



Allscripts® Practice Management 22.0.x

Simply Allscripts Practice Management

User Guide

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Chapter 1

Orientation

Log on to Allscripts Practice Management

The first time you successfully log on to Allscripts® Practice Management, you are asked to set up five security questions and answers.

You can choose to set up the security questions at a later time, but you will continue to be prompted with each logon until you set up your security questions.

1. On your desktop, click .

The Allscripts® Practice Management logon window opens.

Note: The following logon window is an example and might not have the same version number as your application.



2. For **User Name**, enter your assigned Allscripts® Practice Management user name.

Note: Your user name is stamped on the tables of records and transactions you enter while logged on as this user. This means every

financial transaction entered, every quick note saved, every appointment scheduled, cancelled, and so on, is stamped as having been done by the operator associated with the registered user name entered in this logon window. Be sure you only work in a tenant that is opened with your assigned user name. Also, be sure to log off when you leave your workstation.

The user name and password must be registered with Allscripts® Practice Management.

3. For Password, enter your password.

You must enter your password exactly as it is registered on your user record in **User Maintenance**. You are periodically asked to change your password, based on the settings in **Administration > Security Manager > Security Options**.

4. Click Log In.

If you have access to only one tenant and do not have access to **Administration**, you are logged onto your tenant automatically. Otherwise, continue with these steps to select which tenant (that is, practice or organization) to log on to.

5. For Tenant, click the down arrow and select the tenant to log on to.

6. (Optional) To make the current tenant your default tenant, select **Set Tenant as Default**.

7. (Optional) To clear your default tenant setting, select **Clear Default**.

8. Click Log In.

Results of this task

You are logged on to the Allscripts® Practice Management tenant you selected.

Clear a default tenant setting

To clear your default tenant setting, select **Clear Default** on the log on window.

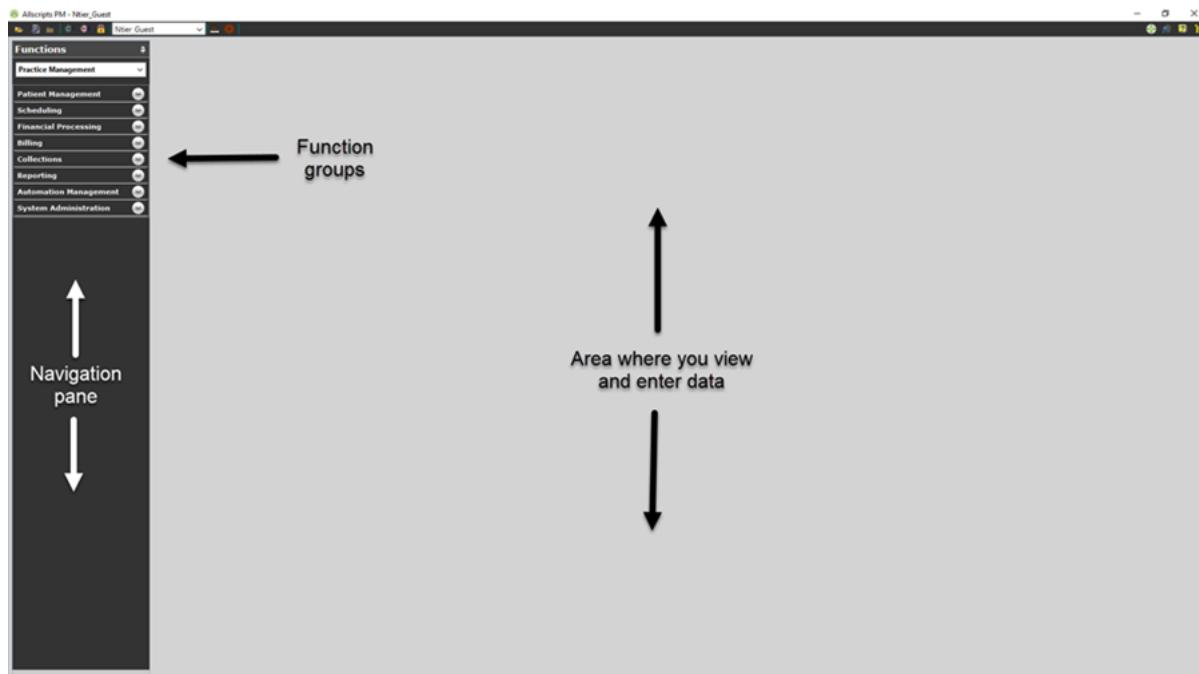
1. Open the logon splash screen either from the desktop by clicking  or from the toolbar on the parent window in Allscripts® Practice Management by clicking .
2. Enter your user name and password and click **Log In**.
3. Beneath the **Tenant** box, select **Clear Default**.
4. To log onto a tenant other than your default tenant, for **Tenant**, click the down arrow and select the applicable tenant from the list.
5. Click **Continue**.

Results of this task

Your default tenant setting is cleared. If you do not select another default tenant, **Tenant** will be blank the next time you open the log on window.

Allscripts Practice Management navigation pane

The navigation pane is a component of the parent window that holds the function groups which make up Allscripts® Practice Management.



Note: A **Payerpath Portal** toolbar button is displayed when the necessary setup is completed on the **External Access** tab in **Practice Options** or **Organization Options**.

The following function groups are under **Practice Management**:

- > **Patient Management**
- > **Scheduling**
- > **Financial Processing**
- > **Billing**
- > **Collections**
- > **Reporting**
- > **Automation Management**
- > **System Administration**

The following function groups are under **Office Manager**:

- > **Appointment Management**
- > **Pending Claims Management**
- > **Self-Pay Collections**
- > **Tasking**
- > **Unpaid Claims Management**

The following function groups are under **Administration**:

- > **Multi-Tenant**
- > **Replication**
- > **Security Manager**

Click the down-arrow icon next to **Practice Management** to select the **Office Manager** or **Administration** function group.

Each of the function groups contain functional areas. Click  or double-click the function group to display the functional areas. Click the functional areas under each function group to open them. You can also open functional areas using quick access codes.

Standard application icons

Use the icons throughout Allscripts® Practice Management to perform standard application functions.

When you hover the cursor over certain icons, a tooltip describes the icon's function.

When a function is unavailable, the icon color is faded. Unavailable icons do not respond when clicked.

Classic icon	Browser-based icon	Function
	 and 	Search for a record by a unique identifier, such as a patient number. In some areas of the application, a Find By Key button performs the same function.
 		Search for a record using a lookup window and search criteria. In some areas of the application, a Search button performs the same function.

Classic icon	Browser-based icon	Function
		Create a new row in a grid. In some areas of the application, a button (such as New Note) performs the same function.
		Delete a row in a grid. In some areas of the application, a button (such as Delete Note) performs the same function.
		Choose specific records to refine a query or report.
		Clear selections made with the Selected Records icon.
	and	Open a separate window with additional details.
		Expand a list box.
		Indicate that a phone number is the primary telephone number.
		Select a person (patient, contact, or guarantor) related to self-pay.
	and	Select a date.
		Select a time.
	and	Sort grid rows in ascending or descending order. Important: The sort icons are only displayed when you click a column header.
		Add a new transplant action on Transplant Management .

Classic icon	Browser-based icon	Function
		View and edit a patient's Social Security Number (SSN) on Access SSN .
		View or edit ailments on Ailment Information .
		View a saved document from the Documents tab in Patient Management > Documents .

Log off of Allscripts Practice Management

To log off of Allscripts® Practice Management, you can either click  on the toolbar or click  in the upper right corner of the window.

You can log off the Allscripts® Practice Management in two ways:

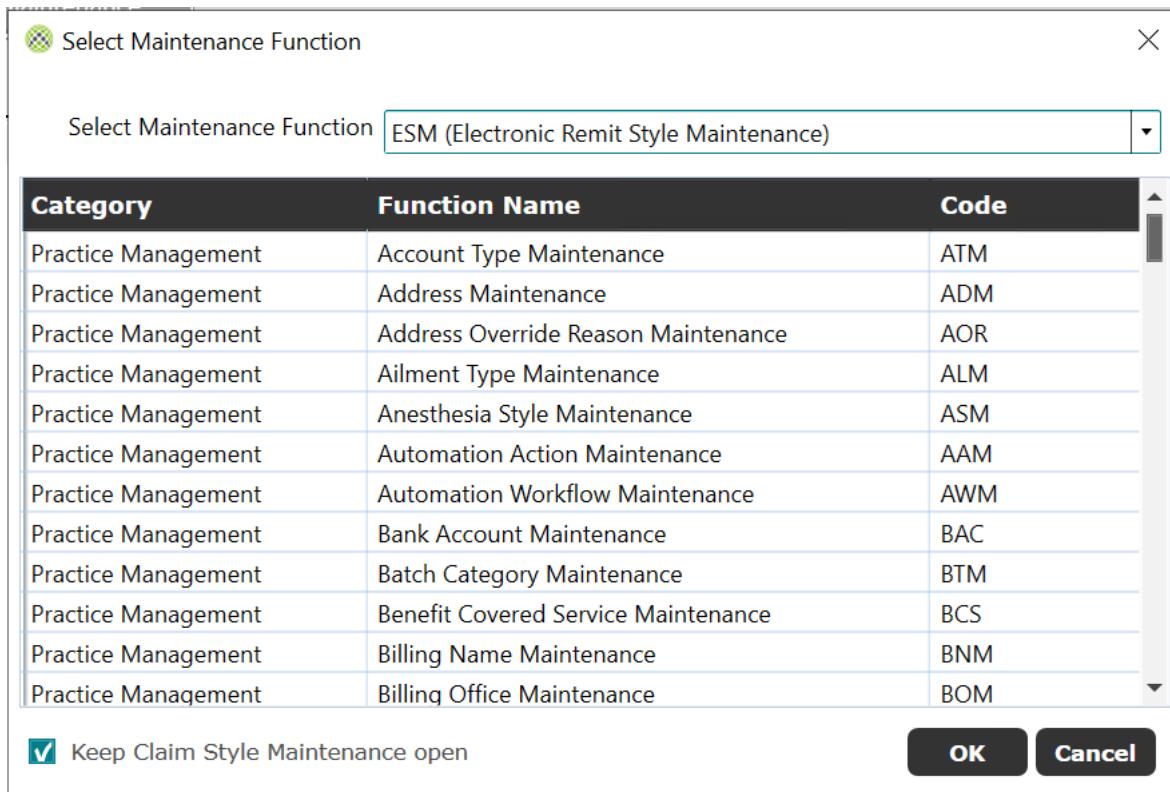
1. On the toolbar, click  to log off of your current tenant but leave the application open. This feature is useful when you leave your workstation, because it guarantees that only authorized users can log on to a practice in your absence.
2. Click  in the upper right corner of the main window to close the application. A message window opens asking if you are sure you want to log off: click **Yes**.

Note: You can use the switch tenants drop-down box on the toolbar to switch between the different tenants you have access to without having to log out of the application and then log back in.

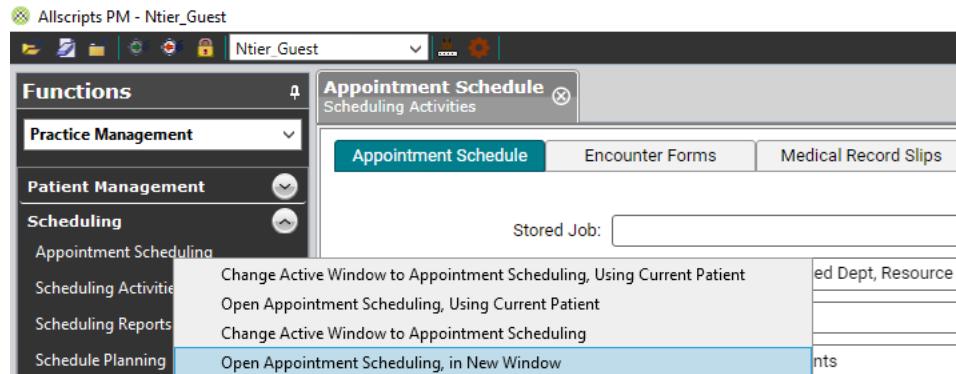
Moving between open function windows

You can have more than one function window open. Tabs enable you to easily move between open windows.

Press **F9** followed by a quick access code, and then select **Keep window name open**. The following image is a sample of **Open function** with **Keep Claim Style Maintenance open** selected.



Optionally, right-click a function in the navigation pane and select **window name**, in New Window. The following image is a sample of the right-click option to open **Appointment Scheduling** in a new window.



Each open function has a tab that you can click to move between the functions.

Selecting scheduling defaults

The fields **Sched. Dept**, **Sched. Location**, **Resource**, and **Coverage Type** on the **Patient Scheduling**, **Appointment Book**, and **Appointment Management** tabs default to your selections

each time you log on this workstation using the same User Name you used when you logged on to set the defaults.

With the exception of the Coverage Type, leaving a combo box blank defaults that combo box to blank when the related screens are opened in Appointment Scheduling. If the Coverage Type is not set on this dialog, the **Coverage Type** combo box throughout Appointment Scheduling defaults to the selected default from the General tab in Practice/Organization Options. If you do not have a default selected in Practice/Organization Options and the Patient only has one policy on his or her account, the coverage type throughout Appointment Scheduling defaults to the coverage type of the Policy. However, if the Patient has no insurance policies or more than one Primary Policy, the **Coverage Type** combo box throughout Appointment Scheduling will be blank and you must populate the combo box in order to make an appointment.

Note: When **Appointment Scheduling** is open and **Coverage Type** is changed in **Options for user [user name] on this workstation**, accessed

by clicking **Update Options**  on the toolbar, coverage type does not refresh the window. The previous coverage type is displayed if an appointment is made. When **Appointment Scheduling** is opened again, the change in coverage type is reflected.

Fields Related to Security Permission Settings

Sched. Dept

The options in the drop-down list are based on the User's department/practice security access.

Coverage Type

The options in the drop-down list are based on the User's coverage type security permissions.

Note: The selected defaults override any other related default for the User and workstation. The following are examples:

- > When a Resource is selected as a default and the default to Usual Provider is also checked on the **Scheduling tab** in Practice/Organization Options, the default selected has highest priority.
- > The coverage type selected here has the highest priority when it comes to determining how the selection in **Coverage Type** defaults in Scheduling. It overrides the default coverage type set in Practice/Organization Options and the coverage type associated with Patient's Primary Policy.

When a default setting is changed, the Appointment Scheduling tabs must be closed and reopened for the changes to take effect.

Select scheduling defaults

You can select a default scheduling department, scheduling location, resource, and coverage type.

Sched Dept, Sched Location, Resource, and Coverage Type on the **Patient Scheduling, Appointment Book, and Appointment Management** tabs default to your selections.

1. Click **Update Options**  on the toolbar.
Options for user [user name] on this workstation opens.
2. Click the **Scheduling** tab.
3. To select a default for any field, click .
4. If necessary scroll through the list and click on the name of your selection.
5. Click **OK** to close the window.

Select Batch Defaults

This topic describes the use of batch format defaults.

You can set User/workstation specific default options for each available Batch Type Format: Charge, Payment and Void. These are used as the default for these functions where you can enter a batch number and/or a batch category:

- > **Financial Processing > Transactions > Batch Management > Charge, Payment, and Void Batches**
- > **Financial Processing > Automatic Transactions**
 - Transferring/Adjusting Account Balances
 - Import Remittances
 - Import Charges
 - Unassigned Payment Management
 - Credit Balance Report
 - Finance Charges
- > **Billing > Occupational Medicine > Print Invoices**
- > **System Administration > Interfaces > Banner Transactions Export**

VRE Batches

A defined Void Batch Type format does not apply to Void Batches created as part of the Void and Re Enter functionality available from the **Edits tab**. Void and Re Enter batches continue to be assigned a system generated batch number with the prefix "VRE."

Batches tab in Update Options

This topic describes the batch format fields types used when setting batch format defaults.

Each field value has been defined in **Practice/Organization Options** by your Practice administrators to accept certain values, each with a specified character minimum or maximum. Be sure to follow your practice policy for entering values in these fields.

Some fields may only accept numbers, others letters and still others are defined as date or combo box fields.

Free text fields

Allow you to enter a limited number of text. For example, a field labeled **User Initials** allows you to enter any combination of letters and numbers up to the minimum required of characters. For example, if the field length is set to 3, then you must enter 3 characters, such as s1a, or cam.

Number fields

Restricted to the entry of numbers. Number fields are also limited to or restricted to a certain number of characters. If the field length is set to 2 then you are required to enter 01.

Date fields

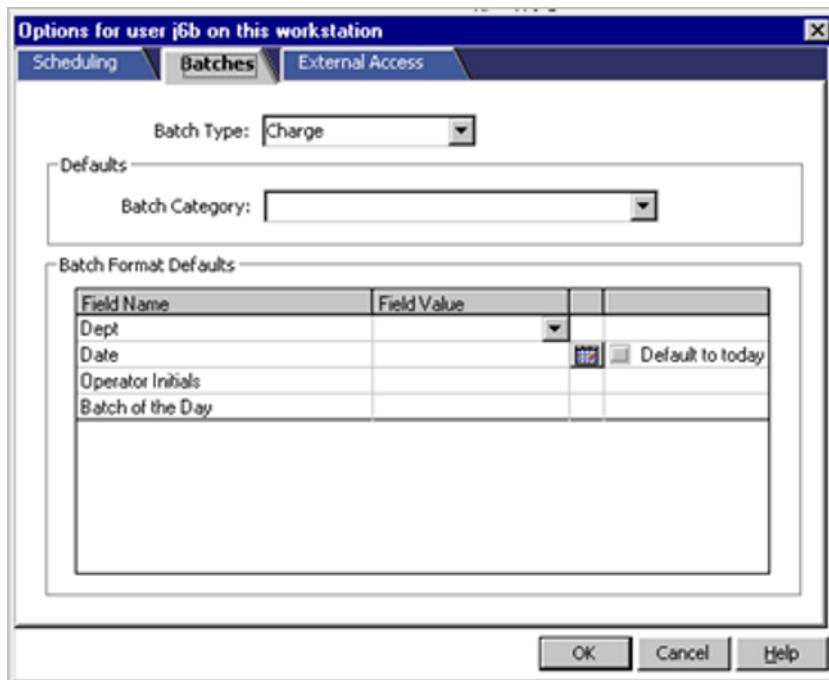
Defined to accept the date and display the standard  icon. Your selection can be made from the calendar or to default the date used in the format to the current (today's) date by clicking the associated in the last column. This last option is available only in **Options for user [user name] on this workstation**, accessed by clicking **Update Options**  on the toolbar, and not on the dialog opened on the various screens which require a batch number.

Note: Because the format for entering the date is also predefined in **Practice/Organization Options**, you cannot enter free text characters in the field. Selecting a future date is accepted as a valid entry, but note that the options entered/selected with that date are not used by the system as a default until the date arrives.

Combo box fields

Offer custom defined selections specific to your practice work flow needs, such as **Departments**, **Locations**, or perhaps **Payor**. These fields display the standard element which you click to open the listing.

Below is a sample Batch Format with defined elements for a Charge Batch Type.



Select batch format defaults

1. Click **Update Options**  on the toolbar.

Options for user [user name] on this workstation opens.

2. Click the **Batches** tab.

Tip: If you want to use the keyboard instead of your mouse, use **Tab** to move from box to box. With the cursor placed in a box, use the down arrow on your keyboard to scroll through the selections.

3. Select a **Batch Type**.
4. Select a **Batch Category**.
5. Each of the **Batch Format Defaults** has been defined in your practice or organization options to accept a certain type of value. .
6. Click **OK** to close the window.

Require batch category only for payment batches

You can set it up so the system only requires a batch category for payment batches. Set defaults for charge and void batches so you do not have to remember to enter those. As a result, the batch category for payment batches is blank, and since it does not default you have to enter it.

1. Check **Require Batch Category** on the **General** tab in **Practice/Organization Options**.
2. Create a default category in **Batch Category Maintenance**, such as Default Batch Category.
3. In **Options for user [user name] on this workstation**, accessed by clicking **Update Options**  on the toolbar, use this default batch category for the batch types of **Charge** and **Void**.

Set a default printer within Allscripts Practice Management

You can set a default printer for all your printing within Allscripts® Practice Management.

This option allows you to set your default printer for use within Allscripts® Practice Management without having to use the Windows® option for printers and faxes.

It is important to keep the following in mind when setting a default printer:

- This default is specific to the combination of user and workstation.
AND
- After you log off of Allscripts® Practice Management, the default printer on your workstation reverts back to the 1 you had selected in Windows®.

To select a printer, do the following:

1. Click **Update Options**  on the toolbar.
Options for user [user name] on this workstation opens.
2. Click the **Printers** tab.
3. Select **Remember Preferred Default Printer**.
4. In **Select Preferred Printer**, click .
5. If necessary, scroll through the list and click the name of the printer you want to select as the default printer.
6. When **Select Preferred Printer** is filled with the name of the printer, click **OK**.

Impact MD setup for the External Access tab in **Options for user [user name]** on this workstation

Results of this task

When **Print** opens in Allscripts® Practice Management, the printer name is the default printer you selected. However, you can select a different printer from the drop-down list.

Impact MD setup for the External Access tab in Options for user [user name] on this workstation

This topic describes defaults used for viewing EOBs scanned into Impact MD (also referred to as Allscripts® Document Management).

Note: This topic does not apply to Laserfiche® for viewing scanned documents.

Use the **External Access** tab in **Options for user [user name]** on this workstation along with the Impact MD options on the **External Access (2)** tab in **Practice Options** or **Organization Options**. The **External Access** tab is where the location of executable files for various external applications used by Allscripts® Practice Management are stored.

Click **Add** to open **Applications**. The grid contains three columns:

Name

The user defined name for the link, for example Impact MD.

File Name

The file path and file name of the executable file.

Parameters

Any command line parameters for the executable file.

Setup for viewing scanned EOBs

For the current user and workstation combination to be able to view images of EOBs scanned into Impact MD, the location of the Impact MD executable file named "ImpactS.exe" must be added correctly.

Note:

- > ImpactMD must be entered in the **Name** field.
- > The location of the ImpactS.exe file that should be used in the **File Name** field is the path that the Impact MD desktop shortcut points to which should be the path to ImpactS.exe on the Server in the "server" folder where Impact MD is installed.
- > /fcs must be entered in the **Parameters** field.

Recalling previously accessed patients

By using the **F9** function you can recall any of the last five Patients accessed during the currently opened session of Allscripts® Practice Management without having to redo a search .

Note: The system remembers up to the last five patients you loaded on function windows and stores these names in a combo box on the **Open Window (F9)** dialog.

- If a Patient is currently loaded in a function window then that patient's name is displayed in the field.
- To select a new function without recalling a patient uncheck the option **Use Current Patient in New Function** or select "(no patient currently selected)" in the new field **Current Patient**.
- When you uncheck **Use Current Patient in New Function** and check **Keep (Name of currently opened function) Open** the previous function window retains the Patient that was originally called in to that window.
- When you select a function whose first field is a Patient field and select a patient from the list then that patient is loaded in the function window when it opens.
- Newly created patients are included in the listing after the new registration has been completed and saved.
- When the Practice Option **Track Encounters** is checked, you cannot recall a patient for the charge entry screen in Transactions because the default field label is "Encounter."
- You must always select a function.

Recall a patient and return to my previous window

Before you begin

You can recall a patient and return to your previous window as long as that patient was one of the last five you selected.

1. F9 to open the Open Window dialog.

When the window opens the cursor is positioned in the field **Select New Function**.

2. Click the down arrow on the field **Current Patient** to open the drop down.

3. Click on the name of the patient you want.

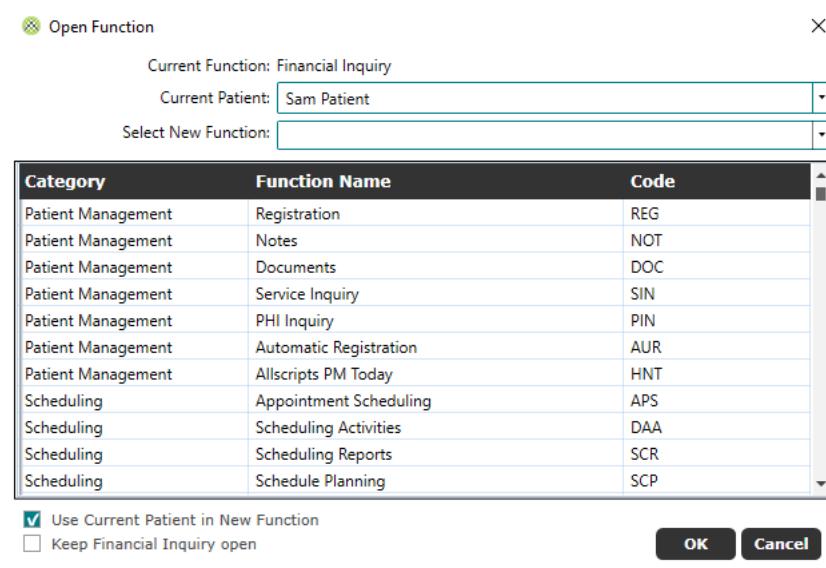
4. Tab then enter the access code or select the function from the list in the grid for the screen you were on.

5. Click **OK** to return to the screen which now loads your selected patient record.

Recall one of the last five patients accessed and move to another window

On the **Open Function** window, you can use the **Current Patient** box to select one of the five most recently accessed patient records to open in a new window (or function).

1. Press **F9** to open the **Open Function** window.



When the window opens the cursor is positioned in the **Select New Function** box. You must select a function.

2. For **Select New Function**, select a function from the grid or enter the quick access code for the window you want to open.

By default, the **Current Patient** box displays the name of the patient whose record is currently open.

If no patient record is open on the current window, the **Current Patient** box displays the following message: (no patient currently selected). In addition, the **Use Current Patient in New Function** option is unavailable and cleared.

When you select a patient for the **Current Patient** box, the **Use Current Patient in New Function** option becomes enabled and selected.

3. Use the **Current Patient** drop-down list to select one of the five most recently accessed patient records.
4. (Optional) If applicable, select the **Keep window name open** option to keep the current window open.
5. Click **OK**.



Chapter 1 Orientation

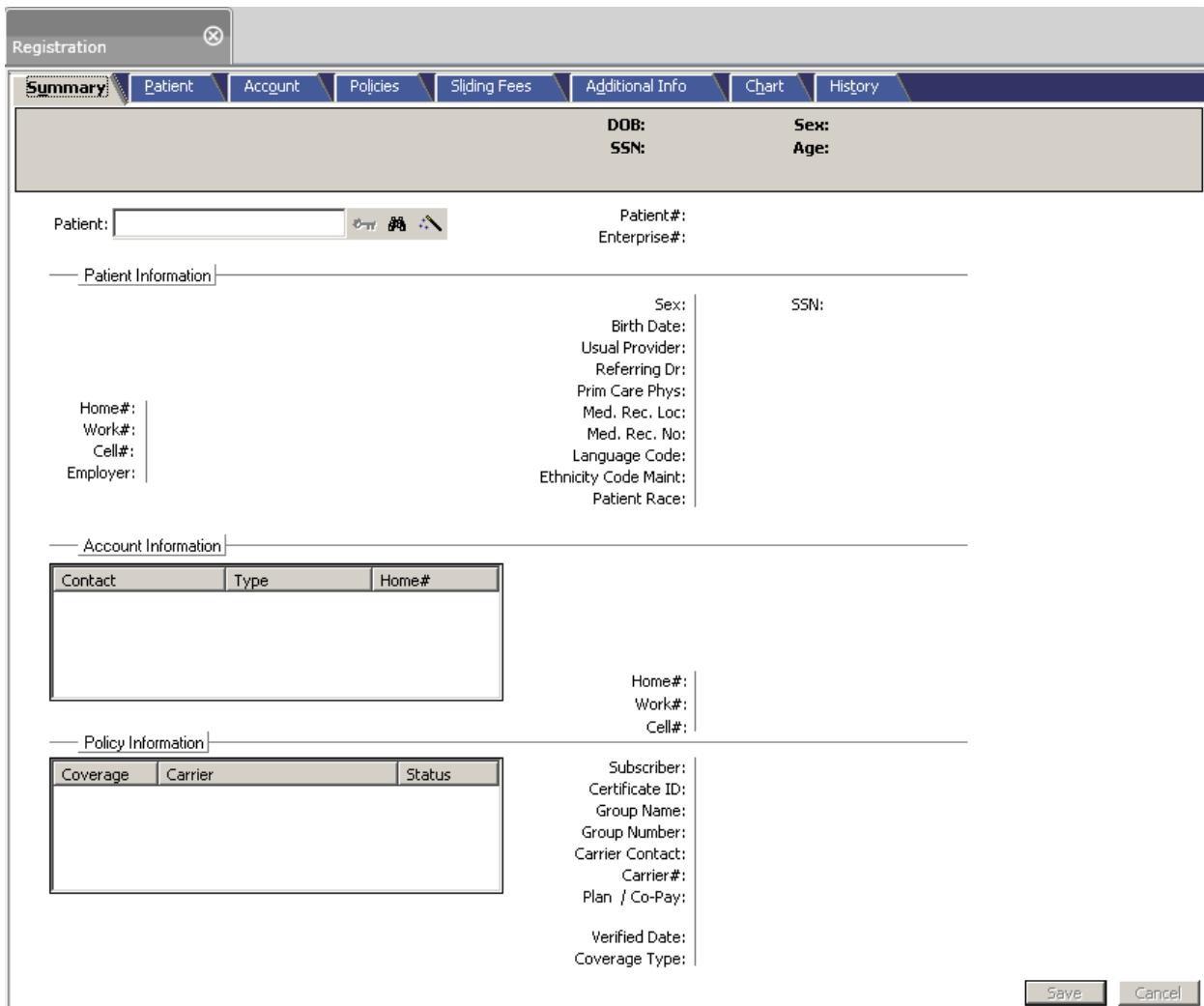
Chapter 2

Registration

Summary tab

When you open an existing patient record, the **Summary** tab is the first to display. As its name implies, the **Summary** tab contains a summary of the information entered for the patient.

Access the **Summary** tab from **Registration**. To access **Registration**, go to **Patient Management > Registration** or press **F9** and then enter **REG**.



The screenshot shows the Allscripts Practice Management software interface. At the top, there's a navigation bar with tabs: Summary, Patient, Account, Policies, Sliding Fees, Additional Info, Chart, and History. The "Summary" tab is currently active. Below the navigation bar, there are several input fields: DOB, Sex, SSN, and Age. The "Patient" section contains fields for Patient#, Enterprise#, Home#, Work#, Cell#, Employer, Birth Date, Usual Provider, Referring Dr, Prim Care Phys, Med. Rec. Loc, Med. Rec. No, Language Code, Ethnicity Code Maint, and Patient Race. The "Account" section features a grid for Contact, Type, and Home#. The "Policy" section includes fields for Coverage, Carrier, Status, Subscriber, Certificate ID, Group Name, Group Number, Carrier Contact, Carrier#, Plan / Co-Pay, Verified Date, and Coverage Type. At the bottom right are "Save" and "Cancel" buttons.

The **Summary** tab is divided into 3 sections.

Patient Information

Selected information from the **Patient** tab. Can also include information from up to 3 patient additional information boxes, if the boxes are selected in on the **Registration** tab in **Practice Options** or **Organization Options**.

Tip: Point to **Employer** to show the full name from **Employer Maintenance**.

Account Information

This grid lists the contact's name, type (such as Patient, Subscriber or Guarantor), and home phone number. To the right of the grid, more detailed information is displayed for the highlighted contact, such as address and cell and work phone numbers.

Policy Information

Based on your security permissions related to coverage types, this grid lists the patient's policies sorted first by alphabetically coverage type and second by coverage (Primary, Secondary, Tertiary, Other Primary, and Other). To the right of the grid, subscriber information is displayed, along with the carrier contact name, the carrier phone number, the date when the policy was last verified, and the policy's coverage type.

If a policy is associated with a benefit plan, **Plan/Co-Pay** is replaced with **Benefit Plan**. The benefit plan name and code are displayed. Click the benefit plan code to open **View Benefit Plan Details**.

Note: Transplant policies do not display on the **Summary** tab in **Registration**.

When you pause the pointer over the labels for any of these sections, the pointer changes to a hand. Left-click the mouse to open the corresponding tab.

Add a new patient in Registration

The purpose of this topic is to describe how an operator with security management permission can add or register a new patient from the Summary and the Patient tabs in Registration or the Registration COMpanion screens.

Note: Restrictions, default and required entries are governed by the options selected on the Registration tab and certain options on the General tab in Practice/Organization Options.

To begin the Registration process do one of the following:

1. Click  found to the right of the **Patient** field.
2. Use the **Insert** key found to the right of the **Backspace** key on the keyboard.
3. The first step is assigning a patient number. This can be done in a few different ways each of which is discussed below.

What to do next

A number of Practice/Organization Options along with your security permissions dictate what you can enter, must enter, when creating a new Patient record.

Based on the setting in Practice/Organization Options, a new Patient record is either manually or system assigned a number. For details on how this works, see Define Registration Entry Options.

Patient tab

Required boxes

The default required boxes on the **Patient** tab are **Patient#**, **Last Name**, and **Sex**. Other boxes might also be required by your practice or organization, based on the selections made in **Required Fields** on the **Registration** tab in **Practice Options** or **Organization Options**.

When **Highlight Required Fields** is selected in **Practice Options** or **Organization Options**, all of the boxes required to save the record you create are highlighted.

Some boxes on the **Patient** tab might be pre-filled for you, depending on information retrieved from an existing patient or contact record, information entered on **Duplicate Patient Checking**, and default information entered on the **Registration** tab in **Practice Options** or **Organization Options**.

The patient number is displayed in the title bar on all windows that display the patient name, which are **Registration** and its COMpanion window, **Notes**, **Service Inquiry**, the **Patient Scheduling** and **Appointment Activity** tabs in **Appointment Scheduling**, as well as **Financial Inquiry** and its COMpanion window. Additionally, the patient number and account number are displayed in **Account Ledger**.

Access the **Patient** tab from **Registration**. To access **Registration**, go to **Patient Management > Registration**.

Tip: To quickly access **Registration**, press **F9**, then enter **REG**.

Registration X

Patient Summary Account Policies Sliding Fees Additional Info Chart History

Patient:	DOB: SSN: Age:																																																																
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Patient Information <hr/> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Patient#:</td> <td style="width: 150px; background-color: #ffffcc;">SSN:</td> <td style="width: 100px;">Home Tel#:</td> <td style="width: 100px;"><input type="checkbox"/> Ext:</td> </tr> <tr> <td>Last Name:</td> <td style="background-color: #ffffcc;"></td> <td>Work Tel#:</td> <td><input type="checkbox"/> Ext:</td> </tr> <tr> <td>First, MI:</td> <td>Suffix:</td> <td>Cell#:</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Middle Name:</td> <td></td> <td>Sex:</td> <td><input type="button" value="▼"/></td> </tr> <tr> <td>Address 1:</td> <td></td> <td>Birth Date:</td> <td><input type="text"/></td> </tr> <tr> <td>Address 2:</td> <td></td> <td>Employer:</td> <td><input type="text"/>  </td> </tr> <tr> <td>City:</td> <td>State:</td> <td>E-Mail:</td> <td></td> </tr> <tr> <td>Zip Code:</td> <td>Country:</td> <td>Enterprise#:</td> <td></td> </tr> <tr> <td colspan="4"><hr/></td> </tr> <tr> <td>Usual Prov:</td> <td>Marital:</td> <td colspan="2"><input type="checkbox"/> Transplant Donor</td> </tr> <tr> <td>Referring Dr:</td> <td>Employment:</td> <td colspan="2"><input type="checkbox"/> Transplant Recipient</td> </tr> <tr> <td>PCP:</td> <td>Student:</td> <td colspan="2"></td> </tr> <tr> <td>Med. Rec. Loc:</td> <td>Inactivation Date:</td> <td colspan="2"></td> </tr> <tr> <td>Med. Rec. No:</td> <td>HIPAA Stmt Exp:</td> <td colspan="2"><input type="text"/>  </td> </tr> <tr> <td colspan="4"><hr/></td> </tr> <tr> <td colspan="4">Comments: <input type="text"/></td> </tr> </table>		Patient#:	SSN:	Home Tel#:	<input type="checkbox"/> Ext:	Last Name:		Work Tel#:	<input type="checkbox"/> Ext:	First, MI:	Suffix:	Cell#:	<input type="checkbox"/>	Middle Name:		Sex:	<input type="button" value="▼"/>	Address 1:		Birth Date:	<input type="text"/>	Address 2:		Employer:	<input type="text"/>  	City:	State:	E-Mail:		Zip Code:	Country:	Enterprise#:		<hr/>				Usual Prov:	Marital:	<input type="checkbox"/> Transplant Donor		Referring Dr:	Employment:	<input type="checkbox"/> Transplant Recipient		PCP:	Student:			Med. Rec. Loc:	Inactivation Date:			Med. Rec. No:	HIPAA Stmt Exp:	<input type="text"/>  		<hr/>				Comments: <input type="text"/>			
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SSN

The patient's 9-digit Social Security number (SSN). When you enter a number in this box, it is automatically hyphenated.

If the option **Hide SSN** is selected on the **General** tab in **Practice Options** or **Organization Options**, when you add a new patient record and enter the patient's SSN, the entire number you enter remains on the window until you **Tab**. After you move to another box, the patient's full SSN is hidden: the last 4 digits of the SSN are still displayed, but the first 5 digit are displayed as asterisks. For example, *****1111. After you save the new patient record,



is displayed to the right of **SSN**: clicking this icon opens a window that displays the patient's full SSN. From this point forward, you must have security permissions assigned in

Administration > Security Manager > Security Permissions to open this window and view or change patient SSNs.

Last Name

The patient's last name. Do not enter commas. Do not enter name suffixes such as Jr. or MD: enter suffixes in the **Suffix** box.

First, MI

The patient's first name and middle initial.

Suffix

The suffix for the patient's name, such as Jr. or M.D.

Address 1

The first line of the patient's address. Prints on insurance claim forms.

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

The second line of the patient's address, if any. For example, a suite number, apartment number, or P.O. Box number. Does not print on insurance claim forms.

City

The patient's city. If you have a default city selected in **Practice Options** or **Organizations**, that city is displayed in this box when you first open the **Patient** tab for a new patient. Enter a different city to change the default. You can sometimes automatically fill the **City** and **State** boxes using the patient's ZIP Code. Refer to the "Zip Code" section for more details.

State

The patient's state or U.S. territory. In the drop-down list, the U.S. territories are listed after the 50 states. If you selected a default state in **Practice Options** or **Organizations**, that state is displayed in this box when you first open the **Patient** tab for a new patient. Enter a different state to change the default. You can sometimes automatically fill the **City** and **State** boxes using the patient's ZIP Code. Refer to the "Zip Code" section for more details.

Zip Code (when ZIP Code validation not enabled)

You must manually enter a city, state and ZIP Code combination at least once before you can use the ZIP Code to automatically fill **City** and **State**. To automatically fill **City** and **State**, skip them and move directly to the **Zip Code** box. Enter the ZIP Code using one of these methods:

- > If you know the exact ZIP Code, enter up to 9 digits in the box and then click  or press **TAB**. If there is only 1 match in the application database for this ZIP Code, **City** and **State** automatically fill with the corresponding information. If there is more than 1 match in the application for the ZIP Code you entered, **Zip Code Lookup**. Select the correct ZIP Code and click **OK**. **City** and **State** automatically fill when you return to the **Patient** tab.
- > To search for the correct ZIP Code, enter up to 9 digits in the box and then click  to open **Zip Code Lookup**, where a list of matching records is displayed in the grid. Select the correct ZIP Code and click **OK**. **City** and **State** automatically fill when you return to the **Patient** tab. If you do not see the correct ZIP Code, you must click **Cancel** and manually enter the ZIP Code, city, and state on the **Patient** tab. After you save this patient record, you will be able to automatically fill **City** and **State** for this ZIP Code the next time you register an applicable patient.

To auto fill the city and state boxes, leave the city and state boxes blank either by tabbing through them or by clicking in the zip code box. When searching for a match, the application uses the first 5 digits as search criteria.

Zip Code (when ZIP Code validation enabled)

If you enable ZIP Code validation, the ZIP Code is validated against the database table used for ZIP Code validation. A warning message, The Zip Code information you have entered was not found, is displayed if the city, state, and ZIP Code combination is not in the database. Depending on whether you have security permissions to access **Zip Code Maintenance**, the message provides different options.

If you have permissions to maintain ZIP Codes in **Zip Code Maintenance**, you have these options:

Yes

The city, state, and ZIP Code are saved with the patient's record as well as in the database table used for ZIP Code validation.

No

The city, state, and ZIP Code are saved with the patient's record but not in the database table used for ZIP Code validation.

Cancel

The city, state, and ZIP Code are not saved. You have the option to change the address information to a valid city, state, and ZIP Code combination.

If you do not have permissions to maintain ZIP Codes in **Zip Code Maintenance**, you have these options:

Yes

The city, state, and ZIP Code are saved with the patient's record but not in the database table used for ZIP Code validation.

No

The city, state, and ZIP Code are not saved. You have the option to change the address information to a valid city, state, and ZIP Code combination.

The **New Zip Code** button is displayed on **Zip Code Lookup**. The button opens **Add New Zip Code**, which provides the ability to add a ZIP Code to the database table used for ZIP Code validation. After the ZIP Code is added, it can be maintained in **Zip Code Maintenance**.

Country

The 2-digit abbreviation of the patient's country.

Home Tel #

The patient's 10-digit telephone number. If you selected a default area code in **Practice Options** or **Organization Options**, the first 3 digits are entered automatically when you open the **Patient** tab for a new patient. Select the check box to the right of **Home Tel #** if that number is the patient's primary phone number.

Tip: To view all telephone numbers associated with a patient's account, click  on the toolbar.

Ext

The extension for the patient's home telephone number, if any.

Work Tel #

The patient's 10-digit work telephone number. If you selected a default area code in **Practice Options** or **Organization Options**, the first 3 digits are entered automatically when you open the **Patient** tab for a new patient. Select the check box to the right of **Work Tel #** if that number is the patient's primary phone number.

Tip: To view all telephone numbers associated with a patient's account, click  on the toolbar.

Ext

The extension for the patient's work telephone number, if any.

Cell

The patient's 10-digit cell number, if any. If you selected a default area code in **Practice Options** or **Organization Options**, the first 3 digits are entered automatically when you open the **Patient** tab for a new patient. Select the check box to the right of **Cell #** if that number is the patient's primary phone number.

Tip: If necessary, you can add additional cell phone numbers using the boxes in **Patient Additional Information**.

Sex

Required box. The patient's sex. If you defined a default sex in **Practice Options** or **Organization Options**, this box is filled automatically when you open the **Patient** tab for a new patient. You can also use your keyboard to fill this box by entering **f** or **m** as applicable. **Unknown** is added as a gender value to the **Sex** drop-down list if the **Include Unknown in Gender Values** check box under **Entry Options** in the **Registration** tab is selected in **Practice Options** or **Organization Options**.

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.

Birth Date

The patient's birth date. To fill this box, enter a date using the format **mmddyyyy**, or click the down arrow and select a date using the calendar.

When the *Edit Contact Birth Date* security permission option in **Administration > Security Manager > Security Permissions > Practice Management > Patient Management > Registration** is denied, **Birth Date** cannot be edited for an existing contact unless a birth date was not previously entered.

Employer

The patient's employer. The employer name can contain up to 60 alphanumeric characters, but only a portion of the name is displayed. Use the arrow keys to scroll through the name, or press **Home** or **End** to move to the beginning or end of the name.

The patient's employer is needed for submitting certain types of claims that pull information from the selected employer record. To fill this box, either search for an existing employer record or create a new employer record.

- > To search for an existing employer record, click  to open **Employer Lookup**. Search for the correct employer, select the employer from the list, and click **OK**.
Tip: If an applicable employer does not exist, click **New Employer** to open **Add New Employer** and create a new employer record. When you click **Save**, you return to the **Patient** tab and the employer you just created entered in **Employer**.
- > To create a new employer record, click  to open **Add New Employer** and create a new employer record. When you click **Save**, you return to the **Patient** tab and the employer you just created entered in **Employer**.

E-mail

The patient's email address.

Enterprise

Free text box which is searchable. This box is sometimes used by Allscripts® Practice Management for database conversions.

Usual Provider

Select the patient's usual provider from the drop-down list. If you selected a default usual provider in **Practice Options** or **Organization Options**, this box is filled automatically when you open the **Patient** tab for a new patient.

Note: If you are using department security or practice security, the list of providers you see in **Actual Providers** is limited by your security settings. You cannot see providers that are associated with departments or practices you do not have access to.

Providers that have both **Member of Organization** selected and an inactivation date entered in **Provider Maintenance** display in the **Usual Provider** list as follows:

- > If the inactivation date is a current or future date, the provider displays at the bottom of the drop-down list with *****Inactive***** following the name.
- > If the inactivation date is before to the current date, the provider does not display in the drop-down list.

If you select a usual provider with an inactivation date that is the same as the current date, an error message is displayed when you try to save the patient record which reads Usual Provider <provider's name> is inactive as of <current date>. Please select an active usual provider..

If you open an existing patient record and the patient has an inactivated provider as his or her usual provider, the provider's name is displayed in red when the current date is after the inactivation date entered in **Provider Maintenance**. You must select an active provider before you can save your changes to the patient record. Otherwise, an error message is displayed when you try to save the record which reads Patient Usual Provider is not valid..

Referring Dr

The patient's referring doctor. To select a referring doctor, click  or press **ALT+down arrow** to open **Referring Doctor Lookup**. Search for and select the applicable referring doctor record, and click **OK**. (You can also double-click the applicable record.)

Tip: You can also enter search criteria based on the doctor's name in the box before you open the search window. Type in the first 3 letters of the doctor's last name, then the first letter of the first name: for example, "Wat, J" or "Wat, J") You can use lower case letters.

Then click  or press **ALT+down arrow** to open **Referring Doctor Lookup**.

PCP

The patient's Primary Care Provider (PCP). To select a PCP, click  or press **ALT+down arrow** to open **Referring Doctor Lookup**. Search for and select the applicable referring doctor record, and click **OK**. (You can also double-click the applicable record.)

Tip: You can also enter search criteria based on the doctor's name in the box before you open the search window. Type in the first 3 letters of the doctor's last name, then the first letter of the first name: for example, "Wat, J" or "Wat, J") You can use lower case letters.

Then click  or press **ALT+down arrow** to open **Referring Doctor Lookup**.

Med. Rec. Loc

The patient's medical record location. This box can be unavailable, available, or available and required based on the selections made on the **Registration tab** in **Practice Options** or **Organization Options**. (Selecting the option **Enter Med. Rec. Loc.** enables this box; selecting the Required Fields item **Patient Med. Rec. Loc** makes it required.) If the box is enabled, click the down arrow and select the applicable medical record location from the list. The list includes the locations created in **Medical Record Location Maintenance**.

Med. Rec. No

The patient's medical record number. This box can be unavailable and filled automatically, available, or available and required based on the selections made on the **Registration tab**

in **Practice Options** or **Organization Options**. Selecting the option **Enter Med. Rec. Loc.** enables this box; selecting the Required Fields item **Patient Med. Rec. No** makes it required. The box is unavailable and filled automatically if you select the option **Assign Med. Rec. No**. In this case, the Allscripts® Practice Management application automatically generates medical record numbers for each new patient. If the box is enabled, enter free text as needed.

Marital

The patient's marital status. Used as a pull field when preparing claims. Click the down arrow and make the applicable selection from the list. The options are:

- > **Single**
- > **Married**
- > **Divorced**
- > **Widowed**
- > **Separated**
- > **Partner**
- > **Unknown**

Employment

The patient's employment status. Used as a pull field when preparing claims. Click the down arrow and make the applicable selection from the list. The options are:

- > **Full Time**
- > **Part Time**
- > **Not Employed**
- > **Self Employed**
- > **Retired**
- > **Military Duty**

Student

The patient's student status: indicates whether the patient is a student, and if so whether he or she is full or part time. Used as a pull field when preparing claims. Click the down arrow and make the applicable selection from the list. The options are:

- > **Full Time**
- > **Part Time**
- > **Not a Student**

Inactivation Date

Enter the date that the patient became inactive. You can enter a date using the format mm/dd/yy or click the down arrow to open a calendar and select the date.

HIPAA Stmt Exp

The date the patient's current Health Insurance Portability and Accountability Act (HIPAA) statement agreement expires. You can enter a date using the format mm/dd/yy or click the down arrow to open a calendar and select the date.

Tip: To better manage HIPAA statement expiration dates, also select **Warning Period for HIPAA Stmt Renewal** on the **General** tab in **Practice Options** or **Organization Options**. When the expiration date falls within the warning period or the expiration date is either the current date or already passed, a warning message is displayed with you open this patient's record anywhere in **Registration** or **Scheduling**.

Rel to Guar

The patient's relationship to the guarantor. Click the down arrow and make the applicable selection from the list. The options are:

- > **Self**
- > **Spouse**
- > **Child**
- > **Other**

Transplant Donor

Select this option to designate the patient as a transplant donor. 1 patient cannot be a transplant donor and a transplant recipient.

You cannot clear this option after transplant status or transplant action records are created for a patient.

Transplant Donor is displayed only when **Enable Transplant Management** is selected on the **Special Billing** tab in **Practice Options** or **Organization Options**.

Transplant Recipient

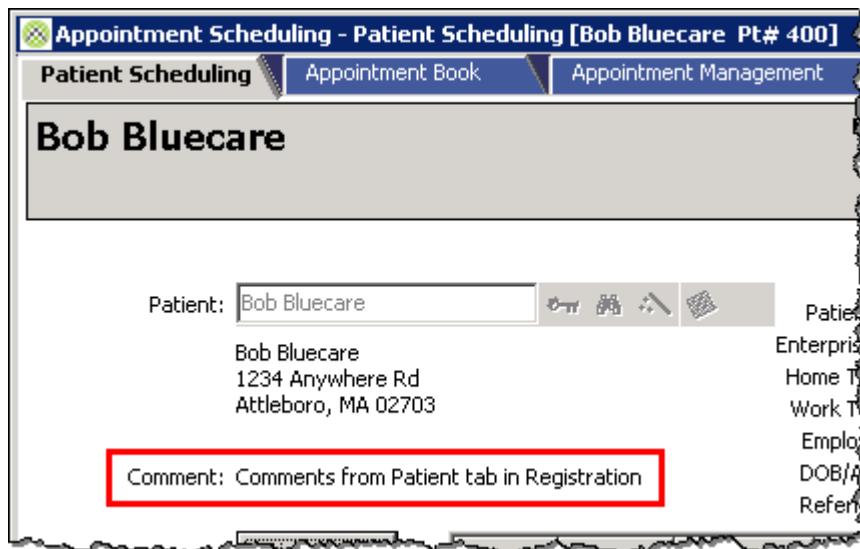
Select this option to designate a patient as a transplant recipient. 1 patient cannot be a transplant donor and a transplant recipient.

You cannot clear this option after transplant status or transplant action records are created for a patient.

Transplant Recipient is only displayed when **Enable Transplant Management** is selected on the **Special Billing** tab in **Practice Options** or **Organization Options**.

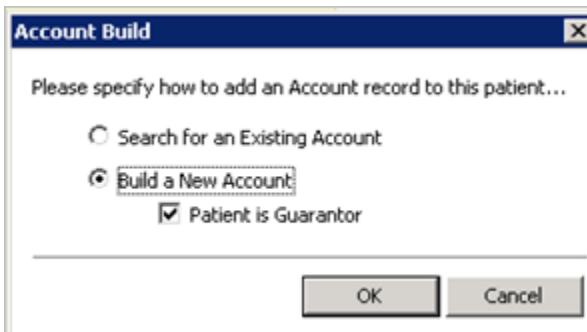
Comments

Free text box. Comment displays on the **Patient Scheduling** tab in **Scheduling**.



Completing the Account tab for the first time

When you are adding a new patient and you click the **Account** tab for the first time, **Account Build** opens.



Account Build lists 2 options: **Search for an Existing Account** and **Build a New Account**.

Tip: You can choose which of these options is the default using **Default Account Build** on the **Registration** tab in **Practice Options** or **Organization Options**.

Search for an Existing Account

Search for an Existing Account enables you to attach 1 or more patients to an existing guarantor, and is meant for use with family billing. When you select **Search for an Existing Account** and click **OK**, **Guarantor Lookup** opens, where you can search for a guarantor.

Note: **Search for an Existing Account** is not available when **Disallow Creation of Family Accounts** is selected on the **General** tab in **Practice Options** or **Organization Options**.

Build a New Account

Build a New Account enables you to build a new account. Use this option if your practice or organization treats each patient a separate account: that is, statements generated for an account include only balances related to the patient on that account. To make the patient the guarantor, leave the **Patient is Guarantor** check box selected. To make 1 of the patient's contacts the guarantor, clear the **Patient is Guarantor** check box. If you clear this check box, when the **Account** tab opens, you must enter information for the guarantor contact before you can click **Save**.

Tip: The guarantor is the patient or contact responsible for the self-pay balance due on the account.

After you make your selections on **Account Build** and click **OK**, the **Account** tab opens. If you selected **Build a New Account** and cleared the **Patient is Guarantor** check box, the contacts grid lists 2 entries: the patient, and another contact with the patient's last name. The contact with the patient's last name is selected in the grid, as has **Guar** and **Stmts** are selected as unavailable: you must enter finish entering information for this contact before you can click **Save**. If you selected **Search for an Existing Account**, some of the boxes on the **Account** tab might fill automatically from the existing account or information entered on **Duplicate Patient Checking**. See "Adding a new patient to Registration" for details. To move through the boxes on the **Account** tab, you can either click with your pointer or press **TAB**.

Important facts about family accounts

When you use **Search for an Existing Account**, the new patient's **Account Type** automatically defaults to the same **Account Type** as the guarantor's. All accounts that share the same guarantor always share the same account type. When you change the account type for 1 of the patients on a family account, the account type also changes for every other patient on that account. This cascading changes occurs because when you view the account information for a patient on a family account who is not the guarantor, the account information you see is actually the guarantor's: each patient linked to the guarantor shares the guarantor's account information. Each patient on a family account has the guarantor listed as the first contact in the contacts grid: the guarantor also has the **Guar** check box selected.

When you check **Print Family Statements of Account** on the **Statement** tab in **Practice Options** or **Organization Options**, voucher balances for this patient are included on a statement with other patients who share the Guarantor.

Policies tab

Use the **Policies** tab in **Patient Management > Registration** to enter information that is used to complete policy information for claims.

The **Policies** tab is active only when you select a patient on the **Summary** tab in **Registration** and that patient has a contact designated as **Subscriber** on the **Account** tab in **Registration**.

When **Highlight Required Fields** is selected in **Practice Options** or **Organization Options**, all boxes required to save the record you create are highlighted.

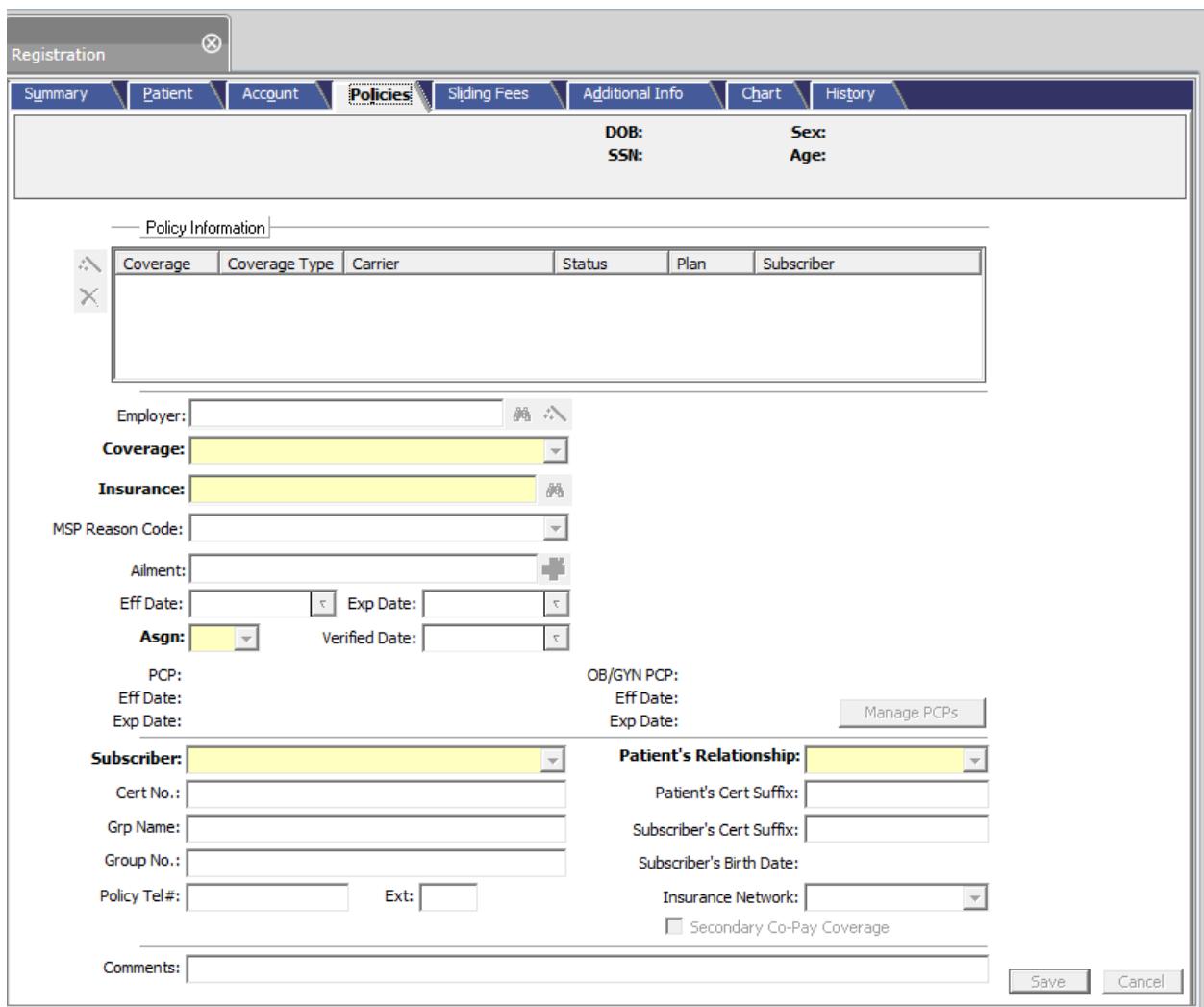
If both the **ANSI 837 Validation Checks** option in **Claim Style Maintenance > Validations** and the **Check Reg related Claim Style Validations** option in **Practice Options** or **Organization Options > Registration** are selected, a warning message is displayed if you save your changes and any of these items is missing:

- > Subscriber's date of birth for the primary policy, if the subscriber is not the patient
- > Subscriber's date of birth for the secondary policy, if the subscriber is not the patient
- > Subscriber's date of birth for the tertiary policy, if the subscriber is not the patient

If this warning message is displayed, you can still save your changes by clicking **OK** on the warning message and then clicking **Save**.

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.

Access the **Policies** tab from **Registration**. To access **Registration**, go to **Patient Management > Registration** or press **F9** and then enter **REG**.



Policy Information grid

Based on your security permissions related to coverage types, this grid lists the patient's policies, sorted first alphabetically by **Coverage Type** and second by **Coverage**. You cannot remove a policy that has been used to bill insurance claims.

Note: Transplant policies do not display on the **Policies** tab in **Registration**.

The **Policy Information** grid contains these columns:

Coverage

Indicates whether the policy is **Primary**, **Secondary**, **Tertiary**, **Other Primary**, **Other**, or **Not Available**.

Coverage Type

Displays the **Coverage Type** for each policy from **Insurance Carrier Maintenance**.

Carrier

Displays the **Carrier Name** from **Insurance Carrier Maintenance**.

Status

Displays the status of the policy. If the **Status** column for a policy is blank, the policy is active. If **Expired** is displayed, the expiration date entered for the policy has passed. **Exp [x] days** indicates the number of days to expiration. This status is displayed only when an expiration date is entered and the option **Warning Period for Policy Expiration** is set on the **General** tab in **Practice Options** or **Organization Options**.

Plan

Displays the **Plan Code** selected for the policy on **Insurance Carrier/Plan Lookup**. When both a PCP (Primary Care Provider) plan code and a specialist plan code are added to a patient's insurance, they are displayed in the **Plan** column as **[PCP Plan Code] / [Specialist Plan Code]**.

Subscriber

Displays the subscriber's name.

Carrier Inactivation Date is displayed when the selected policy is for a carrier with an inactivation date in **Insurance Carrier Maintenance**.

If the selected policy is for an insurance carrier with benefit plans:

- When **Insurance Carrier/Plan Lookup** is opened, only the carriers that are linked to the selected employer are included in the search results. The benefit plans and effective dates are displayed for each carrier.
- The benefit plan name, code, and expiration date (if applicable) are displayed. Click the benefit plan code to open **View Benefit Plan Details**.
- Use **Manage PCPs** to enter primary care providers (PCPs) and their effective dates for policies with benefit plans. The most current PCPs and related dates are displayed.

Manage PCPs

PCP	OB/GYN PCP
	PCP

Effective Date Expiration Date External Id

OK Cancel

- > **Secondary Co-Pay Coverage** is unavailable.

Employer

Enables you to associate an employer to a policy by clicking and opening **Employer Lookup**. Associating an **Employer** to a policy is required if **Policy Employer** is selected on **Patient Registration Required Fields**, which is available on the **Registration** tab in **Practice Options** or **Organization Options**.

If you have the required security permissions, you can also add a new employer by clicking and completing the required information on **Add New Employer**. You can also open **Add New Employer** by clicking **New Employer** on the **Employer Lookup**.

