Medical Office System
Chapter 12: Support File Maintenance

This chapter discusses

- each of the support files used with the Medical Office System.

- the support files used to define letters, medical notes, and procedure groups.

- mass data entry for diagnoses, procedures, insurance carriers, and diagnostic labs

- authorized user access and control.

Introduction

The "Support File Maintenance Menu" includes access to a variety of options: support files, summary files, and letter-writing operations. Many options represent files used during Daily Input as pop up screens and browses. Keeping these files updated will speed up daily activities.
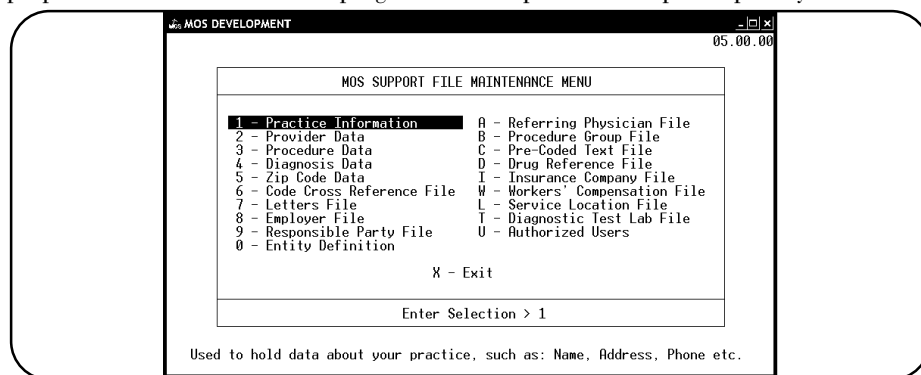


```
MOS DEVELOPMENT                                          _ □ ×
                                                         05.00.00

                MOS SUPPORT FILE MAINTENANCE MENU

        1 - Practice Information      A - Referring Physician File
        2 - Provider Data            B - Procedure Group File
        3 - Procedure Data           C - Pre-Coded Text File
        4 - Diagnosis Data           D - Drug Reference File
        5 - Zip Code Data            I - Insurance Company File
        6 - Code Cross Reference File W - Workers' Compensation File
        7 - Letters File             L - Service Location File
        8 - Employer File            T - Diagnostic Test Lab File
        9 - Responsible Party File    U - Authorized Users
        0 - Entity Definition

                            X - Exit

                     Enter Selection > 1


        Used to hold data about your practice, such as: Name, Address, Phone etc.
```

Figure 12-1 : Support Maintenance Menu

In this chapter, the direct modification of the support files is discussed. Data entry, modification, addition and deletion of records in the Support Files are discussed.

> *Note:* *If you did not read Chapter 3, "Traversing the MOS", you should do so before continuing with this chapter.*

The first option, Practice Information, was covered completely in Chapter 5 and will not be repeated here.

Finding Records (Choose Record Operations Menu)

After choosing one menu option, the Record Selection Menu will be displayed, see Figure 12.1. To find an already-existing record, search for the record using one of these options. For a complete explanation of each of these functions, read Chapter 13, "The Record Selection Menu."
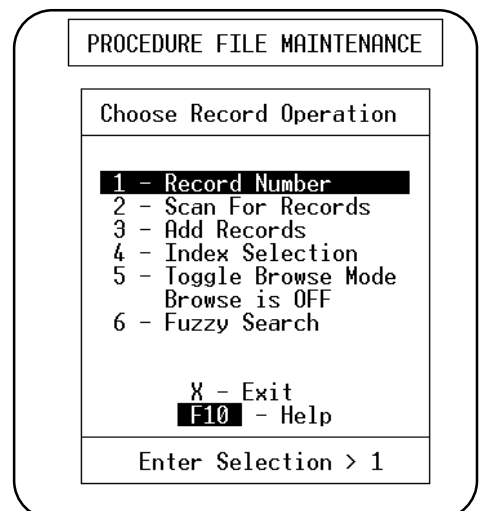


```
PROCEDURE FILE MAINTENANCE


    Choose Record Operation


   1 - Record Number
   2 - Scan For Records
   3 - Add Records
   4 - Index Selection
   5 - Toggle Browse Mode
       Browse is OFF
   6 - Fuzzy Search


       X - Exit
       F10 - Help

    Enter Selection > 1
```

Figure 12-2 : Record Selection Menu

Add Records Mode

To add records to the file, use option 3 - Add Records. In add records mode, after saving one record the next will be displayed, and so on until the add records mode is ended by canceling when a new record is displayed.

Using Record Options (Record Management Prompts)

After selecting an already-created record, a line of options -- Delete, Hardcopy, Update, Exit, Print Form, and Browse -- appears at the bottom of the screen. See Figure 12.1. Although not listed on the option line, the up and down arrow keys will move to the previous or next record. (Record numbers appear at the lower right corner of the screen but are only for reference. The record number is not used as a location for this data.)

```
                         Your Practice Name
                       VSS Medical Office System
                       PATIENTS' EMPLOYER FILE

        Code: ABC ◄
        Name: Abc Company                          ◄
     Address:                                       ◄
            :                                       ◄
  City,St,Zip: Bethel Park       ◄ PA◄      15102      ◄

     Contact:                              ◄
       Phone:                    ◄  Extension:       ◄

  Group Name: Big George                   ◄
  Employer ID: 11211             ◄


   Screen A              Enter Selection >           Record:        1
         D-Delete H-Hardcopy U-Update X-Exit F-Print Form B-Browse
```

Figure 12-3 : Record Management Prompts

Deleting a Record

Press ☐D☐ to delete a record. This message appears at the bottom of the screen:

```
 A Record Deletion Has Been Requested - Confirm (Y/N)
```

Press ☐Y☐ to confirm the deletion and add the record to the list of free (reusable) records. If the request for deletion was made in error, press ☐N☐ to cancel the deletion. **NEVER delete any record that may be currently referenced by a patient or invoice.** To protect the accuracy of your data, some records will not allow deletion. In some support files, a verification that the data is not in use is done before deletion is allowed. This procedure can take some time, if your data is extensive. It is best to allow this test to be done. In the extreme case that the record must still be deleted, an override has been inserted. Press ☐!☐ at the question instead of ☐Y☐ or ☐N☐ and the deletion is done without validation. This can be helpful when a duplicate code has been added.

Making a Hardcopy

To make a hardcopy of the record, make sure that your printer is on and on-line, and press ☐H☐ . (If your system includes a spooler, the report can be spooled now and printed later.)

Updating a Record

To update a record, press ☐U☐ . The cursor will move to the first updatable field on the screen; use the ☐ENTER☐ and ☐◄┘☐ keys to skip fields that do not have to be changed, and change entries by typing over them.

Browse Option

The browse option will display up to 20 records at a time to make it easier to find the one needed.

Press ☐B☐ for the browse option. The order of the browse is determined by the choice made on the Record Selection Menu. If the choice was for a record number, then the records are displayed in record number order. If the choice was by the code or key field using the Index Selection, then the records are displayed in code or key order.

For more information about using the browse functions available at the bottom of a browse screen, see Page 13-7, "Choose Record Operations".

Saving New or Changed Records

To save your new or changed record, press ESC . If in add records mode, the next empty record appears, ready to be filled. To exit from the add-records mode, press CTRL + BREAK after an empty record is displayed. The option line appears, then press X to exit. If changing already-created records, the Record Management Prompts are displayed.

Exiting a file

To exit a file, press X . The Record Selection Menu is displayed. Pick another option or press X to return to the Support File Maintenance Menu.

Print a Form

In some support files, the selection Print Forms is available. Select a form from the list displayed and press ENTER . The form will be printed on the currently selected printer. If this option is selected and no forms are available, a message will be displayed that indicates there are no forms available.

2 - Provider Data

The Provider File contains information about each physician. Information in this file is necessary for the correct functioning of the Appointment Scheduler and must be defined.

The maintenance password is required to update this file.

To get to the Provider file, press 6 at the Main Menu, then 2 at the Support File Maintenance Menu.

> *Note: Entries can also be added or changed during Daily Input.*
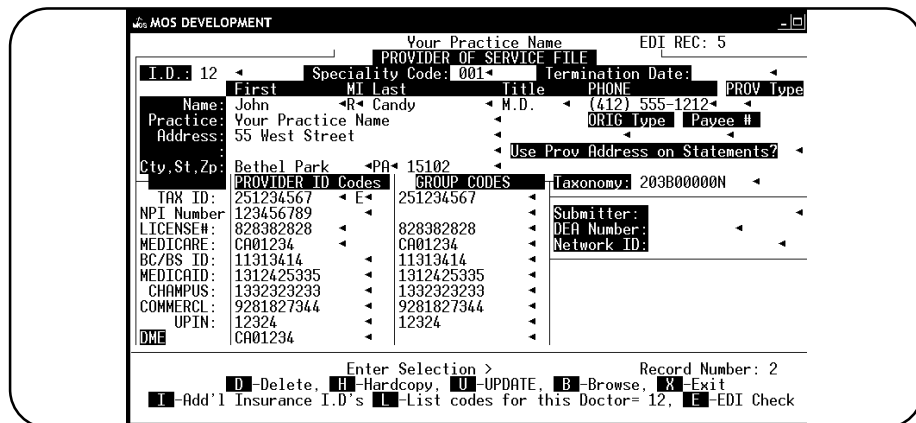
Figure 12-4 : The Provider Record

I.D. The I.D. can be up to four alphanumeric characters long and is usually the provider's initials.

Specialty Code *Code File Browse*

The provider's code for their specialty. Press F6 for a list.

First Name The provider's first name.

MI	Middle Initial of the Provider.
Last Name	The provider's last name.
Title	A suffix for the provider (e.g., M.D. or D.O. or Ph.D.).
Practice	The name of the practice.
Address	The provider's address. The two lines hold up to 25 characters each.

The provider's zip code. Press `F6` to list the zip codes on file and select one. See Page 12-14 for more information on the zip browse.

City	The provider's city. If the zip code was entered, the cursor will not stop for data entry at this field.
State	The provider's state. If the zip code was entered, the cursor will not stop for data entry at this field.

Print Above Address on Statements

/Forms?   Press `Y` , if the physician's name & address should be printed on statements & forms instead of the practice name and address. This can be selected for each provider.

Phone Number   The provider's phone number and area code. Typing the parenthesis or dash is unnecessary. The MOS will do it automatically.

Org Type   Enter the Provider Organization type code. This may be used for electronic claims but is usually not required.

Payee #   Enter a Payee #. This data is available for printed claims and can be used for whatever short numbers might be required. Currently this was added for IL Medicaid claims.

NPI Code   Enter the National Provider ID code when this is assigned.

This is a number that must be selected from a list to define the specialty of provider or services provided by this provider.

Provider ID Codes   The provider's ID codes. Each provider can have as many as eight codes of up to twelve characters each. The order of the codes is defined in the Practice Information File, see Chapter 5, "Setup Practice File". It is important that the codes be consistent for each provider so that the insurance forms can be properly printed.

Provider ID codes are always individual provider numbers, used for rendering providers.

Additional codes can be added that are linked to an insurance company. If one is necessary, refer to additional options below.

Group ID Codes   Enter the Group ID Codes for each insurance type. These are the Billing Codes used to ask for payment. This will make it easier to see what codes are used for each provider. If the provider uses the same codes for both rendering and billing, just put the same numbers in both columns.

After adding or updating the data, press `ESC` to save this data.

If a scheduling password was assigned, a prompt will ask for it at this time. The scheduling password is required for access to the next screen. If there is no scheduling password assigned or the password is entered properly, the scheduling screen is displayed as shown in figure 12.1.
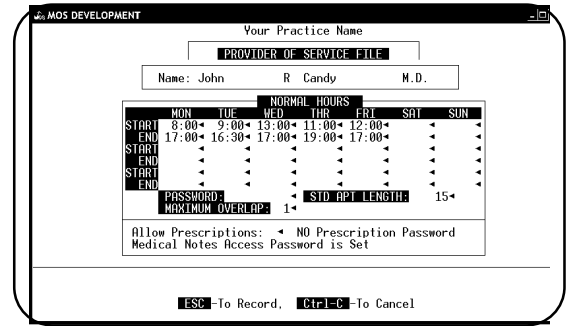
This is where the schedule for each provider in your practice is supplied. This schedule allows for seven days of the week and allows up to three groups of hours per day.

Figure 12-5 : Provider Schedule

Start This is the starting time for an availability period. Use military time to enter the time. There are three start times per-day.

End This is the ending time for an availability period. Use military time to enter the time. There are three end times per-day.

Password Passwords are used to prevent unauthorized modification of a provider's schedule and passwords.

Std Apt Length This is the default number of minutes for each appointment. This may be overridden when scheduling appointments.

Maximum Overlap This indicates how many appointments may be scheduled per time period. A warning will be given if more patients are scheduled than suggested by this entry. Each provider can identify this overlap amount.

