



Allscripts® Practice Management 22.0.x

System Setup

Reference Guide

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Chapter 1

Practice Set Up or Organization Set Up

Practice Set Up or Organization Set Up setup checklist

Use this checklist to record the completion of each tab on **Practice Set Up or Organization Set Up**.

Tab	Completed
Practice Information or Organization Information	
Reporting Periods	
Patient Additional Info	
Voucher Additional Info	
Profiles > Billing Numbers > Diagnosis Codes > Fees > Place of Service > Procedure Codes > Referring Dr. Codes > Specialty > Type of Service	
Billing Numbers	
Taxonomy Codes	
Chart Number Locations	
Office Manager tab for pending claims	
Office Manager tab for unpaid claims	
Automation tab for billing	

Tab	Completed
Automation tab for self-pay collections	

Practice Set Up or Organization Set Up window

Use **Practice Set Up or Organization Set Up** to define templates or enter information used when you perform daily tasks such as registering patients, billing insurance carriers, and tracking financial information.

Practice Set Up or Organization Set Up contains these tabs:

- > Practice Information or Organization Information
- > Reporting Periods
- > Patient Additional Info
- > Voucher Additional Info
- > Profiles
- > Billing Numbers
- > Taxonomy Codes
- > Chart Number Locations
- > Office Manager
- > Automation
- > History

To access **Practice Set Up or Organization Set Up**, go to **System Administration > Practice Set Up > System Administration > Organization Set Up** or press **F9** and then enter **PSU** or **OSU** as applicable.

Practice Information or Organization Information tab

Use the **Practice Information or Organization Information** tab in **Practice Set Up or Organization Set Up** to store information about your practice or organization to be used on claims, forms, transaction acknowledgments, and other items.

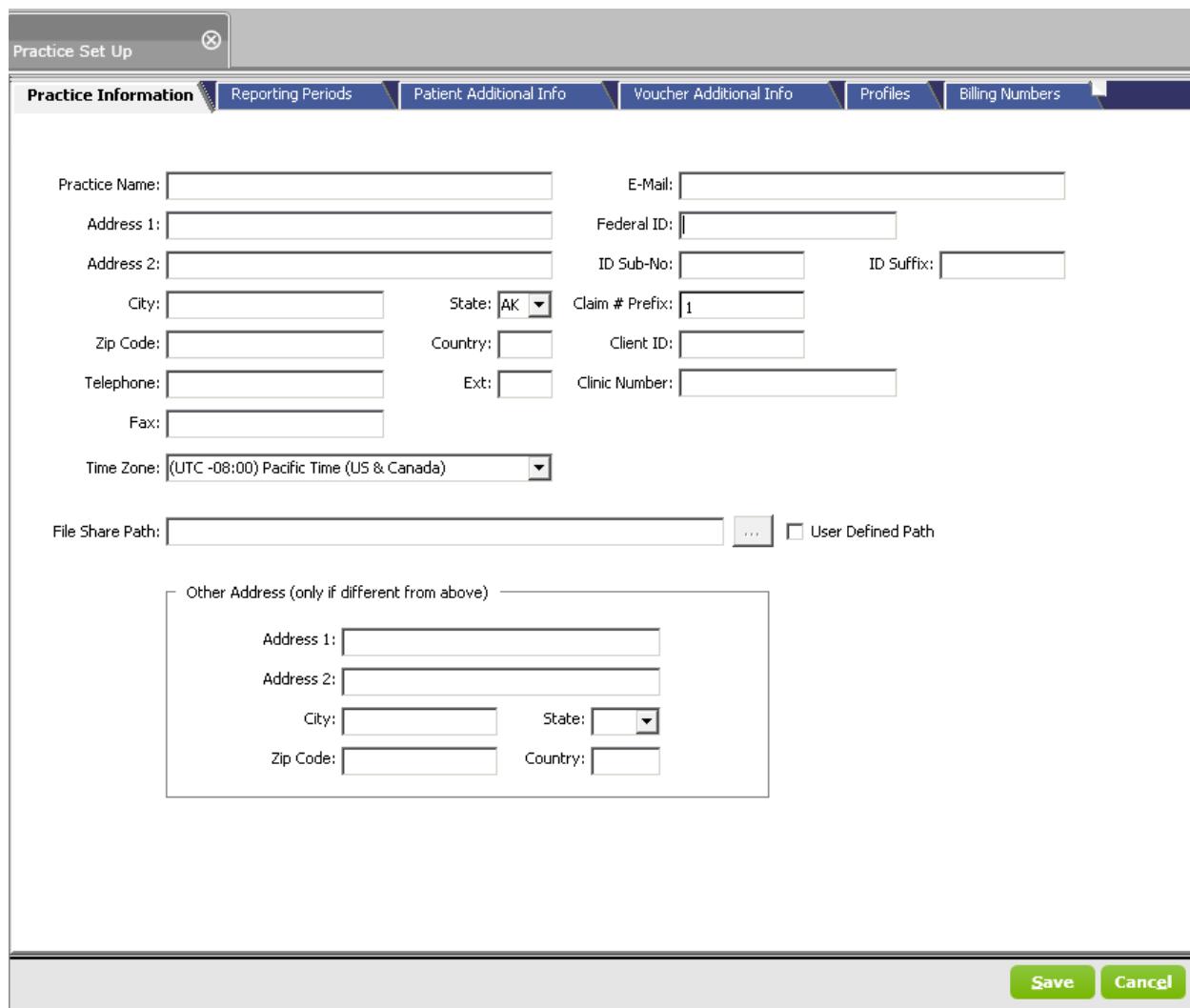
The information entered on this tab can be used in the following ways.

- > As pull or merge fields when generating quick documents, recalls, encounter forms, medical record slips, and so on
- > To print on claim forms or output to a claim file when **Practice** or **Organization** is selected as the billing method option for claim formats
- > As part of the header when generating statements or occupational medicine invoices

Name and main address values are displayed or printed in the following conditions.

- > You print transaction acknowledgments, either as a receipt or an invoice
- > You view and print from **Account Inquiry**, **Financial Inquiry** and **Service Inquiry**

Access the **Practice Information** or **Organization Information** tab from **Practice Set Up or Organization Set Up**. To access **Practice Set Up or Organization Set Up**, go to **System Administration > Practice Set Up or System Administration > Organization Set Up** or press **F9** and then enter **PSU** or **OSU** as applicable.



The screenshot shows the 'Practice Set Up' window with the 'Practice Information' tab selected. The form contains the following fields:

- Practice Name:** [Text Box]
- E-Mail:** [Text Box]
- Address 1:** [Text Box]
- Federal ID:** [Text Box]
- Address 2:** [Text Box]
- ID Sub-No.:** [Text Box]
- ID Suffix:** [Text Box]
- City:** [Text Box]
- State:** [Select Box] (e.g., AK)
- Claim # Prefix:** [Text Box] (e.g., 1)
- Zip Code:** [Text Box]
- Country:** [Text Box]
- Telephone:** [Text Box]
- Ext.:** [Text Box]
- Clinic Number:** [Text Box]
- Fax:** [Text Box]
- Time Zone:** [Select Box] (e.g., (UTC -08:00) Pacific Time (US & Canada))
- File Share Path:** [Text Box] with a browse button (...) and a checkbox for User Defined Path.
- Other Address (only if different from above):** [Section]
 - Address 1:** [Text Box]
 - Address 2:** [Text Box]
 - City:** [Text Box]
 - State:** [Select Box]
 - Zip Code:** [Text Box]
 - Country:** [Text Box]

At the bottom right are the **Save** and **Cancel** buttons.

Practice Name or Organization Name

Enter the name of your practice or organization exactly the way you want to print, for example on a claim form, an encounter form, a medical record slip, patient statements, a quick document or document, and so forth. You can use up to 30 characters.

This box is an optional pull filed in the following conditions.

- > You create encounter forms and medical record slips
- > When you select **Practice or Organization** as the **Billing Address Option** in **Paper Claim Format Maintenance**

The practice or organization name is included in the header information when you select **Practice or Organization** as the statement option.

Practice or organization main address

Enter your practice or organization address exactly the way you want it to print on claim forms, encounter forms, medical record slips, patient statements, occupational medicine invoices, quick documents, documents, and so on.

Keep the following items in mind when you enter the main address:

- > The words **PO Box** cannot be in the address submitted on v5010 electronic claims or printed on CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms. If the main address contains a PO Box number, enter a street address as the other address and set up **Billing Method Address** to use the other address for claims.
- > For v5010 electronic claims, you must enter a full, nine-digit ZIP Code. If you do not know your four-digit additional number, use <your ZIP Code>-9998. For example, enter 27615-9998.
- > **Address 2** outputs to electronic claim files, but does not print on paper claims.
- > The main address boxes are available as pull fields for encounter forms and medical record slips.
- > The main address prints on statements or occupational medicine invoices when you select **Practice or Organization** for **Header Information** on the **Statements** tab or **Occ Medicine** tab in **Practice Options** or **Organization Options**.
- > The main address is displayed in the header when you right-click and select **View** in **Service Inquiry** and **Financial Inquiry**.
- > **State** is a two-letter abbreviation. Abbreviations of the US territories are listed after the 50 states.
- > **Country** holds up to two characters and is optional.
- > For v5010 electronic claims, the main address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Practice or Organization**, and **Billing Method Address** in **Claims Style Maintenance** is set to either **Billing Method Address** or blank.

- > For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the main address (except **Address 2**) prints when **Billing Address Option in Paper Claim Format Maintenance** is set to **Practice** or **Organization**, and **Billing Media** and **Billing Method Address in Claims Style Maintenance** are set to **Paper** and either **Billing Method Address** or blank respectively.

Telephone

- > Requires a 10-digit value.
- > Used as a pull field when you set **Header Information** to **Practice** for statements or occupational medicine invoices.
- > Used as an optional pull field for encounter forms and medical record slips. Included in the header for patient service and financial inquiries.

Ext

- > Holds up to five characters.
- > Used as an optional pull field for encounter forms and medical record slips. Included in the header for patient service and financial inquiries.

Fax

- > Requires a 10-digit value.
- > Used as an optional pull field for encounter forms and medical record slips. Included in the header for patient service and financial inquiries.

Time Zone

- > Controls the default time zone for your practice or organization.
- > Allscripts® Practice Management supports all of the Microsoft®-defined time zones, as well as 26 additional time zones. These include the following 12 US timezones (including US territories), as well as 156 international time zones.

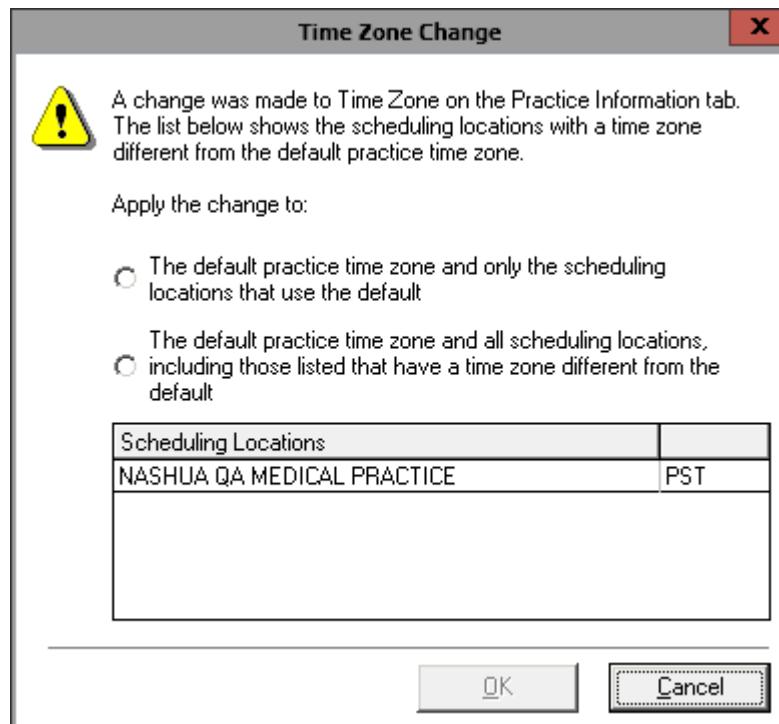
Description	Display name	Abbreviation
Hawaiian Standard Time	(UTC - 10:00) Hawaii	HST
Alaskan Standard Time	(UTC - 09:00) Alaska	AKST
Pacific Standard Time	(UTC - 08:00) Pacific Time (US & Canada)	PST
US Mountain Standard Time	(UTC - 07:00) Arizona	MST
Mountain Standard Time	(UTC - 07:00) Mountain Time (US & Canada)	MST

Description	Display name	Abbreviation
Central Standard Time	(UTC - 06:00) Central Time (US & Canada)	CST
Eastern Standard Time	(UTC - 05:00) Eastern Time (US & Canada)	EST
US Eastern Standard Time	(UTC - 05:00 Indiana (East))	EST
Atlantic Standard Time Note: Use this option for locations in the Atlantic time-zone region that do not use Daylight Saving Time, such as Puerto Rico and the US Virgin Islands.	(UTC - 04:00) Atlantic Time	AST
Hawaii-Aleutian Standard Time	(UTC - 10:00) Hawaii-Aleutian	HAST
Samoa Standard Time	(UTC -11:00) Samoa ST	SST Samoa
Chamorro Standard Time	(UTC +10:00) Chamorro ST	ChST

Note: For a complete list of Microsoft®-defined time zones, go to [https://msdn.microsoft.com/en-us/library/ms912053\(v=winembedded.10\).aspx](https://msdn.microsoft.com/en-us/library/ms912053(v=winembedded.10).aspx).

If all scheduling locations use the default time zone for the practice, when you change the time zone selected in **Time Zone** and click **Save**, the default practice time zone is updated and all scheduling locations use that new time zone.

If one or more scheduling locations use a time zone different from the default time zone for the practice, when you change the time zone selected in **Time Zone** and click **Save**, **Time Zone Change** opens. A list of scheduling locations with time zones different from the practice time zone are displayed.



Use this window to select how you want to update the time zone for scheduling locations:

- Update the default practice time zone and only the scheduling locations that use the default.
- Update the default practice time zone and all scheduling locations, including scheduling locations with a time zone that is different from the default time zone.

E-mail

Informational only

Federal ID

- > Enter the Tax ID number assigned to your practice or organization or to the provider.
- > Can be used when billing insurance claims.
- > Used as a pull field when the options **Federal ID** and **Practice or Organization** are selected as the **Tax ID Source** and the **Tax ID Option** for paper and electronic claim formats in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

ID Sub-No

- > Some payers and clearinghouses require that you include a site ID along with the billing provider's information.
- > Enter the number as it needs to be reported.

- > Applies when submitting v4010A1 claims when you select **Individual Provider** for the option **Output Site ID for ANSI 837** formats the claim style associated with the payer.
- > Used as a pull field when you select **Practice/Organization** as the header information for statements or occupational medicine invoices.

ID Suffix

- > Use for additional billing information required by a payer/clearing house.
- > Outputs to a claim file when you select option **Append ID Suffix to Federal ID** on the **Output Options** tab in **Claim Style Maintenance** for the claim style associated with the payer.
- > Applies to both v4010A1 and v5010 formats.

Claim # Prefix

- > Enter your practice or organization's assigned tenant number.
- > Intended for use when billing or payment entry functions are shared between multiple tenants. Assign each tenant a unique number to identify the source of a claim.

Tip: If you have multiple tenants that share charge entry and payment entry functions, assign each tenant a unique number, such as "1", "2" and so on. Enter this unique number as the **Claim # Prefix**. Then by selecting the appropriate option in **Claim Style Maintenance** this claim # prefix is appended to the claim number. This in turn helps you to quickly identify which tenant claims are printed or transmitted from.

- > The setting for **Claim # Prefix Option** on the **General** tab in **Practice Options** or **Organization Options** determines whether this claim number prefix or the claim number prefix defined in **Department Maintenance** or **Practice Maintenance** is output on claims.
- > Can be used as a pull field when you select the related claim style output option. Prints in Box 26 on the Standard CMS-1500 ICD-10 Standard (02/12) claim form.
- > If you use an 837 ANSI format, it is a best practice to enter a unique claim number prefix, even if you only have a single tenant. Outputs to Segment CLM Loop 2300.

Client ID

- > Enter the client number assigned to your practice or organization by Allscripts®.
- > Required box if you use iBill or iRemind. **Client ID** is displayed on **About Allscripts PM**.

Clinic Number

- > Enter your assigned number only when you are directed to do so by a member of Allscripts® Support.
- > Intended for clients transmitting claims through BCBS of Michigan EDI.

- > The clinic number is reported when the related output option is selected in **Claim Style Maintenance**.

User Defined Path

When you select **User Defined Path**, **File Share Path** and the browse button (...) are enabled.

Important: Only select **User Defined Path** if you are part of a client hosting environment that is shared by one or more practices, and you need to designate a practice specific file server name to be referenced and used by Allscripts® Practice Management.

File Share Path

Important: **File Share Path** is now unavailable for hosted clients, to prevent the default path from being changed by mistake.

- > By default this box is unavailable and blank. When this box is unavailable and blank, the system checks to verify if the Application Server Name exists in the application registry reference. If it does exist, all application file share reference points to: \\<Application Server Name>. <Domain Name>\NtierFiles\<Tenant Name>. If the Application Server registry item is blank, the application defaults to the Application Path (where the executable is located) and the application reference points to: C:\Program Files\CompuSense\ntierprise for Healthcare\.
- > To specify a new file share path, click ..., which opens a **Browse for Folder** window that you use to choose a new file share path. You must select **User Defined Path** for this box and button to become enabled.
- > The file share path can be any path that is set up on the local system, application server, or specific file share server.
- > The file share folder structure should be the same as the NtierFiles folder structure used by default by Allscripts® Practice Management.
- > The **Save** button validates that a path already exists and notifies you that changing the file share path causes existing files in the previous file share location to not be available to Allscripts® Practice Management. The following message displays: Changing the File Share Path does not move any already created subfolders. Are you sure you want to make this change?

Note: This box is required when it is enabled. If you try to save without filling this box when it is enabled, an error message is displayed.

Other Address (only if different from above)

Optional: The address you enter must be different from the main address at the top of the window. Use these boxes if you entered a PO Box in the main address.

Keep the following items in mind when you enter the other address:

- You cannot partially fill the **Other Address** area. For example, if only **Address 1** is different from the main address, you must fill each required box in the **Other Address** area, not only **Address 1**. If you fill all of the boxes in the **Other Address** area, you will not get an error if optional boxes, such as **Address 2** or **Country**, are filled.
- For v5010 electronic claims, you must enter a ZIP code plus a four-digit additional number. If you do not know your four-digit additional number, use <your ZIP code>-9998. For example, enter 27615-9998.
- For v5010 electronic claims, the other address outputs when **Billing Method in Electronic Claim Format Maintenance** is set to **Practice or Organization**, and **Billing Method Address in Claims Style Maintenance** is set to **Billing Method Other Address**. Use this other address to output either billing provider information to Loop 2010AA or pay-to address information to Loop 2010AB. The information in these boxes does not output to a v4010 claim file.
- For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the other address (except **Address 2**) prints when **Billing Address Option in Paper Claim Format Maintenance** is set to **Practice or Organization**, and **Billing Media** and **Billing Method Address in Claims Style Maintenance** are set to **Paper** and **Billing Method Other Address** respectively.

Reporting Periods tab

Use the **Reporting Periods** tab to define periods of time used to group financial information.

Access the **Reporting Periods** tab from **Practice Set Up** or **Organization Set Up**. To access **Practice Set Up** or **Organization Set Up**, go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press F9 and then enter **PSU** or **OSU** as applicable.

Practice Set Up

Practice Information		Reporting Periods		Patient Additional Info		Voucher Additional Info		Profiles		Billing Numbers			
February		2014		March		2014		April		2014			
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1							1
2	3	4	5	6	7	8	2	3	4	5	6	7	8
9	10	11	12	13	14	15	9	10	11	12	13	14	15
16	17	18	19	20	21	22	16	17	18	19	20	21	22
23	24	25	26	27	28		23	24	25	26	27	28	29
							30	31					
02/25/14		<				>							
Monday, March 31, 2014 <input type="checkbox"/> Start of Reporting Period Abbreviation: <input type="text"/> <input type="checkbox"/> Start of Reporting Year <input type="checkbox"/> Set Lock Date Lock Date: (not set) Last Lock Date: January 01, 2010 12:00 AM set by Compusense Compusense on April 19, at 11:17 AM													
<input type="button" value="Save"/> <input type="button" value="Cancel"/>													

Start of Reporting Period

A reporting period is a custom defined period of time used to group financial information. By defining the start of a reporting period, you are telling the system when to begin and when to end calculating financial data for reporting purposes.

Reports run by reporting period pull information from batches that were updated on the start date of the specified period up to and including the day before the start of the next reporting period.

For example, if March 4th is selected as the start of the reporting period of March and April 4th is checked as the start of the reporting period of April, then the reporting period of March covers all the financial transactions updated on March 4th up to and including all those transactions updated on April 3rd—even those updated after you physically open this tab and

select April 4th as the start of the new reporting period. All transactions updated on April 4th are included in the reporting period of April.

Start of reporting year

Defining the start of a reporting year enables you the option to compare the productivity of the current period/range of periods to the current YTD total using the Productivity Analysis and the Procedure Analysis.

The application is programmed to define a reporting year as including reporting periods of less than but not more than 12 months, the counter begins with the date you check as the start of the reporting year.

Use this option only if you have the need or desire to report on YTD totals.

Set lock date

Setting the lock date gives your practice or organization the ability to prevent transactions journals from being updated during month end processing, which helps to ensure journals are updated to the correct reporting period. For example, it is common for a practice or organization to have lag time at the end of a month while charges and payments are finished being posted for a reporting period before beginning a new period. During this time new transactions may be entered for the new reporting period. The **Set Lock Date** option helps a practice or organization keep the new transactions from being updated to the prior reporting period.

Once a lock date is set, the system compares the current system date to the lock date. If the system date is greater than or equal to the lock date, users that do not have the proper security permissions cannot access the **Transaction Journal** tab in **Financial Posting**. The lock date is cleared when the start of the next reporting period is set. The lock date can be set in advance as long as it is in the current reporting period.

When a user accesses **Financial Processing**, Allscripts Practice Management™ checks the user's security permissions for Transaction Journal and Override Set Lock Date. If the user has permissions for the **Transaction Journal** tab, the system checks to see if a lock date is set.

If a lock date is not set and the user has permission for the **Transaction Journal** tab, the user can access the **Transaction Journal** tab.

If a lock date is set, the system compares the current System Date to the lock date and one of three things occurs:

- If the current system date is before the lock date and the user has permission for the **Transaction Journal** tab, the user can access the **Transaction Journal** tab.
- If the current system date is on or after the lock date and the user does not have permission to Override Set Lock Date, all of the boxes on the **Transaction Journal** tab are disabled and a message displays on the tab.

- > If the current system date is on or after the lock date and the user has permissions to Override Set Lock Date, the **Transaction Journal** tab is enabled and a message displays on the tab.

If a user does not have permission for **Financial Posting**, the **Financial Posting** folder does not appear in the navigation pane on the left side of the window.

The system also checks the lock date when you click **Run**, in case a user was already in the **Transaction Journal** tab when the lock date was set. If the user does not have Override Set Lock Date permission and the current system date and time is on or after the lock date, a message displays when you click **Run**.

Tip: Your practice or organization should establish policies and procedures for processing batches during the lock period. Establishing meaningful batch naming conventions such as including the deposit date for payments or using the date in the Batch# to determine the reporting period to which the batch belongs is recommended.

Note: When the automated billing process is active, it runs regardless of whether a lock date is set.

Patient Additional Info tab

Use the **Patient Additional Info** tab in **Practice Set Up** or **Organization Set Up** to create custom boxes for storing patient information.

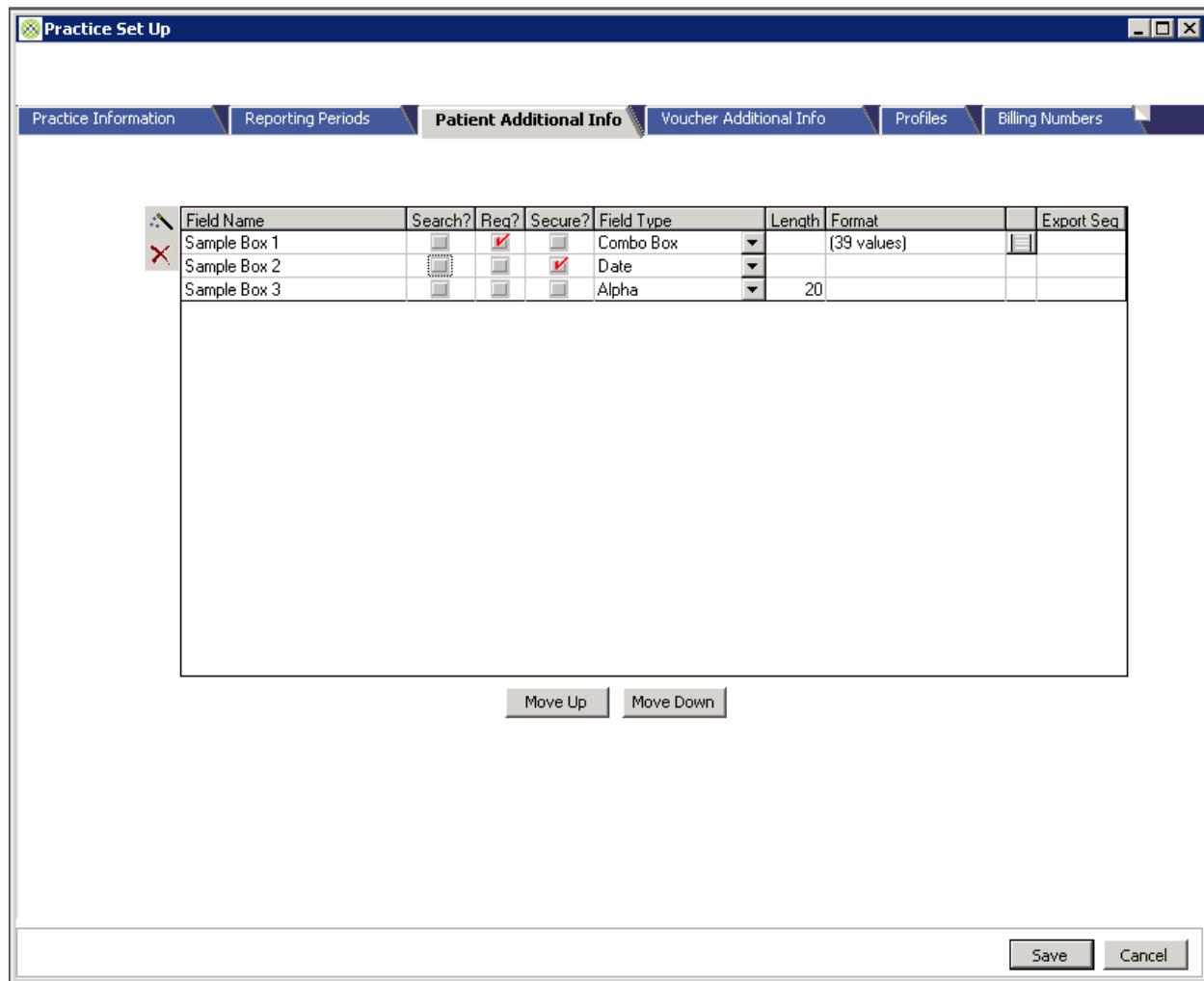
Adds the **Additional Info** tab to **Registration**.

Reportable using the general view **vwGenPatAdditInfo**.

Tip: The first 25 boxes correspond to the 25 **Additional Info** pull fields available when you create a document in **Document Maintenance**.

Access the **Patient Additional Info** tab from **Practice Set Up** or **Organization Set Up**. To access **Practice Set Up** or **Organization Set Up**, go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **OSU** as applicable.

Chapter 1 Practice Set Up or Organization Set Up

**Field Name**

Holds up to 40 characters.

Note: All values entered for **Field Name** are included in the drop-down list for **Patient Additional Info Field Name** on the **Registration** tab in **System Administration > Practice Options** (or **Organization Options**). You can use the **Patient Additional Info Field Name** to display additional information in the patient banner.

Search?

When selected the box is added to the **Search By** options on the **Patient Lookup** window. You can select or clear a box as searchable at any time.

Req?

When selected, you cannot save entries on the **Additional Info** tab in **Registration** until this box is filled in.

You can select or clear a box as required at any time.

Secure?

When you select the check box in **Secure** for a patient additional information box, the security permissions defined in **Administration > Security Manager > Security Permissions** are applied to that box. You can only view or edit the box if you have permission to do so.

If you do not have access to a secure patient additional information box, the box is not displayed on the **Additional Info** tab in **Patient Management > Registration** or in any other areas of Allscripts® Practice Management, such as patient banners or the **Summary** tab in **Patient Management > Registration**.

Note: If you do not have access to secure patient additional information boxes but do have permission to create documents in **Document Maintenance**, you can view and include secure patient additional information boxes on any documents you create. These boxes are also displayed when the documents are printed. Secure patient additional information boxes are also displayed in **Automatic Registration**, on encounter forms, and can be included in demographic exports and imports.

Field Type

Restricts the kind of information that you can enter in the box. The available fields types are:

- > **Alpha**
- > **Alpha or Zero-Filled**
- > **Combo Box**
- > **Date**
- > **Number**
- > **Telephone**
- > **True/False**
- > **Zero-Filled**

Length

Field types that require a defined length are **Alpha**, **Alpha or Zero-Filled**, and **Zero-Filled**.

You can define a length of up to 80 characters. However, standard definitions should match the expected length of the data to be entered.

Format

Field types that require a defined format are **Number** and **Combo Box**.

- > If the **Field Type** is **Number**, enter a format using the pound sign (#) to represent each digit and a period (.) to represent the decimal point. For example, if you want users enter three digits before the decimal point and two after, enter ###.##.
- > If the **Field Type** is **Combo Box**, click  in the unlabeled column to open **Patient Additional Info - Combo Box Values**. The number of values created is displayed in **Format**. The maximum length of **Patient Additional Info - Combo Box Values** is 4000 characters.

Export Seq

Export Seq is meant for use with Allscripts® Interface Engine when importing and exporting data. It enables you to assign a sequence to the boxes that corresponds to the specifications of a vendor without having to reorder all existing entries.

When a vendor requires that a series of boxes be exported in a certain order, enter the number that indicates this **Patient Additional Info** box's order in the export sequence.

Note: Each of these boxes must also be flagged for export in the related information broker format in Allscripts® Interface Engine in **Information Broker Format Maintenance**.

Patient and voucher additional info field types

This topic describes the field types used when creating a patient or voucher additional info field.

Alpha

Enables the user to enter both letters and numbers in the field.

Alpha or Zero-Filled

Allows entry of any combination of letters and/or numbers in the field. Unlike the simple alpha or the simple number types, this option adds leading zeros to any number if its actual length is shorter than the length you define.

For example, if the defined field length is ten, but the actual length of the number entered is eight characters (123678) leading zeros fill in the spaces left by the two missing characters (0000123678).

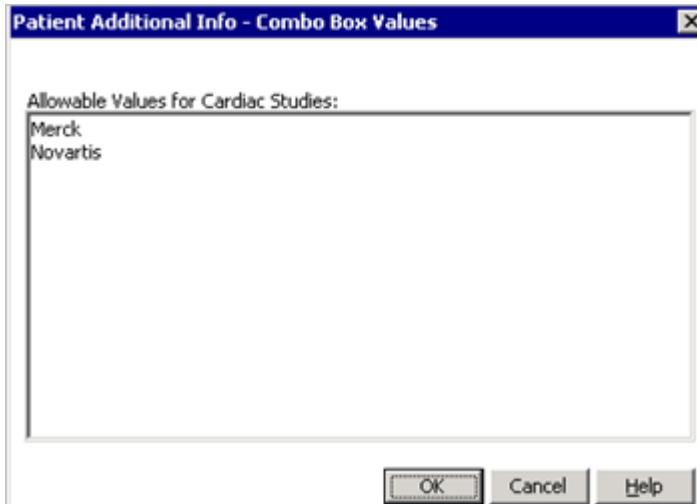
Note: An entry of letters or a combination of letters and numbers

- > does not require the exact number of characters defined in **Length**
- > does not generate leading zeros

Combo Box

Enables you to define a custom list of selections that the operator chooses from when recording information.

You define the combo box pick list using a window that you open by clicking the paper icon (□) in the column between **Format** and **Export Esq.**



Date

Converts any six or eight digit entry to the format of mm/dd/yy or mm/dd/yyyy.

Number

Restricts the entry to numbers only. You do not have to define the length of a number type field. The entry displays as entered; leading zeros are not used.

Telephone

Converts any ten digit entry to the format of (###) ###-####.

True / False

Offers the operator the option of selecting between **True** or **False**.

Zero-filled

Restricts the entry to numbers only. You must define the field length.

Leading zeros are used when the length of the number entered is less than the defined length.

Patient and voucher additional info number formats

The field type **Number** requires that you define a format when you are creating a **Patient Additional Info** or **Voucher Additional Info** field. (**F9 > PSU/OSU**)

The elements used to create a number format are the pound sign (#) and the decimal (.).

- > Use the pound sign to represent each digit
For example: #### allows for the entry of up to a four digit number.
- > Use a period to mark a decimal point where needed.
For example: ###.## allows for the entry of up to three digits to the left of a decimal and 2 digits to the right.

Note: Do not use commas, slashes, dashes or the dollar sign in the format.

Use this table to help you understand how your definition translates to the use of **Number** on **Patient Additional Info** and **Voucher Additional Info**.

Table 1: Formatting the Number field

Defined Format	Entry in Registration	Display in Registration
# ##### (5 #'s)	12345	12345
	123	123
#####.##	123	123.00
	1.23	1.23
	12.3	12.30
	12345	12345.00
	12345.00	12345.00

Create a combo box

You can add a combo box with a custom-defined list of values to the **Patient Additional Info** tab in **Registration** or the **Voucher Additional Info** tab, which is accessible from several different areas in the application.

1. Go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **PSU**, as applicable.
2. Click the **Patient Additional Info** tab or **Voucher Additional Info** tab, as applicable.

3. To create a new entry, click .

4. In **Field Name**, enter a name for the combo box.

For example, if you are creating a box to be used in relation to an Allscripts® Practice Management interface, you might create a combo box field called **County Code**.

5. (Optional) If you are in **Patient Additional Info**, in the column **Search?**, select to add this new field to the search by options on **Patient Lookup**.

6. (Optional) If you are in **Patient Additional Info**, in the column **Req?**, select to require your staff to fill this box before they can save their entries.

7. In the column **Field Type**, select **Combo Box**.

8. Click  in the unlabeled column to open **Combo Box Values**.

9. Enter the name of the first option in your custom list, then press **Enter**.

If you are creating a list for an interface or export used with Allscripts® Practice Management, be sure you follow the directions for entering values.

 **Note:** Never enter a space after the value name.

10. Continue adding entries until you are finished entering all of the values that you need.

Be sure to press **Enter** after each entry to separate them.

11. Click **OK**.

You are returned to **Patient Additional Info** or **Voucher Additional Info**, as applicable. The number of entries you made in **Combo Box Values** is listed in the **Format** column in parentheses.

12. Click **Save**.

Results of this task

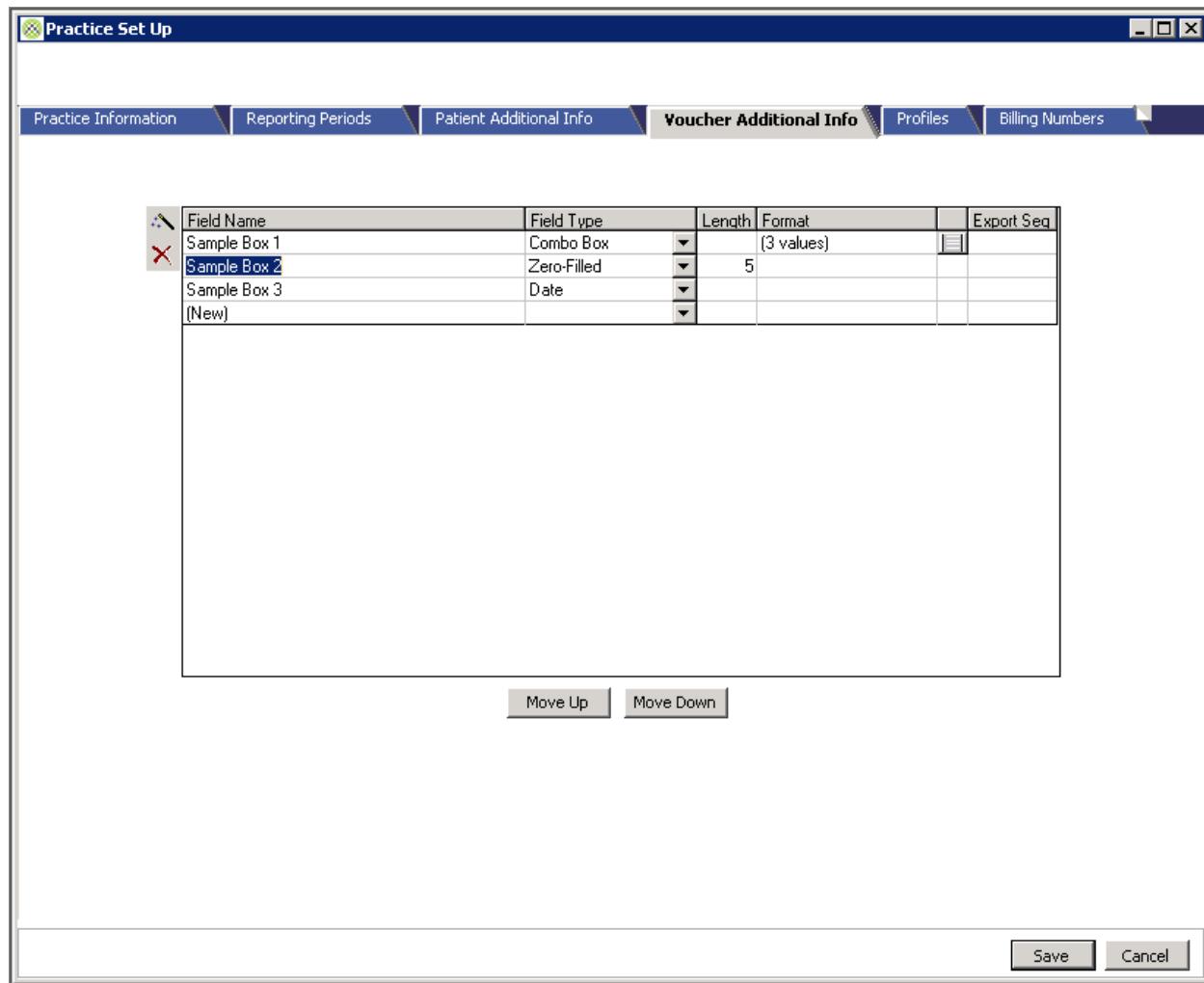
The combo box entry you created is now available from either the **Additional Info** tab in **Registration** or the **Voucher Additional Info** tab, accessible from various areas of the application.

Voucher Additional Info tab

Use the **Voucher Additional Info** tab to create custom boxes for storing voucher information.

Access the **Voucher Additional Info** tab from **Practice Set Up** or **Organization Set Up**. To access **Practice Set Up** or **Organization Set Up**, go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **OSU** as applicable.

Chapter 1 Practice Set Up or Organization Set Up

**Field Name**

You can enter up to 40 characters. You can use letters, numbers, or a combination of both.

Field Type

The available field types are:

- > **Alpha**
- > **Alpha or Zero-Filled**
- > **Combo Box**
- > **Date**
- > **Number**
- > **Telephone**
- > **True/False**

> **Zero-Filled**

Length

- > Fields types that require a defined length include **Alpha**, **Alpha or Zero-Filled**, and **Zero-Filled**.
- > You can define a length of up to 80 characters. However, standard definitions should match the expected length of the data to be entered.

Format

Field types that require a defined format include **Number** and **Combo Box**.

- > If **Field Type** is **Number**, enter a format using the number sign (#) to represent each digit and a period (.) to represent the decimal point. For example, if you want users enter 3 digits before the decimal point and 2 after, enter ###.##.
- > If **Field Type** is **Combo Box**, click  (the paper icon) in the unlabeled column to open **Voucher Additional Info - Combo Box Values**. The number of values created is displayed in **Format**. The maximum length of **Voucher Additional Info - Combo Box Values** is 7500 characters.

Export Seq

- > **Export Seq** is meant for use with Allscripts Interface Engine™ when importing or exporting data. It enables you to assign a sequence to the boxes that corresponds to the specifications of a vendor without having to reorder all existing entries. **Voucher Additional Info** boxes are not assigned default sequence numbers.
- > When a vendor requires that a series of boxes be exported in a certain order, enter the number that indicates this **Voucher Additional Info** box's order in the export sequence.

Note: Each of these boxes must also be flagged for export in the related information broker format in Allscripts Interface Engine™ in **Information Broker Format Maintenance**.

Patient and voucher additional info field types

This topic describes the field types used when creating a patient or voucher additional info field.

Alpha

Enables the user to enter both letters and numbers in the field.

Alpha or Zero-Filled

Allows entry of any combination of letters and/or numbers in the field. Unlike the simple alpha or the simple number types, this option adds leading zeros to any number if its actual length is shorter than the length you define.

For example, if the defined field length is ten, but the actual length of the number entered is eight characters (123678) leading zeros fill in the spaces left by the two missing characters (0000123678).

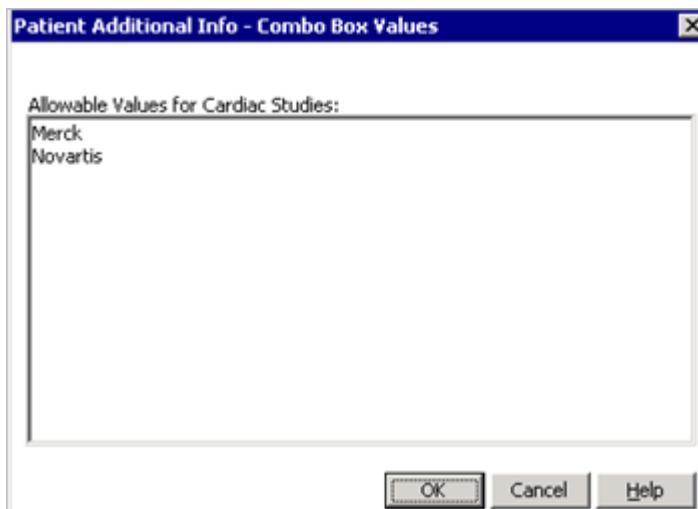
Note: An entry of letters or a combination of letters and numbers

- > does not require the exact number of characters defined in **Length**
- > does not generate leading zeros

Combo Box

Enables you to define a custom list of selections that the operator chooses from when recording information.

You define the combo box pick list using a window that you open by clicking the paper icon (□) in the column between **Format** and **Export Esq.**



Date

Converts any six or eight digit entry to the format of mm/dd/yy or mm/dd/yyyy.

Number

Restricts the entry to numbers only. You do not have to define the length of a number type field. The entry displays as entered; leading zeros are not used.

Telephone

Converts any ten digit entry to the format of (###) ###-####.

True / False

Offers the operator the option of selecting between **True** or **False**.

Zero-filled

Restricts the entry to numbers only. You must define the field length.

Leading zeros are used when the length of the number entered is less than the defined length.

Patient and voucher additional info number formats

The field type **Number** requires that you define a format when you are creating a **Patient Additional Info** or **Voucher Additional Info** field. (**F9 > PSU/OSU**)

The elements used to create a number format are the pound sign (#) and the decimal (.).

- > Use the pound sign to represent each digit
For example: #### allows for the entry of up to a four digit number.
- > Use a period to mark a decimal point where needed.
For example: ### .## allows for the entry of up to three digits to the left of a decimal and 2 digits to the right.

Note: Do not use commas, slashes, dashes or the dollar sign in the format.

Use this table to help you understand how your definition translates to the use of **Number** on **Patient Additional Info** and **Voucher Additional Info**.

Table 2: Formatting the Number field

Defined Format	Entry in Registration	Display in Registration
# ##### (5 #'s)	12345	12345
	123	123
#####.##	123	123.00
	1.23	1.23
	12.3	12.30
	12345	12345.00
	12345.00	12345.00

Create a combo box

You can add a combo box with a custom-defined list of values to the **Patient Additional Info** tab in **Registration** or the **Voucher Additional Info** tab, which is accessible from several different areas in the application.

1. Go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **PSU**, as applicable.
2. Click the **Patient Additional Info** tab or **Voucher Additional Info** tab, as applicable.
3. To create a new entry, click .
4. In **Field Name**, enter a name for the combo box.

For example, if you are creating a box to be used in relation to an Allscripts® Practice Management interface, you might create a combo box field called **County Code**.

5. (Optional) If you are in **Patient Additional Info**, in the column **Search?**, select to add this new field to the search by options on **Patient Lookup**.
6. (Optional) If you are in **Patient Additional Info**, in the column **Req?**, select to require your staff to fill this box before they can save their entries.
7. In the column **Field Type**, select **Combo Box**.
8. Click  in the unlabeled column to open **Combo Box Values**.
9. Enter the name of the first option in your custom list, then press **Enter**.

If you are creating a list for an interface or export used with Allscripts® Practice Management, be sure you follow the directions for entering values.

Note: Never enter a space after the value name.

10. Continue adding entries until you are finished entering all of the values that you need.

Be sure to press **Enter** after each entry to separate them.

11. Click **OK**.

You are returned to **Patient Additional Info** or **Voucher Additional Info**, as applicable. The number of entries you made in **Combo Box Values** is listed in the **Format** column in parentheses.

12. Click **Save**.

Results of this task

The combo box entry you created is now available from either the **Additional Info** tab in **Registration** or the **Voucher Additional Info** tab, accessible from various areas of the application.

Profiles tab in Practice Set Up or Organization Set Up

Profiles are used to facilitate and customize the process of billing insurance carriers.

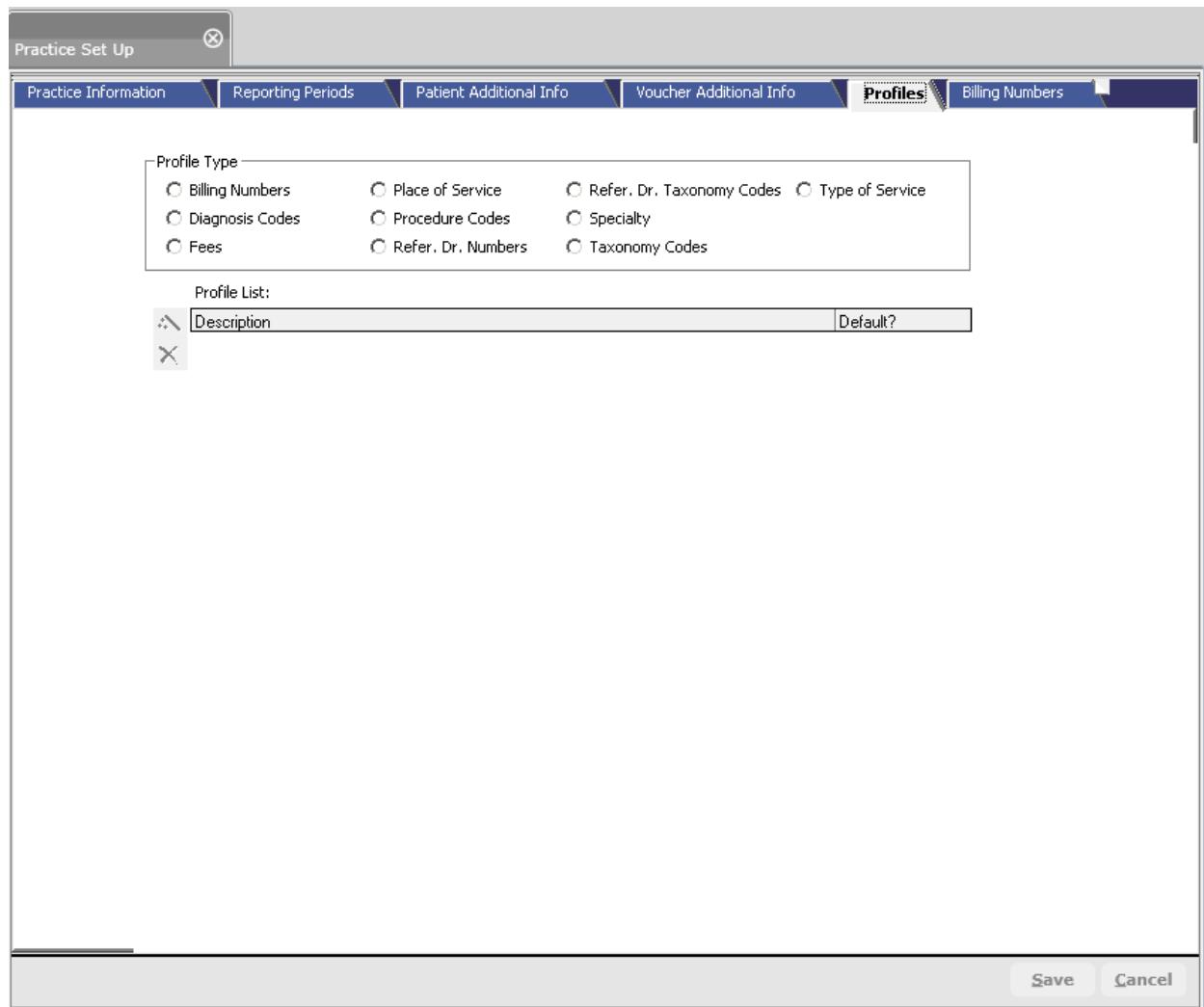
Profiles are custom-created records that define the 10 coding conventions used when you bill insurance carriers.

Each custom-designed **Profile Type** template is used to determine which provider billing numbers, diagnosis codes, fees, place of service billing codes, procedure codes, referring doctor billing numbers, referring doctor taxonomy codes, specialty billing codes, billing provider or entity taxonomy codes, and type of service billing codes are printed on a claim or output to an ANSI 837 file and submitted to a particular carrier.

Selecting a default guarantees that even when the box in the related file maintenance records is left blank, information is printed on the claim or included in the file.

Access the **Profiles** tab from **Practice Set Up or Organization Set Up**. To access **Practice Set Up or Organization Set Up**, go to **System Administration > Practice Set Up or System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **OSU** as applicable.

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**Profile Type**

Select the type of profile you want to work with from the options available.

Description

Enter a description that will help you identify this profile.

Default

Select this option to make this profile the default for the selected profile type.

Override NPI

This column is displayed in the **Profile List** grid on the **Profiles** tab when **Billing Numbers** is selected for **Profile Type**.

The check box in this column is enabled only for newly created profiles. After you save a profile, if you clear the check box and save again, the check box is no longer available for that profile.

When the check box in the **Default** column is selected, the check box in the **Override NPI** column is not enabled. Similarly, when the check box in the **Override NPI** column is selected, the check box in the **Default** column is not enabled.

Select this option for a profile to have that profile displayed on the **Billing Numbers** tab in **Department Maintenance** or **Practice Maintenance**, **Location Maintenance**, and **Practice Set Up** or **Organization Set Up**. In **Place of Service Maintenance**, the profile is displayed only on the **Billing Method Information** tab.

After you save profiles with **Override NPI** selected, the grid is sorted so that the **National Provider Identifier** profile is listed first followed by the profiles with **Override NPI** selected, and then the remaining profiles. The profiles with **Override NPI** selected are displayed in the other file maintenances with the same sort order and with **(Override NPI)** appended to the description.

Billing number profiles

Billing number profiles have **Billing Numbers** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**. Billing number profiles are used to store the billing numbers your third-party payers require to process claims. Allscripts® Practice Management uses these profiles to output the correct billing number when submitting a claim to a carrier.

Create a billing number profile for each carrier that requires a unique provider or group billing number. Examples of some commonly used profiles are: Medicare, Blue Cross Blue Shield, Medicaid, as well each one of your managed care carriers. If your practice or organization has a Federal ID number, create a billing number profile with a **Description of Standard Tax ID**. Select the **Default** check box for this profile. You should make this profile the default because this number is unique to your practice or organization but standard for all of the providers within your practice or organization.

The profile **National Provider Identifier** is hard coded in the application. You cannot edit its description, delete it, or change its position on the **Profile List**. Use this profile to enter the unique 10-digit identifier for health care providers assigned by the National Plan and Provider Enumeration System (NPPES).

Billing number profiles are used in these areas of the application to store the billing numbers required by your third-party payers to process claims.

- > On the **Billing Numbers** tab in **Practice Set Up** or **Organization Set Up** (PSU or OSU)
- > In **Provider Maintenance** (PRM)

Note: Billing number profiles with **Override NPI** selected on **Profiles** tab in **Practice Set Up** or **Organization Set Up** are not displayed on the **Billing Numbers** tab in **Provider Maintenance**.

- > In **Department Maintenance** or **Practice Maintenance** (DEM or PAM)
- > In **Location Maintenance** (LOM)
- > In **Place of Service Maintenance** (PSM) on the **Billing Numbers** tab and the **Billing Method Information** tab

Note:

- Use the **Billing Method Information** tab when billing by place of service, which is billing for a specific line of business at a physical location.
- Billing number profiles with **Override NPI** selected on **Profiles** tab in **Practice Set Up** or **Organization Set Up** are not displayed on the **Billing Numbers** tab. They are displayed on the **Billing Method Information** tab.

- > In **Insurance Carrier Maintenance** (ICM)

You enter carrier-assigned numbers on each **Billing Numbers** tab in the file maintenance that you point to with your selection of a billing method selected in **Electronic Claim Format Maintenance** or the billing number options in **Paper Claim Format Maintenance**.

In **Insurance Carrier Maintenance**, you select the correct electronic billing number profile and paper billing number profile for each carrier.

In **Claim Style Maintenance**, you can make additional selections to override your standard selections, if necessary.

Diagnosis code profiles

Diagnosis code profiles have **Diagnosis Codes** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**.

Because the ICD codes are pre-loaded in your database, the recommended standard setup is to list only the ICD-9 codes as a profile, unless you need to use alternate coding.

- > If you are not using ICD-10 codes yet, create a **Diagnosis Codes** profile called **Standard ICD-9 Code**.
- > If you are preparing to use ICD-10 codes and do not have an existing **Standard ICD-9 Code** profile, create a profile called **Standard ICD Code**.
- > If you are preparing to use ICD-10 codes and have an existing **Standard ICD-9 Code**, rename the **Standard ICD-9 Code** profile to **Standard ICD Code**.

Note: To rename the profile, position your cursor to the right of the **9** and press **Backspace** twice. Do not press **Delete** to remove the characters or the application will prompt you to delete the profile.

Diagnosis code profiles are displayed on the **Billing Codes** tab in **Diagnosis Code Maintenance**.

Fee profiles

Fee profiles have **Fees** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**. Fee profiles are used to define a charge entry amount for a service (procedure code) and submit the correct charge to a carrier, based on the **Procedure Fee Basis** selected in **Practice Options** or **Organization Options** on the **Charge Entry** tab.

The **Procedure Fee Basis** is the standard on which you determine the selection of fees for services rendered. What fee profiles you create depends on which **Procedure Fee Basis** you select. For example, if you decide that the fee charged for a service is determined by the provider of the service, you need to complete these steps:

For example, if you decide that the fee charged for a service is determined by the provider of the service then the following maintenance is necessary:

1. Set **Procedure Fee Basis** to **Actual Provider**.
2. Create corresponding fee profiles, such as **Physician** and **Non-Physician**.
3. In **Provider Maintenance**, select the appropriate profile for the provider.
4. In **Procedure Code Maintenance**, define each fee profile assigning it the charge amount you determined for each type of provider.

The actual fee used for the service by system is then driven by the **Actual Provider** selected in **Charge Entry**.

Here are some example of fee profiles you can create based on your **Procedure Fee Basis** selection

Table 3: Sample fee profiles

Procedure Fee Basis	Sample Fee Profiles
Actual Provider or Billing Provider	Physician
	Non-Physician
	Surgeon
	CRNA
Carrier	Standard
	Other

Procedure Fee Basis	Sample Fee Profiles
Department or Practice	Internal Medicine
	Cardiology
	X-ray
	Dermatology
Location	Office
	Clinic

Place of service profiles

Place of service profiles have **Place of Service** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**. Place of service profiles are used to output the correct place of service code when billing a carrier.

Because most insurance carriers use and recognize the place of service codes developed by Medicare, create the profile **Standard CMS Code**.

Add other profiles you may need. For example, you might want to create a profile for Medicaid or UB billing.

Place of service profiles are displayed on the **Billing Codes** tab in **Place of Service Maintenance**. On this tab, enter the correct code by profile, then select the applicable **Place of Service Profile** for each carrier. When claims are prepared for the carrier, the application uses the profile you associated with the carrier to output the correct code for that carrier.

Procedure code profiles

Procedure code profiles have **Procedure Codes** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**. Procedure code profiles are used on the **Billing Codes** tab in **Procedure Code Maintenance** (PCM) to output the correct procedure code when billing a carrier.

Create a profile named **Standard CPT Code** to refer to the CPT codes preloaded in your tenant.

Create other profiles as needed. For example, Medicare sometimes requires the use of unique coding for certain procedures.

Procedure code profiles are displayed on the **Billing Codes** tab in **Procedure Code Maintenance**, where you can select the applicable **Procedure Code Profile** for each carrier. When claims are prepared for the carrier, the application uses the profile you associated with the carrier to output the code the carrier requires.

Referring doctor number profiles

Referring doctor number profiles have **Refer Dr Numbers** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**. Use referring doctor number profiles to output the correct billing numbers when submitting claims to a carrier that requires referring doctor information.

Create a profile called **Standard UPIN**.

Also create any profile needed for carriers that require a unique carrier-assigned billing number for a referring provider.

The profile **National Provider Identifier** is hard coded in the application. You cannot edit its description, delete it, or change its position on the **Profile List**. Use this profile to enter the unique 10-digit identifier for health care providers assigned by the National Plan and Provider Enumeration System (NPPES).

Referring doctor number profiles are used on the **Billing Numbers** tab in **Referring Doctor Maintenance** to store the correct number by profile. After you have stored the billing numbers, you must select the applicable **Electronic Referring Doctor Profile** and **Paper Referring Doctor Profile** for the carrier on the **Profiles** tab in **Insurance Carrier Maintenance**. When claims are prepared for a carrier, the application uses the profile you associated with that carrier to output the correct number.

Refer doctor taxonomy code profiles

Referring doctor taxonomy code profiles have **Refer Dr Taxonomy Codes** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**. Use referring doctor taxonomy code profiles on the **Taxonomy Codes** tab in **Referring Doctor Maintenance** to store the taxonomy codes required by various carriers to process claims.

The profile you select as the default billing is used when **Referring Dr Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance** is set to **(default)**.

If you opted to use the comprehensive starter database, the profile **Standard Taxonomy Code** has already been created. If you opted not to use the comprehensive starter database, create a new profile called **Standard Taxonomy Code**. You should also create any profile needed for carriers that require a unique carrier-assigned taxonomy code for a referring provider.

After you have created the necessary referring doctor taxonomy codes, enter the correct taxonomy code for each profile on the **Taxonomy Codes** tab in **Referring Doctor Maintenance**. Then select the applicable **Referring Dr Taxonomy Code Profile** for each insurance carrier on the **Profiles** tab in **Insurance Carrier Maintenance**. When claims are prepared for a carrier, the application uses the profile you associated with that carrier to output the number the carrier requires.

Specialty profiles

Specialty profiles have **Specialty** selected on the **Profiles** tab in **Practice Set Up or Organization Set Up**.

In general, insurance carriers use and recognize the specialty codes developed by Medicare. Create a profile called **National (Medicare) Code**. Make it the default by selecting the **Default** check box. Create any other profiles necessary for your practice or organization. For example, a profile to store codes required by your electronic claims vendor, a profile for codes required for transmitting data using a custom Allscripts interface such as the **MDCH MRI Data Collection Export**, or an **ADA Specialty Codes** profile.

Specialty profiles are used on the **Billing Codes** tab in **Specialty Maintenance**. After you have created the necessary specialty codes, go to this tab and enter the correct code for each specialty profile. Then, select the applicable specialty profile for each insurance carrier on the **Profiles** tab in **Insurance Carrier Maintenance**. When claims are prepared for a carrier, the application uses the profile you associated with that carrier to output the correct specialty code.

Taxonomy code profiles

Taxonomy code profiles have **Taxonomy Codes** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**. The taxonomy codes profiles you create are used to store the taxonomy codes required by various carriers to process claims.

In some cases, providers, groups, or organizations are given different taxonomy codes by different carriers. To accommodate this situation, you can create taxonomy code profiles by carrier.

Taxonomy code profiles are used on the **Taxonomy Codes** tab in these windows.

- > **Practice Set Up or Organization Set Up** (PSU or OSU)
- > **Provider Maintenance** (PRM)
- > **Department Maintenance or Practice Maintenance** (DEM or PAM)
- > **Location Maintenance** (LOM)
- > **Place of Service Maintenance** (PSM)

After you have created the necessary taxonomy code profiles, go to **Taxonomy Codes** tab on each of these windows to enter the correct taxonomy code for each profile. Then select the applicable **Taxonomy Code Profile** for each insurance carrier on the **Profiles** tab in **Insurance Carrier Maintenance**. The application uses the profile you selected as the default taxonomy code profile when **Taxonomy Code Profile** is set to **(default)**. When claims are prepared for a carrier, the application uses the profile you associated with that carrier to output the correct number. You also need to select the applicable, carrier-required options for outputting taxonomy codes (if any) on the **Output Options** tab in **Claim Style Maintenance** for the claim style associated with the insurance carrier. For example, if you set the **Standard Taxonomy Code** profile to be the default and the insurance carrier's taxonomy code profile is set to **(default)**

For example, if these conditions are true, the number that is reported when submitting claims to an insurance carrier is the number you entered in **Standard Taxonomy Code** on the **Taxonomy Codes** tab for insurance carrier's associated billing method. (Billing methods for insurance carriers are selected in **Electronic Claim Format Maintenance**.)

- You select **Standard Taxonomy Code** as the **Default** on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**.
- The carrier's **Taxonomy Code Profile** is set to **(default)** on the **Profiles** tab in **Insurance Carrier Maintenance**.
- You select one of the output options related to taxonomy codes on the **Output Options** tab in **Claim Style Maintenance** for the claim style associated with that insurance carrier.

Type of service profiles

Type of service profiles have **Type of Service** selected on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**.

Insurance carriers generally use and recognize the type of service codes approved by Medicare. Create a profile named **Standard CMS Type of Svc Code**.

Some regional vendors and carriers may require coding specific to their claims processing. If so, create the needed additional profiles. Examples of other type of service profiles are **BCBS of State, Medicare Rural Health**, and **Medicaid Rural Health**

Type of service profiles are used on the **Billing Codes** tab in **Type of Service Maintenance**. On this tab, enter the correct code for each type of service profile. Then select the applicable type of service profile for each insurance carrier in **Insurance Carrier Maintenance**. When claims are prepared for a carrier, the application uses the profile you associated with that carrier to output the correct code.

Billing Numbers tab in Practice Set Up or Organization Set Up

Use the **Billing Numbers** tab in **Practice Set Up** or **Organization Set Up** to store the billing numbers assigned to your practice or organization by your payers. Generally, these billing numbers are group numbers or numbers that apply to every member of your practice or organization.

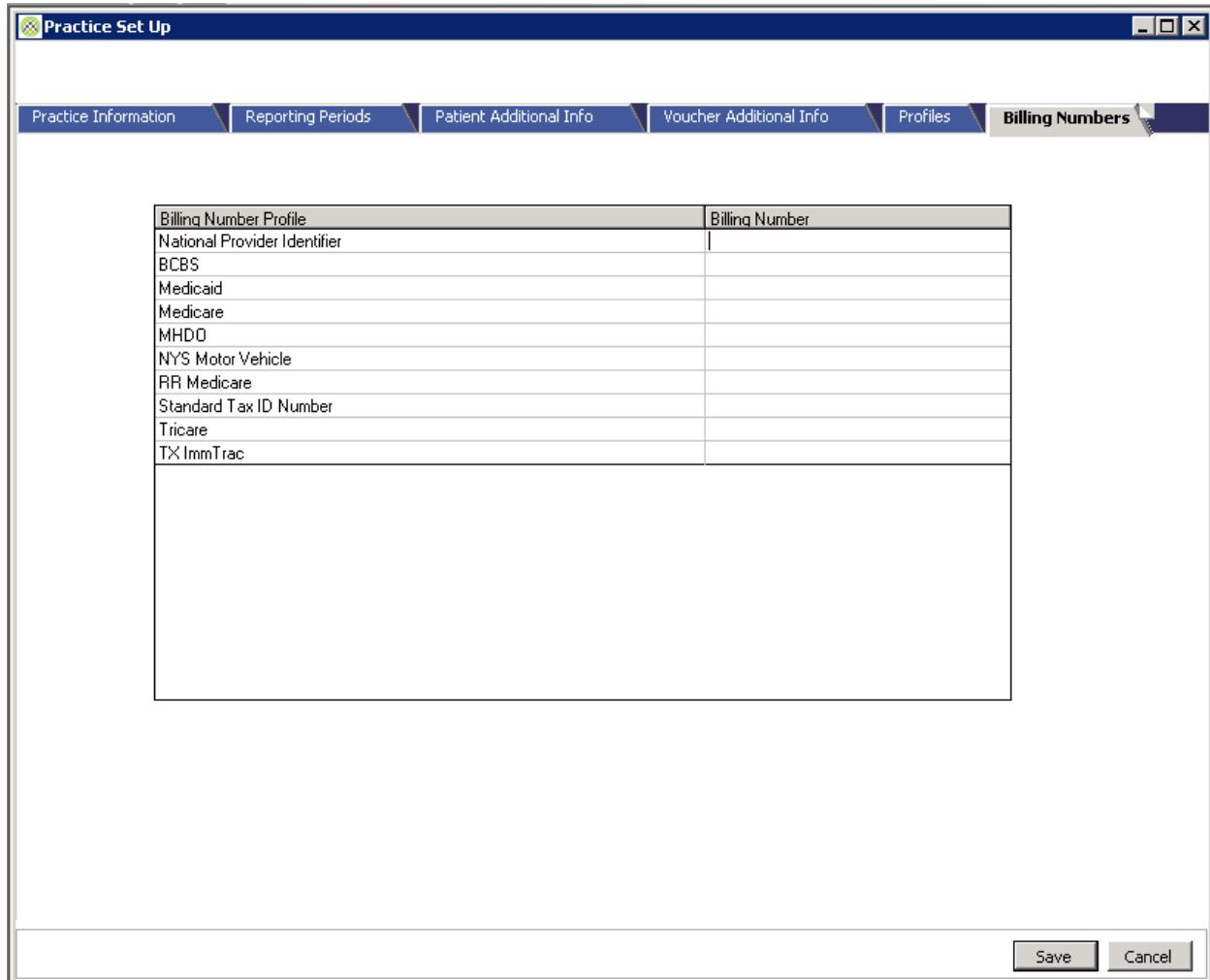
The billing profile list created on the **Profiles** tab in **Practice Set Up** or **Organization Set Up** is displayed on the **Billing Numbers** tab.

Numbers from this tab print on a claim or output to a claim file when you select **Practice** or **Organization** as the **Indiv. Billing No. Option** or the **Group Billing No. Option** in **Paper Claim Format Maintenance** or the **Billing Method** in **Electronic Claim Format Maintenance**.

The application uses the numbers associated with the **Billing Number** profile you selected for the carrier when claims are prepared, based on a combination of selections in **Claim Type Maintenance** and **Claim Style Maintenance**.

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Access the **Billing Numbers** tab from **Practice Set Up** or **Organization Set Up**. To access **Practice Set Up** or **Organization Set Up**, go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **OSU** as applicable.



The screenshot shows the 'Practice Set Up' window with the 'Billing Numbers' tab selected. The window has tabs at the top: Practice Information, Reporting Periods, Patient Additional Info, Voucher Additional Info, Profiles, and Billing Numbers. Below the tabs is a table with two columns: 'Billing Number Profile' and 'Billing Number'. The table contains ten rows, each representing a different carrier profile. The first row is 'National Provider Identifier' with an empty 'Billing Number' field. The other nine rows are: BCBS, Medicaid, Medicare, MHDO, NYS Motor Vehicle, RR Medicare, Standard Tax ID Number, Tricare, and TX ImmTrac. At the bottom right of the table are 'Save' and 'Cancel' buttons.

Billing Number Profile	Billing Number
National Provider Identifier	
BCBS	
Medicaid	
Medicare	
MHDO	
NYS Motor Vehicle	
RR Medicare	
Standard Tax ID Number	
Tricare	
TX ImmTrac	

For each profile, enter the billing number assigned to your practice or organization by the carriers you associated with this profile in **Insurance Carrier Maintenance**.

The **National Provider Identifier** profile on the first row cannot be deleted. Use it to enter your assigned 10-digit NPI group number.

Taxonomy Codes tab in Practice Set Up or Organization Set Up

Use the **Taxonomy Codes** tab in **Practice Set Up** or **Organization Set Up** to record the taxonomy codes assigned to your practice or organization. Generally, these are group numbers or numbers that apply to every member of your practice or organization.

The taxonomy code profile list created on the **Profiles** tab in **Practice Set Up** or **Organization Set Up** is displayed in the grid.

The **Taxonomy Codes** tab functions in the same way as the **Taxonomy Codes** tab related to other file maintenance functions such as provider maintenance, department or practice maintenance, location maintenance, referring doctor maintenance, and so on.

The taxonomy codes entered on this tab are used when you submit claims and the billing method is set to **Practice** or **Organization** and at least one of the output options related to outputting the rendering, billing or performing provider's taxonomy code is checked for the claim style associated with the carrier.

The actual number reported in the electronic file or printed on a claim is the one whose profile matches the taxonomy code profile selected for the carrier in **Insurance Carrier Maintenance** (ICM).

Access the **Taxonomy Codes** tab from **Practice Set Up** or **Organization Set Up**. To access **Practice Set Up** or **Organization Set Up**, go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **OSU** as applicable.

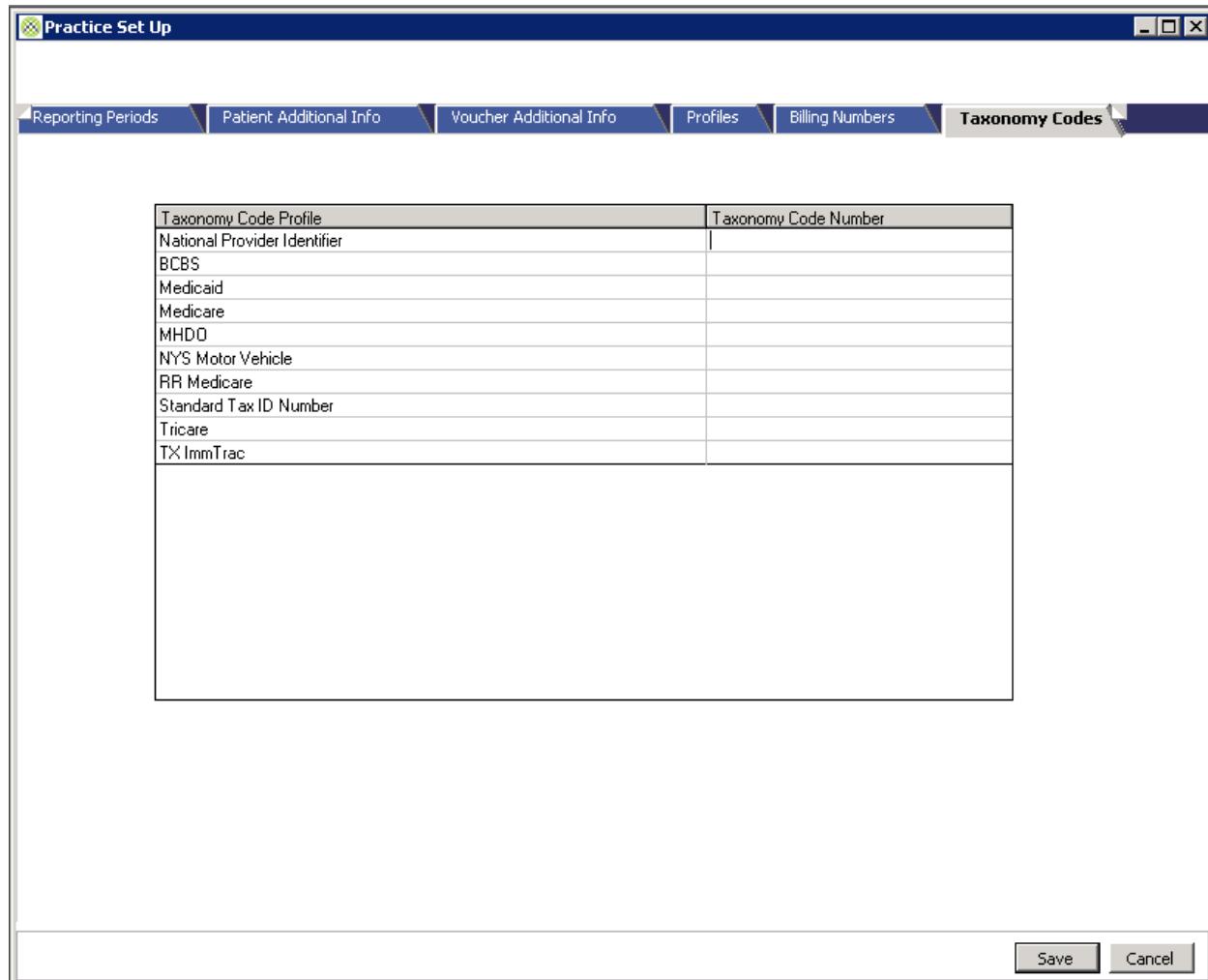


Chart Number Locations tab

Use **Chart Number Locations** tab **Practice Set Up** or **Organization Set Up** to store information about chart locations.

The **Chart Number Locations** tab **Practice Set Up** or **Organization Set Up** is only visible when the option **Enable Chart Tab** is selected on the **Registration** tab in **Practice Options** or **Organization Options**.

Note: Selecting this option also makes the **Chart** tab in **Registration** visible.

Clients who are converting and merging multiple databases into a single Allscripts Practice Management™ database may want to store and view patient and/or chart numbers previously

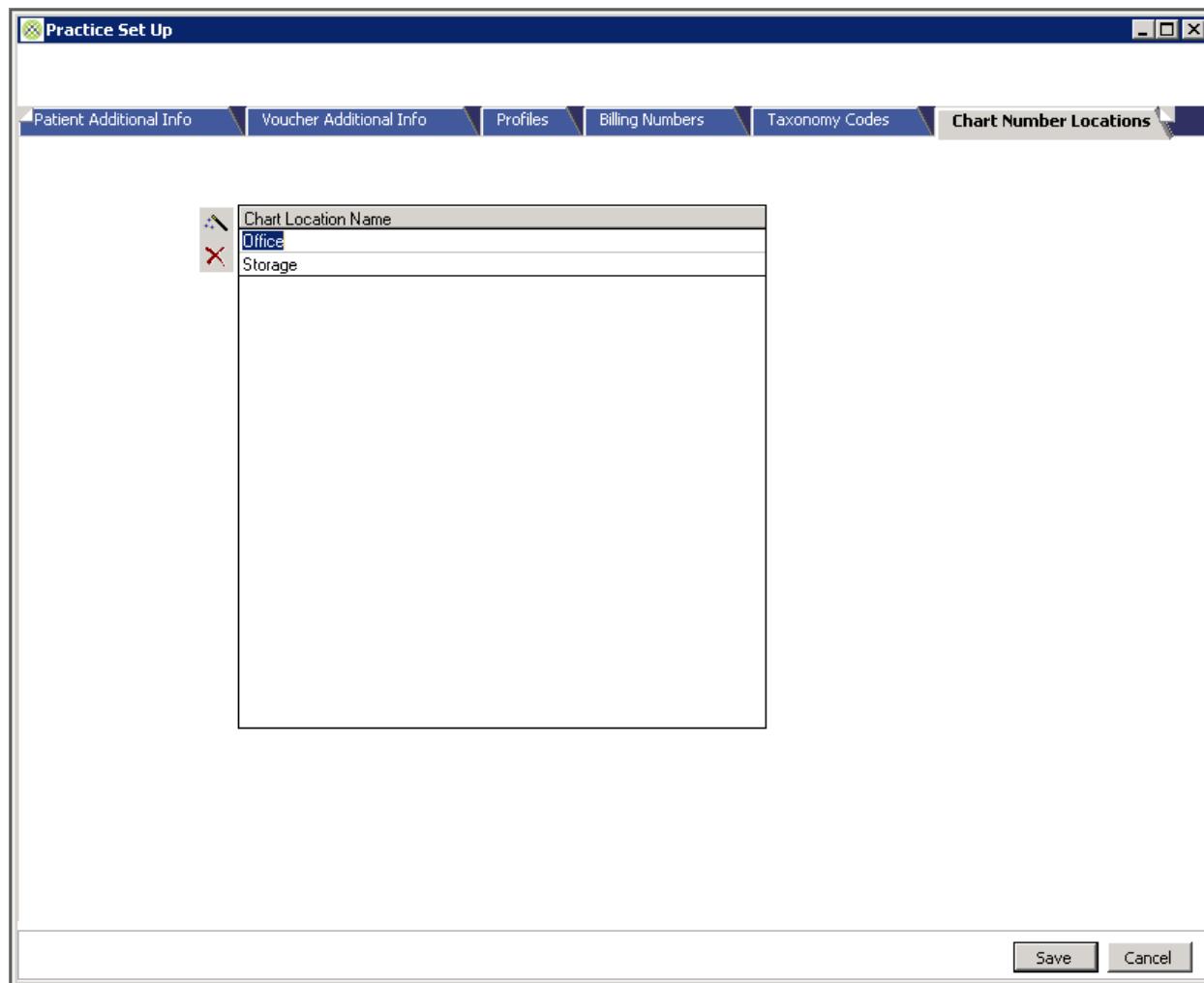
assigned to patients in their legacy databases. This can be done in Allscripts Practice Management™ with a minimum amount of setup.

Until **Chart Locations** are created in **Practice Set Up or Organization Setup** on the **Chart Number Locations** tab, users cannot select a location and enter a number for a patient even when the **Chart** tab is visible in **Registration**.

The locations you create on this tab list in the order you entered each. However, locations display in alphabetical order in the drop down on the **Chart** tab in **Registration**. The application prevents you from entering duplicates.

You cannot delete a chart location that is selected on a patient record in **Registration**.

Access the **Chart Number Locations** tab from **Practice Set Up or Organization Set Up**. To access **Practice Set Up or Organization Set Up**, go to **System Administration > Practice Set Up or System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **OSU** as applicable.



To store and view historical numbers by chart location in **Registration** you must do the following:

Select **Enable Chart Tab** on the **Registration** tab in **Practice Options** or **Organization Options**, which makes the following two tabs visible:

- **Chart Number Locations** tab in **Practice Set Up** or **Organization Set Up** where you must create custom locations that are used on the **Chart** tab in **Registration**.
- **Chart** tab in **Registration** where you store the patient's historical chart and patient numbers by the locations created in **Practice Set Up** or **Organization Set Up**.

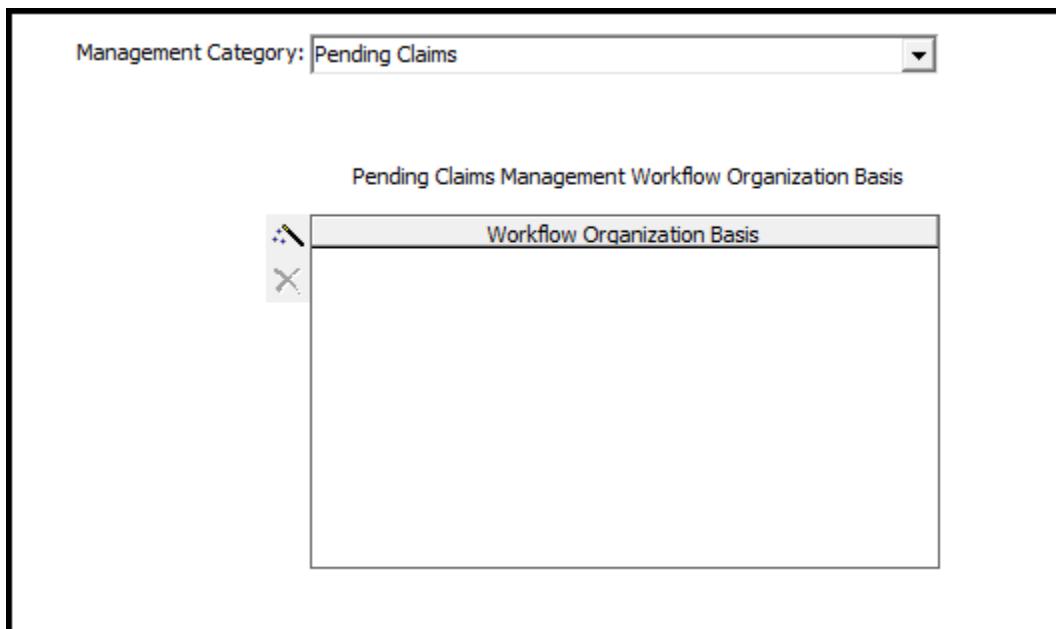
Create chart number locations in **Practice Set Up** or **Organization Set Up**.

Note: Unless chart locations are created in **Practice Set Up** or **Organization Set Up** on the **Chart Number Locations** tab, you cannot enter a chart number and select a location for a patient in **Registration** even if the tab is made visible.

Office Manager tab for pending claims

When you set **Management Category** to **Pending Claims** on the **Office Manager** tab in **Practice Set Up** or **Organization Set Up**, the selections used to manage pending claims are displayed on the lower half of the window.

To access the **Office Manager** tab, go to **System Administration > Practice Set Up** or **Organization Set Up** or press **F9** and then enter **PSU** or **OSU**.



Management Category

Management Category is the only box displayed when you first open this tab. Click the arrow and select the management category to work with: the associated selections are displayed on the lower half of the tab. The management categories are:

- > Pending Claims
- > Unpaid Claims

Pending Claims Management Workflow Organization Basis

Use this area to select how you want accounts in this workflow organization basis to be sorted.

Click  to add a row, and then select the sort criteria from the drop-down box. The choices are:

- > Actual Provider
- > Billing Provider
- > Department
- > Insurance Carrier
- > Insurance Category
- > Insurance Reporting Class
- > Location
- > Visit Type: The visit type option is only available when **Enable Visit Type** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**.

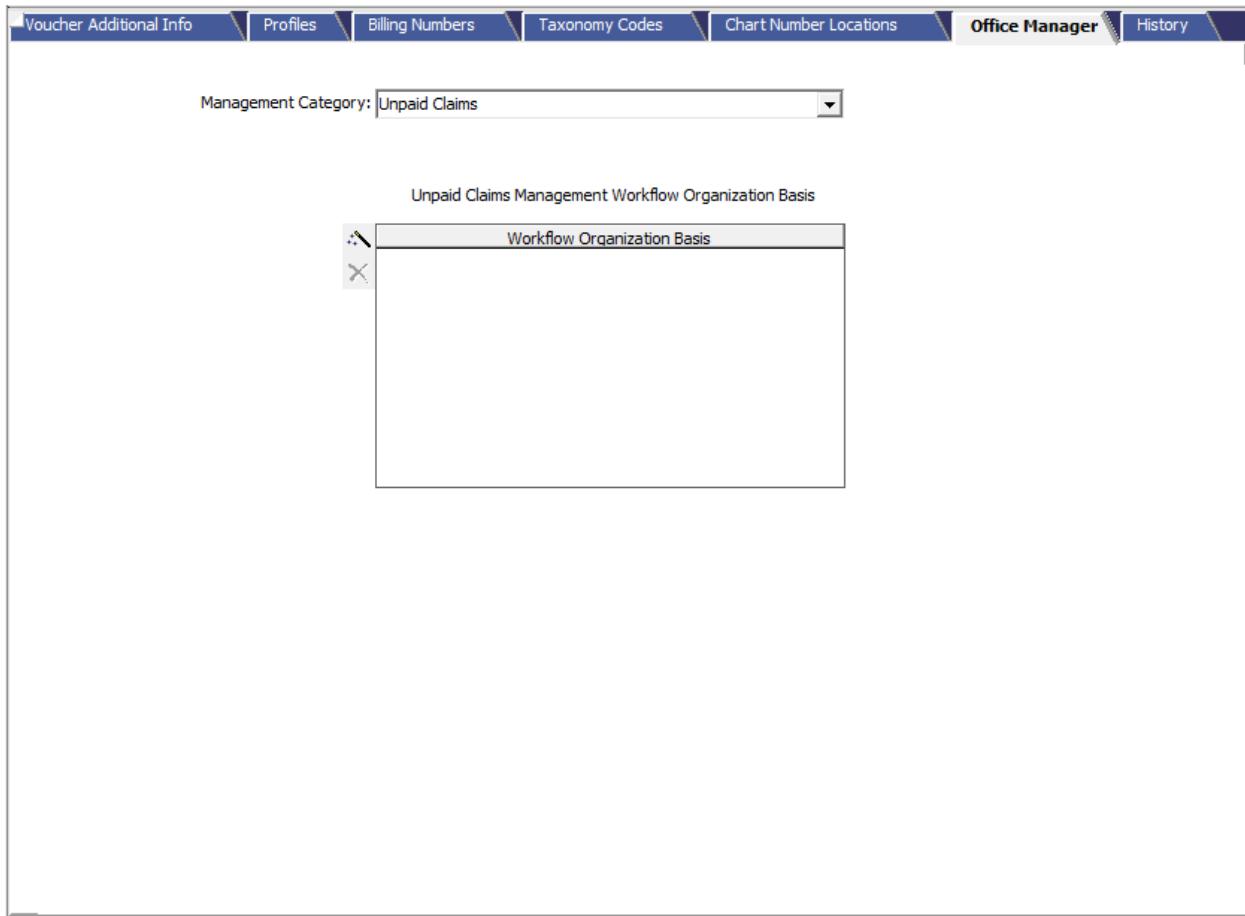
The first item you select is used as the primary sort criteria, the second item is used as the secondary sort criteria, and so forth.

Office Manager tab for unpaid claims

When you set **Management Category** to **Unpaid Clams** on the **Office Manager** tab in **Practice Set Up** or **Organization Set Up**, the selections used to manage unpaid claims are displayed on the lower half of the window.

To access the **Office Manager** tab, go to **System Administration > Practice Set Up** or **Organization Set Up**. You can also **F9** and then enter **PSU** or **OSU**.

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Management Category

Management Category is the only box displayed when you first open this tab. Click the arrow and select the management category to work with: the associated selections are displayed on the lower half of the tab. The management categories are:

- > Pending Claims
- > Unpaid Claims

Unpaid Claims Management Workflow Organization Basis

Use this area to select how to sort accounts in this workflow organization basis. Click  to add a row, and then select the sort criteria from the drop-down box. The choices are:

- > Actual Provider
- > Billing Provider
- > Department
- > Insurance Carrier

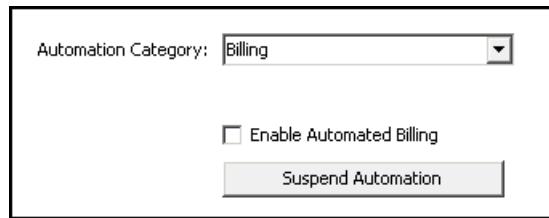
- > **Insurance Category**
- > **Insurance Reporting Class**
- > **Location**
- > **Visit Type:** The visit type option is only available when **Enable Visit Type** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**.

The first item you select is used as the primary sort criteria, the second item is used as the secondary sort criteria, and so forth.

Automation tab for billing

When you set **Automation Category** to **Billing** on the **Automation** tab in **Practice Set Up** or **Organization Set Up**, the selections to enable, suspend, and resume automated billing are displayed.

Access the **Automation** tab from **Practice Set Up** or **Organization Set Up**. To access **Practice Set Up** or **Organization Set Up**, go to **System Administration > Practice Set Up** or **System Administration > Organization Set Up**, or press **F9** and then enter **PSU** or **OSU**, as applicable.



Automation Category

Automation Category is the only box displayed when you first open this tab. Click the arrow and select the automation category to work with. The associated selections are displayed on the lower half of the tab. The automation categories are the following:

- > **Billing**
- > **Self-Pay Collections**

Enable Automated Billing

Select **Enable Automated Billing** to start automated billing processing, which, depending on your setup, includes updating batches, validating claims, preparing electronic claims, adjusting small self-pay balances, assessing finance charges, and generating statements.

Important: Be sure that you have completed the required setup for automated billing before you select this check box.

Suspend Automation

This button is only enabled after you have selected **Enable Automated Billing**, and the automated billing process has begun. Click this button to temporarily stop the automated billing process by pausing the Automation service type for billing. After you click **Suspend Automation**, the button label changes to **Resume Automation**. Click **Resume Automation** to restart the automated billing process where it left off.

Automation tab for self-pay collections

When you set **Automation Category** to **Self-Pay Collections** on the **Automation** tab in **Practice Set Up** or **Organization Set Up**, the selections used to manage automated self-pay collections are displayed on the lower half of the window.



Automation Category

Automation Category is the only box displayed when you first open this tab. Click the arrow and select the automation category to work with. The associated selections are displayed on the lower half of the tab. The automation categories are the following:

- > **Billing**
- > **Self-Pay Collections**

Self-Pay Collections Management Workflow Organization Basis

Use this drop-down list to select the workflow organization basis for your current department or practice. The options are:

Account

Select this option to prepare collections by account.

Department or Practice

Select this option to prepare collections by department or practice.

Division

Select this option to prepare collections by division. This option is displayed only if you have **Enable Divisions** selected on the **Multi Entity** tab in **System Administration**.

Before version 14.0, how self-pay collection accounts were processed was controlled using **Assign Work Option** on the **Collections** tab in **Practice Set Up** or **Organization Set Up**.

The options for the self-pay collections management category work the same way and control the same items, except they are for automated self-pay collections instead of manual self-pay collections.

Note: If you are already using the automated self-pay collections process and want to change your workflow organization basis, you cannot change the workflow organization basis until the self-pay accounts currently in the process are completed. You can automatically complete all self-pay accounts currently in the automated process by clearing **Enable Automated Self-Pay Collections** and clicking **Yes** when a window opens asking whether you want to complete all current automated self-pay accounts.

Enable Automated Self-Pay Collections

Only enabled after you select a workflow organization basis. Select this check box to enable automated self-pay collections for your current department or practice.

Important: Be sure that you have completed all of the required setup for automated self-pay collections before you select this check box. This setup includes:

- > Selecting a workflow organization basis
- > Creating automated actions and automated workflows
- > Creating self-pay collections work queues and setting their priority
- > Enabling collectors to receive accounts automatically

Suspend Automation

Only enabled after you select **Enable Automated Self-Pay Collections** and the collections process has begun. Click this button to temporarily suspend the automated self-pay collections process by pausing the service thread for the Allscripts® Practice Management Self-pay Collection service type. After you click **Suspend Automation**, the button label changes to **Resume Automation**. Click **Resume Automation** to pick up the collections process where it left off.

When you suspend automated self-pay collections, operators can still view their self-pay collections work queues in **Office Manager** and all of the windows and tabs associated with automated self-pay collections are still available. Suspending automation only means that no



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new accounts qualify for the automated workflows and no automatic steps are taken until you click **Resume Automation**.

Chapter 2

Practice Options or Organization Options

Practice Options or Organization Options setup checklist

Use this checklist to record the completion of each tab on **Practice Options or Organization Options**.

Tab	Completed
General	
Registration	
Charge Entry	
Payment Entry	
Statement	
Reporting	
Scheduling	
Scheduling (2)	
Referral	
Collection	
Replication	
Enterprise	
Occ Medicine	
Finance Charge	
External Access	
External Access (2)	
Credit Card Processing	
Special Billing	

Tab	Completed
Multi Entity	
Visit Type	
Case	

Practice Options or Organization Options window

Use **Practice Options or Organization Options** to define data entry rules and defaults that apply to all users. These rules and defaults guarantee standardization as your staff registers patients, enters charges and payments, generates statements, runs reports, schedules appointments, and follows up on collection activity.

Practice Options or Organization Options contains these tabs:

- > General
- > Registration
- > Charge Entry
- > Payment Entry
- > Statement
- > Reporting
- > Scheduling
- > Scheduling (2)
- > Referral
- > Collection
- > Enterprise
- > Occupational Medicine
- > Finance Charge
- > External Access
- > External Access (2)
- > Credit Card Processing
- > Special Billing
- > Multi Entity
- > Visit Type
- > Case
- > History

To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options** or press **F9** and then enter **POP** or **OOP** as applicable.

General tab in Practice Options or Organization Options

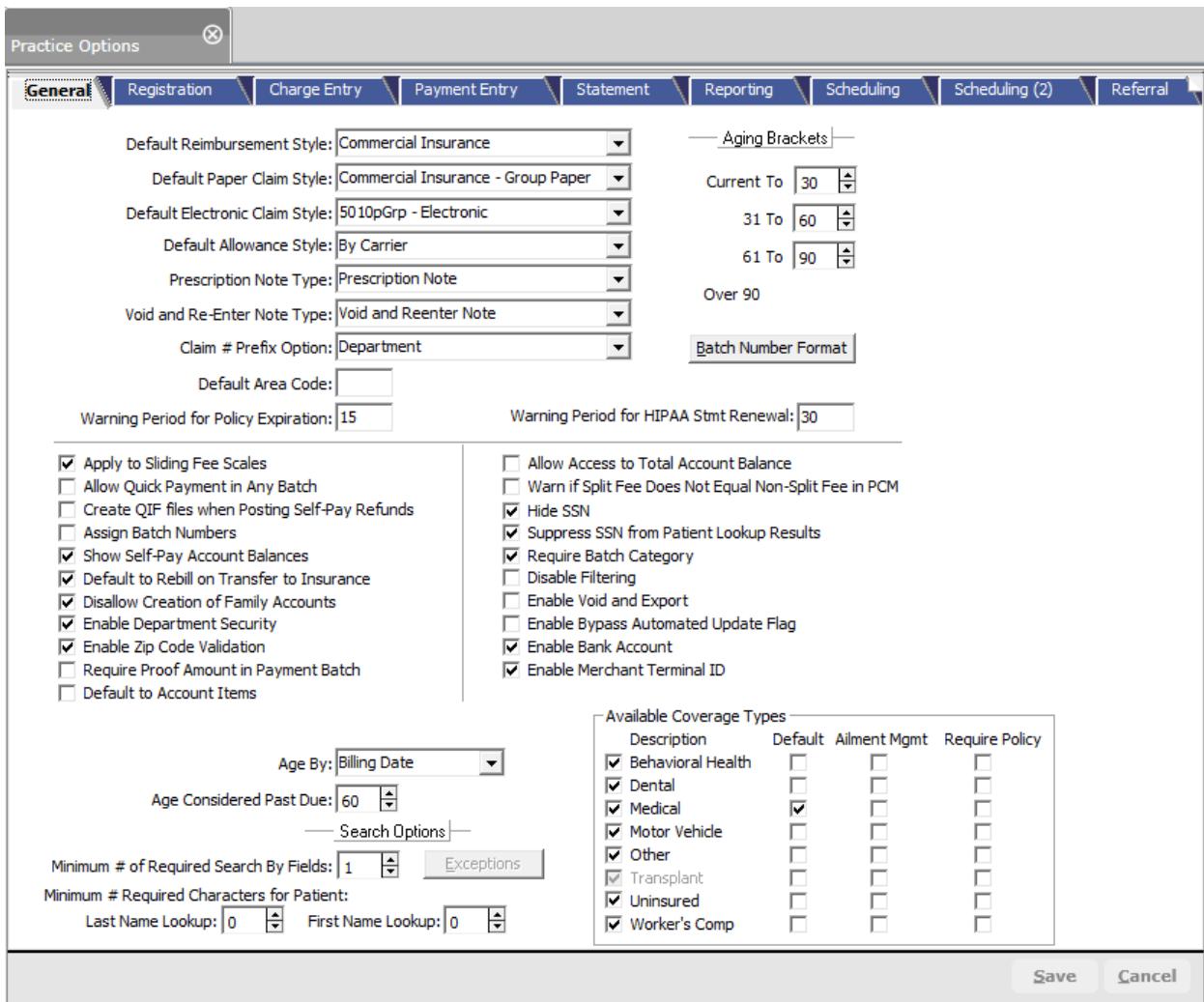
The options you define on the **General** tab are associated with various functions within Allscripts Practice Management™.

For example, **Default Reimbursement Style** is an option for use in payment entry, while importing remittances and when associating a style with a carrier.

Also, the option to assign batch numbers affects batch management and the automatic transactions of transferring and adjusting account balances, importing remittances, importing charges, and the printing of invoices for occupational medicine and assessing finance charges.

Your definitions set standards for activities such as determining how voucher balances are aged, when a self-pay balance is considered overdue, and whether a user posting quick payments can use any open payment batch or must create a specific payment batch for his or her entries.

Access the **General** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options or System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.



The screenshot shows the 'Practice Options' window with the 'General' tab selected. The interface is a grid-based configuration tool.

Top Row:

- Default Reimbursement Style: Commercial Insurance
- Aging Brackets:
 - Current To: 30
 - 31 To: 60
 - 61 To: 90
 - Over 90

Middle Left Column:

- Default Paper Claim Style: Commercial Insurance - Group Paper
- Default Electronic Claim Style: 5010pGrp - Electronic
- Default Allowance Style: By Carrier
- Prescription Note Type: Prescription Note
- Void and Re-Enter Note Type: Void and Reenter Note
- Claim # Prefix Option: Department
- Default Area Code: (empty field)
- Warning Period for Policy Expiration: 15
- Warning Period for HIPAA Stmt Renewal: 30

Middle Right Column:

- Allow Access to Total Account Balance
- Warn if Split Fee Does Not Equal Non-Split Fee in PCM
- Hide SSN
- Suppress SSN from Patient Lookup Results
- Require Batch Category
- Disable Filtering
- Enable Void and Export
- Enable Bypass Automated Update Flag
- Enable Bank Account
- Enable Merchant Terminal ID

Bottom Left Column:

- Age By: Billing Date
- Age Considered Past Due: 60
- Search Options:
 - Minimum # of Required Search By Fields: 1
 - Exceptions
- Minimum # Required Characters for Patient:
 - Last Name Lookup: 0
 - First Name Lookup: 0

Bottom Right Column:

Available Coverage Types			
Description	Default	Aliment Mgmt	Require Policy
Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uninsured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Comp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Buttons:

- Save
- Cancel

Default options on the General tab

The following options are located at the top of the **General** tab in **Practice Options or Organization Options**. (Press **F9**, and then enter **POP** or **OOP**)

Default Reimbursement Style

You must create reimbursement style records in file maintenance before you can select this default.

The default style you choose ties to the options available in **Insurance Carrier Maintenance** when you associate a reimbursement style with a carrier. The default selection on the list in **Insurance Carrier Maintenance** points to the style you set as your default here. In turn, this default style is then used in payment entry and when importing remittances received by the carrier.

If **Use for Uninsured Carriers** is selected for a reimbursement style on the **Reimbursement Style** tab in **Reimbursement Style Maintenance**, that reimbursement style is not available in **Default Reimbursement Style**.

In addition to the style selected as the practice or organization option, there is also a program defined default that is used in payment entry whenever this option is left blank and the reimbursement style associated with a carrier points to **(default)**.

Click to open the drop down list, and then click the name of a reimbursement style to populate the field.

Default Paper Claim Style

You must create paper claim styles in file maintenance before you can select this default.

In **Insurance Carrier Maintenance**, you must select a paper claim style that is used to print claim forms that are submitted to the carrier. The default selection in that list points to the style you set as your practice or organization default.

If you leave this option blank then when a carrier's paper claim style points to **(default)**, claim forms do not print for that carrier.

Click to open the drop down list, and then click the name of a paper claim style to fill the box.

Default Electronic Claim Style

You must create electronic claim styles in file maintenance before you can select this default.

In **Insurance Carrier Maintenance**, you must select an electronic claim style that is used to transmit claims to the carrier. The default selection in that list points to the style you set as your practice or organization default.

If you leave this option blank then when a carrier's electronic claim style points to **(default)**, claims to that carrier do not qualify for electronic transmission.

Click to open the drop down list, and then click the name of an electronic claim style to fill the box.

Default Allowance Style

This sets the default for **Allowance Style** on the **Carrier** tab in **Insurance Carrier Maintenance**.

You can change the default allowance style in **Insurance Carrier Maintenance**.

The available selections in this drop-down list are:

- > **By Carrier** (system default selection)
- > **By Carrier/Department**
- > **By Carrier/Location**
- > **By Carrier/Provider**

Prescription Note Type

Practice and organizations using an electronic medical records application may not need to select a default prescription note type. Check with your Implementation Specialist. You must create patient note types in file maintenance before you can select this default. To view notes on the patient's prescription window you must select a default for this option.

Void and Re-Enter Note Type

In **Note Type Maintenance (NTM)**, create a voucher note named, for example **Void ReEnter Note**, then select that as the default.

When you have selected a default, a voucher note is automatically attached to the voided voucher when you use **Void Re-Enter** in **Edits**.

Viewable from the following functions:

- > **Note Management** when the option **Voucher Note** is selected.
The subject line reads:

```
Voucher# <number>, Void Batch# VREmmddyy<OperAbbrv>, Date mm/dd/yy
```

The text box reads:

```
Voucher# <number> was voided and re-entered on <date>, Void Batch#  
VREmmddyy<OperAbbrv>
```

- > **Account Inquiry** when viewing the voided voucher - the query preference must be set to **Void, Paid, Open Items** and the voucher view option must be set to **Voucher Notes**.

Claim # Prefix Option

If **Multi Entity Label Option** on the **Multi Entity** tab in **Practice Options or Organization Options** is set to **Department**:

- > Select **Practice** to have the application retrieve claim number prefixes from **Practice Set Up**.
- > Select **Department** to have the application retrieve claim number prefixes from **Department Maintenance**.

If **Multi Entity Label Option** on the **Multi Entity** tab in **Practice Options or Organization Options** is set to **Practice**:

- > Select **Organization** to have the application retrieve claim number prefixes from **Organization Set Up**.
- > Select **Practice** to have the application retrieve claim number prefixes from **Practice Maintenance**.

Important: If claim prefix numbers were outputting on claims, after you change the value of **Claim # Prefix Option**, some remittances

might not post if the claim was submitted to the carrier before the change, and the remittance was received after the change.

Claim # Prefix Option is included with starter data sets that have the **Practice Options** information type.

Default Area Code

If the majority of your patient population has the same area code, type in a 3 digit default area code. This box may be left blank.

This default applies to the following fields:

- > **Home Tel#, Work Tel#, and Cell#** on the **Patient** tab in **Registration**
- > Any box on the **Additional Info** tab that uses the **Telephone** type

To use the default, enter 7 digits in the appropriate box, and then press **Tab**.

Note: When an area code is not the same as the default, type in all 10 digits to override the default.

Warning Period for Policy Expiration

Enter the number of days prior to the expiration date of a policy when you want the application to begin notifying you that a patient's primary coverage is about to expire.

Entering a number in this box and entering a policy expiration date on the **Policy** tab in **Registration** initiates the following events:

- > An indicator, such as **Exp 4 days**, is displayed in the **Status** column in the **Policy Information** grid on both the **Summary** tab and the **Policy** tab in **Registration**, as well as in the **Policy** grid in **Patient Information for [patient name]**, which opens when you click **Patient Info** on the **Summary** tab in **Appointment Scheduling**.

This indicator is displayed for any coverage type that is about to expire, not only for primary coverage.

- > A message, **Warning: Primary policy expires in X days**, is displayed in **Appointment Scheduling** when the patient's record is retrieved if there are no other primary policies for the patient that are not already expired or will not expire within the designated number of days.

The warning message only applies to primary policies and is not displayed when other levels of coverage are about to expire. You are not prevented from scheduling an appointment.

Note: An application-generated warning message is displayed when the patient's primary policy has expired even if you do not enter a number for this option. The message is no longer displayed when another policy is designated as the primary policy.

Warning Period for HIPAA Stmt Renewal

Enter a number (up to 3 digits) to indicate the number of days prior to the expiration date entered in **HIPAA Stmt Exp** on the **Patient** tab in **Registration** that you want the application to generate a message alerting your staff to have the patient sign a new HIPAA disclosure statement.

Note: You can designate **HIPAA Stmt Exp** as required in **Registration** by selecting it on the **Required Fields** window, which is accessed by clicking the **Required Fields** button on the **Registration** tab in **Practice Options or Organization Options**.

Aging Brackets

The intervals you set for this option determine the division of the aging table as it appears in **Account Inquiry** and **Collection Account Detail**.

Your setting is also the default for the aging brackets used on reports such as the **Aged Trial Balance** and the **Unpaid Claims Report**. Though you cannot change the setting on the **Account Inquiry** window, you can change the settings on the reports' main windows.

Batch Number Format

Enables you to define the numbering format your staff must use when creating batches.

Batch number formats

When **Assign Batch Numbers** is not selected on the **General** tab in **System Administration > Practice Options or Organization Options**, **Batch Number Format** is available to define a batch formatting convention that your staff must follow when opening new batches.

Tip: To quickly access **Practice Options or Organization Options**, press **F9** on your keyboard, then enter **POP** or **OOP**.

Read the following sections carefully before creating your batch type formats.

Defining batch number formats

Your batch number format can contain elements that identify the contents of a batch, such as when it was created and by whom. Give some thought to the detail and the entry order of the detail you want for your practice or organization. Specifically, keep the following in mind when defining batch formats.

- > The batch number format may not contain:
 - Decimals (.)
 - Slashes (/)
 - Commas (,)

- Single quotation marks (')
- Double quotation marks (")
- Dollar signs (\$)

- > The batch number format can only include 19 characters for a batch number, which enables use of the asterisk (*) when an associated batch is application-generated. Therefore, the sum total of the values for each field type (component of the batch number) cannot exceed 19.
- > The order in which the fields are displayed on **Batch Number Format** is the same display order as on **Batch Information** and **Options for user [user name] on this workstation**. Each field represents an element or component of the batch number used when creating a batch.

Think of the order of the fields as the order in which the components are entered and displayed. Therefore, the order should represent the order in which you want your staff to enter the information.

To change the order of a field, click on **Field Name** to select a row, then click **Move Up** or **Move Down**.

Best Practice: As a best practice, match the first value in **Field Name** with the way you file your journals.

- > The batch number prints on the **Batch Print & Close** and **Transaction Journal** reports, as well as on various financial reports.
- > The batch number is a sort option when validating claims and running various reports.

After you save the defined batch number formats, the application uses them in the following application areas.

- > **Financial Processing > Transactions > Batch Management** (for charge, payment, and void batch types)
- > **Financial Processing > Transactions > Charge Entry > Summary > Self-Pay > New Payment**
- > **Financial Processing > Automatic Transactions**
 - **Transfer Account Balances** tab (for payment batch type)
 - **Adjust Balances** tab (for payment batch type)
 - **Import Remittances** tab (for payment batch type)
 - **Import Charges** tab (for charge batch type)
 - **Unassigned Payment Management** tab (for payment batch type)
 - **Credit Balance Report** tab (for payment batch type)
 - **Finance Charges** tab
- > **Billing > Occupational Medicine > Print Invoices** (for payment batch type)
- > Void and Re-Enter (VRE) batches

Note: A defined void batch type format does not apply to void batches created using the **Void and Re-Enter** window available by clicking the **Void and Re-Enter** button on the **Edits** tab in **Financial Processing > Transactions**. Void and re-enter batches continue to be assigned an application-generated batch number with the prefix **VRE**.

In each of these application areas, all of the following are true for **Batch Number**.

- > **Batch Number** is disabled.
- > If a batch number did not default from **Options for user [user name] on this workstation**, you must click  to open **Batch Information**.
- > When user or workstation defaults were entered for the batch type, the application automatically fills the boxes on the related windows. When all required selections are not made, you must click  to enter the needed batch number elements.
- > For a newly created batch to be saved or for an automatic function to run, each batch number element must be filled.
- > Batch numbers must conform to the batch number format definitions you set up in **Practice Options or Organization Options**, including the:
 - Order of the entries
 - Formatting used to enter the date
 - Length of numbers
 - Text entries
- > Any existing batch number can be edited by clicking .

Editing defined batch number formats

Before you save your defined batch number formats, you can edit the definitions without ramifications. However, any change made to a saved format generates the warning: **All Batch User Options for xxx will be deleted.**

On the warning, click **OK** to save the change or click **Cancel** to cancel the change. When you click **OK**, all options you selected for that batch type are cleared from the **Batches** tab in **Options for user [user name] on this workstation** as accessed by clicking . In addition, the following occurs for any existing open or closed batches that were created using the edited or deleted format.

- >  is no longer displayed to the right of **Batch Number**.
- > **Batch Number** is enabled and can be manually edited.

Batch number format field types

There are several field types that you can use on the **Batch Number Formats** window. Each field type represents an element or component of the batch number that operators must enter on the **Batch Information** window when creating a batch.

Access the **Batch Number Formats** window by clicking the **Batch Number Format** button on the **General** tab in **System Administration > Practice Options** (or **Organization Options**).

Tip: To quickly access **Practice Options** or **Organization Options**, press **F9** on your keyboard, then enter **POP** or **OOP**.

The following field types are available on **Batch Number Formats**:

Alpha

Select this field type to create a box that allows operators to enter numbers, letters, or a combination of both.

Best Practice: Best practice when you use the **Alpha** field type is to only include one element per field. In addition, you should use field names that clearly indicate the use of letters. This prevents operators from entering information in the wrong order.

For example, if you name a field **Operator Initials and Batch of the Day** with the **Alpha** field type, operators could enter information in the reverse order of what you expect. Instead of entering their initials first, they might enter the batch of the day number, then enter their initials.

To prevent that from happening, you could instead create a field named **Operator Initials** with the **Alpha** field type. Then, create a separate field named **Batch of the Day** with the **Number** field type.

Date

Select this field type to create a date box that requires operators to select a date from the calendar. Then, select an option in the **Format** column to define the format for the date.

Best Practice: Best practice is to use field names that clearly indicate what the date in a batch number format is used to identify. For example, the date could identify when the batch was created, the service dates, or the remittance check dates related to the batch entries.

When you select **Date**, a drop-down list is displayed in the **Format** column. Use the drop-down list to select the required format. The available date formats are:

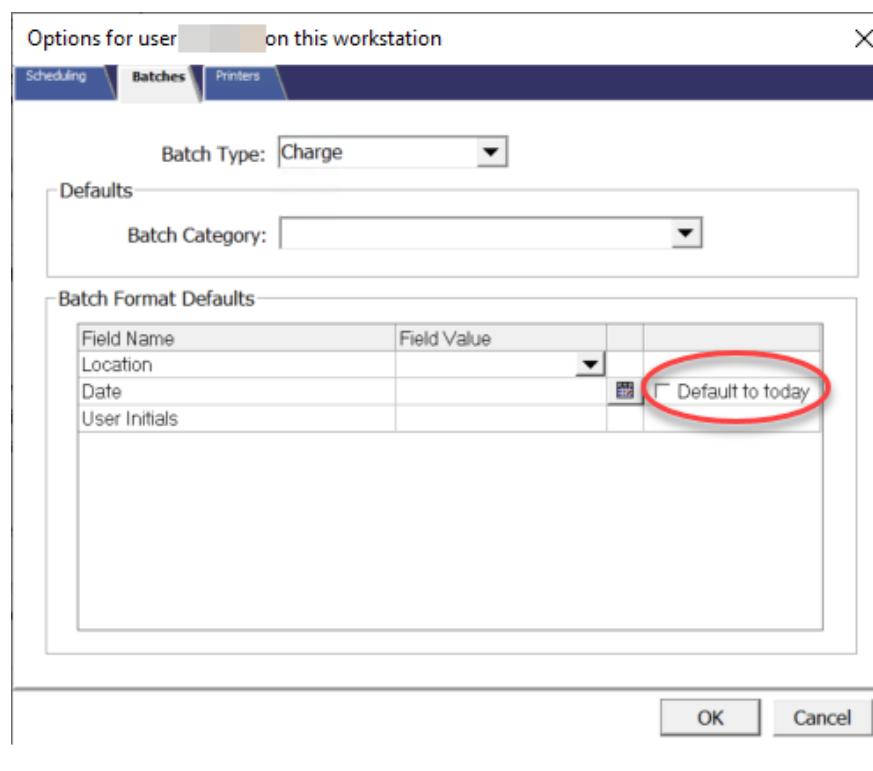
- > **MMDDYY**
- > **MM/DD/YY**
- > **YYMMDD**
- > **YY/MM/DD**
- > **MMDDYYYY**
- > **MM/DD/YYYY**

Each character and slash (/) included in the selected date format represents a character that counts toward the overall 19-character limit allowed for **Batch Number** on related windows.

Tip: After you close the **Batch Number Formats** window, if you click



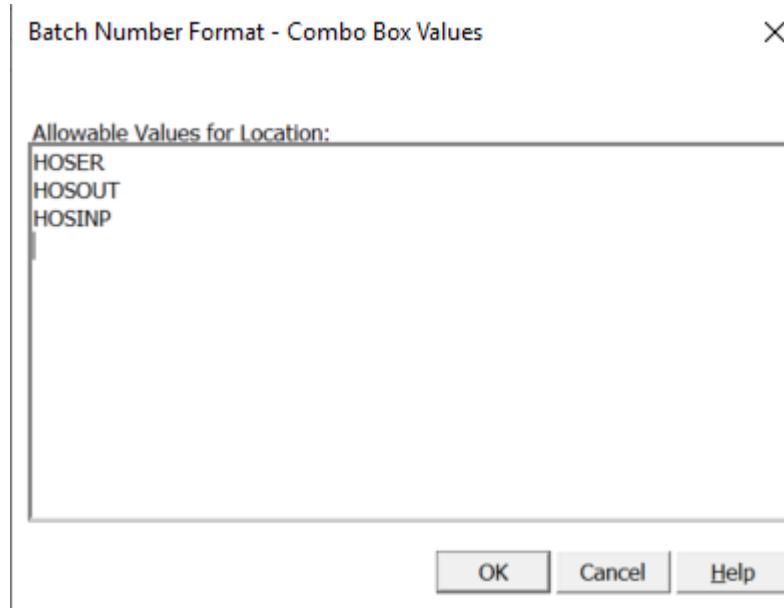
on the toolbar, you can select an option on the **Options for user [user name] on this workstation** window to set the current date as the default value for a date box.



Combo Box

Select this field type to create a drop-down list. Then, click  to define each option that you want to include in the drop-down list.

When you click , the **Batch Number Format - Combo Box Value** window opens.



On **Batch Number Format - Combo Box Value**, enter the value that you want to define as the first option on the drop-down list. Then, press **Enter** to begin entering a value for the next option.

For each option, the number of characters you enter on **Batch Number Format - Combo Box Value** counts toward the 19-character limit for the batch number. For example, if you already created:

- > A **Date** box that requires an 8-character value
- > A **Batch of the Day** box that requires a two-digit value
- > A **User Initials** box that requires a three-character value

Then, each option that you define for the **Location** drop-down list can only contain a maximum of six characters. This ensures that when the values are combined to form the batch number, the total length of the batch number does not exceed 19 characters.

Tip: To ensure that the batch number can fit all of the elements you want to include, use abbreviations instead of full phrases. For example, for a location such as Hospital Emergency Room, use an abbreviation such as HOSER.

Number

Select this field type to create a box that only allows operators to enter a number. Then, enter pound signs (#) in the **Format** column to define how many digits the number can include.

For example, to require a number that consists of two digits, enter ## (two pound signs) in the **Format** column. Do not use any of the following symbols:

- > Decimals (.)
- > Slashes (/)
- > Commas (,)
- > Single quotation marks (')
- > Double quotation marks (")
- > Dollar signs (\$)

Options on the General tab

Configure application wide settings by selecting options on the **General** tab in **Practice Options** or **Organization Options**.

To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and enter **POP** or **OOP** as applicable.

Apply to Sliding Fee Scales

Applies the number of days you defined for **Warning Period for Policy Expiration** to the end date entered on the patient's **Sliding Fees** tab in **Registration**.

This option works similar to a primary policy expiration warning in some aspects:

- > A message, **Warning: Sliding Fee Scale expires in X days, in Scheduling** alerts you when the patient's record is retrieved indicating that the patient's sliding fee scale is about to expire.
- > You can still schedule an appointment for the patient.

However, this option is unlike a primary policy expiration warning in several ways:

- > There is no indication of expiration displayed on the patient's **Summary** tab.
- > There is no indication of expiration displayed on the **Sliding Fees** tab.
- > After the end date is reached, there is no application-generated message to warn you that the fee scale has expired.

Allow Quick Payment in Any Batch

A quick payment is an unassigned payment that is not associated with a specific charge. Quick payments are entered from the toolbar in **Registration**, **Scheduling**, the **Charge Entry** tab and the **Payment Entry** tab in **Transactions**, and the **Collection Management** tab in **Collection Activities**.

When this option is selected, any user can enter a quick payment on a patient's account using any payment batch with the status of Open. All open payment batches are displayed for selection on the drop-down list for **Batch in Quick Payment**.

When this option is cleared, only open payment batches created by the operator are displayed as selections.

Note: The application identifies the current operator by the user name and password entered on that workstation at the time of logon.

Create QIF files when Posting Self-Pay Refunds

Automatically creates a Quicken Interchange Formatted (QIF) file that you can use to import voucher detail into Intuit Quicken® or Microsoft® Money for the purpose of printing checks.

Note: Your implementation specialist will assist you in creating a folder on your application server. This folder must be created before you select this option in order to avoid potential errors from occurring when you update batches.

If your practice or organization uses uninsured carriers, a QIF file is created for a refund associated with a traditional self-pay voucher and a voucher associated with an uninsured carrier.

When you update 1 or more payment batches, the program first checks to determine whether self-pay refunds are included in any of the batches. Batches that contain self-pay refunds are listed in the window.

QIF files are automatically saved to the QIF files directory that you created on your server. A separate file is created for each payment batch containing a self-pay refund. Files are automatically named using the batch number.

You can import the QIF file into Intuit Quicken® or Microsoft® Money using that software's import function.

Note: When this option is selected, if you want to update a batch that contains a self-pay refund without creating a QIF file, you must either void that self-pay refund or clear this option and then update that batch.

Assign Batch Numbers

Makes the batch number box unavailable on various related windows in **Financial Processing**. Automatically assigns batch numbers using increments of 1 beginning with the first available number found in your tenant. To determine availability, the application runs a scan of all previously entered batch numbers. The first unused number is assigned.

Automatically fills the batch number box with the word **New** and makes the box unavailable. When you click **Save** or **Run**, a message is displayed with the number assigned to the batch.

When selected, batch numbers are automatically assigned in the following functions:

- > **Batch Management:** Click  to activate the entry boxes.
- > **Transfer/Adjust Account Balances**
- > **Unassigned Payment Management:** A batch is created for each payment transaction created.
- > **Import Charges tab**

Note: When this option is selected, **Batch Number Format** is unavailable.

You can turn this option on or off at any time.

Show Self-Pay Account Balances

Displays the self-pay account balance in the title bar of the subordinate window in **Registration**, and the **Charge Entry** tab and **Payment Entry** tab in **Transactions**.

If your practice or organization uses uninsured carriers, the total self-pay balances impacted by this box include any traditional self-pay balance and any balance associated with an uninsured carrier.

This option also displays the self-pay account balance and the **Include Ins if Accept Assignment = No** balance at the top of **Apply Transactions to Oldest Self Pay Account Balance**.

Note: These balances are not displayed on **Apply Transactions to Oldest Self Pay Account Balance** when the **Payment Entry** tab is loaded by invoice.

Credit balances are displayed with parentheses.

Default to Rebill on Transfer to Insurance

Automatically selects **Rebill** on the **Payment Entry** tab when you transfer a voucher balance to an insurance that is not flagged as **Collections** or **Occupational Medicine**.

Rebill on the **Payment Entry** tab remains enabled, and you can manually clear it when it does not apply, such as when the primary carrier is Medicare and the remittance advice indicates that Medicare initiated a crossover to the secondary insurance.

Disallow Creation of Family Accounts

Requires that each patient is assigned his or her own account number.

This option makes icons, entry boxes, and options in **Registration** that are used to set up family accounts unavailable when you are adding a new patient or transferring a patient.

For example, if this option is selected and you click  on the toolbar in **Registration**, the message **ATTENTION: Patient cannot be transferred. Creation of Family Accounts is not allowed** is displayed in **Transfer Patient**.

Enable Department Security or Enable Practice Security

When selected, this option enables you to restrict operator access to information by department or practice.

This option adds a tab labeled **Department Members** or **Practice Members** to **Operator Maintenance** where you can restrict the operator's access to the selected departments or practices.

If you do not want to use department security or practice security, you must clear the selections on the **Department Members** tab or **Practice Members** tab for each operator.

Allow Access to Total Account Balance is enabled when this option is selected.

This option is intended to work along with **Disable Filtering**.

Enable Zip Code Validation

Enables the ZIP code validation feature.

After this option is selected, the application validates ZIP codes you enter in **Patient Management > Registration** against the master list of ZIP codes stored for your tenant in the database.

Note: ZIP code validation is only performed on zip codes in **Registration**. For other areas in Allscripts® Practice Management, incorrect ZIP codes must be corrected on the **Corrections** tab in **Zip Code Maintenance**.

Additionally, the following windows are available when **Enable Zip Code Validation** is selected:

Window	Access Path	Use
Zip Code Maintenance	System Administration > File Maintenance > Zip Code Maintenance	<ul style="list-style-type: none"> > Add, change, or delete ZIP Code records that are used for validation. > Correct any inaccurate ZIP codes that were collected before ZIP code validation was enabled.
Zip Code Import	System Administration > Interfaces > Zip Code Import	Import a ZIP code file into the database. The ZIP codes

Window	Access Path	Use
		imported into the database are added to your tenant's master list of ZIP codes.
Zip Code Lookup		Add a new ZIP code to use for ZIP code validation.

Require Proof Amount in Payment Batch

When **Require Proof Amount in Payment Batch** is selected, **Proof Amount** on the **Batch Management** tab in **Financial Processing > Transactions** must match the batch entered amount to close a payment batch.

Default to Account Items

Select this option to make **Account Items** the default value for the third query-filter option in **Account Ledger** and on the **Account Inquiry** tab in **Financial Inquiry** when inquiring by patient.

Allow Access to Total Account Balance

Displays a patient's total self-pay account balance on certain windows in the application, regardless of the user's department or practice access.

If your practice or organization uses uninsured carriers, the total self-pay balances impacted by this box include any traditional self-pay balance and any balance associated with an uninsured carrier.

This option is only enabled when **Enable Department Security** or **Enable Practice Security** is selected.

When this option is selected, the total self-pay balance for the account is displayed in the following places in the application when a patient is selected:

- > **Registration:** On the title bar of the subordinate window; **Show Self-Pay Account Balances** must also be selected
- > **Charge Entry** tab: On the title bar of the subordinate window; **Show Self-Pay Account Balances** must also be selected
- > **Payment Entry** tab: On the title bar of the subordinate window; **Show Self-Pay Account Balances** must also be selected
- > **Financial Inquiry:** On the **Account Inquiry** tab in the **Self** row of the **Aging** grid (when the grid is not blank)

Note: The **Voucher** grid displays all self-pay vouchers (regardless of department or practice security access) and only those insurance vouchers for departments or practice that the user has access to.

The **Payment** grid on the **Payment History** tab displays all unassigned payments and any payments for vouchers displayed in the **Vouchers** grid on the **Account Inquiry** tab.

> **Account Ledger:** In the **Self** row of the **Aging** grid

Note: The **Voucher or Service** grid displays all self-pay vouchers (regardless of department or practice security access) and only insurance vouchers for departments that the user has access to. Right-click functionality is still enabled for all vouchers or services. If users have security access permissions for the right-click menu options, they are able to work vouchers for departments or practices that they do not have access to.

- > **Patient Scheduling** tab: In **Self-Pay Balance** located on the top right of the tab
- > **Patient Info COMpanion**: In the **Self** row of the **Aging** grid
- > **Appointment Detail** window: In **Self-Pay Balance** located at the top right of the window
- > **Schedule New Appt** window: In **Self-Pay Balance** located at the top right of the window
- > **Force Appointment** window: In **Self-Pay Balance** located at the top right of the window
- > **Walk In Appointment** window (from **Appointment Book**): In **Self-Pay Balance** field located at the top right of the window

Note: Do not confuse this window with the **Schedule (Walk In)** **Appointment** window accessed from **Walk In** on the **Patient Scheduling** tab.

Warn if Split Fee Does not Equal Non-Split Fee in PCM

When this option is selected, a warning is displayed in **Procedure Code Maintenance** when **Enable Split Billing** is selected for a **Procedure Code** and the sum of the fees entered for the custom procedure codes selected as institutional or professional does not equal the fee of the procedure code enabled for split billing. This warning occurs when you attempt to save your changes in **Procedure Code Maintenance**.

Hide SSN

When this option is selected, the first 5 digits of the Social Security number (SSN) are hidden using ***** in all SSN boxes for patient, guarantor, subscriber, and contacts in **Registration** and **COMpanion** registration windows.

In addition, throughout the application the patient and guarantor SSN numbers are displayed with 5 asterisks and 4 ending digits on all banners and windows that contain the SSN.

Suppress SSN from Patient Lookup Results

When this option is selected, **SSN** is removed from the results portion of **Patient Lookup**.

Even if **SSN** is selected for **Search By** in **Patient Lookup**, the **SSN** column is not displayed. In this case, the Social Security number (SSN) is still used as part of the search criteria, but the patient's SSN is not returned in the search results.

If **Hide SSN** is selected and **SUPPRESS SSN FROM PATIENT LOOKUP RESULTS** is not selected, the SSN number in the results grid in **Patient Lookup** shows with 5 asterisks and the last 4 digits. (for example, *****1111). When you enter a search-by request, you must use the entire SSN.

Note: This option applies to every patient lookup window throughout Allscripts® Practice Management.

Require Batch Category

When this option is selected, you must select a batch category when creating a new batch in the following places within Allscripts® Practice Management:

- > Charge, payment, and void batches in **Financial Processing > Transactions > Batch Management**
- > The following tabs in **Financial Processing > Automatic Transactions**:
 - **Transfer Account Balances** tab
 - **Adjusting Balances** tab
 - **Import Remittances** tab
 - **Import Charges** tab
 - **Unassigned Payment Management** tab
 - **Credit Balance Report** tab
 - **Finance Charges** tab
- > **Billing > Occupational Medicine > Print Invoices**
- > **System Administration > Interfaces > Banner Transactions Export**

You can still select a batch category even if it is not required.

You can clear this option at any time if you decide you no longer want to require batch categories on your batches.

You can use **User Defaults** to require the selection of a category for payment batches only.

Disable Filtering

Intended for use when **Enable Practice Security** or **Enable Department Security** is selected. This option is selected by default to enable you to build your department or practice memberships without disrupting existing workflow until you are ready to fully implement filtering based on department or practice access.

Enable void and export

Intended for use only by clients who have purchased and are using the Detailed Financial Transaction (DFT) export.

If you are not using the DFT export, verify that this option is not selected.

Enable Bypass Automated Update Flag

When this option is selected, **Bypass Automated Update** is displayed in the following windows:

- > **Charge Batch Defaults**
- > **Payment Batch Defaults**
- > **Void Batch Defaults**

Bypass Automated Update provides the ability to mark batches so that they are not processed by automated billing.

Enable Bank Account

This option facilitates the addition and maintenance of bank accounts in Allscripts® Practice Management. When you select **Enable Bank Account**, the following happens in the application:

- > **Bank Account Maintenance** is available.
- > A **Bank Account** tab is added to **Billing Office Maintenance**.
- > **Bank Account** is available in the following areas of the application:
 - **Location Maintenance**
 - **Batch Management** tab in **Financial Processing > Transactions**
 - **Bank Reconciliation Report** and **Daily Payment Analysis Report**
- > **Bank Account 1** and **Bank Account 2** are selection options for **Sub-Account** on the **GL Category Members** tab in **GL Category Maintenance**.

You cannot clear **Enable Bank Account** when you have saved batches with bank accounts that have general ledger (GL) sub-accounts.

Enable Merchant Terminal ID

When **Enable Merchant Terminal ID** is selected, the following merchant terminal ID enhancements are displayed in Allscripts® Practice Management:

- > **Merchant Terminal ID** on the **Batch Management** tab in **Financial Processing > Transactions**
- > **Require Merchant Terminal ID** on the **Transaction Code** tab in **Transaction Code Maintenance**

- > The **Merchant Terminal ID** grid on the **Billing Office** tab in **Billing Office Maintenance** and on the **Location** tab in **Location Maintenance**

When this option is selected, the information you enter and save in the merchant terminal ID enhancements is stored in the database. If you clear **Enable Merchant Terminal ID**, the merchant terminal ID enhancements are not displayed. If you select **Enable Merchant Terminal ID** at a later time, the merchant terminal ID information that is stored in the database fills the boxes or grids when they are displayed.

Filtering with department security or practice security enabled

You can enable filtering when you enable department security or practice security. Set up filtering on the **General** tab in **Practice Options** or **Organization Options**.

Filtering is enabled when you clear the option **Disable Filtering** on the **General** tab in **Practice Options** or **Organization Options**.

When **Enable Department Security** or **Enable Practice Security** is selected and **Disable Filtering** (which enables further filtering) is cleared, the selection options in all select records windows and combo boxes are based on the operator's selected department or practice members in **Operator Maintenance** and the members selected in each related file maintenance.

- > **Ailment Maintenance**
- > **Batch Category Maintenance**
- > **Claim Type Maintenance**
- > **Collection Action Maintenance**
- > **Held Voucher Reason Maintenance**
- > **Image Category Maintenance**
- > **Location Maintenance**
- > **Message Maintenance**
- > **Place of Service Maintenance**
- > **Operator Maintenance**
- > **Provider Maintenance**
- > **Resource Maintenance**
- > **Scheduling Location Maintenance**

What this means

This means, for example, that in **Registration** the combo box for provider shows only those providers which have department or practice members that include any of the members selected for the operator in **Operator Maintenance**.

In addition, filtering is applied in **Scheduling**, **Charge Entry**, on **Charge Batch Default**, **Quick Payment**, and **Unassigned Payment Refund**, which filters fields such as Provider, Billing Provider,

Resource, Location, Scheduling Location, Place of Service and Batch Category based on the operator's selection of a Department/Practice.

For example, when you open **Quick Payment**, the fields **Associated Department/Practice**, **Associated Provider** and **Associated Location** each show selections based on his/her department/practice security access and the department/practice members selected for each of these records in file maintenance. When she/he selects a department/practice both of the other fields are filtered so that now they include only those Providers and Locations that have the selected department/practice as a member.

Leaving the option checked

The select department/practice records dialogs and department/practice combo fields on screens throughout the application show only those departments/practices to which the Operator has access.

Audit history

Various windows throughout Allscripts® Practice Management have a **History** tab that displays an audit history of the changes made on that window.

A **View History** button is also available on the **Edits** tab in **Financial Processing > Transactions** when changes have been made to the voucher. **View History** enables practice or organization administrators to easily view the history of changes made on a voucher after it has been saved.

The diagnosis audit history for a voucher is displayed in a slightly different manner when you add one-time-only mapped ICD-9 codes from the **Edits** tab using **Diagnosis Code Lookup**. The reason is that the sequence numbers assigned to diagnosis codes in the database are changed. ICD-9 codes always have lower sequence numbers than ICD-10 codes, so they are displayed first.

Table 4: Example: Voucher audit history when one-time-only mapped ICD-9 codes added from the Edits tab

Note: Diagnosis codes used in the example are fictitious codes.

Action	Internal sequence numbers	Old Value contains	New Value contains
Initial charge entered with one ICD-10 code (10.1) that is not mapped to any ICD-9 codes	10.1 = 1		10.1
Voucher accessed in Edits and two mapped ICD-9 codes (9.1 and 9.2) added	9.1 = 1 9.2 = 2 10.1 = 3	10.1	9.1 9.2 10.1

Action	Internal sequence numbers	Old Value contains	New Value contains
Voucher accessed in Edits and one mapped ICD-9 codes (9.3) added	9.1 = 1 9.2 = 2 9.3 = 3 10.1 = 4 Note: There were no changes to 9.1 or 9.2, so they are not displayed for this audit entry.	10.1	9.3 10.1

When you click **View History**, the most recent action is displayed first, and values are displayed in ascending order according to the internal sequence numbers.

	Field Name	Old Value	New Value
-	02/22/2013 02:16 PM Modified by: Compusense Compusense		
-	Show Changed Fields		
	Field Name	Old Value	New Value
	Procedure 50551 SERVICE ID 4072		
	Diagnosis_Code	10.1	9.3
	Diagnosis_Code		10.1
-	02/22/2013 02:15 PM Modified by: Compusense Compusense		
-	Show Changed Fields		
	Field Name	Old Value	New Value
	Procedure 50551 SERVICE ID 4072		
	Diagnosis_Code	10.1	9.1
	Diagnosis_Code		9.2
	Diagnosis_Code		10.1
-	02/22/2013 02:14 PM Modified by: Compusense Compusense		
-	Show Changed Fields		
	Field Name	Old Value	New Value
	Procedure 50551 SERVICE ID 4072		
	Diagnosis_Code		10.1

Detail stored

This following information is stored on the **Audit History** window:

- > date
- > time
- > time zone
- > first and last name of the operator who made the change
- > name of the field
- > value changed and new value entered in the field

Note: The date, time, and by whom the most recent change was made is displayed at the bottom right of the window on which the change was made.

Replication

In the tenant where the change originated, the user is identified by log in name on the main window and by first and last name on the **Audit History** window.

In the tenants receiving the change by replication, the user who made the change is identified on the main window as **System** and on the **Audit History** window as **System Account**.

Aging options on the General tab

This section describes the **Age By** and **Age Considered Pass Due** options found on the **General** tab in **Practice Options** or **Organization Options**.

To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and enter **POP** or **OOP** as applicable.

Age By

Aging is the calculation of the number of days from either the service date or the most current billing date that a claim or voucher remains unpaid. Your selection determines how the application calculates the aging of balances.

Note: You can always run reports aging balances by either billing or service date regardless of the selection that you make for this option.

Billing Date

Aging on a self-pay balance begins the first time that the balance shows on the patient's statement.

Aging on a balance out to insurance begins when the voucher is printed and transmitted as a claim.

Aging is reset on balances when the balance is transferred to another payer and the voucher is flagged for **Rebill**.

Service Date

Aging begins as of the date of service regardless of when a voucher is billed as a claim or as a self-pay balance.

Aging only resets when the balance is paid in full.

Age Considered Past Due

Determines when a balance is flagged as past due when you perform any of the following actions:

- > Run the **Past Due Documents Listing in Collections**, which lists each account's past-due self-pay balance
- > Print a collection information document, which uses the pull field **AcctBalPast**
- > Print a patient information document, which uses the pull field **PatSelfBalPast**
- > Print a scheduling patient information document, which uses the pull field **PatSelfBalPast**
- > Show self-pay balances in **Scheduling**

Note:

- > When you select **Show Self-Pay Balances** on the **Scheduling** tab in **Practice Options or Organization Options**, the balance shows in red when all or even a portion of the patient's self-pay balance is considered past due based on the setting for **Age Considered Past Due**. When your practice or organization uses uninsured carriers, self-pay balance amounts include both traditional self-pay balances and uninsured carrier balances.
- > You can include past-due balances in a collection document if you use the pull field **AcctBalPast** when creating the document.
- > Past due balances print on the **Past Due Documents** listing in **Collections**.

Tip: If you want balances aged over a certain number of days, enter that number of days + 1. For example, if you want balances aged over 44 days flagged as past due, enter 45.

General search options on the General tab

The search options you define on the **General** tab in **Practice Options or Organization Options** (press **F9**, and then enter **POP** or **OOP**) are used when you are doing a local search on the **Patient Lookup** window from anywhere within Allscripts Practice Management™. They give you the ability to set search criteria thresholds for your practice.

Note: When you click **Enterprise Search** or **Search All Sources**, Allscripts Practice Management™ uses the search options settings from the **Enterprise** tab in **Practice Options or Organization Options**. If search options settings do not exist on the **Enterprise** tab, the application

uses these search options settings. **Search All Sources** is only displayed when you select **Force Enterprise Search** on the **Enterprise** tab.

Minimum # of required search by fields

Sets the minimum number of **Search By/Search For** boxes you must use when searching for a patient in **Patient Lookup**. More than the minimum number of **Search By/Search For** boxes may be entered but not less.

Example: If the option is set to **2**, you are required to make a selection in the **Search By** and **Search By 2** boxes as well as enter a value in the corresponding **Search For** boxes.

This spinner control box defaults to **1**. The choices available are **1, 2, or 3**.

If the minimum number of **Search By/Search For** boxes is not filled when you click **Local Search** in **Patient Lookup**, a message is displayed letting you know what the minimum requirement is.

Exceptions

Enabled when **Minimum # of Required Search By Fields** is set to **2 or 3**.

Click to display **Minimum Search Fields Exceptions**, which shows all of the available patient search fields including any patient additional info fields that are designated as searchable.

When any of these fields are selected as exceptions, they are excluded from the minimum number of required search field rule, and you are therefore allowed to search on that one field only.

Minimum # required characters for patient last name lookup

Enables you to set a minimum number of characters that must be entered for the last name in the **Search For** box in **Patient Lookup**. More than the minimum number of characters may be entered but not less.

Example: If this option and the **First Name Lookup** option are both set to **2**, you must enter at least 2 characters for the last name and at least 2 characters for the First Name in **Search For** in **Patient Lookup**.

The default setting is **0**. The available choices are **0, 1, 2, 3, or 4**.

If the minimum number of characters is not entered when you click **Local Search** in **Patient Lookup**, a message is displayed letting you know what the minimum requirement is.

First name lookup

Allows you to set a minimum number of characters that must be entered for the first name in the **Search For** box in **Patient Lookup**. More than the minimum number of characters may be entered but not less.

The default setting is **0**. The available choices are **0, 1, 2, 3, or 4**.

If the minimum number of characters is not entered when you click **Local Search** in **Patient Lookup**, a message is displayed letting you know what the minimum requirement is.

Available coverage types on the General tab

The section **Available Coverage Types** on the **General** tab in **Practice Options or Organization Options** (press **F9**, and then enter **POP** or **OOP**) enables you to decide which coverage types you want to display throughout the application.

You have the option to set one of the coverage types as a default.

You also have the option to set coverage types to require that an ailment be associated with a policy in **Registration** and **Appointment Scheduling**.

The available coverage types are:

- > **Behavioral Health** (previously called Mental Health)
- > **Dental**
- > **Medical**
- > **Motor Vehicle**
- > **Other**
- > **Transplant** (is displayed only when **Enable Transplant Management** on the **Special Billing** tab in **Practice Options or Organization Options** is selected)
- > **Uninsured**
- > **Worker's Comp**

The application default is for all of these to be selected as available and for **Medical** to be selected as the default.

You can only set a coverage type as a default if you have also selected that coverage type as available. You do not have to select a default coverage type. You can change your default selection at any time. If you set a default, it shows in **Scheduling** wherever coverage type is displayed and in **Insurance Carrier Maintenance** when you add a new record. You can override the default.

The default setting in **Practice Options or Organization Options** is superseded in **Scheduling**

by the user default in **Update Options**, accessed by clicking  on the toolbar, and also by the coverage type setting in **Appointment Type Maintenance**.

If you clear the check box for a coverage type in **Practice Options or Organization Options** that is in use in the application, a message is displayed after you click **Save** telling you that the changes you made cannot be saved because the specified coverage type is currently being used.

Select the box in the **Ailment Management** column for a coverage type if you want to require an ailment to be associated to a policy of that coverage type in **Registration**. In addition, selecting the box makes an ailment required in **Appointment Scheduling** for appointments with that specific

coverage type. The check boxes in the **Ailment Management** column are enabled for each coverage type that you have selected to display. If a particular coverage type is not selected to display, the **Ailment Management** check box for that coverage type is not enabled. If you have the **Ailment Management** check box selected for a specific coverage type and then you clear that coverage type, the **Ailment Management** check box is cleared and unavailable automatically.

Require Policy is cleared by default and is available only when the check box to the left of the coverage type description is selected. If **Require Policy** is selected and then the check box to the left of the coverage type description is cleared, **Require Policy** is cleared.

When selected, the application validates that the patient has an active primary policy with the same coverage type that was selected for the appointment being scheduled. You cannot schedule the appointment unless the appointment passes this validation. **Require Policy** applies to appointments scheduled for potential patients but does not apply to memo appointments.

If a medicare patient has both a **Primary** policy and an **Other Primary** policy on their account, this validation checks the **Primary** policy only and does not check the **Other Primary** policy during validation.

Appointments for patients with no insurance (self-pay) fail the validation.

Best Practice: If your practice or organization does not have a placeholder insurance profile created for self-pay patients, do not select **Require Policy** for the coverage types that are used for appointments that are scheduled for self-pay patients.

This validation occurs in the following areas:

- > The **Patient Scheduling** tab in **Scheduling > Appointment Scheduling**
- > **Schedule New Appt (This Patient)**, **Schedule New Appt (Any Patient)**, **Force Appointment**, and **Walk In Appointment** available from the context menu in the **Appointment Book** and **Appointment Management** tabs in **Scheduling > Appointment Scheduling**
- > **Appointment Detail** if you change the coverage type on an existing appointment and click **OK**
- > The scheduling COMpanion windows for **Schedule New Appt (This Patient)**, **Schedule New Appt (Any Patient)**, **Force Appointment**, **Walk In Appointment**, and **Appointment Detail** accessed from the context menu in **Office Manager > Appointment Management**.

Registration tab in Practice Options or Organization Options

Use the **Registration** tab in **Practice Options** or **Organization Options** to define registration options, which set rules that standardize the registration process and determine defaults and validation checks.

Use the registration options on this tab to:

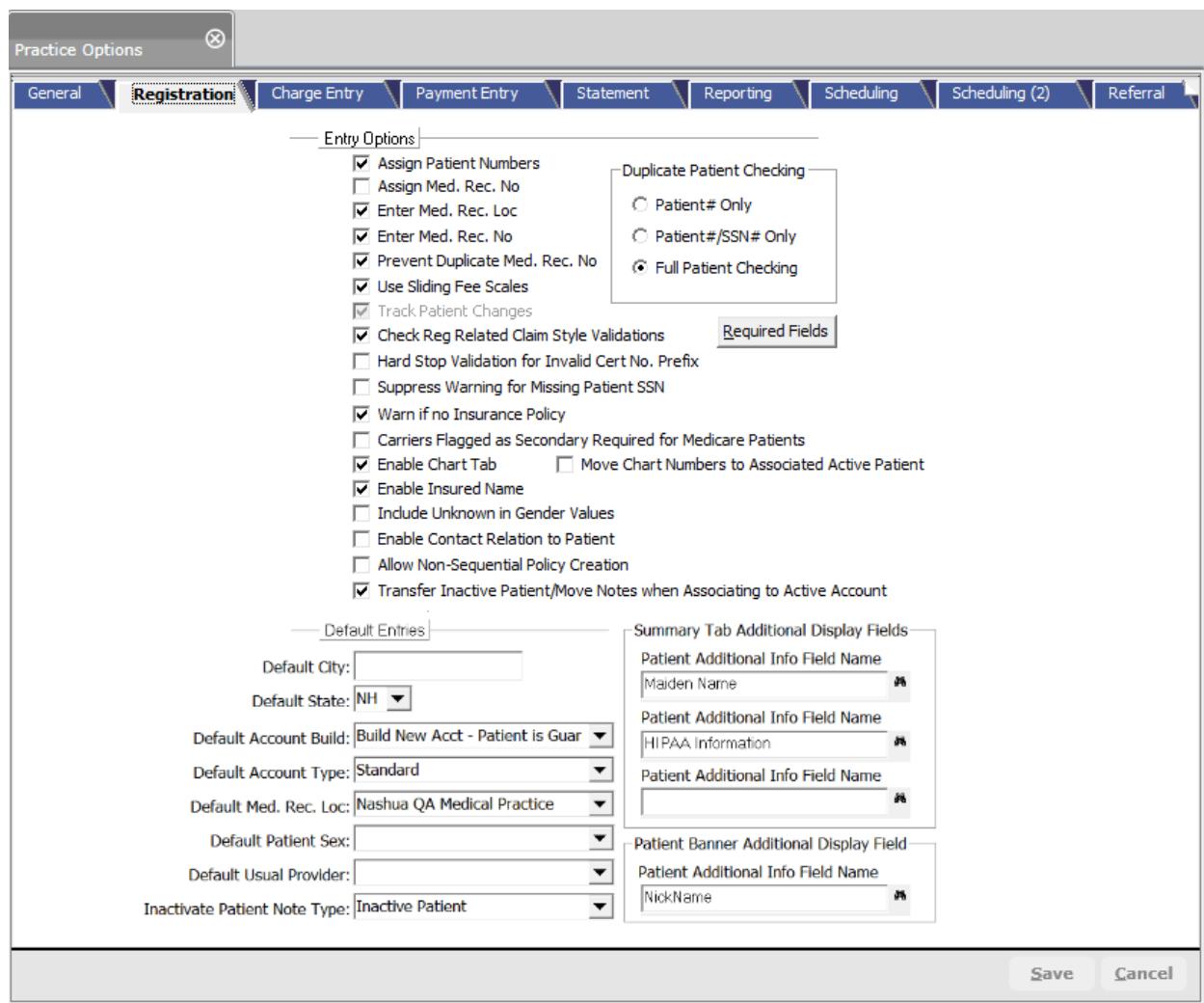
- > Set rules that standardize the registration process based on your office policies.

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- > Define which of the optional registration boxes you must fill when registering a patient.
- > Define the default entries for various boxes to make the registration process quicker.
- > Trigger validation checks during the registration process to ensure clean claim information.
- > Track the changes made on patient records.

As office policies and procedures change, you can change the settings. Any or all of the check boxes on this tab may be left cleared.

Access the **Registration** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options or System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.



The screenshot shows the 'Practice Options' dialog box with the 'Registration' tab selected. The 'Entry Options' section contains numerous checkboxes for various validation and tracking features. The 'Default Entries' section includes dropdown menus for Default City, State, Account Build, Account Type, Medical Record Location, Patient Sex, Usual Provider, and Inactivate Patient Note Type. The 'Summary Tab Additional Display Fields' and 'Patient Banner Additional Display Field' sections show field mappings between patient information and system fields like Maiden Name, HIPAA Information, and NickName. At the bottom right are 'Save' and 'Cancel' buttons.

Entry Options on the Registration tab

The **Entry Options** area on the **Registration** tab in **Practice Options** or **Organization Options** enables you to set rules that standardize the registration process based on the policies of your practice or organization.

Assign Patient Numbers

When you select this option, the application automatically assigns patient numbers at the time of registration. **Patient Number** is unavailable on **Begin New Patient**, preventing any manually entry or revision. Numbers are assigned in increments of 10, except in the case of family billing. For family billing, the guarantor is given a patient number (such as 100) and associated patients are given patient numbers by increments of 1 (such as 101 and 102).

If you select this option, be sure to also change the default **Duplication Patient Checking** option.

Not selecting this option requires you to manually enter random numbers at the time you register a patient. Generally, practices that use a numbered filing system find it necessary to leave this option cleared.

Important: You can activate this option at any time. However, if you decide to select the option after you have manually entered patient numbers, contact Allscripts® Support for assistance. The last number used by you must be entered in the database to avoid potential errors.

Assign Med Rec No

Select this option to automatically assign medical record numbers by increments of 1 when a patient is registered. This application-generated number automatically fills the corresponding box on the **Patient** tab in **Registration**. Selecting this option makes the option **Enter Med. Rec. Loc** unavailable.

The following enterprise search logic is used to fill **Med Rec No** when **Source** on the **Enterprise** tab in **Practice Options** or **Organization Options** is set to **OTHER**:

- If the patient MRN in the response message is blank, and **Assign Med Rec No** is selected, then **Med Rec No** on the **Patient** tab in **Registration** is automatically filled by the application.
- If the patient MRN in the response message is blank, and **Assign Med Rec No** is not selected, then **Med Rec No** on the **Patient** tab in **Registration** remains blank.

Enter Med Rec Loc

Enables you to select a medical record location for the patient during registration, using **Patient Med. Rec. Loc** on the **Patient** tab in **Registration**. Selecting this option activates the option

Require Med. Rec. Loc... This option is helpful for those practice or organizations that have active patient records stored at different sites, such as by specialty.

Note: To select a medical record location for a patient, you must first create medical record locations in **Medical Record Location Maintenance**.

Enter Med Rec No

- > Active only when **Assign Med. Rec. No** is cleared
- > Disabled when **Assign Med. Rec. No** is selected
- > Enables **Med. Rec. No**. on the **Patient** tab in **Registration**.
- > Helpful for practices or organization that are converting records from another application to Allscripts® Practice Management and have, for example, an established alpha-numeric medical record keeping system.

Prevent Duplicate Med Rec No

When selected, the record of a patient whose medical record number is a match to a number already assigned to another patient in your practice or organization cannot be saved or imported. If you import patients using for example, **Enterprise Search**, **Automatic Registration** or **Auto Import**, this option enables you to ensure that each patient receives a unique medical record number.

The following enterprise search logic is used to fill **Med Rec No** when **Source** on the **Enterprise** tab in **Practice Options** or **Organization Options** is set to **OTHER**:

- > If the patient medical record number (MRN) is in a response message, and **Prevent Duplicate Med Rec No** is not selected, then **Med Rec No** on the **Patient** tab in **Registration** is filled with the MRN from the response message.
- > If the patient MRN is in a response message, and **Prevent Duplicate Med Rec No** is selected, and a duplicate MRN is found when saving the patient, then **Duplicate Patients/Contacts** is displayed.

Use Sliding Fee Scales

- > Selecting this option adds the **Sliding Fees** tab to **Registration**, which enables you to apply a sliding fee scale to patients enrolled in federal, state, county, or city income assistance programs.
- > Selecting this option also enables functions and options in **Charge Entry** and **Payment Entry** related to the use of sliding fee scales.
- > A patient's sliding fee information is reportable using the general view `vwGenPatSlidingFeeInfo`.

Track Patient Changes

- > When selected, writes changes made to patient records in **Registration** to the database in Allscripts® Practice Management. Because the tracking process begins as soon as you select this option and click **Save**, do not select this option while anyone is working in Allscripts® Practice Management.
- > When cleared, changes made on a patient's record are not tracked. However, the time, date and operator stamp are displayed on a patient's **Account** tab regardless of this setting.

Check Reg Related Claim Style Validations

Displays a warning message when you click **Save** if one or more of these claim style validations apply to a policy associated with the account and the required information is missing.

- > Certificate number, with or without a specific format
- > Certificate suffix required
- > **Group Number Required**
- > **Group Name Required**
- > **ANSI 837 Validation Checks**

Note: **ANSI 837 Validation Checks** is not an available option for v5010 claim styles. Those validation checks are required for v5010 claims and are automatically performed by the application.

Hard Stop Validation for Invalid Cert No Prefix

Select this option to prevent the user from saving the record until a valid certificate number prefix is entered. When this option is not selected, a soft warning message is presented in **Registration** if the certificate number prefix fails validation, but the user can still save the record. The soft warning does not apply to **Transplant Management**.

Suppress Warning for Missing Patient SSN

When selected, this option prevents the programmed soft warning from being displayed when an operator tries to save a patient record that does not include a social security number.

Note: Selecting this option does not suppress the hard warning generated when **Patient SSN** is selected in **Required Fields**.

Warn if no Insurance Policy

Displays a warning message when you try to save a new patient record if you have not added an insurance policy on the **Policies** tab. Click **OK** to save your changes or click **Cancel** to return to the **Policies** tab and make the necessary changes.

Note: If a primary uninsured policy or an other uninsured policy was added on the **Policies** tab in **Registration**, the patient account passes this validation when it is saved.

Carriers Flagged as Secondary Required for Medicare Patients

Intended to help users when selecting policies that are designated as secondary to Medicare. Before you select this option, carriers that are secondary to Medicare should be flagged as secondary carriers on the **Carrier** tab in **Insurance Carrier Maintenance**. When you select these options, these items occur in **Registration**.

- > You are prevented from saving a selection for secondary coverage when a patient has a primary policy whose **Source of Payment** is set to **Medicare** and the policy selected for secondary coverage is not flagged as a secondary carrier. You must click **OK** and change the policy to one that is flagged as a secondary carrier.
- > When a carrier flagged as a **Secondary Carrier** is selected for primary, tertiary, or other coverage, this message is displayed when you click **save**: Warning, Carrier XXXX is flagged as Secondary in Insurance Carrier Maintenance. You can then click **OK** to save your selection or click **Cancel** to return to the window and select another policy.

Enable Chart Tab

Enables you to store and view historical patient numbers by chart location in **Registration**. This option may be useful if you are converting and merging multiple legacy databases into a single Allscripts® Practice Management database. For example, some multi-specialty practice or organizations may have previously assigned the same patient multiple numbers. When you select this option, these tabs are enabled.

- > The **Chart Number Locations** tab in **Practice Set Up** or **Organization Set Up**. Use this tab to create the custom locations used on the **Chart** tab in **Registration**.
- > The **Chart** tab in **Registration**. Use this tab to store the patient's historical chart and patient numbers by location.

Move Chart Numbers to Associated Active Patient

Select this option to have the chart numbers for an inactivated patient record moved to the associated active patient record, regardless of whether **Transfer Inactive Patient/Move Notes when Associating to Active Account** is selected. Chart numbers are removed from the inactive patient's record and added to the associated active patient's record.

Enable Insured Name

Select this option to enable the insured name functionality, which enables you to store the insured name for a patient in cases where the insured name differs from the standard name entered for the patient in **Registration**. If you select **Enable Insured Name**, an **Insured Name**

box and icon are added to the **Account** tab in **Registration**. Use this box to store a separate insured name for the patient that differs from the standard name.

Additionally, enabling the insured name functionality changes both paper and electronic billing. For both types of billing, the billing process uses the subscriber name instead of the patient name when the 2 differ and the patient's **Subscriber Relationship** is set to **Self**. If the patient's subscriber name differs from the patient name, you can also import the subscriber name using automatic registration or automatic demographic import. In Allscripts® Interface Engine, the eligibility, demographics, and scheduling exports and the demographic import also include patients' subscriber name when it differs from their regular contact name. The insured name functionality fully supports the use of middle name when you have **Add Middle Name for Import/Export** selected on the **External Access** tab in **Practice Options** or **Organization Options**.

Include Unknown in Gender Values

If selected, **Unknown** is added as a gender value to the **Sex** drop-down list in the **Patient** and **Account** tabs in **Practice Management > Registration**.

Note: You cannot clear the **Include Unknown in Gender Values** check box if any patient records are currently using the value **Unknown** in the **Patient** or **Account** tabs in **Patient Management > Registration**.

Best Practice: Before you select **Include Unknown in Gender Values**, confirm that applications or organizations that import demographic data from Allscripts® Practice Management accept U as a gender value.

Unknown is not displayed in the following locations:

- > The **Sex** drop-down list in **Provider Maintenance**.
- > The **Sex** drop-down list in **Referring Doctor Maintenance**.
- > The **Restrict to Sex** drop-down list in **Procedure Code Maintenance**.
- > The **Default Patient Sex** drop-down list in **Practice Options**.

When **Unknown** is selected for **Sex** in **Registration**, **Unknown** is available for **Patient_Sex** and **Guarantor_Sex** in the patient information general view (vwGenPatInfo).

Enable Contact Relation to Patient

Important: Do not select and save **Enable Contact Relation to Patient** unless your Allscripts® Interface Engine import and export interface configurations support this function. You cannot clear **Enable Contact Relation to Patient** after it is saved.

When you select **Enable Contact Relation to Patient**, the following changes occur in Allscripts® Practice Management:

- > **Rel to Guar** on the **Patient** tab in **Registration** is hidden.
- > **Relation to Patient**, located to the right of **Emergency Contact** on the **Account** tab in **Registration**, is available for all contacts on the account instead of only the emergency contact.
- > For any patient that had a value in **Rel to Guar**, that value is transformed to a value in **Relation to Patient** for the contact selected as the guarantor, provided that the contact does not already have a value in **Relation to Patient**. The following are the transformation values:

Value in Rel to Guar	New value in Relation to Patient
Self	Self
Spouse	Spouse
Other	Other
Child	<ul style="list-style-type: none"> — Mother if the guarantor's gender is female — Father if the guarantor's gender is male — Parent if the guarantor's gender is not known

If the transformed value was deleted from **Relationship Maintenance**, **Relation to Patient** is blank. For example, if **Rel to Guar** is set to **Self**, but **Self** was deleted from **Relationship Maintenance**, **Relation to Patient** is blank. If **Rel to Guar** is set to **Child** and the guarantor's gender is female, but **Mother** was deleted from **Relationship Maintenance**, **Relation to Patient** is blank.

- > Allscripts® Interface Engine fills **Relation to Patient**, and not **Rel to Guar**, when patient information is imported.
- > **Patient Relation to Guarantor in Patient Registration Required Fields** is renamed **Guarantor Contact Relation to Patient**. When **Required** is selected for that row and **Highlight Required Fields** is also selected, **Relation to Patient** is highlighted in yellow for the contact selected as the guarantor.
- > **Note:** **Relationship Maintenance** is available regardless of whether **Enable Contact Relation to Patient** is selected.
- > The **GRelPat** pull field in **Document Maintenance** contains the value of **Relation to Patient** for the contact selected as the guarantor on the **Account** tab in **Registration**. If you have patient information or scheduling patient information documents that use the **PRelGuar** pull field, after selecting **Enable Contact Relation to Patient**, you must change those documents to use the **GRelPat** pull field instead.

- > The Guarantor_to_Patient column in the vwGenPatInfo general view contains the value of **Relation to Patient** for the contact selected as the guarantor on the **Account** tab in **Registration**. If you have custom reports created with SAP™ Crystal Reports that use the Patient_Rel_To_Guarantor column, after selecting **Enable Contact Relation to Patient**, you must change those reports to use the Guarantor_to_Patient column instead.

Allow Non-Sequential Policy Creation

When you select this option, the requirement to have a primary medical policy before entering a secondary medical policy is not enforced. You can enter a secondary policy with the **Medical** coverage type on the **Policies** tab in **Registration** when a patient does not have a primary policy with the **Medical** coverage type. The option also applies to **Review Changes** when importing patients.

Transfer Inactive Patient/Move Notes when Associating to Active Account

Select this option to provide the ability to perform the patient inactivation function and transfer patient function in one workflow.

When **Transfer Inactive Patient/Move Notes when Associating to Active Account** is selected, if you enter a date in **Inactivation Date** on the **Patient** tab in **Registration** and click **Save**, the message, Do you want to associate this inactive patient with an active patient and transfer it to the active patient's account? is displayed instead of the standard message, Do you want to associate this inactive patient with an active patient?.

- > If you click **Yes**, the inactivated patient record is transferred to the active patient's account, regardless of whether **Disallow Creation of Family Accounts** is selected. Any HIPAA, patient, other account, and collection notes associated with the inactivated patient are updated, where applicable, to become associated with the active patient. Collection and other account notes that are relevant to all patients on an account continue to display in **Note Management** for the inactivated patient.

Note:

- In **Select Active Patient**, you must enter or select an active patient before **OK** becomes enabled.
- In **Transfer Patient**, the **Search for an Existing Account** and **Build a New Account** transfer options are not displayed.

- > If you click **No**, the patient record is inactivated, but no information is transferred or associated.
- > If you click **Cancel**, the patient record is not inactivated, and no information is transferred or associated.

Preventing duplicate medical record numbers

Use the **Prevent Duplicate Med Rec No** option on the **Registration** tab in **Practice Options** or **Organization Options** prevents the creation of duplicate medical record numbers.

When you select **Prevent Duplicate Med Rec No**, you cannot save or import a patient record if that patient has a medical record number that is already assigned to another patient in your tenant.

If your practice or organization imports patients using, for example, enterprise search, automatic registration, or automatic import, **Prevent Duplicate Med Rec No** enables you to ensure that each patient is given a unique medical record number.

How it works in registration

When you click **Save** on a patient record, the application scans your tenant for records with the same medical record number as the one you are working with. If the application finds a match, the warning message **Duplicate Medical Record Numbers are not allowed due to a Practice/Organization option** is displayed. You cannot save the record unless until the medical record number is unique to the patient.

How it works in Automatic Registration

When you run automatic registration, the application checks:

1. The medical record number in the IB_Patient_Info table against those in your tenant
2. The medical record number of those patients to be imported to ensure that imported records do not contain duplicates

If a match is found, the patient or patients are flagged with a status of Invalid. These patients must be manually entered in your tenant.

Important: Even in manual entry, the medical record number assigned must be unique to the patient.

How it works in automatic import

When the import is run, it checks the medical record number in the IB_Patient_Info table against those in your tenant. If a match is found, the patient is flagged with a status of Invalid. This patient must be manually entered in your tenant.

Important: Even in manual entry, the medical record number assigned must be unique to the patient.

How it works with enterprise searches

Enterprise searches use the medical record number as criteria for duplicate patient checking when you set these options in the application:

- > In **Practice Options** or **Organization Options** on the **Registration** tab, select **Prevent Duplicate Med Rec No.**
- > In **Practice Options** or **Organization Options** on the **Enterprise** tab, select **Include Medical Record Number, Force Enterprise Search**, and **Display unique MRN from local**.

When the application finds a duplicate patient, **Duplicate Patients/Contacts** is displayed. You can continue creating the new patient record, retrieve the existing patient record, or cancel the process.

Important: The options in the **Duplicate Patient Checking** area on the **Registration** tab in **Practice Options** or **Organization Options** are not relevant to the use of medical record number as criteria for duplicate patient checking in enterprise searches.

Required fields on the Registration tab

Some boxes in **Registration** are automatically required. You can select additional required boxes or choose non-required boxes to skip over by clicking **Required Fields** on the **Registration** tab in **Practice Options** or **Organization Options** to open **Patient Registration Required Fields**.

The boxes that are automatically required by the application are:

- > **Patient Number** (this box is not listed on **Patient Registration Required Fields**)
- > **Patient Sex**
- > **Account Type**
- > **Contact Last Name**
- > **Policy Accept Assignment**
- > **Policy Subscriber**
- > **Policy Relationship** (when a policy exists)

These boxes are automatically required by the application when the carrier is an alias insurance carrier:

- > **Alias Carrier Name**
- > **Alias Carrier Address 1**
- > **Alias Carrier City**
- > **Alias Carrier State**

The **Patient Registration Required Fields** window allows the user to determine which additional fields in **Registration** must be filled in by users or which non-required fields may be skipped when tabbing through **Registration**. Leaving any required fields on the **Policies** tab blank prevents the user from saving a patient record when the user adds a policy.

Note:

- > Leaving any required boxes on the **Policies** tab blank prevents the user from saving a patient record when the user adds a policy.
- > Warnings still appear when **Save** is clicked if certain boxes are blank. However, the user is not prevented from saving if the boxes selected as **Skip** are blank.

Selecting required boxes after patient records are entered affects those records when the user attempts to save changes.

All program-defined required boxes listed on the **Patient Registration Required Fields** window are auto-selected and not available, which prevents the user from clearing them.

Patient Med. Rec. Loc is enabled only when the **Entry Option Enter Med. Rec. Loc** is selected.

Note: **Patient Number** is not listed in the grid since the patient number can either be manually entered or generated automatically by the application.

When the entry option **Assign Patient Number** is selected, **Patient #** is grayed out and not available; therefore, it is not highlighted in yellow even when you select **Highlight Required Fields**.

Patient # is highlighted in yellow when you select **Highlight Required Fields** but do not select **Assign Patient Number**.

Selecting required fields and skip fields

To select required fields for Registration do the following:

1. Click **Required Fields** to open the Patient Registration Required Fields dialog box.
2. Click **Highlight Required Fields** to highlight in yellow all required fields (both programmed and selected) on the Registration tabs and on the begin new Patient dialog. The required fields will also display in boldface type. You do not have to select additional fields to check this option.
3. Use the scroll bar to view the entire lists of fields.
4. Click  to select a field as required or tag the fields as a skip field.

Duplicate patient checking

Duplicate patient checking rules are set on the **Registration tab in Practice Options or Organization Options**. Your choice determines how the application scans the tenant for duplicate entries as you register new patients.

There are three options available for checking whether you are entering a duplicate patient record.

Patient # Only

This default setting is a very basic and minimal level of checking.

When adding a new patient, if the operator enters a number that already exists in your tenant, a hard warning is displayed. You are required to enter a new, unique number.

Note: Do not select this option if you have selected the **Assign Patient Number** option.

Patient # / SSN # Only

Displays a warning message when you attempt to register a patient using a number or Social Security number (SSN) that currently exists in the tenant.

When enter an SSN that is already attached to an existing patient record, a warning is displayed listing the duplicates found. You are not prevented from continuing the registration process.

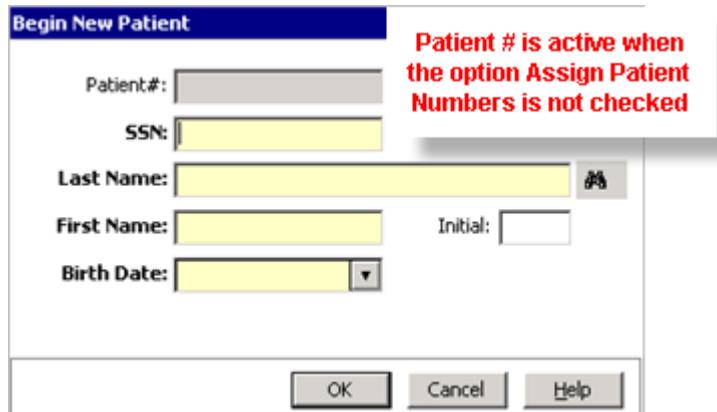
The window offers the following options:

- > Retrieve the existing patient's record — If you notice that the duplicate or one of the duplicates found by the application is the patient you are registering, click on the patient's name in the window. Click **Retrieve** to cancel the new patient registration process. The retrieved patient record is displayed in the window. You can verify or edit any information as needed.
- > Access an existing contact's record — When the SSN you entered matches that of a contact, the **Access** button is enabled. Contacts are not assigned a patient number until they are registered as patients. If the matching record is a duplicate of the 1 you are attempting to add, click on the contact's name in the window. Click **Access** to load the contact information into **Registration**. Review the data entered and make any necessary revisions or additions.
- > Continue the registration process — When you have verified that none of the selections found by the application is a duplication of the patient you are registering, you can continue the process by clicking **New Patient**. When you return to the new registration form, correct the number or SSN that caused the warning to display. Enter all necessary patient information.

Full Patient Checking

Scans the tenant for the existence of a duplicate patient number, SSN, or name and date of birth.

When you click  or use **Insert** to add a new patient, the **Begin New Patient** window opens, and you can enter the patient information.



A warning is displayed when any or all of the following is found to already exist in the tenant:

- > Patient number
- > SSN
- > Name and date of birth

You are not prevented from continuing the registration process. A window prompts you with the available choices.

If a warning message is not displayed, click **OK** to fill the **Patient** tab with the information you already entered.

When a duplicate is found, a message is displayed offering you the following options:

- > Retrieve the existing patient's record — If you notice that the duplicate or one of the duplicates found by the application is the patient you are registering, click on the patient's name in the window. Click **Retrieve** to cancel the new patient registration process. The retrieved patient record is displayed in the window. You can verify or edit information as needed.
- > Access an existing contact's record — When the SSN you entered matches that of a contact, the **Access** button is enabled. Contacts are not assigned a patient number until they are registered as patients. If the matching record is a duplicate of the 1 you are attempting to add, click on the contact name in the window. Click **Access** to bring the contact's information into **Registration**. Review the data entered and make any necessary revisions or additions.
- > Continue the registration process — When you have verified that none of the selections found by the application is a duplication of the patient you are registering, you can continue the process by clicking **New Patient**. When you return to the new registration form, correct the number or SSN entry that caused the warning to display. Enter all necessary patient Information.
- > Cancel the process — Because **Cancel** is the focus, clicking **Enter** cancels the registration process for this entry, which returns you to the **New Patient** window you opened earlier. The focus is returned to **Patient #**, and you can enter a new patient number.

Restriction: If you do not have access to a VIP patient record, you cannot access or retrieve the VIP patient information on **Duplicate Patients/Contacts**.

If you do have access to a VIP patient record, you can retrieve and copy VIP patient information according to the settings on the **Enterprise tab** in **Practice Options** or **Organization Options**. You can also create the same patient in another tenant.

When you create a patient in a different tenant, the patient VIP status and the operators and operator groups that are assigned to the VIP patient are not copied and must be assigned manually.

Default Entries on the Registration tab

The **Default Entries** area on the **Registration tab** in **Practice Options** or **Organization Options** enables you to select default values for specific patient information. Default entries auto fill the corresponding fields on the Patient tab and Account tab in Registration when you add a new Patient. This can save keystrokes during the new Patient registration process. Defaults can be changed by the operator at any time.

Default City

Free text field.

Use if the majority of your Patient population comes from the same city.

Default State

Enter the State, Territory, or Armed Forces abbreviation in the field or click the down arrow button to open the drop-down list of abbreviations. Then click your selection. Use the scroll bar if necessary.

Note: The list of abbreviations for US territories follows the list of States.

The following abbreviations related to the Armed Forces are located at the very bottom of the lists:

- > AA - Armed Forces Americas (except Canada)
- > AE - Armed Forces Africa, Canada, Europe, Middle East
- > AP - Armed Forces Pacific

Default Account Build

This setting controls the default on the Account Build dialog that appears when you add a Guarantor to a new Patient on the Account tab in Registration. See "Completing the Account Tab" for more information.

Click the down arrow button to open the drop-down list, then click one of the following selections:

- > **Build New Acct - Patient is Guar** (default selection): Automatically selects **Build a New Account** and checks **Patient is Guarantor**.
- > **Build New Acct - Patient is Not Guar**: Automatically selects **Build a New Account** and does not check **Patient is Guarantor**.
- > **Search for Existing Account**: Automatically selects **Search for an Existing Account**.

The following exceptions override this default setting:

- > If you select "Custom" in **EAD Workflow** on the External Access tab in Practice/Organization Options (POP), the Default Account Build setting is ignored.
- > If you check **Disallow Creation of Family Accounts**, you can select either "Build New Account - Patient Is Guarantor" or "Build New Account - Patient is Not Guarantor" as the Default Account Build setting and either of these will be honored. If you select **Search for Existing Account** on the Account Build dialog in Registration, it reverts to "Build New Account - Patient Is Guarantor."

Default Account Type

Before you can make a selection, you must create Account Types in file maintenance.

Click the down arrow button to open the drop-down list, then click your selection to populate the field.

Auto-fills the Account Type field on the Account tab in Registration.

Default Med Rec Loc

Before you can make a selection, you must create Medical Record Locations in file maintenance.

Click the down arrow button to open the drop-down list, then click your selection to populate the field.

Automatically fills **Med Rec Loc** on the **Patient** tab in **Registration**.

Default Patient Sex

Enter "F" or "M" to select a default entry.

Useful for practices whose patient population is all male or all female.

Note: **Unknown** is not an available option even if **Include Unknown in Gender Values** is selected under **Entry Options** in the **Registration** tab in **Practice Options** or **Organization Options**.

Default Usual Provider

Before you can make a selection you must create Providers in file maintenance.

Click the down arrow button to open the drop-down list, then click your selection to populate the field.

Inactive Patient Note Type

You must create a patient note type record in **Note Type Maintenance** before you are able to make a selection.

Specifying an 'Inactivate Patient Note Type' triggers the automatic creation of a Patient Note for the associated active Patient when you designate another Patient as inactive.

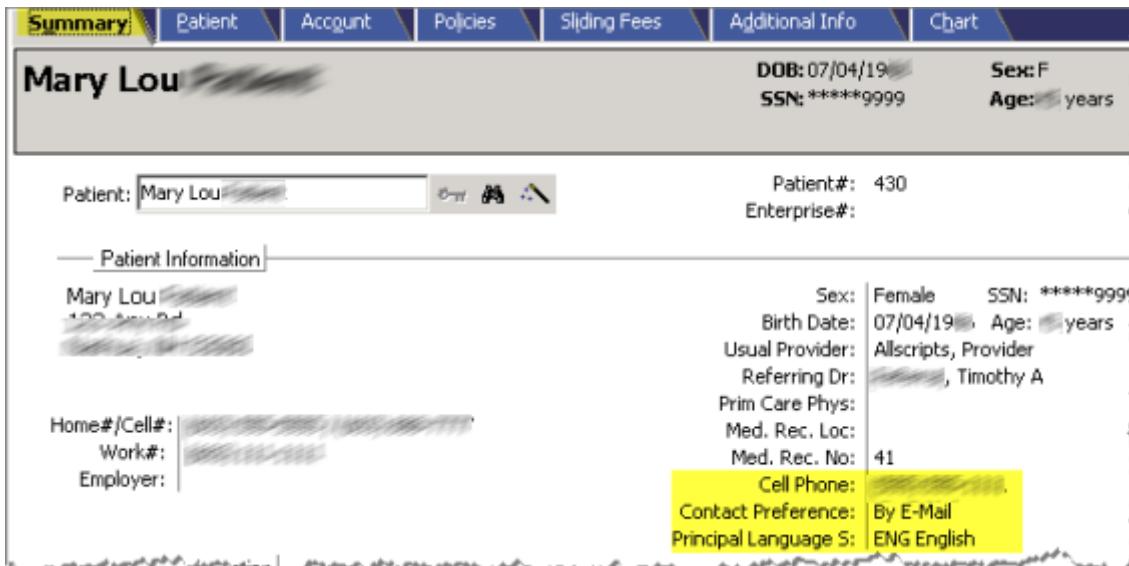
If you choose not to specify a Note Type here, then when you are given the option to associate the inactive patient with an active patient you must manually add a Patient Note to the associated active Patient's record if you want to maintain a visible record of the association.

Tip: By creating a **Patient Additional Info** box in **Practice Set Up** or **Organization Set Up** called **Associated Inactive Patient #**, you can run a Crystal report using vwGenPatAdditInfo to lists those active patients who are associated with inactive patients.

Summary Tab Additional Display Fields on the Registration tab

The combo boxes under **Summary Tab Additional Display Fields** on the **Registration** tab in **Practice Options** or **Organization Options** enable you to select up to 3 patient additional information boxes to be displayed on the **Summary** tab in **Registration**.

This enables your staff to view on the **Summary** tab any pertinent information stored on the **Additional Info** tab in **Registration** without having to move to a different tab.



What if I do not select any boxes?

The corresponding boxes are unavailable on the **Summary** tab in **Registration**.

Field labels read **Pat Add'l Field #**.

Note: Before you can make a selection you must create patient additional information boxes on the **Patient Additional Info** tab in **Practice Set Up** or **Organization Set Up**.

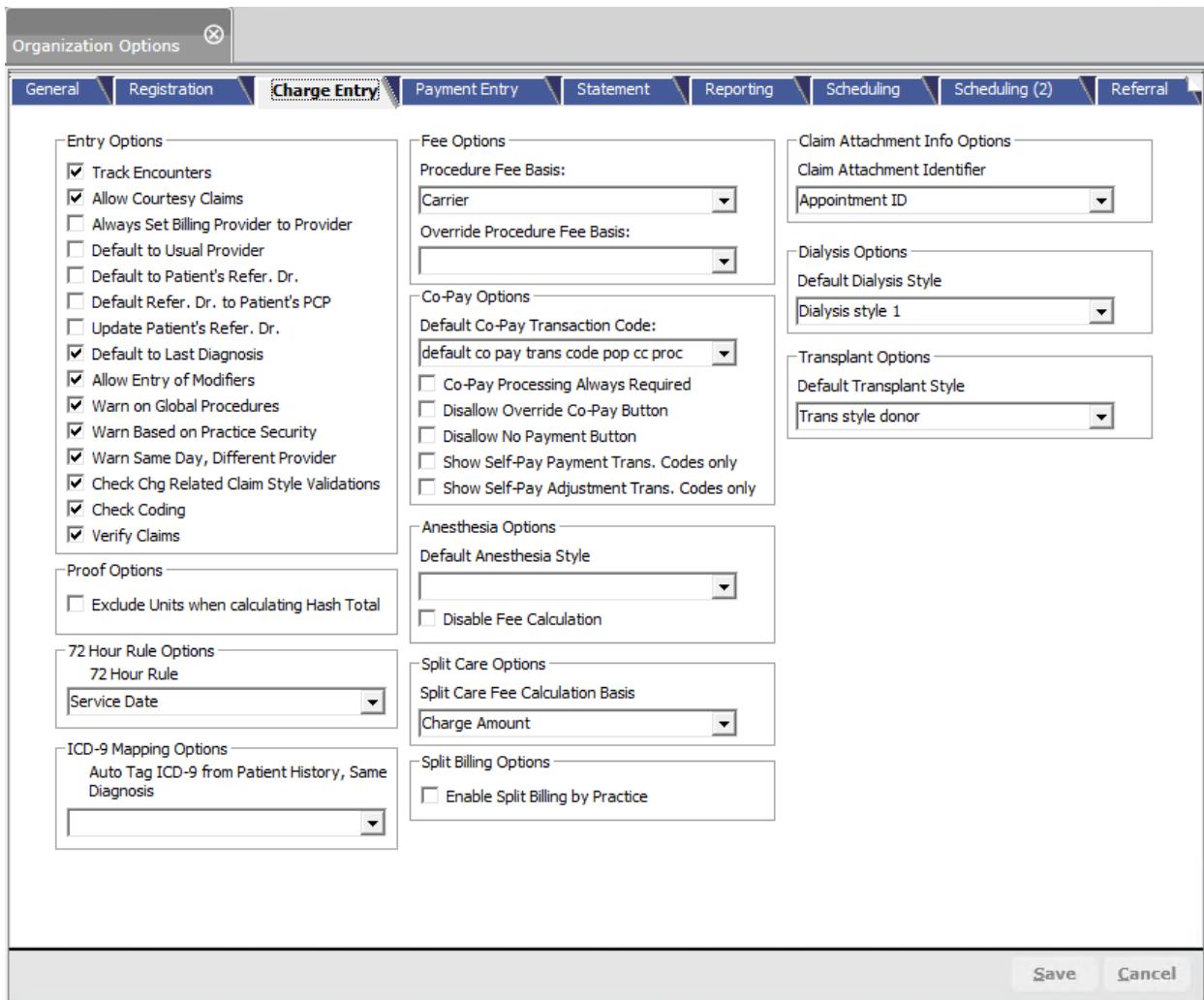
What if 1 of the boxes I select is secure?

If a box you select in a **Summary Tab Additional Display Fields** box is defined as secure (that is, it has the check box in the **Secure** column selected in the **Patient Additional Info** tab in **Practice Set Up** or **Organization Set Up**), it is only displayed on the **Summary** tab in **Registration** if you have the security permissions to view secure patient additional information boxes assigned in **Administration > Security Manager**. If you do not have permission to view secure patient additional information boxes, the box is not displayed.

Charge Entry tab in Practice Options or Organization Options

Use the **Charge Entry** tab in **Practice Options** or **Organization Options**, to set standards, trigger functionality, and define data entry rules that affect the charge entry process.

Access the **Charge Entry** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options or System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.



Entry Options on the Charge Entry tab

This topic describes the options under **Entry Options** on the **Charge Entry** tab in **System Administration > Practice Options (or Organization Options)**.

When you enter charges you have the option of defining batch defaults that override these charge entry options (with the exception of always defaulting the billing provider to the provider of service). Batch defaults that are different from these practice or organization option defaults apply only to the transactions entered for the specified batch.

Track encounters

Checking this option causes the system to track those encounters that do not have charges entered against them.

The Encounter Tracking report is run from Scheduling Reports

Encounter #'s are by default assigned when you print the encounter form. You can, however, determine to have encounter numbers assigned either at the time an appointment is scheduled or at the time an appointment is acknowledged. This is done in Scheduling Options.

Note: This option must be checked if you check either **Assign Encounter # When Scheduled** or **Assign Encounter # When Acknowledged** on the Scheduling tab in Practice/Organization Options.

In Charge Entry, defaults the field label name to "Encounter." This label can be changed by the Operator.

Using the encounter number when entering charges pulls all the appointment detail relevant to the charge into the charge entry screen. When you enter charges the system defaults to the appropriate Policy based on the coverage type selected for the appointment.

The encounter number is used as the voucher number when the Charge(s) is saved.

Unassigned Payments entered via the Quick Pay dialog can be associated with an appointment.

Voided Vouchers linked to an auto-assigned Encounter number print on the Encounter tracking report.

You can use the same Encounter number when reentering voided charges after you close and update the Void batch.

Allow courtesy claims

Selecting this option adds **Courtesy Claim** to the payer selections on the **Charge Entry** tab.

The balance for a voucher printed as a courtesy claim is considered a self-pay balance.

Note: Related to the following four options which can also be set for batch defaults, at the time of Charge Entry you will have the option to define batch defaults which will override the selections you made here (with the exception of always defaulting the billing provider to the provider of service). Batch defaults that are different from these defaults apply only to the transactions entered in the specified batch. When the batch is closed and updated, these Practice/Organization option defaults rule once again.

Always set billing provider to provider

Checking this option triggers the following:

- Charge Entry when creating a voucher: the field **Billing Provider** on the Charge Entry screen auto-fills with the name of the selected Provider; disables this field so that the defaulted entry cannot be edited.

|| **Note:** The field disables even when the Provider's default billing provider from Provider maintenance is used.

- > Charge Entry - Batch Default field **Billing Provider**: disables the field so that a batch default cannot be selected.
This default is honored during Charge Import.
- > If you also check the option to default to Usual Provider then both fields will auto-fill with the Patient's Usual Provider from Registration.

|| **Note:** When a default billing provider is selected in Provider maintenance, that default supersedes the selection made here in Practice / Organization Options.

Default to usual provider

Checking this option auto-fills the charge entry field **Provider** with the name of the Patient's Usual Provider from Registration.

If you also check the option to default to **Always Set Billing Provider to Provider** then both fields auto-fill with the Patient's Usual Provider as entered in Registration.

When you are tracking Encounters and entering Charges by Encounter Number if you want the Referring Doctor selected on the Appointment screen to auto-fill the **Referring Dr** field in Charge Entry leave the next three options unchecked.

|| **Tip:** Also select the registration option **Require Usual Provider**.

Default to patient's refer dr.

Checking this option auto-fills the field **Referring Dr** with the name of the Patient's Referring Dr from Registration.

Default refer. dr. to patient's pcp

Checking this option auto-fills the field **Referring Dr** with the name of the Patient's Primary Care Physician from Registration.

The field remains enabled allowing you to edit the entry.

Do not check this option if you want the Referring Doctor selected on the appointment to auto fill the Referring Dr field for the voucher in Charge Entry.

|| **Note:** When this option is checked the Default to Patient's Refer. Dr. option is disabled.

Update patient's refer dr

Checking this option automatically replaces the entry in the field **Referring Dr** in Registration with the name of the referring provider entered in Charge Entry.

The field remains enabled allowing you to edit the entry.

Do not check this option if you want the Referring Doctor selected on the appointment to auto fill the Referring Dr field for the voucher in Charge Entry.

Default to last diagnosis

Checking this option auto-fills the field **Diagnosis** with the last primary diagnosis entered for the patient.

The field remains enabled allowing you to edit the entry.

Allow entry of modifiers

For modifiers to output to an electronic claim file, an entry must be made in the field in Charge Entry. This can be done manually or by creating default modifiers in **Procedure Code Maintenance**.

Checking this option allows you to enter modifiers when entering charges.

When this option is left unchecked, the field **Modifiers** is disabled. However, default modifiers are accepted in a disabled box.

The charge entry field Modifiers is reportable using the general view, "vwGenSvclInfo."

To report on the use of procedure codes and their modifiers using an Allscripts® Practice Management system report you must build combination codes that are made up of procedure code + modifier, for example codes such as 09954-80.

Warn on global procedures

Checking this option triggers the display of a warning in Charge Entry when a Procedure with a Global Period is part of a Patient's history.

Checking this option also enables the option, **Warn Based on Department/Practice Security**.

Note: When this option is selected, global period warnings are only displayed during a manual charge entry and when charges are imported, but not when a charge is batch imported.

Warn based on department/practice security

Enabled only when the **Warn on Global Procedures** option above is checked. Unchecking **Warn on Global Procedures** while **Warn Based on Department/Practice Security** is checked clears the check mark and disables this option.

When checked, the global period warning only displays if the Operator entering a charge for the patient has access to the Department/Practice used when the global service charge was entered.

Note: For this option to function properly, **Enable Department/Practice Security** located on the General tab in Practice/Organization Options must be checked, and Operators must have Department/Practice Members assigned in Operator Maintenance.

Warn same day, different provider

Checking this option triggers a warning message when a procedure code entered on the current voucher is also included on another voucher that has the same date of service for that Patient regardless of the servicing of provider.

Left unchecked, the warning message displays only when the same procedure is used on multiple vouchers for the patient each voucher having the same date of service and the same provider.

Check Chg related claim style validations

When checked triggers warnings to display in charge entry at the time the operator saves a voucher when a related claim style validation option is checked on the Validations tab in Claim Style Maintenance.

Note: If the claim style validation option is checked and this practice/organization option is not checked then the claim would fail validation but the operator is not given a warning when he/she saves the voucher.

The triggered warning can either be a hard warning or a soft warning depending on the claim style validation option checked or defined.

Hard warning: Prevents the operator from saving the voucher until the required action is taken.

Examples of Validation options which trigger a hard warning are:

- > NDC Info Required for Specified Procedure Group?
- > Separate Claim required for each Calendar Year?

Soft warning: Does not prevent the operator from saving the voucher.

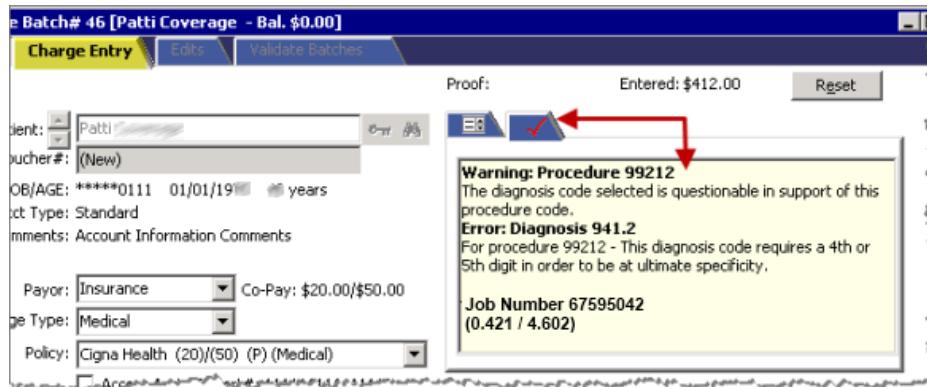
Examples of Validation options which trigger a soft warning are:

- > Maximum diagnoses per voucher
- > Maximum services per voucher
- > Referring Doctor required?
- > Separate claim required for each TOS?

- > Injury Fields Required?

Check coding

Check this option to activate the Alpha II ClaimStaker® Enterprise code-checking application. Adds a tab to the Charge Entry entry screen that alerts the operator to possible errors in coding which could possibly cause the claim to be denied by the carrier.



The job number returned from Alpha II ClaimStaker and the duration of the code checking request are also displayed. The duration is displayed beneath the job number in two parts: the time taken for Alpha II ClaimStaker to receive and process the information followed by the total duration of the call request. Both numbers are displayed in *seconds.milliseconds* format. If there are no applicable edits to present, the message **Codes have been checked** is displayed with the job number and duration below the message.

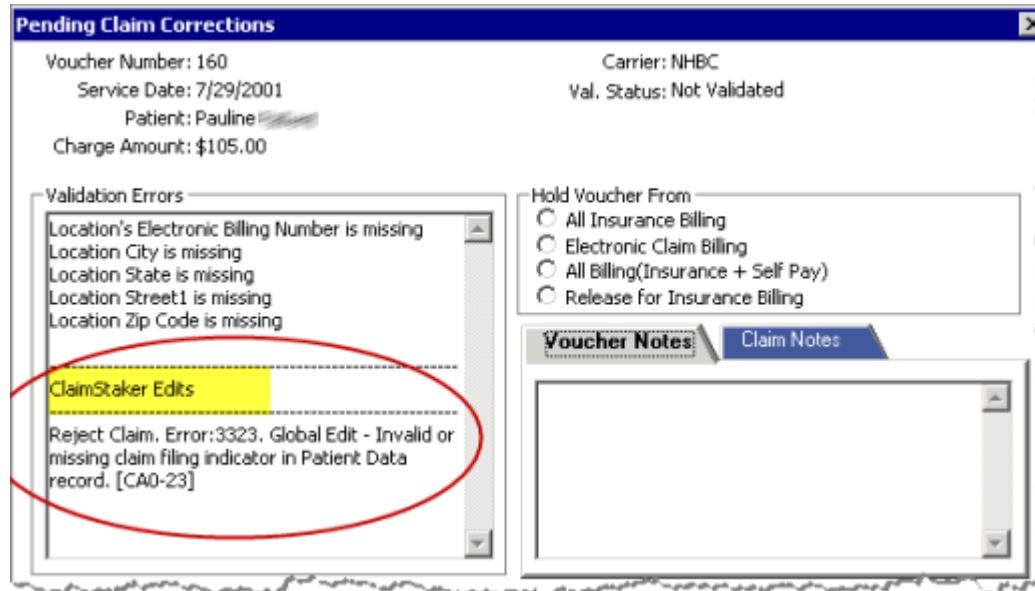
Note: Additional setup is required.

Verify claims

Checking this option activates the Verify Claims application and adds a Verify Claims tab on the Batch Management screen. Set up is required before you can use this function.

When this option is checked, it does the following

- > Allows you to include the verify claims process to check for Alpha II ClaimStaker edits when Validating Batches
- > Allows you to include the verify claims process during the re-validate process in Pending Claims Management
- > Adds the section "ClaimStaker Edits" to the Errors grid on the Pending Claim Corrections dialog box which identifies those errors detected with the use of the Alpha II ClaimStaker application



Proof Options on the Charge Entry tab

Proof options are part of the Charge Entry options in Practice / Organization Options. (F9 > POP/OOP)

Exclude Units when calculating the Hash Total

Checking this option causes each procedure code from each service line to be summed once in the hash total regardless of the number of units entered on the voucher. For example, the hash total for a voucher with a service line 99231 where the units = 2 is 99231.

When this option is left unchecked the number of times each procedure code is summed is based on the number of units entered on the service line. For example, the hash total for a voucher with a service line 99231 where the units = 2 is 198462.

Hash totals print on the **Batch Print and Close** report and on the **Transaction Journal**.

72 Hour Rule Options on the Charge Entry tab

The option to enable the 72-hour rule for billing a Carrier is available in Practice/Organization Options on the Charge Entry tab. (F9>POP/OOP)

72 Hour Rule Options

The 72-hour rule is part of the Medicare Prospective Payment System (PPS).

When this field is blank the check box **72 Hour Rule** is disabled in Insurance Carrier Maintenance and Place of Service Maintenance.

When you make one of the following selections, you are able to flag an Insurance Carrier in file maintenance so that all vouchers with a policy associated with the Carrier are held for 72 hours before they qualify for billing.

Service Date

Determines that claims to the Carrier are released for billing 72 hours from the date of service entered on the voucher.

Update Date

Determines that claims to the Carrier are released for billing 72 hours from the date the voucher is updated.

Using the 72-Hour Rule option

72 Hour Rule is available in **Insurance Carrier Maintenance** and **Place of Service Maintenance**. The 72-hour rule is part of the Medicare Prospective Payment System (PPS).

The 72-hour rule states that any outpatient diagnostic services performed within 72 hours prior to a patient being admitted to the hospital must be bundled into one bill. Another way of wording the rule is that outpatient services performed within 72 hours of inpatient services are considered one claim and must be billed together rather than separately.

Using **72 Hour Rule** enables you to do the following:

- > Identify the places of service where the 72-hour rule should be applied.
- > Identify the carriers that require compliance with the 72-hour rule.
- > Automatically place vouchers with a policy associated with these carriers and places of service on hold from all billing for 72 hours.
- > Automatically release held vouchers for billing 72 hours from either the voucher's service date or update date.

ICD-9 Mapping Options on the Charge Entry tab

ICD-9 Mapping Options are a subset of options on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

Auto Tag ICD-9 from Patient History, Same Diagnosis

Select an **Auto Tag ICD-9 from Patient History, Same Diagnosis** value to automatically tag an ICD-10 to ICD-9 mapping in **Diagnosis Code Lookup** at the time of charge entry. The tagged mapping takes precedence over the mapping designated as the default in **Diagnosis Code Maintenance**. The options are based on **Provider** on the **Charge Entry** tab.

- > **Blank** - Leave the option blank if you want the mapping defined as the default in **Diagnosis Code Maintenance** tagged as the mapping on the current charge.

- > **All Providers** - Select **All Providers** if you want the most recent ICD-10 to ICD-9 mapping from the patient's diagnosis history for the same ICD-10 code and any provider automatically tagged as the mapping on the current charge.
- > **Same Provider Only** - Select **Same Provider Only** if you want the most recent ICD-10 to ICD-9 mapping from the patient's diagnosis history for the same ICD-10 code and the same provider automatically tagged as the mapping on the current charge.

|| **Note:** Only **Provider** is used with these options, not **Billing Provider**.

Fee Options on the Charge Entry tab

You set your practice/organization procedure fee basis in Practice/Organization Options on the Charge Entry tab. (F9 > POP/OOP)

Procedure Fee Basis

The Procedure Fee Basis is the standard on which you determine the selection of fees for services rendered.

The fee profiles created in Practice/Organization Set Up are related to your selection of the Procedure Fee Basis selected here. The available options are: **Actual Provider**, **Billing Provider**, **Carrier**, **Department**, **Location**, and **Place of Service**.

It is important to understand the connection between your choice of Fee Basis with the Fees Profile Types created in Practice/Organization Set Up and with the Fee Profiles defined in Procedure Code Maintenance.

The Fee Profiles you created should relate the "Procedure Fee Basis" selected here.

By clicking on the drop down arrow, a list of choices display. Highlight your choice and click to have it fill in the field. This now is the basis of determining the fee amount used at the time of Charge Entry.

Your selection activates the fee profile fields or tab in the related file maintenance. For example, if you select Carrier the fee profile file tab in insurance carrier maintenance is active.

Correspondingly, the profile tab in provider maintenance and the profile fields in Department/Practice maintenance and location maintenance are disabled. As a result the fee profile selection made in insurance carrier maintenance determines the profile and fee amount used from Procedure Code Maintenance when you enter charges to be submitted to the Carrier.

When the Procedure Fee Basis is changed all the connecting file maintenance pieces must also be revised.

Override Procedure Fee Basis

Selecting a value for **Procedure Fee Basis** enables **Override Procedure Fee Basis**. The selection options for **Override Procedure Fee Basis** are the same as **Procedure Fee Basis**

except that you cannot select the value already selected for **Procedure Fee Basis**. Use **Override Procedure Fee Basis** when you have a need for a procedure fee basis that is different from **Procedure Fee Basis**; otherwise, leave the box blank.

After you select a value for **Override Procedure Fee Basis**, you must enter the applicable fee profiles for the file maintenance that you selected.

If you change the value of **Override Procedure Fee Basis**, you do not have to remove the fee profiles for the previous value. If they exist, they are not used by the application unless you change **Override Procedure Fee Basis** back to the original value.

Co-Pay Options on the Charge Entry tab

You can define a default transaction code as well as set procedure standards related to processing co-pays in Charge Entry by using the co-pay options listed on the Charge Entry tab in Practice/Organization Options. (F9 > POP/OOP)

Default Co-Pay Transaction Code

The drop down list of selections for this default comes from the list of transaction codes built in Transaction Code Maintenance. You must build these codes before you can select a default.

Selecting a default auto-fills the field **Co-Pay Transaction Code** on the Apply Self-Pay Payments dialog in Charge Entry.

You may leave this option blank.

Entering a default does not disable the field in Charge Entry. Selections from a combo box listing are available.

Tip: Consider whether or not you proof your daily receipts by cash, check, and credit card transactions. You may find it more efficient to leave this field blank.

Co-Pay Processing Always Required

Checking this option means that you can never save a voucher that contains a procedure code flagged as "Co-Pay Applies" until you open the Self-Pay dialog and process the co-pay either as a new payment, override, uncollected, or no payment.

Not checking this option, means that you open the self-pay dialog and process a co-pay only when both bulleted items listed below apply to a voucher.

- > The voucher includes a procedure code with the designation of "Co-Pay Applies."
- > The selected policy on the voucher has a co-pay amount due.

Flagging a procedure code as requiring a co-pay is done in Procedure Code Maintenance.

Disallow Override Co-Pay Button

When checked, the **Override Co-Pay** button on the Self-Pay dialog in Charge Entry is always disabled.

Disallow No Payment Button

When checked, the **No Payment** button on the Self-Pay dialog in Charge Entry is always disabled.

Show Self-Pay Payment Trans. Codes only

When checked only those Payment Type Transaction Codes flagged as "Self-Pay Transaction Code" in Transaction Code maintenance display in the "Co- Pay Transaction Code" and "Payment Transaction Code" drop-downs on the Self-Pay dialog in Charge Entry.

By restricting the listings in these two fields on the Self-Pay dialog to those designated Transaction Type Codes, the Operator can quickly find the correct selection with the fewest keystrokes.

Alert: When this option is checked and there are no Payment Type Transactions checked as "Self-Pay Transaction Code" in Transaction Code Maintenance, then the Co-Pay Transaction Code and the Payment Transaction Code drop-downs on the Self-Pay dialog are blank. Therefore, be sure to check all payment type transaction codes that are used to apply self-pay payments as "Self-Pay Transaction Code" if you are going to check this option here.

Transaction codes that are not flagged as self-pay in transaction code maintenance are not available for selection by the operator on the self-pay dialog in Charge Entry. Therefore, if you have selected a default transaction code for self-pay payments on the Payment Entry tab in Practice/Organization Options be sure that it is checked as a self-pay transaction otherwise the corresponding payment fields do not auto-fill on the self-pay dialog.

Show Self-Pay Adjustment Trans. Codes only

When checked only those Adjustment Type Transaction Codes checked as "Self-Pay Transaction Code" in Transaction Code maintenance display in the "Adjustment Transaction Code" drop down on the Self-Pay dialog in Charge Entry.

This can be used to restrict the listing of adjustment codes displayed in the drop down particularly when the Practice/Organization policy is to apply a prompt payment discount on the voucher's Self-Pay balance.

Alert: When this option is checked and there are no adjustment type transactions checked as "Self-Pay Transaction Code" in Transaction Code Maintenance, then the Adjustment Transaction Code drop downs on the Self-Pay dialog are blank. Therefore, be sure to check all adjustment type transaction codes that are used to apply self-pay adjustments as "Self-Pay Transaction Code."

Transaction codes that are not flagged as self-pay in transaction code maintenance are not available for selection by the operator on the self-pay dialog in Charge Entry. Therefore, if you have selected a default transaction code for self-pay adjustments and/or co-pay override on the Payment Entry tab in Practice/Organization Options be sure that both are checked as a self-pay transaction otherwise, the corresponding adjustment fields do not auto-fill on the self-pay dialog.

Anesthesia Options on the Charge Entry tab

You can set anesthesia options, including a default anesthesia style, on the **Charge Entry** tab in **Practice Options** or **Organization Options**, you select.

Default Anesthesia Style

Select a default anesthesia style if it applies to your practice or organization.

You must create anesthesia styles before you can select a default anesthesia style.

If you select **(default)** as the anesthesia style for a carrier in **Insurance Carrier Maintenance**, the anesthesia style you select for **Default Anesthesia Style** is used when the carrier is billed.

Disable Fee Calculation

When you select **Disable Fee Calculation**, the **Recalculate Anesthesia Charge** tab in **Automatic Transactions** becomes unavailable. You can enter the actual fee in **Anesthesia** and not have a calculation take place for manual and imported charges.

For imported charges, you must have **Fee** set to **Unit Value** on the **Import Links** tab of **Information Broker Format Maintenance** in Allscripts® Interface Engine; otherwise, **Disable Fee Calculation** is ignored.

Split Care Options on the Charge Entry tab

Practices/organizations using the automatic transaction Split Care Fee Calculation should select a fee calculation fee basis on the Charge Entry tab in Practice/Organization Options. (F9 > POP/OOP)

Split Care Fee Calculation Basis

The three selections available in the drop down list are as follows:

1. Allowed Amount - Uses the allowed amount entered in Insurance Carrier Maintenance for the procedure codes specified as medically necessary on the Split Care Fee Calculation tab in Automatic Transactions when calculating split care fees.

2. Charge Amount -Uses the fee entered on the Voucher for the procedure codes specified as medically necessary on the Split Care Fee Calculation tab in Automatic Transactions when calculating split care fees.
3. Lesser of Allowed and Charge Amounts - Compares the allowed amount and the fee entered on the Voucher for the procedure codes specified as medically necessary on the Split Care Fee Calculation tab in Automatic Transactions and uses the lesser of the two amounts when calculating split care fees.

Split Billing Options area on the Charge Entry tab

The **Split Billing Options** area on the **Charge Entry** tab in **Practice Options or Organization Options** offers split billing by department or practice.

Enable Split Billing by Department or Enable Split Billing by Practice

Check **Enable Split Billing by Department** or **Enable Split Billing by Practice** to incorporate departments/practices into the split billing logic. Adding department/practices to the split billing logic requires you to enable departments/practices for split billing. For split billing by department to work, you must also enable alternate claim styles, places of service, and procedure codes for split billing with procedure codes flagged as an alternate claim style.

If you only need procedure codes, places of service, and alternate claim styles for split billing, do not check this option.

Checking this field enables fields in Department/Practice Maintenance allowing you to enable split billing by department/practice and to select alternate departments/practices.

The application logs any changes you make to this check box on the **History** tab.

Claim Attachment Info Options area on the Charge Entry tab

The **Claim Attachment Info Options** area on the **Charge Entry** tab in **Practice Options or Organization Options** provides options for assigning unique attachment control numbers to claim attachments that are sent electronically, which helps clearinghouses match claim attachments with claims.

Claim Attachment Identifier

Use this option if you use **Claim Attachments in Transactions > Charge Entry** or **Transactions > Edits** (whether vouchers are entered manually or imported) and send your claim attachments as separate files. Attachment control numbers output in Loop 2300 Segment PWK on v5010 professional and institutional electronic claims.

Attachment control numbers are assigned according to the value of **Claim Attachment Identifier** in **Practice Options or Organization Options** and an application-maintained counter that tracks the order attachments are added to a voucher in **Claim Attachments**.

- > blank: Uses the voucher number and counter. For example, if the voucher number is 50106794, the consecutive attachment control numbers are 5010679401, 5010679402, 5010679403, and so on. Attachment control numbers are initially displayed in **Claim Attachments** as **(New 01)**, **(New 02)**, **(New 03)**, and so on until the voucher is saved and a voucher number is assigned.
- > **Appointment ID:** Uses the internal appointment ID and adds the counter after the first attachment starting at 02. For example, if the appointment ID is 7954, the consecutive attachment control numbers are 7954, 795402, 795403, and so on.

Note: For appointments created in version 22.0 and later, the appointment ID and the encounter number are the same. For encounters that existed prior to version 22.0, the appointment ID and the encounter number are different.

- > **Encounter Number:** Uses the encounter number and adds the counter after the first attachment starting at 02. For example, if the encounter number is 106467, the consecutive attachment control numbers are 106467, 10646702, 10646703, and so on.

If no appointment ID or encounter number is associated with the voucher, the voucher number is used for the attachment control number regardless of the value selected for **Claim Attachment Identifier**.

In **Claim Attachments**, if you delete a row that is not the last row in the grid, the counter used for that row is not used again for subsequent rows added for that claim. For example, if counters 01, 02, and 03 were used sequentially, after deleting the row with counter 02, the next counter would be 04. However, if you delete the last row in the grid, the counter of the deleted row is re-used the next time a row is added for that claim. For example, if counters 01, 02, and 03 were used sequentially, after deleting the row with counter 03, the next counter would be 03.

Attachment control numbers are not assigned to attachments entered with **Available on Request at Provider Site** selected for **Attachment Transmission Type** in **Claim Attachments**.

Claim Attachment Identifier is included in starter data sets with the **Practice Options** information type.

Dialysis Options on the Charge Entry tab

Assign a default dialysis style on the **Charge Entry** tab in **Practice Options (F9 > POP)** or **Organization Options (F9 > OOP)**. The default style is used by the dialysis fee calculation process.

Default Dialysis Style

You must create styles in **Dialysis Style Maintenance** to make a selection in **Default Dialysis Style**.

Specify a default dialysis style (if it applies to your practice or organization) before running the dialysis fee calculation process.

Default Dialysis Style is enabled when **Enable Dialysis Management** is selected on the **Special Billing** tab in **Practice/Organization Options**.

Transplant Options on the Charge Entry tab

Assign a default transplant style on the **Charge Entry** tab in **Practice Options (F9 > POP)** or **Organization Options (F9 > OOP)**. The default style is used by the transplant charge creation process.

Default Transplant Style

You must create styles in **Transplant Style Maintenance** to make a selection in **Default Transplant Style**.

Specify a transplant style before running the transplant charge creation process.

Default Transplant Style is enabled when **Enable Transplant Management** is selected on the **Special Billing** tab in **Practice Options** or **Organization Options**.

Payment Entry tab in Practice Options or Organization Options

Use the **Payment Entry** tab in **Practice Options** or **Organization Options** to select defaults used during the payment entry process.

Some file maintenance might have to be done before you can make certain selections on this tab.

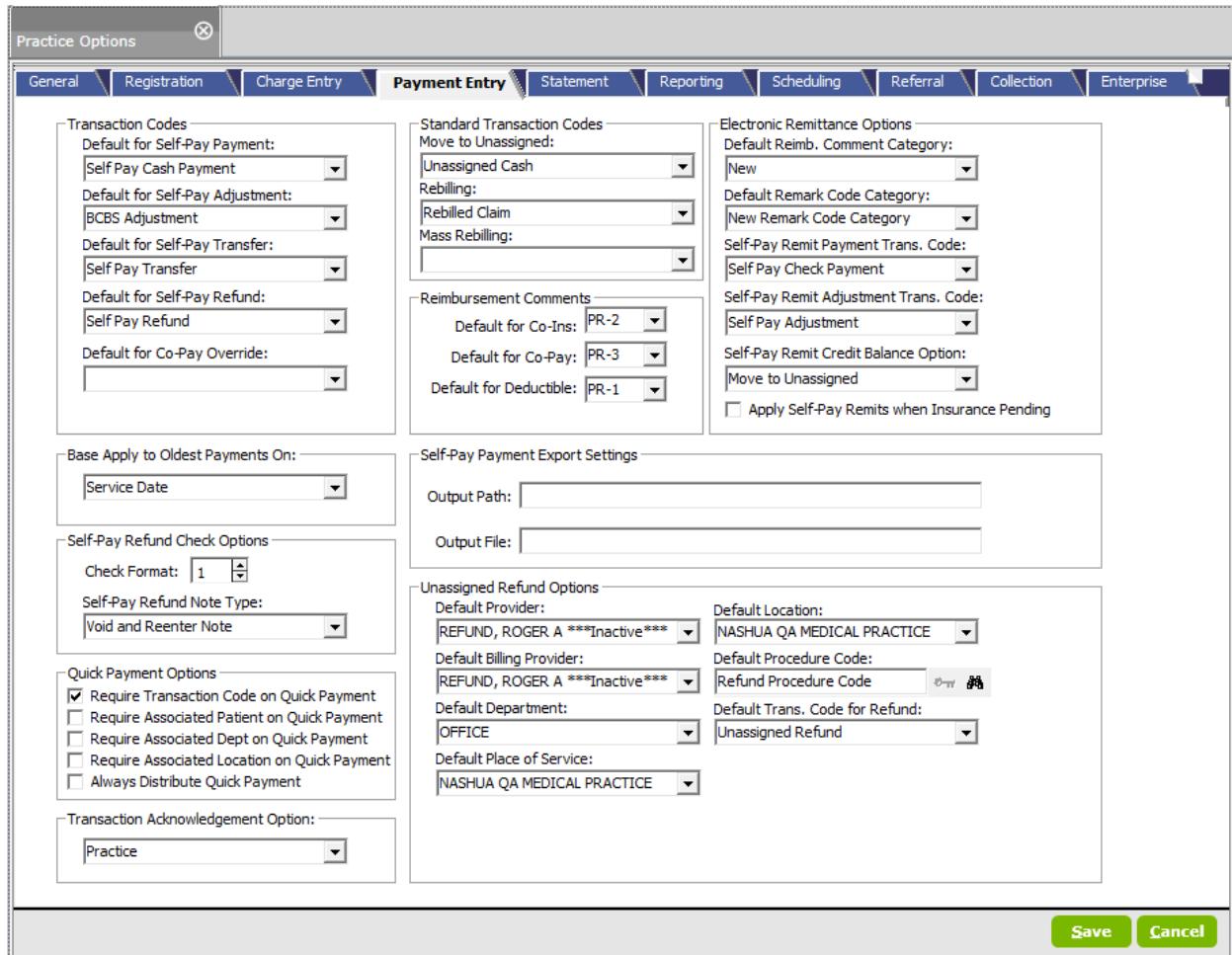
To select options in the **Transaction Codes** area, records must be created in **Transaction Category Maintenance** and in **Transaction Code Maintenance**.

To select options in the **Reimbursement Comments** area and **Default Reimb Comment Category**, records must be created in **Reimbursement Comment Category Maintenance** and **Reimbursement Comment Maintenance**.

To select **Self-Pay Refund Note Type**, you must create at least one **Voucher Type Note in Note Type Maintenance**.

To select **Default Remark Code Category**, you must create records in **Remark Code Category Maintenance**.

Access the **Payment Entry** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options or Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.



Transaction Codes on the Payment Entry tab

On the Payment Entry tab in Practice / Organization Options (F9 > POP/OOP) you can select defaults that automatically fill in the corresponding field on a Self-Pay voucher in Payment Entry, and on the Self-Pay dialog in Charge Entry.

These default transaction codes are used for self-pay transactions in payment entry and on the self-pay dialog in charge entry.

Note: When you also check **Show Self-Pay Payment Trans. Codes only** and/or **Show Self-Pay Adjustment Trans. Codes only** on the Charge Entry tab in Practice/Organization Options, you must check **Self-Pay Transaction Code** in Transaction Code Maintenance for each transaction code you selected as the default payment, adjustment, and co-pay override default.

Leaving the default field blank requires that the operator must always enter a Self-Pay transaction code manually.

Give some thought to the work flow used in your Practice/Organization for proofing the daily receipts. If, for instance, payments are tracked by cash, check, and credit card transactions, then it is recommended that you do not set a Default for Self-Pay Payment transaction code.

Likewise, selecting a default Self-Pay Adjustment transaction code may not be advisable. Discuss how you want to track Self-Pay write-offs.

Each drop down contains the codes by transaction type that you created in Transaction Code file maintenance.

Click on the down arrow button to display the list, then point and click on your selection.

Standard Transaction Codes on the Payment Entry tab

The three Standard Transaction Codes you select on the Payment Entry tab in Practice/Organization Options (F9 > POP/OOP) programmed to "act" in a certain way when they are used in posting Transactions.

Move to Unassigned

An unassigned payment is a payment transaction that is not associated with a charge, that is, one that has not been applied to a voucher. An unassigned payment transaction is by program design created when you generate a quick payment in Registration, Scheduling or Charge Entry.

In addition you can opt to allow your staff to move a voucher's credit balance to an unassigned status. At a later time the unassigned credit amount can then be applied to another voucher that has a balance due.

A default transaction code is required to make use of this function.

Leaving this field blank prevents your staff from moving a voucher's credit balance to unassigned. As a result credit balance remains on the voucher and is automatically applied to the patient's total self-pay balance.

Tip: Discuss the pros and cons of using the move to unassigned function. If you decide to activate this function, make a note to create a miscellaneous debit transaction code called "Move to Unassign" then return to Payment Entry tab to select that transaction code as the default.

Selecting a default Misc Debit Type Transaction Code gives the Operator the option to transfer a voucher's credit balance when the transactions applied to a voucher from the Apply Transaction screen in Payment Entry, result in an overpayment.

It is recommended that you leave this field blank if you do not want to use the Move to Unassigned function in Payment Entry.

Note: Payments collected as Quick Pay payments are automatically held as Unassigned whether or not you select a Transaction code for this field.

You can only make this selection when you have created a Misc Debit Transaction Code in Transaction Code Maintenance.

The Misc Debit Transaction Code selected here is not included in the list of Transaction Codes on the Create Unassigned dialog and the Overpayment Warning dialog. The selected Misc Debit Transaction is used by the system to trigger the movement of the payment to an unassigned state. The move to unassigned transaction is recorded in Account Management using the selected Misc Debit Transaction Code.

Click the down arrow button to open the listing which contains only those Transactions Codes with a Transaction Type of “Misc Debit”, then click on the code you created, for example “Move to Unassign.”

Rebilling

You must enter a default Transaction Code for Rebilling in order to trigger the rebill function.

Create a Transaction code called “Rebill” - be sure to select the Transaction Type Rebill. This drop down only lists those Transaction Codes with the Transaction Type of Rebill. Select the code “Rebill.”

You can manually flag a voucher for rebilling in Payment Entry and on the Edits tab.

Multiple vouchers/claims can be flagged for rebilling using the Rebilling function found under Claims Review.

When a Voucher is flagged Rebill, the bill date is cleared, qualifying the voucher/claim for the next billing process.

All claims flagged for rebilling (whether manually or using Rebilling) must once again pass through the validation process.

Note: Make a note to create a rebill transaction code and then return to Payment Entry tab to select that transaction code as the default.

Mass Rebilling

Important: You must create a unique transaction code for mass rebilling and select it in this field to be able to differentiate between manually rebilled and mass rebilled claims. Otherwise, if this field is blank when you do a rebill from the Rebilling tab in Claims Review, the system uses the transaction code in the Rebilling field.

Allows you to differentiate between manually rebilled claims and claims rebilled using the Rebilling tab in Claims Review.

If you want to be able to differentiate between manually rebilled and mass rebilled claims, you should create a Transaction code called "Mass Rebill" that has a Transaction Type of "Rebill." This drop-down only lists those Transaction Codes with the Transaction Type of "Rebill." Click the down arrow button and select "Mass Rebill."

Multiple vouchers/claims can be flagged for rebilling using the Rebilling function found under Claims Review.

When a voucher is flagged for rebill, the bill date is cleared, which qualifies the voucher/claim for the next billing process.

All claims flagged for rebilling (whether manually or using Rebilling) must once again pass through the validation process.

Reimbursement Comments on the Payment Entry tab

To apply payments in Payment Entry using the Apply Transactions window you must select an option for all 3 reimbursement comment defaults on the Payment Entry tab in Practice/Organization Options. (F9 > POP/OOP). Reimbursement comments must first be built in **Reimbursement Comment Maintenance**.

Leaving one or more of these fields blank prevents you from opening the Apply Transactions screen in Payment Entry.

Each default automatically fills the corresponding field on the Specify Reimbursement Comments dialog in Payment Entry when you enter a Deductible, Co-insurance, and/or Co-Pay amount.

The following three records should exist in Reimbursement Comment Maintenance:

- > PR-1 - Deductible Amount
- > PR-2 - Co-insurance Amount
- > PR-3 - Co-payment Amount

Default for Co-Ins

Select **PR-2**

Default for Co-Pay

Select **PR-3**

Default for Deductible

Select **PR-1**

Note: These defaults are not used when you import remittances. The Import Remittances program uses the codes supplied by the carrier in the remittance file.

Electronic Remittance Options on the Payment Entry tab

On the **Payment Entry** tab in **Practice Options** or **Organization Options**, you can select the options used on **Import Remittances** when processing electronic remittance files.

Default Reimb. Comment Category

A default reimbursement comment category is required if your practice imports electronic remittances.

Best practice is to create a **Reimbursement Comment Category Maintenance** record called **New** to be used as the default.

To simplify the process of identifying reimbursement records that are automatically created as part of the import process, practices and organizations using electronic remittances should select a default reimbursement category.

During import, when the application encounters a reimbursement comment in the file that does not already exist in the practice or organization, it automatically creates a new record using this default to assign a category to each newly created reimbursement comment.

When a default is not selected, the application does not assign a category, leaving that box blank on the file maintenance record.

Type the letter **N** for **New** or click the down arrow button and use the computer mouse to scroll through the list to select **New**.

Reimbursement comment categories flagged **Denial** are excluded from this list.

To identify the newly created codes, run the Reimbursement Comment Analysis report restricting it to the **Reimbursement Comment Category** of **New** after an import has been processed.

The application writes the code found in the file to both **Abbreviation** and **Description** and assigns the default category to the new reimbursement comment record.

You should review each new code in **Reimbursement Comment Maintenance** and do the following:

- > Change the description to the one used on the carrier's remittance advice.
- > Change the category from **New** to the appropriate one.
- > Verify that **Group Code** and **Reason Code** are correct.

This process ensures the accuracy of:

- > The Reimbursement Comment Analysis
- > The **Reimbursement Comment Maintenance** selections, if you need to use the comment when submitting an ANSI 837 electronic secondary claim

The category **New** should already exist in **Reimbursement Comment Category Maintenance**.

Default Remark Code Category

Best practice is to create a record in **Remark Code Category Maintenance** called **New** to be used as the default.

Default Remark Code Category is used by the application at the time remittance files are imported when a matching remark code is not found in your practice or organization.

The application-created remark codes will not have a description – for instance **MA-11** will have a description of **MA-11**.

These descriptions must be manually edited, at which time, the category can also be changed to the appropriate one.

Click the down arrow button then select the category called **New**.

Note: The following three self-pay options relate to the processing of electronic remit files for patient (self-pay) payments that are reported to the practice or organization by the bank that received the payment usually from a lock box account. This function requires the use of Allscripts® Interface Engine. For more information, see *Self Pay Remittances*.

Self-Pay Remit Payment Trans Code

When Allscripts® Interface Engine is not set up to accept and post payment transaction codes received in the self-pay remittance file, the transaction code selected for **Self-Pay Remit Payment Trans Code** is used on each payment transaction that is posted when self-pay electronic remittances are processed.

Self-Pay Remit Payment Trans Code is required if you are processing self-pay electronic remittances and the self-pay remittance file does not contain payment transaction codes.

The drop-down list contains all of the payment type transaction codes in the application.

Self-Pay Remit Adjustment Trans Code

When Allscripts® Interface Engine is not set up to accept and post adjustment transaction codes received in the self-pay remittance file, the transaction code selected for **Self-Pay Remit Adjustment Trans Code** is used on each adjustment transaction that is posted when self-pay electronic remittances are processed.

Self-Pay Remit Adjustment Trans Code is only required if you are processing a self-pay electronic remittance with at least one adjustment amount and the self-pay remittance file does not contain adjustment transaction codes.

The drop-down list contains all of the adjustment type transaction codes in the application.

Self-Pay Remit Credit Balance Option

Self-Pay Remit Credit Balance Option is required field if you are processing self-pay or collection electronic remittances.

The selection determines what the application does when the payment in the self-pay or collection remittance file is greater than the balance on the patient's account.

Choose one of the following from the drop-down list:

- > **Move to Unassigned** - If a credit balance exists on the patient's account after all payments are applied to all self-pay or collection vouchers associated with the account, the remaining balance is moved to **Unassigned Transactions** using the transaction code selected in the **Move to Unassigned** option on the **Payment Entry** tab.

Note: Adjustments are not moved to **Unassigned Transactions**.

- > **Leave as Credit Balance** - If a credit balance exists on the patient's account after all payments are applied to all self-pay or collection vouchers associated with the account, the remaining balance is kept on the last voucher to which money was applied as a credit.

Note: If a payment is received on an account that does not have an existing balance, the money is not applied to the voucher or placed in **Unassigned Transactions**. Instead, the payment is not applied and is listed in the **Non Postable** section of the **Import Remittance Listing**.

Apply Self-Pay Remits when Insurance Pending

Select this option to have the application apply self-pay payments to vouchers that are still pending payment from insurance carriers (including carriers designated as collection agencies) when importing self-pay remittance files. The payments are processed with a remitter of **Self-Pay**, but the payer on the vouchers is not changed.

Important: Only use **Apply Self-Pay Remits when Insurance Pending** when the following is true:

- > The self-pay remittance file is expected to include the voucher number for each payment.
- > In Allscripts® Interface Engine, **Voucher** is selected for **Link Method** on the **Import Links** tab in **Information Broker Maintenance**.

When processing self-pay remittances by voucher according to Allscripts® Interface Engine setup, the voucher number must be included in the remittance file, and the payment is applied directly to that voucher. Remittances without a voucher number are considered not postable.

If you use **Apply Self-Pay Remits when Insurance Pending** when **Account** is selected for **Link Method**, Allscripts® Practice Management uses **Base Apply to Oldest Payments** in **System Administration > Practice Options** or **Organization Options** to determine the voucher that qualifies for payment. Payments will be posted to the oldest voucher regardless whether the voucher is self-pay or pending insurance.

The application also uses the settings for **Co-Pay Applies** in **Procedure Code Maintenance** and **Self-Pay Remit Credit Balance Option** in **Practice Options** or **Organization Options** when applying the payments.

Remittances for voided vouchers are considered not postable.

The payments are included on the **Self-Pay Import Remittance Listing** along with the payments for self-pay vouchers.

If **Apply Self-Pay Remits when Insurance Pending** is not selected, self-pay remittance payments are not applied to vouchers that are still awaiting insurance payment.

Apply Self-Pay Remits when Insurance Pending is included with starter data sets that have the **Practice Options** information type.

Base Apply to Oldest Payments On on the Payment Entry tab

You can designate how the application applies self-pay or collection remittances.

Base Apply to Oldest Payments On

The selection you make in **Base Apply to Oldest Payments On** governs how payments from a collection agency or an outside source post electronically, as well as how payments post manually when you use **Oldest** on the **Payment Entry** tab in **Transactions**.

- **Billing Date** - Self-pay payments or collection agency payments are posted by the oldest billed date. Only vouchers with a billing date on them will have the payment posted against them.
- **Service Date** - Self-pay payments or collection agency payments are posted by the oldest service date. This option is the default selection.

When you receive a payment for an amount greater than the amount owed in the application, the difference is either left on the last voucher on which payments were posted or moved to Unassigned. This action occurs according to your setting for **Self-Pay Remit Credit Balance Option** in the **Electronic Remittance Options** area on the **Payment Entry** tab in **Practice Options** or **Organization Options**.

Self-Pay Refund Check Options on the Payment Entry tab

You can select options pertaining to self-pay refunds on the Payment Entry tab in Practice/Organization Options (F9 > POP/OOP).

Check format

The check formats option is related to the **Print Refund Check** functionality.

You must purchase preprinted checks that match the dimensions of one of these formats which both print on an 8.5" x 11" form.

The default selection is Format 1.

You can select format 2.

Self-Pay Refund Note Type

The selection of a Voucher Type Note is required if you intend to use the function **Print Refund Checks** to generate your Self-Pay refund checks.

The selected Self-Pay Refund Note Type is also used to generate a Note when you Refund Unassigned Payments.

Self-Pay Refund Check Option formats

This topic describes the check format options you have when you select Self-Pay Refund Check Options on the Payment Entry tab in Practice/Organization Options (F9 > POP/OOP).

Format 1

Prints the check at the top of the page and two receipts below.

Receipt detail includes:

- > Date the check was printed and the amount
- > Patient Number and Name
- > Voucher Number
- > Service Date
- > Amount for that voucher

When multiple vouchers qualify for one Account this format prints one check for the total refund amount equal to the total credit balance of up to a maximum of 12 vouchers. When more than 12 vouchers qualify then another check is generated.

<p style="text-align: right;">11/23/2005</p> <p style="text-align: center;">Pulls from the Guarantor field</p> <p>John [REDACTED] 232.00</p> <p>TWO HUNDRED THIRTY-TWO *****</p> <p>John [REDACTED] [REDACTED] [REDACTED]</p> <p>Refund Patient# 250 John [REDACTED]</p> <p>Receipt 1</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Patient No & Name</th> <th style="text-align: left; padding: 2px;">Voucher</th> <th style="text-align: left; padding: 2px;">Svc Date</th> <th style="text-align: right; padding: 2px;">Amount</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">250 John [REDACTED]</td> <td style="padding: 2px;">1580</td> <td style="padding: 2px;">02/25/2002</td> <td style="text-align: right; padding: 2px;">10.00</td> </tr> <tr> <td style="padding: 2px;">250 John [REDACTED]</td> <td style="padding: 2px;">4420</td> <td style="padding: 2px;">04/29/2003</td> <td style="text-align: right; padding: 2px;">142.00</td> </tr> <tr> <td style="padding: 2px;">251 John [REDACTED]</td> <td style="padding: 2px;">6080</td> <td style="padding: 2px;">11/09/2004</td> <td style="text-align: right; padding: 2px;">80.00</td> </tr> </tbody> </table> <p>Receipt 2</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Patient No & Name</th> <th style="text-align: left; padding: 2px;">Voucher</th> <th style="text-align: left; padding: 2px;">Svc Date</th> <th style="text-align: right; padding: 2px;">Amount</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">250 John [REDACTED]</td> <td style="padding: 2px;">1580</td> <td style="padding: 2px;">02/25/2002</td> <td style="text-align: right; padding: 2px;">10.00</td> </tr> <tr> <td style="padding: 2px;">250 John [REDACTED]</td> <td style="padding: 2px;">4420</td> <td style="padding: 2px;">04/29/2003</td> <td style="text-align: right; padding: 2px;">142.00</td> </tr> <tr> <td style="padding: 2px;">251 John [REDACTED]</td> <td style="padding: 2px;">6080</td> <td style="padding: 2px;">11/09/2004</td> <td style="text-align: right; padding: 2px;">80.00</td> </tr> </tbody> </table>	Patient No & Name	Voucher	Svc Date	Amount	250 John [REDACTED]	1580	02/25/2002	10.00	250 John [REDACTED]	4420	04/29/2003	142.00	251 John [REDACTED]	6080	11/09/2004	80.00	Patient No & Name	Voucher	Svc Date	Amount	250 John [REDACTED]	1580	02/25/2002	10.00	250 John [REDACTED]	4420	04/29/2003	142.00	251 John [REDACTED]	6080	11/09/2004	80.00
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Format 2

Prints three 8.5" x 3.5" checks per page. The following is printed on the Memo line for each check: "Refund Patient#XXX (Patient Name)."

When multiple vouchers qualify for one Patient on the Account this format prints one check equal to the Refund amount for that Patient.

When multiple vouchers qualify that are associated with more than one Patient on the Account a separate check is printed for each Patient. The amount of each check is equal to the Refund amount for the Patient.



Selecting a self-pay refund note type

To print refund checks from within Allscripts® Practice Management you must select a note type on the Payment Entry tab in Practice/Organization Options (F9 > POP/OOP).

The drop down holds a list of Voucher Type Notes created in your tenant. The Voucher Note that you select should not contain a default subject line.

The Note Type you select is used to create a system generated note in the following instances:

- > when you print refund checks from Financial Processing > Financial Posting > Print Refund Checks (**F9 > FPO**)

- > when you use the right-click menu option **Refund Unassigned Payment** in Payment Entry or in Unassigned Payment Management.

Note: This means that if you are using the Allscripts® Practice Management function **Print Refund Checks** to generate your Patient refund checks, then a note is generated for a Patient when you apply an unassigned refund and another one when you print the refund check for that unassigned payment.

If you use another method of generating your Patient refund checks then the selected Note Type is used only when Refunding Unassigned Payments.

How it works when printing refund checks

Selecting a Note Type is required if you intend to print self-pay refund checks using the **Print Refund Checks** functionality.

When you run the Print Refund Checks function a Voucher Note is generated for each Patient with a self-pay refund transaction applied within a Payment Batch with the Batch Comment of "Transactions related to credit balances" or within a Payment Batch that is system generated for Unassigned Refund Payments.

A record of this system generated note is kept in Note Management (You must check Voucher Note on the Note Management screen to view the Note).

The system generated subject line reads "Print Refund Checks."

The body of the note includes the following information: "Refund Check# XXXXXX for \$XXX.XX was printed on <Date>." (ex Refund Check# 1475 for \$6.00 was printed on 11/09/2005)

When refund checks are printed using the option **Restart Checks for Updated Batches** the body of the note reads as follows: "Refund Check# XXXXXX for \$XXX.XX was printed (Restart Checks) on <Date>"

When multiple vouchers are included in one check a note is created for each voucher.

System created Voucher Notes can then be viewed in Financial Inquiry > Account Inquiry and on the Payment Entry screen when you check **Voucher Notes** as a viewing option. See the topic on "Setting View Options in Financial Inquiry and Using the Payment Entry Tab."

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adj	Balance	Payor	Ref.
02/01/2002	1410	HIG	\$124.00	\$124.00	\$0.00	Self-Pay	
Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Part
PG	RAD	Office	T11	021120002pata2	Updated	02/25/2002	Sam
Voucher Notes							
Refund Check# 1475 for \$6.00 was printed on 11/09/2005							
Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Unit
02/01/2002	99212		OFFICE/OP/PROBLEM	790.7	Bacteremia	1	1.0

How it works when refunding unassigned amounts

A selection is not required for the unassigned payment refund process to complete successfully.

When you enter a selection a Voucher Note is generated when you click **OK** on the **Unassigned Payment Refund** window.

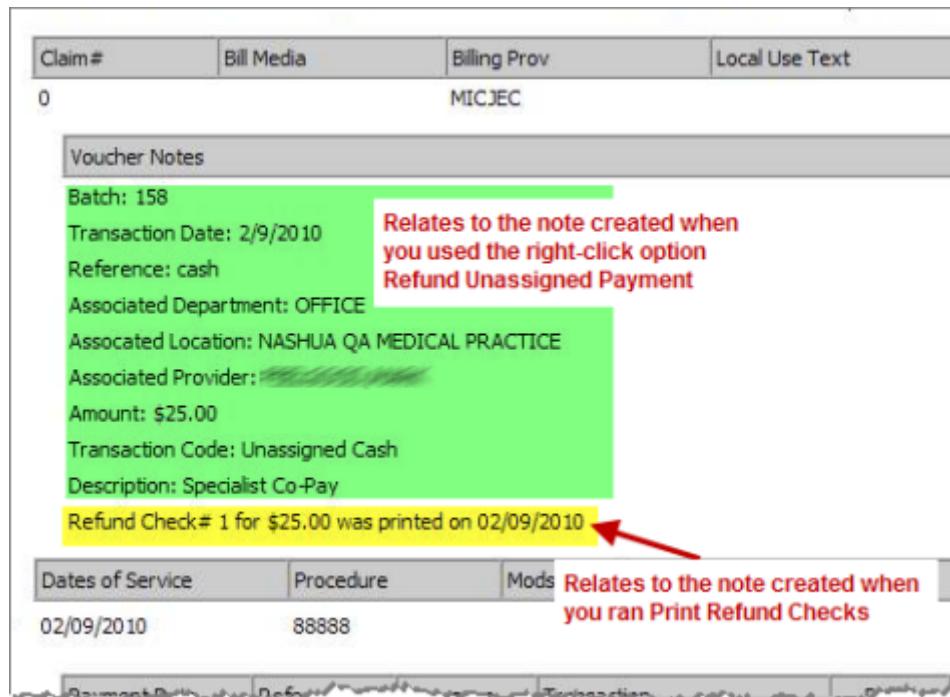
The system generated subject line contains the Voucher # - This is the number given to the \$0.00 charge voucher created by the system during the refund process.

The body of the Note contains the following information:

- > Batch number of the original batch used to post the payment entered on the Quick Pay dialog
- > Transaction Date and the Reference entered on the Quick Pay dialog when the unassigned payment was created.

In addition, the following detail is included if it was entered on the Quick Pay dialog when the unassigned payment was created: the Associated Department/Practice, the Associated Location, the Associated Provider, the Amount, the Transaction Code and the Description.

System generated Voucher Notes can then be viewed in Financial Processing > Account Inquiry and on the Payment Entry screen when you query by **Paid and Open Items** and check **Voucher Notes** as a viewing option. See the topic on "Setting View Options in Financial Inquiry and Using the Payment Entry Tab."



Self-Pay Payment Export Settings on the Payment Entry tab

The Self-Pay Payment Export Settings on the Payment Entry tab in Practice/Organization Options (F9 > POP/OOP) are related to the export of patient and batch information to Third Millennium.

Only for clients exporting Patient and batch information to Third Millennium.

Clients not using the Third Millennium Interface Export should leave these fields blank.

Output Path

The recommended standard path name is C:\Third Millennium\<enter your Practice/Organization name>\.

Create a directory called "Third Millennium" on each workstation used for payment entry.

Output File

The output file must end with the extension ".xml".

The recommended output file name is "ThirdMillennium.xml".

Quick Payment Options on the Payment Entry tab

The Quick Payment options on the Payment Entry tab in Practice/Organization Options (F9 > POP/OOP) relate to the information you want your staff to include when entering a Quick Pay payment.

Consider what information you require for reporting and for balancing your unassigned payments when you reconcile your deposits.

Checking an option requires the operator to enter the data before the Quick Pay payment can be saved.

Read the description of each option carefully, then determine which best fits your workflow and reporting needs.

Require Transaction Code on Quick Payment

When checked prevents the Operator from saving a Quick Pay payment, an overpayment, or from transferring a voucher's credit balance to unassigned, unless he/she has selected a Transaction Code on the related dialog.

Requiring the selection of Transaction Code on the Quick Pay dialog ensures the following:

- > The transaction is included on the Recap by Transaction on the Print & Close and the Transaction Journal
- > The transaction is included on the Bank Reconciliation Report which makes proving your totals for bank deposits more efficient.
- > The automatic application in Charge Entry and Charge Import of the unassigned amount entered and associated with an appointment via the Quick Pay dialog.

Require Associated Patient on Quick Payment

When checked, you cannot save a quick payment or move a payment to unassigned without first selecting an Associated Patient in the dialog.

This requirement affects the Quick Payment dialog, the Overpayment Warning dialog, and the Create Unassigned Transaction dialog. By entering an Associated Patient on these dialogs, you have the ability to track the Patient on an unassigned payment. The Patient selected here displays on the Transaction Acknowledgement, the Unassigned Transactions grids in Charge Entry and Payment Entry, the Unassigned Payment Analysis, and the Payment History grid in Financial Inquiry.

Require Associated Dept/Pract on Quick Payment

When checked, prevents the Operator from saving a Quick Pay payment without selecting an Associated Department/Practice.

In addition, when this option is checked an unassigned payment can only be applied (assigned) to a voucher whose Department/Practice is the same as the one selected for the Quick Pay payment.

When this option is not checked the operator has the option to associate a department/practice with the quick payment. However, the payment can be applied to any voucher regardless of its selected department/practice.

Require Associated Location on Quick Payment

When checked, prevents the Operator from saving a Quick Pay payment until he/she has selected an associated Location.

Always Distribute Quick Payment

Select **Always Distribute Quick Payment** to ensure that any unassigned money associated with an appointment is automatically distributed to the charge. When **Always Distribute Quick Payment** is not selected, unassigned money associated with an appointment is only distributed automatically if it is an exact match to the co-pay amount.

Unassigned Refund Options on the Payment Entry tab

On the **Payment Entry** tab in **Practice Options** or **Organization Options** (F9 > POP/OOP) you can select default entries that automatically fill the corresponding boxes on **Unassigned Payment Refund**. **Unassigned Payment Refund** can be accessed in **Unassigned Payment Management** and **Payment Entry**.

You can select default values for these boxes:

- > **Provider**
- > **Billing Provider**
- > **Department**
- > **Place of Service**
- > **Location**
- > **Procedure Code**
- > **Transaction Code for Refund**

Statement tab

Use the **Statement** tab to define settings and criteria used when you generate patient statements.

Give some thought to the following:

- > Do you intend to use iBill™?
- > How often do you currently generate patient statements? (weekly? monthly?)

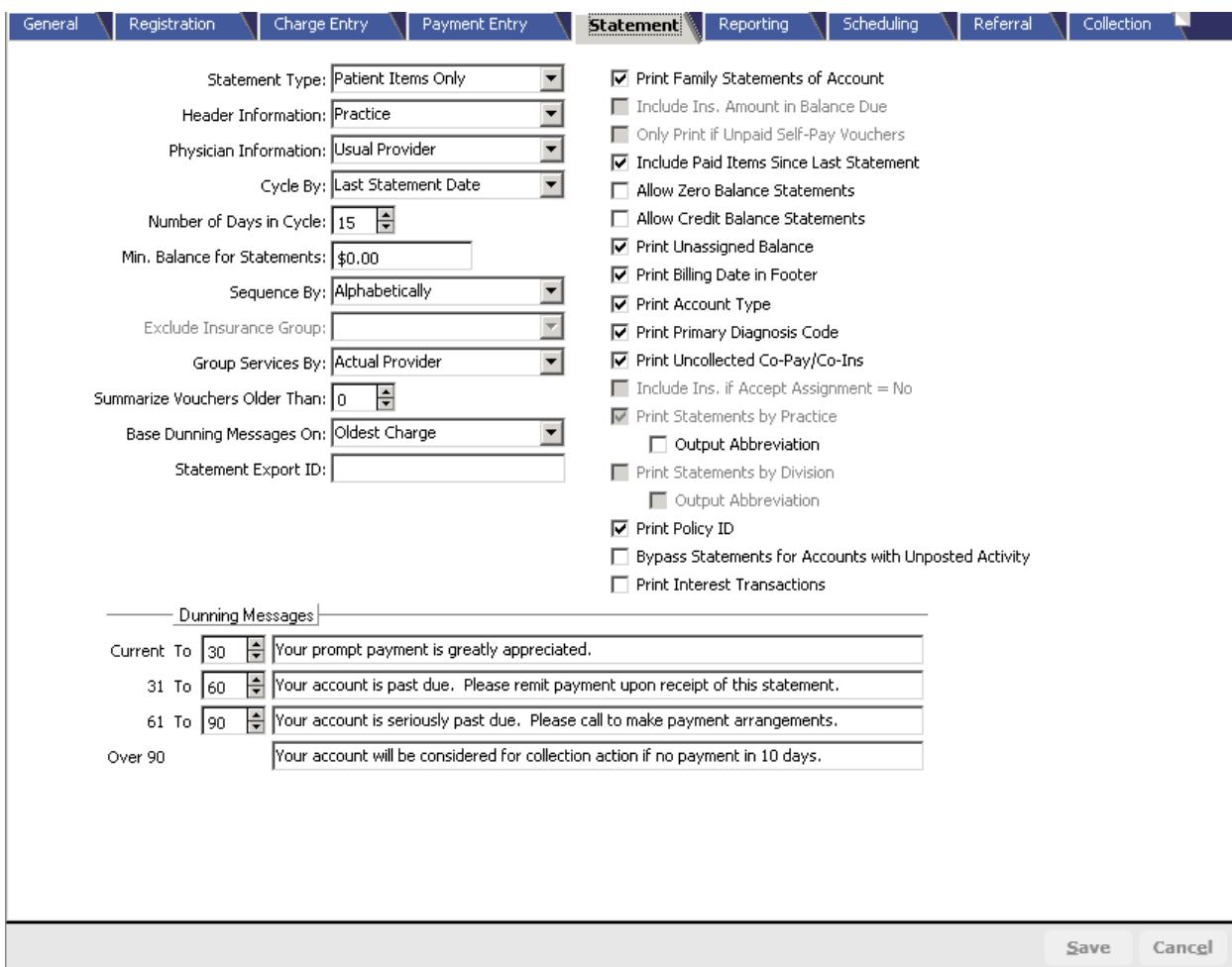
Chapter 2 Practice Options or Organization Options

- > How do you deal with overdue balances?
- > Do you want to set a minimum balance below which a statement is not generated?
- > Do you want balances currently out to insurance included in the total balance due column on a patient's statement?
- > Do you currently run statements by alphabet or by the last statement date?
- > Do you use a collection agency? When do you forward accounts to collections? This helps when it comes to setting up your dunning messages?

Important: After saving your changes on the **Statement** tab, you must restart the application in order to apply the new settings. Click  to log out of the application, then log in again.

Access the **Statement** tab on **Practice Options** or **Organization Options** in **System Administration**.

Tip: To quickly access **Practice Options**, press **F9**, then enter **POP**. To quickly access **Organization Options**, press **F9**, then enter **OOP**.



Statement Type: Patient Items Only

Header Information: Practice

Physician Information: Usual Provider

Cycle By: Last Statement Date

Number of Days in Cycle: 15

Min. Balance for Statements: \$0.00

Sequence By: Alphabetically

Exclude Insurance Group:

Group Services By: Actual Provider

Summarize Vouchers Older Than: 0

Base Dunning Messages On: Oldest Charge

Statement Export ID:

Print Family Statements of Account

Include Ins. Amount in Balance Due

Only Print if Unpaid Self-Pay Vouchers

Include Paid Items Since Last Statement

Allow Zero Balance Statements

Allow Credit Balance Statements

Print Unassigned Balance

Print Billing Date in Footer

Print Account Type

Print Primary Diagnosis Code

Print Uncollected Co-Pay/Co-Ins

Include Ins. if Accept Assignment = No

Print Statements by Practice

Output Abbreviation

Print Statements by Division

Output Abbreviation

Print Policy ID

Bypass Statements for Accounts with Unposted Activity

Print Interest Transactions

— Dunning Messages —

Current To 30	Your prompt payment is greatly appreciated.
31 To 60	Your account is past due. Please remit payment upon receipt of this statement.
61 To 90	Your account is seriously past due. Please call to make payment arrangements.
Over 90	Your account will be considered for collection action if no payment in 10 days.

Save Cancel

Statement Type

This box determines whether the printed statement includes only self-pay or both self-pay and insurance balances.

Note: When your practice or organization uses uninsured carriers, uninsured voucher balances are included. Uninsured voucher balances are qualified for reports using the same criteria as traditional self-pay vouchers.

The options are:

Option	Result
Patient Items Only	Qualifies accounts to receive a statement when a balance has been transferred from

Option	Result
	<p>Insurance to Self-Pay responsibility or when a Co-Pay was recorded as Uncollected in Charge Entry and the Statement option Print Uncollected Co-Pay is also checked.</p> <p>Important: Insurance balances are never included on the statement. Disables the options Include Ins. Amount in Balance Due and Only Print if Unpaid Self-Pay Vouchers.</p>
Patient & Insurance Items	<p>Indicates insurance balances with an asterisk (*) in the voucher detail section of the Statement History Export file and the Pre-Printed Form that contains these three columns:</p> <ul style="list-style-type: none"> > Total Patient Balance > Insurance Balance > Account Total <p>Important: To include the insurance balance in the balance due amount printed on the statement, you must also check Include Ins. Amount in Balance Due.</p> <p>When you select Patient & Insurance Items and Include Paid Items Since Last Statement on the Statement tab in Practice Options (or Organization Options):</p> <ul style="list-style-type: none"> > If Accept Assign? is selected on Financial Processing > Transactions >

Option	Result
	<p>Charge Entry tab (or Edits tab) and Include Ins. if Accept Assignment = No is selected on the Statement tab, the balance is displayed with an asterisk in the Insurance column of the statement.</p> <ul style="list-style-type: none"> > If Accept Assign? is cleared on the Charge Entry tab (or Edits tab) and Include Ins. if Accept Assignment = No is selected on the Statement tab, the balance is displayed without an asterisk in the Self-Pay Now Due column of the statement. > If Include Ins. if Accept Assignment = No is cleared on the Statement tab, the balance is displayed with an asterisk (*) on the statement, regardless whether Accept Assign? is selected or cleared on the Charge Entry tab (or Edits tab).

Header

This box determines which header information prints based on the option you select.

Attention: Only complete this box when you are not using pre-printed statements that include a header.

The options are:

Option	Result
Practice or Organization	<p>Prints the following header information from the Practice Information or Organization Information tab in System Administration > Practice Set Up or Organization Set Up.</p> <ul style="list-style-type: none"> > Practice Name or Organization Name > Address 1 > City > State > Zip Code > Telephone

Option	Result
	<p>Note: Your selection of a multiple entity label option determines whether Practice or Organization is the menu item. This selection is made on the Multi Entity tab in System Administration > Practice Options or Organization Options.</p>
Usual Provider	<p>Prints header information from System Administration > File Maintenance > Provider Maintenance for the patient's usual provider as selected on the Patient tab in Patient Management > Registration.</p> <ul style="list-style-type: none"> > Last Name > First > MI > Address 1 > Address 2 (when filled) > City > State > Zip Code > Telephone
Department or Practice	<p>Prints header information entered for the department or practice associated with the vouchers on the statement. Automatically selects Print Statements by Department/Practice.</p> <ul style="list-style-type: none"> > Name > Address 1 > Address 2 (when filled)

Option	Result
	<ul style="list-style-type: none"> > City > State > Zip Code <p>Note: Your selection of a multiple entity label option determines whether Department or Practice is the menu item.</p>
Division	<p>Prints header information from System Administration > File Maintenance > Division Maintenance on statements. Links a voucher on a statement to a division through the department or practice associated with the voucher.</p> <ul style="list-style-type: none"> > Name > Address 1 > Address 2 (when filled) > City > State > Zip Code > Telephone > Federal ID <p>Attention: This option is only available when Enable Division is selected on the Multi Entity tab in Practice Options or Organization Options.</p>

Physician Information

This box prints the selected information in the **Your Provider** field on the statement. Options include:

Option	Result
Usual Provider	Prints the usual provider from Patient Management > Registration .
Referring Provider	Prints the referring doctor's name from Patient Management > Registration .
Blank	Leaves this portion of the statement blank.

Cycle By

This box determines when and how accounts with self-pay balances are billed.

Attention: To use statement processing in automated billing, **Cycle By** must be set to **Last Statement Date**.

The options are:

Option	Result
Last Statement Date	Qualifies accounts with self-pay balances for billing based on the date of their last statement. Determines the date settings default on Print Statements in Billing based on your selection for the number of days in the cycle. Enables the Finance Charges function by adding the Finance Charge tab to System Administration > Practice Options or Organization Options . And enables Rebill if not Printed After on the Print Statements tab in Billing > Statement Processing .
Guarantor Last Name	Qualifies accounts with self-pay balances for billing based on the range of the first and last

Option	Result
	<p>letter entered for the guarantor's last name when statements are generated.</p> <p>Enables Guarantor First Letters From and To are enabled on the Print Statements tab in Billing > Statement Processing.</p> <p>Adds audit records to the History tab in System Administration > File Maintenance > Billing Automation Maintenance if you have automated billing functionality enabled.</p> <p>Important: To ensure that all billable accounts receive one statement per month it is important to establish a policy that clearly defines:</p> <ul style="list-style-type: none"> > the division of the alphabet (ex: A-F, G-L, M-S, T-Z) > the day of the week and the week of the month when each section is billed <p>The selected initial letters, not a change in the self-pay balance, determine when an account with a self-pay balance qualifies for billing.</p>

Number of Days in Cycle

This box determines the length of time between statements when you cycle by last statement date. Functions only when cycling by last statement date.

Important: The number of days in your cycle, not a change in the self-pay balance, determines when a previously billed account with a self-pay balance next qualifies for another billing.

Whether printing statements daily or weekly, this setting may be used to ensure that accounts are billed once a month. Running statements on the same day of the week each week with a 28 day cycle ensures that each qualifying account receives only one monthly statement.

Min. Balance for Statements

This box only qualifies accounts that have at least one voucher with a self-pay balance that is equal to or more than the specified amount. For qualifying accounts, only vouchers that meet the minimum specified amount are included when printing statements or assessing finance charges.

For example, when **Min. Balance for Statements** is **2.99**, if an account has a voucher with a \$1.67 self-pay balance for one department and a voucher with a \$5.00 self-pay balance for another department, only the voucher with the \$5.00 self-pay balance will be included when printing statements and assessing finance charges for the account.

Note: When your practice or organization uses uninsured carriers, uninsured voucher balances are included when qualifying which statements to print. If a voucher associated with an uninsured carrier is less than the amount specified in this box, then the account does not qualify for statements or for an assessment of finance charges.

Sequence By

This box determines the order in which statements are generated. The options are:

Option	Result
Alphabetically	Generates statements alphabetically.
Zip Code	Generates statements by zip code. Each segment is then sequenced alphabetically.

Exclude Insurance Group

This box excludes the balances due for the specified insurance group from being included in the insurance balance printed on the statement.

Attention: This box is only available when **Statement Type** is **Patient & Insurance Items**.

This field may be left blank.

Group Services By

This box determines how the voucher detail is grouped on the statement. The options are:

Option	Result
Actual Provider	Groups services by actual provider.
Department/Practice	Groups services by department or practice.
Blank	Groups services by voucher. Note: When you select Blank , the statement does not include the provider and department (or practice) of the service.

Summarize Vouchers Older Than

This box prints a statement with a balance forward amount that includes the balances for any voucher older than the number of days specified for **Summarize Vouchers Older Than**.

For example, when you enter 0 for **Summarize Vouchers Older Than**, the balance forward amount on the statement includes balances for all vouchers.