Medical or dental professional paper claims pull the policy employer information if it is available. Otherwise, employer information for these claims is pulled from the **Account** tab for the subscriber in **Registration**.

If you associate an **Employer** to a policy, the Employer Information boxes on a New York Workers' Compensation Board C-4.0 form fill automatically.

The employer name can contain up to 60 alphanumeric characters, but only a portion of the name is displayed. Use the arrow keys to scroll through the name, or press **Home** or **End** to move to the beginning or end of the name.

Coverage

Required box. **Coverage** describes the type of insurance the patient has, such as **Primary**, **Secondary**, or **Other**. You can have multiple policy coverages for each coverage type: each coverage type can have 1 **Primary** policy, 1 **Secondary** policy, 1 **Tertiary** policy, and as many **Other** policies as needed.

To change the default, click the down arrow and select the type of coverage provided by the policy being added to the account. The choices available are:

Primary

Use when the policy is the patient's primary coverage for a given coverage type.

Secondary

Use when the policy is not the patient's primary coverage for a given coverage type. Secondary insurances are those you submit a claim to after the primary insurance has made its payment. If the patient has Medicare, the secondary coverage would be a policy that supplements Medicare coverage. If your practice or organization uses uninsured carriers, you cannot select **Secondary** for uninsured carriers.

Note: If the option **Carriers Flagged as Secondary Required for Medicare Patients** is selected and the patient's **Primary** policy has **Source of Payment** set to **Medicare**, you must select a carrier for secondary carrier that is flagged as a **Secondary Carrier in Insurance Carrier Maintenance** in order to save your changes.

Tertiary

Use when the patient has a primary policy and a secondary policy for a given coverage type: tertiary insurances are those to which you submit a claim after both the primary and secondary have made their payments. If your practice or organization uses uninsured carriers, you cannot select **Tertiary** for uninsured carriers.

Other Primary

Enables you to bill multiple Medicare carriers as **Primary** without having to reset the patient's primary coverage flag each time you bill out a claim. If your practice or organization uses uninsured carriers, you cannot select **Other Primary** for uninsured carriers.

Note: If a medicare patient has both a **Primary** policy and an **Other Primary** policy on their account and **Require Policy** is selected on the **General** tab in **Practice Options** or **Organization Options**, the application checks the **Primary** policy to validate that the patient has an active primary policy that has the same coverage type as the coverage type selected for the appointment being scheduled. The application does not check the **Other Primary** policy during validation.

Other

Use for additional policies. If you add a new policy with the same coverage and coverage type as an existing policy, the application automatically change the **Coverage Type** of that existing policy to **Other**.

Not Available

Used for family billing to indicate those carriers that are flagged as policies for patients who share the same guarantor.

Note: Even for family billing, the designation of coverage type (primary, secondary, tertiary, other, unavailable) is unique to the patient and the policy. Because this information is unique to each patient, you can change the coverage type of a policy that is currently designated **Not Available** to another coverage type for 1 patient on a family account without changing the **Coverage Type** of that policy for the other patients on that family account. Therefore, the coverage type on an unavailable policy for a patient, can be changed without changing the coverage type of that policy for the other patients on that family account.

Insurance

Required box. To search for a carrier, click  to open **Insurance Carrier/Plan Lookup**. Click a PCP or specialist plan in the applicable section to associate it with the carrier for that patient. When you return to the **Policies** tab, the insurance plan you selected is displayed in **Insurance**. The PCP and specialist plans you selected on **Insurance Carrier/Plan Lookup** for this patient and carrier are displayed in **Insurance** after the name of the insurance carrier.

MSP Reason Code

This box is enabled for policies that have **Coverage** set to **Secondary** and are designated as Medicare policies based on **Source of Payment** in **Insurance Carrier Maintenance**. The default value for **MSP Reason Code** is the value in **Default Medicare Secondary Reason Code** on the **Output Options** tab in **Claim Style Maintenance**, but you can change the value.

The selectable options for **MSP Reason Code** in **Registration** are the same values that you can currently select for **Default Medicare Secondary Reason Code** in **Claim Style Maintenance** and **Medicare Secondary Reason Code** in **Claim Information**.

- > 12 - Working Aged Beneficiary or Spouse with Employer GHP
- > 13 - End-Stage Renal Disease Beneficiary
- > 14 - No-fault Insurance Including Auto is Primary
- > 15 - Workers Compensation
- > 16 - Public Health Service (PHS) or Other Federal Agency
- > 41 - Black Lung
- > 42 - Veterans Administration
- > 43 - Disabled Beneficiary Under Age 65 with Large GHP
- > 47 - Other Liability Insurance is Primary

Ailment

Enables you to associate an ailment with the selected policy by clicking  to open **Ailment Information** and selecting **Attach to this Policy**. When you attach an ailment to a policy, you must enter information in **Ailment Comment**. When you return to the **Policies** tab, the text you entered in **Ailment Comment** is displayed in **Ailment**. Associating an ailment to a policy might be required for your practice or organization, depending on the settings selected on the **General** tab in **Practice Options** or **Organization Options**.

Eff Date

Enter the date when the selected policy is effective using the format mm/dd/yyyy. In **Charge Entry**, you cannot save a voucher that includes a date of service earlier than this effective date when this carrier is selected as the payor.

This box is usually optional. It is required only if you have selected **Required for Policy Effective Date on Patient Registration Required Fields**. Open **Patient Registration Required Fields** from the **Registration** tab in **Practice Options** or **Organization Options**.

Exp Date

Enter the date when coverage given by this policy expires using the format mm/dd/yyyy. In **Charge Entry**, you cannot save a voucher with this policy selected when the date or the date range of service includes a date that is later than this expiration date.

This box is usually optional: it is only required if you have selected **Required for Policy Expiration Date on Patient Registration Required Fields**, which is accessible from the **Registration** tab in **Practice Options** or **Organization Options**.

Asgn

Required box. Fills with the default setting from **Insurance Carrier Maintenance** when you select a policy. You can change setting for the current patient only: the application honors the selection in this box over the selection in **Insurance Carrier Maintenance** when the 2 differ.

If you select **Yes**, "Yes" is selected in Box 27 on a standard CMS-1500 NPI paper claim form when a paper claim is printed and "Yes" is included in the ANSI 837 claim file in Loop 2300/Segment CLM.

If you select **No**, "No" is selected in Box 27 on a standard CMS-1500 NPI paper claim form when a paper claim is printed and "No" is included in the ANSI 837 claim file in Loop 2300/Segment CLM.

Verified Date

Enter the date when the insurance policy was last verified. You cannot enter a future date.

Verified Date is not available when **Coverage** is set to **Not Available**.

When **Required** is selected for **Policy Verified Date in Patient Registration Required Fields**, **Verified Date** is required for all policies that are not expired and have **Coverage** set to something other than **Not Available**.

Eligibility responses do not automatically fill **Verified Date**. You must enter the verified date if you want to track eligibility response information.

Alias insurance carrier demographic information

If the carrier entered in the **Insurance** box is flagged as an alias insurance carrier in **Insurance Carrier Maintenance**, then **Carrier**, **Address 1**, **Address 2**, **City**, **State**, **Zip Code**, **Country**, **Telephone**, **Ext**, and **Contact Name** boxes are enabled to the right of the **Insurance** box. Only **Carrier**, **Address 1**, **City**, and **State** are required. These data entry boxes are not tracked when **Track Patient Changes** on the **Registration** tab in **Practice Options** or **Organization Options** is selected.

Subscriber

Required box. When the guarantor has been designated as the subscriber for a policy, this box automatically displays the guarantor's name. If the subscriber for this policy differs from the default, click the down arrow and select the correct subscriber. The list in **Subscriber** includes the names of all other contacts associated with this patient and marked as subscribers on the **Account** tab in **Registration**.

Cert No

Enter the certification number. It does not matter whether you enter dashes, because the claims validation program removes all hyphens before it compares your entry to the defined number format for the carrier's claim style.

Tip: If the certificate number is the subscriber's Social Security Number, enter **SSN**: the application fills in the patient's Social Security Number.

Verify that the certificate number matches the certificate number format defined for carriers with this claim style in **Claim Style Maintenance**. When you click **Save**, a warning is displayed if the policy certificate number you entered does not match the format for the carrier's claim style and you cannot save your changes until you correct the certificate number. This warning exists because if the formats do not match, claims prepared for this patient's services do not pass the validation process and thus are not be billed to the carrier.

The certificate number is validated against the certificate number prefixes in the **Certificate Number Prefix** grid on the **Additional Info** tab in **Insurance Carrier Maintenance**. Use **Certificate Number Prefix** on the **Validations** tab in **Claim Style Maintenance** and **Hard Stop Validation for Invalid Cert No Prefix** on the **Registration** tab in **Practice Options** or **Organization Options** to manage certificate number prefix validation.

This box is usually optional. It is required only if you selected **Required** for **Policy Certificate No** on **Patient Registration Required Fields**. Access **Patient Registration Required Fields** from the **Registration** tab in **Practice Options** or **Organization Options**.

When you are adding a policy associated with a carrier that has **Hide Cert No.** selected on the **Carrier** tab in **Insurance Carrier Maintenance**, **Cert No.** only displays a string of asterisks (*). If you have not saved the record, you can view the certification number by pausing your pointer over **Cert No.**. If you have already saved the record, you can only view or edit the certification number if you have the applicable security permissions. To view or edit the certification number, click  to the right of **Cert No.** to open a window that displays the entire certification number.

Grp Name

Enter the policy group name as it must be displayed on a claim form. You can use up to 40 characters. This box is only required if you selected **Required** for **Policy Group Name** on **Patient Registration Required Fields**. Access **Patient Registration Required Fields** from the **Registration** tab in **Practice Options** or **Organization Options**.

Group No.

Enter the policy group number as it should be displayed on a claim form. This box is only required if you selected **Required** for **Policy Group No** on **Patient Registration Required Fields**. Access **Patient Registration Required Fields** from the **Registration** tab in **Practice Options** or **Organization Options**.

Policy Tel#

Informational only. Can be used as a pull field when creating master documents.

Ext

You can enter an extension number up to 5 digits.

Patient's Relationship

Required. This box is used to identify the patient's relationship to the subscriber of the insurance policy, and triggers which box is selected in Box 6 on a standard CMS-1500 NPI paper claim form. This box defaults to **Self** if the current patient has both **Subscriber** and **Patient** selected on the **Account** tab. You can change the default by clicking the down arrow and choosing the applicable selection from the list.

Self

Use when the patient is the subscriber.

Note: If the patient is the subscriber and you select anything other than **Self** for the **Patient Relationship**, a warning is displayed when

you save to notify you. You can still close the warning message and save your changes, but the claim will fail validation. The same is true if the patient is not the subscriber but **Patient's Relationship** is set to **Self**. In both of these circumstances, the validation error message Invalid data was entered for Patient's Relationship for [carrier name] is displayed on the Claims Validation list, on the **Validate Batches** tab in **Transactions**, in **Pending Claims Management** when you select **Demographic Errors** under **Type of Validation Error**, and on **Pending Claim Corrections** in **Charge Entry**.

Important: If this box is set to **Self**, when billing the carrier electronically, subscriber's name outputs as the patient's name regardless of the patient name entered on the voucher.

Spouse

Use when the subscriber is the patient's spouse.

Child

Use when the subscriber is the patient's parent.

Other

Use when the relationship between the patient and subscriber is not described by any of the other choices. For example, when the subscriber is the patient's legal guardian.

Patient's Cert Suffix

You can enter up to 8 characters, and use both letters and numbers. This box is required only if you selected the option **Certificate Patient Suffix Required** on the **Validations** tab in **Claim Style Maintenance** for the claim style associated with this carrier.

Subscriber's Cert Suffix

Enter a certificate suffix in this box when the subscriber is not the patient and the Subscriber's Certificate Suffix is different from the patient's. You can enter up to 8 characters, including both letters and numbers. This information is required when billing certain carriers using the ANSI 837 format.

Note: If the **Patient's Relationship** to the insured is **Self**, enter the subscriber's suffix in both **Patient's Cert Suffix** and **Subscriber's Cert Suffix**.

This box is required if you selected the option **Certificate Subscriber's Suffix Required?** on the **Validations** tab in **Claim Style Maintenance** for the claim style associated with this carrier, even if the certificate number format includes the suffix.

Insurance Network

Select a network plan for patient policies.

The list of insurance networks is retrieved from **Insurance Network Maintenance**.

Insurance Network is only available if you select **Check Contracted Locations** on the **Scheduling** tab in **Practice Options** or **Organization Options**.

Insurance Network is unavailable for uninsured insurance carriers and alias insurance carriers, regardless of whether you select **Check Contracted Locations**.

Your selection for **Insurance Network** should correspond with the patient's insurance policy information on the **Policies** tab in **Registration**. When scheduling an appointment, the application uses **Insurance Network** to determine whether a location is in network when the applicable carrier is flagged to check the network for contracted locations.

When you use an enterprise search to register a patient, the value of **Insurance Network** is not copied.

Secondary Co-Pay Coverage

Use to indicate that the co-pay amount due by the primary insurance carrier can be billed to the secondary insurance carrier and, therefore, does not have to be collected from the patient at the time of the visit. This is enabled when a policy is designated as **Primary** or **Other Primary** and a **Secondary** policy exists for the patient. When you add a secondary policy that covers the primary policy's co-pay, you must highlight the primary policy in the **Policy Information** grid and then select this check box.

When you select this check box, 4 things happen:

1. The notification "Co-Pay Waiver" is displayed in **Charge Entry** to the right of the **Payor** box when you select the flagged **Primary** or **Other Primary** insurance policy as the **Payor**.
2. Excludes the primary carrier's co-pay amount when calculating the **Patient Due Amount** on the **Self-Pay in Charge Entry**.
3. Prevents the display or entry of a co-pay amount on **Self-Pay in Charge Entry**.
4. The notification "Co-Pay Waiver" is displayed on **Self-Pay in Charge Entry**.

An encounter form pull field indicating the **Secondary Co-Pay** status for a patient can be used on custom encounter form.

Note: Before Allscripts® Practice Management Version 2006, Release 3 of the application, this check box was named **Waive Co-Pay**. Clients who selected **Waive Co-Pay** for a **Secondary**, **Tertiary**, or **Other** policy before the update will notice that **Secondary Co-Pay Coverage** is still enabled and selected when you highlight 1 of these policies. In these instances, Allscripts® recommends that you clear the check box for all policies that have a coverage type other than **Primary** or

Other. When you clear the check box in these instances, it becomes unavailable.

Comments

Enter any free text comment that applies to this policy. Information you enter in **Comments** is only displayed when you highlight this policy in the **Policy Information** grid.

Add a policy to a patient record

In **Patient Management > Registration** on the **Policies** tab, click  to add a new policy. You can assign as many primary, secondary, tertiary, and **Other** policies to a patient record as long as the coverage type is different.

If your practice or organization restricts access to policy information by coverage type, you can only add those policies associated with coverage types you have access to. Security permissions are assigned in **Administration > Security Manager > Security Permissions**.

1. Go to **Patient Management > Registration**. Go to the **Summary** tab.
2. To search for the patient record to add a policy to, click  next to **Patient**.
3. Go to the **Policies** tab.
4. Click  or press **INSERT** to add a new policy.

CAUTION: If you do not click  or press **INSERT**, you do not create a new policy. You only replace the policy that is highlighted in the grid.

5. For **Coverage**, click the down arrow and select the applicable coverage type from the list.

> **Primary**

Note: If the patient already has a primary policy for this coverage type and you add another primary policy for the same coverage type, the coverage for the existing primary policy automatically changes to **Other**.

> **Secondary**

Note: If the patient already has a secondary policy for this coverage type and you add another policy as secondary for the same coverage type, the coverage for the existing secondary policy changes to **Other**.

> **Tertiary**

Note: When a patient already has a tertiary policy for a particular coverage type and you add another policy as tertiary for the same coverage type, the coverage for the existing tertiary policy changes to **Other**.

> **Other Primary**

Note: Enables you to bill multiple Medicare carriers as the primary policy without having to reset the patient's primary coverage each time you bill out a claim.

> **Other**

Note: Use for additional policies. Allscripts® Practice Management automatically assigns this coverage to an existing policy when you add a new policy with the same coverage and coverage type.

> **Not Available**

Note: Allscripts® Practice Management uses this designation for family billing to indicate those carriers that are flagged as policies for patients who share the same guarantor.

6. For **Insurance**, click  to open **Insurance Carrier/Plan Lookup** and select the applicable insurance carrier and plans.

7. Click **OK**.

You return to the **Policies** tab. The policy you selected is displayed in **Insurance**.

8. If the carrier in the **Insurance** box is flagged as an alias insurance carrier in **Insurance Carrier Maintenance**, enter **Carrier Name**, **Address 1**, **City**, and **State**. Optionally enter **Address 2**, **Zip Code**, **Country**, **Telephone**, **Ext**, and **Contact Name**.

9. (Optional) For **Eff Date**, enter the effective date of this policy using the format mm/dd/yyyy.

When you select this carrier as a payor on a voucher in **Charge Entry**, you cannot save a voucher with a date of service before this effective date.

10. For **Exp Date**, enter the expiration date of this policy using the format mm/dd/yyyy.

When you select this carrier as a payor on a voucher in **Charge Entry**, you cannot save a voucher with a date of service after this expiration date.

11. (Optional) For **Asgn**, change the default setting for this patient only.

12. Enter the date when the insurance policy was last verified.

You cannot enter a future date.

Verified Date is not available when **Coverage** is set to **Not Available**.

When **Required** is selected for **Policy Verified Date in Patient Registration Required Fields**, you must fill **Verified Date** if the policy is not expired and has **Coverage** set to something other than **Not Available**.

Eligibility responses do not automatically fill **Verified Date**. You must enter the verified date if you want to track eligibility response information.

- 13 For **Subscriber**, select a subscriber.

This list includes contacts for this patient who have **Subscriber** selected on the **Account** tab.

- 14 For **Cert No**, enter a valid policy certification number.

Cert No might be governed by the carrier's Claim Style Validations option **Certificate Number Format**.

- 15 For **Grp Name**, enter the group name as it must be displayed on a claims form.

This box is required if this carrier is associated with a claim style that has **Group Name Required** selected on the **Validations** tab in **Claim Style Maintenance**.

- 16 For **Group No**, enter the group number as it must be displayed on a claims form.

This box is required if this carrier is associated with a claim style that has **Group Number Required** selected on the **Validations** tab in **Claim Style Maintenance**.

17. (Optional) For **Policy Tel#** and **Ext**, enter a valid phone number.

- 18 For **Patient's Relationship**, select the patient's relationship to the subscriber:

- > **Self**
- > **Spouse**
- > **Child**
- > **Other**

If the patient is the subscriber but **Patient's Relationship** is not set to **Self**, a warning message is displayed when you click **Save**. You can still save the information, but any claims with this information will fail validation with the demographic error "Invalid data was entered for Patient's Relationship for [carrier name]."

- 19 For **Patient's Cert Suffix**, enter the patient's certificate suffix.

This box is required when the **Carrier's Claim Style Validations** option is select, even when the certificate contains the suffix.

- 20 If the subscriber is not the patient and the subscriber's certificate suffix is different from the patient's, for **Subscriber's Cert Suffix**, enter the subscriber's certificate suffix.

This box is required when the **Carrier's Claim Style Validations** option is checked even when the certificate contains the suffix.

21. (Optional) To indicate that the co-pay amount due by the primary carrier can be billed to the secondary carrier, and therefore does not have to be collected from the patient at the time of the visit, select **Secondary Co-Pay Coverage**.

Secondary Co-Pay Coverage is enabled when a policy's **Coverage Type** is **Primary** or **Other Primary** and a **Secondary** policy exists.

22 Click **Save**.

Results of this task

A new policy is added to the patient record.

What to do next

If any warning messages are displayed, read them carefully and determine your next action.

Sliding Fees tab in Registration

Use the **Sliding Fees** tab in **Registration** to assign a sliding fee scale to a patient's account. The **Sliding Fees** tab is available in **Registration** only when you select **Use Sliding Fee Scales** on the **Registration** tab in **Practice Options** or **Organization Options**.

A patients' sliding fee information is reportable using the general view **vwGenPatSlidingFeeInfo**. Refer to the topics about general views for more information.

Access the **Sliding Fees** tab from **Patient Management > Registration**.

Note: The **Sliding Fees** tab is available in **Registration** only when you select **Use Sliding Fee Scales** on the **Registration** tab in **Practice Options** or **Organization Options**.

Registration

Summary | Patient | Account | Policies | **Sliding Fees** | Additional Info | Chart

DOB: Sex:
SSN: Age:

Sliding Fee Information

Sliding Fee Scale	Lock In Date	End Date	Flat Fee	Pct to Pay	Min to Pay	Max to Pay
<input type="button" value="X"/>						

Sliding Fee Scale:

Household Income:

Family Members:

Lock In Date:

End Date:

Flat Fee Amount:

Percent to Pay:

Minimum to Pay:

Maximum to Pay:

Comments:

Sliding Fee Scale

Select the applicable sliding fee scale for this patient from the list. Fee scales are custom-created in **Sliding Fee Scale Maintenance**.

Family Members

Enter the number of family members. This box is required if you intend to automatically calculate the flat fee or percent amount to pay.

Household Income

Enter a dollar amount. This box is required if you intend to automatically calculate the flat fee or percent amount to pay.

Lock In Date

Required box. Enter the date you will start using this sliding fee scale in **Financial Processing > Charge Entry**. In **Charge Entry**, you cannot save a voucher with a service date earlier than this start date when using this sliding fee scale.

Note: If you are using an Ability to Pay file, the application does not automatically calculate the flat fee or percent to pay amount when the lock in date is greater than the end date set in **Sliding Fee Scale Maintenance**.

End Date

Enter a date after which the sliding fee scale no longer applies for the patient. In **Charge Entry**, you cannot save a voucher with a service date after this end date when using this sliding fee scale.

Calculate

Enabled only when the sliding fee scale assigned to the patient has an associated Ability to Pay file and you have filled the boxes **Household Income**, **Family Members**, and **Lock In Date**. Click **Calculate** to use the associated Ability to Pay file to automatically calculate either the flat fee amount or the percent to pay amount based on the information you entered.

Note: If you are using an Ability to Pay file, **Calculate** is not available when you enter a family size of 13 or more. For families with 13 or more members, you must manually enter the flat fee or percent to pay amounts.

Clicking **Calculate** also verifies that the date you entered in **Lock In Date** is between the start date and end date for this sliding fee scale entered in **Sliding Fee Scale Maintenance**: if it is not, a message is displayed and you cannot automatically calculate the flat fee or percent to pay amount.

Calculate is not available when you select **Sliding Fee Scale By Procedure Code** on the **Sliding Fee Scale** tab in **Sliding Fee Scale Maintenance**. (When you select **Sliding Fee Scale By Procedure Code**, a message is also displayed on the **Sliding Fees** tab in **Registration** that reads The Patient Responsibility will be calculated at Charge Entry based on the individual services performed.)

Flat Fee Amount

When you click **Calculate**, either **Flat Fee Amount** or **Percent to Pay** is filled automatically based on the Ability to Pay file. **Flat Fee Amount** displays a flat fee for the patient to pay.

Flat Fee Amount and **Percent to Pay** are mutually exclusive. That is, if **Flat Fee Amount** is filled, **Percent to Pay** is not available.

Note: If you are using an Ability to Pay file, **Calculate** is not available when you enter a family size of 13 or more. For families with 13 or more members, you must manually enter the flat fee or percent to pay amounts.

For manual entry, enter an amount. This amount must be paid by the patient, and is used to calculate the adjustment during charge entry.

Flat Fee Amount is not available when you select **Sliding Fee Scale By Procedure Code** on the **Sliding Fee Scale** tab in **Sliding Fee Scale Maintenance**. (When you select **Sliding Fee Scale By Procedure Code**, a message is also displayed on the **Sliding Fees** tab in **Registration** that reads **The Patient Responsibility will be calculated at Charge Entry based on the individual services performed.**)

Percent to Pay

When you click **Calculate**, either **Flat Fee Amount** or **Percent to Pay** is filled automatically based on the Ability to Pay file. **Percent to Pay** displays the percent of the total amount that the patient must pay. **Percent to Pay** and **Flat Fee Amount** are mutually exclusive. That is, if **Percent to Pay** is filled, **Flat Fee Amount** is not available.

Note: If you are using an Ability to Pay file, **Calculate** is not available when you enter a family size of 13 or more. For families with 13 or more members, you must manually enter the flat fee or percent to pay amounts.

For manual entry, enter a percent. This percent is applied to the voucher during charge entry to determine how much of the total amount that the patient must pay.

Percent to Pay is not available when you select **Sliding Fee Scale By Procedure Code** on the **Sliding Fee Scale** tab in **Sliding Fee Scale Maintenance**. (When you select **Sliding Fee Scale By Procedure Code**, a message is also displayed on the **Sliding Fees** tab in **Registration** that reads **The Patient Responsibility will be calculated at Charge Entry based on the individual services performed.**)

Minimum to Pay

Optional box. Enter the minimum amount that the patient is responsible for. If the sliding fee scale is applied to a voucher and the patient's balance is less than the minimum amount, the patient must still pay the minimum amount.

If the patient is a self-pay patient who qualifies for the sliding fee and the services for that voucher do not add up to the minimum amount, a negative adjustment is applied to the last service line to bring the balance to the minimum amount. If the patient is an insurance patient and the balance transferred to the patient is less than the patient's minimum amount, a negative adjustment is applied to the last service line to bring the patient balance to the minimum amount.

During the Charge Entry process, at summary, if the charges entered do not reach the minimum amount, the difference will be added to the last service line with a negative adjustment, regardless of whether it is a procedure that had a sliding fee or not, to bring the balance up to the minimum amount.

The amount you enter in **Minimum to Pay** must be less than the amount you enter in **Maximum to Pay**. If the minimum to pay amount is greater than the maximum to pay amount, an error message is displayed.

Maximum to Pay

Optional box. Used in conjunction with **Percent to Pay**. This box does not automatically fill, even when you click **Calculate**. You must manually enter an amount when the patient's fee scale includes a maximum amount.

This amount overrides the actual percent amount applied to the voucher when that total exceeds the amount you enter as the maximum amount that the patient pays per visit (voucher). For example, when a patient's sliding fee scale requires a percent to pay of 50% with a maximum amount of \$80 then for a charge amount of \$417, the application does the following:

- > Determines the results of $417 * .50 = 208.50$
- > Matches the amount against the maximum amount of 80
- > Displays the patient due amount as the lower 1 of the 2, in this case it is the \$80.

Comments

Free text box. Information you enter in **Comments** is displayed only on this window when you select the applicable sliding fee scale in the upper grid.

Patient additional information boxes in Registration

Patient additional information boxes can be custom-created for your practice or organization on the **Patient Additional Info** tab in **Practice Set Up** or **Organization Set Up**. After you create 1 or more patient additional information boxes on this tab, the **Additional Info** tab is available in **Patient Management > Registration**.

The first 25 patient additional information can be used as pull fields when creating master documents, and are reportable using the Patient Additional Info general view. Patient additional info boxes can also be flagged as searchable, required, or secure.

- > If a patient additional information box is searchable (has the check box in the **Search** column selected), it is displayed in the **Search By** options in **Patient Lookup**.
- > If a patient additional information box is required (has the check box in the **Req** column selected), you must fill the box before you can save a patient record.

- > If a patient additional information is secure (has the check box in the **Secure** column selected), it is only displayed or editable if you have the applicable security permissions for secure patient additional information boxes assigned in **Administration > Security Manager > Security Permissions**.

How to enter information

Each patient additional information is given certain attributes or data entry characteristics when it is created. Each box is also given a defined type, length, and format. All of these defined values affect what data you can enter. These 2 tables show the different types of patient additional information and give entry tips for each.

Table 1: Table 1 - Types of patient additional information boxes

Type	Entry tips
Name fields	Use alpha characters (that is, letters). Be sure to follow the policies of your practice or organization when entering names.
Date	Enter 6 or 8 digits for the date. The application automatically converts your entry to the format mm/dd/yyyy.
Telephone	10-digit entry (area code + telephone number). The application automatically converts your entries to the format (###) ###-###-###.
True/False	Select True or False from the drop-down list as applicable or enter T or F.
Combo box	Click the down arrow to open the drop-down list and select the applicable option, or enter an option from the drop-down list manually. Drop-down list entries might contain letters, numbers, or both.
Alpha or zero-filled	Depended on the defined length, leading zeros are added to your entry until the entry meets the required length. For example, if the defined length is 10 but you enter only 8 digits (123DC678), leading zeros fill in the spaces left by the 2 missing characters (00123CD678).

Type	Entry tips
Zero-filled	Enter numbers only. Leading zeros are used when the length of the number entered is less than the defined length.

Be familiar with and follow your practice or organization's policies about entering information on this tab.

Number boxes might also have a particular format: any numbers you enter are automatically converted to the correct format. This table provides some examples.

Table 2: Table 2 - Entering data in formatted number boxes

Defined format entry	Display
##### (5 #s)	12345
	123
#####.##	123
	1.23
	12.3
	12345
	12345.00
	12345.00

The most efficient way to select boxes for data entry is to use your mouse. Move your pointer over the applicable box and left click, then enter the applicable data in the box. You can also press **TAB** to move through the boxes on a window.

Add a quick note

On the tool bar, click the  to add a quick note without having to open the **Note Management** tab.

You cannot use **Quick Note** to add a note that has a **Note Type** of **Claim**, **Service**, or **HIPAA**.

1. Do one of the following to make  available on the toolbar, then click 
 - > Open a patient record on **Registration** in **Patient Management**.
 - > Retrieve a patient, guarantor, claim, voucher, invoice, or reference on **Financial Inquiry** in **Financial Processing**.

- > Select a booked appointment slot on the **Appointment Book** tab or **Appointment Management** tab in **Scheduling > Appointment Scheduling**.
- > Retrieve a patient, guarantor, voucher, claim, or encounter on the **Charge Entry** tab, **Payment Entry** tab, or **Edits** tab in **Financial Processing > Transactions**.
- > Select a collections account on the **Collection Management** tab in **Collections > Collection Activities**.

Tip: To quickly access any of the following application areas, press **F9**, then enter the applicable quick access code:

Application area	Quick access code
Appointment Scheduling	APS
Collection Activities	CAC
Financial Inquiry	FIN
Registration	REG
Transactions	TRA

2. On **Quick Note**, for **Note Type**, use the drop-down list to select the type of note you want to add.
3. For **Subject**, enter a subject line that describes the reason for adding the note or edit the default subject line.
4. For **Expiration Date**, click , then select an expiration date from the calendar.

Note: **Expiration Date** is only enabled when the note was created in **Note Type Maintenance** with:

- > **Type Of Note** set to **Patient Note**, **Collection Note**, or **Other Note**
- > **Warning Flag** set to **Red Flag & General Warning** or **Red Flag & Scheduling Warning**.

If the expiration date entered on a note is the current date, the note expires immediately upon save.

If the expiration date entered on a note is a future date, the note expires on that date at midnight.

5. For the unlabeled note box under **Subject**, edit the content of the note.

Note: The text you enter in this box is included with the note when it is displayed. Some note types have default text. You can only edit default text if **Editable Default Text** is selected for the note type on **Note Type Maintenance** in **System Administration > File Maintenance**. If **Editable Default Text** is cleared, you can add text under the default text.

6. Click **Save**.

Results of this task

The note is displayed on the **Note Management** tab in **Patient Management > Notes**. It is also displayed on **Account Inquiry** and **Payment Entry** if you open **View Account Inquiry Information Options** using the **Change Options** and **View** option in the right-click context menu for a voucher, then select **Voucher Notes** in the **Voucher Options** area.

Search for a Patient

This section of topics relates to using the **Patient Lookup** window in **Registration**.

Types of patient searches

You can search for a patient's record from any window that has a **Patient** box with any of the following icons and buttons.

- > 
- > 
- > 
- > **Find By Key**
- > **Search**

Depending on your workflow and **Patient Lookup** settings, you can initiate a patient search from the main window. You can also click  or **Search** to open **Patient Lookup**.

Patient Lookup provides two types of patient searches: local searches and enterprise searches. For both types of patient searches, you must meet certain search criteria requirements.

Local searches

Use **Local Search** to scan the patient table in the Allscripts® Practice Management tenant that you are currently using.

Local Search is the only type of search available outside of **Registration** and **Scheduling**, regardless whether you define enterprise sources.

If you define one or more enterprise sources, and you select **Force Enterprise** on the **Enterprise** tab in **System Administration > Practice Options** or **Organization Options**, **Local Search** is unavailable and the following **Search By** options are selected as the primary search filters.

Local search

- > **Patient Name**
- > **Name (Soundex)**
- > **SSN**
- > **DOB**
- > **Enterprise No.**
- > **Medical Record No.**

Enterprise searches

Use enterprise searches to scan the patient tables in other Allscripts® Practice Management tenants that are within your security database and are defined as enterprise sources.

Depending on your settings on the **Enterprise** tab in **System Administration > Practice Options** or **Organization Options**, the following types of enterprise searches may be available.

Enterprise Search

Click **Enterprise Search** to scan patient tables in other tenants for patient records that are not saved to your local tenant.

The information downloaded is predefined by selections made on the **Enterprise** tab in **System Administration > Practice Options** or **Organization Options**. If a patient record is added to your tenant, it is maintained separate from the other enterprise sources. Changes made to the patient record in your tenant are not reflected or exchanged across tenants.

Important: To enable the **Enterprise Search** button for regular enterprise searches, your practice or organization must:

- > Have enterprise sources defined on the **Enterprise** tab in **System Administration > Practice Options** or **Organization Options**.
- > Have Allscripts® Interface Engine services started to import and export patient demographics from a mirror repository (a single master database that is specifically set up as a repository for the Master Patient Index used by multiple databases).

Search All Sources

Click **Search All Sources** to scan the patient tables in your local tenant, as well as other tenants on your network, when one or a combination of the following search filters is selected:

- > Patient Name
- > Name (Soundex)
- > SSN
- > DOB
- > Enterprise No.
- > Medical Record No.

Important: To enable **Search All Sources**, you must select **Force Enterprise Search** when defining enterprise sources on the **Enterprise tab** in **System Administration > Practice Options** or **Organization Options**. In addition, your practice or organization must:

- > Have enterprise sources defined on the **Enterprise tab** in **System Administration > Practice Options** or **Organization Options**.
- > Have Allscripts® Interface Engine services started to import and export patient demographics from a mirror repository (a single master database that is specifically set up as a repository for the Master Patient Index used by multiple databases).

EAD Search

Click **EAD Search** to scan the databases defined on the **Enterprise tab** in **System Administration > Practice Options** or **Organization Options** when you are using an interface between Allscripts® Practice Management and an Enterprise Access Directory (EAD) application.

Important: To enable **EAD Search**, your practice or organization must use an interface between Allscripts® Practice Management and an EAD system. And the interface must be configured with either **Custom** or **Standard** as the EAD Workflow on the **External Access** tab in **Practice Options** or **Organization Options**.

In addition, your practice or organization must:

- > Have enterprise sources defined on the **Enterprise tab** in **System Administration > Practice Options** or **Organization Options**.
- > Have Allscripts® Interface Engine services started to import and export patient demographics from a mirror repository (a single master database that is specifically set up as a repository for the Master Patient Index used by multiple databases).

Regardless which type you use (**Enterprise Search**, **Search All Sources**, or **EAD Search**), enterprise searches are only available in **Scheduling** and on **Registration** in **Patient Management**.

Moreover, they are only available if you use simple search criteria with none of the following options selected in **Search By**.

- > **Patient Number**
- > **Guarantor**
- > **Telephone No.**
- > **Certificate No.**
- > Any searchable patient additional information boxes

Search criteria

For both local searches and enterprise searches, you can search for patient records using simple search criteria in the **Patient Lookup** area on the **Patient Lookup** window. Simple search criteria enables you to scan your local tenant or other Allscripts® Practice Management tenants using up to three search filters.

Tip: After you complete your simple search criteria, you can select **Save Search By Settings** to reuse the same simple search criteria whenever you can start a search in the **Patient** box on the main Allscripts® Practice Management window.

For local searches only, you have the ability to use advanced search criteria instead of simple search criteria. Advanced search criteria enables you to scan your local database using as many of the available search filters and keywords as you want.

Important: When you use advanced search criteria, **Enterprise Search**, **EAD Search**, and **Search All Sources** are unavailable.

In addition, you cannot use **Save Search By Settings** to save advanced search criteria for reuse.

Whichever you use, you must complete the minimum number of search boxes required to initiate the search.

By default, the available search filters for the search boxes include the guarantor name and other patient information from the **Patient** tab on **Registration** in **Patient Management**. However, you can add additional search filter options using the check boxes in the **Search** column on the **Patient Additional Info** in **System Administration > Practice Set Up** or **Organization Set Up**.

Keywords for each search box must meet the minimum character limit and required format for the associated search filter. For example, keywords for **DOB** must be an eight-digit number formatted as MMDDYYYY. In addition, keywords must exclude spaces. If a keyword includes spaces, the application will display "(no matching records)" in the results grid.

Tip: To change the minimum number of search boxes you must complete or change the character limit for **Patient Name**, go to the **Search Options**

area on the **General** tab and the **Enterprise** tab in **System Administration > Practice Options or Organization Options**.

Search By options in Patient Lookup

When you search for a patient record in **Patient Lookup**, you must fill at least one **Search By** box and one **Search For** box.

In addition to the standard filters, the options in the **Search By** drop-down list and the boxes in the Advanced Search grid also include all the patient additional information boxes you selected as searchable in **Practice Set Up** or **Organization Set Up**.

There are 10 standard options in the **Search By** list.

Patient Name

Patient Name is the default selection for the primary **Search By** box. Unless you specify otherwise in **Practice Options** or **Organization Options**, a standard entry in the corresponding **Search For** box is to type in the first three letters of the patient's last name, a comma, and then enter the first letter of the patient's first name. For example, Pot, H.

Tip: Although you can also enter more letters, the application only uses the first three letters when performing a search.

Name (Soundex)

In the corresponding **Search For** box, enter the phonetic spelling of the patient's name. For example, to search for Samuel Adams, you might enter addums, s.

SSN

In the corresponding **Search For** box, enter nine digits without a hyphen, even if your practice or organization has chosen to prevent full social security numbers from being displayed. You can choose whether to prevent full social security numbers from displaying in the **Patient Lookup** results on the **General** tab in **Practice Options** or **Organization Options**.

- > If you select **Hide SSN**, social security numbers in results grid are displayed with five asterisks and the last four digits. (For example, *****1111).
- > If you select **Suppress SSN from Patient Lookup Results**, then the social security number can be used as part of the search criteria, but the **SSN** column is not included in the results grid.

DOB

In the corresponding **Search For** box, enter the patient's date of birth using either the format mmddyyyy or the format mm/dd/yyyy.

Enterprise Number

Use this option to search based on the **Enterprise#** box on the **Patient** tab in **Registration**. In the corresponding **Search For** box, enter the exact enterprise number.

Patient Number

Note: This search option is only available only for local searches.

In the corresponding **Search For** box, enter the exact patient number.

Guarantor Name

Note: This search option is only available only for local searches.

Use this option to search based on contacts that are marked as the guarantor on the **Polices** tab in **Registration**. In the corresponding **Search For**, enter the first three letters of the guarantor's last name, a comma, and then the first letter of the first name. For example, Pot, H.

Telephone No.

Note: This search option is only available only for local searches.

In the corresponding **Search For** box, enter 10 digits (area code then phone number) without dashes or parentheses.

Medical Rec. No.

Note: This search option is only available only for local searches.

In the corresponding **Search For** box, enter the exact medical record number. Valid entries can contain only letters or numbers.

Certificate No.

Note: This search option is only available only for local searches.

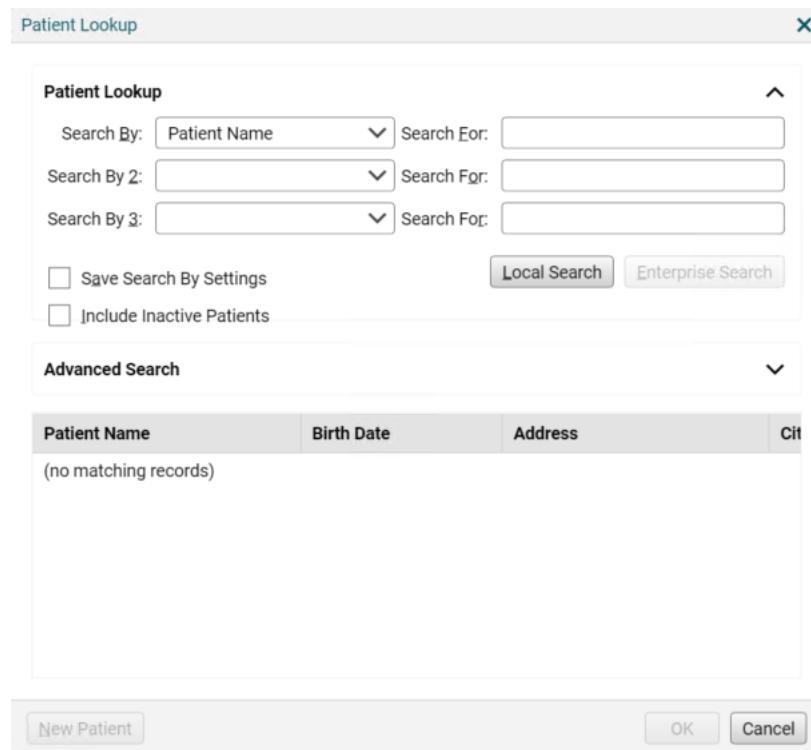
In the corresponding **Search For** box, enter the exact certificate number. Valid entries can contain only letters, numbers, and dashes.

Patient Lookup window

Use the **Patient Lookup** window to open an existing patient record through a keyword search with filters such as **Patient Name** or **SSN**.

Tip: By default, the available search filters for both **Local Search** and **Enterprise Search** include the guarantor name and other patient information from the **Patient** tab on **Registration in Patient Management**. However, you can add additional search filter options using the check boxes in the **Search** column on the **Patient Additional Info** tab in **System Administration > Practice Set Up** or **Organization Set Up**. When selected, the additional search filters become available in the **Search By** drop-down list in the **Patient Lookup** area, as well as the **Patient Additional Info** grid in the **Advanced Search** area.

To access the **Patient Lookup** window from any window, click **Search** or  next to a **Patient** box.



The screenshot shows the 'Patient Lookup' window. At the top, there are three dropdown menus for 'Search By': 'Patient Name', 'Search For:' (empty); 'Search By 2:', 'Search For:' (empty); and 'Search By 3:', 'Search For:' (empty). Below these are two checkboxes: 'Save Search By Settings' and 'Include Inactive Patients'. To the right are 'Local Search' and 'Enterprise Search' buttons. A large 'Advanced Search' section is collapsed. The main area displays a table with columns: 'Patient Name', 'Birth Date', 'Address', and 'City'. A message '(no matching records)' is shown. At the bottom are 'New Patient', 'OK', and 'Cancel' buttons.

Patient Lookup X

Patient Lookup ▼

Save Search By Settings Include Inactive Patients

Advanced Search ^

Patient Name:	<input type="text"/>	Patient Number:	<input type="text"/>
Name (Soundex):	<input type="text"/>	Guarantor Name:	<input type="text"/>
SSN:	<input type="text"/>	Home Tel#:	<input type="text"/>
DOB:	<input type="text"/>	Primary Tel#:	<input type="text"/>
Enterprise Number:	<input type="text"/>	Medical Rec No.:	<input type="text"/>
Certificate No.:	<input type="text"/>		

Patient Additional Information

Field Name	Search For

Local Search Enterprise Search

Patient Name	Birth Date	Address

New Patient OK Cancel

Patient Lookup area

Use the boxes in this area to determine your search criteria.

Search By and Search For

Use the **Search By** boxes to select up to three search filters when performing a simple search. Then, use the corresponding **Search For** boxes to enter keywords for the selected filters.

Keywords must meet the minimum character limit and required format for the selected criteria. For example, keywords for **DOB** must be an eight-digit number formatted as MMDDYYYY.

Tip: By default, **Patient Name** is selected for the first **Search By** box. To change the minimum character limit for **Patient Name**, go to the **Search Options** area on the **General** tab and the **Enterprise** tab in **System Administration > Practice Options or Organization Options**.

In addition, keywords must exclude spaces. If a keyword includes spaces, the application will display "(no matching records)" in the results grid.

Save Search By Settings

Select **Save Search By Settings**, then click **OK** to save the selected search filters as the default **Search By** setting for all patient searches application-wide.

Important: Default **Search By** settings created using **Save Search By Settings** are user-specific and workstation-specific.

Include Inactive Patients

Select **Include Inactive Patients** to include inactive patients in your search results. When you select this option, the application distinguishes inactive patients using strike-through font.

Note: The application determines which patients are inactive based on the date entered in **Inactivation Date** on the **Patient** tab in **Patient Management > Registration**. Patient records with an inactivation date that is earlier than the current system date are considered inactive.

Local Search

Use **Local Search** to perform a simple or advanced search for patient records that are saved on the Allscripts® Practice Management tenant you are currently using.

Enterprise Search

Use **Enterprise Search** to perform a simple or advanced search for patient records that are saved on other predefined tenants on your network.

Tip: To define which tenants are included in **Enterprise Search**, go to the **Enterprise** tab in **System Administration > Practice Options or Organization Options**.

Search All Sources

Use **Search All Sources** to perform a simple search of both your local Allscripts® Practice Management tenant and all predefined tenants on your network when one or a combination of the following search filters is selected:

- > **Patient Name**
- > **Name (Soundex)**
- > **SSN**
- > **DOB**
- > **Enterprise No.**
- > **Medical Record No.**

Important: To enable **Search All Sources**, select **Force Enterprise Search** for the defined enterprise sources on the **Enterprise** tab in **System Administration > Practice Options** or **Organization Options**. When enabled, **Search All Sources** replaces **Local Search** and **Enterprise Search**. In addition, **Advanced Search** becomes unavailable.

EAD Search

Use **EAD Search** to search the databases defined on the **Enterprise** tab in **System Administration > Practice Options** or **Organization Options** when you are using an interface between Allscripts® Practice Management and an Enterprise Access Directory (EAD) application.

Advanced Search area

Expand the **Advanced Search** area to search your local Allscripts® Practice Management tenant using more than three search filters.

Note: **Advanced Search** is only available for patient searches on the **Patient Lookup** window. When you expand the **Advanced Search** area, the **Patient Lookup** area for simple searches collapses and becomes unavailable.

Patient Additional Info grid

This grid includes search criteria boxes for each patient additional information field that is marked as searchable in the **Search** column on the **Patient Additional Info** tab in **System Administration > Practice Set Up** or **Organization Set Up**.

Results grid

This grid lists patient records that are exact matches for your search criteria. For example, if your search criteria are **Patient Name** = ada, s and **DOB** = 07271922, the results grid displays any patient record wherein the patient's:

- > Last name begins with “Ada”
- > First name begins with “S”
- > Date of birth is September 27, 1922

When you perform a local search, the results grid displays search results alphabetically in ascending order by last name, first name, then patient number.

When you use **Enterprise Search** or **Search All Sources**, the results grid displays search results as follows.

- > If the enterprise sources are other Allscripts® Practice Management tenants, the results grid displays search results from local and other tenants alphabetically in ascending order by last name, first name, then patient number.
- > If one or more of the enterprise sources is a non-Allscripts® Practice Management tenant that retrieves search results through Allscripts® Interface Engine, the results grid displays search results in groups based on source.

Your local tenant is the first source group displayed in the results grid, followed by enterprise source groups in order of their Enterprise Search Source ID.

For each source group, the results grid displays search results in the order you selected for **Search Display** on the **Enterprise** tab in **System Administration > Practice Options** or **Organization Options**.

Tip: The results grid only displays VIP patient information if you have VIP access to the patient record. However, you can prevent the results grid from displaying certain patient information even if a patient record is not restricted to VIP access.

To prevent the results grid from displaying full Social Security numbers, select **Hide SSN** or **Suppress SSN from Patient Lookup Results** on the **General** tab in **System Administration > Practice Options** or **Organization Options**.

If you select **Hide SSN**, the results grid displays the first five digits of the Social Security number as asterisks. For example, the results grid displays 000-11-3333 as *****3333. If you select **Suppress SSN from Patient Lookup Results**, the results grid does not include the **SSN** column.

Regardless which option you select, you can still use **SSN** as a search filter.

New Patient

Use **New Patient** to begin registering a new patient on **Begin New Patient** after confirming that the patient is not already registered in the tenant under a different spelling, birth name, or so on.

Important: **New Patient** is only enabled if you have security permissions to create new patient records assigned in **Administration > Security Manager > Security Permissions**. When enabled, **New Patient** is only available on the **Patient Lookup** window as accessed from **Patient Management > Registration** and **Scheduling > Appointment Scheduling**.

OK

Click this button to open a patient record and close the window.

Important: This button is only available if a patient record is selected in the grid. By default, the nearest match is selected.

Cancel

Click this button to close the window without opening a patient record.

Starting a patient search from a main window

You can load a patient's information in any main window by typing the patient's number in **Patient** and clicking .

If you have saved **Search By** settings on **Patient Lookup**, you can also enter values for those search criteria directly in **Patient** separated by semicolons and then click  to start a patient search.

Important: You cannot start a search from the main window if one of your saved **Search By** selections is **Advanced Search**. You must open **Patient Lookup** to perform an advanced search.

Which values you must enter in **Patient** is determined by your saved **Search By** settings on **Patient Lookup**. On **Patient Lookup**, select **Save Search By Settings** to save your search criteria so that you can use them on the main window. In **Patient Name**, enter values for all of your saved **Search By** selections in the order they are displayed in **Patient Lookup**. When entering values, separate each value with a semicolon. Do not put a space after the semicolon.

For example, if your saved search criteria are **Search By = Patient Name**, **Search By 2 = DOB**, and **Search By 3 = SSN**, your entry in **Patient Name** might look like this:



After you enter the applicable search criteria in **Patient**, click  to open **Patient Lookup**. **Patient Lookup** displays the matches for your search criteria are displayed in the search results grid at the bottom of the window.

Chapter 3

Appointment Scheduling

Patient Scheduling tab

Use the **Patient Scheduling** tab to schedule an appointment for an existing or potential patient, schedule a memo appointment, view patient information, or add an incoming referral.

Note: To schedule an appointment for a potential patient, **Allow Potential Patients** must be selected on the **Scheduling** tab in **Practice Options** or **Organization Options**.

Access the **Patient Scheduling** tab from **Scheduling > Appointment Scheduling**.

Patient information header

After a patient is loaded on the screen, the header contains the following information:

- > Patient name — first, middle initial and last name
- > DOB — Patient's date of birth
- > Sex
- > SSN — Patient's social security number

If you selected the option **Hide SSN** on the **General** tab in **Practice Options** or **Organization Options**, then only the last four digits of the SSN are displayed.

- > Age — Patient's age in years

Patient detail section

The following patient detail is displayed at the top of the window:

- > Patient name and address
- > Patient #
- > Enterprise #
- > Home, work, and cell phone numbers
- > Employer — Point-to **Employer** to show the full name from **Employer Maintenance**.
- > DOB/Age
- > # of active referrals
- > # of missed and late appointments

- > **Self-Pay Balance** — A self-pay balance displayed in red indicates that all or a portion of the patient's balance is considered past due based on the rule set in **Practice Options** or **Organization Options**.

If your practice or organization uses uninsured carriers, Self-Pay Balance includes both traditional self-pay balances and uninsured carrier balances.

Note: When a yellow or red flag is displayed to the left of the patient's name and address, this indicates that the Account Type has been flagged. You can view a detail of the Account Type by branching to **Patient Information**.

- > **Medical Co-pay** — determined by a combination of the patient's policy, the coverage type of the appointment, and the specialty of the resource's associated provider.
 - If the patient has an active, non-expired primary policy with the same coverage type as the appointment, the co-pay displayed is from that policy. Otherwise, the co-pay displayed is from the patient's active, non-expired primary medical policy.
 - The **Specialist Co-pay** is displayed if the provider's specialty has **Specialist Co-pay Applies** selected in **Specialty Maintenance**. Otherwise, the **PCP (Primary Care Provider) Co-pay** is displayed.
 - ◆ If **Specialist Co-pay Applies** is selected in **Specialty Maintenance** for the provider but the patient's relevant policy does not have a **Specialist Co-pay**, the **PCP Co-pay** is displayed.

If a policy is associated with a benefit plan, the benefit plan code is displayed instead of the cop-pay.

- > MR Loc.
- > MR No.

Branching buttons

The three branching buttons **Patient Info**, **Referrals**, and **Recalls** each opens a screen that allows you to perform a review or task without leaving **Appointment Scheduling**.

Future appointments grid

The grid located in the center of the form holds a listing of all future appointments scheduled for this patient.

You can also view a complete log of all past, current and future appointments scheduled for this patient from the **Appointment Activity** tab.

Appointment filter fields

These boxes and options allow you to define criteria which the system uses to find open times: that is open slots where you can schedule an appointment for the patient.

Visit Type

When **Enable Visit Type** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**, **Visit Type** is available.

The drop-down list contains the visit types created on the **Visit Type** tab in **Visit Type Maintenance**.

If **Enable Visit Type** on the **Visit Type** tab in **Practice Options** or **Organization Options** is cleared, **Visit Type** is not available and there is no change in functionality.

When **Enable Visit Type** is selected but **Require Visit Type in Appointment Scheduling** is cleared on the **Visit Type** tab in **Practice Options** or **Organization Options**, the following are true:

- > **Visit Type** is available.
- > **Visit Type** fills with the **Default Visit Type** selected on the **Visit Type** tab in **Practice Options** or **Organization Options**.

If there is no default selected for visit type, all visit types created in **Visit Type Maintenance** are available in the drop-down list.

Coverage type

The drop-down list contains the coverage types that are used in **Insurance Carrier Maintenance** to assign a type to a policy:

- > Behavioral 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)
- > Worker's Comp

Coverage Type uses the following hierarchy to determine which coverage type default setting fills the box:

1. The default coverage type selected on the **Coverage Type** tab in **Visit Type Maintenance**.
 **Note:** If your practice or organization does not use visit types, the coverage type default setting hierarchy process ignores this step.
2. **Coverage Type** selected on the **Scheduling** tab in **Update Options**, accessed from the toolbar.
3. **Default** selection in the **Available Coverage Types** area on the **General** tab in **Practice Options** or **Organization Options**.

4. The patient's primary insurance carrier's coverage type selected in **Patient Management > Registration**.
5. The box is not filled and you must select the coverage type from the drop-down list.

When the visit type for the appointment is not associated with the uninsured coverage type, **Coverage Type** uses the following hierarchy to determine which coverage type default setting fills the box:

1. The default coverage type selected in **Visit Type Maintenance > Coverage Types**

Note: If your practice or organization does not use visit types, the coverage type default setting hierarchy process ignores this step.

2. **Coverage Type** selected on the **Scheduling** tab in **Update Options** accessed from the toolbar
3. **Default** selected in the **Available Coverage Types** area on the **General** tab in **Practice Options or Organization Options**
4. The patient's primary insurance carrier's coverage type selected in **Patient Management > Registration**
5. The box is not filled and you must select the coverage type from the drop-down list that displays any coverage types associated to the visit type in **Visit Type Maintenance**

When the visit type for the appointment is associated with the uninsured coverage type, **Coverage Type** uses the following hierarchy to determine which coverage type default setting fills the box:

1. **Uninsured**, if the only active primary policy on the patient record is an uninsured carrier.
2. **Medical**, if the patient has an active primary medical policy, an active primary uninsured policy, and the visit type is associated with the **Medical** coverage type on the **Coverage Type** tab in **Visit Type Maintenance**.
3. The default coverage type that is selected in **Visit Type Maintenance > Coverage Types**, if the patient has an active primary uninsured policy and an active medical primary policy, but the visit type is not associated with the **Medical** coverage type.
4. **Coverage Type** that is selected on the **Scheduling** tab in **Update Options**, which is accessed from the toolbar
5. **Default** is selected in the **Available Coverage Types** area on the **General** tab in **Practice Options or Organization Options**
6. The patient's primary insurance carrier's coverage type that is selected in **Patient Management > Registration**
7. The box is not filled and you must select the coverage type from the list of coverage types that are associated with the visit type in **Visit Type Maintenance**

Note: After **Coverage Type** is filled with the default setting, change the appointment coverage type to any option that is available in the **Coverage Type** list.

Ailment

This box allows you to associate an ailment with an appointment.

Clicking  opens **Ailment Information**, which enables you to select an ailment to attach to the appointment. You must check **Attach to this Appointment** on **Ailment Information** for the ailment to attach to the appointment.

If you select a visit type that has **Case Type** set to **Workers' Comp** on the **Case** tab in **Visit Type Maintenance**, **Ailment** is automatically filled with **WC Case DOI <date of injury> <body part description>** if an ailment is selected on the **Case** tab in **Practice Options** or **Organization Options**. The values for **<date of injury>** and **<body part description>** are obtained from the case.

Associating an ailment to an appointment may be required depending on the settings on the **General** tab in **Practice Options** or **Organization Options**.

When you make an appointment for a particular coverage type which requires an ailment, the only ailments that display are the ones associated to policies with carriers of that particular coverage type as well as the ailment that has been attached to that particular appointment regardless of whether it is attached to a policy. If no ailments are associated to a policy whose carrier's coverage type is the coverage type of the appointment, when you open **Ailment Information** upon first making the appointment, there are no ailments from which to select. You can attach an ailment to the appointment by creating a new ailment. However, you must go back into **Registration** in order to associate the ailment to a specific policy. You can only associate it to a policy whose carrier has the same coverage type as the appointment. Also, if you only attach this ailment to the appointment and not to a policy, this ailment does not display when making future appointments. It does, however, display for this appointment when you view the appointment detail.

Also, one ailment can be associated to multiple appointments.

When you attach an ailment to an appointment, the **Ailment Comment** is required. You cannot save the ailment if you have not entered an **Ailment Comment**.

If you make memo appointments or appointments for potential patients, **Ailment** is disabled. **Ailment** is enabled for all other appointments including linked appointments.

Sched. Dept, Sched Location, Resource

These boxes default to a selection when you have value defined on the **Scheduling** tab in **Options for user [user name] on this workstation**, accessed by clicking **Update Options** 

on the toolbar.

Restricts the search for open times to the selected scheduling department, scheduling location and resource.

When any of these boxes is left blank, the search for open times is not restricted when searching for that particular filter.

Note: Use the up and down arrows beside **Resource** to change the box label between **Resource** and **Res Group** (Resource Group).

Appt Type

Appt Type lists of all the appointment types you created in **Appointment Type Maintenance** alphabetically by **Abbreviation**.

Note: When guided scheduling is enabled, and the applicable appointment type mapping is complete, the list for **Appt Type** on the **Patient Scheduling** tab includes the mapped appointment types.

The application uses the following hierarchy to filter the selections available in the **Appt Type** list:

1. If there is only one appointment type associated with the **Visit Type** value, then that appointment type is the default
2. Any appointment types associated with the **Visit Type** value in **Visit Type Maintenance > Appointment Types**
3. Any appointment types associated with the appointment groups that are associated with the **Resource** value
4. All appointment types created in **Appointment Type Maintenance**

When a resource group is selected on the **Patient Scheduling** tab:

- > If a visit type is not selected, the **Appt Type** is filtered to include the appointment types associated with the selected resource group in **Resource Group Maintenance**.
- > If a visit type is selected, the **Appt Type** list is filtered to include the appointment types associated with the selected visit type in **Visit Type Maintenance** that are also associated with the selected resource group in **Resource Group Maintenance**. If no appointment types qualify for both visit type and resource group, the appointment types associated with the visit type are included in the list.

Duration

Duration automatically displays the time defined in **File Maintenance**.

Refer. Doctor

When **Def to Pat's Ref Dr.** is selected in **Practice Options** or **Organization Options** on the **Scheduling** tab, this box defaults to the patient's **Referring Doctor** as entered in **Registration**.

When the option to require the entry of a referring doctor is selected, you cannot move on to linking appointments or searching for open times unless you select a referring doctor.

Comments

This is a free text box. Enter up to 80 characters.

Displays on the **Appointment Detail** and when the **Appointment** is highlighted on the **Appointment Book**.

When linking appointments, any text entered in this field applies to all the appointments which make up the linked set. Comments which are entered from a specific appointments detail screen will apply to that appointment only.

Days and Times

On or After — The system uses this date as the start date for its search.

Selecting the day(s)/time — Can restrict the search to a specific day/days and time period.

Options

The following options are available from the **Patient Scheduling** tab:

Walk-In

This button is enabled when you have filled in the following boxes: **Coverage Type**, **Scheduling Department**, **Scheduling Location**, **Resource**, and **Appointment Type**.

Allows you to force an appointment for the patient into the next 5 minute interval slot whether or not it is already booked or a restriction applies to the time slot.

Recurring

This button is enabled when you have filled in the **Coverage Type** and the **Appointment Type**.

Allows you to schedule the same appointment type on a recurring basis. For example, a lab appointment every 2 days for a 14 day period.

Link Appts

To select linked appointments you must select a **Coverage Type**.

Allows you to schedule a series of appointments on the same day for the patient that are linked. For example, schedule a lab appt, followed by an appointment for an xray that is later followed by a visit with the doctor.

Open Times

This button is enabled when you have filled in **Coverage Type** and **Appointment Type**.

Triggers a search for and display of available appointments based on the preferences (filters) defined.

Use Book

Opens the Appointment Book using the On or After date with the **Sched. Dept.**, **Sched. Location**, and **Resource** or **Resource Group** preloaded with the selections made on the **Patient Scheduling** tab.

Though this button is not enabled until you select a **Coverage Type**, **Scheduling Department**, **Scheduling Location**, **Resource**, and **Appointment Type**, the appointment book view displays all time slots, even those which are not available for the **Appointment Type** selected.

Note: The **Use Book** button is not available when guided scheduling is enabled.