For more information about the scheduler see Chapter 19, "The Scheduler".

Allow Prescriptions Enter Y to allow prescriptions. To print a prescription will require a password. This should be very restricted. Prescription formats and printing has not been fully developed.

Press ESC to save the data on this screen.

```
Change Medical Records Password?    (Y/N) >
```

Answer Y if you wish to change the medical records password. This is used to close Medical Records and make them permanent. Enter the new password at the prompt.

```
Change Prescription Password?    (Y/N) >
```

Answer Y if you wish to change the prescription password. This is used to print prescriptions. Enter the new password at the prompt.

Additional Options

I - Additional Insurance I.D.s

Use the cross reference file to assign a special Provider ID's to specific carriers. This can also be used if the ID numbers listed on the provider screen should be longer than 12 characters. A number listed in the cross-reference file will supersede any general number listed for a carrier type on insurance forms and when submitting electronically.

Select I from the Enter Selection option to add ID numbers that must be reported on insurance forms, instead of the numbers listed on this screen. A prompt will display with

```
Enter Insurance Company Code  (Leave BLANK to END) >
```

Enter a code for the insurance company and press ENTER . Then the prompt for the Provider ID is displayed. If an ID is already on file for this Carrier and Provider the number is displayed. You can correct it at this time or just press ENTER .

```
Enter Provider ID for Insurance Company: XXXX  >
```

Enter the company specific ID code. Then indicate the type of number supplied. This will insure that the number is used correctly.

```
Rendering
Billing
ALL
```

To display or edit the codes that have been assigned use the second selection.

L   *List Codes for this Doctor*

Press L to list all the codes added for this provider. A display will list the codes with the options to Change, Add or Exit.

ENTER   Select a code to change

A   Add another code

X   Exit

!   Delete a number

To insert this code on an insurance form, use insurance form field 179 (Primary ins co   prac xref ins provider ID Billing). This code is assigned the INSURANCE PRACTICE ID and if a Cross Reference code exists for this carrier and provider the field is replaced

Figure 12-6: Cross Reference Codes For a Provider

with that ID number.   The Insurance Practice ID is the number listed on the insurance company record. This is a number assigned to the practice by this carrier. Additional numbers can be listed for providers from the insurance company screen.
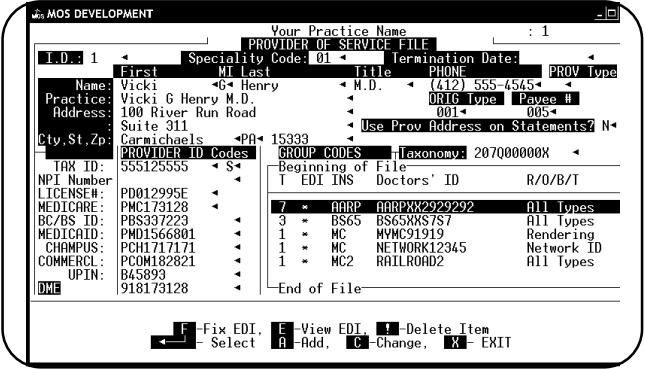
If this is only used for a particular carrier, a copy of the HCFA form can be made just for that carrier. The new code field can then replace the appropriate code.

To use the Rendering number use insurance form fields 945-950 for lines 1-6 on the claim form.

Deleting a Provider

If over the course of your business, you find it necessary to delete a provider, this option is available. However, for your protection, the provider must not still be in use in the system. A check is run to insure that all references to this provider have been removed from patient records and claims. It is best, if the claims have worked through the system, been paid and purged in the normal way.

Press D from the prompts and the following question will appear:

```
Request to Delete Provider.  Continue? (Y/N) >
```

Press Ⓨ to delete the provider but to first check to see if the provider is still on record for any claims or services. Once a check is made, a prompt will indicate if the deletion is allowed. If a problem is found, a message will indicate where the conflict can be found.

Press ⚠ To delete the provider without checking for current use. This is helpful if the provider code has somehow been duplicated. Deleting a provider that is referenced on current data can cause malfunctions of the system. Only do this in extreme circumstances and check with MOS Support first.

Billing and Rendering Provider ID's on Paper and Electronic Claims

A full explanation can be found in Chapter 15 on using the provider numbers on claims.

Special insurance form fields will provide a smarter way of filling provider number fields for insurance forms. Insurance form field 179 will be loaded with the following steps. And will properly select the right number from the Provider Screen, Insurance File and Cross-Reference as detailed below.

Billing Doctor
1. Load the correct provider number from the provider screen depending on the Insurance Type of the primary carrier.

2. If the primary carrier screen has a Practice ID filled in then use the Practice ID.

3. If a code has been added to the Additional ID Numbers (Cross-Reference) file for that doctor and specifically for the primary insurance company than use the code for ALL Types.

4. If a code has been added to the Additional ID Numbers (Cross-Reference) file for that doctor and specifically for the primary insurance company than use the code for Billing Provider.

Cross-Reference Numbers

These numbers can be added from the Provider Data and are specific to a carrier. You can identify a number as for ALL Types, Billing or Rendering. They can be 20 characters long so can allow for a longer number than might be available on the Provider Data.

Rendering Doctor   Now if you have the same difficulty with the rendering provider numbers, they can be handled in the same way. Like all service line data, there is a different number for each line. On service line 1, you can place 945 in 24K to print the correct rendering provider code for the provider of service for procedure 1, the other lines will use insurance form field 946-950. These are loaded in the same sequence as the billing provider. The only difference is will be in step 4 where it will use the Rendering Provider number as the final option.

3 - Procedure Data

This file contains all the procedures used in your practice. These procedures can also be added or changed during Daily Input.

The maintenance password is required to access this file.

To get to the Procedure file, press ⑥ at the Main Menu, then ③ at the Support File Maintenance Menu.

> *Note: Entries can also be added or changed during Daily Input.*

Figure 12-7 : The Procedure Record

To better display the information, the Utilization box has been set aside. To display this box on the screen press ⎡Z⎤ . Then the Utilization box is displayed instead of the new NDC and Drug Information. Month-to-Date Times and Amounts, and Year-to-Date Times and Amounts are statistical information maintained by the Medical Office System.

Provider   Enter a provider code, if the procedure is for a specific provider, or leave blank for all providers. To track procedure utilization by provider or set up a different charge schedule for each provider, creating a procedure record for each provider will be necessary.

RS   (Routing Slip A.K.A. Super Bill) Place a "Y" if this procedure should be listed on your Routing Slip or leave blank for no. In some areas, the routing slip is called a super bill.

Your Code   A code of up to nine alphanumeric characters can be assigned to identify this procedure. This code may be a mnemonic such as IOV for initial office visit or use the actual CPT code. Be consistent in the way this is used. This code will be able to identify a procedure in addition to the code in all situations within the MOS. Do NOT change the codes used once they are referenced by services in the MOS. Add a new procedure record with the new code assigned and begin using that code record for all new service entries. Change the description of this code in a way that will show this procedure is no longer used. It can only be deleted when, the procedure utilization is all blank for as many years as history is saved on your system.

Modifiers   If this procedure requires modifiers add them at this point. Modifiers can also be added on service lines as required.   Up to 4 modifiers can be assigned to this procedure. If you need to see the additional modifiers when adding service lines, use Charge Screen "TT". This can be set as the default charge line screen in the practice information. The default charge line screen only displays the first 2 modifiers.

Description   Enter a description for this procedure code, up to 30 characters. This description will be available to print on insurance forms and routing slips. The description can be modified when listed on an individual claim.

Standard Charge   The standard charge for the procedure. (Remember that the standard charge can be overridden in Daily Input.)

Code (CPT)   "Current Procedural Terminology" code. The CPT code can be as many as nine alphanumeric characters. The code used on the insurance forms is variable depending on the insurance carrier. This is the default code for most. If this is not found, Your Code is used.

> *Note: Leave this field blank, if the CPT code was entered as "Your Code".*

TOS
(Type of Service)   *Browse*

Press ⌷F6⌷ to display the valid list of service codes available for this column. The description of the TOS code is displayed below the Charge/Allowance box.

The TOS code for the standard charge is required to match one on the list. The codes for the other carriers do not have to be valid codes included on the browse list.

Lab and Anesthesia are special types of services and if a code entered here is listed on the practice setup as the code for lab or anesthesia some special logic will be triggered on your claims. The default length of the TOS code entered on the default HCFA form is one character. If using two or three character codes for the TOS, be sure to adjust the insurance form definition.

MC PAR / ALLOW   Enter the charge for participating in medicare. Enter a CPT code if it is different than the standard code. If the claim is assigned to Medicare and a code is listed on this line for CPT or TOS it will be used instead of the code listed next to standard charge.

MC NON PAR   Enter charge for non-participating practice. This will be the charge used if your practice is non-participating with Medicare. Leave this blank if you are always participating.

PYMT   This will automatically display the Medicare Expected payment. This is calculated with the Allowed amount times the Medicare Pays Percent entered in the Practice Setup. Currently this is 80%. If the amount in the MC Non Par is greater than the Allow, then the percent is taken of that number instead. If MC pays you the full amount, then enter 100.00% in the Medicare payment percent in the practice information and enter the actual payment amount in the MC NON PAR amount fields.

The amount in this field is assumed to be the payment received from MC for this procedure. The difference between the allowance and the standard charge is your write-off. The difference between the MC allows and the payment is the Patient responsible portion.

SP %   Special MC Payment Percent, if different from Setup. If this procedure only pays 50%, instead of the normal 80%, then enter that here. This will override the default for just this procedure.

Cert   Code File Browse
Enter code for certification record that would be required for this procedure. A list of codes available are displayed at the bottom of the screen. If HA0 is entered in this field, then the Narr field will automatically indicate "Y". A standard certification record is coded with GC0, GA0, etc. Check the Browse display to see what codes are available for this field.

Narr   Enter ⌷Y⌷ if a narrative record must be sent with this procedure to explain or provide a place for additional data. A narrative record is coded as HA0.

HIPPA   Enter ⌷N⌷ if this is not to be used as HIPPA compliant data. If this is blank, it is assumed to be Yes to be backward compatible with prior MOS customers. You just need to fill it in if it should be No.

Invalid   Enter the date that a code should no longer be used. Since procedures can not be deleted, this will block them from use after the given date but still make them available for reports and existing claims that might require them.

Drug Procedure?   Enter ⌷Y⌷ if this is a drug definition.

NDC#   Enter the National Drug Code # in this spot.

Units   Enter the default units for this drug.

Days   Enter the default days for a prescription of this drug.

Discount   Enter the default discount for this drug.

Updating Standard Charges and MC Allowances

On the Procedure/Diagnosis Report Menu there are two reports that can be used to quickly update prices. The "Change MC Allowances" report will allow you to enter the new Medicare Allowances when they are published each year. This will walk through the procedures and display each one. The price can remain the same or be changed and all the items are printed with the price before and after so the changes can be verified.

A similar function is available for Standard Charges that will allow a quick way to change prices.

These are explained in more detail in Chapter 11 with the report information. ⑤ - Reports Main Menu, ① - Diagnosis/Procedure Menu and the reports are listed here.

Special Pricing / CPT codes / TOS codes

Each procedure has additional fields charge/allowance. These are available to define pricing schedules for each insurance company that does not accept the standard charge. When a new insurance company is added, a procedure allowance can be identified. The default for all carriers is "0", which is your standard charge and Medicare. If any carrier has a procedure allowance other than "0", the Procedure code and TOS code can also be varied for that carrier or group of carriers.

When a charge line is entered for a carrier that has a Procedure Allowance other than 0, the amount entered for the charge can be the standard charge or the allowed amount. If the "Charge Allowed?" answer is "Y" on the Insurance Carrier Screen, then the Allowed amount is automatically entered as the Charge amount for the service line. If the "Charge Allowed?" answer is "N" on the Insurance Carrier Screen, then the Standard Charge amount is automatically entered as the Charge for this service, but when a payment is received the Allowed Amount is automatically entered as the expected payment amount.

In many states, the Medicaid claims require a different TOS code. For more information see the Insurance File section later in this chapter.

A new TOS cross-reference will allow this to be entered once and to change the standard TOS to a special on just for an individual carrier. It is not necessary to correct it on each procedure.

Additional Options

I   Additional Insurance TOS

Select ⌷ from the Enter Selection option to add ID numbers that must be reported on insurance forms, instead of the numbers listed on this screen. A prompt will display with

```
Enter Insurance Company Code   (Leave BLANK to END) >
```

Enter a code for the insurance company and press [ENTER] . A second prompt appears:

```
Enter TOS CODE for Insurance Company: XXXX  >
```

Enter the company specific code.

To display or edit the codes that have been assigned use the second selection. Remember that on an insurance form the TOS code is only 2 characters.

