

Electronic Health Record User's Guide

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Introduction

Aprima patient relationship manager is a comprehensive and flexible application that allows you to fully replicate the workflow processes used in your office or clinic. It is designed to help you streamline your current processes, while maintaining data and audit trails for all physician-patient interaction and subsequent billing.

Aprima includes two fully integrated components:

- Electronic Health Records (EHR)
- Practice Management System (PM)

The system fully integrates both EHR and PM but, as different users will likely use each component, the two components are considered separately for the purpose of training and documentation.

Electronic Health Records

The EHR module contains the features and functions that enable you to chart patient visit notes, order lab tests, write prescriptions, and create and maintain other clinical records.

Purpose and Organization of this Guide

This guide is intended as a reference document for physicians, other providers, nurses, and other clinical staff who are users of the electronic health record module of the application. This guide is primarily intended for users who have received training on the application.

Because this guide is intended as a reference document, it is arranged in alphabetical order by topic. Within a major topic, subtopics may be arranged in various ways. Some topics have subtopics that are only loosely related to each other. In these topics, the subtopics are also arranged alphabetically. Other topics have subtopics that are closely related and dependent upon one another. For these topics, the subtopics are arranged logically.

New and Revised Content

Enhancements and new features are identified in this document using the following conventions.

- **<<New>>**: Identifies new information in the guide. This information may be about a new feature or a new function or workflow for an existing feature.
- **<<Revised>>**: Identifies information in the guide that has been revised as a result of an enhancement or a new feature.

Conventions Used in Documentation

Menu selections are indicated with arrows leading from one item to the next. For example, Tools → List Editor → System → User Group indicates that you should:

1. Select the Tools menu.
2. Choose List Editor from the drop-down list.
3. Select System from the List Editor menu.
4. Select User Group from the System menu.

Field names, menu items, and button names are given in initial upper case, as shown in the steps above. In many instructions, the word 'field' is not included and is instead simply identified by the initial upper case name of the field. For example, the instruction "Enter a Name for the collection status" means "In the Name field, enter a name for the collection status."

Most windows require that you select the OK button to accept your selection or save your entry to the database. Because this is a general requirement of nearly all windows and the procedures in which they are used, this step is not included in most procedures.

Addendums and Deletions

Changes to and deletions of clinical information in a patient's chart are handled very carefully by the application. Information that is entered into the patient chart through the Patient History window or through Full Note Composer or another clinical note type window cannot be deleted once the information has been permanently added to the patient's chart. Once information becomes permanent, then you may change or delete it, but your change or deletion is identified in the patient's chart as an addendum. You can freely change and delete information that is not yet permanent. If the information has been saved, then your change or deletion is logged in the audit trail, but it does not appear in the patient's chart as an addendum. If the information has not yet been saved, then there is no record of your change or deletion.

Patient History

Information entered through the Patient History window is considered pending on the day in which it is entered. While you are in the Patient History, you may enter, change, and remove information freely, without record of any changes. When you select the OK button, all the information entered is saved to the database and the window closes. Although the information has been saved, it is still pending. You may open the Patient History window again on the same day and make changes to the day's entries. Your changes, additions, or deletions are logged in the audit trail.

Information entered through the Patient History window is considered permanent at 12:01 a.m. on the day following its entry. Once the information is permanent, then changes or deletions are identified as addendums.

Patient Visit Notes

Most of the information entered in a patient visit note through Full Note Composer or another clinical note type window is considered pending while that visit note's status is incomplete. The information in the visit note is saved to the database when you select the Save icon or select the OK button to close the window. The information is also saved if you send an electronic prescription, send an electronic lab order, or perform diagnosis and procedure code scrubbing. Each time you save the visit note, entries and changes are logged in the audit trail. Entries that you make but then change or delete between saves are not logged in the audit trail.

Some information in a visit note becomes permanent when it is transmitted out of the application. All other information in a patient visit note becomes permanent when the status of the visit note is changed to complete. When the status of the visit note is complete, then all additions, changes, and deletions are identified in the visit note as addendums when you save the visit note. Full Note Composer and other clinical note type windows only display the net result of all changes. The detail of the original and changed entries is not displayed.

When you need to see the addendums to a patient visit note, you must use either Review Past Note or One Page Summary with the options for showing addendums.

Prescriptions, Lab Tests, and Vaccinations

Prescriptions, lab tests, and vaccinations may become permanent even while the visit note status is incomplete if the information is printed or transmitted out of the application. A prescription is considered written and becomes a permanent part of the record when it is either printed or sent electronically to the pharmacy. A lab test is considered ordered when it is sent to a laboratory through an electronic interface. A vaccination is considered administered and a permanent part of the record when the vaccination administration record is printed or the vaccination is transmitted electronically to a registry.

Attachments

Attachments that require approval, such as lab results, cannot be deleted from the patient's chart. Instead, the approved attachment must be struck through if it was attached in error. Attachments that do not require approval may be deleted from the patient's chart. The deletion of an attachment is identified in the audit trail.

Cancer Registry Reporting

Reporting to a cancer registry may be required for MIPS and other quality programs.

The application includes a number of features that enable you to enter the information needed by a registry. These include:

- Patient's address history enables you to enter a history of the locations in which the patient has lived.
- Patient's employment history enables you to enter occupation and industry.
- Cancer Diagnosis diagnosis note enables you to enter additional information required by registries about a patient's diagnosis. You must use this diagnosis note to trigger submission to the registry.
- Cancer Registry diagnosis search definition for use with the Cancer diagnosis note. This search definition includes the diagnoses that registries want reported.

In addition, the application includes a CCDA document type, CancerCCDA, specifically for cancer registry reporting. The CancerCCDA is similar to the CCDA document type, but it includes additional information required by cancer registries. You can generate CCDA files using this format, and then send the files to your registry. If you want an interface to your registry, please contact your sales representative or send an email to Aprima-InsideSales@aprima.com.

Care Management

The application's care management functionality is used for Medicare's care plan oversight (CPO) and chronic care management (CCM) programs. Both programs allow providers to bill for time they spend managing a patient's care with other physicians and health care professionals who are providing care to the patient. These payments are not for services rendered by the provider either in the provider's office or at another facility or the patient's home.

Care management payments are based on the number of minutes that the physician or other qualified health care professional spends managing a patient's care during a month. Time spent on managing care qualifies for CPO or CCM payment when the provider does not bill for services provided to the patient, either in the practice office or at an external site, on the same calendar date.

The tasks performed while coordinating care must be adequately documented. Documentation to support CPO or CCM activities must include the activities performed, the time spent on the activities, the reason why the activities were necessary.

A patient may be eligible for both CPO and CCM at the same time. However, a provider may only bill for one program for the patient for a month. The CPO program requires more time spent during the month in order to qualify for a payment, but it also pays more for the monthly service.

The rules and qualifications for care management programs and payments are complex, and are not fully described here. Information for these programs is available from the Centers for Medicare & Medicaid Services (CMS) website (<http://www.cms.gov/>). While these are primarily Medicare programs, other insurance payers may have similar programs. Check with your insurance payers to determine their participation and rules.

The application uses the messaging, visit notes, and care management entries for patients to identify and accumulate CCM and CPO minutes. Depending on your practice's policies, you or a billing user may review the documentation for accumulated minutes, approve or deny each item and its minutes. CCM and CPO document should be reviewed regularly throughout the month. Once the CCM or CPO requirements have been met for a patient, you should generate the superbill and submit the claim. If the patient has active entries for both CCM and CPO and has met the requirements for both, then the application determines which programs' requirements have been met, and generates a superbill for the program with the highest charge amount for the month.

Chronic Care Management

Medicare's chronic care management (CCM) program allows providers to bill for time they spend on non-face-to-face care coordination services. The CCM program covers Medicare patients who have two or more chronic conditions that are expected to last at least 12 months or until the patient's death and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Only one provider may receive payment for a patient's CCM service for a given calendar month.

To bill for CCM services for a patient, you must perform qualifying services for 20 or more minutes within a calendar month. Time cannot be rounded up.

The CCM services may be performed by the physician or non-physician provider or by a clinical staff member who is incident to the billing provider. Services performed by non-clinical staff do not qualify for CCM billing. Please refer to your Medicare and CMS documents to determine whether you qualify to bill for CCM services, who can perform the services, and whether the specific services you provide qualify for CCM billing.

In order for a patient to qualify for CCM, the patient must have two or more chronic conditions. Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoarthritis
- Osteoporosis
- Rheumatoid arthritis

Patient Agreement for CCM Billing

Before billing for CCM services for an eligible patient, you must inform the patient of the program and obtain the patient's consent for the services and billing for the services. You only need to obtain informed patient consent once prior to providing CCM services. Patient consent does not have to be renewed.

Obtaining a patient's consent requires that you:

- Explain the CCM program and services to the patient, and offer the services to the patient. This should include:
 - What the CCM service is
 - How the patient may access elements of the service
 - How you will share the patient's information with other practitioners and providers who participate in the patient's care
 - How the patient's co-insurance and deductibles apply to the CCM service
 - How the patient may revoke the service
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.
- Document this discussion in the patient's medical record, including whether the patient accepted or declined the service.
- Obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.

Initial CCM Visit

If the patient is new or has not been seen within a year prior to initiation of CCM, then CMS requires that you conduct an initial visit prior to billing the CCM services. This visit must be a comprehensive evaluation and management (E&M) visit, annual wellness visit, or initial preventive physical examination (IPPE) visit with the patient. You must initiate the CCM service as part of this visit.

Regular and Complex Services

For a given month, you may provide a patient with regular (non-complex) or complex CCM services. The difference between regular and complex services is the complexity of the problems addressed, the extent of care planning performed, and the amount of time spent performing the services.

Complex services are paid at a high rate than regular services, but they also require additional time spent during the month. Regular CCM service requires 20 minutes or more per month. Complex care requires 60 minutes or more per month. When performing complex care, you may bill for an additional CPT code for each additional 30 minutes of time spent.

Please note that reimbursement for complex services may be not be allowed in some circumstances, such as participation in a Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs), even when all the requirements are met. In these circumstances, you should not identify your time spent as qualifying for complex care. This ensures that any superbills generated do not include the procedure codes for complex services. However, if a superbill is generated with the wrong procedure code, your billing staff may correct it before processing a claim.

CircleLink Health

CircleLink Health provides chronic care management and patient engagement services. If your practice has enrolled with CircleLink, then CircleLink will provide care plans for your accepted CCM patients. CircleLink also provides remote monitoring and assessment of patients and sends them automatic alerts by phone or text messaging.

To use CircleLink for a CCM patient, the patient must have consented to data exchange with CircleLink and this must be indicated in the Patient window's Additional tab.

When you create a CCM entry for a patient and give it a status of Accepted, then the application generates a CCD file for the patient and sends it to CircleLink. CircleLink creates a care plan for the patient, and sends it back to the application.

When the application receives a care plan for a patient, it sends a message with the care plan document to the provider on the CCM entry. You can then review and approve the care plan attachment. The document has the attachment type of Care Management.

CircleLink also sends information about their interaction with the patient and the time spent on care management activities. When the application receives this information, it sends a message to the provider on the CCM entry. These system-generated messages are the same as care management messages created by users.

The application also sends CCM minutes that you enter and approve to CircleLink. Your time spent on CCM activities for a patient is sent to CircleLink when the CCM minutes are approved. Therefore, it is important that CCM entries are reviewed and approved regularly throughout the month.

Persivia™

Persivia provides chronic care management and patient engagement services. If your practice has enrolled with Persivia, then Persivia will provide care plans for your accepted CCM patients. Persivia also provides remote monitoring and assessment of patients and sends them automatic alerts by phone or text messaging.

To use Persivia for a CCM patient, the patient must have consented to data exchange with Persivia and this must be indicated in the Patient window's Additional tab.

When you create a CCM entry for a patient and give it a status of Accepted, then the application generates a CCD file for the patient and sends it to Persivia. Persivia creates a care plan for the patient, and sends it back to the application.

When the application receives a care plan for a patient, it sends a message with the care plan document to the provider on the CCM entry. You can then review, edit, and approve the care plan attachment. The document has the attachment type of Care Management.

Persivia also sends information about their interaction with the patient and the time spent on care management activities. When the application receives this information, it sends a message to the provider on the CCM entry. These system-generated messages are the same as care management messages created by users.

The application also sends CCM minutes that you enter and approve to Persivia. Your time spent on CCM activities for a patient is sent to Persivia when the CCM minutes are approved. Therefore, it is important that CCM entries are reviewed and approved regularly throughout the month.

Care Plan Oversight

Care plan oversight (CPO) is a Medicare program that allows a provider to bill for supervision of a patient who is receiving complex and/or multidisciplinary care provided by a participating home health agency or Medicare-approved hospice. CPO payments are for oversight and coordination of other professionals who are providing care to the patient, not for services rendered by the CPO provider either in the provider's office or at another facility or the patient's home.

Only one provider may receive payment for a patient's CPO service for a given calendar month. To bill for CPO services for a patient, you must be the physician who signed the patient's certified care plan. (Certification of a care plan is separate from CPO, but it is required to bill for CPO activities and services.) You must also have had a face-to-face encounter (not including EKG, lab services, or surgery) with the patient in the six-months prior to billing for CPO services.

To bill for services during any given month, you must have coordinated some aspect of the patient's care with the home health agency or hospice during that month. You must perform qualifying services for 30 or more minutes within the calendar month. CPO activities may be performed by a nurse practitioner, physician assistant, or clinical nurse specialist in your practice, depending upon state law. Time cannot be rounded up.

Qualifying CPO services may include the following.

- Creating and revising a patient care plan
- Reviewing reports of the patient's status
- Reviewing laboratory test results and other observation items
- Communicating with other health professionals, external to your practice, who are also providing services to the patient
- Adjusting medical therapies for the patient

Some services that may be necessary in order to provide qualifying CPO services cannot be counted for CPO billing. These services include, but are not limited to, the following.

- Discussions with the patient, family members, or friends to adjust medication or treatment
- Retrieving or filing the patient's chart
- Travel
- Phoning prescriptions into the pharmacy, except when discussing pharmaceutical therapies with the pharmacist.

Certification and Recertification for CPO

The CPO program requires an initial certification for a patient, and then periodic recertification for as long as CPO services are provided.

A patient's initial certification period is when the patient begins receiving home health care or hospice care after not receiving any Medicare-covered home health care for at least 60 days. You must certify a patient before they can receive home health services covered by Medicare. Once you have certified the patient, then the initial certification period is for next 60 days.

A recertification period is needed when the patient has been receiving home health care or hospice care during the past 60 days. Each recertification period is 60 days.

Using the Care Management Functionality

To use the care management functionality, you must have been given the necessary security rights and the ability to document billable time for care management.

Care management tasks include:

- Identifying patients that qualify for CCM and/or CPO.
- Creating a CCM and/or CPO entry for a patient.
- Attaching a signed CCM consent agreement to the patient record.
- Documenting care management time spent in messages or visit notes.
- Reviewing the care management messages and visit notes, and approving the time spent. This is a billing activity, and thus, is explained in the *Practice Management User's Guide*.
- Creating a superbill for the management time spent for a patient. This is a billing activity, and thus, is explained in the *Practice Management User's Guide*.

Identifying and Qualifying Patients for Care Management

Obtain Patient's Consent for CCM Participation and Billing

Before billing for CCM services for an eligible patient, you must inform the patient of the program and obtain the patient's consent for the services and billing for the services. You must have the patient sign a written agreement to have you provide the services. You must scan the signed the CCM agreement and attach it to the patient record. The document must be attached using the Care Management attachment type.

Please note that patient consent is not necessary for CPO billing.

1. Patient Demographics → Demographics tab
2. Select the Patient Name hyperlink to open the Patient window.
3. In the Patient window, select the Attachment slider.
4. In the Attachment slider, select the New button. This opens the Attachment Editor window.

5. In the Attachment Editor window, select the Import button.
6. In the Find window, select the Import Files option.
7. Search for and select the CCM agreement file, and then select the Open button. This returns to the Attachment Editor window.
8. In the Attachment Editor window, the Name field displays the file name for the document. You may accept this as the attachment name or change it if desired.
9. In the Type field, you must select the Care Management attachment type.
10. Enter any Notes, if desired.
11. Select the OK button to attach the file to the patient record. The attachment will be listed in the Attachment slider.

Create a CCM Entry for a Patient

You should create a CCM entry for a patient after you offer CCM services to an eligible patient. The status of the entry identifies whether the patient accepted or declined the services or is already receiving CCM services from another provider. Once you create an entry for the patient, a CCM button appears on the Patient toolbar. The button identifies the status of the CCM entry.

1. Patient Demographics → Patient menu → Care Management
2. In the Patient Care Management window, select the New CCM button. This opens the Patient Care Management entry window.
3. Enter the Effective Date. This is the date on which the patient signed the CCM consent agreement or the effective date identified in that agreement, or the date the patient declined the service.
4. Leave the Expiration Date field empty when creating a new entry.
5. Select the appropriate Status.
 - Accept: The patient has signed the CCM agreement accepting CCM services and authorizing you to bill for them. The status must be Accept in order to create superbills using the care management functionality.
 - Decline: The patient declined the CCM services.
 - Eligible: The patient is eligible for CCM services, but has not yet either accepted or declined them.
 - Exempt: The patient is eligible for CCM services, but is receiving them from another provider or is otherwise exempt.
6. Select the Provider who will bill for the CCM services. This will be the billing provider on superbills created using the care management functionality.
7. Enter any Notes, if needed.
8. Select the qualifying Diagnosis codes from the patient's history. The patient must have at least two chronic conditions.

Create a CPO Entry for a Patient

1. Patient Demographics → Patient menu → Care Management
2. In the Patient Care Management window, select the New CPO button. This opens the Patient Care Management entry window.
3. Select a Medical Services Provider. The selected medical services provider must have a medical services type of Home Health Care or Hospice in order to qualify for CPO billing.
4. Enter the Effective Date. This is the date on which the patient signed the CCM consent agreement or the effective date identified in that agreement, or the date the patient declined the service.
5. Leave the Expiration Date field empty when creating a new entry.
6. In the Status field, select the Accept status. Patients do not have to formally accept CPO services. You do, however, have to set the status as Accept in order to create superbills using the care management functionality.
7. Enter a Location for the patient if desired. This is a text field that enables you to enter a room number or other location identifier.
8. Select the Provider who will bill for the CPO services. This will be the billing provider on superbills created using the care management functionality.
9. Enter any Notes, if needed.
10. Select the qualifying Diagnosis code or codes from the patient's history.
11. Either:
 - Select the For Certification checkbox when the entry is for the patient's initial certification period.
 - Leave the For Certification checkbox unselected when the entry is for a recertification period.

Clone a CPO Entry for a Patient

Cloning a CPO entry is an easy way to create an entry for a new recertification period for a patient. When you clone an entry, an expiration date is entered in the original entry.

1. Patient Demographics → CPO: Accepted button
2. In the Patient Care Management window, enter the desired filtering criteria and select the Search button.
3. Select the Effective Date hyperlink for the CPO entry you want to clone. This opens the Patient Care Management entry window.
4. Select the Clone button to create a new entry for a CPO recertification period for this patient.
This enters yesterday's date in the Expiration Date field of this record.
5. Select the OK button to save and close the record.
This creates a new CPO entry with all the information from the original entry, but with an effective date of today. The new entry is not marked for certification.

View a Patient's Care Management Entries

The Patient Care Management window displays a list of the CCM and CPO entries for a patient. Entries include the approval status, and number of minutes. CPO entries also display the billing provider. CCM entries are not connected to a specific provider, so this column is blank.

You can create, modify, and delete entries from this window.

1. Either:
 - Patient toolbar → Care Management () icon
 - Patient toolbar → CCM: Accepted button
 - Patient toolbar → CPO: Accepted button
2. Enter the desired selection criteria, and then select the Search button. This displays a list of entries matching your criteria.
3. To view or modify an entry, select the Effective Date hyperlink.

Add Attachment to Care Management Entry

1. Patient Demographics → CPO/CCM: Accepted button
2. In the Patient Care Management window, enter the desired filtering criteria and select the Search button.
3. Select the Effective Date hyperlink for the desired entry. This opens the Patient Care Management entry window.
4. In the Patient Care Management window, select the Attachment slider.
5. In the Attachment slider, select the New button. This opens the Attachment Editor window.
6. In the Attachment Editor window, select the Import button.
7. In the Find window, select the Import Files option.
8. Search for and select the desired file, and then select the Open button. This returns to the Attachment Editor window.
9. In the Attachment Editor window, the Name field displays the file name for the document. You may accept this as the attachment name or change it if desired.
10. In the Type field, select the Care Management attachment type.
11. Enter any Notes, if desired.
12. Select the OK button to attach the file to the patient record. The attachment will be listed in the Attachment slider.

Documenting Time for Care Management

Time spent on care management tasks may be entered in a message or in patient visit note when the patient visit is documented using a clinical note type that does not include an SP tab. Time for care management can only be entered for patients who have an active care management record for either CCM or CPO. A patient may have active entries for both programs. If so, then the time entered may be used for either program, but may only be used to bill for one program for any given month.

Create a Message to Document Care Management Minutes

Use this procedure to document care management activities and minutes for a patient.

1. New Message → Any message type
2. Select the Patient for whom you want to record care management minutes.
3. Select a Due Date for the message.
4. In the Assign To field, select yourself as the person who did the work.
5. In the Task field, enter a description of the activities performed that qualify for care management payment.
6. Select the CCM/CPO slider, and make the following entries.
 - a. Select the Billing Provider. This is the provider who will receive credit for the care management minutes.
 - b. Select the Billing Date. This is the date on which the CPO services were provided. The default is today's date, but you can change the date if needed.
 - c. Enter the billable Minutes.
 - The default number of minutes is displayed. Change this as needed.
 - Remove the default entry in any message that does not record tasks that qualify for care management for this patient.
 - d. Select the IS CCM and/or IS CPO checkbox if the minutes entered are to be considered. If neither of these checkboxes is selected, then this message will not be available for care management review.
 - e. If this is a CCM patient and the services you are documenting qualify as complex, then select the checkbox for Medical Decision Making Complexity High or Medium.
7. Select the Complete button to complete this message.

Document Care Management Minutes in a Message Received

Use this procedure to document your care management activities and minutes in a message you received from another user. For example, if you have care management minutes associated with a phone message, lab results message, or refill request message, you can use this procedure to enter your care management minutes as you process the message you received.

1. Select the link for the desired message either from the Desktop or the Message Center.
2. Select the Message Notes tab of the Message window.
3. In the Notes window, enter information about the work you did and the time spent.
4. Select the CCM/CPO slider, and verify the following entries.
 - a. Select the Billing Provider. This is the provider identified in the patient's care management entry, and who will receive credit for the care management minutes.
 - b. Select the Billing Date. This is the date on which the CPO services were provided. The default is today's date, but you can change the date if needed.
 - c. Enter the billable Minutes.
 - Remove the default entry in any message that does not record tasks that qualify for care management for this patient.
 - d. Select the IS CCM and/or IS CPO checkbox if the minutes entered are to be considered. If neither of these checkboxes is selected, then this message will not be available for care management review.
 - e. If this is a CCM patient and the services you are documenting qualify as complex, then select the checkbox for Medical Decision Making Complexity High or Medium.
5. Select the Complete button to complete this message.

Use the Timer to Document Care Management Minutes in a Message

You can use the timer in the CCM/CPO slider to determine the number of minutes used for care management activities.

1. Create a new message or open a message received
2. If a new message, complete the Patient, Due Date, and Assign To fields.
3. Select the CCM/CPO slider, and make the following entries.
 - a. Select the Billing Provider. This is the provider who will receive credit for the care management minutes.
 - b. Select the Billing Date. This is the date on which the CPO services were provided. The default is today's date, but you can change the date if needed.
4. When you are ready to begin your care management activities, such as a phone call or document review, select the Start Timer button in the CCM/CPO slider.
5. When you complete your care management activities, select the Timer Running button in the CCM/CPO slider. This populates the Minutes field.

6. Select the IS CCM and/or IS CPO checkbox if the minutes entered are to be considered. If neither of these checkboxes is selected, then this message will not be available for care management review.
7. If this is a CCM patient and the services you are documenting qualify as complex, then select the checkbox for Medical Decision Making Complexity High or Medium.
8. In the Task field, enter a description of the activities performed that qualify for care management payment.
9. Select the Complete button to complete this message.

Document Care Management Minutes in a Patient Visit Note

You may document care management minutes in a patient visit note when you chart the note in a clinical note type that does not include the SP tab, such as the system-defined Order Note. When you use a patient visit note, the information you chart supports the number of care management minutes that you enter. You may also enter additional information as notes in any tab or in the CCM/CPO slider.

1. Order Note or other clinical note type
2. Select the CCM/CPO slider.
3. In the slider, select the Start Timer button.
4. Chart the visit note as appropriate with diagnosis codes, prescriptions, lab test or other clinical orders, and any other information as appropriate.
5. When you have completed all charting, select the Timer Running button in the CCM/CPO slider. This populates the Minutes field.
6. Select the IS CCM and/or IS CPO checkbox if the minutes entered are to be considered. If neither of these checkboxes is selected, then this visit note will not be available for care management review.
7. If this is a CCM patient and the services you are documenting qualify as complex, then select the checkbox for Medical Decision Making Complexity High or Medium.
8. Select the OK button to close the clinical note type window and open the Visit Checkout window.
9. Complete the Visit Checkout window as appropriate, and then select the OK button.

Process Care Management Minutes

The messages and patient visit notes that are used to document care management minutes must be reviewed regularly, and either approved for billing or denied. The review helps you ensure that minutes inadvertently recorded in messages that are unrelated to care management activities are not used for billing. It also helps you ensure that messages and visit notes contain sufficient documentation to support the number of care management minutes recorded. Depending on your practice's policies, you or a clinical user may perform this review.

If you are using a third-party vendor for chronic care management and patient engagement services, then it is important that care management minutes are reviewed and approved

regularly throughout the month. Time spent by your staff is sent to the third-party when the minutes are approved.

Once the CCM or CPO requirements have been met for a patient, you should generate the superbill and submit the claim. If the patient has active entries for both CCM and CPO and has met the requirements for both, then the application determines which programs' requirements have been met, and generates a superbill for the program with the highest charge amount for the month.

Review and Approve Care Management Minutes

When reviewing and approving care management minutes, you may only view entries for one month at a time. You may review minutes for the current month or for any past month.

Other filtering criteria enable you to search for a particular patient or patients, approved or unapproved minutes, and only patients with enough minutes to be billed or patients with any number of minutes recorded.

1. Desktop Menu → Care Management Review
2. Enter the desired filtering criteria, and then select the Search button.
3. To review entries for a patient, select the Patient name hyperlink.
4. The Patient Care Management Minutes Review window lists all the messages and visit notes with care management minute entries, with the approval status, and number of minutes.
If you are using a third-party for CCM, the Integration Partner column is populated for messages received from that third-party.
5. Select the Billing Source hyperlink to access the message or visit note where the minutes are record.
6. Review the documentation to determine whether the minutes qualify. Then close the item to return to the Patient Care Management Minutes Review window.
7. To approve minutes:
 - a. Select the checkbox for each entry you want to approve.
 - b. Select the Approve button.
8. To deny minutes:
 - a. Select the checkbox for each entry you want to deny.
 - b. Select the Deny button.
9. When you have reviewed all items, select the OK button to close the window and return to the Care Management Review window.
10. Repeat steps 3 through 9 for each patient listed.

Edit a Care Plan from Persivia

If you are using the optional Persivia chronic care management services, then you may edit the patient care plan that you receive from them. When you edit the care plan, the application attaches the edited care plan to the patient record and sends the edited plan back to Persivia.

1. Select the link for the desired message either from the Desktop or the Message Center.
2. In the Attachment tab, review the content of the care plan.
3. If desired, enter text in any Comment field.
4. To add an entry to any section:
 - a. Select the blue plus sign (+) icon to add an entry line.
 - b. Enter text in the entry fields.
 - c. Repeat if desired.
5. To remove an entry from any section, select the delete (X) icon next to the entry.
6. When you have made all the desired changes, select the Approve Attachment checkbox at the top of tab.
7. Select the Complete button to approve the care plan, and complete the message.

Case Management

Case management enables you to track a patient case through multiple patient visits. Although a new visit note is generated for each visit, case management retains information through successive visits until the case is explicitly closed.

When a patient case is associated with an appointment, then that patient case is automatically associated with a visit note created from the appointment. You cannot change or remove a patient case from a visit note created from an appointment associated with the case.

A visit note that is not already associated with a patient case, you may use the Visit Information slider to associate a patient case.

Pregnancy Case Management Type

The application is preconfigured with a Pregnancy case type. The case allows you to associate a pregnancy case with a patient visit in Full Note Composer or Superbill Composer, and track the pregnancy through the different phases. Dates, such as expected date of delivery, are calculated automatically according to the criteria you select.

The pregnancy case type includes five modules:

- Estimated Delivery Date
- Result Tracking
- Other Information

- Summary
- Flow Sheet

It also includes three phases:

- 1st Trimester
- 2nd Trimester
- 3rd Trimester

Your practice may have edited the names and the sequence of the modules and phases that display. However, the contents of the modules, and hence the information that you should complete, will remain the same. Select the module to display from the list in the left pane of the tab.

Estimated Delivery Date (EDD)

The estimated delivery data module allows you to calculate the EDD based on the last menstrual period (LMP) date, the initial exam date and estimated gestational age of the fetus, or an ultrasound date and estimated gestational age of the fetus. The module calculates the EDD when you enter this information. Each criterion is likely to yield a different date, so you can then choose which will be the basis for the calculation by selecting the relevant radio button.

You can then add other information, such as date of quickening, fundal height, etc. to further compute the EDD.

Result Tracking

This module allows you to track tests and results. It uses the standard results tracking data sheet. For further information, see Results Tracking.

1. Select the required view option.
2. Select the Enter button to display the entry form.
3. Select the required laboratory, template, and attachment type.
4. Enter dates as necessary for date ordered, date collected, etc.
5. Enter the results values into the data sheet.
6. You can also request a review of the results by specifying the name of the required reviewer and attaching an urgency to the request.

Other Information

This module includes the questions that were preconfigured in the Pregnancy Misc User Defined Control Group. It includes a series of questions such as:

- Father of the Baby
- Emergency Contact
- Hospital or place of delivery

Summary

This section provides a summary of the information in the case.

Flow Sheet

This module includes a series of questions from which you select or enter a response. The information is stored through subsequent visits so you can track progress. You can make separate entries for each fetus for a multiple birth pregnancy.

You may display information in reverse chronological or chronological order. The order is determined by the setting in the User Settings definition you are using.

You can use the Maximize () and Minimize () icons to increase and restore the flow sheet window.

1. Full Note Composer → Case Mgmt tab → Flow Sheet button
2. Select the total number of fetuses to be delivered for this pregnancy.
When the number selected is greater than 1, the New button in the Flow Sheet Data section becomes active.
3. Enter the flow sheet data for the first fetus, including an identifying fetus number (Fetus #).
4. To enter information for a second fetus, select the New button to add a blank line to the flow sheet.
5. Enter the flow sheet data for the second fetus, including an identifying fetus number (Fetus #).
6. Repeat steps 4 and 5 for each fetus.

Using the Scheduled OB Labs Slider

If your practice has associated lab templates with the pregnancy case, you may use them in a patient visit note. The Scheduled OB Labs Slider makes available the lab templates applicable to the patient's trimester so that the provider can easily select the tests that are needed. The slider is available in Full Note Composer only when the patient visit note is associated with a pregnancy case.

When a lab test or procedure is ordered from the Scheduled OB Labs Slider, it is entered into the SO or SP tab as a service ordered or performed. When a lab test or procedure has been ordered previously, the last ordered date displays in the slider.

The lab tests and procedures available in the Scheduled OB Labs slider are applicable only to the patient's current trimester. Lab tests and procedures associated with a previous trimester are not available from the slider, even if they have been performed.

1. Full Note Composer → Scheduled OB Labs Slider
2. For each lab test or procedure, select either the:
 - SO radio button to select the procedure as a service ordered.
 - SP radio button to select the procedure as a service provided.

Note: If the radio buttons are not visible, move the horizontal scroll bar to the right or increase the width of the slider.

3. Select the link the desired lab test or procedure to order it. This will enter it into the patient visit note as a service ordered or provided, depending on the radio button selected.

If a procedure note is associated with the lab test or procedure, that procedure note will be initiated so that you can complete it.

Using the Education Forms Slider

The Education Forms slider enables you to search for and select education forms from any tab in the Full Note Composer or Superbill Composer window.

The Education Forms slider will be prepopulated with pregnancy-related education forms if your administrative super user has associated specific forms with a phase (trimester) of the pregnancy case. The Education Forms slider makes available the education forms applicable to the patient's trimester so that you can easily select and print the requisite forms. These forms appear in the slider only when the patient visit note is associated with a pregnancy case.

When an education form is printed from the Education Forms slider, it does not appear in the slider for future patient visit notes since printing implies the form has been given to the patient. The slider will automatically close when all of the education forms for the trimester have been printed.

The education forms available in the Education Forms slider are applicable only to the patient's current trimester. Forms associated with a previous trimester are not available from the slider, even if those forms were not printed and given to the patient.

1. Full Note Composer → Education Forms slider
2. Select the link for the desired education form.
3. Select the Print button to print the form.

Custom Case Management Types

Your practice may have defined custom case management types. Any case management type may be associated with education forms frequently used and with lab templates for tests frequently performed or ordered during a patient case.

Simple case management types are used primarily to associate multiple patient visits. Simple case management types do not include case modules, and thus do not enable you to capture or view specific data for the case. When a patient visit is associated with a simple case management type, the Case Management tab does not display in Full Note Composer or other clinical note type windows.

Custom case management types that include case modules do enable you to capture and view data. When a patient visit is associated with a case management type that includes one or more case modules, then the Case Management tab displays in Full Note Composer or other clinical note type window. The Case Management tab displays the case module or modules included in the case management type.

Custom case management types and custom case modules cannot be identified here since they are defined by your practice specifically for your use. But, you will select case modules and enter data into them in the same way as using the system-defined pregnancy case.

Case Alert Messages

Case management types can be configured to display case alert messages in Full Note Composer and other clinical note type windows. The messages appear in a yellow banner at the top of the window, and summarizes the status of the case. The message contains the visit sequence number, the number of authorized units used for a procedure code or code set, the total accrued charges, and the case expiration date.

Required Procedure Codes for Case Types

Some payers require a particular procedure code be included on claims for specified visits within a case. For example, Medicare requires particular procedure codes be included on the first (evaluation) visit, the tenth visit, the twentieth visit, and the discharge visit. Often these required procedure codes are required for visits conducted by a mid-level provider, such as a physical therapist, but not for visits conducted by the fully-qualified MD or OD provider.

Your administrative super user may create rules that the application uses to notify you when a procedure code is required. The application then does not allow you to complete the visit note until you have added the required procedure code.

Some rules will require that you use a specific clinical note type in order to trigger the rule. This is generally used for discharge visits, but may be also used for other purposes.

When a visit note is associated with a case of the defined case type and the visit note meets all the other rule criteria, then the rule will be triggered if you attempt to mark the visit note as complete and it does not include the required procedure code or codes. A popup window will display the explanatory note defined by your administrative super user. This note should tell the procedure code or codes needed in the patient visit note.

Clinical Claim Scrubbing

The optionally purchased clinical claims scrubbing add-in functionality interfaces with the Practice Insight clearinghouse and the Alpha II claim scrubbing engine. Clinical claim scrubbing enables you to identify proper diagnosis and procedure code combinations and to validate coverage policies. It is important to recognize that this validation is against a specific set of insurance rules; it is not a general validation of the completeness or correctness of your coding.

If your practice has purchased clinical claim scrubbing, your administrative user will have enabled the functionality in your practice settings.

The clinical claim scrubbing interface is available from within Full Note Composer, so that you can validate the diagnosis and procedure code combinations entered in a patient visit note while charting the visit. This enables you to determine whether procedures will not be covered, whether an advance beneficiary notice (ABN) is required, or whether some modification to codes is in order.

Select the Validate Codes icon () on the toolbar to send the diagnosis and procedure codes to the claim scrubbing engine. Code validation messages will appear in the Code Validation window.

The Code Validation window and Full Note Composer may be open at the same time so that you can move back and forth between them. If you make changes to the diagnosis and procedure codes in the patient visit, and want to validate them again, you must save the note before selecting the Validate Codes icon again.

Some messages will include links to websites and PDF files with additional information. You must be connected to the Internet to access this additional information. Selecting a link closes the Code Validation window that contains the error messages. You must select the Validate Codes icon again to return to the messages.

Clinical Decision Support from Persivia™

Your practice may choose to enroll with Persivia (formerly known as Alere) to enable downloading clinical decision support information. The functionality enables you to send patient information to Persivia, which then does a health maintenance evaluation based on the patient's age and gender. Persivia then sends back a Clinical Decision Support report.

Your practice may configure the application to automatically make requests for clinical decision support information prior to patients' scheduled appointments. Automatic requests are made for all patients with appointments scheduled within the next 24 hours. You may also make on-demand requests from a clinical note type window if the patient did not have an appointment scheduled in advance.

The Clinical Decision Support report received for the patient appears in the CDS tab of Full Note Composer when you view the patient visit note associated with the appointment or visit. The CDS tab is included in the Full Note Composer window by default when you have licensed the clinical decision support functionality. Your administrative super user or you, if you have the needed security access, can add the CDS tab to other clinical note type windows if desired.

The Clinical Decision Support report contains a patient description and a list of alerts. The alerts section enables you to select one or more recommended services to add them to the patient visit note. It also gives extended reasons for the recommendations and includes hyperlinks to external documentation related to the recommendations.

Although the Clinical Decision Support report appears in Full Note Composer or other clinical note type window, the report is not a part of the patient visit note. Therefore, the report is not included in the Visit Text tab, Review Past Notes, or other visit note summaries. The Clinical Decision Support report cannot be printed.

The Clinical Decision Support report received from Persivia is independent from the application's clinical decision support rules and from the Clinical Decision Support slider that displays those rules. These two separate functions do not interact. CDS rule information does not display in the CDS tab with the Persivia Clinical Decision Support report. Likewise, Persivia Clinical Decision Support report information does not display in the Clinical Decision Support slider.

However, you can select a recommended procedure from the Persivia Clinical Decision Support report to chart in either the SP or SO tab of the clinical note type window. This method of charting the procedure is recognized as an action on a clinical decision support rule that is satisfied by that procedure.

Using the CDS Tab

The CDS tab in Full Note Composer or other clinical note type window displays the clinical decision support report received from the Persivia™ website. The report contains a list of alerts for applicable rules. The alerts section enables you to select one or more recommended procedure codes to the patient visit note.

You can:

- Select the desired CDS rule Catalog.
- Select the Refresh Decision Support button to request a report. The report will appear in the tab once your request has been processed. Information is loaded from the Persivia site so it may take a moment to populate.
- In the Guidelines column, select a hyperlink to expand the guideline information.
- In the References column, select a hyperlink to access the Persivia site for additional information. Then use the Back button to return to the CDS report.
- Select one or more recommended services.
 - Select the SP checkbox for a procedure you will provide to the patient.
 - Select the SO checkbox for a procedure you will order for the patient.
 - Select a Decline reason if appropriate.

Clinical Decision Support Rules

Clinical decision support rules enable you to define a set of parameters or characteristics that apply to a particular preventative health check or recurring test. The parameters may relate to a patient's gender, age, medical history, or medication (drug or drug class), and may be defined to recur after a set period of time, such as annually. When the set of parameters is triggered, by a patient reaching a certain age, or when the defined period of time has passed since the last test, the application sends a message to alert recipients that a patient's health check is due. Then office staff may call the patient to schedule the next appointment. When the rule has been actioned, the rule is reset and will generate another alert when the rule next becomes due.

The comparison of rules with patients is made:

- Every night, when every rule is checked against every patient to see if any tests or checkups are due.
- When a rule is created or edited, the rule is checked against every patient in the database.
- When a new patient is entered in the system, or when patient information is updated. In this case, the patient is checked against every rule to see if any tests are due.