Cancel

Clears the window and cancels the process of scheduling an appointment for the patient.

Attach an ailment to an appointment

Use the **Ailment Information** window to attach an ailment to an appointment.

1. In **Scheduling > Appointment Scheduling > Patient Scheduling**, click  to open the **Ailment Information** window.

The upper grid on the dialog displays this Ailment summary information: **Ailment Type**, **Comment**, **Policy**, and **Status**. A policy only displays in the **Policy** column if the ailment has been attached to a policy.

2. Click  (**Insert**) to add a new ailment to the patient's ailment history.
3. With your cursor in the field **Ailment Type**, click the down arrow to display the list of options.
4. Click on the name of a type to populate the field. At this point, the lower grid fills in with the template defined for the selected **Ailment Type**.
5. Tab to **Ailment Comment**. Type in a free text comment.
6. The following columns in the lower grid fill with optional information depending on the **Ailment Type** selected:
 - > **Field Name** - additional information you can add to describe the selected **Ailment Type**
 - > **Field Value** - this you can enter free-text or make a selection from a drop-down list

Note: If you cannot enter free-text in or there is no drop-down list in the **Field Value** column, click the calendar icon in the column directly to the right of the **Field Value** column. The selected date displays in the **Field Value** column.

- > **Req?** - if there is a value in **Field Value** and the field is designated as required in **Ailment Type Maintenance**, the will be checked.

7. Check **Attach to this Appointment**.
8. Click **Save (Alt+s)**.
9. Click **OK** to return to the main screen.

Attaching an ailment to an appointment and charge entry/import charges

This topic discusses the impact on the **Charge Entry** tab and **Import Charges** tab in **Financial Processing > Transactions** when you attach an ailment to an appointment.

When you enter a charge, an ailment can be viewed or added and attached to the voucher. If you attach an ailment to an appointment and enter the charge by encounter number, either manually or via the **Import Charges** tab (using any of the three ways to import charges), the application automatically attaches the ailment to the charge.  and the words **Ailment Attached** display next to **Policy** on the **Charge Entry** tab. Also,  displays next to **Ailment Info** on the **Summary** window from the **Charge Entry** tab indicating the ailment is attached to the voucher. The ailment can be unattached and a new or different ailment could be attached if necessary.

On the **Import Charges** tab, if you linked the incoming charge to the appointment by appointment ID (best practice) or encounter number, and you attached the ailment to the appointment, the application imports the charge with the ailment attached regardless of the method you used to import the charge. Also, if you import the charge where you can see the the **Charge Entry** tab (one at a time either using the right-click menu on the **Import Charges** tab or importing from the **Charge Entry** tab),  and the words **Ailment Attached** display next to **Policy** on the **Charge Entry** tab. Also,  displays next to of **Ailment Info** on the **Summary** window from the **Charge Entry** tab indicating the ailment is attached to the voucher. However, if an ailment is included as part of the charge message (as it can be with Allscripts TouchWorks® EHR, the ailment in the charge message overrides the ailment that had been attached at the time of the appointment. This is the hierarchy of ailments:

1. the ailment that is part of the charge import message
2. the ailment attached to the appointment
3. the ailment attached to the policy

 and the **Ailment Attached** message display in the same place as the inactivated carrier message so if both are true, the inactivated carrier message displays as  for the ailment being attached still displays on the **Summary** window.

Use the Patient Scheduling tab for standard scheduling

This topic describes how to enter appointment filters for an existing patient from the **Patient Scheduling** tab. (**F9>APS**)

The follow steps apply when guided scheduling is not enabled.

1. Open to the **Patient Scheduling** tab by pressing **F9** then type **APS** then press **Enter**.
2. At **Patient** click  to search for and find a patient by name.

OR

Enter the patient's number then click 

3. If applicable, select a visit type.

Visit Type is available when visit types are enabled in **Practice Options** or **Organization Options**.

4. At **Coverage Type**, click  and select the coverage type associated with the visit.
5. At **Ailment**, click  to associate an Ailment with the appointment.
6. At **Sched. Dept.** accept the default or click  to select a Scheduling Department.
To search for an opening in any scheduling department, leave this field blank.
7. At **Sched. Location** accept the default or click  to select a Scheduling Location.
To search for an opening in any scheduling location, leave this field blank.
8. At **Resource** do one of the following:
 - > Click  at the end of the field to open the listing of Resources then select a Resource.
 - > Leave the field blank to search for any available Resource.
 - > Click on either the up or down arrow to the right of the word Resource to change the field name to Res Group. Then click  at the end of the field to open the listing of Resource Groups then select a Resource Group.
 - > Leave this field blank so that the search is not restricted to any one Resource Group.
9. At **Appt Type** click  and select an Appointment Type from the list.
The length of the appointment defaults in the field **Duration**. You can manually change this default.
10. At **Refer. Doctor** accept the default if there is one or click  to search for a Referring Doctor.

This field may be required if **Require Referring Doctor** is checked in Practice/Organization Options.

11. At **Comments** enter text which can be viewed on the Appointment Detail dialog or when the appointment is highlighted on the Appointment Book tab.
12. At **On or After** enter a date or use the calendar to select a date.
13. Next select a day and time or accept the default of Any Day and Any Time.
14. Proceed by selecting one of the following options:
 - > Walk In
 - > Recurring
 - > Link Appts
 - > Open Times
 - > Use Book
15. When the process you have selected is complete you are returned to the Patient Scheduling tab.
The new appointment appears in the patient's future appointments' grid.

Add a new patient in Scheduling

This topic describes how to add a new patient from the Patient Scheduling tab. (**F9 > APS**)

1. At the field **Patient**, click  or position the cursor, and then press **Insert**.
If your Practice/Organization has turned the full Patient checking, the **Begin New Patient** dialog displays.
2. Enter the Patient's SSN, Last Name, and date of birth in the appropriate fields then **Enter**.
Once the checking process is complete, the Registration COMpanion opens.
3. Complete all tabs as directed in the section on **Registration**.

Schedule a memo appointment from the Patient Scheduling tab

This topic describes how to schedule a memo appointment from the **Patient Scheduling** tab. (Press **F9**, and then enter **APS**).

1. Click the **Memo Appointment** icon , which is located to the right of **Patient**.
Visit Type, **Coverage Type**, and **Appt Type** fill with their default value if you have those defaults set up in Allscripts® Practice Management.

2. If **Enable Visit Type** is selected on the **Visit Type** tab in **Visit Type Maintenance** and there is no default visit type setting, select **Visit Type**.
3. For **Coverage Type**, select the applicable coverage type, which for a memo appointment would usually be **Other**.

|| **Note:** **Ailment** is disabled for memo appointments.

4. For **Sched. Dept**, select the scheduling department or verify the default.
5. For **Sched. Location**, select the scheduling location or verify the default.
6. For **Resource**, select the resource or verify the default.

Click either the up or down arrow to change the box name to **Res Group**, and then select a resource group.

7. For **Appt Type**, select the appointment type.

Meeting is an example of a non-patient-related appointment type.

8. For **Duration**, accept the default or to adjust the length of the appointment click on up arrow to add minutes or the down arrow to decrease the length of time.

|| **Tip:** Place the cursor in the box and use the up and down arrows on your keyboard.

9. For **Comment**, enter a free-text comment that displays in the appointment slot.

Mtg w pharm rep is an example of a free-text comment.

10. Make selection in the **Day and Times** area.

11. Click **Use Book** to open the **Appointment Book** tab.

12. Select the time slot. Right-click and make your selection.

Example of right-click options are **Schedule in this Time Slot** and **Schedule (FORCE) in this Time Slot**.

The window that opens is different depending whether the appointment is to be scheduled or forced into the time slot.

13. Review and verify the details, then click **OK** or press **Enter**.

Results of this task

You are returned to the **Patient Scheduling** tab.

The memo appointment is displayed on the **Appointment Book** tab with **(memo appointment)** following the appointment type. Additionally, **(memo appointment)** is displayed in place of the patient name in **Appointment Detail**.

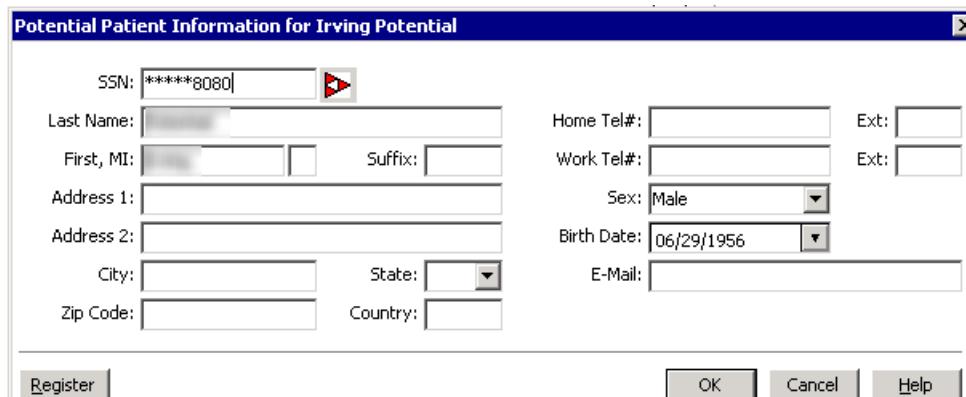
Schedule a Potential Patient from Patient Scheduling

This topic describes how to schedule an appointment for a Potential Patient from the Patient Scheduling tab.

You can open the Patient Scheduling tab to schedule a new appointment for a Potential Patient in any of the following ways:

- > Using the access code: Press **F9**, type in **APS**, then press **Enter**
- > From the Appointment Management screen by doing the following:
 - right-click on an appointment
 - select either Schedule New Appt (This Patient) or Schedule New Appt (Any Patient)

1. At the Patient name field, click  (**Alt+insert**) to open the Potential Patient Information dialog.



Enter as much information as you have and/or that your office policies require.

Tip: Entering at least the Patient's last name, SSN and Date of Birth guarantees that when you later begin the registration process that the duplicate Patient check will detect the existence of the record, if the Potential Patient has already been added through Registration.

The focus is set in the **SSN:** field.

2. At **SSN**, type in the Social Security Number.
3. At **Last Name**. Type in the Last Name.
4. Tab to the field **Birth Date**.
5. Type in the Potential Patient's date of birth using the format mm/dd/yyyy.
6. **Enter**. You now return to the **Patient Scheduling** tab.

7. Select the Appointment Preferences.

Note: **Ailment** is disabled for Potential Patients.

8. Schedule the appointment using one of the following commands: **Open Times** or **Use Book**.

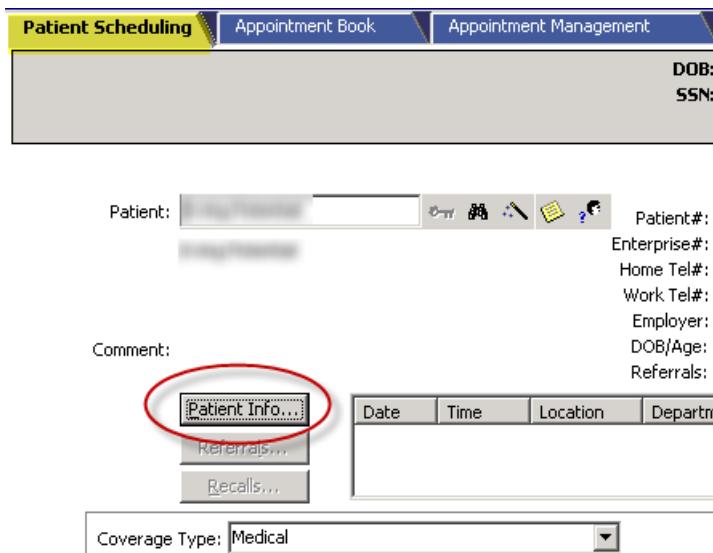
Register a potential patient from patient scheduling

This topic describes the steps for registering a potential patient using the Potential Patient Information screen which you open from the Patient Scheduling tab. (**F9 > APS**)

Before you begin

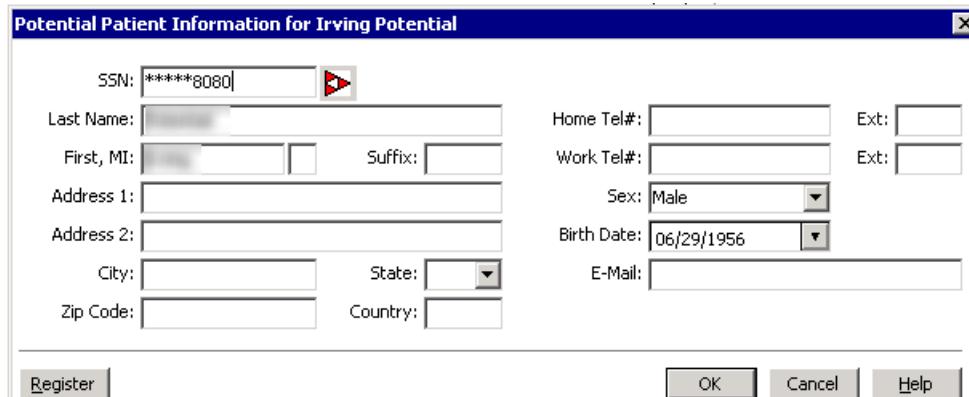
You must have the Potential Patient loaded on the screen.

Note: Names of Potential Patients are listed below all the Registered Patients in the search results grid. Potential Patient names are highlighted in yellow.

1. On the Patient Scheduling tab, click **Patient Info**.

This opens the **Potential Patient Information** screen.

Schedule a walk-in from the Patient Scheduling tab



2. On the **Potential Patient Information** screen, click **Register**.

This opens the **Allscripts COMpanion**.

All the information entered on the **Potential Patient Information** screen is copied to the **Patient** tab on the **COMpanion** screen.

3. Enter information on each tab in the **Allscripts COMpanion** to complete the registration process.
When you have completed registering the patient, click **Save** to return to the **Patient Scheduling** tab.

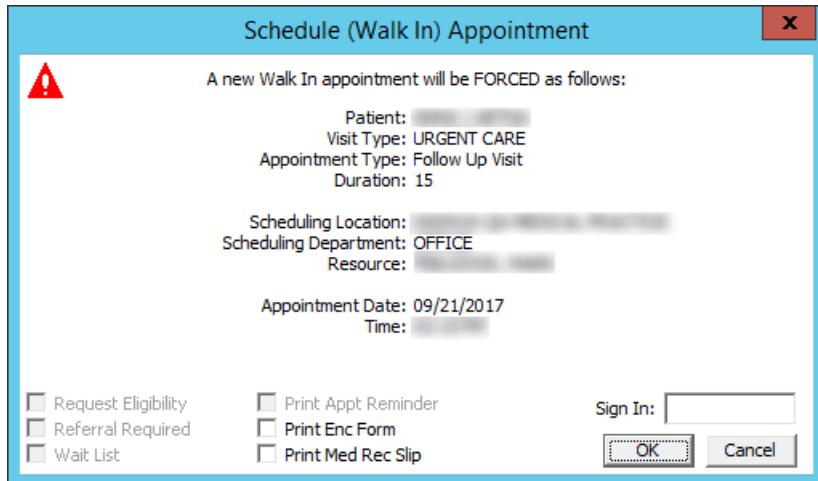
Schedule a walk-in from the Patient Scheduling tab

This topic describes how to schedule a walk-in appointment from the Patient Scheduling tab.

The **Walk In** button on the **Patient Scheduling** tab is enabled when you have filled in the following fields: **Coverage Type**, **Sched Dept**, **Sched Location**, **Resource**, and **Appt Type**.

You cannot schedule a walk-in appointment in a group activity time slot.

1. Click **Walk In (Alt+k)** to open the Schedule (Walk In) Appointment dialog.



2. Check any of the following options as needed:

- > **Request Eligibility** - This option is only enabled when all of the following are true:
The appointment is for the current date.
The patient has an active Primary insurance in which the carrier has an Information Broker (IB) Format record selected on the Eligibility tab in Insurance Carrier Maintenance.
The appointment contains items that are included on the Export Filters tab for the applicable IB Format record.
- > **Print Enc Form**
- > **Print Med Rec Slip**

Note: **Print Appt Reminder** is disabled when booking Walk In appointments.

- 3.** Click the **OK** command button to force an appointment at the next 5 minute interval.
- 4.** When the standard system print dialog opens, print the encounter form and/or medical record slip.
- 5.** After the encounter form and/or medical record slip has printed if **Request Eligibility** is checked, the Request Eligibility dialog appears so you may check eligibility for the patient.

Results of this task

The appointment is scheduled and its status is automatically set to "Acknowledged."

You are returned to the Patient Scheduling tab.

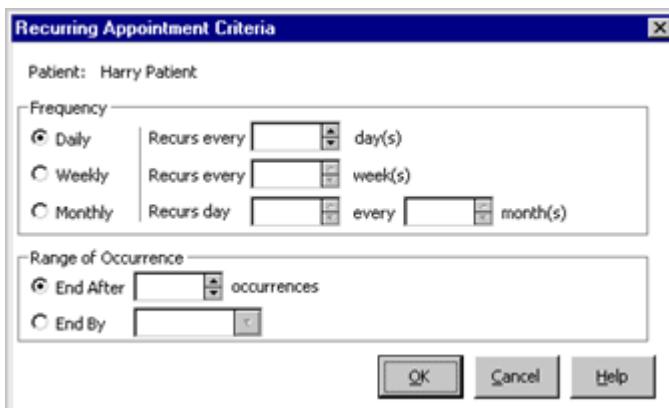
Schedule recurring appointments

Use **Recurring** on the **Patient Scheduling** tab in Appointment Scheduling to the same appointment type with the same duration multiple times for a patient.

On the Patient Scheduling tab (**F9** > type "APS" > **Enter**) you must load a patient on the screen and at a minimum select a **Coverage Type**, an **Appointment Type** and **Duration**. The more information you enter, such as Sched. Dept., Sched. Location, Resource, Days and Times the more refined are the search results.

Then do the following:

1. Click **Recurring (Alt+u)** to open the dialog.



2. Select a Frequency, i.e. do you want an appointment scheduled on a daily, weekly or monthly basis.

When selecting Monthly enter the day of the month on or near which you need to schedule the appointments.

3. Tab then type in the number of days/weeks/months you want to have between appointments.
4. Tab to or click on your selection for Range of Occurrence.
 - > **End After # occurrences** - key in the number of appointments you need to schedule.
 - > **End By** - key in the date beyond which appointments no longer need to be booked.
5. Click **OK** to begin the first search and open the **Find Recurring Times** window which contains the search results.
6. Use the scroll bar to scroll through the available times.
7. Double-click on an available slot in the upper until each of the appointments are selected.

Chapter 3 Appointment Scheduling

Find Recurring Times

Scheduling Weekly Appointment 4 of 4

Sched. Location:	Patient:
Sched. Dept: Laboratory	Appointment Type: LAB
Resource: LAB TECHNICIAN	Duration: 10

Sched Loc	Sched	Resource	Activ Type	Comment	%Bkd	Day	Date	Time
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	08:00 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	08:10 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	08:20 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	08:30 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	08:40 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	08:50 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	09:00 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	09:10 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	09:20 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	09:30 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	09:40 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	09:50 AM
NO	LAB	TECH	LAB		0%	Mon	07/07/2008	10:00 AM

Selected Appointments

Appointment #	Date	Day	Time	Location	Department	Resource
1	06/17/2008	Tue	08:50 AM	NO	LAB	LAB TECHNICIAN
2	06/23/2008	Mon	09:50 AM	NO	LAB	LAB TECHNICIAN
3	06/30/2008	Mon	09:10 AM	NO	LAB	LAB TECHNICIAN
4	07/07/2008	Mon	09:50 AM	NO	LAB	LAB TECHNICIAN

07/06/2008-07/19/2008 Show Every 5 Minute Opening

When all appointments are selected or when you click **Finish** the Schedule Recurring Appointments dialog opens.

Schedule Recurring Appointments

Patient:						
Appointment Type:	LAB					
Duration:	10					

Appt#	Date	Day	Time	Location	Department	Resource	Ref Req?	Wait List	Tag
1	06/17/2008	Tue	08:50 AM	NO	LAB	LAB TECHNICIAN	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2	06/23/2008	Mon	09:50 AM	NO	LAB	LAB TECHNICIAN	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3	06/30/2008	Mon	09:10 AM	NO	LAB	LAB TECHNICIAN	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4	07/07/2008	Mon	09:50 AM	NO	LAB	LAB TECHNICIAN	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Print Appt Reminder

By default all selected appointments are tagged for scheduling.

8. Review each appointment time.
9. To deselect or "untag" an appointment, click on the **Tag** box for that appointment line.
10. By clicking on the appropriate box you can flag an appointment as Referral Required or give the appointment the status of Wait List.
11. Click **Print Appt Reminder** to print appointment reminders for all the appointments listed in grid.

12 Click **Schedule** to initiate the process of scheduling each appointment.

When the process is completed you are returned to the **Patient Scheduling** tab.

Scheduling linked appointments

This section describes the steps in the process of linking appointments for a patient.

Define preferences for linked appointments

You can schedule linked appointments by clicking **Link Appts** from the **Patient Scheduling** tab. (**F9 > APS**)

Before you begin

The first step in the process is of scheduling linked appointments is to define preferences for each of the appointments. The system uses these preferences or criteria to search for available slots that meet your needs.

Tip: Keep your search as simple and as straightforward as possible. On the **Link Appointments** window, refine the filters to minimize the amount of time it takes the system to search for results.

Leaving a field blank causes the system to search through all the related records.

For example: It takes the system longer to search through all Scheduling Departments than to search through one specified scheduling department.

1. Load the Patient into the Patient Scheduling window using one of the following methods:

- > Patient Number - Enter the Patient's number in the field labeled **Patient > Tab**.
- > Search - Type in the first 3 letters of the Patient's name > **Alt+down arrow** > click on the name in the lower grid.

2. Optional: Select appointment preferences.

3. Click **Link Appts (Alt+i)** to open the dialog.



4. Do one or both of the following as it applies to your need:

- > Click  to a column for each appointment you need.
- > Click  to add a resource set.
If you add resource sets a box appears. Click  to open the drop down list of Resource Sets.
Click on a name in the list to select it.
Then, click **OK** to move back to the **Link Appointments** window.

5. Accept the default for any or all of the auto-filled fields or for each Appointment column do the following:

- a. At **Sched Dept** click  and select a Scheduling Department.
- b. At **Sched Loc** click  and select a Scheduling Location.
- c. At **Resource/Grp** click  and select either a Resource or Resource Group.
- d. At **Appt Type** click  and select an Appointment Type.
- e. At **Duration**, accept the default or enter a value to change the length of the appointment.
- f. At **Relationship**, click  to select the relation of each appointment to the one scheduled before it.
Select either: After, Flexible, or Overlap.
The first appointment in the grid is automatically given the relationship of Flexible, you cannot change this setting.
- g. At **Min Wait** enter in minutes the least amount of time you want to have pass between the appointment and the end of the one scheduled just before it.

You cannot enter a value for appointments with the relationship set at **Flexible**.

- h.** At **Max Wait** enter in minutes the maximum amount of time that can occur between the appointment and the one scheduled before it.

The number entered for the maximum wait must be equal to or greater than the number you enter for the minimum wait.

Note: Do not change the default value of 0 when an appointment must overlap with the appointment preceding it in the grid.

- i.** At **Enc. Form** click  to check and trigger the printing of an encounter form for that Appointment. The Encounter Form for the appointment is generated based on the settings in Practice/Organization Options on the **Scheduling** tab.

- 6.** Click **Analyze (Alt+a)** to initiate the search for available times.

The field **First Avail** for each appointment is populated with the appropriate message, which is either a date or an indication that there are no available slots for that appointment. At this point you can change any selection for that appointment and click Analyze.

Repeat this process dates have been found for each appointment.

Note: You can check **Ignore Days & Times** to clear the preferences for the days and times originally selected on the **Patient Scheduling** tab if you entered any. Checking this box automatically restarts the analysis.

What to do next

Once appointment slots have been found for each appointment then your next step is to schedule the appointments. You can do this by using the **Calendars** command or by clicking **OK** to opening the **Schedule Link Appointments** window.

Schedule linked appointments

Once appointment slots have been found using **Analysis** from the **Link Appointments** window, then you can select from the available times to schedule the appointments.

This topic describes how you select and schedule appointments once the available slots have been found. You can view the available slots either by using the **Calendars** view or by directly opening the **Schedule Link Appointments** window.

- 1.** To open the Schedule Appointments window do one of the following:

> Click **Calendars (Alt+c)**, then double-click on a day colored in green.

Chapter 3 Appointment Scheduling

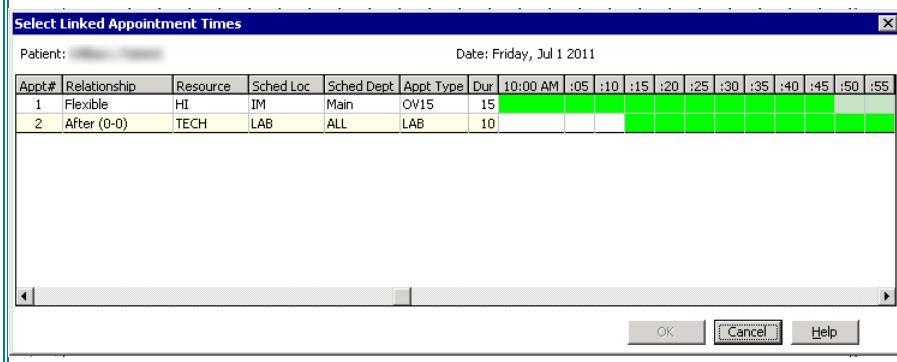
This opens the Schedule Linked Appointments showing the available slots for the day you selected.

Note: If necessary, use the controls < and > found to the left and right of the fields showing the month and year at the lower left of the screen.

- > Click **OK**

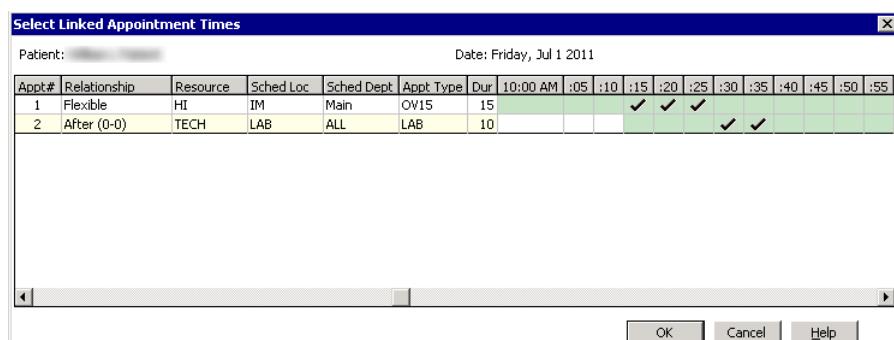
This view shows you the available slots in the first available day.

Note: If necessary use the < and > found to the left and right of the day and date listed at the top of the screen.



Appt#	Relationship	Resource	Sched Loc	Sched Dept	Appt Type	Dur	10:00 AM	:05	:10	:15	:20	:25	:30	:35	:40	:45	:50	:55
1	Flexible	HI	IM	Main	OV15	15	10:00 AM											
2	After (0-0)	TECH	LAB	ALL	LAB	10												

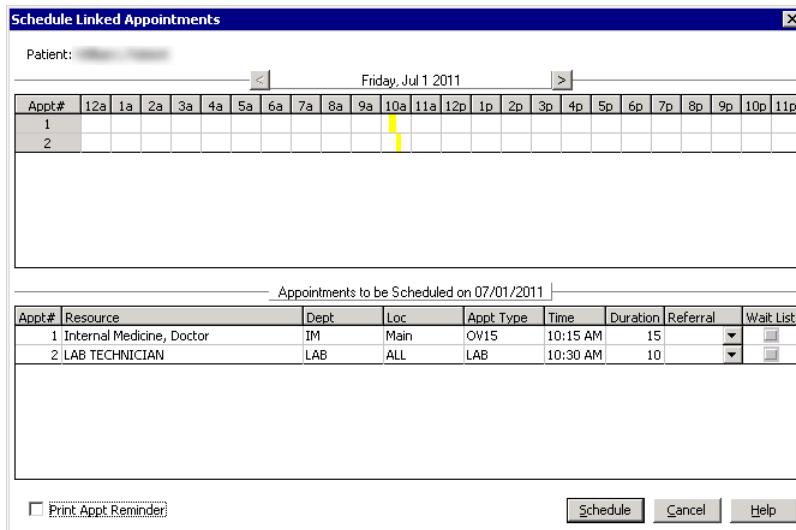
2. When you have found the time slots you want to select, click on an appointment time for the first appointment, then for the second appointment.



Appt#	Relationship	Resource	Sched Loc	Sched Dept	Appt Type	Dur	10:00 AM	:05	:10	:15	:20	:25	:30	:35	:40	:45	:50	:55
1	Flexible	HI	IM	Main	OV15	15												
2	After (0-0)	TECH	LAB	ALL	LAB	10												

3. Click OK when you have selected all the times you need.

This brings you back to the Schedule Linked Appointments window.



Note: Each appointment should show a yellow color -code. If you see a green color on an appointment it means you have not selected a time slot for that appointment. Click on the green to re-open the Select Link Appointments window and make a selection.

4. At Referral, leave blank or click to select Required, whichever applies.
5. At Wait List, click if the patient wants to be added to a wait list for a more convenient appointment time, if it applies.
6. At Print Appt Reminder, click to generate a printed appointment reminder for each appointment.
7. Click Schedule to initiate the process of scheduling each appointment.

When the process is complete you are returned to the Patient Scheduling tab. The newly scheduled appointments are displayed in the appointments grid.

Schedule appointments using Open Times

Use **Find Open Times** for scheduling an appointment for a selected patient.

Before you begin

To search for open times, you must retrieve a patient record on the **Patient Scheduling** tab, and then make the following selections:

- > **Sched. Dept**
- > **Sched. Location**
- > **Resource or Res Group**

> **Appt Type** with duration

Note: Refer. Doctor is required only when **Require Referring Doctor** is selected on the **Scheduling** tab in **Practice Options** or **Organization Options**.

Note: If **Booking Factor Limits** is selected on the **Scheduling** tab in **Practice Options** or **Organization Options**, scheduling logic considers booking limits.

When using **Find Open Times**, time slots are not displayed if they have met booking limits for the selected appointment type.

When using **Open Times**, the search results ensure that scheduling appointments beyond the set booking limits does not happen.

The following steps apply when guided scheduling is not enabled.

1. On the **Patient Scheduling** tab, enter appointment preferences.
2. Click **Open Times**.

Find Open Times opens.

The first set of results is displayed. Use the scroll bar on the right to review the available times.

Find Open Times

Scheduling New Appointment										
Sched. Location: [REDACTED]			Patient: [REDACTED]							
Sched. Dept: Internal Medicine			Appointment Type: OV - 15							
Resource: Allscripts, Internal M			Duration: 15							
Sched Loc	Sched	Resource	Activ Type	Comment	%Bkd	Day	Date	Time		
Main	IM	IMA	OV		0%	Fri	07/01/2011	01:00 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	01:15 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	01:30 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	01:45 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	02:00 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	02:15 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	02:30 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	02:45 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	03:00 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	03:15 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	03:30 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	03:45 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	04:00 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	04:15 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	04:30 PM		
Main	IM	IMA	OV		0%	Fri	07/01/2011	04:45 PM		
Main	IM	IMA	OV		0%	Tue	07/05/2011	01:00 PM		
Main	IM	IMA	OV		0%	Tue	07/05/2011	01:15 PM		
Main	IM	IMA	OV		0%	Tue	07/05/2011	01:30 PM		
Main	IM	IMA	OV		0%	Tue	07/05/2011	01:45 PM		
Main	IM	IMA	OV		0%	Tue	07/05/2011	02:00 PM		

06/28/2011-07/11/2011 Show Every 5 Minute Opening

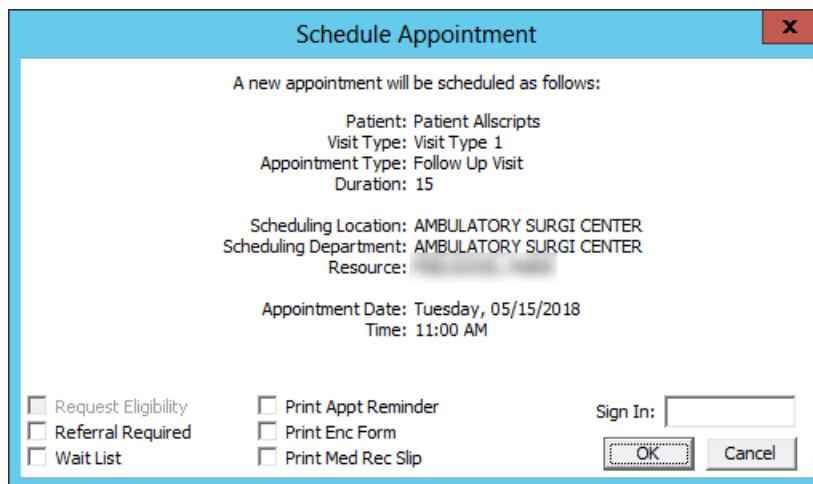
Note: If you select a resource group on the **Patient Scheduling** tab that has **Guided Resource Scheduling** selected in **Resource Group Maintenance**, the display of **Find Open Times** is modified to accommodate guided resource scheduling:

- > The **Resource**, **Activ Type**, **Comment**, and **%Bkd** columns are not displayed.
- > The available time slots are displayed based on a random order of resources in the group instead of alphabetical order, which eliminates scheduling predictability. The resource name is displayed in **Schedule Appointment** after you click **Schedule**.

3. **Optional:** Click **More Times** to search for more available times
4. **Optional:** Select **Show Every 5 Minute Opening** to display all available five-minute segments.
5. **Optional:** Click **Use Book** to open the appointment book format

After you open the **Appointment Book** tab, if you do not select an appointment and close the book, you are returned to the **Patient Scheduling** tab where your selections remain in tact. To resume the process you must restart from step 1.

6. In **Find Open Times**, select a time slot by doing either of the following:
 - > Double-click on the time slot
 - > Highlight the slot, then click **Schedule**
7. When **Schedule Appointment** opens, review the detail.



8. Select **Request Eligibility** if using real-time eligibility verification .
9. Select **Referral Required** if a referral is required for this visit but has not yet been received and attached to the appointment.

10. Selecting **Referral Required** to indicate that a referral is missing for this appointment will cause one or both of the following to occur:
 - > **Referral Required** will also be selected in **Appointment Detail**.
 - > If **Flag Missing Referrals** is selected in **Practice Options** or **Organization Options**, this appointment is displayed with a yellow flag on the **Appointment Management** and **Appointment Activity** tabs.
11. Select **Wait List** for patients who would prefer a more convenient appointment time when and if it should become available.
A list of appointments with the status of **Wait List** can be printed on an **Appointment Detail Report** or displayed on the **Appointment Management** tab.
12. (Optional) Select **Print Appt Reminder** if you want to print an appointment reminder to hand to the patient.
13. If the appointment is a same-day appointment, the options to print an encounter form or a medical record slip are available. Select one or both options as necessary. Because Allscripts® Practice Management "remembers" the selection you make, the next time you schedule a same-day appointment, these options will be default values accordingly until you log out of your session.
14. (Optional) Select **Print Med Rec Slip**.
15. Click **OK** to schedule the appointment.

You are returned to the **Patient Scheduling** tab.

Miscellaneous functions

This section describes functions that you can initiate from either the Appointment Book, Appointment Management or the Appointment Activity tabs.

Context menu options in Appointment Scheduling

Use the context menu options available with the right-click of the mouse from the **Appointment Book**, **Appointment Management** and **Appointment Activity** tabs for quick access to various functions.

Best practice is to frequently see what options are available to you with the right-click of the mouse. Clicking on any active option opens the applicable function. Use that window the same way you would if you opened it directly.

When a selection is grayed out, that function is unavailable.

Depending on the slot you select, the list may contain only valid options.

Appointment Detail

This option opens **Appointment Detail** for the patient scheduled in that time slot. On this window you can see all the detail related to the selected time slot.

You can also do the following:

- > Change the appointment's status
- > Enter a time for **Ack. Time In**, **Started**, and **Check Out**
- > Select a confirmation result or a cancellation reason
- > Change the coverage type, referring doctor, or the referral required status
- > Open and use the **Incoming Referrals** window
- > Perform the following tasks: request eligibility if this function is activated, print an encounter form, print a medical record slip, print an appointment reminder, move the appointment, open **Patient Info**, or initiate the registration process for a potential patient.

Patient Information

This option opens a window that shows a summary of the information related to the patient. The window is the same window that opens on the **Patient Scheduling** tab when you click **Patient Info**.

You can branch to **Registration** and **Financial Inquiry** from this window.

Register

This option is available only if the patient is a potential patient.

This option initiates the registration process by opening **Allscripts COMpanion - Registration**.

Incoming Referrals

This option opens **Incoming Referrals**, which you can use to create a new referral, edit an existing referral, attach or link a referral to the selected appointment.

Recalls

This option opens **Recalls** where you can create a new recall, edit an existing recall, or link a recall to the selected appointment.

Confirm

Use this option to indicate that the patient has been personally contacted and intends to come in for the appointment.

This option opens **Confirm Appointment** where you can select a confirmation result, if it applies to your practice work flow.

Acknowledge

Use this option to indicate that the patient has arrived for the appointment.

Wait List

Use this option to identify an appointment that is tentatively booked in a slot for a patient who would prefer a more convenient time should one become available.

Note: A list of appointments with the status of Wait List can be printed on an Appointment Detail Report or be displayed in **Appointment Management**.

Best Practice is to enter the patient's preference in the **Comments** section of the appointment.

1. Right-click on the appointment line, and then click **Wait List**.
2. Review the detail.
3. If you want to submit a Real Time Eligibility Request, select **Request Eligibility**.
4. Click **OK**.

Started

Use this option to record the time a patient is brought back to an exam room.

Opens **Start Appointment** on which you can define a start time.

When setting the start time for linked appointments, you are given the option to set the time for the selected appointment only or for all the linked appointments.

Check Out

Use this option to enter the time the patient checks out at the desk.

Opens **Check Out Appointment** on which you can define a check out time.

When setting the check out time for linked appointments, you are given the option to set the time for the selected appointment only or for all the linked appointments.

Cancel

This option opens **Cancel Appointment** from which you can enter a cancellation reason.

Note: You can reverse or reschedule a canceled appointment if the appointment was incorrectly canceled..

1. Right-click on the appointment line, and then click **Cancel**.
2. Review the detail.
3. Select **Cancel Reason**.
4. Click **OK**.

When you cancel an appointment with an associated quick payment, **Cancel Appointment** displays the next future appointment and you are prompted to indicate whether the quick payment will be associated with the next future appointment or remain as unassigned money on the account. If no future appointment exists, a message is displayed to alert you that the quick payment will remain as unassigned money.

No Show

This option opens the **Set Appointment Status to No Show** window from which you can set an appointment status to No Show..

1. Right-click on the appointment line, and then click **No Show**.
2. Review the detail.
3. Click **OK**.

Move Appointment

This option brings you to the **Patient Scheduling** tab where you can enter the new appointment preferences and search for a new appointment time.

Bump Appointment

This option opens **Bump Appointment** where you can enter a bump reason.

Transfer Appointment

This option enables you to transfer an appointment from one time slot to another on the same day or to another day's schedule that is visible on the window.

Reschedule Bumped Appointment

Available when the selected appointment has a status of Bumped.

Force Another Appointment

Force Another Appointment is only available if you have permission to force appointments. It is not available for group activities. However, if the time slot is frozen, and you have *Force Appointment in Frozen Slot* security permission, you can schedule appointments provided that the maximum numbers of appointments is not met for that time slot.

This option opens **Force Appointment** and enables you to force another appointment into a time slot that is already scheduled.

Walk In Appointment

Walk In Appointment is only available for same day appointments. It is not available for group activities.

This option opens **Walk In Appointment** from which you can enter the coverage type, appointment type, and duration.

The appointment is scheduled relative to the actual time you are scheduling the appointment.

View Booking Limits

View booking limits for the time slot's eligible appointment categories.

This option is available if booking limits have been set for the time slot's activity type. If a switch period is in effect and booking limits are defined within the switch period, this option is available. If the time slot is frozen, this option is not available.

View Group Appointment Patients

View Group Appointment Patients is available when at least one appointment is scheduled for a group activity in a given time slot.

Select this option to see a list of the patients currently scheduled for the group activity and the statuses of the appointments. VIP patients, potential patients, and memo appointments are included and displayed accordingly.

Cancel Group Appointments

Cancel Group Appointments is available when at least one appointment is scheduled for a group activity in a given time slot.

Select this option to cancel all of the appointments for the group activity at one time. The number of patients for which appointments are being cancelled is displayed in **Cancel Appointment** instead of patient-specific information.

View Activity Restrictions

This feature has not yet been implemented.

Encounter Form

This option opens the standard print window, which enables you to print an encounter form on demand for the patient in the selected time slot.

Med Rec Request

Med Rec Request is only available on **Appointment Management** and the **Appointment Activity** tab.

This option prints a medical record slip for a patient scheduled in a selected time slot.

Med Rec Slip

This option opens the standard print window, which enables you to print a medical record slip on demand for the patient in the selected time slot.

Appointment Reminder Document

This option opens the standard print window, which enables you to print an appointment reminder document on demand for the patient in the selected time slot.

Request Eligibility

This option initiates the process of submitting a real-time eligibility request for the patient.

Request Eligibility is enabled when all of the following are true:

- > The appointment has a status of Scheduled, Acknowledged, Wait List, or Confirmed.
- > The patient has an active Primary insurance in which the carrier has an Information Broker (IB) Format record selected on the **Eligibility** tab in **Insurance Carrier Maintenance**.
- > The appointment contains items that are included on the **Export Filters** tab for the applicable IB Format record.

View Eligibility Response

Provides access to **Eligibility Response**, which displays information from 271 eligibility response files. If an appointment has only one eligibility response, **Eligibility Response** opens. If an appointment has more than one eligibility response, **Eligibility Requests by Appointment** opens, which enables you to double-click an eligibility response to view it in **Eligibility Response**.

View Eligibility Response is only enabled for an appointment when at least one eligibility response was received.

Register

Register is only available when the appointment slot selected is scheduled for a potential patient. A potential patient is a non-registered patient who will not be assigned a patient number until the registration process is complete.

This option opens **Allscripts PM COMPanion - Registration (New Patient)**.

Record appointment start and check out times

You can record the time a patient is brought back to the exam room and the time when a patient checks out using the right-click menu options available from the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs.

1. Right-click on the appointment line.
 - > Select **Started** to record the appointment start time.
 - > Select **Check Out** to record the appointment check out time.
2. Review the detail.
3. Set the time.
 - > To accept the current time, click **OK** or press **Enter**.
 - > To enter a time, on the hour, for example 8:00 am, enter 8 a and press **Tab**, then click **OK** or press **Enter**.
 - > To enter a time with hours and minutes, for example 2:30 pm, enter 2 : 30 p and press **Tab**, then click **OK** or press **Enter**.

Appointment Detail enables you to edit the start and check out times.

These times are reportable using the general view vwGenPatApptInfo.

When setting the start or check out time for linked appointments, you are given the option to set the time for the selected appointment only or for all the linked appointments.

Note:

- When an appointment with the status of Acknowledged is given a start time, the word Acknow is colored in red in the **Status** column on the **Appointment Management** tab.

Transfer an appointment to another time slot

You can transfer an already scheduled appointment to a different time slot using the **Transfer Appointment** context menu option available from the **Appointment Book** tab.

When you transfer an appointment with an associated quick payment to a different time slot, **Transfer Appointment** displays the quick payment amount and indicates that the quick payment will be associated with the new appointment.

1. Go to **Scheduling > Appointment Scheduling** or press **F9** and enter **APS**.
2. Click the **Appointment Book** tab.
3. Select a time slot with an already scheduled appointment.
4. Right-click, and then select **Transfer Appointment**.
5. Move your pointer to the slot where you want to transfer the appointment, and then right-click.
6. Select **Transfer to this Time Slot**.
7. Review the detail on **Transfer Appointment**.
8. Determine whether other boxes need to be selected.
9. Click **OK** to complete the process.

Attach a referral to an appointment

You can attach a referral to an appointment using the right-click menu options available from the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs.

1. Highlight the appointment.
2. Right-click, and then select **Incoming Referrals**.
3. If more than one active referral exists, highlight the applicable referral.
4. Select **Attach to Appointment**.
5. Click **OK**.

Results of this task

The referral is attached to the appointment.

Appointment Detail window

Appointment Detail is a summary of a patient's appointment.

To open **Appointment Detail** you can do either of the following on the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs:

- > Double click on an appointment slot
- > Right-click on an appointment, then click **Appointment Detail**

Patient Info

The demographics and the comment displayed in top section of the screen pull from the **Patient** tab in **Registration**. The following detail displays when it exists:

- > Patient Name
- > Address line 1
- > Address line 2
- > City, State Zip Code
- > Comment
- > Patient #
- > Enterprise #
- > Self-Pay Balance — when **Show Self-Pay Balance** is selected in **Practice Options** or **Organization Options** on the **Scheduling** tab; overdue balances display in red. If your practice or organization uses uninsured carriers, Self-Pay Balance includes both traditional self-pay balances and uninsured carrier balances.
- > Med.Rec. No
- > Home Tel#
- > Work Tel#
- > Employer
- > Birth Date and Age

Appointment Co-Pay Detail

The co-pay displayed in **Appointment Scheduling** and **Appointment Detail** is determined by a combination of the patient's policy, the coverage type of the appointment, and the specialty of the resource's associated provider.

- > If the patient has an active, non-expired primary policy with the same coverage type as the appointment, the co-pay displayed is from that policy. Otherwise, the co-pay displayed is from the patient's active, non-expired primary medical policy.

- > The **Specialist Co-pay** is displayed if the provider's specialty has **Specialist Co-pay Applies** selected in **Specialty Maintenance**. Otherwise, the **PCP (Primary Care Provider) Co-pay** is displayed.
If the **Specialist Co-pay** is displayed, the **Co-pay** label changes to read **Specialist Co-pay**.
 - If **Specialist Co-pay Applies** is selected in **Specialty Maintenance** for the provider but the patient's relevant policy does not have a **Specialist Co-pay**, the **PCP Co-pay** is displayed.
- > If a policy is associated with a benefit plan, the benefit plan code is displayed following the **Co-Pay** label.

Voucher number

The voucher number is displayed in the upper-right corner, including for memo appointments and appointments for potential patients

Note: The **Voucher #** label is not displayed when the appointment status is **Med Rec Request**.

Appointment Detail

The middle grid displays the following detail:

- > **Date/Time** — date and time of the appointment
- > **Sched Loc** — scheduling location
- > **Sched Dept** — scheduling department
- > **Visit Type** — blank or displays the visit type selected for the appointment.
- > **Resource** — provider, room, or equipment for which the appointment was made
- > **Appt Type** — appointment type
- > **Duration** — length of the appointment
- > **Encounter** — displays the date printed or the message **Not Printed** followed by the encounter number, based on when it is assigned
- > **Med Rec Slip** — displays the date printed or the message **Not Printed**
- > **Booked By** — blank or displays the user's logon name and the date and time booked
- > **Confirmed By** — blank or displays the user's logon name and the date and time confirmed
- > **Ack By** — blank or displays the user's logon name and the date and time the appointment was acknowledged
- > **Cancelled By** — blank or displays the user's logon name and the date and time cancelled
- > **No Show By** — blank or displays the user's logon name and the date and time marked as no show; displays the message **System** if the no show status was set by the Automatic No Show process
- > **Override Reason** — blank or displays the override reason selected in **Non Credentialled Provider** during scheduling

Note: The time in **Date/Time**, **Booked By**, **Confirmed By**, **Ack By**, **Cancelled By**, and **No Show By** reflects the time zone for the scheduling location.

Status

Scheduled

Appointment is booked

Wait list

Flags a scheduled appointments with the status of wait list are scheduled and do hold an appointment slot

Confirmed

Stamps the initials of the operator and the date and time the selection was made in the appropriate field in the grid on the left

Confirmed is generally used to indicate that a member of your staff has contacted the patient

Acknowledged

Enters a time in the **Ack. Time In** box. use this function to acknowledge that the patient has arrived at the office for his/her appointment

Bumped

The appointment is removed from its originally scheduled time slot; it must be manually rescheduled.

Cancelled

Stamps the user's log on name and the date and time the appointment was cancelled
Removes the appointment from its slot

Activates **Cancel Reason**

Cancel reason

Drop down holds the custom cancellation reasons created in **Cancellation Reason Maintenance**.

No show

Use to indicate that a patient did not present themselves for their appointment and did not call to cancel or reschedule.

Med Rec Request

An appointment with this status can only be accessed from **Appointment Management** or the **Appointment Activity**.

Indicates that a medical record request was made on the date and time displayed in **Booked By**.

Entry boxes

Note: There are several ways to enter the time in entry boxes that accept a time stamp.

- > To enter a time, on the hour, for example 8:00 am, enter 8 a and then press **Tab**.
- > To enter a time with hours and minutes, for example 2:30 pm, enter 2 : 30 p and then press **Tab**.
- > Click (down arrow) to display a clock, and then use the mouse to move the hands.

Ack. Time In

Automatically populates with current time when **Acknowledged** is selected in the **Status** section.

Sign In

Use to record the time a patient signs in to their appointment. This box is required if **Require Sign-In** is selected on the **Scheduling** tab in **Practice Options** or **Organization Options** and the appointment has been acknowledged.

Started

Use to record or edit the time a patient is brought to an exam room.

Check Out

Use to record or edit the time a patient exits an exam room

Cancel / Bump Reason

Active only when you select either the status of Bumped or the status of Cancelled.

The label name toggles based on the status selected.

This field is reportable using the ad hoc reporting general view vwGenPatApptInfo.

Coverage Type

Records the coverage type selected for the appointment.

You can only edit the coverage type from this box.

Ailment

Enables you to view or change the ailment that is associated with an appointment.

Clicking  opens **Ailment Information**, which allows you to select an ailment to attach to the appointment. You must select **Attach to this Appointment** on **Ailment Information** for the ailment to attach to the appointment.

Associating an ailment to an appointment may be required depending on the settings on the **General** tab in **Practice Options** or **Organization Options**.

When you make an appointment for a particular coverage type which requires an ailment, the only ailments that display are the ones associated to policies with carriers of that particular coverage type as well as the ailment that has been attached to that particular appointment regardless of whether it is attached to a policy. If no ailments are associated to a policy whose carrier's coverage type is the coverage type of the appointment, when you open **Ailment Information** upon first making the appointment, there are no ailments from which to select. You can attach an ailment to the appointment by creating a new ailment. However, you must go back into **Registration** in order to associate the ailment to a specific policy. You can only associate it to a policy whose carrier has the same coverage type as the appointment. Also, if you only attach this ailment to the appointment and not to a policy, this ailment does not display when making future appointments. It does, however, display for this appointment when you view the appointment detail.

One ailment can be associated to multiple appointments.

When you attach an ailment to an appointment, the **Ailment Comment** is required. You cannot save the ailment if you have not entered an **Ailment Comment**.

If you make memo appointments or appointments for potential patients, **Ailment** is disabled. **Ailment** is enabled for all other appointments including linked appointments.

Referring Dr

Defaults to a selection made at the time the appointment was scheduled.

Note: The time in **Ack Time In, Started**, and **Check Out** reflects the time zone for the scheduling location.

Referrals

Use **ALT + I** or click **Referrals...** to open the incoming referrals screen which you can use to create a new incoming referral, attach or link a referral to the selected appointment.

To the right of this button, one of the following messages is displayed:

- No Referral - When no referral exists or when an existing referral has not been attached or linked to the appointment.

- > Referral Attached - When the referral has been attached to the appointment.
- > Referral Linked - When the referral has been linked to the appointment.

Referral Required

This field is active when no referral exists and when an existing referral has not been attached or linked to the appointment.

When checked indicates that a required referral is missing for this appointment.

Note: When the Flag Missing Referrals option is checked as a Practice/Organization Option, then this appointment will also display with a yellow square in the column marked "R" on the Appointment Management and Appointment Activity tabs. You can find more information about color coding for referrals and coverage indicators elsewhere in the Help.

Coverage

Defines patient's eligibility status.

The appointment's coverage status is set in one of two ways:

1. Using the ANSI X12N 271 Eligibility Responses

Indicators are automatically applied to appointments for which you request eligibility. See "*Real Time Eligibility Verification Overview*" for more information.

2. Manually selecting a Coverage Status on the Appointment Detail

Click the down arrow and select one of the following options:

Yes — The patient was covered at the time the inquiry was made.

No — The patient was not covered for the scheduled service as of the time an inquiry was made.

Inactive — You must review **Eligibility History** to understand why the coverage is set to "Inactive." You may need to contact the carrier to determine why.

Pending — Referral is pending review.

Received — An eligibility response was received from the payer.

Exception — An eligibility Response was received from the payer with an exception.

Note: Blank indicates that no inquiry has been made relative to the coverage status for the appointment.

The setting in this box triggers the display of color coded indicators in the column titled "C" on the **Appointment Management** and **Appointment Activity** tabs as well as in the Operators work grid in **Appointment Management** in **Office Manager**. See "*Coverage Status in Referral and Eligibility Flagging Used in Scheduling*" for more information.

Request Eligibility

Allows you to submit a Real Time Eligibility Request.

Enabled when **all** of the following are true:

1. The appointment has a status of Scheduled, Acknowledged, Wait List or Confirmed.
2. The patient has an active primary insurance in which the carrier has an Information Broker (IB) Format record selected on the **Eligibility** tab in **Insurance Carrier Maintenance**.
3. The appointment contains items that are included on the **Export Filters** tab for the applicable IBFormat record.

Comments

Displays any comments added on the original scheduling screen.

You may add or edit comments.

Appointment comments also display on the **Appointment Book** tab, and print on the appointment schedule and the Appointment Detail Report.

Enc. Form

Use **ALT + e**.

Enables you to print or reprint an encounter form on demand.

Med. Rec. Slip

Use **ALT + m**.

Enables you to print or reprint a medical record slip on demand.

Appt. Remind

Use **ALT + a**.

Enables you to print an appointment reminder.

Note: An appointment reminder card must be set up as a Scheduling type document in **Document Maintenance**.

Move Appt

Use **ALT + v**.

Opens the **Patient Scheduling** tab on **Move Linked Appointment** to allow you to move the appointment; changes to **Reschedule** when the appointment's status is changed to Bumped.

Patient Info

Branches to the **Patient's Information** window.

Register

Branches to **Registration** if the appointment was made for a potential patient. Otherwise, this option is inactive.

Acknowledging an appointment in Appointment Detail

Acknowledge an appointment from the **Appointment Detail** window and from the right-click context menu on the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs.

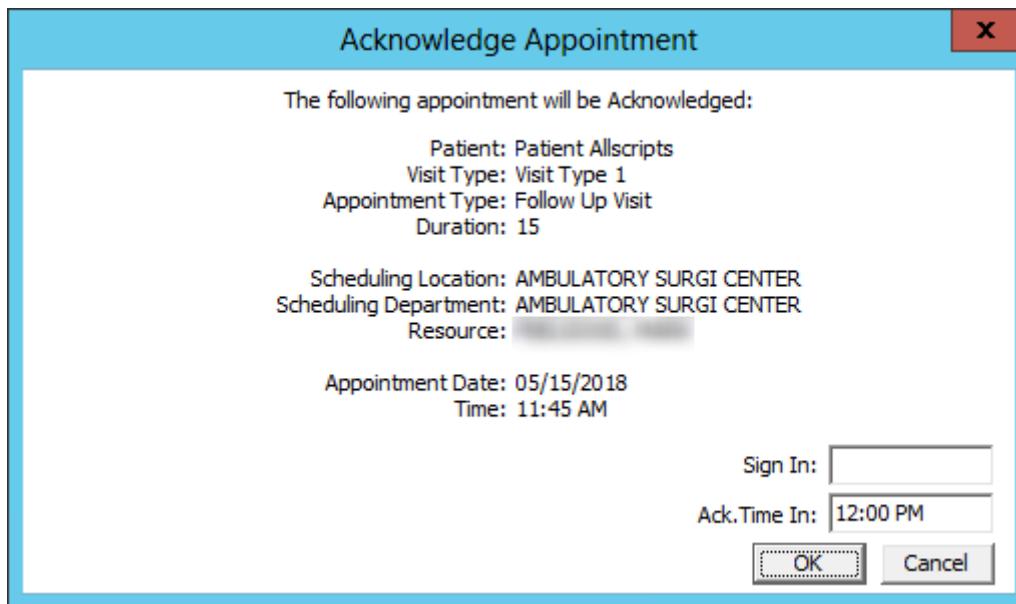
Use **Acknowledged** to indicate that the patient has arrived at the office for his or her appointment.

Selecting **Acknowledged**, triggers the following to occur:

- Displays the time selected in **Ack Time In** on **Acknowledge Appointment** or **Acknowledge Linked Appointment** in **Ack Time In** on **Appointment Detail**. The time in **Ack Time In** reflects the time zone for the scheduling location.
- Stamps the name of the logged-on user as well as the date and actual time the appointment was acknowledged in **Ack. By** on **Appointment Detail**.

Unlinked appointment

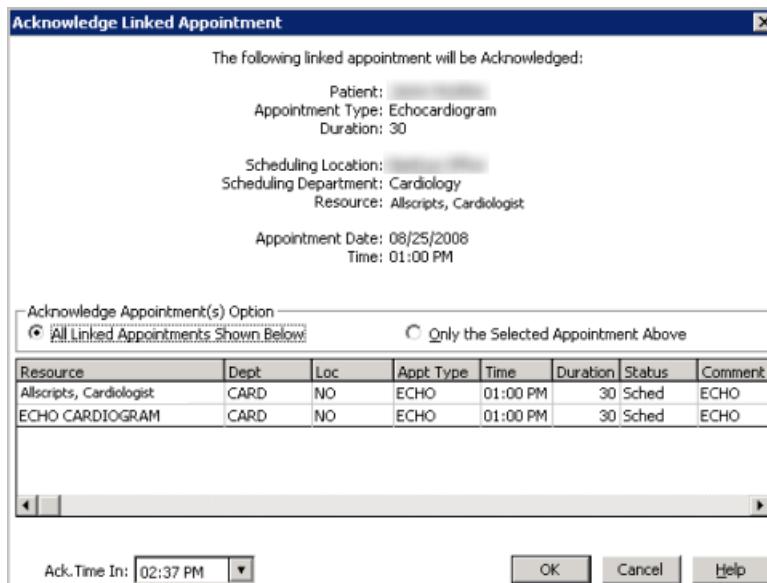
When you are acknowledging an appointment that is not linked to other appointments, the following window is displayed:



Ack Time In on **Acknowledge Appointment** is editable. You can change the default. For example, to enter a time on the hour, such as 8:00 am, enter 8 a. To enter a time with hours and minutes, such as 2:30 pm, enter 2 : 30 p.

Acknowledging a linked appointment

When you acknowledge an appointment that is linked to other appointments, a window is displayed that gives you the option to acknowledge all the linked appointments or just the selected appointment.



Reporting

The viewGenPatApptInfo columns Appt_Time_In, Appt_Ack_By_Operator_Abbr, and Appt_Acknowledged_Date (this column contains both the date and time the appointment was acknowledged) enable you to create a report that tracks the lapse of time between when an appointment is acknowledged, when a patient is shown into an exam room, and when a patient checks out..

Confirming an appointment

You can confirm an appointment from **Appointment Detail** and from the right-click context menu on the **Appointment Book**, **Appointment Management**, and **Appointment Activity** tabs.

Confirming an appointment indicates that the patient was contacted and intends to come in for the appointment.

Using the appointment detail window

To confirm an appointment using **Appointment Detail**, click **Confirmed** and then select a value for **Confirmation Result** if that is consistent with your office workflow policies. In addition, you have the option to use other functions available from this window, such as printing an encounter form, medical record slip, appointment reminder, and so on.

Using the right-click context menu

When you use the right-click context menu option **Confirm**, **Confirm Appointment** is displayed. Review the appointment detail, and then select a value for **Confirmation Result** if that is consistent with your office workflow policies. When you click **OK**, the appointment status is set to **Confirm**.

Confirming linked appointments

Whether you are using **Appointment Detail** or the right-click context menu option **Confirm**, when you confirm an appointment that is linked to other appointments, you are given the option to confirm either the selected appointment only or all of the linked appointments.

Move an appointment

This topic describes how to move an appointment which is not linked to another appointment.

You can initiate the process of moving an appointment from the Appointment Detail screen, the Appointment Book, Appointment Management or the Appointment Activity tabs.

1. From one of the Scheduling screens, right-click on an appointment and do one of the following:

- > Click **Appointment Detail**, then click **Move Appt**, found at the bottom of the dialog.
- > Click **Move**

The Patient Scheduling tab opens with the appointment detail loaded.

2. Make any changes necessary to the appointment Preferences.

3. Click **Open Times** or **Use Book**

- > Using Open Times - select a slot, then click **Schedule**
- > Using Use Book - click on a slot, then right-click and click **Move to this Time Slot**

4. When the **Move Appointment** window opens, review the detail.

Note: When you move an appointment with an associated quick payment to another appointment date and time, **Move Appointment** displays the quick payment amount and indicates that the quick payment will remain associated with the appointment.

5. Determine which other functions need to be checked.

6. Click **OK** to complete the process

Results of this task

You remain at the day and time of the new appointment.

Move a linked appointment

This topic describes the steps for moving a linked appointment.

You can initiate the process of moving an appointment from the **Appointment Detail** screen, the **Appointment Book**, **Appointment Management** or the **Appointment Activity** tabs.