L   *List INS CODES for this TOS*

Press ⎣L⎤ to list all the TOS codes added for this procedure. A display will list the codes with the options to Change, Add or Exit.

⎣ENTER⎤   Select a code to change

⎣A⎤   Add another code

⎣X⎤   Exit

The Cross Reference code is used on insurance forms if the responsible carrier has a code that matched to a TOS code. For example, if the TOS code is "1" on the procedure code and for this carrier a code "1" should be changed to "F" then that will be done automatically.

To insert this code on an insurance form, use insurance form field 179. This will be blank if you have not entered a code for this insurance company and this provider.

If this is only used for a particular carrier, a copy of the HCFA form can be made just for that carrier. The new code field can then replace the appropriate code.

Comments

We recommend that a new list of procedures in both code and alphabetic order be printed if the procedure file has been modified extensively. This operation is reached from "The Reports Menu", then the "Diagnosis/Procedure Menu".

After entering a provider number, the following pop up box will be displayed when the record is saved. (press ⎣ESC⎤ .)

Procedures by Provider

When a procedure is saved, with a provider ID, an option will appear that will allow this same procedure to be created for other providers at the same time. This is helpful to remind you to make a new procedure for each provider. Tracking procedures by provider gives you additional statistical information to help analyze your practice.

Enter any additional provider codes that should have the same procedure added. Just ⎣ENTER⎤ when all have been added.

> *Note:*   *The MOS will always leave a procedure record with no provider code assigned to accumulate utilization totals. DO NOT DELETE THE DUPLICATE RECORD. It is required by the MOS.*

If the charges vary for any particular providers, modify the standard charge on those procedures.

Adding A New Provider for each procedure code to your system

If you have a new provider, and wish to copy each procedure and create a new procedure record for that provider there is a new report available.

⎣5⎤ - Reports Main Menu, ⎣1⎤ - Diagnosis/Procedure Menu, ⎣I⎤ - Duplicate Proc Codes for New Dr. Run this once for each new provider. Refer to report instructions for more information about this report.

Medicare Allowances and Participating/Non-Participating Allowances.

	Standard Charge	MC Allowance	Non Par %	Non-Par MC Allow	MC Pays %	MC Pays	Writeoff	Patient Pays DR
Participating	100.00	85.00 x			80% =	68.00 to doctor	15.00	17.00
Non-Par	100.00	85.00 x	95% =	80.75 x	80% =	64.60 to patient	0	80.75 x115% = 92.86

Standard Charge: $100.00
MC Allowance: 85.00

If you are non-participating then the MC allowance is reduced by 5%.

Non- Participating allowance is 85.00 x .95 = 80.75

Now MC pays 80% of the MC Allowance if you are participating and 80% of the Non-Participating allowance if you are not participating.

The SP% on the Procedure screen will override the 80% normally paid by MC. Use this field if the percent is higher or lower than the default 80% of allowed.

If your standard charge is less than the allowed amount, all calculations are made based on 80% of the standard change.

The NON-Participating Allowance is a percentage of the MC Allowance. If the standard of 95% does not apply to this procedure then enter the allowance manually. It is not changed once it is entered. If it is supplied then the expected payment from MC is calculated from this allowance. If the Non-Participating allowance is blank then the 80% is taken from the Medicare Allowance.

Maximum limiting charge is 115% of the Medicare Non- Participating Physicians Fee Schedule allowance. This is the maximum amount that can be billed to the patient. The standard charge or this amount, whichever is less will be entered on insurance claims as the charge for this procedure.

4 - Diagnosis Data

The Diagnosis File contains data on all diagnoses commonly used in your practice.

The maintenance password is required to change this file.

> *Note: Entries can also be added or changed during Daily Input.*

To access the Diagnosis file, press 6 at the Main Menu, then 4 at the Support File Maintenance Menu.

Figure 12-8 : The Diagnosis Record

Utilization fields are the number of occurrences for a diagnosis and are maintained by the MOS.

Code 1   A code of up to seven alphanumeric characters, used to provide a user-friendly way to remember the codes.

> *Note: You can use ICD-A Code as code 1 if you wish.*

Code 2
(I.C.D.A. Code)   "International Classification of Diseases" code; a standardized classification system from the U.S. Department of Health and Human Services. The code can be up to seven alphanumeric characters.

Code 3
(Other Code)   Use this code when a different code is needed for a special insurance company.

Category   User-assigned categories that will provide a sort level for some reports. Assign a different code to group tumor types, allergy types, pediatric vs. obstetric categories, etc.

RS   Enter Y to include this diagnosis code on the Super Bill or Routing Slip. Only 10 can be included, so pick the most used codes. When any codes are marked, the number of procedures is reduced to the first 80.

Description   A description of the diagnosis. The entry can be up to 30 characters long.

5 - Zip Code Data

The Zip Code File stores the zip codes with the associated city, state, and area code, and is used to speed up data entry. When an address is required during data entry in the MOS the cursor is moved to the zip code field before entering data in the city and state fields. If the zip code entered is on file, the associated city and state will be filled automatically. (In some cases the telephone area code will also be filled automatically.)

To get to the Zip Code file, press ⬚6 at the Main Menu, then ⬚5 at the Support File Maintenance Menu.

Note: Entries can also be added or changed during Daily Input.

```
                        Your Practice Name
                   filePro Medical Office System
                           ZIP CODE FILE


                    Zip Code: 15236       ◄
                        City: Pittsburgh       ◄
                       State: PA◄
                   Area Code: 412◄




          Screen A           Enter Selection >           Record:      1
                 D-Delete H-Hardcopy U-Update X-Exit F-Print Form B-Browse
```

Figure 12-9 : The Zip Code Record

Zip Code   Type the Zip Code.

City   Type the City associated with the Zip Code. More than one city name may be added for each zip code. When using this file in data entry, if a zip code has more than one city on file, a browse list is displayed listing the cities on file. Highlight the correct one and press ENTER .

State   Type the state associated with the Zip Code.

Area Code   Type the telephone area code associated with the Zip Code, if there is only one. When entering a phone number in the MOS, the area code will be supplied automatically. Leave the area code blank, if a zip code can have more than one area code associated with it.

ZIP CODE BROWSES

These browses are available throughout the Medical Office System system. Any place a zip code is requested this feature is available. It is perfectly normal to have more than one city listed under a single zip code. For that reason, whenever a zip is entered with more than one city listed, the browse window is displayed with the cities listed. Unless a new zip code is typed later, the city and state are not pulled again.

If more than one area code common in this zip code, leave this blank. Just fill the appropriate area code when entering the phone number.

A special secret feature is available when browsing the zip code file from Daily Input. An incorrectly entered zip can be deleted by selecting browse, then point at the zip entry to be deleted and press ⬚! .

6 - Code Cross Reference File

The Code Cross Reference File contains the code translations to be used when printing insurance forms. These are managed from the Provider File, Procedure File and Service Location File.

For a particular carrier, you can supply a special ID for a Provider, change the POS (Place of Service) code, or change the TOS (type of service) code.

```
                              Your Practice Name
                          VSS Medical Office System
                          CODE CROSS-REFERENCE DATA


                    Insurance Company ID:      MC  ◄
                              Field ID:      MDID◄
                  Medical Office System Code: 1        ◄
                  Equivalent Ins Company Code: HE73372TWO        ◄



            Screen A             Enter Selection > █            Record:        1
                  D -Delete  H -Hardcopy  U -Update  X -Exit  F -Print Form  B -Browse
```

Figure 12-10: Cross Reference File

7 - Changing Letters

The Medical Office System provides a way to compose, save, and modify patient form letters without the use of a word processor. The letters can be printed online or in a batch. For information about printing letters in a batch, see Page 11-102.

To access the letters file, press ⬚6 at the Main Menu for the Support File Maintenance Menu then press ⬚7 for the Letters File.

```
                          VSS Medical Office System
                             MEDICAL LETTERS FILE
                             OVERDUE 2 MONTHS        ◄

                                DESCRIPTION

                Dunning letter for 2 months overdue patients.     ◄


                        Select by: OLDEST INVOICE  ◄



            Screen his           Enter Selection >            Record:        1
                  D -Delete  H -Hardcopy  U -Update  X -Exit  F -Print Form  B -Browse
```

Figure 12-11 : Letters Record

Name   Name of the letter (20 characters).

Description   Enter a description of the letter (50 characters).

Selected by   When entering "selected by" field a browse screen will be displayed:
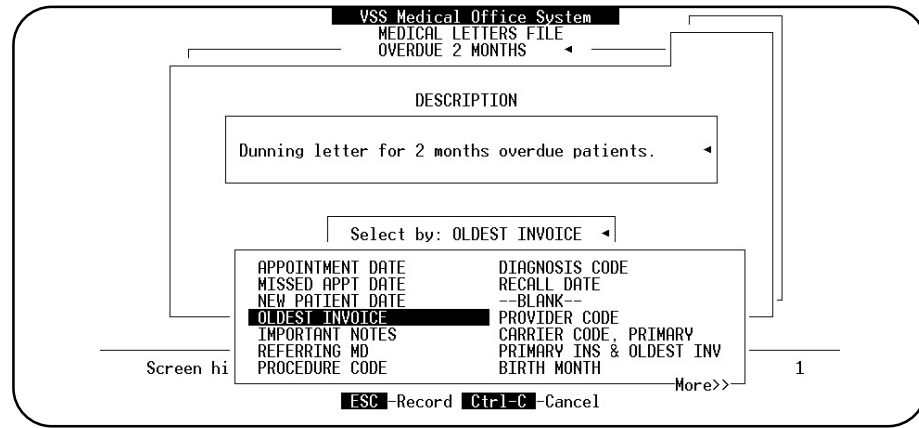
Figure 12-12 : Letter Selection List

Use the up and down arrow keys to highlight the "selection question" that corresponds to your letter and then press e. This field determines what selection question(s) will be asked when printing the letter. The question(s) will determine which records will be selected for printing. The questions available may be expanded with future versions of MOS.

APPOINTMENT DATE: Prompts the user for a "from" and "to" date and selects any patients who have an appointment between the given dates.

MISSED APPT DATE: Prompts the user for a "from" and "to" date and selects any patients who missed an appointment between the given dates.

NEW PATIENT DATE: Prompts the user for a "from" and "to" date and selects any patients who were added to the MOS between the date range.

OLDEST INVOICE: Prompts the user to enter a minimum and maximum number of months that an invoice is overdue. If the patient's billing age is within the range, the patient will be selected.

IMPORTANT NOTES: Prompts the user to enter a string of characters (a word or group of words). If the patient's important notes contain the string of characters, the patient will be selected.

REFERRING MD: Select a referring physician from a list, then select any patients added to the MOS between the given dates. Looks at the patient since date field.

PROCEDURE CODE: This is only used for "Recall letters by Procedure" found on the Patient Reports Menu. The prompts will ask for a procedure and then the cutoff date for last time the patient was seen.

DIAGNOSIS CODE: Selects all patients with a given diagnosis between two service dates. Use this to search for all patients that were given a diagnosis in a given time frame. This uses the new diagnosis history file and will only work if you are storing the history for this data.

RECALL DATE: Select all patients with a matching recall date.

— BLANK --:   Select All Patients.

PROVIDER CODE:	Select patients by Provider. This is useful to notify patients about changes in the provider's schedule, greeting letters customized for a particular provider.
CARRIER CODE, PRIMARY:	This will prompt for a carrier and will select all patients with this carrier listed as the first carrier. Use this to notify patients of changes in the carrier agreements with your practice.
PRIMARY INS & OLDEST INVOICE:	Prompts the user to enter a minimum and maximum number of months that an invoice is overdue. If the patient's billing age is within the range, the patient will be selected. This will also prompt for Primary Carrier code. Only patients with invoices in the age indicated with the indicated primary carrier will be selected.
MONTH of BIRTH	Prompts the user to enter the month number and selects all patients with a birthday in that month.

Example: You want to write a letter to be printed to patients who have a certain referring physician. Now you would choose REFERRING MD for the "selected by" field so when you print the letter you will be prompted to enter a referring physician code along with a "from" and "to" date range.

When this screen is complete, press ⎡ESC⎤. The "create letter" screen shown in Figure 12.1 is displayed.