Note: The application determines how old a voucher is based on the voucher's service date. The application does not consider your setting for **Age By** on the **General** tab when selecting vouchers.

Base Dunning Messages On

This box determines how each of the dunning messages defined in the **Dunning Messages** area are applied to balances. The following options are available:

Option	Result
Most recent Payment	<p>Starts calculating the number of days based on the date of the most recently received self-pay payment. For example, if the most recently received payment has been within the last 28 days, then the dunning message on the statement is the one associated with Current to 28.</p> <p>Note: If you are using the interest payment posting functionality, interest payment transaction codes and interest adjustment transaction codes are not considered payments for the purposes of this setting: the most recent payment is never an interest transaction. Interest payment transaction codes and interest adjustment transaction codes are those that have the Interest Transaction Code selected in System Administration > File Maintenance > Transaction Code Maintenance.</p> <p>Considers payments associated with uninsured vouchers when determining the date of the most recent self-pay payment on the account if your practice or organization uses uninsured carriers.</p>

Option	Result
Oldest Charge	Uses the age of the account's oldest open item, regardless of when payments were applied to determine which dunning message to print on the statement.

Statement Export ID

This box determines the custom export program to which the statement is exported.

Attention: Only complete this box if your practice or organization exports statements using a custom export program.

Dunning Messages area

The options in this area determines dunning messages that are included on statements.

Dunning messages are generally created to act as markers for the aging of balances. For older account balances, dunning messages can remind the guarantor of the consequences if payment is not received.

You can customize the age category for each message. For example, if your billing cycle is based on 28 days, you can divide the categories into 28-day segments and assign messages accordingly:

Segment	Message
Current to 28	Your payment is now due. Thank you for your prompt response.
29 to 56	Your account balance is past due. Please remit payment.
57 to 84	Please call our office to arrange a payment plan. Thank You.
Over 84	Your account is about to be transferred to our collections department.

Print Family Statements of Account

This option prints all the Self-Pay activity for each patient associated with a guarantor on one statement. Affects the way finance charges are assessed.

Use this option for family billing where multiple patients are assigned the same guarantor. The patient's name prints, but the patient number and the patient's usual provider do not print on the statement.

Include Ins. Amount in Balance Due

This option prints a statement any time there is a balance due on a voucher, unless you also select **Only Print if Unpaid Self-Pay Vouchers**.

The total balance due printed on a statement equals the sum of the patient self-pay responsibility and the insurance balance. If your practice or organization uses uninsured carriers, it includes traditional self-pay balances and uninsured carrier balances when calculating the self-pay portion of the total balance.

Attention: This option is only available if you selected **Patient and Insurance Items** for **Statement Type**.

Only print if Unpaid Self-Pay Vouchers

This option prevents a statement from being printed unless there is a self-pay balance due on a voucher.

Only print if Unpaid Self-Pay Vouchers considers traditional self-pay vouchers and vouchers associated with uninsured carriers to determine whether there is a self-pay balance on an account if your practice or organization uses uninsured carriers.

Attention: This option is only available only if you select **Patient and Insurance Items** for **Statement Type**. Not checking this option causes statements to print even when there is only an insurance balance due on a voucher.

Include Paid Items Since Last Statement

This option includes vouchers on the statement that have been fully paid since the last time statements were printed. Checking this option qualifies the voucher for printing even when the voucher balance is zero.

Important: Select this option if you also selected **Allow Zero Balance Statements**.

Allow Zero Balance Statements

This option prints statements for accounts whose total balance was paid since the last time a statement was printed for that account.

Attention: If you select this option, you must also select **Include Paid Items Since Last Statement**. Otherwise, there will be no voucher detail to print.

Allow Credit Balance Statements

This option prints a statement for accounts that have a credit balance.

Print Unassigned Balances

This option prints "Your account has an unassigned balance of \$XX" in the lower left corner of the statement.

Print Billing Date in Footer

This option prints the billing date in the footer of the statement (in addition to the header, where bill date is always printed).

Attention: When exporting statements, you must select this option to include dunning messages in the file.

Print Account Type

This option prints the account type on the second line below the account number.

Print Primary Diagnosis Code

This option prints the primary diagnosis code to the right of the voucher number.

Note: If a charge was entered with ICD-10 codes, the ICD-10 primary diagnosis code prints on statements, regardless of whether the code is mapped to ICD-9 codes. If a charge was entered with ICD-9 codes, the ICD-9 primary diagnosis code prints on statements. If a statement includes multiple vouchers with a mix of ICD-10 and ICD-9 code sets, both code sets print on the statement.

Print Primary Diagnosis Code uses the following logic to determine the primary diagnosis code.

- > When the first diagnosis code entered on the voucher is an ICD-9 code, that ICD-9 code prints on the statement as the primary diagnosis code.

- > When the first diagnosis code entered on the voucher is an ICD-10 code without any mapped ICD-9 codes, that ICD-10 code prints on the statement as the primary diagnosis code.
- > When the first diagnosis code entered on the voucher is an ICD-10 code with mapped ICD-9 codes, the first mapped ICD-9 code prints on the statement as the primary diagnosis code.

Print Uncollected Co-Pay/Co-Ins

This option qualifies an account for a statement when a co-pay amount or co-insurance percent due for a service has been processed as uncollected.

Important: If this option is not selected, the application only generates a statement for an uncollected co-pay or co-insurance after the payment from the carrier is applied and the balance is transferred to self-pay.

Include Ins. if Accept Assignment = No

This option causes the following when a statement is printed that contains one or more vouchers whose accept assignment flag is set to **No**.

- > Includes the balance of those vouchers whose accept assignment flag is set to **No** in the **Total Now Due** column, which indicates the amount currently due by the patient.
- > Excludes the balance of those vouchers whose accept assignment flag is set to **No** from the **Insurance Pending** column.
- > Excludes the voucher balance followed by an asterisk in the detail portion of the statement.
- > Prints voucher balances with an asterisk for vouchers whose accept assignment flag = **Yes**.

Attention: This option is only available if you selected **Patient and Insurance Items** for **Statement Type**.

It is intended for practices and organizations who want to both:

- > Keep non-par carriers as the remitter on vouchers for tracking and reporting purposes.
- > Include the voucher balance in the balance due by the patient on the statement.

These vouchers also qualify for insurance billing, as well.

Print Statements by Department (or Print Statements by Practice)

This option enables you to print statements for all departments or practices without restarting your session. The statement date by account and department (or practice) is written to the Statement_History table to maintain the correct statement cycle and aging.

Attention: You can select this option even if you do not set **Header Information to Department or Practice**. If you set **Header Information to Department or Practice**, this option is selected automatically.

If you do not select this option and you run statements cycled by last statement date, you must process statements for each department or practice on the same day. After the first statement run, you must select **Restart after Account** as the run type on the **Print Statements** tab in **Billing > Statement Processing** for each subsequent statement run.

If you select this option and want to run statements for one department or practice at a time on the same day so separate SN and SP reports from iBill™ will be generated for each department or practice statement run, you must do the following when you process statements for each subsequent department or practice:

1. Select **New Forms** as the run type for the first department or practice
2. Select **Restart after Account** as the run type (leaving that field blank).

Important: When used in conjunction with department security or practice security, the printing of statements is restricted to those departments or practices associated with the operator.

When you select **Print Statements by Department** or **Print Statements by Practice**, **Output Abbreviation** is enabled. Select **Output Abbreviation** to include the prefix PR and the abbreviation for the department or practice in the headers of all statements, regardless of the option you selected for **Header Information**.

Attention: **Output Abbreviation** is associated with **Print Statements by Department** or **Print Statements by Practice**. It is only enabled if **Print Statements by Department** or **Print Statements by Practice** is selected.

Print Statements by Division

This option prints statements by division.

When you select **Print Statements by Division**, **Output Abbreviation** is enabled. Select **Output Abbreviation** to include the prefix PR and the abbreviation for the department or practice in the headers of all statements, regardless of the option you selected for **Header Information**.

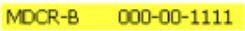
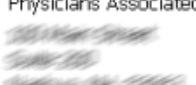
Attention: **Output Abbreviation** is associated with **Print Statements by Department** or **Print Statements by Practice**. It is only enabled if **Print Statements by Department** or **Print Statements by Practice** is selected.

Print Policy ID

This option enables you to determine whether to include the patient's policy ID (certificate number) on statements when printing or exporting. It applies to both printed and exported statements.

By default, this option is selected. However, you may clear and re-select this option as needed. The new setting applies to your next statement run.

For example, you may want to clear this option if you have a number of patients whose certificate number is their SSN. In this scenario, clearing **Print Policy ID** will remove the certificate number from statements so as to protect your patients' privacy.

Physicians Associated 	Account#: 130	Page 1
Option is checked		
 FEI: 043690933Subsuffix	MDCR-B  000-00-1111	
	11/02/2009	130
		48.00
Physicians Associated 	Account#: 130	Page 1
Option is not checked		
 FEI: 043690933Subsuffix	 MDCR-B	
	11/02/2009	130
		48.00

Note: When the option **Hide Cert No.** is selected for a carrier in **System Administration > File Maintenance > Insurance Carrier**

|| **Maintenance**, the certificate number prints on the statement or is exported to the file even when the account's policy is associated with the carrier.

Bypass Statements for Accounts with Unposted Activity

This option causes the application to bypass any statements for accounts with payments (including unassigned payments), adjustments, and transfers that are in batches which have not been updated. Statements are also bypassed for accounts with any charges that were entered and not posted at the time the statements were run.

When you select this option, if an account has unposted activity as described and you selected **Print Family Statements of Account**, the application bypasses the entire account when you process statements.

Statements that have been bypassed because of this option will qualify for statements as soon as the unposted payments or adjustments are posted instead of not qualifying until the next statement cycle.

|| **Attention:** If a self-pay voucher has already been stamped with a bill date, that voucher continues to age and may qualify as past due.

Print Interest Transactions

Select this option to include interest transactions on patient statements if you are using the interest payment posting functionality. Any applicable interest transactions are displayed on both **Patient and Insurance Items** and **Patient Items Only** statements types.

|| **Note:** This option is cleared by default.

Items to consider for statement processing

The rules for generating statements in your practice are defined in **Practice Options** or **Organization Options** and should be based on well-thought-out standards that meet your practice policies and procedures.

|| **Tip:** Run statements regularly.

Run options

The following are options available when you run statements:

- > Print on a preprinted form.
- > Export using a generic export file.
- > Cycle by billing date (based on **Practice Options** or **Organization Options** setting).

- Cycle by a range of guarantor last names (based on **Practice Options** or **Organization Options** setting).
- Generate statements by departments or practices without having to do a restart (based on **Practice Options** or **Organization Options** setting).
- Generate statements grouped by division without having to do a restart of the statements (based on **Practice Options** or **Organization Options** setting; you must select **Enable Division** on the **Multi Entity** tab in **Practice Options** or **Organization Options** to use statements by division functionality).

Note: If you generate statements by division with **All Divisions** selected in the selection criteria, an account with vouchers in 3 divisions will receive 3 statements, 1 for each division.

Qualifying vouchers

Self-pay balances qualify for printing when both of the following are true:

- transactions have been updated
- the criteria relative to the statement cycle set in **Practice Options** or **Organization Options** is met

Exceptions

When statements are prepared, guarantors who have a note attached which is flagged to hold statements are bypassed.

When printing by selected account, hold statement flags set for the account are ignored.

Restrict by selected records

Since the statement history reflects only the last statement run for the patient or account, when you are cycling by statement date and you want to produce separate statement runs by selected provider, location, department or practice, remember to do the following:

- First, run all the statements for each provider, department or practice (see note on Printing Statements by Department/Practice), location on the same day using the run type **New Form**.
- For each subsequent run, select the run type **Restart after Account** (leaving the field blank). This assures that all qualifying statements are included for the selected provider or department, or practice or location. Then make the appropriate selection of a specific provider, location, department or practice. Print or export for each selection.

Selection of divisions

When **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, a **Divisions** tab is displayed on the **Select Departments** or **Select Practices** window that enables you to filter on divisions.

Note: Selecting a division is a shortcut to selecting all of the departments or practices within that division.

Statements still print by department or practice. This means that a patient with vouchers in multiple departments or practices receives multiple statements even if all of the departments or practices are contained in one division. The patient receives a separate statement for each department or practice.

Print statements by department or practice

When **Print Statement by Department/Practice** is selected on the **Statement** tab in **Practice Options** or **Organization Options**, an operator can print statements for one or more department or practices at a time without requiring a restart. When this option is not selected, you must process statements for each of your departments or practices on the same day. After the first run, **Run Type** must be set to **Restart after Account**.

The statement date by account and department or practice is written to the **Statement_History** table in order to maintain the correct statement cycle and aging.

When used in conjunction with department or practice security, the printing of statements is restricted to those departments or practices associated with the operator.

Print statements by department or practice but still receive a separate SN and SP reports from iBILL for each department or practice statement run

If you selected **Print Statements by Department/Practice** and you want to run statements for one department or practice at a time (so that separate SN and SP reports from iBILL are generated for each department or practice statement run) on the same day, you must choose **New Forms** as the run type for the first department or practice, and then choose **Restart after Account** as the run type (leaving that field blank) when you process statements for each subsequent department or practice.

Assess finance charges

When you select **Last Statement Date for Cycle By** on the **Statement** tab in **System Administration > Practice Options** (or **Organization Options**), **Date Finance Charges Last Assessed** is displayed at the top of the **Print Statement** window.

Note: **Date Finance Charges Last Assessed** is only displayed if any vouchers qualify when finance charges are assessed. If no vouchers qualify, **Date Finance Charges Last Assessed** is not displayed.

This information is to help practices who assess finance charges to manage coordinating the assessment of finance charges with running statements.

For practices not using this feature, the statement displays without a date stamp.

View previously printed statements

When printing statements to a preprinted form or generating a generic export file the application automatically creates a backup file that is used to view or print previously printed statements from the account ledger.

Print primary diagnosis codes on statements

Statement processing prints either an ICD-9 or ICD-10 code as the primary diagnosis code when **Print Primary Diagnosis Code** on the **Statement** tab in **Practice Options** or **Organization Options** is selected.

If a charge was entered with ICD-10 codes, the ICD-10 primary diagnosis code prints on statements, regardless of whether the code is mapped to ICD-9 codes. If a charge was entered with ICD-9 codes, the ICD-9 primary diagnosis code prints on statements. If a statement includes multiple vouchers with a mix of ICD-10 and ICD-9 code sets, both code sets print on the statement.

The following logic determines the primary diagnosis code.

- When the first diagnosis code entered on the voucher is an ICD-9 code, that ICD-9 code prints on the statement as the primary diagnosis code.
- When the first diagnosis code entered on the voucher is an ICD-10 code without any mapped ICD-9 codes, that ICD-10 code prints on the statement as the primary diagnosis code.
- When the first diagnosis code entered on the voucher is an ICD-10 code with mapped ICD-9 codes, the first mapped ICD-9 code prints on the statement as the primary diagnosis code.

Understand the Exporting Records Message

During statement processing, the following message displays when you are printing to preprinted forms and when you are generating an export file. NEVER cancel the process.



- Printing to Preprinted Forms

This message displays only once after you hit **Run**. It indicates the creation of the statement history .BAK file.

- Generating an Export File

This message displays twice.

The first time indicates the creation of the .txt file used for the export to your third party vendor.
The second display indicates the creation of the statement history .BAK file.

How statement backup works

The statement history backup file is auto-created and named by the application. It resides in a folder named **Statement History Files**. This folder is automatically created the first time you process statements. It can be found using the path `\<Server Name>. <Domain Name>\NtierFiles\<Tenant Name>\`. Files in this folder are used by the application to display the selected statement in **Account Statement History** in **Account Ledger**.

Including non-par insurance balances on statements

This topic explains what happens when you check the Statement Option **Include Ins.** If **Accept Assignment = No.** (F9 > POP/OOP)

Check the option when you want to keep non-par Carriers as the Remitter on vouchers for tracking and reporting purposes and also want the voucher balance included in the balance due by the Patient on the statement. These vouchers also qualify for insurance billing as well.

This section describes how balances on vouchers whose accept assignment flag is set to **No** are handled in related functions.

Statement processing

Includes the balance of those vouchers whose accept assignment flag is set to **No** in the column "Total Now Due" which indicates the amount currently due by the Patient.

Excludes the balance of those vouchers whose accept assignment flag is set to **No** from the column "Insurance Pending."

Does not print the voucher balance followed by an asterisk in the detail portion of the statement. However, balances of vouchers whose accept assignment flag = **Yes** still print with an asterisk.

Financial Inquiry

Displays an indicator of "N" in the column titled "AA" for vouchers whose assignment flag is set to **No** from the Self-Pay balance in the aging grid. Includes the balance of those vouchers whose accept assignment flag is set to "No" in the Insurance balance in the aging grid. Vouchers whose accept assignment flag is set to "No" are listed in the service lines grid displaying the Carrier as the Payor.

This column is blank for Self-Pay voucher lines.

Lists these vouchers in the service lines grid with the Carrier as the Payor.

Note: The line "Insur" on the Aging Grid includes the balance of vouchers out to all Carriers except those flagged as a Collection Agency. These voucher balances are added on the line "Collect" in the grid.

Account management

Displays the Account's totals for Insurance vouchers whose Accept Assignment = No in the aging grid at the top of the screen on the aging grid line labeled "Insur."

This total does include those voucher balances out to Carriers flagged as collection agencies when their AA flag is set to **No**. But it excludes all those balances for Insurance vouchers whose AA flag is set to **Yes**.

Payment entry

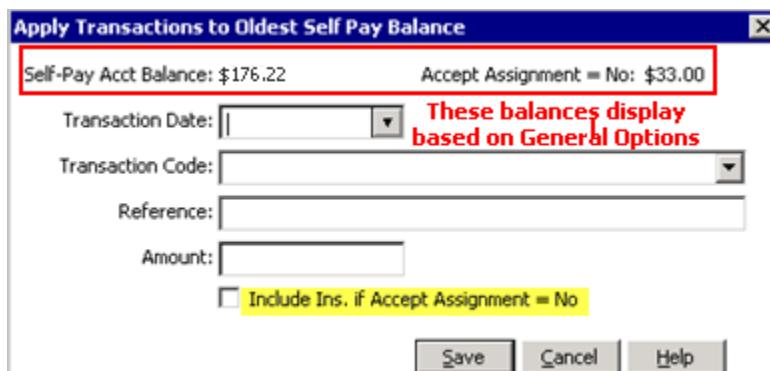
Displays an indicator of "N" in the column titled "AA" for vouchers whose assignment flag is set to **No**.

This column is blank for Self-Pay voucher lines.

Displays the Payor as the Carrier.

On the Apply Transactions to the Oldest Self-Pay balance screen there is an indication in the top right corner the total for Insurance vouchers whose accept assignment flag is set to **No**.

To include these vouchers in the distribution of payment check the box **Include Ins. if Accept Assignment = No** on this screen.



The payment is also recorded with the description "Self-Pay Check Payment" as a credit in the Account Management screen.

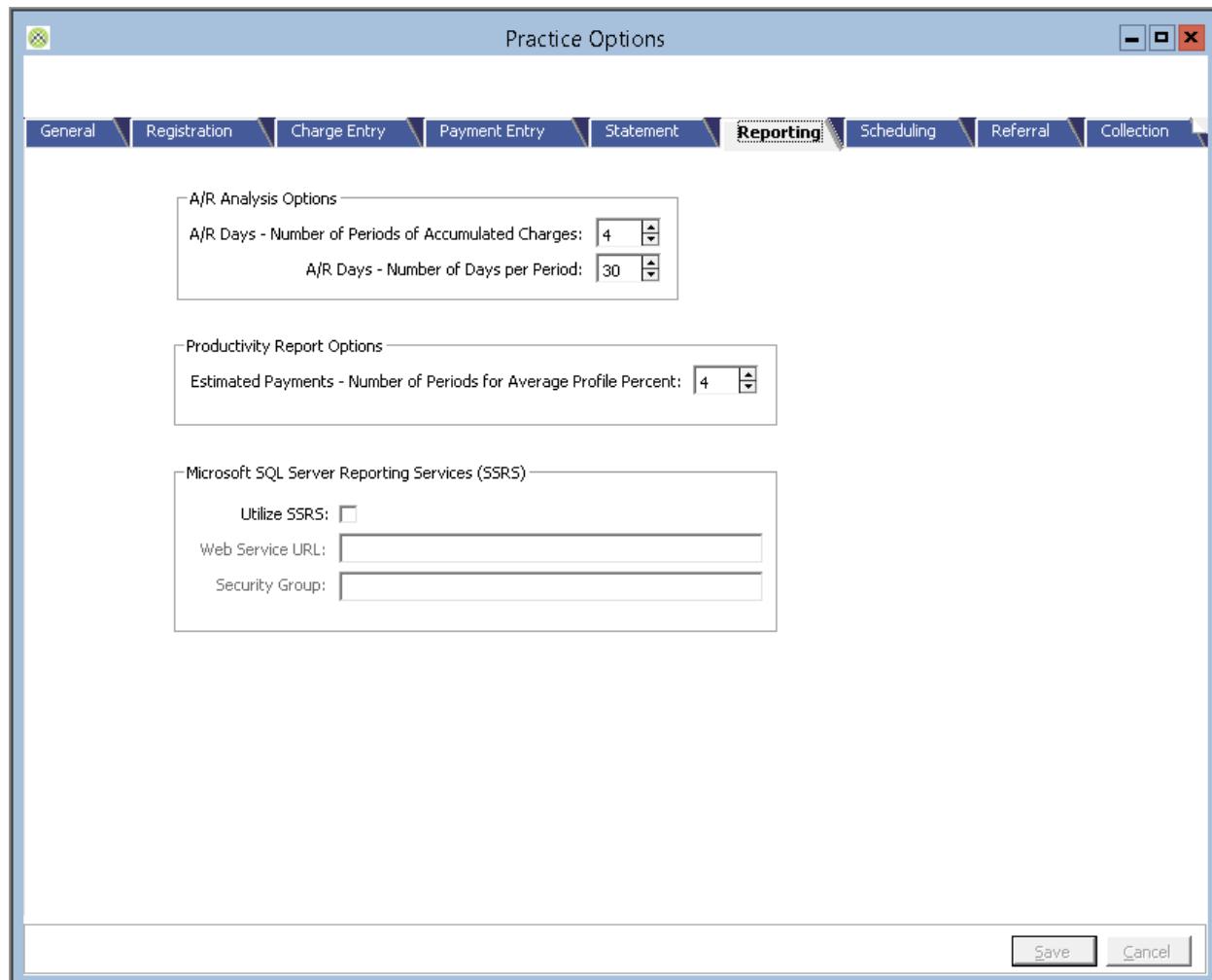
Note: The Self Pay Account Balance and the balance of the Accept Assignment = No display when you also check **Show Self-Pay Account Balances** on the General tab in the Practice/Organization Option.

Tip: To identify these vouchers consider having your staff apply a statement message at the time of charge entry. That message can be viewed from Payment Entry and Financial Inquiry when your view options include "Messages."

Reporting tab

You can set up various options having to do with reports on the Reporting tab in Practice/Organization Options (POP/OOP).

Access the **Reporting** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.



A/R analysis options

You define the Reporting Options related to the A/R Analysis on the Reporting tab in Practice/Organization Options (F9 > POP/OOP). These settings are used in the **A/R Analysis**

Report when calculating the number of days from the time a charge is updated to the time of payment.

The application default settings can be changed to meet the reporting needs of your practice.

The A/R Analysis Options impact the calculation of # A/R Days when running the A/R Analysis.

A/R days are the number of days over a given period that it has taken to collect receivables. This implies that the system needs a sufficient amount of historical data to analyze.

When setting these options it is important for you to understand the impact of your settings.

Number of Periods of Accumulated Charges

This is the average number of days that make up a reporting period, for example 30.

A Reporting Period is a way of grouping financial information. It is the "marker" given to the system so that it "knows" which information to use in reports such as the A/R analysis.

Number of Days per Period

This is a standard number of days which makes up each period.

This setting determines the number of days used to calculate the # of Days printed on the A/R Analysis report when you do not elect to calculate by actual days.

Decide how many reporting periods and days per period you want to use. Your selection should represent a reasonable period of time over which you can evaluate how efficient you are in collecting payments against charges.

To maintain a level of consistency when interpreting your A/R days, it is recommended that once having set the options you do not change them.

Note: Keep in mind that until your practice has accumulated the necessary reporting periods, the system will use the number of reporting periods which are available. For example, if only 2 reporting periods exist, then 2 reporting periods will be used to determine the number of total days.

Productivity report options

You define the Reporting Options related to the Productivity Report on the Reporting tab in Practice/Organization Options (F9 > POP/OOP). This setting determines the number of periods of accumulated payments and adjustments are used when calculating the average practice wide profile percent for estimating payments using the Productivity Report.

The application default settings can be changed to meet the reporting needs of your practice.

The Productivity Report options allows you to generate a bottom line report that gives an estimate of global payments.

The Periods referred to here are Reporting Periods. A Reporting Period is a way of grouping financial information. It is the "marker" given to the system so that it "knows" which information to use in the report.

Estimated Payments - Number of Periods for Average Profile Percent

The default setting is 6 periods.

Using the spin box you can change this setting to meet your Practice needs.

It is recommended that you do not select a setting lower than 6. Also to maintain a level of consistency when estimating payments, it is recommended that you do not change the option once you have decided on a setting.

Note: Until your practice has accumulated the specified number of reporting periods, the system uses the number of reporting periods available to calculate estimated payments. In other words if only two reporting periods exist, then only the payments and adjustments for those two reporting periods are used to determine the average global, practice-wide Profile Percent.

Understand the Programming Logic

When the Productivity Report is run with the option **Calculate Estimated Payments** checked, the system uses the number of reporting periods you set here to calculate the practices average profile percent which is then used to calculate estimated payments.

The Average Profile Percent is determined by adding all the payments received in your Practice for all Providers during the number of reporting periods specified here and then dividing that practice wide total by the same payments plus all the adjustments received during the number of reporting periods specified here.

In other words, Average Profile Percent = Total Payments accumulated for the specified number of reporting periods / (Total Payments for the same number of periods + Total Adjustments for the same number of reporting periods).

Self-Pay payments and adjustments are included in these totals.

Calculate Estimated Payments

Calculating estimated payments is an options available when you run the Productivity Report.

When you check the option to calculate estimated payments, it is important to keep the following points in mind:

- > To calculate estimated payments a global, practice-wide Average Profile Percent must first be calculated. This Average Profile Percent is calculated using payments and adjustments accumulated over a rolling number of reporting periods. This is specified on the Reporting tab in Practice Options (POP) ending with and including the last reporting period selected for the report under Estimated Payments - Number of Periods for Average Profile Percent.

- > To arrive at the Average Profile Percent, the total accumulated payments for the specified number of reporting periods (6 is the default) is divided by the total of the accumulated payments and adjustments over the same number of reporting periods.

Average Profile Percent = Total Payments accumulated for the specified number of reporting periods / (Total Payments for the same number of periods + Total Adjustments for the same number of reporting periods)

You can run the Productivity Analysis to find the Average Profile Percent by running this report with the following selections:

- > Report Preferences: Accept the default settings.
- > Selection Criteria: Accept the default settings.
- > Reporting Periods: Starting with the current reporting period, count back the number of months specified in Practice Options. Enter the range of reporting periods, ending with the current reporting period (for example, if you set the Practice Option to 6 reporting periods, and the current reporting period is June 200x, enter Reporting Periods - From: "Jan 200x" To: "June 200x"). The Average Profile Percent prints on the Grand Totals line in the Prof% column.

The estimated payment amount for any row on the report is calculated by multiplying the charges for that row by the Average Profile Percent, not the Prof% amount displayed on the row, which is calculated based on the payment and adjustment amounts on each row.

Estimated Payments = Charges * Average Profile Percent

Note: The charges include paid and unpaid vouchers.

It is very important to understand that the Average Profile Percent used to calculate estimated payments includes all data for the specified period, and does not change based on the grouping options or the selection criteria when you run the Productivity Analysis. This formula uses the payment and adjustment totals for all providers, insurance carriers, departments and so forth. Example: If the report is run for only one provider or insurance carrier, the payment and adjustment totals used to arrive at the Average Profile Percent looks at the amounts for All Providers and All Carriers, not just the amounts for the single provider or insurance carrier selected.

Since the average Profile Percent is a global, practice-wide number if users want to see the actual Profile Percent used in the calculation of estimated payments for each row on the report, then the report should be run for all records for the same number of reporting periods as is set on the Reporting tab in Practice Options.

The report shown below is an example of this with the report being run for six reporting periods which is also the number of reporting periods selected in the Practice/Organization Option.

4/26/2006 1:00:55PM		Productivity Analysis								Page: 1		
		Associated Physicians										
		Oct 2005 - Mar 2006										
		Units	Total RVUs	Charges	Chg%	Estimated Payments	Payments	Prof%	Refunds & Debits	Adjust	Transf. In/Out	Net
Mar 2006		77.50	248.06	54826.04	17%	40571.27	14581.58	94%	0.00	1005.85	0.00	39238.61
Feb 2006		35.90	155.86	50581.20	15%	37430.09	13163.50	71%	0.00	5496.89	0.00	31920.81
Jan 2006		77.90	308.94	56228.60	17%	41609.16	12249.35	79%	0.00	3179.42	0.00	40799.83
Dec 2005		63.30	45.64	43641.60	13%	32294.78	8928.08	76%	18.00	2843.38	0.00	31888.14
Nov 2005		50.00	618.30	83325.20	25%	61660.65	6369.71	75%	0.00	2135.24	0.00	74820.25
Oct 2005		77.20	206.12	40086.20	12%	29663.79	9712.25	55%	0.00	8047.75	0.00	22326.20
Grand Totals:		381.80	1582.92	328688.84	100%	243229.74	65004.47	74%	18.00	22708.53	0.00	240993.84

Because this report is run for the exact number of reporting periods as is the setting in Practice Options then 74% is equal to the global practice wide average profile percent

Microsoft SQL Server Reporting Services (SSRS) options

Use the **Microsoft SQL Server Reporting Services (SSRS)** area on the **Reporting** tab in **Practice Options** or **Organization Options** to enable and set up Microsoft® SQL Server® Reporting Services (SSRS) for presenting reports in Allscripts® Practice Management.

Note:

- > Specific setup in Microsoft® SQL Server Report Server Configuration Manager is required to use SSRS. Contact your Allscripts® representative if you want to use SSRS.
- > Hosted clients who want to use SSRS should contact their Allscripts® hosting representative.

When setting SSRS options, you must be logged on to Allscripts® Practice Management application server with the approved domain account or Allscripts® service account.

Access the **Reporting** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.

The following reports within Allscripts® Practice Management are designed to look and behave similarly to their SAP Crystal Reports counterparts.

- > Performance Management Report
- > Clinical Analysis Report
- > Aged Trial Balance
- > A/R Analysis
- > Unpaid Claims Report

- > Productivity Analysis
- > Collection Account Report
- > Performance Variance Report
- > Reimbursement Exceptions
- > Daily Charge Analysis
- > Daily Payment Analysis.
- > Revenue Detail Report
- > Account Summary
- > Reimbursement Review

Utilize SSRS

Enables applicable logic to use the SSRS type reports that are active in the application.

When selected, a window is displayed listing the following components that are required for SSRS and must be configured before you use the SSRS feature:

- > SQL Server [version]
- > SQL Server Reporting Services
- > Domain Users group for reporting

Web Service URL

Enables applicable logic to use SSRS type reports that are active in the application.

Security Group

Enables applicable logic to use the SSRS type reports for that are active in the application.

Note: The value for **Security Group** is case sensitive and must match the group or user name in SQL Server Reporting Service Configuration Manager when creating a new role assignment.

After you click **Save**, you are prompted for your SQL Server credentials (domain service account and password). You cannot successfully save the information until you enter those credentials. The database server must also recognize the service account credentials for the security logins with db_datareader, db_datawriter, and public permissions.

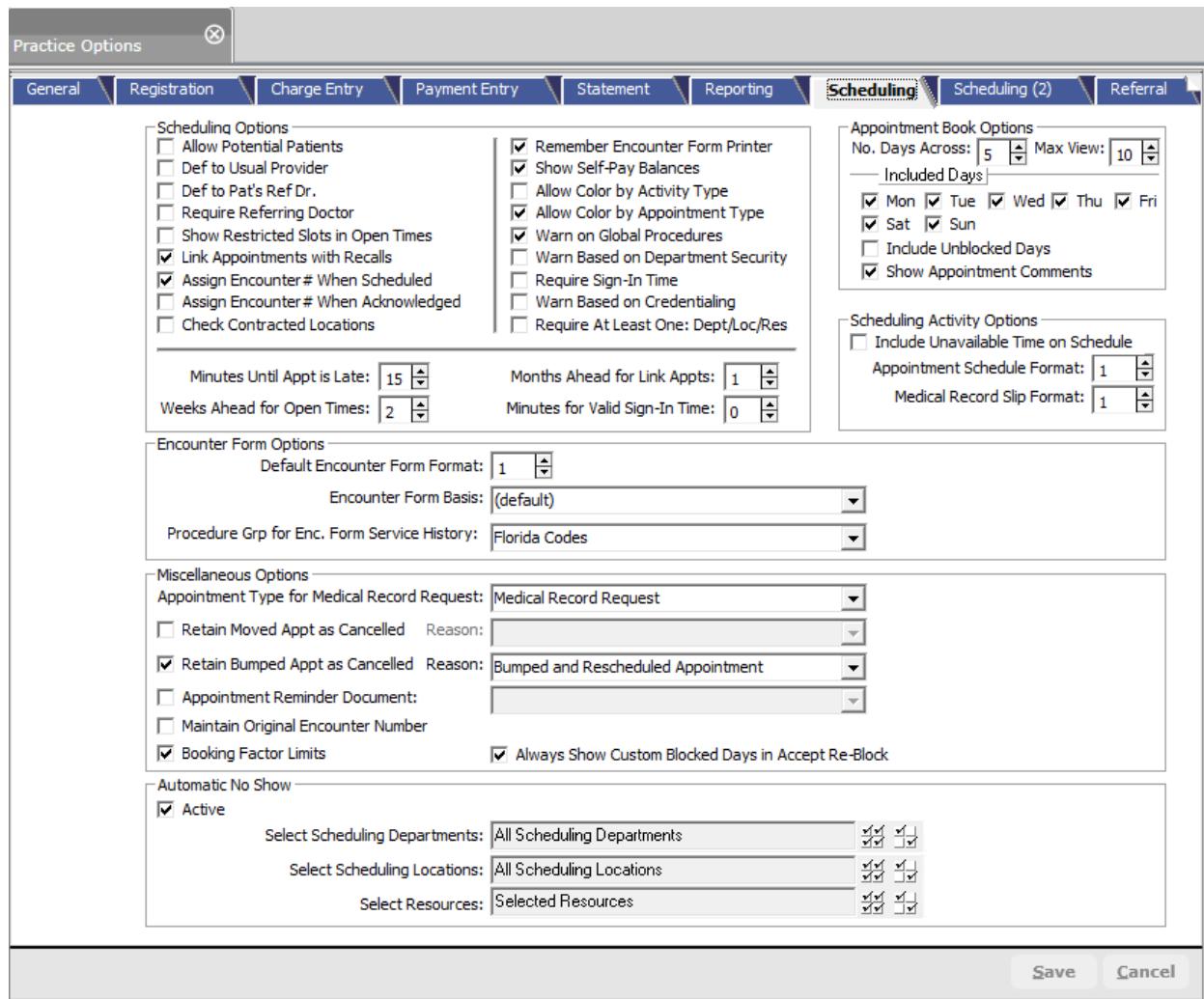
SQL Server Credentials

After saving, a SQL Server authentication form prompts you to enter the domain service account and password.

Scheduling tab

Use the **Scheduling** tab in **Practice Options** or **Organization Options** to manage various scheduling functions.

Access the **Scheduling** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.



Scheduling Options

- Allow Potential Patients
- Def to Usual Provider
- Def to Pat's Ref Dr.
- Require Referring Doctor
- Show Restricted Slots in Open Times
- Link Appointments with Recalls
- Assign Encounter # When Scheduled
- Assign Encounter # When Acknowledged
- Check Contracted Locations

Minutes Until Appt is Late: Months Ahead for Link Appts: Weeks Ahead for Open Times: Minutes for Valid Sign-In Time:

Appointment Book Options

No. Days Across: Max View:
 Included Days
 Mon Tue Wed Thu Fri
 Sat Sun
 Include Unblocked Days
 Show Appointment Comments

Scheduling Activity Options

Include Unavailable Time on Schedule
 Appointment Schedule Format:
 Medical Record Slip Format:

Encounter Form Options

Default Encounter Form Format:
 Encounter Form Basis:
 Procedure Grp for Enc. Form Service History:

Miscellaneous Options

Appointment Type for Medical Record Request:
 Retain Moved Appt as Cancelled Reason:
 Retain Bumped Appt as Cancelled Reason:
 Appointment Reminder Document:
 Maintain Original Encounter Number
 Booking Factor Limits Always Show Custom Blocked Days in Accept Re-Block

Automatic No Show

Active
 Select Scheduling Departments:
 Select Scheduling Locations:
 Select Resources:

Save **Cancel**

Scheduling Options

This topic describes the options under Scheduling Options on the Scheduling tab in Practice/Organization Options. (F9 > POP/OOP)

Allow Potential Patients

Allows the Operator to schedule appointments for non-registered patients.

Def to Usual Provider

Defaults the selection of the resource in scheduling to the patient's usual provider from Registration.

Can be overridden by the user defaults that are workstation and user specific.

Can be edited on the scheduling screen.

When left unchecked, you must manually select a resource when scheduling appointments.

Def to Pat's Ref Dr.

Defaults the selection of the referring doctor on the scheduling screen to the patient's referring doctor from Registration.

Require Referring Doctor

Prevents you from saving an appointment until you have selected a referring doctor for the appointment.

Show Restricted Slots in Open Times

Displays time slots with appointment restrictions in gray when you search for open times or recurring times from the **Patient Scheduling** tab.

Allows you to force an appointment into a restricted slot from the open times and the find recurring times screens.

Note: The ability to force an appointment into a restricted slot in open times is not governed or overridden for a User by the setting in security permissions.

When left unchecked, time slots made unavailable by restrictions are not displayed in open times or when searching for occurring times.

Link Appointments with Recalls

Allows you to link recalls to an appointment by activating the **Link to Appointment** check box on the Recalls dialog.

You can restrict the recall report to linked or not linked recalls.

Assign Encounter # When Scheduled

Intended for use with a paperless encounter systems. When checked will assign an encounter number to a visit at the time the appointment is scheduled.

Recommended when using charge import.

Either this option or **Assign Encounter # When Acknowledged** must be checked along with the Charge Entry option **Track Encounters** to ensure the correct use of coverage types.

Assign Encounter # When Acknowledged

Intended for use with a paperless encounter systems. When checked will assign an encounter number to a visit at the time the appointment is acknowledged.

When either **Assign Encounter # When Scheduled** or **Assign Encounter # When Acknowledged** is checked, the Appointment detail reflects the action at the appropriate time.

Checking either of these options causes Encounters that do not have charges posted against them to qualify for the **Encounter Tracking Report**, even if the Charge Entry option **Track Encounters** is not checked.

Leaving both these options unchecked will trigger the system to assign a number at the time the encounter is printed if the Charge Entry option **Track Encounters** is checked. Using the encounter number when entering charges pulls all the appointment detail relevant to the charge into the charge entry screen.

Check Contracted Locations

Select this option to require that appointments can only be scheduled at locations that are in network for the patient's insurance policy based on the data imported by a SQL Server Integration Service (SSIS) package.

If the location is out of network, the patient must be seen at a different location or use a different policy.

Check Contracted Locations is only available if you select **Enable Division** on the **Multi Entity** tab in **Practice Options** or **Organization Options**.

Note: Restrictions for scheduling appointments at in-network locations do not apply to self-pay patients.

Important: A file with contracted location data in a specific format is required to use this function. The information is imported into Allscripts® Practice Management with an SSIS package. You must work with an Allscripts® representative to implement this function.

When creating a new tenant, **Check Contracted Locations** is excluded from starter data.

Remember Encounter Form Printer

Intended for use when printing single encounter forms on demand.

Once you have printed an encounter form your most current printer selection is remembered for subsequent encounter form printing based on the combination of the user logged into the workstation, scheduling department and scheduling location selected on the originating scheduling screen.

Show Self-Pay Balances

Checking this option triggers the display of the Account's Self-Pay balance on the following tabs and windows:

- 1. Patient Scheduling tab**
- 2. Schedule New Appointment**
- 3. Walk In Appointment**
- 4. Force Appointment**
- 5. Appointment Detail**

The rule for age considered past due set in General Options applies causing any past due balance to display in red.

Note: A self-pay balance displayed in red indicates that all or a portion of the patient's balance is considered past due.

This allows all your staff to have an instant view of the Account's Self-Pay balance and its status without having to open the COMpanion.

Allow Color by Activity Type

Enables the **Custom Color** field in Activity Type Maintenance allowing you to assign a color to Activity Types. See "Using Custom Color Coding in Scheduling" for more information.

Allow Color by Appointment Type

Enables the **Custom Color** field in Appointment Type Maintenance allowing you to assign a color to Appointment Types. See "Using Custom Color Coding in Scheduling" for more information.

Warn on Global Procedures

Checking this option triggers the display of the most recent active global procedure and its expiration date on the Patient Scheduling tab, the Schedule New Appointment dialog, the Walk In Appointment dialog, and the Force Appointment dialog when a Procedure with a Global Period is part of a Patient's history.

Checking this option also enables **Warn Based on Department/Practice Security**.

Warn Based on Department Security

Enabled only when **Warn on Global Procedures** is checked. Unchecking **Warn on Global Procedures** while **Warn Based on Department/Practice Security** is checked, clears the check mark and disables this option.

When checked, the global procedure and the global procedure expiration date only display if the Operator scheduling the appointment for the patient has access to the Department/Practice used when the global service charge was entered.

Note: For this option to function properly, **Enable Department/Practice Security** located on the General tab in Practice/Organization Options must be checked, and Operators must have Department/Practice Members assigned in Operator Maintenance.

Require Sign-In Time

When selected, **Sign In** is a required field after an appointment has been acknowledged. It was added to the following windows accessed from **Practice Management > Scheduling**:

- > **Acknowledge Appointment**
- > **Schedule Appointment**
- > **Schedule (Walk In) Appointment**
- > **Schedule (FORCED) Appointment**

When cleared, **Sign In** can be used as needed but is not required. Additionally, it is not dependent on the acknowledged time when cleared.

Warn Based on Credentialing

This box is cleared by default. When selected, the **Non Credentialed Provider** warning message is displayed in **Appointment Scheduling** when the provider who is associated to the resource being scheduled is not credentialed with the patient's primary policy of the same coverage type that is used in the appointment.

Additionally, when **Warn Based on Credentialing** is selected, **Scheduling Override Reason Maintenance** is available.

Require at Least One; Dept/Loc/Res

This option requires you to provide one of the following criteria before you can query for appointment times:

- > Sched Dept
- > Sched Location
- > Resource or Res Group

Minutes Until Appt is Late

Determines when a patient is considered late for an appointment.

This option allows you determine how many minutes before a Patient is considered late for an appointment.

The system time-stamps an appointment when it is acknowledged. The acknowledgement screen contains an editable field for "time in". If the "time in" exceeds the number of minutes entered in **Minutes Until Appt is Late**, the Appointment Activity will display the Appointment Status as "Ack (Late)". Late detail is only available on the appointment detail screen and the appointment activity screen.

When this option is set to zero, appointments are never acknowledged as late.

Weeks Ahead for Open Times

Sets the default on how many weeks of available appointments are retrieved when you do either of the following:

- > Query on open times. See "Finding Open times' for more information.
- > Schedule Recurring Appointments.

Recommended setting is 2 weeks. Remember, the more weeks you search the longer it will take for the query.

Months Ahead for Link Appts

Used in Multi-Resource Scheduling to control the time period searched when you are trying to schedule linked appointments.

Setting this to a number greater than zero will enable the Link Appts button on the Patient Scheduling tab. See "Linking Appointments: Overview" for more information.

Tip: Keep in mind that the length of time you select may impact on how long it takes the system to perform the search.

Minutes for Valid Sign-Time

In **Minutes for Valid Sign-In Time**, the value entered determines the parameters Allscripts® Practice Management uses to validate the **Sign In** value entered in the following windows accessed from **Practice Management > Scheduling**:

- > **Acknowledge Appointment**
- > **Schedule Appointment**
- > **Schedule (Walk In) Appointment**
- > **Schedule (FORCED) Appointment**

Note: Allscripts® Practice Management only performs the validation if there is an acknowledged time entered for the appointment.

For example, if **Minutes for Valid Sign In Time** is set to 60, **Sign In** for the scheduled appointment must be within 60 minutes before or after the scheduled appointment time when the appointment also has an acknowledged time.

Minutes for Valid Sign-In Time is 0 by default and accepts numeric values up to 999. If the value is 0, Allscripts® Practice Management does not perform the validation.

Appointment Book Options on the Scheduling tab

You can set up various appointment book options on the **Scheduling tab** in **Practice Options** or **Organization Options** that determine the look of the **Appointment Book** tab in **Scheduling > Appointment Scheduling**.

Number of Days Across

Determines the number of days you want displayed on the days grid on the **Appointment Book** tab when you click **Add Week**, **Add Day**, or **Today**.

Max View

Determines the number of days that are displayed when the screen is maximized. The maximum amount of days is 20. The value of **Max View** must be greater than or equal to the value of **No. Days Across**.

Included Days

The days you select are included in the display on the **Appointment Book** tab when you click **Add Week**.

Include Unblocked Days

Adds an empty white column for any unblocked day that is part of the series of days you selected above.

Show Appointment Comments

When this option is selected, appointment comments are displayed to the right of the patient's name on the **Appointment Book** tab. The comment is separated from the patient's name by a hyphen.

Note: When more than one day is displayed, some appointment comments may be hidden from view. To remedy this, you must resize the columns.

Scheduling activity options

This topic describes the options under Scheduling Activity Options on the Scheduling tab in Practice/Organization Options. (F9 > POP/OOP).

This section defines standards used when you perform functions in Scheduling Activities under Scheduling

Include Unavailable Time on Schedule

Checking this option means that those time slots designated for Activity Types that are flagged as **Not Available for Appointments** will also print on the Schedule. Examples of such times might be meetings or lunch.

Not checking this option prevents the printing of activity types that are not available for scheduling appointments on the Provider's Schedule

Appointment Schedule Format

By program design, there are two generic print formats available for printed Schedules.

Currently Appointment Schedule formats cannot be customized.

1. Format 1 - Prints the Appt time, Patient Name, Telephone #(s), Patient #, Patient Date of Birth, Insurance Co-Pay, Appointment or Activity, Appointment Duration, and Appointment Comment.

6/29/2005 9:08:25AM

**Appointment Schedule
Associated Physicians**

Page: 1

**Appointment
Schedule Print
Format 1**

For [REDACTED], Henry J on 11/18/2005
PG / IM

Time	Patient Name Telephone#(s)	Patient# Date of Birth	Insurance Co-Pay	Appointment or Activity Comments	Duration
08:00 AM	Marguerite [REDACTED] H: [REDACTED] W: [REDACTED]	10 10/26/19[REDACTED] [REDACTED] years	AETNA \$5.00	OV15	15
08:00 AM				OV	
08:15 AM	Mary [REDACTED] H: [REDACTED] W: [REDACTED]	440 03/26/19[REDACTED] [REDACTED] years	MICOM	OV15	15
08:30 AM	Andrew [REDACTED] H: [REDACTED] W: [REDACTED]	90 10/15/19[REDACTED] [REDACTED] years	NHBC \$10.00	OV15	15
08:45 AM	Ernest D. [REDACTED] H: [REDACTED] W: [REDACTED]	100 02/13/19[REDACTED] [REDACTED] years	HUNT \$20.00	OV15	15
09:00 AM	Molly [REDACTED]	110 05/01/19[REDACTED] [REDACTED] years	MDCRMI	OV15	15

2. Format 2 - Prints the fields listed above and the Medical Record Location and the Medical Record Number.

6/29/2005 10:51:46AM Appointment Schedule Associated Physicians Page: 1

Appointment Schedule Format 2

For [REDACTED], Henry J on 11/18/2005 PG / IM

Time	Patient Name Telephone#(s)	Patient# Date of Birth	Med Rec Loc Med Rec No.	Insurance Co-Pay	Appt or Activity Comments	Duration
08:00 AM	Marquerite [REDACTED] H: [REDACTED] W: [REDACTED]	10 10/26/19[REDACTED] [REDACTED] years	Main Off	AETNA \$5.00	OV15	15
08:00 AM					OV	
08:15 AM	Mary A [REDACTED] H: [REDACTED] W: [REDACTED]	440 03/26/19[REDACTED] [REDACTED] years	Main Off	MICOM	OV15	15
08:30 AM	Andrew [REDACTED] H: [REDACTED] W: [REDACTED]	90 10/15/19[REDACTED] [REDACTED] years	Main Off	NHBC \$10.00	OV15	15
08:45 AM	Ernest D. [REDACTED] H: [REDACTED] W: [REDACTED]	100 02/13/19[REDACTED] [REDACTED] years	Clinic	HUNT \$20.00	OV15	15
09:00 AM	Molly [REDACTED] H: 555-555-5555	110 05/01/19[REDACTED] [REDACTED] years	Clinic	MDCRMI	OV15	15

Medical Record Slip Format

By program design, there is one generic format available for printing Medical Record Slips. This generic format is Format 1 which prints the following detail: Resource, Print Date and Time, Appointment Date and Time, Scheduling Location, Scheduling Department, Patient Name, Patient DOB, Patient's Sex, and Medical Record Number.

[REDACTED]. Henry J	05/29/2008 5:21 pm
Tue 08/05/2008 8:00A NO IM	
[REDACTED]. Leo	
11/12/1942	M MC10089
*** MEDICAL RECORD REQUEST ***	

A format may be customized for your Practice/Organization. Speak with your Implementation Specialist or a member of the Allscripts Support Staff.

Medical record slip format types

You can define format used to print your medical record slips on the **Scheduling tab** in **Practice Options** or **Organization Options**. You can select a standard format or create a custom format.

Standard Formats

There are 2 standard medical record slip formats:

Format 1

Format 1 is the only standard format available for printing medical record slips.

Format 900

Format 900 includes all the available pull fields and is used as the source for creating custom formats.

The 2 standard formats (1 and 900) are stored on each PC that has Allscripts® Practice Management. They are located in C:\Program Files\Compusense\Ntieprise for Healthcare\Crystal Report Files. If your practice or organization uses terminal services, these files are located on the C drive of the terminal services server.

These .rpt files in the Crystal Report Files folder are updated to the most current standard version when you update the application.

Custom Formats

You can also design a custom medical record slip format. To begin this process, speak with your implementation specialist or contact Allscripts® Support.

Keep the following in mind:

- > Custom reports must be saved to the server where your database resides, using the path \\<Server Name>. <Domain Name>\Ntierfiles\<Tenant Name>\Custom Crystal Reports.
- > Each custom format must be given a unique number from 901 to 999.
- > The custom .rpt must be named using this convention: MedicalRecordSlip9XX.rpt.
- > The custom .rpt files in the Custom Crystal Report folder do not change when your application is updated.

Encounter Form Options on the Scheduling tab

You can set up various encounter form options on the **Scheduling tab** in **Practice Options** or **Organization Options** that govern the format used when you generate encounter forms.

Encounter form options are in effect when you generate encounter forms in the these areas of the application:

- > Appointment Scheduling: on the Appointment Book tab, Appointment Management tab, Appointment Activity tab:
 - when you use the right-click menu option, Encounter Form
 - when you use the right-click menu option, Appointment Detail and click on the Encounter Form command button
 - when you use the encounter form command button on any of the schedule appointment dialogs
- > Scheduling Activities when you batch print encounter forms
- > Office Manager within an operator's work queue:
 - when the operator uses the right-click menu option, Encounter Form
 - when the operator uses the right-click menu option, Appointment Detail and click on the Encounter command button
 - when the operator uses the right-click menu option, Appointment Detail and clicks on the Encounter Form command button.

You can elect to use one or multiple formats.

Regardless of whether you use one or multiple formats, you must do the following in this order:

1. Set a default encounter form format.
2. Next, set the encounter form basis for your Practice/Organization.

Clients using one format should set the spin box to that format's number. Then set the Encounter Form Basis to (default).

Clients using multiple formats should set the spin box to the format you will use most often. Then set the Encounter Form Basis to something other than (default).

Default Encounter Form Format

Determines which format is used when you print encounter forms.

You must set a Default Encounter Form Format whether you are using one or multiple formats.

If you are using one format, set the spin box to that format's number, and then set the Encounter Form Basis to (default).

If you are using multiple formats, set the spin box to the format you will use most often, and then set the Encounter Form Basis to something other than (default).

Note: This default is the format the application uses when you do not select a format for a record in the file maintenance related to your selected encounter form basis.

Encounter Form Basis

Selecting a basis other than (default) allows you to use more than one format when printing encounter forms.

You can associate a standard or custom format with a specific Appointment Type, Resource, Scheduling Department, or Scheduling Location in file maintenance.

Procedure Grp for Enc. Form Service History

A procedure group must be selected in order for you to track and print on your encounter form the number of months since a patient was seen for a specified procedure.

The combo list is available when you create procedure groups.

Making a selection allows you to track time between services and print that information on your encounter form when you use the two encounter form data base fields: Procedure History Lag and Procedure History Lag Desc.

If you intend to include the fields Procedure History Lag and Procedure History Lag Desc on your encounter forms then create a specific procedure group for this function. For example, if your practice intends to track the time that has elapsed between comprehensive exams create a procedure group called Comprehensive Exams.

Encounter form formats

The encounter form format for your practice or organization is defined on the **Scheduling** tab in **Practice Options or Organization Options**. You can select a standard format or create a custom format.

Standard formats

Allscripts provides programmed encounter form formats which are generally distributed with the application and with updates. Currently there are three standard formats available for printing encounter forms. They are Format 1, Format 2, and Format 900. Format 900 includes labels as well as all the available encounter form pull fields and is generally used as the source for creating custom formats.

Standard formats are stored on each PC that has been installed with your Allscripts PM. They can be found under C:\program files\compusense\ntierprise for healthcare\crystal report files. Those Practices/Organizations using terminal services can find these files located on the C drive of the terminal services server.

The .rpt files in this "Crystal Reports" folder are updated each time you run the application's version update wizard.

Encounter Form Database Field Format 1

- > Encounter Number

Chapter 2 Practice Options or Organization Options

- > Patient Number
- > Patient First Name
- > Patient MI
- > Patient Last Name
- > Patient Suffix
- > Patient Street1
- > Patient City
- > Patient State
- > Patient Zip
- > Patient Home Phone
- > Patient Work Phone
- > Patient Cell Phone
- > Patient Work Ext
- > Patient DOB
- > Patient Age
- > Prim Insur Carrier Name
- > Prim Insur Subscr First Name
- > Prim Insur Subscr MI
- > Prim Insur Subscr Last Name
- > Prim Insur Subscr Suffix
- > Prim Insur Cert Number
- > Prim Insur Cert Suffix
- > Prim Insur Group Number
- > Appt Date Time
- > Appt Type Desc
- > Resource Desc
- > Appt Linked Indicator
- > Last Diagnosis Code
- > Last Diagnosis Desc
- > Last Payment Date
- > Last Payment Amount
- > Patient Self-Pay Balance

13200	Blue Choice
410	Barry B [REDACTED]
Barry B [REDACTED]	000CD111111111111
[REDACTED]	
[REDACTED] 53	1/28/10 10:00 am
[REDACTED]	OV - 15
02/01/19[REDACTED]	Internal Medicine, Doctor
[REDACTED] years	
<hr/>	
Prints at the bottom of the form	
V03.7	01/27/2010
Tetanus toxoid inoculation	20.00
	0.00

Encounter Form Database Fields Format 2

- > Encounter Number
- > Patient Number
- > Patient First Name
- > Patient MI
- > Patient Last Name
- > Patient Suffix
- > Patient Street1
- > Patient City
- > Patient State
- > Patient Zip
- > Patient Home Phone
- > Patient Work Phone
- > Patient Work Ext
- > Patient DOB
- > Patient Age
- > Guarantor First Name
- > Guarantor MI
- > Guarantor Last Name
- > Guarantor Suffix
- > Guarantor Street1

Chapter 2 Practice Options or Organization Options

- > Guarantor City
- > Guarantor State
- > Guarantor Zip
- > Guarantor Home Phone
- > Guarantor Work Phone
- > Guarantor Work Ext
- > Guarantor Cell Phone
- > Prim Insur Carrier Name
- > Prim Insur Subscr First Name
- > Prim Insur Subscr MI
- > Prim Insur Subscr Last Name
- > Prim Insur Subscr Suffix
- > Prim Insur Cert Number
- > Prim Insur Cert Suffix
- > Prim Insur Group Number
- > Sec Insur Carrier Name
- > Sec Insur Subscr First Name
- > Sec Insur Subscr MI
- > Sec Insur Subscr Last Name
- > Sec Insur Subscr Suffix
- > Sec Insur Cert Number
- > Sec Insur Group Number
- > Appt Date Time
- > Appt Type Desc
- > Refer Dr First Name
- > Refer Dr MI
- > Refer Dr Last Name
- > Refer Dr Suffix
- > Resource Desc
- > Appt Linked Indicator
- > Last Diagnosis Code
- > Last Diagnosis Desc
- > Last Payment Date
- > Last Payment Amount
- > Patient Self-Pay Balance

13460	Tufts PPO
303	Carol Anne [REDACTED]
Cindy [REDACTED]	999-99-9999 03
[REDACTED]	9999
[REDACTED]	Anthem BCBS of New Hampshire
[REDACTED]	Carol Anne [REDACTED]
[REDACTED]	999-99-9999
[REDACTED]	11111
10/30/19 [REDACTED] years	2/1/10 11:00 am
Carol Anne [REDACTED]	0V - 15
[REDACTED]	Allscripts, Provider
[REDACTED]	John J [REDACTED] MD
Prints at the bottom of the form	
698.4	07/21/2009
Dermatitis factitia	20.00
	20.00

Encounter Form Format 900 contains all the fields available for creating a custom format.

If your practice or organization uses the uninsured coverage type, the uninsured coverage type prints on EncounterForms900.rpt.

Custom formats

Custom formats can be designed for your practice or organization. Speak with your Implementation Specialist or contact Allscripts Support. Keep the following in mind:

- > Each custom format must be given a unique number from 901 to 999.
- > Custom reports must be saved to the server where your database resides, using the path \\<server name>.<domain name>\ntierfiles\<tenant name>\custom crystal reports.
- > The .rpt must be named using this convention EncounterForms9XX.rpt.

The .rpt files in the Custom Crystal Reports folder are not changed when your Application is updated.

Encounter form basis options

The use of an encounter form basis allows you to use multiple encounter form formats based on the Appointment Type, Resource, Scheduling Department, or Scheduling Location for which you are printing the encounter form.

A standard or customized format can be associated with a specific Appointment Type, Resource, Scheduling Department, or Scheduling Location in file maintenance. Then when you print an encounter form or batch print encounter forms the system uses the format you selected for a record in the file maintenance related to your encounter form basis. For example, if you select to generate encounter forms based on Appointment Type you could use a format for Physical Exam visits and another for Workers Compensation visits.

When you print an encounter form or batch print encounter forms the system uses the format you selected for a record in the file maintenance related to your encounter form basis. For example, if you select to generate encounter forms based on Appointment Type you could use a format for physical exams visits and another for workers comp visits.

Note:

Batch printed forms are sorted by format. When you are using paper forms that necessitate your having to physically change the paper in the printer for each format, consider restricting each print job by the applicable records that match your selected encounter form basis.

You can choose one of the following Encounter Form Bases on the **Scheduling** tab in **Practice Options or Organization Options**.

(default)

Uses the format selected as the Default Encounter Form Format whenever an encounter form is printed.

When using only one format for all of your encounter forms set this option to **(default)**.

Appointment Type

Enables you to select an encounter form format for each appointment type in **Appointment Type Maintenance**. Select this basis when you want the appointment type to determine which format is used when you print encounter forms.

Note: If there is no Encounter Form Format selected in for an appointment type in **Appointment Type Maintenance**, then the application generates the encounter form using the default encounter form format you selected above when generating encounter forms for that appointment type.

Resource

Enables you to select an encounter form for each resource in **Resource Maintenance**. Select this basis when you want the resource to determine which format is used when you print encounter forms.

Note: If there is no encounter form format selected in for a resource in **Resource Maintenance**, then the application generates the encounter form using the default encounter form format you selected.

Scheduling Department

Enables you to select an encounter form format for each Scheduling Department in Scheduling Department Maintenance. Select this basis when you want the Scheduling Department to determine which format is used when you print encounter forms

Note: If there is no Encounter Form Format selected in for a Scheduling Department in file maintenance, then the application generates the encounter form using the default encounter form format you selected.

Scheduling Location

Enables you to select an encounter form format for each Scheduling Location in Scheduling Location Maintenance. Select this basis when you want the Scheduling Location to determine which format type is used when printing encounter forms.

Note: If there is no Encounter Form Format selected in for a Scheduling Department in file maintenance, then the application generates the encounter form using the default encounter form format you selected.

Miscellaneous Options on the Scheduling tab

You can set up miscellaneous options on the **Scheduling tab** in **Practice Options** or **Organization Options**.

Appointment Type for Medical Record Request

Appointment Type for Medical Records Request enables you to print an on-demand medical record request.

Appointment types must first be built in **Appointment Type Maintenance**. Create the appointment type **Medical Records Request** in **Appointment Type Maintenance** in order to select it as an **Appointment Type for Medical Records Request** option.

Note: Leaving **Appointment Type for Medical Records Request** blank prevents you from printing a medical record request. The right-click menu option **Med Rec Request** is enabled, but if you select it, the message Appointment Type for Medical Record Request must be specified is displayed.

The right-click option **Med Rec Request** enables you to print or send a message to the **Appointment Management** window requesting a patient's medical record.

An appointment need not be scheduled for this option to be available on the right-click menu on the **Scheduling Management** or **Scheduling Activity** tabs.

Retain Moved Appt as Cancelled

From time to time you may find it necessary to move an appointment to another time slot. When a moved appointment is rescheduled, you lose the record of the existence of the original appointment unless you select **Retain Moved Appt as Cancelled**.

By selecting a cancellation reason, you are telling the application to retain the history that an appointment was moved and rescheduled by giving the original or moved appointment the status of cancel.

Cancellation reasons must first be built in **Cancellation Reason Maintenance**.

To keep a record that the original appointment was moved, select the check box, then select a default cancellation reason.

Tip: Create and use the cancellation reason **Moved and Rescheduled**.

You can manually enter the date and time of the new appointment in **Comment** in **Appointment Detail**.

Retain Bumped Appt as Cancelled

A bumped appointment is one that typically is removed from the schedule when you re-block a day or days containing existing appointments. A bump usually occurs when the appointment does not "fit" into the corresponding time slot of the new day type.

When an appointment is bumped, it is programmatically given the status of **Bumped**. Then, when the bumped appointment is rescheduled, you lose the record of the existence of the original appointment unless you select **Retain Bumped Appt as Cancelled**. You must manually reschedule bumped appointments.

After a bumped appointment is rescheduled, there is no record of the original appointment, unless you select a cancellation reason that is used to change the original appointments status from bumped to cancel.

To keep a record that the original appointment was bumped, select the check box, then select a default cancellation reason.

Tip: Create and use the cancellation reason **Bumped and Rescheduled**.

You can manually enter the date and time of the new appointment in **Comment** in **Appointment Detail**.

Appointment Reminder Document

Appointment Reminder Document enables you to select a document to be used when printing appointment reminders.

Create a document with the document type of **Scheduling** in **Document Maintenance** to be used for appointment reminders. Any document created in Document Maintenance with a Document Type of "Scheduling" will be available for selection in this drop down list.

Select the check box to enable the drop-down list.

If this option is selected, you must select a document from the drop-down list in order to save.

If you try to print an appointment reminder when this option is not selected, you will receive the message **Appointment Reminder Document must be specified**.

The option to print appointment reminders is available in the following places throughout the application:

- > The right-click menu from the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs
- > **Appointment Detail**
- > **Schedule Appointment** (not available for walk-in appointments)
- > **Schedule Linked Appointments**
- > **Schedule Recurring Appointments**
- > **Bump Appointment**
- > **Transfer Appointment**
- > **Move Appointment**
- > **Reschedule Appointment**

Maintain Original Encounter Number

Maintain Original Encounter Number enables any rescheduled appointment to retain the same encounter number and associated patient information as the original appointment.

The ability to maintain the original encounter number enables you to quickly move or transfer an appointment without needing to print a new paper form or having to copy or lose electronic information if there is a scheduling change.

Maintain Original Encounter Number applies to the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs in **Appointment Scheduling**.

If **Maintain Original Encounter Number** in **Practice Options** or **Organization Options** is selected, when you move, transfer, bump, or reschedule an appointment with an encounter

number assigned, the original encounter number is assigned to the new appointment. When you reschedule a bumped linked appointment, the original encounter number from the bumped appointment is assigned to the linked appointment.

Note: After the version upgrade, **Maintain Original Encounter Number** is not selected by default.

Booking Factor Limits

When you select this option, the following elements become visible in Allscripts® Practice Management:

- > The **Limits** button, the **Limits** column, and the **Booking Limits** window on **Activity Type Maintenance** in **File Maintenance** in **System Administration**
- > The **Booking Limits** window, the **(Booking Limits)** tag line, and **View Booking Limits** on the **Appointment Book** tab in **Appointment Scheduling**
- > The **Limits** button, the **Limits** column, and **Booking Factor** on **Custom Block Day(s)** in **Scheduling Planning**

By default, **Booking Factor Limits** is not selected.

Always Show Custom Blocked Days in Accept Re-Block

Select this option to have days with a custom block in **Schedule Planning** displayed in **Accept Re-Block** when those days are re-blocked regardless of whether appointments are scheduled on that date.

Always Show Custom Blocked Days in Accept Re-Block is not included in starter data sets with the **Practice Options** information type.

Automatic No Show options on the Scheduling tab

Use the **Automatic No Show** area on the **Scheduling tab** in **Practice Options** or **Organization Options** to filter the automatic no show process based on scheduling departments, scheduling locations, and resources.

System Administration > Practice/Organization Options > Scheduling

Active

Checking the **Active** check box enables the three select records for Scheduling Departments, Scheduling Locations, and Resources.

Select Scheduling Departments

Use **Select Scheduling Departments** to specify scheduling departments for which the automatic no show process runs.

The default is All Scheduling Departments.

Select Scheduling Locations

Use **Select Scheduling Locations** to specify scheduling locations for which the automatic no show process runs.

The default is All Scheduling Locations.

Select Resources

Use **Select Resources** to specify resources or resource groups for which the automatic no show process runs.

The default is All Resources.

Assigning encounter and voucher numbers

Allscripts® Practice Management manages the assignment of encounter numbers and voucher numbers.

Encounter numbers

Encounter numbers are assigned to appointments at one of the following times depending on your selections on the **Scheduling** tab in **Practice Options or Organization Options**:

- > When you schedule the appointment, if **Assign Encounter # When Scheduled** is selected
- > When you acknowledge the appointment, if **Assign Encounter # When Acknowledged** is selected
- > When you print the encounter form, if neither **Assign Encounter # When Scheduled** nor **Assign Encounter # When Acknowledged** is selected

When you create a new appointment, an internal appointment ID is incremented by 1 and assigned to the appointment. The encounter number is set to the appointment ID at the time that the encounter number is assigned.

Encounter number = Appointment ID

If **Maintain Original Encounter Number** in **Practice Options or Organization Options** is selected, when you move, transfer, bump, or reschedule an appointment that has an encounter number, the appointment ID is incremented by 1, but the original encounter number is assigned to the new appointment.

Voucher numbers

Voucher numbers are assigned during charge entry. When you create a new voucher, an internal voucher ID is incremented by 1 and added to 50000000 to produce the voucher number. This formula is standard for creating voucher numbers during charge entry.

Voucher number = 50000000 + voucher ID

The standard voucher number assignment formula is also used when the application creates new vouchers in the following scenarios:

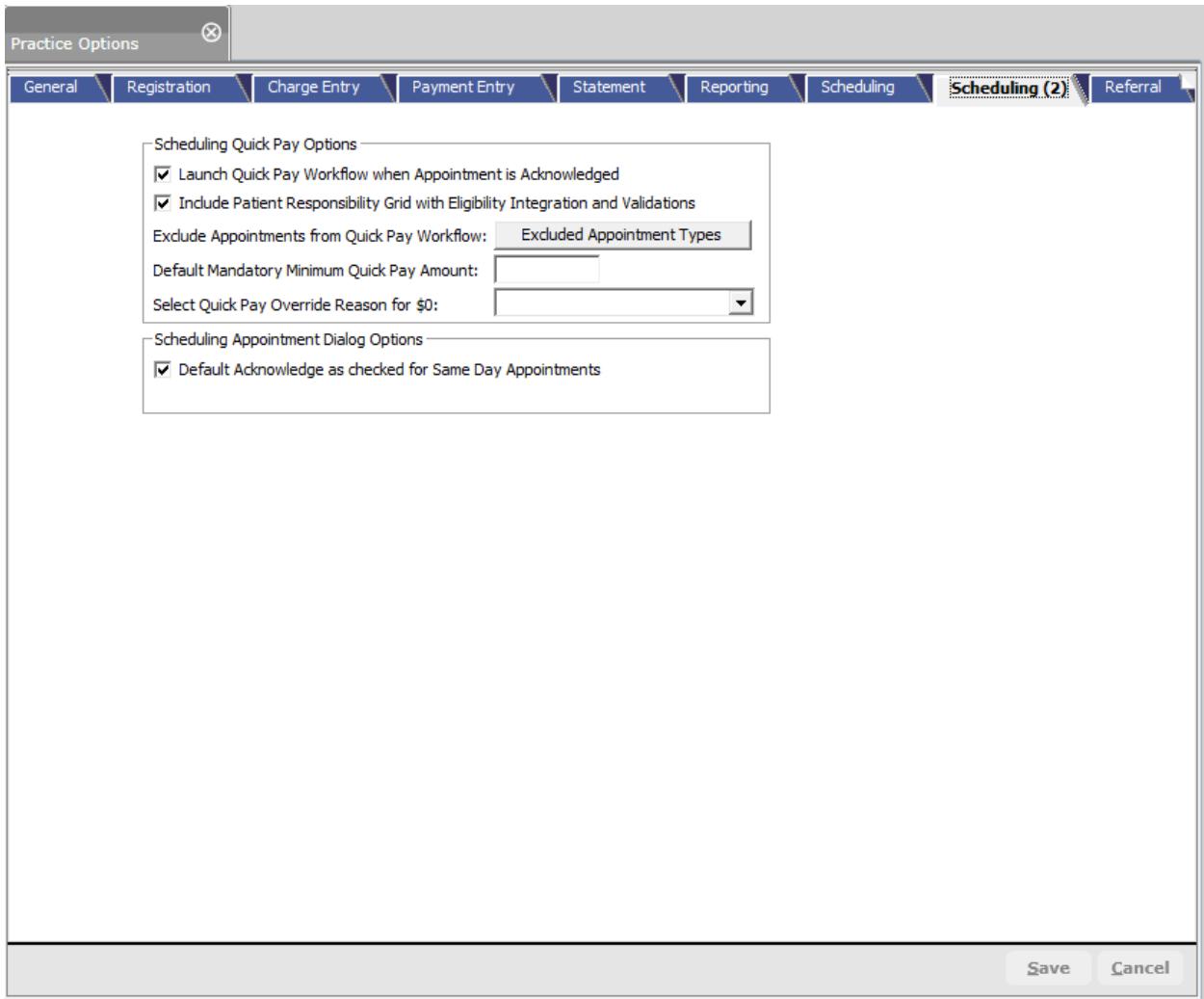
- Service lines were tagged during payment entry.
- Split billing is enabled.
- Charges were imported, including dialysis and transplant charges.

However, when a voucher is voided and re-entered, the original voucher number is assigned to the new voucher.

Scheduling (2) tab

Use the **Scheduling (2) tab** in **Practice Options** or **Organization Options** to manage various scheduling functions.

Access the **Scheduling (2) tab** from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **Organization Options**, or press **F9** and then enter **POP** or **OOP**, as applicable.



Launch Quick Pay Workflow when Appointment is Acknowledged

Select this option to automatically launch **Quick Payment** anywhere that you can acknowledge an appointment. You cannot leave **Quick Payment** until you have entered a payment amount or a quick payment override reason.

Include Patient Responsibility Grid with Eligibility Integration and Validations

Select this option to have a **Patient Responsibility** area displayed in **Quick Payment** with copay and coinsurance information either received in 271 eligibility response files or retrieved from the plans in **Insurance Carrier Maintenance** according to a patient's policies.

Exclude Appointments from Quick Pay Workflow

Select appointment types for which **Quick Payment** will not automatically launch when appointments with those appointment types are acknowledged. Click the button to the right

of the option label to open **Exclude Appointment Types**, and then click  to open **Select Appointment Types**.

Default Mandatory Minimum Quick Pay Amount

Use this option to create a mandatory minimum quick payment amount. You must enter an amount greater than \$0.00 or leave the field blank. The maximum dollar amount that you can enter is \$999.99. The amount is displayed in **Quick Payment as Mandatory Minimum Quick Pay Amount**.

Select Quick Pay Override Reason for \$0

Select a default value to automatically fill **Quick Pay Override Reason** in **Quick Payment** when there is no patient responsibility due.

The available values are defined in **Quick Pay Override Reason Maintenance**.

Best Practice: Create a reason in **Quick Pay Override Reason Maintenance** that is specifically for patients who do not have a patient responsibility returned in the 271 eligibility response.

This option is enabled when **Launch Quick Pay Workflow when Appointment is Acknowledged** and **Include Patient Responsibility Grid with Eligibility Integration and Validations** are both selected.

Default Acknowledge as checked for Same Day Appointments

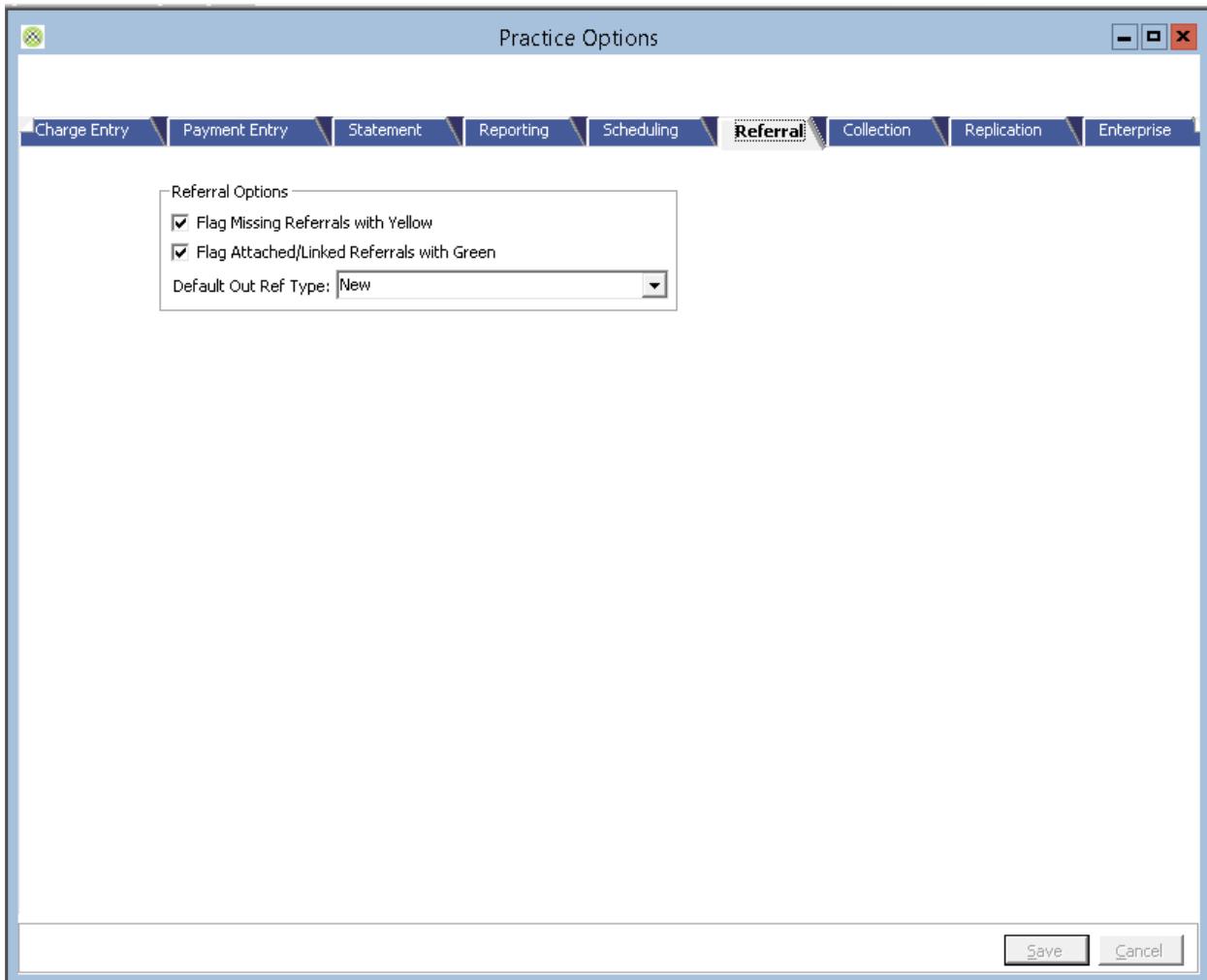
Select this option to have **Acknowledge** automatically selected in **Schedule Appointment** for same-day appointments, so that you do not have to leave **Schedule Appointment** to acknowledge the appointment. This option works independent from the options in **Scheduling Quick Pay Options** area.

Referral tab

Use the **Referral** tab to define options associated with incoming and outgoing referrals.

Access the **Referral** tab on **Practice Options** or **Organization Options** in **System Administration**.

Tip: To quickly access **Practice Options** or **Organization Options**, press **F9**, then enter **POP** or **OOP**.



Flag Missing Referrals with Yellow

Select this option to display a yellow indicator in the **R** column on **Appointment Management** when you select **Referral Required** for an appointment on one of the following windows:

- > **Schedule Appointment**
- > **Force Appointment**
- > **Appointment Detail**

Flag Attached/Linked Referrals Green

Select this option to display a green indicator in the **R** column on **Appointment Management** when you attach or link an incoming referral to the appointment.

Default Out Ref Type

Select a default referral type based on the referral type most often used by your providers when referring patients.

Note: Referral types are created on **Referral Type Maintenance** in **System Administration > File Maintenance**. The use of referral types allows you to track and report on referral trends and patterns in your practice or organization.

When **Outgoing Referral** opens, the referral type selected here as the default auto-fills in **Referral Type**.

Collection tab

Use the **Collection** tab to define default values that automatically fill the corresponding boxes on the **Prepare Collection Accounts** tab in **Collection Planning**.

Important: When you select **Enable Automated Self-Pay Collections**, the options on this tab are not available and are reset back to **0**. If you clear **Enable Automated Self-Pay Collections** and return to using manual self-pay collections, you must re-enter these options.

Allscripts® Practice Management provides you with 2 ways of managing your practice's collection activity. Your internal office policies related to collecting self-pay balances is a factor in determining the function that you use.

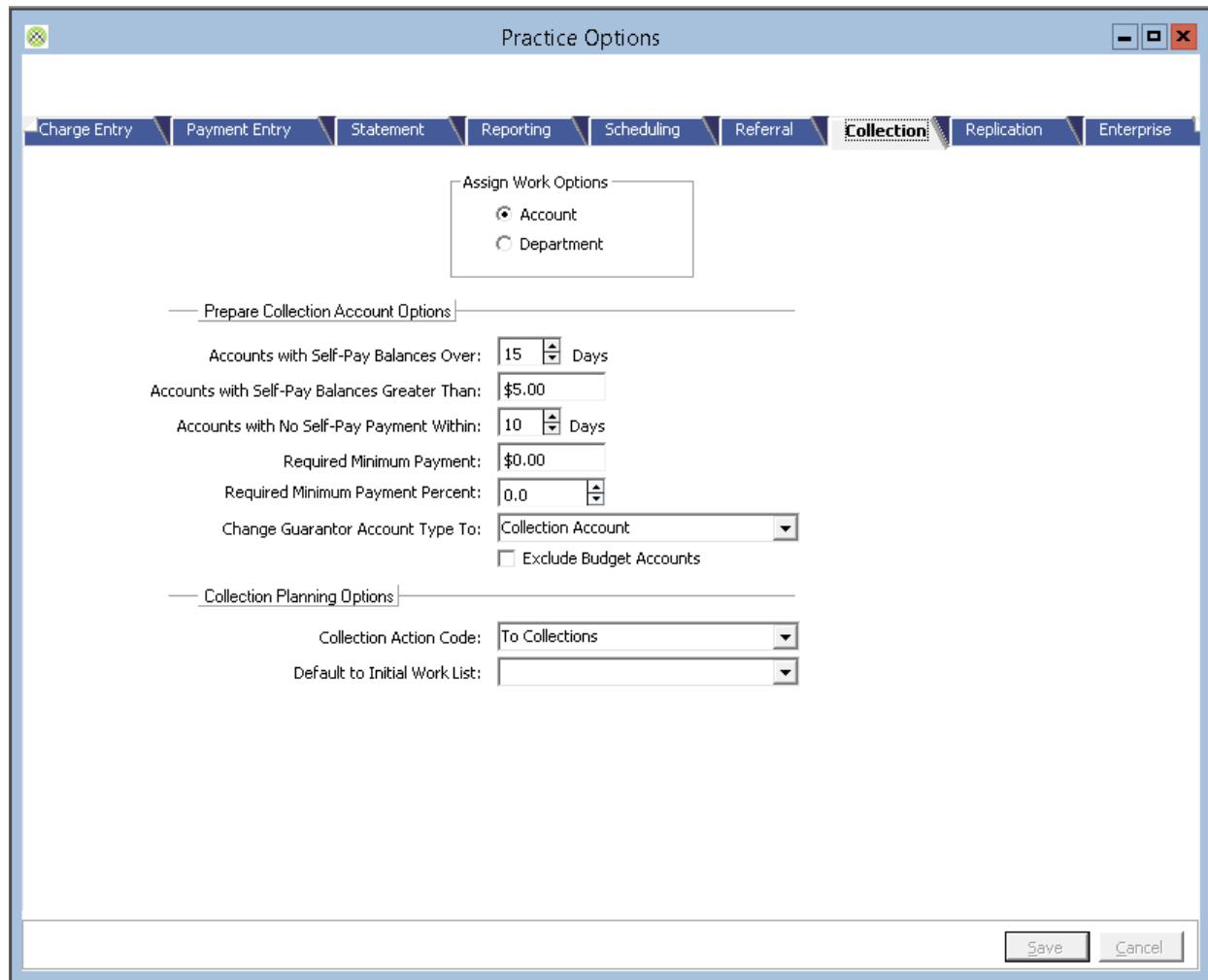
Therefore, you should give some thought to the following items:

- > At which point do you consider a self-pay balance to be delinquent?
- > Do you identify delinquent accounts by account type?
- > Do you notify delinquent accounts of their status by mail? If yes, how often?
- > Do you have an in-house application to work delinquent accounts?
- > Do you turn delinquent self-pay accounts over to a collection agency? If so, when?
- > Do you need to track payments and adjustments sent to a collection agency?

The **Collection** tab settings enable you to define the criteria used when you query for accounts that qualify to be prepared for collections. Your selections automatically fill the corresponding box on the **Prepare Collection Accounts** tab in **Collection Planning**.

You can change the defaults when you run a query in **Collection Planning**. The application saves and reverts to the defaults when you go to the **Prepare Collection Accounts** tab to perform subsequent queries.

Access the **Collection** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP**, as applicable.



Assign work options

By default, self-pay collections are worked by account. If you have enabled department or practice security, you can create and work self-pay collections by department or practice. When **Enable Division** on the **Multi Entity** tab in **Practice Options** or **Organization Options** is selected, you can create and work self-pay collections by division.

If you are already working collections by account, you can select **Division** or **Department** even if you have open collection activity.

If you are already working collections by department, you must complete any open collection activity prior to selecting **Division** or **Account**; otherwise, you are prompted to answer whether

you want to reread the practice or organization options. If prompted, select 1 of the following options:

- Select **Yes** to revert any changes you made to the previous settings and continue working collections by department.
- Select **No** to return to the **Collection** tab where you can click **Cancel** to exit **Practice Options** or **Organization Options** and complete any open collection activity. Then, after completing the open collection activity, you can make the change to **Assign Work Options** on the **Collection** tab in **Practice Options** or **Organization Options** and start working collections by division or account.

Regardless of whether you select **Yes** or **No**, you must complete any open collection activity before you start assigning collections by division or account.

Similarly, after you start working collections by division, you cannot select **Department** or **Account** until you complete any open collection activity.

Prepare collection account options

These options become the default settings used on the **Prepare Collection Accounts** tab in **Collection Planning**. They are used as part of the query criteria when searching for accounts that qualify as collection accounts.

For an account to qualify, the account must have 1 or more non-zero-balance, self-pay vouchers over a certain age, and the sum of the voucher balances (both positive and negative) must exceed the amount specified. The age qualification is based on **Accounts with Self-Pay Balances Over xx Days** and is evaluated in combination with the sum of all vouchers over xx days to arrive at the self-pay balance used to compare against **Accounts with Self-Pay Balances Greater Than \$xx.xx**.

Accounts with Self-Pay Balances Over xx Days

Used in conjunction with the setting for **Accounts with a Self-Pay Balance Greater Than**. Enter the number of days over which the self-pay balance has aged to qualify the account for preparation for collections.

Accounts with a Self-Pay Balance Greater Than

Used in combination with the setting for **Accounts with Self-Pay Balances Over xx Days**. Enter a dollar amount over which the self-pay balance must be to qualify an account for preparation for collections.

Accounts with no Self-Pay Payment Within

Disqualifies vouchers with updated payment transactions with a payment date that falls within the number of days you enter.

Required Minimum Payment

Disqualifies any account that has updated payment transactions with a payment date that falls within the number of days that you entered for **Accounts with no Self-Pay Payment Within** that are equal to or greater than the amount that you enter in this box.

This box can be left blank.

Required Minimum Payment Percent

Disqualifies accounts that have updated payment transactions that are equal to or greater than the defined percentage of its qualifying self-pay balance. Select or enter a number. You can leave this box blank.

Change Guarantor Account Type To

Initiates the automatic change of the guarantor's account type on all qualifying accounts to your selection when accounts are prepared for collections. Select the account type that you want qualifying accounts to be changed to.

Exclude Budget Accounts

When selected, disqualifies any account where a budget amount is entered in **Account Management**.

Collection planning options

Initiates specific actions in **Collection Planning**.

Collection Action Code

Required to assign accounts to collectors in **Collection Planning**. The list includes user-defined collection actions. The selected actions is the default value for **Action** in **Collection Account Detail**.

Note: Select the option for initial transfer to collection activity.

Default to Initial Work List

Each qualifying account is automatically assigned to the selected work list when the accounts are prepared for collections.

Leave this box blank to enable manual assignment of accounts to collectors in **Collection Planning**.

Enterprise tab

Enables you to query an external non-Allscripts® Practice Management database or an Allscripts® Practice Management tenant that is the source tenant for patient demographic information and

maintains the master patient index (MPI). You can then use the search results to create a new patient record in the current tenant.

After the patient is added to your database, the patient record is maintained separately from the other enterprise sources. Changes to a patient record made in 1 tenants are not reflected in nor exchanged between tenants.

You can use the options on the **Enterprise** tab to require users to do an enterprise search and determine how search results are displayed.

Enterprise Search is enabled on **Patient Lookup** in both **Registration** and **Appointment Scheduling**.

If you do not have access to a VIP patient record, you cannot retrieve VIP patient information in an Allscripts® Practice Management tenant or a tenant not within Allscripts® Practice Management.

If you do have access to a VIP patient record, you can retrieve and copy VIP patient information in an Allscripts® Practice Management tenant or tenant not within Allscripts® Practice Management, according to the settings on the **Enterprise** tab in **Practice Options or Organization Options**. You can also create the same patient in another tenant.

Note: When you create a patient in a different tenant, the patient VIP status and the operators and operator groups that are assigned to the VIP patient are not copied and must be assigned manually.

To require the use of enterprise patient searches, use the options in the frame **Enterprise Search/Display Options**.

Access the **Enterprise** tab from **Practice Options or Organization Options**. To access **Practice Options or Organization Options**, go to **System Administration > Practice Options or System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.

Define Enterprise Sources

Use the table in this section of the **Enterprise** tab to define the sources to use in enterprise searches. These sources can be either other Allscripts® Practice Management tenants or external databases.

Source

Select either **PM** or **OTHER** as applicable.

Note: You can set multiple enterprise sources to **PM**, but you should only set 1 source as **OTHER**.

PM

PM indicates that the source is another Allscripts® Practice Management tenant. When you set **Source** to **PM**, the drop-down list in the corresponding row of the **Tenant** column fills with all of the tenants listed in **Administration > Security Manager > Tenant Maintenance**, and **Format** becomes unavailable.

Note: If you have already selected a given tenant as a source for enterprise searches in a previous row, that tenant is not included in the list of tenants in the current row. You cannot select the same tenant twice.

Other

Use **OTHER** to connect to a non-Allscripts® Practice Management database using an Allscripts® Interface Engine query and response interface.

When **OTHER** is selected as the source, data returned by the search process can be stored to selected **Patient Additional Information** boxes or **Chart Number** boxes in **Registration**. This functionality enables a practice or organization to make these boxes required, while still maintaining the data in the MPI, such as the mirror repository. An example of the use of this added functionality is for the required Meaningful Use boxes of **Race**, **Language**, and **Ethnicity**.

Searches of external, non-Allscripts® Practice Management databases return only patients, not guarantors.

When you select this option, **Tenant** becomes unavailable and **Format** becomes available.

Alias

A custom nickname for the tenant. Aliases must contain no more than 8 characters. For example, if the tenant SQL name is `Piedmont_Center` enter `Piedmont`. The alias is displayed in the **Source** column in **Patient Lookup**.

Tenant

Only available when you set **Source** to **PM**. This drop-down lists all of the tenants in **Administration > Security Manager > Tenant Maintenance**, except for any you already selected as enterprise search sources in previous rows on this tab.

Note: This list is restricted according to your security access in **Administration > Security Manager**: only tenants you have permission to access are displayed.

Format

Enabled only when **Source** is set to **OTHER**. Select the applicable information broker format from the list. The list includes all Allscripts® Interface Engine information broker formats that meet the following criteria:

- > **Active** is selected
- > **Export** is selected
- > **Trigger Event Type** is set to **Demographic Query**

Create Accounts Using

Select either **All Available Information** or **Patient Information Only**, depending on how much information you want to pull from the source tenant when creating new patient records.

All Available Information

Creates a new account using patient and contact information from the source tenant.

Note: When this option is selected, employer and insurance policy information is received only when carriers or employers are being shared by both tenants through replication.

Patient Information Only

Creates a new account using information from the **Patient** tab from the source tenant.

Note: **Usual Prov**, **Referring Dr**, **PCP**, and **Med Rec Loc** are not included in the enterprise information that is retrieved.

Include Medical Record Number

When this option is selected, the following occurs along with the other enterprise information that is retrieved:

- > The medical record number (MRN) is pulled into **Med Rec No** on the **Patient** tab in **Registration**. If the patient was not originally given a medical record, **Med Rec No** for the new record remains blank.
- > If an original MRN exists, it is displayed in **Accept Enterprise Data**. If there is no MRN from the source tenant, the box is left blank.

When this option is cleared, the enterprise search function does not pull MRNs, and **Accept Enterprise Data** does not include the **Medical Record Number** label.

Enterprise searches use the MRN as criteria for duplicate patient checking when specific options are set in the application:

- > Select **Prevent Duplicate Med Rec No** on the **Registration** tab in **Practice Options** or **Organization Options**.

- > Select **Include Medical Record Number, Force Enterprise Search, and Display unique MRN from local** on the **Enterprise** tab in **Practice Options** or **Organization Options**.

When the search process encounters a duplicate patient, **Duplicate Patients/Contacts** is displayed. You have the option to continue creating the new patient record, retrieve the existing patient record, or cancel the process.

Note: When you attempt to save the new record in your practice or organization, the application searches for a match in your practice or organization. If the MRN assigned to the patient in the source tenant matches a medical record number in the current practice or organization, you cannot save the patient record until you assign that patient a new, unique MRN.

Enterprise Search/Display Options

Force Enterprise Search

Force Enterprise Search combines the local search and enterprise search options in **Patient Lookup** when you do a patient search in **Registration** or **Scheduling** using 1 or more of the following search criteria.

- > **Patient Name**
- > **Name (Soundex)**
- > **Patient SSN**
- > **SSN**
- > **Enterprise Number**
- > **Medical Rec No**

The **Local Search** and **Enterprise Search** buttons are replaced by 1 button labeled **Search All Sources**.

If other search criteria are selected, such as **Guarantor Name** or **Primary Certificate Number**, **Local Search** is enabled instead of **Search All Sources**.

You cannot perform an enterprise search using any of the advanced search criteria: If you select **Advanced Search**, **Search All Sources** becomes unavailable.

Note: When you attempt to save the new record in your practice or organization, the application searches for a match in your practice or organization. If the MRN assigned to the patient in the source tenant matches a medical record number in the current practice or organization, you cannot save the patient record until you assign that patient a new, unique MRN.

When you select **Force Enterprise Search**, the options underneath are enabled.

Display All

Available when you select **Force Enterprise Search**. **Display All** is the default selection. When this option is selected, enterprise searches return all search results from both local and enterprise sources. Patients may display multiple times if they exist in multiple tenants.

Display Unique MRN from Local

Available when you select **Force Enterprise Search**. When you select **Display Unique MRN from Local**, enterprise searches only include results from the local tenant if a matching MRN is found in the local tenant and the enterprise sources. Selecting this option may reduce the number of duplicate search results.

Note: If an incorrect MRN was entered in the local practice or organization and, therefore, a different patient with the same MRN exists in an enterprise source, selecting this option may prevent an expected search result from being displayed. Your practice or organization should establish a policy and procedure for correcting the inaccurate MRN.

Display Unique Enterprise Number from Local

Available when you select **Force Enterprise Search**. When you select **Display Unique Enterprise Number from Local**, enterprise searches only include results from the local tenant if a match on enterprise number is found in the local tenant and the enterprise sources. This option may reduce the number of duplicate search results.

Note: If an incorrect enterprise number was entered in a local practice or organization and, therefore, a different patient with the same enterprise number exists in an enterprise source, selecting this option may prevent an expected search result from being displayed. You should establish a policy and procedure for correcting the inaccurate enterprise number.

Search Display

This box is set to **Alphabetical** by default. If you set **Source** to **OTHER**, you can display search results alphabetically or in the order they are returned. The choices for **Search Display** include the following.

Alphabetical

Alphabetical is the default search display option. It is the only display option applicable for searches that use only **PM** sources (that is, other Allscripts® Practice Management tenants). Search results are sorted in alphabetical order by last name, first name, and patient number. When you do an enterprise search or search all sources, the local and external search results are interspersed alphabetically.

Order Returned

Order Returned applies only when **Source** is set to **OTHER** and you are using query and response through Allscripts® Interface Engine for the search.

If you have both **PM** and an **OTHER** sources and you select **Order Returned**, the results for **PM** sources are displayed alphabetically and in the order returned when searching using query and response.

Order Returned sorts the results in the order the data is received from the source, which enables you to take advantage of an outside source's complex matching rules. The first result listed has the highest probability of being a match, the second result listed has the second-highest probability of being a match, and so forth.

Enterprise search options

Use the controls in the **Search Options** area on the **Enterprise** tab in **Practice Options** or **Organization Options** to set your search criteria thresholds for an enterprise search. EAD or all sources searches are specific.

These settings apply when doing an enterprise search on any **Patient Lookup** throughout Allscripts® Practice Management.

Note: When you click **Enterprise Search** or **Search All Sources**, if **Search Options** settings exist on the **Enterprise** tab in **Practice Organization** or **Organization Options**, the application uses these settings. If **Search Options** settings do not exist on the **Enterprise** tab, the application uses the **Search Options** settings on the **General** tab instead. **Search All Sources** is only displayed when you select **Force Enterprise Search** on the **Enterprise** tab in **Practice Organization** or **Organization Options**.

Access the **Search Options** area on the **Enterprise** tab from **Practice Options** or **Organization Options** in **System Administration**. To quickly access **Practice Options** or **Organization Options**, press **F9**, then enter **POP** or **OOP**.

Minimum # of Required Search By Field

Minimum # of Required Search By Field defines the minimum number of **Search By** and **Search For** combinations you must use when doing an enterprise search in the **Patient Lookup** window. More than the minimum number of **Search By** or **Search For** values may be entered, but not less.

Example: If **Minimum # of Required Search By Field** is set to **2**, you are required to make a selection in the first 2 **Search By** boxes as well as enter a value in the corresponding **Search For** boxes.

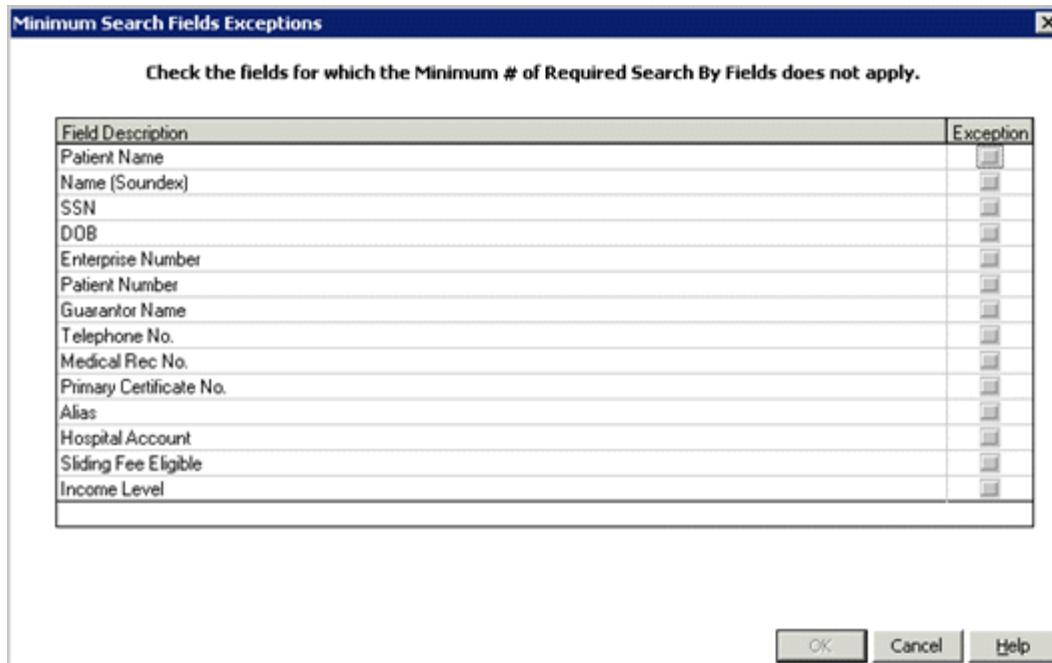
The default setting for **Minimum # of Required Search By Field** is **1**. The available choices are **1** through **3**.

If the minimum number of **Search By** and **Search For** boxes is not filled, when you click **Enterprise Search** or **Search All Sources** on the **Patient Lookup** window, a message is displayed letting you know what the minimum requirement is.

Exceptions

Exceptions is enabled when **Minimum # of Required Search By Field** is set to **2** or **3**.

Click **Exceptions** to display **Minimum Search Fields Exceptions**, which shows all of the available patient search boxes, including any patient additional info boxes, that are designated as searchable.



When any of the field descriptions are selected as exceptions, they are excluded from the minimum number of required search field rule, and you can search on that one criteria only.

Minimum # Required Characters for Patient Last Name Lookup

Minimum # Required Characters for Patient Last Name Lookup enables you to set a minimum number of characters that must be entered for the last name in **Search For** in **Patient Lookup** for an enterprise search. More than the minimum number of characters may be entered, but not less.

Example: If **Minimum # Required Characters for Patient Last Name Lookup** and **First Name Lookup** are both set to **2**, you must enter at least 2 characters for the last name and at least 2 characters for the first name in **Search For** in **Patient Lookup**.

The default setting for **Minimum # Required Characters for Patient Last Name Lookup** is **0**. The available choices are **0** through **4**.

If the minimum number of characters is not entered when you click **Enterprise Search** or **Search All Sources** in **Patient Lookup**, a message is displayed letting you know what the minimum requirement is.

First Name Lookup

First Name Lookup enables you to set a minimum number of characters that must be entered for the first name in **Search For** in **Patient Lookup** for an enterprise search. More than the minimum number of characters may be entered, but not less.

The default setting for **Patient Lookup** is **0**. The available choices are **0** through **4**.

If the minimum number of characters is not entered when you click **Enterprise Search** or **Search All Sources** in **Patient Lookup**, a message is displayed letting you know what the minimum requirement is.

Occ Medicine tab

The settings on the **Occ Medicine** tab govern which information is printed on occupational medicine invoices. If you export invoices, verify with your vendor what information you must include in the file and select the options on this tab accordingly.

Access the **Occ Medicine** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP**, as applicable.

Practice Options

Payment Entry | Statement | Reporting | Scheduling | Scheduling (2) | Referral | Collection | Enterprise | **Occ. Medicine**

Header Information:

Group Invoices By:

SSN Output Option:

Include Birth Date
 Include Voucher Number
 Allow Credit Balance Invoices
 Allow Zero Balance Invoices
 Print Primary Diagnosis Code

Save **Cancel**

Important: Access to the "Print Invoices" under **Billing** is denied until you enter information on this tab.

Header Information

Determines from where the header on the invoice is pulled.

Information in any of the following fields prints as part of the Header on the invoice:

- > Name
- > Address fields - Address1, Address2, City, State, Zip Code
- > Telephone
- > Federal ID
- > ID Sub-No

> ID Suffix

Select 1 of these options

Leave the field blank

Recommended if you are using forms with your address pre-printed on them.

Practice/Organization

Pulls from the Practice/Organization Information tab in Practice/Organization Setup.

Usual Provider

When selected, **Group Invoices By** defaults to **Patient** and is disabled.

Services billed to a Carrier can be provided to Patients with different Usual Providers. In order to provide the correct header information for all the Patients on the invoice, invoices must be grouped by Patient not by Carrier.

Pulls from the Provider tab in Provider maintenance, of the Patient's Usual Provider as designated on the Patient tab in Registration.

When using this Option, be sure that the Usual Provider field is always filled in for each Patient.

Department or Practice

Pulls the address and the Federal ID as entered in Department/Practice maintenance.

Location

Pulls the address and the Federal ID as entered in Location maintenance.

Group Invoices By

Required entry. Except for the combination of Usual Provider and Patient, the **Group Invoices By** selection can be changed on the Print Invoices tab under Insurance Billing.

Defaults to **Patient** and is disabled when Header Information is set to **Usual Provider**.

Your choices are:

Carrier

All the vouchers billed to a carrier print on 1 invoice.

Patient

A separate invoice prints for each patient.

SSN Output Option

Determines the output of Social Security number (SSN) on occupational medicine invoices. Select one of the following:

- > **Do Not Print** or blank: Do not output the SSN.
- > **SSN - Complete**: Output the full SSN.
- > **SSN - Last 4 Digits**: Output the SSN with five asterisks (*) and the last four digits (for example, *****1111).

Include Birth Date

Select this option if you do not want birth dates to output on occupational medicine invoices.

Include Voucher Number

Select this option to include the voucher number in the service detail. When this option is not selected, the voucher number does not print on occupational medicine invoices.

Allow Credit Balance Invoices

Select this option to allow the printing of invoices that have a credit balance.

Allow Zero Balance Invoices

Select this option to allow the printing of invoices that have a \$0.00 balance.

Print Primary Diagnosis Code

Select this option to include the primary diagnosis entered on the voucher in the service detail. Occupational medicine invoice processing prints either an ICD-9 or ICD-10 code as the primary diagnosis code. If a charge was entered with ICD-10 codes, the ICD-10 primary diagnosis code prints on invoices, regardless of whether the code is mapped to ICD-9 codes. If a charge was entered with ICD-9 codes, the ICD-9 primary diagnosis code prints on invoices. If an invoice includes multiple vouchers with a mix of ICD-10 and ICD-9 codes sets, both codes sets print on the invoice.

For clients exporting invoices: verify with your vendor which options should be included in the file.

Carriers: all the vouchers billed to a carrier print on one invoice.

Finance Charge tab in Practice Options or Organization Options

The **Finance Charge** tab becomes available in **System Administration > Practice Options (or Organization Options)** when you select **Last Statement Date** for **Cycle By** on the **Statement** tab.

Note: When you select **Last Statement Date**, **Date Finance Charges Last Assessed** is displayed at the top of the **Print Statement** window if any vouchers qualify when finance charges are assessed.

This information helps practices (or organizations) coordinate the assessment of finance charges with running statements.

If no vouchers qualify, **Date Finance Charges Last Assessed** is not displayed.

The finance charge options define how finance charges are assessed. Finance charges can be applied to accounts with self-pay voucher balances.

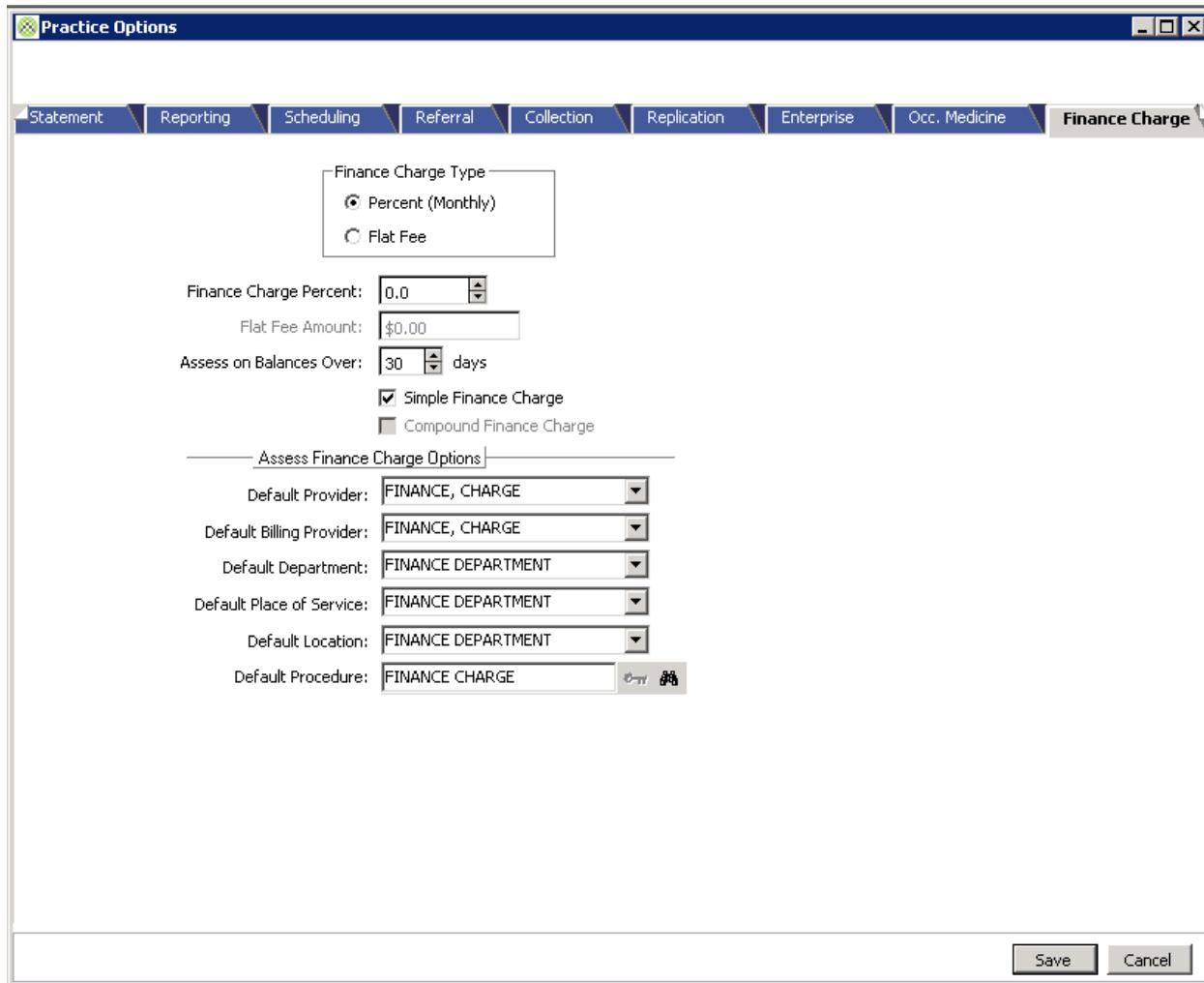
Prior to setting up the finance charge options you should give some thought to the following:

- > Whether your practice will apply a monthly percentage rate or a flat fee
- > Whether you want to use a simple or a compound method of applying finance charges

A certain amount of file maintenance is required to utilize the finance charge function. The creation of finance charge vouchers is done automatically when you run the function.

Access the **Finance Charge** tab from **System Administration > Practice Options** (or **Organization Options**).

Tip: To quickly access **Practice Options** (or **Organization Options**), press **F9**, then enter **POP** (or **OOP**).



Finance Charge Type

Percent (Monthly)

Applies the specified percent (this is specified in a related field on the Finance Charges screen) to the sum of all the self-pay voucher balances that qualify for an Account. One Finance Charge voucher is created for the Account.

➤ **Clients using Family Billing:**

Calculates a separate finance charge for each Patient associated with the Guarantor. The specified percent amount is applied to the sum of all the self-pay voucher balances that qualify for a Patient associated with the Guarantor. A separate Finance Charge voucher is created for each of these qualifying Patients. On the Statement a Finance Charge voucher is listed in each Patient's detail.

Each time you run this function the percentage rate is applied to the sum of all the self-pay voucher balances that qualify for assessment of a Finance Charge and a Finance Charge voucher is created. To avoid the creation of multiple finance charge vouchers on Accounts before Statements are printed you should run Finance Charges only once during your Print Statement cycle.

For example, based on a statement cycle of 28 or 30 days if you have decided to charge an annual interest rate of 18% on over due balances you would enter 1.5 as your monthly finance charge percent, then print Statements right after you run Finance Charges and update the Finance Charge Batch. This ensures that over the course of a year (12 statements) you have assessed an annual rate of 18%.

Flat Fee

Applies the specified flat fee amount (specified in the related field on the Finance Charges screen) to an Account regardless of the number of vouchers that qualify. One Finance Charge voucher is created for the Account.

> Clients using Family Billing:

One Finance Charge voucher is created in the amount of the specified flat fee regardless of the number of Patients that qualify. This voucher is assigned to the qualifying Patient associated with the Guarantor that has the lowest Patient #.

For example, a Family Account has four patients, and two of them have self-pay vouchers that qualify for an assessment. Qualifying Patient Henry Jones has a Patient # of 203; and qualifying Patient Mary Smith has a patient # of 202. The application applies the specified flat fee amount to Mary Smith and creates the Finance Charge voucher assigning it to Mary Smith. In this case when the family statement is printed, the finance charge voucher is listed under the detail for Mary Smith.

Finance Charge Percent

Enabled only when the option **Percent (Monthly)** is selected.

Is the percentage rate applied to the sum of all the self-pay voucher balances that qualify for assessment of a Finance Charge each time you run this function. To guarantee consistency and to avoid the assessment of finance charges multiple times on Accounts before Statements are printed you should run Finance charges once only as part of your Print Statement cycle. This allows you to assess a monthly finance charge percent.

For example, based on a statement cycle of 28 or 30 days if you have decided to charge an annual interest rate of 18% on over due balances you would enter 1.5 as your monthly finance charge percent, then run Finance Charges just before you Print Statements.

Note: To guarantee consistency and to avoid the assessment of finance charges multiple times on accounts before statements are

printed you should run finance charges once only as part of your Print Statement cycle. This allows you to assess a monthly finance percent.

Flat Fee Amount

Enabled only when the option **Flat Fee** is selected.

Amount applied to an Account as a Finance charge regardless of the sum of the self-pay voucher balances that qualify for assessment.

Note: If you have automated billing functionality enabled, when **Finance Charge Percent** and **Flat Fee Amount** are both zero, the **Finance Charges** tab in **System Administration > File Maintenance > Billing Automation Maintenance** is not available. Additionally, depending on whether **Percent (Monthly)** or **Flat Fee** is selected, audit records are added to the **History** tab in **Billing Automation Maintenance** when **Finance Charge Percent** or **Flat Fee Amount** is changed to zero, respectively.

Assess on Balances Over

Important: Accounts with an unassigned balance do not qualify for finance charges regardless of the age of a voucher balance.

To determine the aging on a voucher balance, the application uses the transaction date selected on **Financial Processing > Automatic Transactions > Finance Charges** tab in relation to the voucher's current bill date (or its service date) based on the **Age By** setting on the **General** tab in **System Administration > Practice Options** (or **Organization Options**).

Note: A voucher may have an original bill date, as well as a current bill date. Each time a claim is rebilled, the voucher is assigned a new bill date. The new bill date from the most recent rebilling is considered the voucher's current bill date. If the claim is not rebilled, the voucher's original bill date is considered its current bill date.

The number entered is used by the application to identify which voucher balances qualify for a Finance Charge. Keep in mind that if you enter 30 the application searches for voucher balances that have aged 31 days and more since the date entered as the Transaction date when you run Finance Charges under Automatic Transactions.

Important: If your Statement cycle is set to 28 days, it is recommended that you set this option to 27. This way, all voucher balances aged 28 days and over will be assessed a finance charge. When you assess finance charges on the **Finance Charge** tab in **Financial Processing > Automatic Transactions**, if you enter 30,

the application searches for voucher balances that have aged 31 days or more since the selected transaction date.

Simple Finance Charge

When checked the application calculates the finance charge on the self-pay voucher balances that qualify; it does not include Finance Charge voucher balances.

Compound Finance Charge

When checked, the application calculates the finance charge using the self-pay voucher balances that qualify and Finance Charge voucher balances.

Finance Charge voucher balances are included in the calculation when applying a Finance Charge. These vouchers are identified by the Department/Practice and Location. This means that the calculation includes those balances on vouchers where the Department/Practice is set to the Finance Charge default Department/Practice and the Location is set to the Finance Charge default Location. These defaults are assigned in Finance Charge options.

Note: After you check either Simple Finance Charge or Compound Finance Charge, the check box for the other option is grayed and disabled. In order re-activate the disabled check box you must deselect the box you checked.

Assess Finance Charge Options

These defaults are used to create each of the finance charge vouchers when you run Finance Charges under Automatic Transactions (F9 > AUT).

If you have created defaults specifically to track finance charges in any of the related file maintenances, select that default for the corresponding option:

Default Provider

You must create records in file maintenance before you can make a selection.

Default Billing Provider

You must create records in file maintenance before you can make a selection.

Default Department

You must create records in file maintenance before you can make a selection. The application uses this selection to identify finance charge vouchers.

Default Place of Service

You must create records in file maintenance before you can make a selection.

Default Location

You must create records in file maintenance before you can make a selection. The application uses this selection to identify finance charge vouchers.

Default Procedure

You must create records in file maintenance before you can make a selection.

External Access tab in Practice Options or Organization Options

The **External Access** tab stores information related to external applications accessed from within Allscripts® Practice Management.

Access the **External Access** tab on **Practice Options or Organization Options** in **System Administration**.

Tip: To quickly access **Practice Options or Organization Options**, press **F9**, then enter **POP** or **OOP**.

Chapter 2 Practice Options or Organization Options

Practice Options

External Access [External Access (2) | Credit Card Processing | Special Billing | Multi Entity | Visit Type | Case | History]

Enable copy on external hot key cmd View H & P
 Add Middle Name for Import/Export Enable Server: _____ DB: _____ F ID: _____
 Pro EHR 14.2 & Later

Cerecons Eligibility
 Enable Cerecons Eligibility **Cerecons URL:** <https://www.cerecons.com/test/physician/>

EAD Workflow
 Real Time Eligibility Wait for Eligibility Response **Eligibility History**
 Months to Retain: 18

Payerpath Portal
 Enable Payerpath Portal
Payerpath URL: allscripts.com **Customer Name:** Allscripts **Group ID:** 1234

Claims Adjudication
 Enable Real Time Claims Adjudication
Eligible Insurance Group: HUMANA **Non Adjudication Claim Note:** Non Adjudication Claim Status
Payable Status Claim Note: Payable Claim Status **Denied Status Claim Note:** Denied Claim Status
Pended Status Claim Note: Claim Note (Claim Note) **Rejected Status Claim Note:** Rejected Claim Status

Claims Review
Claims Tool: Alpha II Enterprise **Default Claim Edit Category:** NEW
Alpha II Client ID: allscriptstest **Prof. Client ID:** _____ **Inst. Client ID:** _____
 Send Uninsured Vouchers to Claims Manager
Web Service URL: _____

Education/i-Learn Portal
Education Portal URL: <http://pmilearn.eduserv.myallscripts.com>

Allscripts Application Store
APM URL: <https://expo.allscripts.com/>

SRS
 Enable Access to SRS **Patient Identifier:** _____

Save **Cancel**

Enable copy on external hot key command

This feature is no longer supported.

Add Middle Name for Import/Export

Important: Only use this option if you have an interface with an Enterprise Access Directory (EAD) application.

Select this option to enable the **Middle Name** field for patients and contacts on the **Patient** tab and the **Account** tab in **Patient Management > Registration**.

View H & P area

Complete boxes in this area to enable the **View H & P** button and right-click context menu option found in various areas within Allscripts® Practice Management.

When enabled, click the **View H & P** button to view History & Physical (H & P) information from Allscripts Professional EHR™ for a visit whose voucher was entered since you have been running Allscripts Professional EHR™ version 9.1 and Allscripts® Practice Management version 9.3.1.

Important: You must meet the following criteria to use the **View H & P** functionality:

- > You must be running on Allscripts® Practice Management version 9.3.1 or later.
- > You must be running on Allscripts Professional EHR™ version 9.1 or later.
- > You must select **Track Encounters** on the **Charge Entry** tab in **System Administration > Practice Options or Organization Options**.

Pro EHR 14.2 & Later

Select this option if you are using Allscripts Professional EHR™ version 14.2 or later.

When you select **Pro EHR 14.2 & Later**, the boxes in the **View H&P** area change to support security changes in Allscripts Professional EHR™ version 14.2.

Enable

Select **Enable** to make the entry boxes in the **View H&P** area available to enter data.

Clearing **Enable** makes entry boxes in the **View H&P** area unavailable. However, any previously saved values remain in the boxes.

Server

Note: This box is only available when **Pro EHR 14.2 & Later** is not selected.

Enter the physical name of your Allscripts Professional EHR™ server or the IP address.

DB

Note: This box is only available when **Pro EHR 14.2 & Later** is not selected.

Enter your Allscripts Professional EHR™ database name.

URL

Note: This box is only available when you select **Pro EHR 14.2 & Later**.

Enter a uniform resource locator (URL) path.

To obtain the URL path:

1. Log on to Allscripts Professional EHR™, then open the **Administration Module** as an administrator.
2. Go to **System Options**.
3. Select **H&P Report** from the section drop-down list.
4. Copy the URL from the **Value** that corresponds to the **Url key**.

Tip: The URL should look something like
http://EMRSERVER_NAME:6051

5. Log on to Allscripts® Practice Management.
6. Go to the **External Access** tab in **System Administration > Practice Options or Organization Options**.
7. In the **View H&P** area, select **Enable**, then paste the URL into the **URL** box.
8. Save your changes.

F

Important: To enable this button, you must enter valid values for **Server** and **DB**, or **URL**. After entering the values, click **Save** so the application can confirm that the values you entered are correct.

Click this button to retrieve the information broker format class IDs and descriptions of the Allscripts® Practice Management applications that Allscripts Professional EHR™ recognizes. The **ID** drop-down list contains those format class descriptions.

ID

This drop-down list contains descriptions of information broker format classes that have **Ntierprise** as the **External App Name**.

Select the applicable Allscripts® Practice Management ID from the drop-down list, then click **Save**.

After you click **Save**, **ID** is no longer enabled and the selected ID is stored in the Allscripts® Practice Management database. Storing the ID in the Allscripts® Practice Management database eliminates unnecessary calls to the Allscripts Professional EHR™ database when you access **Practice Options or Organization Options**.

Tip: To select a different ID after you have already saved, click **F** to enable **ID**. Then, select a different ID from the drop-down list before clicking **Save**.

Cerecons Eligibility area

This feature is no longer supported.

EAD Workflow area

Important: **None** is selected by default.

Only change the default if you are using an interface between Allscripts® Practice Management and an Enterprise Access Directory (EAD) application.

If you are using an interface between Allscripts® Practice Management and an Enterprise Access Directory (EAD) application, use the drop-down list to determine which EAD workflow to follow.

Custom

Attention: Only select this option if instructed to do so by Allscripts® Support.

When you select this option, the following things occur in Allscripts® Practice Management:

- > **On Patient Lookup:**
 - The **New Patient** button is unavailable for local searches.
 - The **Enterprise Search** button is renamed **EAD Search**.
- > In **Scheduling > Appointment Scheduling**, the ability to add a new patient using  is unavailable.
- > In **Patient Management > Registration**:
 -  is unavailable.
 - **Guar** is unavailable on the **Account** tab.
 - The ability to create a contact as a patient is unavailable on the **Account** tab.
 - **Transfer Patient** is unavailable on the menu bar under **Actions**.
 - The **Legal Name** tab is enabled and available.

Standard

Important: Only select this option if you are using the Siemens EAD application interface.

When you select this option, the following things occur in Allscripts® Practice Management:

- > **On Patient Lookup:**
 - The **New Patient** button is unavailable for local searches.
 - The **Enterprise Search** button is renamed **EAD Search**.
- > In **Scheduling > Appointment Scheduling**, the ability to add a new patient using  is unavailable.

Real Time Eligibility area

Note: This area is only applicable if you are using real-time eligibility verification.

Use **Wait for Eligibility Response** to determine what happens if a response is returned within 30 seconds of processing a real-time eligibility request.

If you select **Wait for Eligibility Response**, **Eligibility Response** opens automatically. When the window opens, it only displays the eligibility information returned by the payer for the first response received.

If you do not select **Wait for Eligibility Response**, **Request Eligibility** closes when a real-time eligibility request is processed. After the window closes, you must manually open **Eligibility Response** to view responses.

To manually open **Eligibility Response**, select **View Eligibility Response** from the right-click context menu for an appointment in any of the following areas:

- > On the **Appointment Book**, **Appointment Management**, or **Appointment Activity** tabs in **Scheduling > Appointment Scheduling**
- > In the **Appointment Management**, **Pending Claims Management**, or **Unpaid Claims Management** workspaces in **Office Manager**
- > On **Eligibility History** as accessed by clicking  in **Appointment Scheduling**.

Note: If more than one response is returned at the exact same time, **Eligibility Requests by Appointment** opens. Double-click an eligibility response on **Eligibility Requests by Appointment** to view the response on **Eligibility Response**.

Eligibility History area

Use **Months to Retain** to determine how long Allscripts® Practice Management retains eligibility data in your database.

The default value is 18 months. However, you can enter any value between 1 and 999.

Based on the value you enter, an Allscripts® Interface Engine process regularly compares the import date of eligibility data to the current date. When comparing the dates, the process removes any data older than the value in **Months to Retain**.

Payerpath Portal area

Important: Only complete the boxes in this area if you use Allscripts Payerpath®.

Complete the boxes and click **Save** to enable  on the toolbar.

Enable Payerpath Portal

Select this option to enable **Payerpath URL**, **Customer Name**, and **Group ID** as required boxes.

Payerpath URL

Enter the URL used to access the Allscripts Payerpath® web site:

<https://www.payerpath.com/>.

When enabled, this box is required.

Customer Name

Enter the customer name assigned by Allscripts Payerpath®.

When enabled, this box is required.

Group ID

Enter the group ID assigned by Allscripts Payerpath®.

When enabled, this box is required.

Enable Real Time Claims Adjudication

This feature is no longer supported.

Claims Review area

Complete the boxes in this area to determine which external tool Allscripts® Practice Management uses when reviewing claims.

Important: You must complete the boxes in this area if you selected either **Code Checking** or **Verify Claims** on the **Charge Entry** tab in **System Administration > Practice Options or Organization Options**. Otherwise, you cannot save your practice or organization options. If you are not using an external claims tool for claim review, ensure that **Code Checking** or **Verify Claims** is cleared.

Claims Tool

Depending on your selection for **Claims Tool**, various information provided by your Allscripts® representative is required in the **Claims Review** area.

Select one of the following claims review solutions:

- > **Alpha II Enterprise**

Attention: Required setup and coordination with Alpha II must be arranged with Allscripts® Support before using Alpha II ClaimStaker® Enterprise version.

As part of the setup,

`https://services.alphaii.net/scrub/scrub.asmx` must be added as a trusted site on the server where your Allscripts® Practice Management application resides.

Alpha II Client ID, Default Claim Edit Category, and Web Service URL are enabled and required.

The default value for **Default Claim Edit Category** is **NEW** or an existing user-created claim edit category in **Claim Edit Category Maintenance** with any version of **NEW** as the abbreviation (such as **New** or **new**).

> Payerpath Integrated Edits

Important: This feature is currently unavailable.

> Custom Claim Edits

Attention: Only select **Custom Claim Edits** if you have been told to do so by an Allscripts® representative.

When you select **Custom Claim Edits**, a validation is performed to ensure that the URL in **Web Service URL** is formatted with the secure protocol `https`. If the URL is not correctly formatted with `https`, the message `Web Service URL is not valid` is displayed. To prevent errors that might be generated during charge entry, you cannot save your changes until the URL is correctly formatted with `https`.

Alpha II Client ID

Required when **Claims Tool** is set to **Alpha II Enterprise**.

Default Claim Edit Category

Required. Select a value that the application can assign to claim edit codes returned from your claims review solution when they are not already in your database.

Web Service URL

Required. Enter the URL of your claims review solution.

The URL may be up to 100 characters. To view the entire URL, hover the cursor over the box to display a tooltip.

Send Uninsured Vouchers to Claims Manager

If your practice or organization uses the uninsured carrier functionality, select this option to send uninsured vouchers to the URL defined in **Web Service URL** for claim edits.

If your practice or organization does not use the uninsured carrier functionality, Allscripts® Practice Management ignores **Send Uninsured Vouchers to Claims Manager** because uninsured vouchers do not exist.

Education/i-Learn Portal area

Use **Education Portal URL** to connect Allscripts® Practice Management to Allscripts® i-Learn using the URL. The URL is <http://pmilearn.eduserv.myallscripts.com>.

Allscripts® i-Learn provides quick access to information about new release content from anywhere in Allscripts® Practice Management.

Allscripts® Application Store area

Use **APM URL** to view supported, certified products, devices, and applications. The URL is <https://expo.allscripts.com/>.

When the applicable URL is entered,  is visible on the toolbar.

SRS area

Use the options in this area to enable the ability to access SRS from within Allscripts® Practice Management.

Enable Access to SRS

Select this option to add  to the toolbar on **Registration**, **Financial Inquiry**, and **Appointment Scheduling**.

After you select **Enable Access to SRS**,  is only enabled on the toolbar if the following criteria are met:

- > You have selected an option for **Patient Identifier** on the **External Access** tab in **System Administration > Practice Options or Organization Options**.
- > You have the SRS security right under **Toolbar Buttons** on **Administration > Security Permissions > Practice Management**.
- > You have configured SRS as an external application on **Update Options > External Access** tab.

Important: To configure SRS on the **External Access** tab:

1. Click **Add** to open **Applications**.
2. For **Name**, enter SRS.

- || 3. For **File Name**, enter the path to the `srscli.exe` installed on the your local system.
- > You have the Allscripts® Practice Management and SRS applications installed on the same system.
 - > You have a patient in context.

Patient Identifier

Select the patient identifier for the SRS application.

- > **Patient Number**
- > **MRN**
- > **Enterprise Number**

External Access (2) tab in Practice Options or Organization Options

Use the **External Access (2)** tab in **Practice Options or Organization Options** to enter information related to external applications accessed from within Allscripts® Practice Management.

Access the **External Access (2)** tab from **Practice Options or Organization Options**. To access **Practice Options or Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP**, as applicable.

Practice Options

Scheduling (2) Referral Collection Enterprise Occ. Medicine Finance Charge External Access **External Access (2)**

Address Verification

URL: <https://personator.melissadata.net/v3/WEB/ContactVerify/doContactVerify> License Key:
 Always Prompt for AC06-Address Swap

CCM

Enable CCM Integration
 CCM URL:

IAS

URL:
 Username:
 Password: Verify:

Guided Scheduling Integration

Enable Guided Scheduling
 URL: <https://allscripts-uat.opango.com>
 Client ID: Client Key:

Access to Scanned Documents

Impact MD Laserfiche
 EOB File Cabinet ID:
 URL:
 Repository Name:
 Client Folder Name:

Address Verification

URL

Required to use address verification. Enter the URL for an address validation service that is supported by Allscripts® Practice Management.

URL is defined as

<https://personator.melissadata.net/v3/WEB/ContactVerify/doContactVerify>

License Key

Required to use address verification. Enter the license key that your organization received from the address validation service.

Note: You must be on Allscripts® Practice Management 18.0 or later to use the address verification feature. Contact Allscripts® Sales to contract for a license to use within Allscripts® Practice Management. Licenses are issued by Melissa Data for each tenant database, not for each organization.

Always Prompt for AC06-Address Swap

To enable **Always Prompt for AC06-Address Swap**, enter URL and license key information for an address verification service supported by Allscripts® Practice Management.

If you select **Always Prompt for AC06-Address Swap**, **Address Verification** displays **Accept** and **Override Reason** when an address verification service returns AC06 and AS01 codes. These codes are generated when you enter a building name in **Address 1** and a street address in **Address 2**. If you select **Accept**, the application interchanges information from both address fields. However, if you select an option from **Override Reason**, you can prevent the application from interchanging information.

Selecting **Always Prompt for AC06-Address Swap** affects the address verification process in the following locations:

- > **Patient Management > Registration > Patient tab**
- > **Patient Management > Registration > Account tab**
- > **System Administration > File Maintenance > Insurance Carrier Maintenance > Carrier tab**
- > **System Administration > File Maintenance > Insurance Carrier Maintenance > Refund Address tab**
- > **System Administration > File Maintenance > Insurance Carrier Maintenance > Styles tab**
- > **System Administration > File Maintenance > Place of Service Maintenance > Place of Service tab**
- > **System Administration > File Maintenance > Address Maintenance > Address tab**

When creating a new tenant, starter data excludes your selection for **Always Prompt for AC06-Address Swap**.

Best Practice: When replicating data from a source tenant to a target tenant, verify that **Always Prompt for AC06-Address Swap** is selected in both tenants to avoid discrepancies in how the indicator icons are color-coded.

CCM

This area is for custom use. Do not select **Enable CCM Integration** unless directed by an Allscripts® representative.

IAS

The password is stored as an encrypted value and displays as asterisks. The IAS Search function will appear only if the IAS URL is present. This IAS configuration is for a custom interface and should not be set up for clients unless directed by an Allscripts® representative.

Guided Scheduling Integration

The setup in the **Guided Scheduling Integration** area is not included with starter data sets that have the **Practice Options** information type.

Enable Guided Scheduling

Before selecting this box to start using guided scheduling, work with an Allscripts® representative to ensure that the required data extraction and setup are complete.

URL

Enter the uniform resource locator (URL) for the software analytics service that is supported by Allscripts® Practice Management for guided scheduling.

Client ID and Client Key

Enter the information provided by Allscripts® in conjunction with the software analytics service that is supported by Allscripts® Practice Management for guided scheduling.

Important: In addition to the client ID and client key, you must enter the group ID and group key in **Administration > Security Manager > Security Options**.

Test Connection

Tests the guided scheduling connection and returns messages depending on the success of the connection. **Test Connection** is only enabled when there are values entered for **URL**, **Client ID**, and **Client Key**.

Access to Scanned Documents

Impact MD

Selecting this option enables you to view EOBs scanned into Impact MD (also referred to as Allscripts® Document Management) from the **Unpaid Claims Management** tab, **Account Ledger**, the **Payment Entry** tab, **Financial Inquiry**, and **Unpaid Claims Management** in **Office Manager** using a **Search for Scanned EOB** right-click context menu option.

Creates an **External Access** tab on **User Options**, which is displayed when you click  (Update Options) on the toolbar.

Note:

- > Impact MD is only available for use by clients using the professional version of Allscripts® Practice Management who are also using an interface with the standalone Impact MD Back Office.
- > This function is not currently available for clients using the enterprise version of Allscripts® Practice Management.
- > Impact MD Back Office must be installed on each workstation that is going to use this feature.
- > Currently this interface does not function with Impact MD that is also known as TouchWorks Scan or TouchChart.

EOB File Cabinet ID

EOB File Cabinet ID is defined by Impact MD (also referred to as Allscripts® Document Management). It is the location where the EOBS scanned into Impact MD are located.

This ID is obtained by running the File Cabinet Listing report in Impact MD. The Code column on this report is where the File Cabinet ID can be found.

Set **EOB File Cabinet ID** to the value assigned by Impact MD.

Laserfiche

Enables **URL**, **Repository Name**, and **Claim Folder Name**. If you clear **Laserfiche**, any values in **URL**, **Repository Name**, and **Claim Folder Name** are automatically cleared.

Select this option to add **Search for Scanned EOB** to the context menu in the following areas of the application when a voucher has a claim associated with it that has a claim number greater than 1:

- > **Payment Entry** tab in **Transactions**
- > **Account Inquiry** tab and **Payment History** tab in **Financial Inquiry**
- > **Account Ledger**
- > **Unpaid Claims Management** tab and **Pending Claims Management** tab in **Claims Review**
- > **Unpaid Claims Management** workspace and **Pending Claims Management** workspace in **Office Manager**

You can access documents that were scanned into Laserfiche® without having to leave Allscripts® Practice Management, such as while working claims.

You must have a contract and license with Laserfiche before you can use this functionality.

If you do not have the applicable setup completed within Laserfiche, a message is displayed indicating that a license is required.

A website security certificate warning might prevent the Laserfiche application from automatically opening. Override the warning to open Laserfiche only if doing so is in accordance with your organization's security policy.

When the Laserfiche search results find only one document, the document is automatically opened for viewing.

Search for Scanned EOB is not enabled for self-pay transactions, and vouchers, unpaid claims, or pending claims that were not previously billed.

URL

Enter the uniform resource locator (URL) supplied by Laserfiche. Accepts up to 255 characters.

Important: This box is required when **Laserfiche** is selected.

Repository Name

Required when **Laserfiche** is selected. Enter the repository name supplied by Laserfiche.

Client Folder Name

Enter the folder name supplied by Laserfiche.

Note: This box is required when **Laserfiche** is selected.

You must have the applicable permissions granted by Laserfiche to open this folder in the Laserfiche application.

Laserfiche, URL, Repository Name, and Claim Folder Name are not included in starter data sets with the **Practice Options** information type.

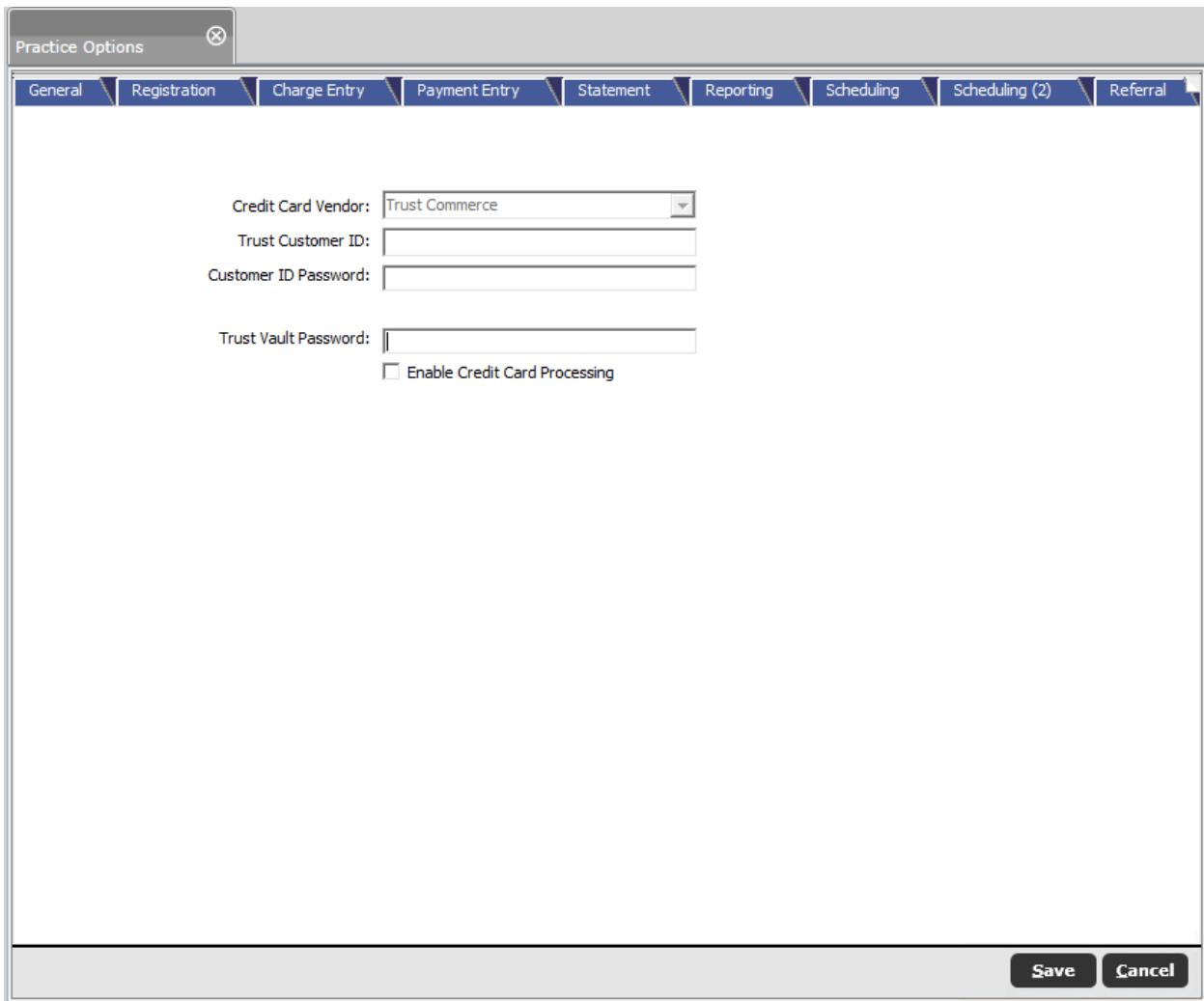
Use the security defined within the Laserfiche application to define which Allscripts® Practice Management users have access to Laserfiche using **Search for Scanned EOB**.

Credit Card Processing tab

The **Credit Card Processing** tab enables you to transmit credit card transactions to the currently supported credit card processing vendor.

Access the **Credit Card Processing** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.

Chapter 2 Practice Options or Organization Options



The screenshot shows the 'Practice Options' window with the 'General' tab selected. The window contains fields for credit card vendor, customer ID, password, and vault password, along with a checkbox for enabling credit card processing.

Credit Card Vendor:	Trust Commerce
Trust Customer ID:	[Empty]
Customer ID Password:	[Empty]
Trust Vault Password:	[Empty]
<input type="checkbox"/> Enable Credit Card Processing	

Save Cancel

Credit Card Vendor

This box is read-only and set to **Trust Commerce**, which is the only option in version 22.0.

Trust Customer ID

Enter the customer ID; supplied by the credit card processing vendor.

Required when **Customer ID Password** or **Trust Vault Password** is filled.

Customer ID Password

Enter the password for the customer ID; supplied by the credit card processing vendor.

Required when **Trust Customer ID** or **Trust Vault Password** is filled.

Trust Vault Password

Enter the password for TrustCommerce® Vault; supplied by the credit card processing vendor.

Used by Allscripts® Practice Management for voiding transactions.

Required when **Trust Customer ID** or **Customer ID Password** is filled.

Enable Credit Card Processing

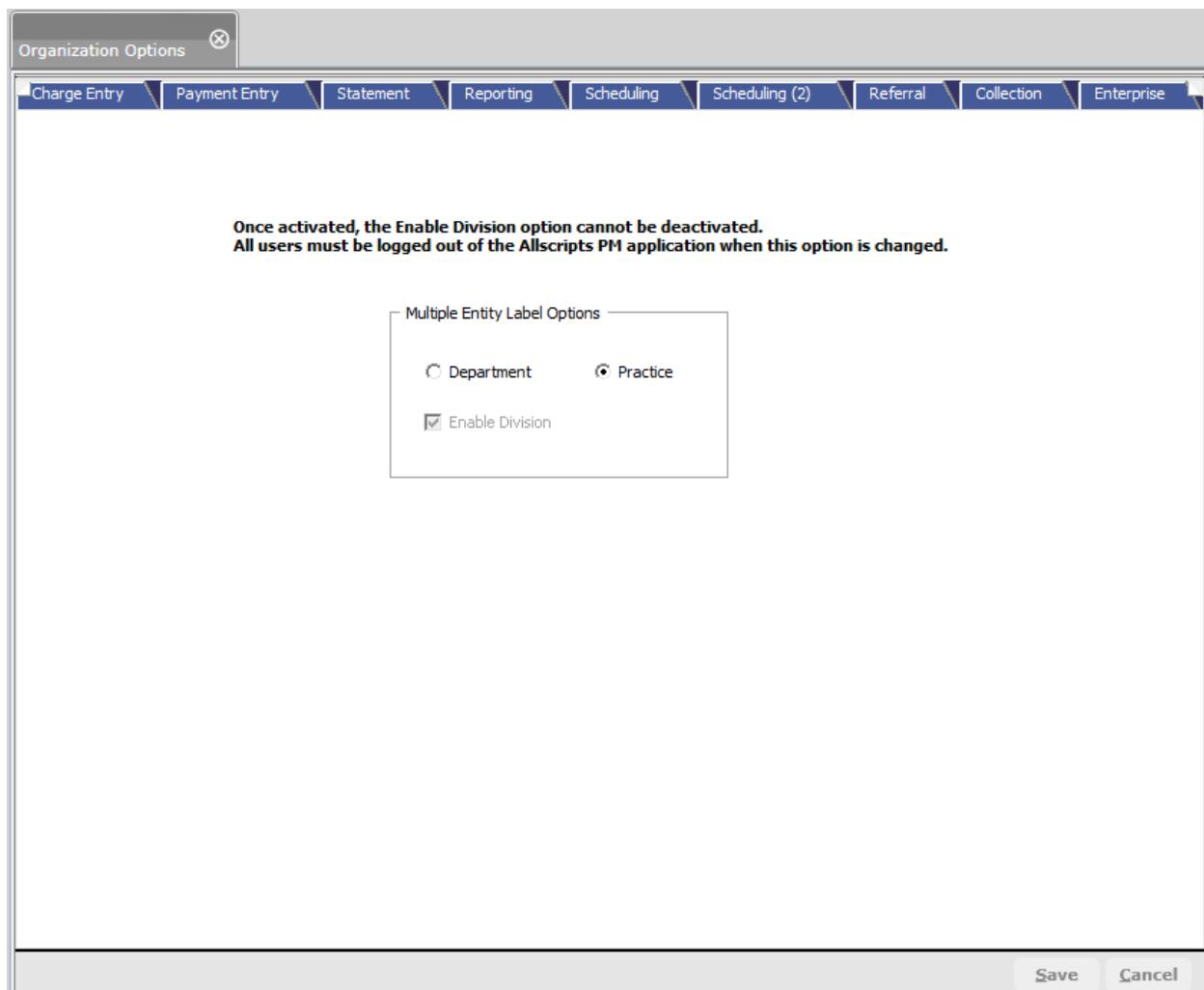
Select this option when your credit card processing setup is complete, and you are ready to have the application prompt to enter credit card information for payment transactions with specific transaction codes.

Multi Entity tab

On the **Multi Entity** tab in **Practice Options** or **Organization Options**, you can define the naming of the hierarchical structure used in Allscripts® Practice Management to match your "real world" environment.

Access the **Multi Entity** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.

Chapter 2 Practice Options or Organization Options



Multi Entity Label Options

The standard hierarchy in Allscripts® Practice Management is for the practice to refer to your practice, and for the departments to identify the areas of specialty or services within your practice. The **Multi Entity** tab give larger groups such as Management Service Organizations (MSOs) and Integrated Healthcare Systems (IHSs) the option to refer to their structure as organization and practices rather than the standard practice and departments.

Important: Throughout the Allscripts® Practice Management user documentation, you will notice the use of "practice or organization" and "department or practice". Which labels apply to you depend on whether you select **Department** or **Practice** as your label option.

Department

Default setting. When you select **Department**, the structured hierarchy in Allscripts® Practice Management is the standard:

- > Practice
- > Department

This model is best suited for smaller to mid-size practices and even larger practices that include multiple specialties. In this model, you can add multiple departments for reporting and billing purposes. Smaller practices might have a single department, while larger multi-physician or specialty practices can create as many departments as necessary.

In this model, a department can represent specialties, such as Internal Medicine, Pediatrics, and so on. Departments can also be services within your practice for which you want to track productivity, such as Lab, Main Office, Nursing Home, and so on.

Practice

When you select **Practice**, the hierarchical structure in Allscripts® Practice Management is relabeled as follows:

- > Organization: throughout Allscripts® Practice Management, any instance of the word "Practice" is relabeled "Organization."
- > Practice - Throughout Allscripts® Practice Management, any instance of the word "Department" is relabeled "Practice."

Large organizations such Management Service Organizations (MSO) and Integrated Healthcare Systems (IHS) might benefit from this structure because it more closely mirrors their "real world" structure.

MSOs are separate entities or divisions of a healthcare entity that manage medical practices within a single primary network, health system, community, or hospital, with the purpose of improving cost effectiveness through managing practice operation more efficiently. IHSs involve a combination of physicians, hospitals, and healthcare plans where certain economic and organization relationships are formed.

Enable Division

Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. A division is made up of multiple departments or practices, all of whose data can be rolled up and reported as 1 entity.

You can run reports for multiple divisions. Each division section on the report is made up of the combined totals for all of the departments or practices assigned to that division.

This option is only available when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**. **Enable Division** is cleared by default.

Select **Enable Division** and click **Save** to enable divisions. Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes.

All users must be logged out of Allscripts® Practice Management when this option is changed.

Note:

- > You can select **Enable Divisions** regardless of whether you use department or practice as a label option.
- > You must select **Enable Divisions** to use collections by division or statements by division functionality.

When you enable divisions, the following events occur.

- > **A message is displayed:** Once selected, the Enable Division option cannot be changed! Please ensure that all users are logged out of the Allscripts PM application before saving. Would you like to cancel these changes?

Note: If you click **No**, from this point forward, an existing department or practice record cannot be edited and a new record cannot be created without selecting a division.

After you click **Save** and link a department or practice to a division, **Enable Division** is no longer available, so the setting cannot be changed.

- > A new window called **Division Maintenance** is added to **System Administration > File Maintenance**. Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes.

Note: A new department or practice record cannot be saved or an existing department or practice record cannot be edited until you select a division in **Department Maintenance** or **Practice Maintenance**.

- > A new layer called **Division** is created for reporting and grouping purposes.

You can select divisions in the following areas of the application:

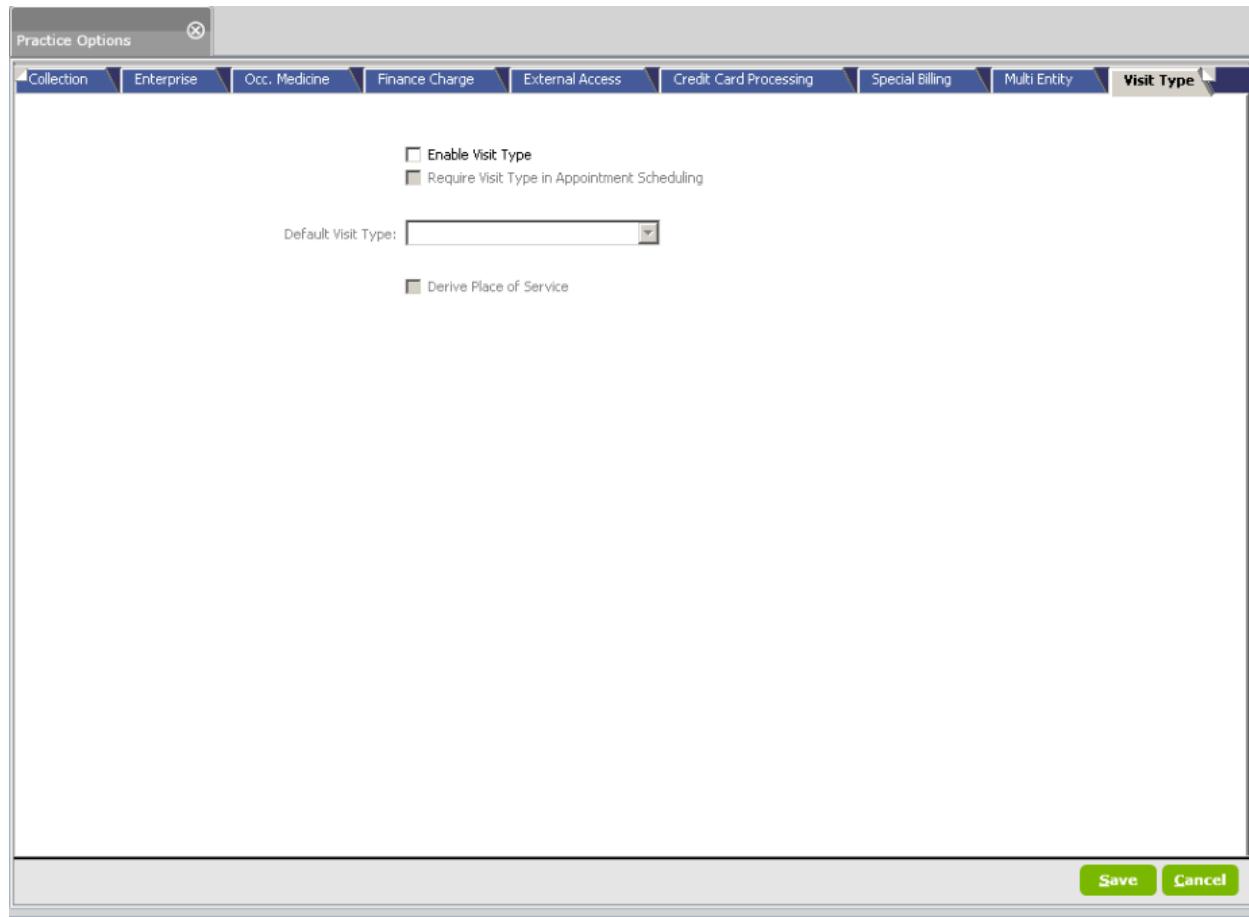
- On **Select Departments** or **Select Practices** for reports that can be restricted by department or practice.
- In **Division** for related file maintenances.

When you have **Enable Division** cleared and **Enable Department Security** or **Enable Practice Security** selected, **Division** is unavailable in the related file maintenances.

Visit Type tab in Practice Options or Organization Options

Use the **Visit Type** tab in **Practice Options** or **Organization Options** to enable the use of visit types in the scheduling process.

Access the **Visit Type** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP** as applicable.



Enable Visit Type

Select **Enable Visit Type** to use visit types in your scheduling process.

When you select this option, you activate the following visit-type specific features for scheduling:

- > **Visit Type Maintenance** is available in **System Administration**.
- > **Visit Type** is available on the **Patient Scheduling** tab in **Scheduling > Appointment Scheduling** and in **Schedule New Appointment** and **Force Appointment**.

- > A **Visit Type** column is included in the grids on the **Appointment Management** and **Appointment Activity** tabs in **Appointment Scheduling**.
- > The visit type is displayed in **Schedule (Walk In) Appointment** and **Appointment Detail**.
- > If you are using **Office Manager**, a **Visit Type** column is included in the folders in **Pending Claims Management**, **Unpaid Claims Management**, and **Appointment Management**.

Require Visit Type in Appointment Scheduling

This option is only available when **Enable Visit Type** is selected.

Select this option to require a selection for **Visit Type** when scheduling an appointment.

When selected, all the boxes below **Visit Type** on the **Patient Scheduling** tab in **Scheduling > Appointment Scheduling** are unavailable until you select a value for **Visit Type**.

Default Visit Type

This option is only available when **Enable Visit Type** is selected.

Select a visit type created in **Visit Type Maintenance** if you want to set a default value for the **Visit Type** drop-down lists in **Scheduling > Appointment Scheduling**.

Derive Place of Service

This option is only available when **Enable Visit Type** and **Require Visit Type in Appointment Scheduling** are selected.

Select this option to have the application derive the place of service on vouchers based on the visit type and location, which ensures that vouchers have the correct place of service when you have multiple places of service with the same default location. This impacts appointment scheduling in the following areas:

- > **Scheduling > Appointment Scheduling > Patient Scheduling**
- > **Schedule New Appointment**, **Force Appointment**, and **Walk In Appointment** accessed from the right-click context menus in the **Appointment Book** and **Appointment Management** tabs in **Scheduling > Appointment Scheduling**
- > Right-click context menu options in the **Appointment Management** tab in **Office Manager**

When selected, **Place of Service** is an available selection in the **Transaction Acknowledgment Option** list on the **Payment Entry** tab in **Practice Options or Organization Options**.

When selected, for claim styles with a **Claim Format** that is associated to the **Professional ANSI 837P v5010A1** electronic claim or the **ICD10 Generic Medical Claim Form** paper claim, the **Override Rendering Provider ID by Visit Type** area is displayed below the output options grid on the **Output Options** tab in **Claim Style Maintenance**.

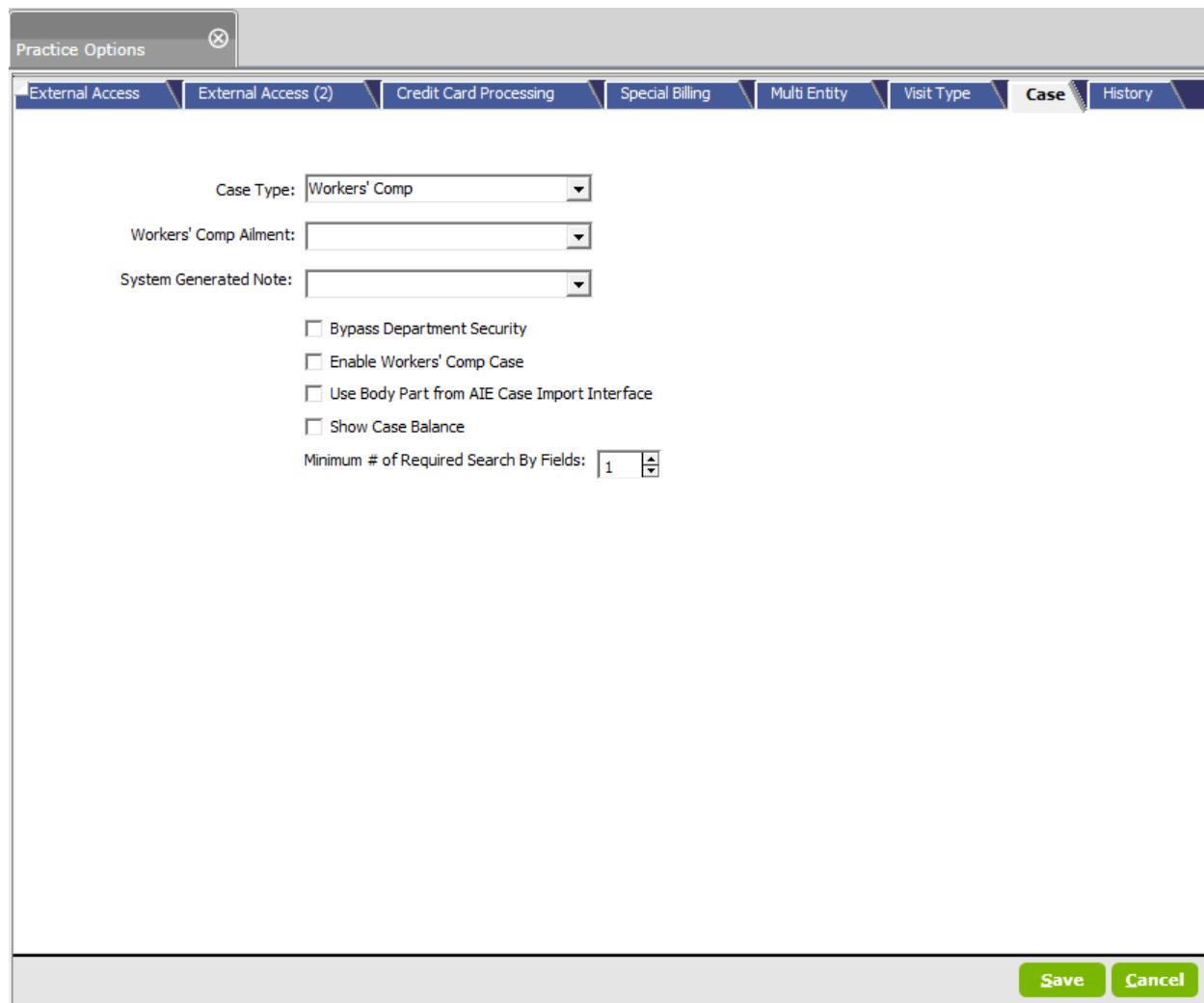
If you create rules in **System Rule Manager** that use a **Visit Type** condition, you cannot clear **Derive Place of Service** unless you remove the **Visit Type** condition from all active and inactive rules, or delete rules that use the **Visit Type** condition.

Case tab for workers' compensation cases

When you set **Case Type** to **Workers' Comp** on the **Case** tab in **Practice Options** or **Organization Options**, the selections to enable functionality to initiate workers' compensation cases are displayed in the window.

Access the **Case** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options** or **System Administration > Organization Options**, or press **F9** and then enter **POP** or **OOP**, as applicable.

The information on this tab is not included when you select **Practice Options** for **Information Type** when creating a new tenant.



Practice Options

External Access External Access (2) Credit Card Processing Special Billing Multi Entity Visit Type Case History

Case Type:

Workers' Comp Ailment:

System Generated Note:

Bypass Department Security
 Enable Workers' Comp Case
 Use Body Part from AIE Case Import Interface
 Show Case Balance

Minimum # of Required Search By Fields:

Save Cancel

Case Type

Case Type is the only box that is displayed when you first open this tab. Select **Workers' Comp** to see the associated options.

Workers' Comp Ailment

Select an ailment type to associate with workers' compensation cases. Required when **Enable Workers' Comp Case** is selected.

The list contains all ailments in **Ailment Type Maintenance** regardless of department or practice security.

Ailment in Appointment Scheduling is filled with **WC Case DOI <date of injury> <body part description>**. The values for **<date of injury>** and **<body part description>** are obtained from the case. For example, **WC Case DOI 03/20/2019 Arm injury-right**.

When you open **Ailment Information**:

- The value of **Workers' Comp Ailment** is displayed in **Ailment Type** and cannot be changed.
- **Condition Related to Employment** is set to **Yes**, and **Date 1st Symptom** is set to the date of injury. Both values are required. **Date 1st Symptom** is not editable. If you have to change **Date 1st Symptom**, you must update it on the case. You cannot change or delete the ailment that is attached to the appointment.
- **Attach to this Appointment** is selected and cannot be changed.

Note: **Ailment** is filled with **WC Case DOI <date of injury> <body part description>** when the case is created initially. Subsequent changes to the date of injury or body part description in the case are not reflected in **Ailment**; the value remains static.

System Generated Notes

Select a note to associate with a workers' compensation case when the case status is changed by another application, such as Allscripts TouchWorks® EHR.

The list contains only notes with a note type of **WC Case Note** in **Note Type Maintenance**. You must select **Enable Workers' Comp Case** before creating workers' compensation notes in **Note Type Maintenance**.

Bypass Department Security or Bypass Practice Security

Select this box to have all appointments that are associated with a workers' compensation case displayed in **Case Management** regardless of department or practice security. Similarly, when you access **Account Ledger** from **Case Management**, all vouchers are displayed.

This box is enabled only when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Enable Workers' Comp Case

Select this box to have **Case Management** open in **Appointment Scheduling** for appointments with a visit type that has **Case Type** set to **Workers' Comp** in **Visit Type Maintenance**. Alternatively, use the **Case Management** toolbar button  to open **Case Management**.

Use Body Part from Allscripts® Interface Engine Case Import Interface

For future use. If you select this option, **Body Part Description** on the **WC Case Management** tab is not available and filled with **Initial Visit**.

Show Case Balance

Select this box to display **Total Amount Due**, which is the total balance for all vouchers attached to a case, in the header section of **WC Case Management** tab. The total includes vouchers with an **Entered**, **Closed**, or **Updated** status. Department or practice security is considered when determining the vouchers to include in the total. **Bypass Department Security** or **Bypass Practice Security** on the **Case** tab also affects the total.

Minimum # of Required Search By Fields

Select the minimum number of **Search By** and **Search For** boxes to use when searching for an employer or employer location in **Employer/Employer Location Lookup**.

For example, if **Minimum # of Required Search By Fields** is set to 2, you must make a selection in the first two **Search By** boxes and enter values in the corresponding **Search For** boxes.

This option applies to **Employer/Employer Location Lookup** only, not the standard **Employer Lookup**.

History tab

Various windows throughout the application have a **History** tab that enables you to view an audit history of changes made on that window.

Information stored on the **History** tab includes the date and time the change was made and the first name and last name of the operator who made the change. The display format of the **History** tab might differ slightly among application windows depending on the information being tracked.

When you click the **History** tab in **Insurance Carrier Maintenance** and **Employer Maintenance**, a set number of records is retrieved and displayed instead of all history records, which decreases the amount of time it takes to display data. If there is enough audit history to display on multiple pages, scroll through the data using navigation buttons at the bottom of the window.

Field Name

This column shows the name of the box that was changed.

Old Value

This column displays the value in the box before the change. If **Old Value** is blank, then the box was blank.

New Value

This column displays the value in the box after the record was saved.

Setup Function

If multiple tabs on this window are included in audit history tracking, select the tab whose history you want to view using **Setup Function**. If only one tab on this window is included in audit history tracking, **Setup Function** is not displayed.

Show Changed Fields

Click the + sign next to **Show Changed Fields** to display the changes each time the window or tab was modified.

Chapter 3

Multiple Entity File Maintenance

Multiple Entity File Maintenance setup checklist

The file maintenance covered in this section deals with the structure of your database. Allscripts® Practice Management offers large practices and organizations the flexibility to configure their database in such a way as to mirror their real workplace setting.

Use this checklist to record the completion of each maintenance record.

Maintenance	Completed
Division Maintenance (DIM)	
Department Maintenance or Practice Maintenance (DEM or PAM)	

Division Maintenance window

Use **Division Maintenance** to create divisions to which you can add departments or practices as members for reporting purposes.

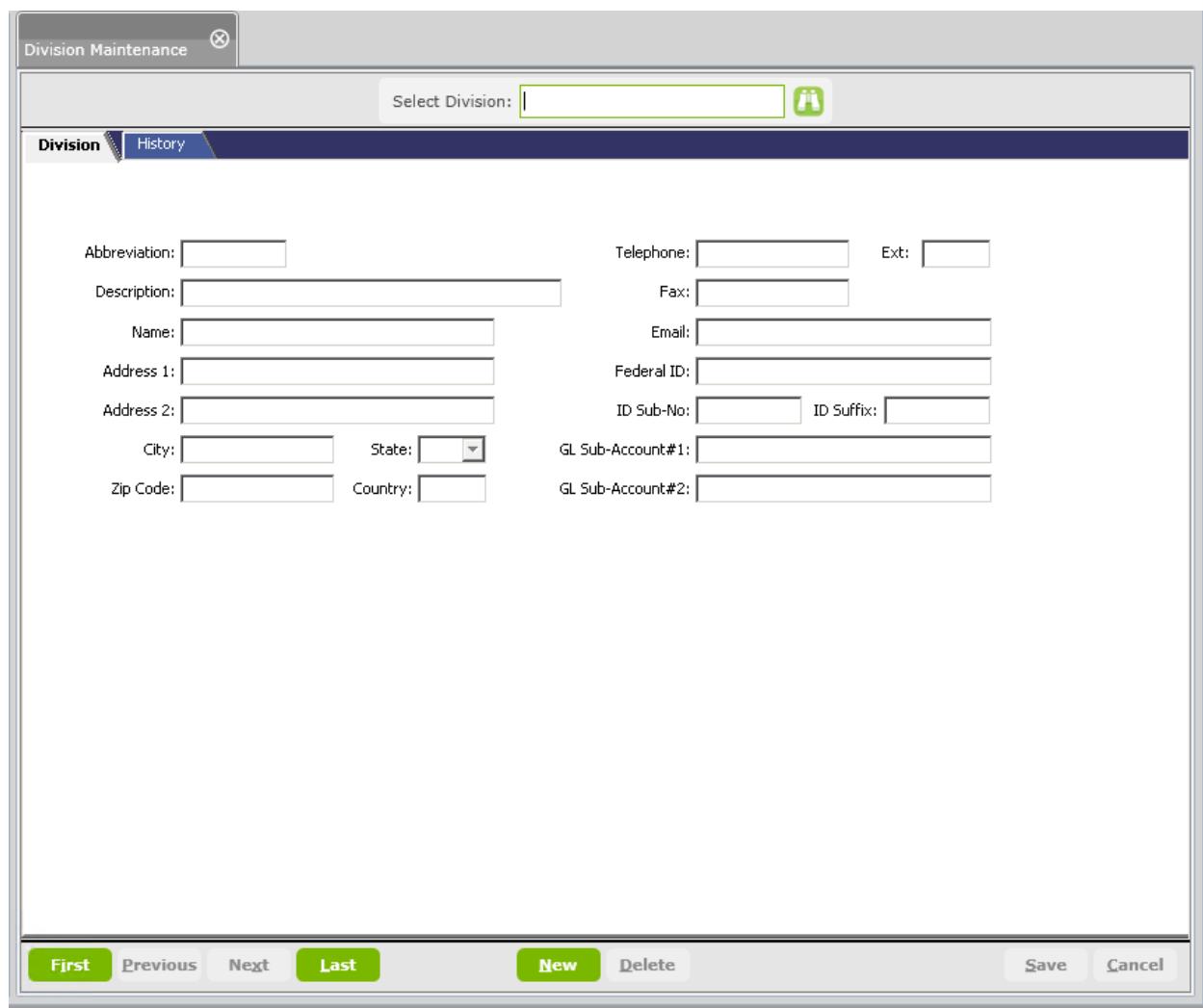
The divisions you create in **Division Maintenance** are available in these areas in Allscripts® Practice Management:

- On **Select Departments** or **Select Practices** for reports that can be restricted by department or practice
- In the **Division** list on the **Department** or **Practice** tab in these related file maintenances:
 - **Department Maintenance or Practice Maintenance**
 - **Ailment Type Maintenance**
 - **Batch Category Maintenance**
 - **Claim Type Maintenance**
 - **Collection Action Maintenance**
 - **Image Category Maintenance**
 - **Location Maintenance**
 - **Message Maintenance**

- Operator Maintenance
- Place of Service Maintenance
- Provider Maintenance
- Resource Maintenance
- Scheduling Location Maintenance

Division Maintenance is only enabled when you select **Enable Division** on the **Multi Entity** tab in **Practice Options** or **Organization Options**.

Access **Division Maintenance** from **System Administration > File Maintenance > Division Maintenance** or press **F9** and then enter **DIM**.



The screenshot shows the 'Division Maintenance' window. At the top, there's a search bar labeled 'Select Division:' with a magnifying glass icon. Below the search bar are two tabs: 'Division' (which is selected) and 'History'. The main area contains various input fields for division details:

- Abbreviation: [Text Box]
- Description: [Text Box]
- Name: [Text Box]
- Address 1: [Text Box]
- Address 2: [Text Box]
- City: [Text Box] State: [Dropdown Box]
- Zip Code: [Text Box] Country: [Text Box]
- Telephone: [Text Box] Ext: [Text Box]
- Fax: [Text Box]
- Email: [Text Box]
- Federal ID: [Text Box]
- ID Sub-No: [Text Box] ID Suffix: [Text Box]
- GL Sub-Account#1: [Text Box]
- GL Sub-Account#2: [Text Box]

At the bottom of the window, there are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

Required entry. You can enter up to 8 characters.

|| **Best Practice:** Use only letters and numbers.

Displays on **Select Departments** or **Select Practices** for reports that can be restricted by department or practice.

Used in the database tables.

Description

Required entry. You can enter up to 40 characters.

|| **Best Practice:** Use only letters and numbers.

Displays in the **Division** list in related file maintenances and on **Select Departments** or **Select Practices** for reports that can be restricted by department or practice.

Name

Accepts up to 40 characters. Outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

|| **Best Practice:** Use only letters and numbers.

Address 1

Accepts up to 40 characters. Outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

Address 2

Accepts up to 40 characters. When filled, outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

City

Accepts up to 30 characters. Outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

State

Select from a list of 2-character U.S. state and territory abbreviations. Outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

Zip Code

Accepts up to 10 characters. Outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

Telephone

Enter a 10-digit telephone number without spaces, dashes, or parentheses; the number is automatically formatted as (###) ###-####. Outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

Federal ID

Enter the 9-digit tax ID assigned to the division; the number is automatically formatted as ##-#####. Outputs on the header of patient statements when **Division** is selected for **Header** on the **Statement** tab in **Practice Options** or **Organization Options**.

ID Sub-No

Enter additional tax ID information, such as a site number.

Accepts up to 8 characters.

ID Suffix

Enter additional tax ID information.

Accepts up to 8 characters.

Country

Accepts up to 2 characters.

Ext

Enter a telephone extension.

Accepts up to 5 characters.

Fax

Enter a 10-digit fax number without spaces, dashes, or parentheses; the number is automatically formatted as (###) ###-####.

Email

Accepts up to 255 characters.

GL Sub-Account#1

If division is a segment of the GL account number, enter a numeric value.

Accepts up to 8 characters.

GL Sub-Account#2 is only available if you are using **GL Export**.

The information in these data entry boxes prints on statements when **Header Information** on the **Statement** tab in **Practice Options** or **Organization Options** is set to **Division**:

- > Name
- > Address 1
- > Address 2
- > City
- > State
- > Zip Code
- > Telephone
- > Federal ID
- > ID Sub-No
- > ID Suffix

The demographic and tax ID entry boxes are not required, but if you are generating statements by division, the best practice is to fill those boxes.

Department Maintenance or Practice Maintenance window

Use **Department Maintenance** or **Practice Maintenance** to create your departments or practices.

The name of this window, **Department Maintenance** or **Practice Maintenance**, is driven by the multi-entity label option you selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**.

You must create at least 1 department or practice for your practice or organization.

Department or Practice is an option for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options**, and for various billing options in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

Department or Practice is also a required box during charge entry.

You can group or restrict various reports by specified departments or practices. To track the productivity of your various scheduling departments or practices, create matching departments or practices in **Department Maintenance** or **Practice Maintenance**.

Department Maintenance or **Practice Maintenance** contains these tabs:

- > **Department or Practice**
- > **Billing Numbers**
- > **Taxonomy Codes**

To access **Department Maintenance** or **Practice Maintenance**, go to **System Administration > File Maintenance > Department Maintenance** or **System Administration > File Maintenance > Practice Maintenance**, or press **F9** and then enter **DEM** or **PAM** as applicable.

Department tab or Practice tab in Department Maintenance or Practice Maintenance

Use **Department Maintenance** or **Practice Maintenance** tab to create your departments or practices.

You must create at least 1 department or practice.

Practice or **Department** is an option for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options** and for various billing options in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

Practice or **Department** is also a required box on the **Charge Entry** tab.

Various reports can be grouped by or restricted to specified departments or practices.

To track the productivity of your various scheduling departments, you must create matching departments or practices in **Department Maintenance** or **Practice Maintenance**.

Access the **Department** tab or **Practice** tab from **Department Maintenance** or **Practice Maintenance**. To access **Department Maintenance** or **Practice Maintenance**, go to **System Administration > File Maintenance** and select **Department Maintenance** or **Practice Maintenance** from the list as applicable, or press **F9** and then enter **DEM** or **PAM** as applicable.

Department Maintenance

Select Department:		<input type="button" value=""/>						
Department	Billing Numbers	Taxonomy Codes	History					
Abbreviation: <input type="text"/>	Telephone: <input type="text"/>	Ext: <input type="text"/>						
Description: <input type="text"/>	Fax: <input type="text"/>							
Name: <input type="text"/>	Email: <input type="text"/>							
Address 1: <input type="text"/>	Federal ID: <input type="text"/>							
Address 2: <input type="text"/>	ID Sub-No: <input type="text"/>	ID Suffix: <input type="text"/>						
City: <input type="text"/>	State: <input type="text"/>	Fee Profile: <input type="text"/>						
Zip Code: <input type="text"/>	Country: <input type="text"/>	Clinic Number: <input type="text"/>						
Claim # Prefix: <input type="text"/>		Division: <input type="text"/>						
<input type="checkbox"/> Other Address (only if different from above) <table border="1"> <tr> <td>Address 1: <input type="text"/></td> </tr> <tr> <td>Address 2: <input type="text"/></td> </tr> <tr> <td>City: <input type="text"/></td> <td>State: <input type="text"/></td> </tr> <tr> <td>Zip Code: <input type="text"/></td> <td>Country: <input type="text"/></td> </tr> </table>			Address 1: <input type="text"/>	Address 2: <input type="text"/>	City: <input type="text"/>	State: <input type="text"/>	Zip Code: <input type="text"/>	Country: <input type="text"/>
Address 1: <input type="text"/>								
Address 2: <input type="text"/>								
City: <input type="text"/>	State: <input type="text"/>							
Zip Code: <input type="text"/>	Country: <input type="text"/>							
<input type="checkbox"/> Split Billing Options <table border="1"> <tr> <td><input type="checkbox"/> Enable Split Billing</td> </tr> <tr> <td>Alternate Department: <input type="text"/></td> </tr> </table>			<input type="checkbox"/> Enable Split Billing	Alternate Department: <input type="text"/>				
<input type="checkbox"/> Enable Split Billing								
Alternate Department: <input type="text"/>								
<input type="button" value="First"/>	<input type="button" value="Previous"/>	<input type="button" value="Next"/>	<input type="button" value="Last"/>	<input type="button" value="New"/>	<input type="button" value="Delete"/>	<input type="button" value="Save"/>	<input type="button" value="Cancel"/>	

Abbreviation

Holds up to 8 characters.

The abbreviation must be unique to this record.

|| Best Practice: Use only letters and numbers.

Description

Holds up to 40 characters.

|| Best Practice: Use only letters and numbers.

The description is displayed on the **Charge Entry** tab in **Transactions**, on the **Department** tab or **Practice** tab of the select records window used for various reports and queries that permit filtering by department or practice.

Name

Holds up to 40 characters.

 **Best Practice:** Use only letters and numbers.

Outputs to electronic claim files, prints on paper claims, documents, encounters, and so on when **Department** or **Practice** is selected.

Department or practice main address

Enter the department or practice address exactly the way you want it to print on claim forms, encounter forms, documents, and so on.

Keep the following items in mind when you enter the main address:

- > The words **PO Box** cannot be in the address submitted on v5010 electronic claims or printed on CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms. If the main address contains a PO box number, enter a street address as the other address and set up **Billing Method Address** to use the other address for claims.
- > For v5010 claims, you must enter a ZIP code plus 4. If you do not know your 4-digit additional number, use <your ZIP Code>-9998. For example, enter 27615-9998.
- > **Address 2** outputs to electronic claim files but does not print on paper claims.
- > The main address boxes are available as pull fields for encounter forms and some documents depending on the type of document.
- > The main address prints on statements or occupational medicine invoices when you select **Department or Practice** for **Header Information** on the **Statements** tab or **Occ Medicine** tab in **Practice Options** or **Organization Options**.
- > **State** is a 2-letter abbreviation. Abbreviations of the US territories are listed after the 50 states.
- > **Country** holds up to 2 characters and is optional.
- > For v5010 electronic claims, the main address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Department** or **Practice**, and **Billing Method Address** in **Claims Style Maintenance** is set to either **Billing Method Address** or blank.
- > For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the main address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Department** or **Practice**, and **Billing Media** and **Billing Method Address** in **Claims Style Maintenance** are set to **Paper** and either **Billing Method Address** or blank respectively.

Claim # Prefix

Enter the applicable prefix number, so that separate remittance files can be returned for the departments within a practice or the practices within an organization. The claim prefix number must be unique for each department or practice in a tenant.

Claim # Prefix Option on the **General** tab in **Practice Options** or **Organization Options** must be set to **Department** or **Practice** to have this number output on claims.

Telephone

Requires an entry of 10 digits.

Enter a telephone number using the format: (###)###-####; enter the numbers without spaces or dashes.

Used as a pull field when you select **Department** or **Practice** as the header information for occupational medicine invoices.

Ext

Holds up to 5 characters.

Fax

Requires an entry of 10 digits.

Entering a fax number using the format: (###)###-####; do not use spaces or dashes.

Email

This box is Informational only.

Federal ID

Enter the Tax ID number assigned to your practice or organization or to the location or facility. Can be used when billing insurance claims when **Tax ID Source** is set to **Federal ID** and **Option** is set to **Location**.

Used as the pull field when **Federal ID** is selected for **Tax ID Source** and **Department** or **Practice** is selected for **Option** for paper and electronic claim formats.

ID Sub-No

Intended for additional tax ID information such as a site number that is required by a carrier or a claims vendor.

Used when the related claim style output option **Output Site ID for ANSI 837 formats** is set to **Department** or **Practice**.

ID Suffix

Enter additional tax ID information when required by your local area.

Used when the related claim style output option is selected.

Fee Profile

This box is only enabled when **Department** or **Practice** is selected for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

When it is enabled, select the fee profile used to determine procedure fees during charge entry.

Clinic Number

Clinic Number is used with the transmission of claims through BCBS of Michigan EDI.

Use this box to store your assigned number only when you are directed to do so by a member of Allscripts® Support.

The clinic number is reported when the related output option is selected in **Claim Style Maintenance**.

Division

This box is not enabled unless **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**.

If you are using department security or practice security, you must select a division.

Note: Each time you create a new department or practice record, be sure to add it to the operators who need access to the department or practice and to records that need to be available for use by operators who have access to the new department or practice.

Each department or practice must be associated with 1 division.

GL Sub-Account#1

Intended for use with the GL Export utility.

Use this box to store the numeric value assigned to this segment of the general ledger (GL) account number.

GL Sub-Account#2

Intended for use with the GL Export utility.

Use this box to store the numeric value assigned to this segment of the general ledger (GL) account number.

Other Address (only if different from above)

Optional: The address you enter must be different from the main address at the top of the window. Use these boxes if you entered a PO Box in the main address.

Keep the following items in mind when you enter the other address:

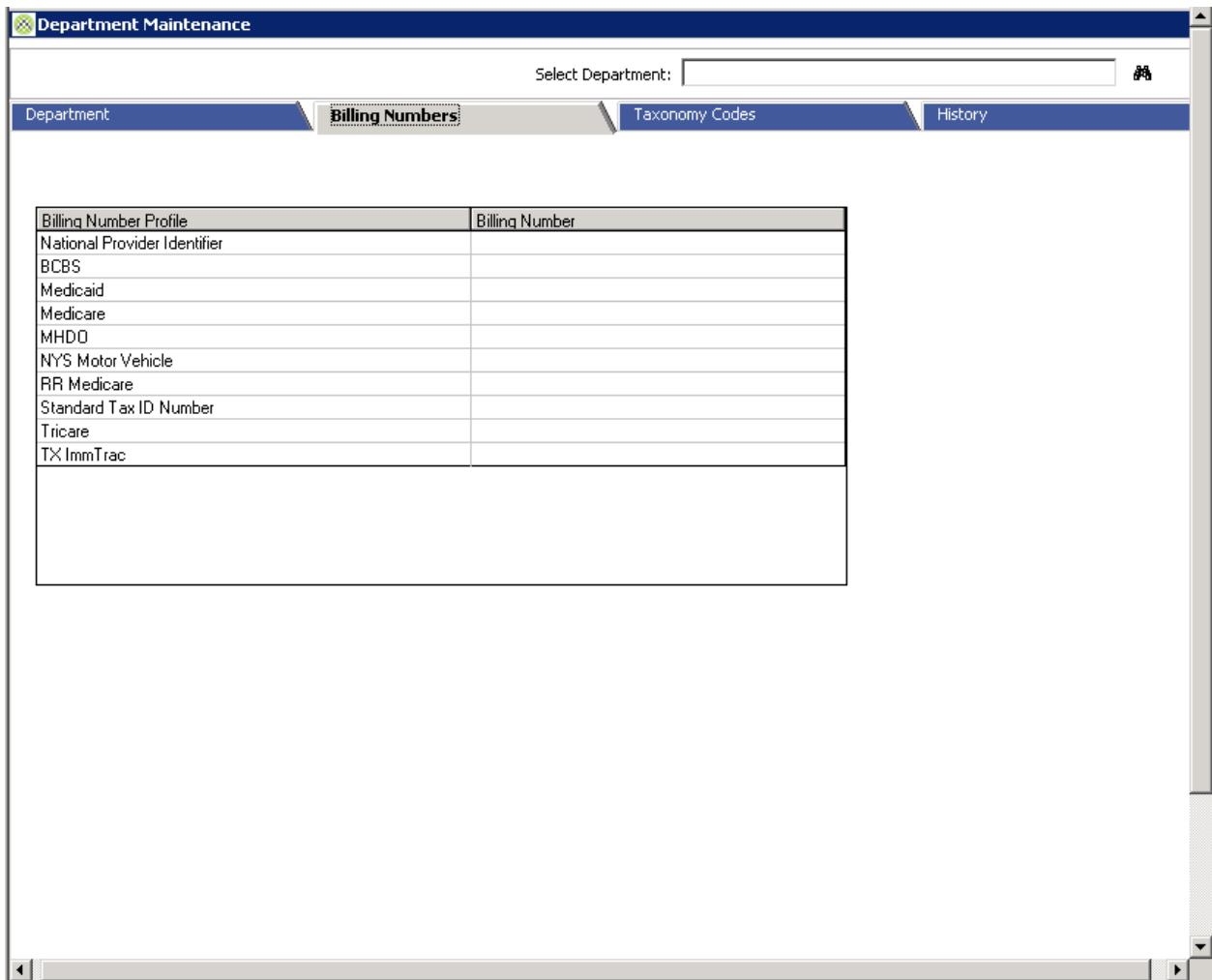
- > You cannot partially fill the **Other Address** area. For example, if only **Address 1** is different from the main address, you must fill each required box in the **Other Address** area, not only **Address 1**. If you fill all of the boxes in the **Other Address** area, you will not get an error if optional boxes, such as **Address 2** or **Country**, are filled.
- > For v5010 electronic claims, you must enter a ZIP Code plus 4. If you do not know your 4-digit additional number, use <your ZIP Code>-9998. For example, enter 27615-9998.
- > For v5010 electronic claims, the other address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Department** or **Practice**, and **Billing Method Address** in **Claims Style Maintenance** is set to **Billing Method Other Address**. Use this other address to output either billing provider information to Loop 2010AA or pay-to address information to Loop 2010AB. The information in these boxes does not output to a v4010 claim file.
- > For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the other address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Department** or **Practice**, and **Billing Media** and **Billing Method Address** in **Claims Style Maintenance** are set to **Paper** and **Billing Method Other Address** respectively.

Billing Numbers tab in Department Maintenance or Practice Maintenance

Use this tab to record the billing numbers assigned to your practice. Generally, these are group numbers or numbers that apply to every member of your practice.

Numbers from this tab print on a claim form or output to a claim file when **Department** is selected as the billing number option in **Paper Claim Format Maintenance** or **Electronic Claim Format Maintenance**.

Access the **Billing Numbers** tab from **Department Maintenance** or **Practice Maintenance**. To access **Department Maintenance** or **Practice Maintenance**, go to **System Administration > File Maintenance** and select **Department Maintenance** or **Practice Maintenance** from the list as applicable, or press **F9** and enter **DEM** or **PAM** as applicable.



Taxonomy Codes tab in Department Maintenance or Practice Maintenance

The taxonomy codes entered on this tab are used when you submit claims if the billing method is set to **Department** or **Practice** and at least 1 of the output options related to outputting the rendering, billing, or performing provider's taxonomy code is selected for the claim style associated with the carrier. The actual number reported in the electronic file or printed on a claim is determined by the profile that matches the taxonomy code profile selected for the carrier in **Insurance Carrier Maintenance**.

Access the **Taxonomy Codes** tab from **Department Maintenance** or **Practice Maintenance**. To access **Department Maintenance** or **Practice Maintenance**, go to **System Administration >**

File Maintenance and select **Department Maintenance** or **Practice Maintenance** from the list as applicable, or press **F9** and enter **DEM** or **PAM** as applicable.

Department Maintenance

Select Department:

Department Billing Numbers **Taxonomy Codes** History

Taxonomy Code Profile	Taxonomy Code
National Provider Identifier	
BCBS	
Medicaid	
Medicare	
MHDO	
NYS Motor Vehicle	
RR Medicare	
Standard Tax ID Number	
Standard UPIN	
Tricare	
TX ImmTrac	

First Previous Next Last New Delete Save Cancel



Chapter 3 Multiple Entity File Maintenance

Chapter 4

Registration File Maintenance

Registration File Maintenance setup checklist

The file maintenance covered in this section deals with functions that you perform in **Patient Management** and particularly when you register a patient.

Use this checklist to record the completion of each maintenance record.

Maintenance	Completed
Zip Code Maintenance (ZCM)	
Account Type Maintenance (ATM)	
Relationship Maintenance (REL)	
Employer Maintenance (EMM)	
Medical Record Location Maintenance (MRM)	
Note Type Maintenance (NTM)	
Income Guideline Maintenance (IUM)	
Sliding Fee Scale Maintenance (SFM)	
Image Category Maintenance (IMM)	
Registration tab on Practice Options or Organization Options (POP or OOP)	

Zip Code Maintenance window

Use **Zip Code Maintenance** to add, change, or delete ZIP Code records used for ZIP Code validation, as well as correct any inaccurate ZIP Codes entered before validation was enabled.

If you are using replication, changes made in **Zip Code Maintenance** are not replicated to other tenants. You must manage ZIP Codes independently in each tenant.

Zip Code Maintenance contains three tabs:

> **Zip Code**

Use this tab to add, change, or delete ZIP Code records used for ZIP Code validation.

> **Corrections**

Use this tab to adjust any inaccurate ZIP Codes entered on patient and file maintenance records.

> **History**

Zip Code Maintenance is only available when **Enable Zip Code Validation** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Access **Zip Code Maintenance** from **System Administration > File Maintenance > Zip Code Maintenance**.

Tip: To quickly access **Zip Code Maintenance**, press **F9**, then enter **ZCM**.

Zip Code tab

Use the **Zip Code** tab to add, change, or delete ZIP code records that are used for ZIP code validation in **Patient Management > Registration**.

Note: ZIP code validation is only performed on zip codes in **Registration**. For other areas in Allscripts® Practice Management, incorrect ZIP codes must be corrected on the **Corrections** tab in **System Administration > File Maintenance > Zip Code Maintenance**.

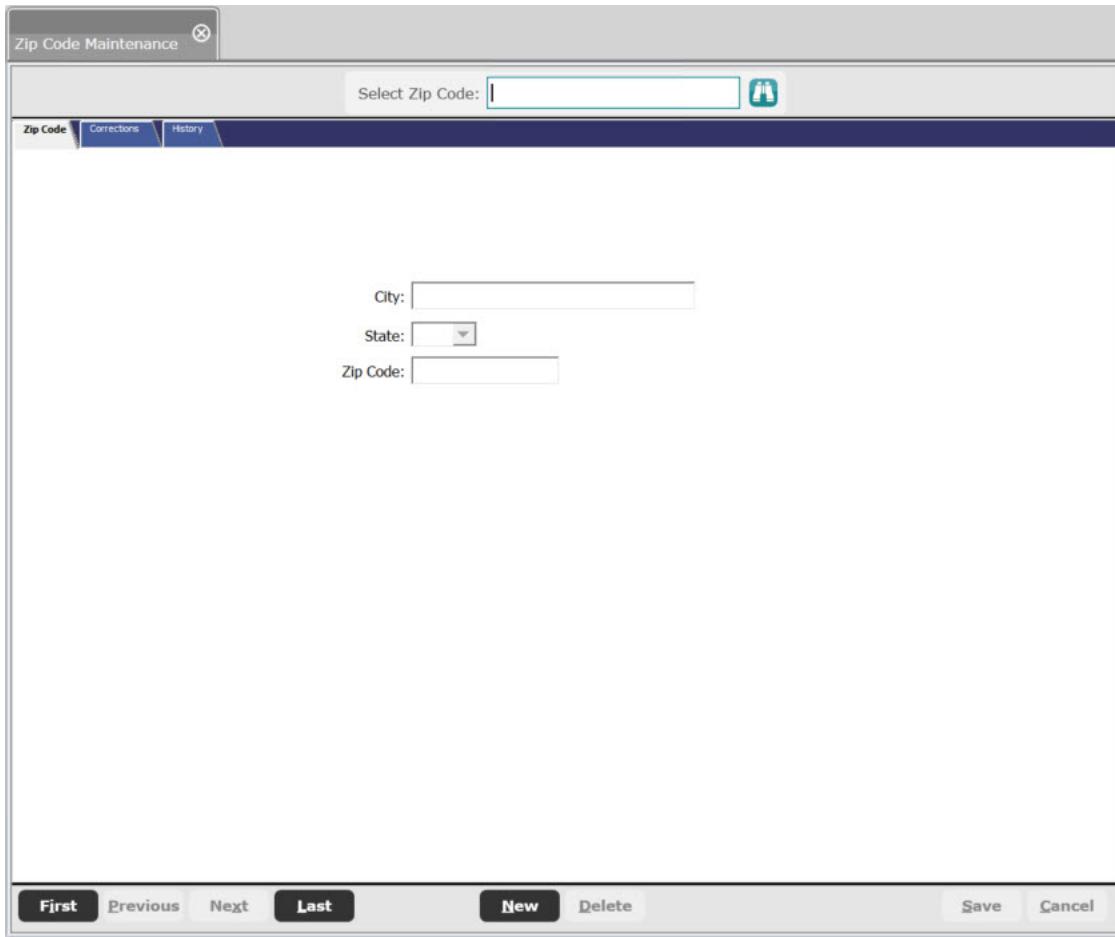
To enable the **Zip Code** tab, select **Enable Zip Code Validation** on the **General** tab in **System Administration > Practice Options** or **Organization Options**.

When enabled, you can access the **Zip Code** tab on **Zip Code Maintenance** and **Add New Zip Code**.

To open **Zip Code Maintenance**, go to **System Administration > File Maintenance > Zip Code Maintenance**.

Tip: To quickly access **Zip Code Maintenance**, press **F9**, then enter **ZCM**.

To open **Add New Zip Code**, go to **Zip Code Lookup** by clicking  next to a ZIP code box. Then, click **New Zip Code** on **Zip Code Lookup**.



The screenshot shows the 'Zip Code Maintenance' window. At the top, there's a search bar labeled 'Select Zip Code:' with a magnifying glass icon. Below the search bar is a navigation bar with tabs: 'Zip Code' (selected), 'Corrections', and 'History'. The main area contains three input fields: 'City:' with a text input field, 'State:' with a dropdown menu, and 'Zip Code:' with a text input field. At the bottom of the window are buttons for navigating through records ('First', 'Previous', 'Next', 'Last') and performing actions ('New', 'Delete', 'Save', 'Cancel').

City

Enter the name of a city.

You can enter up to 30 characters, including special characters (such as + and *), numbers, and spaces.

Best Practice: Do not include commas (,) or vertical bars (|) in city names. When importing or exporting ZIP code records from a comma-delimited file, city names cannot include commas. Likewise, for a pipe-delimited file, city names cannot include vertical bars.

State

Enter or select a state abbreviation code. You can enter up to three characters.

Zip Code

Enter a 5-digit ZIP code.

If you enter more than five digits, the ZIP code is truncated to a length of five digits. This is because ZIP code validation only applies to the first five digits of a ZIP+4 code.

The combination of **City**, **State**, and **Zip Code** must be unique.

When you use **Previous** or **Next**, ZIP code records are displayed in the following order.

- > ZIP code
- > City
- > State

For example, if ZIP code 99999 includes CITY-A and CITY-B, when you use **Next**, the record for CITY-A is displayed before CITY-B.

Note: **Previous** and **Next** are only available when you access the **Zip Code** tab from **Zip Code Maintenance**.

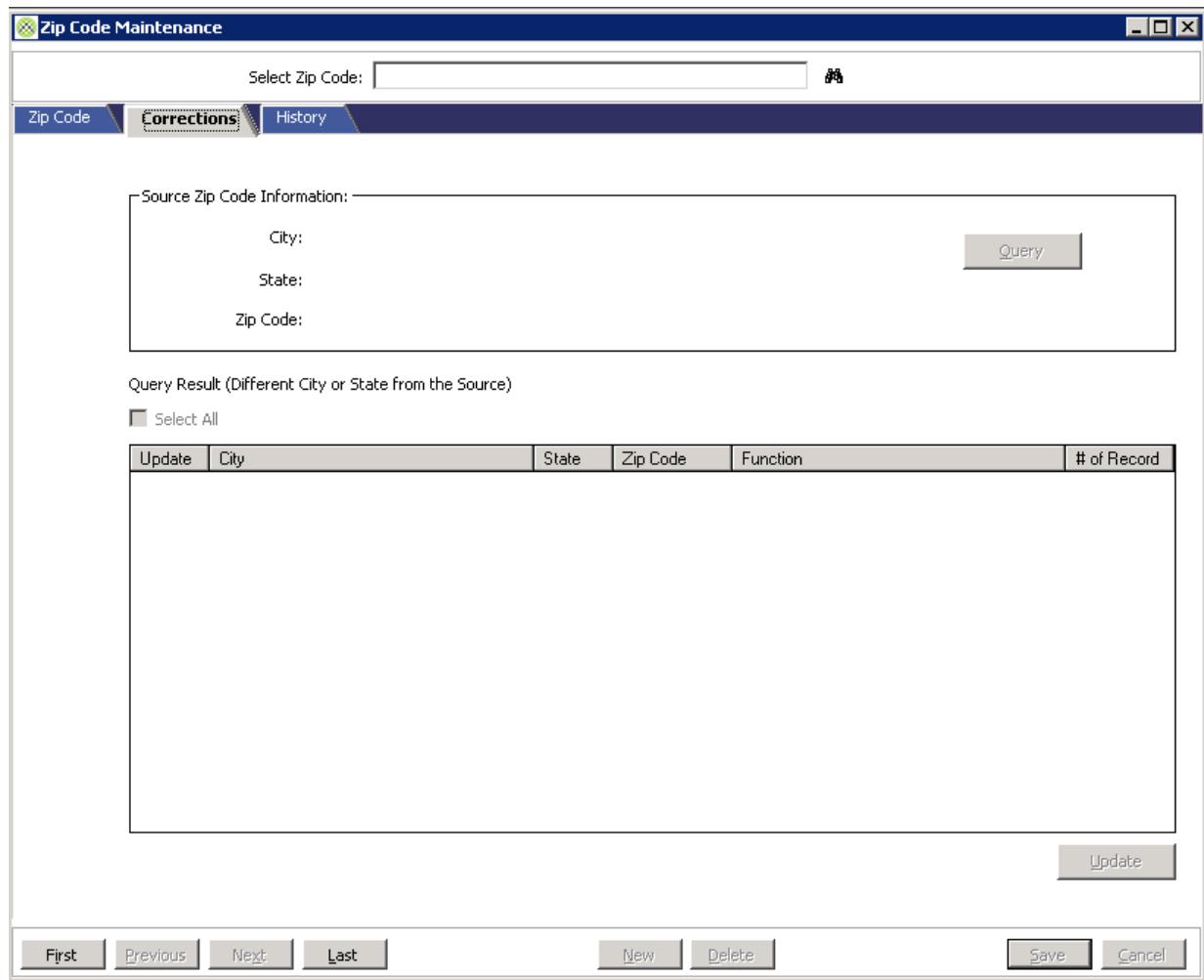
Corrections tab

Use the **Corrections** tab to adjust any inaccurate ZIP Codes entered on patient and file maintenance records.

The **Corrections** tab is only available when **Enable Zip Code Validation** is selected on the **General** tab in **System Administration > Practice Options** or **Organization Options**.

Access the **Corrections** tab from **System Administration > File Maintenance > Zip Code Maintenance**.

Tip: To quickly access **Zip Code Maintenance**, press **F9**, then enter **ZCM**



Source Zip Code Information

Displays the city, state abbreviation, and ZIP Code for your tenant from the database table used for ZIP Code validation that is associated with the ZIP Code in **Select Zip Code**. This information is read-only.

Query button

Finds addresses for your tenant that match the value in **Select Zip Code** but have a city or state abbreviation that does not match the value in the **Source Zip Code Information** area. The query searches specific functions in the application.

- > **Registration**
- > **Insurance Carrier Maintenance - Alternate Info**
- > **Insurance Carrier Maintenance**
- > **Department Maintenance**

- > **Employer Maintenance**
- > **Employer Maintenance-Employer Location**
- > **Location Maintenance - Alternate Info**
- > **Location Maintenance**
- > **Medical Record Maintenance**
- > **Pharmacy Maintenance**
- > **Place of Service Maintenance**
- > **Registration - Potential Patient**
- > **Practice Set Up**
- > **Organization Set Up**
- > **Provider Maintenance**
- > **Referring Doctor Maintenance**
- > **Scheduling Department Maintenance**

Query Result grid

Displays the query results. Select the **Update** check box for each of the query result rows to change to the values in **Source Zip Code Information** for that row. The number of records that will be updated is displayed in the **# of Records** column.

Select All

Selects all rows in the **Query Result** grid.

Update button

Updates query result records in the tenant database with the values in **Source Zip Code Information**.

CAUTION: After you click **Update**, the changes made to the database are not reversible.

Account Type Maintenance window

Account types are custom-defined financial categories related to an account's self-pay status.

Access **Account Type Maintenance** from **System Administration > File Maintenance > Account Type Maintenance** or press **F9** and then enter **ATM**.

Account Type Maintenance

Select Account Type:	<input type="text"/>	
Abbreviation:	<input type="text"/>	
Description:	<input type="text"/>	
<input type="checkbox"/> Hold Statements <input type="checkbox"/> Hold Dunning		
Warning Flag <ul style="list-style-type: none"> <input checked="" type="radio"/> None <input type="radio"/> Yellow Flag <input type="radio"/> Red Flag <input type="radio"/> Red Flag & General Warning <input type="radio"/> Red Flag & Scheduling Warning 		
First	Previous	Next
Last	New	Delete
		Save
		Cancel

Abbreviation

The abbreviation can be up to 8 characters long and must be unique (that is, not used for any other account type).

Description

The description can be up to 40 characters long. Use the description to briefly explain the purpose of this account type. The description is displayed in selection lists and windows throughout the application.

Hold Statements

Prevents a billing statement from being printed for patients given this account type. You can hold a patient's vouchers from qualifying for patient billing on 3 levels:

- > **Voucher level** holds apply to a specific voucher only.

- > **Patient level** holds apply to the specified patient and is set for a limited time span.
- > **Account Type level** holds apply to all the vouchers of all patients that have the same account type.

Hold Dunning

Prevents dunning messages from printing on statements for patients with this account type.

Warning Flags

Warning flags are used to catch the attention of the staff and alert them to follow through on a practice or organization defined policy and procedure. The selections are:

None

Selected by default. None of the warning message or flags are displayed.

Yellow Flag

A yellow flag  is displayed in the following places in the application when a patient has an account type with a yellow flag warning:

- > **Registration > Summary** to the left of **Account Type**
- > **Registration COMpanion**
- > **Registration > Account**
- > **Financial Inquiry > Account Inquiry** and **Financial Inquiry > Payment History**
- > **Account Inquiry** and **Payment History** tabs in **Financial Inquiry COMpanion**
- > **Scheduling > Patient Info** to the left of **Account Type**

Red Flag

A red flag  is displayed in the following places in the application when a patient has an account type with a red flag warning:

- > **Registration > Summary** to the left of **Account Type**
- > **Registration COMpanion**
- > **Registration > Account**
- > **Financial Inquiry > Account Inquiry** and **Financial Inquiry > Payment History**
- > **Account Inquiry** and **Payment History** tabs in **Financial Inquiry COMpanion**
- > **Scheduling > Patient Info** to the left of **Account Type**

Red Flag and General Warning

A red flag  is displayed in the following places in the application when a patient has an account type with a red flag and general warning:

- > **Registration > Summary** to the left of **Account Type**
- > **Registration COMpanion**

- > **Registration > Account**
- > **Financial Inquiry > Account Inquiry** and **Financial Inquiry > Payment History**
- > **Account Inquiry** and **Payment History** tabs in **Financial Inquiry COMpanion**
- > **Scheduling > Patient Info** to the left of **Account Type**
- > **Registration**, **Financial Inquiry**, and the **Patient Scheduling** tab, when accessing a patient
- > On the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs when accessing **Appointment Detail** or any context menu option that accesses the patient's record
- > In **Office Manager > Appointment Management**, when accessing appointment detail or any context menu option that accesses the patient's record

Red Flag and Scheduling Warning

When you select this option, a warning message is displayed in the following instances in **Scheduling** only:

- > On the **Patient Scheduling** tab when accessing the patient
- > On the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs when accessing appointment detail or any context menu option that accesses the patient's record
- > In **Office Manager > Appointment Management**, when accessing appointment detail or any context menu option that accesses the patient's record

Warnings are not generated in **Registration** or **Financial Inquiry**, and users are not prevented from scheduling an appointment for patients with this warning.

A red flag  displays in the following places in the application when a patient has an account type with a red flag and scheduling warning:

- > **Registration > Summary** to the left of **Account Type**
- > **Registration COMpanion**
- > **Registration > Account**
- > **Financial Inquiry > Account Inquiry** and **Financial Inquiry > Payment History**
- > **Account Inquiry** and **Payment History** tabs in **Financial Inquiry COMpanion**
- > **Scheduling > Patient Info** to the left of **Account Type**

Relationship Maintenance window

Use **Relationship Maintenance** to create the relationships that you can select for **Relation to Patient** on the **Account** tab in **Patient Management > Registration**.

The following values are predefined in **Relationship Maintenance**:

- > **Child**
- > **Father**
- > **Guardian**
- > **Mother**
- > **Other**
- > **Parent**
- > **Self**
- > **Sibling**
- > **Spouse**

You can delete a predefined record if that relationship value has not been used elsewhere in the application.

The relationship values that you create in **Relationship Maintenance** are not displayed in **Rel to Guar** on the **Patient** tab or **Patient's Relationship** on the **Policies** tab.

Relationship Maintenance contains these tabs:

- > **Relationship**
- > **History**

To access **Relationship Maintenance**, go to **System Administration > File Maintenance > Relationship Maintenance**, or press **F9** and then enter **REL**.

Relationship tab

Use the **Relationship** tab in **Relationship Maintenance** to create the relationships that you can select for **Relation to Patient** on the **Account** tab in **Patient Management > Registration**.

Access the **Relationship** tab from **Relationship Maintenance**. To access **Relationship Maintenance**, go to **System Administration > File Maintenance > Relationship Maintenance**, or press **F9** and then enter **REL**.

Relationship Maintenance X

Select Relationship: 

Relationship  **History** 

Abbreviation:

Description:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Abbreviation

Required entry. This box contains the abbreviation for this relationship. Each relationship must have a unique abbreviation.

Description

Required entry. This box contains the description for this relationship. Each relationship must have a description.

Employer Maintenance window

Use **Employer Maintenance** to maintain employer information.

You can also create new employer records in **Registration** on both the **Patient** tab and the **Account** tab.

Employer Maintenance contains these tabs:

- > **Employer**
- > **Employer Location**
- > **Payer**
- > **Benefit Plans**

All information on the **Employer** and **Employer Location** tabs is included in replication. The value for **Inactive Date** is replicated only on initial entry because that date is editable in target tenants. The information on the **Payer** tab is not included in replication.

All information on the **Employer** and **Employer Location** tabs is included with starter data sets that have the **Employer Information** information type. All information on the **Payer** tab is included with starter data sets that have the **Carrier Information** information type.

Access **Employer Maintenance** from **System Administration > File Maintenance > Employer Maintenance**, or press **F9** and then enter **EMM**.

Employer tab

Use the **Employer** tab in **Employer Maintenance** to maintain employer information.

Employer information that is required for paper or electronic claim formats is retrieved from various fields on the record in file maintenance. For this reason, never use punctuation, such as a period, to fill free-text boxes.

Tip: When, for example, you do not know the employer's address, enter Unknown in the box. If you do not know the employer's state, select the state where your practice is located.

Access **Employer Maintenance** from **System Administration > File Maintenance > Employer Maintenance**, or press **F9** and then enter **EMM**.

Employer Maintenance

Select Employer:		<input type="button" value=""/>		
Employer	<input type="button" value="Employer Location"/>	<input type="button" value="Payer"/>	<input type="button" value="Benefit Plans"/>	<input type="button" value="History"/>
Employer Abbreviation:	<input type="text"/>			
Employer Name:	<input type="text"/>			
Address 1:	<input type="text"/>			
Address 2:	<input type="text"/>			
City:	<input type="text"/>	State:	<input type="button" value=""/>	<input type="checkbox"/> Tax Exempt
Zip Code:	<input type="text"/>	Country:	<input type="text"/>	
Telephone:	<input type="text"/>	Ext:	<input type="text"/>	
Fax:	<input type="text"/>			
E-Mail:	<input type="text"/>			
Website:	<input type="text"/>			
Contact Name:	<input type="text"/>			
<input type="button" value="First"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Last"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>				

Employer Abbreviation

Required. A unique abbreviation of up to 20 alphanumeric characters; avoid special characters.

Employer Name

Required. A unique name of up to 60 alphanumeric characters.

Address

Required. The first address line, city, and two-character state abbreviation.

Optional. The second address line, ZIP code, and two-character country abbreviation.

Telephone and Ext

A phone number and, if applicable, an extension.

Fax

A fax number.

E-Mail

An email address.

Website

The URL for the employer's website.

Contact Name

A name of a contact for the employer.

Tax Exempt

Select to indicate that the employer is tax-exempt.

Inactive Date

The date when the employer became (or will become) inactive, if applicable. When you enter an inactive date, all employer locations associated with the employer are also made inactive.

Employer Location tab

Use the **Employer Location** tab in **Employer Maintenance** to associate an employer location with its employer.

Employer location records are displayed in the grid at the top of the tab. They are sorted by **Location Name** then **State** regardless of whether the employer location is inactive.

Inactive employer location records are displayed in **Case Management** with **Inactive** following the name.

Use the drop-down lists above the grid columns to filter the locations.

Access the **Employer Location** tab from **Employer Maintenance**. To access **Employer Maintenance**, go to **System Administration > File Maintenance**, or press **F9** and then enter **EMM**.

Employer Maintenance

Select Employer: 

Employer Location

Filter Employer Location Information

Location Name	Address	City	State	Zip

Employer Loc Abbreviation:

Employer Location Name: Inactive Date:

Address 1:

Address 2:

City: State:

Zip Code: Country:

Telephone: Ext:

Fax:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Employer Loc Abbreviation

Required. A unique abbreviation of up to 20 alphanumeric characters; avoid special characters.

Employer Location Name

Required. A name of up to 60 alphanumeric characters.

 **Best Practice:** Make the employer location name unique.

Address

Required. The first address line, city, and two-character state abbreviation.

Optional. The second address line, ZIP code, and two-character country abbreviation.

Telephone and Ext

A phone number and, if applicable, an extension.

Fax

A fax number.

Inactive Date

The date when the employer location became (or will become) inactive, if applicable.

Payer tab

Use the **Payer** tab in **Employer Maintenance** to associate insurance carriers (payers) with an employer.

Associating an insurance carrier with an employer enables the application to automatically add the payer to a workers' compensation case when the employer and date of injury are selected in **Case Management**.

You must have security access to *Workers Comp* under **Practice Management > Patient Management > Coverage Type** in **Security Permissions** to search for and add a new insurance carrier.

Payer records are displayed in the grid at the top of the tab. Active payers are displayed first sorted by **Type of Payer** followed by inactive payers sorted by **Expiration Date** then **Type of Payer**.

Access the **Payer** tab from **Employer Maintenance**. To access **Employer Maintenance**, go to **System Administration > File Maintenance > Employer Maintenance**, or press **F9** and then enter **EMM**.

Employer Maintenance

Select Employer: 

Employer  Employer Location  **Payer**  History 

Type of Payer	Carrier	Expiration Date
<input type="text"/>	<input type="text"/> 	<input type="text"/>

Type of Payer:

Carrier: 

Expiration Date: 

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Type of Payer

Required. Select from:

- > **Injury**
- > **Pharmacy**
- > **Specialist**
- > **Therapy**

A given payer type can have one active payer only.

Carrier

Required. Select an insurance carrier.

The list contains the carriers that have a **Workers' Comp** coverage type in **Insurance Carrier Maintenance**. Alias and collection insurance carriers are excluded from the list.

After you associate an insurance carrier with an employer, you cannot change the coverage type for the carrier in **Insurance Carrier Maintenance** manually or by using the **Change Coverage Type** utility.

Expiration Date

Enter a date when the payer should no longer be associated with the insurance carrier.

When this box is blank, the payer is active.

Benefit Plans tab in Employer Maintenance

Use the **Benefit Plans** tab in **Employer Maintenance** to add the benefit plans in which the employer participates.

Plan participation records are displayed in the grid at the top of the tab. Records are displayed sorted by **Carrier**, **Benefit Plan Name**, and **Participation Exp Date**. When multiple records have the same carrier and benefit plan name, the records without an expiration date are displayed first.

Benefits plans that are linked to carriers are displayed automatically in **Link Employers to Benefit Plans**, which is opened from the **Benefit Plans** tab in **Insurance Carrier Maintenance**.

Access the **Benefit Plans** tab from **Employer Maintenance**. To access **Employer Maintenance**, go to **System Administration > File Maintenance > Employer Maintenance**, or press **F9** and then enter **EMM**.

(New Employer) 

Employer Maintenance

Select Employer: (New Employer) 

Employer  Employer Location  Payer  **Benefit Plans**  History 

Benefit Plan Code	Carrier	Benefit Plan Name	Participation Eff Date	Participation Exp Date
 				

Benefit Plan Detail

Carrier: <input type="text"/>		Benefit Plan Name: <input type="text"/>					
Benefit Plan Eff Date: <input type="text"/>	No. of Benefit Tiers :						
Benefit Plan Exp Date: <input type="text"/>	Employer Co-Pay/Co-Ins Eff and Exp Dates:	 					
Participation Eff Date: <input type="text"/>		Effective Date <input type="text"/> Expiration Date <input type="text"/>					
Participation Exp Date: <input type="text"/>							
<input type="checkbox"/> PCP Required <input type="checkbox"/> Select All Capitated			Collapse All				
Priority	Benefit Covered Service	Capitated	Benefit Tier	Co-Pay or Co-Ins	Referral Reqd.	With Referral	No Referral

Note: The Co-Pay/Co-Ins shown above are Employer variations for the selected Effective and Expiration Date.
Blank implies there are no Employer variations to the Co-Pay/Co-Ins as defined by the Carrier.

First Previous Next Last New Delete  

Carrier

Required. Click  to select an insurance carrier and benefit plan. Only carriers with at least one defined benefit plan are displayed in the search results.

After you select a carrier and benefit plan, the following benefit plan information from **Insurance Carrier Maintenance** is displayed as read-only:

- > Plan name and code
 - || **Note:** If the plan name or code is followed by ellipse (...), point to either to view the full name or code.
- > Effective and expiration dates
- > Benefit covered service information

Benefit plan effective and expiration dates

These dates are read-only as defined in **Insurance Carrier Maintenance**.

Participation Eff Date

Required. Manually enter the date that the employer starts participating in the plan, or select the participation start date using the calendar.

Participation Exp Date

If applicable, manually enter the date that the employer stops participating in the plan, or select the participation stop date using the calendar.

Note: **Participation Exp Date** can be blank for the participation record with the most current effective date.

Benefit plan name and code

The benefit plan name and code are displayed. Click the benefit plan code to open **View Benefit Plan Details**.

No of Benefit Tiers

Displays the number of tiers defined for the benefit plan in **Insurance Carrier Maintenance**. The display is read-only.

Employer Co-Pay/Co-Ins Eff and Exp Dates grid

Enter the co-insurance and co-pay date ranges for the benefit plan if they are different from the dates defined on the **Benefit Plans** tab in **Insurance Carrier Maintenance**.

PCP Required

Displays the corresponding value in **Insurance Carrier Maintenance** indicating whether the selection of a primary care provider (PCP) on the **Policies** tab in **Registration** is required. The display is read-only.

Select All Capitated

Select this option to have the application select **Capitated** for all benefit covered services in the benefit covered services grid for the selected benefit plan.

Benefit covered services grid

Use this grid only if the employer has specific co-pay or co-insurance during the participation period that is different from the co-pay and co-insurance that is defined for the insurance carrier. If the employer adheres to the carrier-defined co-pay and co-insurance, do not enter anything in this grid.

Click a row in the **Employer Co-Pay/Co-Ins Eff and Exp Dates** grid to specify the date ranges within the employer's participation period if you must define in-network and out-of-network co-pay and co-insurance.

Use **Expand All** and **Collapse All** to show or hide all rows in the benefit covered services grid. When you click **Expand All**, it changes to **Collapse All** and the reverse.

Use  and  to show or hide the benefit tier details for a specific benefit covered service. When you click , it changes to  and the reverse.

Priority, **Benefit Covered Service**, and **Benefit Tier** are read-only. Point to **Benefit Covered Service** to view the description in **Benefit Covered Service Maintenance**.

Select **Capitated** to indicate that a benefit covered service is capitated.

Note: The check box is only available for benefit covered service rows.

Co-Pay or Co-Ins is required. Indicate whether copay or coinsurance applies to the benefit tier.

Select **Referral Reqd** to indicate that a referral is required for the benefit tier.

- > If you select **Co-Pay**, enter dollar amounts in **With Referral** and **No Referral**.
- > If you select **Co-Ins**, enter percentages in **With Referral** and **No Referral**.

If the copay or coinsurance charges for a benefit covered service are zero, enter \$0.00 or 0.00% in **With Referral** and **No Referral** for the corresponding benefit tier. If there are no copay or coinsurance charges for a benefit covered service, leave **No Referral** and **Without Referral** blank for the corresponding benefit tier.

Do not enter negative values for a copayment or coinsurance.

When rows are added or deleted in the benefit covered services grid in **Insurance Carrier Maintenance** for the selected insurance carrier, the changes are reflected in this grid.

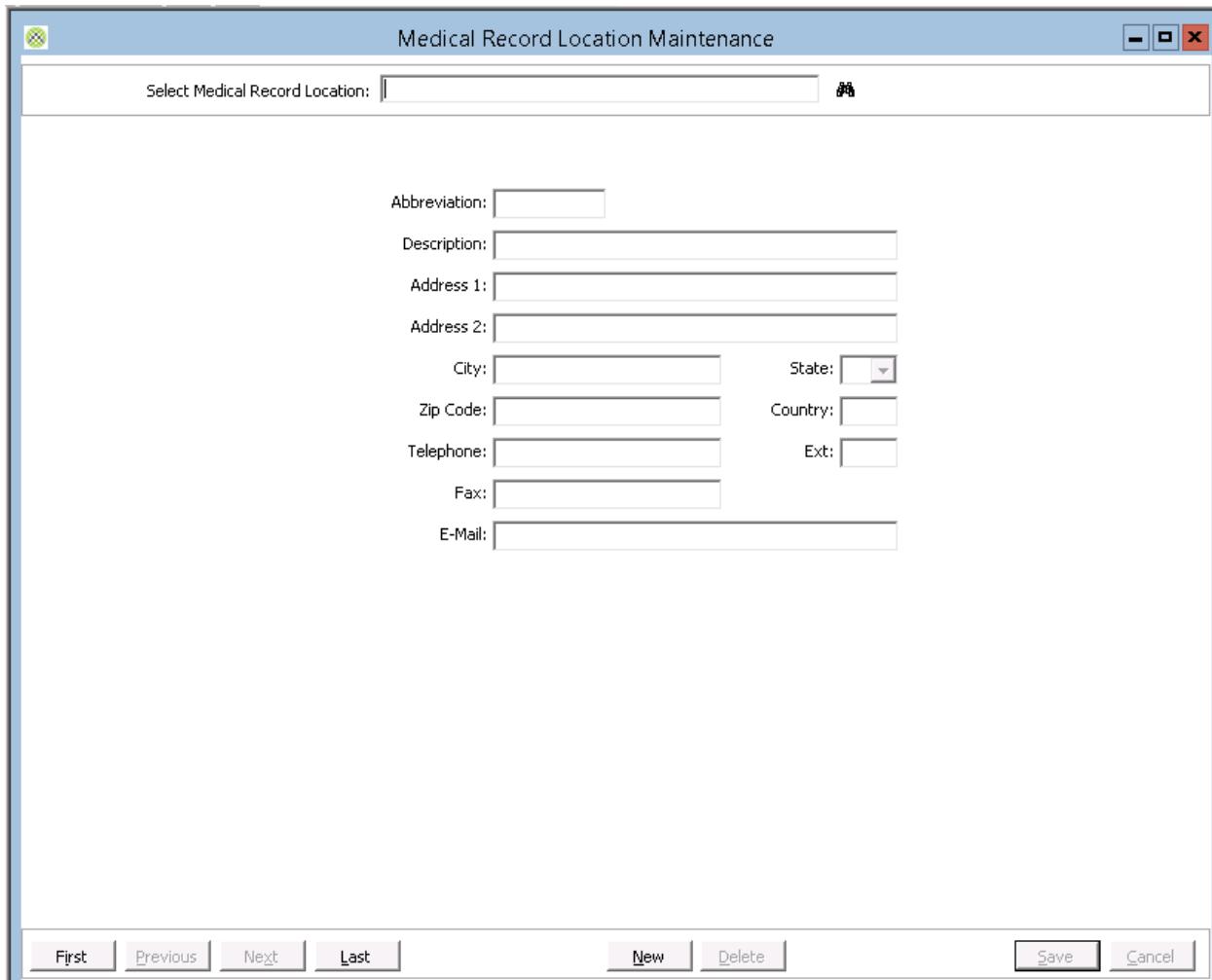
Medical Record Location Maintenance window

Creating medical record locations is especially useful if you have multiple locations for filing patient charts.

Tip: Create records only if you have selected **Enter Med. Rec. Loc. in Practice Options** or **Organization Options**

Medical record locations are selected for each patient in **Registration**.

Access **Medical Record Location Maintenance** from **System Administration > File Maintenance > Medical Record Location Maintenance** or press **F9** and then enter **MRM** as applicable



Note Type Maintenance window

Use **Note Type Maintenance** to create notes that you can attach to a patient's record. Think of notes as the computer equivalent of sticky notes on a patient's record.

Note Type Maintenance contains these tabs:

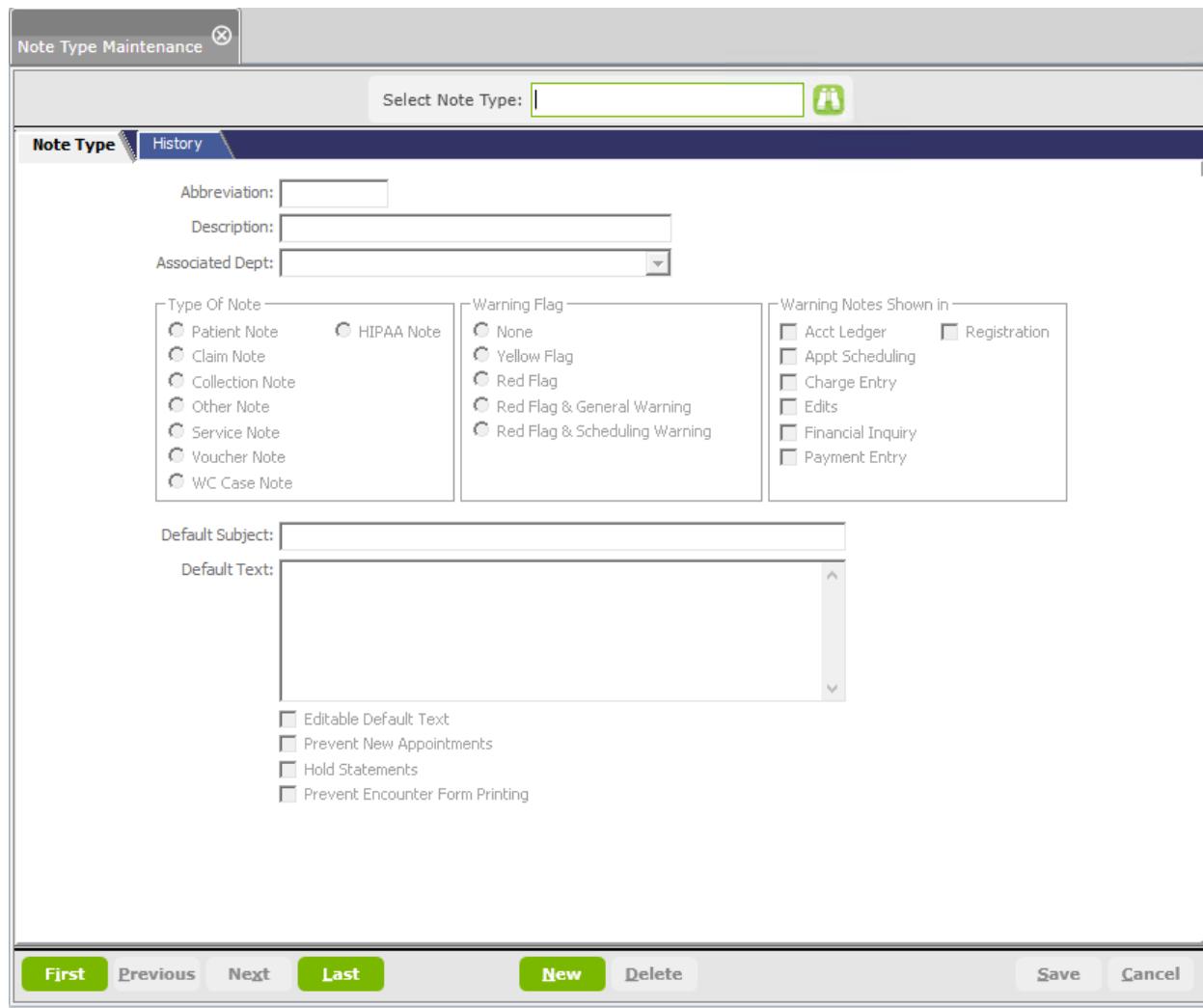
- > Note Type
- > History

Access **Note Type Maintenance** from **System Administration > File Maintenance > Note Type Maintenance**, or press **F9** and then enter **NTM**.

Note Type tab

Use the **Note Type** tab in **Note Type Maintenance** to create notes that you can attach to a patient's record. Think of notes as the computer equivalent of sticky notes on a patient's record.

Access **Note Type Maintenance** from **System Administration > File Maintenance > Note Type Maintenance**, or press **F9** and then enter **NTM**.



The screenshot shows the 'Note Type Maintenance' window with the 'Note Type' tab selected. The interface includes a search bar at the top labeled 'Select Note Type:' with a magnifying glass icon. Below the search bar are fields for 'Abbreviation' (text input), 'Description' (text input), and 'Associated Dept' (dropdown). On the left, a group of radio buttons labeled 'Type Of Note' includes 'Patient Note' (selected), 'Claim Note', 'Collection Note', 'Other Note', 'Service Note', 'Voucher Note', and 'WC Case Note'. To the right of these are groups for 'Warning Flag' (radio buttons for 'None', 'Yellow Flag', 'Red Flag', 'Red Flag & General Warning', and 'Red Flag & Scheduling Warning') and 'Warning Notes Shown in' (checkboxes for 'Acct Ledger', 'Appt Scheduling', 'Charge Entry', 'Edits', 'Financial Inquiry', and 'Payment Entry', where 'Acct Ledger', 'Appt Scheduling', 'Charge Entry', and 'Edits' are checked). Below these are 'Default Subject' (text input) and 'Default Text' (text area with scroll bars). At the bottom are checkboxes for 'Editable Default Text', 'Prevent New Appointments', 'Hold Statements', and 'Prevent Encounter Form Printing'. Navigation buttons at the bottom include 'First', 'Previous', 'Next', 'Last', 'New' (highlighted in green), 'Delete', 'Save', and 'Cancel'.

Abbreviation

Holds up to 8 characters. The abbreviation must be unique and not used for any other note type. Abbreviations are displayed in the history grid in **Note Management**.

Description

Holds up to 40 characters. The description displays in the drop down lists when note types are available, such as on **Note Management**.

Associated Dept / Pract

Intended for use with department security or practice security. If you do not have **Department Security** or **Practice Security** selected, it does not matter what you select for this box. Select a department or practice from the list to restrict user of this note type to users who have access to that department or practice.

Type of Note

Your selection determines how and where the note displays after it is added to a patient or account.

Warning Flags

Use to attach an importance level to a note. Warning flags can be attached to notes with a **Note Type of Patient, Other, Collection, and HIPAA**.

Certain notes types when coupled with a red flag and warning also give you the option to do the following:

- > Prevent the scheduling of new appointments for the patient or account
- > Hold statements from being printed for the patient or account
- > Prevent encounter forms from being printed for the account

Warning Notes Shown in

Enables you to select where warnings display for Patient, Collection, and Other Note Types that are flagged as Red Flag & General Warning.

When this pane is enabled the following selections are checked by default: Appt Scheduling, Financial Inquiry, and Registration. The user can uncheck any or all of these default selections.

Default Subject

Optional. Text you enter in **Default Subject** automatically fills **Subject** when you add a new note of this type to a patient or account. You can edit the default subject when adding the note. If you do not enter a default subject, you must enter a subject when you add the note.

Default Text

Available for Patient Note, Collection Note, Other Note, and HIPAA Note regardless of the Warning Flag setting

Editable default text

When checked you can edit the default text when a note is created or edited.

Note: You must have security permissions set to **Allow** for adding or editing a note.

Prevent New Appointments

Available when you have **Warning Flag** set to **Red Flag & General Warning** or a **Red Flag & Scheduling Warning**. Prevents you from scheduling any new appointments for a patient as of the time this note is attached to the record.

Note: This setting does not affect any appointments scheduled before you attach the note to the patient or account record.

Hold Statements

Available when **Note Type** is set to **Collection Note** or **Other Note**. Accounts with this note type are bypassed when you run statements. The name of the guarantor on the account is listed on the **Statement Audit List**.

Prevent Encounter Form Printing

Available for patient, collection, or other notes that have **Red Flag & Scheduling Warning** selected. If a note of this type is attached to a patient or account record, you cannot print an encounter form from **Appointment Scheduling**. Patients with this note type are also not included when batch printing encounter forms until the note is removed or the note type is changed to a type that does not prevent encounter forms from printing.

Important: Do not check both **Prevent New Appointments** and **Prevent Encounter Form Printing**.

Note types

Note types are custom templates used to add information to a patient or account record, or to remind your staff of actions to be taken. Think of notes as the computer equivalent of sticky notes.

Notes are added to patients or accounts from **Patient Management > Notes** using the toolbar buttons for adding notes:

- >  for HIPAA notes
- >  for all other kinds of notes

You can add notes from various areas in Allscripts® Practice Management depending on the note type.

Types of notes

Patient Note

Patient notes are specific to a claim. They cannot be viewed on the records of any other patients who share the same guarantor. They can prevent new appointments or prevent encounter forms from printing for the patient only.

You can add patient notes from the following areas in the application:

- > **Note Management**
- > The toolbar in the following windows:
 - Registration
 - Scheduling
 - Financial Inquiry
 - Charge Entry
 - Payment Entry
 - Edits
 - Collection Account Management

You can view patient notes from **Note Management**.

Claim Note

Claim notes are specific to a claim. You can add claim notes from the following areas in the application:

- > **Unpaid Claims Management**
- > **Account Ledger**

You can view claim notes from the following areas in the application:

- > **Note Management**
- > **Unpaid Claims Management**
- > **Pending Claims Management**
- > **Account Ledger**

You can print claim notes on the **Reimbursement Comment Analysis** report.

Collection Note

When added to a guarantor record, a collection note is displayed on records for all patients who share that guarantor. If **Hold Statement**, **Prevent New Appointment**, or **Prevent Encounter Form Printing** are selected, they apply to all patients who share that guarantor.

When added to a patient record, a collection note is displayed only on that patient's record and not on the record of any patients who share the same guarantor. If **Hold Statement**,

Prevent New Appointment, or **Prevent Encounter Form Printing** are selected, they apply only to that patient.

You can add collection notes from the following areas in the application:

- > **Note Management**
- > The toolbar in the following windows:
 - Registration
 - Scheduling
 - Financial Inquiry
 - Charge Entry
 - Payment Entry
 - Edits
 - Collection Account Management

You can view collection notes in **Note Management**.

You can print collection notes on the **Account Summary** and **Collection Account** reports.

Other Note

Other notes are a generic type of note specific to the patient's record. This type of note is displayed on the records of all other patients who share the same guarantor. You can use this note type to hold statements, prevent new appointments and prevent encounter forms from printing.

Note: When a **Hold Statement** or **Prevent Encounter Form Printing** is selected for a note type that is attached to a patient, the block applies to the patient and to all patients associated with the same guarantor.

You can add notes with a **Type of Other Note** from these areas in the application:

- > **Note Management**
- > The toolbar in the following windows:
 - Registration
 - Scheduling
 - Financial Inquiry
 - Charge Entry
 - Payment Entry
 - Edits
 - Collection Account Management

You can view notes with a **Type of Other Note** from **Note Management**.

Service Note

Service notes are specific to a service line on a voucher. You can add service notes from the following locations in the application:

- > **Payment Entry**, when applying payments by right-clicking on the service line
- > **Edits**, by right-clicking on the service line
- > **Account Ledger**

You can view service notes from the following locations in the application:

- > **Note Management**
- > **Account Inquiry** and **Payment Entry**, when selected as a view option

You can print service notes on the **Reimbursement Comment Analysis** report.

Voucher Note

Voucher notes are specific to a voucher. You can add voucher notes from the toolbar in these areas of the application:

- > **Financial Inquiry**
- > **Payment Entry**
- > **Edits**
- > **Pending Claims Management**
- > **Account Ledger**

You can view voucher notes in the following locations when it is selected as a view option:

- > **Note Management**
- > **Pending Claims Management**
- > **Account Ledger**
- > **Account Inquiry**
- > **Payment Entry**

You can print voucher notes on the **Reimbursement Comment Analysis** report.

WC Case Note

The option is available only when **Enable Workers' Comp Case** is selected on the **Case** tab in **Practice Options** or **Organization Options**.

When **WC Case Note** is selected, all options in the **Warning Flag** and **Warning Notes Shown in** areas are unavailable. **Default Subject**, **Default Text**, and **Editable Default Text** are available.

WC Case Note is included with starter data sets that have the **Note Type Information** information type.

HIPAA Note

HIPAA notes are specific to a single patient. They cannot be viewed on the records of other patients who share the same guarantor. HIPAA notes can be used to prevent new appointments. You can add and view HIPAA notes from the following areas in the application:

- > **Note Management**, when **HIPAA Notes** is selected
 - || **Note:** HIPAA notes cannot be added if you selected a guarantor instead of a patient.
- > The toolbar in **Registration** and **Scheduling**

Note type warning flags

You can use warning flags in **Note Type Maintenance** to attach an importance level to a note.

Certain note types, when coupled with a red flag and warning, also give you the option to do the following:

- > Prevent the scheduling of new appointments for the patient or account
- > Hold statements from being printed for the patient or account
- > Prevent encounter forms from being printed for the account

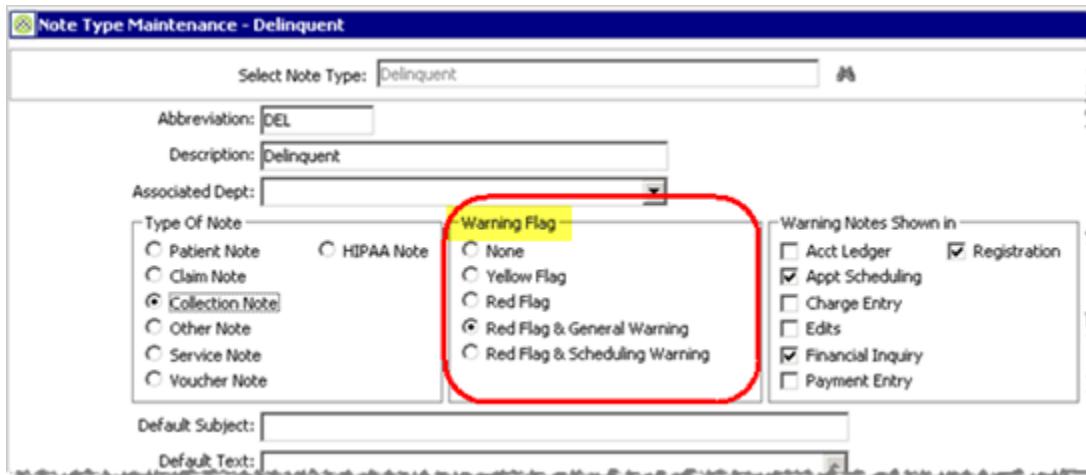
Types of notes you can attach a warning flag to

You can attach warning flags to notes that have **Note Type** on **Note Type Maintenance** set to any of the following:

- > **Patient Note**
- > **Collection Note**
- > **Other Note**
- > **HIPAA Note**

Attaching a warning flag to a note type

Attach a warning flag to a note tab by selecting an option for **Warning Flag** in **Note Type Maintenance**.



Note type warning flags

Yellow Flag

Displays a yellow flag in **Note Management**. Use to indicate that a note has a level of medium importance or priority.

Red Flag

Displays a red flag in **Note Management**. Use to indicate that a note has a level of high importance or priority.

Red Flag & General Warning

Displays a red flag in **Note Management** and generates a warning message in **Account Ledger, Appointment Scheduling, Charge Entry, Edits, Financial Inquiry, Payment Entry**, and **Registration**. Available for patient, collection, other, and HIPAA note types. Based on the note type, this warning flag enables you to prevent new appointments, hold statements, or prevent encounter forms from printing.

Red Flag & Scheduling Warning

Displays a red flag in **Note Management** and a warning message when the patient record is open in **Appointment Scheduling**. Available for patient, collection, other, and HIPAA note types. Based on the note type, this warning flag enables you to prevent new appointments, hold statements, or prevent encounter forms from printing.

Default text for notes

When you create default text for a note type, the default text automatically fills the main body of the note when you create a new note of that type. Default subjects automatically fill the **Subject** line for new notes of that type.

Default text for notes

You can create default text for notes with any of the following note types:

- > **Patient Note**
- > **Collection Note**
- > **Other Note**
- > **HIPAA Note**

Enter default text in the **Default Text** box in **Note Type Maintenance**. When you create default text for a note type, the default text automatically fills the main body of the note when you create a new note of that type from anywhere in the Allscripts® Practice Management application. If you select **Editable Default Text** when creating the note, users with permission to add or edit notes can change the default text. If **Editable Default Text** is cleared, users with permission to add or edit notes can add additional text below the default text.

Default Text can hold up to 2500 characters, although the exact number of characters accepted is determined on whether you include upper case, bold, spaces, and so forth.

Note: If you add default text to an existing note type, be aware that notes of that type that were added to patient or account records before you created the default texts will not display the default text when they are opened or used on reports.

Default subjects for notes

You can create a default subject for any note type. Any text you enter in **Default Subject on Note Type Maintenance** is automatically displayed as the subject line when you create a new note of that type from anywhere in the Allscripts® Practice Management application. You can edit the default subject.

Adding the current date and time to default text

To include the current date and time in the default text for a note, enter either of the following placeholders in **Default Text**, exactly as they are displayed here:

- > <Date> is replaced with the current date in the format mm/dd/yyyy.
- > <Date/Time> is replaced with the date and time in the format mmddyyyy HH:MM am/pm.

Important: These placeholders must be entered exactly as shown here, including the enclosing brackets, a slash between Date and Time, and correct upper and lower case.

When you create a new note of this type, Allscripts® Practice Management automatically replaces these placeholders with the current date or the current date and the current time, as applicable.

Income Guideline Maintenance window

Use **Income Guideline Maintenance** to define the amount that is to be applied to services rendered to a patient who has a sliding fee scale applicable to the encounter.

The income guideline, the discount defined by the household income and the number of family members, is used to determine the discount by looking at the information entered on the Sliding Fees tab in Registration. Both the household income and the number of family members are used to determine how much the patient owes for the services rendered.

When the value entered in **Family Members** on the Sliding Fees tab in Registration is greater than the Family Members listed in Income Guideline Maintenance, the application calculates the reduction using the highest family members column for that household income in the income guideline record.

Access **Income Guideline Maintenance** from **System Administration > File Maintenance > Income Guideline Maintenance** or press **F9** and then enter **IUM**.

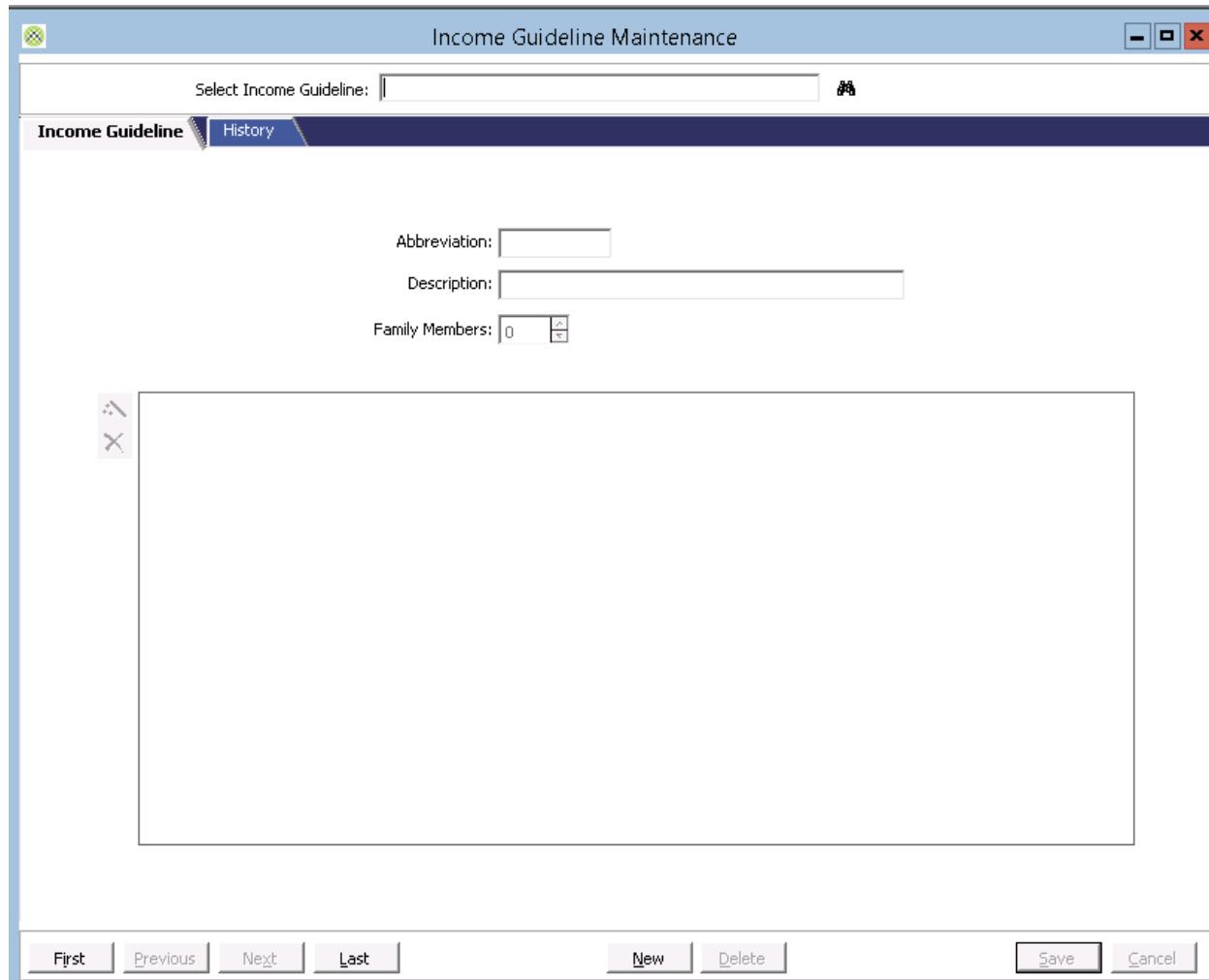
Income Guideline Maintenance contains these tabs:

- > **Image Guideline**
- > **History**

Income Guideline tab

Use the **Income Guideline** tab to define the discount to be applied to services rendered to a patient with a sliding fee scale applicable for an encounter.

Access the **Income Guideline** tab from **System Administration > File Maintenance > Income Guideline Maintenance** or press **F9** and then enter **IUM**.



Abbreviation

Enter an abbreviation for the income guideline. You can use up to 8 alphanumeric characters.

Description

Enter a description for the income guideline. You can use up to 40 alphanumeric characters.

Family Members

Use this box to specify the number of family members. You can select up to 15 family members.

The number selected in this field will be the number of columns that display in the Income Guideline grid on this tab after the **Income From** and **Income To** columns.

When you enter a number higher than 7, you must use the scroll bar to view column 8 and higher.

Income Guideline Grid

This grid contains a column for the Income From value, the Income To value, and a column for each of the number of family members defined in **Family Members**. The Income From and Income To columns contain the household income levels for which the discounts are calculated when the application computes the sliding fee discount. You can enter a maximum of 100 rows in the grid. Use  to add a new row to the grid.

Income From

This column automatically fills with \$0.00 for the first row you add to the grid. When you add each subsequent row, the Income From value of that row is \$.01 greater than the Income To value in the previous row.

Income To

Enter the applicable Income To value in this column.

Number of Family Members

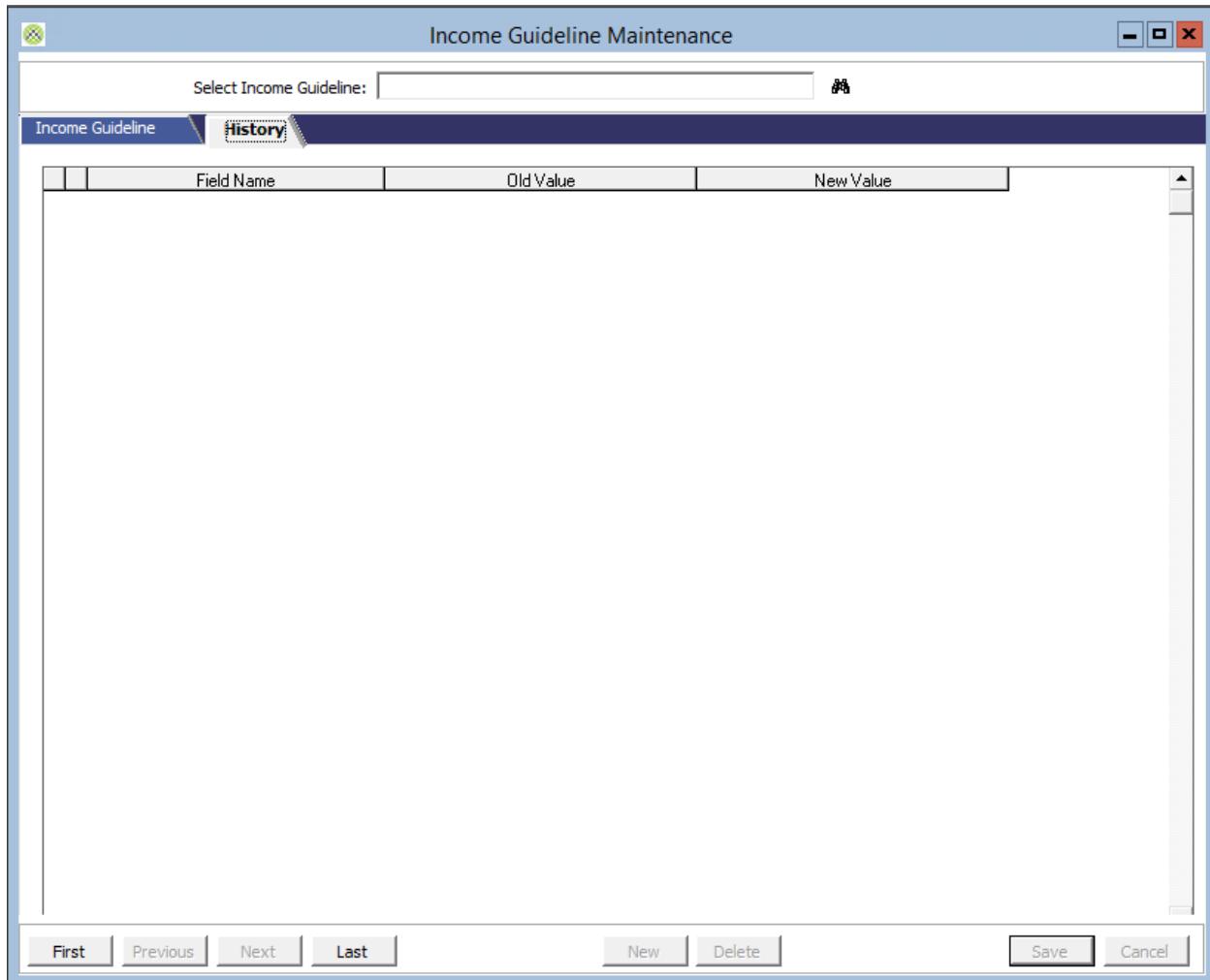
In these columns, enter either percentages or dollar amounts. The default is a dollar amount. If you want to enter a percent discount, you must enter the percent sign (%) either before or after the amount. If you enter a dollar amount in the grid then a dollar sign (\$) will appear in the cell for that value. If you enter a percent value, the percent sign (%) will appear in the cell for that value. When you enter a percent value, the application enables you to enter up to 2 digits to the right of the decimal.

History tab in Income Guideline Maintenance

The History tab in **Income Guideline Maintenance** shows an audit history of the changes made to the income guideline records.

Each major line on the **History** tab displays the date, time, first name and last name of the operator who made the change. Click + to the left of **Show Changed Fields** which is on the line just below the major row, to see which fields were edited.

Access the **History** tab in **Income Guidelines Maintenance** from **System Administration > File Maintenance > Income Guidelines Maintenance** or press **F9** and then enter **IUM**.



Field Name

This column shows the name of the field that was changed. These fields are tracked in Income Guideline Maintenance:

- > Abbreviation
- > Description
- > Family_Members
- > Income_From
- > Income_To
- > Member_Number - x (where x represents the family member value and is replaced with the family member value of the column that was changed)

Old Value

This column displays the value in the field prior to the change. If the column is blank, that means the field was blank.

New Value

This column displays the value in the field upon saving the record.

Sliding Fee Scale Maintenance window

You are able to create sliding fee scale records which correspond to Federal, State, County, and/or City income assistance programs, such as Federal Poverty Guidelines.

Before creating records you must create transaction codes such as Sliding Fee Payment and Sliding Fee Adjustment.

Create records only if you have checked the Use Sliding Fee Scales practice/organization option.

Access **Sliding Fee Scale Maintenance** from **System Administration > File Maintenance > Sliding Fee Scale Maintenance** or press **F9** and then enter **SFM**.