1. From one of the Scheduling screens, right-click on an appointment and do one of the following:

- > Click **Appointment Detail**, then click **Move Appt**, found at the bottom of the dialog.
- > Click **Move**

The **Move Linked Appointment** screen opens with the appointment detail loaded.

2. At **Move Appointment(s)** Option do one of the following:

- > Accept the default: **All Linked Appointments Shown Below** (These appear in the grid below the options)
 - Click **OK**
The **Move Link Appointment** window opens. Use this window as you did when you first scheduled the linked appointments. The process is the same.
 - Follow and respond to all the prompts.
- > Click **Only the Selected Appointment Above** (This is the appointment you selected and whose detail appears above).
 - Click **OK**
 - Opens the **Patient Scheduling** tab
 - Make any changes necessary to the appointment preferences.
 - Click **Open Times** or **Use Book**
Click **Open Times** or **Use Book**
 - When using **Open Times** - select a slot, then click **Schedule**
 - When using **Use Book** - click on a slot, then right-click and click **Move to this Time Slot**
 - When the **Move Appointment** window opens, review the detail.
 - Determine which other functions need to be checked.
 - Click **OK** to complete the process

Bumped appointments

This topic provides you with details about appointments given the status of bump.

An appointment that no longer fits into a re-blocked schedule is automatically given the status of bumped.

You can manually bump an appointment from the Appointment Detail window, or by using the right click menu on the on the **Appointment Book**, **Appointment Management**, or **Appointment Activity** tab.

Keeping track of bumped appointments

To keep a record of an appointment that you bumped and rescheduled, you must check the scheduling option **Retain Bumped Appt as Cancelled**.

You can generate a listing of bumped appointments by Appointment Date or Booked Date by running the Appointment Detail Report found under **Scheduling Reports**.

You can display appointments given the status of Bumped on the two following screens

- **Appointment Management** - by selected by dates and by selected or all Sched Departments, Sched Locations, Resources
- **Appointment Activity** - for the selected patient only

A record of when, why and by whom an appointment was bumped is kept on the Appointment Detail window. The related fields are: Status field of **Bumped**, **Bumped by** and **Bump Reason**. These fields are reportable by using the general view vwGenPatApptInfo.

Bumping appointments when re-blocking a day or days

When you are re-blocking a day in Schedule Planning, existing scheduled appointments for that day can get bumped if they no longer fit into the new defined schedule. When this occurs the combo box Bumped Reason becomes active. This applies the selected reason to all appointments that will be bumped as a result of re-blocking.

Note: Custom blocking a portion of a day still allows other scheduled appointments for that day to get bumped. This is because the entire day is being re-saved, not just the modified slots. If you custom block a day that has scheduled appointments and are making changes to the AM slots, the PM slots also get bumped if there is no time available for them (i.e. forced appts). You have an option to check **Keep Forced Appts that May be Retained** on the **Accept Re-Block** summary screen after making changes and the number of Forced (May be Kept) appointments that will be retained if you check this box displays. It also displays a count of the Regular and Forced appointments that must be bumped.

Rescheduling bumped appointments

You must manually reschedule bumped appointments.

Use the **Appointment Management** screen to generate a list of bumped appointments.

Then for each appointment, use the right-click menu option **Reschedule Bumped Appointment** to reschedule the appointment.

When you bump an appointment with an associated quick payment, **Bump Appointment** displays the quick payment amount. If you use **Reschedule Bumped Appointment**, the quick payment is associated with the new appointment; otherwise, the quick payment becomes unassigned money.

Print a medical record request

The option to print a medical record request is available as a right-click context menu option on the **Appointment Management** and the **Appointment Activity** tabs.

To generate a medical record request from the **Appointment Management** or the **Appointment Activity** tab, do the following:

1. Place your cursor on an appointment line or on a column header and right-click.
2. Click **Medical Rec Request**.

Medical Record Request opens.

3. If **Patient** is blank, select a patient.
4. Select a value for **Coverage Type**.

The time displayed for **Date/Time** reflects the default time zone of the practice because the scheduling location is not known at the time **Medical Record Request** opens.

5. Select values for **Scheduling Dept**, **Sched Location**, and **Resource**.

Note: These boxes are required.

6. Enter a text in **Comments**.

This comment can only be viewed on **Appointment Detail**.

7. Select **Print Med Rec Slip** to send this request to a printer, or clear **Print Med Rec Slip** to display the request on the **Appointment Management** tab.

The time that is displayed in the upper-right corner of the medical record slip reflects the time zone of the scheduling location.

8. Click **OK**. When printing a request continue with step 9.

If you did not select **Print Med Rec Slip**, when you click **OK** the window closes.

9. Make the applicable selections on **Print**, and then click **Print**.

10. Review the alignment form, make any necessary changes, and then click **OK**.

11. To display medical record requests from the **Appointment Management** tab, do the following:

- a. To display all medical record requests for all scheduling departments, scheduling locations, and resources, leave the respective boxes blank. Otherwise, make the applicable selection for each box.
- b. Select the applicable date range.
- c. Click **Query**, and then clear all **Appointment Status** check boxes.
- d. Select **Med Rec Reqs**.

Chapter 4

Appointment Reports

Print appointment schedules

Print a appointment schedules for all resources or specific resources based on selected criteria.

1. Go to the **Appointment Schedule** tab on **Scheduling Activities** in **Scheduling**.

Tip: To quickly access the **Appointment Schedule** tab, press **F9**, then enter **DAA**

2. If a stored jobs exist, click  to select the job you want to use, then go to **step 12**.
3. For **Report Preferences**, click .

 - a. Select one or more groups from the **Available Group Fields** grid.
 - b. Select a level of detail.
 - c. Select a sort field.
 - d. (Optional) Click **New Page per Major Sequence** to apply a page break between major groupings.
 - e. (Optional) Click **View with Drill-Down** to enable detailed breakouts of each group when previewing the document.
 - f. Click **OK**.

4. For the following boxes, click , then use the associated selection windows to select which appointment schedules are included in the print job.

Box	Function
Select Resources	Print appointment schedules for the resources you select
Select Scheduling Departments	Print appointment schedules that only include appointments scheduled by any of the departments you select

Box	Function
Select Scheduling Locations	Print appointment schedules that only include appointments scheduled by any of the locations you select

5. For **Appointment Date**, in **From** and **To**, click , then select a date from the calendar.

The appointment schedules you print will only include appointments that:

- > Are scheduled for or between the selected dates
- > Occurred on or between the selected dates

Tip: To only include appointments that are scheduled for a specific date, select the same date in **From** and **To**.

6. (Optional) Select **AM Appointments Only** or **PM Appointments Only**.

The appointment schedules that you print will only include appointments that are scheduled for the selected time of day.

7. (Optional) Select **Include Coverage Status** to include the coverage status assigned to the appointment.

8. (Optional) For **Range of Times**, in **From** and **To**, click , then select a time from the time list.

The appointment schedules that you print will only include appointments that are scheduled for or between the selected times.

9. (Optional) Click **Store** to save your selections for later reuse:

- a. For **Stored Job Name**, type in a unique name that describes the job selections.
- b. Click **Save**.

10. Click **Run**

11. On the **Print** window, select options based on where and how you want to print this document, then click the **Print** button.

12. On **Job Status**, click **Release** to remove the print job.

Chapter 5

Charges

Creating a charge batch

Charge batches are used to enter the charges you want to submit as claims or bill as self-pay statements.

The system uses the services entered to create a voucher. Each voucher is assigned a number based on the Practice/Organization Options selected for your organization. The voucher number is ultimately used as the claim number when you bill the voucher to a Carrier.

Charges entered do not affect your A/R until you update the batch.

Until you close the batch you can change any of your settings on this screen except the Batch Type. Changes you make to charge batch defaults, however, do not affect any entry made prior to the changes. In other words, the changes made to batch defaults are applied only to the new entries made after you changed your defaults.

Create a Voucher

When the Charge Entry screen opens, the cursor defaults to the first field.

The field label defaults to **Encounter**, when the Practice Option, Track Encounters is checked.

Otherwise, the field label defaults to **Patient**.

To change the field label, use **Ctrl+down arrow** while the cursor is in the field.

The system remembers the change for as long as you keep the Charge Entry screen open.

Look below for explanation of the field label options.

Encounter

When entering Charges by Encounter # the detail from the associated appointment populates the voucher's corresponding fields, i.e. Payor and Policy info fill in based on the coverage type selected for the appointment, the Appointment Resource's associated Provider fills in the field, **Provider**, the Department associated with the Scheduling Department fills in the field, **Department**, etc.

Batch defaults which are set on the Batch Management tab take precedence over the information from the associated appointment.

To create a voucher by Encounter number, enter the number in the field, then **Tab**.

The Search function is not available.

Patient

Creating a voucher by Patient auto fills the Payer and Policy fields based on the status and coverage type of the policies entered in Registration.

Provider, Billing Provider and Referring Doctor fields auto fill based on settings on the Charge Entry tab in Practice/Organization Options.

To create a voucher using the Patient's number, enter the number, then **Tab**.

Note: When tracking encounters if you create a voucher by Patient for a Patient with an appointment that has an encounter number, that encounter is still included on the report as an outstanding voucher.

Voucher

Use this option to edit a voucher created in a batch that is still open.

See [Editing a Voucher on the Charge Entry Screen](#).

Enter payer and policy information

Once you have retrieved a Patient, Voucher, or Encounter, the Charge Entry screen is activated. Fields can auto-fill based on Practice/Organization Option settings and/or Batch Default settings.

Enter payer and policy information

Transactions - Charge Batch# 51 [- Bal. \$0.00]

Batch Management Charge Entry Edits Validate Batches

Proof: Entered: \$3,720.00 **Reset**

Patient:	(New)	Print	Print														
Voucher#:	(New)	Print	Print														
SSN/DOB/AGE: *****1140 02/06/1973 40 years																	
Acct Type: Standard																	
Comments:																	
Payor:	Insurance	No Co-Pay															
Coverage Type:	Medical																
Policy: MEDICARE - PARTNERS (no plan)/(no plan) (P)																	
<input checked="" type="checkbox"/> Accept Assign? Cert#: 000-00-																	
<table border="1"> <tr> <th>Service Date</th> <th>Procedure</th> <th>Modifier</th> <th>Diagnosis Codes</th> <th>TOS</th> <th>Units</th> <th>Fee Amt</th> </tr> <tr> <td colspan="7">(new)</td> </tr> </table>				Service Date	Procedure	Modifier	Diagnosis Codes	TOS	Units	Fee Amt	(new)						
Service Date	Procedure	Modifier	Diagnosis Codes	TOS	Units	Fee Amt											
(new)																	
Date From: <input type="button" value="▼"/> Thru: <input type="button" value="▼"/> Procedure: <input type="button" value="▼"/> <input type="button" value="Print"/> <input type="button" value="Edit"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="List"/> Type of Svc: <input type="button" value="▼"/> Modifiers: <input type="button" value="▼"/> <input type="button" value="Print"/> <input type="button" value="Edit"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="List"/> Units: <input type="text"/> Diagnosis: <input type="button" value="▼"/> <input type="button" value="Print"/> <input type="button" value="Edit"/> <input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="List"/> Fee Amt: <input type="text"/> Anesthesia... Dental... Drug... Purchased Service...				<input type="button" value="View H & P"/> <input type="button" value="New Line"/> <input type="button" value="Summary"/>													
Total Charges: <input type="text"/>				<input type="button" value="Next Patient"/>	<input type="button" value="Same Patient"/>	<input type="button" value="Save"/> <input type="button" value="Cancel"/>											

Title Bar

Displays the following data

- > Function name
- > Batch number
- > Patient name
- > Patient's self-pay balance

Proof Amount

Displays the proof amount entered on the Batch Management screen for this batch.

Entered

Displays the total charges entered in this batch up to but not including the current voucher.

Payor

This field will react in one of the following ways:

- > Defaults to "Self Pay" when there are no Policies attached to the Patient's Account. When you Tab, the cursor will skip over the Policy field.
- > Defaults to "Insurance" when there is a Policy in effect which has been designated as Primary on the Patient's Policies tab in Registration.
- > When a charge is entered by encounter number and there is an ailment attached to the appointment, **Payor** defaults to the payor for the policy that the same ailment is associated with in **Registration**.
- > Remains blank when one or both of the following is true: there are policies listed on the account but none of these policies is designated as the primary; the coverage of the primary policy is expired.

When **Uninsured** is the coverage type and the patient has an active primary uninsured policy or an active other uninsured policy, that policy is charged.

- > If **Uninsured** is the coverage type and the patient does not have an active primary uninsured policy or an active other uninsured policy, the charge is self-pay and you must manually select **Payor** and **Policy**.
- > If a policy is associated with a benefit plan, the following occurs:
 - The benefit plan code is displayed in **Policy**.
 - The label **No Co-Pay** is not displayed next to **Payor**.

In addition to these default settings, the following options are available for selection. Click  to open the pick list then click on an item to populate the field.

Courtesy Claim

Available only when the practice option, **Allow Courtesy Claims** is selected.

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

If your practice or organization uses the uninsured coverage type and there is only an uninsured carrier on the patient account:

- > When **Courtesy Claim** is selected in **Payor**, **Coverage Type** is not available and **Policy** is blank.
- > The **Print Claim** toolbar icon is not available.
- > The uninsured voucher balance is included in the self-pay balance total

- > The remitter for the voucher is **Self Pay**

If the patient account has an additional policy other than uninsured:

- > When **Courtesy Claim** is selected in **Payor**, **Coverage Type** is filled with the coverage type of the other policy.
- > The **Print Claim** toolbar icon is available
- > **Coverage Type** does not list **Uninsured**.
- > The remitter for the voucher is **Self Pay**
- > **Policy** lists all policies associated with the selected coverage type
- > The remitter for the voucher is **Self Pay**

Sliding Fee Scale

Available when Use Sliding Fees is checked in Practice / Organization Options and you have added a sliding fee scale to the Patient's account.

When "Sliding Fee Scale" is designated the payor, the Policy field is renamed "Sliding Fee Scale".

This field reacts in one of the following ways:

- > Remains blank when either of the following conditions is true: more than one of the fee scales applied to the patient's account qualify; none of the fee scales applied to the patient's account qualify.
- > Auto-fills when only one fee scale qualifies.

When you save the charge, a Apply Sliding Fee Adjustment/Payment dialog appears showing the Patient Amount due and allowing you to enter the payment at this time.

Balances due for charges entered using a sliding fee scale are self pay balances.

Co-Pay

The patient's co-pay responsibility associated with the policy selected for the voucher displays on the screen to the right of the field **Payor**.

Coverage Type

The coverage types available in the drop-down list are only those associated to the policies for the patient/encounter/voucher which you have access to according to your security permissions related to coverage types.

The coverage type can be changed if necessary.

This field is disabled if you enter a charge with a Payor of "Self-Pay" or "Sliding Fees." This is true regardless of whether you enter the charge by Patient or by Encounter.

The following conditions describe how the **Coverage Type** combo box gets populated in different scenarios:

- > When you enter a new charge by Patient, if all the Policies for the Patient have only one coverage type, the system automatically populates the **Coverage Type** combo box with that coverage type. If a Patient has policies associated with Carriers with multiple coverage types, the default coverage type set in Practice/Organization Options automatically populates the **Coverage Type** combo box. If no default coverage type is set in Practice/Organization Options, the **Coverage Type** combo box is blank and must be populated manually.
- > When you enter a new charge by Encounter, the system automatically populates the **Coverage Type** combo box with the appointment's coverage type. If the appointment's coverage type does not exist in the drop-down list for the **Coverage Type** combo box, you must manually populate it.
- > If you enter a charge either by Patient or by Encounter Number from an appointment that has a coverage type for which the Patient has no Policy whose Carrier has that coverage type, the **Payor**, **Coverage Type**, and **Policy** fields in Charge Entry are all blank and you must populate them manually.
- > If you change the Payor from "Insurance" or "Courtesy Claim" to "Self-Pay" or "Sliding Fee," the **Coverage Type** combo box is cleared and disabled. If you change the Payor back to "Insurance" or "Courtesy Claim," you must manually select the appropriate coverage type for the Voucher.
- > If you enter a charge by Patient or by Encounter and then change the Payor to "Courtesy Claim," the **Coverage Type** combo box populates with the coverage types of the policies that the Patient has on his/her registration.
- > If you originally entered a charge with a Payor of "Self-Pay" and then transferred it to Insurance (maybe the Insurance was not entered into the system at the time the charge was entered), the original coverage type is blank because self-pay does not have a coverage type. In this scenario, if the original carrier ID equals self-pay, the system looks at the first payment transaction that has a remitting carrier ID to establish the coverage type for that Voucher.

The options available in the **Policy** drop-down list are determined by the setting in the **Coverage Type** field. Once a coverage type is set either automatically or manually, only those Policies associated with that coverage type display in the Policy drop-down list. For example, if the coverage type is set to "Medical," only the Patient's Medical policies display and the Policy defaults to the Patient's Primary Medical policy. Therefore, when you change the coverage type, the list in the **Policy** field also changes. If, after selecting the coverage type and the Policy, you go back to change the coverage type, the **Policy** field changes accordingly.

If your practice or organization uses the uninsured coverage type, when **Uninsured** is selected in **Coverage Type**:

- > **Policy** lists only uninsured carriers
- > **Corrections** is not available

- > **Accept Assign?** No Cert# is cleared

Policy

Available only when you select either "Insurance" or "Courtesy Claim" as the Payor.

The options available in the **Policy** drop-down list are determined by the setting in the **Coverage Type** combo box. Once a coverage type is set either automatically or manually, only those Policies associated with that coverage type display in the **Policy** drop-down list.

This field reacts in one of the following ways:

- > Defaults to the patient's primary policy when the voucher is not related to an encounter from a scheduled appointment.
- > Defaults to the policy designated by the coverage type selected for the appointment when you enter the encounter number to create the voucher. You also must track encounters.
- > When a charge is entered by encounter number and there is an ailment attached to the appointment, **Policy** defaults to the policy that the same ailment is associated with in **Registration**.
- > Remains blank when none of the insurance policies on the patient's account is designated as primary.
- > Remains blank when the patient's primary coverage is expired.
- > Remains blank if you enter a charge either by Patient or by Encounter Number from an appointment that has a coverage type for which the Patient has no Policy whose Carrier has that coverage type.
- > Displays the patient's plan and coverage detail.
- > When you change the coverage type, the list in this field also changes. If, after selecting the coverage type and the Policy, you go back to change the coverage type, this field changes accordingly.
- > The Policy drop-down list displays all the patient's available policies for the selected coverage type.

Note: If your Practice is restricting access to Policy Information by Coverage Type, then only those Policies associated with the Coverage Types(s) to which you have access are listed in this list.

Accept Assign

The default state of this box (checked or not checked) is driven by the setting for the Carrier in Insurance Carrier maintenance and / the setting on the Patient's Policies tab in Registration for the policy selected on the voucher.

Checking this options checks Yes in Box 27 on a Standard CMS-1500 NPI claim form.

Not checking this option checks No in Box 27 on a Standard CMS-1500 NPI claim form. Any change made to the default setting applies to the current voucher only.

Policy Certificate Number

When a policy is selected the certificate number is displayed to the right of **Accept Assign**.

Workers' compensation cases

You can associate an active workers' compensation case with a voucher. The voucher can have the injury payer on the case as the policy or the voucher can be self-pay.

When you enter a charge by patient with **Payor** set to **Insurance** and **Coverage Type** set to

Worker's Comp,  (briefcase icon) is displayed to the right of **Coverage Type**. Click the  to open **Active Cases**, which lists the workers' compensation cases for the patient that are active. The briefcase icon is not displayed if the patient does not have any active workers' compensation cases or the voucher is for a courtesy claim or a sliding fee scale applies. The briefcase is no longer enabled after you save the voucher. Point to the briefcase to see the date of injury and body part description.

After you save a voucher that is associated with a workers' compensation case, if you click **Same Patient, Coverage Type and Policy** are not automatically filled; they are blank so that you can enter a coverage type and policy that are applicable to the next charge.

When a voucher is associated with a workers' compensation case:

- > **Coverage Type** is set to **Worker's Comp** and cannot be changed.
- > **Policy** lists only the policies that are associated with the case. An abbreviation for the type of payer is displayed in parentheses after the policy description.

You cannot enter charges with a policy that is expired in **WC Case Management Policies**.

When you retrieve a voucher on the **Edits** tab that is associated with a workers' compensation case, the briefcase icon is displayed to the right of **Coverage Type**, but it not enabled. Point to the briefcase to see the date of injury and body part description.

Enter encounter detail

Provider, Billing Provider, Department, POS, Location, Referring Dr information auto-fill in their respective fields on the Charge Entry tab in the following circumstances:

- > the voucher is created using the encounter number
- > related batch defaults are defined

CAUTION: Always be sure that these fields are filled in correctly before you add a second procedure line to the voucher. These fields are made

inactive when you add a second service line - even if you delete the second line.

Also, keep in mind that any selection defined as a batch default will override any other default defined for a field.

Reset

Enabled when you are entering charges by Patient or correcting charges by Voucher.

Intended for those clients using Department/Practice Security. See Department/Practice Security and Charge Entry

Once you start entering a second procedure line, the button becomes disabled.

Use this button to clear the following fields on the screen as these are the fields which filter based on your department/practice security settings and the selections you make for the previous field.

- > Provider
- > Billing Provider
- > Department/Practice
- > POS
- > Location

After you click **Reset**, the information that reloads in the drop-down lists for each field is once again based solely on your department/practice security access.

Responsible Party

This is a required field.

The Contact selected as the Responsible Party will qualify to receive a Statement for any Self Pay balance due on the Voucher.

The default will be to the Contact designated as Guarantor on the Patient's Account.

The drop-down list contains a listing of any Contact for which the **Statement** option was checked on the Account tab in Registration.

Provider

This is a required field.

When entering Charges by Encounter, this field will default in this order of priority:

1. The Provider specified as the Batch default
2. The Provider designated on the Encounter.

When entering Charges by Patient, this field will default in this order of priority:

1. The Provider specified as the Batch Default.

2. The Provider specified as the Usual Provider in Registration, when the Practice Option **Default to Usual Provider** is checked and there is no Batch Default for Provider.

This field will be left blank when either of the following is true:

- > there is no Batch Default for Provider and the Practice Option **Default to Usual Provider** is not checked.
- > there is no Batch Default, the Practice Option **Default to Usual Provider** is checked but the Usual Provider is not specified in Registration.

Billing Provider

This is a required field

When the Practice Option **Always set the Billing Provider to Provider** is checked and charges are being entered by Encounter then the field will default in this order of priority:

1. With the Billing Provider specified as the Batch default.
2. With the Provider of the associated appointment when there is no Batch Default for Billing Provider.

When the Practice Option **Always set the Billing Provider to Provider** is checked and charges are being entered by Patient, then the field will default in this order of priority:

1. With the Batch default but the entry will change to the Provider when that field is filled in.
2. With the Provider entered in the field **Provider**.

Department

This is a required field.

When entering Charges by Encounter, this field will default in this order of priority:

1. With the Department selected as the Batch default which takes precedence over the Provider's Default Department and the associated Appointment's Department.
2. With the Provider's Default Department which takes precedence over the associated Appointment's Department when there is no Batch Default.
3. With the associated Appointment's Department when the Provider does not have a Default Department and a Department has not been chosen as the Batch Default.

When entering Charges by Patient, this field will default in this order of priority:

1. Auto-fill with the Department specified in the Batch Defaults.
2. Auto-fill with the Provider's Default Department as designated in file maintenance when there is not a Department designated as the Batch Default.

Left blank if a Department was not specified for the Provider in file maintenance and there is not a Department Batch Default specified.

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. Additionally, **Location** is required and **POS** is display-only because the visit type and location are used to derive the place of service.

Visit Type selection options are limited to the visit types that are associated with a place of service. However, if you select a visit type and location for which the derived place of service does not exist in **Place of Service Maintenance**, **POS** is blank. You cannot save the voucher until you select a valid combination of **Visit Type** and **Location**.

If the value that you select for **Provider** has a value for **Default Dept** or **Default Practice** in **Provider Maintenance**, that department or practice must be a member in **Location Maintenance** and **Place of Service Maintenance**; otherwise, the application cannot derive the place of service.

Place of Service

This field is read-only if **Enable Visit Type** and **Derive Place of Service** are selected on the **Visit Type** tab in **Practice Options** or **Organization Options**; otherwise, this field is required.

When entering Charges by Encounter, this field will default in this order of priority:

1. The Place of Service selected as the Batch Default.
2. The Place of Service for which the Location associated with the Sched. Loc. is the Default when there is no Batch Default specified.

Remain blank when any of the following are true:

- > There is not a Batch Default specified and the Sched. Loc. is not associated with a Location.
- > There is not a Batch Default specified and the Location associated with the Sched. Loc. is a default for more than one Place of Service.
- > There is not a Batch Default specified and the Location associated with the Sched. Loc. is not a default for any Place of Service.

When Entering Charges by Patient, this field will auto-fill only when a Place of Service is selected as the Batch Default.

Location

This is a required field.

When entering Charges by Encounter, this field will default in this order of priority:

1. Auto-fill with the Location selected as the Batch Default.
2. Auto-fill with the Location associated with the Sched. Loc. when there is not a Location Batch Default selected.
3. Auto-fill with the Default Location of the Place of Service selected as the Place of Service for this Voucher, when both of the following are true

There is not a Location Batch Default.

The Sched. Loc. is not associated with a Location.

If the Place of Service is re-selected in Charge Entry, **Location** auto-fills with the default location selected in Place of Service Maintenance.

Remain blank, when all of the following are true

- > There is not a Batch Default
- > The Sched. Loc. is not associated with a Location
- > A Default Location has not been specified for a Place of Service selected in the field

Referring Dr.

This field will react in one of the following ways:

- > Auto-fill with the Referring Dr selected as the Batch Default.
- > Auto-fill with the Referring Dr entered in Registration when the Practice Option **Default to Patient's Referring Dr** is checked and no Referring Dr. has been designated as the Batch Default.

Remain blank when neither a Batch Default is specified, nor the Practice Option is checked.

Creating service lines

The purpose of this topic is to explain the various elements in the service line area on the **Charge Entry** tab.

Transactions - Charge Batch# 51 | - Bal. \$0.00]

Batch Management **Charge Entry** **Edits** **Validate Batches**

Proof: Entered: \$3,765.00 **Reset**

Patient:	Voucher#: (New)	EE ✓	Resp Party:
SSN/DOB/AGE: ****0100 05/12/1960 52 years	Provider:	Billing Provider:	
Acct Type: Standard	Department:	AMBULATORY SURGI CENTER	
Comments:	POS:	AMBULATORY SURGI CENTER	
Payor: Insurance No Co-Pay	Location:	AMBULATORY SURGI CENTER	
Coverage Type: Medical	Referring Dr:		
Policy: MEDICARE1 (no plan)/(no plan) (P) (Medical)	<input checked="" type="checkbox"/> Accept Assign? Cert#: 000-00-0100 01		
<input checked="" type="checkbox"/> Service Date Procedure Modifier Diagnosis Codes TOS Units Fee Amt 03/05/2013 99211 E03.9 MEDICAL 1.00 \$45.00			

Date From: 03/05/2013 Thru: 03/05/2013

Procedure: Office/Outpatient Visit, Est Type of Svc: Medical

Modifiers: Units: 1.0

Diagnosis: Hypothyroidism, unspecified Fee Amt: \$45.00

Anesthesia... Dental... Drug... Purchased Service...

Total Charges: \$45.00 **Next Patient** **Same Patient** **Save** **Cancel**

Use **Tab** to move from box to box on the **Charge Entry** tab.

Date From: Thru

Auto-fills when the voucher is created using the encounter number or the related batch default is set.

When a voucher contains multiple service lines with different service dates, the service date for the voucher is the earliest service date.

Used as a pull field for the following functions:

- > printing claim forms
- > preparing electronic claims
- > financial reporting

This first service line toggles between procedure code and procedure series.

To change the box name, position the cursor in the box, then use **Ctrl + down arrow**.

Note: If a future date is entered, a hard warning message appears and you are not allowed to save the voucher.



Procedure

To enter a procedure code, use one of the following three methods:

- > Type in a CPT Code for example 99215, then **Tab** or click  to populate the box.
- > Use **Alt + down arrow** or click  to open **Procedure Code Lookup**.
- > Use **Shift + down arrow** or click  to open **Specify Procedure** to select a procedure code previously used for this patient.

Editing the description

When **Editable Description** on the **Procedure Code** tab in **Procedure Code Maintenance** is selected, you can use **Specify Procedure Code** to edit the procedure code description on the voucher, if necessary.

On the **Edits** tab, the procedure description can be edited but not the code itself.

Procedure Series

To enter a procedure series, do the following:

Click the up and down arrows found to the right of **Procedure** to change the box to **Proc. Series**.

Add the procedure series to the voucher using one of the following two methods:

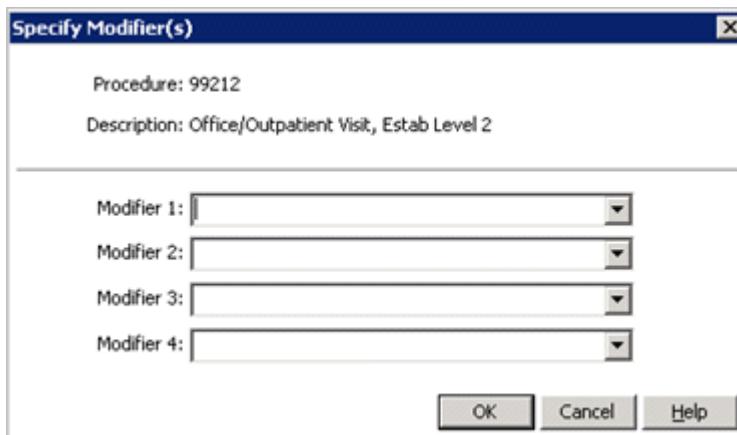
- > Type in the abbreviation used for the series in file maintenance, then **Tab** or click 
- > Use **Alt + down arrow** or click  to open **Procedure Series Lookup** to search for a procedure series.

The procedure history dialog button  is disabled.

Modifiers

Enabled only when **Allow Entry of Modifiers** is selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

- > Enter the modifier value (the code that prints on the claim form) then press **Tab** or click  To enter multiple values use commas between the entries. Use commas to enter multiple values for a service line, such as "80, 59, LT, 51"
- > Click  (Alt + down arrow) to open **Modifier Lookup**.
- > Click  (Shift + down arrow) to open **Specify Modifier(s)**.



Allows you to enter up to 4 modifiers per service line.

- > Click  to display the list of modifiers, and then click a modifier name to populate the box.

Click **OK** to close the window. **Modifiers** on the **Charge Entry** tab is filled with the corresponding modifier value or values.

Diagnosis

This field auto-fills when either or both of the following is true:

1. **Default to Last Diagnosis** is selected in **Practice Options** or **Organization Options** and at least one diagnosis has been previously recorded on the patient's record.
2. A default diagnosis has been designated for the procedure code entered on the service line. This default will take precedence over the **Default to Last Diagnosis** option.

To change or add diagnoses use one of these methods:

- > Enter the exact diagnosis code, for example 719.49, then **Tab** or click  To enter multiple codes use commas between the entries
- > Search for an existing code by clicking  (Alt + down arrow) to open **Diagnosis Code Lookup**.
- > Select a diagnosis code previously used for this patient by clicking  (Shift + down arrow) to open **Specify Diagnosis Code(s)**.

Note:

- > You can enter an unlimited number of diagnosis codes on a service line.
- > You must enter either ICD-10 or ICD-9 codes based on **ICD-10 Effective Date** in **Insurance Carrier Maintenance** for the carrier associated with the policy on the voucher. The ICD-10 effective date for the carrier is displayed above the service date on the **Charge Entry** tab to assist you in determining whether to enter ICD-10 or ICD-9 codes. However, if the policy has an expiration date that is before **Date From**, the policy expiration date is displayed instead of the carrier's ICD-10 effective date. This validation does not apply to self-pay vouchers.
- > You cannot enter a mix of ICD-10 and ICD-9 codes on the same voucher. The first diagnosis code entered on the voucher determines the required code set for the subsequent diagnosis code, including codes entered in **Claim Information**.
- > When an ICD-10 code is entered for a charge, both ICD-10 and mapped ICD-9 codes, if they exist, are saved with the voucher.
- > Mapping status indicators are displayed to the left of **Diagnosis** when you enter an ICD-10 code.
 -  (green circle with a check mark) - Indicates that the ICD-10 code is mapped to only 1 row on the **Mapping** tab in **Diagnosis Code Maintenance**, and that row is marked as the default. You do not need to select an ICD-9 mapping; the default row will be used on the charge.

This icon can also be displayed when the practice option, **Auto Tag ICD-9 from Patient History, Same Diagnosis**, is set to either **All Providers** or **Same Provider Only** and the only qualifying ICD-9 mapping that exists is in the patient's history because of a one-time-only mapping added from **Diagnosis Code Lookup**. In this scenario, the mapped code from the patient's history is automatically tagged and the mapping status is the green circle with a check mark.
 -  (yellow circle with a question mark) - Indicates that the ICD-10 code is mapped to more than 1 row on the **Mapping** tab in **Diagnosis Code Maintenance**. Use **Diagnosis Code Lookup** to review the mapping options; otherwise, the row marked as the default will be used on the charge.
 -  (purple circle with an X) - Indicates that the ICD-10 code does not have any mapped ICD-9 rows tagged for inclusion on the charge.

Use **Diagnosis Code Lookup** to select or create an ICD-9 mapping to be used on the charge.

- You must have security permissions for **Practice Management > Financial Processing > Transactions > Add Mapped Codes** to create an ICD-10 to ICD-9 mapping from **Diagnosis Code Lookup**.
- When multiple ICD-10 codes are entered in **Diagnosis**, the mapping status indicator is displayed based on this hierarchy: (1) ✘ purple circle with an X , (2) ⓘ yellow circle with a question mark , and (3) ✓ green circle with a check mark .
- When a charge (imported or entered directly) contains ICD-10 codes with mapped ICD-9 codes, the ICD-10 codes are displayed in **Diagnosis** even if the insurance carrier is not accepting ICD-10 codes yet.

Type of Svc

Auto-fills when a default type of service is selected for the procedure code in file maintenance.

To enter a type of service, click to open the drop-down list, and then click the type of service name to fill the box.

Units

Entry is governed by the date range entered for the service. For example, if the **Date From** and **Thru** reflect a span of 4 days, then this field defaults to 4.

Exception: Defaults to 1 regardless of the date range when the procedure code entered on the service line has **Default to One** checked in file maintenance.

To change the default type a number.

Fee Amt adjusts based on the number of units entered.

Fee Amt

Auto-fills with the defined fee amount entered for service on the **Fees** tab in **Procedure Code Maintenance**.

Auto-adjusts based on the number of units entered for the service.

Type in an amount to override the defaults.

Note: If you want to restrict a user's ability to change fee amounts, define the applicable user permissions for **Fee Amount** under **Practice Management > Financial Processing > Transactions > Batch Management > Charge Entry** in **Administration > Security Manager >**

Security Permissions. When you restrict permissions for a user, boxes containing fee amounts become read-only.

When **Derive Place of Service** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**, **Fee Amt** is not assigned or changed until you select a value for **Visit Type** and **Location**. The application uses your selections for **Procedure Fee Basis** or **Override Procedure Fee Basis** on the **Charge Entry** tab in **Practice Options** or **Organization Options** when determining fees.

Anesthesia

Enabled when you enter a procedure code with a procedure type of **Anesthesia (Timed)**.

Use **Anesthesia Services** to enter the start and end times. **Actual Minutes** is read-only and contains the minutes between **Start Time** and **Stop Time**. For applicable procedures, enter the anesthesia provider's face-to-face time or discontinuous time spent with the patient in **Billing Minutes**, regardless of the actual start and stop times of the procedure. **Time Units** is auto-filled based on **Anesthesia Style Maintenance**. **Base Units** is auto-filled from **Procedure Code Maintenance**. CRNA boxes should be filled if as applicable.

When importing anesthesia charge messages that have role (ROL) segments and procedure codes with the **Anesthesia (Timed)** procedure type selected in **Procedure Code Maintenance** (import one encounter at a time or when a patient checks out, not batch import), the application automatically fills **Anesthesia Services** with information from the charge message. If all required information is included in the charge message, there is no need to open **Anesthesia Services** to complete the creation of the voucher. If you decide to manually open and close **Anesthesia Services**, an additional service line is not created as it would be for a manually entered voucher.

Dental

Enabled when you enter a procedure code with a procedure type of **Dental**.

Use this window to enter information pertinent to and necessary for a dental claim.

Drug

Enabled when you enter a procedure code with a procedure type of **Drug Code**.

Use this window when billing the claim electronically using any one of the ANSI formats.

When the **Unit of Measure** and **Unit Count** boxes are filled in **Procedure Code Maintenance**, there is no need to manually access the **Drug** window for the values to be included in claims.

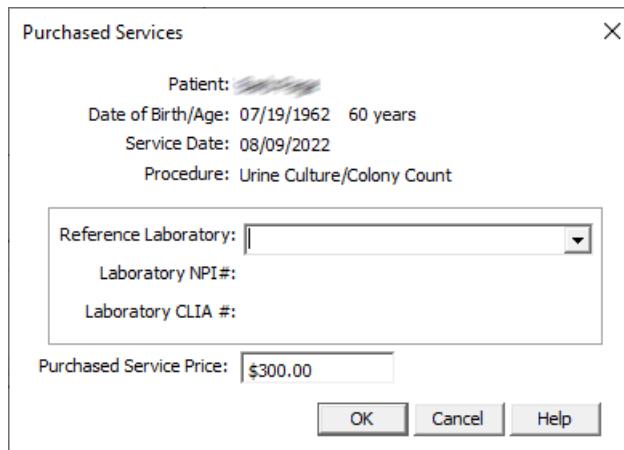
Note: This also applies to imported charges.

Purchased Service

Enabled when you enter a procedure code that has **Purchased Service** selected on the **Procedure Code** tab in **Procedure Code Maintenance**.

Select a place of service for **Reference Laboratory** that applies to the service, which enables the application to automatically fill **Laboratory NPI #**, **Laboratory CLIA #**, and **Purchased Service Price**.

Important: Do not click **Purchased Service** unless the carrier requires service-level purchased-service information in the claim file.



This window contains the following boxes:

Reference Laboratory

Required: Select the applicable place of service.

Laboratory NPI #

Read-only: Filled by the application with the National Provider Identifier (NPI) number retrieved from the **Billing Numbers** tab in **Place of Service Maintenance** for the selected reference laboratory.

Laboratory CLIA #

Read-only: Filled by the application with the Clinical Laboratory Improvement Amendments (CLIA) number from the **Place of Service** tab in **Place of Service Maintenance** for the selected reference laboratory.

Purchased Service Price

Required: Filled by the application with the fee defined on the **Purchase Service Info** tab in **Place of Service Maintenance** for the selected reference laboratory but can be edited.

You must select a **Reference Laboratory** place of service for every service on the voucher that has a procedure code with **Purchased Service** selected in **Procedure Code Maintenance**. The value for **Reference Laboratory** is not retained for subsequent purchased services on the voucher.

The information you enter in **Purchased Services**:

- Displays with the voucher detail in **Financial Inquiry > Account Inquiry** when you right-click a row in the grid and select **View**.
- Outputs in Loop 2400 of the Standard ANSI 837P v5010A1 electronic claim format
 - Segment PS101: laboratory NPI #
 - Segment REF01: F4 qualifier
 - Segment REF02: laboratory CLIA #
 - Segment PS102: purchased service price

You must enter the necessary information and click **OK** in **Purchased Services** for the information to output in Loop 2400.

Note: For v5010 electronic claims, use the purchased service available claim fields in **Claim Type Maintenance** to be able to use **Claim Information** to enter the information that is required at the claim level in Loops 2300 and 2310.
For paper claims, use the outside lab available ailment fields in **Ailment Type Maintenance** to be able to use **Ailment Information** to indicate that the services on the claim are being provided by an outside lab and to include the sum of the charges.

View H&P New Line

Click  (**Alt+i** or **New Line**) to add a new service line.

Summary

Click **Summary** (**Alt+u**) to open the **Summary** view.

Next Encounter/Patient/Voucher

Enabled after a voucher is saved.

Use **Alt + n** or click the button to clear all the information fields and ready the screen for a new entry. The box label is governed by the practice or organization option selected or by the box label selected when this batch was opened.

Same Patient

Enabled after a voucher is saved.

Use **Alt + m** or click the button to enter another voucher using the same patient information. The window retains the service information entered for the previous voucher.

Corrections

Is only present when **Display Pending Claims Correction** is selected in **Charge Batch Defaults** for this batch. Otherwise, it will be hidden.

Enabled after a voucher is saved and **Pending Claim Corrections** is accessed and then closed. Also enabled if the user pulls up the voucher in an open batch by voucher.

The **Corrections** button is not enabled if there are pending changes for a voucher that have not been saved. For example, when the user brings up a voucher that was previously entered to edit it, the **Corrections** button is enabled at that point in time. Once the user makes a change to a voucher, the **Save** and **Cancel** buttons become enabled as they always have and the **Corrections** button is disabled.

Click this button to open **Pending Claim Corrections**.

Save

The voucher number is displayed at the top of the tab when charges are entered by encounter number and saved.

If **Display Pending Claims Correction** is checked in Charge Batch Defaults, the Pending Claim Corrections dialog box displays for insurance responsible vouchers only.

Tip: To generate a claim on demand for any voucher with insurance, click **Print Claim** on the toolbar after you save the voucher. The voucher is not set to self-pay and will still be generated as normal with standard insurance processing. In this scenario, setting **Payor** to **Courtesy Claim** is not required to use **Print Claim**.

Cancel

You can cancel the entry of a voucher any time before you save.

Use **Esc** on your keyboard, **Alt+c**, or click the button.

Search for a diagnosis code

Use **Diagnosis Code Lookup** to search for a diagnosis code.

1. Click  or  next to the **Diagnosis** box.
2. For **Search By**, select a search method.
 - > **Description**
 - > **Diagnosis Code**
3. For **Code Set**, select the code set to filter the search results by:
 - > **Both**
 - > **ICD-9**
 - > **ICD-10**

4. (Optional) Select **Save Search by Setting** to save your settings as the default search criteria for the lookup.
5. For **Search For**, type the applicable text related to the search option you selected for **Search By**.

Use the following table to help you.

Search By option	Search For entry tips
Description Searches on the Description in Diagnosis Code Maintenance .	<ul style="list-style-type: none"> > Enter a minimum of three letters to retrieve diagnosis codes with descriptions that begin with those letters. > Use % followed by letters to retrieve diagnosis codes with descriptions that include those letters regardless of their position in the name.
Diagnosis Code Searches on the Diagnosis Code in Diagnosis Code Maintenance .	<ul style="list-style-type: none"> > Enter the exact diagnosis code (for example, 010.12) to retrieve the diagnosis code. > Enter a partial code to retrieve all diagnosis codes that begin with your entry (for example, 010). > Use % followed by a partial code to retrieve all diagnosis codes that include your entry regardless of the position in the code (for example, %01).

6. Click **Search**.
7. In the grid, select a diagnosis code.

How you select a code depends on whether you are using the standard or expanded version of **Diagnosis Code Lookup**.

Important: If you initiate the search from one of the following locations, you are using an expanded version of **Diagnosis Code Lookup**. Otherwise, you are using the standard **Diagnosis Code Lookup** window. The expanded version includes grids for diagnosis history and mapped codes.

- > **Financial Processing > Transactions > Charge Entry**
- > **Financial Processing > Transactions > Charge Entry > Claim Information**
- > **Financial Processing > Transactions > Edits**

- > **Financial Processing > Transactions > Edits > Claim Information**
- > **Financial Processing > Automatic Transactions > Import Charges > Correct Import Charges**

- > On the standard **Diagnosis Code Lookup** window, select a row in the grid, then click **OK**.
- > On the enhanced **Diagnosis Code Lookup** window, select **Tag** on a row in the grid, then use the following table to determine how to proceed.

If...	Then...
The row you tagged is an ICD-9 code.	Click OK .
The row you tagged is an ICD-10 code with mapped ICD-9 codes.	<p>Do one of the following in the Mapped Codes grid.</p> <ul style="list-style-type: none"> — Accept the mapping that was tagged by the application. — Select Tag for a different mapping row in the Mapped Codes grid. — Double-click a row in the Diagnosis History grid to add it to the Mapped Codes grid as a one-time-only mapping. — Click  in the last blank row of the Mapped Codes grid, then search for and select an ICD-9 code to add as a new, one-time-only mapping.
The row you tagged is an ICD-10 code without mapped ICD-9 codes.	<p>You have several choices:</p> <ul style="list-style-type: none"> — Double-click a row in the Diagnosis History grid to add it to the Mapped Codes grid as a one-time-only mapping. — Click  in the last blank row of the Mapped Codes grid and search for an ICD-9 code to add as a new, one-time-only mapping. — Use the ICD-10 code without a mapping. You will be warned that no mapped code is tagged. Make sure the insurance carrier is accepting ICD-10 codes before you choose this option.

Important: You must have the **Add Mapped Codes** security permission to add a one-time-only mapping. The mapping only applies to the current charge; it is not saved as a mapping in **Diagnosis Code Maintenance**.

After you add a new mapping row, you cannot delete the row, but you can press **Backspace** to clear the code that was entered.

8. Click **OK**.

Summary view on the Charge Entry tab

Use the summary view during charge entry to enter additional information on a voucher.

Access the summary view by clicking **Summary** on the **Charge Entry** tab in **Financial Processing > Transactions**.

The cursor rests in the **Local Use Text** field.

Local Use Text

Free text field that allows a maximum of 50 characters to be entered.

Text entered here outputs in Box 19 on a standard CMS-1500 NPI paper claim form or Loop 2300/Segment NTE of a Standard ANSI X12N 837I v4010A1, or Standard ANSIX12N 837Pv4010A1 electronic claim file.

Alternate Local Use Text

Free text field that allows a maximum of 50 characters to be entered.

Is only present in the summary view when all of the following conditions are met:

- > The voucher contains a split billing procedure code.
- > The voucher contains a split billing place of service.
- > The voucher is entered against an insurance carrier that has an alternate claim style.

Any text entered in this field outputs in Form Locator (FL) 80 on a standard UB-04 paper claim form or Loop 2300/Segment NTE of a Standard ANSI X12N 837I v4010A1 electronic claim file on the Institutional voucher(s) using the alternate claim style.

Void and Re-Enter honors this fields if a procedure code is re-entered in Charge Entry and the Place of Service and Carrier are enabled for split billing.

If a claim type message applies to the Institutional voucher using the alternate claim style in a split bill scenario, the default text only populates the **Local Use Text** field.

If a voucher splits multiple times due to the **Procedure Grp for Separate Claim** setting in Place of Service Maintenance, the text in **Alternate Local Use Text** is copied to all of the Institutional vouchers using the alternate claim style.

Import Charges only honors the **Alternate Local Use Text** field when you bring up the Charge Entry COMpanion screen by right-clicking a charge and selecting Process Import Charge from the Import Charges screen or when you specify an Information Broker Format in Charge Batch Defaults, and then search by Import in Charge Entry.

You can right-click and cut, copy, and paste information from the **Local Use Text** field to the **Alternate Local Use Text** field.

Below are some examples of when the **Alternate Local Use Text** field would be used.

- Unspecified procedure codes - A Practice uses unspecified procedure codes and has to describe what was done in the narrative section of the claim. The unspecified code is only billed on the Institutional voucher and the narrative only needs to be output on a UB-04 paper claim or in an 837I electronic file.
- Unspecified drug codes - A Practice uses an unspecified J code for some of its drugs. The J code must be billed in conjunction with other codes in a split bill scenario. The J code is only billed on the Institutional voucher and the narrative only needs to be output on a UB-04 paper claim or in an 837I electronic file.

Statement Message

From the drop select a message that prints on the Patient's statement.

Statement messages are created in Message Maintenance.

Statement messages can be optional viewed in Financial Inquiry and included on the Account Summary Report and the Collection Account Report.

After it is attached to a voucher, the message always prints when that voucher is billed out unless the message is removed from the voucher using the Edits tab.

Claim Message

The selected message prints on the bottom of a standard CMS-1500 NPI claim form below Box 31. After it is attached to a voucher, the message always prints when that voucher is billed as a paper claim unless the message is removed from the voucher on the **Edits** tab.

Currently, the only instance when the claim message is used to output a value to an electronic claim file is when you bill IL Medicaid as secondary. Status codes created as claim messages in Message Maintenance are appended to the Other Payer Code code in Loop 2330B REF02 of a Standard ANSI 837P v5010A1 claim file. Otherwise, the claim message does not output to an electronic claim file.

Claim messages can be viewed with claim detail in **Unpaid Claims Management** and in **Financial Inquiry**.

The drop-down lists contains all the messages created in **Message Maintenance**.

Hold Voucher From

Selecting a hold option prevents the voucher from qualifying for billing. This field should be left blank unless you want to hold the voucher from billing.

This field is automatically populated when at least one of the following is true:

- > The voucher's selected policy is associated with a Carrier and Place of Service flagged for the 72 Hour Rule. In this instance, the field defaults to **All Insurance Billing**.
- > A procedure code entered on the voucher is flagged to hold from electronic claims. The field defaults to **Electronic Claim Billing**.
- > A diagnosis code entered on the voucher is flagged to hold from electronic billing. The field defaults to **Electronic Claim Billing**.

The operator can change the default.

To put a hold flag on the voucher, do the following:

Click to open the drop-down list which provides the following choices:

- > All Insurance Billing
- > Electronic Claim Billing
- > Self-Pay Statements
- > All Billing (Insurance & Self-Pay)

Click on the name of an option to populate the field.

Note: A voucher held for the 72 Hour Rule is automatically released from hold based on the settings in Practice/Organization Options on the General tab.

Release an Updated Voucher from Hold - To release an updated Voucher from a billing hold, you can do one of the following:

- > Run the Pending Claims Management for Held Claims and use the right-click menu or the Corrections dialog to release the voucher for billing.
- > Call the voucher up on the Edits tab and manually blank this field.

Release a Voucher with the Status of Entered - A held voucher with an entered status can be recalled by number from within its batch in Charge Entry and the field can be blanked.

When a voucher is held from billing, a message that says **Voucher held from All Insurance Billing** displays in the Payment Entry above the Summarized Insurance Reimbursement grid to notify you of its held status.

Hold Voucher Reason

Enabled when the field **Hold Voucher From** is populated.

This field is automatically populated when at least one of the following is true:

- > The voucher's selected policy is associated with a Carrier flagged for the 72 Hour Rule. In this instance, the field defaults to the held voucher reason selected for the Carrier and Place of Service in file maintenance.
- > A procedure code entered on the voucher is flagged to hold from electronic claims and a held voucher reason was entered in for that code in file maintenance.
- > A diagnosis code entered on the voucher is flagged to hold from electronic billing and a held voucher reason was entered in for that code in file maintenance.

The default can be changed by the Operator by doing the following:

- > Click to open the list of held voucher reasons created in file maintenance.
- > Click on the name of the reason you want so that it populates the field.

Not Incident To

This option only appears when both of the following two conditions are met:

1. The voucher is being billed to the patient's primary policy.
2. The Actual Provider on the voucher is flagged as a Mid-Level Provider on the Provider tab in Provider Maintenance.

Check this option when a Mid-Level Provider, such as a Nurse Practitioner may not bill "incident to" and must be billed as the Billing Provider. There are four scenarios where this is the case:

1. The patient is a new patient.
2. The patient is being seen for a new diagnosis/problem.
3. The patient is being seen for a new consult.
4. The patient is being seen when there is no Supervising Physician on site.

See "Billing for Mid-Level Providers."

This option is checked automatically if the Place of Service selected on the charge has **Default Not Incident To** checked on the Place of Service tab in Place of Service Maintenance (PSM). Even if this option is checked by default due to the PSM setting, you can still uncheck it here if necessary. See "Place of Service Maintenance: Complete the Place of Service Tab."

Referrals

Colored flags or icons are used to alert you to the Patient's Incoming Referral status.

 - indicates an Active Referral exists on the Patient record.

 - indicates the Appointment associated with the voucher has been flagged as **Referral Required**.

 - indicates a Referral has either been Attached or Linked to the voucher.

Note: If your practice or organization uses uninsured carriers, this flag is displayed only if the patient account has another insurance policy other than uninsured and an active referral is attached or linked to the other insurance policy.

The absence of an icon indicates that there is not a active incoming referral on the Patient's record.

Click the **Referrals** button (**Alt+r**) to open the Incoming Referrals dialog.

See "Create an Incoming Referral."

Claim Info

Use **Claim Information** to add supplemental information to a voucher for inclusion on a claim. The information is usually required by carriers or specific to institutional claims and rural health billing requirements.

See "Claim Info Color Indicators used in Charge Entry."

Note: If you access a voucher on the **Edits** tab that was created prior to your upgrade to version 10.4, **E-Code 1**, which was previously labeled **E-Code**, contains the original free-text value. A message, No Diagnosis code found for xxxx, where xxxx is the free-text value, displays upon entry to **Claim Information**. You must change the value in **E-Code 1** to a valid diagnosis code defined in **Diagnosis Code Maintenance**.

CMN/DIF Info

When a voucher contains a Procedure Code flagged to enable CMN/DIF Info and the Policy selected for the voucher has a Source of Payment set to "Medicare," **CMN/DIF Info** becomes enabled.

Note: When the claim does not require the submission of a CMN/DIF form, check the Claim Info field **Ordering Dr. Same as Referring Dr?** found in the summary view on the Charge Entry tab. This field may be checked from the Edits tab as well.

Click **CMN/DIF Info** to open the dialog. See "DME Billing: Using the CMN/DIF Information Dialog."

Currently, Allscripts® Practice Management supports the electronic submission of the following two forms using the standard ANSI X12N 837P v4010A1 format:

- > CMS-10125, External Infusion Pumps (DME 09.03)
- > CMS-484, Oxygen (DME 484.03)

Ailment Info

Ailment Info is required when a red circle  displays to left of the button.

A yellow circle  indicates the existence of Ailment records associated with the Patient.

See "Attach a New Ailment to a Voucher," "Attach an Existing Ailment to a Voucher," "Ailment Info: Color Indicators Used in Charge Entry," "Claim Types: Overview" and "Attaching an Ailment to an Appointment and Charge Entry/Import Charges."

Add'l Claim Dx

Add'l Claim Dx displays all diagnosis codes entered on a voucher's service lines and indicates which of those codes are both the service-level and claim-level codes, and which codes are additional codes output only at the claim level. It also enables you to manage the additional claim-level-only diagnosis codes for v4010 and v5010 professional claims. Diagnosis codes selected in **Add'l Claim Dx** are displayed on the **Diagnosis History** tab in **Patient Management > Service Inquiry**.

Attachment Info

Opens the Claim Attachments dialog.

Use of this dialog creates the Segment PWK in Loop 2300 of a Standard ANSI X12N 837I v4010A1 and Standard ANSI X12N 837P v4010A1 electronic file.

See "Use the Claim Attachment Dialog."

Amb Info

Enabled when at least one of the Procedures entered on the voucher has a **Procedure Type** set to **Ambulance Procedure**.

Opens a dialog where the Operator can enter the billing information required by the Carrier or your electronic claims vendor.

See "Ambulance Billing: Complete the Ambulance Information Dialog."

NY Workers' Comp

Only enabled when the carrier on the charge **Source of Payment** in **Insurance Carrier Maintenance** set to **NEW YORK WORKERS' COMPENSATION**.

Click **NY Workers' Comp** to open **NY Workers' Comp**, which enables you to enter the information necessary to fill **NYWC Initial Medical Narrative**, **NYWC Progress Medical Narrative**, and **Doctor's Report of Maximum Medical Improvement/Permanent Partial Impairment C-4.3 (05-22)** claim form.

PM160

Available when **Policy** is set to one where the carrier has an associated paper claim style or an alternate paper claim style with a format type of **CA CHDP Assessment Claim Form**, the control **PM 160** is available in the summary view on the **Charge Entry** tab and on the **Edits** tab.

Click **PM160** to open the form.

There are no required fields on this form from the standpoint of Allscripts® Practice Management. If a box is left blank on the dialog, the corresponding box on the paper form is left blank. Output is programmed to print in Courier 12pt font, which is 10 characters per inch. Some truncation may occur.

The form displays within two windows or screens. Use **Next** and **Previous** to move between the screens.

Self-Pay

Opens the Self-Pay dialog.

The following icons may display to the left of the button:

- ✖ - Indicates that the voucher contains a procedure where the Co-Pay Applies. The **Save** button is disabled. You must open the dialog and process the co-pay before you can save the voucher.
- ✓ - Indicates that the dialog has been opened and co-payments and/or co-insurance payments have been processed.

See "Using the Self-Pay Dialog."

Next Encounter/Patient/Voucher

Enabled after a voucher is saved.

Use **Alt+n** or click the appropriate button to clear all the information fields and ready the screen for a new entry. The field label is governed by the Practice Option selected or by the field label selected when this batch was opened.

Same Patient

Enabled after a voucher is saved.

Use **Alt+m** or click the button to enter another voucher using the same Patient Information. The screen retains the service information entered for the previous voucher.

Corrections

Is only present when **Display Pending Claims Correction** is checked in Charge Batch Defaults for this batch. Otherwise, it will be hidden.

Enabled after a voucher is saved and the Pending Claim Corrections dialog box is accessed and then closed.

Also enabled if the user pulls up the voucher in an open batch by Voucher.

The **Corrections** button will not be enabled if there are pending changes for a voucher that have not been saved. For example, when the user brings up a voucher that was previously entered to edit it, the **Corrections** button is enabled at that point in time. After the user makes a change to a voucher, the **Save** and **Cancel** buttons become enabled as they always have and the Corrections button is disabled.

Any soft warnings such as "This voucher contains self-pay procedures" display when you click **Save**, as they always have. You can click **OK** past the soft warning which then brings up the Pending Claim Corrections dialog box.

Any hard warnings such as "Department is a required entry" display when you click **Save**, as they always have. You have to correct these errors before the system allows you to successfully save the voucher and continue on to the Pending Claim Corrections dialog box.

When you click **Save** in Charge Entry and the Pending Claim Corrections dialog box appears, the voucher is successfully saved. At this point if you click **Cancel** on the Pending Claim Corrections dialog box, you only cancel any change you made to Hold Voucher.

Click this button to open the Pending Claim Corrections dialog.

See "Use Pending Claim Corrections Dialog in Charge Entry."

Save

Save the entry by using **Alt+s** or clicking the button.

If **Display Pending Claims Correction** is checked in Charge Batch Defaults, the Pending Claim Corrections dialog displays for insurance responsible vouchers only.

Cancel

You can cancel the entry of a voucher any time before you execute the Save command.

Use the **Esc** key on your keyboard, **Alt+c**, or click the button.

Manage additional claim-level-only diagnosis codes

Use **Add'l Claim Dx** to manage additional claim-level-only diagnosis codes that are output in Loop 2300 Segment HI on 837P electronic claims and Box 21 on CMS 1500 ICD-10 standard paper claims.

A yellow circle with a question mark  is displayed to the left of **Add'l Claim Dx** in these circumstances:

- ICD-9 codes were entered on the voucher. There are more than 4 diagnosis codes per service line, and there are available slots for additional ICD-9 claim-level-only diagnosis codes to output on the claim.
- ICD-10 codes were entered on the voucher. There are more than 4 diagnosis codes per service line, and there are available slots for additional ICD-10 claim-level-only diagnosis codes to output on the claim.
- ICD-10 codes were entered on the voucher. There are no additional ICD-10 codes to output at the claim level, but there are additional mapped ICD-9 codes.

1. Access **Add'l Claim Dx** by clicking **Add'l Claim Dx** from the **Summary** view in **Financial Processing > Transactions > Charge Entry** or from **Financial Processing > Transactions > Edits**.
2. Select **Code Set**.

The default value is the code set of the first diagnosis code entered on the first service line. When the default value is **ICD-9, Code Set** is unavailable. When the default value is **ICD-10**, all service-level and claim-level ICD-10 codes are displayed. Select **ICD-9** to display mapped ICD-9 codes.

Unique diagnosis codes, compiled from the first 4 diagnosis codes per service line in the order they were entered on the voucher, are displayed in a grid with **Claim Diags** selected and unavailable. These codes are both service-level codes (Loop 2400, Segment SV on 837P electronic claims; Box 24E pointers to Box 21 on CMS 1500 ICD-10 standard paper claims) and claim-level-only codes (Loop 2300, Segment HI on 837P electronic claims; Box 21 on CMS 1500 ICD-10 standard paper claims). Descriptions for the diagnosis codes are displayed beneath the grid in read-only boxes labeled **Scv/CIm Dx #**, where # represents the order in which the diagnoses were entered on the voucher.

If the maximum number of claim-level diagnosis codes was not met, any additional diagnosis codes entered on the service lines are displayed with **Claim Diags** enabled.

3. (Optional) Clear **Claim Diags** for the additional claim-level-only diagnosis codes selected by the application that you do not want on the claim. Select **Claim Diags** for the additional claim-level-only diagnosis codes that you want to include on the claim only at the claim level.

Boxes labeled **CIm Dx [#]**, where # represents the claim-level-only slots, are filled in the order that the additional claim-level-only diagnosis codes are selected. That order is retained after you click **OK**. Boxes labeled **CIm Dx** are read-only.

4. Click **OK** to return to the **Charge Entry** tab or **Edits** tab.

When you clear 1 or more check boxes in the top grid and then click **OK**, the remaining diagnosis codes in the bottom section are moved up so that there are no empty **CIm Dx** boxes.

Tip:

To move a diagnosis code up to the first empty **CIm Dx** box without clicking **OK** and then re-opening **Add'l Claim Dx**, clear and re-select the check box for the diagnosis code that you want to move.