What Will Fit in a Letter

A letter can include up to 100 lines of text with as many as 60 characters per line. When entering text, the MOS letter file acts like a word processor, word wrapping is done automatically. Common word processing functions such as: insert and delete characters, insert and delete lines, find a string of characters, and go to the end of a line are also available. In addition, text can be marked and pasted to allow simple methods of moving, coping and deleting blocks of text. The key strokes to do these operations appear on the menu displayed on the bottom of the "create letter" screen shown in the figure 12.1.
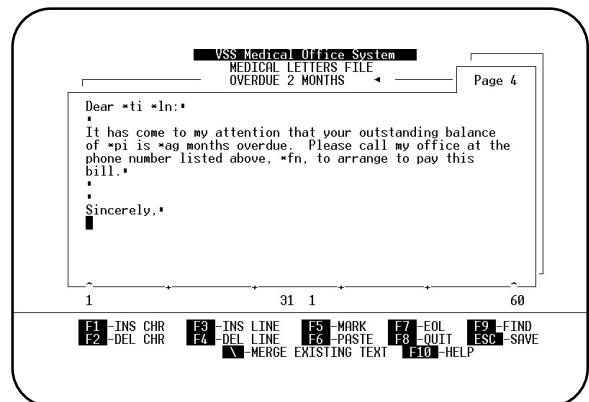

Figure 12-13 : Letter-Definition Screen

Special Size Letters

If the first line of the letter reads "*label", then the format will print on an envelope in column 25.

If the first line of the letter reads "*mail", then the format will print on a label 6 lines long. The width may be up to 100 characters.

If the first line of the letter reads "*laser", then the format will print on a 60 line page.

Any other text on the first line will create a letter for standard 8 x 11 inch paper (66 lines).

How to insert, delete and find text in a letter.

For insert mode press ⎡F1⎤ or to delete a character press ⎡F2⎤. To insert or delete a line press ⎡F3⎤ or ⎡F4⎤. Move the insert point to an end of a line by pressing ⎡F7⎤ or find a string of characters (a word)

by pressing ⌊F9⌋ (FIND). To "mark" text, place the cursor at the beginning of the text to be marked for a copy, move or deletion and press ⌊F5⌋. The following menu bar will be displayed:
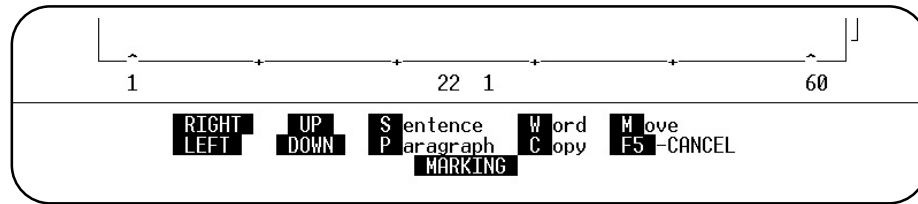

Figure 12-14 : Letter-Definition Screen

Press ⌊S⌋ to mark a sentence, ⌊P⌋ to mark a paragraph or ⌊W⌋ to mark a word. Use the arrow keys to mark additional text. When text is marked, it becomes highlighted.

After the block of text has been marked or highlighted say what should be done with the next key stroke. Press ⌊C⌋ to copy, or press ⌊M⌋ to move or delete. If "M" was selected, the marked text will be saved in a buffer and removed from the remaining text.

After saving the marked text (pressing "C" or "M"), the "create letter" screen will reactivate and the word "Paste" followed by a number will be displayed at the bottom of the "create letter" screen. The number represents the number of characters of marked text saved in the buffer. To insert the saved text, place the cursor in the correct position and press ⌊F6⌋ (PASTE).

Merging Text

Text can be defined in the Pre-Coded Text File and then merged into a MOS letter.

Fields, identified by an asterisk (*) followed by two characters, say to the MOS to supply information to the letter when printing. For example letters can be printed in a batch with variable information like patients' name, the address, account number, etc. by entering the associated field into the letter.

Pre-coded text is available to make letter writing quicker and easier -- for example, broken bones, sprains, next visit and other standard text can be merged into a MOS letter.

For more information about pre-coded text and fields see the "Pre-coded Text File" section later in this chapter.

To merge a field or pre-coded text, position the cursor in the correct location and press ⌊\⌋. A browse with the available fields and pre-coded text will be displayed:
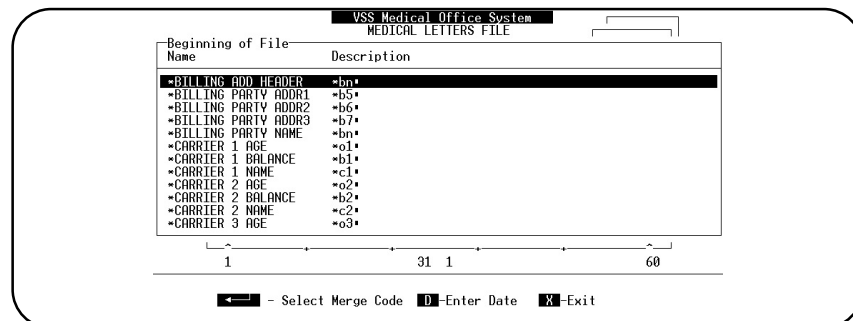

Figure 12-15 : Merge Browse

Use the ⌨PG UP and ⌨PG DN to move though the browse. To merge text, highlight the desired field or text using the up and down arrow keys and then press ⌨ENTER . Your choice will be merged into the letter at the position of the cursor. To cancel this request, press ⌨X .
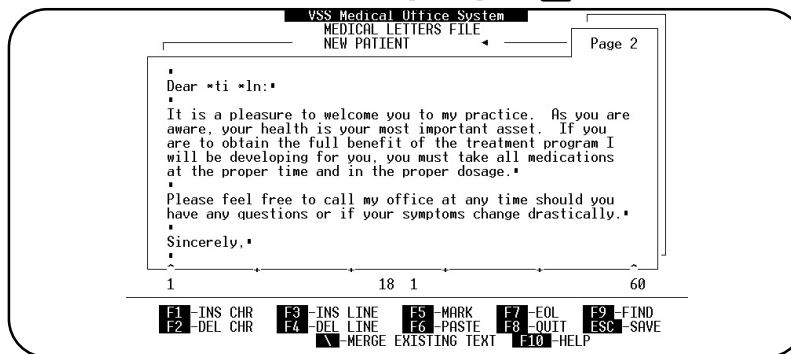

Figure 12-16 : Sample Letter with Fields

Special parameters

Start the first line of the letter with one of the following codes to create a special format:

*label	To print an envelope format, 25 lines per page, indented about 25 chars.
*mail	To print a 6 line label. A sample is called File Label. Six lines per page.
*laser	To print a letter on a laser printer with 60 lines per page
*export	To export data to be merged to WordPerfect

On the Practice Information, there are now options for defining the Top Margin, Paper Length and Page Length. Use these options to print on various printers or skip the letter head that you use.

Exporting Data to WORDPERFECT®

A special setup is available to send data to a export file that can be merged to a word processor. A sample of a name and address setup is show in 12.1. This will create an ASCII comma delimited, encapsulated file.
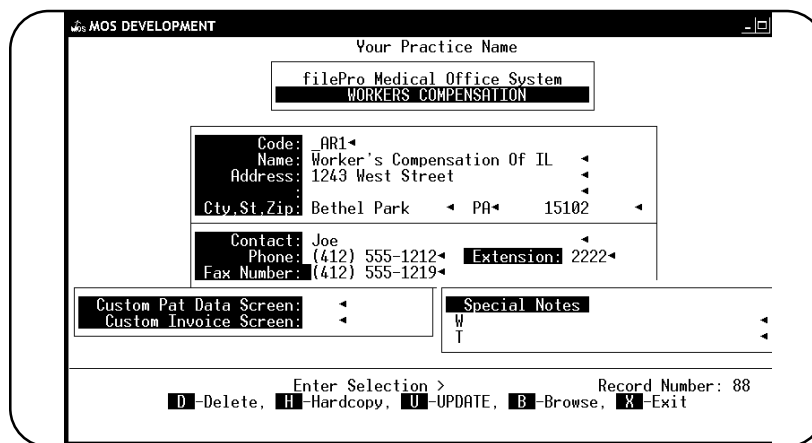

Figure 12-17: Define Export format

The parameters on the *export line are as follows:

len=   Number of data elements to be sent in each record.

rec=   Record delimiter to be used. Default is NL (newline DOS = CF/LF, *nix = LF), but other options would be LF (linefeed hex 0a) or CR (carriage return (hex 0d)

field=	Field delimiter to be used. Any character, such as , * ^ | would work. Special option would translate TAB into the tab code. If comma is used, the fields will be quote delimited.

name=	Filename where data file with the name given. It will be located as follows on the hard drive.
	    DOS \md
	    UNIX \md\fpmerge
	The name is treated as literal unless it has the following format: *YYMD.csv. This will cause the name to be expanded with today's date as follows: YYYYMMDD.csv. This can be handy to create a new file each time the export is generated. For example, a file created on 08/14/2008 would be named: 20080814.csv

Saving or Canceling Changes

To cancel or save any changes since the letter was last saved press s (Quit) and the following prompt will be displayed:
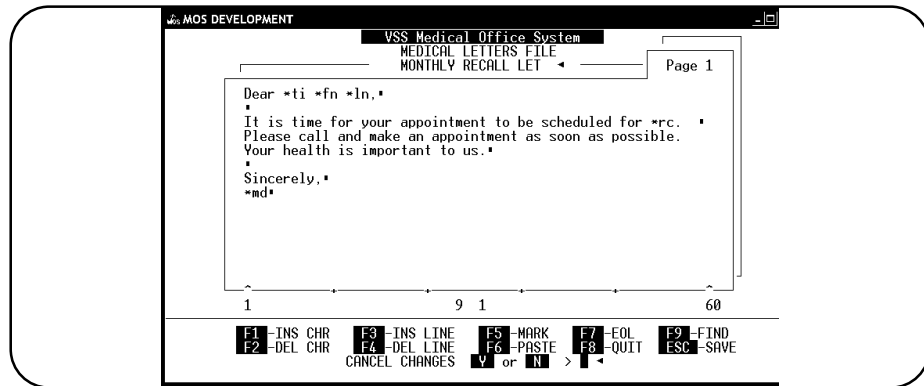
Figure 12-18 : Quitting from Medical Letters

Press [Y] to cancel or [N] to save any changes. To save the letter, press [ESC] .

8 - Employer File

The Employer File contains information about a patient's employer. This is important in Workers' Compensation Claims.

> *Note: Entries can also be added or changed during Daily Input.*

To get to the Employer file, press [6] at the Main Menu, then [8] at the Support File Maintenance Menu.

Figure 12-19 : The Employer Record

|	
Code	The code can be up to four alphanumeric characters long. This is the unique code to identify this employer.
Name	The name of the employer, up to 25 characters long.
Address	The employer's address. The two lines hold up to 25 characters each.
Zip Code	*Support File Browse, If Not Found Add* Type the Zip Code of this employer. Press F6 , to browse the zip code file. If a zip code is entered, the next data entry field will be the contact field. See Page 12-14 for more information on the zip browse.
City	Type the city of this employer.
State	Type the state of this employer.
Contact	Type the name of the supervisor or person in charge of medical benefits.
Phone Number	Type the Phone Number and area code for the employer. The parenthesis and dash will be supplied by the MOS program automatically. If the zip code, which was entered, had an area code assigned, that will also be supplied automatically.
Extension	A six-digit field for the contact's phone extension.
Group Name	This field will identify a group. It is available to print on forms and posts electronically to the field with the same name.
Employer ID	Enter the Employer ID, if one is needed for paper claims or electronically.

9 - Responsible Party File

The Responsible Party File contains information about the person responsible for a patient's bills or the policy holder for insurance coverage. This stores the addresses and information for responsible parties that are not already patients.

Note: Entries can also be added or changed during Daily Input.

To access the Responsible Party file, press 6 at the Main Menu, then 9 at the Support File Maintenance Menu.
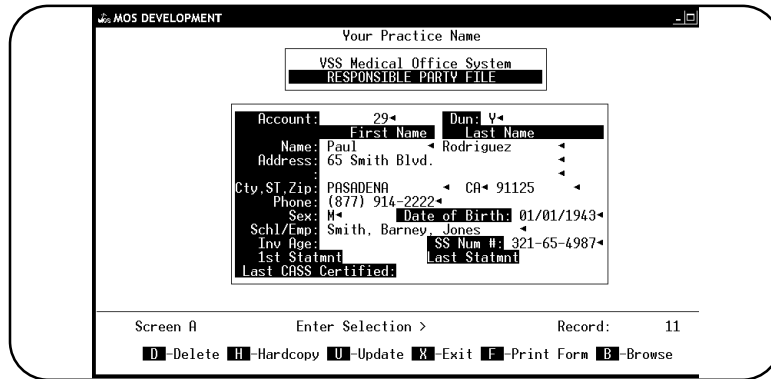
Figure 12-20 : Responsible Party Record

Account: The code can be up to eight digits long and is assigned by the MOS. The last code is listed in the Practice Information can be started during the setup.

Dun Enter "Y" if the patient is to receive dunning messages or "N" if not. This applies to the aging dunning messages defined in the Practice Information file.

Name Enter the first name then the last name of the responsible party.

Address There are two address lines. Each is 30 characters long.