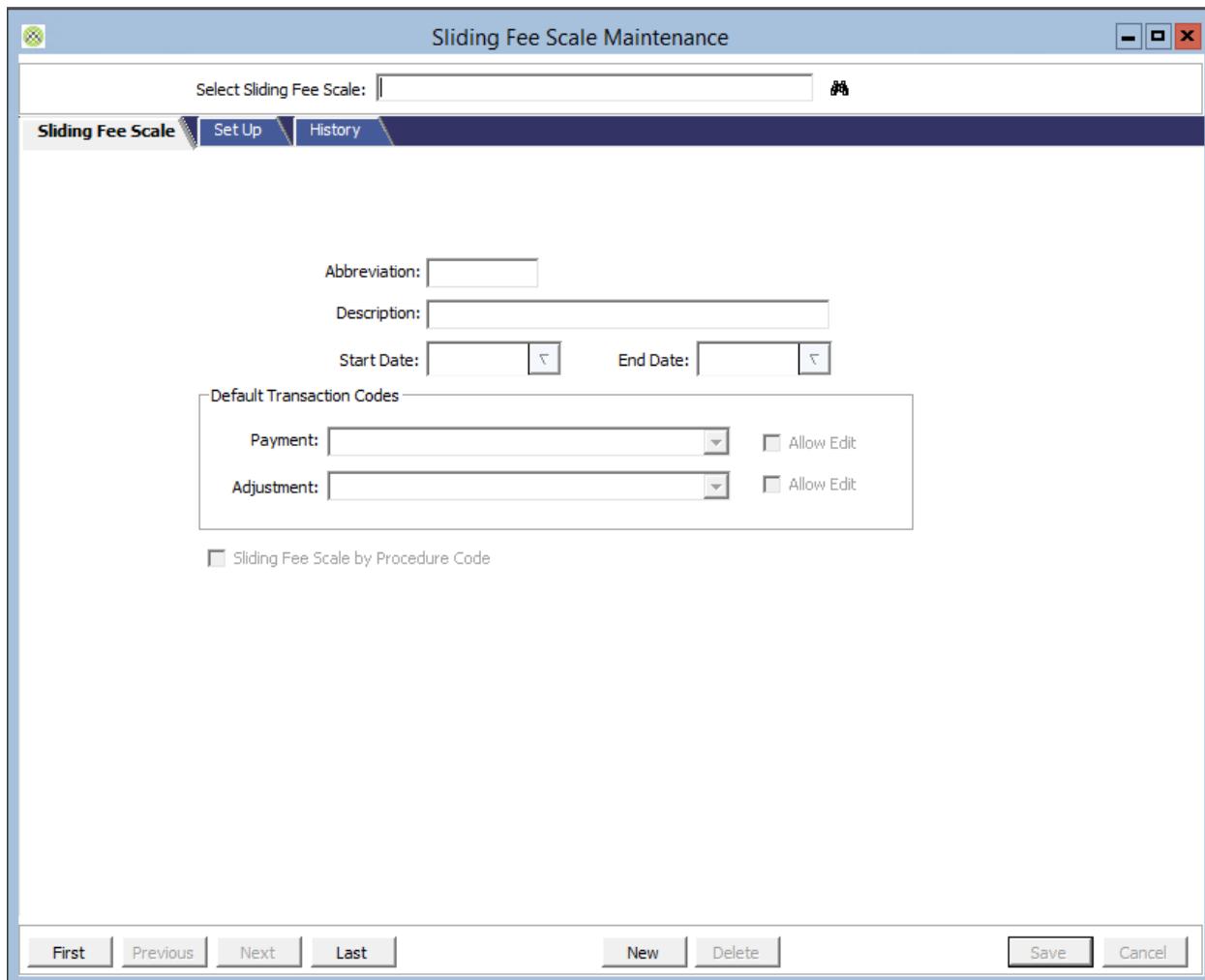
This window contains these tabs.

- > Sliding Fee Scale
- > Set Up
- > History

Sliding Fee Scale tab

Use the **Sliding Fee Scale** tab in **Sliding Fee Scale Maintenance** to begin defining a sliding fee scale record.

Access the **Sliding Fee Scale** tab from **Sliding Fee Scale Maintenance**. To access **Sliding Fee Scale Maintenance**, go to **System Administration > File Maintenance > Sliding Fee Scale Maintenance** or press **F9** and then enter **SFM**.



Abbreviation

Enter an abbreviation for the sliding fee scale. You can use up to 8 alphanumeric characters.

Description

Enter a description for the sliding fee scale. You can use up to 40 alphanumeric characters.

Displays on the following screens:

- > Sliding Fees in Registration - Included in the **Sliding Fee Scale** drop-down list. Identifies the selected fee scales assigned to the Patient record.
- > Transactions in Charge Entry
- > Apply Sliding Fee Adjustment/Payment dialog

Start Date

Relates to the effective date when the file is considered valid or usable to calculate a flat fee or percent to pay amount.

When the lock in date entered on the Sliding Fees tab is earlier than this start date the application does not automatically calculate the a flat fee amount or a percent to pay amount. However, you can still manually enter an amount and **Save** when assigning the Sliding Fee scale to the Patient.

When you enter a Start Date, you must select an Ability to Pay File on the Set Up tab before you can save the sliding fee scale record.

End Date

Optional even when you enter a start date.

Relates to the effective date when the file is considered valid or usable to calculate a flat fee or percent to pay amount.

When the lock in date entered on the Sliding Fees tab is greater than this end date, the application does not automatically calculate the a flat fee amount or a percent to pay amount. However, you can still manually enter an amount and **Save** when assigning the Sliding Fee scale to the Patient.

Default Transaction Codes

The Default Transaction Codes pane contains these fields:

Payment / Allow Edit

Fills the Payment Transaction Code fields on the Apply a Sliding Fee Adjustment/Payment dialog in Charge Entry and on the Apply Transactions screen in Payment Entry.

Only transaction codes with a Transaction Type of Payment display in the drop-down.

Allow Edit becomes enabled when you select a default payment transaction code. Check **Allow Edit** to allow Operators to change the payment transaction code fields on the Apply a Sliding Fee Adjustment/Payment dialog in Charge Entry and on the Apply Transactions screen in Payment Entry.

Adjustment / Allow Edit

Fills the Adjustment Transaction Code fields on the Apply a Sliding Fee Adjustment/Payment dialog in Charge Entry and on the Apply Transactions screen in Payment Entry.

Only transaction codes with a Transaction Type of Adjustment display in the drop-down.

Allow Edit becomes enabled when you select a default adjustment transaction code. Check **Allow Edit** to allow Operators to change the adjustment transaction code fields on the Apply

a Sliding Fee Adjustment/Payment dialog in Charge Entry and on the Apply Transactions screen in Payment Entry.

Sliding Fee Scale by Procedure Code

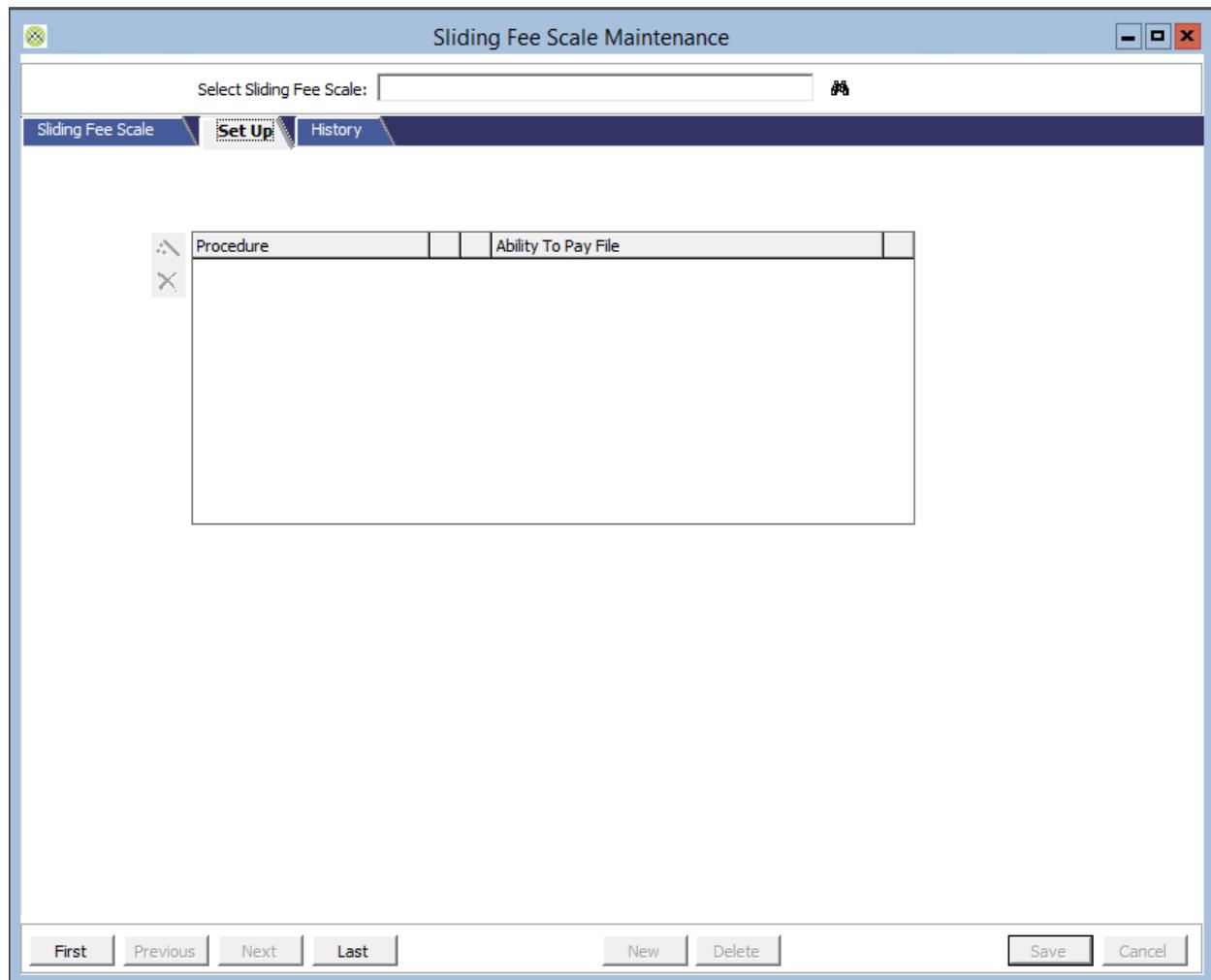
Check **Sliding Fee Scale by Procedure Code** to be able to apply sliding fee discounts to specific procedure categories, groups, types, or codes. Specify these procedure categories, groups, types, or codes on the Set Up tab of Sliding Fee Scale Maintenance.

Set Up tab

The **Set Up** tab in **Sliding Fee Scale Maintenance** gives you a place to store the Ability to Pay File or the procedure code criteria that the application uses to determine the calculation of the sliding fees that your practice determines.

You can differentiate the reduction in fees for procedure codes by either procedure categories, procedure groups, procedure types, or individual procedure codes or have the reduction be applied to the entire voucher.

Access the **Set Up** tab from **Sliding Fee Scale Maintenance**. To access **Sliding Fee Scale Maintenance**, go to **System Administration > File Maintenance > Sliding Fee Scale Maintenance** or press **F9** and then enter **SFM**.



Procedure

The **Procedure** column enables you to choose specific categories, groups, procedure types, or procedure codes when you have checked **Sliding Fee Scale By Procedure Code**. You cannot chose a range of procedure codes.

This column is only enabled when you checked **Sliding Fee Scale By Procedure Code** on the Sliding Fee Scale tab.

Click  to add a new row to the grid.

The default is All Procedure Codes. To select specific procedures, click  to open **Select Procedure Codes** and then make the applicable selections. When you have made selections on the Select Procedure Codes dialog but you want to go back to All Procedure Codes, click .

You cannot associate a procedure with multiple income guidelines within the same sliding fee scale record. When you click OK on the Select procedure dialog, a Duplicate Procedures dialog appears. This dialog says: The following procedure(s) are already associated with another Income Guideline. The duplicate procedures are listed in the grid on the dialog.

Ability To Pay File / Income Guideline

The label on this column depends on whether you check **Sliding Fee Scale By Procedure Code** on the Sliding Fee Scale tab. When you do not check **Sliding Fee Scale By Procedure Code**, the column is labeled **Ability to Pay File**. When you check **Sliding Fee Scale By Procedure Code**, the column is labeled **Income Guideline**.

Ability To Pay File

Click  to open the Open dialog, which enables you to browse to and select an Ability To Pay File.

In order to select a valid file you must create a .csv file that contains the fee scale's data. You must follow the instructions given in "Sliding Fee Scales: Preliminary Setup" when creating this file.

Selecting a file enables you to automate the process of calculating a Patient's flat fee or percent to pay amount when you assign the fee scale in Registration on the Sliding Fees tab.

Leaving this field blank requires that you manually enter a flat fee or percent to pay amount when assigning this fee scale to a Patient.

Note: Before Allscripts® Practice Management 10.1, the Ability To Pay File was on the Sliding Fee Scale tab. After an upgrade to Allscripts® Practice Management 10.1 or higher, any file that existed in the **Ability To Pay File** field on the Sliding Fee Scale tab was moved to the **Ability To Pay File** column on the Set Up tab.

Income Guideline

A list of the income guidelines in your system display in alphabetical order.

View

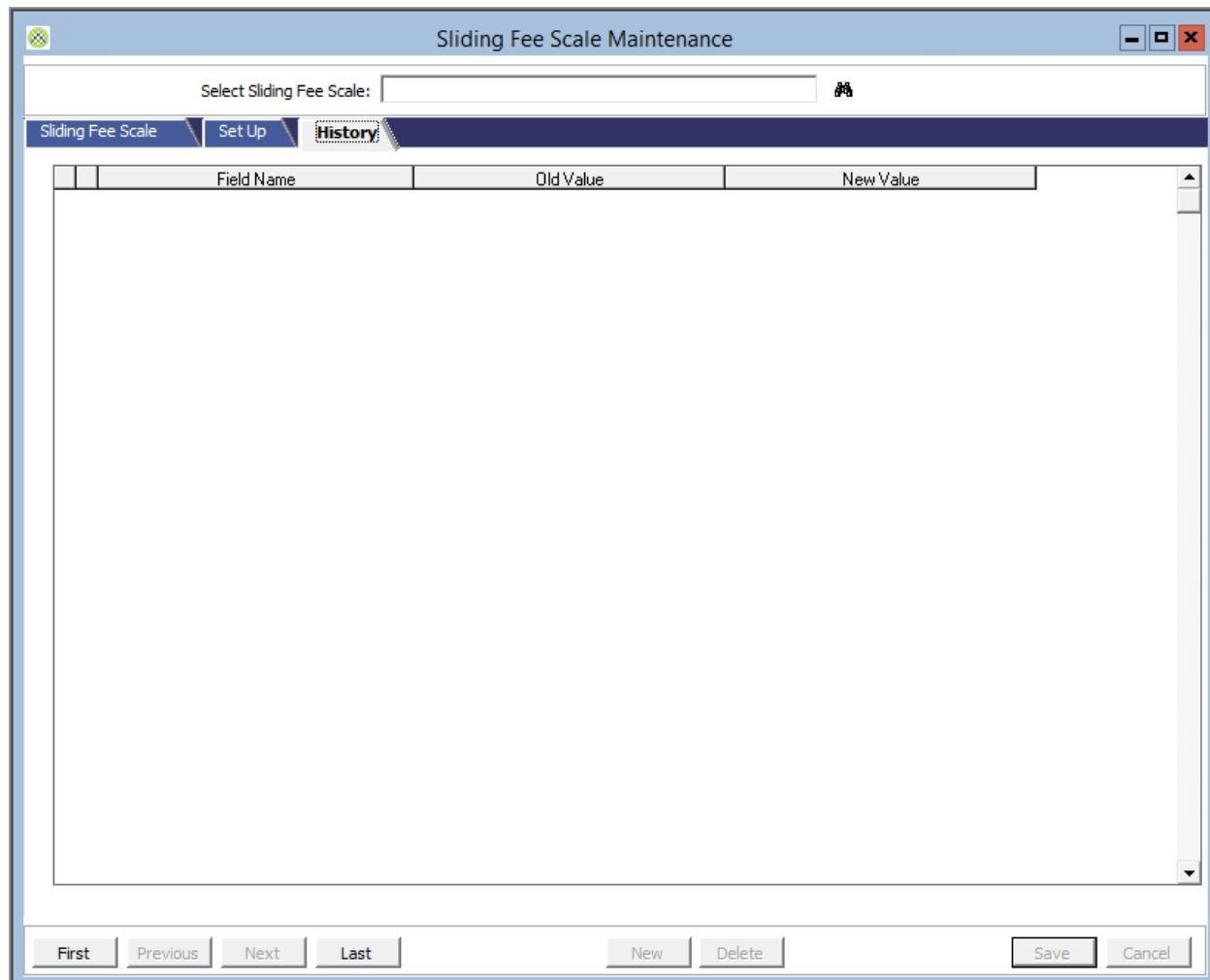
Displayed only if **Sliding Fee Scale By Procedure Code** is selected on the **Sliding Fee Scale** tab and you selected specific procedure codes, procedure categories, procedure types, or procedure groups. Click **View** to open **Selected Procedures**, which shows all the procedure codes you selected in the **Procedure** column on the Set Up tab in Sliding Fee Scale Maintenance (SFM). This window is view only: you cannot make changes on it.

History tab in Sliding Fee Scale Maintenance

The **History** tab in **Sliding Fee Scale Maintenance** shows an audit history of the changes made to the **Sliding Fee Scale** tab.

Each major line on the **History** tab displays the date, time, first name and last name of the Operator who made the change. Click **+** to the left of **Show Changed Fields** which is on the line just below the major row, to see which fields were edited.

Access the **History** tab from **Sliding Fee Scale Maintenance**. To access **Sliding Fee Scale Maintenance**, go to **System Administration > File Maintenance > Sliding Fee Scale Maintenance** or press **F9** and then enter **SFM**.



Field Name

This column shows the name of the field that was changed. These fields are tracked in Sliding Fee Scale Maintenance:

- > Abbreviation
- > Description
- > Start_Date
- > End_Date
- > Def_Payment_Trans_Code_Description
- > Edit_Payment_Trans_Code
- > Def_Adjustment_Trans_Code_Description
- > Edit_Adjustment_Trans_Code
- > Sliding_Fee_Scale_By_Proc

Old Value

This column displays the value in the field prior to the change. If the column is blank, that means the field was blank.

New Value

This column displays the value in the field upon saving the record.

Image Category Maintenance window

Use **Image Category Maintenance** to define the different categories which will be used to store scanned documents/images.

Examples of Image Categories are: "Documents", "Patient ID", "Insurance Cards".

Simple scanning capability is available in Registration from the toolbar by clicking the Scan Images toolbar button .

Advanced scanning-related functions are also available in Registration. These functions are accessed by clicking the **Images** toolbar button .

You must create the file folders where the scanned images in each Category will be saved. These new folders should reside in the default Allscripts® Practice Management file storage location on your server.

The naming convention to be used for the path name is: \\<Server Name>. <Domain Name>\NtierFiles\<Tenant Name>\Image Files\Folder Name.

When a scanned image is saved, the file name is programmed to default to this format: "Patient number_date scanned_time scanned". The date format used is yyyyymmdd and the time is military

time with a format of hhmmss. An example of a file name is "400_20030709_145701." This would be read as: Patient # 400, scanned July 9, 2003 at 02:57:01pm.

The default file name can be changed only when using the Custom option on the Images dialog. If you choose to use this option, you should give some thought before hand as to how you will distinguish and identify each file.

Clients using Department/Practice Security - You must select department/practice members for operators to have access to the record.

Access **Image Category Maintenance** from **System Administration > File Maintenance > Image Category Maintenance** or press **F9** and then enter **IMM**.

This window contains these tabs:

- > **Image Category**
- > **Department Members or Practice Members** — only displayed when **Enable Department Security** or **Enable Practice Security** on the **General** tab in **Practice Options** or **Organization Options** is selected.

Image Category tab

Use image categories to set up how to handle standard types of images. Your implementation specialist will assist you with the setup and training for this function.

Access the **Image Category** tab from **System Administration > File Maintenance > Image Category Maintenance**.

Tip: To quickly access **Image Category Maintenance**, press **F9**, then enter **IMM**.

Image Category Maintenance

Select Image Category: 

Image Category	Department Members
Abbreviation:	<input type="text"/>
Description:	<input type="text"/>
Folder:	<input type="text"/>
File Extension:	<input type="text"/>
Image Type:	<input type="text"/>
JPEG Quality:	<input type="text"/>
Left Offset (Inches):	<input type="text"/>
Top Offset (Inches):	<input type="text"/>
Image Width (Inches):	<input type="text"/>
Image Height (Inches):	<input type="text"/>
Resolution (DPI):	<input type="text"/>
<input type="checkbox"/> Duplex <input type="checkbox"/> Enable Automatic Document Feeder	
Second Page Rotation:	<input type="text"/>

First Last

Abbreviation

Holds up to eight characters. The abbreviation is displayed in the Image Category column in the Images grid located at the top of the Images screen.

Description

Holds up to 40 characters. Displays as a selection in **Image Category** on **Images** and **Scan Images**.

Folder

Use **Folder** to enter the name of the path where the image files created using this category are stored. The folder must exist on your server. For example, a folder for insurance card images might be located in `\Your server name\Your practice or organization name\Image Files\Insurance Cards`.

File Extension

Select the file extension you want to use when images are stored using this category. The choices include the following:

- > **JPG**
- > **BMP**
- > **GIF**

Image Type

The image types include the following:

- > **Black & White (1-bit)** is best for scanning black text on white background. The scanning process for these types of images is faster than the process for grayscale or color, and the file size is smaller.
- > **Gray scale (8-bit)** is best for scanning continuous-tone, black and white images, such as photographs with text, or colored text. The file size is larger than black and white.
- > **Color (24-bit)** is best for scanning full-color documents. The scanning process is slower and the file size larger than black and white or grayscale images. Be aware that small text may not be legible.

JPEG Quality

Reduces the size of stored images on client servers, improves time retrieving and viewing images, and potentially overcomes compatibility issues with viewing images.

Note: **JPEG Quality** applies to the images pasted from the **Images** window that is accessed by clicking  in the toolbar.

Left Offset (Inches)

Determines how many inches from the original image's left edge the scanning process begins. Enter a value from 0.1 to 5.5.

Top Offset (Inches)

Determines how many inches from the original image's top edge the scanning process begins. Enter a value from 0.1 to 8.5.

Note: You can use offsets to reduce the file size when scanning documents with large margins.

Image Width (Inches)

Enter the width in inches of the standard image to be scanned under this category. For example, when scanning documents which are standard letter size, enter 8.5. The maximum width accepted is 11.

Image Height (Inches)

Enter the height in inches of the standard image to be scanned under this category. For example, when scanning documents which are standard letter size, enter 11. The maximum height accepted is 17.

Resolution (DPI)

Sets the dots per inch (DPI) to be scanned from your original image. Selecting a larger number makes fine detail more visible, but also increasing scanning time and file size.

- > The standard setting for **Black & White (1-bit)** is **300**.
- > The standard setting for **Gray scale (8-bit)** is **200**.
- > The standard setting for **Color (24-bit)** is **150**.

Duplex

Select this check box to activate automatic double sided scanning of images and documents. When you select this check box, **Second Page Rotation** is enabled and **Enable Automatic Document Feed** is automatically selected and becomes unavailable.

Enable Automatic Document Feeder

Automatically selected and unavailable when **Duplex** is selected. For single-sided scanning, select this option only if your scanner has a document feeder.

Second Page Rotation

Only enabled when you select **Duplex**. Automatically rotates the second image in degrees. Select the degree of rotation from the drop-down list.



Chapter 4 Registration File Maintenance

Chapter 5

Recall Type File Maintenance

Recall Type File Maintenance setup checklist

Recall type file maintenance relates to the creation and printing of recall documents. Because you must create recall documents before you can associate a recall type with a document name, make a note to return to this file maintenance to complete the setup.

Use this checklist to record the completion of each maintenance record.

Maintenance	Completed
Recall Type Maintenance (RLM)	

Recall Type Maintenance window

Examples of some uses for recall types are:

- Identify the reason why a patient should be contacted. In some cases, you may want to remind patients that they need to call the office to book an appointment for a annual physical or a 3 month follow up for blood work, or a 6 month follow up for weight maintenance.
- Flag those patients such as diabetics, who need to be followed on a maintenance program.
- Keep track of the due date for OB-GYN patients.
- Identify patients who are involved in clinical trials.

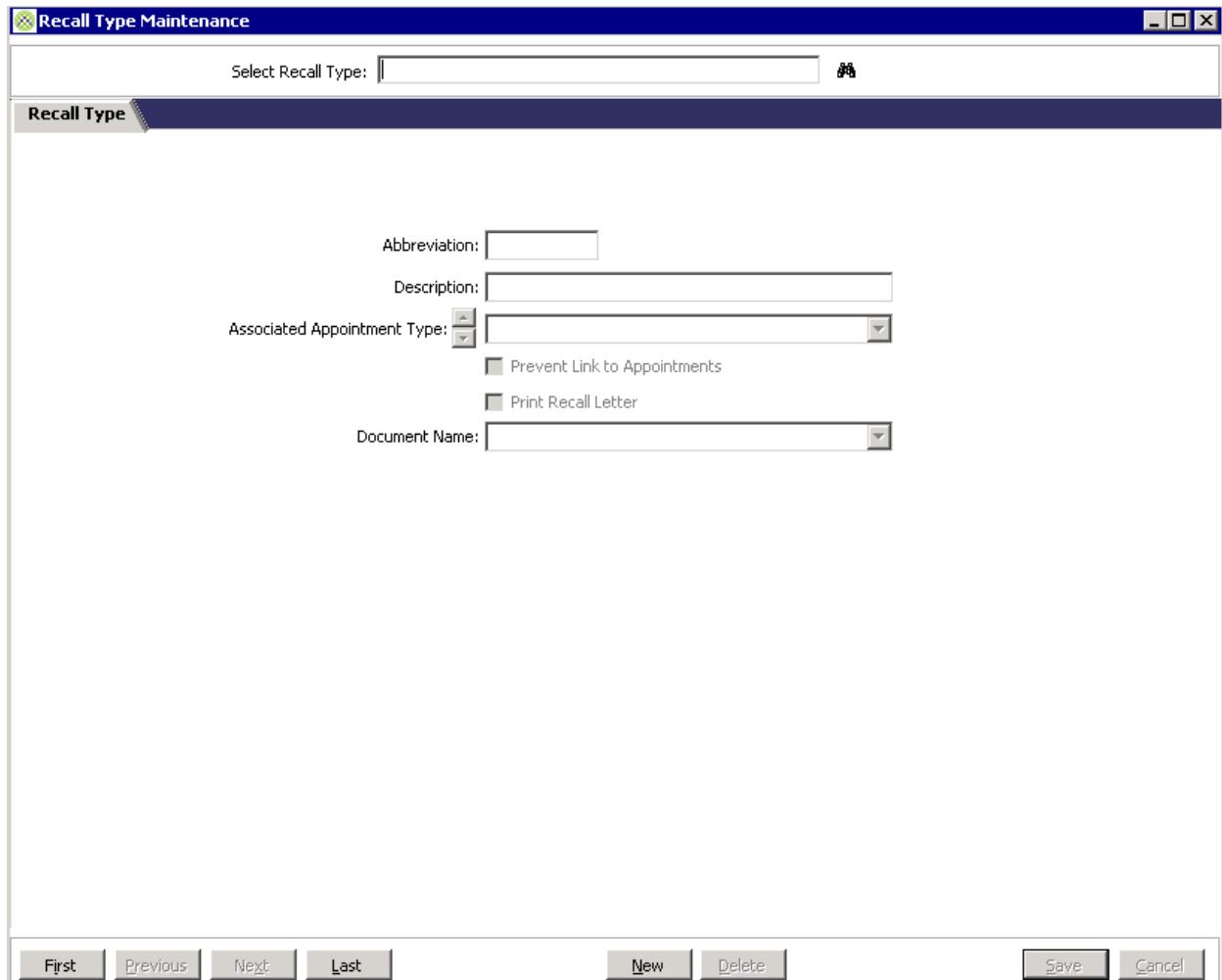
Important: To enable the linking of recalls to appointments, select **Link Appointments with Recalls** on the **Scheduling** tab in **Practice Options** or **Organization Options**.

Access **Recall Type File Maintenance** from **System Administration > File Maintenance > Recall Type File Maintenance** or press **F9** and then enter **RLM**.

This window contains the **Recall Type** tab.

Recall Type tab

Access the **Recall Type** tab from **Recall Type File Maintenance**. To access **Recall Type File Maintenance**, go to **System Administration > File Maintenance > Recall Type File Maintenance** or press **F9** and then enter **RLM**.



Abbreviation

Prints on various related reports.

Description

Included in the recall type listing on the Recalls dialog in Scheduling.

Associated appointment type/category

Restricts the linking of a recall type to the appointment category or appointment type selected. Left blank allows you to link this recall type to all appointments.

Prevent link to appointments

Prevents you from linking this recall type to any appointment.

Note: To link any appointment with recalls the Link Appointments with Recalls Scheduling practice/organization option must also be checked.

Checking this option overrides the practice/organization option for this recall type.

Note: Recalls linked to appointments are not included in the printing of recall documents.

Print recall letter

Enables the field labeled Document Name. You must associate a recall type with a document in order to batch print recall documents to patients given this recall type.

Document name

The document selected is printed when this recall type is included in a recall document run.



Chapter 5 Recall Type File Maintenance

Chapter 6

Referral File Maintenance

Referral File Maintenance setup checklist

Referral file maintenance deals with elements of outgoing referrals.

Use this checklist to record the completion of each maintenance record.

Maintenance	Completed
Referral Type Maintenance (RTM)	
Referral Service Type Maintenance (RVM)	

Referral Type Maintenance window

The records you create on **Referral Type Maintenance** are available in drop down lists when you create an outgoing referral on **Outgoing Referral**.

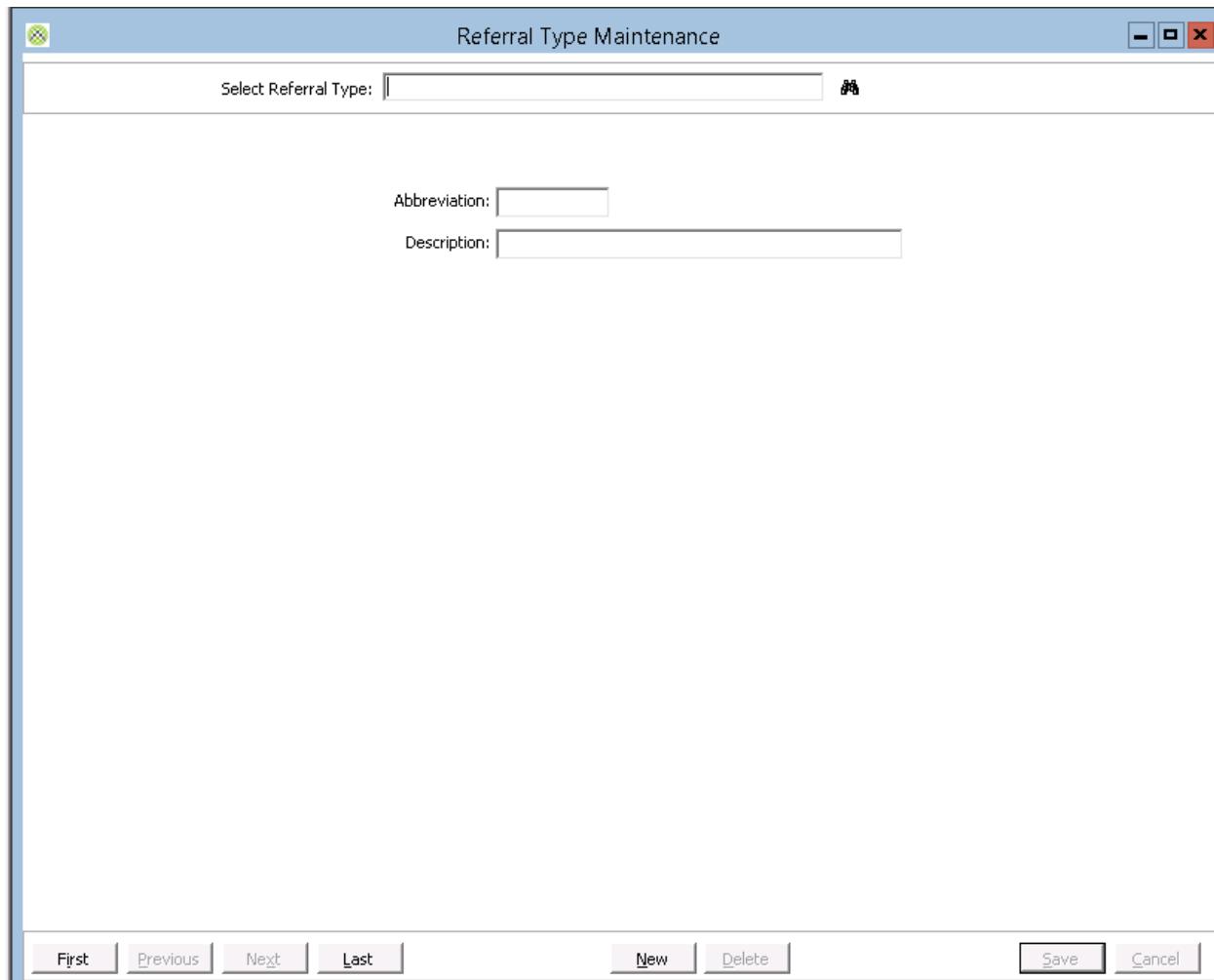
Designed for internally tracking referral trends in your practice or organization, you can use referral type to report on the various types of referrals that your providers generate. These referral types should be customized to fit your reporting needs.

Examples of the type of records which can be created here include:

- > Diagnostic
- > Consultative
- > In network
- > Out of network
- > Mental Health
- > Renewal

Access **Referral Type Maintenance** from **System Administration > File Maintenance > Referral Type Maintenance**.

Tip: To quickly access **Referral Type Maintenance**, press **F9**, then enter **RTM**.



Referral Service Type Maintenance window

This maintenance function allows you to enter into the system all the reasons for referrals that are required by HMOs and Managed Care Organizations when you are filling out referral authorizations.

The entries you create here will be available when you are creating an Outgoing Referral.

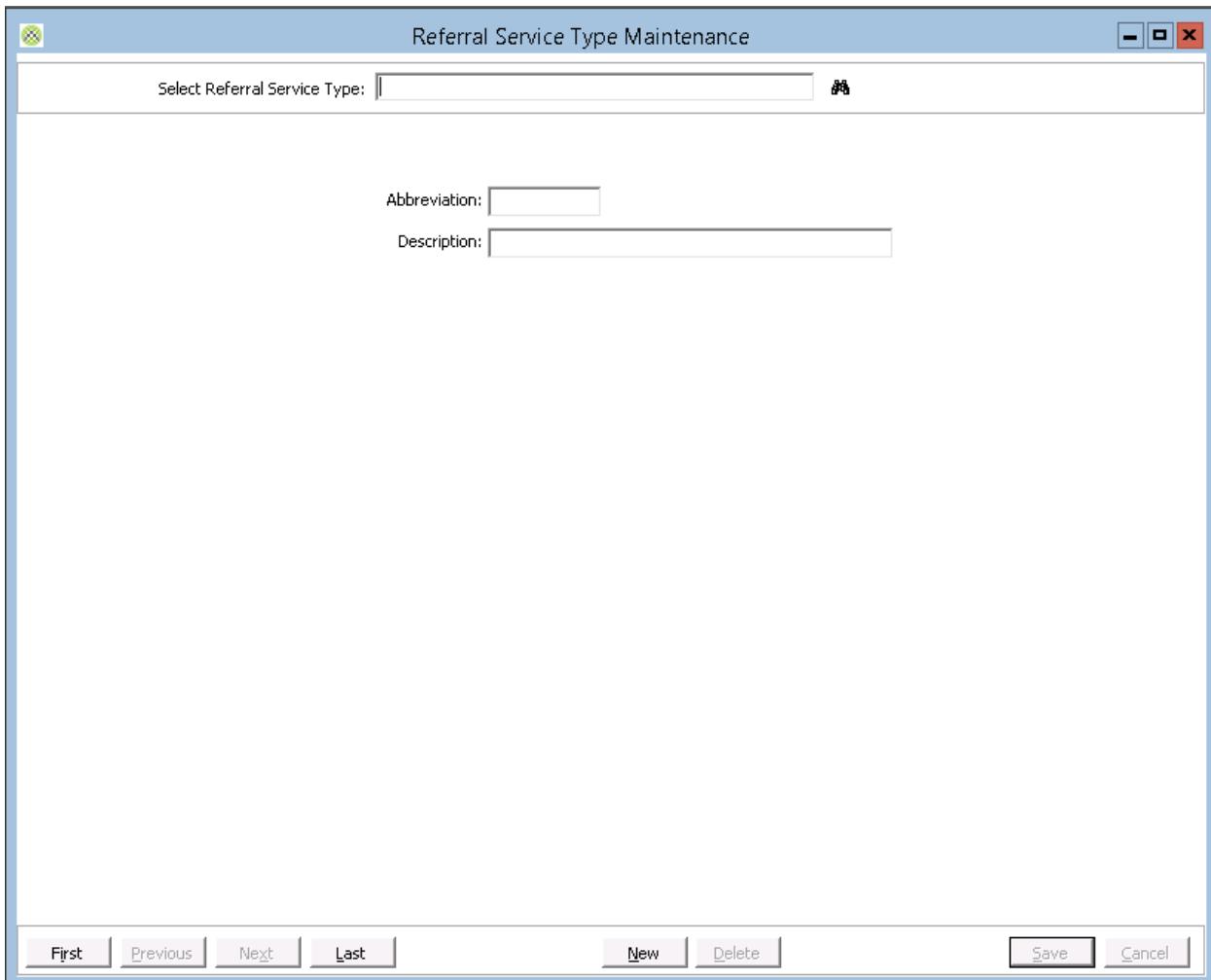


Authorization#: 123456789
Diagnoses: ABNORMALITY OF RED BLOOD CELL
Ref Svc Types: Consultative and diagnostic Studies
Reason for Ref:
Consultatio, diagnostic and treatment
Consultative and diagnostic Studies
Consultative Opinion
Notes: Outpatient Physical Therapy

Typical entries for this file would be

- > Consultative Opinion
- > Consultation and diagnostic studies
- > Consultation, diagnostic studies and treatment
- > Outpatient Physical Therapy

Access **Referral Service Type Maintenance** from **System Administration > File Maintenance > Referral Service Type Maintenance** or press **F9** and then enter **RVM**.





Chapter 6 Referral File Maintenance

Chapter 7

Reimbursement File Maintenance

Reimbursement File Maintenance setup checklist

Reimbursement file maintenance relates to all the elements that you need to enter payments in Allscripts® Practice Management.

Use this checklist to record the completion of each set of records.

Maintenance	Completed
Transaction Category Maintenance (TTM)	
Transaction Code Maintenance (TCM)	
Reimbursement Style Maintenance (RSM)	
Reimbursement Comment Category Maintenance (RCC)	
Reimbursement Comment Maintenance (RCM)	
Remark Code Category Maintenance (RKC)	
Remark Code Maintenance (RKM)	
Message Maintenance (MEM)	
Claim Status Code Maintenance (CSC)	
Claim Status Category Maintenance (CST)	
Electronic Remit Format Maintenance (ERM)	
Electronic Remit Style Maintenance (ESM)	
Charge Entry tab in Practice Options or Organization Options (POP or OOP)	
Payment Entry tab in Practice Options or Organization Options (POP or OOP)	

Transaction Category Maintenance window

Use **Transaction Category Maintenance** to group transaction codes.

Each transaction code must be assigned to a transaction category.

The **Transaction Analysis** report can be grouped by or restricted to specific transaction categories.

Categories can be as diverse or simple as your reporting needs require. Some practices simply create the 1 category, Default, while others develop categories such as Occupational Medicine, Cash Payments, Check Payments, Credit Card Transactions, Unassigned, and Rebill.

Transaction Category Maintenance contains these tabs:

- > **Transaction Category**
- > **History**

To access **Transaction Category Maintenance**, go to **System Administration > File Maintenance > Transaction Category Maintenance** or press **F9** and then enter **TTM**.

Transaction Category tab

Use the **Transaction Category** tab in **Transaction Category Maintenance** to group transaction codes.

Access the **Transaction Category** tab from **Transaction Category Maintenance**. To access **Transaction Category Maintenance**, go to **System Administration > File Maintenance**, or press **F9** and then enter **TTM**.

Transaction Code Maintenance

Select Transaction Code:		
Transaction Code 		
Abbreviation:	<input type="text"/>	
Description:	<input type="text"/>	
Transaction Type:	<input type="text"/>	
Transaction Category:	<input type="text"/>	
<input type="checkbox"/> Alternate Paper Claim Billing <input type="checkbox"/> Interest Transaction Code <input type="checkbox"/> MSR Processing <input type="checkbox"/> Self-Pay Transaction Code <input type="checkbox"/> Require Deposit Slip# <input type="checkbox"/> Require Settlement Date		
Adjustment Percent:	<input type="text"/>	
Associated Pmt Transaction Code:	<input type="text"/>	
GL Sub-Account#1:	<input type="text"/>	
GL Sub-Account#2:	<input type="text"/>	

First  Previous  Last  Delete  Cancel

Abbreviation

Holds 8 characters. Displays on the **Categories** tab in **Select Transactions** for the **Transaction Analysis** report. Prints on the **Transaction Analysis** report.

Description

Holds 40 characters. Displays in the drop-down list for selection in **Transaction Code Maintenance** and on the **Categories** tab in **Select Transactions** for the **Transaction Analysis** report. Prints on the **Transaction Analysis** report.

GL Sub-Account#1

If you are using the **GL Export**, enter the numeric value that represents this segment of the GL account number, if applicable.

GL Sub-Account#2

If you are using the **GL Export**, enter the numeric value that represents this segment of the GL account number, if applicable.

Transaction Code Maintenance window

Transaction Codes Maintenance enables you to record payments, adjustments, transfers, refunds, rebills, and miscellaneous debits.

Transaction Code Maintenance contains these tabs:

- > **Transaction Code**
- > **History**

To access **Transaction Code Maintenance**, go to **System Administration > File Maintenance > Transaction Code Maintenance** or press **F9** and then enter **TCM**.

Transaction Code tab

Use the **Transaction Code** tab in the **Transaction Code Maintenance** to record payments, adjustments, transfers, refunds, rebills, and miscellaneous debits.

Access the **Transaction Code** tab from **Transaction Code Maintenance**. To access **Transaction Code Maintenance**, go to **System Administration > File Maintenance**, or press **F9** and then enter **TCM**.

Transaction Code Maintenance

Select Transaction Code: 

Transaction Code  History

Abbreviation:	<input type="text"/>
Description:	<input type="text"/>
Transaction Type:	<input type="text"/>
Transaction Category:	<input type="text"/>
<input type="checkbox"/> Alternate Paper Claim Billing <input type="checkbox"/> Interest Transaction Code <input type="checkbox"/> Credit Card Processing <input type="checkbox"/> Self-Pay Transaction Code <input type="checkbox"/> Require Deposit Slip# <input type="checkbox"/> Require Settlement Date	
Adjustment Percent:	<input type="text"/>
Associated Pmt Transaction Code: <input type="text"/>	

First  Previous  Last  Delete  Cancel

Abbreviation

Must be unique. Holds up to 8 characters.

Description

Holds up to 40 characters.

Transaction Type

Required field.

The following are program defined designations that trigger programmed behavior when the transaction code is used:

Payment

Increases payments, reduces receivables.

Sample payment transaction codes are: Self-Pay Cash, Self-Pay Check, Self-Pay Credit Card, payment transaction codes for each of your carriers such as Medicare Payment, Medicare Take Back, Tufts Payment, Tufts Take Back, Medicaid Payment, Medicaid Take Back, etc.

Note: When applying a Carrier take back the payment transaction code must be entered as a negative amount.

Adjustment

Increases adjustment (write offs) and reduces receivables.

Create adjustment codes for each of your carriers. Additional sample adjustment codes are: Collection Adjustment (Identifies amount paid out to Collection Agency), Self-Pay Adjustment,

Refund

Decreases payments.

Refunds are applied when a payment should never have been received. The refund transaction type is used by the system to decrease your total receipts.

Refund Type Transaction Codes are used for transactions where you are sending a refund check to a Patient, Guarantor or Insurance Carrier.

Sample refund transaction codes are: Self-Pay Refund, Unassigned Payment Refund, Also create, a Refund Transaction Type Code for each of your Insurance Carriers. These codes should be used only when you send a refund check to the Carrier.

An Insurance take back may require the use of a negative payment and/or an adjustment code. See Applying a Take Back with Primary and Secondary Payments Applied.

Rebill

Clears the bill date on a voucher qualifying it for the next billing cycle. You must create a standard Transaction Code called "Rebill."

You can also create a unique transaction code for mass rebilling called "Mass Rebill." See topic for "Setting Payment Entry Options" in Help for more information.

A voucher can be set to rebill from the Edits tab, or multiple vouchers can be set to rebill using the Rebilling tab in Billing>Claims Review.

Another rebill transaction type called "Rebill Using Alt Report Name" may be required for your Practice. See topic for "Using an Alternate Report Name in Paper Claim Billing" and the explanation under "Alternate Paper Claim Billing" in this topic.

Transfer

Moves a voucher or account balance to another payor's responsibility without affecting receivables in any way.

Create transfer codes such as BCBS Transfer, Medicare Transfer, Self-Pay Transfer to use when transferring a voucher balance from the current payor to another payor.

Misc. Debit

Associated with unassigned payments. A Misc Debit transaction does not affect your accounts receivable until the unassigned amount is applied to a charge.

Designed to allow you to record the receipt of a payment such as a co-pay, co-insurance or prepayment without creating a charge.

Sample Misc Debit Type codes are:

- > If you are using the move to unassigned functionality: "Move to Unassigned" (to be used as a Standard Transaction Code default) , "Overpayment Cash", "Overpayment Check", "Overpayment Credit Card", See Moving a Transaction to Unassigned.
- > If you are using the Quick Pay payment dialog: "QP Cash", "QP Check", "QP Credit Card."

See also the topic for "Associating an Appointment with a Quick Pay Payment."

Transaction category

Required. See Transaction Category File Maintenance

Alternate Paper Claim Billing

Enabled only when the transaction type **Rebill** is selected.

CAUTION: Do not select this box when creating the standard Rebill or Mass Rebill Transaction code used to trigger the rebilling of a voucher.

Used to trigger the use of the alternate report entered on a Paper Claim Format associated with a Carrier when printing a claim as part of the rebilling process. See Completing the Paper Claim Format Tab and Using an Alternate Report Name in Paper Claim Billing.

Interest Transaction Code

Only enabled when you select a **Transaction Type of Payment or Adjustment**.

When selected, this option identifies the payment or adjustment transaction code as an interest transaction code. Once created, these transaction codes are available in **Reimbursement Style Maintenance** as the default transaction codes in **Interest Payment or Interest Adjustment**, and on **Interest in Apply Transactions**.

Credit Card Processing

Enabled when **Transaction Type** is set to **Payment** or **Misc Debit**.

Cleared by default.

Select this option for transaction codes used with integrated credit card processing.

Note: When you set up integrated credit card processing transaction codes, you must set up codes with a **Misc Debit** transaction type for use in **Quick Payment** and a **Payment** transaction type for other payment windows, such as **Apply Self-Pay Payments**.

Self-Pay Transaction Code

Enabled when you select **Payment** or **Adjustment** as the **Transaction Type**.

- > When checked for a Payment Transaction Type, identifies the Transaction Code as qualifying to display as a selection in the following fields:
 - Associated Pmt Transaction in Transaction Code Maintenance for transaction codes with the type of Misc Debit.
 - Payment Transaction Code in the Co-Pay grid and in the Other Patient Balance grid on the Self-Pay dialog when **Show Self-Pay Payment Trans. Codes only** is also checked in Practice/Organization Options on the Charge Entry tab.
- > When checked for an Adjustment Transaction Type, identifies the Transaction Code as qualifying to display as a selection in the Adjustment Transaction Code drop down listing in the Co-Pay grid when overriding a Co-Pay, and in the Other Patient Balance grid on the Self-Pay dialog when **Show Self-Pay Adjustment Trans. Codes only** is also checked on the Charge Entry tab in Practice/Organization Options.

Note: To restrict the listing in the payment and/or adjustment drop down fields on the Self-Pay dialog, you must also check the corresponding options on the Charge Entry tab in Practice/Organization Options. If you check either or both charge entry options, be sure that you flag all the transactions codes that are used to enter self-pay payments and/or adjustments. Transaction codes not flagged as self-pay are not available on the Self-Pay dialog for selection by an operator. This includes any payment or adjustment type transaction selected as a default on the Payment Entry tab in Practice/Organization Options. See "Using the Self-Pay Dialog" in Help for more information.

Require Deposit Slip#

Select this option if you want to require **Deposit Slip#** on the **Batch Management** tab in **Financial Processing > Transactions**.

This option is only enabled when **Transaction Type** is set to **Payment** or **Misc Debit**.

Selecting this option does not stop you from manually saving and closing batches that do not have the deposit slip number entered on the **Batch Management** tab, but you cannot update batches containing that transaction code until you enter the deposit slip number. When you run the **Transaction Journal** from **Financial Processing > Financial Posting**, a validation message is displayed if you selected **Update Transactions**.

The automated billing process does not close or update batches if a required deposit slip number is missing.

Require Settlement Date

Select this option if you want to require **Settlement Date** on the **Batch Management** tab in **Financial Processing > Transactions**.

This option is only enabled when **Transaction Type** is set to **Payment**, **Refund**, or **Misc Debit**.

Selecting this option does not stop you from saving and closing batches that do not have the settlement date entered on the **Batch Management** tab, but you cannot update batches containing that transaction code until you enter the settlement date. When you run the **Transaction Journal** from **Financial Processing > Financial Posting**, a validation message is displayed if you selected **Update Transactions**.

The automated billing process does not close or update batches if a required settlement date is missing.

Adjustment Percent

Enabled when the Transaction Type is set to "Adjustment" and **Self-Pay Transaction Code** is checked.

The % amount entered is used on the Self-Pay dialog in Charge Entry to calculate the prompt payment discount allowed by your Practice.

This field does not accept negative numbers or a number over 100.

Example: If your policy is to apply a 20% discount to a voucher's Self-Pay amount when it is paid in full at the time of service, then enter 20 in this field. Then when the Transaction Code is selected in Charge Entry on the Self-Pay dialog, the system automatically applies the 20% discount on each procedure code entered on the voucher and gives the Operator the discounted balance due by the Patient.

Best Practice: If your Practice/organization uses prompt payment discounts then: (1) Set a Practice Policy on amount of the discount to be applied, then (2) create an Adjustment Type Code that is easily identifiable to the Operator when using the Self-Pay dialog, then (3) restrict the listing that displays in the Adjustment Transaction Code

drop down on the Self-Pay dialog by checking "Show Self-Pay Adjustment Codes" in Practice Options on the Charge Entry tab

Associated Pmt Transaction Code

Enabled when the transaction type **Misc Debit** is selected.

Displays transaction codes with a **Transaction Type of Payment** which are also checked as **Self-Pay Transaction Code**.

Intended for use with those **Misc Debit** type transaction codes used on the **Quick Pay** window.

When the operator associates an unassigned payment with an appointment via the dialog, the system uses the payment transaction code associated with the misc. debit type transaction code selected at the time the quick pay payment is entered to automatically apply the unassigned amount on the charge associated with the appointment.

When the operator associates an unassigned payment with an appointment via the dialog, the system uses the payment transaction code associated with the misc. debit type transaction code selected at the time the quick pay payment is entered to automatically apply the unassigned amount on the charge associated with the appointment.

Note: **Track Encounters** must be selected on the **Charge Entry** tab in **Practice Options** or **Organization Options** in order to display the associated patient's appointments.

Reimbursement Style Maintenance window

Use **Reimbursement Style Maintenance** to reproduce the column setup used on the explanation of benefits (EOB) received from each of your carriers on the **Payment Entry** tab.

A reimbursement style is a customized template created to mirror the column setup used by a carrier on its remittance advices. Assign reimbursement styles to carriers in **Insurance Carrier Maintenance**. You can assign 1 reimbursement style to multiple carriers.

Before you begin

Before creating the reimbursement styles used in your practice, be sure you have the following:

- > Samples of the remittance advices used by your carriers
- > Transaction codes that can be used as the default **Transaction Codes** for each style
- > Reimbursement comments that can be used
- > Detailed reimbursement information that should be included in each style

Your options

The style detail elements available include columns labeled: **Allowed**, **Non-Allowed**, **Deductible**, **Co-pay**, **Co-insurance**, **Withheld**, **Payment**, and **Comment**.

You can create a reimbursement style without the detail. As a result the program default style, which includes only a payment and adjustment column, is displayed on the **Payment Entry** tab.

On **Apply Transactions to Voucher** during payment entry, a remitter's reimbursement style is classified as 1 of the following:

- > Detailed insurance reimbursement

Includes 1 or more of the detail reimbursement information columns: **Allowed**, **Non-Allowed**, **Deductible**, **Co-pay**, **Co-insurance**, **Withheld**, **Payment**, and **Comment**.

Note: A detailed reimbursement style always includes both an **Allowed** and **Non-Allowed** column.

- > Summarized insurance reimbursement

Includes 2 columns only, **Payment** and **Adjustment**.

Summarized insurance reimbursements are those where the style was created with detail.

Importing 835 remittance files

If you are importing 835 remittance files, create reimbursement styles that enable the import of all the detail included in the carrier's remittance file.

Submitting secondary claims electronically

If you are submitting electronic secondary claims, include a **Comments** column in the reimbursement detail.

Reimbursement Style Maintenance contains these tabs

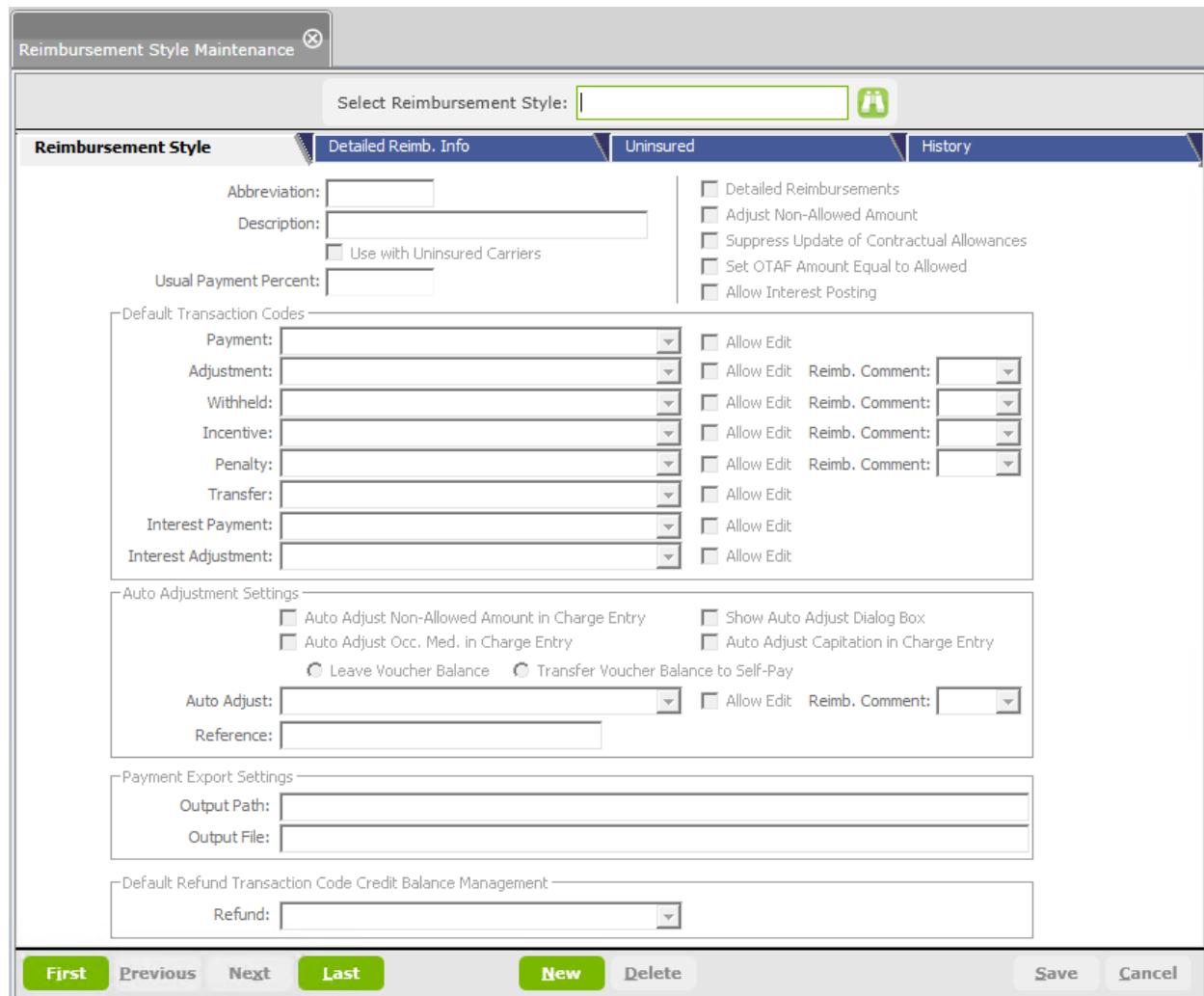
- > **Reimbursement Style**
- > **Detailed Reimbursement Info**
- > **Uninsured**
- > **History**

To access **Reimbursement Style Maintenance**, go to **System Administration > File Maintenance > Reimbursement Style Maintenance**, or press **F9** and then enter **RSM**.

Reimbursement Style tab

This topic describes the characteristics and use of the boxes found on the **Reimbursement Style** tab in **Reimbursement Style maintenance**.

Access the **Reimbursement Style** tab from **Reimbursement Style Maintenance**. To access **Reimbursement Style Maintenance**, go to **System Administration > File Maintenance > Reimbursement Style Maintenance** or press **F9** and then enter **RSM**.



The screenshot shows the 'Reimbursement Style Maintenance' window with the 'Reimbursement Style' tab selected. The interface includes:

- Search Bar:** 'Select Reimbursement Style:' with a search icon.
- Toolbars:** 'Detailed Reimb. Info', 'Uninsured', and 'History'.
- Abbreviation:** Text input field.
- Description:** Text input field.
- Usual Payment Percent:** Text input field.
- Checkboxes:** A group of checkboxes on the right side of the screen, including 'Detailed Reimbursements', 'Adjust Non-Allowed Amount', 'Suppress Update of Contractual Allowances', 'Set OTAF Amount Equal to Allowed', and 'Allow Interest Posting'.
- Default Transaction Codes:** A section with dropdown menus for Payment, Adjustment, Withheld, Incentive, Penalty, Transfer, Interest Payment, and Interest Adjustment, each accompanied by an 'Allow Edit' checkbox.
- Auto Adjustment Settings:** A section with checkboxes for 'Auto Adjust Non-Allowed Amount in Charge Entry', 'Auto Adjust Occ. Med. in Charge Entry', 'Show Auto Adjust Dialog Box', 'Auto Adjust Capitation in Charge Entry', 'Leave Voucher Balance', 'Transfer Voucher Balance to Self-Pay', 'Auto Adjust' dropdown, 'Reference' input field, and 'Allow Edit Reimb. Comment' dropdown.
- Payment Export Settings:** 'Output Path' and 'Output File' dropdowns.
- Default Refund Transaction Code Credit Balance Management:** 'Refund' dropdown.
- Action Buttons:** 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

Holds up to 8 characters.

Use with Uninsured Carriers

This box is displayed only when **Uninsured** is made available in the **Available Coverage Types** area of the **General** tab in **Practice Options** or **Organization Options**.

When **Use with Uninsured Carriers** is selected, the following fields are available on the **Reimbursement Style** tab:

- > **Abbreviation**
- > **Description**
- > In the **Default Transaction Codes** area:
 - **Payment** and the corresponding **Allow Edit** box
 - **Adjustment** and the corresponding **Allow Edit** and **Reimb. Comment** boxes
 - **Transfer** and the corresponding **Allow Edit** box

Note: If you select **Use with Uninsured Carriers** for an existing reimbursement style record, any fields that are not available are cleared when you click **Save**.

When **Use with Uninsured Carriers** is selected, the **Uninsured** and **History** tabs are available. **Detailed Reimb. Info** is not available.

Use with Uninsured Carriers is not available when:

- > The reimbursement style is selected in **Default Reimbursement Style** on the **General** tab in **Practice Options** or **Organization Options**.
- > The reimbursement style is the default reimbursement style for an insurance carrier, which is selected in **Reimbursement Style** on the **Styles** tab in **Insurance Carrier Maintenance**.

Description

Holds up to 40 characters. Displays as an option in **Insurance Carrier Maintenance** and **Practice Options** or **Organization Options**.

Usual Payment Percent

Enter the % of the allowable amount you expect to be reimbursed by the carrier.

Note: Do not fill this box if you are creating a style to be used with a carrier designated for occupational medicine billing.

Detailed Reimbursements

When selected, enables **Adjust Non-Allowed Amount** and the **Detailed Reimb Info** tab where you define the payment boxes used with this style.

Note: If you select **Detailed Reimbursements**, you must make selections on the **Detailed Reimb Info** tab. If you do not define detailed reimbursement information, an inaccurate balance might be displayed during payment entry.

If you do not select this option, only the default boxes **Payment** and **Adjustment** are displayed in **Payment Entry**.

Adjust Non-Allowed Amount

Enabled only when you select **Detailed Reimbursements**. When you select this option, the distribution option **Adjust Non-Allowed on Payment Entry** is automatically selected when you use **Auto Fill**. Ensures that the difference between the fee and the allowed amount is automatically adjusted off the balance due on the voucher.

Does not apply to manual payment entry.

SUPPRESS UPDATE OF CONTRACTUAL ALLOWANCES

Prevents you from updating the carrier tables for allowed amounts from the **Payment Entry** tab. Thus, there is no warning given when the allowed amount entered for a service differs from the allowed amount entered on the contractual allowance table for the carrier associated with this reimbursement style.

Note: This option has no effect on whether contractual allowances are updated by the import remittances process, which is controlled solely by the **Automatically Update Contractual Allowances** import option in **Electronic Remit Style Maintenance**.

Set OTAF Amount Equal to Allowed

Enabled only when you select **Detailed Reimbursements**.

Select this option for each reimbursement style that is associated with a contracted carrier that could be primary to Medicare.

Automatically fills the **OTAF** column on a service line with an amount equal to the allowed amount when the following conditions are true:

- > The allowed amount on the service line is greater than zero.
- > The allowed amount on the service line is not equal to the fee amount.
- > The voucher balance is being transferred to a Medicare secondary policy whose claim style is not selected as **Primary Billing Only**.

Note: Be sure to include **OTAF** when selecting columns on the **Detailed Reimb Info** tab.

Allow Interest Posting

Select this option to enable interest posting for this reimbursement style.

Default Transaction Codes area

To minimize keystrokes at the time of payment entry, select transaction codes that automatically fill the corresponding boxes on the **Payment Entry** tab.

Allow Edit

When selected, you can change the default selection in the box on the **Payment Entry** tab.

Reimb Comments

Made active for the corresponding **Adjustment**, **Withheld**, **Incentive**, or **Penalty** transaction code box when you make a selection enabling you to select default comments for the amounts applied to each service line.

The default adjustment reimbursement comment automatically fills **Comments** on the service when **Adjust Non-Allowed Amount** is selected on the **Apply Transactions to Voucher** during payment entry.

The default withheld, incentive, or penalty reimbursement comment automatically fills **Code** on **Specify Reimbursement Comments** when you enter the applicable amount on the service.

The reimbursement comment defaults are editable.

Incentive and Penalty

Includes adjustment transaction codes that are not defined as self-pay or interest. Automatically fill the corresponding boxes in the **Transaction Codes** area in **Apply Transactions to Voucher #**.

Interest Payment

Only enabled if you select **Allow Interest Posting**. Enables you to choose a default interest payment transaction code. If you select an interest payment transaction code, you must also select a corresponding interest adjustment transaction code.

Interest Adjustment

Only enabled if you select **Allow Interest Posting**. Enables you to choose a default interest adjustment transaction code. If you select an interest adjustment transaction code, you must also select a corresponding interest adjustment transaction code.

Auto Adjustment Settings area

This section enables you to select a default adjustment code and to enter default reference text to use when completing the automatic adjustment for either non-allowed amounts, a capitation charge, or a charge for occupational medicine services.

You can only select 1 of these options per reimbursement style.

Auto Adjust Non-Allowed Amount in Charge Entry

Select this option to have the non-allowed amount for a procedure automatically adjusted off when the charge is entered.

Note: You should load allowed amounts for the payers you want to adjust off the non-allowed during charge entry.

When this option is selected, if either of the other **Auto Adjustment Settings** check boxes are selected, the application automatically clears them. In addition **Allow Edit** is unavailable.

Defaults that are used when the non-allowed amount adjustments are applied are specified in **Auto Adjust**, **Reimb Comment**, and **Reference**. When **Auto Adjust Non-Allowed Amount** on the **Charge Entry** tab is selected, you are required to complete these 3 boxes.

Auto Adjust - Click to select from the list of adjustment type transaction codes.

Note: To differentiate an adjustment taken during charge entry from 1 taken during payment entry, you might choose to create a unique adjustment type transaction code for the non-allowed amount adjustments during charge entry; however, that is not required to use this function.

Reimb Comment - Click to select from the list of reimbursement comments. You must select a reimbursement comment to associate with the non-allowed adjustment that supports secondary billing requirements.

Reference - Enter text to be used as the reference on the payment record for the applied non-allowed adjustment.

Note: If you select this option and **Adjust Non-Allowed Amount in Reimbursement Style Maintenance**, there is a risk that 2 adjustments for the non-allowed amount might be created. There might be certain circumstances that would call for both options to be selected. If both are selected, a soft warning message is displayed when you click **Save** in **Reimbursement Style Maintenance**.

Show Auto Adjust Dialog Box

This option is automatically enabled and selected when you select **Auto Adjust Non-Allowed Amount in Charge Entry**.

When you select this option, **Auto Adjust Non-Allowed Amount** opens when you click **Save** on the **Charge Entry** tab. This window displays the adjustments that will be applied.

When you clear **Show Auto Adjust Dialog Box**, the window is not displayed and the adjustments are automatically applied.

Auto Adjust Capitation in Charge Entry

Select this option to have the non-allowed amount for a procedure automatically adjusted off when the charge is entered.

Note: You should load allowed amounts for the payers you want to adjust off the non-allowed during charge entry.

When this option is selected, if either of the other **Auto Adjustment Settings** check boxes are selected, the application automatically clears them. In addition, **Allow Edit** is unavailable.

Defaults that are used when the non-allowed amount adjustments are applied are specified in **Auto Adjust**, **Reimb Comment**, and **Reference**. When **Auto Adjust Non-Allowed Amount** on the **Charge Entry** tab is selected, you are required to complete these 3 boxes.

Note: If you select this option and **Adjust Non-Allowed Amount** in **Reimbursement Style Maintenance**, there is a risk that 2 adjustments for the non-allowed amount might be created. There might be certain circumstances that would call for both options to be selected. If both are selected, a soft warning message is displayed when you click **Save** in **Reimbursement Style Maintenance**.

Select this option only when the style being created is associated with a carrier with plans flagged for capitation.

To select defaults that automatically fill the corresponding boxes on **Apply Capitation Adjustment**, do the following:

Auto Adjust - Click to select from the list of adjustment type transaction codes.

Reference - Enter free text that will automatically fills **Reference** on **Apply Capitation Adjustment**.

Leave Voucher Balance

The voucher balance remains the payer's responsibility. This option is only enabled when **Auto Adjust Capitation in Charge Entry** is selected.

Transfer Voucher Balance to Self-Pay

The voucher balance transfers to self-pay. If you select this option, you must have a value for **Transfer** in the **Default Transaction Codes** area. This option is only enabled when **Auto Adjust Capitation in Charge Entry** is selected.

Auto Adjust Occ Med in Charge Entry

Select this option only when the style being created is associated with a carrier flagged for occupational medicine and your contract is based on negotiated contract rates.

Select this option if your contract is based on negotiated contract rates. (Applicable rates are entered on the **Contractual Allowance** tab in **Insurance Carrier Maintenance**.)

Triggers the display of a window that enables you to apply the adjustment associated with your contract. This window is displayed when you click **Save** on the **Charge Entry** tab.

Auto Adjust

Automatically fills **Capitation Adj Transaction Code** in the adjustment window during charge entry for a capitation or occupational medicine charge when 1 of the **Auto Adjustment Settings** check boxes is selected.

If **Allow Edit** is selected, users can edit the default transaction code on the adjustment window.

Auto Adjust Capitation in Charge Entry or **Auto Adjust Occ Med in Charge Entry** must be selected for this box to be enabled.

Reference

Free text field that automatically fills **Reference** on the adjustment window during charge entry for a capitation or occupational medicine charge when 1 of the **Auto Adjustment Settings** check boxes is selected.

Auto Adjust Capitation in Charge Entry or **Auto Adjust Occ Med in Charge Entry** must be selected for this box to be enabled.

Payment Export Settings area

Intended for use by clients exporting patient and claim information to Third Millennium.

Important: If you do not use the Third Millennium Interface Export, leave these boxes blank.

Default Refund Transaction Code Credit Balance Management

Enables you to select default transaction codes for the various credit balance management windows.

Refund

Use **Refund** to select a default refund transaction code for use in **Credit Balance Management**. **Refund** is a drop-down list that includes transaction codes created in

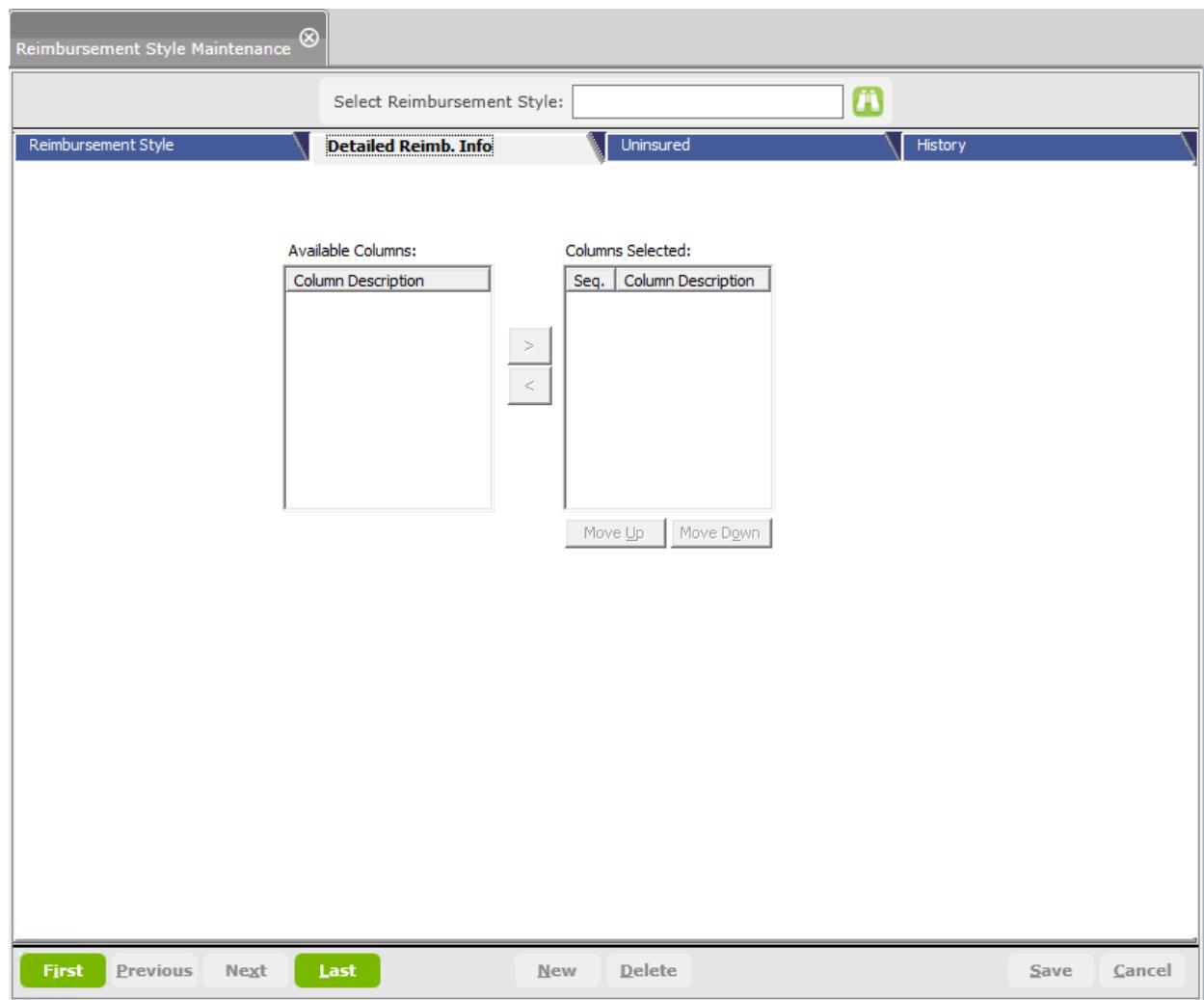
Transaction Code Maintenance with a **Transaction Type of Payment or Refund** that do not have the **Interest** check box selected.

The transaction code you select in **Refund** is used when creating refund transactions in **Credit Balance Management**. When you open **Create Refund Transactions** for vouchers associated with a carrier with this reimbursement style, the transaction code you enter in **Refund** is used to create the refund transaction when you set **Transaction Code to Default**.

Detailed Reimb Info tab

Use the **Detailed Reimb Info** tab in **Reimbursement Style Maintenance** to select the columns that match your payer's remittance advices.

Access the **Detailed Reimb. Info** tab from **Reimbursement Style Maintenance**. To access **Reimbursement Style Maintenance**, go to **System Administration > File Maintenance > Reimbursement Style Maintenance** or press **F9** and then enter **RSM**.



Available Columns

To include a column in this reimbursement style, move it from **Available Columns** to **Columns Selected** using the arrow buttons. The available columns are:

- > Allowed
- > Non-Allowed
- > Deductible
- > Co-pay
- > Co-insurance
- > Withheld
- > Payment
- > Comment
- > OTAF (Obligated to Accept as Payment in Full)

- > Remark
- > Incentive
- > Penalty

Important: A detailed reimbursement style should always include both an **Allowed** and **Non-Allowed** column. To enable the entry of a reimbursement comment at the time of manual payment entry, add the **Comment** column.

Columns Selected

After you move an available column to **Columns Selected** using the arrow buttons, it is displayed here.

Move Up

Click this button to move a selected row in **Columns Selected** higher in the list.

Move Down

Click this button to move a selected row in **Columns Selected** lower in the list.

Uninsured tab in Reimbursement Style Maintenance

Use the **Uninsured** tab to determine whether automatic adjustments are completed after self-pay payments are applied to an uninsured voucher, but before the voucher is saved in charge entry.

The **Uninsured** tab is available only when:

- > **Uninsured** is made available in the **Available Coverage Types** area of the **General** tab in **Practice Options** or **Organization Options**.
- > **Use with Uninsured Carriers** is selected on the **Reimbursement Style** tab in **Reimbursement Style Maintenance**.

Access **Uninsured** from **Reimbursement Style Maintenance**. To access **Reimbursement Style Maintenance**, go to **System Administration > File Maintenance > Reimbursement Style Maintenance** or press **F9** and then enter **RSM**.

(New Reimbursement Style) ×

Reimbursement Style Maintenance

Select Reimbursement Style: (New Reimbursement Style) 🔍

Reimbursement Style Detailed Reimb. Info Uninsured History

Auto Adjust after Self-Pay Payments Applied in Charge Entry

Auto Adjust Transaction Code:

Reference:

Minimum Payment Amount:

Procedure Exceptions:

Proc. Code	Procedure Description

Task for Uninsured Review:

First Previous Next Last New Delete Save Cancel

Auto Adjust after Self-Pay Payments Applied in Charge Entry

Select this option to adjust the balance on uninsured carrier vouchers automatically using this reimbursement style after self-pay payments are applied, but before the voucher is saved in charge entry. When you select this check box, **Auto Adjust Transaction Code**, **Reference**, **Minimum Payment Amount**, **Procedures Exceptions**, and **Task for Vouchers Not Adjusted** are available.

If you clear this box for an existing reimbursement style, any information in the fields is cleared on this tab.

Auto Adjust Transaction Code

This box is available only when **Auto Adjust after Self-Pay Payments in Charge Entry** is selected. It is required when available.

The transaction code you select is applied to any automatic adjustment that is performed by the application associated with that reimbursement style. This list displays transaction codes with **Self-Pay Transaction Code** selected on the **Transaction Code** tab in **Transaction Code Maintenance**.

Reference

This box is available only when **Auto Adjust after Self-Pay Payments in Charge Entry** is selected. It is required when available.

Enter a free text value to associate with the payment record if an automatic adjustment is made to an uninsured voucher after self-payments during charge entry. The value in this box fills **Reference** automatically on the adjustment window during charge entry.

Minimum Payment Amount

This box is available only when **Auto Adjust after Self-Pay Payments in Charge Entry** is selected. It is required when available.

Define the minimum total payments expected by your practice or organization for each uninsured voucher as part of the criteria to determine whether an automatic adjustment is performed by the application before the voucher is saved.

For example, if the total payments applied to the voucher before saving the charge are greater than or equal to the **Minimum Payment Amount**, the remaining voucher balance is adjusted off the voucher when the voucher is saved. The adjustment is not performed if the total payments that are applied to the voucher are equal to the total voucher balance or if the total payments that are applied to the voucher are more than the total voucher balance and result in a credit balance.

Note: \$0.00 is a valid entry. When you enter \$0.00, the application assumes there is no minimum payment due, and the total balance of the voucher is adjusted off if the voucher meets all the other automatic adjustment criteria when the voucher is saved.

Procedures Exceptions grid

This grid is available only when **Auto Adjust after Self-Pay Payments in Charge Entry** is selected.

Add procedures to the reimbursement style record if there are procedures that should be considered for exception when the payment on the uninsured voucher is not greater than or equal to the **Minimum Payment Amount** for the reimbursement style record.

The application adjusts off the remaining voucher balance automatically if all of the following conditions are true when the voucher is saved:

- > Payments are associated with the voucher.

- > The total payments associated with the voucher are not greater than or equal to the minimum payment amount that is associated with the reimbursement style record.
- > The voucher contains at least one of the procedures listed in the exceptions grid.

Proc Code displays **Procedure Code** on the **Procedure Code** tab in **Procedure Code Maintenance**. You cannot enter information in the **Proc Code** column.

Procedure Description displays **Insurance Description** on the **Procedure Code** tab in **Procedure Code Maintenance**.

Click  to add a row to the grid. In the new row, add a procedure to the grid using one of the following methods:

- > Click  to open **Procedure Code Lookup** to search for the procedure code.
- > Enter the procedure code manually in the **Procedure Description** column to fill **Proc Code** and **Procedure Description** with the procedure code information stored in **Procedure Code Maintenance**.

Note: If you enter incorrect or duplicate information, a validation error is displayed.

There is no maximum number of procedure exceptions that you can add to the grid. A scroll bar is displayed when the number of rows exceeds the window size.

Note: When you create a new tenant, if you use a starter data set with the **Transaction Code Information** information type, the existing rows in the **Procedure Exceptions** grid are not copied to the new tenant, but the rest of the information on the **Uninsured** tab is copied. After the new tenant is created and procedure codes have been imported or manually entered into **Procedure Code Maintenance**, you must manually enter the rows in the **Procedure Exceptions** grid.

Task for Uninsured Review

This box is available only when **Auto Adjust after Self-Pay Payments in Charge Entry** is selected.

The list box displays the tasks that were created in **Task File Maintenance**. Select a task to assign vouchers to a task queue in **Office Manager** for further review if they meet the following criteria:

- > A self-pay payment was applied to the voucher before the voucher was saved.
- > The self-pay payment was less than **Minimum Payment Amount**.
- > The voucher did not include any procedures that were listed in the **Procedures Exception** grid.

When an uninsured voucher is successfully assigned to a task queue, the voucher is assigned in **Office Manager > Tasking**. In **Tasking**, **RSM-Uninsured Minimum Payment Amount**

not met is displayed in the **Reason** column for that voucher. You cannot edit this system-defined reason.

Reimbursement Comment Category Maintenance window

Reimbursement comment categories are used to group reimbursement comments for reporting purposes and for working pending and unpaid claims.

Reimbursement comment categories are user-defined records created for the purpose of reporting internally on the adjustment reasons received on adjudicated claims. Give some thought to your reporting needs when creating comment records.

Each reimbursement comment must be assigned to a reimbursement comment category.

Reimbursement Comment Analysis and the query in **Unpaid Claims Management**, under both **Claims Review** and **Office Manager**, can be restricted to specified reimbursement comment categories.

In addition to those categories that apply to your specific needs, best practice is to set up the following categories representing HIPAA-compliant group codes:

Contractual Obligations

Used to identify payer adjustments made due to a contractual agreement.

For **Abbreviation**, use CO.

Correction and Reversal

Used for corrections and reversals to prior claims.

For **Abbreviation**, use CR.

Other Adjustments

Used to identify payer adjustments that do not fall under another category.

For **Abbreviation**, use OA.

Payer Initiated Reduction

Used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (that is, medical review or professional review organization adjustments).

For **Abbreviation**, use PI.

Patient Responsibility

Used to identify the default reimbursement comments selected in **Practice Options** or **Organization Options** for **Co-Ins**, **Co-Pay**, and **Deductible**. For **Abbreviation**, use PR.

In addition to the categories above, best practice is to set up the following categories:

New

Used to identify those new codes created by the application when an electronic remittance file is imported.

You only need to create this category if your practice uses the **Import Remittances** tab. If you do, then use this category for **Default Reimb Comment Category** in **Practice Options** or **Organization Options**.

For **Abbreviation**, use New.

Denials

Used to identify the group or reason codes used by carriers when they deny services. If you submit secondary claims electronically, designate at least 1 category for denials.

For **Abbreviation**, use Denial.

To access **Reimbursement Comment Category Maintenance**, go to **System Administration > File Maintenance > Reimbursement Comment Category Maintenance**, or press **F9** and then enter **RCC**.

Reimbursement Comment Category Maintenance

Select Reimbursement Comment Category:

Abbreviation:

Description:

Denial

First Previous Next Last New Delete Save Cancel

Abbreviation

Holds up to 8 characters.

Description

Holds up to 40 characters.

Denial

When selected, this option indicates that the category includes group or reason codes used by carriers for denying claims or services.

On **Apply Transactions for Voucher # nnnn**, reimbursement comments associated with categories having **Denial** selected are only included in the **Comments** drop-down list when the allowed amount equals \$0.00.

The selection of a comment assigned to a category with **Denial** selected automatically selects **Dnd**, located at the end of the service line.

Note: Practices that submit secondary claims electronically must create at least 1 category with **Denial** selected.

Reimbursement Comment Maintenance window

Use **Reimbursement Comment Maintenance** to create records that duplicate the group and reason codes used by carriers on their explanation of benefits and in their electronic remittance files.

Reimbursement comments are user-defined records created for the following purposes. Give some thought to your reporting needs when creating comment records.

- > Reporting internally on the adjustment reasons received on adjudicated claims
- > Reporting the adjustment, co-pay, co-insurance and withhold amounts applied by a primary payer when you submit ANSI 837 secondary electronic claims to the secondary payer

Clients submitting ANSI 837 secondary claims should create records that match the codes used by their carriers on remittance advices. This maintenance window enables you to create a cross reference to the HIPAA-compliant codes for any carrier's proprietary codes, which simplifies the process of selecting a reimbursement comment during payment entry.

It is the HIPAA-compliant group code and reason code that outputs to the CAS segment in the claim file.

Note: A current listing of these HIPAA-compliant adjustment reason codes can be found by visiting the Washington Publishing Company's website at www.wpc-edi.com/codes/claimadjustment. Because this list is extensive, begin by creating only those codes used by your carriers.

In **Electronic Remittance Style Maintenance**, you can define the action the application takes when it encounters a specific reason code on a claim or on a service line during the processing of a remittance file.

When an electronic remittance file contains reason codes that cannot be found in your reimbursement comment file, the application automatically adds them to your tenant. In these instances, both **Abbreviation** and **Description** contain the reason code.

The use of a reimbursement comment on a claim or service line is reportable when you run the **Reimbursement Comment Analysis**.

In addition to other reimbursement comments needed to meet your practice's needs, create the records that can be used as your practice's default selections on the **Payment Entry** tab in **Practice Options** or **Organization Options**.

PR-1

Deductible Amount

PR-2

Co-Insurance Amount

PR-3

Co-Payment Amount

Notes on Functionality

To enable the entry of a reimbursement comment during payment entry, you must include the **Comment** column as part of the reimbursement detail in the carrier's reimbursement style.

Reimbursement Comments are attached to service lines in 1 of 2 ways:

- > Manually during payment entry
- > As part of the import process for electronic remittances

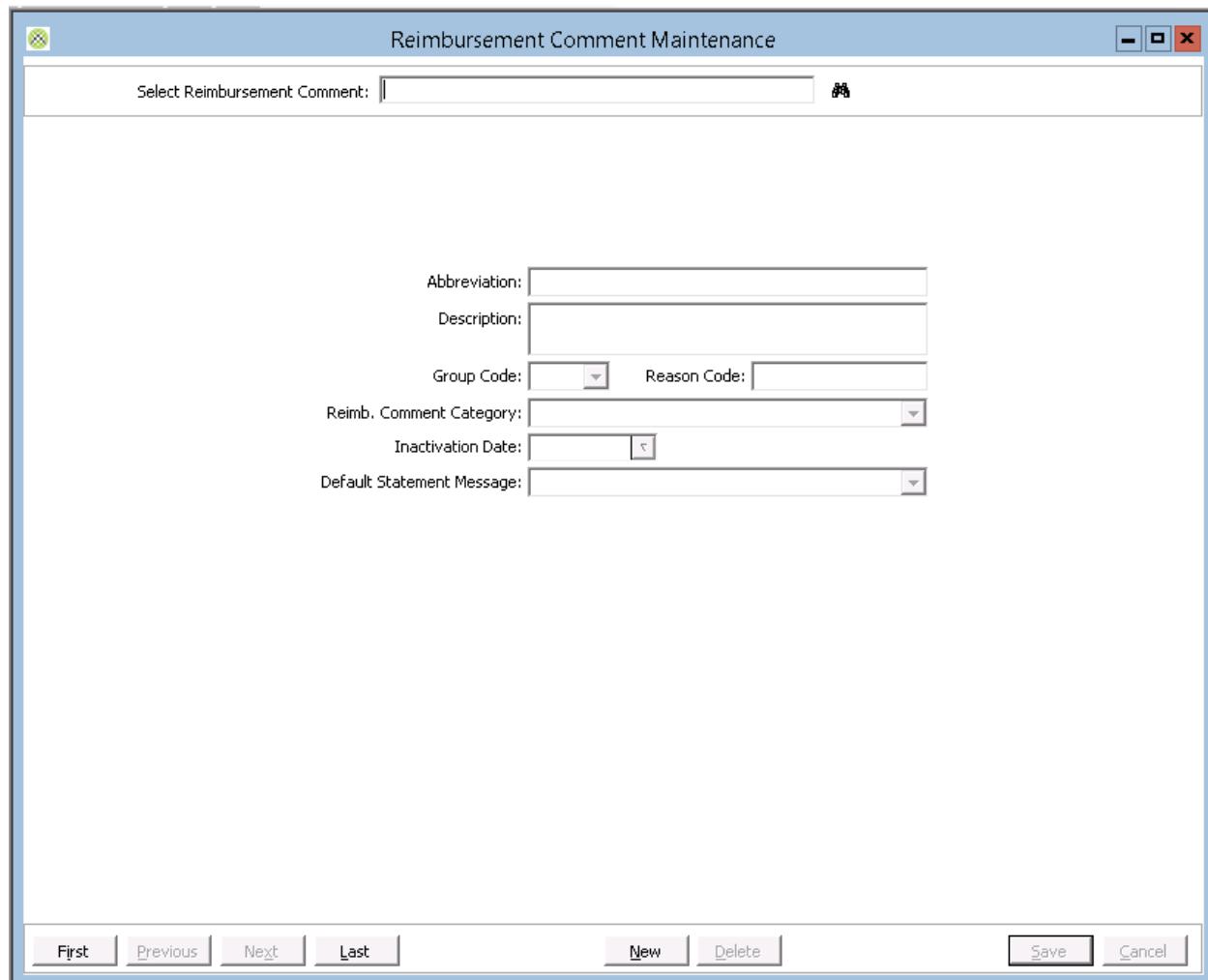
When an electronic remittance file contains group or reason codes that cannot be found in your tenant, the application automatically creates a reimbursement comment and adds it to your tenant.

You must manually review codes created during the import remittance process and make the necessary changes.

You can run **Reimbursement Comment Analysis** under **Reporting > Payment Analysis Reports**.

You can query by reimbursement comment in **Unpaid Claims Management**.

To access **Reimbursement Comment Maintenance**, go to **System Administration > File Maintenance > Reimbursement Comment Maintenance**, or press **F9** and then enter **RCM**.



Abbreviation

The following functions use the value in this box:

> Transactions

Displays in the **Comments** drop-down list on the **Payment Entry** tab.

Displays in the view called from the **Payment Entry** tab when you set **Payment Options to By Service** and select **Detailed Reimbursement Information**.

After you create these reimbursement comments, you must set them as your defaults on the **Payment Entry** tab in **Practice Options** or **Organization Options**.

> Financial Inquiry

Displays in the view called from the **Account Inquiry** tab when you set **Payment Options to By Service** and select **Detailed Reimbursement Information**.

> Reporting

Prints on the **Reimbursement Comment Analysis Report**.

Enter a HIPAA-compliant code using the format Group Code/Reason Code (PR-1).

When creating a carrier-specific code, enter the carrier's name and the code used on the remittance advice, for example Aetna-2.

Description

Enter a description of the group or reason code. This description is displayed on windows opened by clicking **Selected Records** for the **Reimbursement Comment Analysis** and the **Unpaid Claims Management** query.

Use the description found on the carrier's remittance advice to enter up to 80 characters.

Group Code

Group and reason codes are used by the payer to explain why a claim or service line was paid differently than it was billed.

The options for this box are a hard-coded list of HIPAA-compliant group codes.

This box is required when you enter value in **Reason Code**.

Select a group code that describes the reason for adjustment.

The group code outputs to the CAS segment in the electronic file when preparing ANSI 837 electronic claims for submission to a secondary payer.

Always use a HIPAA-compliant group and reason for comments that are intended to be used when electronically submitting secondary claims.

CO

Contractual Obligation

Use this group code when a joint payer or payee contractual agreement or a regulatory requirement results in an adjustment.

CR

Correction and reversal

Use this group code for corrections and reversals to prior claims.

OA

Other Adjustment

Use this group code to identify payer adjustments that do not fall under another category.

PI

Payer Initiated Reduction

Use this group code when, in the opinion of the payer, the adjustment is not the responsibility of the patient , but there is no supporting contract between the provider and the payer (that is, medical review or professional review organization adjustments).

PR

Patient Responsibility

Reason Code

Group and reason codes are used by the payer to explain why a claim or service line was paid differently than it was billed.

A current listing of these HIPAA-compliant adjustment reason codes can be found by visiting the Washington Publishing Company's website at www.wpc-edi.com/codes/claimadjustment. Because this list is extensive, begin by creating only those codes used by your carriers.

Enter the HIPAA-compliant adjustment reason code

To output to a claim file, this entry must not be more than 3 characters.

Outputs to the CAS segment in the electronic file when preparing ANSI 837 electronic claims for submission to a secondary payer.

Reimb Comment Category

This is a required box.

Inactivation Date

Use only when you no longer want this reimbursement comment included in the drop-down list on the **Payment Entry** tab. After this date, the code is considered not valid.

Use the format mmdyyyy to enter the date when this comment is no longer a selection for the **Comments** on the **Payment Entry** tab.

You can still access this comment with a search in **Reimbursement Comment Maintenance**.

The import remittance process does not consider the inactivation date when looking for matches. Therefore, review your remittance advice to determine if you need to reactivate a reimbursement comment.

Default Statement Message

Not a required box.

The drop-down list displays all of the messages from **Message Maintenance** that have **Use on Statements** selected.

Enables you to set a default statement message that prints on the patient's statement when the comment is added to the voucher.

Using a default statement message for a reimbursement comment

This topic explains how a default statement message for a reimbursement comment works in conjunction with **Electronic Remit Style Maintenance** and payment entry.

In **Reimbursement Comment Maintenance**, you can select a default statement message for a reimbursement comment that is attached to voucher.

Effects on Electronic Remit Style Maintenance

Statement Message on the **Reason Options** tab in **Electronic Remit Style Maintenance** is filled with the value from **Default Statement Message** in **Reimbursement Comment Maintenance**.

If an **Electronic Remit Style Maintenance** record contains an existing reimbursement comment code that has a statement message attached, and a default statement message is added in **Reimbursement Comment Maintenance**, the application does not update or overwrite the existing statement message in **Electronic Remit Style Maintenance**.

If **Default Statement Message** is changed at any time, the application does not change the statement message in **Electronic Remit Style Maintenance**. To change the message in **Electronic Remit Style Maintenance**, you must manually change **Statement Message**. If the default message is changed, a warning message, The default statement message has been changed. Please review electronic remittance style maintenance reason options to reflect these changes, is displayed when you click **Save**.

Effects on Payment Entry

During payment entry, **Default Statement Message** in **Reimbursement Comment Maintenance** automatically fills **Statement** in the **Messages** area of **Apply Transactions to Voucher** when the reimbursement comment is applied to a voucher.

Because only 1 statement message can be attached to a voucher, when more than 1 of your selected statement messages qualifies to be attached to the voucher, the application selects and attaches a message based on the following order of priority:

1. Group or reason statement message
2. Deductible statement message
3. Co-pay statement message
4. Co-insurance statement message

If there are multiple service lines on the voucher, the application looks at the messages in service line order, and the last message to qualify on the last service line is the 1 that is applied to the voucher.

If you set up a default statement message in **Reimbursement Comment Maintenance**, and you have a pre-existing statement message that is not linked to a reimbursement comment, the

application overwrites the pre-existing statement message with the value in **Default Statement Message** if you enter the reimbursement comment during payment entry.

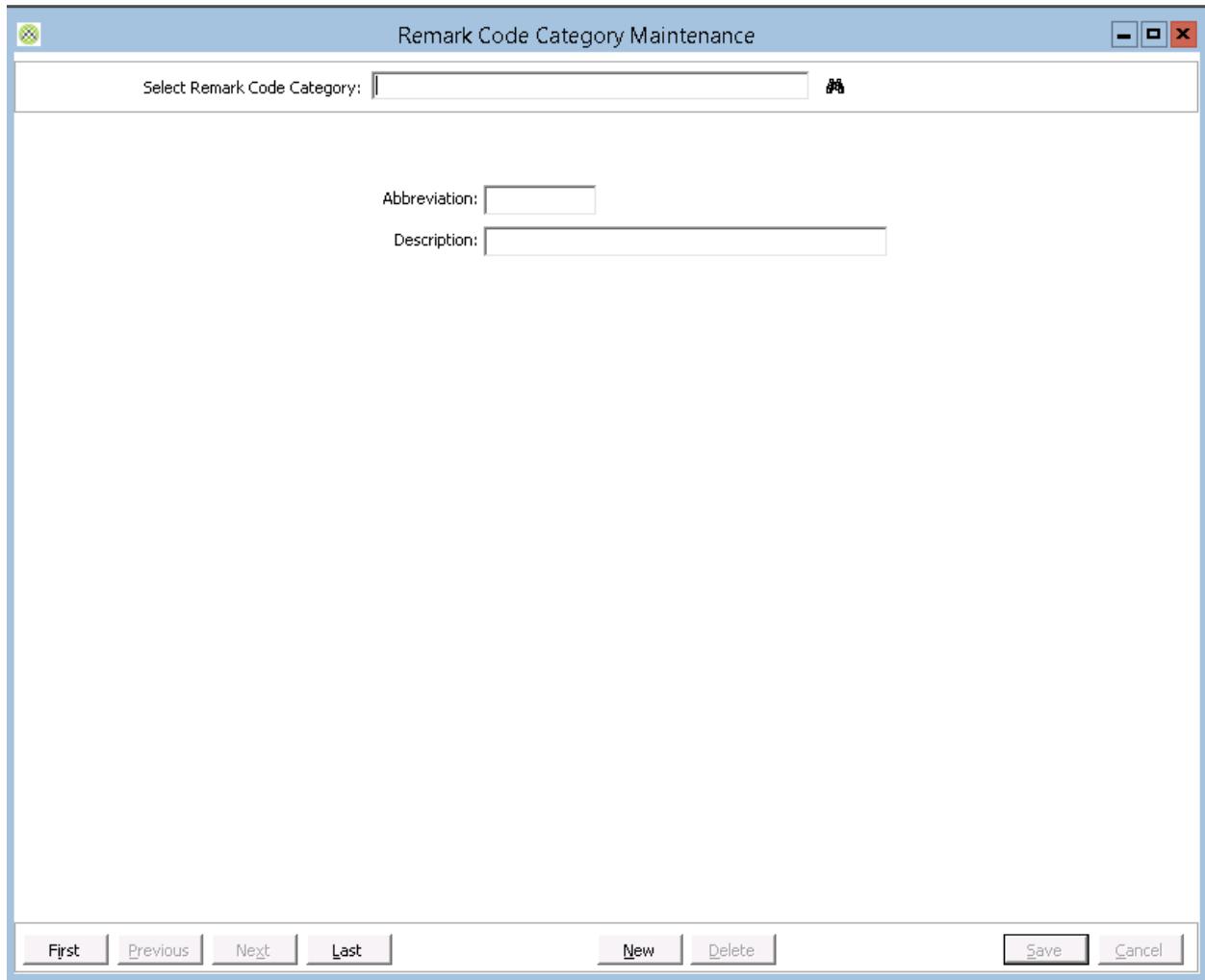
Remark Code Category Maintenance window

Use **Remark Code Category Maintenance** to create remark code categories that you can use to group remark codes for reporting purposes.

Remark codes are used by carriers to provide information as to why a claim or service was denied. If you are using **Import Remittances**, create the category **New** in addition to any other categories that you might need. After you create this category, go to the **Payment Entry** tab in **System Administration > Practice Options** or **System Administration > Organization Options** and select **New** for **Default Remark Code Category**. This default category is used by the application when automatically creating a new record for remark codes reported in the 835 remittance file for which there is no match found in your tenant.

Examples of other types of remark code categories are: Global Services, Missing Documentation, Not Covered Services.

To access **Remark Code Category Maintenance**, go to **System Administration > File Maintenance > Remark Code Category Maintenance**, or press **F9** and enter **RKC**.



Abbreviation

Enter up to 8 characters. Displays in some **Selected Records** windows, such as **Select Remark Codes** in **Unpaid Claims Management**.

Description

Enter up to 44 characters. Displays in some **Selected Records** windows, such as **Select Remark Codes** in **Unpaid Claims Management** and in the drop-down list on the **Payment Entry** tab in **Practice Options** or **Organization Options**.

Remark Code Maintenance window

Use **Remark Code Maintenance** to create remittance advice remark codes that are used by carriers to provide information about the remittance process or to provide additional explanation for an adjustment already described by a claim adjustment reason code.

Remark codes can be entered on vouchers either manually or through electronic remittances.

Refer to the remittance advice from your carriers to create codes that are used frequently.

Each remittance advice remark code identifies a specific message as shown in the remittance advice remark code list available at <http://www.wpc-edi.com/codes/remittanceadvice>.

Using remark codes

Remark codes entered as part of the claim detail can help you identify claims that need to be worked and resubmitted to the carrier.

Remark Codes can be added to a claim in the following ways:

- > Through the import remittance process
- > Manually during payment entry
- > From the **Edits** tab using **Edit Reimbursement Detail**

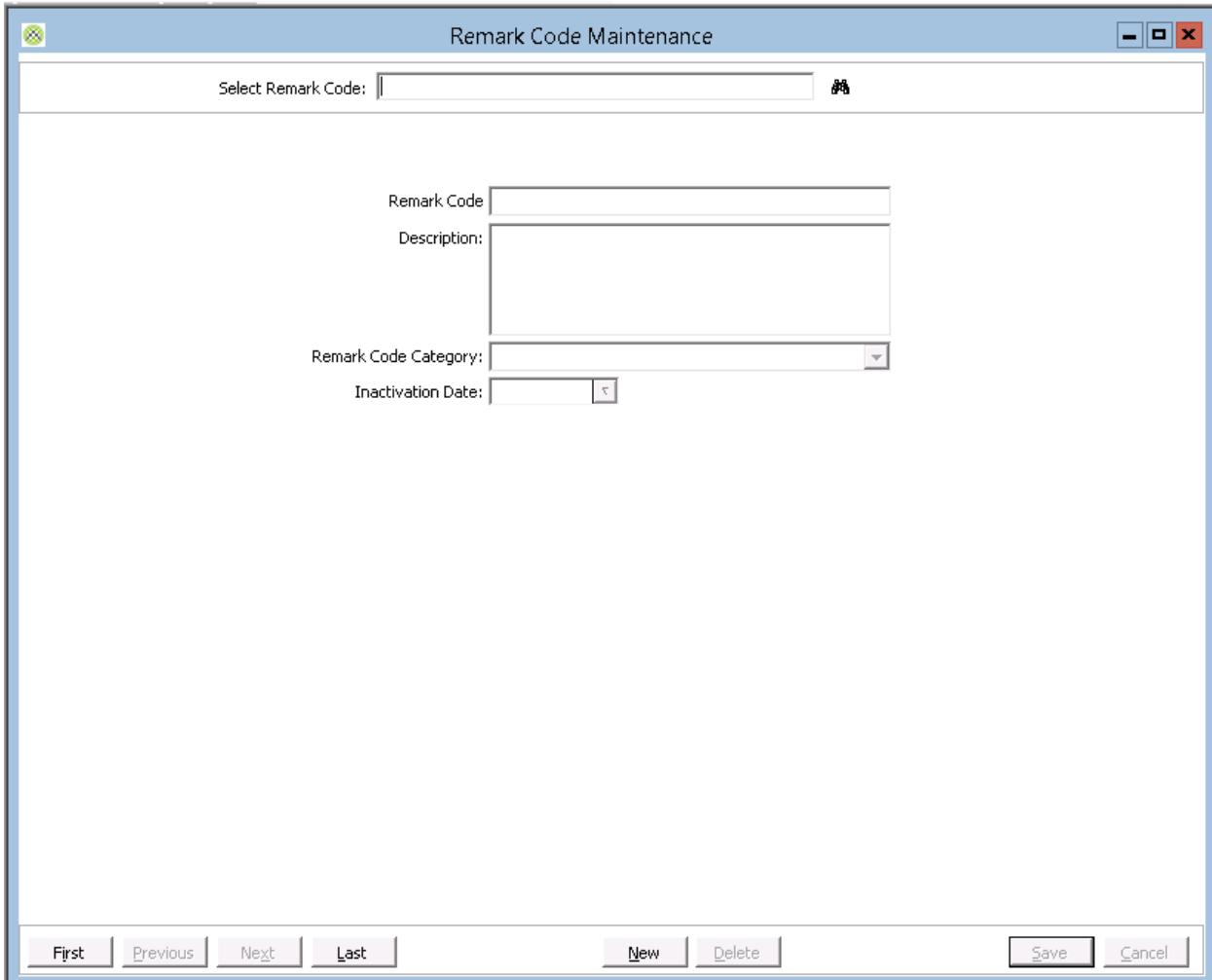
You can also use remark codes to help you manage claims review. You can retrieve unpaid claims by remark code or remark category.

Maintaining remark codes

The following maintenance is required for the proper use of remark codes:

1. Create remark code categories.
2. Create remark codes.
3. Add **Remark** as a column on the **Detailed Reimb Info** tab in **Reimbursement Style Maintenance** for carriers that use remark codes.
If you are importing 835 remittance files, also do the following:
 4. Create a category called **New** in addition to other categories needed for reporting and tracking purposes.
 5. Select a value for **Default Remark Code Category** on the **Payment Entry** tab in **System Administration > Practice Options** or **System Administration > Organization Options**.

To access **Remark Code Maintenance**, go to **System Administration > File Maintenance > Remark Code Maintenance**, or press **F9** and enter **RKM**.



The screenshot shows a Windows application window titled "Remark Code Maintenance". At the top left is a search bar labeled "Select Remark Code:" with a dropdown arrow. The main area contains four input fields: "Remark Code" (text box), "Description" (text area), "Remark Code Category" (dropdown menu), and "Inactivation Date" (text box with a calendar icon). Below these fields is a toolbar with buttons for "First", "Previous", "Next", "Last", "New", "Delete", "Save", and "Cancel".

Remark Code

Enter the remark code used by your carriers, for example M20.

Description

Enter a description for the remark code. You can enter up to 255 characters.

Remark Code Category

This value is required. Select a remark code category to group remark codes for reporting purposes. Remark code categories are created in **Remark Code Category Maintenance**.

Inactivation Date

Enter the date when this code is no longer valid. Use the format mmddyyyy. From this date and beyond, the remark code is excluded from any **Selected Records** windows and drop-down lists except in **Remark Code Maintenance**.

Message Maintenance window

Use **Message Maintenance** to create messages that print on statements or claims.

Messages are voucher-specific and are added either from the **Payment Entry** tab or the **Edits** tab. Only 1 of each type of message can be attached to a voucher. After it is attached to a voucher, the message always prints when that voucher is billed unless the message is removed from the voucher using the **Edits** tab.

Statement messages can be included on the **Account Summary Report** and the **Collection Account Report**. Both statement and claim messages can be optionally viewed in **Financial Inquiry**. Claim messages can be viewed with claim detail in **Unpaid Claims Management**.

To access **Message Maintenance**, go to **System Administration > File Maintenance > Message Maintenance**, or press **F9** and then enter **MEM**.

Message Maintenance contains these tabs:

- > **Message**
- > **Department Members or Practice Members**

Note: This tab is only visible if you have **Enable Department Security** or **Enable Practice Security** selected in **Practice Options** or **Organization Options**.

Message tab

Use the **Message** tab in **Message Maintenance** to create messages that print on statements or claims. Messages created on this tab are voucher-specific.

After it is attached to a voucher, the message always prints when that voucher is billed unless the message is removed from the voucher using the **Edits** tab.

You can attach a message in the following areas of the application:

- > From the summary view on the **Charge Entry** tab, select a value for **Statement Message** or **Claim Message**.
- > On the **Edits** tab, select a value for **Stmt Msg** and **Claims Msg**.
- > On **Apply Transactions to Voucher # xxxx** during payment entry, select a value for **Statement**.

As their names imply, a message designated for use on a statement is printed whenever the voucher's self-pay balance is billed to the patient or account. Only 1 message can print on a statement.

Statement messages can be included on the **Account Summary Report** and the **Collection Account Report**.

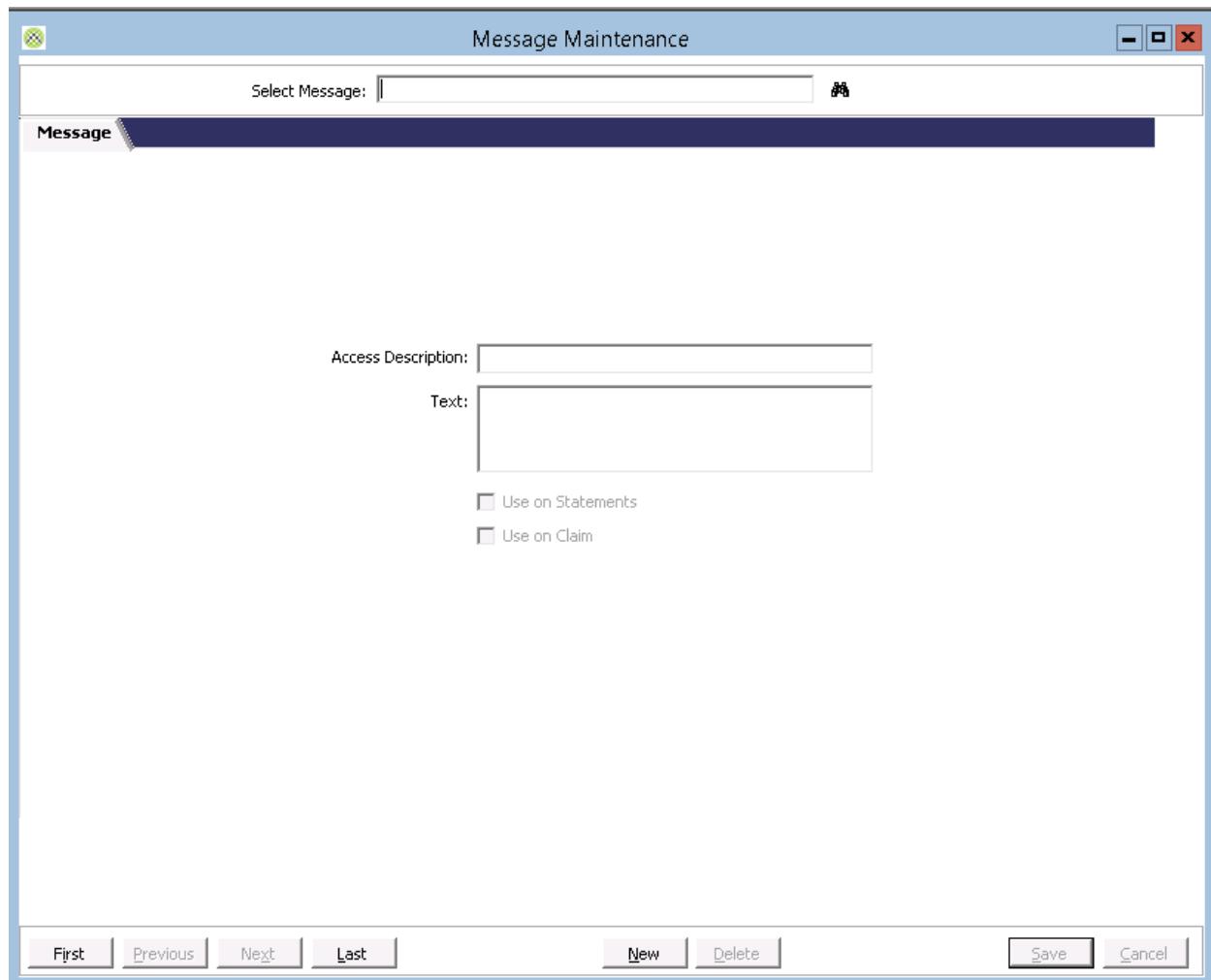
Both statement and claim messages can be viewed in **Financial Inquiry**.

Claim messages can be viewed with claim detail in **Unpaid Claims Management**, either under **Claims Review** or within **Office Manager**.

Sample messages

Access Description	Sample Text
DEN	INSURANCE PAYMENT DENIED - NO COVERAGE ON THE DATE OF SERVICE.
CC	A CLAIM WAS SUBMITTED TO YOUR INSURANCE AS A COURTESY. PLEASE REMIT PAYMENT.
DED	A DEDUCTIBLE WAS APPLIED FOR THESE SERVICES. PLEASE REMIT PAYMENT.
REF	CLAIM DENIED - NO REFERRAL ON FILE.
RSB	THIS CLAIM IS BEING RESUBMITTED TO YOUR INSURANCE.

Access the **Message** tab from **Message Maintenance**. To access **Message Maintenance**, go to **System Administration > File Maintenance > Message Maintenance**, or press **F9** and then enter **MEM**.



Access Description

Enter a value to display in the corresponding drop-down lists on the **Charge Entry** tab and **Payment Entry** tab.

Text

Enter a free-text message that prints on the patient's statement or claim. Also prints when statement messages are included on a report.

Use on Statements

Select this option to print this message on a patient statement.

Use on Claims

Select this option to print this message below Box 31 of a standard CMS-1500 ICD-10 claim form.

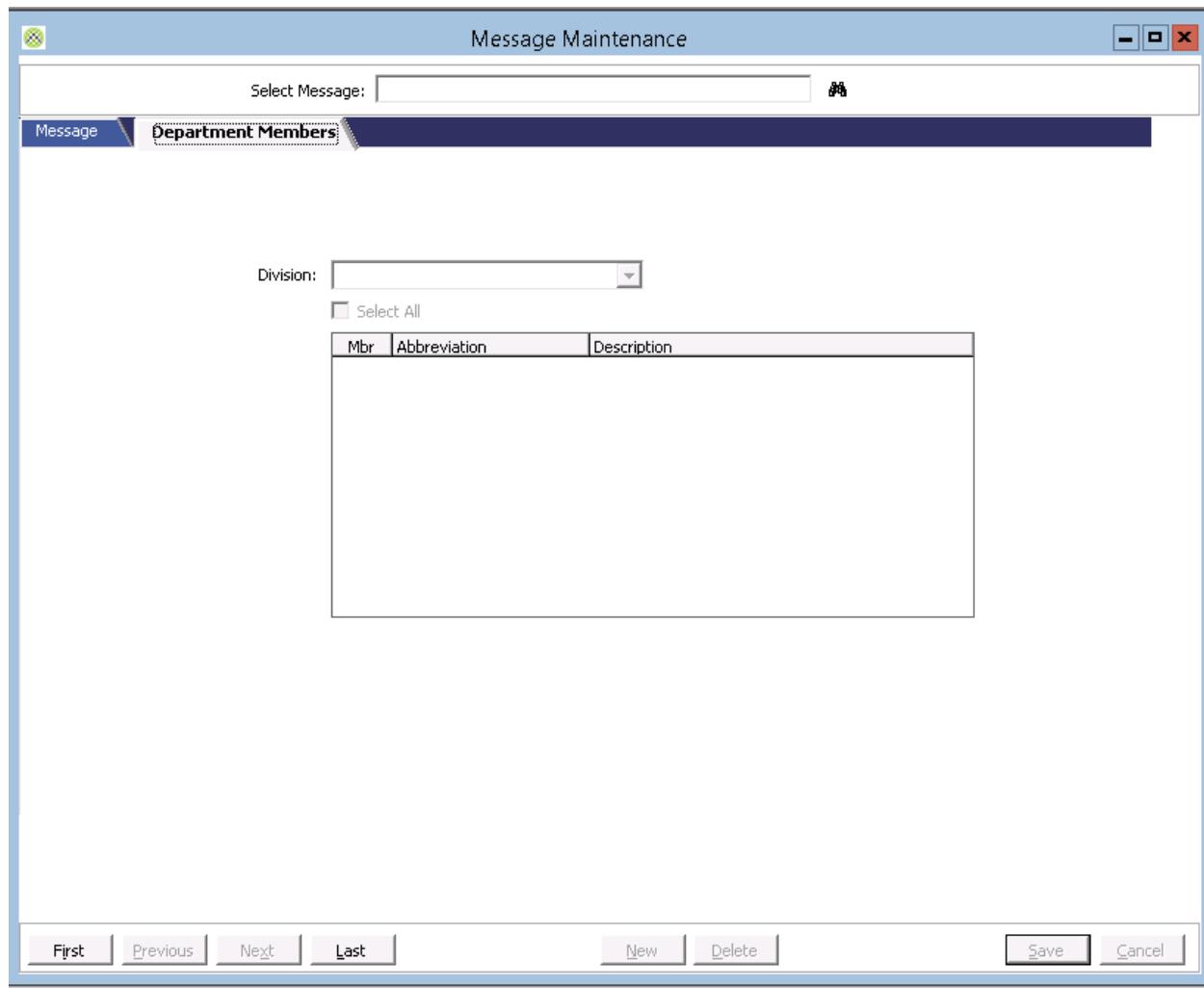
Note: With 1 exception, the claim message does not output to an electronic claim file. A claim message outputs a value to an electronic claim file only when you bill Illinois Medicaid as the secondary payer. Status codes created as claim messages in **Message Maintenance** are appended to the other payer code in Loop 2330B REF02 of a Standard ANSI 837P v5010A1 claim file. The other payer code must be entered on the carrier's **Other Payer Codes** tab in **Insurance Carrier Maintenance**.

Department Members or Practice Members tab in Message Maintenance

This tab is displayed only if you have **Enable Department Security** or **Enable Practice Security** selected on the **General** tab in **Practice Options** or **Organization Options**.

You must select department or practice members for each record that has a members tab.

Access the **Department Members or Practice Members** tab from **Message Maintenance**. To access **Message Maintenance**, go to **System Administration > File Maintenance > Message Maintenance** or press **F9** and then enter **MEM**.



Division

This box is only enabled on the **Department Members** or **Practice Members** tab when you select **Enable Divisions** on the **Multi Entity** tab in **Practice Options** or **Organization Options**. In this case, the selection of department or practice members is done at the level of division.

Note: Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you elect to enable divisions, you must create divisions in **Division Maintenance**. Divisions can be used as a group field or select records option in reporting.

Select All

Select this option if the record should be available for all departments or practices. **Mbr** is selected for all records.

Mbr

If you did not select **Select All**, select **Mbr** to the left of the department or practice you want to add as a member.

Claim Status Code Maintenance window

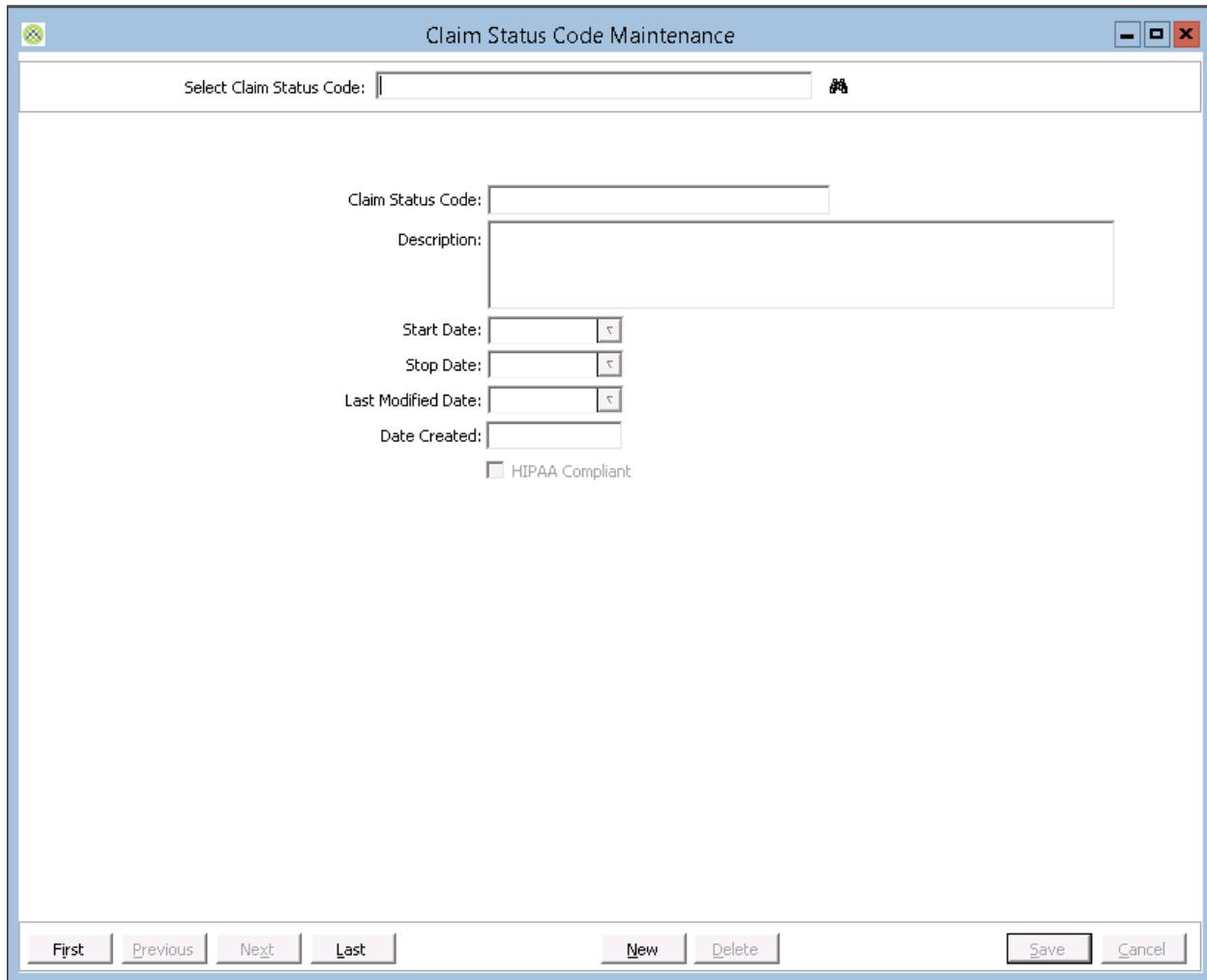
Use **Claim Status Code Maintenance** to create claim status codes.

Claim status codes are used in the Health Care Claim Status Notification (277) transaction by electronic claims vendors and insurance payers to provide additional detail about the status of a claim, such as whether it was received, pended, or paid.

Tip: Because the list of claim status codes on the Washington Publishing Company (WPC) web site <http://www.wpc-edi.com/> is quite large, you might want to have the application create the codes during import. However, you can create a new record manually if needed.

By default, automatically created codes have an abbreviation and description that are the code itself.

To access **Claim Status Code Maintenance**, go to **System Administration > File Maintenance > Claim Status Code Maintenance**, or press **F9** and enter **CSC**.



The screenshot shows a Windows application window titled "Claim Status Code Maintenance". At the top, there is a search bar labeled "Select Claim Status Code:" with a magnifying glass icon. Below the search bar, there is a form with the following fields:

- Claim Status Code: [Text Box]
- Description: [Text Area]
- Start Date: [Text Box] with a calendar icon
- Stop Date: [Text Box] with a calendar icon
- Last Modified Date: [Text Box] with a calendar icon
- Date Created: [Text Box]

Below the form is a checkbox labeled "HIPAA Compliant". At the bottom of the window, there are navigation buttons: "First", "Previous", "Next", "Last", "New", "Delete", "Save", and "Cancel".

Claim Status Code

For codes that are compliant with the Health Insurance Portability and Accountability Act (HIPAA), enter the code as it was used in the file. For example, **6**. This box holds up to 35 characters to support the creation of codes used by Payerpath®.

When a new record is generated during the import process, this box contains the code found in the ANSI file.

Description

Holds up to 255 characters. Enter the HIPAA-compliant code as it is given in either of these sources:

- The **ANSI 277 Unsolicited Claim Status Report** generated from the **ANSI Reports** tab in **Billing > Claims Review**

- > The unsolicited 277 transaction viewed in **Claim Status History** accessed from **Financial Inquiry, Account Ledger, and Unpaid Claims Management** within both **Claims Review Office Manager**
- > The WPC web site

When a new record is generated during the import process, this box contains the code found in the ANSI file.

Start Date

Enter the date when the code was first added to the code list by the Claim Adjustment Status Code Maintenance Committee.

You can find the start date by looking for the code on the WPC web site.

Stop Date

Enter the date after which a code can no longer be used in original business messages, which is the definition for stop date according to the WPC web site.

The code can be used in what is referred to as "derivative" business messages, which are messages transmitted after the stop date but reported from the original business message that was transmitted prior to the stop date.

If a stop date it exists, you can find it by looking for the code on the WPC web site.

Last Date Modified

Enter the date the wording for the code was changed by the Claim Adjustment Status Code Maintenance Committee, which is the definition for last modified date according to the WPC web site.

If a last modified date exists, you can find it by looking for the code on the WPC web site.

Date Created

The date that the claim status category code record was added to Allscripts® Practice Management is automatically entered on the record when it is created.

Use the **Claim Status Code Listing** to identify codes that were automatically created by looking for records with the code in both **Claim Status Code** and **Description**. You can go to the WPC web site to find the description of the code, the start date and stop date (if any) assigned to the code.

HIPAA Compliant

Select **HIPAA Compliant** to indicate that the claims status category code is HIPAA-compliant. If this box is cleared, this code is not HIPAA-compliant such as those used, for example, by Payerpath® for its edits.

Important: You must manually select this box. It is not automatically selected during the import process.

Claim Status Category Maintenance window

Use **Claim Status Category Maintenance** to create claim status categories.

Claim status category codes are used in the Health Care Claim Status Notification (277) transaction by electronic claims vendors and insurance payers to provide additional detail about the status of a claim, such as whether it was received, pended, or paid.

Tip: Because the list of claim status category codes on the Washington Publishing Company (WPC) web site <http://www.wpc-edi.com/> is quite large, you might want to have the application create the codes during import. However, you can create a new record manually if needed.

By default, automatically created codes have an abbreviation and description that are the code itself.

To access **Claim Status Category Maintenance**, go to **System Administration > File Maintenance > Claim Status Category Maintenance**, or press **F9** and enter **CST**.

Claim Status Category Maintenance

Select Claim Status Category:	<input type="text"/>						
Claim Status Category:	<input type="text"/>						
Description:	<input type="text"/>						
Start Date:	<input type="text"/>						
Stop Date:	<input type="text"/>						
Last Modified Date:	<input type="text"/>						
Date Created:	<input type="text"/>						
<input type="checkbox"/> HIPAA Compliant							
First	Previous	Next	Last	New	Delete	Save	Cancel

Claim Status Category

For codes that are compliant with the Health Insurance Portability and Accountability Act (HIPAA), enter the code as it was used in the file. For example, enter R12.

Holds up to 35 characters to support the creation of codes used by Payerpath® for its edits. When a new record is generated during the import process, this box contains the code found in the ANSI file.

Description

Holds up to 255 characters. Enter the HIPAA-compliant code as it is given in either of these sources:

- > The **ANSI 277 Unsolicited Claim Status Report** generated from the **ANSI Reports** tab in **Billing > Claims Review**

- > The unsolicited 277 transaction viewed in **Claim Status History** accessed from **Financial Inquiry, Account Ledger, and Unpaid Claims Management** within both **Claims Review Office Manager**
- > The WPC web site

When a new record is generated during the import process, this box contains the code found in the ANSI file.

Start Date

Enter the date when the code was first added to the code list by the Claim Adjustment Status Code Maintenance Committee.

You can find the start date by looking for the code on the WPC web site.

Stop Date

Enter the date after which a code can no longer be used in original business messages, which is the definition for stop date according to the WPC web site.

The code can be used in what is referred to as "derivative" business messages, which are messages transmitted after the stop date but reported from the original business message that was transmitted prior to the stop date.

If a stop date it exists, you can find it by looking for the code on the WPC web site.

Last Date Modified

Enter the date the wording for the code was changed by the Claim Adjustment Status Code Maintenance Committee, which is the definition for last modified date according to the WPC web site.

If a last modified date exists, you can find it by looking for the code on the WPC web site.

Date Created

The date that the claim status category code record was added to Allscripts® Practice Management is automatically entered on the record when it is created.

Use the **Claim Status Category Listing** to identify codes that were automatically created by looking for records with the code in both **Claim Status Category** and **Description**. You can go to the WPC web site to find the description of the code, the start date and stop date (if any) assigned to the code.

HIPAA Compliant

Select **HIPAA Compliant** to indicate that the claims status category code is HIPAA-compliant. If this box is cleared, this code is not HIPAA-compliant such as those used, for example, by Payerpath® for its edits.

Important: You must manually select this box. It is not automatically selected during the import process.

Electronic Remit Format Maintenance window

Use **Electronic Remit Format Maintenance** to create electronic remittance formats. Electronic remittance formats are associated with an electronic remittance style that governs the import and reason options applied to the file during processing.

Currently, Allscripts® Practice Management supports electronic remittance files in the Health Insurance Portability and Accountability Act (HIPAA)-compliant v4010 and v5010 format for professional and institutional claims, but electronic remit formats are not v4010-specific or v5010-specific.

To access **Electronic Remit Format Maintenance**, go to **System Administration > File Maintenance > Electronic Remit Format Maintenance**, or press **F9** and enter **ERM**.

Electronic Remit Format Maintenance

Select Electronic Remit Format:

Abbreviation:

Description:

EOB Report Type:

EOB Report Name:

Sender ID:

Receiver ID:

Alternate Sender ID:

Alternate Receiver ID:

Sort Listing By:

First | Previous | Next | Last | New | Delete | Save | Cancel |

Abbreviation

Holds up to 8 characters. For example, enter **ANSI**.

Description

Holds up to 40 characters. For example, enter **ANSI X12N 835 v4010** or **ANSI X12N 835 v4010A1**.

EOB Report Type

Standard

Select this option unless you are told otherwise by your Allscripts® Practice Management instructor.

Custom

Select this option if you are using a custom report type. Custom report types are used only by clients who purchase specially designed report types.

EOB Report Name

This box is only used with custom report types. Do not fill this box unless your Allscripts® Practice Management instructor tells you to do so.

Sender ID

This value is assigned to you by the payer. The sender ID must be unique. You cannot use a sender ID that you used on another electronic remit format record. If there is a conflict, contact your carrier.

Tip: If you are required to use the sender and receiver codes given for transmitting claims to the payer, use the receiver code from that format in **Sender ID**. In this case, the payer is the sender of the payment file.

Receiver ID

This value is assigned to you by the payer. The receiver ID must be unique. Therefore, you cannot use a receiver ID that you used on another electronic remit format record. If there is a conflict, contact your carrier.

Tip: When you are required to use the sender and receiver codes given for transmitting claims to the payer, use the sender code from that format in **Receiver ID**. In this case, the provider is receiving the payment file.

Alternate Sender ID

Enter an alternate sender ID assigned to you by the payer only when the carrier producing the remittance file uses 2 different adjudication applications to create the file. As a result, the sender ID might vary even if the files come from the same carrier.

For example, when billing Medicaid for professional and rural health center (RHC) claims, you might have 1 **Insurance Carrier Maintenance** record defined for Medicaid, but 2 separate applications adjudicate the different types of claims.

Because only 1 **Insurance Carrier Maintenance** record exists, only 1 **Electronic Remit Format Maintenance** record can be associated with it. Using an alternate sender ID resolves that situation.

Note: You can only save a value in **Alternate Sender ID** if you entered a value in **Sender ID**. However, do not enter the same value in **Alternate Sender ID** and **Sender ID**.

Alternate Receiver ID

Enter an alternate receiver ID assigned to you by the payer only when the carrier producing the remittance file uses 2 different adjudication applications to create the file. As a result, the receiver ID might vary even if the files come from the same carrier.

For example, when billing Medicaid for professional and rural health center (RHC) claims, you might have 1 **Insurance Carrier Maintenance** record defined for Medicaid, but 2 separate applications adjudicate the different types of claims.

Because only 1 **Insurance Carrier Maintenance** record exists, only 1 **Electronic Remit Format Maintenance** record can be associated with it. Using this alternate receiver ID resolves that situation.

Note: You can only save a value in **Alternate Receiver ID** if you entered a value in **Receiver ID**. However, do not enter the same value in **Alternate Receiver ID** and **Receiver ID**.

Sort Listing By

Enables you to sort the import remittance listing by claim number or by the patient's last name. Make your selection based on the sort used on your explanation of benefits (EOB).

Electronic Remit Style Maintenance window

Electronic Remit Style Maintenance enables you to define the import remittance settings for your payers.

To access **Electronic Remit Style Maintenance**, go to **System Administration > File Maintenance > Electronic Remit Style Maintenance**, or press **F9** and enter **ESM**.

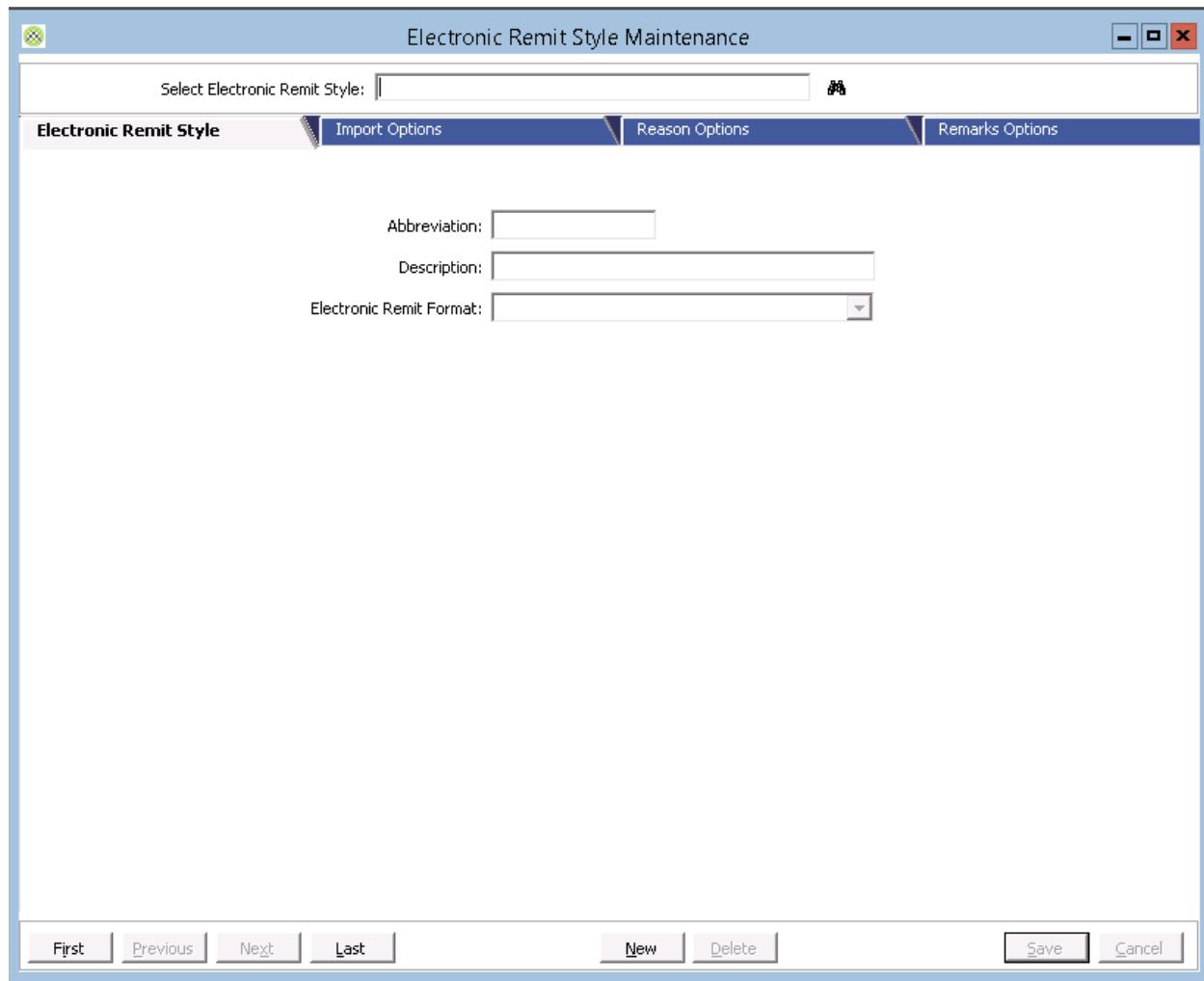
Electronic Remit Style Maintenance contains these tabs:

- > **Electronic Remit Style**
- > **Import Options**
- > **Reason Options**
- > **Remarks Options**
- > **History**

Electronic Remit Style tab

Use the **Electronic Remit Style** tab to define remittance settings by carrier.

Access the **Electronic Remit Style** tab from **Electronic Remit Style Maintenance**. To access **Electronic Remit Style Maintenance**, go to **System Administration > File Maintenance > Electronic Remit Style Maintenance**, or press **F9** and enter **ESM**.



Abbreviation

Enter a unique abbreviation that identifies the payer or carrier. For example, enter MCR for Medicare. Holds up to 8 characters.

Description

Enter the carrier's name. Holds up to 40 characters. This description is displayed in the drop-down list on the **Carrier** tab in **Insurance Carrier Maintenance**.

Electronic Remit Format

Select a value from the List all the electronic remit formats you created in **Electronic Remit Format Maintenance**. The report type of the format is used in combination with the information entered in **Sender ID** and **Receiver ID** when importing and processing a remittance file.

Import Options tab in Electronic Remit Style Maintenance

Use the **Import Options** tab in **Electronic Remit Style Maintenance** to define the import settings by carrier.

Access the **Import Options** tab from **Electronic Remit Style Maintenance**. To access **Electronic Remit Style Maintenance**, go to **System Administration > File Maintenance > Electronic Remit Style Maintenance**, or press **F9** and enter **ESM**.

Electronic Remit Style Maintenance

Select Electronic Remit Style: 

Electronic Remit Style	Import Options	Reason Options	Remarks Options	History
Option Name	Option Value			
Allow Secondary Payments?	<input type="checkbox"/>			
Post Secondary Claim Payments Top-Down	<input type="checkbox"/>			
Apply Non-Allowed Adjustments on Non-Primary Claims?	<input type="checkbox"/>			
Allow Tertiary Payments?	<input type="checkbox"/>			
Rebill if Payer Forwarded to Secondary?	<input type="checkbox"/>			
Rebill if Payer Forwarded to Tertiary?	<input type="checkbox"/>			
Automatically Update Contractual Allowances?	<input type="checkbox"/>			
Ignore Certificate # matching?	<input type="checkbox"/>			
Ignore Modifier matching?	<input type="checkbox"/>			
Ignore Policy Coverage matching ?	<input type="checkbox"/>			
Ignore Policy Coverage matching Transfer Option?	<input type="checkbox"/>			
Calculate Allowed Amount based on Non-Allowed?	<input type="checkbox"/>			
Allow Credit Balance Payment Posting?	<input type="checkbox"/>			
Credit Balance Transfer Option	<input type="checkbox"/>			
Allow Prorated Payments on Institutional/UB Claims?	<input type="checkbox"/>			
Allow Prorated Payments at the Claim Level?	<input type="checkbox"/>			
Allow \$0.00 Payments?	<input type="checkbox"/>			
Prevent Non-Allow Adj if Allow = \$0 and Non-Allow = Fee?	<input type="checkbox"/>			
-Auto-Adjust Non-Allow Amounts Less Than:	<input type="checkbox"/>			
Allow Interest Posting?	<input type="checkbox"/>			
<input type="checkbox"/> Enable Encounter Rate Posting?				
RHC Encounter Procedure Code:		Mod:	<input type="text"/>	
Alt RHC Encounter Procedure Code 1:		Mod:	<input type="text"/>	TOS: <input type="button"/>
Alt RHC Encounter Procedure Code 2:		Mod:	<input type="text"/>	TOS: <input type="button"/>
RHC Encounter Procedure Code Transaction Codes –				
Payment:		<input type="button"/>		
Adjustment:		<input type="button"/>		

First Previous Next Last New Delete Save Cancel

Allow Secondary Payments

When you select this option, claims that include secondary payments made by the carrier are imported and processed.

Post Secondary claim Payments Top-Down

This option is only enabled when you select **Allow Secondary Payments**. When **Post Secondary claim Payments Top-Down** is selected, claim-level payments are applied to a claim with multiple service lines using a top-down payment method, which applies payments to the balance on each service line starting with the first service until the full payment amount is gone. Any service payments reported in the remittance file are ignored.

Apply Non-Allowed Adjustments on Non-Primary Claims

Select this option to adjust the remaining balance off of the nonprimary claim when a remittance file has a nonallowed amount that equals the balance on the claim after nonprimary payments are applied.

This import option is included with the starter data for new tenants when you select **Electronic Remit Information** for **Information Type** in **Administration > Starter Data Maintenance**.

Allow Tertiary Payments

When you select this option, claims that include tertiary payments made by the Carrier are imported.

Rebill if Payer Forwarded to Secondary

When you select this option, claims with the status of having been forwarded to the secondary insurance are automatically flagged for rebilling from Allscripts® Practice Management.

These claims qualify for your next scheduled claims validation run.

Rebill if Payer Forwarded to Tertiary

When you select this option, claims with the indication that the payer has forwarded the claim to a tertiary insurance are flagged for rebilling in Allscripts® Practice Management.

The transferred balance is billed to the tertiary carrier from the application.

Automatically Update Contractual Allowances

When you select this option, the contractual allowance for each service on the contractual allowance table is updated when the allowed amount received is different from the current allowed amount stored on the table.

Note: When this option is selected, an update does not occur when either of the following circumstances is true:

- > When the current effective date entered on the table is greater than the service's **From** date on the claim.
- > When the allowed amount from the remittance is equal to 0 (zero).

Ignore Certificate # matching

Important: Do not select this option and **Ignore Policy Coverage matching**. If you select both options, there is no way to guarantee that the payment being posted is from the current remitter on the voucher.

When you select this option, the application determines which policy to post to by using the following criteria:

- > Match the sender and receiver numbers
- > Match the claim status on the remittance claim to the policy coverage defined in **Registration**.

If you do not select this option, the application uses the certificate number returned in the file to determine which is the correct policy to post the payment against.

Note: You should only use this option if you receive remittance files from payers who do not return the complete certificate number plus the prefix used for billing. Examples of such payers are: GA BCBS, KY BCBS, and PA BCBS.

Ignore Modifier matching

When you select this option, the import remittances function does not look for the existence of a modifier when it is verifying that the remittance service matches a service on the voucher.

If you do not select this option, the import remittances function prevents the posting of services when a modifier is entered on the service line during charge entry, but a modifier is not found in the file.

Select this option for carriers who do not return submitted modifiers in their remittance files.

Ignore Policy Coverage matching

Important: Do not select this option and **Ignore Certificate # matching**. If you select both options, there is no way to guarantee that the payment being posted is from the current remitter on the voucher.

When you select this option, the claim status returned in 2100 CLP02 of the remittance file is ignored if it differs from the policy coverage in Allscripts® Practice Management, and a match is based on the certificate number. If the policy coverage does match the claim status in the remittance file, this option is ignored.

If you do not select this option, the import remittances function prevents the posting of services when the claim status returned in the remittance file does not match the policy coverage in Allscripts® Practice Management.

This option applies only to remittance claims with a claim status indicating that the payer paid as primary, secondary, or tertiary.

The **Import Remittance Listing** shows the following:

- > Attaches the character ⓘ as a prefix to the claim number

- > Prints the message identifying how that claim actually processed. For example: Claim Processed as Primary due to Ignore Policy Coverage matching option .

Note: A claim might be processed by ignoring the policy coverage but still not post for other reasons. In this scenario, the message that identifies how the claim processed still prints, and the claim number still prints prefixed with the  character.

Ignore Policy Coverage matching Transfer Option

This option is enabled and required when **Ignore Policy Coverage matching** is selected.

Select 1 of the following values:

- > **No Transfer** — If a balance exists, no transfer occurs. The voucher stays where it is.
- > **Self-Pay** — If a balance exists, Allscripts® Practice Management transfers the balance and the voucher to self-pay.

If a balance does exist, a message reports whether the balance was transferred to self-pay or not at all.

Multiple policies can have the same certificate number. If you selected Ignore Policy Coverage matching, the first policy found with the correct certificate number is the policy used to process the claim.

If **Ignore Certificate # matching** is also selected, the certificate number matching is replaced by comparing the sender ID and receiver ID in the remittance file to the policy associated with the electronic remit format record with the same sender ID and receiver ID.

Calculate Allowed Amount based on Non-Allowed

If you select this option, the import remittances function uses the formula $\text{<Allowed>} = \text{<Fee amt>} - \text{<Non-allowed amount>}$ to calculate the allowed amount for a service when all of the following are true:

- > The associated group or reason code is marked as non-allowed on the **Reason Options** tab in **Electronic Remit Style Maintenance**.
- > The file does not report an allowed amount for that service.
- > The file reports a non-allowed amount for the service.

Note: The application calculates the allowed amount even if the non-allowed amount is a negative value.

- > Calculated allowed amounts print on the **Remittance Listing** followed by an asterisk (*).

When a service or claim is not postable, the allowed amount might not be calculated because the application was unable to determine the non-allowed amount by the time the service or claim was found to be not-postable.

Note: You should only select **Calculate Allowed Amount based on Non-Allowed** if the carrier does not include allowed amounts in the file.

Allow Credit Balance Payment Posting

Select this option when you want to permit the posting of credit balances.

All services with a credit balance are posted regardless of the reason why the credit balance exists.

Services with a credit balance are given 1 of the following service-level messages:

- > Credit Balance Payment applied but not Transferred per ESM, Import Options
- > Credit Balance Payment/Adjustment applied but not Transferred per ESM, Import Options
- > Credit Balance Adjustment applied but not Transferred per ESM, Import Options

Enables **Credit Balance Transfer Option**.

Credit Balance Transfer Option

This option is enabled and required when **Allow Credit Balance Payment Posting** is selected.

Select 1 of the following options:

- > **No Transfer** — The credit balance on the claim is never automatically transferred.
- > **Self-Pay** — Transfers the claim's credit balance to self-pay when the credit balance is a result of previously posted self-pay payments on the claim if all other services on the claim also qualify to transfer.
- > **Self-Pay CoPay** — Transfers the claim's credit balance to self-pay when the credit balance is equal to a previously posted co-payment if all other services on the claim also qualify to transfer.

When a credit balance service does qualify for transfer, it is given 1 of the following service-level messages:

- > Credit Balance Payment applied with Transfer per ESM, Import Options
- > Credit Balance Payment/Adjustment applied with Transfer per ESM, Import Options
- > Credit Balance Adjustment applied with Transfer per ESM, Import Options

Review the sub-section **Credit Balance for Review** on the **Import Remittance Listing** for claims containing credit balances. This sub-section prints at the end of each section with

Postable and Fully Adjudicated, Postable and Not Fully Adjudicated, and Not Postable when applicable.

This sub-section is printed when a claim contains a service with a credit balance.

The **Credit Balance for Review** sub-sections make it easier to find claims containing credit balances. These sub-sections do not contain sub-totals.

The **Credit Balance Report** might also be used to review payments that resulted in credit balance vouchers.

Allow Prorated Payments on Institutional/UB Claims

Applies to institutional and UB claims that report payments and adjustments under the revenue code that the claim was billed to and more than 1 service is associated with the revenue code on the claim.

Prorating payments is the method of dispersing payments and adjustments associated with 1 revenue code to multiple services. It is based on the percentage of the service's service-fee amount to the total charge amount for the revenue code.

When the import remittances function prorates payments, the following message **Prorated Payments/ Adjustments Applied** – precedes the claim's claim level message.

Allow Prorated Payments at the Claim Level

Disperses claim-level payments and adjustments to the voucher's services based on the percentage of the service's service fee to the total charge on the claim when all of the following criteria are met:

1. The remit claim is being paid as primary.
 2. The remit claim has no service-level information (loop 2110 is missing).
 3. The voucher has more than 1 service associated with it.
- > If the claim was paid as secondary, the **Post Secondary Claim Payments Top-Down** import option can be used.
 - > If only 1 service is associated with the voucher and no service information is reported on the remittance claim, the application applies the claim-level payments and adjustments directly to the service. No prorate method of payment occurs.
 - > The claim-level payments and adjustment amounts are printed on the **Import Remittance Listing** where the service amount is normally printed . The value **N/A** prints in place of the procedure code. When the import remittances function prorates payments, the message **Prorated Payments/ Adjustments Applied** – precedes the claim's claim-level message.

Allow \$0.00 Payments

When you select this option, claims and services denied by the payer are posted.

A claim is considered denied when the claim status reported in the file is set to 4.

A service is considered denied by the import remittances function when both of the following are true:

- > The service's allowed and payment amounts equal zero.
- > The service's deductible amount is not equal to the fee amount.

Prevent Non-Allow Adj if Allow=\$0 and Non-Allow=Fee is enabled when this option is selected.

Prevent Non-Allow Adj if Allow=\$0 and Non-Allow=Fee

This option is enabled when **Allow \$0.00 Payments** is selected. Select this option to stop the remittance import process from applying service-level adjustments to primary claims when a remittance does not have an allowed amount, and the nonallowed amount equals the service fee.

This option is included with the starter data for new tenants when you select **Electronic Remit Information for Information Type** in **Administration > Starter Data Maintenance**.

Auto Adjust Non-Allow Amounts Less Than is enabled when this option is selected.

Auto Adjust Non-Allow Amounts Less Than

To apply the nonallowed amount adjustments automatically when the service fee amount is less than a specific dollar amount, enter an amount up to \$99,999.00; otherwise, leave the box blank. Zero is not a valid value.

This option is included with the starter data for new tenants when you select **Electronic Remit Information for Information Type** in **Administration > Starter Data Maintenance**.

Allow Interest Posting

When you select this option, you can post interest payments directly to claims with this electronic remittance style and then automatically cancel them out with a negative adjustment. This functionality only works if the interest payments are provided in an 835 remittance file in the 2100 AMT loop and segment with an "I" qualifier code and the claim is not in the **Not Postable** section of the **Import Remittance Listing**. Additionally, the required setup for interest payment posting must be done for the carriers' associated reimbursement styles in **Reimbursement Style Maintenance**.

Allow Reversal Posting to Original Patient Policy

Select this option to post reversal transactions during remittance processing when certain criteria are met. Refer to the Help topic about posting reversal transactions during remittance processing for more information about the scenarios when reversal transactions are posted.

This option is included with the starter data for new tenants when you select **Electronic Remit Information for Information Type** in **Administration > Starter Data Maintenance**.

Transfer Option (No Subsequent Coverage)

Select 1 of the following options:

- **Self-Pay** — Transfers any balance on a claim that does not include secondary or tertiary policy information to self-pay responsibility. The claim is automatically flagged for rebill and qualifies for patient billing.
- **No Transfer** — Leaves the balance as the responsibility of the current carrier when the claim does not include secondary or tertiary insurance policy information.

Primary Transfer Option (Secondary Exists)

Select 1 of the following options:

- **Secondary With Rebill** — Always transfers the claim balance to the secondary policy. Claims not forwarded to the secondary insurance by the primary carrier are flagged for rebill.
- **Secondary Without Rebill** — Always transfers the claim's balance to the secondary policy; the rebill flag is not set. Claims that were not crossed over to the secondary insurance by the primary carrier must be manually flagged for rebilling on the **Edits** tab.
- **Self-Pay** — Transfers the claim's balance to self-pay even when a secondary policy exists. The claim is automatically flagged as rebill and qualifies for patient billing.
- **No Transfer** — Leaves the claim's balance as the responsibility of the current carrier even when a secondary policy exists. The bill date is not cleared. You must review the claim to determine the next step.

Secondary Transfer Option (Tertiary Exists)

- **Tertiary With Rebill** — Always transfers the claim's balance to the tertiary policy and sets the rebill flag when the claim has not been forwarded to the tertiary insurance by the secondary carrier. The claim qualifies for insurance billing after the batch is updated.
- **Tertiary Without Rebill** — Always transfers the claim's balance to the tertiary policy. The rebill flag is not set. Claims that were not forwarded to the tertiary insurance by the secondary carrier must be manually flagged for rebilling on the **Edits** tab.
- **Self-Pay** — Transfers the claim's balance to self-pay even when a tertiary policy exists. The claim is automatically flagged as rebill and qualifies for patient billing after the batch is updated.
- **No Transfer** — Leaves the claim's balance as the responsibility of the current carrier even when a tertiary policy exists. The bill date is not cleared. You must review the claim to determine the next step.

Note: Balances are never automatically transferred to policies designated as **Other** in the patient's registration record.

Force Payment when Auto Adj Allowed Amount is Different

When you select this option, the application posts payments from an electronic remittance even when the non-allowed amount in the file does not equal the non-allowed amount previously adjusted.

The adjustment in the remittance file does not post and the balance remains with the current payer.

This option only affects primary payer payments.

These claims show on the **Import Remittance Listing** in the **Adjustments Not Postable** section.

The following scenarios show how this option affects the remittance posting process:

- > When the previously adjusted non-allowed amount equals the non-allowed amount in the remittance file, this option does not have any impact on how the information in the remittance file posts.
- > When the previously adjusted non-allowed amount does not equal the non-allowed amount in the remittance file, the payment posts but the non-allowed adjustment does not post. The balance remains with the current payer. The voucher shows in the **Adjustment Not Postable** section of the **Import Remittance Listing** with the message “**REVIEW** – Payment Only Posted. Adjustment ignored due to ESM Import Option.” that prompts you to review the claim.
- > When there is a previously adjusted non-allowed amount and there is not a non-allowed amount in the remittance file, the payment posts but a non-allowed adjustment does not post because it does not exist. The balance remains with the current payer. The voucher shows in the **Adjustments Not Postable** section of the **Import Remittance Listing** with the message : “**REVIEW** – Payment Only Posted. Adjustment Did Not Exist in Remit File.” that prompts you to review the claim.
- > When there is not an adjustment prior to posting the remittance file, this option does not have any impact on how the information in the remittance file posts.
- > When the previously adjusted non-allowed amount does not equal the non-allowed amount in the remittance file and the payment will create a credit balance (**Allow Credit Balance Payment Posting** must be selected), the payment posts but the balance does not transfer regardless of the **Credit Balance Transfer Option** setting.

Enable Encounter Rate Posting

Important: Prior to importing Rural Health Medicaid remittances for the first time, you must select **E&M Procedure** on the **Procedure Code** tab in **Procedure Code Maintenance** for each procedure code that you use for office visits.

This option enables you to post electronic remittances in which you have office visit services rolled up into a rural health center (RHC) encounter procedure code, such as T1015 which you specified on the **RHC Billing Info** tab in **Electronic Claim Format Maintenance** and **Paper Claim Format Maintenance**.

Select this option only if you bill claims to a carrier that requires the RHC encounter code reported in the file.

RHC Encounter Procedure Code

This box is required if enabled.

Enter the RHC encounter procedure code used for billing claims to the carrier.

RHC Encounter Modifier

This box is optional.

If the claims were required to be billed with a specific modifier along with the RHC encounter procedure code, enter that modifier.

Alt RHC Encounter Procedure Code 1

This box is optional.

If the claims were billed to the carrier using a unique RHC encounter procedure code and modifier specific to a type of service, enter that RHC encounter procedure code.

Alt RHC Encounter Modifier 1

This box is optional.

If the claims were billed to the carrier using a unique RHC encounter procedure code and modifier specific to a type of service, enter that RHC encounter modifier.

Alt RHC Encounter TOS 1

This box is optional.

If the claims were billed to the carrier using a unique RHC encounter procedure code and modifier specific to a type of service, select that type of service.

Alt RHC Encounter Procedure Code 2

This box is optional.

If the claims were billed to the carrier using a unique RHC encounter procedure code and modifier specific to a type of service, enter that RHC encounter procedure code.

Alt RHC Encounter Modifier 2

This box is optional.

If the claims were billed to the carrier using a unique RHC encounter procedure code and modifier specific to a type of service, enter that RHC encounter modifier.

Alt RHC Encounter TOS 2

This box is optional.

If the claims were billed to the carrier using a unique RHC encounter procedure code and modifier specific to a type of service, select that type of service.

RHC Encounter Procedure Code Transaction Codes

These boxes are optional.

Select **Payment** and **Adjustment** transaction codes to be used by the import remittances process when applying encounter code payments and adjustments against procedures flagged as Evaluation and Management (E&M) codes.

The drop-down lists contain the payment and adjustment transaction codes created in **Transaction Code Maintenance**.

Using these transaction codes enables you to view the payment and adjustment transactions applied for the encounter code in **Financial Inquiry** and on the **Transaction Analysis Report**. Because these transactions do not exist on the voucher, they cannot be viewed on existing reports run by procedure code.

If you do not select transaction codes for **Payment** and **Adjustment**, the import remittances process uses the default payment and adjustment transaction codes on the **Reimbursement Style** associated with the carrier on the **Styles** tab in **Insurance Carrier Maintenance**.

Prorated payments at the claim level

Applying Payments and Adjustments from the Claim Level is optional. This functionality will not occur automatically since not all providers will want a Prorated Methodology used. In these cases, the provider must manually apply Payments and Adjustments which were reported on the remit claim. However if the provider does elect to use a Prorated method, then claim level payments and adjustments are dispersed to the Voucher's services based on the percentage of the service's Service Fee to the total Charge on the claim.

Example: Claim # 5930 has the following services associated to it.

- > Service 1) Procedure Code = 99212 Fee = \$75.00
- > Service 2) Procedure Code = 99213 Fee = \$55.40
- > Service 3) Procedure Code = 99214 Fee = \$18.24

The total Charge Amount is \$148.64

To find the prorated percentage:

- > Service 1) $\$75.00 / \$148.64 = 50.4574812\%$

- > Service 2) \$55.40 / \$148.64 = 37.2712594%
- > Service 3) \$18.24 / \$148.64 = 12.2712594%

When the carrier pays the claim, the following amounts are reported:

- > Payment Amount \$92.26
- > Allowed Amount \$148.64
- > CO-42 Adjustment \$31.38 • PR-2 (Co-Insurance) \$50.00

Import Remittances disperse the prorated payments and adjustments as follows:

- > Service 1
 - Payment Amount \$46.55
 - Allowed Amount \$75.00
 - CO-42 Adjustment \$15.83
 - PR-2 (Co-Insurance) \$25.29
- > Service 2
 - Payment Amount \$34.39
 - Allowed Amount \$55.40
 - CO-42 Adjustment \$11.70
 - PR-2 (Co-Insurance) \$18.43
- > Service 3
 - Payment Amount \$11.32
 - Allowed Amount \$18.24
 - CO-42 Adjustment \$3.85
 - PR-2 (Co-Insurance) \$6.07

Note: It is possible that the amount calculated using this Prorated method may not balance correctly. As a result, the amounts on the last service will be adjusted to balance. In the example above, the Co-Insurance amount (PR-2) for Service 3 calculated to \$6.14. But to ensure that all three services' Co-Insurance amount balances to \$50.00, service 3's Co-Insurance amount is adjusted to \$6.07.

However, if you decide not to use this Import Option, any claim which does not have service information reported and the voucher has more than one service associated to it, does not post. The following claim level message appears "Claim Not Postable – Service Detail missing from Remit File, Allow Prorated Payments at Claim Level not selected in ESM."

When Payments and Adjustments are reported at the Claim Level only, the system does not report an Allowed Amount. Allowed amounts are only reflective of a specific service and procedure code.

Therefore the Allowed amount can only appear at the service level. As a result, you need to check Calculate Allowed Amount Based on Non-Allowed? on the Import Options tab in Electronic Remit Style Maintenance to get an Allowed Amount to appear.

Allscripts Practice Management marks each voucher that has Prorated Payments and Adjustments applied with a percent (%) sign in Financial Inquiry. The percent sign appears in the first column of the grid.

Forcing payment when an electronic remittance non-allowed amount is different from the previously adjusted non-allowed amount

This topic describes what occurs during the electronic remittance process when you select **Force Payment when Auto Adj Allowed Amount is Different** on the **Import Options** tab in **Electronic Remit Style Maintenance** (accessed by pressing **F9** and entering **ESM**).

When you select **Force Payment when Auto Adj Allowed Amount is Different**, the application posts payments from an electronic remittance even when a non-allowed amount in the remittance file does not equal a previously adjusted non-allowed amount.

The adjustment in the remittance file does not post and the balance remains with the current payer. This option only affects primary payer payments.

These claims show in the **Adjustments Not Postable** section on the **Import Remittance Listing**.

Sample use cases

The following scenarios show how **Force Payment when Auto Adj Allowed Amount is Different** affects the remittance posting process:

- > When the previously adjusted non-allowed amount equals the non-allowed amount in the remittance file, this option does not have any impact on how the information in the remittance file posts.
- > When the previously adjusted non-allowed amount does not equal the non-allowed amount in the remittance file, the payment posts but the non-allowed adjustment does not post. The balance remains with the current payer. The voucher shows in the **Adjustment Not Postable** section of the **Import Remittance Listing** with the following message prompting you to review the claim: ****REVIEW** – Payment Only Posted. Adjustment ignored due to ESM Import Option.**
- > When there is a previously adjusted non-allowed amount and there is not a non-allowed amount in the remittance file, the payment posts but a non-allowed adjustment does not post because it does not exist. The balance remains with the current payer. The voucher shows in the **Adjustments Not Postable** section of the **Import Remittance Listing** with the following message prompting you to review the claim: ****REVIEW** – Payment Only Posted. Adjustment Did Not Exist in Remit File.**

- > When there is not an adjustment prior to posting the remittance file, this option does not have any impact on how the information in the remittance file posts.
- > When the previously adjusted non-allowed amount does not equal the non-allowed amount in the remittance file and the payment will create a credit balance (**Allow Credit Balance Payment Posting?** must be selected), the payment posts but the balance does not transfer regardless of the **Credit Balance Transfer Option** setting.

Reason Options tab

The **Reason Options** tab in **Electronic Remit Style Maintenance** enables you to determine how to deal with services and claims that are flagged in a remittance file with specific comment or reason codes.

The most recent version of the Health Care Claim Adjustment Reason Codes Listing can be found at <http://www.wpc-edi.com/>. The list of reimbursement comments on the **Reason Options** tab are retrieved from **Reimbursement Comment Maintenance**.

Note: When an electronic remittance file contains a group or reason code that cannot be found in the file, the application automatically adds it to **Reimbursement Comment Maintenance**.

Access the **Reason Options** tab from **Electronic Remit Style Maintenance**. To access **Electronic Remit Style Maintenance**, go to **System Administration > File Maintenance > Electronic Remit Style Maintenance** or press **F9** and then enter **ESM**.

Electronic Remit Style Maintenance X

Select Electronic Remit Style: 

Reason Options

Reimb. Comment	No Import	No Auto Adjust	Allow Transfer	Non-Allowed	Withheld	Incentive	Penalty	Statement Message
CO-144	<input type="checkbox"/>							
CO-16	<input type="checkbox"/>							
CO-18	<input type="checkbox"/>							
CO-237	<input type="checkbox"/>							
CO-42	<input type="checkbox"/>							
CO-45	<input type="checkbox"/>							
DA-42	<input type="checkbox"/>							
DA-45	<input type="checkbox"/>							
PR-1	<input type="checkbox"/>							
PR-2	<input type="checkbox"/>							
PR-3	<input type="checkbox"/>							
PR-50	<input type="checkbox"/>							

Co-Insurance Statement Message:

Co-Pay Statement Message:

Deductible Statement Message:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Reimb Comment

This column lists the reimbursement comments or reason codes in **Reimbursement Comment Maintenance**. You must make a determination for each comment or reason code listed on this tab.

No Import

When this option is selected, payments and adjustments are not applied on services containing this group or reason code. The claim balance is not transferred, regardless of the import options you select.

Claims with services containing this group or reason code are listed in either the **Not Postable** or **Postable But Not Fully Adjudicated** section of the **Import Remittance Listing**, which requires you to review the claim and determine the next step.

No Auto Adjust

When this option is selected, the reimbursement style option **Adjust Non-Allowed Amount** is overridden for services lines containing this group or reason code. The adjustment amount associated with this reason code is not applied to the service.

If a payment also exists for that service, it is applied and the claim is listed on the report under **Postable but Not Fully Adjudicated**. If any of the other service lines on the claim have a payment, the payments are applied and the claim is listed under **Postable and Not Fully Adjudicated**. The claim balance is not transferred, regardless of the import options you select.

Allow Transfer

This option is only enabled when you select **No Auto Adjust**. This option enables the adjustment amounts for specific group or reason codes that are flagged as **No Auto Adjust** to be transferred according to the transfer options on the **Import Options** tab. For example, if you do not want Allscripts® Practice Management to automatically adjust off patient responsibility (PR) amounts and be able to transfer the balance, you can select **Allow Transfer** for the applicable codes. It is not limited to only PR amounts.

If you select both **No Auto Adjust** and **Allow Transfer** but clear **No Auto Adjust**, Allscripts® Practice Management automatically clears **Allow Transfer**.

Services that have a group or reason code set to **No Auto Adjust** and **Allow Transfer** print the following service-level message on the **Import Remittance Listing**: "Grp/Rsn Code 'xx-xx' not adjusted but Xfer is allowed due to ESM Reason Options."

Note: This message does not mean that the claim will split. The balance of the entire claim is transferred, as defined by the selections on the **Import Options** tab in **Electronic Remit Style Maintenance**.

Non-Allowed

This option identifies the adjustment amount associated with this group or reason code as a non-allowed amount. Allscripts® Practice Management processes non-allowed adjustments differently from other adjustments.

A non-allowed adjustment is the amount equal to the difference between the service's fee and allowed amount. Allscripts® Practice Management needs to determine whether an adjustment is a non-allowed adjustment. In instances when a claim has services where more than 1 adjustment exists and those adjustment amounts are all the same amount, (only 1 of them is the actual non-allowed adjustment amount), this option enables Allscripts® Practice Management to identify which adjustment is the non-allowed adjustment.

Select this option for codes such as CO-42 (charges exceed our fee or maximum allowable amount) and CO-45 (charges exceed your contract or legislative fee agreement).

Note: Most carriers report the non-allowed adjustment amount with the group or reason Code CO-42 and CO-45. However, some carriers use other group or reason codes.

For the non-allowed amount to be adjusted, you must also select **Adjust Non-Allowed** for the reimbursement style associated with the carrier.

Withheld

Important: Any XX-104 group or reason Codes (PR-104, CO-104, PI-104, CR- 104, and OA-104) that existed in the application prior to the upgrade to Allscripts PM version 2009.3.2 automatically had **Withheld** selected after the upgrade. If **Withheld** is not applicable for a designated payer, clear **Withheld** before you import any electronic remittances for those payers.

When **Withheld** is selected, Allscripts® Practice Management adjusts the adjustment amount for this group or reason code as a withheld adjustment. Allscripts® Practice Management automatically clears any other check boxed for the particular group or reason Code. If you select **Withheld**, the application automatically clears **No Import** and **Non-Allowed** for that group or reason code if either was previously selected. Additionally, if **Withheld** is selected, and then you select **No Import** or **Non- Allowed** for that group or reason code, the application automatically clears **Withheld**. The application verifies that a transaction code exists for **Withheld** in **Reimbursement Style Maintenance** for the designated payer and uses that transaction code for the withheld adjustment amount.

Note: Even though withheld adjustment amounts are similar to a regular adjustment, Allscripts® Practice Management considers them a different type of adjustment. These adjustment amounts use transaction code entered for **Withheld** in **Reimbursement Style Maintenance**.

On the **Import Remittance Listing**, the following service-level messages print when you select **Withheld**, depending on the situation:

- > Withheld Amt \$nnnn.nn not Adjusted. Missing Withheld Trans Code from RSM
- > Withheld Amt \$nnnn.nn Adjusted

When you select **Withheld** for a XX-104 group or reason code, the applicable withheld transaction code from **Reimbursement Style Maintenance** and the group reason code, along with the withheld adjustment amount, are displayed with the service payment detail in **Financial Inquiry**.

When **Withheld** is not selected, you can select **No Auto Adjust** and **Allow Transfer** if you are permitted to bill patients for the PR-104 amount. If the payer considers the CO-104 amount

as a non-Allowed amount, you can select **Non-Allowed**, which results in the CO-104 amount being adjusted off as a non-allowed transaction. Any balance transfer is based on the import options selected for transfers.

Incentive

When this option is selected, the electronic remittances process links the amount of the Merit-based Incentive Payment System (MIPS) incentive to the corresponding reimbursement code.

When **Incentive** is selected, **Withheld**, **Non-Allowed**, **No Import**, and **Penalty** are automatically cleared, if selected.

Penalty

When this option is selected, the electronic remittances process links the amount of the Merit-based Incentive Payment System (MIPS) penalty to the corresponding reimbursement code.

When **Penalty** is selected, **Withheld**, **Non-Allowed**, **No Import**, and **Incentive** are automatically cleared, if selected.

Statement Message

When a default statement message is selected for a group or reason code in **Reimbursement Comment Maintenance**, that message is automatically attached to the claim and prints on the patient statement when that service is billed as self-pay. Likewise, that value in **Access Description** in **Message Maintenance** for the default statement message is displayed in this column.

Statement message combo boxes

These options automate the process of attaching a statement message to a voucher for a co-insurance, co-pay, and deductible. The selection options for **Co-Insurance Statement Message**, **Co-Pay Statement Message**, and **Deductible Statement Message** come from **Message Maintenance**.

Note:

- > Because only 1 statement message can be attached to a voucher, when more than 1 of your selected statement messages qualifies to be attached to the voucher, the application selects and attaches a message based on the following priority:
 1. Group or reason statement message
 2. Deductible statement message
 3. Co-pay statement message
 4. Co-insurance statement message

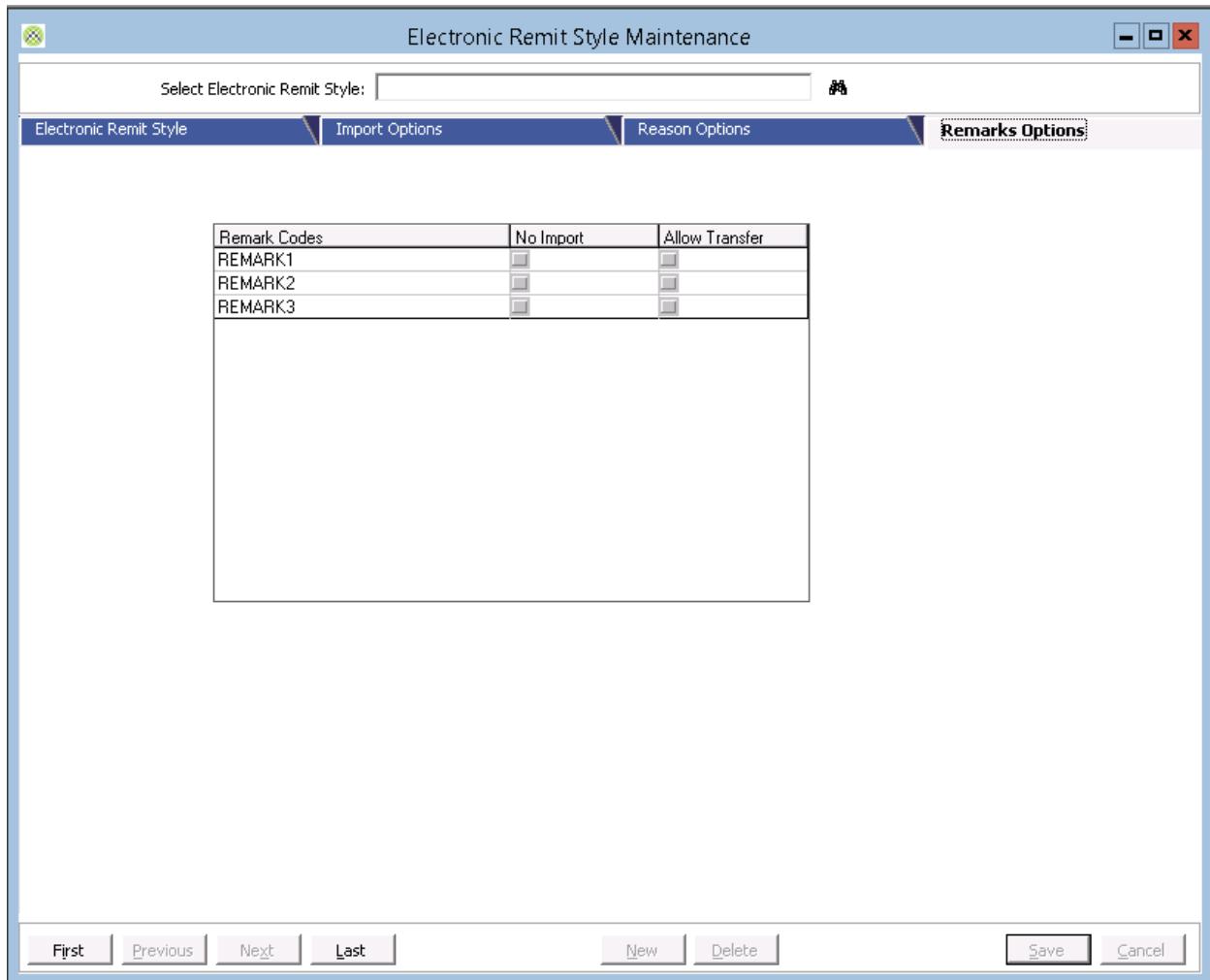
- > Automatically added statement messages can be viewed on the **Payment Entry** tab and the **Edits** tab only after the voucher is updated. However, the automatically added statement message can be viewed in **Financial Inquiry** both before and after the voucher is updated.

Remarks Options tab

Use the **Remarks Options** tab in **Electronic Remit Style Maintenance** to define how the application handles a voucher that has a carrier with the selected electronic remittance style and contains 1 of the remark codes listed on this tab.

This tab displays the remark codes created in **Remark Code Maintenance**.

Access the **Remarks Options** tab from **Electronic Remit Style Maintenance**. To access **Electronic Remit Style Maintenance**, go to **System Administration > File Maintenance > Electronic Remit Style Maintenance** or press **F9** and then enter **ESM**.



The screenshot shows the 'Electronic Remit Style Maintenance' window. At the top, there is a search bar labeled 'Select Electronic Remit Style:' followed by a magnifying glass icon. Below the search bar is a navigation bar with tabs: 'Electronic Remit Style' (selected), 'Import Options', 'Reason Options', and 'Remarks Options' (highlighted with a red border). The main area contains a table with three columns: 'Remark Codes', 'No Import', and 'Allow Transfer'. The table has four rows, each containing a remark code ('REMARK1', 'REMARK2', 'REMARK3') and two checkboxes. At the bottom of the window are standard navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save' (highlighted with a red border), and 'Cancel'.

Remark Codes	No Import	Allow Transfer
REMARK1	<input type="checkbox"/>	<input type="checkbox"/>
REMARK2	<input type="checkbox"/>	<input type="checkbox"/>
REMARK3	<input type="checkbox"/>	<input type="checkbox"/>

No Import

When this option is selected, payments or adjustments are not applied to the service containing this remark code.

When the remark code exists on a service line, the claim's balance is not transferred.

When the remark code is found at the claim level, the entire claim is not postable.

Allow Transfer

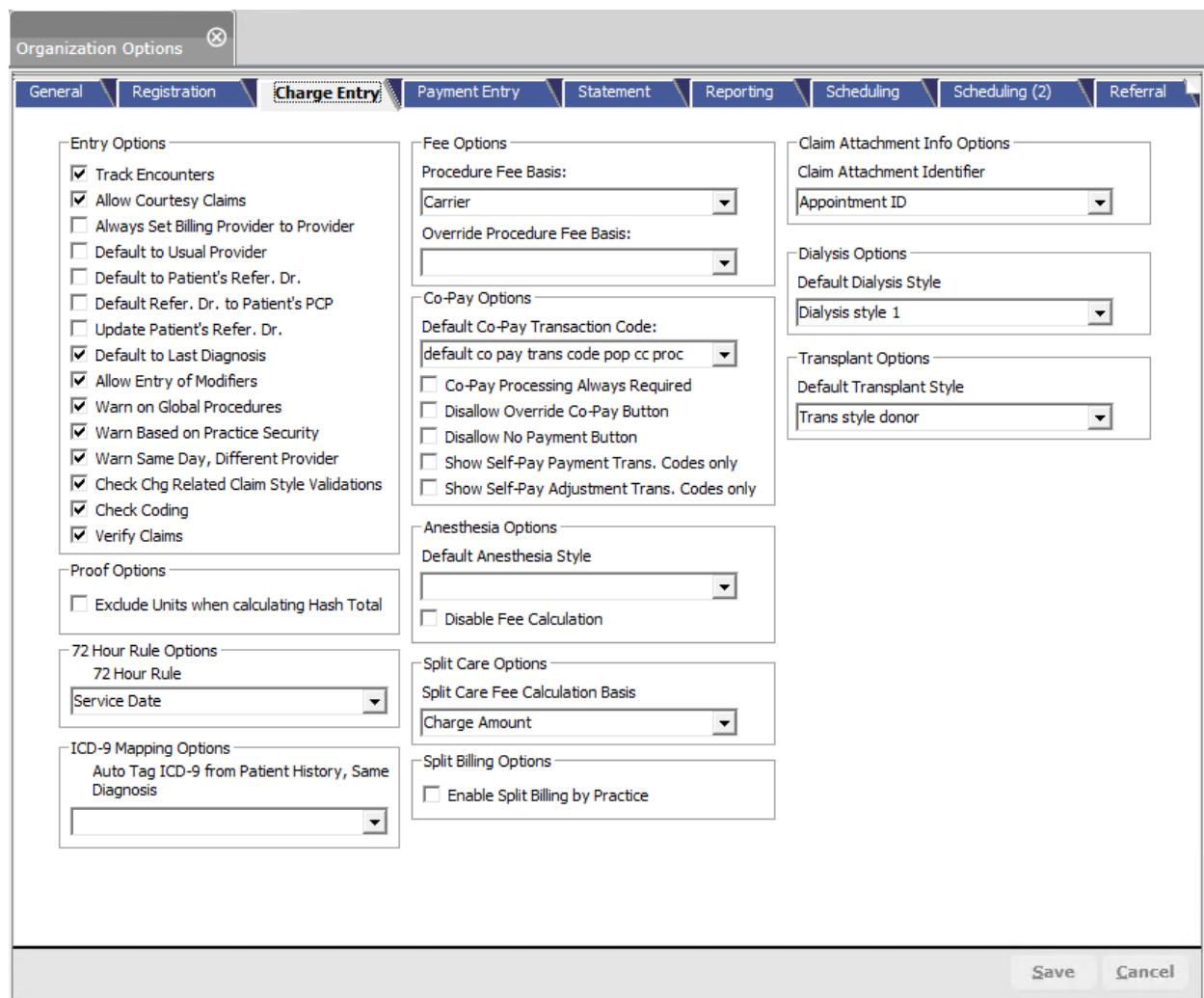
When this option is selected, the balance of the claim or service that contains the remark code is transferred.

Note: When multiple remark codes are reported for a service, and some remark codes have **Allow Transfer** flagged while the others do not, the claim's balance is not transferred.

Returning to Practice Options or Organization Options

Returning to the Charge Entry tab

If necessary, return to the **Co-Pay Options** section on the **Charge Entry** tab in **Practice Options** or **Organization Options** to select a default co-pay transaction code. Refer to the section about the **Charge Entry** tab in **Practice Options** or **Organization Options** for details.



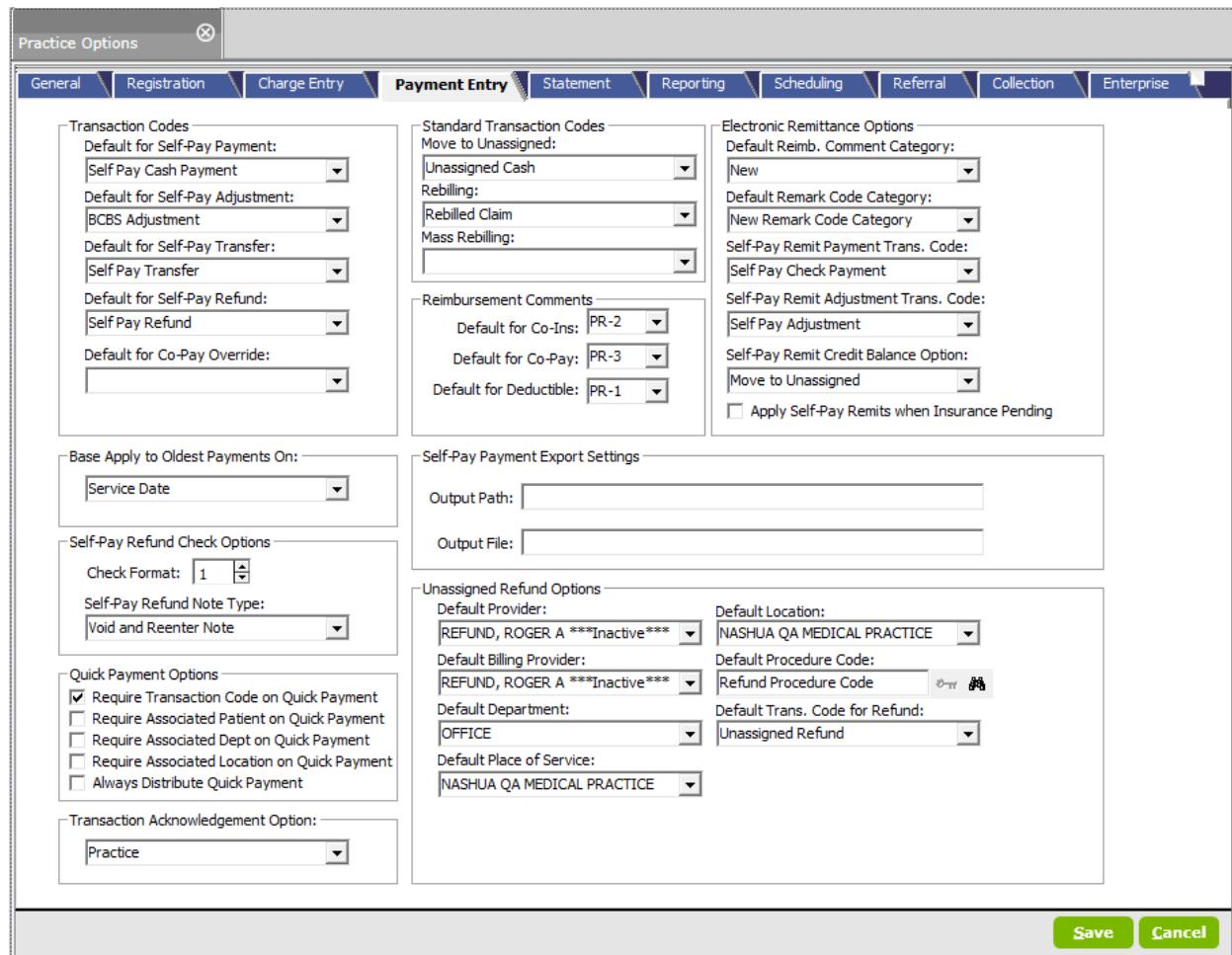
The screenshot shows the 'Organization Options' window with the 'Charge Entry' tab selected. The window is divided into several sections:

- Entry Options:** Includes checkboxes for Track Encounters, Allow Courtesy Claims, Always Set Billing Provider to Provider, Default to Usual Provider, Default to Patient's Refer. Dr., Default Refer. Dr. to Patient's PCP, Update Patient's Refer. Dr., Default to Last Diagnosis, Allow Entry of Modifiers, Warn on Global Procedures, Warn Based on Practice Security, Warn Same Day, Different Provider, Check Chg Related Claim Style Validations, Check Coding, and Verify Claims.
- Fee Options:** Includes 'Procedure Fee Basis' set to 'Carrier' and 'Override Procedure Fee Basis'.
- Co-Pay Options:** Includes 'Default Co-Pay Transaction Code' set to 'default co pay trans code pop cc proc' and checkboxes for Co-Pay Processing Always Required, Disallow Override Co-Pay Button, Disallow No Payment Button, Show Self-Pay Payment Trans. Codes only, and Show Self-Pay Adjustment Trans. Codes only.
- Claim Attachment Info Options:** Includes 'Claim Attachment Identifier' set to 'Appointment ID'.
- Dialysis Options:** Includes 'Default Dialysis Style' set to 'Dialysis style 1'.
- Transplant Options:** Includes 'Default Transplant Style' set to 'Trans style donor'.
- Anesthesia Options:** Includes 'Default Anesthesia Style' and 'Disable Fee Calculation'.
- Split Care Options:** Includes 'Split Care Fee Calculation Basis' set to 'Charge Amount'.
- Split Billing Options:** Includes 'Enable Split Billing by Practice'.

At the bottom right of the window are 'Save' and 'Cancel' buttons.

Returning to the Payment Entry tab

If necessary return to the **Payment Entry** tab in **Practice Options** or **Organization Options** to select default transaction codes, a default reimbursement comment category, and default reimbursement comments. Refer to the section about the **Payment Entry** tab in **Practice Options** or **Organization Options** for details.



Practice Options

Payment Entry (selected)

Transaction Codes

- Default for Self-Pay Payment: Self Pay Cash Payment
- Default for Self-Pay Adjustment: BCBS Adjustment
- Default for Self-Pay Transfer: Self Pay Transfer
- Default for Self-Pay Refund: Self Pay Refund
- Default for Co-Pay Override:

Standard Transaction Codes

- Move to Unassigned: Unassigned Cash
- Rebilling: Rebilled Claim
- Mass Rebilling:

Electronic Remittance Options

- Default Reimb. Comment Category: New
- Default Remark Code Category: New Remark Code Category
- Self-Pay Remit Payment Trans. Code: Self Pay Check Payment
- Self-Pay Remit Adjustment Trans. Code: Self Pay Adjustment
- Self-Pay Remit Credit Balance Option: Move to Unassigned
- Apply Self-Pay Remits when Insurance Pending

Base Apply to Oldest Payments On: Service Date

Self-Pay Refund Check Options

- Check Format: 1
- Self-Pay Refund Note Type: Void and Reenter Note

Quick Payment Options

- Require Transaction Code on Quick Payment
- Require Associated Patient on Quick Payment
- Require Associated Dept on Quick Payment
- Require Associated Location on Quick Payment
- Always Distribute Quick Payment

Transaction Acknowledgement Option: Practice

Self-Pay Payment Export Settings

- Output Path: [empty field]
- Output File: [empty field]

Unassigned Refund Options

- Default Provider: REFUND, ROGER A ***Inactive***
- Default Location: NASHUA QA MEDICAL PRACTICE
- Default Billing Provider: REFUND, ROGER A ***Inactive***
- Default Procedure Code: Refund Procedure Code
- Default Department: OFFICE
- Default Trans. Code for Refund: Unassigned Refund
- Default Place of Service: NASHUA QA MEDICAL PRACTICE

Buttons: Save, Cancel

Chapter 8

Charge Entry File Maintenance

Charge Entry File Maintenance setup checklist

Charge entry file maintenance relates to all the elements that you need to enter charges in Allscripts® Practice Management.

Use this checklist to record the completion of each maintenance record.

Maintenance	Completed
Location Maintenance (LOM)	
Place of Service Maintenance (PSM)	
Department Maintenance (DEM)	
Bank Account Maintenance (BAC)	
Billing Office Maintenance (BOM)	
Specialty Maintenance (SPM)	
Provider Maintenance (PRM)	
Organization Maintenance (ORM)	
Referring Doctor Maintenance (RDM)	
Type of Service Maintenance (TSM)	
Held Voucher Reason Maintenance (HVM)	
Diagnosis Category Maintenance (DYM)	
Diagnosis Code Maintenance (DCM)	
Modifier Maintenance (MOM)	
Anesthesia Maintenance (ASM) Modifier Maintenance (MOM) if necessary	
Procedure Category Maintenance (PTM)	
Procedure Code Maintenance (PCM)	

Maintenance	Completed
Procedure Group Maintenance (PGM)	
Procedure Series Maintenance (PEM)	
Revenue Code Maintenance (RVC)	
Batch Category Maintenance (BTM)	
Quick Pay Override Reason Maintenance (QPO)	

Location Maintenance window

Location is an option for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options**, and for various billing options in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

The main function of a location is to enable you to generate reports on where services were rendered by your providers. However, **Location** is also a required selection in during charge entry.

Information stored in **Location Maintenance** can be used in claims processing, statement processing, and occupational medicine invoice printing.

The location is a required entry on vouchers but an optional selection for the following:

- > **Place of Service Maintenance > Place of Service** — as a default location selection for a place of service
- > **Practice Options > Charge Entry or Organization Options > Charge Entry — Procedure Fee Basis**
- > **Practice Options > Occ Medicine or Organization Options > Occ Medicine — Header Information**
- > **Paper Claim Format Maintenance > Paper Claim Format —**
 - Tax ID Option
 - Indiv Billing No Option
 - Group Billing No Option
 - Billing Address Option
- > **Electronic Claim Format Maintenance > Electronic Claim Format — Billing Method**
- > **Claim Style Maintenance > Output Options —**
 - Billing Method Override
 - Override Rendering Provider ID

- > Quick Payment for [patient name]
- > Unassigned Payment Refund
- > Group-by and sort-by boxes for various reports

In **Location Maintenance**, you store the demographic-specific ID numbers used when billing claims.

You must complete the **Location** tab and then move on to entering billing numbers, taxonomy codes, and alternate billing information.

Selection of department or practice members is required if you have department or practice security enabled.

Various reports can be grouped by or restricted to specified locations.

Location Maintenance contains these tabs:

- > Location
- > Billing Numbers
- > Taxonomy Codes
- > Alternate Billing Info
- > Department Members or Practice Members
- > History

To access **Location Maintenance**, go to **System Administration > File Maintenance > Location Maintenance** or press **F9** and then enter **LOM**.

Location tab

Access the **Location** tab from **Location Maintenance**. To access **Location Maintenance**, go to **System Administration > File Maintenance > Location Maintenance**, or press **F9** and then enter **LOM**.

Location Maintenance

Select Location:		<input type="button" value=""/>			
Location	Billing Numbers	Taxonomy Codes	Alternate Billing Info	Practice Members	History
Abbreviation: <input type="text"/>	Telephone: <input type="text"/>	Ext: <input type="text"/>			
Description: <input type="text"/>	Fax: <input type="text"/>				
Name: <input type="text"/>	Email: <input type="text"/>				
Address 1: <input type="text"/>	Federal ID: <input type="text"/>				
Address 2: <input type="text"/>	ID Sub-No: <input type="text"/> ID Suffix: <input type="text"/>				
City: <input type="text"/> State: <input type="text"/>	Fee Profile: <input type="text"/>				
Zip Code: <input type="text"/> Country: <input type="text"/>	Clinic Number: <input type="text"/>				
		GL Sub-Account#1: <input type="text"/>			
		GL Sub-Account#2: <input type="text"/>			
		Bank Account: <input type="text"/>			
<input type="checkbox"/> Off-Campus Provider Based Dept. <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Merchant Terminal ID <input type="text"/> <input type="button" value="X"/> </div>					
Other Address (only if different from above) <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Address 1: <input type="text"/> Address 2: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/> Country: <input type="text"/> </div>					
<div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Trust Customer ID: <input type="text"/> Customer ID Password: <input type="text"/> Trust Vault Password: <input type="text"/> </div>					
<input type="button" value="First"/>	<input type="button" value="Previous"/>	<input type="button" value="Next"/>	<input type="button" value="Last"/>	<input type="button" value="New"/>	<input type="button" value="Delete"/>
				<input type="button" value="Save"/>	<input type="button" value="Cancel"/>

Abbreviation

Holds up to 8 characters.

This box is a required.

The abbreviation must be unique to this record.

Description

Holds up to 40 characters.

This box is a required.

Displays in the **Location** options on the **Charge Entry** tab in **Financial Processing > Transactions**.

Name**Holds up to 40 characters.**

Outputs on claims, documents, and encounters when a location is selected.

Location main address

Enter the location address exactly the way you want it to print on claim forms, encounter forms, documents, and so on.

Keep the following items in mind when you enter the main address:

- The words **PO Box** cannot be in the address submitted on v5010 electronic claims or printed on CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms. If the main address contains a PO box number, enter a street address as the other address and set up **Billing Method Address** to use the other address for claims.
- For v5010 claims, you must enter a ZIP code plus 4. If you do not know your 4-digit additional number, use <your ZIP code>-9998. For example, enter 27615-9998.
- **Address 2** outputs to electronic claim files but does not print on paper claims.
- The main address boxes are available as pull fields for encounter forms and some documents depending on the type of document.
- The main address prints on occupational medicine invoices when you select **Location** for **Header Information** on the **Occ Medicine** tab in **Practice Options** or **Organization Options**.
- **State** is a 2-letter abbreviation. Abbreviations of the US territories are listed after the 50 states.
- **Country** holds up to 2 characters and is optional.
- For v5010 electronic claims, the main address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Location**, and **Billing Method Address** in **Claims Style Maintenance** is set to either **Billing Method Address** or blank.
- For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the main address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Location**, and **Billing Media** and **Billing Method Address** in **Claims Style Maintenance** are set to **Paper** and either **Billing Method Address** or blank respectively.

Telephone

Requires entry of 10 digits.

Enter a phone number using the (###)###-#### format without spaces or dashes.

Used as a pull field when you select **Location** for **Header Information** for occupational medicine invoices.

Ext

Holds up to 5 characters.

Fax

Requires entry of 10 digits.

Entering a fax number using the (###)###-#### format without spaces or dashes.

Email

Enter an email address (informational only).

Federal ID

Enter the tax ID number assigned to your practice or organization, or to the location or facility.

Used as the pull field when the options **Federal ID** and **Location** are selected for **Tax ID Source** and **Tax ID Option** respectively for paper claim formats.

Can be used when billing insurance claims if **Tax ID Source** is set to **Federal ID** and **Tax ID Option** is set to **Location**.

ID Sub-No

Intended for additional tax ID information such as a site number that is required by a carrier or a claims vendor.

Used when the related claim style output option **Output Site ID for ANSI 837 formats** is set to **Location**.

ID Suffix

Enter additional tax ID information when required by your local area.

Used as pull fields when the related claim style output option is selected.

Fee Profile

This box is only available when **Location** is selected for **Procedure Fee Basis** in **Practice Options** or **Organization Options**.

When **Fee Profile** is available, select the fee profile to use to determine procedure fees during charge entry.

Clinic Number

The clinic number is intended for use with the transmission of claims through BCBS of Michigan EDI.

Use this box to store your assigned number only when you are directed by a member of the Allscripts® support team.

The clinic number is reported when the related output option is selected in **Claim Style Maintenance**.

GL Sub-Account#1

This option is intended for use with GL Export.

Use this box to store the numeric value assigned to this segment of the general ledger (GL) account number.

GL Sub-Account#2

This option is intended for use with GL Export.

Use this box to store the numeric value assigned to this segment of the general ledger (GL) account number.

Bank Account

Select a bank account from the bank accounts defined in **Bank Account Maintenance**.

Bank Account is only available when **Enable Bank Account** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Off-Campus Provider Based Dept

Select this option for any entity that requires the automatic output of a selected modifier for services rendered.

This option works in conjunction with **Output Modifiers for Primary** or **Output Modifiers for Secondary**, and **Output Selected Modifier** for **Off-Campus Provider Based Dept** on the **Output Options** in **Claim Style Maintenance**.

The selected modifier is automatically output on electronic claims with a format type of **Professional ANSI 837P v5010**, **Professional ANSI 837P v5010A1**, **Institutional ANSI 837I v5010**, **Institutional ANSI 837I v5010A1**, or **Institutional ANSI 837I v5010A2**, as well as paper claims with a format type of **ICD10 Generic Medical Claim Form** or **Uniform Billing Claim Form**.

There is no relationship between **Off-Campus Provider Based Dept** in **Place of Service Maintenance** and **Location Maintenance**. The selection of either check box qualifies the entity when the application determines whether to output the modifier.

Merchant Terminal ID

Use to associate a merchant terminal ID to a financial location.

The **Merchant Terminal ID** grid is displayed only when **Enable Merchant Terminal ID** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Other Address (only if different from above)

Optional: The address you enter must be different from the main address at the top of the window. Use these boxes if you entered a PO box in the main address.

Keep the following items in mind when you enter the other address:

- > You cannot partially fill the **Other Address** area. For example, if only **Address 1** is different from the main address, you must fill each required box in the **Other Address** area, not only **Address 1**. If you fill all of the boxes in the **Other Address** area, you will not get an error if optional boxes, such as **Address 2** or **Country**, are filled.
- > For v5010 electronic claims, you must enter a ZIP code plus 4. If you do not know your 4-digit additional number, use <your ZIP code>-9998. For example, enter 27615-9998.
- > For v5010 electronic claims, the other address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Location**, and **Billing Method Address** in **Claims Style Maintenance** is set to **Billing Method Other Address**. Use this other address to output either billing provider information to Loop 2010AA or pay-to address information to Loop 2010AB. The information in these boxes does not output to a v4010 claim file.
- > For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the other address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Location**, and **Billing Media** and **Billing Method Address** in **Claims Style Maintenance** are set to **Paper** and **Billing Method Other Address** respectively.

Trust Customer ID

Enter the customer ID for this location, if it is different from the customer ID on the **Credit Card Processing** tab; supplied by the credit card processing vendor.

Required when **Customer ID Password** or **Trust Vault Password** is filled.

Customer ID Password

Enter the password for the customer ID for this location; supplied by the credit card processing vendor.

Required when **Trust Customer ID** or **Trust Vault Password** is filled.

Trust Vault Password

Enter the password for TrustCommerce® Vault; supplied by the credit card processing vendor.

Used by Allscripts® Practice Management for voiding transactions.

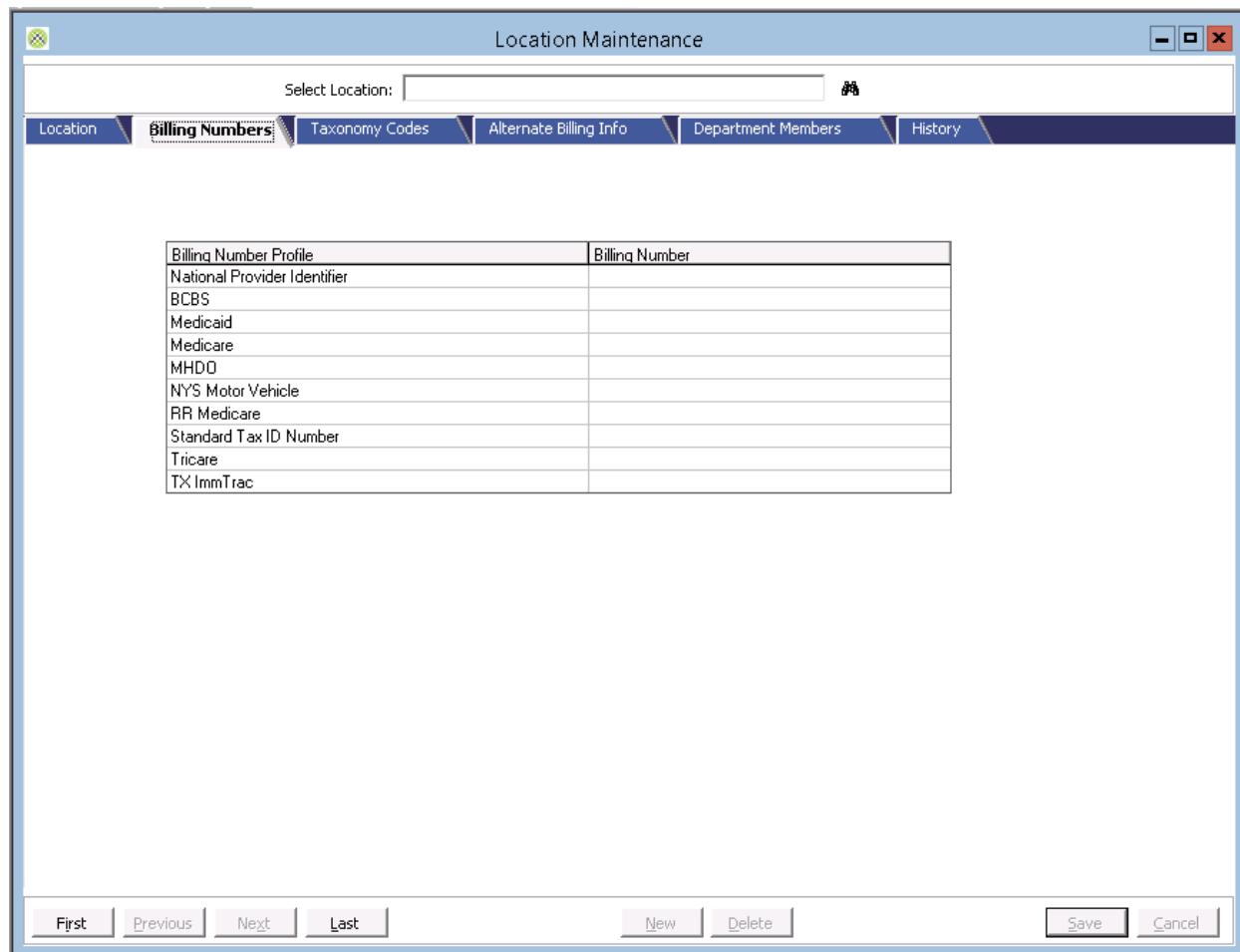
Required when **Trust Customer ID** or **Customer ID Password** is filled.

Billing Numbers tab in Location Maintenance

Use the **Billing Numbers** tab to record the billing numbers assigned to your practice. Generally, these are group numbers or numbers that apply to every member of your practice.

Numbers from this tab print or output to a claim file when Location is selected as either or both the Indiv. Billing No. Option or the Group Billing No. Option for a Paper Claim Format or as the Billing Method for an Electronic Claim Format.

Access the **Billing Numbers** tab from **Location Maintenance**. To access **Location Maintenance**, go to **System Administration > File Maintenance > Location Maintenance** or press **F9** and then enter **LOM**.



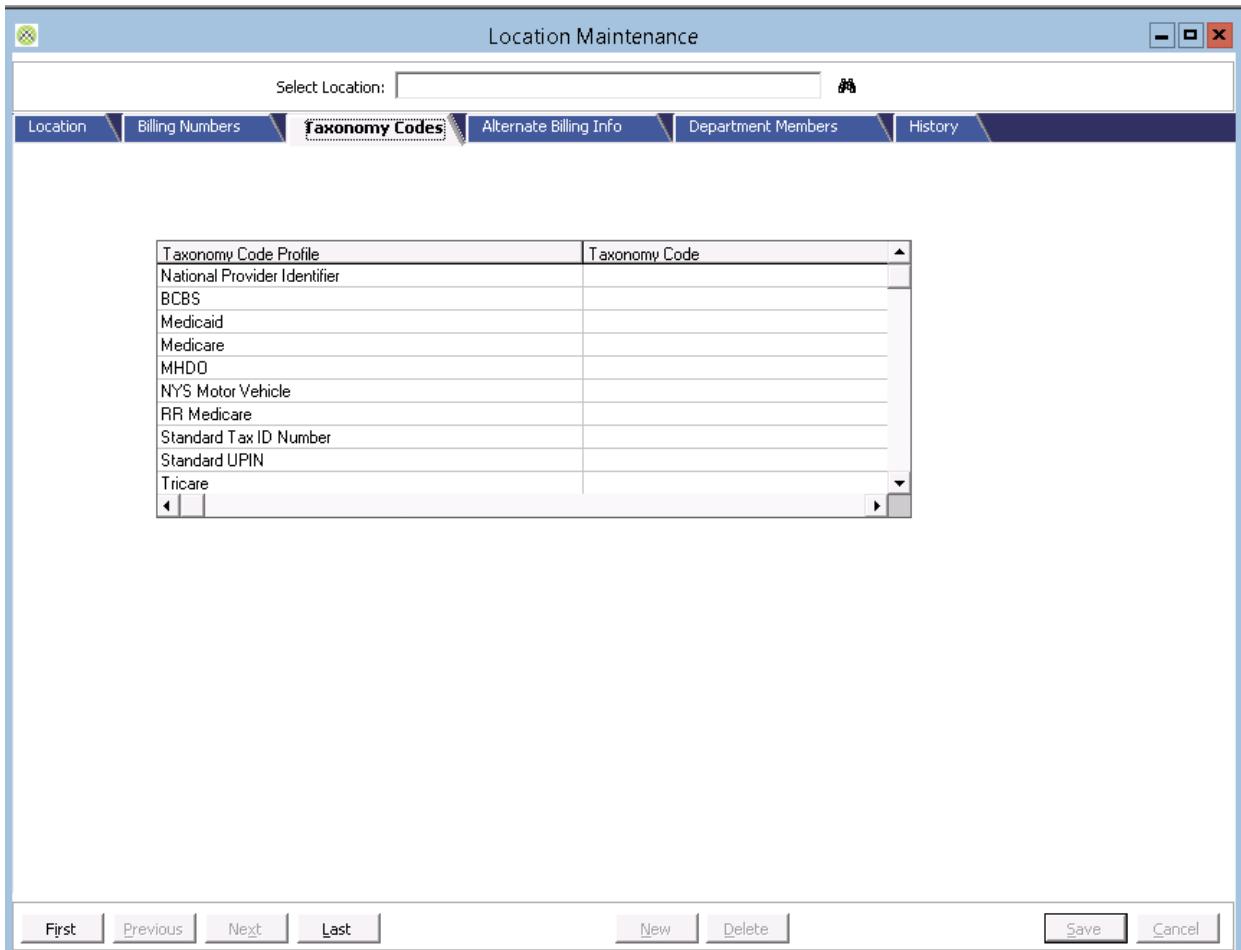
The screenshot shows the 'Location Maintenance' application window. At the top, there is a toolbar with icons for 'New', 'Delete', 'Save', and 'Cancel'. Below the toolbar, a navigation bar contains tabs: 'Location', 'Billing Numbers' (which is currently selected), 'Taxonomy Codes', 'Alternate Billing Info', 'Department Members', and 'History'. A search bar labeled 'Select Location:' is positioned above the tabs. The main area of the window displays a table titled 'Billing Number Profile' with two columns: 'Billing Number Profile' and 'Billing Number'. The table lists various billing identifiers: National Provider Identifier, BCBS, Medicaid, Medicare, MHDO, NYS Motor Vehicle, RR Medicare, Standard Tax ID Number, Tricare, and TX ImmTrac. At the bottom of the window, there are buttons for 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Taxonomy Codes tab in Location Maintenance

Use this tab to store taxonomy codes which allows you to report by Location. Generally, these are Taxonomy Codes that are assigned to a group or the location where the provider rendered the service.

The taxonomy codes entered on this tab are used when you submit claims and the billing method is set to Location and at least one of the output options related to outputting the rendering, billing or performing provider's taxonomy code is checked for the claim style associated with the carrier. The actual number reported in the electronic file or printed on a claim is the one whose profile matches the Taxonomy Code profile selected for the carrier in Insurance Carrier maintenance.

Access the **Taxonomy Codes** tab from **Location Maintenance**. To access **Location Maintenance**, go to **System Administration > File Maintenance > Location Maintenance** or press **F9** and then enter **LOM**.



The screenshot shows the 'Location Maintenance' application window. At the top, there is a toolbar with icons for minimize, maximize, and close. Below the toolbar is a menu bar with tabs: 'Location', 'Billing Numbers', 'Taxonomy Codes' (which is highlighted in blue), 'Alternate Billing Info', 'Department Members', and 'History'. A search bar labeled 'Select Location:' is positioned above the tabs. The main area contains a table with two columns: 'Taxonomy Code Profile' and 'Taxonomy Code'. The table lists various profiles: National Provider Identifier, BCBS, Medicaid, Medicare, MHDO, NYS Motor Vehicle, RR Medicare, Standard Tax ID Number, Standard UPIN, and Tricare. At the bottom of the table are navigation arrows for sorting. At the very bottom of the window are buttons for 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Alternate Billing Info tab

The information on this tab is used when claims are billed using the Carrier's alternate claim style that is associated with a format whose billing options are set to "Location."

Note: If you do not enter any data on this tab, the system uses the information entered on the Location tab when billing claims using either of the Carrier's alternate claim styles.

Keep in mind that if you enter any information at all on this tab, the system will only "look" here to output data when billing a claim using an alternate claim style where the billing options are set to Location. This means that if you leave a field blank, the related information is not output to the file or printed on the form.

When a claim is generated the system determines if an alternate claim style is being used to output the data. If the Carrier has an associated alternate claim style and that alternate style is associated with a format whose billing options are set to Location, then the system looks to see if the Location has alternate billing info filled in for that Carrier. If alternate billing info exists for that Location, the system outputs the alternate billing information on the claim. If alternate billing information does not exist for the Location then system uses the information entered on the Location tab and the Billing Numbers tab. Refer to "Using an Alternate Claim Style" in online Help for details.

Output of alternate info to claims

Information from this tab outputs to a claim file or prints on a claim form when all of the following conditions exist:

- > The Carrier must have an alternate electronic claim style selected.
- > The Billing Number Method and the Tax ID Option for the Electronic Claim Format associated with the Carrier's Alternate Claim style must be set to Location.
- > Any information is entered on this tab. This means that any field blank results in the related information not outputting to the file or printing on the form.

Electronic claims

When the Carrier has an alternate electronic claim style associated with a format whose billing options are set to "Location" then the information on the Alternate Info tab outputs on claims as follows:

- > Institutional Claims - outputs to Loop Loops 2010AA and to 2310E in a Standard ANSI X12N 837I claim file.
- > Professional Claims - outputs to loop 2010AA in a Standard ANSI X12N 837P claim file.

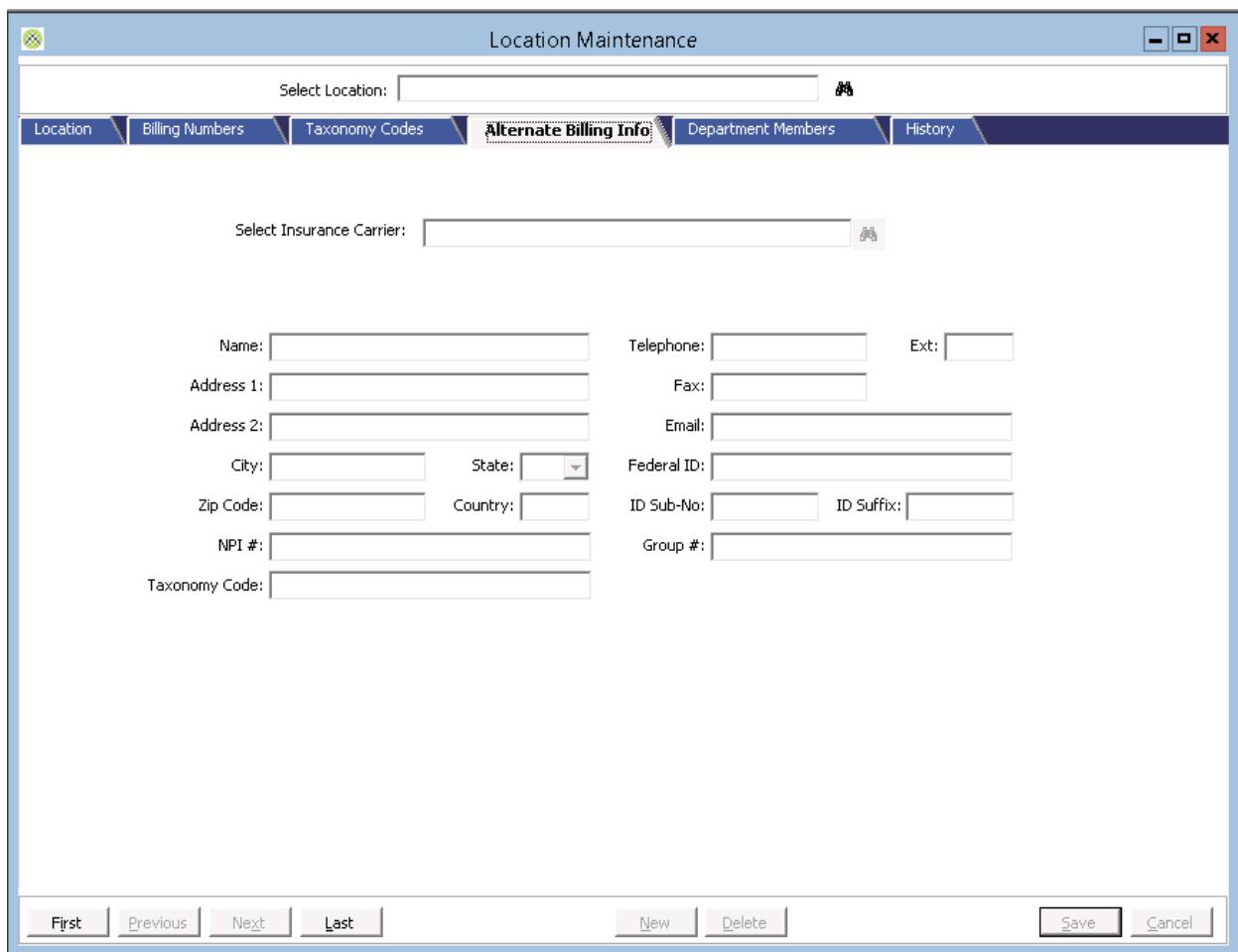
Note: Because this information outputs to the 2010AA loop the address must be a physical street address when you submit v5010 claims.

Also, enter a nine digit zip code.

Paper claims

- > Standard UB-04 - prints to boxes 1,2, 8a (if the patient ID is different from the subscriber's ID), 38, 56, 57, 66, and 81.
- > Standard CMS-1500 - prints to box 33.

Access the **Alternate Billing Info** tab from **Location Maintenance**. To access **Location Maintenance**, go to **System Administration > File Maintenance > Location Maintenance** or press **F9** and then enter **LOM**.



The screenshot shows the 'Location Maintenance' window with the 'Alternate Billing Info' tab selected. The window includes fields for selecting a location and insurance carrier, and various contact and identification details. Navigation buttons at the bottom allow for first, previous, next, last, new, delete, save, and cancel operations.

Name:	Telephone:	Ext:	
Address 1:	Fax:		
Address 2:	Email:		
City:	State:	Federal ID:	
Zip Code:	Country:	ID Sub-No:	ID Suffix:
NPI #:	Group #:	Taxonomy Code:	

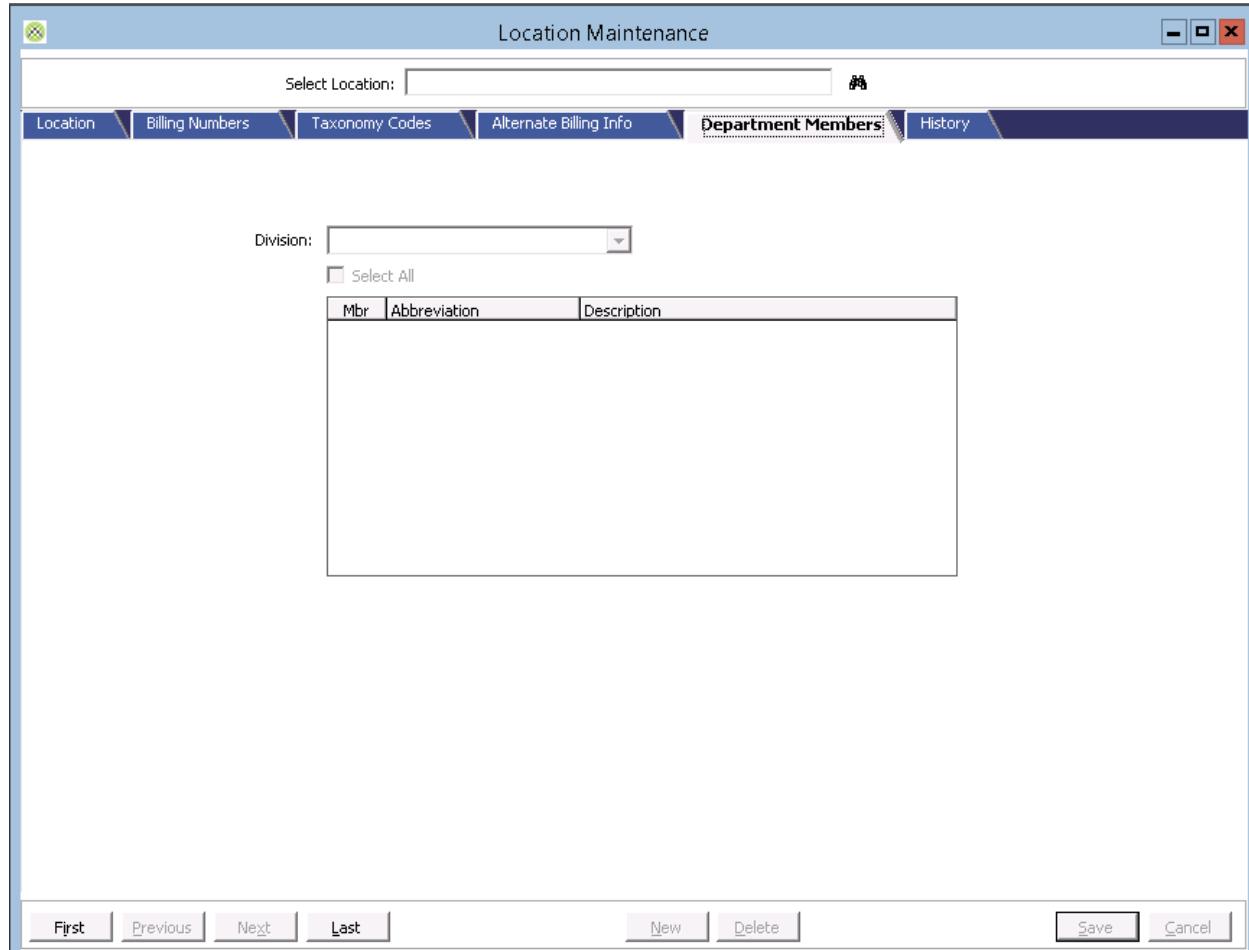
Buttons at the bottom: First, Previous, Next, Last, New, Delete, Save, Cancel.

Department Members or Practice Members tab in Location Maintenance

You must select department members or practice members for each record that has a members tab.

The **Department Members** tab or the **Organization Members** tab is displayed only when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Access the **Department Members** tab or the **Organization Members** tab from **Location Maintenance**. To access **Location Maintenance**, go to **System Administration > File Maintenance > Location Maintenance**, or press **F9** and enter **LOM**.



Division

This box is only enabled on the **Department Members** tab or **Practice Members** tab when you select **Enable Divisions** on the **Multi Entity** tab in **Practice Options** or **Organization Options**. In this case, the selection of department members or practice members is done at the level of division.

Note: Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you elect to enable divisions, you must create divisions in **Division Maintenance**. Divisions can be used as a group field, or a select-records option in reporting.

Place of Service Maintenance window

The information entered in **Place of Service Maintenance** is used to generate insurance claims. Create a records for each of the places and facilities where services are rendered by the providers in your practice or organization. Make each office location, each hospital, each nursing home as a separate place of service. And because inpatient care, outpatient care, and emergency care for a given hospital needs a different billing code, create a record for each of these places of service. Various reports can be grouped by or restricted to specified places of service.

You must enter a place of service during charge entry. The records created in **Place of Service Maintenance** are the selections for **Place of Service** on the **Charge Entry** tab. Be sure that the description enables your staff to distinguish between the selections. For instance, if you are creating a place of service for hospital inpatient care rendered at Community General Hospital, use the abbreviation **CGIP** and the description **Community General IP**. When you create a record for outpatient care, use the abbreviation **CGOP** and the description **Community General OP**.

You must complete the **Place of Service** tab and then enter billing codes, billing numbers, and taxonomy codes.

Place of Service Maintenance contains these tabs:

- > **Place of Service**
 - Note:** You must complete this tab first.
- > **Billing Codes**
- > **Billing Numbers**
- > **Taxonomy Codes**
- > **Department Members or Practice Members**

Note: If you enabled department security or practice security, you must select department or practice members on this tab.

- > Sales Tax
- > History

To access **Place of Service Maintenance**, go to **System Administration > File Maintenance > Place of Service Maintenance**, or press **F9** and then enter **PSM**.

Place of Service tab

Access the **Place of Service** tab from **Place of Service Maintenance**. To access **Place of Service Maintenance**, go to **System Administration > File Maintenance > Place of Service Maintenance**, or press **F9** and then enter **PSM**.

Place of Service Maintenance

Select Place Of Service:	
<input type="text"/> 	
Place of Service  Billing Codes  Billing Numbers  Taxonomy Codes  Department Members  Billing Method Information 	
Abbreviation:	<input type="text"/>
Description:	<input type="text"/>
Visit Type:	<input type="text"/>
Name:	<input type="text"/>
Address 1:	<input type="text"/>
Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip Code:	<input type="text"/>
Country:	<input type="text"/>
Telephone:	<input type="text"/>
Fax:	<input type="text"/>
Email:	<input type="text"/>
Place Of Service Type:	<input type="text"/>
Default Location:	<input type="text"/>
CLIA Number:	<input type="text"/>
Mammography No:	<input type="text"/>
Fee Profile:	<input type="text"/>
GL Sub-Account#1:	<input type="text"/>
GL Sub-Account#2:	<input type="text"/>
Split Billing Options	
<input type="checkbox"/> Enable Split Billing <input type="checkbox"/> Require Split Bill Procedure Procedure Grp for Separate Claim: <input type="text"/>	
Alternate Place Of Service <input type="text"/>	
<input type="button" value="First"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Last"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>	

Abbreviation

Enter an abbreviation. If you have only 1 office location you can use `office`. If you have more than 1 office location, you might want to use an abbreviation that will differentiate offices.

Visit Type

When **Derive Place of Service** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**, **Visit Type** is available and required.

Description

The value entered in this box shows in **POS** on the **Charge Entry** tab.

Name & Address

Enter the name and address of the facility as you want it displayed or printed, such as when printing claims.

Care Plan Oversight Facility

When this option is selected, the place of service is included in the drop-down list in **Claim Type Maintenance**, and in **Claim Information** accessed from the **Charge Entry** and **Edits** tabs.

The NPI of the home health agency or hospice (care plan oversight facilities) outputs to Loop 2300 REF 02 in a v5010 837P claim file.

Default Not Incident To

Select this option to automatically select **Not Incident To** in the **Summary** view on **Charge Entry** tab and on the **Edits** tab. The default selection can be removed, if necessary.

Note: **Not Incident To** is only displayed in the **Summary** view and on the **Edits** tab under certain conditions.

This option can be used to reduce errors for facilities that are unable to bill "Incident To".

Reference Laboratory

Select this option to flag a place of service as a reference laboratory.

When a procedure is selected as a purchased service, you can enter fees by place of service on the **Purchased Service Info** tab in **Procedure Code Maintenance**.

Includes the flagged place of service in the combo boxes in **Procedure Code Maintenance** and on **Purchased Services** in **Charge Entry** and **Edits**.

72 Hour Rule

Select this option to flag this place of service to use the 72 hour rule.

Enabled when **72 Hour Rule** on the **Charge Entry** tab in **Practice Options** or **Organization Options** is filled. The 72 hour rule is part of the Medicare Prospective Payment System (PPS).

This option is used in conjunction with the **72 Hour Rule** check box on the **Carrier** tab in **Insurance Carrier Maintenance** to determine when the application applies the 72 hour rule.

Off-Campus Provider Based Dept

Select this option for any entity that requires the automatic output of a selected modifier for services rendered.

This option works in conjunction with **Output Modifiers for Primary** or **Output Modifiers for Secondary**, and **Output Selected Modifier for Off-Campus Provider Based Dept** on the **Output Options** in **Claim Style Maintenance**.

The selected modifier is automatically output on electronic claims with a format type of **Professional ANSI 837P v5010**, **Professional ANSI 837P v5010A1**, **Institutional ANSI 837I v5010**, **Institutional ANSI 837I v5010A1**, or **Institutional ANSI 837I v5010A2**, as well as paper claims with a format type of **ICD10 Generic Medical Claim Form** or **Uniform Billing Claim Form**.

There is no relationship between **Off-Campus Provider Based Dept in Place of Service Maintenance** and **Location Maintenance**. The selection of either check box qualifies the entity when the application determines whether to output the modifier.

Dialysis Facility

Select this option to designate a place of service as a dialysis facility. If you select **Dialysis Facility**, you are required to select **Default Location** on the **Place of Service** tab in **Place of Service Maintenance**.

This option is enabled when **Enable Dialysis Management** on the **Special Billing** tab in **Practice Options** or **Organization Options** is selected, and it cannot be cleared after the place of service is tied to other records.

This option is disabled when **Enable Split Billing** in **Split Billing Options** is selected because a place of service cannot be a dialysis facility and a facility that uses split billing.

The application logs any changes you make to **Dialysis Facility** on the **History** tab.

Transplant Facility

Select this option to designate a place of service as a transplant facility. If you select **Transplant Facility**, you are required to select **Default Location** on the **Place of Service** tab in **Place of Service Maintenance**.

This option is enabled when **Enable Transplant Management** on the **Special Billing** tab in **Practice Options** or **Organization Options** is selected, and it cannot be cleared after a place of service is tied to other records.

This option is disabled when **Enable Split Billing** in **Split Billing Options** is selected because a place of service cannot be a transplant facility and a facility that uses split billing.

The application logs any changes you make to **Transplant Facility** on the **History** tab.

Place Of Service Type

The predefined selections are:

- > **Emergency Room**
- > **Facility**
- > **Home** (prints HOMEBOUND in Box 19 on a Standard CMS-1500 NPI paper claim form)
- > **Hospice**
- > **Independent Lab**
- > **Office**

- > **Service Location**
- > **Testing Lab**

This box should be left blank if none of the predefined service types match the type of services rendered in the facility.

Note: Fills in Box 24B on a Standard CMS-1500 NPI paper claim form when indicated by programming specs.

Default Location

This drop-down list contains the records built in **Location Maintenance**.

This box must be filled if you intend to report on where services were rendered by the providers in your practice.

CLIA Number

If applicable, enter the Clinical Laboratory Improvement Amendments (CLIA) number.

Prints in Box 23 on a standard CMS-1500 NPI claim form when the claim style output option **Output CLIA #** is selected, and the voucher contains a lab procedure and a prior authorization # is not entered in **Claim Information**.

Mammography No

If applicable, enter in the facility's mammography certification number.

Outputs to Box 32 on Standard CMS-1500 NPI paper claim form and to Loop 2300 and Loop 2400 in an ANSI 837 electronic claim file when the claim style output option **Output Mammography #** is selected, and the voucher contains a procedure with a type of **Mammography**.

Fee Profile

When either **Procedure Fee Basis** or **Override Procedure Fee Basis** is selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**, **Fee Profile** is available. The selection options for **Fee Profile** are the fee profiles entered in the **Profile List** grid on the **Profiles** tab in **Practice Set Up** or **Organization Set Up** when **Fees** is selected as the profile type.

GL Sub-Account#1

If you are using the GL Export, enter the numeric value assigned to this segment of the GL account number, if necessary.

GL Sub-Account#2

If you are using the GL Export, enter the numeric value assigned to this segment of the GL account number, if necessary.

Enable Split Billing

Select this option for any place of service where split billing is required.

This option works in conjunction with the split billing options in **Procedure Code Maintenance** to automatically split charges initially entered during charge entry on 1 voucher based on procedure codes that are flagged for split billing.

Note: **Enable Split Billing in Place of Service Maintenance** and **Enable Split Billing in Procedure Code Maintenance** must both be selected for split billing.

Note: **Enable Split Billing in Place of Service Maintenance** is not available when **Dialysis Facility** or **Transplant Facility** on the **Place of Service** tab in **Place of Service Maintenance** is selected because a place of service cannot be a facility that uses split billing as well as a dialysis facility or transplant facility.

Require Split Bill Procedure

When selected, the operator cannot save the voucher on the **Charge Entry** tab if the voucher contains this place of service and both of the following are true:

1. The payer is a carrier with an alternate paper claim style or an alternate electronic claim style selected.
2. None of the procedure codes entered are enabled for split billing.

Procedure Grp for Separate Claim

Use to identify procedure codes, such as A6 Condition Codes, that must be submitted on a separate claim.

When any of the procedure codes in the selected group are entered on a voucher, the application splits them off from the original voucher and creates a new voucher that contains only these codes.

Enabled only when **Enable Split Billing** is selected.

Alternate Place of Service

Use to identify the alternate place of service billing numbers you want to output with the alternate claim style in a split billing situation.

This option enables you to output billing numbers that are different than those used for the primary claim style in instances when the services split off to an alternate claim style require different billing numbers.

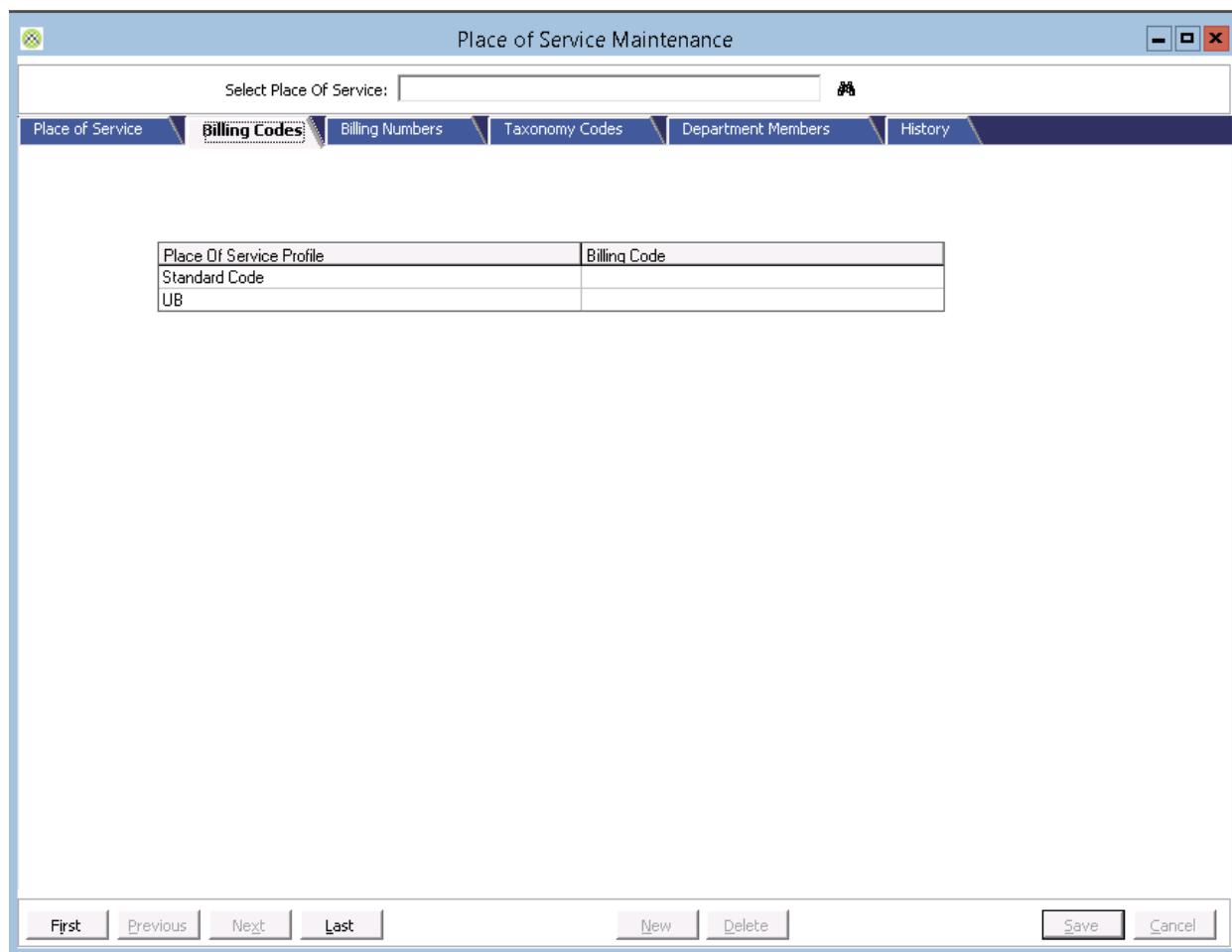
Note: Make sure you load the billing numbers for this place of service in **Provider Maintenance**.

Enabled only when **Enable Split Billing** is selected.

Billing Codes tab in Place of Service Maintenance

Use the **Billing Codes** tab in **Place of Service Maintenance** to associate a billing code with each **Place of Service** profile.

Access this tab from **Place of Service Maintenance**. To access **Place of Service Maintenance**, go to **System Administration > File Maintenance** and select **Place of Service Maintenance** from the list, or press **F9** and enter **PSM**.



Place Of Service Profile

Lists the **Place of Service** profiles created on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**.

Billing Code

Lists the billing codes you entered for each profile.

Prints in Box 24B on a standard CMS 1500 ICD-10 Standard (02/12) form.

Billing Numbers tab in Place of Service Maintenance

Use the **Billing Numbers** in **Place of Service Maintenance** to store the facility ID number required by certain insurance carriers.

The billing number is assigned to the facility by the carrier. It prints in Box 32b on a CMS 1500 ICD-10 Standard (02/12) claim form. The place of service taxonomy code also prints in Box 32b on a CMS 1500 ICD-10 Standard (02/12) claim form with a ZZ qualifier in front of it when the **Claim Style Maintenance** output option **Output Place of Service Taxonomy Code** is selected.

Note: Billing number profiles with **Override NPI** selected on **Profiles** tab in **Practice Set Up** or **Organization Set Up** are not displayed on the **Billing Numbers** tab. They are displayed on the **Billing Method Information** tab.

Access the **Billing Numbers** tab from **Place of Service Maintenance**. To access **Place of Service Maintenance**, go to **System Administration > File Maintenance** and select **Place of Service Maintenance** from the list, or press **F9** and enter **PSM**.

Place of Service Maintenance

Select Place Of Service:

Place of Service | Billing Codes | **Billing Numbers** | Taxonomy Codes | Department Members | History

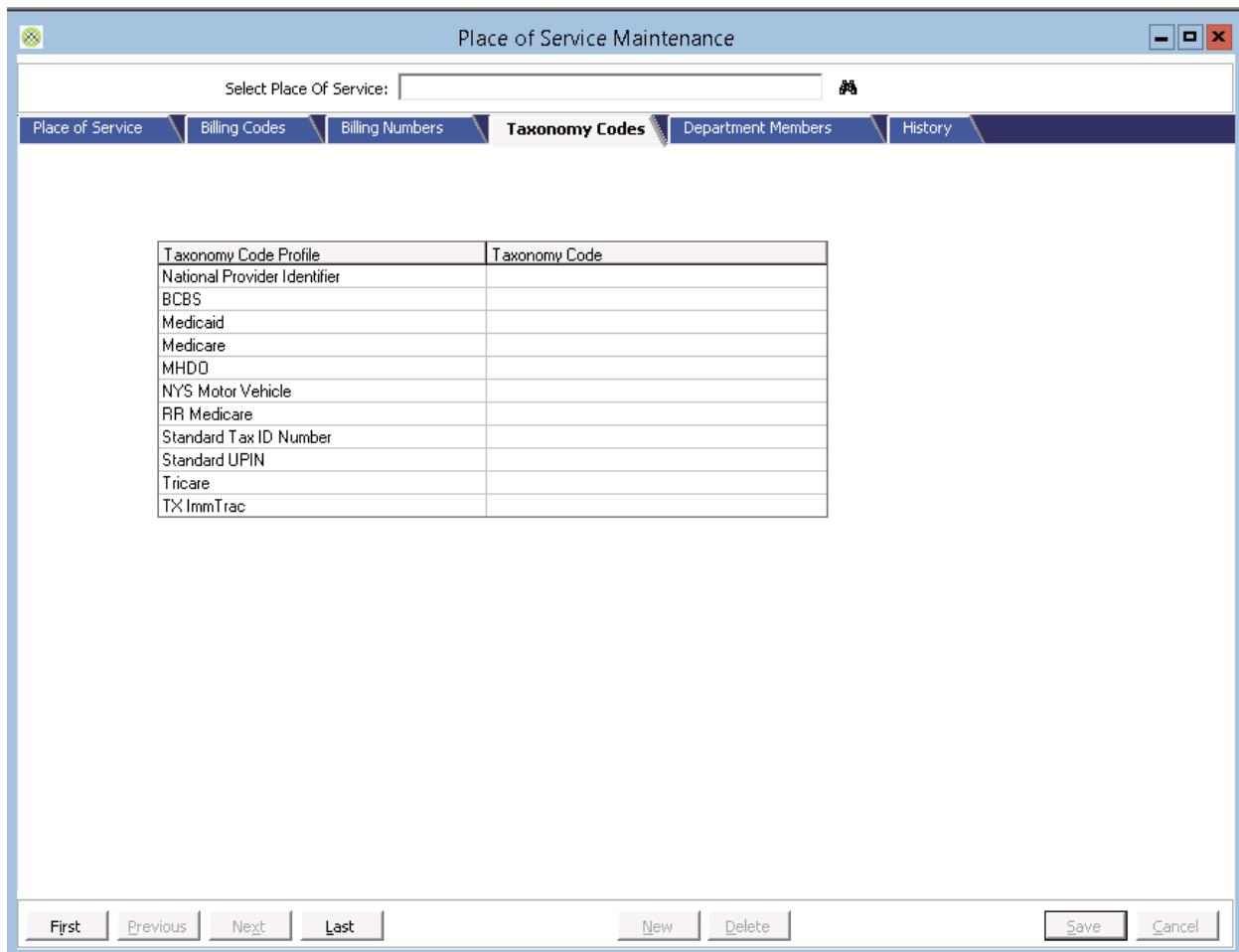
Billing Number Profile	Billing Number
National Provider Identifier	
BCBS	
Medicaid	
Medicare	
MHDO	
NYS Motor Vehicle	
RR Medicare	
Standard Tax ID Number	
Tricare	
TX ImmTrac	

First | Previous | Next | Last | New | Delete | Save | Cancel

Taxonomy Codes tab in Place of Service Maintenance

The taxonomy codes entered on this tab are used when you submit claims and the billing method is set to **Place of Service** and at least 1 of the output options related to outputting the rendering, billing, or performing provider's taxonomy code is selected for the claim style associated with the carrier. The actual number reported in the electronic file or printed on a claim is determined by the profile that matches the taxonomy code profile selected for the carrier in **Insurance Carrier Maintenance**.

Access the **Taxonomy Codes** tab from **Place of Service Maintenance**. To access **Place of Service Maintenance**, go to **System Administration > File Maintenance** and select **Place of Service Maintenance** from the list, or press **F9** and enter **PSM**.

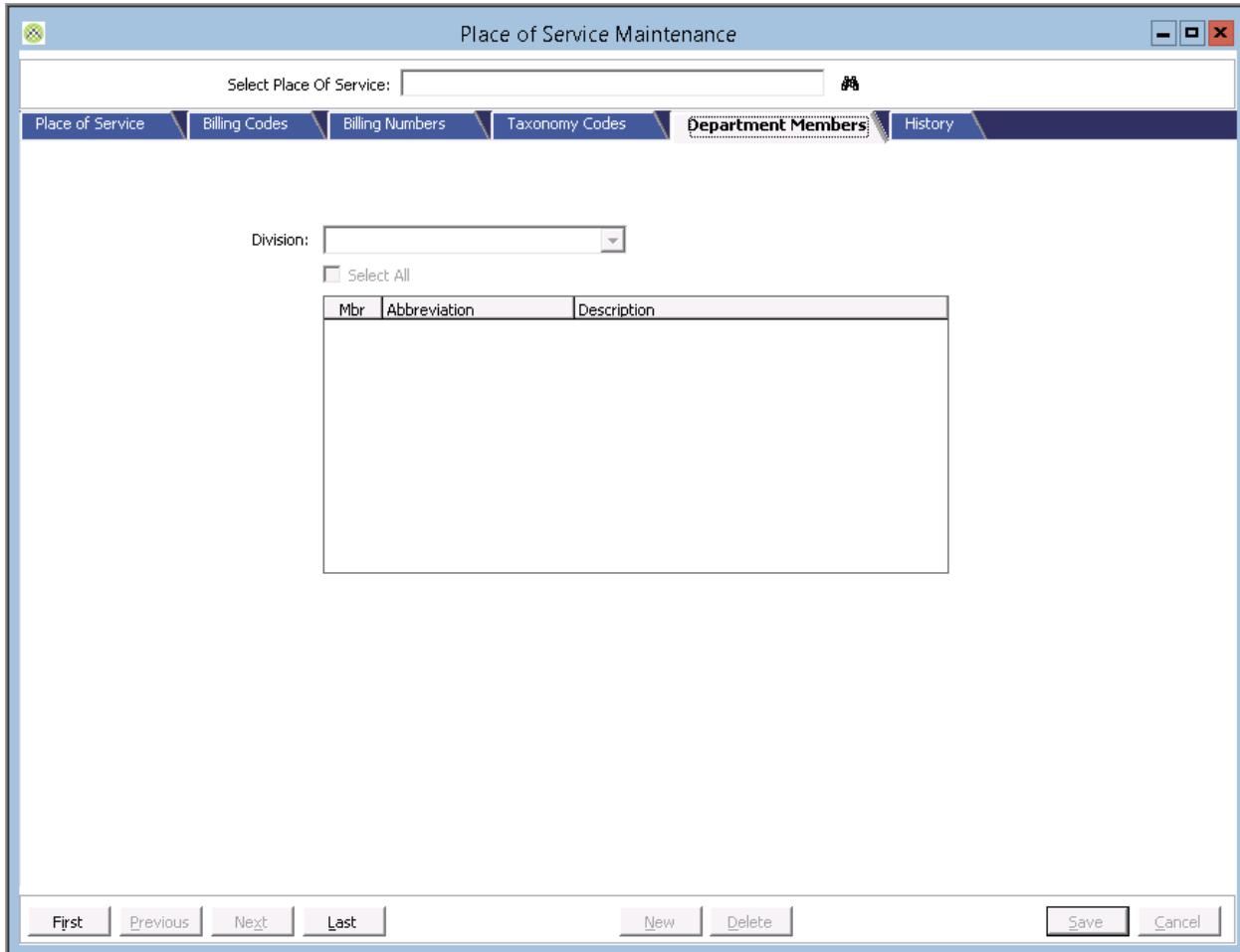


Department Members or Practice Members tab in Place of Service Maintenance

You must select department or practice members for each record that has a members tab.

This tab is only displayed when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Access the **Department Members** or **Practice Members** tab from **Place of Service Maintenance**. To access **Place of Service Maintenance**, go to **System Administration > File Maintenance** and select **Place of Service Maintenance** from the list, or press **F9** and enter **PSM**.



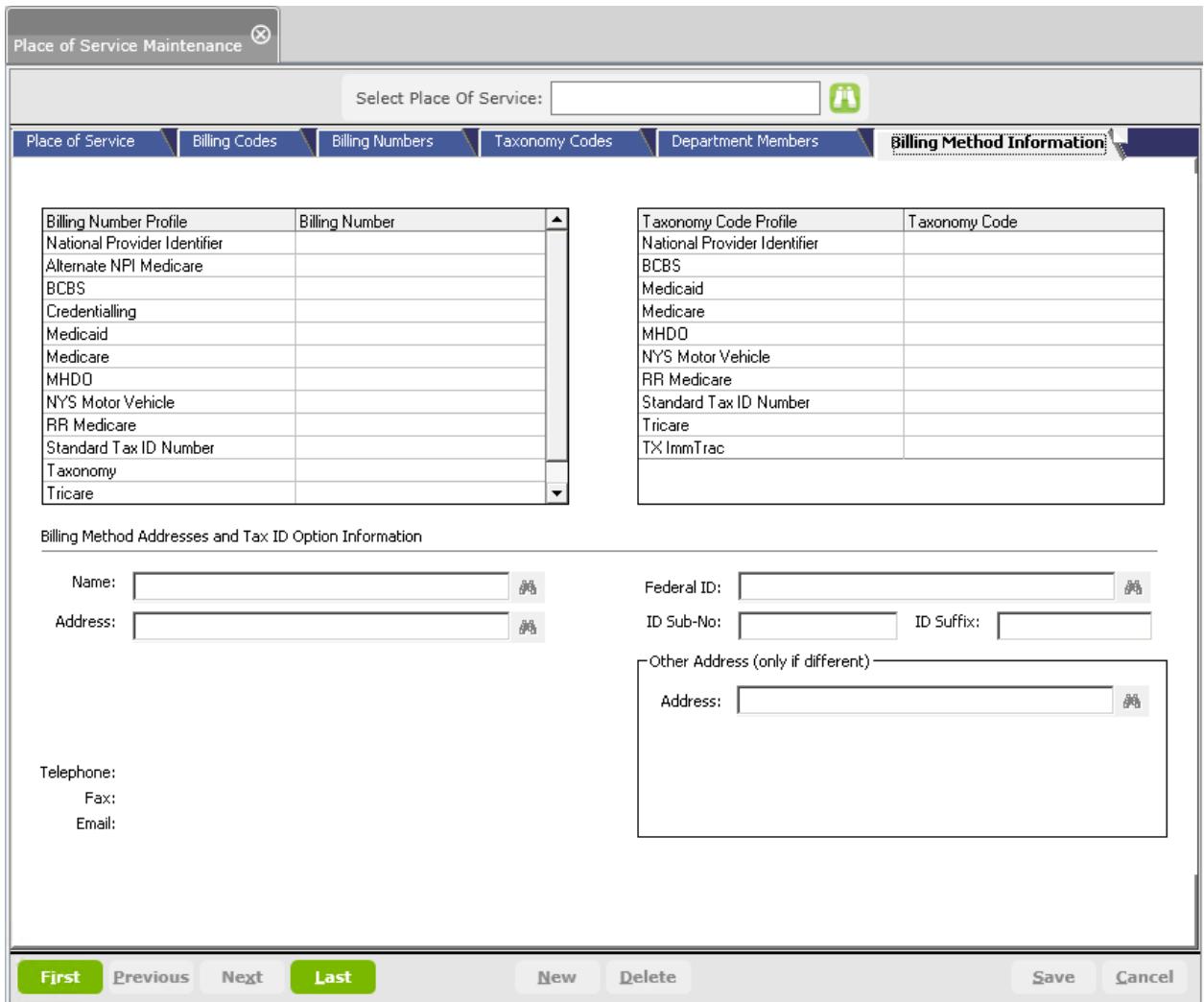
Division

This box is only available when you select **Enable Divisions** on the **Multi Entity** tab in **Practice Options** or **Organization Options**, which enables the selection of department or practice members at the division level.

Note: Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you elect to enable divisions, you must create divisions in **Division Maintenance**. Divisions can be used as a group field or select records option in reporting. .

Billing Method Information tab

Use the **Billing Method Information** tab in **Place of Service Maintenance** to store information that is required when billing by place of service.



The screenshot shows the 'Place of Service Maintenance' window. At the top, there is a search bar labeled 'Select Place Of Service:' with a magnifying glass icon. Below the search bar is a navigation bar with tabs: 'Place of Service', 'Billing Codes', 'Billing Numbers', 'Taxonomy Codes', 'Department Members', and 'Billing Method Information'. The 'Billing Method Information' tab is currently selected, indicated by a blue background and white text.

The main area contains two tables:

Billing Number Profile	Billing Number
National Provider Identifier	
Alternate NPI Medicare	
BCBS	
Credentialling	
Medicaid	
Medicare	
MHDO	
NYS Motor Vehicle	
RR Medicare	
Standard Tax ID Number	
Taxonomy	
Tricare	

Taxonomy Code Profile	Taxonomy Code
National Provider Identifier	
BCBS	
Medicaid	
Medicare	
MHDO	
NYS Motor Vehicle	
RR Medicare	
Standard Tax ID Number	
Tricare	
TX ImmTrac	

Below the tables, there is a section titled 'Billing Method Addresses and Tax ID Option Information' containing fields for Name, Address, Federal ID, ID Sub-No., ID Suffix, and Other Address.

At the bottom of the screen, there are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Access the **Billing Method Information** tab from **Place of Service Maintenance**. To access **Place of Service Maintenance**, go to **System Administration > File Maintenance > Place of Service Maintenance**, or press **F9** and then enter **PSM**.

Billing Number Profile

Display only. Each row in the grid is a billing number profile that is defined on the **Billing Numbers** tab in **Practice Set Up** or **Organization Set Up**.

Billing Number

Enter the applicable billing number for each billing number profile.

Prints on the CMS 1500 ICD-10 Standard (02/12) claim form when **Group Billing No Option** is set to **Place of Service in Paper Claim Format Maintenance**:

- > Prints the National Provider Identifier (NPI) billing number in Box 33a.
- > Prints the applicable secondary billing number in Box 33b.

If **Paper Billing Number Profile** in **Insurance Carrier Maintenance** is set to **(default)**, the billing number profile that is selected as the default on the **Profiles** tab in **Practice Set Up** or **Organization Set Up** determines the billing number that prints; otherwise, the billing number profile selected for **Paper Billing Number Profile** in **Insurance Carrier Maintenance** determines the billing number that prints.

Outputs on v5010 professional electronic claims when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Place of Service**.

- > Outputs the National Provider Identifier (NPI) billing number in Loop 2010AA.
- > Outputs the applicable secondary billing number in Loop 2010BB.

Taxonomy Code Profile

Display only. Each row in the grid is a taxonomy code profile that is defined on the **Taxonomy Codes** tab in **Practice Set Up** or **Organization Set Up**.

Taxonomy Code

Enter the applicable taxonomy code for each taxonomy code profile.

Prints in Box 33b when **Group Billing No Option** is set to **Place of Service in Paper Claim Format Maintenance**.

Outputs in Loop 2000A on v5010 professional electronic claims when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Place of Service**.

Name

Click  to open **Billing Name Lookup**. Search for and select the billing name to use on claims.

Billing names are maintained in **Billing Name Maintenance**.

Prints in Box 33 on the CMS 1500 ICD-10 Standard (02/12) claim form when **Billing Address Option** is set to **Place of Service in Paper Claim Format Maintenance**.

Outputs in Loop 2010AA on v5010 professional electronic claims when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Place of Service**.

Address

Click  to open **Address Lookup**. Search for and select the billing address to use on claims.

Prints in Box 33 on the CMS 1500 ICD-10 Standard (02/12) claim form when **Billing Address Option** is set to **Place of Service** in **Paper Claim Format Maintenance** and **Billing Method Address** on the **Output Options** tab in **Claim Style Maintenance** is set to blank or **Billing Method Address**.

Outputs in Loop 2010AA on v5010 professional electronic claims when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Place of Service**.

Billing addresses are maintained in **Address Maintenance**.

When you select a billing address, the address, telephone number, extension, fax number, and email address are retrieved from **Address Maintenance**.

Federal ID

Click  to open **Federal ID Lookup**. Search for and select the federal tax identification (ID) number to use on claims.

Prints in Box 25 on the CMS 1500 ICD-10 Standard (02/12) claim form when **Tax ID Source** is set to **Federal ID**, and **Options** is set to **Place of Service** in **Paper Claim Format Maintenance**.

Outputs in Loop 2010AA on v5010 professional electronic claims when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Place of Service**.

Federal tax IDs are maintained in **Federal ID Maintenance**.

ID Sub-No

Enter additional tax identification information, such as a site number.

The information in **ID Sub-No** is for informational purposes only. It does not output on v5010 electronic claims.

ID Suffix

Enter additional billing information when required by a payer or clearinghouse.

Outputs in Loop 2010AA on v5010 professional electronic claims when you select **Append ID Suffix to Federal ID** on the **Output Options** tab in **Claim Style Maintenance** for the claim style that is associated with the payer.

