during the user-defined "Work-Day" for each day.
- Detail - No Chart   Report prints case details (individual patients) of cases that occurred during the user-defined "Work-Day" for each O/R for each day. However, Gantt Charts are not printed.
- Detail   Report prints case details (individual patients) of cases that occurred during the user-defined "Work-Day" and Gantt Charts for each O/R for each day.

The O/R Utilization Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer.
Format	Report format to be printed: (see above)
	• Summary
	• Detail - No Chart
	• Detail
Undefined O/R Suites	Indicate how or if "Undefined" O/R Suites should be reported.
	Allowable values are:
	• Include
	• Exclude
	• Only
	Note: The report classifies visits entered with no O/R Suite under "Undefined O/R." These may be excluded from the report, included, or the report may list "Only" the Undefined O/Rs in case these are visits that need to be corrected.
Date Type	Charge Date to examine:
	• Service
	• Posted
	• Closeout

- Entered
- Accounting
- Accounting - Previous
- Accounting - Current

From Date	Beginning date of the (posted or service) date range.
Thru Date	Ending date of the (posted or service) date range.
Working Hours	You should define your working hours for the days of the week. These hours will be used to determine what times of day the suite should be utilized and therefore be included in the report's utilization calculation.
Holidays	Enter any Holidays that fall within the report date range. If you use Report Templates, you can save all Holidays for the year and retrieve them on future runs of this report.
Cube Data	Indicates if report results should be output to a data cube.
Generate Standard Report	Indicates if report results should be output to a formatted report.
Run Now	Indicates in the report should be run immediately.
Schedule	Indicates that the report should be scheduled to run at a future time.
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s).

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.15   Over-Payment Report

The Over-Payment Report produces a report of the "over-paid" accounts or claims. For over-paid claims, the report only considers the claim amount and payments and adjustments posted against the claim and reports claims "balances" that are negative. Self payments and adjustments are not considered. For over-paid accounts, the report lists Visits with a credit (negative) balance. The report will list the accounts or claims that meet the criteria entered by the user.

The Over-Payment Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

Due to the complexity of the queries to produce this report, the range between the Min Days and Max Days is limited to 90.

General Tab

Task Name	Task Name displayed in the Task Viewer
Type	Delinquency Type to examine:

- Self - to list over-paid accounts with self pay balances only
- Claims - to list over-paid insurance claims

Min Days	Minimum days from the last payment posting date for inclusion on the report
Max Days	Maximum days from the last payment posting date for inclusion on the report
Claim Level	The insurance level to qualify for inclusion on the report when running for Claims. Allowable values are:

- (Blank) All Levels
- Level 1
- Level 2
- Level 3

Sort By Amount	Indicates if additional sorting will be performed based on the amount outstanding for the type of report:

Claims
- No Sort
- Amount Billed
- Claim Balance

Self
- No Sort
- Account Balance

Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time

Schedule Button   Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button   Click on item to be selected in the left-hand list and press the right-arrow button.

Drag-and-Drop   Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.

Double-Click   Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button   Click on item to be de-selected in the right-hand list and press the left-arrow button.

Drag-and-Drop   Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.

Double-Click   Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.16   Payment Exception Report

The Payment Exception report produces a list of payments that have been flagged as exceptions via the Payment Reason Code used on the Payment Distribution. Exceptions have been flagged so that someone can determine if there was a problem that requires additional review or followup. In addition, the report can produce a list of payments in which the charge allowed amount (from the Fee Schedule) and the carrier approved amount (entered in Payment Entry) differ by more than a user-defined percentage.

The Payment Exception Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Select Payments By	Payment Date to examine:
	• Entered
	• Remit
	• Posted
	• Accounting
	• Accounting - Previous
	• Accounting - Current
From	Beginning date of the (entered, remit, or posted) date range
Thru	Ending date of the (entered, remit, or posted) date range
Payment Reason Exceptions	Indicates if Payment Distributions with Payment Reasons that have been flagged as exceptions will be included in the report.
Allowed Amount Exceptions	Indicates if Payment Distributions in which the charge allowed amount (from the Fee Schedule) and the carrier approved amount (entered in Payment Entry) will be included in the report.
Within Pct	The percentage difference between the allowed and approved amounts that will qualify a payment to appear on the report.
Report Under-Payments	Indicates Payment Distributions Only in which the charge allowed amount (from the Fee Schedule) is greater than the carrier approved amount (entered in Payment Entry) will be included in the report.
Report Over-Payments	Indicates Payment Distributions Only in which the charge allowed amount (from the Fee Schedule) is less than the carrier approved amount (entered in Payment Entry) will be included in the report.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and

perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.17   Payment Review Report

The Payment Review Report takes a two-fold approach to improperly paid claims. Some of those claims were mis-paid by the payor while others were not responded to (paid or denied) by the payor. The report is generally used in meetings with payor representatives to review mis-paid claims. The report produces a list of patients that have payments posted that were not paid according to the contract as well as claims that are still open after a user-defined number of days. The report can produce a list of payments in which the charge allowed amount (from the Fee Schedule) and the payor approved amount (entered in Payment Entry) differ by more than a user-defined percentage. It is different from the Payment Exception Report in that it includes demographic and charge information such as policy number, claim number, CPT/ASA code, etc. and not the batch number, document number or exception type.

The Payment Review Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Select Payments By	Payment Date to examine:
	• Entered
	• Remit
	• Posted
	• Accounting
	• Accounting - Previous
	• Accounting - Current
From	Beginning date of the (entered, remit, or posted) date range
Thru	Ending date of the (entered, remit, or posted) date range
Payment Reason Exceptions	Indicates if Payment Distributions with Payment Reasons that have been flagged as exceptions will be included in the report.
Allowed Amount Exceptions	Indicates if Payment Distributions in which the charge allowed amount (from the Fee Schedule) and the carrier approved amount (entered in Payment Entry) will be included in the report.
Within Pct	The percentage difference between the allowed and approved amounts that will qualify a payment to appear on the report.
Report Under-Payments	Indicates Payment Distributions Only in which the charge allowed amount (from the Fee Schedule) is **GREATER** than the carrier approved amount (entered in Payment Entry) will be included in the report.
Report Over-Payments	Indicates Payment Distributions Only in which the charge allowed amount (from the Fee Schedule) is **LESS** than the carrier approved amount (entered in Payment Entry) will be included in the report.
Min Days	Enter the minimum age of open claims to be selected in the report
Max Days	Enter the maximum age of open claims to be selected in the report
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.18   Payment Summary Report

Payment Summary Report prints a summarized list of payments for the entered date range.

Task Name	Task Name displayed in the Task Viewer
Un-Posted	Indicates that the Worksheet is to be run against unposted payments for a batch or all batches
By Date	Indicates that the Worksheet is to be run against posted payments for a date range
Batch No	Batch number (blank for all) to run for unposted payments
Released Batches Only	When running the report in Un-Posted mode, you may select only batches that have been released for posting.
Date Type	Payment Date to examine: • Posted • Remit • Closeout • Entered • Accounting • Accounting - Previous • Accounting - Current
From Date	When running the report in Posted Date mode, enter the beginning date of the posted date range
Thru Date	When running the report in Posted Date mode, enter the ending date of the posted date range
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	indicates that the report should be scheduled to run at a future time
Schedule Button	invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the

second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.19   PQRI Report

The PQRI Detail Report has detail and summary options for the reporting of the PQRI Level II procedure codes at the patient level. Access to this report is maintained in System Administration via User Groups - Daily Reporting tab. The report shows the # of cases eligible, the # of cases documented, the # of each of the PQRI codes billed for each measure, and calculates the percentage of eligible cases that were documented (# of documented cases / eligible cases = % documented.)

General Tab

Task Name	Task Name displayed in the Task Viewer
Format	• Detail - gives individual PQRI charges for each patient • Summary - reports cases/visits with one or more PQRI measures in use
Date Type	• Posted • Service • Close Out • Entered
From/Thru Date	Specify the From and Thru dates

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.20   Production Reports

Production Reports cover a wide spectrum of visit and charge-based production data. The report can sort and break on virtually any field available in MedSuite. Therefore, the variety of reports that can be produced from this single report program is astounding. This report can print in two different formats:

- Counts   Procedure Counts, Case Counts, Quantity Counts, Charge Amounts and percentages for each.
- Units   Case Counts, Procedure Counts, Minutes Count, Base and Time Count and a percentage of each. Also included are the P/S, Age & Emergency counts.

The Production Reports request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
Format	Report format to be printed: • Counts • Units
Date Type	Charge Date to examine: • Service • Posted • Closeout • Entered • Accounting • Accounting - Previous • Accounting - Current
From Date	Beginning date of the (posted or service) date range
Thru Date	Ending date of the (posted or service) date range
CRNA Units	Indicates if report results should include or exclude CRNA unit values. Allowable values are: • Include • Exclude When report is run to EXCLUDE CRNA UNITS, it will exclude them if the Medical Direction is not a 0 or a Z so that the units don't get counted for both the MD and the CRNA. If the Medical Direction is a 0 or a Z, the CRNA units will always be included in the totals since there is no separate MD charge on those cases

TIP: When running the Production Report you can break by Plan Type or Plan and get an idea of the payor mix
for your practice.

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.21   Revenue Reports

Revenue Reports cover a wide spectrum of visit, charge, and payment-based revenue data. The report can sort and break on virtually any field available in MedSuite. Therefore, the variety of reports that can be produced from this single report program is astounding. This report can print in two different formats:

- Dollars   Procedure Counts, Case Counts, Charges, Payments, and Adjustments and percentages for each.
- Units   Case and Encounter Counts, Bast, Time and Total Units, Charges, Charges per Billed Unit, Insurance Paid and Adjusted, Self Paid and Adjusted, Paid Units and Amount Paid per Paid Unit.

When selecting the Units Format, there are several issue that the user must be aware of:

- This report prints a "paid units" column...that is units on charges where the paid amount non-zero. This has the effect of removing the units from unpaid charges from the paid per unit calculation which would have the effect of lowering the paid per unit if we include all units, not just paid units.

- CRNA Units can be included or excluded. Including CRNA Units will have the effect of halving the Pd/Unit. For example, assume that the billed rate is $70 and when the practice split bills, the $70 is split $40 and $30 for MD and CRNA. If we have a 10 unit case, the MD get 10 units @ $40 and the CRNA gets 10 units @ $30. If we don't exclude the CRNA units, we will have 20 units but a total billed of only $700. This will "water-down" the paid per unit.

- Flat Fees may be included or excluded. Including Flat Fees will have the effect of increasing the billed charges without a corresponding increase in the billed units or paid units. This will increase the paid per unit.

- The Units Format of this report is run selecting the charges and payments "For the Selected Date Range". All things being equal, this should not present a problem. However,by definition, the payments selected may or may not be for the charges selected. As a result, increases in billed amounts, changes in payor contracts, etc. could have an unexpected effect on the paid per unit.

The Revenue Reports request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Format	Report format to be printed: • Dollars • Units
Date Break	Indicate if the lowest level sort of the report should be date oriented: • (Blank) No Break • Day • Month • Quarter • Year
For Selected Date Ranges	Charge Selection and Payment Selection is based on date range only. The payments selected do not necessarily have anything to do with the charges selected.

Payments for Selected Charges	Charges are selected based on the charge date type (posted or service) and charge date range selected. Payments are selected based on the payment date type (entered, posted, or remit) and date range selected. In addition, the charge that the payment is applied against must be one of the charges selected for the report.
Charge for Selected Payments	Payments are selected based on the payment date type (entered, posted, or service) and payment date range selected. In addition, the charge that the payment is applied against that fall within the charge date type (service or posted) and charge date range date selected for the report.
Charge Date Type	Charge Date to examine: - Service - Posted - Closeout - Entered - Accounting - Accounting - Previous - Accounting - Current
Charge From Date	Beginning date of the (posted or service) date range
Charge Thru Date	Ending date of the (posted or service) date range
Payment Date Type	Payment Date to examine: - Remit - Posted - Closeout - Entered - Accounting - Accounting - Previous - Accounting - Current
Payment Date From	Beginning date of the (entered, posted, or remit) date range
Payment Date Thru	Beginning date of the (entered, posted, or remit) date range
CRNA Units	Indicates if report results should include or exclude CRNA unit values. Allowable values are: - Include - Exclude When report is run to EXCLUDE CRNA UNITS, it will exclude them if the Medical Direction is not a 0 or a Z so that the units don't get counted for both the MD and the CRNA. If the Medical Direction is a 0 or a Z, the CRNA units will always be included in the totals since there is no separate MD charge on those cases.
Flat Fees	Indicates if report results should include or exclude flat fees. Allowable values are: - Include - Exclude
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

TIP: When running the Revenue Report in Dollar format, the Charges Amount column on the report

represents Net Charges
(Charges – Reversals). The Net Amount column on the report represents Net Charges – Payments –
Adjustments for that
row on the report. When running the Revenue Report in Unit format remember that the totals for Cases,
Base and Time are
based on Anesthesia charges only.

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report
and the second list is comprised of the fields that have been selected as sort fields. The fields in the
second list may be sequenced in any order. The report will sort the data into the sequence defined and
perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab
consists of a list of fields they you may use to include or exclude specific data values from the report. For
example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to
include or exclude certain values from the respective tables. The limit to the number of specific values
you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to
the number of selections you can make, you will run out of patience before MedSuite runs out of room to
save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select
one at a time, SHIFT+Click to select a range of maintenance files.

5.22   Report Card

The Report Card generates trend information of collections over time. It reports each service month selected and when payments and adjustments were received for that month of service. The report fields include charges, expected, payments, contractual adjustments, discretionary adjustments, bad debt adjustments, total adjustments, and the open balance. Percentages are calculated for each of the columns on the report. The report also calculates Gross, Expected, and Net Percentages of Collections. The report allow you to include discretionary adjustments as "contractual" adjustments or not. This is quite relevant in the case of Billing Services where the "discretionary" adjustment is not at the Billing Service's discretion; it is at the discretion of their client, the practice.

Gross Pct of Collection

(Payments + Contractual Adjustments + (optionally)Discretionary Adjustments) / Charges

Expected Pct of Collection

Payments / (Allowed Amount from Fee Schedule - (optionally)Discretionary Adjustments)

Net Pct of Collection

Payments / (Charges - Contractual Adjustments - (optionally)Discretionary Adjustments)

You may defined Adjustment Types as Contractual, Discretionary or Bad Debt in Adjustment Types Setup.

General Tab

Task Name	Task Name displayed in the Task Viewer
Format	Indicates the format for the report:
	• Detail - Reports charges for the month breaking down the payments and adjustments to show them in the month in which they were received. (i.e. Jan charges and then Feb, March, April when the payments were received on those charges.)
	• Summary - Reports totals for each month of charges showing the total payments and adjustments against those charges on one line.
Charge Date Type	Charge Date to examine:
	• Service
	• Posted
	• Closeout
	• Entered
	• Accounting
	• Accounting - Previous
	• Accounting - Current
Charge From Date	Beginning date of the (posted or service) date range
Charge Thru Date	Ending date of the (posted or service) date range
Payment Date Type	Payment Date to examine:
	• Remit
	• Posted
	• Closeout

- Entered
- Accounting
- Accounting - Previous
- Accounting - Current

Payment Date From	Beginning date of the (entered, posted, or remit) date range
Payment Date Thru	Beginning date of the (entered, posted, or remit) date range
Treat Discretionary Adjustments Like Contractual Adjustments	Indicates if report results should be shown with Discretionary Adjustments counted like Contractual Adjustments.
Show Expected Columns	De selecting this option will cause the report to suppress the two "expected" columns, the 4th column on the report and the Exp column in the Collection Percentages area of the report
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.23   Small Balance Write-Off

The Small Balance Write-Off Report produces a report and optionally generates Write-Offs for accounts whose balances have fallen below a user-defined minimum for a given number of days.

The Small Balance Write-Off Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Age In Days	The number of days since the last payment or adjustment activity that must elapse before the Write-Off is taken. This will (hopefully) allow some recurring patient to return and drop additional balances that will be high enough to begin billing again.
Maximum Write-Off Amount	The amount that will be written-off. This is generally the minimum billing amount defined for the practice. However, some states have small Medicaid Co-Pays ($2.00-$3.00) that must be "billed". Practices in these states set their minimum billing amount low enough to bill these Co-Pays. However, their Small Balance Write-Off amount may really be $10.00 or higher.
Listing Only	Indicates that you want to generate only a listing of the accounts that "qualify" for the Small Balance Write-Off.
Listing With Write-Off	Indicates that you want to generate a listing of the accounts that "qualify" for the Small Balance Write-Off and perform the Write-off as well.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.24 Summary Report

The Summary Report generates totals of charges from charge type, and payments and adjustments by payment and adjustment type.

The Summary Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
Date Break	Indicate if the lowest level sort of the report should be date oriented:

- (Blank) No Break
- Day
- Month
- Quarter
- Year

For Selected Date Ranges	Charge Selection and Payment Selection is based on date range only. The payments selected do not necessarily have anything to do with the charges selected.
Payments for Selected Charges	Charges are selected based on the charge date type (posted or service) and charge date range selected. Payments are selected based on the payment date type (entered, posted, or remit) and date range selected. In addition, the charge that the payment is applied against must be one of the charges selected for the report.
Charge for Selected Payments	Payments are selected based on the payment date type (entered, posted, or service) and payment date range selected. In addition, the charge that the payment is applied against that fall within the charge date type (service or posted) and charge date range date selected for the report.
Charge Date Type	Charge Date to examine:

- Service
- Posted
- Closeout
- Entered
- Accounting
- Accounting - Previous
- Accounting - Current

Charge From Date	Beginning date of the (posted or service) date range
Charge Thru Date	Ending date of the (posted or service) date range
Payment Date Type	Payment Date to examine:

- Remit
- Posted

- Closeout
- Entered
- Accounting
- Accounting - Previous
- Accounting - Current

Payment Date From	Beginning date of the (entered, posted, or remit) date range
Payment Date Thru	Beginning date of the (entered, posted, or remit) date range
Report Pmt/Adj Type	Report payments and adjustments in the report detail by the payment and adjustment types in the Setup Tables.
Report Pmt/Adj Type and Pmt/Adj Source Plan	Report payments and adjustments in the report detail by the payment and adjustment types concatenated with the plan description from the claim that the payments and adjustments were applied against.

This option is quite useful when you are frequently using "generic" descriptions for payment and adjustment codes such as "Insurance Payment", "Insurance Adjustment", or "Commercial Payment".

TIP: When running the Summary Report the Charges column on the report represents Net Charges (Charges – Reversals).
The Net column on the report represents Net Charges – Payments – Adjustments for that row on the report.

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.25   Visit Detail Report

The Visit Detail Report provides a listing of Visit and Charge information for a user-defined date range and the request form
is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
Format	Detail level on the report can be selected as follows:

- Detail - Details the CHARGES on each Visit in the date range selected.
- Summary - Selects the last procedure entered on a Visit but Payment, Adjustment and Charge totals include all procedures entered for the Visit.

Date Type	Charge Date to examine:

- Service
- Posted
- Closeout
- Entered
- Accounting
- Accounting - Previous
- Accounting - Current

From Date	Beginning date of the date range
Thru Date	Ending date of the date range

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.26   Generate Cubes

Data Cubes are special type of report that "rolls-up" much of the supporting data (procedure codes, diagnosis codes, surgeons, payments, adjustments, etc.) into one of three levels:

- Charges   Data is "rolled-up" to the charge-level. Payments and Adjustments are included on each charge line.

- Patients   Data is "rolled-up" to the patient-level. Individual visit and charge detail is lost. Total Charges, Payments, and Adjustments are included on each patient line. No date range is selected if the Patient option is selected; it will report data on all patients (patients do not have date ranges; charges, visits, and transactions do).

- Visits   Data is "rolled-up" to the visit-level. Individual charge detail is lost. Total Charges, Payments, and Adjustments are included on each visit line.

- Transactions   This reports all Charge, Payment, and Adjustment transactions on a separate line.

- Anesthesia Times   This reports all main anesthesia charges by anesthesia time segment. Depending on selection criteria, the report will contain an entry for each anesthesiologist and each anesthetist on a case, with each start and stop time, and minutes. Charge information (dollars and units) are reported both as a total for the charge and a "pro-rata" share of the total based on a percentage of the minutes for each time segment.

The Data Cubes are different from the data cubes available on virtually all other reports in that these data cubes are designed to allow the user to explore "what-if" scenarios by changing sorting and roll-ups on "on-the-fly". Standard report data cubes only report the information available on those reports in a data cube. The Data Cubes request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name   Task Name displayed in the Task Viewer.

Cube Type   Roll-up Level to be selected: (see explanations above)
- Charges
- Patients
- Visits
- Transactions
- Anesthesia Times

Patient Details   Indicates if patient details such as name, address, date of birth, sex, etc should be included in the cube.

Date Details   Indicates if date details such as service dates, remit dates, posted dates, etc should be included in the cube.

Anesthesia Details   Indicates if anesthesia details such as base, time, age, physical status, minutes, etc should be included in the cube.

For Selected Date Ranges   Charge Selection and Payment Selection is based on date range only. The payments selected do not necessarily have anything to do with the charges selected. Note: Only available when Cube Type is Transactions.

Payments for Selected Charges Charges are selected based on the charge date type (posted or service) and charge date range selected. Payments are selected based on the payment date type (entered, posted, or remit) and date range selected.

In addition, the charge that the payment is applied against must be one of the charges selected for the report. Note: Only available when Cube Type is Transactions.

Charges for Selected Payments	Payments are selected based on the payment date type (entered, posted, or service) and payment date range selected. In addition, the charge that the payment is applied against that fall within the charge date type (service or posted) and charge date range date selected for the report. Note: Only available when Cube Type is Transactions.
Select Charges By	Charge Date to examine for Date Type:

- Entered
- Posted
- Service
- Accounting
- Accounting - Previous
- Accounting - Current

Not available when Charges for Selected Payments has been selected.

Charge Date From	Beginning date of the (posted or service) date range.
Charge Date Thru	Ending date of the (posted or service) date range.
Select Payments By	Payment Date to examine for Date Type:

- Entered
- Remit
- Posted
- Accounting
- Accounting - Previous
- Accounting - Current

Note: Only available when Cube Type is Transactions.

Payment Date From	Beginning date of the (entered, posted, or remit) date range.
Payment Date Thru	Ending date of the (entered, posted, or remit) date range.
Run Now	Indicates in the report should be run immediately.
Schedule	Indicates that the report should be scheduled to run at a future time.
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s).

Breaks Tab

An extensive list of break fields may be included or excluded from the data cube. If a break is included in a cube, the field (e.g. facility) will be included in the cube and the data will be "rolled-up" and broken by that field.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to

the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.27   Accounts Receivable Audit Report

The Accounts Receivable Audit Report presents aged accounts receivable balances for all practices within a company (database). It runs much like the Accounts Receivable Report. However, you may define a series of "target" percentages of the aging break-down. For example, you feel that 15%-25% of your receivable should be 0 to 30 days old and 20%-30% should be 31-60 days old, etc. The percentages selected by a user the first time they run the report are remembered and filled in by the system the next time the anyone runs the report. If different percentages are needed they will need to be updated the next time a user runs the report. When the aging breakdown is performed, the percentage in any given aging category is within the target range, the amounts will print in black, if the percentage falls below the target range the amounts will print in green, and if the percentage is above the target range the amount will print in red. In addition the report contains a column for "AR Days", which is calculated as follows: Total charges for last 90 days divided by 90 = Avg. charges per day. AR Balance divided by Avg. charges per day = AR Days. Total charges for the last 90 days is shown on the first column of the report.

The Accounts Receivable Audit Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Report A/R Balances for Pending Claims	Indicates whether the report should Include, Exclude, or report Only balances for accounts with claims that have not filed due to Pending provider ID numbers.
Charge Date Type	Charge Date to examine: • Service Date • Posted Date • Closeout Date • Entered Date
Charge Ending Date	Charges after this date will be ignored
Payment Date Type	Payment Date to examine: • Remit Date • Posted Date • Closeout Date • Entered Date
Payment Ending Date	Payments after this date will be ignored
Target A/R Percentages	Enter the target A/R Percentages for each aging category.
Report Under Primary	Report activity under the primary insurance plan (or Self) if the report is sorted by plan
Report Under Current	Report activity under the current insurance plan (or Self) if the report is sorted by plan
Report Self Pay AR Balances	Indicates whether the report should Include, Exclude, or report Only self pay balances. Selecting the Include option will include any accounts at the self-pay level in the report. The Exclude option will not report any accounts without insurance, accounts with balances after insurance has paid, nor any accounts where the insurance is set to not wait for payment and the charges are at the self pay level. The Only option will report only balances at the self pay level, whether they had insurance or not.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard	Indicates if report results should be output to a formatted report

Report

Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Task Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.28   Company Billing Cube

The Company Billing Cube generates a data cube that is designed to provide statistics on charges entered and payments remitted and posted.

Task Name	Task Name displayed in the Task Viewer
Run Now	Indicates that the data cube should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
Charge Month	Enter the beginning and ending posted dates of the charge "month" you are requesting.
Charge Quarter	Enter the beginning and ending posted dates of the charge "quarter" you are requesting.
Payment Posted Month	Enter the beginning and ending posted date ranges for the payment "month" you are requesting.
Payment Remit Month	Enter the beginning and ending remit date ranges for the payment "month" you are requesting.

5.29   User Productivity Report

The User Productivity Report allows the practice to track user productivity by counting demographics, charges, payments and adjustments by date entered for each user.

The User Productivity Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Format	Detail level on the report can be selected as follows:
	• Summary - Reports subtotals by User and by Transaction type (Demographics, Charges, Payments and Adjustments).
	• Detail - Reports detailed transactions that make up the totals reported in the Summary format.
From Date	Beginning Entered Date for the report.
Thru Date	Ending Entered Date for the report.
Demographics	Include/Exclude demographic activity on report
Charges	Include/Exclude charges activity on report
Payments	Include/Exclude payments activity on report
Followup	Include/Exclude followup activity on report
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)
From Date	Beginning date of the date range to examine
Thru Date	Ending date of the date range to examine

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.30   Annotation Production Report

The Annotation Production Report allows the company to track the number of Annotations that have been added to images over a given time period. Sort by Practice is selected by default; other sort options include Month, Date Entered, Image Type, Imaging Station, User and User Type. The report content can be defined further by limiting the Selection options of Imaging Type, Imaging Station, Practice, User and User Type. If none of the Selection options are chosen, the default is to report on all of the options.

The User Productivity Report request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
From Date	Beginning Entered Date for the report.
Thru Date	Ending Entered Date for the report.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to

include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

5.31   Logs

The Log Reports in MedSuite track Access and Security to assist the System Administrator in tracking these items for a certain specified date range.

5.31.1   Access Log

The Access Log produces a report for a user-specified time frame that logs user access to Patients and Accounts in the system, or to certain other functions within the system.   Administrator users have access to this report, while other users will receive an error saying they do not have access to run the report. The Log is comprised of the Date/Time the access occurred, the user that accessed the function, the Practice they were in, the Account/Patient accessed if it the activity is one that contains protected health information, and the Activity that was accessed, such as Patient Ledger, Patient Demographic, Visit, Followup Queue, etc.

The Access Log shows user access for the following functions: Opening an account or patient demographic, opening an account or patient ledger, opening a visit, opening the Follow-up Queue, opening Collection Turnover, opening the Refund Manager and opening Imaging.

The Access Log request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab. The Sorting options are Date Entered, Practice, User and User Type. Selection options are for Practice, Users and User Types.

General Tab

Task Name	Task Name displayed in the Task Viewer.
From Date	Indicates the beginning date range for the report to track Access check points in the system.
Thru Date	Indicates the ending date range for the report to track Access check points in the system.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report.
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Task	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.

Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

NOTE: For system performance reasons, the local MedSuite client software does not send every access event from the client to the server every time one occurs. Instead, access events are sent after a user has performed 25 events, or logged out of MedSuite, or gone to a patient Ledger tab and selected the Access History tab. If any of those 3 things occur, MedSuite will send the local access log to the server so that the access events can be reported on the Access Log or on the Access History tab of the patient ledger.

5.31.2 Security Log

The Security Log produces a report for a user-specified time frame for certain security "events" that occur within MedSuite. The purpose of this report is for Management to review to monitor for any security breaches or violations. Administrator users have access to this report, while other users will receive an error saying they do not have access to run the report.

Events that are logged that will show on the Security Log include the following:

Event Messages

1000: Unlocked a User Login	Administrator user unlocked a user that had been "locked-out" due to successive login failures.
1100: New User Created	A new user has been added to the user dictionary.
2000: Password Reset	Password Reset has been performed by an Administrator or MedSuite.

2100: Password Expired	A user's password has expired.
2200: User Changed Password	A user changed their password upon login.
3000: Security Changed for User	Security settings have been changed, such as changing the user group to which they were assigned.
3100: User Granted Admin Rights	The [Administrator](#) flag has been set (checked) for the user.
3200: Admin Rights Removed from User	The [Administrator](#) flag has been un-checked for the user.
4000: User Successfully Logged In	User logged in to MedSuite.
4100: Attempted Login into Locked Account	Login has been refused for a user who is a valid, "Active" user in the MedSuite Users Dictionary who has been "locked-out" due to previously failed attempts at logging in to MedSuite.
4200: Invalid Login Attempt	Login has been refused for a user that has not been defined in the MedSuite Users Dictionary or by a user who has been flagged as "Not Active" in the MedSuite Users Dictionary.
4300: User Locked Out	A user who is a valid, "Active" user in the MedSuite Users Dictionary has been "locked-out" due to successive login failures.

NOTE: In an attempt to identify unauthorized users and/or "hackers", MedSuite will capture information about the user for whom the event was logged including the login name used, the Computer Name, I/P Address, the MAC address of the Network Interface Card, the Windows Serial Number, and any other pertinent information that we feel may help positively identify attempts at unauthorized access. This information will not show on the standard report; in order to see this additional information, the Security Log should be run to Cube.

The Security Log request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab. The Sorting options are Date Entered, User and [User Type](#). Selection options are for Users and User Types.

General Tab

Task Name	Task Name displayed in the Task Viewer.
From Date	Indicates the beginning date range for the report to track security check points in the system.
Thru Date	Indicates the ending date range for the report to track security check points in the system.
Messages	Select the "event messages" as defined above that you would like to see on the report. By default all of the event messages will be selected. To exclude an event message from displaying on the report simply click on the check mark beside the message to remove the check mark.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report.
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Task	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

6   MedSuite Setup

The Setup menu of MedSuite provides access to all of the maintenance functions necessary to configure and operate the application. These functions are divided into several large groupings:

- Cases/Visits
- Demographics
- Financial
- Followup
- Insurance
- Procedure/Diagnosis
- Providers
- System Administration

6.1   Cases/Visits

The Cases/Visits sub-menu of the Setup menu provides access to all of the functions that are Case or Visit in nature. These functions include:

Function	Global	Description
Anesthesia Preference		Define how Extreme Age, Emergency Conditions, and Physical Status are handled. Anesthesia preferences are tied to plans.
Anesthesia Time Preference		Define how minutes per unit, unit rounding, and unit and minute maximums are handled. Anesthesia time preferences are tied to plans.
Anesthesia Type	Y	Type of anesthesia. To be entered on the Visit.
Modifier	Y	HCPCS Modifier Codes
Medical Direction	Y	Number of concurrent cases
O/R Suites		O/R to be entered on the Visit. Used for O/R Suite Utilization Reporting. O/R Suite can be entered and tracked for both Primary and Secondary Procedures on a Visit.
Service Types	Y	HCFA (CMS) Types of Service
Visit Types	Y	Anesthesia or Front-Office

6.1.1   Anesthesia Preference

Anesthesia Preferences define how Extreme Age, Emergency Conditions, and Physical Status are handled. Anesthesia preferences are defined as a separate function so that the user may define a "standard" preference or a "Medicare" preference and then share it among several plans. An Anesthesia Preference is tied to a plan or multiple plans via the Anesthesia Tab of the Plan Setup.

Lookup Name	Lookup value assigned Description

Extreme Age

Do Not Bill/Allow	Extreme Age is not billable
Bill/Allow Bundled Units	Extreme age is included in the anesthesia fee as an additional unit
Bill/Allow CPT-99100	Extreme age is included in the anesthesia fee as an additional procedure (CPT-99100)
Minimum Age: Years / Months	If the patient's age at the time of service is less than the age indicated here, the patient is considered to be of extreme age and the additional unit(s) or procedure will be included in the anesthesia fee.
Maximum Age: Years / Months	If the patient's age at the time of service is greater than the age indicated here, the patient is considered to be of extreme age and the additional unit(s) or procedure will be included in the anesthesia fee.

Emergency Conditions

If the Emergency Conditions on the Risk Factors tab Visit Entry is checked, the additional unit(s) or procedure will be included in the anesthesia fee as indicated here.

Do Not Bill/Allow	Extreme Age is not billable
Bill/Allow Bundled Units	Extreme age is included in the anesthesia fee as an additional unit
Bill/Allow CPT-99140	Extreme age is included in the anesthesia fee as an additional procedure (CPT-99140)

Physical Status

The Physical Status on the Risk Factors tab Visit Entry is used in conjunction with the physical status setup here to determine additional units (if any) to use in the anesthesia calculation and/or modifier (if any) to report on claims.

P1 Units	Additional units to bill when P1 physical status is selected
P1 Modifier	Modifier to report on claims when the P1 physical status is selected
Create P1 Charge	Bills a procedure (99101) when the P1 physical status is selected
P2 Units	Additional units to bill when P2 physical status is selected
P2 Modifier	Modifier to report on claims when the P2 physical status is selected
Create P2 Charge	Bills a procedure (99102) when the P2 physical status is selected
P3 Units	Additional units to bill when P3 physical status is selected
P3 Modifier	Modifier to report on claims when the P3 physical status is selected

Create P3 Charge	Bills a procedure (99103) when the P3 physical status is selected
P4 Units	Additional units to bill when P4 physical status is selected
P4 Modifier	Modifier to report on claims when the P4 physical status is selected
Create P4 Charge	Bills a procedure (99104) when the P4 physical status is selected
P5 Units	Additional units to bill when P5 physical status is selected
P5 Modifier	Modifier to report on claims when the P5 physical status is selected
Create P5 Charge	Bills a procedure (99105) when the P5 physical status is selected
P6 Units	Additional units to bill when P6 physical status is selected
P6 Modifier	Modifier to report on claims when the P6 physical status is selected
Create P6 Charge	Bills a procedure (99106) when the P6 physical status is selected

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

∩ Date Changed - The date the change was made to the file.
∩ User Name - The name of the user that made the change.
∩ Item Changed - The file name of the item that was changed.
∩ Old Value - The system value before the change was made.
∩ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.1.2   Anesthesia Type

Anesthesia Types are used to classify and categorize the anesthetic technique(s) used by the anesthesiologist on a case. Anesthesia Types can be entered on both primary and secondary procedures on a Visit.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

∩ Date Changed - The date the change was made to the file.
∩ User Name - The name of the user that made the change.
∩ Item Changed - The file name of the item that was changed.
∩ Old Value - The system value before the change was made.
∩ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.1.3   Modifier

Modifiers are reported on claims for unusual conditions or to tell the carrier something about a Visit.

Lookup	Lookup value assigned
Name	Description
Code	Two-character modifier code to be reported on the claim
Apply to Physician and Assistant on Anes Cases	Indicates if the modifier when keyed into a primary surgical procedure on an anesthesia case affects both the physician and assistant charges or just the physician charge.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.1.4　O/R Suites

O/R Suites are defined within a Facility, are captured in Visit Entry, and are used for reporting purposes. O/R Suite can be tracked for both primary and secondary procedures on a Visit.

Lookup	Lookup value assigned
Facility	Facility in which O/R Suite is located
Override Facility Working Hours and Holidays	Indicates if on the O/R Utilization Report that this O/R Suites Working Hours and Holidays override those of the Facility. In a Facility with a number of O/R Suites, several of the suites may not conform to the "normal" working hours of the Facility.
Working Hours	Enter the From and Thru Working Hours for the O/R Suite for each day of the week.
Holidays	Enter the dates of up to fourteen Holidays

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.1.5　Visit Types

Visit Types are used control the behavior of Visit Entry, the charge calculation, and other functions. Visit Types may be user-defined. However, the Visit Type of "Anesthesia" has special processing tied to it.

Lookup	Anesthesia / Front-Office
Service Type	The default Type of Service to be used for this Visit Type. This may be

overridden in <u>Procedure Maintenance</u> for certain procedures that should not use the default Service Type.

Statement Group Desc	Description to print on statements in place of the procedure description if the Practice - Statement Tab <u>Group Visits by Visit Type</u> indicator is set.
Bump Date from Previous Charge	If charges are added in the Visit Charges Tab, this indicator (if checked) will cause the service date for new charges to be the next date from the last charge entered.
Warn When Visit Date does not Match Charge Date(s)	Indicates if a warning will be issued if the Visit Date does not match the service date of the charges.
Position to Charge from Date on New Charge	If charges are added in the Visit Charges Tab, this indicator (if checked) will cause the cursor to "jump" from the service date to the procedure code field.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.1.6   Anesthesia Time Preference

Anesthesia Time Preferences define how time units are calculated. Anesthesia Time Preferences are defined as a separate function so that the user may define a "standard" time preference or a "Medicare" time preference and then share it among several plans.

Lookup	Lookup value assigned
Name	Description
Minutes Per Unit	Generally, anesthesia is billed in 15, 12, or 10 minute units for all procedures for a plan. Some procedures such as Labor & Delivery procedures generally take several hours. Some practices will bill graduated minutes unit for these procedures. For example, the first hour may be at 10 minutes per units the send hour at 20 minutes per unit and all subsequent hours at 30 minutes per unit.
From	Beginning of minutes range
Thru	Ending of minutes range
Min/Unit	Number of minute per unit for the range
Maximum Minutes	The total number of minutes for a charge may be capped at some practice or plan-defined maximum
Maximum Units	The total number of time units for a charge may be capped at some practice or plan-defined maximum

Time Calculation Default

Total minutes of anesthesia is either calculated as "face-to-face" time or as "elapsed" time. The difference between the two is that the Case Time Segments on a Visit together may not be contiguous. There may be gaps in the times. This would generally be the case with Epidural procedures. If there are no gaps in time on a case then the two calculation types will result in the same total minutes for the case.

Units Rounding

Frequently, the conversion of minutes to time units results in the calculation of partial time units. These partial time units are frequently rounded based on fractional units or rounded based on the minutes remainder. Assume in following example that a case for a total of 2:05 (125 minutes) was entered and the Anesthesia Time Preference called for 15 minutes per unit for all minutes. The available rounding options would operate in the following manner:

Rounding Option	**How it Works**
R - Round up or Down to the Next Unit	125 / 15 = 8.333333 Rounded to 8
T - Truncate Decimal Places	125 / 15 = 8.333333 Rounded to 8
U - Round to Next Full Unit for Any Partial Unit	125 / 15 = 8.333333 Rounded to 9
Decimal Places	Indicates how many decimal places will be rounded. For example: 125 / 15 = 8.333333 Rounded to 8.3 125 / 15 = 8.333333 Rounded to 8.33

Rounding Option	**How it Works**
M - Round on Minutes	125 / 15 = 8 Remainder 5
Minutes	Indicates how many minutes will be rounded to the next whole unit. For example, if Minutes = 5 then: 125 / 15 = 8 Remainder 5 Rounded to 9 124 / 15 = 8 Remainder 4 Rounded to 8

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.

⌇ Item Changed - The file name of the item that was changed.

⌇ Old Value - The system value before the change was made.

⌇ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.2   Demographics

The Demographics sub-menu of the Setup menu provides access to all of the functions that are demographic in nature. These functions include:

Function	Global	Description
Account Classes	Y	Define how accounts are to be billed
Account Types	Y	Account reporting group
Employers		Employers defined for a practice
Relationship to Patient	Y	HCFA (CMS) patient relationships to account and subscriber

6.2.1   Account Classes

Account Classes control certain billing functions of accounts and are also used for reporting purposes.

Lookup	Lookup value assigned
Name	Description
Is Billable	Indicates if the Account Class is billable
Bill Monthly	Indicates if the Account Class is billable if it will bill monthly or "standard".
Days to Cycle Stmt	Enter the length of the Statement Billing Cycle for the Account Class
Bill Finance Charges	Indicates if the Account Class permits the calculation of Finance Charges

Standard Billing

Any time there is activity that changes the amount of money at the self-pay level, the account will bill. This includes patient payments, insurance payments causing balances to drop to the self-pay level, etc. If there is no activity on the account, the account will re-bill in thirty days.

Monthly Billing

Once an account has billed for the first time, new account activity will not affect the billing. The account will re-bill every thirty days.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.2.2   Account Types

Account Types can be added to accounts and can be used as a sort or break on MedSuite Reports.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.2.3   Employers

Practice Maintenance allows the system to be configured so that, when entering Demographics, the user can use the Employer Lookup, enter an Employer Name/Description, or both. If the user intends on using the Employer Lookup, the Employers must be predefined.

Lookup	Lookup value
Name	Employer name
Address	Address consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code
	The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Prov/Country	A province and/or foreign country may be entered if needed.
Phone	Main telephone number.
Fax	Fax telephone number
Other	Other telephone number
Contact	Primary contact name
Default Plan	Plan to use as a default in demographics when this employer is the patient's employer
Default Group	Group Number to use as a default in demographics when this employer is the patient's employer
E-Mail	E-Mail address

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

❧ Date Changed - The date the change was made to the file.
❧ User Name - The name of the user that made the change.
❧ Item Changed - The file name of the item that was changed.
❧ Old Value - The system value before the change was made.
❧ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.2.4   Relationships

Relationships are reported on claims to insurance carriers. The HCFA 1500 form contains a block that is used to indicate the patient's relationship to the subscriber. The "Process Type" in the relationship indicates which of the relationship types are indicated.