Clinical Decision Support Slider

The Clinical Decision Support slider enables you to view and action the clinical decision support rules that are associated with the patient whose visit you are charting. You can update clinical decision support rules at any time when you have the patient visit note open.

The Clinical Decision Support slider icon has a red background when clinical decision support rules are due for the patient.

In the slider, the text color of the due date indicates the status of the rule for the patient.

- Red indicates the rule is due today or is overdue.
- Blue indicates the recurring rule is due in the future.
- Black indicates that you have taken action on the rule in today's visit.

Action a Rule

1. Select the Clinical Decision Support slider. It will be easier to access information if you pin the slider in place.
2. By default, the slider displays only rules associated with the rendering provider's care team. To view all rules, select the checkbox at the foot of the slider.
3. To view a summary of a rule, select the Rule Name.
4. The slider shows any rules that are due, as well as historical information of rules that have previously been actioned.
5. Select the Action button to action current rules. The Action window displays. All procedures in the rule are initially set to N/A, meaning they have not been documented.

6. Select the method by which the rule will be actioned.
 - HM Hx indicates that the rule has been reviewed, but no action is taken.
 - SP, SO, Plan indicate that the rule will be actioned via the Services Performed/Ordered or the Plan tabs.
 - Patient Declined indicate that the patient chose not to proceed with the procedure.

Note: Whichever action is selected, the rule is reset, and will trigger an alert the next time the rule becomes due. When a performed date for the procedure is entered, the next due date is calculated from that performed date.
7. To discontinue the rule for a patient, deselect the checkbox at the far right of rule entry. Discontinue a rule when the patient meets the rule's criteria, and yet the rule does not apply to that patient.
8. The current chart is updated as a result of the action type, and the history information on the Clinical Decision Support slider is updated.
9. When the note is saved, the Clinical Decision Support tab on the patient appointment is updated with the new information.

Clinical Decision Support Rule Customization for a Patient

You can customize a clinical decision support rule for a particular patient by modifying the frequency of the rule recurrence, modifying the age criteria, or making the rule inactive for the patient. So for example if you have a rule for mammogram screening every two years for women 50 years old and older, you could modify the rule to every year for a patient with a slightly higher risk.

1. Full Note Composer or other clinical note type window → Clinical Decision Support slider
2. Select the link for the rule you want to customize for this patient.

The Clinical Decision Support Rule Information window displays the rule as it currently applies to the patient.
3. Select the Edit button to modify the rule for the patient.
4. In the New Clinical Decision Support Rule Information window, modify the rule as desired.
 - Enter a different Recurrence frequency.
 - Select the Limit Recurrences checkbox, and enter a number of recurrences.
 - Select the Inactive checkbox to make inactive the rule for this patient.
 - Enter different Age criteria.
5. Select the OK button to return to the Clinical Decision Support Rule Information window.

When a rule has been modified for a patient, the unmodified icon () changes to modified ()

Access More Information for a Rule

1. Full Note Composer or other clinical note type → Clinical Decision Support slider
2. Select the Rule Name hyperlink to access the Clinical Decision Support Information window. This window displays a summary of the rule and its criteria.
3. Select the More Information button to access additional information about the procedure or medical condition. Your default browser window will open to the URL associated with the rule.
4. The Notes field displays the bibliographic source of the reference URL. This will have been entered by your administrative super user.

Clinical Decision Support Rule Decline Reason

When you act on a clinical decision support rule for a patient, you can select a reason why a patient declines the test or service. The application includes several predefined decline reasons, and your administrative super user may have defined additional reasons.

An override note is automatically entered when you select a decline reason. Please see the Clinical Decision Support Rule Override Notes section below for more information.

1. Full Note Composer or other clinical note type window → Clinical Decision Support slider
2. Select the Action button for the desired rule.
3. In the Declined Reason field, select the appropriate reason.

Clinical Decision Support Rule Override Notes

When you act on a clinical decision support rule for a patient, you can now use the general Note functionality to enter any notes about the action taken or not taken. This enables you to enter rich text format notes, reuse previously created notes, and reuse and modify a previously created note.

1. Full Note Composer or other clinical note type window → Clinical Decision Support slider
2. Select the Action button for the desired rule.
3. Select the Note icon () to enter your note.

UpToDate®

UpToDate is a clinical decision support resource. If you subscribe to UpToDate services, then you may choose to display the UpToDate button on the Desktop toolbar. Selecting the button accesses the UpToDate website, where you log in and search for information.

To display the UpToDate button on the Desktop toolbar, your administrative super user or you, if you have the necessary security access, may add the UpToDate add-in to your user setting definition.

Clinical Summaries

A clinical summary is a document that summarizes information from a patient visit. The document may be given to the patient or to another a provider, such as the referred-to or referred-by provider.

Some performance measures for MIPS and other clinical quality programs require that patients be provided with a clinical summary of each office visit within a certain time. Other performance measures require that a clinical summary be sent to a referred-to provider. The clinical summary used for performance measures must include diagnostic test results, problem list, medication list, and medication allergy list, and may include other information as appropriate.

The continuity of care document (CCD) is by definition designated as a clinical summary document. Your administrative super user may have defined formatting models for document generation that are designed as clinical summary documents. When you generate a CCD or other designated clinical summary document for a specific patient visit within three days of that visit, the application records that you have met the clinical summary requirement for that visit.

The clinical summary may be provided in paper or electronic format. A clinical summary that is provided in electronic format must be readable by people, not just by a computer application.

Common Problem Palettes

A common problem palette (CPP) is a set of information, such as diagnosis, prescription, and services performed and ordered, that may reoccur frequently enough to package the information into a group, or palette. Using a common problem palette makes charting a patient visit note faster and easier.

Common problem pallets for many standard checkups are included in the application. Additional common problem palettes may have been defined for your practice, care teams, or providers. You may also create your own common problem palettes, either while you are charting a patient visit note or after the visit note has been completed. There are two types of common problem pallets, diagnosis-specific plans and disease-specific plans, that will be created automatically by the application while you chart a note if your Provider definition is set up to auto learn CPPs.

There are several types of common problem palettes:

- Common problem palettes must be created deliberately. They may include everything from a visit note except history, review of systems, and physical exam documentation (it can contain the exam to be used).
- Diagnosis specific plans may be learned by the application. That is, they may be created automatically from Full Note Composer when charting a note if the Provider definition is set up to auto learn CPPs. Unlike regular common problem palettes, diagnosis specific plans are based on diagnosis codes rather than generalized diseases. A diagnosis specific plan contains a single diagnosis, and may include prescription, procedure, and plan information. When a diagnosis specific plan that was created by auto-learning has been marked inactive, then any new items selected for that diagnosis are ignored by the auto-learning functionality.
- Disease specific plans may be learned by the application. That is, they may be created automatically from Full Note Composer when charting a note if the Provider definition is set up to auto learn CPPs. Disease specific plans are similar to diagnosis specific plans except that they may multiple diagnoses for a particular disease.
- Symptom complexes are similar to regular common problem palettes, but they may contain multiple chief complaints and history of present illness items.

Common problem palettes require structured charting information. Therefore, they can only be used in Full Note Composer and other clinical note type windows that use structured charting information from the CC, HPI, ROS, and PE tabs. Common problem palettes cannot be used in Superbill Composer and other clinical note type windows that do not use structured charting information but use the CC/HPI and ROS/PE tabs instead.

Use a Common Problem Palette to Chart a Patient Visit Note

When you use a common problem palette, you can select specific information from the common problem palette before adding the information to a note for a patient visit.

1. Full Note Composer or other clinical note type window
2. When you begin a patient chart, you will have to enter Vitals that are specific to the patient. None of this information is saved in a CPP.
3. Select the CPP icon ()
4. Enter the desired selection criteria, and then select the Search button.
5. Common problem palettes matching your selection criteria are displayed in the panel on the left. Select the desired common problem pallet.
6. Items in the common problem palette are displayed in the panel on the right, and are sorted by chief complaint, diagnosis, services ordered, services performed, and prescriptions.
 - Expand or collapse a category by selecting the Expand or Collapse icon.
 - Expand or collapse all categories by selecting the Expand All or Collapse All buttons.

7. Select and highlight the information that you want to include in the patient's new visit note. Only highlighted information is added to the visit note. To select all information, select the check icon at the top of the list and this will highlight all entries in the CPP.

If you select a procedure or diagnosis that is associated with a dynamic procedure note or dynamic diagnosis note, then you may select the procedure note/diagnosis note icon () and complete the note.

8. To select a medication, either:
 - Highlight the desired medication to accept the prescription as is.
 - Select the Edit button for the desired medication to access the SIG Writer window to modify the prescription for this patient. Note that changing the prescription for this patient does not change the prescription in the common problem palette.
9. Select the OK button to add the information is added to the patient chart.

Using a Common Problem Palette to Write a Prescription

1. Select the CPP icon ()
2. Enter the desired selection criteria, and then select the Search button.
3. Common problem palettes matching your selection criteria are displayed in the panel on the left. Select the desired common problem pallet.
4. Items in the common problem palette are displayed in the panel on the right, and are sorted by chief complaint, diagnosis, services ordered, services performed, and prescriptions.
 - Expand or collapse a category by selecting the Expand or Collapse icon.
 - Expand or collapse all categories by selecting the Expand All or Collapse All buttons.
5. Select and highlight the medication for which you wish to write a prescription.
6. Select the OK button to add the information is added to the patient chart.

Creating a Common Problem Palette from Full Note Composer

1. Full Note Composer
2. Chart the items that you want to include in the common problem palette. This may include any or all of the following items.
 - Chief complaint
 - History of present illness
 - Review of systems
 - Physical exam
 - Assessment forms
 - Diagnosis
 - Prescribed or administered medications
 - Services performed or ordered

3. File → Save as New Common Problem Palette
4. Enter a Name for the common problem palette.
5. Edit any entries as desired.

Confidential Information in a Visit Note

The Confidential tab for clinical note type windows enables you to enter confidential comments in a patient visit note. Information entered in the Confidential tab can only be accessed by those clinical users to whom you have explicitly given permission. If you have a default list of providers and care teams that have access to your confidential comments, those users are defaulted to having access when you create a new confidential comment. You can add to or remove users from this list if desired. Once a confidential note has been entered on a patient visit note, the list of users with access to that information cannot be edited.

Please note that the Confidential tab is not included in Full Note Composer, Superbill Composer, or any of the other system-defined clinical note type windows. If you want to be able to enter confidential comments in a visit note when needed, then your administrative super user, or you if you have the needed security access rights, must create a custom clinical note type window, and then make that custom clinical note type window available to you and your clinical through the User Settings definition applied to you.

Please also note that if you want the Confidential tab to available to you if needed, then you and your clinical staff will need to use the clinical note type window that includes the Confidential tab for all patient visits. A patient visit note can be opened in only one clinical note type window. Once a visit note has been started in a one clinical note type window, such as Full Note Composer, then that patient visit note cannot be opened in any other clinical note type window, such as Superbill Composer or a custom clinical note type window. You cannot start a patient visit note in a clinical note type window that does not include the Confidential tab, recognize the need for entering confidential information, and then switch the visit note to another clinical note type window that does include the Confidential tab. Instead, the Confidential tab must be available from the beginning.

It is important to understand the difference between confidential information in a visit note, private visits, and restricted visit note access. Confidential information restricts user access to information in the visit note, but only to the information entered in the Confidential tab. A restricted visit also restricts user access to the information in the visit note, but it restricts access to the entire note and all of the information in it. Thus, both confidential information and restricted visit notes are intended to restrict provider and staff member access to information. The Private visit type is intended to identify patient visit notes that are to be kept confidential from people external to your practice, such as a patient's parents or spouse. All provider and non-provider users with access to patient visit notes can access private visit notes.

Entering Confidential Comments in a Patient Visit Note

The Confidential tab enables you to enter confidential comments in a patient visit note. Information entered in the Confidential tab can only be accessed by those users to whom you have explicitly given permission.

If you have a default list of providers and care teams that have access to your confidential comments, those users are defaulted to having access when you create a new confidential comment. You can add to or remove users from this list if desired when entering confidential information in a visit note. However, once a confidential note has been entered on a patient visit note, the list of users with access to that information cannot be edited.

1. Custom clinical note type window → Confidential tab
2. Verify or modify the Providers and/or Care Teams with Access to the confidential comments.
3. Select the Ink or Text radio button to identify how you will enter the comments.
4. Write or type the comments in the notes field.

Set the Confidential Information Default for One Page Summary

By default, confidential information is not displayed in the One Page Summary. You may choose to include this information. Including confidential information will include your confidential information and confidential information to which other providers have granted you access. Please refer to the One Page Summary section for more information on including this information.

Set the Confidential Information Default Review Past Notes

By default, confidential information is not displayed in Review Past Notes. You may choose to include this information. Including confidential information will include your confidential information and confidential information to which other providers have granted you access. Please refer to the Review Past Notes section for more information on including this information.

Diagnosis Notes

You can use diagnosis notes to enter information specific to a patient's diagnosis, such as the diagnosis date, the site, or other characteristics.

The application includes a system-defined diagnosis note for cancer. This diagnosis note enables you to document information required by cancer registries.

Your administrative super user may have defined additional diagnosis notes for your practice.

You can access diagnosis notes from within Full Note Composer or another clinical note type window when entering a diagnosis code in the Dx tab. When a diagnosis note has been defined for a diagnosis, the Diagnosis Note icon () appears next to the charted diagnosis.

Complete a Diagnosis Note

1. Full Note Composer or other clinical note type window → Dx tab
2. Select the desired diagnosis code.
3. Select the Diagnosis Note icon (.
4. If there is more than one diagnosis note associated with the diagnosis, then highlight the diagnosis note you want to use and select the OK button.
5. The Diagnosis Note window displays the categories and their findings defined for the diagnosis.
6. In the Diagnosis Note window's Category pane, select the checkbox for the item you want to document.
7. In the KDB Finding pane, either:
 - Select the finding for the selected category item.
 - Select the <Find> listing or the Find () icon to search for an item not in the list. This option is available only when the finding is an item in the database, such location.

This adds the selected category and finding to the Diagnosis Note section in the top of the window.

8. Repeat steps 6 and 7 to enter all appropriate categories and findings.
9. Select the OK button to close the window and add the patient data to the patient chart.

Dictation and Transcription

The dictation and transcription functionality enables you to:

- Dictate and review patient visit notes.
- Manage the workflow from recorded notes to transcribed and merged notes.
- Link a voice note to Patient Demographics. For example if a physician dictates a referral note, this may be linked to the patient information. The note may be transcribed, and the transcribed file linked with the voice file.
- Link a voice note to a patient chart. This may be used to add a voice note to an attachment such as a scan, where the note may add information that is pertinent to the scan. Similarly, the transcribed file may be linked alongside the voice file.
- Link a recording to a patient chart. For example, a sonogram recording of a baby's heartbeat.
- Embed specific voice notes that relate to different tabs in Full Note Composer. In this case, the transcribed text is merged into the appropriate notes sections of the patient chart.

The application includes jobs that export your dictated voice files for the transcriptionist and import the transcribed files back into the database. Your administrative user will have set up these jobs to run on a regular basis. You can also manage the dictation process by manually exporting and importing files when needed.

The jobs for exporting and importing files use specifically identified file folders on the server for each transcriptionist and for each type of file (voice dictation and transcribed text). Your administrative user will have set up these file folders, and may also have defined a default transcriptionist for each provider.

The general workflow for dictation and transcription is:

1. The provider dictates the note.
2. The voice file is exported to the transcriptionist's folder, either by the automated job or by a user manually exporting it.
3. The transcriptionist transcribes the dictated note, and saves the text file to the appropriate folder.
4. The transcribed file is imported into the application database, either by the automated job or by a user manually importing it.
5. The provider reviews and approves the transcribed file, and if appropriate, merges it with the patient visit note.

Using Dictation

Dictation may be used in two ways:

- As an attachment to Patient Demographics or a patient chart. These notes are dictated and linked via the Attachments slider and the New Attachment Window.
- To record voice notes and import transcribed notes that are embedded into a patient visit note; notes may be associated with individual sections (tabs) of the patient visit note. These

notes are dictated using the Dictation slider or the voice link from Full Note Composer or other clinical note type window.

Although processing of both types of notes is similar, voice notes that are recorded and transcribed as attachments (via the Attachment slider) are linked to the Patient Demographics or patient visit as a separate document. The document may be edited until the attachment is approved. Notes that are associated with a patient chart using the Dictation slider (or the voice link on the FNC), are embedded in the chart; if required, these notes may be edited before merging.

Dictation Length

When dictating, be aware that your hardware configuration can affect the length of time that you can dictate before experiencing a time out error. Avoid time out errors and the loss of dictation files by dictating no more than 20 minutes at a time for a single patient visit note.

Dictation Icons

Icon	Description
	Record
	Stop
	Play
	Delete recording

Dictation/Transcription File Statuses

The transcription file statuses are used identify and process dictated voice files and transcribed text files. The statuses are also used as filtering criteria on the Voice Transcription Log window and the Visit Center window.

Status	Description
Recorded	Used for new voice files that have not yet been exported.
Sent	Used for voice files that have been exported to the defined file location for a transcriptionist.
Received	Used for transcribed text files that have been imported into the application.
Merged	Used for transcribed text files that have been imported into the application and merged into the patient visit note.

Attachments Slider

When you begin recording, a timer at the foot of the window indicates the length of the note.

The volume bar gives you a graphic representation of your volume as you dictate.

In the Attachments window, (accessed from the slider), you can add notes, specify a transcriptionist, and mark the note as urgent if desired. The Attachment window also enables you to dictate information to be included in specific tabs in Full Note Composer. This is useful when previously dictated file for the patient visit note has already been transcribed and imported.

Select the In Note Dictation checkbox to include the transcribed dictation in the Notes areas of specific tabs of Full Note Composer.

Full Note Composer tab tags are not added to the recording when dictating from the Attachments window. To include the transcribed dictation in the Notes areas of specific tabs, you must indicate the desired tab when you dictate so that your transcriptionist can add the tab tags when transcribing the file.

1. Attachments slider → New
2. Select the Import button.
3. Select the Voice attachment type.
4. Enter a Name for the dictation recording.
5. Select the appropriate attachment Type.
6. Add Notes, specify a Transcriptionist, and mark the note as Urgent, as desired.
7. Either:
 - Select the In Note Dictation checkbox to include the transcribed dictation in the Notes areas of specific tabs of Full Note Composer.

- Deselect the In Note Dictation checkbox to simply include the transcribed dictation as an attachment to the patient's record or visit note.
8. Select the Ready to Transcribe checkbox if the file is ready for transcription. The file cannot be exported until it is marked as ready.
 9. Select Start Recording (), and begin dictating the note.

Dictation within Full Note Composer or Other Clinical Note Type Window

When you begin recording, a timer at the foot of the window indicates the length of the note.

The volume bar gives you a graphic representation of your volume as you dictate. There is also a volume indicator in the status bar area at the bottom of the Full Note Composer window.

If you are using the Dictation slider, you can add notes, specify a transcriptionist, and mark the note as urgent.

If you have a default transcriptionist indicated in the Provider record, that transcriptionist will be selected in the Dictation slider. This can be changed if needed.

You can use a single voice note to enter information for multiple FNC tabs. If you identify the tab you are referencing, the transcriptionist will add a code so the transcribed document may be imported to the correct section of the patient chart. (You cannot dictate for the Hx tab since the patient's history is not specific to a single visit note.)

If you want to record a note while viewing multiple FNC tabs, float the slider so it is not associated with the FNC.

If you start a new note without stopping the original note, the original note stops automatically. If you restart recording the original note, new information is appended to the file.

1. Full Note Composer or other clinical note type window → Dictation slider
2. Specify a Transcriptionist.
3. Mark the note as Urgent, as desired.
4. Select Start Recording () for the desired tab, and begin dictating the note.

Manually Export Voice Files

The Voice Transcription Log lists all voice messages and the associated status and date of each action. It lists the patient name, the recorded by user, and the transcriptionist (if included), the attachment type and filename. It also indicates if the file is in "In Note," that is, dictated via the Dictation slider or FNC voice icon and embedded in a patient chart, or linked as a separate attachment via the Attachments slider.

You can manually export voice dictation files from this window. Files that have not yet been exported have the status Recorded.

Note: Exporting dictation files is not absolutely necessary. If your transcriptionist is a user of the application, the transcriptionist may listen to dictation files directly from the Voice Transcription Log window.

Export Files

1. Either:
 - Desktop → Voice Transcription
 - Voice Transcription icon ()
2. Enter the desired search criteria, and then select the Search button to display a list of files.
3. Select the checkbox for the files you want to export.
4. Select the Export button. This button is active only when file ready for export has been selected.
5. Browse to the folder where you want to save the file.
 - By default, the name of the file is the ID associated with the recording.
 - The status changes to Sent once you save the file.

Transcribe the File

There are a number of ways that a transcriptionist can identify or be notified of voice files that are ready for transcription. The method used depends on the processes and workflow of your practice.

- The transcriptionist may regularly check the appropriate file folder for files ready for transcription.
- Messaging may be used to notify the transcriptionist that a file is ready for transcription.
- The transcriptionist may regularly use the Voice Transcription Log window to identify files ready for transcription. The transcriptionist can also listen to files directly from this window.
- The transcriptionist may regularly use the Visit Center window to identify files ready for transcription.

The transcriptionist must follow the transcription rules below in order for the transcribed file to be imported and merged with the patient visit note.

Once the transcriptionist completes the transcribed file, it must be saved in the appropriate folder so that it can be processed by the import job. Again, depending on your practice's processes and workflow, notification may be done by simply placing the file in the proper folder or messaging may be used.

Transcription Rules

You may be asked to transcribe two types of notes:

- A note where the only identification is a file ID. This will typically be for correspondence or instructions.
- A note that relates to a patient visit note that includes one or more separate sections. Tags in the note will tell you the file ID and the sections with which each item in the visit note must be associated. It is essential that you add the correct format tags so that the note may be merged automatically into the patient chart.

Please adhere to the following rules when transcribing notes.

- All tags are enclosed in square brackets [].
- The first entry in the file should be the file ID, in the format [id]nnn where nnn is the ID that is dictated at the beginning of the note. The ID should be followed by a carriage return. This may be the only tag in the file.
- If the file includes sections, each section of the note must be introduced by a specific tag, enclosed in square brackets. For example, if the dictation indicates cc, transcribe as [cc]. Section tags are:
 - [vitals]
 - [cc]
 - [hpi]
 - [hx]
 - [ros]
 - [pe]
 - [dx]
 - [rx]
 - [sp]
 - [so]
 - [plan]
 - [standalone]
- Dictation recorded in the CC/HPI tab uses the [CC] voice dictation tag. Dictation from the CC/HPI tab is displayed in both the CC/HPI and CC tabs. Likewise, dictation from the CC tab is displayed in both the CC/HPI and CC tabs. However, dictation from the HPI tab does not display in the CC/HPI tab.
- Dictation recorded in the ROS/PE tab uses the [PE] voice dictation tag. Dictation from the ROS/PE tab is displayed in both the ROS/PE and PE tabs. Likewise, dictation from the PE tab is displayed in both the ROS/PE and PE tabs. However, dictation from the ROS tab does not display in the ROS/PE tab.

- Section tags may, or may not be, followed by a carriage return. All text after the tag is considered part of the section text, and is only ended by the next tag or the end of file.
- Transcription files must be saved as text files (.txt) or as rich text format (.rtf) files.
- If the file contains any special characters, it must be saved in rich text format (.rtf). Plain text files (.txt) cannot be imported if they contain special characters.

Approving Dictation

The Export Dictation job only exports dictation files that are marked as ready to transcribe. You can manually export dictation files only when they are marked as ready to transcribe. Dictation files can be marked as ready to transcribe from the Attachments window and from the Visit Checkout window when closing a patient visit note.

Import and Merge Transcribed Notes

Use the Voice Transcription Log window to identify transcribed files that are ready to be reviewed and imported. When transcribed notes are merged into a patient visit note, information is put into the relevant tab of Full Note Composer. The application automatically updates the patient visit note using the tags in the transcribed note.

1. Either:
 - Desktop → Voice Transcription
 - Voice Transcription icon ()
2. Select Import or Import/Merge and browse to the folder containing transcribed files:
 - To review and edit transcribed files, select Import and browse to the folder for transcribed files. Review and edit the text before merging.
 - a. Select the patient name from the Voice Dictation Log. This accesses the Modify Voice Attachment window.
 - b. Review the transcribed note and edit if necessary.
 - c. Select Approve/Merge. The note is merged into the patient visit note.
 - To merge files without review, select Import.
 - For voice attachments, the effect of both buttons is the same: to import the file and attach it to the patient demographic or patient chart.
3. A message indicates that files have been imported. The status of entries in the Voice Transcription Log changes to Received (for imported files) or Merged (for imported and merged files).

Approve a Transcribed Note When Accessing the Incomplete Patient Visit Note

The user who dictated information for a patient visit note may approve the transcribed file when accessing the incomplete visit note. Use the Visit Center window to identify visit notes with transcribed files ready for approval.

1. Desktop → Visit Center
2. Select the Transcription Status “Received”.
3. Enter any other desired search criteria.
4. Select the Search button to obtain a list of all visit notes meeting your criteria.
5. Select the appropriate link to access the desired visit note.
6. An unapproved transcription file will be displayed in a text box when the incomplete visit note is opened.
7. Select Approve/Merge to approve the transcription.

After selecting Approve/Merge, you must save the visit note in order for the transcription to be approved. This also completes the approval message for the transcription file.

Approve a Transcribed Note from the Transcription Message

The transcription approval message now enables you to complete the patient visit note when approving the transcription. When you select the checkbox to approve and merge the transcription, the checkbox to complete the patient visit note is automatically selected. You may change this, if desired. When you complete the message, the transcription will be merged into the visit note, and the visit note will be completed if the checkbox was selected.

Review and Approve an Attachment

1. Select the Attachment slider from either Patient Demographics or Full Note Composer.
2. Select the attachment that you wish to review.
3. Review the file, and make any modifications to the transcribed file.
4. Select Approve. The file is now updated to read only, and you can no longer edit the information.

DICOM Image Interface

If your practice has an optional interface to a DICOM (Digital Imaging and Communications in Medicine) image system, then you may access a DICOM image from Full Note Composer or another clinical note type window.

Note: The DICOM Image () icon will be available only if your administrative super user has configured it in your user settings definition.

1. Full Note Composer or other clinical note type window
2. Select the DICOM Image () icon.
3. The application searches the DICOM image system (or PACS server) for an image matching the following criteria:
 - Patient's first and last name.
 - Patient's date of birth.
 - Visit date
4. If more than one image is available for the patient and visit date, then a popup window will display a list of images. Select the desired image.
5. The DICOM Image Viewer window displays the DICOM image.

<<Revised>> Direct Messaging

You may use the Direct messaging functionality to send patient documents to and receive patient documents from other providers. You may send any type of patient or visit document that can be generated from the application or attached to the patient or a visit note.

When using the Direct messaging functionality specifically for MIPS measures for transition of care, then the document you send to another provider must either be a C-CDA continuity of care document or a document generated from a formatting model that is defined as qualifying as a clinical summary. A C-CDA document is a structured data file that many EHR applications can process so that the content can be imported into a patient's record. Clinical summary documents generated from a formatting model are PDF files that the receiving provider can read, but the content cannot be imported.

When another provider transitions a patient to you, then you should receive a C-CDA document from that provider. You must attach the document to the patient record and review the content. You may import content from C-CDA document in to the patient history if desired. Please note that to count for MIPS, you must associate the document sent or received to a referral. This association is to a referral entry, not simply to a patient/provider tracking entry.

Clinical summaries and other documents that are other file types (such as .pdf, .doc, or .txt) may also be received through Direct messaging and can be attached to a patient record or visit record. The application cannot import information from these unstructured files into the database.

When a zipped file is received through Direct messaging, then the application extracts files of known file types. The extracted file or files are then imported, and the zipped file is discarded and not imported.

The zipped file is discarded if at least one file is extracted. So, if the zipped file contained a file that was not a recognized format, that file will be discarded with the zipped file and will not be imported.

If a zipped file is received that does not contain any files in a recognized format, then the zipped file is imported into Document Linking as a zipped file. You or another staff member must export the zipped file from Document Linking, extract the contents, and then import the extracted files back into Document Linking.

Send a Test Message

Aprima recommends that you send a test Direct message, using a test patient, to any provider with whom you plan to exchange Direct messages. After sending the test Direct message, contact the provider to verify that the Direct message and its attachment were received. Once you know that the provider has received your test, then you can send Direct messages for patients to that provider.

Please refer to the *Administrative User's Guide* for instructions on verifying that a Direct message was successfully sent.

If a recipient is not receiving Direct messages from you, and you have confirmed that your Direct messages were successfully sent and that you are using the correct Direct address for that recipient, please contact Support so that they can investigate the problem.

Generate and Send a Document

There are several ways in which you may generate and send documents through Direct messaging. The easiest way to generate and send documents for a referral for transition of care is to use the Create Referral dynamic procedure note.

You may also generate and send a document from the Generate Patient Document window. It is recommended that the referral entry exist before you attempt to generate the document. This is because you may not be able to create the referral entry that you want if you do it when generating the document. You cannot associate a referral entry to an existing patient/provider tracking entry when generating a document. You can, however, create a new patient/provider tracking entry and associate a referral entry to it when generating a document.

You may also send a previously generated document through Direct messaging. Remember that a document may be associated with a referral only when generating the document. You cannot associate a previously generated document with a referral when you are sending it. Therefore, if the document was not associated with a referral when the document was generated, then sending that document to the referred to provider through Direct messaging will not count toward MIPS.

Use the Create Referral Dynamic Procedure Note

1. Full Note Composer or other clinical note type window
2. Chart the information for the visit in the usual manner.
3. Select the SO tab.
4. Select a procedure code that is associated with the Create Referral dynamic procedure note.
5. Select the Procedure Note () icon shown to the left of the procedure in the upper portion of the SO tab.
6. In the Dynamic Procedure Note window, complete the information needed to create the referral entry and the document to be sent with the referral.
 - a. Select the Providers and Medical Service Providers category, and then select the provider to whom you want to refer the patient. If the desired provider is not listed, select the <<Find>> entry to search for and select the provider.
 - b. Select the Provider's Role category, and then select the desired role. If the desired role is not listed, select the <<Find>> entry to search for and select the role. For referrals that you want counted toward MIPS, you must select Specialist, Other, or a custom-defined provider role. (It cannot be Primary Care or Referring Provider.)
 - c. Select the Formatting Model/CDA Sections category, and then select the document or documents that you want to send to the referred to provider. If the desired document is not listed, select the <<Find>> entry to search for and select the document. For referrals that you want counted toward MIPS, you must select a clinical summary document, a continuity of care document (CCD), or a consolidated clinical data architecture document (C-CDA).
 - d. Select the Patient Provider Tracking Status category, and then select the desired status. If the desired status is not listed, select the <<Find>> entry to search for and select the status. In most cases, you will want to select Initiated, but you may select another appropriate status.
 - e. Select the Disclosure Reason category, and then select the desired reason. If the desired reason is not listed, select the <<Find>> entry to search for and select the reason. For referrals that you want counted toward MIPS, select the Referral entry.
 - f. Select the Assigned To category, and then select the user to whom you want to send a message if the application is unable to generate the referral and documents.
 - g. Select any other categories you wish to complete.
 - h. Select the OK button to close the Dynamic Procedure Note window and save your selections.
7. In the Full Note Composer or other clinical note type window, finish charting any other information for the visit in the usual manner.
8. When you are finished, select the OK button to close and save the visit note.

9. In the Visit Checkout window:
 - a. Select the desired options and entries. Please be aware that the referral is created and the referral document sent only when you select the Complete Note radio button.
 - b. Select the OK button. If you selected the Complete Note radio button, the referral is created. If the referred to provider that you selected in the dynamic procedure note has a Direct address, then the document or documents you selected are automatically sent.
10. When the Unified Summary appears, the referred to provider appears in the Patient/Provider Summary section.
 - a. If desired, select any additional documents you want to send to the provider.
 - b. If desired, select the Delete () icon to remove all the documents for a provider that you do not wish to send to.
 - c. Select the OK button. Documents will be generated and sent through Direct messaging automatically.

Generate and Send a C-CDA Document

1. Patient toolbar → Generate Document () icon
2. Select the Patient radio button.
3. Either:
 - Select the Visit radio button, and then select the desired visit date.
 - Select the Visits Between radio button, and then select the desired date range.
4. In the Related Patient Referral field, select the desired outgoing referral entry if desired. This is necessary for MIPS, but it not required for sending a document through Direct messaging.
5. In the Use Formatting Model, select the desired CCD or C-CDA document definition.
6. Select the desired Attachment Type or accept the default.
7. If you want to preview the generated document:
 - a. Select the Preview button.
 - b. In the Generated Document From Formatting Model window, review and edit the generated document.
 - c. Select the OK button to access the Send Documents window.
8. Select the Print button to generate the document and access the Send Document window.
 - If you selected a referral in step 4 and you have a Direct address or fax number entered for the provider identified in the referral, then the application immediately sends the document to that provider. This completes this process.
 - If you did not select a referral in step 4 then you must continue with the next step to complete this process.
9. In the Send Documents window, select the Provider radio button.
10. Select the Provider to whom you are sending the document.
11. The Description field will automatically populate with the provider's name and address, if entered in the provider record.

12. The Disclosed By field identifies the user releasing the information.
13. Select the Disclosure Reason.

For referrals that you want counted for MIPS, select the Referral reason. If you are sending the document for some other reason, then select the appropriate reason.
14. In the Requested of Provider field, select the provider authorizing the disclosure.
15. Select the Direct Message radio button. The Direct Message option is enabled only if the selected provider recipient has a Direct address defined.
16. The Direct Message addresses are automatically populated.
 - The Direct Address (To) field will be populated with the Direct address defined in the recipient provider's Provider record.
 - In the Direct Address (From) field, select the provider for whom the message is being sent. This field will automatically populate if the sending user is a provider.
17. Enter a brief Subject message, if desired.
18. Enter a brief Message, if desired.
19. Select the Direct button to complete the document generation and send the document.

Generate and Send Another Type of Document

Use this process to generate any patient or visit document, and send it to another provider using Direct messaging.

1. Patient toolbar → Document Generation () icon
2. Select the Patient radio button.
3. Either:
 - Select the Visit radio button and a visit date for a document that contains data from a particular visit.
 - Select the Visits Between radio button, and enter start and end dates for the date range. This produces a document file for each visit within the date range.
 - Select the Visit for Procedure radio button for a document that contains data from a particular visit and procedure.
 - Select the Appointment radio button and an appointment date for a document that contains data from or for a particular appointment.
 - Select the Only Use Patient Data radio button for a document that does not require visit or appointment data.
4. If the document is related to an outgoing referral, then select the desired referral entry in the Related Patient Referral field.
5. Select the Use Formatting Model radio button, and then select the document model or models you want to generate.
6. Select the Attachment Type. The attachment type is used to name the attachment and to group it in the Attachment slider and in Review Past Notes.

7. If you want to preview the generated document:
 - a. Select the Preview button.
 - b. In the Generated Document From Formatting Model window, review and edit the generated document.
 - c. If a signature is needed, select the Sign Document button to initiate the signature capture process.
 - d. If you made any edits or captured a signature, select the File menu and Save and Close option. This accesses the Send Documents window.
 - e. Select the OK button to access the Send Documents window.
8. Select the Print button to generate the document and access the Send Document window.
 - If you selected a referral in step 4 and you have a Direct address or fax number entered for the provider identified in the referral, then the application immediately sends the document to that provider. This completes this process.
 - If you did not select a referral in step 4, then continue with the next step.
9. In the Send Documents window, select the Provider radio button.
10. Select the Provider to whom you are sending the document.
11. The Description field will automatically populate with the provider's name and address, if entered in the provider record.
12. The Disclosed By field identifies the user releasing the information.
13. Select the Disclosure Reason.
14. In the Requested of Provider field, select the provider authorizing the disclosure.
15. Select the Direct Message radio button. The Direct Message option is enabled only if the selected provider recipient has a Direct address defined.
16. The Direct Message addresses are automatically populated.
 - The Direct Address (To) field will be populated with the Direct address defined in the recipient provider's Provider record.
 - In the Direct Address (From) field, select the provider for whom the message is being sent. This field will automatically populate if the sending user is a provider.
17. Enter a brief Subject message, if desired.
18. Enter a brief Message, if desired.
19. Select the Direct button to complete the document generation and send the document.

Send an Attached Document

Use this process to send a document that is attached to a patient or visit.

1. Either
 - Desktop → Document Management
 - Patient Demographics → Patient menu → Patient Documents
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkboxes for the files that you want to release to another person or entity.
4. Select the Send Documents button.
5. In the Send Documents window, select the Provider radio button.
6. Select the Provider to whom you are sending the document.
7. The Description field will automatically populate with the provider's name and address, if entered in the provider record.
8. The Disclosed By field identifies the user releasing the information.
9. Select the Disclosure Reason.
10. In the Requested of Provider field, select the provider authorizing the disclosure.
11. Select the Direct Message radio button. The Direct Message option is enabled only if the selected provider recipient has a Direct address defined.
12. The Direct Message addresses are automatically populated.
 - The Direct Address (To) field will be populated with the Direct address defined in the recipient provider's Provider record.
 - In the Direct Address (From) field, select the provider for whom the message is being sent. This field will automatically populate if the sending user is a provider.
13. Enter a brief Subject message, if desired.
14. Enter a brief Message, if desired.
15. Select the Direct button to complete the document generation and send the document.

<<Revised>> Receiving Direct Messages

When the application receives a Direct message, the application matches the recipient provider identified in the Direct message to an internal provider record in your database. Then the application determines how to process the Direct message and any attachments, if included.

- An approval message is generated to the provider if the Direct message includes a C-CDA that matches a patient record in the database. The message has the message type Attachment Approval and the message subtype Direct Message with Attachment. The message is associated with the identified patient record. Please see the Receive a C-CDA that Matches a Patient Record section below for instructions.
- An approval message is generated to the provider if the Direct message includes a C-CDA that cannot be matched to a patient record in the database. The message has the message type Attachment Approval and the message subtype Direct Message with Attachment. The message is not associated with a patient record. Please see the C-CDA that Does Not Match a Patient Record section below for instructions.
- A task message is generated to the provider if the Direct message did not include any type of attachment, but it did include text in the subject and/or body of the Direct message. The message has the subtype Direct Message without Attachment. You review and process these messages as you do any other task message. Instructions are not included in this document.
- No message is generated for the provider if the Direct message does not include a C-CDA, but it does include an attachment of any other file type (.PDF, .txt, image, etc.). Instead, the text in the subject and/or body of the Direct message and any attached files are stored in Document Linking. Please see the Received Direct Message with Attachment that is not a C-CDA section below for instructions.

As with other messages, the messages generated for Direct message appear in the Message Center and in the Message control for the Desktop.

The following sections explain how the application processes Direct message with C-CDA attachments or with other types of attachments, and how you can review and use the attachments.

Receiving C-CDA Documents through Direct Messaging

Receive a C-CDA that Matches a Patient Record

When a Direct message contains a C-CDA document that the application is able to match to a patient record in your database, then the application generates an attachment approval message to the identified provider. This message identifies the patient and includes the C-CDA document. (Please see the Received Direct Message Not Matched to a Patient section for information on C-CDA documents that cannot be matched to a patient record.)

From the message, you can review the C-CDA document contents, approve the attachment, and import information from the document into the patient's medical history. You may import medications, medication allergies, and medical problems.

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. In the Message window, select the Attachments tab and review the document content.
3. Either:
 - Select the Approve Attachment radio button if you want to approve the document. Go to step 4.
 - Select the Reject Attachment radio button if you want to reject the attachment. Go to step 6.
4. In the Type field, select the CCD for DataExchange attachment type.
5. If desired, import information from the document into the patient's history using the Import Medications, Import Medication Allergies, and Import Problems buttons. Please see the Import Patient Information from a C-CDA Summary of Care Document section below for instructions.
6. Select the Complete button to complete the message and either accept or reject the attachment.