Other Address (only if different)

Click  to open **Address Lookup**. Search for and select an alternate billing address to use on claims. The address you enter must be different from the main address at the top of the tab. Use these boxes if you entered a PO Box in the main address.

Prints in Box 33 on the CMS 1500 ICD-10 Standard (02/12) claim form when **Billing Address Option** is set to **Place of Service** in **Paper Claim Format Maintenance** and **Billing Method Address** on the **Output Options** tab in **Claim Style Maintenance** is set to **Billing Method Other Address**.

Outputs in Loop 2010AA on v5010 professional electronic claims when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Place of Service** and **Billing Method Address** on the **Output Options** tab in **Claim Style Maintenance** is set to **Billing Method Other Address**. Outputs in Loop 2010AB when **Output Pay-To Address from** on the **Output Options** tab is set to **Billing Method Other Address**.

Sales Tax tab

Use the **Sales Tax** tab to configure sales tax.

Sales Tax tab

The **Sales Tax** tab is located at **System Administration > File Maintenance > Place of Service Maintenance > Sales Tax**.

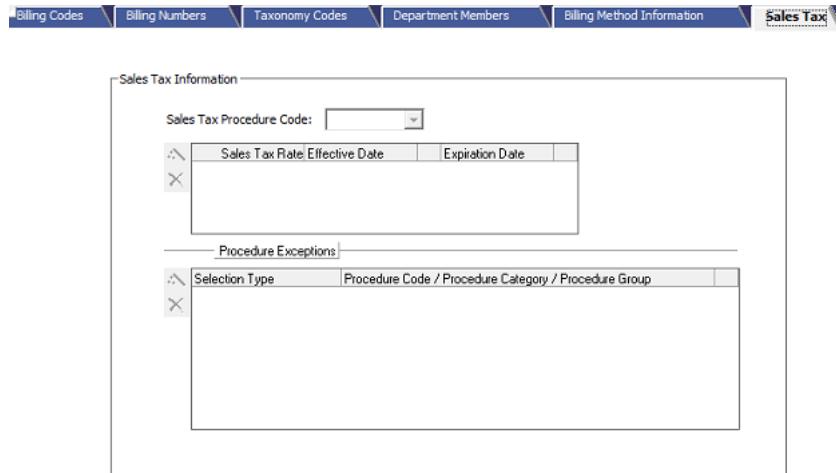
The tab is enabled if the procedure code **Sales Tax** is present in the application database. The sales tax details in the **Sales Tax** tab calculate the sales tax for every service line during charge entry, where applicable.

The **Sales Tax** tab contains:

- > Fields to add a default procedure code for the place of service
- > A grid to add the effective tax rates for a given time
- > An option to exempt a procedure code from being taxed

If a state requires the fee amount to include the sales tax and not to bill sales tax as a separate service line, the total amount of the procedure fee and the applicable tax is set up in **PCM Fee Profile**.

The **Sales Tax** tab is not included in the starter database. You must enter at least one **Sales Tax Procedure Code** in **Procedure Code Maintenance** to enable it



Sales Tax Procedure Code

If sales tax must be calculated for the place of service, you must set a default sales tax procedure code. You can select an existing code, or type in an existing code.

Sales Tax Rate Grid

You must select a procedure code in the **Sales Tax Procedure Code** to enable the grid. Use the **Wand** to add new rows. The grid consists of three columns:

- > Sales Tax Rate
- > Effective Date
- > Expiration Date

You can only edit or delete the most recent row in the grid.

Procedure Exceptions

You must select a procedure code in the **Sales Tax Procedure Code** to enable **Procedure Exceptions**. **Procedure Exceptions** contains two columns:

- > Selection Type
- > Procedure Code/Procedure Category/Procedure Group

Department Maintenance or Practice Maintenance window

Use **Department Maintenance or Practice Maintenance** to create your departments or practices.

The name of this window, **Department Maintenance or Practice Maintenance**, is driven by the multi-entity label option you selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**.

You must create at least 1 department or practice for your practice or organization.

Department or Practice is an option for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options**, and for various billing options in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

Department or Practice is also a required box during charge entry.

You can group or restrict various reports by specified departments or practices. To track the productivity of your various scheduling departments or practices, create matching departments or practices in **Department Maintenance or Practice Maintenance**.

Department Maintenance or Practice Maintenance contains these tabs:

- > **Department or Practice**
- > **Billing Numbers**
- > **Taxonomy Codes**

To access **Department Maintenance or Practice Maintenance**, go to **System Administration** > **File Maintenance** > **Department Maintenance** or **System Administration** > **File Maintenance** > **Practice Maintenance**, or press **F9** and then enter **DEM** or **PAM** as applicable.

Department tab or Practice tab in Department Maintenance or Practice Maintenance

Use **Department Maintenance or Practice Maintenance** tab to create your departments or practices.

You musts create at least 1 department or practice.

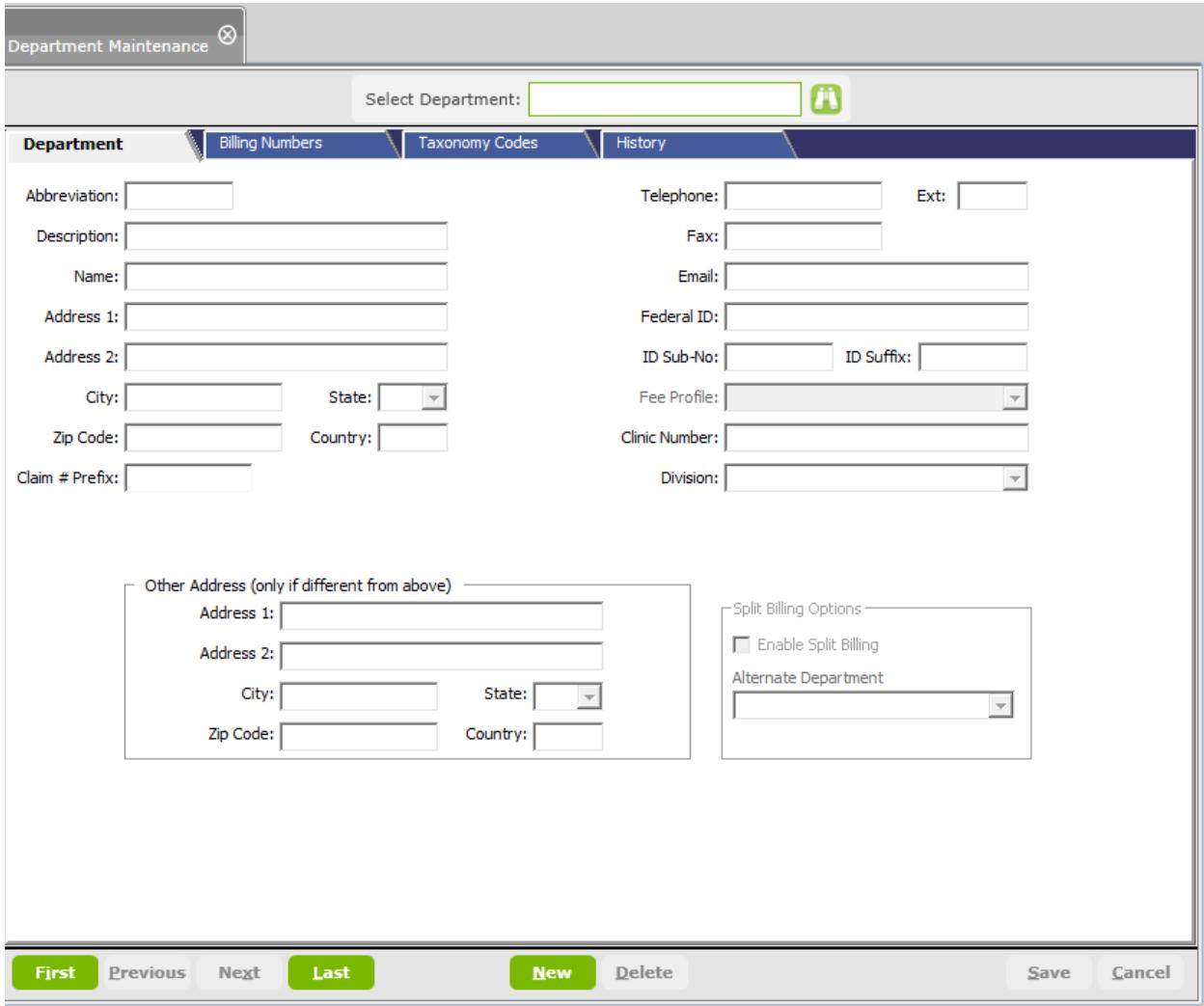
Practice or Department is an option for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options** and for various billing options in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

Practice or Department is also a required box on the **Charge Entry** tab.

Various reports can be grouped by or restricted to specified departments or practices.

To track the productivity of your various scheduling departments, you must create matching departments or practices in **Department Maintenance** or **Practice Maintenance**.

Access the **Department** tab or **Practice** tab from **Department Maintenance** or **Practice Maintenance**. To access **Department Maintenance** or **Practice Maintenance**, go to **System Administration > File Maintenance** and select **Department Maintenance** or **Practice Maintenance** from the list as applicable, or press **F9** and then enter **DEM** or **PAM** as applicable.



The screenshot shows the 'Department Maintenance' window. At the top, there is a search bar labeled 'Select Department:' with a magnifying glass icon. Below the search bar is a navigation bar with tabs: 'Department' (selected), 'Billing Numbers', 'Taxonomy Codes', and 'History'. The main form area contains the following fields:

Abbreviation:	Telephone:	Ext:
Description:	Fax:	
Name:	Email:	
Address 1:	Federal ID:	
Address 2:	ID Sub-No:	ID Suffix:
City:	Fee Profile:	
Zip Code:	Clinic Number:	
Claim # Prefix:	Division:	

Below these fields are two additional sections:

- Other Address (only if different from above)**: Contains fields for Address 1, Address 2, City, State, Zip Code, and Country.
- Split Billing Options**: Contains a checkbox for 'Enable Split Billing' and a dropdown menu for 'Alternate Department'.

At the bottom of the window are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

Holds up to 8 characters.

The abbreviation must be unique to this record.

|| Best Practice: Use only letters and numbers.

Description

Holds up to 40 characters.

|| **Best Practice:** Use only letters and numbers.

The description is displayed on the **Charge Entry** tab in **Transactions**, on the **Department** tab or **Practice** tab of the select records window used for various reports and queries that permit filtering by department or practice.

Name

Holds up to 40 characters.

|| **Best Practice:** Use only letters and numbers.

Outputs to electronic claim files, prints on paper claims, documents, encounters, and so on when **Department** or **Practice** is selected.

Department or practice main address

Enter the department or practice address exactly the way you want it to print on claim forms, encounter forms, documents, and so on.

Keep the following items in mind when you enter the main address:

- > The words **PO Box** cannot be in the address submitted on v5010 electronic claims or printed on CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms. If the main address contains a PO box number, enter a street address as the other address and set up **Billing Method Address** to use the other address for claims.
- > For v5010 claims, you must enter a ZIP code plus 4. If you do not know your 4-digit additional number, use <your ZIP Code>-9998. For example, enter 27615-9998.
- > **Address 2** outputs to electronic claim files but does not print on paper claims.
- > The main address boxes are available as pull fields for encounter forms and some documents depending on the type of document.
- > The main address prints on statements or occupational medicine invoices when you select **Department or Practice** for **Header Information** on the **Statements** tab or **Occ Medicine** tab in **Practice Options** or **Organization Options**.
- > **State** is a 2-letter abbreviation. Abbreviations of the US territories are listed after the 50 states.
- > **Country** holds up to 2 characters and is optional.
- > For v5010 electronic claims, the main address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Department** or **Practice**, and **Billing Method Address** in **Claims Style Maintenance** is set to either **Billing Method Address** or blank.
- > For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the main address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Department** or

Practice, and Billing Media and Billing Method Address in Claims Style Maintenance are set to **Paper** and either **Billing Method Address** or blank respectively.

Claim # Prefix

Enter the applicable prefix number, so that separate remittance files can be returned for the departments within a practice or the practices within an organization. The claim prefix number must be unique for each department or practice in a tenant.

Claim # Prefix Option on the **General** tab in **Practice Options** or **Organization Options** must be set to **Department** or **Practice** to have this number output on claims.

Telephone

Requires an entry of 10 digits.

Enter a telephone number using the format: (###)###-####; enter the numbers without spaces or dashes.

Used as a pull field when you select **Department** or **Practice** as the header information for occupational medicine invoices.

Ext

Holds up to 5 characters.

Fax

Requires an entry of 10 digits.

Entering a fax number using the format: (###)###-####; do not use spaces or dashes.

Email

This box is Informational only.

Federal ID

Enter the Tax ID number assigned to your practice or organization or to the location or facility. Can be used when billing insurance claims when **Tax ID Source** is set to **Federal ID** and **Option** is set to **Location**.

Used as the pull field when **Federal ID** is selected for **Tax ID Source** and **Department** or **Practice** is selected for **Option** for paper and electronic claim formats.

ID Sub-No

Intended for additional tax ID information such as a site number that is required by a carrier or a claims vendor.

Used when the related claim style output option **Output Site ID for ANSI 837 formats** is set to **Department** or **Practice**.

ID Suffix

Enter additional tax ID information when required by your local area.

Used when the related claim style output option is selected.

Fee Profile

This box is only enabled when **Department or Practice** is selected for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

When it is enabled, select the fee profile used to determine procedure fees during charge entry.

Clinic Number

Clinic Number is used with the transmission of claims through BCBS of Michigan EDI.

Use this box to store your assigned number only when you are directed to do so by a member of Allscripts® Support.

The clinic number is reported when the related output option is selected in **Claim Style Maintenance**.

Division

This box is not enabled unless **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**.

If you are using department security or practice security, you must select a division.

Note: Each time you create a new department or practice record, be sure to add it to the operators who need access to the department or practice and to records that need to be available for use by operators who have access to the new department or practice.

Each department or practice must be associated with 1 division.

GL Sub-Account#1

Intended for use with the GL Export utility.

Use this box to store the numeric value assigned to this segment of the general ledger (GL) account number.

GL Sub-Account#2

Intended for use with the GL Export utility.

Use this box to store the numeric value assigned to this segment of the general ledger (GL) account number.

Other Address (only if different from above)

Optional: The address you enter must be different from the main address at the top of the window. Use these boxes if you entered a PO Box in the main address.

Keep the following items in mind when you enter the other address:

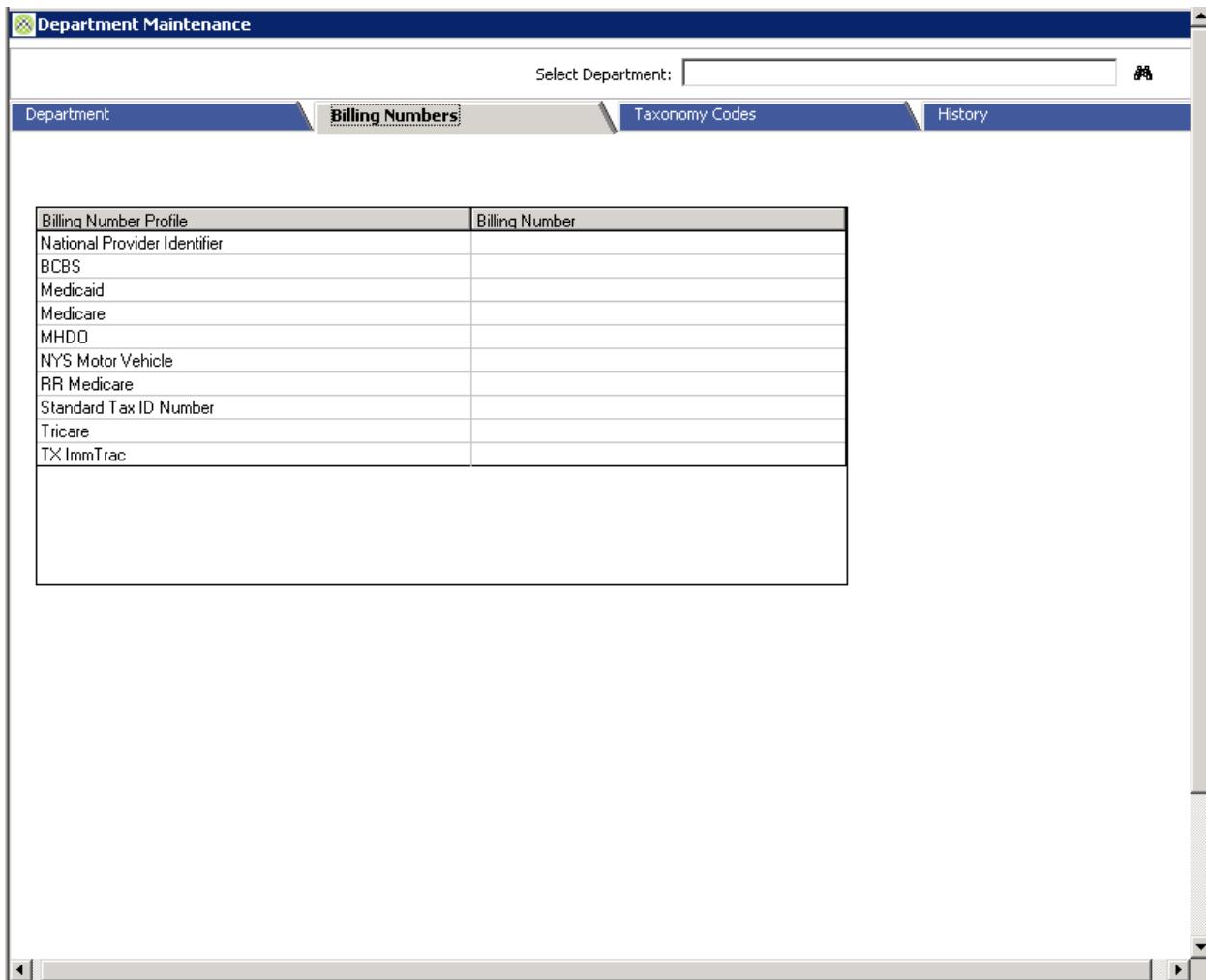
- You cannot partially fill the **Other Address** area. For example, if only **Address 1** is different from the main address, you must fill each required box in the **Other Address** area, not only **Address 1**. If you fill all of the boxes in the **Other Address** area, you will not get an error if optional boxes, such as **Address 2** or **Country**, are filled.
- For v5010 electronic claims, you must enter a ZIP Code plus 4. If you do not know your 4-digit additional number, use <your ZIP Code>-9998. For example, enter 27615-9998.
- For v5010 electronic claims, the other address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Department** or **Practice**, and **Billing Method Address** in **Claims Style Maintenance** is set to **Billing Method Other Address**. Use this other address to output either billing provider information to Loop 2010AA or pay-to address information to Loop 2010AB. The information in these boxes does not output to a v4010 claim file.
- For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the other address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Department** or **Practice**, and **Billing Media** and **Billing Method Address** in **Claims Style Maintenance** are set to **Paper** and **Billing Method Other Address** respectively.

Billing Numbers tab in Department Maintenance or Practice Maintenance

Use this tab to record the billing numbers assigned to your practice. Generally, these are group numbers or numbers that apply to every member of your practice.

Numbers from this tab print on a claim form or output to a claim file when **Department** is selected as the billing number option in **Paper Claim Format Maintenance** or **Electronic Claim Format Maintenance**.

Access the **Billing Numbers** tab from **Department Maintenance** or **Practice Maintenance**. To access **Department Maintenance** or **Practice Maintenance**, go to **System Administration > File Maintenance** and select **Department Maintenance** or **Practice Maintenance** from the list as applicable, or press **F9** and enter **DEM** or **PAM** as applicable.

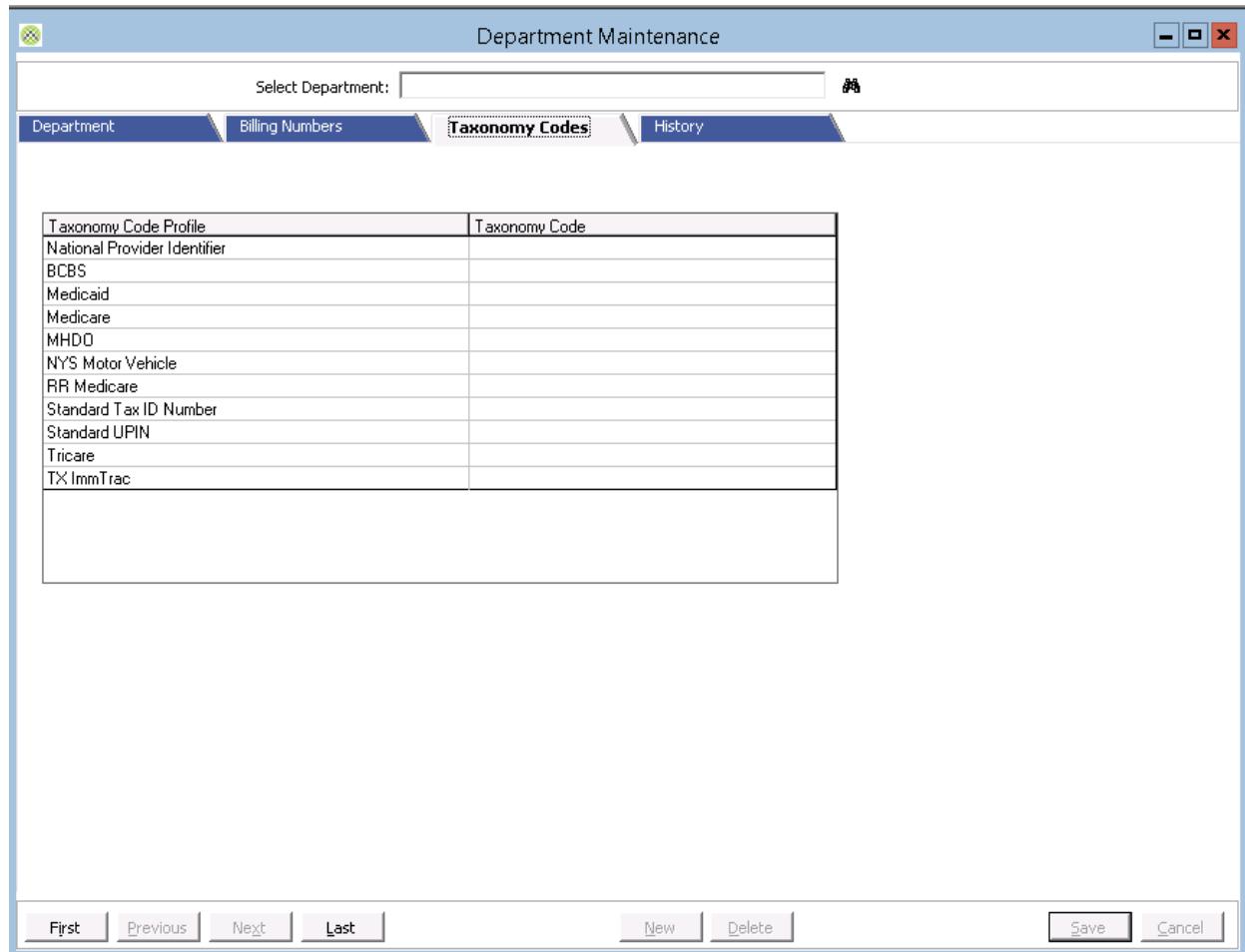


Taxonomy Codes tab in Department Maintenance or Practice Maintenance

The taxonomy codes entered on this tab are used when you submit claims if the billing method is set to **Department** or **Practice** and at least 1 of the output options related to outputting the rendering, billing, or performing provider's taxonomy code is selected for the claim style associated with the carrier. The actual number reported in the electronic file or printed on a claim is determined by the profile that matches the taxonomy code profile selected for the carrier in **Insurance Carrier Maintenance**.

Access the **Taxonomy Codes** tab from **Department Maintenance** or **Practice Maintenance**. To access **Department Maintenance** or **Practice Maintenance**, go to **System Administration >**

File Maintenance and select **Department Maintenance** or **Practice Maintenance** from the list as applicable, or press **F9** and enter **DEM** or **PAM** as applicable.



Bank Account Maintenance window

Use **Bank Account Maintenance** to define the bank accounts that are used by your practice or organization.

Bank Account Maintenance is available when **Enable Bank Account** is selected on the **General** tab in **Practice Options** or **Organization Options**.

If you clear **Enable Bank Account** after you have entered bank accounts, **Bank Account Maintenance** is no longer available, but the bank account information is saved and is displayed if you select **Enable Bank Account** again.

Bank Account Maintenance contains these tabs:

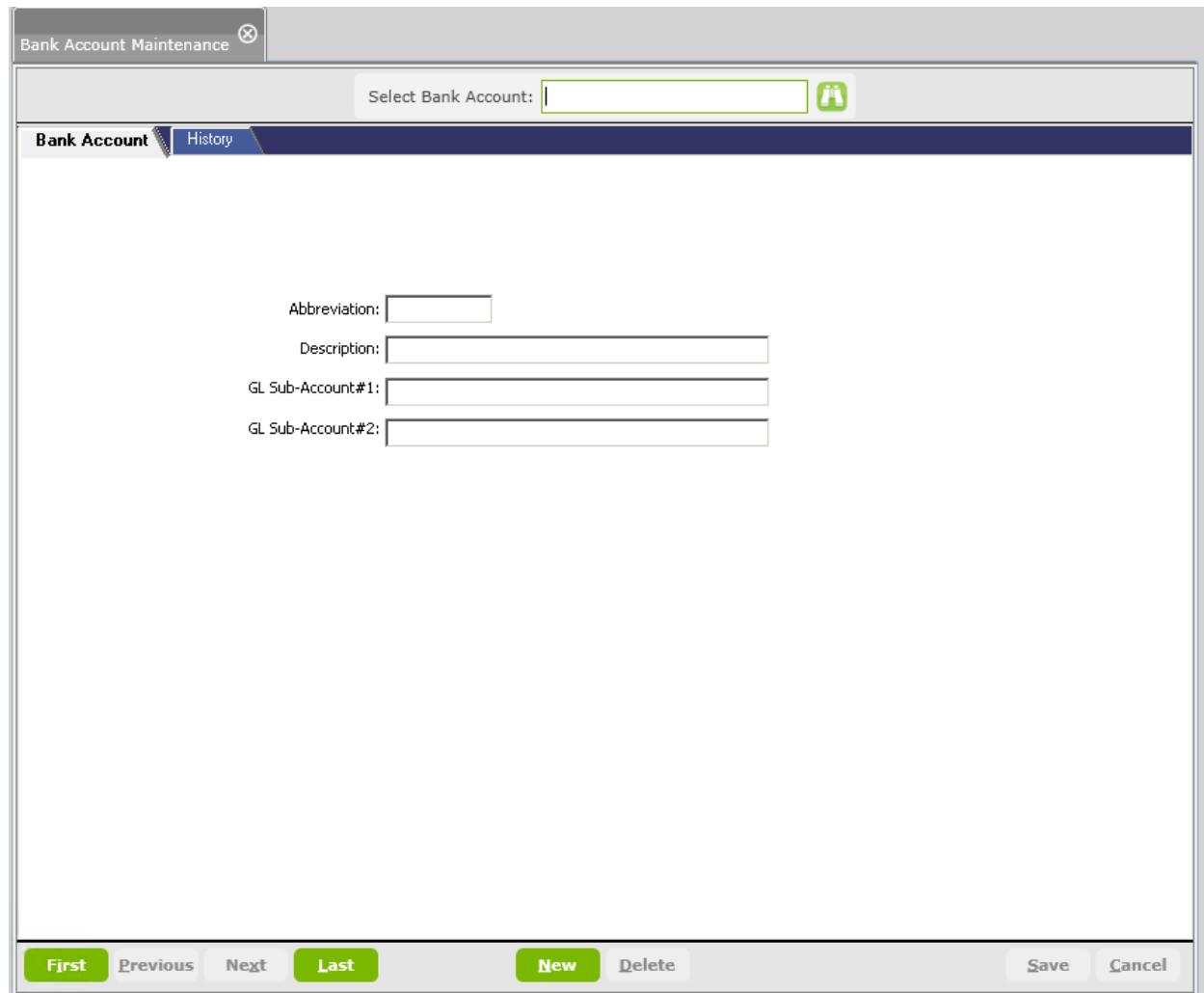
- > **Bank Account**
- > **History**

To access **Bank Account Maintenance**, go to **System Administration > File Maintenance > Bank Account Maintenance**, or press **F9** and enter **BAC**.

Bank Account tab

Use the **Bank Account** tab in **Bank Account Maintenance** to define the bank accounts that are used by your practice or organization.

Access the **Bank Account** tab from **Bank Account Maintenance**. To access **Bank Account Maintenance**, go to **System Administration > File Maintenance > Bank Account Maintenance**, or press **F9** and then enter **BAC**.



The screenshot shows the 'Bank Account Maintenance' window. At the top, there's a header bar with the title 'Bank Account Maintenance' and a close button. Below the header is a search bar labeled 'Select Bank Account:' with a magnifying glass icon. The main area has two tabs: 'Bank Account' (which is selected) and 'History'. Under the 'Bank Account' tab, there are four input fields: 'Abbreviation:' (empty), 'Description:' (empty), 'GL Sub-Account#1:' (empty), and 'GL Sub-Account#2:' (empty). At the bottom of the window are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New' (highlighted in green), 'Delete', 'Save' (disabled), and 'Cancel'.

Abbreviation

Required. Enter an abbreviation for the bank account record. Each bank account record must have a unique abbreviation.

Description

Required. Enter a description for the bank account record.

Best Practice: Make the description unique, so that it is not confused with other bank account records.

GL Sub-Account #1

Enter the numeric value that is assigned to this segment of the general ledger (GL) account number.

GL Sub-Account #1 is available only when **GL Processing** is selected in **Administration > Security Manager > Tenant Maintenance**.

GL Sub-Account #2

Enter the numeric value that is assigned to this segment of the general ledger (GL) account number.

GL Sub-Account #2 is available only when **GL Processing** is selected in **Administration > Security Manager > Tenant Maintenance**.

Create a bank account

Use the **Bank Account** tab in **Bank Account Maintenance** to define the bank accounts that are used by your practice or organization.

1. Go to **System Administration > File Maintenance > Bank Account Maintenance**, or press **F9** and then enter **BAC**.
2. Click **New**.
3. For **Abbreviation**, enter an abbreviation for the bank account record.
Each bank account record must have a unique abbreviation.
4. For **Description**, enter a description for the bank account record.

Note: Make the description unique, so that it is not confused with other bank account records.

5. If you are using **GL Export**, for **GL Sub-Account #1**, enter the numeric value that is assigned to this segment of the general ledger (GL) account number, if applicable.

6. If you are using **GL Export**, for **GL Sub-Account #2**, enter the numeric value that is assigned to this segment of the general ledger (GL) account number, if applicable.
7. Click **Save**.

Billing Office Maintenance window

Use **Billing Office Maintenance** to define the billing offices that are used by your practice or organization.

Billing Office Maintenance contains these tabs:

- > **Billing Office**
- > **Bank Account(s)**
- > **Operators**
- > **History**

The **Bank Account(s)** tab is only available when **Enable Bank Account** is selected on the **General** tab in **Practice Options** or **Organization Options**.

To access **Billing Office Maintenance**, go to **System Administration > File Maintenance > Billing Office Maintenance**, or press **F9** and enter **BOM**.

Billing Office tab

Use the **Billing Office** tab in **Billing Office Maintenance** to define the billing offices that are used by your practice or organization.

Access the **Billing Office** tab from **Billing Office Maintenance**. To access **Billing Office Maintenance**, go to **System Administration > File Maintenance > Billing Office Maintenance**, or press **F9** and then enter **BOM**.

Billing Office Maintenance

Select Billing Office:		
Billing Office Bank Account(s) Operators History		
Abbreviation:	Telephone:	Ext:
Description:	Fax:	
Name:	Email:	
Address 1:		
Address 2:		
City:	State:	
Zip Code:	Country:	
Other Address (only if different from above)		
Address 1:	  Merchant Terminal ID	
Address 2:		
City:	State:	
Zip Code:	Country:	

[First](#) [Previous](#) [Next](#) [Last](#) [New](#) [Delete](#) [Save](#) [Cancel](#)

Abbreviation

Required. Enter an abbreviation for the billing office record. Each billing office record must have a unique abbreviation.

Description

Required. Enter a description for the billing office record.

Best Practice: Make the description unique, so that it is not confused with other billing office records.

Name

Required. Enter the name of the billing office.

Address 1

Required. Enter the first line of the billing office address.

Address 2

Enter the second line of the billing office address, if any. For example, enter a suite number, apartment number, or PO Box number.

City

Required. Enter the city.

State

Required. Select the two-character state abbreviation.

Zip Code

Required. Enter the ZIP Code.

Country

Enter the two-digit abbreviation for the country.

Telephone

Enter a 10-digit telephone number that is associated with this billing office address.

Ext

Enter the extension for the telephone number.

Fax

Enter a 10-digit fax number that is associated with this billing office address.

E-Mail

Enter an email address that is associated with this billing office address.

Other Address (only if different from above)

The address you enter must be different from the main address at the top of the window. Use these boxes if you entered a PO box in the main address.

You cannot partially fill the **Other Address** area. For example, if only **Address 1** is different from the main address, you must fill each required box in the **Other Address** area, not just **Address 1**.

Merchant Terminal ID

Use to associate a merchant terminal ID to a billing office.

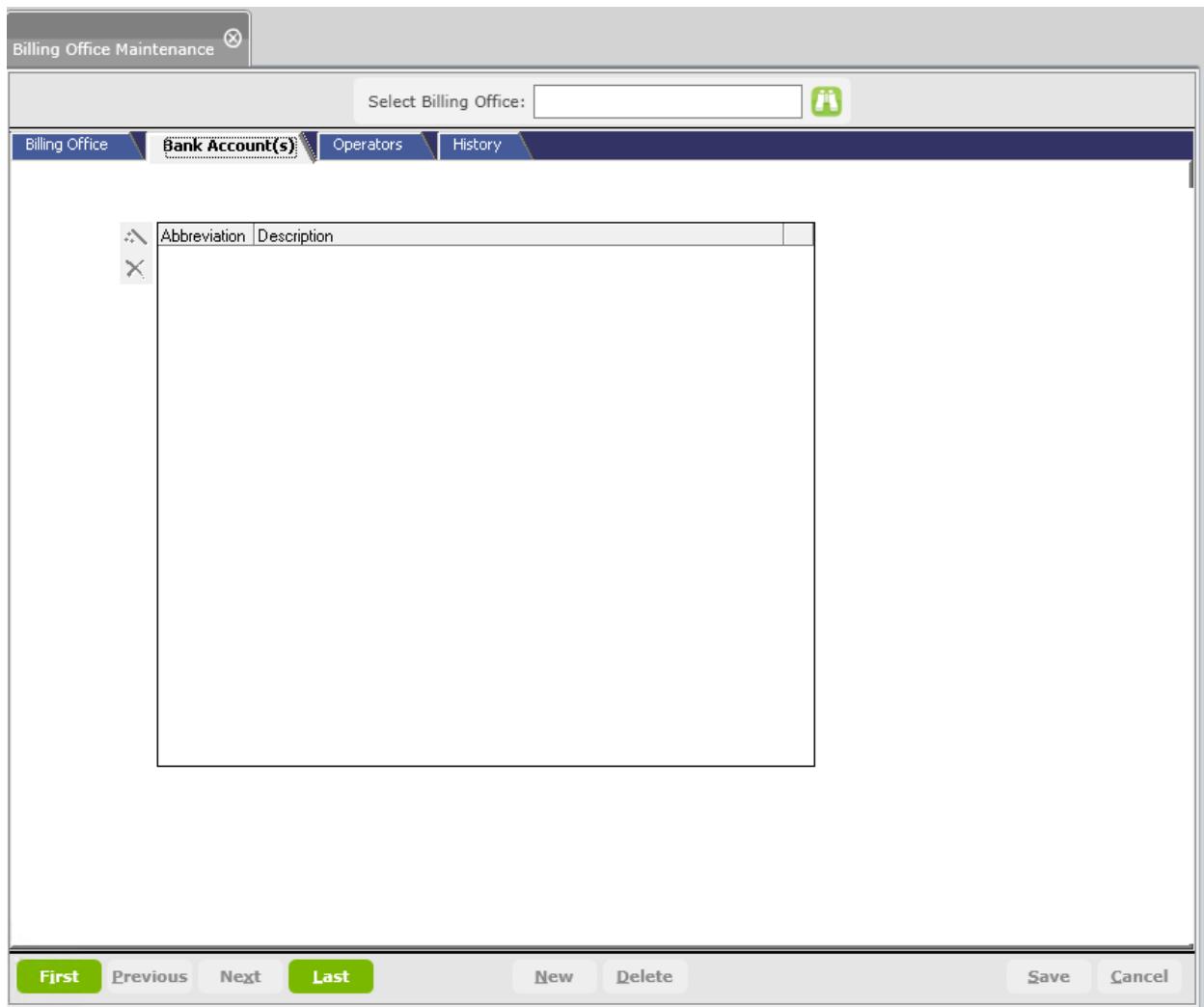
The **Merchant Terminal ID** grid is displayed only when **Enable Merchant Terminal ID** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Bank Account(s) tab in Billing Office Maintenance

Use the **Bank Account(s)** tab in **Billing Office Maintenance** to associate bank accounts with billing offices.

The **Bank Account(s)** tab is available only when **Enable Bank Account** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Access the **Bank Account(s)** tab from **Billing Office Maintenance**. To access **Billing Office Maintenance**, go to **System Administration > File Maintenance > Billing Office Maintenance**, or press **F9** and then enter **BOM**.



Abbreviation

Displays the abbreviation for the bank account.

Description

Displays the description of the bank account.

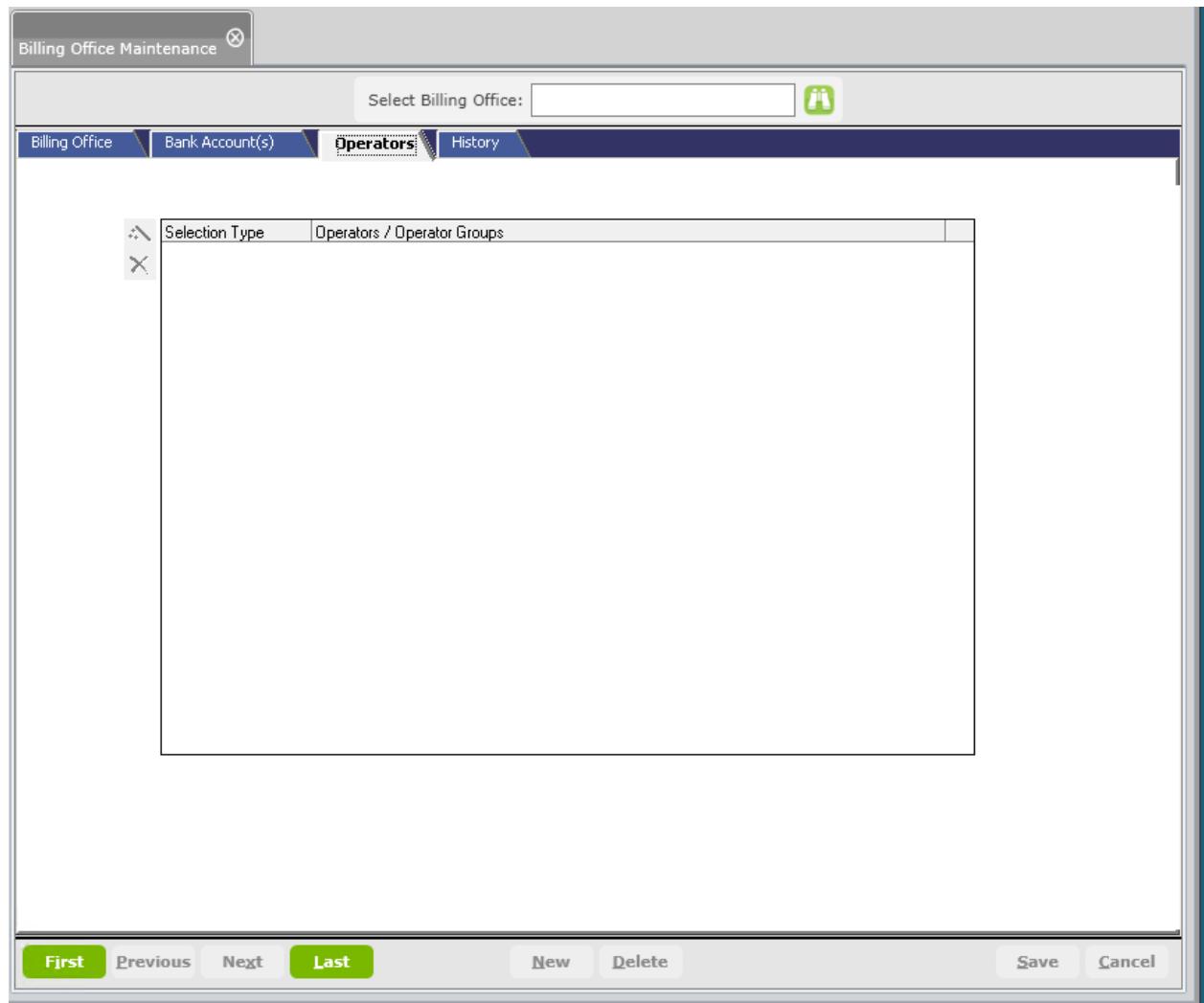
Blank column

Displays  when a row is activated and enables you to access **Select Bank Accounts**.

Operators tab in Billing Office Maintenance

Use the **Operators** tab in **Billing Office Maintenance** to associate operators with billing offices.

Access the **Operators** tab from **Billing Office Maintenance**. To access **Billing Office Maintenance**, go to **System Administration > File Maintenance > Billing Office Maintenance**, or press **F9** and then enter **BOM**.



Selection Type

Select **Operators** or **Operator Groups** from the list to determine the available options in the **Select Operators** window.

Operators/Operator Groups

Displays the operators or operator groups that are associated with the billing office.

Blank column

Displays  when a row is activated and enables you to access **Select Operators**.

Create a billing office

Use **Billing Office Maintenance** to define the billing offices that are used by your practice or organization, as well as associate bank accounts and operators with those billing offices.

1. Go to **System Administration > File Maintenance > Billing Office Maintenance**, or press **F9** and then enter **BOM**.
2. On the **Billing Office** tab, click **New**.
3. For **Abbreviation**, enter an abbreviation for the billing office record.
Each billing office record must have a unique abbreviation.
4. For **Description**, enter a description for the billing office record.

Note: Make the description unique, so that it is not confused with other billing office records.

5. For **Name**, enter the name of the billing office.
6. For **Address 1**, enter the first line of the billing office address.
7. For **Address 2**, enter the second line of the billing office address, if any.
For example, enter a suite number, apartment number, or PO Box number.
8. For **City**, enter the city.
9. For **State**, select the two-character state abbreviation.
10. For **Zip Code**, enter the ZIP Code.
11. For **Country**, enter the two-digit abbreviation for the country.
12. For **Telephone**, enter a 10-digit telephone number that is associated with this billing office address.
13. For **Ext**, enter the extension for the telephone number.
14. For **Fax**, enter a 10-digit fax number that is associated with this billing office address.
15. For **E-Mail**, enter an email address that is associated with this billing office address.
16. In the **Other Address (only if different from above)** area, enter an address that is different from the main address at the top of the window, if applicable.
Use these boxes if you entered a PO box in the main address.
You cannot partially fill the **Other Address** area. For example, if only **Address 1** is different from the main address, you must fill each required box in the **Other Address** area, not just **Address 1**.
17. If you are using bank accounts, click the **Bank Account(s)** tab.
The **Bank Account(s)** tab is available only when **Enable Bank Account** is selected on the **General** tab in **Practice Options** or **Organization Options**.

- a. Click .

A row opens in the grid.

- b. Click .

Select Bank Accounts opens.

- c. Select one or more rows in the grid.

Hold **Ctrl** to select multiple rows.

- d. Click **OK**.

18 Click the **Operators** tab.

- a. Click .

A row opens in the grid and **Selection Type** is highlighted.

- b. For **Selection Type**, select **Operators** or **Operator Groups**.

- c. Click  to open **Select Operators**.

Note: **Select Operators** displays available operators or operator groups that were created in **Operator Maintenance** or **Operator Group Maintenance** respectively, depending on the value in **Selection Type**.

- d. In **Select Operators**, select one or more operators or operator groups to add to the grid.

Hold **Ctrl** to select multiple rows.

- e. Click **OK**.

A row is added to the grid for each of the operators or operator groups that you selected.

Note: Operator groups are listed above operators. Rows are sorted alphabetically by **Operators/Operator Groups**.

- f. Repeat steps a through e, as applicable.

19 Click **Save**.

Specialty Maintenance window

Some electronic vendors require the submission of specialty codes when processing electronic claims. You can also search for providers and referring doctors by specialty.

Specialty Maintenance contains these tabs:

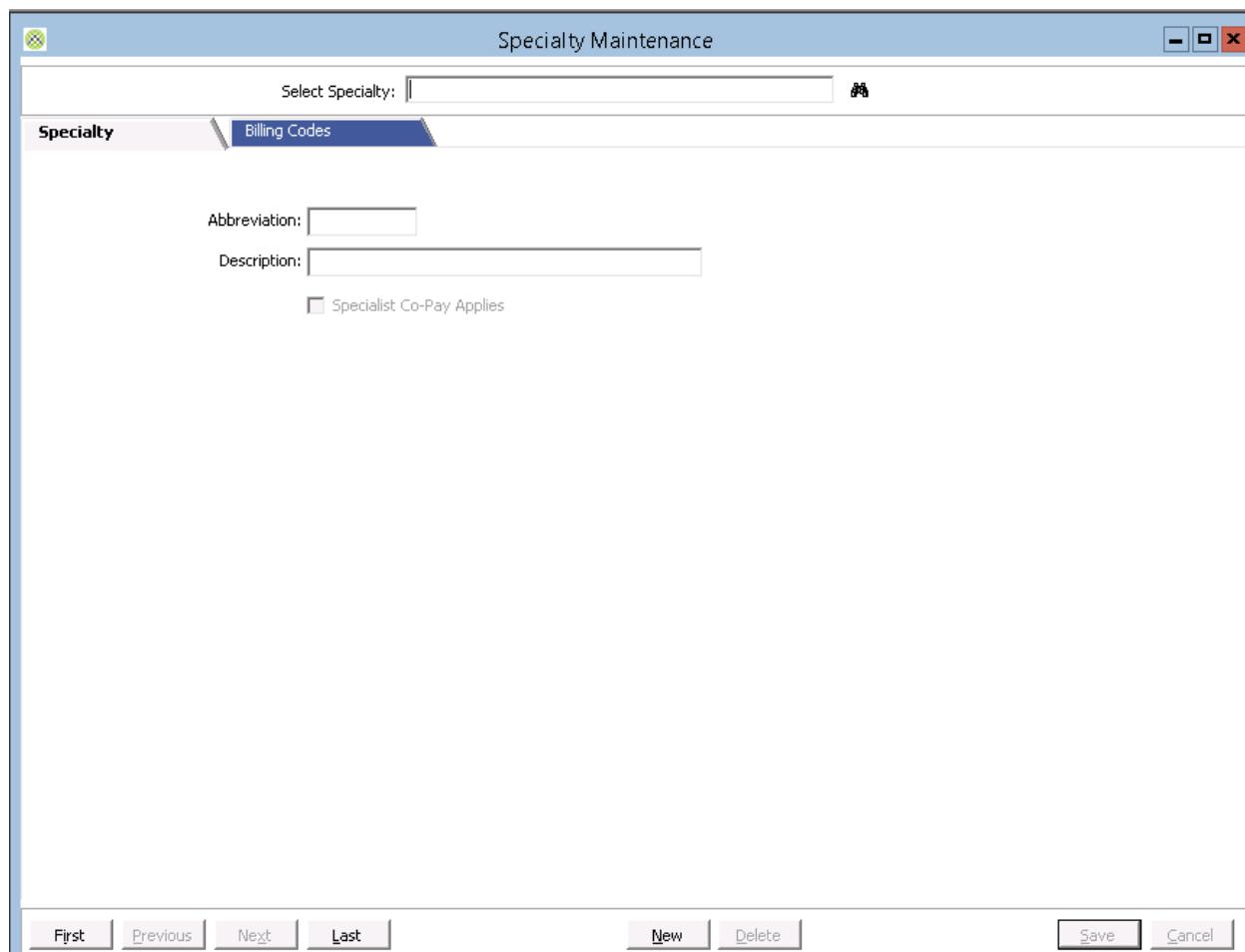
- > **Specialty**
- > **Billing Codes**

To access **Specialty Maintenance**, go to **System Administration > File Maintenance > Specialty Maintenance** or press **F9** and then enter **SPM**.

Specialty tab

Use the **Specialty** tab in **Specialty Maintenance** to define practice specialties such as cardiology or dermatology.

Access the **Specialty** tab from **Specialty Maintenance**. To access **Specialty Maintenance**, go to **System Administration > File Maintenance > Specialty Maintenance**, or press **F9** and then enter **SPM**.



Abbreviation

Enter the national specialty code. For example, enter 08 for family practice or 10 for gastroenterology.

Description

Enter a description for the specialty code. For example, enter Family Practice or Gastroenterology.

The description is displayed in **Specialty** on the **Provider** tab in **Provider Maintenance** and the **Referring Doctor** tab in **Referring Doctor Maintenance**.

The description also prints on reports and lists for providers or referring doctors.

Specialist Co-Pay Applies

Selecting this option determines the co-pay amount that applies for services rendered by a provider who is associated with a specialty flagged as **Specialist Co-Pay Applies** in **Provider Maintenance**.

Select this option when 1 or more carriers require a different co-pay amount for the specialty services.

Be sure to also do the following:

- > In **Provider Maintenance**, associate the provider with this specialty.
- > In **Insurance Carrier Maintenance**, create plans with specialty co-pays in addition to plans with primary care provider (PCP) co-pays, and so on.
- > In **Registration**, for patients whose policies require a different co-pay amount for primary and specialty visits, assign a plan for the PCP co-pay and another plan for the specialty co-pay. Also, assign a usual provider.

The co-pay amount used during charge entry is determined by whether the provider associated with the service, transaction, or appointment is associated with a specialty flagged as **Specialist Co-Pay Applies**.

Billing Codes tab in Specialty Maintenance

Use the **Billing Codes** tab in **Specialty Maintenance** to associate a billing code with each specialty profile.

Access the **Billing Codes** tab from **Specialty Maintenance**. To access **Specialty Maintenance**, go to **System Administration > File Maintenance** and select **Specialty Maintenance**, or press **F9** and then enter **SPM**.

Specialty Maintenance

Select Specialty:

Specialty **Billing Codes**

Specialty Profile	Billing Code
NYS Motor Vehicle	
Standard National Code	

First Previous Next Last New Delete Save Cancel

Billing Code

Enter the billing code for each specialty profile.

Provider Maintenance window

Provider Maintenance enables you to create records that hold the required billing information needed for submitting both electronic and paper claims for services rendered by your providers (actual physicians and mid-level practitioners). The information entered on this tab and the selections made for various options available affect billing and referral functions.

The data stored in these records is not only used for reporting billing information; it can also be included when printing documents, creating Crystal Reports, defining encounter forms, running various reports, and generating the **Provider Listing**.

Reporting a non-person in an ANSI 837 file

If you are required to report a 2 (non-person) instead of 1 (person) in the ANSI 837 claim file, use **Provider Maintenance** to create a non-person record, for example for a lab or urgent care facility.

Relationship between provider records and referring doctor records

For providers who are also designated as a referral source, you only have to enter the information once, either in **Referring Doctor Maintenance** or **Provider Maintenance**. The information entered is written to the same table in the database.

However, enter the billing numbers in the applicable file maintenance. That is, enter billing numbers that apply when a provider or referral Source is selected as the referring doctor or as an actual or billing provider on a claim.

Important: Always create the **Provider Maintenance** record first, then go to **Referring Doctor Maintenance** to enter the referring doctor billing number information.

Changes made to the record

The date, time, and user who made the most recent change to a provider record are tracked on the **Provider** tab.

Attention: Changes you make to the boxes in the **Other Address** grid are not tracked in the audit history.

Note for Practices/Organizations using Replication

In the tenant where a change originated, the user who made the change is identified by logon name on the **Provider** tab and by first and last name on the **History** tab. In the tenants receiving the change by replication, the user who made the change is identified on the **Provider** tab as **System** and as **System Account** on the **History** tab.

Provider Maintenance contains these tabs:

> **Provider**

Note: You must complete this tab first.

- > **Billing Numbers**
- > **Taxonomy Codes**
- > **The Fee Profiles**

Note: This tab is displayed only if you selected **Actual Provider** or **Billing Provider** for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

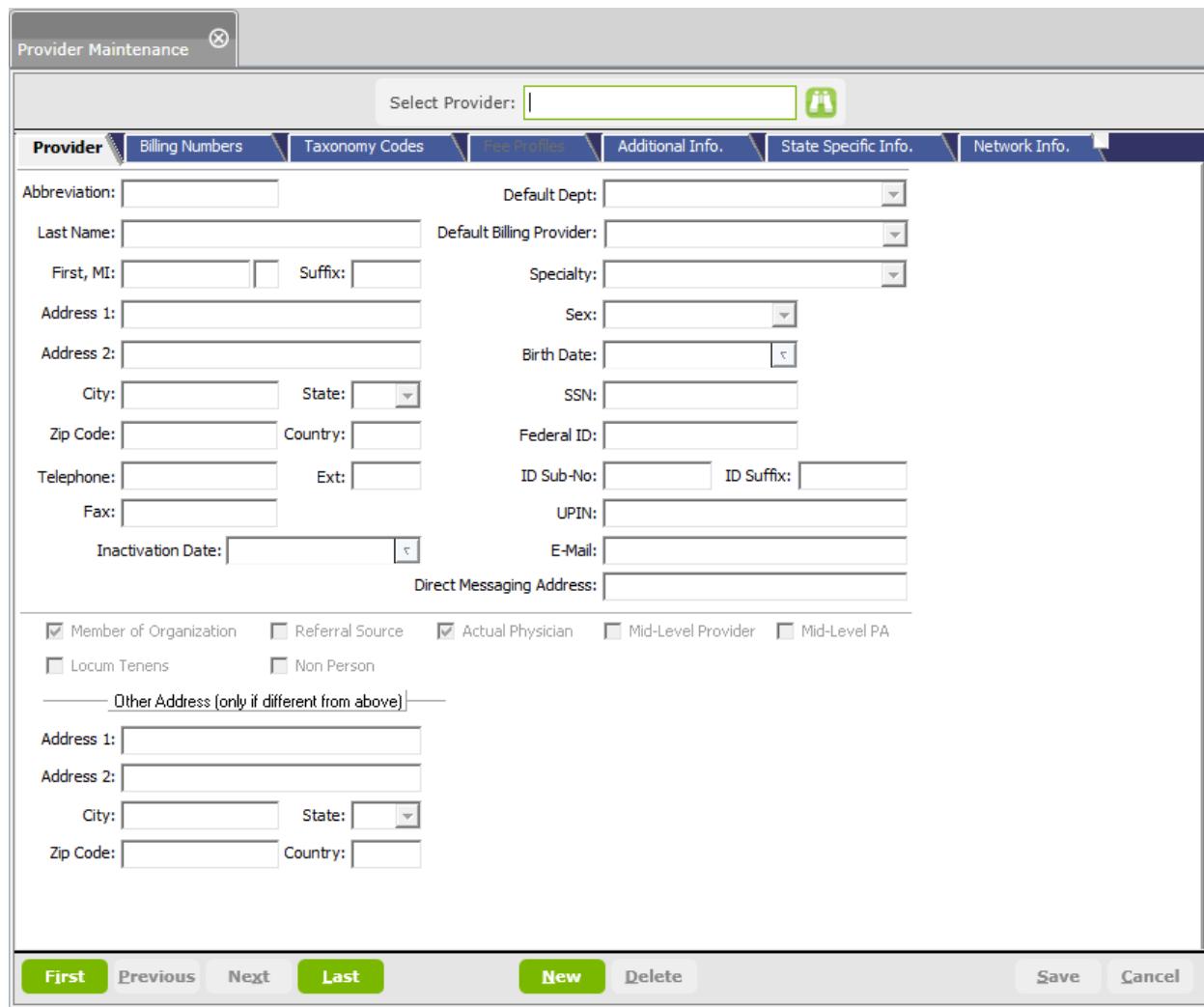
- > **Additional Info**
- > **State Specific Info**

- > Network Info
- > Locum Coverage
- > History

To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.

Provider tab

Access the **Provider** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.



The screenshot shows the 'Provider Maintenance' window with the 'Provider' tab selected. The interface is a grid of input fields and dropdown menus. At the top, there's a search bar labeled 'Select Provider:' with a magnifying glass icon. Below the search bar is a horizontal menu bar with tabs: Provider (selected), Billing Numbers, Taxonomy Codes, Fee Profiles, Additional Info., State Specific Info., and Network Info. The main area contains the following fields:

- Abbreviation:** [Text Box]
- Last Name:** [Text Box]
- First, MI:** [Text Box] [Check Box] **Suffix:** [Text Box]
- Address 1:** [Text Box]
- Address 2:** [Text Box]
- City:** [Text Box] **State:** [Text Box]
- Zip Code:** [Text Box] **Country:** [Text Box]
- Telephone:** [Text Box] **Ext:** [Text Box]
- Fax:** [Text Box]
- Inactivation Date:** [Text Box]
- Default Dept:** [Text Box]
- Default Billing Provider:** [Text Box]
- Specialty:** [Text Box]
- Sex:** [Text Box]
- Birth Date:** [Text Box]
- SSN:** [Text Box]
- Federal ID:** [Text Box]
- ID Sub-No:** [Text Box] **ID Suffix:** [Text Box]
- UPIN:** [Text Box]
- E-Mail:** [Text Box]
- Direct Messaging Address:** [Text Box]

Below the main form area, there are several checkboxes:

- Member of Organization
- Referral Source
- Actual Physician
- Mid-Level Provider
- Mid-Level PA
- Locum Tenens
- Non Person

There is also a section labeled 'Other Address (only if different from above)' with fields for Address 1, Address 2, City, State, and Zip Code.

At the bottom of the window are navigation buttons: First, Previous, Next, Last, New, Delete, Save, and Cancel.

Abbreviation

Enter an abbreviation that you have not already used for another provider record. Holds up to 8 characters.

Last Name

Enter the provider's last name the way that you want it to show on statements, documents, claim forms, and in a claim file.

Do not add professional initials.

Holds up to 30 characters.

Can be used as a pull field when creating documents or encounter forms.

Used as a pull field when you select **Usual Provider** for **Header Information** on the **Statement tab** or **Occ Medicine tab** in **Practice Options** or **Organization Options**.

First, MI

Holds up to 20 characters in **First** and 1 character **MI**.

Enter the provider's first name and middle initial as you want them to show on statements, documents, claim forms, and in a claim file

Used as a pull field when you select **Usual Provider** for **Header Information** on the **Statement tab** or **Occ Medicine tab** in **Practice Options** or **Organization Options**.

Suffix

Holds up to 8 characters

Enter the provider's professional initials.

The suffix shows in the following areas of the application:

- > All search results for provider
- > All drop-down lists with providers (**Actual Provider**, **Billing Provider**, **Usual Provider**, **PCP**, **All Providers**, **Associated Provider**, **Provider**, **Other Operating Physician/Other Physician A**, **Other Physician B**, **Operating Physician**, **Default Billing Provider**, **Default Usual Provider**)
- > All select records for providers (**Actual Provider**, **Billing Provider**, **Usual Provider**, **Prim Care Phys**, **Provider**)

Provider main address

Enter the provider address exactly the way that you want it to print on claim forms, encounter forms, documents, and so on.

Keep the following items in mind when you enter the main address:

- > The words **PO Box** cannot be in the address submitted on v5010 electronic claims or printed on CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms. If the main address contains a PO box number, enter a street address as the other address and set up **Billing Method Address** to use the other address for claims.
- > For v5010 claims, you must enter a ZIP code plus 4. If you do not know your 4-digit additional number, use <your ZIP code>-9998. For example, enter 27615-9998.
- > **Address 2** outputs to electronic claim files but does not print on paper claims.
- > The main address boxes are available as pull fields for encounter forms and some documents depending on the type of document.
- > The main address prints on statements or occupational medicine invoices when you select **Usual Provider for Header Information** on the **Statements** tab or **Occ Medicine** tab in **Practice Options** or **Organization Options**.
- > **State** is a 2-letter abbreviation. Abbreviations of the US territories are listed after the 50 states.
- > **Country** holds up to 2 characters and is optional.
- > For v5010 electronic claims, the main address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Individual Provider** or **Provider Group**, and **Billing Method Address** in **Claims Style Maintenance** is set to either **Billing Method Address** or blank.
- > For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the main address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Actual Provider** or **Billing Provider**, and **Billing Media** and **Billing Method Address** in **Claims Style Maintenance** are set to **Paper** and either **Billing Method Address** or blank respectively.

Telephone

Requires an entry of 10 digits

Enter a phone number using the format (###)###-#### or enter the numbers without spaces or dashes. When you press **Enter**, the application formats the phone number for you. This box is used as a pull field when you select **Usual Provider for Header Information** on the **Statements** tab or **Occ Medicine** tab in **Practice Options** or **Organization Options**.

Ext

Holds up to 5 characters. Enter the telephone extension, if any.

Fax

Requires an entry of 10 digits.

Enter a fax number using the format (###)###-#### or enter the numbers without spaces or dashes. When you press **Enter**, the application formats the fax number for you.

Inactivation Date

The provider's status becomes inactive when the current application date is equal to or past the date you enter in **Inactivation Date**. You can enter dates in the past, future, or the current date.

Entering a past inactivation date enables you to maintain and report on a provider's historical data and still rebill for that provider while also preventing your staff from selecting the provider with an effective inactivation date when performing tasks such as registering a patient and entering or importing charges with a service date that is equal to or later than the inactivation date.

To reactivate a provider's record, remove the inactivation date and click **Save**.

Note: This box is not included in replication.

Default Dept or Default Practice

Not a required entry.

Select a department or practice to automatically fill **Department** or **Practice** during charge entry when the provider is selected as the rendering provider.

This department is included on the **Provider Listing**.

Default Billing Provider

Select the provider to use as the default billing provider on all vouchers where the current provider is selected as the actual provider.

Note: This default value supersedes all other default values related to the billing provider including **Practice Options** or **Organization Options**, charge batch defaults, encounter defaults, and the billing provider received in a charge import file.

Note:

- > When creating a record for a mid-level provider, if there are any payers that do not credential mid-level providers, select his or her supervising physician as the default billing provider. Additional setup is required to bill mid-level providers.
- > If you are using department or practice security, be sure to select a default provider that has the same department or practice members as the provider whose record you are creating.

Specialty

Not a required selection.

Shows in **Referred To Practitioner Lookup** when you create an outgoing referral.

Because some vendors might require a specialty, select a specialty for each provider.

This specialty value is included on the **Provider Listing**.

Having a provider associated with a specialty that has **Specialist Co-Pay Applies** selected initiates actions in various functions throughout the application.

Sex

Male or **Female** are available options.

Unknown is not an available option even if **Include Unknown in Gender Values** is selected under **Entry Options** in the **Registration** tab in **Practice Options** or **Organization Options**.

Birth Date

Informational only.

SSN

Used as the pull field when the options **SSN** and **Actual Provider** or **Billing Provider** are selected for **Tax ID Source** and **Tax ID Option** for paper and electronic claim formats.

This value can be used when billing insurance claims.

Requires a 9-digit value. You can enter the 9 numbers using dashes in the applicable places or simply enter 9 numbers and let the application insert the dashes.

Federal ID

Enter the tax ID number assigned to your practice or organization or to the provider.

Used as the pull field when the options **Federal ID** and **Actual Provider** or **Billing Provider** are selected for **Tax ID Source** and **Tax ID Option** for paper and electronic claim formats.

This value can be used when billing insurance claims.

ID Sub-No

Some payers or clearinghouses require that you include a site ID along with the billing provider's information. Enter the number as it needs to be reported.

Applies when submitting electronic claims if you select **Individual Provider** for the output option **Output Site ID for ANSI 837 formats** for the claim style associated with the payer.

Used as a pull field when you select **Usual Provider** for **Header Information** on the **Statement** tab or **Occ Medicine tab** in **Practice Options** or **Organization Options**.

ID Suffix

Use for additional billing information required by a payer or clearinghouse.

Outputs to a claim file when you also select the output option **Append ID Suffix to Federal ID** for the claim style associated with the payer.

Applies to both v4010A1 and v5010 formats.

UPIN

Enter the provider's unique physician identification number (UPIN). Used as a pull field for billing purposes.

E-mail

Informational only.

Direct Messaging Address

For future use. Enter an address if your electronic health record (EHR) supports direct messaging.

Account#1 (Actual)

If you are using the General Ledger Export, enter the numeric value assigned to the segment of the GL account number used for the actual providers on claims.

Account#2 (Actual)

If you are using the General Ledger Export, enter the numeric value assigned to the segment of the GL account number used for the actual providers on claims.

Account#1 (Billing)

If you are using the General Ledger (GL) Export, enter the numeric value assigned to the segment of the GL account number used for the billing providers on claims.

Account#2 (Billing)

If you are using the General Ledger (GL) Export, enter the numeric value assigned to the segment of the GL account number used for the billing providers on claims.

Member of Organization

This option is selected by default and indicates that the provider is a member of your practice or organization.

When **Member of Organization** is selected, the provider's name is included in following selection lists:

- > **Usual Provider on Registration and Registration COMpanion**
- > **Provider and Billing Provider in Charge Entry and Charge Entry COMpanion**
- > **Provider and Billing Provider in Charge Batch Defaults** accessed from the **Batch Management** tab
- > **Associated Provider on Quick Pay Payments and Unassigned Payments**

- > **Referred To** for an incoming referral
- > **Referred From** when creating an outgoing referral
- > **Provider in Prescriptions**
- > The query option **All Providers** on the **Account Inquiry** tab in **Financial Inquiry**
- > **All Providers in Account Ledger**
- > **Default Billing Provider in Provider Maintenance**
- > **Associated Provider in Resource Maintenance**
- > **Default Provider** on the **Registration** tab in **Practice Options or Organization Options**
- > **Default Provider** and **Default Billing Provider** on the **Finance Charge** tab in **Practice Options or Organization Options**
- > On the windows associated with the selection of providers, usual providers, actual providers, and billing provider on various reports and within various functions throughout the application.

Note: If you have to clear **Member of Organization** for a provider, be sure that the provider is not selected as a default billing provider for another provider; otherwise, the changes you make cannot be saved until you clear the provider as a default billing provider. Clearing this option also removes the provider from the list of providers accessed from **Provider Maintenance**.

Referral Source

Adds the provider's name to the following lookup windows:

- > **Referred To Practitioner Lookup** accessed from **Referred To** on **Outgoing Referrals**
- > **Practitioner Lookup** accessed from **Referral From** on **Incoming Referrals**
- > **Referring Doctor Lookup** accessed from the following areas:
 - **Referring Dr** and **PCP** on the **Patient** tab in **Registration**
 - **Referring Dr** on the **Charge Entry** tab

Note: When an inactivation date is entered for a provider that has both **Member of Organization** and **Referral Source** selected, the inactivation status does not apply to the provider's status as a referral source, which means that the provider's name continues to show on all of the windows listed above.

Actual Physician

Selected by default. Select this option only if the provider is an actual physician. Clear this option if the provider is, for example, a physician's assistant, a nurse practitioner, or a certified registered nurse anesthetist (CRNA).

Related to billing functions for certain formats.

Initiates billing functions when the provider is included on a voucher where the carrier's claim style includes specific formats or has claim style options selected.

If you are billing Massachusetts Medicaid, select this box when the provider is an actual physician whose services must print to Massachusetts Medicaid Form 5 (MAMedicaid5.rpt). Clear this box when the provider is a mid-level provider (physician's assistant, nurse practitioner, CRNA, registered nurse, podiatrist, and so on) whose services must print to MA Medicaid Form 9 (MAMedicaid9.rpt).

Note: Be sure the report name and the alternate report name for the paper claim format associated with your Massachusetts Medicaid carrier are set correctly.

Clear this option if you are creating a record for a mid-level provider or non-person.

You can use provider credentialing with this option.

Mid-Level Provider

Only enabled when you clear **Actual Physician**. Select this option when you are creating a record for a nurse practitioner, nurse midwife, nurse anesthetist, clinical nurse specialist, or physician's assistant.

Initiated validation or an output action when a voucher includes this provider as the actual provider and also includes a payer whose associated claim styles contain specific validation or output options. .

You can use provider credentialing with this option.

Mid-Level PA

When creating a provider profile, you can distinguish between mid-level providers and mid-level physician assistants for billing purposes. For example, a carrier might credential nurse practitioners but not physician assistants, and this enhancement enables you to print the billing provider information if the mid-level physician assistant is not credentialed with the carrier.

Mid-Level PA is available only when **Mid-Level Provider** is selected. **Mid-Level PA** clears if you clear **Mid-Level Provider**.

Locum Tenens

Select this option for physicians who substitute for staff providers when necessary.

Note: Only select **Actual Physician** if the locum tenens provider becomes employed as a physician at your practice or organization.

When **Locum Tenens** is selected:

- > If **Actual Physician** is cleared, **Mid-Level Provider** and **Mid-Level PA** are unavailable.

- > **Mid-Level Provider**, **Mid-Level PA**, and **Non Person** are unavailable, as is the other way around.
- > The **Locum Coverage** tab is enabled.
- > You must select a value for either **Output Locum Covering For Provider with Selected Modifier** or **Output Actual Locum with Selected Modifier** on the **Output Options** tab in **Claim Style Maintenance**. You cannot select values for both options.

You cannot select **Locum Tenens** if **Supplier** is selected on the **Additional Info** tab, as is the other way around. If both options were selected prior to upgrading to version 20.0, locum tenens logic takes precedence for vouchers with that provider.

Non-Person

Select this option only when the provider record is for an entity such as a lab or an urgent care facility, and you are required to report a 2 (non-person) instead of a 1 (person) in the ANSI 837 claim file.

Note: If you think this feature would benefit your practice or organization, contact Allscripts® Support for assistance.

When selected, reports 2 (non-person) instead of 1 person) in the following loops and segments for the Entity Type Qualifier in the ANSI 837 formats:

- > Loop 2010 (Billing Provider), Segment NM102
- > Loop 2310B (Rendering Provider), Segment NM102
- > Loop 2310E (Supervising Provider), Segment NM102
- > Loop 2420A (Rendering Provider), Segment NM102
- > Loop 2420E (Ordering Provider). Segment NM102

Be sure that **Member of Organization** is selected so that this non-person provider is included in the drop-down listings on the **Charge Entry** tab.

When you select this box, clear **Actual Physician**.

Other Address (only if different from above)

Optional: The address you enter must be different from the main address at the top of the window. Use these boxes if you entered a PO Box in the main address.

Keep the following items in mind when you enter the other address:

- > You cannot partially fill the **Other Address** area. For example, if only **Address 1** is different from the main address, you must fill each required box in the **Other Address** area, not only **Address 1**. If you fill all of the boxes in the **Other Address** area, you will not get an error if optional boxes, such as **Address 2** or **Country**, are filled.
- > For v5010 electronic claims, you must enter a ZIP code plus 4. If you do not know your 4-digit additional number, use <your ZIP code>-9998. For example, enter 27615-9998.

- > For v5010 electronic claims, the other address outputs when **Billing Method** in **Electronic Claim Format Maintenance** is set to **Individual Provider** or **Provider Group**, and **Billing Method Address** in **Claims Style Maintenance** is set to **Billing Method Other Address**. Use this other address to output either billing provider information to Loop 2010AA or pay-to address information to Loop 2010AB. The information in these boxes does not output to a v4010 claim file.
- > For CMS-1500 and UB-04 paper claim forms, and any claim forms that are based on them, such as state-specific Medicaid forms, the other address (except **Address 2**) prints when **Billing Address Option** in **Paper Claim Format Maintenance** is set to **Actual Provider** or **Billing Provider**, and **Billing Media** and **Billing Method Address** in **Claims Style Maintenance** are set to **Paper** and **Billing Method Other Address** respectively.

Billing Numbers tab in Provider Maintenance

Use the **Billing Numbers** tab in **Provider Maintenance** to store the numbers that are required by your carriers when submitting claims.

The application uses the numbers on the **Billing Numbers** tab in the following instances:

- > The paper claim format billing number options are set to 1 of the actual or billing provider options for a carrier's associated paper billing number profile.
- > The electronic claim format billing method is set to **Individual Provider** or **Provider Group**, or an output option related to billing, attending, rendering, or operating provider billing numbers is selected for a carrier's associated electronic billing number profile.

Note: Billing number profiles with **Override NPI** selected on **Profiles** tab in **Practice Set Up** or **Organization Set Up** are not displayed on the **Billing Numbers** tab.

Access the **Billing Numbers** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.

Provider Maintenance

Select Provider:

Provider **Billing Numbers** Taxonomy Codes Fee Profiles Additional Info. Network Info. History

Place of Service: (default)

Billing Number Profile	Crd	Indiv. Provider Number	Group Number	Other Number(s)
National Provider Identifier	<input type="checkbox"/>			
BCBS	<input type="checkbox"/>			
Medicaid	<input type="checkbox"/>			
Medicare	<input type="checkbox"/>			
MHDO	<input type="checkbox"/>			
NYS Motor Vehicle	<input type="checkbox"/>			
PR Medicare	<input type="checkbox"/>			
Standard Tax ID Number	<input type="checkbox"/>			
Tricare	<input type="checkbox"/>			
TX ImmTrac	<input type="checkbox"/>			

First Previous Next Last New Delete Save Cancel

Place of Service

Enables you to enter billing numbers by place of service for providers assigned to more than 1 billing number who must submit information based on the place of service. The application outputs the correct billing number when preparing claims based on the place of service entered during charge entry. The application looks for numbers entered for specified places of service. If none exist, the number entered for the default place of service is reported.

Start by entering billing numbers with **Place of Service** set to **(default)**, and then click the arrow to open the listing of places of service or enter the first letter of the name of the place of service. When you select a place of service, the cells in the grid are cleared so you can enter a new set of numbers.

Enter the number or numbers required for the selected place of service.

Note: Only enter the provider NPI with **Place of Service** set to **(default)**.

Billing Number Profile

Use the **National Provider Identifier** profile to enter the 10-digit unique identifier for health care providers that are assigned by the National Plan and Provider Enumeration System (NPPES).

Enter the following:

- > The provider's 10-digit individual NPI in **Indiv Provider Number** for the **National Provider Identifier** profile located in the first row
- > Your organization's assigned 10-digit NPI in **Group Number** for the **National Provider Identifier** profile located in the first row
- > The NPI must be 10 digits long and numeric

For custom-defined profiles, enter the billing number assigned to the provider by the profile's associated carrier.

Crd

Select this option to identify providers as credentialed when the applicable setup exists in **Claim Style Maintenance** and **Insurance Carrier Maintenance**. When this setup is complete, claims for providers without **Crd** selected fail validation.

Enables you to hold a provider's vouchers when billing 1 or more specific carriers.

Enables you to use provider credentialing.

Indiv Provider Number

For paper claims, outputs the provider's individual billing number based on the billing number option selected for the format type and report name associated with a claim style.

For electronic claims, outputs the provider's individual billing number based on the billing method and claim style options for the related profiles associated with the carrier.

The related billing number options are the following:

- > ANSI formats: Individual provider number outputs to the second REF segment.
- > Standard CMS-1500 paper claims: Actual provider individual number, billing provider individual number or individual billing number option for paper claim formats. Prints in box 33.

Important: Enter each billing number exactly as the carrier requires it on paper forms or in electronic claim files.

Group Number

For paper claims, outputs the provider's group billing number based on the billing number option selected for the format type and report name associated with a claim style.

For electronic claims, outputs the provider's group billing number based on the billing method and claim style options for the related profiles associated with the carrier.

The related billing number options are the following:

- > Provider group for electronic claim formats
- > Actual provider group number, billing provider group number or group billing number option for paper claim formats

Note: Enter each billing number exactly as the carrier requires it on paper forms or in electronic claim files.

Other Number(s)

Add a provider's turnaround time (TAT) number or vendor-specific number requirements for transmitting claims, such as through iCLAIM or BCBS of Michigan or to store an additional identifier for a facility that is required by a carrier.

Taxonomy Codes tab in Provider Maintenance

Use the **Taxonomy Codes** tab in **Provider Maintenance** to enter taxonomy codes that are used when you electronically submit claims, the electronic claim format billing method is set to **Individual Provider** or **Provider Group**, and an output option related to outputting the rendering, billing, or performing provider's taxonomy code is selected for the claim style associated with the carrier. The actual number reported is for the profile that matches the taxonomy code profile selected for the carrier in **Insurance Carrier Maintenance**.

Access the **Taxonomy Codes** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.

Provider Maintenance

Select Provider:

Provider Billing Numbers **Taxonomy Codes** Fee Profiles Additional Info. Network Info. History

Place of Service: (default)

Taxonomy Code Profile	Taxonomy Code	Group Taxonomy Code
National Provider Identifier		
BCBS		
Medicaid		
Medicare		
MHDO		
NYS Motor Vehicle		
RR Medicare		
Standard Tax ID Number		
Standard UPIN		
Tricare		
TX ImmTrac		

First Previous Next Last New Delete Save Cancel

Place of Service

Enables you to enter billing numbers by place of service for providers who have been assigned more than 1 taxonomy code and must submit this information based on the place where they render the service. The correct code outputs when you prepare claims based on the place of service entered on the voucher. The application obtains numbers entered for the voucher's place of service from **Provider Maintenance**. If none exists, the number entered for **(default)** is reported using the profile associated with the carrier.

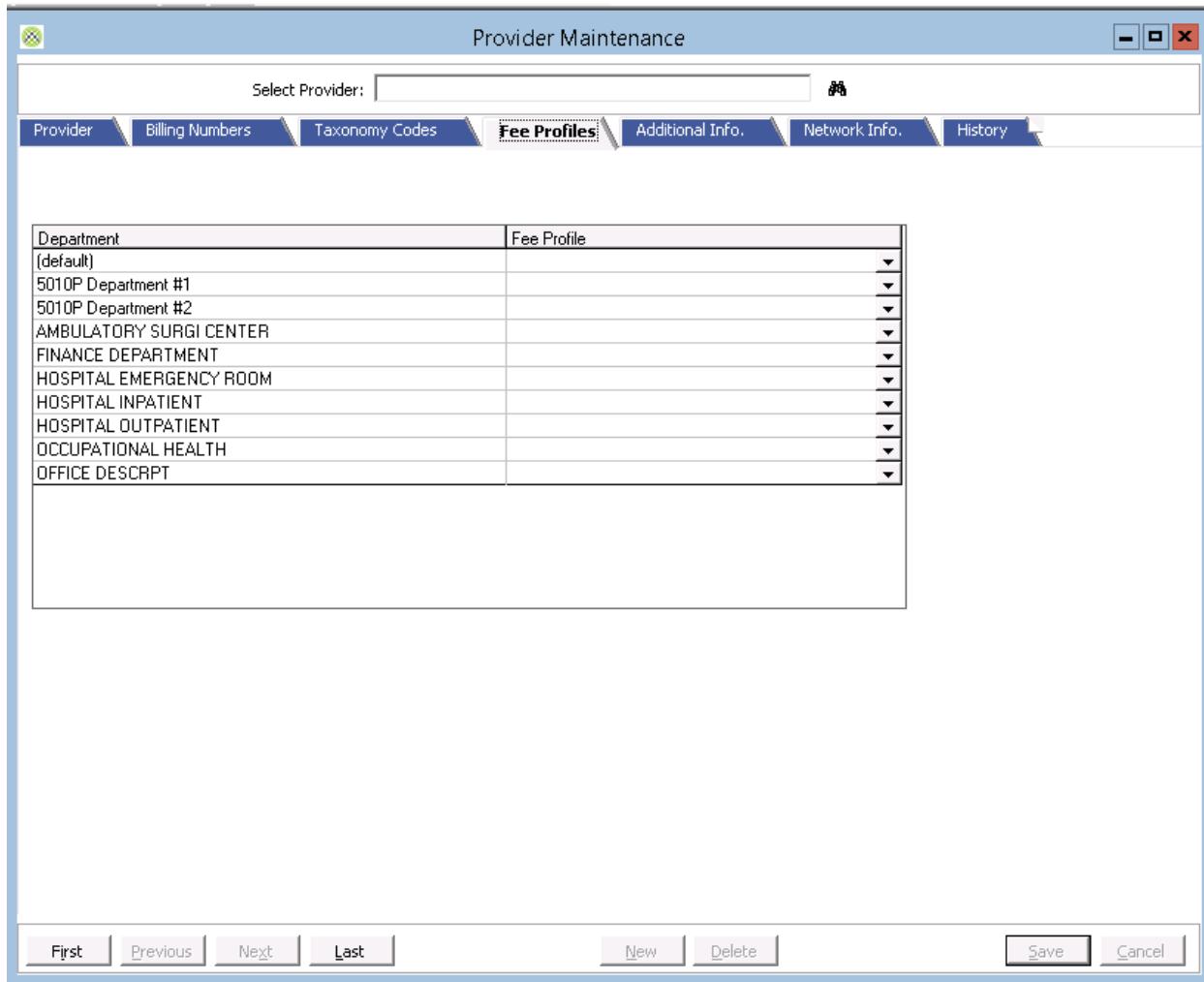
Fee Profiles tab

When **Actual Provider** or **Billing Provider** is your procedure fee basis, the fee profile you select for a department or practice on this tab determines which charge is given to a procedure code on

a voucher when the voucher's provider and department or practice match your selections. The actual charge is obtained from the profile in **Procedure Code Maintenance**.

Note: This tab is only enabled if you selected **Actual Provider** or **Billing Provider** for **Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

Access the **Fee Profiles** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.



The screenshot shows the 'Provider Maintenance' application window. At the top, there is a title bar with the window title and standard minimize, maximize, and close buttons. Below the title bar is a toolbar with several tabs: 'Provider', 'Billing Numbers', 'Taxonomy Codes', 'Fee Profiles' (which is highlighted in blue), 'Additional Info.', 'Network Info.', and 'History'. A 'Select Provider:' dropdown menu is located above the tabs. The main area contains a table with two columns: 'Department' and 'Fee Profile'. The 'Fee Profile' column contains dropdown arrows. Below the table is a large empty rectangular area. At the bottom of the window are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Department	Fee Profile
(default)	
5010P Department #1	
5010P Department #2	
AMBULATORY SURGI CENTER	
FINANCE DEPARTMENT	
HOSPITAL EMERGENCY ROOM	
HOSPITAL INPATIENT	
HOSPITAL OUTPATIENT	
OCCUPATIONAL HEALTH	
OFFICE DESCRIPT	

Additional Info tab in Provider Maintenance

The **Additional Info** tab in Provider Maintenance enables you to store information related to the provider that can be used when billing claims.

Entries on this tab initiate specific billing functions and actions based on the format type and report name associated with the claim style used to bill a carrier.

For example, selecting **Supplier** for a provider that is not an actual physician instructs the application to suppress that provider's billing information on claims. **Supplier** is located near the bottom of the list of options on this tab.

Access the **Additional Info** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.

Provider Maintenance ×

Select Provider: 

Provider V Billing Numbers V Taxonomy Codes V Fee Profiles V Additional Info V State Specific Info. V Network Info. V

Field Name	Field Value
Practitioner Category	
Date Entered Practice	
Specialty License Number	
Dentist License Number	
Anesthesia License Number	
MRI/CT License Number	
General Ledger Number	
County Number	
DEA Number	
Labor & Industries Number	
Training License Number	
Name of Specialty Governing Board	
Certification Status	
Date Certified	
External ID	

Provider Signature: 

Add Delete

First Previous Next Last New Delete Save Cancel

Default boxes

- > **Practitioner Category**
- > **Date Entered Practice**
- > **Specialty License Number**
- > **Dentist License Number**
- > **Anesthesia License Number**
- > **MRI/CT License Number**
- > **General Ledger Number**
- > **County Number**
- > **DEA Number**
- > **Labor & Industries Number**
- > **Training License Number**

- > **Name of Specialty Governing Board**
- > **Certification Status**
- > **Date Certified**
- > **External ID**
- > **License Type**
- > **Supplier**

Note: You cannot select **Locum Tenens** on the **Provider** tab if **Supplier** is selected, as is the other way around. If both options were selected prior to upgrading to version 20.0, locum tenens logic takes precedence for vouchers with that provider.

- > **Override Billing Method**
- > **Override Rendering Provider ID**
- > **Employed by Specified Hospices**
- > **Other ID-1**
- > **Other ID-2**
- > **Other ID-3**

Each free text box holds up to 35 or 40 characters depending upon the combination of letters, numbers, and spaces you enter.

The General Ledger Number field is no longer in use.

The standard calendar icon identifies boxes that only accept a valid date.

 indicates that you must click on the icon to select that option.

Provider Signature

You can store an image of a provider's signature. Use **Add** to store a new signature image or update an existing image. Use **Delete** to remove an image.

Signature images can be any of the following formats:

- > BMP
- > JPG
- > JPEG
- > GIF

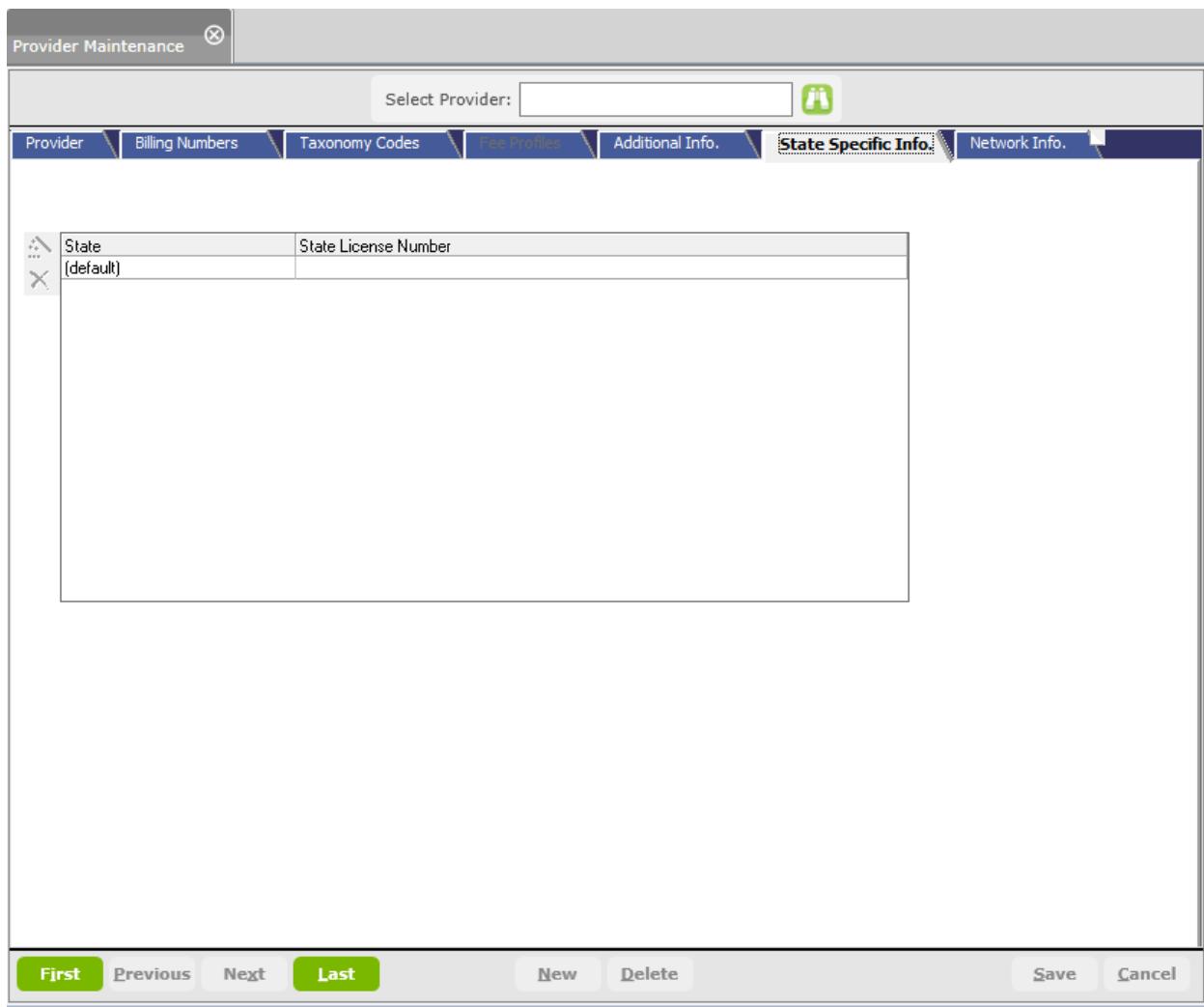
State Specific Info tab in Provider Maintenance

Use the **State Specific Info** tab in **Provider Maintenance** to store state license numbers for providers.

For providers that have **Referral Source** selected on the **Provider** tab, when you add, change, or remove a state license number, the same action is automatically applied on the **State Specific Info** tab in **Referring Doctor Maintenance**.

If you are using replication, state license numbers are replicated from the source tenant to the target tenant and cannot be edited in the target tenant.

Access the **State Specific Info** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > Provider Maintenance**, or press **F9** and then enter **PRM**.



The screenshot shows the 'Provider Maintenance' window. At the top, there is a header bar with tabs: 'Provider', 'Billing Numbers', 'Taxonomy Codes', 'Fee Profiles', 'Additional Info.', 'State Specific Info' (which is highlighted with a dotted border), and 'Network Info.'. Below the header is a search bar labeled 'Select Provider:' with a magnifying glass icon. The main content area contains a table with two columns: 'State' and 'State License Number'. A single row is visible, showing 'State (default)' and an empty 'State License Number' field. On the left side of the table, there are icons for adding a new entry ('+') and deleting an entry ('X'). At the bottom of the window, there are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save' (in green), and 'Cancel'.

State

The **(default)** row cannot be removed.

For providers with more than one state license, click  to create a new row, and then select a state or U.S. territory.

State License Number

For providers with one state license only, enter the license number in the **(default)** row.

For providers with more than one state license, enter a license number for each state or U.S. territory.

Best Practice: Enter a value for **(default)** to ensure that claims are not created without a state license number.

Network Info tab in Provider Maintenance

Many healthcare insurers may require that a provider and a referred-to provider be a member of their network. Use the **Network Info** tab in **Provider Maintenance** to store the provider's status within insurance networks.

Many Healthcare Insurers extend different types of products to their members. For instance, Blue Cross Blue Shield may offer HMO Blue, Blue Care Elect, Blue Choice.

Each of these products may require that a provider and a referred-to-provider be a member of their network. Full coverage for services rendered may depend upon your selecting providers and referred-to doctors within a carrier's network.

Identifying a provider as either out-of-network or as preferred-for-referrals qualifies the provider as a referred-to practitioner on the **Outgoing Referrals**. A search can be limited to only those providers designated as in network.

Note: Insurance network records are built in **Insurance Network Maintenance**.

Access the **Network Info** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.

Provider Maintenance X

Select Provider: 

Provider | Billing Numbers | Taxonomy Codes | Fee Profiles | Additional Info. | State Specific Info. | **Network Info.** 

Insurance Network	Field Name	Field Value
Healthcare - Arizona	Network Status	<input type="button" value="▼"/>
	Preferred for Referrals	<input type="checkbox"/>
Healthcare - Nevada	Network Status	<input type="button" value="▼"/>
	Preferred for Referrals	<input type="checkbox"/>
Healthcare - Sierra	Network Status	<input type="button" value="▼"/>
	Preferred for Referrals	<input type="checkbox"/>

First Previous Next Last New Delete Save Cancel

Network Status

Select from:

- **In Network:** Click  to open **Manage Network Participation**, where you can define the date ranges and tiers for a benefit plan within a provider's insurance network. The **(default network tier)** benefit tier indicates that the provider will adhere to the benefit tier defined in **Insurance Network Maintenance**.
- **Out of Network:** Indicates that the provider does not belong to the carrier's network and is therefore, not preferred as a referred to provider when you create outgoing referrals.

When you query for referred-to practitioners, you can include out of network providers in your results. They however are shown with the indication that they are out of network.

Preferred for Referrals

Indicates that the provider does belong to the carrier's network and is therefore, preferred as a referred to provider when you create outgoing referrals.

Department Members or Practice Members tab in Provider Maintenance

You must select department or practice members for each record that has a members tab.

Appears only when Enable Department/Practice Security is checked on the General tab in Practice/Organization Options.

Access the **Department Members or Practice Members** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance** or press **F9** and then enter **PRM**.

Provider Maintenance

Select Provider:

Billing Numbers Taxonomy Codes Fee Profiles Additional Info. Network Info. History Department Members

Division:

Select All

Mbr	Abbreviation	Description
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First Previous Next Last New Delete Save Cancel

Division

This field is only enabled on the Department/Practice Members tab when you check Enable Divisions on the Multi Entity tab (F9 > DBA). In this case, the selection of department/practice members is done at the level of division.

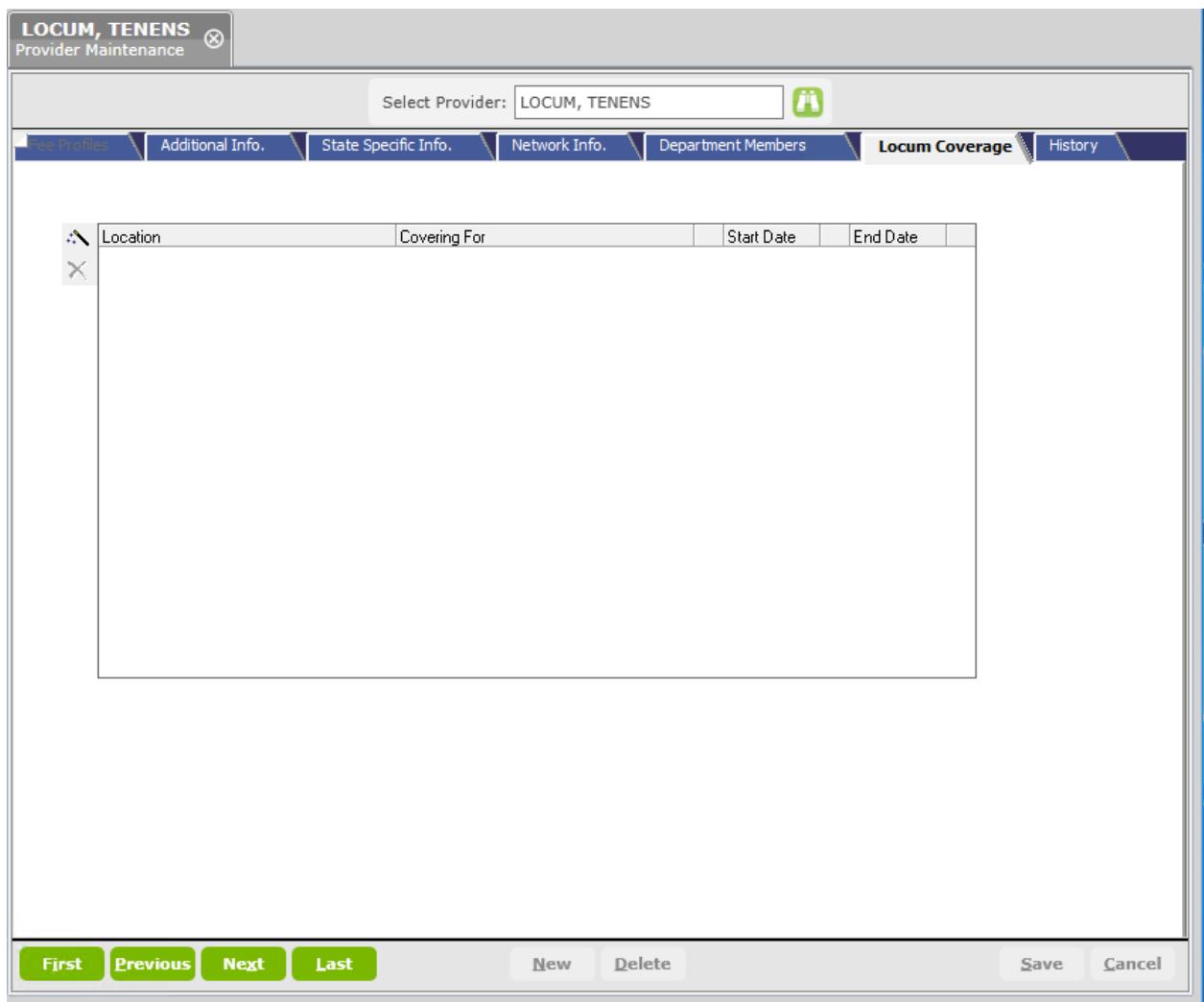
Note: Divisions are containers that provide a way to gather financial data related to Departments/Practices for reporting purposes. If you elect to enable divisions, you must create divisions in Division Maintenance. Divisions can be used as a group field, or select records option in reporting. See “Divisions in Allscripts PM” in online Help for more information.

Locum Coverage tab

Use the **Locum Coverage** tab to record the location, provider, and date range for locum tenens coverage.

Access the **Locum Coverage** tab from **Provider Maintenance**. To access **Provider Maintenance**, go to **System Administration > File Maintenance > Provider Maintenance**, or press **F9** and then enter **PRM**.

You must select **Locum Tenens** on the **Provider** tab in **Provider Maintenance** to enable the **Locum Coverage** tab.



The screenshot shows the 'LOCUM, TENENS' tab within the 'Provider Maintenance' module. The top navigation bar includes tabs for 'Free Profiles', 'Additional Info.', 'State Specific Info.', 'Network Info.', 'Department Members', 'Locum Coverage' (which is currently selected), and 'History'. Below the tabs is a search bar with the placeholder 'Select Provider: LOCUM, TENENS'. The main area features a grid with four columns: 'Location', 'Covering For', 'Start Date', and 'End Date'. At the bottom of the grid are buttons for navigating through records ('First', 'Previous', 'Next', 'Last') and performing actions ('New', 'Delete', 'Save', 'Cancel').

Locum coverage grid

The grid contains the following columns:

> **Location:** Select the coverage location for the locum tenens provider. The list of locations is obtained from **Location Maintenance**.

> **Covering For:** Click  to search for the provider to which the locum tenens coverage applies. The list of providers is obtained from **Provider Maintenance**.

Note: A locum tenens provider cannot cover for another locum tenens provider, a mid-level provider, a mid-level physician's assistant (PA), a non-person, or a provider designated as a supplier. If any one of these options is selected in **Provider Maintenance**, the provider is not displayed in the **Covering For** list.

> **Start Date and End Date:** Click  to select the date range of the locum tenens coverage. The date range cannot span more than 60 days.

Note: You cannot enter duplicate coverage for the same location and date.

Entries in the grid are sorted from newest to oldest, and then alphabetically by location.

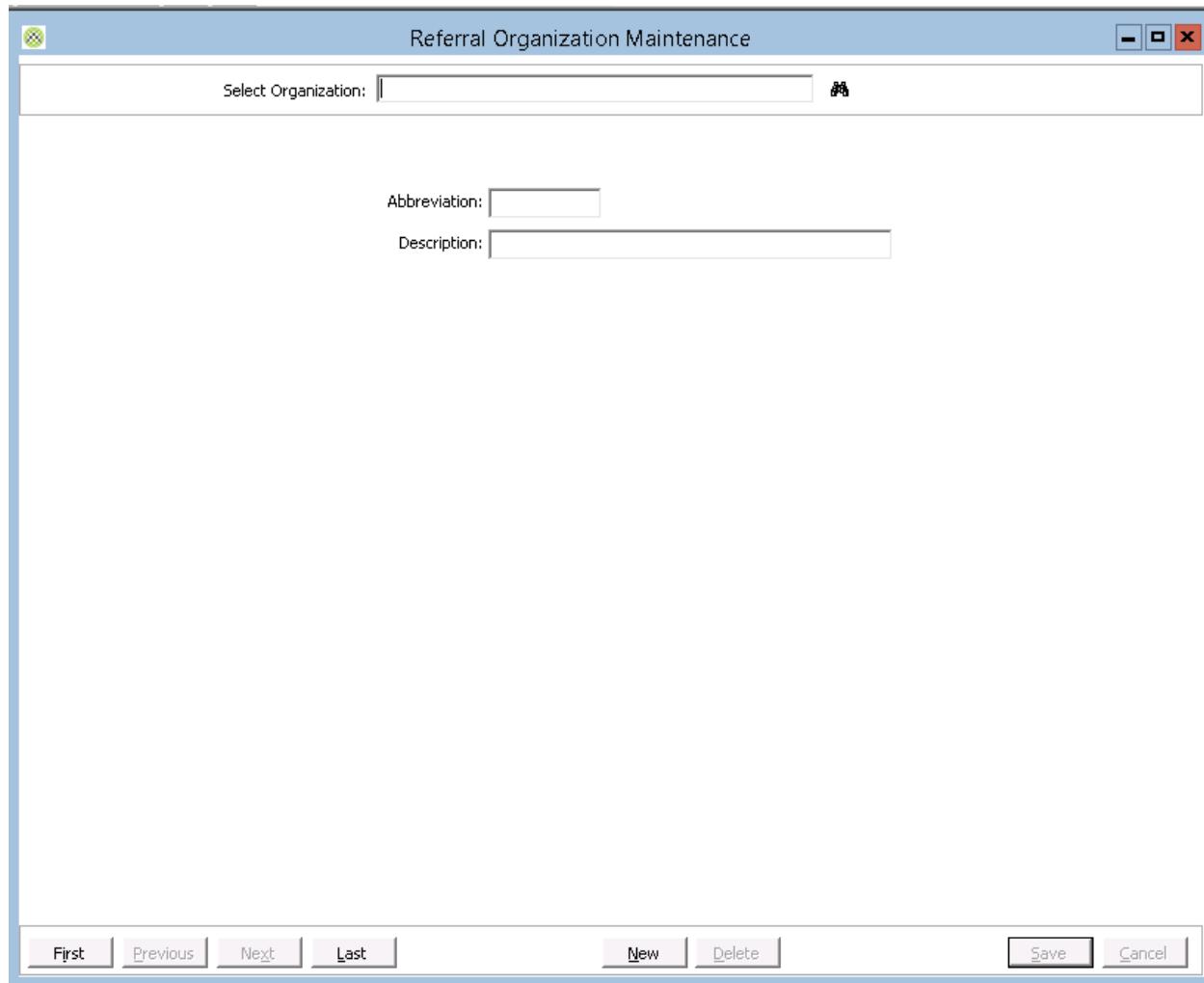
When **Actual Physician** is selected on the **Provider** tab, you cannot add new rows to the grid.

Referral Organization Maintenance window

Use **Referral Organization Maintenance** to create a record of the organizations that referred to providers are affiliated with.

A search for a referred to practitioner for outgoing referrals can be done by organization. The records you create here display in the drop down lists used when creating a referring doctor record. The abbreviation prints on reports. In addition, when creating an Outgoing Referral, you can search for a Practitioner by organization.

To access **Referral Organization Maintenance** go to **System Administration > File Maintenance > Referral Organization Maintenance** or press **F9** and then enter **ORM** or **ROM**.



Abbreviation

Holds up to 8 characters

Prints on reports and listings

Must be unique to the record

Description

Holds up to 40 characters

Referring Doctor Maintenance window

Referring Doctor Maintenance contains these tabs:

- > Referring Doctor
- > Billing Numbers
- > Taxonomy Codes
- > Additional Info
- > State Specific Info
- > Network Info
- > History

To access **Referring Doctor Maintenance**, go to **System Administration > File Maintenance > Referring Doctor Maintenance** or press **F9** and then enter **RDM**.

Referring Doctor tab

Use the **Referring Doctor** tab to create a record for each referring doctor.

A referring doctor already exists for those providers designated as both a member of your organization and a referral source in **Provider Maintenance**. When a record was previously created in **Provider Maintenance** which you checked Referral Source, load that record on the screen in RDM rather than create a new record. The fields you filled in on the Provider record in Provider maintenance auto fill with the values you entered in PRM.

Access the **Referring Doctor** tab from **Referring Doctor Maintenance**. To access **Referring Doctor Maintenance**, go to **System Administration > File Maintenance > Referring Doctor Maintenance** or press **F9** and then enter **RDM**.

Chapter 8 Charge Entry File Maintenance

Referring Doctor Maintenance

Select Referring Doctor:							
Referring Doctor	Billing Numbers	Taxonomy Codes	Additional Info	State Specific Info.	Network Info.	History	
Abbreviation: <input type="text"/>	Referral Organization: <input type="text"/>						
Last Name: <input type="text"/>	Specialty: <input type="text"/>						
First, MI: <input type="text"/> <input type="checkbox"/> Suffix: <input type="text"/>	Sex: <input type="text"/>						
Address 1: <input type="text"/>	Birth Date: <input type="text"/>						
Address 2: <input type="text"/>	SSN: <input type="text"/>						
City: <input type="text"/> State: <input type="text"/>	Federal ID: <input type="text"/>						
Zip Code: <input type="text"/> Country: <input type="text"/>	ID Sub-No: <input type="text"/> ID Suffix: <input type="text"/>						
Telephone: <input type="text"/> Ext: <input type="text"/>	UPIN: <input type="text"/>						
Fax: <input type="text"/>	E-Mail: <input type="text"/>						
Direct Messaging Address: <input type="text"/>							
<input type="checkbox"/> Member of Organization <input checked="" type="checkbox"/> Referral Source <input checked="" type="checkbox"/> Actual Physician <input type="checkbox"/> Non Person							
First	Previous	Next	Last	New	Delete	Save	Cancel

Abbreviation

Holds up to 8 characters

Must be unique to this record

Auto-fills

Last Name

Enter the Referring Doctor's last name as you want it to appear on documents, claim forms and in a claim file.

Enter professional initials in Suffix.

Used as a pull field for various Documents.

First, MI

Enter the Provider's first name and middle initial as you want them to appear on Statements, documents, claim forms and in a claim file.

First, MI: Henry

Used as a pull field for various Documents.

Suffix

Enter the referring doctor's professional initials, up to 8 characters.

This suffix is displayed with the referring provider's first name, last name, and middle initial in the following areas:

- > all search lookup results for referring doctor
- > all drop-down lists for referring doctors (referred from, referred to)
- > all select records for referring doctors (referring doctors, referred-from providers, referred-to providers)

Address Fields

Fill in each address field as you want them to appear on documents

Used as pull fields for various Documents.

Telephone

Enter a phone number using the format (###)###-####.

Type in 10 digits without spaces and **Enter**

Used a pull field for various documents.

Ext

Allows up to 5 digits

Used as a pull field for various documents.

Fax

Enter a phone number using the format (###)###-####.

Type in 10 digits without spaces and **Enter**

Used as a pull field for various documents.

Referral Organization

Associating a referring doctor with an organization allows you to search for a referred to practitioner by organization..

Click to view the pick list of Referral Organizations created in Referral Organization Maintenance.

Note: With the cursor positioned in the field enter the first letter of the organization's name.

Specialty

Because some vendors may require a specialty code, select a specialty for each referring doctor.

Sex

Male or **Female** are available options.

Unknown is not an available option even if **Include Unknown in Gender Values** is selected under **Entry Options** in the **Registration** tab in **Practice Options** or **Organization Options**.

SSN

Informational only.

Federal ID

Informational only.

ID Sub-No

Some payers/clearinghouses require that you include a Site ID along with the Referring Doctor's billing information.

Use these fields to enter the Site ID as a 4 digit zero filled value (0001, 0002, etc.)

Note: Outputs to a claim file when you also select Individual Provider for the option Output Site ID for ANSI 837 formats the claim style associated with the Payer.

ID Suffix

Use for additional billing information required by a payer/clearing house.

Enter additional tax ID information when required by your local area.

UPIN

Used as a pull field for billing purposes.

E-Mail

Informational only.

Direct Messaging Address

For future use. Enter an address if your electronic health record (EHR) supports direct messaging.

Member of Organization

Designates the Referring Doctor as a member of your Practice/Organization.

Note: This box should only be checked in Provider maintenance which causes it to be auto checked when you open the record in Referring Doctor maintenance.

The Referring Doctor's name is also included in the following selection lists:

- > Provider and Billing provider in Charge Entry
- > Referred To lists for an Incoming Referral
- > Referred From list when creating an outgoing referral
- > Usual Provider lists in Registration

Referral Source

By design this option is auto checked. Do not clear this option.

Referring doctor's name is include:

- > on a list of referring practitioners when you conduct a referring doctor search.
- > in a list of referral from practitioner when an outgoing or an incoming referral is created.
- > in the Referring Doctor Lookup on the Patient tab in Registration and in Charge Entry

Actual Physician

Informational only.

Check this option when the Referring Doctor is an actual physician.

Do not check when the Referring Doctor is for example a physician's assistant, a nurse practitioner, a CRNA, a Registered Nurse.

Non-Person

Check this option only when the Provider record is for an entity such as a Lab or an Urgent Care Facility and you are required to report a "2" (non-person) instead of "1" (person) in the ANSI 837claim file.

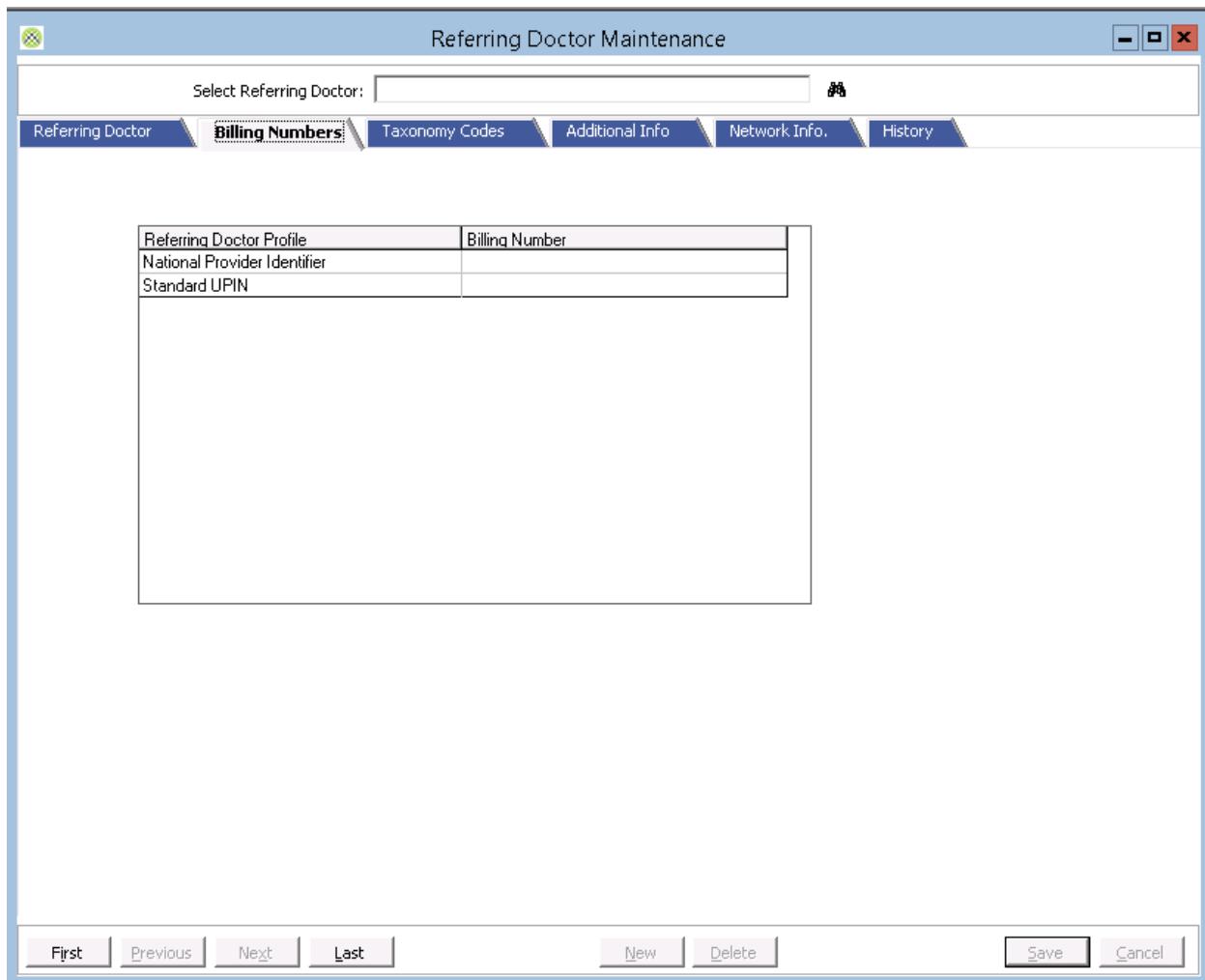
When checked reports "2" (non-person) instead of "1" (person) to Loop 2310A NM1 for the Entity Type Qualifier in the ANSI 837 formats.

Note: To display this Non-Person Referring Doctor in the drop down listings in Charge Entry for Provider and Billing Provider you must also check Member of Organization.

Billing Numbers tab in Referring Doctor Maintenance

Use the **Billing Numbers** tab in **Referring Doctor Maintenance** to enter the provider's UPIN and any other assigned billing numbers.

Access the **Billing Numbers** tab from **Referring Doctor Maintenance**. To access **Referring Doctor Maintenance**, go to **System Administration > File Maintenance > Referring Doctor Maintenance** or press **F9** and then enter **RDM**.



The screenshot shows the 'Referring Doctor Maintenance' application window. At the top, there is a search bar labeled 'Select Referring Doctor:' followed by a magnifying glass icon. Below the search bar is a navigation bar with tabs: 'Referring Doctor', 'Billing Numbers' (which is highlighted in bold), 'Taxonomy Codes', 'Additional Info', 'Network Info.', and 'History'. The main content area contains a table with two columns: 'Referring Doctor Profile' and 'Billing Number'. The first row of the table has three entries: 'National Provider Identifier', 'Standard UPIN', and an empty 'Billing Number' field. Below the table is a large empty rectangular area. At the bottom of the window, there are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save' (highlighted in blue), and 'Cancel'.

National provider identifier

Enter the provider's 10 digit individual NPI in the Billing Number column for the National Provider Identifier profile located on the first row.

Enter the referring provider's Taxonomy code only when your claims vendor or carrier requires it.

Taxonomy Codes tab in Referring Doctor Maintenance

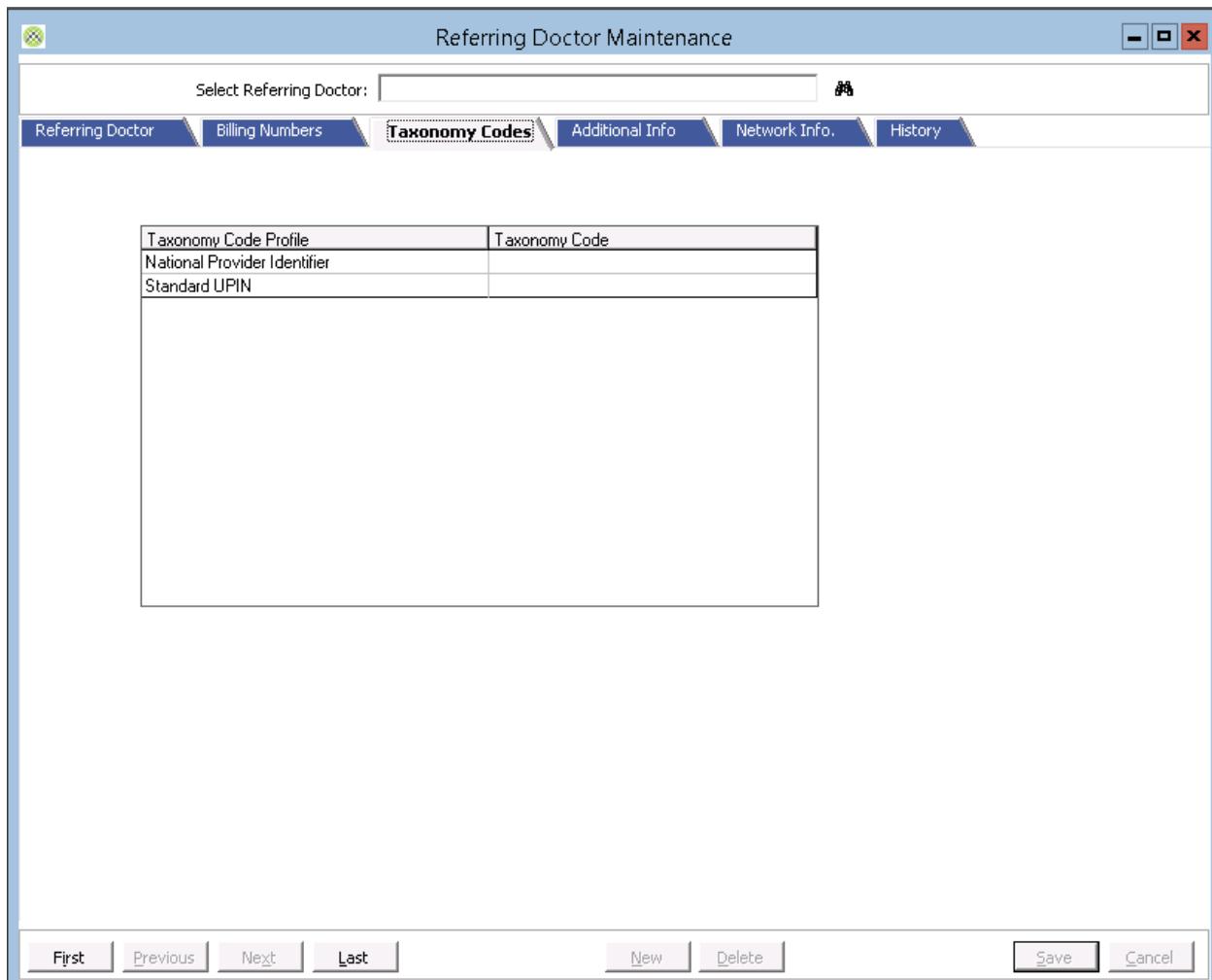
Enter the referring provider's taxonomy code only when your claims vendor or carrier requires that you report the code in an HIPAA compliant ANSI file or on a claim form.

The taxonomy codes entered on this tab are used when you submit a Professional or Dental electronic claim file and you have checked the Output Option, Output Referring Doctor Taxonomy Code on the electronic claim style selected for the Carrier.

The Referring Doctor's Taxonomy Code is printed on a Standard 1500 claim form when you select Referring Dr. Indiv. Taxonomy as the Referring Doctor Option for the paper claim format associated with the paper claim style selected for the Carrier.

The actual number reported in the electronic file or printed on a claim is the one whose profile matches the Taxonomy Code profile selected for the carrier in Insurance Carrier maintenance.

Access the **Taxonomy Codes** tab from **Referring Doctor Maintenance**. To access **Referring Doctor Maintenance**, go to **System Administration > File Maintenance > Referring Doctor Maintenance** or press **F9** and then enter **RDM**.



Additional Info tab in Referring Doctor Maintenance

Use the Additional Info tab in Referring Doctor Maintenance (F9 > RDM) to store professional and billing information not included on the Referring Doctor tab.

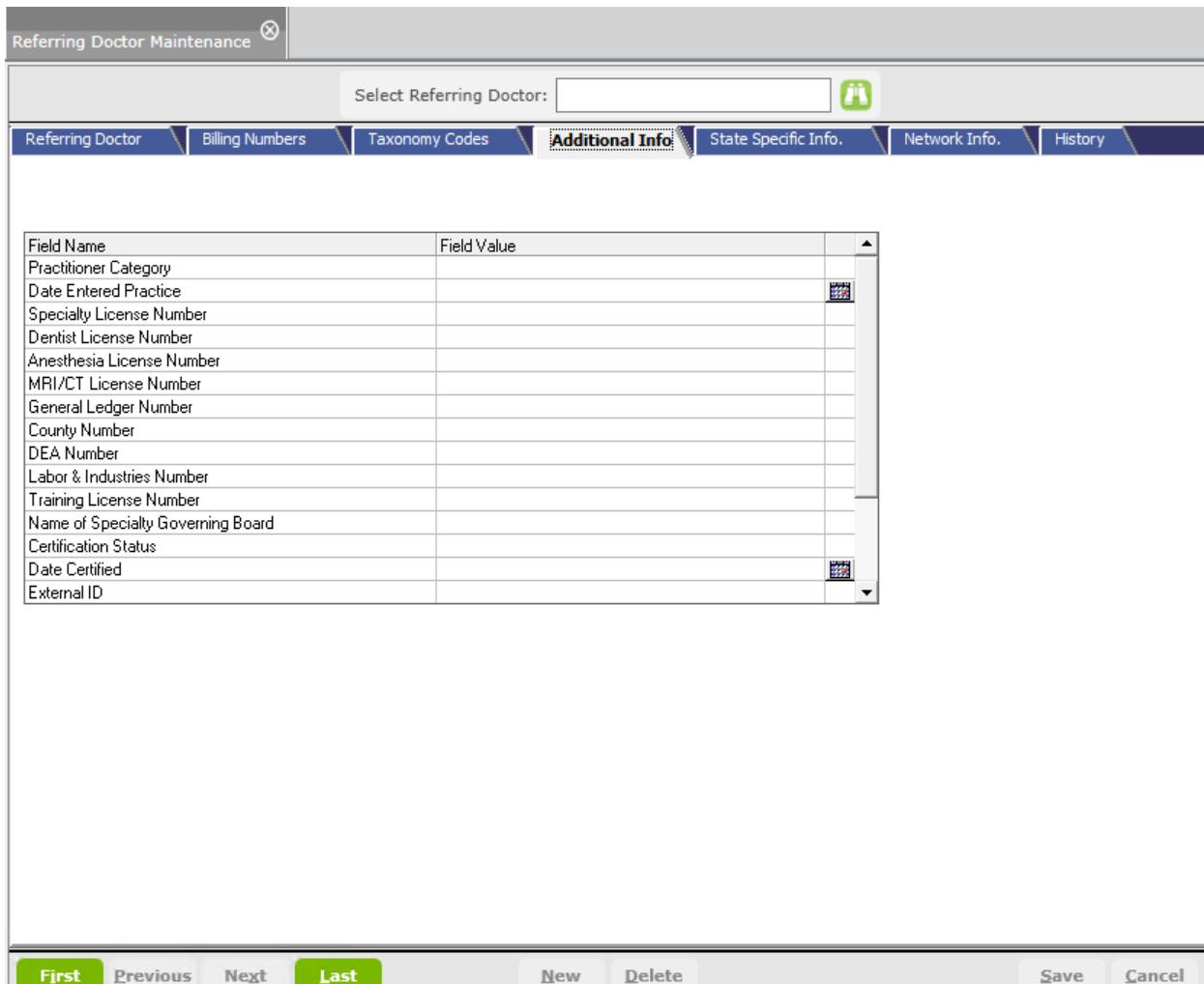
Note: When a Referring Doctor record was previously created in Provider Maintenance (PRM), and is flagged as Member of Organization, the information you entered in PRM is available here because the same record is accessed.

Entries in each field trigger specific billing functions and actions based on the format type (and the format subtype and report name for paper claims) associated with the claim style used when billing a Carrier.

Fields specifically programmed to relate to Provider billing information do not apply when the Provider is selected as the Referring Doctor on a voucher.

Note: The field, **Employed by Specified Hospice(s)** has no relevance to the Referring Doctor. It only displays here because Provider Maintenance and Referring Doctor Maintenance share the same tables. Any selections made in this field on this tab do not trigger anything in the system.

Access the **Additional Info** tab from **Referring Doctor Maintenance**. To access **Referring Doctor Maintenance**, go to **System Administration > File Maintenance > Referring Doctor Maintenance** or press **F9** and then enter **RDM**.



The screenshot shows the 'Referring Doctor Maintenance' window. At the top, there is a search bar labeled 'Select Referring Doctor:' with a magnifying glass icon. Below the search bar is a navigation bar with tabs: 'Referring Doctor', 'Billing Numbers', 'Taxonomy Codes', 'Additional Info' (which is highlighted in blue), 'State Specific Info.', 'Network Info.', and 'History'. The main area contains a table with two columns: 'Field Name' and 'Field Value'. The 'Field Name' column lists various practitioner-related fields such as Practitioner Category, Date Entered Practice, Specialty License Number, Dentist License Number, Anesthesia License Number, MRI/CT License Number, General Ledger Number, County Number, DEA Number, Labor & Industries Number, Training License Number, Name of Specialty Governing Board, Certification Status, Date Certified, and External ID. The 'Field Value' column contains empty text boxes for each corresponding field. At the bottom of the window are buttons for 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

- > Practitioner Category
- > Date Entered Practice

- > Specialty License Number
- > Dentist License Number
- > Anesthesia License Number
- > MRI/CT License Number
- > General Ledger Number
- > County Number
- > DEA Number
- > Labor & Industries Number
- > Training License Number
- > Name of Specialty Governing Board
- > Certification Status
- > Date Certified
- > External ID
- > License Type
- > Supplier
- > Override Billing Method
- > Override Rendering Provider ID
- > Employed by Specified Hospices
- > Other ID-1
- > Other ID-2
- > Other ID-3

Each free text field holds up to 35 or 40 characters depending upon the combination of letters, numbers and spaces you enter.

The standard calendar icon identifies those fields which only accept a valid date entry.

indicates that you must click on the icon to check it or select that action.

State Specific Info tab in Referring Doctor Maintenance

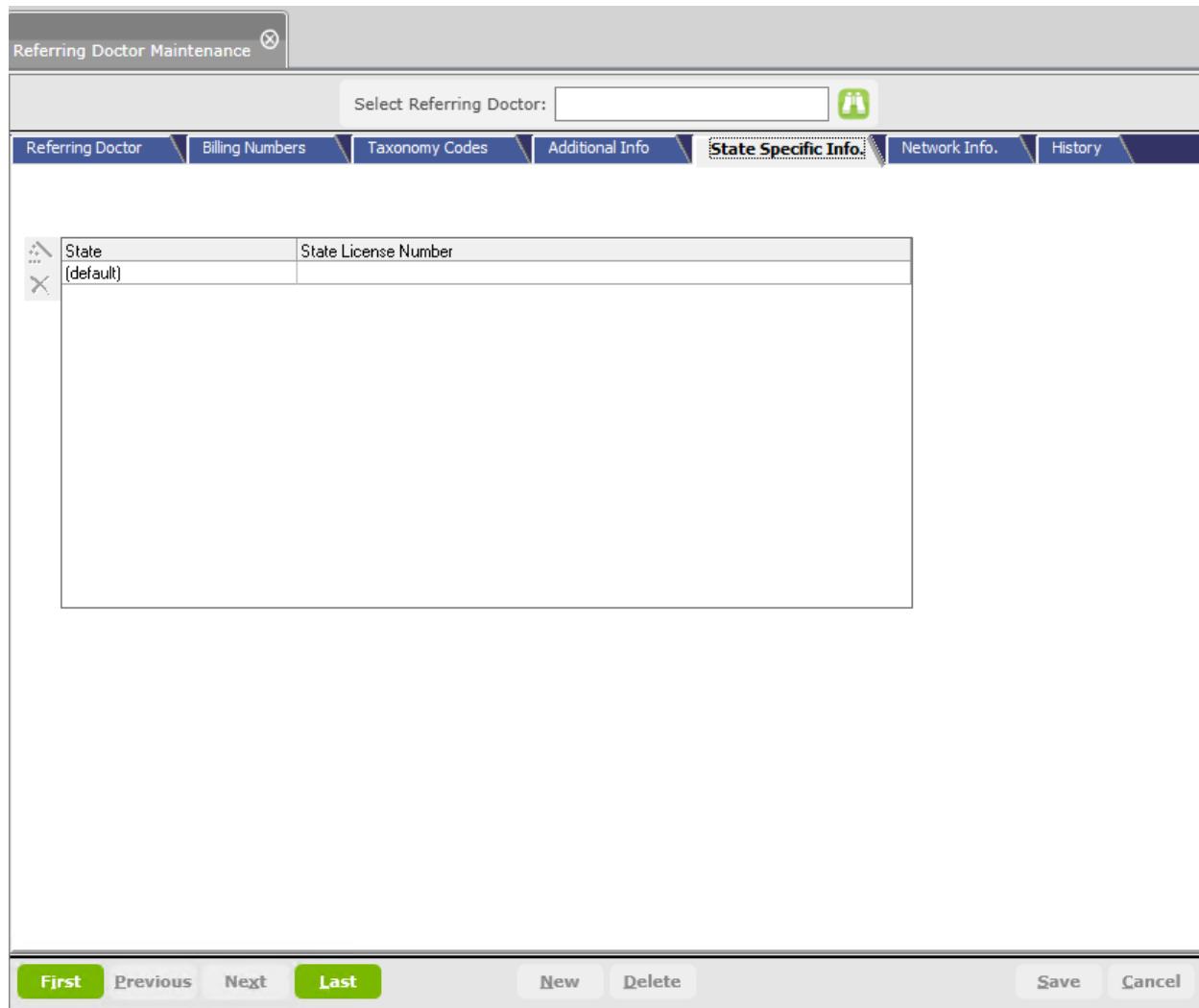
Use the **State Specific Info** tab in **Referring Doctor Maintenance** to store state license numbers for referring providers.

For referring providers that have **Referral Source** selected on the **Referring Doctor** tab, when you add, change, or remove a state license number, the same action is automatically applied on the **State Specific Info** tab in **Provider Maintenance**.

If you are using replication, state license numbers are replicated from the source tenant to the target tenant and cannot be edited in the target tenant.

The **State Specific Info** tab is included in the **Referring Doctor Information** starter data set.

Access the **State Specific Info** tab from **Referring Doctor Maintenance**. To access **Referring Doctor Maintenance**, go to **System Administration > Referring Doctor Maintenance**, or press **F9** and then enter **RDM**.



The screenshot shows the 'Referring Doctor Maintenance' window. At the top, there is a search bar labeled 'Select Referring Doctor:' with a magnifying glass icon. Below the search bar is a navigation menu with tabs: 'Referring Doctor', 'Billing Numbers', 'Taxonomy Codes', 'Additional Info', 'State Specific Info' (which is highlighted in blue), 'Network Info.', and 'History'. The main content area displays a table with one row. The table has two columns: 'State' and 'State License Number'. The 'State' column contains '(default)' with icons for edit and delete. The 'State License Number' column is empty. At the bottom of the window, there are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save' (highlighted in green), and 'Cancel'.

State

The **(default)** row cannot be removed.

For referring providers with more than one state license, click  to create a new row, and then select a state or U.S. territory.

State License Number

For referring providers with one state license only, enter the license number in the **(default)** row.

For referring providers with more than one state license, enter a license number for each state or U.S. territory.

Best Practice: Enter a value for (**default**) to ensure that claims are not created without a state license number.

Network Info tab in Referring Doctor Maintenance

Many healthcare insurers may require that a provider and a referred-to provider be a member of their network. Use the **Network Info** tab in **Referring Doctor Maintenance** to store the referring doctor's status within insurance networks.

Note: When a Referring Doctor record was previously created in **Provider Maintenance**, and is flagged as Member of Organization, the information you entered in **Provider Maintenance** is available here because the same record is accessed.

Many Healthcare Insurers extend different types of products to their members. For instance, Blue Cross Blue Shield may offer HMO Blue, Blue Care Elect, Blue Choice.

Each of these products may require that a provider and a referred-to provider be a member of their network. Full coverage for services rendered may depend upon your selecting providers and referred to doctors within a carrier's network.

Identifying a provider as either as out-of-network or as preferred-for-referrals qualifies the provider as a referred-to practitioner on the **Outgoing Referrals**. A search can be limited to only those providers designated as in network.

Note: Insurance network records are built in **Insurance Network Maintenance**.

Access the **Network Info** tab from **Referring Doctor Maintenance**. To access **Referring Doctor Maintenance**, go to **System Administration > File Maintenance > Referring Doctor Maintenance**, or press **F9** and then enter **RDM**.

Referring Doctor Maintenance X

Select Referring Doctor: <input type="text"/>																							
Referring Doctor	Billing Numbers	Taxonomy Codes																					
Additional Info	State Specific Info.	Network Info.																					
History																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Insurance Network</th> <th style="width: 20%;">Field Name</th> <th style="width: 20%;">Field Value</th> </tr> </thead> <tbody> <tr> <td>Healthcare - Arizona</td> <td>Network Status</td> <td><input type="button" value="▼"/></td> </tr> <tr> <td>Healthcare - Nevada</td> <td>Preferred for Referrals</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Healthcare - Sierra</td> <td>Network Status</td> <td><input type="button" value="▼"/></td> </tr> <tr> <td></td> <td>Preferred for Referrals</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>Network Status</td> <td><input type="button" value="▼"/></td> </tr> <tr> <td></td> <td>Preferred for Referrals</td> <td><input type="checkbox"/></td> </tr> </tbody> </table>			Insurance Network	Field Name	Field Value	Healthcare - Arizona	Network Status	<input type="button" value="▼"/>	Healthcare - Nevada	Preferred for Referrals	<input type="checkbox"/>	Healthcare - Sierra	Network Status	<input type="button" value="▼"/>		Preferred for Referrals	<input type="checkbox"/>		Network Status	<input type="button" value="▼"/>		Preferred for Referrals	<input type="checkbox"/>
Insurance Network	Field Name	Field Value																					
Healthcare - Arizona	Network Status	<input type="button" value="▼"/>																					
Healthcare - Nevada	Preferred for Referrals	<input type="checkbox"/>																					
Healthcare - Sierra	Network Status	<input type="button" value="▼"/>																					
	Preferred for Referrals	<input type="checkbox"/>																					
	Network Status	<input type="button" value="▼"/>																					
	Preferred for Referrals	<input type="checkbox"/>																					

First Previous Next Last New Delete Save Cancel

Network Status

Select from:

- > **In Network:** Click to open **Manage Network Participation**, where you can define the date ranges and tiers for a benefit plan within a provider's insurance network. The (**default network tier**) benefit tier indicates that the provider will adhere to the benefit tier defined in **Insurance Network Maintenance**.
- > **Out of Network:** Indicates that the provider does not belong to the carrier's network and is therefore, not preferred as a referred to provider when you create outgoing referrals.

When you query for referred-to practitioners, you can include out of network providers in your results. They however are shown with the indication that they are out of network.

Preferred for Referrals

Indicates that the provider does belong to the carrier's network and is therefore, preferred as a referred to provider when you create outgoing referrals.

Type of Service Maintenance window

Use **Type of Service Maintenance** to manage type of service (TOS) indicators and associated billing codes required by insurance carriers.

TOS indicators are used when generating insurance claims. On a claim form or in a claim file these codes are generally represented numerically or with a letter.

In **Insurance Carrier Maintenance**, select the appropriate type of service profile for the carrier. The application outputs the code you entered on the **Billing Codes** tab for that profile when you bill the carrier.

Type of Service Maintenance contains these tabs:

- > Type of Service
- > Billing Codes
- > History

To access **Type of Service Maintenance**, go to **System Administration > File Maintenance > Type of Service Maintenance** or press **F9** and then enter **TSM**.

Type of Service tab

Use the **Type of Service** tab to create records that correspond to the type of service (TOS) indicators required by insurance carriers.

The standard types of service recognized by most insurance carriers are:

- > Medical Care (1)
- > Surgery (2)
- > Consultation (3)
- > Technical X-ray Component
- > Diagnostic Radiology
- > Hospice (H)
- > Physical Therapy (W)

Access the **Type of Service** tab from **Type of Service Maintenance**. To access **Type of Service Maintenance**, go to **System Administration > File Maintenance > Type of Service Maintenance** or press **F9** and then enter **TSM**.

Type of Service Maintenance X

Select Type Of Service:	<input type="text"/>	
Type Of Service Billing Codes History		
<p>Abbreviation: <input type="text"/></p> <p>Description: <input type="text"/></p> <p>GL Sub-Account#1: <input type="text"/></p> <p>GL Sub-Account#2: <input type="text"/></p>		
First Previous Next Last	New Delete	Save Cancel

Abbreviation

- > Holds up to 8 characters.
- > Displays in the **TOS** column of the service line grid during charge entry, and in **Account Inquiry**.

Description

- > Holds up to 40 characters.
- > Used in **Procedure Code Maintenance** for **Default Type of Service** values and on the **Charge Entry** tab for **Type of Svc** values.

GL Sub-Account#1

Enter the numeric value assigned to this segment of the GL account number, if necessary.

GL Sub-Account#2

Enter the numeric value assigned to this segment of the GL account number, if necessary.

Billing Codes tab in Type of Service Maintenance

Use the **Billing Codes** tab to store the actual code by profile required by each of your insurance carriers.

The billing code entered for each type of service profile:

- Displays in the **TOS** column during charge entry.
- Prints in box 24C on a standard CMS-1500 claim form.
- Outputs in the TOS field in an electronic claim file.

Access the **Billing Codes** tab from **Type of Service Maintenance**. To access **Type of Service Maintenance**, go to **System Administration > File Maintenance > Type of Service Maintenance** or press **F9** and then enter **TSM**.

Type of Service Maintenance

Select Type Of Service:	
Type Of Service	Billing Codes
History	

Type Of Service Profile	Billing Code
BCBS MA Code	
Medicaid Rural Health	
Medicare Rural Health	
NC Ambulatory Surgery Data Export	
Standard CMS Code	

First Previous Next Last New Delete Save Cancel

Type Of Service Profile

Displays the profiles created on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**.

Billing Code

Enter the correct code for each profile.

Held Voucher Reason Maintenance window

Use **Held Voucher Reason Maintenance** to identify reasons why a voucher was put on hold.

A held voucher reason can be selected on the following windows and functions:

- > File Maintenance

- **Procedure Code Maintenance** when you select **Hold Electronic Claims**
- **Diagnosis Code maintenance** when you select **Hold Electronic Claims**
- **Insurance Carrier Maintenance** when you select **72 Hour Rule**

|| **Note:** In this last instance, you are required to select a reason.

- > Summary view in charge entry when you make a selection for **Hold Voucher From**
- > **Apply Transactions** window in payment entry when you select **Hold From Electronic Billing**
- > **Edits** tab when you make a selection for **Hold Voucher From**

Some examples of the types of reasons you can create are:

- > 72-hour rule - if your practice or organization enabled this function
- > Procedure code
- > Diagnosis code
- > Needs documentation
- > Provider credentialing
- > Custom code (when you create custom diagnosis or procedure codes.)

Held Voucher Reason Maintenance contains these tabs:

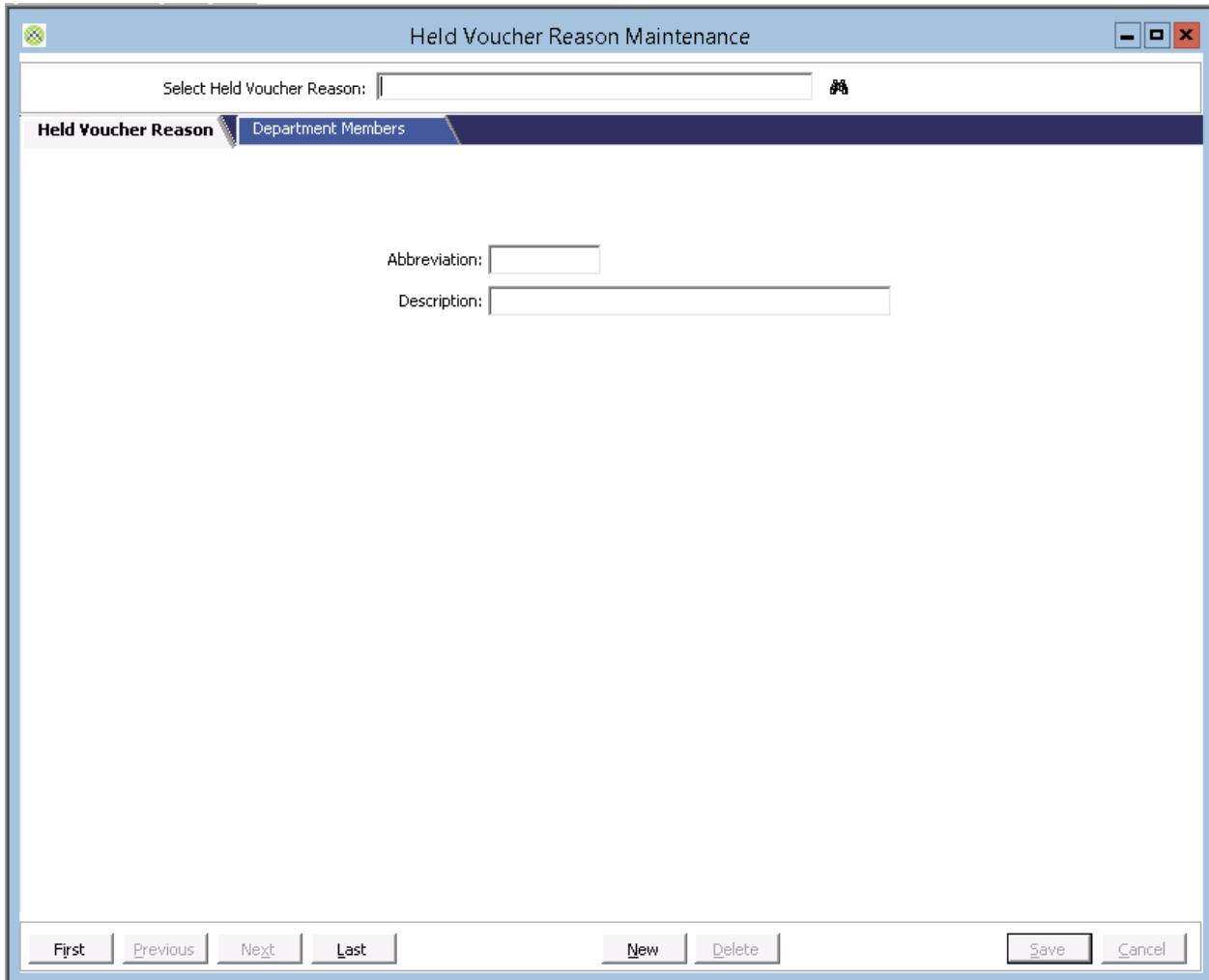
- > **Held Voucher Reason**
- > **Department Members or Practice Members**

To access **Held Voucher Reason Maintenance**, go to **System Administration > File Maintenance > Held Voucher Reason Maintenance** or press **F9** and then enter **HVM**.

Held Voucher Reason tab

Use **Held Voucher Reason** tab to create a new record identifying a reason why a voucher was put on hold.

Access the **Held Voucher Reason** tab **Held Voucher Reason Maintenance**. To access **Held Voucher Reason Maintenance**, go to **System Administration > File Maintenance > Held Voucher Reason Maintenance** or press **F9** and then enter **HVM**.



Abbreviation

- > Holds up to 8 characters.
- > Must be a unique **Held Voucher Reason Maintenance** record.
- > The abbreviation prints on the **Held Voucher List** run from **Claims Review**.

Description

- > Holds up to 40 characters.
- > This description displays in the combo box listings on the various windows where you can add a reason.

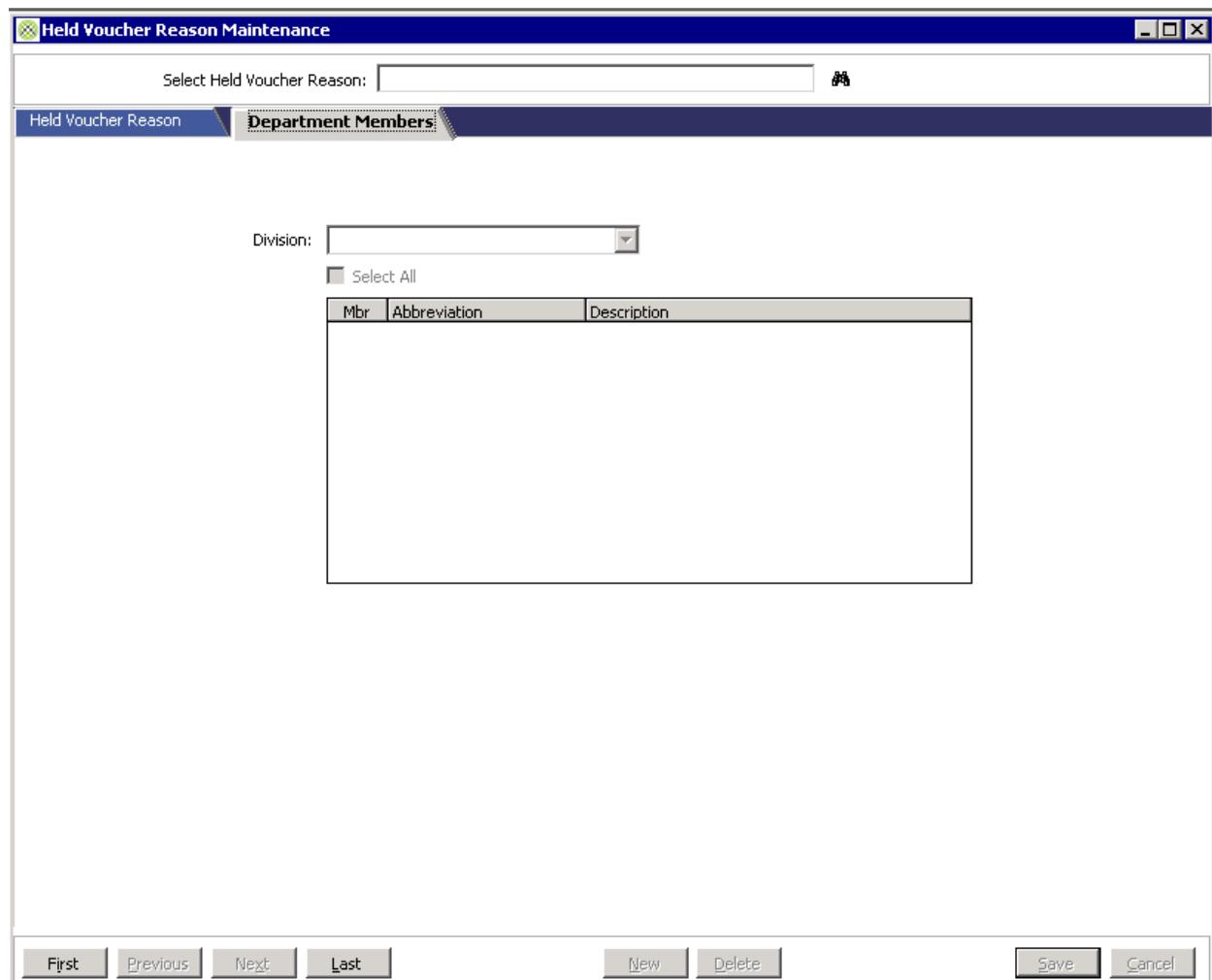
Department Members or Practice Members tab in Held Voucher Reason Maintenance

Use the **Department Members** tab or the **Practice Members** tab to define the relationship between **Held Voucher Reason Maintenance** records and departments or practices.

This tab is displayed only when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

You must select department or practice members for each record that has a members tab.

Access the **Department Members** or **Practice Members** tab **Held Voucher Reason Maintenance**. To access **Held Voucher Reason Maintenance**, go to **System Administration > File Maintenance > Held Voucher Reason Maintenance** or press **F9** and then enter **HVM**.



Division

This box is only enabled on the **Department Members** or **Practice Members** tab when you select **Enable Divisions** on the **Multi Entity** tab in **Practice Options** or **Organization Options**. In this case, the selection of a department or practice members is done at the level of division. Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you elect to enable divisions, you must create divisions in **Division Maintenance**. Divisions can be used as a group field, or select records option in reporting.

Diagnosis Category Maintenance window

Use **Diagnosis Category Maintenance** to create custom-defined groupings for your diagnosis codes that meet your reporting needs.

Sample categories

Each new client database comes with a **Diagnosis Category** called **Default**. Your practice may decide to be more specific in categorizing your use of diagnosis codes. Some examples of are:

Non-Medical

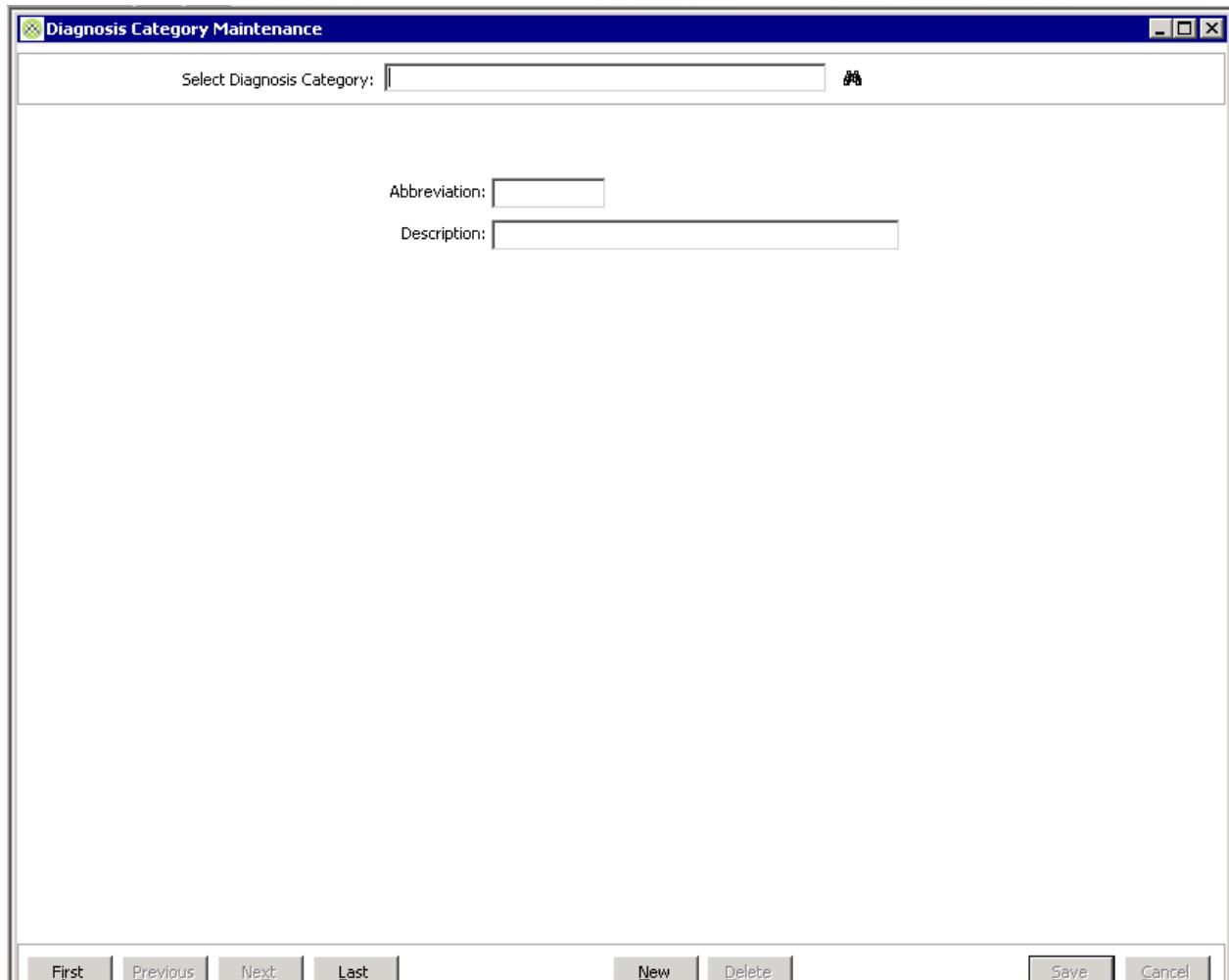
Use on vouchers created for non-medical reasons, such as transferring balances from your legacy application into Allscripts Practice Management™.

New

Use for new diagnosis codes added to table as a result of an ICD import. You can then run the **Diagnosis Code Listing** by filtering on the category **New** to quickly identify these application-created records.

Diagnosis Category is required in **Diagnosis Code Maintenance**. Various reports can be grouped by or restricted to specified diagnosis categories.

To access **Diagnosis Category Maintenance**, go to **System Administration > File Maintenance > Diagnosis Category Maintenance** or press **F9** and then enter **DYM**.



Abbreviation

- > Holds up to 8 characters.
- > Must be a unique **Diagnosis Category Maintenance** record.

Description

Holds up to 40 characters.

Diagnosis Code Maintenance window

As a general rule, Allscripts® Practice Management comes preconfigured with the most current standard diagnosis codes. However, you must enter the billing code on the **Billing Codes** tab for each profile.

Annual updates for ICD-10 codes are available on Allscripts® Central for download and import into Allscripts® Practice Management.

Importing the annual updates does not delete any of your custom-created diagnosis codes. However, during the import process if a matching code already exists in your file, then the description and related billing codes for that diagnosis code are changed.

Diagnosis Code Maintenance contains these tabs:

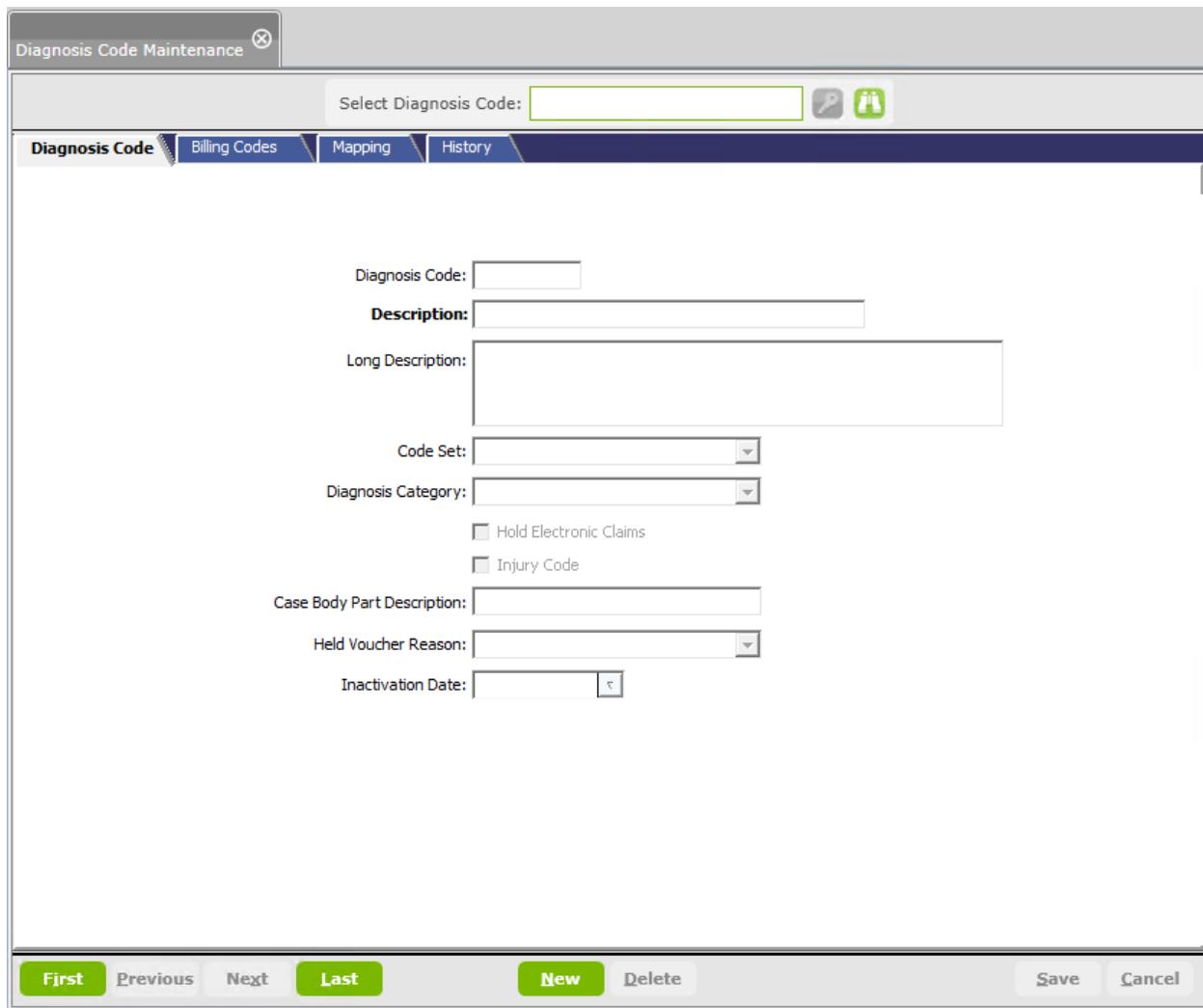
- > Diagnosis Code
- > Billing Codes
- > Mapping
- > History

To access **Diagnosis Code Maintenance**, go to **System Administration > File Maintenance > Diagnosis Code Maintenance** or press **F9** and then enter **DCM**.

Diagnosis Code tab

Use the **Diagnosis Codes** tab in **Diagnosis Code Maintenance** to define ICD codes.

Access the **Diagnosis Code** tab from **Diagnosis Code Maintenance**. To access **Diagnosis Code Maintenance**, go to **System Administration > File Maintenance > Diagnosis Code Maintenance** or press **F9** and then enter **DCM**.



Diagnosis Code

Diagnosis Code holds up to 10 characters.

Displays or prints in the following functions:

- > **Charge Entry** tab, in the service line grid; also in **Diagnosis** when more than one diagnosis is entered for the service line
- > **Financial Inquiry** views, when the view option **Include All Diagnosis** is selected
- > **Service Inquiry**, on the **Diagnosis History** tab
- > **Payment Entry** tab, when the view option **Include All Diagnosis** is selected
- > Various reports such as the **Outgoing Referral Report**
- > **Outgoing Referrals** and **Incoming Referrals** windows when multiple diagnoses are entered

Enter a valid diagnosis code (for example, 003.20, or when creating a custom-defined code such as for use when generating finance charges, enter FINCHRG).

Diagnosis Code is a searchable box when you use **Diagnosis Code Lookup**.

Description

Description holds up to 60 characters.

Displays or prints in the following functions:

- > **Charge Entry** tab, in the service line grid; also in **Diagnosis** when only one diagnosis is entered for the service line
- > **Financial Inquiry** views, when the view option **Include All Diagnosis** is selected
- > **Service Inquiry**, on the **Diagnosis History** tab
- > **Payment Entry** tab, when the view option **Include All Diagnosis** is selected
- > **Outgoing Referrals** and **Incoming Referrals** windows when only one diagnosis is entered

Description is a searchable box when you use **Diagnosis Code Lookup**.

Diagnosis codes created without a description are displayed with a blank description box in **Diagnosis Code Lookup**. The codes list first in the results grid. On the **Charge Entry** tab, the word **(blank)** displays for codes without a description.

Long Description

Long Description is a second description that holds up to 300 characters.

Code Set

- > Select whether the diagnosis code belongs to the ICD-9 or ICD-10 code set. The same diagnosis code cannot be entered twice with different code sets.
- > The code set can be changed only if the diagnosis code has never been used in another part of the application.

Note: If you attempt to change **Code Set** and are presented with the message **Code set modification you have requested could not be performed. This record is referenced by records in other files, click OK, then click Cancel** followed by **Yes** to cancel your changes.

- > If you are using replication, **Code Set** can be replicated from source tenants to target tenants.

Diagnosis Category

Diagnosis Category is required.

You can filter the **Diagnosis Code Listing** and some reports by **Diagnosis Category**.

Hold Electronic Claims

Hold Electronic Claims is optional.

Prevents vouchers that contain the diagnosis from qualifying for electronic billing

Vouchers that contain the diagnosis where this option is selected print to paper once they have passed validation.

Note: Select this box when creating a custom diagnosis code that is to be used for non-medical vouchers.

When the diagnosis code is entered on the voucher, **Hold Voucher From** on the **Summary** view on the **Charge Entry** tab defaults to **Electronic Claim Billing** unless the policy selected for the voucher is associated with a carrier flagged for the **72 Hour Rule**. In this instance, the box defaults to **All Insurance Billing**.

Note: Use the **Held Voucher Listing** to review those voucher placed on hold.

Injury Code

Injury Code is only available when **ICD-10** is selected in **Code Set** and is cleared by default.

Injury code settings are not imported with ICD-10 codes. You must manually select **Injury Code** for any imported diagnosis codes in **System Administration > Interfaces > ICD Codes and Mapping**.

If a diagnosis code is not being used in Allscripts® Practice Management and **Code Set** is changed from **ICD-10** to **ICD-9**, **Injury Code** is cleared and unavailable.

Case Body Part Description

The value entered in this box:

- > Is used to update workers' compensation cases (for future use)
- > Is replicated only on initial entry in the source tenant or when the target tenant is blank
- > Is editable in target tenants
- > Is included in the **Diagnosis Code Information** starter data set

Held Voucher Reason

Hold Voucher Reason optional and only enabled when you select **Hold Electronic Claims**.

If a reason is selected, then when the diagnosis code is entered on the voucher, **Hold Voucher Reason** in the **Summary** view on **Charge Entry** tab defaults to this reason, unless the policy selected for the voucher is associated with a carrier flagged for the **72 Hour Rule** or if a procedure code entered on the voucher has a selected held voucher reason.

In these instances, the reason selected follows the hierarchical order of defaulting to the reason selected

- > From **Insurance Carrier Maintenance**
- > From **Procedure Code Maintenance**
- > From **Diagnosis Code Maintenance**

Note: The **Held Voucher List** prints the held voucher reason selected on the voucher.

Inactivation Date

When an **Inactivation Date** is entered on a diagnosis code, the diagnosis code is no longer displayed on or after that date in searches, nor is it available for selection in **Diagnosis Code Lookup** available in **Procedure Code Maintenance**, the **Charge Entry** tab, **Incoming Referrals**, **Outgoing Referrals**, and so on.

The date of service in **Charge Entry** is compared to the **Inactivation Date** value in **Diagnosis Code Maintenance**. If you enter a date of service equal to or later than the **Inactivation Date**, the following error message displays:

Diagnosis Code XXX is no longer in use

Note: XXX is the assigned diagnosis code number.

If an inactivation date needs to be changed, inactive diagnosis codes are accessible in **Diagnosis Code Maintenance**.

Billing Codes tab in Diagnosis Code Maintenance

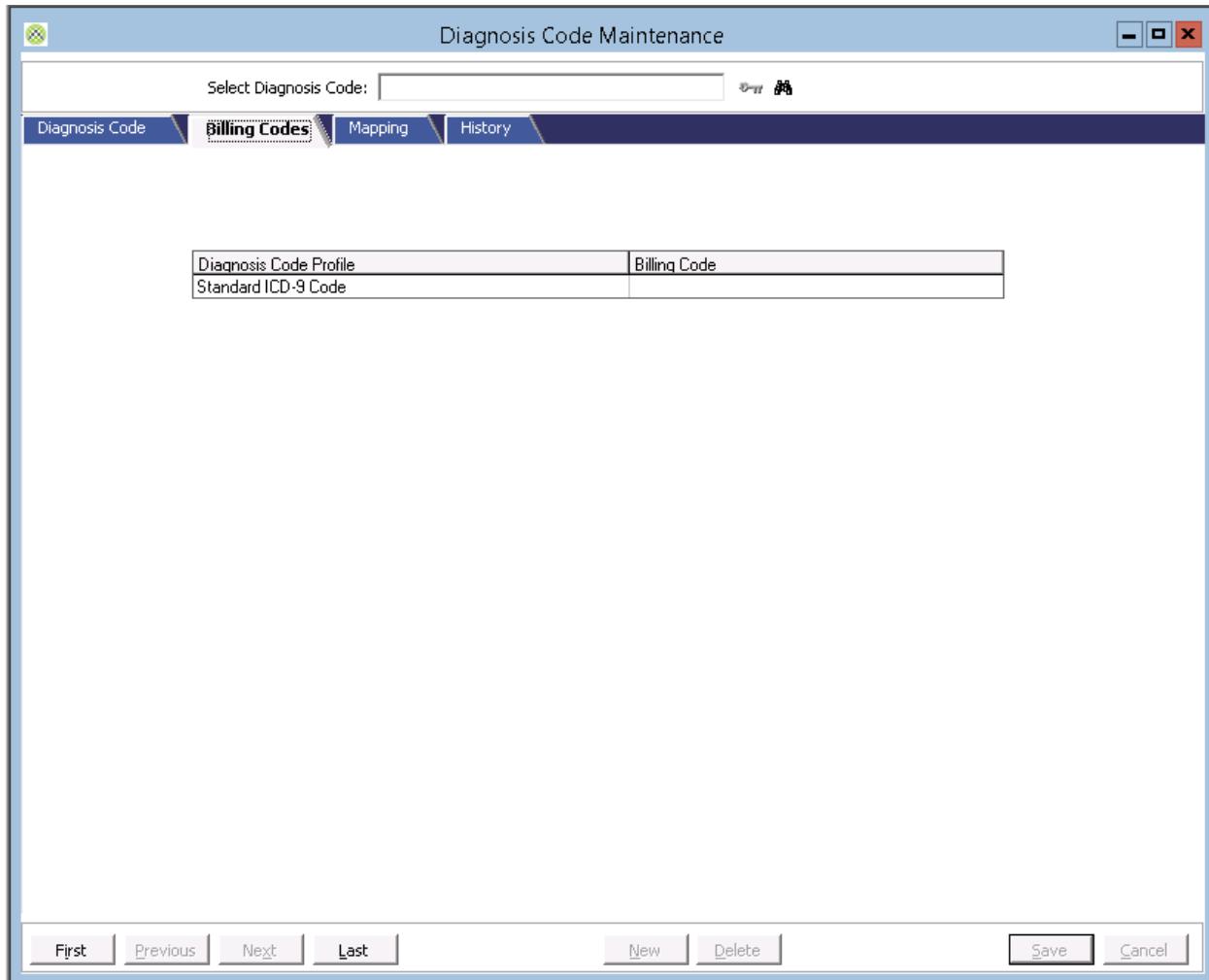
Use the **Billing Codes** tab in **Diagnosis Code Maintenance** to add the billing code, by profile, that is accepted by your carriers when you submit claims.

Important: When creating a custom diagnosis code for internal purposes, leave this tab blank.

Prints in Box 21 on a standard CMS-1500 NPI claim form.

Also prints in Box 24E on a standard CMS-1500 NPI claim form when Diagnosis Code is selected as the Diagnosis Option in Paper Claim Format Maintenance.

Access the **Billing Codes** tab from **Diagnosis Code Maintenance**. To access **Diagnosis Code Maintenance**, go to **System Administration > File Maintenance > Diagnosis Code Maintenance** or press **F9** and then enter **DCM**.



Diagnosis Code Profile

Diagnosis code profiles are created on the **Profiles** tab in **Practice Set Up or Organization Set Up**. The application uses the diagnosis code profile you select for each carrier to output billing codes in the following areas.

- In the Standard ANSI X12N 837P v4010A1 and v5010 format types - Segment HI Loop 2300
- On the Revised CMS 1500 (08/05) in box 21 and box 24E when the diagnosis code option **Diagnosis Code** is selected in **Paper Claim Format Maintenance**
- On **Statements**, when the option **Print Primary Diagnosis Code** is selected

Billing Code

Enter the code to output on claims.

Mapping tab

Use the **Mapping** tab in **Diagnosis Code Maintenance** to map an ICD-10 code to 1 or more ICD-9 codes or combinations of codes. ICD-10 to ICD-9 mapping translates an ICD-10 code to its ICD-9 equivalents.

The mapping grid has 10 columns with mapping information relative to the ICD-10 code being added or updated in **Diagnosis Code Maintenance**:

- Columns 1 through 6 (labeled **ICD9-1** through **ICD9-6**) contain ICD-9 codes.
- Columns 7 through 9 (labeled **Reimbursement Mapping**, **GEM**, and **Manual**) indicate the source of the mapping.
- Column 10 (labeled **Default**) designates whether the mapping is tagged to be used as the default during charge entry.

There is no limit to the number of rows you can enter in the mapping grid, but each row must be unique. Two rows containing the same ICD-9 codes in a different order are considered unique. For example, a row with **585.2** in **ICD9-1** and **585.9** in **ICD9-2** is different from a row with **585.9** in **ICD9-1** and **585.2** in **ICD9-2**.

After an ICD-9 code is used on the **Mapping** tab, it cannot be inactivated on the **Diagnosis Code** tab.

Note: If you enter a date in **Inactivation Date** on the **Diagnosis Code**

tab for a mapped ICD-9 code, you are presented with a message

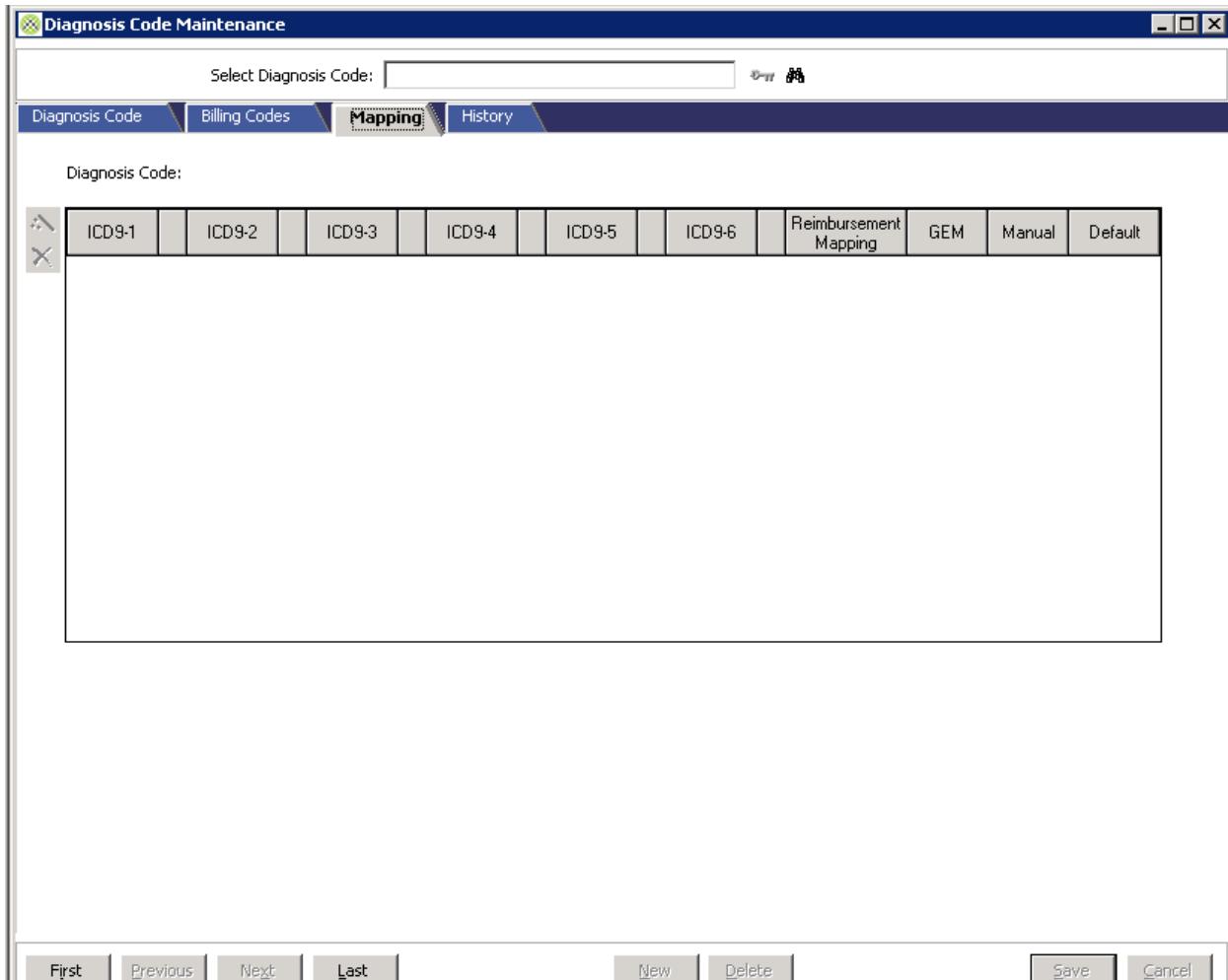
Diagnosis code ##.# cannot be inactivated because it
is mapped to the following code(s) : and the ICD-10 codes
that have the ICD-9 code as a mapped code are listed.

If you are using replication, the **Mapping** tab can be replicated from source to target tenants. You must create and maintain mappings in the source tenant; however, the **Default** option can be changed in target tenants.

Figure 1: Mapping grid example

ICD9-1		ICD9-2		ICD9-3		ICD9-4		ICD9-5		ICD9-6		Source Reimbursement Mapping	GEM	Manual	Default
966.2	☒	E855.8	☒		☒		☒		☒		☒	✓	✓		✓
966	☒	E855.8	☒		☒		☒		☒		☒		✓		

Access the **Mapping** tab from **Diagnosis Code Maintenance**. To access **Diagnosis Code Maintenance**, go to **System Administration > File Maintenance > Diagnosis Code Maintenance** or press **F9** and then enter **DCM**.



ICD9-1 through ICD9-6

Enter or select ICD-9 codes. At a minimum, you must fill **ICD9-1**. In a given row, columns **ICD9-1** through **ICD9-6** cannot contain the same ICD-9 code. Point to a column to see **Long Description** for the ICD-9 code, obtained from the **Diagnosis Code** tab.

Note: If you enter the same ICD-9 code in 2 columns, for example **ICD9-1** and **ICD9-2**, you are presented with the message A duplicate mapping code has been created. All mapping codes in a row must be unique.

Reimbursement Mapping

This column is display-only and indicates whether the mapping was imported with the Reimbursement Mappings developed by the Centers for Medicare and Medicaid Services (CMS). An imported row cannot be changed, and binoculars icons are not available.

However, you can change the selections in the **Default** column, and you can delete Reimbursement Mappings rows.

GEM

This column is display-only and indicates whether the mapping was imported with the General Equivalence Mappings developed by the Centers for Medicare and Medicaid Services (CMS).

An imported row cannot be changed, and  (binoculars icons) are not available. However, you can change the selections in the **Default** column, and you can delete GEMs rows.

Manual

This column is display-only and indicates whether the mapping was entered manually.

Default

(Optional) Select this option to make the mapping the default during charge entry. Even if a mapping is tagged as the default, you can select a different mapping when you enter the charge. You are not required to designate a mapping as the default, but at most, only 1 mapping row can be tagged as the default.

Modifier Maintenance window

Use **Modifier Maintenance** to create records that match the codes added to procedures when billing insurance claims.

Modifier Maintenance contains these tabs:

- > **Modifier**
- > **Anesthesia Detail**
- > **History**

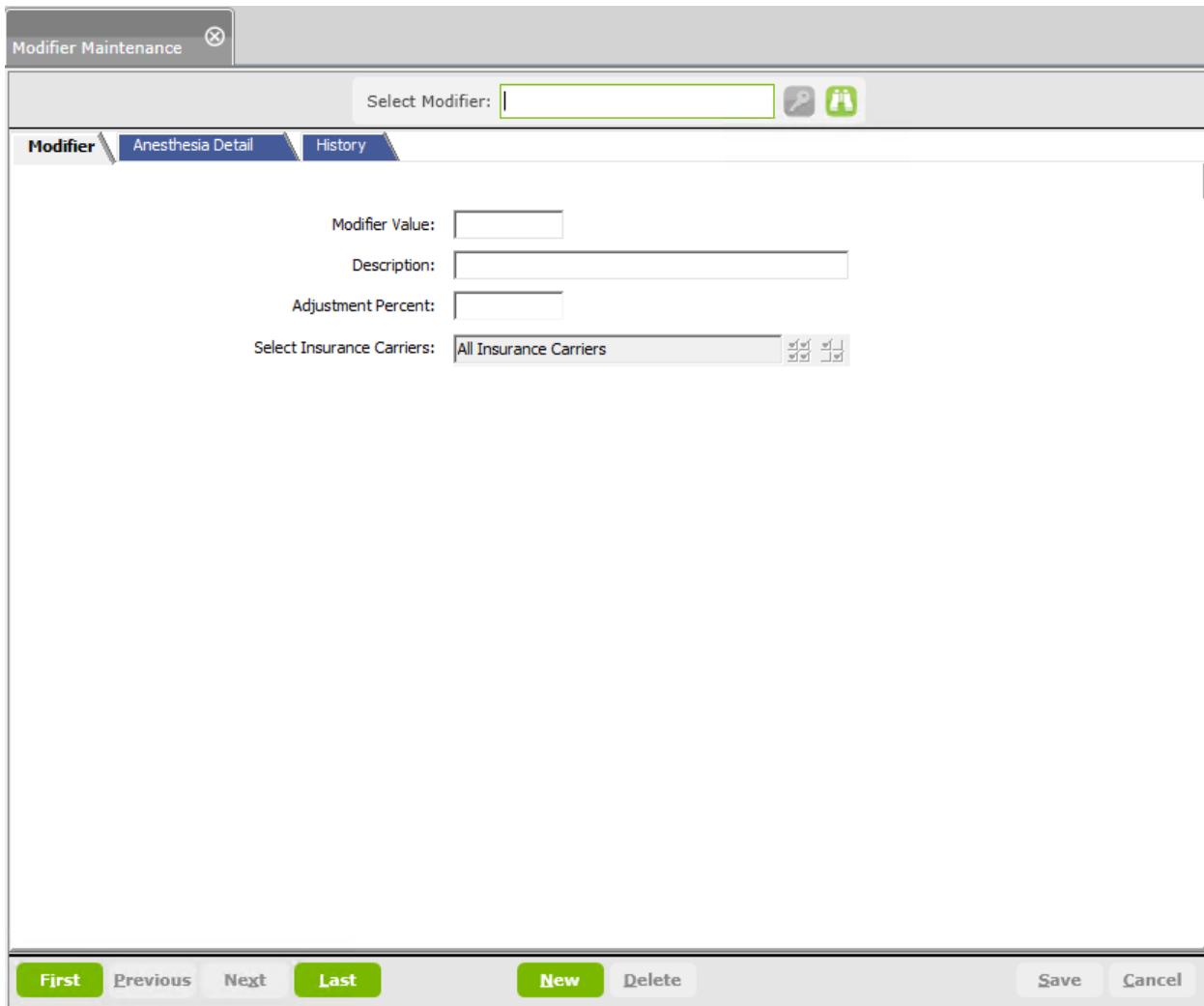
To access **Modifier Maintenance**, go to **System Administration > File Maintenance > Modifier Maintenance**, or press **F9** and then enter **MOM**.

Modifier tab

Use the **Modifier** tab in **Modifier Maintenance** to create records that match the codes added to procedures when billing insurance claims.

For Medicare purposes, modifiers can be a 1 or 2 character code appended to procedure codes and/or HCPCS codes, to provide additional information about the billed procedure. In some cases, addition of a modifier may directly affect payment.

Access the **Modifier** tab from **Modifier Maintenance**. To access **Modifier Maintenance**, go to **System Administration > File Maintenance > Modifier Maintenance** or press **F9** and then enter **MOM**.



The screenshot shows the 'Modifier Maintenance' window. At the top, there's a search bar labeled 'Select Modifier:' with a magnifying glass icon and a key icon. Below the search bar, there are three tabs: 'Modifier' (which is selected), 'Anesthesia Detail', and 'History'. Under the 'Modifier' tab, there are four input fields: 'Modifier Value:' (empty), 'Description:' (empty), 'Adjustment Percent:' (empty), and 'Select Insurance Carriers:' which contains the text 'All Insurance Carriers'. At the bottom of the window, there are several buttons: 'First', 'Previous', 'Next', 'Last', 'New' (highlighted in green), 'Delete', 'Save' (disabled), and 'Cancel'.

Modifier Value

Type in the actual code, for example **GC**. Prints in Box 24D on a standard CMS-1500 NPI claim form. Only modifiers created here are used as cross references when you import contractual allowances.

Description

Enter the description provider by CMS or the Carrier. For example, This service has been performed in part by a resident under the direction of a teaching physician. Displays as a selection in Procedure Code Maintenance and in Charge Entry.

Adjustment Percent

The application uses this number to automatically calculate the new fee based on the percent entered. Enter a value up to 999.99. An adjustment percent of 100% or less reduces the procedure fee; an adjustment percent greater than 100% increases the procedure fee.

The formula for applying the adjustment percent, whether for a fee decrease or increase, is: $(\text{Procedure fee} \times \text{Adjustment percent}) \div 100$.

For example, to decrease a procedure fee to 80% of the fee, enter 80 in **Adjustment Percent**. The formula with a procedure fee of \$100 and an adjustment percent of 80% is: $(100 \times 80) \div 100 = 80$. The procedure fee is decreased from \$100 to \$80.

As another example, to increase a procedure fee by 25% of the fee, enter 125 in **Adjustment Percent**. The formula with a procedure fee of \$40 and an adjustment percent of 125% is: $(40 \times 125) \div 100 = 50$. The procedure fee is increased from \$40 to \$50.

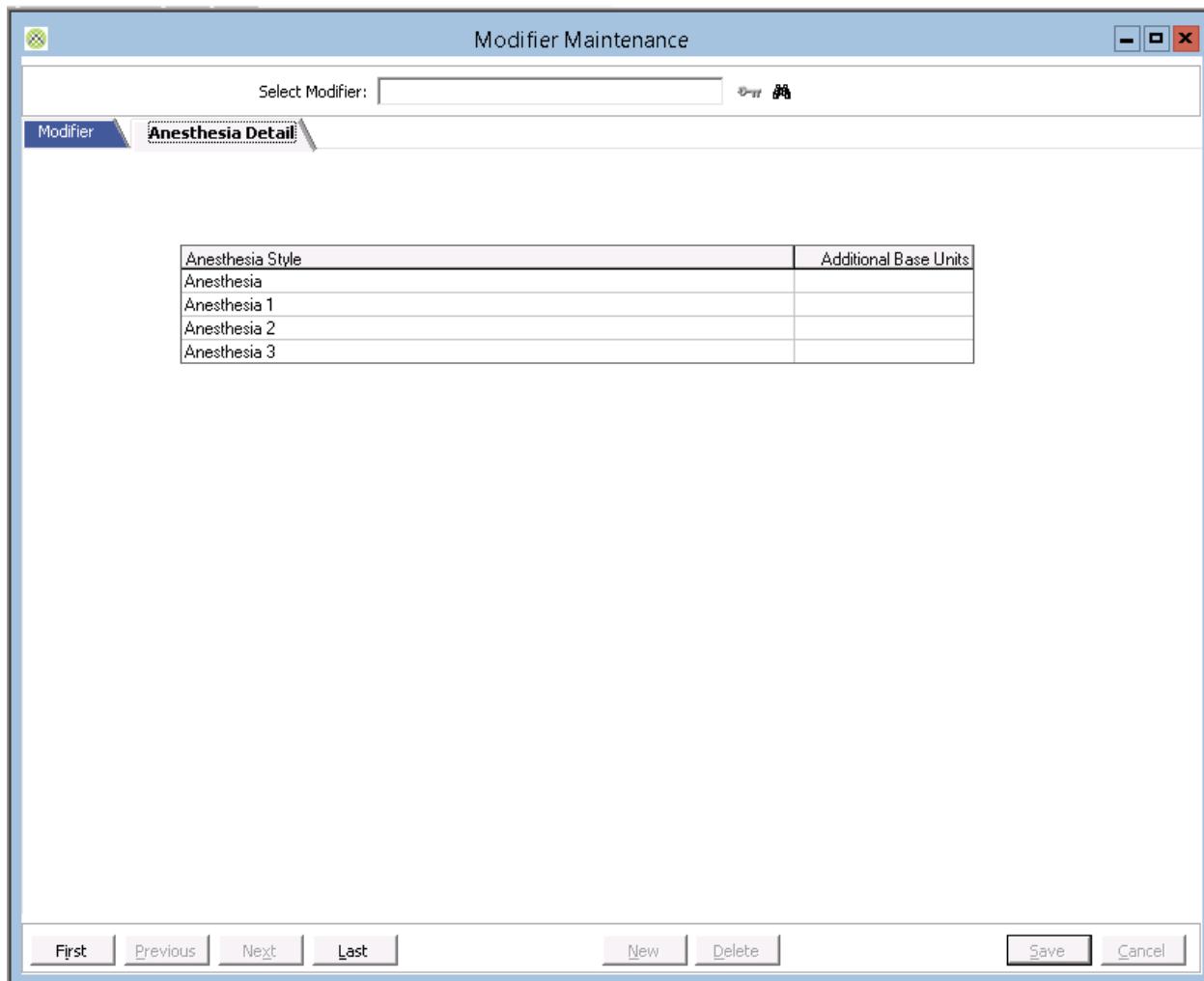
Select Insurance Carriers

Click  to open a separate window that enables you to narrow the procedure fee adjustment to specific insurance carriers or categories. Uninsured carriers and **(Self Pay)** are also available for selection.

Anesthesia Detail tab

Use the **Anesthesia Detail** tab to add the additional base units associated with this modifier. To use this tab, you must first have created anesthesia styles in **Anesthesia Style Maintenance**.

Access the **Anesthesia Detail** tab from **Modifier Maintenance**. To access **Modifier Maintenance**, go to **System Administration > File Maintenance > Modifier Maintenance** or press **F9** and then enter **MOM**.



Anesthesia Style Maintenance window

Use **Anesthesia Style Maintenance** to create an anesthesia style for each carrier that requires a different default modifier, time unit factors, break points, or round up policy.

Anesthesia Style Maintenance is also where your concurrency modifiers are established for medical direction. If necessary, return to **Modifier Maintenance** to fill in the **Anesthesia Detail** tab for modifiers related to anesthesia billing.

To access **Anesthesia Style Maintenance**, go to **System Administration > File Maintenance > Modifier Maintenance** or press **F9** and then enter **ASM**.

Anesthesia Style Maintenance

Select Anesthesia Style:	<input type="text"/>																									
Abbreviation:	<input type="text"/>																									
Description:	<input type="text"/>																									
Default Modifiers:	<input type="text"/>   																									
Service Line Recalculation:	<input type="text"/>																									
Time Unit Factors																										
Primary Time Unit Factor:	<input type="text"/>	Primary Time Unit Round Up: <input type="text"/>																								
Break Point:	<input type="text"/>																									
Secondary Time Unit Factor:	<input type="text"/>	Secondary Time Unit Round Up: <input type="text"/>																								
<table border="1"> <thead> <tr> <th>Concurrent Anesthesia Info</th> <th>Modifier</th> <th>Time Units</th> </tr> </thead> <tbody> <tr><td>Physician personally performed</td><td></td><td></td></tr> <tr><td>Two concurrent procedures</td><td></td><td></td></tr> <tr><td>Three concurrent procedures</td><td></td><td></td></tr> <tr><td>Four concurrent procedures</td><td></td><td></td></tr> <tr><td>More than four concurrent procedures</td><td></td><td></td></tr> <tr><td>CRNA medically directed by physician</td><td></td><td></td></tr> <tr><td>CRNA without direction by physician</td><td></td><td></td></tr> </tbody> </table>			Concurrent Anesthesia Info	Modifier	Time Units	Physician personally performed			Two concurrent procedures			Three concurrent procedures			Four concurrent procedures			More than four concurrent procedures			CRNA medically directed by physician			CRNA without direction by physician		
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Procedure Category Maintenance window

Is a custom defined grouping for procedure codes designed to meet your reporting needs. Is a required selection in **Procedure Code Maintenance**.

Is a required selection in Procedure Code Maintenance.

A procedure code can only be assigned to one category. Various reports can be grouped by and/or restricted to specified categories.

Examples of procedure categories are: Medical, Surgical, Lab, X-Ray.

Procedure Category Maintenance these tabs:

> **Procedure Category**

> History

To access **Procedure Category Maintenance**, go to **System Administration > File Maintenance > Procedure Category Maintenance** or press **F9** and then enter **PTM**.

Procedure Category tab

Use the **Procedure Category** tab in **Procedure Category Maintenance** to create procedure categories. Every procedure code must be assigned to a procedure category.

A Procedure Code can only be assigned to one Procedure Category. A Procedure Category is a user defined records created for the purpose of creating clear, useful reports. All of the Comparative Analysis Reports as well as the Reimbursement Review and Allowed Amount Analysis can be restricted or grouped by Procedures Category. Examples of typical procedure categories include "Medical", "Surgical", "Lab", and "Xray."

Access the **Procedure Category** tab from **Procedure Category Maintenance**. To access **Procedure Category Maintenance**, go to **System Administration > File Maintenance > Modifier Maintenance** or press **F9** and then enter **PTM**.

Procedure Category Maintenance 

Select Procedure Category: 

Procedure Category  History

Abbreviation:

Description:

GL Sub-Account#1:

GL Sub-Account#2:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Abbreviation

Holds up to 8 characters

Must be unique to this record.

Description

Holds up to 40 characters

GL Sub-Account#1

Used to store the value assigned to this segment of the GL account number if necessary.

GL Sub-Account#2

Used to store the value assigned to this segment of the GL account number if necessary.

Procedure Code Maintenance window

Many new client implementations include an existing Procedure Code table. These pre-loaded files must be reviewed and billing codes and fees must be entered.

Before creating or editing Procedure Code records you must:

- Create the Procedure Code Categories needed to produce clear and useful reports.
- Create Fee Profiles and Procedure Code Profiles in Practice/Organization Set Up.

Procedure Code Maintenance contains these tabs:

- **Procedure Code**
- **Billing Codes**
- **Fees**
- **Anesthesia Detail**
- **Purchased Services Info**
- **History** — The application stores the following information as it relates to each change made to the record: date, time, first name and last name of the operator who made a change as well as the name of the box, the value changed, and the new value entered in the box.

To access **Procedure Code Maintenance**, go to **System Administration > File Maintenance > Procedure Code Maintenance** or press **F9** and then enter **PCM**.

Procedure Code tab

Use the **Procedure Code** tab to define defaults, set parameters, and options which trigger actions when the procedure code is entered on a voucher.

Access the **Procedure Code** tab on **Procedure Code Maintenance** in **System Administration > File Maintenance**.

Tip: To quickly access **Procedure Code Maintenance**, press **F9**, then enter **PCM**.

Procedure Code Maintenance

Select Procedure Code:

Procedure Code **Billing Codes** **Fees** **Anesthesia Detail** **Purchased Service Info** **History**

Procedure Code:	<input type="text"/>	<input type="checkbox"/> Same As Insurance Description	GL Priority: <input type="text"/>
Insurance Description:	<input type="text"/>	<input type="checkbox"/> Co-Pay Applies	<input type="checkbox"/> Editable Description
Statement Description:	<input type="text"/>	<input type="checkbox"/> Hold Electronic Claims	
Procedure Category:	<input type="text"/>	<input type="checkbox"/> Default to One Unit	
Procedure Type:	<input type="text"/>	<input type="checkbox"/> Require Modifier	
Default Type Of Service:	<input type="text"/>	<input type="checkbox"/> Global Period Days: <input type="text"/>	
Default Diagnosis:	<input type="text"/>	<input type="checkbox"/> Alternate Claim Style	
Default Modifier:	<input type="text"/>	<input type="checkbox"/> Self-Pay Procedure	<input type="checkbox"/> Appropriate Use Criteria
Default National Drug Code:	<input type="text"/>	<input type="checkbox"/> Enable CMN/DIF Info	<input type="checkbox"/> Immunization
Default Original MFR NDC:	<input type="text"/>	<input type="checkbox"/> E&M Procedure	<input type="checkbox"/> Dispensed Medication
Default Manufacturer Code:	<input type="text"/>	<input type="checkbox"/> Purchased Service	<input type="checkbox"/> Do Not Calculate Extended Fee
Default Lot Number:	<input type="text"/>	Split Billing Options	
Unit of Measure:	<input type="text"/>	<input type="checkbox"/> Enable Split Billing	
Unit Count:	<input type="text"/>	Institutional: <input type="text"/>	<input type="checkbox"/>
Restrict To Sex:	<input type="text"/>	Professional: <input type="text"/>	<input type="checkbox"/>
Work RVUs:	<input type="text"/>	Inventory	
Practice Expense RVUs:	<input type="text"/>	Item #: <input type="text"/>	
Malpractice RVUs:	<input type="text"/>	Description: <input type="text"/>	
PA BWC Service Type:	<input type="text"/>	Cost: <input type="text"/>	
PA BWC Crosswalk Code:	<input type="text"/>		
Activation Date:	<input type="text"/>		
Inactivation Date:	<input type="text"/>		

Buttons: First Last

Procedure Code

Enter the CPT code, ex. 99215. When you enter a procedure code in **Charge Entry**, Allscripts® Practice Management uses this box to access the code and fill the window. When creating a procedure code with a procedure type **Special Services**, enter no more than 5 characters. To successfully use the Contractual Allowance Import to import carrier fee schedules, you must enter a valid CPT code in this box.

Note: To report on the use of procedure codes and their modifiers using an Allscripts® Practice Management, report you must build combinations of procedure codes and modifiers, for example 09954-80. You should also enter the modifier as the default modifier for the procedure code. These combination codes are not considered

a match when you import carrier fee schedules using the Contractual Allowance Import.

Tip: When creating a custom defined code, for example, a code that enables you to bill a finance charge, enter an identifiable abbreviation such as FINCHRG.

Insurance Description

Enter the description (up to 40 characters) used in the CPT Coding manual. The insurance description is displayed in the following locations:

- > **Procedure on Charge Entry**
- > **Procedure Code Lookup** window
- > Various reports

Same as Insurance Description

Select to automatically fill **Statement Description** with the text from **Insurance Description**

Statement Description

Fill this box if you want a description (up to 40 characters) for this code in your application that is different from insurance description you want to print on patient statements.

Procedure Category

Required. Click the down arrow to open the combo box and select the applicable procedure category.

Procedure Type

Procedure types are used as triggers for running certain billing requirements or functions.

Click to open the combo box listing to select the appropriate type.

When none of these options applies, leave this field blank.

Ambulance Procedure

Enables the **Amb Info** button on the **Summary** window in **Charge Entry**, where you can add ambulance information to the claim.

Anesthesia (Timed)

Enables the **Anesthesia Detail** tab. Activates **Anesthesia** button on **Charge Entry**, enabling you to add required anesthesia related detail to the claim.

Anesthesia (Non-Timed)

Enables the **Anesthesia Detail** tab.

Dental

Enables the **Dental** button on **Charge Entry**, enabling you to make selections for tooth quadrants in addition to tooth numbers. The tooth quadrant will output in the column for surfaces on the dental claim form.

Drug Procedure

Meant to support the use of NDC codes when required by carriers such as Idaho Medicaid. Activates the **Drug** button on **Charge Entry**, enabling you to add required NDC related detail to the claim.

Select when you are required to submit National Drug Codes and you are using any ANSI 837P electronic claim format > Auto checks the option Editable Description.

Note:

When editing a description for a drug procedure keep the following in mind:

- > If the description contains exactly 11 characters, Allscripts® Practice Management considers it an NDC and outputs it to Loop 2410/Segment LIN.
- > If the description contains more or less than 11 characters, Allscripts® Practice Management does not consider it an NDC, and outputs it to Loop 2400/Segment NTE.
- > Blank description fields for drug procedure codes cause the claim to fail validation.

Lab Procedure

Prints the CLIA # on the claim form in Box 23 on a standard CMS-1500 NPI claim form when all of the following is also true:

- > A CLIA # is entered on **Place Of Service Maintenance**
- > The output option for the corresponding claim style is selected on **Claim Style Maintenance**
- > A prior authorization number is not entered in **Claim Info** for the voucher

Mammography

Prints the Mammography No. in Box 32 on a standard CMS-1500 NPI claim form when all of the following is also true:

- > A mammography certification number is entered on **Place Of Service Maintenance**
- > The output option for the corresponding claim style is selected on **Claim Style Maintenance**

Physical Therapy

Prints in Box 19 on a standard CMS-1500 NPI claim form. If billing Medicare, use **Ailment Info on Charge Entry** to enter a date last seen.

Podiatry

Prints in Box 19 on a standard CMS-1500 NPI claim form. If billing Medicare, use **Ailment Info on Charge Entry** to enter a date last seen.

Special Service

For use by clients with Allscripts Professional EHR™

- > Requires the use of a special interface.
- > Meant to identify practice-specific procedure codes that are clinical in nature.
- > Use when you need to represent special service codes in Allscripts Professional EHR™ as PM service codes.

X-Ray Professional Component

X-Ray Technical Services

Prints the group number in Box 24K on a standard CMS-1500 form when the option **Output Group No for X-Ray Technical Services** is selected on the **Output Options** tab on **Claim Style Maintenance**.

Default Type of Service

The selection automatically fills the corresponding box on **Charge Entry**. When this box is blank, you must manually fill **Type of Service** for each procedure.

Default Diagnosis

Optional. Fill this box if a specific diagnosis code is always used with this procedure code.

Default Modifier

Optional. Fill this box if a specific modifier is always used with this procedure code by all carriers.

You can select this option even if **Allow Entry Of Modifiers** is cleared in **Practice Options** or **Organization Options**. However, you must select **Allow Entry Of Modifiers** to be able to manually enter a modifier on **Charge Entry**, or change the default modifier.

Note: If you are creating a combination procedure code and modifier, you must enter the modifier as the default modifier for the procedure code. For example, for the procedure code and modifier 09954-80, you must set **Default Modifier** to **80**.

Default National Drug Code

Optional. This box is available only when you set **Procedure Type** to **Drug Procedure**. When a National Drug Code (NDC) is required, entering the 11-digit code here automatically fills the corresponding box on **Drug Services** when you enter this procedure code on a voucher. This set up eliminates the need to manually enter the code when you create the voucher.

Point to the label to see the tooltip NDC of drug as dispensed.

Note: This box is not included in replicated procedure code information, and is not exportable using Allscripts® Interface Engine

Default Original MFR NDC

Optional. This box is available only when you set **Procedure Type** to **Drug Procedure**. Enter the 11-character alphanumeric original manufacturer's National Drug Code (NDC) for repackaged and relabeled drugs that was assigned to the bulk package of the drug.

Point to the label to see the tooltip NDC of drug in bulk packaging.

Default Original MFR NDC is not replicated or included with starter data sets that have the **Procedure Code Information** information type.

Default Manufacturer Code

Optional. This box is available only when you set **Procedure Type** to **Drug Procedure**. The default manufacturer code automatically fills the corresponding window on **Drug Services** when you enter this procedure code on a voucher. You can edit the default manufacturer code.

Point to the label to see the tooltip FDA Manufacturer Code.

Important: If you use the MI Care Improvement Registry Export and participate in the Vaccine Inventory Module, you can enter a manufacturer code here and eliminate the need for manual entry when the voucher is created.

Default Lot Number

Optional. This box is available only when you set **Procedure Type** to **Drug Procedure**. The default lot number automatically fills the corresponding window on **Drug Services** when you enter this procedure code on a voucher. You can edit the default lot number.

Important: If you use the MI Care Improvement Registry Export and participate in the Vaccine Inventory Module, you can enter a lot number here and eliminate the need for manual entry when the voucher is created.

Unit of Measure

This box is a drop-down list containing the following options:

- > **Gram**
- > **International Unit**
- > **Milligram**
- > **Milliliter**
- > **Unit**

Unit Count

This box defaults to 0.0 and accepts a numeric value up to 10000.00.

Restrict to Sex

Note: This box does not trigger any restrictions when entering the procedure code in **Charge Entry**.

If this procedure is sex-specific, select the applicable option: **M** for male or **F** for female.

Note: **Unknown** is not an available option even if **Include Unknown in Gender Values** is selected under **Entry Options** in the **Registration** tab in **Practice Options** or **Organization Options**.

Work RVUs, Practice Expense RVUs, and Malpractice RVUs

RVUs refers to Relative Value Units. The values for these 3 boxes are available from the Federal Register. Allscripts® provides an interface which enables you to download RVU information directly into the application.

PA BWC Service Type

This box is for use with the Pennsylvania Bureau of Worker's Compensation (PA BWC) Charge Master Export only. Use this box to indicate the service type (procedure code), as defined by PA BWC. The choices include the following.

- > **A1 - New Service:** select this option if you have not submitted this procedure code to PA BWC before.
- > **C2 - New Service Crosswalk:** select this option if you are using this procedure code to replace or duplicate an existing code that you submitted to PA BWC in the past.

This box is not included in replication or when you create a new tenant with a starter data set that contains **Procedure Code Maintenance**.

PA BWC Crosswalk Code

This box is for use with the PA BWC Charge Master Export only. Required if you set **PA BWC Service Type** to **C2 - New Service Crosswalk**. Use this box to cross reference to the previous procedure code that this new procedure code represents. You can enter the procedure code and click the key icon () , or click the binoculars icon () to open a search window, search for the correct procedure code, and click **OK**.

This box is not included in replication or when you create a new tenant with a starter data set that contains **Procedure Code Maintenance**.

Activation Date

This box is for use with the PA BWC Charge Master Export only. Use this box to indicate the date when your practice began using this procedure code. When you are creating a new procedure code, this box displays the current date by default. The PA BWC Charge Master Export uses this date as a reference and includes it in the export, but it does not control any functionality in the application.

Note: When you run the PA BWC Charge Master Export with **Submission Type** set to **Initial**, all procedure codes are included regardless of whether **Activation Date** is filled. The application updates **Activation Date** with the current export date for any procedure codes that are included in the initial submission.

The application updates this box with the system date when you manually enter a procedure code and when you import procedure codes using **Procedure Code Import**.

This box is not included in replication or when you create a new tenant with a starter data set that contains **Procedure Code Maintenance**.

Inactivation Date

As of the date entered, this procedure code is no longer included in search results except when you search in **Procedure Code Maintenance**.

GL Sub-Account#1

Enter the numeric value assigned to this segment of the GL account number, if necessary.

GL Sub-Account#2

Enter the numeric value assigned to this segment of the GL account number, if necessary.

GL Priority

Enables you to identify procedure codes by priority when extracting data to your general ledger (GL). You can enter a 3-digit numeric value.

Co-Pay Applies

When you select the option **Co-Pay Processing Always Required in Practice Options**, and this procedure code option is also selected, then you are always required to process a co-pay payment through the Self-Pay dialog in **Charge Entry**.

When the practice option is not selected, but the procedure code option is selected, then you are required to process a co-pay payment using the charge entry self-pay dialog only when both of the following apply to the voucher:

The voucher includes a procedure code with the designation of Co-Pay Applies.

The selected policy on the voucher has a co-pay amount due.

Editable Description

Selecting this option enables **Description** in **Charge Entry** when you click  for the related procedure code.

If you are using replication, **Editable Description** is not replicated to target tenants.

Additionally, selecting this option enables the unlabeled text box below **Editable Description**.

Unlabeled text box

This box is enabled when **Editable Description** is selected. Enter the editable procedure code description that you want to show on claims without having to manually update vouchers.

When you enter the editable procedure code description, do not press **Enter** or **Return** on your keyboard to create multiple lines; otherwise, the description might not show correctly in other areas of the application.

The description in this box is not used when searching for procedure codes by procedure description using **Procedure Code Lookup**.

Up to 80 characters of the editable procedure code description output on v5010 electronic claims, but only the first 40 characters output on CMS-1500 paper claims. The editable procedure code description text does not output on v4010 electronic claims.

If **Editable Description** is selected but there is no description in the unlabeled text box, **Insurance Description in Procedure Code Maintenance** is displayed in **Procedure** on the **Charge Entry** and **Edits** tabs. If you want the value in **Insurance Description** to output on claims, you must open **Specify Procedure Code** and then click **OK**. If you do not open **Specify Procedure Code**, the procedure code description on claims is blank.

Long procedure code descriptions are truncated to 40 characters on some windows and reports in the application that display the service procedure description.

If you are using replication, the editable procedure code description text is not replicated to target tenants.

If you create a new tenant using a starter data set with procedure code information, the editable procedure code description text is included in the new tenant.

Hold Electronic Claims

Selecting this option prevents claims with this procedure to qualify for electronic submission.

Tip: This restriction applies to those procedures entered on vouchers created and updated from the point that the option is selected.

Vouchers containing this service, which were created and updated prior to the restriction being selected continue to qualify for electronic billing.

When the procedure code is entered on the voucher, **Hold Voucher From** on the **Summary** tab in **Charge Entry** defaults to "Electronic Claim Billing" unless the policy selected for the voucher is associated with a Carrier flagged for the 72 Hour Rule. In this instance the field defaults to "All Insurance Billing."

Held Voucher Reason

Enabled when you select **Hold Electronic Claims**.

Optional. If a reason is selected then when the procedure code is entered on the voucher, the Hold Voucher reason field on the **Summary** tab in **Charge Entry** defaults to this reason, **unless** the policy selected for the voucher is associated with a Carrier flagged for the 72 Hour Rule. In this instance, the reason selected in **Insurance Carrier Maintenance** is the default selection.

Tip: Create a Held Voucher Reason specifically for your custom procedure codes.

Note: The Held Voucher List prints the held voucher reason attached to the voucher.

Default to One Unit

Selecting this default auto fills the charge entry field Units with "1" even when you enter a date range for this procedure code. When a date range is entered the fee amount is calculated based on one unit instead of the number of days within the date range.

Note: Even with this default selected you can manually change the unit value in charge entry. When the value is manually changed, the fee amount changes accordingly.

Require Modifier

Selecting this option will require the operator to enter a modifier at the time of charge entry.

Either select a default modifier for this procedure code or select the practice option **Allow Entry of Modifiers**.

Global Period

Select if a global period applies to the procedure code. Enables the box **Days**, where you enter the number of days that make up the global period.

- > To display a warning on **Charge Entry**, also select the option **Warn on Global Procedures** on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

After a voucher is created with a procedure having a global period defined, whenever a new voucher is created for that Patient within the number of days specified, a warning flag and message will be displayed on the screen.

Note: The warning is displayed during manual charge entry and when a charge is imported, but not when a charge is batch imported.

- > To display a warning based on the global period in Scheduling, also select **Warn on Global Procedures** on the **Scheduling** tab in **Practice Options** or **Organization Options**.

After a voucher is created with a procedure having a global period defined, whenever an appointment is being scheduled for that patient within the number of days specified, the most recent active global procedure and its expiration date display on the **Patient Scheduling** tab, **Schedule New Appointment**, **Force Appointment**, and **Walk In Appointment**.

Note: When the charge entry or scheduling option **Warn Based on Department Security** is selected in **Practice Options** or **Organization Options**, the global period warning only displays if you are entering a charge or scheduling an appointment for the patient and have access to the department used when the global service charge was entered.

When the charge entry option **Warn on Global Procedures** is selected in **Practice Options** or **Organization Options**, global period warnings are only displayed during manual charge entry, not when charges are imported.

Alternate Claim Style

Select if you have 1 or more carriers that require you to submit this service either on a different paper form or using a different electronic format than you generally use when submitting claims to them.

When the voucher contains only procedures that have **Alternate Claim Style** selected, Allscripts® Practice Management uses the alternate paper or electronic claim style assigned to the carrier on **Insurance Carrier Maintenance** to generate the claim.

During manual charge entry if a voucher contains both Alternate Claim Style and Standard Procedure Codes and the selected Policy on the voucher has an alternate claim style defined in Insurance Carrier Maintenance then the voucher cannot be saved. See "Using an Alternate Claim Style" for more information.

Note: A procedure code can be selected as both Alternate Claim Style and a Self-Pay Procedure.

Self-Pay Procedure

Select to indicate that on a general basis the procedure code should not be billed to insurance.

Do NOT select **Co-Pay Applies** if you are selecting **Self-Pay Procedure**.

A procedure code can be selected as both Alternate Claim Style and a Self-Pay Procedure.

Enables the operator to use the system to split a voucher whose Payer is set to a Policy or to Courtesy Claim and its services include one of the following specific combinations of Procedure Codes:

- > Self-Pay and Standard (Standard equals those Procedures Codes that are **not** flagged as either Self-Pay or Alternate Claim Style.)
- > Self-Pay and Alternate Claim Style when the Carrier does **not** have a selected alternate claim style
- > Alternate Claim Style and those Procedures that are flagged as **both** Self-Pay and Alternate Claim Style

A new voucher is created using Self-Pay as the Payer and it contains all the Self-Pay Procedures from the original voucher. The new voucher is assigned the next available voucher number.

The original voucher retains its assigned number, original payer and any Standard or Alternate Claim Style Procedure Code with associated detail.

Enable CMN/DIF Info

Unavailable if you selected **Self-Pay Procedure**. Enables the entry of claim information on a Medical Necessity Form or a DME MAC Information Form when this Procedure is included on a claim and the policy selected on the voucher has its **Source of Payment** set to **Medicare**.

E&M Procedure

By default, this option is not selected.

Procedure codes used to bill well or sick office visits are considered evaluation and management (E&M) procedures.

Used in conjunction with "Output CPT's in RVU order on Prof. Claims?" on the Output Options tab in Claim Style Maintenance for both electronic and paper claims.

Check this option for any procedure code classified as an E&M Code when also selecting either "E&M Code and Work RVU" or "E&M Code and Total RVU" in the claim style output option, "Output CPT's in RVU order on Prof. Claims?".

Procedure codes flagged as E&M are used in the following circumstances:

- > When you have **E&M Code and Work RVU** or **E&M Code and Total RVU** selected for **Output CPTs in RVU order on Prof. Claims?** on the **Output Options** tab in **Claim Style Maintenance** for electronic and paper claims.
- > When you electronically process a remittance file that contains payments and adjustments applied to the Encounter Code in the file. In this instance, the remit program applies the payments and adjustments to the E&M code that was entered on the voucher.

Purchased Service

By default, this option is not selected.

Select this box to flag a procedure code as a purchased service.

Enables the **Purchased Services Info** tab.

Enables **Purchased Service** on the **Charge Entry** and **Edits** tabs in **Transactions**, and on the **Charge Import** COMpanion window, which opens **Purchased Services** where you can select a reference laboratory place of service at the service level. The laboratory NPI #, laboratory CLIA #, and purchased service price are retrieved based on the selected reference laboratory.

Appropriate Use Criteria

Select this option to indicate that a procedure is used for the Appropriate Use Criteria (AUC) Program.

If you are using replication, **Appropriate Use Criteria** is replicated from the source tenant to the target tenant when the procedure code is created, but it is not replicated with subsequent updates in the source tenant. **Appropriate Use Criteria** is editable in the target tenant.

Appropriate Use Criteria is included with starter data sets that have the **Procedure Code Information** information type.

Immunization

Intended for use with the paper claim format type **CA CHDP Assessment Claim Form**. Select **Immunization** for each procedure code you want to report on the Confidentiality Screening/Billing Report PM160 Information only (03/07) form in the section for Immunizations.

Note: If you use the Arizona Immunization Export, Michigan Care Improvement Registry Export, or the Texas ImmTrac Export, do not

check this box. The status of this check box does not apply to these exports.

Dispensed Medication

For future use. **Dispensed Medication** is included:

- > In replication but is replicated only on initial entry because that option is editable in target tenants
- > With starter data sets that have the **Procedure Code Information** information type

Do Not Calculate Extended Fee

Select this option to prevent the calculation of an extended fee (*Fee x Number of units*) for this procedure code. This option is useful if the fee entered on the **Fees** tab in **Procedure Code Maintenance** represents a packaged fee for an item that contains multiple units.

The extended fee is not calculated during manual charge entry or when charges are imported regardless of the number of units recorded for the voucher. The fee remains as the packaged fee amount on the **Fees** tab.

If you use replication, **Do Not Calculate Extended Fee** is replicated only on initial entry because that option is editable in target tenants.

Do Not Calculate Extended Fee is included with starter data sets that have the **Procedure Code Information** information type.

Split Billing Options

This pane enables you to set up the ability to have institutional and professional charges that are entered on a single voucher split automatically and bill out in their appropriate formats.

Enable Split Billing

Check this option for the Procedure Code that is entered by the Operator on vouchers in Charge Entry.

When all the necessary conditions exist on the voucher the custom Procedure Code(s) associated with the Procedure Code entered by the Operator, display in the service line grid instead of the code standard code that was entered by the Operator.

When **Enable Split Billing** is checked you must select either **Institutional** or **Professional**.

Institutional

Enter the custom procedure code required on an Institutional claim when billing the Carrier for this service.

Note: The **Alternate Claim Style** option must be checked on the specific Institutional procedure code record, not on the main procedure code that has **Enable Split Billing** checked.

Professional

Enter the Procedure Code that is to be billed on a Professional claim.

It is possible for only one of the Split Billing procedure code fields to have a code entered. In this case, nothing populates from that field in Charge Entry.

Note: When the Practice Option, **Warn if Split Fee Does Not Equal Non-Split Fee in PCM** is checked on the General tab, then a hard warning displays if the sum of the Fees entered for the custom Procedure Code(s) selected as Institutional and/or Professional do(es) not equal the fee of the Procedure Code enabled for split billing. This warning occurs at Save.

Inventory

These 3 boxes are primarily used with the **Cost Import** in **System Administration > Interfaces**, which fills these boxes automatically. However, they can be filled in manually and used for reporting using the general view vwGenSvclInfo.

Item

This field can be populated via the Cost Import.

Reportable using the vwGenSvclInfo.

Note: When populated, the field's description and value are included in the Procedure Code Listing when the detail is expanded down to "Billing Codes and Fees."

Description

This field can be populated via the Cost Import.

Reportable using the vwGenSvclInfo.

Note: When populated, the field's description and value are included in the Procedure Code Listing when the detail is expanded down to "Billing Codes and Fees."

Cost

Can be used as an aid in determining the cost of a service versus the reimbursement received by a selected Carrier.

This field can be populated via the Cost Import.

Reportable using the vwGenSvclInfo. Visit our secure Clients-Only website for the Ad Hoc report, "Procedure Cost Analysis."

Note: When populated, the field's description and value are included in the Procedure Code Listing when the detail is expanded down to "Billing Codes and Fees."

Billing Codes tab in Procedure Code Maintenance

Use the **Billing Codes** tab in **Procedure Code Maintenance** (**F9 > PCM**) to enter the correct code by profile associated with each of your Carriers. When claims are prepared for the Carrier, the system uses the profile you associated with the Carrier to output the code the Carrier requires.

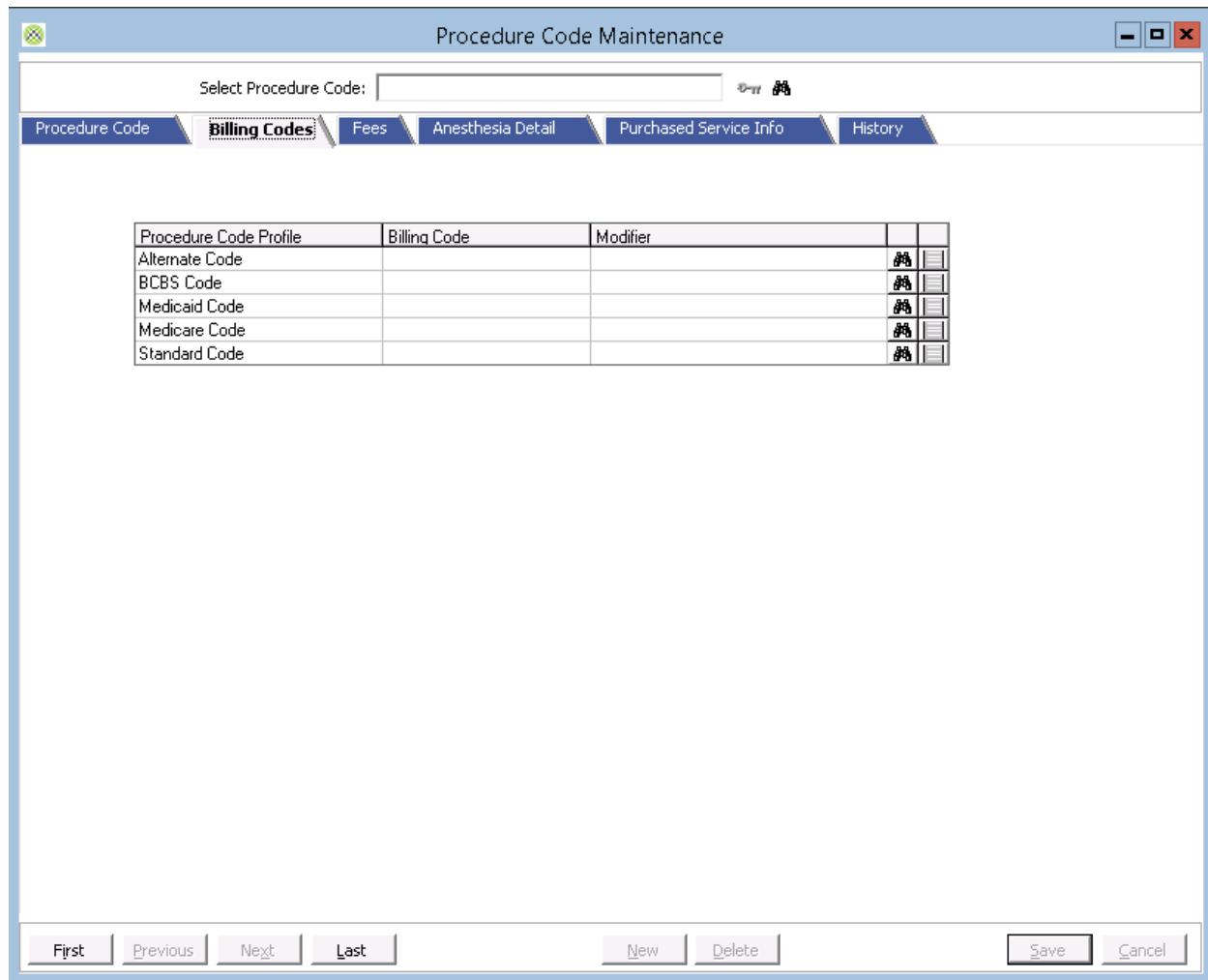
To minimize keystrokes, use the copy and paste method to enter the CPT code on this tab for each profile.

Note: For anesthesia billing, this is where you would need to assign the ASA code if a carrier requires the use of an ASA code instead of a CPT code.

The Modifier column allows the user to link up to four modifiers which are entered in Modifier Maintenance to a specific profile. When a procedure code is entered in Charge Entry for an insurance or courtesy claim voucher, the modifier(s) from entered here is auto-filled in the Modifiers field on the service line for the procedure code used based on the procedure code profile assigned to the carrier.

Note: Self-pay vouchers do not use the modifier(s) from this tab in Charge Entry.

Access the **Billing Codes** tab from **Procedure Code Maintenance**. To access **Procedure Code Maintenance**, go to **System Administration > File Maintenance > Procedure Code Maintenance** or press **F9** and then enter **PCM**.



Procedure Code Profile

These procedure code profiles are created on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**.

Billing Code

The entries in this column are generally the same as the CPT code entered Procedure Code on the Procedure Code tab.

When this is the case you use the copy and paste method to enter the CPT code on this tab for each profile.

If you are entering a code that is different than the one entered on the Procedure Code tab, then point and click to position your cursor in the cell, then type in the code.

Note: For anesthesia billing, this is where you assign the ASA code if a carrier requires the use of an ASA code instead of a CPT code.

Modifier

Enables you to link up to four modifiers which are entered in Modifier Maintenance to a specific profile.

When a procedure code is entered in Charge Entry for an insurance or courtesy claim voucher, the modifier(s) from entered here is auto-filled in the Modifiers field on the service line for the procedure code used based on the procedure code profile assigned to the carrier.

Note: These Profile specific default Modifiers can only be changed in Charge Entry when the *Option Allow Entry of Modifiers* is checked on the Charge Entry tab in Practice/Organization Options.

Self-pay vouchers do not use the modifier(s) from this tab in Charge Entry.

Click  to search for one Modifier.

Click  to select multiple Modifiers from pick lists.

Fees tab in Procedure Code Maintenance

Use the **Fees** tab in **Procedure Code Maintenance** to define the charge of a service by profile.

Always define a fee for the profile which is checked as the default. If a fee for a profile differs from the default, then enter the appropriate fee for that profile, too. In other words, if a procedure code is charged at the same fee amount regardless of which profile is used, then define only the fee associated with the fee profile default. If, on the other hand, the fee amount differs by profile, then enter a fee for the profiles that differ from the default.

Note: For anesthesia billing, enter the fees per unit associated with the procedure code.

Access the **Fees** tab from **Procedure Code Maintenance**. To access **Procedure Code Maintenance**, go to **System Administration > File Maintenance > Procedure Code Maintenance** or press **F9** and then enter **PCM**.

Procedure Code Maintenance 

Select Procedure Code:  

Procedure Code \ Billing Codes \ **Fees** \ Anesthesia Detail \ Purchased Service Info \ History

Fee Profile	Fee Defined?	Fee	Effective Date	Expiration Date
BCBS	<input type="checkbox"/>			
CA PM160	<input type="checkbox"/>			
Medicare	<input type="checkbox"/>			
Standard Fee	<input type="checkbox"/>			
Student Fee	<input type="checkbox"/>			

First Previous Next **Last** New Delete Save Cancel

icon column

Displays the + and - icons. Select the + icon to expand the row and view the previous fee information for a fee profile. Select the - icon to collapse the row if expanded.

When a fee profile is expanded by clicking the + icon, all previous fees for the profile are displayed in descending date order of expiration.

Note: The fee information grid expands vertically as more fees are entered. A scroll bar activates when the number of saved fees exceeds window size.

Fee Profile

Fee profiles are created in **Practice Set Up** or **Organization Set Up**.

Fee Defined

Selecting **Fee Defined** for a profile enables you to activate, deactivate, add, or edit fees for procedures.

If there are no existing profile fees, selecting **Fee Defined** activates **Fee** and **Effective Date** for the fee profile.

If selected, all programs that create charge vouchers use the fees associated with the fee profile unless there are other restrictions placed on the fees elsewhere in Allscripts® Practice Management.

If selected, **Procedure Fee Manager** updates the fee profile and includes the fee profile in reports generated by the **Procedure Fee Manager** process. If **Fee Defined** is cleared, ignores the fee profile and does not include the fee profile in any reports generated by **Procedure Fee Manager**.

Fee

Displays the fee value assigned to the fee profile for the specified date range. Always define a fee for the profile which is checked as the default.

If a fee for a profile differs from the default, then enter the appropriate fee for that profile, too. In other words, if a procedure code fee is the same fee amount regardless of which profile used, then define only the fee associated with the default profile. If, on the other hand, the fee amount differs by profile, then enter a fee for the profile(s) which are different from the default.

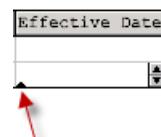
For anesthesia billing, enter the fees per unit associated with the procedure code.

Effective Date

Displays the date a fee becomes available for use on a charge or a voucher and must have a value of 01/01/1900 or later. This field is required.

Click your mouse pointer in the field. Spin arrows display .

A pointer is positioned at the month's field.



Use the spin arrows to enter a date and the keyboard arrows to move the pointer from the month/day/year fields. Each click on the spin arrow changes up or down the number in the field indicated by the pointer.

Or, double click in the field to display a calendar.

Expiration Date

Displays the date a fee is no longer used on a charge or voucher. When a new fee is added, the **Expiration Date** value for the most recent previous fee is automatically generated as 1 calendar day less than the **Effective Date** value for the latest fee.

Note: You can update your fee schedule by using the Procedure Fee Manager found under System Administration Interfaces. This interface, however, only updates those fee profiles that have a fee defined.

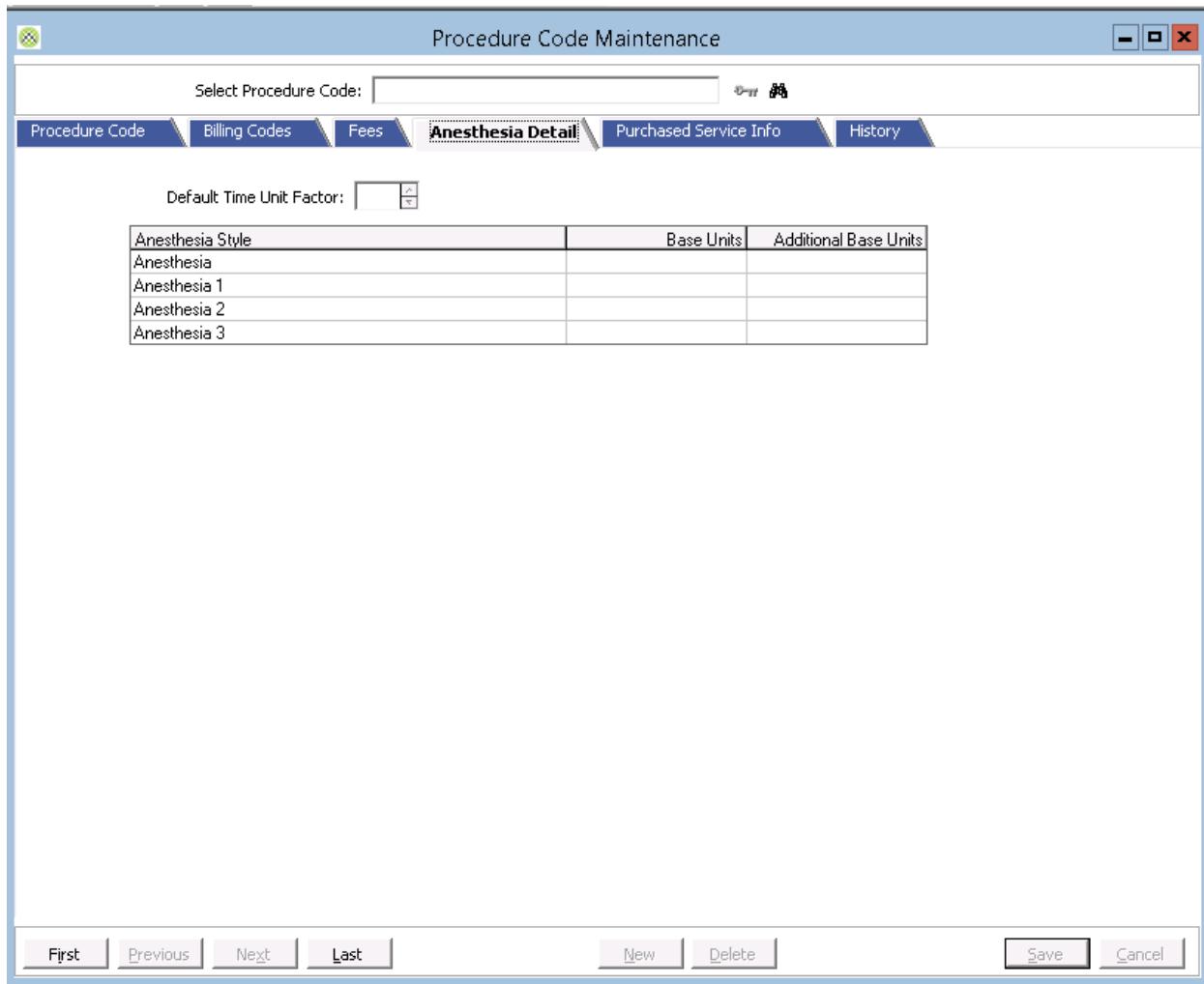
Anesthesia Detail tab in Procedure Code Maintenance

Use the **Anesthesia Detail** tab in **Procedure Code Maintenance** (**F9 > PCM**) only if the selections for the current procedure code vary from the anesthesia style defined using **Anesthesia Style Maintenance**.

The **Anesthesia Detail** tab is enabled when Procedure Type **Anesthesia (Timed)** or **Anesthesia (Non-Timed)** is selected on the Procedure Code tab in Procedure Code Maintenance.

These entries control the default time unit factor for this specific procedure code. Required only if this varies from the anesthesia style.

Access the **Anesthesia Detail** tab from **Procedure Code Maintenance**. To access **Procedure Code Maintenance**, go to **System Administration > File Maintenance > Procedure Code Maintenance** or press **F9** and then enter **PCM**.



Purchased Service Info tab

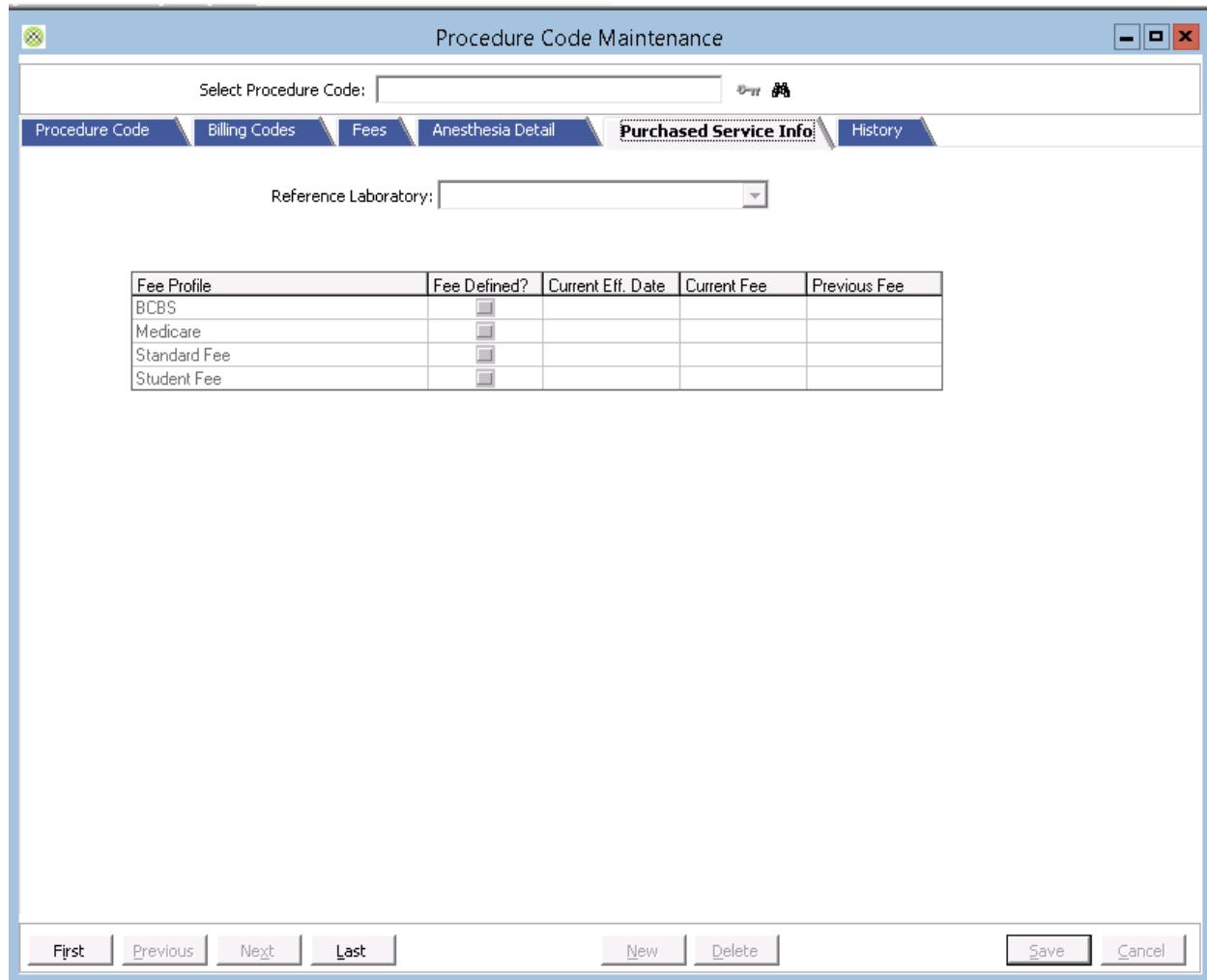
This tab is enabled for procedure codes that have **Purchased Services** selected.

The **Reference Laboratory** list has **(default)** and the name of each place of service flagged as reference laboratory in **Place of Service Maintenance**.

You can enter fees specific to one or more places of service. The fee profiles are retrieved from the **Profiles** tab in **Practice Set Up** or **Organization Set Up** for the **Fees** profile type.

Always enter fees for the **Reference Laboratory** setting of **(default)**.

Access the **Purchased Service Info** tab from **Procedure Code Maintenance**. To access **Procedure Code Maintenance**, go to **System Administration > File Maintenance** and select **Procedure Code Maintenance** from the list or use **F9 > PCM**



Procedure Group Maintenance window

Uses for procedure groups:

- > restricting claim types to a group of procedure codes
- > restricting reports to specified procedure group or groups
- > viewing a patient's service history in Service Inquiry.

Create a group then add procedure codes to it as group members. A procedure code can be added as a member to multiple groups.

Procedure Group Maintenance contains these tabs:

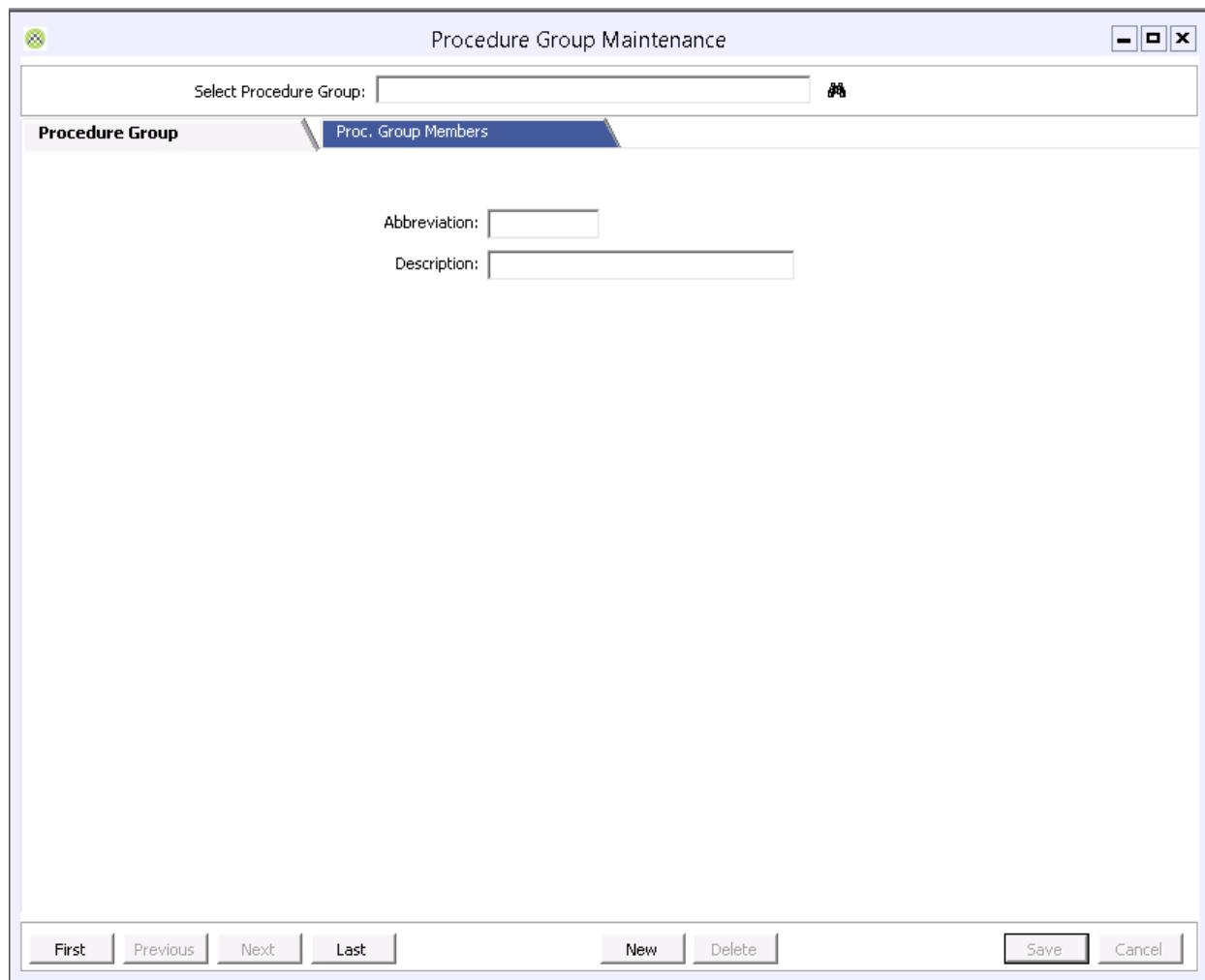
- > **Procedure Group**

> Procedure Group Members

To access **Procedure Group Maintenance**, go to **System Administration > File Maintenance > Procedure Group Maintenance** or press **F9** and then enter **PGM**.

Procedure Group tab

Access the **Procedure Group** tab from **Procedure Group Maintenance**. To access **Procedure Group Maintenance**, go to **System Administration > File Maintenance > Procedure Group Maintenance** or press **F9** and then enter **PGM**.



The screenshot shows the 'Procedure Group Maintenance' window. At the top, there is a title bar with the window name. Below the title bar is a toolbar with a search field labeled 'Select Procedure Group:' and three icons. A navigation bar below the toolbar has two tabs: 'Procedure Group' and 'Proc. Group Members', with 'Proc. Group Members' being the active tab. The main area contains two input fields: 'Abbreviation:' and 'Description:', each with its own input box. At the bottom of the window are several buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

Accepts up to 8 characters

Description

Displays in Claim Type Maintenance, Service Inquiry and on the Select Procedure Codes dialog for many reports. Examples are: Office, Hospital, Covered, Non-Covered, Immunizations.

Add members to a procedure group

Add members to a procedure group using the **Procedure Group Members** tab in **Procedure Group Maintenance**.

1. Go to **System Administration > File Maintenance > Procedure Group Maintenance**.
2. Click the **Procedure Group Members** tab.
3. Click  to add a new row to the grid.
4. Enter the procedure code.
 - > Enter the procedure code description in the box and press **TAB**.
 - > Press  to open a window and search for the procedure code to add. Click **OK**.
5. Click **Save**.

Procedure Series Maintenance window

Procedure Series Maintenance contains these tabs:

- > **Procedure Series**
- > **Procedure Series Members**

To access **Procedure Series Maintenance**, go to **System Administration > File Maintenance > Procedure Series Maintenance** or press **F9** and then enter **PEM**.

Procedure Series tab

A procedure series is a way of grouping procedures which are generally performed at a particular type of visit. A procedure series is essentially an explosion code.

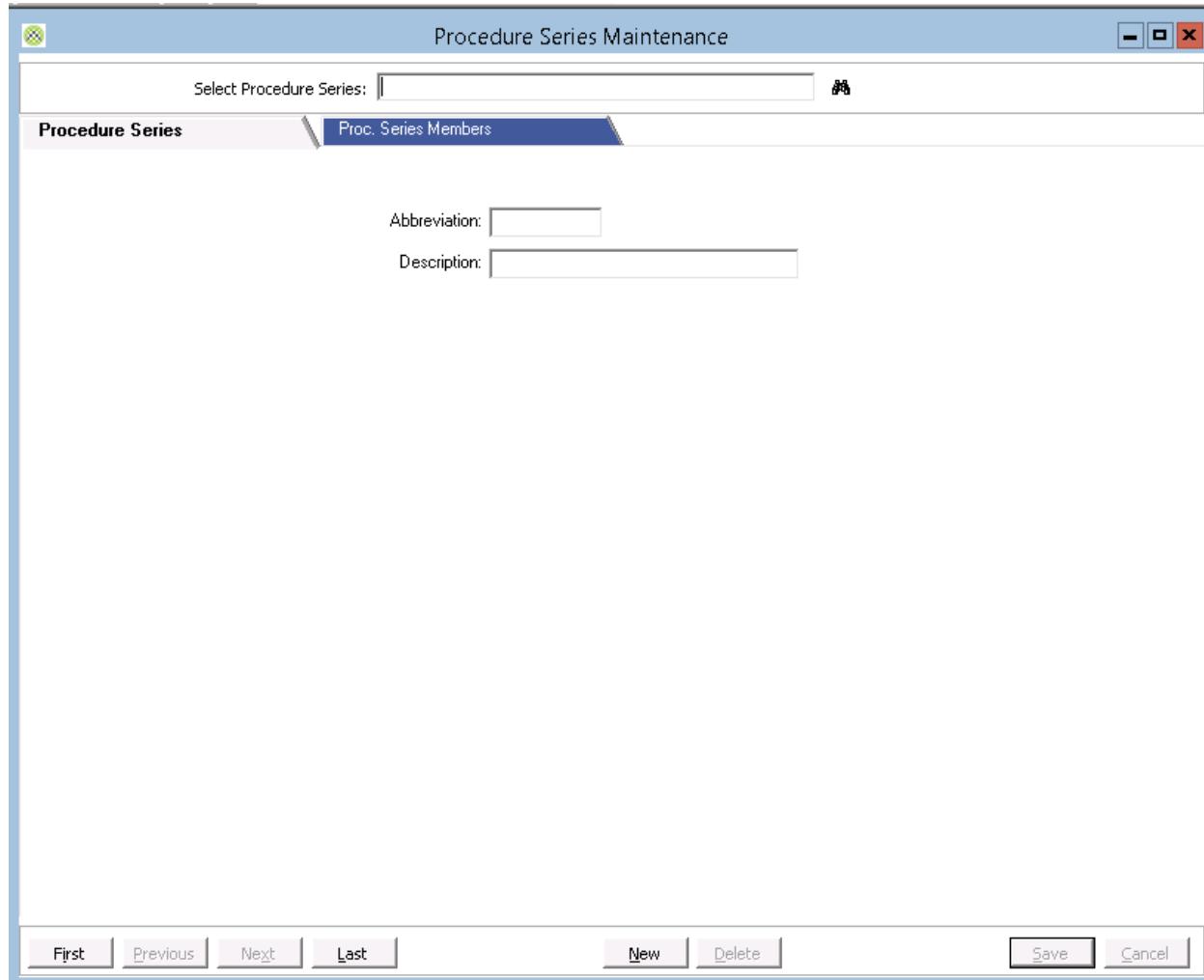
You then use the series in Charge Entry essentially as an explosion code.

For example, to create the procedure series New Patient Evaluation each procedure that is normally performed when a new patient is seen is entered as a series member.

At the time of Charge Entry when the abbreviation for this series is entered in **Procedure Series** the service lines auto-fill with those procedure codes you selected as its members. This saves

keystrokes when entering procedures that are generally always performed at a particular type of visit.

Access the **Procedure Series** tab from **Procedure Series Maintenance**. To access **Procedure Series Maintenance**, go to **System Administration > File Maintenance > Procedure Series Maintenance** or press **F9** and then enter **PEM**.



Abbreviation

Holds up to 8 characters

Must be unique to the record you are creating

Used in Charge Entry as the Access Code, that is the code you enter to in the field, to fill the service line grid with the series members.

Description

Holds up to 35 characters and spaces

Displays as the results of a procedure series lookup and displays on the select records dialogs for reports that you can restrict by Procedure Code.

Add members to a procedure series

Add members to a procedure group using the **Procedure Series Members** tab in **Procedure Series Maintenance**. Enter the codes in the order they are to appear on the voucher.

1. Go to **System Administration > File Maintenance > Procedure Series Maintenance**.
2. Click the **Procedure Series Members** tab.
3. Click  to add a new row to the grid.
4. Enter the procedure code.
 - > Enter the procedure code description in the box and press **TAB**.
 - > Press  to open a window and search for the procedure code to add. Click **OK**.
5. Click **Save**.

Revenue Code Maintenance window

Use **Revenue Code Maintenance** to create 3-digit revenue codes that print on the UB-04 claim form.

A revenue code may be linked either to a procedure group or a specific list of procedure codes defined as revenue code members.

- > A procedure group can be linked to only one revenue code.
- > A procedure code can be selected as a member of one revenue code only.
- > A procedure code that is a member of a procedure group linked to a revenue code cannot be used as a member for another revenue code.

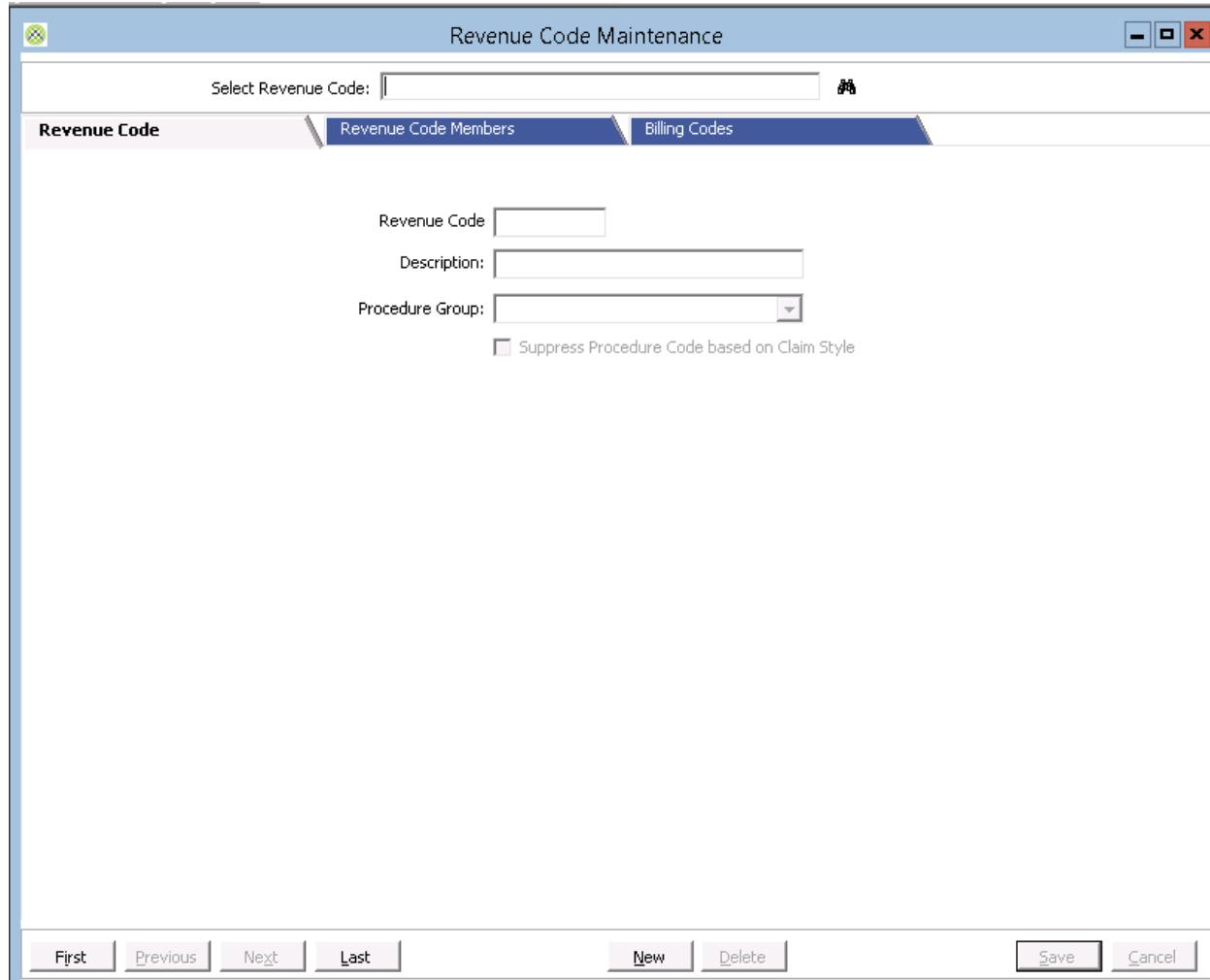
Revenue Code Maintenance contains these tabs:

- > **Revenue Code**
- > **Revenue Code Members**
- > **Billing Codes**

To access **Revenue Code Maintenance**, go to **System Administration > File Maintenance > Revenue Code Maintenance** or press **F9** and then enter **RVC**.

Revenue Code tab

Access the **Revenue Code** tab from **Revenue Code Maintenance**. To access **Revenue Code Maintenance**, go to **System Administration > File Maintenance > Revenue Code Maintenance** or press **F9** and then enter **RVC**.



The screenshot shows the 'Revenue Code Maintenance' window. At the top, there is a search bar labeled 'Select Revenue Code:' with a magnifying glass icon. Below the search bar, there are three tabs: 'Revenue Code' (selected), 'Revenue Code Members', and 'Billing Codes'. Under the 'Revenue Code' tab, there are four input fields: 'Revenue Code' (with a dropdown arrow), 'Description' (with a dropdown arrow), 'Procedure Group' (with a dropdown arrow), and a checkbox labeled 'Suppress Procedure Code based on Claim Style'. At the bottom of the window, there are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save' (highlighted in blue), and 'Cancel'.

Revenue Code

Type in the actual code required on your claims. Prints in Form Locator 42 on a standard UB-04 paper claim form.

Description

Prints in Form Locator 43 on a standard UB-04 paper claim form

Procedure Group

Combo box which contains the list of Procedure Groups you created in Procedure Group maintenance.

Note: You can associate Revenue Codes with a Procedure Group only if you assigned a procedure code as a member to only one Procedure Group. If you assigned procedure codes to multiple groups, you must use the Revenue Code Members tab to link Revenue Codes to Procedure Codes.

Suppress Procedure Code based on Claim Style

Works in conjunction with the Claim Style Output Option **Suppress Procedure Codes by Revenue Code?**.