Lookup	Lookup value assigned
Name	Description

Process Type   Indicates if the relationship is Self, Spouse, Child, or Other

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3   Financial

The Financial sub-menu of the Setup menu provides access to all of the functions that are Financial in nature. These functions include:

Function	Global	Description
Agencies		Define collection agencies
Billing Messages	Y	Billing messages that may be tied to an account
Charge Card Type	Y	Charge Card Types may be defined. These are used in Payment Entry.
Facilities		Facility in which services may be performed. These are used in Visits
Facility Types	Y	HCFA (CMS) Facility Type (Hospital, Ambulatory Surgical Center, etc.)
Facility Groups		Group of Facilities, often a local hospital network used for reporting
Locations		Place of Service within a Facility. Tied to the HCFA (CMS) Place of Service (Inpatient Hospital, Outpatient Hospital, etc.)
Localities	Y	Medicare Locality for Pricing and Provider IDs
Service Places	Y	HCFA (CMS) Place of Service (Inpatient Hospital, Outpatient Hospital, etc.)
Payment Type	Y	Payment Codes tied to Plans and used to post Payment Distributions.
Adjustment Type	Y	Adjustment Codes tied to Plans and used to post Payment Distributions.
Payment Reason	Y	Reason code entered in Payment Distributions indicating why payment was denied or payment was different than expected.
Payment Exception Type	Y	Groups Payment Reasons into higher level categories such as coverage problems, data problems, etc.

6.3.1   Agencies

An account in collections may have an affiliated collection agency.

Lookup	Lookup value
Name	Agency name
Address	Address consisting of:

- Street Address
- Street Address (Add'l)
- City
- State
- Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Prov/Country	A province and/or foreign country may be entered if needed.
Phone	Main telephone number.
Fax	Fax telephone number
Other	Other telephone number
Contact	Primary contact name
E-Mail	E-Mail address

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3.2   Billing Messages

An account may be configured with a special Billing Message to be printed on statements for the account

Lookup	Lookup value
Message	Text of message. Up to four lines of 60-characters of text per line may be entered, for a total of 240 characters.

Library Change Logs

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- ᪄ Item Changed - The file name of the item that was changed.
- ᪄ Old Value - The system value before the change was made.
- ᪄ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3.3   Charge Card Type

Charge Card Types may be entered in Payment Entry.

> Description   Description of Charge Card Type

6.3.4   Facilities

The facility in which a service is performed is entered in Visit entry. A facility also contains locations (places of service) and O/R Suites. The facility name and place of service is reported on claims. The Facility, Location, and O/R Suite are also user for reporting purposes.

FACILITY TAB

> Lookup   Lookup value
> Locality   Medicare Locality for Facility.
>
> **Locality is either unused or required based on the Locality "switch" in Practice Setup - Default Tab.**
> Facility Type   HCFA (CMS) facility type
> Facility Group   Hospital "chain"; used for reporting purposes

Facility Information

> Name   Facility name
> Address   Address consisting of:
> - Street Address
> - Street Address (Add'l)
> - City
> - State
> - Postal Code
>
> The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
> Prov/Country   A province and/or foreign country may be entered if needed.
> Phone   Main telephone number.

Fax	Fax telephone number
Other	Other telephone number
Contact	Primary contact name
E-Mail	E-Mail address

Details

State Lic No	State License Number
Tax ID No	Tax ID number of the referral provider's practice
UPIN	Universal Provider Identification Number
NPID	National Provider Identifier number
User-Defined	Up to four (4) user-defined fields may be defined on the practice for use at the facility level

O/R UTILIZATION TAB

Override Facility Working Hours and Holidays	Indicates if on the O/R Utilization Report that this Facilities' Working Hours and Holidays override those of the report screen. Some Facilities have different working hours than other or than the practice "default".
Working Hours	Enter the From and Thru Working Hours for the Facility for each day of the week.
Holidays	Enter the dates of up to fourteen Holidays

IMAGING TAB

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

- Patient - Images indexed to the patient (Action = Patient)
- Visits - Images indexed to visits (Action = Visit-New)
- Payments - Images indexed to visits (Action = Payment Insurance -
  New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
  entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print   Prints the displayed image

Un-Index   Displays the [Move Images to Imaging Station](#) screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.

                                          In effect, the image is placed in an Imaging Station in a "ready to be processed" state.

                                          Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

Library Change Logs

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NOTE: Items not tracked are description fields such as degrees and titles.

6.3.5 Facility Type

The Facility Type file is Global and categorizes the type of Facility. These are descriptions for reporting purposes such as Ambulatory Surgical Center, Hospice, Hospital, Office, Skilled Nursing Facility etc...

6.3.6 Facility Group

This is an optional field for grouping facilities.

6.3.7 Locations

The location or place of service in which a service is performed is entered in Visit entry. The place of service is reported on claims. The Location is also user for reporting purposes.

Lookup	Lookup value
Facility	Facility that the Location is in

Location Information

Name	Location name
Address	Address consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code
	The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Prov/Country	A province and/or foreign country may be entered if needed.
Phone	Main telephone number.
Fax	Fax telephone number
Other	Other telephone number
Contact	Primary contact name
E-Mail	E-Mail address

Details

State Lic No	State License Number
Tax ID No	Tax ID number of the referral provider's practice
UPIN	Universal Provider Identification Number
NPID	National Provider Identifier number
Service Place	Lookup to the Service Place

HPSA Indicator

HPSA Area   Indicates location is in a HPSA area. This will cause the HPSA Modifier
                         on the Plan - Claims Tab to be reported on charges.

Visit Defaults

Hospital Dates   Indicates how or if Hospitalization Dates on the Visit - HCFA Tab are
                         managed by MedSuite. Values are:
                         Do Not Default
                             The user is responsible for entering the hospitalization dates or
                             they are not necessary for the Location

                         Default from Begin and End Service Dates
                             The Hospitalization Dates will default from the oldest begin
                             service date and newest ending service date on the Visit.

                         Default from the Patient
                             The Hospitalization Dates will default from the Hospitalization
                             Dates on the Patient - Additional Info Tab.

                         Do Not Default but Require Values
                             The Hospitalization Dates are required fields, but do not default
                             from anyplace in the software.

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☞ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3.8   Localites

The Medicare Locality that is used to Pricing overrides and Provider IDs

Lookup   Lookup value
Name   Name

6.3.9   Place of Service

Service Places are reported on claims based on the HCFA (CMS) defined service place assigned to the location in which the procedure was performed.

Lookup	Lookup value assigned
Code	Two-character code to be reported on the claim
UDF1-UDF4	User-Defined fields for reporting non-standard Places of Service on claims.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

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- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3.10   Type of Service

Service Types are reported on claims based on the HCFA (CMS) defined service type assigned to the procedure performed.

Lookup	Lookup value assigned
Code	Two-character code to be reported on the claim
UDF1-UDF4	User-Defined fields for reporting non-standard Types of Service on claims.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

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- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3.11   Payment Types

Payment Types are tied to Plans and used to post Payment Distributions.

Lookup	Lookup value assigned
Name	Description

Stmt Report As	Description to appear on patient statements for the payment type
Interest Clearing	Indicates that the Payment Type is for Interest. Interest Types can be included/excluded on the Payment Worksheet/Journal.
Remove from Collection	Indicates that a payment that is over the minimum payment amount with this Payment Type should remove all associated visits from Collection Turnover and reset the Collection Letter count. By default, all Payment Types have this field checked.

Library Change Logs

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- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3.12   Payment Exception Type

Payment Exception Types are used to categorize Payment Reason Codes for reporting on the Payment Exception Report.

6.3.13   Payment Reason

Payment Reasons are entered in Payment Distributions and indicate why a payment was denied or a payment amount was different than the expected amount.

Code	Payment Reason Code. May be the same code reported by HCFA (CMS) on EOBs
Lookup	Lookup value assigned
Name	Description

Reason Type

Paid	Payment Distributions with this reason on them were claims that were paid
Held	Payment Distributions with this reason on them were claims that were partially paid
Denied	Payment Distributions with this reason on them were claims that were denied

Send To

| Followup Manager | Payment Distributions with Reason flagged to go to the Followup Manager will be sent to the Followup Manager for resolution. |
| Exception Log | Payment Distributions with Reasons flagged as Exceptions may be printed on the Payment Exception Report. |

Type   Indicates the HCFA (CMS) Type of Exception. Values include appeals,
                              coverage problems, enrollment problems, etc.

Library Change Logs

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- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.3.14 Adjustment Types

Adjustment Types are tied to Plans and used to post Payment Distributions.

Lookup   Lookup value assigned
Name   Description
Stmt Report As   Description to appear on patient statements for the adjustment type
Write-Off Type   Category for reporting the adjustment type. Values are Contractual,
                              Discretionary, and Bad Debt.
Interest Clearing   Indicates that the Payment Type is for Interest. Interest Types can be
                              included/excluded on the Payment Worksheet/Journal.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.4   Followup

The Followup sub-menu of the Setup menu provides access to all of the setup functions that have to do with Followup. For the most part, these functions include setup criteria for the Followup Queue, but also include setup for Form Letters:

Function	Global	Description
Queue Definitions	N	Queue Definitions are used to define what is put into the Followup Queue.
Followup Actions	N	Followup Actions are performed on claims and accounts. A default timeframe is specified for the next action to take place.
Followup Action Classes	Y	Action Classes categorize the Action Codes for reporting purposes on the Followup Report. (Contacts, Demographics, etc.)
Followup Action Codes	Y	Action Codes categorize the Actions and specify if the system should perform some special function, such as calling the Followup Wizard or sending a Form Letter, when an Action is performed.
Form Letters	Y	Definition of Form Letters

6.4.1   Intro to Action Classes, Action Codes, & Actions

Action Classes are used to categorize Action Codes, which are used to categorize Actions.

Actions are performed on claims and accounts. A default timeframe is specified for the next action to take place. ACTIONS are practice-specific, because different practices may have different procedures regarding these timeframes.

Action CODES categorize the Actions and specify if the system should perform some special function, such as calling the Followup Wizard or sending a Form Letter when an Action is performed.

Action CLASSES categorize the CODES for reporting purposes only. Action CLASSES and CODES are set up globally and apply to all practices.

The Followup Report can break on and select on all three of these.

Let's look at some examples:
Action CLASSES are general, broad categories of actions, such as CONTACTS, PROMISES, CORRESPONDENCE, OTHER.

Action CODES are more specific. These might be LEFT MESSAGE, BUSY SIGNAL, CALLED & SPOKE, CONTACT, INS CONTACT, CLAIM FOLLOWUP, PT CORRESPONDENCE, INS CORRESPONDENCE.

The Actions themselves may be even more specific. Actions that fall under the PT CORRESPONDENCE CODE might be PT UCR LETTER, PT PAST DUE LETTER, PT PAY PLAN LETTER. Actions under the CLAIM FOLLOWUP CODE could be REFILE CLAIM, RESET BILLING SAME PLAN, RESET BILLING NEW PLAN.

6.4.2   Queue Definitions

Queue Definitions are used to define what is put into the Followup Queue. For example, at what point do Claims get sent to the Followup Queue, and what point do Accounts get sent to the Followup Queue? Different Queue Definitions may be created so that certain claims are added to the Queue at a certain timeframe, and others are added at other times. The Queues are built during the Closeout when that option is selected. New claims/accounts that meet the criteria will be added to the Queue so that users see them the next day. The queues can be updated nightly during the Closeout so that new accounts are added and paid claims/accounts are removed. Other practices may choose to only update the Queues weekly so that new claims/accounts are not added every day. This is up to the discretion of the practice.

Note that after adding a new queue definition, claims/accounts will not show in that Queue in the Followup Queue until after the CloseOut has been run and the option to Create Collection Followup has been selected.

Followup Queue Definitions are defined by Queue Type, either Self (for Account followup) or Insurance (for Claims followup).

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
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- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.

–   New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.4.2.1   Self Queue Type Criteria

Followup Queue Definitions are defined by Queue Type, either Self (for Account followup) or Insurance (for Claims followup).

Note: Leaving the Minimum and Maximum values empty for a field will ignore the field during the queue selection process. You may leave both fields blank, or you may enter a minimum or a maximum. If you enter a minimum and not a maximum the system will automatically assume the maximum amount. If you enter a maximum and not a minimum system will automatically assume the minimum amount. For example, if you enter a minimum age of 60 and no maximum, the system will assume the maximum is 9999.   If you enter a minimum last name of M, the system will assume the maximum is ZZZZZZ.

Account Type	Enter/Select Criteria for a specific Account Type to be selected for this queue. Leaving this blank will select all Account Types.
Account Class	Enter/Select Criteria for a specific Account Class to be selected for this queue. Leaving this blank will select all Account Classes.
Minimum Account No	Enter the minimum Account number to be selected for this queue.
Maximum Account No	Enter the maximum Account number to be selected for this queue.
Minimum Phone No	Enter the minimum Phone number to be selected for this queue.
Maximum Phone No	Enter the maximum Phone number to be selected for this queue.
Minimum SSN	Enter the minimum Social Security number to be selected for this queue.
Maximum SSN	Enter the maximum Social Security number to be selected for this queue.
Minimum Last Name	Enter the minimum Account Last name to be selected for this queue.
Maximum Last Name	Enter the maximum Account Last name to be selected for this queue.
Minimum Birth Date	Enter the minimum Birth Date to be selected for this queue.
Maximum Birth Date	Enter the maximum Birth Date to be selected for this queue.
Minimum Age (in Days)	Enter the minimum Age at which a Visit will be sent to Followup. This is the number of days since the first statement to the Account or since the last payment.
Maximum Age	Enter the maximum Age at which a Visit will be sent to Followup. This is the number of days since the first statement to the Account or since the last payment.
Minimum Amount	Enter the Minimum Balance Amount of the Accounts that will be selected.
Maximum Amount	Enter the Maximum Balance Amount of the Accounts that will be selected.
Broken Promises	Select whether this Queue should Include or Exclude accounts with a Broken Promise, or should ONLY include accounts with a Broken Promise.
Broken Payment Plans	Select whether this Queue should Include or Exclude accounts with Broken Payment Plans, or should ONLY include accounts with Broken Payment Plans.
Return Mail	Select whether this Queue should Include or Exclude accounts with

| Include Dunning 1, 2, 3, 4 | Return Mail, or should ONLY include accounts with Return Mail. Select what Dunning Levels should be selected for this queue. The system defaults to all dunning levels being selected. |

Additional Tabs are available adding DIVISION, FACILITY, and LOCATION selection criteria. If you wish to build separate Queues by Division, Facility, or Location, access the separate tabs to indicate which one(s) you would like to include or exclude. If you wish to include accounts for all divisions, all facilities, and all locations, leave these tabs blank.

SELF PAY BROKEN PROMISES & PAYMENT PLANS

You may need a separate Queue for monitoring promises and payment plans. If patients make partial payments and not the agreed-upon amounts of the promise or payment plan, you will need a place to monitor and followup on those accounts. A partial payment on an account with a Promise that is greater than the Minimum Payment amount will reset the aging on the account, even if it is not the amount that was promised. Therefore, it is possible that it may not show up in a Self Pay Queue if your queues are set up to only show delinquent accounts (with a minimum age of 45 or 60). In addition, if you use the Payment Plan amounts on the Account Billing tab to set up monthly payment plans, you may monitor those accounts via a separate Followup Queue.

To ensure that you see any accounts where the promise is broken because only a partial payment is made, or any accounts where they have failed to pay an amount equal to or greater than they Payment Plan amount on the Account Billing tab, create a Self Pay Queue with TWO SEPARATE CRITERIA. They will each have NO max or minimum age. In the first, specify Only Broken Promises and Include Broken Payment Plans.

Then, create another criteria with no max or minimum and specify Include Broken Promises and Only Broken Payment Plans.

The Queue Definition screen will display the two separate criteria for the Broken Promises and Broken Payment Plans. It is important to have two separate criteria because if you build just one that says "only" broken promises and "only" broken payment plans, you will get no accounts as they will exclude each other.

If you would like this Queue to display all the self pay broken promises and payment plans and you do NOT want to display self pay broken promises and payment plans in any OTHER self pay queues, specify that you want to EXCLUDE Broken Promises and Broken Payment Plans in the other queues so that the accounts do not show up in BOTH queues.

RETURN MAIL

You may wish to create a separate Queue for monitoring accounts flagged for Return Mail, to eliminate the need to run an Account Listing report for return mail. Do not enter any Minimum or Maximum Age, as the aging is reset when the account is flagged for Return Mail. Not specifying any age will ensure that all return mail accounts are pulled into the queue.

6.4.2.2   Insurance Queue Type Criteria

Followup Queue Definitions are defined by Queue Type, either Self (for Account followup) or Insurance (for Claims followup).

Note: Leaving the Minimum and Maximum values empty for a field will ignore the field during the queue selection process. You may leave both fields blank, or you may enter a minimum or a maximum. If you enter a minimum and not a maximum the system will automatically assume the maximum amount. If you enter a maximum and not a minimum system will automatically assume the minimum amount. For example, if you enter a minimum age of 60 and no maximum, the system will assume the maximum is 9999.   If you enter a minimum subscriber of M, the system will assume the maximum is ZZZZZ.

Plan Type	Enter/Select Criteria for a specific Plan Type to be selected for this queue. Leaving this blank will select all Plan Types.
Plan	Enter/Select Criteria for a specifc Plan to be selected for this queue. Leaving this blank will select all Plans.
Minimum Claim No	Enter the minimum Claim number to be selected for this queue.
Maximum Claim No	Enter the maximum Claim number to be selected for this queue.
Minimum Policy No	Enter the minimum Policy number to be selected for this queue.
Maximum Policy No	Enter the maximum Policy number to be selected for this queue.
Minimum Subscriber	Enter the minimum Subscriber Name to be selected for this queue.
Maximum Subscriber	Enter the maximum Subscriber Name to be selected for this queue.
Age Claims by Date	If selecting claims by Age, indicate whether they should be aged from the Submitted date or from the Refiled date.
Minimum Age (in Days)	Enter the minimum Age at which the claims will be selected for this queue. This will either be the number of days from the date the claim was submitted or the number of days from the refile date, depending on what was specified in the parameter above.
Maximum Age	Enter the maximum Age at which the claims will be selected for this queue. This will either be the number of days from the date the claim was submitted or the number of days from the refile date, depending on what was specified in the parameter above.
Minimum Amount	Enter the Minimum Claim Amount of the claims to be sent to this queue.
Maximum Amount	Enter the Maximum Claim Amount of the claims to be sent to this queue.
Medigap Claims	Indicate whether Medigap claims should be Included or Excluded. The default is that they be Included.
Paper/Electronic	Indicate whether All claims should be included, or whether just Paper claims should be selected, just Electronic claims, or just Test claims.
Broken Promises	Select whether this Queue should Include or Exclude claims with a Broken Promise, or should ONLY include claims with Broken Promises.
Held Claims	Select whether this Queue should Include or Exclude claims with a HELD status, or should ONLY include Held claims.
Disputed Claims	Select whether this Queue should Include or Exclude Held claims with a DISPUTED status, or should ONLY include Disputed claims. If you wish to Include or Only Disputed, you must Include Held Claims, since Disputed claims are always held claims (although all held claims are not disputed claims). You cannot Exclude Held claims and Include Disputed claims.
Payment Reason	Select whether this Queue should Include or Exclude Held claims with a Payment Reason code on them, or should ONLY include Held claims with Payment Reasons. If you wish to Include or select Only claims

with Payment Reasons, you must Include Held Claims. You cannot Exclude Held claims and Include Payment Reason claims.

Level — Select what Claim Levels should be included in this queue - primary, secondary, tertiary. The system defaults to all claim levels being selected.

Additional Tabs are available adding DIVISION, FACILITY, LOCATION, PROVIDER, and SURGEON selection criteria. If you wish to build separate Queues by Division, Facility, Location, Provider, or Surgeon, access the separate tabs to indicate which one(s) you would like to include or exclude. If you wish to include accounts for all divisions, all facilities, all locations, all providers, and all surgeons leave these tabs blank.

When defining insurance queue criteria, a Plan Type or a Plan may be specified and is suggested. If you decide to build queues by Plan Type or Plan, you will need to be sure that queue criteria are created for each and every plan or plan type that needs to be seen in the Followup Queue. Because multiple criteria can be specified when creating a Queue it does make it easier in that you do not need a Queue for every plan or plan type. However, you will need to make sure that there is a *criteria* for each plan or plan type that goes into a Queue. For example, you could create one Queue that includes COMM, WC, and Champus claims in it. You just need to make sure that other Queues cover all the other remaining plan types that exist. Remember that if you ever add a new plan type in your practice, then you will also need to update your Followup Queue Definitions so that new plan type is included in the Followup and not overlooked.

SUGGESTION:
In order to ensure that claims do not "fall through the cracks" because of a Plan Type inadvertently not having been created that will catch those claims, you might want to set up a "catch all" queue for very delinquent claims that can be used as a spot check. For example, it could be set up to catch all claims over 120 days that are still open. Another "spot check" that could be used is the Claim Delinquency Report run periodically for very delinquent claims to ensure that these claims are being worked.

6.4.3   Followup Actions

ollowup Actions are performed on claims and accounts. A default timeframe is specified for the next action to take place. Actions are set up by practice in order to allow one practice to be managed differently than another by having a different number of followup days for certain actions in certain practices, if a billing company has different arrangements with different clients in regard to how claims/ accounts are worked.

Lookup — Enter a description of the Action
Action Code — Enter/Select Action Code to which this Action should be linked
Followup Type — Enter/Select the type of followup that the Action will be used in:
- Single Followup - This action may only be performed on one claim/account at a time, such as Left Message for Pt, Spoke w/ Pt, Promise by Pt.
- Batch Followup - This action may only be performed on multiple claims/accounts.
- Single and Batch Followup - This action may be performed either on a single claim/account, or on multiple claims/accounts at the same time. Possible examples may be Refiling Claims, Add to Turnover, Sending Letters.

Advance Followup Date By

Advance Followup Date By is used to specify how far the Followup Date of a claim/account should advance so that it is again displayed in the Queue. This, of course, assumes that it still meets the queue criteria. For example, if a Refile Claim action advances the Followup Date by 14 days, the claim will be redisplayed in the Queue in 2 weeks if it still meets the criteria that adds claims to the Queue (i.e. if it is still delinquent and has not been paid). If the claim no longer meets the criteria (i.e. if it is paid) then it will NOT be displayed in 14 days. The default Period Type is Days; you may specify the number of days before the claim/account should be displayed. Other period types are minutes, hours, weeks, and months.

Note that this is merely a *default*. Users may override the date and time at the time they use an action on a claim/account. However, there are some edits on how they may override the default. A user may override the date to any date sooner than the default, but they are limited on how far into the future they can override the default. The default override edits depend on the Period Type.

Period Type: Days, Hours or Minutes
Override of default may be up to twice the Period or 5 Periods whichever is greater. For example if the followup period is 5 days, the Override limit will be 10 days which is twice the period but greater than 5 days. If the period is 2 days, the overide limit will be 5 days which greater than twice the period of 2 days.

If the Period is left blank or is zero, the Override limit will be 5 Periods.

Period Type: Weeks or Months
Override of default may be up to twice the Period. For example if the followup period is 3 weeks, the Override limit will be 6 weeks which is twice the period.

If the Period is left blank or is zero, the Override limit will be 1 Period.

Period   Enter the number of periods that the date will be advanced by...
Period Type   Enter/Select the period type: (the default is Days)
- Minutes
- Hours
- Days
- Weeks
- Months

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.4.4   Followup Action Classes

Action Classes categorize the Action Codes for reporting purposes on the Followup Report. Action Classes are set up globally and apply to all practices

To set up the Action Classes, go to Setup, Followup, then Followup Action Classes. Select NEW and enter the name of the Class.

6.4.5   Followup Action Codes

Action Codes categorize the Actions and specify if the system should perform some special function, such as calling the Followup Wizard or sending a Form Letter, when an Action is performed. The Followup Action Codes are global.

Lookup	Enter a description for the .Followup Action Code
Action Class	Enter/Select Action Class to which this Action Code should belong.
Process	The Process is used to specify how the system responds when an action with this action code is taken. In other words, it specifies how the system will respond when an Action Code with a certain Process is selected. A drop-down list displays the different Process options:

- Collection - Turnover - This will cause the system to prompt the user for a new Acct Class to go onto the account, and it is then added to the Collection Turnover. The new account class entered at that time will be the one that the account will be changed to when it is turned over to collection.
- Correspondence- This will cause the system to prompt the user for the Form Letter that is to be sent. The form letter will be mail merged during the next Closeout (assuming that option is selected during the Closeout).
- Followup Wizard - This will invoke the Followup Wizard where the user will then proceed to take further steps, such as resetting the insurance, requesting a statement, refiling a claim, etc.
- Promise - This will cause the system to prompt the user for the amount that has been promised. The system will then monitor that account for the payment. If the amount promised is not received by the date specified, it will incur a "broken" status. The amount promised is used on accounts only, not claims.
- Other - No additional special processing is done by the system. Only a next followup date is set. This would be used for action codes such as LM, Busy Signals, Called & Spoke.

Library Change Logs

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❖ User Name - The name of the user that made the change.
❖ Item Changed - The file name of the item that was changed.
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NOTE: Items not tracked are description fields such as degrees and titles.

6.4.6   Form Letters

Form Letter Setup allows the user to define documents or letters that have been previously created in the built-in Word Processor as documents that a "mail merge" can be performed on.

Lookup	Lookup value
Name	Name / Description of the Letter
Document	Click on the elipsis (...) button and select a document from the built-in Word Processor.
Addressee	Indicates who or what entity the addressee for the letter is. This allows a single document with a generic "addressee" to be sent to patients, accounts, subscribers, physicians, etc.

Library Change Logs

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❖ User Name - The name of the user that made the change.
❖ Item Changed - The file name of the item that was changed.
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❖ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.5   Imaging Workflow

MedSuite's Imaging Workflow module supports two major features. The first feature is the ability to create an electronic workflow that accurately reflects the way in which a paper workflow might progress from task to task to complete a procedure. For example, in an anesthesia billing office, some documents like a Hospital Face Sheet are data input, indexed, and closed in a single step, while others such as a Charge Ticket can go to coding, data input, batch verification and balancing, and then are closed. The Workflow feature of Imaging is based on Imaging Stations and Image Types. Imaging Stations are setup in a way that scanned documents of specific types (e.g. a Face Sheet) can be routed to specific stations, have tasks performed on them, and then route them to the next appropriate station until the process is complete.

The second major feature is to provide ability to "index" a scanned document to some data. Indexing generally refers to linking either specific documents (by Document ID) or batches of documents (by some other criteria) to some recognizable search data in an automated manner. The whole purpose behind scanning documents is to make retrieval both possible and easier than searching for the paper document in a storage facility. If a practice or billing company would like to retrieve a scanned document at some point in the future, then Indexing the document to some recognizable search data is crucial - whether that data represents a Patient, an Account, a Visit, a Payment, or some other entity such as a Plan, a Fee Schedule, or a Staff Member.

Setup Imaging Stations
Define Imaging Types

NOTE: Users responsible for setup and maintenance of Imaging in MedSuite must be granted access to the Imaging Stations and Imaging Types dictionaries. Navigate to the Setup - System Administration - Users - User Groups menu option and select the Dictionary tab.

6.5.1   Imaging Station

Imaging Stations define the various points that a user may interface with a scanned image. One or more of these points make up a Workflow. We are trying to replace a paper flow through an office with an Image Workflow. As a result, the same points in the office where paper "stops" to be processed will likely be Imaging Stations. For example, a paper charge document such as an Anesthesia Record follows a number of steps through the office. First it is reviewed for completeness and compliance issues. It is then sent to coding. It is then sent to charge input for input, verification, and concurrency processing. Finally it is filed for permanent storage. A scanned image will also follow a similar path. However, the scanned image's path will be an electronic path.

Imaging Stations can be defined with an Action that will occur when the Action button is pressed in the Image Workflow window. The Action performed at the Image Station for Coding could be to forward the image to the Charge Entry station once coding has been completed. The Action performed at the Image Station for Charge Entry could be to find and add the Visit associated with the image and then Index the image to that Visit.

To setup or maintain Imaging Stations:

1. Navigate to the **Setup - Imaging - Imaging Station** menu.
2. Enter a Lookup.
3. Select an Action. If the Action is Move to Another Station, enter a value for the Imaging Station.
4. Select whether or not to Show in Imaging on the Station Tab.

To modify station, highlight it and select **Edit**. To delete a station, highlight it and select **Delete.** The

fields and their functions are as follows:

Lookup	Enter a description of the Imaging Station
Action	Select the activity that will occur when the user selects the **Action** button in the Image Workflow window:

- **Patient** - Opens the Patient Search window where you can search for an existing patient or add a new one. The image is then indexed to that Patient record.
- **Visit-New** - Opens the New Visit function and then indexes the image to the Visit record
- **Visit-Open** - Opens an existing visit and indexes the image to the visit
- **Payment EOB - New -** Opens the Bulk Insurance Payment window to allow entry of a new bulk check. The image is then indexed to the bulk payment and allows selections from the image to be indexed to individual payments on the bulk payment.
- **Payment Insurance-New** - Creates a new Insurance Payment and indexes the image to the payment
- **Payment Insurance-Open** - Opens an existing Insurance Payment and indexes the image to the payment
- **Payment Self-New** - Creates a new Self Payment and indexes the image to the payment
- **Payment Self-Open** - Opens an existing Self Payment and indexes the image to the payment
- **Payment Select-New** - Allows you to select the type of payment to be used for the image – Bulk, Insurance, or Self.
- **Claim-Followup Wizard** - Opens the Claim Search window and then the Followup Claim Wizard. The image can then be indexed to a claim.
- **Move to Another Station** - Move the Image to another station in the workflow, i.e. from the Coding station to the Charge station.
- **No Action** - No system initiated action will occur. This is useful for images that will be Indexed directly to a patient, physician, plan, etc.

Imaging Station	The station to which a image will be sent when the Imaging Station **Action** (above) is **Move to Another Station**.
Show in Imaging on the Station Tab	Selecting this option will allow users to see and work in the station while on the **Imaging - Station** tab. If it is not selected, the station will not appear in the station lookup list, however you can still select the station as criteria on the **Imaging - Search** tab.
Annotation	Annotations are system defined fields that can be added to a particular image or group of images (images that have been **Merged**.) Some Annotations have a specific function within MedSuite and are intended to facilitate data entry and your efficiency within the system by populating fields in Visit entry or Payment entry from data entered in an Imaging station. Click here for a detailed description of the available Annotation Types.

Library Change Logs

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∩ Item Changed - The file name of the item that was changed.
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∩ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.5.1.1 Imaging Annotation Types

Annotations are system defined fields that can be added to a particular image or group of images (images that have been **Merged**.) Some Annotations have a specific function within MedSuite and are intended to facilitate data entry and your efficiency within the system by populating fields in Visit entry or Payment entry from data entered in an Imaging station.

To add an Annotation Type to a station:

1. Select **New**.
2. Enter a **Caption** for the annotation. This is the label that will be displayed next to the field in Imaging. As an example, you might enter "Patient Phone #" as the caption for the Annotation Type of Phone.
3. Enter an **Annotation Type**. See the table below for a detailed description of the Annotation Types and their significance in the system.
4. Select **Show in Grid** if you would like this annotation field to be displayed in the Grid of the Station Tab in Imaging. This option can be useful because it enables you to tell at a glance what has been entered as an annotation for each image from the Station tab view as opposed to having to open the Image and then the Annotations on the Image tab.
5. Select **OK** to save your entry or **Cancel** to exit without saving.

You can change the order in which the annotations will appear within the station by highlighting the annotation and selecting **Up** or **Down** respectively. To modify an annotation, highlight it and select **Edit**. To remove an annotation from the station, highlight it and select **Delete**. The fields and their functions are as follows:

Auto - Patient	The Auto-Patient annotation will allow a user to open the patient lookup window, search and then select the patient they wish to associate with the image. If the selected Action within that station is Visit - New, then the Patient information will be automatically populated in Visit Entry. *Note: This should only be used on Charge images when going to Visit Entry. It is not intended for use on Payments, which should utilize the Account holder (Guarantor) and not the Patient.*
Checkbox	The Checkbox annotation allows a user to enter a value of True if selected or False if not selected.
Currency	The Currency annotation allows a user to enter a properly formatted dollar amount, e.g. $999.99.
Date	The Date annotation will allow the user to enter a properly formatted date, e.g. dd/mm/yyyy

Insurance Verification The Insurance Verification annotation is a checkbox that allows a user to enter a value of True if selected or False if not selected.

Payment - Remit Date The Payment - Remit Date annotation allows a user to enter a properly formatted date value. If the selected Action within that station is any of the Payment Entry options, then the Remit Date will be automatically populated in Payment Entry. You may only add 1 Remit Date per Imaging Station.

Payment - Document Number The Payment - Document Number annotation allows a user to enter a numeric value. If the selected Action within that station is any of the Payment Entry options, then the Document Number will be automatically populated in Payment Entry. You may only add 1 Document Number per Imaging Station.

Payment - Method The Payment - Method annotation allows a user to select a value of Cash, Check or Charge. If the selected Action within that station is any of the Payment Entry options, then the Payment - Method will be automatically populated in Payment Entry. You may only add 1 Payment - Method per Imaging Station.

Phone The Phone annotation will allow the user to enter a properly formatted phone number, e.g. (999) 999-9999.

Text The Text annotation will allow the user to enter free-form alphanumeric text on the image.

Time The Time annotation allows the user to enter a properly formatted value for hours and minutes, e.g. 13:00.

Visit - Diagnosis The Visit - Diagnosis annotation allows the user to access the Diagnosis Code lookup window, select a code and add it to an image. If the selected Action within that station is Visit - New, then the Diagnosis information will be automatically populated in Visit Entry. You may add up to 4 Diagnosis codes per Imaging Station.

Visit - Facility/Location The Visit - Facility/Location annotation allows the user to access the lookup windows for Facility and Location, select the appropriate values and add them to the image. If the selected Action within that station is Visit - New, then the Facility/Location information will be automatically populated in Visit Entry. If you enter a value for Facility, you are required to enter a value for Location. Only 1 Facility/Location annotation may be added per Imaging Station.

Visit - Procedure Charge The Visit - Procedure Charge annotation allows the user to access the Procedure Code lookup window, select a procedure and add it to an image. If the selected Action within that station is Visit - New, then the Procedure Charge information will be automatically populated in Visit Entry. You may add up to 20 Procedure Charge annotations per station, however, only a total of 20 procedures will be added during Visit Entry. Each Procedure Charge, Procedure/ASA and Quick Pick annotation counts against the 20 total limit.

Visit - Procedure Secondary	The Visit - Procedure Secondary annotation allows the user to access the Procedure Code lookup window, select a procedure and add it to an image. The Secondary Surgical Procedure is used when the procedure is to be billed and is not informational (not "floated"). An example would be Labor Epidural/C-section cases. If the selected Action within that station is Visit - New, then the Secondary Procedure information will automatically be populated in Visit Entry. The user will still be prompted to enter case times for this procedure before saving the visit. Only 1 Procedure Secondary annotation may be added per Imaging Station.
Visit - Procedure/ASA	The Visit - Procedure/ASA annotation allows the user to access the Procedure Code and ASA lookup windows, select the appropriate values and add them to the image. If you enter a value for Procedure, ASA becomes a required field. These codes should only be used for anesthesia cases. If the selected Action within that station is Visit - New, then the Procedure/ASA information will be automatically populated in Visit Entry. The system will "float" the Procedure/ASA with the highest Base Unit Value to the "top" to be billed, and the other Procedure/ASAs will not be billed. You may add up to 5 Procedure/ASA codes per Imaging Station, however, only a total of 20 procedures will be added during Visit Entry. Each Procedure Charge, Procedure/ASA and Quick Pick annotation counts against the 20 total limit.
Visit - Quick Pick	The Visit - Quick Pick annotation allows the user to access the Quick Pick lookup window and select from the codes that have been set-up for Practices that use Visit Types of Anesthesia or Blank. If the selected Action within that station is Visit - New, then the Quick Pick information will be automatically populated in Visit Entry. Only 1 Quick Pick annotation may be added per Imaging Station. Although the user may enter multiple Quick Picks in Imaging, only a total of 20 procedures will be added during Visit Entry. Each Procedure Charge, Procedure/ASA and Quick Pick annotation counts against the 20 total limit.
Visit - Service Date	The Visit - Service Date annotation allows the user to enter a Date of Service and add it to an image. If the selected Action within that station is Visit - New, then the Service Date information will be automatically populated in Visit Entry. You may only add 1 Service Date annotation per Imaging Station.
Visit - Visit Type	The Visit Type annotation allows a user to access the Visit Type lookup, select a value and add it to an image. If the selected Action within that station is Visit - New, then the Visit Type information will be automatically populated in Visit Entry. You may only add 1 Visit Type annotation per Imaging Station.

6.5.2   Imaging Type

Imaging Types define the various types of documents that a practice may wish to scan. Imaging Types generally refer to a specific type of document that will be indexed using a specific function in MedSuite. Examples include Hospital Face Sheets, Charge Tickets, Anesthesia Records, EOBs, etc.

There is generally a one-to-one relationship between an image and the item (patient, visit, payment, etc.) that indexes the image. For example, each Hospital Face Sheet or Admitting Record represents a Patient that will be added to MedSuite. In some cases, however, multiple images will be represented by a single index. A good example of this is a practice that has both an Anesthesia Record and a Charge Ticket for a single anesthesia case. If both of these items are sent to the same station, the Visit will be added along with and indexed to the first image. The second image will need to be indexed to the same Visit as the first image. We will see how this actually works in the MedSuite Imaging window.

To add an Imaging Type:

1. Navigate to the **Setup - Imaging Type** menu.
2. Select **New**.
3. Enter a **Lookup name, Initial Imaging Station, Default Description, Default Brightness** and **Default Threshold**.
4. Select **OK** to save or **Cancel** to exit without saving.

To modify an annotation, highlight it and select **Edit**. To remove an annotation from the station, highlight it and select **Delete.** The fields and their functions are as follows:

Lookup	Enter a name for the Image Type type that makes sense to you, that will represent the type of document, such as Hospital Face Sheets, Charge Tickets, Anesthesia Records, EOBs, etc.
Initial Imaging Station	If the Imaging Type is to be attached to a Station, enter/select the Station in which these images should be placed when they are scanned. For example, Hospital Face Sheets might go to a Demographic Station, and EOB's might go to a Payment Entry Station.
Default Description	Enter the first portion of the description assigned to the image documents. MedSuite will append a sequential number after the description. For example, Hospital Demographics can be called DEMO and then MedSuite will assign 00001, 00002, etc to create unique document ID's DEMO00001, DEMO00002, etc..
Default Brightness	If certain images are typically scanned from a poor quality original such as the yellow copy of a carbon-less form, MedSuite can, by default, brighten those images to make them more legible. A higher number will brighten the image. You might want to leave this set at the default to begin with and see how the images scan, and adjust later if needed.
Default Threshold	MedSuite scans in black and white. The resolution (horizontal and vertical dots per inch) of a scanner dictates how many dots-per-inch an image is made up of. In black and white mode, each dot is "seen" as either white or black. Changing the threshold to a higher value will darken the "black" of an image. You might want to leave this set at the default to begin with and see how the images scan, and adjust later if needed.

Library Change Logs

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NOTE: Items not tracked are description fields such as degrees and titles.

6.5.3 Imaging - Display as Separate Window

The main image workflow form can either be embedded within MedSuite like any other screen, or it may be "broken-out" into its own separate window. Breaking this window out into a separate window allows the user to view the image and the associated input screen (demographics, visits, etc) simultaneously.

The ability to break this form out into a separate window is controlled by a menu option on the Imaging Setup Menu called "Display Imaging as Separate Window." This option is set for each user log-in individually.

6.6   Insurance

The Insurance sub-menu of the Setup menu provides access to all of the functions that are Insurance in nature. These functions include:

Function	Global	Description
Carriers	Y	Maintain insurance carriers
Carrier Types	Y	Maintain carrier types (Medicare, etc.) for reporting purposes
Plans		Maintain insurance plans
Plan Types	Y	Maintain plan types (Medicare, etc.) for reporting purposes
Fee Schedules		Maintain Fee Schedules which are tied to plans
Rate Structures		Maintain Rate Structures which are tied to plans
Networks		Maintain Pricing (HMO, PPO, etc) Networks which are tied to plans and used for reporting purposes
Network Types	Y	Maintain Network Types (HMO, PPO, etc) which is used for reporting purposes
Contacts		Maintain Contacts (people) for plans, employers, etc.
Contact Types	Y	Maintain Contact Types (Eligibility, HR, etc) for contacts which is used for reporting purposes
Contract Types	Y	Maintain Contract Types (Managed Care, etc.) which is used for reporting purposes
Claim Editing Indicator	Y	HCFA (CMS) Claim Edit Indicator for electronic claims
Claim Payment Source	Y	HCFA (CMS) Claim Payment Source for electronic claims
Payer Type	Y	Payer Type (Medicare, Medicaid, etc.) for claim control
Claim Formats		Paper Claim Formats
EMC Claim Formats		Electronic claim format and control information for the practice
EMC Claim Formats - Plan		Electronic claim format and control information for specific plans

6.6.1   Carriers

The carrier table is designed to hold all medical insurance carriers in the United States. The carrier is used as a default address for plans and is used as a reporting control break.

CARRIER TAB

Lookup	Lookup value
Carrier Name	Legal Carrier Name
Additional Name	Additional "doing business as" name
Carrier Type	Carrier type such as Commercial, Medicare, Medicaid, etc.