For example, assume **CIm Dx 5** and **CIm Dx 6** are empty and **CIm Dx 7** is filled. To move the diagnosis code description currently in **CIm Dx 7** to **CIm Dx 5**, clear and re-select the check box for the diagnosis code currently in **CIm Dx 7**. The diagnosis code description in **CIm Dx 7** moves to **CIm Dx 5**.

Apply Self-Pay Payments window

Use **Self-Pay** to process Co-Pay/Co-Ins% and/or other Self-Pay payments which apply to the current Voucher.

Access path

The Self-Pay dialog is opened from the Summary screen in Charge Entry when you click the **Self-Pay** button.

When and why does a red circle display to the left of the Self-Pay button?

When the icon  displays to the left of the **Self-Pay** button, the **Save** button is disabled. In this instance, you must open the dialog and process any co-pay/co-insurance amounts due before you can save the voucher entries. When you close the dialog and return to the Summary screen, this icon  now displays to the left of the **Self-Pay** button.

Whether the red circle displays is triggered by the inclusion on the voucher of a procedure code flagged as **Co-Pay Applies**.

The existence on a voucher of procedures defined with co-insurance percentages does not trigger the display of the red circle.

Associated Payment Batch

When you apply payment transactions from the Self-Pay dialog you are actually working in a Charge batch. That is why when you apply the first payment transaction you are prompted to

create a system generated Payment batch that is associated with the charges you are entering. A Transaction message box with the following message displays: OK to create a new batch for associated payments?.

Always click **OK**.

This system generated batch is given the same batch number as the charge batch and is identified on the Batch Management screen with an asterisk.

Close and update an associated payment batch at the same time that you close and update the charge batch.

For those using batch categories: When the associated payment batch is created, the batch category will match the batch category of the charge batch with which it is associated. If the batch category of the associated charge batch is blank, the batch category of the payment batch that the system automatically creates will also be blank. You can change the batch category assigned to this batch on the Batch Management screen.

Note about Capitated Plans

If the Voucher contains capitated services and/or plan exceptions, when you save the Voucher you will be prompted to deal with the appropriate adjustments and transfers. See Auto Adjust Capitated Procedure Amounts.

Header Detail

The header includes policy information and these items.

Patient Due amount

The Patient Due amount is the amount due by the Patient for the services entered on the current voucher. It is not the Patient's Self-Pay account balance.

Patient Due amount (PDA) is equal to the sum of the Co-Pay Payment Amount (CPA) plus the Other Patient Balance (OPB) minus Previous Credits (PC). $PD = (CPA + OPB) - PC$

Note: Manually entered adjustment amounts are not reflected in the Patient Due nor in the Other Patient Balance totals.

Keep the following in mind when viewing the Patient Due amount:

- > On a voucher where the Payor is set to Self-Pay or Courtesy Claim - PD includes the total of the charges entered on the voucher.
- > On a voucher where the Payor is set to Insurance

Co-Pay Amounts are not included in the Patient Due amount for the Primary Carrier when the option **Secondary Co-Pay Coverage** is checked on the Policies tab in Registration.

The total fee amount for procedures designated as non-covered are included in the Patient Due

The Co-Insurance % amount is not calculated when the Primary Carrier is being billed and the Patient has a Secondary Policy. For a Co-Insurance percentage to be calculated an allowed amount must be entered for the procedure on the Payor's Contractual Allowance tab in Insurance Carrier Maintenance

Co-Pay

The co-pay amount is entered on the Carrier's Plans tab in Insurance Carrier Maintenance.

Note: Co-Pay amount is not included for the Primary Carrier when the option **Secondary Co-Pay Coverage** is checked on the Policies tab in Registration.

Previous Credits

Equals the total payments previously applied to this voucher using this Self-Pay dialog

Example: An Account has multiple available unassigned amounts. To satisfy the Patient Due amount on the voucher you must apply at least two of these unassigned amounts. However, the program allows you to only apply one unassigned payment at a time. Apply the first unassigned amount then **Enter** or click **OK** to close the dialog. When you re-open the dialog, the payment you previously applied is displayed in this field. You can then proceed to apply another available unassigned amount.

Unassigned payments available for application

This grid lists any unassigned payments that are available for you to apply to this voucher.

Unassigned payments are created in the following instances

- > a payment is entered on the Quick Pay payment dialog
- > an overpayment is moved to unassigned when using the **Oldest** button on the Payment Entry screen
- > a voucher's credit balance is moved to unassigned from the apply transactions screen in Payment Entry

Note: To move overpayments and credit balances to unassigned, a Misc Debit transaction code must be selected in Practice/Organization Options on the Payment Entry tab.

When there are unassigned payments available the dialog opens with the focus resting on the title bar of the available Unassigned Payments grid. The grid holds the following detail:

- > **Credit Date** - is the transaction date entered on the Quick Pay dialog, the apply oldest dialog when an overpayment is moved to unassigned and the apply transactions screen in Payment Entry when a credit balance is moved to unassigned.

- > **Reference** pulls from the reference field on the dialog on which the unassigned payment was created.
- > **Associated Dept/Pract** - displays the abbreviation of the selected associated department/practice from the quick pay payment dialog. When the Practice/Organization option **Require Associated Dept/Pract on Quick Payment** is checked on the Payment Entry tab the payment can only be applied if the voucher's department/practice is the same as the unassigned payment's associated dept/pract.
- > **Encounter No.** - displays the encounter number assigned to an appointment associated with a quick pay payment. The payment must be manually applied to the voucher that corresponds to the encounter number.
 - Note:** When applying an unassigned payment and it has an encounter number, be sure that you are applying the payment to the correct voucher.
- > **Associated Patient** - displays the patient selected as the **Associated Patient** when the unassigned transaction was saved. If an Associated Patient was not selected, this column is blank.
- > **Amount** - displays the total available money available from the unassigned payment.
- > **Description** - pulls from the free text field labeled **Description** on the original dialog used to create the unassigned payment.

Transaction Date

Enabled when you click either **New Payment** or **Override Co-Pay**.

Defaults to the current date.

If you enter the date the Payment was made and if that date is previous to the current date, then click the down arrow to use the calendar or enter a date using the format mm/dd/yyyy.

Other Patient Payment Grid

This grid displays information related to each Procedure on the voucher, the Self-Pay balance due which is other than the Co-Pay amount due, as well as containing the transaction code fields used for applying the Self-Pay payments and /or adjustments.

Amount Due

Is equal to the fee amount associated with the Procedure.

Co-Ins

When a co-insurance amount or % applies based on Patient's plan, that amount displays in this field. .

This is not editable from this dialog.

The Co-Ins amount is included in the total shown for **Other Patient Balance**.

Payment

Is equal to the amount due by the Patient for that procedure. This total includes any Co-Insurance amount and any non-covered amount (an allowed must exists for the procedure for the Carrier). When a prompt payment adjustment is applied using a specially flagged Transaction code, then the discounted total is also added to this column.

Becomes enabled when you click **New Payment** or **Override Co-Pay**.

- > **New Payment** auto displays the amount from the **Co-Ins** field and any Patient amount due for each procedure, i.e. non-covered or Patient Due amount as specified on the Carrier's Plan Exceptions screen.

Note: Manually entered adjustment amounts are not automatically reflected in the Payment column.

- > **Override Co-Pay** - enables the field but keeps it blank even if there is an amount in the **Co-Ins** field.

Adjustment

Enabled when you click **New Payment** or **Override Co-Pay**.

- > **New Payment** - enables the field but keeps it blank even if there is an amount in the **Co-Ins** field.
- > **Override Co-Pay** - auto displays the amount from the **Co-Ins** field.

An adjustment may be entered manually or applied using a Transaction Code which is checked as a Self-Pay Transaction Code and has a discount % amount entered in Transaction Code Maintenance.

Note: Manually entered adjustment amounts are not reflected in the Patient Due nor in the Other Patient Balance totals.

Other Patient Balance

Displays the Self-Pay balance due for all services, in other words it is the total sum of the Payments column.

Note: Manually entered adjustment amounts are not reflected in the Patient Due nor in the Other Patient Balance totals. See "Prompt Payment Discount" below.

New Payment

Use this command to record Co-Pay, Co-Insurance, and other Self-Pay payments when not applying available unassigned payments.

This button is also enabled when you manually enter a voucher with all zero-dollar service lines.

Override Co-Pay

The function of the **Override Co-Pay** button applies to co-insurance amounts as well as to co-pay amounts.

This button allows you to adjust or write-off the Co-Payment/Co-Insurance due on this voucher only. To make a universal change, the plan must be changed on the Patient's Policies tab in Registration.

Note: The **Override Co-Pay** button is always disabled when **Disallow Override Co-Pay Button** is checked on the Charge Entry tab in Practice Options.

This button is also enabled when you manually enter a voucher with all zero-dollar service lines.

Uncollected Co-Pay

This button allows you to bill the Patient for the co-pay/co-insurance while the balance on the Voucher is still out to the Carrier.

When you are using this button it triggers one or both of the following actions:

- The words "Co-Ins Due" along with the amount display in the Aging grid in Financial Inquiry and the Account Ledger.
- The Voucher qualifies to be included on a statement when the option **Print Uncollected Co-Pay/Co-Ins** is checked in Practice/Organization Options even though the Voucher's balance is still out to the Carrier.

This button is also enabled when you manually enter a voucher with all zero-dollar service lines.

No Payment

This button is used to record that no payment was received. The co-pay/co-insurance is not billed to the Patient until after the EOB is received from the Carrier.

Note: The **No Payment** button is always disabled when **Disallow No Payment Button** is checked on the Charge Entry tab in Practice Options.

It is important that you understand how this command works in the following instances:

Self-pay only vouchers

On self-pay only vouchers, only the **New Payment** and the **No Payment** buttons are enabled.

Using **No Payment** on a self-pay only voucher indicates that no payment is being applied to the Voucher.

No transaction is recorded.

You do not have the option to print an invoice.

When processing a co-pay

When you use **No Payment** to process a Co-Pay, the following is true:

- > The Co-Pay Applies flag for the procedure is rendered null for this Voucher only.
- > Later when you apply a payment to this voucher in Payment Entry, the field **Co-Pay** displays "\$0.00."
- > No adjustment is made to the amount due. In other words, the co-pay amount is not subtracted from the fee/charge amount. The entire charge is left as Insurance responsibility.
- > The words "Co-Ins Due" along with the amount do not display in Financial Inquiry or the Account Ledger.
- > The Account does not qualify for a Statement until the voucher's balance has been transferred to Self-Pay even when the Practice Option **Print Un-Collected Co-Pay/Co-Ins** is checked.

Benefit plans

If a policy is associated with a benefit plan, the following occurs:

- > The benefit plan code is displayed with the policy name next to **Insurance**.
- > There is no value for **Patient Due**.
- > The benefit plan code is displayed next to **Co-Pay**. Click the benefit plan code to open **View Benefit Plan Details**.
- > **Co-Pay Amount**, **Co-Pay Balance Due**, and **Co-Pay Payment Amount** are filled with zeros and cannot be changed.

Applying unassigned payments

Note: This topic describes how the application functions when **Always Distribute Quick Payment** is not selected on the **Payment Entry** tab in **Practice Options** or **Organization Options**.

When applying an assigned payment and it has an encounter number, be sure that you are applying the payment to the correct voucher.

If your practice/organization requires an associated department/practice be selected for a quick payment then you can only select an unassigned payment that has an associated department/practice that is the same as the one selected for the voucher.

Click the line or press the **down arrow key** to move the highlight over the unassigned payment you want to apply.

By program design, the unassigned amount is automatically distributed in this order:

1. Co-Pay Amounts due - When a voucher contains multiple procedures but only one that has a Patient due amount coming from the co-pay then the program applies a payment to the Co-Pay Payment Amount.
2. Co-Insurance Amount due - When a voucher contains multiple procedures, one that has a Patient due amount coming from the co-pay and one with a co-insurance due, then the program applies full payment for the Co-Pay Amount due then distributes any surplus to the payment field or fields for co-insurance payments due.
3. Other Patient Payments in order by procedure line

In addition to understanding how the system works it is important that you always review and verify the fields that auto-fill. Then make any necessary manual edits. But it is recommended that you never change a distribution to partially pay the co-pay and to partially pay the co-insurance. When you must make a choice to apply payments that do not cover the entire balance due then pay the Co-Pay Amount first and only then apply any surplus if there is one to the Co-Ins then Other Patient Due balances.

Here the system distributed the unassigned payments in the following way:

- > Co-Pay amounts
- > Co-Insurance amounts

In our example, the Patient Due amount is \$55.05 (Co-Pay Due + Co-Ins) while the Unassigned Payment equals \$60.00. We see that the remaining \$4.95 has not been applied. In this case you must manually enter a payment in the column related to the procedure code that has a patient due amount.

The amount due for the procedure J9260 (flagged as a **Carve Out** in Plan Exceptions) does not display anywhere on the dialog. In a situation like this you have two options:

Once you have selected the appropriate transaction codes, click **OK** to close the dialog. Then reopen the dialog. The Other Patient Balance now displays as \$125. As this is equal to the amount due, the remaining Unassigned Payment can now be manually applied to this procedure line.

Apply the remainder of the Unassigned Payment later in Payment Entry.

Review the default entries.

Use the **Tab** key to move through each field and make any necessary changes. Remember, never apply a partial co-pay payment and a partial co-insurance payment. Apply payments first to the co-pay amount then apply any surplus payment to the co-insurance then to Other Patient Due.

From the combo boxes, select a Co-Pay Transaction Code, a Payment Transaction Code, and an Adjustment Transaction Code when it applies.

Enter or click **OK** to return to the Summary screen.

Apply unassigned payments with multiple available amounts

Note: This topic applies when **Always Distribute Quick Payment** is not selected on the **Payment Entry** tab in **Practice Options** or **Organization Options**.

By program design only 1 unassigned payment can be applied at a time.

Note: When applying an assigned payment and it has an encounter number, be sure that you are applying the payment to the correct voucher.

If your practice or organization requires that an associated department or practice be selected for a quick payment, you can only select an unassigned payment that has an associated department or practice that is the same as the 1 selected for the voucher.

To apply more than 1 available unassigned amount to a voucher follow these steps:

1. Select and apply 1 unassigned amount in **Apply Self-Pay Payments**.
2. Close **Apply Self-Pay Payments**
3. Re-open **Apply Self-Pay Payments** from the summary area and apply the next available unassigned amount.

Results of this task

When you re-open **Apply Self-Pay Payments**, notice that the amount you previously applied is displayed in **Previous Credits**.

Applying a portion on an unassigned payment

All or a portion of the unassigned amount can be applied to a voucher. When applying payments from an unassigned amount that is greater than the Co-Pay Payment / Co-Insurance due and/or Other Patient Due, you must check all the payment fields and determine the correct distribution of payments. It is recommended that you never change a distribution to partially pay the Co-Pay and to partially pay the Co-Insurance. When you must make a choice to apply payments that do not cover the entire balance due then pay the Co-Pay Amount first and only then apply any surplus if there is one to the Co-Ins then Other Patient Due balances.

Any surplus unassigned payments can be kept to be applied later to this or another voucher.

When applying payments, be sure to distribute using the following order:

1. Co-Pay payments
2. Co-Insurance payments
3. Other Patient payments

Note: When applying an assigned payment and it has an encounter number, be sure that you are applying the payment to the correct voucher.

If your practice/organization requires an associated department/practice be selected for a quick payment then you can only select an unassigned payment that has an associated department/practice that is the same as the one selected for the voucher.

Applying unassigned payments to zero-dollar charges

The application automatically distributes quick payments associated with an appointment as a credit amount when all service lines on a voucher have zero-dollar amounts.

The automatic distribution applies to charges that were imported from **Financial Processing > Automatic Transactions > Import Charges** either one encounter at a time or by using the batch mode, and when importing charges from **Financial Processing > Transactions > Charge Entry** as a patient checks out.

If the payer has a copay plan, and the voucher has at least one procedure code with **Co-Pay Applies** selected in **Procedure Code Maintenance**, the quick payment is applied to the first of the copay service lines; otherwise, the quick payment is applied to the last service line.

When a quick payment is not associated with an appointment, you can manually enter a voucher with all zero-dollar service lines and apply the quick payment as a credit. The service lines are displayed in the **Other Patient Payment** area in **Apply Self-Pay Payments** where you can apply the payment as applicable to one or more of the services lines.

You can also apply a payment that exceeds the copay amount without receiving a validation message about exceeding the amount due.

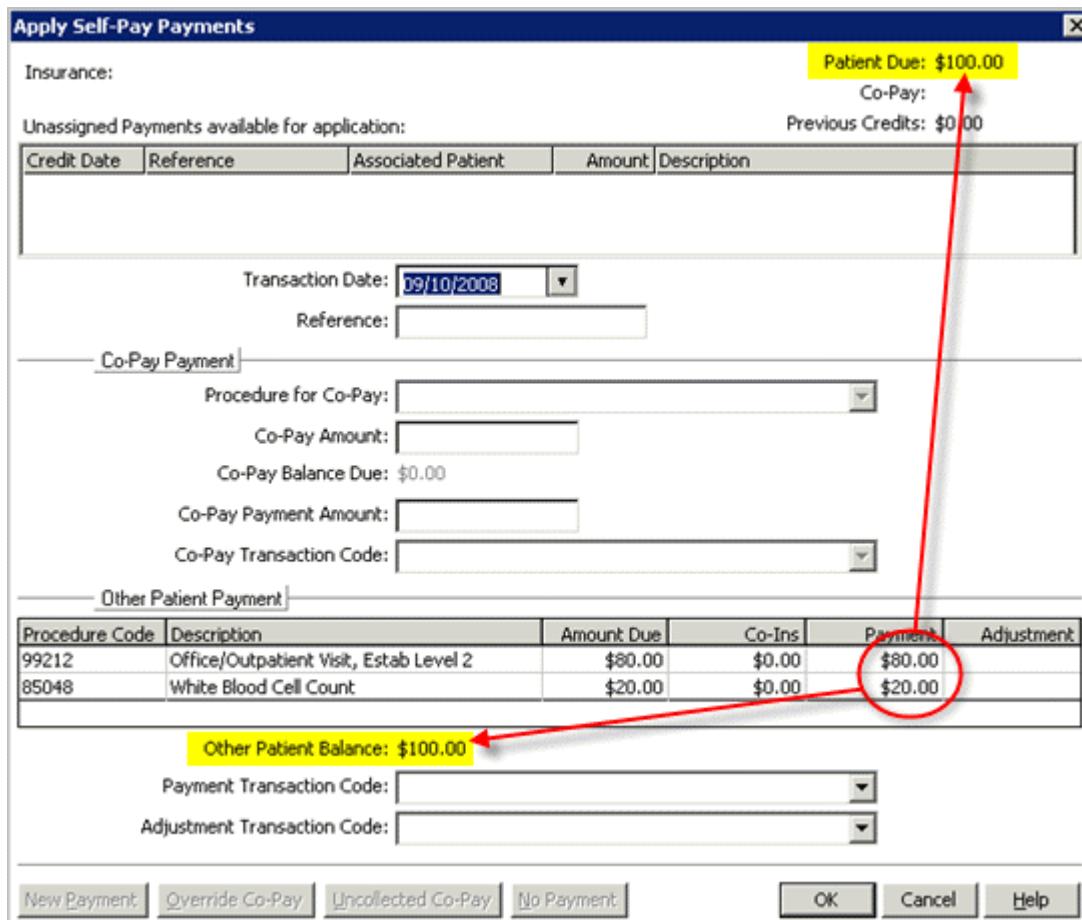
When you manually enter a voucher with all zero-dollar service lines, the **New Payment**, **Override Co-Pay**, and **Uncollected Co-Pay** functions in **Apply Self-Pay Payments** are available.

Self-pay only voucher

When there are no unassigned payments available and the voucher is self-pay only, the Self-Pay dialog opens with the focus resting on the **New Payment** button.

1. Click **New Payment (Alt+p)** to enter a new payment.

Apply Self-Pay Payments window



The screenshot shows the 'Apply Self-Pay Payments' window. At the top right, it displays 'Patient Due: \$100.00' and 'Co-Pay: \$0.00'. Below this is a table for 'Unassigned Payments available for application' with columns: Credit Date, Reference, Associated Patient, Amount, and Description. A red arrow points from the 'Patient Due' field down to the 'Other Patient Payment' section. In the 'Co-Pay Payment' section, there are fields for Procedure for Co-Pay, Co-Pay Amount, Co-Pay Balance Due (\$0.00), Co-Pay Payment Amount, and Co-Pay Transaction Code. A red circle highlights the 'Payment' column in the 'Other Patient Payment' grid, which lists two items: '99212 Office/Outpatient Visit, Estab Level 2' with a payment of '\$80.00' and '85048 White Blood Cell Count' with a payment of '\$20.00'. Below the grid, the 'Other Patient Balance' is shown as '\$100.00'. At the bottom, there are buttons for New Payment, Override Co-Pay, Uncollected Co-Pay, No Payment, OK, Cancel, and Help.

Procedure Code	Description	Amount Due	Co-Ins	Payment	Adjustment
99212	Office/Outpatient Visit, Estab Level 2	\$80.00	\$0.00	\$80.00	
85048	White Blood Cell Count	\$20.00	\$0.00	\$20.00	

The focus now rests in the **Transaction Date** field and the **Payment** fields in the lower grid auto-fill.

2. Use the **Tab** key to move through the active fields on the screen.
3. To change the Transaction Date, enter a new date using the format mm/dd/ccyy.
4. Enter text in the **Reference** field which can be used to identify the reason for this transaction.

Note: The **Reference** field allows you to enter a maximum of 50 characters.

5. Always verify the default entries.
6. The payment fields in the Other Patient Payment grid auto-fill. These fields are editable. Make any necessary changes.
7. If necessary, select a payment transaction code from the combo box.

If you are using integrated credit card processing, when you save a voucher with a credit card processing transaction code entered in **Apply Self-Pay Payments**, Allscripts® Practice Management displays a message that prompts you to insert or swipe a card.

8. When a self pay payment transaction code is selected as a default on the Payment Entry tab in Practice/Organization Options and you **Tab** from the payment field the default self-pay payment transaction code populates the field.

Note: To restrict the listing in the Co-Pay Transaction Code and the Payment Transaction Code fields, you must check the corresponding option on the Charge Entry tab in Practice/Organization Options. If you choose this option be sure all your transaction codes used to apply self-pay payments are flagged as self-pay in Transaction Code maintenance.

9. If necessary, enter an adjustment amount in the field on the grid then select an adjustment transaction code.

An adjustment transaction code is necessary only when you apply an adjustment. When a default self-pay adjustment code is selected on the Payment Entry tab in Practice/Organization Options, when you manually enter an adjustment in the adjustment field in the grid and **Tab**, the default transaction code auto-fills the field **Adjustment Transaction Code**.

Note: To restrict the listing in the **Adjustment Transaction Code** field, you must check the corresponding option on the Charge Entry tab in Practice Options. If you choose this option be sure all your transaction codes used to apply self-pay adjustments are flagged as self-pay in Transaction Code Maintenance.

10. **Enter** or click **OK**. You receive a prompt to print a transaction acknowledgement.

Prompt Payment Discount

Some Practices apply a discount based on the % of the voucher's total charge for Patients that pay the voucher's Patient Due balance in full at the time of the visit. A discount % amount can be auto applied to the voucher's total balance by using specially flagged Adjustment Type Transaction Codes. These specially flagged Adjustment Type Transactions codes are available only from this Self-Pay dialog.

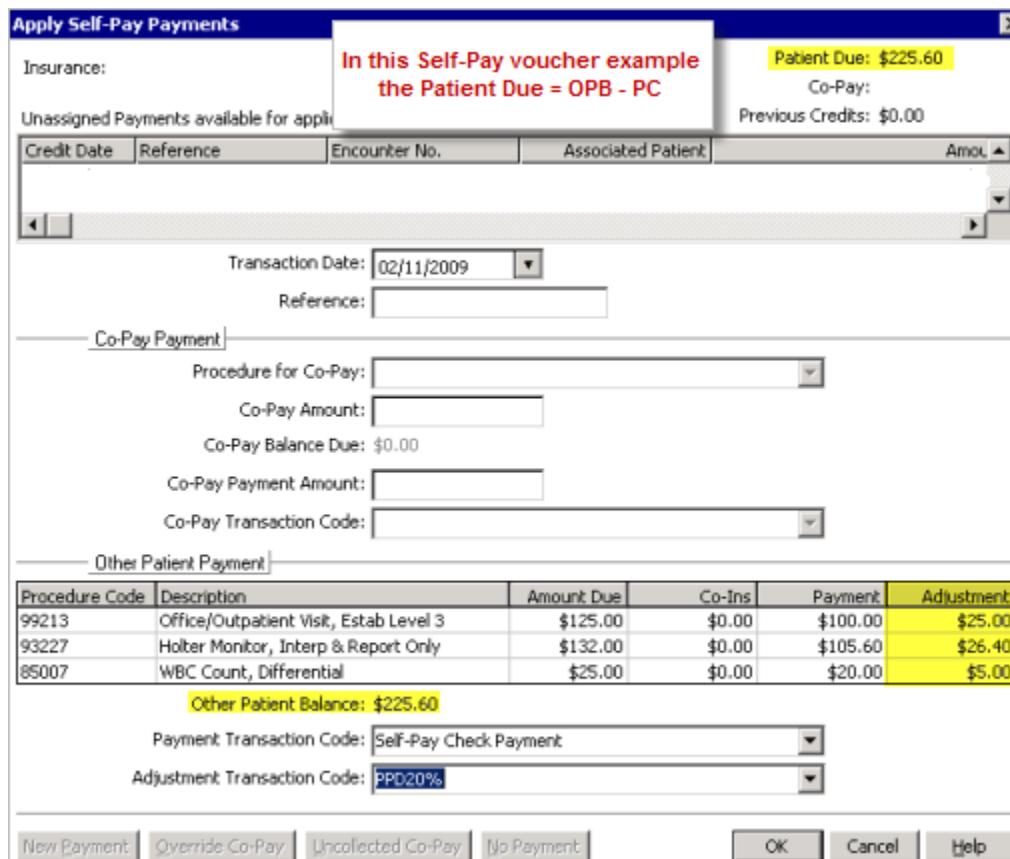
When the discounted amount is applied the Other Patient Balance and the Patient Due amount instantly reflect the change displaying what is now due by the Patient.

How it works on Self-Pay vouchers

When an Adjustment Type Self-Pay Transaction Code with a discount % amount is selected as the Adjustment Transaction Code in the Other Patient Payment grid, then the system automatically calculates the discount on each procedure fee. The resulting amount is added to the amount

Apply Self-Pay Payments window

displayed in the Payment column and the discount dollar amount is displayed in the Adjustment column.



Procedure Code	Description	Amount Due	Co-Ins	Payment	Adjustment
99213	Office/Outpatient Visit, Estab Level 3	\$125.00	\$0.00	\$100.00	\$25.00
93227	Holter Monitor, Interp & Report Only	\$132.00	\$0.00	\$105.60	\$26.40
85007	WBC Count, Differential	\$25.00	\$0.00	\$20.00	\$5.00

Other Patient Balance: \$225.60

Payment Transaction Code: Self-Pay Check Payment
 Adjustment Transaction Code: PPD20%

How it works on insurance vouchers

Best Practice Recommendation: Self-Pay Adjustment Transaction codes with a % amount specified in Transaction Code maintenance when printing a Courtesy Claim and your practice policy is to apply a discount when the Patient pays in full at the time of the visit.

Note: When using an Adjustment Transaction code with a discount %, the discount is calculated on the procedure fee (Amount Due column) not on the existing amount entered in the Payment column. Keep this in mind when the Payor is set to Insurance or Courtesy Claim.

The system automatically calculates the discount on each procedure fee. The resulting amount is added to the amount in the Payment column and the discount dollar amount is displayed in the Adjustment column.

The Other Patient Balance (OPB) and the Patient Due (PD) amount instantly reflect the change displaying what is now due by the Patient.

Apply Self-Pay Payments

Insurance: Blue Care Elect (15)/(no plan) (Medical)		Patient Due: \$240.60 Co-Pay: \$15.00 Previous Credits: \$0.00																								
Unassigned Payments available for application:																										
Credit Date	Reference	Encounter No.																								
<input type="button" value="New"/> <input type="button" value="Delete"/> <input type="button" value="Edit"/> <input type="button" value="Print"/>																										
Transaction Date: 02/11/2009																										
Reference: <input type="text"/>																										
In this example Patient Due = OPB + Co-Pay - PC																										
Co-Pay Payment Procedure for Co-Pay: 99213 Office/Outpatient Visit, Estab Level 3 Co-Pay Amount: \$15.00 Co-Pay Balance Due: \$15.00 Co-Pay Payment Amount: <input type="text"/> \$15.00 Co-Pay Transaction Code: Self-Pay Cash Payment																										
Other Patient Payment <table border="1"> <thead> <tr> <th>Procedure Code</th> <th>Description</th> <th>Amount Due</th> <th>Co-Ins</th> <th>Payment</th> <th>Adjustment</th> </tr> </thead> <tbody> <tr> <td>99213</td> <td>Office/Outpatient Visit, Estab Level 3</td> <td>\$125.00</td> <td>\$0.00</td> <td>\$100.00</td> <td>\$25.00</td> </tr> <tr> <td>93227</td> <td>Holter Monitor, Interp & Report Only</td> <td>\$132.00</td> <td>\$0.00</td> <td>\$105.60</td> <td>\$26.40</td> </tr> <tr> <td>85007</td> <td>WBC Count, Differential</td> <td>\$25.00</td> <td>\$0.00</td> <td>\$20.00</td> <td>\$5.00</td> </tr> </tbody> </table> Other Patient Balance: \$225.60 Payment Transaction Code: Self-Pay Cash Payment Adjustment Transaction Code: PPD20%			Procedure Code	Description	Amount Due	Co-Ins	Payment	Adjustment	99213	Office/Outpatient Visit, Estab Level 3	\$125.00	\$0.00	\$100.00	\$25.00	93227	Holter Monitor, Interp & Report Only	\$132.00	\$0.00	\$105.60	\$26.40	85007	WBC Count, Differential	\$25.00	\$0.00	\$20.00	\$5.00
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<input type="button" value="New Payment"/> <input type="button" value="Override Co-Pay"/> <input type="button" value="Uncollected Co-Pay"/> <input type="button" value="No Payment"/> <input type="button" value="OK"/> <input type="button" value="Cancel"/> <input type="button" value="Help"/>																										

What outputs to the claim - The original fees, not the adjustment amounts, output to the claim.

Understand what is due when a PPD is applied

Co-Ins = Amount calculated after the % entered on the Plans tab in Insurance Carrier maintenance is applied to the Allowed Amount on the Carrier's Contractual Allowance Tab.

Payment = Sum of the adjustment applied when a specially flagged adjustment code is selected.

Other Patient Balance = Sum Co-Ins + Sum Payment

Patient Due = Co-Pay + Other Patient Balance - PC

Apply a Prompt Payment Discount

You can apply a prompt payment discount when entering payments.

1. Click **New Payment**.
2. Tab to bring the focus into the **Reference** field, then type in a text which describes the transaction. For example, type "PPD" or "Prompt payment discount."

Note: The **Reference** field allows you to enter a maximum of 50 characters.

3. Tab through the fields. If necessary, click on the down arrow to select a Co-Pay Transaction Code.
4. At the field **Payment Transaction Code** click the down arrow button and select a Payment Transaction code.

Note: To restrict the listing in the Co-Pay Transaction Code and the Payment Transaction Code fields, you must check the corresponding option on the **Charge Entry** tab in **System Administration > Practice Options** or **Organization Options**.

If you are using integrated credit card processing, when you save a voucher with a credit card processing transaction code entered in **Apply Self-Pay Payments**, Allscripts® Practice Management displays a message that prompts you to insert or swipe a card.

5. At the field **Adjustment Transaction Code** click the down arrow button and select an Adjustment Type code specially flagged with a discount % entered in Transaction Code maintenance. (The suggested naming for this code is for example, "PPDxx%.")

Note: To restrict the listing in the Adjustment Transaction Code field, you must check the corresponding option on the **Charge Entry** tab in **System Administration > Practice Options** or **Organization Options**.

6. The discount is immediately applied, review the Patient Due amount to determine what the Patient now owes for the visit.
7. When you have collected the Patient Due amount, click **OK**.
You receive a prompt to print a transaction acknowledgment.

Apply a PPD to a voucher containing Self-Pay procedures and standard procedures

To receive the prompt to split the Self-Pay procedures to a separate voucher do the following after you have selected the adjustment transaction:

1. Delete the discount for those procedures not flagged as Self-Pay procedures
2. Click **OK** then when you save the voucher the prompt will display to split the voucher.

Apply a co-pay payment only

When there are no unassigned payments available and the voucher contains a procedure where the Co-Pay Applies and there are no Co-Insurance or Other Patient balances due then the Self-Pay dialog opens with the focus resting on the **New Payment** button.

1. **Enter.**
2. The focus now rests in the **Transaction Date** field. Use the **Tab** key to move through the active fields on the screen.
3. To change the Transaction Date, enter a date using the format mm/dd/ccyy.
4. Enter text in the **Reference** field which can be used to identify the reason for this transaction.

Note: The **Reference** field allows you to enter a maximum of 50 characters.

5. Always verify the default entries.

The procedure code combo box only contains selections when the voucher contains more than one procedure code with a co-pay.

6. Changing the Co-Pay Amount automatically changes the entries in the fields **Co-Pay Balance Due** and **Co-Pay Payment Amount**. The change affects this voucher only. To make a universal change, the plan must be changed on the Patient's Policies tab in Registration.
7. Select a co-pay transaction code from the combo box.
If you are using integrated credit card processing, when you save a voucher with a credit card processing transaction code entered in **Apply Self-Pay Payments**, Allscripts® Practice Management displays a message that prompts you to insert or swipe a card.
8. **Enter** or click **OK**. You receive a prompt to print a transaction acknowledgement.

Apply a Co-pay payment and co-insurance % payment

When there are no unassigned payments available and the voucher contains a procedure where the Co-Pay Applies and a co-insurance amount is due, the Self-Pay dialog opens with the focus resting on the **New Payment** button.

Always apply the Co-Pay Amount due, and then apply the Co-Insurance Amount due.

1. Use **Alt+p** to enter a New Payment.
2. The focus now rests in the **Transaction Date** field. Use the **Tab** key to move through each field on the screen.
3. To change the Transaction Date, enter a new date using the format mm/dd/ccyy.

4. Enter text in the **Reference** field which can be used to identify the reason for this transaction.

Note: The **Reference** field allows you to enter a maximum of 50 characters.

5. Always verify the default entries.
6. When applying a partial payment that is more than the Co-Pay Amount due but less than the total due for co-pay and co-insurance then always pay the co-pay in full and apply any surplus to the Co-Insurance due. Never apply partial payment to the Co-Pay Amount due and partial payment to the Co-Insurance due. As a result, the Transaction Acknowledgement will accurately record the Co-Pay/Co-Insurance amount due.

The procedure code combo box only contains selections when the voucher contains more than one procedure code with a co-pay. Changing the Co-Pay Amount automatically changes the entries in the fields **Co-Pay Balance Due** and **Co-Pay Payment Amount**. The change affects this voucher only. To make a universal change, the plan must be changed on the Patient's Policies tab in Registration.

7. Select a co-pay transaction code for the co-pay payment.

If both the Co-Pay Payment and the Other Patient Payment are made with credit cards, regardless of the transaction codes (assuming both transaction codes have **Credit Card Processing** selected in **Transaction Code Maintenance**), the transactions roll up together as one and are sent to the currently supported credit card processing vendor.

If the Co-Pay Payment and the Other Patient Payment are made with two different forms of payment, such as cash and credit card, only the amount of the transaction code flagged for credit card processing is sent to the credit card processing vendor.

8. Select a payment transaction code for the co-insurance payment.

If you are using integrated credit card processing, when you save a voucher with a credit card processing transaction code entered in **Apply Self-Pay Payments**, Allscripts® Practice Management displays a message that prompts you to insert or swipe a card.

9. Enter or click **OK**. You receive a prompt to print a Transaction Acknowledgement.

Applying partial co-pay payments

When you apply a partial co-pay payment and click **OK**, a confirmation message is displayed.

Co-Pay is only partially paid, is this correct? is displayed in **Apply Self-Pay Payments**.

This message is only displayed when the co-pay is partially paid. It is not displayed when co-insurance amounts are partially paid.

When applying a partial payment that is more than the Co-Pay Amount due but less than the total due for Co-Pay and Co-Insurance then always pay the Co-Pay in full and apply any surplus to the Co-Insurance due. Never apply partial payment to the Co-Pay amount due and partial payment to the Co-Insurance due.

For example, on a voucher with a Co-Pay due of \$20 and a Co-Ins of \$35.05 when the Patient is making a payment of \$25.05. Apply the payments this way:

Leave the Co-Pay Payment at \$20.00

Change the payment amount in the Other Patient Payment grid from 35.05 to 5.05.

As a result, the Transaction Acknowledgement will accurately record the Co-Pay and Co-Insurance Amounts due.

Override a co-pay

Adjust or write-off the co-payment or co-insurance due on a voucher.

The function of the **Override Co-Pay** button applies to co-insurance amounts as well as to co-pay amounts.

This button allows you to adjust or write-off the Co-Payment/Co-Insurance due on this voucher only. To make a universal change, the plan must be changed on the Patient's Policies tab in Registration.

Note: The **Override Co-Pay** button is always disabled when **Disallow Override Co-Pay Button** is checked on the **Charge Entry** tab in **System Administration > Practice Options or Organization Options**.

1. Click the **Override Co-Pay** button (**Alt+o**).
2. The focus is now in the **Reference** field. Use the **Tab** key to move through the active fields on the screen.

Note: The fields labels for "Co-Pay Amount" and "Co-Pay Transaction Code" change to "Adjustment Amount" and "Adjustment Transaction Code" when **Override Co-Pay** is clicked.

3. Enter text in the **Reference** field which can be used to identify the reason for this transaction.

Note: The **Reference** field allows you to enter a maximum of 50 characters.

4. Always review the default entries.
5. Changing the Co-Pay Amount automatically changes the entries in the fields **Co-Pay Balance Due** and **Adjustment Amount**.

6. Select an adjustment transaction code from the combo box.
7. Enter or click **OK** to return to the Summary screen.

Mark a co-pay as uncollected

Optional short description

This button allows you to bill the Patient for the co-pay/co-insurance while the balance on the Voucher is still out to the Carrier.

When you are using this button it triggers one or both of the following actions:

- > The words "Co-Ins Due" along with the amount display in the Aging grid in Financial Inquiry and the Account Ledger.
- > The Voucher qualifies to be included on a statement when the option **Print Uncollected Co-Pay/Co-Ins** is checked in Practice/Organization Options even though the Voucher's balance is still out to the Carrier.

To designate the co-pay as uncollected:

1. Click the **Uncollected Co-Pay** button (**Alt+u**).
2. The focus highlights the **Procedure for Co-Pay** field. Use the **Tab** key to move through the active fields on the screen.
3. Always verify the procedure code and the co-pay amount.
4. Any change made to the Co-Pay Amount is automatically recorded in the field **Co-Pay Balance Due**. The change you make applies only to this voucher. The fields **Co-Pay Payment Amount** and **Co-Pay Transaction Code** are inactive and blank.
5. Enter or click **OK**. You receive a prompt to print a Transaction Acknowledgement.

Mark a co-pay as unpaid

Use **No Payment** in **Apply Self-Pay Payments** to indicate that a co-pay was not paid.

When you use **No Payment** to process a Co-Pay, the following is true:

- > The Co-Pay Applies flag for the procedure is rendered null for this Voucher only.
- > Later when you apply a payment to this voucher in Payment Entry, the field **Co-Pay** displays "\$0.00."
- > No adjustment is made to the amount due. In other words, the co-pay amount is not subtracted from the fee/charge amount. The entire charge is left as Insurance responsibility.
- > The words "Co-Ins Due" along with the amount do not display in Financial Inquiry or the Account Ledger.

- > The Account does not qualify for a Statement until the voucher's balance has been transferred to Self-Pay even when the Practice Option **Print Un-Collected Co-Pay/Co-Ins** is checked.

To flag a co-pay as not paid do the following

1. When the Self-Pay dialog opens, click **No Payment (Alt+n)**. All the fields on the Self-Pay dialog become disabled. The focus rests on the **Cancel** button.
2. **Enter** or click **Cancel** to cancel the No Payment process. Depending on the type of voucher you can now apply available unassigned amounts, or new payments, override a Co-Pay or process a Co-payment as Uncollected.
3. Press  to move the focus to the **OK** button, and then **Enter** or click **OK**. This executes the No Payment process, closes the Self-Pay dialog, and returns you to the Summary screen.

Medflow Interface

Medflow is a proprietary third party EMR for Eyecare specialists. Allscripts® uses a translation file HL7DFT Medflow.xsl, to import and process charges as well as discount amounts entered through the Medflow application.

Note: To process discounts entered in Medflow, the Transaction Code used in Medflow must also exist as an Adjustment Type Transaction Code in your Allscripts® Practice Management tenant.

The discount amounts are reported on this dialog as they are received from Medflow. For example, if there are multiple services on the voucher and the discount amount for the entire service was applied to the first service line, then the Operator must make manual adjustments so that the service line does not balance out to a credit when the adjustment is applied by the system.

The discount amounts are not calculated into the Patient Due nor the Other Patient Balance amounts at this point. The adjustment is applied when the voucher is saved.

When the voucher is saved if it is called up again in Charge Entry or Edits the adjustment column and adjustment field labels are once again displayed as the standard **Adjustment** and **Adjustment Transaction Code** respectively.

Adjustments and the resulting voucher balance can be viewed in Financial Inquiry.

Import by batch

When importing by batch the discount amount is automatically adjusted off each service using the Adjustment Type Transaction Code that matches the Transaction Code reported in the file.

Import each Charge individually

When a voucher with one or more discounts is imported via the right click menu in Automatic Transactions or through the Charge Import option in Charge Entry the following occurs upon opening the dialog:

- > the labels for the Adjustment column and the Adjustment Transaction Code field are changed to read **Discount** and **Discount Transaction Code** respectively
- > when either **New Payment** or **Override Co-Pay** is clicked, fields in the column marked **Discount** are auto filled with the amounts received from Medflow
- > the field **Discount Transaction** defaults to the Transaction Code that matches the one received from Medflow
- > the Payment column is blank

Print a transaction acknowledgement

Print a receipt for collected payments.

By program design the transaction acknowledgement is meant to be the following:

- > A receipt for complete or partial payments on self-pay only vouchers.
- > Either a receipt for collected co-pay or co-insurance amounts or an invoice for uncollected co-pay or co-insurance amounts - not both.

The prompt **Do you want to Print a Transaction Acknowledgement?** is displayed when you do any of the following:

- > Apply a new payment or process a co-pay as uncollected on **Apply Self-Pay Payments**
- > Enter a quick payment
- > Apply a sliding-fee payment during charge entry

When the prompt mentioned above is displayed, follow these steps to print an acknowledgement:

1. Click **Yes** to open the standard **Print** window.
2. Make the applicable selections.
3. Click **Print**.

When the job is completed, the message, **Did Transaction Acknowledgement print Ok?** is displayed.

4. Click the applicable button on the message window.
5. Continue with processing payments.

Transaction acknowledgement samples

Invoice for partially paid co-pay/co-insurance

The transaction acknowledgement is intended to be used as either a receipt or an invoice for uncollected Co-Pay/Co-Insurance amounts due on a voucher.

Chapter 5 Charges

For example, on a voucher with a Co-Pay due of \$15 when the Patient is making a payment of \$10.

Physicians Associated				
 Tel: [REDACTED] Tax ID #: [REDACTED]				
Invoice for Uncollected Co-Pay/Co-Ins Date: 02/24/2010				
Account No. [REDACTED]				
Guarantor Information: [REDACTED] [REDACTED] [REDACTED]				
Patient Information: Patient No. [REDACTED] [REDACTED] [REDACTED]				
Provider:		Insurance:		
Internal M Allscripts		[REDACTED] Usual Co-Pay: 15.00		
Date Paid	Reference	Operator	Description	Amount
02/24/2010	cash	susanj	Partial Co-Pay	\$10.00
Co-Pay/Co-Ins Amount Due				\$5.00
Please remit promptly.				Total Due From Patient \$5.00

Receipt for self-pay only vouchers

On Self-Pay only vouchers you only have the option to print a transaction acknowledgement when you use the **New Payment** button.

Even when only partial payment is applied on a Self-Pay only voucher the Transaction acknowledgement prints as a receipt for the amount received only. It does not print the balance remaining on the voucher.

Apply Self-Pay Payments window

Physicians Associated				
[REDACTED]				
[REDACTED]				
Tel: [REDACTED] Tax ID #: [REDACTED]				
Received on Account		Date: 02/24/2010		
Account No. [REDACTED]				
Guarantor Information: [REDACTED] [REDACTED] [REDACTED]				
Patient Information: Patient No. [REDACTED] [REDACTED] [REDACTED] [REDACTED]				
Provider: Internal M Allscripts				
Date Paid	Reference	Operator	Description	Amount
02/24/2010	Cash	[REDACTED]	Self Pay	\$75.00

Thank you for your Payment.

Transaction acknowledgements printed from the Quick Payment dialog print patient information only if a Patient is selected in the **Associated Patient** field on the Quick Payment dialog. If the **Associated Patient** field is left blank, no patient information prints on the transaction acknowledgement.

Receipt for full payment due

Physicians Associated [REDACTED] Tel: [REDACTED] Tax ID #: [REDACTED]				
Received on Account		Date: 02/24/2010		
Account No. [REDACTED]				
Guarantor Information: [REDACTED] [REDACTED] [REDACTED] [REDACTED]				
Patient Information: Patient No. [REDACTED] [REDACTED] [REDACTED] [REDACTED]				
Provider: Internal M Allscripts		Insurance: [REDACTED] Usual Co-Pay: 10.00		
Date Paid	Reference	Operator	Description	Amount
02/24/2010	Ok #00000	susanj	Self Pay	\$10.00
Thank you for your Payment.				

Apply Self-Pay Payments window

Quick payment with 2 transactions

AMBULATORY SURGI CENTER

Tel: [REDACTED]
Tax ID #: [REDACTED]

Received on Account

Date: 04/04/2018

Account No. [REDACTED]

Guarantor Information:

[REDACTED]
[REDACTED]
[REDACTED]

Patient Information:

Patient No. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Provider:

[REDACTED]

Date Paid	Reference	Operator	Description	Amount
04/04/2018	Cash	Barb	co-pay	\$10.00
04/04/2018	Check #1234	Barb	co-pay	\$25.00

Credit card transaction acknowledgement

For credit card transactions, the transaction ID and authorization ID returned from the credit card processing vendor are included on transaction acknowledgements. The transaction ID prints in the **Reference** column, and a separate row prints with the transaction ID and authorization ID. Copay payments and other-patient payments print as individual transactions.

QA MEDICAL PRACTICE				
Tel: - Tax ID #: 				
Received on Account Date: 02/16/2022 Account No. 1990 Guarantor Information: \$10 COPAY 				
Patient Information: Patient No. 1990 \$10 COPAY 				
Provider: 		Insurance: BCBS OF MI Usual Co-Pay: 10.00 		
Date Paid	Reference	Operator	Description	Amount
02/16/2022	037-0104450116	Jim	Self Pay	\$10.00
	CC Transaction ID: 037-0104450116		Authorization #: 123456	
02/16/2022	037-0104450116	Jim	Self Pay	\$15.00
	CC Transaction ID: 037-0104450116		Authorization #: 123456	

Transaction acknowledgements printed from payment history

The transaction acknowledgement formats used when printing acknowledgements from **Financial Inquiry > Payment History** are consistent with the formats used to print acknowledgements while making a quick payment or entering charges.

Transaction acknowledgements for patients that are members of a family billing account have only the patient name in the Patient Information area.

Edit a voucher on the Charge Entry tab

Voucher detail may be edited from the Charge Entry tab using the following methods:

On a current voucher

Voucher detail may be edited from the Charge Entry tab on a current voucher until you call for the next patient or encounter, or begin a new voucher for the same patient.

By recalling a voucher

Voucher detail may be edited from the Charge Entry tab by retrieving a voucher originally created within the batch, as long as that batch has an open status.

1. Add a service line on the current voucher:
 - a. From the Summary screen, **Shift+Tab** until the focus rests in the Service line grid.
 - b. **Insert**.
 - c. Enter information in the relevant fields.
 - d. Use **Alt+s** to save the changes.
2. Edit an existing service line on the current voucher:
 - a. **Tab** or **Shift+Tab** to highlight the service line.
 - b. **Spacebar**. This will bring you back to the beginning of the form. The highlight is on the first service line.
 - c. Use the **arrow keys** to highlight the service line to be edited.
 - d. **Tab** to the field which you want to edit and make the necessary changes.
 - e. Use **Alt+s** to save the changes.
 - f. To edit any field, use either of the following methods:
 - > The keyboard: **Tab** to move forward and **Shift+Tab** to move back.
 - > Your mouse arrow: point and click on a field.
 - g. Use **Alt+s** to save any changes
3. Retrieve vouchers created within a batch:
 - a. Change the field label to Voucher. **Ctrl+down arrow** until the label reads Voucher.
 - b. Enter the voucher number.
 - c. Press **Tab**.

At this point all of the Voucher detail is available for editing. New Service lines may also be added.

All fields are editable from Charge Entry when you recall a voucher entered in a Open Batch unless a payment/adjustment transaction is entered on the Voucher.

Note: The Coverage Type field is automatically populated with the coverage type associated with the current Policy for the Voucher.

Note: If a future date is entered, a hard warning message appears and you are not allowed to save the voucher.



When payment transactions which have not been updated exist on a voucher, you cannot do the following:

- > Edit the Payor/Policy
- > Delete a service line when an insurance payment has been applied to that procedure

You can do the following:

- > Delete service lines for which payments do not exist.
- > Delete service lines with self-pay payments, including on vouchers that are associated with the uninsured coverage type, provided there are no insurance payments or self-pay adjustments applied to the service line.

Edits tab

This topic describes the editable fields and the functions available on the Edits tab found under **Financial Processing > Transactions**

Use the Edits tab to edit certain fields on a voucher with a status of "Updated" or "Entered."

Important: Only vouchers with a status of "Entered" can be edited in Charge Entry when the voucher's batch is opened and highlighted on the Batch Management screen.

The Edits tab is always available in Batch Management.

Open the Edits tab using one of the following two methods:

- > Use the Access Code: **F9 > type TRA > Enter > click Edits tab**
- > Use the Navigation Pane: **Double-click Financial Processing > click Transactions > click Edits tab**

Enter a voucher number in the field labeled **Voucher** then **Tab**.

Note: Search does not function.

The following fields can be edited.

Editable boxes

Visit Type

If **Derive Place of Service** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options** and **Status** for a voucher is **Entered**, **Visit Type** is available. You can change **Visit Type** by making a selection.

If you select a visit type and location for which the derived place of service does not exist in **Place of Service Maintenance**, **Place of Service** is blank. You cannot save the voucher until you select a valid combination of **Visit Type** and **Location**.

Location

You can change **Location** by making a selection.

Note: If you have **Allow** security permission for **Location** within **Practice Management > Financial Processing > Transactions > Edits** in **Security Permissions**, and any location is selected in the **Sub-Account** column on the **GL Category Members** tab in **GL Category Maintenance**, you cannot change the value in **Location** for a voucher with an **Updated** status.

Place of Service

If **Derive Place of Service** is selected on the **Visit Type** tab in **Practice Options** or **Organization Options**, **Place of Service** is display-only; otherwise, you can change **Place of Service** by making a selection.

Note: If you have **Allow** security permission for **Place of Service** within **Practice Management > Financial Processing > Transactions > Edits**, and any place of service is selected in the **Sub-Account** column on the **GL Category Members** tab in **GL Category Maintenance**, you cannot change the value in **Place of Service** for a voucher with an **Updated** status.

Accept Assign?

Click to change the original setting.

When selected an X prints in box 27 on a standard CMS-1500 (08/05) form when the claims is printed.

Yes is included in the Standard ANSI 837 claim file in Loop 2300 Segment CLM

Student Billing?

Click to change the original setting.

Intended for use with the Banner Transactions Export interface.

Flags a voucher for export to the Banner system when a live export is run.

If you should manually check this option and you are not using the live Banner Transactions Export, the voucher qualifies for insurance or self-pay billing based on the other billing related selections you have made.

Resp Party

You can change the selection.

Selections are those Contacts where **Stmts** is selected on the patient's record in Registration.

Referring Dr

You can change the selection of the referring doctor by clicking on the binoculars and opening the **Referring Doctor Lookup**.

Date From - Thru

You can change the service date using the format mmccyyyy.

Drug

Available when you highlight a procedure code with a Procedure Type of **Drug Code**.

When the **Unit of Measure** and **Unit Count** boxes are filled in **Procedure Code Maintenance**, there is no need to manually access the **Drug** window for the values to be included in claims.

Note: This also applies to imported charges.

Use this dialog when billing the claim electronically using any one of the Standard ANSI formats.

Purchased Services

Available when you highlight a procedure code that has **Purchased Service** selected on the **Procedure Code** tab in **Procedure Code Maintenance**.

Enables you to add or change **Reference Laboratory** in **Purchased Services**, which updates **Laboratory NPI #**, **Laboratory CLIA #**, and **Purchased Service Price**.

Procedure

When **Editable Description** on the **Procedure Code** tab in **Procedure Code Maintenance** is selected and the text box below contains a procedure code description, that description is displayed in **Procedure** on the **Charge Entry** and **Edits** tabs, and it outputs on claims without the need to access **Specify Procedure Code**.

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.

This box is editable when **Editable Description** in **Procedure Code Maintenance** is selected.

You can edit the procedure description but not the procedure code.

You cannot enter additional procedure codes.

Modifiers

Enabled only when the Charge Entry Practice Option, **Allow Entry of Modifiers** is checked.

To change or enter a modifier, use one of the following methods:

- > Enter the Modifier Value (the code which prints on the Claim form) as entered in Modifier Maintenance, and then **Tab** or click .
- > Click or with the cursor in the field use **Alt+down arrow** to search.
- > To specify one or more Modifiers, use one of the following two methods:
Type in a series of Modifiers separated by commas.

Use **Shift+down arrow** or click  to open the Specify Modifier(s) dialog.

Enter up to four modifiers using the fields on the dialog.

Diagnosis

To change or add diagnosis codes, use one of the following methods:

- > Enter the diagnosis code
 1. Type in a Code, for example 719.49.
 2. **Tab** or click .

To enter multiple codes use commas between the entries like you would do in the **Modifiers** field.

- > Search for an existing Code:
Click  or with the cursor positioned in the field use **Alt+down arrow** to open the Diagnosis Code Lookup dialog.
- > Select a Diagnosis Code previously used for this Patient:
Click , or with the cursor positioned in the field, use **Shift+down arrow** to open the dialog.

Local Use Text

Free text field that allows for a maximum of 50 characters to be entered.

Text entered here outputs in Box 19 on a standard CMS-1500 NPI paper claim form or Loop 2300/Segment NTE of a Standard ANSI X12N 837I v4010A1 or Standard ANSIX12N 837P v4010A1 electronic claim file.

Note: If the voucher brought up in the Edits tab is the Institutional voucher using an alternate claim style in a split bill scenario, the text that shows in this field if any was entered originally in Charge Entry is from the **Alternate Local Use Text** field on the Summary tab. Text entered in this case outputs in Form Locator (FL) 80 on a standard UB-04 paper claim form or Loop 2300/Segment NTE of a Standard ANSI X12N 837I v4010A1 electronic claim file.

Hold Voucher From

Defaults to the most recently saved selection. See Use the Summary Screen and Get Around the Apply Transaction Dialog to Enter Insurance Payments.

Selecting a hold option prevents the voucher from qualifying for billing.

Leave blank unless you want to hold it from billing.

Use the drop to make a selection.

- > All Insurance Billing
- > Electronic Claim Billing
- > Self-Pay Statements
- > All Billing (Insurance & Self-Pay)

When the option Hold Vouchers with Errors is checked during the validation of claims, the appropriate hold flag is set. Removing the hold status must be done on a voucher by voucher basis here on the Edits screen or from Pending Claims Management.

Note: A voucher held for the 72 Hour Rule automatically is released from hold based on the settings in Practice/Organization Options on the General tab.

Held Voucher Reason

Enabled when the field **Hold from Billing** is populated.

Defaults to the most recently saved selection.

Change the setting by making a selection.

Stmt Message

The selected message prints on statements.

Statement messages can be viewed in Financial Inquiry and included on the Account Summary Report and the Collection Account Report.

After it is attached to a voucher the message always prints when that voucher is billed out unless the message is removed from the voucher on the Edits tab.

Claim Msg

The availability of **Claim Msg**: is conditional.

- > **Claim Msg:** is active in the following circumstances.
 - On a voucher that has un-posted charges and no payment or adjustment transactions. You can select a Claim Message or change the selection previously made in **Charge Entry**.
 - On a voucher with un-posted payments or adjustments when a message was not previously selected.
In this instance **Claim Msg:** is active and you can make a selection.
- > **Claim Msg:** is disabled on a voucher with un-posted payments or adjustments when a message was selected previously in **Payment Entry**.
In this instance you must update the associated payment batch before you can select a new message.

The drop-down lists contains all the messages created in **Message Maintenance**.

Add'l Claim Dx

Opens **Add'l Claim Dx**, which displays all diagnosis codes entered on a voucher's service lines and indicates which of those codes are both the service-level and claim-level codes, and which codes are additional codes output only at the claim level. It also enables you to manage the additional claim-level-only diagnosis codes for v4010 and v5010 professional claims. Diagnosis codes selected in **Add'l Claim Dx** are displayed on the **Diagnosis History** tab in **Patient Management > Service Inquiry**.

Referrals

When enabled, click **Referrals** to attach or link a Referral to the voucher. You can also open this dialog to un-attach or un-link a Referral from the voucher. Deselect the related box on the Incoming Referral form. Remove the Authorization # from the corresponding field in Claim Info.

Claim Info

When enabled, click **Claim Info** to attach or link claim information to the voucher. You can also open this dialog to un-attach or un-link claim information from the voucher. De-select the related box on the form. Remove the Prior Authorization # from the corresponding field in Claim Info.

Ailment Info

Click **Ailment Info** to add to the Patient's Ailment record.

CMN/DIF Info

When a voucher contains a Procedure Code flagged to enable CMN/DIF Info and the Policy selected for the voucher has a Source of Payment set to "Medicare," **CMN/DIF Info** becomes enabled.

Note: When the claim does not require the submission of a CMN/DIF form, check the Claim Info field **Ordering Dr. Same as Referring Dr?** found on the Summary in Charge Entry. This field may be checked from the Edits tab, as well.

Click **CMN/DIF Info** to open the dialog. See DME Billing: Use the CMN/DIF Information Dialog.

Currently, Allscripts® Practice Management supports the electronic submission of the following two forms using the standard ANSI X12N 837P v4010A1 format:

- > CMS-10125, External Infusion Pumps (DME 09.03)
- > CMS-484, Oxygen (DME 484.03)

Attach Info

Opens the Claim Attachments dialog.

Use of this dialog creates the Segment PWK in Loop 2300 of a Standard ANSI X12N 837I v4010A1 and Standard ANSI X12N 837P v4010A1 electronic claim file.

See Use Claim Attachment Dialog.

Amb Info

Enabled when the voucher contains services (Procedure Codes) with the Procedure Type set to **Ambulance Procedure**.

NY WC

Only enabled when the carrier on the charge has **Source of Payment** in **Insurance Carrier Maintenance** set to **NEW YORK WORKERS' COMPENSATION**.

Click **NY WC** to open **NY Workers' Comp**, which enables you to enter the information necessary to fill the **NYWC Initial Medical Narrative**, **NYWC Progress Medical Narrative**, and **Doctor's Report of Maximum Medical Improvement/Permanent Partial Impairment C-4.3 (05-22)** claim form.

Note: Allscripts® Practice Management does not generate medical narrative reports for the **Ancillary Medical Report (AMR)**.

PM160

Available when **Policy** is set to one where the carrier has an associated paper claim style or an alternate paper claim style with a format type of **CA CHDP Assessment Claim Form**, the control **PM 160** is available on the **Summary** tab in **Charge Entry** and in **Edits**.

Click **PM160** to open the form.

There are no required fields on this form from the standpoint of Allscripts® Practice Management. If a box is left blank on the dialog, the corresponding box on the paper form is left blank. Output is programmed to print in Courier 12pt font, which is 10 characters per inch. Some truncation may occur.

The form displays within two windows or screens. Use **Next** and **Previous** to move between the screens.

Co-Pay

Enables you to change the copay amount due on the voucher.

Rebill?

Checking this option strips the voucher of its current bill date and qualifies it for the next Insurance Billing run.

This option is not available for vouchers with an occupational medicine carrier that were already invoiced.

Associated combo box

The associated combo box is enabled when an additional Rebill Type Transaction Code flagged for Alternate Paper Claim Billing exists.

The selections in the drop-down list are as follows:

- > **Rebill** - Default selection; clears the bill date.
After it is updated, the claim is processed using the report name associated with the Carrier's Paper Claim Format, i.e. the same form used for the original submission.
- > **Rebill Using Alt Report Name** - clears the bill date
After it is updated, the claim is processed using the alternate report name associated with Carrier's Paper Claim Format

Override Failed Validation

Check this option to qualify a Voucher that has failed the Validation process to print or be transmitted in the next Insurance Billing run.

Important: Use this option only when you want the Validation criteria and/or Output Options associated with the Carrier's Claim Style not to be applied to this one voucher.

Not Incident To

Available when both of the following two conditions are met:

1. The voucher is being billed to the Patient's Patient Primary policy which has a Source of Payment of "Medicare."
2. The Actual Provider on the voucher is flagged as a Mid-Level Provider on the Provider tab in Provider Maintenance.