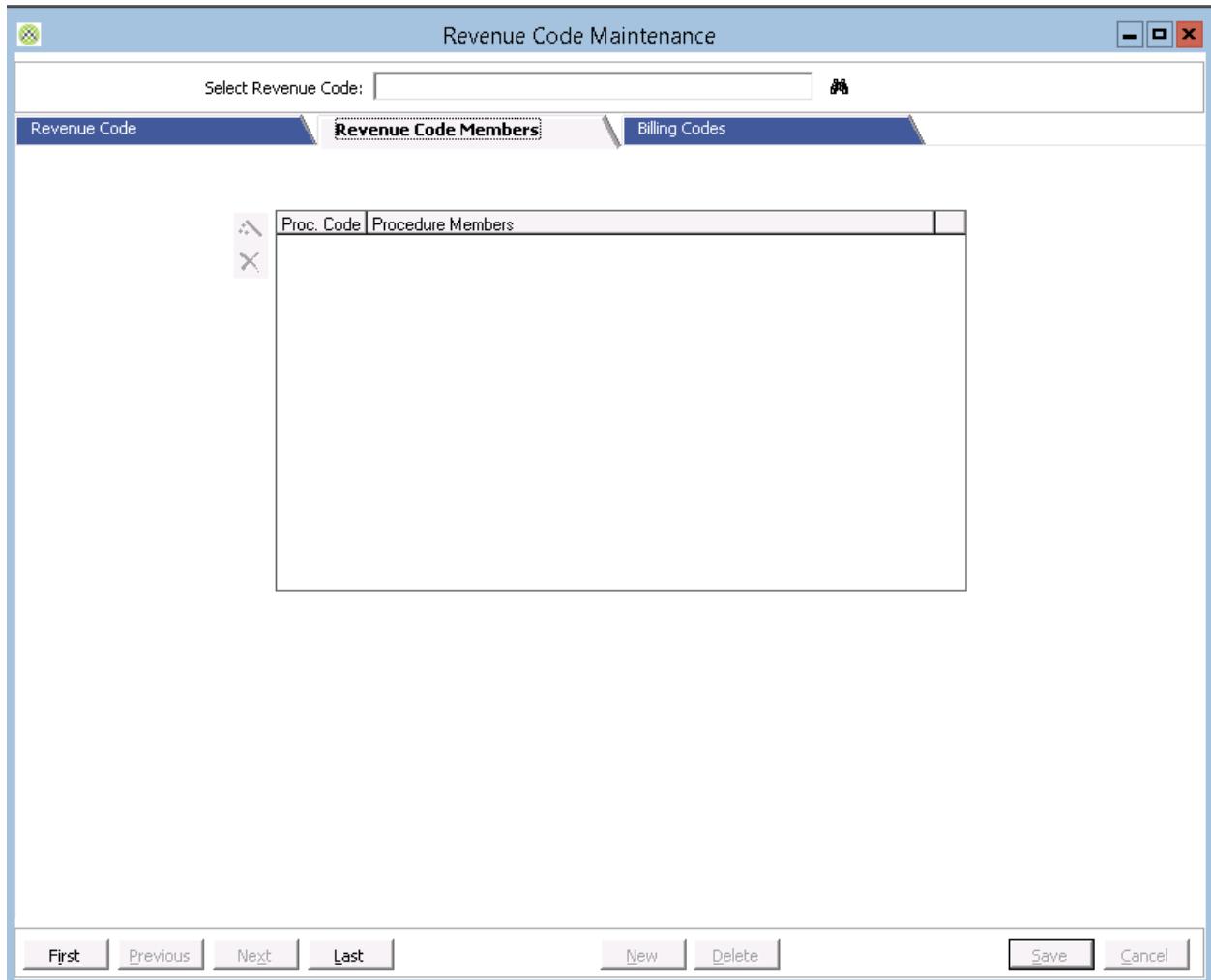
When both options are checked for a claim's associated claim style and revenue code, the Service Line Procedure Code data element (Loop 2400/Segment SV2-02) does not output in a Standard ANSI X12N 837I v4010A1 electronic claim file.

Revenue Code Members tab

Press **INSERT** or click  to add the procedure codes that make up the services included in this revenue code.

Note: You are prevented from using a procedure code that is a member of another revenue code or is a member of a procedure group linked to another revenue code.

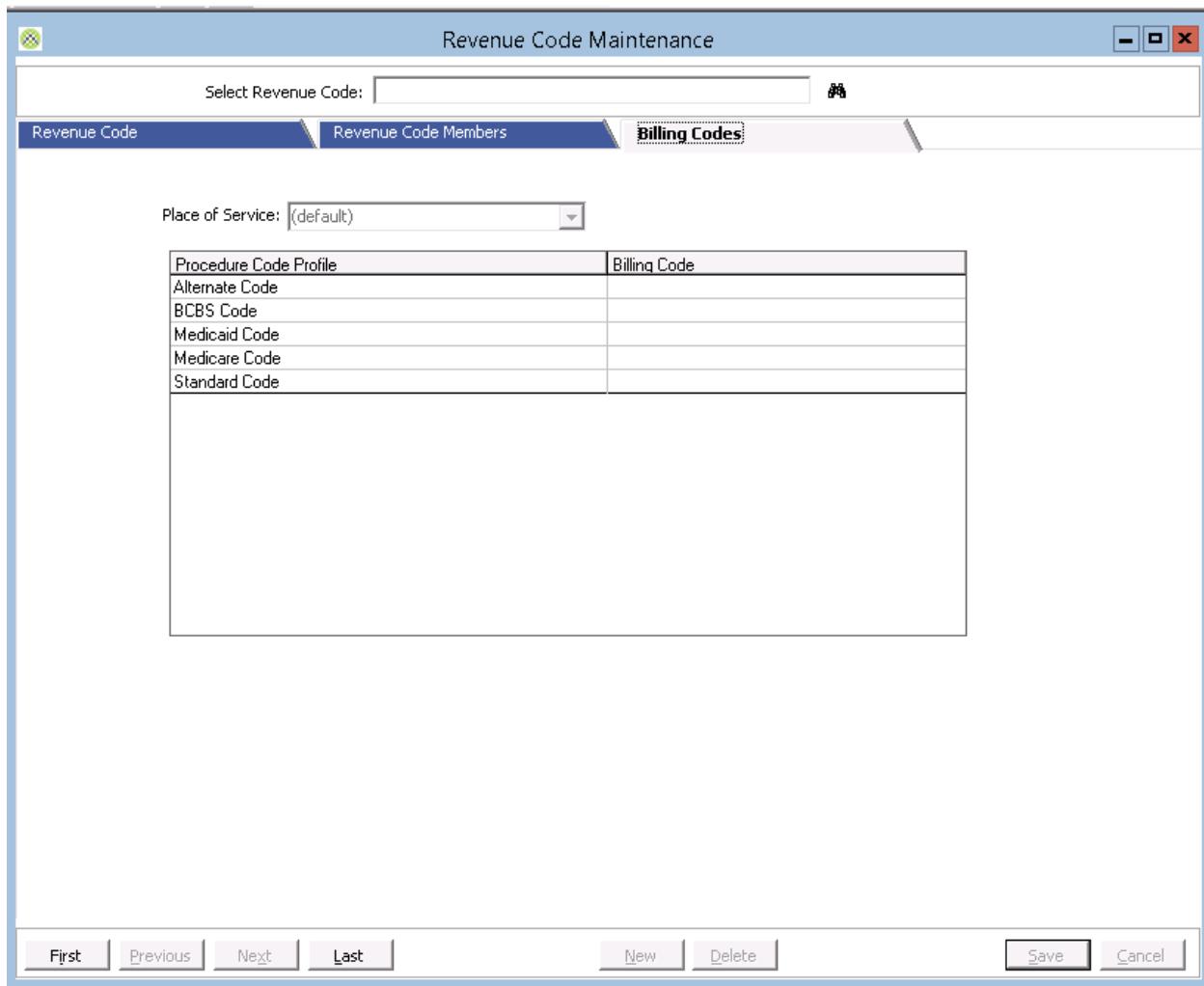
Access the **Revenue Code Members** tab from **Revenue Code Maintenance**. To access **Revenue Code Maintenance**, go to **System Administration > File Maintenance > Revenue Code Maintenance** or press **F9** and then enter **RVC**.



Billing Codes tab in Revenue Code Maintenance

Enter Revenue Code Billing Codes for the Procedure Code Profiles. If you do not have different codes depending on the place of service (used by RHCs and FQHCs), all codes should be entered under the (default) Place of Service.

Access the **Billing Codes** tab from **Revenue Code Maintenance**. To access **Revenue Code Maintenance**, go to **System Administration > File Maintenance > Revenue Code Maintenance** or press **F9** and then enter **RVC**.



Place of Service

Allows Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to report revenue codes on claims by sites of service.

The program outputs the correct Billing Code when preparing claims based on the Place of Service entered in Charge Entry.

The system checks for the existence of Billing Codes for specific Places of Services. If none exists then the Billing Codes entered for the default Place of Service output to the claim form or file.

Important: Always begin by entering billing codes with the setting at (default).

Batch Category Maintenance window

Batch categories allow you to group your batches to better meet your reporting and accounting needs.

The following are examples of how batch categories can be used:

- > You want to balance by locations where money is collected so your batch categories would be equivalent to the office locations.
- > You want to balance by the bank where money gets deposited, so your batch categories would be equivalent to the different banks where you deposit money.

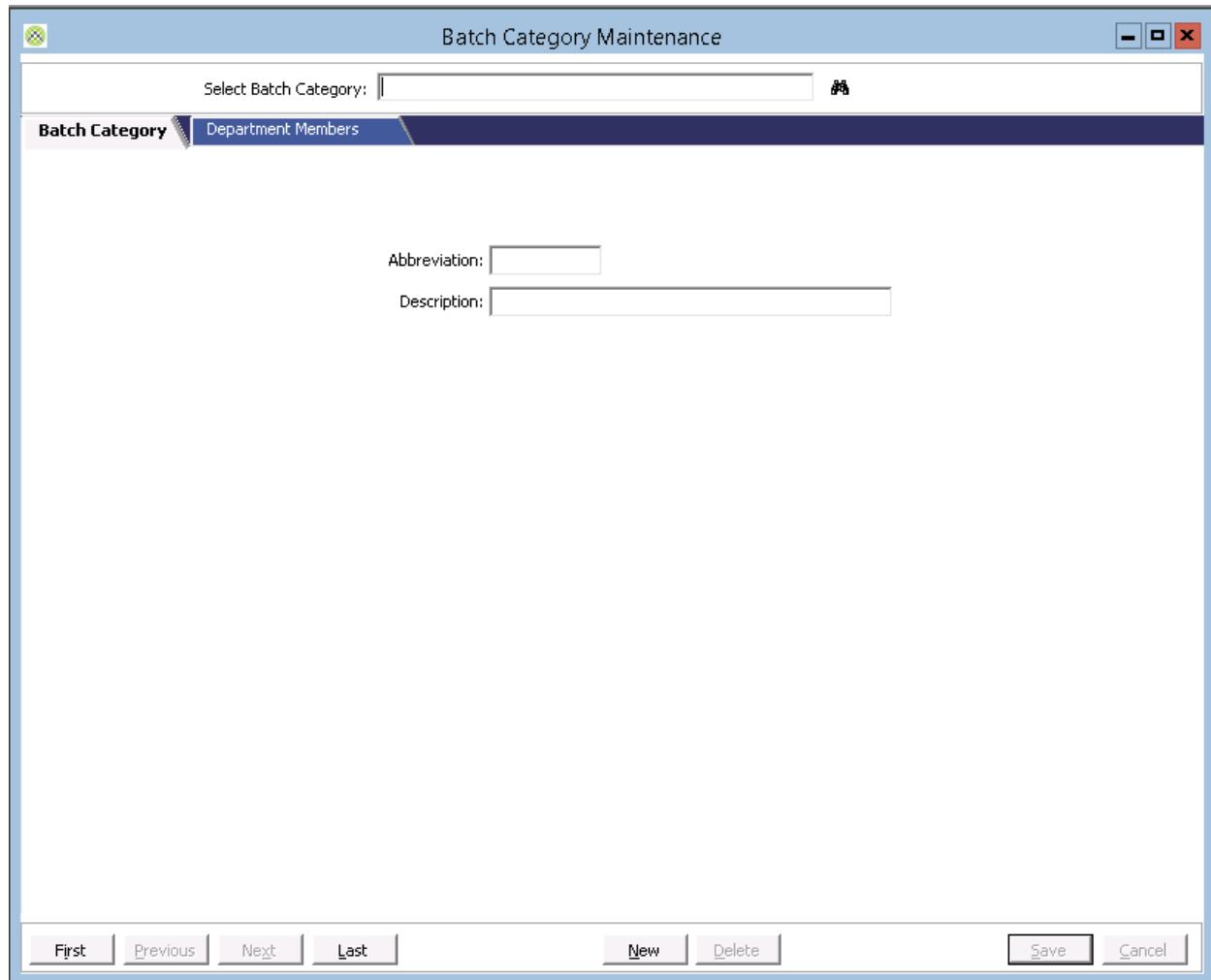
Batch Category Maintenance contains these tabs:

- > **Batch Category**
- > **Department Members or Practice Members**

To access **Batch Category Maintenance**, go to **System Administration > File Maintenance > Batch Category Maintenance** or press **F9** and then enter **BTM**.

Batch Category tab

Access the **Batch Category** tab from **Batch Category Maintenance**. To access **Batch Category Maintenance**, go to **System Administration > File Maintenance > Batch Category Maintenance** or press **F9** and then enter **BTM**.



Abbreviation

Displays in the Batch Management Screen grid

Description

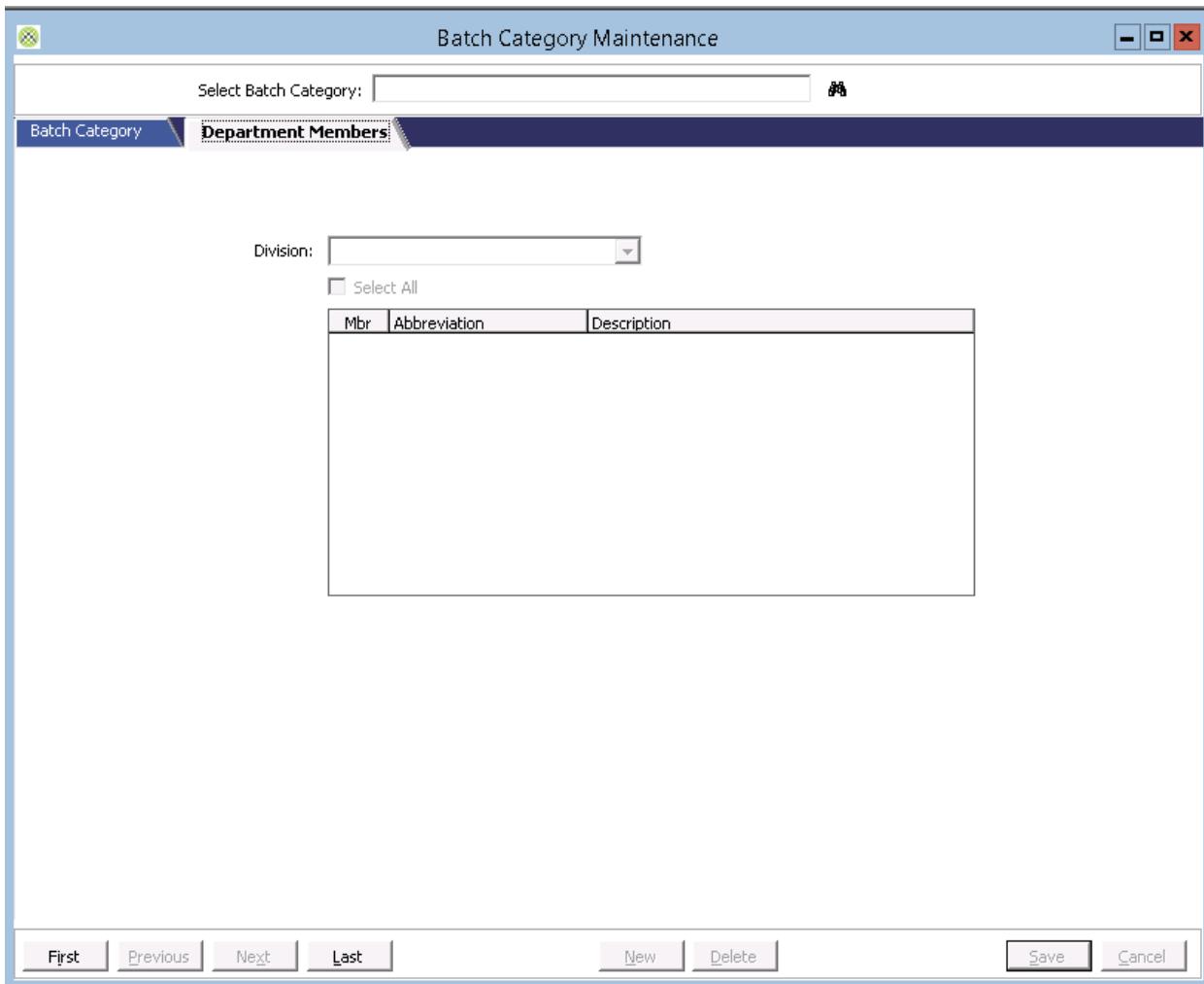
Displays as a combo box selection

Department Members or Practice Members tab in Batch Category Maintenance

You must select department or practice members for each record that has a members tab.

This tab is only displayed when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Access the **Department Members** or **Practice Members** tab from **Batch Category Maintenance**. To access **Batch Category Maintenance**, go to **System Administration > File Maintenance > Batch Category Maintenance** or press **F9** and then enter **BCM**.



Division

This box is only available when you select **Enable Divisions** on the **Multi Entity** tab in **Practice Options** or **Organization Options**, which enables the selection of department or practice members at the division level.

Note: Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you elect to enable divisions, you must create divisions in **Division Maintenance**. Divisions can be used as a group field, or select records option in reporting. .

Quick Pay Override Reason Maintenance window

Use **Quick Pay Override Reason Maintenance** to define reasons for not entering a payment amount in **Quick Payment**.

Quick Pay Override Reason Maintenance contains these tabs:

- > Quick pay Override Reason
- > History

To access **Quick Pay Override Reason Maintenance**, go to **System Administration > File Maintenance > Quick Pay Override Reason Maintenance**, or press **F9** and then enter **QPO**.

Quick Pay Override Reason tab

Use the **Quick Pay Override Reason** tab to define reasons for not entering a payment amount in **Quick Payment**.

Access the **Quick Pay Override Reason** tab from **Quick Pay Override Reason Maintenance**.

To access **Quick Pay Override Reason Maintenance**, go to **System Administration > File Maintenance > Quick Pay Override Reason Maintenance**, or press **F9** and then enter **QPO**.

Quick Pay Override Reason Maintenance ×

Select Quick Pay Override Reason: 

Quick Pay Override Reason  History 

Abbreviation:

Description:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Abbreviation

Required. A unique abbreviation of up to eight alphanumeric characters; avoid special characters.

Description

Required. A unique description of up to 40 alphanumeric characters.



Chapter 8 Charge Entry File Maintenance

Chapter 9

Billing File Maintenance

Billing File Maintenance setup checklist

Billing file maintenance comprises all the pieces of setup required to generate an insurance claim. Accuracy in completing this setup leads to your producing clean claims both in print and electronic formats.

Use this checklist to record the completion of each maintenance record.

Maintenance	Completed
Paper Claim Format Maintenance (PCF)	
Electronic Claim Format Maintenance (ECM)	
Claim Style Maintenance (CSM)	
General tab on Practice Options or Organization Options (POP/OOP)	
Insurance Category Maintenance (ITM)	
Insurance Reporting Class Maintenance (IRM)	
Insurance Network Maintenance (INM)	
L&I Services Maintenance (LIM)	
Benefit Covered Service Maintenance (BCS)	
Insurance Carrier Maintenance	
Insurance Group Maintenance (IGM)	
Ailment Type Maintenance (ALM)	
Claim Type Maintenance (CTM)	
Federal ID Maintenance (FIM)	
Billing Name Maintenance (BNM)	
Address Maintenance (ADM)	

Maintenance	Completed
Claim Edit Category Maintenance(CEC)	
Claim Edit Management (CEM)	

Billing by place of service setup

If your practice or organization must bill for a specific line of business at a physical location, you can bill by place of service.

Billing by place of service functionality is available for electronic claims with the **Professional ANSI 837P v5010** or **Professional ANSI 837P v5010A1** format types and paper claims with the **ICD10 Generic Medical Claim Form** format type.

Before you can bill by place of service, you must enter applicable federal tax identification (ID) numbers, billing names, and billing addresses in **Federal ID Maintenance**, **Billing Name Maintenance**, and **Address Maintenance**, respectively.

Electronic claims

Billing by place of service for v5010 professional electronic claims requires the following additional setup:

- > In **Electronic Claim Format Maintenance**, set **Billing Method** and **Billing Numbers** on the **Electronic Claim Format** tab to **Place of Service** for the applicable electronic claim formats.
 - | **Note:** **Billing Numbers** is only available when **Billing Method** is set to **Place of Service**.
- > In **Claim Style Maintenance**, set **Billing Provider Tax ID Option** on the **Output Options** tab to **Place of Service** for the applicable electronic claim styles.
- > In **Place of Service Maintenance**, enter the billing numbers, taxonomy codes, billing names, billing addresses, and tax information on the **Billing Method Information** tab for the applicable places of service.

Paper claims

Billing by place of service for CMS 1500 ICD-10 Standard (02/12) paper claims requires the following additional setup:

- > In **Paper Claim Format Maintenance**, set **Tax ID Source** to **Federal ID** and set **Option** to **Place of Service** on the **Paper Claim Format** tab for the applicable paper claim formats.
- > In **Paper Claim Format Maintenance**, set **Group Billing No Option** and **Billing Address Option** on the **Paper Claim Format** tab to **Place of Service** for the applicable paper claim formats.

- > In **Place of Service Maintenance**, enter the billing numbers, taxonomy codes, billing names, billing addresses, and tax information on the **Billing Method Information** tab for the applicable places of service.

Paper Claim Format Maintenance window

Paper Claim Format Maintenance enables you to define formats used when printing claims.

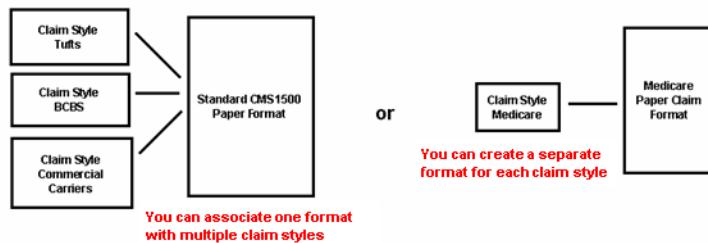
You must associate each claim format you create with 1 of these programmed format types:

- > CA CHDP Assessment Claim Form
- > Dental Claim Form
- > Generic Medical Claim Form
- > ICD10 Generic Medical Claim Form
- > NY Workers' Comp Claim Form
- > Uniform Billing Claim Form

When creating a paper claim style, you must assign it a paper claim format that tells the application which information to print out on the claim form.

You can associate a paper claim format with more than 1 claim style. Picture your created paper claim format as being the actual print form, for example the CMS-1500 NPI claim form with all of its boxes. The claim style is the tool you use to individualize the format to a carrier's unique specifications for such things as a required format used for reporting the subscriber's certificate number, the allowed maximum number of diagnoses you can enter on a claim, the printing of a CLIA or Mammography number, and so forth.

Remember, it is the claim style that defines the distinctive validation and output options that a carrier requires when you submit a claim. In some instances, you may want to create a one-to-one match between a claim format and a claim style. You may also determine that you can use 1 claim format with multiple claim styles. The diagram illustrates your choices.



Sample formats

Examples of some standard formats are:

- > CMS-1500 NPI Standard format

- > Your State Medicaid format
- > A specific HMO format, such a HMO Blue or Tufts
- > A Worker's Comp format
- > A Standard UB-04 format

Allscripts® provides numerous standard paper claim formats that are programmed to carrier and vendor specifications. In addition when necessary a custom format is created specifically for your practice or organization. For assistance, contact an Allscripts® professional services representative.

We are using the Standard CMS-1500 NPI format based on Medicare specifications to supply you with output examples. Actual output is governed by a combination of the settings made here in **Paper Claim Format Maintenance** and those you make in the format's associated claim style.

Claim formats should be defined with the assistance of a member of the Allscripts® Support or training team.

Paper Claim Format Maintenance contains these tabs:

- > **Paper Claim Format**
- > **Anesthesia Info**
- > **Uniform Billing Info**
- > **RHC Billing Info**

Access **Paper Claim Format Maintenance** from **System Administration > File Maintenance > Paper Claim Format Maintenance** or press **F9**, and then enter **PCF**.

Paper Claim Format tab

Paper Claim Format is the first tab in **Paper Claim Format Maintenance**. Use it to create paper claim formats.

Access the **Paper Claim Format** tab from **Paper Claim Format Maintenance**. To access **Paper Claim Format Maintenance**, go to **System Administration > File Maintenance > Paper Claim Format Maintenance** or press **F9** and then enter **PCF**.

Paper Claim Format Maintenance X

Select Paper Claim Format: []

Paper Claim Format [] Anesthesia Info [] Uniform Billing Info [] RHC Billing Info []

Abbreviation:	<input type="text"/>	Subtype:	<input type="text"/>	Option:	<input type="text"/>
Description:					<input type="checkbox"/> Test Billing
Format Type:					<input type="checkbox"/> Include \$0.00 Charge Services
Report Name:					<input type="checkbox"/> Include Insurance Payments
Alternate Report Name:					<input type="checkbox"/> Include Insurance Adjustments
Carrier Address Option:					<input type="checkbox"/> Include Self-Pay Payments
Referring Doctor Option:					<input type="checkbox"/> Include Self-Pay Adjustments
Supervising Phys. Option:					<input type="checkbox"/> Include Phone In Billing Address
Diagnosis Option:					<input type="checkbox"/> Print Name if Insured is Patient
Service Line Option:					<input type="checkbox"/> Print Addr if Insured is Patient
Tax ID Source:					<input type="checkbox"/> Print Six-Digit Dates (mm/dd/yy)
Phys. Signature Option:					<input type="checkbox"/> Print Decimal Point in Currency
Indiv. Billing No. Option:					<input type="checkbox"/> Print Decimal Point in Diagnosis
Group Billing No. Option:					<input type="checkbox"/> RHC Billing
Billing Address Option:					
Release of Information:					
Auth. for Payment:					

First Previous Next Last
 New Delete
 Save Cancel

Abbreviation

An abbreviation used to identify the format in selection lists. Holds a maximum of 8 characters. It is a best practice to use the naming convention indicated in the project documentation provided by Allscripts®.

Description

Describes the use of the format. Holds a maximum of 40 characters. It is a best practice to use the naming convention indicated in the project documentation provided by Allscripts®.

Displays as a selection when you associate a format with a claim style in **Claim Style Maintenance**.

Format Type

Determines the source used to print data on the form:

CA CHDP Assessment Claim Form

Generates claims on the PM160 Standard Form - Confidential Screening/Billing Report (PM 160, Revised 3/07).

Dental Claim Form

Generates dental claims.

Generic Medical Claim Form

Generates claims printed on a CMS 1500 NPI Standard Claim Form (08/05).

ICD10 Generic Medical Claim Form

Generates claims printed on a CMS 1500 ICD-10 Standard Claim Form (02/12).

NY Workers' Comp Claim Form

Generates New York Workers' Compensation claim forms:

- > New York Workers' Compensation CMS 1500 (prints on the CMS 1500 ICD-10 Standard Claim Form (02/12))
- > Doctor's Initial Report C-4.0 (10-15)
- > Doctor's Progress Report C-4.2 (10-15)
- > Doctor's Report of Maximum Medical Improvement/Permanent Partial Impairment C-4.3 (05-22)
- > Ancillary Medical Report C-4 AMR (10-15)

Note: Use New York Workers' Compensation CMS 1500 ICD-10 (02/12) or Doctor's Report of Maximum Medical Improvement/Permanent Partial Impairment C-4.3 (05-22) if paper claims are needed. The C-4.0 (10-15), C-4.2 (10-15), and C-4 AMR (10-15) forms are no longer accepted by the New York Workers' Compensation Board (NYWCB) after July 1, 2022.

When you select **NY Workers' Comp Claim Form** as the format type, the following four boxes replace the **Report Name** and **Alternate Report Name**.

- > **Doctor's Initial Report:** Enter NYWCMS1500ICD10.rpt (replaces NYC40.rpt).
- > **Doctor's Progress Report:** Enter NYWCMS1500ICD10.rpt (replaces NYC42.rpt).
- > **Doctor's Report of MMI/Perm. Impair.:** Enter NYC43_0522.rpt.
- > **Ancillary Medical Report:** Enter NYWCMS1500ICD10.rpt (replaces NYC4AMR.rpt).

Uniform Billing Claim Form

Generates claims printed on a UB-04 form.

Format Subtype

Directs the application to browse a specific directory path when searching for the report name. There are 2 choices:

Standard

Select **Standard** when you are using a standardized report delivered with an Allscripts® Practice Management installation or upgrade.

Points to files with the extension of `.rpt` that are stored on your C drive under `C:\ProgramFiles\CompuSense\ntierprise for Healthcare\Crystal Report Files`.

Custom

Select **Custom** when you are using a report that Allscripts® was customized specifically for your practice, or you downloaded prior to upgrading to the release that contains the `.rpt`.

Points to files with the extension of `.rpt` stored on your application server.domain in the shared `NtierFiles\<Tenant Name>\Custom Crystal Reports` subdirectory.

Report Name

Enter the name of the `.rpt` file, exactly as given to you by a member of the Allscripts® Support or Training team. This file contains all the programming used to output and print data onto the form.

Important: Your entry must end with the file extension `.rpt`.

Note: Formats with a report name that contains the words "CMS1500"(either in upper or lower case) trigger the option "View CMS-1500Image" in **Unpaid Claims Management**. Be sure that you do not include a space between CMS and 1500 or use a hyphen or other special character.

Alternate Report Name

Enter an alternate report name to be used when you must print claims to the carrier on a different form based on criteria such as place of service, type of service, the rendering provider, or as part of the carrier's billing process.

Examples of when you might use alternate report names:

- > Massachusetts Medicaid requirements for the use Form 5 or Form 9 based on the rendering Provider
- > Used when you are required to print claims for the same carrier using either of two forms, for example, as in the case of Massachusetts Medicaid. The paper claim processing for

MAMedicaid5.rpt is hard-coded to only include vouchers that are rendered by an actual physician as designated in **Provider Maintenance** and **Referring Doctor Maintenance**. While paper claim processing for MAMedicaid9.rpt is hard coded to only include vouchers that are rendered by a non-physician.

Enter the report name exactly as you are directed. Be sure to end the report name with the file extension ".rpt."

See "Using an Alternate Report Name in Paper Claim Billing" for more information.

Carrier Address Option

Determines whether the carrier address prints on the top right or top left of the form. If you leave this box blank, the carrier address does not print on the form at all. Refer to the carrier's specifications to make the correct selection.

Referring Doctor Option

Prints in Box 17a on a Standard CMS-1500 NPI form unless a referral number is entered in **Miscellaneous Box 17 text** on **Claim Info**. The options include the following:

Referring Dr. Billing No.

This information comes from the **Billing Numbers** tab in **Referring Doctor Maintenance**. The printed qualifier information includes:

- > The value entered in **ANSI 837P Qualifier Code for Referring Prov (Loop 2310A)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > One of the following qualifiers when a match is found between the entry on the **Billing Numbers** tab and either the Federal ID, SSN or UPIN entered on the **Referring Doctor** tab. Note the entry on the **Billing Numbers** tab must not contain hyphens while the entry in the corresponding field can contain hyphens.
 - SY: This qualifier prints when the number on the **Billing Numbers** tab matches the SSN
 - EI: This qualifier prints when the number on the **Billing Numbers tab** matches the Federal ID
 - 1G: This qualifier prints when the number on the **Billing Numbers** tab matches the UPIN
- > Cross references the carrier's Source of Payment and prints the Qualifier that corresponds to the carrier's Source of Payment

Referring Dr. State Lic. No.

Pulls from the **State License Number** box on the **Additional Info** tab in **Referring Doctor Maintenance**. Prints the referring doctor's state license number preceded by "0B" (zero B).

Note: The carrier's associated paper claim style must have the output option **Output State License Number** selected.

Referring Dr. Indiv. Taxonomy Code

Pulls from the **Taxonomy Code** column on the **Billing Numbers** tab in **Referring Doctor Maintenance**. Prints the referring doctor's taxonomy code preceded by "ZZ".

Note: The carrier's associated claim style must have the output option **Output Taxonomy Code** selected.

Referring Dr. UPIN

Pulls from the **UPIN** box on the **Referring Doctor** tab in **Referring Doctor Maintenance**. Prints the UPIN preceded by "1G"

Supervising Phys Option

Enabled only when you select **ICD10 Generic Medical Claim Form** for **Format Type**. Determines the ID number that prints in Box 17a on the CMS 1500 ICD-10 Standard Claim Form (02/12). The selections include the following:

- > **Supervising Phys Billing No**
- > **Supervising Phys State License No**
- > **Supervising Phys Indiv Taxonomy**
- > **Supervising Phys UPIN**
- > **Supervising Phys State Location No**

If you make a selection for **Supervising Phys Option** and then change **Format Type** to something other than **ICD10 Generic Medical Claim Form**, **Supervising Phys Option** is cleared, and the box becomes unavailable.

Diagnosis Option

Prints in Box 24E on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12). Click the down arrow and select one of the following options:

Cross Reference

Prints the cross reference number or numbers which correspond to the diagnoses printed in Box 21.

Diagnosis Code

Prints the actual diagnosis codes (ex. 401.9). Prints the code without the decimal point when **Print Decimal Point in Diagnosis** is cleared.

Primary Diagnosis Code

Prints the first diagnosis code listed in Box 21.

Primary Cross Reference

Prints the cross reference # which corresponds to the first diagnosis code listed in Box 21.

Service Line Option

Prints in Box 24J on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

- > Blank
- > Actual Provider Indiv. No. - pulls from the Billing Numbers tab in Provider Maintenance
Prints the Rendering Provider's Individual Billing Number preceded with "1D"
- > Actual Provider Group No. - available only when you select the Format Type "Generic Medical Claim Form"
Pulls from the "Group Number" column on the Billing Numbers tab in Provider Maintenance
- > Actual Provider Other No. available only when you select the Format Type "Generic Medical Claim Form"
Pulls from the "Other Number(s)" column on the Billing Numbers tab in Provider Maintenance
Prints the Rendering Providers Other Billing Number preceded with "1D"
Use this option for those carriers who have different requirements for submitting billing numbers when you bill a claim on paper and when you bill electronically.
An example of such a carrier is NHIC Medicare who requires an 8 digit billing number that includes 2 control letters to print in Box 24J. However, for electronic billing, the control letters preceding the Medicare B provider number are not to be used.
- > Actual Provider State Lic. No. - available only when you select the Format Type "Generic Medical Claim Form"
Pulls from the State License Number field on the Additional Info tab in Provider Maintenance
Prints the Rendering Provider's License Number preceded with "0B"
 - || **Note:** The Output State Lic. No.? Output Option must also be checked for the paper claim style assigned to the carrier.
- > Actual Provider Indiv. Taxonomy - available only when you select the Format Type "Generic Medical Claim Form"
Pulls from the "Taxonomy" column on the Billing Numbers tab in Provider Maintenance
Prints the rendering Provider's Taxonomy Code preceded with "ZZ"
 - || **Note:** The Output Taxonomy Code? Output Option must also be checked for the paper claim style assigned to the Carrier.

- > Actual Provider Group Taxonomy - available only when you select the Format Type "Generic Medical Claim Form"

Pulls from the column labeled "Group Taxonomy" on the Billing Numbers tab in Provider Maintenance

Prints the rendering Provider's Group Taxonomy Code preceded with "ZZ"

Note: The Output Taxonomy Code? Output Option must also be checked for the paper claim style assigned to the Carrier

- > Actual Provider Zip Code - pulls from Zip Code field on the Provider tab in Provider Maintenance

Prints without qualifier

- > Billing Provider Indiv. No - pulls from the Billing Numbers tab in Provider Maintenance

Prints the Billing Provider's Indiv. Provider Number preceded with "1D"

- > Billing Provider Group No. - available only when you select the Format Type "Generic Medical Claim Form"

Pulls from the "Group Number" column on the Billing Numbers tab in Provider Maintenance

- > Billing Provider Other No. - available only when you select the Format Type "Generic Medical Claim Form"

Pulls from the Provider Maintenance "Other Number(s)" column of the billing provider entered on the claim

Prints the Billing Provider's Other Number preceded with "1D"

Use this option for those carriers who have different requirements for submitting billing numbers when you bill a claim on paper and when you bill electronically.

An example of such a carrier is NHIC Medicare who requires an 8 digit billing number that includes 2 control letters to print in Box 24J. However, for electronic billing, the control letters preceding the Medicare B provider number are not to be used.

- > Billing Provider State Lic. No. - available only when you select the Format Type "Generic Medical Claim Form"

Pulls from the State License Number field on the Additional Info tab in Provider Maintenance

Note: The Output State Lic. No.? Output Option must also be checked for the paper claim style assigned to the carrier

- > Billing Provider Indiv. Taxonomy - available only when you select the Format Type "Generic Medical Claim Form" Pulls from the "Taxonomy" column on the Billing Numbers tab in Provider Maintenance

Prints the Billing Provider's Taxonomy Code preceded with "ZZ"

|| **Note:** The Output Taxonomy Code? Output Option must also be checked for the paper claim style assigned to the carrier

- > Billing Provider Group Taxonomy - available only when you select the Format Type "Generic Medical Claim Form"

Pulls from the column labeled "Group Taxonomy" on the Billing Numbers tab in Provider Maintenance

Prints the Billing Provider's Group Taxonomy Code preceded with "ZZ"

|| **Note:** The Output Taxonomy Code? Output Option must also be checked for the paper claim style assigned to the carrier.

- > Modifier 2 - prints the service's second Modifier code in Box 24J instead of in Box 24D

Prints without a Qualifier

- > POS Billing No. - pulls from the Billing Numbers tab in Place of Service maintenance

Prints the Billing Number preceded with "1D"

Tax ID Source

Prints in Box 25 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12). Click the down arrow and select one of the following options.

Federal ID

Select this option if your practice or organization bills using a federal tax id number.

Social Security Number

Select this option if your practice or organization bills using a provider's Social Security Number.

None

Select if you are billing BCBS of Michigan.

Where the Federal ID or Social Security Number pulls from depends on the option that you select next. In addition, the ID suffix is automatically appended to the Federal ID when **Append ID Suffix to Federal ID** is selected on the **Output Options** tab in **Claim Style Maintenance**.

Option

Controls where the applications finds the numbers to output the Federal ID or the SSN

Click the down arrow located to the right of the field and select one of the following:

- > Actual Provider - pulls the Federal ID or SSN from the provider maintenance record of the actual provider entered on the claim

- > Billing Provider - pulls the Federal ID or SSN from the provider maintenance record of the billing provider entered on the claim
- > Department - pulls the Federal ID or SSN from the file maintenance record of the department entered on the claim
- > Location - pulls the Federal ID or SSN from the file maintenance record of the location entered on the claim
- > Place of Service - pulls the Federal ID from the **Billing Method Information** tab in **Place of Service Maintenance**.
- > Practice - pulls the Federal ID or SSN from the Practice Information tab in Practice Setup

NOTES

- > Michigan clients billing BCBS of Michigan
For the format BCBSM, set the Tax ID Source to "None."
For the format BCN, set the Tax ID Source to "Federal ID" and set the Tax ID Option appropriately for your practice/organization.
- > Providers outside of Michigan who bill BCBS of Michigan
For the format BCBSM, set the Tax ID Source to "Federal ID" or "SSN" and set the Tax ID Option appropriately for your practice/organization.
For the format BCN, set the Tax ID Source to "Federal ID" or "SSN" and set the Tax ID Option appropriately for your practice/organization.

Phys. Signature Option

Prints in Box 31 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

- > Actual Provider Name
- > Billing Provider Name
- > Practice Name
- > Actual Provider Individual Billing Number
- > Billing Provider Individual Billing Number
- > Practice Billing Number
- > Indiv. Billing No. Option

Indiv. Billing No. Option

Does not affect output when using the CMS 1500 NPI Standard Claim Form (08/05) or CMS 1500 ICD-10 Standard Claim Form (02/12).

- > Actual Provider Individual Billing Number
- > Actual Provider Group Billing Number
- > Billing Provider Individual Billing Number
- > Billing Provider Group Billing Number
- > Department Billing Number
- > Location Billing Number
- > Practice Billing Number

Group Billing No. Option

Prints in Box 33a on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

- > Actual Provider Individual Billing Number - pulls from Billing Numbers tab in Provider Maintenance
- > Actual Provider Group Billing Number - pulls from Billing Numbers tab in Provider Maintenance
- > Actual Provider Indiv. Taxonomy Code - pulls from the column labeled "Taxonomy" on the Billing Numbers tab in Provider Maintenance NOTE: You must also check the Output Option "Output Taxonomy Code?" for the paper claim style assigned to the Carrier.
- > Actual Provider Group Taxonomy Code - pulls from the column labeled "Group Taxonomy" on the Billing Numbers tab in Provider Maintenance NOTE: You must also check the Output Option "Output Taxonomy Code?" for the paper claim style assigned to the Carrier.
- > Billing Provider Individual Billing Number - pulls from Billing Numbers tab in Provider Maintenance
- > Billing Provider Group Billing Number - pulls from Billing Numbers tab in Provider Maintenance
- > Billing Provider Indiv. Taxonomy Code - pulls from the column labeled "Taxonomy" on the Billing Numbers tab in Provider Maintenance

Note: You must also check the Output Option "Output Taxonomy Code" for the paper claim style assigned to the Carrier.

- > Billing Provider Group Taxonomy Code - pulls from the column labeled "Group Taxonomy" on the Billing Numbers tab in Provider Maintenance

Note: You must also check the Output Option "Output Taxonomy Code?" for the paper claim style assigned to the Carrier.

- > Department/Practice Billing Number - pulls from the Billing Numbers tab in Department/Practice Maintenance
- > Location Billing Number - pulls from the Billing Numbers tab in Location Maintenance

- > Place of Service - the billing numbers and taxonomy codes are retrieved from the **Billing Method Information** tab in **Place of Service Maintenance** (only applies to CMS 1500 ICD-10 Standard Claim Form (02/12))
- > Practice/Organization Billing Number - pulls from the Billing Numbers tab in Practice/Organization Set Up

Billing Address Option

Prints in Box 33 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

When you select **Place of Service**, the billing name and billing address are retrieved from the **Billing Method Information** tab in **Place of Service Maintenance** (only applies to CMS 1500 ICD-10 Standard Claim Form (02/12)).

Release of Information

Free text field

Holds up to 40 characters, however only 24 characters print in Box12 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

Refer to your Carrier's specifications for directions on how to fill in this field.

The standard entry for this field is, "SIGNATURE ON FILE".

Auth. for Payment

Free text field

Holds up to 40 characters, however only 24 characters print in Box13 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

Refer to your Carrier's specifications for directions on how to fill in this field.

The standard entry for this field is, "SIGNATURE ON FILE".

On the right hand side of the tab is a series of check boxes. Use the **Tab** key to move from one check box to the next. Use the **space bar** to check a box.

Test Billing

CAUTION: This option should only be checked when a test print run is done. When this box is checked the system will not flag the claims that are printed with a bill date.

This means printed claims using this format will continue to qualify for validation and printing.

Include \$0.00 Charge Services

Prints a service line for those procedures on the claim that have a \$0.00 charge.

Checked by default.

Unchecking this option prints only those services which have a charge to print on the form.

With the exception of PQRI or ePrescribe incentive procedure codes billed to Medicare, it is recommended that \$0.00 charges be billed on Self-Pay vouchers.

Include Insurance Payments

Prints the amount of any updated insurance payments applied to the claim in Box 29 on a Standard CMS-1500 NPI form.

When this option is checked in combination with any or all of the following three options each applicable amount that is updated on the claim is included in the total amount printed in Box 29.

Include Insurance Adjustments

Prints the amount of any updated insurance adjustments applied to the claim in Box 29 on a Standard CMS-1500 NPI form.

When this option is checked in combination with the previous option and/or with either or both of the following two options each applicable amount that is updated on the claim is included in the total amount printed in Box 29.

Include Self-Pay Payments

Prints the amount of any updated self-pay payments applied on the claim in Box 29 on a Standard CMS-1500 NPI form.

If your practice or organization uses uninsured carriers, **Include Self-Pay Payments** includes both traditional self-pay payments and payments associated with uninsured carriers.

When this option is checked in combination with either or both of the two previous options or with the following option each applicable amount that is updated on the claim is included in the total amount printed in Box 29.

Include Self-Pay Adjustments

Prints the amount of any updated self-pay adjustments applied on the claim in Box 29 on a Standard CMS-1500 NPI form.

If your practice or organization uses uninsured carriers, **Include Self-Pay Payments** includes both traditional self-pay payments and payments associated with uninsured carriers.

When this option is checked in combination with one or more of the previous 3 options each applicable amount that is updated on the claim is included in the total amount printed in Box 29.

Include Phone In Billing Address

Prints the phone # from the Billing Address Option in Box 33 on Standard CMS-1500 NPI form.

Print Name if Insured is Patient

Prints the patient name in Box 4 of a Standard CMS-1500 NPI form in the following circumstances:

- > when you are billing Medicare as secondary and the subscriber's relationship is self
- > when you are billing a primary Carrier other than Medicare when the subscriber's relationship is self

When you are billing Medicare as primary, and the insured and the patient are the same, Box 4 is left blank even if this option is checked. This is hard coded to comply with CMS specifications.

Print Addr if Insured is Patient

Prints the patient's address in Box 7 on a Standard CMS-1500 NPI form in the following circumstances:

- > when you are billing Medicare as secondary and the subscriber's relationship is self
- > when you are billing a primary Carrier other than Medicare when the subscriber's relationship is self

When you are billing Medicare as primary, and the insured and the patient are the same, Box 7 is left blank even if this option is checked. This is hard coded to comply with CMS specifications.

Print Six-Digit Dates (mm/dd/yy)

Enabled only for format types "Generic Medical Claim Form" and "ICD10 Generic Medical Claim Form".

Prints on the claim form in the following 6-digit format: mm/dd/yy.

Not checking this option prints all dates on the claim form in the following 8-digit format: mm/dd/ccyy.

Print Decimal Point in Currency

When checked prints all charge, payment and adjustment amounts printed on the claim using a decimal point to separate dollars and cents.

When unchecked prints dollar amounts without a decimal and without spaces.

Impacts Boxes 20, 24F, 28, 29, 30.

Refer to your Carrier or vendor's requirements.

Print Decimal Point in Diagnosis Code

When checked prints the diagnosis code with a decimal point.

Unchecked the code is printed without a decimal and without spaces.

Impacts Boxes 21 and 24E when the Diagnosis Option is set to either "Diagnosis Code" or "Primary Diagnosis Code"

Refer to your Carrier or vendor's requirements.

RHC Billing

Important: Call Allscripts® Support for Setup and Billing instructions related to this feature.

Intended for use by practices or organizations who submit claims to a Medicaid program that requires a RHC Encounter Code on the claims that is different from the actual services rendered.

Enabled with the selection of either "General Medical Claim Form ", "ICD10 Generic Medical Claim Form", or "Uniform Billing Claim Form" as a format type.

When checked the following occurs in **Paper Claim Format Maintenance**:

- > **Roll Up Fees by Revenue Code** becomes unavailable on the **Uniform Billing Info** tab
- > The **RHC Billing Info** tab is enabled

For Institutional and Professional paper claim formats, when **RHC Billing** is checked each voucher has an Encounter Service inserted as the first service on the claim.

Click **Save (Alt+s)** to save your entries.

Note: The selected RHC Encounter Revenue Code outputs only to UB-04 claim forms. The code prints in FL 42 and its description prints in FL 43 on the first line of the claim along with its corresponding RHC Encounter Procedure Code.

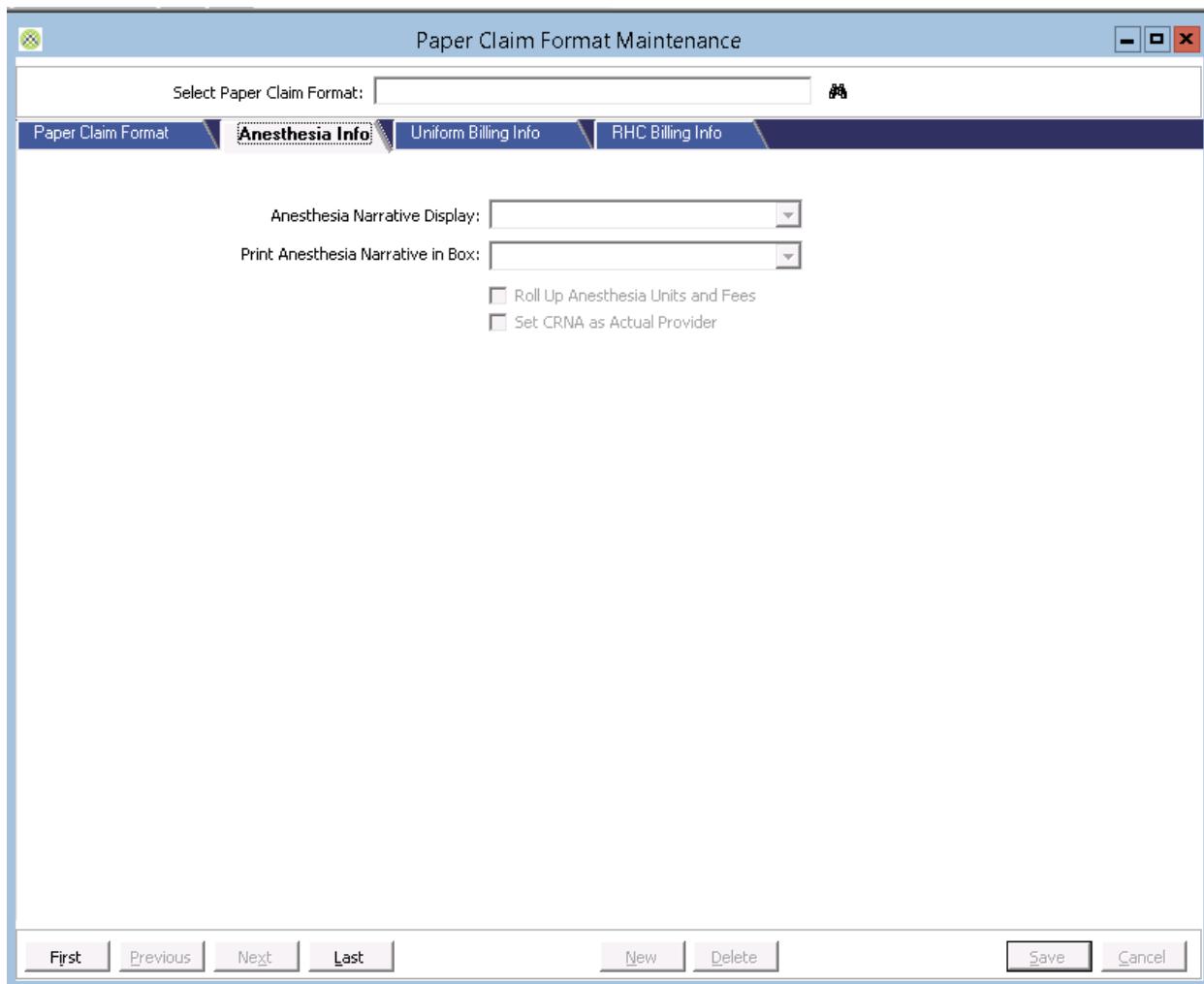
Anesthesia Info tab

Use the **Anesthesia Info** tab in **Paper Claim Format Maintenance (F9 > PCF)** to define how data for anesthesia billing should print on the claim form. Base your selections on the carrier's requirements.

We are using the standard CMS 1500 format based on Medicare specifications to supply you with output examples.

Actual output is governed by a combination of the settings made Paper Claim Format Maintenance and those you make in the format's associated claim style.

Access the **Anesthesia Info** tab from **Paper Claim Format Maintenance**. To access **Paper Claim Format Maintenance**, go to **System Administration > File Maintenance > Paper Claim Format Maintenance** or press **F9** and then enter **PCF**.



Anesthesia Narrative Display

Determines whether the start and stop times for anesthesia services output as either Military Time or Actual Time.

Print Anesthesia Narrative in Box

Determines where the start and stop times print on the form.

There are two options:

- > **Reserved for Local Use** - prints the entered stop and start times for the first anesthesia service line in box 19 on a standard CMS-1500NPI form as "TIME: NN;NNx-NN:NNx (x = AM or PM)."
- > **Procedure Lines Box** - prints the start and stop times in box 24 in the shaded area for each anesthesia service line on a standard CMS-1500NPI form when billing a Carrier other

than Medicare. Format used is NN>NNx – NN>NNx” (x = Am or Pm), preceded by the qualifier “7”.

Roll Up Anesthesia Units and Fees

Only check when you want the following to occur:

- > Total charges and units for all anesthesia services print on the first anesthesia service line in boxes 24F and 24G respectively
- > Zero prints on all subsequent anesthesia service lines

Set CRNA as Actual Provider

Check when the payer requires that timed anesthesia services rendered by both a physician and a CRNA on the same date of service be submitted on two separate claims.

How it Works: When the option **Set CRNA as Actual Provider** is checked, CRNA information is printed on the standard CMS-1500 form instead of the actual provider information for all the options on the paper claim format tab that are set to Actual Provider.

For this to occur all of the following conditions must be true:

1. The billing provider and the actual provider on the original voucher are the same.
2. The voucher contains only the CRNA line of service.
3. Only timed anesthesia services exists on the voucher.
4. The option is check on the paper claim format associated with the carrier.

For example: A voucher is entered in Charge Entry for timed anesthesia services. (Condition 3)

The actual provider and the billing provider is entered as James Watson and the CRNA is entered Melissa Quinn. (Condition 1)

The Anesthesia Recalculation is run and the Charge Batch is updated.

A payment batch is opened and the CRNA service line is tagged and split off from the original voucher. (Condition 2 - as this creates a separate voucher containing only the timed CRNA service)

When these charges are billed to a carrier with the option **Set CRNA as Actual Provider** checked in paper claim format the following occurs:

- > On the claim for the anesthesia services (James Watson) - the information for James Watson prints wherever the format options are set to print actual provider information. James Watson here is the actual and billing provider.
- > On the claim containing the CRNA services - (the claim generated as a result of having tagged the updated CRNA service line.) the information for Melissa Quinn is printed wherever the format options are set to print actual provider information.

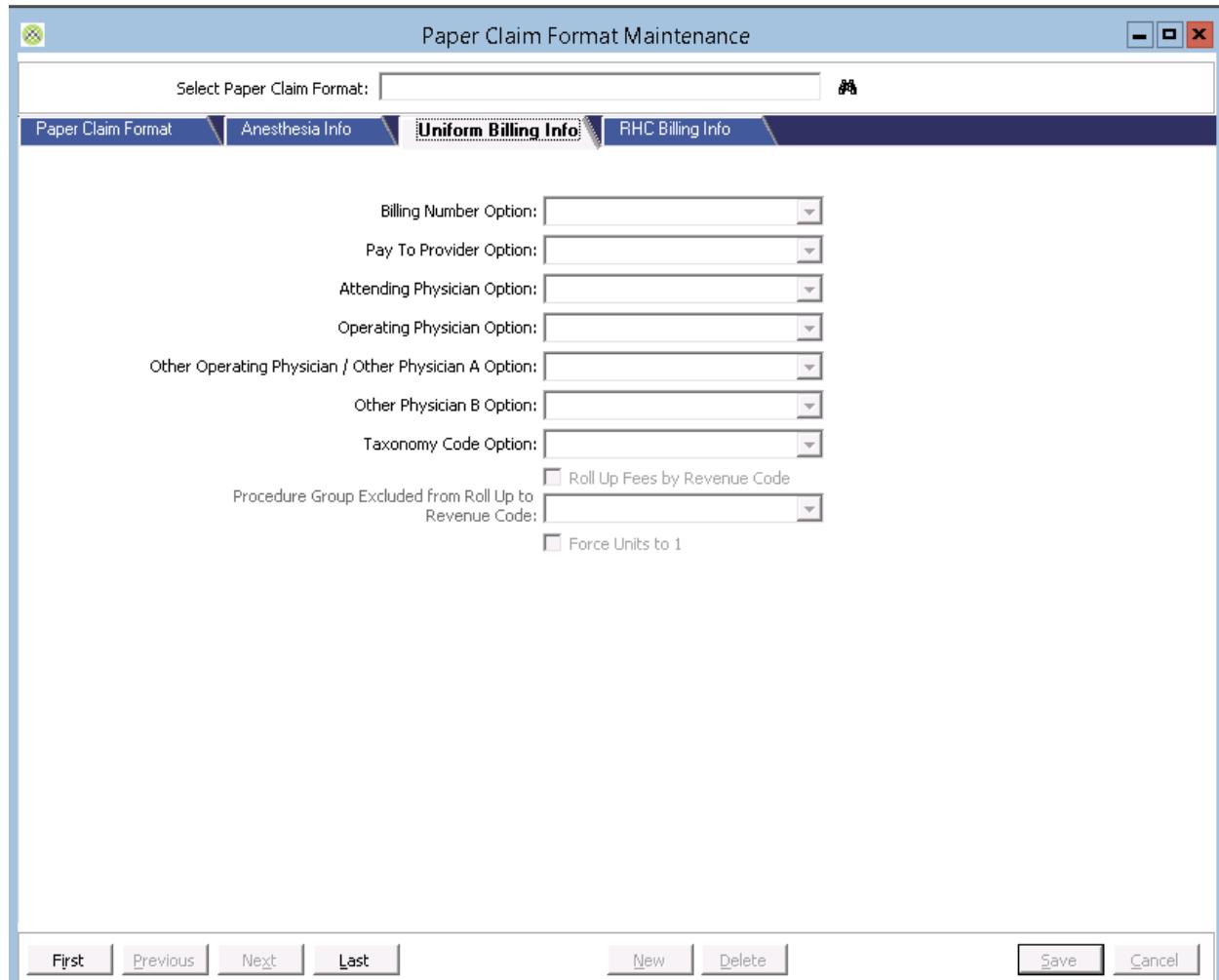
Uniform Billing Info tab in Paper Claim Format Maintenance

Use the **Uniform Billing Info** tab in **Paper Claim Format Maintenance** (**F9 > PCF**) to define how data required on UB-04 claims prints on the form. Base your selections on the carrier's requirements.

The **Uniform Billing Info** tab is available only when you select the format type **Uniform Billing Claim Form** on the **Paper Claim Format** tab.

Note: For each box description on this tab, the standard UB-04 format based on Medicare specifications is used for output examples.

Access the **Uniform Billing Info** tab from **Paper Claim Format Maintenance**. To access **Paper Claim Format Maintenance**, go to **System Administration > File Maintenance > Paper Claim Format Maintenance**, or press **F9** and then enter **PCF**.



Paper Claim Format Maintenance

Select Paper Claim Format:

Paper Claim Format | Anesthesia Info | **Uniform Billing Info** | RHC Billing Info

Billing Number Option:

Pay To Provider Option:

Attending Physician Option:

Operating Physician Option:

Other Operating Physician / Other Physician A Option:

Other Physician B Option:

Taxonomy Code Option:

Roll Up Fees by Revenue Code

Procedure Group Excluded From Roll Up to Revenue Code:

Force Units to 1

First | Previous | Next | Last | New | Delete | Save | Cancel

Billing Number Option

Relates to the provider entered as the billing provider during charge entry.

Prints in FL 56 on 1 of the lines in FL 57A-C on a standard UB-04 claim form.

For example, the billing number prints in FL 51A when the patient's primary policy is billed.

Select from **Billing Provider Indiv No**, **Billing Provider Group No**, **Billing Provider Other No**.

Pay to Provider Option

Prints the address and billing number in FL 2 on a standard UB-04 form from the file maintenances related to your selection:

> **Billing Provider Indiv No**

- > **Billing Provider Group No**
- > **Department or Practice**
- > **Location**
- > **Practice or Organization**

Physician options

The following selections determine the qualifier and billing number reported in FL 76-79.

The qualifier code for the physician is determined in 1 of the following ways:

1. Cross-referencing **Source of Payment** for the carrier being billed to the list of hard-coded HIPAA qualifier codes.
2. Using an ANSI 837I qualifier code selected on the **Additional Info** tab in **Insurance Carrier Maintenance** for the carrier being billed.

The qualifier code selected on the **Additional Info** tab overrides the following:

- > the qualifier code derived by cross-referencing the carrier's **Source of Payment**
- > the selections on this tab unless you select a provider or referring provider's state license number

Taxonomy codes always prints with the qualifier ZZ. In **Provider Maintenance**, the taxonomy codes for the selection in **Place of Service** take precedence over the taxonomy codes for the default place of service unless the taxonomy code for the place of service is blank.

Attending Physician Option

Prints the secondary qualifier in the right FL 76 on a standard UB-04 claim form from the file maintenances related to your selection:

- > **Actual Provider UPIN**: Always prints with the qualifier of IG.
- > **Actual Provider Indiv. No**: Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Attending Physician (Loop 2310A)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Actual Provider Group No**: Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Attending Physician (Loop 2310A)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Actual Provider State Lic No**: Prints with the qualifier 0B when the output option **Output State License Number** is selected for the claim style assigned to the carrier.
- > **Actual Provider Indiv Taxonomy**: Determines which taxonomy code to print based on values in **Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Provider Maintenance**. Prints with the qualifier ZZ.
- > **Billing Provider UPIN**: Prints with the qualifier 1G.

- > **Billing Provider Indiv No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Attending Physician (Loop 2310A)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Billing Provider Group No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Attending Physician (Loop 2310A)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Billing Provider State Lic No:** Prints with the qualifier 0B when the output option **Output State License Number** is selected for the claim style assigned to the carrier.
- > **Billing Provider Indiv Taxonomy:** Determines which taxonomy code to print based on values in **Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Provider Maintenance**. Prints with the qualifier ZZ.
- > **Referring Provider UPIN:** Prints with the qualifier 1G.
- > **Referring Provider Billing No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for the **ANSI 837I Qualifier Code for Attending Physician (Loop 2310A)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Referring Provider State Lic No:** Prints with the qualifier 0B. The output option **Output State License Number** must be selected for the claim style assigned to the carrier being billed.
- > **Referring Provider Taxonomy:** Determines which taxonomy code to print based on values in **Referring Dr Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Referring Doctor Maintenance**. Prints with the qualifier ZZ.

Operating Physician Option

Determines what operating physician's ID is used.

The operating physician is selected during charge entry using **Claim Information**.

Prints in FL 77 on a standard UB-04 claim form.

Make your selection based on the carrier's requirements. Your options are the following:

- > **Operating Physician UPIN:** Prints with the qualifier 1G.
- > **Operating Physician Indiv. No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Operating Prov (Loop 2310B)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Operating Physician Group No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Operating Prov (Loop 2310B)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.

- > **Operating Physician Other No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for the **ANSI 837I Qualifier Code for Operating Prov (Loop 2310B)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Operating Physician State Lic No:** Prints with the qualifier 0B. The output option **Output State License Number** must be selected for the claim style assigned to the carrier being billed.
- > **Operating Physician Indiv Taxonomy:** Determines which taxonomy code to print based on values in **Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Provider Maintenance**. Prints with the qualifier ZZ.

Other Operating Physician/Other Physician A Option

Prints in box FL 78 on a standard UB-04 claim form.

Required for foot care claims only.

Other Physician A is selected during charge entry using **Claim Information**.

Your options are the following:

- > **Other Physician A UPIN:** Always prints with the qualifier of IG.
- > **Other Physician A Indiv No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for the **ANSI 837I Qualifier Code for Other Prov (Loop 2310C)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Other Physician A Group No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Other Prov (Loop 2310C)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Other Physician A Other No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Other Prov (Loop 2310C)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Other Physician A State Lic No:** Prints with the qualifier 0B when the output option **Output State License Number** is selected for the claim style assigned to the carrier.
- > **Other Physician A Indiv Taxonomy:** Determines which taxonomy code to print based on values in **Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Provider Maintenance**. Prints with the qualifier ZZ.
- > **Referring Provider UPIN:** Always prints with the qualifier of IG.
- > **Referring Provider Billing No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for the

ANSI 837I Qualifier Code for Other Prov (Loop 2310C) on the **Additional Info** tab in **Insurance Carrier Maintenance**.

- > **Referring Provider State Lic No:** Prints with the qualifier 0B when the output option **Output State License Number** is selected for the claim style assigned to the carrier.
- > **Referring Provider Taxonomy:** Determines which taxonomy code to print based on values in **Referring Dr Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Referring Doctor Maintenance**. Prints with the qualifier ZZ.

Other Physician B Option

Prints in FL 79 on a standard UB-04 form.

Other Physician B is selected during charge entry using **Claim Information**.

Your options are the following:

- > **Other Physician B UPIN:** Always prints with the qualifier of IG.
- > **Other Physician B Indiv No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Other Prov (Loop 2310C)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Other Physician B Group No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Other Prov (Loop 2310C)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Other Physician B Other No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for **ANSI 837I Qualifier Code for Other Prov (Loop 2310C)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Other Physician B State Lic No:** Prints with the qualifier 0B when the output option **Output State License Number** is selected for the claim style assigned to the carrier.
- > **Other Physician B Indiv Taxonomy:** Determines which taxonomy code to print based on values in **Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Provider Maintenance**. Prints with the qualifier ZZ.
- > **Referring Provider UPIN:** Always prints with the qualifier of IG.
- > **Referring Provider Billing No:** Prints with the qualifier that corresponds to the carrier's cross-referenced code from **Source of Payment** unless there is a selection made for the **ANSI 837I Qualifier Code for Other Prov (Loop 2310C)** on the **Additional Info** tab in **Insurance Carrier Maintenance**.
- > **Referring Provider State Lic No:** Prints with the qualifier 0B when the output option **Output State License Number** is selected for the claim style assigned to the carrier.

- > **Referring Provider Taxonomy:** Determines which taxonomy code to print based on values in **Referring Dr Taxonomy Code Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**. The taxonomy code is then retrieved from the **Taxonomy Codes** tab in **Referring Doctor Maintenance**. Prints with the qualifier ZZ.

Taxonomy Code Option

Prints in FL 81 on a standard UB-04 form.

Your options are the following:

- > **Billing Provider Indiv. Taxonomy:** Retrieves the taxonomy code from the **Taxonomy Codes** tab in **Provider Maintenance**.
- > **Billing Provider Group Taxonomy:** Retrieves the taxonomy code from the **Taxonomy Codes** tab in **Provider Maintenance**.

Roll Up Fees by Revenue Code

Prints 1 service line per revenue code.

Total fees for all services for that revenue code print in FL 47 of the corresponding service line on a standard UB-04 form.

Not available when **RHC Billing** is selected on the **Paper Claim Format** tab.

Procedure Group Excluded from Roll Up to Revenue Code

Click the drop-down arrow to display a list of your procedure groups.

Selecting a procedure group excludes the procedures that are members of that procedure group from rolling up to a revenue code for claims with service dates on or after 01/01/2011.

Tip: Create a procedure group that contains only procedures that must be excluded from rolling up to a revenue code.

This option is only enabled when **Roll Up Fees by Revenue Code** is selected.

Force Units to 1

Always prints 1 in FL 46 on a standard UB-04 form.

RHC Billing Info tab in Paper Claim Format Maintenance

Use the **RHC Billing Info tab in Paper Claim Format Maintenance (F9 > PCF)** if your practice or organization must submit claims to a Medicaid program that requires a RHC Encounter Code to output on the claims that is different from the actual services rendered.

For assistance with setup and billing related to your specific state call Allscripts Support.

Claim Info Output

For institutional and professional paper claim formats, when **RHC Billing** is checked, each voucher has an Encounter Service inserted as the first service on the claim. RHC billing info prints to Form Locators (FL) 42-47 on a UB-04 form and to Boxes 24a-k on the CMS-1500 form.

Note: The selected RHC Encounter Revenue Code outputs only to UB-04 claim forms. The code prints in FL 42 and its description prints in FL 43 on the first line of the claim along with its corresponding RHC Encounter Procedure Code.

Access the **RHC Billing Info** tab from **Paper Claim Format Maintenance**. To access **Paper Claim Format Maintenance**, go to **System Administration > File Maintenance > Paper Claim Format Maintenance** or press **F9** and then enter **PCF**.

This tab is made active when you have done both of the following on the **Paper Claim Format** tab:

1. The **Format Type** is set to either **General Medical Claim Form**, **ICD10 Generic Medical Claim Form**, or **Uniform Billing Claim Form**.
AND
2. **RHC Billing** is checked

Paper Claim Format Maintenance

Select Paper Claim Format:

RHC Billing Info

Output RHC Encounter Service and Fee:	<input type="button" value="▼"/>
RHC Encounter Procedure Code:	<input type="text"/> Mod: <input type="text"/>
Alt RHC Encounter Procedure Code 1:	<input type="text"/> Mod: <input type="text"/> TOS: <input type="text"/>
Alt RHC Encounter Procedure Code 2:	<input type="text"/> Mod: <input type="text"/> TOS: <input type="text"/>
RHC Encounter Procedure Fee:	<input type="text"/>
Output Actual Services and Fees:	<input type="button" value="▼"/>
Output Actual Reimbursement Amounts:	<input type="button" value="▼"/>
Procedure Group Excluded from RHC Encounter	<input type="text"/>
Procedure Code:	<input type="text"/>
Revenue Code	
RHC Encounter Revenue Code:	<input type="text"/>
Alt RHC Encounter Revenue Code 1:	<input type="text"/>
Alt RHC Encounter Revenue Code 2:	<input type="text"/>

Buttons: First | Previous | Next | Last | New | Delete | Save | Cancel

Output RHC Encounter Service and Fee

Required field. Determines which Service Fee Amount is reported on the Encounter service line.

The hard coded options are the following:

- > **RHC Encounter Procedure Fee** - Selecting this option enables the **RHC Encounter Procedure Fee** field. Reports the fee entered in **RHC Encounter Procedure Fee**.
- > **Voucher Total** - Selecting this option reports a fee that is equal to the sum of all the services on the claim.

To make a selection, do one of the following:

- > Click the down arrow button to open the listing then click a selection to populate the field.

- > With the cursor positioned in the field type "r" to populate the field with "RHC Encounter Procedure Fee" or type in "v" to populate the field with "Voucher Total."

RHC Encounter Procedure Code

Required free text field.

Allows a maximum of 10 characters.

Enter the Encounter Procedure Code required by the carrier, example "T1015."

RHC Encounter Mod

Optional free text field.

Allows a maximum of 20 characters.

Enter the Encounter Modifier if all Encounter service lines must contain a specific modifier.

Note: If more than one modifier must be reported, use a comma to separate each one. Example: MO,ACB,RX.

Alt RHC Encounter Procedure Code 1

Optional free text field.

Allows a maximum of 10 characters.

If a unique Encounter Procedure Code must be reported based on Type of Service, enter the code here.

Alt RHC Encounter Mod 1

Optional free text field.

Allows a maximum of 20 characters.

If a unique Encounter Modifier must be reported based on the Type of Service, enter the modifier here.

Note: If a modifier is entered, an Alt Encounter Procedure Code 1 must also be entered. If more than one modifier must be reported, use a comma to separate each one.

Alt RHC Type of Service 1

Required field if an Alt RHC Encounter Procedure Code 1 is entered.

If a unique Encounter Procedure Code or Modifier must be reported based on Type of Service (TOS), select the Type of Service from the drop-down list.

Note: The Alternate RHC Procedure Code and Modifier is output when the Type of Service you select matches with the Type of Service on the first service on the voucher (as entered in Charge Entry).

Alt RHC Encounter Procedure Code 2

Optional free text field.

Allows a maximum of 10 characters.

If a unique Encounter Procedure Code must be reported based on Type of Service, enter the code here.

Alt RHC Encounter Mod 2

Optional free text field.

Allows a maximum of 20 characters.

If a unique Encounter Modifier must be reported based on the Type of Service, enter the modifier here.

Note: If a modifier is entered, an Alt Encounter Procedure Code 1 must also be entered. If more than one modifier must be reported, use a comma to separate each one.

Alt RHC Type of Service 2

Required field if an Alt RHC Encounter Procedure Code 2 is entered.

If a unique Encounter Procedure Code and/or Modifier must be reported based on Type of Service (TOS), select the Type of Service from the drop-down list.

Note: The Alternate RHC Procedure Code and Modifier is output when the Type of Service you select matches with the Type of Service on the first service on the voucher (as entered in Charge Entry).

RHC Encounter Procedure Fee

Enabled when **Output RHC Encounter Service and Fee** is set to "Procedure Fee."

Required when enabled.

Enter the flat rate amount, or zero, to be reported on the Encounter service.

Output Actual Services and Fees

Required field.

Determines how non-Encounter service lines are reported on the claim.

The options available are the following:

- > Do Not Output - Prevents all non-Encounter services from outputting to the claim.
- > Zero - Forces the Service Fee Amount for all non-Encounter services on the claim to be zero.
- > Service Fee - Outputs the fee entered in Charge Entry as the Service Fee Amount for each non-Encounter service on the claim.

Output Actual Reimbursement Amounts

Available for billing Professional claims and enabled only when **Output Actual Services and Fee** is set to "Do Not Output."

When enabled, the field selection defaults to "Zero."

Output is dependent on the combination of the Report Name used and the options selected and boxes checked on the other available tabs for the format being defined.

For example, clients using ILMedicaid3797RHC.rpt, the following selections result in the indicated output:

- > Zero prints \$0.00 to boxes 10G, 10H, and 10I.
- > Voucher Total prints Deductible amount applied to Box 10G, Coinsurance paid to Box 10H and Net payment amount to Box 10I.

Note: For amounts to be included the corresponding options should be checked on the Paper Format tab.

For Clients using SCMedicaidCSM1500NPI.rpt, output is printed to Box 9C based on the option selected.

- > "Zero" prints \$0.00.
- > "Voucher Total" prints the sum of insurance payments on the claim.

Note: For insurance adjustments and/or payments to be included the corresponding option(s) should be checked on the Paper Claim Format tab.

Suppress rendering provider from claim and service levels

Available only for ANSI 837P X12N v4010A1 (Professional) formats.

Prevents the creation of Loops 2310B and 2420A.

Note: Check only if the Carrier does not want you to send rendering provider information in the file.

Procedure Group Excluded from RHC Encounter Procedure Code

This option is only enabled when **Output Actual Services and Fees** is set to "Do Not Output."

When this drop-down is populated with a procedure group, the procedure codes and fees from that group are not rolled up to the Encounter Procedure Code.

All procedure codes associated to the selected procedure group will not be included in the Roll Up to the Encounter Code service line. These services will print on their own service detail line.

These services will print on the claim as its own service, including the service's unit and fee regardless of how the RHC Encounter Line is defined to print (Voucher Total or RHC Encounter Procedure Fee).

Each of these procedures outputs on the claim with the fee amount entered in Charge Entry.

If the same voucher contains procedures that are part of the selected group as well as procedures that are not, the system outputs the encounter procedure code with the appropriate encounter rate for the codes not in the group and the procedure codes with their corresponding fees that are part of the group on the same claim.

The procedure codes in the selected procedure group are excluded from all other RHC Billing Info options.

Revenue Code

This grid is enabled only when the selected format type is **Uniform Billing Claim Form**.

The drop-down lists all the Revenue Codes you created in Revenue Code Maintenance.

Allows you to select a revenue code for each of the corresponding encounter procedure codes you entered above when the payer requires that a separate revenue code other than the revenue code of the actual Evaluation and Management Code (E&M code) is printed on the first line of the claim along with its corresponding RHC Encounter Procedure Code. [view example](#)

Note: When the "Output Actual Services and Fees" is set to either "Zero" or "Service Fee" the RHC Encounter Procedure Code and the corresponding revenue code are printed on the first service line.

All other procedure codes and corresponding revenue codes are then printed listed on the following service lines.

Electronic Claim Format Maintenance window

An electronic claim format is associated with a claim style that governs the validation and output criteria used when generating an electronic claims file. Allscripts® provides you with numerous electronic claim formats. Your trainer and your Implementation Specialist will guide you through the steps for setting up the formats you need.

Note: When you pause your pointer over a box, a tooltip is displayed indicating where the value is reported in the claim file.

Electronic Claim Format Maintenance contains these tabs:

- > **Electronic Claim Format**
- > **File Info**
- > **Submitter/Receiver Info**
- > **RHC Billing Info**

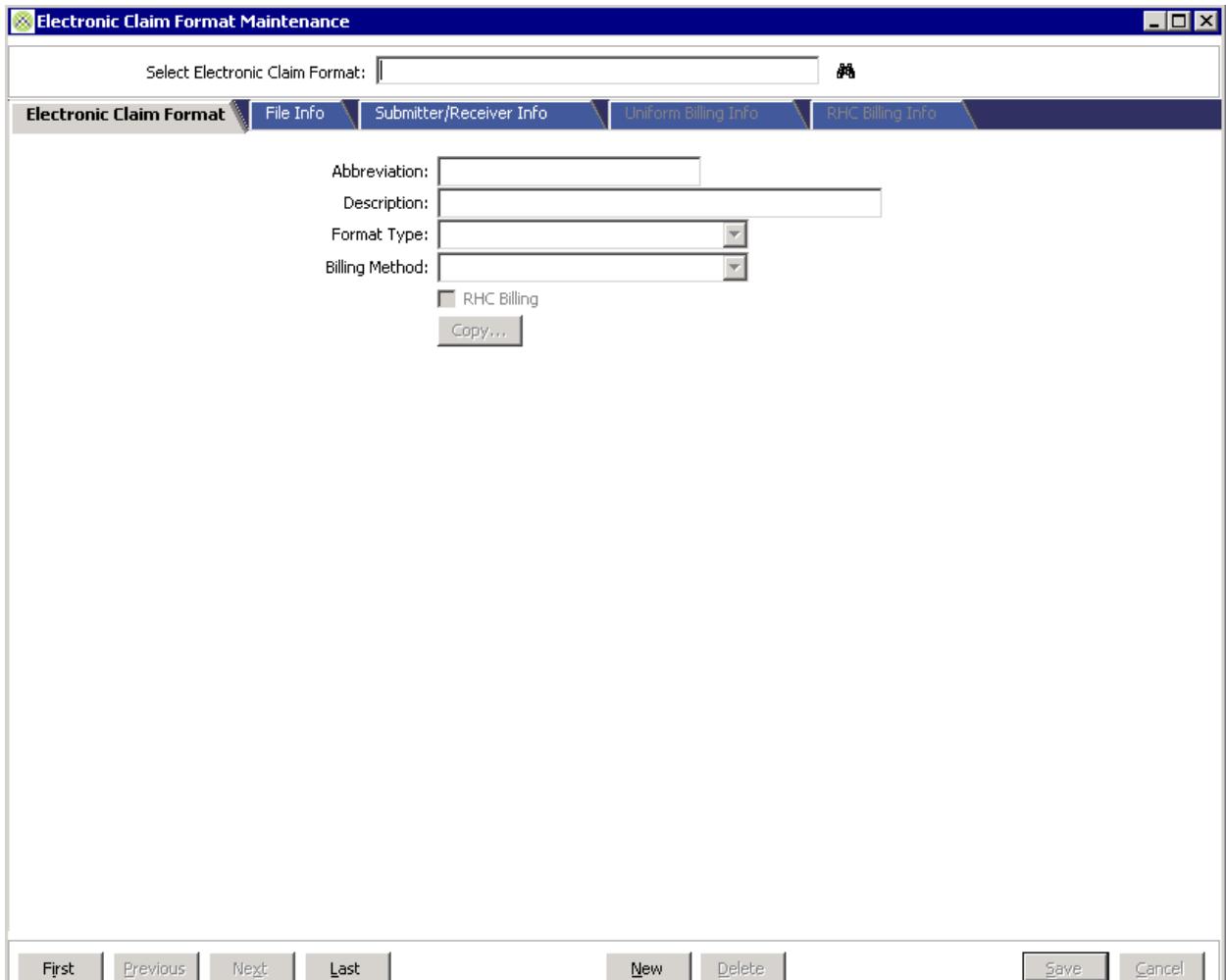
To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance** or press **F9** and then enter **ECM**.

Electronic Claim Format tab

This topic describes the boxes on the **Electronic Claim Format** tab in **Electronic Claim Format Maintenance** that are common to both the ANSI v4010 and the V5010 format types. The boxes on this tab must be filled in based on vendor and carrier requirements.

Access the **Electronic Claim Format** tab from **Electronic Claim Format Maintenance**. To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance**.

Tip: To quickly access **Electronic Claim Format Maintenance**, press **F9**, then enter **ECM**.



Abbreviation

Holds up to 8 characters. The number of characters accepted depend upon the combination of upper & lower case lettering you use.

Type in the abbreviation which identifies the new format; it is recommended that you use the naming convention indicated in the project documentation provided by Allscripts®.

Important: DO NOT use any extra characters such as commas, dashes, underscores, slashes, apostrophes, quotes. The inclusion of these characters can cause errors when running verification programs such as Alpha II ClaimStaker® Enterprise.

Best Practice: When creating a format record for a v5010 format type, begin the abbreviation with the number 5. For example, 5Prof. This way when you sort the list by abbreviation in the ECM lookup, all the v5010 formats are grouped together.

Description

Holds up to 40 characters. The number of characters accepted depend upon the combination of upper & lower case lettering you use.

Type in text which describes the use of this format. It is recommended that you use the naming convention indicated in the project documentation provided by Allscripts®.

Displays as a selection Claim Style Maintenance.

Best Practice: When creating a format record add the version number to the end of the description. For example, Standard Profv5010.

Format Type

Determines the source used to generate the claim file. Picture the format type as being the file structure, for example loops and segments. The claim style you associate with this format is how you customize the validation and output criteria to a Carrier or clearing house's unique specifications.

Allscripts® has developed the following format types for HIPAA compliant transmission of claims. This list contains v4010A1 formats. However, with the guidance of an Allscripts® representative you will most likely create format records using the v5010 format types.

Refer to Allscripts® Support to provide you with the correct selection for your needs.

- > The format types which relate to v4010 claims submission are:
 - HSN ANSI 837P v4010A1 - for Professional claims to Health Safety Net Office (HSN), which was previously known as Massachusetts Uncompensated Care Pool
 - Standard ANSI X12N 837D v4010A1 - for Dental claims
 - Standard ANSI X12N 837I v4010A1 - for Institutional claims
 - Standard ANSI X12N 837P v4010A1 - for Professional claims
- > The formats that relate to v5010 claims submission are:
 - Dental ANSI 837D v5010
 - Dental ANSI 837D v5010A1
 - Dental ANSI 837D v5010A2
 - Institutional ANSI 837I v5010
 - Institutional ANSI 837I v5010A1
 - Institutional ANSI 837I v5010A2
 - Professional ANSI 837P v5010
 - Professional ANSI 837P v5010A1

Billing Method

The field previously labeled **Billing Number Option** is now called **Billing Method** to match the terminology used for the v5010 format types.

This new label name is applied to both the 4010 and 5010 versions.

The selection for billing method drives where the claim's billing number is pulled from. Your selection also determines how certain claim style options pull information into the claim file.

Your selections are:

Individual Provider

Pulls the voucher's billing provider's name and address and individual billing number from Provider Maintenance PRM.

Provider Group

For v4010 format types:

- > Pulls the voucher's billing provider's billing number from the billing provider's group column in (PRM).
- > Pulls the name and address of the billing entity from the **Practice/Organization** tab in Practice/Organization Setup (PSU / OSU).

For v5010 format types:

- > Pulls the voucher's billing provider's billing number from the billing provider's group column in (PRM).
- > Displays the field **Provider Group Address** which enables you to select whether the address pulls from Department/ Practice or Practice/ Organization.

Department or Practice

For v4010 or v5010 format types:

- > Pulls the voucher's department/practice's name, address and billing number from Department or Practice maintenance.

For v5010 format types:

- > Adds another 2000A and 2010AA loop when the file contains claims that output a different address for the same billing entity. If the billing entity's pay-to-address (department or practice) is output, the pay-to-address is included in the 2010AB loop.

Location

For v4010 or v5010 format types:

- > Pulls the voucher's location's name, address and billing number from Location maintenance.

For v5010 format types:

- > Adds another 2000A and 2010AA loop when the file contains claims that output a different address for the same billing entity. If the billing entity's pay-to-address (location) is output, the pay-to-address is included in the 2010AB loop.

Practice or Organization

Pulls the name, address and billing number from Practice/Organization Set Up.

Place of Service

When you select **Place of Service** for **Billing Method**, a **Billing Numbers** drop-down list is enabled with options for **Place of Service** and **Provider Group**.

When you select **Place of Service** for **Billing Numbers**, the billing numbers and taxonomy codes are retrieved from the **Billing Method Information** tab in **Place of Service Maintenance**.

When you select **Provider Group** for **Billing Numbers**, the billing numbers and taxonomy codes are retrieved from the **Billing Numbers** and **Taxonomy Codes** tabs, respectively, in **Provider Maintenance**.

Regardless of whether you select **Place of Service** or **Provider Group** for **Billing Numbers**, the billing name and billing address are retrieved from the **Billing Method Information** tab in **Place of Service Maintenance**.

Provider Group Address

Available only when you select one of the v5010 format types and the Billing Method **Provider Group**.

Determine which address is reported to Loop 2010AA Segment NM1, Loop 2010AA Segment N3 and Loop 2010AA Segment N4. Your options are:

Department/Practice

Using the voucher's Department or Practice pulls the billing entity's name and address from Department or Practice maintenance.

Practice/Organization

Pulls the name and address for the billing entity from Practice/Organization Set Up.

Note: When you leave this field blank the system outputs the address from Practice/Organization Set Up.

RHC Billing

This field is enabled when the format type selected is either institutional or professional. When selected, the **RHC Billing Info** tab is enabled and accessible.

Intended for use by Practices who submit claims to a Medicaid program that requires an RHC Encounter Code to display on the claims that is different from the actual services rendered.

When **RHC Billing** is selected, each voucher has an encounter service inserted as the first service on the claim. However, **Ignore RHC Billing Info for Secondary Claims?** on the **RHC**

Billing Info tab provides the option to suppress encounter code information on secondary electronic claims (v4010 or v5010).

Important: Call Allscripts® Support for Setup and Billing instructions related to this feature.

Copy

Enabled after you click **Save**.

Use this feature to create another new record with the same or most of the same selections.

Note: Be sure you complete all the tabs before you copy.

When you select one of the v4010 formats a grid displays below **Copy**.

For v5010 format types, there are no other fields on this tab.

Boxes for v5010 format types that are defined in Claim Style Maintenance

When creating a v5010 format type, the following eight boxes are defined in **Claim Style Maintenance** (CSM):

- > Billing Provider Tax ID Option (required)
- > Billing Provider Tax ID Source (required)
- > Default Release of Information
- > Default Signature Source
- > Include \$0.00 Charge Services
- > Include Self-Pay Adjustments
- > Include Self-Pay Payments
- > Signature /Release Option

Electronic Claim Format tab: Version 4010A1 section

The **Version 4010A1** section on the **Electronic Claim Format** tab in **Electronic Claim Format Maintenance** (**F9 > ECM**) defines information that is unique to v4010 format types. It is displayed only for electronic claim format types that have a version 4010A1 format type.

Always consult with an Allscripts claim adviser before making selections or changes.

Access the **Electronic Claim Format** tab from **Electronic Claim Format Maintenance**. To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance** or press **F9** and then enter **ECM**. The **Version 4010A1** section is displayed only for records with a v4010A1 format type.

Electronic Claim Format Maintenance - iClaim Group ANSI 837P v4010A1

Select Electronic Claim Format: iClaim Group ANSI 837P v4010A1													
Electronic Claim Format	File Info												
Submitter/Receiver Info	Uniform Billing Info												
RHC Billing Info													
Abbreviation: GROUP Description: iClaim Group ANSI 837P v4010A1 Format Type: Standard ANSI X12N 837P v4010A1 Billing Method: Provider Group <input type="checkbox"/> RHC Billing Copy...													
Version 4010A1 <table border="1"> <tr> <td>Pay-To Provider Option:</td> <td>None</td> </tr> <tr> <td>Tax ID Source:</td> <td>Federal ID</td> </tr> <tr> <td>Tax ID Option:</td> <td>Practice</td> </tr> <tr> <td>Primary Batch Option:</td> <td>Individual Provider</td> </tr> <tr> <td>Secondary Batch Option:</td> <td>None</td> </tr> <tr> <td colspan="2"> <input type="checkbox"/> Include \$0.00 Charge Services <input type="checkbox"/> Include Self-Pay Adjustments <input type="checkbox"/> Include Insurance Payments <input checked="" type="checkbox"/> Default Release of Information <input type="checkbox"/> Include Insurance Adjustments <input checked="" type="checkbox"/> Default Signature on File <input type="checkbox"/> Include Self-Pay Payments <input checked="" type="checkbox"/> Increment Batch Numbers </td> </tr> </table>		Pay-To Provider Option:	None	Tax ID Source:	Federal ID	Tax ID Option:	Practice	Primary Batch Option:	Individual Provider	Secondary Batch Option:	None	<input type="checkbox"/> Include \$0.00 Charge Services <input type="checkbox"/> Include Self-Pay Adjustments <input type="checkbox"/> Include Insurance Payments <input checked="" type="checkbox"/> Default Release of Information <input type="checkbox"/> Include Insurance Adjustments <input checked="" type="checkbox"/> Default Signature on File <input type="checkbox"/> Include Self-Pay Payments <input checked="" type="checkbox"/> Increment Batch Numbers	
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First Previous Next Last New Delete Save Cancel													

Pay-To Provider Option

Outputs to loop 2010AB when using the Standard ANSI X12N 837P v4010A1format.

Determines where the Billing entity's demographic information pulls from

Select one of the following options based on the Carrier or clearing house's specifications:

Provider Group

pulls from Practice/Organization Set Up and Provider Maintenance specifically:

1. Practice/Organization Set Up > Practice/Organization Information Tab - Name and address
2. Provider maintenance > Billing Numbers tab - number entered in the column Group Number for the profile associated with the Carrier.

Department or Practice

Pulls from Department/Practice Maintenance specifically

1. Department/Practice tab - Name and address
2. Billing Numbers tab - Number entered for the related profile in the column Billing Number

Location

Pulls from Location Maintenance specifically:

1. Location tab - Name and address
2. Billing Numbers tab - Number entered for the related profile in the column Billing Number

Practice or Organization

Pulls from Practice/Organization Set Up specifically:

1. Practice/Organization Information tab - Name and address
2. Billing Numbers tab - Number entered for the related profile in the column Billing Number

None

No demographic information is sent in the file

Tax ID Source

Determines whether the federal ID or a SSN outputs to loop 2010AA when using the Standard ANSI X12N 837P v4010A1 format.

The Tax ID Source and the Tax ID option are used in conjunction with one another.

Tax ID Option

Determines where the Federal ID or Social Security Number pulls from to output to loop 2010AA when using the Standard ANSI X12N837P v4010A1 format.

Actual Provider

Pulls from the appropriate field on the Provider tab in Provider Maintenance for the Provider designated on the voucher

Billing Provider

Pulls from the appropriate field on the Provider tab in Provider Maintenance for the Provider designated on the voucher

Department or Practice

Pulls from the appropriate field on the Department/Practice tab in Department or Practice Maintenance for the Department/Practice designated on the voucher

Location

Pulls from the appropriate field on the Location tab in Location Maintenance for the Location designated on the voucher

Practice or Organization

Pulls from the appropriate field on the Practice/Organization Information tab in Practice/Organization Set Up.

Primary Batch Option

Determines how the file is sorted

Individual Provider

Sorts the file by the Billing Provider's abbreviation

This option does not actually cause a batch break.

Important: Do not select any of the four options unless you are directed by an Allscripts specialist.

Secondary Batch Option

Unless otherwise directed, select "None."

Currently the ANSI structure does not require a secondary batch option.

Signature/Release Opt

Outputs to Loops 2300 and 2320 when using the Standard ANSI X12N837P v4010A1 format.

The table below lists the HIPAA approved codes that can be output to the file.

HIPAA Code	Description	Notes
B	Signed signature authorization form or forms for both CMS1500 ClaimForm block 12 and block 13 are on file.	Default value
C	Signed CMS1500 Claim Form on file.	
M	Signed signature authorization form for CMS1500 Claim Form block13 on file.	

HIPAA Code	Description	Notes
P	Signature generated by provider because the patient was not physically present for services.	
S	Signed signature authorization form for CMS1500 Claim Form block12 on file.	

Include \$0.00 Charge Services

Includes \$0.00 charge service lines in the file.

Checked by default.

Unchecking this option prevents services with a \$0.00 charge from outputting to the file.

With the exception of PQRI or ePrescribe incentive procedure codes billed to Medicare, it is recommended that \$0.00 charges be billed on Self-Pay vouchers and not included in a claim file.

Include Insurance Payments

Outputs to Segment AMT Loop 2320 when using the Standard ANSI X12N837P v4010A1 format.

Outputs all updated insurance payments applied to the claim.

Use when submitting to Medicare as the secondary payer.

Include Insurance Adjustments

Outputs to Segment AMT Loop 2320 when using the Standard ANSI X12N837P v4010A1 format.

Outputs all updated insurance adjustments applied to the claim.

Use when submitting to Medicare as the secondary payer.

Include Self-Pay Payments

Primary Billing - Outputs to Segment AMT Loop 2300 when using the Standard ANSI X12N 837P v4010A1 format

Secondary Billing - Outputs to Segment AMT Loop 2320 when using the Standard ANSI X12N 837P v4010A1 format. If your practice or organization uses uninsured carriers, payments posted to an uninsured voucher are calculated as self-pay and output to Segment AMT Loop 2300 for primary billing and output to Segment AMT Loop 2320 for secondary billing.

Segment AMT Loop 2320 does not include Self-Pay payments applied as Co-Pay payments. Required if the patient has paid any amount towards the claim.

Outputs all updated Self-Pay payments applied to the claim.

Include Self-Pay Adjustments

Primary Billing - Outputs to Segment AMT Loop 2300 along with Self-Pay payments when using the Standard ANSI X12N 837P v4010A1 format.

Secondary Billing - Outputs to Segment AMT Loop 2320 along with Self-Pay payments when using the Standard ANSI X12N 837P v4010A1 format; Segment AMT Loop 2320 does not include Self-Pay payments applied as Co-Pay payments. If your practice or organization uses uninsured carriers, payments posted to an uninsured voucher are calculated as self-pay and output to Segment AMT Loop 2300 for primary billing and output to Segment AMT Loop 2320 for secondary billing.

Default Release of Information

Outputs "Y" to Loop 2300 Segment CLM Ref 09 and Loop 2320 Segment OI REF06 when using the Standard ANSI X12N 837P v4010A1 format

Default Signature on File

Outputs "B" to Loop 2300 Segment CLM10 and Loop 2320 Segment OI REF04 when using the Standard ANSI X12N 837P v4010A1 format

Increment Batch Numbers

Check when using the Standard ANSI X12N 837P v4010A1 format

Increments the batch count by 1 beginning with the start number entered in the field "Starting Batch Number."

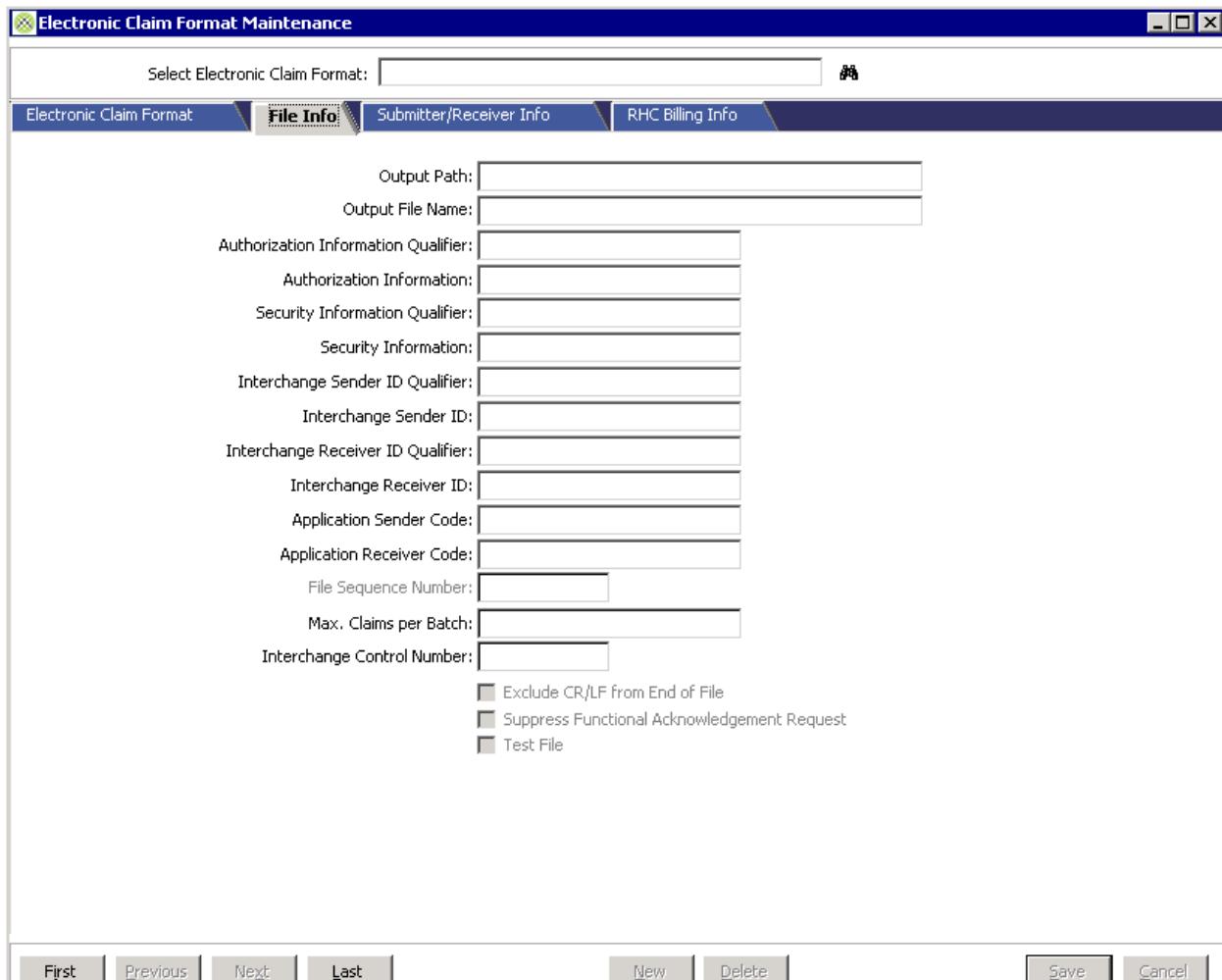
File Info tab

The **File Info** tab in **Electronic Claim Format Maintenance** holds all the boxes that pertain to file level data for an electronic claim.

All but one of the fields on this tab are available for both v4010 and v5010 format types. The exception is the field **Transaction Type Code Pilot Indicator**. This field displays only for v4010A1 format types and is enabled when you select **Test File**.

Note: Pause your pointer over a box for a v5010 format type to display a tooltip that indicates where the entered value reports in the file.

Access the **File Info** tab from **Electronic Claim Format Maintenance**. To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance** or press **F9** and then enter **ECM**.



Output Path

Determines where the system outputs the generated claim .txt file and its backup file.

The standard location for claim folders is \\<Server Name>.<Domain Name>\ntierFiles\<Tenant Name>\Electronic Claims\

Enter the correct output path as given in the format project documentation.

Note: Clients sending claims through Payerpath using the desktop Send/Receive icon must enter the following path name:
 \\<Server Name>.<Domain Name>\NtierFiles\<Tenant Name>\electronic claims\iClaim.

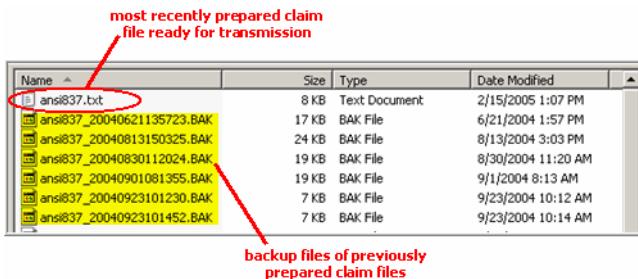
When preparing electronic claims if the folder using the path entered here is not found, a hard-stop error message is displayed. You must resolve the error by coming to Electronic Claim Maintenance and correcting the entry.

Output File Name

This is a free text field that is used to name the output file for the claim format generated during the prepare electronic claims process. What you enter here is the name given to the file.

This file is overwritten each time you prepare electronic claims under Insurance Billing. A backup copy is auto created and named using this convention: <name of Output File>_ccyymmddhhmmss.BAK

Below is a screen shot showing a sample listing of files of in a directory



Name	Size	Type	Date Modified
ansi837.txt	8 KB	Text Document	2/15/2005 1:07 PM
ansi837_20040621135723.BAK	17 KB	BAK File	6/21/2004 1:57 PM
ansi837_20040813150325.BAK	24 KB	BAK File	8/13/2004 3:03 PM
ansi837_20040830112024.BAK	19 KB	BAK File	8/30/2004 11:20 AM
ansi837_20040901081355.BAK	19 KB	BAK File	9/1/2004 8:13 AM
ansi837_20040923101230.BAK	7 KB	BAK File	9/23/2004 10:12 AM
ansi837_20040923101452.BAK	7 KB	BAK File	9/23/2004 10:14 AM

Variable Data Triggers

Some carriers such as Mass Health require that specific variable information be included as part of the file name or file extension (Date, time). Some carriers require the inclusion of variables such as dates, times, Julian dates, sequencing order in the file name or file extension. In such cases you must use program supported variable data triggers as part of the output file name.

With the help of an Allscripts specialist, enter the correct file name exactly as you are directed.

Best Practice: Append MMDDYYHHMMSS to the file name, for example iClaimMMDDYYHHMMSS.txt. This creates files with a date and time stamp (month, day, year, hour, minute, and second) as part of the file name.

Be sure your payer does not have unique requirements for the way you name the claim file.

When creating a 5010 format record, name the output file using the prefix 5010_ to distinguish it from the file name used for the v4010 file.

Note: When using the copy feature to create a v5010 format, the output file name defaults to having a prefix of "5010." You can change the default.

Contact your clearing house or payer to verify what file naming convention is required.

Authorization Information Qualifier

Outputs to Segment ISA Ref 01 in a v4010 and v5020 claim file.

When left blank outputs "00."

Authorization Information

Outputs to Segment ISA Ref 02 in a v4010 claim file.

Outputs to Segment ISA Ref 01 in a v5020 claim file

When left blank the default is Space Filled.

Security Information Qualifier

Outputs to Segment ISA Ref 03 in either a v4010 or v5010 claim file.

When left blank outputs "00."

Security Information

Outputs to Segment ISA Ref 04 in either a v4010 or v5010 claim file.

When left blank the default is Space Filled.

Interchange Sender IQ Qualifier

Outputs to Segment ISA Ref 05 in either a v4010 or v5010 claim file.

Interchange Sender ID

Outputs to Segment ISA Ref 06 in either a v4010 or v5010 claim file.

Generally the same as the Submitter Number.

Interchange Receiver ID Qualifier

Outputs to Segment ISA Ref 07 in either a v4010 or v5010 claim file.

Interchange Receiver ID

Outputs to Segment ISA Ref 08 in either a v4010 or v5010 claim file.

General the same as the Receiver ID.

Application Sender Code

Outputs Segment GS Ref 02 in either a v4010 or v5010 claim file.

This number is generally the same as your Submitter Number.

Application Receiver Code

Outputs Segment GS Ref 03 in either a v4010 or v5010 claim file.

This number is generally the same as your Submitter Number.

File Sequence Number

The entry in this field should remain at "0" unless you are required to include a file sequence number trigger in your file name or file extension. Contact Allscripts for assistance.

Increments occur only when the output file name contains a file sequencing number trigger and the electronic claim file has been prepared. That means that it does not increment when you check the prepare electronic claim option "Preliminary List Only."

Max. Claims per Batch

HIPAA enables for a maximum of 5000 claims per transaction set .

Enter "5000" unless otherwise directed.

Interchange Control Number

This field was previously labeled: **Starting Batch Number**

Outputs to the following Segments: ISA, GS, ST, BHT, SE, GE, IEA in either a v4010 or v5010 claim file.

Unless otherwise directed enter "1" in the field.

Increments only when you also check the option "Increment Batch Numbers."

Exclude CR/LF from End of File

Enables you to exclude a carriage return/line feed from the end of an electronic claims file. Check when the payer requires you to exclude a carriage or line feed at the end of a file.

Applies to both v4010 and v5010 claim format.

SUPPRESS FUNCTIONAL ACKNOWLEDGEMENT REQUEST

Outputs "0" to Segment ISA Ref 14 to indicate you do not want a functional acknowledgement. Applies to either a v4010 or v5010 claim format.

Test File

When this option is checked the vouchers processed are not stamped with a bill date. This means that they will qualify the next time you run the Prepare.

Applies to both a v4010 or v5010 claim format.

TRANSMISSION TYPE CODE PILOT INDICATOR

Applies only to v4010 claim formats.

Specifically for those clients using Value Options for claims solution where the use of the pilot indicator is a requirement.

Enabled only when you check **Test File**

Adds a "D" to Segment REF Ref 02.

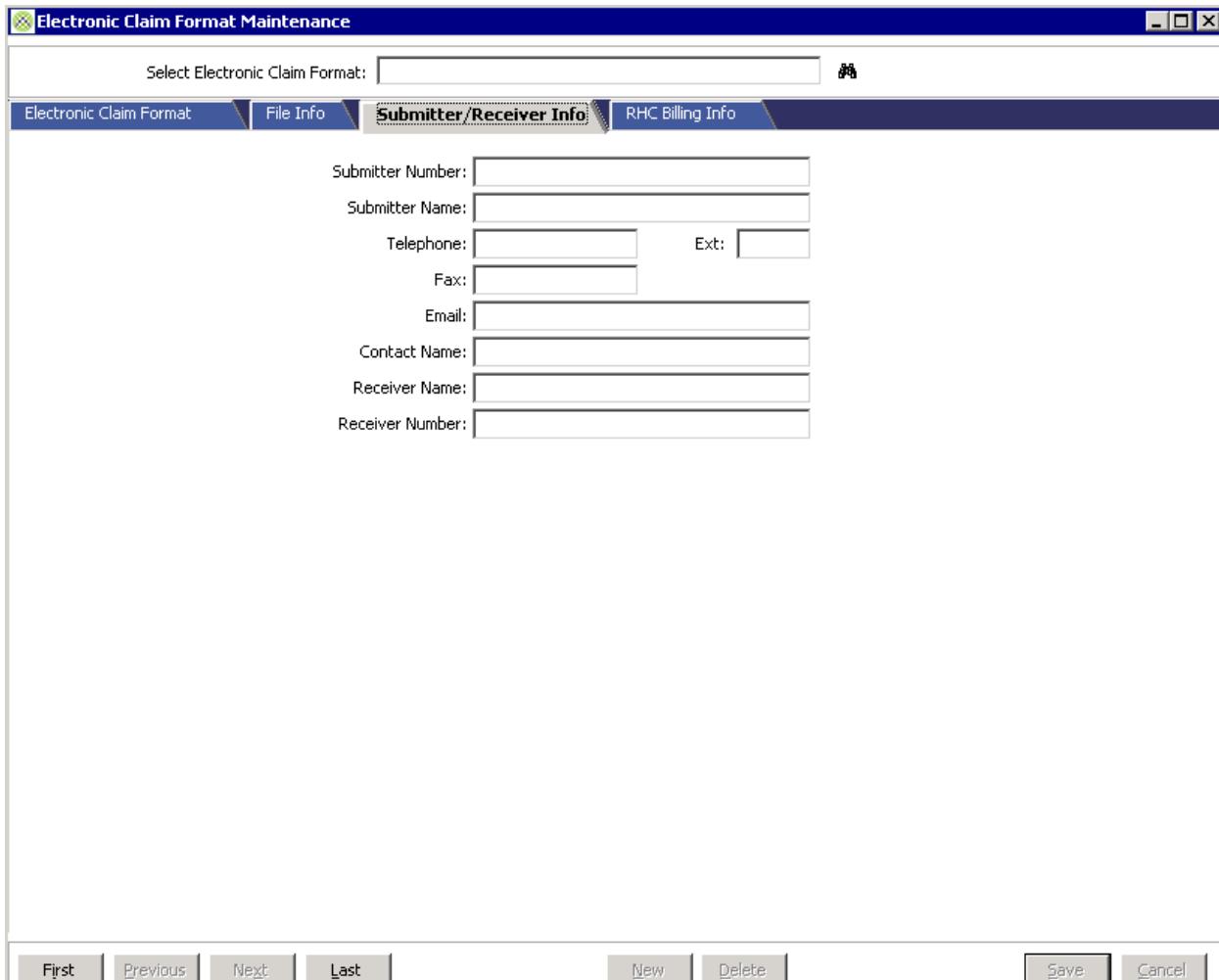
Submitter/Receiver Info tab

Use the **Submitter/Receiver Info** tab in **Electronic Claim Format Maintenance** to define information for the selected format type that is unique to the submission of the claim file.

Nine fields are available and active for use when you are creating either a v4010 and v5010 format types. While the v4010 format types have additional boxes to fill, the v5010 format types use only these nine boxes.

Tip: When creating a v5010 format, point your cursor to a box to see a tooltip.

Access the **Submitter/Receiver Info** tab from **Electronic Claim Format Maintenance**. To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance** or press **F9** and then enter **ECM**.



The screenshot shows a Windows application window titled "Electronic Claim Format Maintenance". The window has a menu bar with "File", "Edit", "View", "Format", "Help", and a toolbar with icons for "New", "Delete", "Save", and "Cancel". The main area contains tabs: "Electronic Claim Format", "File Info", "Submitter/Receiver Info" (which is selected and highlighted in blue), and "RHC Billing Info". Below the tabs are several input fields:

- Submitter Number: [Text Box]
- Submitter Name: [Text Box]
- Telephone: [Text Box] Ext: [Text Box]
- Fax: [Text Box]
- Email: [Text Box]
- Contact Name: [Text Box]
- Receiver Name: [Text Box]
- Receiver Number: [Text Box]

At the bottom of the window are navigation buttons: "First", "Previous", "Next", "Last", "New", "Delete", "Save", and "Cancel".

Submitter Number

Enter the number assigned to you by the carrier or clearinghouse.

Outputs in Loop 1000A Segment NM1 Ref 09 for all Standard ANSI 837 formats.

Submitter Name

Enter your organization name as recognized by the carrier or clearinghouse.

Outputs in Loop 1000A Segment NM1 Ref 03 for all Standard ANSI 837 formats.

Telephone

Enter if required.

Outputs with the qualifier TE in Loop 1000A Segment PER04, PER06, or PER08 for all Standard ANSI 837 formats.

Ext

Enter if required.

Outputs with the qualifier EX in Loop 1000A Segment PER04, PER06, or PER08 for all Standard ANSI 837 formats.

Note: The extension number does not output when you leave **Telephone** blank.

Fax

Enter if required.

Outputs with the qualifier FX in Loop 1000A Segment PER04, PER06, or PER08 for all Standard ANSI 837 formats.

Email

Enter if required.

Outputs with the qualifier EM in Loop 1000A Segment PER04, PER06, or PER08 for Standard ANSI 837 formats.

Contact Name

Enter if required.

Outputs in Loop 1000A Segment PER02 for Standard ANSI 837 formats.

Receiver Name

Enter if required.

Outputs in Loop 1000B Segment NM1 Ref09 for Standard ANSI 837 formats.

Receiver Number

Enter the ID as provided by the carrier or clearinghouse.

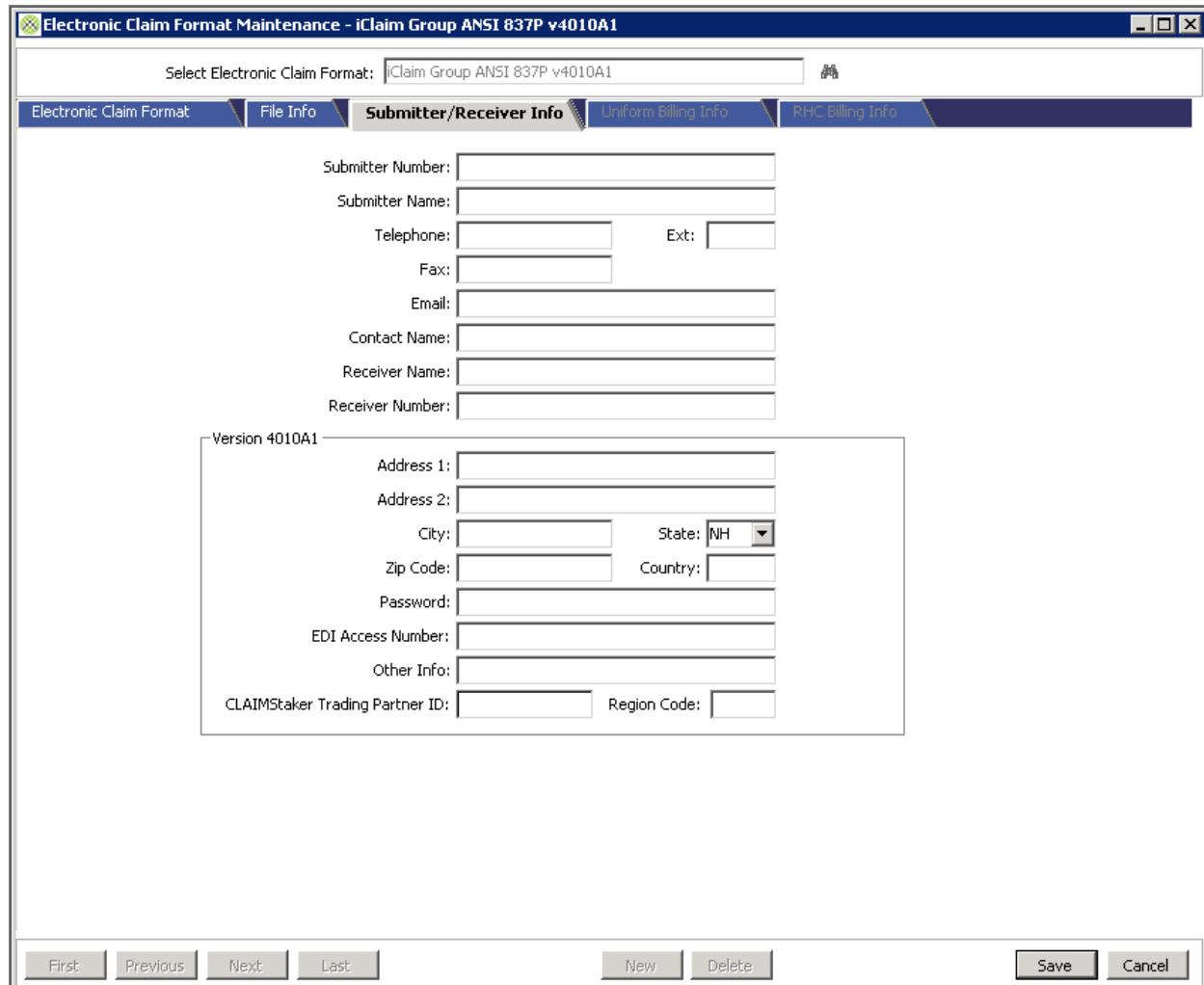
Outputs in Loop 1000B Segment NM1 Ref 03 for all Standard ANSI 837 formats.

Version 4010A1 area of the Submitter/Receiver Info tab

This topic describes the boxes on the **Submitter/Receiver Info** tab in **Electronic Claim Format Maintenance** that apply specifically to v4010 format types.

Access the **Submitter/Receiver Info** tab from **Electronic Claim Format Maintenance**. To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance** or press F9 and then enter ECM. The **Version 4010A1**

area is displayed only for records that have a v4010A1 format type selected on the **Electronic Claim Format** tab.



The screenshot shows the 'Electronic Claim Format Maintenance - iClaim Group ANSI 837P v4010A1' window. The 'Submitter/Receiver Info' tab is active. At the top, there is a dropdown menu 'Select Electronic Claim Format: iClaim Group ANSI 837P v4010A1'. Below the tabs, there are several input fields for submitter information: Submitter Number, Submitter Name, Telephone, Ext, Fax, Email, Contact Name, Receiver Name, and Receiver Number. A large section titled 'Version 4010A1' contains the following fields: Address 1, Address 2, City, State (with a dropdown menu showing 'NH'), Zip Code, Country, Password, EDI Access Number, Other Info, CLAIMstaker Trading Partner ID, and Region Code. At the bottom of the window are buttons for First, Previous, Next, Last, New, Delete, Save, and Cancel.

When you are creating a v4010A1 format type, a **Version 4010A1** area is displayed with the following boxes:

Version 4010A1

The following boxes are informational only and do not output to the file:

- > **Address 1**
- > **Address 2**
- > **City**
- > **State**
- > **Zip Code**

- > **Country**
- > **Password**

The telephone, telephone extension, fax, email address and EDI access number along with the applicable qualifier output in Loop 1000A Segment NM1 Ref 03 through Ref 08 when using the Standard ANSI X12N 837P v4010A1 format. Because this segment can only fit up to three different communication numbers and qualifiers, a second PER Segment is automatically created when more than three communication numbers are entered on this tab.

Password

Enter as directed.

EDI Access Number

Enter your Electronic Data Interchange Access Number. Outputs with the qualifier ED.

Other Info

Enter as directed.

CLAIMStaker Trading Partner ID

Provided if you are using the third-party application Alpha II ClaimStaker® Enterprise to match the **Electronic Claim Format Maintenance** record with its trading partner ID in Alpha II ClaimStaker.

Leave this box blank if you are using the Enterprise version of Alpha II ClaimStaker.

Region Code

Previously used for NSF claim files. This box does not apply to ANSI 837 formats.

Uniform Billing Info tab in Electronic Claim Format Maintenance

The **Uniform Billing Info** tab in **Electronic Claim Format Maintenance** is available only for v4010A1 format types.

This topic is intended to help you understand the relationship between your entries on the **Uniform Billing Info** tab and the process of generating an ANSI 837 file. The output examples presented use the Standard ANSI X12N 837I v4010A1 format based on Medicare specifications.

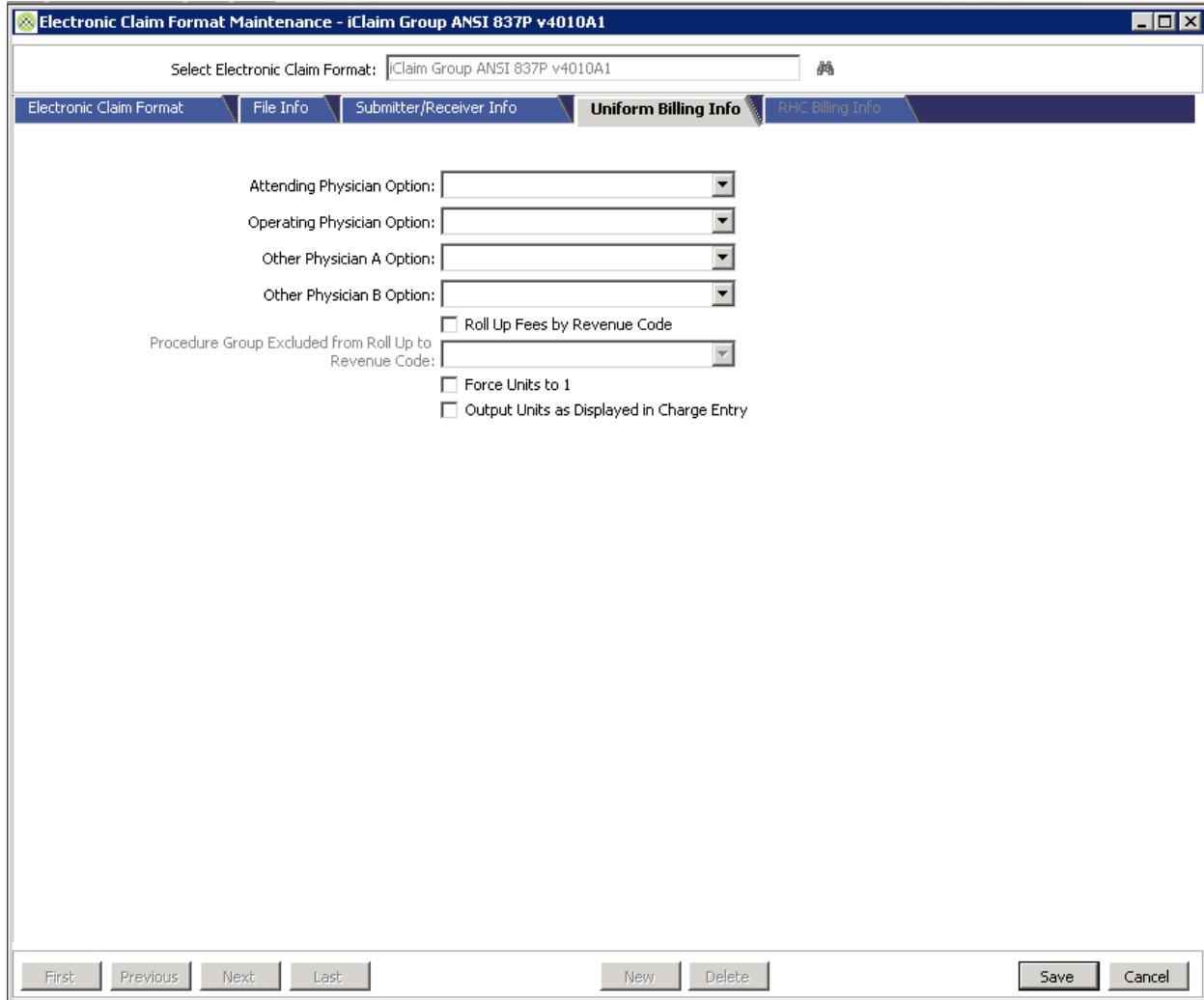
Note: If you are creating an institutional ANSI 837I v5010, v5010A1 or v5010A2 format type, you must make uniform billing selections on the **Validations** and **Output Options** tabs in **Claim Style Maintenance**.

You must complete this tab if you are creating a v4010A1 institutional format.

Always define claim formats with the assistance of a member of the Allscripts® Support or training team.

Access the **Uniform Billing Info** tab from **Electronic Claim Format Maintenance**. To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance** or press **F9** and then enter **ECM**.

Note: This tab is active only when **Format Type** is set to **Standard ANSI X12N 837I v4010A1** on the **Electronic Claim Format** tab.



The screenshot shows the 'Electronic Claim Format Maintenance' application window for 'iClaim Group ANSI 837P v4010A1'. The 'Uniform Billing Info' tab is selected. The interface includes a top navigation bar with tabs: 'Electronic Claim Format', 'File Info', 'Submitter/Receiver Info', 'Uniform Billing Info' (selected), and 'RHC Billing Info'. Below the tabs is a search bar labeled 'Select Electronic Claim Format: iClaim Group ANSI 837P v4010A1'. The main content area contains several dropdown menus for physician options ('Attending Physician Option', 'Operating Physician Option', 'Other Physician A Option', 'Other Physician B Option') and a checkbox for 'Roll Up Fees by Revenue Code'. There is also a dropdown menu for 'Procedure Group Excluded from Roll Up to Revenue Code'. At the bottom of the window are standard navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Attending Physician Option

Outputs is in Loop 2310A/Segment NM1 in a standard ANSI X12N 837I v4010A1 electronic claim file. When you also select the claim style output option **Output NPI Number**, the provider's NPI becomes the primary ID (NM108 & NM109).

- > **Actual Provider UPIN:** Retrieves the rendering provider's UPIN from the **Provider** tab in **Provider Maintenance**.

- > **Actual Provider Indiv No:** Retrieves the rendering provider's billing number from the **Indiv Provider Number** column entered on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Actual Provider Group No:** Retrieves the rendering provider's group billing number from the **Group Number** column entered on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Billing Provider UPIN:** Retrieves the billing provider's UPIN from the **Provider** tab in **Provider Maintenance**.
- > **Billing Provider Indiv No:** Retrieves the billing provider's billing number from the **Indiv Provider Number** column entered on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Billing Provider Group No:** Retrieves the billing provider's group billing number from the **cGroup Number** column entered on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Referring Provider UPIN:** Retrieves the referring doctor's UPIN from the **Referring Doctor** tab in **Referring Doctor Maintenance**.
- > **Referring Provider Billing No:** Retrieves the referring doctor's billing number from **Billing Numbers** tab in **Referring Doctor Maintenance**.

Operating Physician Option

Determines the operating physician's ID to use.

The operating physician is selected during charge entry using the **Claim Information** window.

When a selection exists, outputs in Loop 2310B Segment NM1 using a standard ANSI X12N 837I v4010A1 file. When you also select the claim style output option **Output NPI Number**, the provider's NPI becomes the primary ID (NM108 & NM109).

- > **Operating Physician UPIN:** Retrieves the provider's UPIN from the **Provider** tab in **Provider Maintenance**.
- > **Operating Physician Indiv No:** Retrieves the provider's billing number from the **Indiv Provider Number** column entered on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Operating Physician Group No:** Retrieves the provider's group billing number from the **Group Number** column on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Operating Physician Other No:** Retrieves the provider's billing number from the **Other Number(s)** column from the **Billing Numbers** tab in **Provider Maintenance**.

Other Physician A Option

When a selection exists, the NM1 segment in Loop 2310C is created in a standard ANSI X12N 837I v4010A1 file. When you also select the claim style output option **Output NPI Number**, the provider's NPI becomes the primary ID in Ref 08 and 09.

A value for **Other Physician A** is selected during charge entry using the **Claim Information** window.

- > **Other Physician A UPIN:** Retrieves the provider's UPIN from the **Provider** tab in **Provider Maintenance**.
- > **Other Physician A Indiv No:** Retrieves the provider's billing number from the **Indiv Provider Number** column on the **Billing Numbers** tab in **Provider Maintenance**.

- > **Other Physician A Group No:** Retrieves the provider's group billing number from the **Group Number** column on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Other Physician A Other No:** Retrieves the provider's billing number from the **Other Number(s)** column on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Referring Provider UPIN:** Retrieves the referring doctor's UPIN from the **Referring Doctor** tab in **Referring Doctor Maintenance**. An extra REF segment is created in Loop 2310C outputting the referring doctor's UPIN with a 1G qualifier code in REF01. The NPI still outputs to NM109, if it is flagged to output.
- > **Referring Provider Billing No:** Retrieves the referring doctor's billing number from the **Billing Number** column on the **Billing Numbers** tab in **Referring Doctor Maintenance**. Additionally, the referring doctor's federal tax ID outputs to its own REF segment.

Note: If a voucher has a referring provider and you select one of the referring provider options, Loop 2310C contains that referring doctor's information. However, the primary (NM109) and secondary identifiers (REF02) can vary based on two factors: the **Other Physician A Option** and whether the carrier is flagged to output the NPI.

Other Physician B Option

Does not output to the file.

A value for **Other Physician B** is selected during charge entry using the **Claim Information** window.

- > **Other Physician B UPIN:** Retrieves the provider's UPIN from the **Provider** tab in **Provider Maintenance**.
- > **Other Physician B Indiv No:** Retrieves the provider's billing number the **Indiv Provider Number** column entered on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Other Physician B Group No:** Retrieves the provider's group billing number from the **Group Number** column on the **Billing Numbers** tab in **Provider Maintenance**.
- > **Other Physician B Other No:** Retrieves the provider's billing number from **Other Number(s)** column on the **Billing Numbers** tab in **Provider Maintenance**.

Roll Up Fees by Revenue Code

Enabled only when you save the entries made on the **Electronic Claim Format** tab.

Unavailable when **RHC Billing** is selected on the **Electronic Claim Format** tab.

Important:

- > This option is ignored when revenue code 116 (or 0116) is billed. When revenue code 116 (or 0116) is billed, the service-line rate amount is output to Loop 2400/Segment SV2, Element 06.

- ||> This option is ignored when **FQHC Fee Calculation** on the **Output Options** tab in **Claim Style Maintenance** is set to **Voucher Total**.

When selected, the following occurs when the file is prepared:

- > The total fee amount for all the services outputs to the file.
- > Only one loop is created for all the services with the same revenue code and the same date of service. The revenue code, the primary procedure code, the total fee amount, and the units are identified in one loop in Segment SV2 of the electronic file.

For example, the entry for a claim that includes the procedure code members for revenue code 300 would look like this: SV2*300*HC:99211:25*12.25*Un1~.

|| **Note:** When you also select **Force Units to 1**, the total for the rolled-up units outputs as 1; otherwise, the total units for all services outputs to the file.

- > The service-line rate is not output to the SV2 segment even when a revenue code is within the range of 100-219.
- > When this option is not selected, a separate loop is generated for each service and procedure code.

Procedure Group Excluded from Roll Up to Revenue Code

Display a list of procedure groups.

Selecting a procedure group excludes the procedures that are members of that procedure group from rolling up to a revenue code for claims with service dates on or after 01/01/2011.

|| **Tip:** Create a procedure group that contains only procedures that must be excluded from rolling up to a revenue code.

This option is only enabled when **Roll Up Fees by Revenue Code** is selected.

Force Units to 1

Outputs 1 to Loop 2400 Segment SV2 Ref 05 for all services with the same service from and through date.

When not selected, the application outputs the total units for all services outputs to the file.

|| **Note:** This option is ignored when revenue code 116 (or 0116) is billed. When revenue code 116 (or 0116) is billed, the service-line rate amount is output to Loop 2400 Segment SV206.

This check box is only enabled when **Output Units as Displayed in Charge Entry** is not selected.

Output Units as Displayed in Charge Entry

This option is only used when the service spans more than one day.

When selected, units are reported on institutional (837I) claims as they are entered during charge entry instead of reporting the units automatically as the number of days.

This check box is only enabled when **Force Units to 1** is not selected.

RHC Billing Info tab in Electronic Claim Format Maintenance

The **RHC Billing Info** tab is intended for practices or organizations that submit claims to a Medicaid program that require a rural health center (RHC) encounter code on the claims that is different from the actual services rendered.

This tab is enabled only when **RHC Billing** is selected on the **Electronic Claim Format** tab in **Electronic Claim Format Maintenance**.

Using the **RHC Billing Info** tab affects all claims to the carrier that are in the claims file. Therefore, define separate paper claim format records for Medicare and Medicaid RHC claims.

Note: Allscripts® Practice Management does not support secondary RHC institutional claims; only secondary RHC professional claims are supported. Secondary RHC institutional claims should be submitted as UB-04 claims.

Access the **RHC Billing Info** tab from **Electronic Claim Format Maintenance**. To access **Electronic Claim Format Maintenance**, go to **System Administration > File Maintenance > Electronic Claim Format Maintenance** or press **F9** and then enter **ECM**.

Electronic Claim Format Maintenance - iClaim Ins ANSI 837I v4010A1

Select Electronic Claim Format: iClaim Ins ANSI 837I v4010A1

Electronic Claim Format | File Info | Submitter/Receiver Info | Uniform Billing Info | **RHC Billing Info**

Output RHC Encounter Service and Fee:

RHC Encounter Procedure Code: Mod:

Alt RHC Encounter Procedure Code 1: Mod: TOS:

Alt RHC Encounter Procedure Code 2: Mod: TOS:

RHC Encounter Procedure Fee: \$0.00

Output Actual Services and Fees:

Suppress Rendering Provider from Claim and Service Levels

Procedure Group Excluded from RHC Encounter
Procedure Code:

Revenue Code

RHC Encounter Revenue Code:

Alt RHC Encounter Revenue Code 1:

Alt RHC Encounter Revenue Code 2:

Ignore RHC Billing Info for Secondary Claims?

First | Previous | Next | Last | New | Delete | Save | Cancel

Output RHC Encounter Service and Fee

Required field. Determines which service fee amount is reported on the encounter service line.

The hardcoded options are the following:

- > **RHC Encounter Procedure Fee:** Selecting this option enables the **RHC Encounter Procedure Fee**. Reports the fee entered in **RHC Encounter Procedure Fee**.
- > **Voucher Total:** Selecting this option reports a fee that is equal to the sum of all of the services on the claim.

If you select **Voucher Total**, **RHC Encounter Procedure Fee** is not available.

RHC Encounter Procedure Code

Required. Enter the encounter procedure code required by the carrier, for example T1015.

Holds up to 10 characters.

Mod

Optional. Enter the encounter modifier required if all encounter service lines must contain a specific modifier code.

If more than one modifier must be reported, use a comma (,) to separate each modifier, for example: MO, ACB, RX.

Alt RHC Encounter Procedure Code 1

Optional unless you enter a modifier.

Enter an alternate encounter procedure code if a unique encounter procedure code must be reported based on type of service.

Mod

Optional. Enter the encounter modifier required if all encounter service lines must contain a specific modifier code.

If more than one modifier must be reported, use a comma (,) to separate each modifier, for example: MO, ACB, RX.

TOS

Required if a procedure code is entered in **Alt RHC Encounter Procedure Code 1**.

Select a type of service.

Note: The alternate RHC procedure code and modifier are output when the type of service that you select matches with the type of service on the first service on the voucher (as entered during charge entry).

Alt RHC Encounter Procedure Code 2

Optional unless you enter a Modifier.

Enter another alternate encounter procedure code if a unique encounter procedure code must be reported based on type of service.

Mod

Optional. Enter the encounter modifier required if all encounter service lines must contain a specific modifier code.

If more than one modifier must be reported, use a comma (,) to separate each modifier, for example: MO, ACB, RX.

TOS

Required if a procedure code is entered in **Alt RHC Encounter Procedure Code 2**

Select a type of service.

Note: The alternate RHC procedure code and modifier are output when the type of service that you select matches with the type of service on the first service on the voucher (as entered in during charge entry).

RHC Encounter Procedure Fee

Enabled and required when **Output RHC Encounter Service and Fee** is set to **RHC Encounter Procedure Fee**.

Enter the flat rate amount, or zero, to be reported on the encounter service.

Output Actual Services and Fees

Required. Determines how non-encounter service lines are reported on the claim.

- > **Do Not Output:** Prevents all non-encounter services from outputting on the claim.
- > **Zero:** Forces the service fee amount for non-encounter services to zero.
- > **Service Fee:** Outputs all non-encounter services on the claim. The service fee reported is the service fee entered during charge entry.

SUPPRESS RENDERING PROVIDER FROM CLAIM AND SERVICE LEVELS

Enabled for professional format types only.

Select when the carrier does not want you to send rendering provider information.

When selected, Loops 2310B and 2420A are not created in the file.

PROCEDURE GROUP EXCLUDED FROM RHC ENCOUNTER PROCEDURE CODE

Enabled when **Output Actual Services and Fees** is set to **Do Not Output**.

All procedure codes associated to the selected procedure group will not be included in the roll up to the encounter code service line. These services will appear in their own SV2 segment.

These services print on the claim as its own service, including the service's unit and fee regardless of how the RHC encounter line is defined to print (**Voucher Total** or **RHC Encounter Procedure Fee**).

Each of these procedures outputs on the claim with the fee amount entered during charge entry.

If the same voucher contains procedures that are part of the selected group as well as procedures that are not, the application outputs the encounter procedure code with the appropriate encounter rate for the codes not in the group and the procedure codes with their corresponding fees that are part of the group on the same claim.

The procedure codes in the selected procedure group are excluded from all other **RHC Billing Info** tab options.

The **Revenue Code** grid, which enables you to select revenue codes used in RHC billing, is active only for institutional format types.

This section enables you to select a revenue code for each of the corresponding encounter procedure codes that you entered in the boxes at the top of the tab.

Make a selection when the payer requires you to report a revenue code that is different from the revenue code associated with the actual Evaluation and Management Code (E&M code).

RHC Encounter Revenue Code

Select if the revenue code associated with the RHC encounter code must be unique.

If you do not make a selection, the revenue code associated with the first service on the claim is used.

The list shows all of the revenue codes that you created in **Revenue Code Maintenance**.

Enables you to select a revenue code for each of the corresponding encounter procedure codes that you entered above when the payer requires you to report a revenue code that is different from the revenue code associated with the actual Evaluation and Management Code (E&M code).

When **Output Actual Services and Fees** is set to either **Zero** or **Service Fee**. Each service on the voucher outputs to Loop 2400 Segment SV2-02.

Alt RHC Encounter Revenue Code 1

Select if the revenue code associated with **Alt RHC Encounter Code 1** must be unique.

If not selected, the revenue code associated with the first service on the claim is used.

Alt RHC Encounter Revenue Code 2

Select if the revenue code associated with **Alt RHC Encounter Code 2** must be unique.

If not selected, the revenue code associated to the first service on the claim is used.

Ignore RHC Billing Info for Secondary Claims?

Select this option to suppress encounter code information (the information on the **RHC Billing Info** tab) on secondary electronic claims (v4010 or v5010). Only services entered on the voucher during charge entry are output on the secondary claim. Primary electronic claims are not affected by this option.

Claim Style Maintenance window

Claim Style Maintenance enables you to create different printed and electronic formats to process claims.

You might want to create a one-to-one match between a claim format and a claim style, or you might be able use one claim format with multiple claim styles.

The paper claim style and electronic claim style that you select for a carrier in **Insurance Carrier Maintenance** governs the validation criteria and output options used to print claim forms and generate an electronic file for claims billed to the carrier.

You must create at least one claim style for each claim format used by your practice or organization.

Think of the claim format as the actual print form or electronic file structure (loops and segments) and the claim style as the tool that you use to customize the format to a carrier's unique specifications.

The styles that you create in **Claim Style Maintenance** are included in the related lists in **Insurance Carrier Maintenance**.

Before you can create records in **Claim Style Maintenance**, the paper claim formats and electronic claim formats used by your practice must be defined in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

Examples of some of the styles that you will need to consider are:

Sample claim styles for paper claims

Standard CMS NPI 1500

Standard UB-04

State-specific Medicaid

Workers' compensation

Sample claim styles for electronic claims

Currently Allscripts® Practice Management supports the Standard ANSI X12N 837D, Standard ANSI X12N 835I and Standard ANSI X12N 837P format types for v4010A1 and v5010 and higher.

However, going forward you will most likely be creating claim styles only for the v5010 format types.

If necessary, create other styles that define specifications required by your vendor or carrier. Allscripts® claims specialists are available to assist you in determining the correct setup for your practice or organization.

Claim Style Maintenance contains these tabs:

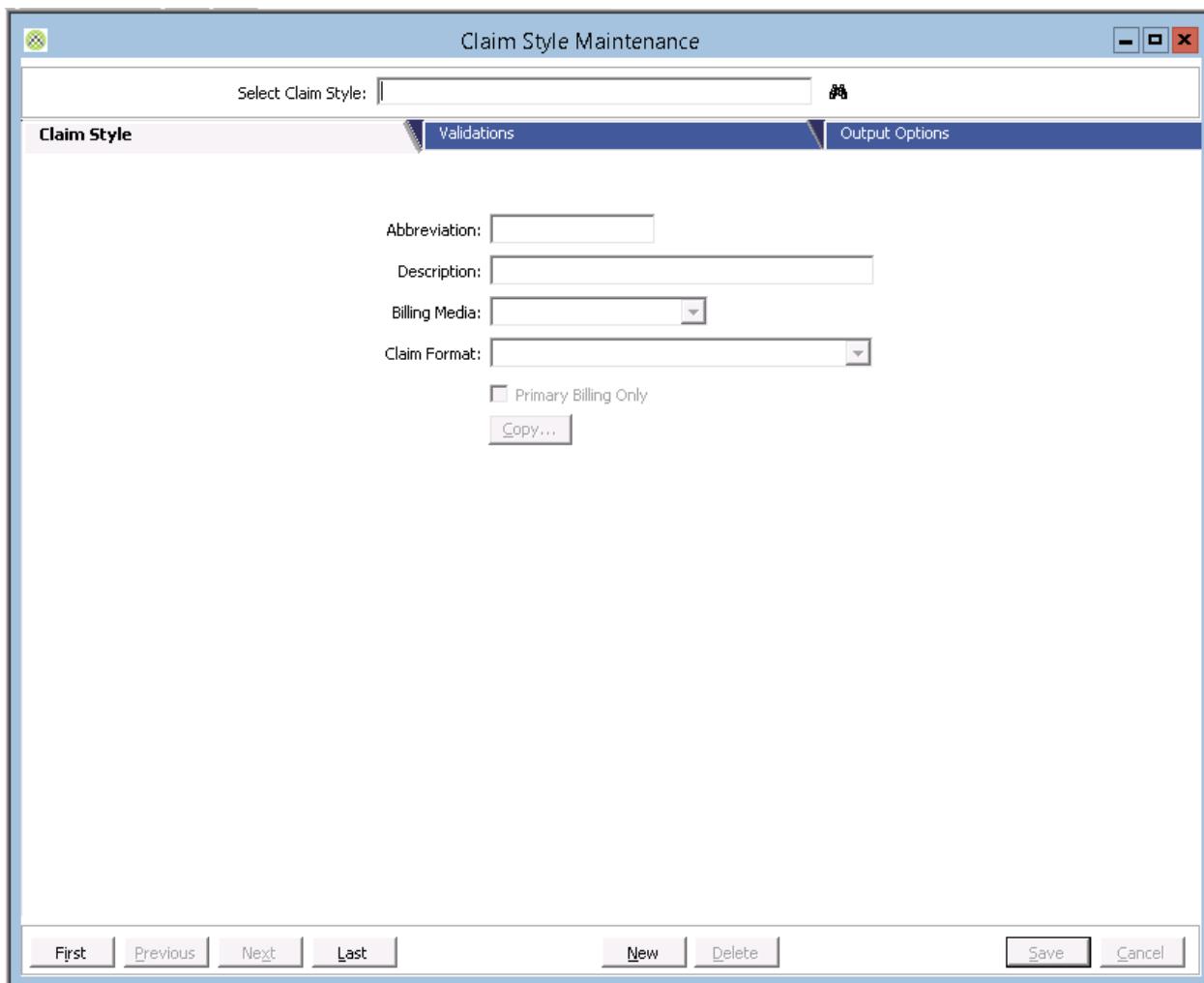
- > **Claim Style**
- > **Validations**
- > **Output Options**
- > **History**

Access **Claim Style Maintenance** from **System Administration > File Maintenance > Claim Style Maintenance**, or press **F9** and then enter **CSM**.

Claim Style tab

Use the **Claim Style** tab in **Claim Style Maintenance** when creating a claim style record .

Access the **Claim Style** tab from the **Claim Style Maintenance**. To access **Claim Style Maintenance**, go to **System Administration > File Maintenance > Claim Style Maintenance**, or press **F9** and then enter **CSM**.



The screenshot shows the 'Claim Style Maintenance' window. At the top, there is a search bar labeled 'Select Claim Style:' with a magnifying glass icon. Below the search bar, there are three tabs: 'Claim Style' (which is selected), 'Validations', and 'Output Options'. The main area contains the following fields:

- 'Abbreviation:' input field
- 'Description:' input field
- 'Billing Media:' dropdown menu
- 'Claim Format:' dropdown menu
- A checkbox labeled 'Primary Billing Only'
- A 'Copy...' button

At the bottom of the window, there are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

This is a required box that holds up to 8 characters.

Enter the abbreviation that identifies the claim style.

Best Practice: For support purposes, use the naming convention indicated in the project documentation provided by Allscripts®.

You must enter a unique value, which means that no other claim style record can have the same abbreviation.

Description

This is a required box that holds up to 40 characters.

The description indicates when and how the claim style can be used.

The value in this box is displayed in **Insurance Carrier Maintenance**.

Best Practice: For support purposes, use the naming convention indicated in the project documentation provided by Allscripts®.

Billing Media

The drop-down list enables you to select either **Paper** or **Electronic**.

The media selected determines the formats that are available in **Claim Format** and on the **Output Options** tab.

Claim Format

If you selected **Paper** for **Billing Media**, select from the list of paper claim formats that are defined in **Paper Claim Format Maintenance**.

If you selected **Electronic** for **Billing Media**, select from the list of electronic claim formats that are defined in **Electronic Claim Format Maintenance**.

Note: The display of options on the **Validations** tab and **Output Options** tabs is driven by the combination of the billing media (electronic or paper), claim format's format type (dental, institutional, or professional), and version (4010A1, or 5010 and higher).

Primary Billing

Select this option to use the claim style to bill the carrier for primary claims only.

Qualifies only claims that are billed out to the primary insurance indicated on the **Policies** tab in **Registration** for the patient.

Determines the selection list that this claim style is included in. For example, "Electronic" determines that the Claim Style is included as an option for electronic claim styles.

Related options are on the **General** tab in **Practice Options** or **Organization Options**.

Do not select this option if you want all claims (primary, secondary, and so on) to go to the carrier electronically.

Copy

This button is enabled only when the record is saved.

Opens **Copy Claim Style**. Use **Copy Claim Style** to create a new claim style record using the existing record as the basis.

Validations tab in Claim Style Maintenance

There are generic validation requirements that are hardcoded within Allscripts® Practice Management. Additionally, in **Claim Style Maintenance**, you can define carrier-specific criteria that governs the validation of claims associated with that carrier's claim style.

The list of validations that are displayed on this tab is driven by the combination of the format type (dental, institutional, or professional), format version (4010A1, or 5010 and higher) and billing media (electronic or paper) that you selected on the **Claim Style** tab.

Note: A claim that fails the validation process is flagged as ineligible for printing or transmission until the validation errors are manually corrected. Therefore, accuracy in setting these options is extremely important.

The following custom-defined validation checks are considered registration-related checks:

- > **Certificate Number Format**
- > **Certificate Patient Suffix Required**
- > **Certificate Subscriber Suffix Required**
- > **Group Number Required**
- > **Group Name Required**

A warning message is displayed in **Registration** when you define one of these validation options for the claim style that is associated with a patient's policy and you have **Check Reg Related Claim Style Validation** selected on the **Registration** tab in **Practice Options** or **Organization Options**.

How it works

When the selected or defined criteria is not met on a voucher whose selected policy is the claim style's associated carrier, the voucher fails validation.

Vouchers are validated on the **Charge Entry** tab and **Edits** tab in **Transactions** based on the correct claim style validation options. As with billing, the primary claim style (paper or electronic) is used unless the voucher qualifies to use an alternate claim style if one exists. An alternate claim style is used if all of the service's procedure codes are flagged for alternate claim style in **Procedure**

Code Maintenance. The electronic claim style is always used unless the carrier record has no electronic claim style, in which case the paper claim style is used. Whether an alternate claim style is used is determined during charge entry.

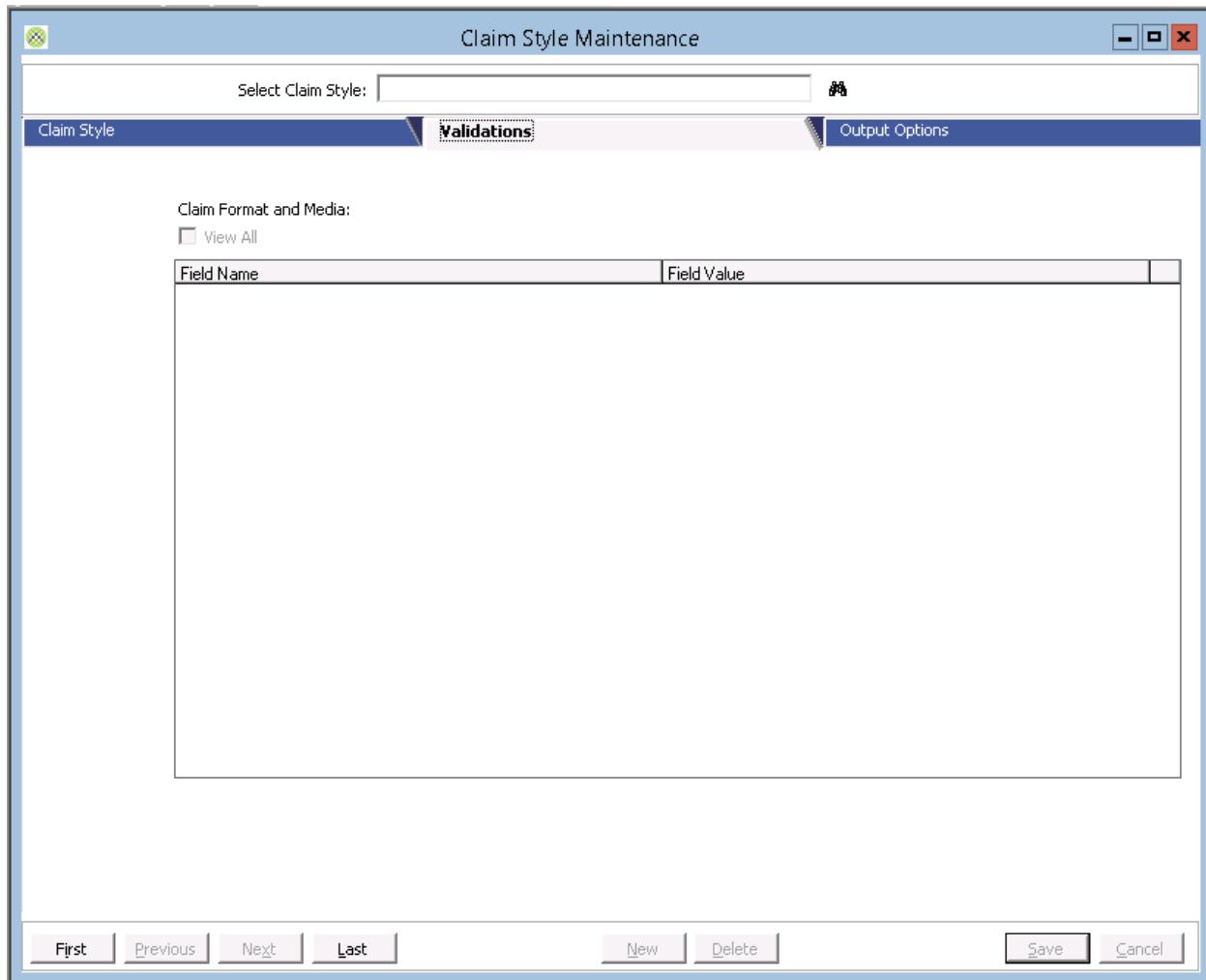
When the registration process validates against a claim style, the validations are only based on the carrier's primary claim style.

How validation errors are corrected

Claims that fail validation can be corrected using one of the following functions:

- Pending Management Corrections access from the **Validate Batches** tab in **Batch Management**.
- The **Pending Claims Management** tab in **Billing > Claims Review**.
- **Pending Claims Management** in **Office Manager**.
- The **Edits** tab in **Batch Management**.

Access the **Validations** tab from the **Claim Style Maintenance**. To access **Claim Style Maintenance** go to **System Administration > File Maintenance > Claim Style Maintenance**, or press **F9** and then enter **CSM**.



Validations for paper claims and v4010 electronic claims

The following validation options are on the **Validations** tab in **Claim Style Maintenance** for paper claims and v4010 electronic claims.

ANSI 837 Validation Checks

When selected, the application performs a series of checks when the voucher qualifies for validation.

Certificate Number Format

Determines whether the format used to enter the Patient's Certificate Number in Registration is used to validate claims. Displays a soft warning in Registration when the option "Check

"Reg Related Claims Style Validation" is selected in Practice/Organization Options on the Registration tab.

Note: A soft warning enables the operator to save the voucher without making the necessary changes. However, the voucher does fail validation if the required information is not entered.

When defining a format keep the following in mind:

- > use an **X** to represent a place holder within the prefix
- > use an **N** to represent a place holder within the certificate number
- > use an **A** to represent a place holder within the suffix

So, if a Carrier requires a 9 digit certificate number to contain a 2 character prefix and a 1 character suffix your entry on this tab would look like this: XXNNNNNNNNNA. (refer above for use of hyphens and dashes)

Available format options for **Field Value** are the following:

- > Leave blank: A validation check of the certificate number will not take place.
- > Question mark: Enter ? when a carrier's certificate number format might vary. For example some patient certificate numbers issued by the carrier include alpha prefixes while others include only numbers.
- > Hyphens or dashes: To pass validation, the exact format entered here must be used when entering the certificate number in **Registration**. For example, when the format NNN-NN-NNNN is defined, the entry in **Registration** must include nine digits, and there must be a dash after the third and fifth numbers in the certificate number, such as 010-25-2313.
- > No hyphens, dashes, or spaces: To pass validation, the exact format entered here must be used when entering the certificate number in **Registration**. For example, when the format NNNNNNNNN is defined, the entry in **Registration** must include nine digits without spaces, dashes or hyphens, such as, 010252313.
- > Underscore: Enables the optional use of hyphens or dashes. For example, when the format NNN_NN_NNNN is defined, the entry in **Registration** can be any nine-digit certificate number entered with or without hyphens or dashes.

Certificate Number Prefix

Enables validation on the certificate number prefix entered for the policy in Registration.

Certificate Patient Suffix Required

Selecting this option requires the entry of a suffix in **Patient Certificate Suffix** on the **Policies** tab in **Registration**.

Displays a soft warning in **Registration** when **Check Reg Related Claims Style Validation** is selected on the **Registration** tab in **Practice Options** or **Organization Options**.

Note: A soft warning enables you to save the voucher without making the necessary changes. However, the voucher fails validation if you do not enter the required information.

Certificate Subscriber Suffix Required

Selecting this option requires the entry of a suffix in **Subscriber's Certificate Suffix** in **Registration** if the patient is not the subscriber, that is, if the entry in **Patient Relationship** is anything other than **Self**.

Displays a soft warning in **Registration** when **Check Reg Related Claims Style Validation** is selected on the **Registration** tab in **Practice Options** or **Organization Options**.

Note: A soft warning enables you to save the voucher without making the necessary changes. However, the voucher fails validation if you do not enter the required information.

Credentialing for Billing Provider Required

Works in conjunction with the following:

- > **Billing Numbers** tab in **Provider Maintenance**: Crd option associated with a profile
- > **Profiles** tab in **Insurance Carrier Maintenance**: with the selection of **Billing Number Credentialing Profile** in **Insurance Carrier Maintenance**

When all pieces of setup are complete, vouchers for providers who do not have **Crd** selected for the carrier's associated profile fail validation.

In **Validate Claims**, you can exclude vouchers that fail this validation by selecting **Exclude Non-Credentialed Provider**.

Different Act & Billing Providers for Mid-Levels Required

Selecting this option requires that the actual provider and billing provider on the voucher are different when the actual provider is flagged as a mid-level provider in **Provider Maintenance**.

During charge entry, the soft-warning **Invalid Data** was entered for **Billing Provider** is displayed when **Check Chg Related Claim Style Validations** is also selected in **Practice Options** or **Organization Options**.

Select this option when the carrier does not credential mid-level providers.

Group Name Required

Selecting this option requires an entry in **Grp Name** on the **Policies** tab in **Registration**.

Displays a soft warning in **Registration** when **Check Reg Related Claim Style Validations** is selected on the **Registration** tab in **Practice Options** or **Organization Options**.

Note: A soft warning enables you to save the voucher without making the necessary changes. However, the voucher fails validation if you do not enter the required information.

Group Number Required

Selecting this option requires an entry in **Group No** on the **Policies** tab in **Registration**.

Displays a soft warning in **Registration** when **Check Reg Related Claim Style Validations** is selected on the **Registration** tab in **Practice Options** or **Organization Options**.

Note: A soft warning enables you to save the voucher without making the necessary changes. However, the voucher fails validation if you do not enter the required information.

Maximum Diagnoses per Voucher

Enter a number if the carrier restricts the number of diagnoses per claim.

When selected, prevents a claim with more diagnoses from passing validation.

Displays a soft warning during charge entry when **Check Chg Related Claim Style Validations** is also selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

Note: A soft warning enables you to save the voucher without making the necessary changes. However, the voucher fails validation if you do not enter the required information.

Maximum Services per Voucher

Enter a number if the carrier restricts the number of procedure codes per claim.

Prevents a claim that contains more services from passing validation.

Displays a soft warning during charge entry when **Check Chg Related Claim Style Validations** is also selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

Note: A soft warning enables you to save the voucher without making the necessary changes. However, the voucher fails validation if you do not enter the required information.

NDC Info Required for Specified Procedure Group

List all the procedure groups in your tenant.

When a procedure group is entered, any procedure code that is part of that group is required to have **NDC#, Unit of Measure, Unit Count on Drug Services** completed. Failure to complete

those boxes results in a hard stop message during charge entry when **Check Chg Related Claim Style Validations** is also selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**. A hard warning prevents you from saving the voucher until the required information is entered.

If the claim style validation option is selected but the practice or organization option is not selected, the claim fails validation, but you are not given a warning when you save the voucher.

Note: The charge import process also uses this validation option.

NPI Required

When this option is selected, the following must be true for claims to pass validation:

- > A national provider identifier (NPI) is entered in the related file maintenance table
- > The NPI is 10 digits long and numeric, and its 10th digit is a check digit that can be used to identify it as a national provider identifier

Important: Be sure to select the output option **Output NPI Number**.

If this option is not selected and **Output NPI Number** is selected, the validation process verifies that the number entered is a valid NPI number, but it does not verify that it is the correct NPI for your provider or practice. This validation only verifies that the NPI has the correct configuration to identify it as a national provider identifier. Claims with an NPI that is not configured correctly fail validation.

Referral Required for Specified Places of Service

A voucher fails validation when all of the following conditions exist:

1. It is billed to the carrier associates with the claim style.
2. It contains one of the selected places of service.
3. A referral is not attached to it.

Displays a soft warning during charge entry when **Check Chg Related Claim Style Validations** is also selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**. If the you are unable to attach a referral to the voucher at that time, you can still save the voucher; however, it will fail validation.

To select one or more places of service, do the following:

1. Click  to open **Select Places of Service**.
2. Select a place of service by clicking on it in the grid.

Note: To select places of service listed consecutively, click the first place of service that you want, and then press **Shift** while clicking the last place of service in the series, which selects all the items in the range.

To select places of service not listed consecutively, click a place of service, and then press **Ctrl** while clicking each place of service that you want to select.

The charge import, split billing, and void and re-enter processes all use this validation.

Referring Doctor Required

Selecting this option require that a referring doctor is selected for the voucher.

This requirement applies only to the validation process. Selection this options does not prevent you from saving the transaction during charge entry.

Separate Claim required for each Calendar Year

Select this option when the carrier requires that the service dates on a voucher do not span more than one calendar year.

When this option is not selected, you can enter service dates that span more than one calendar on the same voucher when it is billed to the carrier.

Note: The application prevents you from saving a voucher that has a service date in the future.

The date or date range for each service entered on the voucher is selected when the voucher is validated. For example, a voucher would fail this validation check if it had either or both of the following:

- > One service line with a service date range spanning more than one calendar year, such as 12/28/2008 to 01/04/2009
- > Multiple service lines when the combined date ranges span more than one calendar year.
For example:
 - service line 1: 12/28/2008 to 12/31/2008
 - service line 2: 01/01/2009 to 01/04/2009

To also display a hard stop warning during charge entry that prevents you from saving the voucher, **Check Chg Related Claim Style Validations** must also be selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**. A hard stop warning prevents the voucher from being saved until the necessary correction is made. When that option is not selected, you can save the voucher if the service dates span more than one year, but it will fail the validation process.

Note: This logic is used by the charge import process only when charges are imported individually.

Separate Claim required for each TOS

Select this option if a carrier requires that a claim can include only one type of service.

Suppress Warning for Subscriber DOB

When you select this option and **Check Reg Related Claim Style Validations** is also selected on the **Registration** tab in **Practice Options** or **Organization Options**, and you leave **Subscriber's Birth Date** blank for a patient's policy, the soft warning **Warning**, no data was entered for **Subscriber Birth Date** is not displayed when you save the registration record or proceed to another tab in **Registration**.

Important: Because the subscriber's date of birth is part of the ANSI 837 checks that the application performs, using this option might result in claim rejections when **Subscriber's Birth Date** is blank.

Taxonomy Code Required

Provider taxonomy codes are maintained by the National Uniform Claim Committee. A listing can be obtained at <http://www.wpc-edi.com/codes/Codes.asp>.

Allscripts® Practice Management retrieves this information from the **Billing Numbers** tab in **Provider Maintenance** and **Referring Doctor Maintenance**.

Output Options tab for v4010 electronic claims

The options selected on the **Output Options** tab in **Claim Style Maintenance** govern if and how billing data outputs to an electronic claim file.

Access the **Output Options** tab from **Claim Style Maintenance**. To access **Claim Style Maintenance** go to **System Administration > File Maintenance > Claim Style Maintenance**, or press **F9** and then enter **CSM**.

Select the applicable options using your carrier's specifications. If you have any questions regarding the completion of this tab, call Allscripts® Support.

Claim Style Maintenance - ANSI X12N 837P v4010A1

Select Claim Style: **ANSI X12N 837P v4010A1**

Field Name	Field Value
Anesthesia Unit Display	<input type="checkbox"/>
Append Suffix to Certificate Number	<input type="checkbox"/>
Append ID Suffix to Federal ID	<input type="checkbox"/>
Billing Number Option Override	<input type="checkbox"/>
Default Medicare Secondary Reason Code	<input type="checkbox"/>
Ignore Billing Provider for Mid-Levels?	All Charges
K3 Type	<input type="checkbox"/>
Output Alt. Medicare Suppl. Number?	<input type="checkbox"/>
Output Certificate Number as entered?	<input type="checkbox"/>
Output Claim # Prefix?	<input type="checkbox"/>
Output Clinic # for ANSI 837 formats	<input type="checkbox"/>
Output CLIA #?	<input type="checkbox"/>
Output CPT's in RVU order on Prof. Claims	<input type="checkbox"/>
Output Denial Description on Secondary Claims?	<input type="checkbox"/>
Output Dentist License Number?	<input type="checkbox"/>

Anesthesia Unit Display

Prints anesthesia related units in Box 24G on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when a service with a procedure type of Anesthesia (Timed) is included on the claim.

This option should be left blank if anesthesia billing does not apply.

Select the applicable options from the list.

- > Charge Units
- > Time Units
- > Additional Base Units
- > Minutes
- > Hours/Minutes
- > Force to 1 Unit
- > Zero Fill

When transmitting claims using **McKesson ANSI 837P v4010A1**, **Standard ANSI X12N 837P v4010A1**, or **Texan THIN ANSI 837P v4010A1** electronic claim formats, the following applies.

- > If set to **Default/Blank** or **Minutes**, the Unit or Measurement Code (SV103) will be MJ and the Unit Count (SV104) will be in minutes.
- > If set to **Charge Units**, **Time Units**, **Additional Base Units**, or **Hours/Minutes**, the Unit or Measurement Code will be set to UN and the Unit Count will contain the unit value for the option selected.

- > **Procedure Type** for the service must be defined as **Anesthesia in Procedure Code Maintenance**.

Append Suffix to Certificate Number

Prints the insured's certificate with suffix in Box 1a on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when either patient's certificate suffix (when the patient is the subscriber) or subscriber's certificate (when the subscriber is a contact other than the patient) is entered on the **Policies** tab in **Registration**.

When this option is selected both the patient and subscriber certificated suffixes are automatically added to the certificate number. This information must be entered in **Patient Certificate Suffix** and **Subscriber's Certificate Suffix** on the **Policies** tab in **Registration**.

Append ID Suffix to Federal ID

Prints the Federal Tax ID number with ID Suffix in Box 25 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/ 12).

When this option is selected, the application retrieves the value from **ID Suffix** in the maintenance file relative to **Tax ID Option** selected in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

Example: If the selected **Tax ID Option** for a format is **Practice/Organization**, the application will retrieve the tax ID suffix from the information on the **Practice Information** or **Organization Information** tab in **Practice Set Up** or **Organization Set Up**.

Billing Method Override

Important: If you think this feature might benefit your practice or organization, contact Allscripts® Support for assistance.

Use this option when a billing provider needs to submit a billing method that is different from the billing method set in **Electronic Claim Format Maintenance** associated with this claim style.

Default Medicare Secondary Reason Code

Select a HIPAA-compliant secondary reason code for the claim style associated with your Medicare Secondary Payer (MSP) carrier.

Sets the default secondary reason C=code that reports to Loop 2000B, SBR05 in a standard ANSI X12N 837P v4010A1 when billing the carrier.

To select a code:

1. Click to open the drop-down list of HIPAA-compliant secondary reason codes with their descriptions.
2. Scroll through the list to locate the reason code that is most often used by your practice or organization when submitting MSP claims.
3. Click on your selection to fill the box.

FQHC Fee Calculation

Select **Voucher Total** to output Federally Qualified Health Center (FQHC) claims with the total voucher fees, excluding the fees for any preventive services and other non-covered FQHC services. Otherwise, leave this option blank.

Note:

This option only applies to institutional claims.

When **Voucher Total** is selected, **Roll Up Fees by Revenue Code** on the **Uniform Billing** tab on **Electronic Claim Format Maintenance** is ignored, even if you select it.

--Encounter Rate Exclusions

Select the procedure group that includes those preventive and non-covered Federally Qualified Health Center (FQHC) services where the fee must be excluded from the voucher total on the encounter line that includes the 052X revenue code and a 99XXX procedure code flagged as an E&M procedure.

Note: This option is only enabled when **FQHC Fee Calculation** is set to **Voucher Total**.

Ignore Billing Provider for Mid-Levels

Used when the carrier credentials mid-levels.

Select one of the following from the drop-down list:

- > **All Charges:** When selected and the voucher's actual provider has **Mid-Level Provider** selected, the voucher's actual provider becomes the voucher's billing provider.
- > **Not Incident To Charges:** When selected and the voucher's actual provider has **Mid-Level Provider** selected and the voucher has **Not Incident To** selected on the **Charge Entry** or **Edits** tab, the voucher's actual provider becomes the voucher's billing provider.

K3 Type

Used for Louisiana KidMed billing only.

Selecting **LA KidMed** from the drop-down list causes the following loops and segments to be created in a Standard ANSI X12N 837P v4010A1 electronic claim file:

- > Loop 2010BC (Responsible Party Information) for patients under the age of 21 if the responsible party's address is the same as the patient's
- > Loop 2300/Segment K3

Output Add'l Claim Dx

Select this option when the payer requires you to report additional claim-level-only diagnosis codes a professional claim.

The additional claim-level-only codes output to Loop 2300, Segment HI in the Standard ANSI X12N 837P v4010A1 claim file for professional claims.

Note: If you select this option for a claim style whose associated claim format is either Standard ANSI X12N 837I v4010A1 or the Standard ANSI X12N 837D v4010A1, nothing outputs as this option only works with the Standard ANSI X12N 837P v4010A1 format.

Output Alt. Medicare Suppl. Number?

Because some Medicare intermediaries use unique MediGap numbers that differ from those used by other intermediaries, clients who have offices in different states are sometimes required to submit a different supplemental number for cross over claims depending on the state in which the service was rendered.

When you are given two different MediGap numbers by two Medicare intermediaries for submitting crossover claims to the same supplemental insurer, follow these steps:

1. Enter a Medicare supplemental number and an alternate Medicare supplemental number for the supplemental carrier (for example, AARP) on the **Additional Info** tab in **Insurance Carrier Maintenance**.
2. Select the output option **Output Alt Medicare Suppl. Number** on the claim style associated with the primary carrier requiring the submission of the number you identified as the alternate supplemental number.

Note: The prepare claims process recognizes and outputs an alternate Medicare supplemental number when the alternate Medicare supplemental number is entered in **Insurance Carrier Maintenance** and the option **Output Alt Medicare Suppl Number** in **Claim Style Maintenance** is selected. This logic applies to all paper claim formats and for the following electronic claim formats: Standard ANSI X12N 837I v4010A1 and Standard ANSI X12N 837P v4010A1.

Output Certificate Number as entered?

Selecting this option prevents a certificate number from being stripped of hyphens and spaces.

Use this option with the following formats:

- > Standard ANSI X12N 837P v4010A1
- > Standard ANSI X12N 837I v4010A1

Output Claim # Prefix

When selected, the claim # prefix unique to your practice or organization will be attached to the claim number when it is printed or transmitted electronically.

If you are working with only one data base enter the number **1** in this box.

If you have multiple tenants, enter the number assigned to identify your practice or organization.

Appends the claim # prefix to the claim number in Box 26 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/ 12).

Output Clinic # for ANSI 837 formats

Your assigned clinic number is entered on the file maintenance form in **Practice Set Up** or **Organization Set Up, Department Maintenance** or **Practice Maintenance**, and **Location Maintenance**.

Use the combo box to tell the application where you want it to find and use the clinic related to the current claim style.

The selections available are the following:

- > **Blank:** Leave blank when there is no clinic number to report.
- > **Department or Practice:** Retrieves the clinic number entered in **Department Maintenance** or **Practice Maintenance**.
- > **Location:** Retrieves the clinic number entered in **Location Maintenance**.
- > **Practice or Organization:** Retrieves the clinic number entered in **Practice Set Up** or **Organization Set Up**.

Output CLIA #

This option must be selected to fill the corresponding record in an electronic file.

The **CLIA #** transmits when no **Prior Auth #** exists on those claims which include a procedure code with the procedure type of **Lab Procedure**.

Be sure that you have done both of the following:

Prints the CLIA # in Box 23 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when no prior authorization # exists on those claims which include a service with the procedure type of Lab.

- > Entered your assigned CLIA # in **Place of Service Maintenance**
- > Selected the procedure type of **Lab Procedure** for the relevant codes

Output CPTs in RVU order on Prof Claims

Use this option to control the order in which services are reported on a professional claim no matter what order they were entered during charge entry.

Select the appropriate option from the drop-down list:

- > **Work RVU:** Work relative value unit (RVU) procedures are output in descending work RVU order for professional claims. Procedures without a Work RVU are output in the order in which they were entered starting below any procedures with Work RVUs.
- > **Total RVU:** Total RVU procedures are output in descending total RVU order for professional claims. Procedures without any RVUs or where the total RVU equals 0.00 are output in the order in which they were entered starting below any procedures with total RVUs.

Note: Note: The total RVU is the sum of all three RVU values in **Procedure Code Maintenance**.

- > **E&M Code and Work RVU:** E&M code and work RVU procedures with **E&M Procedure** selected in **Procedure Code Maintenance** are output first followed by procedures in descending work RVU order for professional claims. Procedures without **E&M Procedure** selected and a work RVU are output in the order in which they were entered starting below any procedures with work RVUs.

Note: If there are multiple procedure codes with **E&M Procedure** selected, these codes are output in descending work RVU order amongst themselves.

- > **E&M Code and Total RVU:** E&M code and total RVU procedures with **E&M Procedure** selected in **Procedure Code Maintenance** are output first followed by procedures in descending total RVU order for professional claims. Procedures without **E&M Procedure** selected and any RVUs or where the total RVU equals 0.00 are output in the order in which they were entered starting below any procedures with total RVUs.

Note: If there are multiple procedure codes with **E&M Procedure** selected, these codes are then output in descending total RVU order amongst themselves. Also note that the total RVU is the sum of all three RVU values in **Procedure Code Maintenance**.

Output Denial Description on Secondary Claims

This option is intended for use by clients who submit Michigan Medicare secondary payer claims.

Only select this option if you submit secondary claims to Michigan Medicare.

The application outputs the reimbursement comment description (from the description in **Reimbursement Comment Maintenance**) for denied service lines to the NTE Segment of Loop 2400 when using the Standard ANSI X12N 837P v4010A1, McKesson ANSI 837P v4010A1, and Texas THIN ANSI 837P v4010A1 formats.

Output Dental License Number

This option is intended for use with the Standard ANSI X12N 837D v4010A1 format.

When this option is selected, the dental license number outputs with a "1E" Qualifier in the following Loops/Segments of the Standard ANSI X12N 837D v4010A1 electronic claim file if certain conditions exist:

- > Loop 2010AA/Segment REF: Outputs if a dentist license number exists on the **Additional Info** tab in **Provider Maintenance** for the voucher's billing provider and **Billing Number Option** in **Electronic Claim Format Maintenance** is set to **Individual Provider** and the **Output Dental License Number** output option in **Claim Style Maintenance** is selected.

- > Loop 2310A/Segment REF: Outputs if a dental license number exists on the **Additional Info** tab in **Referring Doctor Maintenance** for the voucher's referring doctor and the **Output Dental License Number** output option in **Claim Style Maintenance** is selected.
- > Loop 2310B/Segment REF: Outputs if a dental license number exists on the **Additional Info** tab in **Provider Maintenance** for the voucher's actual provider and the **Output Dental License Number** output option in **Claim Style Maintenance** is selected.

Output First Procedure as Princ Procedure

This option is intended for use with the Standard ANSI X12N 837I v4010A1 format. It enables you to output a claim's principal procedure code and date without having to enter the principal procedure code and date in **Claim Information**.

When selected, **Procedure Code** and **Date From** entered on the first service line on the voucher outputs to Loop 2300/Segment HI as the principal procedure code and date.

To override this setting for a specific voucher, you must manually enter a different procedure code and date in the **Principal Procedure Code** and **Principal Procedure Date** in **Claim Information**.

Codes and dates must be entered for **Other Procedure Code #** and **Other Procedure Date #** in **Claim Information** for them to also output to Loop 2300/Segment HI.

Output Group No for X-Ray Technical Services

Prints the group National Provider Identifier (NPI) in the lower portion of box 24J on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) for services with the procedure type **X-Ray Technical Component** and when **Output NPI Number** is selected.

Select this option to output group number for procedure codes with the procedure type of **X-Ray Technical**.

Output Group Taxonomy Code for Billing Prov. in 2000A

Select this option to report the group taxonomy code (TC) for the billing provider.

For professional and dental claims, also select the option **Output Rendering Provider by Service** when the payer also requires the rendering provider's individual TC.

See Submitting Group Taxonomy Codes in an ANSI 837 File.

Notes for ANSI 837P claims:

- > When the **Claim Style Maintenance** output options **Output Group Taxonomy Code for Billing Prov. in 2000A** and **Output Rendering Provider by Service** are both selected, the taxonomy code outputs in the PRV segment of Loops 2000A and 2420A. If the group taxonomy code for the billing provider (Loop 2000A) has changed from one claim to another, then a new Loop 2000A must be created.
- > If **Output Group Taxonomy Code for Billing Prov. in 2000A** is not selected and **Output Rendering Provider by Service** is selected, the individual taxonomy code for the billing provider outputs in the PRV segment of Loop 2000A. The individual taxonomy code for

the billing provider (Loop 2000A/Segment PRV) can change from one claim to the next, resulting in the creation of a new Loop 2000A to represent each billing provider change. The rendering (actual) provider outputs in Loop 2420A for each line of service present on the claim. The rendering (actual) provider's individual taxonomy code outputs in Loop 2420A/Segment PRV.

- For rural health center (RHC) billing, when you select both **Output Group Taxonomy Code for Billing Prov. in 2000A** and **Output Rendering Provider by Service**, the individual provider's taxonomy code outputs to Loop 2420A/Segment PRV only when you roll up RHC encounter code services to one line of service.

Output Group Taxonomy Code for Billing Prov. in 2310B

When selected, the PRV Segment in Loop 2310B reports the voucher's billing provider's taxonomy code. Additionally, Loop 2420A is automatically created and reports the voucher's actual provider's individual taxonomy code.

Notes

- This option only affects the 837P claims where **Billing Method in Electronic Claim Format Maintenance** is set to **Provider Group**.
- Even though Loop 2310B reports the voucher's billing provider taxonomy, all other information reported in this loop comes from the voucher's actual provider.
- If the voucher's actual provider is marked as a supplier and **Claim Style Maintenance** has **Suppress Supplier** selected, then the voucher's billing provider information outputs in Loops 2310B and 2420A.
- When billing by provider group, if the billing provider's group taxonomy code must output to Loop 2310B and the rendering provider's individual taxonomy code must output to Loop 2420A, the following setup should be completed to make sure claims that require this output correctly in the ANSI 837P electronic file:
 - **Electronic Claim Format Maintenance - Billing Method** set to **Provider Group**

Claim Style Maintenance - output options:

- **Output Group Taxonomy Code for Billing Prov. in 2000A** should be cleared
- **Output Group Taxonomy Code for Billing Prov. In 2310B** should be selected
- **Output Group Taxonomy Code for Performing Provider** should be cleared
- **Output Rendering Provider by Service** should be cleared
- **Output Group Taxonomy Code for Performing Provider** - select to report the group taxonomy code for the rendering provider

Output Inst Payor Number for ANSI 837I formats

This option is for clients submitting claims through McKesson. It outputs the proprietary McKesson carrier payer identification number (CPID) entered on the carrier's **Additional Info** tab.

Output Location Number for ANSI 837P formats

Some payers such as NY Medicaid require that a location code or number be reported in addition to the billing provider and rendering provider numbers. In such a case, the assigned location number must be entered in the **Other Number(s)** on the **Billing Numbers** tab in **Provider Maintenance**. If a provider has been assigned a separate location number for each location, then the provider's individual, group, and other number must be entered for each place of service.

Output first procedure as princ. procedure

For use with UB billing.

Enables you to include a principal procedure code and date on a claim without having to enter them in **Claim Information**.

When selected, the procedure code and from-date entered on the first service line on the voucher prints on the claim form as the principal procedure code and date in Form Locator (FL) 74 on a standard UB-04 claim form.

To override this setting for a specific voucher you must manually enter a different procedure code and date in the **Claim Information** fields **Principal Procedure Code** and **Principal Procedure Date**.

Codes and dates must be entered in **Claim Information** in the fields for **Other Procedure CodeX** and **Other Procedure DateX** in order for them to print on the claim form in Form Locator 81.

Output Mammography

Select this option to output mammography certification # to Loop 2300/Segment CLM and to Loop 2400/Segment REF. The reference identification qualifier EW is hardcoded to output to the file.

Prints the Mammography # in Box 32 of a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) for services with the procedure type **Mammography** and the mammography # is entered in **Place Of Service Maintenance**.

You must also complete the following:

- > Set the procedure type for mammography services to **Mammography** in **Procedure Code Maintenance**.
- > Enter the mammography certification # on the **Place of Service** tab in **Place of Service Maintenance**.

Output Modifiers if Secondary

When this option is selected, the application fills the corresponding record in an electronic file.

Prints modifiers in Box 24D of a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when the claim is billed to the patient's secondary policy.

Output Modifiers if Primary

When this option is selected, the application fills the corresponding record in an electronic file.

Prints modifiers in Box 24D of a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when the claim is billed to the patient's primary policy.

Output NPI Number

When this option is selected, the application validates that the National Provider Identifier (NPI), when it exists (entered in the related file maintenance table), is a valid NPI and outputs the NPI to Segment NM109 as the primary ID.

The application does not validate that you have the correct number for the provider or organization. Using the Luhn formula, it validates only that the number configuration is correct to be identified as an NPI.

Use this option during the transition period when carriers allow but do not require the submission of the provider's NPI. In this way, you are able to output NPI numbers that you have received while not causing a validation error when submitting claims for providers who have not received an NPI number.

This box should be selected only when the carrier is willing to accept the NPI on claims and the CMS-1500 NPI form is approved and the file CMS1500NPIStandard.rpt or CMS1500ICD10Standard.rpt is available.

When selected, outputs the NPI number to the bottom portion of Box 24J on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

Output Other Billing Number(s)

Use this option with MCC NSF 2.00 electronic claims when billing Illinois Medicaid.

When this option is selected, **Other Billing Number(s)** on the **Billing Numbers** tab in from **Provider Maintenance** is sent to the BA0 record, field 16.0 – 'Other Provider Number 1' field.

Output Pmts/Adjs at Claim Level on Secondary Claims

This option is intended for use when billing secondary claims using the Standard ANSI X12N 837I v4010A1 or Standard ANSI X12N 837P v4010A1 electronic formats. It is used when a carrier only wants payments and adjustments reported at the claim level not by service.

When this option is selected, all secondary claims linked to this claim style do not output in Loop 2430. All payments and adjustments are reported in Loop 2320/Segment CAS.

Output Primary Carrier address on Secondary Claims

This option is intended for use by clients who submit Michigan Medicare Secondary Payer claims.

Select this option only if you submit secondary claims to Michigan Medicare.

The application outputs the primary carrier's address to the NTE Segment of Loop 2300 when using the Standard ANSI X12N 837P v4010A1, McKesson ANSI 837P v4010A1, and Texas THIN ANSI 837P v4010A1 formats.

Output Provider Billing Number for Medicare Crossovers

This option is required when billing Michigan Medicare using either McKesson ANSI 837P v4010A1 or Standard ANSI X12N 837P v4010A1.

When this option is selected, the application creates an additional REF segment in Loop 2010AA for the Medicaid provider individual billing number on Medicare claims when Medicaid is the secondary.

Output Rendering Prov Number for Medicare Crossovers

This option is intended for use when billing Indiana Medicaid using the Standard ANSI X12N 837P v4010A1 or the Texas THIN 837P v4010A1 formats. Select this option for the electronic claim style associated with the Medicare carrier being billed as primary or other primary to Indiana Medicaid.

You must also do the following:

In **Provider Maintenance**, enter the provider's Indiana Medicaid billing number in **Indiv Provider Number** for the appropriate profile used on the **Billing Numbers** tab to record the Indiana Medicaid billing numbers.

Note: Create a billing number profile called **Indiana Medicaid** on the **Profiles** tab in **Practice Set Up** or **Organization Set Up**.

In Insurance Carrier Maintenance:

1. Enter the MediGap number in the **Medicare Supplemental Number** on the **Additional Info** tab for the secondary carrier used to bill Indiana Medicaid.
2. Set the secondary carrier's billing number profile to the profile that points to the rendering provider's Indiana Medicaid billing number entered in **Provider Maintenance**, for example the billing number profile named **Indiana Medicaid**.

This option outputs the Indiana Medicaid billing number for rendering provider identified on the voucher as **Provider** in Loop 2330E with NM1 and REF Segments and an additional REF Segment in Loop 2420A as required by Indiana Medicaid.

Output Rendering Provider by Service

Select this option when billing professional or dental claims using a group NPI and the payer requires 2 separate taxonomy codes be reported such as the group TC for the billing provider and the rendering provider's individual TC.

The application outputs the rendering provider's individual TC.

You should also select the **Output Group Taxonomy Code for Billing Provider** output option.

Notes for ANSI 837P claims:

- > When **Claim Style Maintenance** output options **Output Rendering Provider by Service** and **Output Group Taxonomy Code for Billing Prov in 2000A** are both selected, the taxonomy code outputs in the PRV segment of Loops 2000A and 2420A. If the group taxonomy code for the billing provider (Loop 2000A) changes from one claim to another, a new Loop 2000A must be created.
- > If **Output Rendering Provider by Service** is selected and **Output Group Taxonomy Code for Billing Prov. in 2000A** is not selected, the individual taxonomy code for the billing provider outputs in the PRV segment of Loop 2000A. The individual taxonomy code for the billing provider (Loop 2000A/Segment PRV) can change from one claim to the next, resulting in the creation of a new Loop 2000A to represent each billing provider change. The rendering (actual) provider outputs in Loop 2420A for each line of service present on the claim. The rendering (actual) provider's individual taxonomy code outputs in Loop 2420A/Segment PRV.
- > For rural health center (RHC) billing, when you select both **Output Rendering Provider by Service** and **Output Group Taxonomy Code for Billing Prov in 2000A**, the individual provider's taxonomy code outputs to Loop 2420A/Segment PRV only when you roll up RHC encounter code services to one line of service.

Output Selected Indicator for 2320 SBR09 when 2ndary

This option is only used for secondary billing and defines the primary policy's claim filing indicator such as when billing an Ohio or New York Medicaid claim that is secondary to a Medicare Part C carrier.

The drop-down list for this option contains all the claim filing Indicators as defined in the HIPAA implementation guides.

The selected claim filing indicator outputs to Loop 2320/Segment SBR-09 in a Standard ANSI X12N 837P v4010A1 or Standard ANSI X12N 837I v4010A1 electronic claim file.

Only one indicator may be selected per claim style.

When a selection is made for this option, **Claim Filing Indicator for Specified Insurance Group** is enabled.

Claim Filing Indicator for Specified Insurance Group

This option is only enabled when a claim filing indicator is selected in **Output Selected Indicator for 2320 SBR-09 when 2ndary**. When it is enabled, this option is required.

This option defines which insurance groups associated to the primary policy will output the selected claim filing indicator from **Output Selected Indicator for 2320 SBR-09 when 2ndary**.

Click  to select one or more insurance groups as necessary. After at least one insurance group is selected, **Selected Insurance Groups** displays in the **Field Value**.

When a secondary carrier associated with this claim style is being billed and the primary is a member of the insurance groups selected in this option, the claim filing indicator selected in **Output Selected Indicator for 2320 SBR09 when 2ndary** is output in Loop 2320/Segment SBR-09 of a Standard ANSI X12N 837P v4010A1 or Standard ANSI X12N 837I v4010A1 electronic claim file.

Output Site ID for ANSI 837 formats

This option is For clients required to submit a site ID number.

The application outputs the qualifier code "G5" (provider site number) and the site number to the REF Segment in Loop 2010AA.

The selection from the drop-down list governs from where the site ID number is to be pulled. The site ID number must be entered in **ID Sub-No** in the selected maintenance table:

- > Individual Provider
- > Department or Practice
- > Location
- > Practice or Organization

Note: When a **Pay-To Provider Option** has been selected in the electronic claim format, the Site ID REF Segment is also created in Loop 2010AB.

Output State License Number?

Select this option if any option for the associated paper claim format is set to output a provider's state license number.

When this option is selected, the provider's state license number is reported in Loop 2010AA/Segment REF.

Note: If this option is not selected, the state license number does not output regardless of any paper claim format settings.

Some insurance carriers may require the dual submission of a provider's state license number along with the NPI for a period of time as part of a transition to the use of NPIs. For these carriers, be sure to clear the output option when required.

Note: Be sure to enter the provider's state license number in the **State License Number** on the **Additional Info** tab in **Provider Maintenance**. Do not enter the provider's state license number on the **Billing Numbers** tab.

Based on paper claim format settings, the provider's state license number can print in either Box 24J or 33b on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) or in FL 76 - 79 on the UB-04 claim form.

Based on the **Referring Doctor Option** set in **Paper Claim Format Maintenance**, the referring doctor's state license number can print in Box 17a on the standard CMS 1500 NPI Standard Claim Form (08/05) unless an entry is made in Miscellaneous Box 17a text in **Claim Information**.

Based on the **Referring Doctor Option** or the **Supervising Phys Option** set in **Paper Claim Format Maintenance**, the referring doctor or supervising physician's state license number can print in Box 17a on the standard CMS 1500 NPI Standard Claim Form (08/05) unless an entry is made in **Miscellaneous Box 17a** text in **Claim Information**.

Output TOS for ANSI 837 formats

Use this option with the Standard ANSI X12N 837P v4010A1 electronic claim format when billing commercial claims through BCBSM EDI.

When this option is selected, the type of service will be output in Segment SV1 (Professional Service Information), element 6, Loop 2400 (Service Line).

Override Rendering Provider ID

This option is intended for use with the Standard ANSI X12N 837P v4010A1 electronic claim format when certain specialties are billing payers for which they are enrolled as "Exempt." Such specialties include but are not limited to: Physical, Occupational, and Speech Therapy; Mental and Behavioral Health; Hospital Based Physicians; and some ER, Anesthesia, Radiology, and Pathology. In these instances, the payers require the rendering provider's group NPI to report instead of the individual NPI as the rendering provider's ID.

The application outputs the group NPI in Loop 2310B/Segment NM109 and Loop 2420A/Segment NM109 and the group legacy billing number (TIN) in Loop 2310B/Segment REF02 and Loop 2420A/Segment REF02.

The selection in the drop down list determines from where the group NPI is pulled in the application.

- > **Blank:** Does not change how the system functions; continues to pull the rendering provider or CRNA's individual NPI.
- > **Department or Practice:** Retrieves the group NPI and legacy billing number for the rendering provider or CRNA for the department or practice entered on the voucher.
- > **Location:** Retrieves the group NPI and legacy billing number for the rendering provider or CRNA for the location entered on the voucher.

- > **Practice or Organization:** Retrieves the group NPI and legacy billing number for the rendering provider or CRNA from **Practice Set Up** or **Organization Set Up**.
- > **Provider Group:** Retrieves the group NPI and legacy billing number for the rendering provider or CRNA from **Provider Maintenance** for the actual provider on the voucher.

Note: This option works in conjunction with **Override Rendering Provider ID** on the **Additional Info** tab in **Provider Maintenance**. For the **Override Rendering Provider ID** selection to output correctly, **Override Rendering Provider ID** must be selected.

Output taxonomy code?

Select if any option for the associated paper claim format is set to output a provider or referring doctor's taxonomy code.

Output place of service taxonomy code?

Select to output the taxonomy code from the **Billing Numbers** tab in **Place of Service Maintenance** to Box 32b on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) with a ZZ qualifier in front of it.

Procedure Code Profile for Princ/Other Proc

For use in UB billing when a carrier requires you to submit both HCPCS and ICD-9 procedure codes on the same claim.

Use this option with the Standard ANSI X12N 837I v4010A1 electronic claim format when billing a carrier that requires you to submit both CPT or HCPCS code in Loop 2400/Segment SV2 and either ICD-9 or ICD-10 procedure codes in Loop 2300, Segment HI.

This option enables you to submit both a CPT or HCPCS code and the ICD procedure codes on the same claim without having to create duplicate procedure code records such as one for the CPT or HCPCS and another one for the ICD procedure code. Your setting for this option allows you to determine which profile is used when outputting codes to Loop 2300/Segment HI.

To make a selection for this option:

1. Click to open the drop-down list containing your procedure code profiles.
2. Click the name of a profile to fill the box.

For a carrier that requires both CPT or HCPCS and ICD procedure codes on the same claim:

1. In **Practice Set Up** or **Organization Set Up**, create a procedure code profile called either **ICD-9 Procedure Code** or **ICD-10 Procedure Code** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim) in addition to the other profiles that already exist.
2. Create a **Procedure Code Maintenance** record for the CPT or HCPCS code, if one does not already exist.

3. On the **Billing Codes** tab in **Procedure Code Maintenance**, enter the appropriate code for each profile.
4. For the claim style associated with the carrier, set the following on the **Output Options** tab:
 - a. Select **Output First Procedure as Princ Procedure**.
 - b. Set **Procedure Code Profile for Princ/Other Proc** to **ICD-9 Procedure Code or ICD-10 Procedure Code** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim).

During charge entry, enter the following:

1. The appropriate CPT or HCPCS code on the first service line
2. The other procedure codes and dates related to the voucher as usual
3. The other procedure codes in **Claim Information** if you need them to print in FL 81
4. The **Procedure Coding Method** in **Claim Information**: **9** for ICD-9 procedure code qualifiers or **10** for ICD-10 procedure code qualifiers

Using this method causes the CPT or HCPCS code to output to Loop 2400/Segment SV2 and the ICD procedure code to output to Loop 2300/Segment HI.

To determine which value to print on the form, the application uses the following logic:

Loop 2400/Segment SV2: Outputs the code from the **Billing Codes** tab in **Procedure Code Maintenance** that corresponds to the profile setting in **Insurance Carrier Maintenance**.

Loop 2300/Segment HI: Output the code from the **Billing Codes** tab in **Procedure Code Maintenance** that corresponds to the profile setting in **Insurance Carrier Maintenance** unless a procedure code profile is selected in **Claim Style Maintenance**.

When this **Claim Style Maintenance** output option setting is blank, the application prints the procedure access code entered in the **Procedure Code** field in **Procedure Code Maintenance** that corresponds to the profile setting in **Insurance Carrier Maintenance**.

What actually outputs to Loop 2300/Segment HI is driven by a combination of factors. Use the table to help you understand the application logic. The conditions that exist as an example are:

- > The voucher's first service line contains the procedure code 19102.
- > The **Procedure Code Maintenance** record for 19102 contains the following values:
 - Procedure access code (entry in **Procedure Code** on the **Procedure Code** tab): **19102**
 - Billing code for the procedure code profile that corresponds to the carrier's procedure code profile setting in **Insurance Carrier Maintenance**: **19102**
 - **ICD-9 Procedure Code Profile or ICD-10 Procedure Code Profile** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim) on the **Billing Codes** tab: **8511**
 - **Principal Procedure Code in Claim Information**: **45355**

The **Procedure Code Maintenance** record for 45355 contains the following values:

- > Procedure access code (entry in **Procedure Code** on the **Procedure Code** tab): **45355**
- > Billing code for the procedure code profile that corresponds to the carrier's procedure code profile setting in **Insurance Carrier Maintenance**: **45355**
- > **ICD-9 Procedure Code Profile or ICD-10 Procedure Code Profile** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim) on the **Billing Codes** tab: **4525**

CSM Option: Output First Procedure as Princ Procedure	CSM Option: Procedure Code Profile for Princ/Other Proc	Value Entered in Claim Info for "Principal Procedure Code"	Prints in FL44	Prints in FL80
Not selected	Blank (no value entered)	Blank (no value entered)	19102	Blank (no value entered)
Not selected	Blank (no value entered)	45355	19102	45355
Selected	Blank (no value entered)	45355	19102	45355
Selected	ICD-9 Procedure Code or ICD-10 Procedure Code	45355	19102	4525
Selected	ICD-9 Procedure Code or ICD-10 Procedure Code	Blank (no value entered)	19102	8511
Not selected	ICD-9 Procedure Code or ICD-10 Procedure Code	45355	19102	4525
Not selected	ICD-9 Procedure Code or ICD-10 Procedure Code	Blank (no value entered)	19102	Blank (no value entered)

Rendering Provider Primary ID for ANSI formats

This option is intended to support an ANSI billing requirement by Nebraska Medicaid. For use with Standard ANSI X12N 837P v4010A1 and McKesson ANSI 837P v4010A1 electronic claim formats.

The application sends the rendering provider's Social Security number (SSN) as the primary identifier in Loop 2310B, Segment NM1 - Field 09.

The drop-down list offers the following three settings:

- > **Blank**: continues to function as this has in the past, using the federal tax ID for the provider if one exists, or when there is no federal tax ID it will use the provider's SSN
- > **Federal ID**: vouchers fail validation when a federal tax ID number does not exist for the actual (rendering) provider
- > **Social Security Number**: vouchers fail validation when a SSN does not exist for the actual (rendering) provider

Note: When the actual provider is flagged as a supplier, the billing provider's federal ID and SSN are validated and output to the file.

Suppress Procedure Codes by Revenue Code

This output option works in conjunction with the **Revenue Code Maintenance** option **Suppress Procedure Code based on Claim Style**. When both flags are selected for a claim's associated claim style and revenue code, the service line procedure code data element (Loop 2400/Segment SV2-02) does not output in a Standard ANSI X12N 837I v4010A1 electronic claim file.

Suppress Rendering Provider Information

When this option is selected, Loops 2310B and 2420A do not output in an ANSI 837P v4010A1 electronic claim file.

This option allows you to be able to bill by department, practice, or location instead of having to bill by individual provider just so you can flag the provider as a supplier and suppress the supplier information in **Claim Style Maintenance**.

With this option you do not have to enter the facility as the billing provider instead of entering the actual provider as the billing provider when you enter charges.

Suppress Service Facility for ANSI 837I format

When this option is selected, the PRV Segment is output in Loop 2000A even if the billing or pay-to provider's address and the service facility address do not match.

In addition, the Service Facility Loop (2310E) is not created. **Output Group Taxonomy for Billing Prov. in 2000A?** must also be selected to ensure that the group taxonomy code does output in the PRV Segment.

In order for the group taxonomy code to output in Loop 2000A/Segment PRV and Loop 2310E not output when the billing or pay-to provider's address and the service facility address do not match, make sure the following is set up correctly:

Electronic Claim Format Maintenance: Billing Number Option set to Provider Group

Claim Style Maintenance: Suppress Service Facility for ANSI 837I format output option should be selected

Claim Style Maintenance: Output Group Taxonomy for Billing Prov. in 2000A output option should be selected

Suppress Supplier Information

Selecting this option will suppress the information associated with the rendering provider identified during charge entry.

The provider must be flagged as a supplier in **Provider Maintenance** or **Referring Doctor Maintenance** on the **Additional Info** tab.

Note: When suppress supplier logic is used, the actual provider information does not appear and claims only contain billing provider information. However, the actual provider of the service is still stored on the voucher in the application. If **Allowance Style** for the carrier is set to **By Carrier/Provider**, then when you use auto fill during payment entry the allowed amount is based on the actual provider for the voucher.

Suppress Tax ID/SSN for Referring Prov(837D 2310A)

When this option is selected, the application prevents a REF segment from creating in Loop 2310A in a Standard ANSI X12N 837D v4010A1 file for the federal tax ID or SSN.

Note: This option is only applicable when submitting NPIs.

Suppress Tax ID/SSN for Rendering Prov(837D 2310B)

When this option is selected, the application prevents a REF segment from creating in Loop 2310B and 2420A in a Standard ANSI X12N 837D v4010A1 file for the federal tax ID or SSN.

Note: This option is only applicable when submitting NPIs.

Suppress Tax ID/SSN for Attending Prov(837I 2310A)

When this option is selected, the application prevents a REF segment from creating in Loop 2310A in a Standard ANSI X12N 837I v4010A1 file for the federal tax ID or SSN.

Note: This is only applicable when submitting NPIs.

Suppress Tax ID/SSN for Operating Prov(837I 2310B)

When this option is selected, the application prevents a REF segment from creating in Loop 2310B in a Standard ANSI X12N 837I v4010A1 file for the federal tax ID or SSN.

Note: This option is only applicable when submitting NPIs.

SUPPRESS TAX ID/SSN FOR OTHER PROV(837I 2310C)

When this option is selected, the application prevents a REF segment from creating in Loop 2310C in a Standard ANSI X12N 837I v4010A1 file for the federal tax ID or SSN.

SUPPRESS TAX ID/SSN FOR SERVICE FACILITY(837I 2310E)

When this option is selected, the application prevents a REF segment from creating in Loop 2310E in a Standard ANSI X12N 837I v4010A1 file for the federal tax ID or SSN.

SUPPRESS TAX ID/SSN FOR REFERRING PROV (837P 2310A)

When this option is selected, the application prevents a REF segment from creating in Loop 2310A in a Standard ANSI X12N 837P v4010A1 file for the federal tax ID or SSN.

|| **Note:** This option is only applicable when submitting NPIs.

SUPPRESS TAX ID/SSN FOR RENDERING PROV (837P 2310B)

When this option is selected, the application prevents a REF segment from creating in Loop 2310B & 2420A in a Standard ANSI X12N 837P v4010A1 file for the federal tax ID or SSN.

|| **Note:** This option is only applicable when submitting NPIs.

SUPPRESS TAX ID/SSN FOR SUPERVISING PROV (837P 2310E)

When this option is selected, the application prevents a REF segment from creating in Loop 2310E in a Standard ANSI X12N 837P v4010A1 file for the federal tax ID or SSN.

|| **Note:** This option is only applicable when submitting NPIs.

SUPPRESS TAX ID/SSN FOR ORDERING PROV (837P 2420E)

When this option is selected, the application prevents a REF segment from creating in Loop 2420E in a Standard ANSI X12N 837P v4010A1 file for the federal tax ID or SSN.

|| **Note:** This option is only applicable when submitting NPIs.

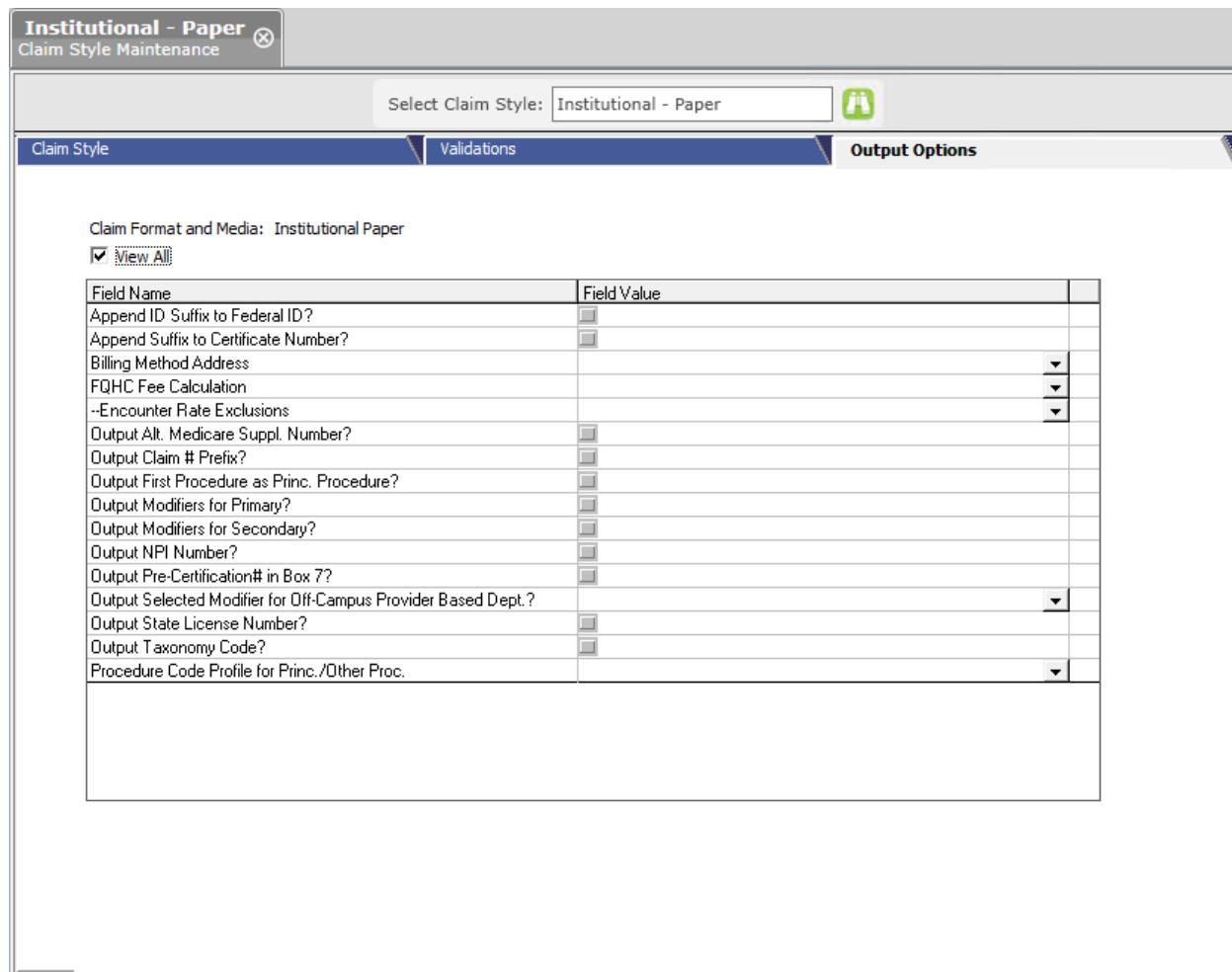
Output Options tab for paper claims

The boxes on the **Output Options** tab in **Claim Style Maintenance** must be defined based on vendor, carrier requirements, and electronic format used.

The list of output options on this tab is driven by the claim format that you selected on the **Claim Style** tab.

Point your mouse over an output option to display the tooltip.

Access the **Output Options** tab from **Claim Style Maintenance**. To access **Claim Style Maintenance** go to **System Administration > File Maintenance > Claim Style Maintenance**, or press **F9** and then enter **CSM**.



The screenshot shows the 'Institutional - Paper' claim style selected in the top left. The top navigation bar includes 'Select Claim Style: Institutional - Paper' and a search icon. Below the bar, there are three tabs: 'Claim Style' (selected), 'Validations', and 'Output Options'. The 'Output Options' tab is active, displaying a table of configuration options:

Field Name	Field Value
Append ID Suffix to Federal ID?	<input type="checkbox"/>
Append Suffix to Certificate Number?	<input type="checkbox"/>
Billing Method Address	<input type="checkbox"/>
FQHC Fee Calculation	<input type="checkbox"/>
-Encounter Rate Exclusions	<input type="checkbox"/>
Output Alt. Medicare Suppl. Number?	<input type="checkbox"/>
Output Claim # Prefix?	<input type="checkbox"/>
Output First Procedure as Princ. Procedure?	<input type="checkbox"/>
Output Modifiers for Primary?	<input type="checkbox"/>
Output Modifiers for Secondary?	<input type="checkbox"/>
Output NPI Number?	<input type="checkbox"/>
Output Pre-Certification# in Box 7?	<input type="checkbox"/>
Output Selected Modifier for Off-Campus Provider Based Dept.?	<input type="checkbox"/>
Output State License Number?	<input type="checkbox"/>
Output Taxonomy Code?	<input type="checkbox"/>
Procedure Code Profile for Princ./Other Proc.	<input type="checkbox"/>

Select the applicable options using your carrier's specifications. If you have any questions regarding the completion of this tab, call the Allscripts® Support desk.

Anesthesia Unit Display

Prints in Box 24G on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

Prints anesthesia-related units in Box 24G on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when a service with a procedure type of **Anesthesia (Timed)** or **Anesthesia (Non-Timed)** is included on the claim.

Select the applicable options from the list.

> Charge Units

- > **Time Units**
- > **Additional Base Units**
- > **Minutes**
- > **Hours/Minutes**
- > **Force to 1 Unit**
- > **Zero Fill**

Append Suffix to Certificate Number

Prints the insured's certificate with suffix in Box 1a on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

You must enter the suffix in either **Patient's Certificate Suffix** (when the patient is the subscriber) or **Subscriber's Certificate** (when the subscriber is a contact other than the patient) on the **Policy** tab in **Registration**.

Append ID Suffix to Federal ID

Prints the federal tax ID number with ID suffix in Box 25 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

Billing Method Address

The **Billing Method Address** output option is displayed when **Billing Media** is set to **Paper** on the **Claim Style** tab in **Claim Style Maintenance**. You can use this option with the ICD-10 Generic Medical Claim Form, the UB-04 paper claim form, and any claim forms that are based on them, such as state-specific Medicaid forms. There are 3 options:

Blank

If you leave this option blank, the address that prints on the paper claim is the same as if you had selected **Billing Method Address**.

Billing Method Address

If you set this option to **Billing Method Address**, the address that prints on the paper claim is the main address for the file maintenance option selected in **Billing Address Option** on the **Paper Claim Format** tab in **Paper Claim Format Maintenance: Provider Maintenance, Department Maintenance or Practice Maintenance, Location Maintenance, or Practice Set Up or Organization Set Up**.

For example, if you set **Billing Address Option** to **Location Maintenance** and **Billing Method Address** to **Billing Method Address**, the address that prints on paper claims with this claim style is the main address entered in **Location Maintenance** for the location on the claim.

Billing Method Other Address

If you set this option to **Billing Method Other Address**, the address that prints on the paper claim is the alternate address for the file maintenance option selected in **Billing Address**

Option on the Paper Claim Format tab in Paper Claim Format Maintenance: Provider Maintenance, Department Maintenance or Practice Maintenance, Location Maintenance, or Practice Set Up or Organization Set Up.

For example, if you set **Billing Address Option** to **Actual Provider** or **Billing Provider** and **Billing Method Address** to **Billing Method Other Address**, the address that prints on the paper claim is the address entered in the **Other Address** area in **Provider Maintenance**.

FQHC Fee Calculation

Select **Voucher Total** to output Federally Qualified Health Center (FQHC) claims with the total voucher fees, excluding the fees for any preventive services and other non-covered FQHC services. Otherwise, leave this option blank.

Note:

This option only applies to institutional claims.

When **Voucher Total** is selected, **Roll Up Fees by Revenue Code** on the **Uniform Billing Info** tab in **Paper Claim Format Maintenance** is ignored, even if you select it.

Encounter Rate Exclusions

Select the procedure group that includes those preventive and non-covered Federally Qualified Health Center (FQHC) services where the fee must be excluded from the voucher total on the encounter line that includes the 052X revenue code and a 99XXX procedure code flagged as an E&M procedure.

Note: This option is only enabled when **FQHC Fee Calculation** is set to **Voucher Total**.

Output Alt. Medicare Suppl Number

Because some Medicare intermediaries use unique MediGap numbers that differ from those used by other intermediaries, clients who have offices in different states are sometimes required to submit a different supplemental number for cross over claims depending on the state in where the service was rendered.

When you are given two different MediGap numbers by two Medicare intermediaries for submitting crossover claims to the same supplemental insurer, follow these steps:

1. Enter a Medicare supplemental number and an alternate Medicare supplemental number for the supplemental carrier (for example, AARP) on the **Additional Info** tab in **Insurance Carrier Maintenance**.
2. Select the output option **Output Alt Medicare Suppl. Number** on the claim style associated with the primary carrier requiring the submission of the number you identified as the alternate supplemental number.

Note: The prepare claims process recognizes and outputs an alternate Medicare supplemental number when the alternate Medicare supplemental number is entered in **Insurance Carrier Maintenance** and the option **Output Alt Medicare Suppl Number** in **Claim Style Maintenance** is selected. This logic applies to all paper claim formats.

Output Claim # Prefix

Appends the claim number prefix to the claim number in Box 26 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

When this option is selected, **Claim # Prefix** on the **Practice Information** tab in **Practice Set Up** or **Organization Set Up** will be attached to the claim number when it is printed.

Output CLIA

Prints the CLIA # in Box 23 on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when no prior auth # exists on those claims, which include a service with the procedure type of **Lab**.

Output CPTs in RVU order on Prof Claims

Use this option to control the order in which services are reported on a professional claim no matter what order they were entered during charge entry.

Select the applicable option from the drop-down list:

- > **Work RVU:** Work relative value unit (RVU) procedures are output in descending work RVU order for professional claims. Procedures without a Work RVU are output in the order in which they were entered starting below any procedures with Work RVUs.
- > **Total RVU:** Total RVU procedures are output in descending total RVU order for professional claims. Procedures without any RVUs or where the total RVU equals 0.00 are output in the order in which they were entered starting below any procedures with total RVUs.

Note: The total RVU is the sum of all three RVU values in **Procedure Code Maintenance**.

- > **E&M Code and Work RVU:** E&M code and work RVU procedures with **E&M Procedure** selected in **Procedure Code Maintenance** are output first followed by procedures in descending work RVU order for professional claims. Procedures without **E&M Procedure** selected and a work RVU are output in the order in which they were entered starting below any procedures with work RVUs.

Note: If there are multiple procedure codes with **E&M Procedure** selected, these codes are output in descending work RVU order amongst themselves.

- > **E&M Code and Total RVU:** E&M code and total RVU procedures with **E&M Procedure** selected in **Procedure Code Maintenance** are output first followed by procedures in descending total RVU order for professional claims. Procedures without **E&M Procedure** selected and any RVUs or where the total RVU equals 0.00 are output in the order in which they were entered starting below any procedures with total RVUs.

Note: If there are multiple procedure codes with **E&M Procedure** selected, these codes are then output in descending total RVU order amongst themselves. Also note that the total RVU is the sum of all three RVU values in **Procedure Code Maintenance**.

Output Group No for X-ray Technical Services

Prints the group National Provider Identifier (NPI) in the lower portion of Box 24J on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) for services with the procedure type **X-RayTechnical Component** and when **Output NPI Number** is selected.

Note: Box 24J is blank if **Output NPI Number** is not selected.

Output Locum Covering For Provider with Selected Modifier

Outputs the provider for whom the locum provider is covering as the rendering provider with the selected modifier. If four modifiers already exist for a service line, the last modifier is replaced with the selected modifier.

If you do not want modifiers on claims, select <**No Locum Modifier**>.

If you select a value for **Output Locum Covering For Provider with Selected Modifier**, you cannot select a value for **Output Actual Locum with Selected Modifier**.

Output Actual Locum with Selected Modifier

Outputs the locum provider as the rendering provider with the selected modifier. If four modifiers already exist for a service line, the last modifier is replaced with the selected modifier.

If you do not want modifiers on claims, select <**No Locum Modifier**>.

If you select a value for **Output Actual Locum with Selected Modifier**, you cannot select a value for **Output Locum Covering For Provider with Selected Modifier**.

Output First Procedure as Princ. Procedure

This option is for institutional and facility billing. It enables you to include a principal procedure code and date on a claim without having to enter **Principal Procedure Code** and date in **Claim Information**.

Click to select this option.

When selected, **Procedure Code** and **Date From** entered on the first service line on the voucher prints on the claim form as the principal procedure code and date in Form Locator (Box) 80 on a standard UB-04 claim form.

To override this setting for a specific voucher, you must manually enter a different procedure code and date in the **Principal Procedure Code** and **Principal Procedure Date** in **Claim Information**.

Codes and dates must be entered for **Other Procedure Code #** and **Other Procedure Date #** in **Claim Information** for them to print on the claim form in Form Locator (FL) 81.

Output Mammography #

Prints the mammography number in Box 32 of a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

You must also enter **Mammography No** in **Place of Service Maintenance**.

Output Modifiers if Secondary

Prints modifiers in Box 24D of a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when the claim is billed to the patient's secondary policy.

Output Modifiers if Primary

Prints modifiers in Box 24D of a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) when the claim is billed to the patient's primary policy.

Output NPI Number

Important: This box should be selected only when the carrier is willing to accept the NPI on claims and the revised CMS-1500 is approved and the file CMS1500NPIStandard.rpt or CMS1500ICD10Standard.rpt is available.

When **Output NPI Number** is selected, the NPI number outputs to the lower portion of Box 24J on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12).

Selecting this option validates that the NPI, when it exists (that is, entered in the related file maintenance table), is a valid NPI. This validation does not mean that it is the correct NPI used for your provider or Practice or Organization but that it contains the correct configuration to identify it as a National Provider Identifier. Claims with an invalid NPI fail validation. Claims without an NPI or with a valid NPI pass validation.

Output Pre-Certification # in Box 7

Select **Output Pre-Certification # in Box 7** if you want to print the passport referral number in Form Locator (Box) 7.

The passport referral number is based on the numeric value in **Pre-Certification #** in **Claim Information** accessed from **Transactions > Charge Entry > Claim Information**.

Output Selected Modifier for Off-Campus Provider Based Dept

Outputs a selected modifier for all services on the claim if **Off-Campus Provider Based Dept** in **Place of Service Maintenance** or **Location Maintenance** is also selected.

Note: **Output Selected Modifier for Off-Campus Provider Based Dept** is enabled only when either **Output Modifiers for Primary** or **Output Modifiers for Secondary** on the **Output Options** tab is selected.

Output State License Number

Select this option if any option for the associated paper claim format is set to output a provider or referring doctor's state license number.

Note: If this option is not selected, the state license number does not output regardless of any paper claim format settings.

Some insurance carriers may require the dual submission of a provider's state license number along with the NPI for a period of time as part of a transition to the use of NPIs. For these carriers, be sure to clear the output option when required.

Note: Be sure to enter the provider's state license number in the **State License Number** on the **Additional Info** tab in **Provider Maintenance**. Do not enter the provider's state license number on the **Billing Numbers** tab.

Based on paper claim format settings, the provider's state license number can print in either Box 24J or 33b on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) or in FL 76 - 79 on the UB-04 claim form.

Based on the **Referring Doctor Option** set in **Paper Claim Format Maintenance**, the referring doctor's state license number can print in Box 17a on the standard CMS 1500 NPI Standard Claim Form (08/05) unless an entry is made in **Miscellaneous Box 17a text in Claim Information**.

Based on the **Referring Doctor Option** or the **Supervising Phys Option** set in **Paper Claim Format Maintenance**, the referring doctor or supervising physician's state license number can print in Box 17a on the standard CMS 1500 NPI Standard Claim Form (08/05) unless an entry is made in **Miscellaneous Box 17a text in Claim Information**.

Output Taxonomy Code

Select this option if any option for the associated paper claim format is set to output a provider or referring doctor's taxonomy code.

Output Place of Service Taxonomy Code

Select this option to output the taxonomy code from the **Billing Numbers** tab in **Place of Service Maintenance** to Box 32b on a CMS 1500 NPI Standard Claim Form (08/05) and a CMS 1500 ICD-10 Standard Claim Form (02/12) with a ZZ qualifier in front of it.

Procedure Code Profile for Princ/Other Proc

Use this option with uniform billing when a carrier requires that you submit HCPCS and either ICD-9 or ICD-10 procedure codes on the same claim.

This option enables you to submit a CPT or HCPCS code in FL 44 and ICD procedure codes in FL 80 and 81 of a standard UB-04 paper claim form for the same claim without having to create duplicate procedure code records, that is, one procedure for the CPT or HCPCS code and another code for the ICD procedure code.

This option also enables you to determine which profile is used when printing codes in FL 80 and 81 on a standard UB-04 paper claim form.

To make a selection for this option:

1. Click to open the drop-down list containing your procedure code profiles.
2. Click the name of a profile to fill the box.

For a carrier that requires both CPT or HCPCS and ICD procedure codes on the same claim:

1. In **Practice Set Up** or **Organization Set Up**, create a procedure code profile called either **ICD-9 Procedure Code** or **ICD-10 Procedure Code** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim) in addition to the other profiles that already exist.
2. Create a **Procedure Code Maintenance** record for the CPT or HCPCS code, if one does not already exist.
3. On the **Billing Codes** tab in **Procedure Code Maintenance**, enter the appropriate code for each profile.
4. For the claim style associated with the carrier, set the following on the **Output Options** tab:
 - a. Select **Output First Procedure as Princ Procedure**.
 - b. Set **Procedure Code Profile for Princ/Other Proc** to **ICD-9 Procedure Code** or **ICD-10 Procedure Code** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim).

During charge entry, enter the following:

1. The appropriate CPT or HCPCS code on the first service line
2. The other procedure codes and dates related to the voucher as usual
3. The other procedure codes in **Claim Information** if you need them to print in FL 81
4. The **Procedure Coding Method** in **Claim Information**: **9** for ICD-9 procedure code qualifiers or **10** for ICD-10 procedure code qualifiers

Using this method, the CPT or HCPCS code prints in FL 44 and the ICD procedure code prints in FL 80 and 81.

To determine which value to print on the form, the application uses the following logic:

- > Form Locator 44: Prints the code from the **Billing Codes** tab in **Procedure Code Maintenance** that corresponds to the profile setting in **Insurance Carrier Maintenance**.
- > Form Locators 80 and 81: Prints the code from the **Billing Codes** tab in **Procedure Code Maintenance** that corresponds to the profile setting in **Insurance Carrier Maintenance** unless a procedure code profile is selected in **Claim Style Maintenance**.

What actually prints in boxes 80 and 81 is driven by a combination of factors. Use the table to help you understand the application logic. The conditions that exist as an example are:

- > The voucher's first service line contains the procedure code 19102.
- > The **Procedure Code Maintenance** record for 19102 contains the following values:
 - Procedure access code (entry in **Procedure Code** on the **Procedure Code** tab): **19102**
 - Billing code for the procedure code profile that corresponds to the carrier's procedure code profile setting in **Insurance Carrier Maintenance**: **19102**
 - **ICD-9 Procedure Code Profile or ICD-10 Procedure Code Profile** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim) on the **Billing Codes** tab: **8511**
 - **Principal Procedure Code in Claim Information**: **45355**

The **Procedure Code Maintenance** record for 45355 contains the following values:

- > Procedure access code (entry in **Procedure Code** on the **Procedure Code** tab): **45355**
- > Billing code for the procedure code profile that corresponds to the carrier's procedure code profile setting in **Insurance Carrier Maintenance**: **45355**
- > **ICD-9 Procedure Code Profile or ICD-10 Procedure Code Profile** (depending on whether ICD-9 or ICD-10 procedure codes are needed on the claim) on the **Billing Codes** tab: **4525**

CSM Option: Output First Procedure as Princ Procedure	CSM Option: Procedure Code Profile for Princ/Other Proc	Value Entered in Claim Info for "Principal Procedure Code"	Prints in FL44	Prints in FL80
Not selected	Blank (no value entered)	Blank (no value entered)	19102	Blank (no value entered)
Not selected	Blank (no value entered)	45355	19102	45355

CSM Option: Output First Procedure as Princ Procedure	CSM Option: Procedure Code Profile for Princ/Other Proc	Value Entered in Claim Info for "Principal Procedure Code"	Prints in FL44	Prints in FL80
Selected	Blank (no value entered)	45355	19102	45355
Selected	ICD-9 Procedure Code or ICD-10 Procedure Code	45355	19102	4525
Selected	ICD-9 Procedure Code or ICD-10 Procedure Code	Blank (no value entered)	19102	8511
Not selected	ICD-9 Procedure Code or ICD-10 Procedure Code	45355	19102	4525
Not selected	ICD-9 Procedure Code or ICD-10 Procedure Code	Blank (no value entered)	19102	Blank (no value entered)

Sales Tax Output

This option is for professional claims. Determines output of Sales Tax: Leave blank for System Standard: Output tax per procedure in Loop 2400 AMT02 and include tax amount in SV102.

Use EPSDT Family Planning

This option can be left blank indicating that no Early and Periodic Screening, Diagnostic and Treatment (EPSDT) family planning rules apply. Otherwise, your selection for this option combined with **Ailment Information** values determine what prints on the claim.

Standard Medicaid Rules prints:

- > 1: if **EPSDT = Y** and **Family Planning = Y**
- > 2: if **EPSDT = N** and **Family Planning = N**
- > 3: if **EPSDT = Y** and **Family Planning = N**
- > 4 :if **EPSDT = N** and **Family Planning = Y**

New Jersey Medicaid Rule prints:

- > 1: if **EPSDT = Y**
- > 2: if **Family Planning = Y**
- > 3: if **Both = Y**

E/F Medicaid Rule prints:

- > E: if **EPSDT** = Y
- > F: if **Family Planning** = Y

KanCare Medicaid Rule prints:

- > Y in Box 24h shaded for the following scenarios.
 - **EPSDT** has a value other than blank, **No**, or **No Referral Necessary**
 - **Family Planning** has a value of **Yes**
 - **EPSDT** has a value of blank, **No**, or **No Referral Necessary**, and also, **Family Planning** has a value of **Yes**
- > AV in Box 24h unshaded: if **EPSDT Referral Condition Code** is set to **Available - Not Used**
- > NU in Box 24h unshaded: if **EPSDT Referral Condition Code** is set to **Not Used**
- > S2 in Box 24h unshaded: if **EPSDT Referral Condition Code** is set to **Under Treatment**
- > ST in Box 24h unshaded: if **EPSDT Referral Condition Code** is set to **New Services Request**

Return to the General tab

If necessary return to the **General** tab in **Practice/Organization Options** to select a default paper claim style and/or a default electronic claim style.

See *Default paper claim style* and *Default electronic claim style*. You can also select a **Default Anesthesia Style** on the **Charge Entry** tab if you bill anesthesia services.

Access the Return to the **General** tab from **System Administration > Practice Options or Organization Options >** or use **F9 > POP or OOP**.

Insurance Category Maintenance window

An insurance category is a broad, general grouping. You must assign each insurance carrier to an insurance category.

Examples of standard categories are Blue Shield, Medicare, Medicaid, Commercial, Workers' Comp, Managed Care, Occupational Medicine.

Various reports can be grouped and/or restricted by insurance category.

Allscripts Practice Management™ provides other ways of categorizing carriers with the use of insurance groups, and the insurance reporting class.

After version 18.3, if your practice or organization uses uninsured carriers, the system-defined (**Self-Pay**) insurance category includes both traditional self-pay vouchers and vouchers associated

with a carrier that uses the uninsured coverage type. You cannot access **(Self-Pay)** by searching with **Select Insurance Category** or by using the **First**, **Previous**, **Next**, or **Last** buttons.

System is the **Abbreviation** for **(Self-Pay)**. You cannot create a record in **Insurance Category Maintenance** using any combination of uppercase or lowercase letters that spell **System** or a warning message is displayed. For example, you cannot use **SYSTEM** or **system** in **Abbreviation** for any record.

(Self-Pay) is the **Description** for the new insurance category. You can create a record in **Insurance Category Maintenance** using **(Self-Pay)** as the **Description**, but it is not recommended.

The **(Self-Pay)** insurance category is available on the **Categories** tab in **Select Insurance Carriers** where uninsured carriers are available for selection.

When you create an uninsured carrier in **Insurance Carrier Maintenance**, **(Self-Pay)** is the default in **Ins. Category** and cannot be changed.

Insurance Category Maintenance contains these tabs:

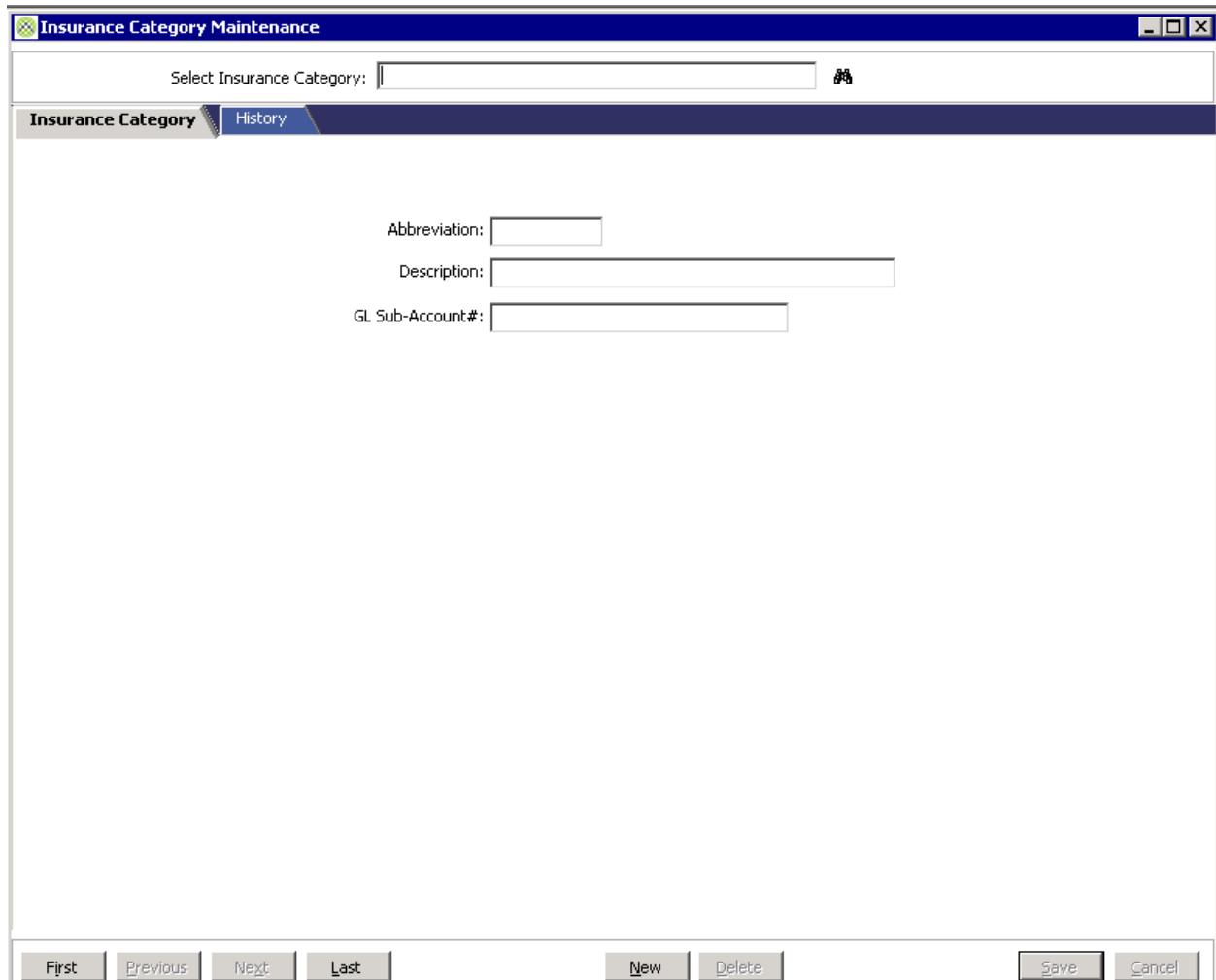
- > **Insurance Category**
- > **History**

To access **Insurance Category Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Category Maintenance** or use **F9 > ITM**.

Insurance Category tab

Use the **Insurance Category** tab to create categories by which insurance carriers can be grouped.

Access the **Insurance Category** tab from **System Administration > File Maintenance > Insurance Category Maintenance** or use **F9 > ITM**.



Abbreviation

- Accepts up to 8 characters.
- Is a search by option for an insurance carrier or plan lookup.
- Displays in **Unpaid Claims Management** and **Financial Inquiry**.

Description

- Accepts up to 25 characters.
- Displays as an option in **Insurance Carrier Maintenance**.
- Prints on reports.

Insurance Reporting Class Maintenance window

Each carrier must be assigned to one reporting class.

Insurance reporting classes add flexibility to your practice's reporting capabilities. For example, a carrier such as HMO Blue could be placed in the insurance category of Blue Shield. However, because the carrier represents a Blue Shield HMO product, its reporting class could be HMO.

Tip: Reports can be generated by insurance carrier, insurance category, insurance group, and insurance reporting class.

After version 18.3, if your practice or organization uses uninsured carriers, the system-defined (**Self-Pay**) insurance reporting class includes both traditional self-pay vouchers and vouchers associated with a carrier that uses the uninsured coverage type. You cannot access the (**Self-Pay**) insurance reporting class by searching with **Select Insurance Reporting Class** or by using the **First**, **Previous**, **Next**, or **Last** buttons.

System is the **Abbreviation** for (**Self-Pay**). You cannot create a record in **Insurance Reporting Class Maintenance** using any combination of uppercase or lowercase letters that spell **System**, or a warning message is displayed. For example, you cannot use **SYSTEM** or **system** in **Abbreviation** for any record.

(**Self-Pay**) is the **Description** for the new reporting class. You can create a record in **Insurance Reporting Class Maintenance** using (**Self-Pay**) as the **Description**, but it is not recommended.

The (**Self-Pay**) insurance reporting class is available on the **Reporting Classes** tab in **Select Insurance Carriers** where uninsured carriers are available for selection.

When you create an uninsured carrier in **Insurance Carrier Maintenance**, (**Self-Pay**) is the default in **Ins. Reporting Class** and cannot be changed.

Access **Insurance Reporting Class Maintenance** from **System Administration > File Maintenance > Insurance Reporting Class Maintenance** or press **F9** and then enter **IRM**.

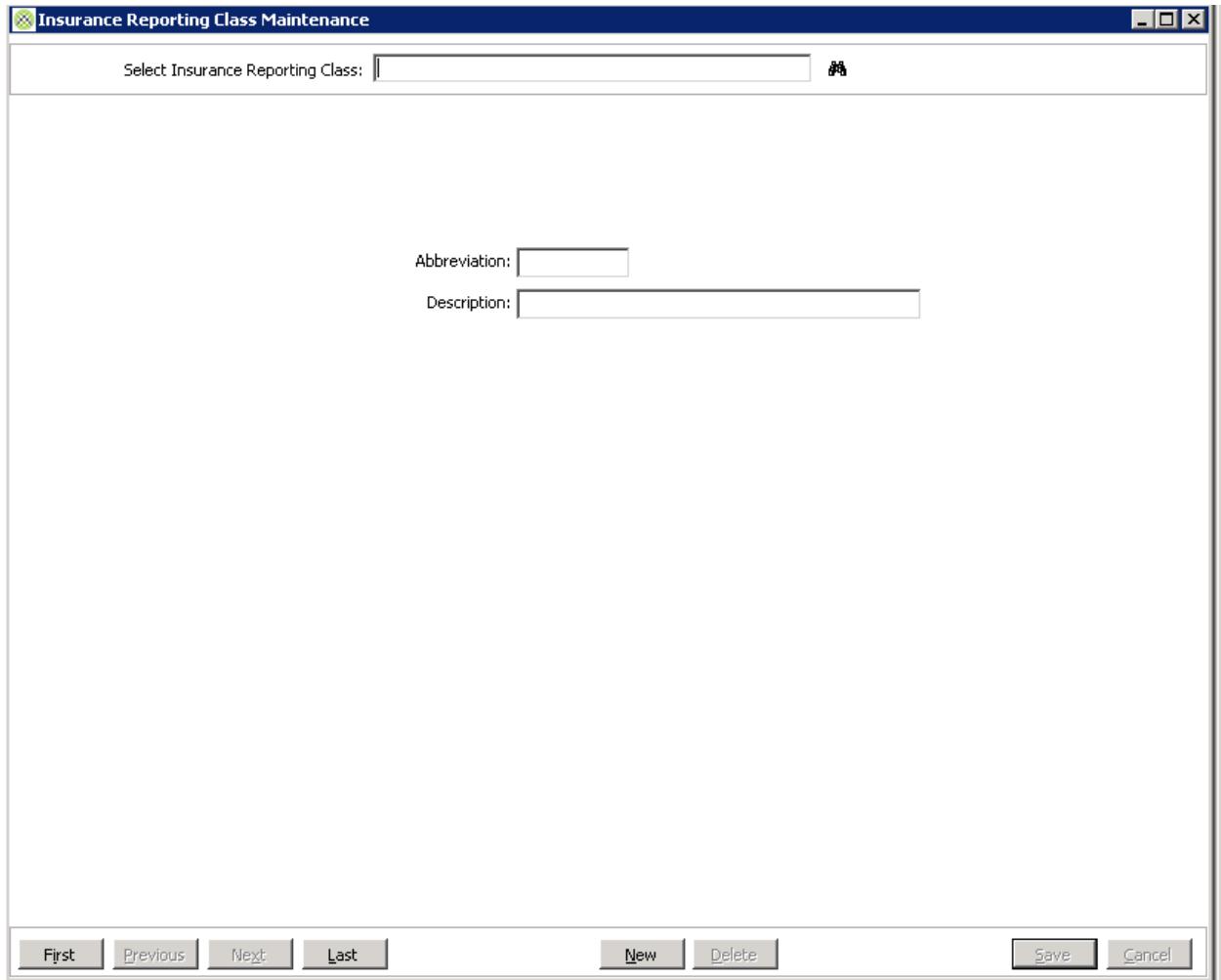
Insurance Reporting Class Maintenance

Select Insurance Reporting Class:

Abbreviation:

Description:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

**Abbreviation**

Accepts up to 8 characters

Description

Accepts up to 25 characters.

Displays as an option in Insurance Carrier Maintenance.

Prints on reports.

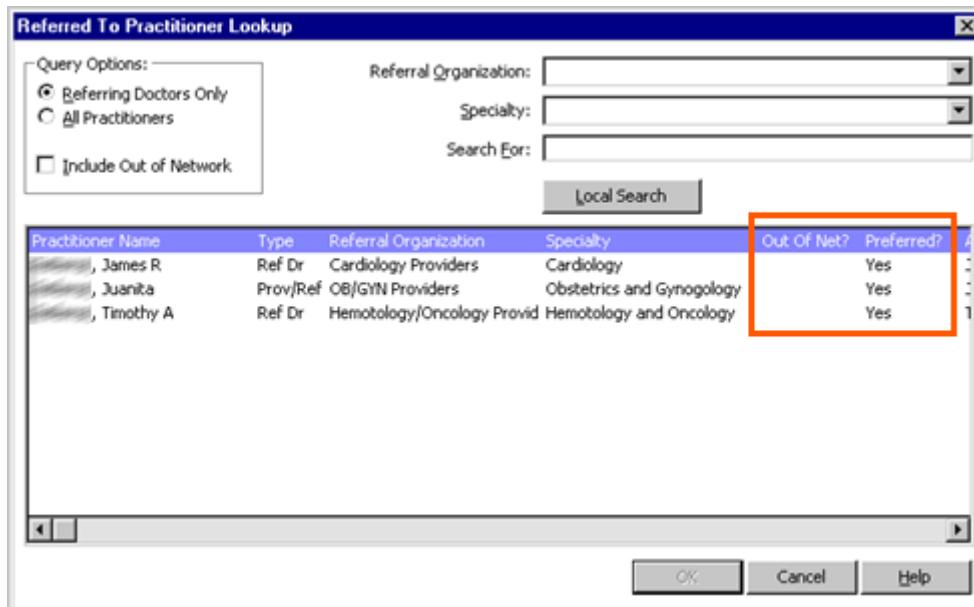
Insurance Network Maintenance window

Use **Insurance Network Maintenance** to create custom records to match the various carrier plans that your practice participates with, for example Blue Cross, Blue Shield, Tufts Healthcare, Cigna, and so on.

A carrier can be associated with a network in **Insurance Carrier Maintenance**.

You can also associate providers and referred-to providers with their contracted insurance plans by indicating their network status on the **Network Info** tab in **Provider Maintenance** and **Referring Doctor Maintenance**.

A provider and referring doctor's out-of-network or preferred-for-referrals status with the patient's carrier can be clearly viewed when you initiate a referred-to practitioner lookup while creating an outgoing referral.



Insurance Network Maintenance contains these tabs:

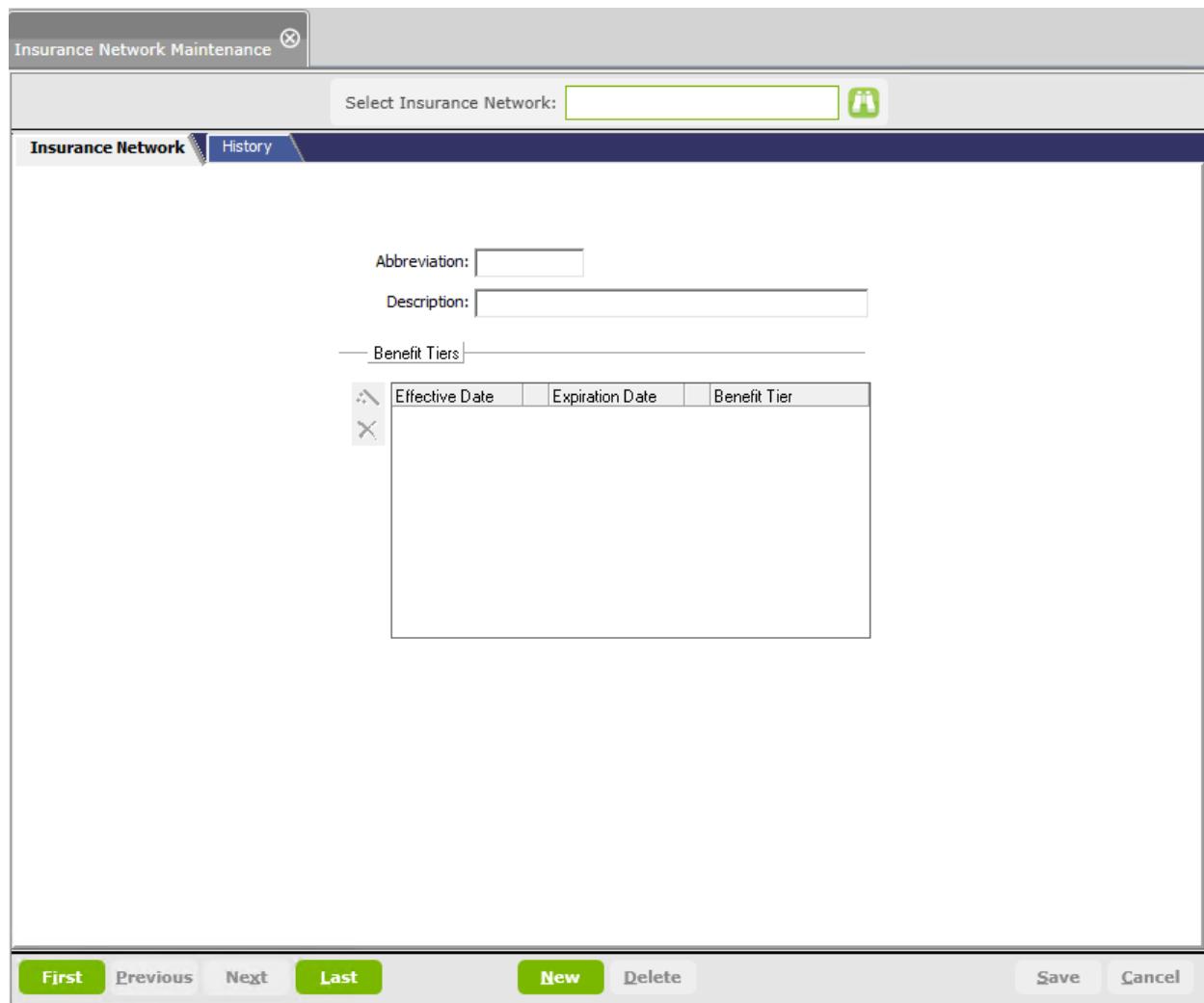
- > **Insurance Network**
- > **History**

Access **Insurance Network Maintenance** from **System Administration > File Maintenance > Insurance Network Maintenance**, or press **F9** and then enter **INM**.

Insurance Network tab

Use the **Insurance Network** tab in **Insurance Network Maintenance** to create custom records to match the various carrier plans that your practice participates with, for example Blue Cross, Blue Shield, Tufts Healthcare, Cigna, and so on.

Access the **Insurance Network** tab from **Insurance Network Maintenance**. To access **Insurance Network Maintenance**, go to **System Administration > File Maintenance > Insurance Network Maintenance**, or press **F9** and then enter **INM**.



The screenshot shows the 'Insurance Network Maintenance' window. At the top, there's a title bar with the window name and a close button. Below the title bar is a toolbar with a search field labeled 'Select Insurance Network:' and a magnifying glass icon. The main area has two tabs: 'Insurance Network' (which is selected) and 'History'. Under the 'Insurance Network' tab, there are input fields for 'Abbreviation:' and 'Description:', both with empty text boxes. Below these is a section titled 'Benefit Tiers' with a grid table. The table has columns for 'Effective Date', 'Expiration Date', and 'Benefit Tier'. There are also icons for adding (plus sign) and deleting (minus sign) rows. At the bottom of the window are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New' (highlighted in green), 'Delete', 'Save', and 'Cancel'.

Abbreviation

Enter a unique abbreviation of up to 8 alphanumeric characters; avoid special characters.

Description

Enter a unique description of up to 40 alphanumeric characters that distinguishes this record from other insurance network records.

The value is displayed as an option in **Insurance Carrier Maintenance**.

The value is displayed on the **Network Info** tab in **Provider Maintenance** and **Referring Doctor Maintenance**.

Note: Make a note to return to **Provider Maintenance** and **Referring Doctor Maintenance** to flag each provider as either out-of-network or preferred-for-referrals.

Benefit Tiers grid

Provides the ability to select effective dates and expiration dates for each benefit tier in an insurance network, which enables you to manage the participation of insurance networks.

Effective Date

Click  to select the date when a benefit tier takes effect.

Expiration Date

Click  to select the date when a benefit tier expires.

Benefit Tier

Select the benefit tier to which the effective and expiration dates apply.

The row with the most current effective date can exist without an expiration date. The row with the oldest expiration date can exist without an effective date. Dates cannot overlap among rows in the grid.

The information in the **Benefit Tiers** grid is not included in replication or starter data sets.

L & I Maintenance window

L&I Maintenance is used to build the records that allow you to provide your staff with the information they need to complete the requirements of the payer or contracted employer.

How it works

Custom built L&I records can hold information about the contracts, services requested by the employer, or special instructions or notes that your staff needs to have at the time of a Patient's visit.

These records (forms) are associated with a payer/employer in Insurance Carrier maintenance.

Staff with the security permission to access this information can do so via the tool bar button in Registration or Scheduling.

Sample types of records: DOT physical exam, Drug Screening Exam, Worker' Comp Treatment. Also, you can create records for specific contracted employer's or payers, for example, Aetna WC or TI WC.

L&I Maintenance contains these tabs:

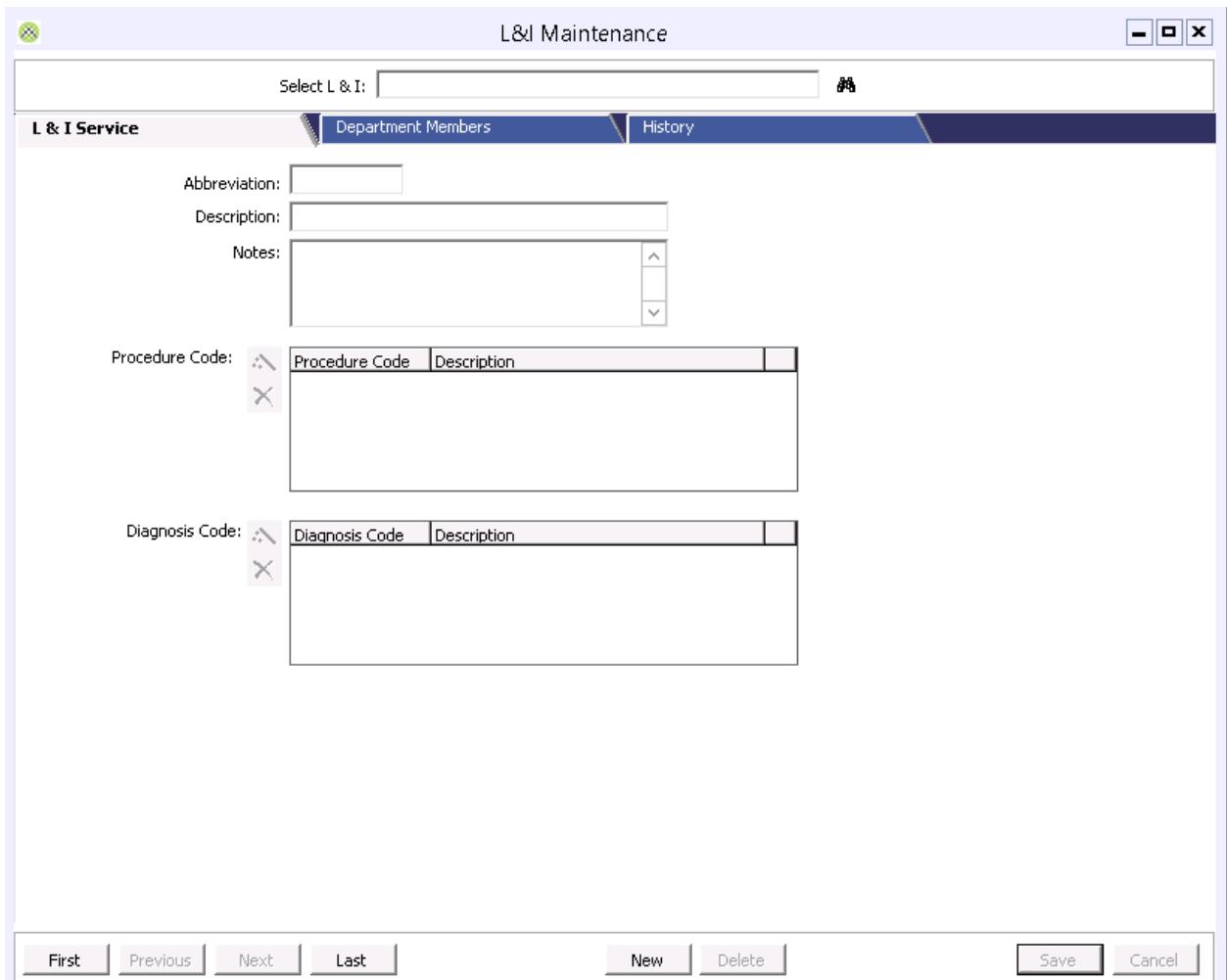
- > **L & I Service**
- > **Department Members or Practice Members**
- > **History**

To access **L&I Maintenance**, go to **System Administration > File Maintenance > L&I Maintenance** or press **F9** and then enter **LIM**.

L & I Service tab

L&I (Labor and Industry) Services are those provided to patients who are seen at an employer's request or due to a work related injury. Generally, you are required to provide specific information, forms, or services as part of these visits.

You can generate a listing of all your existing L&I Maintenance records by running the **L&I Listing**. Access the **L&I Service** tab from **System Administration > File Maintenance > L&I Maintenance** or press **F9** and then enter **LIM**.



The screenshot shows the 'L&I Maintenance' window. At the top, there is a search bar labeled 'Select L & I:' with a magnifying glass icon. Below the search bar is a navigation bar with tabs: 'L & I Service' (selected), 'Department Members', and 'History'. The main area contains four input fields: 'Abbreviation' (empty), 'Description' (empty), 'Notes' (empty text area with scroll bars), and 'Procedure Code' (empty list box). Below these are two more list boxes: 'Procedure Code' and 'Diagnosis Code', both of which are currently empty. At the bottom of the window are standard navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save' (disabled), and 'Cancel'.

Abbreviation

Enter up to 8 characters. Examples: DOTPE for DOT Physical; OCMXX, for Occupational Medicine where the XX indicates the Employer's initials, WCXX for A Worker's Comp where the XX indicates the payer's initials.

Description

Enter up to 40 characters which describes the service title or name of the record. For example, WC <Name of Payer>.

Notes

You can enter up to 255 characters. Use this field to record special instructions or requirements related to this service. For example, if you are required to send lab specimens to a specific lab, etc.

This is not a required entry.

Procedure code

This grid holds an unlimited number of selections. A scroll bar appears when you add more than 5 codes.

Use this field to enter the required or recommended procedures for this service. For example, select the procedures required to complete a DOT exam.

Note: Your selections are informational only. The system does not automatically default to using these procedures when you create a voucher for a payer associated to the record.

To remove a procedure code from the grid you must do the following

1. Click on the procedure code to highlight it in the grid
2. Click  to the left of the grid
3. Click **Yes** at the prompt.

Note: If you enter a procedure code by mistake you must delete it to remove from the grid. You cannot simply replace it with another procedure code.

Diagnosis code

This grid holds an unlimited number of selections.

A scroll bar appears when you add more than 5 codes.

Use this field to enter the required or recommended diagnosis codes for this service.

Note: Your selections are informational only. The system does not automatically default to using these diagnosis codes when you create a voucher for a payer associated to the record.