Address Information

Name	Facility name
Address	Address **(frequently a PO Box)** consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Country	A foreign country may be entered if needed.
Street Address	**Street** Address consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Prov/Country	A province and/or foreign country may be entered if needed.
Phone	Main telephone number.
Fax	Fax telephone number
Phone Other	Other telephone number

Setup Information

Is Generic - Demo Dowwnload (Use Hospital Info)	This used in Demo Downloads when the PLAN IS ALSO GENERIC to indicate if MedSuite should use the name and address from the hospital or the name and address from the carrier table in the patient policy (insurance demographics).
	If the flag is "OFF" (un-checked), the download will use the carrier name on the carrier file in MedSuite. If it is "ON" (checked), then the download will use the carrier name from the hospital.
Self Insured	Indicates if the carrier is self-insured
3rd Party Admin	Tax ID number of the referral provider's practice
Medigap	Universal Provider Identification Number
HMO	Nation Payer Identifier
Workers Comp	Up to four (4) user-defined fields may be defined on the practice for use at the facility level
HCPCS	
Prior Authorization	Indicates if the carrier requires service to be pre authorized
Medical Claims	
Electronic Claims	Indicates if the carrier supports electronic claims
EMC No	Electronic claims number assigned to the carrier

Setup Information

E-Mail	Carrier email address
Home Page	URL of carrier's home web page
Link Page	URL or carrier's private web page from practices and physicians
Login	Login to Link Page
Password	Password for Link Page

Electronic Claims

NAIC No	NAIC number assigned to the carrier
PerSe Code	PerSe number assigned to the carrier
Max Items	Maximum number of line items that may be sent in a single claim via electronic claims
Other EMC Code	This field is only used if you are using a 3rd party vendor not Per-se. Leave blank if using Per-se as your clearinghouse.
Emdeon No	Insurance payer code for Emdeon Clearing house claim submission.
Eligibility Emdeon Code	Insurance payer code for Emdeon Clearing house Eligibility request.

IMAGING TAB

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch

- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

- Patient - Images indexed to the patient (Action = Patient)
- Visits - Images indexed to visits (Action = Visit-New)
- Payments - Images indexed to visits (Action = Payment Insurance -
     New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
     entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image

Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.
	In effect, the image is placed in an Imaging Station in a "ready to be processed" state.
	Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

Library Change Logs

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6.6.2   Carrier Types

Carrier Types define groups of Carriers that are used for reporting purposes on the MedSuite Reports.

6.6.3   Plans

Plans control virtually every aspect of MedSuite. In fact, plans control so much of the fee calculation, claim filing, and payment determination features of MedSuite, that without plans, MedSuite would be a virtually useless product. If you understand how plans work you will understand how MedSuite works. Plans control:

- Where claims are filed
- How claims are filed
- When claims are filed
- Billed fee schedules
- Allowed (contracted) fee schedules
- Special payment posting logic

MedSuite approaches Plan Setup with the idea of maximizing flexibility and reporting capabilities while at the same time minimizing the number of plans that need to be maintained. We make this approach by utilizing the concept of the "generic" plan. Conceptually, a "carrier" can be both at a "higher-level" than a plan and at a "lower-level" than a plan. A practice usually has contracts with a number of carriers for one or more plans offered by those carriers. In addition, some plans that the practice has no contracts for are widely purchased and many patients will have plans for these "high-volume" carriers. For example, a practice may have contracts with Blue Shield for their Blue Shield HMO, Blue Shield PPO, and Blue Shiled 80/20 Plans. Let's assume that all of these plans "report" to a single Blue Shield Carrier.

On the other hand, many patients have insurance that is realtively seldom seen and for which the practice has no contractual agreement. These plans may comprise dozens if not hundreds of different carriers. Having to maintain a separate plan for each one of these carriers is an onerous proposition. MedSuite uses "generic" plans to bill these "low-volume carriers". A generic plan is simply a single plan that supports all of the fee schedules, rate structures, and billing control information to be used for the low-volume carriers.

How are multiple carriers bill through this single plan? Quite simply, the specific carrier for a patient is selected from the MedSuite carrier table while entering the insurance demographics. For example, you can add a plan called "Commercial Insurance". For each patient that is entered that has "low-volume" plan, select the "Commercial Insurance" plan when entering the insurance information for the patient. Then select the carrier specific to that patient. Using this method, you can have a single plan called "Commercial Insurance" billing for carriers such as Globe Life, Lumberman's Life, Steam Fitters Local 1234, etc.

The Blue Shield example above illustrates the concept of multiple plans billed under a single carrier. The "Commercial Insurance" example illustrates the concept of multiple carriers billed under a single plan. How then does this affect carrier reporting? Patients with a carrier in their insurance demographic information ("low-volume" carriers) would report the carrier from the insurance demographic information. Patients without a carrier in their insurance demographic information ("high-volume" carriers) would report the carrier associated with the plan in their insurance demographic information.

Plan maintenance is performed via a tabbed dialog made up of six (6) tabs:

General
Details

[Claims](#)
[HCFA](#)
[HCFA-Medigap](#)
[ERA](#)
[Pricing](#)
[Anesthesia](#)
[ASA Overrides](#)

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.3.1   General

The Plan Maintenance - General tab maintains basic name and address information about a plan.

Plan is Generic	Indicates if the plan is a "generic" plan that is used for low volume plans where a contract is not in place. When a generic plan is entered in demographics, the user should select the specific carrier so that electronic claims may be sent for the plan.
Lookup	Lookup value
Name	Description
Plan Type	Type of Plan (Medicare, Medicaid, etc.)
Carrier	Carrier name for the plan. Used for reporting purposes.

Claim Filing Office - HCFA

Same as Carrier	Indicates that the plan address is the same as the carrier and there is no need to replicate it here.
Name	Plan name for address purposes
Address	Address consisting of: • Street Address • Street Address (Add'l) • City • State • Postal Code The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Country	A foreign country may be entered if needed.
Phone	Main telephone number.
Fax	Fax telephone number
Phone Other	Other telephone number

Claim Review Office - HCFA

Same As Carrier	Indicates that the plan address for claim reviews is the same as the carrier and there is no need to replicate it here.
Name	Plan name for address purposes
Address	Address consisting of: • Street Address • Street Address (Add'l) • City • State • Postal Code The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone

numbers if the Area Code is defined in Postal Code Maintenance.

Country	A foreign country may be entered if needed.
Phone	Main telephone number.
Fax	Fax telephone number
Phone Other	Other telephone number

Policy Number Edit Mask

Policy Mask	Mask that is used to enforce policy number structure rules such as number of characters, which characters are alphabetic, alphanumeric, numeric, etc.
Examples Button	Displays examples of how masks may be used
Default Policy Number to Patient Social Security No	If you would like the Policy Numbers for this Plan to default in Demographic Entry to the Patient's Social Security Number, select this option. This is useful on payors such as Medicare that utilize the SS# as part of the Policy Number. For payors that do not utilize the SS# as part of the Policy Number, it is more helpful to leave this option unchecked so that the Policy Number is blank, instead of being defaulted to the SS#.
Require Group Number	Indicates if the group number will be a required field for this plan in Demographic Entry.
Require Group Name	Indicates if the group name will be required will be a required field for this planin Demographic Entry.
Electronic Pre-pend	The contents of this field will be added to the beginning of the policy number on claims sent electronically for the Plan.

Contact

(Blank)	Enter/Select the Contact Name
Phone	The Contact Phone is displayed
Address	The Contact Address Line 1 is displayed

User Defined Fields

If these user-defined fields are set up, they will appear in the Demographics - Insurance tab with the field tag or label defined here.

UDF 1 - UDF 4	User-defined fields 1-4
Req	Indicates if the associated UDF will be a required input field in insurance demogaphics

Miscellaneous

Display Unspecified Diagnosis Warning	Indicates whether unspecified diagnoses (as indiicated by the Unspecified flag being set on the Diagnosis Setup) will display a warning message in Visit Entry indicating that the payer may not pay claims with unspecified diagnoses.

6.6.3.2   Details

The Plan Maintenance - Details tab maintains contract, network, payment and other control information about a plan. The information maintained about payment and adjustment calculations allows the user to predefine payment and adjustment types and calculation options so that payment entry will be easier and more controllable by the manager with less information left up to the user.

Account Class	When adding a New Patient, the Account Class specified on the patient's Primary Insurance Plan will default into the patient's account class. This will override the default account class from the Practice Defaults Tab. If the patient's account class is overridden by the user, the Plan Account Class will not be loaded.
Report As	The plan description displayed on patient statements

Claims Options

Report Full Charge on Primary Insurance Claim	Indicates that the full charge should be reported on claims
Report Allowed Charge on Primary Insurance Claim	Indicates that the allowed charge should be reported on claims, usually as the result of performing the write-off on Charge Entry

Network Details

Network Name	Enter/Select the Network Name. This is used for reporting purposes.
In-Network	Captures deductible and coinsurance information about in-network services including: • Individual Deductible • Family Deductible • Visit Co-pay • Coinsurance Percentage These values do not perform any special processing functions in MedSuite. However they may be used to verify that proper payment calculation has been made.
Out-of-Network	Captures deductible and coinsurance information about out-of-network services including: • Individual Deductible • Family Deductible • Visit Co-pay • Coinsurance Percentage These values do not perform any special processing functions in MedSuite. However they may be used to verify that proper payment calculation has been made.

Payment Distributions

Payment

Payment Type | Enter/select the payment type to be used for the plan
Approved | Enter/select how the approved is used on payments for the plan:

- Allowed Amount (Default to the allowed amount)
- Entered by the User
- Not Used

Deductible | Enter/select how the deductible and co-pays are used on payments for the plan:

- Entered by the User - If selected the system will **enable** the Co-pay fields in payment entry (Insurance & Bulk) screens but does not require the user to enter co-pay or deductible.
- Not Used - If selected the system will **disable** the Co-pay fields in the payment entry (Insurance & Bulk) screens.

Note: The Co-pay fields that are captured in Payment Entry are displayed in the Activity View of the Ledger. A true co-pay (patient payment) needs to be entered on the Visit or as a payment in Self Payment Entry. The Co-pay fields in Insurance and Bulk Payment Entry screens are only recorded in the Ledger for use in a follow-up situation. They are informational only.

Payment | Enter/select how the payment is calculated on payments for the plan:

- Entered by the User
- Calc = Approved - Deduct @ Pct
- Calc = Billed - Deduct @ Pct

Pct | Enter the percentage to apply to the payment calculation (above)

Primary Adjustment

Adj Type | Enter/select the primary adjustment type to be used for the plan
Calculation | Enter/select how the adjustment is calculated for the plan:

- Entered by the User
- Adjustment = Billed - Approved
- Adjustment = Billed - Allowed
- Adjustment = Billed - Paid
- Adjustment = Approved - Paid
- Not Used

Secondary Adjustment

Adj Type
Enter/select the secondary adjustment type to be used for the plan

Calculation
Enter/select how the adjustment is calculated for the plan:

- Entered by the User
- Adjustment = Allowed - Approved
- Not Used

Pre-Authorizations

Pre-Authorize Hospital-Based Services
Indicates that hospital-based services should be pre-authorized. If a visit occurs at a Location that has a Service Place that has a place of service code of 20, 21, 22, 23, 24, 25, 26, 27, 28, or 29, the system will require a Prior Authorization No. to be entered on the HCFA tab of the visit. If a user tries to save a visit with the authorization no., an error will be displayed, and the system will position the cursor on the Prior Autho No. field of the visit's HCFA tab.

Pre-Authorize Office-Based Services
Indicates that office-based services should be pre-authorized. If a visit occurs at a Location that has a Service Place that has a place of service code OTHER THAN 20, 21, 22, 23, 24, 25, 26, 27, 28, or 29, the system will require a Prior Authorization No. to be entered on the HCFA tab of the visit. If a user tries to save a visit with the authorization no., an error will be displayed, and the system will position the cursor on the Prior Autho No. field of the visit's HCFA tab.

Request Statement

Special Billing Message
The billing message that will appear on the informational statements requested for this plan. Optionally, if the Wait for Payment flag is not selected on the Claims tab, this billing message will appear on the account holder's first monthly statement in lieu of the first dunning message, unless a Special Billing Message is specified on the Account Billing tab, which will override the Special Billing Message on the Plan.

Request Informational Statement
Indicates that an informational statement will be sent to the account holder when a visit with this plan as primary insurance has been entered. This is used when the Wait for Payment flag is selected on the Claims tab. In that case, the account holder does not receive monthly statements until after the insurance has paid or denied, but a one-time Informational Statement may be requested to let them know that a claim has been filed as a courtesy.

6.6.3.3   Claims

The Plan Maintenance - Claims tab maintains claims control information about a plan.

Claim Breaks

A claim is made up of the charges on a visit and will never be made up of charges on more than one visit. However, in some circumstances, more that one claim may be generated from a single visit. A claim "break" will **always** occur for each combination of physician and facility on a visit. However, breaks for different diagnosis codes, different dates of service, and separate claims for anesthetists are not normally mode unless specifically asked for by the user:

Date of Service	Indicates if claims will break for each date of service within a Visit.
Anesthetist	Indicates if a separate claim will be created for the anesthetist.

Claim Control

Payer Type	Type of payor (Medicare, Medicaid, etc.) for controlling special claims logic.
Pmt Source	HCFA (CMS) Source of Payment for electronic claims
Editing Ind	HCFA (CMS) Claims Editing Indicator. Note - If this is a Medigap payor, both this field and the Plan Type field on the General Tab of the Plan Maintenance form must be set to Medicare or Medigap for electronic processing to function properly.

HPSA Modifier

HPSA Modifier	Enter/Select the Modifer to be billed for this plan for Health Provider Shortage Areas. The standard CMS Modifier is AQ.

Claim Audit Options

Enforce Group No Present	Checking this "On" will enforce an edit in the Claims Audit that will generate an error if the Provider's Group Number cannot be found.
Enforce Indiv No Present	Checking this "On" will enforce an edit in the Claims Audit that will generate an error if the Provider's Individual Number cannot be found.

Staff ID Qualifiers

Group No	Select the ANSI Claim qualifier to report on paper claims for combined Legacy/NPI mode
Indiv No	Select the ANSI Claim qualifier to report on paper claims for combined Legacy/NPI mode

Claims Control by Level

There are a number of fields that control how and when claims are to be filed and refiled. MedSuite

supports up to three levels of insurance on a patient. As a result, the claim control fields are repeated for each of the three levels; primary, secondary and tertiary. It should be understood that the fields in this section repeat for each of the applicable levels.

Valid for Level	Indicates that the plan is valid for the level. For example Medicare Supplement plans may be valid for secondary and tertiary insurance, but not appropriate for primary insurance.
Wait for Payment	Indicates if the billing cycle will bill this plan and wait at the level until the claim is paid or denied. If the plan does not wait for payment, the next level of insurance (or self if there is no next level of insurance) will be billed.

File Claims

File Claims	Indicates whether or not claims should be filed and if claims are filed, how they are handled based on the following fields.
Hold Days	Number of days after charge is posted to hold claims from being filed. May be overridden in Visit Entry. This applies only to Primary claims. Secondary and Tertiary claims are not Held.
Type	Indicates how claims are to be generated: • Paper • Electronic/Paper (Based on Carrier) • Test (Paper and Electronic) • Test (Electronic)
Paper Format	Paper claim format
EMC Format	Electronic Claims Format

Refile Claims

Refile Claims	Indicates whether or not claims should be refiled and if claims are refiled, how they are handled based on the following fields.
Refile After Days	Number of days after initial submission to refile claims
Force Refile to Paper	Indicates if system-generated refiles will be forced to paper or if they will be sent in the same manner as the original claim

6.6.3.4   HCFA

The Plan Maintenance - HCFA tab maintains claims printing information about a plan.

Box 1

HCFA Box 1	Indicates if which claim type will be selected on Box 1 of the HCFA-1500 form. Values are:

- Medicare
- Medicare
- CHAMPUS
- CHAMP/VA
- Group Health Plan
- FECA Black Lung
- Other

This is a required field.

Box 4

Blank on Level 1	Indicates if Box4 should be blank on the primary claim when this plan is primary.
Special Msg When Patient is the Subscriber	Indicates if a special message is to be used in Box 4 when this plan is primary on the primary claim and the patient is the subscriber.
Special Box 4 Msg	The special message to appear in Box 4 when the this plan is primary on the primary claim. Allowable values are:

- SAME

Box 7

Blank on Level 1	Indicates if Box7 should be blank on the primary claim when this plan is primary.
Special Msg When Patient is the Subscriber	Indicates if a special message is to be used in Box 7 when this plan is primary on the primary claim and the patient is the subscriber.
Special Box 7 Msg	The special message to appear in Box 7 when the this plan is primary on the primary claim. Allowable values are:

- SAME

Box 9

Special Msg When Patient is the Subscriber	Indicates if a special message is to be used in Box 9 when this plan is primary on the primary claim and the patient is the subscriber.
Special Box 9 Msg	The special message to appear in Box 9 when the this plan is primary

on the primary claim. Allowable values are:
- SAME
- SELF

Level 1   Indicates which insurance information will appear in Box 9 on claims for this plan when this plan is primary. Allowable values are:
- Blank
- Previous Level of Insurance
- Current Level of Insurance
- Next Level of Insurance

Level 2   Indicates which insurance information will appear in Box 9 on claims for this plan when this plan is secondary. Allowable values are:
- Blank
- Previous Level of Insurance
- Current Level of Insurance
- Next Level of Insurance

Level 3   Indicates which insurance information will appear in Box 9 on claims for this plan when this plan is tertiary. Allowable values are:
- Blank
- Previous Level of Insurance
- Current Level of Insurance
- Next Level of Insurance

Box 10 (Condition Related To)

Not Applicable   Indicates if, for this plan, the software should default the "Condition Related To" to "Not Applicable".

Related to Employment   Indicates if, for this plan, the software should default the "Condition Related To" to "Related to Employment".

Related to Auto Accident   Indicates if, for this plan, the software should default the "Condition Related To" to "Related to Auto Accident".

Box 11

Print   Indicates what should print in Box 11 on the HCFA-1500 form. Allowable values are:
- Policy Number
- Group Number

Level 1   Indicates which insurance information will appear in Box 11 on claims for this plan when this plan is primary. Allowable values are:
- Blank
- Previous Level of Insurance
- Current Level of Insurance
- Next Level of Insurance

Level 2   Indicates which insurance information will appear in Box 11 on claims for
                            this plan when this plan is secondary. Allowable values are:
                            • Blank
                            • Previous Level of Insurance
                            • Current Level of Insurance
                            • Next Level of Insurance

Level 3   Indicates which insurance information will appear in Box 11 on claims for
                            this plan when this plan is tertiary. Allowable values are:
                            • Blank
                            • Previous Level of Insurance
                            • Current Level of Insurance
                            • Next Level of Insurance

Box 17

Source   Indicates what should print in Box 17 on the HCFA-1500 form. Allowable
                            values are:
                            • Referring
                            • PCP

17A   Indicates what should print in Box 17a on the HCFA-1500 form. Leaving
                            this field EMPTY will default the UPIN # into Box 17a on the claim form.
                            Other allowable values are:
                            • Blank - Will leave Box 17a on the HCFA form BLANK
                            • UPIN - Print the Referring or PCP UPIN
                            • UDF1 - Print the Referring or PCP User-Defined Field 1
                            • UDF2 - Print the Referring or PCP User-Defined Field 2
                            • UDF3 - Print the Referring or PCP User-Defined Field 3
                            • UDF4 - Print the Referring or PCP User-Defined Field 4
                            .

Detail Items

HCFA Box 24d   Indicates what coding system should be printed in Box 24D.
                            • CPT
                            • ASA
                            • HCPCS
                            • OTHER
                            This is a required field.

HCFA Box 24g   Indicates what the default value to be used in the claim detail units
                            should be. This value may be overridden for a specific procedure in the
                            Procedure Setup, or by the Fee Schedule for a specific procedure.

                            • Quantity
                            • Minutes
                            • Total Units
                            • Base Units

- Time Units
- All Units Except Base Units

This is a required field.

Anes Text   Indicates what procedure code value should print in the Anesthesia Text block on the HCFA-1500 form. Allowable values are:

- CPT
- ASA
- HCPCS
- OTHER

Claim Totals

"SEE EOB" in Boxes 28 and 30   Indicates that the literals "SEE" and "EOB" should be printed in Boxes 28 and 30 respectively on the HCFA-1500 form for secondary and tertiary insurance claims.

Claim Totals in Boxes 28 and 30   Indicates that the claim totals should be printed in Boxes 28 and 30 respectively on the HCFA-1500 form for secondary and tertiary insurance claims.

Page Totals

Page Totals on each Page   Indicates that a claim total for each page of the claim should be printed in the totals boxes on the claim.

CONT'D w/ Totals on last Page   Indicates that the literal "CONT'D" should be printed for each page of the claim other than the last page and the claim totals should be printed in the totals boxes on the last page of the claim.

6.6.3.5 HCFA-Medigap

The Plan Maintenance - HCFA Medigap tab maintains Medigap claims control information about a plan.

Medigap No   Medigap number assigned by Medicare to this plan/carrier

Fields to Blank

Box 9a	Indicates if Box 9a should be blank on Medigap Claims for this plan.
Box 9b	Indicates if Box 9b should be blank on Medigap Claims for this plan.
Box 9c	Indicates if Box 9c should be blank on Medigap Claims for this plan.
Box 9d	Indicates if Box 9d should be blank on Medigap Claims for this plan.
Box 10d	Indicates if Box 10d should be blank on Medigap Claims for this plan.
Box 11	Indicates if Box 11 should be blank on Medigap Claims for this plan.
Box 11a	Indicates if Box 11a should be blank on Medigap Claims for this plan.
Box 11b	Indicates if Box 11b should be blank on Medigap Claims for this plan.
Box 11c	Indicates if Box 11c should be blank on Medigap Claims for this plan.
Box 11d	Indicates if Box 11d should be blank on Medigap Claims for this plan.

Medigap Message 1

Prefix	Literal prefix to print in first Medigap field. This may be anything defined by the carrier, but is frequently "MG" or "MEDIGAP".
Option	First Optional part of the first Medigap field. Allowable values are: - Blank - Policy Number - Medigap Number
Option	Second Optional part of the first Medigap field. Allowable values are: - Blank - Plan Name
Suffix	Literal suffix to print in first Medigap field. This may be anything defined by the carrier.
Show Message 1 In	Indicates where Medigap Message 1 should print on the HCFA-1500 form. Allowable values are: - Box 9 - Box 9a - Box 9c - Box 9d - Box 10d - Do Not Show

Medigap Message 2

Prefix	Literal prefix to print in second Medigap field. This may be anything

defined by the carrier, but is frequently "MG" or "MEDIGAP".

Option	First Optional part of the second Medigap field. Allowable values are: • Blank • Policy Number • Medigap Number
Option	Second Optional part of the second Medigap field. Allowable values are: • Blank • Plan Name
Suffix	Literal suffix to print in second Medigap field. This may be anything defined by the carrier.
Show Message 2 In	Indicates where Medigap Message 2 should print on the HCFA-1500 form. Allowable values are: • Box 9 • Box 9a • Box 9c • Box 9d • Box 10d • Do Not Show

6.6.3.6 ERA

The Plan Maintenance - ERA tab allows you to control how certain ERA (electronic Remittance Advice) functions will be handled.

Modifier to Ignore in the ERA File

Modifier 1	ERAs are posted against charges by matching Date of Service, Procedure Code, Modifier(s), and Charge Amounts. Certain carriers are inserting a modifier on certain charges within their own processing system and returning that modifier in the ERA.
	Enter the modifier to ignore in the ERA so that payments can be matched against charges.
	Currently, this is only the AA Modifier for Cigna.

Late Filing

Adj Type	If a claim is filed late to Medicare, there may be a fee for filing late. The fee is deducted from the payment but is not the patient's responsibility. In order to get the ERA to "balance" between payment to the provider, contractual write-offs, and patient responsibility, the late filing fee is returned as an adjustment on the ERA.
	Enter / Select the adjustment type that represents the adjustment for Late Filing Fees on a claim.

Adjustments

Post Adjs from ERAs for this Plan (Primary Level)	Indicates if adjustments in the ERA File(s) should be taken on primary claims.
Post Adjs from ERAs for this Plan (Other Levels)	Indicates if adjustments in the ERA File(s) should be taken on non-primary claims.
Post Timely Filing Adjustment (AMT*KH)	Indicates if a timely filing adjustment reported as AMT*KH should be posted. Some payers are reporting the timely filing adjustment in multiple places in the ANSI File and the ERA processing was taking the adjustments multiple times.
	Do not set this unless instructed to do so by MedSuite Support.
Calc Approved from Adjust if not Reported as AMT*B6	Indicates the approved amount should be determined by subtracting the adjustment from the billed amount of if the approved amount is reported in the ERA.
	The posting rules (below) are generally based on the approved amount. As a result unreported approved amounts could be seen as a denial by

the ERA program. This feature handles this issue.

Do not set this unless instructed to do so by MedSuite Support.

Posting Rules

Under-Payments

Underpayments fall into the following categories:
1.   Approved equals Allowed, but Payment is Zero (Zero Payment)
2.   Approved is less than the Allowed (or Expected) by
       a.   A percentage
       b   A dollar amount
3.   Approved equals zero (Denials)

When one of these conditions occurs, MedSuite can be configured to take an action:

1.   Post the Payment
2.   Post the Payment, but give a Warning
3.   Do not Post the Payment and put a Message on the Error Report

Zero Payment

Action	Action to Take on a Zero Payment • Blank (Do Nothing) • Do not Post and Report an Error • Post • Post and Report a Warning
Status	Status to set on the Payment when a Zero Payment occurs: • Blank (Deniedl) • Paid - Mark as Paid • Held - Hold Claim Open • Denied - Mark as Denied

When the Approved is Less than the Allowed by a Percentage

Percent	Percent difference considered "less than"
Action	Action to Take on a when "Less Than" • Blank (Do Nothing) • Do not Post and Report an Error • Post • Post and Report a Warning
Status	Status to set on the Payment when "Less Than" occurs: • Blank (Paid) • Paid - Mark as Paid • Held - Hold Claim Open

• Denied - Mark as Denied

When the Approved is Less than the Allowed by an Amount

Amount | Amount difference considered "less than"

Action | Action to Take on a when "Less Than"
- Blank (Do Nothing)
- Do not Post and Report an Error
- Post
- Post and Report a Warning

Status | Status to set on the Payment when "Less Than" occurs:
- Blank (Paid)
- Paid - Mark as Paid
- Held - Hold Claim Open
- Denied - Mark as Denied

When the Approved is Zero and the Payment is Zero (Denials)

Action | Action to Take on a Denial
- Blank (Do Nothing)
- Do not Post and Report an Error
- Post
- Post and Report a Warning

Status | Status to set on the Payment when a Denial occurs:
- Blank (Deniedl)
- Paid - Mark as Paid
- Held - Hold Claim Open
- Denied - Mark as Denied

**Note - these rules only apply to level one Claims.

Special Procedure Rules

Sometimes, charges are billed to carriers that are not expected to be paid. This is often due to a desire to bill all carriers in the same way while acknowledging that the contract often vary. For example, some practices bill the Extreme Age Modifier (99100) to Medicare which does not pay for Extreme Age. The Special Procedure Rules allow the practice to accept and post these denials while not accepting other denials (above).

Procedure | Enter / Select a procedure for which denial will be accepted.
Post Denial | Indicates if the Denial will be Posted

6.6.3.7   Pricing

The Plan Maintenance - Pricing tab maintains information about <u>fee schedules</u> and <u>rate structures</u> for a plan. The fee schedules and rate structures may be different for billed fees and rates and allowed fees and rates. As a result, this tab contains a tabbed dialog for Billed and Allowed. Since the information for billed and allowed fees and rates is the same, it is only documented one time and not repeated. Typically for contraced payors, on the Billed Tab a Fee Schedule and a Rate Structure are selected to be used to calculate Billed Amounts. On the Allowed Tab, an allowed Fee Schedule and allowed Rate Structure are selected to be used to calculate Allowed Amounts.

Fee Schedule

A list of Fee Schedules by effective and expiration date is maintained. If a plan has different fee schedules by staff member, facility, or a combination of staff and facility, add each necessary combination with the appropriate fee schedule. You **do not** need to add fee schedules for staff, facility, or staff and facility **unless** there are different fee schedules.

Effective Date	Effective date of the fee schedule. This will be the SERVICE DATE that this fee schedule becomes effective.
Expiration Date	Expiration date of the fee schedule. This will be the SERVICE DATE that this fee schedule expires.
Division	Division to vary fee schedule by if needed. Leave blank if all divisions use the same fees.
Locality	Locality to vary fee schedule by if needed. Leave blank if Localities are not used or if all Localities use the same fees.
Facility	Facility to vary fee schedule by if needed. Leave blank if all Facilities use the same fees.
Staff	Staff member to vary fee schedule by if needed. Leave blank if all staff use the same fees.
Fee Schedule	Fee Schedule to be used for the plan.

The use of Division, Locality, Facility and Staff are "weighted" from least specific (Division) to most specific (Staff). The weights are cumulative when used in combination. For example, a combination of Division and Locality will override an entry with Staff only.

Fee Schedule Buttons

New	Add a new Fee Schedule to the plan
Edit	Change a Fee Schedule on the plan
Delete	Delete a Fee Schedule from the plan

Rate Structure

A rate structure is a set of rates per unit to be used for the calculation of anesthesia charges. A list of Rate Structures by effective and expiration date is maintained. If a plan has different rate structure by division, add each division with the appropriate rate structure. You **do not** need to add rate structures for every division **unless** there are different rate structures.

Effective Date	Effective date of the rate structure. This will be the SERVICE DATE that this rate structure becomes effective.
Expiration Date	Expiration date of the rate structure. This will be the SERVICE DATE that this rate structure becomes effective.
Division	Division to vary rate structure by if needed. Leave blank if all divisions use the same rate.
Locality	Locality to vary rate structure by if needed. Leave blank if Localities are not used or if all Localities use the same rate.
Facility	Facility to vary rate structure by if needed. Leave blank if all Facilities use the same rate.
Rate Structure	Rate Structure to be used for the plan.
Anesthesia Time Preference	The Anesthesia Time Preference that is used for the plan. This should be filled in for the anesthesia time calculations to perform correctly.

The use of Division, Locality and Facility are "weighted" from least specific (Division) to most specific (Facility). The weights are cumulative when used in combination. For example, a combination of Division and Locality will override an entry with Facility only.

Rate Structure Buttons

New	Add a new Rate Structure to the plan
Edit	Change a Rate Structure on the plan
Delete	Delete a Rate Structure from the plan

6.6.3.8   Anesthesia

The Plan Maintenance - Anesthesia tab maintains information about anesthesia billing and modifiers.

Miscellaneous

Billed Anes Preference	Enter/Select the anesthesia preference to be used for the plan on the "billing side". Anesthesia Preferences define how Extreme Age, Emergency Conditions, and Physical Status are handled, so this is a required field for all plans.
Allowed Anes Preference	Enter/Select the anesthesia preference to be used for the plan on the "allowed side". Anesthesia Preferences define how Extreme Age, Emergency Conditions, and Physical Status are handled, so this is a required field for all plans.
MAC Anesthesia Type	Enter/Select the anesthesia type representing Monitored Anesthesia Care (MAC).
MAC Modifier	Enter/Select the modifier to be used for Monitored Anesthesia Care (MAC) if this payor requires a special modifer on MAC cases. An example is Medicare, which requires a QS modifier on these cases.
non-MAC Modifier	Enter/Select the modifier to be used for non-MAC services (if any). This modifier should be entered only if there is an anesthesia modifier that is used on ALL anesthesia services. Medical Direction modifiers should be entered into the Medical Direction table.
Report Modifiers on all Claim Levels	Select this option if Medical Direction Modifiers for this plan should be used on all levels of claims for this plan (primary, secondary, and tertiary). If this option is selected, this plan's modifiers will override the primary plan's modifiers when this plan is secondary or tertiary. If this option is NOT selected, then the primary plan's modifiers will print on claims for this plan when it is secondary or tertiary. The only exception is when this option is NOT selected on a Medicare plan; when Medicare is secondary it will use an AA modifier. If the option is selected and Medicare is secondary, it will use the correct modifier.
Special Med-Cal Narrative Overrides	Indicates the the plan is a Medi-Cal (CA Medicaid) plan and that special processing of the charge narrative will take place to meet Medi-Cal billing requirements.
Special Med-Cal Unit/ Modifier Overrides	Indicates the the plan is a Medi-Cal (CA Medicaid) plan and that special modifiers and unit overrides will take place in the Charge Calculation to meet Medi-Cal billing requirements
Delegated Services on Z-Force Nurse Alone	Indicates that the plan is a BCBS TN plan nad that special handling of MDs and CRNAs is required to meet the delegated services requirements of BCBS TN.

Anesthesia Medical Directions

This grid is used to specify what modifiers should be used on this plan for different medical directions. If the payor does not require any medical direction modifiers (such as a Commercial plan) there would be nothing set up in this grid. For a payor such as Medicare, the different medical directions (1, 2, 3, etc.) and corresponding modifiers (AA, QK, QX) are defined here.

Medical Direction	Medical Direction
Nurse Billable	Indicates if nurse charges are billable for the medical direction. Nurse

charges are billable based on this indicator and the billing indicator(s) in
<u>Staff Maintenance</u>

Mod1	First modifier to bill for physician for the medical direction
Mod2	Second modifier to bill for physician for the medical direction
Nurse Mod1	First modifier to bill for anesthetists for the medical direction
Nurse Mod2	Second modifier to bill for anesthetists for the medical direction
Res Mod1	First modifier to bill for residents for the medical direction
Res Mod2	Second modifier to bill for residents for the medical direction

Anesthesia Medical Direction Buttons

New	Add a new Anesthesia Medical Direction to the plan
Edit	Change a Anesthesia Medical Direction on the plan
Delete	Delete a Anesthesia Medical Direction from the plan

6.6.3.9   ASA Overrides

The Plan Maintenance - ASA Overrides tab maintains information about ASA Overrides for a plan. This feature allows the user to override ASA base unit and to set time and minute maximums by ASA Code and plan. These overrides may vary by billed and allowed and as a result, this tab contains a tabbed dialog for Billed and Allowed. Since the information for billed and allowed fees and rates is the same, it is only documented one time and not repeated.

Override Matrix

Minimum Base Units	Enter a minimum base unit value if you want all procedures billed or allowed with a minimum value.

A list of Overrides by effective and expiration date is maintained.

Effective Date	Effective date of the ASA override
Expiration Date	Expiration date of the ASA override
ASA	ASA Code to be overridden
Procedure	Procedure to be overridden. This is only used in conjunction with the ASA so that a CPT/ASA combination may be overridden.
Anesthesia Units	Number of units to override with
Max Units	Used to indicate that an ASA has a maximum number of time units that may be billed
Max Minutes	Used to indicate that an ASA has a maximum number of minutes that may be billed
Min Fee	Indicates that an ASA has a minimum fee that can be billed
Max Fee	Indicates that an ASA has a maximum fee that can be billed.

If the minimum fee and the maximum fee are the same the ASA will, in effect, be billed like a Flat Fee, but it will be billed with Anesthesia Units. A true "Flat Fee" from the Fee Schedule skips the anesthesia unit calculation entirely.

Override Matrix Buttons

New	Add a new Override to the plan
Edit	Change a Override on the plan
Delete	Delete a Override from the plan

6.6.3.10 Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images
to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual
Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions
of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

	• Patient - Images indexed to the patient (Action = Patient)
	• Visits - Images indexed to visits (Action = Visit-New)
	• Payments - Images indexed to visits (Action = Payment Insurance -
	  New or Payment Self - New)
	• Claims - Images indexed to claims (Action = Claim Followup)
	• Miscellaneous - Images indexed via Manual Indexing to some other
	  entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image. In effect, the image is placed in an Imaging Station in a "ready to be processed" state. Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

6.6.4   Plan Types

Plan Types define groups of Plans that are used for reporting purposes on the MedSuite Reports.
Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.5   Copy Plans

This Utility program allows the user to copy one or all plans from one practice to another or the same practice. The options available in this utility are as follows:

Option...	Where...	What...
Copy All Plans	From One Practice to Another	What is Copied?
		Plan - General Tab
		Plan - Details Tab
		Plan - Claims Tab
		The EMC Format "points" to an EMC Format Plan in the "From" practice. The new Plan in the "To" practice cannot be permitted to "point" to the EMC Format Plan from a different practice, so the EMC Format cannot be copied.
		Plan - HCFA Tab
		Plan - HCFA Medigap Tab
		Plan - ERA Tab
		Plan - Anesthesia Tab
		The Anesthesia Preference is "replicated" into the "To" practice using the same names and values as the "From" practice.
		Plan - ASA Overrides Tab
		What isn't Copied?
		Plan - Pricing Tab
		The Plan Fee Schedule and Plan Rates "point" to a Fee Schedule and Rate Structure in the "From" practice. The new Plan in the "To" practice cannot be permitted to "point" to the Fees and Rates from a different practice, so the Fees and Rates cannot be copied.
Copy All Plans	Within the Same Practice	This capability is not supported as it would have the effect of "doubling" all of the plans

		in a Practice.	
Copy One Plan	From One Practice to Another	What is copied?	
		Plan - General Tab	
		Plan - Details Tab	
		Plan - Claims Tab	
			The EMC Format "points" to an EMC Format Plan in the "From" practice. The new Plan in the "To" practice cannot be permitted to "point" to the EMC Format Plan from a different practice, so the EMC Format cannot be copied.
		Plan - HCFA Tab	
		Plan - HCFA Medigap Tab	
		Plan - ERA Tab	
		Plan - Anesthesia Tab	
		Plan - ASA Overrides Tab	
			The Anesthesia Preference is "replicated" into the "To" practice using the same names and values as the "From" practice.
		What isn't Copied?	
		Plan - Pricing Tab	
			The Plan Fee Schedule and Plan Rates "point" to a Fee Schedule and Rate Structure in the "From" practice. The new Plan in the "To" practice cannot be permitted to "point" to the Fees and Rates from a different practice, so the Fees and Rates cannot be copied.
Copy One Plan	Within the Same Practice	What is Copied?	
		Plan - General Tab	
		Plan - Details Tab	
		Plan - Claims Tab	
		Plan - HCFA Tab	
		Plan - HCFA Medigap Tab	
		Plan - ERA Tab	
		Plan - Pricing Tab	
			Since the "From" and "To" practices are the same, the Plan Fee Schedule and Plan Rates "point" to a the same Fee Schedule and Rate Structure in the "To" Plan as the "From" Plan. There is no "pointing" problem with the Pricing information.
		Plan - Anesthesia Tab	
		Plan - ASA Override Tab	

Copy Plan From

Practice	Enter/Select the Practice to Copy the Plan(s) from
Copy All Plans	The "radio-button" indicates whether all plan should be copied.
Copy One Plan	The "radio-button" indicates that one plan should be copied. Enter/Select the Plan to be copied in the unlabeled field.

Copy Plan To

| Practice | Enter/Select the Practice to Copy the Plan(s) to |
| Name | Enter the Name that the selected plan will be copied to. |

6.6.6   PQRI

Physician Quality Reporting Initiative (PQRI) formerly known as "Pay for Performance" is a CMS (Medicare) program that provides financial incentives for certain provider actions. While MedSuite can accommodate any procedure codes for PQRI measures, the following measures have been created to facilitate billing and reporting.

Measure Number	Description
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol
193	Perioperative Temperature

Access

Access to PQRI setup is secured. Administrators have access by default however other users can be granted permissions via the User Groups section of the application. Select the group you wish to grant access to and then select **Edit**. Select the **Dictionary** tab and then select **PQRI**.

Configuring PQRI in MedSuite

PQRI setup is Practice specific, not global, therefore this setup must be completed for each Practice that is participating in PQRI reporting. Perform the following activities to set up PQRI in MedSuite:

Add the desired plans to each measure.
Set up the procedures.
Set up the plans.
Refresh the Dictionary Cache to make the changes visible to all users. If users are currently entering visits, they will need to refresh their local Dictionary Cache as well.