<<New>> Receive a C-CDA that Does Not Match a Patient Record

When a Direct message contains a C-CDA document that the application is able to match to a patient record in your database, then the application generates an attachment approval message to the identified provider. This includes the C-CDA document. It does not, however, identify a patient.

You must identify the patient from the information in the C-CDA. Then, if you can match that patient to a patient record in your database, you must associate the message to that patient record.

Once you have selected a patient record, you can review the C-CDA document contents, approve the attachment, and import information from the document into the patient's medical history. You may import medications, medication allergies, and medical problems.

It is important that you make sure you are associating the correct patient record to the message before you save the message, approve the attachment, or import any information from the C-

CDA. Until any of these things are done, you may change the patient record selected. But, once any of these things are done, you cannot change the selected patient record.

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. In the Message window, select the Attachments tab and review the document content.
3. In the Patient field, select the correct patient record. The C-CDA will be attached to this record and the message associated with it.

Do not select the OK button, Complete button, or import any information from the C-CDA until you are certain that the correct patient record is selected. Select the Cancel button if you need to exit the message without associating a patient record.

4. Once a patient record is selected, you may either:
 - Select the Approve Attachment radio button if you want to approve the document. Go to step 4.
 - Select the Reject Attachment radio button if you want to reject the attachment. Go to step 6.
5. In the Type field, select the CCD for DataExchange attachment type.
6. If desired, import information from the document into the patient's history using the Import Medications, Import Medication Allergies, and Import Problems buttons. Please see the Import Patient Information from a C-CDA Summary of Care Document section below for instructions.
7. Select the Complete button to complete the message and either accept or reject the attachment.

Import Patient Information from a C-CDA Summary of Care Document

Once a C-CDA summary of care document has been attached to a patient record, you may import information from the document into the patient's medical history. You may import medications, medication allergies, and medical problems. You may only import medications that are a dispensable drug or a routed drug. The application will not allow the import if the medication is not a dispensable drug or a routed drug.

When importing please remember that a CCD document contains two portions: a human-readable portion and a machine-readable portion. Some CCD documents are generated with more information in one section than in the other. Only the information in the machine-readable portion of the document is imported.

Please note that you cannot import patient demographic information from the C-CDA document.

1. Patient Demographics → Patient Name hyperlink
2. In the Patient window, select the Attachments slider.
3. In the Attachment slider, select the hyperlink for the summary of care document.
4. In the Attachment Editor window, review the document.

5. Scroll down in the window, and you may
 - In the Table of Contents, unselect the checkbox for section to hide that section from the display.
 - In the Table of Contents, select the section name hyperlink to move to that section.
 - In the body of the document, select the section name hyperlink to move to the Table of Contents.
6. To import medication information:
 - a. Select the Import Medications button to access the Import CCD Medication History window.
 - b. When you highlight an item in either the Received History pane or the Medication History pane, detailed information on that item appears beneath the pane.
 - c. To map an item from the summary of care document, highlight the desired item in the Received History pane and drag it to the Medication History pane and drop it on the corresponding item or on the Add New Hx item.
 - d. To map several items at a time:
 1. In the Received History pane, select the checkboxes for the items you want to import.
 - Use the Select All icon () to select all items.
 - Use the Clear All icon () to deselect all selected items.
 2. Select the Add Hx icon () to import the selected items.
 3. The imported items will appear in the Medication History pane. Items imported and mapped are displayed in blue text. Items that are in the patient's history, but that have not been mapped to a summary of care medication history item are displayed in black text.
 4. If needed, you can undo an import by selecting the item and then selecting the Unlink icon (). This removes the link to the item in the Medication History pane. If the item was mapped to an existing item in the patient's medication history, that existing item remains in the history and is displayed in black text.
 - e. To replace an item in the patient's history with new or additional information from the summary of care document:
 1. Select the checkbox for the desired item in the Received History pane.
 2. Select the item in the Medication History pane to be updated.
 3. Select the Replace button.
 - f. Once you have reviewed summary of care history items, you should mark them as reviewed whether you import them or not. Then you will not have to review the same items over and over.
 1. Select the checkboxes for the desired items, and then select the Mark as Reviewed () icon.
 2. If needed, select a reviewed item or items, and then select the Mark as Unreviewed () icon.

- g. You can change the items displayed or the order in which they are displayed using the icons in the toolbar. These icons toggle.
- Show reviewed items () / Hide reviewed items ()
 - Show inactive items () / Hide inactive items ()
 - Sort by date () / Sort by name ()
- h. If desired, you can display lines between items in the Received History pane and the items in the Medication History pane to which they are mapped.
- Use Diagonal lines ()
 - Use Stepped corner lines ()
 - Use No lines ()
7. To import medication allergies:
- a. Select the Import Medication Allergies button to access the Import CCD Medication Allergy History window.
 - b. When you highlight an item in either the Received History pane or the Medication Allergy History pane, detailed information on that item appears beneath the pane.
 - c. To map an item from the summary of care document, highlight the desired item in the Received History pane and drag it to the Medication Allergy History pane and drop it on the corresponding item or on the Add New Hx item.
 - d. To map several items at a time:
 1. In the Received History pane, select the checkboxes for the items you want to import.
 2. Select the Add Hx icon () to import the selected items.
 3. The imported items will appear in the Medication Allergy History pane.
 4. If needed, you can undo an import by selecting the item and then selecting the Unlink icon ()
 - e. To replace an item in the patient's history with new or additional information from the summary of care document:
 1. Select the checkbox for the desired item in the Received History pane.
 2. Select the item in the Medication Allergy History pane to be updated.
 3. Select the Replace button.
 - f. Once you have reviewed summary of care history items, you should mark them as reviewed whether you import them or not. Then you will not have to review the same items over and over.
 - g. You can change the items displayed or the order in which they are displayed using the Show/Hide, Active/Inactive, and Sort by Date/Sort by Name icons in the toolbar. These icons toggle.
 - h. If desired, you can display lines between items in the Received History pane and the items in the Medication Allergy History pane to which they are mapped.

8. To import medical problems:
 - a. Select the Import Problems button to access the Import CCD Problem History window.
 - b. When you highlight an item in either the Received History pane or the Problem History pane, detailed information on that item appears beneath the pane.
 - c. To map an item from the summary of care document, highlight the desired item in the Received History pane and drag it to the Problem History pane and drop it on the corresponding item or on the Add New Hx item.
 - d. To map several items at a time:
 1. In the Received History pane, select the checkboxes for the items you want to import.
 2. Select the Add Hx icon () to import the selected items.
 3. The imported items will appear in the Problem History pane.
 4. If needed, you can undo an import by selecting the item and then selecting the Unlink icon (.
 - e. To replace an item in the patient's history with new or additional information from the summary of care document:
 1. Select the checkbox for the desired item in the Received History pane.
 2. Select the item in the Problem History pane to be updated.
 3. Select the Replace button.
 - f. Once you have reviewed summary of care history items, you should mark them as reviewed whether you import them or not. Then you will not have to review the same items over and over.
 - g. You can change the items displayed or the order in which they are displayed using the Show/Hide, Active/Inactive, and Sort by Date/Sort by Name icons in the toolbar. These icons toggle.
 - h. If desired, you can display lines between items in the Received History pane and the items in the Problem History pane to which they are mapped.

<<New>> Received Direct Message with Attachment that is not a C-CDA

When a received Direct message does not include a C-CDA, but it does include an attachment of any other file type (.PDF, .txt, image, etc.), the application does create an approval message or a task message for the provider. Instead, the text in the subject and/or body of the Direct message and any attached files are stored in the Direct Mail destination folder in Document Linking. You can then use document linking to associate the received file or files with a patient or patient visit note.

It is important that someone monitor the Direct Mail document linking folder on a regular basis, and process the unidentified files received. Please refer to the *General User's Guide* for instructions on linking files to patient records or patient visits.

Drug Sample Orders

Providers may order drug samples from Mitochon Systems through Aprima. The drug samples that are offered to each provider are determined by the samples available from the drug manufacturers and are based upon the patient population seen by that provider.

When you open a new patient visit note, the application sends the patient's age, gender, and medical history information to Mitochon. No patient identifying data or PHI is sent. Mitochon reviews the patient information to determine whether samples are available for any medication that might be of interest.

When drug samples are available, Mitochon sends a notification to your database. The application generates a message to you, the provider, and also displays an image on the Rx tab of Full Note Composer or other clinical note type. Both the message and the image link in the Rx tab access a list of the drug samples that are available to you. You may then order samples of the offered drugs.

The drug samples available are specific to you. Other providers in your practice may be offered different drug samples. The list of drug samples available is pulled directly from Mitochon. The list updates continually as you conduct patient visits and order samples and as the manufacturers make new offers and end offers for particular drugs.

Although the drug samples that are offered to you are based on your patient information, the drug samples are not intended for any specific patient. Mitochon simply uses your patient information to determine the samples in which you may be interested. Once you receive the drug samples, you may give the samples to any patient for whom they are appropriate.

Ordering Samples through the Message

Drug sample messages are task messages with the subtype 'Mitochon Drug Sample'. These messages are sent to individual providers. Drug sample messages cannot be forwarded to another user for processing because you, as the provider, must sign the order for the samples.

It is recommended that you view the drug samples message once a day to review all the samples offered for the day. This is most easily done by adding the Mitochon Drug Sample message subtype to a message filter that you monitor regularly. Viewing the message once a day enables you to easily review the offered drug samples and order those you are interested in without spending unnecessary time reviewing messages repeatedly throughout the day.

You will only have one drug sample message at a time. Additional medications may be added to the list of available samples as long as the message is incomplete. Once you complete a message, then a new message will be sent to you when the next medication sample is available.

To order samples from a message:

1. Select the image in the message. This opens another window displaying a list of available drug samples. The information in this window is directly from Mitochon.
2. Select the checkboxes for the drug samples you want to order.

3. Select the Sign and Submit button.
4. In the popup window, sign the order, and then select the Submit button to place the order.
5. The window then displays a message stating the order was placed. Close the window.
6. Select the Complete button to complete the message.

<<Revised>> Ordering Samples from the Rx Tab in a Visit Note

When drug samples are available, a Samples Available banner displays on the Rx tab of Full Note Composer or other clinical note type. The drug samples available are not necessarily related to the patient whose visit note you are working with. This is simply another place where you can review and order samples.

1. Full Note Composer or other clinical note type → Rx tab
2. Select the drug same image. The image will close after a few moments, and it will be replaced by a Samples Available link. You may reopen the image if desired.

Selecting the image opens another window displaying a list of available drug samples. The information in this window is directly from Mitochon.
3. Select the checkboxes for the drug samples you want to order.
4. Select the Sign and Submit button.
5. In the popup window, sign the order, and then select the Submit button to place the order.
6. The window then displays a message stating the order was placed. Close the window.

Drug Screening

Drug screening is configured for either the provider or the practice. The practice configuration is the default, and the provider's configuration, if available, overrides the practice's configuration.

The drug screening functionality includes screening for medical conditions as well as drug-to-drug, allergies, duplicate ingredients, and other precautions. Drug screening can be configured to run when a provider adds an allergy or a diagnosis to the patient's chart. The screening configuration determines the severity level of the drug screening messages displayed to you when writing prescriptions for patients.

When you select a medication to write a prescription or administer the medication, the application performs a drug screening against the patient's currently active medications and for any contra-indications with the patient's medical history.

You can also explicitly check for interaction by selecting the Drug Screening () icon. An alert message then displays indicating whether there are any potential issues. You may want to do this, for example, after entering allergy or medication information in the patient's history.

Drug Screening and User-Defined Medications

It is very important to understand that user-defined medications do not trigger drug screening when they are prescribed to a patient. They are also not considered in drug screening when a patient is prescribed another drug. Therefore, drug screening will be incomplete when done for a patient who has been prescribed a user-defined drug.

In the drug search window, drugs that are preconfigured in the drug database are listed with Type = Brand Name. User-defined drugs have Type = User Defined. In addition, user-defined drugs do not show an entry in the AKA column.

<<Revised>> Display Drug Screening Results

Drug screening results appear in the upper right corner of the SIG Writer window. The high-level categories for any warnings are listed at the top of the Drug Screening pane. Select the Expand  icon to open the Drug Screening window to review the full text of all warnings.

The Drug Screening window also enables you to enter a reason for overriding the drug warning if you choose to prescribe or administer the medication.

If you do not open the Drug Screening window to review the warnings, it will open automatically when you attempt to save the prescription and close the SIG Writer window.

<<Revised>> Overriding the Drug Screening

Drug screening alerts are informational; they do not prevent you from writing the prescription. If you choose to write prescription for a medication for which an alert has been given, you may enter a reason for overriding the screening alert.

1. Full Note Composer or other clinical note type window → Rx tab → Select Medication
2. In the SIG Writer window, review the high-level categories for any warnings at the top of the Drug Screening pane.
3. Select the Expand  icon to open the Drug Screening window and review the full text of all warnings.
4. In the Reason for Override field, enter a text note.
5. Select the OK button to return to the SIG Writer window.

DSM Charting

The application includes the following items for psychiatric practices that use the multiaxial approach to diagnosis defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*.

- DSM Full Note Composer
- DSM Dx tab
- DSM IV Axis IV history category
- DSM axis identifier on diagnosis codes

Using the DSM Clinical Note Type Window and Tab

The DSM Dx tab enables you to enter the patient's global assessment of functioning (GAF) score, and to select the DSM axis identifier for the patient's diagnosis. The DSM Dx tab is included in the DSM Full Note Composer clinical note type by default. Your administrative super user may also have included the DSM Dx tab in custom clinical note types.

1. DSM Full Note Composer → DSM Dx tab
2. Select the appropriate diagnosis.
3. In the Axis column for the charted diagnosis, select the appropriate axis identifier.
4. Enter the GAF Score.

DSM Axis History Category

The Patient History window and the Hx tab in Full Note Composer and other clinical note type windows include a category for DSM IV Axis IV. Use this category to chart events in the patient's life that can impact the patient's clinical syndrome (Axis I) or developmental or personality disorder (Axis II).

Education Forms

Several kinds of patient information forms are available in the application. They include the Patient Medication Summary report, purchased education forms from Persivia™, practice-defined education forms, and ScriptGuide® prescription education forms from LDM Group.

Your administrative super user may have uploaded practice-defined education forms used by your practice. Practice-defined education forms are used in the same way as education forms purchased from Persivia. You can select them on-demand for a patient visit note or they can be associated with a chief complaint symptom, diagnosis, procedure, patient communication types, or case management type so that they are automatically available with a patient visit note when the necessary conditions are met.

ScriptGuide prescription education forms are automatically generated based on the prescriptions written during a patient visit.

Education Form Associations

Practice-defined education forms and education forms provided by Persivia may be associated with one or more chief complaint symptom, diagnosis, procedure, patient communication type, or with a specific phase in the pregnancy case management type. Your administrative super user may have defined a set of education form associations for you, or you may be able to define these associations if you have the necessary security access rights.

When education form associations have been made, then when you charts a chief complaint symptom, diagnosis, or procedure in a patient visit note or a pregnancy case is associated with the visit, any education forms associated with that item will appear in the Education Form slider in Full Note Composer or other clinical note type window so that you can easily select and print them for the patient.

Education Forms Slider

The Education Forms slider enables you to search for and select education forms from any tab in a clinical note type window. There are also several ways in which the Education Forms slider can be prepopulated with education forms, including the provider's education form association rule set, patient communication type, and associations with a phase (trimester) of the pregnancy case.

When an education form has been associated with a symptom, diagnosis, or procedure and the association rule set has been defined for a provider, then that education form is automatically assigned to the patient visit note when the provider selects the associated symptom, diagnosis, or procedure. The education form will appear in the Education Forms slider of Full Note Composer or other clinical note type window, and can be printed or reprinted from there.

When pregnancy-related education forms are associated with a phase in the pregnancy case, the Education Forms slider makes available the education forms applicable to the patient's trimester so that the provider can easily select and print the requisite forms. These forms appear in the slider only when the patient visit note is associated with a pregnancy case.

When a pregnancy-related education form is printed from the Education Forms slider, it does not appear in the slider for future patient visit notes since printing implies the form has been given to the patient. The slider will automatically close when all of the education forms for the trimester have been printed. The education forms available in the Education Forms slider are applicable only to the patient's current trimester. Education forms associated with a previous trimester are not available from the slider, even if those education forms were not printed and given to the patient.

The Patient Medication Summary is always available from the Education Form slider. You can print it from the Education Form slider or from the Checkout window. The Patient Medication Summary lists the patient's current, new, and discontinued prescriptions and the next appointment, if scheduled.

Language Preference

The Education Form slider search criteria will default to the language selected for a patient (in the Patient window). You can then search for any education forms in your database that are

identified as that language. If you do not have education forms identified as that language, then clear the Language field in the search criteria to search for all forms.

Persivia Education Forms

Your practice may choose to purchase optional education forms from Persivia. Many of the education forms from Persivia are available in both English and Spanish. Both the English and Spanish versions of a form have the same English title when searching for the form so the form is listed twice in the search results. When Spanish is the selected language for a patient (in the Patient window), then, when available, the Spanish version of the form is automatically assigned to the patient when you select an education form, regardless of which of the two you select. You can override this language selection if desired when printing or displaying the education form. If the selected language for the patient is anything other than Spanish, then the English version of the form is always assigned, regardless of which of the two you select.

Please note that this automatic language selection only works for education forms provided by Persivia, and only works with English and Spanish, the two languages in which Persivia provides forms. This does not work for user-defined education forms which your practice has added to the database.

Search for an Education Form

1. Full Note Composer or other clinical note type → Education Forms slider
2. Select the desired Language.
3. Select the Add button to search for the form you want to add to the patient visit note.
4. In the Find Education Form window, search for and select the education form you want to add to the visit note.
5. Enter a Note about the education form assigned to the patient, if desired.

Print an Education Form Assigned to the Visit Note

1. Full Note Composer or other clinical note type → Education Forms slider
2. In the Print Language Preference field, select the language in which you want to view or print the education forms.
 - If the patient's preferred language is Spanish, you may select English.
 - If the patient's preferred language is English or is not identified, you may select Spanish.
3. Select the Print or Reprint button to print the form.

Delete an Education Form from the Slider

If an education form appears in the slider but you do not want to give it to the patient, then you may delete it from the slider. Once deleted, the education form will not print with other visit documents.

1. Full Note Composer or other clinical note type → Education Forms slider
2. Select the Delete () icon for the education form that you do not want to include.

Viewing and Restoring an Education Form Deleted from the Slider

You may view the education forms that have been deleted from the Education Form slider. If desired, you may restore the education form to the slider so that it can be printed and given to the patient.

1. Full Note Composer or other clinical note type → Education Forms slider
2. Select the All checkbox to display the deleted education forms. The titles will appear in italics.
3. If you want to restore an education form to the slider, select the Undo () icon.

Patient Communication Types

Patient education forms may be associated with topics that you may discuss with a patient. Then when you indicate in a patient visit note that the topic has been addressed, the application adds the associated education form to the Education Forms slider so that you can easily give that education form to the patient.

The application includes a number of predefined patient communication types for specific topics. The predefined communication types are used to trigger the appropriate education form selection. The predefined patient communication types include nutrition, overweight, physical activity, smoking cessation, and underweight. If you are participating a quality program, such as PCMH or MIPS, that requires or encourages the use of education forms with certain conditions or behaviors, then your administrative super user can associate the education form or forms with the appropriate patient communication type.

Your administrative super user may have defined additional patient communication types that you frequently discuss with patients, and associated the appropriate education forms with those patient communication types.

Patient Medication Summary

The Patient Medication Summary report is available only from within a patient visit note, through the Education Form slider in either Full Note Composer or another clinical note type window. The report lists:

- Current Medications: These are active medications prescribed prior to this visit.
- Prescriptions Written Today: These are medications prescribed in this visit.
- Prescriptions Discontinued Today: These are previously prescribed medications which were active until discontinued by the provider during this visit.
- Next Appointment: Date and time of the patient's next appointment if scheduled.

You can print the Patient Medication Summary from the Education Form slider or from the Checkout window.

The Patient Medication Summary populates the Education Form slider by default. You can change the default for a provider who does not want the report to automatically populate.

Prescription Education Documents

The application includes prescription education documents from ScriptGuide®, OptimizeRX®, and others. Some prescription documents include information about the medication and its benefits to the patient. They may also include a coupon, rebate offer, or other financial incentive. Other prescription documents only include a coupon, rebate offer, or other incentive. The medication information and any incentive included in the prescription education documents are provided by the drug manufacturer.

Prescription education documents are not stored in your database. They are delivered from the vendor at the time a prescription is written. The documents, and any incentives, available at any given time are controlled by the drug manufacturers, and are subject to change.

A prescription education document is automatically generated when you prescribe a medication for which the manufacturer has provided information to a qualifying patient. You cannot generate a prescription education document without prescribing the medication.

When you prescribe a medication for which a prescription education document is available, that document will be included in the documents generated and printed when the patient checks out. You do not need to select the document or perform any additional steps. If your practice is using the Patient Portal and has enabled education materials on it, then the prescription education form is also made available to the patient on your Patient Portal.

By default, all providers are set up to use prescription education documents. You may choose to opt out of automatic printing of the documents or from enabling the documents on the Patient Portal. You may also opt of the service completely. Your administrative super user can configure your preferences.

Some prescription education forms must be printed on a PCL5-compliant printer. Most printers are PCL5 compliant; some newer photo-printers are not.

Persivia™ Education Forms

Persivia supplies the education forms available in the application. The education forms are an optional licensed product.

Many of the education forms from Persivia are available in both English and Spanish. Both the English and Spanish versions of a form have the same English title when searching for the form so the form is listed twice in the search results. When Spanish is the selected language for a patient (in the Patient window), then, when available, the Spanish version of the form is automatically assigned to the patient when you select an education form, regardless of which of the two you select. If the selected language for the patient is anything other than Spanish, then the English version of the form is always assigned, regardless of which of the two you select.

Electronic Prescription Benefits and Medication History Information

You can download patients' prescription benefits and medication history information from the Surescripts® pharmacy clearinghouse. Requests for prescription benefits and medication history must be associated with a provider who has a valid Surescripts provider ID.

You can download prescription benefits information without the patient's permission. However, due to HIPAA regulations, you can only download medication history for patients who have given their permission. You indicate that the patient has granted permission in the Patient window. If the patient record does not indicate that permission has been received, then the application cannot request or download the medication history for that patient.

Drug Formulary

Drug formulary information is available through Surescripts when requesting prescription benefits information and when writing prescriptions.

Prescription Benefits Information

You can download patients' prescription benefits information from the Surescripts pharmacy clearinghouse. Prescription benefits information includes a patient's eligibility, benefits, and formulary. This enables the provider to select medications that are on the patient's formulary and are covered by the patient's drug benefit. It also informs the provider of lower cost alternatives for selected medications, such as generic drugs. A patient's prescription benefits information can be requested once in a 72-hour period, and the information received is good for 72 hours.

When you request prescription benefits information for a patient, you may also receive some medication history information if that information is available, whether or not the patient has granted permission for medication history requests. Please see the Electronic Medication History section below for more information.

Your administrative super user may have configured your database to download prescription benefits information for all the patients scheduled for visits on the following day. The visit must be scheduled with a provider who has a valid Surescripts provider ID in order for the patient's prescription benefits information to be requested and downloaded. These requests are made by a job that runs each night, and these requests are subject to the 72-hour period during which only one request may be made.

You can also download the prescription benefits information for a single patient when that patient's information was not requested by the nightly job. (If you attempt to request information for a patient who was included in the nightly job, then you will receive an error message stating that you are attempting to download the information again within 72-hours.) As with requests made by the nightly job, the on-demand request must also include the name of a provider who has a valid Surescripts provider ID.

Prescription benefits eligibility statuses are:

- Undetermined
- Approved
- Unapproved

Electronic Medication History

A patient's electronic medication history may come from two sources. The first source of information about prescriptions is pharmacies that report dispensed medications to the pharmacy clearinghouse. The second source of information about prescriptions is insurance payers who report medication claims to the pharmacy clearinghouse.

To request medication history from pharmacies, you must first obtain the patient's permission. You do not need to obtain the patient's permission to request medication history information from insurance payers since the patient will have already granted you permission to exchange data with their insurance payer.

Not all pharmacies report medication history, even if they otherwise participate in the Surescripts program. So, if your patient's pharmacy receives electronic prescriptions but does not report medication history to Surescripts, you may receive incomplete information or the 'patient not found' error.

Medication history information from insurance payers is available only for patients who have prescription benefits. Be aware that if the patient has recently changed insurance payers, you may receive medication history information that is incomplete or you may receive a 'patient not found' message.

You make requests to pharmacies for medication history as distinct medication history requests. You make requests to insurance payers for medication history as part of the prescription benefits and formulary request. Therefore, it is recommended that you make both requests when you want medication history information for a patient.

Because medication history information can come from two sources, you may receive two messages from Surescripts. The two messages may conflict if medication history information is available from one source but not from the other. So for example, if you request information for

a patient, and that patient's insurance payer has reported information but their pharmacy has not reported information, you may get two messages that seem to conflict.

Once you have downloaded a patient's electronic medication history, you can import all items or selected items into the patient's medication history within the application. This can give you more accurate and more complete medication history information. However, some information may not be available in a report, and some information in a report may not be accurate. For example, a patient may request that prescription information not be disclosed to other parties, low cost prescriptions and prescriptions paid for by the patient may not be reported by the pharmacy or insurance payer, and over-the-counter medications are not included because they are not dispensed by a pharmacist or paid for by an insurance payer. In addition, there can be errors in the insurance claim information used for the report.

Therefore, while electronic medication history is supplemental information that can help you verify the patient's medication history, you should not think of it as comprehensive or as a replacement for obtaining information directly from the patient. As the provider, you should independently verify the medication history with the patient.

You can download medication history for all the patients scheduled for visits on the following day. The visit must be scheduled with a provider who has a valid Surescripts provider ID in order for the patient's medication history to be requested and downloaded. You can also download the medication history for a single patient when needed. The on-demand medication history request must include the name of a provider who has a valid Surescripts provider ID. Remember that the application will only make medication history requests from the pharmacies for patients who have granted their permission.

Patient Identification

When medication history and prescription benefits information requests are sent to Surescripts, the pharmacy clearinghouse identifies the patient using the following information. Therefore, it is important that your patient records include all of this information if you will use the electronic medication history and prescription benefits functionality.

- Last name
- First name
- Date of birth
- Complete address, including ZIP code
- Gender

If the patient name is different in your patient record and in either the pharmacy or insurance payer record for the patient, then the two records will not match. (For example, Tom Smith and Thomas Smith are different names.) Also, patients may move and not notify their pharmacy or insurance payer of their new address. So, the pharmacy or insurance payer record for the patient may include a different ZIP code than your patient record. Simple data entry errors may also result in the patient records not matching. If any of the identifying information is entered incorrectly in the patient's record for the provider, pharmacy, or insurance payer, then the records will not match. As a result you may receive incomplete information or even a 'patient not found' error.

Downloading Prescription Benefits and Medication History from a Patient Visit Note

Download the Prescription Benefits from a Patient Visit Note

If information is not already available, you can request an on-demand download of a patient's prescription benefits and medication history from the Full Note Composer or other clinical note type window when charting a patient visit note. This process generates a request that is then sent to Surescripts. Surescripts checks the patient's prescription benefits and medication history, and then sends the information back. This can take a while.

You will receive medication history for the patient only if the patient has given authorization, and only if history is available. Medication history from pharmacies is available only if the patient's pharmacy reports to Surescripts. Medication history from insurance payers is available only if the patient has prescription benefits.

1. Full Note Composer or other clinical note type window
2. The date of the last successful download is shown on the Rx Summary slider.
3. Select the Download Rx Benefits icon ().

Note: If the icon appears as  , then recent information is already available and you do not need to download information.

4. The icon will change to  while the request is being made and information is downloaded. The request is generated using the patient, provider, and service site identified in the visit note.
5. When the download is complete, the icon will change to  if information has been downloaded or to  if no information was available for download.

Download the Electronic Medication History from a Patient Visit Note

You can request an on-demand download of a patient's medication history from the Full Note Composer or Superbill Composer window when charting a patient visit note. This process generates a request which is then sent to Surescripts. Surescripts checks the patient's medication history, and then sends the information back. This can take a few seconds.

You will receive medication history for the patient only if the patient has given authorization, and only if history is available. Medication history from pharmacies is available only if the patient's pharmacy reports to Surescripts. Medication history from insurance payers is available only if the patient has prescription benefits, and only if you have obtained the patient's prescription benefits within the past 24 hours.

1. Full Note Composer or other clinical note type window
2. The date of the last successful download is shown on the Rx Summary slider.
3. Select the Download e-Med Hx icon ().

Note: If the icon appears as , then recent information is already available and you do not need to download information.

4. The icon will change to  while the request is being made and information is downloaded. The request is generated using the patient, provider, and service site identified in the visit note.
5. When the download is complete, the icon will change to  if information has been downloaded or to  if no information was available for download.

Tracking Downloads

Tracking the Prescription Benefits Download Requests

You can review the prescription benefits download requests to determine the status of the download. The Track e- Rx Benefits window displays the downloads from the overnight schedule request, and any on-demand download requests that have been made.

You can review the prescription benefits download requests made to determine the status of the download. The Track e- Rx Benefits window displays the downloads from the overnight schedule request, and any on-demand download requests that have been made.

1. Tools → Track Rx Benefits ()
2. In the Track Rx Benefits window, enter the desired selection criteria.
3. Select the Search button to display a list of medication history requests matching your selection criteria.

Please note that the message "Transmitted Successfully to Surescripts" means only that your request has been transmitted. When Surescripts replies, this will change to either a message saying that coverage information was received, a message that the subscriber was not found, or a message that the request failed.

Tracking the Electronic Medication History Download Requests

You can review the medication history download requests made to determine the status of the download. The Track e-Med Hx window displays the downloads from the overnight schedule request, and any on-demand download requests that have been made.

1. Tools → Track e-Med Hx 
2. In the Track e-Med Hx window, enter the desired selection criteria.
3. Select the Search button to display a list of medication history requests matching your selection criteria.

Please note that the message 'Transmitted Successfully to Surescripts' means only that your request has been transmitted. When Surescripts replies, this will change to either a message saying that medication history information was received, a message that the patient was not found, or a message that the request failed.

Import a Patient's Electronic Medication History

Once a patient's medication history has been downloaded from Surescripts, you may use the Import Medication Hx window to import all or part of that history into the patient's chart within the database. The Import Medication History icon in Full Note Composer or Superbill Composer indicates whether the patient has any history to be reviewed and imported.

- When no download request has been made or when the available history has already been reviewed, the icon appears as .
- When medication history has been downloaded and is ready for review, the icon appears with a checkmark .
- When there was no information available for the download, the icon appears as .

Please remember that the information available or not available to import is the information received in the medication history download from Surescripts, who received the information from pharmacies and insurance payers. Aprima has no control over the information received.

When you import an item from the electronic medication history, the application maps it to an item in the patient's medication history in the database. If no corresponding item exists, the application creates a new entry in the database. Once you have imported an item, it is a permanent part of the patient's record in the same way as any item you had entered.

If desired, you may choose to update the medication history item in the database with the history item from the electronic medication history. For example, you may choose to update the item if you prescribed a brand name medication but the pharmacy dispensed a generic medication. Or, if the patient provided some information about a medication taken in the past or prescribed by another physician, you can update that historical entry with details from the electronic medication history. When you update an item with information from the electronic medication history, the original item in the patient's history is inactivated and a new item is created with the information from Surescripts.

The Import Medication Hx window contains four panes. The eRx History pane in the top left lists the medication history items received from the pharmacy clearinghouse. The Medication Hx pane displays the list of items that you have identified to add to the patient's medication history in the database. Beneath each of these panes is a smaller pane that displays detailed information about the item selected in the upper pane. Included in this detail are the name of the prescribing provider, the dispensing pharmacy, the medication details, and the source of the information.

Import the Medication History

1. Full Note Composer or other clinical note type window → Import Medication History icon ()
2. When you highlight an item in either the eRx History pane or the Medication Hx pane, detailed information on that item appears beneath the pane.
3. To map an item, highlight the desired item in the eRx History pane and drag it to the Medication Hx pane and drop it on the corresponding item or the Add New Hx item.
4. To map several items at a time, in the eRx History pane, select the checkboxes for the items you want to import.
 - Use the Select All icon () to select all items.
 - Use the Clear All icon () to deselect all selected items.
5. Select the Add Hx icon () to import the selected items.
6. The imported items will appear in the Medication Hx pane. Items imported and mapped are displayed in blue text. Items that are in the patient's history, but that have not been mapped to an electronic medication history item are displayed in black text.
7. If needed, you can undo an import by selecting the item and then selecting the Unlink icon (). This removes the link to the item in the Medication Hx pane. If the item was mapped to an existing item in the patient's medication history, that item remains in the history and is displayed in black text.
8. To replace an item in the patient's history with new or additional information from Surescripts:
 - a. Select the checkbox for the desired item in the eRx History pane.
 - b. Select the item in the Med History pane to be updated.
 - c. Select the Replace button.
9. Once you have reviewed electronic history items, you should mark them as reviewed whether you import them or not. Then you will not have to review the same items over and over.
 - a. Select the checkboxes for the desired items, and then select the Mark as Reviewed () icon.
 - b. If needed, select a reviewed item or items, and then select the Mark as Unreviewed () icon.
10. You can change the items displayed or the order in which they are displayed using the icons in the toolbar. These icons toggle.
 - Show reviewed items () / Hide reviewed items ()

- Show inactive items () / Hide inactive items ()
- Sort by date () / Sort by name ()

11. If desired, you can display lines between items in the eRx History pane and the items in the Medication Hx pane to which they are mapped.

- Use Diagonal lines ()
- Use Stepped corner lines ()
- Use No lines ()

Using Prescription Benefits and Formulary Information

Review a Patient's Prescription Benefits Coverage

Once you have received a patient's formulary and prescription benefits information from Surescripts, you can review that information. The information includes the prescription benefits payer, the associated health plan name and ID, the group name and ID, the expiration date of the benefits, and whether eligibility is for retail or mail order pharmacies.

1. Patient Demographics → Accounts tab
2. When formulary and benefits information have been received, the Drug Formulary field and the formulary and prescription benefits provider appear in the primary account section. This field is not displayed if no information has been received or if previously received information is now out of date.
3. To view detailed information, select the Account name hyperlink to access the Account window.
4. The Formulary field displays the formulary and prescription benefits provider. The name displayed here may not be the same as the name displayed on the Patient Demographics window's Accounts tab.
5. If the patient has more than one insurance payer, then you may have received more than one formulary and benefits record. You can use the Find icon in the Formulary field to see if another record is listed, and then select another record if appropriate.

Important: The Find Patient Rx Eligibility window displays all the records that you have ever received for the patient, not just the most recently received record or records. If you select another record, you must perform the next step and review the information carefully to ensure that the selected record is currently valid.

6. To view the details of the selected formulary and benefits record, select the Rx Benefits next to the Formulary field. This accesses the Display Rx Benefits Coverage window.

To determine whether the coverage information is current and accurate, review:

- Last Rx Benefits Download Date: If this date is recent, the information is more likely to be current. The older the date, the greater the possibility that the information may not be current. Most coverage plans are only good for one year, so if the date is a year or more in the past, then the information is likely no longer valid.

- Health Plan Name: Compare the health plan shown here to the insurance payer and plan shown on the Account window. If these are not the same, the information may not be current. Verify the insurance payer and plan with the patient before using this information.
 - Eligibility Date: This is the eligibility date at the time the record was received. If this date is recent, the information is more likely to be current. The older the date, the greater the possibility that the information may not be current. Most coverage plans are only good for one year, so if the date is a year or more in the past, then the information is likely no longer valid.
 - Coverage Type: This is the coverage type at the time the record was received. So, if the coverage type is 'Active Coverage' but the record was received some time in the past, the coverage may or may not still be active. If the record is a year or more old, then it is likely that the coverage is no longer active.
7. Repeat steps 5 and 6 until you have selected the current and appropriate formulary. If none of the records are current, then leave the Formulary field blank so that no formulary record is associated with the patient's account.

<<Revised>> Using a Patient's Formulary Information

Once a patient's prescription benefits have been downloaded, you can view the formulary information while writing a prescription or charting an administered medication. The information available includes medications on the formulary, therapeutic alternatives, and cost and copay information. It also includes the formulary status for the currently selected medication.

In the Full Note Composer or other clinical note type window, the prescription benefits icon will appear as  if the information has not been downloaded, as  when the information has been downloaded, or as  if a request was made but no information was available for download.

In the SIG Writer window, the status of the prescription benefits and formulary download is indicated by the color bar on the left of the Formulary pane.

- Yellow indicates not enough information for the request. You must select a PBM, a pharmacy, or both.
- Blue indicates that the request is in progress; waiting on response.
- Green indicates that the response has been received.
- Red indicates an error occurred in sending or receiving. This can include that the information displayed is old because the prescription benefits have not been downloaded recently.

Note: In some cases, you may receive Patient Medication Benefit Check (PMBC) in addition to the standard formulary information. Please refer to the Using the PMBC Information While Charting a Prescription section for more information about PMBC and instructions for using the functionality.

In the Rx tab, select the Patient Formulary link to access a window displaying the patient's formulary information.

- The benefits payer name is shown on the tab. If the patient has more than one benefits payer, there will be a tab for each payer.

Important: The window displays all the records that you have ever received for the patient, not just the most recently received record or records. If you select another record, you review the information carefully to ensure that the selected record is currently valid.

- The Last Rx Benefits Download Date displays the date the information was obtained. The more recent the date, especially if within the same calendar month, the greater the likelihood that the information is current. The older the date, the greater the possibility that the information may not be current. Most coverage plans are only good for one year, so if the date is a year or more in the past, then the information is likely no longer valid.

In the SIG Writer window, any formulary information and therapeutic alternatives for the selected medication are shown in the bottom right pane of the window.

- The Rx Benefit field contains the selected benefits payer. If the patient has benefits from more than one payer, the Find icon will include a red checkmark, and you can select another payer from the Find Patient Rx Eligibility window.

Important: The Find Patient Rx Eligibility window displays all the records that you have ever received for the patient, not just the most recently received record or records. If you select another record, you must select the Rx Benefits button to review the formulary information, and then check it carefully to ensure that the selected record is currently valid.

- The Rx Benefits link displays the date the information was obtained. The more recent the date, especially if within the same calendar month, the greater the likelihood that the information is current. The older the date, the greater the possibility that the information may not be current. Most coverage plans are only good for one year, so if the date is a year or more in the past, then the information is likely no longer valid.
- Any available alternative medications are listed with their formulary status. To use an alternative, select the desired medication from the list.
- To see additional information, select the Expand () icon.

<<Revised>> Evaluation and Management

The Evaluation and Management (E&M) window enables you to review the parameters that have been included in a patient visit note prior to filing a claim for the visit. It also provides an audit trail of the billing that is attached to the patient visit note.

Use the E&M window to confirm or select a level of care. If you have not already entered an E&M code in the patient visit note, the entries on this window will determine the appropriate code and record it in the SP tab of Full Note Composer or other clinical note type window when you select the OK button to close the window. You may also select entries on this window to determine the code to be recorded in the SP tab.

The E&M calculation is based on the U.S. Department of Health and Human Services' 1997 Documentation Guidelines for Evaluation and Management Services, which can be found on the Centers for Medicare & Medicaid Services website at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>

There are three key components to the E&M calculation. These components are the patient history, the physical exam, and medical decision making. For new patients and consult patients,

all three components are required to calculate the E&M level of care. For established patients, only the patient history and physical exam are required.

To access the Evaluation and Management window, select the E&M icon () from the toolbar in Full Note Composer or other clinical note type window.

The format and content of the window will change based on the place of service selected and the basis of the E&M calculation (whether on documentation or time). The table below describes the various sections that may appear on the window.