Zip Code   *Support File Browse, If Not Found Add*

Type the zip code of the responsible party's address. Press F6 , to browse the zip code file. If there is more than one city on file, for that zip code, a browse window is displayed listing the cities. Highlight the correct city and press ENTER . See Page 12-14 for more information on the zip browse.

City Type the city of the responsible party's address. The city will be supplied from the zip choice and this field will be skipped.

State Type the state of the responsible party's address. The state is entered from the zip code choice and this field will be skipped.

Phone Number Type the Area code + Phone Number the responsible party. Entering the parenthesis or dash is unnecessary. The MOS will do it automatically.

Sex Type the Sex of the responsible party.

Date of Birth Type the Birth Date of the responsible party in the format MM/DD/YY or MM/DD/YYYY.

School/Employer Type the responsible party's employer or schools name.

Inv Age; 1st Statement; &
Last Statement These fields are maintained by the MOS and are not accessible.

Last CASS
Certified This will display the last date this address was CASS certified. This feature is an optional feature that enables your addresses to be CASS certified by a data base at our location. This certification will allow you to receive reduced rates on postage. Call Virtual Software Systems, for more information about this feature.

A - Referring Physician File

The Referring Physicians File contains information on a physician who has referred patients to the practice. This file will now also contain physicians that are used by your practice to refer patients TO. If your practice is a Primary Care practice and you often refer patients to other physicians, you will now be able to track those referrals.

Note: ***Entries can also be added or changed during Daily Input.***

To get to the Referring Physician file, press ⑥ at the Main Menu, then Ⓐ at the Support File Maintenance Menu.

Figure 12-21 : Referring Physician File

|	
I.D.	Enter a unique ID for each physician. It can be up to four digits long.
Specialty Code	Type the physician's specialty code if available. Press q to select a code from the validity file. This field may be left blank.
First Name	The physician's first name.
Last Name	The physician's last name.
Title	Suffix if physician (e.g., M.D. or D.O. or Ph.D.).
Address	The physician address. The two lines hold up to 25 characters each.
Zip Code	*Support File Browse, If Not Found Add* Type the physician's zip code. Press F6 , to browse the zip code file. If a zip code is entered, the next data entry field will be the phone field. See Page 12-14 for more information on the zip browse.
City	Type the city of this physician.
State	Type the state of this physician.
Phone	Type the phone number of this physician. Also now a fax number can be entered.
UPIN# 1, 2, 3, 4	The MOS allows up to four identification numbers or provider numbers per referring physician to be printed on a particular insurance form. The first should always be the UPIN number. It is important that if the other ID numbers are used, the same type of number is listed in the same order for each referring physician. For example, if ID#2 is for the Medicaid number, every referring physician should use ID#2 for Medicaid.

B - Procedure Groups File
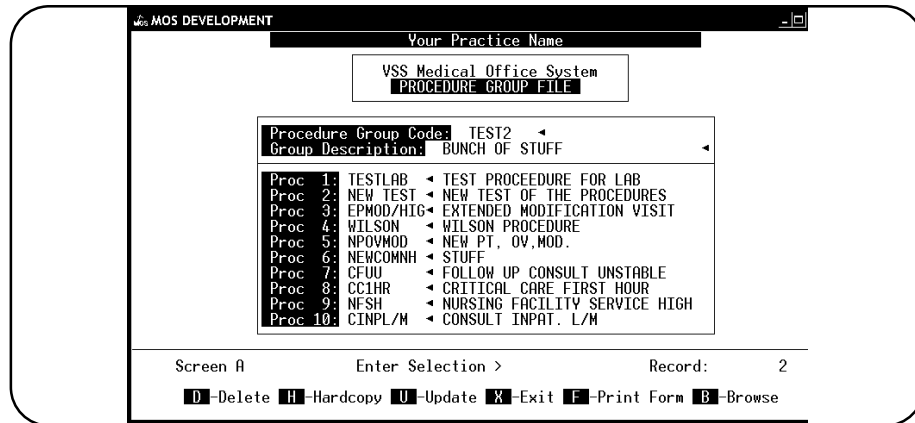
Figure 12-22 : Procedure Group Screen

Medical Office System allows a group procedures commonly done together to be identified and referenced as one entry. In the example presented above, each time the procedure code " **!TEST2**" is used it will be replaced with the ten procedures listed in this group.

To access the Procedure Group file, press $\boxed{6}$ at the Main Menu, then $\boxed{B}$ at the Support File Maintenance Menu.

Procedure
Group Code   This is a code assigned to represent this group of procedures.

Group Description   A description used to describe this group of services.

Proc 1 - Proc 10   *Support File Browse*

A CPT code from the procedure file to be included in this group. The description will be displayed to help verify the proper CPT code was selected. Browse is available to help find a procedure code from your Procedure File. Your code is used when it is selected from the browse display. The CPT code can also be supplied and will identify the procedure just the same. Both codes are interchangeable whenever the procedure code is used.

Also, $\boxed{F8}$ is available to Insert or Paste a CPT code into an existing list of codes. To insert a blank row, position the cursor on the row and press $\boxed{F8}$. To paste a code to a different row(s), use the space bar to blank out an existing code then move the cursor to the new row(s) and press $\boxed{F8}$.

C - Pre-Coded Text File

The Medical Office System provides a way to compose, save, and modify pre-coded text to be merged with patient form letters and with patients' notes without the use of a word processor. Included in the Pre-Coded Text File are preassigned fields used within letters for variable information on a letter for example --- patients' name and address. For more information about creating patient form letters, see Page 12-15 earlier in this chapter and for more information about patients' note see Page 6-9, Daily Input. To access the pre-coded text file, press $\boxed{6}$ at the Main Menu for the Support File Maintenance Menu then press $\boxed{C}$.
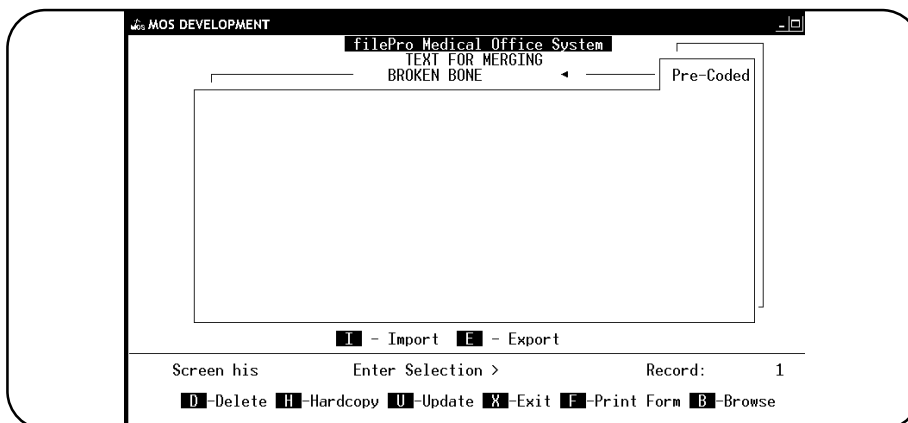

Figure 12-23 : Pre-Coded Text Record

Pre-Code Name   Name of the text (20 characters).

> *Note: Records having an asterisk (*), brace ({) or, at (@) as the first character for the name field are denoted as "field" records. You should not delete these records and caution should be taken if modifying.*

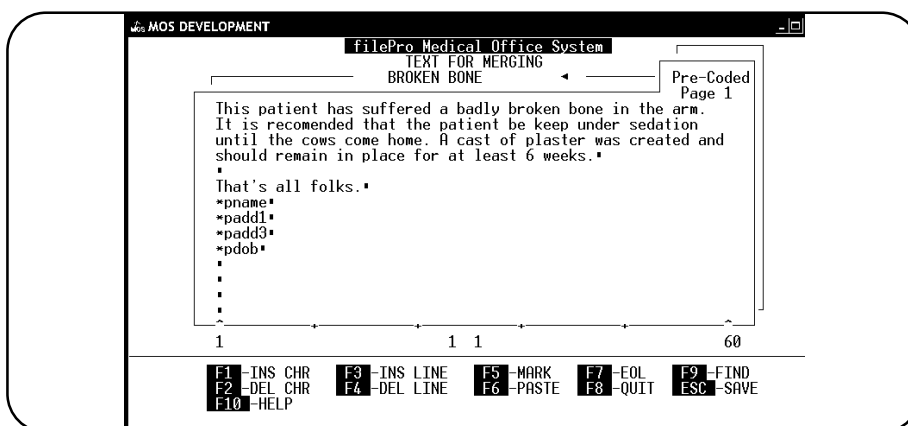When the screen is complete, press $\boxed{ESC}$. The "create text" screen is displayed:

Figure 12-24 : Pre-Coded Text Screen

What Limits on Pre-Coded Text?
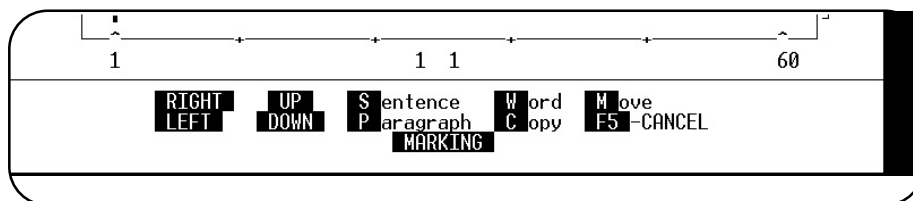
A maximum of 60 lines of text with as many as 60 characters per-line can be entered. However, with the branching from one page to another, the resulting medical note can be much longer. When entering text, the MOS pre-coded text file acts like a word processor, word wrapping is done automatically and functions for: insert and delete characters, insert and delete lines, find a string

of characters, and go to the end of a line are available. Also, available is marking and pasting routines for moving, coping and deleting blocks of text. The key strokes to do these operations appear on the menu displayed on the bottom of the "create text" screen:

How to insert, delete and find text.

To insert or delete a character press `F1` or `F2` . To insert or delete a line press `F3` or `F4` . To move to an end of a line, press `F7` or find a string of characters (a word) by press `F9` (FIND).

To "mark" text place the cursor at the beginning of the text to be copied, moved or deleted and press `P` . The following menu bar will be displayed:


```
                 ▪                                               ^    ┐
  ┌──────────────────────+──────────+──────────+──────────────────────
  1                             1  1                            60
  ─────────────────────────────────────────────────────────────

         RIGHT    UP     S entence    W ord    M ove
         LEFT     DOWN   P aragraph   C opy    F5 –CANCEL
                            MARKING
```

Figure 12-25 : Selecting Text Options

Press `S` to mark a sentence, `P` to mark a paragraph or `W` to mark a word. The arrow keys can be used to mark additional text. When text is marked, it is displayed as highlighted.

Once some text has been marked, it can be copied, moved, or deleted. Press `C` to copy, or press `M` to move or delete. The MOVE function will remove the selected text and place it in a buffer. Use the PASTE function to place it somewhere else in the text.

After saving the marked text (pressing "C" or "M"), the "create text" screen will be displayed and the word "Paste" followed by a number will be shown at the bottom of the screen. The number represents the number of characters of marked text saved in the buffer. To insert the saved text, place the cursor in the correct position and press `F6` (PASTE).

Tutorial Available

The examples that follow are included in the IMPORT merge file tables sent with your Medical Office System. Select and IMPORT the tables with the following names to play with them and learn the new logic: Vanilla, chocolate, endice, ice cream example, test results.

To see the true workings of the Pre-Coded Text, it is helpful to use the examples while entering a Medical Note and see the way it will look to the end user. This will help clarify the explanations below. To do this, first you must IMPORT the notes listed above. Then return to the Daily Input, select a test patient, then start a Medical Note. Now you can merge text (\) and select the indicated note. Each of the five notes are displayed in one of the next five figures.

Making the Medical Notes Interactive

Special symbols are used to make the note behave in special ways. Each of the symbols and their use will be explained below.

Listing Options

-	to omit selection from medical text.
*	to contain a selection option.
|	to contain the list of selections.
[	to open a branch option
]	to close the branch option
+	precedes name of branch to merge text

Fields	Syntax: *pname
	Result: Helen Adells

Fields, identified by an asterisk (*) followed by two characters, say to the MOS to supply information to the letter when printing. For example the patient name, birthdate, today's date, doctor name or referring doctor name. When the text is merged the patient information is inserted into the medical note. For a list of available fields, press ⧵ or see Appendix E.

These data fields can be embedded into a note or selected when the Medical Note is created.

Pipe symbol

The pipe symbols are used to surround a question to be given to the user.

Syntax: *text |question| text*
Result: *text answer text*
Example: This patient has suffered a broken |What Bone is broken?|.

Note Result: This patient has suffered a broken neck.