6.6.6.1   Modify a PQRI Measure

PQRI setup is Practice specific, not Global, therefore setup must be completed for each Practice that is participating in PQRI reporting. To access the PQRI maintenance screen, select **Setup**, **Insurance**, and the **PQRI** menu item. Select a measure and then **Edit** to modify the plans associated with it.
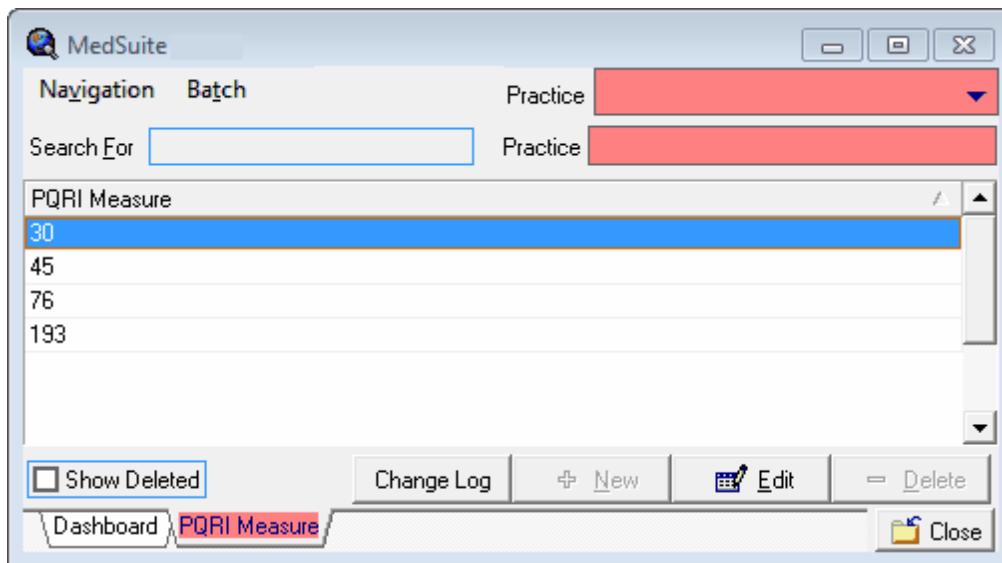
In the example below, all the Plans listed will bill PQRI measure #30 on the claims. MedSuite has set default **Effective** and **Expiration** Dates. The **Doctor Only** flag is not checked, as this is a measure that applies to both the MD and CRNA (i.e. the codes are billed for both the MD and CRNA in a care-team scenario). The **Capture this PQRI for all plans** option will track a PQRI measure for all plans during Visit Entry, but will not bill on a claim to any plan unless it is included in the **Report PQRI to these Plans** list.
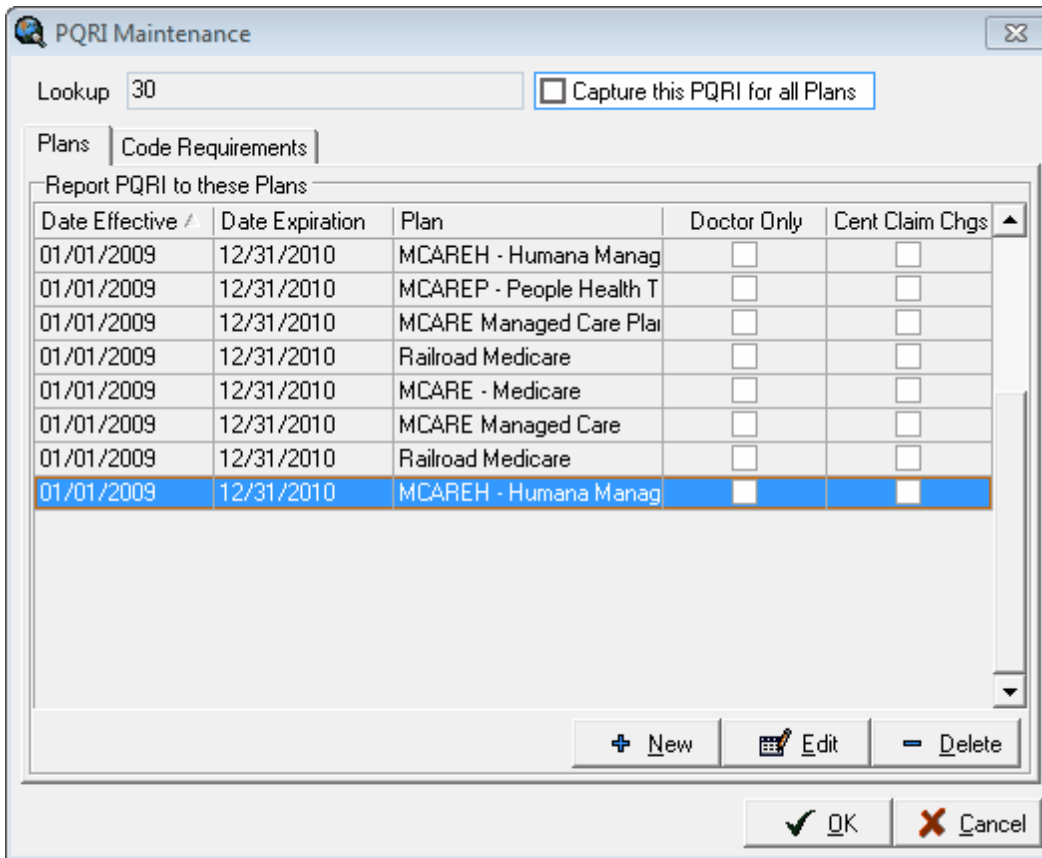
Select **New** to add a Plan to the measure. Select **Edit** to modify the Plan's Dates or Doctor Only billing. Select **Delete** to remove a Plan from the measure. Select the **Code Requirements** tab to display the eligible procedures or ASA codes associated with the measure. Once the codes have been added here, users will be prompted to select PQRI measures when entering visit information.

PQRI Maintenance

Lookup 193   ☐ Capture this PQRI for all Plans

Plans | Code Requirements

Perform PQRI when these Codes are present on a Visit

Code Type	Code	Description
ASA	00100	00100-ANESTH, Salivary Glands
ASA	00102	00102-ANESTH, Repair of Cleft
ASA	00103	00103-ANESTH, Blepharoplasty
ASA	00104	00104-ANESTH for Electroshock
ASA	00120	00120-ANESTHESIA for Ear Surge
ASA	00124	00124-ANESTHESIA for Ear Exam
ASA	00126	00126-ANESTH, Tympanotomy
ASA	00140	00140-ANESTH, Procedures on Ey
ASA	00142	00142-ANESTHESIA for Lens Surg
ASA	00144	00144-ANESTH, Corneal Transpla
ASA	00145	00145-ANESTH, Vitrectomy
ASA	00147	00147-ANESTH, Iridectomy
ASA	00148	00148-ANESTHESIA for Eye Exam
ASA	00160	00160-ANESTH, Nose, Sinus Surg
ASA	00162	00162-ANESTH, Nose, Sinus Surg

✓ OK   ✗ Cancel

6.6.6.2 Procedure Set Up for PQRI

To report on and bill for PQRI measures, there must be procedures associated with the measures. Select **Setup**, **Procedures/Diagnosis**, **Procedure Codes** to display the **Procedure Lookup** screen. Use the Search function to find existing procedures, New to create a procedure, Edit to modify an existing procedure and **Delete** to remove a procedure from the system.

In the example, although 4048F can be added only once, and the system will apply the 1P and 8P modifiers when necessary, it is recommended that a procedure code be created for each one to allow reporting by procedure only as opposed to procedure and modifier. The **Bill Zero $ Charge** indicates if the procedure should be billed in the event the charge amount is zero. This overrides the option on the Practice Setup – Claims Tab to suppress zero dollar charges. It is a CMS requirement to bill a zero dollar charge.

Note - Some claims clearinghouses will reject zero dollar charges. In that case, CMS will permit billing of $0.01.

6.6.6.3 Plan Set Up for PQRI

In order to post zero payments received in ERA files from Medicare without error, the PQRI Procedure codes must be added to the **Special Procedure Rules** on the **ERA** tab of the Plan Maintenance.

1. Select **Set Up**, **Insurance**, then **Plans**.
2. Select the plan you wish to modify, then **Edit**.
3. Select the **ERA** tab and then **Special Procedure Rules**.

Select **New** to add a Procedure and **Edit** to make modifications to a Procedure.

6.6.7   Fee Schedules

Fee Schedule Maintenance consists of a list grid along with a form that allows the user to maintain individual items in the list grid.

- Fee Schedule List
- Fee Schedule Details

6.6.7.1   Fee Schedules List

The Fee Schedule Maintenance - List maintains information about Fee Schedules. This feature allows the user to add, edit, or delete procedures in a Fee Schedule. Since there may be as many as 10,000 procedures in a Fee Schedule, a procedure search capability is supported in this form.

FEE SCHEDULE TAB

Lookup	Enter the Lookup of the Fee Schedule
Name	Enter the name of the Fee Schedule
RBRVS Conversion Factor	Enter the conversion factor for RBRVS units
Other Units Conversion Factor	Enter the conversion factor for non-RBRVS units

Fee Schedule Procedures List

Procedure Code	Enter the procedure code at which the search should begin
Procedure	Procedure Lookup is displayed
Fee	The flat fee amount of the procedure displayed
M1	The primary default modifier of the procedure displayed
M2	The secondary default modifier of the procedure displayed
File Ins	The file insurance value of the procedure displayed
Anes Time Pref	The override anesthesia time preference of the procedure displayed
Excl Conc	Exclude the procedure from the Concurrency Audit for the Fee Schedule
Force	Force an override to the Units.

Fee Schedule Buttons

Prev 500	Display the previous 500 procedures on the Fee Schedule
Next 500	Display next 500 procedures on the Fee Schedule
Search	Enter a procedure code to "position" the list at.
New	Add a new procedure to the Fee Schedule
Edit	Edit and existing procedure on the Fee Schedule
Delete	Delete a procedure from the Fee Schedule

IMAGING TAB

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images

to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

- Patient - Images indexed to the patient (Action = Patient)
- Visits - Images indexed to visits (Action = Visit-New)
- Payments - Images indexed to visits (Action = Payment Insurance -
  New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
  entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains

buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.
	In effect, the image is placed in an Imaging Station in a "ready to be processed" state.
	Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.

☞ Old Value - The system value before the change was made.
☞ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.7.2 Fee Schedules Details

The Fee Schedule Maintenance - Details maintains individual procedure items of a Fee Schedules. Procedures that should be added to the Fee Schedule include procedures with flat fee amounts, either billed or allowed. Typically a "Standard" Fee Schedule is maintained for Flat Fee Billing Amounts, and separate "Allowed" Fee Schedules are maintained for different contracted payors. In addition, procedures that need special overrides, such as modifier overrides, file insurance option overrides, anesthesia time preference overrides, overrides for HCFA Box 24G, base unit overrides, or concurrency overrides, may all be added to a Fee Schedule.   The Fee Schedules are tied to the Plans on the Pricing tab of the Plan Setup.

General

Practice	The current practice is displayed
Fee Schedule	Fee Schedule selected is displayed
Procedure	Enter/Select the procedure to be added or edited
Report As	Enter the procedure description to report on statements
Flat Fee	Enter the flat fee amount of the procedure.

A true "Flat Fee" from the Fee Schedule skips the anesthesia unit calculation entirely. If you need anesthesia units as well as a "flat fee", you should use the Plan ASA Override. You can set the Minimum Fee and Maximum Fee to the fee amount and, in effect, bill the ASA Code as a "flat fee", but with anesthesia units.

RBRVS Units	Enter the RBRVS Units of the procedure
Other Units	Enter the other (Relative Value) Units of the procedure
Modifier 1	Enter/Select the default primary modifier of the procedure
Modifier 2	Enter/Select the default secondary modifier of the procedure
File Insurance	Enter/Select the File Insurance option of the procedure. This setting will override the setting in both the Procedure Setup and the HCFA tab of the Plan Setup. Options include:

- File Claim - to file paper or electronic according to Procedure Setup or the Plan setup.
- File Claim - Paper Only - to override both the Procedure Setup and the Plan setup and always force a claim to file to paper; to not allow it to be sent electronically.
- Do not File Claim - to override both the Procedure Setup and the Plan setup so that no claim is created at all.
- If the field is left BLANK, the claim will be filed according to the Plan setup, or the Procedure Setup if an override has been specified there.

HCFA Box 24G	Select the HCFA Box 24G options for the procedure. This setting will override the setting in both the Procedure Setup and the Plan Setup.

Options include:

- Quantity
- Minutes
- Total Units
- Time Units
- Base Units
- All Units Except Base
- If the field is left BLANK, the claim will be filed according to the Plan setup, or the Procedure Setup if an override has been specified there.

Exclude from Concurrency	Indicates if this procedure is excluded from concurrency processing. If selected to be excluded, it will not be counted in overlaps on other cases, and will not be updated by concurrency (i.e. the modifier nor the medical direction will be modified on the case with this procedure). If checked, this flag overrides the Exclude from Concurrency flag in the Procedure Setup. If un-checked, the flag in Procedure Setup will override.
Do Not Update Concurrency	Indicates if the procedure is included in concurrency processing for the purposes of calculating the "overlap" of other cases, but the case that this procedure is on will not be updated by concurrency (i.e. the modifier nor the medical direction will be modified on the case with this procedure). If checked, this flag overrides the Do Not Update Concurrency flag in the Procedure Setup. If un-checked, the flag in Procedure Setup will override. This is done sometimes on OB C-Section Cases where the carrier wants no concurrent case modifier, but the case should be included with all other concurrent cases for the purposes of calculating the number of overlapping cases. Performing the concurrency update would put a modifier on the case and excluding it from concurrency altogether would affect the concurrent case count of other cases.
Bill Zero $ Charges	Indicates if the Fee Schedule Detail will force the billing of zero dollar fees even if the File Zero Fee Charges on Claims on the Practice Claims Tab normally excludes these charges from claims. This is a feature of PQRI processing where "Pay for Performance" procedures need to be billed.
Capitation Carve out	Indicates if this procedure is excluded from capitation and is always processed as fee-for-service.
Override Default Anes Times	Indicates if this procedure will use a different Anesthesia Time Preference from that assigned to the plan.
(Blank)	Enter/Select the Anesthesia Time Preference to use for the procedure if it is different from the one assigned to the plan.

Force Fee Override

This tab is used to force the override of a procedure so that, for example, base units will be pulled on a flat fee calculation.

Force Fee Override	Indicates the fee and units overrides will be forced on this procedure

Base Units	Base unit override
Other Units	Other unit override
Override the Default Conversion Factor	Indicates if the conversion factor should be forced as an override
Conversion Factor	Conversion factor override

6.6.8   Copy Fee Schedule

This Utility program allows the user to copy a Fee Schedule from the "current" practice to a new Fee Schedule in the same or a different practice.

Fee Schedule   Enter/Select the Fee Schedule to copy in the "current" practice

New Values

Practice   Enter/Select the Practice to copy the Fee Schedule into
Lookup   Enter the Lookup of the New Fee Schedule
Name   Enter the Name of the New Fee Schedule
Change Percentage   Percentage to increase or decrease fees from the "From" Schedule to the "To" Schedule

Enter the percentage to increase (+) or decrease (-) fees. An increase of 10% should be entered as 10. A decrease of 15.5% should be entered as -15.5.

6.6.9   Rate Structures

The Rate Structure Maintenance maintains information about Rate Structures. This feature allows the user to add, edit, or delete the rates per unit in a Rate Structure. Typically a "Standard" Rate Structure is maintained for the per unit amount to be billed, and separate "Allowed" Rate Structures are maintained for the allowed amount per unit for the different contracted payors. The Rate Structures are tied to the Plans on the Pricing tab of the Plan Setup.

RATE STRUCTURE TAB

Lookup   Enter the Lookup of the Rate Structure
Name   Enter the Name of the Rate Structure

Rate Structure List

Medical Direction   Enter the medical direction applicable to the rate
Override Units   Enter the number of units to override the anesthesia calculation with. This is generally used with medical direction values 5 thru 9. These are considered supervision and we should override the physician charges with three total units.
Phys Rate 1   Enter the anesthesiologist rate per unit
Asst Rate 1   Enter the anesthetist rate per until

Phys Rate 2	Enter the anesthesiologist rate per unit when they are directing an anesthetist who is configured to use the alternate rate in Staff Setup.
Asst Rate 2	Enter the anesthetist rate per unit for anesthetists who are configured to use the alternate rate in Staff Setup.

Rate Structure Buttons

New	Add a new Rate Structure
Edit	Edit an existing Rate Structure
Delete	Delete an existing Rate Structure

IMAGING TAB

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
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- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

- Patient - Images indexed to the patient (Action = Patient)
- Visits - Images indexed to visits (Action = Visit-New)
- Payments - Images indexed to visits (Action = Payment

Insurance -
New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.
	In effect, the image is placed in an Imaging Station in a "ready to be processed" state.

Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.10 Networks

Networks are tied to Plans and may be used for reporting purposes.

Lookup	Lookup value assigned to describe the network
Network Type	Network Type to which this network is assigned.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.11 Network Type

Network Types define categories of Networks that may be used on plans for reporting purposes.

6.6.12 Contacts

Contacts may be created and maintained.

Lookup	Lookup value assigned to describe the Contact
Title	Title (Mr, Ms, Mrs, etc.)
Salutation	Indicates how letters to the patient will be addressed (Dear Salutation....)
	Values are:
	• Title & Last Name
	• First Name
	• Nickname
First/M/Last	Name entered in First, Middle and Last sequence
Nickname	Nickname. Will default from patient first name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, PhD, etc.)
Address	Address consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code
	The tab order will skip from Street Address (Add'l) to the Postal Code.
	The Postal Code lookup will complete the City and State. In addition,
	the Postal Code lookup will default the Area Code of the telephone

	numbers if the Area Code is defined in Postal Code Maintenance.
Country	A foreign country may be entered if needed.
Home	Home telephone number.
Fax	Fax telephone number
Work / Ext	Work telephone number and extension
Other	Other telephone number
Mobile	Mobile telephone number
Pager	Pager telephone number
E-Mail	E-Mail address
Contact Type	Contact Type to categorize this contact

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ☞ Date Changed - The date the change was made to the file.
- ☞ User Name - The name of the user that made the change.
- ☞ Item Changed - The file name of the item that was changed.
- ☞ Old Value - The system value before the change was made.
- ☞ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.13   Contact Types

Contact Types define types of <u>Contacts</u> that are used throughout the system.

6.6.14   Claim Formats

This file contains the paper claim formats for the HCFA 1500 forms. The Name of the format is displayed, version (which is how many times it has been edited and saved) and the date it was entered into the system.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.15   EMC Claim Formats

This screen contains the Submitter and Default Field Sources for electronic claim formats.

Submitter Tab

Lookup	Lookup value assigned to describe the Format
Name	Practice or Provider Name
Address	Address consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Country	A foreign country may be entered if needed.
Phone	Contact Phone Number
Contact	Contact Lookup
Submitter Code	Code assigned by Payer or Clearinghouse to the practiceor Provider
File Name / Seq	File name assigned to output files. The name is made up of a clearinghouse assigned code and a file sequence number starting at 1. For each file created the sequence is incremented by 1. When it hits 999, it rolls-over back to 1.
Subm No	Submission Number assigned to the claims file. This numberis stored internally in thefile and is incremented by 1 for each file.
Create Report	Unused
Save Archive Files	Unused

Default Field Sources

These fields should be set carefully with guidance from MedSuite and the clearinghouse or payer. Failure to set this field properly will likely result in high levels of claim rejections.

Provider ID Source (2010AA)

The provider id in the ANSI Billing Provider Loop is pulled based on the information provided in this drop-down:

- blank
- Staff Social Security
- Staff Tax ID
- Staff Individual ID
- Staff Group ID
- Staff NPID
- Staff UPIN
- Staff UDF 1-4 (Staff Level)
- Staff Details UDF 1-4 (Staff/Plan Level)

If the ID to be submitted is plan specific, then the user should fill out the EMC Claim Formats - Plan.

Qualifier

Select the ANSI Qualifier code for the Provider ID Source (2010AA). This field is only used for ANSI claims.

Provider Tax ID (2010AA) Select the Default Tax ID to be submitted on electronic claims.

- blank
- Division Tax No
- Staff Social Security

Provider ID Source (2310B)

Select the appropriate field for the default vaule of the provider id in the ANSI Line Item records from the drop-down:

- blank
- Staff Social Security
- Staff Tax ID
- Staff Individual ID
- Staff Group ID
- Staff NPID
- Staff UPIN
- Staff UDF 1-4 (Staff Level)
- Staff Details UDF 1-4 (Staff/Plan Level)

If the ID to be submitted is plan specific, then the user should fill out the EMC Claim Formats - Plan.

Qualifier

Select the ANSI Qualifier code for the Provider ID Source (FA0). This field is only used for ANSI claims.

Facility ID Source

Select the default Facility ID from the available fields in the drop-down:

- blank (none)
- Facility UDF 1-4

Place of Service Source Select the default Place of Service from the available fields in the drop-down:

- POS-HCFA
- POS UDF 1-4

Type of Service Source Select the default Type of Service from the available fields in the drop-down:

- TOS-HCFA
- TOS UDF 1-4

Procedure Code Source Select the default Procedure Code to report in the line item records of the electronic claim:

- CPT Code
- ASA Code
- HCPCS Code
- User Defined Code 1
- User Defined Code 2

PSP ID Source Select the default source of the PSP ID to report on PSP claims

CLIA Source Select the default source of the CLIA number to report on claims

Site Code Enter the Site Code assigned by the clearinghouse

Organization Type Enter the Organization Type of the practice. Values are defined as follows:

001 - Solo Practitioner
002 - Partnership
003 - Professional Association
007 - Individual Corporation
008 - Corporation

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.16 EMC Claim Formats File

This screen contains payer-specific or clearinghouse-specific electronic claim filing information. It allows one or more EMC Format PLans to be grouped into a single file. Most MedSuite clients will only have one EMC Claim Format File as ther eis generally only a single clearinghouse in use. However, certain MedSuite clients use multiple clearinghouses and therefore need to separate the claims for each clearinghouse into a separate ANSI claim file.

> **These fields should be set carefully with guidance from MedSuite and the clearinghouse or payer. Failure to set this field properly will likely result in high levels of claim rejections.**

Lookup	Lookup value assigned to describe the EMC File
Name	Long description assigned to describe the EMC File
File Name/Seq	Enter the beginning of the claim file name and the next sequence number to be used. For example if you enter ANEGRP and 123, then the next file created will be called ANEGRP.123.

Include Date/Time Stamp in File Name — Indicates if the date and time the file is cretaed should be included in its name. If this option is selected, the file name example from above could be ANEGRP_200707010430.123.

Break 2000A by Provider — Indicates if the claim file should be sorted and broken each time the "Bill To" provider on the claim changes.

> **This issue is dependent on the clearinghouse's or payer's requirements. If there is any doubt on this, this option should be checked "on".**

Break 2000B by Claim — Indicates if multiple claims for the same subscriber can be submitted under a single subscriber (2000B) segment or if each claim needs a separate subscriber (2000B) segment.

> **This issue is dependent on the clearinghouse's or payer's requirements. If there is any doubt on this, this option should be checked "on".**

Carrier Code XRef — Indicates which field from the Carier Setup will be used for as the "Payer Code" in the claims file.

- NAIC No
- Per-Se Code
- Other EMC Code

Qualifier — Select the ANSI Qualifier code for the Provider ID Source (BA0). This field is only used for ANSI claims.

Provider Tax ID (2010AA) Select the Default Tax ID to be submitted on electronic claims.

- blank
- Division Tax No
- Staff Social Security

Suppress 2310B	Some payer cannot accept the 2310B Segment when the provider in the 2310B Sgement is the same as the 2010AA Segment. The 2310B Segment may be suppressed when necessary.

Provider ID Source (2310B)	MedSuite will instruct you which file version to select from the list Select the appropriate field for the default vaule of the provider id in the ANSI Line Item records from the drop-down:

- blank
- Staff Social Security
- Staff Tax ID
- Staff Individual ID
- Staff Group ID
- Staff NPID
- Staff UPIN
- Staff UDF 1-4 (Staff Level)
- Staff Details UDF 1-4 (Staff/Plan Level)

Qualifier	Select the ANSI Qualifier code for the Provider ID Source (FA0). This field is only used for ANSI claims.

Facility ID Source	Select the default Facility ID from the available fields in the drop-down:

- blank (none)
- Facility UDF 1-4

Place of Service Source	Select the default Place of Service from the available fields in the drop-down:

- POS-HCFA
- POS UDF 1-4

Type of Service Source	Select the default Type of Service from the available fields in the drop-down:

- TOS-HCFA
- TOS UDF 1-4

Procedure Code Source	Select the default Procedure Code to report in the line item records of the electronic claim:

- CPT Code
- ASA Code
- HCPCS Code
- User Defined Code 1
- User Defined Code 2

Service Units	Indicates what field will be reported in the claims fiel for the number of units. On anesthesia claims this is often the quantity (001). However,

certain carriers may have other requirements.

Improperly setting this field can result in improper claim payments!!

This setting is only used for NSF Claims!!

Anesthesia Units   Indicates what field will be reported in the claims fiel for the "anesthesia minutes". Not all carriers want the numbe rof minutes in this field. some want time Units or total units. On non-anesthesia claims this field will be set to 000.

Improperly setting this field can result in improper claim payments!!

Report Start/Stop in NTE Indicates if the anesthesia start and stop times will be automatically reported in the NTE (Notes / Narrative) Segment in the ANSI Claim File.

PSP ID Source   Select the source of the PSP ID to report on PSP claims

PSP ID Name   Select the source of the PSP Name to report on PSP claims

.
Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.17 EMC Claim Formats - Plan

This screen contains payer specific electronic claim filing information that vary from the Default Field Sources for electronic claim formats

These fields should be set carefully with guidance from MedSuite and the clearinghouse or payer. Failure to set this field properly will likely result in high levels of claim rejections.

Lookup   Lookup value assigned to describe the Format
EMC File Version   MedSuite will instruct you which file version to select from the list
EMC File Format   Select the desired format from the EMC Claim Formats File lookup
NPI Usage Mode   Select from the available modes:
- Dual-Use - Send both Legacy IDs and NPI
- Legacy - Send Legacy Only
- NPI - Send NPI Only
PPO/HMO Indicator   Sets the EMC PPO/HMO indicator in the claims file for the plan

PPO/HMO Code   Sets the EMC PPO/HMO Code in the claims file for the plan

Bill-To Provider

Bill-To Provider
Taxonomy Type
   Indicates the source of the Bill-To Provider Taxonomy

- [Division Taxonomy](#)
- Staff Taxonomy
- Staff UDF1 - 4
- Staff Detail UDF1 - 4

Blank will not report a PRV Segment at the 2000A level.

Bill-To Provider Entity
Type
   Indicates the source of the Bill-To Provider address in the 2010AA Loop
of the ANSI claims file:

- Division
- Division Alt
- Facility
- Practice
- Provider
- Provider Home
- Other

Blank will continue to report the provider address

Bill-To Provider Other
Addr
   Allows you to enter a "custom" address in the Bill-To Provider
Information.

Provider NPI Source
(2010AA)
   The "Billing" Provider NPI in the ANSI 2000-Loop is pulled based on the
information provided in this drop-down:

- Division NPI
- Staff UPIN
- Staff UDF 1-4 (Staff Level)

**This should generally be set to Division NPI. However is
physicians and CRNAs have different NPIs, then one of the Staff
fields should be used to report the NPI in the 2000-Loop.**

Provider ID Source
(2010AA)
   The "Billing" Provider ID in the ANSI 2000-Loop is pulled based on the
information provided in this drop-down:

- blank
- Staff Social Security
- Staff Tax ID
- Staff Individual ID
- Staff Group ID
- Staff NPID
- Staff UPIN
- Staff UDF 1-4 (Staff Level)
- Staff Details UDF 1-4 (Staff/Plan Level)

Qualifier   Select the ANSI Qualifier code for the Provider ID Source (2010AA).
This field is only used for ANSI claims.

Provider Tax ID (2010AA) Select the Default Tax ID to be submitted on electronic claims.

- blank
- Division Tax No
- Staff Social Security

Pay-To Provider

Pay-To Provider
Taxonomy Type

Indicates the source of the Bill-To Provider Taxonomy

- Division Taxonomy
- Staff Taxonomy
- Staff UDF1 - 4
- Staff Detail UDF1 - 4

Blank will not report a PRV Segment at the 2000A level.

Pay-To Provider Entity
Type

Indicates the source of the Pay-To Provider address in the 2010AB Loop of the ANSI claims file:

- Division
- Division Alt
- Facility
- Practice
- Provider
- Provider Home
- Other

Blank will NOT report a Pay-To Provider

Pay-To Provider Other
Addr

Allows you to enter a "custom" address in the Pay-To Provider Information.

Claim and Svc Line

Suppress 2310B

Some payer cannot accept the 2310B Segment when the provider in the 2310B Sgement is the same as the 2010AA Segment. The 2310B Segment may be suppressed when necessary.

Provider ID Source
(2310B)

MedSuite will instruct you which file version to select from the list
Select the appropriate field for the default vaule of the provider id in the ANSI Line Item records from the drop-down:

- blank
- Staff Social Security
- Staff Tax ID
- Staff Individual ID
- Staff Group ID
- Staff NPID
- Staff UPIN
- Staff UDF 1-4 (Staff Level)
- Staff Details UDF 1-4 (Staff/Plan Level)

Qualifier	Select the ANSI Qualifier code for the Provider ID Source (2310B). This field is only used for ANSI claims.
Facility ID Source	Select the default Facility ID from the available fields in the drop-down:

- blank (none)
- Facility UDF 1-4

Place of Service Source	Select the default Place of Service from the available fields in the drop-down:

- POS-HCFA
- POS UDF 1-4

Type of Service Source	Select the default Type of Service from the available fields in the drop-down:

- TOS-HCFA
- TOS UDF 1-4

Procedure Code Source	Select the default Procedure Code to report in the line item records of the electronic claim:

- CPT Code
- ASA Code
- HCPCS Code
- User Defined Code 1
- User Defined Code 2

Service Units	Indicates what field will be reported in the claims file for the number of units. On anesthesia claims this is often the quantity (001). However, certain carriers may have other requirements.

Improperly setting this field can result in improper claim payments!!

This setting is only used for NSF Claims!!

Anesthesia Units	Indicates which field will be reported in the claims file for the "units or minutes" of the SV1 - Professional Service Segment. Not all carriers want the number of minutes in this field. some want Time Units or Total units. On non-anesthesia claims this field will be set to 000.

Improperly setting this field can result in improper claim payments!!

Report Start/Stop in NTE	Indicates if the anesthesia start and stop times will be automatically reported in the NTE (Notes / Narrative) Segment in the ANSI Claim File.
PSP ID Source	Select the source of the PSP ID to report on PSP claims

PSP ID Name   Select the source of the PSP Name to report on PSP claims

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

-   Date Changed - The date the change was made to the file.
-   User Name - The name of the user that made the change.
-   Item Changed - The file name of the item that was changed.
-   Old Value - The system value before the change was made.
-   New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.6.18 Plans Listing

For a variety of reasons's, you may want to print a list of Plans with detailed plan information. The Plan Listing request form is a tabbed dialog that consists of a General tab, a Sorting tab, and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Sorting Tab

The Sorting tab consists of two lists. The first list is comprised of the available sort fields for the report and the second list is comprised of the fields that have been selected as sort fields. The fields in the second list may be sequenced in any order. The report will sort the data into the sequence defined and perform a "break" on the sort field as well.

Selecting Sort Options:

Right-Arrow Button	Click on item to be selected in the left-hand list and press the right-arrow button.
Drag-and-Drop	Click on the item to be selected in the left-hand list and while holding the mouse button down, "drag" the item to the right-hand list and release the mouse button.
Double-Click	Double-click on the item to be selected in the left-hand list.

De-Selecting Sort Options:

Left-Arrow Button	Click on item to be de-selected in the right-hand list and press the left-arrow button.
Drag-and-Drop	Click on the item to be de-selected in the right-hand list and while holding the mouse button down, "drag" the item to the left-hand list and release the mouse button.
Double-Click	Double-click on the item to be de-selected in the right-hand list.

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

6.6.19 Fee Schedules Listing

For a variety of reasons's, you may want to print a list of Fee Schedules Listing. The Fee Schedules Listing request form is a tabbed dialog that consists of a General tab and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Select Flat Fees Only	Selection of this check-box indicates that Flat Fees from the Fee Schedule are the only items to be printed.
Print Procedures/ASA XWalk	Selection of this check-box indicates that the Procedure / ASA XWalk should be printed with the Fee Schedule.
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

6.6.20 Rate Structures Listing

For a variety of reasons's, you may want to print a list of Rate Structures. The Rate Structure Listing request form is a tabbed dialog that consists of a General tab and a Selection tab.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Selection Tab

Frequently when a report is run, you only wish to see data meeting certain criteria. The Selection tab consists of a list of fields they you may use to include or exclude specific data values from the report. For example, you may wish to run a report for just a certain physician or excluding a certain location.

By clicking on the checklist for the appropriate field (physicians, facilities, etc.) you may then select to include or exclude certain values from the respective tables. The limit to the number of specific values you can select is limited to your ability (or willingness) to enter them. While there is a theoretical limit to the number of selections you can make, you will run out of patience before MedSuite runs out of room to save them. Muli-Selections work with standard Windows keyboard functionality. CTRL+Click to select one at a time, SHIFT+Click to select a range of maintenance files.

6.7   Procedure/Diagnosis

The Procedure/Diagnosis sub-menu of the Setup menu provides access to all of the Procedure/Diagnosis maintenance functions including:

Function	Global	Description
ASA Codes	Y	Maintain ASA Codes, Descriptions, and ASA Base Units
Diagnoses	Y	Maintain ICD Codes and Descriptions
Diagnosis Category	Y	Maintain Categories (Neoplasms, Infections, etc) for reporting purposes
Diagnosis Types	Y	Maintain Types of Diagnoses for reporting purposes
Diagnosis Sub-Types	Y	Maintain Sub-Types of Diagnoses for reporting purposes
Procedures	Y	Maintain CPT and HCPCS Codes and Descriptions
Procedure Category	Y	Maintain Categories (Integumentary, Skeletal, etc) for reporting purposes
Procedure Types	Y	Maintain Types of Procedures for reporting purposes
Procedure Sub-Types	Y	Maintain Sub-Types of Procedures for reporting purposes
Procedure / ASA X-Walk	Y	Maintain valid combinations of Procedures and ASA Codes
Procedure / Diagnosis X-Walk	Y	Maintain valid combinations or Procedures and Diagnosis Codes

6.7.1 ASA Codes

ASA Codes Maintenance consists of a list grid along with a form that allows the user to maintain individual items in the list grid.

- ASA Lookup
- ASA Code Maintenance

6.7.1.1 ASA Codes Lookup

The ASA Codes Lookup maintains information about ASA Codes. This feature allows the user to add, edit, or delete ASA procedures. Since there are several hundred ASA procedures, a procedure search capability is supported in this form.

Search	Enter the keywords or codes to perform the search with

Search Results

Code	The ASA Code is displayed
Description	The ASA Abbreviated Procedure Description is displayed
Type	The ASA Procedure Type is displayed
Description (Full)	The ASA Full Procedure Description is displayed
Base	The ASA Base Units are displayed

Buttons

Search	Begin Search based on the value entered in the Search field
New	Add a new procedure to the ASA Procedure List
Edit	Edit an existing procedure to the ASA Procedure List
Delete	Delete an existing procedure from the ASA Procedure List
Close	Close the window

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ☞ Date Changed - The date the change was made to the file.
- ☞ User Name - The name of the user that made the change.
- ☞ Item Changed - The file name of the item that was changed.
- ☞ Old Value - The system value before the change was made.
- ☞ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.7.1.2   ASA Codes Details

ASA Procedures Maintenance maintains individual ASA procedure codes.

Lookup	Enter the ASA Procedure Lookup value
Code	Enter the ASA Procedure Code
Name	Enter the ASA Procedure Description
Brief Name	Enter the ASA Procedure Abbreviate Description
User Name	Enter the description in user terminology
Base Units	Enter the ASA Base Units
Begin Date	Enter the effective date of the procedure
End Date	Enter the expiration date of the procedure
Exclude Age from Charge Calculation	Check this field to prevent Extreme Age from being billed for this ASA Code under any circumstances. Some ASA Codes already include a unit for Extreme Age in the base unit value and Extreme Age should not be billed twice.
Exclude Hypothermia (99116) from Charge Calculation	Check this field to prevent Hypothermia from being billed for this ASA Code under any circumstances. Some ASA Codes already include units for Hypothermia in the base unit value and Hypothermia should not be billed twice.
Exclude Hypotension (99135) from Charge Calculation	Check this field to prevent Hypotension from being billed for this ASA Code under any circumstances. Some ASA Codes already include units for Hypotension in the base unit value and Hypotension should not be billed twice.
Exclude Emergency (99140) from Charge Calculation	Check this field to prevent Emergency from being billed for this ASA Code under any circumstances. Some ASA Codes already include units for Emergency in the base unit value and Emergency should not be billed twice.

6.7.2   Diagnoses

Diagnosis Codes Maintenance consists of a list grid along with a form that allows the user to maintain individual items in the list grid.

- Diagnosis Search
- Diagnosis Maintenance

6.7.2.1   Diagnoses Search

The Diagnosis Codes Lookup maintains information about Diagnosis Codes. This feature allows the user to add, edit, or delete Diagnoses. Since there are several thousand diagnoses, a diagnosis search capability is supported in this form.

Search	Enter the keywords or codes to perform the search with
Maternity	Indicate if the search should be performed on maternity diagnoses only
Unspecified	Indicate if the search should be performed on unspecified diagnoses only
Sex	Indicate if the search should be performed on sex-specific diagnoses only
Age	Indicate if the search should be performed on age-specific diagnoses only

Search Results

Code	The Diagnosis Code is displayed
Description	The Diagnosis Abbreviated Description is displayed
Type	The Diagnosis Type is displayed
Unspec	Indicates if the diagnosis is unspecified
Matern	Indicates if the diagnosis is a maternity code
Other	Indicates if the diagnosis is defined as Other type
Sex	Indicates if the diagnosis is defined as sex-specific
Age	Indicates if the diagnosis is defined as age-specific
Description	Displays the diagnosis description
Description (Full)	Displays the diagnosis description

Buttons

Search	Begin Search based on the value entered in the Search field
New	Add a new diagnosis to the Diagnosis List
Edit	Edit an existing diagnosis to the Diagnosis List
Delete	Delete an existing diagnosis from the Diagnosis List
Close	Close the window

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✍ Date Changed - The date the change was made to the file.
- ✍ User Name - The name of the user that made the change.
- ✍ Item Changed - The file name of the item that was changed.
- ✍ Old Value - The system value before the change was made.
- ✍ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.7.2.2   Diagnoses Details

Diagnosis Details maintains individual diagnosis items.

Lookup	Enter the Diagnosis Lookup value
Code	Enter the Diagnosis Code
Name	Enter the Diagnosis Description
Brief Name	Enter the Diagnosis Abbreviated Description
Begin Date	Enter the effective date of the diagnosis
End Date	Enter the expiration date of the diagnosis
Category	Enter/Select the category for this diagnosis for reporting purposes
Diag Type	Enter/Select the diagnosis type for this diagnosis for reporting purposes
Diag Sub-Type	Enter/Select the diagnosis sub-type for this diagnosis for reporting purposes
Age Min	Enter the minimum permitted age for this diagnosis which will be compared to the patient are in charge entry
Age Max	Enter the maximum permitted age for this diagnosis which will be compared to the patient are in charge entry
Sex Specific	Select the sex if the diagnosis is sex-specific
Maternity	Indicate if the diagnosis is a maternity code.
4th Digit Required	Indicate if the diagnosis is a three digit code that requires a fourth digit
5th Digit Required	Indicate if the diagnosis is a four digit code that requires a fifth digit
External Causes	Indicate if the diagnosis is the result of external causes
Manifestation	Indicate if the diagnosis is a manifestation
Unspecified	Indicate if the diagnosis is unspecified
MSP Alert	Indicate if the diagnosis requires an MSP alert
Signs Symptoms	Indicate if the diagnosis is signs or symptoms
Other Specified	Indicate if the diagnosis is an "other specified"

6.7.3   Diagnosis Category

Diagnosis Categories tied to Diagnoses and are used for reporting breaks.

     Lookup   Lookup value assigned
     Name   Description

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.7.4   Diagnosis Type

Diagnosis Types are tied to Diagnoses and are used for reporting breaks.

Description   Description assigned to the Diagnosis Type

6.7.5   Diagnosis Sub-Type

Diagnosis Sub-Types are tied to Diagnoses and are used for reporting breaks.

Description   Description assigned to the Diagnosis Sub-Type

6.7.6   Procedures

Procedure Code Maintenance consists of a list grid along with a form that allows the user to maintain individual items in the list grid.

- Procedures Search
- Procedures Maintenance
- Linked Fee Schedules

6.7.6.1   Procedures Search

The Procedure Codes Lookup maintains information about Procedures Codes. This feature allows the user to add, edit, or delete Procedures. Since there are several thousand procedures, a procedures search capability is supported in this form.

Search   Enter the keywords or codes to perform the search with
Maternity   Indicate if the search should be performed on maternity procedures only
Unlisted   Indicate if the search should be performed on unlisted procedures only
Sex   Indicate if the search should be performed on sex-specific procedures only
Age   Indicate if the search should be performed on age-specific procedures only

Search Results

Code   The Procedure Code is displayed
Description   The Procedure Abbreviated Description is displayed
Type   The Procedure Type is displayed
Unlisted   Indicates if the procedure is unlisted (ends in "'99")
Matern   Indicates if the procedure is a maternity code
*   Indicates if the procedure is Starred

Sex	Indicates if the procedure is defined as sex-specific
Age	Indicates if the procedure is defined as age-specific
Description	Displays the procedure description

Buttons

Search	Begin Search based on the value entered in the Search field
New	Add a new procedure to the Procedure List
Edit	Edit an existing procedure to the Procedure List
Delete	Delete an existing procedure from the Procedure List
Close	Close the window

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.7.6.2   Procedures Details

Procedure Details maintains individual procedure items.

Lookup	Enter the Procedure Lookup value
CPT Code	Enter the CPT Code if the procedure is a CPT
HCPCS Code	Enter the HCPCS Code if the procedure is a HCPCS
Name	Enter the Procedure Description
Hash to Total	Enter the number to be used on the Visit Worksheet/Journal for the Hash Total for balancing purposes. This must be at least 5 characters in length. This is typically the same as the CPT code, but it could be a drug code such as J2300. If it has an alpha prefix such as J2300, the system will total the number only and ignore the alpha prefix. Alternatively, a drug code could be entered as 02300 instead of J2300, however it must be at least 5 characters to total properly on the Visit Worksheet/Journal.
Brief Name	Enter the Procedure Abbreviated Description
User Name	Enter a User-Defined Description if desired
Begin Date	Enter the effective date of the procedure
End Date	Enter the expiration date of the procedure
Category	Enter/Select the category for this procedure for reporting purposes. MedSuite provides a standard set that is available with the Procedure File.
Type	Enter/Select the procedure type for this procedure for reporting

	purposes
Sub-Type	Enter/Select the procedure sub-type for this procedure for reporting purposes
File Insurance	Select the default insurance filing option for this procedure if it should override the Plan Setup. Options include:

- File Claim - to file the claim according to Plan setup (paper or electronic). However, if this procedure has an override set up in a Fee Schedule to file to Paper or Do Not File, it will override this setting on the Procedure and the Plan.
- File Claim - Paper Only - to override the Plan setup and always force a claim to file to paper; to not allow it to be sent electronically. However, if this procedure has an override set up in a Fee Schedule of Do Not File, it will override this setting on the Procedure and the Plan.
- Do not File Claim - to override the Plan setup so that no claim is created at all.
- If the field is left BLANK, the claim will be filed according to the Plan setup, or the Fee Schedule if an override of File to Paper or Do Not File is specified there.

HCFA Box 24G	Select the default HCFA Box 24G options for the procedure if it should override the Plan Setup. Options include:

- Quantity
- Minutes
- Total Units
- Time Units
- Base Units
- All Units Except Base
- If the field is left BLANK, the claim will be filed according to the setup on the HCFA tab of the Plan setup, or the Fee Schedule if an override is specified there.