Section	Description
Place of Service	The default place of service selection is determined by the service site type associated with the service site on the patient visit note. You may select another place of service if desired. For hospital sites, you must select the type of care provided. For rest home sites, you may select a more detailed place of service identifier.
Patient/Visit	The type of patient or visit options are determined by the place of service selected.
Based On	<p>E&M coding may be based on the documentation in the visit note or on the time spent by the provider. The default is Documentation.</p> <ul style="list-style-type: none"> • An initial hospital observation visit must be based on documentation; it cannot be based on time. • A discharge hospital observation visit has only one possible code, and does not need a selection basis. • A discharge hospital inpatient visit can only be based on time. • A hospital critical care visit can only be based on time. • A hospital ER visit can only be based on documentation. • A hospital ER advanced life support visit has only one possible code, and does not need a selection basis.
Chief Complaint	Will be identified as Present, when a chief complaint has been selected, or Not Present, when a chief complaint has not been selected.

Section	Description
History	<p data-bbox="467 275 1406 432">Includes history of present illness, review of systems, and past, family, and social history. Each section will indicate number of items documented and the associated level of service or None Charted. You may select the link to return to the appropriate Full Note Composer or Superbill Composer tab to complete your charting if desired.</p> <p data-bbox="467 474 1308 533">The History slider indicates the completeness of the patient history charted in the visit note.</p> <p data-bbox="467 575 768 606"><i>History of Present Illness</i></p> <p data-bbox="467 648 1406 707">One point is earned for charting the history of the present illness, whether for one or more chief complaints.</p> <p data-bbox="467 749 1370 873">When the patient has three or more problems with a status of Chronic, the HPI is Extended regardless of the HPI entries in the visit note. This applies only when using 1997 rules; it does not apply when using 1995 rules.</p> <p data-bbox="467 915 683 947"><i>Review of Systems</i></p> <p data-bbox="467 989 1393 1050">Depending on the complexity of the patient visit, you should review one or more systems for the patient visit.</p> <p data-bbox="467 1092 651 1123"><i>Patient History</i></p> <p data-bbox="467 1165 1346 1262">There can be a maximum of three points for history. Points are determined as follows; selecting more than one item in the following categories does not increase the points.</p> <ul data-bbox="467 1304 1414 1524" style="list-style-type: none"> <li data-bbox="467 1304 1321 1335">• One point for Family History, either Family or Genetic Screening <li data-bbox="467 1350 1349 1381">• One point for Social History, either Social History or Specialty Q&A <li data-bbox="467 1396 1414 1524">• One point for Past Medical History, either Medical History, Infection History, Surgical History, Medication History, Food Allergy, Drug Allergy, Environmental Allergy, Immunization History, Menstrual History, or Pregnancy History

Section	Description
Physical Exam	<p>Vitals will be identified as Present, when three or more standard vital signs have been entered; Incomplete, when less than three vital signs have been entered; or Not Present, when no vital signs have been entered. Some specialties may require additional vital entries for E&M counting. When vitals are identified as Present, they qualify as the constitutional system in the physical exam.</p> <p>The Physical Exam slider indicates the completeness of the physical exam charted in the visit note. The bullet count for the physical exam is determined by the E&M guidelines used to define the exam. The 1995 guidelines count only systems; the 1997 guidelines count systems and items within systems. The E&M does not show the specific bullet count. The bullet count is shown in the footer of the clinical note type window.</p>
Medical Decision Making	<p>You may select the level of complexity or you may enter information on which the level complexity is calculated. A medical decision making selection is required for new patients and for consult patients.</p> <ul style="list-style-type: none"> • To select the level of complexity, select the desired point on the Medical Decision Making slider. • To calculate the level of complexity, select the Guidelines button to access the Medical Decision Making window. Enter the information requested on each of the three screens, and then select the OK button.
Level of Care Based on Time	<p>This section appears only when you have selected Time as the basis of the E&M calculation.</p> <p>Select the radio button for the amount of time spent with the patient or coordinating care for the patient.</p> <p>If desired, you may enter a Description of Service. Information entered in this field is not included in Review Past Notes or One Page Summary.</p>
Level of Service Code	<p>For established patients, the application selects the level of service code based on your entries. You may select another of the available codes if desired.</p> <p>For new and consult patients, the application will select the level of service code only if you have selected a medical decision making level. If you have not selected a medical decision making level, then no level of service code is selected since a medical decision making level is required for new and consult patients.</p>
Total Duration of Critical Care	<p>This section appears only for hospital critical care visits. Code 99291 is selected for the first 1 to 60 minutes of care. For more than sixty minutes, code 99292 is also selected with 1 unit for each additional 30 minutes.</p>

For more information, please see the E&M Levels of Risk topic in the online help.

E&M Warning Message at Visit Checkout

A warning message is displayed at checkout when an E&M code has not been selected. However, if the visit note does not contain any services performed (procedure codes entered on the SP tab), then this warning message is not displayed.

Follow Up Slider

The Follow Up slider enables you to reuse information from previous visits when charting the current patient visit note.

Because the Follow Up slider requires structured charting information, it cannot be used in Superbill Composer or another clinical note type window that uses the CC/HPI and ROS/PE tabs. It also cannot display information from visits that were charted using the CC/HPI and ROS/PE tabs.

The table below shows the Follow Up slider icons and their meanings.

Icon	Meaning
	Not applicable. Select this checkbox if you do not want to document this item.
	Condition resolved.
	Condition improving.
	Condition worsening.
	Condition remains the same.

Clinical Note Type

The clinical note type (Full Note Composer, Superbill Composer, etc.) used to chart the previous visit note is identified in the Date column.

Custom Items

Items on a custom clinical note type tab can be displayed in the Follow-Up slider if the clinical note type window being used contains the same custom tab. In the Follow-Up slider, you must select the Other checkbox to display the custom items. You can chart information in the slider in the usual manner.

Chart Using the Follow Up Slider

1. Select the Follow Up slider. It will be easier to access information if you pin the slider in place.
2. Select the visit that you want to reuse from the list in the left pane. Information from the visit is displayed in the right pane.
3. Select which information you want to view by selecting one or more of the checkboxes (All, CC/HPI, ROS, PE, Dx, RX, SP, etc.).
 - By default, all checkboxes are selected and all data is displayed.
 - Expired diagnosis codes are displayed in italic. If you select an expired code, the application will prompt you to search for a current code. It will not prevent you from selecting the code.
4. Select the current condition of items by selecting the appropriate checkbox.
5. Information you select is included in the current chart.

Using an ICD-10 Diagnosis Code Based on an ICD-9 Diagnosis Code in the Follow Up Slider

You may chart an ICD-10 code based on an ICD-9 code selected from a common problem palette.

1. Full Note Composer or other clinical note type window
2. Select a diagnosis from the Follow Up slider.
3. The IMO Diagnosis Search window appears, displaying a list of possible ICD-10 codes for the ICD-9 code you selected.
4. Select the desired ICD-10 code, with appropriate modifiers/qualifiers.
5. Select the OK button to chart the selected ICD-10 diagnosis code in the Dx tab.

Selecting a Subsequent Treatment ICD-10 Code

Many ICD-10 base codes include modifiers for initial treatment and for subsequent treatment. Therefore, the diagnosis code appropriate for a follow up visit may not be the same as the diagnosis code used in the initial visit.

If your user setting definition is defined to prompt for subsequent treatment codes, then when you use the Follow Up slider to identify the diagnosis code for a visit, the application determines whether the diagnosis code from the previous visit was for initial treatment. If it was, then the application prompts you to select a diagnosis code for subsequent treatment.

1. Full Note Composer or other clinical note type window
2. Select the Follow Up slider.
3. Select the previous visit for which this visit is a follow up.
4. Select the Dx checkbox to display the previous diagnosis. You may select the checkboxes for additional items if desired.
5. Select the checkbox that indicates whether the condition is resolved, improving, deteriorating, or the same.
6. A prompt displays stating the identified ICD-10 code is for an initial diagnosis, and asking if you want to select a subsequent code.
 - Select Yes to access the IMO Diagnosis Search window to select the subsequent code.
 - Select No to continue with the initial diagnosis code.
7. The IMO Diagnosis Search window displays the specific range of diagnosis codes that are subsequent diagnoses for the original initial diagnosis code. Select the desired code.
8. The selected diagnosis code is added to the Dx tab.

<<New>> Genomic Testing and Drug-Genome Screening

Genomic testing and subsequent drug screening based on the results is an optionally purchased service provided by ActX™. ActX performs genomic testing for enrolled patients, then provides you with information on an enrolled patients' hereditary risks and alerts for adverse drug reactions when writing prescriptions for an enrolled patient.

To enroll a patient in ActX, the patient must have a valid email address entered in the Patient window. Then you must order the ActX service using one of the custom procedure codes for ActX tests. When you place the ActX order, you must also enter the patient's consent to release information to ActX. This is done in the Patient window's Additional tab. The patient's consent is necessary to receive drug alerts.

When ActX receives the order, they send an email to the patient. This email contains instructions on how to enroll for the ActX service. The patient enrolls on the ActX website and pays for the service (the service is not covered by insurance). ActX then sends a saliva collection kit to the patient. The patient collects a saliva sample, and then sends it to ActX's CLIA-certified laboratory.

Once the patient's saliva sample has been genotyped, the ActX Genomic Decision SupportSM Service is activated. You receive a lab test results message from ActX, which you must review and approve. Once approved, a results entry is listed in Review Past Notes. However, the ActX test results are not stored directly in your database. The ActX results entry in Review Past Notes identifies the test ordered and includes a link to the patient's test results on the ActX website.

ActX's patient genomic profile shows the patient's genomic risks. You can discuss the genomic risks with the patient, and then determine when and if any additional testing for specific conditions is needed.

ActX's carrier status panel includes over 180 conditions. You can use this information to discuss with the patient any risk the patient has of passing on serious recessive genetic conditions to their children.

Once the test has been performed and the results approved, then ActX drug screening will be performed when you write a prescription or chart an administered medication for the patient. ActX's drug-genome screening covers all common U.S. prescription drugs. Drug-genome interaction alerts are incorporated into the application's standard drug screening functionality. When you write a prescription for an enrolled patient, ActX checks the drug against the patient's genetics, and then it sends back an alert if there is an issue with adverse drug reactions, efficacy, or dosing.

The ActX drug-genome alerts appears in the Drug Screening pane of the SIG Writer window. When an ActX alert is received, the message "ActX results available below" appears at the top of the Drug Screening pane. The ActX alert is at the bottom of the pane beneath any standard drug screening results and the First Databank drug database copywrite information. The. Scroll to the bottom of the pane to review the ActX alert.

Procedure Codes for ActX Tests

Use the following custom procedure codes to order an ActX test. You order ActX tests as you would order any other lab test, by charting the procedure code on the SO tab in Full Note Composer or other clinical note type and submitting the electronic order.

Procedure Code	ActX Test
101	ActX Full Service
102	ActX Pharmacogenomics Service
103	Expand to ActX Full Service

Graphs of Vitals and Lab Results

Vital signs and the results for certain types of lab procedures can be displayed on a graph. You may graph multiple items on a single graph or graph up to four items at a time on individual graphs. You can include all the patient tracking events of a certain type on a graph so that you can see the effect of an event, such as a procedure or medication change.

The dates of the observations are shown on the horizontal X axis. The measurement range is shown on the vertical Y axis. When displaying multiple items on a single graph, you may choose how you want the Y axis to display. For each item in the graph, you may display the Y axis on the left or right of the graph. You may also display a single Y axis for all the items (or all the items on each side), or an individual Y axis for each item. The unit demarcation on a single Y axis will use the highest number of units appropriate for the items.

Hover the cursor over the dot representing a single instance to display the date and results of that lab procedure instance.

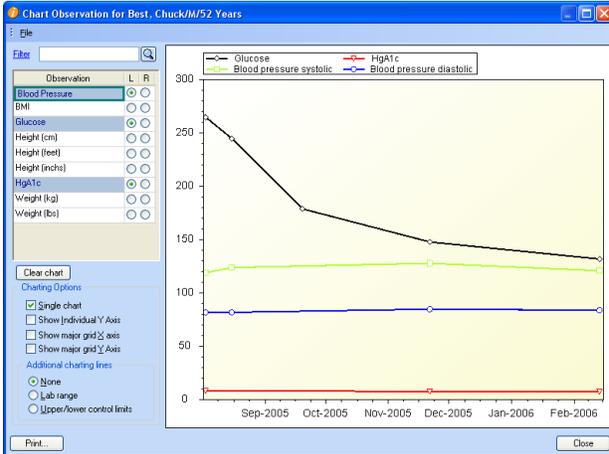
In order to be graphed, the results must be discrete data that have been manually entered or received through a lab interface. Results on attached documents cannot be graphed. The graph will be blank if there are no results to display.

The graphing functionality can display ratio values, such as for lab results and other observations. A ratio such as 100:30 will be plotted on a graph as 3.333. The following ratio formats are supported 100:30, 100/30, 100::30, and 100 | 30.

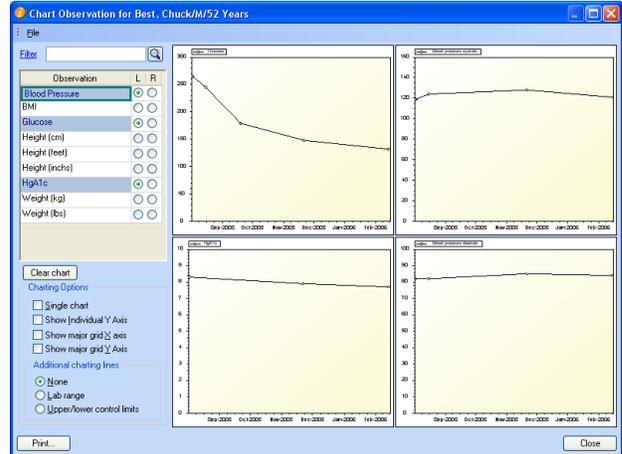
The window also enables you to toggle between a graph and flowsheet when viewing the observations and results.

Graph Displays

You can view vitals or test results as graphs. You can plot multiple items on a single graph, or plot up to four items at a time on individual graphs.

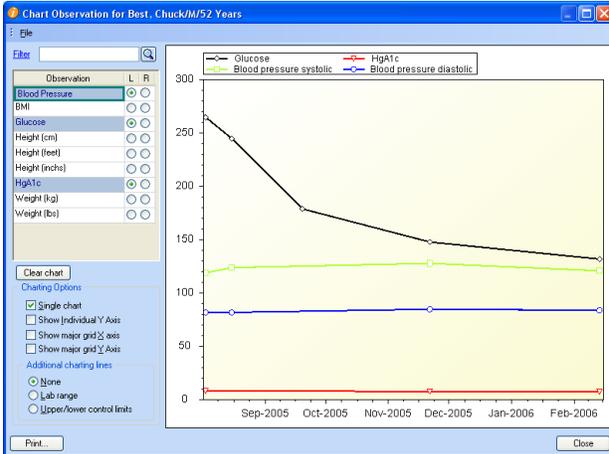


Single Graph

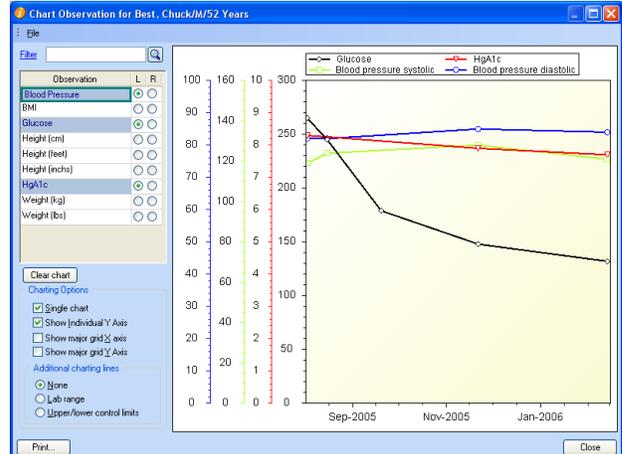


Multiple Graphs

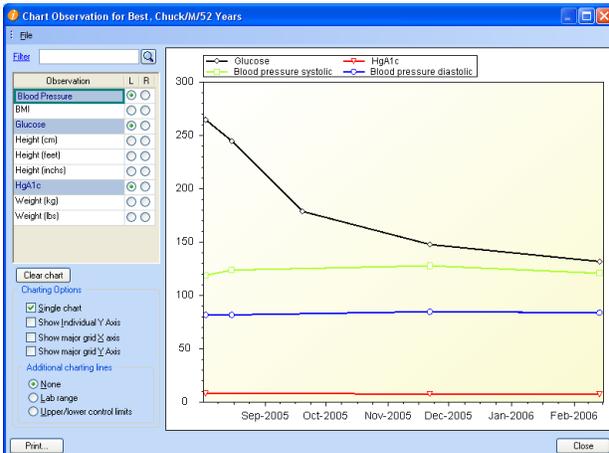
When you plot multiple items on a single graph, you may choose how you want the Y axis to display. For each item in the graph, you may display the Y axis on the left or right of the graph. You may also display a single Y axis for all the items (or all the items on each side), or an individual Y axis for each item. The unit demarcation on a single Y axis will use the highest number of units appropriate for the items.



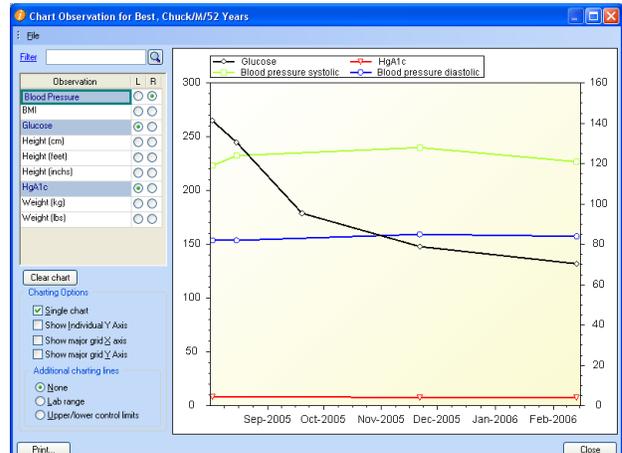
Single Y Axis



Individual Y Axes



Left Y Axis



Left and Right Y Axes

Plot a Graph

1. Save the visit note.
2. Select the Graph icon (.
3. Select a Filter if desired. Filtering enables you to limit the graph to the most recent observations or to observations within a specified timespan.
4. From the Observations list, select the vital signs, lab procedures, and patient tracking event types that you want to graph from the list on the left. The list will only include vitals that have been taken and procedures that have been ordered for the patient.

As you select items, they will be graphed in a single graph or in multiple graphs, depending on the charting option selected. (See step 7.)

5. Select the L(ef) or R(ight) radio button for each vital sign or lab procedure indicating on which side of the graph you want the Y axis for that item to appear.
6. Select the type or types of events that you want to appear on the graph. Event types are always at the bottom of the Observation list.
7. Select the Graph radio button.
8. Select the desired Charting Options.
 - Single Chart: Select to display all the selected items in a single chart. Deselect to chart each selected item individually.
 - Show Individual Y Axis: Select to display the horizontal axis units for each item graphed.
 - Show Major Grid X Axis: Select to display gridlines for the major tick marks on the X (horizontal) axis. Deselect to remove the gridlines.
 - Show Major Grid Y Axis: Select to display gridlines for the major tick marks on the Y (vertical) axis. Deselect to remove the gridlines.
9. Select the desired Charting Lines.
 - None: The range on the X axis is determined by the lab results themselves.
 - Lab Range: The range on the X axis is determined by the standard range of results for the selected lab procedure or vitals sign.
 - Upper/Lower Control Limits: The range on the X axis is determined by the lab results themselves. A grid line displays for the calculated upper most limit and lower most limit of the samples.
10. If desired, select the Clear Chart button to clear all selections and start over.

View as Flowsheet

1. Save the visit note.
2. Select the Graph icon ()
3. Select a Filter if desired. Filtering enables you to limit the graph to the most recent observations or to observations within a specified timespan.
4. From the Observations list, select the vital signs, lab procedures, and patient tracking event types that you want to graph from the list on the left. The list will only include vitals that have been taken and procedures that have been ordered for the patient.
5. Select the Flow radio button.

Patient Tracking Events

A patient tracking event is anything that may have an effect on the lab results or vitals, such as a change in medication or diet or a procedure, and that can be identified as occurring or beginning on a specific date. The patient tracking event can then be plotted on a graph. So, for example, when you change a patient's blood pressure medication, you can define a patient tracking event for that change. Then when you graph the patient's blood pressure, you can include the patient tracking event on the graph so that you can show the change in medication affected the patient's blood pressure.

Patient tracking event types identify kinds of events that can be used when graphing vitals or lab results. Events are plotted on a patient graph by type rather than by specific event. So, you may want to define a number of different event types in order to keep individual graphs from becoming too cluttered. The application has two predefined event types, general and visit. Your administrative super user may have defined additional event types for your use, or if you have the necessary security access rights, you may define additional event types.

Growth Charts

You can maintain growth charts for infants (birth to 36 months) and young adults (ages 2 to 20 years). Growth charts are updated on subsequent visits to provide a graphical view of patient data against percentiles.

The format of system-defined growth charts is taken from the Department of Health, Centers for Disease Control and Prevention (CDC) (www.cdc.gov/growthcharts) and the United Nation's World Health Organization (WHO) distributed by the CDC (www.cdc.gov/growthcharts/who_charts.htm). Your administrative super user may have created additional growth charts for your use.

You must save the patient visit note after entering the latest set of vitals before you can view that information on the growth chart.

For the first year of a baby's life, the baby's age is calculated as the number of days since birth, and this is divided by 30 to calculate the number of months. Although the growth charts include a grid in months, the first year will show points on the chart that relate to the day within the month (e.g., the chart for a baby of one month and 14 days old will show a point midway between months 1 and 2).

When a baby is one year old, the age is calculated from the month in which the baby was born, so points on the chart are plotted according to the monthly grid.

A chart will not display if either the patient's date of birth or gender has not been entered in Patient Demographics. The gender must have been defined to include the corresponding ANSI code. So, if a new gender has been added (e.g., 'young girl'), this must be associated with the corresponding ANSI code (in this case F - Female) or the chart cannot be accessed.

Premature Babies and Growth Charts

For premature babies, you can adjust the age calculation by entering the baby's gestational age in the Specialty Q&A history category. Once entered, the gestational age can be used in the growth chart. The application subtracts the gestational age from the normal gestation period, and then subtracts that same amount from the baby's current age when plotting data on the growth chart. So, for example, if you are examining a nine-month old baby that had a gestational age of 30 weeks, then the application will subtract 10 weeks from the baby's age, and plot the data at 6.5 months on the growth chart.

The application includes standard growth charts from the CDC and WHO; it does not include growth charts specifically for premature babies. If you have a preferred growth chart for premature babies, your administrative super user may import that growth chart into the application.

Use a Growth Chart

1. Full Note Composer or other clinical note type → Vital tab
2. Enter weight, height, head circumference, and other vitals, and then select the Update button.

3. Select the Growth Charts  icon.
4. Select the desired growth chart from the list on the left. Chart types include:
 - Weight
 - Height (Length for infants)
 - Weight/Height
 - Body Mass Index (not applicable for infants)
 - Head Circumference (not applicable for young adults)
5. If desired, select the Include Gestational Age checkbox to include the gestational age in the calculation. This is appropriate for patients who were born prematurely. The patient's gestational age must be entered in the Specialty Q&A category in the Hx tab or History window to be used in the growth chart.
6. If desired, select the Show Plotting Symbol checkbox. When selected the plot for the child's growth includes plot symbols for the dates measurements were taken. When not selected, these symbols are not included.
7. Select the radio button for either Metric or English units.
8. Select the desired grid option:
 - No grid
 - Major grid only
 - Both major and minor grid
9. Review the data in the chart by selecting one of the points on the chart. The display shows the data and the date of the plot.

Image Attachments

The application is preconfigured with a series of images that you may wish to use as attachments to patient visit notes or records. Your administrative super user may also have added other images to the database. When used in attachments, you can annotate the images and display a thumbnail of the image in the One Page Summary and patient visit notes.

Annotate an Image Attachment

An Attachments Slider is available from the Full Note Composer, Patient, and Responsible Party windows. Although the method of attaching a file and annotating it are similar, the displays are slightly different.

In Full Note Composer and other clinical note type windows, the attachments slider lists all attachments that have been added to the patient visit note for the specific visit only. Attachments to a patient visit note may be added and modified at any time, even after the patient visit note has been completed.

Attachments are categorized by attachment type, and may be modified by selecting the item in the attachments slider and selecting Modify, or by selecting the attachment hyperlink.

1. Either:
 - Full Note Composer or other clinical note type window → Attachment Slider
 - Patient → Attachment Slider
 - Responsible Party → Attachment Slider
2. Select the New button to add an attachment.
3. In the Attachments window, select the Import button to choose the format of the attachment.
4. Select Existing Images, then search for and select the desired image.
5. The Name of the selected image and the image itself populate the Attachments window.
6. Select the Attachment Type. This is important in categorizing the attachment in the attachment slider, especially if the attachment is to be used in Results Tracking.
7. Select the desired ink color from the toolbar.
8. Using the stylus, draw or write on the image.

Info Button for Patient Education Resources

Patient education resources are third parties which provide information on medical problems based on information about the patient, including age, gender, diagnoses, lab results, and prescribed medications. While charting a visit, you are able to select an Info Button to send patient information, in a standard HL7 format, to the patient education resource provider. The patient education resource provider then returns education information and material to the application. You may print the education material to give it to the patient, or may simply discuss the information with the patient.

By default, the application uses the National Institutes of Health's MedlinePlus® Connect website for patient education resources. Your practice may change this to another resource if desired. And, different users or groups of users may use different patient education resources. The patient education resource is identified in the user setting definition.

Use the Info Button for Problems

You can use the Info Button to obtain information about medical problems in the patient's history. To obtain information about a medical problem, the problem must be associated with a SNOMED code. Your administrative super user or you, if you have the necessary security permissions, may associate a SNOMED code to a problem.

1. Either:
 - Full Note Composer or other clinical note type → Hx tab → Problem/Diagnosis History category
 - Patient History → Problem/Diagnosis History category
2. In the line item for the problem or diagnosis of interest, scroll to the far right and select the Info Button () icon in the Info column.
3. Your default browser will open to your patient education resources provider, and will display information about the selected problem.

Use the Info Button for Diagnoses

You can use the Info Button to obtain information about diagnoses when charting a patient visit note.

1. Full Note Composer or other clinical note type → Dx
2. Chart the diagnosis in the usual manner.
3. In the line item for the charted diagnosis, scroll to the far right and select the Info Button () icon in the Info column.
4. Your default browser will open to your patient education resources provider, and will display information about the selected diagnosis.

Use the Info Button for Medications

You can use the Info Button to obtain information about medications when charting a patient visit note or when reviewing the patient's medication history.

1. Either:
 - Full Note Composer or other clinical note type → Rx tab
 - Full Note Composer or other clinical note type → Hx tab → Medication History category
 - Patient History → Medication History category
2. If charting a patient visit note, prescribe the medication in the usual manner. If reviewing the medication history skip this step.
3. In the line item for the medication, select the Info Button () icon to the right of the medication name.
4. Your default browser will open to your patient education resources provider, and will display information about the selected medication.

Use the Info Button for Lab Tests and Results

You can use the Info Button to obtain information about lab tests and their results when entering or reviewing a patient's lab results.

1. Patient Demographics → Track Patient Results
2. If entering results, do so in the usual manner. If reviewing results, skip this step.
3. Select the order or template which you want to review.
4. In the line item for the lab test component, scroll to the far right and select the Info Button () icon in the Info column.
5. Your default browser will open to your patient education resources provider, and will display information about the selected lab test component.

Lab Test and Other Clinical Orders

The process for ordering lab tests, x-rays, vaccinations, durable medical equipment (DME), physical therapy, referrals to specialists or for consultations, and other clinical services enables providers to follow their natural workflow.

To initiate an order, a provider selects the desired procedure code from either the Services Performed (SP) tab or the Services Ordered (SO) tab of Full Note Composer or other clinical note type window. Then, if the provider wants the order completed or performed by a clinical staff member, such as a nurse or medical assistant, the provider can send the staff member a clinical order message. Or, if desired, the provider may simply complete the order.

Note: If results will be entered for an order, then the procedure code used to place the order must be configured to 'Generate an Order'. This will have done by your administrative super user.

When the procedure is performed or the service provided by a physician or other clinical staff member, then you may need to document how the procedure was performed. When the procedure or service will be performed by an external medical service provider, such as a laboratory or imaging center, then you may need to document how you want the service performed. For example, you may need to tell the laboratory the source of a specimen or how it was obtained.

Procedure notes may be used to enter information about a procedure to be ordered or how a procedure was performed. A procedure note asks standard questions or includes standard information and enables you to enter answers or information specific to an individual patient and visit. The application includes two types of procedure notes: standard and dynamic. Standard procedure notes are the most structured; dynamic procedure notes are more flexible.

A standard procedure note requires that the user enter discreet data for each variable; a dynamic procedure note enables the user to enter qualitative data, to make entries for only those variables that apply to the situation, and to select multiple responses when needed. A standard procedure note allows static text introducing or surrounding the variables. A dynamic procedure note allows a brief natural language phrase introducing each variable. A dynamic procedure note may be associated with an action or actions within the application, such as sending a message or generating and printing a document, that are to take place when the dynamic procedure note is used.

The application includes a small number of procedure notes, and, if you have a laboratory interface, then custom-defined standard procedure notes will have been defined as part of the interface implementation. Your administrative super user may have defined any other procedure notes needed by your practice.

Procedure Notes for Orders

Because standard procedure notes use discreet data, they are appropriate for documenting information needed for lab tests and procedures that are ordered through a laboratory interface. The structured standard procedure note ensures that the user enters data in the manner that can be identified and transmitted by the interface and that can be recognized when received by the laboratory. If you have an interface with a laboratory, then as part of the development and implementation of that interface, standard procedure notes will have been created for those procedures that require certain information to be provided when the procedure is ordered from the laboratory.

The standard procedure note for a given procedure code will contain the ask-on-order-entry questions, or AOE's, required by the laboratory. Different laboratories may have different AOE's for a procedure code. Therefore, the procedure notes used with your lab interface are developed specifically for the laboratory with which you have an interface. If you have interfaces with more than one laboratory, then you will have procedure notes developed specifically for each of those laboratories.

To complete an order sent through a laboratory interface, the clinical staff member — or the provider, if desired — must also enter information needed to direct the order to a particular laboratory and to identify how the service will be billed by the laboratory or other medical services provider. This information is entered in the Patient Lab Order window, which may be accessed an order message or through Full Note Composer or another clinical note type window.

Dynamic procedure notes for clinical orders are generally used for procedures, such as x-rays or MRIs or lab tests performed in-house, which are not sent to a laboratory through an interface. You can also use procedure notes to order a referral to a specialist or consulting physician, durable medical equipment, physical therapy, or other types of services. The procedure note enables the provider or other clinical staff member to enter any details needed, such as the views for an x-ray, when creating the order for a specific patient.

Dynamic procedure notes for orders can also include actions, such as sending an order message, generating a document, and printing or faxing the generated document. The procedure note's definition determines when the action is triggered. The trigger may be when you save the patient visit note, select the Send Orders  icon, close the patient visit note, or mark the patient visit note as complete.

To use a dynamic procedure note for an order, you must know how your administrative super user has defined your procedure notes so that you start by ordering the correct procedure. Procedure notes for referrals, DME orders, physical therapy, and similar services may be associated with specific CPT and HCPCS procedure codes. Or your administrative super user may have created a generic custom procedure code for each of the services, and associated a procedure note with the custom procedure code only. So for example, you may place all DME orders by selecting a custom DME order procedure code, and then entering all the details for the equipment and its specifications in the procedure note.

Please note that both standard and dynamic procedure notes may also be used to document how a procedure was performed. These procedure notes are also defined by your administrative super user, and they are accessed and used in the same way as procedure notes for orders.

Lab Orders

Lab Orders and Completing Patient Visit Notes

When using a laboratory interface, a patient visit note that includes a procedure code or codes for laboratory orders cannot be completed until the lab order has been sent. However, your practice can define whether the lab order must be sent to the laboratory or whether the lab order can simply be sent to another user as a lab order message. The user receiving the lab order message will then process the lab order and send it to the laboratory. This is a practice-wide setting that applies to all providers and other users.

When you allow a patient visit note to be completed with unsent lab orders, then the provider must send a lab order message to another user or user group prior to completing the visit note. If the provider has a defined default recipient for patient lab order messages, then the application will automatically generate the lab order message and send it to the defined recipient when the patient visit note is closed and marked as complete. If the provider does not have a defined default recipient for patient lab order messages, then when the patient visit is closed and marked complete, the application will open the lab order message window so that the user can select the message recipient.

When you do not allow a patient visit note to be completed until the lab orders are sent to the laboratory, then the Visit Checkout window will not allow the Complete Note radio button to be selected until the lab order has been sent to the laboratory.

Lab Order Billing

The billing behavior for lab orders placed through a lab interface is determined by how the lab order is placed and whether or not the patient has insurance. The billing behavior is:

- When the procedure is entered on SP tab and the patient has insurance, the bill type is Client Bill (lab bills the provider).
- When the procedure is entered on SP tab and the patient does not have insurance, the bill type is Client Bill (lab bills the provider).
- When the procedure is entered on SO tab and the patient has insurance, the bill type is Insurance Bill (lab bills the insurance payer).
- When the procedure is entered on SO tab and the patient does not have insurance, the bill type is Patient Bill (lab bills the patient).

Print Set for Lab Requisitions

It is recommended that you use a print set that contains your lab requisition or lab requisitions. If you do not have a print set selected or the selected print set does not include the lab requisition, the lab requisition will print on your default printer.

To select a print set: Tools menu → Print Set → desired print set

Please refer to the Administrative User's Guide for information on creating or modifying a print set.

Lab Decision Support

The lab decision support functionality identifies clinical orders that may require authorization from the patient's insurance payer or that the insurance payer will pay for only under specific conditions. If an insurance payer requires the use of lab decision support, then your administrative super user will have set up the functionality for that insurance payer.

When you send an order for a patient with that insurance payer, the application transmits information about that order to the insurance payer's lab decision support company for assessment. If additional information is needed, then the application displays the lab decision support company's questionnaire. The questionnaire is displayed in an application window, but the questionnaire is actually on the lab decision support company's website. Your responses are assessed by the lab decision support website, and the response is displayed in the window.

You can then determine whether to continue with the order, to order an alternative test or procedure, or to cancel the order. When you place the order, the application generates a PDF document of the questionnaire with your responses, and attaches the document to the visit note. The questionnaire and responses are not saved when you cancel the order.

Future Order Dates and Repeating Orders

When using a laboratory interface, you may submit orders for tests or procedures to be performed on a future date. You may also submit orders for tests or procedures that are to be performed on a repeating schedule.

For laboratories that are defined as able to receive orders for a future date, the application transmits orders dated in the future and repeating orders to the laboratory when you send the order. For laboratories that are defined as not able to receive orders for a future date, the application holds each individual instance of the order until the order date. Each night, a job runs that identifies these orders, and on the proper date, sends the individual orders to the laboratories.

You may associate a message to the patient with an order for a future date or for repeating orders. The message is sent to the patient through the optional Patient Portal if the patient has a Portal account. You can use the message to remind the patient of the test or procedure, and to give instructions or information needed for preparing for the test. You can define the number of prior to the order date that this message is sent to the patient.

You can also associate a message to a staff member. You can use this message to remind the staff member of the test or procedure and any tasks they need to perform prior to it. You can define the number of prior to order date that this message is sent to the staff member.

Your administrative super user may have defined defaults for patient and staff messages for individual procedure codes. When order a procedure, you may use the defaults defined for that procedure code or you may make changes.

You can set the collection date for future orders, whether one-time or repeating, in a number of ways. You can set in in the Modify Service Order window when creating the order. If set here, the collection date defaults to the Save and Send Orders window. If not set in the Order Details window, then you can set the collection date in the Save and Send Orders window. If defaulted to or set in the Save and Send Orders window, then the collection date will be shown on the lab

requisition. You cannot change the collection date in the Save and Send Orders window once you have entered and saved it. You can always set or change the collection date in the Outstanding Orders window. You can also print the lab requisition with the new collection date from the Outstanding Orders window.

Once a future order are placed, whether a one-time order or repeating orders, the future order may be seen in the Patient Results window.

Once a repeating order has been placed, you cannot make changes to the scheduled orders. If you need to make changes, you must cancel the order instance or instances that you need to change. You may cancel future orders in the same manner that you cancel a regular order.

Clinical Order Messages

A clinical order message is any message that is associated with a clinical order. Lab order request and vaccine administration request messages are always clinical order messages because they are always associated with a clinical order in a patient visit note. Other types of messages, such as patient visit note approval, attachment approval, insurance authorization, lab order request, patient referral, vaccine administration request, and general phone and task messages, become clinical order messages when the message is associated with a clinical order in a patient visit note.

Most clinical messages are created automatically by a dynamic procedure note that has been used to create a clinical order. The dynamic procedure note and the message or messages automatically created by its use will have been defined by your administrative super user. The message definition that is part of the dynamic procedure note determines the information that is displayed as the message reason and that is displayed in the Service Order tab.

A clinical order message contains a Service Order tab in addition to the tabs associated with the message's message type and subtype. The Service Order tab contains information about the order, and buttons that enable you to access related information. From the Service Order tab, you can:

- Select the Print button to print the information displayed in the Service Order tab.
- Select the Visit button to access the patient visit note that contains the order.
- Select the Order button to access the Order Results Summary window, which displays a simplified view of the order and its results.
- Select the Procedure Note button to access the Dynamic Procedure Note window displaying the procedure note used to create this message.
- Select the Dx button to display a list of the diagnoses charted in the patient visit note.
- Select the Attachments button to display a menu of documents attached to the order. Select the desired document to open the attachment.

Your administrative super user – or you, if you have the necessary security rights – can define a default recipient for your lab order request, vaccine administration, and other types of messages. When you select a procedure code that is defined to generate an order, a lab order request message is automatically sent to your defined recipient when you close the note. A provider's default recipients for lab order messages are configured on the Messaging tab of the User window.

Order Status

All orders for lab tests, x-rays, MRIs, and similar procedures have an order status. The application automatically updates the order status as an order moves through its lifecycle and dates are entered or received for the collection of the specimen, the receipt by the lab of the specimen, the performance of the test or procedure, and your receipt of the results.

The order statuses are:

- **Ordered:** The lab test has been entered on the SP or SO tab, but has not yet been sent to the laboratory. This status is skipped for orders that are not associated with a laboratory and will not be sent out through an interface.
- **Pending:** For lab orders sent to a laboratory, the order has gone out through the interface, but results have not been received or the results received have a lab status of preliminary results. For orders that are not associated with a laboratory and are not sent out through an interface, the order is placed and waiting for results to be entered.
- **Collected:** Lab order has been sent to a laboratory and one or more lab specimens have been collected. This status is usually set manually, rather than through an interface message.
- **Performed:** Lab order has been sent to a laboratory and the lab test or tests have been performed. This status is set manually; it is not set through the message interface.
- **Pending/Resulted:** Lab order has been sent to a laboratory; some lab test results are complete but others are still pending. This status is usually set manually, rather than through an interface message. However, incoming results with a lab status of correction to results will set the order status to Pending/Resulted.
- **Resulted:** The lab test results have been received from the laboratory or entered manually, and are awaiting review and approval.
- **Reviewed:** Lab test results have been reviewed but not yet approved.
- **Approved:** Lab test results have been received from the laboratory, and have been approved. Once received results have been approved, the status cannot be changed.
- **Cancelled:** The lab test was cancelled after that order was placed. The test cannot be cancelled once results are received.