The user can be prompted for information when merging text into patient notes. The following is an additional example of using questions in patients' notes:
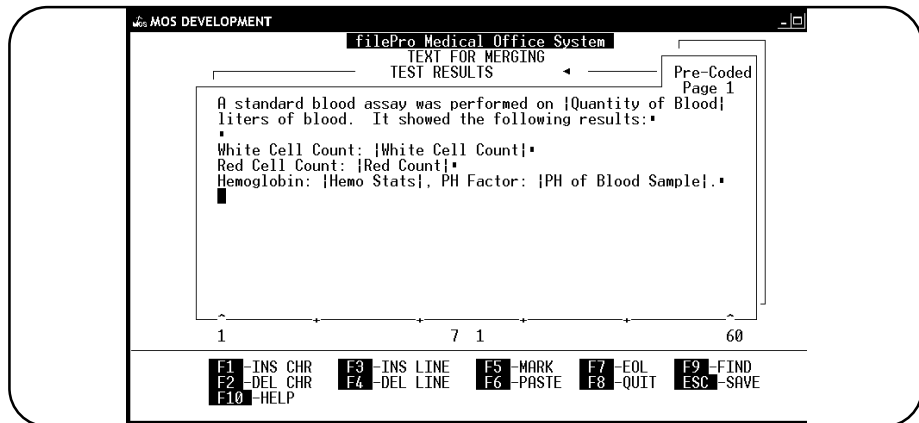

Figure 12-26 : Sample With Questions

Tutorial Note:

Merge the note called "test results. The following prompts will be displayed:

Quantity of Blood:	Enter the liters of blood used. (.10)
White Cell Count:	Enter the white cell count (100)
Red Count	Enter the Red count (200)
Hemo Stats	Enter the Hemo Stats (123)
PH Of Blood Sample	Enter the PH (6.5)

Then the screen is displayed with the final note.

A standard blood assay was performed on .10 liters of blood. It showed the following results:
White Cell Count: 100
Red Cell Count: 200

Hemoglobin: 123   **PH Factor: 6.5**

When merging this example, the text between the pipes (|) will be prompted to the user as a question and the user's response will replace the text and be inserted as part of the patient's notes.

Listing selections

available   This will display a list of options for the user to select. Each option listed is surrounded with asterisks. When the possible options are limited, this is ideal.

Syntax: *Text |Question *option1*option2*option3*|text*
Result: *Text option2 text* (if option 2 was selected)
Example: My   favorite   ice   cream   is |Highlight   favorite   ice   cream flavor*chocolate*vanilla*strawberry*|.
Resulting Note: My favorite ice cream is chocolate.

Tutorial

The ice cream I like the best is |My favorite ice cream is *chocolate*vanilla*strawberry*|.
In this sentence the question "My favorite ice cream is" is the prompt with the list of choices displayed below it. Highlight and press [ENTER] . The selected text will be added to the sentence "The ice cream I like the best is". For example, if you select "chocolate", the sentence created will read: "The ice cream I like the best is chocolate."

Listing Selections – without inserting selection

If the option1 code starts with a - (dash) it will not be included in the text, if it does not start with a - (dash) it will be included in the text.

Syntax: *Text |Question *-option1*-option2*-option3*| text*
Result: *Text text*
Example   The ice cream I like the best is |My favorite ice cream is *-chocolate*-vanilla*-strawberry*|.
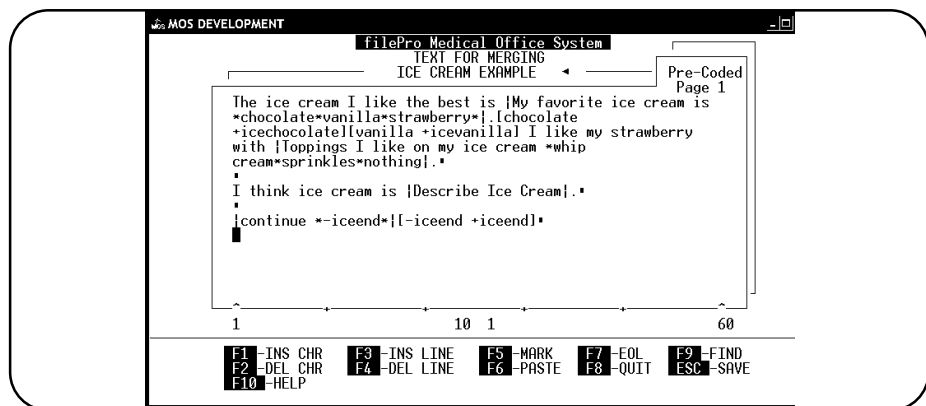Resulting Note   The ice cream I like the best is .

Figure 12-27: Ice Cream Merge Text Example

The dash will not insert the selected text. The selected option can be used to identify a secondary question or branch to another note.

Brackets with functions

The brackets [] are used to indicate branching. Branching would start another note execution or supply additional options.

Syntax: *Text |Question   *option1*option2*option3*|[option1   function1][option2 function2][option3 function 3]text*
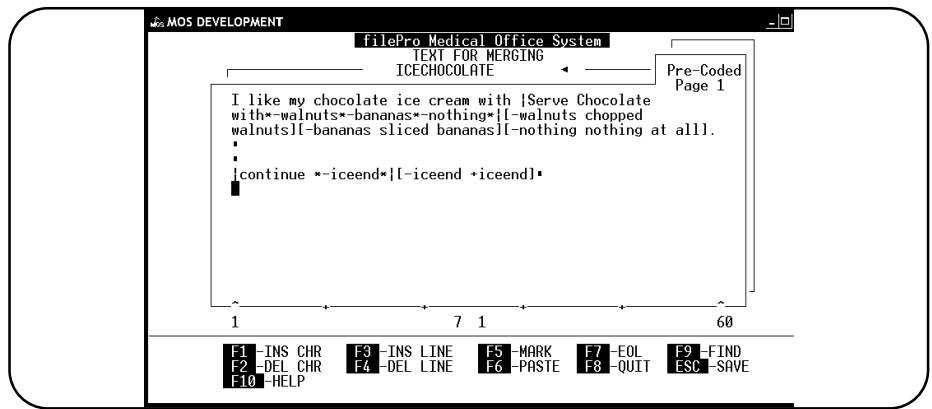
Figure 12-28: Chocolate Ice Screen Merge Text

Function adds text

The function can just be an expanded amount of text as in the following example:

Tutorial Example: I like my chocolate ice cream with |Serve Chocolate with*-walnuts*-bananas*-nothing*|[-walnuts chopped walnuts][-bananas sliced bananas][-nothing nothing at all].

Resulting Note: I like my chocolate ice cream with chopped walnuts.
(If walnuts is the selected option.)

Function gives additional selections

Refer to Figure 1.29 for an example of secondary options. If the selection of vanilla ice cream with cookies is made a second choice is given.
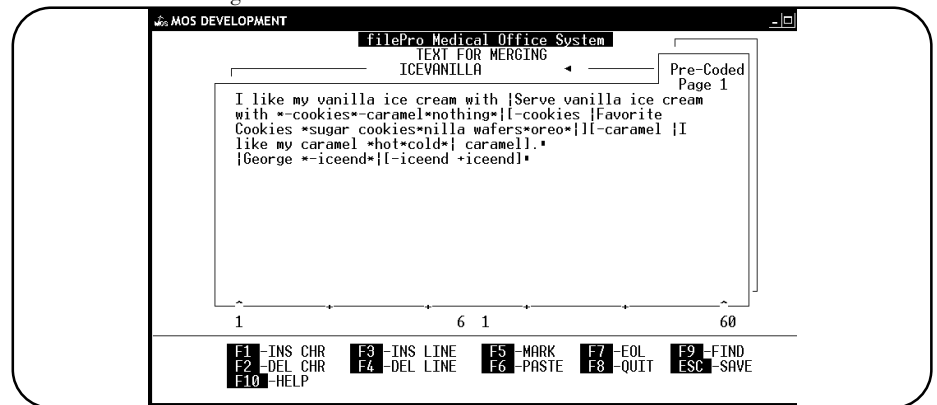

Figure 12-29:Vanilla Merge Text Example

Now an additional question will display a list of choices for cookies, so it does not have to be typed.

The answer to one question can lead to other connected questions.
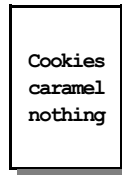
Syntax: Text |QuestionA *-option1*-option2*|[-option1 |QuestionB *option1a*option1b*|] [-option2 QuestionC *option2a*option2b*option2c*|]

Tutorial: I like my vanilla ice cream with |Serve vanilla ice cream with *-cookies*-caramel*nothing*|

This will prompt with the following:

Serve vanilla ice cream with

```
Cookies
caramel
nothing
```

The selection made in this list will start another list. Notice that the pre-coded text continues with

[-cookies |Favorite Cookies *sugar cookies*nilla wafers*oreo*|

When cookies is the option selected, the selection of cookie types is displayed.

Favorite Cookies

```
sugar cookies
nilla wafers
oreo
```
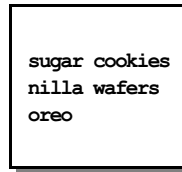
Try selecting caramel and see if you can tell what would happen next.

Function start another merge file

The function can be an option to load another merge file. If the name is preceded by a "+" then it indicates another merge file.

Syntax: |Question *-option1*-option2*|[-option1 +branch1][-option2 +branch2]
If the answer selected is option1, then the pre-coded text called branch1 is begun.
If the answer selected is option2, then the pre-coded text called branch2 is begun.

In the text the pipe starts and stops the options. After the opening pipe is the Question, then the options are listed with asterisks separating, finally close the last option with a pipe.

Then the brackets are used as the branches. When option1 is selected "-endice" then the merge file "endice" is started.
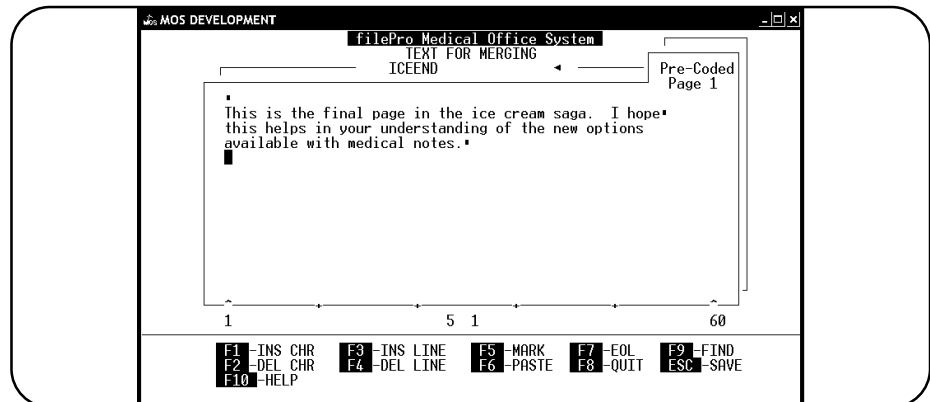

Figure 12-30:End Ice Cream Merge Questions

Tutorial   In the following example, if the selection was -vanilla, the merge file "vanilla" will be loaded.

|*-chocolate*-vanilla*|[-chocolate +chocolate][-vanilla +vanilla]

In the line above the choices -chocolate, and -vanilla are given. (The - 'minus' is used to keep the word from adding to the medical notes. Then in the brackets the matching selection "-chocolate" is given followed by the destination "+chocolate" and the bracket is closed. Then the second selection is also branched to another file. At this point a new merge document would be opened with the name "chocolate" or "vanilla" if that was selected.

If the merge text is too short or too complex it can be continued on a new page with the following special command.

Continuing to a new merge file

Syntax: |continue *-end*|[-end +endfile]

Only the word "continue" must be given as shown, the other options can be altered as needed to supply appropriate names.

This will display as follows:

Continue
Press ⌸ENTER

When you press ⌸ENTER the processing will branch to the pre-coded text called "endice".

Saving or Canceling Changes

To cancel or save any changes since the text was last saved press s (Quit) and the following prompt will be displayed:

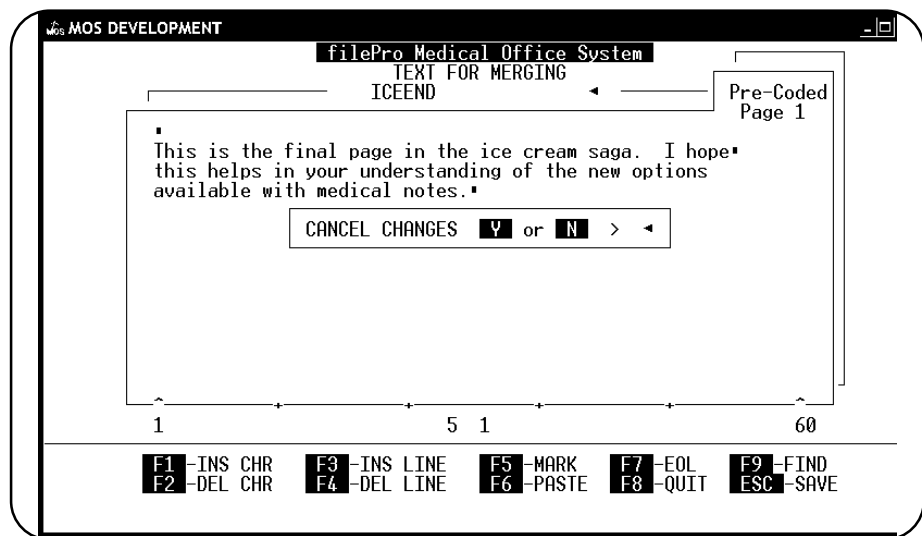**Figure 12-31** : Quitting Pre-Coded Text Editing

Press ⌷Y then ⌸ENTER to cancel or ⌷N then ⌸ENTER to save any changes.

To save the text, press ⌷ESC .

After exiting the record, the text definition screen is displayed.

D - Drug Reference File

This file will allow entry of a list of drugs commonly prescribed in your practice. These can be used as a reference list when entering a prescription for a patient.
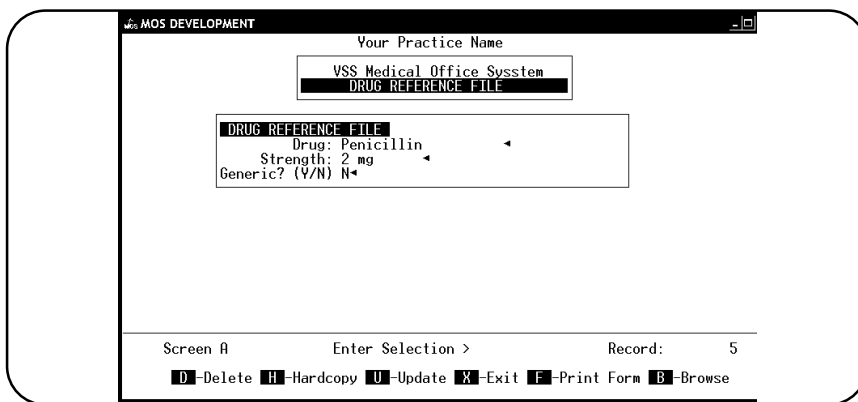
Figure 12-32: Drug Reference File

Drug: Enter the name of the drug.

Strength: Enter the common strength for the drug, such as 10 mg, or 1 cc.

Generic? (Y/N) Enter ⌐Y⌐ if the drug has a generic equivalent.

This aspect of the software is under development. If you have suggestions as to what additional information might be helpful, it will help our expansion.

I - Insurance Company File

The Insurance Company File contains information about each insurance company and procedure allowance codes to set amounts allowed for certain procedures.

Note: Entries can also be added or changed during Daily Input.

To access the Insurance Company file, press ⌐6⌐ at the Main Menu, then ⌐I⌐ at the Support File Maintenance Menu.

Figure 12-33 : The Insurance Companies Record

Company Code The code can be up to four alphanumeric characters. Medicare should always start with the letters "MC". Any carriers that might act as a group and use the same non-standard insurance

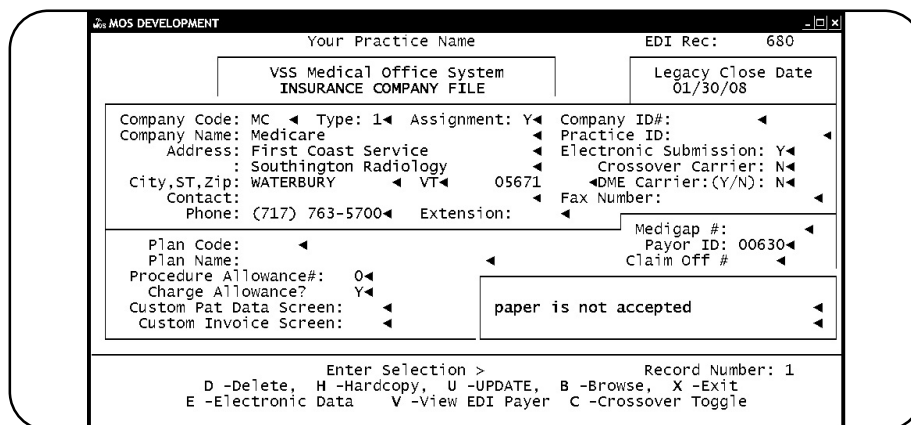form should be coded with the same first letters. For example, Blue Shield carriers might all start with "BS". This makes them easier to identify when browsing and forms can be selected to print for them as a group more easily.

Any unique code may be assigned for the insurance company code, however the following codes should be used for these carriers to conform to some of the standards in the MOS software.

BS	for Blue Shield	CH	for Champus
MC	for Medicare	WC	for Workers' Compensation
MD	for Medicaid or Welfare		

Use these codes to build new ones; Say that some of your patients are covered by Blue Shield of Connecticut and others by Blue Shield of NY. When printing insurance forms, to select only the Blue Shield accounts for the Blue Shield form, but show the two different addresses. To group the Blue Shield companies assign codes that begin with the letters "BS", such as BSCT (Blue Shield, Connecticut) and BSNY (Blue Shield, NY). At print time, the system will use the "BS" form, and will print the appropriate addresses on the individual forms. See Page 15-8, for more information about matching forms to carrier codes.

Type   There are nine codes for insurance type as follows:

MOS Ins Type	Description	SOP (DA005)	Ins Type (DA006)	EDI Ins Type
1	Medicare			1
2	Medicaid	M	OT	3
3	Blue Shield	G	SP	2
4	Blue Cross	G	SP	2
5	Champus	Z	OT	4
6	No Fault	Z	OT	4
7	Commercial	F	SP	5
8	HMO	I	MG	6
9	MGAP	Z	MG	5

These are used to control some functions within the MOS. The default code is "9" if you leave this blank. A type "1" carrier (Medicare) can not change the Procedure Allowance number. The special allowance and write off programming explained in the Payments for Medicare section are dependent on the carrier being a type "1" or Medicare carrier.
SOP and Ins Type codes have some variation specific to given states.

These codes apply to MOS EDI claims and the NSF transmission format. Call support for exceptions to the list above.

ID#   The numeric code reserved for this insurance company. This is not required but may be useful in some states.

Name   The name of the carrier, up to 25 characters long.

Address   The carrier's billing address. The two address lines hold up to 25 characters each.

Zip Code   *Support File Browse, If Not Found Add*

Type the Zip Code of this company. Press ⌈F6⌋, to browse the zip code file. If a zip code is entered, the next data entry field will be the Practice ID. See Page 12-14 for more information on the zip browse.

City   Type the city of this company.

State   Type the state of this company.

Practice ID   Type the Practice ID for this insurance company, if applicable. It is now possible to attach a special ID to each provider for any carrier that requires a non standard ID. Use this field if only one number needs to be assigned for your practice. This number will print on the insurance claims forms, if you select the correct insurance form field. If an ID is assigned in the cross-reference file to the provider for this carrier, that number will be printed instead.

Electronic

Transmission   Does your practice submit this insurance company's claims electronically? Press ⌈Y⌋ for yes or ⌈N⌋ if not. Only answer "Y" if the claims for this carrier as billing party should be reported electronically instead of by paper. If the answer is "Y", a special screen is displayed after this screen for electronic submission. If the answer is changed to "N" after that information is entered, the screen will be skipped. To change information on the electronic screen, just enter "Y" and press ⌈ESC⌋, change the data as needed then come back to this field and change it to "N" again. See Chapter 20, "Electronic Transmission", for more information.

Crossover Carrier   This field will be answered "Y" if this carrier, when listed secondary to Medicare should **NOT** be reported when creating electronic claims. Many states have agreements with other carriers to automatically forward claims to secondary carriers. If your Medicare carrier does not want certain carriers reported as secondary to Medicare because of such an agreement, mark all such carriers with "Y". If your state does not require this, then leave it blank or answer "N". This will not affect the paper forms in any way.

Payor ID   This is a five-digit code used for electronic identification of Medigap and crossover carriers. In some states this is required information for electronic submission.

Claim Office #   This code is also part of the identification information for a carrier. It is required information in some states.

> *Note:*   *The Payor ID and the Claim Office # are sometimes combined into a nine digit code. In Mississippi this is called the LONG ID and a list can be obtained from your carrier.*

Plan Name   This would allow a different plan name to be used on insurance claims to be entered. This is normally printed in box 11c when required.

Plan Code   Enter any special plan code used for this carrier

Contact   Type the name of the person in charge of claim inquiries.

Phone Number   Type the Phone Number and area code for the insurance company. Entering the parenthesis or dash is not necessary. The MOS will do it automatically.

Extension   A six-digit field for the contact's phone extension.

Fax Number   Enter the Insurance Company fax number.

Procedure

Allowance code   This code, from 0 to 9, is used to indicate the pricing, CPT code and/or TOS to be used for this carrier. All carriers are assigned "0" by default. This will use the standard charge, CPT code and TOS code listed for each procedure. If it is necessary to offer a different charge, CPT or TOS for this carrier or a group of carriers, then assign a number 1-9. You will then notice when the procedure file is updated, a line will be available for the special needs of this carrier. If any of the three columns is left blank the standard options is always used. The amount is entered in the Procedure File described earlier in this chapter, see "The Procedure File". A code of "0" is assigned if this is left blank.

Chg Allow?   This will allow you to indicate if this carrier should use a special pricing schedule. The Procedure Allowance code normally indicates an alternate pricing table should be used for this carrier. When only the standard charge should be used, answer $\boxed{Y}$ to this question. The default to this is $\boxed{N}$. If the standard charge is used for the service line, then the allowed amount is used as the expected payment amount.

Custom Pat Data
Screen   This screen can be created and attached to the carrier to be displayed with prompts that collect data that is not usually collected for each carrier. Since this is a custom screen, there may not be any available when your system is installed. It must be created with a filePro development package.

Custom Invoice
Screen   This can be used to display additional prompts when an invoice is entered that is to be sent to this insurance company. This can display prompts that comply with the requirements of this insurance company. There are many fields of data that are available to be used for miscellaneous data and these can be displayed with the appropriate prompts on this screen. Since this is a custom screen, there may not be any available when your system is installed. It must be created with a filePro development package.

Special Notes   The notes are available to list any information that should be available for reference at the invoicing or patient screens. These notes can indicate co-pay amounts, special rules for prior authorization, special exclusions, etc.

Press $\boxed{ESC}$ to record the data and the following screen is displayed, if the carrier is electronic.
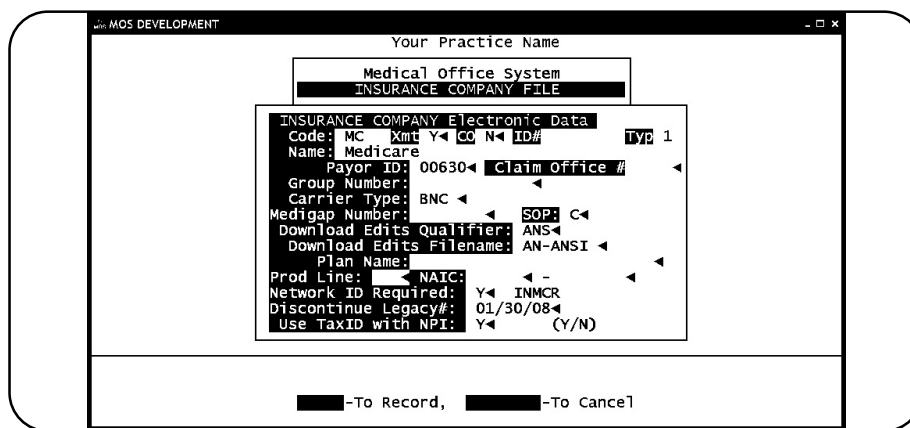

Figure 12-34 : Electronic Insurance Information Screen

Payor ID   Enter the Payor ID if needed for your electronic transmission. See explanation above.

Claim Office   Enter the claim office code for this carrier. See explanation above.

Group Number	Enter an identifying group number for this carrier.
Carrier Type	Enter one of the following codes:

        CARD - if the policy number and office number are required for this carrier.
        BNC - Both numbers are optional.
        NC - Policy number required, office number optional
        SKIP - skip office number

The default for this entry should be "BNC". Other options will cause the Download Edit report to check for certain ID numbers.

OCNA Number	Enter OCNA# for Medicare Medigap insurance companies. These insurance carriers are only used for Medigap Supplemental crossovers from Medicare.
SOP	Enter the proper source of pay code. Use HELP to review the choices. This is currently not required.
Download Edits Qualifier	This will determine the correct file to use for verifying data during the download edits for electronic claims.
Download Edits Filename	This is the processing table that will be used to test the completeness, validity, and acceptability of the claim for electronic processing. The table is not applied until the claim is moved to the Electronic Claim File.
Plan Name	Enter the Insurance Company plan name. This name can be used to print on an insurance form in box 11c if different than the Carrier Name.
Prod Line	This code is used to identify electronic carrier insurance plan. In all cases so far where it was required it was MS. Do not supply anything, unless needed.
NAIC	National Association Insurance Commission Number and suffix if needed to submit the claims electronically. This can be used in the electronic submission and should only be entered if required by a given carrier.
Network ID Required	Enter Y if this carrier will require a special Network ID number. This is common with Clearinghouse claims. If the answer is marked as Y, then a popup screen will request the Clearinghouse ID. Enter the code that should be used.
Discontinue Legacy#	Enter a date that will act as the cut-off date for sending or printing Legacy numbers for this carrier. This will apply to a line of business when assigning it to Medicare, Medicaid, Champus or DME. Use this to mark individual carriers. A mass date can be entered for any line of business on the Practice Information Screen E. Be sure to Update Insurance Carriers when you post to EDI to make sure your data is posted for EDI also.
Use TaxID with NPI	Mark Y if it is required to send the EIN with the NPI number at the Rendering Provider Level of a EDI claim. Every payer with the same PayorID, will automatically be marked the same if this is changed. By pressing F8 in the field, you can indicate that all payers of this TYPE would be marked the same. TYPE would indicate Medicare, Blue Shield, Blue Cross, etc. Be sure to Update Insurance Carriers when you post to EDI to make sure your data is posted for EDI also.

Deleting Insurance Companies

If over the course of your business, you find it necessary to delete an insurance company, this option is available. However, for your protection, the insurance carrier code must not still be in use in the system. A check is run to insure that all references to this provider have been removed

from patient records and claims. It is best if the claims have worked through the system, been paid and purged in the normal way.

Electronic Filing Notes

E *- Electronic Data*   This option at the bottom of the screen is used to quickly access the screen with the electronic information.

C *- Crossover Toggle*   This option will change the Crossover Carrier data from Y to N or N to Y. A quick way to make that change.

V *- View EDI Payer*   This option will display the EDI Insurance Information for this carrier. It will offer the options to update the data, Find another carrier that matches, or Add a payer. To file electronically, every payer in the MOS must also be in the FastEMC database to provide the data needed to generate the transmission. So when changing or adding Payer information, it must be changed for electronic filing also. So this will offer a one at a time update, you can also select "Update Electronic Insurance Carriers" when processing claims for electronic filing.

W - Workers' Compensation File

The Workers' Compensation File contains information about a carrier a patient is using for workers' compensation.

> *Note: Entries can also be added or changed during Daily Input.*

To access the Workers' Compensation file, press ⑥ at the Main Menu, then Ⓦ at the Support File Maintenance Menu.

Figure 12-35 : Workers' Compensation Record

Code   The code can be up to four alphanumeric characters.

Name   The name of the carrier, up to 25 characters long.

Address   The carrier's billing address. The two address lines hold up to 25 characters each.

Zip Code   Type the Zip Code of this company. Press F6 to browse the zip code file. See Page 12-14 for more information on the zip browse.

City   Type the city of this workers' compensation company.

State   Type the state of this workers' compensation company.

Contact   Type the name of the person in charge of claim inquiries.

Phone Number   Type the Phone Number and area code for the carrier. Entering the parenthesis or dash is not necessary. The MOS will do it automatically.

Extension   A six-digit field for the claims adjuster's phone extension.

L - Service Location File

The Location file contains places of service for the providers.

Note: Entries can also be added or changed during Daily Input.

To get to the Location file, press ⬚6 at the Main Menu, then ⬚L at the Support File
Maintenance Menu.

Figure 12-36 : Location File

I.D.	The ID can be up to four digits long.

Place of Service   *Browse*

These codes are selected from a validity file. Enter the code or press ⬚F6 to display the valid
codes. This is the code used on the insurance forms for POS.

On electronic claims, Facility ID#'s and CLIA#'s are mutually exclusive. If both numbers are
supplied on the Service Location, only the Facility ID# will be sent to identify the location. The
CLIA # only should be used for OFFICE Locations, Place of Service code is 11.

Facility ID#   This number is required for some types of facilities such as nursing homes.

C.L.I.A.#   This number is now required for practices that do some lab procedures in the office.   Enter the
required number for the service location that is covered. On electronic claims, this number is
added on any services that are identified as LAB procedures. (The TOS for the procedure will
indicate LAB.) This field is also available for paper claims.

Mammography
Certification #   This number is used to report a Mammography Certification for this location. It can be used to
print insurance forms or send electronic claims.

Name   The name of the location, up to 25 characters long.

Address   The location address. The two lines hold up to 25 characters each.

Zip Code   *Support File Browse, If Not Found Add*

Type the Zip Code of this location. Press ⬚F6 , to browse the zip code file. If a zip code is
entered, the next data entry field will be the phone number field. See Page 12-14 for more
information on the zip browse.

City   Type the city of this location.

State   Type the state of this location.

Phone Number   Type the Phone Number and area code for the location. Entering the parenthesis or dash is not necessary. The MOS will do it automatically.

Additional Options

I   *Additional POS codes*

Select ⬚I from the Enter Selection option to add POS codes that will be used instead of the displayed code for a specific carrier. This will translate for insurance forms and electronic.   A prompt will display with

```
Enter Insurance Company Code  (Leave BLANK to END) >
```

Enter a code for the insurance company and press ⬚ENTER . A second prompt appears:

```
Enter Provider ID for Insurance Company: XXXX  >
```

Enter the company specific code.

To display or edit the codes that have been assigned use the second selection.

L   *List Codes for this Carrier*

Press ⬚L to list all the codes added for this carrier. A display will list the codes with the options to Change, Add or Exit.

⬚ENTER   Select a code to change
⬚A   Add another code
⬚X   Exit

To insert this code on an insurance form, use insurance form field 179. This will be blank if you have not entered a code for this insurance company and this provider.

If this is only used for a particular carrier, a copy of the HCFA form can be made just for that carrier. The new code field can then replace the appropriate code.

T -Diagnosis Test Lab File

The Diagnosis Test Lab File contains the name and address of companies that do laboratory tests for the practice. The Diagnosis Test Lab file includes a field for the Medicare ID. When creating a bill for a patient, if the procedure is a lab procedure, a lab must be identified.

> *Note: Entries can also be added or changed during Daily Input.*

To get to the press ⬚6 at the Main Menu for the Support File Maintenance Menu then press ⬚T .
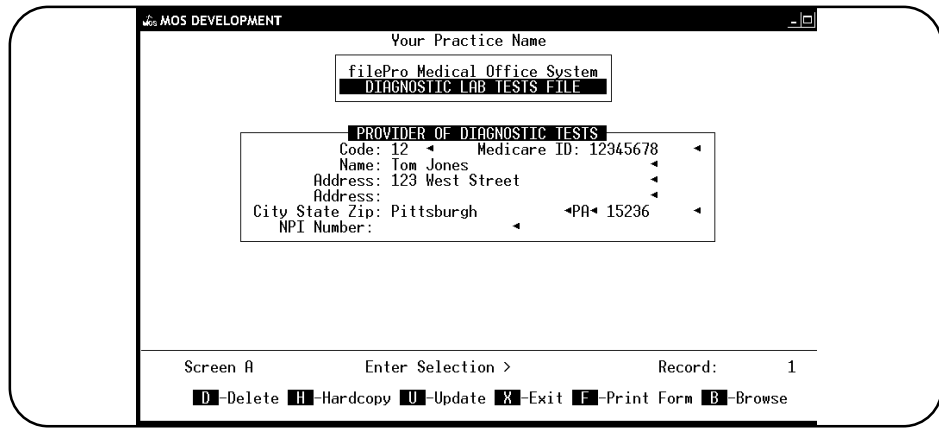
Figure 12-37 : The Diagnosis Test Lab Record

Code   Enter a four-character code representing the lab.

Medicare ID   A ten character alphanumeric field to store the Medicare ID for the lab.

Name   Name of the lab.

Address   Two lines for the lab's address

Zip Code   *Support File Browse, If Not Found Add*

Type the lab's zip code. Press ⌨F6 , to browse the zip code file. See Page 12-14 for more information on the zip browse.

City   The lab's city.

State   The lab's state.

U - Authorized Users

This allows control of the users that will access your system. A user can be given full access to the data or inquiry access only. The user id will be marked on any transaction the user adds to the system.

On a UNIX system, to make the security best it is important to limit access to the Unix prompts and only allow limited access users to go straight into Medical Office System and remove all other access.

The Master Password is required to access this support file.

Activating Authorized Users will allow users to enter a Default Transaction Date when logging into the Daily Input option to enter transactions. Services, Notes, Payments and Dates collected on the Claim will default to the date entered as the Default Transaction Date. Usually the system would use the System Date for this type of thing. All items such as Invoice Dates, Recap Dates and Report Dates will still show the System Date. This will allow all systems to reflect the correct date on their computers to properly tag all items with that date but to allow the data entry people to enter transactions from yesterday with the least amount of data entry keystrokes.

To get to the Authorized User file, press ⌨6 at the Main Menu, then ⌨U at the Support File Maintenance Menu.

The filePro data entry menu is displayed. Press ③ to add records.

```
                          Your Practice Name
                        ┌─────────────────────────┐
                        │   AUTHORIZED USER DATA   │
                        └─────────────────────────┘

            ┌──────────────────────────────────────────────────┐
            │   User Name: BILLING      ◄  Password: #######    │
            │F/I/A/R Inquiry: I◄           PHI Access Level: F◄  │
            │Allow Administrator Access? (Y/N): N◄               │
            └──────────────────────────────────────────────────┘
                            ACCESS CONTROL DATES
                            Activated    Terminated
                            01/01/01◄              ◄
            ┌──────────────────────────────────────────────────┐
            │First Name: Mary      ◄ Last Name: Jane      ◄     │
            │   Address: 1222 West Street                  ◄     │
            │                                              ◄     │
            │      City: Pittsburgh     ◄ State: PA◄ Zip: 12222  ◄│
            │     Phone:               ◄                         │
            └──────────────────────────────────────────────────┘

         Screen A            Enter Selection >            Record:       1

            D-Delete  H-Hardcopy  U-Update  X-Exit  F-Print Form  B-Browse
```
Figure 12-38: Authorized User Data Screen

User Name   Enter the user name that will be used as the login name. Upper - lower case is not significant and all names will be changed to all caps. It is imperative that all users have a unique name and password to properly comply with HIPPA.

Access Level   Enter the level of access the user will be given.

>   F   for full access to all Daily Input functions.
>   I   for Inquiry Only.
>   A   Appointment access and Inquiry for all other areas.
>   R   Receptionist - Appointments and Adding/Updating Patient information on
>   screens 0 & 1.

On the select patient screen, your user name and access level will be displayed when you are logged in with a user name.
Passwords for access to appointments, medical notes, etc. are also in effect and can restrict the user to viewing only the information required.

Name and Address   Enter the full name and address for this user. Because of the new HIPPA regulations, it is necessary to be able to track who has access to the data stored in the computer

Date Access
Activated   Enter the date this user was granted access to the data.

Date Access
Terminated   Enter the date the access is terminated. If the employee is terminated or changes responsibilities and is no longer allowed to access the data, enter the date here.

PHI Access Level   This indicates the area of responsibility given to this user. Each person should only be allowed to view data relevant to their employment responsibilities. The least amount of access necessary to provide treatment and do billing is required by HIPPA.

>   B   Billing Functions
>   T   Treatment, Medical Notes
>   F   Full Access for people who do both Billing and Treatment
>   N   No Access Allowed - Just to make sure.

Press ⎋ to save the data and then you will be able to assign a password to this user.

Administrator

Access Allowed   Enter ⟦Y⟧ if this user is allowed to access output formats that are for administration use only. Since each output is now designed to have a security setting, they can be controlled to allow an administrator only to print such a report. Great for financials or sensitive practice information.

Password   Enter the password the user will use.   It might be good if the user, entered their own password at this time.

A password must be entered twice to insure it is properly typed.

This password, when entered correctly, will allow the user to enter data and access data under the given user name. If the passwords, are not going to be kept secret, this security is worthless. It will still mark each transaction done with the User ID.

This user name will be attached to each transaction entered, appointments made or deleted, and output functions. The level of access given this user now will control the data that the user is allowed to view or print. This is the central part of the HIPPA security and privacy requirements.

Security measures each person can take to protect their identity on the computer.
1. Keep your password secret.
2. Log off when you are not at the keyboard or near your computer.
3. Remove PHI data from the screen before you leave your computer.
4. Do not allow others to look over your shoulder when using the computer.

Notes;