Excluded From Concurrency	Indicates if this procedure is excluded from concurrency processing. If selected to be excluded, it will not be counted in overlaps on other cases, and will not be updated by concurrency (i.e. the modifier nor the medical direction will be modified on the case with this procedure). If this option is un-checked on this procedure in this screen, but is checked on this procedure in a Fee Schedule, the flag in the Fee Schedule will override a blank flag here.
Do Not Update in Concurrency	Indicates if the procedure is included in concurrency processing for the purposes of calculating the "overlap" of other cases, but the case that this procedure is on will not be updated by concurrency. If this option is un-checked on this procedure in this screen, but is checked on this procedure in a Fee Schedule, the flag in the Fee Schedule will override a blank flag here.
	This is done sometimes on OB C-Section Cases where the carrier wants no concurrent case modifier, but the case should be included with all other concurrent cases for the purposes of calculating the number of overlapping cases. Performing the concurrency update would put a modifier on the case and excluding it from concurrency altogether would affect the concurrent case count of other cases.

Bill Zero $ Charge	Indicates if the procedure will force the billing of zero dollar fees even if the File Zero Fee Charges on Claims on the Practice Claims Tab normally excludes these charges from claims.
	This is a feature of PQRI processing where "Pay for Performance" procedures need to be billed.
Medical Direction Overrides	Indicates the Medical Direction Override that should be used when a procedure is Primary on a case with a Secondary Procedure. This is specifically designed for epidural to C-section procedures when the epidural procedure code is excluded from concurrency. The Medical Direction Override will place the Medical Direction selected here on the epidural ONLY when it is entered with a secondary procedure. If the override is left blank the system will put the concurrency modifier of the secondary procedure (C-section not excluded from concurrency) on both the primary epidural and secondary C-section.
	NOTE: If the Z-Medical Direction is keyed in Visit Entry on the Anesthesia Tab the system will honor the Z-Medical Direction and ignore the Medical Direction Override set on the procedure code.
Service Type	Allows override of service type specified in Visit Type Maintenance for specific procedures
Age Min	Enter the minimum permitted age for this procedure which will be compared to the patient are in charge entry
Age Max	Enter the maximum permitted age for this procedure which will be compared to the patient are in charge entry
Sex Specific	Select the sex if the procedure is sex-specific
Maternity	Indicate if the procedure is a maternity code.
Unlisted	Indicate if the procedure is unlisted (ends with "99")
Starred	Indicate if the procedure is "starred"

6.7.6.3 Linked Fee Schedules

The Linked Fee Schedules tab displays a list of all Fee Schedules that the procedure is used on. You may add, edit, and delete the procedure on Fee Schedules from this form.

6.7.7   Procedure Category

Procedure Categories tied to Procedures and are used for reporting breaks. MedSuite provides a standard set that is available with the Procedure File.

Lookup	Lookup value assigned
Name	Description

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.7.8   Procedure Types

Optional field for additional categories or types of procedures for reporting.

6.7.9   Procedure Sub-Types

Optional field for additional categories or types of procedures for reporting.

6.7.10   Procedure / ASA X-Walk

Procedure / ASA X-Walk is a tabbed dialog that consists of the Procedure Search tied to a list grid (on a second tab) that displays the ASA Codes tied (or X-Walked) to the procedure selected.

- Procedures Search
- ASA X-Walk List
- ASA X-Walk Details

6.7.10.1   ASA X-Walk List

The ASA X-Walk list maintains information about ASA Procedure Codes that have been X-Walked to the selected procedure code. This feature allows the user to add, edit, or delete ASA X-Walks. The Procedure ASA/XWalk List first requires that you search for a procedure. After you have selected a procedure, you can go to the second tab which displays the ASA X-Walk List.

Procedure Search

Code	The Procedure Code is displayed
Description	The Procedure Abbreviated Description is displayed
Type	The Procedure Type is displayed
Unlisted	Indicates if the procedure is unlisted (ends in "'99")
Matern	Indicates if the procedure is a maternity code
*	Indicates if the procedure is Starred
Sex	Indicates if the procedure is defined as sex-specific
Age	Indicates if the procedure is defined as age-specific
Description	Displays the procedure description

ASA X-Walk List

Code	The ASA Procedure Code is displayed
Description	The ASA Procedure Abbreviated Description is displayed
Base Units	The ASA base units is displayed

Buttons

New	Add a new X-Walk to the List

Edit	Edit an existing X-Walk on the List
Delete	Delete an existing X-Walk from the List
Close	Close the window

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.7.10.2 ASA X-Walk Details

ASA X-Walk Details maintains individual X-Walk items.

CPT Code	Enter the code of the procedure selected for the X-Walk is displayed
ASA Code	Enter/Select the ASA Code to be X-Walked
Begin Date	Enter the effective date of the X-Walk
End Date	Enter the expiration date of the X-Walk

6.7.11   Procedure / Diagnosis X-Walk

Procedure / Diagnosis X-Walk is a tabbed dialog that consists of the Procedure Search tied to a list grid (on a second tab) that displays the Diagnosis Codes tied (or X-Walked) to the procedure selected.

- Procedures Search
- Diagnosis X-Walk List
- Diagnosis X-Walk Details

6.7.11.1   Diagnosis X-Walk List

The Diagnosis X-Walk list maintains information about Diagnosis Codes that have been X-Walked to the selected procedure code. This feature allows the user to add, edit, or delete Diagnosis X-Walks. The Procedure Diagnosis X-Walk first requires that you search for a procedure. After you have selected a procedure, you can go to the second tab which displays the Diagnosis X-Walk List.

Procedure Search

Code	The Procedure Code is displayed
Description	The Procedure Abbreviated Description is displayed
Type	The Procedure Type is displayed
Unlisted	Indicates if the procedure is unlisted (ends in "'99")
Matern	Indicates if the procedure is a maternity code
*	Indicates if the procedure is Starred
Sex	Indicates if the procedure is defined as sex-specific
Age	Indicates if the procedure is defined as age-specific
Description	Displays the procedure description

Diagnosis X-Walk List

Code	The Diagnosis Code is displayed
Description	The Diagnosis Abbreviated Description is displayed
Type	The Diagnosis Type is displayed
Unspec	Indicates if the diagnosis is unspecified
Matern	Indicates if the diagnosis is a maternity code
Other	Indicates if the diagnosis is defined as Other type
Sex	Indicates if the diagnosis is defined as sex-specific
Age	Indicates if the diagnosis is defined as age-specific

Buttons

New	Add a new diagnosis to the Diagnosis List
Edit	Edit an existing diagnosis to the Diagnosis List
Delete	Delete an existing diagnosis from the Diagnosis List

Close   Close the window
Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

&⁓   Date Changed - The date the change was made to the file.
&⁓   User Name - The name of the user that made the change.
&⁓   Item Changed - The file name of the item that was changed.
&⁓   Old Value - The system value before the change was made.
&⁓   New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.7.11.2 Diagnosis X-Walk Details

Diagnosis X-Walk Details maintains individual X-Walk items.

CPT Code   Enter the code of the procedure selected for the X-Walk is displayed
Diagnosis Code   Enter/Select the Diagnosis Code to be X-Walked
Begin Date   Enter the effective date of the X-Walk
End Date   Enter the expiration date of the X-Walk

6.7.12   Coding Listings

The Coding Listings request form is a tabbed dialog that consists of a General tab, a Table tab, and a Fields tab. The Table tab allows you to select which table you would like to print. Once you have selected a table, you may select the fields that you wish to report.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Table Tab

The Table Tab consists of a list of tables that you may select to print.

Fields Tab

The Fields Tab contains the list of fields that you may print on the listing.

6.8   Providers

The Providers sub-menu of the Setup menu provides access to all of the functions that support and maintain providers. These functions include:

Function	Global	Description
Staff		Maintain Staff (Provider) names, addresses, etc.
Staff Groups		Maintain Groups of Staff to be used for reporting purposes
Staff Types	Y	Maintain Staff Types (Physicians, Nurses, etc.)
Referrals		Maintain Referral names, addresses, etc.
Referral Groups		Maintain Groups of Referrals to be used for reporting purposes
Referral Types	Y	Maintain Referral Types (Physicians, Nurses, etc.)
Specialty Codes	Y	Maintain HCFA (CMS) Provider Specialty Codes

6.8.1   Staff

Staff maintenance is presented to the user as a tabbed dialog consisting of two (2) tabs:

- General
- Identification
- Identification Details

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.8.1.1   General

The Staff - General tab contains demographic and billing control information about the staff member

Lookup	Lookup value assign to the staff member
Staff Group	Staff group (if any) that the staff member belongs to

Personal Information

Title	Title (Mr, Ms, Mrs, etc.)
Salutation	Indicates how letters to the patient will be addressed (Dear Salutation....) Values are: - Title & Last Name

- First Name
- Nickname

First/M/Last	Name entered in First, Middle and Last sequence
Nickname	NickName. Will default from patient fiest name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, Phd, etc.)
Address	Address consisting of:

- Street Address
- Street Address (Add'l)
- City
- State
- Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Country	A foreign country may be entered if needed.
Home	Home telehone number.
Fax	Fax telephone number
Work / Ext	Work telephone number and extension
Other	Other telephone number
Mobile	Mobile telephone number
Pager	Pager telephone number
E-Mail	E-Mail address
Date of Birth	Date of Birth. See date field definition for use of two/four digit years.
Sex	Sex (Male, Female, Unknown)
Specialty	Specialty that best describes the specialty of the staff member
Type	Type of staff member
Use Alternate Rate	Indicates if the Anesthesia Fee calculation should use the primary or the alternate rate per unit for the staff member
Staff is Billable	Indicates in the staff member is billable by the practice
Staff is Employee	Indicates if the staff member is employed by the practice
Staff is Locum Tenen	Indicates if the staff member is a locum tenen
User-Defined	Up to four (4) user-defined fields may be defined on the practice for use at the staff level

Buttons

Imaging	Invokes the imaging software to scan a document an attach the document to the staff member
OK	Close the form and save the changes
Cancel	Close the form and do not save the changes (if any).

6.8.1.2 Identification

The Staff - Identification tab contains demographic and billing control information about the staff member

Identification Numbers

SSNo	Social Security number of staff member
DEA No	DEA number of staff member
Med Lic	Medical License number of staff member
UPIN	Universal Provider Identification Number of staff member
NPID	National Provider Identifier number of staff member

If the NPI is unknown or recently applied for, entered "PENDING" as the NPI and MedSuite will hold all claims for the staff member.

Details

Division	If a staff member has plan-based ID's that vary by Division, then enter a Staff Identification Detail entry with the appropriate division
Locality	If a staff member has plan-based ID's that vary by Locality, then enter a Staff Identification Detail entry with the appropriate locality
Facility	If a staff member has plan-based ID's that vary by Facility, then enter a Staff Identification Detail entry with the appropriate facility
Plan	Enter a Staff Identification Detail entry with the appropriate plan
Group No	Displays the group number assigned to the staff member/division/plan/facility combination
Individual No	Displays the individual number assigned to the staff member/division/plan/facility combination
Force Paper	Forces claims to paper for the Staff/Staff Detail combination.

The use of Division, Locality and Facility are "weighted" from least specific (Division) to most specific (Facility). The weights are cumulative when used in combination. For example, a combination of Division and Locality will override an entry with Facility only.

Details - Buttons

New	Creates a new Staff Identification Details entry
Edit	Edits the selected Staff Identification Details entry
Delete	Deletes the selected Staff Identification Details entry

Buttons

Imaging	Invokes the imaging software to scan a document an attach the document to the staff member
OK	Close the form and save the changes
Cancel	Close the form and do not save the changes (if any).

6.8.1.3 Identification Details

Staff Identification Details allows the user to define a group number, individual number and up to four other miscellaneous numbers for each staff member that can vary by any combination of Division, Plan, and/or Facility.

Division	If a staff member has plan-based ID's that vary by Division, then enter a Staff Identification Detail entry with the appropriate division
Locality	If a staff member has plan-based ID's that vary by Locality, then enter a Staff Identification Detail entry with the appropriate locality
Facility	If a staff member has plan-based ID's that vary by Facility, then enter a Staff Identification Detail entry with the appropriate facility
Plan	Enter a Staff Identification Detail entry with the appropriate plan
Group No	Maintains the group number assigned to the staff member/division//locality/facility/plan combination
Individual No	Maintains the individual number assigned to the staff member/division//locality/facility/plan combination
Misc Details 1	Maintains the miscellaneous detail number 1 assigned to the staff member / division / locality / facility / plan combination
Misc Details 2	Maintains the miscellaneous detail number 2 assigned to the staff member / division / locality / facility / plan combination
Misc Details 3	Maintains the miscellaneous detail number 3 assigned to the staff member / division / locality / facility / plan combination
Misc Details 4	Maintains the miscellaneous detail number 4 assigned to the staff member / division / locality / facility / plan combination
Force to Paper	If a provider is not yet approved to send claims electronically but the provider ID's have been obtained from the payor, simply check the force to paper option for these claims to print paper even if the Plan is set to file claims electronically.

The use of Division, Locality and Facility are "weighted" from least specific (Division) to most specific (Facility). The weights are cumulative when used in combination. For example, a combination of Division and Locality will override an entry with Facility only.

TIP: If there are providers in your practice that have not yet been assigned ID numbers by the payor but you want to enter the charges into the system, enter the word PENDING in the provider Group No field or Individual No field or BOTH. The word PENDING in the provider ID field will cause the claim to be pended in the system until the actual number is entered into the staff file or the word pending is removed. The claims will automatically release once the word PENDING has been replaced with the providers ID numbers.

6.8.1.4   Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

	• Patient - Images indexed to the patient (Action = Patient)
	 • Visits - Images indexed to visits (Action = Visit-New)
	 • Payments - Images indexed to visits (Action = Payment Insurance -
	    New or Payment Self - New)
	 • Claims - Images indexed to claims (Action = Claim Followup)
	 • Miscellaneous - Images indexed via Manual Indexing to some other
	    entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the

selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.
	In effect, the image is placed in an Imaging Station in a "ready to be processed" state.
	Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

6.8.2   Staff Types

Staff Types are used to help categorize staff members. Each Staff Type supports a "process-as" type. These "process-as" types are Physician, Resident, Nurse, and Student and control certain logic in

MedSuite. For example, only a physician may be entered into the anesthesiologist field in the Anesthesia tab of Visit Entry and only a Nurse, Resident, or Student may be entered into the anesthetist field in the Anesthesia tab of Visit Entry. This is but one example.

Lookup	Lookup value assigned to the group
Name	Name assigned to the group

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✐ Date Changed - The date the change was made to the file.
- ✐ User Name - The name of the user that made the change.
- ✐ Item Changed - The file name of the item that was changed.
- ✐ Old Value - The system value before the change was made.
- ✐ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.8.3   Staff Groups

Staff members may be organized into groups. For example, a practice might want to track all physician stockholders in one group, physician non-stockholder in another group, and assistants in a third group. These groups may be designated as control breaks on reports.

Lookup	Lookup value assigned to the group
Name	Name assigned to the group

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ✐ Date Changed - The date the change was made to the file.
- ✐ User Name - The name of the user that made the change.
- ✐ Item Changed - The file name of the item that was changed.
- ✐ Old Value - The system value before the change was made.
- ✐ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.8.4   Referrals

Referring providers are maintained via Referrals maintenance. The following demographic and billing control information is maintained about the referring provider:

REFERRAL TAB

Lookup	Lookup value assigned to the referring provider
Referral Type	Type of referral
Referral Group	Group (if any) that the referral provider belongs to

Personal Information

Title	Title (Mr, Ms, Mrs, etc.)
Salutation	Indicates how letters to the patient will be addressed (Dear Salutation....)
	Values are:
	• Title & Last Name
	• First Name
	• Nickname
First/M/Last	Name entered in First, Middle and Last sequence
Nickname	NickName. Will default from patient fiest name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, Phd, etc.)
Address	Address consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code
	The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Country	A foreign country may be entered if needed.
Home	Home telehone number.
Fax	Fax telephone number
Work / Ext	Work telephone number and extension
Other	Other telephone number
Mobile	Mobile telephone number
Pager	Pager telephone number
E-Mail	E-Mail address

Details

Birth	Date of Birth. See date field definition for use of two/four digit years.
Marital Status	Marital Status

Sex   Sex (Male, Female, Unknown)
Specialty   [Specialty](#) that best describes the specialty of the staff member

Identification Numbers

Soc Sec No   Social Security Number
Tax ID No   Tax ID number of the referral provider's practice
UPIN   Universal Provider Identification Number

If the UPIN is unknown or recently applied for, entered "PENDING" as the UPIN and MedSuite will hold all claims for the referring provider.

NPID   National Provider Identifier number

If the NPI is unknown or recently applied for, entered "PENDING" as the NPI and MedSuite will hold all claims for the referring provider.

State Lic No   State License Number

User-Defined Fields

Up to four user-defined fields may be entered. These fields may be set up in the [Practice Setup - UDF Info Tab](#)

Buttons

OK   Close the form and save the changes
Cancel   Close the form and do not save the changes (if any).

IMAGING TAB

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral

- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree   A "tree" structure containing a list of the images tied to the displayed
                    entity (Patient, Visit, Plan, etc.) is displayed on the left side of the
                    window.

                    The "tree" contains five "branches" although all five are never displayed
                    at the same time. The "leaves" on each branch represent images
                    indexed to the branch. The branches are:

                    - Patient - Images indexed to the patient (Action = Patient)
                    - Visits - Images indexed to visits (Action = Visit-New)
                    - Payments - Images indexed to visits (Action = Payment
                      Insurance -
                        New or Payment Self - New)
                    - Claims - Images indexed to claims (Action = Claim Followup)
                    - Miscellaneous - Images indexed via Manual Indexing to some
                    other
                        entity from the list above

Refresh   Refreshes the Image Tree
View   Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc   The description assigned to the image by MedSuite is displayed.
Toolbar   MedSuite's Imaging Workflow screen contains a toolbar that contains
                    buttons that perform image manipulation.

Zoom-In   Zooms-In (enlarges) the image
Zoom-Out   Zooms-Out (reduces) the image
Rotate Left   Rotates the image 90-degrees to the left
Rotate Right   Rotates the image 90-degrees to the right
Show / Hide   Enlarges the image by hiding the annotations on the right side of the
Annotations   screen
Actual Size   The image is displayed at its actual size. This is the default setting
                    upon entering the imaging screens.
Fit Page   The image is re-sized so that the entire image is displayed on the
                    screen. If you change to the Fit Page setting and don't go back to

	Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.
	In effect, the image is placed in an Imaging Station in a "ready to be processed" state.
	Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.8.5   Referral Types

Referral Types are used to help categorize staff members. Each Referral Type supports a "process-as" type. These "process-as" types are P-Physician and R-Resident and control certain logic in MedSuite.

Lookup	Lookup value assigned to the group
Name	Name assigned to the group
Process Type	P-Physician

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ❧ Date Changed - The date the change was made to the file.
- ❧ User Name - The name of the user that made the change.
- ❧ Item Changed - The file name of the item that was changed.
- ❧ Old Value - The system value before the change was made.
- ❧ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.8.6   Referral Groups

Referring providers may be organized into groups. For example, a practice might want to track the physicians who are members of an OB-Gyn group as a group of physicians and not individual providers. These groups may be designated as control breaks on reports.

Lookup	Lookup value assigned to the group
Name	Name assigned to the group

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ❧ Date Changed - The date the change was made to the file.
- ❧ User Name - The name of the user that made the change.
- ❧ Item Changed - The file name of the item that was changed.
- ❧ Old Value - The system value before the change was made.
- ❧ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.8.7   Copy Referrals

This Utility program allows the user to copy all Referrals and Referral Groups from the "current" practice to a different practice.

New Values

Practice   Enter/Select the Practice to copy the Referrals and Referral Groups.

6.8.8   Staff Listing

Task Name   Task Name displayed in the Task Viewer
Cube Data   Indicates if report results should be output to a data cube
Generate Standard   Indicates if report results should be output to a formatted report
Report
Run Now   Indicates in the report should be run immediately
Schedule   Indicates that the report should be scheduled to run at a future time
Schedule Button   Invokes the Task Schedule Wizard to guide the user through setting the
                            report run date(s) and time(s)

6.9   System Administration

The System Administration sub-menu of the Setup menu provides access to all of the System Administration functions including:

Function	Global	Description
Company	Y	Maintain password control information and requirements.
Practices	Y	Maintain practice names, addresses, and other control information
Practice Types	Y	Maintain practice types to be used for reporting purposes
Divisions	Y	Maintain division names, addresses, and other control information
Division Types	Y	Maintain division types to be used for reporting purposes
Users	Y	Maintain user names, addresses, and other control information
User Groups	Y	Maintain user groups and security information
User Types	Y	Maintain user types to be used for reporting purposes

6.9.1   Practices

Practice maintenance contains a great deal of practice setup information. Practice maintenance is performed via a tabbed dialog made up of seven (7) tabs:

- General
- Anesthesia
- Claims
- Statements
- Dunning Messages
- Defaults
- UDF Info
- Quick Picks
- Imaging

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.9.1.1   General

The Practices - General tab contains demographic and billing control information about the practice

Practice Information

Lookup	Lookup value assigned
Name	Description
Address	Address consisting of:

- Street Address
- Street Address (Add'l)
- City
- State
- Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

The Street Address fields have been limited to 30-characters of input as the electronic statement file layout has a 30-character limitation o the address.

Country	A foreign country may be entered if needed.

Phone	Telephone number.
Fax	Fax telephone number
Phone Other	Other telephone number
Contact	Select/Enter contact at company
Email	Enter email address of contact
Practice Type	Select/Enter practice type
Report Name	Enter Practice Name to appear in headings of reports
Domain Name	Enter Domain Name (medsuite.com, etc.)
PerSe Client ID	Enter the Per-Se Code assigned to this practice

Control Information

Patient/Account Auto Number	Indicate if automatic numbering of patients and account-holders will be used for the practice.
Pat No Prefix	You may assign up to a three-character prefix to the account number. This is most helpful to billing companies with multiple practices to distinguish the patients from one practice to another.
Starting At	Enter the "seed number" of the patient number. This will be the starting point of the account numbers.
Account No is Patient No w/Suffix	Account Holders have different #s than Patients. If this box is left un-checked, it will be the next available number. If this box is checked, the Account Number and Patient Number will be the same, but with the addition of the Suffix defined below.
Account No Suffix	If the option above is selected for Account No is Patient No with Suffix, enter the Suffix to be assigned to the Account No here, such as A, which would attach an A to the end of the Account No.
Allow Patient Number Modification	Allows users to override patient numbers that are system generated.
Require Diagnosis on Visit	Indicates if a diagnosis code will be required in Visit Entry.
Skip Title and Salutation	Indicates if the Title and Salutation fields should always be skipped. This apply's to demographic entry as well as other dictionary files with this field such as Contacts.

Patient Search Information

Note: Running a search using Enhanced Search List or excluding Zero Balance Accounts is slightly slower than the non-Enhanced Search List and including all accounts. The reason for this is than the Enhanced Search is more complicated and performs additional sub-queries that are not otherwise necessary.

Enhanced Search List	The Patient/Account Search will retrieve the oldest Visit Date with an open balance, the Patient/Account Balance, the Division from the oldest Visit with an open balance, and display Patients/Accounts which have visits in Collection in red.
Include Zero Balance	Sets the default value that will be used by the Patient/Account Search

Accounts by Default   for retrieving Patient or Accounts with Zero Balances. This option can be overridden on a search-by-search basis.

Practice Display Colors

Font Color   Select the foreground color to display in the practice selector and the Open Record segment for the practice.

Background   Select the background color to display in the practice selector and the Open Record segment for the practice.

Co-Pay

[Payment Type](#)   Enter/Select the payment type code to be used on account prepayments.

Group Practice Menu

Group Name   Enter the Menu Group Name

6.9.1.2   Anesthesia

The Practices - Anesthesia tab is used to control a number of anesthesia-specific functions :

Providers of Record

Anesthesiologist   Select how the provider of record will be determined for anesthesiologists when there are multiple anesthesiologists on a case:
- First on Case
- Last on Case
- Longest Time on Case

Anesthetist   Select how the provider of record will be determined for anesthetists when there are multiple anesthetists on a case:
- First on Case
- Last on Case
- Longest Time on Case

Concurrency Edits

The following are are default editing indicators used when running the concurrency report:

Physicians   Perform Physician Edits:
Personally Performing on more than on case simultaneously
Personally Performing and Medically Directing simultaneously

Assistants   Perform Assistant Edits:
Personally Performing on more than on case simultaneously
Personally Performing and Medically Directed simultaneously

Surgeons   Perform Surgeon Edits:
Performing on more than on case simultaneously

Facilities   Perform Facility Edits:
Physician is performing in multiple facilities simultaneously

Locations   Perform Location Edits:
Physician is performing in multiple locations simultaneously

O/R Suites   Perform O/R Suite Edits:
O/R is being used for multiple cases simultaneously

Miscellaneous

Perform Concurrent Time   Indicates if the Concurrent Case Audit will be performed in the nightly
Audit in Batch   Close Out.
Release Batches w/   Indicates if Visit Batches with Concurrency Errors can be released for
Concurrency Errors   the Close-Out and posting.

Require Case Times on Visit	Indicates if start and stop times must be entered on anesthesia visits.

Required

If the time is required, the user must enter a start or stop time that is not equal to 0:00. Both times cannot be 0:00. In addition, if a physician is present on the case, then there must be a time segment on the case for the physician where either the start or stop time is not 0:00. If an assistant (CRNA, AA, etc) is present on the case, then there must be a time segment on the case for the assistant where either the start or stop time is not 0:00

Not Required

If the time is not required, the user will receive a warning message if both the start and stop times are 0:00. In addition, a warning mesage will be generated if a physician is present on the case, and there is no time segment for the physician or there is a time segment from the physician and both the start and stop times are 0:00. A warning mmessage will be generated if an assistant (CRNA, AA, etc.) is present on the case, and there is no time segment for the assistant or there is a time segment from the assistant and both the start and stop times are 0:00.

Lock Date on Posted Anesthesia Visit	Indicates if the Visit Date will be a modifiable field after a Visit is posted.

Anesthesia Procedures

99100 - Extreme Age	Select the procedure that will be billed for the Extreme Age anesthesia risk factor for the practice
99116 - Hypothermia	Select the procedure that will be billed for the Hypothermia anesthesia risk factor for the practice
99135 - Hypo tension	Select the procedure that will be billed for the Hypo tension anesthesia risk factor for the practice
99140 - Emergency	Select the procedure that will be billed for the Emergency anesthesia risk factor for the practice

Physical Status Procedures

Include Bundled Units in Charge Journal Hash	Indicates if the bundled units for the respective physical status values are to be included in the hash total on the Visit Worksheet/Journal
P1 Procedure - P6 Procedure	Select the procedure that will be billed for each of the applicable physical status values

Batch Concurrency Audits

If the Concurrent Time Audit is to be run during the nightly CloseOut, select which audit errors it should perform and report. If none are selected, the report will run but not report any errors.

In addition, when the "stand-alone" Concurrent Case Audit is run, it will default in the settings from this screen, unless nothing is selected on this screen. In that case, the "stand-alone" Audit will default to Physician and Assistant audits.

Physicians	Warning if the anesthesiologist is personally performing one case and medically directing another case simultaneously.
Assistants	Warning if the anesthetist is performing two cases simultaneously.
Surgeons	Warning if the surgeon is performing two cases simultaneously.
Facilities	Warning if the physician is directing cases in more than one facility simultaneously. This audit is optional as the "facility" as defined in MedSuite may not directly correspond to a physically separate building. In some cases it may be a physically separate building, making medical direction an impossibility.
Locations	Warning if the physician is directing cases in more than one location simultaneously. This audit is optional as the "location" as defined in MedSuite may not directly correspond to a physically separate building. In some cases it may be a physically separate building, making medical direction an impossibility.
O/R Suites	Warning if the physician is directing cases in more than one O/R Suite simultaneously. This audit is optional as the "OR Suite" as defined in MedSuite may not directly correspond to a physically separate building. In some cases it may be a physically separate building, making medical direction an impossibility.

6.9.1.3   Claims

The Practices - Claims tab is used to indicate certain claims controls for the practice.

Claim Sorting

The tab contains two lists, "Unused" and "Sorted". The Unused list contains fields that may be used for claim sorting, while the Sorted list contains the fields that are currently being used for claims sorting. The fields in the Sorted list may be arranged by the user into the sequence that the claims will be sorted in.

Claim Control

File Zero Fee Charges on Claims	Indicates whether or not zero dollar charges will be reported on claims or suppressed. If un-checked, the "main" anesthesia charge of an anesthesia case will not be suppressed. In addition, the first charge of a non-anesthesia encounter will not be suppressed. Any other zero dollar charges will be suppressed on anesthesia and non-anesthesia encounters.
	NOTE: If the main anesthesia charge is overridden to zero, the Claim Audit report will produce a warning. If the first charge of a non-anesthesia encoencounterter is overridden to zero, the Claim Audit report will produce an error.
Assign Claim No. Prefix	Indicates if you wish to assign a practice-specific prefix to claim numbers as the ANSI 837 files are created. This prefix can be used to identifiy claims coming from one practice vs. another or from MedSuite vs. an old system during the transition period to MedSuite.
	Ths prefix is not stored in the MedSuite Billing Table and should not be entered with the payment.
Claim No. Prefix	Prefix to be assigned to claim numbers for the practice.

Default Payment Status Values

Zero Balance Claims	Indicates what the payment status should be set to when an insurance payment causes the balance of a claim to go to zero.

Allowable values are:
- Blank - Do nothing allow any other defaults or manual override to occur
- Paid - Default to the next level of processing. This may produce a secondary claim with no amount due
- Held - Hold the claim open at the current level
- Self - Proceed to the self-pay level. Does no produce a secondary claim.

Defaulting of the payment status only occurs on open claims. If a claim has been previously closed, this default will not occur.

Credit Balance Charges	Indicates what the payment status should be set to when an insurance payment causes the balance of a charge to go to below zero (credit balance).

Allowable values are:

- Blank - Do nothing, but any other defaults or manual override to occur
- Paid - Default to the next level of processing. This may produce a secondary claim with no amount due
- Held - Hold the claim open at the current level
- Self - Proceed to the self-pay level. Do no produce a secondary claim.

Defaulting of the payment status only occurs on open claims. If a claim has been previously closed, this default will not occur.

6.9.1.4   Statements

The Practices - Statements Tab contains setup information that controls how and when statements will be created.

Billing Control Information

Min Balance to Send a Statement	Enter the minimum amount to bill. Amounts below this will be written-off as small balance adjustments.
Small Bal Adj	Enter/Select the small balance adjustment type.
Min Pay Amount to Reset Dunning	Enter the minimum amount at will be accepted as sufficient payment to keep the account current.
Days to Bill without a Payment	Enter the maximum number of days to bill with receiving a self-payment that satisfies the Min Pay Amount to Reset Dunning.
Bad Debt Type	Enter the bad debt adjustment type that should be used when accounts are written-off to Collection.
Bad Debt Class	Enter/Select the account class that collection accounts should be changed to after the write-off.

Finance Charge Control

Bill Finance Charges	Indicates whether Finance Charges should be added to delinquent self-pay balances. NOTE: Account Classes must be set up with the option to "Bill Finance Charges" in order for this to be utilized.
After _____ Days	Enter the number of Days after which a Finance Charge should be added to a delinquent self-pay balance. Select how the number of days should be counted: • From the Original Bill Date • From the Last Payment Date
Monthly Rate (%)	Enter the percentage that should be used in calculating the Finance Charge. The delinquent self pay balance will be multiplied by this percentage to arrive at the finance charge. Example: delinquent balance of $324 at 1.5% is a finance charge of 4.86.
Minimum Amount	If you want to set a Minimum Amount for the Finance Charges, enter it here. If the calulated Finance Charge is less than the specified minimum, the system will use the minimum amount instead.
Fin Chrg Adj Type	Enter the adjustment type to be used on Finance Charge Adjustments.

Statement Control

Break By	Indicates the break level on the statement: • Account • Patient • Visit
Return Address	Indicates the return address and phone number to use on statements: • Practice • Division **Statements WILL NOT NECESSARILY break by division, but that the return address on the statement will be the division from the oldest visit with an open self pay balance. So a patient may have open balances in two different division and only one will be reported on the statement.**
Create Full Transaction Detail Statements	Indicates if statements are to be generated with full transaction detail every time they are created or if detail will be printed once and the "roll-up" into a balance forward on subsequent statements.
Print Zero Fee Charges on Statements	Indicates if charges for zero amount will be printed on statements.
Print On-Bill Payment Notes on Statement	Indicates if payment notes will be printed on statements.
Print Claim and Statement History	Indicates if claim and statement history messages will be printed on statements.
Group Visits by Visit Type	Indicates if statements will be grouped by Visit Type and if the Visit Type Statement Group Description will be printed on the statement rather than the procedure description.
After Acct Balance Zero, Print one Last Statement	Indicates if there should be a zero balance statement sent to the patient when the account reaches a zero balance. ". If this field is checked, MedSuite will print a final bill for all accounts that go to a zero balance so that the patient can both get a final statement and also see how their account went to zero balance. Please note that unless a Special Bill Message is selected to print on the statement, this final statement will print the first dunning message, but it will show a Balance Due 0.00. If you would like, create a Special Bill Message to be used to tell the patients that you received their payment and the account has been paid, this is an informational statement only.
Supress Zero Balance Activity that is 60 Days or Older	MedSuite will attempt to print any statement detail tha has not previosuly printed on a statement. So, for example, if a patient made a payment that resulted in a zero balance account and the "Print One Last Statement" option above is not used, then a statement will not print. However if subsequent self pay actvity occurs (a new balance dropping to self) then the old activity (the patient payment that dropped the balance to zero) may create a statement. This option prevents this occurrence if the activity is older than 60 days old.
Send Electronically	Indicates if statements will be generated to electronic transmission or if hard-copy will be created.
Production	Indicates in electronic statements are in a production or test status.
Vendor	Select the electronic statement vendor

File Name / Seq No   Enter the file name and sequence number for electronic statements. This is filled in by MedSuite.

Accept VISA   Flag to send on electronic statements to indicate if the practice accepts VISA.

Accept MasterCard   Flag to send on electronic statements to indicate if the practice accepts MasterCard.

Accept Discover   Flag to send on electronic statements to indicate if the practice accepts Discover.

Accept American Express   Flag to send on electronic statements to indicate if the practice accepts American Express.

Statement Messages

Statement Message Box   Enter a special message to appear on all statements.

Statement Credit Card Message   Enter a special credit card message to appear on all statements.

Statement Checks Payable Message   Enter a "Make Checks Payable To: line on all statements.

Statement Visit Captions

Anesthesia Caption   Caption Defaults to "Anesthesia Services:" for all visit types that are entered with an Anesthesia visit type. This is the visit-level description that will print on statements for anesthesia visits. Enter an alternate caption if this should be different for the practice.

All Other Visit Types Caption   Caption Defaults to "Patient Encounter:" for non-anesthesia visit types. This is the visit-level description that will print on statements for non-anesthesia visits. Enter an alternate Caption if this should be different for the practice.

6.9.1.5   Dunning Messages

The Practice - Dunning Messages Tab contains the text of up to four Dunning Messages that will appear on statements unless they are overridden by Special Billing Messages. Up to four lines of 60-characters of text per line may be entered, for a total of 240 characters.

6.9.1.6   Defaults

The Practices - Defaults tab contains information about how certain items in demographics, visits, and payments may obtain default values.

Default into New Demographics

Collector Group	Enter/Select the collector group to be used as the default on new accounts. This may be left blank.
Agency	Enter/Select the collection agency to be used as the default on new accounts. This may be left blank.
Account Class	Enter/Select the account class to be used as the default account class on new accounts. This may be left blank. Note: If an Account Class is specified on the patient's PRIMARY Insurance Plan Details Tab, it will override the Practice Default Account Class specified here.
	Regarding Self Pay Plans: This function does NOT work on a Self Pay Plan. Because there is NO plan on a self pay patient, they software doesn't know what plan to look at to pull the account class. The programs are pulling the account class from the patient's primary plan. If there is NO primary plan, it can't pull anything except the default from the practice. If you want a special account class to be used specifically for Self Pay accounts with no insurance, then you may want to set up the Practice Default to the Self Pay account class. Then, make sure ALL other plans have a different account class specified, otherwise, they will also default to the Self Pay account class.

Demographic Entry

Enter Employer Using Lookup Control	Indicates that the employer will be selected from a pre-defined list
Enter Employer Free-Form	Indicates that the employer will be entered as free-form text.
Allow Both	Indicates that either mode may be used (selecting from a pre-defined list or entered as free-form text.

Default from Last Visit

Division	Default the Division from the Previous Visit
Visit Date	Default the Visit Date from the Previous Visit
Batch Number	Default the Batch Number from the Previous Visit
Anesthesia Type	Default the Anesthesia Type from the Previous Visit
Physician	Default the Physician from the Previous Visit
Facility	Default the Facility from the Previous Visit
Location	Default the Location from the Previous Visit
O/R Suite	Default the O/R Suite from the Previous Visit

Remittance Defaults

Blank the Remit Date   On Electronic Remittance Advice, checking this option will leave the
                          Remit Date on the payment blank instead of using the Check Date.
                          Users will need to enter the correct Remit Date before releasing the
                          Payment Batch. Leaving this option un-checked will default the
                          Check Date into the Remit Date field on the payment.

Locality Processing

Require Entry of Locality   Indicates if the Locality field will be required in Facility Setup and on
       on Facilities   Facilities in Visit Entry.

6.9.1.7   UDF Info

The Practice - UDF Info Tab contains information about how user defined fields may be created in several
functions in MedSuite including:

Staff	Maintains up to four field tags that, if entered, will be displayed as data entry fields in Staff maintenance.
Referrals	Maintains up to four field tags that, if entered, will be displayed as data entry fields in Staff maintenance.
Facilities	Maintains up to four field tags that, if entered, will be displayed as data entry fields in Staff maintenance.
Employers	Maintains up to four field tags that, if entered, will be displayed as data entry fields in Staff maintenance.
Patients	Maintains up to ten field tags that, if entered, will be displayed as data entry fields in Staff maintenance.

6.9.1.8   Quick Picks

The Practices - Quick Picks tab contains information about how Quick Picks may be billed for a practice.

Procedure	Enter/Select the procedure to appear on the Quick Pick List in visit entry
Visit Type	Allows the user to set the Visit Type for Quick Picks so based on the Visit Type in Visit Entry the user can have different sets of Quick Picks (i.e. one for set Pain & one set for Anesthesia). If the Visit Type is left blank it is used for all Visit Types.

Quick Pick Buttons

New	Add a new procedure to the Quick Pick List
Edit	Edit and existing procedure on the Quick Pick List
Delete	Delete a procedure from the Quick Pick List

6.9.1.9   Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

	• Patient - Images indexed to the patient (Action = Patient)
	• Visits - Images indexed to visits (Action = Visit-New)
	• Payments - Images indexed to visits (Action = Payment Insurance -
	   New or Payment Self - New)
	• Claims - Images indexed to claims (Action = Claim Followup)
	• Miscellaneous - Images indexed via Manual Indexing to some other
	   entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the

selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.
	In effect, the image is placed in an Imaging Station in a "ready to be processed" state.
	Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

6.9.2   Practice Types

Divisions may be categorized by Division Type for reporting purposes. This is an optional file.

6.9.3   Set Accounting Period

This function allows the user to "close" the current accounting period and open a new one. Each charge, apyment and adjustmetn transaction is "stamped" with the current accounting period. An accounting period (or month) may be held open until all charges, payments, and adjustments are posted.

The benefits of accounting period over posted date as a reporting period is that the user doesn't have to remember what posting date range defines a month for a specific practice. When all work has been entered and posted, the user simply "closes" the accounting period.

Practice	Select the practice to be closed from the drop-down list.
Current Period	Displays the current accounting period for the practice.
Next Period	Displays the "next" accounting period for the practice.

When the Ok button is pressed, the Next Period becomes the "Current" Period.

6.9.4   Divisions

Division maintenance contains division setup information. Division maintenance is performed via a tabbed dialog made up of three (3) tabs:

- General
- Allowed Facilities
- Allowed Staff
- Imaging

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.9.4.1   General

Division maintenance contains setup information about divisions including:

Division Information

Lookup	Lookup value assigned
Name	Description
Address	Address consisting of:
	• Street Address

- Street Address (Add'l)
- City
- State
- Postal Code

	The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Country	A foreign country may be entered if needed.
Phone	Telephone number.
Fax	Fax telephone number
Phone Other	Other telephone number
Tax ID	Federal Tax ID
NPI	National Provider Identifier number for the division, if applicable. If the practice has been assigned an NPI#, enter it here.
Taxonomy	Group Taxonomy Code (required by some plans for electronic claims)
Contact	Select/Enter contact at the division
Email	Enter email address of contact
Division Type	Select/Enter division type
Report Name	Enter Division Name to appear in headings of reports

Defaults

Visit Type	Enter/Select the visit type to be used as the default visit type on new visits. This may be left blank.
Medical Direction	Enter/Select the Medical Direction to be used as the default on new anesthesia visits. This may be left blank so that no Medical Direction will default in Visit Entry. However, an anesthesia visit may not be saved without having a Medical Direction.

EMC Information

EMC Format	Enter/Select the format used for electronic claims

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.9.4.2 Allowed Facilities

Allowed Facilities

The Allowed Facilities Tab allow you to create a cross-reference of Facilities that are valid within each Division. Many large practice break their Division's along Facility lines. The Allowed Facilities creates a "sanity check" that tries to ensure that the Division on a Visit is in synch with the list of valid Facilities for that Division.

6.9.4.3 Allowed Staff

Allowed Staff

The Allowed Staff Tab allow you to create a cross-reference of Staff that are valid within each Division. Many large practices either break their Divisions along Staff lines or are setup so that certain Staff may only provide services for certain Divisions. The Allowed Staff creates a "sanity check" that tries to ensure that the Division on a Visit is in synch with the list of valid Staff for that Division.

The floowing check-boxes indicate whether a Staff not in the Allowed Staff will be permitted to be entered in Visit Entry.

Non-Allowed Staff is Error	Do not permit non-allowed staff to be saved with visit.
Non-Allowed Staff is Warning	Permit non-allowed staff to be saved with visit but issue a warning.

6.9.4.4 Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral

- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree	A "tree" structure containing a list of the images tied to the displayed entity (Patient, Visit, Plan, etc.) is displayed on the left side of the window.
	The "tree" contains five "branches" although all five are never displayed at the same time. The "leaves" on each branch represent images indexed to the branch. The branches are:

- Patient - Images indexed to the patient (Action = Patient)
- Visits - Images indexed to visits (Action = Visit-New)
- Payments - Images indexed to visits (Action = Payment Insurance -
  New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
  entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to

Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Fit Width   The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print   Prints the displayed image

Un-Index   Displays the Move Images to Imaging Station screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image.

In effect, the image is placed in an Imaging Station in a "ready to be processed" state.

Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

6.9.5 Division Type

Divisions may be categorized by Division Type for reporting purposes. This is an optional file.

6.9.6 Company

Company maintenance contains company setup information. Company maintenance is performed via a tabbed dialog made up of two (2) tabs:

- General
- Imaging

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ⚭ Date Changed - The date the change was made to the file.
- ⚭ User Name - The name of the user that made the change.
- ⚭ Item Changed - The file name of the item that was changed.
- ⚭ Old Value - The system value before the change was made.
- ⚭ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.9.6.1   General

The Company Setup/Maintenance allows the user to specify the login security and criteria for all users in the Company database. The Company Maintenance screen consists of 5 options that are listed below.

Security

Minimum Password Length	Indicates the minimum number of characters required in a users password. If a user selects a password with fewer characters, they will receive a system error. They must select a password with at least the number of characters specified in this field. If you prefer that no minimum password length be required, then leave this field 0.
Number of Unique Passwords Required	Indicates the number of unique passwords required before a password can be reused. Passwords may not be re-used for the number of iterations specified here. If the number of unique passwords required is set to 3, then the password can only be re-used after 3 other unique passwords have been used. If left 0 for no minimum number of unique passwords required, the user may re-use their password each time it expires.
Days Before Requiring New Password	Indicates the number of days that should pass before passwords expire and the user is required to change their password. The current password set for the user will expire after the number of days specified here. At that time, MedSuite will prompt the user to enter a new password that meets the minimum length, minimum number of unique passwords required, and/or the strong password criteria setup by the Administrator. If left 0, there is no password expiration date and the user passwords will never expire.
Number of Failed Logins Before Lockout	Indicates the number of times a user can attempt to login before they are "locked out" of the system. The will be "locked out" of the system until a "Password Reset" or "Unlock User" is performed by an Administrator. If left 0, then there will be no user lockouts after failing to log in properly. *Note: An Administrator can become "locked-out" due to reaching the number of failed logins before lockout. In this situation, only MedSuite can reset the Administrator's password.*
Require Strong Passwords	Indicates that the system should require a password to contain at least one alpha (A-Z) and one numeric (0-9) character. The system will then prompt the user to enter a different password that contains this required criteria. The system will not allow the user to log in until a password meeting this criteria is entered. Leave the check box blank if you do not want the system to require that the user password contain at least one alpha (A-Z) and one numeric (0 -9) character.

The Security Log tracks a number of security events such as users who have becomed locked out, users who have changed their passwords, etc. and should be reviewed to monitor for any security breaches or violations.

Configuration Options

Default Patient/Account   Indicates the Multi-Practice Search option in Patient/Account Search will
Search to Multi-Practice be set "on" or "off" as a default.

6.9.6.2   Company Imaging

MedSuite supports both Workflow Indexing and Manual Indexing. Workflow Indexing may index images
to Patients, Visits, Payments, and Claims. In addition to Patients, Visits, and Payments, Manual
Indexing allows images to be indexde to the following list of "entities":

- Account
- Visit
- Visit Batch
- Payment
- Payment Batch
- Claim
- Company
- Practice
- Division
- Carrier
- Staff
- Referral
- Facility
- Plan
- Fee Schedule
- Rate Structure

An Imaging Tab has been added to the Patient, Visit, Payments, Ledger, as well as the Setup functions
of the above entities so that images indexed to the entity may be viewed by the user.

This tab contains a common frame that is used throughout MedSuite.

Image Tree   A "tree" structure containing a list of the images tied to the displayed
                          entity (Patient, Visit, Plan, etc.) is displayed on the left side of the
                          window.

                          The "tree" contains five "branches" although all five are never displayed
                          at the same time. The "leaves" on each branch represent images
                          indexed to the branch. The branches are:

                          - Patient - Images indexed to the patient (Action = Patient)
                          - Visits - Images indexed to visits (Action = Visit-New)
                          - Payments - Images indexed to visits (Action = Payment
                          Insurance -

New or Payment Self - New)
- Claims - Images indexed to claims (Action = Claim Followup)
- Miscellaneous - Images indexed via Manual Indexing to some other
entity from the list above

Refresh	Refreshes the Image Tree
View	Views the selected image from the Image Tree

The "image" portion of the window covers the right-most 3/4 of the window. It contains a copy of the selected image as well as button that permit manipulation of the image.

Desc	The description assigned to the image by MedSuite is displayed.
Toolbar	MedSuite's Imaging Workflow screen contains a toolbar that contains buttons that perform image manipulation.

Zoom-In	Zooms-In (enlarges) the image
Zoom-Out	Zooms-Out (reduces) the image
Rotate Left	Rotates the image 90-degrees to the left
Rotate Right	Rotates the image 90-degrees to the right
Show / Hide Annotations	Enlarges the image by hiding the annotations on the right side of the screen
Actual Size	The image is displayed at its actual size. This is the default setting upon entering the imaging screens.
Fit Page	The image is re-sized so that the entire image is displayed on the screen. If you change to the Fit Page setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.
Fit Width	The image is re-sized so that the width of the image fills the image area. If you change to the Fit Width setting and don't go back to Actual Size, subsequently viewed images will display with this setting until you change it back to Actual Size.

Buttons

Several buttons are displayed across the bottom of the screen and are used as follows:

Print	Prints the displayed image
Un-Index	Displays the [Move Images to Imaging Station](#) screen. You should enter/ select the Imaging Station that you want the document moved to. When you press Ok on the Move Images screen, the selected image is removed from the Image Tree and any indexes on the image are removed from the image. In effect, the image is placed in an Imaging Station in a "ready to be processed" state.

Un-Index can be used any time that an image is index to the wrong entity. Although it may be used on Patients, Visits, Payments, or Claims, this is not typical. The Workflow will generally create these entities so it is unlikely that they will be incorrectly indexed.

6.9.7   Users

User Setup is a relatively straight-forward function. The only item with any complexity to it is the definition of MedSuite's Security functions which are discussed in User Groups Setup. User Setup consists of the following functions:

- Collector Groups
- Users
- User Groups
- User Types

Collector Groups and User Types are optional. However, Users and at least one User Group need to be set up to allow access to a company and a practice within the MedSuite software.

6.9.7.1   Collector Groups

Collector Groups are used to assign Users to accounts for pre-collection purposes. A User may be assigned to a Collector Group and a Collector Group may be assigned to an Account. This is an optional file.

Lookup	Lookup value assigned to the group
Name	Name assigned to the group

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- ☞ Date Changed - The date the change was made to the file.
- ☞ User Name - The name of the user that made the change.
- ☞ Item Changed - The file name of the item that was changed.
- ☞ Old Value - The system value before the change was made.
- ☞ New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.9.7.2   Users

User setup is available to <u>Administrator</u> users. Upon entering the Users setup from the menu, a table is displayed of Users already set up in the Company. Any users who have been "locked out" because they exceeded the number of failed login attempts allowed are displayed in Blue.   Buttons display at the bottom of the screen:

There are several security restrictions in User Maintenance

- A User (other than the "Admin" User) cannot modify their own security setting
- A User (other than the "Admin" User) cannot modify the "Admin" User
- A User cannot grant access rights to a practice to another user if the user trying to grant access rights does not already have access rights to that practice

Unlock User	Removes a "lockout" from the selected user if they have exceeded the number of failed logins allowed and have been locked out of the system. It will not reset their password.
Reset Password	Resets the selected user's password. The next time the user attempts to log in to MedSuite, they will be required to enter a new password. The "Reset Password" option also removes a "lockout" from the selected user if they have exceeded the number of failed logins allowed and have been locked out of the system.
New Button	Opens the Users Dictionary so that a new user may be added.
Edit Button	Opens the selected user from the table in an edit mode.
Delete Button	Deletes the selected user from the Users Dictionary.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.9.7.2.1 Users - Setup Screens

General - Tab

The Users - General tab contains demographic and billing control information about the staff member. Users are created and assigned to User Groups. The User Group setup is where you may define exactly to which menu items members of a User Group have access.

Lookup	Enter the Lookup value assign to the User
User Type	Enter/Select the User Type assigned to the User. The User Type is utilized by reports in MedSuite as well as the <u>Access History</u> tab of the Ledger.
Staff	Enter/Select the Staff Member if the User is a Staff Member
Collector Group	Enter/Select the Collector Group that the User is a member of

Login

Login Name	Enter the name this user will use to log into the MedSuite software.

Name

Title	Title (Mr, Ms, Mrs, etc.)
Salutation	Indicates how letters will be addressed (Dear Salutation....) Values are:
	• Title & Last Name
	• First Name
	• Nickname
First/M/Last	Name entered in First, Middle and Last sequence
Nickname	Nickname. Will default from the user's first name
Generation	Generation (Jr., Sr., etc.)
Degree	Degree (MD, CRNA, PhD, etc.)
Address	Address consisting of:
	• Street Address
	• Street Address (Add'l)
	• City
	• State
	• Postal Code
	The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.
Country	A foreign country may be entered if needed.
Home	Home telephone number.
Fax	Fax telephone number
Work / Ext	Work telephone number and extension
Other	Other telephone number
Mobile	Mobile telephone number
Pager	Pager telephone number
E-Mail	E-Mail address

Flags

Administrator	Indicates if the User is a MedSuite Administrator. Administrators have access to the System Adminstration menu under the Setup menu. Only Administrator users may access the System Administration menu.

In addition, Administrator users have access to the Setup files with Edit, New, and Delete capabilities. This is true even if the user is assigned to a User Group that does NOT have access to the Setups. The Administrator flag grants them overriding access to the setup files. Administrators also have the ability in Patient Lookup screens to Delete |

accounts with demographics only. Other users will see the Delete button greyed out so only Administrators have the button active for use. Restrictions are as follows:

      1. Patients must only have one Account Holder.

      2. Patient Account must no have other patients linked to it.

      3. Patients with Charges or Payments cannot be deleted.

In addition, if Administrator is checked the user will have the ability to see Close-Out, Per-se and Backup Log Report tasks in the task viewer. If the Administrator flag is unchecked the Close-Out, Per-Se and Backup Log tabs and reports produced by those processes will not show in the task viewer unless the View Close-Out /Per-Se Tasks flag is checked.

To disable the user from viewing Closeout, Per-Se and Backup Log task reports and tabs, leave Administrator and View Close-Out/Per-Se Tasks UNCHECKED.

Administrator users have access to Reset Passwords in the User file if a user has forgotten their password. Administrators also have access to Unlock Users who have become locked-out by exceeding the number of allowable login attempts.

Administrator users have access to the Logs under the Reporting menu, including the Access Log and Security Log.

View Close-Out / Per-Se Tasks	Indicates if the User may view Close-Out, Per-Se and Backup Report tasks. If this option is unchecked, the user will not be able to see the Closeout, Per-Se or Backup Log tabs in the task viewer or any reports those processes produce unless the Administrator flag is checked.
	To disable the user from viewing Closeout, Per-Se and Backup Log task reports and tabs, leave Administrator and View Close-Out/Per-Se Tasks UNCHECKED.
Tickler Administrator	Indicates if the User is a Tickler Administrator. Tickler Administrators are permitted to view and send Ticklers to other users.
Web Restricted	Indicates if the User uses the MedSuite restricted Web Browser
Toolkit Only Company	Indicates if the User uses the Toolkit functions only

Internet

MedSuite Name	
E-Mail Address	Enter the users MedSuite email account

Security - Tab

Practice	Each Practice defined in the Company is in the list.
User Group	The User may be assigned to a User Group for each Practice in the Company list.

Additional - Tab

Dashboard Setup

Display Charts	Indicates if the Running A/R Balance Chart is displayed on the User's Dashboard
Display Payment/Visit Batches	Indicates if the Payment and Visit Batches for the User are displayed on the User's Dashboard.
Display Top Ten Tasks	Indicates if the User's Top Ten Previous Tasks are displayed on the User's Dashboard.

Limit Payment Entry Amounts

Some practices restrict users who perform insurance or self-pay follow-up from doing payment entry. Unfortunately, these same follow-up users need to use payment entry to enter insurance denials or to refresh the billing on a self-pay account by entering a zero dollar payment. Perhaps a new payment entry clerk will be restricted to entering payments and/or adjustments only up to a certain amount because they are a new employee, or possibly the billing manager wants to restrict payment and/or adjustment amounts to some "reasonable" amount to help prevent data input problems.

Payment and / or adjustment amounts can be limited for any of these reasons by entering an amount in the following fields. A blank in one of the amount fields indicates that there is no restriction on the amount that can be entered. A zero indicates that the user can only enter zero dollar payments and/ or adjustments. If an amount is entered, the amount is considered both a positive amount and a negative amount restriction. For example, if the limit is $100.00, the user will not be allowed to key in more than $100.00 or less than $100.00-(negative).

Self Amount Pay	Self Payment limit that can be entered by the user
Self Amount Adj	Self Adjustment limit that can be entered by the user
Ins Amount Pay	Insurance Payment limit that can be entered by the user
Ins Amount Adj	Insurance Adjustment limit that can be entered by the user

Buttons

OK	Close the form and save the changes
Cancel	Close the form and do not save the changes (if any).

6.9.7.3   User Groups

Access is granted to the various functions in MedSuite by granting access to the function in question to a User Group and then assigning the User Group to one or more Users within a Practice. Each User Group is defined via a tabbed dialog that contains access control information for almost all of the functions of MedSuite.

The login process provides two important pieces of Security information to MedSuite. The first is that the User is a valid User for the Company that they are attempting to login to. The second is that during the login process the User's Password has been validated. Once the user has logged-in, they will select a practice. The "intersection" of User, Practice, and User Group, provides the Security profile for a User.

Library Change Logs

The Change Log button at the bottom of any MedSuite Maintenance File will track the following:

- Date Changed - The date the change was made to the file.
- User Name - The name of the user that made the change.
- Item Changed - The file name of the item that was changed.
- Old Value - The system value before the change was made.
- New Value - The system value after the change was made and saved.

NOTE: Items not tracked are description fields such as degrees and titles.

6.9.7.4 User Types

Users may be categorized by User Type for reporting purposes. This is an optional file.

6.9.8   Utilities

Enter topic text here.

6.9.8.1 Close Zero Balance Visit Claims

The Followup Queues include all open claims, regardless of claim balance, even if the visit balance is zero. There are numerous reasons a claim could have a status of "Open" even though there is a zero balance on a visit. For example:

- A payment is posted, the balance is adjusted-off bringing balance to zero, and claim is held. This often happens with remittance processing.
- According to the ERA Rules set up on the Plan, the claim may be put on "Hold" status if the approved is less than the allowed.
- A secondary payment is inadvertently posted to the primary claim #, bringing visit balance to zero but leaving the 2ndary claim open
- Someone reprocesses a visit creating new claims that never have a payment or denial posted to them
- Primary payment/adjustment creates zero balance visit, but a secondary Medigap claim remains open

The purpose of including zero balance claims in the Queues is to allow someone to verify payment and resolve any issues associated with these claims. Managers may decide to utilize the Close Zero Balance Visit Claims utility to automatically "close" some of these claims at their discretion. MedSuite strongly recommends utilizing this program with discretion as there is no way to "undo" the results.

Practice	Select a practice from the drop down menu
Close Claims Created On/ Before	Enter a date. All claims with a zero balance created on or before that date will be closed.
Claim Options	You may select from the following options for the type of claim you want to close: • Close Held Claims w/Zero Balance Visits • Close Claims NOT Held w/Zero Balance Visits • Close Held Claims w/Credit Balance Visits • Close Claims NOT Held w/Credit Balance Visits
OK / Cancel	Select the OK button to run the utility. Select Cancel to exit the dialog without running the utility.

6.9.8.2   Reset Collection Letter

Enter topic text here.

6.9.8.3   Copy Followup Actions

This Utility program allows the user to copy one or all Followup Actions from one practice to another practice or within the same practice. The options available in this utility are as follows:

Option...	**Where...**
Copy All Actions	From One Practice to Another
Copy All Actions	Within the Same Practice
	This capability is not supported as it would have the effect of "doubling" all of the plans in a Practice.
Copy One Action	From One Practice to Another
Copy One Action	Within the Same Practice

Copy Followup From

Practice	Enter/Select the Practice to Copy the Action(s) from
Copy All Actions	The "radio-button" indicates whether all actions should be copied.
Copy One Action	The "radio-button" indicates that one action should be copied. Enter/Select the Action to be copied in the unlabeled field.

Copy Followup To

Practice	Enter/Select the Practice to Copy the Action(s) to
Name	Enter the Name that the selected actionwill be copied to.

6.9.8.4   Reset Collection Turnover

Enter topic text here.

6.9.8.5   Update Plan Filing

Enter topic text here.

6.9.8.6   Update Acct Classes from Plans

This utility will update any Account that has the Default Account Class from the Practice Default Tab with the Account Class specified on the Patient's PRIMARY Insurance Plan Details Tab.

6.9.9   Company Setup Listings

The Company Setup Listings request form is a tabbed dialog that consists of a General tab, a Table tab, and a Fields tab. The Table tab allows you to select which table(s) you would like to print. Once you have selected one or more tables, you may select the fields that you wish to report. The available tables consist of most of the Company-Level tables in MedSuite.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Table Tab

The Table Tab consists of a list of tables that you may select to print.

Fields Tab

The Fields Tab contains the list of fields that you may print on the listing.

6.9.10 Practice Setup Listings

The Practice Setup Listings request form is a tabbed dialog that consists of a General tab, a Table tab, and a Fields tab. The Table tab allows you to select which table(s) you would like to print. Once you have selected one or more tables, you may select the fields that you wish to report. The available tables consist of most of the Practice-Level tables in MedSuite.

General Tab

Task Name	Task Name displayed in the Task Viewer
Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Table Tab

The Table Tab consists of a list of tables that you may select to print.

Fields Tab

The Fields Tab contains the list of fields that you may print on the listing.

6.9.11 Approved Web Sites

If you elect to use the MedSuite Web Browser, you may restrict user's access to specific web sites. Approved Web Sites Setup allows you to define the sites that you would like to allow your users to access.

Address	Address of the web site. "Wildcards" such as * can be used to allow access all sites that contain "Blue Shield" by entering *Blue Shield*
Description	Description of the web site.

6.9.12 Favorite Web Sites

If you elect to use the MedSuite Web Browser, you may provide a list of "favorite" web sites for your User's Web Browsers.

Name	Name to appear in the "favorites" list.
Address	Address of the web site.

6.9.13 Schedule Manager

The Schedule Manager allows you to manages previously scheduled tasks. Typically, this involves changing the parameters or criteria entered when a task was scheduled or cancelling (deleting) a scheduled task.

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6.10   MedSuite Company Administration

MedSuite Company Administration items are available to MedSuite staff only.

6.10.1   Company - MedSuite only

MedSuite Company Administration items are available to MedSuite staff only.

6.10.1.1   Company - MedSuite only

MedSuite Company Administration items are available to MedSuite staff only. The Company - General tab contains demographic and billing control information about the company.

Lookup   Lookup value assigned
Name   Description
Address   Address consisting of:
- Street Address
- Street Address (Add'l)
- City
- State
- Postal Code

The tab order will skip from Street Address (Add'l) to the Postal Code. The Postal Code lookup will complete the City and State. In addition, the Postal Code lookup will default the Area Code of the telephone numbers if the Area Code is defined in Postal Code Maintenance.

Prov/Country   A province and/or foreign country may be entered if needed.
Phone   Telephone number.
Fax   Fax telephone number
Phone Other   Other telephone number
Contact   Select/Enter contact at company
Company Type   Select/Enter company type
Domain Name   Enter Domain Name (medsuite.com, etc.)
Toolkit Only Company   Indicates if the company uses the toolkit only

6.10.1.2 Company Types

MedSuite Company Administration items are available to MedSuite staff only.

6.10.1.3 Company Invoice

MedSuite Company Administration items are available to MedSuite staff only.

6.10.2 Demographics - MedSuite only

Enter topic text here.

6.10.2.1 Degrees

Enter topic text here.

6.10.2.2 Employment Status

Enter topic text here.

6.10.2.3 Gender

Enter topic text here.

6.10.2.4 Generations

Enter topic text here.

6.10.2.5 Marital Status

Enter topic text here.

6.10.2.6 Relationship to Patient

Enter topic text here.

6.10.2.7 Student Status

Enter topic text here.

6.10.2.8 Titles

Enter topic text here.

6.10.3 Financials/Visit

Enter topic text here.

6.10.3.1 Medical Direction

Enter topic text here.

6.10.4 Insurance

Enter topic text here.

6.10.4.1 Claim Editing Indicator

Claim Editing Indicator is defined by HCFA (CMS) and used on electronic claims to indicate claim type.

Lookup	Lookup value assigned
Code	One-character code to be reported on the electronic claim

6.10.4.2 Claim Payment Source

Claim Payment Source is defined by HCFA (CMS) and used on electronic claims to indicate claim type.

Lookup   Lookup value assigned
Code   One-character code to be reported on the electronic claim

6.10.5 Other

The Other sub-menu of the Setup/System Administrator menu provides access to provider specialty codes.
:

6.10.5.1 Specialty Codes

Specialty Codes are used to help categorize staff members. Each Staff Type supports a "process-as" type. These "process-as" types are Physician, Resident, Nurse, and Student and control certain logic in MedSuite. For example, only a physician may be entered into the anesthesiologist field in the Anesthesia tab of Visit Entry and only a Nurse, Resident, or Student may be entered into the anesthetist field in the Anesthesia tab of Visit Entry. This is but one example.

Lookup   Lookup value assigned to the group
Name   Name assigned to the group
Code   HCFA (CMS) Specialty Code value (01-General Practice, 05-
                              Anesthesiology, etc.)

Taxonomy

Code   HCFA (CMS) 10-character Taxonomy Code
Type   HCFA (CMS) Taxonomy Type that includes Physicians, Suppliers,
                              Agencies, etc.
Class   HCFA (CMS) Taxonomy Class that refines the Taxonomy Type and
                              includes Physician/Osteopaths, Podiatrists, Chiropractors, etc.
Description   HCFA (CMS) description for the Taxonomy Code.

6.10.6 User Listing

The User Listing request form is a tabbed dialog that consists of a General tab and a Fields tab. The Fields tab allows you to select the fields that you wish to report.

General Tab

Task Name   Task Name displayed in the Task Viewer

Cube Data	Indicates if report results should be output to a data cube
Generate Standard Report	Indicates if report results should be output to a formatted report
Run Now	Indicates in the report should be run immediately
Schedule	Indicates that the report should be scheduled to run at a future time
Schedule Button	Invokes the Task Schedule Wizard to guide the user through setting the report run date(s) and time(s)

Fields Tab

The Fields Tab contains the list of fields that you may print on the listing.

6.11   Refresh Dictionary Cache

This menu option restarts the MedSuite software and refreshes all of the locally cached dictionary (Staff, Plan, Carrier, etc) items.

7 Help Resources

MedSuite provides a variety of Help Resources both in terms of an Online Help file, complete system documentation, as well as a variety of diagnostic tools that can help your IT Staff or MedSuite's Support personnel diagnose problems.

- On-Line Help
- Hard-Copy Manual

7.1   Help

MedSuite's Help System contains a number of components. Some of these components will help you directly, while other will help MedSuite's support staff help you. Let's take a look at them:

- Contents   Executes the online help file (this document).
- Search for Help On...   Executes the online help file (this document) in "search mode"
- Keyboard Shortcuts   Displays a list of helpful Keyboard Shortcuts
- Contact Support   Displays a document containing Support Contact information and telephone numbers.
- About   Displays an "About" screen that contains MedSuite's address, telephone numbers, and web site address as well as information that may be helpful for MedSuite Support personnel such as the MedSuite version and build date.
- Splash Screen   Displays the "Splash" screen that appears after you login to MedSuite and before the MedSuite application is fully loaded.
- Diagnostics   Give the end user the ability to diagnose network.
- Network Information   Displays a good deal of Network Information for your IT Staff or MedSuite's Support personnel which may help explain why you may be having trouble connecting or staying connected to MedSuite.
- Network Test   Runs a utility that provides feedback on network speeds and response times. Select the option to Run Tests. This will run a test on your network by performing a test download to see at what speed your network is running. In addition, it will perform a Trace Route that will tell you how many "hops" are being made from your office to the servers. These diagnostic tests could be run to help you diagnosis any problems on your end if you believe your network is running slowly.
- System Information   Displays a great deal of information about your computer to your IT Staff or MedSuite's Support personnel.

7.2   Manual

You will be provided with a manual in Adobe Portable Document Format (pdf). You may create desktop shortcuts to this manual for each or your users. In addition, you may print as many copies of this manual as you would like for your users.

8 Tutorials and How-To's

This section contains a series of Tutorials and "How-To's" on a variety of topics. Many functions or features in a complex product like MedSuite are often made up of several functions. System documentation often tells us what a function is or does, but it sometimes doesn't tell us how that function is used in the "bigger picture" or how a function is tied in with other functions to perform a more complex task.

For example, Refund Processing is a relatively simple function that requires the use of the Account Listing, the Refund Manager, the Refund Listing, and Payment Entry. Since a Refund Adjustment is just another type of adjustment, is It is probably not appropriate to specifically address Refund Adjustments in the Payment Entry documentation. However, the user does need to know how and where Payment Entry is tied into the "flow" of Refund Processing.

We will be adding more tutorials to this document as they are developed.

8.1   Collection Selection / Turnover

Collection Selection and Turnover consists of the following steps:

- Collection Selection - Selects Visits for Collection Turnover
- Collection Turnover - Add and Delete Visits from Turnover
- Collection Turnover Listing - For Final Review
- Collection Turnover Listing - Write-Off / Turnover Accounts
- Payment/Adjustment Worksheet - To Balance

Before beginning the you'll need to verify the following items have been setup properly:

- Collection Agency must be setup in MedSuite under Setup/Financial/Agencies.

- The Bad Debt Adjustment Type and Bad Debt Class should be setup in MedSuite under Setup/ System Admin./Practice/Practices and the Statements tab respectively.

- Verify that the Bad Debt Class (Collection) is defined as a billable Account Class in the Account Class Set-up. This will ensure that statements will still generate on accounts that have open visits that are not in Collections.

<p align="center">**<u>If the account class is not a billable class, no statement will generate on any visits on that account.</u>**</p>

A visit in collections has two statuses:

- In-Turnover – The visit has been selected by Collection Selection, but has not yet been processed through Collection Turnover. In-Turnover visits will display in YELLOW. In-Collection – The visit has been turned over to Collections through the Collection Turnover option in the Collection Listing. The In-Collection visit will be shown in RED.

Collection Selection –Selects Visits for Turnover to Collections

Select Collection Selection from the Queues

Complete the screen with the following information on the General Tab. When the screen has been completed, select OK.

Task Name:	Will default to Collection Selection
Account Class:	Leave blank for default. It will default to the account class setup in the Practice Maintenance Statement Tab. This is the Account Class the accounts meeting the collection criteria will be **changed to** when they are turned-over. You may leave this blank.
Account Type:	If you are further categorizing your collection accounts, you may specify an Account Type. This is the Account Type the accounts meeting the collection criteria will be **changed to** when they are turned-over. You may leave this blank.
Agency:	Enter/Select the Agency to which the accounts will be turned-over
Days No Payment:	Enter the number of days at which you consider a visit to be at Collection status. Accounts that have not made a payment in this number of days will be selected for collection.
Minimum Balance:	Accounts with a balance of at least this amount will be selected for

                                  collection.

Maximum Balance: Accounts with a balance of not more than this amount will be selected for collection.

Visits that meet the criteria entered (Days No Payment, Max & Min Balances) will be submitted to the Collection Manager. Work the Collection Selection report by adding and deleting patients in the Collection Turnover screen. The Collection Selection should not be run more than once for the <u>same criteria</u>. If it is it will undo any deletions or additions you have made in the Collection Turnover screen.

Visits on accounts that have been selected for collection turnover now display in yellow in the patient ledger.

Collection Turnover – Add and Delete Visits for Turnover

To add a visit that did not show on the Collection Selection but you may want to turnover anyway (i.e. returned mail), go to the Collection Turnover screen. In the Collection Lookup Window select NEW, and then in the Collection Maintenance Window choose SELECT. In the search box type in the account holder's last name (or whatever criteria you choose) then choose OK.

Under VISIT SELECTION enter the visit date if you know it, or choose SELECT and choose it from the Collection Visit Lookup. In this example there were two visits so you can select the visit you wish to turn over. If you need to turnover multiple visits you will have to do this one at a time. The Collection Visit Lookup will ONLY display visits at the self-pay level.

Once you select the VISIT DATE in the Collection Maintenance screen you should enter the criteria you would like in each field. Select OK.

Name: Name of the account holder (i.e. Anna Alschen)

Visit Selection: Enter the visit date for the visit you wish to turnover to Collections. The Procedure Description for the 1st procedure on the visit will default from the visit selected.

Account Class: Leave blank for default. It will default to whatever is setup in the Practice Maintenance on the Statement Tab – Bad Debt Class. This is the Account Class the account will be **changed to** when it is turned-over.

Account Type: This is the Account Type the account will be **changed to** when it is turned-over. You may leave this blank.

Agency: Enter/Select the Agency to which the account will be turned-over

User Name: Defaults to the user selecting the collection turnover

Amount: Amount to be turned over to collections

Date Requested: Date of the collection turnover request

NOTE:
Any visit that has been selected by Collection Selection and is therefore in collection turnover that is subsequently paid-off and reaches a zero balance will be automatically removed from collection turnover and will not be turned over to collection by the collection turnover process. In addition, any visit that has been selected by Collection Selection and is therefore in collection turnover that has a payment made on it where the payment meets the "<u>Minimum Payment to Reset Dunning</u>" and that is flagged to "<u>Remove from Collection</u>," will be automatically removed from collection turnover and will not be turned over to collection by the collection turnover process.

Collection Turnover Listing - To Review before Turnover

After you have added all the accounts to turnover print a listing for review. To print a turnover listing, go to Queues, Collection Listing. Make sure that under Collection Options you have selected COLLECTION LISTING and under Turnover Options you have PRINT ACCOUNT LISTING checked. Printing cover sheets for the collection agency may be checked as well. The cover sheet will print out a one page summary on every account. Select OK. Go to the Task Manager to print the Collection Listing.

To remove an account or visit from the Collection Listing, go to the Collection Turnover, select the account number and select the DELETE option. The Collection Listing can be run as many times as needed.

Collection Turnover Listing – Turnover to Collections

Once satisfied with the Collection Listing go back to Queues, Collection Listing. Under the Collection Options choose COLLECTION TURNOVER. Under Turnover Options select the desired "Turnover Options". Then choose OK.

Print Account Listing:	Prints a list of all the accounts and visits on every account to be turned over to collections.
Print Cover Sheets:	Prints summary sheet needed to send to the Collection Agency.
Change Account Class:	In Turnover Context, this will change the account class, the Account Type and Agency that were entered during Collection Selection.
Write-Off Balance:	In Turnover Context, will write-off the account balance using the Bad Debt Type adjustment defined in practice maintenance.

Go to the Task Manager to print the Collection Listing/Turnover.

Visits on accounts that have been turned over to collection now display in red in the patient ledger.

Payment/Adjustment Worksheet - To Balance

Run a Payment/Adjustment Worksheet for the Collection Batch. The total on the Collection Listing should match the total on the Payment Adjustment worksheet for the Collection Batch.

After completing the Collection Process and you access an account the has had one or more visits turned-over to Collection, you may notice the following:

- The "Patient Alert" screen indicating that an account is IN COLLECTIONS will be displayed
- The Visit that was turned-over to Collection will display in RED
- A collection adjustment will show in the patient ledger

8.2　Collection Letters

In order to use Collection Letters, there is a one-time setup function that you will need to do for each practice:

Set up the Collection Letter in the Word Processor

Create a New Folder in the Word Processor for the practice you are setting up. Call the folder COLLECTION LETTER or LETTERS. Create a New Document in the new folder by right-clicking and selecting New Document. You may enter your practice name and address/phone number in the top center of the document to create a letterhead.

Insert Merge fields. From the right side of the menu bar, select Mail Merge, then View. This will display a list on the right side of the screen with categories of fields that may be used.

Select SYSTEM, then DATE to insert the date onto the letter.

Select Account, then First Name to insert the account holder's first name onto the letter. Continue by selecting the Account's last name, address 1, address 2, city, state, and zip for insertion into the letter.

Save the letter when you are done...

When the letter is saved, the software "tracks" merge fields that you have used in the letter and will make sure that all of the necessary data is available for the letter when the letter is later requested. Since a statement is not necessarily tied to a specific patient, visit or charge, letters containing merge fields that are patient, visit or charge based such as division, patient, provider, referring, procedure, date-of-service, etc. cannot be requested when a "statement" (Self Billing record) is selected in the Billing View of the Ledger. The FollowUp Queue does not have this problem as the "Self" items in the FollowUp Queue are actually visits (which do have a patient and charges) not "statements" (Self Billing records). Claims are, by definition, visit and charged based and do not have this problem either in the Billing View of the Ledger or in the FollowUp Queue.

If you have several practices that need to have letters set up, you may "copy and paste" only the portion of the collection letter that does not contain merge fields. If you copy the entire letter including the merge fields, the word processor will not recognize the merge fields as ones that need to have data inserted into them. You will then end up with collection letters that don't have any patient information on them. Therefore, you can copy the body of the letter from one practice to the next, but you will have to manually insert the merge fields on each letter as detailed above.

Add the Collection Letter to the Practice Setup

Go to Setup, Followup, Form Letters. Select NEW. Add Collection Letter to the Lookup and Name fields. Click the button next to the Document field to associate the letter in the Word Processor with this form letter. Select the letter for the practice you are working on.

To Run Weekly Letters:

Go to Queues, Collection Letters

Select the Form Letter (Collection Letter). Select Self Pay accounts. Select Letter Count 0. Select the Minimum number of Days with no payment at which self pay accounts should receive a Collection Letter. For example: Select Min Days – 75. Leave Max Days blank. This will select accounts that have had 3 statements (at day 0, 30, and 60) and it has been at least 15 days since their last statement was sent. Select to Run Now. The selected Collection Letters will be submitted to the Mail Merge Request table. The generation of the merged letters will occur during the next Close Out process.

Option: You may also use the SCHEDULE function to automate the generation of the letters so that they run automatically each week.

Print the report from Task Viewer

Go to the Task Viewer. The Collection Letters Select is a report listing the accounts to get letters.

After the Close Out completes - Print the letters from Task Viewer

After the next Close Out completes, the Collection Letters will be in the Task Viewer with the rest of your reports from Close Out. Select the Collection Letters and Print!

8.3   Form Letters

Set up the Collection Letter in the Word Processor

Create a New Document in the Word Processor by right-clicking and selecting New Document. You may create it under the Practice Documents if it will be specific to a particular practice, or create it under the Company Documents if it will be used by all practices.

Insert Merge fields. From the right side of the menu bar, select Mail Merge, then View. This will display a list on the right side of the screen with categories of fields that may be used.

Select SYSTEM, then DATE to insert the date onto the letter.

Select Account, then First Name to insert the account holder's first name onto the letter. Continue by selecting the Account's last name, address 1, address 2, city, state, and zip for insertion into the letter. Proceed with the letter, inserting fields as you wish.

Save the letter when you are done.

If you have several practices that need to have letters set up, you may "copy and paste" only the portion of the letter that does not contain merge fields. If you copy the entire letter including the merge fields, the word processor will not recognize the merge fields as ones that need to have data inserted into them. You will then end up with letters that don't have any patient information on them. Therefore, you can copy the body of the letter from one practice to the next, but you will have to manually insert the merge fields on each letter as detailed above.

Add the Letter to the Practice Setup

Go to Setup, Followup, Form Letters. Select NEW. Add the Letter to the Lookup and Name fields. Click the button next to the Document field to associate the letter in the Word Processor with this form letter. Select the letter for the practice you are working on. Indicate to whom this letter will be sent. The addressee name is used to notate the ledger when the letter is sent.

To Send a Form Letter:

"Send Form Letter" from Patient Ledger

From the Activity View or Billing View of the Ledger, right-click and select Send Form Letter. You will then be prompted as to which letter you would like to send, and whether you would like it created now or during the Closeout.

Print the Letter immediately with "Create Document Now" option

If you select Create Document Now, the letter will be created and displayed on the screen immediately in the Word Processor. You may then proceed to print the letter.

Print the Letter after the Closeout with "Create Document in Closeout" option

If you select Create Document in Closeout, the letter will be created during the next Closeout process. You will see a Mail Merge task and a Document Listing in the Closeout reports. The Mail Merge task contains the letters that have been requested that need to be printed. The Document Listing is a report showing all the different letters and the accounts getting

each letter.

After the letter has been generated (which may be after the next Closeout is run) the Activity view of the ledger will display the date the letter was generated, the name of the letter, the user who requested it, and the addressee (which could be the account holder, patient, insurance plan, etc).   The View Form Letter option can now be used to view the letter.

8.4   FollowUp Queue

MEDSUITE FOLLOWUP QUEUE

The Followup Queue in MedSuite provides a means of following-up on claims and accounts on the screen, virtually eliminating the need to run lengthy followup or delinquency reports. Followup "queues," built by criteria determined by each practice, allow "actions" to be taken on a claim or account, track those actions by user, and allow the user to set a future followup date at which point it will re-appear in its queue.

This document covers the setup steps necessary to begin building the Followup Queues, and then contains instructions on the use of the Queues.

1. Setup Followup Action Classes (global)
2. Setup Followup Action Codes (global)
3. Setup Followup Actions (by practice)
4. Setup Followup Queue Definitions (by practice)
5. Closeout – Create Collection Followup
6. Working with the Followup Queue
7. Followup & the Ledger
8. Followup Report

INTRODUCTION: ACTION CLASSES, ACTION CODES, & ACTIONS

Action Classes are used to categorize Action Codes, which are used to categorize Actions.

Actions are performed on claims and accounts. A default timeframe is specified for the next action to take place. ACTIONS are practice-specific, because different practices may have different procedures regarding these timeframes.

Action CODES categorize the Actions and specify if the system should perform some special function, such as calling the Followup Wizard or sending a Form Letter when an Action is performed.

Action CLASSES categorize the CODES for reporting purposes only. Action CLASSES and CODES are set up globally and apply to all practices.

The Followup Report can break on and select on all three of these.

Let's look at some examples:
Action CLASSES are general, broad categories of actions, such as CONTACTS, PROMISES, CORRESPONDENCE, OTHER.

Action CODES are more specific. These might be LEFT MESSAGE, BUSY SIGNAL, CALLED & SPOKE, CONTACT, INS CONTACT, CLAIM FOLLOWUP, PT CORRESPONDENCE, INS CORRESPONDENCE.

The Actions themselves may be even more specific. Actions that fall under the PT CORRESPONDENCE CODE might be PT UCR LETTER, PT PAST DUE LETTER, PT PAY PLAN LETTER. Actions under the CLAIM FOLLOWUP CODE could be REFILE CLAIM, RESET BILLING SAME PLAN, RESET BILLING NEW PLAN.

The following table illustrates with a few examples how the hierarchy of Classes, Codes, and Actions might be structured.

ACTION CLASS	ACTION CODE	ACTION
Correspondence	Pt Correspondence	Pt UCR Letter
		Pt Past Due Letter
		Pt Payment Plan Letter
		Request Statement
	Ins Correspondence	Ins UCR Letter
		Ins Appeal Letter
Contacts	LM	LM for Patient
		LM for Insurance
	Called & Spoke	Spoke with Patient/Acct
		Spoke with Insurance
	Busy Signal	Busy Signal at Pt
		Busy Signal at Ins
Promises	Promise to Pay	Promise by Patient
		Promise by Insurance
Other	Claim Followup	Refile Original Claim
		Refile Corrected Claim
		Reset Ins Billing - New Plan
		Reset Ins Billing - Same Plan
	Add to Coll Turnover	Add to Coll Turnover
	Billing	Suspend Statements
		Un-suspend Statements
		Reset Self Billing

SETUP FOLLOWUP ACTION CLASSES (GLOBAL)

Action Classes categorize the Action Codes for reporting purposes only. Action Classes are set up globally and apply to all practices

To set up the Action Classes, go to Setup, Followup, then Followup Action Classes. Select NEW and enter the name of the Class.
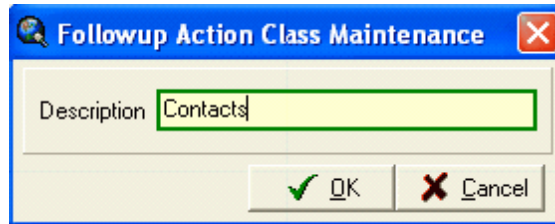
SETUP FOLLOWUP ACTION CODES (GLOBAL)

Action Codes categorize the Actions and specify if the system should perform some special function, such as calling the Followup Wizard or sending a Form Letter, when an Action is performed.

To set up the Action Codes, go to Setup, Followup, then Followup Action Codes. Select NEW to add an Action Code. Enter the description, the associated Action Class, and a Process.
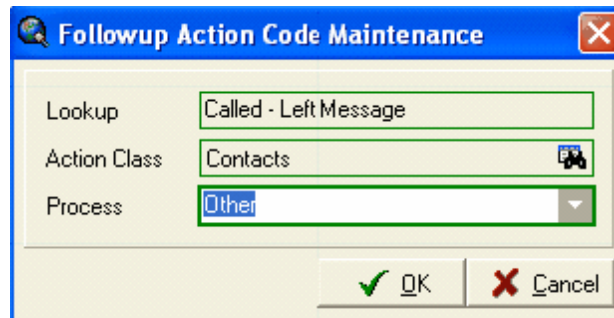
.

PROCESS:
The Process is used to specify how the system responds when an action with this action code is taken. In other words, it specifies how the system will respond when an Action Code with a certain Process is selected. A drop-down list displays the different Process options.

> **Collection – Turnover**: This will invoke the Collection Turnover Maintenance window which will prompt the user to enter the Account Class, Account Type, and Agency that should be added to the account when it is turned over to collections. The account is then added to the Collection Turnover file.

> **Correspondence**: This will cause the system to prompt the user for the Form Letter that is to be sent. The form letter will be mail merged during the next Closeout (assuming that option is selected during the Closeout).

> **Followup Wizard**: This will invoke the Followup Wizard where the user will then proceed to take further steps, such as resetting the insurance, requesting a statement, refiling a claim, etc.

> **Promise**: This will cause the system to prompt the user for the amount that has been promised. The system will then monitor that account for the payment. If the amount promised is not received by the date specified, it will incur a "broken" status. The amount promised is used on accounts only, not claims.

> **Other**: No additional special processing is done by the system. Only a next followup date is set. This would be used for action codes such as LM, Busy Signals, Called & Spoke.

SETUP FOLLOWUP ACTIONS (BY PRACTICE)

Actions are performed on claims and accounts. A default timeframe is specified for the next action to take place. Actions are set up by practice in order to allow one practice to be managed differently than another by having a different number of followup days for certain actions in certain practices, if a billing company has different arrangements with different clients in regard to how claims/accounts are worked.

To set up Actions, go to Setup, Followup, then Followup Actions. Select NEW to add an Action.

After entering the description of the Action in the Lookup field, enter the Action Code to which this Action should be linked.

Select a Followup Type, which are displayed in the drop-down list:
- Single Followup: This action may only be performed on one claim/account at a time, such as Left Message for Pt, Spoke w/Pt, Promise by Pt.
- Batch Followup: This action may only be performed on multiple claims/accounts.
- Single and Batch Followup: This action may be performed either on a single claim/account, or on multiple claims/accounts at the same time. Possible examples may be Refiling Claims, Add to Turnover, Sending Letters.

FOLLOWUP DATES

Advance Followup Date By is used to specify how far the Followup Date of a claim/account should advance so that it is again displayed in the Queue. This, of course, assumes that it still meets the queue criteria. For example, if a Refile Claim action advances the Followup Date by 14 days, the claim will be redisplayed in the Queue in 2 weeks if it still meets the criteria that adds claims to the Queue (i.e. if it is still delinquent and has not been paid). If the claim no longer meets the criteria (i.e. if it is paid) then it will NOT be displayed in 14 days. The default Period Type is Days; you may specify the number of days before the claim/account should be displayed. Other period types are minutes, hours, weeks, and months.

Note that this is merely a *default*. Users may override the date and time at the time they use an action on a claim/account. However, there are some edits on how they may override the default. A user may override the date to any date sooner than the default, but they are limited on how far into the future they can override the default. They may enter a date that is double the default, unless the default is 1 or 2 days; in that case, they may enter a date up to 5 days in the future. For example, if a Refile Claim action

advances the Followup Date by 14 days, a user may override the date that displays by 28 days into the future but no more. If a Left Message Action advances the Followup Date by 2 days, they may override the date that displays by another 3 days into the future but no more (for a total of 5 days from the current date).

SETUP FOLLOWUP QUEUE DEFINITIONS (BY PRACTICE)

Queue Definitions are used to define what is put into the Followup Queue. For example, at what point do Claims get sent to the Followup Queue, and what point do Accounts get sent to the Followup Queue? Different Queue Definitions may be created so that certain claims are added to the Queue at a certain timeframe, and others are added at other times. The Queues are built during the Closeout when that option is selected. New claims/accounts that meet the criteria will be added to the Queue so that users see them the next day. The queues can be updated nightly during the Closeout so that new accounts are added and paid claims/accounts are removed. Other practices may choose to only update the Queues weekly so that new claims/accounts are not added every day. This is up to the discretion of the practice.

Note that after adding a new queue definition, claims/accounts will not show in that Queue in the Followup Queue until after the Close Out has been run and the option to Create Collection Followup has been selected.

To set up the Queue Definitions. go to Setup, Followup, then Queue Definitions. Select NEW to add a Queue Definition. The following screen is displayed.

In the drop-down box in the top right, indicate whether you are creating an Insurance Queue or a Self Queue, then select New.

SELF QUEUE TYPE

If you select the SELF queue type, the following box is displayed where you will then indicate the specific criteria of the accounts that should be added to this queue.

In the screen example above, it will simply select accounts with self pay balances that are over 60 days old with no payment. You may specify particular Account Types, Account Classes, build the queues alphabetically and have separate queues for different parts of the alphabet, specify dollar amounts, etc. You may specify to only include accounts with a particular dunning level. The example above has excluded Broken Promises and Payment Plans as well as Return Mail. You may want to create separate queues for those types of accounts because they may need attention sooner than 60 days, for example.

Note that a Queue can be rather generic, such as Self Pay over 60 as above. Users will have the ability in the Followup Queue to use "filters" to narrow down the accounts they see, instead of seeing everything in the Queue. For example, the Queue will contain all accounts with self pay balances that are over 60 days old with no payment. Instead of looking at all those accounts, a user may then filter by this same criteria and look at accounts over a certain dollar amount, accounts over 120 days, accounts in a certain account

class or type, or a portion of the alphabet.

If you wish to build separate Queues by Division, Facility, or Location, access the separate tabs to indicate which one(s) you would like to include or exclude. If you wish to include accounts for all divisions, all facilities, and all locations, leave these tabs blank.

After completing the screen and selecting OK, you will be returned to the previous screen, with the Queue Selection Criteria that you just entered showing in the Description on the grid. Enter a Queue Name that describes the Queue you have just defined. Select OK to save the Queue Definition.

SELF PAY BROKEN PROMISES & PAYMENT PLANS

You may need a separate Queue for monitoring promises and payment plans. If patients make partial payments and not the agreed-upon amounts of the promise or payment plan, you will need a place to monitor and followup on those accounts. A partial payment on an account with a Promise that is greater than the Minimum Payment amount will reset the aging on the account, even if it is not the amount that was promised. Therefore, it is possible that it may not show up in a Self Pay Queue if your queues are set up to only show delinquent accounts (with a minimum age of 45 or 60). In addition, if you use the Payment Plan amounts on the Account Billing tab to set up monthly payment plans, you may monitor those accounts via a separate Followup Queue.

To ensure that you see any accounts where the promise is broken because only a partial payment is made, or any accounts where they have failed to pay an amount equal to or greater than they Payment Plan amount on the Account Billing tab, create a Self Pay Queue with TWO SEPARATE CRITERIA. They will each have NO max or minimum age. In the first, specify Only Broken Promises and Include Broken Payment Plans, as in the example below.

Then, create another criteria with no max or minimum and specify Include Broken Promises and Only

Broken Payment Plans, as in the example below.

The Queue Definition screen will look like this, with the two separate criteria for the Broken Promises and Broken Payment Plans. It is important to have two separate criteria because if you build just one that says "only" broken promises and "only" broken payment plans, you will get no accounts as they will exclude each other.

If you would like this Queue to display all the self pay broken promises and payment plans and you do NOT want to display self pay broken promises and payment plans in any OTHER self pay queues, specify that you want to EXCLUDE Broken Promises and Broken Payment Plans in the other queues so that the accounts do not show up in BOTH queues. See the example below.

SELF PAY RETURN MAIL

You may wish to create a separate Queue for monitoring accounts flagged for Return Mail, to eliminate the need to run an Account Listing report for return mail.

Do not enter any Minimum or Maximum Age, as the aging is reset when the account is flagged for Return Mail. Not specifying any age will ensure that all return mail accounts are pulled into the queue.

INSURANCE QUEUE TYPE

If you select the INSURANCE queue type, the following box is displayed where you will then indicate the specific criteria of the claims that should be added to this queue.

In the screen example above, it will simply select for Medicare Plan Types open claims that are over 40 days old from the Submitted date whether they are primary, secondary, or third level claims. Additionally, you may specify Paper or Electronic, build the queues alphabetically and have separate queues for different parts of the alphabet, specify dollar amounts, etc. Although this example includes broken promises, you could exclude them and create a separate queue that includes only claims with broken promises. This example includes claims flagged as Held/Disputed and with a Reason flag, but you could exclude those and create a separate queue for those if you so desired.

Note that a Queue can be rather generic, such as MCR Over 40 as above. Users will have the ability in the Followup Queue to use "filters" to narrow down the claims they see, instead of seeing everything in the Queue. For example, this Queue will contain all open Medicare claims that are over 40 days old. Instead of looking at all those claims, a user may then filter by this same criteria and look at claims over a

certain dollar amount, claims over 120 days, only Held/Disputed claims, exclude Medigap claims, narrow it down to a portion of the alphabet, or specify primary claims only, for example.

The MEDIGAP CLAIMS field has three different options: Include, Exclude, and Exclude Medigap Claims with Unpaid Primary Claims. You may include all Medigap claims, which will include them whether or not Medicare has already paid. Optionally, you may exclude all Medigap claims and not display any of them. The third option allows you to build the queue to show only the Medigap claims where Medicare has already paid, by excluding Medigaps on visits that Medicare has not yet paid. The Medigap claims that do show will be aged from the date of the Medicare payment. It is recommended that in the Insurance Queues you select the option to Exclude Medigaps with Unpaid Primary Claims so that they do not display in the Queues.

If you wish to build separate Queues by Division, Facility, or Location, access the separate tabs to indicate which one(s) you would like to include or exclude. If you wish to include accounts for all divisions, all facilities, and all locations, leave these tabs blank.

After completing the screen and selecting OK, you will be returned to the previous screen, with the Queue Selection Criteria that you just entered showing in the Description on the grid. Enter a Queue Name that describes the Queue you have just defined. Select OK to save the Queue Definition.

MULTIPLE CRITERIA WITHIN ONE QUEUE

Several Queue Selection Criteria may be created that all make up one Queue Definition. For example, one queue could be created that includes Commercial, Workers Comp, and Champus claims.

Again, remember that "filters" can be used within the Followup Queue to narrow down the list of claims that are displayed.

It is strongly suggested that the Queues be built to break down the claims in some manner, such as by Plan Type, so that there is not one enormous queue for all claims over 45 or 60 days old. The drawback to having one large queue is that when a user opens the queue in the morning, it will take some time to download the queue to their local machine. Smaller queues make this process more manageable.

A NOTE OF CAUTION:

As noted previously, when defining queue criteria, a Plan Type or a Plan may be specified and is suggested, as in the Medicare example given previously. If you decide to build queues by Plan Type or Plan, you will need to be sure that queue criteria are created for each and every plan or plan type that needs to be seen in the Followup Queue. Because multiple criteria can be specified when creating a Queue, as in the example above, it does make it easier in that you do not need a Queue for every plan or plan type. However, you will need to make sure that there is a *criteria* for each plan or plan type that goes into a Queue. In the example above, one Queue was created that has COMM, WC, and Champus claims in it. We just need to make sure that other Queues cover all the other remaining plan types that exist.

Remember that if you ever add a new plan type in your practice, then you will also need to update your Followup Queue Definitions so that new plan type is included in the Followup!

SUGGESTION:
In order to ensure that claims do not "fall through the cracks" because of a Plan Type inadvertently not having been created that will catch those claims, you might want to set up a "catch all" queue for very delinquent claims that can be used as a spot check. It could be set up as follows to catch all claims over 120 days that are still open.

Another "spot check" that could be used is the Claim Delinquency Report run periodically for very delinquent claims to ensure that these claims are being worked.

PAYMENT REASON CODES AND INSURANCE FOLLOWUP QUEUES

Payment Reason Codes can be configured so that Held/Disputed claims are flagged as having a Reason Code. This will allow users to access queues or filters that will display only claims that have been flagged with reasons on them for additional review or appeal. (Note that claims that have been Held/Disputed *without* reason codes may also be accessed separately by using the options available in the Queue Criteria or in the Filters).

To configure the Reason Codes to use this functionality, go to Setup, Financial, and Payment Reasons.

Payment Reasons can be set up so that when used, they default the status to Paid, Held, Denied, or Disputed. If a Reason is set with the Held or Disputed Reason Type, then the option is available to Send To Followup Queue. Held/Disputed claims remain open and remain in the Followup Queues, whereas Paid and Denied claims do not. The option here on the Payment Reason to Send To Followup Queue flags the claim in such a way that the Followup Queue knows that it is not only Held/Disputed, but that it is flagged with a Reason.

In order to display claims that are flagged with a Reason, you might want to set up a queue that will pull those claims regardless of the age of the claim. If you've set up queues to show *delinquent* claims, you might not see all the claims that have been Held/Disputed with a Reason Code if they do not meet the minimum age. Therefore, you need a queue to pull those regardless of the age. If you want to keep those separate from the other queues, you can set up the *delinquent* queues to *exclude* the Held/Disputed claims, and just have them show up in their own queue (or they might show up in *both* queues.

The queue example above will pull ONLY HELD claims, regardless of age, including ones that have been flagged as disputed, and including ones that have Reason Codes on them.

NOTE: In Payment Entry a claim may be HELD. A claim may be DISPUTED, which means internally to the system that it is also HELD (although one flagged as HELD is not always flagged as DISPUTED). HELD claims or HELD/DISPUTED claims may either have REASONS on them or not. The example above includes all of them.

CLOSEOUT – CREATE COLLECTION FOLLOWUP

The Followup Queues will be built and populated with the claims/accounts that meet the criteria you've specified when the Close Out is run with the option selected to Create Collection Followup.

New claims/accounts that meet the criteria will be added to the Queue so that users see them the next day. The queues can be updated nightly during the Closeout so that new accounts are added and paid claims/accounts are removed. Other practices may choose to only update the Queues weekly so that new claims/accounts are not added every day. This is up to the discretion of the practice.

When creating the Followup Queues, the system includes in the Queue claims/accounts with followup dates/times up to 15 days past the current date, even though users will not see them on their screen until the specified date/time. After the queues have been built the very first time and users have begun working claims/accounts and advancing the followup dates, each time the queues are built they include claims/accounts with followup dates up to 15 days in the future. Therefore, it IS possible to build the queues weekly or bi-weekly and still have claims/accounts show up on the specified followup date, although NEW claims/accounts that meet the followup criteria will NOT be added to the queues, and claims/accounts that have received payments on them will NOT be removed or updated in the queue. This would be much like a Delinquency Report that is run and is not updated until it is worked again.

NOTE: The Closeout will produce a YELLOW entry in the Task Viewer called Followup Queue Creation. The task has run, but there is no output created, so the task is yellow. As noted in the legend in the Task Viewer, "items highlighted in yellow are tasks that ran with no output." No output tasks are on a short delete cycle of 5 days.

A NOTE OF CAUTION if you do not Create Collection Followup nightly:

The queues will need to be recreated every two weeks to ensure that claims/accounts are added to the

queue with followup dates that fall into the 15 day window that was described above.

Let's look at an example scenario:

Q created October 1. Accounts are worked, followup dates entered of November and December. These STAY in the queue and will show up in November and December *if* the queue is never created again.

Q created October 15. New claims/accounts added, paid claims/accounts removed. Claims/accounts with followup days up to 15 days in the future are in the queue so they will display on the appropriate day. Claims/accounts with November and December followup dates are removed (because they are beyond the 15 day window).

Q NOT created until November 15. Claims/accounts that had followup dates of November 1 – 15 did not show up at the appropriate time. They will show up now, however, when the Q is built on November 15.

WORKING WITH THE FOLLOWUP QUEUES

Access the Followup Queue by clicking the Followup Button on the Dashboard Toolbar, or entering the short-cut key combination CTRL+Q, or by selecting Followup Queue from the Queues menu.

Press F9 or click the search on the Queue field to display a list of the Followup Queues. Select the Queue that you wish to view.
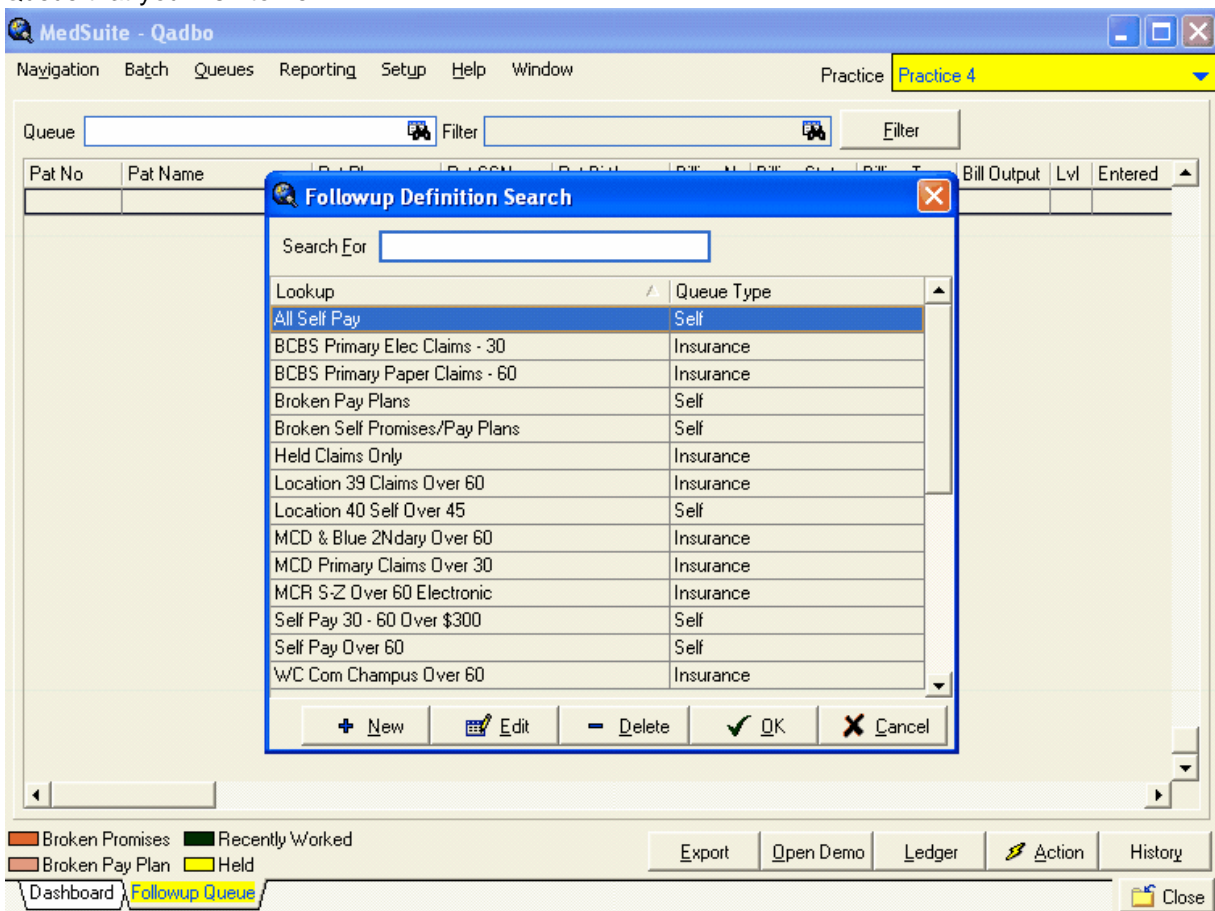
Select the Filter button to go ahead and display the entire Queue without applying any filters to it. Filters are discussed further later in this manual.

NAVIGATING THE FOLLOWUP QUEUE

The following example shows accounts with self pay balances over 60 days with no payment. No filters have been applied.

Use the horizontal and vertical scroll bars to move around the grid to see all the data for each record, and to see more records that follow. The system displays the number of records contained in the Queue in the top right corner so that you have an idea as to what you're going to be looking at.

There are many ways to control how this screen is displayed.
- Clicking at the top of any of the fields sorts the records in that order so that you can list them by Patient Number, alphabetically by name, or group by Acct Class, sort by patient birthday, phone #, Service Date, Amount Billed, etc.
- Fields may be rearranged by dragging columns to the left or right.
- Fields may be removed by using a right-click, then the Remove option. A list of all the fields will be displayed so you can proceed to remove the ones you do not wish to see. After removing fields, you may always use a right-click then the Add option to put them back.
- After rearranging or removing fields, the Default option will restore the fields to their original default setting. Right-click, then select the Default option. Changes that a user makes to a Self Queue display apply to all Self Queues that user brings up on their machine. Insurance Queues retain the last setup done for an Insurance Queue.

BUTTONS:

After clicking on a record to select it, the buttons at the bottom of the screen will allow different functions to be performed.

Export: Invokes the Export Wizard which allows Followup Queue data to be exported to a text file, Excel file, Word file, etc. This feature might be used by managers wishing to run some additional data analysis or reports on the Queue data.

Open Demo: Opens the Patient Demographics for the selected record. Note that it opens a separate window that can be closed with the CTRL+E shortcut (E as in Exit).

Open Billing: Opens the Account Holders Billing Tab for the selected record. This allows quick access to change Acct Class or Types, Suspend/Un suspend statements, and set the Return Mail flag. Note that it opens a separate window that can be closed with the CTRL+E shortcut (E as in Exit). This button only displays in Self Queues.

Ledger: From a SELF Queue, this opens the Account Ledger for the selected account record. From an INSURANCE Queue, this opens the Patient Ledger for the selected claim record. Note that it opens a separate window that can be closed with the CTRL+E shortcut (E as in Exit).

Action: Displays the Followup Action dialogue box where you specify what action you are taking on the claim/account and the next followup date. This will be discussed in more detail later in this manual.

History: Displays the Followup Activity box which lists followup actions that have previously taken place on this claim/account. Some other information is displayed as well, such as the Account Name, Address, and Phone #, and billing information such as bill dates and dunning level.

REFRESH QUEUE alert:

You may see an alert in the top right corner of your screen periodically. This is letting you know that additional entries should be displayed in your queue because the next followup date/time have been met. For example, you might call and get a busy signal, and set followup date/time for 2 hours in the future to try again. This will display in 2 hours to let you know that there is an entry out there whose followup date/ time has passed, and you need to refilter to refresh the screen to display the entries that should now be followed up on.

Note: Self Queue displays records by VISIT, so you could see a patient listed more than once if there are

multiple visits that have met the queue criteria.

FILTERING THE FOLLOWUP QUEUE

"Filters" may be applied to Followup Queues to limit the number of claims/accounts that are on display, to make working the Queues more manageable if they are very large.

After selecting the Queue you wish to work in, press F9 or click the search on the Filter field to display a list of the available Filters. Select the Filter that you wish to apply to the Queue.

To create a new filter, select New from the Followup Filter Search window.

Enter a Name for the Filter. If you've accessed the Filter Maintenance from a Self Queue, the Criteria Type will default to Self. If you've accessed the Filter Maintenance from an Insurance Queue, the Criteria Type will default to Insurance. Enter the filter criteria you'd like to use.

Examples of Filters could be ones that select portions of queues based on the last name alphabetically, Filters to display only primary or secondary and third level claims, Filters to display only Disputed claims, only paper or electronic claims, claims/accounts over a certain amount, Filters by Acct Class or Acct Type, etc.

A NOTE OF CAUTION if you are using Filters:

Filters limit the number of records that are displayed from within a queue. For example, a Medicare queue might have 200 claims in it, but after applying a filter to show only Primary claims, it might be limited to 180. Or, if you apply an A-L filter it will only show claims for patients with a last name starting with A-L. If you limit the queues with the use of filters, you will need to make sure that another appropriate filter is run to display any other claims you may wish to see, such as claims for patients with a last name starting with M-Z.

QUEUES AND MULTIPLE USERS

Ideally, one user should access a queue at a time, or the queue should be filtered in such a way that users are accessing different claims/accounts within the queue. For example, in a Self Pay Over 60 queue, it could be filtered so that someone sees A-L accounts and someone else sees M-Z accounts so that they are not trying to work on the same queue entries simultaneously.

However, it is possible for multiple users to access a queue if so desired. After the queue has been opened by one user, any subsequent users who open it will receive a warning message alerting them that the queue is already open by someone else. This is merely a warning, and the user may continue on to use the queue.

If the warning is received, it is advised that the user refresh their displayed entries periodically by re-filtering. This will remove from their display the entries that the first user has worked and updated with a future followup date.

However, it is possible for multiple users to access a queue if so desired. After the queue has been opened by one user, any subsequent users who open it will receive a warning message alerting them that the queue is already open by someone else. This is merely a warning, and the user may continue on to use the queue.

If the warning is received, it is advised that the user refresh their displayed entries periodically by re-filtering. This will remove from their display the entries that the first user has worked and updated with a future followup date.

ACTIONS WITHIN THE FOLLOWUP QUEUE

Once you are in a Queue you will take Action on claims/accounts within the queue. As discussed in the BUTTONS section previously, after selecting a record in the queue, you may view a ledger, go to demographics, account billing, and view the followup history. The ACTION button at the bottom of the screen will display the Followup Action dialogue box where you specify what action you are taking on the claim/account and the next followup date.

Choose the Action that you are taking.

The Form Letter field is only active when you've selected an Action that is linked to an Action Code that has a Process Type of Correspondence.

The Promise Amount field is only active when you've selected a Self Pay record and an Action that is linked to an Action Code that has a Process Type of Promise.

In this example where the Action is linked to an Action Code that has a Process Type of Other, the cursor will jump from the Action to the Next Action date and time fields.

The Next Action date will default to a future date and/or time if the Action is set up with a period to advance the Followup Date by. For example, the date/time may advance by 2 days or 14 days or 2 hours or 1 week. If the Action is NOT set up to advance the Followup Date, the current date will display.

You may override the date to any date sooner than the default, but you are limited on how far into the future you can override the default. You may enter a date that is double the default, unless the default is 1 or 2 days; in that case, you may enter a date up to 5 days in the future. For example, if a Refile Claim action advances the Followup Date by 14 days, you may override the date that displays by 28 days into the future but no more. If a Left Message Action advances the Followup Date by 2 days, you may override the date that displays by another 3 days into the future but no more (for a total of 5 days from the current date).

After selecting OK to save the action, you are returned to the Queue.

Pat No	Pat Name	Pat Phone	Pat SSN	Pat Birth	Billing No	Billing Status	Billing Type	Bill Output	Er
61517	Ezhaya, Phyliss	(662) 555-5813	099-59-0830	04/08/1978	1020	OPEN	DUNNING	Electronic	08
61503	Fleeger, Loida E	(662) 555-6096	718-86-0564	02/12/1960	1007	OPEN	DUNNING	Electronic	08
61384	Graham, Cathy A	(662) 555-1511	635-74-6995	06/22/1960	996	OPEN	DUNNING	Electronic	08
61237	Gray, Sharon Renee	(662) 555-6350	829-94-0436	12/16/1982	991	OPEN	DUNNING	Electronic	08
61528	Gregg, Thomas Mark	(662) 555-6059	650-84-8869	09/04/1968	1012	OPEN	DUNNING	Electronic	08
61548	Guffin, Linda Kay	(740) 555-1551	231-76-1633	02/04/1990	1224	OPEN	DUNNING	Electronic	09
61548	Guffin, Linda Kay	(740) 555-1551	231-76-1633	02/04/1990	1224	OPEN	DUNNING	Electronic	09
60594	Haszlakiewicz, Danny W	(662) 555-3398	490-88-6222	10/12/1960	964	OPEN	DUNNING	Electronic	07
60921	Horowitz, Barbara J	(606) 555-7207	573-87-6535	09/24/1969	973	OPEN	DUNNING	Electronic	07
61515	Ivanov, Walter Basil	(662) 555-3031	549-58-7313	06/27/1982	1010	OPEN	DUNNING	Electronic	08
61507	Juckett, Sonia Prevette	(662) 555-4777	509-55-0432	11/21/1948	1008	OPEN	DUNNING	Electronic	08
61502	Kissinger, Bennie N	(662) 555-3306	918-10-9754	05/20/1959	1006	OPEN	DUNNING	Electronic	08
61538	Lake, Elizabeth W	(212) 555-8114	904-98-6613	07/08/1975	1014	OPEN	DUNNING	Electronic	08
61518	Leshane, Lucy Sloop	(662) 555-8681	844-49-5867	06/15/1975	1021	OPEN	DUNNING	Electronic	08
60216	Lucia, Dana L	(662) 555-3909	421-40-4603	03/23/1974	1142	OPEN	DUNNING	Electronic	06
61227	MCCRIMON, Brent E	(662) 555-5103	007-06-6705	04/11/1959	1061	OPEN	DUNNING	Electronic	08
61455	Mick, Brenda O	(662) 555-5216	033-09-2247	12/05/1947	1003	OPEN	DUNNING	Electronic	08
60417	Paley, Shawn	(662) 555-6019	341-02-5854	05/17/1965	1232	OPEN	DUNNING	Electronic	09
61241	Panzer, Kellie	(662) 555-8232	698-24-3564	01/08/1957	992	OPEN	DUNNING	Electronic	08
61242	Parsekian, Harmon Spenc	(662) 555-2012	654-92-1047	01/03/1945	993	OPEN	DUNNING	Electronic	08
61421	Pepper, Denise S	(662) 555-5244	177-33-1005	07/28/1980	1000	OPEN	DUNNING	Electronic	08
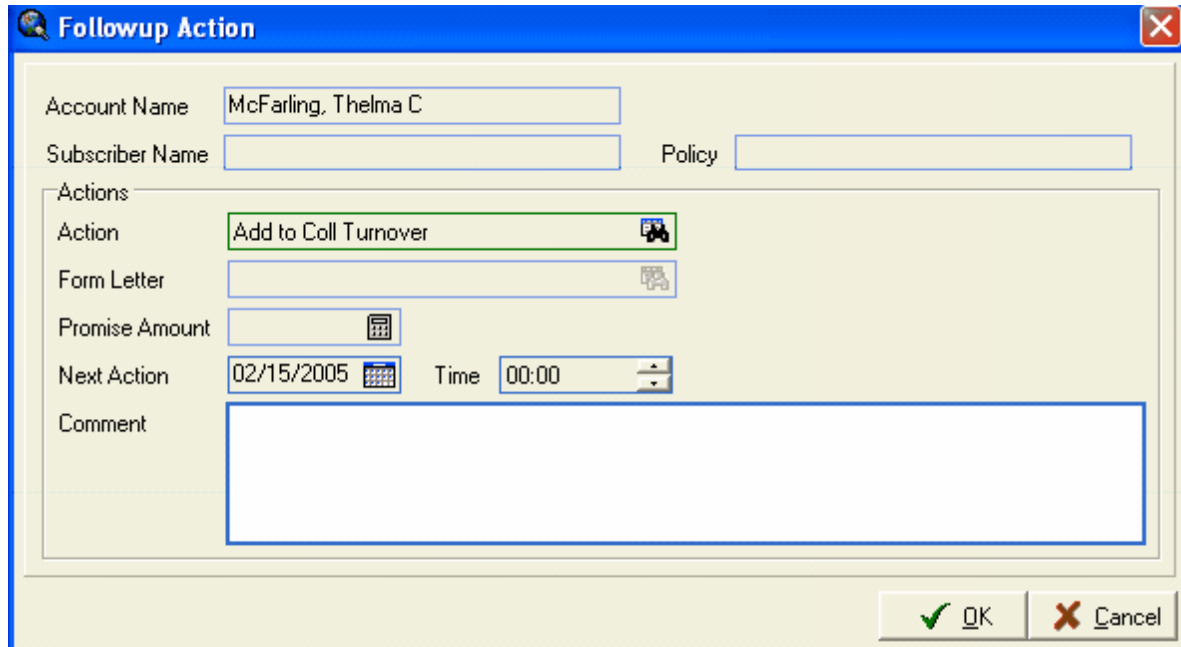
The queue entry you just worked will display in green. You may continue to take additional actions on it. To remove the green entries from your screen, simply Filter again.

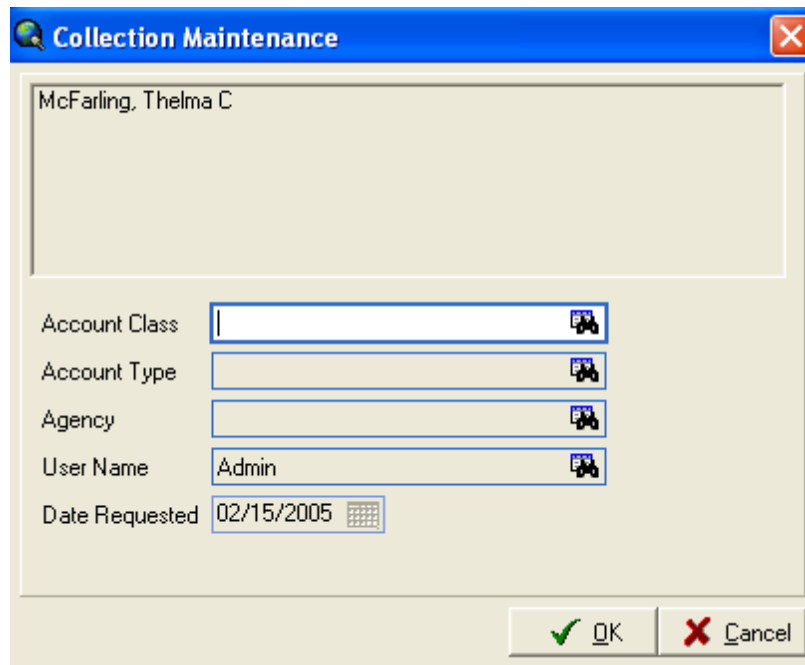### Collection-Turnover

An Action may be created and used that is linked to an Action Code that has a Process Type of Collection Turnover. This is used in cases where a collector needs to manually add a visit to the Collection Turnover file.

After selecting OK to save the action, the Collection Maintenance window is displayed.

Specify the Account Class that should be assigned to the account when it is turned over to collection. If the Account Type should be changed when it is turned over to collection, specify the Account Type to

which the account should be changed. Specify the Agency to which it should be sent when it is turned over to collection. These fields will all be updated to these new values when the Collection Turnover process is run and the account is turned over.

After selecting OK to save the action, you will be returned to the Queue.

After performing this action, the visit will display in yellow in the ledger to indicate that it is now in Collection Turnover. If a future Next Action date is entered, it will no longer display in the Collection Queue, and it will not display on the Next Action date either. Accounts that are in Collection Turnover do NOT display in the Queues; the assumption is that they have already been worked or are being dealt with via the Collection Turnover, and that they do not need to be worked or followed up on in the queue any longer. (Note: if the Next Action date is left as the current date, it will continue to display. We suggest that the Action set up to default the date by 1 day so that it will disappear).

Correspondence

If you select an Action that is linked to an Action Code that has a Process Type of Correspondence, then the Form Letter field is required. As when you request to Send Form Letter from a ledger, you need to specify which letter you want to send. The form letter will be mail merged during the next Closeout (assuming that option is selected during the Closeout). The ledger will then display the letter that was sent and the user that sent the letter.

After selecting OK to save the action, you will be returned to the Queue. The queue entry you just worked will display in green. You may continue to take additional actions on it. To remove the green entries from your screen, simply Filter again.

Followup Wizard

Some Actions may be linked to an Action Code that have a Process Type of Followup Wizard, such as actions that involve requesting statements, refiling/reprinting claims, and resetting insurance billing.

After selecting OK to save the action, the Followup Wizard screen is displayed.

If you were working a self queue entry, only the Self-Pay options are available. If you were working on a claim, only the Insurance options are available. Select the option you want then select OK. Depending on the option, you may receive different additional pop-up boxes asking for the billing message you want on the statement, or whether you wish to force a claim refile to paper or electronic, etc. You may then receive a message that you have successfully queued a statement or claim, depending on the option selected.

After completing the Followup Wizard prompts, you will be returned to the Queue. The queue entry you just worked will display in green. You may continue to take additional actions on it. To remove the green entries from your screen, simply Filter again.

Promises - Self

If you select an entry from a Self Pay Queue and select an Action that is linked to an Action Code that has a Process Type of Promise, then the Promise Amount field is required. Enter the amount to be paid, and then the date the account should come back into the Queue if it is NOT paid.

After selecting OK to save the action, you will be returned to the Queue.

The system will monitor that account for the payment. If no payment is received by the date specified, it will incur a "broken" status and will redisplay in the Queue on the specified Followup Date (assuming the Queue is set up to include Broken Promise statuses). If a payment is posted that is greater than or equal to the promised amount, the account will not incur a broken status and will not come back into the queue unless it meets the queue criteria at some point.

Partial Payments on Self Promises

You may need a separate Queue for monitoring promises if patients make partial payments. A partial payment that is greater than the Minimum Payment amount will reset the aging on the account, even if it is not the amount that was promised. Therefore, it is possible that it may not show up in a Self Pay Queue if your queues are set up to only show delinquent accounts such as a minimum age of 45 or 60.

To ensure that you see any accounts where the promise is broken because only a partial payment is made, create a Self Pay Queue with NO max or minimum age, and specify Only Broken Promises. Refer back to the section on Self Queue Types for examples on how to set this up.

Claims/Accounts with a broken status display in red in the queue.

Promises - Insurance

If you select an entry from an Insurance Queue and select an Action that is linked to an Action Code that has a Process Type of Promise, enter the date the claim should come back into the Queue if it is NOT paid. Note that the Promise Amount field is NOT used on promises on claims.

After selecting OK to save the action, you will be returned to the Queue.

The system will monitor that claim for the payment. If no payment is received by the date specified, it will incur a "broken" status and will redisplay in the Queue on the specified Followup Date (assuming the Queue is set up to include Broken Promise statuses). If a payment is received or a denial is posted to cause the claim to be closed, it will not come back into the queue.

FREQUENTLY ASKED QUESTIONS ABOUT THE FOLLOWUP QUEUES

Q: This patient's visit balance is 0.00. Why is the claim showing up in my queue?

A: If there is an open claim that has not had a payment or denial posted to it that *closes* it, if it meets the queue criteria (x # of days old, etc.) it will show in the followup queue because it is open. Until it is *closed* it will continue to show. This can occur, for example, if it is a secondary claim, and the secondary payment was inadvertently posted to the primary claim.

To remove the claim from the followup queue, a zero payment/denial can be entered on the open claim in order to close it, thereby removing it from the queue.

Q: This patient's visit balance is a credit balance. Why is the claim showing up in my queue?

A: The answer to this question is the same as the answer to the first question. If there is an open claim that has not had a payment or denial posted to it that *closes* it, if it meets the queue criteria (x # of days old, etc.) it will show in the followup queue because it is open. Until it is *closed* it will continue to show. To remove the claim from the followup queue, a zero payment/denial can be entered on the open claim in order to close it, thereby removing it from the queue.

Q: This patient's visit is in collections, is showing in red in the patient ledger, and the visit balance is 0.00. Why is the claim showing up in my queue?

A: The answer to this question is the same as the answer to the first two questions. If there is an open claim that has not had a payment or denial posted to it that *closes* it, if it meets the queue criteria (x # of days old, etc.) it will show in the followup queue because it is open. Until it is *closed* it will continue to show.

To remove the claim from the followup queue, a zero payment/denial can be entered on the open claim in order to close it, thereby removing it from the queue.

FOLLOWUP & THE LEDGER

As you begin using the Followup Queue to work your accounts, the Followup History tab in the patient and account ledgers will be updated with the actions that are taking place with the Followup Queue. The date and time of the action are displayed, along with the user name and any comments they may have entered. The Action Data field will display the name of the Form Letter that was requested if the action is linked to an action code with a process type of Correspondence. It will display the amount promised if the action is linked to an action code with a process type of Promise.

One of the important fields to note here is the *next* followup date, which is 10/01/04 in the example above. This will be of use if users are ever wondering why a particular account is not showing in the Followup Queue. If it has a future followup date, then it is not displayed until that date. Therefore, it is possible to have accounts listed on the Self Delinquency Report that are not currently being displayed in the Followup Queue.

FOLLOWUP REPORT

The Followup Report on the Reporting menu is used to track actions that take place within the Followup Queue to analyze productivity. It may be run for a specific date range and may be run either with summary counts or with detail, which will list the specific accounts that had actions on them. When the Detail option is selected, it will show the date/time that each action was performed.

By using the available Sorting options, you may break down the activity by User, Action, Account Class, Patient, Account, etc. When sorting by Patient or Account with the Details option, it will list the patients/ accounts alphabetically and the actions taken on them during the date range specified.

The Selection options will allow you to narrow down the data contained on the report by selecting certain Account Classes, Actions, Action Codes or Action Classes, etc. This could be helpful if you only wanted a list of accounts that had a Promise Action Class used on them.

To get a list of accounts worked by each user, use the Details option and Sort By User.

To get just a summary of how many of each action each user has performed, use the Counts option and Sort By User and then Action.

Experiment with the report options to see the different ways that this report might be utilized in your office.

8.5   Payment Entry

The Payment Entry functions in MedSuite are divided into separate screens for entering Self Payments, Insurance Payments, and Bulk Insurance Payments. Each screen is specifically tailored to make the entry of each type of payment easier and more efficient. In addition, there are features such as jumping to the ledger and returning right to payment entry, a payment search function to allow you to search for a previously entered payment, and special bill message and print Medigap options.

> SELF PAYMENT ENTRY is used to enter payments sent by patients or account holders, or to enter refund adjustments for refunds being made to account holders.

> INSURANCE PAYMENT is used to enter insurance checks that are sent to you with one patient on them.

> BULK INSURANCE PAYMENT is used to enter payments that come to you on a "bulk EOB" from and insurance companies. These EOBs and checks contain payments for many patients, such as payments received from Medicare, Medicaid, etc. This Bulk Insurance option allows you to enter the amount of the entire bulk check, and then enter the individual payments for each patient listed on the bulk EOB. The system will track the total payment and what you have entered for each patient so that you can easily see when you have entered the entire check and when you balance to the total.

SELF PAYMENT ENTRY

> After creating a payment batch, batch, click on **1-Self** and The Self Payment screen will be displayed. As in other MedSuite data entry screens, TAB will move the cursor forward one field, and SHIFT-TAB will move it backwards.