To remove a diagnosis code from the grid you must do the following:

1. Click on the diagnosis code to highlight it in the grid
2. Click the red  to the left of the grid
3. Click **Yes** at the prompt.

Note: If you enter a diagnosis code by mistake you must delete it to remove from the grid. You cannot simply replace it with another diagnosis code.

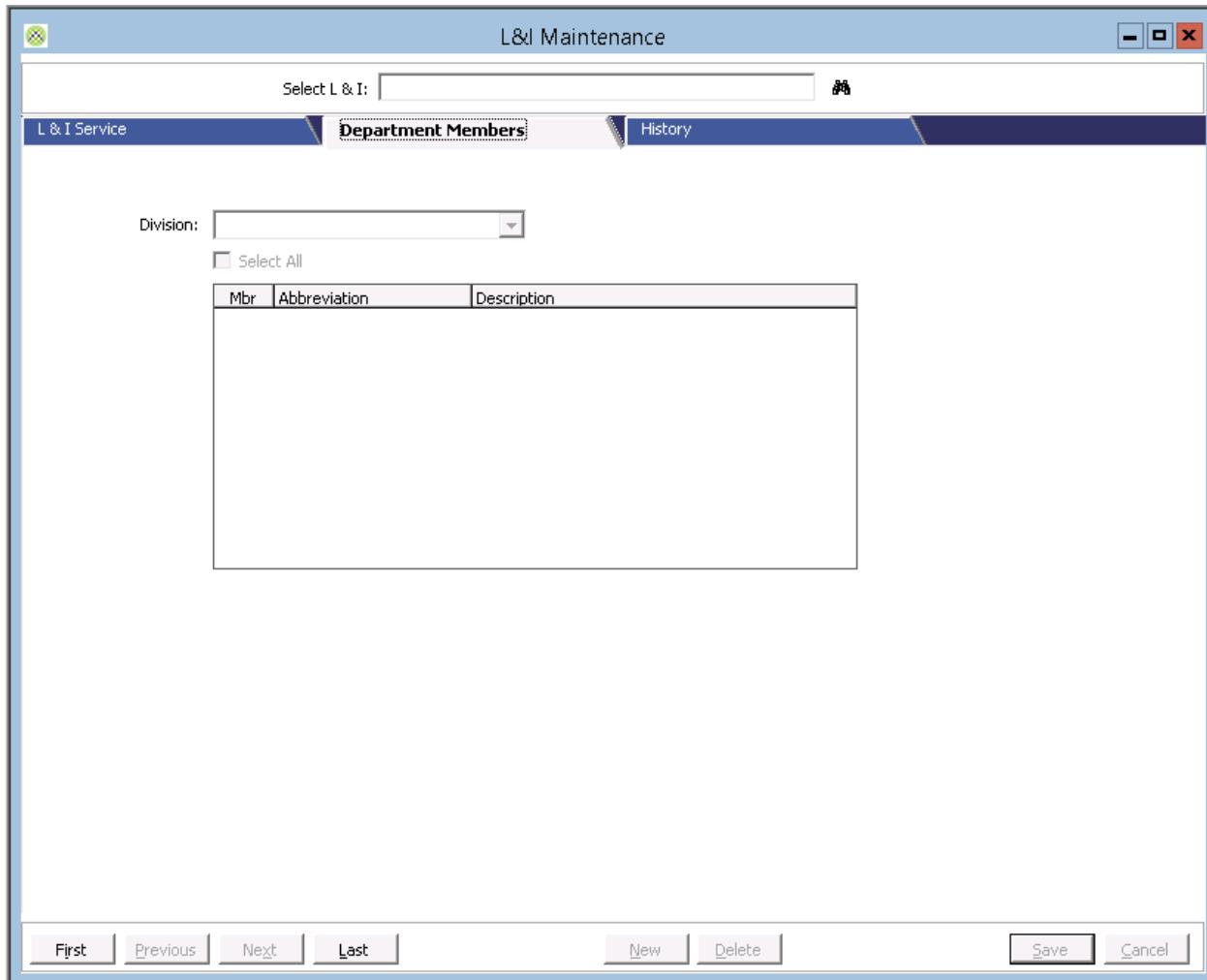
Clients using Department/Practice Security must select Department/Practice Members.

Department Members or Practice Members tab in L&I Maintenance

Appears only when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

You must select department members or practice members for each record that has a members tab.

Access the **Department Members** or **Practice Members** tab from **System Administration > File Maintenance > L&I Maintenance** or press **F9** and then enter **LIM**.



Division

This field is only enabled on the **Department Members** or **Practice Members** tab when you select **Enable Divisions** on the **Multi Entity** tab in **Practice Options** or **Organization Options**. In this case, the selection of department members or practice members is done at the level of division.

Note: Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you elect to enable divisions, you must create divisions in **Division Maintenance**. Divisions can be used as a group field

Benefit Covered Service Maintenance window

Use **Benefit Covered Service Maintenance** to define the covered services that are included in the benefit plans offered by insurance carriers.

Benefit Covered Service Maintenance contains these tabs:

- > **Benefit Covered Service**
- > **History**

Benefit Covered Service Maintenance is not included in replication or starter data sets.

To access **Benefit Covered Service Maintenance**, go to **System Administration > File Maintenance > Benefit Covered Service Maintenance**, or press **F9** and then enter **BCS**.

Benefit Covered Service tab

Use the **Benefit Covered Service** tab in **Benefit Covered Service Maintenance** to define the covered services that are included in the benefit plans offered by insurance carriers.

Access the **Benefit Covered Service** tab from **Benefit Covered Service Maintenance**. To access **Benefit Covered Service Maintenance**, go to **System Administration > File Maintenance > Benefit Covered Service Maintenance**, or press **F9** and then enter **BCS**.

Benefit Covered Service Maintenance X

Select Benefit Covered Service: 

Benefit Covered Service History

Abbreviation: <input type="text"/> Name: <input type="text"/> Description: <input type="text"/> <input type="checkbox"/> Specialist Service <input type="checkbox"/> OB/GYN Service
Select Departments: <input type="text" value="All Departments"/>   Select Locations: <input type="text" value="All Locations"/>   Select Providers: <input type="text" value="All Providers"/>   Select Provider Specialties: <input type="text" value="All Provider Specialties"/>   Select Appointment Types: <input type="text" value="All Appointment Types"/>  
Charges Select Places of Service: <input type="text" value="All Places of Service"/>   Select Diagnosis Codes: <input type="text" value="All Diagnosis Codes"/>   Select Procedure Codes: <input type="text" value="All Procedure Codes"/>   Select Modifiers: <input type="text" value="All Modifiers"/>  

First Previous Next Last **New** **Delete** **Save** **Cancel**

Abbreviation

Required. A unique abbreviation of up to 8 alphanumeric characters (avoid special characters).

Name

Required. The name, up to 40 alphanumeric characters, to be displayed in various areas of the application, such as **Quick Payment**.

Description

Required. A unique description of up to 300 alphanumeric characters that distinguishes this record from other benefit covered service records.

Specialist Service

Select this option to define a benefit covered service as a specialist service.

OB/GYN Service

Select this option to define a benefit covered service as an OB/GYN service.

Criteria that determine the applicable co-pay or co-insurance.

All entities for the following criteria are selected by default. To limit the entities for a specific criteria, click  to open a window and make selections.

- > **Select Departments or Select Practices:** If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, a **Division** tab is displayed to filter by division.
- > **Select Locations**
- > **Select Providers:** In addition to the standard **All Providers** option that is available in **Select Providers**, **Actual Physicians Only** and **Mid-Level Providers Only** filtering options are available, which coincide with the options in **Provider Maintenance**.
- > **Select Provider Specialties**
- > **Select Appointment Types**
- > **Select Places of Service**
- > **Select Diagnosis Codes**
- > **Select Procedure Codes**
- > **Select Modifiers**

Insurance Carrier Maintenance window

Create a record for each carrier you bill for services. Also create a record for your outside collection agency and any company with which you have occupational medicine contracts.

Tip: Practices or organizations often find it helpful to create a carrier record that is used to post payments erroneously received for non-patients.

Insurance Carrier Maintenance contains these tabs:

- > **Carrier**
- > **Refund Address**
- > **Plans**
- > **Profiles**
- > **Styles**
- > **Transplant**
- > **Additional Info**
- > **Other Payer Codes**
- > **Contractual Allowances tab**

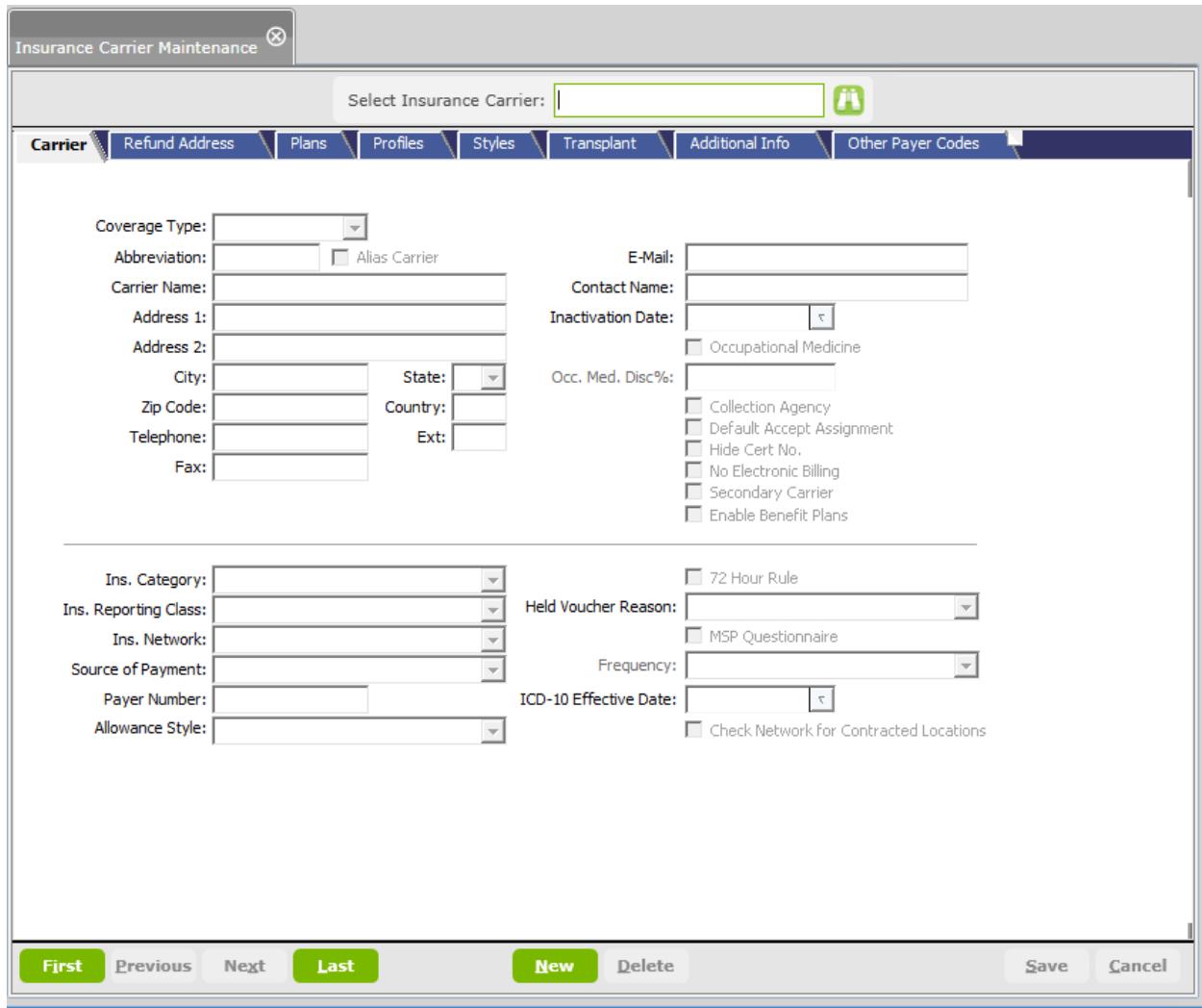
- > **Eligibility**
- > **Benefit Plans**
- > **History**

To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance > Insurance Carrier Maintenance** or press **F9** and then enter **ICM**.

Carrier tab in Insurance Carrier Maintenance

Use the **Carrier** tab in **Insurance Carrier Maintenance** to create records for the insurance carriers that you bill for services.

Access the **Carrier** tab from **System Administration > File Maintenance > Insurance Carrier Maintenance** or use **F9 > ICM**.



The screenshot shows the 'Insurance Carrier Maintenance' window with the 'Carrier' tab selected. The window has a title bar 'Insurance Carrier Maintenance' with a close button. Below the title bar is a search bar 'Select Insurance Carrier:' with a magnifying glass icon. The main area is divided into several sections:

- Carrier Information:** Fields include Coverage Type (dropdown), Abbreviation (text box), Carrier Name (text box), Address 1 (text box), Address 2 (text box), City (text box), State (dropdown), Zip Code (text box), Country (dropdown), Telephone (text box), Fax (text box), E-Mail (text box), Contact Name (text box), Inactivation Date (date picker), Occ. Med. Disc% (text box), and a list of checkboxes for various carrier options: Alias Carrier, Occupational Medicine, Collection Agency, Default Accept Assignment, Hide Cert No., No Electronic Billing, Secondary Carrier, and Enable Benefit Plans.
- Insurance Details:** Fields include Ins. Category (dropdown), Ins. Reporting Class (dropdown), Ins. Network (dropdown), Source of Payment (dropdown), Payer Number (text box), Allowance Style (dropdown), Held Voucher Reason (dropdown), Frequency (dropdown), ICD-10 Effective Date (date picker), and a checkbox for 'Check Network for Contracted Locations'.
- Action Buttons:** At the bottom are buttons for First, Previous, Next, Last, New, Delete, Save, and Cancel.

Coverage Type

This is a required field.

This drop-down list contains those coverage types marked as available on the **General** tab in **Practice Options** or **Organization Options** that you also have security permissions to see. If a coverage type is set as default in **Practice Options** or **Organization Options** and you have security permission to see it, that coverage type populates as the default here.

Note: You cannot change a carrier's coverage type after vouchers exist for that carrier, or if changing the coverage type will result in a patient having two primary policies with the same coverage type. Transplant policies (policies associated with carriers that have **Coverage Type** set to **Transplant**) only display in **Transplant Management**; they do not display on the **Policies** tab in **Registration**. Similarly, when searching for a policy from the **Policies** tab in **Registration**, carriers with a **Coverage Type** set to **Transplant** are not included in the search results.

If the coverage type of a carrier changes as a result of the Change Coverage Type utility, the change appears on the History tab in Insurance Carrier Maintenance for that carrier.

Tip: Use **Other** for Occupational Medicine and Collection carriers.

Worker's Comp - When you select **Worker's Comp** as the coverage type, the tab, **L&I Services** is added for this carrier.

Abbreviation

Holds up to eight characters. You can search by abbreviation when you are looking up an insurance carrier or plan. The abbreviation is also displayed in **Financial Inquiry**.

Alias Carrier

Alias Carrier is available when you create a new insurance carrier record; it is unavailable for a carrier record after you select **Alias Carrier** and click **Save**.

When you select **Alias Carrier**, certain rules apply:

- > **No Electronic Billing** on the **Carrier** tab is selected but unavailable because the application does not generate electronic claims for alias insurance carriers.
- > Required data entry boxes on the **Carrier** tab are **Abbreviation**, **Carrier Name**, **Ins Category**, **Ins Reporting Class**, **Source of Payment**, and **Coverage Type**. **ICD-10 Effective Date** is available but optional. All other data entry boxes on the **Carrier** tab are unavailable after you select **Alias Carrier**.
- > You can enter the insurance carrier name, address, telephone number, and contact name on the **Policies** tab in **Registration** on a patient-by-patient basis. Only **Carrier Name**, **Address 1**, **City**, and **State** are required.

- > **Transplant** is not a valid coverage type for an alias insurance carrier.
- > The **Refund Address, Plans, Additional Info, Other Payer Codes, Contractual Allowances**, and **Eligibility** tabs in **Insurance Carrier Maintenance** are unavailable for alias insurance carriers.
- > **Alt Paper Claim Style, Anesthesia Style, Dialysis Style**, and **Elect Remit Style** on the **Styles** tab are unavailable for alias insurance carriers. Likewise, the **Alternate Info** and **Split Billing Exceptions** areas are unavailable.
- > The application uses existing insurance billing logic for paper claims. Electronic billing is not supported for alias insurance carriers, so claims must be on paper only. When the primary policy is for an alias carrier, secondary claims must also be on paper.

The selection of **Alias Carrier** is not captured in the audit history for **Insurance Carrier Maintenance**.

Existing carriers cannot be designated as alias insurance carriers.

When replication is activated, alias insurance carrier records are replicated from the source tenant to target tenants when the record is saved. If you create an alias insurance carrier in a target tenant using **New Carrier** in **Insurance Carrier/Plan Lookup**, the new insurance carrier record is first replicated to the source tenant, and then to the other target tenants. Maintain replicated alias insurance carriers in the same manner that you maintain other replicated insurance carriers.

Vouchers associated to an alias insurance carrier are not output in ambulatory exports.

Carrier Name

Holds up to 40 characters. You can search by carrier name when you are looking up an insurance carrier or plan.

The carrier name prints on paper claims, outputs to electronic claim files, and prints on reports. Carrier names that are too long are automatically truncated if needed on the unpaid claims report so that the carrier name does not overprint into the next column of data.

Displays on the **Summary** tab and **Policies** tab in **Registration**

Can be viewed in **Unpaid Claims Management**

Address 1

Optionally prints on a paper claim and outputs to an electronic claim file.

Displays on the **Policies** tab in **Registration**.

Can be viewed in Unpaid Claims Management.

If the address is verified,  is displayed to the right of this box. If an override reason code was selected to save the address information,  is displayed to the right of this box.

Address 2

Optionally prints on a paper claim and outputs to an electronic claim file
 Displays on the Policies tab in Registration
 Can be viewed in Unpaid Claims Management

City / State / Zip Code

Optionally prints on a paper claim and outputs to an electronic claim file
 Displays on the Policies tab in Registration
 Can be viewed in Unpaid Claims Management

Telephone / Ext / Fax

Prints on an **Unpaid Claims Report**
 Displays on the Summary tab and Policies tab in Registration
 The telephone number can be viewed in Unpaid Claims Management

E-Mail

Informational only

Contact Name

Contact Name displays on the Summary tab and Policies tab in Registration
 It can be viewed in Unpaid Claims Management
 This box is used as the pull field for the **ATTN** (Attention) box on occupational medicine invoices.

Inactivation Date

As of the date entered, the Insurance Carrier is not included in the Insurance Carrier Lookup search results.

Enter a date when you no longer want your staff to select this Carrier as a policy in registration and bill this Carrier for services.

An alert is generated in Charge Entry when the Carrier is selected as the Policy on the voucher and the Inactivation Date is earlier than or equal to the current date.

The Operator can save the voucher with an inactive Carrier selected. For example, because the service date or dates precede the inactivation date, the voucher can safely be billed to the Carrier.

This alert also displays on the Charge Entry COMpanion when charges are being processed via the right-click menu item "Process Charge" on the Charge Import tab in Automatic Transactions.

Note: Entering an inactivation date does not trigger a warning in Scheduling when you attempt to schedule an appointment or save charges for patients who have this carrier set as their primary policy. You must manually enter an expiration date for this carrier on each related patient's policy tab.

You can run a report using the general view **vwGenPatInfo**. Instructions are available on the Allscripts® Clients Only Website.

Occupational Medicine

Checking this box identifies this carrier for occupational medicine billing and triggers various billing functions associated with occupational medicine billing.

Note: When you check this box the tab L&I Services tab is added for this Carrier.

Occ. Med. Disc%

Checking this box triggers various billing functions associated with occupational medicine billing.

Enabled only when Occupational Medicine is checked.

Enter a percent amount only if your occ. med. contract is based on a straight percentage discount. A company should not have a discount% specified in Insurance Carrier Maintenance when the associated reimbursement style is set to auto adjust occupational medicine services in Charge Entry.

For assistance, contact Allscripts® Support.

Collection Agency

Checking this box prevents claims from qualifying for billing to this Carrier.

Default Accept Assignment

Checks Yes in Box 27 on a standard CMS-1500 NPI claim form.

When checked, indicates that you accept the Carrier's contractual allowed amount as full payment for contracted services.

This is a global setting. You are also able to make a determination on accept on assignment at a Patient or voucher level.

Hide Cert No.

When checked, any place in Allscripts® Practice Management that displays the Patient's policy certificate number for this carrier shows the Certificate Number as a string of asterisks (*****) in place of the certificate number.

Clients using Replication: The selection of this option is not replicated.

No Electronic Billing

Check to prevent claims to this Carrier from qualifying for electronic billing.

All claims out to this Carrier print to paper.

Secondary Carrier

Check to identify this Carrier as one to be selected for Secondary Coverage

- > A search for Insurance Carriers using the Insurance Carrier/Plan Lookup dialog can be restricted to Secondary Carriers.
- > When this option is checked and the Practice Option, "Carriers Flagged as Secondary Required for Medicare Patients" is also checked, this Carrier can be selected as Secondary for a Patient with Medicare as Primary.
- > When this option is checked and this Carrier is selected as a Primary or Other Primary in Registration, a hard warning message, "Warning, this carrier is a secondary insurance!" displays and does not allow you to save the record.

Note: Creating a Reporting Class called "Secondary Carriers" and grouping report results by Reporting Class, allows you to report on payments, adjustments, for Carriers flagged as Secondary.

Enable Benefit Plans

Select this option to enable the **Benefit Plans** tab to define benefit plans for this carrier.

If the carrier has traditional plans defined on the **Plans** tab, **Enable Benefit Plans** is not available. To define benefit plans for this carrier, you must create a new record in **Insurance Carrier Maintenance** for that carrier.

Enable Benefit Plans is unavailable when **Alias Carrier** is selected or **Coverage Type** is set to one of the following values:

- > **Transplant**
- > **Uninsured**
- > **Worker's Comp**

When an insurance carrier has benefit plans defined, the coverage type cannot be changed.

When **Enable Benefit Plans** is selected, the **Plans** tab is unavailable.

Plans selected in **Copy Insurance Plans** are copied only to carriers that do not have **Enable Benefit Plans** selected.

Enable Benefit Plans is not replicated.

Insurance Category

This is a required field.

Select from the listing of custom-created insurance categories.

Insurance Reporting Class

This is a required field.

Select from the listing of custom-created insurance reporting classes.

Insurance Network

This field is optional.

Select from the listing of custom-created insurance networks.

Source of Payment

Triggers billing and verification functions related to certain claim formats and to Alpha II ClaimStaker® Enterprise, therefore it is important that you verify the accuracy of this information.

Check with the carrier or your electronic claims clearinghouse to determine the correct **Source of Payment Code**.

Payer Number

Enter the five-digit payer number provided by the carrier or by your electronic claims clearinghouse.

Note: Triggers billing functions related to certain claim formats. Verify that the information entered is accurate.

Allowance Style

This option allows you to determine the way allowed amounts are stored.

- By Carrier (system default selection) - Accept the default when the allowed amount is based only on the carrier.
- By Carrier/Department - Select when the allowed amount is based on the department where the service is provided.
- By Carrier/Location - Select when the allowed amount is based on the location where the service is provided.
- By Carrier/Provider - Select when the allowed amount is based on the provider of the service.

The **Contractual Allowance** tab will not become available until you save the entries made on this tab. If you change the **Allowance Style** after a record of allowances has been stored,

when you click **Save** you will be prompted to select a record from which the system can copy the existing history of allowed amounts to the new destination.

Example: If you change the **Allowance Style** from **By Carrier** to **By Carrier/Provider**, the following prompt displays: "Convert Contractual Allowances from Carriers to Carriers/Provider." Click to select the provider the system will use to store the existing current history of allowed amounts.

The copy function on the **Contractual Allowances** tab allows you to copy amounts between carriers, carriers/departments, carriers/locations, or carriers/providers.

72 Hour Rule

Enabled when a setting exists in **Practice Options** or **Organization Options** on the **Charge Entry** tab. The 72-hour rule is part of the Medicare Prospective Payment System (PPS).

When selected:

- > All vouchers with a policy associated with this carrier are held for 72 hours before being released for billing.
- > **Hold Voucher From** in Charge Entry defaults to **All Insurance Billing**.
- > **Held Voucher Reason** is enabled and required for this carrier's record.

Held Voucher Reason

Enabled and required when **72 Hour Rule** is selected.

The selected reason fills **Held Voucher Reason** in Charge Entry.

MSP Questionnaire

Enabled when you select **Medicare Part A**, **Medicare Part B** or **HMO Medicare Risk** as the carrier's **Source of Payment** on this tab. Selecting **MSP Questionnaire** enables the **Frequency** box.

Note:

If the carrier is edited and the **Source of Payment** is changed from any of the Medicare options to any other non-Medicare option, then the following occurs:

- > **MSP Questionnaire** is cleared and disabled
- > **Frequency** is cleared and disabled
 - If a **Define Number of Days** was selected in the spin box, it is cleared and the field no long displays.
- > Prompts no longer occur in Scheduling.

Enabled when the carrier's **Source of Payment** on the **Carrier** tab is set to **Medicare Part A, Medicare Part B or HMO Medicare Risk**.

Note: The **Source of Payment** on the **Styles** tab does not affect the availability of this check box.

Frequency

Enabled when you select **MSP Questionnaire**. Your selection determines when your staff receives a prompt to update the MSP Questionnaire.

The prompt is displayed when you are scheduling an appointment for a patient who has an active policy (not expired) that is associated with the carrier that has **MSP Questionnaire** selected.

The options for **Frequency** include the following:

Every Visit

The questionnaire displays each time you schedule a new appointment for the patient.

Only if Not Seen in Month of Appointment

The **MSP Questionnaire** window is displayed when the patient does not already have an appointment scheduled in the same month you are scheduling the new appointment. The existing appointment cannot have a status of Cancel or No Show. For example, if you schedule a new appointment for 9/28/11:

- > The questionnaire does not open when the patient already has another appointment scheduled in the month of September, 2011.
- > The questionnaire opens when the patient does not already have an appointment scheduled in September, 2011.

Defined Days Between Visits

Adds a **Define Number of Days** box to the window, which is set to **2** by default. You can change the default to any number of days from 3 to 99. Triggers the display of the window when there is no appointment already scheduled for the patient within the range of the defined number of days before or after the new appointment you are scheduling. For example:

- > The defined number of days between visits is set at 5.
- > The patient already has an appointment for 10/20/2011.
 - The MSP questionnaire does not display when you schedule a new appointment for 10/15/11 to 10/25/11.
 - The MSP questionnaire displays when you schedule a new appointment prior to 10/15/11 or after 10/25/11.

Define Number of Days

Enabled when you select **Defined Days Between Patient Visits** as the **Frequency**.

Note: If you are using replication, the selections made for these boxes are not replicated. The boxes are editable in target tenants.

ICD-10 Effective Date

(Optional) Enter the date when the carrier is ready to accept ICD-10 codes and your practice or organization is ready to send them. The default value for this date is **10/01/2015**.

This date is unavailable when a carrier has a claim style that is associated with a v4010 claim format.

Claims are generated with ICD-9 codes when:

- > **ICD-10 Effective Date** is blank, even if charges were entered with ICD-10 codes.
- > Thru dates of service are prior to **ICD-10 Effective Date**.

Claims are generated with ICD-10 codes when **Thru** dates of service are on or after **ICD-10 Effective Date**.

ICD-10 Effective Date is also used to determine the correct qualifier to include in the 2300 segment for ANSI 5010 837 professional, dental, and institutional claims.

If you are replicating carrier information, **ICD-10 Effective Date** is included. It is only editable in the source tenant, not in the target tenants. However, if you create a new insurance carrier record in a target tenant, **ICD-10 Effective Date** is replicated first to the source tenant, and then from the source tenant to all target tenants.

Check Network for Contracted Locations

Select this option to expand logic to include the plan network level before determining whether a location is in or out of network.

Important: **Check Network for Contracted Locations** is only used by the application when **Check Contracted Locations** is selected on the **Scheduling** tab in **Practice Options** or **Organization Options**.

When **Check Network for Contracted Locations** is selected, additional checking is performed based on **Ins Network** on the **Carrier** tab and **Insurance Network** on the **Policies** tab in **Registration**.

If the application determines that the patient cannot be seen because the location is out of the network, you are prompted to optionally select a different insurance network. If you do not select an in-network location, the patient must be seen at an in-network location or be considered self-pay.

By default, **Check Network for Contracted Locations** is enabled for all insurance carriers except the following:

- > Uninsured insurance carriers
- > Transplant insurance carriers
- > Alias insurance carriers
- > Workers' compensation insurance carriers
- > Collection insurance carriers

If you clear **Check Contracted Locations**, Allscripts® Practice Management will clear **Insurance Network** on the **Policies** tab in **Registration**.

Check Network for Contracted Locations is not replicated and is not included with starter data when creating a new tenant.

Refund Address tab

Use the **Refund Address** tab in **Insurance Carrier Maintenance** to store separate refund addresses for insurance carriers.

The **Refund Address** tab lists all refund addresses for the selected insurance carrier in the upper grid, sorted by description. The refund address that has the **Default** check box selected has **Default** displayed in the **Default** column. All refund addresses listed for an insurance carrier on the **Refund Address** tab are also available in the **Address** list on the credit balance management windows **Request Refund** and **Approve/Not Approve Refund** for vouchers associated with that insurance carrier. Refund addresses are also displayed on the **Refund Status Report**.

Note: When you upgrade to Allscripts® Practice Management version 10.5, refund address information is automatically moved from the **Refund Address** section on the **Carrier** tab to the new **Refund Address** tab. Existing refund addresses are automatically given a **Description of Refund Address** and have the **Default** check box selected.

Changes to the **Refund Address** tab are captured on the **History** tab.

If you are replicating carrier information, the values entered in the **Refund Address** boxes are replicated. You can enter a refund address when adding a new carrier in **Registration** in a target tenant. For existing carriers, you can only make changes to the **Refund Address** tab in the source tenant.

Using the Accounts Payable (AP) Refund Export

When you use the AP Refund Export, the values the following boxes are included in the .xml file for refund transactions that include a refund address:

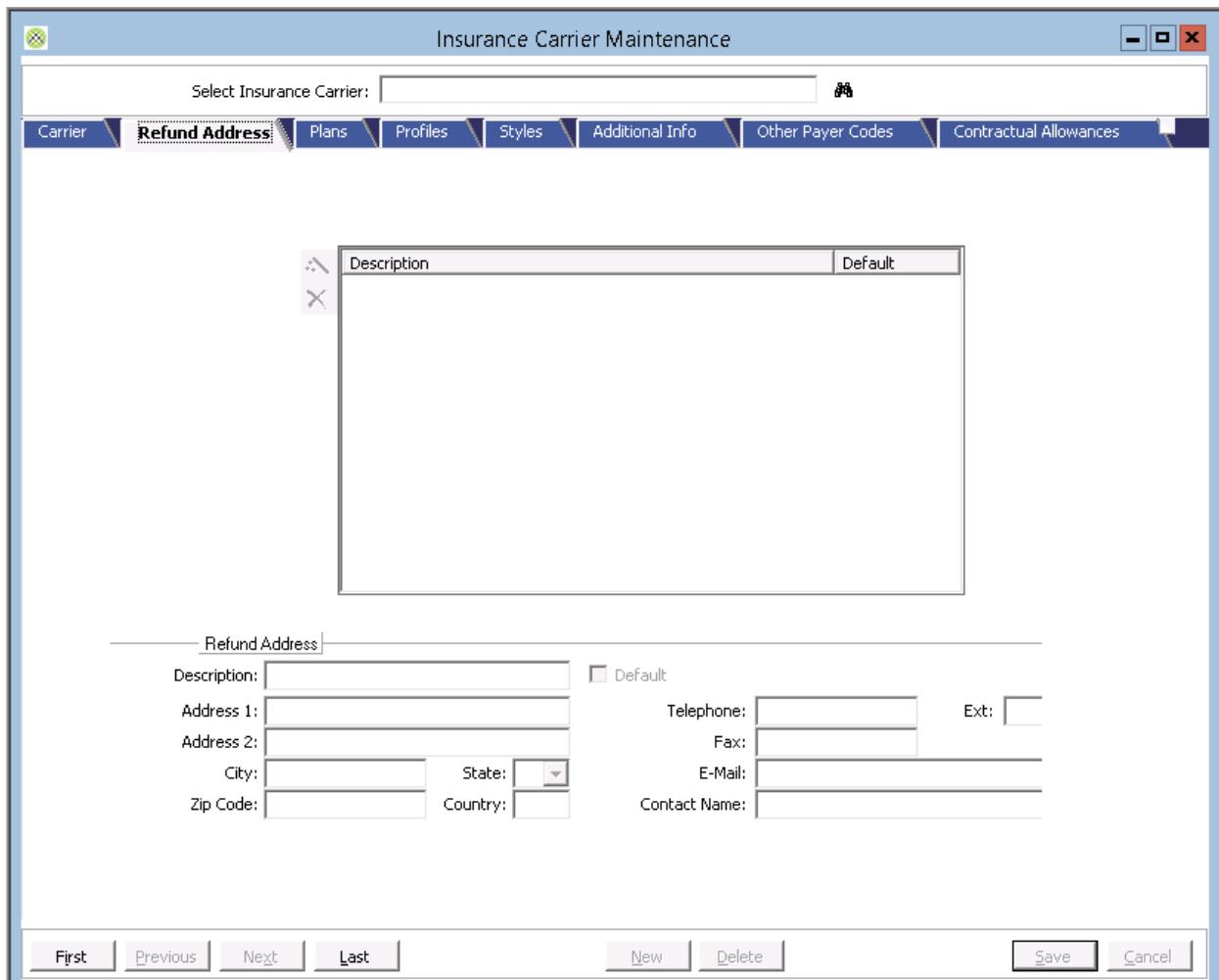
- > **Address 1**
- > **Address 2**

- > City
- > State
- > Zip Code

For the AP Refund Export to function correctly, the **Information Broker Format Maintenance** record in Allscripts® Interface Engine that is associated with the export must have **Active** selected and have **Trigger Event Type** set to **AP Refund**.

If the boxes on the **Refund Address** tab are blank, the carrier's made address is used instead.

Access the **Refund Address** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.



The screenshot shows the 'Insurance Carrier Maintenance' application window. The title bar reads 'Insurance Carrier Maintenance'. Below the title bar is a menu bar with tabs: Carrier, Refund Address (which is selected and highlighted in blue), Plans, Profiles, Styles, Additional Info, Other Payer Codes, and Contractual Allowances. A sub-menu window titled 'Description' is open over the main window, showing a single row with 'Default' checked. At the bottom of the main window, there is a section labeled 'Refund Address' containing fields for Description, Address 1, Address 2, City, State, Zip Code, Country, Telephone, Fax, E-Mail, and Contact Name. There is also a 'Default' checkbox next to the Description field. Navigation buttons at the bottom include First, Previous, Next, Last, New, Delete, Save, and Cancel.

Description

Required box. Enter an applicable description for the refund address. Each refund address must have a unique description.

Default

Select the **Default** check box to indicate that this refund address is the default refund address for this insurance carrier. If a carrier has any refund addresses, you must always have a default refund address selected. If a carrier has only 1 refund address, the **Default** check box is automatically selected and unavailable. If a carrier has more than 1 refund address, you can only change the default by selecting the **Default** check box for the refund address you want to make the new default. Once you select the **Default** check box, it becomes unavailable. This behavior is meant to ensure that you always have a default refund address selected.

Default refund addresses are used on the **Insurance Cr Bal Vouchers** tab in **Credit Balance Management** in 2 ways.

- > When you first open **Request Refund or Approve/Not Approve Refund** for a refund associated with this insurance carrier, the default refund address is automatically displayed in **Pay To Address**.
- > If a voucher does not have a current refund status and you set its refund status to **R**, **A**, or **N** using the applicable context menu option after selecting multiple vouchers, the pay to address for that voucher is automatically set to the default refund address for the associated insurance carrier.

Refund addresses with **Default** selected also output in place of the carrier address on certain refund-specific exports, such as the AP Refund Export.

Address 1

Required box. Enter the first line of the refund address.

If the address is verified,  is displayed to the right of this box. If an override reason code was selected to save the address information,  is displayed to the right of this box.

Address 2

Optional. Enter the second line of the refund address.

City

Required box. Enter a city.

Note: If this refund address has **Default** selected, the value in this box is sent to the .xml file for the Accounts Payable (AP) Refund Export when the **Information Broker Format Maintenance** record for the AP Refund Export in Allscripts® Practice Management is active

and has **Trigger Event Type** set to **AP Refund**. If no default refund address exists, the export uses the address on the **Carrier** tab.

State

Required box. Select a state from the list.

Zip Code

Required box. Enter a ZIP code using a 9-character ZIP code and a 4-digit identifier, or click  to open **ZIP Code Lookup** and select a ZIP code.

Country

Enter a 2-character country code.

Telephone

Enter a 20-character telephone number. All 20-character entries are automatically converted to the format (###) ###-####. If you enter a number in an incorrect format, it is displayed in red.

Ext

Enter the telephone extension, if any. You can use up to 5 characters.

Fax

Enter a 20-character fax number. All 20-character entries are automatically converted to the format (###) ###-####. If you enter a number in an incorrect format, it is displayed in red.

E-Mail

Enter an email address for this refund address. You can use up to 255 characters.

Contact Name

Enter a contact name for this refund address. You can use up to 40 characters. This box is optional, even when using the AP Refund Export.

L & I Services tab in Insurance Carrier Maintenance

Use the **L & I Services** tab to associate 1 or more of the records created in **L & I Maintenance** to this carrier. This tab is only available when, on the **Carrier** tab, either **Occupational Medicine** is selected or the carrier's **Coverage Type** is set to **Worker's Comp**. Selecting L & I service records for the carrier is optional.

Labor and Industries (L & I) services are those provided to patients who are seen at an employer's request or due to a work related injury. Generally, you are required to provide specific information, forms, or services as part of these visits.

In **L & I Maintenance**, you can build custom records which enable you to provide your staff with the information they need to complete the requirements of the payer or contracted employer. These can hold information about the contracts, services requested by the employer, or special instructions or notes that your staff needs to have at the time of a patient's visit.

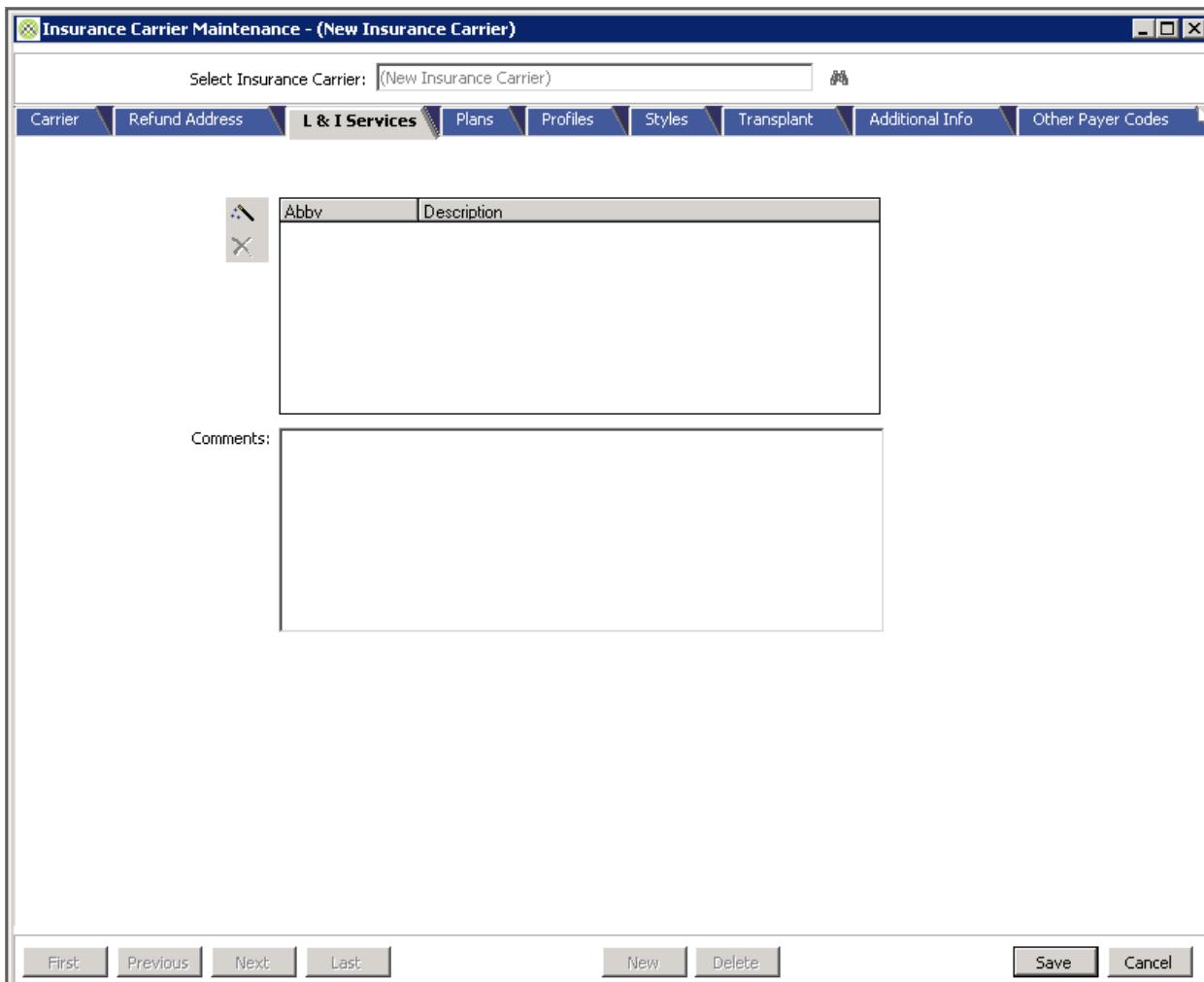
Then in **Insurance Carrier Maintenance** you can associate the appropriate record or records with a carrier.

Note: Selecting L & I service records for the carrier is optional: this tab can remain blank. You can save a record without adding any services or comments on this tab.

Click  to search for and add an L & I service to the carrier. An operator with security access can then view/print this information in Registration and Scheduling via the tool bar button . If you use replication, selections made on this tab are not replicated across tenants.

Access the **L & I Services** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.

Note: This tab is only available when, on the **Carrier** tab, either **Occupational Medicine** is selected or the carrier's **Coverage Type** is set to **Worker's Comp**.



Comments

The carrier comments are unrelated to the services you associate to the carrier in the grid above. The comments are unique to the carrier, regardless of the services entered or selected in the grid on the **L & I Services** tab in **Insurance Carrier Maintenance**. This independence means that you can add a comment without selecting a service in the top grid. When your staff opens the L & I Services form in **Registration** or **Scheduling**, they see the comment in the lower grid on the form.

You can add a comment without adding a service in the top grid. In this way, you can use **Comments** to convey general instructions that apply when a patient with a carrier's policy receives L & I-related services.

You can enter up to 255 characters.

Plans tab

Carrier plans include identifying a capitated carrier, plan exceptions, usual co-pay payment amounts, usual co-insurance% and co-pay/co-insurance exceptions that can apply to any patient covered by this carrier.

Note: For plans that have a combination of co-pays for office visits and coinsurance percentages for ancillary services create a combination plan such as 20/20. Enter the usual co-pay amount then enter the usual co-ins% in Co-Pay/Co-Ins Exceptions.

Information entered on this tab are used to alert your staff to co-pay, deductible, and co-insurance responsibilities. Plan information is displayed on various windows, including the following, such as on the **Patient Summary** tab in **Registration** and the **Patient Information** window opened from **Scheduling and Charge Entry**.

Co-pay amounts, co-insurance percentages as well as exceptions are used on the **Self-Pay** window in **Charge Entry**. Co-insurance percentages are calculated on the allowed amount entered in the carrier's contractual allowance table.

New plans can also be added to a carrier from the **Policies** tab in **Registration**.

Access the **Plans** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.

Insurance Carrier Maintenance

Select Insurance Carrier:

Carrier | Refund Address | **Plans** | Profiles | Styles | Additional Info | Other Payer Codes | Contractual Allowances

Plan Code	Description

Plan Code: PCP Co-Pay:
 Capitated Plan Specialist Co-Pay:
 Description: Deductible:
 Plan Exceptions: Usual Co-Ins%:
 Co-Pay/Co-Ins Exceptions:
 Comments:

First | Previous | Next | Last | New | Delete | Save | Cancel |

Plan Code Grid

Lists all the plans in alphabetical order.

Add and Delete buttons

Click  to add a new plan to the list. Click  to delete a selected plan.

Plan Code

Enter the co-pay amount or co-insurance percent associated with the plan: for example, 10 or \$10 for a plan with a \$10 co-pay. For plans that have a combination of co-pays for office visits and co-insurance percentages for ancillary services, create a combination plan such as 20/20.

Displayed in **Registration**, in **Patient Scheduling** on **Patient Info**, in the **Policy** drop down on **Charge Entry**, and on insurance carrier and plan search windows.

Description

Generally, it is a best practice to enter the Co-Pay, Co-Ins or CP/Co-Ins.

Displayed on insurance carrier and plan search windows. Prints in Box 11c on a standard CMS-1500 NPI claim form when billing any insurance other than Medicare either as primary or secondary.

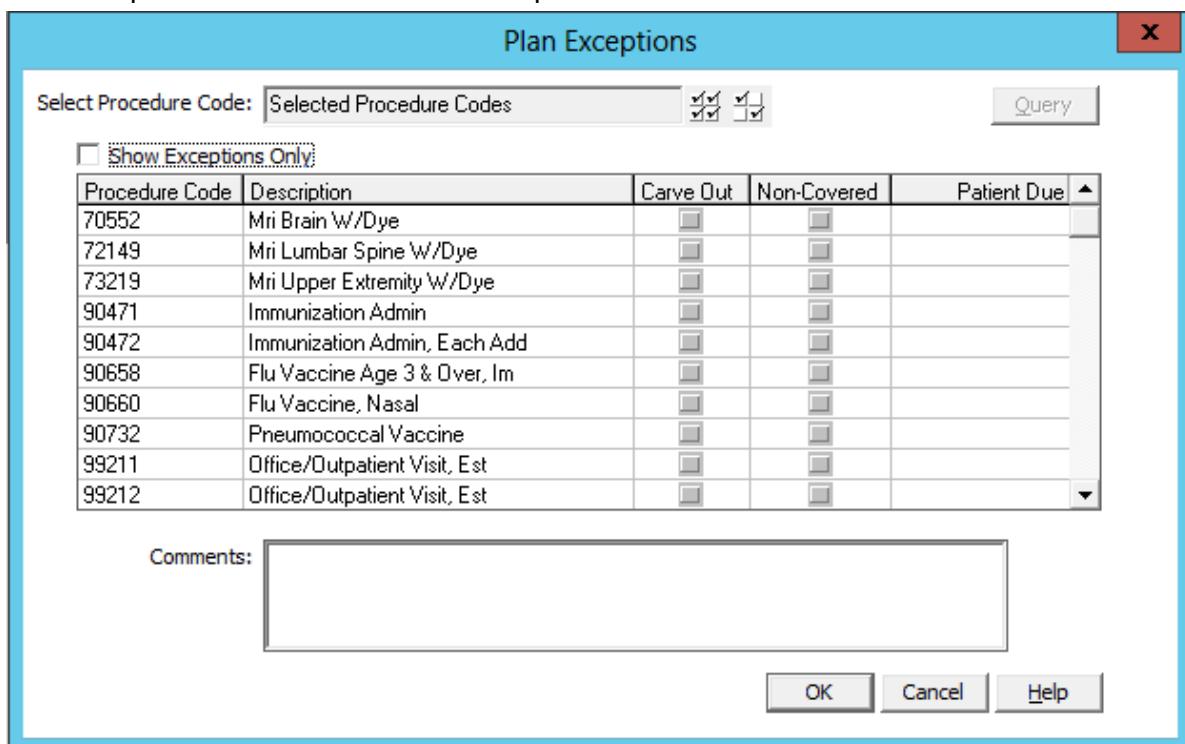
Capitated Plan

Select if you have contracted for capitated services with this carrier.

Note: The reimbursement style associated with this carrier can include Auto Adjust Capitation in **Charge Entry**.

Plan Exceptions

Enables you to identify those services that are considered carve outs or non-covered based on your contract with a capitated carrier. Click  to open **Plan Exceptions**, where you can enter the patient due amount for various procedure codes.



Procedure Code	Description	Carve Out	Non-Covered	Patient Due
70552	Mri Brain W/Dye	<input type="checkbox"/>	<input type="checkbox"/>	
72149	Mri Lumbar Spine W/Dye	<input type="checkbox"/>	<input type="checkbox"/>	
73219	Mri Upper Extremity W/Dye	<input type="checkbox"/>	<input type="checkbox"/>	
90471	Immunization Admin	<input type="checkbox"/>	<input type="checkbox"/>	
90472	Immunization Admin, Each Add	<input type="checkbox"/>	<input type="checkbox"/>	
90658	Flu Vaccine Age 3 & Over, Im	<input type="checkbox"/>	<input type="checkbox"/>	
90660	Flu Vaccine, Nasal	<input type="checkbox"/>	<input type="checkbox"/>	
90732	Pneumococcal Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	
99211	Office/Outpatient Visit, Est	<input type="checkbox"/>	<input type="checkbox"/>	
99212	Office/Outpatient Visit, Est	<input type="checkbox"/>	<input type="checkbox"/>	

Plan exceptions fall into 3 categories:

Carve Out

Fee for service procedures that are billed to the carrier. Vouchers that include carve out procedures are not automatically adjusted and qualify for billing to the carrier.

Non-Covered

If you select **Non-Covered**, the total charge for this procedure code is transferred to self-pay. When you enter an amount on this window in **Patient Due** for a non-covered procedure then that amount is included on the **Self-Pay** window as **Other Patient Balance**. When you do not enter an amount in **Patient Due**, the procedure fee entered on the fees tab in **Procedure Code Maintenance** is included in the **Other Patient Balance** on the **Self-Pay** window when this carrier is the payor.

Patient Due

Available when you select **Non-Covered**. Unavailable when you select **Carve Out**. The amount you enter in **Patient Due** is included in the **Other Patient Balance** on the **Self-Pay** window in **Charge Entry**.

If you leave this box blank and you select **Non-Covered**, the procedure fee entered on the fees tab in **Procedure Code Maintenance** is included in the **Other Patient Balance** on the **Self-Pay** window in **Charge Entry** when this carrier is the payor.

When you click **OK**, you return to the **Plans** tab and the words **Exceptions Exist** are displayed in the **Plan Exceptions** box.

PCP Co-Pay

The amount due when a patient is seen by his or her Primary Care Physician (PCP). **PCP Co-Pay** is unavailable when you enter a value in **Specialist Co-Pay**.

Enter an amount, for example, 20. The application automatically converts your entry to dollars.

Specialist Co-Pay

The amount due when the patient is seen by a specialist. When you fill this box, **PCP Co-Pay** and **Usual Co-Ins%** become unavailable.

Enter an amount, for example, 20. The application converts your entry to dollars.

Note: The co-pay amount used depends on whether the provider associated with the service, transaction, or appointment is associated with a specialty that has **Specialist Co-Pay Applies** selected in **Specialty Maintenance**.

Deductible

Informational only.

Usual Co-Ins%

This box is unavailable if you fill either **PCP Co-Pay** or **Specialist Co-Pay**. This amount is used when calculating the percentage of the allowed amount that is the patient's responsibility: the allowed amount comes from the carrier's contractual allowances table. Enter the percent that is the patient's responsibility. When you enter a value, the application automatically enters the decimal point.

Note: For co-insurance amounts to be calculated, allowed amounts must be entered for procedure codes.

The co-insurance percent amount is not calculated when the primary carrier is being billed and the patient has a secondary policy.

Co-Pay/Co-Ins Exceptions

Co-Pay/Co-Ins Exceptions are exceptions to the general rule when applying co-pay or co-insurance percent to specific services. This box enables you to flag a procedure as having a different a co-pay or co-insurance, or no co-pay or co-insurance percent.

Click  to open **Co-Pay/Co-Ins Exceptions**. You can use this window to define by procedure code those co-pay payment amounts or co-insurance percentages that are different than the PCP or specialist co-pay or co-insurance percent defined for the Plan.

When the procedure has **Co-Pay Applies** selected in **Procedure Code Maintenance**, the co-pay amount recorded in **Co-Pay/Co-Ins Exceptions** is displayed on the **Self-Pay** window in **Charge Entry**. The usual co-pay amount associated with the plan continues to display on **Charge Entry**.

Comments

Free text field. Comments entered here are displayed only on this tab.

Copy

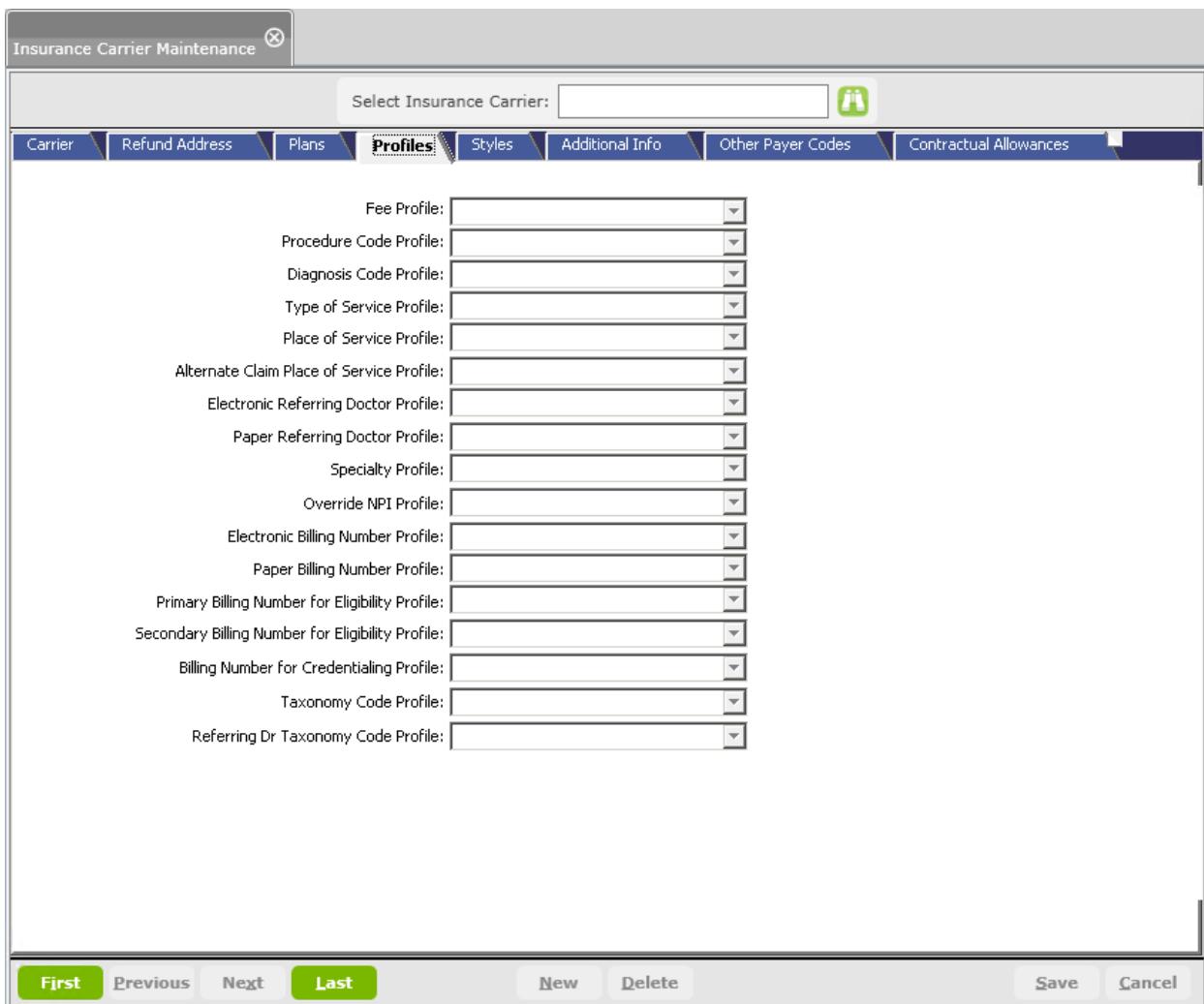
Enabled when you have at least 1 saved plan. If you have created a set of plans for a carrier that you know you can use for other carriers, click **Copy** to open **Copy Insurance Plans** and select the other carriers you want to copy these plans to.

Profiles tab in Insurance Carrier Maintenance

Use the **Profiles** tab in **Insurance Carrier Maintenance** to select the coding conventions that apply to the carrier.

Your selection for each profile directs the application to the billing code or billing number to use on a claim submitted to the Carrier. The default program selection for each profile is **(default)**, which indicates the profile selected as the default on the **Profiles** tab in **Practice Setup** or **Organization Setup**.

Access the **Profiles** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.



Fee Profile:	Procedure Code Profile:	Diagnosis Code Profile:	Type of Service Profile:	Place of Service Profile:
Alternate Claim Place of Service Profile:	Electronic Referring Doctor Profile:	Paper Referring Doctor Profile:	Specialty Profile:	Override NPI Profile:
Electronic Billing Number Profile:	Paper Billing Number Profile:	Primary Billing Number for Eligibility Profile:	Secondary Billing Number for Eligibility Profile:	Billing Number for Credentialing Profile:
Taxonomy Code Profile:	Referring Dr Taxonomy Code Profile:			

Fee Profile

Available when **Procedure Fee Basis** is set to **Carrier** on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

If **Fee Profile** is enabled, your selection determines which fee is used when billing a service to this carrier.

Pulls the current fee entered for the selected profile on the **Fees** tab in **Procedure Code Maintenance** (PCM).

Procedure Code Profile

Determines which billing code is used to identify the procedures submitted to the carrier.

Pulls the value entered for the selected procedure code profile on the **Billing Codes** tab in **Procedure Code Maintenance** (PCM).

Diagnosis Code Profile

Determines which diagnosis billing code is used when a claim is submitted to the carrier.

Pulls the value entered for the selected diagnosis code profile on the **Billing Codes** tab in **Diagnosis Code Maintenance** (DCM).

Type of Service Profile

Determines which Type of Service billing code is used on a claim submitted to the carrier.

Pulls the value entered for the selected type of service profile on the **Billing Codes** tab in **Type of Service Maintenance** (TSM).

Place of Service Profile

Determines which Place of Service billing code is used on claims submitted to the carrier.

Pulls the value entered for the selected place of service profile on the **Billing Codes** tab in **Place of Service Maintenance** (PSM).

Alternate Claim Place of Service Profile

Determines the Place of Service Billing code used when billing claims using one of the carrier's alternate claim styles.

An alternate paper claim style is selected when an insurance carrier requires that you print claims on either a CMS-1500 NPI claim form or a UB-04 claim form based on where the services are rendered.

Electronic Referring Doctor Profile

Select the billing number profile associated with the referring doctor billing number required by the carrier when submitting claims electronically.

Note: Enables you to report different billing numbers when billing the same carrier electronically and on paper.

Paper Referring Doctor Profile

Select the profile associated with the provider billing number required by the carrier when submitting paper claims.

Note: Enables you to report different billing numbers when billing the same carrier electronically and on paper.

Specialty Profile

Determines which specialty billing code is used when submitting a claim to the carrier.

Note: You must select a specialty for the provider in **Provider Maintenance** (PRM).

Override NPI Profile

If you have a need to output an alternate National Provider Identifier (NPI) for a facility or place of service in Box 33a on CMS 1500 ICD-10 Standard (02/12) claim forms or Loop 2010AA on v5010 professional electronic claims, select an alternate NPI profile. An alternate NPI is an NPI other than the standard NPI.

This box is enabled only when 1 or more **Billing Numbers** profiles in the grid on the **Profiles** tab in **Practice Set Up** or **Organization Set Up** has **Override NPI** selected. Those **Billing Numbers** profiles are the selection options for this box.

Electronic Billing Number Profile

Select the profile associated with the provider billing number required by the carrier when submitting a claim electronically.

Note: Enables you to report different billing numbers when billing the same carrier electronically and on paper.

Paper Billing Number Profile

Select the profile that points to the provider billing number required by the carrier when submitting a claim on paper.

Primary Billing Number for Eligibility Profile

Important: Use this box only if you submit eligibility requests to the carrier. If you submit eligibility requests, you must make a selection in this box. If you do not submit eligibility requests, leave this profile set to **(default)**.

Select the profile which represents the individual provider number required by the carrier when you request eligibility verification.

If a carrier assigns unique provider numbers for Eligibility Requests, select the applicable eligibility profile created in **Practice Set Up** or **Organization Set Up**. If the carrier requires the same billing number that you use for electronic billing, select the primary billing number for the eligibility profile.

Note: Before Allscripts® Practice Management, this box was called **Billing Number for Eligibility Profile**. Selections made before your upgrade are preserved in the renamed box.

Secondary Billing Number for Eligibility Profile

Only use if you submit Eligibility Requests and the carrier requires a secondary provider identification qualifier.

Contact the carrier for specific requirements.

Note: If **Secondary Provider Identification Qualifier Code** on the **Eligibility** tab in **Insurance Carrier Maintenance** is set to **None**, this profile should be set to **(default)**.

Billing Number for Credentialing Profile

This profile is linked to preventing the billing of services performed by a provider not yet credentialled by the carrier.

If selecting a credentialing profile, be sure that either or both the paper claim style and the electronic claim style associated with this carrier have **Credentialing for Billing Provider Required** selected on the **Validations** tab in **Paper Claim Style Maintenance** or **Electronic Claim Style Maintenance**, as applicable.

Taxonomy Code Profile

Based on the billing method selected in **Electronic Claim Format Maintenance**; determines which profile is used to report the billing entity's taxonomy code when submitting claims to this carrier.

To report the billing entity's taxonomy code in an electronic claim file, you must also select at least 1 of the output options related to outputting the rendering, billing or performing provider's taxonomy code for the claim style associated with the carrier.

To print the billing provider's taxonomy code on a Standard 1500 claim form you must also select **Output Taxonomy Code** for the paper claim style selected for the carrier.

Used to determine which taxonomy codes print in FL 76 through 79 on the UB-04 (CMS-1450) claim form when **Actual Provider Indiv Taxonomy**, **Billing Provider Indiv Taxonomy**, **Operating Physician Indiv Taxonomy**, **Other Physician A Indiv Taxonomy**, or **Other Physician B Indiv Taxonomy** are selected on the **Uniform Billing Info** tab in **Paper Claim Format Maintenance**. The taxonomy code is retrieved from the **Taxonomy Codes** tab in **Provider Maintenance**. The taxonomy codes for the selection in **Place of Service** in **Provider Maintenance** take precedence over the taxonomy codes for the default place of service unless the taxonomy code for the place of service is blank.

Referring Dr Taxonomy Code Profile

Determines which taxonomy code profile to use when reporting the taxonomy code for the voucher's referring doctor. The taxonomy code is pulled from the **Taxonomy Code** tab in **Referring Doctor Maintenance** (RDM).

To report the voucher's referring doctor taxonomy code in a professional or dental electronic claim file you must also select the output option **Output Referring Doctor Taxonomy Code** on the electronic claim style selected for the carrier.

To print the referring doctor's taxonomy code on a Standard 1500 claim form you must also select **Referring Dr. Indiv. Taxonomy** as the **Referring Doctor Option** for the paper claim format associated with the paper claim style selected for the carrier.

Used to determine which taxonomy codes print in FL 76, FL 78, and FL 79 on the UB-04 (CMS-1450) claim form when **Referring Provider Taxonomy** is selected on the **Uniform Billing Info** tab in **Paper Claim Format Maintenance**. The taxonomy code is retrieved from the **Taxonomy Codes** tab in **Referring Doctor Maintenance**.

Styles tab

The **Styles** tab describes the styles you can assign to a carrier.

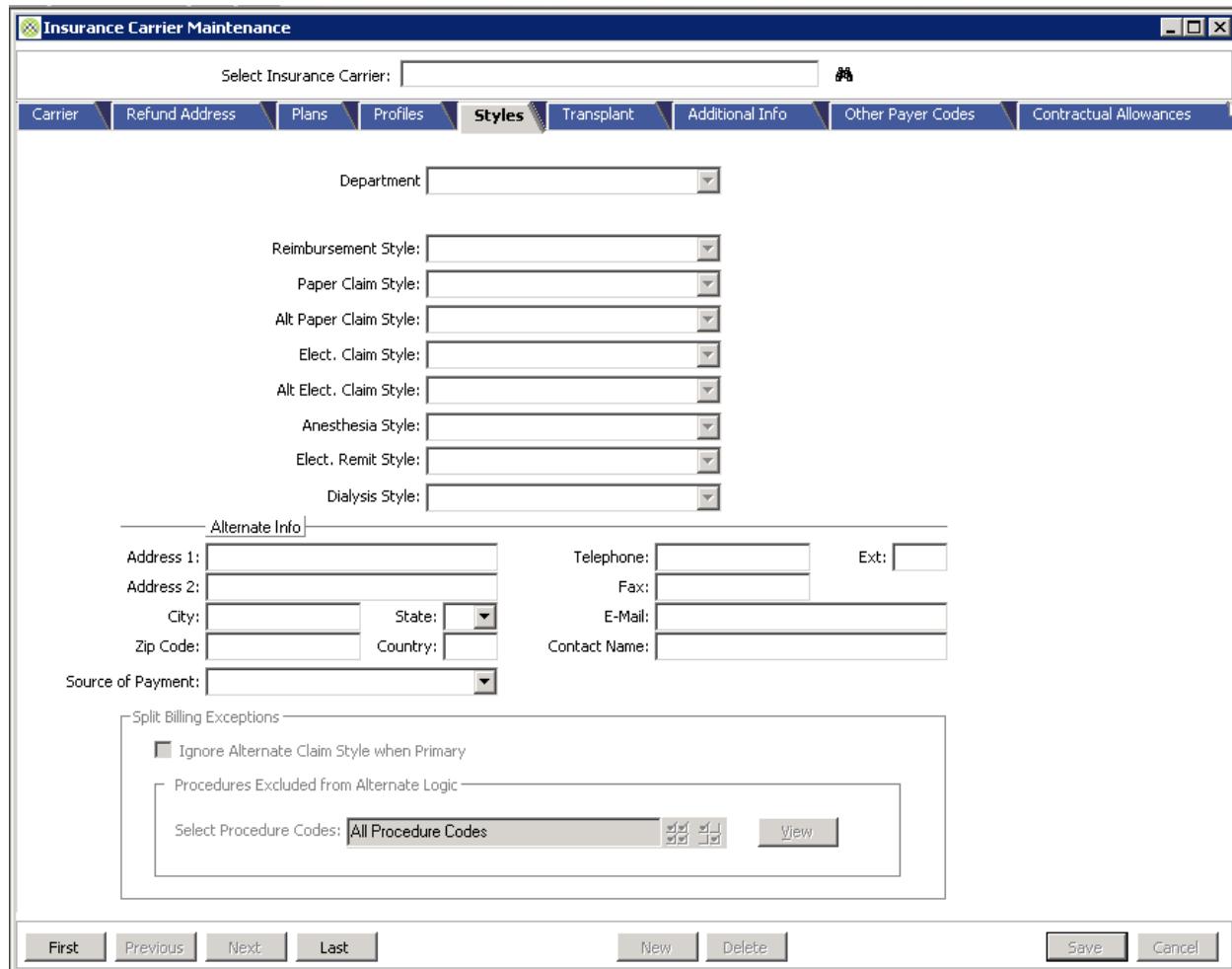
The **Styles** tab enables you to store different styles and alternate claim information for each department or practice.

You can create a department or practice for each separate location within your practice or organization if you have more than 1 entity and you need different claim styles to be used for the same carrier.

After you set up styles for a specific department or practice for this carrier, Allscripts® Practice Management does the following:

- If the Reimbursement, Paper, Electronic, Dialysis, and Anesthesia styles point to **(default)** instead of a particular style, Allscripts® Practice Management uses the defaults in **Practice Options** or **Organization Options**.
- If you leave the Alternate Paper, Alternate Electronic, and Electronic Remit Styles blank, they remain blank on the **Styles** tab.
- Any style pointing to **(default)** or left blank after you enter styles for a specific department or practice will not use the styles of the default department or practice.

Access the **Styles** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.



Department or Practice

Enables you to select styles and alternate claim information for the carrier by department or practice.

The hierarchy of how styles are used in Allscripts® Practice Management is as follows:

1. When set to **(default)** and the Style boxes are blank, the style selected as the corresponding **Default Style in Practice Options** or **Organization Options** (POP) is used.
2. When you make selections in any Style box when **Department/Practice** is set to **(default)**, your selections are used instead of the corresponding style selected as the **Default Style in Practice Options** or **Organization Options**.
3. When you select a specific **Department/Practice** and you make selections in any Style boxes, the selected style or styles are used when the voucher contains that department or practice.

Reimbursement Style

In addition to **(default)**, this list is comprised of the **Reimbursement Styles** you created in **Reimbursement Style Maintenance**.

Accepting **(default)** causes 1 of 2 things to happen:

1. The default reimbursement style selected in **Practice Options** or **Organization Options** is used, if it exists.
OR
2. If no default reimbursement style was selected in **Practice Options** or **Organization Options**, the application default style **Summarized Insurance Reimbursement** is used.

Select the reimbursement style that corresponds to the format used by the carrier on its paper remittance advice.

If your practice or organization uses uninsured carriers, when a new tenant is created using starter data that includes **Carrier Information**, the **Reimbursement Style** field on the **Styles** tab in **Insurance Carrier Maintenance** is blank. For all other carriers, **Reimbursement Style** is filled with **(default)**.

Best Practice: After you create an uninsured carrier, set the **Reimbursement Style** on the **Styles** tab in **Insurance Carrier Maintenance** on any tenant that replicates that tenant's carrier information to prevent warnings and unwanted changes to workflows.

If you try to edit and save an uninsured carrier record without making a selection in **Reimbursement Style** on the **Styles** tab in **Insurance Carrier Maintenance**, you receive a warning.

If **Reimbursement Style** is left blank and you either add or import a voucher associated with that uninsured carrier, any automatic balance adjustments configured on the **Uninsured** tab in **Reimbursement Style Maintenance** are not performed when the voucher is saved. You must manually adjust the balance off the voucher or void the voucher and re-enter the charge using **Void Re-Enter** on the **Edits** tab in **Financial Processing > Transactions > Edits**.

Paper Claim Style

The style selected determines the validation criteria and the output options used when claims are printed for this carrier.

Selecting **(default)** means the application uses the default paper claim style selected in **Practice Options** or **Organization Options**.

CAUTION: If you do not have a default paper claim style in **Practice Options** or **Organization Options**, claims for this carrier do not qualify for printing.

Alt Paper Claim Style

The list includes the paper claim styles created in **Claim Style Maintenance**. This option is not available for alias insurance carriers.

When you leave this box blank, any claims that are associated with the carrier are prepared using the **Paper Claim Style** selected above.

When you select an alternate paper claim style, the boxes under **Alternate Info** are enabled.

Elect. Claim Style

This option is not available if you selected **No Electronic Billing** on the **Carrier** tab. This option is not available for alias insurance carriers.

The style selected determines the validation criteria and the output options used when an electronic claims file is generated for this carrier.

In addition to **(default)**, this list includes the electronic claim styles you created in **Claim Style Maintenance**.

Selecting **(default)** means the system will use the Electronic Claim Style selected in **Practice Options** or **Organization Options**.

CAUTION: If you do not have a default style in **Practice Options** or **Organization Options** but leave this box set to **(default)**, claims for this carrier do not qualify for electronic billing.

Alt Elect. Claim Style

The list includes the electronic claim styles created in **Claim Style Maintenance**.

If you leave this box blank, any claims that are associated with the carrier are prepared using the electronic claim style selected above.

If you select an alternate electronic claim style, the boxes under **Alternate Info** are enabled.

Anesthesia Style

Select an **Anesthesia Style** only if you bill for anesthesia type services. This option is not available for alias insurance carriers.

Select an anesthesia style used when services with the procedure type **Anesthesia (Timed)** or **Anesthesia (Not Timed)** are included on a claim billed to this carrier.

If you leave this box blank, the application uses the practice or organization **Default Anesthesia Style** selected in **Practice Options** or **Organization Options**.

Note: If you leave this box blank and do not have a **Default Anesthesia Style** selected in **Practice Options** or **Organization Options**, an anesthesia style is not applied when a claim contains a

service with a procedure type of either **Anesthesia (Timed)** or **Anesthesia (Not Timed)**.

Elect. Remit Style

During your initial setup, leave this box blank. Your Allscripts® Implementation Specialist will assist you in creating the electronic remit styles for your practice or organization.

Dialysis Style

Select the style to use when the dialysis fee calculation process runs. This option is not available for alias insurance carriers.

In addition to a value of **(default)**, this list includes the styles created in **Dialysis Style Maintenance**.

Select **(default)** to have the dialysis fee calculation process use the dialysis style selected in **Practice Options** or **Organization Options**.

This option is enabled when **Enable Dialysis Management** on the **Special Billing** tab in **Practice Options** or **Organization Options** is selected.

The application logs any changes you make to **Dialysis Style** on the **History** tab.

Alternate Info

The boxes in this section are only enabled if **Alt Paper Claim Style** or **Alt Elect. Claim Style** is completed.

Use the **Alternate Info** section to enter a different address for a carrier to be used when billing claims to the carrier using an alternate claim style.

Note: If you do not enter any data in this section, the application uses the information entered on the **Carrier** tab when billing claims using either of the carrier's alternate claim styles.

Keep in mind that if you enter any information at all in this section, the application only looks here to output data when billing a claim using an alternate claim style. If you leave a box blank, the related information is not included on the claim.

Information from this section is used in billing claims to the carrier when both of the following are true:

- > The carrier has an alternate claim style selected.
- > Any information is entered in this section. Any blank boxes results in the related information not being included on the claim.

For electronic claims, when the carrier has an alternate electronic claim style, the information in the **Alternate Info** section outputs on claims as follows:

- > Institutional claims - Outputs to Loop 2010BC/Segments N3 and N4 in a Standard ANSI X12N 837I v4010A1 claim file
- > Professional claims - Outputs to Loop 2010BB/Segments N3 and N4 in a Standard ANSI X12N 837P v4010A1 claim file

For paper claims, when the carrier has an alternate paper claim style, the information in the **Alternate Info** section on the carrier's **Styles** tab prints at the top of the CMS-1500 or UB-04 paper claim form based on the **Carrier Address Option** setting in **Paper Claim Format Maintenance** that is linked to the selected alternate paper claim style.

E-Mail and **Contact Name** are informational only. Values entered in these boxes do not output to claims.

If an alternate address is partially entered, a soft warning displays when information is not entered for **Address 1**, **City**, or **State**. You can still save your entry without this information.

If **Address 1** is verified,  is displayed to the right of this box. If an override reason code was selected to save the address information,  is displayed to the right of this box.

Split billing exceptions

Ignore Alternate Claim Style when Primary

Select **Ignore Alternate Claim Style when Primary** when all of the following are true.

- > The carrier is set up with an Alternate Paper Claim Style and/or an Alternate Electronic Claim Style.
- > The alternate claim style logic should only be used when the carrier is secondary to a carrier that uses the alternate claim logic.

Note: This check box is enabled when an alternate paper claim style and/or an electronic paper claim style is defined for this carrier.

Select procedure codes

procedure types, or individual procedure codes to exclude from the alternate claim logic.

Selecting procedure codes to be excluded from the alternate claim logic means that the procedure codes are set up to split and bill on the alternate claim form. However, for this carrier if you select to exclude those procedure codes, then they do not split to another claim, instead they bill out with the procedures that stay on the main claim form.

Note: This Select Procedure Codes dialog does not allow you to select a range of codes. In addition, the Exclude check box that is available on other Select Procedure Codes dialogs in the application is not available on this particular dialog.

If Select Procedure Codes is set to “All Procedure Codes,” because no selections have been made, this means that no codes are excluded.

This field works independently of the Ignore Alternate Claim Style when Primary check box. This means if you select procedure codes to exclude from being used in alternate claim logic, these procedures codes stay on the main claim regardless of whether you set the carrier to split.

The View button brings up the Procedures Excluded from Alternate Logic dialog. This dialog shows the procedure code, the procedure description, the procedure category, the procedure group (if applicable), and the procedure type. The codes are listed in numerical order. How the code was selected displays in bold font. This means the following.

- If you selected the code by Procedure Code, the procedure code and procedure description display in bold font.
- If you selected the code by Procedure Category, the procedure category displays in bold font.
- If you selected the code by Procedure Group, the procedure group displays in bold font.
- If you selected the code by Procedure Type, the procedure type displays in bold font.

Note: This dialog is view only, which means changes cannot be made on the dialog.

If the procedure code displays on the dialog, because you selected it as an individual code and also because it is part of the group selected, the procedure code, the procedure description, and the procedure group display in bold font. Also, if the procedure code belongs to multiple procedure groups and is on list because it is part of one of the Procedure Groups, all procedure groups display in bold font.

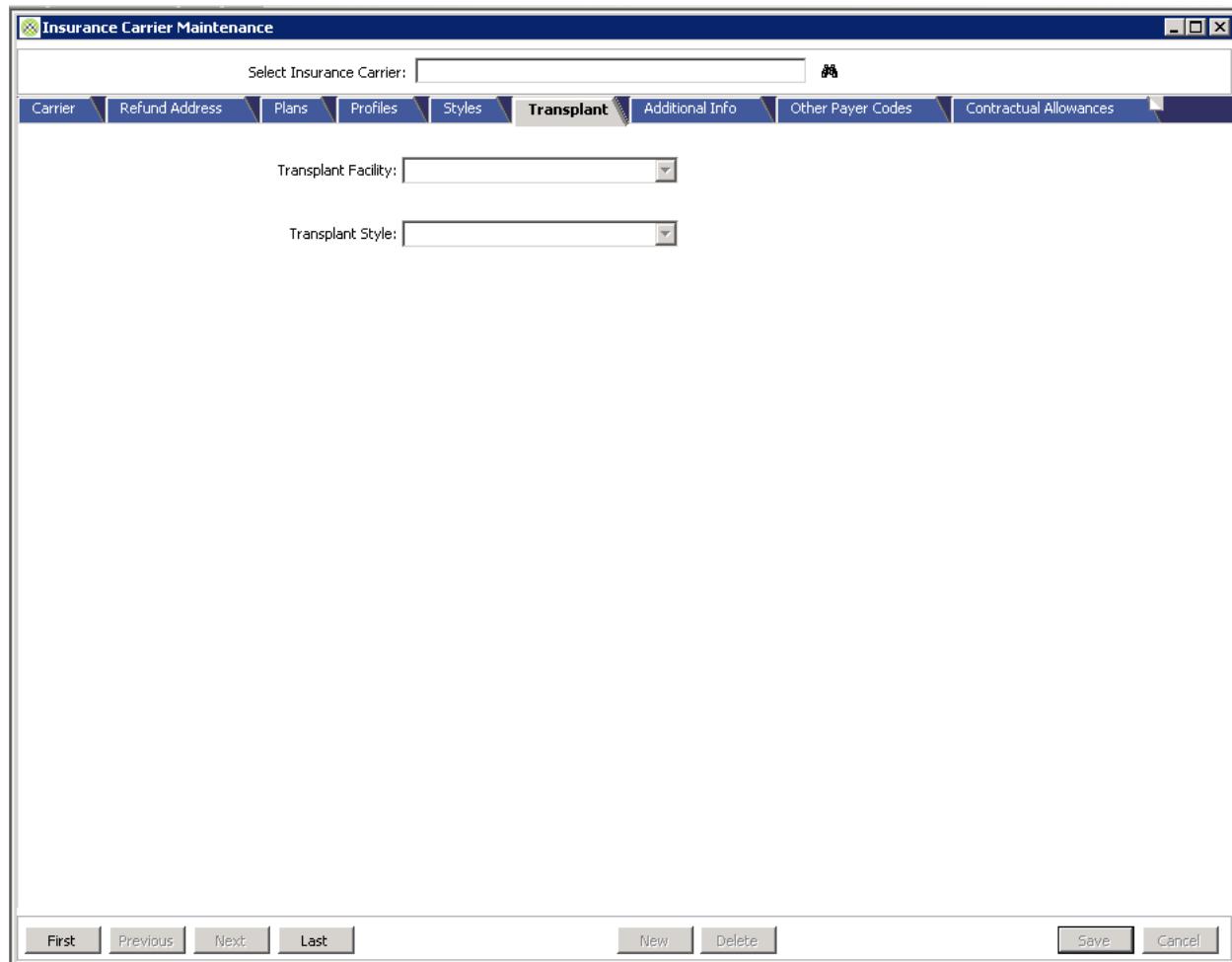
Transplant tab

Use the **Transplant** tab in **Insurance Carrier Maintenance** to associate a transplant style to an insurance carrier and a transplant facility place of service.

The **Transplant** tab is enabled when **Enable Transplant Management** on the **Special Billing** tab in **Practice Options** or **Organization Options** is selected. However, the **Transplant** tab is not available for alias insurance carriers.

The application logs any changes you make to the **Transplant** tab on the **History** tab.

Access the **Transplant** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or press **F9** and then enter **ICM**.



Transplant Facility

Select a facility when a different transplant style is needed for a specific transplant facility; otherwise, keep the value of **(default)**.

In addition to a value of **(default)**, this list is comprised of the facilities you selected as transplant facilities in **Place of Service Maintenance**.

Transplant Style

Select the transplant style to use when the transplant charge creation process runs.

Keep the value of **(default)** to have the transplant charge creation process use the transplant style selected in **Practice Options** or **Organization Options**.

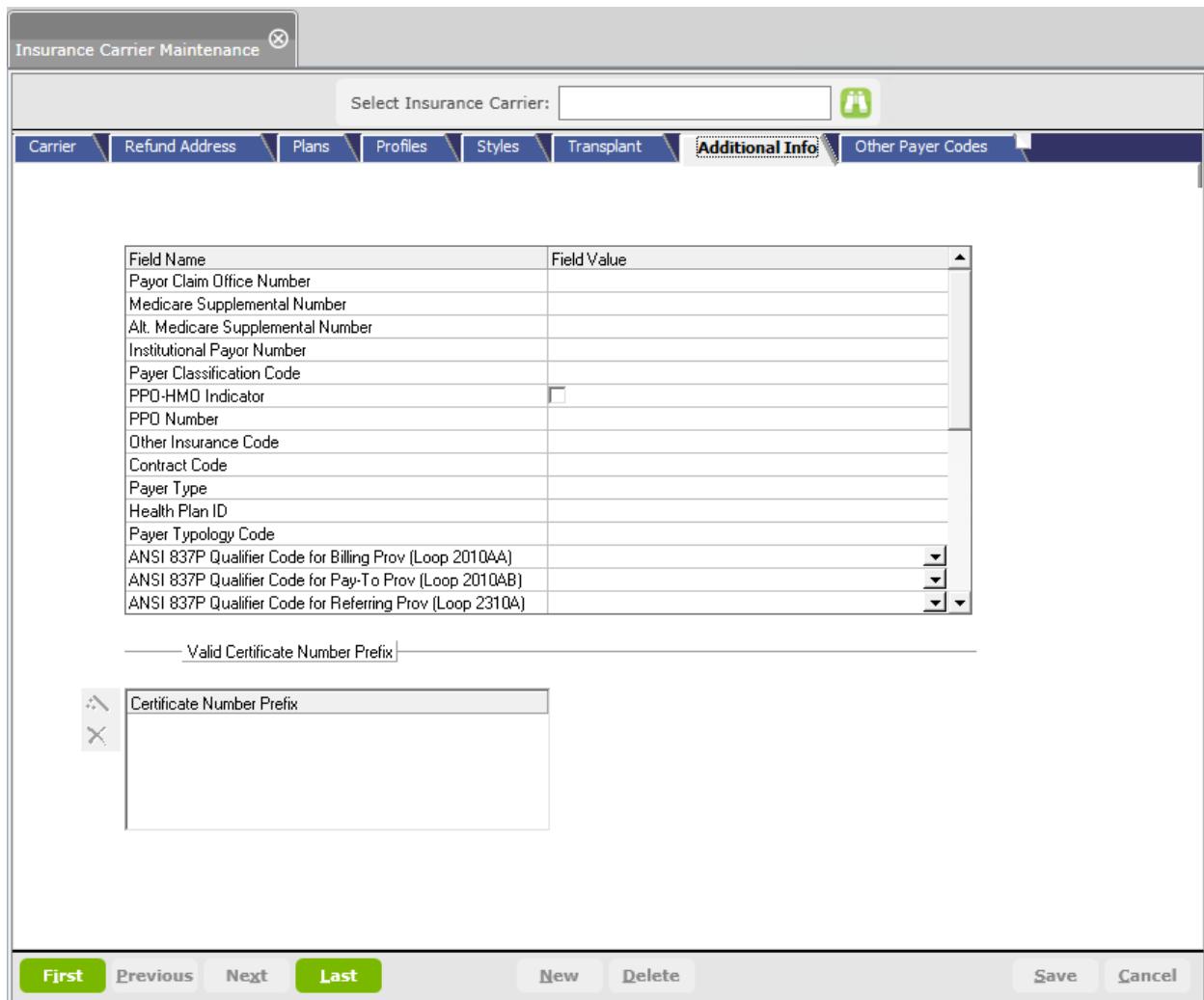
In addition to a value of **(default)**, this list is comprised of the styles you created in **Transplant Style Maintenance**.

Additional Info tab in Insurance Carrier Maintenance

The **Additional Info** boxes are used as pull fields for billing or claim data reporting purposes. Define these boxes as you are directed by Allscripts® Practice Management.

Access the **Additional Info** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance > Insurance Carrier Maintenance**.

Tip: To quickly access **Insurance Carrier Maintenance**, press **F9**, then enter **ICM**.



The screenshot shows the 'Insurance Carrier Maintenance' window. At the top, there is a search bar labeled 'Select Insurance Carrier:' with a magnifying glass icon. Below the search bar is a navigation menu with tabs: Carrier, Refund Address, Plans, Profiles, Styles, Transplant, Additional Info (which is highlighted in blue), and Other Payer Codes. The main area of the window displays a table titled 'Field Name' and 'Field Value'. The table contains several rows of data, many of which have dropdown arrows indicating they are pulldown menus. The rows include: Payor Claim Office Number, Medicare Supplemental Number, Alt. Medicare Supplemental Number, Institutional Payor Number, Payer Classification Code, PPO-HMO Indicator (with a checked checkbox), PPO Number, Other Insurance Code, Contract Code, Payer Type, Health Plan ID, Payer Typology Code, ANSI 837P Qualifier Code for Billing Prov (Loop 2010AA), ANSI 837P Qualifier Code for Pay-To Prov (Loop 2010AB), and ANSI 837P Qualifier Code for Referring Prov (Loop 2310A). Below the table is a field labeled 'Valid Certificate Number Prefix' with a dropdown arrow. At the bottom of the window are buttons for 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Payor Claim Office Number

The payor claim office number is an extension of the payor number that is assigned by the carrier.

When a value is entered, the Segment REF is created in Loop 2010BB. Outputs to Loop 2010BB/Segment REF with a “FY” Qualifier when using ANSI 837 electronic claim formats.

Medicare Supplemental Number

When a carrier is supplemental to Medicare, enter the MediGap number assigned to the carrier.

Outputs to Loop 2330B Segment NM1 09 in a Standard ANSI X12N 837P v5010A1, Standard ANSI X12N 837I v5010A2 and Standard ANSI X12N 837D v5010A2.

Alt. Medicare Supplemental Number

Some Medicare intermediaries use unique MediGap numbers that differ from those used by other intermediaries requiring clients who have offices in different states to submit a different supplemental number for cross over claims depending on the state in which the service was rendered.

If you are given two different MediGap numbers by two Medicare intermediaries for submitting crossover claims to the same supplemental insurer, follow these steps:

1. Enter a Medicare supplemental number and an alternate Medicare supplemental number for the supplemental carrier (for example, AARP) on the **Additional Info** tab in **Insurance Carrier Maintenance**.
2. Then select the output option **Output Alt. Medicare Suppl. Number** on the claim style associated with the primary carrier requiring the submission of the number you identified as the alternate supplemental number.

Outputs to Loop 2330B Segment NM1 09 in a Standard ANSI X12N 837P v5010A1, Standard ANSI X12N 837I v5010A2 and Standard ANSI X12N 837D v5010A2, including clients submitting ANSI 837I electronic claims to McKesson and clients submitting claims to BCBS of Michigan.

Note: The prepare claims process recognizes and outputs an alternate medicare supplemental number when the alternate Medicare supplemental number is entered in **Insurance Carrier Maintenance** and the option **Output Alt. Medicare Suppl Number** is selected on the **Output Options** tab in **Claim Style Maintenance**. This is true for all paper claim formats and for the following electronic claim formats: MCC NSF 2.00, McKesson ANSI 837P v4010A1, Standard ANSI X12N 837I v4010A1, Standard ANSI X12N 837P v4010A1, Texas THIN 837P v4010A1.

Institutional Payer Number

Works in conjunction with the **Claim Style Maintenance** output option **Output Inst. Payer Number**.

Use this box only if you bill professional and institutional claims using the same **Insurance Carrier Maintenance** record but different payer numbers are assigned by the carrier or clearinghouse.

Note: If you bill BCBS of Michigan using the UB92_BCBSM_MH.rpt, you must enter the Organization Code required by BCBS of Michigan in Form Locator 50 in this field.

If you replicate insurance carrier information, you must enter the McKesson CPID number or the BCBS of Michigan Organization Code in the source tenant. The information in **Institutional Payer Number** replicates down to the target tenants from the source tenant.

Submitting ANSI 837I electronic claims to McKesson

If you bill submitting claims through McKesson, enter the proprietary McKesson CPID (Carrier Payer Identification) number that is required for ANSI 837I formats.

This box is also programmed to hold and output the Organization Code required by BCBS of Michigan in Form Locator 50 when submitting claims using the new paper claim form UB92_BCBSM_MH.rpt.

Submitting claims to BCBS of Michigan

If you bill BCBS of Michigan using the UB92_BCBSM_MH.rpt, you must enter the Organization Code required by BCBS of Michigan in Form Locator 50 in this box.

Payer Classification Code

Intended for use with the Tennessee ASTC Data Export to report claim data to the Tennessee Department of Health and submit UB/Institutional Claims. Also used by the Kentucky Ambulatory Export.

If you submit UB/Institutional claims, check with the payer to determine if a classification code is required.

PPO-HMO Indicator

Originally intended for use with the NSF Format. This indicator is assigned by the carrier or by your electronic claims vendor.

PPO Number

Originally intended for use with the NSF Format. The PPO number is assigned by the carrier.

Other Insurance Code

Outputs to paper claims based on the .rpt used to print the claim.

For example, the value entered prints to Box 9 on most standard CMS 1500 NPI forms programmed to print the other insurer's information. However, clients using a defined .rpt can have the code print or export to a designated box. For example, the MAMedicaidCMS1500NPI.rpt prints this other insurance code to Box 11C.

This identifier is required by secondary payers receiving a claim whose primary payer is the current carrier.

For example, a state Medicaid, has assigned a payer code to be used when a secondary claim which has been paid by the carrier as primary is then submitted to the state insurance.

Note: Enter a value in this box only when directed by a member of the Allscripts® claims team. Always refer to the specific format project documentation.

Contract Code

Intended for clients using the MPV Phynance Export. Medical Present Value, Inc. (MPV) assigns a contract identifier to each carrier it supports. Enter the ID assigned by MPV.

Payer Type

Intended for clients using state-specific export utilities. If applicable, enter the payer type code as defined by your state.

Health Plan ID

Intended for clients using state-specific export utilities. If applicable, enter the NAIC code as defined by your state.

Payer Typology Code

This box enables the export of payer typology codes to electronic health record (HER) applications for use in registry reporting.

This box accepts the Public Health Data Standards Consortium (PHDSC) numeric code value. For example, enter 219 for Medicaid Managed Care Other.

ANSI Qualifier Codes

None of the ANSI Qualifier Code boxes are used for claims submitted using any of the v5010 format types. For clients still using a v4010 format, refer to the topic about alternate ANSI 837 qualifier codes in the online help.

Certificate Number Prefix grid

Enter the valid certificate number prefixes for patient insurance policies.

Certificate number validation is performed against the value in **Cert No** on the **Policies** tab in **Registration and Policy Information for [patient name]**, accessed from **Transplant Management**, to ensure that one or more characters entered from left to right in **Cert No** exactly match a prefix entered in the **Certificate Number Prefix** grid.

For example, if the prefix is **1234**, the values **1234** and **123456** are valid certificate numbers, but **4321** and **561234** are not valid. There must be at least one row in the **Certificate Number Prefix** grid for validation to occur.

Note: The validation does not apply to **Cert No** in **WC Case Management Policies**, accessed from the **WC Case Management** tab in **Case Management**.

- > Certificate number prefix validation is included with electronic claim validation for the following format types:
 - Professional ANSI 837P v5010
 - Professional ANSI 837P v5010A1
 - Institutional ANSI 837I v5010
 - Institutional ANSI 837I v5010A1
 - Institutional ANSI 837I v5010A2
 - Dental ANSI 837D v5010
 - Dental ANSI 837ID v5010A1
 - Dental ANSI 837ID v5010A2
- > Certificate number prefix validation is included with paper claim validation for the following format types:
 - ICD10 Generic Medical Claim Form
 - Uniform Billing Claim Form
 - Dental Claim Form
 - NY Workers' Comp Claim Form
 - CA CHDP Assessment Claim Form (PM160)

Other Payer Codes tab

Use the **Other Payer Codes** tab to store the unique identifier payer codes that a carrier uses to identify a primary payer when it processes a secondary claim.

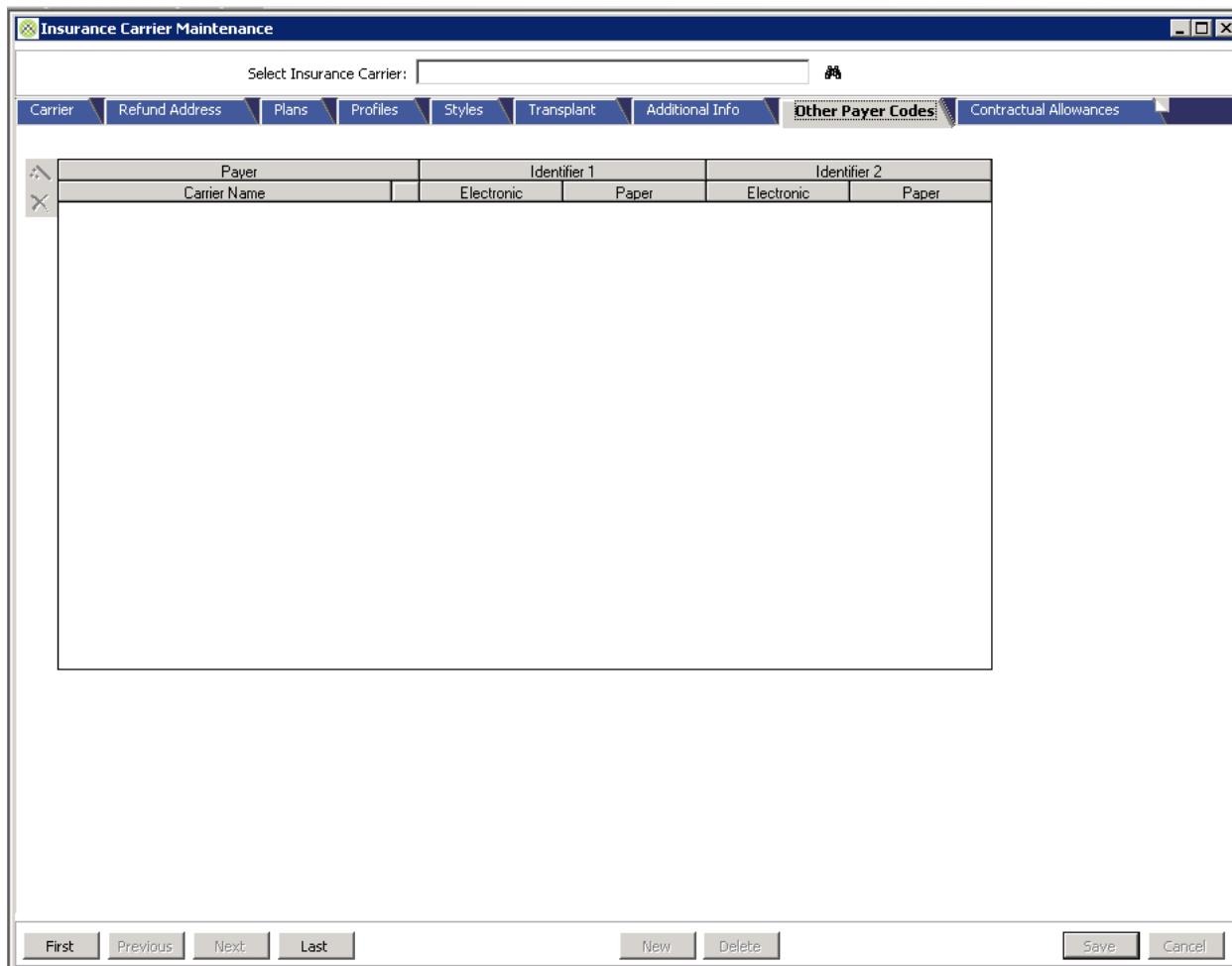
When you submit a secondary claim to a carrier, you must also include the primary policy information on the claim. By default Allscripts® Practice Management reports the primary payer's (policy) payer number entered on the **Carrier** tab.

However, there are some carriers who require that when you submit a secondary claim to them, you use a unique identifier that they have assigned to identify the primary payer. When a carrier uses their own unique identifiers, those identifiers are stored on the **Other Payer Codes** tab. Only use this tab for carriers to whom you submit secondary claims.

Clients using replication

The entries on this tab are not replicated.

Access the **Other Payer Codes** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.



Claim output

When a secondary claim is billed to the carrier, the Allscripts® Practice Management searches for other payer information to report on the claim.

Note: It is rare for carriers to require 2 separate identifiers to identify the primary payer. Be sure that you verify the secondary payer's requirements.

Electronic claims

For each added carrier, you can store 2 unique payer identifiers for submitting electronic claims.

Identifier 1

The value in **Identifier 1** outputs to Loop 2330B Segment NM1, Element 09 (Other Payer Primary Identifier)

If **Identifier 1** is blank, Allscripts® Practice Management uses the primary payer's **Payer Number** from the **Carrier** tab in **Insurance Carrier Maintenance**.

Identifier 2

If **Identifier 2** is filled, then a REF Segment (Other Payer Secondary Identifier) is created in Loop 2330B and the value is output to Loop 2330B, Segment REF, Element O2. (When this identifier exists, 2U is output to Element 01.)

If **Identifier 2** is blank, the REF Segment is not created in Loop 2330B

For example, say you are using NH Medicaid as the secondary payer and BCBS of MA as the primary payer. When you prepare a secondary claim for the carrier NH Medicaid, the application checks the **Other Payer Codes** tab for NH Medicaid in **Insurance Carrier Maintenance** for the entry BCBS of MA in the column **Carrier**. If that entry exists, it then searches for Identifier 1 and Identifier 2.

Note:

If the primary carrier's name is not on the **Other Payer Codes** tab, the system uses the **Payer Number** for the primary payer on the **Carrier** tab in **Insurance Carrier Maintenance**. (In our example that is BCBS of MA's Payer Number.)

If there is neither an identifier entered for the primary carrier on the secondary payer's **Other Payer Codes** tab nor a **Payer Number** entered on the primary payer's **Carrier** tab in **Insurance Carrier Maintenance**, a validation error occurs whether you prepare or validate claims.

Paper claims

For each added carrier, you can store 2 unique payer identifiers for submitting paper claims. The values enter print to paper claims based on the .rpt used.

For example, the value entered prints to box 9d on most standard CMS 1500 NPI forms programmed to print the other insurer's information.

Clients using a defined .rpt can have the code print or export to a designated box. For example, the IILMedicaid2360RHC.rpt prints or exports the identifier to box 37A.

For this section we are using Illinois Medicaid as an example of a secondary payer to BCBS of Wisconsin.

When a secondary claim is printed or exported for the carrier Illinois Medicaid the application does the following checks in the order listed below:

1. The **Other Payer Codes** tab for IL Medicaid (the secondary payer in this example) in **Insurance Carrier Maintenance** for the following:
 - > An entry for BCBS of WI under the column carrier. If found, then it searches for an entry for **Identifier 1**, then for **Identifier 2**.
 - If **Identifier 1** is filled, that value is printed or exported to the appropriate box based on the .rpt used to print the claim
 - If **Identifier 1** is blank then the application checks **Identifier 2**. If there is a value in **Identifier 2**, that value is printed or exported to the appropriate box based on the .rpt being used.
2. If there is no entry for BCBS IL or if both applicable boxes on the **Other Payer Codes** tab are blank, then the application looks for an entry in **Other Insurance Code** on the **Additional Info** tab for the primary payer (in our example, this is BCBSWI). If **Other Insurance Code** is filled, that value is printed or exported to the appropriate box based on the .rpt being used.
3. If there are no entries on the secondary payer's **Other Payer Codes** tab for the primary payer and there is no entry in **Other Insurance Code** on the **Additional Info** tab for the primary payer then the application uses the primary payer's **Payer Number** on the **Carrier** tab.

Contractual Allowances tab

Use the **Contractual Allowances** tab in **Insurance Carrier Maintenance** to do the following:

- > Enter, or delete allowed amounts

Note: You can also use the Contractual Allowance Import to enter and edit Carrier Allowance Tables

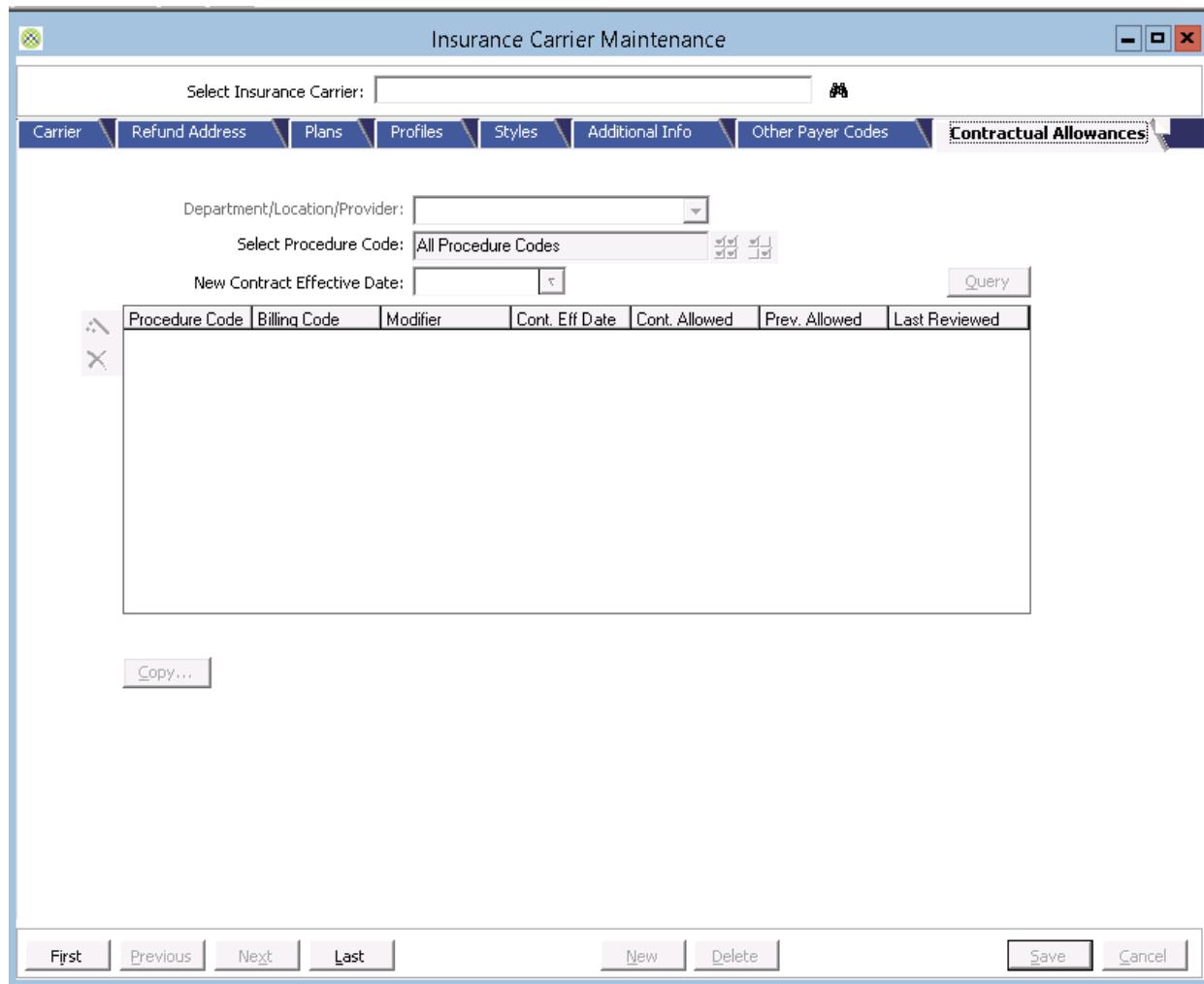
- > Copy a Carrier's allowed amounts to other carriers, departments/practices, locations, or providers
- > Add Contractual Allowed Amounts for Procedures which are submitted with Modifiers
- > Delete Contractual Allowances for one or more Procedure Codes.

- > View the history of the Contractual Allowances previously recorded for a Procedure Code.

When adding a new Carrier record, the **Contractual Allowances** tab is inaccessible until you **Save**.

The **Contractual Allowances** tab is not available for alias insurance carriers.

Access the **Contractual Allowances** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.



The screenshot shows the 'Insurance Carrier Maintenance' application window. At the top, there is a toolbar with various tabs: Carrier, Refund Address, Plans, Profiles, Styles, Additional Info, Other Payer Codes, and Contractual Allowances. The 'Contractual Allowances' tab is highlighted with a blue border. Below the toolbar, there are several search and filter fields: 'Select Insurance Carrier:' (dropdown), 'Department/Location/Provider:' (dropdown), 'Select Procedure Code:' (dropdown with 'All Procedure Codes' selected), and 'New Contract Effective Date:' (text input). To the right of these fields is a 'Query' button. The main area is a grid table with columns: Procedure Code, Billing Code, Modifier, Cont. Eff Date, Cont. Allowed, Prev. Allowed, and Last Reviewed. At the bottom of the grid, there is a 'Copy...' button. At the very bottom of the window are navigation buttons: First, Previous, Next, Last, New, Delete, Save, and Cancel.

First field on the tab

The name of this field as well as whether it is active is driven by the selection of the Allowance Style on the **Carrier** tab.

Possibilities:

1. The field is disabled - the Allowance Style is set to **Carrier**

Select the procedure codes for which you have a contractual allowance with the Carrier.

2. Department or Practice - the Allowance Style is set to **Carrier/Department or Practice**

Enables you to enter contractual allowances by Department/Practice when the Carrier has for example a different payment scheduled based on specialty.

The drop down list all the departments/practices you have created in Department/Practice Maintenance.

You must enter allowances for each Department/Practice. When allowances are the same for multiple departments/practices you can use the copy function.

3. Location - the Allowance Style is set to **Carrier/Location**

Enables you to enter contractual allowances by Location when the Carrier has for example, a different payment scheduled based on where the service is provided.

The drop down list all the locations you have created in Location Maintenance.

You must enter allowances for each Location. When allowances are the same for multiple Locations you can use the copy function.

4. Provider - the Allowance Style is set to **Carrier/Provider**

Enables you to enter contractual allowances by Location when the Carrier has, for example, a different payment scheduled based on a Provider's specialty and you do not use separate Departments/Practices.

The drop down list all the Providers you have created in Provider Maintenance.

You must enter allowances for each Provider. When allowances are the same for multiple Locations you can use the copy function.

Select Procedure Code

Standard select records dialog which enables you to filter the search for procedure codes by categories, groups, types and to include or exclude selected codes or a range of codes.

New Contract Effective Date

Date field.

You can click to use the standard calendar feature.

This is an optional field. When you enter a date, that date auto fills the Contract Effective Date field on the Add Contractual Allowance dialog.

Query

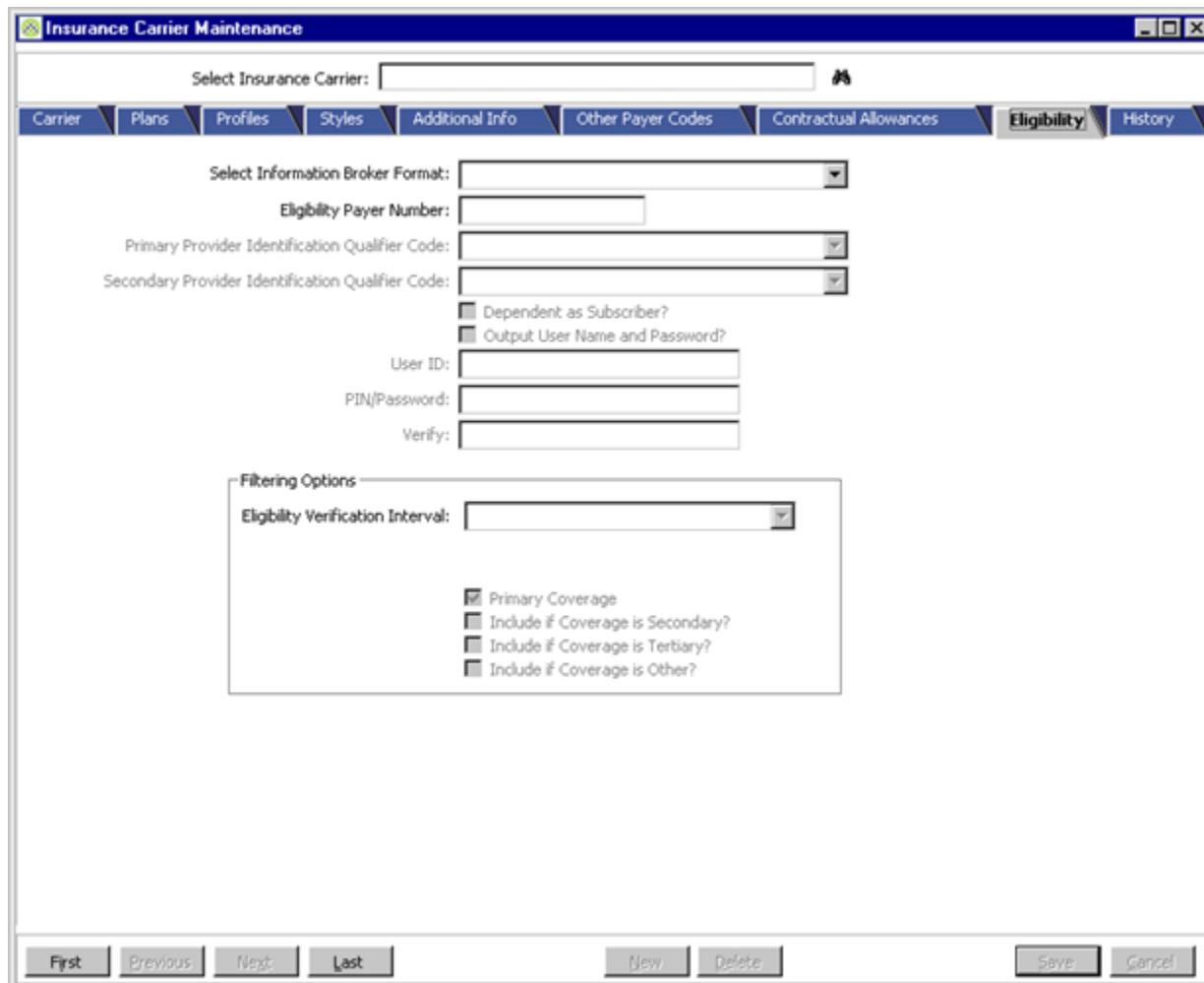
Triggers a search for the selected Procedure Codes.

Eligibility tab

Use the **Eligibility** tab in **Insurance Carrier Maintenance** to enter information for a carrier using eligibility verification. Any carrier for which you want to submit eligibility requests (ANSI 270) and receive eligibility responses (ANSI 271) must have this tab completed.

Access the **Eligibility** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Carrier Maintenance** or use **F9 > ICM**.

The **Eligibility** tab is only available when eligibility is enabled, which requires that eligibility formats exist and are active in **Information Broker Format Maintenance** in Allscripts® Interface Engine.



The screenshot shows the 'Insurance Carrier Maintenance' application window. The title bar says 'Insurance Carrier Maintenance'. The top menu bar has tabs: Carrier, Plans, Profiles, Styles, Additional Info, Other Payer Codes, Contractual Allowances, **Eligibility** (which is highlighted), and History. Below the tabs are several input fields and dropdown menus:

- 'Select Insurance Carrier:' dropdown menu.
- 'Select Information Broker Format:' dropdown menu.
- 'Eligibility Payer Number:' text input field.
- 'Primary Provider Identification Qualifier Code:' dropdown menu.
- 'Secondary Provider Identification Qualifier Code:' dropdown menu.
- 'User ID:' text input field.
- 'PIN/Password:' text input field.
- 'Verify:' text input field.
- 'Filtering Options' section with a dropdown menu for 'Eligibility Verification Interval'.
- Checkboxes in the 'Filtering Options' section:
 - Primary Coverage
 - Include if Coverage is Secondary?
 - Include if Coverage is Tertiary?
 - Include if Coverage is Other?

At the bottom of the window are buttons: First, Previous, Next, Last, New, Delete, Save, and Cancel.

Select Information Broker Format

Required field if submitting eligibility requests.

Only active ANSI270 eligibility request formats display in the drop-down list.

If the drop-down list is blank, and you want to utilize eligibility verification, contact Allscripts® Support to enroll.

In **Select Information Broker Format**, select the record that the carrier uses for eligibility verification from the drop-down list.

Note: If you submitted batch eligibility requests prior to Allscripts® Practice Management Version 2008.1, selecting an active ANSI270 eligibility request IB format record in the **Select Information Broker Format** field takes the place of having an insurance group for eligibility payers. Be sure any carrier you previously included in your insurance group for eligibility payers has the eligibility tab completed in its **Insurance Carrier Maintenance** record.

When a carrier has an information broker (IB) format record selected, all appointments that are linked to primary patient policies for the carrier are included in the ANSI 270 query and HIE honors any filter selections that exist on the IB format record during the eligibility process.

Eligibility Payor Number

Required field if submitting eligibility requests

Type in the number the carrier requires, this may be a payer number that is different from the payer number used to submit claims.

Note: If you submitted batch eligibility requests prior to Allscripts® Practice Management Version 2008.1, the number you may have entered in the **Eligibility Payer ID** field on the **Additional Info** tab in **Insurance Carrier Maintenance** was converted to this field.

Primary Provider Identification Qualifier Code

Select the applicable qualifier for the provider's primary ID number from the drop-down list:

- > **FI - Federal Taxpayer's Identification Number**
- > **PI - Payer Identification**
- > **SV - Servicing Provider Number**
- > **XX - National Provider Identification Number**

Note: **XX - National Provider Identification Number** is the default selection.

Note: If a billing number profile does not already exist for the qualifier code you select, it must be added on the **Profiles** tab in **Practice Options** or **Organization Options** set up.

The qualifier code selected here is linked to the **Primary Billing Number for Eligibility Profile** number selected on the carrier's **Profiles** tab.

Outputs to Loop 2100B/Segment NM1-08 in an ANSI 270 file

Secondary Provider Identification Qualifier Code

Select the applicable qualifier for the provider's secondary ID number from the drop-down list.

- > None (default selection)

If the **Secondary Billing Number for Eligibility Profile** on the **Profiles** tab is set to (default) then your selection here should be None.

Select one of the following if you have selected a value in **Secondary Billing Number for Eligibility Profile**:

- > 0B - State License Number
- > 1C - Medicare Provider Number
- > 1D - Medicaid Provider Number
- > 1J - Facility ID Number
- > CT - Contract Number
- > EL - Electronic Device PIN Number
- > EO - Submitter Identification Number
- > N5 - Provider Plan Network Identification Number
- > N7 - Facility Network Identification Number
- > Q4 - Prior Identifier Number
- > SY - Social Security Number
- > TJ - Federal Taxpayer's Identification Number

When a qualifier code is selected, it is linked to the **Secondary Billing Number for Eligibility Profile** number selected on the carrier's **Profiles** tab.

Outputs to Loop 2100B/Segment REF in an ANSI270 file

Note:

If a billing number profile does not already exist for the qualifier code you select, it must be added on the **Profiles** tab in **Practice Options** or **Organization Options** set up.

Outputs to Loop 2100B/Segment REF in an ANSI 270 file

The qualifier code selected is linked to the applicable billing number in **Provider Maintenance** according to the billing number profile

selected in **Secondary Billing Number for Eligibility Profile** on the **Profiles** tab in **Insurance Carrier Maintenance**.

Dependent as Subscriber?

Check only when the carrier wants dependent information sent in the ANSI 270 file. When checked, 1 is output in Loop 2000C/Segment HL04. In addition Loops 2000D and 2100D are created and both subscriber and dependent information are sent in the file.

Note:

Do NOT check when the carrier does not support dependent information in the ANSI 270 file.

In this case, dependent information is included in the Subscriber loops and "0" outputs to Loop 2000C/Segment HL04. Loop 2000D and Loop 2100D are not created.

Output User Name and Password?

Check this box when the carrier requires that a User ID and PIN/Password be included in the ANSI 270 file.

When checked, the following fields are enabled and required:

User ID

Type in the User ID assigned to you by the Carrier.

Outputs to Loop 2100B/Segment REF01 with a "JD" Qualifier in an ANSI 270 file.

PIN/Password

Type in the PIN or password assigned to you by the Carrier.

Outputs to Loop 2100B/Segment REF02 with a "4A" Qualifier in an ANSI 270 file.

Verify

Re-enter the PIN or password from the carrier.

Note: A hard warning displays if the PIN or password you enter here does not match the **PIN/Password** field entry or if you leave this field blank.

Filtering Options

Eligibility Verification Interval

Allows you to select how often you want to generate eligibility requests. This helps to reduce the number of redundant requests sent in situations such as when a patient has appointments

multiple times a week or on a weekly basis. This selection determines if an eligibility request is sent during automated eligibility verification.

The Allscripts® Interface Engine Information Broker Scheduler only queries and updates appointments for the eligibility verification interval selected for those appointments that fall within the designated number of days in **Select Days from Run Date** as found in the **Information Broker Scheduler**.

This option only works for eligibility requests that are transmitted using batch eligibility from the Allscripts® Interface Engine Information Broker Scheduler.

Select one of the following options:

> Always submit patient

Automatically populates this field when you select an **Information Broker Format** on the tab.

When you select this option, the system sends out an eligibility request for every patient that has a policy linked to the carrier with this option selected for every appointment that the patient has, regardless of how frequent the appointment is, when the appointment date is within the policy's effective date.

> Submit if patient not verified in current month

When you select this option, the Allscripts® Interface Engine Information Broker Scheduler queries the appointment records for the current month based on the calendar month to determine whether they qualify for an eligibility request to be created based on the carrier linked to the patient's policy. Only appointment dates within the policy's effective date qualify for an eligibility request to be created.

Any appointment that does not qualify for an eligibility request to be created due to an existing eligibility record within the calendar month is updated with the current coverage status of the previous appointment. If a user has changed the original coverage status to "Yes" or "No," that coverage status is used to update the new appointment.

> Defined Days between Patient Submission

When you select this option, a **Define Number of Days** spin box displays below **Eligibility Verification Interval**. You can enter up to 99 in the spin box. The default value is 0.

Note: You must select a value greater than 1 in the **Define Number of Days** spin box. If you click **Save** and the value selected is not greater than 1, a hard stop message displays stating **Define Number of Days** must be greater than 1.

When you select the number of days, the Allscripts® Interface Engine Information Broker Scheduler queries the appointment records for the specified number of days from the run date to determine whether they qualify for an eligibility request to be created based on the carrier linked to the patient's policy. If an existing eligibility request during the number of days specified in **Define Number of Days** is not found, a new eligibility request is created.

Only appointment dates within the policy's effective date qualify for an eligibility request to be created.

Any appointment that does not qualify for an eligibility request to be created due to an existing eligibility record within the calendar month is updated with the current coverage status of the previous appointment. If a user has changed the original coverage status to **Yes** or **No**, that coverage status is used to update the new appointment.

Primary Coverage?

Is for informational purposes only. This check box is always checked and disabled.

The eligibility program always sends eligibility requests for the patient's primary policy if it is active and if the carrier linked to the primary policy is enabled for eligibility verification.

When checked, for either batch eligibility or real time eligibility, the system looks at the patient's primary and secondary policies and coverage types for the specified appointments. If both of those policies are active, both of the carriers linked to the policies are set up for eligibility, and both have the applicable coverage options checked, the system creates an eligibility request. It is possible for 2 eligibility requests to be created, 1 for the primary and 1 for the secondary.

Include if Coverage is Tertiary?

When checked, for either batch eligibility or real time eligibility, the system looks at the patient's primary, secondary, and tertiary policies and coverage types for the specified appointments. If all of those policies are active, the carriers linked to the policies are set up for eligibility, and the applicable coverage options are checked, the system creates an eligibility request. It is possible for 3 eligibility requests to be created, 1 for the primary, 1 for the secondary, and 1 for the tertiary.

Include if Coverage is Other?

When checked, for either batch eligibility or real time eligibility, the system looks at the patient's primary, secondary, tertiary, and other policies and coverage types for the specified appointments. If all of those policies are active, the carriers linked to the policies are set up for eligibility, and the applicable coverage options are checked, the system creates an eligibility request. It is possible for 4 eligibility requests to be created, 1 for the primary, 1 for the secondary, 1 for the tertiary, and 1 for other.

Note: Any or all of the coverage check boxes above may be selected without any validation errors. For example, if you checked **Include if Coverage is Tertiary?**, but **Include if Coverage is Secondary?** is not checked, the system only creates the primary and tertiary eligibility requests for the carrier.

Benefit Plans tab in Insurance Carrier Maintenance

Use the **Benefit Plans** tab in **Insurance Carrier Maintenance** to define benefit plans, co-pays, and co-insurance for insurance carriers, and link employers to those benefit plans.

Note: Benefit plan management does not support collection carriers. Do not define benefits plans for carriers that have **Collection Agency** selected on the **Carrier** tab in **Insurance Carrier Maintenance**.

Benefit plan records are displayed in the grid at the top of the tab. Active plans are sorted by **Benefit Plan Exp Date** starting with records that have no expiration date.

If a policy is associated with a benefit plan, the benefit plan code is displayed in the following areas of the application as a link to open **View Benefit Plan Details**:

- > **Benefit Plans** tab in **Employer Maintenance**
- > **Summary** tab and **Policies** tab in **Registration**
- > **Patient Information** for [patient name]
- > Various areas in **Appointment Scheduling**
- > **Eligibility History**
- > **L&I Service Form**

Access the **Benefit Plans** tab from **Insurance Carrier Maintenance**. To access **Insurance Carrier Maintenance**, go to **System Administration > File Maintenance > Insurance Carrier Maintenance**, or press **F9** and then enter **ICM**.

This tab is available only when **Enable Benefit Plans** is selected on the **Carrier** tab in **Insurance Carrier Maintenance**.

Click  to open **Copy Benefit Plan** and create a copy of a benefit plan.

(New Insurance Carrier) X
Insurance Carrier Maintenance

Select Insurance Carrier: **(New Insurance Carrier)**

Profiles Styles Transplant Additional Info Other Payer Codes Contractual Allowances Eligibility **Benefit Plans** ▼

Benefit Plan Code	Product Code	Benefit Plan Name	Benefit Plan Eff Date	Benefit Plan Exp Date
 	 	 	 	

Benefit Plan Details

Benefit Plan Code: <input type="text"/> Product Code: <input type="text"/> Benefit Plan Eff Date: <input type="text"/> Benefit Plan Exp Date: <input type="text"/> No. of Benefit Tiers: <input type="text"/>	Benefit Plan Name: <input type="text"/> Co-Pay/Co-Ins Eff and Exp Dates: <input type="text"/> Effective Date Expiration Date
---	---

PCP Required
 Select All Capitated [Expand All](#)

Priority	Benefit Covered Service	Capitated	Benefit Tier	Co-Pay or Co-Ins	Referral Reqd.	With Referral	No Referral	Exceptions
 								

Move Up
Move Down
View Order
Link Employers

[First](#) [Previous](#) [Next](#) [Last](#) New Delete Save Cancel

Product Code

The insurance product code up to 30 alphanumeric characters.

Benefit Plan Code

Required. A code containing up to 30 alphanumeric characters to identify the benefit plan. This code is displayed in various areas of the application.

Benefit Plan Eff Date

Required. Enter the date on which the plan takes effect. A row is automatically inserted into the co-pay and co-insurance dates grid.

Benefit Plan Exp Date

If applicable, enter the date that the plan expires.

Benefit Plan Name

Required. Up to 80 alphanumeric characters that describe the benefit plan. Point to **Benefit Plan Name** to see a tooltip with the full plan name. This name is displayed in various areas of the application.

Co-Pay/Co-Ins Eff and Exp Dates grid

The co-insurance and co-pay date ranges for the benefit plan.

The earliest effective date is set to the value in **Benefit Plan Eff Date**, and that row cannot be removed.

When you insert a new record into the grid and select an effective date, the expiration date for the prior record is set to the newly entered effective date minus one day. You cannot enter expiration dates manually.

Records are sorted by effective date with the blank expiration date displayed first.

The latest expiration date is set to the value in **Benefit Plan Exp Date** and cannot be changed. After you set a benefit plan expiration date, you cannot insert new record into the grid.

You can only delete the top row in the grid regardless of the row in the grid that is selected.

No of Benefit Tiers

Enter a number or click  to select the number of tiers included in the benefit plan. The minimum number of tiers is 1 and the maximum number of tiers is 3. The default field value is 1.

PCP Required

Select this option to require the selection of a primary care provider (PCP) on the **Policies** tab in **Registration**.

Select All Capitated

Select this option to have the application select **Capitated** for all benefit covered services in the benefit covered services grid for the selected benefit plan.

Benefit covered services grid

Add a row for each of the benefit covered services that are defined for the benefit plan. The available covered services must exist in **Benefit Covered Service Maintenance**. You must enter at least one benefit covered services row for each benefit plan.

Every benefit covered service in the benefit covered services grid has a row for each benefit tier in the benefit plan, as well as an out-of-network row.

Use **Expand All** and **Collapse All** to show or hide all rows in the benefit covered services grid. When you click **Expand All**, it changes to **Collapse All** and the reverse.

Use  and  to show or hide the benefit tier details for a specific benefit covered service.

When you click , it changes to  and the reverse.

Priority is an application-generated value that is incremented by one for every new benefit covered service. Use **Move Up** and **Move Down** to change the priority of the benefit covered service rows and their corresponding benefit tier rows after they are entered.

Benefit Covered Service is required. Point to **Benefit Covered Service** to view the description in **Benefit Covered Service Maintenance**.

Select **Capitated** to indicate that a benefit covered service is capitated.

Note: The check box is only available for benefit covered service rows.

Co-Pay or Co-Ins is required. Indicate whether copay or coinsurance applies to the benefit tier.

Select **Referral Reqd** to indicate that a referral is required for the benefit tier.

- > If you select **Co-Pay**, enter dollar amounts in **With Referral** and **No Referral**.
- > If you select **Co-Ins**, enter percentages in **With Referral** and **No Referral**.

If the copay or coinsurance charges for a benefit covered service are zero, enter \$0.00 or 0.00% in **With Referral** and **No Referral** for the corresponding benefit tier. If there are no copay or coinsurance charges for a benefit covered service, leave **No Referral** and **Without Referral** blank for the corresponding benefit tier.

Do not enter negative values for a copayment or coinsurance.

Note: When you enter a benefit covered services row, it is associated with the top row in the co-pay and co-insurance dates grid. After you add a new row to the co-pay and co-insurance dates grid, you can no longer add benefit covered services, but you can change the in-network and out-of-network referral information to reflect the new date range.

Click a row in the co-pay and co-insurance dates grid to see the in-network and out-of-network referral information that is associated with that date range.

Deleting a benefit covered service row removes the in-network and out-of-network referral information for all date ranges.

When rows are added or deleted in this grid, the changes are reflected in the benefit covered services grid in **Employer Maintenance** for linked employers that participate in the benefit plan.

View Order

Click this button to open **View Order** and define the order in which benefit covered services are listed in **Quick Payment**. This function is optional. If a view order is not assigned, the benefit covered services are listed by the priority in the benefit covered services grid.

Benefit covered service exceptions

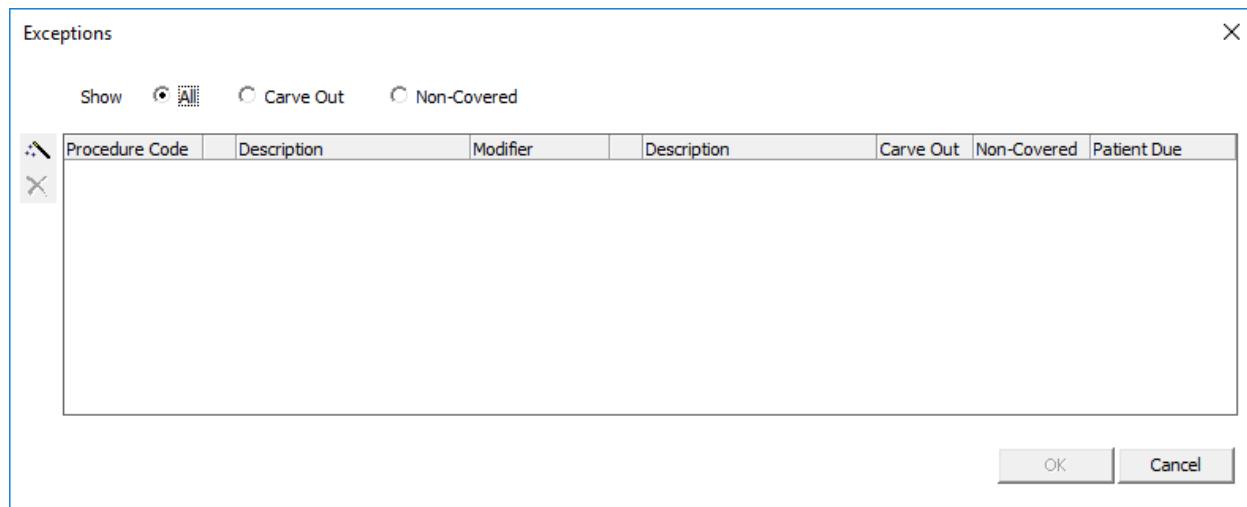
 opens **Exceptions** where you can add exceptions to a benefit covered service tier, if applicable.

Use **All**, **Carve Out**, or **Non-Covered** to filter the display of the grid.

Procedure Code and either **Carve Out** or **Non-Covered** are required. Modifiers are optional.

For non-covered exceptions, optionally enter an amount for **Patient Due**.

When exceptions are entered, **Yes** is displayed in the **Exceptions** column in the benefit covered services grid



Procedure Code	Description	Modifier	Description	Carve Out	Non-Covered	Patient Due

Link Employers

Click **Link Employers** to select the employers that participate in the benefit plan and enter participation date ranges.

Employer Participation Eff Date and **Employer Participation Exp Date** are required and must be within the effective and expiration dates for the benefit plan.

If one employer record has multiple participation date ranges, the active record is displayed. Click the plus sign (+) to the left of the active row to view the expired records.

Benefits plan that are linked to employers in **Insurance Carrier Maintenance** are displayed automatically on the **Benefit Plans** tab in **Employer Maintenance** for those employers.

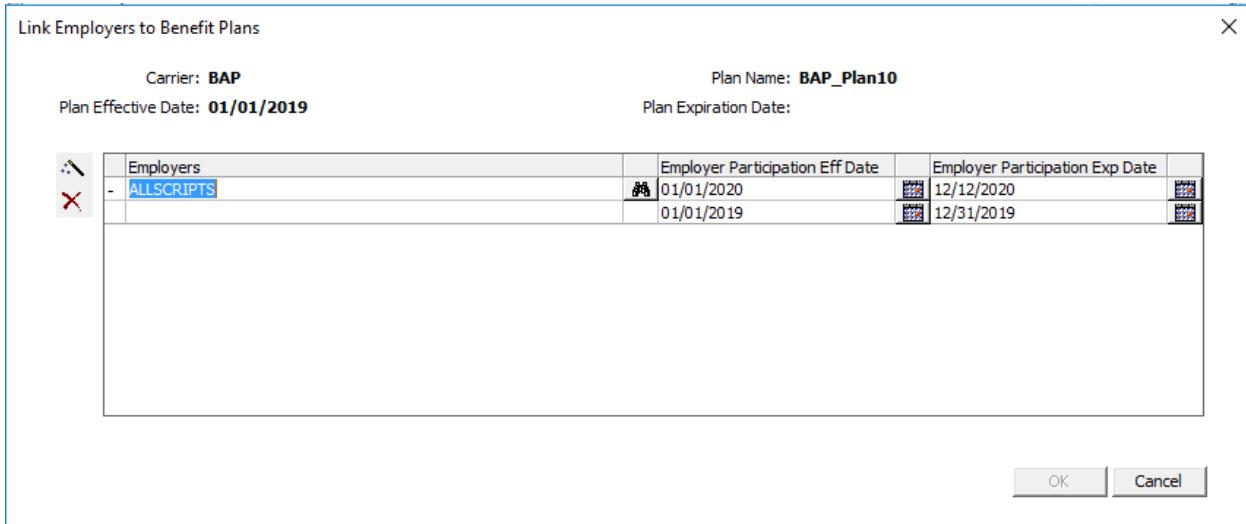
Link Employers to Benefit Plans

Carrier: **BAP** Plan Name: **BAP_Plan10**

Plan Effective Date: **01/01/2019** Plan Expiration Date:

Employers	Employer Participation Eff Date	Employer Participation Exp Date
- ALLSCRIPTS	01/01/2020	12/12/2020
	01/01/2019	12/31/2019

OK Cancel



Insurance Group Maintenance window

Insurance Groups are another way to classify Carriers.

Intended specifically for use with Claim Types.

A Group is created and Carriers are added to it as members.

Insurance Group Members are Carriers which share a common qualification though they do not belong to the same Categories and/or Reporting Classes.

Example: For example, create a group called “PT Auth” for those carriers that require prior authorization for outpatient physical therapy.

Also, various reports can be generated using Insurance Group as a group field in Report Preferences.

Note: Carriers may be members of more than one Insurance Group.

Insurance Group Maintenance contains these tabs:

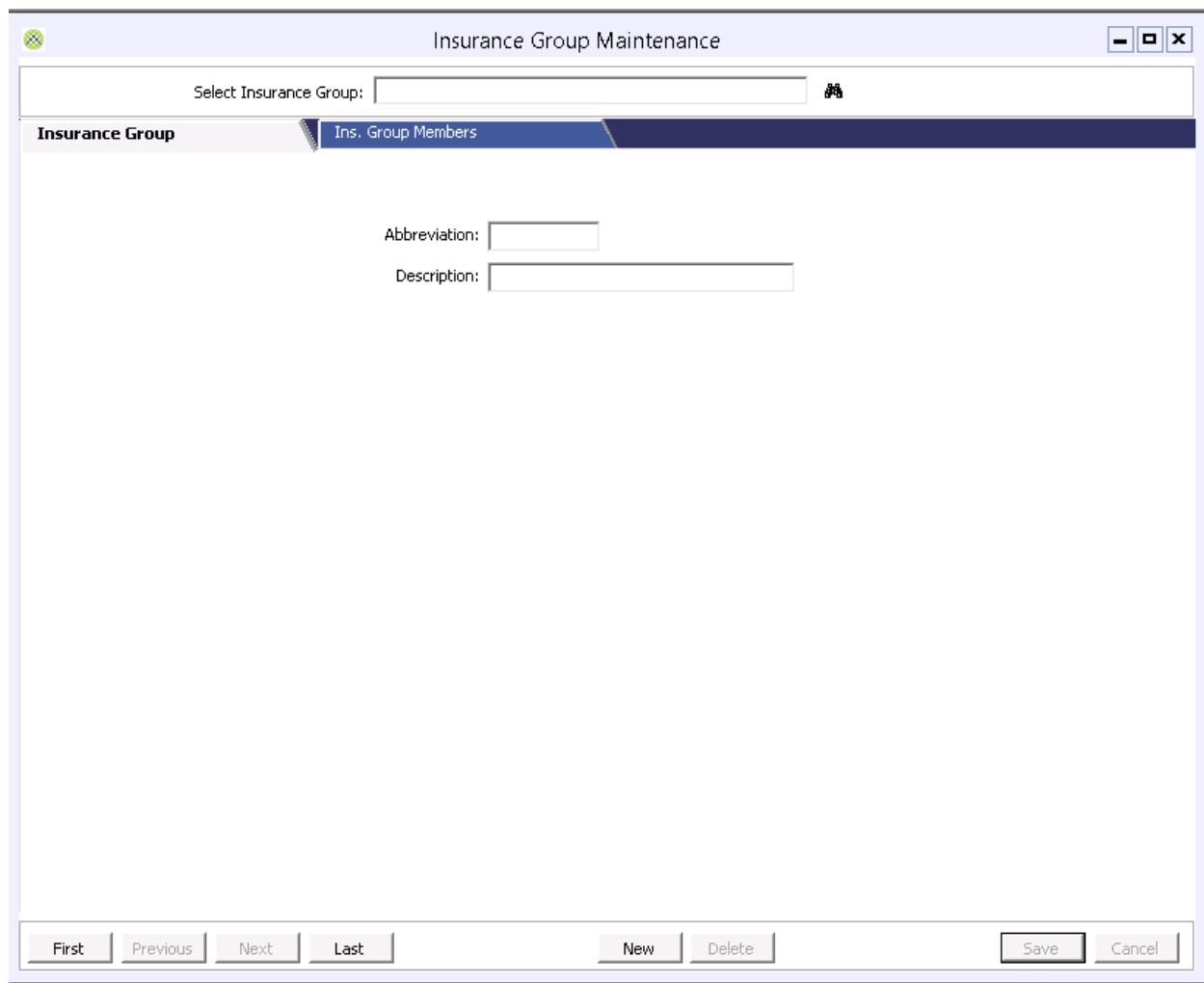
- > **Insurance Group**
- > **Ins Group Members**

Access **Insurance Group Maintenance** from **System Administration > File Maintenance > Insurance Group Maintenance** or press **F9** and then enter **IGM**.

Insurance Group tab

Intended specifically for use with claim types.

Access the **Insurance Group** tab from **Insurance Group Maintenance**. To access **Insurance Group Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Group Maintenance** or use **F9 > IGM**.



The screenshot shows the 'Insurance Group Maintenance' window. At the top, there is a search bar labeled 'Select Insurance Group:' with a dropdown arrow icon. Below the search bar, there are two tabs: 'Insurance Group' (which is the active tab, indicated by a blue background) and 'Ins. Group Members' (which is indicated by a dark blue background). In the main area, there are two input fields: 'Abbreviation:' with an empty text box and 'Description:' with an empty text box. At the bottom of the window, there is a navigation bar with buttons for 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

Accepts up to 8 characters.
Displays on reports.

Description

Accepts up to 40 characters.

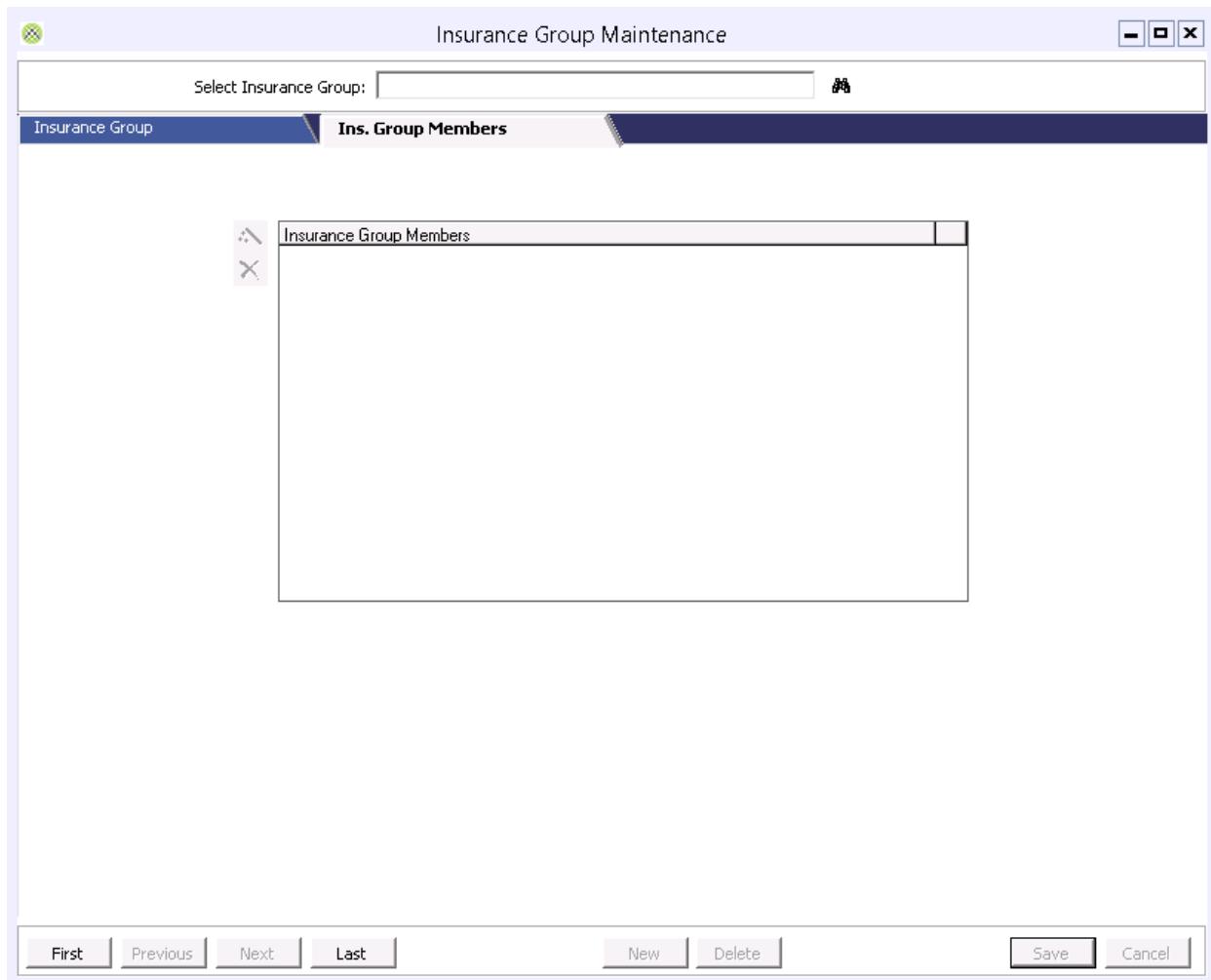
Displays in Claim Type Maintenance and on the selected records dialogs for various reports.

Ins Group Members tab

Group members are added using the Insurance Carrier Lookup dialog.

Tip: To add the first group using the keyboard, be sure that the heading **Insurance Group Members** is highlighted, and then use the **Insert** key.

Access the **Ins. Group Members** tab from **Insurance Group Maintenance**. To access **Insurance Group Maintenance**, go to **System Administration > File Maintenance** and select **Insurance Group Maintenance** or use **F9 > IGM**.



Ailment Type Maintenance window

Use **Ailment Type Maintenance** to create custom templates to add information related to an auto accident, workers' comp issue, hospitalization, disability, etc. to a Patient's record that can then be used to add to vouchers, policies, and appointments.

Information held on a Patient's Ailment record can be used over and over again on several different vouchers, policies, and appointments. Ailment information can be attached to a patient's record in Registration, Scheduling, or Charge Entry.

Ailment Type Maintenance contains these tabs:

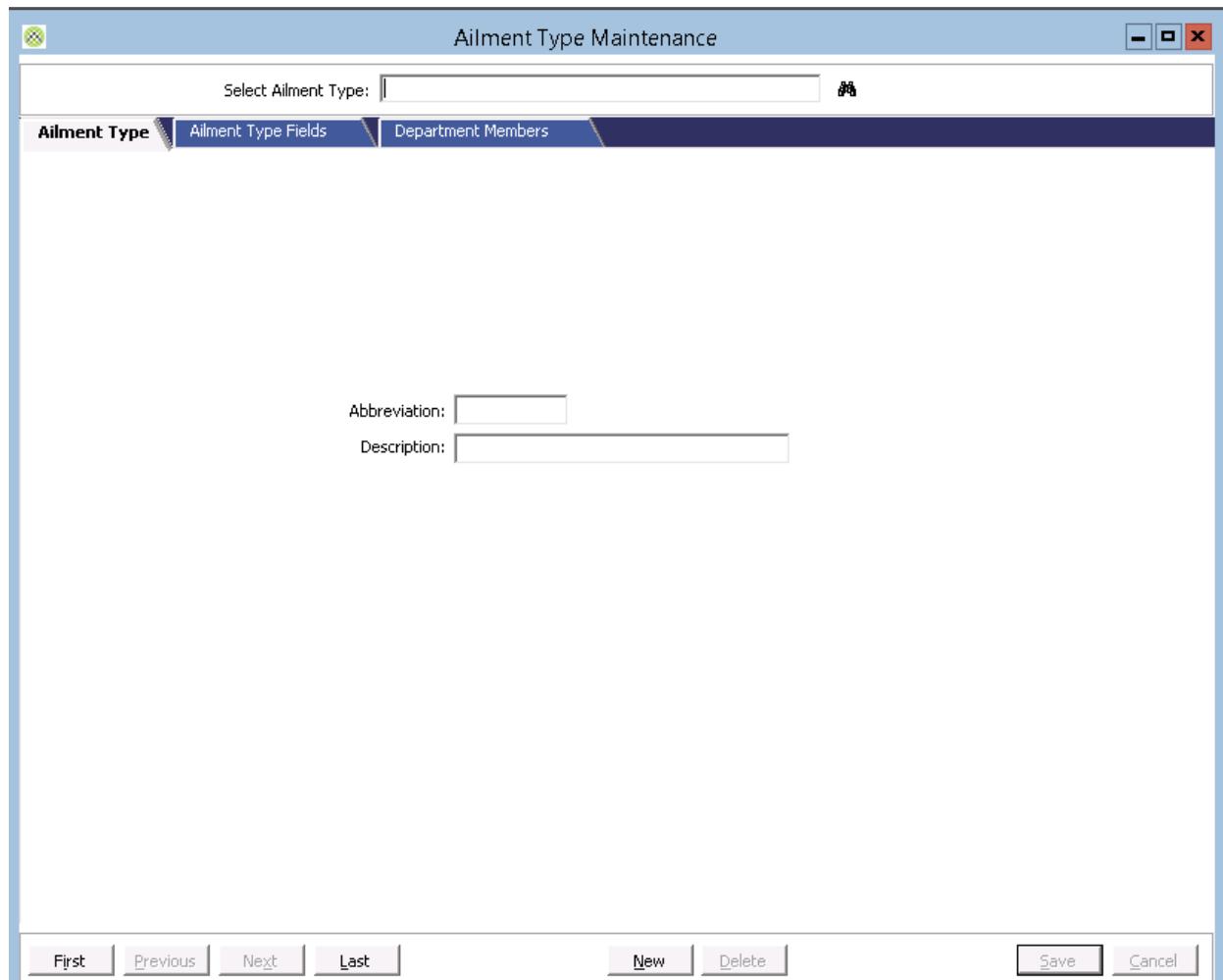
- > **Ailment Type**
- > **Ailment Type Fields**

- > Department Members or Practice Members
- > History

Access **Ailment Type Maintenance** from **System Administration > File Maintenance > Ailment Type Maintenance** or press **F9** and then enter **ALM**.

Ailment Type tab

Access the **Ailment Type** tab from **Ailment Type Maintenance**. To access **Ailment Type Maintenance**, go to **System Administration > File Maintenance** and select **Ailment Type Maintenance** or use **F9 > ALM**.



The screenshot shows the 'Ailment Type Maintenance' window. At the top, there is a search bar labeled 'Select Ailment Type:' with a magnifying glass icon. Below the search bar is a navigation bar with three tabs: 'Ailment Type' (selected), 'Ailment Type Fields', and 'Department Members'. The main area contains two input fields: 'Abbreviation:' with an empty text box and 'Description:' with an empty text box. At the bottom of the window are several buttons: 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save' (highlighted in blue), and 'Cancel'.

Abbreviation

Accepts up to 8 characters.

Description

Accepts up to 40 characters.

Displays on the Ailment Information dialog.

Ailment Type Fields tab

Select ailment fields from the list on the left.

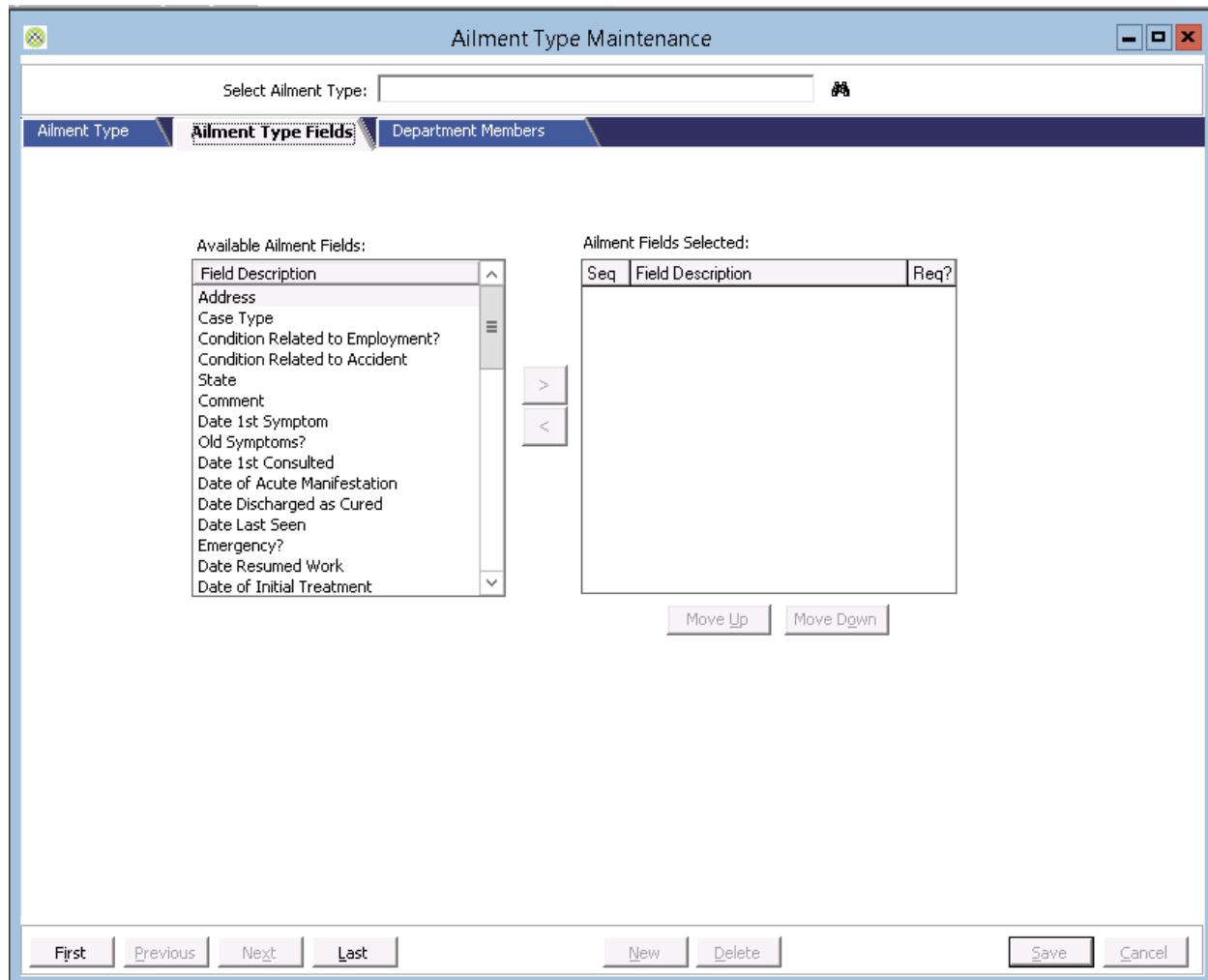
Enables you to keep a record of information such as case type, whether a condition is related to an accident, date a patient resumed work, if a visit comes under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) rules, and so on.

Ailment information can be attached to a voucher.

Flagging a field as required prevents you from saving the voucher until the required information is entered.

For ailment types selected in **Workers' Comp Ailment** on the **Case** tab in **Practice Options** or **Organization Options**, you cannot remove **Date 1st Symptom** or **Condition Related to Employment** from the **Ailment Fields Selected** area, nor can you clear **Req** for either of those ailment fields.

Access the **Ailment Type Fields** tab from **Ailment Type Maintenance**. To access **Ailment Type Maintenance**, go to **System Administration > File Maintenance** and select **Ailment Type Maintenance** or use **F9 > ALM**.

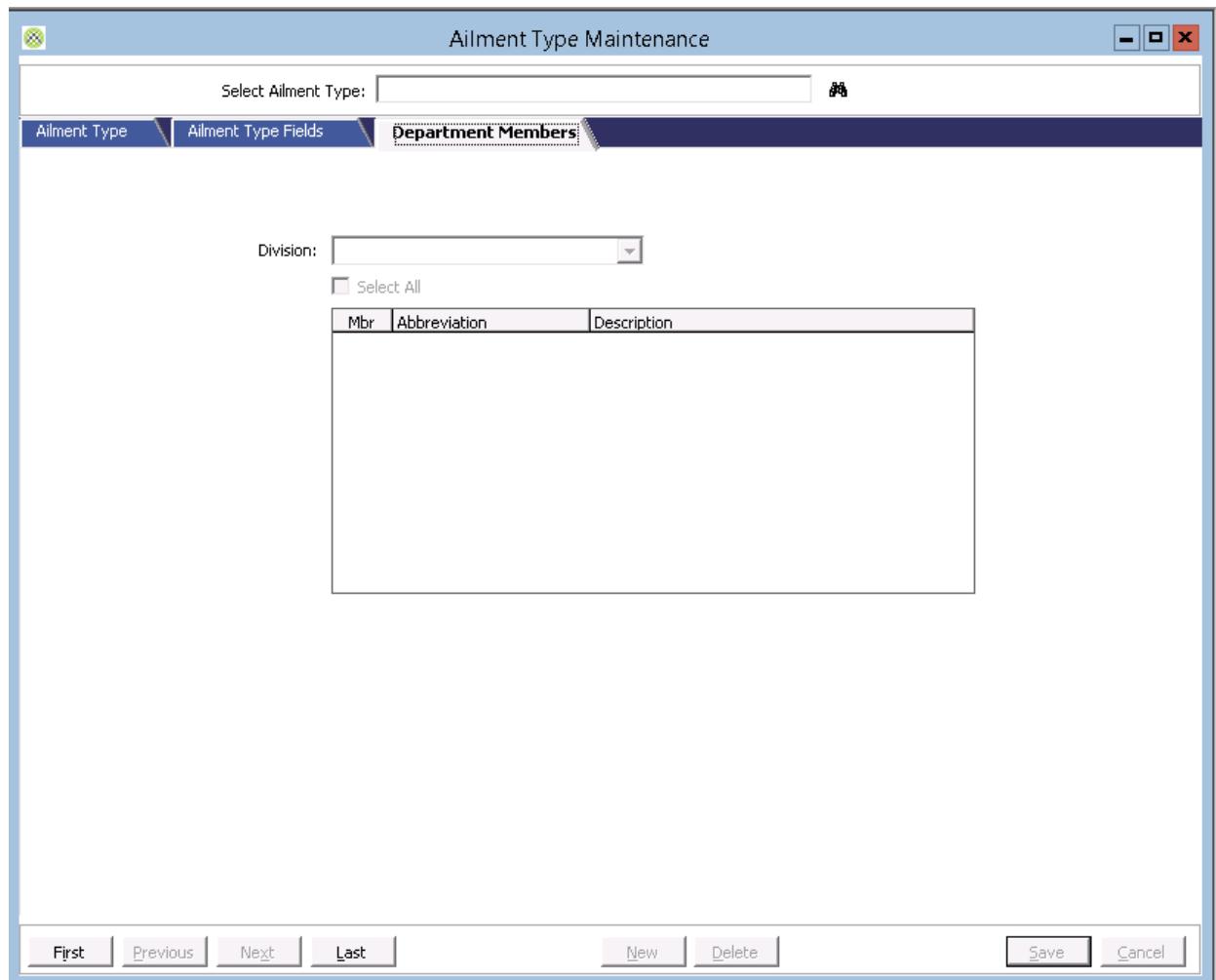


Department Members or Practice Members tab in Ailment Type Maintenance

Appears only when **Enable Department or Practice Security** is checked on the **General** tab in **Practice or Organization Options**.

You must select department/practice members for each record that has a members tab.

Access the **Department Members** or **Practice Members** tab from **Ailment Type Maintenance**. To access **Ailment Type Maintenance**, go to **System Administration > File Maintenance** and select **Ailment Type Maintenance** or use **F9 > ALM**.



Claim Type Maintenance window

Claim types remind and require staff to add specific claim and ailment information when entering charges on certain vouchers in **Financial Processing > Transactions > Charge Entry** tab (or **Edits** tab). Configure claim types in **Claim Type Maintenance** to ensure that insurance carriers receive all information needed for claim adjudication.

When configuring a claim type, you can define which vouchers are associated with the claim type based on a specific combination of:

- > Insurance carrier
- > Procedure code
- > Diagnosis code

- > Place of service

For each voucher that is associated with the claim type, the settings and options on **Claim Type Maintenance** determine:

- > The pop-up claim notes that display as reminders during manual charge entry

CAUTION: Do not confuse pop-up claim notes with the Claim note type that you add to a claim from **Unpaid Claims Management**. Pop-up claim notes are only displayed during manual charge entry, not during charge import. As soon as you enter a related procedure or diagnosis code on a voucher, the **Charge Entry** tab displays the associated pop-up claim note.

These pop-up messages can serve to remind staff members of requirements set by carriers, or a group of carriers when certain procedure codes or diagnosis codes are entered on a voucher for specific places of service.

For example, you can create a claim type reminding your staff that Medicare does not consider procedure 99215 as a covered service when accompanied by a diagnosis code that indicates screening.

- > The specific fields that are required or optional for certain vouchers on the **Claim Information** window during charge entry, as well as the default values for some required fields

Note: When one or more fields are required for a voucher on the **Claim Information** window,  displays next to the **Claim Info** button on **Financial Processing > Transactions > Charge Entry** tab.

- > The ailment information that is required for certain vouchers on the **Ailment Information** window during charge entry, as well as the default ailment that is automatically selected for those vouchers

Claim Type Maintenance contains these tabs:

- > **Claim Type** tab
- > **Claim Type Fields** tab
- > **Department Members** tab (or **Practice Members** tab)

Important: If you use department security or practice security, you must select department members (or practice members) to give operators access to the record.

Access the **Claim Type Fields** tab from **Claim Type Maintenance**. To access **Claim Type Maintenance**, go to **System Administration > File Maintenance > Claim Type Maintenance**.

Tip: To quickly access **Claim Type Maintenance**, press **F9**, then enter **CTM**.

Claim Type tab

Define claim types that control the pop-up claim notes, information requirements, and default options for certain vouchers in **Financial Processing > Transactions > Charge Entry** tab (or **Edits** tab) based on the vouchers' insurance carrier, procedure code, diagnosis code, and place of service.

CAUTION: Do not confuse pop-up claim notes with the Claim note type that you add to a claim from **Unpaid Claims Management**.

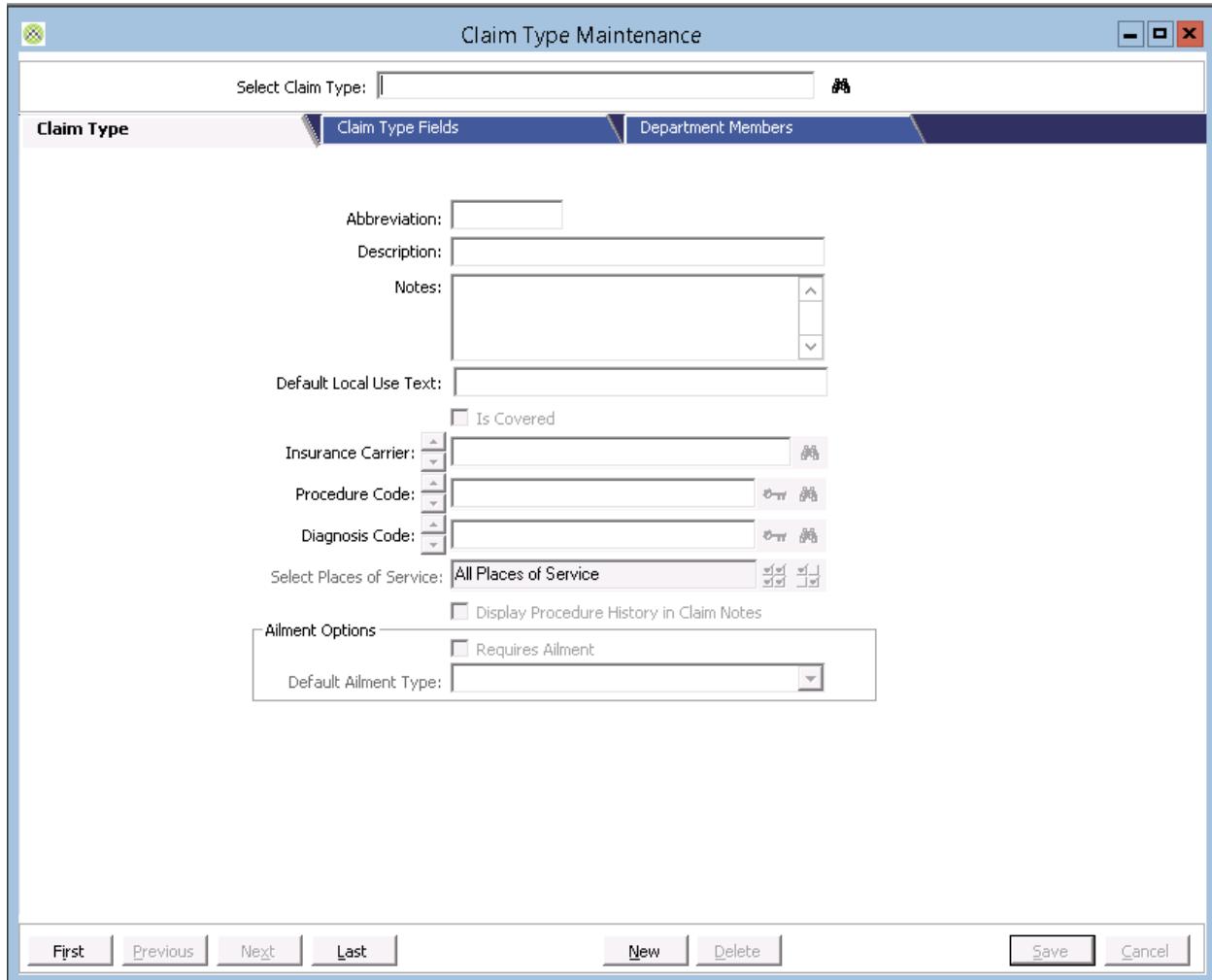
Pop-up claim notes are only displayed during manual charge entry, not during charge import. As soon as you enter a related procedure or diagnosis code on a voucher, the **Charge Entry** tab displays the associated pop-up claim note.

These pop-up messages can serve to remind staff members of requirements set by carriers, or a group of carriers when certain procedure codes or diagnosis codes are entered on a voucher for specific places of service.

For example, you can create a claim type reminding your staff that Medicare does not consider procedure 99215 as a covered service when accompanied by a diagnosis code that indicates screening.

Access the **Claim Type** tab from **Claim Type Maintenance**. To access **Claim Type Maintenance**, go to **System Administration > File Maintenance > Claim Type Maintenance**.

Tip: To quickly access **Claim Type Maintenance**, press **F9**, then enter **CTM**.



The screenshot shows the 'Claim Type Maintenance' window. At the top, there is a search bar labeled 'Select Claim Type:' with a magnifying glass icon. Below the search bar, there are two tabs: 'Claim Type Fields' (selected) and 'Department Members'. The main area contains several input fields and dropdown menus:

- Abbreviation:** Text input field.
- Description:** Text input field.
- Notes:** Text area with scroll bars.
- Default Local Use Text:** Text input field.
- Insurance Carrier:** Text input field with a dropdown arrow.
- Procedure Code:** Text input field with a dropdown arrow.
- Diagnosis Code:** Text input field with a dropdown arrow.
- Select Places of Service:** Text input field with a dropdown arrow.
- Ailment Options:** A group of checkboxes:
 - Is Covered
 - Display Procedure History in Claim Notes
 - Requires Ailment
- Default Ailment Type:** Text input field with a dropdown arrow.

At the bottom of the window, there are navigation buttons: First, Previous, Next, Last, New, Delete, Save, and Cancel.

Abbreviation

Enter up to eight characters.

Description

Enter up to 40 characters.

The information from the **Description** box is displayed on the pop-up claim note.

Notes

Enter up to 250 characters of free text.

The information from the **Notes** box is displayed in the **Notes** grid on the claim note.

Default local use text

Enter up to 40 characters.

The information from the **Default local use text** box prints in **Box 19** of a standard CMS-1500 NPI claim form or the narrative segment of an electronic claim file.

Is covered

This option is selected by default.

When you clear this option, the claim note displays **Not Covered**.

Insurance carrier/group

When left blank, this box triggers the claim note to display for all carriers.

Displays this claim note when the carrier on the voucher is the selected carrier or member of the selected insurance group and the selected procedure or a member of the selected procedure group and the selected diagnosis code or a member of the selected diagnosis category are entered on the voucher.

Tip: Toggle the field label name by pressing **Ctrl + Down** on your keyboard.

Procedure code/group

When left blank, triggers the claim note to display for all procedures.

Displays this claim note when the selected procedure code or a member of the selected procedure group and the selected diagnosis code or a member of the selected diagnosis category are entered on a voucher where the payer is the selected carrier or a member of the selected insurance group.

Note: If the claim type's selected diagnosis code is different from the default diagnosis selected for the procedure code in **Procedure Code Maintenance** then the diagnosis field in **Charge Entry** defaults to the code from **Procedure Code Maintenance**. In this instance the claim type note does not display.

Tip: Toggle the field label name by pressing **Ctrl + Down** on your keyboard.

Diagnosis code/category

When left blank, triggers the claim note to display for all diagnoses.

Displays this claim note when the selected diagnosis code or a member of the selected diagnosis category and the selected procedure code or a member of the selected procedure

group are entered on a voucher where the payer is the selected carrier or a member of the selected insurance group.

Note: If the claim type's selected diagnosis code is different from the default diagnosis selected for the procedure code in **Procedure Code Maintenance** then the diagnosis field on the **Charge Entry** tab defaults to the code from **Procedure Code Maintenance**. In this instance the claim type note does not display.

Tip: Toggle the field label name by pressing **Ctrl + Down** on your keyboard.

Select places of service

Allows you to restrict this claim type to only apply to selected places of service.

The default selection is **All Places of Service**, which triggers the claim note to display for all places of service.

Displays this claim note when the selected place of service and the selected diagnosis code or a member of the selected diagnosis category and the selected procedure code or a member of the selected procedure group are entered on a voucher where the payer is the selected carrier or a member of the selected insurance group.

To select one or more places of service that triggers whether an ailment is required during charge entry, do the following:

1. Click 
2. Select one or more places of service.

Display procedure history in claim notes

If checked, the procedure history for the patient entered on the **Charge Entry** tab appears in the **Claim Notes**. The carrier, provider, specialty, and procedure for the charge appear at the top of the **Claim Notes** as well.

If the procedure code entered on the **Charge Entry** tab already exists in the **Procedure History** grid, it is highlighted. In addition, if it is not already visible due to a long list of history items in the grid, it is brought into the visible portion of the grid automatically. The most recent occurrence of the procedure code is highlighted in the **Procedure History** grid.

If no procedure history exists for the patient, the **Procedure History** grid displays but is blank.

If this option is not checked, the **Claim Note** does not display the **Procedure History** grid. The carrier, provider, specialty, and procedure also do not display.

Ailment options

Both options in this area work in conjunction with the selections made for insurance carrier (or insurance group), procedure code (or procedure group), and diagnosis code (or diagnosis category).

For example, if a procedure code (or procedure group) is not specified and a place of service is selected, then the claim note displays for all places of service. However, the entry of ailment info is required only for the selected place of service. When you enter a place of service other than the one selected here, you are not required to enter ailment info in order to save the voucher.

Requires ailment

This option prevents you from saving the voucher entries until you enter the required ailment info.

Default ailment type

This option is enabled when the **Requires Ailment** option is selected.

Restricts the selection available on the **Ailment Info** window on the **Charge Entry** tab to the specified ailment.

Claim Type Fields tab

For vouchers associated with the selected claim type, determine which fields are required on the **Claim Information** window in **Financial Processing > Transactions > Charge Entry** tab (or **Edits** tab).

Access the **Claim Type Fields** tab from **Claim Type Maintenance**. To access **Claim Type Maintenance**, go to **System Administration > File Maintenance > Claim Type Maintenance**.

Tip: To quickly access **Claim Type Maintenance**, press **F9**, then enter **CTM**.

Claim Type Maintenance

Select Claim Type:	
Claim Type	Claim Type Fields
Department Members	

Available Claim Fields:	
Field Description	
Prior Authorization Number	
Pre-Certification #	
Medicare Secondary Reason Code	
Resubmission Code	
Original Reference Number	
Purchased Service UPIN	
Purchased Service Price	
Purchased Service Provider Name	
Purchased Service NPI	
Miscellaneous Box 10d text	
Miscellaneous Box 11 text	
Miscellaneous Box 17a text	
Covered Days	
Non-Covered Days	
Coinsurance Days	

Seq	Field Description	Req?

Move Up Move Down

Default Values:	
Field Name	Value
Patient Status	
Type of Admission	

First Previous Next Last New Delete Save Cancel

Available Claim Fields grid

This grid displays all of the available claim information that can be added as required or optional fields for the claim type on the **Claim Information** window in the **Charge Entry** tab (or **Edits** tab).

Tip: To access the **Claim Information** window from the **Charge Entry** tab, click the **Summary** button, then click the **Claim Info** button. To access the (or **Edits** tab) by clicking the **Claim** button. When accessing the **Claim Information** window from the **Charge Entry** tab, the **Claim Info** button is only displayed in the summary view. To open the summary view, click the **Summary** button on the **Charge Entry** tab.

When one or more fields are required for a voucher on the **Claim Information** window,  displays next to the **Claim Info** button on the **Charge Entry** tab. Before you can save the voucher, you must enter the required information on the **Claim Information** window.

Important: The first three rows in the grid in **Claim Information** are reserved for the following field names:

- > **Operating Physician**
- > **Other Operating Physician/Other Physician A**
- > **Other Physician B**

It's best to not move these three field names to **Claim Fields**

Selected. However, if you have a valid reason for including them in **Claim Fields Selected**, they should occupy the first three rows in the grid.

Claim Fields Selected grid

Seq

The **Seq** column indicates the order in which the fields are displayed on the **Claim Information** window in the **Charge Entry** tab (or **Edits** tab).

Field Name

This column lists all of the claim information that are optional or required for the claim type on the **Claim Information** window.

Req?

Use the option in the **Req?** column to control which fields are required for the claim type on the **Claim Information** window.

To mark a field as required, select the option in the **Req?** column. To mark a field as optional, clear the option in the **Req?** column.

Note: Your settings for the **Req?** column on the **Claim Type Fields** tab determine the settings for the **Req?** column on the **Claim Information** window.

Default Values grid

This grid enables you to set up default values for some of the fields listed in the **Claim Fields Selected** grid. By default, this grid displays **Patient Status** and **Type of Admission**.

Note: When you select **Patient Status** or **Type of Admission** as a required field in the **Claim Fields Selected** grid, the associated row on the **Default Values** grid becomes available.

Patient Status

This free text field allows up to two characters.

Enter a valid value based on the carrier's specifications. Examples of values include:

Value	Use
01	Indicates discharge to home or self-care
02	Indicates discharge to another short term general hospital for in-patient care
30	Indicates that the patient is still a current patient

Type of Admission

This drop down list contains the following items:

- > Emergency
- > Urgent
- > Elective
- > Newborn
- > Information not available

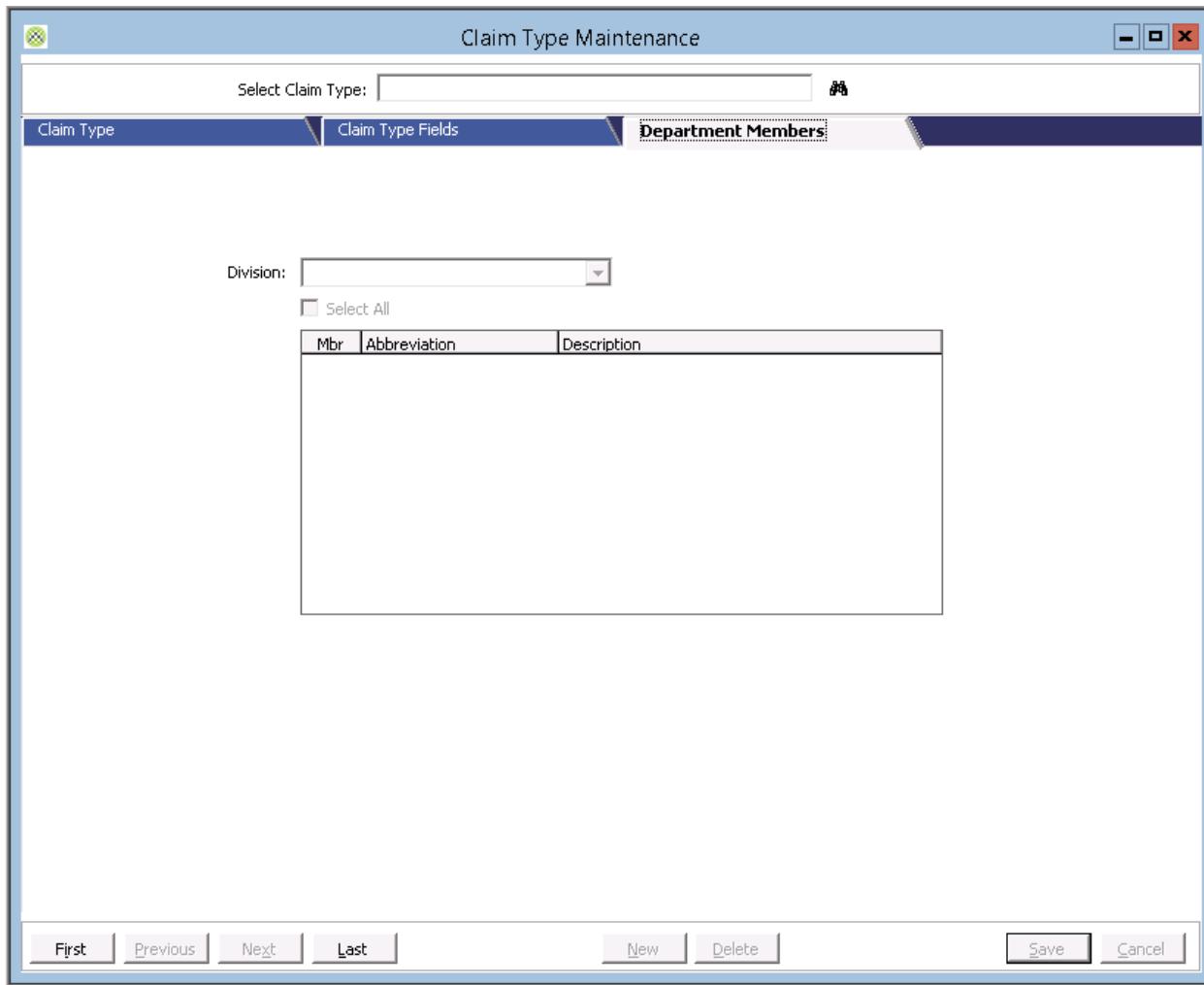
Note: If values are entered in both of these fields then  indicator is displayed on the **Charge Entry** tab unless other required fields are included in the claim type.

Department Members or Practice Members tab in Claim Type Maintenance

Appears only when **Enable Department/Practice Security** is checked on the **General** tab in **Practice/Organization Options**.

You must select department/practice members for each record that has a members tab.

Access the **Department Members** or **Practice Members** tab from **Claim Type Maintenance**. To access **Claim Type Maintenance**, go to **System Administration > File Maintenance > Claim Type Maintenance** or press **F9** and then enter **CTM**.



Division

This field is only enabled on the **Department/Practice Members** tab when you check **Enable Divisions** on the **Multi Entity** tab. In this case, the selection of department/practice members is done at the level of division.

Federal ID Maintenance window

Use **Federal ID Maintenance** to store federal tax identification (ID) numbers that you can select for **Federal ID** on the **Billing Method Information** tab in **Place of Service Maintenance**.

Federal ID Maintenance contains these tabs:

- > **Federal ID**
- > **History**

To access **Federal ID Maintenance**, go to **System Administration > File Maintenance > Federal ID Maintenance**, or press **F9** and then enter **FIM**.

Federal ID tab

Use the **Federal ID** tab in **Federal ID Maintenance** to store federal tax identification (ID) numbers that you can select on the **Billing Method Information** tab in **Place of Service Maintenance**.

Access the **Federal ID** tab from **Federal ID Maintenance**. To access **Federal ID Maintenance**, go to **System Administration > File Maintenance > Federal ID Maintenance**, or press **F9** and then enter **FIM**.

Federal ID Maintenance 

Select Federal ID: 

Federal ID  History

Federal ID:

Description:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Federal ID

Required. Enter the nine-digit federal tax ID assigned to your practice or organization. Each federal tax ID record must be unique.

Description

Required. Enter a description for this federal tax ID. Best practice is to make the description unique, so that it is not confused with other federal tax ID records.

Create a federal identification number record

Use **Federal ID Maintenance** to store federal tax identification (ID) numbers that you can select on the **Billing Method Information** tab in **Place of Service Maintenance**.

1. Go to **System Administration > File Maintenance > Federal ID Maintenance**, or press **F9** and then enter **FIM**.
2. Click **New**.
3. For **Federal ID**, enter the nine-digit federal tax ID assigned to your practice or organization.
Each federal tax ID record must be unique.
4. For **Description**, enter a description for this federal tax ID.

Note: Make the description unique, so that it is not confused with other federal tax ID records.

5. Click **Save**.

Billing Name Maintenance window

Use **Billing Name Maintenance** to store billing names that you can select for **Name** on the **Billing Method Information** tab in **Place of Service Maintenance**.

Billing Name Maintenance contains these tabs:

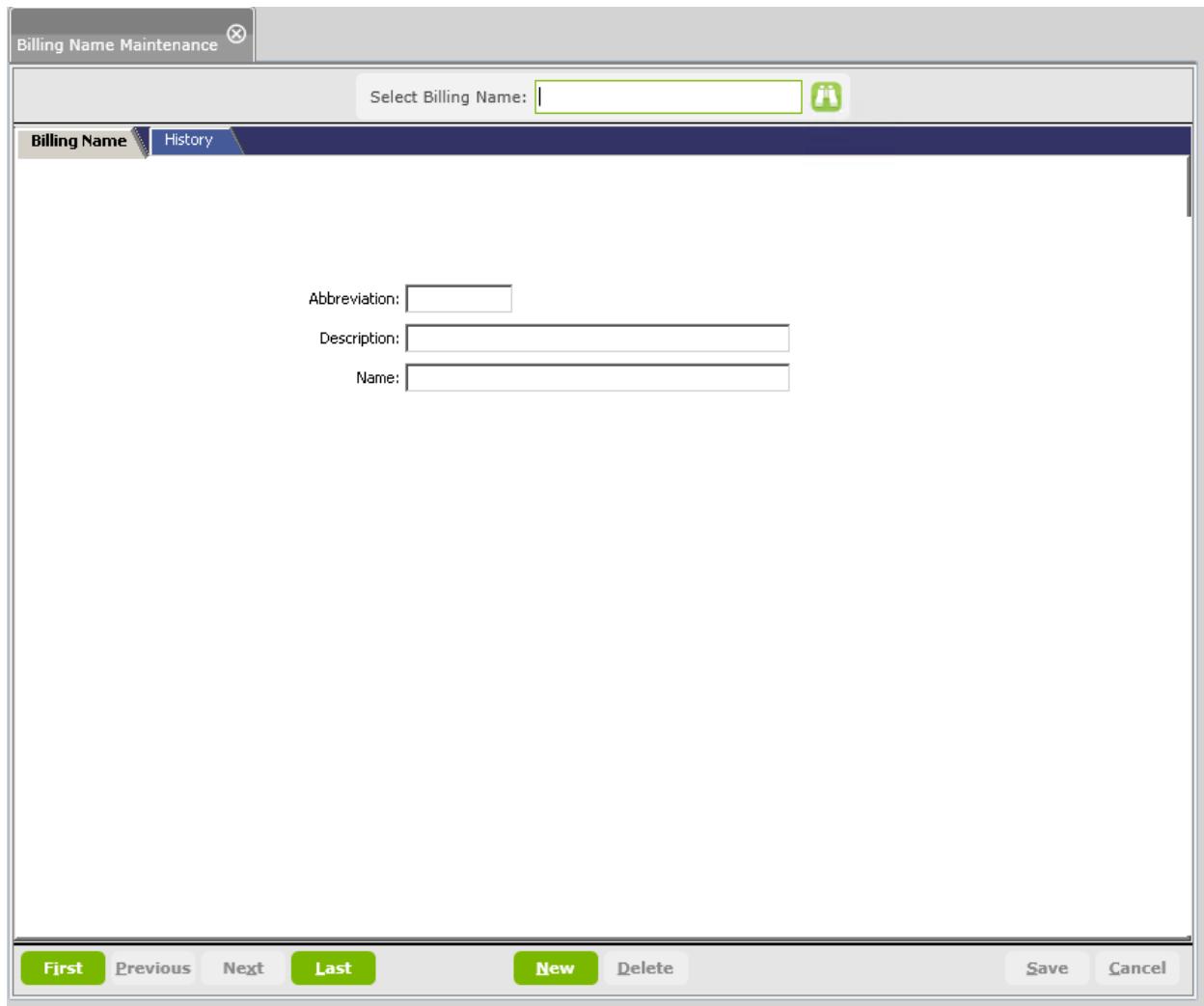
- > **Billing Name**
- > **History**

To access **Billing Name Maintenance**, go to **System Administration > File Maintenance > Billing Name Maintenance**, or press **F9** and then enter **BNM**.

Billing Name tab

Use the **Billing Name** tab in **Billing Name Maintenance** to store billing names that you can select on the **Billing Method Information** tab in **Place of Service Maintenance**.

Access the **Billing Name** tab from **Billing Name Maintenance**. To access **Billing Name Maintenance**, go to **System Administration > File Maintenance > Billing Name Maintenance**, or press **F9** and then enter **BNM**.



Abbreviation

Required. Enter an abbreviation for this billing name record. Each billing name record must have a unique abbreviation.

Description

Required. Enter a description for this billing name record. Best practice is to make the description unique, so that it is not confused with other billing name records.

Name

Required. Enter the billing name to use on claims.

Create a billing name record

Use **Billing Name Maintenance** to store billing names that you can select on the **Billing Method Information** tab in **Place of Service Maintenance**.

1. Go to **System Administration > File Maintenance > Billing Name Maintenance**, or press **F9** and then enter **BNM**.
 2. Click **New**.
 3. For **Abbreviation**, enter an abbreviation for this billing name record.
Each billing name record must have a unique abbreviation.
 4. For **Description**, enter a description for this billing name record.
- Note:** Make the description unique, so that it is not confused with other billing name records.
5. For **Name**, enter the billing name to use on claims.
 6. Click **Save**.

Address Maintenance window

Use **Address Maintenance** to store billing addresses that you can select on the **Billing Method Information** tab in **Place of Service Maintenance**.

Address Maintenance contains these tabs:

- > **Address**
- > **History**

To access **Address Maintenance**, go to **System Administration > File Maintenance > Address Maintenance**, or press **F9** and then enter **ADM**.

Address tab

Use the **Address** tab in **Address Maintenance** to store the billing addresses that you can select on the **Billing Method Information** tab in **Place of Service Maintenance**.

Access the **Address** tab from **Address Maintenance**. To access **Address Maintenance**, go to **System Administration > File Maintenance > Address Maintenance**, or press **F9** and then enter **ADM**.

Address Maintenance

Select Address: 

Address  History

Description: <input type="text"/>	Telephone: <input type="text"/>	Ext: <input type="text"/>
Address 1: <input type="text"/>	Fax: <input type="text"/>	
Address 2: <input type="text"/>	E-Mail: <input type="text"/>	
City: <input type="text"/>	State: <input type="text"/>	
Zip Code: <input type="text"/>	Country: <input type="text"/>	

Description

Required. Enter a description for this billing address record. Each billing address record must have a unique description.

Address 1

Required. Enter the first line of the billing address to use on claims.

Address 2

Enter the second line of the billing address, if any. For example, enter a suite number, apartment number, or PO Box number.

City

Required. Enter the city to use on claims.

State

Required. Select the two-character state abbreviation to use on claims.

Zip Code

Required. Enter the ZIP Code to use on claims. For v5010 electronic claims, you must enter a ZIP code plus four. If you do not know your four-digit additional number, use <your ZIP code>-9998. For example, enter 27615-9998

Country

Enter the two-digit abbreviation for the country.

Telephone

Enter a 10-digit telephone number that is associated with this billing address.

Ext

Enter the extension for the telephone number.

Fax

Enter a 10-digit fax number that is associated with this billing address.

E-Mail

Enter an email address that is associated with this billing address.

Create an address record

Use **Address Maintenance** to store billing addresses that you can select on the **Billing Method Information** tab in **Place of Service Maintenance**.

1. Go to **System Administration > File Maintenance > Address Maintenance**, or press **F9** and then enter **ADM**.
2. Click **New**.
3. For **Description**, enter a description for this billing address record.
Each billing address record must have a unique description.
4. For **Address 1**, enter the first line of the billing address to use on claims.
5. For **Address 2**, enter the second line of the billing address, if any.
For example, enter a suite number, apartment number, or PO Box number.
6. For **City**, enter the city to use on claims.
7. For **State**, select the two-character state abbreviation to use on claims.
8. For **Zip Code**, enter the ZIP Code to use on claims.

9. For **Country**, enter the two-digit abbreviation for the country.
10. For **Telephone**, enter a 10-digit telephone number that is associated with this billing address.
11. For **Ext**, enter the extension for the telephone number.
12. For **Fax**, enter a 10-digit fax number that is associated with this billing address.
13. For **E-Mail**, enter an email address that is associated with this billing address.
14. Click **Save**.

Claim Edit Category Maintenance window

Use **Claim Edit Category Maintenance** to define categories that you can assign to the claim edit codes that are returned from your claims review solution. Use the claim edit categories to group claim edit codes.

Before you can use claim edits, at least one claim edit category is required to use for **Default Claim Edit Category** in **Practice Options** or **Organization Options**. A **NEW** claim edit category might have been automatically created and assigned to **Default Claim Edit Category** during a prior Allscripts® Practice Management upgrade.

Claim Edit Category Maintenance contains these tabs:

- > **Claim Edit Category**
- > **History**

To access **Claim Edit Category Maintenance**, go to **System Administration > File Maintenance > Claim Edit Category Maintenance**, or press **F9** and enter **CEC**.

Claim Edit Category tab

Use the **Claim Edit Category** tab in **Claim Edit Category Maintenance** to define categories that you can assign to the claim edit codes that are returned from your claims review solution. Use the claim edit categories to group claim edit codes.

Access the **Claim Edit Category** tab from **Claim Edit Category Maintenance**. To access **Claim Edit Category Maintenance**, go to **System Administration > File Maintenance > Claim Edit Category Maintenance**, or press **F9** and then enter **CEC**.

Claim Edit Category Maintenance ×

Select Claim Edit Category: 

Claim Edit Category  History

Abbreviation:

Description:

Default to Fail Validation

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Abbreviation

Required. Enter an abbreviation for the claim edit category record. Each claim edit category record must have a unique abbreviation.

Description

Required. Enter a description for the claim edit category record.

Best Practice: Make the description unique, so that it is not confused with other claim edit category records.

Default to Fail Validation

Select this option to assign a **Fail** validation attribute to claim edit codes when the claim edit category is assigned. You can change validation attributes in **Claim Edit Management**, as necessary.

Claim Edit Management window

Use **Claim Edit Management** to modify the claim edit codes that are returned from your claims review solution.

Claim Edit Management contains these tabs:

- > **Claim Edit Management**
- > **History**

To access **Claim Edit Management**, go to **System Administration > File Maintenance > Claim Edit Management**, or press **F9** and enter **CEM**.

Claim Edit Management tab

Use the **Claim Edit Management** tab in **Claim Edit Management** to modify the claim edit codes that are returned from your claims review solution.

This tab incorporates three functional areas. The top area provides selection criteria and filtering options. The middle area contains a grid with your query results and a context menu option for updating message text. The bottom area enables you to reassign claim edit categories and validation attributes to one or more rows in the grid.

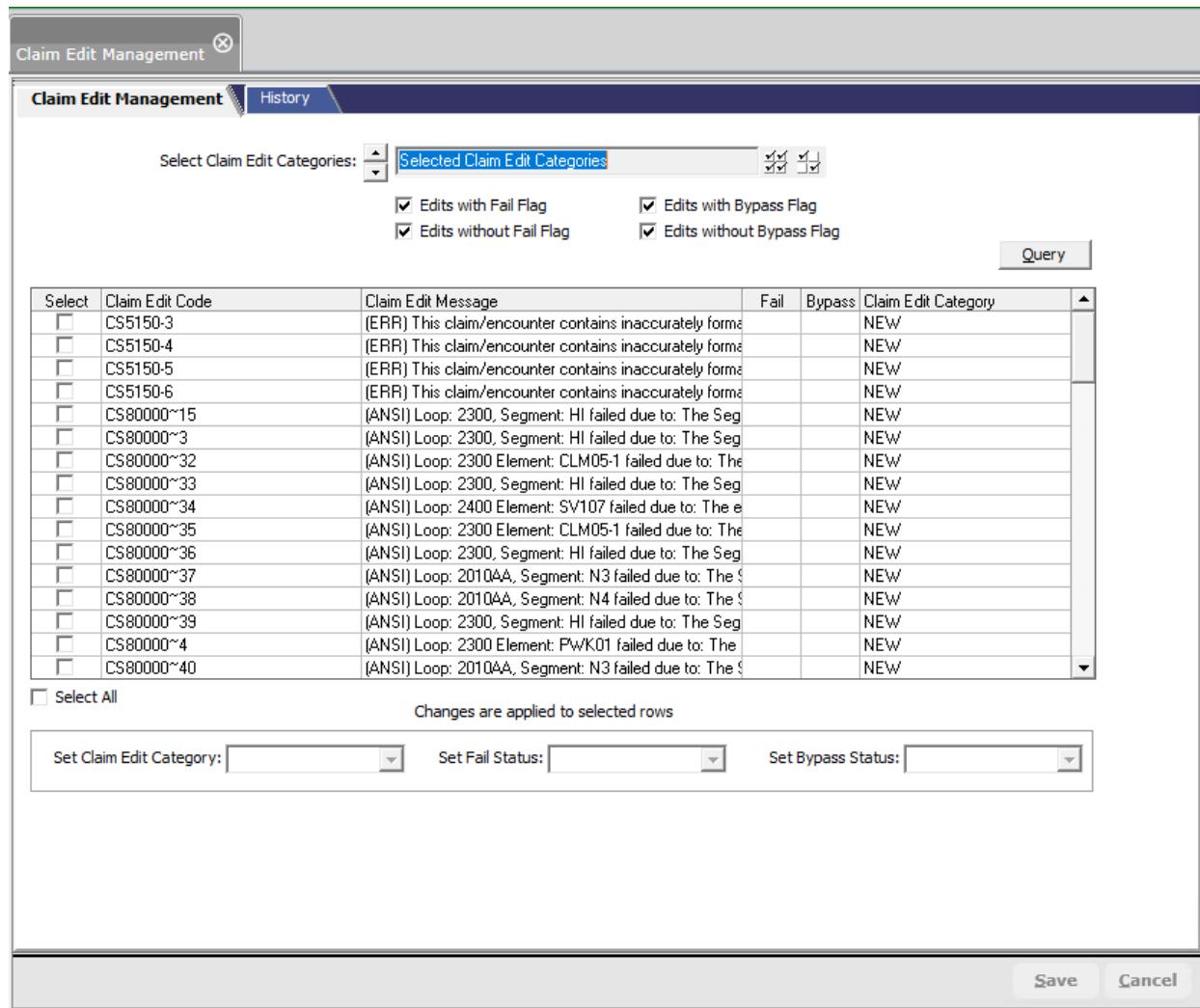
You can query claim edit codes based on claim edit categories or a single claim edit code or claim edit message. Click the arrows to display either **Select Claim Edit Categories** or **Single Claim Edit Lookup**, as applicable.

You cannot add or delete claim edit codes in **Claim Edit Management**. You can only modify the message text, claim edit categories, and validation attributes (blank, **Fail**, or **Bypass**) of stored claim edit codes. If you change and save a claim edit code record, those changes are not overwritten when that code is subsequently returned from your claims review solution. However, if you change the text of a message, those changes are not displayed throughout the application because the original version of the message is returned from your claims review solution each time code checking and claim verification are done.

The claim edit code grid enables you to update multiple codes at the same time.

Access the **Claim Edit Management** tab from **Claim Edit Management**. To access **Claim Edit Management**, go to **System Administration > File Maintenance > Claim Edit Management**, or press **F9** and then enter **CEM**.

Figure 2: Claim Edit Management tab - Select Claim Edit Categories view



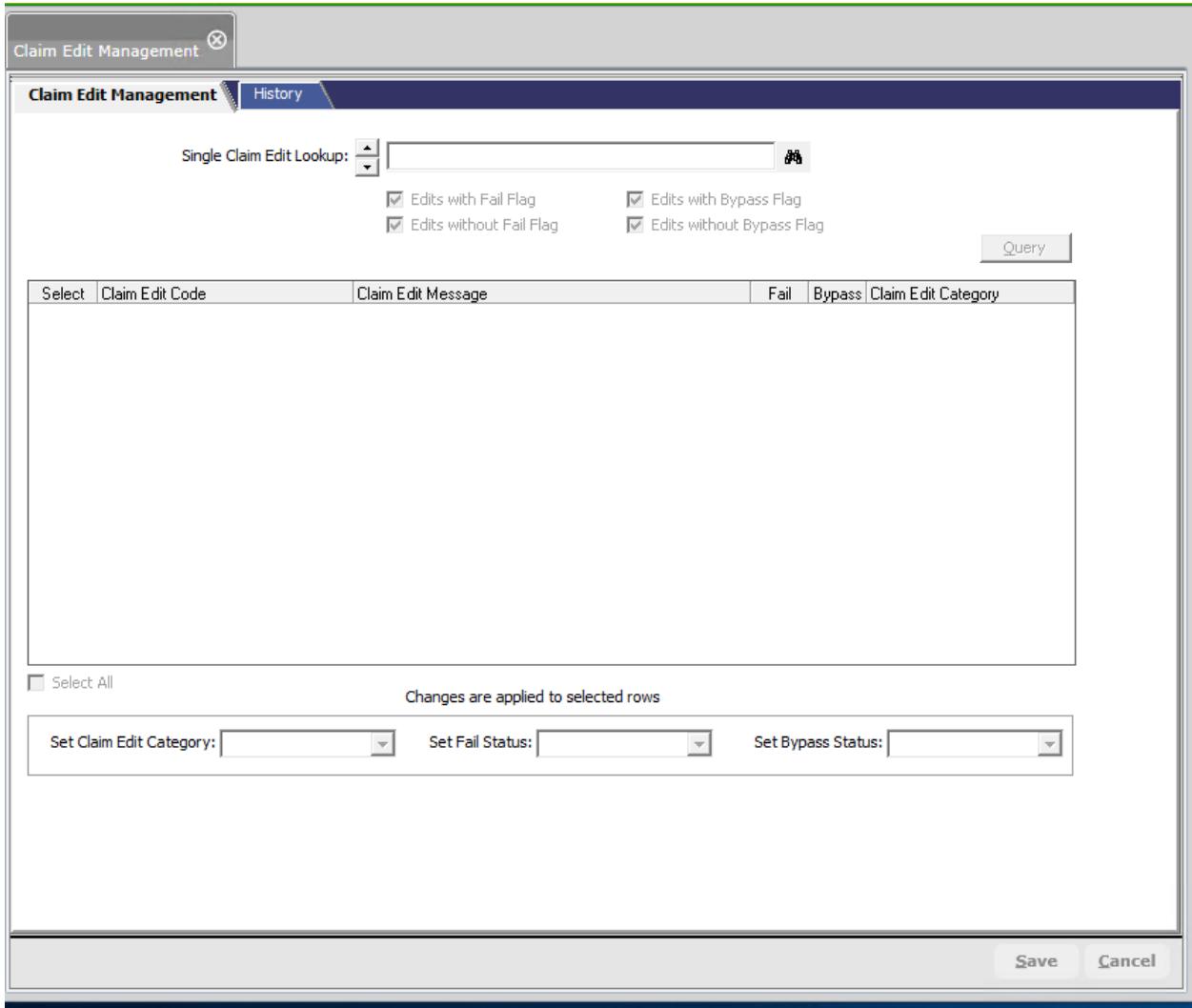
Select	Claim Edit Code	Claim Edit Message	Fail	Bypass	Claim Edit Category
<input type="checkbox"/>	CS5150-3	(ERR) This claim/encounter contains inaccurately forma			NEW
<input type="checkbox"/>	CS5150-4	(ERR) This claim/encounter contains inaccurately forma			NEW
<input type="checkbox"/>	CS5150-5	(ERR) This claim/encounter contains inaccurately forma			NEW
<input type="checkbox"/>	CS5150-6	(ERR) This claim/encounter contains inaccurately forma			NEW
<input type="checkbox"/>	CS80000~15	(ANSI) Loop: 2300, Segment: H1 failed due to: The Seg			NEW
<input type="checkbox"/>	CS80000~3	(ANSI) Loop: 2300, Segment: H1 failed due to: The Seg			NEW
<input type="checkbox"/>	CS80000~32	(ANSI) Loop: 2300 Element: CLM05-1 failed due to: The			NEW
<input type="checkbox"/>	CS80000~33	(ANSI) Loop: 2300, Segment: H1 failed due to: The Seg			NEW
<input type="checkbox"/>	CS80000~34	(ANSI) Loop: 2400 Element: SV107 failed due to: The e			NEW
<input type="checkbox"/>	CS80000~35	(ANSI) Loop: 2300 Element: CLM05-1 failed due to: The			NEW
<input type="checkbox"/>	CS80000~36	(ANSI) Loop: 2300, Segment: H1 failed due to: The Seg			NEW
<input type="checkbox"/>	CS80000~37	(ANSI) Loop: 2010AA, Segment: N3 failed due to: The \$			NEW
<input type="checkbox"/>	CS80000~38	(ANSI) Loop: 2010AA, Segment: N4 failed due to: The \$			NEW
<input type="checkbox"/>	CS80000~39	(ANSI) Loop: 2300, Segment: H1 failed due to: The Seg			NEW
<input type="checkbox"/>	CS80000~4	(ANSI) Loop: 2300 Element: PwK01 failed due to: The			NEW
<input type="checkbox"/>	CS80000~40	(ANSI) Loop: 2010AA, Segment: N3 failed due to: The \$			NEW

Select All Changes are applied to selected rows

Set Claim Edit Category: Set Fail Status: Set Bypass Status:

Save Cancel

Figure 3: Claim Edit Management tab - Single Claim Edit Lookup view



The screenshot shows the 'Claim Edit Management' tab selected in the top navigation bar. Below it is a sub-tab labeled 'Single Claim Edit Lookup'. A search bar contains the placeholder text 'Single Claim Edit Lookup:'. To its right are two groups of checkboxes: 'Edits with Fail Flag' (checked) and 'Edits without Fail Flag' (checked), and 'Edits with Bypass Flag' (checked) and 'Edits without Bypass Flag' (checked). A 'Query' button is located to the right of these checkboxes. Below the search bar is a table header with columns: 'Select', 'Claim Edit Code', 'Claim Edit Message', 'Fail', 'Bypass', and 'Claim Edit Category'. The main body of the table is currently empty. At the bottom left of the table area are three dropdown menus: 'Set Claim Edit Category', 'Set Fail Status', and 'Set Bypass Status'. At the very bottom of the screen are 'Save' and 'Cancel' buttons.

When you initially navigate to the **Claim Edit Management** tab, the default display is **Select Claim Edit Categories** with the default claim edit category from **Practice Options** or **Organization Options** selected. If **Default to Fail Validation** is selected in **Claim Edit Category Maintenance** for the default claim edit category, **Fail** is selected in the grid.

Select Claim Edit Categories

To limit the claim edit categories, click  to open a separate window and select the claim edit categories.

Single Claim Edit Lookup

Click  to open a separate window and search for either a single claim edit code or claim edit message.

When searching against message text, use % (percent sign) to limit the query results to messages with specific text in the message. For example, to find claim edit codes with diagnosis in the message, select **Claim Edit Message** for **Search By** and enter %diagnosis in **Search For**.

When **Select Claim Edit Categories** is displayed, you can further filter the query results by validation attribute. You do not have to click **Query** for the filter to take effect.

Edits with Fail Flag

Select this option to filter the query results to show claim edit codes with a **Fail** validation attribute. This option is paired with **Edits without Fail Flag**. You must select at least one option within the pair.

Edits without Fail Flag

Select this option to filter the query results to show claim edit codes without a **Fail** validation attribute. This option is paired with **Edits with Fail Flag**. You must select at least one option within the pair.

Edits with Bypass Flag

Select this option to filter the query results to show claim edit codes with a **Bypass** validation attribute. This option is paired with **Edits without Bypass Flag**. You must select at least one option within the pair.

Edits without Bypass Flag

Select this option to filter the query results to show claim edit codes with have a **Bypass** validation attribute. This option is paired with **Edits with Bypass Flag**. You must select at least one option within the pair.

Query

Click **Query** to fill the grid with the claim edit codes that qualify based on your selection criteria and filters.

Claim edit code grid

Select

Select the check box to mark a row for update.

Claim Edit Code

The read-only claim edit code is displayed.

Claim Edit Message

The read-only message text is displayed. Point to this column to see the full message displayed as a tooltip. Right-click on the row in the grid and select **Claim Edit Message** to change the message text.

Fail

A read-only green check mark is displayed if the claim edit code has a **Fail** validation attribute.

Bypass

A read-only green check mark is displayed if the claim edit code has a **Bypass** validation attribute.

Claim Edit Category

The read-only claim edit category is displayed.

Assigned Task

Note: This column is only displayed when **Claims Tool in Practice Options** or **Organization Options** is set to **Custom Claim Edits** and **Send Uninsured Vouchers to Claims Manager** is selected. Do not select **Custom Claim Edits** unless you have been told to do so by an Allscripts® representative.

Assigned Task displays the selection in **Task for Uninsured Vouchers with Failed Edit** for the claim edit. **Task for Uninsured Vouchers with Failed Edit** lists the **Name** on the **Task** tab for each task created in **Task Maintenance**. If there is no task assigned to the claim edit, **Assigned Task** is blank.

The **Name** field on the **Task** tab in **Task Maintenance** accepts up to 80 characters. Manually adjust the **Assigned Task** column width to view the entire task name when necessary.

Select All

Click this option to mark all query result rows for update.

Set Claim Edit Category

Select the claim edit category that you want to assign to the rows in the grid that are marked for update.

Note: If you select a claim edit category with **Default to Fail Validation** selected in **Claim Edit Category Maintenance**, the application fills **Set Fail Status** with **Fail Validation** and **Set Bypass Status** with **Do Not Bypass Edit**.

Set Fail Status

Select the **Fail** attribute to assign to the rows in the grid that are marked for update. You can select blank, **Fail Validation**, or **Do Not Fail Validation**.

If you select **Fail Validation**, **Set Bypass Status** is set automatically to **Do Not Bypass Edit**.

Set Bypass Status

Select the **Bypass** attribute that you want to assign to the rows in the grid that are marked for update. You can select blank, **Bypass Edit**, or **Do Not Bypass Edit**.

If you select **Bypass Edit**, **Set Fail Status** is set automatically to **Do Not Fail Validation**.

Task for Uninsured Vouchers with Failed Edit

Note: This box is only displayed when **Claims Tool in Practice Options** or **Organization Options** is set to **Custom Claim Edits** and **Send Uninsured Vouchers to Claims Manager** is selected. Do not select **Custom Claim Edits** unless you have been told to do so by an Allscripts® representative.

Task for Uninsured Vouchers with Failed Edit lists the **Name** on the **Task** tab for each task created in **Task Maintenance**. **Task for Uninsured Vouchers with Failed Edit** is blank by default.

When the check box in the **Select** column is selected for a claim edit row, use **Task for Uninsured Vouchers with Failed Edit** to assign an uninsured voucher that was returned by the claims manager with a failed claim edit to a task queue in **Office Manager** for further review. Assign the same task to as many claim edit messages as your practice or organization requires.

Task for Uninsured Vouchers with Failed Edit is cleared when **Do Not Fail Validation** is selected in **Set Fail Status**. Additionally, **Task for Uninsured Vouchers with Failed Edit** is cleared when you click **Save** with **Bypass Edit** selected in **Set Bypass Edit** because selecting **Bypass Edit** automatically fills **Set Fail Status** with **Do Not Fail Validation**.

Chapter 10

Document File Maintenance

Document File Maintenance setup checklist

Document file maintenance requires setup in Microsoft® Word. In addition the creation of documents in document file maintenance requires that you define a document path name. You must define the document path name in your database after it is delivered to your server.

Your Allscripts® Implementation Specialist will help you with this setup when he or she visits your office. In the meantime, give some thought to the types of documents that you need to create.

These master documents are used as Quick Documents and when you batch print documents (for example, patient documents, collection documents, scheduling documents, recall documents, and so on).

Use this checklist to record the completion in **Document Maintenance** of each type of document that you need.

Document	Completed
Patient Info letters	
Scheduling Info letters	
Scheduling Patient Info letters	
Collection Info letters	
Prescription Info letters	
Recall Info letters	
Referral Info letters	

Document Maintenance window

Use **Document Maintenance** to create and manage documents to give to patients.

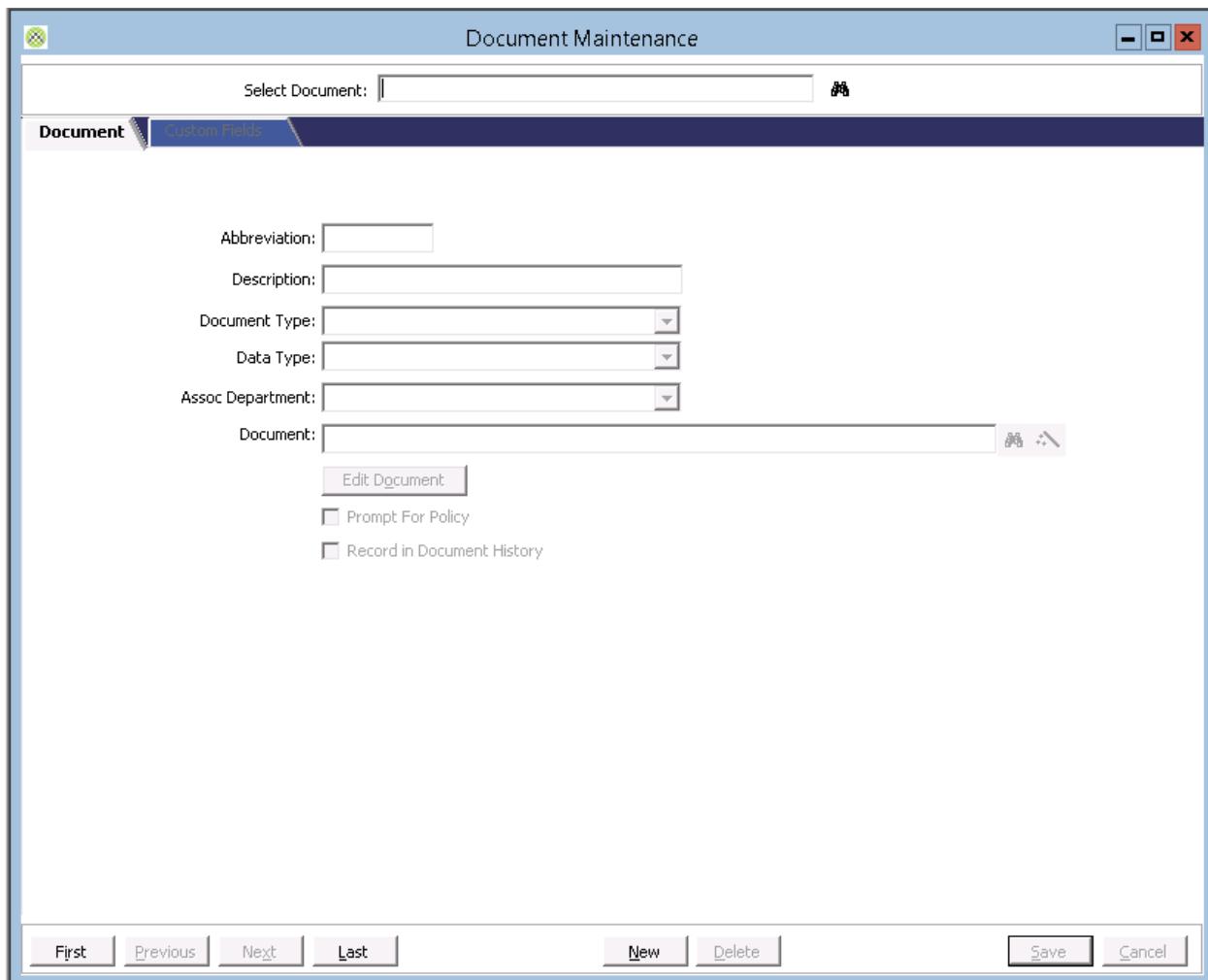
To access **Document Maintenance**, go to **System Administration > File Maintenance** and select **Document Maintenance** or use **F9 > DOM**.

Document Maintenance contains these tabs:

- > **Documents**
- > **Custom Fields**
- > **Payerpath**
- > **History**

Document tab

Access the **Document** tab from the **Document Maintenance**. To access **Document Maintenance**, go to **System Administration > File Maintenance > Document Maintenance** or press **F9** and then enter **DOM**.



The screenshot shows the 'Document Maintenance' application window. At the top, there is a title bar with the window title 'Document Maintenance'. Below the title bar is a toolbar with icons for 'New', 'Edit', 'Delete', 'Save', and 'Cancel'. The main area of the window is a form for managing documents. It includes fields for 'Select Document' (with a dropdown arrow icon), 'Abbreviation' (text input field), 'Description' (text input field), 'Document Type' (dropdown menu), 'Data Type' (dropdown menu), 'Assoc Department' (dropdown menu), and 'Document' (text input field). Below these fields are three checkboxes: 'Edit Document', 'Prompt For Policy', and 'Record in Document History'. At the bottom of the window are navigation buttons for 'First', 'Previous', 'Next', and 'Last', along with 'New', 'Delete', 'Save', and 'Cancel' buttons.

Abbreviation

Accepts up to 8 characters.

Description

Displays as a selection for Quick Documents and when you batch print the corresponding data type documents.

Document type

Select one of the following document types:

- > Word Document
- > XML

Data Type

The data type determines when the document is available for selection. For example, only those documents created with a **Data Type** of **Collection Information** are available in **Collection Action Maintenance** and when you prepare and print past due documents and print past due labels.

After you save a new document, this box becomes inactive and you cannot change the data type.

The available data types include:

- > Collection Information
- > Patient Information
- > Prescription Information
- > Recall Information
- > Referral Information
- > Scheduling Information
- > Scheduling Patient Information

Assoc Department or Assoc Practice

Intended for use with department security or practice security. Do not use this box if you do not use department security or practice security. To limit this document for use with a specific department or practice, select the department or practice from the list. Only users with access to that department or practice can use this document.

Document

When you create a new document, the application automatically fills the path name.

Edit document

Opens the Allscripts® alternate document processor. If you are creating a document for the first time, your Allscripts® implementation specialist will guide you through these steps.

Prompt for Policy

Only available for documents with a **Data Type of Patient Information**. Selecting this check box activates **Select Policy** when you add a quick document to a patient record: to print the name of the policy selected on **Quick Document**, you must include the policy info pull fields that begin with PLX.... when editing the document in the Allscripts® alternate document processor.

Note: Do not select this box for documents intended for batch printing.

Record in Document History

Select to record the printing of this document on the patient's history in **Document Management**.

Save in Document History

Only available for documents with a **Data Type of Patient Information** when **Record in Document History** is selected. When you select this option, a user cannot overwrite the original file that is created attaching a document to a patient using **Quick Documents**.

Custom Fields tab

Define custom boxes to use on your documents on the **Custom Fields** tab in **Document Maintenance**.

This tab is enabled when you set **Data Type** to one of the following:

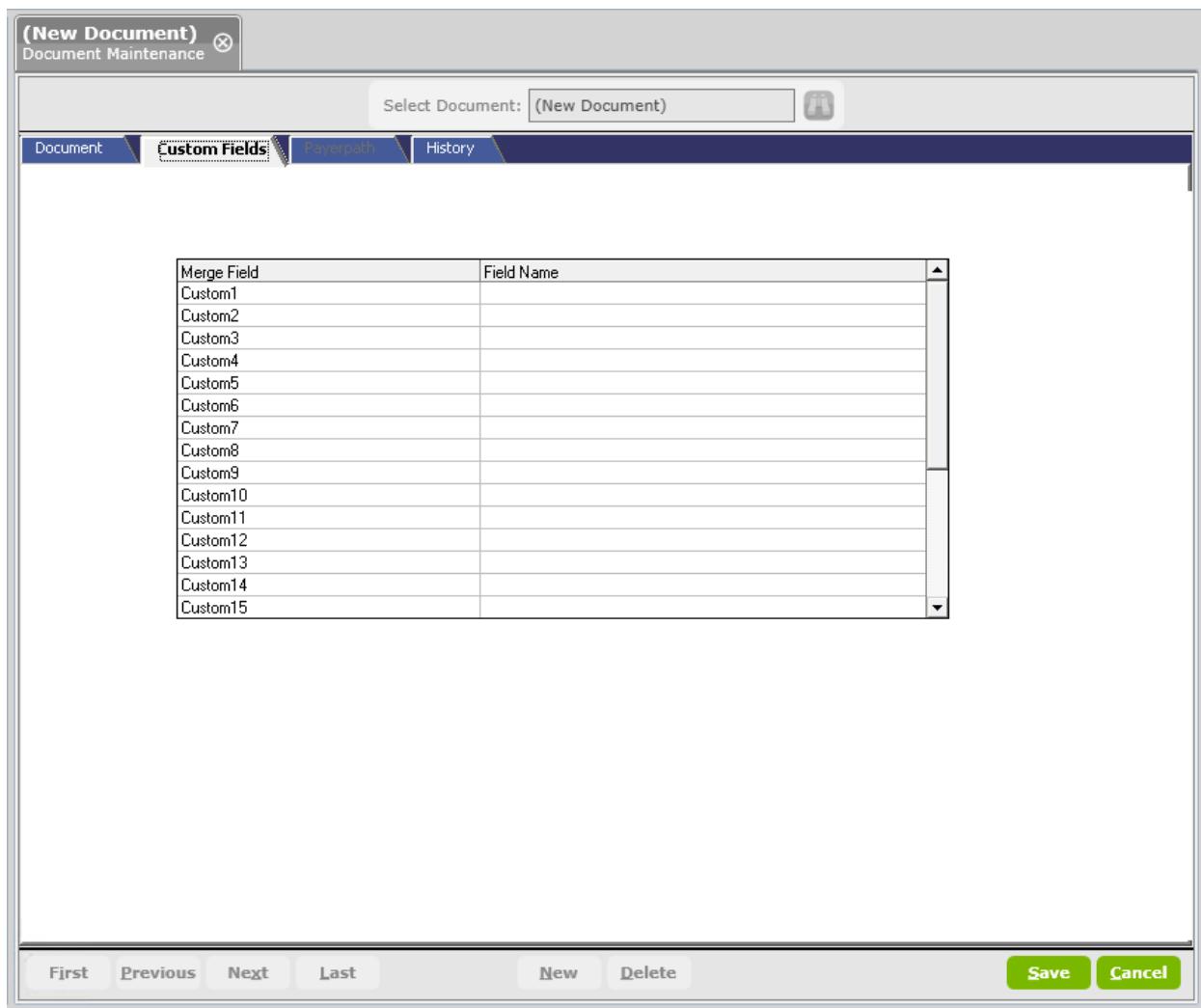
- > **Patient Information**
- > **Prescription Information**
- > **Referral Information**

Custom-defined fields attached to a document enable you to insert information or detail that is printed during the current document run.

You can insert a merge field when you edit the document that corresponds to the custom numbered fields on this tab.

Tip: Keep a listing of the custom fields you define for each document.

Access the **Custom Fields** tab from **Document Maintenance**. To access **Document Maintenance**, go to **System Administration > File Maintenance > Document Maintenance** or press **F9** and then enter **DOM**.

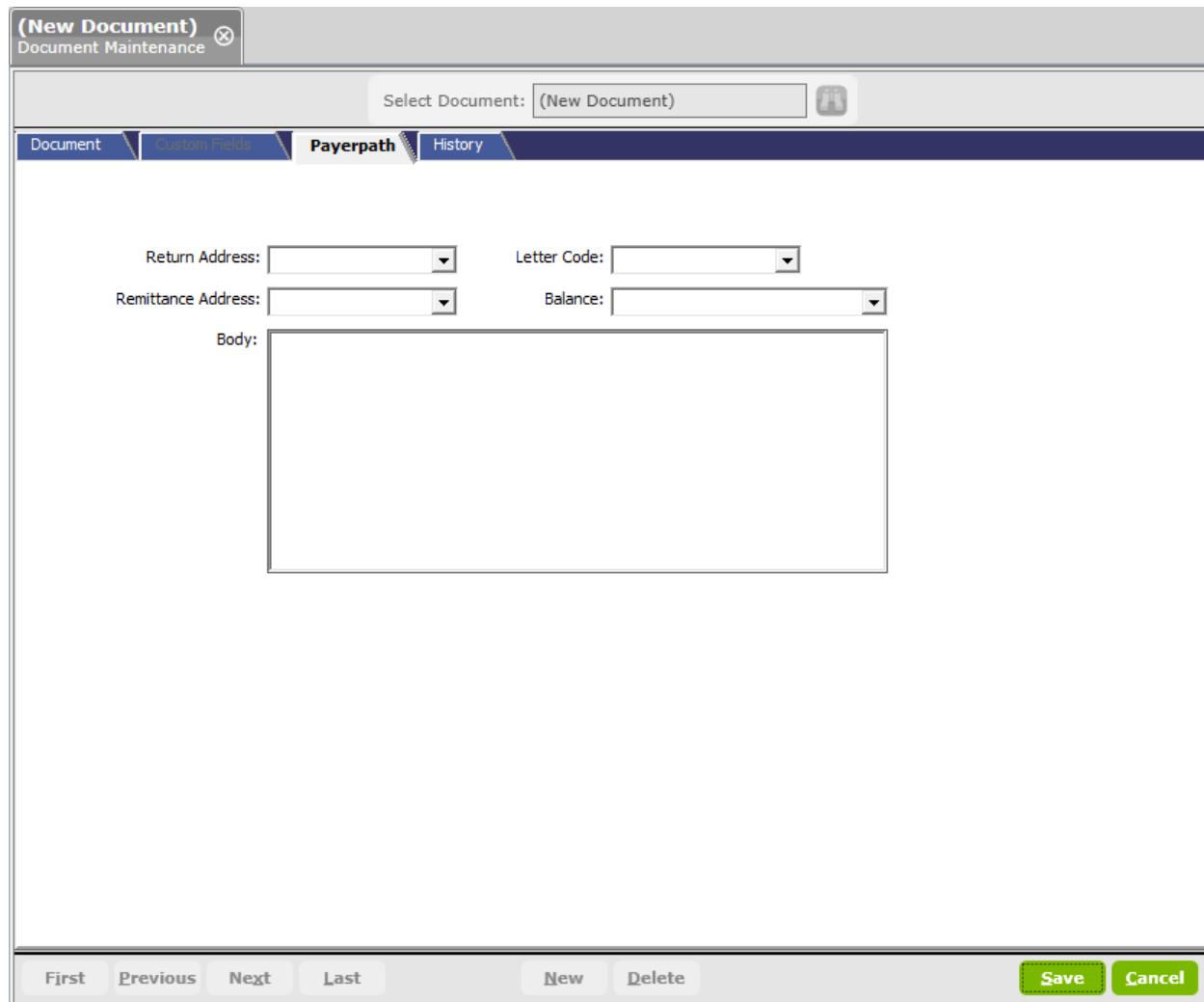


Payerpath® tab in Document Maintenance

Use the **Payerpath** tab in **Document Maintenance** to enter criteria to define the content for exported XML collection letters.

Access the **Payerpath** tab from **Document Maintenance**. To access **Document Maintenance**, go to **System Administration > File Maintenance > Document Maintenance** or press **F9** and then enter **DOM**.

Note: The **Payerpath** tab is available only if **XML** is selected in **Document Type** on the **Document** tab.



The screenshot shows the Allscripts Document Maintenance screen with the Payerpath tab selected. At the top, there's a header bar with the title '(New Document)' and a close button. Below the header is a toolbar with tabs: Document, Custom Fields, Payerpath (which is highlighted in blue), and History. A search bar says 'Select Document: (New Document)' with a magnifying glass icon. The main content area has four input fields: 'Return Address' and 'Letter Code' each with dropdown menus; 'Remittance Address' and 'Balance' each with dropdown menus. Below these is a large text area labeled 'Body' with a placeholder 'Body'. At the bottom, there are navigation buttons: First, Previous, Next, Last, New, Delete, Save (in a green button), and Cancel.

Return Address

Required. Select one of the following from the list to determine which address prints on the collection letter:

- > Practice
- > Practice Other
- > Division
- > Department
- > Department Other

Tenant configuration limits the **Return Address** selection options that can be exported successfully to the XML file. Selections are not filtered in **Document Maintenance**, so use the following options to ensure that information prints correctly on the collection letter:

- > If the tenant is configured by account, use **Practice** or **Practice Other**.
- > If the tenant is configured by department, use **Practice**, **Practice Other**, **Department**, or **Department Other**.
- > If the tenant is configured by division, use **Practice**, **Practice Other**, or **Division**.

Remittance Address

Required. Select one of the following options from the list to determine which address prints on the collection letter:

- > **Practice**
- > **Practice Other**
- > **Division**
- > **Department**
- > **Department Other**

Tenant configuration limits the **Remittance Address** selection options that can be exported successfully export to the XML file. Selections are not filtered in **Document Maintenance**, so use the following options to ensure that information prints correctly on the collection letter:

- > If the tenant is configured by account, use **Practice** or **Practice Other**.
- > If the tenant is configured by department, use **Practice**, **Practice Other**, **Department**, or **Department Other**.
- > If the tenant is configured by division, use **Practice**, **Practice Other**, or **Division**.

Letter Code

Required. The **Letter Code** indicates which collection letter format is used for this document. Select one of the following specific format collection letters from the list:

- > **First**
- > **Second**
- > **Final**
- > **Blank**

Note: If you select **Blank**, you must have an agreement arranged with Payerpath® to use a custom form.

Balance

Required. Select one of the following account balance values from the list to be added to the collection letter :

- > **Account Self-Pay Balance**: Prints the balance of the account from self-pay vouchers (that is, current and past self-pay balance total).

- > **Account Self-Pay Balance Past:** Prints the balance of the account from self-pay vouchers that have an age greater than the selection in **Accounts with Self-Pay Balance Over** in **Work Queue Maintenance** (that is, self-pay balance that is past due).
- > **Account Self-Pay Balance Current:** Prints *Account Self-Pay Balance - Account Self-Pay Balance Past* (that is, self-pay balance that is current).
- > **Budget Amount:** Prints the budget amount for the account (**Budget Amount** is displayed in **Budget**, accessed from **Account Ledger**).

Body

Required. Enter the text that is sent in the collection letter. This box accepts unlimited letters and numbers.

Note: A one-page collection letter allows 15 lines of text with 100 characters on each line. The collection letter generates additional pages if you enter more than that amount in **Body**.

Do not include a salutation in the text. The guarantor's salutation is included in the XML file and is displayed in *First Name Last Name* format.

The text box wraps the text automatically when it reaches the end of a line in the text box. When letters are printed, wrapped lines read as a continuous paragraph. A carriage return creates a new line of text directly below the previous line of text when the letter is printed. You cannot create blank lines of text or indent text on the printed collection letter.

Note: Special characters such as <, &, ", and ' are supported by the XML format when entered in **Body**.

Chapter 11

Administration

Security Maintenance setup checklist

Use this checklist to record the completion of each maintenance record related to security permissions. These security-related items enable you create user accounts, set defaults, and manage which tenants and application areas various users and groups of users have access to.

Maintenance	Completed
Security Group Maintenance (SGM)	
Tenant Maintenance (TRM)	
Permission Group Maintenance (GRM)	
User Maintenance (USM)	
Operator Maintenance (OPM)	
Operator Group Maintenance (OGM)	
Security Permissions in Administration	
Security Options in Administration	

Security Permissions

Security permissions help secure your workstations and provide management oversight of user access to your data.

You can define security permissions for Allscripts® Practice Management (**Practice Management**, **Office Manager**, and **Administration** functions), and Allscripts® Interface Engine. If you have multiple tenants, define security permissions for each tenant. The settings in **Security Options** apply to all tenants.

With a few exceptions, all users and groups have access to all functions by default. Use **Administration > Security Manager > Security Permissions** to restrict access to various areas of the application to selected users and groups.

Note: You must enter full names, logon names and passwords in **Administration > Security Manager** even when all of your users retain full security access to all functions in Allscripts® Practice Management and Allscripts® Interface Engine.

Security permissions are associated with operators in Allscripts® Practice Management. A user must enter the logon name and password assigned in **Administration > Security Manager** to log on to Allscripts® Practice Management and Allscripts® Interface Engine. The association between the logon and the operator record is what the application uses to stamp the records created and edited in **Patient Management**, **Financial Processing**, **Scheduling**, and so on. This logon name is also written to the audit log table.

Best practice is to draw up a list of users and then divide them into groups by tasks. Use this list to create your security groups and to define the security permissions for each group. Security permissions are assigned by groups or individual users. You also have the flexibility to override specific group privileges for a user in **Security Permissions**.

Security Options window

Security Options enables you to set global parameters that apply to all users.

Use the **User Override Settings** in **User Maintenance** to create any exceptions to these general rules.

Each option has a program default. The list provided here includes the default setting.

As indicated, some options are disabled when you select **Enable Active Directory Integration**.

Security Options contains the **General** tab.

To access **Security Options**, go to **Administration > Security Manager > Security Options** or press **F9** and then enter **SOP**.

General tab in Security Options

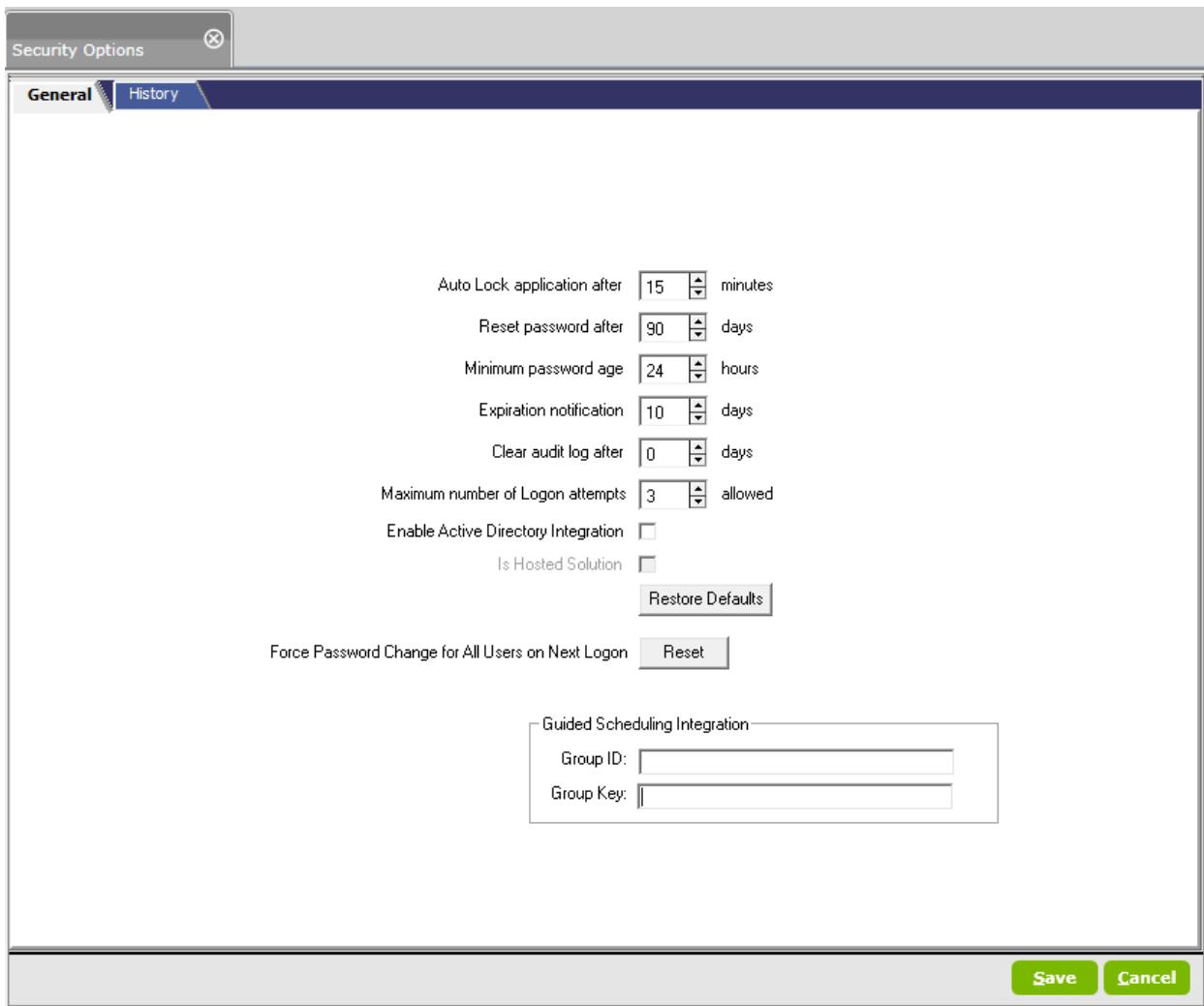
The **General** tab in **Security Options** enables you to set global parameters that apply to all users.

Use the **User Override Settings** in **User Maintenance** to create any exceptions to these general rules.

Each option has a program default. The list provided includes the default setting.

Where indicated, some options are not available when you select **Enable Active Directory Integration**.

Access the **General** tab from **Security Options**. To access **Security Options**, go to **Administration > Security Manager > Security Options** or press **F9** and then enter **SOP**.



Auto Lock Application after

This option governs when a user's application automatically locks due to inactivity. Automatic locking occurs when no one enters data in Allscripts® Practice Management or uses any other windows in the application for a designated number of minutes. Use **Auto Lock Application after** to control how long a user must be inactive before Allscripts® Practice Management locks.

Valid values for **Auto Lock application after** are **0** through **90** minutes.

The default value is **15** minutes. Enter **0** if you do not want the application to lock automatically.

Reset password after

Unavailable when **Enable Active Directory Integration** is selected.

When enabled, governs how often users must change their password. Using the default, users would be required to change their password every 90 days.

Based on the setting, the application counts to the number of days in any of the following circumstances:

- > from the day you install your application
- > a password is entered in **User Maintenance**
- > a user changes his or her password

You can override this setting for 1 or more specific users in **User Maintenance**.

Valid entries are 1 to 90.

Minimum password age

Not available when **Enable Active Directory Integration** is selected.

When enabled, determines the least amount of time before a user can change his or her password again.

The default entry is 24, preventing users from changing their password unless it is more than 24 hours since the last time they changed their password.

Reset password after determines the maximum amount of time you can use a password, **Minimum password age** determines the minimum amount of time. For example, if you change your password on Monday at 10am, you cannot change your password again until Tuesday after 10am.

Valid entries are 24 to 168 (1 day to 7 days).

Expiration notification

Not available when **Enable Active Directory Integration** is selected.

When enabled triggers a series of notifications xx number of days prior to the expiration of a user's password.

The default is set at 10, meaning that users begin to be notified 10 days prior to the time their password expires.

For example, if **Reset Password After** is set to 90 days and the expiration notification is set for 10 days, then at 80 days when the user logs on to an Allscripts® Practice Management application, the following notification is displayed:

Your password will expire in 10 days. Do you want to change your password? Yes
No

If the user clicks, **Yes** then **Change Password** is displayed.

If the user clicks **No**, then the process of logging on continues.

Until the user changes the password, the notification count indicates how many days left until the password expires.

If the notification count is equal to zero or the logon is taking place after the expiration date, then the user is forced to change password in order to enter the application.

Clear audit log after

Each time a user logs on to a tenant or switches tenants within the application, logs on directly to the **Administration** function, or logs on to Allscripts® Interface Engine, an entry is made in the database.

The default setting triggers the clearing of the logging table every 0 days, which means that the table is not ever scheduled to be cleared.

Valid entries are 0 to 255 days or 7 years.

If you enter a number other than 0, the application runs a clean up job on Saturday at 3:00 am based on the number of days you entered. For example, if you enter 255, then the logging table is cleared every 255 days on a Saturday at 3am.

Note: The Microsoft® SQL Server® Agent must be running for this job to run, and the job must have an owner assigned to it with full permissions to access the security database.

The audit log tracks these items for the **Administration** and **Practice Management** modules in Allscripts® Practice Management, and Allscripts® Interface Engine.

- > Logon date and time
- > User's Allscripts® Practice Management application logon name
- > Workstation logged on to
- > User's Windows® logon name

The **Audit Log Listing** is available under **System Administration > File Listings**. This listing enables you to print the audit log information grouped within **Administration**, **Interface Engines**, and **Practice Management** headings.

Maximum number of Logon attempts *nn* allowed

Enables you to configure the upper limit for logon attempts so that users do not receive a forced lock after 3 unsuccessful logon attempts. The lowest number of logon attempts permitted is 3. The highest number of logon attempts permitted is 25.

Enable Active Directory Integration

When selected, your organization's Microsoft® Active Directory is used to authenticate a user's access into any Allscripts® Practice Management application.

Thus, a user's credentials when logging on to Allscripts® Practice Management are validated against the user's account in your Microsoft® Active Directory, which enables users to log on to an Microsoft® application without having to enter a user name and password on the log on window.

When Microsoft® Active Directory is used, all Allscripts® Practice Management built-in password features are unavailable.

All security options, with the exception of 2, are unavailable and no longer apply. The 2 exceptions are: (1) Auto **Auto Lock Application after 10 minutes** and (2) **Clear audit log after 0 days**.

Important: Prerequisites apply and extensive setup is involved.

Before selecting this option, please read the other related Help topics.

Is Hosted Solution

This check box, which indicates that your Allscripts® Practice Management application is hosted by Allscripts®, is read-only and for Allscripts® internal use.

Restore Defaults

Unavailable when **Enable Active Directory Integration** is selected.

When enabled and you click **Restore Defaults**, the selection in each spin box is changed to its programmed default setting.

All of your custom settings are cleared and all of the settings revert to the default.

Force Password Change for All Users on Next Logon

This option is unavailable when you have **Enable Active Directory Integration** selected.

When available and selected and you click **Save**, users are required to change their password the next time they log on to Allscripts® Practice Management or Allscripts® Interface Engine, whichever occurs first.

After the user successfully changes his or her password, the following happens:

- **Force Password Change for All Users on Next Logon** is automatically cleared on the user's **User Maintenance** record.
- The application begins a new count down to the day when the user begins to receive a change password reminder based on the setting for **Expiration notification**.

Note: Use **Force Password Change on Next Logon** as an override to the minimum required age of a password when a user locks his or her account and the minimum age requirement has not been met.

Guided Scheduling Integration

Group ID and Group Key

Enter the information provided by Allscripts® in conjunction with the software analytics service that is supported by Allscripts® Practice Management for guided scheduling.

Important: In addition to entering the group ID and group key in **Security Options**, you must enter the URL, client ID, and client key on the **External Access (2)** tab in **Practice Options** or **Organization Options**. You cannot successfully test the guided scheduling connection or enable guided scheduling until you have entered the URL, client ID, client key, group ID, and group key.

The group key will expire after 181 days. Within the 30-day period before the group key expires, Allscripts® Practice Management automatically updates **GroupKey** whenever an application server attempts to access the software analytics service. If an application server attempts to access the software analytics service after the group key expires, the following message is displayed: **Unable to Authenticate. Group Key may have expired.** If this occurs, contact an Allscripts® support representative.

Automatically locking Allscripts Practice Management

Automatic locking occurs when no one enters data in Allscripts® Practice Management or uses any other windows in the application for a designated number of minutes. Use **Auto Lock Application after** to control how long a user must be inactive before Allscripts® Practice Management locks.

Auto Lock Application after is on the **General** tab under **Security Options** in **Administration > Security Manager**. It is available regardless of whether you enable Microsoft® Active Directory® Integration.

Important: An open, locked Allscripts® Practice Management tenant constitutes the use of one of your practice or organization licenses.

Valid values for **Auto Lock application after** are **0** through **90** minutes.

The default value is **15** minutes. Enter **0** if you do not want the application to lock automatically.

Auto Lock Application after is a global setting: that is, it applies to all users. To override the global setting for an individual user, set **Auto Lock Application after** in **Administration > Security Manager > User Maintenance**. All users must have an automatic locking time associated with their Allscripts® Practice Management logon name. Values 0-90 are accepted.

When a function such as validating claims, importing remittance files, transferring accounts to collections, running a report, and so forth, exceed the parameters set and is the only activity occurring on the workstation, the auto lock is still triggered. However, the function itself continues to run in the background.

What happens when the application locks?

When Allscripts® Practice Management automatically locks after a period of inactivity, the entire computer screen turns white and the Allscripts® Practice Management logon window is displayed.

Password is the only entry box that is enabled, and the current user's password is required to unlock the application. Other users who need to access the application must start their own sessions.

Running an interface

Because of VB6 limitations, workstations running interfaces do not immediately respond to the auto-lock command. These workstations will not auto-lock while running an interface. The command to lock the workstation is held and is started after the interface stops running.

Unlock a local or network-connected workstation

If you are on a local or network-connected workstation that is locked due to inactivity, press **CTRL+ALT+DEL** and enter your password to unlock the workstation.

When you workstation locks, the following message displays if you are using a local or network-connected workstation: This computer is in use and has been locked. Only *Domain Name\User Name* or an administrator can unlock this computer. Press Ctrl+Alt+Del to unlock this computer.

1. On your keyboard, press **CTRL+ALT+DEL**.

A new window opens with the **User Name** box filled automatically and the **Password** box blank.

2. For **Password**, enter your password.
3. Click **OK**.

Results of this task

Your workstation is now unlocked and you may resume your work.

Unlock a workstation using a terminal services session

If you are on a workstation using a terminal services session and your workstation is locked due to inactivity, press **CTRL+ALT+DEL** and enter your password to unlock it. You can also enter the username and password of a user with full administrative rights.

When you workstation locks, the following message displays: This computer is in use and has been locked. Only *Domain Name\User Name* or an administrator can unlock this computer. Press Ctrl+Alt+Del to unlock this computer. The window also includes the boxes **User Name** and **Password**.

User Name is automatically filled with the name used when logging onto the workstation. You can only unlock the workstation by entering the user's matching password or entering the name of a user with full administrative privileges.

1. On your keyboard, press **CTRL+ALT+DEL**.
2. For **User Name** accept the default or enter the name of a user with full administrative rights.

3. For **Password** enter the password which matches the user name.
4. Press **Enter** or click **OK**.

Results of this task

Your workstation is now unlocked and you may resume your work.

Change your password

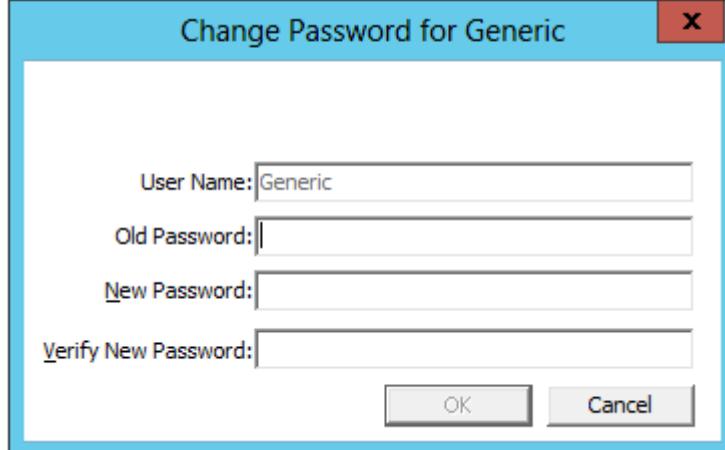
You can change your Allscripts® Practice Management password on demand using **Change Password**.

Note: The option to change your Allscripts® Practice Management password on demand is not available when you have Active Directory Integration enabled.

You are prompted to change your password in these cases:

- > Your password has expired and you are logging on to Allscripts® Practice Management.
 - > Your practice or organization administrators used the reset function, which requires you to change your password on your next logon.
 - > You clicked **Change Password**  on the toolbar to change your password at a time determined by you.
1. If you were not prompted by the application to change your password, click  on the toolbar and select **Change Password**.

Change Password for [user name] opens.



2. Enter the applicable data in each box.

Your new password must be different from your existing password.

The characters you enter are displayed as asterisks, which makes it impossible for others to see your password as you type.

Note: Your password is case-sensitive. After you successfully change your password, when logging on, you must enter the password exactly as you entered it in this window.

3. Press **Enter** or click **OK**.

A message opens that reads Your password has been changed.

4. Press **Enter** or click **OK**.

Results of this task

Allscripts® Practice Management begins a count down to when your new password expires, based on the setting for **Reset password after xxx days** in **Administration > Security Manager > Security Options**.

Permission Group Maintenance window

Permission groups are groups of users who perform common tasks. You can assign certain groups to have access only to selected areas of the application.

Note: This window was called **Group Maintenance** before version 15.0.

Permission Group Maintenance contains these tabs:

- > **Permission Group Maintenance**
- > **History**

To access **Permission Group Maintenance**, go to **Administration > Security Manager > Permission Group Maintenance**, or press **F9** and then enter **GRM**.

Permission Group Maintenance tab

Sample permission groups are Administration, Billing, Scheduling, Reception, and Billing Management.

Tip: Create a permission group called **Inactive** that can be used for former employees. Access to all functions should be denied for all members of this permission group.

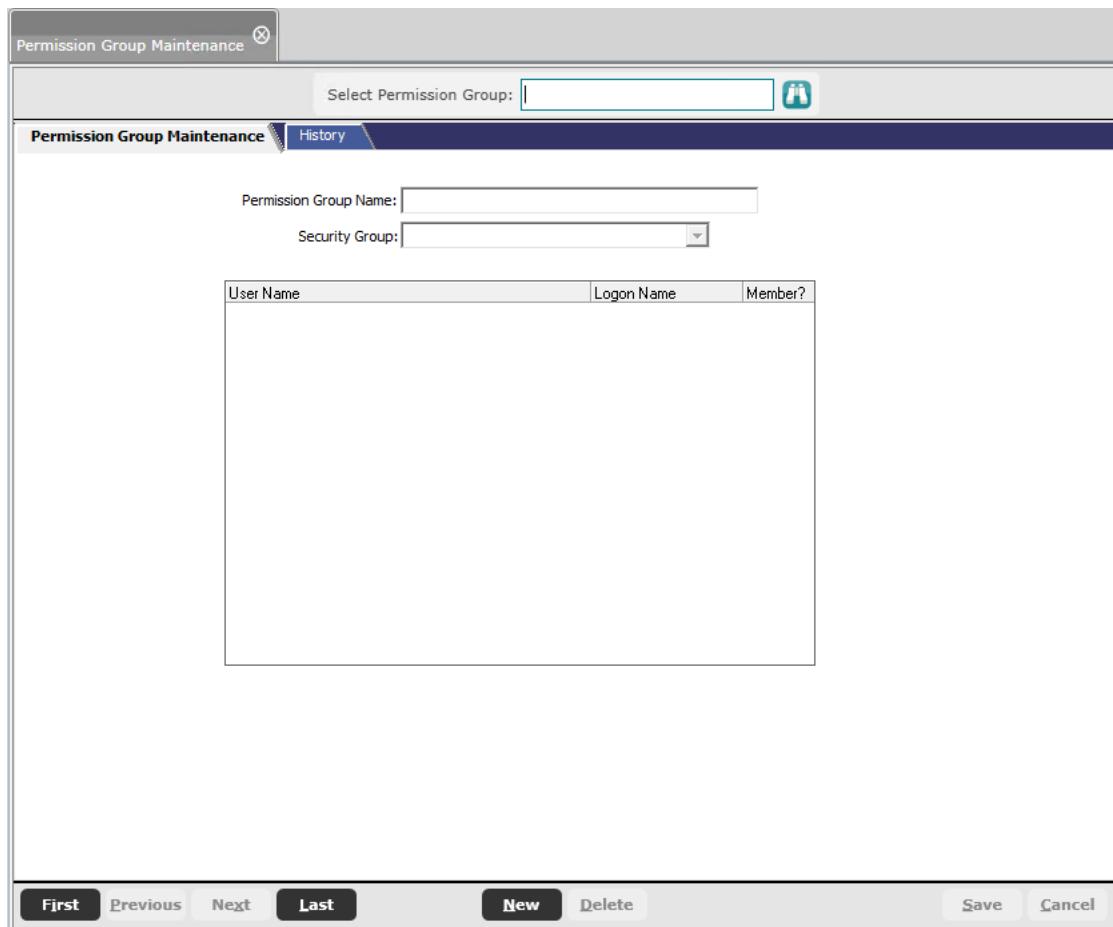
The list of current users is displayed in the grid. Additional user records are defined in **User Maintenance**. Permission groups and users have full permissions to access all functions except the **Administration** function until you limit the access in **Security Permissions**. Only permissions

groups that are members of the ADMINISTRATION security group have access to the **Administration** function.

You can add or remove a current user from a permission group either from **Permission Group Maintenance** or from **User Maintenance**. Create permission groups that apply to your practice organization structure and workflow. As you add staff members as users, assign each to 1 or more permission groups.

Note: Each permission group can only be associated with 1 security group. You can have duplicate permission group names as long as they are in different security groups. You cannot create duplicate permission groups in the same security group.

To access **Permission Group Maintenance**, go to **Administration > Security Manager > Permission Group Maintenance**, or press **F9** and then enter **GRM**.



User Name	Logon Name	Member?

Permission Group Name

Accepts up to 50 characters.

The permission group name displays in the grid in **User Maintenance** and in **Security Permissions**.

Security Group

Select a security group. Each permission group can only be associated with 1 security group. The security group determines which tenants the permission group is associated with.

Member column in the grid

Select the check box to make the user a member of the permission group.

User Maintenance window

Everyone in your organization who will access Allscripts® Practice Management or Allscripts® Interface Engine must have a user record created in **User Maintenance** with a logon name and password. On each tenant that a user has access to, their user record is associated with an operator record in **Operator Maintenance**.

Note: Use **User Maintenance** when you have NOT selected **Enable Active Directory Integration** on the **General** tab in **Security Options**.

To access **User Maintenance**, go to **Administration > Security Manager > User Maintenance**. Or, press **F9**, then enter **USM**.

Important: You must have permission to access **User Maintenance** assigned in **Administration > Security Manager > Security Permissions**.

User Maintenance contains the following tabs:

User Maintenance tab

Use the **User Maintenance** tab to edit a user's:

- > Security options
- > Logon credentials and settings
- > Tenant access
- > Permission group membership

Security Group Membership tab

Use the **Security Group Membership** tab to add users to or remove users from security groups.

History tab

The **History** tab for **User Maintenance** is always enabled. Data on the **History** tab for **User Maintenance** is recorded by logon user and stored in your security database. Use this tab to view changes made to a user record.