Check this option when a Mid-Level Provider, such as a Nurse Practitioner may not bill "incident to" and must be billed as the Billing Provider. There are four scenarios Medicare has identified where this is the case:

1. The patient is a new patient.
2. The patient is being seen for a new diagnosis/problem.
3. The patient is being seen for a new consult.
4. The patient is being seen when there is no Supervising Physician on site.

See Billing for Mid-Level Providers.

This option is checked automatically if the Place of Service selected on the voucher has **Default Not Incident To** checked on the Place of Service tab in Place of Service Maintenance (PSM). Even if this option is checked by default due to the PSM setting, you can still uncheck it here if necessary. See Place of Service Maintenance: Complete the Place of Service Tab.

Void Re-Enter

Enabled when all the transactions on a voucher are updated and the voucher's current payor does not equal **Sliding Fees**.

Note: If a voucher's Reimbursement Style has **Auto Adjust Non-Allowed Amount in Charge Entry** or **Auto Adjust after Self-Pay Payments Applied in Charge Entry** selected, the **Void Re-Enter** button is not enabled. Voids must then be performed manually on the Voids tab in Transactions.

Void and Export

When enabled is designed to function in conjunction with a custom Allscripts® Interface Engine Detailed Financial Transaction (DFT) export which allows for a one-way transfer of voucher/claim information out of Allscripts® Practice Management.

Payments

Enabled when payments have been applied to a voucher.

Enables you to edit the **Payment Date** and **Reference** fields related to each payment transaction applied to the voucher.

If you have **Allow** security permission for **Practice Management > Financial Processing > Transactions > Edits > Transaction Code** in **Security Permissions**, you can change the value in **Transaction** for payment and adjustment transactions with a status of **Updated**. The new transaction code must be the same type (adjustment or payment) as the original transaction code.

Transaction codes that have **Interest Transaction Code** selected in **Transaction Code Maintenance** are not available values for **Transaction** when you change the transaction code for an updated transaction.

Even if you have security permission to change transaction codes, **Transaction** is unavailable when any transaction code or transaction category is selected for a general ledger (GL) category member in **GL Category Maintenance**. Likewise, you cannot change transaction codes if there are adjustment or payment exceptions defined on the **GL Account Worksheet** tab in **Practice Set Up** or **Organization Set Up**. Both of these restrictions ensure that GL interfaces are not impacted by changed transaction codes.

Modifying an updated transaction code does not initiate any post-change logic, such as automatic adjustments, payment exports, or adjustment thresholds.

View H&P

Enabled only when the View H&P pane is completed on the External Access tab in Practice/Organization Options.

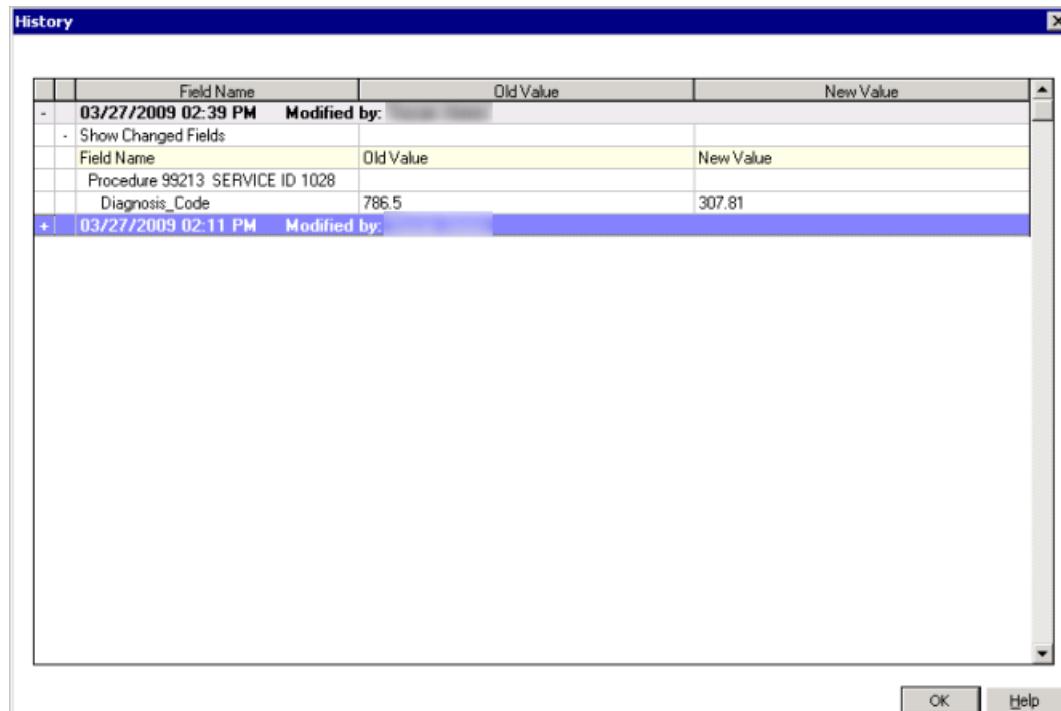
Enables you to see the H & P from Allscripts Professional EHR™ for a particular visit.

Note: The H&P can only be viewed for vouchers entered since you have been running Allscripts Professional EHR™ version 9.1 and Allscripts® Practice Management version 2009.3.1.

View History

This screen stores the following information: date, time, first name and last name of the Operator who made the change as well as the name of the field, the value changed and the new value entered in the field.

This window stores the history of changes made to the voucher's editable fields on the Edits tab. These changes can be made from the Edits tab, Charge Entry after the voucher was saved or during the Void and Re-Enter process.



Important: After you take any action on a voucher that is in a Closed or Updated Batch, that Batch is temporarily displayed in the grid at the top of the Batch Management Screen. Use the Refresh toolbar button to immediately clear the screen.

Vouchers with the status of "Void" can be displayed in Financial Inquiry when you query for Void, Paid, Open Items. Voided vouchers do not display for selection in the Centralized Voucher Locate window.

Chapter 6

Transaction Posting

Creating a payment batch

Payment batches are created on the **Batch Management** tab in **Transactions**.

When are payment Batches auto-created?

Some payment batches are automatically created as a result of certain functions. These functions are: import remittances, assessing finance charges, and when running the **Credit Balance Report** with the option **Create Refund Transactions** selected.

Also in **Charge Entry** when you apply a self-pay payment or adjustment, you are prompted to have the application create an associated payment batch.

Note: When Allscripts® Practice Management automatically creates a payment batch, the batch category used for the auto-created batch matches the batch category of the batch with which it is associated.

Can I manually create a batch that only contains self-pay refunds?

Yes. To enter self-pay refunds create a unique batch that is used only for refund transactions.

Use the batch comment "Transactions related to credit balances" to qualify the vouchers when you print self-pay refund checks.

Why are some of the payment batch numbers followed by an asterisk (*)?

In **Charge Entry**, when you apply a self-pay payment or adjustment you are prompted to have the application create an associated payment batch. This auto-created payment batch is given the same batch number as its associated charge batch. The payment batch number is followed by an asterisk (*).

Apply a payment to the oldest voucher

This function is programmed to be used when you are applying payments to self-pay vouchers or to an invoice.

When the amount being applied is greater than the amount due on the oldest voucher, the system will automatically distribute payment among vouchers by age of balance.

1. On the Payment tab, change the label name to Patient, Guarantor, or Invoice by using the **Ctrl+down arrow key**. While holding down the **Ctrl** key, tap the **down arrow key** until the label reads what you want it to. The focus remains in the field.
2. If unassigned payments exists in the credit grid, you can click on the credit line to select that payment to apply. Otherwise, you can skip this step.

Note: If you select an unassigned payment from the credit grid in Payment and use the apply oldest functionality the voucher number is ignored and the payment is applied using the oldest balance logic.

3. Click **Oldest (Alt+o)** to open the dialog.
4. For **Department**, select a specific Department to post the payment to or leave it blank for all Departments.

When you use department security, only those Departments to which you have access appear in the drop-down.

5. For **Location**, select a specific Location to post the payment to or leave it blank for all Locations.

When you use department security, only the Locations associated with the Departments to which you have access appear in the drop-down.

6. For **Provider**, select a specific Provider to post the payment to or leave it blank for all Providers.

When you use department security, only the Providers associated with the Departments to which you have access appear in the drop-down.

7. Type in the date or **Tab** to default to today's date.

8. From the drop-down list, select the appropriate Transaction Code.

If you are using integrated credit card processing and select a credit card transaction code, when you click **Save**, Allscripts® Practice Management displays a message that prompts you to insert or swipe a card.

9. **Tab**, then type text into the **Reference** field which will help identify the source of this payment.

Note: The **Reference** field allows you to enter a maximum of 50 characters.

10. **Tab**, then type in the payment amount.

11. **Alt+s** to save.

12. To view those vouchers which have been paid, change the preference field to **Paid & Open Items** and requery.

Apply a self-pay refund

Manually apply self-pay refunds for vouchers on the **Payment** tab in **Transactions**.

Note: If you use **Print Refund Checks** you must manually create a payment batch and give it a batch comment of "Transactions related to credit balances" (This batch comment should only be used when you create a payment batch that contains only self-pay refund transactions.).

1. Go to the **Payment** tab on **Financial Processing > Transactions**.
 2. On the **Payment** tab, retrieve a payment by patient or guarantor.
 3. Double-click the voucher line or use the right-click menu to open the voucher that has a credit balance.
 4. For **Remitter**, verify that **Self Pay** is selected.
 5. For **Reference**, enter text that will help identify the transaction.
 - || **Note:** For example, enter "Refund Ck 1145."
 6. For **Date**, select a date from the calendar.
 7. Click **Manual Entry**.
 8. For **Refund**, enter the refund amount.
 - || **Important:** Do not enter a negative number.
 9. For **Voucher Balance**, verify that the value is \$0.00.
 10. For **Transaction Code**, verify that the transaction code is a refund transaction type.
 11. Review and verify the transaction summary at the bottom of the window.
 12. Click **Save**.

Results of this task

Apply Transactions to Voucher # 4670

Remitter: <input type="text" value="Self Pay"/>	Date: <input type="text" value="05/13/2008"/>						
Reference: <input type="text" value="Refund Ck 1145"/>	Amount Paid: <input type="text"/>						
Self Pay Reimbursement							
<input type="button" value="Auto Fill"/> <input type="button" value="Manual Entry"/>							
Svc Date	Procedure	Fee	Prev Pd/Adj	Amount Due	Payment	Adjustment	Refund
04/15/2003	99212	\$46.00	\$54.23	-\$8.23	\$0.00	\$0.00	\$8.23
Key in the digits only							
Distribution Co-Pay Due: \$0.00 Other Due: \$0.00 Voucher Balance: \$0.00				Transaction Codes <input type="checkbox"/> Override <input type="checkbox"/> Adjust <input checked="" type="radio"/> Leave <input type="radio"/> Transfer <input type="checkbox"/> Rebill Payment: <input type="text"/> Co-Pay Override: <input type="text"/> Adjustment: <input type="text"/> Refund: Self-Pay Refund <input type="text"/> Transfer: <input type="text"/>			
Transfer To: <input type="checkbox"/> Hold from Electronic Billing				Messages Statement: <input type="text"/>			
Co-Pay Payment: \$0.00 Co-Pay Override: \$0.00 Transfer Amount: N/A Other Payment: \$0.00 Adjustment: \$0.00 Total Payments: \$0.00 Refund Amount: \$8.23							
<input type="button" value="Save"/> <input type="button" value="Cancel"/> <input type="button" value="Help"/>							

Apply an unassigned payment from the Payment Entry tab

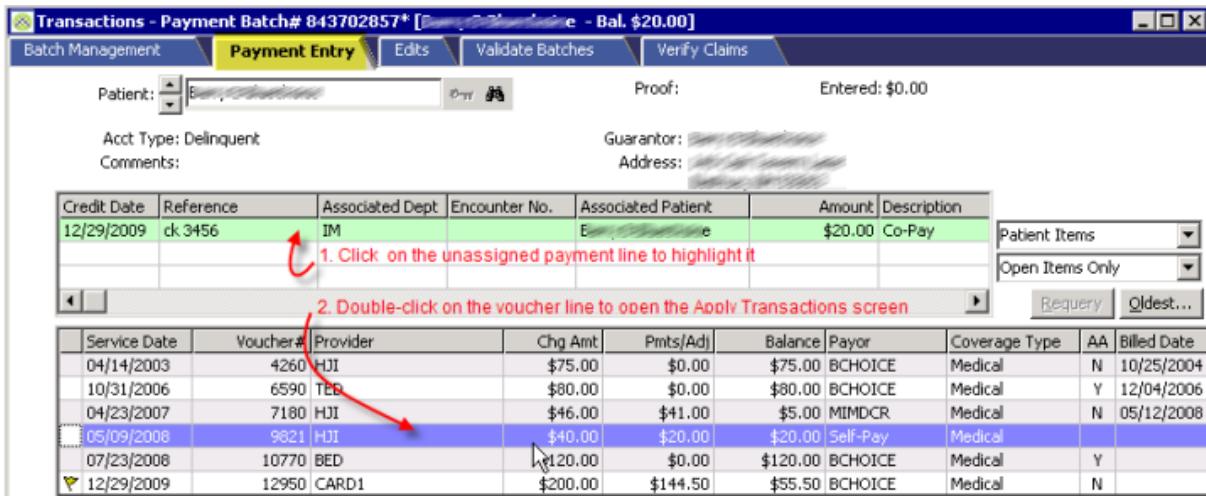
An unassigned payment can be applied or refunded in Payment Entry.

The purpose of this topic is to describe the process of applying an unassigned payment to a voucher with a self-pay balance.

Note: When the option **Require Associated Dept/Pract on Quick Payment** is checked on the Payment Entry tab in Practice/Organization Options, you can only apply the payment to a voucher whose department/practice is the same as the unassigned payment's associated department/practice.

1. On the Payment Entry tab, retrieve by Patient or Guarantor
2. Point and click on the unassigned payment row in the credit grid. This highlights the row in green.

Apply an unassigned payment from the Payment Entry tab



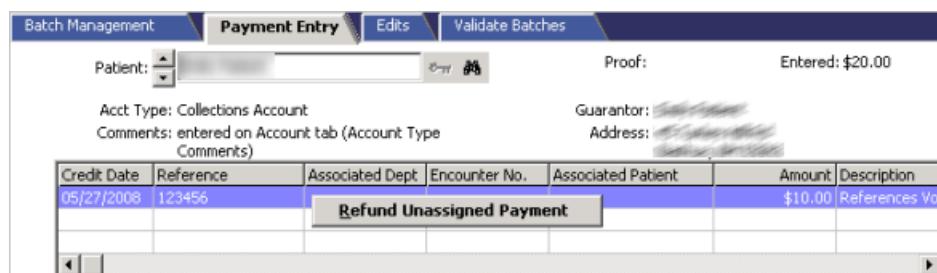
Note: When an encounter number is displayed, it is the encounter number assigned to an appointment associated with a quick pay payment. The payment must be manually applied to the voucher that corresponds to the encounter number.

3. Double-click on a voucher line in the service grid. This opens the Apply Transactions screen. When the dialog opens, the focus is resting in the **Reference** field which pulled in the reference from the credit grid.
4. Tab once to enter a date using the format mmddyyyy. Tab twice to auto-fill the field with the current date. To use the calendar click then click on a date to populate the field.
5. Tab. The dollar amount from the credit line is pulled into Amount Paid field when the voucher is out to Self-Pay. Enter an amount if you need to or Tab again to accept the default.
6. Click **Auto Fill** or **Manual**. Use **Auto Fill** when the Amount Paid equals the Payment amount entered on the transaction line. When using **Manual** go to step 7 next. When using **Auto Fill** go to step 8 next.
7. Using Manual Entry: The focus is in the **Payment** field. Type in the payment amount. Tab through the remaining fields if necessary.
8. Review and verify the distribution detail. If necessary, select the appropriate option related to the balance.
9. Select the appropriate Transaction Codes.
10. Review and verify the Transaction detail summarized at the bottom of the screen.
11. **Alt+s** or **Save**.

Refund a portion of an unassigned amount

When a portion of an unassigned payment has been applied, you can refund the remaining unassigned amount.

1. On the Payment Entry tab, retrieve by Patient or Guarantor
2. When retrieving by Guarantor, the option to refund an unassigned payment is not available if the Guarantor is not also registered as a Patient. In this case you must retrieve the record by Patient.
3. Point and click on the unassigned payment row in the credit grid. This highlights the row.
4. Right-click and click **Refund Unassigned Payment**.



This opens the Refund Unassigned dialog.

Unassigned Payment Refund

The Refund will be Posted with the following:

Batch Category:	<input type="text"/>
Provider:	<input type="text"/>
Billing Provider:	<input type="text"/>
Department:	<input type="text"/>
Place of Service:	<input type="text"/>
Location:	<input type="text"/>
Procedure:	<input type="text"/> <small>(optional)</small>
Refund Transaction Code:	<input type="text"/>

OK **Cancel** **Reset**

When unassigned payment default options are selected in Practice/Organization Options on the Payment Entry tab the dialog opens with those fields populated. The defaults can be changed. All fields are required.

Note: The reset button allows you to clear all the populated fields and begin over.

5. When making the following selections, your practice/organization's policies and setup determines what you selections you make. If your practice/organization has created generic records such as **Refund** or **Refund Unassigned** for use then be sure to make that your selection.
6. If all of the fields are defaulted to selections made in Practice Options, review each entry, then go to the next step.
7. Batch Category: This field defaults based on the following hierarchy
 - > To the batch category used for the payment batch selected on **Quick Payment for [user name] on this workstation** when the unassigned payment was entered
 - > To the default batch category for payment batches entered on the **Batches** tab in **Options for user [user name] on this workstation**, accessed by clicking **Update Options**  on the toolbar
 - > To blank if none of the above exists

Note: This field is required if the option **Require Batch Category** is checked on the General tab in Practice/Organization Options.

8. Select a Provider by entering the first letters of his/her last name or clicking to open the listing and clicking on the name of a Provider. If your practice does not associate unassigned payments with a Provider, select a generic option, for example **Refund** or **Unassigned Refund**.
9. Select a Billing Provider by entering the first letters of his/her last name or clicking to open the listing and clicking on the name of a Provider. If your practice does not associate unassigned payments with a Provider, select a generic option, for example **Refund** or **Unassigned Refund**.
10. Select a Department/Practice by clicking to open the listing and clicking on the name of a Department/Practice. If your practice does not associate unassigned payments with a Department/Practice, select a generic option, for example **Refund** or **Unassigned Refund**.
11. Select a Place of Service by clicking to open the listing and clicking on the name of a Place of Service. If your practice does not associate unassigned payments with a Place of Service, select a generic option, for example **Refund** or **Unassigned Refund**.
12. Select a Location by clicking to open the listing and clicking on the name of a Location. If your practice does not associate unassigned payments with a Location, select a generic option, for example **Refund** or **Unassigned Refund**.
13. Select a procedure code using one of the following:
 - > Enter the code, then **Tab** or click 
 - > Position the cursor in the field and use **Alt+down arrow** to open the Procedure Code Lookup.

- 14** Click  to open the Procedure Code Lookup.
- 15** Click **OK**. The prompt "Do you want to print a Transaction Acknowledgement" appears.
- 16** Click **Yes** to print a transaction acknowledgement.

Physicians Associated

[REDACTED]
Tel: [REDACTED] Tax ID #: [REDACTED]

Refund on Account	Date: 02/08/2010										
Account No. [REDACTED]											
Guarantor Information: [REDACTED]											
Patient Information: Patient No. [REDACTED]											
Provider: Allscripts, Provider											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Date Paid</th> <th>Reference</th> <th>Operator</th> <th>Description</th> <th>Amount</th> </tr> </thead> <tbody> <tr> <td>02/08/2010</td> <td>Cash</td> <td>susanj</td> <td>Refund Unassigned Pmt on New Voucher on 02/08/2010 for [REDACTED]</td> <td>\$5.00</td> </tr> </tbody> </table>		Date Paid	Reference	Operator	Description	Amount	02/08/2010	Cash	susanj	Refund Unassigned Pmt on New Voucher on 02/08/2010 for [REDACTED]	\$5.00
Date Paid	Reference	Operator	Description	Amount							
02/08/2010	Cash	susanj	Refund Unassigned Pmt on New Voucher on 02/08/2010 for [REDACTED]	\$5.00							

- 17**. When the acknowledgement has printed successfully, click **Yes** at the next prompt to close the dialog and return to the Payment Entry screen where the unassigned payment is removed from the credit grid.
- 18** The Charge and Payment batches created as a result of this process must be manually closed and updated. Charge Batches are auto numbered using the format the naming convention of UR/date/operator's abbreviation/number of batch/# (ex. UR0921091opabbrev1#). Payment Batches have an * added (ex. UR0921091opabbrev1#*).
- 19** Use your practice/organization's system to generate refund checks.

Applying primary insurance payments

When a voucher was originally posted to the wrong primary carrier, it is recommended that you void the charge and reenter it on a new voucher in order to guarantee the integrity of your reports.

Each example below outlines steps for a specific scenario when applying a primary insurance payment to a voucher using the "**Detailed Insurance Reimbursement**" style.

Apply primary insurance payments: example 1

The following attributes apply to this example:

- > No prior payments or adjustments
- > Existing allowed amount
- > **Adjust Non-Allowed Amount** selected
- > Balance transfers to secondary carrier

1. On the **Payment Entry** tab, double-click the voucher row in the grid.
Apply Transactions to Voucher # opens.
2. Verify that you have the correct **Remitter**.
3. Press **Tab**. Enter text in **Reference** that will help identify the source of this payment.

Note: **Reference** enables you to enter a maximum of 50 characters.

4. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.
5. Select a data entry method:
 - > Click **Auto Fill** (or press **Alt + a**) to auto-fill data.
 - > Click **Manual Entry** (or press **Alt + m**) to manually enter data, and then enter the allowed amount in the **Allowed** column.
6. Verify other amounts that may apply, such as **Deductible**, **Withheld**, **Co-Insurance**, **Co-Pay**, and **Payment** match the EOB detail.

Tip: Make any changes beginning with the columns on the left and then moving to those on the right. Remember, Allscripts Practice Management™ is programmed to calculate the payment amount for you based on the entries in these columns.

7. Select an applicable **Comment**.

You can include more than 1 comment by selecting **(multi)**, when it's available in the list.

8. Select **Adjust Non-Allowed Amount**, if it's not already selected.
9. Select **Transfer**, if it's not already selected, and ensure the secondary carrier is highlighted.
10. If the primary carrier does not forward the claim to the secondary carrier, select **Rebill**.
11. Verify or change the transaction codes.
12. Always review and verify the transaction summary information at the bottom of the window.
13. Click **Save** (or press **Alt + s**).

Apply primary insurance payments: example 2

The following attributes apply to this example:

- > No prior payments or adjustments
- > No existing allowed amount
- > **Adjust Non-Allowed Amount** selected
- > Balance transfers to secondary carrier

1. On the **Payment Entry** tab, double-click the voucher row in the grid.
Apply Transactions to Voucher # opens.
2. Verify that you have the correct **Remitter**.
3. Press **Tab**. Enter text in **Reference** that will help identify the source of this payment.

Note: **Reference** enables you to enter a maximum of 50 characters.

4. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.
5. Select a data entry method:
 - > Click **Auto Fill** (or press **Alt + a**) to auto-fill data. The allowed amount is \$0.00.
 - > Click **Manual Entry** (or press **Alt + m**) to manually enter data.
6. Enter the allowed amount in the **Allowed** column.
7. Verify other amounts that may apply, such as **Deductible**, **Withheld**, **Co-Insurance**, **Co-Pay**, and **Payment** match the EOB detail.

Tip: Make any changes beginning with the columns on the left and then moving to those on the right. Remember, Allscripts Practice Management™ is programmed to calculate the payment amount for you based on the entries in these columns.

8. Select an applicable **Comment**.
You can include more than 1 comment by selecting **(multi)**, when it's available in the list.
9. Select **Adjust Non-Allowed Amount**, if it's not already selected.
10. Select **Transfer**, if it's not already selected, and ensure the secondary carrier is highlighted.
11. If the primary carrier does not forward the claim to the secondary carrier, select **Rebill**.
12. Verify or change the transaction codes.
13. Always review and verify the transaction summary information at the bottom of the window.
14. Click **Save** (or press **Alt + s**).
15. If **Review/Update Contractual Allowance** is displayed, update the **Contractual Allowance** table.

You are returned to the **Payment Entry** tab.

Apply primary insurance payments: example 3

The following attributes apply to this example for applying a payment from the primary insurance to a voucher that already has payments applied from secondary insurance:

- > Prior payments or adjustments
- > Existing allowed amount
- > **Adjust Non-Allowed Amount** selected
- > Voucher balance will equal \$0.00

1. On the **Payment Entry** tab, double-click the voucher row in the grid.

Apply Transactions to Voucher # opens.

2. Verify that you have the correct **Remitter**.

3. Press **Tab**. Enter text in **Reference** that will help identify the source of this payment.

Note: **Reference** enables you to enter a maximum of 50 characters.

4. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.

5. Select a data entry method:

> Click **Auto Fill** (or press **Alt + a**) to auto-fill data.

> Click **Manual Entry** (or press **Alt + m**) to manually enter data, and then enter the allowed amount in the **Allowed** column.

6. Verify other amounts that may apply, such as **Deductible**, **Withheld**, **Co-Insurance**, **Co-Pay**, and **Payment** match the EOB detail.

Tip: Make any changes beginning with the columns on the left and then moving to those on the right. Remember, Allscripts Practice Management™ is programmed to calculate the payment amount for you based on the entries in these columns.

7. Select an applicable **Comment**.

You can include more than 1 comment by selecting **(multi)**, when it's available in the list.

8. Select **Adjust Non-Allowed Amount**, if it's not already selected.

The voucher balance is \$0.00.

9. Verify or change the transaction codes.

10. Always review and verify the transaction summary information at the bottom of the window.

11. Click **Save** (or press **Alt + s**).

You are returned to the **Payment Entry** tab.

Apply primary insurance payments: example 4

The following attributes apply to this example for applying a payment from the primary insurance to a voucher that already has payments applied from secondary insurance, and the procedure does not have a recorded contractual allowance:

- > Prior payments or adjustments
- > No allowed amount
- > **Adjust Non-Allowed Amount** selected
- > Voucher balance will equal \$0.00

1. On the **Payment Entry** tab, double-click the voucher row in the grid.

Apply Transactions to Voucher # opens.

2. Verify that you have the correct **Remitter**.

3. Press **Tab**. Enter text in **Reference** that will help identify the source of this payment.

Note: **Reference** enables you to enter a maximum of 50 characters.

4. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.

5. Select a data entry method:

- > Click **Auto Fill** (or press **Alt + a**) to auto-fill data.
- > Click **Manual Entry** (or press **Alt + m**) to manually enter data.

6. Enter the allowed amount in the **Allowed** column.

7. Verify other amounts that may apply, such as **Deductible**, **Withheld**, **Co-Insurance**, **Co-Pay**, and **Payment** match the EOB detail.

Tip: Make any changes beginning with the columns on the left and then moving to those on the right. Remember, Allscripts® Practice Management is programmed to calculate the payment amount for you based on the entries in these columns.

8. Select an applicable **Comment**.

You can include more than 1 comment by selecting **(multi)**, when it's available in the list.

9. Select **Adjust Non-Allowed Amount**, if it's not already selected.

The voucher balance is \$0.00.

- 10 Verify or change the transaction codes.
- 11 Always review and verify the transaction summary information at the bottom of the window.
- 12 Click **Save** (or press **Alt + s**).
- 13 When **Review/Update Contractual Allowance** is displayed, update the **Contractual Allowance** table.

You are returned to the **Payment Entry** tab.

Apply primary insurance payments: example 5

The following attributes apply to this example:

- > No prior reimbursement
- > Capitated adjustment applied to a procedure line on the voucher
- > Voucher balance will equal \$0.00

Note: When applying a payment on a voucher where 1 service line already has a capitated adjustment applied, do not adjust the **Non-Allowed** amount.

1. On the **Payment Entry** tab, double-click the voucher row in the grid. **Apply Transactions to Voucher #** opens.
2. Verify that you have the correct **Remitter**.
3. Press **Tab**. Enter text in **Reference** that will help identify the source of this payment.

Note: **Reference** enables you to enter a maximum of 50 characters.

4. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.
5. Select a data entry method:
 - > Click **Auto Fill** (or press **Alt + a**) to auto-fill data, and then enter 0 (zero) the **Allowed** column on the procedure line for the capitated service, if necessary.
 - > Click **Manual Entry** (or press **Alt + m**) to manually enter data.
6. For each procedure being paid, if the allowed amount is already in the **Allowed** column, verify or change it; otherwise, enter an allowed amount.

Note: Do not enter an allowed amount on the procedure line for the capitated services.

7. Verify other amounts that may apply, such as **Deductible**, **Withheld**, **Co-Insurance**, **Co-Pay**, and **Payment** match the EOB detail.

Tip: Make any changes beginning with the columns on the left and then moving to those on the right. Remember, Allscripts Practice Management™ is programmed to calculate the payment amount for you based on the entries in these columns.

8. Select an applicable Comment.

You can include more than 1 comment by selecting **(multi)**, when it's available in the list.

9. Make sure Adjust Non-Allowed Amount is not selected.

10. Select Write Off.

11. Verify or change the transaction codes.

12. Always review and verify the transaction summary information at the bottom of the window.

13. Click Save (or press Alt + s).

14. If Review/Update Contractual Allowance is displayed, update the Contractual Allowance table.

Applying secondary insurance payments

Each example below outlines steps for a specific scenario when applying a payment from the secondary insurance to a voucher.

Apply secondary insurance payments: example 1

The following attributes apply to this example:

- > Prior reimbursement with non-allowed adjustment
- > Voucher balance will equal \$0.00

When applying payment from the Secondary Insurance to a Voucher which already has payments from the Primary Insurance applied, the program default is to use the Summarized insurance reimbursement style.

1. On the Payment Entry tab, double-click the voucher row in the grid.

Apply Transactions to Voucher # opens.

2. Verify that you have the correct Remitter.

3. Press Tab. Enter text in **Reference** that will help identify the source of this payment.

Note: **Reference** enables you to enter a maximum of 50 characters.

4. Press Tab once, and then enter the date, or press Tab twice to default to today's date.

5. Select a data entry method:

- > Click **Auto Fill** (or press **Alt + a**) to auto-fill data. The default payment amount in the **Payment** column equals the amount due. Verify or change the payment amount.
- > Click **Manual Entry** (or press **Alt + m**) to manually enter data, and then enter the allowed amount in the **Payment** column.

6. In the **Adjustment** column, enter any adjustments that might apply.

7. Select an applicable **Comment**.

You can include more than 1 comment by selecting **(multi)**, when it's available in the list.

8. Select an applicable **Remark**.

You can include more than 1 remark by selecting **(multi)**, when it's available in the list.

9. Select **Write Off**.

10. Verify or change the transaction codes.

11. Always review and verify the transaction summary information at the bottom of the window.

12. Click **Save** (or press **Alt + s**).

You are returned to the **Payment Entry** tab.

Apply secondary insurance payments: example 2

The following attributes apply to this example:

- > No prior reimbursement
- > Use **Summarized** reimbursement style
- > Voucher balance remains with primary insurance

1. On the **Payment Entry** tab, double-click the voucher row in the grid.

Apply Transactions to Voucher # opens.

2. Change **Remitter** to the secondary insurance.

3. Press **Tab**. Enter text in **Reference** that will help identify the source of this payment.

|| **Note:** **Reference** enables you to enter a maximum of 50 characters.

4. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.

5. Click **Manual Entry** (or press **Alt + m**) to manually enter data, and then enter the amount being applied in the **Payment** column.

|| **Note:** Auto-fill is not available .

6. Always review and verify the transaction summary information at the bottom of the window.

7. Click **Save** (or press **Alt + s**).

You are returned to the **Payment Entry** tab.

Results of this task

The primary insurance remains the remitter. When you open the voucher to apply the primary payment, you will not have to change the remitter.

Apply secondary insurance payments: example 3

The following attributes apply to this example:

- > No prior reimbursement
- > Existing allowed amount
- > Use the **Detailed** reimbursement style
- > Voucher balance remains with the primary insurance

To retain the **Detailed** reimbursement style, transfer the voucher balance from the primary carrier to the secondary carrier, and then click **Save**. Reopen the voucher.

1. Transfer the voucher balance to a new remitter:

- a. On the **Payment Entry** tab, double-click the voucher row in the grid.

Apply Transactions to Voucher # opens.

- b. Accept the default **Remitter**.
 - c. Press **Tab**. Enter **Transfer** in **Reference**.
 - d. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.
 - e. Click **Manual Entry** (or press **Alt + m**).
 - f. Clear **Adjust Non-Allowed Amount** if it is selected.
 - g. Select the distribution option **Transfer**.
 - h. Clear **Rebill** if it is selected.
 - i. Select the name of the carrier to whom you are transferring the voucher balance.

The only policies displayed in the transfer grid are self-pay and those associated with the coverage type selected in **Coverage Type**. Additionally, all collection policies are displayed regardless of the coverage type on the voucher.

Note: If you need to transfer the voucher balance to a policy with a coverage type that is different from the one currently on the voucher, change **Coverage Type**.

- j. Verify that the transaction detail displayed at the bottom of the window shows 0.00 for **Payment Amount**, 0.00 for **Write-Off/Adjust**, 0.00 for **WithHeld Amount** and **Transfer Amount** equal to the voucher balance.
 - a. Click **Save** (or press **Alt + s**) .
You are returned to the **Payment Entry** tab.
 - b. Double-click on the voucher row to reopen the voucher and apply the payment or adjustment transactions made by the new remitter.
2. Accept the default **Remitter**.
3. Press **Tab**. Enter text in **Reference** that will help identify the source of this payment.

Note: **Reference** allows you to enter a maximum of 50 characters.

4. Press **Tab** once, and then enter the date, or press **Tab** twice to default to today's date.
5. Select a data entry method. The application calculates the payment amount based on the entries you make.

> Click **Auto Fill** (or press **Alt + a**) to auto-fill data.

Note: If the payment amount received is not equal to the payment amount displayed, make changes in this order:

1. the allowed amount
2. any deductible amount that applies
3. any co-pay amount that applies

Because the focus is on the **Adjust Non-Allowed Amount** option, use your mouse to click in the box that needs to be changed, and then enter the amounts as they are given on the carrier's remittance advice.

> Click **Manual Entry** (or press **Alt + m**) to manually enter data, and then enter the allowed amount in the **Allowed** column for each procedure line.

Note: Enter amounts in this order:

1. the allowed amount
2. any deductible amount that applies
3. any co-pay amount that applies

Because the allowed amount is set to \$0.00, **Dnd** and **Pnd** are auto selected. After you have entered the allowed amounts, verify that these selections are cleared.

Using a **Detailed** reimbursement style triggers the application to drive its calculations off of the allowed amount. It would be helpful here to review the way the application is programmed to do calculations:

- > Total Expected Payment = Allowed - Deductible - Co-Pay
- > Primary Payment = Total Expected Payment x Usual Payment % Taken from the Reimbursement Style
- > Co-Insurance = Total Expected Payment - Primary Payment
- > Payment received for each Procedure = Primary Payment - Withheld

The amount displayed as the payment for each procedure is affected by the rules defined for the reimbursement style being used.

6. Because this is a co-insurance payment, verify that the **Adjust Non-Allowed Amount** option is not selected.
7. Select **Transfer** as the **Distribution** option.
8. Clear **Rebill** if necessary.
9. Highlight the primary insurance policy.

The only policies displayed in the transfer grid are self-pay and those associated with the coverage type selected in **Coverage Type**. Additionally, all collection policies are displayed regardless of the coverage type on the voucher.

Note: If you need to transfer the voucher balance to a policy with a coverage type that is different from the one currently on the voucher, change **Coverage Type**.

10. Verify or change the transaction codes.
11. Always review and verify the transaction summary information at the bottom of the window.
12. Click **Save** (or press **Alt + s**).
13. If a change was made to the allowed amount, when the window is displayed, update the contractual allowance table.

Manually post interest to a voucher

If the voucher you are working with has interest posting enabled, you can manually apply interest in **Payment Entry > Apply Transactions**.

1. In **Payment Entry > Apply Transactions**, click **Interest** or press **ALT + i**.

If **Interest** is unavailable, you cannot apply interest to this voucher because the voucher's remitter is associated with a reimbursement style that does not have **Allow Interest Posting** selected in **Reimbursement Style Maintenance**.

Apply Interest Transactions opens.

2. For **Interest Pmt**, enter the amount of interest you want to apply to the voucher.

Interest Adj automatically fills with a corresponding negative interest adjustment. You cannot edit this amount; **Interest Pmt** and **Interest Adj** always add up to zero.

3. (Optional) If **Interest Payment** is enabled in the transaction codes section and you want to select an interest payment transaction code other than the default, click the down arrow to open the list and select the interest payment transaction code you want to use for this voucher.
If **Interest Payment** is unavailable, you cannot change the interest payment transaction code from the default.
4. If **Interest Adjustment** is enabled in the transaction codes section and you want to select an interest adjustment transaction code other than the default, click the down arrow to open the list and select the interest adjustment transaction code you want to use for this voucher.
If **Interest Adjustment** is unavailable, you cannot change the interest adjustment transaction code from the default.
5. To apply the interest to the voucher, click **OK**.
You return to **Apply Transactions**. The interest you applied is displayed at **Interest Pmt** and **Interest Adj**, which are at the bottom of **Apply Transactions** in the **Payment Amount** section.
6. When you have finished making any other necessary edits to the voucher, click **Save**.

Edit reimbursement detail

Reimbursement Detail must be used to do the following:

- > Edit reimbursement comments and the OTAF amount entered and saved on a voucher during payment entry
- > Add or edit the reimbursement comment for an adjustment transaction
- > Add or edit remark codes

Reimbursement Detail is accessible only from the **Edits** tab on vouchers where payments or adjustments have been applied.

Changes are made by service line. When there is more than 1 service line on a voucher, changing the detail for 1 service line does not edit the detail associated with the other service lines.

The lower grid contains detail related to the highlighted line in the **Transactions Lines** grid.

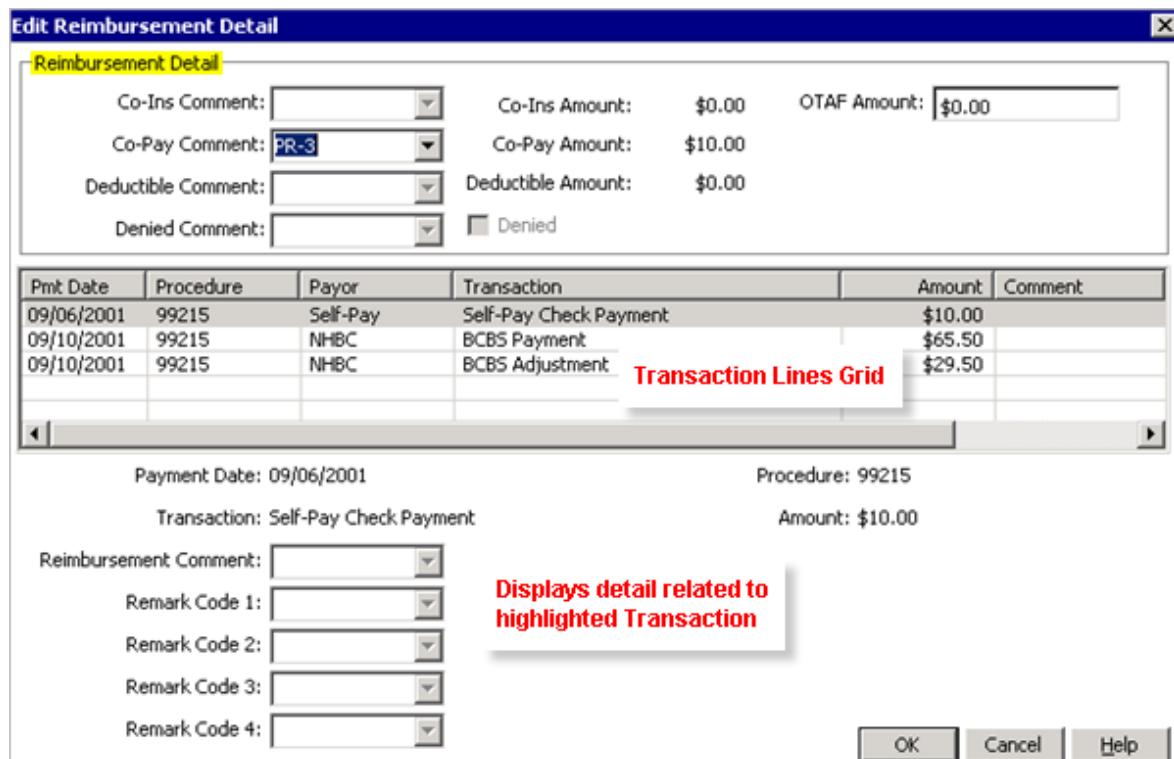
This detail is retrieved from the service payment table and displays payment date, procedure code, payer, transaction code, amount, and comment.

When a line is highlighted, the following transaction detail displays below the grid:

- > **Payment Date** - Display only
- > **Procedure** - Display only
- > **Transaction** - Display only
- > **Amount** - Display only

1. Open Reimbursement Detail.

- a. In **Financial Processing > Transactions**, click the **Edits** tab.
- b. Enter the voucher number in **Voucher**, and then press **Tab** or click .
- c. In the service line grid, right-click a service line to display the right-click menu.
- d. Click **Edit Reimbursement Detail** to open the window that enables you to edit or enter a comment associated with the selected line of service.



2. Change a **Co-Insurance Comment**, **Co-Pay Comment**, **Deductible Comment**, and **Denied Comment**, as needed.

The amount displayed to the right of each box is non-editable. **Co-Pay Amount** can be edited from the main **Edits** tab.

Denied is also a non editable check box that displays the status applied at during payment entry.

Only the comment boxes that were filled at payment entry time for the service are active and editable.

3. Edit **OTAF Amount**.

4. Add or edit **Reimbursement Comment**.

Reimbursement Comment is active and editable when an adjustment transaction line is highlighted.

5. Add or edit **Remark Code x**, where x is 1 through 4.

All 4 boxes are active for each transaction line even when remarks were not entered at during payment entry.

6. When you have finished making your edits, click **OK** to close **Reimbursement Detail**.

Quick Payment window

Use **Quick Payment** to create an unassigned payment that can be associated with a charge later.

Access **Quick Payment** using , which is available in several different areas of the application:

- **Registration:** The toolbar button is active when a patient is retrieved.
- **Appointment Scheduling:** On the **Patient Scheduling** and **Appointment Activity** tabs, the toolbar button is enabled when a patient record is retrieved. The button is active on the **Appointment Book** and **Appointment Management** tabs when an appointment row is highlighted.
- **Charge Entry tab:** The toolbar button is not available until the voucher is saved.
- **Payment Entry tab:** The toolbar button is enabled when open items are brought into the form.
- **Collection Activities:** The toolbar button is enabled on the **Collection Management** tab when a collection account is highlighted in the work list grid.

If **Launch Quick Pay Workflow when Appointment is Acknowledge** is selected on the **Scheduling (2)** tab in **System Administrations > Practice Options** or **Organization Options**, **Quick Payment** opens automatically after you acknowledge an appointment.

If **Include Patient Responsibility Grid with Eligibility Integration and Validations** is selected on the **Scheduling (2)** tab, **Quick Payment** includes the **Patient Responsibility** grid.

When both **Launch Quick Pay Workflow when Appointment is Acknowledge** and **Include Patient Responsibility Grid with Eligibility Integration and Validations** are selected, a progress bar is displayed immediately after you acknowledge an appointment and initiate an eligibility request, indicating that the application is **Attempting to Retrieve Eligibility Response**. The application then closes the progress bar and opens **Quick Payment** based on the following criteria.

- If an eligibility response is received within 30 seconds, the application automatically opens **Quick Payment** with the eligibility status marked as **Received**. By default, the **Co-Pay** option is selected in the **Patient Responsibility** grid and the co-pay from the eligibility response is entered in **Amount #1**.
- If an eligibility response is not received within 30 seconds, the application automatically opens **Quick Payment** with the eligibility status marked as **Pending**. By default, the **Co-Pay** option is selected in the **Patient Responsibility** grid and \$0 is entered in **Amount #1** instead of the mandatory minimum.

Unassigned payments are reportable using two reports.

- > **Unassigned Payment Analysis**
- > **Bank Reconciliation Report**

Quick Payment enables you to apply two forms of payment, such as cash and a check, or two different credit cards, to a single appointment. Thus, you can collect two payments at the same time, or alternatively, collect a flat fee upfront and then potentially more money at the time of checkout based on the services rendered. If you must enter more than two quick payments for the same appointment, save and re-open **Quick Payment** to add more payments.

For unassigned amounts entered on **Quick Payment** to qualify for the **Bank Reconciliation Report**, you must select a transaction code. To ensure that your staff always selects a transaction

code when entering a quick payment, select **Require Transaction Code on Quick Payment** on the **Payment Entry** tab in **System Administrations > Practice Options**.

Figure 1: Quick Payment window without Patient Responsibility grid

Quick Payment for [REDACTED]

Elig Status:

Mandatory Minimum Quick Pay Amount:

Batch:	234						
Transaction Date:		Quick Pay Override Reason:					
Reference #1:							
Associated Patient:	[REDACTED]						
Associated Appt:	Date	Time	Location	Department	Resource	Encounter #	Assoc.Quick Pay
	06/11/21	08:30 AM	AMBSURG	SURGI	MARFEE	105200	

Associated Dept: AMBULATORY SURGI CENTER

Associated Location: AMBULATORY SURGI CENTER

Associated Provider: [REDACTED] MD, MARK

Amount #1: \$10.00

Transaction Code #1:

Reference #2:

Amount #2:

Transaction Code #2:

Description: Co-Pay

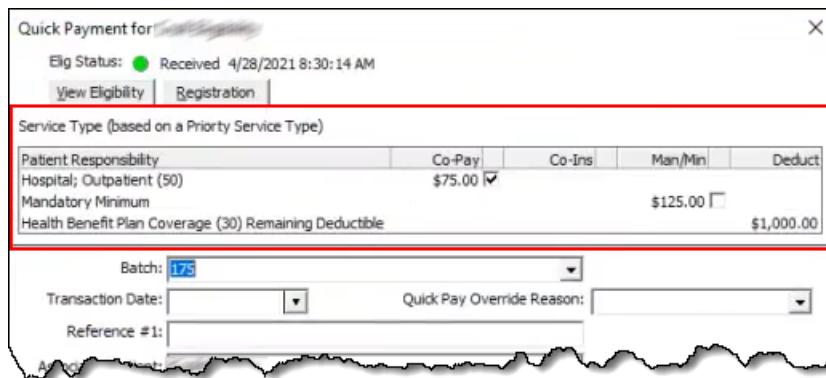
Policy: AETNA

Coverage Type: Medical

Visit Type:

Co-Pay Exceptions: Comments from Co-Pay/Co-Ins Exceptions

Figure 2: Patient Responsibility grid in Quick Payment window



Elig Status

Displays the most recent eligibility response coverage status indicator with the response date and time.

View Eligibility

Opens **Eligibility Response** with information received from the 271 eligibility response files.

Registration

Opens **Allscripts PM COMpanion - Registration**. The button is enabled when **Quick Payment** is opened within the context of appointment scheduling, and you have security permissions to access **Registration**. The **Quick Payment** toolbar button is not available from **Allscripts PM COMpanion - Registration**.

Patient Responsibility grid

A **Patient Responsibility** grid is displayed when **Include Patient Responsibility Grid with Eligibility Integration and Validations** is selected on the **Scheduling (2)** tab in **System Administrations > Practice Options** or **Organization Options**, and eligibility verification is configured in Allscripts® Interface Engine and **Insurance Carrier Maintenance**.

Mandatory Minimum Quick Pay Amount

Informational only. If visit types are enabled, the application retrieves the amount from **Visit Type Maintenance**; otherwise, the amount is obtained from the **Scheduling (2)** tab in **System Administrations > Practice Options** or **Organization Options**. If there is no the dollar value in either location, no amount is displayed.

Mandatory Minimum Quick Pay Amount is not displayed when the **Patient Responsibility** grid is displayed.

Quick Pay Override Reason

Enter the reason that a payment was not entered. The available options are defined in **Quick Pay Override Maintenance**. This box is required when **Amount #1** is \$0.00 or blank.

You must select a batch when you enter an override reason because a zero-dollar unassigned payment transaction is created.

If **Launch Quick Pay Workflow when Appointment is Acknowledged** is selected on the **Scheduling (2)** tab in **System Administrations > Practice Options** or **Organization Options**, when you click **Save**, **Transaction Date** and **Reference #1** are automatically filled with the current date and **QP Override Zero Pay**, respectively.

The override reason is also displayed on the **Payment History** tab in **Financial Inquiry**.

Batch

Batch contains a list of open payment batches that the operator has access to based on the setting of **Allow Quick Payment in Any Batch** in **System Administrations > Practice Options** or **Organization Options**.

Batches made as part of the Centralized Payment function are not included in the list.

You can create a unique payment batch for quick payments.

After you have selected the batch for your first quick payment, **Batch** defaults to that batch the next time you open **Quick Payment**.

Transaction Date

In **Transactions**, fills **Credit Date** in the credit grid on the **Payment Entry** tab and **Apply Self-Pay Payments** accessed from the summary area of the **Charge Entry** tab.

Reference #1

Required. Enter information that identifies this transaction based on the policies of your practice or organization, such as the ck #, cash, or credit card transaction.

Note: **Reference #1** enables you to enter a maximum of 50 characters.

Fills **Reference** in the credit grid on the **Payment Entry** tab in **Transactions**.

Associated Patient

The current patient is the default value.

The drop-down list contains all of the patients that are linked to the current account.

If you change the default patient, **Amount** and **Associated Provider** change to reflect the co-pay and the usual provider for the new patient selected.

When this information is added to a transaction, it guarantees that the payment is applied throughout the process as applicable.

Associated Patient is required when **Require Associated Patient on Quick Payment** is selected on the **Payment Entry** tab in **System Administrations > Practice Options** or **Organization Options**. If this option is cleared, **Associated Patient** still contains the current patient, even though selecting an associated patient is not required to save the quick payment.

Associated Appt

Enabled when **Track Encounters** is selected on the **Charge Entry** tab in **System Administrations > Practice Options** or **Organization Options**.

Lists all of the associated patient's appointments scheduled for the current day and forward.

When you enter a payment from **Registration**, **Transactions**, or **Collection Management**, click on an appointment listed in the grid; the selected appointment is highlighted in green.

When you open **Quick Payment for [patient]** from **Registration** or **Allscripts PM COMpanion - Registration**, if there are appointments in the **Associated Appt** grid, but the quick payment is not associated with one of the appointments, a message is displayed warning you that there is no association.

If you open **Quick Payment** from **Appointment Scheduling**, when you highlight an appointment, **Quick Payment** shows that appointment highlighted in the associated appointments grid. The appointment's resource automatically fills **Associated Provider** if the appointment's resource is a provider. If the resource is not associated with a provider, the associated patient's usual provider is the default selection. Clicking on the title bar in the appointments grid or pressing the space bar on your keyboard moves the focus to the title row in the grid, which invokes a validation to ensure that quick payments are associated with appointments during scheduling.

When you save the quick payment transaction with a selected transaction code, the application automatically applies the unassigned amount to the voucher associated with the appointment using that transaction code's associated payment transaction code when the charge is posted.

The **Assoc Quick Pay** column shows the total amount of the payments associated with the appointment.

Appointments are removed after midnight (12 A.M.) regardless of whether a payment was applied, but appointments created at 11 P.M. or later are retained for an additional 24 hours.

If the encounter number is used as a voucher, the appointment is immediately removed from the **Associated Appt** grid.

Associated Dept or Associated Practice

The name of this box is determined by the **Label Option** selected on the **Multi Entity** tab in **System Administrations > Practice Options** or **Organization Options**.

When **Require Associated Dept on Quick Payment** or **Require Associated Pract on Quick Payment** is selected on the **Payment Entry** tab in **System Administrations > Practice Options** or **Organization Options**, this box is required.

Note: When you are required to select an associated department or practice, an unassigned payment can only be applied (assigned) to a voucher whose department or practice is the same as what is selected for the quick payment.

When you select an associated appointment, this box is filled with the financial department or practice associated with the appointment's scheduling department or practice. If you change the default value, a message is displayed warning you that the payment is no longer associated with the appointment.

Clicking **OK** in the message box prevents the application from automatically applying the unassigned amount to the selected associated appointment's voucher when the charge is posted. Also, when you return to **Quick Payment**, the appointment is no longer selected.

Associated Location

When **Require Associated Location on Quick Payment** is selected in **System Administrations > Practice Options** or **Organization Options**, this box is required.

When you select an associated appointment, this box is filled with the financial location associated with the appointment's scheduling location. If you change the default value, a message is displayed warning you that the payment is no longer associated with the appointment.

Clicking **OK** in the message box prevents the application from automatically applying the unassigned amount to the selected associated appointment's voucher when the charge is posted. Also, when you return to **Quick Payment**, the appointment is no longer selected.

Associated Provider

In general, this box is filled with the patient's usual provider.

When you open **Quick Payment** from the **Appointment Book**, **Appointment Activity**, or **Appointment Management** tabs in **Appointment Scheduling**, and you highlight an appointment on 1 of these tabs, if the appointment's resource is a provider, this box is filled with the resource. If the resource is not associated with a provider, the associated patient's usual provider is the default selection.

If you select an associated appointment for the quick payment, the resource on the appointment fills this box. In this scenario, the resource must have an associated provider assigned in **Resource Maintenance**.

If you do not select an associated appointment for the quick payment (or if you select a blank line in the **Associated Appt** grid to disassociate an appointment from the quick payment),

the usual provider for the patient in **Registration** fills this box. If **Usual Provider** in **Registration** is blank, this box is blank as well.

If necessary, select the provider associated with the service toward which a payment is being made. Do not select a provider marked *****Inactive*****.

Amount #1

Is displayed in the **Credit** grid on the **Payment Entry** tab.

You can access **Quick Payment** from several different areas in the application. The co-pay that is displayed in **Amount #1** differs based on the window from which you accessed **Quick Payment**.

When you access **Quick Payment** from a past appointment or from the **Charge Entry**, **Payment Entry**, or **Collection Management** tabs, **Amount** is filled with the primary care provider (PCP) co-pay for the patient's active, non-expired primary medical policy. The default value changes in the following situations:

- > If both the PCP plan code and specialist plan code for the patient's active, non-expired primary medical policy have no insurance plan (shown as **(no plan)** in **Insurance** on the **Policies** tab in **Registration**), or if the patient's active, non-expired primary medical policy only has a specialist plan code, **Amount** is set to \$0.00.
- > If the patient is self-pay or has no active, non-expired primary medical policy, **Amount** is left blank.
- > If, when posting the payment, you select an associated provider whose specialty has **Specialist Co-Pay Applies** selected in **Specialty Maintenance**, **Amount #1** contains the specialist co-pay from the patient's active, non-expired primary medical policy.
 - If **Specialist Co-Pay Applies** is selected in **Specialty Maintenance** for the associated provider, but the patient's active, non-expired primary policy does not have a specialist co-pay amount, **Amount #1** continues to show the value from PCP co-pay.

When you access **Quick Payment** from **Registration**, after selecting an upcoming appointment, or by selecting an associated appointment from the **Associated Appt** grid on **Quick Payment**, the co-pay that is displayed in **Amount #1** is determined by a combination of the patient's policy, the coverage type of the appointment, and the specialty of the resource's associated provider. (The same combination determines the co-pay displayed in **Appointment Scheduling**.)

- > If the patient has an active, non-expired primary policy with the same coverage type as the appointment, the co-pay that is displayed is from that policy. Otherwise, the co-pay that is displayed is from the patient's active, non-expired primary medical policy.
- > The specialist co-pay is displayed if the provider's specialty has **Specialist Co-Pay Applies** selected in **Specialty Maintenance**. Otherwise, the PCP co-pay is displayed.

- If **Specialist Co-Pay Applies** is selected in **Specialty Maintenance** for the provider, but the patient's relevant policy does not have a specialist co-pay, the PCP co-pay is displayed.

Transaction Code#1

When **Require Transaction Code on Quick Payment** is selected in **System Administrations > Practice Options or Organization Options**, this box is required.

Lists only transaction codes with a transaction type of **Misc Debit**.

The transaction code selected for **Move to Unassigned** on the **Payment Entry** tab in **System Administrations > Practice Options or Organization Options** is excluded from the list.

Note: If you created a transaction code called `Move to Unassigned` and then elected not to use the move to unassigned function in **Payment Entry**, you should rename the code `ZZMove to Unassign` to place that code at the bottom of the list of transaction codes on **Quick Payment**, making it less likely for a user to select it.

Select a code that clearly identifies the unassigned amount as cash, check, or credit for use when the **Bank Reconciliation Report** is run.

The unassigned payment transactions are displayed along with the associated transaction code on the patient's **Payment History** as well as the viewer in **Financial Inquiry** and the **Payment Entry** tab. To view the entire entry, you must widen the column.

Note: Always select a transaction code when you associate an appointment, department, location, or provider with the quick pay payment.

If you are using integrated credit card processing:

- > When you save payments that are greater than zero using a transaction code with **Credit Card Processing** selected in **Transaction Code Maintenance**, Allscripts® Practice Management displays a message that prompts you to insert or swipe a card.
- > Only one of the transactions entered in **Quick Payment** can be a credit card transaction. If a patient wants to use two credit cards, process the first card, and then re-open **Quick Payment** to process the second card.
- > The information entered in the reference box associated with the credit card transaction is replaced with the transaction ID returned from the vendor. Information that was manually entered in that box is overwritten.
- > If an override reason is selected with a zero-dollar amount, the insert or swipe prompt is not displayed, even if the transaction code has **Credit Card Processing** selected.

Reference #2

If you have a second payment transaction, enter information that identifies that transaction.

Amount #2

If you have a second payment transaction, enter the dollar amount for that transaction. The default value for **Amount #2** is blank, not **\$0.00**.

Transaction Code #2

If you have a second payment transaction, select a transaction code for that payment.

Description

Automatically fills with the plan or co-pay amount from the primary policy on the patient's **Policies** tab.

Free-text box that you can edit.

Is displayed in the **Credit** grid on the **Payment Entry** tab. You must scroll to the right to see this column.

Can be optionally viewed in **Payment History**.

Prints on the **Batch Print & Close** report and on the **Transaction Journal**.

Co-Pay Exceptions

When co-pay exceptions exists, they are displayed in a non-editable grid. The text displayed in this grid is retrieved from **Comments on Co-Pay Exceptions**, which is opened from the **Plans** tab in **Insurance Carrier Maintenance**.

Policy

Informational only. Displays the policy name whose co-pay is displayed in **Amount**. This information comes from the policy's associated insurance carrier and is retrieved from the **Policy** tab in **Registration**.

Coverage Type

Informational only. Display the coverage type of the policy whose co-pay is displayed in **Amount**. This information comes from the policy's associated insurance carrier and is retrieved from the **Policy** tab in **Registration**.

Visit Type

Informational only. When **Enable Visit Type** is selected on the **Visit Type** tab in **System Administrations > Practice Options** or **Organization Options**, the visit type for the selected appointment is displayed; otherwise, **Visit Type** is not displayed.

Benefit Plan

Informational only. If the policy for the selected appointment is associated with a benefit plan, the benefit plan name is displayed.

Benefit covered services grid

Informational only. If the policy for the selected appointment is associated with a benefit plan, a read-only benefit covered services grid is displayed with the benefit covered services and benefit tiers defined for the policy. The information is retrieved from either **Employer Maintenance** or **Insurance Carrier Maintenance**, depending on whether the policy is linked to an employer.

Every benefit covered service in the benefit covered services grid has a benefit tier row for each benefit tier in the benefit plan, as well as an out-of-network row.

When an appointment is selected in the grid, the application uses predefined decision logic to determine the benefit covered service that best matches the appointment attributes. That benefit covered service and associated benefit tiers are displayed in the benefit covered services grid. To determine the copayment or coinsurance yourself, select **View All Benefit Covered Services** to view all the benefit tiers for all the benefit covered services included in the patient's benefit plan. **View All Benefit Covered Services** is cleared and unavailable if the patient has no associated appointments or you have not selected an associated appointment in the **Associated Appt** grid.

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.

The benefit covered services that apply (in-network or out-of-network) are selected and bolded, based on the appointment attributes and the network status on the **Network Info** tab in either **Provider Maintenance** or **Referring Doctor Maintenance** for the associated provider.

If the application cannot determine the network status, both in-network and out-of-network information is bolded.

When you select a row in the benefit covered services grid, if a referral is not required, **Amount #1** is filled automatically with the no-referral amount for that benefit covered service; otherwise, **Amount #1** is **\$0.00**.



Chapter 6 Transaction Posting

Chapter 7

Insurance Processing

Validate Claims tab

Validate claims to apply various generic and user-defined validations on claims data to ensure billing integrity. Claims with errors are excluded from claims processing until they are corrected and re-validated.

Note: If you are using claim edit integration, the verify claims process also runs when you validate claims.

Stored Job

Lists saved search criteria. Save your search criteria by clicking **Store**.

Select Media Type

Allows you to validate claims for both electronic and paper claims at the same time, or separately.

> All v4010 Electronic and Paper Formats

Disabled when even one format (paper or electronic) is flagged for Test Billing.

Validates both electronic claims with a v4010 format type only and paper claims.

Claims generated using a v5010 format type do not qualify.

This is the default setting - to validate both v4010 electronic and paper claims you need not do anything.

> v4010 Electronic Format

Validates claims marked for electronic billing.

Tab or click  to select this option.

> v5010 Electronic Format

Validates claims marked for electronic billing.

Tab or click  to select this option.

> Paper Format

Validates claims held from electronic billing or whose associated Carrier does not have a selected Electronic Claim style.

Tab or click  to select this option.

Select Formats

Disabled default to **All Formats** when the media type **All Electronic and Paper Formats** is selected.

> **All Formats**

Validates all claims associated to the selected media type.

> **Selected Format Type**

Validates all claims with the selected format type that are associated to the selected media type such as either Paper Format or Electronic Format. The contents of the pick list is determined by the media type selected.

Click  to select **Selected Format Type**. Click  to open the drop-down list. Use the scroll bar if necessary, then click an item to populate the field.

> **Selected Format**

Validates all claims with the selected format that are associated to the selected media type, i.e. either Paper Format or Electronic Format. The contents of the pick list is determined by the media type selected.

Click  to select **Selected Format**. Click  to open the drop-down list. Use the scroll bar if necessary, then click an item to populate the field.

Select Actual Providers

Allows you to validate claims associated with one or more specific Actual Providers.

1. To select one or more specific Actual Providers, click  or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.
2. To select only one Provider, click the name of the Provider.
3. To select more than one provider, hold down the **Ctrl** key, point and click the name of a Provider; then while continuing to hold **Ctrl** click names until you are finished selecting.
4. Click **OK** to return to the main report screen.

Select Billing Providers

Allows you to validate claims associated with one or more specific Billing Providers.

1. To select one or more specific Billing Providers, click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.
2. To select only one Provider, click the name of the Provider.
3. To select more than one provider, hold down the **Ctrl** key, point and click the name of a Provider; then while continuing to hold **Ctrl** click names until you are finished selecting.
4. Click **OK** to return to the main report screen.

Select Departments

Allows you to validate claims associated with one or more selected Departments/Practices.

1. To select one or more specific Departments/Practices, click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.
2. To select only one Department, click the name of the Department.
3. To select more than one Department, hold down the **Ctrl** key, point and click the name of a Department; then while continuing to hold **Ctrl** click names until you are finished selecting.
4. Click **OK** to return to the main report screen.

Note: If you have divisions enabled, regardless of the label option that is selected, a Division tab also appears on **Select Departments** or **Select Practices** that allows you to filter on Divisions.

Select Insurance Carriers

Allows you to validate claims associated with one or more specific categories, reporting classes, group, or specific carriers.

Please note that selecting a range of carriers is not an option on this Select Insurance Carriers window.

Select Locations

Allows you to validate claims associated to one or more specific Locations.

1. To select one or more specific Locations, click or position the cursor in the field, and then press **Alt+down arrow** to open the window.
2. To select only one Location, click the name of the Location.
3. To select more than one Location, hold down the **Ctrl** key, point and click the name of a Location; then while continuing to hold **Ctrl** click names until you are finished selecting.
4. Click **OK** to return to the main report screen.

Sort Claims By

If left blank and you select the option **Print Totals Only**, "Batch Number" auto fills this field.

The available Sort Claims By options are:

- > Batch Number
- > Department/Practice
- > Location
- > Provider

To make a selection, click  to open the drop-down list. Then click the name of an item to populate the field.:.

Exclude Non-Credentialed Providers

Check this option when you want vouchers that fail validation for Credentialing for Billing Provider Required to be excluded from the Claims Validation list.

If a voucher fails validation for multiple reasons, one of which is Credentialing for Billing Provider Required, the voucher does not print on the Claims Validation List.

Note: When you check this option and export the Claims Validation List, the export file does not exclude the vouchers that failed validation for Credentialing from Billing Provider Required.

This check box is a "sticky setting," meaning each time you open Validate Claims the check box defaults to how you had it set (checked or unchecked) the last time you ran Validate Claims on this workstation.

Important: Checking this box does not prevent the vouchers from appearing in Pending Claims Management or Validate Batches. Vouchers that fail validation for Credentialing from Billing Provider Required still appear as failed vouchers in Pending Claims Management, Validate Batches, and Office Manager/Pending Claims Management.

Hold Vouchers with Errors

Gives all vouchers that do not pass validation the voucher hold status of "All Insurance Billing."

Check this option when you want to hold Vouchers that fail validation from qualifying the validation process again.

For example, when a new Provider has not yet been assigned billing numbers from one or more Carriers. The missing Provider billing number causes vouchers to fail validation until the appropriate billing number is entered in Provider Maintenance. Checking this option and the option to print a validation list allows for the following:

Charges are entered and updated without your having to manually "hold" each voucher from billing.

Vouchers that failed the validation process no longer continue to qualify for validation.

Be sure to check the option to **Print Validation List**, so that you have a listing of vouchers that need to be manually released from the hold status.

Print Claims Validation List

Prints the Claims Validation List.

Checked by program default.

Must be checked to enable the option **Print Totals Only**.

Print Totals Only

Prints only the Totals Summary section of the Claims Validation List.

Disabled when **Print Claims Validation List** is not checked.

When selected if the Sort By field is blank then the system auto fills the field with the sort by option **Batch Number**.

Store

Enables you to create a stored job with the criteria you selected.

Run

Click to open the standard Allscripts® Practice Management **Print** window, and then click **Print** to begin the validation process.

Prepare electronic claims with manual billing

The Prepare Electronic Claims process creates a `.txt` file that you send to your payer or clearing house. A backup file (`.bak`) is also created.

1. Go to **Prepare Electronic Claims**.

- > Press **F9**, enter **IBI**, then select **Prepare Electronic Claims**.
- > Go to **Billing > Insurance Billing > Prepare Electronic Claims**.

2. (Optional) Select **Preliminary List Only**.

This step generates a list of the claims that are included in the file. A billing date is not stamped on the claims.

Important: When running the final prepare eliminate this step.

3. (Optional) To select all the formats in the grid, select **All Electronic Formats**.

All Electronic Formats is disabled when a format in the grid is flagged as **Test** or is a Uniform Billing Format. The Uniform Billing Format must be prepared separately.

To select formats from the grid, press **Ctrl** while selecting the name of each format you want.

4. At **Billing Date**, verify or change the date.

This date should correspond to the date you transmit the file.

5. (Optional) At **Select Actual Providers**, select or position the cursor in the field, then press **Alt+down arrow**.

The **Providers** window opens. Select providers to restrict the prepare to those claims that have a servicing provider who is one of the selected providers.

6. Select **OK** to return to the main screen.

7. (Optional) At **Select Billing Providers**, select or position the cursor in the field, then press **Alt+down arrow**.

The **Providers** window opens. Select providers to restrict the prepare to those claims that have a billing provider who is one of the selected providers.

8. Select **OK** to return to the main screen.

9. (Optional) At **Select Departments** or **Select Practices**, select or position the cursor in the field, then press **Alt+down arrow**.

The **Departments** or **Practices** window opens. Select departments or practices to restrict the prepare to those claims that have a department or practice which is one of the selected departments or practices.

10. Select **OK** to return to the main screen.

Note: When **Enable Division**, is selected on the **Multi-Entity** tab on **Practice Options** or **Organization Options**, a **Division** tab is included which enables you to filter by division.

11. (Optional) At **Select Insurance Carriers**, click or position the cursor in the field, and then press **Alt+down arrow**.

A window opens with a series of tabs, **Categories**, **Reporting Classes**, **Groups**, and **Carriers**.

Restricts the prepare to those claims that have a policy associated to the selected carrier, category, reporting class or group.

12. (Optional) At **Select Locations**, click or position the cursor in the field, then press **Alt+down arrow**.

The **Locations** window opens. Select locations to restrict the prepare to those claims that have a location which is one of the selected locations.

13. Select **OK** to return to the main screen.

14. (Optional) At **Analyze By**, select the sorting method for the break down of the claims in the file.

15. (Optional) Select **Analyze (Alt+z)**.

When complete the detail displays in the grid for your review.

16. Select **Run (Alt+r)**.

17. At the prompt XXXXXX: Output File XXXXX.txt already exists. Overwrite?, review the names of the files that are to be overwritten.

- > To overwrite the files and proceed with the prepare process, select **OK**, then continue with step 18.
- > To end the process at this point, select **Cancel**.

This returns you to the main screen. You must change the file name in Electronic Claim Format Maintenance and then return to **Prepare Electronic Claims**.

18. When the print window opens, click **Print (Alt+p)**.

The Preliminary Listing is printed.

19. Review the Listing.

20. Return to **Insurance Billing > Prepare Electronic Claims**.

21. Run a final prepare eliminating step 1.

When the billing process is complete a list of the prepared claims is generated and a claim file and a backup file are created.

What to do next

Be sure to release the job on the **Job Status** window and close the window.

Print paper claims

All vouchers which have passed validation qualify for either electronic or paper billing. Use **Print Paper Claims** to batch print your paper claims.

Print Formats with Alternate Report Names

When a paper claim format has an alternate report name, you must use **Report Name** to bill the related claims.

Always begin by printing those claims associated with alternate paper claim billing, then continue to print all other claims.

Run a Print Test and Adjust the Alignment

Always print a test sheet before running the entire job.

The alignment dialog displays when you click **Print (Alt+p)**.

There are two spin box fields which allow you to adjust the top and/or the left margins.

Tip: Increasing or decreasing the setting by 50 is roughly equivalent to moving the text about an eighth (1/8) of an inch.

Enter a number or use the **up arrow** to increase the number, the **down arrow** decreases the number.

Adjust the Top Margin

To move the printing down, increase the number.

To move the printing up, decrease the number.

Adjust the Left Margin

By changing the left margin, you can move the text to the left or the right.

To move the text more to the left, decrease the number.

To move the text more to the right, increase the number.

1. Open the Print Paper Claims screen using one of the following methods:

- > Use the Access Code: **F9** > Type "IBI" > Click Print Paper Claims tab
- > Use the Navigation Pane: Double-click **Billing** > Click **Insurance Billing** > Click Print Paper Claims tab

2. Select one of the following Run Types

3. New Forms (Default) - Prints all newly pending claims.

4. Restart after Claim - To resume printing as of a specified claim: Type in the claim number of the last claim which printed correctly, **Tab** (Click ).

Printing resumes with the next claim.

To reprint entire batch: Leave this field blank.

The bill date entered determines which claims are reprinted.

5. Selected Vouchers - Click  (**Tab** then **Shift+down arrow**)

6. Click  to select one of the following:

- > Item - allows to specify voucher numbers
- > Range - allows you to specify a range of voucher numbers

Note: If you enter a voucher number on this window, that voucher is included in the paper claim regardless of whether it is updated, has failed paper validation, or is on hold from insurance billing.

7. Click **OK** to return to the main screen

When you use this Run Type, **Select Actual Providers**, **Select Billing Providers**, **Select Departments**, and **Select Insurance Carriers** are all inactive. **Sort Claims By** is also inactive.

8. Verify the Billing Date or enter a new date using the format mmddyyyy, and then press **Enter**.

9. Click  to select one of the following Format Types:

- > CA CHDP Assessment Claim Form
- > Dental Claim Form
- > Generic Medical Claim Form
- > ICD10 Generic Medical Claim Form
- > NY Workers' Comp Claim Form - selecting this changes the Field Label below to **Report Name**
- > Uniform Billing Claim Form

10. At **Report Name/Paper Claim Format**, click  to select the report name/paper claim format.

11. To change the field label, do one of the following:

- > Position the cursor in the field then press  or 
- > Click  or  to toggle the label name to **Paper Claim Format**.

When a paper claim format has an alternate report name, you must use **Report Name** to bill the related claims. Always begin by printing those claims associated with alternate paper claim billing, then continue to print all other claims.

12. When running for selected vouchers, be sure to match the Format Type correctly.

Note: When the Format Type selected above is "NY Workers' Comp Claim Form," the field label changes to **Report Name**. For NY Worker's Comp forms, you must click the down arrow to the right of Report Name and select the appropriate Crystal Report from the Report Name drop-down list.

13. At **Select Actual Providers**, do the following to select one or more specific Actual Providers:

Click  or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.

14. To select only one Provider, click the Provider.

15. To select more than one Provider, hold down the **Ctrl** key, point and click a Provider, and then while continuing to hold **Ctrl**, click other Providers until you are finished selecting.

16. Click **OK** to return to the main report screen.

Note: This field is inactive when printing selected vouchers.

17. At **Select Billing Providers**, do the following to select one or more specific Billing Providers:

Click  or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.

18. To select only one Provider, click the Provider.

19. To select more than one Provider, hold down the **Ctrl** key, point and click a Provider, and then while continuing to hold **Ctrl**, click other Providers until you are finished selecting.

20. Click **OK** to return to the main report screen.

|| **Note:** This field is inactive when printing selected vouchers.

21. At **Select Departments/Practices**, do the following to select one or more specific Departments/Practices: Click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.
22. To select only one Department, click the Department/Practice.
23. To select more than one Department/Practice, hold down the **Ctrl** key, point and click the Department/Practice, and then while continuing to hold **Ctrl**, click other Departments/Practices until you are finished selecting.
24. Click **OK** to return to the main screen.

|| **Note:** When **Enable Division** is select on the **Multi-Entity** tab in **Practice Options** or **Organization Options**, regardless of the label option that is selected, a Division tab also appears on the Select Departments/Practices dialog that allows you to filter on Divisions.

|| **Note:** This field is inactive when printing selected vouchers.

25. At **Select Insurance Carriers**, click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.

This dialog allows you to validate claims associated with one or more specific categories, reporting classes, groups, or specific carriers.

Please note that selecting a range of carriers is not an option on this Select Insurance Carriers dialog.

|| **Note:** This field is inactive when printing selected vouchers.

26. At **Select Locations**, do the following to select one or more specific Locations: Click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.
27. To select only one Location, click the Location.
28. To select more than one Location, hold down the **Ctrl** key, point and click a Location, and then while continuing to hold **Ctrl**, click other Locations until you are finished selecting.
29. Click **OK** to return to the main report screen.

|| **Note:** This field is inactive when printing selected vouchers.

30. Click then click one of the following to select which claims are included in the print run.
 - > All Claims
 - > Billed as Primary/Other
 - > Billed as Secondary/Tertiary

31. Click then click one of the following to select how claims are to be sorted

- > Carrier Name
- > Patient Name
- > Voucher Number

|| **Note:** This field is inactive when printing selected vouchers.

32. Click **Run (Alt+r)**.

33. Make the appropriate selections on the dialog, then click **Print**.

34. On the alignment dialog, set the margins, then click **Test**.

35. Review the test print out.

36. Test as often as is necessary.

37. To adjust a margin enter a number. The up arrow increases the number while the down arrow decreases the number.

38. When satisfied, click **OK** the Alignment dialog which remains open during this process.

|| **Note:** When the process is complete, all printed claims have a bill date.

This bill date can be viewed on the appropriate screens in Financial Inquiry and Payment Entry.

A summary list does not print.



Chapter 7 Insurance Processing

Chapter 8

Patient Billing

Statement tab

Use the **Statement** tab to define settings and criteria used when you generate patient statements.

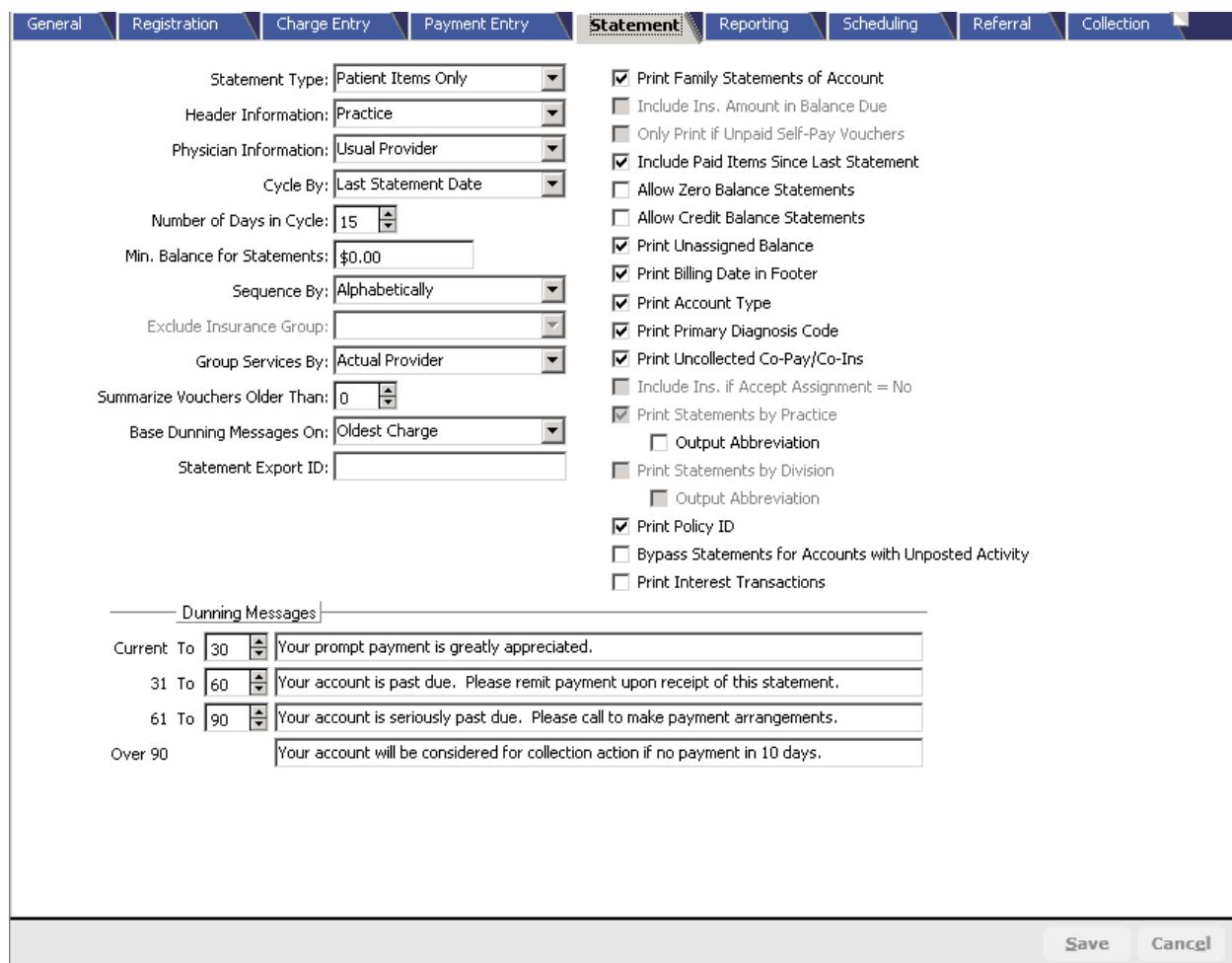
Give some thought to the following:

- > Do you intend to use iBill™?
- > How often do you currently generate patient statements? (weekly? monthly?)
- > 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:

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.

Print Options:

- 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

Buttons: 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
	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.

Print statements using the New Forms Run Type option

The **New Forms** Run Type option on the Print Statement tab in Statement Processing allows you to generate a new run of paper statements that qualify for printing based on the Cycle By option selected on the Statement tab in Practice/Organization Options.

1. Open the Statement Processing tab using one of the following methods:
 - > Using the Access Code: **F9>Type SPR > Enter**
 - > Using the Navigation Pane: Double-click **Billing** > Click **Statement Processing**
2. For **Run Type**, select **New Forms**.
3. For **Output Format**, type **p** or click the drop-down arrow, and then select **Preprinted Form**.

4. For **Billing Date**, do one of the following:

- > To change the billing date, enter a date using the format mm/dd/yyyy.
- > To accept the default date, **Tab** through the field.

5. For **Select Departments/Practices**, do one of the following:

- > To restrict your statement run to one or more Departments/Practices, click  or position the cursor in the field, and then press **Alt+down arrow** to open the dialog. Now, select the appropriate Departments/Practices.
- > To accept the default, which is to print statements for all Departments/Practices, skip this field.

6. For **Select Locations**, do one of the following:

- > To restrict your statement run to one or more Locations, click  or position the cursor in the field, and then press **Alt+down arrow** to open the dialog. Now, select the appropriate Locations.
- > To accept the default, which is to print statements for all Locations, skip this field.

7. For **Select Providers**, do one of the following:

- > To restrict your statement run to one or more Providers, click  or position the cursor in the field, and then press **Alt+down arrow** to open the dialog. Now, select the appropriate Providers.
- > To accept the default, which is to print statements for all Providers, skip this field.

8. For **Select Accounts**, do one of the following to print a statement for one or more selected Patients.

- > Click  or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.
- > To accept the default, which is to print statements for all Accounts, skip this field.

Printing a statement for a selected Patient or Account prints a statement for with the self-pay balance activity that is current as of the time you run the statement. To print or view a statement for a specific Patient or Account that reflects the activity recorded on the statement when it was originally run, use the view Statement History function in the Account Ledger.

9. For **Rebill if Printed After**, DO NOT change this default.

The default date is relative to the billing date base on the number entered for **Number of Days in Cycle** on the Statement tab in Practice/Organization Options. This field is enabled only when **Cycle By** on the Statement tab in Practice/Organization Options is set to **Last Statement Date**.

- 10.** For **Guarantor First Letters From**, enter the first letter of the last name of the Accounts from which you want to start billing.

Enabled only when **Cycle By** on the Statement tab in Practice/Organization Options is set to **Guarantor Last Name**.

- 11.** For **Guarantor First Letters To**, enter the first letter of the last name of those Accounts up to and including those you want to bill.

For example, **From "A" To "G"** runs statements for qualifying accounts whose last names begin with A up to and including those whose last names begin with G.

Enabled only when **Cycle By** on the Statement tab in Practice/Organization Options is set to **Guarantor Last Name**.

- 12.** For **General Message**, enter a free text message to be printed in the upper right hand portion of the statement.

The text entered in this grid only prints for the current run of statements.

- 13.** Click **Run** to open the Print dialog.

- 14.** Review the selections on the Print dialog.

- 15.** Click **Print**.

Job Status appears. During the process, the Exporting Records dialog appears to indicate that the statement history backup file is being created. This file is used by the system when you view an Account's statement history using the Account Ledger. Do not cancel the process.

- 16.** When the Job Status is complete, click **Release**.

- 17.** Click  to close the window.

Specify account numbers by item on the Select Accounts dialog

Use the Select Accounts dialog to select specific account numbers by item.

- 1.** On the Select Accounts dialog, in the **Item/Rang** column on the appropriate row, type **i** or click the drop-down arrow and select **Item**.
- 2.** In the **Account** column on the appropriate row, and then enter the Account Number.
- 3.** To search for a Guarantor, click  to open the Guarantor Lookup dialog and select a Guarantor.
- 4.** Repeat these steps until you have entered each Account.
- 5.** Click **OK**.

The Select Accounts dialog closes and you are returned to the screen from which you accessed Select Accounts.

Specify account numbers by range on the Select Accounts dialog

Use the Select Accounts dialog to select specific account numbers by range.

1. On the Select Accounts dialog, in the **Item/Rang** column on the appropriate row, type `r` or click the drop-down arrow and select **Range**.
2. In the **Range From** column, then enter the first Account Number in the range.
3. In the **Range To** column, enter the last Account Number in the range.
4. Repeat these steps until you have entered each range of Account Numbers as needed.
5. Click **OK**.

The Select Accounts dialog closes and you are returned to the screen from which you accessed Select Accounts.

Restart Statements

Use the **Restart after Account** Run Type option on the **Print Statements** tab to regenerate an entire statement run, restart statements after a specified account, or reprint a run for statements with a past billing date.

1. Open the **Print Statements** tab by doing one of the following:
 - > Using the Access Code: F9 >Type SPR > Enter
 - > Using the Navigation Pane: Double-click **Billing** > Click **Statement Processing**
2. For **Run Type**, select **Restart after Account**.
 - > To regenerate an entire statement run, leave this field blank.
 - > To restart by account number, enter the account number.
 - > To restart by Guarantor name, press **Alt+down arrow** or click , and then search for a Guarantor.
3. For **Output Format**, click the drop-down arrow to open the drop-down list, and then select one of these options:
 - > Generic Export File
 - > Preprinted Form
4. For **Billing Date**, do one of the following:
 - > To change the billing date, enter a date using the format mm/dd/yyyy.

- > To accept the default date, **Tab** through the field.

5. For Select Departments/Practices, do one of the following:

- > To restrict your statement run to one or more Departments/Practices, click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog. Now, select the appropriate Departments/Practices.
- > To accept the default, which is to print statements for all Departments/Practices, skip this field.

When printing by selected Departments/Practices, it is recommended that you check **Print Statements by Department/Practice** on the Statement tab in Practice/Organization Options. This allows you to run statements for one or more Department at a time without requiring a restart. If the Practice/Organization Option is not checked and you run statements by last statement day, you must then process statements for each of your Departments/Practices on the same day. Subsequent to the first run, the **Run Type** must be set to **Restart after Account**.

6. For Select Locations, do one of the following:

- > To restrict your statement run to one or more Locations, click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog. Now, select the appropriate Locations.
- > To accept the default, which is to print statements for all Locations, skip this field.

When cycling statements by statement date, billing must be done for all of your Locations, Providers, and Accounts on the same day and requires a restart.

7. For Select Providers, do one of the following:

- > To restrict your statement run to one or more Providers, click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog. Now, select the appropriate Providers.
- > To accept the default, which is to print statements for all Providers, skip this field.

When cycling statements by statement date, billing must be done for all of your Locations, Providers, and Accounts on the same day and requires a restart.

8. For Select Accounts, do one of the following to print a statement for one or more selected Patients.

- > Click or position the cursor in the field, and then press **Alt+down arrow** to open the dialog.
- > To accept the default, which is to print statements for all Accounts, skip this field.

Printing a statement for a selected Patient or Account prints a statement for with the self-pay balance activity that is current as of the time you run the statement. To print or view a statement

for a specific Patient or Account that reflects the activity recorded on the statement when it was originally run, use the view Statement History function in the Account Ledger.

Note: When printing by selected account, hold statement flags set for the account are ignored.

9. For **Rebill if Printed After**, DO NOT change this default.

The default date is relative to the billing date base on the number entered for **Number of Days in Cycle** on the Statement tab in Practice/Organization Options.

10. For **Guarantor First Letters From**, enter the first letter of the last name of the Accounts from which you want to start billing.

11. For **Guarantor First Letters To**, enter the first letter of the last name of those Accounts up to and including those you want to bill.

For example, **From "A" To "G"** runs statements for qualifying accounts whose last names begin with A up to and including those whose last names begin with G.

12. For **General Message**, enter a free text message to be printed in the upper right hand portion of the statement.

The text entered in this grid only prints for the current run of statements.

13. Click **Run** to open the print dialog.

14. Review the selections on the dialog.

Note: If you selected **Generic Export File** as the **Output Format**, see "Prepare a Statement Export File" for the final steps in this process.

15. Click **Print**.

The Job Status window opens.

During the process, the Exporting Records dialog displays while the application creates the statement history backup file. The application uses this file when you view an Account's statement history using the Account Ledger. DO NOT cancel the process.

16. When the Job Status is complete, click **Release**.

17. Click  to close the window.

Print a statement audit list

You can print a statement audit list for all statements run or for only those statements bypassed on specified billing dates.

1. To access the **Statement Audit List** tab, do one of the following:

> Press **F9** and then enter **SPR**. Click **Statement Audit List** tab.

- > Go to **Billing > Statement Processing > Statement Audit List.**
2. (Optional) To use previously saved search criteria, select the saved search criteria to use for **Stored Job**.
3. Next to **Report Preferences**, click .
- Note:** Opening **Report Preferences** is required, even if you accept the default settings, unless you selected a stored job.
- Report Preferences** opens.
4. (Optional) For **Available Group Fields**, double-click the categories to group the report by. **Department** and, if enabled, **Division** are available grouping options for the report. The categories you select move to **Level of Detail**.
5. For **Level of Detail**, choose how much detail to display on the report. Click the minus sign (-) next to a category to collapse all the categories below it. Click the plus sign (+) next to a category to expand it.
- Tip:** To move a category out of the report, select the category in **Level of Detail** and click the left arrow in the middle of the window to move the category back to **Available Group Fields**.
- The default sort is patient last name within statement date.
6. For **Select Options**, select one of these options:
- > **All Statements (Default)** - Prints a listing of all the statements for a specified billing date range. This includes those statements which were bypassed.
- > **Bypassed Statements Only** - Prints a listing of bypassed statements from a specified billing date range.
7. For **Billing Date - From: To**, enter a date range using the format mmddyyyy. The default is the last billing date on which statements ran.
8. For **Select Accounts**, accept the default for **All Accounts**, unless you have a reason to run the listing for selected accounts.
9. For **Select Departments**, accept the default for **All Departments**, unless you have a reason to run the listing for selected departments or, if enabled, divisions.
- When **Enable Division** is selected on the **Multi-Entity** tab in **Practice Options** or **Organization Options**, **Select Departments** is displayed with 2 tabs labeled **Divisions** and **Departments**; otherwise, only the **Departments** tab is displayed.
- Because divisions are directly associated with departments and not the statement history, when you make a division-to-department relationship change, that change is reflected the next time you generate the audit list.
10. Click **Run** (or press **Alt + r**) to open **Print**.

11. On **Print**, select 1 of the following:

- > Print
- > Preview
- > Export

Statement Audit List report

The **Statement Audit List** report shows all statements run during a specified range of billing dates (including bypassed statements) or only those bypassed statements from a specified range of billing dates.

Detail printed on the Statement Audit List report

The **Statement Audit List** contains the following information:

- > Statement Date
- > Account # and Name
- > Amount Due (not included for bypassed statements)
- > Dunning Level (not included for bypassed statements)
- > Comments (included only for bypassed statements) - These are system generated comments that indicate the reason for a statements being bypassed.
 - Bypassed - Account Type
 - Bypassed - Note Type
 - Bypassed - Held Until Date (set in Account Management)
 - Bypassed - Credit Balance
 - Bypassed - Below Minimum Balance
 - Bypassed - Unposted Activity
 - Total due for statements printed/exported
 - Total due for statements bypassed due to having a credit balance
 - Total due for all statements bypassed for other reasons, which are Account Type, Note Type, Held Until Date, Below Minimum Balance, and Unposted Activity

Note: The total for Unassigned statements is not currently calculated.

When you run a listing for a range of dates, the application groups and totals each billing date separately. The list of Account sorts based on the **Sequence By** option selected on the Statement tab in Practice/Organization Options.

Samples of the Statement Audit List report

The following sample of the **Statement Audit List** shows how the application totals statements for billing dates separately. That is, there are totals for billing dates of 02/15/2010 and 03/03/2010.

7/1/2011 1:25:07PM

Statement Audit List

Physicians Associated

Page: 1

Statement Date	Account # & Name	Amount Due	Dunning Lvl	Comments
02/15/2010		40.00	1	Bypassed - Account Type
02/15/2010				Bypassed - Below Minimum Balance
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Below Minimum Balance
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
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02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Below Minimum Balance
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Account Type
02/15/2010				Bypassed - Below Minimum Balance
02/15/2010				Bypassed - Below Minimum Balance
<hr/>				
Total Statements Due:				
Total Unassigned Statements:				
Bypassed Due to Credit Balance:				
Bypassed Due to Other Reasons:				
<hr/>				
03/03/2010		50.00	1	
03/03/2010		305.00	1	
03/03/2010		305.00	1	
03/03/2010		32.28	1	
03/03/2010		31.00	1	
03/03/2010		39.50	1	
03/03/2010		39.50	1	
03/03/2010		39.50	1	
<hr/>				
Total Statements Due:				
Total Unassigned Statements:				
Bypassed Due to Credit Balance:				
Bypassed Due to Other Reasons:				

The following sample of the **Statement Audit List** shows the report grouped by department.

6/12/2013 12:45:48PM		Statement Audit List * Clinical Associates			Page: 1
Statement Date	Account # & Name	Amount Due	Dunning Lvl	Comments	
Department: DEPT A					
08/08/2012		100.00	4		
08/08/2012				Bypassed - Credit Balance	
08/08/2012		175.00	4		
08/08/2012		175.00	4		
Totals for: Department DEPT A					
	Total Statements Due:	4	450.00		
	Total Unassigned Statements:	0	0.00		
	Bypassed Due to Credit Balance:	1	-0.97		
	Bypassed Due to Other Reasons:	0	0.00		
Department: DEPT B					
08/08/2012				Bypassed - Account Type	
08/08/2012				Bypassed - Credit Balance	
08/08/2012		10.00	1		
08/08/2012		10.00	1		
Totals for: Department DEPT B					
	Total Statements Due:	4	20.00		
	Total Unassigned Statements:	0	0.00		
	Bypassed Due to Credit Balance:	1	-5.00		
	Bypassed Due to Other Reasons:	1	10.00		
Department: DEPT C					
08/08/2012				Bypassed - Account Type	
08/08/2012		20.00	4		
08/08/2012		10.00	4		
08/08/2012		30.00	4		
Totals for: Department DEPT C					
	Total Statements Due:	4	60.00		
	Total Unassigned Statements:	0	0.00		
	Bypassed Due to Credit Balance:	0	0.00		
	Bypassed Due to Other Reasons:	1	10.00		
Grand Total					
	Total Statements Due:	12	530.00		
	Total Unassigned Statements:	0	0.00		
	Bypassed Due to Credit Balance:	2	-5.97		
	Bypassed Due to Other Reasons:	2	20.00		

The following sample of the **Statement Audit List** shows the report grouped by division. **Enable Division** on the **Multi-Entity** tab in **Practice Options** or **Organization Options** must be selected to group the report by division. Because divisions are directly associated with departments and not the statement history, when you make a division-to-department relationship change, that change is reflected the next time you generate the audit list.

Chapter 8 Patient Billing

Statement Audit List *Clinical Associates					Page: 1
Statement Date	Account # & Name	Amount Due	Dunning Lvl	Comments	
Division: DIV A					
08/08/2012		100.00	4	Bypassed - Credit Balance	
08/08/2012					
08/08/2012		175.00	4		
08/08/2012		175.00	4		
Totals for: Division DIV A					
Total Statements Due:	4	450.00			
Total Unassigned Statements:	0	0.00			
Bypassed Due to Credit Balance:	1	-0.97			
Bypassed Due to Other Reasons:	0	0.00			
Division: DIV B					
08/08/2012				Bypassed - Account Type	
08/08/2012				Bypassed - Credit Balance	
08/08/2012		10.00	1		
08/08/2012		10.00	1		
Totals for: Division DIV B					
Total Statements Due:	4	20.00			
Total Unassigned Statements:	0	0.00			
Bypassed Due to Credit Balance:	1	-5.00			
Bypassed Due to Other Reasons:	1	10.00			
Division: DIV C					
08/08/2012				Bypassed - Account Type	
08/08/2012		20.00	4		
08/08/2012		10.00	4		
08/08/2012		30.00	4		
Totals for: Division DIV C					
Total Statements Due:	4	60.00			
Total Unassigned Statements:	0	0.00			
Bypassed Due to Credit Balance:	0	0.00			
Bypassed Due to Other Reasons:	1	10.00			
Grand Total					
Total Statements Due:	12	530.00			
Total Unassigned Statements:	0	0.00			
Bypassed Due to Credit Balance:	2	-5.97			
Bypassed Due to Other Reasons:	2	20.00			

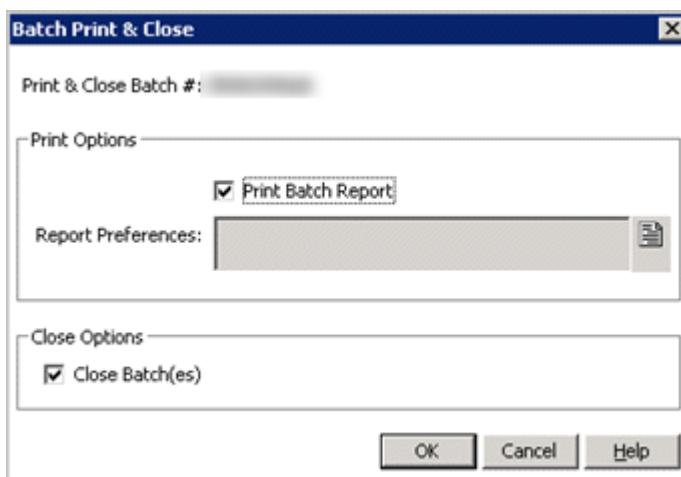
Chapter 9

Close of Day Processes

Print and Close Batches

Batches are closed from the Batch Management screen under Transactions using the Batch Print & Close dialog.

1. Use one of the following methods:
 - > Use the Access Code: **F9** > Type "TRA" > **Enter**
 - > Using the Navigation Pane: Double-click **Financial Processing** > click **Transactions**
2. On the Batch Management screen, select the batch or batches in the upper grid by clicking on a batch line.
3. To select batches that are listed consecutively in the grid, hold down the **Shift** key while you click on the first line then on the last line of the list of batches you want to close.
4. To select batches that are not listed consecutively in the grid, hold down the **Ctrl** key while you click on each line of the batches you want to close.
5. Click **Print & Close (Alt+p)** to open the dialog.



6. On the Batch Print & Close dialog, do one of the following:
 - > Uncheck **Close Batch(es)** to print a preliminary batch report. The batch or batches remain open. This option is checked by default.

- > Uncheck **Print Batch Report** to close the selected batches without printing a report. The batch or batches are closed but a report does not print. This option is checked by default.

Note: You must select Report Preferences when this option is checked.

7. Accept the default settings to print a final batch report and close all selected batches.

Tip: It is recommended that you run a preliminary report before you close any batch. This allows you to review your entries and make any necessary corrections.

8. Click  to open the Report Preferences dialog.

This dialog must be open even if you intend to use the program defaults.

See Understanding the Report Preferences for more information on the report preferences for the Batch Print & Close.

9. Click **OK** to close the Report Preferences dialog.

10. Click **OK** to close the Batch Print & Close dialog and open the Print dialog.

11. Click **Print**.

Printing and closing batches

All transactions are placed in batches. Different transaction types, such as charges, payments and adjustments, and voids, may be placed in separate batches. You can print reports that list the transactions placed in each batch. Batch Print & Close provides a list of transactions placed in each batch. This report can be printed, previewed, or exported to Microsoft® Excel in a standard CSV format.

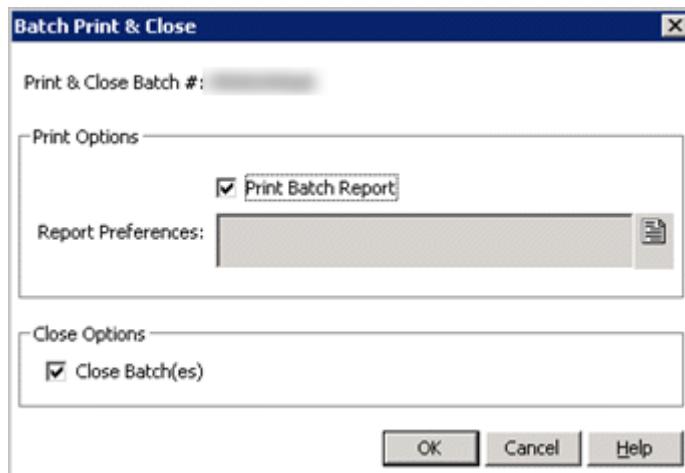
Always print and close, or update, void batches separately and before you close or update any related charge or payment batches. Charge and payment batches may be printed and closed at the same time.

To get to **Batch Print & Close**, you must first select the batch you want to print or close (or both) from the list near the top of the window, and then click **Print & Close** on the **Batch Management** tab.

Batch Print & Close window

Batch Print & Close enables you to print the batch report, to close the batches, and to select the report preferences used when the Batch Print & Close prints.

Figure 3: Batch Print & Close window



Controls on this window

This tab also includes **OK**, **Cancel**, and **Help** buttons.

Print & Close Batch

Displays the **Batch #** selected on the **Batch Management** tab.

Print Batch Report

When selected, a report will print for the batches selected.

You must select **Report Preferences** when this option is selected.

Report Preferences

Select report preferences as desired and click **OK**.

Selections display on the main report screen in **Report Preferences**.

The following options are available:

- > **Available Group Fields** — Highlighting and moving fields from left to right determines the print output of the report. The program default is to group all detail by batch number. This enables you to easily and quickly proof batch totals as well as transaction and service detail.

Report detail can be grouped by the following:

— Batch Category

- > **Level of Detail** — The detail that prints on the batch report is determined by the **Level of Detail** you select on **Report Preferences**. You can run this report for detail on the batch category (if you select as an **Available Group Field**), batch, transaction, or service level. The default setting is to group detail by batch and to report down to the service level.

Regardless of whether you include **Batch Category** in the **Level of Detail**, the category prints on the report at the end of the batch information line. If a batch does not have a batch category assigned to it, "none" prints.

If you select **Batch Category** as an **Available Group Field** and collapse the **Level of Detail** up to **Batch Category**, the following things occur:

1. The non-recap pages print as they do if you collapse the **Level of Detail** up to **Batch**: that is, the batch information and the totals print.
2. The recap pages print with a single summary line for each batch category and the totals.

If you select **Batch Category** as an **Available Group Field** and collapse the **Level of Detail** up to **Batch**, the following things occur:

1. The non-recap pages print the batch information and the totals.
2. The recap pages print the detail, grouped by batch category, which is the same as if the **Level of Detail** was not collapsed up to **Batch**.

> **Available Sort Fields**

- **Original Order** — Default selection. Each voucher is listed in the order it was entered into the batch.

For void batches, each voucher is listed based on the original record's entry order, not by the order in which the transactions were voided. Voided payments are sorted by payment ID and voided charges are sorted by voucher ID.

- **Patient Name** — Each voucher is listed in alphabetical order according to the patient's last name.

Because unassigned payments are not made against a patient but are instead associated with an account, they are sorted by guarantor name rather than by patient name when this sort option is used.

- **Voucher Number** — Each voucher is listed in ascending order by voucher number.

Because unassigned payments are not associated with a voucher, they are sorted by the order in which they were entered when this sort option is used.

- > **New Page per Major Sequence** — Select this check box to trigger a page break between each major sequence. Leave this check box cleared to print the report information continuously.

- > **View with Drill-Down** — This option is not available for this report.

Close Batch(es)

When selected, the system will close the batches selected. This option is disabled if a closed batch is selected.

Note: Always print and close void batches separately before you close or update any related payment or charge batches. Charge and payment batches can be printed and closed at the same time.

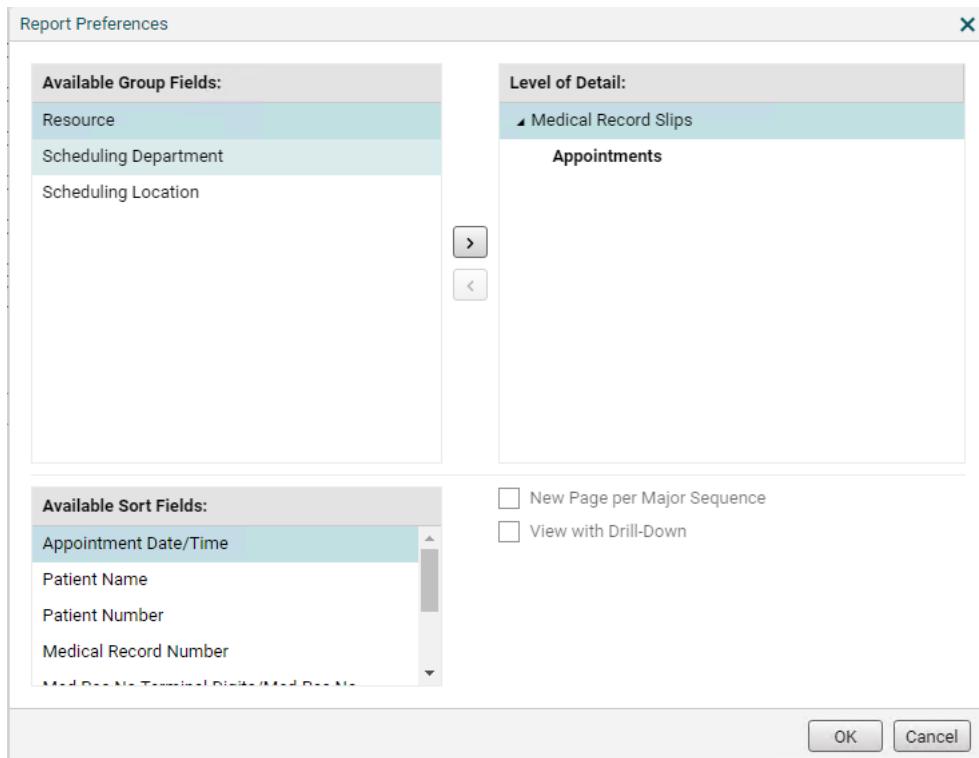
Report Preferences

You can access **Report Preferences** from any application area that includes  or . Use **Report Preferences** to configure how information will be displayed on a report.

Before using **Report Preferences**, you should take some time to consider the following questions:

- > Why am I running the report?
- > How do I need to present the detail?
- > How much detail do I need?
- > How do I want the information in the major sequence to be sorted?
- > Do I need to collate each major sequence?

Knowing the answers to these questions ensures that you create a useful report. After you have answered these questions, use the following elements to sequence and sort the information generated on a report so it meets your needs.



Available Group Fields

This area lists the details that you can include for each item on the report.

To add a level of detail to the report, select an option from the **Available Group Fields** area, then click the right arrow button. To remove a level detail from the report, select an option in the **Level of Detail** area, then click the left arrow button.

Level of Detail

This area displays which details are included for each item on the report, as well as the order in which the details are listed for each item. The detail listed first in the **Level of Detail** area determines how items will be grouped on the report. These groups are referred to as major sequences.

For example, if **Scheduling Location** is listed first for a **Medical Record Slips** report, the medical record slips listed on the report will be grouped by the associated appointment's scheduling location.

Available Sort Fields

This area lists available sort options you can select to control the order that items are listed in each major sequence of a report.

For example, if **Patient Name** is selected as the sort option for a **Medical Record Slips** report, the medical record slips in each major sequence will be listed in alphabetical order by patient last name.

New Page Major Sequence

Select this option to begin each major sequence on a new page of the report.

View with Drill-Down

Select this option to enable the ability to expand and collapse details when viewing a report in digital format.

Selecting group fields

The group fields you select determine how the report's detail is organized. You want to select the group fields that help you analyze the results as quickly as possible.

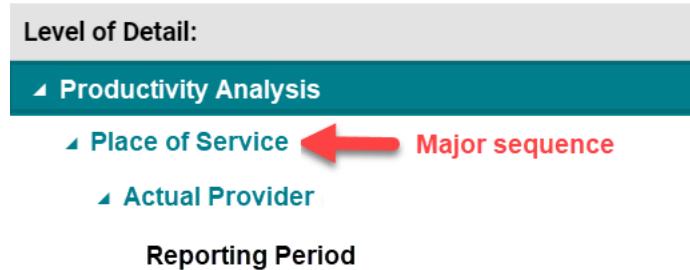
When running a Productivity Analysis, for example, ask yourself if you need information related to the actual provider, billing provider, place of service, insurance carrier, and so on. Do so by going through the list of available group fields: looking through the list helps you to determine which fields you want to include in your report.

For the sake of demonstration, assume you need information dealing with actual providers and places of service. The next question to ask is: "How do I want to present the detail?"

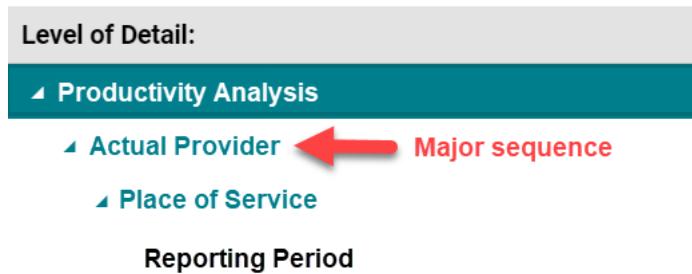
Selecting the major sequence

Use the major sequence to determine how you want to group information on the report.

Using our example of creating a Productivity Analysis for actual providers and places of service, ask yourself "Why am I running the report?" If the reason for the report is to generate numbers for each place of service and then to list the services rendered in each by provider, then the place of service is your major sequence followed by actual provider.



On the other hand, if the reason for the report is to generate statistics for each provider breaking down each one's total by place of service, then you want all of your information to print by actual provider and next by place of service. For this report the actual provider is your major sequence.



Moving group fields to the Level of Detail

You must select and add each group you need to the level of detail tree. Always begin by selecting the major sequence.

To add a group field to the level of detail:

1. Click an item from the list of available group fields so that it is highlighted.
2. Click > in the center of the window to move your selection to the right column.

You can also double click an item in the left grid to move it over to the right grid.

Determining the Level of Detail

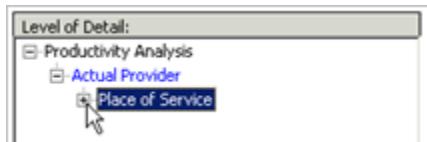
The amount of detail printed is governed by how you structure the detail tree. Ask yourself: "How much detail do I need?"

Most reports can either print a one line report giving grand totals only or one that details each voucher associated with every qualifying patient. Productivity Analysis is an exception, as shown in the following example. The lowest level of detail for it is reporting period.

The following report shows an example of what the Productivity Analysis would look like with **Level of Detail** expanded or drilled down to the greatest level of detail. When run at this level of detail, data prints for each reporting period.

4/27/2010 2:29:49PM		Productivity Analysis Allscripts Practice Jan 2009 - APR 2009							Page: 1	
		Units	Total RVUs	Charges Chg%	Payments Prof%	Refunds & Debits	Adjust	Transf. In/Out	Net	
Actual Provider: [REDACTED] (BED)										
Place of Service: [REDACTED] (MLK)										
APR 2009	0.00	0.00	0.00	0%	0.00	0%	0.00	0.00	0.00	0.00
Mar 2009	0.00	0.00	0.00	0%	121.50	162%	0.00	-46.50	0.00	-75.00
Feb 2009	0.00	0.00	0.00	0%	0.00	0%	0.00	0.00	0.00	0.00
Jan 2009	2.00	0.00	80.00	100%	0.00	0%	0.00	0.00	0.00	80.00
Totals for Place of Service: [REDACTED] Clinic (MLK)	2.00	0.00	80.00	18%	121.50	162%	0.00	-46.50	0.00	5.00
Place of Service Nashua Office (NASOFF)										
APR 2009	6.00	0.00	150.00	40%	0.00	0%	0.00	0.00	0.00	150.00
Mar 2009	0.00	0.00	0.00	0%	0.00	0%	0.00	0.00	0.00	0.00
Feb 2009	1.00	3.56	170.00	45%	0.00	0%	0.00	0.00	0.00	170.00
Jan 2009	2.00	1.03	56.00	15%	0.00	0%	0.00	0.00	0.00	56.00
Totals for Place of Service: Nashua Office (NASOFF)	9.00	4.59	376.00	82%	0.00	0%	0.00	0.00	0.00	376.00
Totals for Actual Provider: [REDACTED] (BED)	11.00	4.59	456.00	8%	121.50	162%	0.00	-46.50	0.00	381.00
Actual Provider: [REDACTED] (TED)										
Place of Service: [REDACTED] (MLK)										
APR 2009	0.00	0.00	0.00	0%	0.00	0%	0.00	0.00	0.00	0.00
Mar 2009	0.00	0.00	0.00	0%	0.00	0%	0.00	0.00	0.00	0.00
Feb 2009	0.00	0.00	0.00	0%	0.00	0%	0.00	0.00	0.00	0.00
Jan 2009	1.00	0.50	33.00	100%	0.00	0%	0.00	0.00	0.00	33.00
Totals for Place of Service: [REDACTED] Clinic (MLK)	1.00	0.50	33.00	100%	0.00	0%	0.00	0.00	0.00	33.00

Rolling up the level summarizes what is printed up to that level. To roll up a level, click the minus sign to the left of the level item:



The following report shows an example of what the Productivity Analysis would look like with the **Level Of Detail** set as shown above.

Productivity Analysis Allscripts Practice APR 2009									Page: 1
	Units	Total RVUs	Charges Chg%	Payments Prof%	Refunds & Debits	Adjust	Transf. In/Out	Net	
Actual Provider: ██████████ (BED)									
Place of Service: ██████████ Clinic (MLK)									
Totals for Place of Service:	Clinic (MLK)	2.00	0.00	80.00 18%	121.50 162%	0.00	-46.50	0.00	5.00
Place of Service: Nashua Office (NASOFF)									
Totals for Place of Service: Nashua Office (NASOFF)	Nashua Office (NASOFF)	9.00	4.59	376.00 82%	0.00 0%	0.00	0.00	0.00	376.00
Totals for Actual Provider:	(BED)	11.00	4.59	456.00 8%	121.50 162%	0.00	-46.50	0.00	381.00
Actual Provider: ██████████ (TED)									
Place of Service: ██████████ (MLK)									
Totals for Place of Service:	Clinic (MLK)	1.00	0.50	33.00 100%	0.00 0%	0.00	0.00	0.00	33.00
Totals for Actual Provider:	(TED)	1.00	0.50	33.00 1%	0.00 0%	0.00	0.00	0.00	33.00

Rolling up the level changes the minus sign to a plus sign. To print a one line grand total, roll up the detail to the highest level:



The following report shows an example of what the Productivity Analysis would look like with the **Level Of Detail** set as shown above.

Productivity Analysis Allscripts Practice APR 2009									Page: 1
	Units	Total RVUs	Charges Chg%	Payments Prof%	Refunds & Debits	Adjust	Transf. In/Out	Net	
Grand Totals:	80.00	73.52	5637.97 100%	1239.56 70%	0.00	542.78	0.00	3855.63	

Sorting information within the major sequence

Selecting a sequence sort gives you one more way to control the presentation of detail. Ask yourself "How do I want the information within the major sequence sorted?"

Some reports, such as the Comparative Analysis reports, do not offer the option to sort the detail printed for each major sequence. When this is the case, the section under available sort fields indicates that sort fields are not available for the current report.

To demonstrate the function of sort fields we are using the Aged Trial Balance (ATB) as an example. The major sequence selected is **Insurance Category** and the **Level of Detail** is rolled up to show only carrier balances for each account. The same level of detail is used each time the report runs:

Level of Detail:**▲ Aged Trial Balance****▲ Insurance Category****▲ Guarantor****▼ Carrier Balances**

The following report shows an example of the ATB run with the **Level of Detail** as shown above and sorted by **Guarantor Name**. Within the major sequence, accounts are arranged alphabetically by the guarantor's last name.

4/27/2010 2:39:24PM		Aged Trial Balance Allscripts Practice					Page: 1
		0 To 30 Days	31 To 60 Days	61 To 90 Days	Over 90 Days	Total Due	
Insurance Category: [REDACTED]							
Account: 470 [REDACTED]	Type: Standard	Totals for ANTHEMNH: 0.00	0.00	0.00	45.00	45.00	
		Totals for BCPEP: 75.00	0.00	0.00	0.00	75.00	
		Total Balances For Account: 75.00	0.00	0.00	45.00	120.00	
Account: 230 [REDACTED]	Type: Standard	Totals for ANTHEMNH: 5.00	0.00	0.00	535.00	540.00	
		Total Balances For Account: 5.00	0.00	0.00	535.00	540.00	
Account: 410 [REDACTED]	Type: DEL	Totals for BCHOLICE: 40.00	0.00	0.00	155.00	195.00	
		Total Balances For Account: 40.00	0.00	0.00	155.00	195.00	

The following report shows an example of the ATB run with the **Level of Detail** as shown above and sorted by **Account Number**. Within the major sequence, accounts are arranged numerically by account number.

4/27/2010 2:44:26PM		Aged Trial Balance Allscripts Practice					Page: 1
		0 To 30 Days	31 To 60 Days	61 To 90 Days	Over 90 Days	Total Due	
Insurance Category: [REDACTED]							
Account: 2 [REDACTED]	Type: COL	Totals for [REDACTED]:	0.00	0.00	0.00	241.00	241.00
		Total Balances For Account:	0.00	0.00	0.00	241.00	241.00
Account: 10 [REDACTED]	Type: Standard	Totals for [REDACTED]:	10.41	0.00	0.00	208.50	218.91
		Total Balances For Account:	10.41	0.00	0.00	208.50	218.91
Account: 20 [REDACTED]	Type: Standard	Totals for BCARE:	0.00	0.00	0.00	250.00	250.00
		Totals for [REDACTED]:	370.00	0.00	0.00	296.85	666.85
		Total Balances For Account:	370.00	0.00	0.00	546.85	916.85

Beginning a new page with each major sequence

How do you know if you want to begin a new page with each major sequence? Typically, you select **New Page per Major Sequence** when you want to collate and distribute the detail for each major grouping separately.

For example, you are asked to provide each doctor with a monthly report of his or her productivity. The major sequence is the first level of detail just below the report name.

The ability to select this option becomes inactive when you roll up the detail to the level of the report name.

Viewing with drill-down

Select **View with Drill-Down** when you are viewing a report on the computer's screen. Viewing with drill down enables you to display the detail for each group by command.

Levels of detail on Batch Print & Close

The following information prints on Batch Print & Close for void batches:

Note: If a void batch contains both charges and payments, the report prints a section for each. Only marked voids are included in totals.

Voided Charges

- > Void Batch Detail

— Number

(Preliminary) — Printed with **Close Batch** unchecked. The batch status remains open.

(Final) — Batch status is closed.

— Time batch was opened and by whom.

— Batch Comment

— Category — Prints the batch category. If there is not a batch category assigned, it prints (none).

> Voucher #

> Transaction Date

> Patient # & Name/Payor

> Actual Provider/Department

> Billing Provider/Place of Service

> Referring Doctor/Location

> Service Date

> Procedure Code/Description

> Diagnoses ICD-10/ICD-9

— Up to 4 unique diagnosis codes per service line are displayed.

— ICD-10 codes are displayed with corresponding mapped ICD-9 codes listed directly beneath.

> Type of Service

> Units

> Procedure Fee

> Memo Voids are listed but not included in the totals.

> Batch Totals For

— Proof Totals — Displays blank because proof totals cannot be entered for void batches.

— Actual Totals — Totals of the actual entries

— Amount - Prints \$0.00.

— Proc Count

— Hash — Shows the sum of all the procedure codes entered in a batch.

Example: The hash total of the 99213 + 99213 + 72170 = 270,596. Modifiers and codes containing alpha characters are excluded.

> Total Charges

Voided Payments & Adjustments

> Batch Detail

— Number

- (Preliminary) — Printed with **Close Batch** cleared. The batch status remains open.
- (Final) — Batch status is closed.
 - Time batch was opened and by whom.
 - Batch Comment
 - Category — Prints the batch category. If there is not a batch category assigned, it prints (none).
- > Date Paid
- > Remitter/Reference
- > Patient # & Name/Voucher #
- > Voucher Payment/Adjustment/Transfer Transactions
 - Each voided transaction is detailed.
 - Memo voids are identified but not added to totals.
- > Voided Unassigned and Assigned Payments
 - Date Paid
 - Remitter/Reference
 - Account: Patient # & Name/Description
 - Unassigned/Assigned Amount voided
- > Batch Totals For
 - Proof Amount — Displays blank since proof totals cannot be entered for void batches.
 - Total Unassigned Amount
 - Total Assigned Amount
 - Total Payment Amount = Payments + marked voided assigned payments
 - Total Adjustment Amount
 - Total Transfer Amount

Payments & Adjustments — Recap by Transaction

- > Recap totals will all equal \$0.00.
- > Voided Transaction Count — Memo voided transactions are included in the voided transaction count.
 - Unassigned Payments
 - Assigned Payments — Voided assigned payments are not counted in the **Assigned** payments column. They are counted in the **Payment** column. This column will not display a count.
 - Payment — Voided assigned payments are counted in the **Payment** column. They are not counted in the **Assigned** payments column.
 - Refund

- Adjustment — Voided withheld transactions are counted in the **Adjustment** column.
- Transfer

Note: When assigned payments are voided, the transaction is listed in both the payments and the unassigned sections. For instance, if a \$20 assigned payment is voided, the payment transaction appears in the body of Batch Print & Close and the detail of when it was applied to the voucher appears in the unassigned portion of Batch Print & Close with the total in the **Assigned** column.

The following prints on Batch Print & Close for payment batches:

Payments & Adjustments

- > Batch Detail
 - Number
 - (Preliminary) — Printed with **Close Batch** unchecked. The batch status remains open.
 - (Final) — Batch status is closed.
 - Time batch was opened and by whom.
 - Batch Comment
 - Category — Prints the batch category. If there is not a batch category assigned, it prints (none).
 - Deposit Date
 - Deposit Slip#
 - Settlement Date
 - Bank Account — Only shows when **Enable Bank Account** is selected on the **General** tab in **Practice Options** or **Organization Options**.
- > Date Paid
- > Remitter/Reference
- > Patient # & Name/Voucher #
- > Voucher Payment/Adjustment/Transfer Transactions
- > Total Voucher Payment
- > Total Voucher Adjustment
- > Total Voucher Transfer
- > Unassigned Payments
 - Date Paid
 - Remitter/Reference
 - Account: Patient # & Name/Voucher #
 - Unassigned Amount

- Assigned Amount
- > Batch Totals For
 - Proof Amount — Displays blank since proof totals cannot be entered for void batches.
 - Total Unassigned Amount
 - Total Assigned Amount
 - Total Payment Amount = Payments + marked voided assigned payments
 - Total Adjustment Amount
 - Total Transfer Amount

Payments & Adjustments — Recap by Transaction

- > Transaction Abbreviation
- > Transaction Description
- > Unassigned Payments — Lists Misc Debit transactions used when a credit balance was created in the following circumstances:
 - When the amount applied to an account's self-pay balance exceeds the total self-pay account balance due using the **Oldest** command in **Payment Entry**, or the **Apply Oldest Self-Pay** toolbar button in **Registration, Scheduling, and Charge Entry**
 - When a credit balance is moved to Unassigned from the **Apply Transactions to Voucher** window in **Payment Entry**

Only those practices or organizations that have selected a default **Move to Unassigned** transaction code in **Practice Options** or **Organization Options** can move credit balances to an Unassigned status.

- > Assigned Payments
- > Payments (includes assigned amounts; excludes refunds)
- > Refunds
- > Adjustments
- > Transfers
- > Net Payments = (Payments - Assigned) + Unassigned

When unassigned payments are assigned to a voucher, the transaction will be listed in both the payments and the unassigned sections. For instance, if a \$20 unassigned payment is applied, the payment transaction appears in the body of the Batch Print & Close and the apply piece shows in the unassigned portion of the Batch Print & Close with the total in the **Assigned** column.

- > Transaction Count
 - Unassigned Payments

- Assigned Payments — Applied Unassigned payments are not counted in the **Applied Unassigned** payments column. They are counted in the **Payment** column. This column will not display a count.
- Payment — Zero dollar payments are counted. Also, Applied Unassigned payments are counted in the **Payment** column. They are not counted in the **Applied Unassigned** payments column.
- Refund — Move to Unassigned transactions that have a transaction type of Misc Debit are counted in the **Refund** column. In addition, since the dollar amount is also being moved into **Unassigned**, the transaction is counted as an Unassigned Payment Transaction in the **Unassigned** column. This means for every refund transaction that is the result of a **Move to Unassigned** transaction, there should be a matching Unassigned Payment transaction.
- Adjustment
- Transfer

The following prints on the Batch & Close for charge batches:

Charges

- > Batch Line Detail
 - Number
 - (Preliminary) — Printed with **Close Batch** unchecked. The batch status remains open.
 - (Final) — Batch status is closed.
 - Time batch was opened and by whom.
 - Batch Comment
 - Category — Prints the batch category. If there is not a batch category assigned, it prints (none) .
- > Voucher #
- > Transaction Date
- > Patient # & Name/Payor
- > Actual Provider/Department
- > Billing Provider/Place of Service
- > Referring Doctor/Location
- > Voucher Charge
- > Service Date
- > Procedure Code/Description
- > Diagnoses ICD-10/ICD-9
 - Up to 4 unique diagnosis codes per service line are displayed.
 - ICD-10 codes are displayed with corresponding mapped ICD-9 codes listed directly beneath.

- > Type of Service
- > Units
- > Procedure Fee
- > Batch Totals For
 - Proof Totals — Totals as entered in **Batch Management**
 - Actual Totals — Totals of the actual entries
 - ◆ Amount — When a **Proof Amount** is entered for the batch, the system does not allow you to close the batch if the proof total and the actual total do not match.
 - ◆ Proc Count - A batch can be closed even when these totals do not match.
 - ◆ Hash — Shows the sum of all the procedure codes entered in a batch.
Example: The hash total of the 99213 + 99213 + 72170 = 270,596. Modifiers and codes containing alpha characters are excluded.
A batch can be closed even when these totals do not match.
 - Total Charges

Batch Print & Close samples

Figure 4: Sample Batch Print & Close for Voided Charges - No Group Fields

Batch Print & Close Allscripts Practice							Page: 1
Voucher	Date	Patient No. & Name Payor	Actual Provider Department	Billing Provider Place of Service	Refer Doctor Location	Charges	
Batch: [REDACTED] - Opened 6/9/2009 11:56:01AM - By [REDACTED] Batch Category: none							
void charge							
3530	05/18/2009	[REDACTED] BCN Service Date 05/18/2009 99213 Office/Outpatient Visit, Est	MARFEE OFFICE Diagnoses ICD-10/ICD-9	MARFEE OFFICE TOS MEDIC	RANREF OFFICE Units 1.00	76.00 Fee 76.00	
3540	05/18/2009	[REDACTED] BCN Service Date 05/18/2009 99213 Office/Outpatient Visit, Est	MARFEE OFFICE Diagnoses ICD-10/ICD-9	MARFEE OFFICE TOS MEDIC	RANREF OFFICE Units 1.00	76.00 Fee 76.00	
Batch Totals for : [REDACTED]			Proof Totals	Actual Totals		Charges	
			Amount:	152.00		152.00	
			Proc Count:	2			
			Hash:	198,426			

Figure 5: Sample Batch Print & Close for Voided Payments - No Group Fields

4/17/2018 2:32:36 PM (CST)				Batch Print & Close			Page: 1		
				Automated Collections Medical Center					
				Voided Payments & Adjustments					
Date Paid	Remitter Reference	Patient No. & Name Voucher		Payment	Adjustment	Transfer			
Batch: 367 (Preliminary) - Opened 4/17/2018 2:27:55 PM (CST) - By Barb Batch Category: PMVoid									
Deposit Date:		Deposit Slip #:		Settlement Date:		Bank Account:			
Memo Voids									
04/17/2018	MCR check #4637	██████████ 85360		Procedure: 99211	Aetna Payment	Memo Void Payment	300.00		
				Procedure: 99214	Aetna Payment	Memo Void Payment	0.00		
04/17/2018	MCR cash	██████████ 85360		Procedure: 99211	Aetna Payment	Memo Void Payment	0.00		
				Procedure: 99214	Aetna Payment	Memo Void Payment	50.00		
Batch Totals for		367		<u>Proof Amount</u>	<u>Unassigned</u>	<u>Assigned</u>	<u>Payment</u>	<u>Adjustment</u>	<u>Transfer</u>
					0.00	0.00	0.00	0.00	0.00

Figure 6: Sample Batch Print & Close for Charges - No Group Fields

5/15/2013 2:15:06PM				Batch Print & Close			Page: 1		
				Allscripts Practice					
				Charges					
Voucher	Date	Patient No. & Name Payor		Actual Provider Department	Billing Provider Place of Service	Refer Doctor Location	Charges		
Batch: ██████████ - Opened 4/17/2008 3:17:17PM - By ██████████ Batch Category: none									
Charge batch for Split care fees do not close									
1370	04/01/2008	290 BILL SPLIT CARE SPLIT		MARFEE OFFICE	MARFEE OFFICE		OFFICE		85.00
	<u>Service Date</u>	<u>Procedure Information</u>		<u>Diagnoses ICD-10/ICD-9</u>			<u>TOS</u>	<u>Units</u>	<u>Fee</u>
	04/01/2008	99211 Office/Outpatient Visit, Est		V70.7			MEDIC	1.00	45.00
	04/01/2008	99381 Prev Visit, New, Infant		V70.7			MEDIC	1.00	40.00
1380	04/02/2008	290 BILL SPLIT CARE SPLIT		MARFEE OFFICE	MARFEE OFFICE		OFFICE		245.00
	<u>Service Date</u>	<u>Procedure Information</u>		<u>Diagnoses ICD-10/ICD-9</u>			<u>TOS</u>	<u>Units</u>	<u>Fee</u>
	04/02/2008	99211 Office/Outpatient Visit, Est		V70.7			MEDIC	1.00	45.00
	04/02/2008	99396 Prev Visit, Est, Age 40-64		V70.7			MEDIC	1.00	200.00

Figure 7: Sample Batch Print & Close for Payments - No Group Fields

Batch Print & Close Automated Collections Medical Center				Payments & Adjustments		
Date Paid	Remitter Reference	Patient No. & Name Voucher		Payment	Adjustment	Transfer
Batch: 366 (Preliminary) - Opened 4/17/2018 1:27:08 PM (CST) - By Barb Batch Category: AMPay Deposit Date: 04/17/2018 Deposit Slip #: 7564 Settlement Date: 04/17/2018 Bank Account: CO CBO bank account						
04/17/2018	MCR check #4637	██████████ 85360 Procedure: 99211 Procedure: 99214	Aetna Payment Aetna Payment	300.00 0.00	0.00	0.00
04/17/2018	MCR cash	██████████ 85360 Procedure: 99211 Procedure: 99214	Aetna Payment Aetna Payment	0.00 50.00	50.00	0.00
Batch Totals for 366		<u>Proof Amount</u>	<u>Unassigned</u> 0.00	<u>Assigned</u> 0.00	<u>Payment</u> 350.00	<u>Adjustment</u> 0.00
						<u>Transfer</u> 0.00

Validating batches

The **Validate Batches** tab in **Financial Processing > Transactions** enables you to perform checks on vouchers prior to updating batches to verify that all Allscripts® Practice Management hardcoded and **Claim Style Maintenance** validations are met.

Select **Verify Claims** on the **Charge Entry** tab in **Practice Options** or **Organization Options** to add the process of scrubbing claims using the third-party Alpha II ClaimStaker® Enterprise application. **Validate Claims** and **Verify Claims** are available at the bottom of the **Validate Batches** tab, which provides the option to determine if you want claim validation and claim verification scrubbing performed on claims. If these boxes are not available, your practice is not using Verify Claims. In other words, when you validate batches, the application looks only for validation errors. Use **Pending Claims Corrections** to correct errors.

Note: This process does NOT replace the validate required for insurance billing.

Frequently asked questions

How is the Validate Batches function helpful?

Correcting errors before the charge batch is updated enables you to prevent a voucher from failing claim validation.

Will I still have to run the Validate under Billing > Insurance Billing?

Yes.

How do security settings impact who runs this function?

Batches that qualify for the query are only those to which the operator has access.

Can I validate payment or void Batches?

No. Payment batches and void batches do not qualify for validation.

Understanding the check box options

The **Validate Batches** tab enables you to perform checks prior to updating batches on each claim within the selected open or closed batches to verify that all hardcoded and **Claim Style Maintenance** validations are met as well as Alpha II ClaimStaker edits.

Validate Claims option

Enables you to identify vouchers that fail validation based either the Allscripts® Practice Management validations criteria or the criteria selected for the claim style associated with the voucher's carrier.

Note: When **Verify Claims** is not available, **Validate Claims** is selected and unavailable.

Verify Claims option

Available when **Verify Claims** is selected on the **Charge Entry** tab in **Practice Options** or **Organization Options**.

Enables you to identify vouchers that fail based on Alpha II ClaimStaker edits, which includes Correct Coding Initiative (CCI) and payer edits.

When you go to the **Validate Batches** tab for the first time, if **Validate Claims** and **Verify Claims** are available, they are both selected. If you validate batches with only one option selected and leave the window, the application remembers your selection based on the logon you used to open Allscripts® Practice Management. The next time you go to the **Validate Batches** tab, your previous selection remains.

Why would I not want to both validate and verify claims if that option is available to me?

You might want to restrict the process to one process for the following reasons:

- > Your practice or organization divides the tasks of correcting claims with certain staff responsible for correcting validation errors and other staff members for correcting edits.
- > You find the process of both validating and verifying claims to be too lengthy.

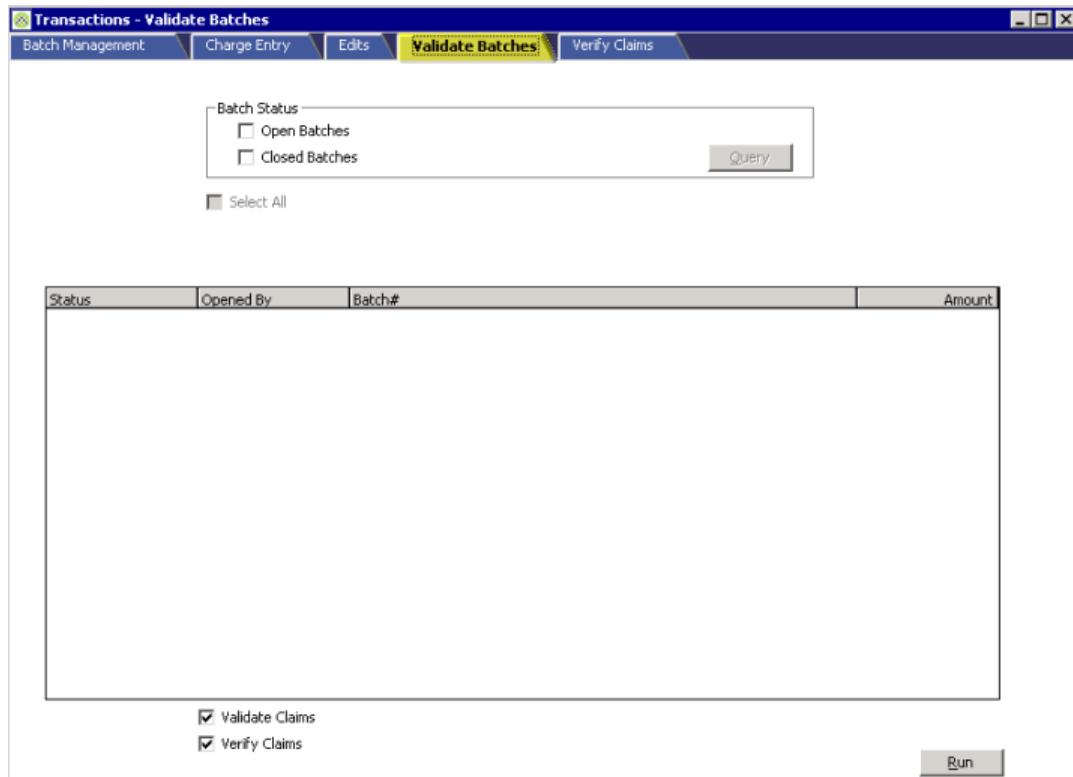
Note: If you use only one process, after the errors are corrected or the edits made, the voucher is removed from the list even if that voucher still contains data that can cause it to fail validation or be denied by the carrier. If you only do claim validation, after validation errors are corrected, you will not know whether Alpha II ClaimStaker edits exists. Not addressing these edits could cause the claim to be denied or incorrectly reimbursed by the carrier. Be sure you have a workflow policy that ensures all corrections and edits are addressed.

Validate vouchers with Open or Closed status

Only vouchers in Open or Closed Charge Batches qualify for Validate Batches. To validate batches do the following:

1. Use one of the following methods:

- > **F9** > type "TRA" > **Enter** > click Validate Batches tab
- > From the Navigation Pane Double-click **Financial Processing** > click **Transactions** > click Validate Batches tab



- 2.** Click **Open Batches** and/or **Closed Batches**.
- 3.** Using your keyboard: Press **Tab**, then press **Space bar** to check **Open Batches**.
- 4.** Press **Tab** again, then press **Space bar** to check **Closed Batches**.

Note: Your choice should be determined by your policies and workflow.

- 5.** Click **Query**.

Enables the **Select All** check box.

Clients using Department/Practice Security: The list of Open and/or Closed Batches available to the logged on Operator display in the grid which is now given the name "Available Batches."

- 6.** Click **Select All** to run the validate claims and/or verify claims process(es) on all the vouchers with errors in all the batches listed in the grid.

Remember, the larger the "job" the longer it will take. Make your selection based on how large each batch is.

- 7.** To select specific batches listed consecutively in the grid see steps 8-10. To select batches not listed consecutively see steps 11-13.
- 8.** When all the batches you want are listed consecutively, click on the first selected voucher.
- 9.** Press and hold the **Shift** key while clicking on the last batch in the list that you want.
- 10.** Release **Shift**. All the batches you want should be highlighted in a shade of light purple.

11. When all the batches you want are not listed consecutively, click the first batch you want to select
- 12 Press and hold the **Ctrl** key while clicking on each batch you want
- 13 Release **Ctrl**. Each batch you clicked on should be highlighted in a shade of light purple.
- 14 If you have an option to uncheck or check a processes (Verify Claims / Validate Claims), point and click on it.
- 15 Click **Run**. Based on your selection of processes, a message shows at the bottom of the screen: "Please wait. Validating and Verifying vouchers in selected batches."

Results of this task

When the process(es) is/are completed, the grid's label name changes to "# Failed Vouchers"

Correcting errors on a voucher

Do the following when vouchers with errors are displayed in the grid which now is labeled "# Failed Vouchers."

Double-click on a voucher line or right-click on the voucher line and click **Corrections**.

Note the message at the bottom of the screen: "Please wait. Validating selected voucher."

When the process is completed, the Pending Claims Corrections dialog opens loaded with the various errors discovered for that voucher and allow them to branch and make the corrections. See Use the Pending Claims Dialog when Validating Batches for detail instruction on how to use this dialog

What happens when a change or correction is made on a voucher?

When you make a change on the Corrections screen, i.e. correct an error, or change the **Hold** option, then click **OK** to close the dialog, the failed vouchers currently loaded in the Failed Vouchers Grid on the Validate Batch tab are all revalidated.

If any/all of those vouchers now pass Validation as a result of the change(s) made they are removed from the Failed Vouchers grid on the Validate Batch tab.

Transaction Journal

Use the Transaction Journal to post transactions to patient accounts and update the accounts receivable totals.

The update process posts the entered transactions and updates your practice's A/R totals.

A Transaction Journal is a record of one or more updated batches.

The process of updating or posting entered transactions is done on the **Transaction Journal** tab found under **Financial Processing > Financial Posting**. The report can be printed, previewed, or exported to Microsoft® Excel in a standard CSV format.

There are also options to run the Transaction Journal on the **Financial Posting** tab and the **Adjust Small Balances** tab in **Billing Automation Maintenance**.

Update void batches separately before any related charge or payment batches.

Charge and payment batches may be updated at the sametime.

Note: Only closed batches can be updated.

The following information prints on the Transaction Journal for void batches:

Note:

If a void batch contains charges and payments, the report prints a section for each.

When assigned payments are voided, the transaction is listed in both the payments and the unassigned sections. For instance, if you void a \$20 assigned payment, the payment transaction prints in the body of the journal and the detail of when it was applied to the voucher prints in the unassigned portion of the journal with the total in the **Assigned** column.

Manually voided transactions designated as marked voids are included in totals.

Manually voided transactions designated as memo voids are not included in totals.

VRE void batches are automatically updated by the system. The totals for VRE void batches appear in the Totals Summary section of the Transaction Journal on a line labeled "VRE Void Batches Since Last Update."

Voided Charges

- > Void Batch Detail
- > Voucher #
- > Transaction Date

- > Patient # & Name/Payor
- > Actual Provider/Department
- > Billing Provider/Place of Service
- > Referring Doctor/Location
- > Voucher Charge
- > Service Date
- > Procedure Code/Description
- > Diagnosis ICD-10/ICD-9
 - Up to 4 unique diagnosis codes per service line are displayed.
 - ICD-10 codes are displayed with corresponding mapped ICD-9 codes listed directly beneath.
- > Type of Service
- > Units
- > Procedure Fee
- > Batch Totals
 - Proof Totals — Displays blank since Proof Totals cannot be entered for Void Batches.
 - Actual Totals — Totals of the actual entries
 - Charges
 - ◆ Amount
 - ◆ Proc Count — The total number of procedures entered in a batch.
 - ◆ Hash — The sum of all the procedure codes numbers entered in a batch, excluding modifiers and codes containing alpha characters

Voided Payments and Adjustments

- > Void Batch Detail
- > Date Paid
- > Remitter/Reference — Includes the type of payment, adjustment, or EOB and the procedure code to which it was applied
- > Patient # & Name/Voucher #
- > Payment
- > Adjustment
- > Transfer
- > Unassigned Payments — When assigned payments are voided, the payment is listed in both the regular **Payment** column and the **Unassigned Payments** section at the bottom of the journal.

Example: A voided \$20 assigned payment appears as a **Payment**, as well as an entry under **Unassigned Payments**, along with the detail of when it was applied to the voucher.

- > Batch Totals
 - Total Unassigned Amount
 - Total Assigned Amount
 - Total Payment Amount = Payments + marked voided assigned payments
 - Total Adjustment Amount
 - Total Transfer Amount

Payments & Adjustments - Recap by Transaction

- > The Recap by Transaction Totals in each column should equal \$0.00.
- > Voided Transaction Count — Memo voided transactions are included in the voided transaction count.
 - Unassigned Payments
 - Assigned Payments — Voided Assigned payments are not counted in the **Assigned** payments column. They are counted in the **Payment** column. This column will not display a count.
 - Payment — Voided Assigned payments are counted in the **Payment** column. They are not counted in the **Assigned** payments column.
 - Refund
 - Adjustment — Voided Withheld transactions are counted in the **Adjustment** column.
 - Transfer

Totals Summary

- > Previous A/R

CAUTION: The previous A/R on this Transaction Journal should match the new A/R from the last updated Transaction Journal. If these totals do not match, contact Allscripts® Practice Management Support immediately.

- > VRE Void Batches Since Last Update

The date and time the update is performed is recorded and the system checks to see if any voids were updated using the **Void Re-Enter** function since the last update was performed. This line reflects the totals of any charges voided using **Void Re-Enter** and the totals of any payments voided using **Void Re-Enter** as well as a calculated Net Amount.

Keep in mind that where voids are concerned the effect on A/R is the reverse of regular charges and payments. For instance, normally charges add to A/R and payments subtract from A/R. However, voided charges subtract from A/R while voided payments add to A/R. To illustrate this point, if I had voided charges on my Transaction Journal Totals Summary of \$142.00 and voided payments of \$15.00, the Net Amount for these would be -\$127.00.

- > New Transactions

Since void batches should be closed and updated separately from charge and payment batches, each category on this line should equal \$0.00.

- > Voided Transactions
 - Total Voided Charges
 - Total Voided Payments (will include voided assigned payments)
 - Total Voided Refunds
 - Total Voided Adjustments
 - Net Amount for Voided Transactions = Voided Charges - Voided Payments + Voided Refunds
- Voided Adjustments
- > Net This Journal
 - Charges = New Charge Transactions - Voided Charges
 - Payments = New Payment Transactions - Voided Payments (includes voided assigned amounts)
 - Refunds = New Refund Transactions - Voided Refunds
 - Adjustments = New Adjustment Transactions - Voided Adjustments
 - Net Amount for this journal = Charges - Payments + Refunds - Adjustments
- > New A/R = Previous A/R + Net Amount for this journal
- > Unassigned Transactions

The status of unassigned transactions prints at the end of each journal.

 - Previous Unassigned = Total of unassigned amounts before these transactions were updated
 - New Transactions

Since void batches should be closed and updated separately from payment and charge batches, each category on this line should equal \$0.00.

 - Voided Transactions
 - ◆ Total Voided Unassigned payments updated with this journal
 - ◆ Total Assigned payments updated with this journal
 - Assigned payments are included in the Payments total.
 - ◆ Net Amount Voided Transactions = - (Total Voided Unassigned) + Total Voided Assigned amounts
 - New Unassigned = Previous Assigned + Net Amount Voided Transactions

This amount indicates how much unassigned dollars are associated with accounts in your practice.

The following information prints on the Transaction Journal for charge batches:

Note: When a journal includes charge and payment batches, the report prints a section for each and the Totals Summary page includes the totals for all batches.

Charges

- > Charge Batch Detail
- > Voucher #
- > Transaction Date
- > Patient # & Name/Payor
- > Actual Provider/Department
- > Billing Provider/Place of Service
- > Referring Doctor/Location
- > Voucher Charge
- > Service Date
- > Procedure Code/Description
- > Diagnosis ICD-10/ICD-9
 - Up to 4 unique diagnosis codes per service line are displayed.
 - ICD-10 codes are displayed with corresponding mapped ICD-9 codes listed directly beneath.
- > Type of Service
- > Units
- > Procedure Fee
- > Batch Totals
 - Proof Totals (totals entered in **Batch Management**)
 - Actual Totals (totals of the actual entries)
 - ◆ Amount
 - ◆ Procedure Count — The total number of procedures entered in a batch.
 - ◆ Hash — The sum of all procedure codes numbers entered in a batch excluding modifiers and codes containing alpha characters.
- Charges

Totals Summary

- > Previous A/R

CAUTION: The previous A/R on this Transaction Journal should match the new A/R from the last updated Transaction Journal. If these totals do not match, contact Allscripts® Support immediately.
- > VRE Void Batches Since Last Update

The date and time the Update is performed is recorded and the system checks to see if any voids were updated using the **Void Re-Enter** function since the last Update was performed. This line reflects the totals of any charges voided using **Void Re-Enter** and the totals of any payments voided using **Void Re-Enter** as well as a calculated Net Amount.

Keep in mind that where Voids are concerned the effect on A/R is the reverse of regular charges and payments. For instance, normally charges add to A/R and payments subtract from A/R. However, voided charges subtract from A/R while voided payments add to A/R. To illustrate this point, if I had voided charges on my Transaction Journal Totals Summary of \$142.00 and voided payments of \$15.00, the Net Amount for these would be -\$127.00.

> New Transactions

- Total Charges
- Total Payment \$ amount = Payments (includes assigned payments) - Refunds
- Total Refunds
- Total Adjustments
- Net Amount = Charges - Payments + Refunds - Adjustments

> Voided Transactions

Since void batches should be closed and updated separately from payment and charge batches, each category on this line should equal \$0.00.

> Net This Journal

- Total Charges
- Total Payments = Payments (includes assigned payments) - Refunds
- Total Refunds
- Total Adjustments
- Net Amount for this journal = Charges - Payments + Refunds - Adjustments

> New A/R = Previous A/R + Net Amount for this Journal

> Unassigneds — At the end of each journal you are given the status of unassigned transactions.

— Previous Unassigned = the total of unassigned amounts before these transactions were updated

— New Transactions

— Voided Transactions

- ◆ Total Voided Unassigned payments updated with this journal
- ◆ Total Assigned payments updated with this journal

Assigned payments are included in the Payments total.

- ◆ Net Amount Voided Transactions = - (Total Voided Unassigned) + (Total Voided Assigned amounts)

- New Unassigned = (Previous Assigned) + (Net Amount Voided Transactions)

This amount indicates how much unassigned dollars are associated with accounts in your practice.

The following information prints on the Transaction Journal for payment batches:

Note:

When a journal includes charge and payment batches, the report prints a section for each and the Totals Summary page includes the totals for all batches.

When assigned payments are applied to a voucher, the transaction is listed both under Payment and under Unassigned Payments at the bottom of the journal.

Example: If you assign a \$20 unassigned payment, the payment transaction appears in the body of the journal, and the detail of when it was applied to the voucher appears in the unassigned portion of the journal, with the total in the assigned column.

Payments & Adjustments

- > Payment Batch Detail
- > Date Paid
- > Remitter/Reference
- > Patient # & Name/Voucher #
- > Voucher Payment/Adjustment/Transfer Transactions
- > Total Voucher Payment
- > Total Voucher Adjustment
- > Total Voucher Transfer
- > Unassigned Payments
 - Date Paid
 - Remitter/Reference
 - Patient # & Name/Voucher #
 - Unassigned Amount
 - Assigned Amount
- > Batch Totals
 - Total Unassigned Amount
 - Total Assigned Amount
 - Total Payment Amount = Payments (includes assigned payments) - Refunds
 - Total Adjustment Amount

— Total Transfer Amount

Payments & Adjustments - Recap by Transaction

- > Transaction Abbreviation
- > Transaction Description
- > Unassigned Payments
- > Assigned Payments
- > Payments (includes assigned amounts; excludes refunds)
- > Refunds
- > Adjustments
- > Recap by Transaction Totals
- > Transaction Count
 - Unassigned Payments
 - Assigned Payments — Applied Unassigned payments are not counted in the **Applied Unassigned** payments column. They are counted in the **Payment** column. This column will not display a count.
 - Payment — Zero dollar payments are counted. Also, Applied Unassigned payments are counted in the **Payment** column. They are not counted in the **Applied Unassigned** payments column.
 - Refund — Move to Unassigned transactions that have a transaction type of Misc Debit are counted in the **Refund** column. In addition, since the dollar amount is also being moved into **Unassigned**, the transaction is counted as an Unassigned Payment Transaction in the **Unassigned** column. This means for every refund transaction that is the result of a Move to Unassigned transaction, there should be a matching Unassigned Payment transaction.
 - Adjustment
 - Transfer

Totals Summary

- > Previous A/R

CAUTION: The previous A/R on this Transaction Journal should match the new A/R from the last updated Transaction Journal. If these totals do not match, contact Allscripts® Support immediately.

- > VRE Void Batches Since Last Update

The date and time the update is performed is recorded and the system checks to see if any voids were updated using the **Void Re-Enter** function since the last update was performed. This line reflects the totals of any charges voided using **Void Re-Enter** and the totals of any payments voided using **Void Re-Enter** as well as a calculated Net Amount.

Keep in mind that where voids are concerned the effect on A/R is the reverse of regular charges and payments. For instance, normally charges add to A/R and payments subtract from A/R. However, voided charges subtract from A/R while voided payments add to A/R. To illustrate this point, if I had voided charges on my Transaction Journal Totals Summary of \$142.00 and voided payments of \$15.00, the Net Amount for these would be -\$127.00.

> New Transactions

- Total Charges
- Total Payment Amount = Payments (includes assigned payments) - Refunds
- Total Refunds
- Total Adjustments
- Net Amount = Charges - Payments + Refunds - Adjustments

> Voided Transactions

Since void batches should be closed and updated separately and before charge and payment batches, each category on this line should equal \$0.00.

> Net This Journal

- Total Charges
- Total Payments = Payment (includes assigned payments) - Refund
- Total Refunds
- Total Adjustments
- Net Amount for this journal = Charges - Payments + Refunds -Adjustments

> New A/R = Previous A/R + Net Amount for this journal

> Unassigned Transactions

The status of unassigned transactions prints at the end of each journal.

- Previous Unassigned = Total of unassigned amounts before these transactions were updated
- New Transactions

- ◆ Total unassigned payments updated with this journal
- ◆ Total assigned payments updated with this journal

Assigned payments are included in the Payments total and affect the A/R.

- ◆ Net Amount = Total Unassigned Payments - Total Assigned Payments

> Voided Transactions

Since void batches should be closed and updated separately from payment and charge batches, each category on this line should equal \$0.00.

> New Unassigned = Previous Assigned + Total of New Transactions

This is the current total of unassigned dollars associated with accounts in your practice.

Why run a Preliminary Journal?

Running a Preliminary Journal allows you to run a journal and review the entries without updating the transactions. This means you get to review the detail before transactions hit your A/R.

Please note that the default is to run a preliminary journal.

What does the Reprint Journal function do?

When reprinting journals, the detail printed is the same as that of the original journal except for the following:

- > The batch detail line indicates **Reprint**
- > The totals summary page does not include the following information:
 - Previous A/R
 - New A/R
 - Previous Unassigned
 - New Unassigned
- > Line detailing when and by whom the transactions were updated as final.

Transaction Journal Samples

Figure 8: Sample Transaction Journal for Void Batches - Charges (No Group Fields)

Transaction Journal							Page: 1
Allscripts Practice							
Voucher	Date	Patient No. & Name Payor	Actual Provider Department	Billing Provider Place of Service	Refer Doctor Location	Charges	
Batch: [REDACTED] (Preliminary) - Opened 6/3/2009 12:19:47PM - By [REDACTED] Batch Category: none do not update							
1860	04/29/2008	[REDACTED]	MARFEE OFFICE	MARFEE FLPOS Diagnoses ICD-10/ICD-9	FLREF FLLOM TOS SURG	Units 1.00	Fee 75.00
	Service Date 04/29/2008	Procedure Information Cabg, Art-Vein, Six Or More		V70.7			
	04/29/2008	C/O For Orthotic/Prosth Use		V70.7	MEDI	1.00	125.00
	04/29/2008	C-Reactive Protein		V70.7	LAB	1.00	35.00
	04/29/2008	Ear Microscopy Examination		V70.7	MEDI	1.00	25.00

Figure 9: Sample Transaction Journal for Void Batches - Payments & Adjustments (No Group Fields)

Transaction Journal							Page: 2
Allscripts Practice							
Voided Payments & Adjustments							
Date Paid	Remitter Reference	Patient No. & Name Voucher			Payment	Adjustment	Transfer
Batch: [REDACTED] (Final) - Opened 5/1/2009 2:49:21PM - By [REDACTED] Batch Category: none void							
Memo Voids							
Memo Void Unassigned Payments				Unassigned	Assigned		
05/01/2009	Self-Pay sosm cash copay	Account: [REDACTED] Co-Pay ov cash		3.00	0.00		
Batch Totals for [REDACTED]				Proof Amount	Unassigned 0.00	Assigned 0.00	Payment 0.00
						Adjustment 0.00	Transfer 0.00

Figure 10: Sample Transaction Journal for Void Batches - Recap by Transactions (No Group Fields)

4/6/2010 2:29:56PM		Transaction Journal Allscripts Practice						Page: 3	
		Payments & Adjustments - Recap by Transaction							
Transaction	Transaction Description	Unassigned	Assigned	Payment	Refund	Adjustment	Transfer		
Unassigned Payments									
		0.00	0.00						
Recap by Transaction Totals:									
		0.00	0.00	0.00	0.00	0.00	0.00		
Net Payments:									
				0.00					
Voided Transaction Count:									
		1.00		0.00	0.00	0.00	0.00		

Figure 11: Sample Transaction Journal for Void Batches - Totals Summary (No Group Fields)

4/6/2010 2:29:56PM		Transaction Journal Allscripts Practice					Page: 4	
		Totals Summary						
Description		Charges	Payments	Refunds	Adjustments	Net Amount		
Previous A/R:						102776793.91		
VRE Void Batches Since Last Update:		0.00	0.00	0.00	0.00	0.00		
New Transactions:		0.00	0.00	0.00	0.00	0.00		
Voided Transactions:		481.00	0.00	0.00	0.00	-481.00		
Net This Journal:		-481.00	0.00	0.00	0.00	-481.00		
New A/R:						102776312.91		
		Unassigned	Assigned					
Previous Unassigned:						475025.41		
New Transactions:		0.00	0.00			0.00		
Voided Transactions:		0.00	0.00			0.00		
New Unassigned:						475025.41		
Transactions have been updated as Final on		4/6/2010 2:29:56PM	by					

Figure 12: Sample Transaction Journal for Charge Batches - Charges (No Group Fields)

Transaction Journal Allscripts Practice							Page: 1
Charges							
Voucher	Date	Patient No. & Name Payor	Actual Provider Department	Billing Provider Place of Service	Refer Doctor Location	Charges	
Batch: [REDACTED] (Preliminary) - Opened 8/19/2008 4:23:16PM - By [REDACTED] Batch Category: none							
3000	08/19/2008	[REDACTED]	MARFEE OFFICE	MARFEE OFFICE	RANREF OFFICE	84.00	
	<u>Service Date</u>	<u>Procedure Information</u>		Diagnoses ICD-10/ICD-9	TOS	Units	Fee
	08/19/2008	99212 Office/Outpatient Visit, Est		V70.7	MEDI	1.00	84.00
Batch Totals for : [REDACTED]			Amount:	Proof Totals	Actual Totals	Charges	
			Proc Count:	84.00	1	84.00	
			Hash:	99,212			

Figure 13: Sample Transaction Journal for Charge Batches - Totals Summary (No Group Fields)

Transaction Journal Allscripts Practice						Page: 2
Totals Summary						
Description	Charges	Payments	Refunds	Adjustments	Net Amount	
Previous A/R:					102776312.91	
VRE Void Batches Since Last Update:	0.00	0.00	0.00	0.00	0.00	
New Transactions:	189.00	0.00	0.00	0.00	189.00	
Voided Transactions:	0.00	0.00	0.00	0.00	0.00	
Net This Journal:	189.00	0.00	0.00	0.00	189.00	
New A/R:					102776501.91	
Unassigned		Assigned				
Previous Unassigned:					475025.41	
New Transactions:	0.00	0.00	0.00	0.00	0.00	
Voided Transactions:	0.00	0.00	0.00	0.00	0.00	
New Unassigned:					475025.41	
Transactions have been updated as Final on 4/6/2010 2:46:24PM by [REDACTED]						

Figure 14: Sample Transaction Journal for Payment Batches - Payments & Adjustments (No Group Fields)

Date Paid	Remitter Reference	Patient No. & Name Voucher	Payment	Adjustment	Transfer
Batch: [REDACTED] (Final) - Opened 4/30/2009 6:34:56AM - By [REDACTED] Batch Category: none					
Unassigned Payments					
04/30/2009	Self-Pay PPCC VISA	Account: [REDACTED] Specialist Co-Pay	30.00	0.00	
04/30/2009	Self-Pay ppcc visa	Account: [REDACTED] Co-Pay	25.00	0.00	
04/30/2009	Self-Pay ppcc cash	Account: [REDACTED] Co-Pay	25.00	0.00	
04/30/2009	Self-Pay ppccc debit	Account: [REDACTED] Co-Pay	30.00	0.00	
04/30/2009	Self-Pay ppcc mastercard	Account: [REDACTED] Co-Pay	25.00	0.00	
04/30/2009	Self-Pay ppcc debit	Account: [REDACTED] Co-Pay	50.00	0.00	
04/30/2009	Self-Pay PPCC VISA	Account: [REDACTED] Specialist Co-Pay	40.00	0.00	
04/30/2009	Self-Pay ppcc cash	Account: [REDACTED] Co-Pay	30.00	0.00	
04/30/2009	Self-Pay ppcc 30.00	Account: [REDACTED] Co-Pay	30.00	0.00	
04/30/2009	Self-Pay ppcc mastercard	Account: [REDACTED] Co-Pay	30.00	0.00	
04/30/2009	Self-Pay debit	Account: [REDACTED] Co-Pay	15.00	0.00	
Batch Totals for [REDACTED]			Proof Amount	Unassigned	Assigned
				330.00	0.00
				0.00	0.00
				0.00	0.00

Figure 15: Sample Transaction Journal for Payment Batches - Recap by Transaction (No Group Fields)

		Transaction Journal Allscripts Practice						Page: 2
Transaction	Transaction Description	Unassigned	Assigned	Payment	Refund	Adjustment	Transfer	
Unassigned Payments								
CPCA	Copay Cash	55.00	0.00					
CPCC	Copay Credit Card	275.00	0.00					
Recap by Transaction Totals:		330.00	0.00	0.00	0.00	0.00	0.00	
Net Payments:				330.00				
Transaction Count:		11.00		0.00	0.00	0.00	0.00	

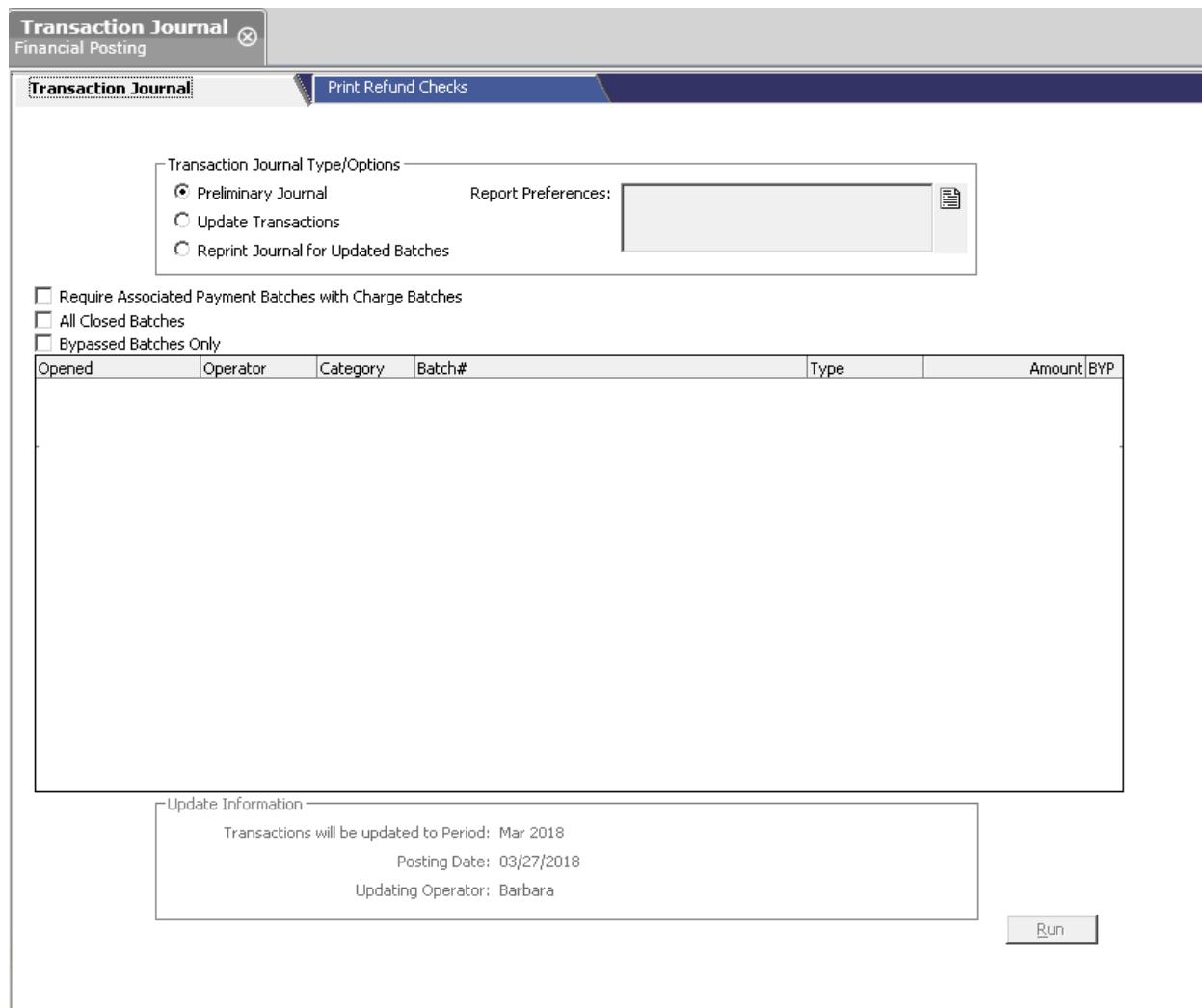
Figure 16: Sample Transaction Journal for Payment Batches - Totals Summary (No Group Fields)

		Transaction Journal Allscripts Practice					Page: 3
		Totals Summary					
Description		Charges	Payments	Refunds	Adjustments	Net Amount	
Previous A/R:						102776501.91	
VRE Void Batches Since Last Update:		0.00	0.00	0.00	0.00	0.00	
New Transactions:		0.00	0.00	0.00	0.00	0.00	
Voided Transactions:		0.00	0.00	0.00	0.00	0.00	
Net This Journal:		0.00	0.00	0.00	0.00	0.00	
New A/R:						102776501.91	
		Unassigned	Assigned				
Previous Unassigned:							
New Transactions:		330.00	0.00				
Voided Transactions:		0.00	0.00				
New Unassigned:							
Transactions have been updated as Final on		4/6/2010 2:58:44PM	by				

Transaction Journal tab

The **Transaction Journal** tab enables you to select the criteria you want to use to run the report.

Figure 17: Transaction Journal tab



Opened	Operator	Category	Batch#	Type	Amount	BYP

Transaction Journal tab fields

This tab also includes **Store** and **Run** buttons.

Preliminary Journal

Select this option to run a journal and review the entries without updating the transactions.

Note: Unless you select **Preliminary Journal**, the update process is completed when you click **Run**, even if you click **Preview** or **Export** on **Print**.

Update Transactions

Select this option to update transactions and change the A/R.

Reprint Journal for Updated Transactions

Select this option to reprint journals for a specified update date. The detail of the reprinted journal is the same as that of the original journal except for the following:

- > The batch detail line indicates “Reprint.”
- > The Totals Summary page does not include the following information:
 - Previous A/R
 - New A/R
 - Previous Unassigned
 - New Unassigned
 - When and by whom the transactions were updated as final.

Report Preferences

Select report preferences as desired and click **OK**.

Selections display on the main report screen in **Report Preferences**.

The following options are available:

- > Available Group Fields — Highlighting and moving fields from left to right determines the print output of the report. The program default is to group all detail by batch number. This enables you to easily and quickly proof batch totals as well as transaction and service detail. Report detail can be grouped by the following:

- Batch Category
- > Level of Detail — The detail that prints on the batch report is determined by the **Level of Detail** you select in **Report Preferences**. You can run this report for detail on the batch category (if you select as an **Available Group Field**), batch, transaction, or service level.

The default setting is to group detail by batch and to report down to the service level.

Regardless of whether you include **Batch Category** in the **Level of Detail**, the category prints on the report at the end of the batch information line. If a batch does not have a batch category assigned to it, none prints.

If you select **Batch Category** as an **Available Group Field** and collapse the **Level of Detail** up to **Transaction Journal**, the following things occur:

1. The non-recap pages do not print.
2. The recap pages print full detail, grouped by **Batch Category**.

If you select **Batch Category** as an **Available Group Field** and collapse the **Level of Detail** up to **Batch Category**, the following things occur:

1. The non-recap pages print the summary information as it does when collapsed up to **Batch**.
2. The recap pages print a one line summary for each batch category with grand totals at the bottom.

If you select **Batch Category** as an **Available Group Field** and collapse the **Level of Detail** up to **Batch**, the following things occur:

1. The non-recap pages print the summary information.
2. The recap pages print full detail, grouped by **Batch Category**.

If you do not select **Batch Category** as an **Available Group Field** and collapse the **Level of Detail** up to **Transaction Journal**, the following things occur:

1. The non-recap pages do not print.
2. The recap pages print full detail.

If you do not select **Batch Category** as an **Available Group Field** and collapse the **Level of Detail** up to **Batch**, the following things occur:

1. The non-recap pages print the summary information.
 2. The recap pages print full detail.
- > Available Sort Fields — None available for this report.
- > New Page per Major Sequence — When selected, this option triggers a page break between each major sequence. Left cleared, the report information prints continuously.
- > View with Drill-Down — Not available for this report

Require Associated Payment Batches with Charge Batches

When you select this option and click **Run**, if you are trying to update a charge batch that has an associated payment batch and you are not updating that associated payment batch (which is in an Open or Closed status) at the same time, a hard stop warning appears that says Associated Payment Batch (x) must be updated with the Charge Batch (x) where (x) is the respective batch numbers. After you click **OK** to close the warning message, you can either select the appropriate associated payment batch or deselect the charge batch that has an associated payment batch. One or the other must be done before you can click **Run** and successfully complete the process.

Note: This option is a "sticky setting," meaning each time you open the **Transaction Journal** tab the option defaults to how you had it

set (selected or cleared) the last time you updated transactions on this workstation.

All Closed Batches

Select this option to select all batches listed in the grid below for the report or select one or more batches from the grid below to include on the report.

Note: Void batches should be updated before or along with any related charge or payment batches.

Charge and payment batches may be updated at the same time.

Bypassed Batches Only

Select this option to limit the display in the grid to only batches that have **Bypass Automated Update** selected.

Run a Transaction Journal

A Transaction Journal is a record of one or more updated batches. Different options on the **Transaction Journal** tab allow you to view a regular report, a preliminary report (which allows you to review transactions without affecting your A/R), a past report, or a summarized version only.

1. Open the **Transaction Journal** tab using one of the following methods:

- > Use the Access Code: **F9** > Type "FPO" > **Enter**
- > Use the Navigation Pane: **Financial Processing** > **Financial Posting**

Note: There are also options to run the Transaction Journal on the **Financial Posting** tab and the **Adjust Small Balances** tab in **Billing Automation Maintenance**.

2. Click  to select one of the **Transaction Journal Type/Options**:

- > Preliminary Journal — Default selection. Allows you to review Transactions without affecting your A/R.
- > Update Transactions — Transactions are updated and the A/R is changed.
- > Reprint Journal for Updated Batches — Allows you to reprint journals for a specified update date.

3. Click  or **Tab** then **Alt+down arrow** to open the **Report Preferences** window.

You must open this window even when you intend to accept the defaults.

4. It is recommended that you accept the defaults.

5. By collapsing the level of detail, you can generate a summarized print out. Click  located to the left of the level name, or use the appropriate arrow keys to move up or down, then press **Enter** to collapse or expand the level of detail.
6. Click **OK** to close the **Report Preferences** window.
7. (Optional) Select **Require Associated Payment Batches with Charge Batches** to receive a hard-stop warning if you are trying to update a charge batch that has an associated payment batch and you are not updating that associated payment batch (which is in an Open or Closed status) at the same time.
8. (Optional) Select **All Closed Batches** to select all batches listed in the grid.
9. (Optional) Select **Bypassed Batches Only** to limit the display in the grid to only batches that have **Bypass Automated Update** selected.
10. Click **Run (Alt+r) > Print**.

Reprint a Transaction Journal

The **Reprint Journal** option allows you to view past Transaction Journals.

1. Click  to select **Reprint Journal** for Updated Batches
2. Enter a date in the dialog, then click **OK**
3. Click  or **Tab** then **Alt+down arrow** to open the **Report Preferences** window.

The Bank Reconciliation Report

This report allows you to reconcile payments entered into your Allscripts® Practice Management application with bank deposit amounts.

Before running the report

There are several options to consider when running the Bank Reconciliation Report. For example, your work flow determines how you group the report. For example, if you are reconciling by batch and transaction code within each batch, your group by selections should reflect this.

If you use Department/Practice Security and have enabled Divisions and you are reconciling payments entered to deposits by Division, then your principle grouping should be Division.

Always give some thought to what detail you need from the report to help you easily and quickly reconcile to the total you are depositing.

Clients using Department/Practice Security

This report honors the operators security settings. This means the following:

- > Select Records dialogs are filtered.

- > Even when the selection is for "all," the results generated are only for those payments posted to vouchers whose department/practice is one to which the operator has access.

See "Department/Practice Security and Reports, Listings and Analyses."

Detail generated

The detail generated differs when you run the report in summarized format vs. detailed format. See "Understanding the Bank Reconciliation Report."

Run the Bank Reconciliation Report

Before you begin

Be sure all void batches are updated before running this report.

1. Open the Bank Reconciliation Report tab using one of the following methods:

- > Use the Access Code: **F9** > Type "FAN" > **Enter** > Click Bank Reconciliation Report tab
- > Use the Navigation Pane: Double-click **Financial Processing** >Click **Financial Analysis** >Click Bank Reconciliation Report tab

2. If you are not selecting a stored job, move on to step 4.

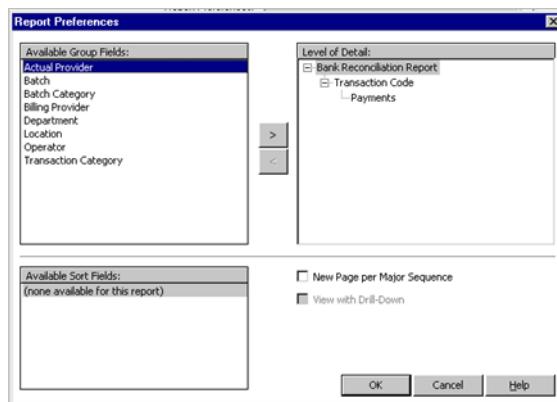
3. To select a Stored Job use one of the following methods

- > Click  to open the drop-down list, and then highlight and click your selection.
- > Position the cursor in the field then type in the first letter of the stored job, use the **down arrow** key if necessary to scroll through the list.

See "Recalling a Stored Job."

4. If you are not changing any of the jobs selections, then move down to where you must enter a date range, otherwise make the necessary changes following the corresponding step.

5. Click  or **Tab** to bring the cursor into the field, then **Alt+down** to open the dialog box.



Note: You must open this dialog even if you intend to accept the defaults unless you are selecting a stored job.

6. To review your options, see "Understanding the Bank Reconciliation Report."
7. To select a group by field, double click on its name, this moves the field over to the level of detail tree.

Note: The order in which you select the field determines the major and sub groupings. Your first selection is the major group.

8. To minimize (close up) the level of detail, click .
9. Optional: To trigger a page break between each major grouping while printing, check **New Page per Major Sequence**.
When you don't check this option the report prints continuously.
10. Optional: To allow you to view a report on the screen and open each grouping at will, check **Viewing with Drill Down**.
11. Click **OK** to return to the main screen.
12. Optional: Select specific Actual Providers by clicking  (or **Tabbing** into the field and holding down **Alt+down arrow** on the keyboard to open the dialog).
13. Hold down **Ctrl** while clicking on the name or names of the providers you want included on the report.
14. Click **OK** to return to the main screen.
15. Optional: Select specific Billing Providers by clicking  (or **Tabbing** into the field and holding down **Alt+down arrow** on the keyboard to open the dialog).
16. Hold down **Ctrl** while clicking on the name or names of the providers you want included on the report.
17. Click **OK** to return to the main screen.
18. Optional: Select specific Batch Categories by clicking  (or **Tabbing** into the field and pressing **Alt+down arrow** on the keyboard to open the dialog).
19. Hold down **Ctrl** while clicking on the name or names of the categories you want included on the report.
20. Click **OK** to return to the main screen.
21. Optional: Select specific Departments/Practices by clicking  (or **Tabbing** into the field and pressing **Alt+down arrow** on the keyboard to open the dialog).
22. Hold down **Ctrl** while clicking on the name or names of the departments/practices you want included on the report.
23. Click **OK** to return to the main screen.

- 24 Optional: Select specific Locations by clicking (or **Tabbing** into the field and pressing **Alt+down arrow** on the keyboard to open the dialog).
- 25 Hold down **Ctrl** while clicking on the name or names of the locations you want included on the report.
- 26 Click **OK** to return to the main screen.
- 27 Optional: Select specific Operators by clicking (or **Tabbing** into the field and pressing **Alt+down arrow** on the keyboard to open the dialog).
- 28 Hold down **Ctrl** while clicking on the name or names of the operators you want included on the report.
- 29 Click **OK** to return to the main screen.
- 30 Optional: Select specific Transaction Codes by clicking (or **Tabbing** into the field and pressing **Alt+down arrow** on the keyboard to open the dialog). Select transaction codes by one of the following:
 - 31 Categories: Hold down **Ctrl** while clicking on the name or names of the categories you want included on the report.
 - 32 Click **OK** to return to the main screen.
 - 33 Click on the tab name **Transaction Types (Alt+t)**.
 - 34 Hold down **Ctrl** while clicking on the name or names of the transaction types you want included on the report.
 - 35 Click **OK** to return to the main screen.
 - 36 Click on the tab name **Transaction Codes (Alt+r)**.
 - 37 Hold down **Ctrl** while clicking on the name or names of the transaction codes you want included on the report.
 - 38 Click **OK** to return to the main screen.
- 39 Required: Enter a date range using one the format mm/dd/yyyy for one of the following date types:

> **Payment Dates**

Default setting.

This is the date that the operator entered in the date/transaction date field at the time he or she entered a payment.

Includes all payments with a status of Entered, Updated, and Marked for Void

> **Entered Dates**

This was the date on the work station/network system at the time the operator entered the payment. Allscripts PM stores this in the Date_Time_Entered field on the payments tables.

Includes all payment transactions with the status of Entered, Updated and Marked for Void whose entered date falls within the range defined.

> **Update Dates**

This was the date on the work station/network system at the time the operator entered the payment. Allscripts PM stores this in the Date_Time_Entered field on the payments tables. Includes all payment transactions with the status of Entered, Updated and Marked for Void whose entered date falls within the range defined.

40. To make a selection do one of the following:

- > Click the up or down arrow
- > With the cursor positioned in the **From date** field use **Ctrl+down arrow** on your computer's keyboard.

41. Optional: To include transactions that are posted to batches flagged as correction batches click on the option to uncheck it.

Note: Be sure you understand how this works. See "Understanding the Bank Reconciliation Report."

42. To exclude unassigned payments, check the option.

Note: This is required when you are grouping by Billing Provider. See "Understanding the Bank Reconciliation Report."

43. Optional: To print a cover page, check the option. See "Printing a Cover Page for Reports."

44. Optional: To save your settings, click **Store (Alt+s)** See Storing a Job."

45. Click **Run (Alt+r)** to open the Print dialog box. See "Using the Print, Preview, and Export Commands."



Chapter 9 Close of Day Processes

Chapter 10

Month/Year End Processing

Begin a New Reporting Period

A reporting period is a way of grouping financial information. When you set the beginning of reporting period, you give the system a marker so that it "knows" which information to use when you generate certain reports.

You cannot update batches to two different reporting periods on the same day. See "Define Reporting Periods" for more information.

Follow these steps when you are ready to close or end the activity for one period and to begin a new reporting period:

1. Enter all charges for the current Reporting Period.
2. Enter all payments for the current Reporting Period.
3. Proof and Close each batch which relates to the current Reporting Period.
4. Update all closed Batches which relate to the current Reporting Period.
5. Run the following three reports:
 - > **ATB** - (Found under Period End Reports)
Report Preferences: Insurance Category – no detail.
All other selections should be set to ALL
Age: base on Service Dates
 - > **Transaction Update Summary** - (Found under Period End Reports)
Select: **Range of Reporting Periods**
 - > **A/R Analysis** - (Found under Comparative Analysis Reports)
Report Preference: Insurance Category
All other selections should be set to ALL.
Enter the Reporting Period

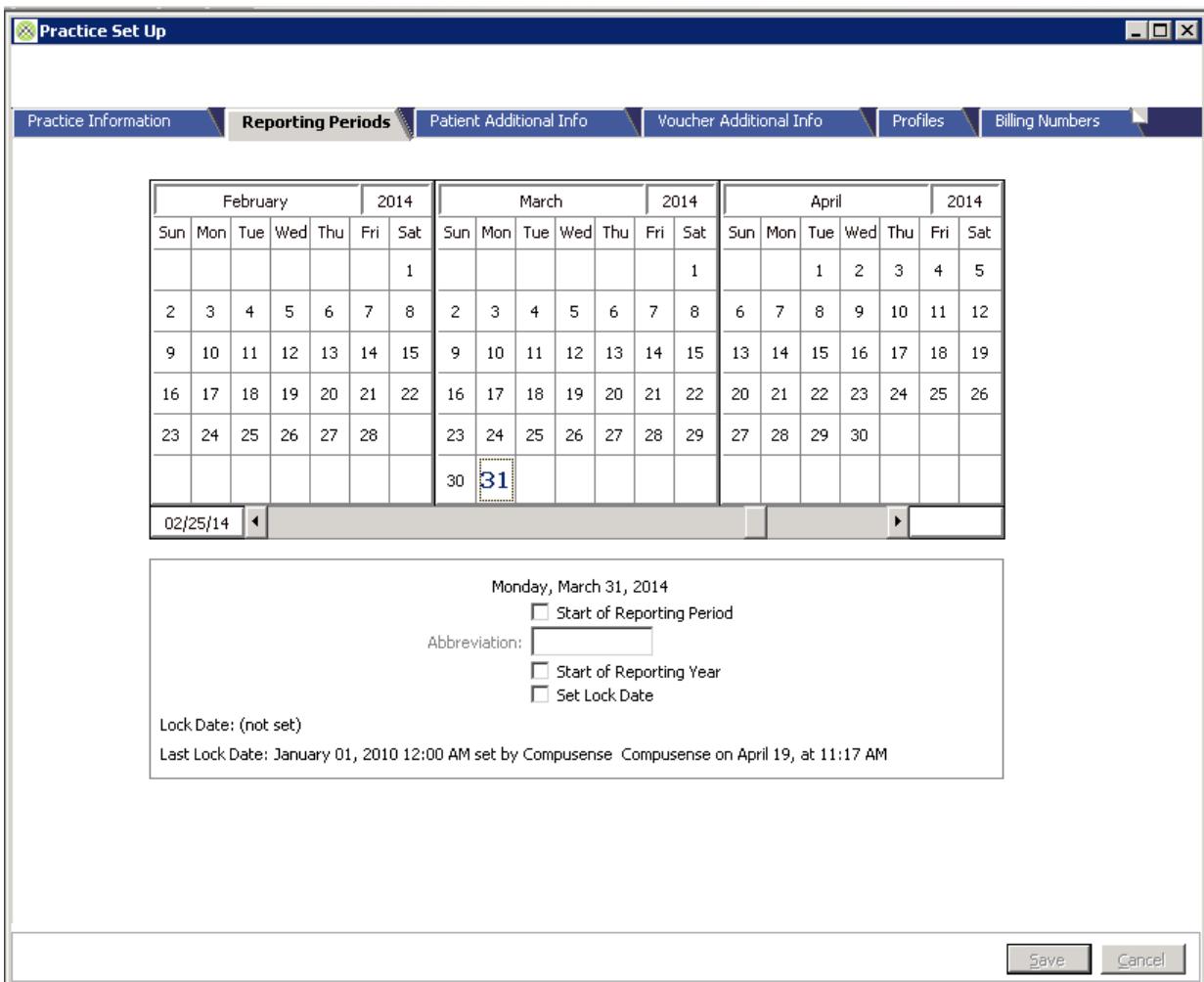
The grand totals for each of these reports must match. If the grand totals of these reports do not match, call Support.

The grand total on the A/R analysis must match the total A/R printed on the last updated transaction journal.

6. Print the Aged Trial Balance after updating the last transaction journal that is to be posted to the current reporting period.

Because the ATB is a snap shot of your financial status at the time you run the report, this report must be run before batches for the new period are updated. Unlike the A/R Analysis and the TUS reports, the ATB cannot be run by reporting period or update date. Therefore, it is recommend that you keep a copy of your monthly ATB on file since you will not be able to recapture the financial picture for previous reporting period(s). All other reports can be run at anytime.

7. Begin a new reporting period.
8. **F9** > Type "PSU" > **Enter** > Click the Reporting Periods tab.



February							March							April									
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat			
						1						1				1	2	3	4	5			
2	3	4	5	6	7	8	2	3	4	5	6	7	8	6	7	8	9	10	11	12			
9	10	11	12	13	14	15	9	10	11	12	13	14	15	13	14	15	16	17	18	19			
16	17	18	19	20	21	22	16	17	18	19	20	21	22	20	21	22	23	24	25	26			
23	24	25	26	27	28		23	24	25	26	27	28	29	27	28	29	30						
							30	31															

02/25/14 ▶

Monday, March 31, 2014

Start of Reporting Period
 Abbreviation:
 Start of Reporting Year
 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

Save **Cancel**

9. Using your computer's mouse, point and click on the date you want the new period to begin. For example, if you updated all the batches for the current period on the 3rd, you should select the 4th as the beginning of the new reporting period. In this case, you should not update batches

for the new reporting period until the 4th because that is the first day of your new reporting period.

10. Check the box, **Start of Reporting Period**

11. Click **Save (Alt+s)** to save your entry.

Results of this task

Be sure to wait until the date of the new period to update batches that are to be posted to the new reporting period.



Chapter 10 Month/Year End Processing

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.