> Enter the **Account Number** for the payment that you are entering. If you do not know the Account Number, you may enter a name. The system will pull up the account matching the criteria you entered, or go to the Account Lookup Window displaying the results of the name search if there is more than one account that matched the criteria. You may enter a last name followed by a comma and first initial to narrow the search. Alternatively, you may press F9 to invoke the Account Lookup window.

> The **Batch No** will default to the batch selected on the previous page. The **Remit Date** will default if one was entered when the batch was created. Otherwise, enter the remit date.

> Select the **PMT METHOD**, such as Check, Cash, or Credit Card.

> The **PMT TYPE** will default depending on what is set up on the Self Pay Plan in the Insurance Setup. The cursor will proceed to the Adj Type 1 field. If you do not enter an adjustment there, it will skip to the **Payment** field. Enter the Payment amount and any adjustment amounts if applicable. TAB to the **Auto Disb** field, and press the SPACE bar to have the system automatically disburse the payment to the charges. The system will calculate the remaining **Open** amount. Use the **OK** button (Alt+O) if you are done with the payment.

> As a rule, the system displays only the open charges at the self pay level. If nothing is displayed, click the **SHOW ALL** button to see any charges that are at a zero or credit balance or still waiting for payment from the insurance company.

> The **Payment Note** option allows you to enter a free-form note regarding the payment that will display in the Activity View in the ledger and on the Memo tab of the ledger as a note. The date

beside the note will be blank as there may be multiple dates of service on a single Self-payment note. The Self Payment Note will also appear in the body of the account statement if you indicate that it should.

The **Special Bill Message** allows you to select a pre-defined special message to be printed on the next patient statement, and you may indicate whether that message should be recurring.

You may enter a free-form special bill message in the box below. You should not use a free-form special message if you have selected a pre-defined special message in the box above. The system cannot print both messages on a patient statement.

The **IMAGING** button is not used at this time.

The **SUSPENSE** button allows you to "suspend" claims and/or statements, and enter the reason why you are doing so.

Once the account is accessed after the SUSPEND is placed on an account a message will display showing that the account has been suspended.

The **VIEW** button allows you to jump to the patient ledger or to the account.

To go back to the payment screen, use the green **Show Pay Entry** button at the top right corner of the screen.

INSURANCE PAYMENTS

To enter individual Insurance Payments (as opposed to a Bulk Check from a Payor) select **2-Ins**. The Insurance Payment screen is displayed. As in other MedSuite data entry screens, TAB will move the cursor forward one field, and SHIFT-TAB will move it backwards.

Enter the **Claim No**. for the insurance payment that you are entering. If you do not know the Claim Number, you may enter a name. The system will pull up the open claim matching the criteria you entered, or go to the claim search window and display the results of the name search if more than one open claim matched the criteria. You may enter a last name followed by a comma and first initial to narrow the search. Alternatively, you may press F9 to invoke the claim search window.

The system will display open/unpaid claims that match the search criteria you entered. If you do not have a name, TAB to go to the **Search All** field. You may enter a visit date (in the format mm/dd/yyyy) or a policy #, SS# (in the format 999-99-9999), or plan name. You may enter the full policy# or SS#, or just a portion of the #. Note that you should select the "**Show Closed Claims**" box if you need to post a payment or adjustment to a claim that has already had a payment entered on it. After selecting the claim from the claim search, the Insurance Payment screen is displayed again.

The **Batch No** will default to the batch selected on the previous page. The **Remitted date** will default if one was entered when the batch was created. Otherwise, enter the remit date. Enter the **Payment Method**. This would probably be Check for an Insurance Payment.
Enter the **Doc No**, which is usually the check number.

The **Pmt Type** and **Adj Types** default from the Insurance Plan setup. These may be overridden if you are posting a Refund, for example. In that case, you may blank out the Pmt Type and change the Adj Type to Refund. **Payment Reasons** are entered to indicate why a payment was denied or a payment amount was different than the expected amount. Enter Co-Pay, Co-Ins, and Co-Ins% if

applicable. Select the link for detail on where to setup the system to enable or disable these fields in Payment Entry Insurance. Anything entered in these fields will display in the patient ledger. These fields are not used to perform any calculations.

The cursor will move down to the charges. Enter the payment information, for each charge, including the **Approved Amount, Deductible**, **Payment, and Adjustments**, if applicable. The system may calculate some of these fields automatically, depending on the current insurance plan setup. For example, a Medicare payment and adjustment may be calculated and displayed automatically. The system will calculate the remaining **Open** amount.

If you are unable to post the payment to each line-item charge because the payor did not indicate the payment for each line-item, use the **Auto Disb** button. Instead of keying the amounts on each line item charge, enter the payment/adjustment amounts in the fields available on the Copay line on the screen. Then TAB to the Auto Disb field, and press the SPACE bar to have the system automatically disburse the payment to the charges.

The **Status** will default to Paid if there is a paid amount. If DO NOT want the secondary claim to be filed, (for example, if the primary plan has paid in full and you want to drop the charges to the self-pay level), select SELF. This will prevent the secondary claim from filing and will bill the account for any remaining balance. Use the HELD Status if you would like to prevent the secondary claim from filing and hold the charges at the current level. This option is typically used if the payor has not paid the claim correctly and you are going to send an appeal.

Selecting the **Disputed** status will keep a claim "open" instead of "closing" it like a Paid status would. This is typically used when a payor approved amount is different from the expected approved (allowed) amount. The claim would be sent to the FollowUp Manager if a Payment Reason code has been entered that is flagged to send a claim to the Manager. The adjustment can be calculated using the Adjustment Type 2 payment calculation on the Plan Setup, and would be set up as the Allowed – Approved, and a special adjustment code for Disputed Amounts would be used. It becomes "disputed A/R," and this adjustment type and amount can be reported on. A special message is usually entered on the patient statement to let them know that there is a problem with the insurance payment, and that all or some of the amount in dispute may become the patient's responsibility.

Tab through the remainder of the fields. Use the check-box to indicate whether a **Medigap claim** should be printed.

The **Payment Note** option allows you to enter a note regarding the payment that will display in the Activity View of the ledger and on the Memo tab. The date beside Insurance payment notes are posted and displayed with the Visit date of the claim the note was entered on. The Insurance payment note will also appear in the body of the account statement if you indicate that it should. This is a free-form field where you could put a note regarding an appeal, for example.

The **Special Bill Message** allows you to select a pre-defined special message to be printed on the next patient statement, and you may indicate whether that message should be recurring.

You may enter a free-form special bill message in the box below. You should not use a free-form special message if you have selected a pre-defined special message in the box above. The system cannot print both messages on a patient statement.

The **IMAGING** button is not used at this time.

The **SUSPENSE** button allows you to "suspend" claims and/or statements, and enter the reason why

you are doing so.

The **VIEW** button allows you to jump to the patient ledger or to the account, and then come back to the payment. To go back to the payment screen, use the green **Show Pay Entry** button at the top right corner of the screen.

BULK INSURANCE PAYMENTS

To enter Bulk Insurance Payments select **3-Bulk Ins.** The Payment screen is displayed where the information about this bulk check is entered. As in other MedSuite data entry screens, TAB will move the cursor forward one field, and SHIFT-TAB will move it backwards.

The **Batch No** will default to the batch selected on the previous page. The **Remit Date** will default if one was entered when the batch was created. Otherwise, enter the remit date. Enter the **Payment Method**. This would probably be Check for an Insurance Payment.
Enter the **Doc No**, which is usually the check number. Enter the **Amount** of the bulk payment on this check.

When you select **NEW** to add a payment distribution for this bulk payment, the Insurance Payment screen is displayed. As in other MedSuite data entry screens, TAB will move the cursor forward one field, and SHIFT-TAB will move it backwards.

Enter the **Claim No**. for the insurance payment that you are entering. If you do not know the Claim Number, you may enter a name. The system will pull up the open claim matching the criteria you entered, or go to the claim search window and display the results of the name search if more than one open claim matched the criteria. You may enter a last name followed by a comma and first initial to narrow the search. Alternatively, you may press F9 to invoke the claim search window. If you do not have a name or claim number, TAB to go to the **Search All** field. You may enter a visit date (in the format mm/dd/yyyy) or a policy #, SS# (in the format 999-99-9999), or plan name. You may enter the full policy# or SS#, or just a portion of the #. Note that you should select the "**Show Closed Claims**" box if you need to post a payment or adjustment to a claim that has already had a payment entered on it.

After selecting the claim, the Insurance Payment screen is displayed. Notice in this insurance payment screen that the Bulk Payment Amount is displayed along with the amount that has already been applied and the amount remaining that is still un-applied. This will be updated after each payment that you key, until the up-applied amount reaches 0.00. Note that a batch with funds still unapplied may NOT be released. As in other MedSuite data entry screens, TAB will move the cursor forward one field, and SHIFT-TAB will move it backwards.

The **Batch No** will default to the batch selected on the previous page. The **Remitted** date will default if one was entered when the batch was created. Otherwise, enter the remit date. Enter the **Payment Method**. This would probably be Check for an Insurance Payment.
Enter the **Doc No**, which is usually the check number.

The **Pmt Type** and **Adj Types** default from the Insurance Plan setup. These may be overridden if you are posting a Refund, for example. In that case, you may blank out the Pmt Type and change the Adj Type to Refund. **Payment Reasons** are entered to indicate why a payment was denied or a payment amount was different than the expected amount. Enter Co-Pay, Co-Ins, and Co-Ins% if applicable. Select the link for detail on where to setup the system to enable or disable these fields in Payment Entry Insurance. Anything entered in these fields will display in the patient ledger. These fields are not used to perform any calculations.

The cursor will move down to the charges. Enter the payment information, for each charge, including the **Approved Amount, Deductible**, **Payment, and Adjustments**, if applicable. The system may calculate some of these fields automatically, depending on the current insurance plan setup. For example, a Medicare payment and adjustment may be calculated and displayed automatically. The system will calculate the remaining **Open** amount.

If you are unable to post the payment to each line-item charge because the payor did not indicate the payment for each line-item, use the **Auto Disb** button. Instead of keying the amounts on each line item charge, enter the payment/adjustment amounts in the fields available on the Copay line on the screen. Then TAB to the Auto Disb field, and press the SPACE bar to have the system automatically disburse the payment to the charges.

The **Status** will default to Paid if there is a paid amount. If DO NOT want the secondary claim to be filed, (for example, if the primary plan has paid in full and you want to drop the charges to the self-pay level), select SELF. This will prevent the secondary claim from filing and will bill the account for any remaining balance. Use the HELD Status if you would like to prevent the secondary claim from filing and hold the charges at the current level. This option is typically used if the payor has not paid the claim correctly and you are going to send an appeal.

Selecting the **Disputed** status will keep a claim "open" instead of "closing" it like a Paid status would. This is typically used when a payor approved amount is different from the expected approved (allowed) amount. The claim would be sent to the FollowUp Manager if a Payment Reason code has been entered that is flagged to send a claim to the Manager. The adjustment can be calculated using the Adjustment Type 2 payment calculation on the Plan Setup, and would be set up as the Allowed – Approved, and a special adjustment code for Disputed Amounts would be used. It becomes "disputed A/R," and this adjustment type and amount can be reported on. A special message is usually entered on the patient statement to let them know that there is a problem with the insurance payment, and that all or some of the amount in dispute may become the patient's responsibility.

Tab through the remainder of the fields. Use the check-box to indicate whether a **Medigap claim** should be printed.

The **Payment Note** option allows you to enter a note regarding the payment that will display in the Activity View of the ledger and on the Memo tab. The date beside Insurance payment notes are posted and displayed with the Visit date of the claim the note was entered on. The Insurance payment note will also appear in the body of the account statement if you indicate that it should. This is a free-form field where you could put a note regarding an appeal, for example.

The **Special Bill Message** allows you to select a pre-defined special message to be printed on the next patient statement, and you may indicated whether that message should be recurring.

You may enter a free-form special bill message in the box below. You should not use a free-form special message if you have selected a pre-defined special message in the box above. The system cannot print both messages on a patient statement.

The **IMAGING** button is not used at this time.

The **SUSPENSE** button allows you to "suspend" claims and or statements, and enter the reason why you are doing so.

The **VIEW** button allows you to jump to the patient ledger or to the account, and then come back to the payment. To go back to the payment screen, use the green **Show Pay Entry** button at the top

right corner of the screen.

As you continue to enter payment distributions for the bulk payment, the Payment Information screen is updated. The system will track the total payment and what you have entered for each patient so that you can easily see when you have entered the entire check and when you balance to the total. Note that a batch with funds still unapplied may NOT be released.

PAYMENT SEARCH

If you need to locate a payment, click on the PAYMENT SEARCH tab. The system will go back and search all payments to find ones that meet your criteria, such as a $200.00 payment as in the example below. The search criteria are listed under the SEARCH EXAMPLES tab. You may search by document number (check #), payment amount, payment date, name, etc. to locate "lost" payments.

PAYMENT DEBITS / RECOUPMENTS / RETRACTIONS

To add money back on to an account, (to debit the account) enter a NEGATIVE payment. That is, enter a "-" in front of the amount that you are debiting back onto the account. As a rule, when you enter an amount in the payment field, it *lowers* the account balance. To raise (debit) the account balance, you do the opposite of what you normally do, by entering a negative payment.

If the amount needs to be added back on because of an insurance recoup or retraction, enter the negative payment via the Insurance Payment screen and post it to the insurance claim. When you are searching for the claim, you may need to use the "Show Closed Claims" option in order to locate it.

Negative payments should be used and NOT adjustments to perform this function. Negative payments are used to transfer an incorrectly posted payment from one account to another, or from one claim to another on the same account if it was posted to the incorrect claim, or from one procedure to another on one claim on one patient if it was posted to the incorrect procedure on a claim.

The following steps should be taken to transfer an incorrectly posted insurance payment from one claim to another.

Access the Insurance Payment entry screen. Press F9 to invoke the claim search window. Enter the patient's name or the claim number of the claim you wish to remove the payment from. Select the "**Show Closed Claims**" to access a claim that has already had a payment entered on it. After selecting the claim from the claim search, the Insurance Payment screen is displayed again.

The **Batch No** will default to the batch selected on the previous page. The **Remitted date** will default if one was entered when the batch was created. Otherwise, enter the remit date. THE DATE ENTERED HERE SHOULD BE THE DATE OF THE ORIGINAL PAYMENT.
Enter the **Payment Method**. This would probably be Check for an Insurance Payment. Enter the **Doc No**, which is usually the check number.

The **Pmt Type** and **Adj Types** default from the Insurance Plan setup. These may be overridden. The cursor will move through the fields and down to the charges. Since the claim has already had a payment made on it, the system will not calculate any of these fields automatically like it might be set up to on a new insurance payment.

When you get to the **payment amount** field, enter a NEGATIVE payment. That is, enter a "-" in

front of the amount that you are debiting back onto the account. As a rule, when you enter an amount in the payment field, it *lowers* the account balance. To raise (debit) the account balance, you do the opposite of what you normally do, by entering a negative payment. You will notice that the system will display the amount that you entered within parentheses. The Open amount will be increased by the amount that you entered.

The **Payment Note** option allows you to enter a note regarding the payment that will display in the Activity View of the ledger and on the Memo tab. The date beside an Insurance payment note is both posted and displayed with the Visit date of the claim the note was entered on. The Insurance payment note will also appear in the body of the account statement if you indicate that it should. This is a free-form field where you could put a note as to why you are posting the negative payment amount.

Then you would post the payment to the correct claim by searching for it and posting the payment as you normally would. The only difference would be that you must be careful with the **Remitted Date** and put the correct date of the original payment.

The procedure to move an incorrectly posted insurance payment from one procedure to another on the same claim would be the same as above, except that after entering the negative payment on the incorrect procedure, you would stay on the same claim, same screen, and proceed to enter the payment on the correct procedure.

The procedure to move an incorrectly posted patient payment from one patient to another patient would also be the same as above, except that you would enter the transaction through the Self Payment Entry screen instead of the Insurance Payment screen.

REFUNDS

Patient/Account refunds should be posted through Self Payment Entry. You will need to use the "Show All" function in the Self Payment Entry screen in order to see the charges that are at a zero or credit balance.

Insurance Refunds should be posted through Insurance Payment Entry, and applied to the claim that was overpaid. When you are searching for the claim, you may need to use the "Show Closed Claims" option in order to locate it.

SUSPENSE ACCOUNT

You may want to set up a "Suspense Account" where you can post payments that you don't know where else to put them, i.e. you cannot locate the patient and/or claim to post the payment to. A zero charge should be entered to which payments can be posted. Payments that you are posting to the Suspense Account are entered via Self Payment Entry. You will need to use the "Show All" function in the Self Payment Entry screen in order to see the charge to post the payment to, since it will be at a zero or credit balance. When the funds are to be removed from the suspense account and applied to a patient or refunded to a carrier, payment and/or adjustment transactions to accomplish this are entered. A refund adjustment would be posted to issue a refund. Payment codes should be used to post the payment to the correct account. This can be accomplished by entering a *negative* payment on the Suspense Account to un-do the original payment, and entering a normal payment on the correct account (both of these should be entered with the original remit date). These will zero each other out so that you are still in balance. Using Payments to transfer the funds instead of adjustments will ensure that payments are reported correctly.

You may create suspense accounts for other functions if you would like. Many practices use other suspense accounts to handle prepayments and collection payments.

PREPAYMENTS

PrePayments can be posted to a "dummy charge" that has been entered on a patient or on to a "PrePay Account," which is much like the Suspense Account above. When the service is rendered and the visit is entered, then the payment must be moved and applied to the visit in order for the payments to be reported correctly. This is accomplished by entering a *negative* payment on the "dummy charge" to un-do the original payment, and entering a normal payment on the new visit (both of these should be entered with the original remit date). These will zero each other out so that you are still in balance. Using Payments to transfer the funds instead of adjustments (or not moving the prepayment at all) will ensure that payments are reported correctly. If the prepayment is not applied to the new visit, the system will try to bill that visit. Therefore, it is important to post the prepay to the visit when it is entered.

8.6   Refunds

Overview

Refund Processing in MedSuite can be accomplished by moving refunds through a cycle in which they are requested, then "issued," and then paid. Here is a sample scenario:

A refund request could be added by anyone in the office, such as a payment entry person who notices that a claim goes to a credit balance because an insurance carrier has paid twice. Or, you could print a list of credit balance accounts to review to determine which of the credit balance accounts need refunds, and enter the refund requests accordingly. A manager would then print a Refund Listing to review the requested refunds. Then manager would change the status to "issued" on the ones that he/she feels really should be issued, or "revoke" the ones that should not. The manager could then run a Refund Listing showing the "issued" refunds to get approval from the physician and/or practice administrator if necessary.   Once it has been determined that the refunds need to be paid and checks generated, the would change the status "paid" and post the refund adjustment to the account.

Account Listing - Credit Balances

You can run a listing of accounts with Credit Balances by going to the Reporting Menu and selecting the Account Listings report. Select the Credit Balance Accounts option, and run now. This listing shows basic information such as the account and patient name, patient number, and balance.

Add Refund Requests to Refund Manager

When you have an account that needs a refund, enter it into the Refund Manager by going to the Queues Menu. Once you are in the Refund Manager, select NEW.   Indicate whether the refund is to be issued to the account holder, plan, patient, etc. Then search for the account and the plan, if applicable.   The address will default, but you may change it if necessary (for example, if an insurance refund should go to a different address than the claim filing address). Enter the amount to be refunded, and a note to indicate the reason, if desired. The Status will default to Requested, and the requested date will be the current date.

Print a Refund Listing

You can print a list of the Refunds by going to the Queues Menu and selecting Refund Listing. It will default to run a Listing Only, with all Refund Status options selected. You may un-check the Paid and Revoked options so that you do not see refunds that you've already processed or that you've revoked because they should not have been issued. You may also enter a date range if you like to show refunds requested or flagged to be issued for the current month only. The Refund Listing shows the Payee Name/ Address, the patient name, who requested the refund and the refund note if they entered one, the refund amount, the current status of the refund and the date it was requested/issued/paid/revoked, if applicable.

Change Refund Status to "Issued"

After reviewing the requested refunds that may have been entered by anyone in the office, the manager may choose to change the status of the ones that really should be paid to "Issued." The ones that should NOT be refunded should be "Revoked."

This is done by going back into the Refund Manager and Editing the refund. You may bring up the refund by entering the refund number from the Refund Listing in the Quick Search, or by entering the patient's last name, etc. Select the Edit option, and then you may change the status to Issued or Revoked, change the amount, the address, etc.

You may then run a new Refund Listing to show the refunds that are now flagged as "issued."

Change Refund Status to "Paid"

When you are ready to enter the refund adjustments and send the refund checks, edit the refunds and change the status to Paid.   Run a new Refund Listing to show all the refunds you are now going to "pay."

Enter Refund Adjustments

In Payment Entry, you should create a separate batch for the refunds you are going to enter. The Payment Method is Other (because it is not a payment at all). You could enter the check # in the Doc No field. Blank out the Payment Type which defaults to Patient Payment. Enter the Refund adjustment code in the Adj Type 1 field.

You may need to use the Show All option in order to display the charges. Enter the refund amount on the charge line with the credit balance. This should be entered as a *negative* amount, such as -14.00 as in the example below. You should see the Open balance amount change, typically to 0.

Run a Payment Worksheet for the batch of refunds you just entered. The total on the worksheet should match the total of the last Refund Listing you ran.

8.7   Remittance (ERA)

The Electronic Remittance function in MedSuite allows automated payment posting of electronic files received from PerSe or Emdeon for payors such as Medicare.

Electronic Remittance files are automatically received from PerSe during the PerSe transmission if they exist. They are then processed for each practice during the next Close Out if that option is selected. This process creates unreleased payment batches and enters the payments and adjustments to the patient claims in MedSuite. Several reports are generated and displayed in the Task Viewer. A Remittance Error report is created for payments that it is unable to post, and a Remittance Listing Zero Paid report lists rejected claims. Users are then able to work the rejected claims, handle the errors, and release the batches of payments that were created.

REMITTANCE SETUP

Before beginning to process remittance files, the Payment Type and Adjustment Type that are to be used should be set up on the Plan. If they are not set up, MedSuite will use a generic payment and adjustment code such as "Remit Payment" and "Remit Adjustment."   This is the only setup that needs to be completed prior to starting Electronic Remittance.

PROCESS REMITTANCE FILES (DURING CLOSE OUT)

Electronic Remittance files are automatically received from PerSe during the PerSe transmission if they exist. They are then processed for each practice during the next Close Out if that option is selected. If your Close Out is set up as a Scheduled Task, you will need to re-schedule it with the PROCESS REMITTANCE option selected. The Close Out will generate several reports that will be listed in the Task View after it is finished.

REPORTS IN TASK VIEWER:

Several reports are generated by the Close Out and displayed in the Task Viewer with the other Close Out reports. The REMITTANCE LISTING ZERO PAID and the REMITTANCE ERROR reports are ones that should be printed because they will require some action to be taken.

REMITTANCE LISTING

The Remittance Listing shows in an EOB format all the payments included in the remittance file. There may be several different checks contained in the remittance file and on the listing. The check number, amount, and remit date are listed at the top of each page. Patients are listed in alphabetical order, and the list shows the amount paid and adjusted for each charge, along with Reason Codes, CoInsurance amounts, Crossover Insurance, etc., just as an EOB would show.

This report will also print an error for any payment that the system was unable to apply. A typical error is **Claim not applied please see the Error Listing.** This occurs when the system cannot match the claim on the remittance with a claim in MedSuite.

It may not be necessary to print this report at this time. You will have an opportunity later to print a new EOB as needed after the errors have been corrected.

REMITTANCE LISTING ZERO PAID

The Remittance Listing Zero Paid report lists rejected claims, and any claims where the payment amount was zero, such as denials for duplicate claims.

This report provides a more efficient way of locating problem claims by printing them all in one place on one report, instead of having to search through pages and pages of correctly paid claims in order to find the ones with problems. These are claims that should be investigated to determine whether they should be appealed or disputed.

REMITTANCE ERRORS

The Remittance Errors report lists patients that were contained in the remittance file but that MedSuite was unable to locate the correct claim to post the payment to. A typical error on this report is "Could not find the Patient in the MedSuite system." This could occur when a claim for this patient was filed from a previous system; the payment cannot be posted into MedSuite and would need to be posted in the old system instead. This report provides a more efficient way of locating problem claims by printing them all in one place on one report, instead of having to search through pages and pages of correctly paid claims in order to find the ones with problems. These errors will correspond to any on the Remittance Listing that say **Claim not applied please see the Error Listing.** Again, these are payments that will need to be investigated so that the payments can be posted correctly.

PAYMENT ENTRY SCREENS

You may find that you need to correct some errors in the Remittance File. TO do this, go to Batch, Payments. Go to Batch, Payments. You will see that batches have been created for each check contained in the remittance file. The Batch No will be Remit, the User will be Remit, and the Check No. is contained in the Description so that you can match it up to the Remittance Listing. The Date Remit is the date the electronic remittance was *issued"* by the payor. In addition, you will see the amount of the check in the Bulk Payment at the bottom, along with the amount applied and amount still unapplied, if there were remittance errors on that check. Clicking the + next to the Bulk Payment will display the payments on that check in that batch.

Double-click on the Bulk Payment, or select Edit. The Bulk Payment information screen is displayed. If you need to change the Remit Date to the date of the deposit, rather than the date the remittance was *issued* by the payor, edit the Remit Date on the Bulk Payment Information screen, as well as on the Batch List as displayed above by editing the Batch.

If there were errors on this remittance, the Remit Errors button will be displayed at the bottom of the screen. It will not display if there were no errors. If the Remit Errors button is showing, select it. A list of the payments that had errors is displayed. These are the ones on the Remittance Listing that said **Claim not applied please see the Error Listing.** These were also listed on the Remittance Error Listing, usually with the error that "Could not find the Patient in the MedSuite system. These payments may need to be posted manually, or they may need to be deleted. If you need to delete a payment because it is a payment for a patient on your previous system, or a zero payment/denial for a duplicate payment, use the Delete button.

To post one of these payments, select a patient, and then select New. The Insurance Payment screen is displayed, with the information for the patient you selected. The cursor is in the Claim Number field. Search to find the claim that this payment should be posted to. Start by keying in the Claim No. displayed in the bottom left corner of the screen. This is the claim number that came back from the payor in the remittance file. This may or may not produce the desired results. If you get no results, try clicking on the Show Closed Claims option. Again, this may or may not produce the desired results. It may find some closed claims; these could be claims that have had payments already posted to them, claims that

were closed because the billing was reset for some reason, etc. If one of these is the claim the payment should be posted to, click on it and then OK.

The Insurance Payment screen will be displayed with the claim information of the selected claim. Proceed through the screen to enter the payment. The bottom of the screen shows the payment information received in the remittance file.

If you cannot find a claim to post the payment to, it may need to be posted to a Suspense Account. The dollars need to be applied somewhere, as a batch cannot be released while it still has unapplied payments. If you are going to post it to a Suspense Account, you will need to edit the amount of the payment on the Bulk Payment Information screen and change the total to reflect the payment that you are removing from this batch. You might create a new batch to be used for payments you are putting on the Suspense Account. You might also need to edit the amount of the Bulk Payment if you remove payments that belong to patients in a different system, such as patients in a previous billing system on which you are still receiving some payments.

After all the Remit Errors have been posted, the Remit Errors button will disappear. The Print EOB button is used to print a new Remittance Listing that will no longer have the errors listed on it. Once the errors have been corrected and there is no more unapplied dollars, enter the Release Date on the batch so that it will post during the next Closeout.

8.8   Ticklers

The Tickler provides a means to add reminders to yourself or others into the system. The ticklers will pop-up to remind you of a certain task at a future date and time. The Tickler is displayed on each user's Dashboard in MedSuite. When you first access the system, the Tickler portion of the screen will be blank until you add some ticklers. By default, each time you access the system, it will display open ticklers with a reminder date and time that are less than the current date and time. As you add ticklers for the future, they will not be displayed until that date and time are reached, unless you modify the "Filter." We'll talk about "filtering" later.

NEW

To add a tickler, click the NEW button. A pop-up window will be displayed where you can add the tickler. The User to Remind will default to the user name under which you logged in. You may select another user if you are adding a reminder for someone else. The date will default to the current date. Enter the date you want to be reminded of this tickler. You may enter a specific time of day that you would like the tickler to display (in MILITARY time) or leave the time field at 0:00 if you would just like it to display on that day first thing.

The Link Tickler To field is to designate whether this reminder is about a particular Patient, Account, or Claim. If this is just a general reminder to yourself or another user, you may leave it blank. If you are linking the tickler, select the particular Patient, Account, or Claim to which it is to be linked. You may use the scrolling functions (clicking the binoculars or pressing F9) or you may type in the name of the patient or account holder. You may also key in a claim number when linking the tickler to a claim.

In the Note field type in the reminder note. The first line of the Note will be displayed on the Dashboard. The remainder of the note is visible after double-clicking the tickler on the Dashboard or selecting Edit.

After entering the Note, select OK.

REMIND

The REMIND button can be used to change the reminder time on a tickler by allowing you to postpone it by a few minutes, hours, days, or weeks. Make sure the tickler you want to update is selected in the tickler list, and then click the Remind option that you'd like. The tickler will be removed from the display, and will re-display at the designated date and time.

EDIT

The EDIT button will allow you to modify an existing tickler. You may change the reminder date, time, or note. NOTE: If you need to change the Patient, Account, or Claim, you need to close the existing tickler and add a new one.

CLOSE

The CLOSE button is used to remove the tickler from the list of open reminders once you've taken action or don't need to be reminded anymore. Closed ticklers may be viewed by changing the filter options. If you change the filter to display closed ticklers, they will be displayed in red.

FILTER

The FILTER option is used to change the display of the ticklers on the Dashboard. You may select a particular practice to limit the number of ticklers that display. Leaving it blank will display ticklers for all practices. By default, it shows ticklers for all practices.

If you have Tickler Administrator privileges, you may choose to view ticklers for other users by selecting the user, or leaving the User field blank to see ticklers for all users. By default, it displays the user name under which you logged in   You may view ticklers for future dates by changing the date, and view Closed Ticklers by selecting that option. NOTE: Tickler Administrator privileges are assigned in User Maintenance.

JUMP

The JUMP button provides a quick way to go to the patient/account ledger or demographics for the selected tickler.

After clicking on the tickler for the patient you want, click JUMP, then either the Demographic or Ledger option and that screen will be displayed. To go back to the tickler, close the ledger or demographic screen, or click on the Dashboard leaving the other screen open, or use the keyboard shortcut CTRL+PAGEDN.

PRINT

The PRINT button will print the currently displayed tickler list to the selected printer. If you need to change what is being printed, change the Filter options to print future ticklers, ticklers for other users, or closed ticklers.

8.9   Small Balance Write-Offs

MedSuite provides an automated way to make Small Balance Write-Offs.

Small Balance Write-Off – Print Listing

To print the Small Balance Write-Off listing, go to the Reporting option on the MedSuite Menu. Select Reporting, Small Balance Write-Off.

In the Age in Days field, you may enter a # of days since the last payment or adjustment activity that must elapse before the Write-Off is taken. This will allow some recurring patients to return and drop additional balances to the self pay level that will be high enough to begin billing again. For example, you may want the small balances to sit there for 60 days before being written off.

The system defaults the Maximum Write-Off Amount to the amount on the setup in the Practice Maintenance on the Statements tab in Billing Control Information, in the "Minimum Balance to Send a Statement" field. You may leave this amount or override it to a different amount. If left at $10 as in this example, the system will locate accounts with balances of $10 and less to be written off. Select LISTING ONLY. This will generate a listing of accounts that meet the Small Balance criteria, but it will not write the accounts off. The listing may be printed for review.

Small Balance Write-Off – Listing with Write-Off

To obtain a listing of account to be written off and to have the system automatically perform the write-off adjustments on the account, go to the Reporting option on the MedSuite Menu. Select Reporting, Small Balance Write-Off.

In the Age in Days field, you may enter a # of days since the last payment or adjustment activity that must elapse before the Write-Off is taken. This will allow some recurring patients to return and drop additional balances to the self pay level that will be high enough to begin billing again. For example, you may want the small balances to sit there for 60 days before being written off.

The system defaults the Maximum Write-Off Amount to the amount on the setup in the Practice Maintenance on the Statements tab in Billing Control Information, in the "Minimum Balance to Send a Statement" field. You may leave this amount or override it to a different amount. If left at $10 as in this example, the system will post adjustments to accounts with balances of $10 and less to be written off.

Select LISTING WITH WRITE-OFF. This will generate a listing of accounts that meet the Small Balance criteria, and will post adjustments to the accounts that meet the criteria entered. The adjustment code that is used is contained in the Practice Maintenance on the Statements tab in Billing Control Information, in the "Small Bal Adj" field.

Payment Worksheet/Journal – Verify Balances

Run a Payment/Adjustment worksheet for the Small Balance Adjustment Batch that the system created. The total on the Small Balance Write-Off Listing should match the total on the Payment Adjustment worksheet for the Small Balance Adjustment Batch. The Batch will have the current date as a release date.

After these steps are completed and an account is accessed through the ledger, in the Charge/ Payment View, an un-posted Adjustment line will display with the description Self-Small Balance Adjust. This will be posted during the Close Out process adjusting off the "small balance" and leaving

that visit at a zero balance.

8.10 WebTrack Call Tracking System

The MedSuite WebTrack Call Tracking system creates a synergy between our clients' internal problem logging system and MedSuite's support call tracking system. Webtrack is used by MedSuite and MedSuite clients to log and track client questions and issues for the MedSuite Support Department. WebTrack is also available for clients to use internally within their own organization for question and problem tracking. For example, an office staffed with 40 people may use Webtrack to allow their staff members to enter problems and questions to their manager via "tickets." The manager may then have access to "link" a problem ticket to the MedSuite Support Department if they determine that the problem is a MedSuite software issue or an issue they cannot resolve on their own. Once a ticket has been "linked" to MedSuite, the MedSuite staff have internal processes in place in which to "work" these tickets. These processes are explained in this document.

ACCESSING WEBTRACK

To access the MedSuite WebTrack Call Tracking System, go to Internet Explorer and type WWW. MEDSUITE.NET/WEBTRACK in the address line. This will bring up the WebTrack Login Screen. Enter your Username, Password and Company then select Login. If you would like to create a shortcut on the desktop simply Right click on the address (the E Icon) and drag it to your desktop and select "Create Shortcut Here". Then Right click and Re-name the shortcut WebTrack.

LOGGING TICKETS

To log a New Ticket in MedSuite select New Ticket from the menu. Enter the following information:

User	Choose your name from the drop down menu. This will usually be yourself unless you are logging a ticket for someone else. Only authorized employees in the practice have the ability to log tickets.
Status	The Status of the ticket will always be New when you are logging a new one.
Type	The Type defaults to New on a new ticket. MedSuite will change the type as the ticket is "worked" within the MedSuite Support, Development and QA teams.
Category	The Category will default to MedSuite. You may change this to EDI, Enrollment, Hardware/Network, Legacy System, MedSuite, Practice Management (client internal category for credentialing etc.) or Training.
Sub Category	Each Category has its own set of Subcategories. For example in the MedSuite category there are subcategories of Billing, Charges, Close Outs, Demographics, Discussion, Enhancement, Follow-up / Collections, Ledger, Payments, etc.
Subject	Enter a short, concise and explanatory Subject. i.e. Skull & Crossbones – Demographic Entry. It should be descriptive enough that if you have to go back

	and search for it you can find it again.
Description	Enter in a complete description of the issue. Normally this would include the company name, group or practice, account examples, EOB's that show any denials etc. On reporting issues or paper claims, please include where it is found in the Task Viewer - practice, the date, user initials of the person who ran the task. For Electronic claims or statement issues, the transmission tracking number, page # and date in the Task Viewer helps. Please provide as much detail as you can to describe your problem or question.
File Attachment	To attach a file (print screen of an error, example report etc.) click Browse and select the file.

SUBMIT the ticket. When you have completed the ticket select Submit. The ticket will be displayed on the screen.

You will see a **Call ID** in the top left corner. Please reference this if you are calling or emailing about a status update or have questions about a previously logged ticket.

LINK TO MEDSUITE: Only an authorized person can link tickets to MedSuite. If you are using the call tracking system for internal purposes and the issue is not a MedSuite system issue but an internal issue such as a request for a plan to be added, credentialing to be done for a physician, or a procedural question, there is no need to "link" this to MedSuite. However, if it is a software issue and you need MedSuite to look at it, you must link the ticket to MedSuite.

IMPORTANT: MedSuite cannot see the ticket in the tracking system until it is "linked" to MedSuite.

UPDATES TO TICKETS

Once the New Ticket has been linked to MedSuite, the MedSuite support team will review the new ticket and assign a Type on the ticket (i.e. Pending, Discussion, etc…). WebTrack will automatically notify you via Email of any updates that are put on the ticket unless it is an internal update.   The emails that you receive will be from support@medsuite.net.

If you need to respond to an email that you receive from support@medsuite.net that references a ticket, please click the link in the email that says "**Click here to view this ticket."** That will display the ticket on your screen so that you may enter a response. Please update the ticket so that all information about the problem is in the ticket itself; this will alleviate the problem of having some information in the ticket and more information in a separate email.

IMPORTANT: Please DO NOT use your email to REPLY to the email, as this will NOT update the ticket itself and you will not receive a response from MedSuite support.

As MedSuite works on a ticket, the ticket "Type" and "Status" will change. The **STATUS** will change from NEW to OPEN when a staff member has viewed your ticket and begins working on it. When the issue is resolved or MedSuite has answered the question, they will change the status to CLOSED. You may re-open a closed ticket if necessary. If your ticket is an enhancement request, the ticket status may be changed to HOLD.

The **TYPE** will change from NEW to one of the types listed below:

NEW	No one has yet looked at the ticket.
SUPPORT	Someone from the Support department will be working on your ticket.

EDI	The ticket is an EDI problem that a programmer from Development will be working on.
FUTURE RELEASE	A ticket that MedSuite is not currently looking at, but something that will be considered for a future release.
UNSCHEDULED	A ticket that will be worked on by Development in the near future (next release or so).
DEVELOPMENT	A ticket that Development is currently working on or will be working on in the immediate future. This may be a bug or a problem in the system that needs to be corrected in the next release.
DISCUSSION	A ticket that MedSuite is trying to decide what to do, how to handle, whether to do. These may be customer requests for things that fall into a "gray area" between an enhancement request or a problem in the software.
RESOLUTION PENDING	This is used when Support is waiting on an answer from a client or from a third party, such as a clearinghouse.
QA	A ticket is moved to QA when Development has made a program change and it needs to be tested (QA'd to ensure that it is working properly). Please note that when your ticket is moved to QA it is NOT fixed on your system yet.
CURRENT RELEASE	A ticket is moved from QA to CURRENT RELEASE when the QA Department has tested the fix and has deemed it working properly. The fix will come out in the NEXT RELEASE. Please note that when your ticket is changed to CURRENT RELEASE it is NOT yet fixed on your system. When the STATUS of a Current Release ticket is changed to CLOSED, it has gone out in an update and is working on your system.

VIEWING TICKETS

To view Tickets that have been logged and are already open choose **Tickets**. There will be a list of tickets displayed. Based on the criteria that is selected different tickets will display.

To see ALL Tickets that have an Open status, select the following:
Type – ALL, **Submitted By** – ALL, **Status** – All Non-closed/Held**, Owned By** – ALL, **Category** – ALL, and **Subcategory** – ALL. By selecting the drop down beside each option you can narrow down the criteria of the tickets to be displayed. For instance, you might want to see just new tickets that have been logged. Simply change the **Status** from All Non-closed/Held to NEW.

Note that tickets have a status of NEW until a staff member from MedSuite changes the status to OPEN. You should periodically check NEW tickets to ensure that if they are a MedSuite issue they have been "LINKED" to MedSuite so that someone is seeing them. MedSuite does NOT see your tickets and change them from NEW to OPEN unless you Link them to MedSuite.

SEARCHING FOR TICKETS

You may search tickets if you wish to go back and find one, for example, if there is an issue that comes up and you remember that you may have had a similar ticket. To search for a ticket that was previously logged, change all of your options to ALL. In the box to the left of **Find Ticket** type in a key word to your issue such as "claim" or "statement" or "Revenue Report" etc. Then click **Find Ticket.**   This will search all of your tickets and will display any ticket that has those key words in the description of the ticket.

WHEN SHOULD YOU LOG A TICKET?

As a rule, you always need to log a ticket in WebTrack on any issue that is related to MedSuite and "Link to MedSuite" so Support can begin working to get it resolved. Here are few reasons why this is so important:

1. Logging a ticket into WebTrack assures that someone will look at your issues. If someone is out of the office and you email or leave a message for a specific person, they will not respond to your issue until they return. If it is logged into WebTrack then whoever is responsible for working the support queue will

be able to respond to your issue and get the issue resolved in a timely manner. MedSuite has several staff members who monitor WebTrack all day long and are aware of new tickets that are logged.

2. Logging a ticket into WebTrack keeps MedSuite aware of what types of issues are arising. Via WebTrack we can see what types of issues our client base is having and work toward resolution. For example, there may be lots of ticket logged into MedSuite on "how to" type of issues for a certain topic. This might indicate that maybe more training is needed or documentation created to help prevent these types of questions in the future.

3. Logging a ticket into WebTrack keeps you updated on the progress of your issue. At any given time, no matter who has been working on your issue, you can look in the tracking system to see the status of your ticket.

There are only a few occasions when you need to log a ticket and call MedSuite Support. They are the following:

1. If your MedSuite software is down and you are unable to work or you have an employee whose system is down and is unable to work.

2. The closeout did not finish.

3. The balance sheets are out of balance.

In any of these events, you should log a ticket and then call MedSuite Support at 239-945-7100 immediately. In the event that you are unable to reach someone at that number because it may be outside of business hours, please see the MedSuite Contact Support procedures found on the Help Menu in the MedSuite Software.

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