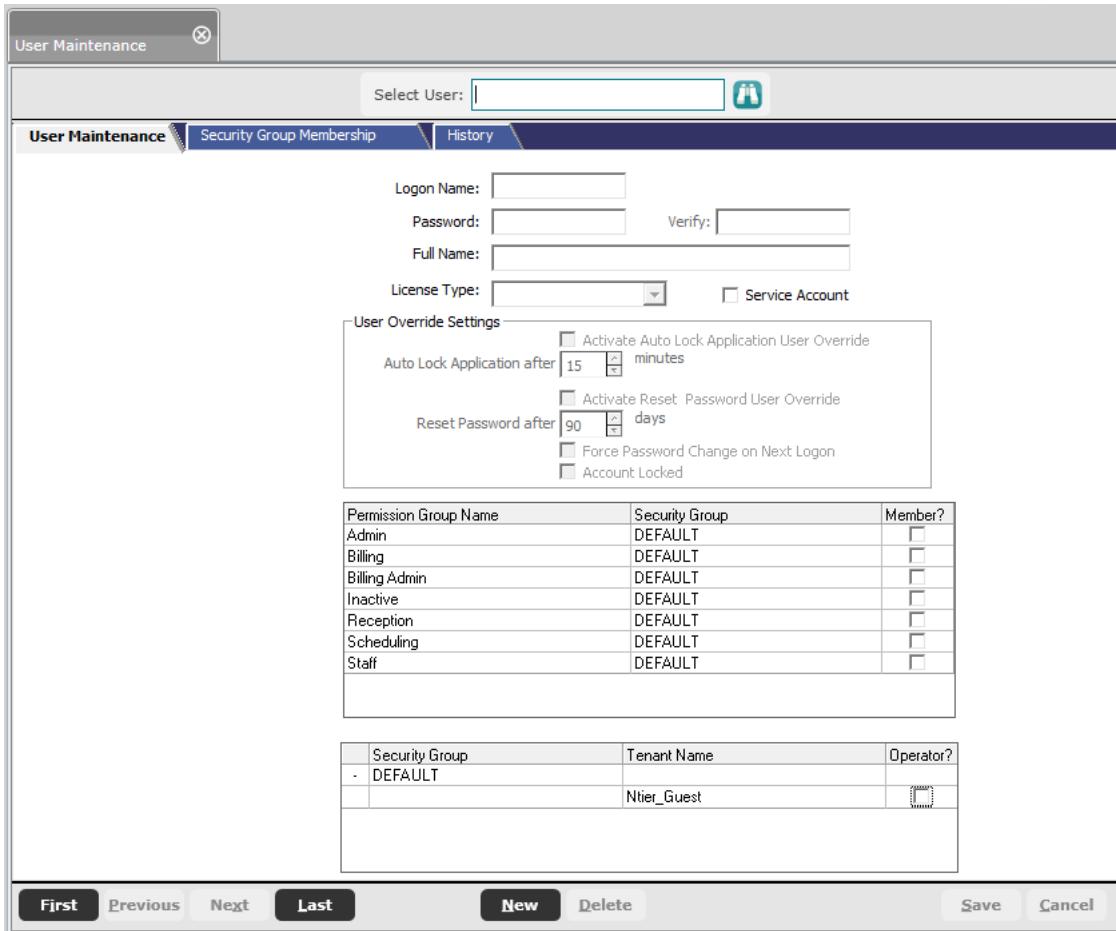
User Maintenance contains the following three tabs.

User Maintenance tab

Use the **User Maintenance** tab on **User Maintenance** to manage or create user records.

Access the **User Maintenance** tab from **User Maintenance**. To access **User Maintenance**, go to **Administration > Security Manager > User Maintenance**.

Tip: To quickly access **User Maintenance**, press **F9**, then enter **USM**.



The screenshot shows the User Maintenance application interface. At the top, there's a search bar labeled "Select User:" and a magnifying glass icon. Below the search bar is a navigation bar with tabs: "User Maintenance" (selected), "Security Group Membership", and "History".

The main area contains several input fields and dropdown menus:

- "Logon Name:" input field
- "Password:" input field and "Verify:" input field
- "Full Name:" input field
- "License Type:" dropdown menu
- "Service Account" checkbox

Below these fields is a section titled "User Override Settings" with the following options:

- "Activate Auto Lock Application User Override" checkbox
- "Auto Lock Application after" dropdown menu set to 15 minutes
- "Activate Reset Password User Override" checkbox
- "Reset Password after" dropdown menu set to 90 days
- "Force Password Change on Next Logon" checkbox
- "Account Locked" checkbox

There are two tables below the override settings:

Permission Group Name	Security Group	Member?
Admin	DEFAULT	<input type="checkbox"/>
Billing	DEFAULT	<input type="checkbox"/>
Billing Admin	DEFAULT	<input type="checkbox"/>
Inactive	DEFAULT	<input type="checkbox"/>
Reception	DEFAULT	<input type="checkbox"/>
Scheduling	DEFAULT	<input type="checkbox"/>
Staff	DEFAULT	<input type="checkbox"/>

Security Group	Tenant Name	Operator?
- DEFAULT	Ntier_Guest	<input type="checkbox"/>

At the bottom of the screen are navigation buttons: "First", "Previous", "Next", "Last", "New", "Delete", "Save", and "Cancel".

User Information

Select User

Enables you to search for existing user records. Click  (the binoculars icon), or with the cursor placed in the box, press **ALT + down arrow** to open the search window.

Logon Name

The logon name is the name that the user enters when logging on to Allscripts® Practice Management and Allscripts® Interface Engine.

Tip: When you create a new operator record, the first 8 characters of the value in **Logon Name** automatically fill **Abbreviation** on the **Operator** tab in **Operator Maintenance**. To have the entire logon name show in **Operator Maintenance**, best practice is to limit **Logon Name** to 8 characters.

This box is filled differently depending on whether you selected **Enable Active Directory Integration** on the **General** tab under **Security Options**.

Without Active Directory Integration

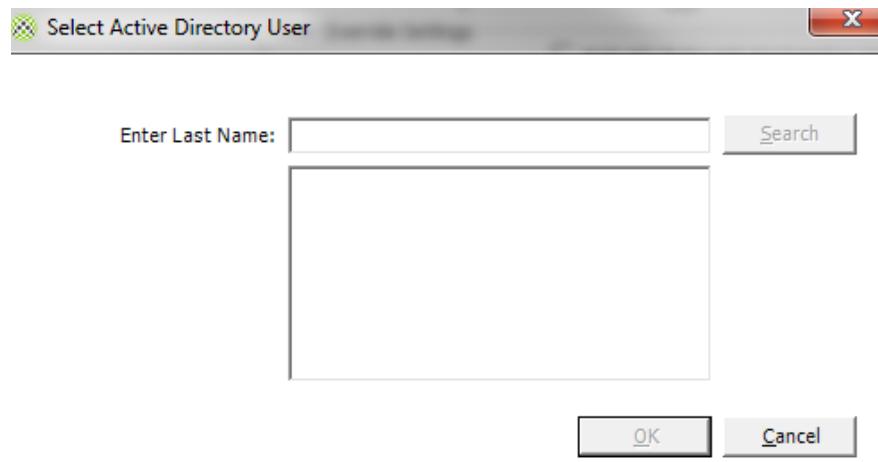
You must manually enter the name the user would enter to log on.

With Active Directory Integration

You must search your Microsoft® Active Directory® and bring in the user's Microsoft® Windows® log on name. To do this, click **Active Directory Lookup** (or with the cursor placed in the box, press **ALT + A**).

Note:

Active Directory Lookup is not displayed when Active Directory® Integration is not enabled.



Use this to search for the user's Windows® log on name. The more precise you are, the more specific the search results. For example, if you enter **Kerry**, your results would include users with a first or a last name of Kerry. If you enter **Kerry, M**, the results would include any user with the last name of Kerry and a first name which begins with M.

When the results are returned in the grid, click on your selection in the grid. The user's logon name fills the box on **User Maintenance**. For instance, if you select **Kerry, M (KMAN)**, the logon name is **KMAN**.

Password

Not available when Microsoft® Active Directory® Integration is enabled.

When enabled all of the following apply:

- > Is a required field
- > Holds up to 20 characters
- > An asterisk displays for each character you type
- > Your password must been these guidelines:
 1. Contains at least eight characters
 2. Has not been used by the User for any of his or her last 10 previous passwords
 3. Contains three of the following four character combinations:
 - Uppercase characters (A -Z)
 - Lowercase characters (a -z)
 - Numerals (0 - 9)
 - Characters (such as but not limited to: !, \$, #, %, ~,) - these are any of the 32 non-alphabetic and non-numeric characters on your computer's keypad

Verify

Not available when Microsoft® Active Directory® Integration is enabled. When enabled, you must enter the user's password exactly as you entered it in **Password**. If your entry does not match the entry in **Password**, the message **The entry made to verify your password does not match the password. Please re-verify your password.** is displayed.

Full Name

Enter the user's full name. You can use up to 50 characters. Displays in **Permission Group Maintenance** and **Security Permissions**.

License Type

Intended for use by clients who have 2 or more unrelated Allscripts® Practice Management tenants that share the same server to enable assigning of licenses on a per tenant basis.

The default setting is **Unrestricted**. This setting should only be changed by clients defining licenses by Allscripts® Practice Management tenant when they have a user or users who must be restricted from logging in to 1 or more of the Allscripts® Practice Management tenants on their server.

You must select one of the following:

Restricted

Enables the user to log on to an Allscripts® Practice Management application as long as maximum the number of assigned licenses for that tenant has not been reached.

Unrestricted

Enables the user to log on to an Allscripts® Practice Management application even when the maximum number of assigned licenses for that tenant has been reached, if the overall maximum number of licenses for the entire organization has not been reached.

Service Account

Select this check box to create a service account user that supports the use of a passphrase. When this check box is selected, the following applies to the service account user:

- > A passphrase is required instead of a single password.
- > The passphrase must be a combination of at least 3 words separated by a space. Each word must be at least 6 characters, and the length of the passphrase including spaces must be at least 20 characters. Repeated words and the word 'password' or substitutes for 'password' are not permitted. The use of special characters, uppercase characters, and numeric characters are valid but not required.
- > The passphrase does not expire.
- > The passphrase can be changed but not until a minimum of 24 hours have passed. Before a previous passphrase can be re-used, the passphrase must be changed at least 10 times.
- > The logon name cannot be used to log on to Allscripts® Practice Management.
- > **Account Locked** is the only option that is enabled in the **User Override Settings** area in **User Maintenance**.
- > The service account user is visible in **Security Permissions**, **Security Group Maintenance**, **Permission Group Maintenance**, and **Operator Maintenance**.
- > A service account cannot be changed to a non-service account. To deactivate a service account, select **Account Locked** or remove the security permissions.
- > The service account user supports non-trusted applications through Unity.

User Override Settings

Activate Auto Lock Application User Override

Select this check box to enable **Auto Lock Application after**, which you can use to override the default timeout for this user only.

Auto Lock Application after

Enabled only after you select **Activate Auto Lock Application User Override**. Use this box to override the default timeout for this user only. (The default application timeout is set on the **General** tab in **Security Options**.) The number you enter should differ from the global setting. Valid values are **0** through **90** minutes. The default value is **15** minutes. Enter **0** if you do not want the application to lock automatically.

Activate Reset Password User Override

This override is not available when you have enabled Active Directory® Integration. When the check box is enabled, you can use this override to change when this user must change his or her password.

Selecting **Active Reset Password User Override** enables **Reset Password after**. Use **Reset Password after** to enter the number of days after which this user's password will expire.

The number you enter should be different from the global setting and must be equal to or less than 90.

Force Password Change on Next Logon

This option is not available when you have enabled Active Directory® Integration. When available and selected and you click **Save**, the user is required to change his or her password the next time he or she logs on to either Allscripts® Practice Management or Allscripts® Interface Engine.

After the user successfully changes his or her password, the following occurs:

1. This check box is automatically cleared.
2. The application begins a new count down to the day when the user begins to receive a change password reminder based on the setting for **Expiration notification** on the **General** tab in **Security Options**.

Important: When **Force Password Change on Next Logon** is selected and the user who has changed his or her password will be able to change password before the minimum required time has been met. But this override applies only once during the prescribed period.

Account Locked

This option is not available when Microsoft® Active Directory® Integration is enabled.

When this option is available and selected, the user's account is locked, and the user is unable to log on to Allscripts® Practice Management.

This box is automatically selected when the user exceeds the maximum number of logon attempts defined in **Security Options**, or the user attempts to reset his or her password but is unable to answer the security questions after 2 attempts.

A system administrator can use this option to manually lock an account.

Permission group grid

The first grid on **User Maintenance**, the permission group grid, controls which permission groups the user in **Select User** is a member of. The permission group grid has 3 columns: **Permission Group Name**, **Security Group**, and **Member**.

Rows in the permission group grid are displayed alphabetically by permission group name.

Permission Group Name

This column lists all of the permission groups that the logon user (that is, you) has permissions to see. The user whose record you are viewing might or might not be a member of all of the permission groups listed. Permission groups are listed alphabetically first by security group and then by permission group.

Security Group

This column lists the security group that each permission group is a member of.

Member

Select a check box to give the user selected in **Select User** access to the permission group listed in that row.

Tenant grid

The second grid on **User Maintenance**, the tenant grid, controls which tenants the user in **Select User** is a member of. The tenant table has 3 columns: **Security Group**, **Tenant Name**, and **Operator**.

Rows in the tenant grid are displayed alphabetically by security group name.

Security Group

This column lists the security group that each tenant is a member of. Click the plus sign (+) to show the tenants that belong to that security group.

Tenant Name

This column lists all of the tenants that the logon user has permissions to see.

Operator

Select a check box to give the user selected in **Select User** access to the tenant listed in that row.

Security Group Membership tab in User Maintenance

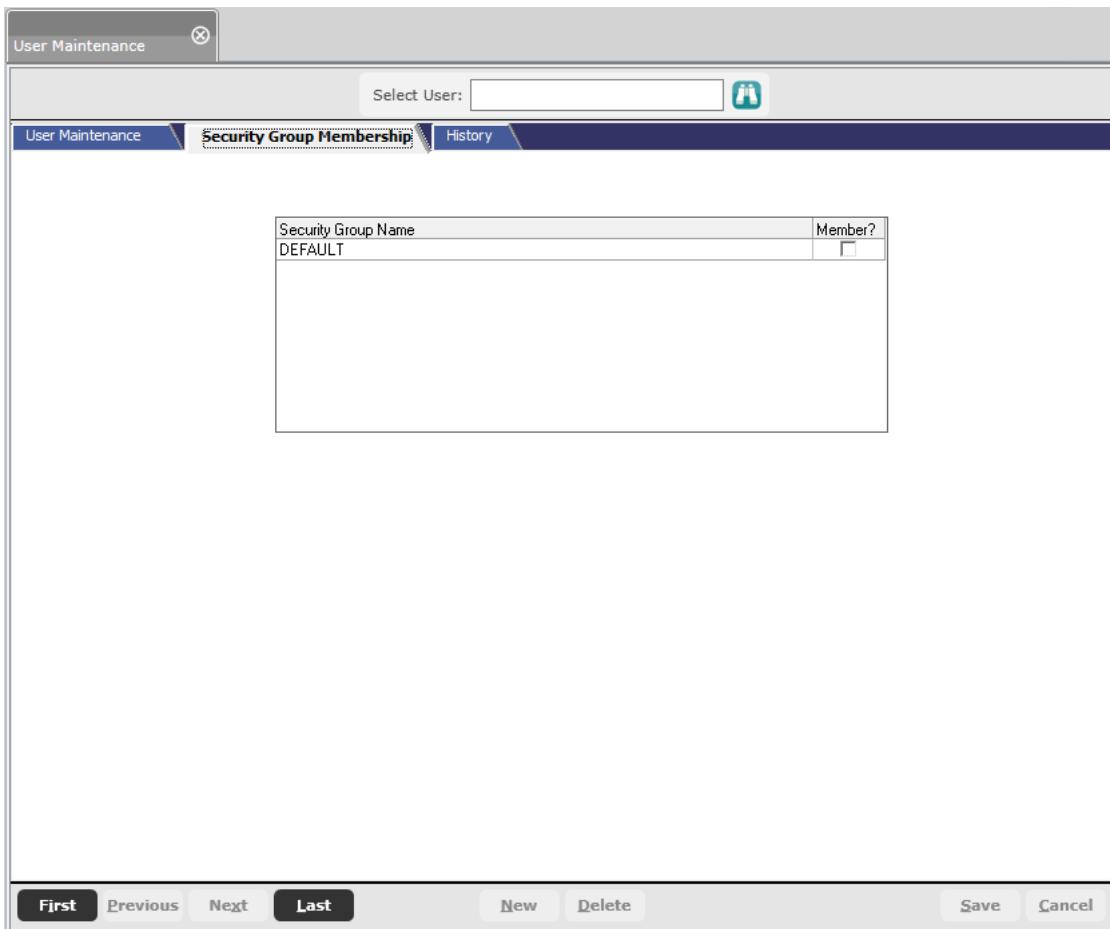
Use the **Security Group Membership** tab in **User Maintenance** to control which security groups a given user is a member of.

Users are members of security groups. When you upgrade to version 15.0 or later, existing users in a given security group has access to all tenants in that security group by default. A user must be a member of at least 1 security group, but can be a member of as many security groups as necessary. You can also assign users different security permissions in each security group they are a member of. For example, you might give a user access to **Administration** in only 1 of the security groups the user is a member of.

When you create new user records after your upgrade, they are not automatically assigned to tenants. User records created after the upgrade must be manually associated with security groups and tenants.

Note: You can also control user membership in security groups from the **Security Group Membership** tab in **Security Group Maintenance**.

Access the **Security Group Membership** tab from **User Maintenance**. To access **User Maintenance**, go to **Administration > Security Manager > User Maintenance** or press **F9** and enter **USM**. You must have permission to access **User Maintenance** assigned in **Administration > Security Manager > Security Permissions**.



Security Group Name

A list of all of the security groups you have access to.

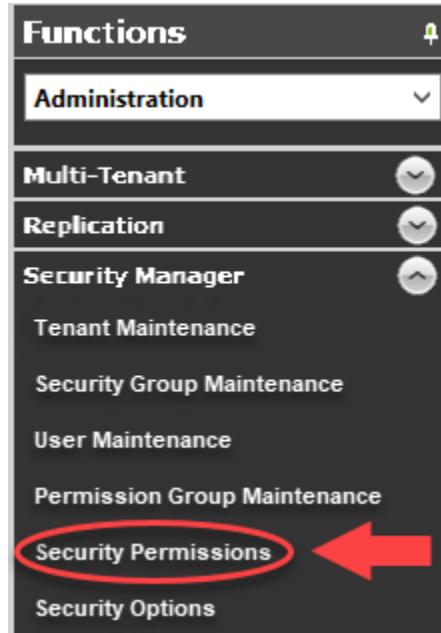
Member

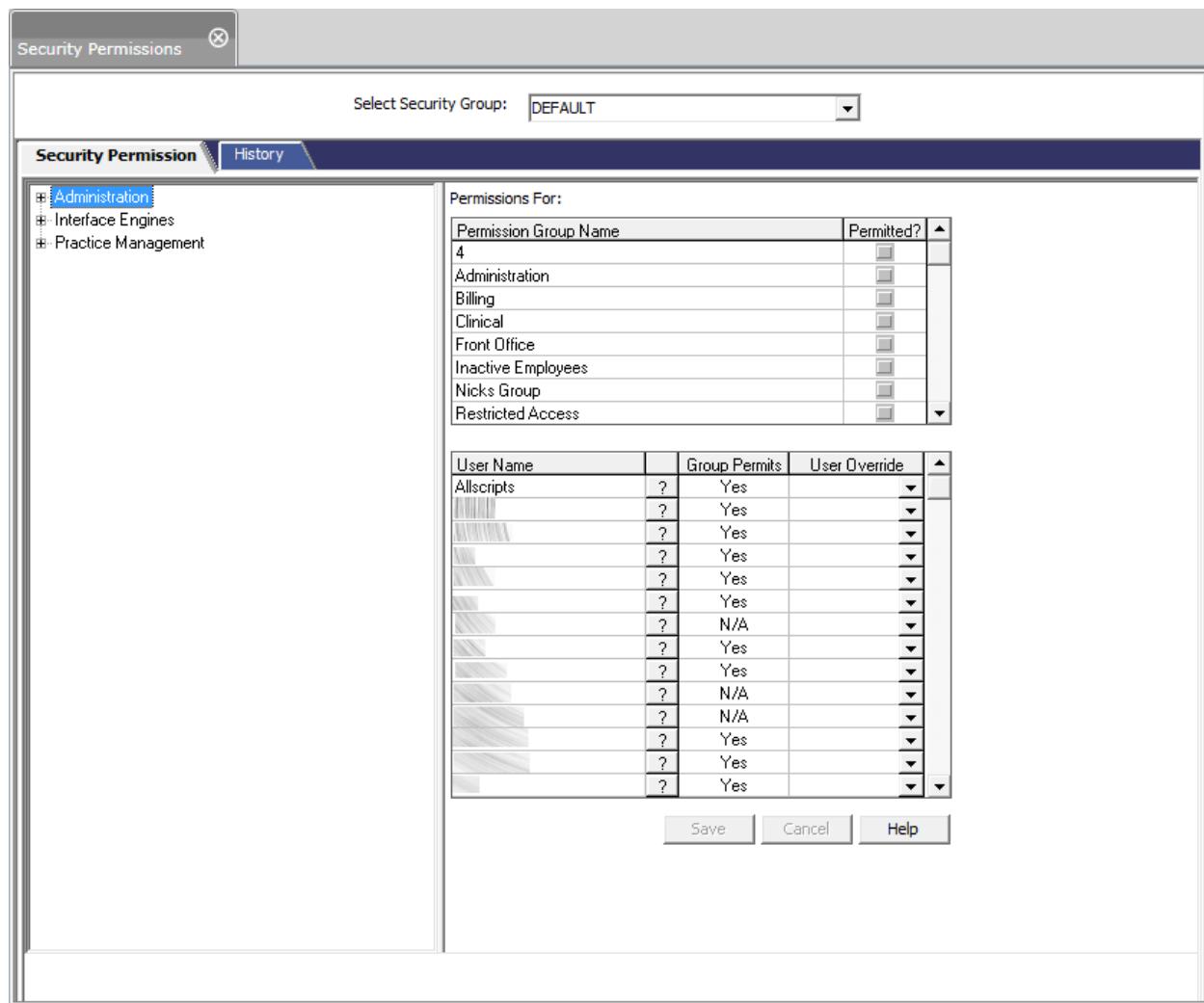
Select the check box in this column to make the current user a member of the security group in the associated column.

Security Permissions window

Use this area to assign security permissions. Security permissions control which users and groups of users have access to the different areas of Allscripts® Practice Management. With a few exceptions, users have access to all areas by default. You can assign users different security permissions in each security group they are a member of.

To access **Security Permissions**, go to **Administration > Security Manager > Security Permissions** or press **F9** and then enter **SEP**.





Select Security Group search box

Before you can set any permissions, you must use the **Select Security Group** box at the top of **Security Permissions** to select a security group. The rest of the window fills with the permission groups and users associated with that security group, and you can proceed with setting or editing permissions for them.

Tip: You can assign the same user different security permissions in each security group the user is a member of. For example, you could give a user access to **Administration** in Security Group A and deny the user access to **Administration** in Security Group B.

The tree in the left pane displays the major function areas you can restrict access to: the **Administration** area in Allscripts® Practice Management, Allscripts® Interface Engine, and Allscripts® Practice Management.

Click **+** to the left of a function area to expand the tree. Expand down to the most specific level of functionality you feel is necessary to apply restrictions.

As you highlight each function area in the left pane, the right pane synchronizes to display the current status for access associated with each permission group and user within the security group.

Note:

- > **N/A** by a user name indicates that the user was not assigned to a group.
- > **Administrative Notes**, **Clinical Notes**, and **Employer Notes** under **Practice Management > Workers' Comp Case** are custom settings. Do not set security access for those options unless you have been told to do so by an Allscripts® representative.

When a user has access to only selected areas of a tenant, the folders, toolbar buttons, and areas that the user does not have access to are greyed out and unavailable.

Use the combo box under **User Override** to override the group's access or restriction for a particular user.

Operator Maintenance window

Use **Operator Maintenance** to create operator records for your users and, if necessary, assign them to departments or practices. You must create an operator record in your Allscripts® Practice Management tenant for each of your users and associate each operator with a security user logon name.

To access **Operator Maintenance**, go to **System Administration > File Maintenance > Operator Maintenance** or press **F9** and then enter **OPM**.

Operator Maintenance contains these tabs:

- > **Operator**
- > **Department Members or Practice Members**

Note: This tab is enabled only when you have **Enable Department/Practice Security** checked on the **General** tab in **Practice Options** or **Organization Options**.

- > **History**

Operator tab

Create operator records for your users on the **Operator** tab. To log on to an Allscripts® Practice Management tenant, a user must have their user record in **User Maintenance** associated with an operator record in **Operator Maintenance** in that tenant.

You must create an operator record in your Allscripts® Practice Management tenant for each of your users, and associate each operator with a user record in **User Maintenance**.

To create an operator record, click **New** and select an associated security user. Best practice is to select the defaults from the associated security user record.

Tip: If the value in **Logon Name** on the **User Maintenance** tab in **User Maintenance** is more than 8 characters, only the first 8 characters are used to automatically fill **Abbreviation** when you create a new operator record. To have the entire logon name show in **Operator Maintenance**, limit **Logon Name** in **User Maintenance** to 8 characters before creating an operator record.

Access the **Operators** tab from **Operator Maintenance**. To access **Operator Maintenance**, go to **System Administration > File Maintenance > Operator Maintenance** or press **F9** and then enter **OPM**.

Operator Maintenance

Select Operator: 

Operator  **Department Members** 

Associated Security User:

Abbreviation:

Last Name:

First, MI: Suffix:

Can Assign Workspace Items
 Education Portal Administrator

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Can Assign Workspace Items

Applies to operators using **Office Manager**.

If your operator record has **Can Assign Workspace Items** selected:

- > You can assign any voucher or task to yourself.
- > You can assign any voucher or task to any operator regardless of whether that operator has **Can Assign Workspace Items** selected.

If your operator record does not have **Can Assign Workspace Items** selected:

- > You can assign a not-yet-assigned voucher or task to yourself.
- > You can assign a not-yet-assigned voucher or task to any operator who has **Can Assign Workspace Items** selected.
- > You cannot assign a voucher or task that is already assigned to another operator.

Clients using department or practice security must select department or practice members.

Education Portal Administrator

Designates the operator as an Allscripts® i-Learn education portal administrator. Education portal administrators can do the following when they access the portal:

- > Add and delete Allscripts® i-Learn users
- > Create and edit groups of Allscripts® i-Learn users
- > Recommend content per user or user group

Department Members or Practice Members tab in Operator Maintenance

You must select department or practice members for each record that has a members tab.

This allows you to determine the relationship between:

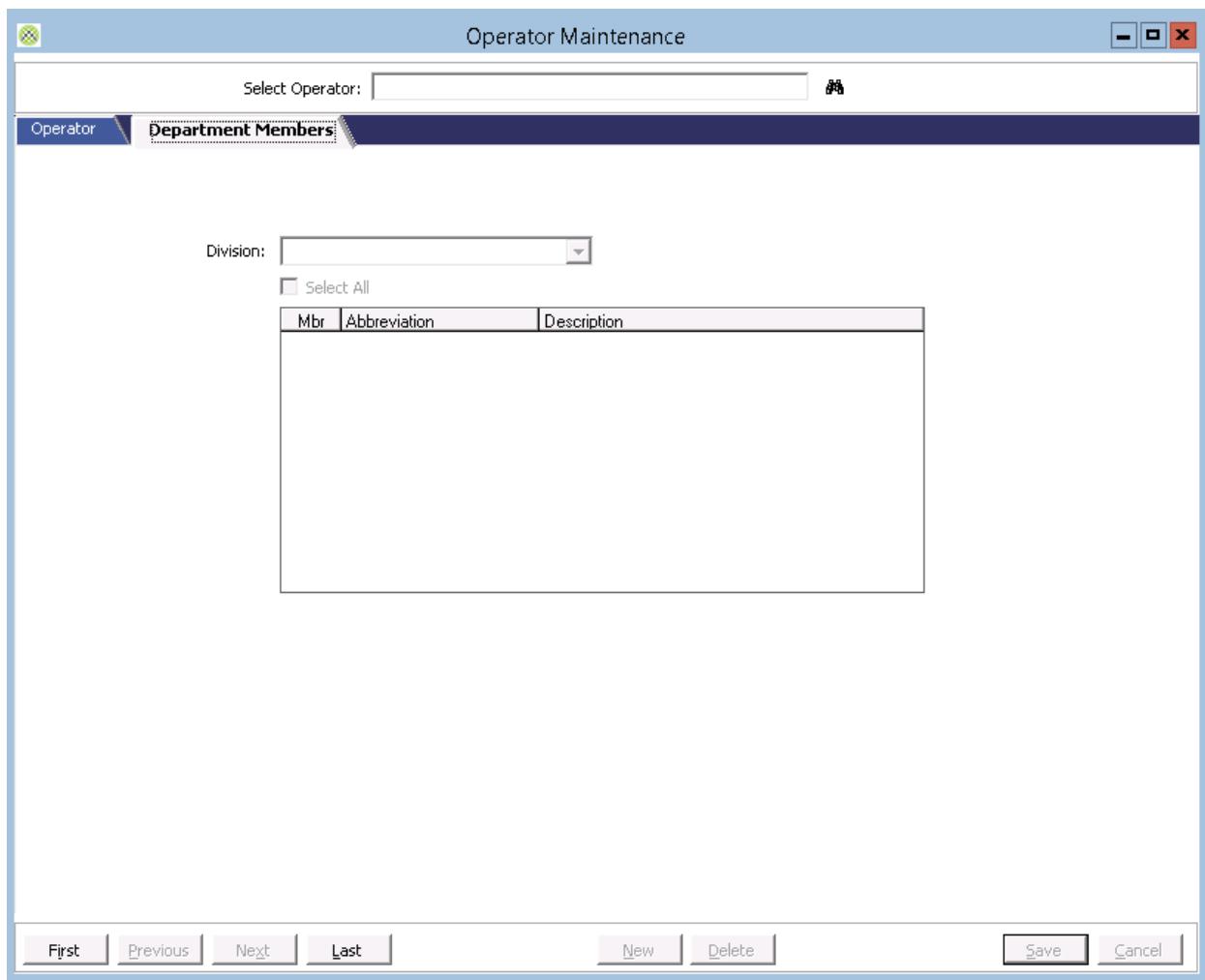
- > Operators and departments/practices
- > Specific file maintenance records and departments/practices

You must select department/practice members for operators to have any access to the records that also have department/practice members selected in the following windows:

- > **Ailment Type Maintenance**
- > **Claim Type Maintenance**
- > **Image Category Maintenance**
- > **Location Maintenance**
- > **Message Maintenance**
- > **Place of Service Maintenance**
- > **Provider Maintenance**
- > **Resource Maintenance**
- > **Scheduling Location Maintenance**

Operators have access to the record by way of their access to the departments/ practices selected as members for each record. An operator record that does not have department/practice members does not have access to any department/ practice, nor to any of the records listed above that are associated with departments/practices. In other words, an operator without department/practice members cannot enter vouchers, print statements, enter payments, and so on.

Access the **Department Members or Practice Members** tab from **Operator Maintenance**. To access **Operator Maintenance**, go to **System Administration > File Maintenance > Operator Maintenance** or press **F9** and then enter **OPM**.



Division

This field is only enabled on the **Department or Practice Members** tab when you select **Enable Divisions** on the **Multi Entity** tab. In this case, the selection of department/practice members is done at the level of division.

Note: Divisions are containers that provide a way to gather financial data related to Departments/Practices for reporting purposes. If you elect to enable divisions, you must create divisions in Division Maintenance. Divisions can be used as a group field, or select records option in reporting.

Operator Group Maintenance window

Use **Operator Group Maintenance** to create operator groups and add operators to those groups.

Operator groups provide the ability to include or exclude multiple operators from having their batches updated by the automated billing process. You can select operator groups in **Select Operators**, accessed from the **Financial Posting** tab in **Billing Automation Maintenance**.

Operator Group Maintenance contains the following tabs:

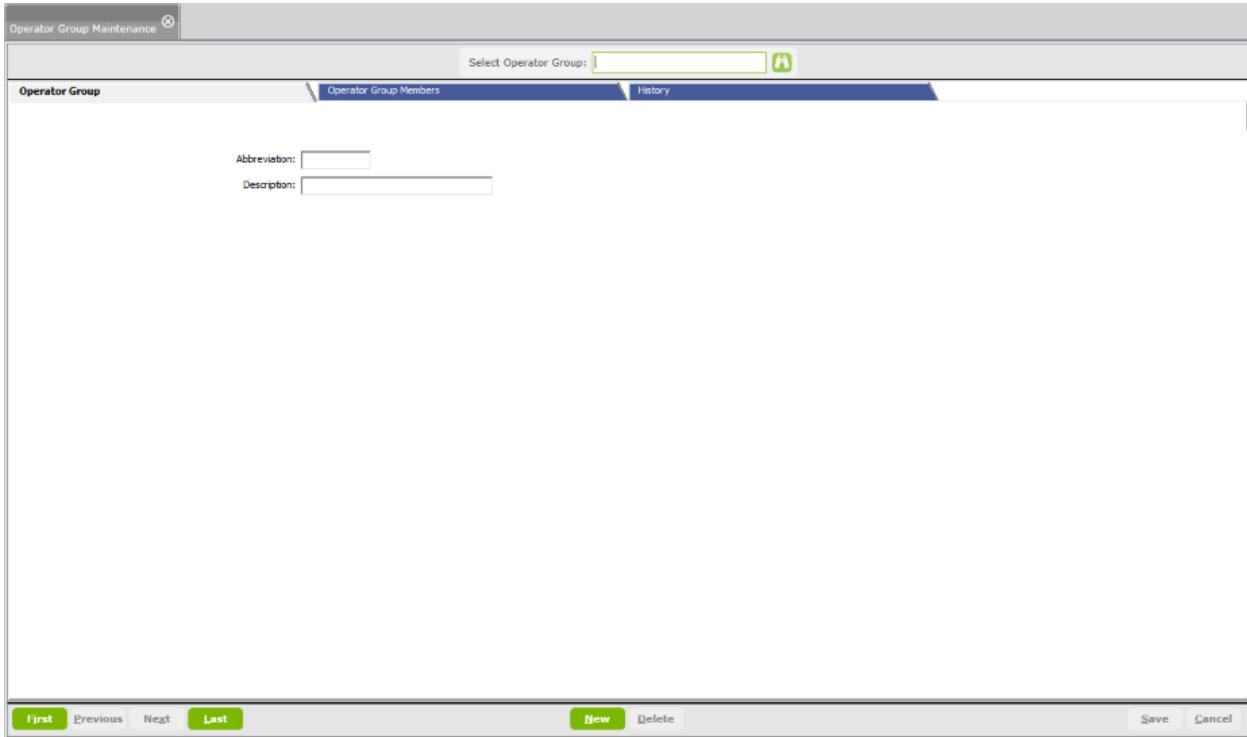
- > **Operator Group**
- > **Operator Group Members**
- > **History**

To access **Operator Group Maintenance**, go to **System Administration > File Maintenance > Operator Group Maintenance**, or press **F9** and then enter **OGM**.

Operator Group tab

Use the **Operator Group** tab in **Operator Group Maintenance** to create operator groups that you can select from **Select Operators** in the **Batch Options** area in **Billing Automation Maintenance > Financial Posting**.

Access the **Operator Group** tab from **Operator Group Maintenance**. To access **Operator Group Maintenance**, go to **System Administration > File Maintenance > Operator Group Maintenance**, or press **F9** and then enter **OGM**.



Abbreviation

Required. Enter an abbreviation for this operator group record. Each operator group record must have a unique abbreviation.

Description

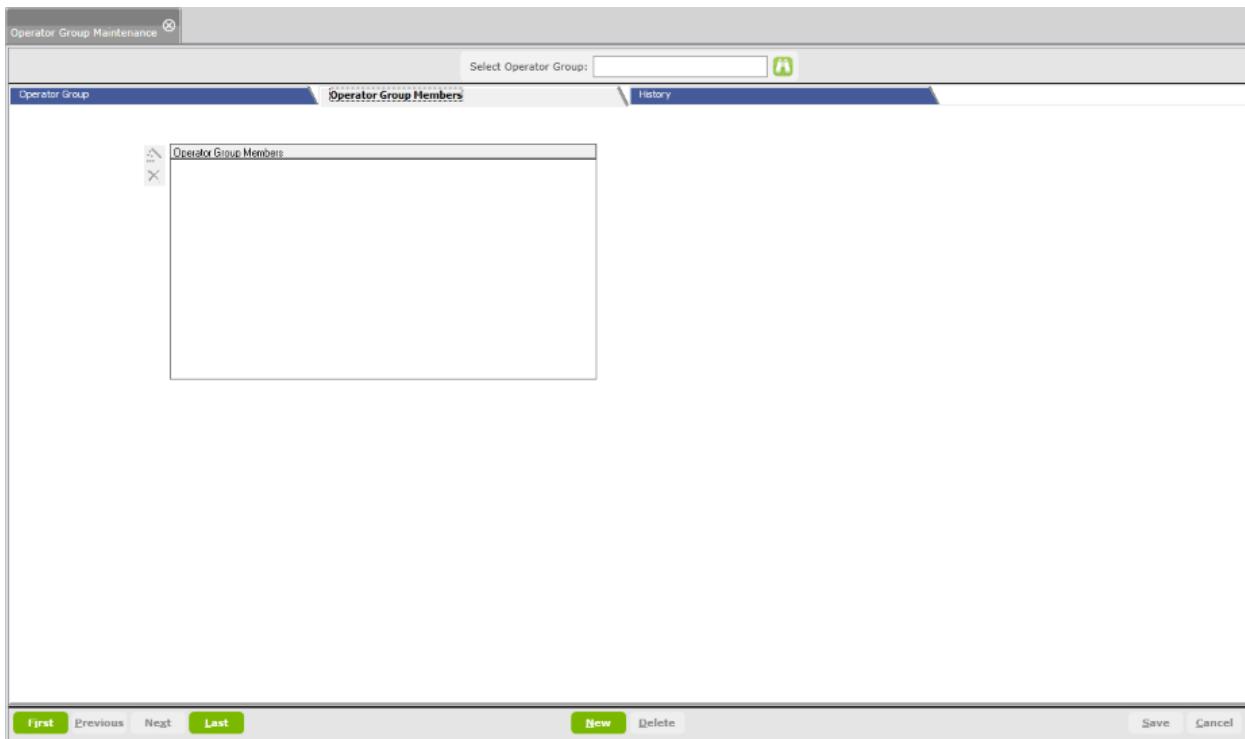
Required. Enter a description for this operator group record.

Best Practice: Make the description unique, so that it is not confused with other operator group records.

Operator Group Members tab

Use the **Operator Group Members** tab to add operators to operator groups.

Access the **Operator Group Members** tab from **Operator Group Maintenance**. To access **Operator Group Maintenance**, go to **System Administration > File Maintenance > Operator Group Maintenance**, or press **F9** and then enter **OGM**.



After you select a value for **Select Operator Group**, click  to insert an empty row in the grid. Click  to open **Select Operators** where you can select one or more operators to add to the operator group.

Because automation processes, like automated billing, create batches with **SYSTEM** as the operator, you can include **SYSTEM** as a member of an operator group. However, **SYSTEM** is not displayed as an operator in **Operator Maintenance**.

Note: An operator can only be selected once for each operator group but can be a member of multiple operator groups.

Create an operator group

Use **Operator Group Maintenance** to create operator groups and assign operators to those groups.

1. Go to **System Administration > File Maintenance > Operator Group Maintenance**, or press **F9** and then enter **OGM**.
2. On the **Operator Group** tab, click **New**.
3. For **Abbreviation**, enter an abbreviation for this operator group.
Each operator group must have a unique abbreviation.

4. For **Description**, enter a description for this operator group.

5. Click the **Operator Group Members** tab.

6. Click .

A row opens in the **Operator Group Members** grid.

7. Click  on the right side of the row.

8. Select Operators opens.

9. Select one or more operators to add to the operator group.

To select multiple operators, hold **Ctrl** while you click the operators that you want to add to the operator group.

A row is added to the grid for each operator that you selected.

Note: **All Operators** is not enabled because an operator group with all operators would be purposeless.

10. Click **Save**.

Replication setup checklist

Use this grid to record the completion of the **Replication** tab in **Administration > Replication > Setup**.

Tab	Completed
Replication	

Setup window for replication

Use the **Setup** window in the **Replication** area to set up replication data sets and track changes to them.

To access **Setup**, go to **Administration > Replication**, or press **F9** and then enter **RPM**.

Setup contains 2 tabs:

- > **Replication**: Use this tab to set up and manage replication.
- > **History**: Use this tab to track changes made to the **Replication** tab by user.

Important: Although any tenant can be a source tenant, only new tenants can be target tenants because the affected tables must be blank. If you

If you are creating a new tenant and using a starter data set, be sure to select the types of information that the tenant will be a target for in the **Replication** area so that information from the starter data set is not copied into them.

Replication tab in Setup

Use the **Replication** tab in **Replication > Setup** to create and edit replication data sets to manage replication between your tenants.

Rules for replication

You must comply with these rules when setting up replication.

- A tenant cannot be a source for more than 1 replication data set.
- A tenant cannot be both a source and a target for the same replication data set.
- A tenant cannot be a source in 1 replication data set and a target in another for the same information type.
- A tenant cannot be a target in multiple replication data sets for the same information type.
- A tenant cannot be located outside the single security database.
- A tenant is not available for replication if you do not have security permissions for that tenant.

Important: Although any tenant can be a source tenant, only new tenants can be target tenants because the affected tables must be blank. If you are creating a new tenant and using a starter data set, be sure to select the types of information that the tenant will be a target for in the **Replication** area so that information from the starter data set is not copied into them.

To access the **Replication** tab, go to **Administration > Replication**, or press **F9** and then enter **RPM**. The **Setup** window automatically opens on the **Replication** tab.

(New Replication Data Set) X

Setup

Select Replication Data Set: **(New Replication Data Set)**

Replication **History**

Select Source Tenant: **Ntier_Tenant1**

Replication Data Set Name: **Sample Data Set**

Enable Replication

Type of Data Replicated	Target Tenant(s)
Diagnosis Code Information	Selected Tenants
Carrier Information	Selected Tenants

X
+/-
X

First
Previous
Next
Last
New
Delete
Save
Cancel

Select Source Tenant

The source tenant for replication. All of the information types that you select in the **Type of Data Replicated** column replicate from this source tenant to the target tenants that you select in the **Target Tenant(s)** column.

Replication Data Set Name

The name of the replication data set. If you are creating a new data set, pick a name that will help you remember what this data set is for.

Enable Replication

Select this check box to enable the current replication data set. After you select **Enable Replication** and click **Save**, you cannot change the source tenant or any of the existing rows.

Note: This check box is not tracked on the **History** tab.

Type of Data Replicated

The type of data to replicate from the source tenant.

> **Carrier Information**

Note: The **ICD-10 Effective Date** for carriers is included in the carrier information replicated from the source tenant to the target tenant. **ICD-10 Effective Date** is only editable in the source tenant, not in the target tenants. However, you can create a new insurance carrier record in a target tenant; when you do so, the record is replicated first to the source tenant, and then from the source tenant to all target tenants.

- > **Diagnosis Code Information**
- > **Employer Information**
- > **Procedure Code Information**
- > **Referring Doctor Information**

Note: When you replicate a data type, the associated profiles for that data type from the **Profiles** tab in **Practice Options** or **Organization Options** are also replicated. For example, if you replicate diagnosis code information from a source tenant to a target tenant, the diagnosis code profile information is also replicated. You can only add, edit, or delete these profiles from the source tenant, not from the target tenant.

Target Tenant(s)

The target tenants for replication. The information that you selected in **Type of Data Replicated** for this row will be replicated to these tenants. Click  to open **Select Tenants** and choose the target tenants; only tenants that you have permission to view are displayed.

Note: If a tenant is listed on **Select Tenants** but you cannot select it, it is not currently available for replication because the target tables for the data type that you selected in this column are not empty. Source tables for replication must be emptied manually to prevent accidental data loss.

Multi-tenant setup checklist

Use this grid to record the completion of setup related to creating a new tenant.

Tab	Completed
Starter Data Maintenance	
Create New Tenant	

Starter Data Maintenance window

Use **Starter Data Maintenance** to create starter data sets from a source tenant. You can then use these starter data sets when creating new tenants to automatically import selected information from the source tenant, saving time and setup.

To access **Starter Data Maintenance**, go to **Administration > Multi Tenant > Starter Data Maintenance**, or press **F9** and then enter **STD**.

Note: Only on-premise clients can access the **Multi-Tenant** area in **Administration**. If you are a hosted client, this area is not available.

Starter Data Maintenance has 2 tabs:

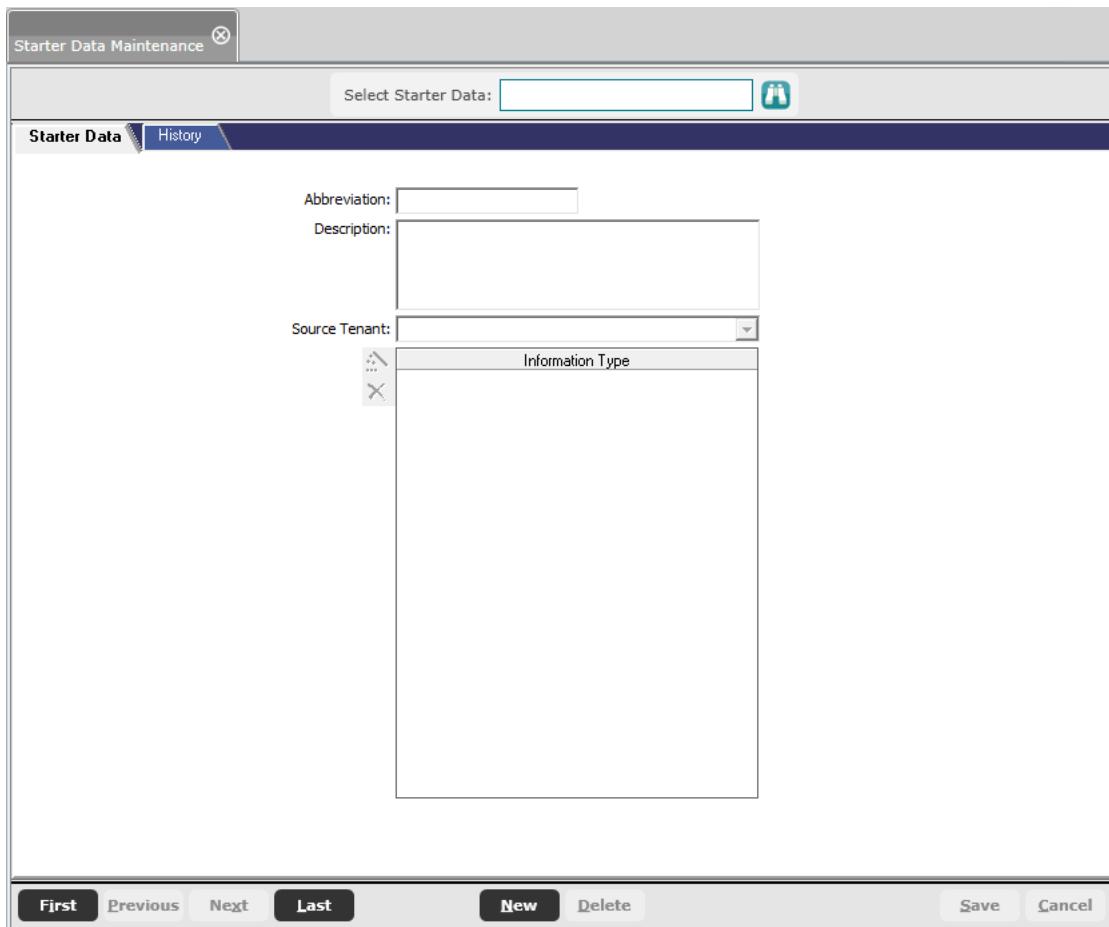
- **Starter Data:** Use this tab to create and manage starter data sets.
- **History:** Use this tab to track activity on the **Starter Data** tab.

Starter Data tab

Use the **Starter Data** tab in **Starter Data Maintenance** to create starter data sets to use when creating new tenants. You can then use these starter data sets when creating new tenants to automatically import selected information from the source tenant, saving time and setup.

To access the **Starter Data** tab, go to **Administration > Multi Tenant > Starter Data Maintenance** or press **F9** and then enter **STD**. **Starter Data Maintenance** opens on the **Starter Data** tab automatically.

Users who are part of the **Administration** group have access to **Starter Data Maintenance** by default. You can refine who has permission to access **Starter Data Maintenance** in **Administration > Security Manager > Security Permissions**.



The screenshot shows the 'Starter Data Maintenance' window. At the top, there is a search bar labeled 'Select Starter Data:' with a magnifying glass icon. Below the search bar, there are tabs for 'Starter Data' and 'History'. The main area contains three input fields: 'Abbreviation' (empty), 'Description' (empty), and 'Source Tenant' (empty). To the right of these fields is a grid titled 'Information Type' with a delete icon. At the bottom of the window are buttons for 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

Required entry. The abbreviation for the starter data set.

Description

The description for the starter data set. You can enter up to 255 characters.

Source Tenant

Required entry. Select an existing tenant to import the starter data from. You can only select a single source tenant.

Note: This list only includes tenants that you have permissions for in **Security Manager**. For example, if you have access to tenants (that is, practices) in Security Group A but not Security Group B, only tenants from Security Group A are displayed in this list.

Information Type

Required entry. The categories to include in the starter database. When you create a new tenant using this starter data set, the information for all of the categories you include in the **Information Type** list is imported into the data set for the new tenant. To add a new information type to the list, click  and select an information type from the list. The information types include the following.

Table 5: Sources for information types

Information Types	Sources in application
Account Type Information	Account Type Maintenance
Carrier Information	Insurance Category Maintenance, Insurance Reporting Class, Insurance Network Maintenance, Insurance Carrier Maintenance, Payer tab in Employer Maintenance Note: <ul style="list-style-type: none"> > Benefit tier information in Insurance Network Maintenance is not included. > Enable Benefit Plans and the Benefits Plans tab in Insurance Carrier Maintenance are not included.
Claim Status Information	Claim Status Category Maintenance, Claim Status Code Maintenance
Claim Style Information	Claim Style Maintenance, Electronic Claim Format Maintenance, Paper Claim Maintenance
Claim Type Information	Claim Type Maintenance, Ailment Type Maintenance
Diagnosis Code Information	Diagnosis Category Maintenance, Diagnosis Code Maintenance
Electronic Remit Information	Electronic Remit Format Maintenance, Electronic Remit Style Maintenance
Employer Information	Employer Maintenance Note: The Benefit Plans tab is not included.
Image Information	Image Category Maintenance

Information Types	Sources in application
Integration Format Information	Information Broker Format Class Maintenance
Location Information	Location Maintenance
Message Information	Message Maintenance
Note Type Information	Note Type Maintenance
Place of Service Information	Place of Service Maintenance
Practice Options	Practice Options or Organization Options
Procedure Code Information	Modifier Maintenance, Type of Service Maintenance, Procedure Category Maintenance, Anesthesia Style Maintenance
Recall Type Information	Recall Type Maintenance
Referral Type Information	Referral Type Maintenance
Referring Doctor Information	Specialty Maintenance, Referral Tenant Maintenance, Referring Doctor Maintenance Note: The Network Info tab in Referring Doctor Maintenance is not included.
Reimbursement Comment Information	Reimbursement Comment Category Maintenance, Reimbursement Comment Maintenance
Remark Code Information	Remark Code Category Maintenance, Remark Code Maintenance
Revenue Information	Revenue Code Maintenance

Information Types	Sources in application
Transaction Code Information	Transaction Category Maintenance, Transaction Code Maintenance, Reimbursement Style Maintenance Note: When you create a new tenant, if you use a starter data set with the Transaction Code Information information type, the existing rows in the Procedure Exceptions grid on the Uninsured tab in Reimbursement Style Maintenance are not copied to the new tenant, but the rest of the information on the Uninsured tab is copied. After the new tenant is created and procedure codes have been imported or manually entered into Procedure Code Maintenance , you must manually enter the rows in the Procedure Exceptions grid.

After you select a given information type, the application removes it from the drop-down list so that you do not select it again.

Create New Tenant window

Use **Create New Tenant** in **Administration > Multi-Tenant** to create a new tenant (that is, a new practice or organization). If you created a starter data set in **Starter Data Maintenance**, you can automatically fill the tables for the new tenant with starter information from another tenant.

Create New Tenant is only available if you:

- Are an on-premise client
- Have the applicable security permissions assigned in **Administration > Security Manager > Security Permissions**
- Have an available license to create a new tenant on **Create New Tenant**

Important: Contact Allscripts® Support for details about obtaining an additional license.

To access **Create New Tenant** from **Administration > Multi-Tenant > Create New Tenant**. Or, press **F9**, then enter **CNT**.

When creating tenants on **Create New Tenant**, each tenant must be linked to an existing database. No new database is created when you create a new tenant; the application adds a new tenant

area to your existing application database and security database. All of the database tables for the new tenant are identified with a unique tenant ID.

To ensure that the application functions correctly, selected core options from **Practice Options** or **Organization Options** are set in the new tenant by default. In addition to these defaults, you can use a starter data set (created in **Starter Data Maintenance**) to load selected information into the new tenant from an exiting tenant, or create an empty tenant and load data afterward.

Note: If you use a starter data set that includes practice options information, that information replaces the defaults.

However, even if you use a starter data set, your new tenant will still require significant setup, including:

- > Practice options (or organization options)
- > Documents and document templates
- > Notes
- > Reports
- > Patient information
- > Other tenant-specific information

Warning: Do not use **Create New Tenant** to edit information for an existing tenant. To edit information for an existing tenant, log onto that tenant and go to **System Administration > Practice Set Up** (or **Organization Set Up**). To delete an existing tenant, go to **Administration > Security Manager > Tenant Maintenance**. After a tenant is deleted, the only way to restore a tenant is to restore the entire linked database.

Create New Tenant

Tenant Name:	E-Mail:	
Address 1:	Federal ID:	
Address 2:	ID Sub-No:	
City:	State:	Claim # Prefix:
Zip Code:	Country:	Client ID:
Telephone:	Ext:	Clinic Number:
Fax:	Time Zone:	
File Share Path:	<input type="button" value="..."/> <input type="checkbox"/> User Defined Path	
Tenant Config: <input checked="" type="radio"/> Existing DB Set Up: <input checked="" type="radio"/> Empty <input type="radio"/> Starter Data Set <input type="button" value="..."/> Type: <input checked="" type="radio"/> Production <input type="radio"/> Non-Production		
Security Transaction Group: <input type="button" value="..."/> Security Group: <input type="button" value="..."/> SQL Server Instance Name: <input type="button" value="..."/> SQL Database Name: <input type="button" value="..."/>		
Replication Required? <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="checkbox"/> Carrier Information <input type="checkbox"/> Diagnosis Code Information <input type="checkbox"/> Employer Information <input type="checkbox"/> Procedure Code Information <input type="checkbox"/> Referring Doctor Information		
If Replication is required, the information type(s) selected here will prevent the associated information types (if defined) in the Starter Data Set from being copied when a new tenant is created. Once created, replication for the new tenant will need to be configured in the Administration>Replication function.		
<input type="button" value="Create"/> <input type="button" value="Cancel"/>		

Tenant Name

The tenant name. Enter the name of the new practice or organization exactly as you want to see it printed out (for example on a claim form, an encounter form, a medical record slip, or a patient statement). This information is displayed on the **Practice Information** or **Organization Information** tab in **Practice Set Up** or **Organization Set Up**.

Address 1

The main address line for the tenant. Enter the address exactly as you want to see it printed out (for example on a claim form, an encounter form, a medical record slip, or a patient statement). **Address 1** is used as an optional pull field for encounter forms and medical record slips.

Address 2

The secondary address line for the tenant. Values in **Address 2** print on electronic claims but not on paper claims.

City

The tenant's city.

State

The tenant's state.

Zip Code

The tenant's ZIP Code.

Country

The tenant's country.

Telephone

The telephone number for the tenant. You must enter 10 digits.

Ext

The extension for the telephone number, if any.

Fax

The fax number for the tenant. You must enter 10 digits.

E-Mail

The main email address for the tenant. This box is informational only

Federal ID

Enter the tax ID number assigned to your practice or organization or to the provider. This number can be used when billing insurance claims.

Federal ID is used as a pull field when the options **Federal ID** and **Practice or Organization** are selected as for **Tax ID Source** and **Tax ID Option** for paper and electronic claim formats in **Paper Claim Format Maintenance** and **Electronic Claim Format Maintenance**.

ID Sub-No

Some payers and clearinghouses require that you include a site ID along with the billing provider's information. Enter the number exactly as it must be displayed on the claim form. The ID sub-number applies when submitting v4010A1 claims when you select **Individual Provider** for the option **Output Site ID for ANSI 837** formats the claim style associated with the payer.

Id Sub-No is used as a pull field when you select **Usual Provider** as the header information for statements or occupational medicine invoices.

ID Suffix

Use this box for additional billing information required by a payer or clearinghouse. The ID suffix applies to both v4010A1 and v5010 formats. It outputs to a claim file when you select **Append ID Suffix to Federal ID** on the **Output Options** tab in **Claim Style Maintenance** for the claim style associated with the payer.

Claim # Prefix

Enter your practice or organization's assigned database number. The claim number prefix is intended for use when billing or payment entry functions are shared between multiple practice or organization databases. Assign each database a unique number to identify the source of a claim.

Tip: Practices or organizations using multiple databases that share charge entry and payment entry functions must assign each practice or organization database a unique number, such as 1, 2 and so on. Enter this unique number for **Claim # Prefix**. Then, select the applicable option in **Claim Style Maintenance** to append this prefix to the claim number. This setup helps you to quickly identify the practice or organization database claims are printed or transmitted from electronically.

Claim # Prefix can be used as a pull field when you select the related claim style output option. Prints in Box 26 on the Standard CMS-1500 NPI claim form. Although optional, it is a best practice that clients transmitting claims using an 837 ANSI format enter a unique practice or organization number even when there is only 1 practice or organization database. This prefix outputs to Segment CLM Loop 2300.

Client ID

Enter the client number assigned to your practice or organization by Allscripts®. This is a required box if you use iBill or iRemind. **Client ID** is displayed on **About Allscripts PM**, in **Allscripts Client ID** on **Tenant Maintenance**, and in **Client ID** on the **Practice Information** or **Organization Information** tab in **Practice Set Up** or **Organization Set Up**.

Clinic Number

Enter your assigned number only when you are directed to do so by a member of Allscripts® Support. This box is intended for use only when transmitting claims through BCBS of Michigan EDI. The clinic number is reported when the related output option is selected in **Claim Style Maintenance**.

Time Zone

The default time zone for the tenant. This box displays the application server time zone by default. If necessary, click the down arrow to change the time zone.

Allscripts® Practice Management supports all of the Microsoft®-defined time zones, as well as 26 additional time zones. These include the following 12 US timezones (including US territories), as well as 156 international time zones.

Description	Display name	Abbreviation
Hawaiian Standard Time	(UTC - 10:00) Hawaii	HST
Alaskan Standard Time	(UTC - 09:00) Alaska	AKST
Pacific Standard Time	(UTC - 08:00) Pacific Time (US & Canada)	PST
US Mountain Standard Time	(UTC - 07:00) Arizona	MST
Mountain Standard Time	(UTC - 07:00) Mountain Time (US & Canada)	MST
Central Standard Time	(UTC - 06:00) Central Time (US & Canada)	CST
Eastern Standard Time	(UTC - 05:00) Eastern Time (US & Canada)	EST
US Eastern Standard Time	(UTC - 05:00) Indiana (East)	EST
Atlantic Standard Time	(UTC - 04:00) Atlantic Time	AST
Note: Use this option for locations in the Atlantic time-zone region that do not use Daylight Saving Time, such as Puerto Rico and the US Virgin Islands.		
Hawaii-Aleutian Standard Time	(UTC - 10:00) Hawaii-Aleutian	HAST
Samoa Standard Time	(UTC -11:00) Samoa ST	SST Samoa
Chamorro Standard Time	(UTC +10:00) Chamorro ST	ChST

File Share Path

By default, this path is `\<Server Name>.<Domain Name>\NtierFiles\<Tenant Name>\`. To select a different location, select **User Defined Path**  to open a separate window and select the area.

Tenant area

Config

Existing DB is the only option in this area, and it is always selected. The new tenant will be created in the existing database that you select in **SQL Database Name**.

Set Up

Choose 1 of these 2 options.

Empty

This option is the default. Select this option to create a new tenant that is empty, without using a starter data set.

Starter Data Set

Select this option if you are using a starter data set, then select the starter data set to use from the drop-down list next to this option. The list includes all of the starter data sets created in **Starter Data Maintenance**.

Note: If **Cycle By** on the **Statement** tab in **Practice Options** or **Organization Options** is set to **Guarantor Name**, the **Finance Charges** tab is not available. Therefore, when you create a new tenant using a starter data set that includes the **Practice Options** information type, if **Cycle By** on the **Statement** tab is set to **Guarantor Name** in the source tenant, none of the source finance charge information is copied to the new tenant.

Type

Choose 1 of these 2 options.

Production

This option is the default. Select this option to make the new tenant a production environment for normal use.

Non-Production

Select this option to make the new tenant a non-production, test environment.

Note: When you open the switch tenant drop-down list on the toolbar, non-production tenants are always at the bottom of the list.

Security area

Transaction Group

If this tenant will participate in centralized payments, use this box to associate the tenant with an existing transaction group. When you associate a tenant with a transaction group, you can only switch to other tenants in the same transaction group using the switch practice icon.

Security Group

Use to associate the new tenant with an existing security group. The drop-down list includes both the security groups that you have access to and any security groups that are not yet associated with a tenant. When you select a security group, **App SQL Server Name** is enabled.

Important: If you have existing users who need to access this new tenant, be sure that you select the security group that these users are associated with.

SQL Server Instance Name

Enabled when you fill **Security Group**. The drop-down list includes all Microsoft® SQL Server™ servers on the domain that are associated with security groups you have access to. Select which server to create the new tenant on. When you select a server, **SQL Database Name** is enabled.

SQL Database Name

Enabled when you fill **App SQL Server Name**. Select the database to create the new tenant in.

Replication area

Important: This area does not actually set up replication: it keeps the tables intended for replication clear so that you can complete the required setup later. After you create the new tenant, you must go to **Administration > Replication > Setup** to set up replication for the new tenant.

Required

Select **Yes** if you plan to use replication for this tenant. **No** is selected by default. If you select **Yes**, the other check boxes in the **Replication** area are enabled. If you are using a starter data set, information is not copied for the check boxes you select, since those information types will be replicated from another tenant.

Carrier Information

Select this check box to prevent any carrier information in your starter data set from being copied to this tenant.

Diagnosis Code Information

Select this check box to prevent any diagnosis code information in your starter data set from being copied to this tenant.

Employer Information

Select this check box to prevent any employer information in your starter data set from being copied to this tenant.

Procedure Code Information

Select this check box to prevent any employer information in your starter data set from being copied to this tenant.

Referring Doctor Information

Select this check box to prevent any employer information in your starter data set from being copied to this tenant.

Create

Click **Create** to create the new tenant.

Important: You must have an available license to create a new tenant. If you have reached your limit of available licenses, this button is not available.

After you click **Create**, the following events occur.

- > New tables for the tenant are added to your security database and application database and labeled with the new tenant ID.
- > Starter data is copied to affected tables in the application database, if any.
- > A standard folder structure is created for the new tenant, either in the default area or the area that you specified in **File Share Path**.
- > Selected default practice options are copied to the new tenant
- > You are automatically added to the tenant (that is, a new operator record is created in **Operator Maintenance** and associated with your user record). You are also given full security permissions for the tenant.

A progress bar is displayed while the application creates the tenant. Then a message is displayed to indicate that the new tenant is complete.

Practice options that are always included in new tenants

To ensure that the application functions correctly, selected core options from **Practice Options** or **Organization Options** are set in the new tenant regardless of whether you use a starter data set. If you use a starter data set that includes practice options information, that information will replace these defaults.

Table 6: Practice options that are always included in new tenants

Tab on Practice Options or Organization Options	Box or area	Setting
General tab	Available Coverage Types area in lower-right corner: Description column	The check box in the Description is selected for all of the following coverage types: <ul style="list-style-type: none"> > Behavioral Health > Dental > Medical > Motor Vehicle > Other > Worker's Comp
General tab	Available Coverage Types area in lower-right corner: Default column	The check box in the Default is selected for the Medical coverage type
Statement tab	Statement Type	Patient Items Only
Statement tab	Cycle By	Last Statement Date
Statement tab	Sequence By	Alphabetically
Statement tab	Base Dunning Message On	Oldest Charge
Scheduling tab	In the Appointment Book Options area under Included Days	All days of the week are selected
Scheduling tab	Weeks Ahead for Open Times in the Scheduling Option area	2
External Access tab	Education Portal URL	http://pmilearn.eduserv.myallscripts.com

Chapter 12

Office Manager

Office Manager enables you to create work queues (stored jobs) for selected operators so that each has his/her own work space to deal with work items (appointments, claims, or accounts) generated under the following management categories:

- > Appointments
- > Pending Claims
- > Unpaid Claims
- > Self-Pay Collections

Additionally, you can use the **Tasking** workspace in **Office Manager** to work on tasks associated with entities, such as vouchers.

What Office Manager offers

Office Manager offers the following flexibility and functionality:

- > Multiple work queues within each category that generate work items based on your Practice/Organization's established workflow. Some examples of the types of work queues you can create are:
 - Appointment Management: You can create a work queue which generates appointments with, for example specified appointment statuses, range of dates, by Resource, Scheduling Department, etc.
 - Pending Claims: You can create work queues which generate vouchers that failed validation and /or have a held status. You can restrict the list of vouchers to those with, for example selected held statuses, specified validation type errors, for specific format, by departments/practices, providers, etc.
 - Unpaid Claims: You can define work queues, each to capture a payer's claims that are aged over a specified number of days, for example over 45 days, another for over 90 days, etc.. You can also create a work queue that captures self-pay vouchers with a balance older than a defined number of days, for example over 89 days.
 - Self-Pay Collections: You can create work queues to manage accounts from the automated self-pay collections process that have reached a manual step or did not complete an automated step correctly and require user intervention. These work queues can be based on the voucher's account type, age, balance, or required minimum payment amount. Only users who have **Eligible for Distribution** selected in **Collector Maintenance** can have automated self-pay collections accounts assigned to them.

Note: Self-pay collections work queues function slightly differently than other work queues, in that an account always stays with the work queue that it initially qualifies for, even if it meets the criteria for another work queue or it is assigned to another operator. This restriction enables the automatic self-pay collections process to function correctly.

- > Assignment of Operators to custom defined work queues that are governed by rules you set. Based on those rules the operator is given items (appointments or vouchers) to work without having to setup and run their own query.
- > Option to have work items (vouchers) served one at a time or to have an operator work from a list of all of the vouchers that qualify for the queue.

Note: This option is not available in Appointment Management.

- > Full access to screens in Scheduling, Pending Claims or Unpaid Claims Management via the COMpanion which provides the Operator with the tools needed to complete assignments.
- > Easy assignment of a voucher to oneself or to another specified Operator.
- > Safeguard against the possibility of two operators working on the same item at the same time. An item assigned to another operator, is placed in a view only mode to other Users.

In addition **Office Manager** enables you to choose between two methods for managing pending claims and unpaid claims. These are:

- > using only Work Queues and Work Groups
- > using a Workflow Organization Basis

You must use a workflow organization basis with the automated self-pay collections process. For details about setting up automated self-pay collections, refer to the automated self-pay collections setup checklist.

Using a Workflow Organization Basis requires

- > the creation of Work Queues
- > (with this option, the creation of Work Groups is not required)
- > the creation of at least one Workflow Organization Maintenance
- > the activation of your Allscripts® Practice Management tenant using the Work Flow service type

Whether you decide to create a Workflow Organization Basis determines the setup required for using **Office Manager** in your Practice/Organization.

Define your needs

Before you actually begin setup it is recommended that you give some thought to the following.

For each Management Category define what needs to be done and how it should be accomplished.

Example: What do you need Work Queues for?

Appointment Management

- > To confirm appointments?
- > To move Patients off Wait List?

Pending Claims

- > To review claims that have a hold status?
- > To correct claims that failed validation?

Unpaid Claims

- > To follow-up on claims over a certain age?
- > To follow-up on claims by Carrier?
- > To manage unpaid Self-Pay vouchers over a certain age?

Self-Pay Collections

- > To correct any issues encounter in automatic steps?
- > To manager vouchers by age, amount, or payer?

Determine who should do the work

- > Which Users should have access to Office Manager?
- > Who should have access to creating Work Queues, Work Groups , Workflow Maintenances?
- > Which Operators will you allow to assign vouchers or not-yet-assigned tasks to other Operators?
- > Do you want Operators to view all eligible vouchers as they do in the Unpaid Claims and Pending Management screens or do you want the Operators to be served one voucher at a time?
- > If you use automated self-pay collections, which users will be eligible for distribution?
- > If you use tasking, which users can see tasks in the **Voucher** folder.

Determine how you want the work done for Pending Claims Management and Unpaid Claims Management

For these two management categories Allscripts **Office Manager** enables you to build work queues using work groups and/or a workflow organization basis.

How your Practice/Organization manages claims determines which option is best suited for you.

Determine security options for each operator

- > Create User records

In **Administration > Security Manager > User Maintenance**, create, if necessary, a User record for each staff member who will work in Office Manager

- > Verify that the Security Permissions for each Operator are set to allow access to **Office Manager**

Note: By default, all users have access, so you may need to deny certain operators permission to **Office Manager**.

- > Create an Operator record that is associated with a Security User for each individual you intend to work in **Office Manager**.

For each Operator you must do the following

- Associate the Operator with a Security User
- Determine whether the operator has rights to assign vouchers or tasks to other operators.
 - ◆ For operators using **Office Manager** who need rights to assign vouchers or tasks to other operators or one's self, check **Can Assign Workspace Items**.
 - ◆ Leave that option unchecked for **Office Manager** who only need to assign vouchers or not-yet-assigned tasks to one's self or other operators who have **Can Assign Workspace Items** selected for their operator record.

Regardless of the setting the operator will always be able to assign a voucher or not-yet-assigned task to him/herself and those Operators who have this option checked. For example, an Operator not given the permission to assign workspace items can assign a voucher to a Manager with the right to assign workspace items. This allows for the appropriate transfer of vouchers that need further review by a supervisor.

Office Manager setup checklist

This setup checklist covers **Office Manager** setup for using the **Appointment**, **Unpaid Claims**, and **Pending Claims** workspaces. To set up automated self-pay collections, refer to the automated self-pay collections setup checklist.

Maintenance	Completed
Office Manager tab in Practice Set Up or Organization Set Up (PSU or OSU)	
Operator Maintenance (OPM)	
Work Queue Maintenance (WQM)	

Maintenance	Completed
Work Group Maintenance (WGM)	
Workflow Organization Maintenance (WOM)	
Activate your tenant	

Define a workflow organization basis for pending claims or unpaid claims

A workflow organization basis defines the hierarchy that your practice or organization uses to work pending, unpaid, or self-pay collections claims. Define a workflow organization basis for pending and unpaid claims on the **Office Manager** tab in **Practice Set Up** or **Organization Set Up**.

The steps for defining a work organization basis is identical for both pending claims and unpaid claims.

1. Go to the **Office Manager** tab on **System Administration > Practice Set Up** or **Organization Set Up**.

Tip: To quickly access **Practice Set Up** or **Organization Set Up**, press **F9** on your keyboard, then enter **PSU** or **OSU**.

2. For **Management Category**, select **Pending Claims** or **Unpaid Claims**.
3. In the **Workflow Organization Basis** grid, click  to add a row for each category you want to use to sort claims on **Office Manager**.
4. For each row in the grid, select one of the following categories from the drop-down list:

- > **Actual Provider**
- > **Billing Provider**
- > **Department (or Practice)**
- > **Insurance Carrier**
- > **Insurance Category**
- > **Insurance Reporting Class**
- > **Location**

Important: The order that a category is positioned in the grid determines its level in the hierarchy used to sort claims in **Office Manager**.

For example, if you want to work and sort your claims first by location, then by department, add two rows to the **Workflow Organization Basis** grid. For the first row, select **Location**. For the second row, select **Department**.

5. Click **Save**.

Results of this task

Selection boxes are added to **Workflow Organization Maintenance** in **System Administration > File Maintenance** for each category you selected when configuring the workflow organization basis for pending claims or unpaid claims. Use the selection boxes to select criteria that limit which claims are displayed in **Office Manager > Pending Claims Management** or **Unpaid Claims Management**.

Note: For example, if you selected **Location** and **Department** as your workflow organization basis for the **Pending Claims** management category, **Select Locations** and **Select Departments** are displayed for the **Pending Claims** management category on **Workflow Organization Maintenance**. You can then use **Select Locations** and **Select Departments** to configure **Pending Claims Management** to only display claims for specific departments at specific locations.

Claims that match the selected criteria are displayed and sorted in **Office Manager > Pending Claims Management** or **Unpaid Claims Management** according to the hierarchy you defined for the associated workflow organization basis.

What to do next

If you do not already have them, create work queues for the **Unpaid Claims** or **Pending Claims** management category on **Work Queue Maintenance** in **System Administration > File Maintenance**. Then, assign operators and groups of operators to the work queues on **Workflow Organization Maintenance**.

Important: After you define a workflow organization basis, you must use **Workflow Organization Maintenance** to assign operators and groups of operators to work queues.

The **Available Work Queues** grid on **Work Group Maintenance** becomes unavailable for assigning operators and groups of operators to work queues. In addition, the application ignores any work queues you selected on **Work Group Maintenance**.

Operator Maintenance Setup for Office Manager window

For each Operator who is assigned to working in Office Manager you must complete these steps.

- > Associate the Operator with a Security User
- > Determine whether the Operator has rights to assign vouchers to other Operators.
- > For operators using Office Manager who need rights to assign vouchers to other operators or one's self, check Can Assign Workspace Items on the Operator tab in Operator Maintenance. Leave that option unchecked for Operators who only need to assign vouchers to one's self or other operators who have Can Assign Workspace Items selected for their operator record.

For example, Operator A is not given the permission to assign workspace items (check box is not checked in Operator Maintenance). Operator X can assign a work item (check box is checked in Operator Maintenance).

This means that Operator A can assign work items to herself (assign the work item to her My Assigned Work queue) and to Operator X's My Assigned Work queue.

Operator X can assign work items to his My Assigned Work queue and to all other Operators associated My Assigned Work queues.

Access **Operator Maintenance** from **System Administration > File Maintenance > Operator Maintenance** or use **F9 > OPM**.

My Assigned Work

My Assigned Work is a system generated queue. This queue is located on the Work Queues tree in the navigation pane in Office Manager. The Operator has a My Assigned Work queue for each management category for which he/she has custom defined work queues.

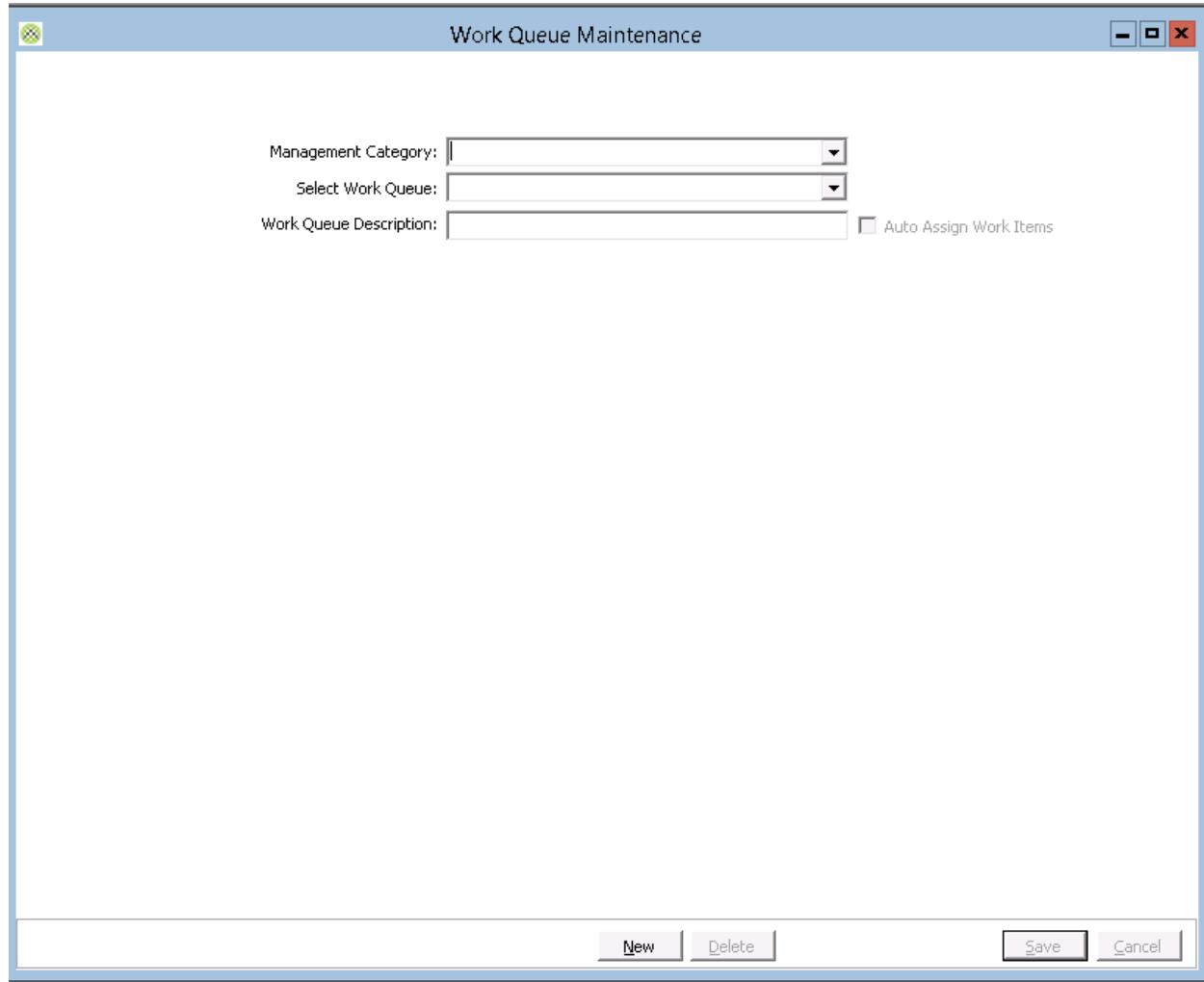
Each My Assigned Work queue hold those work items specifically assigned to the Operator either by him/herself or another Operator who is given the right to assign work items in Operator Maintenance.

Work Queue Maintenance window

In Office Manager work items are organized under Management Categories that are made up of work queues. Create work queues that define the task you want your operators to perform.

Work Queues are essentially stored jobs that define the filters used to capture work items.

To access **Work Queue Maintenance**, go to **System Administration > File Maintenance > Work Queue Maintenance** or press **F9** and enter **WQM**.



Management Category

When you select a management category, the corresponding selections for that management category are displayed on the lower half of the window. The management categories are:

- > **Appointment**
- > **Pending Claims**
- > **Self-Pay Collections**
- > **Unpaid Claims**

Select Work Queue

This drop-down list enables you to select an existing work queue. When you click **New**, this box becomes unavailable.

Note: Stored Jobs saved in Appointment Management in Scheduling are not included in the pick list for Appointment Management in Office Manager.

Work queue description

Enter a description to help you remember the purpose of the work queue. For example, Confirm Appts.

Selections

Make selections that define the scope of the Work Queue. For example, a queue can be created where the Operators assigned to it only work with bumped appointments.

Appointments qualify for an Operator's queue based on a combination of the following:

- > the Operator's Department/Practice security permissions when the Practice/ Organization has Department/Practice Security setup.
- > the selections made relative to the filters on the work queue management screen

Note: Auto assigning work items is not an option for this management category. All work items display in list view in the Operator's work space.

The field Inactivation Date is informational only.

Appointment management selections in Work Queue Maintenance

This section describes the configuration of **Work Queue Maintenance** when you set **Management Category** to **Appointment**.

To access the Appointment Management category, set **Management Category** to **Appointment** in **Work Queue Maintenance**. To access **Work Queue Maintenance**, go to **System Administration > File Maintenance** and click on **Work Queue Maintenance** or use **F9 > WQM**.

Management Category:

Select Work Queue:

Work Queue Description:

Selections

VIP Patients Only

Select Sched. Location:

Select Sched. Dept:

Select Resource:

Select Coverage Status:

Select Confirmation Result:

Select Referral Status:

Referral Required?

No. of Appt Days from today:

Appt Date From: To:

No. of Appt Days Prior to today:

Inactivation Date:

Scheduled Cancelled

Wait List No Show

Confirmed Med Rec Reqs

Acknowledged Bumped

Acknowledged & Started

Acknowledged & Checked Out

Acknowledged & Started & Checked Out

Include Only Missing Charges

VIP Patients Only

Select this option to create appointment workflows exclusively for VIP patients.

Select Sched. Location

Restricts the search for qualifying appointments to the selected scheduling locations.

Select Sched. Dept

Restricts the search for qualifying appointments to the selected Scheduling Departments.

Note: If you are using Department Security or Practice Security: the actual results retrieved for a given operator's queue is driven by that operator's access to the departments associated with the scheduling departments selected as search filters. For example, if operator X is given access to departments A and B, he or she only receives appointments scheduled for those scheduling departments associated with departments A and B, even if the search filters are set for scheduling departments associated with departments A, B, C, and D.

Select Resource

Restricts the search for qualifying appointments to those scheduled with the selected resource or resource group.

Select Coverage Status

Restricts the search for qualifying appointments to those with the selected coverage status(es).

The select records dialog lists those coverage statuses available on **Appointment Detail:** Yes, No, Pending, Received, Exception.

You can find more information about color coding for referrals and coverage indicators elsewhere in the Help.

Select Referral Status

Restricts the search for qualifying appointments to those with the selected referral status(es).

The dialog lists the following options: Referral Attached, Referral Linked, No Referral

You can find more information about color coding for referrals and coverage indicators elsewhere in the Help.

Referral Required

Select this option when you want qualifying appointments to also have **Referral Required** checked.

Appointment Days selections

Appointment days refers to blocked days, i.e. days defined in Schedule Planning.

For example, if the month of April has 13 days that are blocked then only those 13 days are counted or searched when the system looks for appointments to add to the Operator's queue.

Also, keep in mind that the exact blocked days of those 13 days which are used to gather query results is also dependent on the combination of Schedule Locations, Schedule Departments and Resources selected as filters for the queue. For example, if the query is setup to search for appointments for Resource X and Resource X only has 3 days blocked for appointments in April then based on the appointment days filter you define, only those 3 days are used in the search.

Note: You can only select 1 of these options. To change your selection you must first delete the value entered in the field or fields. This enables the fields for all three options.

No. of Appt Days from today

An entry of "0" equals "today."

Searches for those appointments scheduled for today's date, that is, the date the Operator opens his/her queue to work on assigned appointments.

An entry of "1" or higher tells the system to find the first blocked day from today (the day the Operator opens his/her queue) and begin counting days

Examples:

No. of Appt Days from today = 1- If the Operator opens his/her queue on Friday, April 10th and the first appointment date (day blocked for appointments) from today, the 10th, is Monday April 13th then the Operator's queue is made up of those appointments booked for Monday the 13th. If the Operator opens his/her queue on Monday April 13 and the first appointment date from today, the 13th is Tuesday the 14th, then the Operator's queue is made up of those appointments booked for Tuesday the 14th.

No. of Appt Days from today = 3 - In this example all weekdays in May are blocked. Saturdays and Sundays are not blocked. If the Operator opens his/her queue on Monday, May 4th. The system will search for the 3rd day from the 4th of May,(i.e. 5th, 6th, 7th) and add the appointments booked on May 7th to the Operator's queue. If the Operator opens his/her queue on Thurs May 7th ... the blocked days used are May 8, 11,12 because weekend days are not blocked. In this example the Operator is given those appointments booked on May 12th.

Appt Date From and To

Enter a range of appointment (blocked) dates the system will scan to search for qualifying appointments.

No. of Appt Days Prior to today

An entry of "0" equals "today."

Searches for those appointments scheduled for today's date, that is, the date the Operator opens his/her queue to work on assigned appointments.

An entry of "1" or higher tells the system to find the first blocked day prior to today (the day the Operator opens his/her queue) and begin counting backwards.

Example: No. of Appt Days prior to today = 3. If the Operator opens his/her queue on Monday, July 6 and the first appointment date prior to today is July 2 with blocked days for July 1, June 30th and June 29th. When the Operator opens his/her queue the system starts counting backwards starting with July 2nd. In this example, appointments for June 30th are added to the Operators queue as June 30th is the 3rd appointment (blocked) day from today's date of July 6th.

Inactivation Date

Informational only. This function is specifically for pending claims and unpaid claims work queues created with a defined Workflow Organization Basis.

Appointment Status section

This grid holds the standard list of appointment statuses. All check boxes in this section are selected by default. Click a check box to clear it. Only appointments that also have a status that is selected qualify to be included in the search results.

Note: Selecting **Acknowledged** queries for acknowledged appointments that do not have a start or check out time entered.

Acknowledgement Status section

When the status **Acknowledged** is checked the options in the lower grid **Acknowledgment Status** are enabled. All the check boxes in this are optional. You can combine these options: for example, to search for acknowledged appointments that have either the **Started** or the **Checked Out** time box blank, select both **Acknowledged & Started** and **Acknowledged & Checked Out**. If you do not select an option and **Acknowledged** is selected in the Appointment Status section, the application searches for acknowledged appointments that have both the **Started** and **Checked Out** time boxes blank.

Acknowledged & Started

Looks for appointments with the status of acknowledged and that also have a start time only entered. (No check out time is entered for the appointment).

Acknowledged & Checked Out

Looks for appointments with the status of acknowledged and that also have a check out time only entered. (No start time is entered for the appointment.)

Acknowledged & Started & Checked Out

Looks for appointments with the status of acknowledged and that also have both a start time and a check out time entered.

Appointment Encounters section

Include Only Missing Charges

When selected, you can create work queues that only include appointments that do not have a charge associated to the appointment encounter number.

Analyze button

Use this button to get a sense of how many work items would be included in the queue if it were opened by an Operator at this point. **Analyze** calculates the total number of patient records that qualify for the work queue, regardless of your VIP privileges.

Note: If your Practice/Organization is using department security, be sure to factor this into your understanding of the results. Make any changes you feel are necessary.

Pending claims management selections in Work Queue Maintenance

To create or manage pending claims work queues, set **Management Category** to **Pending Claims** on **Work Queue Maintenance**.

To access the options for pending claims, set **Management Category** to **Appointment** in **Work Queue Maintenance**. To access **Work Queue Maintenance**, go to **System Administration > File Maintenance** and click on **Work Queue Maintenance** or use **F9 > WQM**.

Note: If you have a workflow organization basis selected in **Practice Options** or **Organization Options**, the selection boxes for the bases you selected are unavailable. For example, if you set the **Workflow Organization Basis** for pending claims to **Department** or **Practice**, **Select Departments** or **Select Practices** is unavailable.

Work Queue Maintenance

Management Category: <input type="button" value="Pending Claims"/>	Select Work Queue: <input type="button" value=""/>	Work Queue Description: <input type="text"/> <input type="checkbox"/> Auto Assign Work Items
Selections		
Type of Pending Claim <input checked="" type="radio"/> All Pending Claims <input type="radio"/> Failed Validation <input type="radio"/> Held Vouchers	Select Media Type <input checked="" type="radio"/> All v4010 Electronic and Paper Formats <input type="radio"/> v4010 Electronic Format <input type="radio"/> v5010 Electronic Format <input type="radio"/> Paper Format	
Type of Validation Error <input type="checkbox"/> Claim Errors <input type="checkbox"/> Demographic Errors <input type="checkbox"/> File Maintenance Errors <input type="checkbox"/> Claim Edit Errors	Select Formats <input checked="" type="radio"/> All Formats <input type="radio"/> Selected Format Type <input type="button" value=""/> <input type="radio"/> Selected Format <input type="button" value=""/>	
<input type="checkbox"/> VIP Patients Only		
Select Actual Providers: <input type="button" value="All Actual Providers"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Select Locations: <input type="button" value="All Locations"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Select Billing Providers: <input type="button" value="All Billing Providers"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Select Places of Service: <input type="button" value="All Places of Service"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Select Departments: <input type="button" value="All Departments"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Select Visit Types: <input type="button" value="All Visit Types"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Select Insurance Carriers: <input type="button" value="All Insurance Carriers"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Select Claim Edits: <input type="button" value="All Claim Edits"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Inactivation Date: <input type="text"/>		
<input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>		

Type of Pending Claim

Required. The type of pending claim to include in the work queue. You must select 1 of the following options:

- > **All Pending Claims**
- > **Failed Validation:** If you select this option, the **Type of Validation Error** area is enabled.
- > **Held Vouchers:** If you select this option, the **Select Hold Status** area is displayed instead of the **Select Media Type** area.

Select Media Type

Required. The work queue includes only pending claims with a format that matches the selection here. You must select 1 of the following options:

- > **All v4010 Electronic and Paper Formats**
- > **v4010 Electronic Format**
- > **v5010 Electronic Format**
- > **Paper Format**

If you select **v4010 Electronic Format**, **v5010 Electronic Format**, or **Paper Format**, the options in **Select Formats** are enabled. Use these options to determine which formats to include in this work queue.

Select Hold Status

This area is displayed only when you set **Type of Pending Claim** to **Held Vouchers**. (It replaces the **Select Media Type** area.) Select any combination of the following options.

- > **All Insurance Billing**
- > **Electronic Claim Billing**
- > **All Billing (Insurance + Self Pay)**

Type of Validation Error

Available when you set **Type of Pending Claim** to **Failed Validation**. Use this area to select the types of validation errors to include in this work queue. You can select any combination of the following options.

- > **Claim Errors**
- > **Demographic Errors**
- > **File Maintenance Errors**

Select Formats

Available when you set **Select Media Type** to **v4010 Electronic Format**, **v5010 Electronic Format**, or **Paper Format**. Use these options to determine exactly which claim formats to include in this work queue: only pending claims that have 1 of the formats you select here qualify for this work queue. If this section is enabled, you must select 1 of the following options:

- > **All Formats**
- > **Selected Format Type**: when you select this option, the drop-down box next to it is enabled. Use the drop-down box to select which format type to include in this work queue. You can only select 1 format type. The list includes all format types that have the media type you selected in **Select Media Type**.
- > **Selected Format**: when you select this option, the drop-down box next to it is enabled. Use the drop-down box to select which format to include in this work queue. You can only select 1 format.

VIP Patients Only

Select this option to create pending claims workflows exclusively for VIP patients.

Select Actual Providers

Restricts the work queue to include only pending claims with selected providers. Click  to open **Select Actual Providers** and choose the providers to include.

Select Billing Providers

Restricts the work queue to include only pending claims with selected billing providers. Click  to open **Select Billing Providers** and choose the billing providers to include.

Select Departments or Select Practices

Restricts the work queue to include only pending claims associated with selected departments. Click  to open **Select Departments or Select Practices** and choose the departments or practices to include.

Select Insurance Carriers

Restricts the work queue to include only pending claims associated with selected insurance carriers, categories, or reporting classes. Click  to open **Select Insurance Carriers**. **Select Insurance Carriers** has 3 tabs: **Categories**, **Reporting Classes**, and **Insurance Carriers**. Use these tabs to limit the work queue to include only selected insurance categories, reporting classes, and insurance carriers as necessary.

Select Locations

Restricts the work queue to include only pending claims associated with selected locations. Click  to open **Select Locations** and select the locations to include.

Select Places of Service

Restricts the work queue to include only pending claims associated with selected places of service. Click  to open **Select Places of Service** and select the places of service to include.

Select Visit Types

Restricts the work queue to include only pending claims associated with selected visit types. Click  to open **Select Visit Types** and select the visit types to include.

This option is only available when **Enable Visit Type** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**.

Inactivation Date

The date when this work queue will no longer be active. Enter a date in the format mm/dd/yyyy or click the down arrow and use the calendar to select a date.

Analyze

Analyze is displayed only when you are creating a new work queue. After you make your selections for the work queue, click **Analyze** to determine how many vouchers currently qualify for the work queue. The total is displayed next to **Analyze**.

Note: **Analyze** calculates the total number of patient records that qualify for the work queue, regardless of your VIP privileges.

Unpaid claims management category selections in Work Queue Maintenance

To create or manage unpaid claims work queues, set **Management Category** to **Unpaid Claims** on **Work Queue Maintenance**.

Access **Work Queue Maintenance** from **System Administration > File Maintenance > Work Queue Maintenance**.

Tip: To quickly access **Work Queue Maintenance**, press **F9**, then enter **WQM**.

Work Queue Maintenance

Management Category: <input type="button" value="Unpaid Claims"/> Select Work Queue: <input type="button"/> Work Queue Description: <input type="text"/> <input type="checkbox"/> Auto Assign Work Items	Selection <input type="checkbox"/> VIP Patients Only Select Account Types: <input type="button" value="All Account Types"/> Select Actual Providers: <input type="button" value="All Actual Providers"/> Select Billing Providers: <input type="button" value="All Billing Providers"/> Select Claim Note Types: <input type="button" value="All Claim Note Types"/> Select Claim Stat Cats: <input type="button" value="All Claim Status Categories"/> Select Claim Stat Codes: <input type="button" value="All Claim Status Codes"/> Select Departments: <input type="button" value="All Departments"/> Select Insurance Carriers: <input type="button" value="All Insurance Carriers"/> Select Locations: <input type="button" value="All Locations"/> Select Places of Service: <input type="button" value="All Places of Service"/> Select Visit Types: <input type="button" value="All Visit Types"/>	Select Reimb. Comments: <input type="button" value="All Reimbursement Comments"/> Select Remark Codes: <input type="button" value="All Remark Codes"/> Include Claims Over: <input type="button" value="Days Old"/> Billing Date - From: <input type="button"/> To: <input type="button"/> C/S Import Date - From: <input type="button"/> To: <input type="button"/> F/U Date - From: <input type="button"/> To: <input type="button"/> No. of F/U days from today: <input type="button"/> Patient Last Name From: <input type="button"/> To: <input type="button"/> Updated Voucher Balance: <input type="button"/> Order Claims By: <input type="button"/> <input checked="" type="checkbox"/> Include Partially Paid Claims
<input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>		

Note: If you have a workflow organization basis selected in **System Administration > File Maintenance > Practice Options** (or **Organization Options**), the selection boxes for the bases you selected are unavailable. For example, if you set the **Workflow Organization Basis** for unpaid claims to **Department** or **Practice**, **Select Departments** or **Select Practices** is unavailable.

Select Account Types

Restrict the work queue to include only unpaid claims with selected account types. Click to open **Select Account Types**, then select which providers to include.

Select Actual Providers

Restrict the work queue to include only unpaid claims with selected providers. Click  to open **Select Actual Providers**, then select which providers to include.

Select Billing Providers

Restrict the work queue to include only unpaid claims with selected billing providers. Click  to open **Select Billing Providers**, then select which providers to include.

Select Claim Note Types

Restrict the work queue to include only unpaid claims with selected claim note types. Click  to open **Select Claim Note Types**, then select which claim note types to include.

Select Claim Stat Cats

Restrict the work queue to include only unpaid claims with selected claim status categories. Click  to open **Select Claim Status Categories**, then select which claim status categories to include.

Select Claim Stat Codes

Restrict the work queue to include only unpaid claims with selected claim status codes. Click  to open **Select Claim Status Codes**, then select which claim status codes to include.

Select Departments or Select Practices

Restrict the work queue to include only unpaid claims from selected departments or practices. Click  to open **Select Departments or Select Practices**, then select which departments or practices to include.

Select Insurance Carriers

Restrict the work queue to include only unpaid claims associated with selected insurance carriers, categories, or reporting classes, or with self-pay.

To include only self-pay claims, click .

Click  to open **Select Insurance Carriers**. **Select Insurance Carriers** has three tabs:

- > **Categories**
- > **Reporting Classes**
- > **Insurance Carriers**.

Use these tabs to limit the work queue to include only selected insurance categories, reporting classes, and insurance carriers as necessary.

Select Locations

Restrict the work queue to include only unpaid claims from selected locations. Click to open **Select Locations**, then select which locations to include.

Select Places of Service

Restrict the work queue to include only unpaid claims from selected places of service. Click to open **Select Places of Service**, then select which places of service to include.

Select Visit Types

Restrict the work queue to include only unpaid claims from selected visit types. Click to open **Select Visit Types**, then select which visit types to include.

Important: This option is only available when **Enable Visit Type** is selected on the **Visit Type** tab in **System Administration > File Maintenance > Practice Options or Organization Options**.

Select Reimb Comments

Restrict the work queue to include only unpaid claims with selected reimbursement comments. Click to open **Select Locations**, then select which reimbursement comments to include.

Select Remark Codes

Restrict the work queue to include only unpaid claims associated with selected remark codes. Click to open **Select Locations**, then select which remark codes to include.

Include Claims Over [xx] Days Old

Restrict the work queue to include only unpaid claims that are older than the number of days you select. Enter a number.

Billing Date From and To

Restrict the work queue to include only unpaid claims with a billing date on or between the dates you select. Enter a date using mm/dd/yyyy format or select a date from the list.

C/S Import Date From and To

Important: These boxes are for use with Allscripts® Interface Engine Claim Status Interface. If you use the Allscripts® Interface Engine Claims Status Interface, you can enter a claims status import date or date range.

Restrict the search to those claims for which an unsolicited 277 message file has been received and processed through the interface thus linking the message codes to the claims. This entry

should be used in conjunction with the selection of specified claim status category codes and claim status codes.

F/U Date From and To

Restrict the work queue to include only unpaid claims with a follow-up date within the range of date you select. Enter a date using the format mm/dd/yyyy or select a date from the calendar.

No. of F/U days from today

Restrict the work queue to include only unpaid claims with a follow-up date that is a certain number of days from the current date. Enter a number or select a number from the list.

For example, if you enter 1 in **No. of F/U days from today**, you will see vouchers that have a claim note with a follow up date one day from today. If today is 5/16/19 and a voucher has a claim note with a follow up date of 5/17/19, that voucher will display because the follow up date is one day from today.

If you enter 2 in **No. of F/U days from today**, you will see vouchers that have a claim note with a follow up date of up to two days from today. If today is 5/16/19 and one voucher has a claim note with a follow up date of 5/17/19 and another voucher has a follow up date of 5/18/19, both vouchers will display.

Patient Last Name From and To

Restrict the work queue to include only patients with a last name within the range that you select. Enter letters or select letters from the drop-down list.

Updated Voucher Balance

Restrict the work queue to include only vouchers with an updated voucher balance greater than or less than the amount you enter. Click the less than symbol (>) to change it to a greater than symbol (<).

Order Claims By

Select how to order claims in the work queue. You must select one of the following options.

- > Age of Claim
- > Claim Balance

Include Partially Paid Claims

Select this option to include partially paid claims in the work queue.

Inactivation Date

|| **Note:** The date when this work queue will no longer be active.

Enter a date in the format mm/dd/yyyy or click the down arrow and use the calendar to select a date.

Analyze

Important: **Analyze** is displayed only when you are creating a new work queue.

Click **Analyze** to determine how many vouchers currently qualify for the work queue. The total is displayed next to **Analyze**.

Work items in Office Manager

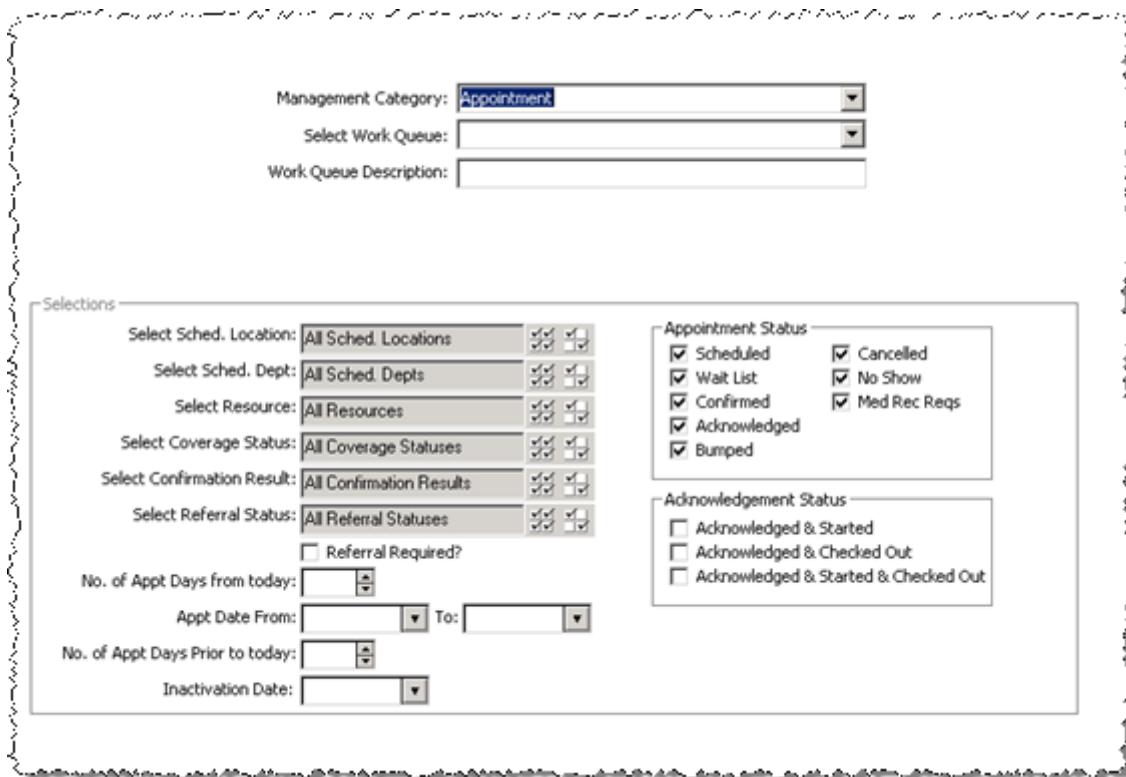
The type of work items that qualify for work queues depends on the type of work queue that the item is a member of.

Management category	Types of work items
Appointment	Each appointment is a work item.
Pending Claims	Each voucher is a work item.
Unpaid Claims	Each claim is a work item.
Automated self-pay collections	Each voucher is a work item.

Appointment work queues

Create work queues that define the task you want your Operators to perform.

The screen shot below depicts the configuration of the Work Queue maintenance screen when Appointment is selected as the Management Category.



Select work queue

Drop down that allows you to select previously created work queues.

Note: Stored Jobs saved in Appointment Management in Scheduling are not included in the pick list for Appointment Management in Office Manager.

When you click New this field is disabled.

Work queue description

Enter a description which defines the purpose of the work queue. For example, "Confirm Appts."

Selections

Make selections that define the scope of the Work Queue. For example, a queue can be created where the Operators assigned to it only work with bumped appointments.

Appointments qualify for an Operator's queue based on a combination of the following:

- > the Operator's Department/Practice security permissions when the Practice/ Organization has Department/Practice Security setup.
- > the selections made relative to the filters on the work queue management screen

Note:

Auto assigning work items is not an option for this management category.
 All work items display in list view in the Operator's work space.
 The field Inactivation Date is informational only.

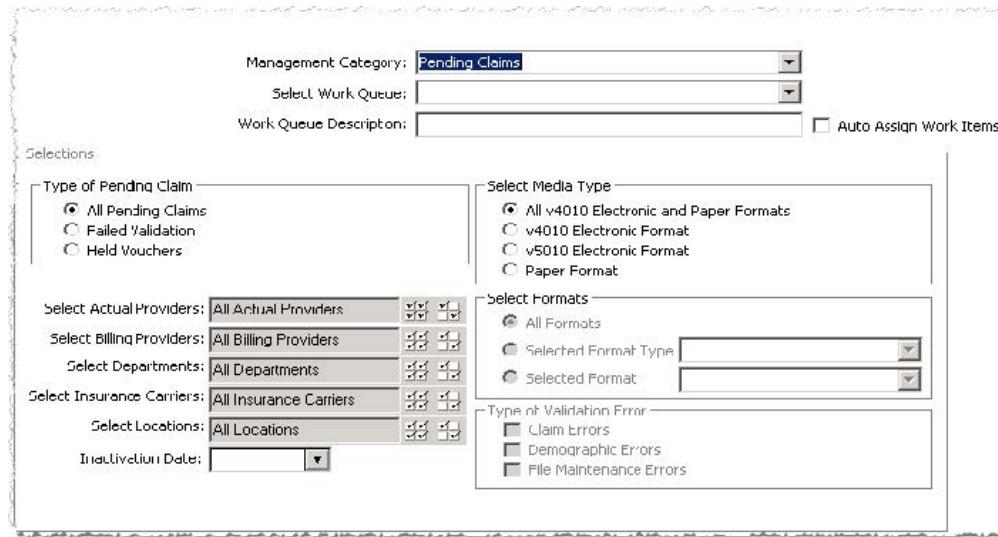
Pending claims work queues

Use pending claims work queues to define the task you want your operators to perform. The steps you must take to create a work queue depends on whether or not you are using a workflow organization basis for Pending Claims Management.

The selections displayed for the pending claims management category vary depending on whether or not you use a workflow organization basis.

Creating a work queue when a workflow organization basis is not defined

The screen shot below depicts the configuration of the Work Queue Maintenance screen when Pending Claims is selected as the Management Category and you are not using a workflow organization basis.

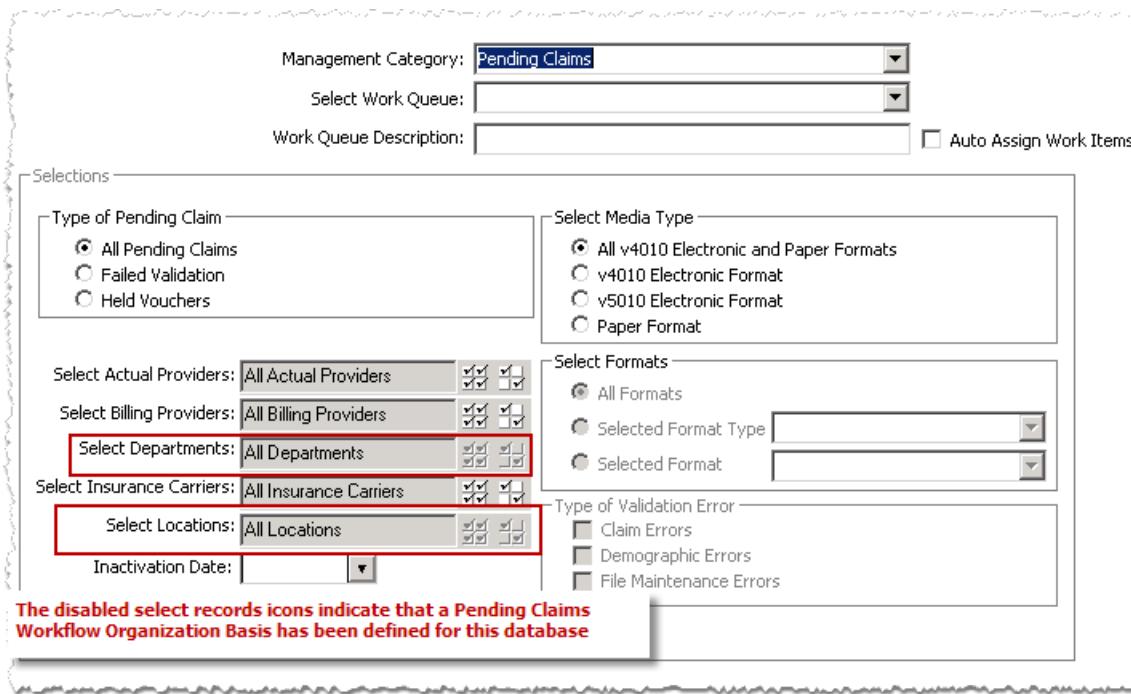


The screenshot shows the 'Work Queue Maintenance' screen with the following configuration:

- Management Category:** Pending Claims
- Select Work Queues:** (empty dropdown)
- Work Queue Description:** (empty text box)
- Auto Assign Work Items:** (unchecked checkbox)
- Selections:**
 - Type of Pending Claim:** All Pending Claims (radio button selected)
 - Select Actual Providers:** All Actual Providers
 - Select Billing Providers:** All Billing Providers
 - Select Departments:** All Departments
 - Select Insurance Carriers:** All Insurance Carriers
 - Select Locations:** All Locations
 - Inactivation Date:** (dropdown menu)
- Select Media Type:**
 - All v4010 Electronic and Paper Formats (radio button selected)
 - v4010 Electronic Format
 - v5010 Electronic Format
 - Paper Format
- Select Formats:**
 - All Formats
 - Selected Format Type: (dropdown menu)
 - Selected Format: (dropdown menu)
- Type of Validation Errr:**
 - Claim Errors
 - Demographic Errors
 - File Maintenance Errors

Creating a work queue when a workflow organization basis is defined

When you have defined a Pending Claims Workflow Organization Basis the select record(s) that correspond to your basis is/are disabled on the Pending Claims Work Queue Maintenance form. For example, if your Pending Claims Workflow Organization Basis is: Location then Department, then in Work Queue Maintenance the select records dialogs for Locations and Department are unavailable. You will be making those selections in Workflow Organization Maintenance. The screen shot below illustrates this.



The screenshot shows the Pending Claims Management screen with several selection fields:

- Management Category:** Pending Claims (selected)
- Select Work Queue:** (disabled dropdown)
- Work Queue Description:** (disabled input field)
- Type of Pending Claim:**
 - All Pending Claims
 - Failed Validation
 - Held Vouchers
- Select Media Type:**
 - All v4010 Electronic and Paper Formats
 - v4010 Electronic Format
 - v5010 Electronic Format
 - Paper Format
- Select Actual Providers:** All Actual Providers (disabled dropdown)
- Select Billing Providers:** All Billing Providers (disabled dropdown)
- Select Departments:** All Departments (disabled dropdown)
- Select Insurance Carriers:** All Insurance Carriers (disabled dropdown)
- Select Locations:** All Locations (disabled dropdown)
- Inactivation Date:** (disabled input field)
- Select Formats:**
 - All Formats
 - Selected Format Type (disabled dropdown)
 - Selected Format (disabled dropdown)
- Type of Validation Error:**
 - Claim Errors
 - Demographic Errors
 - File Maintenance Errors

A red box highlights the "Select Departments" field. A red note at the bottom left of the form area states: "The disabled select records icons indicate that a Pending Claims Workflow Organization Basis has been defined for this database".

Completing the form

Except for the disabled select records related to a workflow organization basis, the way you make selections on the Pending Claims Management screen is the same whether or not you have defined a workflow organization basis.

Select work queue

Drop down that allows you to select previously created work queues and Pending Claims stored jobs. When you click **New** this field is disabled.

Work queue description

Enter a description which clearly identifies the nature of the queue, for example, Failed Electronic, Failed Paper or Held Claims.

Auto assign work items

When Checked - Work is served to the operator one voucher at a time using the system associated Work Screen for the Management Category, i.e. for Pending Claims the Operator's workspace is the Pending Claims Correction screen; for Unpaid Claims the workspace is the Account Ledger screen.

When Not Checked - Work items (vouchers) display in a list view the same way they appear in Pending Claims Management and Unpaid Claims Management. Users are then free to select any voucher from the list.

Selections

Make selections that define the scope of the Work Queue. For example, a Queue can be created where the Members of the Group assigned to it only work with claims that have failed Validation.

Unpaid claims work queues

Create work queues that define the task you want your Operators to perform.

The steps you must take to create a work queue depends on whether or not you are using a workflow organization basis for Pending Claims Management.

Creating a work queue when a workflow organization basis is not defined

The screen shot below depicts the configuration of the screen in Work Queue maintenance when Unpaid Claims is selected as the Management Category and you are not using a workflow organization basis.

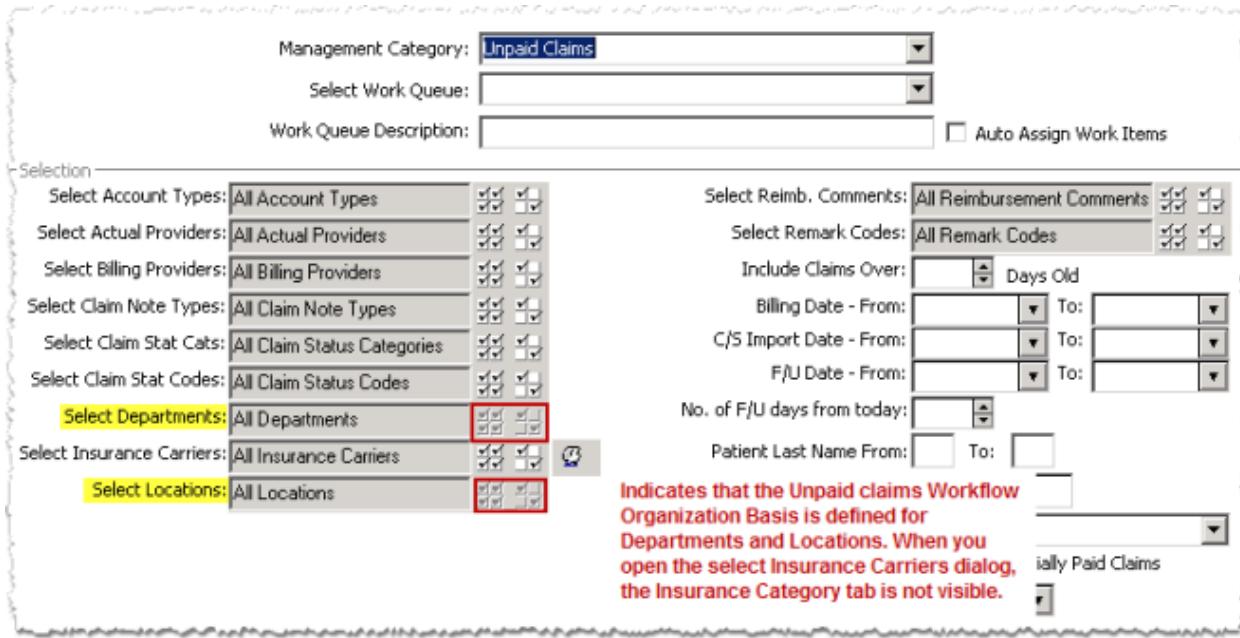
Work Queue Maintenance

Management Category: <input type="text" value="Unpaid Claims"/> Select Work Queue: <input type="text"/> Work Queue Description: <input type="text"/> <input type="checkbox"/> Auto Assign Work Items	Selection <input type="checkbox"/> VIP Patients Only Select Account Types: <input type="text" value="All Account Types"/> Select Actual Providers: <input type="text" value="All Actual Providers"/> Select Billing Providers: <input type="text" value="All Billing Providers"/> Select Claim Note Types: <input type="text" value="All Claim Note Types"/> Select Claim Stat Cats: <input type="text" value="All Claim Status Categories"/> Select Claim Stat Codes: <input type="text" value="All Claim Status Codes"/> Select Departments: <input type="text" value="All Departments"/> Select Insurance Carriers: <input type="text" value="All Insurance Carriers"/> Select Locations: <input type="text" value="All Locations"/> Select Places of Service: <input type="text" value="All Places of Service"/> Select Visit Types: <input type="text" value="All Visit Types"/>	Select Reimb. Comments: <input type="text" value="All Reimbursement Comments"/> Select Remark Codes: <input type="text" value="All Remark Codes"/> Include Claims Over: <input type="text" value="Days Old"/> Billing Date - From: <input type="text"/> To: <input type="text"/> C/S Import Date - From: <input type="text"/> To: <input type="text"/> F/U Date - From: <input type="text"/> To: <input type="text"/> No. of F/U days from today: <input type="text"/> Patient Last Name From: <input type="text"/> To: <input type="text"/> Updated Voucher Balance: <input type="text"/> Order Claims By: <input type="text"/> <input checked="" type="checkbox"/> Include Partially Paid Claims
<input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>		

Creating a work queue when a workflow organization basis is defined

When you have defined an Unpaid Claims Workflow Organization Basis the select record(s) that correspond to your basis is/are disabled on the Unpaid Claims Work Queue Maintenance form.

For example, if your Unpaid Claims Workflow Organization Basis is: **Location > Department** or **Practice > Insurance Category** then in Work Queue Maintenance the select records dialogs for Locations and Departments/Practices are unavailable. The Insurance Carriers select records dialog does not include the tab for Insurance Category. You will be making those selections in Workflow Organization Maintenance. The screen shot below illustrates this.



The screenshot shows the 'Management Category' set to 'Unpaid Claims'. Under 'Selection', 'Select Account Types', 'Select Actual Providers', 'Select Billing Providers', 'Select Claim Note Types', 'Select Claim Stat Cats', 'Select Claim Stat Codes', and 'Select Departments' are all set to 'All [Category]'. 'Select Insurance Carriers' and 'Select Locations' are also present. A note in red text indicates: 'Indicates that the Unpaid claims Workflow Organization Basis is defined for Departments and Locations. When you open the select Insurance Carriers dialog, the Insurance Category tab is not visible.' There are dropdown menus for 'Select Reimb. Comments', 'Select Remark Codes', and date ranges for 'Include Claims Over', 'C/S Import Date - From', 'F/U Date - From', and 'No. of F/U days from today'. A checkbox for 'Auto Assign Work Items' is also shown.

Completing the form

Except for the disabled select records related to a workflow organization basis, the way you make selections on the Unpaid Claims Management screen is the same whether or not you have defined a workflow organization basis.

Select work queue

Drop down that allows you to select previously created work queues and Unpaid Claims stored jobs. When you click **New** this field is disabled.

Work queue description

Enter a description which clearly identifies the nature of the queue, for example, Failed Electronic, Failed Paper or Held Claims.

Auto assign work items

When Checked - Work is served to the operator one voucher at a time using the system associated Work Screen for the Management Category, i.e. for Pending Claims the Operator's workspace is the Pending Claims Correction screen; for Unpaid Claims the workspace is the Account Ledger screen.

When Not Checked - Work items (vouchers) display in a list view the same way they appear in Pending Claims Management and Unpaid Claims Management. Users are then free to select any voucher from the list.

Selections

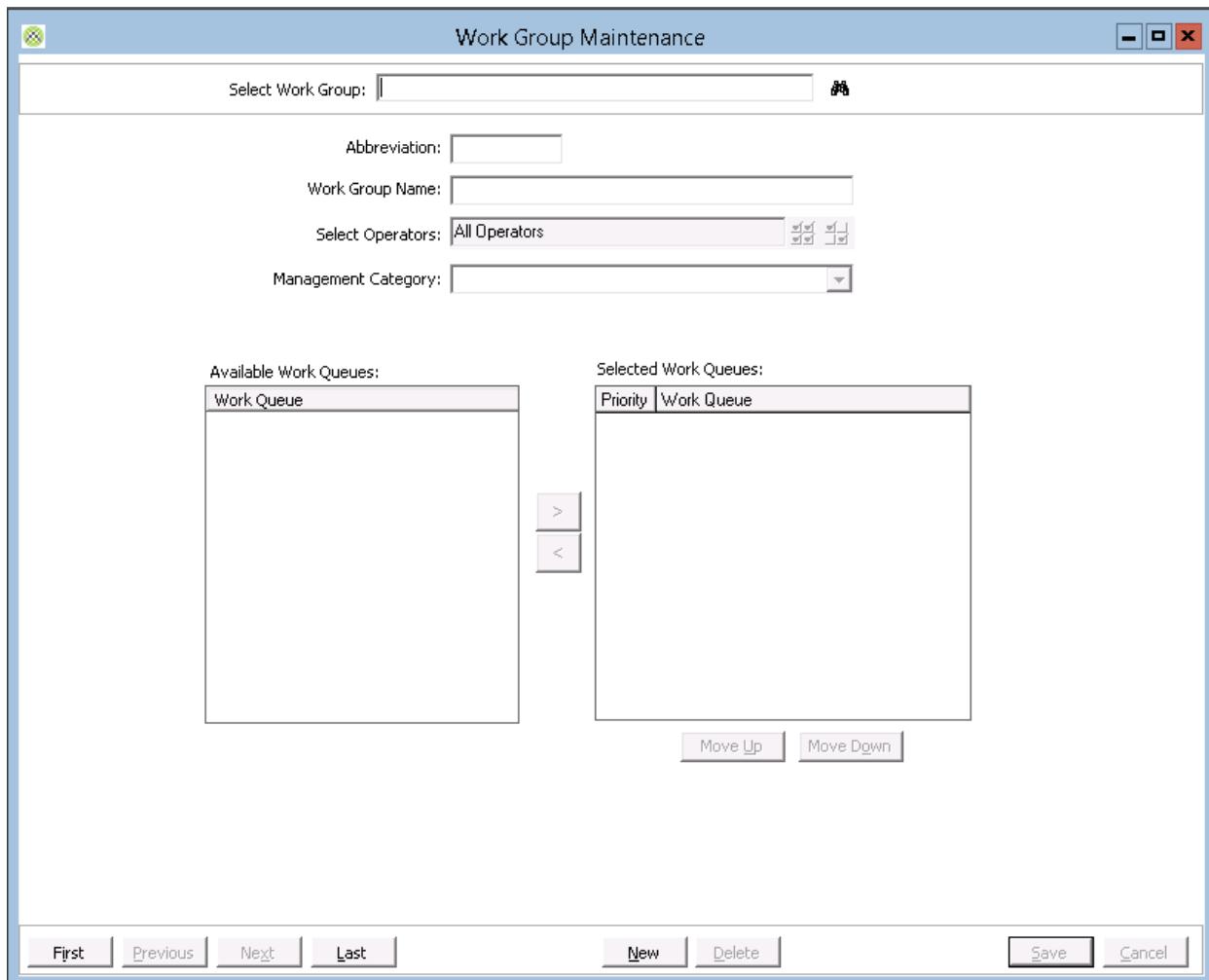
Make selections that define the scope of the Work Queue. For example, a Queue can be created where the Operators assigned to it, only work with BCBS claims out 45 days or more.

If your practice or organization uses uninsured carriers, vouchers associated with uninsured carriers are included in workflows where self-pay vouchers are selected and the vouchers qualify.

Note: By clicking on the Self-Pay icon on the Select Insurance Carriers field, you can define a work queue to manage unpaid self-pay vouchers. You cannot select both insurance carriers and self-pay vouchers for the same work queue. If your practice or organization uses uninsured carriers, only traditional self-pay vouchers are added to **Select Insurance Carriers** when you click the self-pay icon.

Work Group Maintenance window

Access **Work Group Maintenance** from **System Administration > File Maintenance > Work Group Maintenance** or press **F9** and then enter **WGM**.



Creating work groups when there is no workflow organization

You must associate each work queue with a work group and its selected operators in order for a queue to be available when an Operator opens Office Manager.

Only those Operators selected in Work Group Maintenance for that group's associated work queue(s) have access to the queue.

Operators are assigned to work queues when they are selected as members of a work group.

An Operator can be assigned to more than one work group.

A work group can consist of one Operator and/or work queue or of multiple Operators and/or queues.

Items that qualify for the work group or groups to which the Operator is assigned are loaded when he/she opens Office Manager.

Operators and/or work queues can be added or removed from a work group at will. For example, if you notice a spike in the number of claims to be worked for the group BCBS 90+, you can temporarily assign an additional Operator to this group. Once the volume of claims to be worked is reduced, the additional Operator can be removed and added to another group.

Note: Because you cannot define a workflow organization basis for Appointment Management you must always associate work queues and work groups in the Appointment Management category.

Creating work groups when there is a workflow organization

When you have defined a workflow basis for a management category then work groups are used to group operators who have the same tasks and are, as a result, assigned to the same work queues within that management category.

In this way when you assign operators to work queues in Workflow Organization Maintenance you can select the group rather than a number of individual operators.

Operators can be selected for multiple groups.

Each Work Group you create is available to be assigned to a Work Queue in Workflow Organization Maintenance.

See the online topics related to creating work groups.

Workflow Organization Maintenance window

Use **Workflow Organization Maintenance** to set the priority of the different work queues created in **Work Queue Maintenance**. When an account qualifies for multiple work queue, the workflow organization basis determines which work queue the account goes to.

The select records dialogs that correspond to the workflow organization basis criteria are now made available. This allows you to set up work queues for operators based on your workflow.

For example, if your unpaid claims management workflow basis is Location > Billing Provider > Insurance Category, and you created work queues: Over 45 Days, Over 60 Days, Over 90 Days, you can now create workflow organizations that filter the claims in each of these work queues by Location, by Billing Provider, by Insurance Category.

Access **Workflow Organization Maintenance** from **System Administration > File Maintenance > Workflow Organization Maintenance** or press **F9** and then enter **WOM**.

Workflow Organization Maintenance

Select Workflow Organization:

Abbreviation:

Description:

Management Category:

Select Workflow Organization Criteria

Available Work Queues:

Work Queue

Work Queues Selected:

Priority	Work Queue

> <

Move Up Move Down

First Previous Next Last New Delete Save Cancel

Abbreviation

The abbreviated name of the workflow organization basis.

Description

The full name of the workflow organization basis.

Management Category

When you select a management category, any additional selections for that category are displayed below **Select Workflow Organization Criteria** and the available work queues for that management category are listed in **Available Work Queues**. The management categories are:

- Pending Claims
 - Self-Pay Collections

> Unpaid Claims

Select Departments, Select Practices, or Select Divisions

This box is labeled **Select Departments**, **Select Practices**, or **Select Division** depending on your selection for **Workflow Basis** in **Practice Set Up** or **Organization Set Up**.

Click the icon with 2 check marks to open a selection window and select which departments, practices, or divisions you want to include in this workflow organization basis.

Best Practice:

It is a best practice to have each workflow organization basis associated with only 1 department, practice or division.

If necessary, you can create a workflow organization basis that includes work queues from multiple departments, practices, or divisions; however, the same department, practice, or division cannot be associated with multiple workflow organization bases, even if not all of the work queues are included in the workflow.

Available Work Queues

This list includes all of your current work queues. To be displayed in this list, a work queue must:

- > Exist in **Work Queue Maintenance**
- > Have **Management Category** set to **Self-Pay Collections**
- > Have an inactivation date that is not on or before the current date

Use the > arrow to move a work queue from **Available Work Queues** to **Work Queues Selected** and the < arrow to move it back. First move the queue you want to give the highest priority, then the second-highest priority, and so forth.

Work Queues Selected

When you move a work queue from **Available Work Queues** to **Work Queues Selected**, it is automatically assigned a priority number based on the order you moved it in. For example, the very first work queue you move to **Available Work Queues** always has a **Priority of 1**. Use **Move Up** and **Move Down** to rearrange the priority of the queues in **Work Queues Selected** as necessary.

The priority order you set determines which work queue an account goes to when it qualifies for more than 1 work queue. If an account qualifies for more than 1 work queue, it is always assigned to the queue that has the higher priority number in the associated workflow organization basis.

Note: The priority order determines what work queues an account is associated with when it first qualifies for automated self-pay collections. The account stays in that work queue through the entire automated self-pay collections process.

To associate particular operators with a work queue, click  to open a selection window.

Setting queue priorities

As you move each work queue to the right pane in the lower grid a number is assigned to the queue. This number represents the priority the system uses when searching for vouchers that should be assigned. Number 1 is the highest priority.

Keep in mind that the system looks at the queues in the order in which you prioritize them to determine if a voucher fits the criteria, if it doesn't then it moves on to see if the voucher fits the criteria for the next queue and so on. If a voucher meets the criteria of the first queue, it is assigned to that queue.

For example, If you have work queues for Over 45 Days, Over 60 Days, Over 90 Days, be sure that the priority is:

1. Over 90 Days
2. Over 60 Days
3. Over 45 Days

If you reverse the order and make Over 45 Days priority 1, then all vouchers over 45 days (that includes those over 60 and over 90) would fall into this queue with nothing going into the over 60 and 90 queues.

See the online help topics "Creating a Workflow Organization Maintenance for Unpaid Claims" and "Creating a Workflow Organization Maintenance for Pending Claims."



Chapter 12 Office Manager

Chapter 13

Automated Self-Pay Collections

Automated self-pay collections setup checklist

You must complete setup configuration within Allscripts® Practice Management to use automated self-pay collections.

Use this checklist to configure your application for automated self-pay collections. This checklist is meant to be a high-level overview only; refer to the tasks for each item in the online Help or the *Automated Self-Pay Collections Feature Guide* for specific steps.

Task	Completed
Verify that there are no self-pay accounts currently going through the collections process.	
In System Administration > Practice Set Up or Organization Set Up on the Automation tab, set Automation Category to Self-Pay Collections and then set Self-Pay Collections Management Workflow Organization Basis to the applicable workflow organization basis: Account, Department or Practice, or Division .	
In System Administration > File Maintenance > Automation Action Maintenance , create the automated actions to include in automated workflows.	
In System Administration > File Maintenance > Automation Workflow Maintenance , use the automated actions that you created to assemble 1 or more automated workflows.	
Create a self-pay collections work queue or queues in Work Queue Maintenance and assign the automated workflow that you created to that queue.	

Task	Completed
In System Administration > File Maintenance > Collector Maintenance , verify that Eligible for Distribution is selected for each collector who will have self-pay accounts automatically assigned to them in Office Manager .	
If you created more than 1 self-pay collections work queue, set the priority of the different queues in System Administration > File Maintenance > Workflow Organization Maintenance .	
If you have department security or practice security enabled, verify that the operator record for System in Operator Maintenance has access to all of your departments or practices granted on the Departments or Practices tab.	
Verify that all collectors are given access to the following security permissions in Administration > Security Manager > Security Permissions : <ul style="list-style-type: none"> <li data-bbox="241 1094 861 1127">> Office Manager > Self-Pay Collections <li data-bbox="241 1132 861 1199">> Actions/Toolbar Buttons > Collection Account Detail 	
In System Administration > Practice Set Up or Organization Set Up on the Automation tab, set Automation Category to Self-Pay Collections and then select Enable Automated Self-Pay Collections .	

Select a workflow organization basis for automated self-pay collections

To begin setting up automated self-pay collections, select a workflow organization basis on the **Automation** tab in **Practice Set Up** or **Organization Set Up**.

1. Go to the **Automation** tab on **System Administration > Practice Set Up** or **Organization Set Up**.

Tip: To quickly access **Practice Set Up** or **Organization Set Up**, press **F9**, then enter **PSU** or **OSU**.

2. For **Automation Category**, select **Self-Pay Collections**.

The self-pay collections options are displayed.

3. For **Self-Pay Collections Management Workflow Organization Basis**, select a workflow organization basis to use for automated self-pay collections in your current department or practice.

- > **Account**
- > **Department or Practice**
- > **Division**

Important: This option is displayed only if you have divisions enabled.

4. Click **Save**.

What to do next

Create automated actions in **Automation Action Maintenance**.

Automation Action Maintenance window

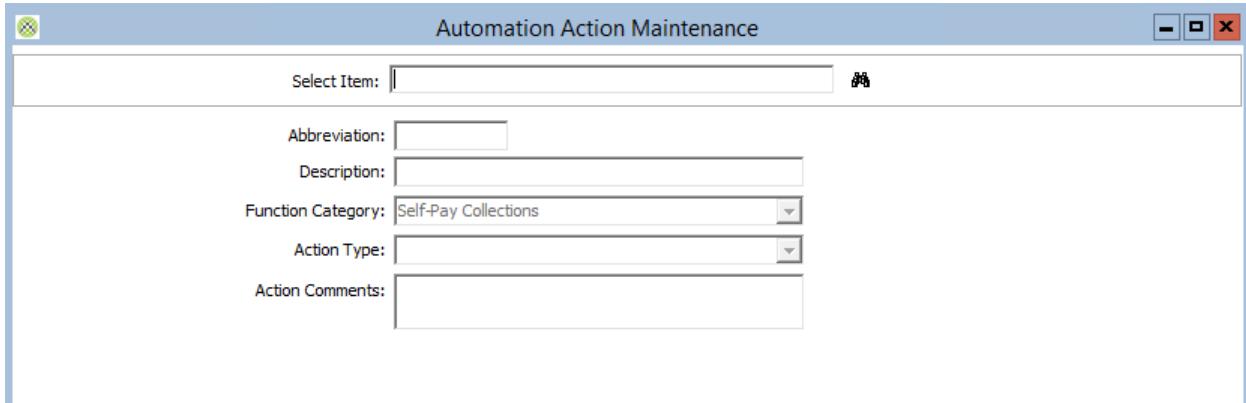
Use **Automation Action Maintenance** to create automated actions for use in automated self-pay collections workflows.

Note: Automated billing actions are not defined in **Automation Action Maintenance**. Use **Billing Automation Maintenance** to set up automated billing actions.

When you begin creating a new automated action, only the boxes on the top half of the window (**Abbreviation** through **Action Comment**) are displayed. These boxes are the same for every action type. The selections available on the lower half of the window vary depending on what selection you make in **Action Type**. When you select an action type, the corresponding boxes and selections for that action type are displayed on the lower half of **Automation Action Maintenance**. For example, if you set **Action Type** to **Adjust**, an area labeled **Adjust Selections** is displayed. Use the boxes in this area to complete your setup for the automated action.

Note: If you set **Action Type** to **Manual**, no additional selections are displayed. All you need to do to finish creating the automated action is click **Save**.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.



Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Create an automated action

Create automated actions from **Automation Action Maintenance**. These actions are performed by the application automatically when they are part of an automated self-pay collections workflow created in **Automation Workflow Maintenance**. You can also use **Automation Action Maintenance** to create an action to send an account out to a user to take a manual step.

1. Go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.

Automation Action Maintenance opens.

2. Click **New**.
3. For **Abbreviation**, enter a unique abbreviation to identify the automated action.
You can use up to 6 characters. Each automated action must have a unique abbreviation.
4. For **Description**, enter a unique description to distinguish the automated action from other actions.
5. For **Function Category**, select the type of automated action to create.

- > Change Account Type
- > Collection Note
- > Document
- > Export
- > Transfer

When you select a function category, the corresponding selections for that function category are displayed on the lower half of the window.

6. (Optional) For **Action Comments**, enter any notes, comments, or reminders that you want to remain with this record.

Note: The text entered in this box is automatically entered as the action comment when the application performs an action. It is also displayed in **Collections History** and **Collections Detail** for this action.

7. Depending on which function type you selected, complete the remaining selections on the lower half of the window as applicable.

8. Click Save.

What to do next

Add the automated action to an automation workflow in **Automation Workflow Maintenance**.

Automated actions are not performed unless they are part of an automated workflow that is associated with a work queue.

Adjustment action selections in Automation Action Maintenance

When you set **Action Type** to **Adjust** on **Automation Action Maintenance**, the adjustment selections are displayed on the lower half of the window. Use these selections to complete the automated action.

The adjust action type automatically adjusts the balances for qualifying vouchers that reach this step. All transactions generated as part of this action have a transaction date equal to the current practice date. All adjustment batches are given the default batch comment **Adjustments related to Collections Workflow**.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.

Automation Action Maintenance - (New Automation Action)

Select Item:	(New Automation Action)													
Abbreviation:	<input type="text"/>													
Description:	<input type="text"/>													
Function Category:	Self-Pay Collections													
Action Type:	Adjust													
Action Comments:	<input type="text"/>													
Adjust Selections: <table border="1"> <tr> <td>Adjust:</td> <td><input type="text"/></td> <td></td> </tr> <tr> <td>Select Carrier:</td> <td><input type="text"/></td> <td></td> </tr> <tr> <td>Batch Category:</td> <td><input type="text"/></td> <td></td> </tr> <tr> <td>Transaction Code:</td> <td><input type="text"/></td> <td></td> </tr> </table>			Adjust:	<input type="text"/>		Select Carrier:	<input type="text"/>		Batch Category:	<input type="text"/>		Transaction Code:	<input type="text"/>	
Adjust:	<input type="text"/>													
Select Carrier:	<input type="text"/>													
Batch Category:	<input type="text"/>													
Transaction Code:	<input type="text"/>													
Batches will be Automatically Updated														
<input type="button" value="First"/>	<input type="button" value="Previous"/>	<input type="button" value="Next"/>	<input type="button" value="Last"/>	<input type="button" value="New"/>	<input type="button" value="Delete"/>	<input type="button" value="Save"/>	<input type="button" value="Cancel"/>							

Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Adjust

Select which type of vouchers to adjust. Qualifying vouchers are adjusted automatically when they are in an automation workflow and the associated account reaches this action. The available selections include the following:

- > **All Self-Pay Balances**
- > **Overdue Self-Pay Balances**
- > **Vouchers from Selected Carrier(s)**

Select Carriers

Only enabled when **Adjust** is set to **Select Carriers**. When enabled, this box is required.

Click the select records icon () to the right of the box to open **Select Carriers** and select the collection carriers to include. **Select Carriers** only displays carriers that have **Collections Carrier** selected in **Insurance Carrier Maintenance**. Only vouchers associated with the carriers you select qualify for adjustment.

Batch Category

Select which batch category the application uses when it creates a batch for adjusted vouchers. This drop-down list includes all batch categories created in **Batch Category Maintenance**. You cannot create a new batch category from the list. **Batch Category** is a required entry if you have **Require Batch Category** selected on the **General** tab in **Practice Options** or **Organization Options**.

Transaction Code

Required entry. Select the adjustment transaction code. This transaction code will be used to adjust vouchers that go through this adjustment action. This drop-down list displays transaction codes that have **Transaction Type** set to **Adjustment** in **Transaction Code Maintenance**.

Automated collection adjustments

When creating an automated action with the **Adjust** action type on **Automation Action Maintenance** in **System Administration > File Maintenance**, you can choose to adjust all self-pay balances, only overdue self-pay balances, or only vouchers from selected carriers.

Tip: To quickly access **Automation Action Maintenance**, press **F9** on your keyboard, then enter **AAM**.

Adjustment action types

Select the type of automated adjustment action that you want to create using **Adjust**. The options are:

All Self-Pay Balances

Select this option to adjust all qualifying self-pay vouchers, regardless of whether they are considered overdue in your collections process.

To qualify, self-pay vouchers must have a billed date. In addition, which vouchers qualify depends on whether you process collections by account, department, or division.

Tip: To select how the system processes collections, use **Self-Pay Collections Management Workflow Organization Basis** on the **Automation** tab in **System Administration > Practice Set Up** or **Organization Set Up**.

When you process collections by account, the application adjusts all self-pay vouchers that qualify for the work queue. When you process collections by department, the application adjusts self-pay balances on the account that are associated with the department that qualified for the work queue. When you process collections by division, the application adjusts self-pay balances on the account that are associated with the division that qualified for the work queue.

Overdue Self-Pay Balances

Select this option to only adjust overdue self-pay vouchers.

A self-pay voucher is considered overdue if it is older than the number of days entered in **Accounts with Self-Pay Balances Over** for the voucher's work queue on **Work Queue Maintenance** in **System Administration > File Maintenance**. Which overdue vouchers qualify depends on whether you process collections by account, department, or division.

Tip: To select how the system processes collections, use **Self-Pay Collections Management Workflow Organization Basis** on the **Automation** tab in **System Administration > Practice Set Up** or **Organization Set Up**.

When you process collections by account, the application adjusts all overdue self-pay vouchers on the account. When you process collections by department, the application adjusts overdue self-pay vouchers on the account that are associated with the same department as the current work queue. When you process collections by division, the application adjusts overdue self-pay vouchers on the account that are associated with the same division as the current work queue.

Note: If you select this option, vouchers are only adjusted if they are older than the number of days entered in **Accounts with Self-Pay Balances Over** on **Work Queue Maintenance** for the voucher's work queue. Any vouchers on the account that do not meet this age requirement are not adjusted and remain on the account.

Vouchers from Selected Carrier(s)

Select this option to only adjust voucher balances if they are out to a specific carrier or carriers.

When you select this option, **Select Carriers** is enabled and required. Use **Select Carriers** to specify the carriers whose voucher balances you want to adjust. Which vouchers qualify depends on whether you process collections by account, department, or division.

Tip: To select how the system processes collections, use **Self-Pay Collections Management Workflow Organization Basis** on the **Automation** tab in **System Administration > Practice Set Up** or **Organization Set Up**.

When you process collections by account, the application adjusts all vouchers that are out to the specified carriers. When you process collections by department, the application adjusts vouchers that are both out to the specified carrier and associated with the same department as the current work queue. When you process collections by division, the application adjusts vouchers that are both out to the specified carrier and associated with the same division as the current work queue.

Automatically created payment batches

Allscripts® Practice Management automatically places all automated adjustment actions in a payment batch created by the application. The application automatically creates and numbers the payment batch regardless of whether **Assign Batch Number** is selected on the **General** tab in **System Administration > Practice Options** or **Organization Options**, much like the Void and Re-Enter (VRE) batch process. The batches follow a naming convention that includes four parts:

1. The phrase COL.

Note: The application uses this phrase to designate batches that were created as part of the automatic self-pay collections process.

2. The current date for the practice in a two-digit format.

Note: For example, 05.

3. The first eight characters of the abbreviation from **Workflow Organization Maintenance** in **System Administration > File Maintenance**.
4. An incremented number.

Note: The application uses this number to separate batches if multiple batches are created on the same day. For example, the first batch created during the day is one, the second batch is two, and so on.

For example, the first payment batch created by the automated self-pay collections process on the fifth day of the month at 5:14p.m. containing transfer transactions for the **Small Balance** work queue would be named COL050514SmallBall.

The **Opened Date** and **Opened Time** for the payment batch are set to the practice's date and time when the application created the batch. The operator logged as creating the batch is **SYSTEM**.

Change Account Type action selections in Automation Action Maintenance

When you set **Action Type** to **Change Account Type** on **Automation Action Maintenance**, the change account type selections are displayed on the lower half of the window. Use these selections to complete the automated action.

The change account type action automatically changes the accounts type of accounts that reach this step in the workflow to the account type you select.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.

Automation Action Maintenance - (New Automation Action)

Select Item:	(New Automation Action)						
Abbreviation:	<input type="text"/>						
Description:	<input type="text"/>						
Function Category:	Self-Pay Collections						
Action Type:	Change Account Type						
Action Comments:	<input type="text"/>						
Change Account Type Selection:							
Change Guarantor Account Type:							
First	Previous	Next	Last	New	Delete	Save	Cancel

Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Change Guarantor Account Type

Required box. Click the down arrow to select the account type for qualifying accounts to be changed to. Accounts are automatically changed to this account type when the application reaches this stage of an automatic self-pay collections workflow created in **Automation Workflow Maintenance**. The drop-down list includes all account types created in **Account Type Maintenance**.

Tip: To create an automated action to hold statements by account type, select an account type for this box that has **Hold Statements** selected in **Account Type Maintenance**.

Create an automated action to hold statements by account type

When the application reaches this step in the workflow, it automatically changes the accounts type of affected accounts to the account type you selected. Statements are held for all affected accounts.

1. Verify that you have an account type that has **Hold Statements** selected in **Account Type Maintenance**. If you do not, create an account that has **Hold Statements** selected for use with automated self-pay collections.
2. Go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.
Automation Action Maintenance opens.
3. Click **New**.
4. For **Abbreviation**, enter a unique abbreviation to identify the automated action.
You can use up to 6 characters. Each automated action must have a unique abbreviation.
5. For **Description**, enter a unique description to distinguish the automated action from other actions.
6. For **Function Category**, select **Change Account Type**.
The selections for the change account type action are displayed.
7. For **Change Guarantor Account Type**, select the account that you selected in Step 1.
8. Click **Save**.

Results of this task

When the application reaches this step in the workflow, it automatically changes the accounts type of affected accounts to the account type you selected. Statements are held for all affected accounts.

What to do next

Add this automated action to a workflow in **Automation Workflow Maintenance**.

Collection Note action selections in Automation Action Maintenance

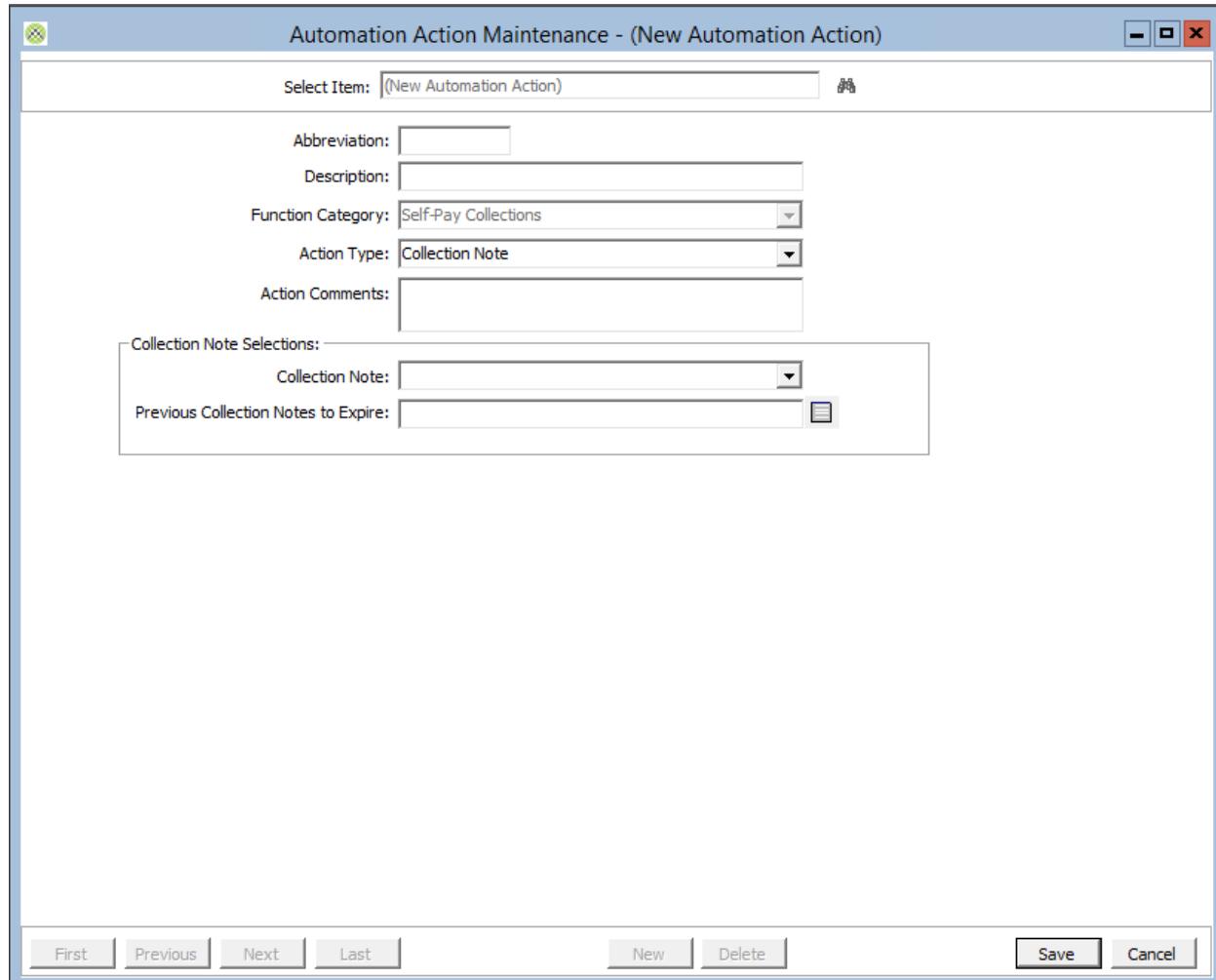
When you set **Action Type** to **Collection Note** on **Automation Action Maintenance**, the collection note selections are displayed on the lower half of the window. Use these selections to configure the automated action.

Collection note actions are used to automatically add a collection note to an account or automatically set other collections notes already associated with the account to expire. You might only need to add collection notes but not to expire them, depending on your workflow.

Depending on your existing collection note setup, you can also use automatic collection notes to stop statements or appointments from being made for certain accounts or to display warning flags.

For example, if you created a collection note that has **Hold Statements** selected in **Note Type Maintenance**, you can create an automated action to hold statements for an account automatically and add the action to the collection note. This functionality adds additional flexibility to what you can automate in the self-pay collections process.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.



The screenshot shows the "Automation Action Maintenance - (New Automation Action)" window. It includes fields for Select Item, Abbreviation, Description, Function Category (set to "Self-Pay Collections"), Action Type (set to "Collection Note"), and Action Comments. Below these, there is a section titled "Collection Note Selections" with dropdown menus for "Collection Note" and "Previous Collection Notes to Exire". At the bottom, there are navigation buttons (First, Previous, Next, Last) and action buttons (New, Delete, Save, Cancel).

Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Collection Note

Select the type of collection note to add to accounts when they reach this stage in an automated workflow. The drop-down list includes all note types that have **Type of Note** set to **Collection Note** on **Note Type Maintenance**. However, you can only view collections notes that have no department associated or are associated with departments you have access to. You must fill either **Collection Note** or **Previous Collection Notes to Expire**.

Previous Collection Notes to Expire

Click  to open **Select Note Types** and select the collection notes to expire. Click **All Note Types** to have all collection notes on the account expire.

The list includes only notes that have **Type of Note** set to **Collection Note** and **Warning Flag** set to **Red Flag & General Warning** or **Red Flag & Scheduling Warning** on **Note Type Maintenance**. (The latter restriction is because only notes with **Red Flag & General Warning** or **Red Flag & Scheduling Warning** can be expired in Allscripts® Practice Management.) However, you can only view collection notes that have no department associated or are associated with departments you have access to.

When you select a collection note to expire, all collection notes of that type automatically have **Expiration Date** set to the current practice date when they reach this step in an automated workflow. Collection notes are affected by this step regardless of whether they were added by the automated self-pay collections process or by an individual user. You must fill either **Collection Note** or **Previous Collection Notes to Expire**.

Tip: To create an automated action to hold statements by note, select a collection note for this box that has **Hold Statements** selected in **Note Type Maintenance**.

Create an automated action to hold statements by note

When the application reaches this step in the workflow, it automatically adds this note to the affected accounts, which causes statements to be held for those accounts.

1. In **System Administration > File Maintenance > Note Type Maintenance**, create a note for use with self-pay collections.

Note: If you already have a note that meets all of the following criteria, you can reuse it. However, most practices and organizations will need to create a new note.

- a. Click **New**.
- b. For **Abbreviation**, enter a unique abbreviation.
- c. For **Description**, enter a description.
- d. (Optional) For **Associated Dept** or **Associated Pract**, select the department or practice that will use this note.
- e. For **Type of Note**, select **Collection Note**.
- f. For **Warning Flag** select **Red Flag & General Warning**.
- g. For **Default Subject**, enter **Hold** by automated self-pay collections.
- h. Select **Hold Statements**.

- i. Click **Save**.
2. Go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.
Automation Action Maintenance opens.
3. Click **New**.
4. For **Abbreviation**, enter a unique abbreviation to identify the automated action.
You can use up to 6 characters. Each automated action must have a unique abbreviation.
5. For **Description**, enter a unique description to distinguish the automated action from other actions.
6. For **Function Category**, select **Collection Note**.
The selections for the collection note action are displayed.
7. For **Collection Note**, select the note that you created in Step 1.
8. Click **Save**.

Results of this task

When the application reaches this step in the workflow, it automatically adds this note to the affected accounts, which causes statements to be held for those accounts.

What to do next

Add this automated action to a workflow in **Automation Workflow Maintenance**.

Document action selections in Automation Action Maintenance

When you set **Action Type** to **Document** on **Automation Action Maintenance**, the document selections are displayed on the lower half of the window. Use these selections to complete the automated action.

Document actions are used to generate a document for an account and then export that document to designated location. The document is exported in **.pdf** format.

Note: If the application reaches this step in an automated workflow and cannot generate the required document, then the step in the workflow, the work queue, the action, and the account are added to the **Review** worklist in **Office Manager > Self-Pay Collections**. Make the necessary corrections from the queue: the action will be reperformed the next night when the Self-pay Collection service type runs automatically.

Exported documents are named automatically. The naming convention has 3 parts:

1. The description entered for the document action in **Automation Action Maintenance**.
2. The date for the practice the batch was created in, in the format **mmddyyyy**.

- 3.** The time for the practice the batch was created in, in the format hhmmss.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.

(New Automation Action) X

Automation Action Maintenance

Select Automation Action: (New Automation Action)	
Abbreviation:	<input type="text"/>
Description:	<input type="text"/>
Function Category:	<input type="text" value="Self-Pay Collections"/>
Action Type:	<input type="text" value="Document"/>
Action Comments:	<input type="text"/>
Document Selections:	
<input type="checkbox"/> Export (XML Format) Document to Send: <input type="text"/> Export Path: <input type="text"/> ...	
First Previous Next Last New Delete Save Cancel	

Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Export (XML Format)

Export (XML Format) is cleared by default.

When selected, **Documents to Send** displays only documents with **XML** selected as the **Document Type** in **Document Maintenance**. Additionally, **Export Path** is unavailable and any existing export path is cleared. XML documents are exported to the defined path on the **Practice Information** tab in **Practice Set Up** or **Organization Set Up**.

When **Export (XML Format)** is cleared, **Documents to Send** displays documents only with **Word Document** selected as the **Document Type** in **Document Maintenance**.

If you use automated self-pay collections and add a new automation workflow record that is associated to an XML document, you must update your existing workflows in **Work Queue Maintenance** to include the new automated actions.

If you edit an existing automated action and associate it to an XML document, select **Export (XML Format)** and then select the XML document you want to use for the existing action in **Document to Send**.

Document to Send

Required. Select the document to send for the account. The drop-down list includes documents that have **Data Type** set to **Collection Information** in **Document Maintenance**.

Export Path

Required. Select the path to the folder for the document to be exported to. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients.

- > If your practice or organization is on-premise, **Browse for Folder** opens. By default, **Browse for Folder** opens to the export folder entered in **Document Maintenance** for the document selected in **Document to Send**.
- > If your practice or organization is hosted by Allscripts®, **Select Folder** opens, with the hosted file tree open to the area you have access to. The area you have access to is defined in **File Share Path** on the **Practice Information** tab in **Practice Set Up** or the **Organization** tab in **Organization Set Up**.

After you select a folder and click **OK**, **Export Path** displays the filepath to the folder you selected. You cannot manually type a path into this box. Allscripts® Practice Management must have read and write permissions to the folder that you select.

Note: The only limit to the number of letters in the document file is your disk space.

Export action selections in Automation Action Maintenance

When you set **Action Type** to **Export** on **Automation Action Maintenance**, the export selections are displayed on the lower half of the window. Use these selections to complete the automated action.

An export action automatically exports qualifying accounts when they reach that action in the automated self-pay collections process, or when they are manually transferred to collections.

Export actions and transfer actions

Each export automated action must be associated with a transport automated action in the automated workflow. You cannot put an export action in an automated workflow without associating it with a transport action. This dependency exists because accounts must have a transfer transaction to a collection carrier on the voucher to qualify for export in the collections process. The **Collection Account Report** also pulls accounts based on whether they have a transfer transaction to a collection agency; otherwise, the account is not included on the report.

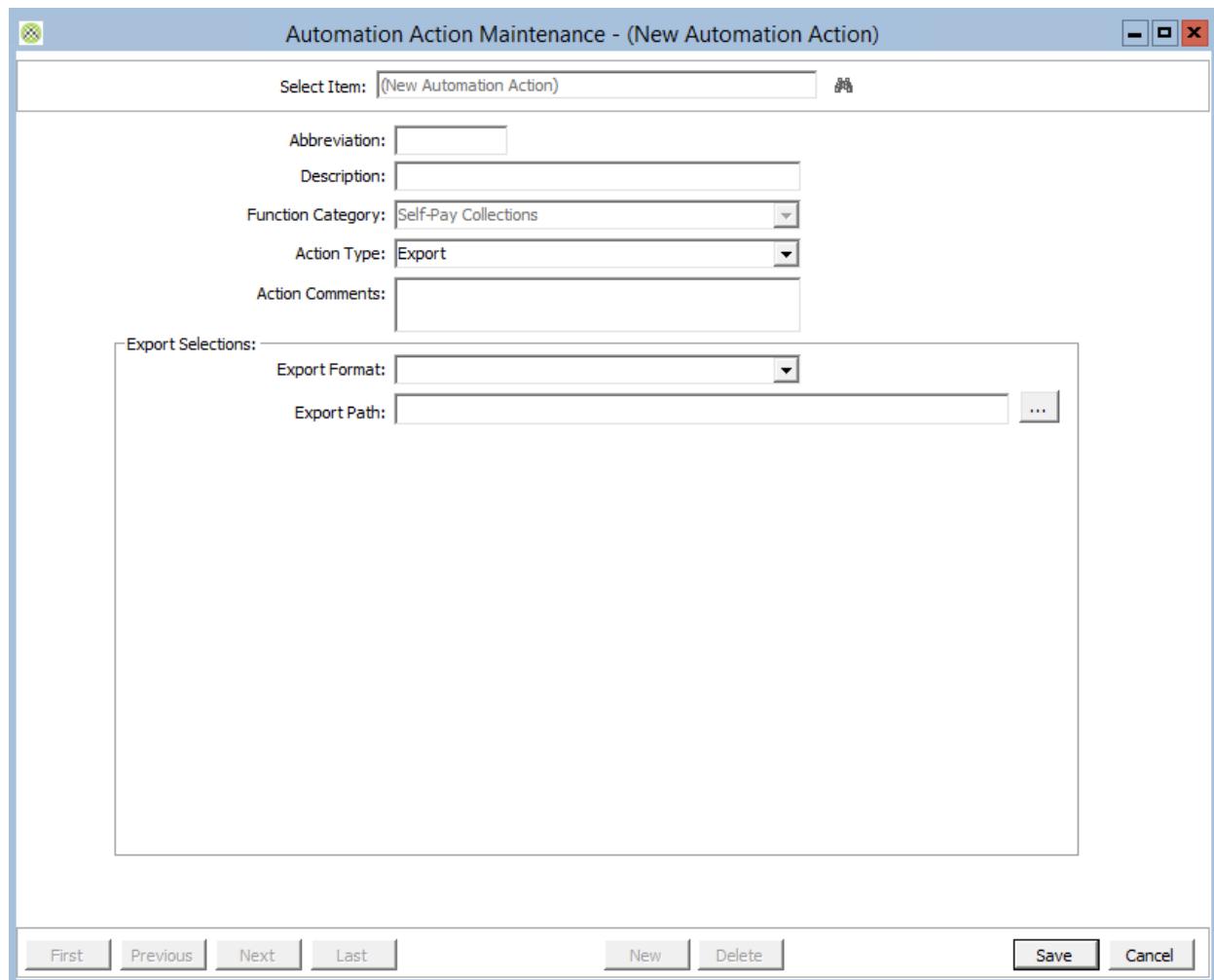
After the associated transfer action is completed, the export is completed based on the selections that you make on this window. Each export includes all accounts that have reached this step since the last export ran.

Naming convention for automated exports

When the Allscripts® Practice Management application generates a file for export, the name follows a convention that has 3 parts:

1. The description for the export action from **Automation Action Maintenance**.
2. The current date for the practice the file was created in, in the format mmddyyyy.
3. The current time for the practice the file was created in, in the format hhmmss.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.



The screenshot shows the 'Automation Action Maintenance - (New Automation Action)' window. At the top, there is a 'Select Item' field containing '(New Automation Action)'. Below it are fields for 'Abbreviation' (empty), 'Description' (empty), 'Function Category' (set to 'Self-Pay Collections'), 'Action Type' (set to 'Export'), and 'Action Comments' (empty). A section titled 'Export Selections' contains a 'Export Format' dropdown and an 'Export Path' input field with a browse button ('...'). At the bottom, there are navigation buttons for 'First', 'Previous', 'Next', 'Last', 'New', 'Delete', 'Save', and 'Cancel'.

Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Export Format

Required box. Select **Standard** or **Custom**.

- > The standard export format uses the standard **Collection Account Report** layout that enables you to specify export preferences, age by option, and whether to include emergency contacts, employer information, statement history, or collection notes.

- > The custom export format enables you to construct a custom report file. You can select exactly what information to include, what order to put it in, and what type of delimiter the file must use.

Export Path

Required. Select the path to the folder for the document to be exported to. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients.

- > If your practice or organization is on-premise, **Browse for Folder** opens. By default, **Browse for Folder** opens to the export folder entered in **Document Maintenance** for the document selected in **Document to Send**.
- > If your practice or organization is hosted by Allscripts®, **Select Folder** opens, with the hosted file tree open to the area you have access to. The area you have access to is defined in **File Share Path** on the **Practice Information** tab in **Practice Set Up** or the **Organization** tab in **Organization Set Up**.

After you select a folder and click **OK**, **Export Path** displays the filepath to the folder you selected. You cannot manually type a path into this box. Allscripts® Practice Management must have read and write permissions to the folder you select.

Note: The only limit to the number of letters in the document file is your disk space.

Standard export format selections

Report Preferences

Required. Click  to open **Report Preferences**. The selections are the same as the report preferences on the **Collection Account Report**.

Age by Billing Date and Age by Service Date

You must select either **Age by Billing Date** or **Age by Service Date**. Which of these 2 options is selected by default depends on the setting of **Age By** on the **General** tab in **Practice Options** or **Organization Options**. Use these options to determine how the vouchers in the export are sorted.

Include Emergency Contact Information

Select this check box to include emergency contact information for the account in the export file.

Include Employer Information

Select this check box to include employer information for the guarantor on the account in the export file. For inactive employers, **Inactive** is not included after the name in the export file.

Print Statement/Collection Notes

Select this check box to include the statement history and collection notes for the account in the export file.

Custom export format selections

File Type

Required. Select the type of delimiter to use to separate the data elements in the exported file.

Available Custom Fields and Custom Fields Selected

Use the right and left arrows to move items from **Available Custom Fields** to **Custom Fields Selected**. All items in **Custom Fields Selected** are included in the export.

Tip: To move all items back and forth between the 2 lists, use the double left and right arrows.

The available custom fields include the following:

Available Custom Fields	Available Custom Fields
1st Diagnosis Code	Patient Number
Account Number	Patient Suffix
Actual Prov Abbrev	Pmt Amount
Carrier Name	Pmt Date Paid
Department Abbrev	Pmt Reference
Guarantor Cell Phone	Responsible Party City
Guarantor City	Responsible Party Home Tel#
Guarantor DOB	Responsible Party Home Tel Ext
Guarantor First Name	Responsible Party First Name
Guarantor Home Tel#	Responsible Party Last Name
Guarantor Home Tel Ext	Responsible Party MI
Guarantor Last Name	Responsible Party State
Guarantor MI	Responsible Party Street1
Guarantor SSN	Responsible Party Street2
Guarantor State	Responsible Party Suffix
Guarantor Street1	Responsible Party Zip

Available Custom Fields	Available Custom Fields
Guarantor Street2	Service Procedure Code
Guarantor Suffix	Service Procedure Desc
Guarantor Work Phone	Statement Amount
Guarantor Work Phone Ext	Voucher Fee
Guarantor Zip Code	Voucher Number
Last Statement Date	Voucher Original Billing Date
Location Abbrev	Voucher Posted Adjustments (total)
Net Due ¹	Voucher Posted Misc. Debits (total)
Patient DOB	Voucher Posted Payments (total)
Patient First Name	Voucher Posted Refunds (total)
Patient Last Name	Voucher Service Date
Patient MI	Overdue Self-Pay Balance

Manual actions in Automation Action Maintenance

To add a manual step to your automated workflow, set **Action Type** to **Manual** on **Automation Action Maintenance**. A manual action automatically assigns the account to a user to complete some action (such as a telephone call to the client) before returning the account to the automated workflow.

Accounts that reach a manual step in a work queue are distributed evenly between collectors assigned to that work queue who are eligible for distribution (that is, have **Eligible for Distribution** selected in **Collector Maintenance**). Accounts assigned to a user are displayed in that user's **Self-Pay Collections** workspace in **Office Manager**. After a user has completed the manual step, he or she can right-click the account in **Office Manager** and select the applicable option to return the account to the automated workflow.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.

¹ Net Due is the balance owed on the account, which could potentially be the self-pay and collection balances.

Abbreviation:	<input type="text"/>
Description:	<input type="text"/>
Function Category:	<input type="text" value="Self-Pay Collections"/>
Action Type:	<input type="text" value="Manual"/>
Action Comments:	<input type="text"/>

Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Transfer action selections in Automation Action Maintenance

When you set **Action Type** to **Transfer** on **Automation Action Maintenance**, the export selections are displayed on the lower half of the window. Use these selections to complete the automated action.

A transfer action automatically transfers the balances for vouchers that reach that step to a selected collection carrier. All transfer batches are given the default batch comment `Transfers related to Collections Workflow`. The batch's opened date, opened time, updated date, and updated time are set to the practice date and time when the application created the batch. The batch's closed date and time are set to the practice date and time when the application closed the batch. The application follows the transfer run schedule set in **Automation Workflow Maintenance** when determining how often to create transfer batches.

Transfer batch naming conventions

When the Allscripts® Practice Management application generates a transfer batch, the name follows a convention that has 3 parts:

1. The current date for the practice in a 2-digit format (for example, 05).
2. The first 8 characters of the work queue description from **Workflow Organization Maintenance**, to identify which work queue the export was created for.
3. An incremented number, starting with 1, to separate batches if multiple batches are run in the same day.

To access **Automation Action Maintenance**, go to **System Administration > File Maintenance > Automation Action Maintenance** or press **F9** and then enter **AAM**.

Automation Action Maintenance - (New Automation Action)

Select Item:	(New Automation Action)	
Abbreviation:	<input type="text"/>	
Description:	<input type="text"/>	
Function Category:	Self-Pay Collections	
Action Type:	Export	
Action Comments:	<input type="text"/>	
Export Selections:	Export Format: <input type="text"/> Export Path: <input type="text"/> 	
<input type="button" value="First"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Last"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>		

Abbreviation

Required entry. This box contains the abbreviation for this automated action. Each automated action must have a unique abbreviation.

Description

Required entry. This box contains the description for this automated action. Each automated action must have a unique description.

Function Category

This box is always set to **Self-Pay Collections**.

Action Type

Required entry. Select one of the predefined action types. When you select an action type, the selections for that action type are displayed in the lower part of the window. The selections that you make for this action type are performed by the application when the self-pay collections automatic workflow reaches this step. The following action types are available:

- > **Adjust**
- > **Change Account Type**
- > **Collection Note**
- > **Document**
- > **Export**
- > **Manual**
- > **Transfer**

You cannot change the action type of an automated action if that automated action is referenced by records in other files, such as an automated workflow in **Automation Workflow Maintenance**.

Action Comments

Use this box to enter more details about the action. Text entered in this box is displayed by default in the comments window on **Collection Account Detail** when **Collection Account Detail** is used as part of the automated self-pay collections process. This comment is saved automatically if the application performs the step independently as part of the automated self-pay collections process.

Transfer Vouchers to Carrier

Required. Select the collection carrier to transfer the vouchers to. Click  to open **Select Carrier** and select the applicable carrier. The list includes only carriers that have **Collection Carrier** selected in **Insurance Carrier Maintenance**.

Vouchers to Transfer

Required. Select which vouchers to transfer. The choices are:

All Self-Pay Balances

If you select this option, all qualifying self-pay balances are transferred, regardless of whether they are considered overdue in your collections process. Which balances qualify depends on whether you process collections by account, department, or division, based on the setting of **Self-Pay Collections Management Workflow Organization Basis** on the **Automation** tab in **Practice Set Up** or **Organization Set Up**.

If you process collections by account, all self-pay vouchers on the account are transferred. If you process collections by department, self-pay vouchers on the account are transferred only

if they are associated with the department that qualified for the work queue. If you process collections by division, self-pay vouchers on the account are transferred only if they are associated with the division that qualified for the work queue.

Overdue Self-Pay Balances

If you select this option, only qualifying balances on overdue self-pay vouchers are transferred. A self-pay voucher is considered overdue if it is older than the number of days entered in **Accounts with Self-Pay Balances Over on Work Queue Maintenance** for the work queue the voucher is in. Which overdue balances qualify depends on whether you process collections by account, department, or division, based on the setting of **Self-Pay Collections Management Workflow Organization Basis** on the **Automation** tab in **Practice Set Up** or **Organization Set Up**.

If you process collections by account, all overdue self-pay vouchers on the account are transferred. If you process collections by department, overdue self-pay balances on the account are transferred only if they are associated with the same department. If you process collections by division, overdue self-pay balances on the account are adjusted off only if they are associated with the same division as the current work queue.

Batch Category

Required if **Batch Category Required** is selected on the **General** tab in **Practice Options** or **Organization Options**. Select the batch category to use when creating a batch for the transfer items. The drop-down list includes all existing batch categories created in **Batch Category Maintenance**. You cannot create a new batch category from this list.

Transaction Code

Required. Select the transaction code to use when transferring balances on affected vouchers. The drop-down list includes all transaction codes that have **Transaction Type** set to **Transfer** in **Transaction Code Maintenance**.

Automation Workflow Maintenance window

Use **Automation Workflow Maintenance** to create automated workflows for the automated self-pay collections process. Automated workflows are composed of automated actions created in **Automation Action Maintenance**, the predefined **Complete** action, and options such as **Days to Wait before Next Action** that enable you to customize the pace of the workflow.

You can create multiple automated workflows to handle the various needs of your practice or organization. A single automated workflow can also be associated with multiple work queues in **Work Queue Maintenance**.

Important: If accounts are currently being processed in an automated workflow, the only boxes you can edit in **Automation Workflow Maintenance** for that workflow are **Days to Wait before Next Action**, **Extend Wait Days if Partial Payment**, and **Transfer Run Schedule**. To edit any of the other boxes or change the order of the automated actions in the workflow, you must complete all of the accounts associated with that workflow. You can complete the accounts automatically: when you make your changes and click **Save**, a message will ask if you want to complete all the accounts currently associated with the workflow.

Completing automated workflows

The predefined action **Complete** is always the last step in an automated workflow. This action is added to the automated workflow automatically after you click **Save**. You cannot remove the **Complete** when editing a workflow, but you can place other actions in front of it if necessary.

To access **Automation Workflow Maintenance**, go to **System Administration > File Maintenance > Automation Workflow Maintenance** or press **F9** and then enter **AWM**.

Automation Workflow Maintenance - (New Automation Workflow)

Seq.	Action	Wait Days	Pmt Days	Schedule	Export Action
1	(New)				

Self-Pay Collection Options

Automation Action:	<input type="text"/>
Days to Wait before Next Action:	<input type="text"/>
Extend Wait Days if Partial Payment:	<input type="text"/>
Transfer Run Schedule:	<input type="text"/>
Export Action:	<input type="text"/>

Action(s) to take when self-pay balance is paid in full:

Automation Action
<input type="text"/>

First Previous Next Last New Delete Save Cancel

Abbreviation

Required. The unique abbreviation for the automated workflow.

Description

Required. The unique description for the automated workflow.

Function Category

The type of automated workflow. Currently, **Self-Pay Collections** is the only option. Selections corresponding to the function category are displayed on the lower half of the window below the grid.

Workflow sequence grid (unlabeled)

This grid lists the workflow actions you add.

Seq

A number representing the action's place in the workflow (1, 2, 3, and so on). The number is automatically added when you add an action to the grid.

Action

The description for the automated action.

Wait Days

How many days to wait before proceeding to the next action in the sequence.

Pmt Days

If the automated action is a document action, displays how many days to wait if a partial payment is received. This number comes from the **Extend Wait Days if Partial Payment** on the lower half of the window. A payment must meet the minimum payment amount or minimum payment percent specified in the associated work queue.

CAUTION: If the minimum payment amount is entered on the workflow but not in **Work Queue Maintenance**, the account moves to the next action without delay.

Schedule

If the action type is **Transfer**, displays the option selected for **Transfer Run Schedule** on the lower half of the window.

Export Action

If the action type is **Transfer**, displays the description for the associated export action selected in **Export Action** on the lower half of the window.

Automation Action

Required. This drop-down box lists the automated actions from **Automation Action Maintenance**. The automated action that you select is added to the list when you click **Save**.

Days to Wait before Next Action

How many days to wait before proceeding to the next action in the sequence.

Extend Wait Days if Partial Payment

How many extra days to wait if a partial payment is received.

Transfer Run Schedule

Required for transfer action types. How often to run a transfer action. The options are **Daily**, **Weekly**, and **Monthly**. When you select a frequency, additional options are displayed that enable you to select a specific weekday or day of the month to run the transfer on.

Export Action

Only enabled if **Automation Action** is set to a transfer action type. This box enables you to select an export action for the application to complete immediately after it completes a transfer action.

Action(s) to take when self-pay balance is paid in full

Enables you to select document, change account type, and collection note actions types to complete when the self-pay balance is paid if full. You can select automated actions that have **Action Type** set to **Document**, **Changes Account Type**, or **Collection Note** on **Automation Action Maintenance**. The last step in the list is always the application-generated action **Complete**, which is added automatically after you save the automated workflow.

Note: These actions are only taken when the self-pay balance on an account is brought to \$0.00 at any point when the account is in an automatic step not visible on an operator's work queue. If the self-pay balance is brought to \$0.00 because of an automated action, such as a transfer, the account goes through the remaining steps in the workflow and then is set directly to **Complete**.

Create an automated workflow

Use **Automation Workflow Maintenance** to create automated workflows that instruct your Allscripts® Practice Management application what automated steps to perform in what order for your automated self-pay collections process.

Before you begin

You must have the automated actions you want to add to this automated workflow created in **Automation Action Maintenance**.

1. Go to **System Administration > File Maintenance > Automation Workflow Maintenance** or press **F9** and enter AWM.
Automation Workflow Maintenance opens. **Function Category** is set to **Self-Pay Collections** and cannot be edited.
2. Click **New**.
3. For **Abbreviation**, enter a unique abbreviation for the automated workflow.
4. For **Description**, enter a unique description for the automated workflow.

5. Click  next to the grid on the upper half of the window.

Self-Pay Collections Options are enabled.

6. For **Automation Action**, select the automated action to add to the workflow.

7. (Optional) Complete the following steps for document actions only.

- a. For **Days to Wait before Next Action**, enter how many days to wait before proceeding to the next action in the sequence.

Enter whole numbers only. If you do not enter anything in this box, the application proceeds to the next step in the sequence as soon as the current step is complete.

- b. For **Extend Wait Days if Partial Payment**, enter how many extra days to wait before proceeding to the next action if a partial payment is received for the account.

To extend the wait days for the next action, a posted payment amount must meet either the minimum payment amount or the minimum payment percent specified in **Work Queue Maintenance**.

8. If you are adding a transfer action, for **Transfer Run Schedule**, select how often to run the transfer:

- > **Daily**
- > **Weekly**
- > **Monthly**

If you selected **Weekly** or **Monthly**, the selections for that frequency are displayed to the right. These selections enable you to choose a time, day of the week, or date of the month to run the transfer, depending on the frequency that you selected.

9. If you set **Transfer Run Schedule** to **Weekly** or **Monthly**, use the selections displayed to the right of the box to choose when to run the transfer.

- > If the **Day of the Week** area is displayed, select which day to run the transfer on.
- > If **Day** is displayed, select the day of the month to run the transfer on. You can also select the option **Last Day**.

CAUTION: If you select a particular day, the transfer only runs on that day. Therefore, if you select **31**, the transfer does not run on months that only have 30 days. If you want to run the transfer on the last day of the month, select **Last Day**.

10. (Optional) If you are adding a transfer action, for **Export Action**, select an export action to run immediately after the transfer action is complete.

Important: You can only add an export action by associating it with a transfer action.

11. In the **Action(s) to take when self-pay balance is paid in full** section, select the actions for the application to perform when the self-pay balance is completely paid. To add an action, complete these steps:

- a. Click  next to the **Action(s) to take when self-pay balance is paid in full**.

A new row is added to the list.

- b. Click the down arrow and select the action to perform.

The drop-down list includes all automated actions with an **Action Type** of **Change Account Type**, **Collection Note**, or **Document**.

Note: You cannot add wait days to a document action in this step the way you can with a document action in the main automated workflow. The document action you select here will be completed as soon as the self-pay balance on the account is paid in full.

12 Click **Save**.

Results of this task

The automated workflow is created. The **Complete** action is automatically added to the end of the list in the **Action(s) to take when self-pay balance is paid in full** section.

What to do next

Associate the automatic workflow with a work queue in **Work Queue Maintenance**.

Workflow rules for Automation Workflow Maintenance

The following rules apply when creating automated workflows in **Automation Workflow Maintenance**.

Workflow rules for all actions

> If the self-pay balance on an account reaches \$0.00 because of a step taken in the automatic workflow, such as a balance transfer to a collection carrier, the account continues to move through the automated workflow and is set to Complete only when it reaches the end of the workflow steps. This setup is because if an account's self-pay balances reaches \$0.00 during the automated workflow, the patient might not have actually paid off the balance. For example, if the remaining self-pay balance is transferred to a collection carrier, the self-pay balance on the account is \$0.00 only because the amount that the patient owes has been transferred to collections.

Because the patient has not actually paid the balance on the account, Allscripts® Practice Management continues to move the account through the remaining workflow steps before setting the account to **Complete** at the end of the workflow. Any actions specified in **Action(s)**

to take when self-pay balance is paid in full on Automation Workflow Maintenance are not taken because the self-pay balance was not paid in full.

- > If an account does not qualify for a particular step in the automated self-pay workflow (for example, a step to adjust all vouchers out to a particular collection carrier), a history item is still created for the account for that step. However, no action is taken against the account because it does not qualify.

Workflow rules for transfer actions

- > You cannot have multiple transfer actions in a single automatic workflow.
- > You cannot have a transfer action immediately after an adjustment action. (This rule exists because if you had a transfer action directly after an adjust action, there would be no balance left to transfer.)

Workflow rules for document actions

- > You cannot place a document action immediately after a transfer action.
- > You cannot place a document action immediately after an adjustment action.
- > If your workflow has steps for generating collection letters before a manual step is reached, the collection letter documents cannot contain **Collector Info** pull-fields. A collector is not assigned until a manual step is reached; therefore, **Collector Info** pull fields in a document generated before a manual step are empty and print as blanks in the letter.

Workflow rules for manual actions

- > You cannot place a manual action immediately after a transfer action.
- > You cannot place a manual action immediately after an adjustment action.

Edit an automated workflow with active accounts

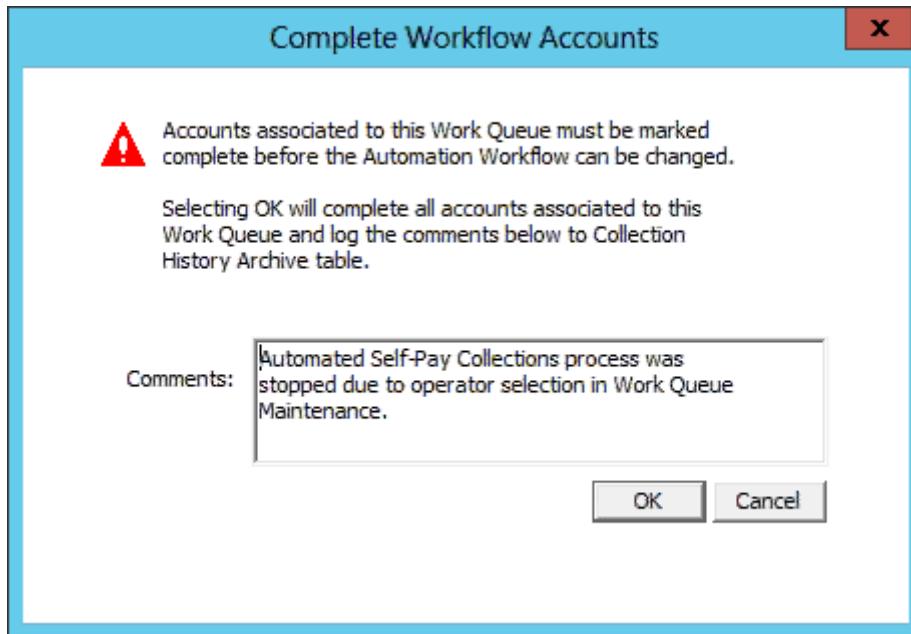
For automated workflows with accounts currently being processed, you can only edit **Days to Wait before Next Action**, **Extend Wait Days if Partial Payment**, and **Transfer Run Schedule** without completing the accounts in the workflow.

1. Go to **System Administration > File Maintenance > Automation Workflow Maintenance** or press **F9** and enter **AWM**.
Automation Workflow Maintenance opens. **Function Category** is set to **Self-Pay Collections** and cannot be edited.
2. Click  to open the search window and search for the automated workflow to edit. Click **OK**.
3. Make any necessary changes to **Days to Wait before Next Action**, **Extend Wait Days if Partial Payment**, and **Transfer Run Schedule**.

Note: You can make changes to these 3 boxes without completing the accounts that are currently in the automated workflow.

4. (Optional) Make changes to the other boxes on the window and the order of the automated actions as necessary.
5. Click **Save**.

If you made changes to anything other than **Days to Wait before Next Action**, **Extend Wait Days if Partial Payment**, and **Transfer Run Schedule**, **Complete Workflow Accounts** opens, confirming that you want to complete all accounts associated with this workflow.



6. For **Comments**, edit the comments as necessary.
7. Click **OK**.

Results of this task

Your changes are saved. All accounts associated with this automated workflow are automatically completed with the comment that you entered **Complete Workflow Accounts**.

Work Queue Maintenance for self-pay collections

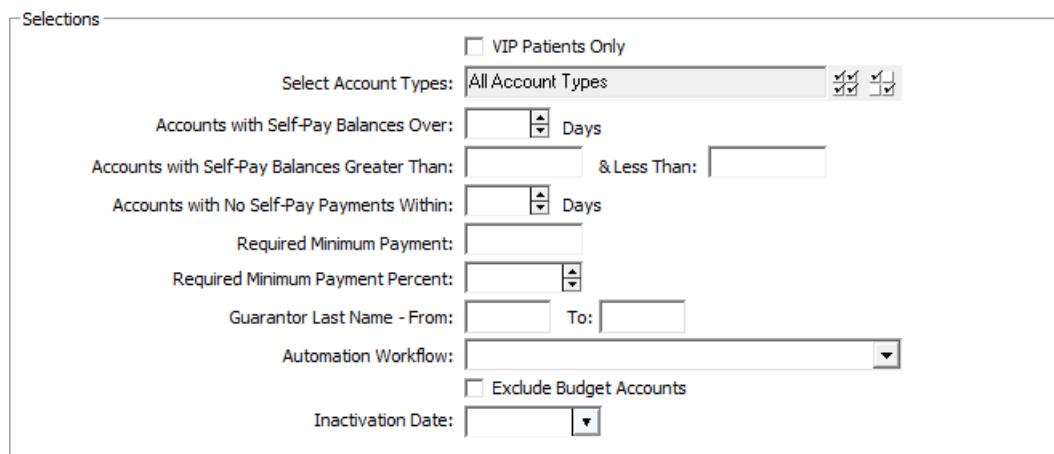
When you set **Management Category** to **Self-Pay Collections**, the selections for that management category are displayed on the lower half of the window.

Self-pay collections work queues function slightly differently than other work queues, in that an account always stays with the work queue that it initially qualifies for, even if it meets the criteria

for another work queue or it is assigned to another operator. This restriction enables the automatic self-pay collections process to function correctly. Because accounts in the automatic self-pay collections process always stay with the work queue they are first assigned to, your selections on this window govern the data in the collections process.

Work queues created on this window are associated with **Workflow Organization Maintenance** records in **Office Manager** in the same way that other work queues are. If you create multiple work queues for automatic self-pay collections, use **Workflow Organization Maintenance** to set the priority for various queues and which operators should be assigned to specific accounts. If an account qualifies for multiple work queues, the account is assigned to the work queue that is listed first in **Workflow Organization Maintenance**.

Figure 4: Self-Pay Selections on Work Queue Maintenance



The screenshot shows the 'Selections' section of the Work Queue Maintenance window. It includes the following fields:

- VIP Patients Only
- Select Account Types: All Account Types (with checkboxes for 'VIP' and 'Self-Pay')
- Accounts with Self-Pay Balances Over: Days (spin box)
- Accounts with Self-Pay Balances Greater Than: & Less Than: (text boxes)
- Accounts with No Self-Pay Payments Within: Days (spin box)
- Required Minimum Payment: (text box)
- Required Minimum Payment Percent: (spin box)
- Guarantor Last Name - From: To: (text boxes)
- Automation Workflow: (dropdown menu)
- Exclude Budget Accounts
- Inactivation Date: (text box)

VIP Patients Only

Select this option to create self-pay collections workflows exclusively for VIP patients.

Select Account Types

The account types to include in the work queue. Click  to open **Select Account Types** and select the account types to include. This box was previously in **Collection Planning** and works the same way as in previous versions.

Accounts with Self-Pay Balances Over

An account must have a self-pay voucher that meets or exceeds the age specified here to qualify the account for automated self-pay collections in this work queue.

If your practice or organization uses uninsured carriers, this setting considers vouchers associated with uninsured carriers.

Accounts with Self-Pay Balances Greater Than & Less Than

An account must have a self-pay balance that falls within the range you set in these 2 boxes to qualify for the work queue.

If your practice or organization uses uninsured carriers, this setting considers vouchers associated with uninsured carriers.

Accounts with No Self-Pay Payments Within

If a self-pay payment is not applied and updated to an account within the number of days you specify in this box, the account qualifies for the automated self-pay collections process.

Note: Non self-pay payments posted to the voucher and payments on self-pay vouchers out to a non-collection carrier are not included when calculating this amount.

If your practice or organization uses uninsured carriers, this setting considers vouchers associated with uninsured carriers.

Required Minimum Payment

The minimum acceptable payment amount. For an account to qualify for automated self-pay collections, the account must not have an applied and updated self-pay payment that is greater than or equal to this amount within the number of days specified in **Accounts with No Self-Pay Payments Within**.

Note: Non self-pay payments posted to the voucher and payments on self-pay vouchers out to a non-collection carrier are not included when calculating this amount.

If your practice or organization uses uninsured carriers, this setting considers vouchers associated with uninsured carriers.

Required Minimum Payment Percent

The minimum acceptable payment percentage, based on the total qualifying self-pay account balance. For an account to qualify for automated self-pay collections, the account must not have an applied and updated self-pay payment that is greater than or equal to this payment percent within the number of days specified in **Accounts with No Self-Pay Payments Within**.

If your practice or organization uses uninsured carriers, this setting considers vouchers associated with uninsured carriers.

Guarantor Last Name From and To

Optional. These boxes enable you to limit which accounts qualify for this work queue by guarantor last name.

Automation Workflow

Required. Select the automated workflow to use for this work queue. When accounts qualify for this work queue, they go through the steps entered in **Automation Workflow Maintenance** for the automated workflow that you select here.

Important: If a work queue has accounts that are currently in the automated self-pay collections process, you cannot change this box without first completing all accounts associated with this work queue. You can complete the accounts automatically; if you change the selection for **Automation Workflow** and click **Save**, a window opens asking if you want to complete the associated accounts.

Exclude Budget Accounts

Select this check box to exclude budget accounts from the work queue. An account cannot qualify for the work queue if it has **Budget Amount** filled in **Account Management**.

Inactivation Date

The inactivation date for the account. After the date you enter, Allscripts® Practice Management considers the queue expired and accounts can no longer qualify for it.

Create a self-pay collections work queue

Self-pay collections work queues are used in the automated self-pay collections process.

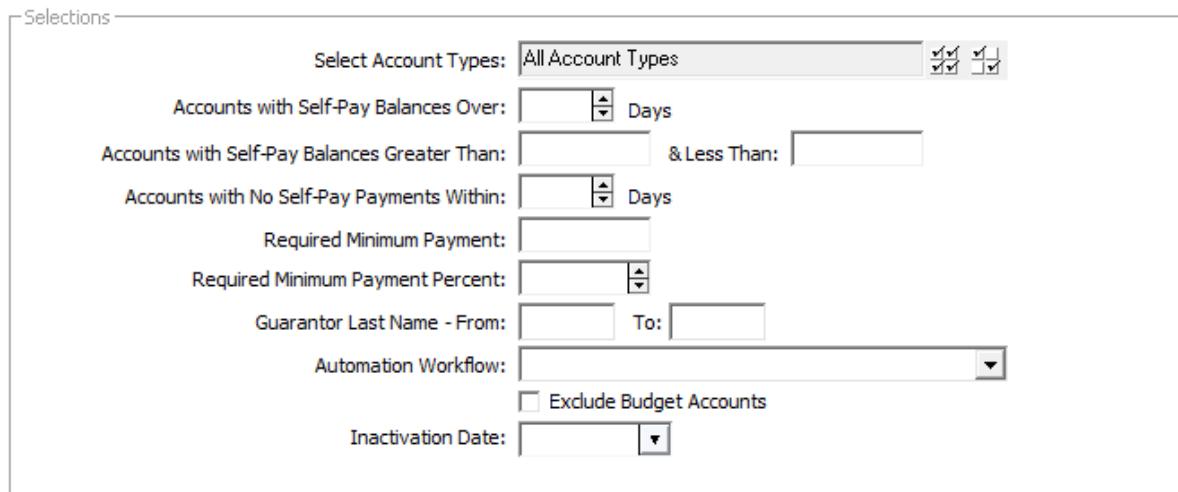
Before you begin

You must have created automated workflows in **Automation Workflow Maintenance**.

1. Go to **System Administration > File Maintenance > Work Queue Maintenance**.
Work Queue Maintenance opens.
2. At the bottom of the window, click **New**.
Select Work Queue becomes unavailable.
3. For **Work Queue Description**, enter a unique name for the work queue.
4. For **Management Category**, select **Self-Pay Collections**.

The selections for the self-pay collections management category are displayed on the lower half of the window.

Figure 5: Self-Pay Selections on Work Queue Maintenance



The screenshot shows a 'Selections' panel with the following fields:

- Select Account Types: A dropdown menu labeled 'All Account Types' with a checkmark icon.
- Accounts with Self-Pay Balances Over: An input field with a dropdown arrow and a value of '0'.
- Accounts with Self-Pay Balances Greater Than: An input field with a dropdown arrow and a value of '0'.
- Accounts with No Self-Pay Payments Within: An input field with a dropdown arrow and a value of '0'.
- Required Minimum Payment: An input field.
- Required Minimum Payment Percent: An input field with a dropdown arrow.
- Guarantor Last Name - From: An input field.
- To: An input field.
- Automation Workflow: A dropdown menu.
- Exclude Budget Accounts: A checkbox.
- Inactivation Date: An input field with a dropdown arrow.

5. (Optional) For **Select Account Types**, click to open **Select Account Types** and select the account types to include in the work queue.

Only self-pay accounts with 1 of the account types you select can qualify for this work queue.

6. (Optional) For **Accounts with Self-Pay Balances Over**, enter how many days old a self-pay voucher must be before the associated account qualifies for this work queue.

7. (Optional) For **Accounts with Self-Pay Balances Greater Than and Less Than**, enter the range that a self-pay voucher's balance must fall within to qualify for this work queue.

8. (Optional) For **Accounts with No Self-Pay Payments Within**, enter how many days a self-pay voucher can go without a payment before the account qualifies for this work queue.

9. (Optional) For **Required Minimum Payment**, enter the minimum acceptable payment amount.

If a payment is made on a self-pay voucher in collections that does not meet the amount you enter in this box, that payment does not influence whether the account qualifies for automated self-pay collections or whether the wait period is extended when a partial payment is received.

Note: Any payments made on self-pay vouchers that are out to a non-collection insurance carrier are not included in this amount.

10. (Optional) For **Required Minimum Payment Percent**, enter the minimum acceptable payment percentage.

Any payment made on a self-pay voucher in collections must be equal to or greater than this percentage of the total balance. Payments less than this percentage do not prevent the account from qualifying for automated self-pay collections. Payments less than this amount also do not

extend the wait period for accounts already in collections if you entered a number of days in **Extend Wait Days if Partial Payment** on **Automated Workflow Maintenance** for the associated workflow.

Note: Any payments made on self-pay vouchers out to a non-collection insurance carrier are not included in this amount.

11. (Optional) For **Guarantor Last Name From** and **To**, enter the range of the alphabet that the guarantor's last name must be in for the account to qualify for this work queue.
12. For **Automation Workflow**, select the automated workflow that the account in this work queue will go through.
The drop-down list includes all automated workflows currently created in **Automation Workflow Maintenance**.
13. (Optional) To exclude budget accounts from this work queue, select **Exclude Budget Accounts**.
14. (Optional) For **Inactivation Date**, enter the date when this work queue will become inactive.
15. Click **Save**.

Results of this task

The self-pay collections work queue is ready for use. Accounts can now qualify for this work queue as part of the automated self-pay collections process.

What to do next

If you created more than 1 self-pay collections work queue, set the priority of the different queues in **Workflow Organization Maintenance**.

Workflow Organization Maintenance window

Use **Workflow Organization Maintenance** to set the priority of the different work queues created in **Work Queue Maintenance**. When an account qualifies for multiple work queue, the workflow organization basis determines which work queue the account goes to.

The select records dialogs that correspond to the workflow organization basis criteria are now made available. This allows you to set up work queues for operators based on your workflow.

For example, if your unpaid claims management workflow basis is Location > Billing Provider > Insurance Category, and you created work queues: Over 45 Days, Over 60 Days, Over 90 Days, you can now create workflow organizations that filter the claims in each of these work queues by Location, by Billing Provider, by Insurance Category.

Access **Workflow Organization Maintenance** from **System Administration > File Maintenance > Workflow Organization Maintenance** or press **F9** and then enter **WOM**.

Workflow Organization Maintenance

Select Workflow Organization:	<input type="text"/>							
Abbreviation:	<input type="text"/>							
Description:	<input type="text"/>							
Management Category:	<input type="text"/>							
Select Workflow Organization Criteria								
Available Work Queues:		Work Queues Selected:						
<table border="1"> <thead> <tr> <th>Work Queue</th> </tr> </thead> <tbody> <tr><td> </td></tr> </tbody> </table>		Work Queue		<table border="1"> <thead> <tr> <th>Priority</th> <th>Work Queue</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> </tbody> </table>	Priority	Work Queue		
Work Queue								
Priority	Work Queue							
		<input type="button" value=">"/> <input type="button" value="<"/> <input type="button" value="Move Up"/> <input type="button" value="Move Down"/>						
<input type="button" value="First"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Last"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>								

Abbreviation

The abbreviated name of the workflow organization basis.

Description

The full name of the workflow organization basis.

Management Category

When you select a management category, any additional selections for that category are displayed below **Select Workflow Organization Criteria** and the available work queues for that management category are listed in **Available Work Queues**. The management categories are:

- > Pending Claims
- > Self-Pay Collections

> **Unpaid Claims**

Select Departments, Select Practices, or Select Divisions

This box is labeled **Select Departments**, **Select Practices**, or **Select Division** depending on your selection for **Workflow Basis** in **Practice Set Up** or **Organization Set Up**.

Click the icon with 2 check marks to open a selection window and select which departments, practices, or divisions you want to include in this workflow organization basis.

Best Practice:

It is a best practice to have each workflow organization basis associated with only 1 department, practice or division.

If necessary, you can create a workflow organization basis that includes work queues from multiple departments, practices, or divisions; however, the same department, practice, or division cannot be associated with multiple workflow organization bases, even if not all of the work queues are included in the workflow.

Available Work Queues

This list includes all of your current work queues. To be displayed in this list, a work queue must:

- > Exist in **Work Queue Maintenance**
- > Have **Management Category** set to **Self-Pay Collections**
- > Have an inactivation date that is not on or before the current date

Use the > arrow to move a work queue from **Available Work Queues** to **Work Queues Selected** and the < arrow to move it back. First move the queue you want to give the highest priority, then the second-highest priority, and so forth.

Work Queues Selected

When you move a work queue from **Available Work Queues** to **Work Queues Selected**, it is automatically assigned a priority number based on the order you moved it in. For example, the very first work queue you move to **Available Work Queues** always has a **Priority of 1**. Use **Move Up** and **Move Down** to rearrange the priority of the queues in **Work Queues Selected** as necessary.

The priority order you set determines which work queue an account goes to when it qualifies for more than 1 work queue. If an account qualifies for more than 1 work queue, it is always assigned to the queue that has the higher priority number in the associated workflow organization basis.

Note: The priority order determines what work queues an account is associated with when it first qualifies for automated self-pay collections. The account stays in that work queue through the entire automated self-pay collections process.

To associate particular operators with a work queue, click  to open a selection window.

Create a workflow organization for self-pay collections

Use a workflow organization to set the priority of your work queues. When an account qualifies for multiple work queues, the workflow organization determines which work queue the account goes to.

Before you begin

You must have the work queues that you want to use created in **Work Queue Maintenance**.

1. Go to **Workflow Organization Maintenance**.

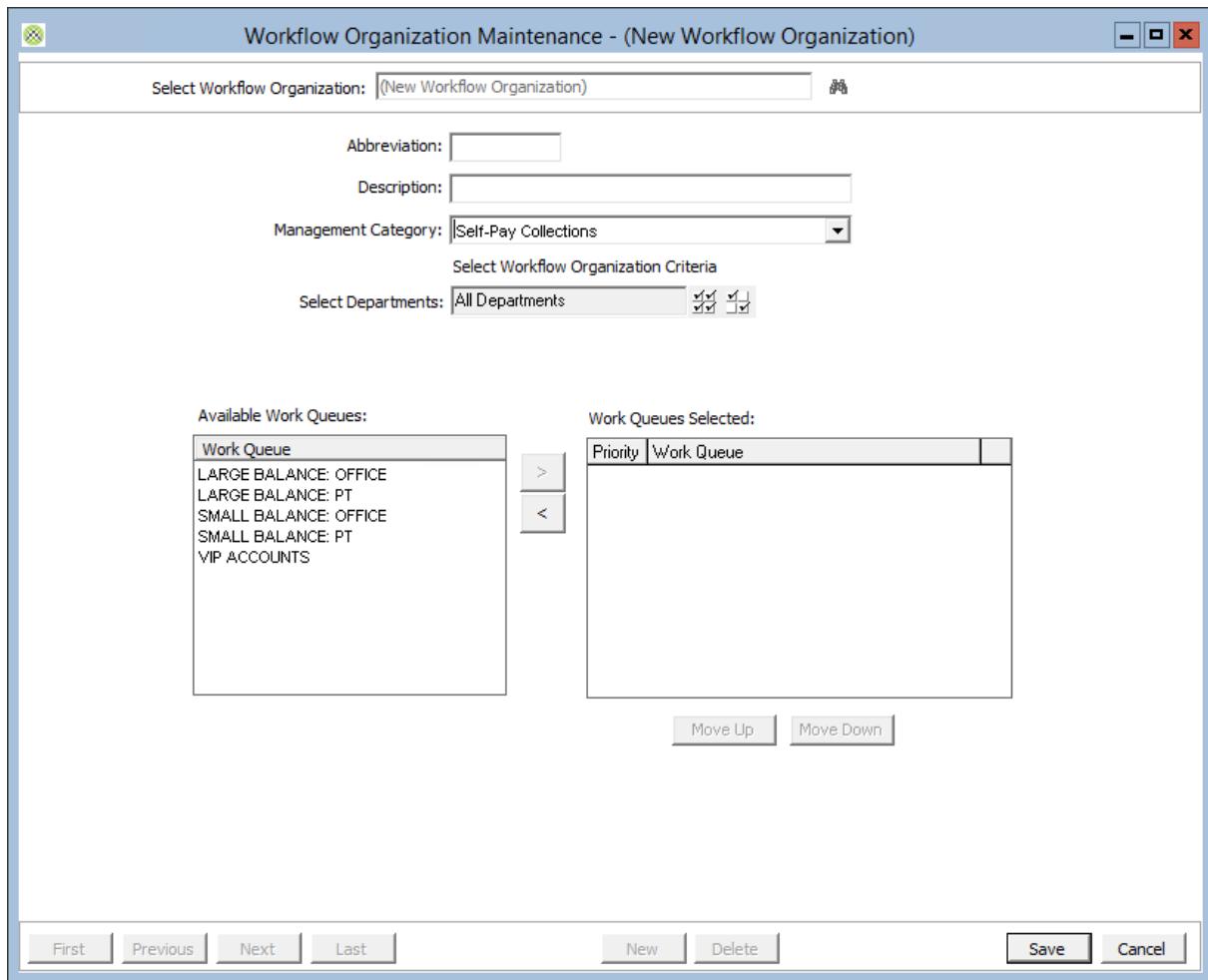
- > Go to **System Administration > File Maintenance > Workflow Organization Maintenance**.
- > Press **F9** and then enter **WOM**.

Workflow Organization Maintenance opens.

2. Click **New**.

- 3.** For **Abbreviation**, enter an abbreviation for this workflow organization.
- 4.** For **Description**, enter a description for this workflow organization, such as its purpose.
- 5.** For **Management Category**, select **Self-Pay Collections**.

The selections for self-pay collections are displayed on the lower half of the window. The label for the box **Select [Departments, Practices, or Divisions]** varies depending on whether you set **Workflow Basis** to **Practice**, **Department**, or **Division** in **Practice Set Up** or **Organization Set Up**. If you do not use departments, practices, or divisions, this box is not displayed.



- 6.** For **Select [Departments, Practices, or Divisions]**, click  to open a separate window and select the departments, practices or divisions that this workflow organization applies to.

Best Practice:

It is a best practice to have each workflow organization associated with only 1 department, practice or division.

If necessary, you can create a workflow organization that includes work queues from multiple departments, practices, or divisions; however, the same department, practice, or division cannot be associated with multiple workflow organization bases, even if not all of the work queues are included in the workflow.

- 7.** Use the arrow buttons to move the work queues to include in this workflow organization from **Available Work Queues** to **Work Queues Selected**.

When you move a queue to **Work Queues Selected**, it is automatically given a priority number based on the order that you moved it in. The first queue that you move has a priority of 1, and so forth.

8. If necessary, use **Move Up** and **Move Down** to change a queue's priority.
9. (Optional) To restrict a given work queue so that it can only be accessed by certain operators, in **Work Queues Selected**, click  to open a selection window and choose the operators who can access the queue.
Only collection operators (that is, operators who are associated with a record in **Collector Maintenance**) are displayed.
10. Click **Save**.

What to do next

Select **Eligible for Distribution** in **Collector Maintenance** make collectors eligible to have vouchers that have reached a manual step assigned to them.

Select collectors who are eligible for distribution

Select **Eligible for Distribution** to make collectors eligible to receive accounts that reach a manual step in the automated self-pay collections process and to use the **Review** queue to view accounts that have encountered an issue in the automated process.

1. Go to **System Administration > File Maintenance > Collector Maintenance** or press **F9** and enter **CLM**.
Collector Maintenance.
2. Enable distribution for collectors that are participating in the automated self-pay collections process.
You must complete these steps for each collector that is participating in the automated self-pay collections process.
 - a. Click  to open the search window and search for the applicable collector, then click **OK**.
The information for the collector that you selected is displayed.
 - b. Select **Eligible for Distribution**.
 - c. Click **Save**.

Results of this task

Accounts that reach a manual step in a work queue are distributed evenly between collectors assigned to that work queue who are eligible for distribution. Accounts assigned to an operator are displayed in the **Self-Pay Collections** workspace in **Office Manager**.

What to do next

Enable automated self-pay collections in **Practice Set Up** or **Organization Set Up**.

Enable automated self-pay collections

Before you begin

Set the priority of your self-pay collections work queues in **Workflow Organization Maintenance**.

1. Go to **System Administration > Practice Set Up or Organization Set Up** or press **F9** and then enter **PSU** or **OSU** as applicable.
 2. Go to the **Automation** tab.
 3. For **Automation Category**, select **Self-Pay Collections**.
The self-pay collections options are displayed.
 4. Select **Enable Self-Pay Collections**.
 5. Click **Save**.
- A confirmation message opens to remind you that after you enable self-pay collections, you cannot manually prepare collection accounts in **Collection Planning**.

6. Click **OK**.

Results of this task

Automated self-pay collections functionality is enabled for your practice or organization. When you enable automated self-pay collections, items related to manual self-pay collections become unavailable automatically, including on the **Collections** tab in **Practice Set Up** or **Organization Set Up**. However, you can still access the **Assign Collection Accounts** tab in **Collections Planning** if necessary to complete any accounts that you prepared before enabling automation.

Chapter 14

Automated Billing

Automated billing setup checklist

You must complete setup configuration within Allscripts® Practice Management to use automated billing.

Use this checklist to configure your application for automated billing. This checklist is meant to be a high-level overview only; refer to the tasks for each item in the Help or the *Allscripts® Practice Management 18.0 Automated Billing* feature guide for specific steps.

Task	Completed
If you want to include or exclude multiple operators from having their batches updated by the automated billing process, create one or more operator groups, as applicable, in System Administration > File Maintenance > Operator Group Maintenance .	
If you want the ability to mark individual charge, payment, and void batches so that they are not processed by automated billing, select Enable Bypass Automated Update Flag on the General tab in Practice Options or Organization Options .	
If you selected Enable Bypass Automated Update Flag , go to Administration > Security Manager > Security Permissions and use Practice Management > Financial Processing > Transactions > Batch Management > Defaults > Bypass Automated Update to control which users can mark batches to be bypassed by the automated billing process.	

Task	Completed
Go to Administration > Security Manager > Security Permissions and use Practice Management > Automation Management > Billing Automation Maintenance to control which users can create and maintain automation workflow records.	
Create a folder structure under <code>\\<i><Server Name>.<Domain Name>\Ntierfiles\<Tenant Name>\</i></code> from which you can select the applicable folders for Report Export Path when you create automation workflow records. See Folder structure for Report Export Path on page 887.	
In System Administration > File Maintenance > Billing Automation Maintenance , create automation workflow records for the areas of billing that you want to automate. Do not select Active until you are ready to enable automated billing.	
If you want to use automated billing to prepare electronic claims, ensure that in your active automation workflow records for preparing electronic claims, each claim format selected has a valid output path on the File Info tab in System Administration > File Maintenance > Electronic Claim Format Maintenance .	
In System Administration > Practice Set Up or Organization Set Up on the Automation tab, set Automation Category to Billing and then select Enable Automated Billing .	
Go to Automation Management > Automation Dashboard > Configuration to customize the display of Automation Dashboard .	
When you are ready to start using automated billing, select Active on the automation workflow records that you want automated billing to process.	

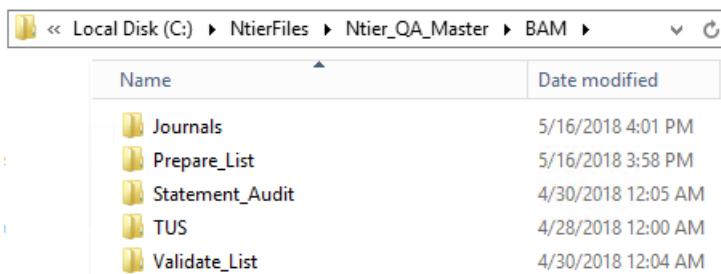
Task	Completed
<p>Ensure that the Automation service type is running.</p> <p>Note: If you are using automated self-pay collections, the Automation service type ensures that automated billing processing happens before automated self-pay collections processing.</p>	

Folder structure for Report Export Path

To accommodate reports exported by automation workflow records, create a **BAM** folder under `\\<Server Name>.<Domain Name>\Ntierfiles\<i>Tenant Name>\`, and then create subfolders under **BAM** based on the billing functions that you are automating.

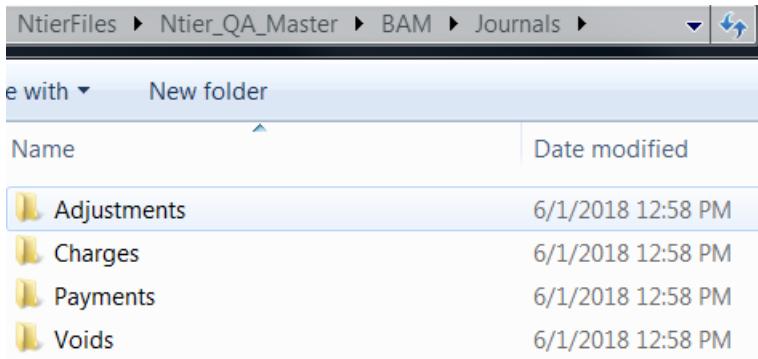
There is not one universal folder structure for automated billing, but you can use the following folder structure as a model. Under **BAM**, create only the subfolders that you need.

- **Journals:** for **Transaction Journal** files
- **Prepare_List:** for **Prepared Claims List** files
- **Statement_Audit:** for **Statement Audit List** files
- **TUS:** for **Transaction Update Summary** files
- **Validate_List:** for **Claims Validation List** files



If you have separate financial processing automation workflow records for charges, payments, and voids, create subfolders under **Journals** for each. Also include a folder for small self-pay adjustments, if applicable.

- **Adjustments**
- **Charges**
- **Payments**
- **Voids**



Billing Automation Maintenance window

Use **Billing Automation Maintenance** to configure the billing processes that you want to automate.

Billing Automation Maintenance contains these tabs:

- > **Financial Posting**
- > **Validate Claims**
- > **Prepare Electronic Claims**
- > **Adjust Small Balances**
- > **Finance Charges**
- > **Statement Processing**
- > **History**

Keep the following in mind:

- > **Clear Form** on the toolbar is not available for any of the tabs in **Billing Automation Maintenance**.
- > The **Finance Charges** tab is only available when **Finance Charge Percent** or **Flat Fee Amount** (depending on the finance charge type) on the **Finance Charge** tab in **Practice Options** or **Organization Options** is greater than zero.
- > If the **Finance Charges** tab or the **Statement Processing** tab is not available in **Billing Automation Maintenance**, that tab name is not listed in **Billing Automation Function** on the **History** tab.
- > The **Statement Processing** tab is only available when **Cycle By** on the **Statement** tab in **Practice Options** or **Organization Options** is set to **Last Statement Date**.

To access **Billing Automation Maintenance**, go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.

Financial Posting tab in Billing Automation Maintenance

Use the **Financial Posting** tab in **Automation Management > Billing Automation Maintenance** to enter the criteria used by the automated billing process to determine which batches are updated.

You can create automation workflow records to perform the functions manually done from **Financial Processing > Transactions > Batch Management > Print & Close > Batch Print & Close**, **Financial Processing > Financial Posting > Transaction Journal**, and **Reporting > Period End Reports > Transaction Update Summary**. Batches are updated based on batch type, batch status (open or closed), and batch category, as well as the operators or operator groups who open batches. For charge batches, you can have the automated billing process also update associated payment batches.

Automation workflow records are displayed in the grid at the top of the tab. They are sorted by **Active** then **Description**, so active records are displayed first.

Financial Posting

Billing Automation Maintenance

Description	Batch Type	Schedule	Active?
(new)			No

Abbreviation:

Description:

Batch Options

Batch Types

Charge Payment Void Void & Re-Enter

Charge Batch Options

Select Batch Categories: All Batch Categories

Select Operators: All Operators

Open Batches Closed Batches

Force Update of Associated Payment Batches with Charge Batches

Payment Batch Options

Select Batch Categories: All Batch Categories

Select Operators: All Operators

Open Batches Closed Batches

Void Batch Options

Select Batch Categories: All Batch Categories

Select Operators: All Operators

Open Batches Closed Batches

VRE Batch Options

Select Batch Categories: All Batch Categories

Select Operators: All Operators

Open Batches Closed Batches

Transaction Journal Options

Generate Transaction Journal

Report Preferences:

Save as PDF file Save as CSV file

Report Export Path:

Transaction Update Summary Options

Generate Transaction Update Summary

Report Preferences:

Save as PDF file Save as CSV file

Report Export Path:

Run Schedule

Run Schedule:

Active

Buttons

Access the **Financial Posting** tab from **Billing Automation Maintenance**. To access **Billing Automation Maintenance**, go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.

Abbreviation

Required. Enter an abbreviation for the automation workflow record. Each automation workflow record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the automation workflow record.

Best Practice: Make the description unique, so that it is not confused with other automation workflow records.

Batch Types

Required. Select the batch types that you want the automated billing process to update. You can select one or more of the following batch types:

- > Charge
- > Payment
- > Void
- > Void & Re-Enter

When you select a batch type, the corresponding batch options to select batch categories and operators, as well as open and closed batches, are enabled.

Select Batch Categories

For each batch type that you select, specify the batch categories to include when the automated billing process runs. When you first create an automation workflow record, all batch categories are included by default. To limit the batch categories, click  to open a separate window and select the batch categories.

Select **(None)** to include batches that do not have a batch category.

Select Operators

For each batch type that you select, specify the operators who opened a batch to include when the automated billing process runs. When you first create an automation workflow record, all operators are included by default. To limit the operators, click  to open a separate window and select the operators or operator groups.

Note: You can select operators or operator groups. You do not need to make selections on both tabs.

Open Batches

For each batch type that you select, select this option to include open batches. The automated billing process closes open batches before updating them.

Closed Batches

For each batch type that you select, select this option to include closed batches.

Force Update of Associated Payment Batches with Charge Batches

Select this option to have the automated billing process update payment batches (open or closed) that are associated with the charge batches that it updates. An associated payment batch is not updated if has **Bypass Automated Update** selected in the batch defaults window.

Generate Transaction Journal

Select **Generate Transaction Journal** to have the automated billing process generate a **Transaction Journal** report when batches are updated. When you select this option, **Report Preferences**, **Save as PDF file**, **Save as CSV file**, and **Report Export Path** are enabled.

Report Preferences

Click  to select your preferences for presenting the output of the report. These report preferences are the same as when you generate a **Transaction Journal** from **Financial Processing > Financial Posting > Transaction Journal**. You must open **Report Preferences** even if you want to accept the default preferences.

Generate Transaction Update Summary

Select this option to have the automated billing process generate a **Transaction Update Summary** report when batches are updated. When you select this option, **Report Preferences**, **Save as PDF file**, **Save as CSV file**, and **Report Export Path** are enabled.

Report Preferences

Click  to select your preferences for presenting the output of the report. These report preferences are the same as when you generate a **Transaction Update Summary** report from **Reporting > Period End Reports > Transaction Update Summary**. You must open **Report Preferences** even if you want to accept the default preferences.

Save as PDF file

Select this option to save the report output as a PDF file.

Save as CSV file

Select this option to save the report output as a comma-separated values (CSV) file.

Report Export Path

Select the path to the folder where the report will be exported. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients. Point to the box to see a tooltip with the entire path.

The **Transaction Journal** and **Transaction Update Summary** reports are saved with the following information in the file name:

- > automation workflow abbreviation
- > report name
- > date that the report was created in mmddyyyy format
- > time that the report was created in hhmmss format
- > .pdf or .csv file extension

For example, the file name for a **Transaction Journal** report might be

FINBAM_TranJrn1_04252018_035042.pdf or FINBAM_TranJrn1_04252018_035042.csv.

The file name for a **Transaction Update Summary** report might be

FINBAM_TranUpdSumm_04252018_035532.pdf or

FINBAM_TranUpdSumm_04252018_035532.csv.

Run Schedule

Required. Select whether you want the automation workflow record processed daily or weekly (one day a week).

Selected Days of the Week

Required. Select the days when you want the automation workflow record processed.

If **Run Schedule** is set to **Daily**, do one of the following:

- > Select **All Days** to have the automation workflow record processed on Monday through Sunday.
- > Select **Weekdays** to have the automation workflow record processed Monday through Friday.
- > Select one or more specific days to have the automation workflow record processed.

If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

Active

Select this option to make the automation workflow record available to the automated billing processing.

Create an automation workflow record for financial posting

Use the **Financial Posting** tab in **Billing Automation Maintenance** to create an automation workflow record for financial posting that is processed by the Automation service type.

1. Go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.
2. Click the **Financial Posting** tab.
3. Click .

4. For **Abbreviation**, enter an abbreviation for the automation workflow record.

Each automation workflow record must have a unique abbreviation.

5. For **Description**, enter a description for the automation workflow record.

Best Practice: Make the description unique, so that it is not confused with other automation workflow records.

6. For **Batch Types**, select the batch types that you want the automated billing process to update.

You can select one or more batch types.

- > Charge
- > Payment
- > Void
- > Void & Re-Enter

For each batch type that you selected, the default batch options include all batch categories and operators.

7. To limit your selections, specify the following:

- a. For **Select Batch Categories**, click  to open a separate window and select the batch categories.
 - b. For **Select Operators**, click  to open a separate window and select the operators or operator groups who opened a batch.
 - c. Select **Open Batches** to have the automated billing process close and update qualifying open batches.
 - d. Select **Closed Batches** to have the automated billing process update qualifying closed batches.
8. For charge batches, select **Force Update of Associated Payment Batches with Charge Batches** to have the automated billing process update payment batches (open or closed) that are associated with the charge batches that it updates.
- An associated payment batch is not updated if has **Bypass Automated Update** selected in the batch defaults window.
9. To have the automated billing process generate a **Transaction Journal**, select **Generate Transaction Journal** and select your report preferences, output file type, and export path.

Best Practice: Select **Generate Transaction Journal** so that you know if the automated financial posting process completed but no batches qualified.

- 10.** To have the automated billing process generate a **Transaction Update Summary** report, select **Generate Transaction Update Summary** and select your report preferences, output file type, and export path.

If the automated financial posting process completed but no batches qualified, the **Transaction Update Summary** report displays data based on what has been updated in the current reporting period.

- 11.** For **Run Schedule**, select when you want the automation workflow record processed.

- > **Daily**
- > **Weekly** (one day a week)

- 12.** For **Selected Days of the Week**, select the days when you want the automation workflow record processed.

- > If **Run Schedule** is set to **Daily**, do one of the following:
 - Select **All Days** to have the automation workflow record processed on Monday through Sunday.
 - Select **Weekdays** to have the automation workflow record processed Monday through Friday.
 - Select one or more specific days to have the automation workflow record processed.
- > If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

- 13.** If you are ready to make the automation workflow record available to the automated billing process, select **Active**.

- 14.** Click **Save**.

You can save an automation workflow record without selecting **Active**. The automated billing process ignores the record until you click **Active** and save again.

Validate Claims tab in Billing Automation Maintenance

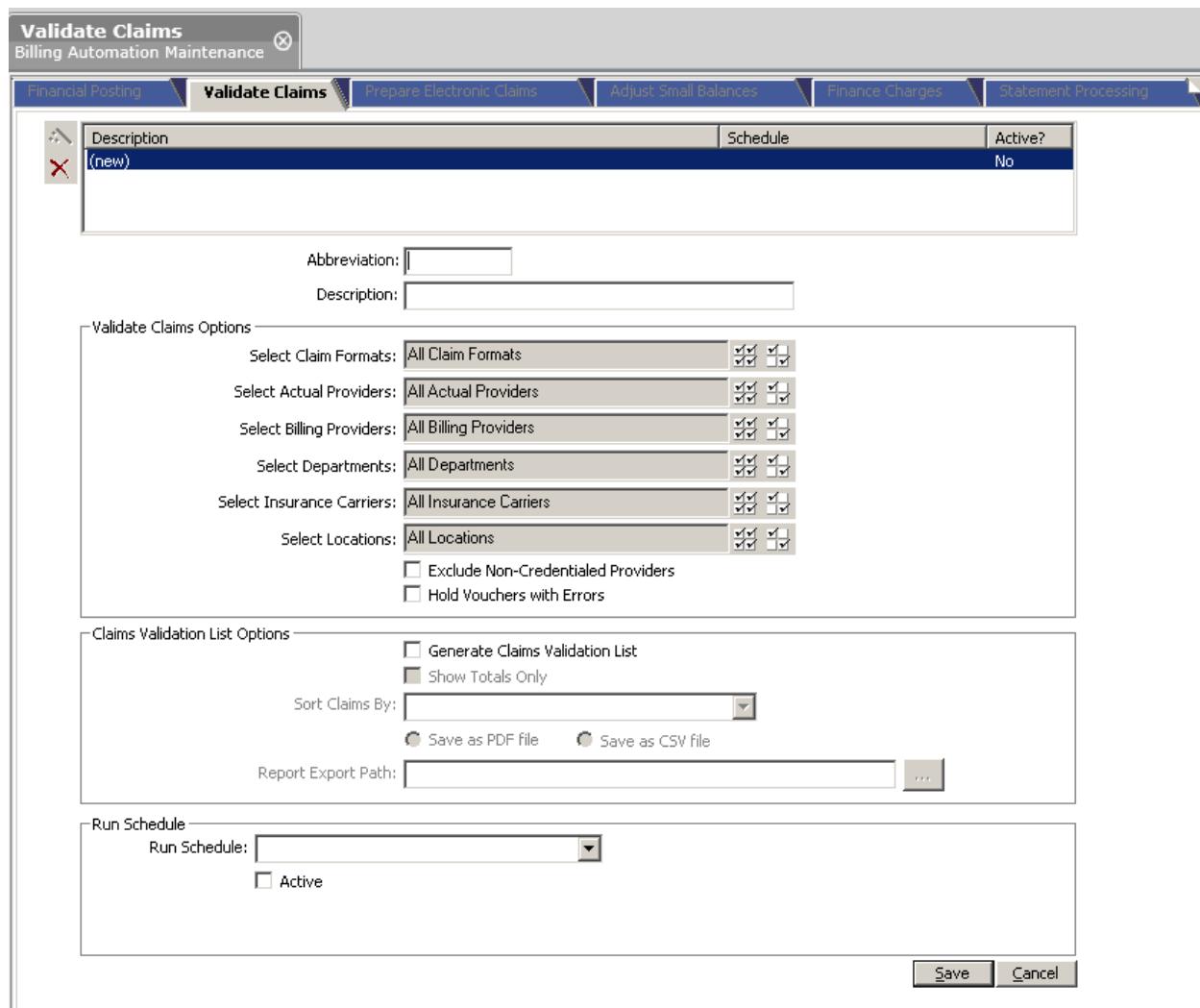
Use the **Validate Claims** tab in **Practice Management > Automation Management > Billing Automation Management** to enter the criteria used by the automated billing process to determine which claims are validated.

You can create automation workflow records to perform the functions manually done from **Billing > Insurance Billing > Validate Claims**. This function validates professional, institutional, and dental electronic and paper claims. Electronic claims must have a v5010 electronic claim format type and paper claims must have an **ICD10 Generic Medical Claim Form** format type.

Note: You must manually validate v4010 claims.

You can optionally generate a **Claims Validation List** report.

Automation workflow records are displayed in the grid at the top of the tab. They are sorted by **Active** then **Description**, so active records are displayed first.



Description	Schedule	Active?
(new)		No

Validate Claims Options

- Select Claim Formats: All Claim Formats
- Select Actual Providers: All Actual Providers
- Select Billing Providers: All Billing Providers
- Select Departments: All Departments
- Select Insurance Carriers: All Insurance Carriers
- Select Locations: All Locations
- Exclude Non-Credentialed Providers
- Hold Vouchers with Errors

Claims Validation List Options

- Generate Claims Validation List
- Show Totals Only
- Sort Claims By:
- Save as PDF file Save as CSV file
- Report Export Path:

Run Schedule

- Run Schedule:
- Active

Access the **Validate Claims** tab from **Billing Automation Maintenance**. To access **Billing Automation Maintenance**, go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.

Abbreviation

Required. Enter an abbreviation for the automation workflow record. Each automation workflow record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the automation workflow record.

Best Practice: Make the description unique, so that it is not confused with other automation workflow records.

Select Claim Formats

Specify the claim formats to include when the automated billing process runs. When you first create an automation workflow record, all claim formats are included by default. To limit the claim formats, click  to open a separate window and select the claim formats.

Note: The **Select Claim Formats** window that opens when you click  is slightly different from other selection windows. You can clear **All v5010 Electronic Claim Formats** without having something selected on the **Elect Claim Formats** tab provided that something is selected on the **Paper Claim Formats** tab. Similarly, you can clear **All Paper Claim Formats** without having something selected on the **Paper Claim Formats** tab provided that something is selected on the **Elect Claim Formats** tab. You must, however, have something selected on at least one of the tabs.

Select Actual Providers

Specify the actual providers to include when the automated billing process runs. When you first create an automation workflow record, all actual providers are included by default. To limit the actual providers, click  to open a separate window and select the actual providers.

Select Billing Providers

Specify the billing providers to include when the automated billing process runs. When you first create an automation workflow record, all billing providers are included by default. To limit the billing providers, click  to open a separate window and select the billing providers.

Select Departments or Select Practices

Specify the departments or practices to include when the automated billing process runs. When you first create an automation workflow record, all departments or practices are included by default. To limit the departments or practices, click  to open **Select Departments** or **Select Practices** and select the departments or practices.

If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, a **Division** tab is displayed in **Select Departments** or **Select Practices** that enables you to filter by division.

Select Insurance Carriers

Specify the insurance carriers to include when the automated billing process runs. When you first create an automation workflow record, all insurance carriers are included by default. To limit the insurance carriers, click  to open **Select Insurance Carriers** and enter selection criteria for one or more specific **Categories**, **Reporting Classes**, **Groups**, or **Insurance Carriers**.

Select Locations

Specify the locations to include when the automated billing process runs. When you first create an automation workflow record, all locations are included by default. To limit the locations, click  to open a separate window and select the locations.

Exclude Non-Credentialed Providers

The setup used for **Exclude Non-Credentialed Provider** in **Billing > Insurance Billing > Validate Claims** also applies to this function in the automated billing process.

Hold Vouchers with Errors

Select this option to put vouchers that fail the validation process on hold.

This option functions the same as **Hold Vouchers with Errors** in **Billing > Insurance Billing > Validate Claims**.

Generate Claims Validation List

Select this option to print a **Claims Validation List** report when claims are validated.

When selected, **Show Totals Only**, **Sort Claims By**, report format options, and **Report Export Path** become available.

Show Totals Only

Select this option to print the totals summary version of the **Claims Validation List** report. This option is only available when **Generate Claims Validations List** is selected.

Note: When **Show Totals Only** is selected, **Save as CSV file** is not available.

Sort Claims By

Select how the claims are sorted on the **Claims Validation List** report. This option is only available when **Generate Claims Validations List** is selected.

Save as PDF file

Select this option to save the report output as a PDF file.

Save as CSV file

Select this option to save the report output as a comma-separated values (CSV) file.

Report Export Path

Select the path to the folder where the report will be exported. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients. Point to the box to see a tooltip with the entire path.

The **Claims Validation List** report is saved with the following information in the file name:

- > *automation workflow abbreviation*
- > *report name*
- > *date the report was created in mmddyyyy format*
- > *time the report was created in hhmmss format*
- > *.pdf or .csv file extension*

For example, the file name for a **Claims Validation List** report might be

VALBAM_InvClaimList_04252018_034517.pdf or

VALBAM_InvClaimList_04252018_034517.csv.

Run Schedule

Required. Select whether you want the automation workflow record processed daily or weekly (one day a week).

Selected Days of the Week

Required. Select the days when you want the automation workflow record processed.

If **Run Schedule** is set to **Daily**, do one of the following:

- > Select **All Days** to have the automation workflow record processed on Monday through Sunday.
- > Select **Weekdays** to have the automation workflow record processed Monday through Friday.
- > Select one or more specific days to have the automation workflow record processed.

If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

Active

Select this option to make the automation workflow record available to the automated billing processing.

Create an automation workflow record for validating claims

Use the **Validate Claims** tab in **Billing Automation Maintenance** to create an automation workflow record for claim validation that is processed by the Automation service type.

1. Go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.
2. Click the **Validate Claims** tab.
3. Click .
4. For **Abbreviation**, enter an abbreviation for the automation workflow record.
Each automation workflow record must have a unique abbreviation.
5. For **Description**, enter a description for the automation workflow record.

Note: Make the description unique, so that it is not confused with other automation workflow records.

By default, all electronic and paper claim formats, actual providers, billing providers, departments or practices, insurance carriers, and locations are included with an automation workflow record.

6. To limit your selections, specify the following:
 - a. For **Select Claim Formats**, click  to open a separate window and select v5010 electronic claim formats and paper claim formats.
 - b. For **Select Actual Providers**, click  to open a separate window and select actual providers.
 - c. For **Select Billing Providers**, click  to open a separate window and select billing providers.
 - d. For **Select Departments** or **Select Practices**, click  to open a separate window and select departments or practices. If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, you can also select divisions.
 - e. For **Select Insurance Carriers**, click  to open a separate window and select insurance categories, reporting classes, groups, or carriers.
 - f. For **Locations**, click  to open a separate window and select locations.
7. Select **Exclude Non-Credentialed Provider** if you want to exclude vouchers for providers not credentialed with specific payers.
8. Select **Hold Vouchers with Errors** if you want to put vouchers that fail the validation process on hold.

9. To have the automated billing process generate a list of the claims that are validated, select **Generate Claims Validation List** and select the output file type and export path.
The claim list is the same as the list generated in **Billing > Insurance Billing > Validate Claims**.

Best Practice: Select **Generate Claims Validation List** so you know if the automated validate claims process completed but no vouchers qualified.

10. Select **Show Totals Only** to print the totals summary version of the **Claims Validation List** report.
11. Select a value for **Sort Claims By** to have the **Claims Validation List** report sorted in a specific order.
- > **Batch Number**
 - > **Department or Practice**
 - > **Location**
 - > **Provider**
12. For **Run Schedule**, select when you want the automation workflow record processed.
- > **Daily**
 - > **Weekly** (one day a week)
13. For **Selected Days of the Week**, select the days when you want the automation workflow record processed.
- > If **Run Schedule** is set to **Daily**, do one of the following:
 - Select **All Days** to have the automation workflow record processed on Monday through Sunday.
 - Select **Weekdays** to have the automation workflow record processed Monday through Friday.
 - Select one or more specific days to have the automation workflow record processed.
 - > If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.
14. If you are ready to make the automation workflow record available to the automated billing process, select **Active**.
15. Click **Save**.

You can save an automation workflow record without selecting **Active**. The automated billing process ignores the record until you click **Active** and save again.

Prepare Electronic Claims tab in Billing Automation Maintenance

Use the **Prepare Electronic Claims** tab in **Automation Management > Billing Automation Maintenance** to enter the criteria used by the automated billing process to determine which electronic claims are prepared.

You can create automation workflow records to perform the functions manually done from **Billing > Insurance Billing > Prepare Electronic Claims**.

Professional, institutional, or dental v5010 electronic claims that have passed validation are prepared. You can optionally generate a **Prepared Claims List** report for each electronic claim file. Unlike with manual billing, the **Prepared Claims List** report is not a preliminary listing.

Automation workflow records are displayed in the grid at the top of the tab. They are sorted by **Active** then **Description**, so active records are displayed first.

Prepare Electronic Claims X

Billing Automation Maintenance

Financial Posting Validate Claims **Prepare Electronic Claims** Adjust Small Balances Finance Charges Statement Processing

Description	Schedule	Active?
(new)		No

Abbreviation:

Description:

Prepare Electronic Claims Options

Select Claim Formats:	All Electronic Claim Formats	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Select Actual Providers:	All Actual Providers	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Select Billing Providers:	All Billing Providers	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Select Departments:	All Departments	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Select Insurance Carriers:	All Insurance Carriers	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Select Locations:	All Locations	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>

Prepared Claims List Options

<input type="checkbox"/> Generate Prepared Claims List
<input checked="" type="radio"/> Save as PDF file <input type="radio"/> Save as CSV file
Report Export Path: <input type="text"/> <input type="button" value="..."/>

Run Schedule

Run Schedule: <input type="text"/>
<input type="checkbox"/> Active

Save **Cancel**

Access the **Prepare Electronic Claims** tab from **Billing Automation Maintenance**. To access **Billing Automation Maintenance**, go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.

Abbreviation

Required. Enter an abbreviation for the automation workflow record. Each automation workflow record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the automation workflow record.

Best Practice: Make the description unique, so that it is not confused with other automation workflow records.

Select Claim Formats

Specify the v5010 electronic claim formats to include when the automated billing process runs. When you first create an automation workflow record, all electronic claim formats are included by default. To limit the electronic claim formats, click  to open a separate window and select the electronic claim formats.

The automated billing process creates an electronic claim file for each claim format that you select.

Electronic claims are not prepared for claim formats that have **Test File** selected on the **File Info** tab in **Electronic Claim Format Maintenance**.

Select Actual Providers

Specify the actual providers to include when the automated billing process runs. When you first create an automation workflow record, all actual providers are included by default. To limit the actual providers, click  to open a separate window and select the actual providers.

Select Billing Providers

Specify the billing providers to include when the automated billing process runs. When you first create an automation workflow record, all billing providers are included by default. To limit the billing providers, click  to open a separate window and select the billing providers.

Select Departments or Select Practices

Specify the departments or practices to include when the automated billing process runs. When you first create an automation workflow record, all departments or practices are included by default. To limit the departments or practices, click  to open **Select Departments** or **Select Practices** and select the departments or practices.

If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, a **Division** tab is displayed in **Select Departments** or **Select Practices** that enables you to filter by division.

Select Insurance Carriers

Specify the insurance carriers to include when the automated billing process runs. When you first create an automation workflow record, all insurance carriers are included by default. To limit the insurance carriers, click  to open **Select Insurance Carriers** and enter selection criteria for one or more specific **Categories**, **Reporting Classes**, **Groups**, or **Insurance Carriers**.

Select Locations

Specify the locations to include when the automated billing process runs. When you first create an automation workflow record, all locations are included by default. To limit the locations, click  to open a separate window and select the locations.

Generate Prepared Claims List

Select this option to configure the automated billing process to generate a **Prepared Claims List** for each electronic claim file. When selected, **Save as PDF file**, **Save as CSV file**, and **Report Export Path** are enabled.

Save as PDF file

Select this option to save the report output as a PDF file.

Save as CSV file

Select this option to save the report output as a comma-separated values (CSV) file.

Report Export Path

Select the path to the folder where the report will be exported. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients. Point to the box to see a tooltip with the entire path.

The **Prepared Claims List** is saved with the following information in the file name:

- > *automation workflow abbreviation*
- > *report name*
- > *format type indicator: P (professional), I (institutional), D (dental)*
- > *date the report was created in mmddyyyy format*
- > *time the report was created in hhmmss format*
- > *.pdf or .csv file extension*

For example, the file name for a **Prepared Claims List** report for professional claims might be `PREPEBAM_PrepClaimList_P_04272018_000458.pdf` or `PREPEBAM_PrepClaimList_P_04272018_000458.csv`.

Run Schedule

Required. Select whether you want the automation workflow record processed daily or weekly (one day a week).

Selected Days of the Week

Required. Select the days when you want the automation workflow record processed.

If **Run Schedule** is set to **Daily**, do one of the following:

- > Select **All Days** to have the automation workflow record processed on Monday through Sunday.
- > Select **Weekdays** to have the automation workflow record processed Monday through Friday.
- > Select one or more specific days to have the automation workflow record processed.

If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

Active

Select this option to make the automation workflow record available to the automated billing processing.

Create an automation workflow record for preparing electronic claims

Use the **Prepare Electronic Claims** tab in **Billing Automation Maintenance** to create an automation workflow record for preparing electronic claims that is processed by the Automation service type.

1. Go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.
2. Click the **Prepare Electronic Claims** tab.
3. Click .
4. For **Abbreviation**, enter an abbreviation for the automation workflow record.
Each automation workflow record must have a unique abbreviation.
5. For **Description**, enter a description for the automation workflow record.

Note: Make the description unique, so that it is not confused with other automation workflow records.

By default, all electronic claim formats, actual providers, billing providers, departments or practices, insurance carriers, and locations are included with an automation workflow record.

6. To limit your selections, specify the following:

- a. For **Select Claim Formats**, click  to open a separate window and select v5010 electronic claim formats.
- b. For **Select Actual Providers**, click  to open a separate window and select actual providers.
- c. For **Select Billing Providers**, click  to open a separate window and select billing providers.

- d. For **Select Departments** or **Select Practices**, click to open a separate window and select departments or practices. If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, you can also select divisions.
 - e. For **Select Insurance Carriers**, click to open a separate window and select insurance categories, reporting classes, groups, or carriers.
 - f. For **Locations**, click to open a separate window and select locations.
7. To have the automated billing process generate a list of the claims that are prepared, select **Generate Prepared Claims List** and select the output file type and export path.

The claim list is the same as the list generated in **Billing > Insurance Billing > Prepare Electronic Claims**.

Best Practice: Select **Generate Prepared Claims List** so that you know if the automated prepare claims process completed but no claims qualified.

8. For **Run Schedule**, select when you want the automation workflow record processed.
 - > **Daily**
 - > **Weekly** (one day a week)
9. For **Selected Days of the Week**, select the days when you want the automation workflow record processed.
 - > If **Run Schedule** is set to **Daily**, do one of the following:
 - Select **All Days** to have the automation workflow record processed on Monday through Sunday.
 - Select **Weekdays** to have the automation workflow record processed Monday through Friday.
 - Select one or more specific days to have the automation workflow record processed.
 - > If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

10. If you are ready to make the automation workflow record available to the automated billing process, select **Active**.

11. Click **Save**.

You can save an automation workflow record without selecting **Active**. The automated billing process ignores the record until you click **Active** and save again.

Adjust Small Balances tab in Billing Automation Maintenance

Use the **Adjust Small Balances** tab in **Automation Management > Billing Automation Management** to enter the criteria that the automated billing process uses to determine which small self-pay balances are adjusted.

You can create automation workflow records to perform the small self-pay adjustments that are manually done from **Financial Processing > Automatic Transactions > Adjust Balances**. The automated billing process adjusts traditional self-pay balances and self-pay balances associated with uninsured carriers by account, department, or division depending on how statements are generated in the tenant.

Important: Adjustment batches are automatically closed and updated by the automated billing process.

If your practice or organization uses uninsured carriers, vouchers associated with uninsured carriers can qualify to have any self-pay balance adjusted based on the criteria defined on the **Adjust Small Balances** tab. If the uninsured voucher qualifies for adjustment, the adjustment is done during automated billing.

You can optionally generate a **Transaction Journal** report.

Automation workflow records are displayed in the grid at the top of the tab. They are sorted by **Active** then **Description**, so active records are displayed first.

Adjust Small Balances X

Billing Automation Maintenance

Description	Schedule	Active?
(new)		No

Abbreviation:

Description:

Self-Pay Adjustment Options

Batch Category:	Select Account Types: <input checked="" type="checkbox"/> All Account Types <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Transaction Code:	Select Departments: <input checked="" type="checkbox"/> All Departments <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Stmt Message:	Include Accts w/Balances less than: <input type="text"/> \$0.01
Apply Voucher Note:	Accts with Service Dates older than: <input type="text"/> 0
Accounts with Unassigned Money are not adjusted Adjust Small Balances calculates based on Department Departments with Unposted Activity or Credit Vouchers are not adjusted Batches are automatically updated	

Transaction Journal Options

<input type="checkbox"/> Generate Transaction Journal
Report Preferences: <input type="button" value="..."/>
<input checked="" type="radio"/> Save as PDF file <input type="radio"/> Save as CSV file
Report Export Path: <input type="text"/> <input type="button" value="..."/>

Run Schedule

Run Schedule: <input type="text"/>
<input type="checkbox"/> Active

Note:

The message at the bottom of the **Self-Pay Adjustment Selections** area changes depending on whether you are generating statements by account, department or practice, or division. For example, if **Print Statements by Department** is selected on the **Statements** tab in **Practice Options** or **Organization Options**, the message **Account balances will be adjusted by Department** is displayed. Similarly, when **Print Statements by Division** is selected, the message changes to **Account balances will be adjusted by Division**.

When applicable, additional messages are also displayed indicating that accounts with unassigned balances or unposted activity are not automatically adjusted off.

Access the **Adjust Small Balances** tab from **Billing Automation Maintenance**. To access **Billing Automation Maintenance**, go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.

Abbreviation

Required. Enter an abbreviation for the automation workflow record. Each automation workflow record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the automation workflow record.

Best Practice: Make the description unique, so that it is not confused with other automation workflow records.

Batch Category

Select the batch category that you want to assign to the payment batch created by the automated billing process. To select a batch category, you must have access to the batch category according to department security or practice security.

Note: This box is only required if **Require Batch Category** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Transaction Code

Required. Select the transaction code that you want used when voucher balances are adjusted by the automated billing process.

Stmt Message

Select a statement message to print on the statements for accounts that have a balance adjusted by the automated billing process. You can create statement messages in **System Administration > File Maintenance > Message Maintenance**.

Apply Voucher Note

Select a voucher note to apply to vouchers that have a balance adjusted by the automated billing process. The subject line of the voucher note is **Automatic Adjustment - Voucher # xxxx** where xxxx is the voucher number.

You can create voucher notes in **System Administration > File Maintenance > Note Type Maintenance**.

Select Account Types

Specify the account types to include when the automated billing process runs. When you first create an automation workflow record, all account types are included by default. To limit the account types, click  to open a separate window and select the account types.

Select Departments or Select Practices

Specify the departments or practices to include when the automated billing process runs. When you first create an automation workflow record, all departments or practices are included by default. To limit the departments or practices, click  to open **Select Departments** or **Select Practices** and select the departments or practices.

If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, a **Division** tab is displayed in **Select Departments** or **Select Practices** that enables you to filter by division.

Include Accts w/Balances less than

Enter a dollar amount for the automated billing process to use to determine if an account should have balances adjusted.

Note: When your practice or organization uses uninsured carriers, this field includes traditional self-pay balances and self-pay balances associated with uninsured carriers.

Self-pay balances below the specified amount qualify based on how statements are generated in the tenant. For example, if statements are generated by account, the entire self-pay balance for the account determines whether the balance is adjusted. When statements are generated by department or practice, or division, accounts are adjusted based on the self-pay balance of those organizational structures.

Note: \$0.00 and blank are not valid values for **Include Accts w/Balances less than**.

Accts with Service Dates older than

Enter a number of days for the automated billing process to use to determine, based on service date, if an account should have balances adjusted.

Generate Transaction Journal

Select **Generate Transaction Journal** to have the automated billing process generate a **Transaction Journal** report when batches are updated. When you select this option, **Report Preferences**, **Save as PDF file**, **Save as CSV file**, and **Report Export Path** are enabled.

Report Preferences

Click  to select your preferences for presenting the output of the report. These report preferences are the same as when you generate a **Transaction Journal** from **Financial Processing > Financial Posting > Transaction Journal**. You must open **Report Preferences** even if you want to accept the default preferences.

Save as PDF file

Select this option to save the report output as a PDF file.

Save as CSV file

Select this option to save the report output as a comma-separated values (CSV) file.

Report Export Path

Select the path to the folder where the report will be exported. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients. Point to the box to see a tooltip with the entire path.

The **Transaction Journal** report is saved with the following information in the file name:

- > automation workflow abbreviation
- > report name
- > date the report was created in mmddyyyy format
- > time the report was created in hhmmss format
- > .pdf or .csv file extension

For example, the file name for a **Transaction Journal** report might be

ADJUST_TranJrn1_04252018_035035.pdf or ADJUST_TranJrn1_04252018_035035.csv.

Run Schedule

Required. Select whether you want the automation workflow record processed daily, weekly (one day a week), or monthly (one day a month).

Selected Days of the Week

Required. Select the days when you want the automation workflow record processed.

If **Run Schedule** is set to **Daily**, do one of the following:

- > Select **All Days** to have the automation workflow record processed on Monday through Sunday.
- > Select **Weekdays** to have the automation workflow record processed on Monday through Friday.
- > Select one or more specific days to have the automation workflow record processed.

If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

Selected Day of the Month

Required. If **Run Schedule** is set to **Monthly**, select the number representing the day when the automation workflow record will be processed each month, or select **Last Day** to have the automation workflow record processed on the last day of each month. Keep in mind that some months do not have dates of 29, 30, and 31. If you want to have the automation workflow record processed at the end of every month, select **Last Day** to ensure that no months are missed.

Active

Select this option to make the automation workflow record available to the automated billing processing.

Create an automation workflow record for adjusting small self-pay balances

Use the **Adjust Small Balances** tab in **Billing Automation Maintenance** to create an automation workflow record for adjusting small self-pay balances that is processed by the Automation service type.

1. Go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.
2. Click the **Adjust Small Balances** tab.
3. Click .
4. For **Abbreviation**, enter an abbreviation for the automation workflow record.
Each automation workflow record must have a unique abbreviation.
5. For **Description**, enter a description for the automation workflow record.

Note: Make the description unique, so that it is not confused with other automation workflow records.

6. For **Batch Category**, select a batch category to assign to the batch created by the automated billing process.

This option is only required if **Require Batch Category** is selected on the **General** tab in **Practice Options** or **Organization Options**.

7. For **Transaction Code**, select the transaction code that you want used when voucher balances are adjusted by the automated billing process.
8. For **Stmt Message**, select a message to print on the statements for accounts that have a balance adjusted during the automated billing process.

You can create statement messages in **System Administration > File Maintenance > Message Maintenance**.

9. For **Apply Voucher Note**, select a voucher note to apply to vouchers that have a balance adjusted by the automated billing process.

You can create voucher notes in **System Administration > File Maintenance > Note Type Maintenance**.

By default, all account types are included with an automation workflow record.

10. To limit your selections, for **Select Account Types**, click  to open a separate window and select account types.

By default, all departments or practices are included with an automation workflow record.

11. To limit your selections, for **Select Departments** or **Select Practices**, click  to open a separate window and select departments or practices.

If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, you can also select divisions.

12. For **Include Accts w/Balances less than**, enter a dollar amount for the automated billing process to use to determine if an account should have balances adjusted. Accounts with balances below the specified amount qualify.

Note: This value must be greater than \$0.00.

13. For **Accts with Service Dates older than**, enter a number of days for the automated billing process to use to determine, based on service date, if an account should have balances adjusted.

14. To have the automated billing process generate a **Transaction Journal** report, select **Generate Transaction Journal** and select your report preferences, output file type, and export path.

Best Practice: Select **Generate Transaction Journal** so that you know if the adjust small balances process completed but no adjustment transactions were created.

15. For **Run Schedule**, select when you want the automation workflow record processed.

- > **Daily**
- > **Weekly** (one day a week)
- > **Monthly** (one day a month)

16. Select the days when you want the automation workflow record processed.

- > If **Run Schedule** is set to **Daily**, for **Selected Days of the Week**, do one of the following:
 - Select **All Days** to have the automation workflow record processed on Monday through Sunday.

- Select **Weekdays** to have the automation workflow record processed Monday through Friday.
 - Select one or more specific days to have the automation workflow record processed.
- > If **Run Schedule** is set to **Weekly**, for **Selected Days of the Week**, select the day of the week when the automation workflow record will be processed.
- > If **Run Schedule** is set to **Monthly**, for **Day**, select one day of the month when the automation workflow record will be processed.
17. If you are ready to make the automation workflow record available to the automated billing process, select **Active**.
18. Click **Save**.
You can save an automation workflow record without selecting **Active**. The automated billing process ignores the record until you click **Active** and save again.

Finance Charges tab in Billing Automation Maintenance

Use the **Finance Charges** tab in **Automation Management > Billing Automation Maintenance** to enter the criteria that the automated billing process uses to assess finance charges and create the necessary vouchers.

The **Finance Charges** tab in **Billing Automation Maintenance** is only available when you have the following setup in **Practice Options** or **Organization Options**:

- > On the **Statement** tab, **Cycle By** is set to **Last Statement Date**.
- > On the **Finance Charge** tab, **Finance Charge Percent** or **Flat Fee Amount** must be greater than zero, depending on whether **Percent (Monthly)** or **Flat Fee** is selected.

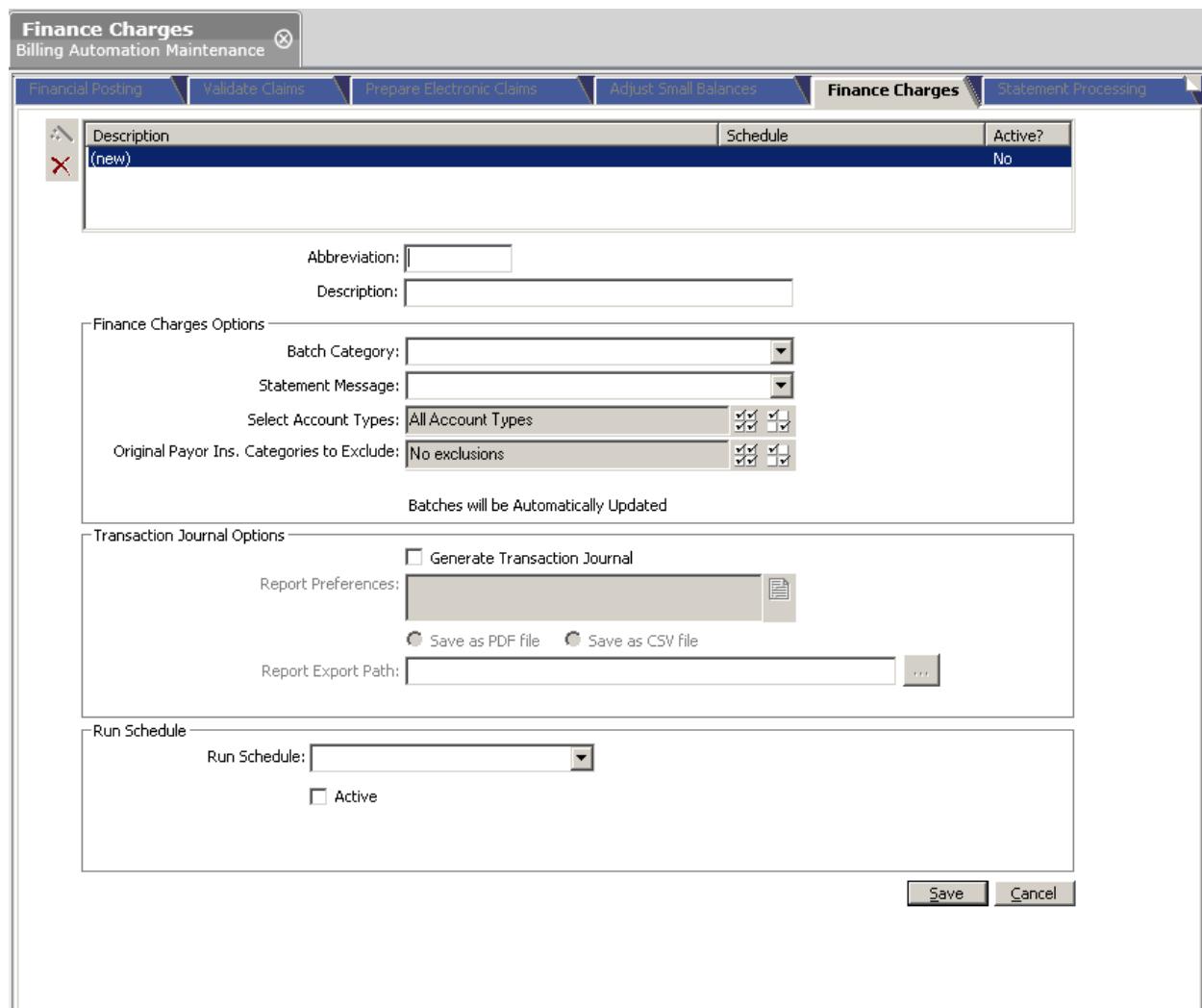
You can create automation workflow records to perform the functions manually done from **Financial Processing > Automatic Transactions > Finance Charges**.