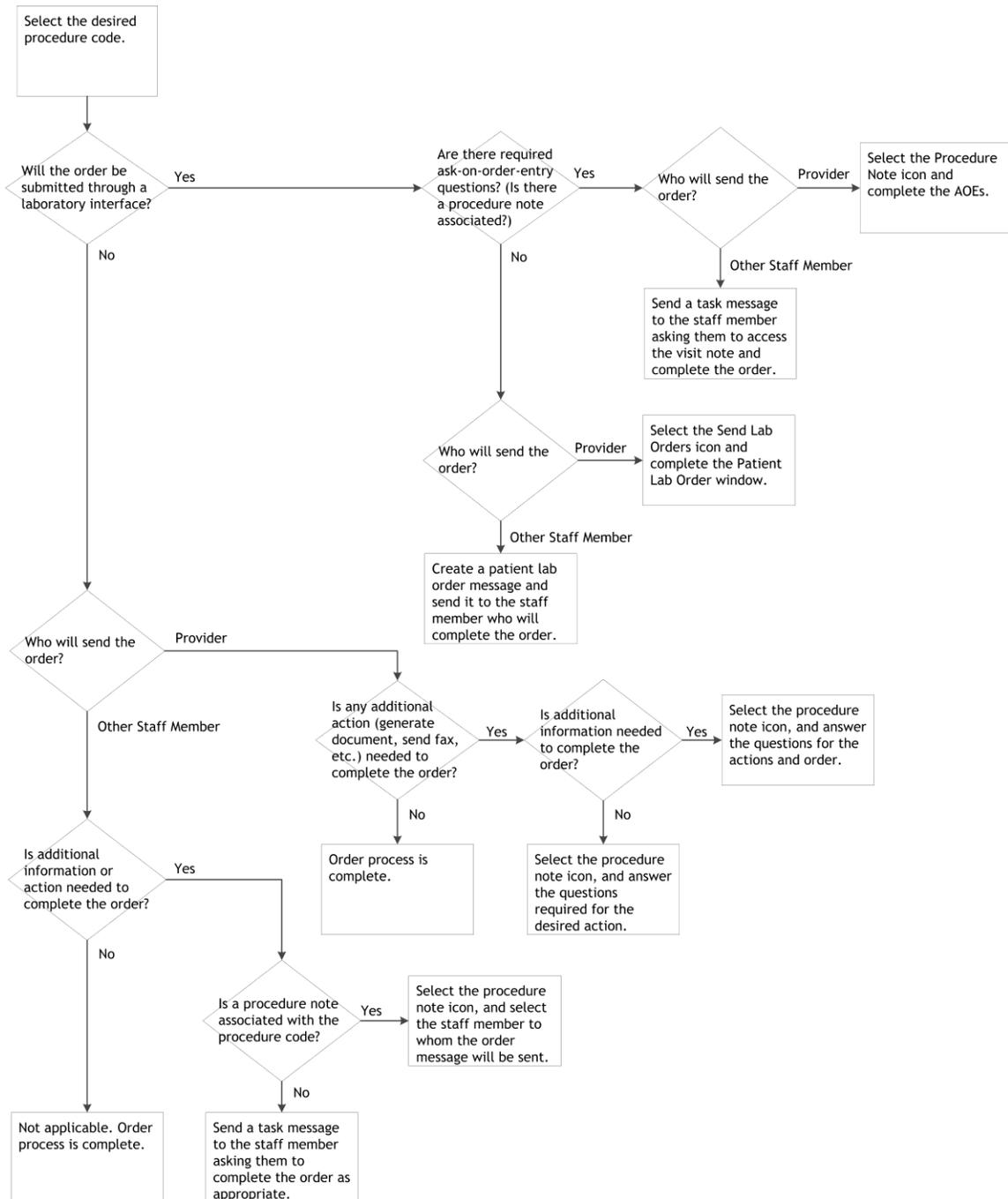
Ordering Workflows

There are a number of ways in which you can place and process an order for a lab test or other clinical service. The workflow that you choose will depend in part on your preferences and in part on the characteristics of the procedure you are ordering. These characteristics include:

- Whether the order will be submitted to a laboratory through an interface,
- Whether additional information is needed to complete the order (either ask-on-order-entry (AOE) questions for a laboratory or other information for other orders),
- Whether any additional action is needed, such as generating and printing a document, and
- Whether you, as the provider, will do all the work associated with placing and processing the order, or if you want another staff member to do the bulk of this work.

The Ordering Workflows flowchart below will help you identify the general workflow for placing and processing an order based upon these characteristics. Please note that to use some of these workflows, your administrative super user (or you, if you have the needed security access) must have created the dynamic procedure note needed for the procedure code being ordered.

Instructions for specific tasks are in the following subsections.



Ordering Workflows

Order a Lab Procedure through a Laboratory Interface

Use this process when you, as the provider, want to place and process a lab order that will be submitted through a laboratory interface. Using this process will not involve the participation of another staff member.

You can use this process for both orders with and without ask-on-order-entry (AOE) questions. When the procedure code being ordered does have AOE questions, there will be a standard procedure note associated with the procedure code. When the procedure code being ordered does not have AOE questions, there will not be an associated procedure note.

Other clinical staff member will also use this process to complete orders for providers. The request is generally received as a task message from the provider to the staff member.

1. Full Note Composer or other clinical note type window → SP or SO tab
2. Chart the patient visit note, including the diagnosis code, to avoid any billing issues for the lab order. You may also include chief complaint, history of present illness, and other information. (However, this additional information will not be sent to the laboratory.)
3. Select a procedure code or procedure group from the patient's list, the frequently used orders lists, or via the search field. The service is added to the list of charted services.
4. Modify the service order for the procedure if needed.
 - a. Select the procedure code hyperlink in the Test/CPT column to access the Modify Service Order window.
 - b. Specify a Quantity of units for the service. You can specify a quantity of 1 to 999.
 - c. Add up to four modifiers. You can enter the modifier code, or search for the modifier you need. Modifier codes must be separated with a semicolon (;).
 - d. The ABN Estimated Fee displays the total of the quantity times the procedure fee amount from the fee schedule.
 - e. Attachments, if any, will be available in the upper right corner.
 - f. Enter any Notes, if needed.
 - g. Select the Order tab to modify the service order, if need. This tab appears in the window only if the procedure code has been defined as an order.
 - h. Verify and enter the basic order information.
 1. Define the Urgency of the service. By default, the urgency is Routine, but you can change this as needed.
 2. Enter the name of Lab Technician if desired. This enables you to designate a draw technician associated with the specimen. It can be the name of anyone you want to be associated with the lab order, and does not have to be a user of the application.
 3. The Laboratory field defaults to the laboratory associated with the procedure.
 4. Select the Bill Type to identify how billing for the procedure will be handled.
 - Patient Bill: Laboratory will bill patient.
 - Insurance Bill: Laboratory will bill the insurance company.
 - Client Bill: Laboratory will bill clinic.

5. Select the PSC checkbox if the patient is going to the lab's patient service center to have the lab specimen collected.
 6. If the patient is or must be fasting, select the Fasting checkbox.
 7. The Scheduled Order Date field populates with today's date. If the procedure is to be performed in the future, enter the date you want the procedure it to be performed.
 8. The Due Date is calculated from the scheduled order date and the number of days until due defined for the procedure. You may change this date if desired.
 9. Select the Actual Collection Date/Time if the specimen was collected in-house. Do not enter a collection date if the specimen is to be collected at the lab's patient service center.
- i. Verify and enter message information, if needed.
1. The Patient Message checkbox is enabled only when the order date is in the future and is equal to or greater than the number of days prior defined for patient messages. Select the checkbox if you want to send a message to the patient, and modify the Days Prior to Order Date if needed.
 2. The User Message checkbox is automatically selected if message defaults are defined for the procedure. Select the checkbox if you want to send a message to staff members, and modify the users to receive the message and the Days Prior to Order Date if needed.
 3. The Overdue Message checkbox is automatically selected if message defaults are defined for the procedure. Select the checkbox if you want to send a message to staff members, and modify the users to receive the message and the Days Prior to Order Date if needed.
- j. Complete the Order Recurrence information, if you want this test to be repeated.
1. Select the Order Recurrence hyperlink. This accesses the Order Recurrence window.
 2. Select the radio button for the desired Scheduled Recurrence period (daily, weekly, etc.).
 3. Select the appropriate Recurrence End.
 - If you want the test performed a certain number of times, select the End After radio button and then enter the number of occurrences desired.
 - If you want the test performed through a certain time period, select the End By radio button and then enter the end date of the time period.
 4. Enter the Recurrence Pattern information. This information depends on your schedule recurrence selection.
 5. Select the OK button to save the recurrence information, and return to the Modify Service Order window.
 6. The recurrence information is displayed. You can change this information by selecting the Order Recurrence hyperlink. However, once you select the OK button to save the order information and close the Modify Service Order window, you can no longer change the recurrence information.

- k. Select the Dx Association tab to associate a diagnosis with the procedure. The diagnosis codes and descriptions are listed in the Dx Association field. If you have already associated the procedure codes with the diagnosis codes, the associations are listed. You can also associate the codes in the window by selecting the field to the right of the diagnosis. Scroll bars appear and you can enter the required association.
 - l. Select the OK button to save the order information, and return to the Full Note Composer window.
5. If you select a procedure code with questions attached in a procedure note, the Procedure Note () icon is shown to the left of the procedure in the upper portion of the SP or SO tab.
 - a. Select the Procedure Note icon to open the procedure note, if desired.
 - b. If there is more than one procedure note associated with the procedure, then highlight the procedure note you want to use and select the OK button.
 - c. In the Questions section of the Procedure Note, enter the additional information required for the laboratory order. These questions are commonly known as the ask-on-order-entry (AOE) questions.

Some procedures may require different AOE questions for different laboratories. If the question differences are minor, then you may have one procedure note that includes all questions for all laboratories. The procedure note may identify certain questions as laboratory specific. Or, if the questions are significantly different, then you may have more than one procedure note associated with the procedure. In this instance, you must select the appropriate procedure note for the laboratory you want to use.
 - d. Select the OK button to return to the SP or SO tab. The Procedure Note icon now has a checkmark on it indicating that the questions have been completed.

Note: You can ignore the procedure note and still send the laboratory order. You may choose to ignore the procedure note if, for example, you are not taking the laboratory specimens in your office, but are sending the patient to the laboratory to have the specimen collected.
 - e. Select the Save Note () icon to save your work.
6. Repeat steps 3 through 5 for each procedure needed.
7. When you are ready to send the order to the lab or imaging center, select the Save and Send Lab Orders () icon. This accesses the Patient Lab Order window.

Note: You can also wait until you close the patient visit note, and send the lab orders as part of the checkout process. However, the visit note cannot be marked as complete until the lab orders have been sent.
8. Enter the name of the Lab Technician if desired. This enables you to designate a draw technician associated with the specimen. It can be the name of anyone you want to be associated with the lab order, and does not have to be a user of the application. This is for internal tracking purposes only; this information is not sent to the laboratory.
9. In the Order column, select the checkbox for each lab procedure you wish to submit electronically to the laboratory.
10. Select or verify the Laboratory for the procedure. This will default to the laboratory associated with the procedure, if one has been defined. You can change it if, for example, the patient's insurance requires a different laboratory be used.

11. Select the Collection Date/Time if the specimen was collected in-house. Do not enter a collection date if the specimen is to be collected at the lab's patient service center.
12. Select the Bill Type to identify how billing for the procedure will be handled.
 - Patient Bill: Laboratory will bill patient.
 - Insurance Bill: Laboratory will bill the insurance company.
 - Client Bill: Laboratory will bill clinic.
13. Select the PSC checkbox if the patient is going to the lab's patient service center to have the lab specimen collected.
14. When you are satisfied with the order details, select the checkboxes for the items you want to send or select the Select All icon to select all the items.
15. Select the Send button to submit the order.
 - If the patient's insurance payer requires lab decision support and the order requires authorization, then a window pops up displaying the lab decision support company's online questionnaire. Please refer to the Using Lab Decision Support section for instructions and more information before continuing.
 - Once the Send button is selected, the selected items are sent and locked and cannot be changed.
 - Unsent test items or test items added to the visit note can still be edited and sent.
16. The Order Date, Accession #, and Lab Tech columns are automatically completed when the order is submitted. Wait until these columns are completed before proceeding to the next step.
17. In the Preview/Print Sent Orders areas, identify the laboratories and documents you want to print.
 - a. If you are sending orders to more than one laboratory, select the laboratory or laboratories for which you want to print the requisition and/or specimen label. If you want to print these documents for all the laboratories in the order, leave this field blank.
 - b. Select the checkboxes for Lab Requisition and/or Specimen Label to identify the items to print.
 - c. Select the Preview button if you want to view the documents before printing.
18. When you are finished, select the OK button to close the window and return to Full Note Composer.

Send a Task Message to a Staff Member Requesting Orders be Processed

Use this process when you, as the provider, want to have a staff member complete the ask-on-order-entry questions and send the order to the laboratory through an interface. You may also use this process when you want to have a staff member complete a clinical service order that will not be sent through a laboratory interface and there is not a dynamic procedure note associated with the procedure code being ordered.

It is important to understand that the other staff member will not be able to access the patient visit note to complete the order process while you are still working in the visit note. When the other staff member receives your message, the staff member will use the Ordering a Lab Procedure through a Lab Interface process above to process and complete the order.

1. Full Note Composer or other clinical note type window → New → Task Message
2. The Patient will be default to the patient identified in the patient visit note.
3. Change the Urgency level from the default setting if desired.
4. Select a Due Date if desired.
5. In the Assign To field, search for and select a user or user group to whom you wish to assign the task of completing the lab order.
6. In the Task field, enter a note requesting that the staff member access the patient visit note and complete the lab orders.
7. Select the OK button to return to the patient visit note window.
Note: Do not select the Complete button as this will mark the message as complete and it will not be sent.
8. Select the Save () icon to save the visit note and send the message. The message cannot be sent until the visit note has been saved.

Create and Send a Lab Order Request Message

Use this process when you, as the provider, want to have another staff member complete the processing on a lab order that does not include ask-on-order-entry questions. Use this process when none of the procedure codes ordered include AOE questions. (That is, none of the procedure codes has an associated standard procedure note.) If any of the procedure codes ordered do include AOE questions, then you must use the 'Send a Task Message to a Staff Member Requesting Orders be Processed' process described above.

Lab order request messages are associated with a patient and visit note. The lab procedures entered in the patient visit note do not appear in the request message, but they are associated with the message.

1. Full Note Composer or other clinical note type window → New → Patient Lab Order Message
2. The Patient field will be default to the patient identified in the patient visit note.
3. Change the Urgency level from the default setting if desired.
4. Select a Due Date if desired.
5. In the Assign To field, search for and select a user or user group to whom you wish to assign the task of completing the lab order.
6. In the Reason field, add any additional notes if desired. You can select the Reason hyperlink to add a standardized text note if desired.
7. Under Lab Order Information, select the patient's visit date when the order was created. This will be prepopulated if you create the message from within Full Note Composer.
8. Select the OK button to return to the clinical note type window.
Note: Do not select the Complete button as this will mark the message as complete and it will not be sent.
9. Select the Save () icon to save the visit note and send the message. The message cannot be sent until the visit note has been saved.

Complete and Submit the Lab Order from a Lab Order Message

Clinical staff members use this process to complete and submit the lab test order when they receive a patient lab order message.

1. Either:
 - Desktop → Message Date/Time hyperlink
 - Message Center → Message Date/Time hyperlink
2. The standard message routing information appears at the top of the message window. You can change this information as needed.
3. Select the Patient Lab Orders tab.
4. Enter the name of Lab Technician if desired. This enables you to designate a draw technician associated with the specimen. It can be the name of anyone you want to be associated with the lab order, and it does not have to be a user of the application. This is for internal tracking purposes only; this information is not sent to the laboratory. (You may need to scroll up in the message to see this field.)
5. In the Order column, select the checkbox for each lab procedure you wish to submit electronically to the laboratory.
6. Select or verify the Laboratory for the procedure. This will default to the laboratory associated with the procedure. You can change it if, for example, the patient's insurance requires a different laboratory be used.
7. Select the Collection Date/Time if the specimen was collected in-house. Do not enter a collection date if the specimen is to be collected at the lab's patient service center.
8. Select the Bill Type to indicate to the laboratory how billing for the procedure should be handled.
 - Patient Bill: Lab will bill patient.
 - Insurance Bill: Lab will bill the patient's insurance company.
 - Client Bill: Lab will bill clinic.
9. Select the PSC checkbox if the patient is going to the lab's patient service center to have the lab specimen collected.
10. When you are satisfied with the order details, select the checkboxes for the items you want to send or select the Select All icon to select all the items.
11. Select the Send button to submit the order.
 - If the patient's insurance payer requires lab decision support and the order requires authorization, then a window pops up displaying the lab decision support company's online questionnaire. Please refer to the Using Lab Decision Support section for instructions and more information before continuing.
 - Once the Send button is selected, the selected items are sent and locked and cannot be changed.
 - Unsent test items or test items added to the visit note can still be edited and sent.
12. The Order Date, Accession #, and Lab Tech columns are automatically completed when the order is submitted. Wait until these columns are completed before proceeding to the next step.

13. In the Preview/Print Sent Orders areas, identify the laboratories and documents you want to print.
 - a. If you are sending orders to more than one laboratory, select the laboratory or laboratories for which you want to print the requisition and/or specimen label. If you want to print these documents for all the laboratories in the order, leave this field blank.
 - b. Select the checkboxes for Lab Requisition and/or Specimen Label to identify the items to print.
 - c. Select the Preview button if you want to view the documents before printing.

Note: The lab requisition can also be printed from the Check Out window.

14. Either:

- From the Lab Order window, select the OK button to close the Lab Order window and save the visit note.
- From the Lab Order Message, select the OK button to close the message but leave it visible in your message queue on your Desktop.
- From the Lab Order Message, select the Complete button to complete the message and remove it from your message queue on your Desktop. Do not select the Complete button unless you have sent all of the lab orders, or else you may forget there are pending lab orders associated with this message.

Viewing the Lab Test Order from the Patient Visit Note

Once a lab procedure order has been completed and submitted to the laboratory or laboratories, you can review the order from within Full Note Composer or other clinical note type window.

1. Full Note Composer or other clinical note type window → SP/SO tab
2. Select the hyperlink for the charted procedure.
3. In the Modify Service Performed window, select the Order tab.
4. Review the lab order details.

Note: This information is read-only. It cannot be modified.

Ordering a Clinical Service

Use this process when you, as the provider, want to order any type of clinical service that is not submitted through a laboratory interface. This may include, for example, x-rays, other imaging, durable medical equipment, referrals, and other clinical services. You may also use this procedure for lab procedures performed in your own office or that are not sent to a laboratory through an interface. (

You can use this process both when you want to completely process the order yourself, and when you want to have a staff member complete the processing of the order. To complete the order yourself, you must respond to all the items in the associated dynamic procedure note so that all needed information for order is entered and all actions are performed. To have staff member complete the processing of the order, you must use the dynamic procedure note to

select a recipient for the clinical order message. The staff member receiving the message will then complete the procedure note and associated actions.

It is important to understand that the other staff member will not be able to access the dynamic procedure note to complete the order process while you are still working in the patient visit note. When the other staff member receives your message, the staff member will use the Completing the Clinical Order Message process below to process and complete the order.

1. Full Note Composer or other clinical note type window → SP or SO tab
2. Chart the patient visit note, including the diagnosis code, to avoid any billing issues for the lab order. You may also include chief complaint, history of present illness, and other information.
3. Select a procedure code or procedure group from the patient's list, the frequently used orders lists, or via the search field. The service is added to the list of charted services.
4. Modify the service order for the procedure if needed.
 - a. Select the procedure code hyperlink in the Test/CPT column to access the Modify Service Order window.
 - b. Specify a Quantity of units for the service. You can specify a quantity of 1 to 999.
 - c. Add up to four modifiers. You can enter the modifier code, or search for the modifier you need. Modifier codes must be separated with a semicolon (;).
 - d. The ABN Estimated Fee displays the total of the quantity times the procedure fee amount from the fee schedule.
 - e. Attachments, if any, will be available in the upper right corner.
 - f. Enter any Notes, if needed.
 - g. Select the Order tab to modify the service order, if need. This tab appears in the window only if the procedure code has been defined as an order.
 - h. Verify and enter the basic order information.
 1. Define the Urgency of the service. By default, the urgency is Routine, but you can change this as needed.
 2. Enter the name of Lab Technician if desired. This enables you to designate a draw technician associated with the specimen. It can be the name of anyone you want to be associated with the lab order, and does not have to be a user of the application.
 3. Select or verify the Laboratory for the procedure. This will default to the laboratory associated with the procedure, if one has been defined. You can change it if, for example, the patient's insurance requires a different laboratory be used.
 4. Select the Bill Type to identify how billing for the procedure will be handled.
 - Patient Bill: Laboratory will bill patient.
 - Insurance Bill: Laboratory will bill the insurance company.
 - Client Bill: Laboratory will bill clinic.
 5. Select the PSC checkbox if the patient is going to the lab's patient service center to have the lab specimen collected.
 6. If the patient is or must be fasting, select the Fasting checkbox.

7. The Scheduled Order Date field populates with today's date. If the procedure is to be performed in the future, enter the date you want the procedure it to be performed.
 8. The Due Date is calculated from the scheduled order date and the number of days until due defined for the procedure. You may change this date if desired.
 9. Select the Actual Collection Date/Time if the specimen was collected in-house. Do not enter a collection date if the specimen is to be collected at the lab's patient service center.
- i. Verify and enter message information, if needed.
1. The Patient Message checkbox is enabled only when the order date is in the future and is equal to or greater than the number of days prior defined for patient messages. Select the checkbox if you want to send a message to the patient, and modify the Days Prior to Order Date if needed.
 2. The User Message checkbox is automatically selected if message defaults are defined for the procedure. Select the checkbox if you want to send a message to staff members, and modify the users to receive the message and the Days Prior to Order Date if needed.
 3. The Overdue Message checkbox is automatically selected if message defaults are defined for the procedure. Select the checkbox if you want to send a message to staff members, and modify the users to receive the message and the Days Prior to Order Date if needed.
- j. Complete the Order Recurrence information, if you want this test to be repeated.
1. Select the Order Recurrence hyperlink. This accesses the Order Recurrence window.
 2. Select the radio button for the desired Scheduled Recurrence period (daily, weekly, etc.).
 3. Select the appropriate Recurrence End.
 - If you want the test performed a certain number of times, select the End After radio button and then enter the number of occurrences desired.
 - If you want the test performed through a certain time period, select the End By radio button and then enter the end date of the time period.
 4. Enter the Recurrence Pattern information. This information depends on your schedule recurrence selection.
 5. Select the OK button to save the recurrence information, and return to the Modify Service Order window.
 6. The recurrence information is displayed. You can change this information by selecting the Order Recurrence hyperlink. However, once you select the OK button to save the order information and close the Modify Service Order window, you can no longer change the recurrence information.
- k. Select the Dx Association tab to associate a diagnosis with the procedure. The diagnosis codes and descriptions are listed in the Dx Association field. If you have already associated the procedure codes with the diagnosis codes, the associations are listed. You can also associate the codes in the window by selecting the field to the right of the diagnosis. Scroll bars appear and you can enter the required association.

- I. Select the OK button to save the order information, and return to the Full Note Composer window.
5. If you select a procedure code with questions attached in a procedure note, the Procedure Note () icon is shown to the left of the procedure in the upper portion of the SP or SO tab.
 - a. Select the Procedure Note icon to open the procedure note, if desired.
 - b. If there is more than one procedure note associated with the procedure, then highlight the procedure note you want to use and select the OK button.
 - c. In the Questions section of the Procedure Note, enter the additional information required for the laboratory order. These questions are commonly known as the ask-on-order-entry (AOE) questions.

Some procedures may require different AOE questions for different laboratories. If the question differences are minor, then you may have one procedure note that includes all questions for all laboratories. The procedure note may identify certain questions as laboratory specific. Or, if the questions are significantly different, then you may have more than one procedure note associated with the procedure. In this instance, you must select the appropriate procedure note for the laboratory you want to use.

- d. Select the OK button to return to the SP or SO tab. The Procedure Note icon now has a checkmark on it indicating that the questions have been completed.

Note: You can ignore the procedure note and still send the laboratory order. You may choose to ignore the procedure note if, for example, you are not taking the laboratory specimens in your office, but are sending the patient to the laboratory to have the specimen collected.

Completing the Clinical Order Message

Clinical staff members use this process to complete orders for clinical services that are not submitted through a laboratory interface. This may be an order that will be performed by another medical service provider (such as an imaging center), a durable medical equipment order, a referral to another physician, a physical therapy order, or similar. It may also be an order for a procedure you will perform, such as an x-ray or a lab test you perform in-house, or for equipment you provide and bill for.

When you have performed an in-house procedure, you must indicate that it has been performed.

It is important to understand that you will not be able to access the dynamic procedure note to complete the order process while the provider or another staff member is working in the patient visit note.

1. Either:
 - Desktop → Message Date/Time hyperlink
 - Message Center → Message Date/Time hyperlink
2. The standard message routing information appears at the top of the message window. You can change this information as needed.
3. Select the Service Order tab. The procedures ordered are listed in the message area.

4. Select the Dx button to view the diagnosis or diagnoses if desired.
5. Select the Visit button to access the patient visit note if desired.

Note: You will not be able to access the patient visit note if the provider or another user has it open.
6. Select the Procedure Note button to access the procedure note. This enables you to complete any information needed for the order. This button will appear only when there is an associated procedure note.

Note: You will not be able to access the procedure note if the provider or another user has the associated patient visit note open.

 - a. If there is more than one procedure note associated with the procedure, then highlight the procedure note you want to use and select the OK button.
 - b. In the Procedure Note window's Category (or left) pane, select the checkbox for the item you want to document.
 - c. In the KDB Finding (or right) pane, either:
 - Select the finding for the selected category item.
 - Select the <Find> listing or the Find () icon to search for an item not in the list. This option is available only when the finding is an item in the database, such as user, provider, or medical service provider.

This adds the selected category and finding to the Dynamic Procedure Note section in the top of the window.
 - d. Repeat substeps b and c to enter all appropriate categories and findings.
 - e. Select the OK button to close the window and save the order information.
7. Select the Attachments button, and then Generate Attachments to generate all documents to be generated with the order. This button will appear only when there is an associated document to be generated.
8. Select the Attachments button again, and then:
 - Select the Edit Attachments option to review and edit the document.
 - Select the Print Attachments option to print the document.
 - Select the Fax Attachments option to fax the document.
9. Select the Order button to access the Order Results Summary window where you can review and complete the order.
 - a. Select any of the menus to review additional data as needed.
 - Select the Dx menu to display a list of the diagnoses charted in the patient visit note.
 - Select the Procedure Note menu to access the Dynamic Procedure Note window displaying the procedure note used to create this message.
 - Select the Referring Provider menu to see the name of the referring provider on the patient visit note.
 - b. In the Order Status field, select the appropriate status for the order.
 - c. If the status is Resulted, then enter the Resulted Date.
 - d. Select the appropriate Urgency.

- e. Select the Add Results Attachment link to attach a results document to the order.
- f. If appropriate, select the Mark Order As Billable/Performed checkbox to indicate that the procedure has been performed.

Selecting this checkbox moves the procedure code from the SO tab in the patient visit note to the SP tab so that the procedure code will be included in the superbill generated for the patient visit. Select this checkbox for any procedure you perform in-house or any equipment you provide and for which you will bill the patient. You may also select this checkbox for a service that will be provided by another medical service provider if that medical services provider will bill your practice rather than the patient.

- g. If desired, select the Switch to Advanced Results Dialog link to access the Results Entry window to enter additional details. When you select the OK button on this window, you return to the Message window.
- h. To create an approval message for a resulted order:
 - i. Select the Create Review Result Data Message checkbox.
 - ii. In the Reviewers field, select the user to whom you want to send the lab result message.
 - iii. Select a message Urgency for the lab result message.
 - iv. Select the Message link if you wish to add text to the message.
 - v. Select the Message Note tab if you want enter additional notes regarding the results.
- i. Select the OK button to return to the order message.

10. Select the Complete button to complete and close the order message.

Using Lab Decision Support

If the patient's insurance payer requires lab decision support and the order requires authorization, then when you attempt to send the order – regardless of which workflow you use—a window pops up displaying the lab decision support company's online questionnaire. Complete the questionnaire to perform the assessment and determine whether the order is authorized.

1. Full Note Composer or other clinical note type window → SP or SO tab
2. Chart the patient visit note, including the diagnosis code, to avoid any billing issues for the lab order. You may also include chief complaint, history of present illness, and other information.
3. Select a procedure code or procedure group from the patient's list, the frequently used orders lists, or via the search field. The service is added to the list of charted services.
4. Complete any information needed for the order, such as modifying the service order or completing a procedure note.
5. Either:
 - Select the Save and Send Lab Orders () icon. Then in the Patient Lab Order window, select the orders to send and elect the Send button to submit the order.
 - When you have finished the visit, select the OK button to save and close the visit note. Then on the Visit Checkout window, select the Mark Orders Ready to Send checkbox.

6. If an order requires authorization, the Browser window displays the lab decision support questionnaire. This window is directly connected to the lab decision support web application, and is displaying that company's content.
7. Enter your answers in the questionnaire. If there are multiple pages of questions, select the Continue button that is in the lab decision support web application.
8. Once you have answered all the necessary questions, the lab decision support web application will display a summary telling if the orders are accepted, if there are alerts for any orders, or if any orders are rejected.
 - If needed and desired, select the Edit Answers button to modify your questionnaire answers.
 - To submit all the orders, select the Continue button in the lab decision support web application. If you are using a lab interface, the orders are sent to the laboratory.
 - To cancel all the orders, select the Cancel button in the Browser window. This returns you to the Full Note Composer window, where you can make changes to the services ordered or to any other information in the visit note.
 - If the authorization cannot be completed for some reason, you may select the Skip button to submit the orders to the lab without authorization from the lab decision support company.

Cancelling an Order

You may cancel an order that been placed, but not yet resulted. It is important to understand that a lab order cannot be cancelled after the results have been received.

The application's behavior for the cancelling an order depends on several things, including whether the order was submitted through an interface and whether the receiving laboratory accepts cancellation messages.

- If the procedure was selected on the SO tab, was not sent using the Save and Send Lab Orders  icon, and the visit note has not been completed, then deleting the procedure simply removes it from the visit note as if it had never been ordered.
- If the procedure was selected on the SO tab, was not sent using the Save and Send Lab Orders  icon, and the visit note has been completed, then cancelling the order does not remove it from the visit note. You must open the visit note, and strikeout the procedure.
- If the procedure was selected on the SO tab, was ordered using the Save and Send Lab Orders  icon, then cancelling the order causes the procedure to be struck out whether the visit note has been completed or not. In addition, one of the following occurs:
 - If the laboratory accepts cancellation messages, then an order cancellation message is sent to the laboratory. No further action is needed from you.
 - If the laboratory does not accept cancellation messages, then the application displays a popup message reminding you that you must contact the laboratory to cancel the order.

Note that the laboratory may also send you a result message back with a result status of Cancelled for an order. This could be due to a contaminated specimen, a failure in the laboratory testing process, or some other problem.

1. Desktop → Results Tracking icon ()
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the Status hyperlink for the order you want to cancel.
4. In the Order Results Summary window, change the Order Status to 'Cancelled'.
5. Select the OK button to cancel the order, and send a message to the ordering provider.

Setting the Order Status

You can manually override the order status of an order if necessary. You cannot, however, set a status that appears in the lifecycle prior to the last status date entered for the order. For example, if the order has a received date, you cannot change the status to Ordered.

1. Patient Demographics → Track Patient Results () icon
2. Select the desired order from the list in the left panel.
3. Select either the Edit button or the Enter Lab Result button.
4. In the Order Status field, select the desired status.

Viewing the Order Status History

Please note that the order status history is only available for status changes made after upgrading to the 2011 release of the application. Status changes made prior to upgrading to this release were not recorded, and therefore, cannot be displayed.

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. In the Message window, select the Service Order tab.
3. Select the Order button to access the Order Results Summary window.
4. Select the Order Status hyperlink.
5. The Order Result Status History window displays the history of the results status.

Lab Specimen Labels

You can generate and print lab specimen labels when ordering lab procedures from a LabCorp or Quest lab. Print the label by selecting the Print Specimen Label checkbox on the Visit Checkout window. This checkbox will be active only when the lab order is associated to a laboratory. The checkbox will be inactive if the order is not associated with a laboratory.

The Generic Specimen Label report prints a label containing the patient's name, a barcode of a patient's external ID, the patients external ID, and the lab requisition number.

The LabCorp label contains the date the procedure was ordered, the patient's name, and a bar code of the unique lab order tracking number (also called accession number).

The Quest label contains the patient name, the order tracking number, the account number supplied by Quest, and bar code of the tracking number and account number.

This functionality requires that the lab interface be configured for label printing. To schedule the interface installation or to configure your current lab interface for lab specimen labels, please contact Support.

A label printer is recommended for this functionality. Please contact your LabCorp or Quest representative for printer suggestions or specifications.

Outstanding Orders for a Patient

Use the Outstanding Orders window to view a list of lab tests, other procedures, and referrals ordered for a patient, but not yet resulted.

1. Patient Demographics → Patient menu → Patient Outstanding Orders
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the Procedure hyperlink to access additional information about the order by selecting the Procedure hyperlink.
4. In the Modify Outstanding Order window, you may:
 - Change certain information about the order.
 - Select the Cancel Order button to cancel the order.

Electronic DME Orders through DMEhub™

You may enroll with DMEhub for electronic orders of durable medical equipment (DME). DMEhub creates an electronic certificate of medical necessity (eCMN) using patient, patient account, diagnosis, provider, and service site information from the patient visit note. The provider can then complete the order through the DMEhub website, where it is electronically signed and then sent to the DME supplier.

You must have the patient's permission to send their information to DMEhub when placing an order.

DMEhub keeps a record of all your electronic DME orders.

Submit an Electronic DME Order

1. Full Note Composer or other clinical note type window
2. Chart the visit note in the usual manner, including a diagnosis code and information about the DME being order.
3. To initiate the order, select the DME Hub button from the toolbar.
4. This opens a browser window, displaying the DMEhub order.
5. DMEhub determines the equipment needed based on the diagnosis from the visit note. If needed, you may select the radio button for another type of equipment.

6. The Last Visit Date field is populated with the visit date from your patient visit note.
7. In the Notes For Visit/Over Utilization Statement field, enter any notes needed for the order.
8. In the Order Information section:
 - a. Complete the information needed for the order. The information needed varies with type of DME being ordered.
 - b. Select the Save Changes button.
9. Review the patient, insurance, and physician information.
 - a. Select the desired section heading.
 - b. Review and verify the information sent from the application.
 - c. Select the Save Changes button to save the added or changed information for the order.
10. Select the checkbox to acknowledge that the patient agreed to have their information sent to DMEhub. This is required for all orders.
11. Select the Submit Order button.
12. DMEhub displays the electronic certificate of medical necessity form.
 - a. Select the Signature field. This inserts your electronic signature into the form. This is the signature you established with DMEhub, not your signature from the application.
 - b. Select the Click to eSign button to complete the order.
 - c. The completed order displays in the window, and is sent back to application and attached to the patient visit note.
 - d. Close the browser to return to the application.
13. Complete the visit note in the usual manner.

DMEhub Support

Please contact DMEhub support for any questions or problems with the DMEhub site. You may contact them by phone or email.

- Toll free (877) 739-5909
- Email: support@dmehub.com

Lab Test and Other Clinical Order Results

Lab Result Messages

Lab result messages contain discreet results for lab tests. A lab result message may be created by a user when a lab test is performed in-house or created by the application when lab results

are received electronically through a lab interface. You may view lab result messages from the Desktop or from the Message Center.

When lab results are received electronically, the application sends a lab result message to the ordering provider (this is the billing provider, unless a rendering provider is specified). The lab result message displays all the lab orders associated with the same order and accession number.

A lab result message from a laboratory may display results received at different times. Newly received results will appear in an existing lab result message as long as the results are from the same laboratory and the message has not been completed. If a lab result message is completed, then no newly received results are displayed in it. Instead, a new lab result message is sent to the ordering provider. The new lab result message displays all the orders and all the received results, both approved and unapproved. Therefore, it is recommended that you complete your lab messages as you review them, even if not all the results have been received.

In the message, results are sorted on three levels: approved status, criticality, and alphabetically. Unapproved results are displayed at the top of the list. Results are listed with the most urgent results status first. Critical, abnormal, and alert results for the lab order appear red.

Electronically Received Results not Match to an Order

When lab test results are received through a lab interface, the application matches the results to an order with the accession number. However, results are occasionally received without an accession number or with an accession number that is different than the accession number on the order. When the accession number on a lab result does not match an accession number for an order, then the application attempts to match the result to an order using the patient, ordering provider, procedure code, and other information. If the application identifies an order that matches the results, it will associate the lab result to that order if the result was received within three days of the order date.

If the application cannot identify a matching order placed within three days of the order date, then the application creates a visit note with an order for the lab test and associates the lab test results to that order. The ordering provider on the order and the rendering provider on the visit note are the ordering provider identified in the results. The visit type of the visit note is Lab Result. The application handles lab result visits in a manner similar to prescription refill visit notes.

Unsolicited Lab Test Results

Unsolicited lab test results are results received through a lab interface for tests not ordered by a provider in your practice. Unsolicited lab test results may be received for a number of reasons, such as:

- A referring or consulting provider, external to your practice, includes your name on a test ordered for a mutual patient.
- A patient obtains a lab test without an order, such as at a health fair or mobile testing facility, and identifies you as their provider.
- The lab sends the results to you by mistake.

When the application receives lab results from a provider that is not identified in the database, then it associates the results with either the ordering provider, if your database includes an external provider record for that provider, or with the system-defined external provider, named Ordering Provider External.

The application also generates a lab result message for the results, and sends that message to you, as the copied provider on the results. In the notes section of the message, the name of the provider who actually ordered the test appears at the Ordering Provider. You, as the provider copied on the lab order, are identified as the Rendering Provider.

If you choose to approve the lab results, then the application creates a visit note with an order for the lab test and associates the lab test results to that order. The ordering provider on the order is the system-defined external provider, named Ordering Provider External. The rendering provider on the visit note is you, the provider copied on the lab order. The visit type of the visit note is Lab Result. The application handles lab result visits in a manner similar to prescription refill visit notes.

Once you approve the unsolicited lab results, they can be found in Results Status window and the Patient Results window. You may review the results details, and if desired approve the results.

Lab Result Messages on the Desktop

When lab result messages are displayed on the Desktop, the message entry includes the result status and the approval date and status.

- **Result Status:** Statuses are, in order of urgency, critical, abnormal, alert, and normal. The system displays the most urgent result status within the group of lab orders in the message. Please note that the results status does not affect the message status. (In the Message Center window, the Result column displays the result status.)
- **Approval Date/Status:** The status of the approval for the results is now displayed in the message. The status displayed is Approved when the results of all the lab orders in the message are approved. This is followed by the date of the last approval. The status displayed is Unapproved when the results for any lab orders have not been approved.

Creating a Lab Result Message

When you perform a lab test and you have changed the order status to Resulted, you can create a lab result message from a clinical order message so that the results can be reviewed and approved. The lab result message that is generated from the clinical order message is not associated with the original clinical order message and so does not contain the clinical order information.

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. In the Message window, select the Service Order tab.
3. Select the Order button to access the Order Results Summary window.
4. Select the Create Review Result Data Message checkbox.
5. In the Reviewers field, select the user to whom you want to send the lab result message.
6. Select a message Urgency for the lab result message.

7. Select the OK button to generate the new lab result message.

Viewing and Approving Results from a Lab Result Message

When you approve lab results, the application enters the name of the approving user and the date the results were approved.

It is important to understand that completing a lab result message does not approve the results contained in the message. It is strongly advised that you always approve results before completing a message. If you complete a message before approving results, the message may be removed from your Desktop or default filter results in the Message Center and, if so, you may forget that you still need to approve the results.

1. Either:
 - Desktop → Message date/time hyperlink
 - Message Center → Message date/time hyperlink
2. Select the Review Test Data tab. This may be selected by default.
3. If necessary, expand the tree icon () at the far left of the row to display the lab results. The results display is expanded by default.
4. In the Description column, select the hyperlink for a result to view a graph of the result.
5. To approve results:
 - Select the Approve button for an individual result to approve that result.
 - Select the Approval All button to approve all the results in the message.
6. To enter or review lab order notes associated with the procedure, select the Note icon () in the far right column.
7. To enter a lab order note associated with all the procedures, select the Comments All button from the toolbar.
8. Select the Print icon () to print all of the lab results in the message.
9. Either:
 - Select the OK button to close the message without completing it.
 - Select the Complete button to complete the message. Remember that this does not approve any unapproved results.

Adding Notes to the Message

You can add a note to the message itself from any tab by selecting the Message Note () icon from the message toolbar. These notes are added to the Message Notes tab. Message

notes are not associated with the lab order results, and do not appear in the Patient Results window.

Adding Notes to Orders and Results

When a message contains multiple orders and results, you can add a note to a single test item's results or you can add the same note to all test items' results if desired.

- To enter a note for a single test item's results, select the Notes () icon for the specific item.
- To enter a note for all results, select the Comment All button from the toolbar. Your notes appear at the bottom of the order. These notes are associated with the order and results, and so they will appear in the Patient Results window as well.

Lab Result Tracking

Lab and clinical orders and their results can be tracked from the Result Status/Result window. This window displays information for both manually entered results and results received via electronic interface. This window enables you to search for and review lab results for more than one patient at a time. You can define a filter or filters for selecting the lab orders and results that you commonly review.

It is recommended that you review all orders with a status of Ordered at least once a week. Then you can follow up on any orders for which you have not received results.

1. Either:
 - Desktop → Result Tracking
 - Results Tracking icon ()
2. Enter the desired filtering criteria or select a filter, and then select the Search button.
3. If desired, select the Include Strike Outs checkbox to include results that have been struck out.
4. All lab results meeting the criteria of the selected view option will be displayed.
5. If desired, select the Status hyperlink to open the Order Results Summary window, which enables you to change the order status and urgency, and to review the results message if available.
6. If desired, select the Ordered hyperlink to open the Result window where you can view the detailed results.
7. If desired, select the Patient hyperlink to open the Patient Demographics window where you can view patient and account details.

Patient Results

Use the Patient Results window to manually enter lab results and to view test results received from a lab interfaces, entered manually, or provided in a scanned document. Results may be viewed by attachment type, date, lab template, or results. The Patient Results window can display details for the procedure line items in a lab template. If you assign LOINC codes to your lab templates and/or line items within templates, then you can view results from multiple labs at one time.

You may select a specific lab template in which to display lab test results. This is useful if you are particularly interested in monitoring a few specific tests whose results may be entered in several different templates. You can create a template that includes only the test items you want to regularly monitor. To display the results from more than one template, the templates must include the LOINC code for the test item.

You may also display the all the results for a lab test received for the same day in a single column, much like a flowsheet. This is useful if you order multiple test panels which contain some of the same tests.

Data Mapping for Lab Tests and Lab Templates

A lab test may be identified in different ways on different lab templates. For example, a test may be identified in one lab template as “Complete Blood Count” and in another lab template as “CBC”. When you review lab test results, the results of a particular test may be viewed in a single lab template if the various test items in the different templates are all associated with the same LOINC code. However, there are times when you want to view the results of two different tests, which have different LOINC codes, but which measure the same thing. For example, the SurePath™ and ThinPrep® pap tests both test for the same thing, so the provider could want to monitor their results together even though the two tests use different methodologies and have different LOINC codes.

Data mapping enables you to associate different tests so that you can view the test results through a single lab template. You or your administrative super user can define data mapping for the lab tests which enables you to view the test results in the same template.

Viewing Medication Details with Results

You can select one or more medications when viewing results so that you can see the prescribed medication details with the lab test or observation results. The medication details include the medication name, strength, route, dosage, and frequency. Keep in mind that this view shows only the details for the medication prescribed at the time of the observation. This view does not identify when the medication was prescribed or medication changes made between observations.

Searching for Results

1. Either:
 - Patient Demographics → Patient → Patient Results ()
 - Patient Toolbar → Patient Results ()
2. Enter any or all of the following search criteria:
 - Select a Group (Attachment Type, Date, Results, Lab Template, or Flowsheet).
 - Select one or more Test Values (Show Test Items, Merge Lab Templates by LOINC, or Merge Test Items by Mapping/LOINC)
 - To include medications with the results, select the Show Medications on Flowsheet checkbox, and then select one or more medications.
 - Select a date type (such as ordered or resulted).
 - Enter a date range.
 - Select the Include Cancelled checkbox to include cancelled orders.
 - Select the Include Strike Outs checkbox to include struck out results.
3. Select the Search button.

Group

- When viewing by Attachment Type, select the desired template and date from the left pane. The right pane then displays the date, the results' status, the name of the attachment file if results were scanned, and the lab template used. Only results that were scanned in are listed.

To view the attachment, select the desired entry in the tree structure in the left pane.

- When viewing by Date, select the desired date and template from the left pane. The right pane then displays the date, the results' status, the attachment if results were scanned, and the lab template used. All results for the selected date are listed, whether received by interface, entered manually, or scanned in.
- When viewing by Results, select the desired result status and date from the left pane. The right pane then displays the date, the results' status, the attachment if results were scanned, and the lab template used. All results for the selected date are listed, whether received by interface, entered manually, or scanned in.
- When viewing by Lab Template, either:
 - Use the search field to select a specific template in which you want to display the results. Note that you must select the Merge Test Items by Mapping/LOINC to use a specific lab template.
 - Select the desired template and date from the left pane. The selected template then appears in the right pane, with results for each procedure and lab in the template, by date performed.

When viewing by lab template, only results received by interface or entered manually appear in this view. You can select the hyperlink for a line item to view a graph of that item.

- When viewing by Flowsheet, all the results for a lab test received for the same day are displayed in a single column, much like a flowsheet. This is useful if you order multiple test panels which contain some of the same tests.

You can either:

- Use the search field to select a specific template in which you want to display the results. Note that you must select the Merge Test Items by Mapping/LOINC to use a specific lab template.
- Select the desired template and date from the left pane. The selected template then appears in the right pane, with results for each procedure and lab in the template, by date performed.

When viewing by as a flowsheet, only results received by interface or entered manually appear in this view. You can select the hyperlink for a line item to view a graph of that item.

Test Values

- Show Test Items: Displays the test line items from the template, and their results. Select the link to display a graph of the result values.
- Merge Lab Templates by LOINC: When LOINC codes are used with the lab templates, then this option combines results from the different templates with the same LOINC code. Test line items are also combined when they are assigned the same LOINC code.

- Merge Test Items by Mapping/LOINC: When LOINC codes are used with the test line items in lab templates, then this option combines results from different templates for line items with the same LOINC code. Select the link to display a graph of the result values.

Data Mapping

Once the data mapping has been defined, you may use it to view the results from different tests at one time. The window will display the results data for the selected template and data for all test items from other templates that contain test items with the same LOINC codes as the test items in the selected template.

- In the Group area, select the Lab Template radio button so that the results are grouped by lab template.
- In the search field, select the lab template in which you want to display the results.
- In the Test Values area:
 - a. Select the Show Test Items checkbox.
 - b. Select the Merge Test Items By Mapping/LOINC checkbox.

Medication Details

You can select one or more medications when viewing results so that you can see the prescribed medication details with the lab test or observation results. The medication details include the medication name, strength, route, dosage, and frequency. Keep in mind that this view shows only the details for the medication prescribed at the time of the observation. This view does not identify when the medication was prescribed or medication changes made between observations.

- In the Group area, select either the
 - Lab Template radio button so that the results are grouped by lab template.
 - Flowsheet radio button so that all the results for a lab test received for the same day are displayed in a single column, much like a flowsheet.
- In the search field, select the lab template in which you want to display the results.
- Select the desired Test Values option.
- To include medication details:
 - a. Select the Show Medications on Flowsheet checkbox.
 - b. Select one or more medications to include.

Viewing Results

- Abnormal results are shown in red.
- The Technician field contains data only on results received via lab interface, and only if provided by the lab. This information cannot be entered for manually entered results.
- To increase or decrease the relative widths of the panes, select the splitter bar between the panes and drag it to the desired location.

- To view an attachment, select the link for the attachment.
- Data entered in the Comments field is shown in a monospaced font so that tabular data may be entered if desired.
- Use the arrow buttons to move forward and back through the results or to move to the beginning or end of the results.
- Use the Graph button to graph results. If you have entered LOINC codes in lab templates, you can graph results from multiple labs.
- Use the Track Patient Results button to access the Track Patient Results window.
- Use the Enter Lab Results button to access the window where you can manually enter results.

Printing Results

You can print all lab results in a date range from the Patient Results window.

1. Patient Demographics → Patient → Patient Results
2. Select the Lab Template radio button.
3. Select any other filtering criteria, and then select the Search button.
4. Expand the desired item in the top left pane, and then select a detailed item.
5. From the File menu, select Print Lab Results.
6. In the Print Range field, select the timespan or custom dates for which you want to print.

Enter Results

Lab test results that are not received via an interface may be entered directly into the database. In order to enter lab results, you must have a lab template defined for the test or tests.

1. Patient Demographics → Patient Results icon () → Enter Lab Result button
2. Select the required laboratory, template, and attachment type.
3. Enter dates as necessary for date ordered, date collected, etc.
4. Enter the results values into the data sheet by selecting the desired row and column.
5. If desired, you can select whether or not the results are normal.
6. If desired, enter any notes or explanation.

Reviewing and Resulting Outstanding Orders

Review outstanding orders regularly so that you can follow up on tests that have not been performed, and can identify results that have been received but have not been associated to the order.

Associating results to the original order for the test helps you ensure that ordered tests and procedures were actually performed, and that the results were reviewed. It is also important for MIPS and other quality programs. There are a number of circumstances in which results may be received but not correctly associated to the original order. The two most common are:

- The application could not correctly match results received through a lab interface to the original order.
- A user processing results in document linking incorrectly associated the results document with either the patient record or the visit note instead of the order.

Use the following the process to identify outstanding orders, identify results received that may be for an outstanding order, and if so, correctly associate the results to the original order.

1. Desktop menu → Outstanding Orders
2. In the Outstanding Orders/Referrals window, enter the desired filtering criteria.
 - Unselect the Outstanding Referrals checkbox.
 - Unselect the Future Orders checkbox.
 - Unselect the Patient/Provider Relationships checkbox.
 - Unselect the Patient Procedure History checkbox.
 - Enter any other criteria needed.
3. Select the Search button. This displays a list of orders matching your criteria.
4. Select a Procedure hyperlink to access the Outstanding Order window.
5. Select the 'Result the Outstanding Order from Existing Patient Result' hyperlink.

This accesses a list of results associated to system-created (rather than user-created) orders for the patient and attachments associated with the patient or with visit notes for the patient.
6. Review the results and attachments to determine if an item is the results for your selected order.

If needed, select the Result Date hyperlink to view the document.
7. To associate an item to the selected order as the results:
 - a. Select the desired item from the list.
 - b. Select the OK button to close the window and return to the Outstanding Order window.
 - c. In the Outstanding Order window, select the OK button to result the order.

Automated Lab Result Notification Calls

Automated lab result notification calls are an optional service provided by West™ (formerly CallPointe). West interfaces with the application to identify lab results that need to be given to patients. West uses information from the application to contact the patient (by phone, email, or text) to notify the patient.

West works with your practice to develop the content of the notification message or messages given to patients. West is a HIPAA business associate, and is familiar with the HIPAA regulations and requirements.

Voice Messages

In addition to the notification messages you develop with West, you may also choose to record a personal voice message for the patient. Your voice message is transmitted to West. When West contacts the patient or the patient's voice mail, then West plays your voice message.

A voice message is completely optional. You decide when sending a patient's lab results to West whether or not you want to include a voice message. If a voice message is not included, then West uses their standard notification message when contacting the patient.

The voice message file is attached to the lab result message, which is a permanent part of the patient's chart. The voice message may be replayed at any time.

Dictation for voice message is not supported in a Citrix hosted environment, and is subject to the same limitations as visit note dictation.

Notification Workflow

The steps for using automated lab result notification calls are outlined below.

1. After reviewing and approving lab results in the usual manner, the provider must forward the lab result message to the CallPointe Export user. Instructions for sending the notification to West are below.
2. The application sends notification information to West.
3. West notifies the patient.
 - If West successfully contacts the patient, then West updates the lab result message sent to the CallPointe Export user with the date and time of the patient notification and completes the message.
 - If West is unable to contact the patient within your practice's established time period, then West updates the lab result message sent to the CallPointe Export user with the date and time of the attempted patient notification. West will continue to try to notify the patient, and to update the message, according to the parameters your practice has established.
4. A user or user group in your practice will have been given responsibility for monitoring the CallPointe Export user's messages. This user will process lab result notifications for patients that West is unable to reach. Instructions for monitoring the CallPointe Export user's messages are in the Monitor the Lab Result Notification Messages section.

Send Message for Automated Lab Result Notification

Use this process to send a lab results message to West for patient notification. If desired, you may include a personal voice message for the patient.

1. Message Center () icon
2. Search for your lab result messages. You may have a filter for these messages, or you may want to search for message type Service Order Approval.
3. Select the message date and time to open a message.
4. Review the results, and if you are satisfied with them, select the Approve button or the Approve All icon.
5. In the Assign To field, select 'Export, CallPointe'.
6. If desired, record a personal voice message for this patient. (Note that you can record a voice message only after assigning the messages to the CallPointe Export user.)
 - a. Select Record () icon to begin dictating the message.
 - b. Select the Stop () icon to stop recording the message.
 - c. Select the Play () icon to play back the message for review.
 - d. If needed, select the Delete () icon to delete the message. Then you may start over.
7. Select the OK button to send the notification message to West. If you have recorded a voice message, it will be attached and sent to West.

Notification Responses

When West attempts to notify the patient, they send one of the following responses so that you know whether the patient was successfully notified or not. The response appears in the lab notification message.

Message	Status
Error contacting patient, probable bad phone number, please validate and try again. Status as of <date and time>	Error
Patient phone number is blocked, please validate and try again. Status as of <date and time>	Error
Attempting to contact patient on <date and time>	Contacting
Patient has been contacted on <date and time>	Contacted
Patient retrieved message <date and time>	Complete

Monitor the Lab Result Notification Messages

You must monitor the lab result notification messages to ensure that all patients are notified. Your administrative super user will have created a message filter to be used to monitor lab result notification messages. The filter should identify notification messages of a certain age that have not been completed because West was unable to contact the patient.

The point at which you want to review and take action on a message will be based upon the arrangements your practice has made with West for notifying patients. For example, if you directed West to attempt to contact the patient five times, then you may not want to review messages until they are old enough that five contact attempts will have been made.

Your practice policies regarding lab result notification will determine how you process notifications that West was unable to make. For example, you may want to attempt to contact the patient using another method, such as a different phone number. Or you may want to mail the lab results to the patient. However you handle the notifications, you want to complete the lab result message once a notification has been made. You will also want to complete a lab result message if the patient contacts your office and obtains their results before West has contacted the patient.

Use this process to review and complete the lab result notification messages.

1. Message Center () icon
2. In the Filter field, select the automated lab result notification filter created by your administrative super user.
3. Select the Search button to display a list of all messages matching the filtering criteria.
4. Select the message date and time to open a message.
5. Select the Message Notes tab to see the notes from West (formerly CallPointe).
6. Enter notes for any action you take and the results of the action.
 - a. Select the Add Note hyperlink.
 - b. In the Note window, enter your notes.
 - c. Select the OK button to save your notes and return to the Message window.
7. Either:
 - Select the OK button to save your notes and close the message if you are not ready to complete it.
 - Once you have contacted the patient, select the Complete button to complete the message.

Strike Out Order Results

You may strike out lab and other medical order results that have been associated with the wrong patient or were associated with the patient rather than the visit note. You can only strike out results that have a status of Resulted. You cannot strike out results that have a status of Approved.

When you strike out the results, a new line item is created for the order so that the correct results can be entered. The new item has a status of Pending.

You can include results that have been struck out when searching for results in the Patient Results window. Results that have been struck out are identified as such in the Description column in the last line. This will include the date and time the result were struck out, the user name, and the reason.

Strike Out from the Order Results Summary Window

1. Patient Demographics → Results Tracking icon ()
2. Enter the desired filtering criteria, and then select the Search button.
3. Highlight the desired order, and then select the Edit button.
4. In the Order Results Summary window, select the Strikeout button.
5. In the Strikeout Reason popup window:
 - a. Enter a reason for striking out the results.
 - b. Select the OK button.

Strike Out from the Results Entry Window

1. Patient Demographics → Results Tracking icon ()
2. Enter the desired filtering criteria, and then select the Search button.
3. Highlight the desired order, and then select the Edit button.
4. In the Order Results Summary window, select the 'Switch to Advanced Results Dialog' hyperlink.
5. In the Results window, select the Strikeout button.
6. In the Strikeout Reason popup window:
 - a. Enter a reason for striking out the results.
 - b. Select the OK button.

View Struck Out Results

You can include results that have been struck out when searching for results in the Result Status window.

1. Desktop → Result Tracking icon ()
2. Select the Include Strike Outs checkbox to include struck out results in the search.
3. Enter any other filtering criteria, and then select the Search button.
4. Results that have been struck out have a status of Cancelled and have a Resulted Date.
5. Select the Status hyperlink to view the results.
6. The Order Results Summary window shows the Order Status and Urgency as struck out and displays the date and time the results were struck out, the user's name, and the strikeout reason.

View Struck Out Results for a Patient

1. Patient Demographics → Results Tracking icon ()
2. Select the Include Cancelled checkbox to include cancelled orders.
3. Select the Include Strike Outs checkbox to include struck out results in the search.
4. Enter any other filtering criteria, and then select the Search button.
5. Select a result item to view the item details.
 - Cancelled items are identified in the Status column.
 - Struck out items are identified in the Description column of the last line. This will include the date and time that the result were struck out, the user name, and the reason.

Messages for Lab Interface Errors

Errors for HL7 interfaces are available in the Interface Data Center. However, clinical users may not have security rights to that window, or may not be comfortable searching for errors related to lab or imaging interface. So, your administrative super user may define users or user groups to receive messages when errors are generated when a lab order or result has failed.

One Page Summary

The One Page Summary (OPS) provides a summary of a patient's last three visit notes. It includes information relating to all visits, whether the visit note has been completed or was saved as Incomplete. The OPS also includes the status of the visit note, the name of the billing provider, the name of the rendering provider, the name of the approving provider, and the date and time stamp of when the visit note was last saved.

The One Page Summary uses the document formatting model functionality. The document formatting model functionality enables your administrative super user – or you, if you have the necessary security access – to define the format of the One Page Summary document and the content fields that it contains. This enables, for example, establishing different One Page Summary documents for different providers, care teams, or other user groups. The functionality that you are using is defined in the User Setting definition associated with your user ID.

Note: Your Windows default printer must be configured as an existing printer on your network. This is because the formatting model functionality uses the default printer definition to determine text layout. Therefore, One Page Summary will perform poorly if the default printer is not available or invalid.

Access the One Page Summary from:

- More Options icon () → One Page Summary
- Patient Demographics → Patient → One Page Summary
- One Page Summary icon ()

Open or Create Note

You can open a visit note that is summarized in the OPS by selecting the visit date from the Visit date selection box at the top of the OPS (select the date and the corresponding visit note opens), or from Visit → Complete Notes → Select date.

Create a new note from the New icon or from Visit → New Note.

View Format

Use the View Format field to select the formatting model you wish to use. The formatting model determines the content and format of information from visit notes.

Attachments

The Attachments slider displays all documents that have been attached to the patient visit, but not documents attached to Patient Demographics. You can reorder the attachments or view attachments. You cannot add new attachments via the OPS.

Return to Top

Use the Return to Top () icon in the One Page Summary toolbar to return to the top of the document. This icon is active only when using the new formatting model functionality. When using the original functionality, use the Return to Top hyperlinks in the document.

Patient Care Console

You can access the Patient Care Console from the Review menu. The Patient Care Console displays the repeating procedures in effect for the patient and the clinical decision support rules that apply to the patient.

Generate Documents

You can generate documents using information from a patient visit note by selecting Visit → Generate Documents.

Bilateral Physical Exam Results

Descriptions of bilateral symptoms and findings in a physical exam are grouped into “left” and “right” sentences. All findings for the left are grouped together, followed by all findings for the right. A finding that is marked as “both” in the physical exam will appear twice; once with the findings for the left and once with the findings for the right.

When the symptom description in the knowledge database includes a caret symbol (^), then the “left” or “right” identifier is inserted at the location of the caret. For example, “The ^ shoulder has no” is written as the “The left shoulder has no” or “The right shoulder has no.” When the symptom description does not include a caret symbol, then the “left” or “right” identifier is inserted before the description. For example, “upper arm” will be written as “left upper arm” or “right upper arm.”

Lab Result Notes

One Page Summary can display the lab result notes in the Remark column of the index. This enables you to view a summary of the results without opening the Patient Results window to view the detail. To display the lab result notes, your One Page Summary options must include Show Index and Results Tracking.

Printing the One Page Summary

Select the Print icon to print the One Page Summary. Select a date icon to print one of the three most recent visit notes.

When you print the One Page Summary, the printed document appears exactly like the onscreen format with the addition of page numbers and a page header. The page number and header options are defined as a part of the formatting model.

Patient Care Console

The Patient Care Console displays the repeating procedures in effect for the patient and the clinical decision support rules that apply to the patient. The clinical decision support rule information displayed in the Patient Care Console is the same as the information in the Clinical Decision Support slider in Full Note Composer, but the Patient Care Console displays all rules associated with the patient and all providers, not just the current provider.

1. Either:
 - Full Note Composer or other clinical note type window → View → Patient Care Console
 - One Page Summary → Review → Patient Care Console
 - Review Past Notes → Review → Patient Care Console
2. Select the Code link for a repeating procedure to access the Modify Service Order window. You can then adjust the start and end dates and frequency if desired.
3. Select the Rule Name link to view the clinical decision support rule information. The due date for a clinical decision support rule will be red if the procedure is overdue.
4. To discontinue the rule for a patient, deselect the checkbox at the far right of rule entry. Discontinue a rule when the patient meets the rule's criteria, and yet the rule does not apply to that patient.

<<New>> Patient Care Plan

The Patient Care Plan functionality enables you to define a care plan with health concerns, goals related to those health concerns, and interventions related to the goals. Goals may be based on observation items (such as vital signs and lab tests) or may be anything you define for patient. Interventions may be anything that you have done or that the patient has done that contributes to the patient achieving the goal.

It is recommended that a patient have a single care plan that encompasses all aspects of the patient's care for as long as the patient remains in the care of your practice. Different providers and other users may use and contribute to that care plan. This ensures that the care plan is a complete view of the patient's needs and care.

You may, however, have a second care plan for a patient if your practice provides different types of service which you want to document separately. For example, you may have a health care plan and a case management care plan instead of a single plan.

You may identify in the care plan the people on the patient's care team. This may include anyone involved in the patient's care, such as internal providers, other staff members, external providers, the patient, and any person entered as a contact for the patient, such as family members or care givers. Members of a patient's care team may be added and removed over time.

Once you have defined a care plan, you can monitor and add to it as needed. You may enter notes on the patient's progress towards a goal and indicate when a goal has been achieved. You may add new interventions to an existing goal, add new goals to a health concern, and

add new health concerns. When appropriate, you may also indicate that a health concern is completed.

The basic care plan functionality included in this release of the application will be expanded in future releases. It is recommended that, in this release, you only record interventions that have been completed or that are performed during the current patient visit. A future release will enable entering interventions to be performed in the future and then indicating when they have been performed.

Patient Care Plan, Care Planning, and Plan Tabs

The application contains three clinical note type tabs that are related to planning care for a patient. Though there is some overlap in the purpose of these tabs, each tab was designed for a specific purpose. Understanding the intended purpose of each tab will help you determine how you want to use them.

- The Patient Care Plan tab is the same as the Patient Care Plan window. The Patient Care Plan is intended for long-term, inclusive planning for the patient.
- The Care Planning tab is designed to meet the care plan requirements defined for Patient-Centered Medical Home (PCMH) participation. It contains fields for entering patient preferences and functional/lifestyle goals, treatment goals, potential barriers to meeting goals, strategies for addressing those barriers, and a self-care plan.
- The Plan tab is for short-term, specific planning for the diagnoses charted in the patient visit. It uses system-defined and custom diagnosis plan definitions associated with diagnosis codes.

Care Plan Editing Toolbars

A popup toolbar enables you to edit the care plan and the items in it. The toolbar displays only when you move the cursor over its location. When the toolbar appears, you may select an icon on it. The toolbar is located to the far right of the item name.

Icon	Description
	Edit the item.
	Delete the item and any sub-items. Items should be deleted only when they were entered in error. Items should not be deleted because they are completed or have been achieved, or because a decision has been made that the item is no longer relevant. Instead, change the status of the item. This ensures that the care plan is a complete record over time.
	Enter your evaluation of the patient's progress toward the goal. Evaluation entries are only available for goals.

Care Plan Icons

Icon	Description
	Expand a category or subcategory of information.
	Collapse a category or subcategory of information.
	Move the cursor over the Information icon to display the date the health concern was created. Select the icon to expand or collapse the concern and all of its related items. The icon is blue for active concerns and green for completed concerns.

Saving the Patient Care Plan in a Visit Note

When using the Patient Care Plan tab in a visit note, you should save any information entered in the care plan before you can access another tab in the clinical note type window. Any information entered into the care plan but not saved will not be saved if you close the visit note without saving from another tab.

Establish and Monitor Patient Care Plans

Establish a Patient's Initial Care Plan

Use this process to establish the care plan for a patient. Once a care plan is established, you can monitor and update it for as long as the patient is under your care.

1. Either:
 - Custom clinical note type → Care Plan tab
 - Patient Demographics window → Patient menu → Care Plan
2. In the Care Plan tab or Patient Care Plan window, select the New Care Plan link.
3. In the Create Care Plan window, enter a Name for the care plan.
4. Enter any Notes about the care plan, if desired.
5. Add members to the Care Team, as needed, by either:
 - Typing the person's last name and selecting the appropriate person from the database.
 - Selecting the View List button. Then search by last name and by provider, contact, or user.
6. Select the Save button. This returns you to the Care Plan tab or Patient Care Plan window.
7. Use any of the processes described below to add health concerns, goals, and interventions to the care plan.

8. Once you have added all the health concerns, goals, and interventions, select the Concerns tab to review the care plan.
 - The Concerns tab displays a summary of the full care plan.
 - Expand or collapse a category by selecting the Expand (⌵) or Collapse (⌶) icon.
9. When you have made all entries and changes, either:
 - In the Care Plan tab, continue charting the visit note and save it in the usual manner.
 - In the Patient Care Plan window, select the Close button.

Monitor and Update a Patient's Care Plan

Once a care plan is established, you can monitor and update it for as long as the patient is under your care.

1. Either:
 - Custom clinical note type → Care Plan tab
 - Patient Demographics window → Patient menu → Care Plan
2. The care plan opens to the Concerns tab, which displays a summary of the full plan. Expand or collapse a category by selecting the Expand (⌵) or Collapse (⌶) icon.
3. Use any of the processes described below to update the care plan.
4. When you have made all entries and changes, either:
 - In the Care Plan tab, continue charting the visit note and save it in the usual manner.
 - In the Patient Care Plan window, select the Close button.

Edit the Care Plan Definition

Use this process to edit the general notes for the care plan, or to add or remove care team members.

1. Scroll the cursor to the right of the care plan name to display the popup editing toolbar.
2. Select the Edit (✎) icon.
3. Make any changes to the name, notes, or care team.
4. Select the Save button. This returns you to the Care Plan tab or Patient Care Plan window.

Add or Edit a Health Concern

Use this process to add a health concern to the plan or to edit an existing health concern.

1. Select the Concerns tab.
2. Either:
 - To add a health concern, select the Add New Concern link. This opens the Concern view.
 - To edit a health concern, scroll the cursor to the right of the health concern name (beneath the Add New Concern link) to display the popup editing toolbar. Then, select the Edit () icon.
3. If the concern is not an active diagnosis or problem but the patient has an increased risk (due to family history, certain behaviors, or other factors), then select the checkbox for 'Is health concern a risk'.
4. Enter a brief statement of the health concern. As you type, the application searches the medical problem list for possible matches. You may select an item or continue typing your own concern.
5. The Status defaults to Active. When appropriate, you may change the status to Completed.
6. Enter any Notes needed about the concern for the patient.
7. If appropriate, select the objective findings that support this concern. These include:
 - Active problems or diagnoses from the patient's history.
 - Observation items and the patient's most recent result for that item or items. You may select items from the past year, the past two years, or the patient's complete history.
 - Items from the patient's social history.
8. Select the Save button to save the concern and return to the Care Plan view.

Add or Edit a Goal

Use this process to add a goal to the care plan or to edit an existing goal. Edit the goal when it has been achieved or when you need to change the goal value or the targeted achieved by date.

Use the goal evaluation functionality to enter information about progress toward a goal.

1. Select the Goals tab.
2. Either:
 - To add a goal, select the Add New Goal link. This opens the Goal view.
 - To edit a goal, scroll the cursor to the right of the goal name (beneath the Add New Goal link) to display the popup editing toolbar. Then, select the Edit () icon.
3. Enter a Name for the goal.
4. Enter any Notes about the goal, if desired.

5. Select one or more of the care plan's Related Health Concerns to be associated with the goal. As you select items, they are added to the list above the search field.
6. If desired, select an Observation item that you will use to monitor the goal.
The selected observation item's results or outcomes will be displayed on the Goals tab.
7. If you added an observation, you may define the Goal Value. The options for the goal value are determined by the observation item selected.
8. In the Achieve By field, select the time period (days, weeks, or months) and then enter the number or select the calendar option and then enter a date.
9. The Authored By field defaults to Provider. You may change this to Patient or to Both.
10. Select the Save button to return to the Patient Care Plan window. The goal is now listed in the Goals area.

Enter a Goal Evaluation

Use this process to review the goals, and to enter your evaluation of the patient's progress toward the goal. Evaluations are only available for goals.

1. Select the Goals tab to review the goals.
2. Enter an evaluation of progress toward a goal:
 - a. Either:
 - Select the Add New Evaluation link.
 - Scroll the cursor to the right of the goal name (beneath the Add New Goal link) to display the popup editing toolbar. Then select the Evaluation () icon.
 - b. In the Goal Evaluation field, enter text documenting the patient's progress toward the goal.
 - c. Select the OK button. This returns you to the Care Plan tab or Patient Care Plan window.

Add or Edit an Intervention

Use this process to add an intervention to the care plan or to edit an existing intervention.

1. Select the Interventions tab.
2. Either:
 - To add an intervention, select the Add New Intervention link. This opens the Intervention view.
 - To edit an intervention, scroll the cursor to the right of the intervention name (beneath the Add New Intervention link) to display the popup editing toolbar. Then, select the Edit () icon.
3. Enter a brief Intervention Description.
4. Enter the Performed Date by selecting the time period (days, weeks, or months) and then entering the number.

5. Select one or more of the care plan's Related Health Goals to be associated with the intervention. As you select items, they are added to the list above the search field.
6. Select the Save button to return to the Patient Care Plan window.

Patient-Centered Medical Home

The application includes optionally licensed features and functionality that you can use to meet patient-centered medical home (PCMH) requirements and earn the points needed to achieve 'recognized' status by the National Committee for Quality Assurance (NCQA). Information about NCQA's PCMH Recognition program is available from the NCQA website at: <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>

Please refer to the *Patient-Centered Medical Home Guide* for information and instructions on using the PCMH functionality.

Patient Dashboard

The Patient Dashboard window enables users to quickly scan a patient's demographic, medical, appointment, and visit information. Patient dashboard configurations are also associated with diagnosis plan definitions, and appear with them in the Plan tab of Full Note Composer and other clinical note types. They are also used with the Aprima NOW application for mobile devices.

Your administrative super user may configure the Patient Dashboard with the information you want to include and how you want the information arranged. The following information may be included in the dashboard:

- Allergies
- Appointments
- Demographics
- Health Reminders
- Active Medications
- Observation Results
- Orders
- Problem List
- Remarks
- Visits
- Vitals

View the Patient Dashboard

Use the Patient Dashboard to quickly scan a patient's demographic, medical, appointment, and visit information. From the Patient Dashboard you may access additional functions, such as creating an appointment or a message.

1. Either:
 - Appointment entry on Desktop → More Options () icon → Patient Dashboard
 - External patient entry on Desktop → More Options () icon → Patient Dashboard
 - Patient Demographics window → Patient menu → Patient Dashboard
2. Select the dropdown arrow () for the section you want to view.
3. Select the up arrow () to close the section.
4. Select the Ellipses () icon to access additional functions. You may:
 - View the Patient Dashboard.
 - Add an appointment for the patient.
 - Start charge capture.
 - Create a task message.
 - Create a portal message for the patient.
 - Select another patient dashboard configuration.

<<Revised>> Patient History

The Patient History window enables you to review and enter a patient's history. You can also import a patient's history questionnaires. This window is very similar to the History tab in the Full Note Composer and other clinical note type windows. However, there are some differences as noted below.

- Users who are not providers may use the Select Provider button in order to view the patient's history using the selected provider's knowledge database. This button does not display on the window for users who are providers since providers view the history using their own knowledge database.
- Questionnaires that include review of systems questions cannot be imported from this window. They must be imported from the Hx tab of Full Note Composer or another clinical note type window that includes the ROS tab since review of systems questions must be associated with a particular patient visit and they are dependent on the ROS knowledge database.
- Where you enter a time qualifier (such as 2 months ago), it is recommended that you add the actual date in the note field against the symptom. For example, add June 2005 as a note. As dates are not updated in the FNC, if you add 'two months ago', you will always have to check the date that the note was created to establish the timeline.

- Use the Add button to enter a drug into the medication history. You may enter a dispensable drug if enough information is available, or you may enter only a drug name and route. Both the dispensable drug and the drug name and route provide enough information for drug screening.
- Use the Drug Screening link to perform the drug screening at any time.
- Use the Filter () icon to select a medication history filter. The selected filter defines both the medications to be displayed and the sort order in which they are displayed. A filter can define up to a three-level sort order for the medications in a patient's history. The medications are then displayed in a tree structure which can be collapsed and expanded. Select the Filter icon and then the Modify option to define or modify a medication history sorting filter.
- When entering the problem history, you may enter a diagnosis code in a patient's medical history, as well as selecting a problem from the knowledge database. Select the Diagnosis button, then search for and select one or more diagnosis codes.
- You can enter and view family history by relationship or by disease.
- If you have identified a disease as the cause of death for a family member, that disease will be displayed in red text.
- You can enter procedures in the system-defined Surgical History category or any user-defined procedure history category.
- The entries displayed in the History may be customized for your practice, or for specific care teams and/or providers. Define customized entries via List Editor or from the History tab by selecting any of the linked qualifier headings: Surgery, Timeframe, Allergen, Reaction.
- You can add general notes to the chart, if desired.
 - Add notes that have been predefined in the system by selecting the Notes link.
 - Add voice notes via the voice icon or dictation slider. Transcribed notes are merged into the notes section.
 - Add free form text notes to the notes section or by selecting the notes icon ()

Enter Patient History

1. Select from the History Categories displayed. The associated descriptors vary, depending on the category selected. All History Categories are defined as questions with associated answers. For example:
 - Medical history displays a list of diseases and medical conditions, each of which is associated with options for date or timeframe. You may enter a diagnosis code by selecting the Diagnosis button, and searching for and selecting the desired diagnosis.
 - Infection history displays a list of questions; the associated answers for history are Yes/No.
 - Medication history allows you to search for a drug or default SIG.
 - Allergies are associated with a list of allergens and corresponding reactions.
2. Select the qualifiers as necessary for each of the history categories you choose to document.
 - If you select a qualifier for which you need to add a number (for example, _ years ago), enter the number via the stylus, keyboard, or number pad slider.
 - If you select a qualifier for which you need to add a date (for example, . since, or __/__/__), enter the date via the stylus, keyboard, or calendar slider.

Enter Family History

You may enter family history information by relationship or disease.

The application contains a number of first- (parents, children, and siblings), second- (grandparents, half-siblings, aunts and uncles, etc.), and third-degree relationships (great-grandparents, first cousins). It also contains 'Adopted', 'Runs in Family', and 'Side' relationships. Your administrative super user or you, if you have the needed security permissions, may create additional relationships if needed.

If you have identified a disease as the cause of death for a family member, that disease will be displayed in red text in the Hx tab or Patient History window.

Use the following procedure to enter family history.

1. Either:
 - Full Note Composer or other clinical note type window → Hx tab
 - Patient History ()
2. Select the Family History category.
3. To enter items by family relationship:
 - a. Select the Relationship radio button.
 - b. In the Relationship field, select the relationship for which you want to make entries.
 - c. In the Family History Item window, if appropriate for the relationship, you may select the Paternal or Maternal radio button to identify which side of the family the person is on.
 - d. Enter the Name of the individual family member if desired. This is helpful if the patient has, for example, more than one sister.

- e. Enter the family member's Birth Date.
 - You may enter an actual date or an approximate date. An actual date must be entered in mm/dd/yyyy format.
 - You may also enter the person's current age, then select the conversion () icon to convert the age to an approximate birth date. This ensures that the person's age progresses appropriately over time.
 - f. If appropriate, enter a Death Date.
 - You may enter an actual date or an approximate date. An actual date must be entered in mm/dd/yyyy format.
 - You may also enter the person's age at death by selecting the underscore (_).
 - g. Enter any Notes about this individual, if desired.
 - h. Select the No Known Diseases checkbox if the patient does not know of any medical problems for this individual.
 - i. Select a Disease to add an item to this individual.
 - j. Select the Cause of Death checkbox if this disease was the cause of the individual's death.
 - k. Select the Denies checkbox if the family member does not have and has not had this disease.
 - l. Select an Onset date for the disease, if known.
 - You may enter an actual date or an approximate date. An actual date must be entered in mm/dd/yyyy format.
 - You may also enter the person's age at onset by selecting the underscore (_).
 - m. Enter any Notes about this disease if desired.
 - n. Repeat substeps i through m for each additional disease.
 - o. Repeat substeps b through n for each additional relative.
 - p. Select the OK button to return to the family history.
4. To enter items by disease:
- a. Select the Disease radio button.
 - b. In the Disease field, select the disease for which you want to make entries.
 - c. In the Add Disease to Family Members window, select a family Relationship. If family relationships have already been entered for the patient, they will display here.
 - d. Select the Has Disease checkbox if the family member has the disease.
 - e. Select the Denies checkbox if the family member does not have and has not had the disease.
 - f. If the family member has or had the disease, enter an Onset date if known. You may enter a date or a timeframe, such as a number of years ago, or in childhood.
 - g. Repeat substeps c through f for each additional family member.
 - h. Select the OK button to return to the family history.

<<New>> Enter Implantable Medical Device History

You may enter information about a patient's implanted medical devices. Information about an implantable medical device is usually obtained from an information card given to the patient when the device was implanted.

1. Either:
 - Select the Please Scan Unique Device Identifier field, and then use your barcode scanner to scan the medical device information card.
 - Enter the unique device identifier (UDI) shown on the medical device information card into the Please Scan Unique Device Identifier field, and then select the Find Device button.
2. When the device information displays, review it to verify that it is correct.
3. Select the Edit () icon to enter the active date and, when appropriate, inactive date for the device.
 - a. In the New Medical Device window, enter any Notes for the device, if desired.
 - b. Enter the Device Active Date.
 - c. If appropriate, enter the Device Inactive Date.
 - d. Select the Save button.
4. Either:
 - Select the Add Device button to add the device information to the patient's history.
 - Select the Cancel button to cancel the entry

<<New>> Deactivate an Implantable Medical Device

When an implanted medical device is no longer active, then deactivate the device entry in the patient's history.

1. Select the Expand icon for the device entry.
2. Select the Deactivate Device button. This opens the New Medical Device window.
3. Enter any Notes for the device, if desired.
4. Enter the Device Inactive Date.
5. Select the Save button.

<<New>> Delete an Implantable Medical Device

When an implanted medical device entry was made in error, you may delete the entry.

1. Select the Expand icon for the device entry.
2. Select the Delete Device button. This opens confirmation window.
3. Enter the reason for deleting the device entry.
4. Select the Delete Device button.

<<New>> Drag an Implantable Medical Device Entry to Deactivate or Delete It

You may use drag-and-drop functionality to deactivate or delete an entry for an implantable medical device.

1. Click and hold the Expand icon for the device entry.
2. Drag the entry to the desired location at the bottom of the window, and then drop it by releasing the mouse button.
 - Use the bottom left section of the window to deactivate the device entry.
 - Use the bottom right section of the window to delete the device entry.
3. Use the Edit () icon to enter any additional information, such as the deactivate date or delete reason.

Import Patient History

1. Select the Import Questionnaire () icon from the toolbar.

Note: If the Import Questionnaire icon is not visible, select the drop down button on the toolbar to display additional icons.
2. All patient input from all questionnaires is imported into the History. Fields containing patient input are highlighted as defined in User Options.
3. Verify the patient input by selecting the highlighted field. The input is now considered approved.
4. If desired, make changes or additions to the patient input.

Patient Tracking Events

You can view all of the patient tracking events for a particular patient. Patient tracking events are used when graphing lab results and vitals. An event is anything that may have an effect on the lab results or vitals, such as a change in medication or diet or a procedure, and that can be identified as occurring or beginning on a specific date. The patient tracking event can then be plotted on a graph. So, for example, when you change a patient's blood pressure medication, you can define a patient tracking event for that change. Then when you graph the patient's blood pressure, you can include the patient tracking event on the graph so that you can how the change in medication affected the patient's blood pressure.

1. Either:
 - Full Note Composer → View → Patient Tracking Events
 - Superbill Composer → View → Patient Tracking Events
 - Patient Demographics () → Patient → Patient Tracking Events
2. Enter the desired filtering criteria. You may filter by:
 - Patient
 - Tracking Event Type
 - Event Date
3. Select the Search button to display a list of the tracking events matching your criteria.
4. Select the Event Date link to access the event.
5. Select the Delete icon () to delete an event.

Patient Visit Notes

Clinical note type windows are used by physicians, other providers, medical assistants, and nurses to chart patient visit notes. The application includes a number of system-defined clinical note type windows, and your administrative super user may have defined additional clinical note type windows to meet the specific needs and preferences of your practice and providers.

A patient visit note, regardless of the window in which it is created, does not have to be completed all at once. The visit note may be saved as incomplete until all information has been entered. For example, a medical assistant or nurse may create the visit note, enter information such as vital signs and chief complaint, then save the note as Incomplete. A physician may then reopen the visit note and add diagnosis and prescription information. In this way, the visit note may be updated by different users, each using his or her own computer.

You can have multiple clinical note type windows open at the same time with different visit notes for the same patient. The visit date is included in the title bar of the window.

If the clinical note type window is maximized (that is, it covers the whole screen) when you save a visit note, the setting is retained and the window will be maximized the next time you open a patient visit note.

Visit Notes, Superbills, and Financial Batches

The application automatically creates a superbill from a patient visit note created and saved in Full Note Composer or another clinical note type window. That superbill contains all the information needed for billing and subsequent insurance claims. Because a superbill contains charges for services performed, it must be associated to a financial batch when it is created.

Providers and non-provider clinical users may create a default financial batch or select an existing financial batch as their default, if desired. However, if the provider or other user does not have a default financial selected, the application automatically defines the batch to be used when creating a superbill from a patient visit note. For providers, the application automatically creates a financial batch with the provider as the batch owner and the visit date as the posting date. This batch becomes the provider's default batch for all financial activity.

For non-provider user, who create and save patient visit notes, the application uses the financial batch for the rendering provider on the visit note. If the rendering provider does not yet have a financial batch, the application automatically creates the batch with the rendering provider as the batch owner and the visit date as the posting date. This batch does not become the user's default batch. It is used only for the specific visit note.

If a non-provider clinical user performs any other financial activity, then the user must have a default batch selected. When the user has a default batch, the user's default batch, rather than the rendering provider's batch, is used for all superbills automatically created from superbills.

Clinical Note Types

Clinical Note Type Windows

The application includes the following system-defined clinical note type windows:

- **Full Note Composer:** This is the primary clinical note type window, and as the name implies, it includes all the tabs and sliders needed to fully document a patient visit in line with the 1997 Documentation Guidelines
- **Superbill Composer:** This clinical note type window is similar to the Full Note Composer window, in that enables the provider to fully document a patient visit in line with the 1997 Documentation Guidelines. However, the Superbill Composer window contains tabs that are less structured than the Full Note Composer, and so allows the user to chart in a manner that is similar to writing progress reports.
- **Order Note:** This window may be used to document an order for a service when there is no actual patient visit. This window includes the Dx, Rx, and SO tabs and the Rx Summary slider.
- **General Note:** This window may be used to document a patient visit through text only. This window includes the General Note tab, which contains a note field where you can enter free text or select a previously entered and saved text note. This window also includes the Visit Information slider.

Your administrative super user may define custom windows for charting a patient visit. Custom clinical note type windows may have been defined for particular types of patient visits or to accommodate a provider's or care team's preferences. Custom clinical note type windows may contain any combination of the tabs and sliders available for clinical note type windows.

Clinical Note Type Window Elements

Both the system-defined and custom clinical note type windows are comprised of the following elements.

- Title bar that displays information about the patient and visit. You may customize the information that displays in Full Note Composer, Superbill Composer, and other clinical note types.
- Menus that enable you to save a patient visit note, customize the appearance of the window, and create new messages and tasks.
- Quick link icons across the top of the window. These make it easy to select frequently used tasks, such as Results Tracking or performing an E&M calculation.
- Tabs that link to each section of a patient chart, such as Vital Signs, Chief Complaint, and Diagnosis. Many tabs are available in both the Full Note Composer and the Superbill Composer windows. However, some tabs are specific to one or the other of these windows.
- Sliders around the edges of the window that provide additional functionality.
- Footer which displays your default batch and the Evaluation and Management (E&M) bullet count, once you start charting the visit. While you are charting a patient visit note, the clinical note type window displays your E&M progress in the status bar at the bottom of the window when you are on the Vitals, HPI, Hx, ROS, and PE tabs. The status indicator includes the number of items that have been documented and the associated level of service.
- OK button that saves the data entered in the note and closes the window.
- Cancel button that discards any data entered since the last save, if any, and closes the window.

Title Bar

The title bar of Full Note Composer or any other clinical note type window displays information about the patient and visit. By default, it displays patient name, external ID, gender, age, and insurance, plus weight, height, temperature, respiratory rate, heart rate and blood pressure, if entered. Any demographic or vital sign not entered is simply skipped; the title bar does not indicate that the item is missing. When the vitals default being used is set for metric measurements, the height and weight are shown in metric units in the title bar. The title bar also indicates the visit type for any visit marked as a Lab Visit, Private Visit, Refill Visit, or Strike Out Visit.

Your administrative super user or you, if you have the necessary security rights, can configure the title bar for Full Note Composer and other clinical note type windows to include more or less information about the patient. Please refer to the *Administrative User's Guide* for instructions.

Menus

File Menu

Menu Item	Description
Save	<p>Save data at any time while charting a patient visit note. The note is saved as an Incomplete note, but the Full Note Composer remains open and you can continue to chart the patient information.</p> <p>Note: If you save the note after a prescription has been included, the prescription information is saved to the Rx section of Patient History. This means that checks for drug interactions may always be made in a new note, even if the note in which the medication was added is still incomplete.</p>
Save As a New Common Problem Palette	<p>Saves the information from the current note as a Common Problem Palette. That is, the information from the CC, HPI, Dx, Rx, SP, and SO tabs is saved and may be reused for any patient.</p> <p>This menu item is specific to Full Note Composer. Common Problem Palettes require structured charting information. Therefore, they cannot be used in Superbill Composer.</p>
Close	<p>When you select close, you will see the Visit Checkout window from which you can choose the option you require for closing the note:</p> <ul style="list-style-type: none">• You have the option of forwarding the note for cosignature, if that has been defined for you. If you specify to save as an incomplete note, this is optional even if a cosignature is mandatory on complete notes. If you must request a cosignature, select one or more supervisors to co-sign the note. If a cosignature is optional, you may choose whether to forward the note to the specified supervisors.• Set the status of the superbill or superbills associated with the patient visit note.• You may request electronic transmission of prescriptions, generate a document, or close a case if required. (See Visit Checkout for more information.) <p>When a patient visit note includes dictation, the Voice Dictation Ready to Transcribe checkbox will be active. Select this checkbox if the dictation is complete and ready for transcription. Deselect the checkbox if the dictation is not ready for transcription. You cannot mark the patient visit note as complete until the associated dictation file is marked as ready to transcribe.</p>

View Menu

Menu Item	Description
Toolbar	Toolbars contain the quick link icons. By default, all toolbars are visible. Customize the Full Note Composer or Superbill Composer by unchecking the toolbars that you do not want to use.
Sliders	Sliders allow increased functionality on the FNC. By default, all sliders are visible. Customize the Full Note Composer or Superbill Composer by unchecking the sliders you do not want to use.
Get Remarks	Opens the Remarks window so that you can view any active remarks associated with the patient.
Patient Care Console	Opens the Patient Care Console, which displays the repeating procedures in effect for the patient and the clinical decision support rules that apply to the patient. The clinical decision support rule information displayed in the Patient Care Console is the same as the information in the Clinical Decision Support slider in Full Note Composer, but the Patient Care Console displays all rules associated with the patient and all providers, not just the current provider.
Get Global Period	Opens the Global Period window, which displays information regarding any current and expired global periods associated with a patient.
Patient Provider Tracking	Opens the Patient Provider Tracking window, which lists all the providers involved in a patient's care. This may include a provider who referred a patient to you, providers to whom you have referred the patient, or any other providers the patient sees.
Patient Tracking Events	Opens the Patient Tracking Events window which lists all of the patient tracking events for a particular patient. Patient tracking events are used when graphing lab results and vitals.
Generate Document	Opens the Generate Document window, which enables you to generate a document using data from a specific visit.

Quick Link Icons

Quick link icons provide shortcuts to frequently used functions. The icons are grouped into toolbars, which you can choose to display or hide. The tables below show the icons associated with each toolbar. By default, all toolbars are visible. To make one or more toolbars unavailable, select the View menu, then Toolbars, and uncheck each group you wish to hide.

Patient Toolbar

The Patient toolbar cannot be hidden. The following table defines the standards icons available on the Patient toolbar. The Patient toolbar may contain additional icons if your user setting definition has been configured for any optional add-in applications which are accessed through this toolbar.

Icon	Description
	Patient condition is displayed when a condition has been applied to a patient record. Patient conditions on the Patient Toolbar may appear in different colors, as defined by the administrative super user. You may select the patient condition shown on the toolbar to select another condition.
	The Print icon accesses a drop-down menu from which you can print Patient Information or Patient Mailing labels. The Print drop-down is available only if set up in your user setting definition.
	<p>Accesses a popup window containing the patient's basic demographics and contact information, account information, pharmacies, and up to five future appointments.</p> <p>If you are using the optional Aprima Patient Portal to communicate with your patients, you can use the Patient Information icon to identify patients whose record includes an email address, a Portal account, or both.</p> <ul style="list-style-type: none">  indicates the patient record does not include an email address or a Portal account.  indicates the patient records includes an email address.  indicates the patient records includes a Portal account.  indicates the patient records includes both a Portal account and an email address.
	Accesses the Patient Demographics window for this patient.
	Accesses the One Page Summary for this patient.
	Review enables you to Review Past Notes (i.e., data from previous visits) associated with the patient whose chart you are updating.

Icon	Description
	Result links you to Results Tracking, where you can enter new results or review previous information.
	Patient Provider Tracking enables you keep track of all the providers involved in a patient's care.
	Accesses the Growth Chart to plot the height/length and weight of infants and children. This enables you access the growth chart functionality without accessing Full Note Composer. You must have security access to Review Past Notes in order to access the growth chart functionality.
	Accesses the Chart Observation window to graph patient vital signs, such as weight and blood pressure. This enables you access the graphing functionality without accessing Full Note Composer. You must have security access to Review Past Notes in order to access the graphing functionality.
	Accesses the Document Generation window.
	Accesses the Attachment Editor window so that you can create an advance directive attachment.
	The New drop-down menu enables you to create a new appointment, visit note, superbill, message, or other item for the patient.

Full Note Composer Toolbar

Icon	Description
	Saves the patient visit note.
	Saves and closes the patient visit note, and accesses the Visit Checkout window.
	Saves and closes the patient visit note, without accessing the Visit Checkout window.
	Sends prescriptions to the clearinghouse.
	Sends lab orders to the laboratory.
	Send the diagnosis and procedure codes to Alpha II ClaimStaker in order to validate proper diagnosis and procedure code combinations and Medicare coverage.

Icon	Description
	<p data-bbox="334 275 732 306">Opens the Follow Up visit slider.</p> <p data-bbox="334 344 1409 501">The Follow Up slider requires structured charting information. Therefore, this icon is specific to Full Note Composer and other clinical note type windows that use structured charting information. The Follow Up slider cannot be used in Superbill Composer and other clinical note type windows that do not use structured charting information.</p>
	<p data-bbox="334 537 1406 695">A common problem palette is a set of information, such as diagnosis, prescription, services performed/ordered that may reoccur frequently enough to package the information into a group, or palette. The Palette button lets you choose a previously saved Common Problem Palette that you can use unchanged or edit, if necessary, for individual charts.</p> <p data-bbox="334 737 1409 894">Common problem palettes require structured charting information. Therefore, this icon is specific to Full Note Composer and other clinical note type windows that use structured charting information. Common problem palettes cannot be used in Superbill Composer and other clinical note type windows that do not use structured charting information.</p>

General Toolbar

Icon	Description
	<p data-bbox="334 1094 1357 1188">Each of the tabs in the FNC has a description area. When multiple entries are included, this area may be difficult to view. Use the Max button to maximize the description area while you review the information.</p>
	<p data-bbox="334 1224 1414 1318">When the Max button increases the size of the description area, it hides much of the other information on the tab. Use the Min button after you have reviewed the information to minimize the description area.</p>
	<p data-bbox="334 1354 1403 1512">Clear All gives you the option of deleting all information from the tab you are using. This may also delete information on other tabs, if that data is dependent on information in the current tab. For example, if you enter data into Vitals, CC, and HPI, then Clear All from CC, this will not affect the Vitals data, but will clear the HPI information, as that is dependent on the entry in CC.</p>
	<p data-bbox="334 1549 1414 1738">Opens the Evaluation & Management window in which you can define the superbill information and add a procedure code for the visit to the patient chart. E&M counting requires structured charting information. Therefore, it is available in Full Note composer and other clinical note type windows that use structured charting. It is not available in Superbill Composer and other clinical note type windows that do not use structured charting.</p>
	<p data-bbox="334 1776 1373 1835">The PQRS tab of the Evaluation & Management window has been removed from the application.</p>

Icon	Description
	When you have added a diagnosis (via the Dx tab), and services performed or ordered (via SP, SO), you must associate the diagnoses with the appropriate procedure codes before the superbill can be generated. You can complete this association in the superbill itself, or you can perform the association from the SP or SO tab by selecting the Dx Association button.
	Opens the Vaccine Administration Record for the patient.
	Previews a summary of the patient chart and any attachments that have been linked to the chart, which you can use to review the contents of the chart and subsequently print.
	Performs drug screening.
	Imports information from a patient questionnaire. This icon is available only if a patient question has been received.
	Accesses the Import Medication Hx window which enables you to import into the patient's history all or part of the downloaded medication history for the patient.
	Accesses the Download e-Med Hx window which enables you to download the patient's medication history from the Surescripts pharmacy clearinghouse. You can request a medication history only one time in a patient visit note. Once you download the medication history during a visit, this icon is disabled.
	Downloads the patient's prescription benefits information from the pharmacy clearinghouse.

Dictation Toolbar

This series of icons enables you to include dictation in the note. Start, stop, replay, and delete a dictated note. The text changes to reflect the current tab, that is, stand alone for Vitals (dictation is not available to associate with vital signs), CC for Chief Complaint, Hx for History tab etc.

Icon	Description
	Record
	Stop
	Play
	Delete recording

Tabs

Tabs are an integral part of the Full Note Composer (FNC), Superbill Composer (SBC), and other clinical note type windows. Tabs enable you to enter patient information for specific areas of the patient chart. Many tabs are available in both the FNC and SBC windows. However, some tabs are specific to one window or the other. Any tab may be included in any custom clinical note type created for your practice.

The following table gives a high-level overview of each system-defined tab. It also indicates those tabs that are specific to FNC, SBC, or another clinical note type window. The tabs and their functionality are further explained in the following sections.

Tabs are listed in the table in the following order:

- Tabs that are included in FNC are listed first, and are listed in the order in which they appear in FNC. These are the most commonly used tabs. They appear in FNC in the order mostly commonly used to chart most patient visit notes.
- Tabs for special purposes are listed second, and are listed in alphabetical order.

Custom clinical note type windows may include custom-defined tabs created specifically for your practice. Custom-defined tabs enable you to enter any information needed by your practice not otherwise entered in the application.

In most tabs, you can use the vertical and/or horizontal splitter bar to change the size of the display. Simply select the splitter bar and drag it to the desired location.

Tab	Description
Vitals (Vital Signs)	<ul style="list-style-type: none">• Enter relevant information regarding patient vital signs: weight, height, temperature, heart rate, blood pressure, etc.• For a child or young adult, you can chart the patient's height and weight using Growth Charts.• Graph vital signs and lab results.• Vitals are included in the Evaluation & Management (E&M) calculation for the visit.
CC (Chief Complaint)	<ul style="list-style-type: none">• Enter the patient's chief complaints (CC) and any associated symptoms.• CC categories may be customized for your specific practice, care team, or individual provider.

Tab	Description
<p>HPI (History of Present Illness)</p>	<ul style="list-style-type: none"> • History of present illness (HPI) relates to chief complaint. This tab displays the information from the systems list that you input in the CC tab; you can add qualifying information, such as quality, onset of symptoms, etc. • HPI categories may also be customized for your practice, care team, or for individual providers. • HPI is scored for the E&M calculation.
<p>Hx (Patient History)</p>	<ul style="list-style-type: none"> • The History tab relates to patient history, and includes sections for infection and surgical history, family and social history, allergies, etc. • When saved, this information is included in any new notes that are created for the patient on subsequent visits. • When a note is completed, Dx and Rx information from the current note are included in the Hx tab of any new notes that are created for the patient. • The questions and answers associated with the Hx tab may be customized.
<p>Results</p>	<ul style="list-style-type: none"> • Displays resulted but not yet approved lab test results. • Enables you to review the results of tests you ordered prior to the patient's visit and any the results of any unsolicited test received for the patient. • The tab is similar to the Patient Results window and message.
<p>ROS (Review of Systems)</p>	<ul style="list-style-type: none"> • Review of Systems includes a review of a minimum number of body systems. • ROS is one of the requirements for the History section of an Evaluation and Management code, and so is an important component of billing. • You cannot edit the names of systems in ROS, although you can edit symptoms.
<p>PE (Physical Exam)</p>	<ul style="list-style-type: none"> • Select the type of exam you are performing, then add the findings for each system. The components of each system may vary, depending on the type of exam selected. • Systems and symptoms may be customized for your practice.
<p>Dx (Diagnosis)</p>	<ul style="list-style-type: none"> • Enter the patient diagnosis.

Tab	Description
Rx (Prescription)	<ul style="list-style-type: none"> • Add the prescription for the patient and specify the dosage and how administered. A listing of all drugs is stored in the drugs database. • Use predefined SIGs for the prescription if these have been defined. • Review allergy, medication, and medical history. • Check for drug interaction.
SP (Services Performed)	<ul style="list-style-type: none"> • Select procedures from the customized list of services that have been predefined in your database. • Services performed are those services that are available from within your own office (i.e., not an external site), and for which you bill directly. • You can also add the procedure code for the patient visit. If you know the code, you can add this to the SP tab, or you can use the E&M window (via the E&M icon) to automatically add the appropriate visit code to SP. Note: The E&M window will automatically add codes for regular office visits and consultations. Other visits, such as a well woman visit, must be added manually to SP. • You can associate the services performed with the diagnosis via the Dx Association icon. You can make the associations on this window, or wait and make the associations in the superbill.
SO (Services Ordered)	<ul style="list-style-type: none"> • Select Services Ordered from the customized list of services that have been predefined in your database. • Services Ordered are those services that are not available from within your own office, or for which you are sending the patient to an external facility. You cannot bill directly for SO. • You can associate the services ordered with the diagnosis via the Dx Association icon.
Plan (Plan)	<ul style="list-style-type: none"> • Add information such as a return visit, or diet and exercise requirements. • Add specific patient instructions, notes, and internal notes as needed.

Tab	Description
Visit Text	<ul style="list-style-type: none"> • Displays the information from the current patient visit note as it appears in Review Past Notes. • Following each tab section of the visit note is an Editable Comment field where you may enter additional text that will be stored in the Notes field of the appropriate tab. • You can format the font, size, and appearance of the text. • Select the Refresh button to refresh the text with any changes made in other tabs.
Assessment Form	<p>This tab is not included by default in any system defined clinical note type.</p> <p>Select and complete a specific assessment form. The application includes several system-defined assessment forms. Your administrative super user may have defined additional custom assessment forms.</p>
Care Planning	<p>This tab is not included by default in any system defined clinical note type.</p> <p>Enter textual information into any of the following fields. This information may be needed for PCMH or similar programs.</p> <ul style="list-style-type: none"> • Patient preferences and functional/lifestyle goals • Treatment goals • Potential barriers to meeting goals • Strategies for addressing potential barriers to meeting goals • Self-care plan
Case Mgmt (Case Management)	<p>This tab is automatically included in any clinical note type window when the visit note is associated with a patient case.</p> <p>Enter information into the case depending on the status of the phase and module that is current for the case. For example, for the first trimester pregnancy case type, calculate the estimated date of delivery based on the criterion that you prefer to use.</p> <p>Note: You cannot include or exclude this tab in your custom visit note window. This tab will appear in all visit note windows when a patient case is associated with the visit.</p>

Tab	Description
CC/HPI Notes (Chief Complaint/History of Present Illness)	<p>This tab is used in Superbill Composer instead of the standard CC and HPI tabs.</p> <ul style="list-style-type: none"> • Enter progress notes about the patient's chief complaint, symptoms, and history of present illness. • You can enter text by selecting a general note, typing directly into the notes field, or by using the stylus to write or draw in the notes field. • You can enter and select from reusable general notes in the left pane.
CDS	<p>This tab is included in FNC by default if your practice is licensed for Persivia™ CDS and education forms. It may be added to any other clinical note type. The tab is functional only when your practice is licensed for Persivia.</p> <p>This tab displays the clinical decision support report received from the Persivia™ website. The report contains a list of recommendations and a list of alerts for applicable rules. The alerts section enables you to select one or more recommended procedure codes to the patient visit note.</p> <p>You can:</p> <ul style="list-style-type: none"> • Select the desired CDS rule Catalog. • Select the Refresh Decision Support button to request a report. The report will appear in the tab once your request has been processed. Information is loaded from the Persivia site so it may take a moment to populate. • In the References column, select a hyperlink to access the Persivia site for additional information. Then use the Back button to return to the CDS report. • Select one or more recommended services. <ul style="list-style-type: none"> • Select the SP checkbox for a procedure you will provide to the patient. • Select the SO checkbox for a procedure you will order for the patient. • Select the Process Selected Recommendations to add the selected items to the visit note.
Confidential	<p>This tab is not included by default in any system defined clinical note type.</p> <ul style="list-style-type: none"> • Enables you to enter confidential comments in a patient visit note. Information entered in the Confidential tab can only be accessed by those users to whom you have explicitly given permission. • Information is entered as unstructured text.

Tab	Description
CPP (Common Problem Palette)	<p>This tab is not included by default in any system defined clinical note type.</p> <p>This tab enables you to select a common problem palette, and to use it to chart a patient visit. The tab is similar to the Common Problem Palette window.</p>
DSM Dx	<p>This tab is similar to the Dx tab expect that it enables the you to enter the patient's global assessment of functioning (GAF) score, as well as the patient's diagnosis.</p> <ul style="list-style-type: none"> • Included in the DSM Full Note Composer clinical note type by default. • You may also include the DSM Dx tab in custom clinical note types if desired.
General Note	<p>This tab is included in the General Note clinical note type.</p> <p>This tab uses the general Note functionality. You can enter text or select from standard text notes that you have created. This tab does not include general notes entered on the CC and PE tabs, if included in the visit note.</p>
General Note CC	<p>This tab is included in the General Note CC clinical note type.</p> <p>Uses the general Note functionality. You can enter text or select from standard text notes that you have created. This tab also includes general notes entered on the CC and PE tabs, if included in the visit note.</p>
Observation	<p>This tab is not included by default in any system defined clinical note type.</p> <p>This tab enables you to enter and view observation findings in patient visit note using a simple flowsheet view. In the Observation tab, you can select one or more observation templates containing the observation items which you are monitoring for the patient.</p>
ROS/PE Notes (Physical Exam)	<p>This tab is used in Superbill Composer instead of the standard ROS and PE tabs.</p> <ul style="list-style-type: none"> • Enter progress notes about the review of systems and physical exam. • You can enter text by selecting a general note, typing directly into the notes field, or by using the stylus to write or draw in the notes field. • You can enter and select from reusable general notes in the left pane.

Tab	Description
Single CPP	<p>This tab is not included by default in any system defined clinical note type.</p> <p>This tab may be copied so that the copy can then be associated with a specific common problem palette (CPP). The tab can then be used to chart a patient visit using that CPP.</p>

Sliders

Sliders provide additional functionality for the Full Note Composer and other clinical note type windows. You do not need to use the sliders to complete a patient visit note, but the extra functionality may streamline and expedite your workflow.

Slider	Description
Attachments	Attach scanned images, results, or voice notes to a patient chart.
Dictation	Dictate notes for one or more of the tabs on the patient chart.
Numeric Keypad	Provides an easy way to enter data into numeric fields. The Number Pad is only active when you have focus on a numeric field.
Calendar	Enter dates into a patient chart. The Calendar slider is only active when you have focus on a field that required a date.
Clinical Decision Support	Apply clinical decision support rules to alert for follow up visits, patient tests, etc.
Visit Information	<p>Displays Provider and Site information for the patient visit. If a patient case is selected in this slider, the case management tab will display in the Full Note Composer.</p> <p>If you have the necessary security access, you may associate the patient visit note with an appointment or change the appointment to which it is associated.</p> <p>When another person, such as parent, provides information on behalf of the patient, you can identify the historian's role and relationship to the patient.</p> <p>Displays the electronic signature of the rendering provider once the patient visit note has been completed.</p>

Slider	Description
Rx Summary	Displays allergy, active medication, and medical history information. You or your administrative super user can add frequently ordered procedures to the Rx Summary slider that appears in Full Note Composer and other clinical note type windows. This is an easy one-click way to place the order.
Education Forms	Enables you to search for and select education forms from any tab in the window. May display education forms associated with a case.
HPI Category	Provides a checklist of categories for E&M calculations. This slider is only available in FNC and only when you are using the HPI tab.
Follow Up	Re-use patient information from a previous visit, and indicate status (e.g., improved, worsened). This slider is only available in FNC.

Customize Sliders

You can select which sliders you want available for easy access. Please note that not all sliders are defined for all clinical note type windows. You can only display those sliders are defined as part of the clinical note type window you are using.

1. View →Sliders
2. Select the desired slider to display it in the clinical note type window.

Using Sliders

- Open a slider by selecting the slider: move the mouse over the slider, or select the tab with the stylus. The slider will close if you move focus back to the FNC or SBC.
- Lock a slider in position by selecting the push pin. The pin changes from horizontal to vertical when the slider is locked; the slider is locked in position, that is, the information on the tab is moved to accommodate the slider.
- Move (float) the slider to any position on the window. First lock the slider, then select the title bar and drag the slider to the required position. At this point it may float, i.e. it is not necessary for the slider to be attached to the FNC or SBC tab. This allows you to review the slider while viewing different tabs. You may find this useful for dictating notes (using the Dictation slider) while reviewing other content in the FNC or SBC.
- Dock the slider on any side of the window by selecting the title bar and dragging the slider to the location you require. To make it easy to dock the slider, move the title bar over one or the displayed arrows (, , , ) that pops up as you move the slider. The slider will dock on the side indicated by the arrow.
- Unlock a slider by selecting the pushpin. The pin changes from vertical to horizontal. When the slider retracts, it remains on the side of the window on which it was docked.

Visit Types

There may be times when reviewing a patient's chart in One Page Summary or Review Past Notes that you do not wish to see all the available patient visit notes. Visit Types enable you to identify specific types of patient visit notes. Options for One Page Summary and Review Past Notes enable you to identify the types of patient visit notes you want to include for review.

There are five visit types. One is the standard visit type that is the default for most visit notes. Two types can be set by users, two can only be set by the application when a visit note is automatically created. Once a visit type is assigned to a patient visit note, it cannot be changed. The visit types are:

- **Lab Visit:** This visit type is assigned to visit notes created automatically when an unordered lab result is received electronically.
- **Private Visit:** This visit type can be assigned to a patient visit note at any time. You can use this visit type on any patient visit note, but it is most frequently used for visits that include sexual activity information on a minor. This enables you to keep this information confidential with the patient and not shared with the patient's parents. All provider and non-provider users with access to patient visit notes can access private visit notes. (To restrict user access to some or all of the information in a visit note, use either the confidential information functionality or the restricted visit note functionality.) Private visits are not available on the Patient Portal when the Portal user is the responsible party, rather than the patient.
- **Refill Visit:** This visit type is assigned to visit notes created automatically when a prescription is refilled from a refill request message.
- **Standard Visit:** This is the default visit type. It is assigned to all patient visit notes created by users. Visit notes with this type are always included in One Page Summary and Review Past Notes.
- **Strike Out:** This visit type can be assigned only to completed patient visit notes. Use this visit type to indicate that an entire visit note is not valid (for example, it was created and entered for the wrong patient). Striking out the visit note does not, however, strike out the details entered in the note. In the visit note, you must strike out each problem or diagnosis, prescription, and vaccine entered and you must strike out problems, medications, and vitals entered into the patient history in this visit note.

Procedures and diagnoses in the struck out visit will not be used to compile the patient's most frequently used lists in Full Note Composer.

When a visit note is given the visit type strike out, then any attachments on that visit note are also struck out.

Note: Visit types are a clinical function, not a practice management function. As such, there is little connection between the assignment of a visit type to a visit note and the behavior of the subsequent superbill for that visit note.

Changing the Visit Type on a Patient Visit Note

When necessary you can change the visit type on a patient visit note to Private Visit or Strike Out.

1. Full Note Composer or other clinical note type window → Visit Information slider
2. In the Visit Type section, select the radio button for the desired visit type.
 - Private Visit: This visit type can be assigned to a patient visit note at any time. You can use this visit type on any patient visit note, but it is most frequently used for visits that include sexual activity information on a minor. This enables you to keep this information confidential with the patient and not shared with the patient's parents.
 - Strike Out: This visit type can be assigned only to completed patient visit notes. Use this visit type to indicate that an entire visit note is not valid (for example, it was created and entered for the wrong patient).
3. Use the Reason For Type note field to explain the reason is the visit type has been assigned. This field is required.

Automatic Saving of Data in a Visit Note

Because the diagnosis information entered into a visit note is needed to enter other aspects of the visit, such as the diagnosis plan, the application automatically saves the diagnosis code when you enter one in a visit note. This saves the diagnosis code as an active diagnosis in the visit note and in the patient's problem/diagnosis history.

When you enter a general note in the Plan Information field in the NOS diagnosis plan in the Plan tab or in the classic Plan tab, then application automatically saves that general note.

These items of information are saved in the visit note even if you have saved the entire visit note and all the information entered into it. Therefore, you must be cautious if you cancel out of the visit note without saving it.

Saving a Visit Note Saved by Another User

The application locks a visit note when the visit note or its associated superbill is open. In most cases, when a visit note that is locked because a user is using it, that visit note cannot be opened by another user. However, there are rare circumstances in which a visit note may be open by two users at one time. When a visit note is open by two users at one time, the first user to save the visit note is allowed to save in the usual manner. When the second user attempts to save the visit note, then one of two things will happen:

- If the second user is not a provider, then the application displays a message stating that the visit note has been saved by another user and that your changes will not be saved. All changes that you have made in the visit note will be lost when you close the visit note. You must then reopen the visit note, and re-enter your changes.

- If the second user is a provider, then the application displays a message stating that the visit note has been saved by another user, and asking if you want to overwrite that user's changes.
 - If you select Yes, then your changes to the visit note are saved. If you entered data in the same data field as the first user, then your data will overwrite the data the first user entered in that data field.
 - If you select No, then your data is not saved and all the changes that you made in the visit note will be lost when you close the visit note. You must then reopen the visit note, and re-enter your changes.

Addendums

When a completed patient visit note is changed, the change is marked as an addendum to the visit note.

By default, addendums do not appear in Full Note Composer, other clinical note type windows, One Page Summary, or Review Past Notes. Only the net results of all changes are displayed. The detail of original and changed entries is not displayed.

When you need to see all entries and changes to a patient visit note, then you must use Review Past Notes or One Page Summary with the settings defined to show addendums.

Warning Message when Editing a Completed Visit Note

Your administrative super user may have configured the application so that you will receive a warning message in Full Note Composer or another clinical note type window when attempting to edit a patient visit note that has been completed. This can be important if you typically open the patient's most recent visit note for review before starting the visit note for today's visit. This warning can help prevent you from accidentally adding information from today's visit into the old note as an addendum.

Patient Visit Note Workflow

This workflow shows the steps you need to perform to chart a patient visit note in Full Note Composer or another clinical note type window. The steps make reference to reusing information from previous visits, but for follow up visits you may want to enter data via the Follow Up slider.

Charting a patient visit note may actually be performed by more than one user during the course of a patient visit; however, there are security limitations on concurrent use. More than one user may view a patient's notes at the same time, but only one person at a time can access a note to create or update the information.

You can add free text notes to any of the tabs in the window. You can also use the general Note window to enter notes and comments for individual line items in any of the tabs. To enter a line item note, select the note icon () on the line for the desired entry. The Notes window enables you to create and save comments and notes for re-use. Notes for line items in Full Notes Composer do not use rich text format (RTF).

At any point, you can use the sliders to add and review supplemental information. For example:

- Add attachments
- Review and update clinical decision support rules from the Clinical Decision Support slider
- Select an print education forms for the patient
- Add voice notes for specific tabs or for the whole visit note
- Review the text of the visit note

Begin a New Visit Note

Begin a Visit Note from an Appointment

1. From the Desktop or Scheduler, select the note icon () by the patient name or appointment.
2. The Full Note Composer (FNC) or other clinical note type window opens at the Vitals tab or to the tab defined as your default.

Note: If there is already an incomplete note open for the patient, you will see a prompt allowing you to select the incomplete note or open a new note.

Begin the Visit Notes from a Group Appointment

A group visit is one in which two or more patients are seen at the same time. When you initiate a visit note for a group visit, you can enter information about the visit that is common for all the patients. Then the application creates an individual patient visit note for each patient. All of the individual patient visit notes include the common information that you entered when you initiated the visit notes. Please note that attempting to create visit notes by using the New Visit note icon may cause the application to shut down if the group includes more than 10 patients.

It is important to understand that there is not a single visit note for the group.

1. From the Desktop or Scheduler, select the note icon () by the appointment. This accesses the Group Visit window.
2. In the Group Visit tab:
 - a. Select the Billing Provider.
 - b. Select the Rendering Provider if different than the billing provider.
 - c. Select the Service Site at which the visit is performed.
 - d. Select the Supervising Provider, if appropriate.
 - e. Modify the Date of Service, if needed. This defaults to today's date.

- f. Select the Financial Center, if other than the default.
 - g. In the Visit Information area, enter information about the session objectives for the visit.
 - Type directly into the text field if desired.
 - Select the Session Objectives hyperlink to access the general Notes window where you can select a predefined session objectives note.
 - h. In the Target Comments field, select the clinical note type window tab in which you want the session objectives to appear. The session objectives text will appear in the Notes field of the selected tab.
3. Select the Group Patients tab to view the patients and their appointment status.
Patients are listed by name, with their individual appointment status, and their accounts.
 4. If desired, change the appointment status for individual patients or for all the patients.
 - For an individual patient, select the desired Appointment Status next to the patient's name.
 - For all patients, select the Appointment Status field at the bottom of the window, and then select the Set Status – All button.
 5. Select the OK button to open individual clinical note type windows for each of the patient visit notes.

Begin a Visit Note from Patient Demographics

1. Patient Demographics → New → Full Note Composer or other clinical note type window
If there is already an incomplete note open for the patient, you will see a prompt asking if you wish to continue to original note. Either select an existing note or select the New button.
2. In the Visit Information window:
 - a. Select the Billing Provider. The billing provider identified on the visit note is the provider who bills for the service. The billing provider will be identified as the rendering provider on the claim.
 - b. Select the Rendering Provider if different than the billing provider. The rendering provider identified on the visit note is the provider who performs the service. The provider identified as the rendering provider on the visit note is not identified on the subsequent claim.

The Billing and Rendering Providers may be the same person or different people. For example, a physician may be both the billing provider who bills for the service and the rendering provider who performed the service. Or a physician may be the billing provider who bills for the service, but the rendering provider is a nurse practitioner who performed the service, but who cannot bill. (Remember that the provider identified as the billing provider on the patient visit note and superbill is identified as the rendering provider on insurance claims. The provider identified as the rendering provider on a patient visit note and superbill does not appear on the subsequent claim.)
 - c. Select the Service Site at which the visit is performed.
 - d. Supervising Provider: Use this field to enter the Supervising Provider if needed. When a supervising provider is identified, the supervising provider's information will be included in any printed prescription format that requires a supervising provider.

- e. Enter the insurance payer's Authorization Code, if applicable.
- f. Select a Referring Provider, if appropriate. This is the provider who referred the patient to you. If entered, the referring provider will be used in the insurance claim.

The Referring Provider field will populate automatically when a referring provider relationship exists for the patient. Please see the Referrals, Referral Tracking, and Patient/Provider Tracking section of the *General User's Guide* for more information.
- g. Enter the Referring Date, if appropriate.
- h. Select a Patient Case, if appropriate.
- i. Modify the Date of Service, if needed. This defaults to today's date.
- j. Enter an Appointment Date, if appropriate.
- k. Select the Financial Center, if other than the default. The financial center defaults to the financial center associated with the rendering provider, if defined. If the rendering provider is not associated with a financial center, then it defaults to the financial center associated with the billing provider. If the billing provider is not associated with a financial center, then it defaults to the financial center associated to the service site.
- l. Select the patient insurance Account to be associated with the patient visit.
- m. Select the Require Superbill checkbox if you want to create a superbill from the visit note.
- n. In the Visit Type section, select the Private Visit radio button when applicable.
- o. Use the Reason For Type note field to explain the reason is the visit type has been assigned. This field is required.

Canceling a Visit Note

There may be times when you want to cancel out of a patient visit note without saving the work you have done. In basic terms, canceling discards anything entered into the visit note since it was last saved. However, it is important to remember:

- The application automatically saves the entire visit note when you perform certain actions, such as printing or electronically submitting a prescription, send a lab order, and clinical claim scrubbing.
- The application automatically saves certain information in the visit note when you enter it. This includes the diagnosis, diagnosis history, and diagnosis plan comment.

Therefore, if you decide to cancel out of a visit note, you must ensure that the resulting visit note contains all the information it should, and none of the information you want to discard.

When a visit note has been previously saved by a user, either you or another user, then the diagnosis codes, diagnosis history, and diagnosis plan information in the visit note are saved once you enter them, even if you cancel out of the visit note without saving any of your other entries. When a visit note has not been previously saved by a user (that is, it is a completely new visit note), then no information is saved if you cancel out of the visit note.

The following process is recommended for cancelling out of a visit note and discarding information entered since the last full save of the visit note.

1. Full Note Composer (FNC) or other clinical note type window
2. Select the Cancel button to exit the visit note without saving.
3. One of the following popup messages will appear, depending on the conditions of the visit note.
 - "Are you sure you want to close this note? All unsaved data will be lost."

This message means that the application can completely discard all the information entered in the visit note since it was last saved.

 - Select the Yes button to close the visit note and discard all the information entered since the last save.
 - Select the No button to return to the visit note and continue working.
 - "The following tab changes have already been saved. *[List of items]* Are you sure you want to close this note? All other saved data will be lost."

This message means that the application has already saved some of the data you have entered. You must delete this data before cancelling.

 - a. Select the No button to return to the visit note.
 - b. Select the Dx tab, and delete any diagnosis codes charted since the visit note was last saved. (This removes the diagnosis from the patient history as well.)
 - c. Select the Plan tab, and delete the text entered in the Plans Note field of the NOS diagnosis plan (or in the classic Plan tab).
 - d. Select the Cancel button again. The same popup message will appear again because by deleting items you have made changes that the application has saved.
 - e. Select the Yes button in the popup message. This closes the visit note and discards all other information entered since the last full save of the visit note.
4. If the visit note had been previously saved, then it still exists. It is recommended that you open the visit note, and review all tabs to ensure that all the information entered is as it should be. If anything in the visit note is not correct, then either:
 - Make the necessary changes and save the visit note.
 - If you do not want to keep the visit note at all, you may delete the visit note by selecting the File menu, and Delete option. The application will only allow you to delete a visit note if it does not contain any information and no information from it has been disclosed outside the application in any way (for example, never been printed, used for a generated document, had an order sent, had a prescription printed or submitted electronically, etc.).
 - If you do not want to keep the visit note, but the conditions of the visit note will not allow it to be deleted, then you must save the visit note as complete and then strike it out.

Enter Vital Signs (Vitals Tab)

The Vitals tab enables you to record standard (those needed for E&M coding) and custom-defined vital signs by entering the measured data and adding qualifying information from the associated search fields. Standard vitals are entered in the left pane of the tab, and custom vitals are entered in the right pane. You can also enter overall notes, either by typing in the Notes field or by using dictation.

Once you enter vital signs, information appears in the title bar and footer of the window. The title bar displays the last set of vitals recorded.

List and Flowsheet Displays

You can display the patient's vital signs in the standard list format, or you can select the Flow checkbox to display them in flowsheet format. When displayed as a list, only vitals taken during the current visit are displayed. When displayed as a flowsheet, vitals from both the current visit and past visits can be displayed. Both formats can display either metric or U.S. standard values or both.

Values Above or Below Defined Maximum and Minimum

A vitals measurement that is above or below the defined maximum and minimum is displayed in red. A measurement within the maximum and minimum range is displayed in black. Note that vitals measurements cannot be tested against defined ranges unless the patient's birth date and gender are entered in the Patient Demographics. Maximum and minimum are not predefined. Your administrative super user must have defined these for the vitals measure.

E&M Count

The footer displays the E&M point count, which is updated when you enter data for the required categories. It is not necessary to enter data in all fields, but you should chart at least three vital signs for 1997 E&M bullet counting. Some specialties may require additional vital entries for E&M counting.

Observation Templates

Providers who wish to enter multiple instances of blood pressure or heart rate measurements may do so by including these items in the new custom vitals area of the tab. Your administrative super user or you, if you have the necessary security access, can add this or other custom vital signs to your vitals default template.

If you have selected a vitals template, the selections on that template will default on the Vitals tab.

Blood Pressure Percentile for Pediatric Patients

The blood pressure percentile can be calculated for pediatric patients (through age 17). The application calculates the blood pressure percentile using the patient's height, weight, and blood pressure. The blood pressure percentile is displayed in the Vitals tab when you use an observation default setting definition that is defined to display the units with the percentage.

The blood pressure percentile calculation is based on the National Institutes of Health (NIH) blood pressure tables for children and adolescents. These tables are available on the NIH website at http://www.nhlbi.nih.gov/guidelines/hypertension/child_tbl.htm.

<<Revised>> Procedure Codes for Blood Pressure

The add-in utility Blood Pressure Note Processor enables the appropriate systolic and diastolic blood pressure measurement procedure codes to be automatically added to a patient visit note when you enter the patient's blood pressure. These procedure codes are used for MIPS and other quality reporting programs.

The application charts the appropriate systolic and diastolic blood pressure measurement procedure codes on the SP tab. You may need to reorder the codes entered on these tabs after you have entered all the codes for the visit.

Please refer to the online Help for the specific procedure codes used.

<<Revised>> Procedure Codes and Diagnosis Codes for Body Mass Index

The add-in utility Body Mass Index Note Processor enables the appropriate body mass index (BMI) diagnosis code and the appropriate BMI documented procedure code to be automatically added to a patient visit note when you enter the height and weight for patients two-years old and older. These diagnosis and procedure codes are used for MIPS and other quality reporting programs.

The application charts the appropriate body mass index diagnosis code in the DX tab and the appropriate BMI documented procedure code in the SP tab. You may need to reorder the codes entered on these tabs after you have entered all the codes for the visit.

The BMI procedure codes identify the range which includes the patient's BMI. The BMI procedure codes also specify that a follow-up plan has been documented when the patient's BMI is above or below normal. If your practice is using this add-in utility to enter procedure codes, then you must ensure that you are properly documenting a follow-up in the visit note or that you remove the BMI procedure code from the visit note.

Please refer to the online Help for the specific diagnosis and procedure codes used.

Height, Weight, and BMI Percentages

Percentages shown for height, weight, and BMI are from the standard for Disease Control and Prevention (CDC) growth chart, not from World Health Organization (WHO) growth chart or any custom growth chart.

Enter the Vitals

1. If desired, select a set of Defaults using the Find button.
2. To enter metric values, select the Metric Entries Mode checkbox. To enter U.S. standard values, deselect the checkbox. Weight, height, and head circumference are shown as the selected value type in the data entry fields, and as the other value type to the right of the date entry fields. Metric mode also changes temperature from Fahrenheit to centigrade.
3. Select the Flow checkbox to display as a flowsheet.

4. Enter vital signs, adding qualifiers where necessary. For example, to indicate whether weight was measured clothed/unclothed, or blood pressure was taken manually or electronically.

Note: Weight and height are used to determine the patient's body mass index (BMI), which in turn is used to determine if the patient is underweight or overweight. Some clinical quality measures related to the BMI require reporting on BMI and related consulting when appropriate. This reporting requirement can include that the patient refused either weight or height or both. To indicate that the patient refused measurement, select the Pt. Refused checkbox for weight or height.

5. If you wish to retake any of the Vitals within the same visit, select the New button. The review table or flow chart retains all the saved information, but entry fields are cleared. When you enter new data, the new data is listed in the description window, with newest information listed first, and the title bar is updated with the latest information.
6. Select the Save () icon to save the visit note.
7. To delete a set of vitals, highlight the set you want to delete and select the Delete () icon.
8. If desired, select the Growth Chart () icon to review the growth chart for babies and children. Please see the Growth Charts section for more information.
9. If desired, select the hyperlink for any vital sign or select the Graph () icon to graph vital signs and lab results. Please see the Graphs of Vitals and Lab Results section for more information. (Please note that the Weight and Height hyperlinks access the graphing functionality, not the growth chart functionality, even for pediatric patients.)
10. If desired, select the Printer () icon to print the vitals display.

Enter Using a Common Problem Palette (CPP Tab)

The CPP tab is an optional tab that you may have added to custom-defined clinical note type window. The tab enables you to select a common problem palette, and to use it to chart a patient visit. The tab is similar to the Common Problem Palette window available from the CPP icon (). Please refer to the Common Problem Palettes section for more information and instructions.

Enter Chief Complaint (CC Tab)

Enter the Chief Complaint (CC), or reason for the patient visit. This tab is used to reflect information that the patient provides. You can enter multiple chief complaints.

Your administrative super user may associate a chief complaint with a diagnosis code. Then when you select that chief complaint, the application adds the associated diagnosis code to the Dx tab.

When a visit note is created from an appointment, the appointment type and reason are displayed in this tab.

1. Select the CC tab.
2. Select a Chief Complaint. Select:
 - The Most Frequently Used section, which is the first entry in the list of systems, provides a list of the Chief Complaints used most often by the Provider, sorted alphabetically. Select from this list if relevant.
 - By entering the first one, two or any number of characters of the system name in the System entry field. This will highlight the first term that begins with the letters you have entered, and provides an easy way of scanning through a long list of systems.
 - Using the search field to find a specific symptom, by entering all or part of the required word in the search field (e.g. headache, head). This will display a list of systems that contain the term.
3. Select the system. The list of symptoms changes to reflect the selected system.
4. Select the relevant symptoms.
5. The selected system and symptoms are displayed in the CC description area.
6. Add notes to any of the symptoms as necessary by selecting the notes field alongside the symptoms you want to annotate. You can also select the notes icon () to access the Notes window where you can select predefined notes.

Enter History of Present Illness (HPI Tab)

Define the history of the present illness. This reflects information provided by the patient.

Where you enter a time qualifier (e.g., 2 months ago), it is recommended that you add the actual date in the note field against the symptom. For example, add June 2005 as a note. As dates are not updated in the FNC, if you only enter 2 months ago, you will always have to check the date that the note was created to establish the timeline.

The entries displayed in the HPI tab may be customized for your practice, or for specific care teams and/or providers. Define customized entries via List Editor or from the HPI tab by selecting any of the hyperlinked headings: Category, Symptoms, Triggers, etc.

Your administrative super user may associate an HPI description item with a diagnosis code and/or procedure code. Then, when you select the history category and description item in a

patient visit note, the diagnosis code is added to the DX tab and the procedure code is added to the SP tab.

The HPI slider is a CMS list of recommended categories for E&M scoring for the type of complaint you are referencing. You can use it as a checklist of the items that should be reviewed. The HPI slider is available only on this tab.

The footer on the window lists the E&M points you have charted. One point is earned for charting the history of the present illness, whether for one or more chief complaints.

1. Select the HPI tab.
2. The Symptom pane lists the chief complaints that you have already entered.
3. Highlighted each of the chief complaints, and then select associated symptoms from either the provider's frequently used list or the symptoms list.
4. Select qualifiers to each of the symptoms
Each category has its own qualifying information. For example, for the Quality category, qualifiers are items such as Acute and Chronic. For the Onset and Resolution, and Onset of Symptoms categories, the qualifiers are Severity and Length of Episodes.
5. Add notes to any of the qualifiers as necessary by selecting the notes field alongside the symptoms you want to annotate. You can also select the notes icon () to access the Notes window where you can select predefined notes.

Enter Chief Complaint and History of Present Illness Notes (CC/HPI)

This tab enables you to enter the chief complaint and history of the present illness in a manner similar to writing a progress report. It is used instead of the CC and HPI tabs, rather than in addition to them.

- The left pane contains a list of the standard chief complaint and history of present illness notes that you have created.
 - To create a new note, select the New button. Then enter a Name and any general Notes you want to include.
 - To use a note, select it from the list. This adds the general note text to the right pane.
- Use the right pane to enter text regarding this patient and this visit. Standard text can be added by selecting a predefined note from the left pane, and by typing directly into the notes field. You can also use a stylus to write or draw in this area.

Enter Patient History (Hx Tab)

Define the patient's past, family, and social history. You may enter the history, or you may import patient history and review of systems questionnaires. Because questionnaires are dependent on the use of the knowledge database, review of systems questionnaires may be imported only from clinical note type windows that include the ROS tab. They cannot be imported from clinical note type windows that use the ROS/PE Notes tab.

- Where you enter a time qualifier (such as 2 months ago), it is recommended that you add the actual date in the note field against the symptom. For example, add June 2005 as a note. As dates are not updated in the FNC, if you add 'two months ago', you will always have to check the date that the note was created to establish the timeline.
- When entering any item in the patient history, you may enter an actual date or an approximate date. When you select the Approximate Date icon () , you can enter an approximate date or timeframe, such as Birth, Childhood, or number of days, weeks, or years ago. You can also enter free text. To enter an actual date, you must enter it in mm/dd/yyyy format or select the Calendar entry, and then select a date.
- The entries displayed in the History tab may be customized for your practice, or for specific care teams and/or providers. Define customized entries via List Editor or from the History tab by selecting any of the linked qualifier headings: Surgery, Timeframe, Allergen, and Reaction.
- The footer on the window lists the E&M points you have charted. See the Patient History and E&M Count section below for more information.
- You can add general notes to the chart, if desired.
 - Add notes that have been predefined in the system by selecting the Notes link.
 - Add voice notes via the voice icon or dictation slider. Transcribed notes are merged into the notes section.
 - Add free form text notes to the notes section or by selecting the notes icon ().
- Select the Delete () icon to delete an entry from the history.
 - When you delete an item in the patient's history, the item becomes inactive and is shown as struck through.
 - When you delete an item, a confirmation popup window is displayed. You can enter a reason for deleting or inactivating the item in the delete confirmation window. The reason then appears in the Notes column for the item.
 - Items that are entered into the patient's history, through either the Hx tab of a clinical note type window or the History window, may be deleted without record if you delete the item on the same day that it was entered, and, if entered in a visit note, the visit note has not been completed.

History Categories

Because of the nature of their contents, the different history categories behave in specific ways regarding making entries and making multiple entries of the same item. These differences are explained below.

- Address history
 - The patient's address history is maintained in both the Patient History and Patient Demographics.
 - You may enter previous addresses for a patient, if a historical record is needed, such as for a cancer registry.
 - You can identify an address in the patient's address history as the patient's birth place. The identification of birth place may be needed for a cancer registry, other specialty registry, or other reporting.

- Cognitive assessment history
 - This history category may be used to document assessment findings. Cognitive assessment finding may be included in CCDA documents.
 - The Cognitive Assessment history category does not include any system-defined questions or answers. In order for you to use this history category, your administrative super user must define history questions and answers for this category in the knowledge database.
- Diabetes history, Preventative Care history, Surgical history and custom procedure history categories
 - Use the Find Procedure Term field, the most frequently used procedure list, or the Find Procedure field to add items to the patient's history.
 - Procedure terms include predefined items in the knowledge database, and items added by your administrative super user or other users with the necessary access rights. Procedure terms may be associated with one or more procedures.
 - You may enter a problem or diagnosis more than once. To view each instance of a problem, select the procedure count icon.
 - Select the Perform Date column for an entry to enter the date or time frame for the procedure.
 - Select the Result Date column for an entry to enter the date or time frame for the results if the procedure is a test.
 - In the Result column, select the result if the procedure is test.
 - Select the Notes () icon to enter any notes, as desired.
 - The Order Date, Order Status, and Negation columns are populated from the order.
 - Select the Reorder Columns () icon to modify the column order and the width of individual columns in the Problem/Diagnosis history. You can also define whether the Notes column uses word wrapping.
- Family history
 - You can enter information for multiple family relationships when entering family history.
- Food, drug, and environmental allergies
 - If a patient's reaction to an allergen changes over time, you may either add the new reaction to the original entry for that allergen or you may make a duplicate entry of the allergen with the new reaction. You may want to enter an explanation in the Notes section when you change an entry or make a duplicate entry.
 - Drug screening is performed when you enter a drug allergy.
- Functional assessment history
 - This history category may be used to document assessment findings. Functional assessment findings may be included in CCDA documents.
 - The Functional Assessment history category does not include any system-defined questions or answers. In order for you to use this history category, your administrative super user must define history questions and answers for this category in the knowledge database.

- Genetic screening
 - You cannot enter an item more than one time. If you select an item that has already been entered in the patient's history, that item is deleted. (The deletion will appear as an addendum.)
 - Blood type is included in the OB Genetic and Infection Hx report.
- Immunization history
 - You may enter a vaccination in the immunization history any number of times, as long as the details for each entry are distinct.
 - Note that the Vaccination () icon used to access the Vaccine Administration Record is disabled when you are in the Immunization History category of the Hx tab. This is because the Vaccine Administration Record is already displayed and being used to enter historical information; therefore, it is not appropriate to access the Vaccine Administration Record to chart a vaccination given.
- Infection history
 - You cannot enter an item more than one time. If you select an item that has already been entered in the patient's history, that item is deleted. (The deletion will appear as an addendum.)
- Medication history
 - When entering the medication history, you can specify that the patient does not take any medications by selecting the Patient Takes No Medications checkbox. This option is available only when the patient does not have any active medications. 'Takes No Medications' is included in the OB Genetic and Infection Hx report.
 - One of the HHS's MIPS quality measures is whether you have reviewed the medications taken by a patient who has transferred to your care or who has been referred to you by another provider.
 - Select the Transition of Care checkbox when the patient has transferred or been referred to you. This checkbox may be selected automatically in some circumstances, such as when a document has been attached with a summary of care attachment type.
 - Then select the checkbox for Medication History. This checkbox will be automatically selected if you made any changes while reconciling the electronic medication history. If you do medication reconciliation from the Patient History window, then you must select this checkbox within Full Note Composer.
 - **<<Revised>>** Use the Filter () icon to select a medication history filter. The selected filter defines both the medications to be displayed and the sort order in which they are displayed. A filter can define up to a three-level sort order for the medications in a patient's history. The medications are then displayed in a tree structure which can be collapsed and expanded.
 - **<<Revised>>** Use the Add button to enter a drug in the medication history. You may enter a dispensable drug if enough information is available, or a drug name and route. Both the dispensable drug and the drug name and route provide enough information for drug screening.
 - You may enter a drug in the medication history any number of times, as long as the details for each entry are distinct.

- **<<Revised>>** Select the Action (🔍 🔍 🔍) icon for a medication to refill the prescription. Selecting the Refill option opens the Order Note window.
- **<<Revised>>** Select the Action (🔍 🔍 🔍) icon for a medication to discontinue, change, or delete the prescription. You may perform an action on more than one medication by selecting the checkboxes for the desired medications, and then selecting the Action icon in the column header.
- When you discontinue a medication that has previously been prescribed for a patient, you must identify why the medication is being discontinued (using a discontinue reason code) and the date on which the medication is discontinued. A medication is considered active through and including the date on which it is discontinued.
- When a medication is discontinued because of an allergic reaction, you may enter the patient's reaction.
- **<<New>>** When you discontinue a medication, you may also send a cancellation notice to the pharmacy.
- When a maintenance medication has passed its stop date and is due for a refill or needs to be discontinued, it appears in bold.
- **<<Revised>>** The Action (🔍 🔍 🔍) icon also enables you to access the medication Details and the PDR information. These actions can only be performed on one medication at a time.
- **<<Revised>>** When the medication entry is for a prescription in your database, then you can print or reprint the prescription from the Action (🔍 🔍 🔍) icon.
- Menstrual History
 - The last menstrual period (LMP) date must be entered and updated here in order to be used in a pregnancy case.
- Problem/Diagnosis history
 - Use the Problem field, most frequently used problem list, or Diagnosis field to add items to the patient's history.
 - Problems include predefined items in the knowledge database, and items added by your administrative super user or other users with the necessary access rights. Problems may be associated with one or more diagnoses.
 - When a patient's diagnosis is associated with a medical problem, then the problem is included in the problem list. Select the View button in the Related column to view all the diagnoses associated with the problem.
 - A patient's diagnosis that is not associated with any medical problem is listed separately.
 - You may enter a problem or diagnosis more than once. To view each instance of a problem, select the Problem History icon (📄).
 - Select the Onset column for an entry to enter the date or time frame for the onset of the problem or diagnosis. This defaults to the visit date on which the problem was first entered.
 - Select the Resolved column for an entry to enter the date or time frame for the resolution of the problem or diagnosis.

Entering a resolved date changes the status of the entry to Inactive. This will change the entry's order in the list if your medical history filter sorts entries by status.

- In the Status column, select the current status of the problem.
This will change the entry's order in the list if your medical history filter sorts entries by status. Predefined statuses are Active, Chronic, Resolved, and Inactive. Your administrative super user may have created additional statuses.
- The Provider column displays the name of the provider who added the problem or diagnosis to the history or who charted the diagnosis in a patient visit note. If desired, you may also select a provider for a problem or diagnosis reported by the patient.
- Select the Notes () icon to enter any notes, as desired.
- The Last Dx Date is the date the most recent entry was made in the history or charted in a patient visit note.
- The HCC column displays the diagnosis code's HCC score, if assigned. CMS assigns HCC scores to chronic diseases, such as diabetes and kidney disease, which are costly to treat. Higher scores indicate a higher cost to treat.
- The Total HCC is the total of the HCC scores for all active diagnoses in the patient's history.
- You can define medical history filters to specify how you want to display this information.
- To indicate that the patient has no known medical problems, select the *Denies Any Medical Problems entry from the top left list of problems.
- Select the Reorder Columns () icon to modify the column order and the width of individual columns in the Problem/Diagnosis history. You can also define whether the Notes column uses word wrapping.
- Social history
 - You cannot enter an item more than one time. If you select an item that has already been entered in the patient's history, that item is deleted. (The deletion will appear as an addendum.)
 - You can enter changes to the patient's social history by entering information in the Notes section. For example, if the number of children in the patient's household changes over time, you can indicate the change and the date in the Notes section.
- Specialty Q&A
 - You may enter the gestational age of a premature baby in the medical history. Once entered, the gestational age will be used to adjust the baby's age when plotting data on a growth chart. Enter the gestational age at birth in weeks and days. For example, if the gestational age was 30 weeks and 5 days, it will appear as "30 5/7 weeks".
- Vital history
 - Displays all vital sign measures entered in patient visit notes or through the history in flowsheet format.
 - The standard vitals (those needed for E&M reporting) are displayed by default.
 - Additional vital signs included in the observation default setting will be displayed when available. A different observation default setting may not display all the data that has been captured. That data is still available in the patient's chart; it is simply not displayed if the observation default setting does not include it.

- Measure entered through the history can be edited. Entries made through patient visit notes cannot be edited.

Patient History and E&M Count

Entries in the history affect the point counted for E&M. There can be a maximum of three points for history. Points are determined as follows; selecting more than one item in the following categories does not increase the points.

- One point for Family History, either Family or Genetic Screening
- One point for Social History, either Social History or Specialty Q&A
- One point for Past Medical History, either Medical History, Infection History, Surgical History, Medication History, Food Allergy, Drug Allergy, Environmental Allergy, Immunization History, Menstrual History, or Pregnancy History

Premature Baby’s Gestational Age

You can enter a premature baby's gestational age in the Specialty Q&A history. The gestational age can then be used to adjust the baby's age when plotting on a standard growth chart. To enter the gestational age, select the Gestational Age entry from the Question column. Then enter the gestational age at birth in the Answer column. Enter any additional days in the gestational age. This will result in a number of weeks and a fraction of a week. For example, if the gestational age was 30 weeks and 5 days, it will appear as “30 5/7 weeks”.

<<New>> Procedure Codes for Alcohol Misuse

The add-in utility Alcohol Misuse Note Processor enables the appropriate procedure code for alcohol screening or counseling to be automatically added to a patient's next visit note. This entry in the next visit note is triggered by the necessary alcohol use information having been previously entered in the patient's history.

The G0443 code for brief alcohol misuse counseling is added to the next visit note when the patient's history contains a Yes answer to the Alcohol Misuse question in the Social History category. The G0442 code for annual alcohol screening is added to the next visit note when the patient's history contains the following questions and answers in the Social History category.

Please note that only the system-defined questions and answers shown in the table below will trigger the add-in.

Question	Females	Males
Alcohol Misuse	No	No
Frequency of Drinks	Either: <ul style="list-style-type: none"> • 7+ drinks per week • 3 drinks per day • 4+ drinks per day 	Either: <ul style="list-style-type: none"> • 14+ drinks per week • 4+ drinks per day

When using the Alcohol Misuse Note Processor add-in utility it is important that you verify the procedures entered in your visit note, and that you properly document in your visit note any additional screening and any counseling service provided to the patient. In most cases, alcohol screening and brief counseling cannot be billed separately from the primary visit on the same date. However, the use of these screening and counseling codes without supporting clinical documentation, even if not billed, may be questioned during an audit.

<<New>> **Diagnosis Code for Tobacco Use**

The add-in utility Positive Smoking Note Processor enables diagnosis code Z72.0 for tobacco use to be automatically added to the patient's next visit note when the necessary tobacco use information has previously been entered in the patient's history.

The add-in is triggered by any of the following system-defined tobacco use entries:

- Currently smokes tobacco
- Currently uses smokeless tobacco
- Heavy tobacco smoker
- Light tobacco smoker
- Current every day smoker
- Current some days smoker

Entering the History

1. Select the Hx tab.
2. Select from the History Categories displayed, and then select corresponding descriptions.
3. The E&M score displays in the footer.

Enter Vitals History

1. Select Vital History.
2. In the Defaults field, select an observation default setting, if desired.
3. Select the New button.
4. In the Date Performed field, enter the date that the vitals were originally recorded.
5. In the Source field, enter the source of the vitals information. For example, the source may be your own paper chart or information from another physician.
6. Enter the vitals information as you normally would.
7. Repeat steps 3 through 6 to enter another set of vitals.

Defining a Medical History Filter

You can define filters for viewing the Problem/Diagnosis History category in the Hx tab of patient visit notes and the Patient History window.

1. Either:
 - Patient Demographics → Patient menu → Patient History
 - Full Note Composer or other clinical note type window → Hx tab
2. Select the Problem/Diagnosis History category.
3. Select the Medical History Filter link.
4. In the New Filter window, enter a Name for the filter.
5. Select the appropriate radio button to display problems, diagnoses, or both.
6. If desired, select the Show Only Active Problems checkbox.
7. If desired, select the Diagnosis Before Problems checkbox. By default, problems display before diagnoses.
8. In the Sort Level 1 field, select the item to be used for the primary sorting of entries.
9. Order sorting of the selected item. This depends on the item selected.

Item	Sort
Name	Select the radio button for alphabetical order or reverse alphabetical order.
Onset	Select the radio button for newest date first or oldest date first.
Resolved	Select the radio button for newest date first or oldest date first.
Problem Status	Select a status and then use the arrow buttons to range the desired order.
Problem Duration	Select a duration and then use the arrow buttons to range the desired order.
Record Date	Select the radio button for newest date first or oldest date first.

10. Repeat steps 8 and 9 for Sort Level 2 and 3.

Deleting or Inactivating History Items

When you delete an item in the patient's history, the item becomes inactive and is shown as struck through. When you select the Delete () icon, a confirmation popup window is

displayed. You can enter a reason for deleting or inactivating the item in the delete confirmation window. The reason then appears in the Notes column for the item.

Items that are entered into the patient's history, through either the Hx tab of a clinical note type window or the History window, may be deleted without record if you delete the item on the same day that it was entered, and, if entered in a visit note, the note has not been completed.

Import Patient History

The patient questionnaire feature offers you the means to capture patient history and review of systems information directly from the patient, and import it into the patient's record. This can decrease the time needed to enter the patient history information. It is incumbent on the practitioner to verify the imported information, and in some cases, the practitioner may want to enter additional information in the patient's record.

If the patient has completed a patient questionnaire for history information, you can import and review the information provided by the patient.

1. Select the Import Questionnaire () icon from the toolbar.
Note: If the Import Questionnaire icon is not visible, select the drop down button on the toolbar to display additional icons.
2. All patient input from all questionnaires is imported into the History. Fields containing patient input are highlighted as defined in your User Options.
3. Verify the patient input by selecting the highlighted field. The input is now considered approved.
4. If desired, make changes or additions to the patient input.

Save the Visit Note as Incomplete

If you are a nurse or medical assistant, and you have created and charted the visit note so far, you may now want to save the current information and close the visit note so that the provider may continue with it.

1. Either:
 - File →Close
 - Select the Close icon ()
 - Select the OK button.
2. Select the Incomplete Note radio button.
3. Select the OK button to save and close the note. Once closed, the visit note can be reopened from a different computer.

Open the Incomplete Visit Note

When the visit note has been closed, the physician can access One Page Summary to review the patient's recent history, and reopen the current visit note from his or her own computer.

1. From the patient appointment, select the One Page Summary icon ()
2. Review the information displayed. The information included depends on your selected options, which will be covered in the next topic.
3. To open the current patient visit note, select the button for the appointment date.

Enter Medical Service Order Results (Results Tab)

The Results tab enables you to process lab results that may need to be or that are associated with the current visit note. The Results tab displays results that have not yet been approved and results that have been both approved and associated to this visit. This lets you review results of services you ordered prior to the patient's visit and the results of any unsolicited test received for the patient so that you can process them.

The Results tab is similar to the Patient Results window; however, there are important differences in how it is used and what it displays. The Results tab is not intended for reviewing all of a patient's results. The Patient Results window does display all of results for a patient and is intended for that purpose. The Results tab only displays the specific results identified in the paragraph above. It does not display any other results. If you want to see other results, you may select the Existing Results button.

In the Results tab, you can review and approve results, add any needed notes, and complete the lab results message from the tab. You can also choose to include the results in the patient visit note. A result can only be associated with a single visit. A warning message will display if you attempt to associate a result with a second visit.

The Results tab displays result details when they have been received through an interface or entered manually. When a lab result report is attached as a file, the attached report is displayed as a thumbnail image on the tab. You can then select the thumbnail image to open the attachment.

The Results tab is included in the Full Note Composer window by default. Your administrative super user may include the Results tab in any other system-defined or user-defined clinical note type window or may remove it from a custom copy of Full Note Composer if your practice chooses not to use the tab.

View Results

By default, the Results tab displays resulted but not approved lab tests and other clinical orders and any approved results that have already been associated with the visit.

1. Full Note Composer → Results tab
2. In the top left panel, expand the tree icon () and highlight the lab test result you wish to view.

The appearance of the window depends on the form of results received. These are described in the sections below.
3. If desired, select the New Attachment button to add an attachment for the selected lab test. This accesses the Attachment Editor window.
4. If desired, select the New Result button to add results for the selected lab test. This accesses the Results window.
5. If desired, select the Existing Result button to associate an approved lab test or order with the visit note.
 - a. In the Find Patient Results window, search for and select the desired item.
 - b. The selected item is added to the tree structure list of orders in the top left panel. It appears under the heading 'Other Approved Results'.
6. To approve any result selected in any of the previous steps, select the Approve Results checkbox.
7. To associate any result selected in any of the previous steps to this visit note, select the Include in Note checkbox.

Detailed Results

Details of discreet data results associated with a lab template are listed in the bottom pane of the tab.

1. Full Note Composer → Results tab
2. In the top left panel, expand the tree icon () and highlight the lab test result you wish to view.
3. Select a Procedure hyperlink to access the Patient Results window.
4. In the Description column, select the hyperlink for a result to view a graph of the result.
5. To enter an additional result for this set, select the Add Result button.
6. To add an attachment, select the Add Attachment link in the attachment display pane.
7. To approve results:
 - Select the Approve button for an individual procedure to approve the results for that procedure.
 - Select the Approval All button to approve all the results in the message.
8. To enter or review lab order notes associated with the procedure, select the Note icon () in the far right column.

9. To enter or review lab order notes associated with all the procedures, select the Comment All button.
10. Select the Print icon () to print all of the lab results in the message.
11. To include the results in the patient visit note, select the Include in Note checkbox.
12. To complete the lab message associated with these results, select the Complete Message checkbox.

Result Attachments

When the result is a file, such as a scanned lab result report or x-ray, the attached file appears as a thumbnail image at the top of the tab.

1. Full Note Composer → Results tab
2. In the top left panel, expand the tree icon () and highlight the lab test result you wish to view.
3. Select the thumbnail image to open the Attachment Editor window.
4. To include the results in the patient visit note, select the Include in Note checkbox.
5. To approve the results, select the Approve Results checkbox.
6. To enter the results so they can be used in graphs, select the Add Result button to access the Results window.
7. Enter any Notes, if desired.

Procedure Notes

Procedure notes can be used to enter findings from x-rays, MRIs, and other procedures in a structured way. When a results procedure note is associated with the procedure, the Edit Procedure Note button at the top of the window is active.

1. Full Note Composer → Results tab
2. In the top left panel, expand the tree icon () and highlight the lab test result you wish to view.
3. Select the Edit Procedure Note button.
4. Select the desired procedure note from the popup window listing the available procedure notes, and then select the OK button.
5. In the Procedure Note window, enter your findings using the data fields defined in the procedure note.
6. Select the OK button to add the procedure note data to the patient visit note. The fields and your responses will appear in the top right panel of the Results tab.
7. If desired, select the Text button to enter a text note.

<<New>> Procedure Codes for A1C Results

The add-in utility A1C Results Note Processor enables the appropriate procedure code for HgbA1C lab test results to be automatically added to the SP tab of a patient's next visit note. The entry is triggered by entering or receiving through a lab interface the results for an A1C test. The next visit note must be within 12 months of receiving the test results.

The table below shows the procedure codes for test results ranges.

Procedure Code	HgbA1C Results
3044F	< 7.0
3045F	7.0 - 9.0
3046F	>= 9.0

<<New>> Procedure Codes for LDL Results

The add-in utility LDL Results Note Processor enables the appropriate procedure code for LDL-C test results to be automatically added to the SP tab of a patient's next visit note. The entry is triggered by entering or receiving through a lab interface the results for an LDL-C test. The next visit note must be within 12 months of receiving the test results.

The table below shows the procedure codes for test results ranges.

Procedure Code	LDL-C Results
3048F	< 100 mg/dL
3049F	100-129 mg/dL
3050F	>= 130 mg/dL

Enter the Review of Systems (ROS Tab)

The Review of Systems (ROS) tab provides the list of systems defined by the 1997 Documentation Guidelines. Depending on the complexity of the patient visit, you should review one or more systems for the patient visit.

- The symptoms displayed in the ROS tab may be customized for your practice, or for specific care teams and/or providers. Define customized entries via List Editor or from the ROS tab by selecting one of linked headings: System or Symptom.
- You can define the order in which systems and symptoms are listed, where the order may be alphabetic or a user-defined order. This is defined by provider.
- Abnormal findings are highlighted in bold.
- All systems and symptoms you review are added to the patient chart.

- The footer on the window lists the E&M points you have charted.

Enter the Review of Systems

1. Select the ROS tab.
2. Search for the system you need by adding one or two characters of the system name in the System field. This highlights the first system that displays the combination of letters you have included. Alternatively, highlight the system you require; the list of symptoms varies depending on the system selected.
3. You can search for symptoms in a similar way, by adding one or two characters of the symptom in the Symptom field, or highlight the symptom you require.
4. All symptoms are initially set to N/A. N/A means that the symptom will not be documented. Check the Y or N buttons as relevant. Y and N buttons are documented as Y = abnormal, N = normal.
5. You can mark the whole system as reviewed by checking the checkbox to the left of the system name. This updates the status of all symptoms associated with that system to the default values that have been customized for your practice. You can still override the default status if necessary.
6. You can mark all systems as reviewed by checking the checkbox to the right of the System field. This sets the status of all symptoms of all systems to N.
7. All systems that you mark as reviewed are included in the patient chart.
8. Symptoms are listed in the descriptions section of the ROS window. You can add notes to individual items alongside each symptom.
9. Add notes to any of the entries as necessary by selecting the notes field alongside the symptoms you want to annotate. You can also select the notes icon () to access the Notes window where you can select predefined notes.
10. Delete symptoms from the note by selecting the delete button () at the side of the symptom.

Enter the Physical Exam (PE Tab)

The Physical Exam tab includes a number of predefined exam types specified by the *CMS 1997 Documentation Guidelines for Evaluation and Management Services*. It also contains a single Full Exam based on the 1995 guidelines. Your practice may have defined additional physical exam types using either the 1995 or the 1997 E&M guidelines. Some of the system-defined exams are:

- Basic PE — This exam contains as defaults the items needed for the most E&M points.
- Full Exam — General Bilateral. This is similar to the regular general exam, but it is set to use Bilateral instead of left/right categories.
- Full Exam — General 1995. This is built for 1995 E&M coding.
- Orthopedic Full Body Exam

The E&M guidelines used to develop the exam type determine what items can be counted for E&M bullets and how those items are counted when an exam is used. Please note that the 1995

and 1997 guidelines are different in what they count and how they count. The 1995 guidelines count only systems; the 1997 guidelines count systems and items within systems. Therefore, an exam must be completely defined to use either the 1995 guidelines or the 1997 guidelines, but not a mixture of both. Once an exam is defined, only the count defined in that exam is available when that exam is used.

For each type of exam, the application makes it as easy as possible to list normal and abnormal findings, and the E&M score is updated in the footer.

You can include all default findings for a particular exam by selecting the Check icon () , but please be aware that this may take a long time to complete.

<<Revised>> Lifelong Findings

Your administrative super user may define a physical exam finding as 'lifelong'. This indicates that the finding is one from which a patient will not recover, or which cannot be corrected, removed, or any way resolved. When a finding is defined as 'lifelong', then once that finding has been charted for a patient, the lifelong finding is automatically charted anytime the same physical exam is used in a visit note for that patient.

This can save you time when charting a visit note. However, there are several important points to keep in mind:

- The definition as 'lifelong' applies only to that finding in the specific physical exam in which it is identified. It does not apply to the same finding in other physical exams. So, if you use a different physical exam in a later visit note, the lifelong finding will not be automatically charted. You must select the finding if you want that finding charted in that visit note.
- Once a lifelong finding has been charted for a patient, then for that patient that finding will automatically be charted in every visit note in which that physical exam is used. The finding will be charted even if you were not the provider who originally charted the lifelong finding for the patient. If you do not want that finding charted in a particular visit note, then you must either use a different physical exam in which the finding is not identified as 'lifelong' or delete the finding from the visit note after it has been automatically charted.
- A finding defined as 'lifelong' is identified as a lifelong finding for a patient every time that specific physical exam is used and that finding is charted.
- When charting a physical exam finding that is not defined as 'lifelong', you may define it as such for that particular patient.

Changing Exam Types

Each exam type has a different set of requirements. Therefore, if you change the exam type that you are completing, then in most cases, you will lose the information you have already entered.

There is one exception to this. You can, in some instances, use the Convert to Full Exam button to change to the Full Exam - General exam without losing the information you have entered. Please note the following limitations to changing exam types.

- You must have started with either:
 - A system-defined exam that is not a full exam, or
 - A user-defined exam that was based upon a system defined exam that is not a full exam.
- You cannot change from a user-defined exam type that was created from scratch.
- You cannot change from another full exam type, such as Full Exam - Pediatrics, to the Full Exam - General exam.
- You must use the Convert to Full Exam button to convert to the Full Exam - General exam. If you simply select the Full Exam - General exam type, the information you have already charted will be lost.
- You cannot change back to the original exam type or to another exam type without losing the information you have already charted.

Charting the Exam

1. Select the PE tab.
2. Select the Physical Exam type:
 - Enter the name, or part of the name, in the PE Type field. This will move the focus to the first exam with the series of letters you have specified.
 - Scroll through the list of exams to find the one you need.
3. Select the System or Systems you require.
4. Select the "plus" at the left of the system. The system expands, showing the sub-systems you must review.
5. Highlight the sub-system you will review.
6. Select the Findings and Descriptions. By default, the application lists all normal findings, and you can highlight any abnormal findings you want to include.
 - When you expand the system name, the first entry in the Findings column (the middle column) is <Overall>, and the entries in the Descriptions column (the right column) list all normal findings.
 - By default, all items are set to Not Applicable.
 - To include all normal findings in the patient chart, Select <Overall>, or check the checkbox above the descriptions column.
 - To include abnormal findings in the chart, select one of the findings in the middle column. This causes the list of descriptions to change. