

Medical Office System

Chapter 6: Daily Input

This chapter discusses

- adding/modifying patient information.
- adding/modifying charges and payments.
- adding/modifying support file information.
- scheduling patients.
- adding/modifying patient medical notes.

Daily Input, choice "1" on the Main Menu, is the heart of the Medical Office System. It is used to add and modify ALL patients, charges, and payment information. While in Daily Input, records in the support files can be modified and new records added. Entering data into these support files before beginning your daily functions is not necessary.

Providers of service *	Locations of Service *
Zip Codes *	Referring Physicians *
Medical Notes *	Insurance Carriers *
Workers' Compensation Carriers *	Diagnosis File *
Procedure File *	Diagnosis File *
Appointment Schedules	Patient Recall
Employers/Schools *	Policy Holders *
Billing Parties *	Authorized Users

Note: *The support files followed by an asterisk (*) can also be updated or managed from the "MOS Support File Maintenance Menu". See chapter 12 for more information about these files.*

Review Chapter 3, Traversing the MOS, for general data entry hints and special function discussions. Any special activity allowed on a field will be shown by its label across from the field label. These functions are described in detail in Chapter 3.

Finding/Adding Patients

Press **[1]** from the Main Menu to start into the Daily Input function. If a DAILY INPUT password was assigned, it must be supplied at this time.

HIPPA required login

The next test is for an authorized user. If you activate the authorized user function in the Practice Information 2, then a prompt will request the user id and password.

Please Enter Your User ID >

Now Enter Your Password >

Once you have successfully entered the authorized user information, a request for the default date will be displayed. This date will be used for transactions only to speed data entry. It can be used just as any default date, by pressing “/” in a date field.

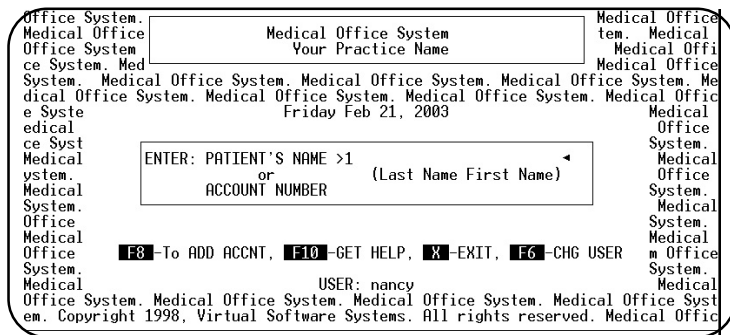


Figure 6-1: Finding Patients

Then the following screen is displayed:

If adding a new patient, press **[F8]**.

Finding a patient by Account Number

To find a patient by account number enter a numeric value at the Finding Patients screen and press **[ENTER]**. If your accounts have been assigned letter codes instead of numbers, they cannot be found using this option. See "Other Ways to Find/Add Patients" below.

Finding a patient by Name

To find a patient by name enter the last name, a space, then first name or the last name as close as possible and press **[ENTER]**.

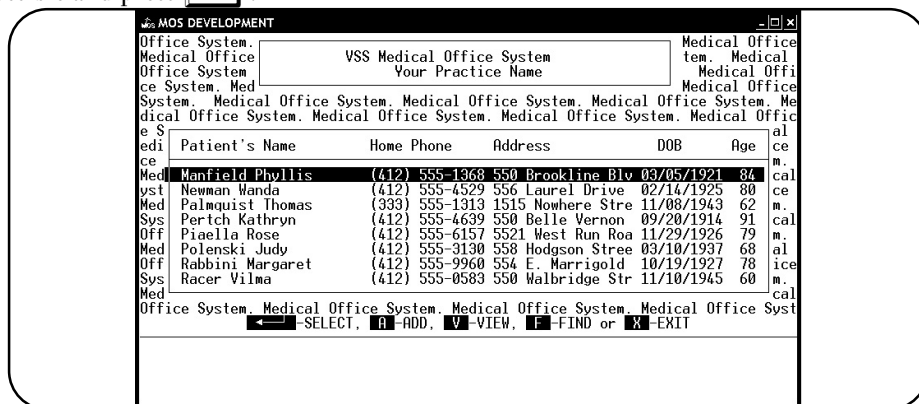


Figure 6-2: Find by Patient Name

A list of the closest matches is displayed with options for **ENTER** select, **A**dd, **V**iew, **F**ind or **X**-Exit. Highlight the correct patient and press **ENTER** or select one of the other choices as appropriate.

Fuzzy Name Searches

Enter a patient's name or partial name at this prompt and press **ENTER** .

The fuzzy search will find the closest matches to the patient's name despite the spelling. For example: you enter Brian as a last name the system may show a list of names including O'Brian, Mac Brian, Briane, or even Briggs depending on the patients on file and the closest matches the MOS can find. Losing a patient in the MOS is very hard

If the patient is shown on the list, highlight your choice and press **ENTER** . To display more information about this patient, press **V** to view the patient's General Information Screen. If the patient is still not found, select **F** for Fuzzy Search.

After the screen appears, press **ENTER** to return to the list.

If the patient is not on file, press **A** to add. See Adding New Patients for more information about entering data.

Other ways to find/add Patients

To search for a patient using other criteria or to add multiple patients at a time press **ENTER** (Figure 6.1) to bring up the selection menu shown in figure 6.1.

The Daily Input Selection menu displays five options. Choice four in the selection menu is Add Records and is described later in this section. Each of the selection methods is described here.

A patient can be found by name, account code or by social security number. Choose one of these options, and enter the requested information (such as name, or account code.)

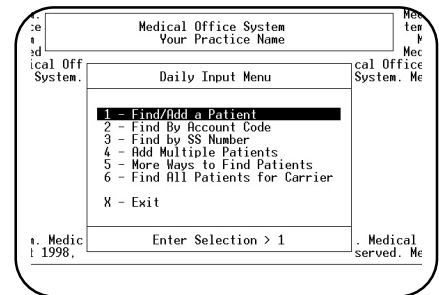


Figure 6-3: The Selection Menu

1 - FIND/ADD A PATIENT

This choice displays the previous box. The patients' name or account number can be entered.

2 - FIND by ACCOUNT CODE

The fastest way to find a record is to search for it by number. Select option "2 Finding by Account Code", and type the number or letters assigned to the patient as the account code and press **ENTER** . The patient's record is now displayed.

3 - FIND BY Social Security Number

To search by social security number, use option "3 - Find by SS Number", and enter the entire social security number of the patient. Some practices use the SS Number to hold other information: x-ray number, phone number, chart number, etc. Make sure to type the information exactly as it is entered.

4 - ADD MULTIPLE PATIENTS

Press **4** to add more than one patient in series. This will continue automatically to the next starting patient screen after the prior patient is recorded. This is very handy for adding a group of patients at one time.

5 - MORE WAYS TO FIND PATIENTS

Press **[5]** to continue to try to find the patient by the following information. The menu shown in Figure 6.1 provides a few more ways to find patients.

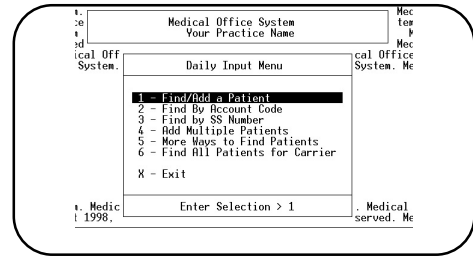


Figure 6-4: More Ways Screen

6 - List All Patients for Carrier

Press **[6]** to display a browse with all the patients that have a given carrier. A prompt will request the carrier and then the browse is displayed. This can be handy if you need to find all patients that have a carrier listed to make a correction to the carrier information.

1 - By INVOICE NUMBER

This option is used to find a patient by an invoice number. Press **[1]** and the following prompt appears:

```
ENTER INVOICE NUMBER >
```

Enter an invoice number and press **[ENTER]**.

2 - By PATIENT NOTES

This is used to find a patient by the patient's notes. Press **[2]** and the following prompt appears:

```
ENTER NOTES TO FIND >
```

Enter the string of characters to be matched and press **[ENTER]**. All patients with the characters entered appearing in any of the six important note fields will be displayed. The characters need not be the first on a line. Upper/lower case is not significant in this match, however, spelling and punctuation is critical.

3 - By RECALL DATE

This will display a list of patients who have a given recall date. Press **[3]** and the following prompt appears:

```
ENTER MM/YYYY of RECALL >
```

Enter a recall date and press **[ENTER]**. A list of patients who have the same recall date will be displayed, highlight the patient and press **[ENTER]**.

4 - By PATIENT DATA

Choose this prompt to search for information using the Scan option. The Scan option allows a search of the file using special logical operators that limit the search according to special criteria. Scanning is described in detailed in Chapter 13, The Record Selection Menu, in the section Scan for Records.

5 - By RECORD NUMBER

Use option "5" to find a patient by record number. Press **[5]** and the following prompt appears:

```
Enter Record Number (1-nn) >
```

Enter a record number and press **ENTER**. On most systems, the record number is used as the default account number, so that the two can be used interchangeably. This is not always the case, however.

6 - By POLICY NUMBER

Use option "6" to find a patient by policy number. Press **6** and the following prompt appears:

Enter Policy Number >

Type any policy number listed for a patient and press **ENTER**.

Adding New Patient Information

When adding a new patient, two data-entry screens are displayed in turn. Then a question will ask if an invoice is to be added also. If adding an invoice, two additional screens of information will be collected. (Adding an invoice is described in the next section of this chapter.)

Enter the appropriate data, and press **ESC** to save your entries and go on to the next screen. After the second screen is saved, a question will determine if an invoice will be added also. If the answer is "no" and you are not in Add Multiple Patients mode, the Main Patient Menu (See Chapter 7 for more information) is displayed. Otherwise the next patient screen is displayed and the next patient can be added.

To add one Patient Press **F8** from the "ENTER: Patient Name" prompt.

To add more than one Patient Press **ENTER**, **4** to add MULTIPLE PATIENTS. This will start ADD MULTIPLE PATIENT MODE.

Ending the ADD MULTIPLE PATIENT MODE

When the last patient has been added for this session, press **ESC** to record this patient and a blank patient screen will appear. From the account number field press **CTRL** + **BREAK** (hold **CTRL** and press **BREAK**) to cancel the add function. Be sure to wait until the cursor is blinking on the screen before pressing **CTRL** + **BREAK**.

The General Information Screen

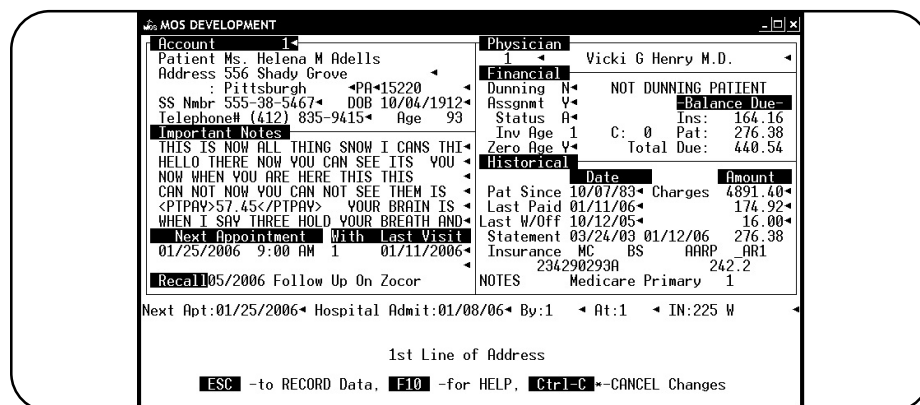


Figure 6-5: General Information Screen

Each field on the general information screen is described below. Note that some fields -- location code, first visit date, provider code, etc. -- are already filled. The Medical Office System puts default information in some fields to make data entry faster. If the information is not correct for this patient, just type over it.

Also, keep in mind the patient demographics provide the patient's general data and expected provider, location, and so on. (The first two patient screens are background information and can be filled before the patient ever comes into the office.)The actual provider, service location, and fees are supplied when an invoice is added. For example, Sally Smith's regular doctor appears on her general information screen. However, when she comes into the office, her regular doctor is on vacation so she is seen by someone else. When the invoice is entered for this appointment, another doctor's code can be given as the provider in the invoice screen.

General Information Screen Fields

Account Code

This field contains the patient's account number. It can be any unique code assigned to a patient. If left blank, the system automatically fills the account number with the record number. The code can be up to eight characters long and include any numbers or letters. Once the record is saved, the account number cannot be changed.

If **[F5]** is pressed in this field (duplicate from the previous record) or an account number is supplied that has already been assigned, the following prompt will appear:

```
Account on File...GO TO PATIENT, MAKE FAMILY MEMBER or Enter - REDO >
```

This prompt is a warning that the account code has been used. It will also provide a quick way to add family members or move to another patient record. Press **[G]** to go to the account in question. Press **[M]** to add a family member related to the patient indicated. This is a great way to add multiple family members easily. The information such as address, insurance carriers and last name are copied to save data entry. Simply fill the rest.

If the account code was entered correctly, just press **[ENTER]** from this warning box and repeat this data entry.

Note: *There are provisions for combining duplicate accounts when a patient has been entered twice with different account numbers. Also an account number can be changed through a special process after the fact if that is necessary. See the Utility Menu from Patient Menu on Page 7-8.*

Title

"Mr," "Mrs," "Miss," "Dr," etc. When the cursor is in this field, the system lists some appropriate titles at the bottom of the screen.

Note: *The system enters the sex of the patient if you enter a valid title here; see "Sex" below.*

First Name

Type the patient's first name. Twelve characters are permitted. A double name is permissible (e.g. Billy Joe). Do not use punctuation characters in this field if your claims will be filed electronically. Be sure to put the Middle Initial in the correct field.

Middle Initial

Enter the patient's middle initial. Never enter a period.

Last Name

Type the patient's last name. Do not use punctuation characters in this field if you intend to use electronic submission. This information must always be supplied when adding a new patient.

- Gen** Enter the generation indicator for the patient, such as “SR, JR, II, III, etc.” This part of the last name must be split apart when filing electronically.
- Birth Date** The birth date is entered either with or without slashes (i.e., MM/DD/YY, MMDDYY, MM/DD/YYYY, or MMDDYYYY).
- Dun** This field is used to indicate the dunning status of a patient.
- Y Indicates that this patient will receive progressive dunning messages on their bills if the amount owed goes beyond 30, 60, 90, or 120 days. If this is left blank, a “Y” is supplied by the computer.
 - I Limits this patient to print insurance forms only. No patient statements will be printed.
 - H Will place all claims for this patient on hold.
 - N Indicates that the patient should not receive a dunning message and no interest will be applied when the statements are printed, even if interest is indicated for the practice or age of invoice.
- NOTE: If Zero Age is set to “Y”, the invoice will reset to current each time a payment is entered and the dunning message will indicate current also.
- Status** This field is for information only. This field is used to sort or select some reports. If deceased is indicated a prompt for date of death is displayed. This date may be left blank.
- A Active
 - D Deceased
 - I Inactive
 - T Terminated
 - C Completed
- Home Address** The first line is for number and street. The second line is for apartment number, suite #, c/o, etc.
- Zip Code** *Support File Browse, Add if Not Found*
- Accepts 5 or 5+4 digit zip codes. After pressing the MOS determines if the zip code entered is in the Zip Code File. If the zip code is found and unique, the associated city and state will be filled automatically. If a zip has more than one city associated with it, a list will be displayed. Use your arrow keys to highlight the correct city and press . If the zip code is not found, a prompt will ask if it should be added to the zip code file. To add a new zip code, press . For more information about the Zip Code file see page 12-14.
- City** Type the name of city for patient's mailing address. If a zip code is entered, the city/state is drawn from the zip code file. If a zip code was provided, this field is skipped. If no zip code is entered, enter the city name.
- State** Two character state abbreviation (i.e., NY, PA, IL). Typing the zip code automatically provides the city, state and default area code for phone numbers. If a zip code has been entered, this field is skipped.
- Occupation** Type the patient's occupation.
- Social Security Number** Type the patient's social security number. The number may be typed with dashes or the system will provide dashes when nine-digits are entered. Some people do not track the patient's SSN and use this field to track the patient's X-RAY number or other identifying criteria. An index is built on this field, thus allowing a fast search method. See "Other Way to Find/Add Patients" early in this chapter for more information about selecting patients by SS number. However this field is used, be consistent so this will be a helpful way to find patients.

A test has been added to warn if a patient with the same Social Security Number is already on file. This should be an excellent way to insure that duplicates are not added.

Sex Enter "M" for Male or "F" for Female.

Home Phone Type the patient's home phone number. The area code will be added automatically if provided in the zip code file. The MOS will automatically enter hyphens and parentheses for phone numbers -- if you type 2125559290, the program changes it to (212) 555-9290.

Work Phone Type the patient's employment or school phone number. The MOS will automatically enter hyphens and parentheses for phone numbers -- if you type 2125559290, the program changes it to (212) 555-9290.

Extension Work or school phone number extension, if any.

Provider Code *Support File Browse, Add if Not Found*
Enter the code for the physician who normally sees this patient. This will provide the default code for subsequent invoices. The provider ID and/or UPIN number will be derived from this default code for printing on claim forms. For more information about the Provider file see page 12-3.

Provider Name *Fuzzy Browse*
If the code was left blank, enter an approximate name in this field to try to find the provider by name. This field is only available if the provider code is left blank.

Location *Support File Browse, Add if not Found*
Enter the code for the location where this patient is seen most frequently. For more information about the Location file see Page 12-38.

Location Name *Fuzzy Browse*
Enter the location name and press for a fuzzy browse of the location file. This field is only available if the location code is left blank.

Marital Status Enter the code for the patient's marital status from the following list:

M	Married	L	Separated
S	Single	W	Widowed
D	Divorced	U	Unknown

Employed Use one of these choices:

F	Full-time	R	Retired
P	Part-time	U	Unemployed

If the patient is not employed press .

Student Use one of these choices:

F	Full-time
P	Part-time
N	Not a student

Signature (on file) Type for Yes or for No. This indicates that the patient's signature is on file.

Note: *This field appears on some insurance company forms and many companies will not pay unless this field is yes.*

Privacy Press for Yes, OK to release information or No, do not release information.

Patient Since Pressing will supply today's date. This field should be the first date this patient was treated by this practice.

LMP Date Enter the date of the Last Menstrual Period. The following two fields are calculated from this date.

Weeks Numbers of weeks gestation from LMP date. This is recalculated each time the patient is displayed.

Due Date The expected delivery date based on the LMP date. The day of the week the baby is due is also displayed.

Other Refer by This is provided to help identify the source of your patients, other than by another doctor (Walk-in, telephone book, other patient, etc.). It can be used for determining how to attract new patients, by identifying what has worked in the past. A report is available which will analyze your patients by this field.

Assignment Type if accepting assignment for insurance claims for this patient. is the default value and may be overridden on a claim-by-claim basis. Even if assignment is "Y", the balance left after the insurance carrier has paid can be transferred to the patient if the carrier permits this. Some carriers, such as Medicare, require that your practice accept assignment and that the amount over the Medicare Allowance be written-off.

Referring M. D. *Support File Browse, Add if Not Found*
This is the default referring physician used when entering claims. It can be overwritten or eliminated on a claim-to-claim basis.

Note: For Medicare lab claims the MOS will automatically use the provider of service for that invoice as the referring physician.

For more information about the Referring Physician file see page 12-22.

Referring MD Name *Fuzzy Browse*
This will fill automatically and the field will be skipped if a Referring MD code is given.

Important Notes Six (6) lines to keep important notes about a patient -- Allergic reactions to certain drugs, additional demographic info, specific conditions about a patient, co-pay amounts and deductibles, etc. Though this important information may be kept in the MOS, we suggest a paper copy should be saved in the patient's folder. This data can be used to find a patient from the MORE WAYS menu.

After completing this screen, press to continue.

Insurance Information Screen

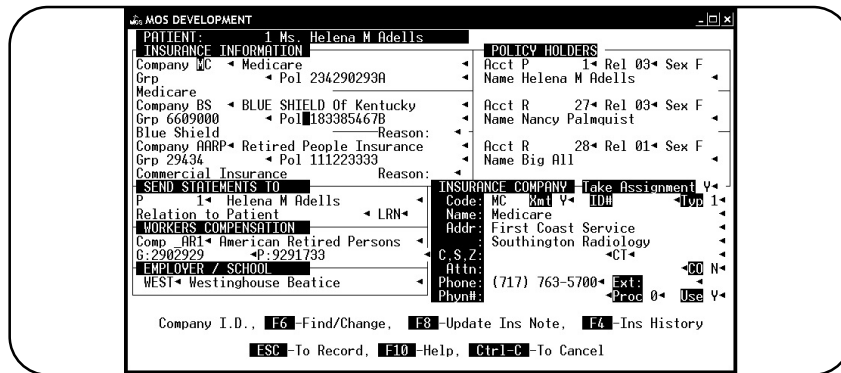


Figure 6-6: Insurance Information

The Insurance information screen contains the patient's insurance company and policyholder information. Supply information for up to three insurance policies and one workers' compensation carrier.

Company

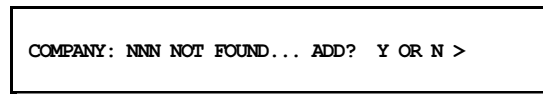
Support file Browse, If Not Found Add

The Insurance company code is entered here (i.e., "MC" for Medicare, "BS" for Blue Shield) Type the appropriate code and the program displays the full name, address, and other data in the lower right corner of the screen.

Any unique code may be assigned for the insurance company, however the following codes should be used for these carriers:

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

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 all the Blue Shield accounts to be printed on the Blue Shield form, but show the two different addresses. Define one code as BSCT (Blue Shield, Connecticut) and the other as 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 Chapter 15, Adding/Changing Forms for more information about matching forms to carrier codes. If the code entered is not found the following prompt will appear:



Press **Y** and a box appears which will allow the insurance company information to be added. Refer to page 12-32 for explanations of the data fields.

F8 Update Ins Note

A new note feature has been added. A note can be added to the insurance file to track miscellaneous information about this carrier. A note can also be added for this particular patient. Both notes are displayed when you select this feature. The following screen is displayed:

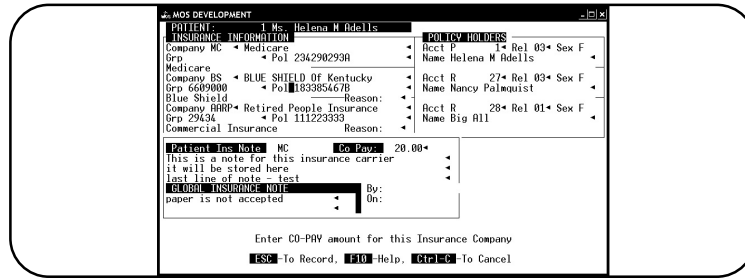


Figure 6-7: Insurance Note

Patient Ins Note Enter the information that should be tracked for this patient's insurance, such as prior authorization, limits, etc.

Co Pay Enter co pay amount. This is not used in calculations but as a reference tool.

Global Insurance Note This is the note attached to this carrier. It can be changed here, and the change will appear for all patients with this carrier.

The notes entered here can be displayed from the Invoice Options. Press **[?]** to display the insurance notes from the invoicing options.

Insurance Company Name **Fuzzy Browse**
Filled in by the system if the company ID code is on file. Enter a company name in this field to find a company by a fuzzy name match and press **[F6]** or **[ENTER]** to see a list of matches to pick an insurance company.

Group Number Enter the Group Number for the Patient.

Policy Number The group and/or contract number, if applicable, or the patient's insurance policy number. The group number can contain up to 13 characters; the policy number can contain up to 20 characters. If the carrier is a Medicare type, the Group field is skipped and the MOS validates the policy number to be in Medicare format. If the policy number is not a valid Medicare policy number, the MOS will display a message.

To add a new insurance company to the file, enter a new code or leave the code field blank and then press **[ENTER]**. The MOS will ask if a new insurance company should be added. For more information about the Insurance Company File see page 12-32.

[F4] to View Insurance History

This will display the insurance information both current and prior to the information displayed on the current screen. Insurance is changed so frequently, it became important to retain information from older policies while the claims are still in the system. Each policy used by this patient since the upgrade 4.00.00, has been recorded. Each policy can be given termination date to allow the system to warn you when a claim is attempted against a closed policy. The policy may also be reactivated by removing the termination date.

Note: *A policy that has been terminated and then re-activated will not be able to recall that period of time it was inactive.*

Further features will be added using this information, should it prove helpful.

A - Activate
T - Terminate

- U - Update (Not currently working)
- X - Exit Browse Display and return to Patient Insurance Screen

Policy Holder Box

Since the policy holder may be this patient, another patient or a third party, we have set up a method of determining which it is. If the policy holder is the patient skip this section by pressing **ENTER** twice or by pressing **F4** the MOS will fill the appropriate information when the screen is saved.

If the policy holder is another patient, the patient's account number preceded with a "P" is entered. To find the correct patient press **e** and then type the patient's name and press **ENTER**. The following prompt will appear:

```
Scan Patient File? >
```

Enter **Y** to scan the patient file, if you want to scan the Responsible Party File enter **N**.

A list of patients that closely match the name given will appear. Use the arrow keys to select a patient and press **ENTER**. The policy holder information will be filled automatically. To exit, press **X**.

If the policy holder is not another patient a sequential number is assigned to the responsible parties and this number preceded with an "R" is entered.

If responsible party number is unknown, use the **F6** key option described earlier in the chapter in the section Data Entry Hints. For more information about the Responsible Party File see page 12-21.

Account

Support File Browse, Add if Not Found

When selecting the Account field, the following prompt appears:

```
P+acct, R+code#, Add or BROWSE-Browse >
```

Press **P** and the patient account code or **R** and the responsible-party code. For the current list of responsible-party codes, press **F6** or just type an **A** to add and let the system assign the code numbers.

When adding a policy holder, supply the information shown in Figure 6.1. This information is required on insurance forms so be sure it is accurate. For a complete explanation of this information see Page 12-21, Support File Maintenance, Responsible Parties.

```

POLICY HOLDER
< Acct: 24          SSH: 555-12-1212<
  Name: Mary      < Peters
  Addr: 1443 West Street
  :
< C, S, Z: Bethel Park < PA< 15102
  Phone: (412) 555-1212<
  Emp/Sch: Westinghouse
  Date of Birth: 05/01/1965<  Sex: F<
  
```

Figure 6-8: Adding a Policy Holder

Name

Fuzzy Browse

If Account Code is left blank, enter the name of the person that is responsible. You will be asked if you wish to scan the Patient File, press **[Y]** to fuzzy search the patient file. Press **[N]** or **[ENTER]** to fuzzy search the responsible party file. To send the name properly electronically, put any middle initial in the right most position of the first name.

Relationship (to insured)

Browse

Press **[F6]** to select from an extensive list of relationship codes.

Sex (insured)

"M" for Male or "F" for Female. This would refer to the sex of the policy holder.

Send Statements To

Support File Browse, Add If Not Found

This field identifies the head of a family group or legal representative for this patient. When checking for family members, the tie is made with the code in this field.

Press **[ENTER]** to leave blank for patient responsibility and the system fills in the field when the record is saved. Type **[P]** plus the patient account number if the responsible party is a patient, or type **[R]** and the responsible party number, or press **[A]** to add a new responsible person. If adding or changing the following screen is displayed. For more information about the Responsible Party File see Page 12-21.

Company AMR Retired People Insurance Acct R I Rel Sex M
 Grp 29434 Pol 111223333 Name Richard V. Affinito
 Commercial Insurance

SEND STATEMENTS TO	PATIENT RESPONSIBLE
P 1 Helena M Adells	Account 1
Relation to Patient Self LRN	NM Helena M Adells
WORKERS COMPENSATION	Address 556 Shady Grove
Comp AR1 American Retired Persons	C, S, Z: Pittsburgh PA 15220
G:12345 P:678898	Phone: (412) 835-9415
EMPLOYER / SCHOOL	Date of Birth: 10/04/1912
WEST Westinghouse Beatice	Emp/Sch: Westinghouse Beatice

[P]+acct, **[R]**+code#, **[A]**dd or **[F6]**-Browse

Figure 6-9: Send Statements To

Name

Fuzzy Browse

This field is skipped when the Send Statement To Code is supplied. To find a person by name, enter an approximate name in this field and press **[ENTER]**. A prompt will ask "Scan the Patient File?", answer **[Y]** to browse the patient file, answer **[N]** to browse the responsible party file.

Workers' Compensation

Support File Browse, Add if Not Found

Fill the company identification code. This data is only necessary for worker's compensation claims. For more information see Page 12-37.

If adding or changing the Workers' Compensation Carrier, the following screen appears:

Commercial Insurance

SEND STATEMENTS TO	WORKERS COMPENSATION CARRIER
P 1 Helena M Adells	Code: AR1
Relation to Patient Self LRN	Company American Retired Persons
WORKERS COMPENSATION	Address 1243 West Street
Comp AR1 American Retired Persons	Cty:St: Bethel Park PA 15102
G:12345 P:678898	ATT: Joe
EMPLOYER / SCHOOL	Phone: (412) 555-1212 Ext: 2222
WEST Westinghouse Beatice	

Workers' Comp Company I.D., **[F6]** -to Find or Change, **[F8]** -Update Ins Note

Figure 6-10: Workers' Compensation

Workers' Compensation Company Name

Fuzzy Browse

The cursor will skip this field if a code was supplied. To find a company, enter the best approximation of the name here and press **ENTER** or **F6**. Select your company and press **ENTER**.

G

Enter the Workers' Compensation group number as required.

P

Enter the Workers' Compensation policy number as required.

Employer

Support File Browse, Add if Not Found

Type the patient's employer code here. This information is only necessary if it is required on insurance claims.

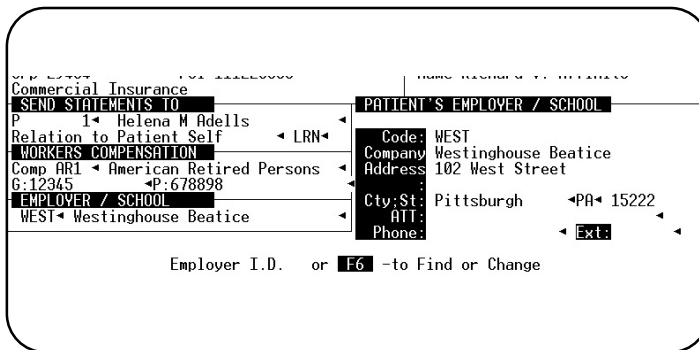


Figure 6-11: Patient's Employer

Employer Name

Fuzzy Browse

This field is skipped if the employer's code was entered.

Saving the Data

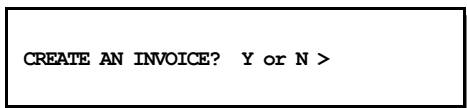
When finished, save the data by pressing **ESC**. The REDO question is displayed. Press **N** for "no" when the data is correct. Press **ENTER** to store the data.

If no invoice needs to be created, press **N** for "no" or just press **ENTER**. The next new patient record will appear. If MULTIPLE ADD MODE is active, and you would like to stop adding at this time, wait for the next patient screen to be displayed and press **CTRL** + **BREAK** from the Account Code Field. This will end MULTIPLE ADD MODE. If an invoice should be added, press **Y** and move to the ADDING INVOICES information.

BE sure to wait for the screen to be fully displayed and the cursor to be displayed before pressing **CTRL + **BREAK**. If it is pressed too quickly, data loss can occur.**

ADDING INVOICES

After saving the insurance information screen, a question appears:



Press **[Y]** to begin a new invoice. To create an invoice without first updating the insurance screen, select "I-Invoice Menu" from the Patient Sliding Menu, then "A - Add an Invoice". The Patient Sliding Menu is covered in detail in Chapter 7.

Invoices Header Screen

Filling In Invoice Data

When creating invoices, the Invoice Header Screen comes up first. If this is to be an insurance claim, just fill the necessary data and go on to the Charge/Payment screen. If it is not an insurance claim, press **[ESC]** when the screen comes up and go directly to the Charge/Payment Screen.

The layout and content of this screen can be varied to better fit your practice. A second invoice header screen can also be displayed for a particular carrier to collect special carrier related information. This screen can be created by MOS support and attached to the insurance carrier.

Note: *These special screens must be created by the filePro full development system. Call MOS support for more information*

Invoice Header Screen Fields

Account Number / Patient Name

The account number and patient name are filled automatically.

Sign-In

May be left blank, if your office does not use a sign-in number. This field is used to enter the sign-in # from the patient sign-in sheet. If a sign-in number is assigned, the recap will print in that sequence. This will provide a double check that all patients have been invoiced.

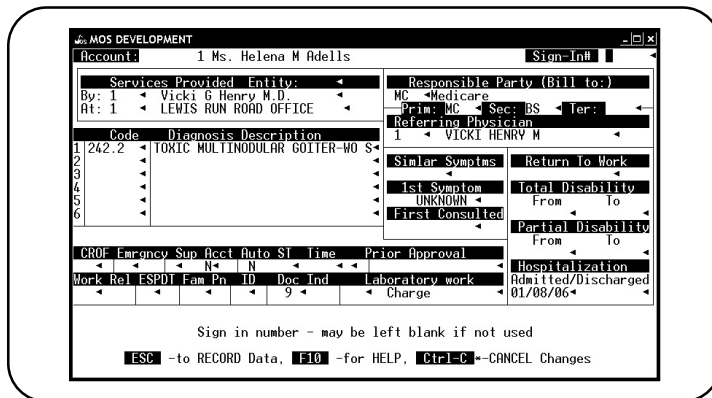
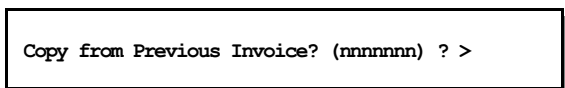


Figure 6-12: Invoice Header Screen

If there has been a previous invoice for that patient, the following message will appear:



Press **[Y]** for the information from the previous invoice to be copied to this invoice. If the diagnosis and other data copied is correct, answer **[Y]**. This will save data entry time. Make sure all the appropriate information, such as location and provider codes, has been supplied before continuing to the section called "Adding Charges", below.

Entity

Support File Browse

The cursor will only stop in this field if you have defined at least one entity in the support files. As long as no entities are defined this field will be ignored. Use the ENTITY code like a profit center code if you need to get totals for different parts of your practice and the location or provider codes do not offer a clear division. When the invoice is recapped, the entity code will be used to separate the money for the month or detail reports. It will be possible to move money from a blank Entity to an existing Entity after a recap. It will look like a transfer would look for changing the location or provider after the data is recapped.

The Recaps, YTD Summaries, Transaction Review and other financial reports will sort and subtotal your data by the entity.

Services Provided By

Support File Browse, Add if Not Found

The patient default attending physician is displayed. Modify as needed.

Services Provided At

Support File Browse, Add if Not Found

The patient default service location is displayed. Modify as needed.

Responsible Party (Bill to)

Indicates to whom the bill should be sent. The options are either "PT " (for the patient or a billing party) or any insurance code (BS for Blue Shield, for example) already on file for this patient. A list of possible codes appears in the pop up box. Enter a code from this list. If the party needed is not listed, return to the Insurance Information screen and modify the information to include the correct responsible party. This field may change through the life of a claim as the payment responsibility shifts from primary carrier, secondary carrier, to patient.

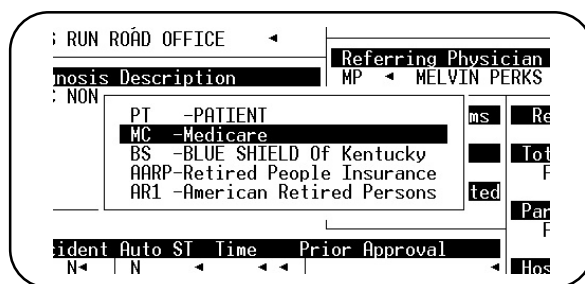


Figure 6-13: Responsible Party Pop Up Box

Diagnosis Code

Support File Browse, Add if Not Found

Up to six diagnoses can be listed on each invoice. Type in the diagnosis identification code, if known.

Note: *You can enter your code or the standard ICD-9 code.*

Diagnosis Description

Fuzzy Browse

If the code field is blank, a diagnosis description can be entered to help find the correct diagnosis

Referring Physician ID

Support File Browse, Add if Not Found

Supply the code and name of the physician who referred the patient. Up to 18 spaces are available. The MOS will automatically supply the patient's default referring physician if they have one. See Patient General Information Screen on how to add default referring physicians.

Note: *If you are adding a physician you must know their UPIN number.*

If the patient does not have a default referring physician, the provider will default as the referring physician. If the provider is not in the referring physician file, the MOS will add the provider automatically.

Referring Physician Name

Fuzzy Search

If the code field is blank, enter the name of the referring physician to display a browse and select the best match for that name.

Similar Symptom

If the patient had similar symptoms before type, Y for yes, or press ENTER for no.

<i>1st Symptom</i>	The date, in MM/DD/YY format when the symptom was first diagnosed. Type a dash (-) and a number and the MOS will automatically supply a date that is that number of days from today's date. (i.e., Enter -3 and today's date is 01/05/95, the MOS will fill the field as 01/02/95). If this field is left blank, it will be filled with the word "UNKNOWN".
<i>First Consulted</i>	The date, in MM/DD/YY format when the patient first consulted your practice regarding this diagnosis. This date must be before today's date.
<i>Return to Work</i>	The date, in MM/DD/YY format, when the patient can resume his employment duties.
<i>Total Disability</i>	The dates, in MM/DD/YY format, when the patient will be on total disability. If the "From" date is empty, the cursor skips to "Partial Disability".
<i>Partial Disability</i>	The dates, in MM/DD/YY format, when the patient will be on partial disability.
<i>Hospitalization</i>	The dates in MM/DD/YY format for hospital admission and discharge.
<i>CROF</i>	Consulting Report on file? (Y or N).
<i>Emergency</i>	Type <input type="checkbox"/> for yes, if this were an emergency, or press <input type="button" value="ENTER"/> for no.
<i>Accident</i>	Enter the correct code. If the code selected indicates an auto accident, additional information will be required. New codes are available. Select <input type="button" value="F6"/> to display new choices. <i>Browse</i>
<i>Auto</i>	Fills in with a "Y" with proper selection above. Defaults to "N".
<i>State</i>	Enter the two character state abbreviation of the state where the auto accident occurred. Invalid state codes will not be accepted.
<i>Time</i>	The time of the auto accident, in HH:MM format (hour:min). Then type "A" for AM or "P" for PM.
<i>Prior approval</i>	This is the carrier's approval number for procedures requiring prior approval. This is required for payment of some procedures.
<i>Work Related</i>	If the injury was related to the patient's employment, enter <input type="checkbox"/> for yes, or press <input type="button" value="ENTER"/> for no.
<i>EPSDT</i>	If the patient is here for "Early Periodic Screening and Detection Tests". Type <input type="checkbox"/> for yes, or press <input type="button" value="ENTER"/> for no.
<i>Family Planning</i>	Type <input type="checkbox"/> for yes, or press <input type="button" value="ENTER"/> for no.
<i>ID</i>	Enter <input type="checkbox"/> to supply a special provider ID. This ID can be the sponsor provider ID or other special Provider ID that must be assigned to this claim. It would only be used for a provider other than referring, ordering or performing.
<i>Doc Ind</i>	Enter the correct code to indicate if documentation is available to support this claim and where it is to be found.
<i>Laboratory Work</i>	Enter <input type="checkbox"/> for yes, or press <input type="button" value="ENTER"/> for no. If yes, enter charge in \$\$\$\$cc in the next field.

Note: If a patient has Medicare primary and you are billing a secondary insurance company or the patient and you have lab fees the MOS will create a separate invoice for the lab fees. This operation is done to meet Medicare requirements.

Saving the Data

When finished, save the data by pressing **[ESC]**. The REDO question appears. Press **[H]** if you would like a hard copy. Check the screen. If everything is correct, press **[N]** ore to save the information. Once the screens are saved, the Charge Screen is displayed.

If the billing party has an additional screen specified, it will appear at this time. This is a customization option and the additional screen must exist to make this function work at all.

Adding Charges

Charge screen

After leaving the insurance header information screen, the charge screen is displayed, since every invoice must have at least one charge line. Charge lines can also be added to an existing invoice from the "I-Invoice Menu" on the Patient Sliding Menus. Select "V - Invoice Overview", then select the invoice and press **[ENTER]**. Finally press **[C]** - Add Charges. Refer to Chapter 7 for more information on the "Invoice Menu".

The screenshot shows the Invoice Detail Screen with the following information:

1 Ms. Helena M Adells
Provider: Vicki G Henry M.D.
Invoice: 02/21/03 271 1
MC Medicare
NO BILL PRODUCED

CHARGE	Statmt	Ins	Insurance	MC	BS	AARP	ARI
02/21/03	02/21/03	1	1	1	1	1	1
02/21/03	02/21/03	1	1	1	1	1	1

Procedure Description: EPMOD/HIG
Mod1 Mod2 Mod3 Mod4 Narr IMPES

line	Fn-ToDate	Diag#	Procedure	NOS	Loc	Rsp	Amount	Pcode	Description
1	02/21-21	1	EPMOD/HIG		1	1	35.00		EXTENDED MODIFIC

CHARGES: 35.00 - PAYMENTS: .00 = BALANCE DUE: 35.00
First Date of Service or **[F8]** to CANCEL
[ESC] -to RECORD Data, **[F10]** -for HELP, **[Ctrl-C]** -CANCEL Changes

Figure 6-14: Invoice Detail Screen

Note: *If your practice is required to send a narrative with your electronic claims, to describe or justify the payment for this procedure, a special screen can be used to allow this new feature. The CHARGE SCREEN option is made in the Practice Information. Enter screen "th" and new options are included for the narrative. To enter charges with 4 modifiers, providers per line or referring physician or from and to dates, use screen "tt".*

Date

Today's date is the default. Enter a different date; use the MM/DD/YY format. An option can be provided to allow for a from and to date to be entered here. The new fields are available on an alternate CHARGE SCREEN.

Procedure

Support File Browse, Add if Not Found

The procedure identification code. Input the procedure code, CPT code, group code, or your code and press **[ENTER]**. The code is translated to the correct procedure code for the insurance form being printed. If your in-house code is printing on forms, check that the procedure data is properly entered the support files. Your code is the last choice if no other can be found.

If adding a procedure code at this time is necessary, refer to page 12-8, Support Files for complete information about the data fields.

Note: *To enter a group procedure enter an ! as the first character of the code. A Group Procedure allows a list of procedures to be identified as a group with only one code. This can save data entry time. For more information about Group Procedures see page 12-23.*

Description of Procedure

Fuzzy Browse

The procedure's description; it appears automatically if the procedure is already on file. If the procedure code is left blank, a description can be entered to search the procedure file for a match.

Days This field is used in place of the to date of service and will automatically create a line item for each date. If the number of days is more than one, you will be prompted for the dates. The first date should be the earliest date of service. We allow a date to be skipped if necessary. (Enter Y to skip a date.)If a group procedure code was entered, each procedure in the group will be listed once for each date that the group procedure was provided. REMEMBER most carriers require the claim to remain within a given calendar month. It is always necessary to keep a claim within one calendar year.


Dx# The diagnosis number, from 1 to 6 that relates to this line item. These numbers refer to the diagnoses entered on the previous screen. This number relates the procedure to the diagnosis or diagnoses (more than one). Medicare and some carriers allow a procedure to relate to more than one diagnosis. If the claim lists four diagnoses and one procedure, the diagnosis pointer would read, "1234". Be sure if listing six diagnosis codes that they are printing in the prescribed fashion on the insurance claim, so the pointer will be understood correctly by the insurance carrier.

Times Number of units or times this service was done. This multiplies the charge per service to calculate the line charge. Decimal numbers are allowed. Be careful of the context in which they are used. If this is indicating, hours of anesthesia, a decimal is appropriate, however, if this indicates an office visit then a whole number is required.

Loc *Support File Browse, If not Found Add*
Location code where procedure was done, the code entered on the invoice header screen will already be entered. Enter your in-house code here. It is translated to the POS code on the insurance form. (Be sure the PLACE OF SERVICE field in the location file lists the correct code for the insurance forms.)Money earned in your practice is detailed by location for some reports.

Amount This amount is the standard charge for the procedure; it appears automatically if the procedure is already on file. The standard charge can be modified for this individual by typing over the default charge. If it is changed, a prompt will ask if the procedure file should be updated with the new charge, respond Y and the standard charge in the procedure file will be adjusted.

If billing a patient, the Medical Office System uses the procedure's standard charge. When billing an insurance company the MOS will use the insurance company's charge and if the insurance company's charge is left blank the MOS will use the standard charge.

 to start the Charge Amount Calculator Charge Amount Field. The amount currently displayed is automatically loaded as the first number. See Chapter 18, for complete information on how to use the calculator.

Md1 Two digit modifier code (if allowed by procedure setup). See page 12-8, for more information on the Procedure file. If the modifier was included in the procedure file, it will load automatically when the procedure is selected. You can change it or remove it if this is appropriate.

Md2 Two digit modifier code (if allowed by procedure setup). See page 12-8, for more information on the Procedure File.

Md3 Two digit modifier code (if allowed by procedure setup). See page 12-8, for more information on the Procedure File. This modifier can be added from CHARGE SCREEN "tt".

Md4 Two digit modifier code (if allowed by procedure setup). See page 12-8, for more information on the Procedure File. This modifier can be added from CHARGE SCREEN "tt".

Medicare Calculation Example

Standard Charge	Medicare Allows	Expected MC (80% of Allows)
100.00	92.00	73.60
Amount printed on claim will be \$100.00		
When the payment from Medicare arrives, it will indicate the Medicare expected amount is \$73.60. It will write-off \$8.00 and will have a balance of \$18.40 which is billable to the patient. This would be the normal breakdown for the money.		
ST CHG	= Write-Off	+ MC Pays + Patient Co-Pay
\$100.00	= 8.00	+ 73.60 + 18.40

Note: *If your carrier type is Medicare, the MOS will use the procedure's standard charge or maximum Medicare charge, whichever is greater, and the "expected charge received" will appear on the top of the screen "Received MC .00 of \$\$\$\$cc" (See box below) for reference. When making payments, the expected amount will appear on the screen as amount owed. The expected rate is calculated from the Medicare payment field in the Practice file. Medicare Payment Percentage is defined in Chapter 5, Setting up the Practice. See, also, Making Payments later in this chapter.*

Hr/Mins The time in HH:MM that patient was administered this service. Normally used only for Anesthesia and Psychiatric services.

Narr A narrative is sometimes needed when filing electronically to add information that will support the need for payment. This comment or narrative is then added to the line item as an HA0 or Narrative record. Other record types are also be available called certification records. These are coded GA0 to GZ0 and are only used for some specialities. A line with a narrative attached will list with an "*" in the first column when the Invoice Options are displayed.

Types This will display the type of narrative record that is currently attached to this line item. The narrative above will always be type "HA0" and will automatically be supplied here. A GC0 type has been added to allow Chiropractic Certification. Browse is available to list the available Types. A line with a narrative attached will list with an "*" in the first column when the Invoice Options are displayed.

Purchase Diag test from *Support File Browse, Add if Not Found*
If diagnostic tests were purchased for this service, show the vendor of these tests. From the Support File Browse function, a diagnostic test provider can be added. For more information see page 12-39, Diagnostic Test Provider File.

Test cost Input the cost of the diagnostic test in \$\$\$\$cc. Not accessible if previous field is blank.

Saving the Data

Once the cursor leaves the last field or if is pressed, the system saves the line item and displays it on the screen.

If a Narrative or Certification screen is indicated it will be displayed at this point. These are associated with the charge lines. More information about each type available can be found at the end of this chapter. When the screen has been completed press .

REDO Prompts

These will appear after each line item. They can be suppressed from the practice information if you do not want to do the additional keystrokes.

If a hard copy is wanted at this point, press **H**.

If the line item should be corrected, press **Y** at the "Redo" option.

Press **ENTER** or **N** to save the line and continue forward.

If the charge or description was modified on a new charge line, a box is displayed asking if the procedure file should be updated also.

When the changes are meant only for this invoice, press **N**, for "No", then press **ENTER**. If the procedure data should be modified, press **Y** and **ENTER**.

Instead of moving to another screen once these operations are finished, the charge/payment option list appears.

Charge/Payment Screen: The Sliding Menu Options

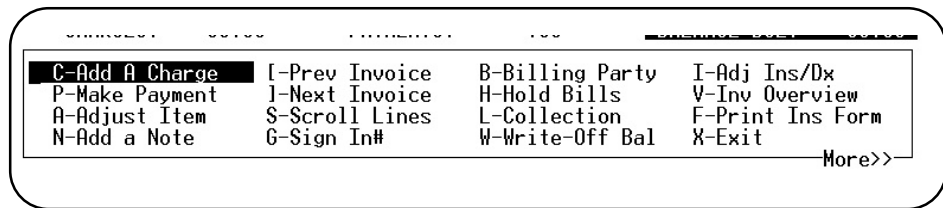


Figure 6-15: Sliding Menu List Box Part 1

On some displays all of the prompts may not be displayed at the same time. Move right or left with the arrows past the edge of the screen to see additional prompts. The words "More >>" shows additional prompts are available.

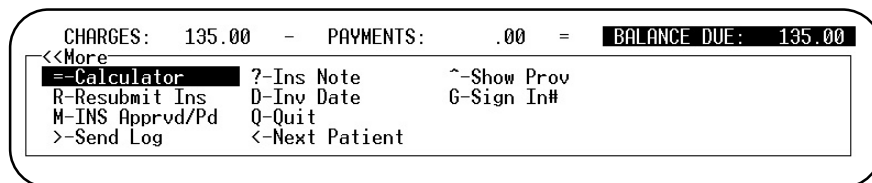


Figure 6-16: Sliding Menu List Box Part 2

The available options:

C	Add A Charge	add another charge
P	Make Payment	add a payment
A	Adjust Item	adjust detail lines or the insurance header information
N	Add a Note	add a note line to the invoice detail
[Previous Invoice	list previous invoice
]	Next Invoice	list next invoice
S	Scroll lines	list charge/payment lines in scroll format includes adjustments
G	Sign In#	change sign in number
B	Billing Party	change the responsible party for the invoice
H	Hold Bills	toggle invoice hold status
L	Collection	toggle collection status
W	Write Off Bal	to write off balance

I	Adjust Ins/Dx	change the insurance information, or diagnoses information
V	Inv. Overview	switch to Invoice overview screen
F	Print Ins form	print Insurance form
=	Calculator	calculator
R	Resubmit Ins	resubmit insurance claim
M	MC approved/paid	display Medicare approved or paid amounts
?	Ins Note	display the insurance note for the carrier responsible for this invoice.
D	Inv Date	Change the date the claim was processed.
>	Send Log	view the history of requests for payment of this claim
^	Show Prov	Display Rendering Provider in Description on Browse
Q	Quit	exit to Medical Office Main Menu
X	Exit	go on to the next record; or if not in "add records mode", return to the patient menu.

Press the uppercase letter or highlight your choice using the arrow keys, and press **ENTER**. A description of each option is listed below.

C - Add a Charge

Press **C**. The cursor moves to the date field. Type the new line-item information as described earlier in "Adding Charges. "

1 Ms. Helena M Adells	MC Medicare
Provider: Vicki G Henry M.D.	
Invoice: 02/21/03 271 1	NO BILL PRODUCED
CHARGE Statmt Ins	Insurance: MC BS AARP ARI
Date To Date Dx# Times Loc	Amount Rendering Provider
02/21/03 02/21/03 1 1 1	1 VICKI G HENRY M.D.
Procedure Procedure Description	Mod1 Mod2 Mod3 Mod4 Narr TVPES
Purchased Dx Test From:	Test Cost HH:MM AD SP LB Opt
<hr/>	
line Fm-ToDate Diag# Procedure NOS Loc Rsp	Amount Pcode Description
1 02/21-21 1 EPMOD/HIG 1 1 MC	35.00 EXTENDED MODIFIC
<hr/>	
CHARGES: 35.00 - PAYMENTS: .00 =	BALANCE DUE: 35.00
First Date of Service or F8 to CANCEL	
ESC -to RECORD Data, F10 -for HELP, Ctrl-C -CANCEL Changes	

Figure 6-17: Add a Charge

When the cursor moves from the last field or **ESC** is pressed, the REDO prompt is displayed. Check the screen. If everything is correct, press **ENTER** for no.

P - Make a Payment

1	Ms. Helena M Adells	MC	Medicare	
Provider: Vicki G Henry M.D.				
Invoice: 02/21/03 271 1		Insurance: MC NO BILL PRODUCED		
		BS AARP ARI		
PAYMENT				
Line	Date	From	Method	Amount Description
2	02/21/03	MC	CK	14.40

CHARGES: 35.00 - PAYMENTS: .00 = **BALANCE DUE: 35.00**

Change Line Number to apply payment to specific item or Press **F8** to CANCEL

Figure 6-18: Make a Payment

Press **P** and enter the following information.

A Payment password has been added to allow your practice to control access to payments. If a payment password has been defined, you will need to enter it here.

Line

The program generates a new line number for each transaction (payment or charge). If the insurance company supplies a breakdown of payments made on each charge, making line-item payments is possible. To apply a payment to a specific line, type its number in the LN# field. When the entry has been saved, the payment number will appear to the right of the line number.

Note: *To get any reports that might breakdown the income by procedure it is necessary to apply payments to each line number. Otherwise, all that is tracked is the charge by procedure that may not be the amount paid. Since this is not commonly how the Medical Office System is used, such a report is not currently available in this version.*

If the payment is applied to a specific line, then the amount expected from Medicare will automatically be displayed for the amount. Then the allowed amount is displayed with the opportunity to change it if incorrect. Finally, the write-off for that line number will be displayed for only that line.

Press **F8** to cancel the payment request. No record is made if this is done at this point.

Date

Either press **ENTER** for the current date, or enter another date in MM/DD/YY format. It is suggested that today's date be entered here or the deposit date to help when balancing the bank deposits with the payment entries.

From

Either the patient/billing party or an insurance company. Press **ENTER** to show the current responsible party (PT or INS). An insurance code not listed on the insurance data for this patient will not be accepted.

Method

Enter the method of payment from the list below. Medical Office System track payments so that at the end of the day the daily recap reports will help with reconciling the day's deposit. The options appear at the bottom of the screen:

- | | | |
|-----------------------|-------------------|----------------------------|
| CA - Cash | VS - VISA | WO - Write-off |
| CK - Check | DC - Diner's Club | NC - No charge |
| MO - Money order | CC - Credit card | NA - Not applicable. |
| AX - American Express | OT - Other | PC - Professional courtesy |
| MC - Master Charge | | UC - Uncollectible |

RF - Refund
RC - Returned Check NSF
TB - Insurance Take Back

Amount

The payment amount defaults to the balance due. If the payment is the same as the balance due, press **ENTER**, or type in the new amount. (The program supplies the decimal point and two digits when whole dollars are entered). If the type of payment is entered as CASH, a box will appear requesting the amount tendered. Enter the cash paid by patient and the change will be displayed.

Description

Enter the check number or a memo. Press **F8** to attach this check to the current check track list. An error box is displayed if you have not activated the Check Track function. When you press **F8** to connect the check, the check number assigned to the check track is automatically written, and the payment detail is copied to the Check Track list for this check. You will also notice that at the bottom of the screen the running balance of the currently active check is displayed. The amount of the payment has not been added to the check until you press **ESC**.

MEDICARE Primary

If the patient has Medicare Primary and the billing party shown for this claim is the patient or a secondary carrier, the Medicare allowance amount less the Medicare Payment Percent total will appear as the default balance due. If Medicare is not the responsible carrier, the write-off feature is not activated.

When billing Medicare (this is the amount printed on the insurance form) the amount due is the total of the standard charges. Your practice expects to be paid a percentage of this standard charge. The percentage (currently 80% in most cases) is entered in the practice setup information. When a payment is entered, the default payment received will be calculated as what Medicare Allows times the Medicare Payment Percentage. The Medicare Approved Amount is displayed in a pop-up box that can be corrected if necessary. (This is the amount listed as the Medicare Allows on the procedure screen.)

Then a second payment screen is displayed, if the amount allowed is less than the standard charge for this invoice, to write-off this difference. Press **ENTER** to accept the write-off or **Y** to make a change. Then a pop-up box will display the expected amount received, press **ENTER**. Finally a box is displayed asking who is responsible for the balance. This would usually be the secondary carrier or the patient. When a billing party is assigned, press **ESC** and the payment function has been completed.

EXAMPLE: \$100.00 is your standard charge
\$97.00 is the Medicare allows
Medicare Payment is 80% as defined in Practice Setup

The invoice to Medicare would list 100.00 as the charge amount. When you enter the payment, the default amount would be displayed at \$77.60 or (80% of \$97.00). Then the write-off will be \$3.00 or (\$100-97). The balance to be billed to the patient is \$19.40 or (\$100-\$3-\$77.60).

Note: *After receiving payment of an invoice, you can bill the remainder to another carrier or to the patient by changing the billing party.*

Description

The description field can be used for notes about a payment, such as check or voucher number or explaining a write-off.

N - Add a Note - Invoice Notes

Press **[N]** to add a note line to the invoice.

Date

If the date on the screen is correct, press **[ENTER]** or type a new date.

Note

There are three kinds of notes - one internal and two external. Internal notes appear only in the invoice record and use no special syntax. External notes can be printed either on insurance forms or statements. For insurance forms the note must start with a number from 1 to 9 and a right-parenthesis. For example, you could type:

1)Pre-approved by claims adjuster 1084

It will appear on an insurance form as:

Pre-approved by claims adjuster 1084

When **[ENTER]** is pressed, the note is saved and the menu line reappears.

If the note is for a statement, it must start with an asterisk (*). For example, you could type:

*This note explains the procedure

It will appear on the statement as:

This note explains the procedure

Any other character starting the note will indicate the note should be internal.

A - Adjust Item

1 Ms. Helena M Adells
Provider: Vicki G Henry, M.D.
Invoice: 02/21/03 271 1

PT PATIENT
NO BILL PRODUCED

Beginning of File

line	Date	Diag#	Proc#	NOS	Loc	Rsp	Amount	Pcode	Description
1	02/21/03	1	EPMOD/HIG	1	1	MC	35.00		EXTENDED MODIFICATIO
2	02/21/03					MC	-14.40	CK	PAYMENT
3	02/21/03					MC	-17.00	NA	*WRTOFF

End of File

[←] -Choose Item, **[C]**ollection, **[H]**old, **[D]**elete or **[X]**it >

Figure 6-19: Adjust Item

This option will allow the charges, payments or notes to be adjusted. Press **[A]**, to display the detail lines for this invoice. If an ADJUSTMENT PASSWORD is assigned, supply it now. From this screen, note the following choices:

[ENTER] to choose an item, **[C]**ollection, **[H]**old, **[D]**elete or **[X]**it. >

Place the highlight bar over the item to be adjusted and press **[ENTER]**. Make your changes and press **[ESC]** as necessary.

If the line item has a different billing party than the responsible party for the claim at this time a prompt is displayed:

Change Billing Party from MC to BS65? (Y/N)

Press **Y** to change the billing party on just this line item. The line item billing party is not used to accumulate your financial information, it is used for electronic claims and transaction reports. The line item should be responsible to primary carrier, there is no reason to change it as the billing party changes.

To delete a line, first it must be adjusted to zero. Select Adjust an Item, change the amount to zero and press **ESC**, then highlight the line item and press **D**.

From the adjustment browse an invoice can be placed on HOLD by pressing **H** or in COLLECTION by pressing **C**. These keystrokes for HOLD and COLLECTION are toggles and pressing the key again will remove the HOLD or COLLECTION status.

[- Previous Invoice

Press "[" to display the invoice details of the previous invoice listed for the patient. This would be the one chronologically before the current invoice. A beep will sound when the earliest invoice is displayed.

] - Next Invoice

Press "]" to display the invoice details of the next invoice listed for the patient. This would be the one chronologically after the current invoice. A beep will sound when the latest invoice is reached.

S - Scroll Lines

Press **S** to display the browse screen. Move up and down as needed through the transactions with the arrows and page keys.

Press **W** to view the User ID of the user that created the transaction.

Press **P** to view a popup of the transaction screen. No data may be changed while viewing this display.

Press **X** when finished and return to the Charge/Payment Sliding Menu. This prompt will display the complete record of transactions listed for the current invoice. Any adjustments or corrections are displayed that are usually omitted from the Invoice Detail screen because they have a zero affect on the total. This list will show all adjustments, corrections and changes that have been made to the invoice detail. This might be helpful information currently displayed does not match paper reports or claims that have been printed before the changes were made. The information on this screen will show the original entries as well as each and every change that was made to those entries since the beginning. This is the complete audit trail for the invoice.

Color has been added to this display to make it easier to read. To activate this feature, PFCOLOR=ON must be listed in your configuration table.

G - Sign In#

Enter the line number next to the patient's name on the office sign-in sheet. This is an excellent way to verify that all claims for the day have been created. Press **G** to change the number, then **ESC** to return to the current display. This sign-in number is used to sort for the daily recap and will list the patients by sign-in number so the claims can be matched to the recap to verify the daily work

I - Adjust Ins/Dx (Insurance and Diagnosis)

Press **I** and **ENTER** to change any of the information on the insurance header screen. See the "Invoice Header Screen" section for more information about this data.

L - Collection

Toggle the collections field by pressing **L**. Pressing this key will put an invoice in and take it out of collection status. To put an invoice into collection, press **L** then **ENTER**. The message "COLLECTN" appears next to BALANCE at the top of the screen. The system will not include this invoice in the statement and claim form batch operations until its status has been changed to non-collection. The claim will also not be deleted in the Period-End Purge even if the balance is zero. To change the status, press **L** then **ENTER** a second time. The "IN COLLECTION" message disappears and the option line reappears.

H - Hold Bills

The hold option is also a toggle. Press **H** then **ENTER** to place an invoice on hold. When monthly statements are run, the invoice won't be aged or printed. The message "HELD" appears next to balance at the top of the screen together with the date placed on hold. To remove the hold status, simply press **H** then **ENTER** again. Invoices that are on hold are not purged in the Period-End Purge even if the balance is zero.

F - Print Ins. Forms

Use this option to print an insurance form or an invoice on demand. The invoice can be handed to the patient to serve as a receipt. If your practice does not accept insurance company assignments in your practice, this prompt could be used to print an insurance form as a courtesy to the patient, who can then submit it to his or her insurance company for reimbursement. **Note that printing an insurance form from Daily Input does not age the invoice.** Also, if an insurance form is printed in Daily Input, the form will not be reprinted in batch unless you specifically instruct the program to do so. See Chapter 9, Printing Insurance Forms, for details.

To print a form, press **F** **ENTER**. The box shown in Figure 6.1 appears.

Make sure the printer is connected, on-line, and loaded with the proper forms.

Note: *On multi-tasking systems, each terminal can use it's own printer. This may lock up your terminal. Special printing setup may be required to allow all users access to this function. See Chapter 21, Insurance Forms from Daily Input.*

A list of the forms available will be displayed, move the highlight to select the correct form and press **ENTER**.

If any general form is indicted (one with "====" for the company match) and the patient is responsible for this claim, a prompt similar to this appears for each carrier listed for this patient that matches the wildcard on the form.

Name	Ins Code	Version/Purpose	Length
HCFAL	====	HCFA form for Laser printers	66
HCFAMD	MD==	HCFA 1500 for Medicaid PA	66
HCFA	====	HCFA 1500 standard form 66	66
INVOICE	PT	Patient Invoice Format	66
LHCF	====	test for landscape	60
PAMD	MD	PA Medicaid form	66
TEST	====	To test data fields	66
TOTALS	====	Test totals at bottom of invoice page	33

CHARGES: 35.00 - PAYMENTS: 31.40 = BALANCE DUE: 3.60

Figure 6-20: Select Insurance Form

#	Procedure	NOS	Loc	Rsp	Amount
E	PRINT FORM FOR MC ?				4.40

Figure 6-21: Printing Forms for Patients

When printing the forms the prompt will repeat for each insurance company that matches the wildcard and is listed for the patient. Press **[Y]** for each form needed, press **[N]** for any unnecessary forms.

This allows your practice to print insurance forms as a courtesy for your patients at the time of service and send them to the patient. These only work from Daily Input, in batch printing the claims are printed to the primary, secondary, tertiary and workers' compensation carriers when they are the billing party on the claim and the patient responsible claims are only printed if they are requested.

Note: To print a paper claim form for a carrier that is usually sent electronically, it is easiest to print them one at a time form this option.

B - Billing Party

Press **[B]** to change the Billing Party. This field will not accept an insurance code that was not preset on this patient's insurance screen.

W - Write- Off Bal

Press **[W]** to write off the balance of this claim. The billing party on the claim is entered as the FROM, the amount is the balance due, and the method is marked as "WO". Then the REDO? prompt is displayed. To make changes to the write-off information press **[Y]** and make your changes then press **[ESC]** to record the write-off. Press **[ENTER]** to the REDO? prompt and the write-off is recorded as displayed. Use this option instead of a payment with a w/o code for quicker data entry.

V - Inv Overview

Press **[V]** to view all invoices, select a different invoice by moving the highlighted bar. The highlighted invoice can then be selected or functions listed at the bottom of the screen can be selected. See page 7-2.

= - Calculator

Press **[=]** to start the calculator. For more information on the calculator see Chapter 18, Calculator.

R - Resubmit Insurance

Press **[R]** to change the status of an invoice to NO BILL PRODUCED. This will allow the invoice to be selected in the next batch of new claims that are printed.

M - MC Approved / Paid

Press **[M]** to see the amount that is approved by Medicare as the Medicare allowed for one unit of service and then the amount that Medicare will pay for that one unit of service. Remember this is a percentage of the Medicare allowance or approved amount, the percentage is supplied as part of the Practice Set-up and is currently 80%. A sum of the Medicare Approved Amount for this invoice is displayed at the end for all charge lines. If a line has more than one unit of service the sum will factor the units into the Medicare Approved Amount. If the Medicare Allowed amount is changed, it is stored for this transaction for reports that are generated later. If the Medicare approved amounts, or expected payment amounts need to be updated from the file, just erase each one as it is displayed. Then press M to step through them again. The new numbers will be calculated and displayed.

? - Ins Note

Press **[?]** to display the patient and insurance company notes. The notes can be changed if necessary at this time. Refer to page 6-10 for more information about this screen.

X - Exit

Press **[X]** to return to the Patient Menu and end this invoice.

Q - Quit

Press **[Q]** to return to the MOS Main Menu quickly from this menu.

> - Send Log

Press **[>]** to view the Send Log. This will list a dated entry for each time the claim has been submitted. This includes electronic, insurance claims and patient claims or statements. The billing party for that submission is listed and how the claim was sent.

P Paper Claim
E Electronic Claim
O Daily Input
S Patient Statement

The browse display included a **[H]** hardcopy choice to get a paper copy of the claim.

^ - Show Prov

Press **^** to replace the Procedure Description on a charge line with the Rendering Provider ID. This will only last until you select another option from these items or move to another invoice or patient. Since some practices must enter a Render Provider on each line item this is a quick way to double check the data entry.

Ending an "Add Records" Daily Input Session

If you've been adding patients, finish entering data in the last patient record, save that record, and then, when the next new record appears on the screen, press **[CTRL] + [BREAK]** to exit from "Add Records" mode. Press **[X]** to exit to the Daily Input selection menu, and **[X]** to return to the main menu.

Changing Records

You can change any entry on any Medical Office System patient record, except those the cursor skips, and the account and invoice numbers, which are assigned by the system to prevent duplication. Charge lines, adjustments, notes and payments can be added to any invoice, even after it has been submitted. A warning message is given if the claim has been submitted, but you can still continue if you choose.

Medicare Claims with Lab Procedures

Special things happen when entering a claim for a Medicare patient with lab charges. Lab procedures are always billable to Medicare even if the patient is responsible for the claim, so if a lab procedure is listed (as indicated by the TOS code on the procedure which matches the Lab TOS code entered on the Practice Setup) on a patient responsible claim, the claim will be split into two claims. The lab charges will be moved to a second invoice with Medicare as the responsible party and the rendering physician entered as the referring physician.

The split will happen under the following conditions:

1. A Medicare patient with a patient responsible claim listing any lab procedures will split. The resulting claim listing the lab charges will list the rendering physician as the referring physician.
2. A Medicare claim with lab charges and no referring physician listed will split. The claim is split with the lab charges listed with a referring physician entered the same as the rendering physician.
3. A Medicare claim with lab charges and the referring physician is not the same as the rendering physician (based on the key code). The lab charges are split and the rendering physician is entered as the referring physician on the lab claim.

When the claim is split, if the rendering physician code is not also entered in the referring physician file, it will be added the UPIN ID# will be requested if it is not known.

If a claim is entered with Medicare responsible, the charges used are always the standard charge.

If a claim is entered with the patient responsible, but the patient has Medicare as one of their carriers, the charges used will always be the Medicare allowed amount.

The charge amount is not recalculated if the billing party is changed after the claim is entered. If a patient responsible claim is split to list Medicare lab on a separate invoice the charge on the claim for the lab will be the Medicare allowable amount, not the standard charge. This will not affect the amount you are paid, the only thing affected will be the amount written off in excess of the Medicare allowable amount.

Lab Assignment for Medicare forms

Use form field 114, in pos 39 to change not assigned to assigned on claims where the patient assignment is not Yes and the responsible party is MC (Medicare) and the TOS is 05 (Lab). Currently, you may have used form field 94.

CLIA Numbers on Lab Claims

CLIA numbers are assigned to an office that does lab work. It is to be reported on claims whenever lab work is done in an office. So some things must be set properly for the claims to respond to this combination of information.

Default TOS code for LAB work

First look in the Practice Information data and see the code designated as TOS for LAB. It is found on the Misc Options screen. In most cases, this code should be 05. If you have set it to some other code then all TOS codes used for LAB work should be set to this same code. If you have left it blank, no CLIA number will be used. (Be sure the code is not starting with a space.)

Default POS code for OFFICE

On the same screen in the Practice Information data that you found the default TOS for LAB there is also a default POS for OFFICE. Verify that this code is set to "11". That is usually the code used for OFFICE.

TOS code on Procedures for LAB work

Now look in the Procedure Data at the procedures that are used for LAB work. Is the TOS for the Standard Charge the same code as the Default TOS for LAB that we checked in the previous step? If not, the software has no way of knowing that this is a lab procedure.

To fix a large number of incorrect TOS codes, we have a utility that was installed for the 3.0 MOS upgrade. It will easily change all the 5 codes to 05 or any other similar change. To use this utility

on a UNIX system type: “mos mosupgd” at a Unix Prompt. To use this option on a DOS platform, type “mos30u” from the Prompt. On the menu that is displayed, select “3-Update TOS Codes in Procedures”. It will show you each TOS that is used and ask you what code should be used instead.

POS for Office on Location Data

POS code must be for office on any location that is used for office claims. On the same location record is the CLIA # assigned to the office.

Paper Insurance Forms

On a paper claims, the Insurance form field should be 933 and is placed in the correct position on the claim. This number will print on all claims that are done in that location. There is currently no need to only print the CLIA # on claims with lab charges. They ignore it if no lab charges are present. They just require it be there when there are lab charges listed.

Electronic Claims

On electronic claims, the logic is more sophisticated. The CLIA # is submitted on claims with the service line detail. It is only sent if the TOS is for LAB and the POS is for OFFICE on a service line that is for LAB work.

If you have verified the codes are entered correctly in the files above and you still find that the CLIA # is not printing or sending electronically please give us a call. We will gladly review the data files with you.

Medicare Allowances

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	100.00

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 $85.00 \times .95 = 80.75$

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.

Certification or Narrative Screens

If you indicated that a narrative or a certification are necessary it will be displayed next.

A narrative screen allows for a explanation that would help you get paid. It has not specific format and allows for any kind of data to be entered.

Narrative Screen

1 Ms. Helena M Adells	PT PATIENT
Provider: Vicki G Henry M.D.	
Invoice: 02/21/03 271 1	Medicare Primary NO BILL PRODUCED
CHARGE Statmnt Ins a 022103	Insurance: MC BS AARP AR1
Date To Date Dx# Times Loc Amount Rendering Provider	
02/21/03 02/21/03 1 1 1 32.00 1 VICKI G HENRY M.D.	
Procedure Procedure Description	Mod1 Mod2 Mod3 Mod4 Narr TYPES
FORM GC0	CHIROPRACTIC CERTIFICATION KA
Treat-Dt Xray-Date #Series Lev-Sub Tr- m/y #Tr-Month	
02/21/03 02/21/03 012 001 C1 03 M 02	
Nature Manis-Date Comp-Ind X-ray Indicator	
A 02/01/03 C V	
Back Pain	Symptoms Description
Enter Free Form Description of Patient's Condition	

Figure 6-22: Narrative Data Screen

Chiropractic Screen

A Chiropractic Certification is also available, if you indicated GC0 for the type above. This would present a screen with these fields:

4 Joyce Afish	AR5 Association Of Retired 3
Provider: John R Candy M.D.	
Invoice: 07/30/98 228 12	AGE 1 102799
CHARGE Statmnt 102799 Ins W 102799	Insurance: BS AR5
Date To Date Dx# Times Loc Amount Rendering Provider	
07/30/98 07/30/98 1 1 1 50.00 12 V	
Procedure Procedure Description	Mod1 Mod2 Mod3 Mod4 Narr TYPES
FORM GC0	CHIROPRACTIC CERTIFICATION KA
Treat-Dt Xray-Date #Series Lev-Sub Tr- m/y #Tr-Month	
05/24/00 05/24/00 005 010 T1 04 M 02	
Nature Manis-Date Comp-Ind X-ray Indicator	
A 05/24/00 C V	
THIS IS A TEST	Symptoms Description
Enter Code to Indicate the nature of the patient's Condition A -Acute C -Chronic M -Acute Manifestation of Chronic	

Figure 6-23: Chiropractic Certification Screen

- Treatment Date** Enter the date of Initial Treatment.
- Xray Date** Enter the date of the Last Xray.
- #Series** Enter first the number in the series and then in the next spot the Total Number in the series. For example, 5-10 would be treatment 5 in a series of 10.
- Level - Sub** Enter the Level of Subluxation Code(s). One or two codes may be entered. Use Browse to select from a list of codes.
- Tr- M/Y** Enter the number of treatments and then the M or Y to indicate per month or per year.
- #Tr-Month** Enter the number of treatments this month. This will increment from the last GC0 created if you chose to copy the data. It is up to you to indicate that a month has passed and start the count to 1 again when appropriate.
- Nature** Enter the Nature of the Patient's Condition. Code values are displayed on the screen.
- Manis-Date** Enter the date of acute manifestation.

Comp-Ind Enter Complication Indicator. The code choices appear on the screen.

X-ray Indicator Enter **Y** if xrays are kept on site for review. **N** o if they are not.

Symptoms Description Enter a description of the symptoms.