Important:

- > If you have active automation workflow records for finance charges and you attempt to change your setup in **Practice Options** or **Organization Options** so that finance charges are no longer assessed, a warning message is displayed indicating that changing the practice or organization options conflicts with your billing automation for finance charges. If you decide to save your changes in **Practice Options** or **Organization Options**, active automation workflow records for finance charges are made inactive.
- > Finance charge batches are automatically closed and updated by the automated billing process.

You can optionally generate a **Transaction Journal** report.

Automation workflow records are displayed in the grid at the top of the tab. They are sorted by **Active** then **Description**, so active records are displayed first.



The screenshot shows the 'Finance Charges' tab within the 'Billing Automation Maintenance' application. The interface includes a navigation bar with tabs: Financial Posting, Validate Claims, Prepare Electronic Claims, Adjust Small Balances, Finance Charges (selected), and Statement Processing. The main area contains a table with columns: Description, Schedule, and Active?. A new record is currently being edited, with '(new)' displayed in the Description field. Below the table are several configuration sections:

- Abbreviation:** A text input field.
- Description:** A text input field.
- Finance Charges Options:**
 - Batch Category:** A dropdown menu.
 - Statement Message:** A dropdown menu.
 - Select Account Types:** A dropdown menu with checkboxes for 'All Account Types' and other options.
 - Original Payor Ins. Categories to Exclude:** A dropdown menu with checkboxes for 'No exclusions' and other options.
- Transaction Journal Options:**
 - Generate Transaction Journal:** A checkbox.
 - Report Preferences:** A dropdown menu with a file icon.
 - Save as PDF file** and **Save as CSV file**: Radio buttons.
 - Report Export Path:** A text input field with a browse button (...).
- Run Schedule:**
 - Run Schedule:** A dropdown menu.
 - Active:** A checkbox.

At the bottom right are 'Save' and 'Cancel' buttons.

Access the **Finance Charges** tab from **Billing Automation Maintenance**. To access **Billing Automation Maintenance**, go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.

Abbreviation

Required. Enter an abbreviation for the automation workflow record. Each automation workflow record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the automation workflow record.

Best Practice: Make the description unique, so that it is not confused with other automation workflow records.

Batch Category

Select a batch category to assign to the batch created by the automated billing process.

Note: This option is only required if **Require Batch Category** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Statement Message

Optional. Select a message to print on the statements that include finance charges. You can create statement messages in **System Administration > File Maintenance > Message Maintenance**.

Select Account Types

Specify the account types to include when the automated billing process runs. When you first create an automation workflow record, all account types are included by default. To limit an automation workflow record to include only selected account types, click  to open a separate window and select the account types.

Original Payor Ins Categories to Exclude

Specify insurance categories to exclude from the finance charge assessment process. The exclusion is based on the original payor. When you first create an automation workflow record, no insurance categories are excluded by default.

Note: This option is labeled **Original Payor Ins Categories to Exclude** for conciseness. Point to the label to see a tooltip with a longer description: **Exclude Vouchers with Original Payer Insurance Category.**

Generate Transaction Journal

Select **Generate Transaction Journal** to have the automated billing process generate a **Transaction Journal** report when batches are updated. When you select this option, **Report Preferences**, **Save as PDF file**, **Save as CSV file**, and **Report Export Path** are enabled.

Report Preferences

Click  to select your preferences for presenting the output of the report. These report preferences are the same as when you generate a **Transaction Journal** from **Financial Processing > Financial Posting > Transaction Journal**. You must open **Report Preferences** even if you want to accept the default preferences.

Save as PDF file

Select this option to save the report output as a PDF file.

Save as CSV file

Select this option to save the report output as a comma-separated values (CSV) file.

Report Export Path

Select the path to the folder where the report will be exported. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients. Point to the box to see a tooltip with the entire path.

The **Transaction Journal** report is saved with the following information in the file name:

- > automation workflow abbreviation
- > report name
- > date the report was created in mmddyyyy format
- > time the report was created in hhmmss format
- > .pdf or .csv file extension

For example, the file name for a **Transaction Journal** report might be

FINCHG_TranJrn1_04252018_034431.pdf or FINCHG_TranJrn1_4252018_034431.csv.

Run Schedule

Required. Select whether you want the automation workflow record processed daily, weekly (one day a week), or monthly (one day a month).

Selected Days of the Week

Required. Select the days when you want the automation workflow record processed.

If **Run Schedule** is set to **Daily**, do one of the following:

- > Select **All Days** to have the automation workflow record processed on Monday through Sunday.
- > Select **Weekdays** to have the automation workflow record processed on Monday through Friday.
- > Select one or more specific days to have the automation workflow record processed.

If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

Selected Day of the Month

Required. If **Run Schedule** is set to **Monthly**, select the number representing the day when the automation workflow record will be processed each month, or select **Last Day** to have the automation workflow record processed on the last day of each month. Keep in mind that some months do not have dates of 29, 30, and 31. If you want to have the automation workflow record processed at the end of every month, select **Last Day** to ensure that no months are missed.

Active

Select this option to make the automation workflow record available to the automated billing processing.

Create an automation workflow record for assessing finance charges

Use the **Finance Charges** tab in **Billing Automation Maintenance** to create an automation workflow record for assessing finance charges and creating vouchers that is processed by the Automation service type.

1. Go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.
2. Click the **Finance Charges** tab.
3. Click .
4. For **Abbreviation**, enter an abbreviation for the automation workflow record.
Each automation workflow record must have a unique abbreviation.
5. For **Description**, enter a description for the automation workflow record.

Note: Make the description unique, so that it is not confused with other automation workflow records.

6. For **Batch Category**, select a batch category to assign to the batch created by the automated billing process.

This option is only required if **Require Batch Category** is selected on the **General** tab in **Practice Options** or **Organization Options**.

7. For **Statement Message**, select a message to print on the statements that include finance charges.

You can create statement messages in **System Administration > File Maintenance > Message Maintenance**.

By default, all account types are included with an automation workflow record.

8. To limit your selections, for **Select Account Types**, click to open a separate window and select account types.
By default, no insurance categories are excluded from the finance charge assessment process.
9. To exclude specific insurance categories, for **Original Payor Ins Categories to Exclude**, click to open a separate window and select insurance categories.
The exclusion is based on the original payor.
10. To have the automated billing process generate a **Transaction Journal** report, select **Generate Transaction Journal** and select your report preferences, output file type, and export path.

Best Practice: Select **Generate Transaction Journal** so you know if the automated finance charge process completed but no finance charge vouchers were created.

11. For **Run Schedule**, select when you want the automation workflow record processed.
 - > **Daily**
 - > **Weekly** (one day a week)
 - > **Monthly** (one day a month)
12. Select the days when you want the automation workflow record processed.
 - > If **Run Schedule** is set to **Daily**, for **Selected Days of the Week**, do one of the following:
 - Select **All Days** to have the automation workflow record processed on Monday through Sunday.
 - Select **Weekdays** to have the automation workflow record processed Monday through Friday.
 - Select one or more specific days to have the automation workflow record processed.
 - > If **Run Schedule** is set to **Weekly**, for **Selected Days of the Week**, select the day of the week when the automation workflow record will be processed.
 - > If **Run Schedule** is set to **Monthly**, for **Day**, select one day of the month when the automation workflow record will be processed.
13. If you are ready to make the automation workflow record available to the automated billing process, select **Active**.
14. Click **Save**.
You can save an automation workflow record without selecting **Active**. The automated billing process ignores the record until you click **Active** and save again.

Statement Processing tab in Billing Automation Maintenance

Use the **Statement Processing** tab in **Practice Management > Automation Management > Billing Automation Management** to enter the criteria that the automated billing process uses to generate patient statements.

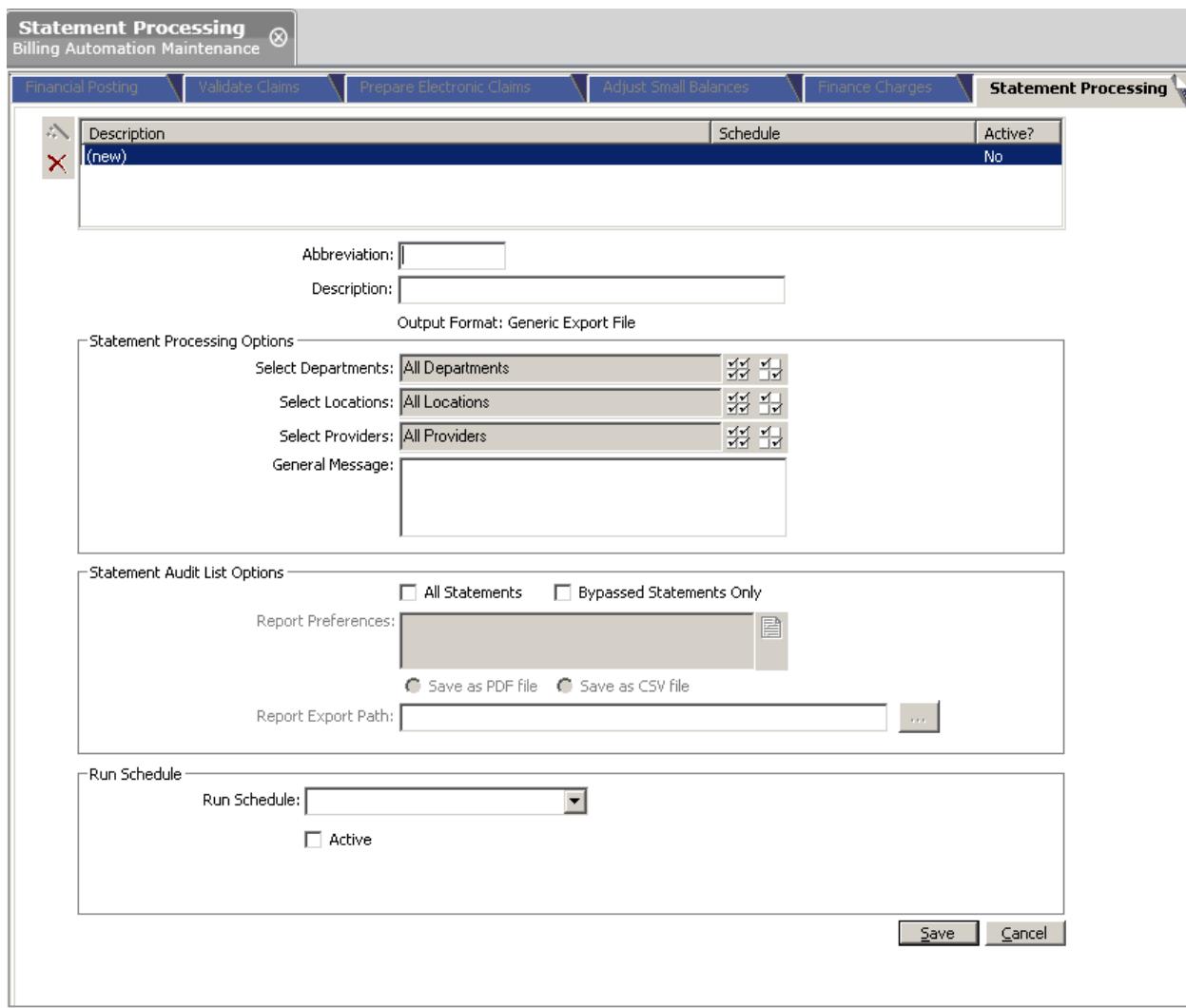
You can create automation workflow records to generate the patient statements that are manually done from **Billing > Statement Processing > Print Statements**.

The **Statement Processing** tab is only available when **Cycle By** on the **Statement** tab in **Practice Options** or **Organization Options** is set to **Last Statement Date**.

Important: If you have active automation workflow records for statement processing, and you attempt to change your setup in **Practice Options** or **Organization Options** so that **Cycle By** is not set to **Last Statement Date**, a warning message is displayed indicating that changing the practice or organization options conflicts with your billing automation for statement processing. If you decide to save your changes in **Practice Options** or **Organization Options**, active automation workflow records for statement processing are made inactive.

You can optionally generate a **Statement Audit List** report.

Automation workflow records are displayed in the grid at the top of the tab. They are sorted by **Active** then **Description**, so active records are displayed first.



The screenshot shows the **Statement Processing** dialog box within the **Billing Automation Maintenance** application. The **Statement Processing** tab is selected. The interface includes several tabs at the top: **Financial Posting**, **Validate Claims**, **Prepare Electronic Claims**, **Adjust Small Balances**, **Finance Charges**, and **Statement Processing**. The **Description** field is populated with '(new)'. Below it are fields for **Abbreviation** and **Description**. The **Output Format** is set to **Generic Export File**. The **Statement Processing Options** section contains three dropdown menus: **Select Departments** (All Departments), **Select Locations** (All Locations), and **Select Providers** (All Providers), each with a checkbox group next to it. A **General Message** text area is also present. The **Statement Audit List Options** section includes checkboxes for **All Statements** and **Bypassed Statements Only**, a **Report Preferences** button, and options to **Save as PDF file** or **Save as CSV file**. The **Report Export Path** is a text input field with a browse button. The **Run Schedule** section has a dropdown for **Run Schedule** and a **Active** checkbox. At the bottom right are **Save** and **Cancel** buttons.

Access the **Statement Processing** tab from **Billing Automation Maintenance**. To access **Billing Automation Maintenance**, go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.

Abbreviation

Required. Enter an abbreviation for the automation workflow record. Each automation workflow record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the automation workflow record.

Best Practice: Make the description unique, so that it is not confused with other automation workflow records.

Select Departments or Select Practices

Specify the departments or practices to include when the automated billing process runs. When you first create an automation workflow record, all departments or practices are included by default. To limit the departments or practices, click  to open **Select Departments** or **Select Practices** and select the departments or practices. If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, a **Division** tab is displayed in **Select Departments** or **Select Practices** that enables you to filter by division.

Select Locations

Specify the locations to include when the automated billing process runs. When you first create an automation workflow record, all locations are included by default. To limit the locations, click  to open a separate window and select the locations.

Select Providers

Specify the providers to include when the automated billing process runs. When you first create an automation workflow record, all providers are included by default. To limit the providers, click  to open a separate window and select the providers.

General Message

Enter a free text message to print in the upper-right portion of the patient statements. The message can contain up to 255 characters.

All Statements

Select this option to have the automated billing process generate a listing of all statements. When selected, **Report Preferences**, **Save as PDF file**, **Save as CSV file**, and **Report Export Path** are enabled.

Bypasses Statements Only

Select this option to have the automated billing process generate a listing of only bypassed statements. When selected, **Report Preferences**, **Save as PDF file**, **Save as CSV file**, and **Report Export Path** are enabled.

Report Preferences

Click  to select your preferences for presenting the output of the report. These report preferences are the same as when you generate a statement audit list from **Billing >**

Statement Processing > Statement Audit List. You must open **Report Preferences** even if you want to accept the default preferences.

Save as PDF file

Select this option to save the report output as a PDF file.

Save as CSV file

Select this option to save the report output as a comma-separated values (CSV) file.

Report Export Path

Select the path to the folder where the report will be exported. Click  to open **Browse for Folder** for on-premise clients or **Select Folder** for hosted clients. Point to the box to see a tooltip with the entire path.

The **Statement Audit List** report is saved with the following information in the file name:

- > *automation workflow abbreviation*
- > *report name*
- > All (when **All Statements** is selected) or Byp (when **Bypassed Statements Only** is selected)
- > *date that the report was created in mmddyyyy format*
- > *time that the report was created in hhmmss format*
- > .pdf or .csv file extension

For example, the file name for a **Statement Audit List** report when **All Statements** is selected might be STMTBAM_StmtAuditListAll_04252018_035055.pdf or STMTBAM_StmtAuditListAll_04252018_035055.csv.

The file name for a **Statement Audit List** when **Bypassed Statements Only** is selected might be STMTBAM_StmtAuditListByp_04252018_035055.pdf or STMTBAM_StmtAuditListByp_04252018_035055.csv.

Run Schedule

Required. Select whether you want the automation workflow record processed daily, weekly (one day a week), or monthly (one day a month).

Selected Days of the Week

Required. Select the days when you want the automation workflow record processed.

If **Run Schedule** is set to **Daily**, do one of the following:

- > Select **All Days** to have the automation workflow record processed on Monday through Sunday.
- > Select **Weekdays** to have the automation workflow record processed on Monday through Friday.

- > Select one or more specific days to have the automation workflow record processed.

If **Run Schedule** is set to **Weekly**, select the day of the week when the automation workflow record will be processed.

Selected Day of the Month

Required. If **Run Schedule** is set to **Monthly**, select the number representing the day when the automation workflow record will be processed each month, or select **Last Day** to have the automation workflow record processed on the last day of each month. Keep in mind that some months do not have dates of 29, 30, and 31. If you want to have the automation workflow record processed at the end of every month, select **Last Day** to ensure that no months are missed.

Active

Select this option to make the automation workflow record available to the automated billing processing.

Create an automation workflow record for statement processing

Use the **Statement Processing** tab in **Billing Automation Maintenance** to create an automation workflow record for patient statement generation that is processed by the Automation service type.

1. Go to **Automation Management > Billing Automation Maintenance**, or press **F9** and then enter **BAM**.
2. Click the **Statement Processing** tab.
3. Click .
4. For **Abbreviation**, enter an abbreviation for the automation workflow record.
Each automation workflow record must have a unique abbreviation.
5. For **Description**, enter a description for the automation workflow record.

Note: Make the description unique, so that it is not confused with other automation workflow records.

By default, all departments or practices, locations, and providers are included with an automation workflow record.

6. To limit your selections, specify the following:
 - a. For **Select Departments** or **Select Practices**, click  to open a separate window and select departments or practices. If **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization Options**, you can also select divisions.
 - b. For **Locations**, click  to open a separate window and select locations.

- c. For **Select Providers**, click to open a separate window and select providers.
7. For **General Message**, enter a free-text message to print in the upper-right portion of the statements.
8. To configure the automated billing process to generate the **Statement Audit List** report containing all statements, select **All Statements** and select the output file type and export path. The **All Statements** list is the same as the list generated in **Billing > Statement Processing > Statement Audit List**.

Best Practice: Select **All Statements** so that you know if the automated statements process completed but no accounts qualified.
9. To configure the automated billing process to generate the **Statement Audit List** report containing only bypassed statements, select **Bypassed Statements Only** and select the output file type and export path. The **Statement Audit List** report is the same as the list generated in **Billing > Statement Processing > Statement Audit List**.
10. For **Run Schedule**, select when you want the automation workflow record processed.
 - > **Daily**
 - > **Weekly** (one day a week)
 - > **Monthly** (one day a month)
11. Select the days when you want the automation workflow record processed.
 - > If **Run Schedule** is set to **Daily**, for **Selected Days of the Week**, do one of the following:
 - Select **All Days** to have the automation workflow record processed on Monday through Sunday.
 - Select **Weekdays** to have the automation workflow record processed Monday through Friday.
 - Select one or more specific days to have the automation workflow record processed.
 - > If **Run Schedule** is set to **Weekly**, for **Selected Days of the Week**, select the day of the week when the automation workflow record will be processed.
 - > If **Run Schedule** is set to **Monthly**, for **Day**, select one day of the month when the automation workflow record will be processed.
12. If you are ready to make the automation workflow record available to the automated billing process, select **Active**.
13. Click **Save**.

You can save an automation workflow record without selecting **Active**. The automated billing process ignores the record until you click **Active** and save again.

Enable automated billing

Use the **Automation** tab in **Practice Set Up** or **Organization Set Up** to start automated billing processing, which, depending on your setup, includes updating batches, validating claims, preparing electronic claims, adjusting small self-pay balances, assessing finance charges, and generating statements.

1. Go to **System Administration > Practice Set Up or Organization Set Up**, or press **F9** and then enter **PSU** or **OSU** as applicable.
2. Click the **Automation** tab.
3. For **Automation Category**, select **Billing**.
The billing options are displayed.
4. Select **Enable Automated Billing**.
5. Click **Save**.

Results of this task

Automated billing functionality is enabled for your practice or organization.



Chapter 14 Automated Billing

Chapter 15

System Rule Manager

System Rule Manager setup checklist

You must enter conditions and actions for system rules.

Use this checklist to record the completion of system rules.

Maintenance	Completed
System Rule Manager (SRM)	

System Rule Manager window

Use **System Rule Manager** to define system rules that are applied to an entity, such as a non-updated voucher, when you click **Save**.

System Rule Manager contains these tabs:

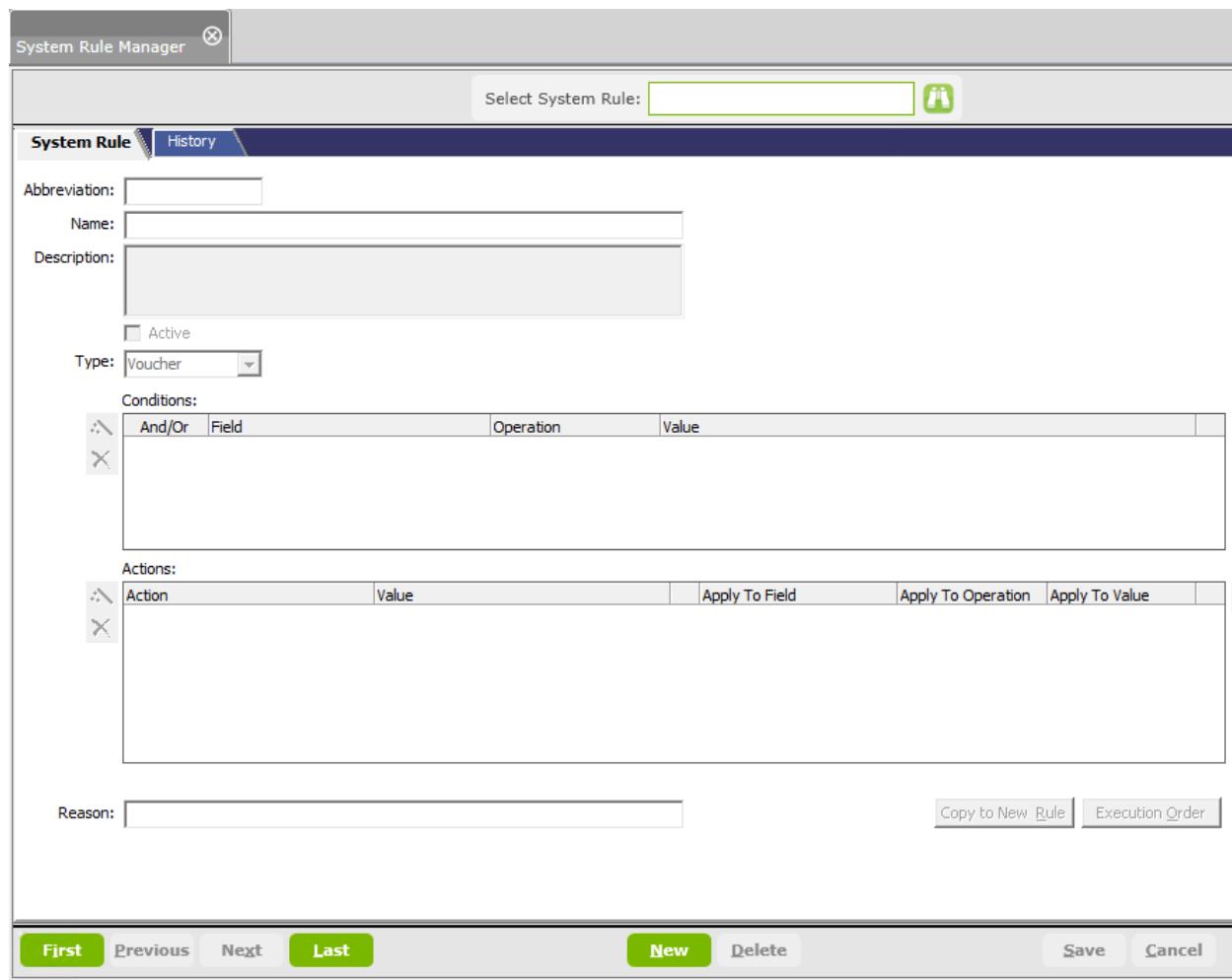
- > System Rule
- > History

To access **System Rule Manager**, go to **Automation Management > System Rule Manager**, or press **F9** and then enter **SRM**.

System Rule tab

Use the **System Rule** tab in **Automation Management > System Rule Manager** to enter the conditions and actions for system rules that are applied to an entity, such as a nonupdated voucher, when the entity is saved.

Important: To see the entire width of the **Conditions** and **Actions** grids, maximize the Allscripts® Practice Management application window or unpin (hide) the **Functions** navigation pane.



The screenshot shows the 'System Rule Manager' window. At the top, there's a search bar labeled 'Select System Rule:' with a magnifying glass icon. Below the search bar, the tab 'System Rule' is selected. The main area contains fields for 'Abbreviation', 'Name', and 'Description'. A checkbox for 'Active' is checked. The 'Type' dropdown is set to 'Voucher'. Under 'Conditions', there's a table with columns 'And/Or', 'Field', 'Operation', and 'Value', which is currently empty. Under 'Actions', there's another table with columns 'Action', 'Value', 'Apply To Field', 'Apply To Operation', and 'Apply To Value', also empty. A 'Reason' field is present at the bottom. At the bottom of the window are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New' (highlighted in green), 'Delete', 'Save' (disabled), and 'Cancel'.

To access **System Rule Manager**, go to **Automation Management > System Rule Manager**.

Tip: To quickly access **System Rule Manager**, press **F9**, then enter **SRM**.

Abbreviation

Enter an abbreviation for the system rule record. Each system rule record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters. Make the abbreviation meaningful so that you will recognize the rule by its abbreviation in other areas of the application, such as voucher history.

Name

Required. Enter a name for the system rule record.

Best Practice: Make the name unique so that it is not confused with other system rule records.

Description

Required. Enter a description that explains the purpose of the system rule.

Active

Select this option to have the application start applying the system rule.

Important: To verify that the conditions and actions work as intended, use the rule in a test scenario first.

Type

This box is read-only and set to **Voucher**. In version 18.3, you can only create voucher rules.

Conditions grid

Enter one or more condition rows with the qualifiers that must be met before actions are applied.

> **And/Or:** Required for all rows except the first row. Select an operator.

With **And** operators, all rows of the condition must be met. With **Or** operators, only one row of the condition must be met.

CAUTION: Be careful when mixing **And** and **Or** operators in the same condition. **System Rule Manager** does not provide the ability to group rows to ensure that they are evaluated together.

> **Field:** Required. Select a field to which the condition applies.

> **Operation:** Required. Select the operator to use when evaluating the condition. The selection options for **Operation** vary depending on the value in **Field**.

> **Value:** Required. Select values that correspond with your selections for **Field** and **Operation**.

Tip: If you select more values than can be displayed in the **Value** column, point to the values in the row to see a tooltip with all of the values.

Actions grid

Enter one or more action rows with the changes to apply when the conditions are met.

An action row must have an action and a value to apply. You can also include one or more requirements that must be met for the action to be applied. These apply-to requirements each have a field, operation, and value. The action is applied only if the field meets the value requirement according to the operation.

If you add an action with the option to enter apply-to requirements, but you do not enter values, the action is applied to all areas where it makes sense. For example, if you do not specify a specific procedure code as an apply-to requirement for an **Add Modifier** action, the modifier is added to all procedure codes on the voucher.

- > **Action:** Required. Select the action to apply.
- > **Value:** Required for all actions except **Zero Fees**. Select the value that corresponds with your selection for **Action**.
- > **Apply To Field:** Optional. Select the field for the apply-to requirement.
- > **Apply To Operation:** Required if a value is selected for **Apply To Field**. Select the operator for the apply-to requirement.
- > **Apply To Value:** Required if a value is selected for **Apply To Field**. Select the value for the apply-to requirement.

Tip: If you selected more values than can be displayed in the **Apply To Value** column, point to the values in the row to see a tooltip with all of the values.

Reason

Required. Enabled only when **Assign To Task** is selected for **Action**.

Chapter 16

Scheduling File Maintenance

Scheduling File Maintenance

Scheduling file maintenance allows you to define the elements for managing the varied appointment schedules used by the providers in your practice/organization.

Before completing this section, give some thought to the following:

- List the various kinds of appointments (along with duration time) needed, i.e. new patient OV, BP check.
Indicate which appointments are not available for new patient booking, general patient booking, such as lunch etc.
- List the scheduled hours by day for each provider. Use blocks of time, for example 8-9:30 - Physicals.
- List the various departments where patients are seen, for example Family Practice, Orthopedics, Dermatology, Lab. Include a list of the providers/ resources who see patients in these departments.
- Draw up a list of resources: providers/rooms/equipment that need to be grouped for linked appointments.

Scheduling File Maintenance setup checklist

Use this checklist to record the completion of each scheduling-related file maintenance or task.

Maintenance	Completed
Appointment Category Maintenance (ACM)	
Appointment Type Maintenance (APM)	
Appointment Group Maintenance (AGM)	
Visit Type Maintenance (VTM)	
Activity Type Maintenance (AIM)	
Day Type Maintenance (DTM)	

Maintenance	Completed
Resource Maintenance (REM)	
Resource Group Maintenance (RGM)	
Resource Set Maintenance (RRM)	
Scheduling Department Maintenance (SDM)	
Scheduling Location Maintenance (SLM)	
Scheduling Override Reason Maintenance (SOR)	
Cancellation Reason Maintenance (CRM)	
Appointment Message Maintenance (AMM)	
Appointment Restriction Maintenance (ARM)	
Appt Confirmation Result Code Maintenance (CCM)	
User workstation defaults (tools and options)	
Scheduling tab on Practice Options or Organization Options (POP or OOP)	

Appointment Category Maintenance window

Appointment categories are used to group appointment types.

These categories may reflect:

- > The department or practice structure in the practice or organization
- > Specialties of the practice
- > Type of visits such as new patient visits, follow-up visits, annual exams, walk-ins, lab visits

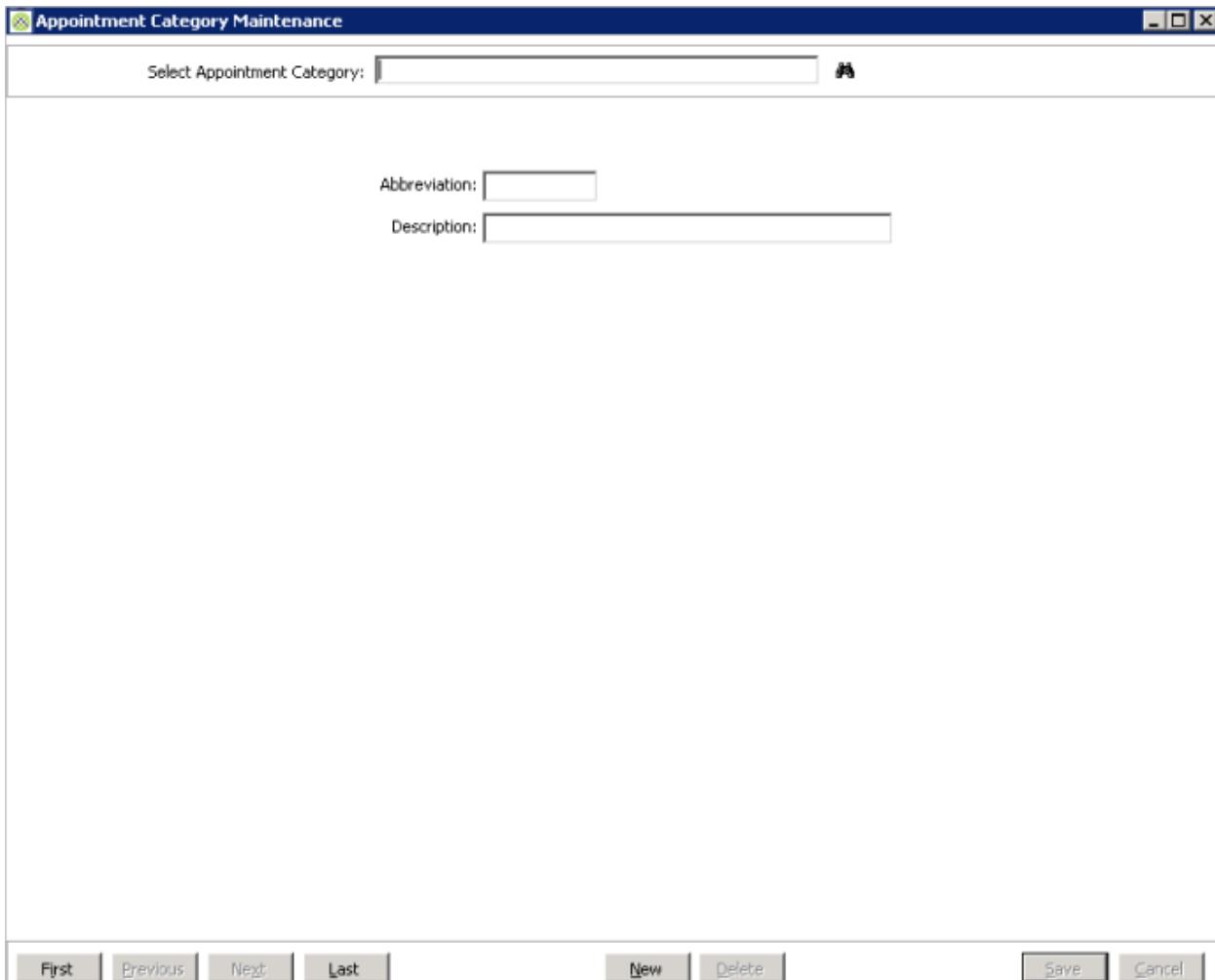
You may want to group all non-patient related appointment types such as meetings and luncheons, in a distinctive appointment category.

Tip: **Appointment Category** on the **Appointment Type** tab in **Appointment Type Maintenance** is required. **Appointment Type for Medical Record Request** is required on the **Scheduling** tab in **Practice Options** or **Organization Options**, so build an appointment category

"Medical Record Request" that you can use in **Appointment Type Maintenance**.

Appointment categories are used to determine eligibility when defining provider schedules.

Access **Appointment Category Maintenance** from **System Administration > File Maintenance > Appointment Category Maintenance** or press **F9** and then enter **ACM**.



The screenshot shows a Windows application window titled "Appointment Category Maintenance". At the top, there is a toolbar with standard window controls (Minimize, Maximize, Close) and a magnifying glass icon. Below the title bar is a menu bar with "File", "Edit", "View", "Insert", "Format", "Table", "Database", "Report", "Help", and "About". The main area contains several input fields and buttons. At the top left is a dropdown menu labeled "Select Appointment Category:" with a small arrow indicating it is expandable. To its right is a "Find" button. Below this are two text input fields: "Abbreviation:" followed by a text box, and "Description:" followed by a larger text box. At the bottom of the window is a toolbar with buttons for "First", "Previous", "Next", "Last", "New", "Delete", "Save", and "Cancel".

Appointment Type Maintenance window

Use **Appointment Type Maintenance** to create customized appointment types that reflect the types of appointments scheduled for the providers and resources in your practice or organization.

Each appointment type must be:

- > Associated with an appointment category.
- > Defined with a usual duration associated with it
- > Associated with a coverage type

Sample Appointment Types

Appointment types are the kinds of appointments used when scheduling or booking time slots.

- > Annual:1-4
- > Annual:5-11
- > Annual:12-17
- > Annual: 18+
- > BP check up
- > Follow Up: Dressing Change
- > Follow Up: 1 month
- > Follow Up: 3 month
- > Injection: Mantoux
- > Injection: DPT
- > Injection: Hepatitis A
- > Hospital Board Meeting
- > Lunch
- > Medical Record Requests
- > New Patient: same day visit
- > New Patient: Initial visit
- > Post op check up
- > Suture Removal

Appointment Type Maintenance contains these tabs:

- > **Appointment Type**
- > **History**

To access **Appointment Type Maintenance**, go to **System Administration > File Maintenance > Appointment Type Maintenance**, or press **F9** and then enter **APM**.

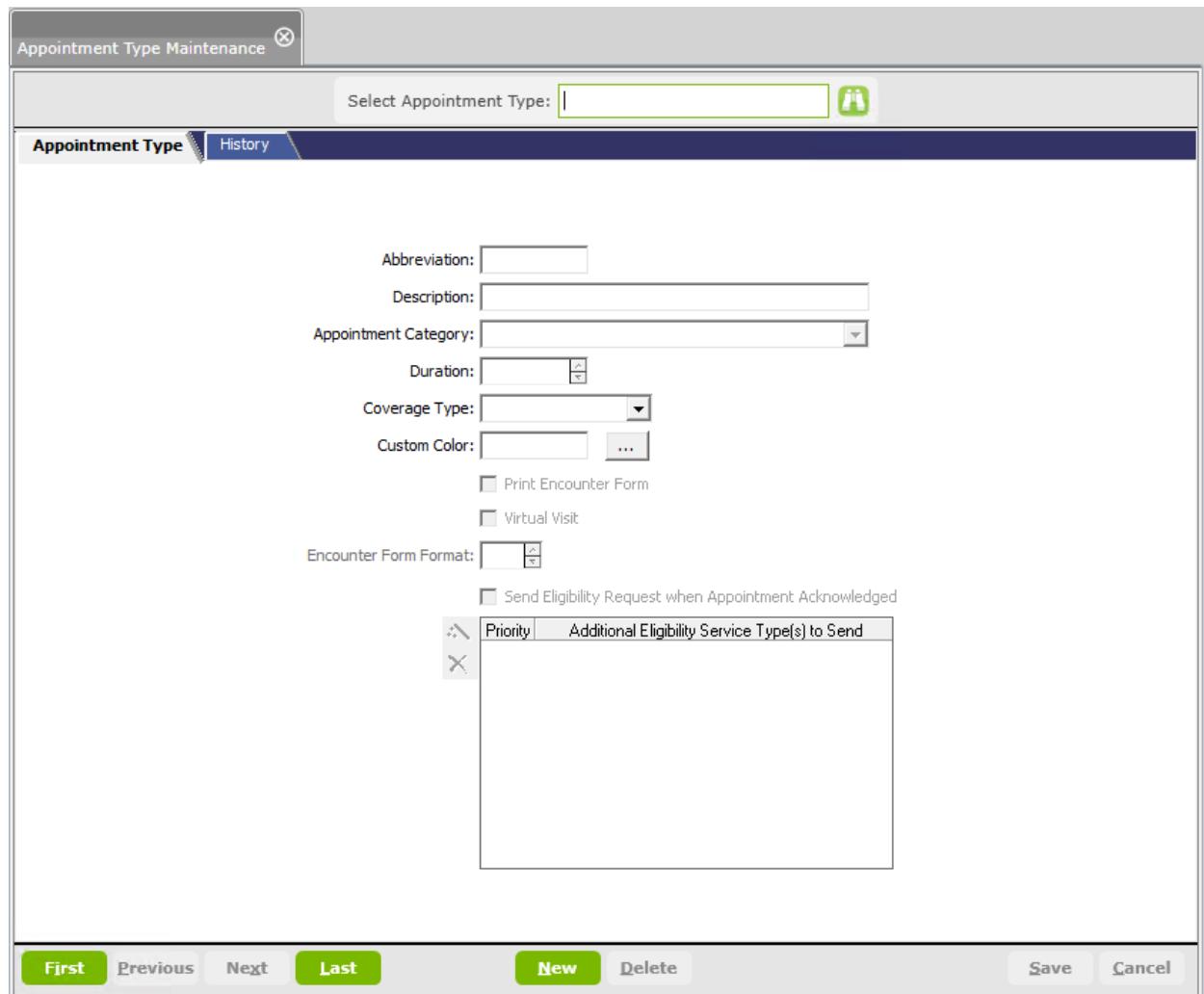
Appointment Type tab

Use the **Appointment Type** tab in **Appointment Type Maintenance** to create customized appointment types that reflect the types of appointments scheduled for the providers and resources in your practice or organization.

Appointment types created on the **Appointment Type** tab are automatically added to each activity type in **System Administration > File Maintenance > Activity Type Maintenance** as either an eligible or ineligible appointment category.

For activity types that have more eligible appointment categories than ineligible appointment categories, the appointment type is added to the activity type as an eligible appointment category. For activity types that have more ineligible appointment categories, the appointment type is added to the activity type as an ineligible appointment category.

Access the **Appointment Type** tab from **Appointment Type Maintenance**. To access **Appointment Type Maintenance**, go to **System Administration > File Maintenance > Appointment Type Maintenance**, or press **F9** and then enter **APM**.



Appointment Type Maintenance ×

Select Appointment Type: 

Appointment Type History

Abbreviation:

Description:

Appointment Category:

Duration:

Coverage Type:

Custom Color: ...

Print Encounter Form

Virtual Visit

Encounter Form Format:

Send Eligibility Request when Appointment Acknowledged

Priority	Additional Eligibility Service Type(s) to Send

A X

First Previous Next Last New Delete Save Cancel

Abbreviation

You can enter up to eight characters. The abbreviation is used optionally on encounter forms and medical records forms.

Description

You can enter up to 40 characters.

Appointment category

Appointment categories are used to determine whether an appointment type is eligible for booking into a time slot when you define the provider's or resource's schedule.

Duration

Enter the length of the appointment in minutes.

Coverage Type

Select a coverage type to associate with the appointment type.

This field defaults to the coverage type selected as the default on the **General** tab in **Practice Options** or **Organization Options**. The list contains only the coverage types flagged as available on the **General** tab in **Practice Options** or **Organization Options** and to which you have security access.

If a default was not selected in **Practice Options** or **Organization Options**, **All** is selected by default.

If you change **Coverage Type** to **Uninsured** for an existing appointment type that uses a coverage type other than **Uninsured**, **Send Eligibility Request when Appointment Acknowledged** is cleared. If you change **Coverage Type** from **Uninsured** to any other coverage type for an existing appointment type, **Send Eligibility Request when Appointment Acknowledged** is cleared by default.

When **All** is selected in **Coverage Type**, any appointments scheduled using that appointment type and an uninsured coverage type ignore the eligibility settings that were created with **Send Eligibility Request when Appointment Acknowledged** or the **Additional Eligibility Service Type(s) to Send** grid. The uninsured coverage type applies all the other settings that were configured for the appointment type. Coverage types other than uninsured apply all settings configured for the appointment type, including any eligibility settings.

Custom Color

Enables you to assign a custom color to this appointment type. To assign a custom color, **Allow Color by Appointment Type** must be selected on the **Scheduling** tab in **Practice Options** or **Organization Options**. If you do not assign a custom color, the application uses the standard set of color coding values.

Print Encounter Form

Qualifies an appointment for the printing of an encounter form. Clear this option for appointment types such as lunch.

Virtual Visit

Select this check box if the appointment type is used for a virtual visit appointment. This option is useful only if your electronic health record (EHR) application supports virtual visits.

Encounter Form Format

This box is enabled only when **Encounter Form Basis** is set to **Appointment Type** on the **Scheduling** tab in **Practice Options** or **Organization Options**. After you select **Print Encounter Form**, use the arrow buttons to select the format the application will use when printing encounter forms for this appointment type.

Note: When this box is enabled and you select **Print Encounter Form** but do not select an encounter form format, the application uses the default encounter form format defined on the **Scheduling** tab in **Practice Options** or **Organization Options** to print encounters for this appointment type.

Send Eligibility Request when Appointment Acknowledged

Select this to initiate the automated eligibility verification process when an appointment with that appointment type is acknowledged.

This check box is not available when **Uninsured** is selected in **Coverage Type**.

Additional Eligibility Service Type(s) to Send grid

Your organization must use the Allscripts® Interface Engine translation files that support eligibility transactions in a 5010 format to use the **Additional Eligibility Service Type(s) to Send** grid functionality. If your organization uses Allscripts® Interface Engine translation files that support eligibility transactions in a 4010 format, the **Additional Eligibility Service Type(s) to Send** grid is functional, but the application ignores any service types are added to the grid and sends only **Service Type 30 (Health Benefit Plan Coverage)**.

Use the **Additional Eligibility Service Type(s) to Send** grid to select which service types are submitted in an eligibility request for that appointment type during batch eligibility requests, real time eligibility requests, and automated eligibility requests.

Select **Priority** to indicate the preferred service type to display in the **Patient Responsibility** area in **Quick Payment**. Only one row can have **Priority** selected.

Note: **Service Type 30 (Health Benefit Plan Coverage)** is not included in the list options because it is always submitted in an eligibility request regardless of the format or the configurations on the **Appointment Type** tab.

This grid is not available when **Uninsured** is selected in **Coverage Type**.

Appointment Group Maintenance window

Appointment Group Maintenance provides the a way to classify appointment types.

Access **Appointment Group Maintenance** from **System Administration > File Maintenance > Appointment Group Maintenance** or press **F9** and then enter **AGM**.

Appointment Group Maintenance contains these tabs:

> **Appointment Group**

> **Appt. Group Members**

Use **Appointment Group Maintenance** to:

- > Add appointment types to a group

Create a group record then add appointment types on the **Appt. Group Members** tab.

An appointment type can be a member of multiple groups.

- > Uses for appointment groups

Appointment groups can be used to link specific appointment types to a resource. This will help to minimize scheduling errors by only allowing the appointment types used by a specific resource to be selected.

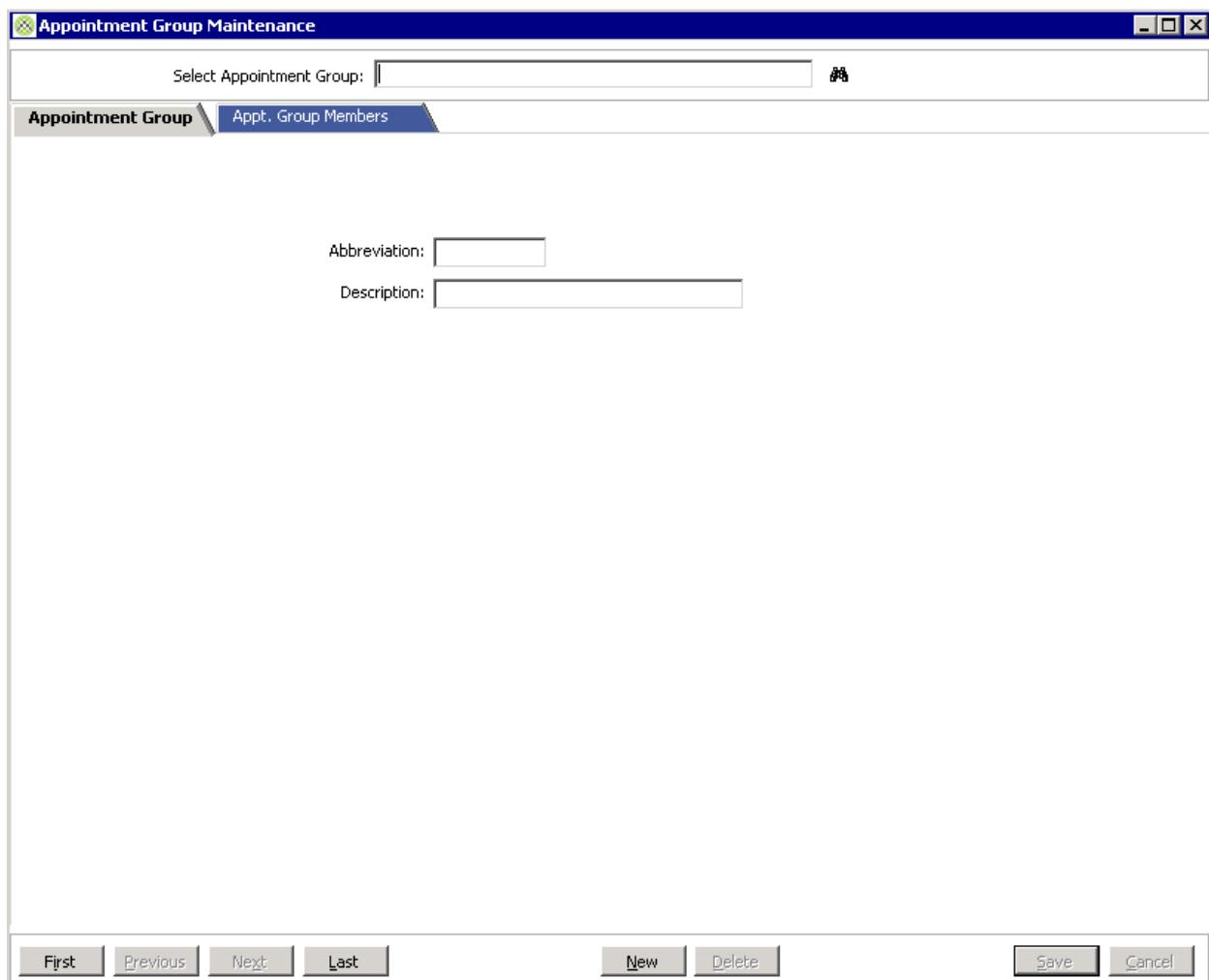
Appointment groups are not honored in the following areas:

- > When transferring a patient on the **Appointment Book** tab in **Scheduling > Appointment Scheduling**
- > If you have an appointment scheduled with a resource who allows that appointment type as part of his eligible appointment group, and then you transfer that appointment, the application allows that appointment to be transferred to any resource whether his eligible appointment group includes that appointment type or not.
- > When starting on the **Patient Scheduling** tab in **Scheduling > Appointment Scheduling** and leaving the **Resource** field blank and either using the **Open Times** button or the **Use Book** button
- > When you bring up a patient and leave resource blank on the **Patient Scheduling** tab in **Scheduling > Appointment Scheduling** and click the **Open Times** button, all resources who have available times with an activity type that allows the appointment type come up as available regardless of the eligible appointment group for the resource.
- > When you bring up a patient and leave resource blank on the **Patient Scheduling** tab in **Scheduling > Appointment Scheduling** and click the **Use Book** button, all resources who have available times with an activity type that allows the appointment type come up as available regardless of the eligible appointment group for the resource.
- > When starting on the **Patient Scheduling** tab in **Scheduling > Appointment Scheduling** and selecting a resource group
- > When you bring up a patient and select a resource group, the appointment type field displays all available appointment types and is not restricting by the eligible appointment group for the resource.

Appointment Group tab

Use the **Appointment Group** tab to create groups that can be used to link specific appointment types to a resource.

Access the **Appointment Group** tab from the **Appointment Group Maintenance**. To access **Appointment Group Maintenance**, go to **System AdministrationFile MaintenanceAppointment Group Maintenance** or use **F9** and then enter **AGM**.



Abbreviation

Accepts up to eight characters and must be a unique entry

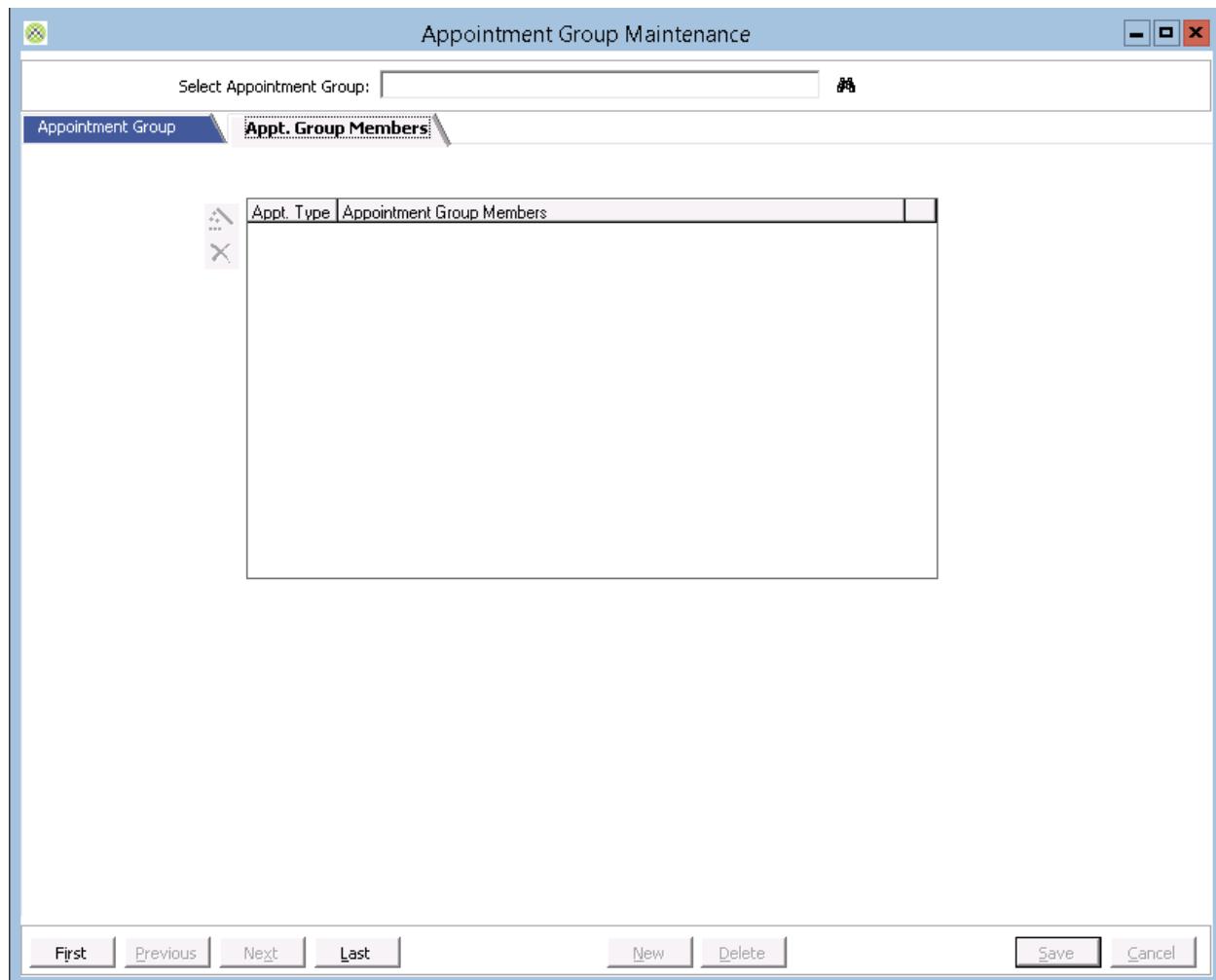
Description

Displays in **Resource Maintenance**, **Appointment Message Maintenance**, and on the **Select Appointment Types** window for reports and interfaces that can be restricted by appointment type.

Appt Group Members tab

Use the **Appt. Group Members** tab to add appointment types to appointment groups.

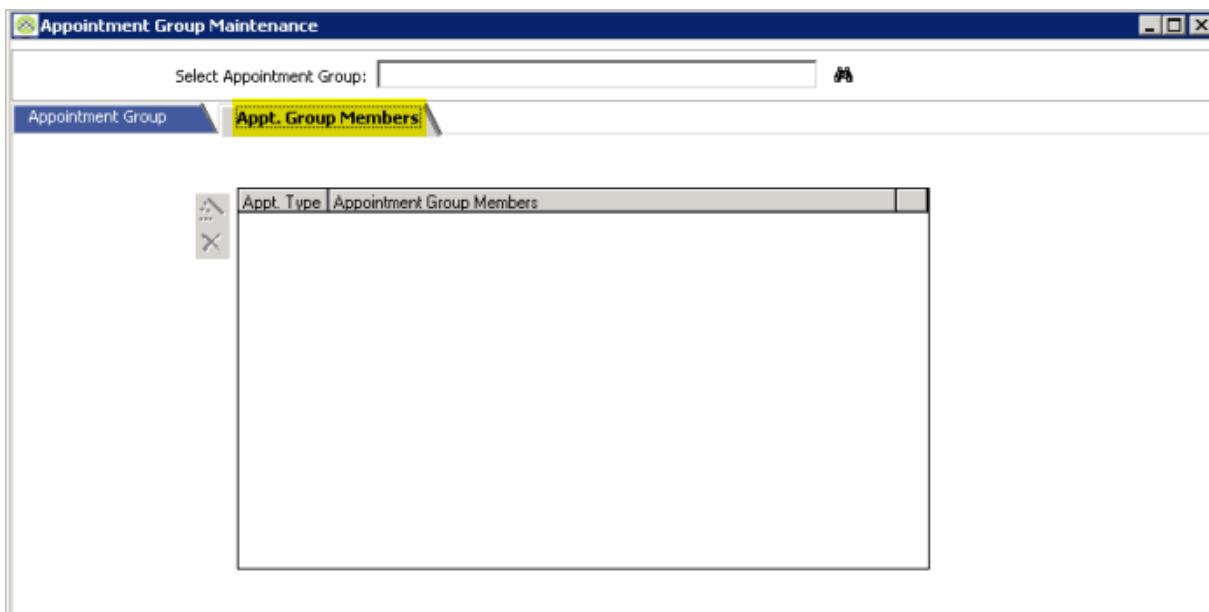
Access the **Appt Group Members** tab from the **System Administration > File Maintenance > Appointment Group Maintenance** or press **F9** and then enter **AGM**.



Add appointment group members

Associate appointment types with appointment groups on the **Appt. Group Members** tab.

1. Go to **System Administration > File Maintenance > Appointment Group Maintenance** or press **F9** and then enter AGM.
2. Click the **Appt. Group Members** tab.
3. Click  or use **Insert** to begin the process of adding an appointment type to this group.
4. Point the cursor to the **Appointment Group Members** column and type in an appointment type abbreviation, then **Tab** or click  to search for an appointment type.
5. Click **Save** or use **Alt+s** to save your entries.



Visit Type Maintenance window

Use **Visit Type Maintenance** to create visit types, associate coverage types to visit types, and associate appointment types to visit types.

Visit Type Maintenance is available when **Enable Visit Type** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**.

Visit Type Maintenance contains the following tabs:

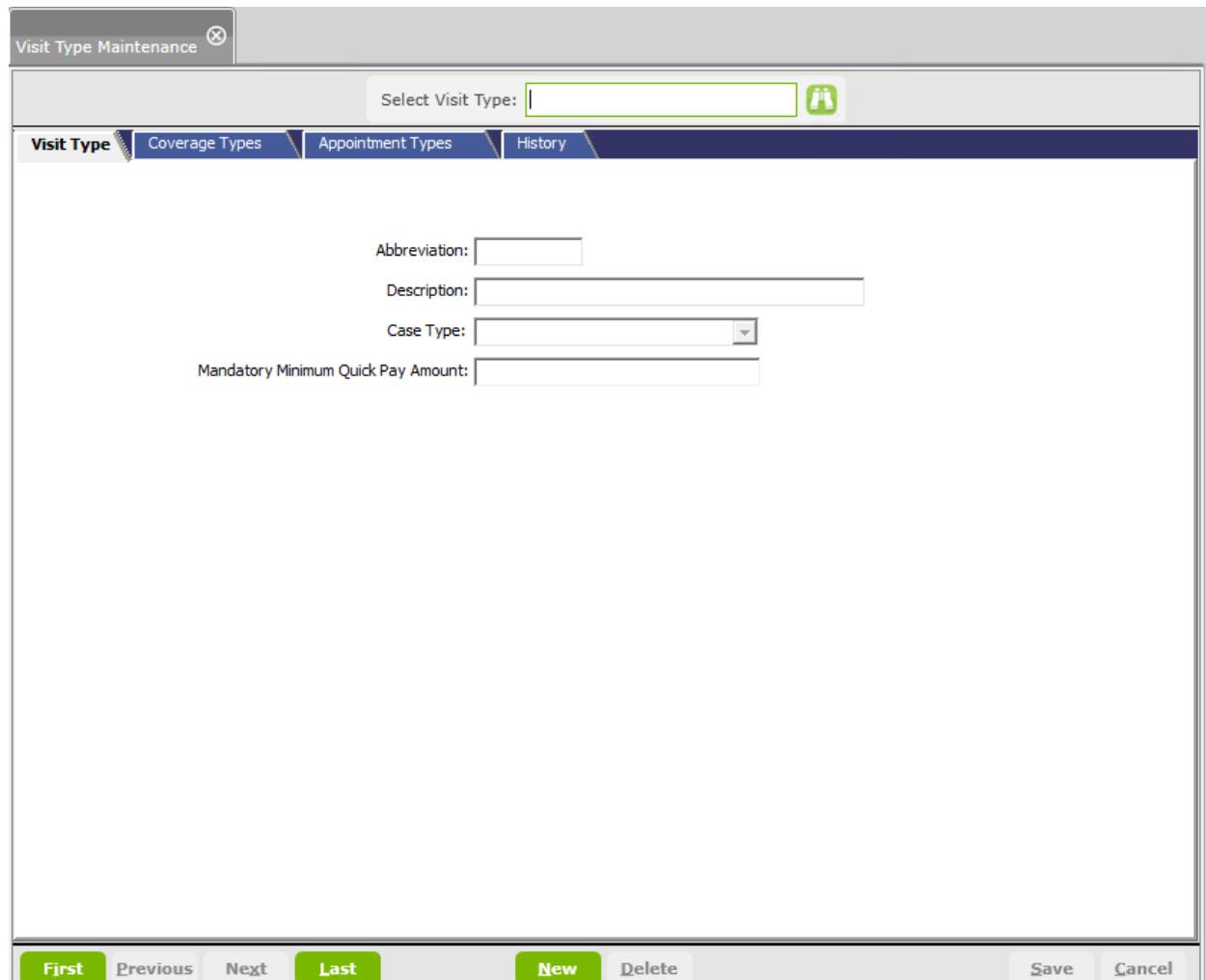
- > **Visit Type**
- > **Coverage Types**

- > Appointment Types
- > History

Visit Type tab in Visit Type Maintenance

Use the **Visit Type** tab in **Visit Type Maintenance** to enter criteria to define visit types that identify the different lines of business related to appointment scheduling.

Access the **Visit Type** tab from **Visit Type Maintenance**. To access **Visit Type Maintenance**, go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter **VTM**.



The screenshot shows the 'Visit Type Maintenance' application window. At the top, there's a title bar with the window name and a close button. Below the title bar is a toolbar with a search field labeled 'Select Visit Type:' and a magnifying glass icon. The main interface has a navigation bar with tabs: 'Visit Type' (which is selected and highlighted in blue), 'Coverage Types', 'Appointment Types', and 'History'. Under the 'Visit Type' tab, there are four input fields: 'Abbreviation' (with an empty text box), 'Description' (with an empty text box), 'Case Type' (with a dropdown menu), and 'Mandatory Minimum Quick Pay Amount' (with an empty text box). At the bottom of the window are standard navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New' (highlighted in green), 'Delete', 'Save', and 'Cancel'.

Abbreviation

Required. Enter an abbreviation for the visit type. Each visit type must have a unique abbreviation.

Note: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the visit type. Best practice is to make the description unique, so that it is not confused with other visit types.

Case Type

Workers' Comp is the only case type. Required for the visit types that should automatically open **Case Management** when you book an appointment. If necessary, you can clear **Case Type** after you use a visit type to book an appointment and a workers' compensation case is created.

- > In **Practice Options** or **Organization Options**, you must have **Worker's Comp** selected in the **Available Coverage Types** area on the **General** tab and **Workers' Comp Ailment** filled on the **Case** tab before selecting a case type.
- > When **Case Type** is set to **Workers' Comp**, **Type of Payer** is displayed and enabled. For future use: Select either **Specialist** or **Therapy** to indicate the payer type associated with workers' compensation cases.

Type of Payer

Optional: Displayed only when **Case Type** is set to **Workers' Comp**.

Mandatory Minimum Quick Pay Amount

Enter a minimum quick payment amount, up to \$999.99, to be collected from the patient if the patient responsibility amount is not known at the time of the visit. When this amount is greater than \$0.00, it is displayed in **Quick Payment** for informational purposes.

GL Sub-Account#1

Enter the numeric value assigned to this segment of the general ledger (GL) account number you want to associate to the visit type.

Note: This box is only displayed when **GL Processing** is selected on the **Tenant Maintenance** tab in **Administration > Security Manager > Tenant Maintenance**

GL Sub-Account#2

Enter the numeric value assigned to this segment of the general ledger (GL) account number you want to associate to the visit type.

Note: This box is only displayed when **GL Processing** is selected on the **Tenant Maintenance** tab in **Administration > Security Manager > Tenant Maintenance**

Create a visit type in Visit Type Maintenance

Use the **Visit Type** tab in **Visit Type Maintenance** to create visit types to identify the different lines of business related to scheduling activity.

1. Go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter **VTM**.
2. Click the **Visit Type** tab.
3. Click **New**.
4. For **Abbreviation**, enter an abbreviation for the visit type.

Note: Each visit type must have a unique abbreviation.

5. For **Description**, enter a description of the visit type.

Note: Make the description unique, so that it is not confused with other visit types.

6. For **Case Type**, if the visit type should automatically open **Case Management** when you book an appointment, select **Workers' Comp**.

Workers' Comp is the only case type.

When **Case Type** is set to **Workers' Comp**, **Type of Payer** is displayed, but it is for future use.

7. For **Mandatory Minimum Quick Pay Amount**, enter a minimum quick payment amount, up to \$999.99, to be collected from the patient if the patient responsibility amount is not known at the time of the visit. When this amount is greater than \$0.00, it is displayed in **Quick Payment** for informational purposes.
8. For **GL Sub-Account#1**, enter the numeric value assigned to this segment of the general ledger (GL) account number, if applicable.

Note: This box is only displayed when **GL Processing** is selected on the **Tenant Maintenance** tab in **Administration > Security Manager > Tenant Maintenance**

9. For **GL Sub-Account#2**, enter the numeric value assigned to this segment of the general ledger (GL) account number, if applicable.

Note: This box is only displayed when **GL Processing** is selected on the **Tenant Maintenance** tab in **Administration > Security Manager > Tenant Maintenance**

10. Click **Save**.

Coverage Types tab in Visit Type Maintenance

Use the **Coverage Types** tab in **Visit Type Maintenance** to select which coverage types you want to associate with a visit type when scheduling an appointment.

The grid on the **Coverage Types** tab displays the coverage types selected in the **Available Coverage Types** section of the **General** tab in **Practice Options** or **Organization Options**.

Access the **Coverage Types** tab from **Visit Type Maintenance**. To access **Visit Type Maintenance**, go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter VTM.

Visit Type Maintenance ×

Select Visit Type: 

Visit Type Coverage Types Appointment Types History

Include	Default	Coverage Type
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Health
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Motor Vehicle
<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Uninsured
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Comp

First Previous Next Last New Delete Save Cancel

Include

This column enables you to select what coverage types are included in the available selections for a visit type selection in **Scheduling**.

Note: When **Include** is selected for a coverage type, you do not have to select a default for the coverage type.

Default

You must select **Include** for the coverage type before selecting **Default** for the same coverage type.

This column enables you to select the default coverage type for a visit type selection in **Scheduling**.

Note: This check box is not automatically selected if the **Default** check box on the **General** tab in **Practice Options** or **Organization Options** is selected for the corresponding coverage type.

Coverage Type

This column displays the coverage types selected in the **Available Coverage Types** area of the **General** tab in **Practice Options** or **Organization Options**.

Note: When **Case Type** on the **Visit Type** tab is set to **Workers' Comp, Include** and **Default** are selected for **Worker's Comp** and cannot be changed. For an existing visit type record, if another coverage type has **Default** selected, it is cleared. Multiple coverage types can be included for new and existing visit type records, but **Worker's Comp** must be the default coverage type.

Associate a coverage type to a visit type in Visit Type Maintenance

Use the **Coverage Types** tab in **Visit Type Maintenance** to associate a coverage type to a visit type.

It is not required to associate a coverage type with a visit type.

1. Go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter VTM.
2. Click the **Coverage Types** tab.
3. Click  to open **Select Visit Type**.
4. Select the visit type you want to associate with a coverage type.
5. Click **OK**.

The list box displays the existing coverage type selections for the visit type.

Include	Default	Coverage Type
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Health
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Motor Vehicle
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Other
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Comp

Note: For new visit types, all check boxes are cleared by default.

6. Select **Include** for each coverage type you want to associate with the new visit type.

7. (Optional) Select **Default** for 1 coverage type.
8. Click **Save**.

Disassociate a coverage type from a visit type in Visit Type Maintenance

Use the **Coverage Types** tab in **Visit Type Maintenance** to disassociate a coverage type currently associated with a visit type.

It is not required to associate a coverage type with a visit type.

1. Go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter VTM.
2. Click the **Coverage Types** tab.
3. Click  to open **Select Visit Type**.
4. Select the visit type you want to edit.
5. Click **OK**.

The list box displays the existing coverage type selections for the visit type.

Include	Default	Coverage Type
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Health
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Motor Vehicle
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Other
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Comp

6. Click the check boxes to clear the selection and disassociate the coverage type from the visit type.

Include	Default	Coverage Type
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Health
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Motor Vehicle
<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Comp

Note: You can clear all coverage type selections for a visit type.

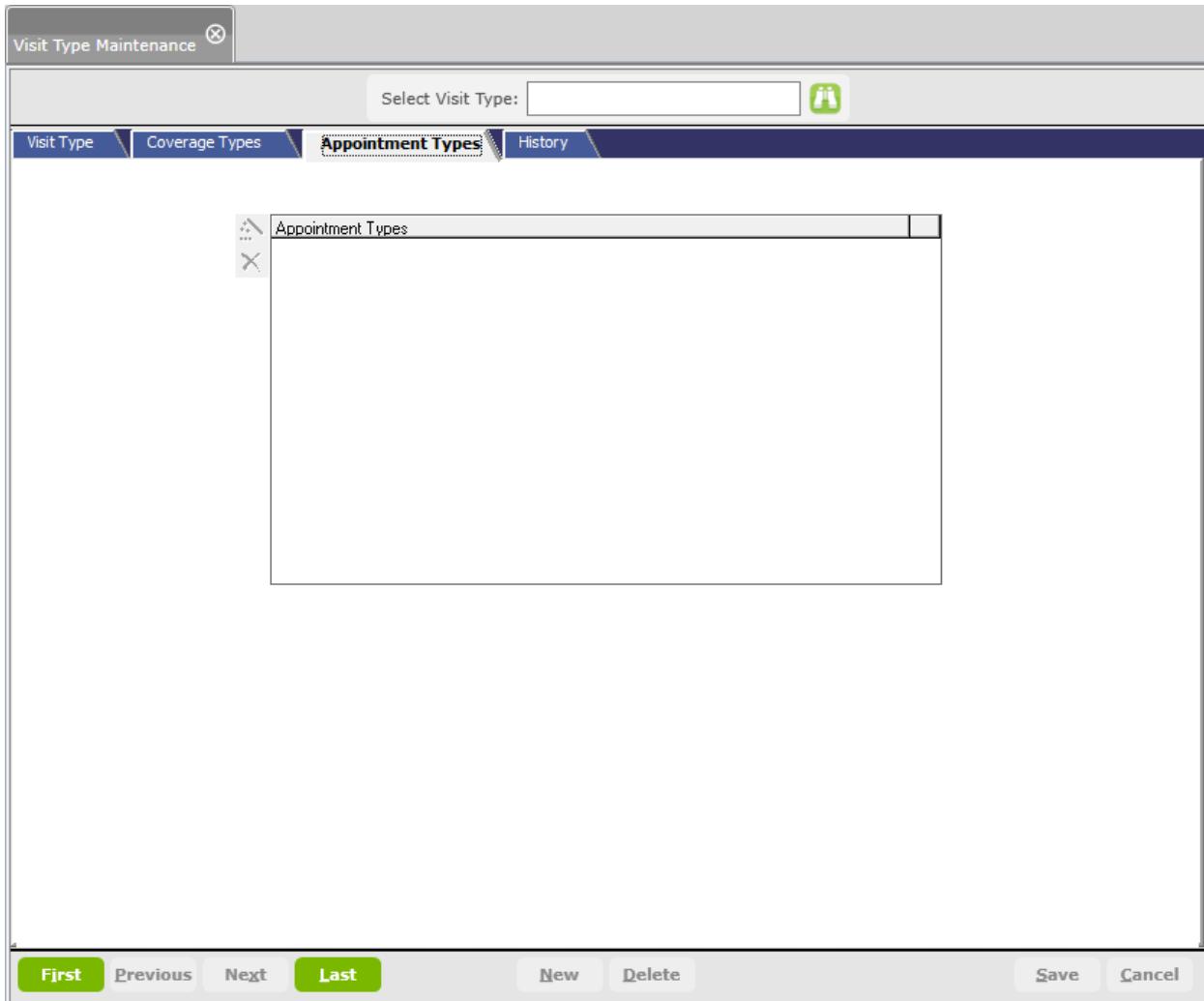
7. Click **Save**.

Note: If you try to disassociate a coverage type that is currently being used for a scheduled appointment, a warning message is displayed and you cannot save the changes.

Appointment Types tab in Visit Type Maintenance

Use the **Appointment Types** tab in **Visit Type Maintenance** to associate an appointment type with a visit type when scheduling an appointment.

Access the **Appointment Types** tab from **Visit Type Maintenance**. To access **Visit Type Maintenance**, go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter VTM.



Appointment Types

This tab displays the appointment types associated with the visit type selected in **Select Visit Type**.

In **Scheduling**, appointment types assigned to a visit type are the only options that display in the **Appt Type** drop-down lists when the associated visit type is being used.

Associate an appointment type to a visit type in Visit Type Maintenance

Use the **Appointment Types** tab in **Visit Type Maintenance** to associate an appointment type to a visit type.

It is not required to associate an appointment type with a visit type.

1. Go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter VTM.
2. Click the **Appointment Types** tab.
3. Click  to open **Select Visit Type**.
4. Select the visit type you want to associate with an appointment type.
5. Click **OK**.

The grid displays the appointment types currently associated with the visit type.

Note: For new visit types, the **Appointment Types** grid is cleared by default.

6. Click  to insert a row in the **Appointment Types** list box.
A blank row is displayed and is highlighted.
7. On the blank row, click .

Select Appointment Types opens and displays the appointment types created in **Appointment Type Maintenance**.

8. Select 1 or more appointment types to associate with the visit type.

Tip: To select multiple appointment types, hold **Ctrl** while you click the appointment types that you want to add to the grid.

A row is added to the grid for each appointment type that you selected.

9. Click **Save**.

Note: If you only associate 1 appointment type to a visit type, the appointment type is the default when that visit type is used in **Scheduling**.

Disassociate an appointment type from a visit type in Visit Type Maintenance

Use the **Appointment Types** tab in **Visit Type Maintenance** to disassociate an appointment type from a visit type.

1. Go to **System Administration > File Maintenance > Visit Type Maintenance** or press **F9** and then enter **VTM**.
2. Click the **Appointment Types** tab.
3. Click  to open **Select Visit Type**.
4. Select the visit type you want to edit.
5. Click **OK**.

The **Appointment Types** grid displays the appointment types currently associated with the visit type.

6. In the **Appointment Types** grid, click on the row containing the appointment type you want to disassociate from the visit type.
The row is highlighted.
7. Click  to delete the row from the **Appointment Types** grid.
8. Click **Save**.

Activity Type Maintenance window

Use **Activity Type Maintenance** during scheduling setup. Define activity types used in **Day Type Maintenance** to determine the types of appointments by category that are eligible for scheduling in open time slots.

Activity Type Maintenance contains these tabs:

- > **Activity Type**
- > **History**

Access **Activity Type Maintenance** from **System Administration > File Maintenance > Activity Type Maintenance**, or press **F9** and then enter **AIM**.

Activity Type tab

Use the **Activity Type** tab in **Activity Type Maintenance** during scheduling setup. Define activity types used in **Day Type Maintenance** to determine the types of appointments by category that are eligible for scheduling in open time slots.

The activity type set for designated time slots when you define a day type determines the types of appointments by category that qualify for an open times search.

For this maintenance you must define which appointment categories (that is, the appointment types which make up the categories) can be scheduled into defined appointment slots on a given day type.

Activity types can be defined:

- > for non-patient related appointments such as meetings, lunch
- > to allow single or multiple booking factors

Access **Activity Type Maintenance** from **System Administration > File Maintenance > Activity Type Maintenance**, or press **F9** and then enter **AIM**.

Activity Type Maintenance

Activity Type Maintenance	
<input type="text" value="Select Activity Type:"/> <input type="button" value="Search"/> <input type="button" value="Print"/>	
Activity Type <input checked="" type="radio"/> History	
Abbreviation: <input type="text"/> Description: <input type="text"/> Select Scheduling Departments: All Scheduling Departments <input type="button" value="Edit"/> Custom Color: <input type="color"/> <input type="button" value="..."/> Time Availability <input checked="" type="radio"/> Not Available for Appointments <input type="radio"/> Single Booking <input type="radio"/> Double Booking <input type="radio"/> Triple Booking <input type="radio"/> Other Booking Factor: <input type="text"/> Usual Duration of Appts: <input type="text"/>	
<input type="checkbox"/> Group Activity Max No. of Patients: <input type="text"/> Appointment Type: <input type="button" value="..."/>	
Categories <input type="button" value="Search Categories"/>	
Ineligible Appointment Categories <input type="button" value=">"/> <input type="button" value="<"/> <input type="button" value=">>"/> <input type="button" value="<<"/>	Eligible Appointment Categories <input type="button" value="Limits"/>
Freeze/Release Rules <input checked="" type="radio"/> No Freeze <input type="radio"/> Release Same Day <input type="radio"/> Release <input type="text"/> day(s) prior	
<input type="button" value="First"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Last"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>	

Abbreviation

Accepts up to eight characters.

Displays in **Open Times** and on the **Appointment Book** tab in **Scheduling > Appointment Scheduling** in slots that are not yet scheduled.

Prints on the appointment schedule for times that are not booked with appointments.

Description

Accepts up to 40 characters.

Displays in **Day Type Maintenance**.

Displays in the lower right corner of the **Appointment Book** tab in **Scheduling > Appointment Scheduling** detailing the highlighted time slot.

Selecting Scheduling Departments

Allows one or more specific departments to be associated with this activity type.

The default is **All Scheduling Departments**.

Only activity types associated with the scheduling departments selected for the day type are available in the **Set Activity Type** list box in **Day Type Maintenance**.

Custom color

Allows a custom color to be assigned to this activity type.

To assign a custom color to this activity type, **Allow Color by Activity Type** must be selected on the **Scheduling** tab in **Practice Options** or **Organization Options**.

Note: If a custom color is not assigned, the system uses the standard set of color coding values.

Time availability

Not available for appointments

Use to designate times that are not available for scheduling appointments, such as holiday, vacation, etc.

When selected, all slots are not available on the **Appointment Book** tab in **Scheduling > Appointment Scheduling**. Appointments can be forced if the user has security permissions.

Prevents slots given this activity type from qualifying for any search for open times.

When **Include Unavailable Time on Schedule** is selected on the **Scheduling** tab in **Practice Options** or **Organization Options**, the activity type description is displayed on the schedule.

Deletes the appointment categories in the lower grids.

Single booking

Allows for one appointment only to be scheduled in each slot given this activity type.

Additional appointments may be forced into these slots from the **Appointment Book** tab in **Scheduling > Appointment Scheduling** if the user has security permissions. Prevents the slots given this activity type from qualifying for an open times search after the slot is booked with one appointment.

Double booking

Allows for two appointments to be scheduled in each slot given this activity type.

Additional appointments may be forced into these slots from the **Appointment Book** tab in **Scheduling > Appointment Scheduling** if the operator's security permissions allow.

Prevents the slots given this activity type from qualifying for an open times search after the slot is booked with two appointments.

Triple booking

Allows for three appointments to be scheduled in each slot given this activity type.

Additional appointments may be forced into these slots from the **Appointment Book** tab in **Scheduling > Appointment Scheduling** if the user has security permissions.

Prevents the slots given this activity type from qualifying for an open times search after the slot is booked with three appointments.

Other booking factor

Allows you to define a multiple booking factor from four up to nine appointments for each slot given this activity type.

Additional appointments may be forced into these slots from the **Appointment Book** tab in **Scheduling > Appointment Scheduling** if the user has security permissions.

Prevents the slots given this activity type from qualifying for an open times search after the slot is booked with the designated number of appointments.

Usual duration of appts

Defines the span of time covered by the activity type.

Group Activity

Select this option if the activity type is for an activity in which multiple patients will participate, such as an education seminar.

When **Group Activity** is selected:

- > **Time Availability** is set to **Single Booking** and cannot be changed.
- > The **Time Availability** area, **Categories** subtab, and **Switch Categories** subtab are no longer enabled.

Max No of Patients

Enter the maximum number of patients, up to 200, who can be scheduled in a time slot with this activity type. If you change the maximum number of patients, re-blocking of schedules is required.

Appointment Type

Select an appointment type from the list.

- > **Usual Duration of Appts** is automatically set and cannot be changed.
- > The appointment category associated with the selected appointment type is automatically moved to **Eligible Appointment Categories** and cannot be removed.

- > The appointment type cannot be changed when appointments are associated with the activity type. If there are no associated appointments, and you change the appointment type, re-blocking of schedules is required.

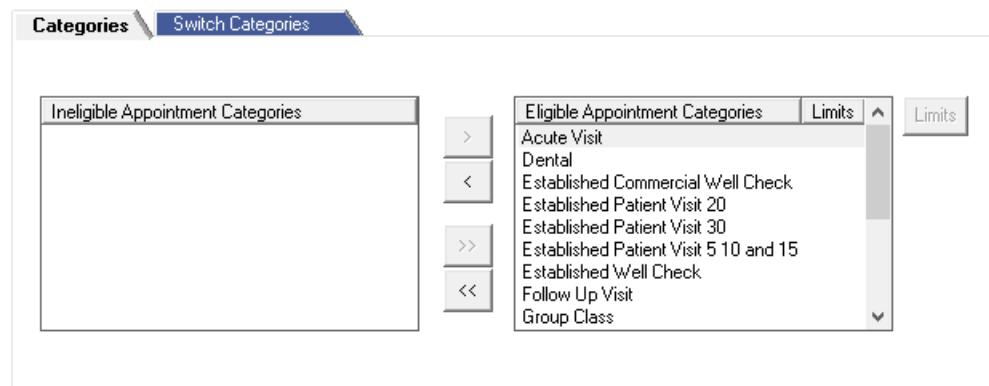
Limits button and column

The **Limits** button is available on the **Categories** subtab and **Switch Categories** subtab when you select **Double Booking**, **Triple Booking**, or a number for **Other Booking Factor** that is greater than 1 in the **Time Availability** area.

Click **Limits** to open **Booking Limits** and define booking limits for the activity type's eligible appointment categories.

The **Limits** column in the **Eligible Appointment Categories** grid on the **Categories** subtab and the **Switch Categories** subtab displays the booking limits defined when **Booking Limits** is opened from **Activity Type Maintenance**.

Categories subtab



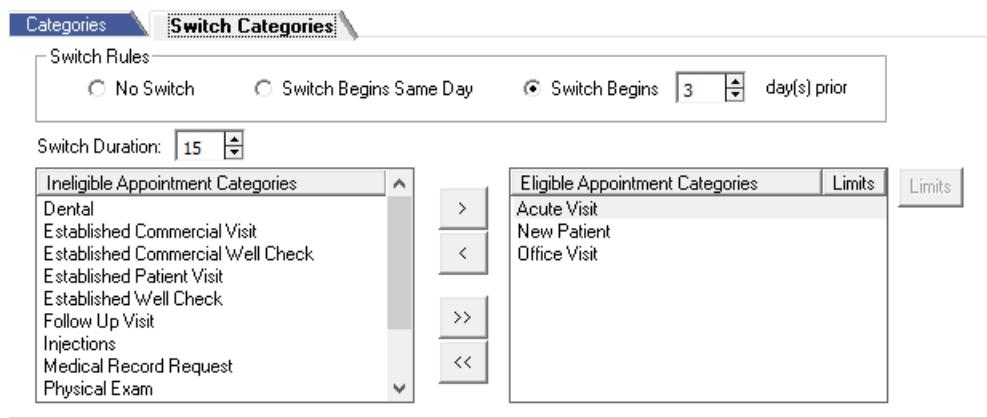
Ineligible Appointment Categories

Enables you to define appointment categories that cannot be entered for an activity type.

Eligible Appointment Categories

Enables you to define appointment categories that can be entered for an activity type.

Switch Categories subtab



If a block of time only permits you to schedule appointments in a specific category, you can add a switch rule to schedule appointments in other categories. This rule permits you to use switch categories during the switch period and revert back to original appointment categories after the switch period ends.

No Switch

Indicates that there are no switch rules for this activity type. This is the default option.

Switch Begins Same Day

Indicates that the switch rule is in effect from the availability date.

Switch begins __ day(s) prior

Specifies the number of days prior to the **Availability Date** from which the switch rule is in effect. The minimum value is 1 and the maximum value is 999.

Switch Duration

Enter a duration for the activity type used during the switch period. The switch duration must be a multiple of five minutes and cannot be greater than the value for **Usual Duration of Apps**. **Switch Duration** is not available when **No Switch** is selected.

Ineligible Appointment Categories

Enables you to define appointment categories that cannot be entered for an activity type while the switch rule is in effect.

Eligible Appointment Categories

Enables you to define appointment categories that can be entered for an activity type while the switch rule is in effect.

Freeze and release rules

If **Not Available for Appointments** is selected, the **Freeze Release Rules** area is not enabled.

Editing freeze or release rules in **Activity Type Maintenance** does not affect existing appointments in **Scheduling** nor existing freeze or release rules for blocked days and custom blocked days.

No Freeze

There are no freeze or release rules for the activity type. This option is the default selection. Time slots are available for scheduling according to the applied activity type.

Release Same Day

Frozen time slots become available for scheduling on the blocked date (also referred to as the availability date) in **Schedule Planning**.

Release __ day(s) prior

Frozen time slots become available for scheduling a designated number of calendar days before the blocked date in **Schedule Planning**. The minimum value is 1 and the maximum value is 999.

Day Type Maintenance window

Use **Day Type Maintenance** to create templates that enable you to customize the schedules for each of your scheduling resources.

Day Type Maintenance contains these tabs:

- > Day Type
- > History

Access **Day Type Maintenance** from **System Administration > File Maintenance > Day Type Maintenance**, or press **F9** and then enter **DTM**.

Day Type tab

Use the **Day Type** tab in **Day Type Maintenance** to create templates that enable you to customize the schedules for each of your scheduling resources.

Each day type can be as simple or as intricate as the practice needs. Activity types created in **Activity Type Maintenance** are used in defining the day types that you define.

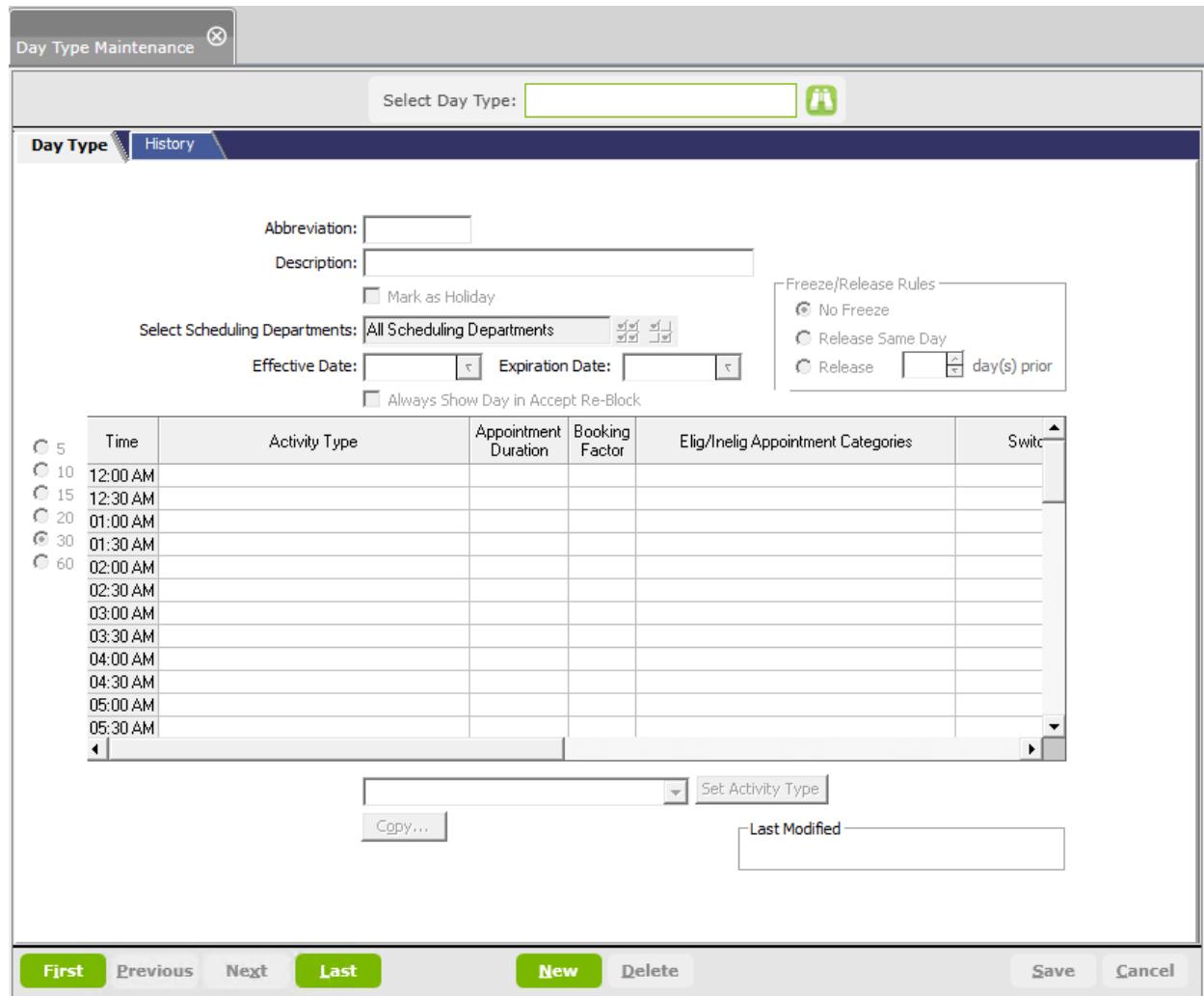
Day types are used in **Scheduling > Schedule Planning** to block schedules for each resource by scheduling department and scheduling location. It is these blocked schedules that display in the **Appointment Book** tab in **Scheduling > Appointment Scheduling** and serve as a search source in open times.

Examples of commonly used day types are:

- > Therapy - OT

- > *Doctor Name:* Regular Hours
- > *Doctor Name:* Surgery
- > Vacation
- > Holiday
- > Day Off

Access Day Type Maintenance from System Administration > File Maintenance > Day Type Maintenance or press **F9** and then enter **DTM**.



Time	Activity Type	Appointment Duration	Booking Factor	Elig/Inelig Appointment Categories	Switch
5					
10	12:00 AM				
15	12:30 AM				
20	01:00 AM				
25	01:30 AM				
30	02:00 AM				
35	02:30 AM				
40	03:00 AM				
45	03:30 AM				
50	04:00 AM				
55	04:30 AM				
60	05:00 AM				
	05:30 AM				

Abbreviation

Accepts up to 8 characters.

Displays in **Scheduling > Schedule Planning** to identify time blocked by calendar.

Description

Accepts up to 40 characters.

Displays in the options lists on the **Block Time By Calendar** and **Block Time By Criteria** tabs in **Schedule Planning**.

Mark as Holiday

Designate a day type as a **Holiday Day Type** which applies to all Scheduling Departments. If a Day Type is marked as a holiday in **Holiday Calendar**, the check box **Mark as Holiday** cannot be cleared.

Selecting scheduling departments

Allows specific department(s) to be associated with this day type.

The default is **All Scheduling Departments**.

Only activity types associated with the scheduling departments selected for the day type are available in the list box to the left of **Set Activity Type** in **Day Type Maintenance**.

Effective date

Not required.

Expiration date

Not required.

Always Show Day in Accept Re-Block

Select this option to have dates with that day type displayed in **Accept Re-Block** when those dates are re-blocked regardless of whether appointments are scheduled on that date.

If **Always Show Day in Accept Re-Block** is selected in **Day Type Maintenance**, it is automatically selected in **Copy Day Type**, but you can clear it.

Time slot increments

Use the grid on the far left of the screen to set time slot increments.

Tip: Use the time that corresponds to the appointment type with the shortest duration that you intend to include in this day type.

Set activity type

Time slots are assigned activity types when you highlight one or more rows in the main grid and then make a selection from the list to the left of **Set Activity Type**.

The following columns fill with the corresponding information entered in **Activity Type Maintenance**:

> **Appointment Duration**

- > Booking Factor
- > Elig/Inelig Appointment Categories
- > Switch Rules
- > Switch Eligible Appointment Categories
- > Freeze/Release Rules

If you select a group activity type and click **Set Activity Type**, the activity type description is prefixed with **(GRP)** to indicate that it is a group activity type.

If an activity type is set to **No Switch** in **Activity Type Maintenance**, then **Switch Rules** is blank. If an activity type is set to **Same Day** in **Activity Type Maintenance**, then the text **Same Day** displays in **Switch Rules**. If **Switch begins __ day(s) prior** is selected in **Activity Type Maintenance**, then the selected number of days displays in **Switch Rules**.

If an activity type is set to **No Freeze** in **Activity Type Maintenance**, then **Freeze/Release Rules** is blank. If **Release begins __ day(s) prior** is selected in **Activity Type Maintenance**, then the selected number of days displays in **Freeze/Release Rules**.

Last modified

Stamps when and by whom entries were made on this day type.

Copy

Creates a new day type record using an existing record as the basis.

Note: **Add Day Type** and **Edit Day Type** permissions for **Day Type Maintenance** are required to copy an existing record and then modify the new record before it is saved.

Freeze and release rules

Editing freeze or release rules in **Day Type Maintenance** does not affect existing appointments in **Scheduling** nor existing freeze or release rules for blocked days and custom blocked days.

No Freeze

There are no freeze or release rules for the day type. This option is the default selection. Time slots are available for scheduling according to the applied day type.

Release Same Day

Frozen time slots become available for scheduling on the blocked date (also referred to as the availability date) in **Schedule Planning**.

Release __ day(s) prior

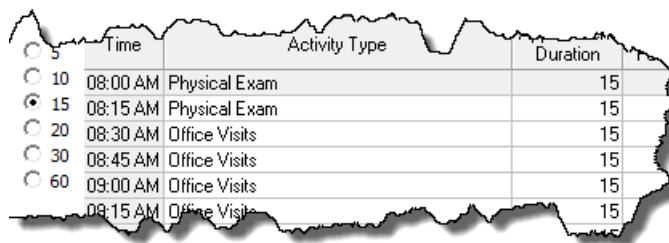
Frozen time slots become available for scheduling a designated number of calendar days before the blocked date in **Schedule Planning**. The minimum value is 1 and the maximum value is 999.

Reading the History tab

When you update the time-slot grid on the **Day Type** tab, regardless of whether you add or remove time slots or change activity types, the **Old Value** and **New Value** columns on the **History** tab show time slots in the grid grouped by the same activity type.

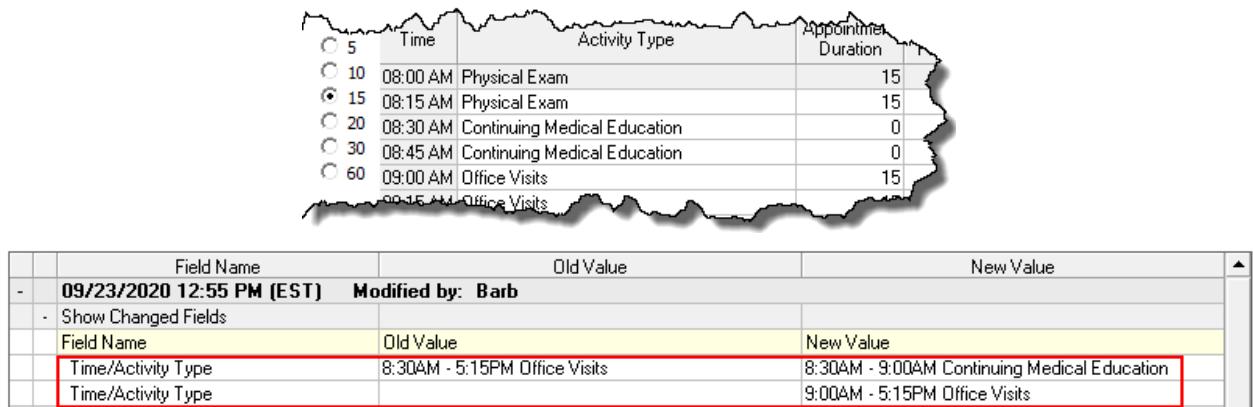
To best interpret a given audit change, read the **Old Value** and **New Value** columns on the **History** tab from top to bottom instead of left to right. When read from top to bottom, the **Old Value** column shows the time slots before the update, and the **New Value** column shows the time slots after the update.

For example, if you create a day type with the first two time slots (8:00-8:15 and 8:15-8:30) for physical exams, and the remainder of the day (8:30-5:15) for regular office visits, the **New Value** column on the **History** tab shows 8:00AM - 8:30AM with the physical exam activity type description followed by 8:30AM - 5:15PM with the office visit activity type description.



	Field Name	Old Value	New Value
-	09/23/2020 12:37 PM (EST)	Modified by: Barb	
-	Show Changed Fields		
	Field Name	Old Value	New Value
	Abbreviation		PHYS
	Description		Physical Exam
	Effective Date		09/23/2020
	Mark as Holiday		False
	Is Frozen		False
	Time/Activity Type	8:00AM - 8:30AM Physical Exam	
	Time/Activity Type		8:30AM - 5:15PM Office Visits

If you later assign a continuing education activity type to the 8:30-8:45 and 8:45-9:00 time slots, there is no audit entry for the 8:00-8:30 physical exam time slots because they were not affected by the update. The **Old Value** column shows 8:30AM - 5:15PM with the office visit activity type description because that group of time slots with the same activity type was affected by the update. The **New Value** column shows 8:30AM - 9:00AM with the continuing education activity type description followed by 9:00AM - 5:15PM with the office visit activity type description.



Resource Maintenance window

Use **Resource Maintenance** to manage resources.

Resources are providers, rooms, or equipment for which there is a need to create and manage a schedule. For example, you may require that in addition to having a provider be available for an appointment, a room or piece of equipment must also be reserved for that provider's use at the same time. Each one of the resources must be entered in **Resource Maintenance** with the applicable resource type.

Schedules are blocked (or defined) by scheduling location, scheduling department, and resource.

Resources are used when setting scheduling preferences, printing schedules, and generating encounter forms and medical record slips.

Various scheduling reports and activities can be grouped and or restricted to selected resources.

Access **Resource Maintenance** from **System Administration > File Maintenance > Resource Maintenance** or press **F9** and then enter **REM**.

Resource Maintenance contains the following tabs.

- > **Resource tab**
- > **Department Members or Practice Members tab**

Resource tab

Use the **Resource tab** in **Resource Maintenance** to maintain providers, rooms, or equipment required for schedules.

Access the **Resource tab** from **System Administration > File Maintenance > Resource Maintenance**, or press **F9** and enter **REM**.

Resource Maintenance

Select Resource:

Resource Department Members

Resource Type
 Provider
 Room
 Equipment

Associated Provider:

Abbreviation:

Description:

Eligible Appointment Group:

Default Appointment Type:

Encounter Form Format:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Resource Type

Resources are divided into the following categories:

- > Provider
- > Room
- > Equipment

Associated Provider

Associated Provider is enabled only when you select **Provider** as a resource type. It is not available when you select **Room** or **Equipment**.

Resources are associated with a provider for the purpose of tracking productivity from a financial standpoint. To associate a resource with a provider listed in **Provider Maintenance**, keep **Provider** selected.

When you associate a resource with a provider, **Abbreviation** and **Description** are automatically filled with the detail from **Provider Maintenance**. Accept these defaults as they are the link used for reporting purposes.

Note: Generally, you would not associate the resource with a provider if you do not bill for that resource's services or if you do not enter the provider on a voucher. For example, a nurse, a lab technician, or a physician who sees patients at your facility but does his or her own billing. The exception is for those clients using a third-party interface. Follow the interface documentation related to the setup necessary for activation.

Abbreviation

Abbreviation is automatically filled when an associated provider is selected. Accept the default when associating this resource with a provider: Do not change the default value.

Accepts up to 8 characters.

Displays on **Open Times** and the **Appointment Management** tab.

Can be used on an encounter form.

Description

Description is automatically filled when an associated provider is selected. Accept the default when associating this resource with a provider.

Accepts up to 40 characters.

Enter a description that displays in **Scheduling Preferences** in **Scheduling**. This description is used on the **Appointment Activity** tab, **Appointment Detail**, and various reports.

Prints on the schedule.

Can be used on an encounter form.

Eligible appointment group

Select an appointment group that restricts the selections available for **Appt Type** on the **Patient Scheduling** tab and when scheduling an appointment using the **Appointment Book** tab.

May be left blank.

If an appointment group is selected, the only choices available in the **Appt Type** field when scheduling an appointment are those appointment types assigned to the group.

If an appointment group is not selected, all appointment types are available in **Appt Type**.

Default appointment type

Select an appointment type to automatically fill **Appt Type** on the **Patient Scheduling** tab.

May be left blank.

Encounter form format

Enabled only when the **Encounter Form Basis** in **Scheduling Options** is set to **Resource**.

Select the format uses by the application when printing encounter forms for this resource.

When this box is enabled, if an encounter form format is not selected for this resource, the format you selected as the default in **Practice Options** or **Organization Options** is used when printing encounter forms for this resource.

Department Members or Practice Members tab in Resource Maintenance

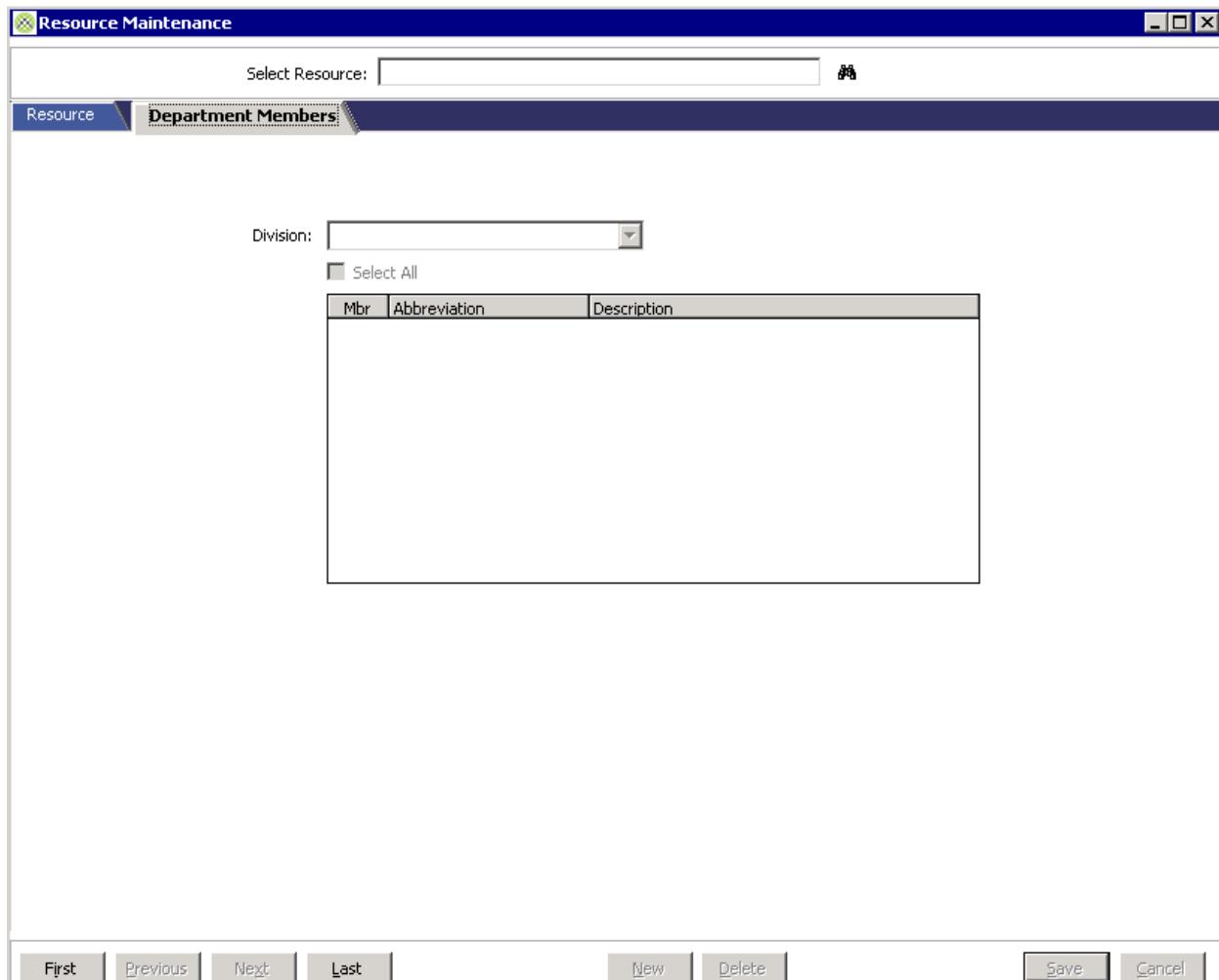
Use the **Department Members** or **Practice Members** tab to determine the relationship between operators and departments or practices, or specific **Resource Maintenance** records and departments or practices.

This tab is displayed only when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

The **Department Members** or **Practice Members** tab can be either view only or enabled, based on whether you have selected an associated provider.

- **View Only** - When an associated provider is selected, this tab is view only. The operator is able to see which members are selected for the associated provider, but can neither select nor clear a department or practice from this tab. In this instance, department or practice members can only be selected in **Provider Maintenance**.
- **Enabled** - This tab is enabled when **Associated Provider** is blank or disabled. In this case, the operator must select at least one department or practice; otherwise, none of the operators have access to the record.

Access the **Department Members** or **Practice Members** tab from **System Administration > File Maintenance > Resource Maintenance** or press **F9** and then enter **REM**.



Division

This box is only enabled on the **Department Members** or **Practice Members** tab when you select **Enable Divisions** on the **Multi Entity** tab in **Practice Options** or **Organization Options**. In this case, the selection of department or practice members is done at the level of division.

Note: Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you elect to enable divisions, you must create divisions in **Division Maintenance**. Divisions can be used as a group field, or select records option in reporting.

Resource Group Maintenance window

Resource Group Maintenance is made up of resources that can be used as options when search for available appointment.

Resource groups are made up of resources which can be used as options when searching for available appointments. When a resource group is selected, Allscripts® Practice Management will search for and display the appointments which are open with any one of the resource group members. For example, the resource group “Nurse Practitioners” includes 3 members: Sally, Harry, and Mary. When this resource group is selected and appointment preferences are set either on the Patient tab or the Appointment Book tab, the results shown could be for Sally and/or Harry, and/or Mary.

A resource group may be designated as a resource set member.

Used when setting scheduling preferences.

Various scheduling reports and activities can be restricted to one or more selected resource group.

Resource Group Maintenance contains these tabs:

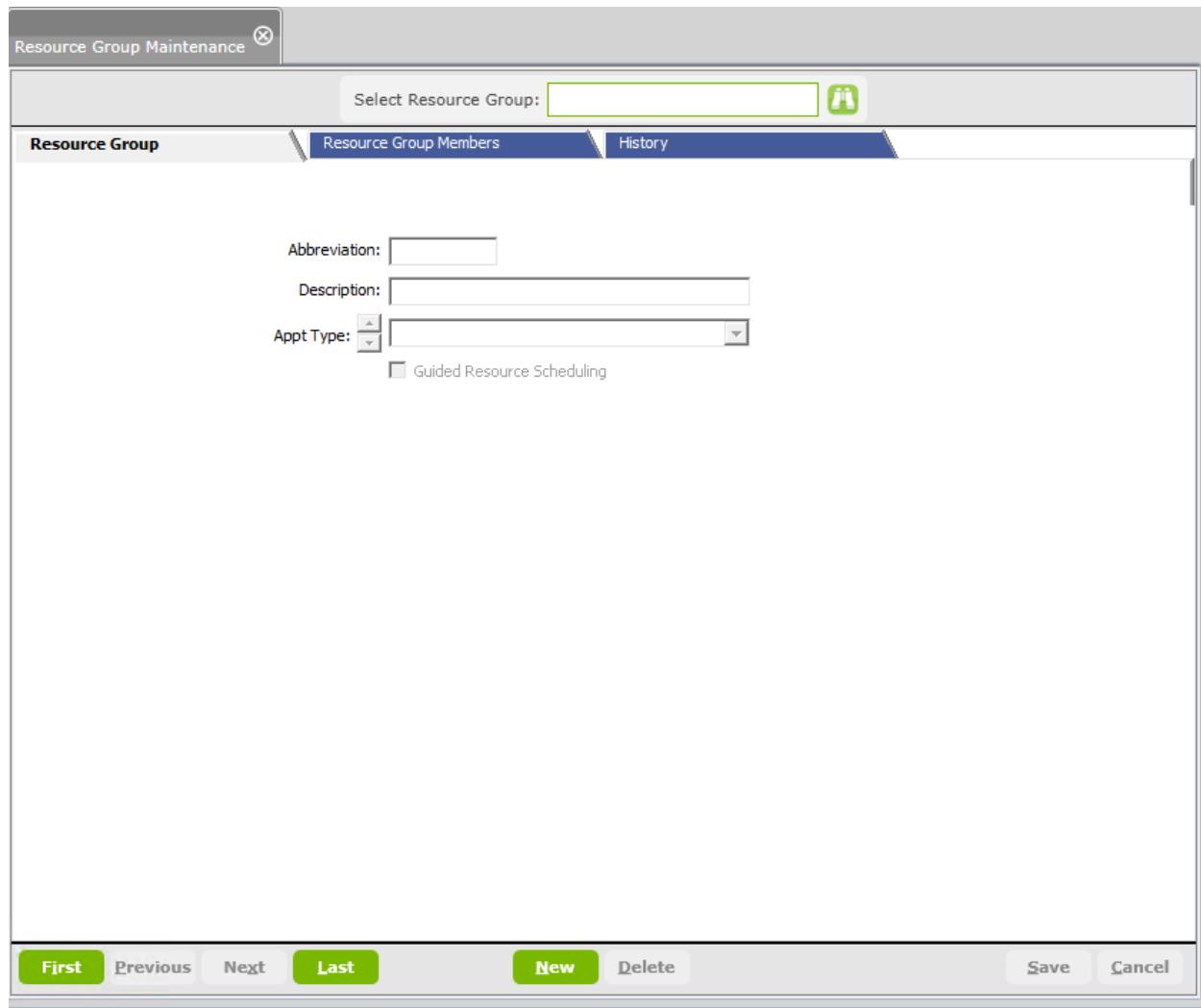
- > **Resource Group**
- > **Resource Group Members**
- > **History**

Access **Resource Group Maintenance** from **System Administration > File Maintenance > Resource Group Maintenance** or press **F9** and then enter **RGM**.

Resource Group tab

Use the **Resource Group** tab in **Resource Group Maintenance** to create resource groups.

Access the **Resource Group** tab from **Resource Group Maintenance**. To access **Resource Group Maintenance**, go to **System Administration > File Maintenance** and click **Resource Group Maintenance** or use **F9 > RGM**.



Abbreviation

Accepts up to 8 characters.

Description

Accepts up to 40 characters.

Displays as options in the list box on the scheduling windows when the box name **Resource** is changed to **Res. Group**.

Appt Type/Appt Group

Click  to toggle between **Appt Type** and **Appt Group**.

Associate the resource group with an appointment type or appointment group. When a resource group is selected on the **Patient Scheduling** tab, the application filters the **Appt Type** list on the **Patient Scheduling** tab to display only the associated appointment type or the appointment types within the associated appointment group.

Guided Resource Scheduling

Select this option to indicate that the resource group conforms to guided resource scheduling functionality.

Resource Group Members tab

Use the **Resource Group Members** tab to add group members from the drop-down lists of resources that is enabled when you click on the wand.

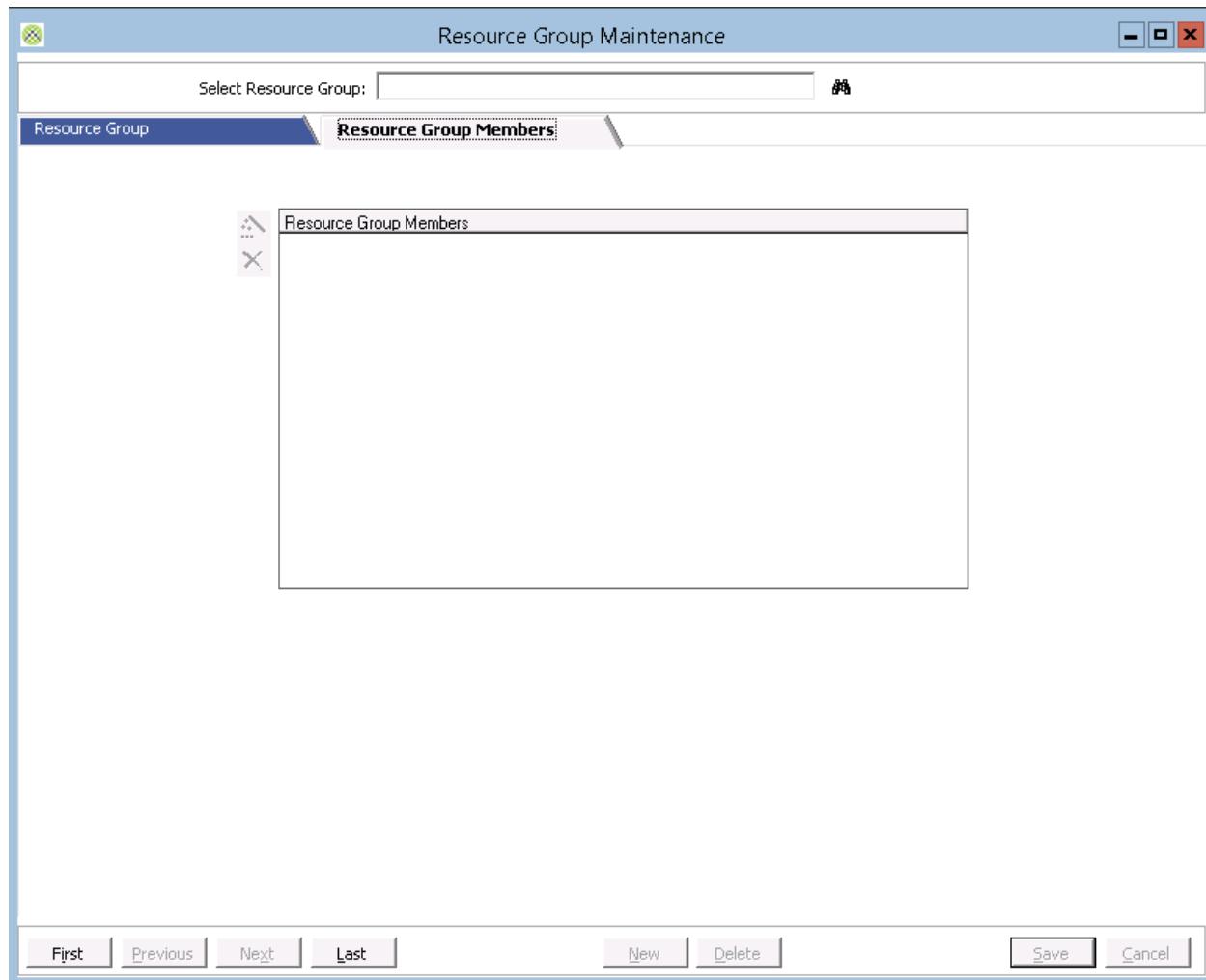
Clients using department security or practice security

The drop-down list on the **Resource Group Members** tab is filtered based on the operator's security permissions. The operator who is creating resource groups should:

- > have rights to all departments or practices
- > know the departments or practices selected as members for each the resources associated provider

Selecting resources that do not share the same department members will cause conflicts when operators book appointments.

Access the **Resource Group Members** tab from **Resource Group Maintenance**. To access **Resource Group Maintenance**, go to **System Administration > File Maintenance** and click **Resource Group Maintenance** or use **F9 > RGM**.



Resource Set Maintenance window

Resource sets are made up of resources or resource groups and appointment types that you can use to link appointments that require the availability of a combination of resources, rooms, and pieces of equipment on the same day.

For example, create sets for booking a stress test with a follow up office visit, or for booking a provider, room, and piece of equipment all at the same time.

Resource Set Maintenance contains these tab:

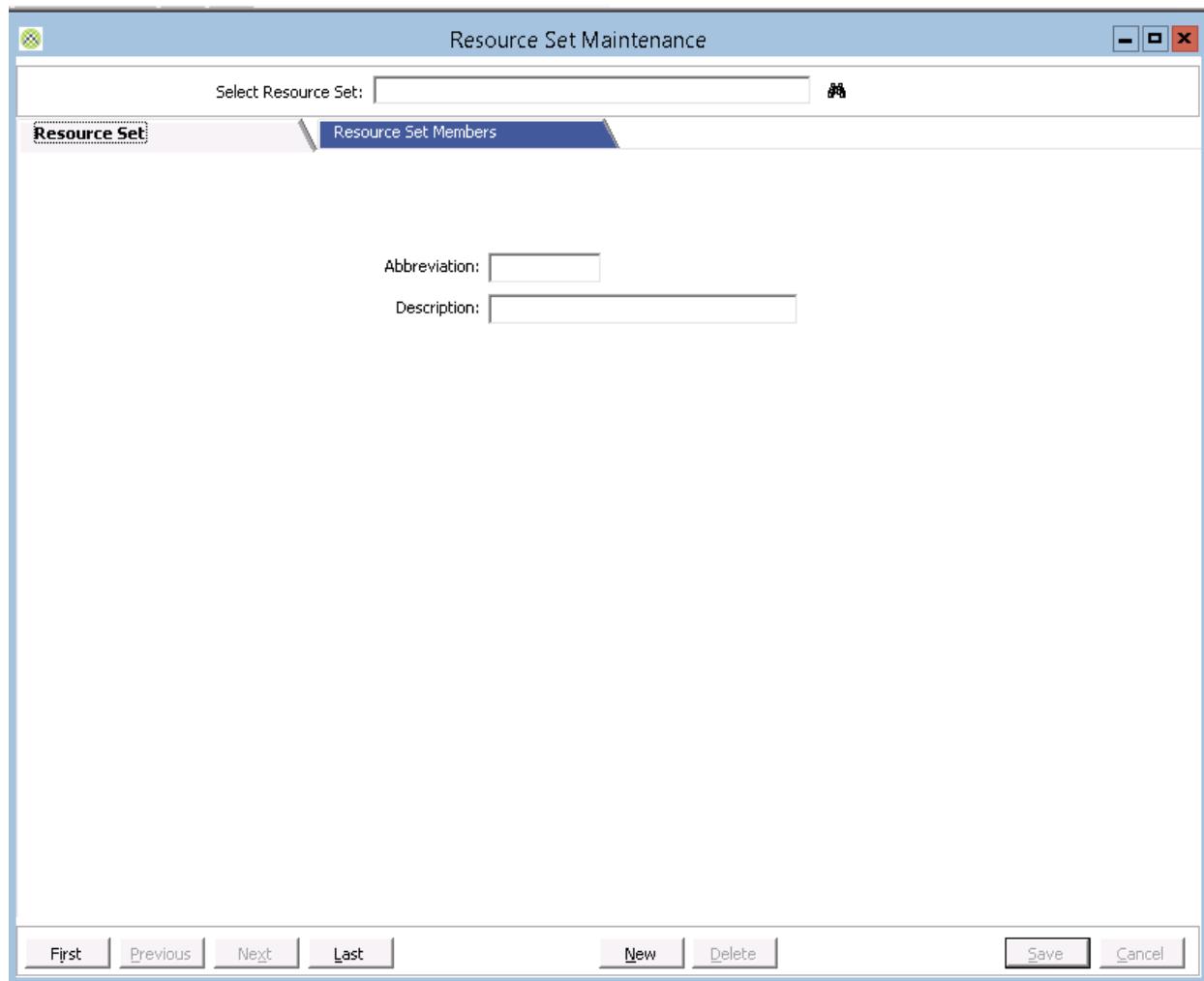
- > **Resource Set**
- > **Resource Set Members**

To access **Resource Set Maintenance**, go to **System Administration > File Maintenance** and click **Resource Set Maintenance** or press **F9** and then enter **RRM**.

Resource Set tab

Use the **Resource Set** tab in **Resource Set Maintenance** to create resource sets to which you can then add members using the **Resource Set Members** tab.

Access the **Resource Set** tab from **Resource Set Maintenance**. To access **Resource Set Maintenance**, go to **System Administration > File Maintenance** and click **Resource Set Maintenance** or use **F9 > RRM**.



Abbreviation

You can enter up to 8 characters.

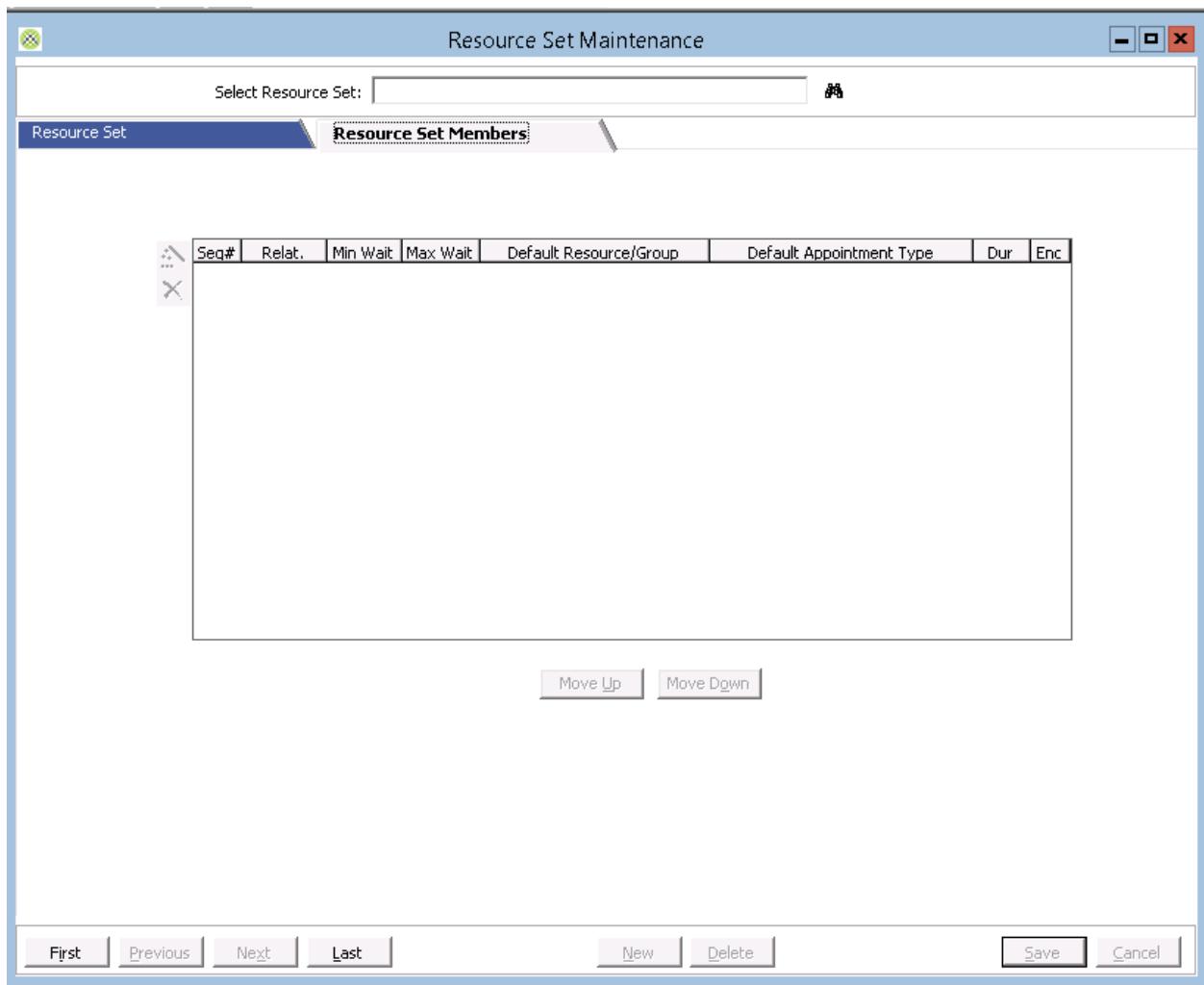
Description

You can enter up to 40 characters. The description is displayed on **Add Resource Set** when you link appointments.

Resource Set Members tab

Use the **Resource Set Members** tab in **Resource Set Maintenance** to add members to your resource sets and define their relationships to one another.

Access the **Resource Set Members** tab from **Resource Set Maintenance**. To access **Resource Set Maintenance**, go to **System Administration > File Maintenance** and click **Resource Set Maintenance** or press **F9** and then enter **RRM**.



Seq. #

Fills automatically when you add a set member. Used to help determine the relationship of appointments to each other.

Use **Move Up** and **Move Down** to reorder the sequence.

Note: Always review the relationship of appointments when reordering the sequence.

Relat.

Flags an appointment as being concurrent, consecutive, staggered or not concurrent with the previous appointment.

The selections available are:

After

Use for an appointment that is meant to follow the previous appointment.

Flexible

Use for an appointment that may start at anytime on the chosen day. The first member in a set must always be defined as **Flexible**.

Overlap

Use for an appointment that should be staggered or concurrent with the previous appointment.

Min Wait and Max Wait

Use these two boxes to specify the time lapse between an appointment and the one preceding it. The examples given in this table are meant to help you understand how this works:

Relationship	Minimum Wait	Maximum Wait	Means that this appointment
After	15	30	must start 15-30 minutes after the end of the previous appointment
After	0	0	must start immediately after the end of the previous appointment
Overlap	15	30	must start 15-30 minutes after the start of the previous appointment

Relationship	Minimum Wait	Maximum Wait	Means that this appointment
Overlap	0	0	must start at the exact same time as the previous appointment
Flexible	N/A	N/A	may start at any time on the chosen day

Default Resource/Group

Optional. Make the applicable selection for this appointment from the list.

Default Appointment Type

Optional. Make the applicable selection for this appointment from the list.

Dur

This box fills automatically with the duration entered in **Appointment Type Maintenance** for the selected appointment type. You can edit this box: doing so overrides the default only when this resource set is used.

Enc

Select this check box to qualify this appointment for the printing of an encounter form. Defaults to the setting defined in **Appointment Type Maintenance** for the selected appointment type. You can edit this box: doing so overrides the default only when this resource set is used.

Note: Each of these fields may also be edited on the Link Appointments dialog which will override these defaults for the set being scheduled at that specific time.

Scheduling Department Maintenance window

A scheduling department is a department or practice for which you manage appointment scheduling.

Create a scheduling department for each department used for seeing patients.

Schedules are blocked (or defined) by scheduling location, scheduling department, and resource.

Scheduling departments are used as filters when the following functions are performed:

- > Blocking (defining) schedules
- > Scheduling appointments
- > Batch printing schedules
- > Batch printing encounter forms

- > Printing scheduling documents
- > Generating various scheduling reports

The following table shows the boxes in **Scheduling Department Maintenance** which have a corresponding pull-field in **Scheduling Information.dot**. This document template is used in **Document Maintenance** to create scheduling documents.

Schedule Department Maintenance box	Scheduling Information pull field
Abbreviation	<<ApptDeptAbbr>>
Description	<<ApptDeptDesc>>
Address 1	<<ApptDeptStreet1>>
Address 2	<<ApptDeptStreet2>>
City	<<ApptDeptCity>>
State	<<ApptDeptState>>
Zip Code	<<ApptDeptZipCode>>
Country	<<ApptDeptCountry>>
Telephone/Ext	<<ApptDeptTele>>

Access **Scheduling Department Maintenance** from **System Administration > File Maintenance > Scheduling Department Maintenance** or press **F9** and then enter **SDM**.

Scheduling Department Maintenance

Select Scheduling Department:

Associated Department:

Abbreviation:

Description:

Address 1:

Address 2:

City: State:

Zip Code: Country:

Telephone: Ext:

Encounter Form Format:

First Previous Next Last New Delete Save Cancel

Associating a Department/Practice

Associating a scheduling department with a department or practice is optional. It allows you to associate the scheduling department with a department or practice used in billing.

Information related to scheduling departments is reportable using scheduling reports. These reports found under scheduling offer analysis of a non financial nature, such as the number of appointments scheduled within a date range for each resource.

Why would I want to associate a scheduling department with a department or practice

Associating a scheduling department with the department or practice that is used in billing, allows you to also track and report on the financial productivity of a scheduling department.

How can I ensure that we have charges for all patients seen?

Use encounter tracking to ensure that all scheduled appointments given auto generated encounter numbers have charges posted against them.

Searching for an existing record

Before creating a new scheduling department record, always search to make sure it does not already exist.

To search for an existing record do the following:

1. Click  to open the dialog, select scheduling department.
2. Enter the first letters of the description. The box automatically fills when a match is found. If the box does not automatically fill, no match was found.
3. Click **OK** to close the dialog and return to maintenance screen.

Associated department/practice

Optional.

To track and report on the financial productivity of a scheduling department, you must associate it with a department or practice created in department or practice maintenance.

Abbreviation

Accept the default abbreviation, when associating with a department or practice.

Accepts up to 8 characters.

Displays on the **Open Times** window and the **Appointment Management** tab.

Can be used on an encounter form.

Description

Accept the default description when associating with a department or practice.

The default should not be changed, unless you are associating multiple scheduling departments or practices with the selected department or practice.

If not associating with a billing department or practice, enter a description.

Accepts up to 40 characters.

Displays on all the scheduling screens and the patient's **Appointment Detail**.

Prints on the schedule. Can be used on an encounter form.

Address 1

Automatically fills when one exists for the selected associated department or practice.

Note: If not associating with a billing department or practice, enter a street address.

Address 2

Auto-fills when one exists for the selected associated department or practice.

Note: If not associating with a billing department or practice, enter an apartment, suite, PO Box number.

City

Automatically fills when one exists for the selected associated department or practice.

Note: If not associating with a billing Department/Practice, enter a City.

State

Automatically fills when one exists for the selected associated department or practice.

Note: If not associating with a billing department or practice, enter a state.

Zip code

Automatically fills when one exists for the selected associated department or practice.

Note: If not associating with a billing department or practice, enter a zip code.

Country

Automatically fills when one exists for the selected associated department or practice.

Note: If not associating with a billing department practice, enter a country.

Telephone

Automatically fills when one exists for the selected associated department or practice.

Note: If not associating with a billing department or practice, enter a telephone number.

Ext

Automatically fills when one exists for the selected associated department or practice.

Note: If not associating with a billing department or practice, enter a telephone extension number.

Encounter form format

Encounter form format Enabled only when **Encounter Form Basis** in the **Scheduling Options** section of **Practice Options** or **Organization Options** is set to **Scheduling Department**.

Use the spin box to select the format Allscripts® Practice Management uses when printing encounter forms for this scheduling department.

When left blank, the **Default Encounter Form Format** value selected in the **Scheduling Options** section of **Practice Options** or **Organization Options** is used to print encounters for this scheduling department.

Scheduling Location Maintenance window

A scheduling location is where you manage a schedule. Schedules are blocked (or defined) by scheduling location, scheduling department, and resource.

When generating availability for a specific resource, you must also identify the scheduling department and a scheduling location where the appointment is to be booked.

The locations used for scheduling can be associated with those created in **Location Maintenance** in Practice Management File Maintenance. Other locations can also be created to be used exclusively in scheduling.

Locations entered in scheduling maintenance will be used for generating schedules, printing encounter forms, as well as for the selection of criteria when scheduling appointments, and generating scheduling reports.

Scheduling Location Maintenance contains these tabs:

- > **Scheduling Location**
- > **Department Members or Practice Members**
- > **Resource Association**

Access **Scheduling Location Maintenance** from **System Administration > File Maintenance > Scheduling Location Maintenance** or press **F9** and then enter **SLM**.

Scheduling Location tab

To track and report on the financial productivity of a scheduling location, it must be associated with a location created in Allscripts® Practice Management.

Access the **Scheduling Location** tab from **Scheduling Location Maintenance**. To access **Scheduling Location Maintenance**, go to **System Administration > File Maintenance > Schedule Location Maintenance** or press **F9** and then enter **SLM**.

Scheduling Location Maintenance X

Select Scheduling Location: 

Scheduling Location Department Members

Associated Location:

Abbreviation:

Description:

Encounter Form Format:

Time Zone:

First Previous Next Last New Delete Save Cancel

Associated Location

Select an associated location.

Abbreviation

Auto fills when an associated location is selected. This default should not be changed.

Enter up to eight characters when not associating with a department.

Displays on the **Appointment Management** in **Scheduling > Appointment Scheduling** and in various reports. Can be used on an encounter form.

Description

Auto fills when an associated provider is selected. This default should not be changed.

Accepts up to 40 characters.

Enter a description that displays in **Scheduling Preferences** in **Scheduling**.

Displays also on the **Appointment Activity** tab, **Appointment Detail** tab, and various reports.

Prints on the schedule.

Can be used on an encounter form.

Encounter Form Format

Enabled only when **Encounter Form Basis** on the **Scheduling** tab in **Practice Options** or **Organization Options** is set to **Scheduling Location**.

Use the spin box to set the format Allscripts® Practice Management should use when printing encounter forms for this scheduling location.

When this field is enabled if you do not select a format then, the **Default Encounter Form Format** defined on the **Scheduling** tab in **Practice Options** or **Organization Options** is used to print encounters for this scheduling location.

Time Zone

By default, **Time Zone** is set to the same time zone as your practice or organization (this time zone is set on the **Practice Information** tab in **Practice Set Up** or **Organization Set Up**). Use **Time Zone** to set individual scheduling locations to a different time zone than the default time zone used by the rest of your practice or organization.

Allscripts® Practice Management supports all of the Microsoft®-defined time zones, as well as 26 additional time zones. These include the following 12 US timezones (including US territories), as well as 156 international time zones.

Description	Display name	Abbreviation
Hawaiian Standard Time	(UTC - 10:00) Hawaii	HST
Alaskan Standard Time	(UTC - 09:00) Alaska	AKST
Pacific Standard Time	(UTC - 08:00) Pacific Time (US & Canada)	PST
US Mountain Standard Time	(UTC - 07:00) Arizona	MST
Mountain Standard Time	(UTC - 07:00) Mountain Time (US & Canada)	MST
Central Standard Time	(UTC - 06:00) Central Time (US & Canada)	CST
Eastern Standard Time	(UTC - 05:00) Eastern Time (US & Canada)	EST
US Eastern Standard Time	(UTC - 05:00) Indiana (East)	EST

Description	Display name	Abbreviation
Atlantic Standard Time Note: Use this option for locations in the Atlantic time-zone region that do not use Daylight Saving Time, such as Puerto Rico and the US Virgin Islands.	(UTC - 04:00) Atlantic Time	AST
Hawaii-Aleutian Standard Time	(UTC - 10:00) Hawaii-Aleutian	HAST
Samoa Standard Time	(UTC -11:00) Samoa ST	SST Samoa
Chamorro Standard Time	(UTC +10:00) Chamorro ST	ChST

Note: For a complete list of Microsoft®-defined time zones, go to [https://msdn.microsoft.com/en-us/library/ms912053\(v=winembedded.10\).aspx](https://msdn.microsoft.com/en-us/library/ms912053(v=winembedded.10).aspx).

Clients using Department Security or Practice Security

The **Department Members** or **Practice Members** tab can be either view only or enabled based on whether you have selected an associated provider:

- **View Only** - When an associated location is selected this tab is view only. The operator is able to see which members are selected for the associated location, but can neither select nor clear a department or practice from this screen. In this instance, department members or practice members can only be selected in **Location Maintenance**.
- **Enabled** - This tab is enabled when **Associated Location** is clear or not available. In this case the operator must select at least one department or practice otherwise none of the operators will have access to the record.

Department Members or Practice Members tab in Scheduling Location Maintenance

The **Department Members** or **Practice Members** tab is available only when **Enable Department Security** or **Enable Practice Security** is selected on the **General** tab in **Practice Options** or **Organization Options**.

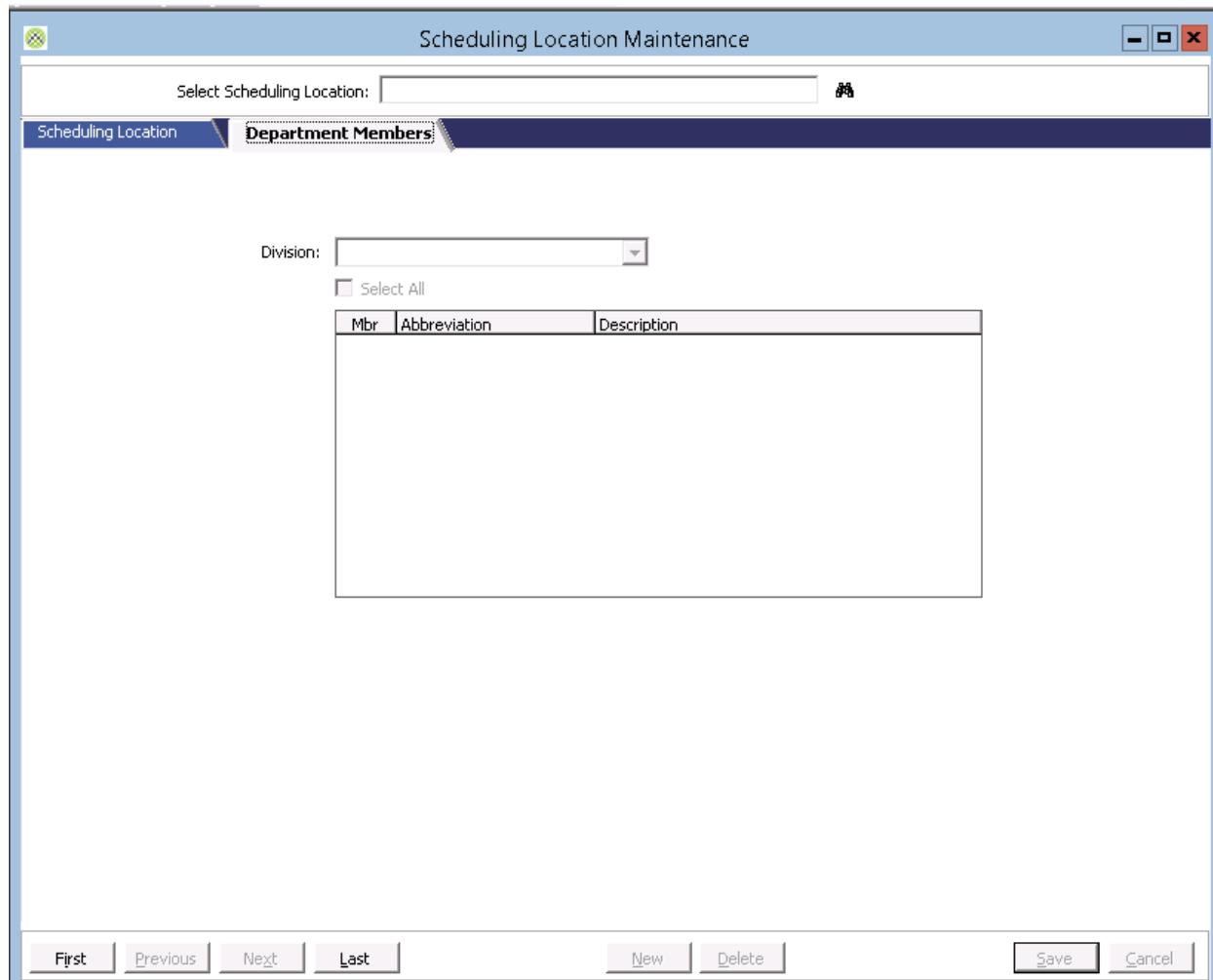
The **Department Members** or **Practice Members** tab can be either “view only” or enabled, based on whether you have selected an associated location:

- **View Only** - When an associated location is selected this tab is “view only.” The user is able to see which members are selected for the associated location but cannot select or clear a

department or practice. In this instance, department or practice members can only be selected in **Location Maintenance**.

- Enabled - This tab is enabled when the **Associated Location** is clear or not available. In this case the, the user must select at least one department or practice. Otherwise, none of the users have access to the record.

Access the **Department Members** or **Practice Members** tab from **Scheduling Location Maintenance**. To access **Scheduling Location Maintenance**, go to **System Administration > File Maintenance > Schedule Location Maintenance** or press **F9** and then enter **SLM**.



The screenshot shows the 'Scheduling Location Maintenance' application window. At the top, there is a title bar with the window title. Below the title bar, there is a toolbar with a 'Select Scheduling Location:' dropdown menu and some icons. The main area of the window has two tabs: 'Scheduling Location' and 'Department Members'. The 'Department Members' tab is currently selected, indicated by a dark blue background. Below the tabs, there is a 'Division:' dropdown menu and a 'Select All' checkbox. A large table grid is present, with columns labeled 'Mbr', 'Abbreviation', and 'Description'. At the bottom of the window, there are navigation buttons ('First', 'Previous', 'Next', 'Last'), a toolbar with 'New', 'Delete' buttons, and a set of standard window control buttons ('Minimize', 'Maximize', 'Close').

Division

This field is available on the **Department Members** or **Practice Members** tab only when **Enable Division** is selected on the **Multi Entity** tab in **Practice Options** or **Organization**

Options. In this case, the selection of department members or practice members is done at the level of division.

Note: Divisions are containers that provide a way to gather financial data related to departments or practices for reporting purposes. If you enable divisions, you must create divisions in **Division**

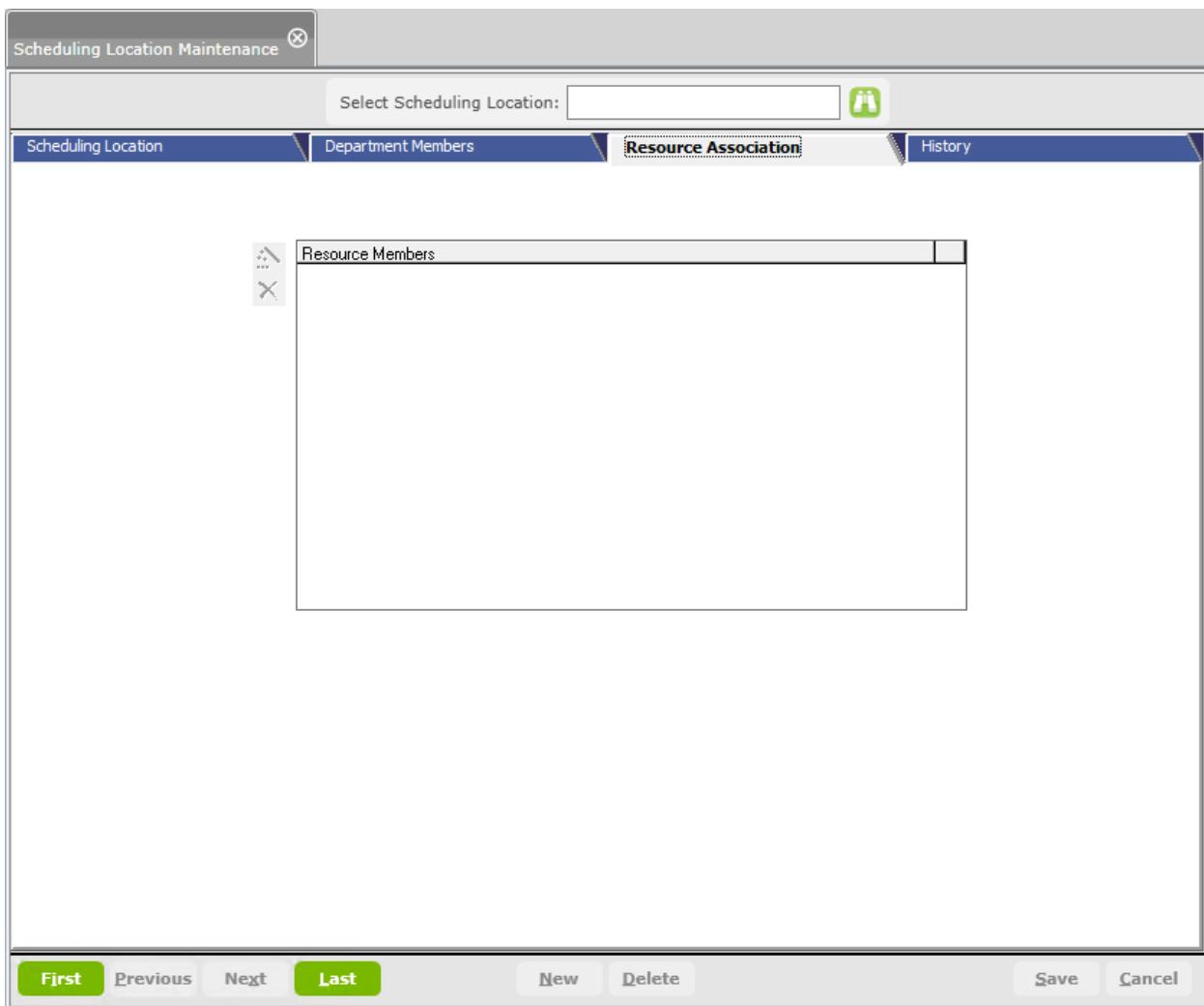
Maintenance. Divisions can be used as a group field or as a select records option in reporting. See *Divisions in Allscripts PM* in online Help for more information.

Resource Association tab in Scheduling Location Maintenance

Use the **Resource Association** tab in **Scheduling Location Maintenance** to associate resources to scheduling locations.

Access the **Resource Association** tab from **Scheduling Location Maintenance**. To access **Scheduling Location Maintenance**, go to **System Administration > File Maintenance**, or press **F9** and then enter **SLM**.

Important: You must have **Enable Visit Type** selected on the **Visit Type** tab in **Practice Options** or **Organization Options** to access the **Resource Association** tab.



Resource Members

This grid displays the resource members associated with the scheduling location selected in **Select Scheduling Location**.

The resource members associated with the scheduling location are the only options that are displayed in the **Resource** drop-down list in the following tabs after a scheduling location has been selected:

- > **Scheduling > Appointment Scheduling > Patient Scheduling**
- > **Scheduling > Appointment Scheduling > Appointment Management**
- > **Scheduling > Schedule Planning > Block Time by Calendar**
- > **Scheduling > Schedule Planning > Block Time by Criteria**

If department or practice security is enabled, when you add a row to the **Resource Members** grid on the **Resource Association** tab in **Scheduling Location Maintenance**, the resources that you can select from depend on the departments or practices that you have access to in **Operator Maintenance** as well as the departments or practices that the resources have access to in **Resource Maintenance**.

Use the following department access as an example:

- > Operator 1 has access to Department 1 and Department 2 in **Operator Maintenance**.
- > Resource 1 has access to Department 2 and Department 3 in **Resource Maintenance**.
- > Resource 2 has access to Department 3 in **Resource Maintenance**.
- > Resource 3 has access to Department 1 and Department 3 in **Resource Maintenance**.

When Operator 1 attempts to add a resource to the **Resource Members** grid in **Scheduling Location Maintenance**, Resource 1 and Resource 3 are available for selection because Operator 1 and Resource 1 both have access to Department 2, and Operator 1 and Resource 3 both have access to Department 1. Resource 2 is not available for selection because Operator 1 does not have access to Department 3.

The departments or practices selected on the **Department Members** or **Practice Members** tab in **Scheduling Location Maintenance** do not affect the resources available for selection on the **Resource Association** tab.

If there are no resources associated to a scheduling location on **Resource Association**, the resources that you have access to according to department security are displayed in the **Resource** drop-down list on the **Patient Scheduling** tab in **Scheduling > Appointment Scheduling**.

Associate a resource member to a scheduling location

Use the **Resource Association** tab in **Scheduling Location Maintenance** to associate a resource member to a scheduling location.

Before you begin

You must have **Enable Visit Type** selected on the **Visit Type** tab in **Practice Options** or **Organization Options** to access the **Resource Association** tab.

1. Go to **System Administration > File Maintenance > Scheduling Location Maintenance** or press **F9** and then enter **SLM**.
2. Click the **Resource Association** tab.
3. Click  to open **Select Scheduling Location**.
4. Select the scheduling location you want to associate to a resource member.
5. Click **OK**.

The grid displays the resource members currently associated with the scheduling location.

Note: For new scheduling locations, the grid is cleared by default.

6. Click  to insert a row in the **Resource Members** grid.

A blank row is displayed and is highlighted.

7. On the blank row, click .

Select Resources opens and displays the resources created in **Resource Maintenance**.

8. Select 1 or more resources to associate to the scheduling location.

Tip: To select multiple resources, hold **Ctrl** while you click the resources that you want to add to the grid.

A row is added to the grid for each resource that you selected.

9. Click **Save**.

Disassociate a resource member from a scheduling location in Scheduling Location Maintenance

Use the **Resource Association** tab in **Scheduling Location Maintenance** to disassociate a resource member from a scheduling location.

Before you begin

You must have **Enable Visit Type** selected on the **Visit Type** tab in **Practice Options** or **Organization Options** to access the **Resource Association** tab.

1. Go to **System Administration > File Maintenance > Scheduling Location Maintenance** or press **F9** and then enter **SLM**.
2. Click the **Resource Association** tab.
3. Click  to open **Select Scheduling Location**.
4. Select the scheduling location you want to edit.
5. Click **OK**.
The grid displays the resource members currently associated with the scheduling location.
6. Click on the row containing the resource members you would like to disassociate from the scheduling location.
7. Click  to delete the row from the **Resource Members** grid.
8. Click **Save**.

Scheduling Override Reason Maintenance window

Use **Scheduling Override Reason Maintenance** to create override codes in **Non Credentialed Provider** to continue scheduling an appointment when a resource fails provider credentialing.

Scheduling Override Reason Maintenance is available when **Warn Based on Credentialing** is selected on the **Scheduling** tab in **Practice Options** or **Organization Options**.

Scheduling Override Reason Maintenance contains the following tabs:

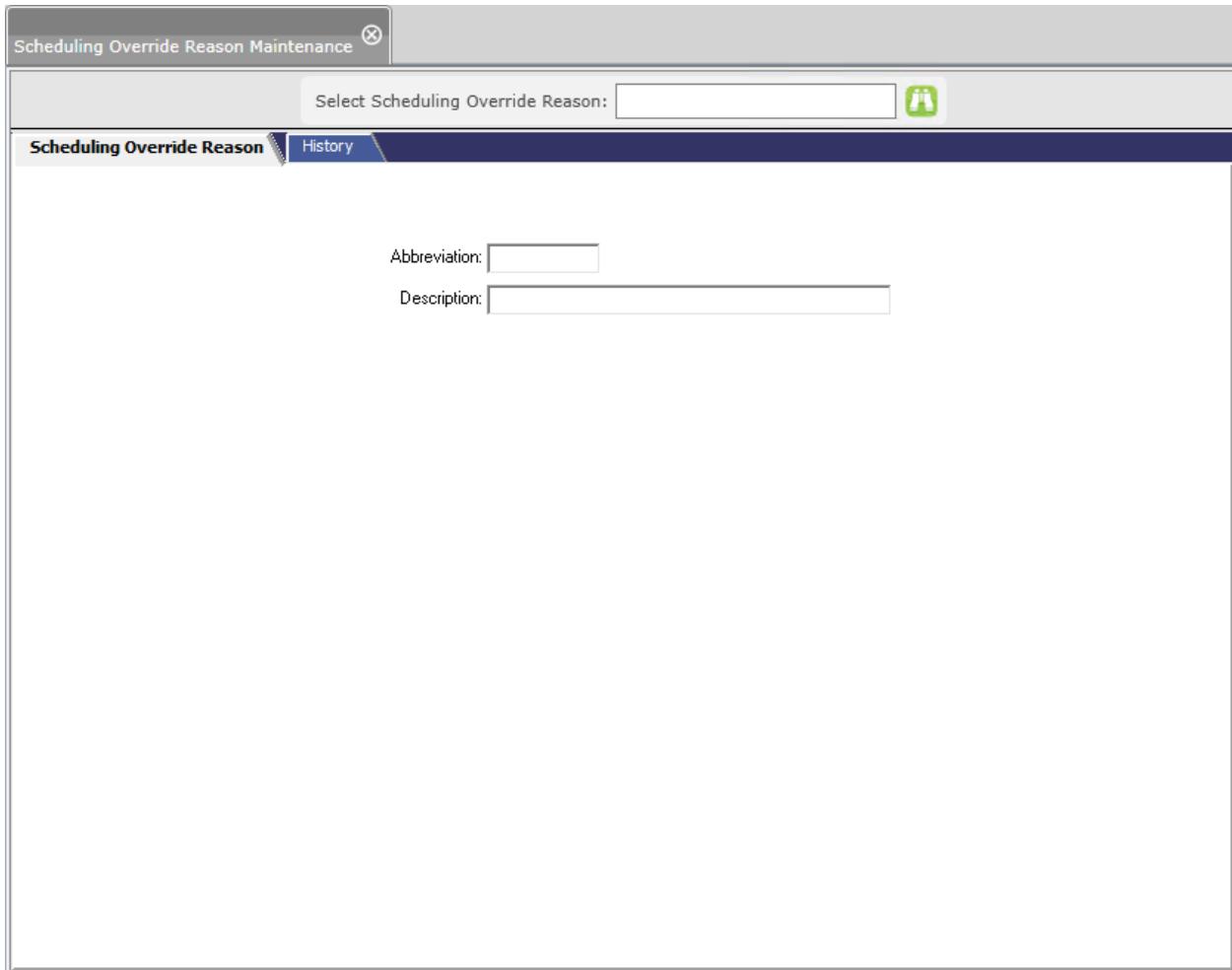
- > **Scheduling Override Reason**
- > **History**

To access **Scheduling Override Reason Maintenance**, go to **System Administration > File Maintenance > Scheduling Override Reason Maintenance** or press **F9** and then enter **SOR**.

Scheduling Override Reason tab

Use the **Scheduling Override Reason** tab in **Scheduling Override Reason Maintenance** to enter criteria to define scheduling override codes to select in **Non Credentialed Provider** to continue scheduling an appointment when a resource fails provider credentialing.

Access the **Scheduling Override Reason** tab from **Scheduling Override Reason Maintenance**. To access **Scheduling Override Reason Maintenance**, go to **System Administration > File Maintenance > Scheduling Override Reason Maintenance** or press **F9** and then enter **SOR**.



Abbreviation

Required. Enter an abbreviation for the scheduling override reason. Each scheduling override reason must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the scheduling override reason.

Note: Make the description unique, so that it is not confused with other scheduling override reasons.

Cancellation Reason Maintenance window

Cancellation Reason Maintenance enables you to record the moving or bumping of an appointment. Cancellation reasons are stored as part of the appointment detail.

Beside the obviously cancelled appointment, you can direct Allscripts® Practice Management to recognize two other instances when an appointment is given the status of cancelled. That is when an appointment is "Bumped" or "Moved".

When you check one or both scheduling options in **System Administration > Practice Options** or **Organization Options**, a record of the moving or the bumping of an appointment is kept on the Appointment Detail.

The moved or bumped appointment is given the status of cancelled.

Cancellation reasons are available for your selection from the combo box found on the following screens:

- > **Cancel Appointment**
- > **Bump Appointment**
- > **Accept Re-Block** (when the re-blocking of existing appointments results in one or more appointments being bumped)
- > **Bumped Linked Appointment** (when you bump a linked appointment using the right click menu on the **Appointment Book**, **Appointment Management**, and the **Appointment Activity** tabs in **Scheduling > Appointment Scheduling**)
- > **Appointment Detail**

Note: The field label name is programmed to toggle between **Cancel Reason** and **Bump Reason**. The field name is determined by the status selected.

Example 1: Cancel Reason - This is the screen default.

Example 2: Bump Reason - Field name toggles when you check the Appointment Status Bumped.

Create Cancellation Reasons that you can use to help you track why appointments are cancelled or bumped.

You can report on this field using the vwGenPatApptInfo general view.

Examples of Typical Cancellation Reasons are:

- > Cancelled by Patient
- > Cancelled per Doctor
- > Rescheduled per Doctor
- > Rescheduled per Patient

- > Bumped and Rescheduled
- > Bumped Scheduling Change
- > Moved Rescheduled per Patient
- > Moved Rescheduled per Dr

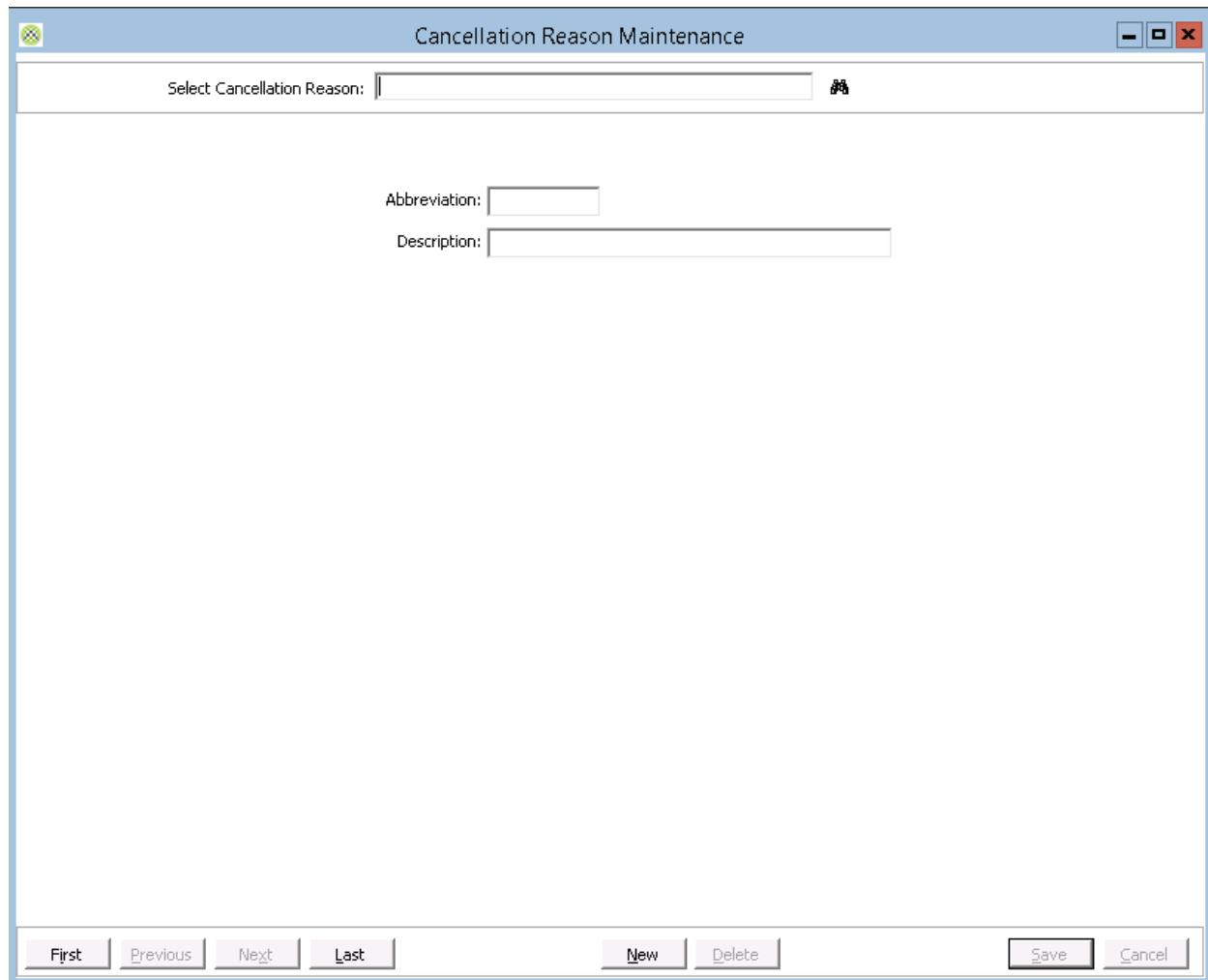
Your list of reasons should include those which best apply to your Practice.

Tip: If you intend to retain moved and bumped appointments as cancelled be sure to create a reason for each that you can use as a default in Scheduling Options.

Cancellation/Bumped Reasons are stored as part of the Patient's Appointment Detail.

Access **Cancellation Reason Maintenance** from **System Administration > File Maintenance > Cancellation Reason Maintenance**.

Tip: To quickly access **Cancellation Reason Maintenance**, press **F9**, then enter **CRM**.



Abbreviation

Accepts up to eight characters.

Description

Accepts up to 40 characters.

Displays as a selection on the following screens

- > **Cancel Appointment**
- > **Bump Appointment**
- > **Accept Re-Block**

(when the re-blocking of existing appointments results in one or more appointments being bumped)

- > **Bumped Linked Appointment**

(when you bump a linked appointment using the right click menu on the **Appointment Book**, **Appointment Management**, and the **Appointment Activity** tabs in **Scheduling > Appointment Scheduling**)

> **Appointment Detail**

Note: The field label name is programmed to toggle between **Cancel Reason** and **Bump Reason**. The field name is determined by the status selected.

Example 1: Cancel Reason - This is the screen default.

Example 2: Bump Reason - Field name toggles when you check the Appointment Status Bumped.

Contact Maintenance window

Use **Contact Maintenance** to store contact information for workers' compensation cases.

Contact Maintenance contains these tabs:

- > **Contact**
- > **History**

Contact Maintenance is not included in replication or starter data sets.

To access **Contact Maintenance**, go to **System Administration > File Maintenance > Contact Maintenance**, or press **F9** and then enter **COM**.

Contact tab

Use the **Contact** tab in **Contact Maintenance** to store contact information for workers' compensation cases.

Access the **Contact** tab from **Contact Maintenance**. To access **Contact Maintenance**, go to **System Administration > File Maintenance > Contact Maintenance**, or press **F9** and then enter **COM**.

Contact Maintenance X

Select Contact: 

Contact  History

Last Name:	<input type="text"/>	Primary Phone:	<input type="text"/>	Ext:	<input type="text"/>
First, MI:	<input type="text"/> <input type="checkbox"/>	Title:	<input type="text"/>	Secondary Phone:	<input type="text"/> Ext: <input type="text"/>
Address 1:				Fax:	<input type="text"/>
Address 2:				E-Mail:	<input type="text"/>
City:	<input type="text"/>	State:	<input type="button" value="▼"/>	Inactivation Date:	<input type="text"/> <input type="button" value="▼"/>
Zip Code:	<input type="text"/>	Country:	<input type="text"/>		

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Demographic information

Last name and first name are required.

Contact information

A phone number, fax numbers, and email address.

Inactivation Date

The date when the contact became (or will become) inactive.

Appointment Message Maintenance window

Appointment messages are used as reminders in **Scheduling**.

When applicable, an appointment message is displayed. After you have selected the appointment type, click on one of the following command buttons on the **Patient Scheduling**:

- > **Walk In**
- > **Link Appts**
- > **Open Times**
- > **Use Book**

On the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs, the message displays from any one of the **Schedule Appointment** windows; after you have selected the appointment type, click **OK**.

Access **Appointment Message Maintenance** from **System Administration > File Maintenance > Appointment Message Maintenance** or press **F9** and then enter **AMM**.

Appointment Message Maintenance

Select Appointment Message:

Abbreviation:

Description:

Notes:

Is Covered

Insurance Carrier:

Appointment Type:

First Previous Next Last New Delete Save Cancel

Abbreviation

Accepts up to 8 characters.

Description

Accepts up to 40 characters.

Displays on the appointment message.

Notes

Accepts up to 250 characters of free text.

Displays in the notes grid on the Appointment Message dialog.

Is covered

Cleared by default.

When cleared, the appointment message displays the indication Not Covered.

Insurance carrier/group

Left blank triggers the appointment message to display for all carriers.

Displays this message when the carrier associated with the coverage type selected for the appointment matches the message's defined carrier or is a member of the defined insurance group and when the selected appointment type matches the defined appointment type or is included in the defined appointment category.

Tip: Toggle the field label name using **Ctrl+down arrow**.

Appointment type/category/group

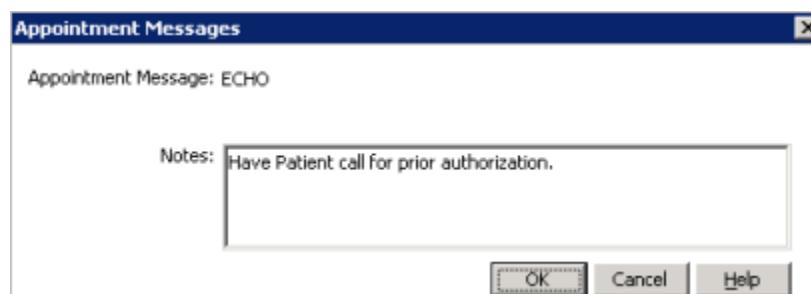
Click the down arrow or use **Ctrl+down arrow** to toggle the field label name to read Appointment Category or Appointment Group.

When left blank triggers the appointment message to display for all appointment types/categories/groups.

Selecting an Appointment Type restricts the display of this message to the specified type.

Selecting an Appointment Category restricts the display of this message to any of the appointment types that are included within a particular category.

Selecting an Appointment Group restricts the display of this message to any of the appointment types that are included within a particular group.



Appointment Restriction Maintenance window

Appointment Restriction Maintenance enables you to set and control restrictions by appointment category or appointment type for one or more resources and scheduling departments.

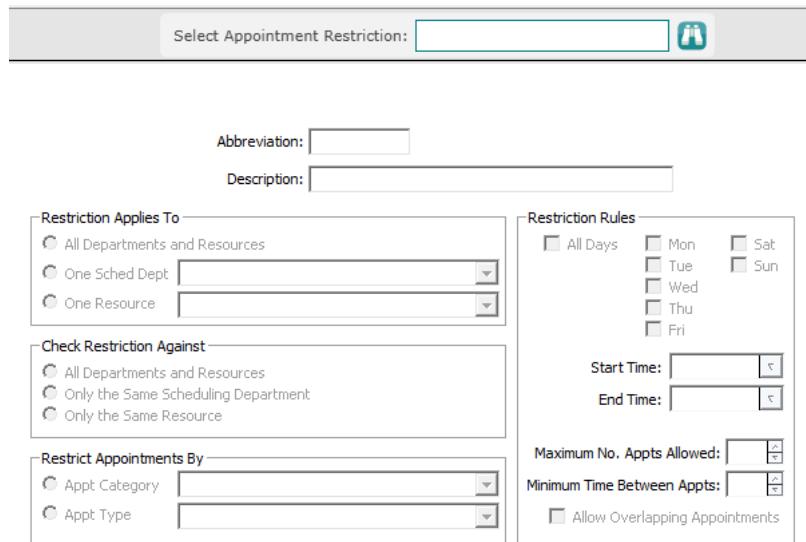
Important: Appointment restrictions become active as soon as you create them. You do not have to re-block existing schedules.

Before creating an appointment restriction, take some time to think through the restrictions that you want to apply. Ask yourself the following questions:

- > Do the restrictions apply to all resources and departments?
- > Are these restrictions against all or certain resources or departments?
- > Are the restrictions against certain appointment types or categories?
- > Are the restrictions to apply for all blocked days?
- > What time period is covered by the restrictions?
- > How many appointments can be included within the restricted time period?
- > Must you schedule an interval between appointment types?
- > Can appointments overlap?

Access **Appointment Restriction Maintenance** from **System Administration > File Maintenance**.

Tip: To quickly access **Appointment Restriction Maintenance**, press **F9** and then enter **ARM**.



The screenshot shows the 'Appointment Restriction Maintenance' form. At the top, there is a search bar labeled 'Select Appointment Restriction:' with a magnifying glass icon. Below the search bar are two text input fields: 'Abbreviation:' and 'Description:'. Under 'Restriction Applies To', there are three radio button options: 'All Departments and Resources' (selected), 'One Sched Dept' (with a dropdown menu), and 'One Resource' (with a dropdown menu). Under 'Check Restriction Against', there are three radio button options: 'All Departments and Resources' (selected), 'Only the Same Scheduling Department', and 'Only the Same Resource'. Under 'Restriction Rules', there are several controls: a checkbox for 'All Days' with individual checkboxes for each day of the week (Mon through Sun); two time input fields for 'Start Time' and 'End Time'; two numeric input fields for 'Maximum No. Appts Allowed' and 'Minimum Time Between Appts'; and a checkbox for 'Allow Overlapping Appointments'.

Abbreviation

Enter a unique abbreviation for the appointment restriction. You can use up to eight alphanumeric characters.

Description

Enter a description for the appointment restriction. You can use up to 40 alphanumeric characters.

Restriction Applies To

Select the scheduling departments and resources whose appointments you want to restrict. The available options are:

All Departments and Resources

Restrict appointments for all resources in all scheduling departments.

One Sched Dept

Restrict appointments for all resources that are in a specific scheduling department.

One Resource

Restrict appointments for a specific resource that is in one or more scheduling departments.

When scheduling appointments for the selected scheduling departments and resources, restricted appointment slots are always displayed on the **Appointment Book** tab in **Scheduling > Appointment Scheduling**. However, you can also display them on **Open Times** and **Recurring Times** as accessed from **Scheduling > Appointment Scheduling > Patient Scheduling** tab.

To display restricted appointment slots on **Open Times** and **Recurring Times**, select the **Show Restricted Slots in Open Times** option on **System Administration > Practice Options** or **Organization Options**. When selected, restricted appointment slots are displayed in grey on **Open Times** and **Recurring Times**.

Tip: Regardless whether the **Show Restricted Slots in Open Times** option is selected, you can use **Force Appointment** to schedule an appointment in a restricted appointment slot on the **Appointment Book** tab or **Open Times**. When you force the appointment, the following message is displayed: "Appointment is restricted by other appointments. Force into this time slot?"

Check Restriction Against

Select which schedules you want to check restrictions against when querying available appointment slots in **Scheduling > Appointment Scheduling** on:

- > **Open Times** (as accessed from the **Patient Scheduling** tab)
- > **Recurring Times** (as accessed from the **Patient Scheduling** tab)
- > **Appointment Book** tab

Important: Available appointment slots only include those that qualify based on the applicable restriction rules for the appointment.

The options for **Check Restriction Against** are:

- > **All Departments and Resources**
- > **Only the Same Scheduling Department**
- > **Only the Same Resource**

Note: If **All Departments and Resources** is selected for **Restriction Applies To**, the application checks for any appointment slots that qualify, regardless which option you select for **Check Restriction Against**.

All Departments and Resources

The following table describes how this option functions with the **One Sched Dept** and **One Resource** options for **Restriction Applies To**.

If	And	Then
One Sched Dept is selected for Restriction Applies To .	Resource is blank on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for all resources within the one scheduling department.
One Sched Dept is selected for Restriction Applies To .	A resource is selected on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for the selected resource within the one scheduling department.
One Resource is selected for Restriction Applies To .	Scheduling Department is blank on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots within all the scheduling departments where the one resource is included on the Department Members tab in System Administration > File Maintenance > Resource Maintenance .
One Resource is selected for Restriction Applies To .	A scheduling department is selected on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for the one resource within the selected scheduling department.

Only the Same Scheduling Department

The following table describes how this option functions with the **One Sched Dept** and **One Resource** options for **Restriction Applies To**.

If	And	Then
One Sched Dept is selected for Restriction Applies To.	Resource is blank on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for all resources within the one scheduling department.
One Sched Dept is selected for Restriction Applies To.	A resource is selected on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for the selected resource within the one scheduling department.
One Resource is selected for Restriction Applies To.	Scheduling Department is blank on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots within all the scheduling departments where the one resource is included on the Department Members tab in System Administration > File Maintenance > Resource Maintenance .
One Resource is selected for Restriction Applies To.	A scheduling department is selected on the Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for the one resource within the selected scheduling department.

Only the Same Resource

The following table describes how this option functions with the **One Sched Dept** and **One Resource** options for **Restriction Applies To.**

If	And	Then
One Sched Dept is selected for Restriction Applies To.	Resource is blank on Scheduling > Appointment Scheduling > Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for all resources within the one scheduling department.
One Sched Dept is selected for Restriction Applies To.	A resource is selected on Scheduling > Appointment	The application checks for qualifying appointment slots

If	And	Then
	Scheduling > Patient Scheduling tab (or Appointment Book tab).	for the selected resource within the one scheduling department.
One Resource is selected for Restriction Applies To.	Scheduling Department is blank on Scheduling > Appointment Scheduling > Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots within all the scheduling departments where the one resource is included on the Department Members tab in System Administration > File Maintenance > Resource Maintenance .
One Resource is selected for Restriction Applies To.	A scheduling department is selected on Scheduling > Appointment Scheduling > Patient Scheduling tab (or Appointment Book tab).	The application checks for qualifying appointment slots for the one resource within the selected scheduling department.

Restrict Appointments By

Select which appointments you want to restrict based on their appointment type or their appointment category.

Restriction Rules

Define rules for scheduling appointments that have the selected appointment type or category.

Days of the week

Select which days of the week that restricted appointments can occur.

Start Time and End Time

Specify a time range during which restricted appointments can occur.

Maximum No. of Appts Allowed

Define how many restricted appointments can occur during the specified time range and days of the week.

Minimum Time Between Appts

Define how many minutes must lapse between restricted appointments.

Note: For example, if you want to have a five-minute break between appointments, enter 5.

Allow Overlapping Appointments

Enable the ability to schedule back-to-back restricted appointments.

Important: When you select **Allow Overlapping Appointments**, **Minimum Time Between Appts** is automatically set to 0.

Example Appointment Restriction

A provider may want to set restrictions on certain appointment types. They may want these restrictions applied only on certain days or certain segments of a day type.

For example, every Monday, Wednesday, and Friday morning between 8:30 and 11:45 am, Dr. Provider Allscripts wants to:

- > Schedule a maximum of two 30-minute physical exams
- > Use any remaining available appointment slots to schedule 15-minute office visits
- > Allow a break of at least 15-minutes between the appointments

To achieve this, do the following:

1. In **System Administration > File Maintenance > Appointment Type Maintenance**, create two appointment types: **Physical Exam** and **Office Visit**.
 - a. For the **Physical Exam** appointment type, set the duration to 30 minutes
 - b. For the **Office Visit** appointment type, set the duration to 15 minutes.
2. In **System Administration > File Maintenance > Activity Type Maintenance**, create an activity type that includes the **Physical Exam** and **Office Visit** appointment types.
3. In **System Administration > File Maintenance > Day Type Maintenance**, create a day type that has time slots from **08:30 AM** to **11:45 AM** blocked for the activity type you created.
4. In **System Administration > File Maintenance > Appointment Restriction Maintenance**, set up an appointment restriction for Dr. Provider Allscripts.
 - a. For **Restriction Applies To**, select **One Resource**, then select **Dr. Provider** from the drop-down list.
 - b. For **Check Restriction Against**, select **Only the Same Resource**.
 - c. For **Restrict Appointments By**, select the **Physical Exam** appointment type.
 - d. Select **Mon, Wed, and Fri**.
 - e. For **Start**, enter **08:30 AM**.
 - f. For **End Time**, enter **11:45 AM**.
 - g. For **Maximum No. of Appts**, enter **2**.

- h. For **Minimum Time Between Appts**, enter 15.

Appt Confirmation Result Code Maintenance window

Appt Confirmation Result Code Maintenance comes with pre-loaded records for those clients using an Allscripts® Practice Management appointment reminder interface. These pre-loaded records match the codes most frequently used by West® (formerly Televox) in a result file.

Even if you are not using an appointment reminder interface you can create your own custom defined confirmation result code records, which you can use in **Scheduling and Appointment Management in Office Manager**.

You are also able to inactivate or edit any record whether it was manually created or pre-loaded.

Tip: To prevent the pre-loaded codes from displaying in drop downs, simply call up each pre-loaded record using **First** and **Next** and uncheck **Active** on these records.

Using the Televox Import: If a code comes in the .csv file that is not in this file maintenance, a new record is automatically created. The descriptions on the new code defaults to “Unknown.” This is what you see in your drop downs and in the related columns.

Not Using the Televox Import: You can create your own custom defined confirmation result code records, which you can use in **Scheduling and Appointment Management in Office Manager**.

Setting security permissions

You can deny or limit a user's access to **Appt Confirmation Result Code Maintenance** in **Administration > Security Manager > Security Permissions**. Permissions for **Appt Confirmation Result Code Maintenance** are located under **Practice Management > System Administration > File Maintenance > Scheduling > Appt. Confirmation Result Code**.

Access **Appt Confirmation Result Code Maintenance** from **System Administration > File Maintenance > Appt Confirmation Result Code Maintenance** or press **F9** and then enter **CCM**.

Appt. Confirmation Result Code Maintenance

Select Confirmation Result Code:

Confirmation Result Code:

Short Description:

Long Description:

Active

First Previous Next Last New Delete Save Cancel

Confirmation result code

Enter an abbreviation.

This field is labeled for a code, as this is where the code used by West® is inserted when you are using the export/import utility.

Short description

Enter a short description of the call result. For example, "Called. No answer." The short description is displayed in drop-down box lists in **Scheduling** and **Appointment Management** in **Office Manager**.

Long description

Enter either a repeat of the short description or a lengthier note. The long description is displayed in the column **Call Confirmation Result** on **Appointment Activity** and in your **Appointment Management** workspace in **Office Manager**.

Active

Check this box to activate a code. Clear this box to deactivate a code.

User workstation defaults

You can set user and workstation defaults for scheduling, batches, and printers.

The defaults apply only for the user logged on at the time the defaults are selected.

These settings are workstation specific.

The defaults auto-fill in the corresponding boxes on the scheduling windows.

When a resource is selected as a default and the scheduling option **Def to Usual Provider** is also selected, the user and workstation default takes precedence.

Return to the Scheduling tab in Practice Options or Organization Options

Return to the scheduling options to select the default reason codes for bumped and for move appointments to be retained as cancelled.

Access the **Scheduling** tab from **Practice Options** or **Organization Options**. To access **Practice Options** or **Organization Options**, go to **System Administration > Practice Options >** or **Organization Options** and click **Scheduling** or press **F9** and then enter **POP** or **OOP**.

Chapter 17

Schedule Planning

Schedule Planning setup checklist

Before you can begin to schedule appointments, time must be blocked or defined for each combination of related scheduling, scheduling department, and resource.

All pieces of the scheduling file maintenances should be complete at this point.

Blocking time is assigning day types to actual calendar days. You can block time by calendar or criteria.

Use this checklist to record the completion of this scheduling activity.

Maintenance	Completed
Blocking time by calendar <ul style="list-style-type: none">> Block selected days> Custom block days	
Blocking time by criteria	
Defining global holidays	

Block Time by Calendar tab

Use the **Block Time by Calendar** tab to apply a day type or custom block to selected days on a resource's calendar. The day type or custom block determines which types of appointments and activities can be scheduled for that resource on the selected days.

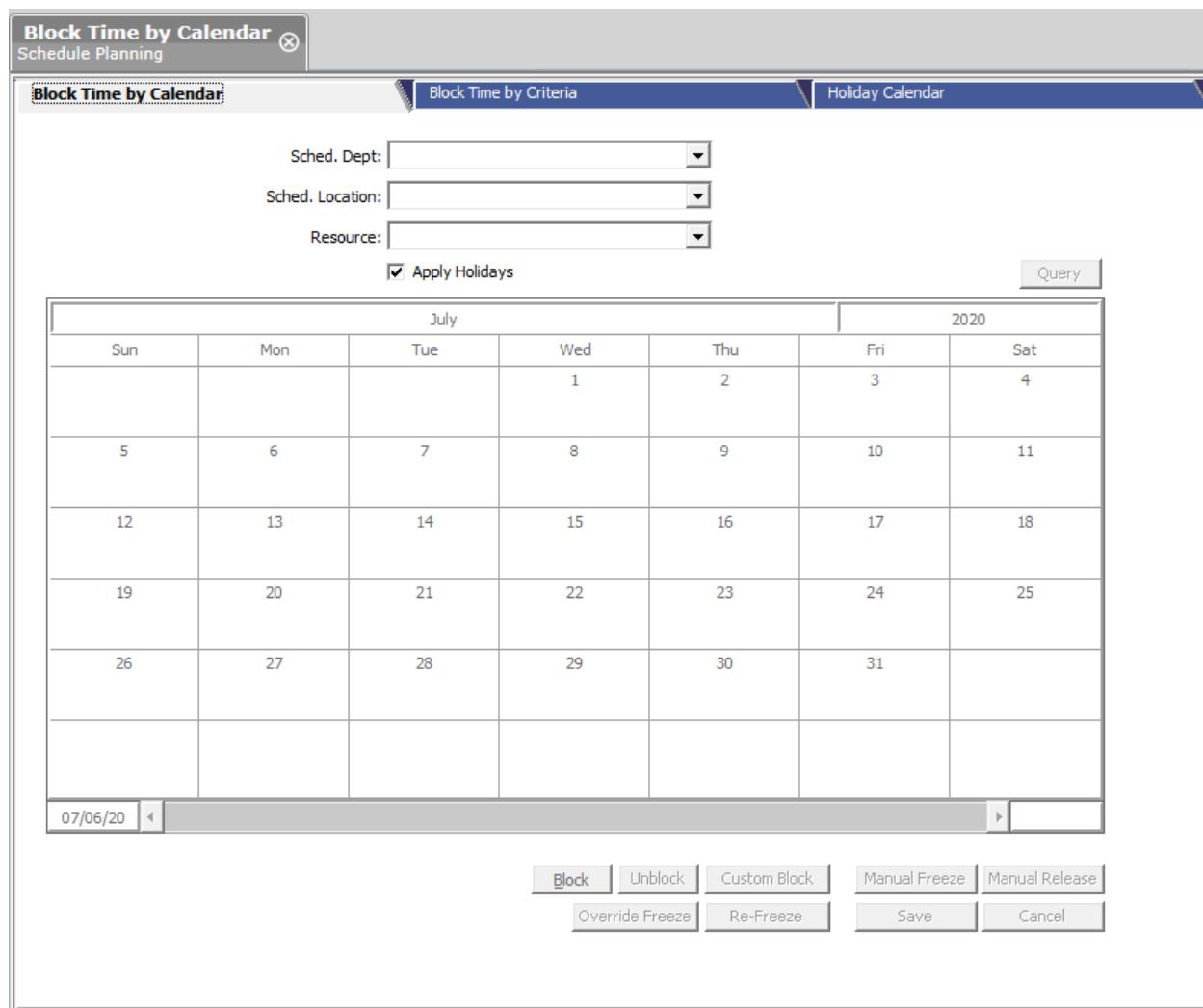
The **Block Time by Calendar** tab enables you to easily identify holidays, vacation time, conference days, and so on. It also enables you to preview the calendar before saving the definitions. To view these details, select a specific day.

Additionally, you can use the **Block Time by Calendar** tab to apply, override, or remove freeze rules.

Before you begin blocking time on this tab, you must block days for each combination of schedule location, department, and resource for which you need to book appointments. Also, have a list of all the day types you need for each combination.

Access the **Block Time by Calendar** tab on **Schedule Planning** in **Scheduling**.

Tip: To quickly access **Schedule Planning**, press **F9**, then enter **SCP**.



The screenshot shows the 'Block Time by Calendar' window. At the top, there are three tabs: 'Block Time by Calendar' (selected), 'Block Time by Criteria', and 'Holiday Calendar'. Below the tabs are three dropdown menus: 'Sched. Dept:', 'Sched. Location:', and 'Resource:'. A checkbox labeled 'Apply Holidays' is checked. A 'Query' button is located to the right of the calendar grid. The calendar itself displays the month of July 2020. The days are numbered 1 through 31. Below the calendar is a date navigation bar with '07/06/20' and arrows for navigating between months. At the bottom of the window are several buttons: 'Block', 'Unblock', 'Custom Block', 'Manual Freeze', 'Manual Release', 'Override Freeze', 'Re-Freeze', 'Save', and 'Cancel'.

Sched Dept

This box displays your workstation default (if applicable). Accept the default or select a department.

Sched Location

This box displays your workstation default (if applicable). Accept the default or select a location.

Resource

This box displays your workstation default (if applicable). Accept the default or select a resource.

Apply Holidays

When you select this option and click **Query**, the calendar displays the day type followed by **(H)** in red font to indicate all holidays that are defined on the **Holiday Calendar** tab.

After clicking **Save**, all holidays defined on the **Holiday Calendar** tab are associated with the selected resource. If you do not select **Apply Holidays** for the selected resource, then days marked as holidays on the **Holiday Calendar** tab are ignored when blocking time by calendar.

Query

After you enter the resource, scheduling department, and scheduling location, click **Query** to retrieve and activate the applicable calendar. After the calendar is retrieved, you are able to unblock and re-block days, custom block days, or block additional days related to the selected resource at the specified scheduling location and department.

By default, when you click **Query**, the calendar displays the current month with the focus on the current date.

To move the calendar forward by one month, use the  . To move the calendar back by one month, use  .

To move the calendar forward by a year, click to the right of the marker on the scroll bar.

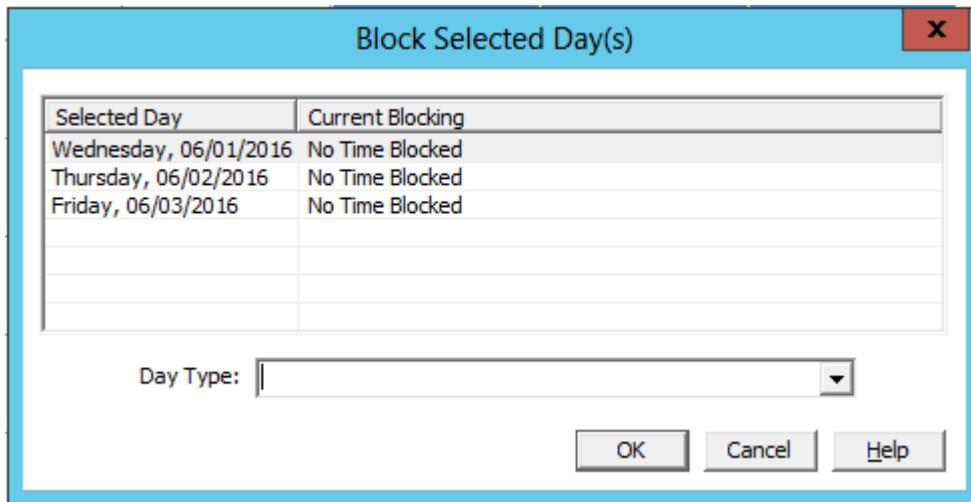


To move the calendar back by a year, click to the left of the scroll bar marker.



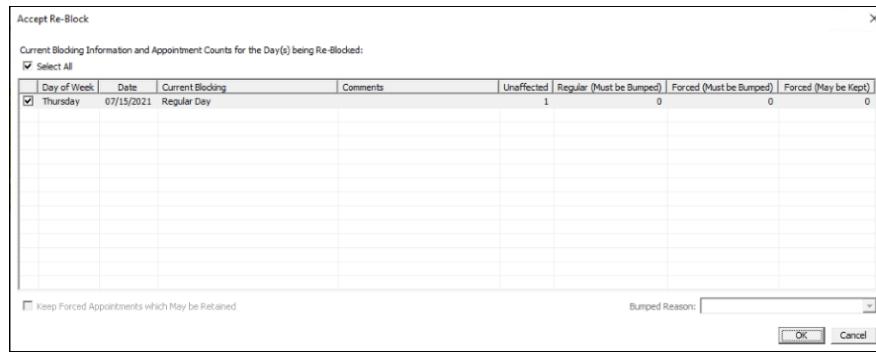
Block

After you select calendar days to block using the same day type, click **Block** to open **Block Selected Day(s)**.



For **Day Type**, select a day type that applies to all of the dates selected and click **OK**. You can also use this functionality to assign a different day type to a previously blocked day.

Note: If you try to re-block days that have previously scheduled or forced appointments, **Accept Re-Block** opens when you click **Save**. **Accept Re-Block** displays the appointment count for the days you are re-blocking. Click **OK** to continue.



Unblock

After you select dates on the calendar, click **Unblock** to either:

- > Clear a day of all appointments and make it unavailable
- > Clear a previously blocked day, then block the day and assign it a different day type

In both cases, when you unblock a day that includes previously scheduled or forced appointments, **Accept Re-Block** opens when you click **Save**. **Accept Re-Block** displays the appointment count for the days you are unblocking. Click **OK** to continue.

Custom Block

After you select dates on the calendar, select **Custom Block** to open **Custom Block Day(s)**. On **Custom Block Day(s)**, define a schedule that is unique to the circumstances and commitments of a particular day.

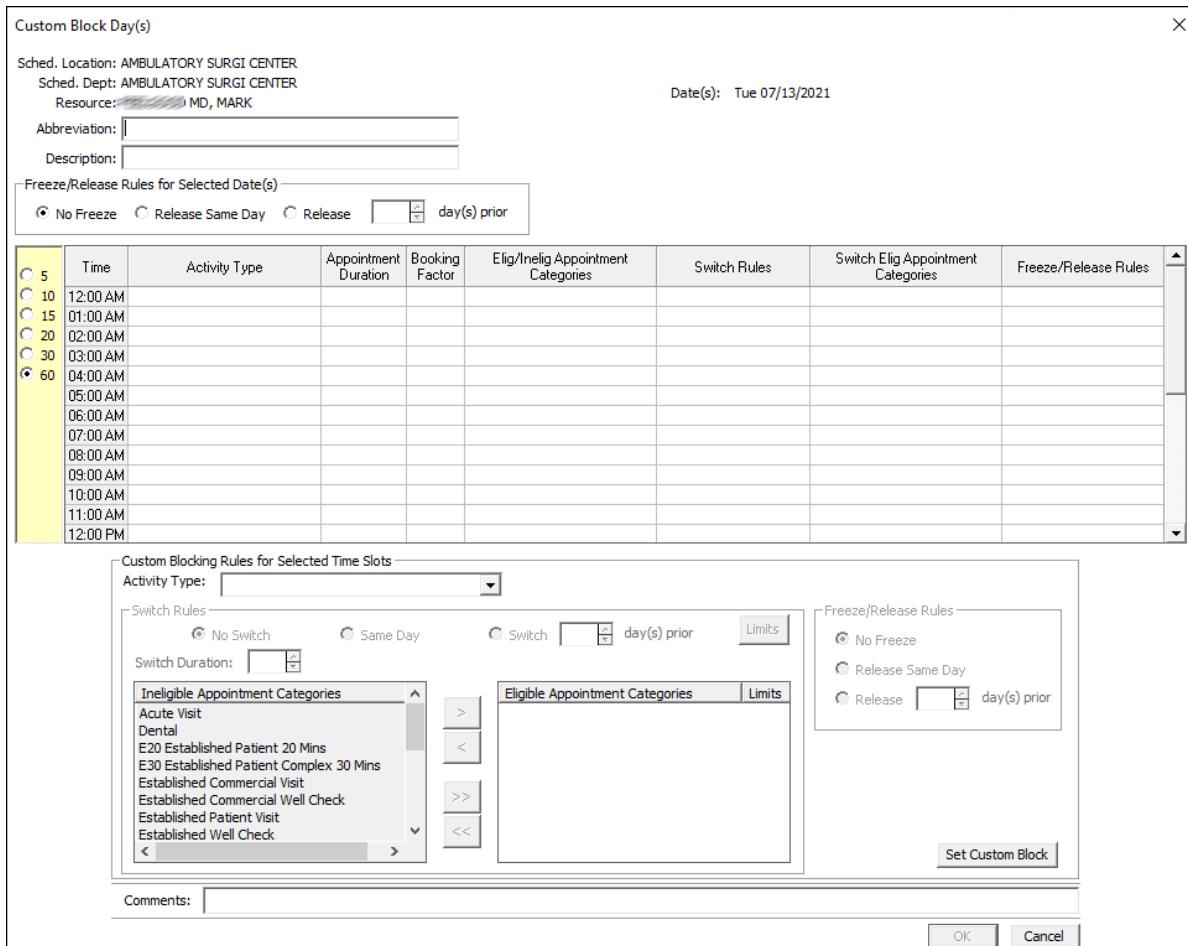
Tip: This option enables you to block a day without using your predefined day types. It is particularly useful if you need to create a unique schedule for only a few days because a custom block template applies only to the selected day or days. The application does not save the custom block template as a record in **Day Type Maintenance**. Therefore, the custom block template is not available as a day type when blocking days.

You can custom block:

- > Multiple days at a time
- > One or more time slots of a previously blocked day

When you select a previously blocked day to custom block, the current activity types defined for the day fill the window. Activity types are defined in **Activity Type Maintenance**.

Figure 6: Custom Block Day(s) window



The screenshot shows the 'Custom Block Day(s)' window. At the top, it displays scheduling details: Sched. Location: AMBULATORY SURGI CENTER, Sched. Dept: AMBULATORY SURGI CENTER, Resource: MD, MARK, Date(s): Tue 07/13/2021. Below this, there's a section for 'Abbreviation:' and 'Description:'. A radio button group for 'Freeze/Release Rules for Selected Date(s)' includes 'No Freeze' (selected), 'Release Same Day', and 'Release [] day(s) prior'. The main area is a grid of time slots from 5 AM to 12:00 PM. Each slot has a radio button next to its number. The 6:00 AM slot is selected. To the right of the grid are columns for 'Time', 'Activity Type', 'Appointment Duration', 'Booking Factor', 'Elig/Inelig Appointment Categories', 'Switch Rules', 'Switch Elig Appointment Categories', and 'Freeze/Release Rules'. Below the grid, there's a 'Custom Blocking Rules for Selected Time Slots' section with dropdowns for 'Activity Type' and 'Switch Rules' (No Switch, Same Day, Switch [] day(s) prior). It also includes 'Ineligible Appointment Categories' and 'Eligible Appointment Categories' lists with mapping buttons (>, <, >>, <<). To the right is another 'Freeze/Release Rules' section with radio buttons for 'No Freeze', 'Release Same Day', and 'Release [] day(s) prior'. At the bottom are 'Comments:' and 'Set Custom Block' buttons, followed by 'OK' and 'Cancel' buttons.

After a day is custom blocked, comments for the custom block are displayed on:

- > **Find Open Times**
- > **Block Time by Calendar tab**
- > **Find Recurring Times**

In addition, the abbreviation for the custom blocked day is displayed followed by **(C)**. If there is no abbreviation for the custom block, **Custom** is displayed.

Manual Freeze

When freeze rules are defined in **Activity Type Maintenance** or **Day Type Maintenance**, select one or more days on the calendar and click **Manual Freeze**. **(FRZ)** is displayed in the upper-right corner of each day to indicate that the entire day is frozen.

Manual Release

Click this button to make manually frozen days available for scheduling again, select the days on the calendar and click **Manual Release**. After you manually release a day, time slots with activity type freeze rules remain frozen.

Override Freeze

Click this button to make frozen days available for appointment scheduling, select the days and click **Override Freeze**. After you override a frozen day, **(OFZ)** is displayed in the upper-right corner of the days that had freeze rules overridden.

Re-Freeze

Click this button to re-freeze days after freeze rules were overridden, select the days and click **Re-Freeze**. After a day is re-frozen, **(FRZ)** is displayed in the upper-right corner of the days that had freeze rules reapplied.

Block Time by Criteria tab

Use the **Block Time by Criteria** tab to mass-block time for a range or group of days all at the same time.

The length of time it takes to block days using this method depends on a number of factors, including:

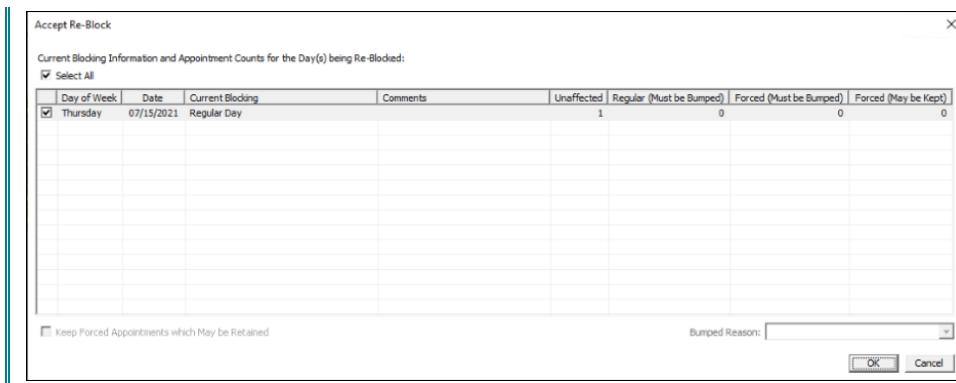
- > The date range you define
 - | **Note:** Divide the job into small increments of time.
- > The number of different day types you select
- > Other network activity going on simultaneously

When blocking days for an extensive period of time, be sure no one else is running large jobs such as batch printing statements, billing insurance claims, batch printing encounters forms, and so forth.

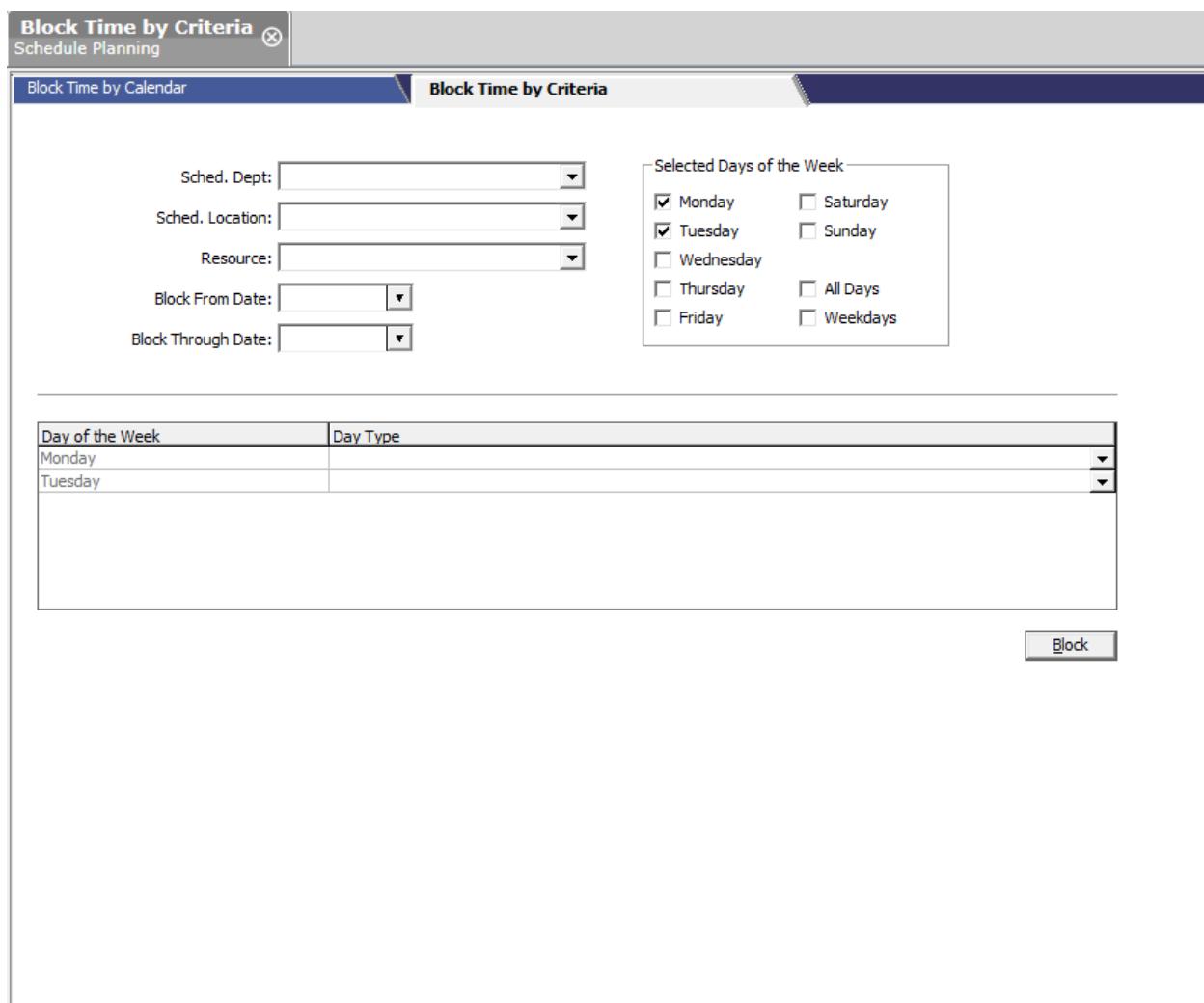
Note:

If you try to reblock days for which previously scheduled or forced appointments exist, **Accept Re-Block** opens when you click **Save**, displaying the appointment count for the days you are reblocking. Click **OK** to continue.

Chapter 17 Schedule Planning



Access the **Block Time by Criteria** tab from **Schedule Planning**. To access **Schedule Planning**, go to **Scheduling > Schedule Planning** or press **F9** and then enter **SCP**.



The interface shows the **Block Time by Criteria** tab selected. The left panel contains fields for:

- Sched. Dept: [dropdown]
- Sched. Location: [dropdown]
- Resource: [dropdown]
- Block From Date: [dropdown]
- Block Through Date: [dropdown]

The right panel includes a "Selected Days of the Week" section with checkboxes:

<input checked="" type="checkbox"/> Monday	<input type="checkbox"/> Saturday
<input checked="" type="checkbox"/> Tuesday	<input type="checkbox"/> Sunday
<input type="checkbox"/> Wednesday	
<input type="checkbox"/> Thursday	<input type="checkbox"/> All Days
<input type="checkbox"/> Friday	<input type="checkbox"/> Weekdays

A table below lists "Day of the Week" and "Day Type" for Monday and Tuesday.

Day of the Week	Day Type
Monday	
Tuesday	

A "Block" button is located at the bottom right.

Sched. Dept.

The scheduling department to block time for.

Sched. Location

The scheduling location to block time for.

Resource

The resource to block time for.

Block From Date and Block Through Date

The span of days, inclusive, that the blocked time applies to.

Tip: To block a single day, enter the same date in both boxes.

Selected Days of the Week

Use this area to select which days to block time for. You can select specific days of the week, **All Days**, or **Weekdays**. When you select days in this area,

Apply Holidays

All days defined as holidays in **Holiday Calendar** are displayed on the calendar with a white background, with **Day Type** followed by **(H)** in red text. Upon clicking **Save**, all holidays are associated to the selected resource, but only for the months that you have scrolled. If the **Apply Holidays** check box is not checked for the selected resource, then days marked as holidays in **Holiday Calendar** are ignored when blocking time by calendar.

Grid

After you make selections on the upper half of the window, the grid fills with the days of the week that you are blocking time for. Use the area to block time by selecting which day type to use for each day from the list, or selecting **(Unblocked)** to unblock the day.

The selections you make in this area apply to all days of the week of that type in the date range you selected. For example, if you set the **Day Type** for **Monday** to **Patient Visit**, all of the Mondays in the range of dates you selected in **Block From Date** and **Block Through Date** would be blocked for patient visits.

Block

Click **Block** to apply the selections you made to the calendar.

Holiday Calendar tab

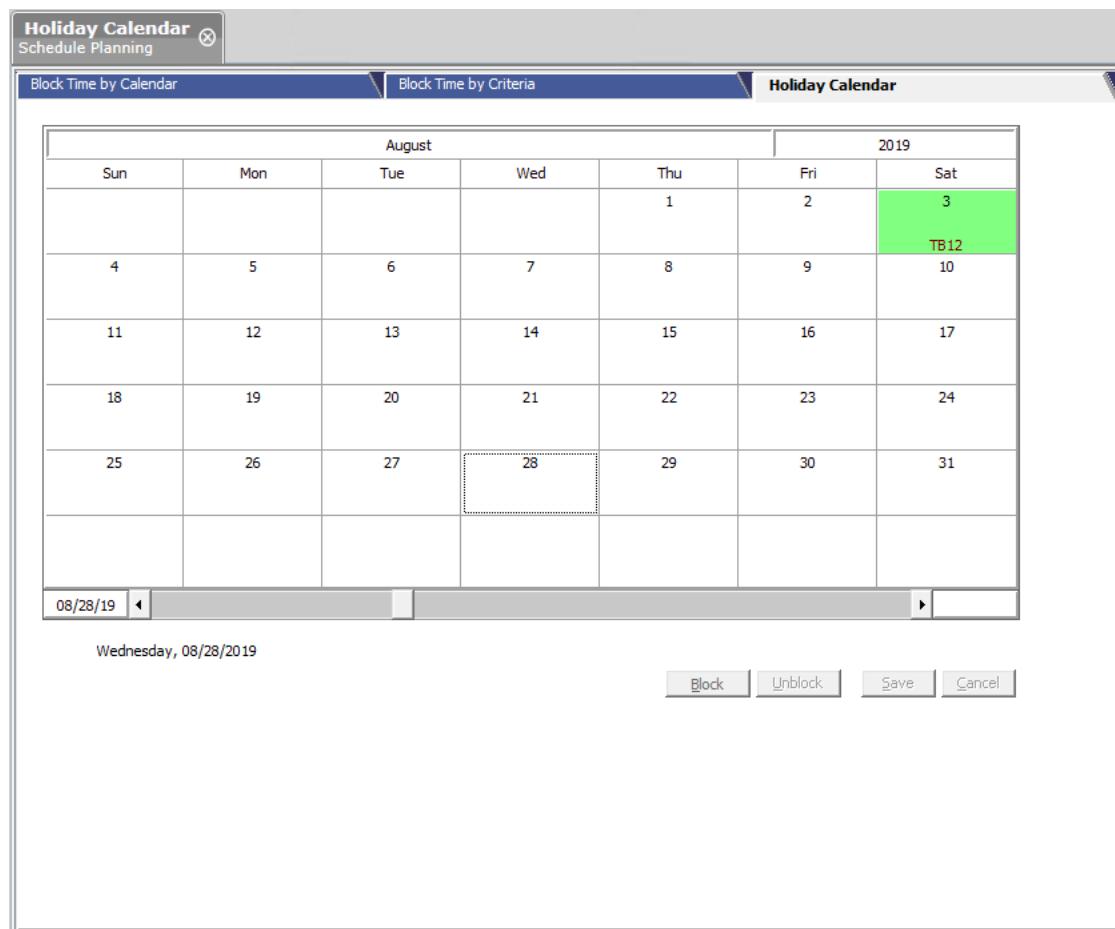
Use the **Holiday Calendar** to define a global holiday calendar for the tenant.

By default, the **Holiday Calendar** displays the current month, with the current date in focus.

When you block a holiday on the **Holiday Calendar** tab, the blocked date is displayed in green and includes the abbreviation for the holiday as defined on **Day Type Maintenance**.

Associating a day with a **Holiday Day Type** does not impact existing availability records or appointments.

Scheduling > Schedule Planning > Holiday Calendar



The following is available on **Holiday Calendar**:

Calendar

By default, the calendar displays the current month.

Block

Use **Block** to open **Block Selected Day(s)**.

Note:

When selected from **Holiday Calendar**, **Block Selected Day(s)** shows only days that are marked as holidays in **Day Type Maintenance**.

Unblock

Use **Unblock** to remove the associated day type from the day.



Chapter 17 Schedule Planning

Chapter 18

Address Override Reason File Maintenance

Address Override Reason File Maintenance setup checklist

Address Override Reason Maintenance relates to the creation of address override reason codes to select during address verification.

Use this checklist to record the completion of each maintenance record.

Maintenance	Completed
Address Override Reason Maintenance (AOR)	

Address Override Reason Maintenance window

Use **Address Override Reason Maintenance** to create address override reason codes to select in **Verify Address** during address verification.

Address Override Reason Maintenance contains the following tabs:

- > **Override Reason**
- > **History**

To access **Address Override Reason Maintenance**, go to **System Administration > File Maintenance > Address Override Reason Maintenance** or press **F9** and then enter **AOR**.

Override Reason tab

Use the **Override Reason** tab in **Address Override Reason Maintenance** to enter criteria to define address override reason codes to select in **Verify Address** during address verification.

Access the **Override Reason** tab from **Address Override Reason Maintenance**. To access **Address Override Reason Maintenance**, go to **System Administration > File Maintenance > Address Override Reason Maintenance** or press **F9** and then enter **AOR**.

Address Override Reason Maintenance ×

Select Address Override Reason: 

Override Reason  History

Abbreviation:

Description:

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Abbreviation

Required. Enter an abbreviation for the address override reason code. Each address override reason code must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters.

Description

Required. Enter a description for the address override reason code. Each address override reason code must have a unique description.

Chapter 19

Task File Maintenance

Task File Maintenance setup checklist

Task Maintenance relates to the creation of tasks to associate with entities, such as vouchers.

Use this checklist to record the completion of each task.

Maintenance	Completed
Task Maintenance (TKM)	

Task Maintenance window

Use **Task Maintenance** to define tasks that you want to associate with entities, such as vouchers, so that certain operators or groups of operators can complete the tasks.

You cannot delete a task in **Task Maintenance** after it has been associated with an entity or used in an **Assign To Task** action in **System Rule Manager**.

Task Maintenance contains these tabs:

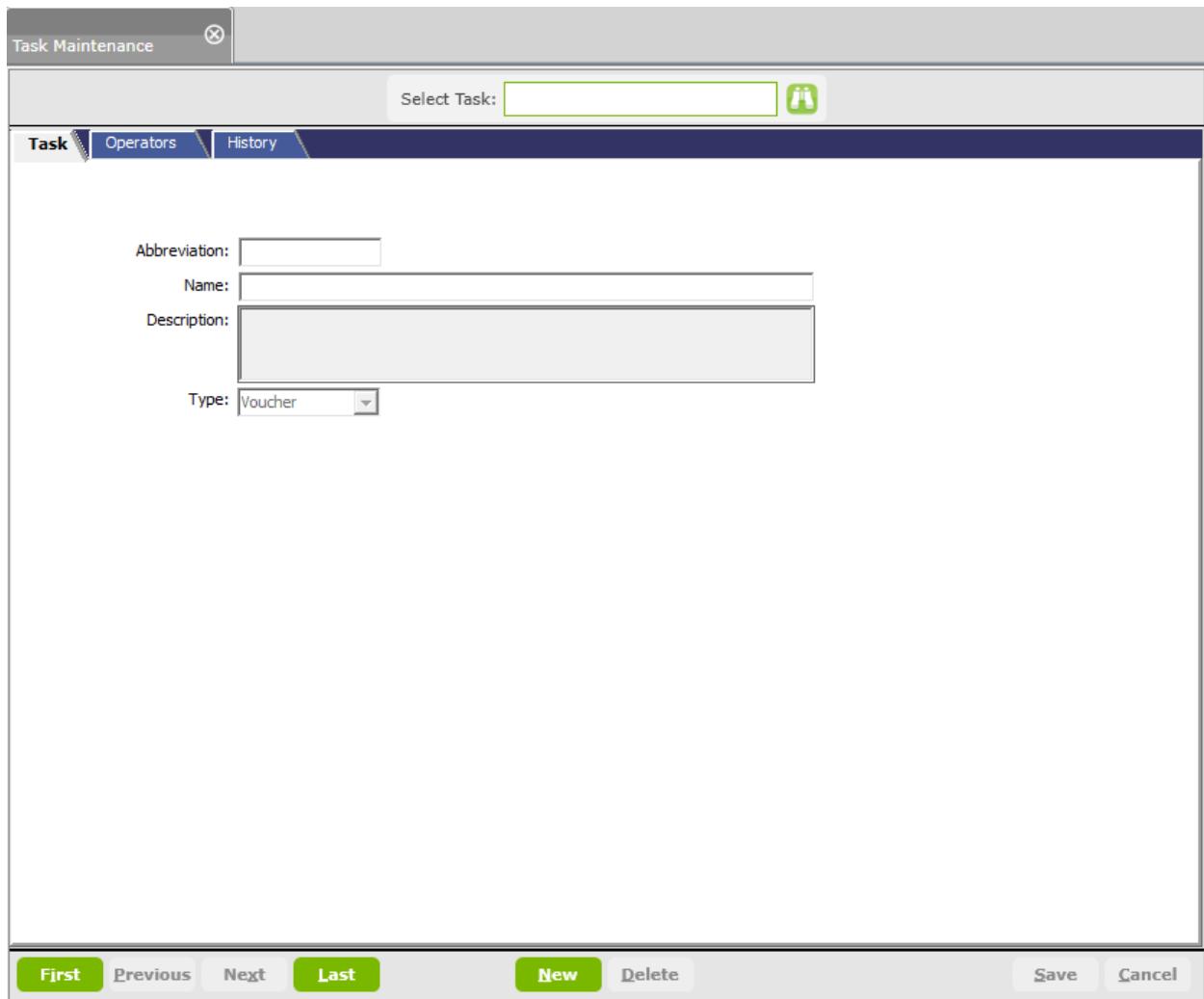
- > Task
- > Operators
- > History

To access **Task Maintenance**, go to **System Administration > File Maintenance > Task Maintenance**, or press **F9** and enter **TKM**.

Task tab

Use the **Task** tab in **Task Maintenance** to define tasks that you want to associate with entities, such as vouchers, so that certain operators or groups of operators can complete the tasks.

Access the **Task** tab from **Task Maintenance**. To access **Task Maintenance**, go to **System Administration > File Maintenance > Task Maintenance**, or press **F9** and then enter **TKM**.



The screenshot shows the 'Task Maintenance' window. At the top, there is a search bar labeled 'Select Task:' with a magnifying glass icon. Below the search bar is a navigation menu with tabs: 'Task' (which is selected), 'Operators', and 'History'. The main area contains four input fields: 'Abbreviation' (empty), 'Name' (empty), 'Description' (empty), and 'Type' (set to 'Voucher'). At the bottom of the window are navigation buttons: 'First', 'Previous', 'Next', 'Last', 'New' (highlighted in green), 'Delete', 'Save', and 'Cancel'.

Abbreviation

Required. Enter an abbreviation for the task record. Each task record must have a unique abbreviation.

Best Practice: Use only letters and numbers because the abbreviation cannot contain certain special characters. Make the abbreviation meaningful, so that you recognize the task by its abbreviation in other areas of the application.

Name

Required. Enter a name for the task record. This name is displayed in **System Rule Manager**.

Best Practice: Make the name unique, so that it is not confused with other task records.

Description

Required. Enter a description that explains the purpose of the task.

Type

This box is read-only and set to **Voucher**. In version 18.3, you can create only voucher tasks.

Operators tab in Task Maintenance

Use the **Operators** tab in **Task Maintenance** to relate operators to tasks.

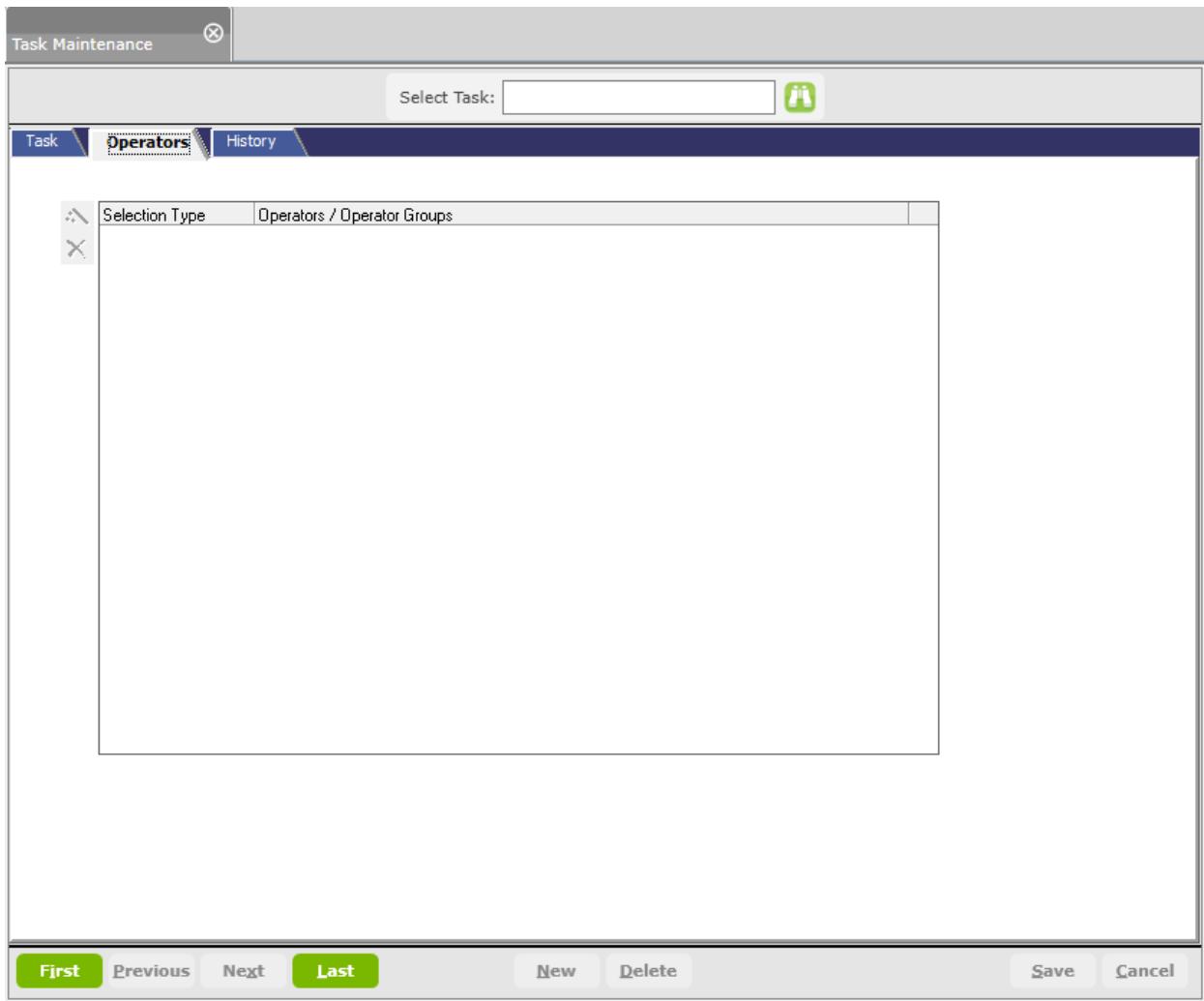
Operators can see tasks assigned to them in their **My Assigned Work** folder regardless of whether they are selected on the **Operators** tab. However, you must add at least one operator or operator group on this tab for the task to be visible in the **Voucher** folder in **Office Manager**.

For example, you might want Operator A to see only **Coding** tasks in the **Voucher** folder, Operator B to see only **Review** tasks, and Manager C to see both **Coding** and **Review** tasks.

The operators who are selected on this tab are not automatically assigned to this task.

If you select additional operators or operator groups after the task has been assigned, the newly added operators can see the task in **Voucher** folder.

Access the **Operators** tab from **Task Maintenance**. To access **Task Maintenance**, go to **System Administration > File Maintenance > Task Maintenance**, or press **F9** and then enter **TKM**.



Selection Type

Select **Operators** or **Operator Groups** from the list to determine the available options in the **Select Operators** window.

Operators/Operator Groups

Displays the operators or operator groups that are related to the task.

Blank column

Displays  when a row is activated and enables you to access **Select Operators**.

Chapter 20

Workers' Compensation Case Management

Workers' compensation case management setup checklist

You must complete setup configuration within Allscripts® Practice Management to use workers' compensation case management.

Use this checklist to configure your application for worker's compensation case management.

Task	Location	Completed
Optional. Define contact roles.	Go to System Administration > File Maintenance > Contact Role Maintenance .	
Optional. Define contacts.	Go to System Administration > File Maintenance > Contact Maintenance .	
Required if using Compensability Status . Define work-injury reason codes.	Go to System Administration > File Maintenance > Case Compensability Reason Maintenance .	
> Required. Define employers. > Optional: Define employer locations. > Optional: Define payers.	Go to System Administration > File Maintenance > Employer Maintenance .	

Task	Location	Completed
Required if using notes with workers' compensation cases. Define workers' compensation notes that you can attach to cases. Note: You must temporarily select Enable Workers' Comp Case on the Case tab in Practice Options or Organization Options before you can define workers' compensation case notes. After you have created workers' compensation notes, clear Enable Workers' Comp Case until you are ready to start creating workers' compensation cases.	Go to System Administration > File Maintenance > Note Type Maintenance .	
Required. > Enable visit types. > Define workers' compensation visit types.	> Go to System Administration > Practice Options > Visit Type or System Administration > Organization Options > Visit Type . > Go to System Administration > File Maintenance > Visit Type Maintenance .	
Required. > Define attributes for the Workers' Comp case type. > Select Enable Workers' Comp Case when you are ready to start creating workers' compensation cases.	Go to System Administration > Practice Options > Case or System Administration > Organization Options > Case .	

Case Compensability Reason Maintenance window

Use **Case Compensability Reason Maintenance** to create work-injury reason codes that support the compensability statuses on the **WC Case Management** tab in **Case Management**.

Case Compensability Reason Maintenance contains these tabs:

- > **Compensability Reason**

> History

Case Compensability Reason Maintenance is not included in replication or starter data sets. To access **Case Compensability Reason Maintenance**, go to **System Administration > File Maintenance > Case Compensability Reason Maintenance**, or press **F9** and then enter **CPM**.

Compensability Reason tab

Use the **Compensability Reason** tab in **Case Compensability Reason Maintenance** to create work-injury reason codes that support the compensability statuses on the **WC Case Management** tab in **Case Management**.

Access the **Compensability Reason** tab from **Case Compensability Reason Maintenance**. To access **Case Compensability Reason Maintenance**, go to **System Administration > File Maintenance > Case Compensability Reason Maintenance**, or press **F9** and then enter **CPM**.

Case Compensability Reason Maintenance X

Select Case Compensability Reason: [Search icon]

Compensability Reason History

Abbreviation:

Description:

First Previous Next Last New Delete Save Cancel

Abbreviation

Required. A unique abbreviation of up to 10 alphanumeric characters; avoid special characters.

Description

Required. A description of up to 40 characters.

|| Best Practice: Make the description unique.

Contact Role Maintenance window

Use **Contact Role Maintenance** to create the roles that contacts are assigned to in **Case Management**.

Contact Role Maintenance contains these tabs:

- > **Contact Role**
- > **History**

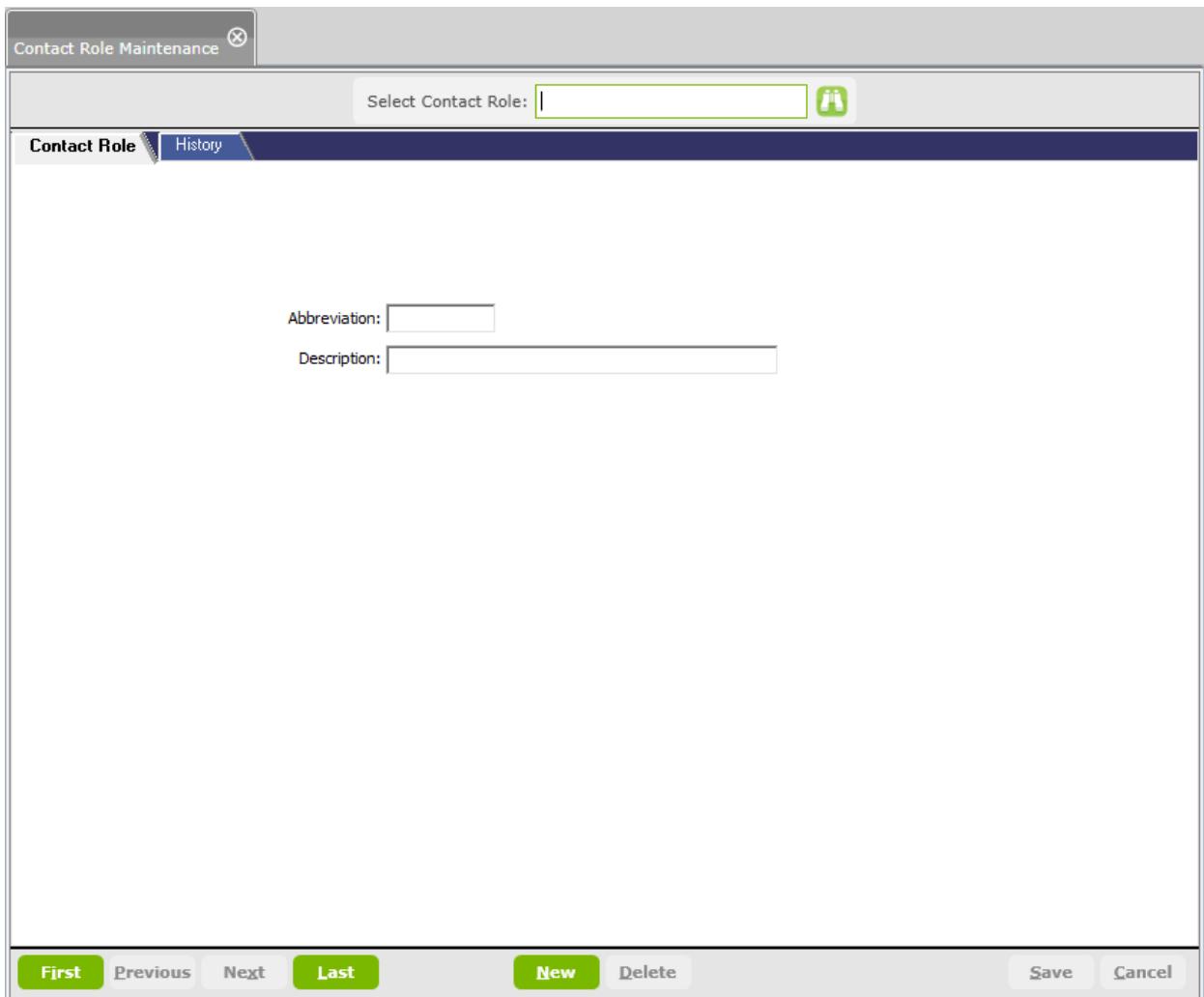
Contact Role Maintenance is not included in replication or starter data sets.

To access **Contact Role Maintenance**, go to **System Administration > File Maintenance > Contact Role Maintenance**, or press **F9** and then enter **CCR**.

Contact Role tab

Use the **Contact Role** tab in **Contact Role Maintenance** to create the roles that contacts are assigned to in **Comp Case Management**.

Access the **Contact Role** tab from **Contact Role Maintenance**. To access **Contact Role Maintenance**, go to **System Administration > File Maintenance > Contact Role Maintenance**, or press **F9** and then enter **CCR**.



Contact Role Maintenance ✖

Select Contact Role: []

Contact Role [] History

Abbreviation:

Description:

First Previous Next Last New Delete Save Cancel

Abbreviation

Required. A unique abbreviation of up to 8 alphanumeric characters; avoid special characters.

Description

Required. A description of up to 40 alphanumeric characters.

Best Practice: Make the description unique.

Contact Maintenance window

Use **Contact Maintenance** to store contact information for workers' compensation cases.

Contact Maintenance contains these tabs:

- > Contact
- > History

Contact Maintenance is not included in replication or starter data sets.

To access **Contact Maintenance**, go to **System Administration > File Maintenance > Contact Maintenance**, or press **F9** and then enter COM.

Contact tab

Use the **Contact** tab in **Contact Maintenance** to store contact information for workers' compensation cases.

Access the **Contact** tab from **Contact Maintenance**. To access **Contact Maintenance**, go to **System Administration > File Maintenance > Contact Maintenance**, or press **F9** and then enter COM.

Contact Maintenance X

Select Contact: 

Contact History

Last Name: <input type="text"/>	Primary Phone: <input type="text"/> Ext: <input type="text"/>
First, MI: <input type="text"/> <input type="checkbox"/> Title: <input type="text"/>	Secondary Phone: <input type="text"/> Ext: <input type="text"/>
Address 1: <input type="text"/>	
Address 2: <input type="text"/>	
City: <input type="text"/>	State: <input type="button" value="▼"/>
Zip Code: <input type="text"/>	Country: <input type="text"/> Inactivation Date: <input type="text"/> <input type="button" value="▼"/>

First **Previous** **Next** **Last** **New** **Delete** **Save** **Cancel**

Demographic information

Last name and first name are required.

Contact information

A phone number, fax numbers, and email address.

Inactivation Date

The date when the contact became (or will become) inactive.

Chapter 21

Feature-level setup checklists

Automated billing setup checklist

You must complete setup configuration within Allscripts® Practice Management to use automated billing.

Use this checklist to configure your application for automated billing. This checklist is meant to be a high-level overview only; refer to the tasks for each item in the Help or the *Allscripts® Practice Management 18.0 Automated Billing* feature guide for specific steps.

Task	Completed
If you want to include or exclude multiple operators from having their batches updated by the automated billing process, create one or more operator groups, as applicable, in System Administration > File Maintenance > Operator Group Maintenance .	
If you want the ability to mark individual charge, payment, and void batches so that they are not processed by automated billing, select Enable Bypass Automated Update Flag on the General tab in Practice Options or Organization Options .	
If you selected Enable Bypass Automated Update Flag , go to Administration > Security Manager > Security Permissions and use Practice Management > Financial Processing > Transactions > Batch Management > Defaults > Bypass Automated Update to control which users can mark batches to be bypassed by the automated billing process.	

Task	Completed
<p>Go to Administration > Security Manager > Security Permissions and use Practice Management > Automation Management > Billing Automation Maintenance to control which users can create and maintain automation workflow records.</p>	
<p>Create a folder structure under <code>\\<i><Server Name>.<Domain Name>\Ntierfiles\<Tenant Name>\</i></code> from which you can select the applicable folders for Report Export Path when you create automation workflow records. See Folder structure for Report Export Path on page 1039.</p>	
<p>In System Administration > File Maintenance > Billing Automation Maintenance, create automation workflow records for the areas of billing that you want to automate. Do not select Active until you are ready to enable automated billing.</p>	
<p>If you want to use automated billing to prepare electronic claims, ensure that in your active automation workflow records for preparing electronic claims, each claim format selected has a valid output path on the File Info tab in System Administration > File Maintenance > Electronic Claim Format Maintenance.</p>	
<p>In System Administration > Practice Set Up or Organization Set Up on the Automation tab, set Automation Category to Billing and then select Enable Automated Billing.</p>	
<p>Go to Automation Management > Automation Dashboard > Configuration to customize the display of Automation Dashboard.</p>	
<p>When you are ready to start using automated billing, select Active on the automation workflow records that you want automated billing to process.</p>	

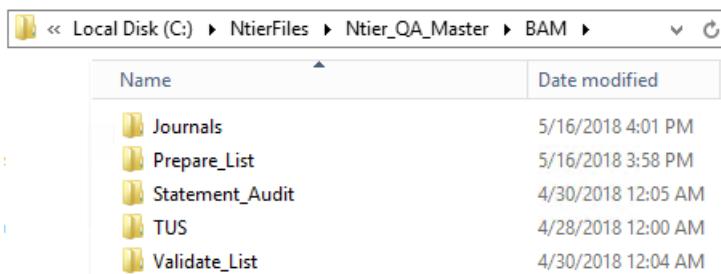
Task	Completed
<p>Ensure that the Automation service type is running.</p> <p>Note: If you are using automated self-pay collections, the Automation service type ensures that automated billing processing happens before automated self-pay collections processing.</p>	

Folder structure for Report Export Path

To accommodate reports exported by automation workflow records, create a **BAM** folder under `\\"<Server Name>.<Domain Name>\Ntierfiles\<Tenant Name>\`, and then create subfolders under **BAM** based on the billing functions that you are automating.

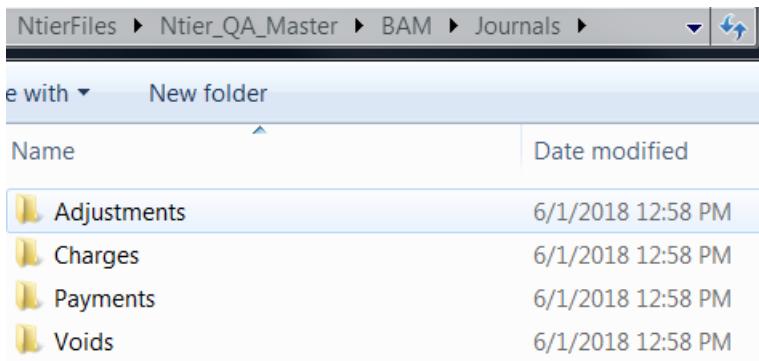
There is not one universal folder structure for automated billing, but you can use the following folder structure as a model. Under **BAM**, create only the subfolders that you need.

- **Journals:** for **Transaction Journal** files
- **Prepare_List:** for **Prepared Claims List** files
- **Statement_Audit:** for **Statement Audit List** files
- **TUS:** for **Transaction Update Summary** files
- **Validate_List:** for **Claims Validation List** files



If you have separate financial processing automation workflow records for charges, payments, and voids, create subfolders under **Journals** for each. Also include a folder for small self-pay adjustments, if applicable.

- **Adjustments**
- **Charges**
- **Payments**
- **Voids**



Automated self-pay collections setup checklist

You must complete setup configuration within Allscripts® Practice Management to use automated self-pay collections.

Use this checklist to configure your application for automated self-pay collections. This checklist is meant to be a high-level overview only; refer to the tasks for each item in the online Help or the *Automated Self-Pay Collections Feature Guide* for specific steps.

Task	Completed
Verify that there are no self-pay accounts currently going through the collections process.	
In System Administration > Practice Set Up or Organization Set Up on the Automation tab, set Automation Category to Self-Pay Collections and then set Self-Pay Collections Management Workflow Organization Basis to the applicable workflow organization basis: Account, Department or Practice, or Division .	
In System Administration > File Maintenance > Automation Action Maintenance , create the automated actions to include in automated workflows.	
In System Administration > File Maintenance > Automation Workflow Maintenance , use the automated actions that you created to assemble 1 or more automated workflows.	

Task	Completed
Create a self-pay collections work queue or queues in Work Queue Maintenance and assign the automated workflow that you created to that queue.	
In System Administration > File Maintenance > Collector Maintenance , verify that Eligible for Distribution is selected for each collector who will have self-pay accounts automatically assigned to them in Office Manager .	
If you created more than 1 self-pay collections work queue, set the priority of the different queues in System Administration > File Maintenance > Workflow Organization Maintenance .	
If you have department security or practice security enabled, verify that the operator record for System in Operator Maintenance has access to all of your departments or practices granted on the Departments or Practices tab.	
Verify that all collectors are given access to the following security permissions in Administration > Security Manager > Security Permissions : <ul style="list-style-type: none"> <li data-bbox="241 1262 861 1296">> Office Manager > Self-Pay Collections <li data-bbox="241 1300 861 1368">> Actions/Toolbar Buttons > Collection Account Detail 	
In System Administration > Practice Set Up or Organization Set Up on the Automation tab, set Automation Category to Self-Pay Collections and then select Enable Automated Self-Pay Collections .	

Benefit plan management setup checklist

You must complete setup configuration within Allscripts® Practice Management to use benefit plan management.

Use this checklist to configure your application for benefit plan management. This checklist is meant to be a high-level setup list only; refer to the tasks for each item in the Help or the *Allscripts® Practice Management 19.0 Benefit Plan Management* feature guide for specific steps.

Task	Location	Completed
Control which users can create and maintain benefit covered services.	Go to Administration > Security Manager > Security Permissions and use Practice Management > System Administration > File Maintenance > Practice Management > Benefit Covered Service Maintenance .	
Control which users can search for and maintain benefit plan policies on the Policies tab in Registration .	Go to Administration > Security Manager > Security Permissions and use Practice Management > Patient Management > Registration > Benefit Plan Policies .	
Define benefit covered services.	Go to System Administration > File Maintenance > Benefit Covered Service Maintenance .	
Define insurance carrier benefit plans and optionally link the benefit plans to employers. Note: You can link employers to benefit plans in either Insurance Carrier Maintenance or Employer Maintenance .	Go to System Administration > File Maintenance > Insurance Carrier Maintenance .	
Define employer benefit plans and employer-specific co-pay or co-insurance, and optionally link the benefit plans to insurance carriers.	Go to System Administration > File Maintenance > Employer Maintenance .	
Link employers to benefit plans.	Go to System Administration > File Maintenance > Insurance Carrier Maintenance .	

Task	Location	Completed
Define the networks for which providers and referring providers are members.	Go to System Administration > File Maintenance > Insurance Network Maintenance.	
Define network participation for providers and referring providers.	Go to System Administration > File Maintenance > Provider Maintenance and System Administration > File Maintenance > Referring Doctor Maintenance.	
Update the policy information for applicable patients.	Go to Patient Management > Registration > Policies.	

Billing by place of service setup

If your practice or organization must bill for a specific line of business at a physical location, you can bill by place of service.

Billing by place of service functionality is available for electronic claims with the **Professional ANSI 837P v5010** or **Professional ANSI 837P v5010A1** format types and paper claims with the **ICD10 Generic Medical Claim Form** format type.

Before you can bill by place of service, you must enter applicable federal tax identification (ID) numbers, billing names, and billing addresses in **Federal ID Maintenance**, **Billing Name Maintenance**, and **Address Maintenance**, respectively.

Electronic claims

Billing by place of service for v5010 professional electronic claims requires the following additional setup:

- In **Electronic Claim Format Maintenance**, set **Billing Method** and **Billing Numbers** on the **Electronic Claim Format** tab to **Place of Service** for the applicable electronic claim formats.

Note: **Billing Numbers** is only available when **Billing Method** is set to **Place of Service**.
- In **Claim Style Maintenance**, set **Billing Provider Tax ID Option** on the **Output Options** tab to **Place of Service** for the applicable electronic claim styles.
- In **Place of Service Maintenance**, enter the billing numbers, taxonomy codes, billing names, billing addresses, and tax information on the **Billing Method Information** tab for the applicable places of service.

Paper claims

Billing by place of service for CMS 1500 ICD-10 Standard (02/12) paper claims requires the following additional setup:

- > In **Paper Claim Format Maintenance**, set **Tax ID Source** to **Federal ID** and set **Option** to **Place of Service** on the **Paper Claim Format** tab for the applicable paper claim formats.
- > In **Paper Claim Format Maintenance**, set **Group Billing No Option** and **Billing Address Option** on the **Paper Claim Format** tab to **Place of Service** for the applicable paper claim formats.
- > In **Place of Service Maintenance**, enter the billing numbers, taxonomy codes, billing names, billing addresses, and tax information on the **Billing Method Information** tab for the applicable places of service.

Claim edit integration setup checklist

You must complete setup configuration within Allscripts® Practice Management to use claim edit integration.

Perform the following tasks to use claim edit integration:

Task	Location	Completed
<p>Ensure there is a claim edit category that the application can assign to claim edit codes that are returned from your claims review solution when they are not already in your database.</p> <p>Best Practice: Use NEW for the abbreviation of the default claim edit category.</p> <p>A NEW claim edit category might have been automatically created and assigned to Default Claim Edit Category in Practice Options or Organization Options during a prior Allscripts® Practice Management upgrade.</p> <p>If you use claim edit categories as a means of grouping claim edit codes, create additional categories.</p>	Go to System Administration > File Maintenance > Claim Edit Category Maintenance	

Task	Location	Completed
Enable code checking and claim verification, if not already enabled.	Go to the Charge Entry tab in Practice Options or Organization Options and select Code Checking and Verify Claims .	
Configure your claims tool.	Go to the External Access tab in Practice Options or Organization Options . <ul style="list-style-type: none"> > Select the applicable value for Claims Tool. > Ensure that there is a value for Default Claim Edit Category. > Enter any other required information in the Claims Review area. Depending on the value of Claims Tool, you might have to obtain a username and password from Allscripts®. 	
Create a folder for claim verification.	Create a VerifyClaims folder under the <code>\\<i>Server Name</i>\<Domain Name>\NtierFiles\<Tenant Name>\Electronic Claims\</code> directory path. Note: If you previously used Alpha II ClaimStaker to verify claims, your CLAIMstaker folder was renamed VerifyClaims by Allscripts® Practice Management.	

ICD-10 setup checklist

You must complete setup configurations within Allscripts® Practice Management to use ICD-10 diagnosis codes.

Use the following checklist to configure your application to use ICD-10 codes.

	On the Profiles tab in System Administration > Practice Set Up or System Administration > Organization Set Up , select Diagnosis Codes under Profile Type and rename the Standard ICD-9 Code profile to Standard ICD Code . Note: To rename the profile, position your cursor to the right of the 9 and press Backspace twice. Do not press Delete to remove the characters or the application will prompt you to delete the profile.
--	---

	Download the latest ICD-9, ICD-10, and ICD-10 to ICD-9 mapping files from the Allscripts® client-only web site: www.allscripts.com/en/client-login.html .
	Use System Administration > Interfaces > ICD Codes and Mapping Import to import the latest ICD-9 and ICD-10 codes into your tenants.
	Use System Administration > Interfaces > ICD Codes and Mapping Import to import the latest ICD-10 to ICD-9 mapping file into your tenants.
	<p>On the Carrier tab in System Administration > File Maintenance > Insurance Carrier Maintenance, fill ICD-10 Effective Date for carriers that have communicated the date when they will start accepting claims with ICD-10 codes. Alternately, you can use the System Administration > Interfaces > Change ICD-10 Effective Date Utility to fill ICD-10 Effective Date for all insurance carriers or a subset of carriers.</p> <p>Important: ICD-10 codes are output on electronic claims when the ICD-10 effective date is reached. If you fill ICD-10 Effective Date, make sure you will be ready to start sending electronic claims with ICD-10 codes by that date.</p>
	(Best practice) On the Validations tab in Claim Style Maintenance , enter a value in Maximum Diagnosis per Voucher for claim styles associated with a v5010 professional electronic claim format that have a service-level diagnosis code limit less than 12.
	(Best practice) Set up the application to enable you to use Add'l Claim Dx for managing additional diagnosis codes that output at the claim level (Loop 2300 Segment H1) for v4010 and v5010 professional claims.
	Set up the applicable paper claim formats, claim styles, and insurance carriers to be able to print the CMS 1500 ICD-10 Standard Claim Form (02/12).
	(Optional) On the Charge Entry tab in System Administration > Practice Options or System Administration > Organization Options , select a value for Auto Tag ICD-9 from Patient History, Same Diagnosis .
	Set ICD-10 Code Set on the Import Options tab in Information Broker Format Maintenance in Allscripts® Interface Engine.
	In Administration > Security Manager > Security Permissions , remove user permissions to Practice Management > System Administration > Interfaces > Practice Management > Change ICD-10 Effective Date Utility and Practice Management > Financial Processing > Transactions > Add Mapped Codes , as needed. By default, all users have access to these new features after you upgrade to version 10.4.

Integrated credit card processing setup checklist

You must contract with the currently supported credit card processing vendor and complete setup configuration within Allscripts® Practice Management to use integrated credit card processing.

Note: Allscripts® does not supply credit card readers. Contact the credit card processing vendor for supported devices.

Use this checklist to configure your application for integrated credit card processing. This checklist is meant to be a high-level overview only; refer to the tasks for each item in the Help or the *Allscripts® Practice Management 22.0 Integrated Credit Card Processing* feature guide for specific information.

Task	Completed
Obtain connection credentials from the currently supported credit card processing vendor.	
In Practice Options or Organization Options , on the Credit Card Processing tab, enter connection credentials supplied by the vendor.	

Task	Completed
<p>If applicable, in Location Maintenance, on the Location tab, enter connection credentials supplied by the vendor.</p> <p>Note: When Allscripts® Practice Management interacts with the vendor:</p> <ul style="list-style-type: none"> > If the location that the payment is associated with cannot be determined (for example, the associated location is not selected when a quick payment is taken), the connection credentials at the practice or organization level are used. > If the location that the payment is associated with can be determined, but location-level connection credentials do not exist for that location, the connection credentials at the practice or organization level are used. > If the location that the payment is associated with can be determined, and location-level connection credentials exist for that location, those credentials are used. If a connection cannot be made with the existing location-level credentials, Allscripts® Practice Management does not use the connection credentials at the practice or organization level; an error is returned instead. 	
<p>In Transaction Code Maintenance, create payment and miscellaneous debit transaction codes with Credit Card Processing selected that are specifically for credit card transactions.</p>	
<p>After setup is complete, and you are ready to use integrated credit card processing, in Practice Options or Organization Options, on the Credit Card Processing tab, select Enable Credit Card Processing.</p>	

Workers' compensation case management setup checklist

You must complete setup configuration within Allscripts® Practice Management to use workers' compensation case management.

Use this checklist to configure your application for worker's compensation case management.

Task	Location	Completed
Optional. Define contact roles.	Go to System Administration > File Maintenance > Contact Role Maintenance .	
Optional. Define contacts.	Go to System Administration > File Maintenance > Contact Maintenance .	
Required if using Compensability Status . Define work-injury reason codes.	Go to System Administration > File Maintenance > Case Compensability Reason Maintenance .	
<ul style="list-style-type: none"> > Required. Define employers. > Optional: Define employer locations. > Optional: Define payers. 	Go to System Administration > File Maintenance > Employer Maintenance .	
Required if using notes with workers' compensation cases. Define workers' compensation notes that you can attach to cases. Note: You must temporarily select Enable Workers' Comp Case on the Case tab in Practice Options or Organization Options before you can define workers' compensation case notes. After you have created workers' compensation notes, clear Enable Workers' Comp Case until you are ready to start creating workers' compensation cases.	Go to System Administration > File Maintenance > Note Type Maintenance .	

Task	Location	Completed
Required. <ul style="list-style-type: none"> <li data-bbox="241 403 698 435">> Enable visit types. <li data-bbox="241 445 698 508">> Define workers' compensation visit types. 	<ul style="list-style-type: none"> <li data-bbox="714 361 1323 487">> Go to System Administration > Practice Options > Visit Type or System Administration > Organization Options > Visit Type. <li data-bbox="714 498 1290 572">> Go to System Administration > File Maintenance > Visit Type Maintenance. 	
Required. <ul style="list-style-type: none"> <li data-bbox="241 656 698 720">> Define attributes for the Workers' Comp case type. <li data-bbox="241 730 698 868">> Select Enable Workers' Comp Case when you are ready to start creating workers' compensation cases. 	Go to System Administration > Practice Options > Case or System Administration > Organization Options > Case .	

For more information

For more information and the most up-to-date documentation, go to the Allscripts® Central website at <https://central.allscripts.com>. You can access the Product Documentation portal from this website.

1. Sign in to the Allscripts® Central website.

- > If you have an Allscripts® Central account, enter your user name and password, and then click **Sign in**.
- > If you do not have an Allscripts® Central account, click **Create one!** to begin creating a new account.

The **Allscripts Central** home page is displayed.

2. Go to **My Products > Product Documentation**.

The Product Documentation portal landing page is displayed.

The list of products under the **Product Name** box reflects your preferences in Allscripts® Central. You can navigate to the documentation for a product using **Product Name** in conjunction with the search function.

Product tiles are also displayed and reflect your Allscripts® preferences.

3. From **Product Name**, select the product on which to search for documentation.

Product Name uses predictive searching, so as you type the product name, the list displays only matching products. Select the correct product when it is displayed.

4. In the search box, enter search criteria.

The search box also uses predictive searching. As you type, topics that match the criteria are displayed below the search box.

5. To complete your search, perform one of the following actions:

- > Click the magnifying glass.
- > Select one of the topics displayed beneath the search box.

Search results are displayed in the main pane. You can use the filters in the left pane to further narrow your results. For example, you can select **Feature Guides** from **Document Type** to display only topics that are included in a feature guide.

6. Click a topic title to open the topic in the context of the book indicated by the product, version, and document type tags that are displayed beneath the title.



For more information

Note: If a topic is included in more than one book, a list of the books in which the topic is included is displayed beneath the topic title. Select the applicable book from the list. The topic opens in the context of that specific publication.

What to do next

You can navigate the Product Documentation portal using multiple methods. From the bottom of the portal landing page, click **Helpful Tips** under **Getting Started** to learn more about using the portal.

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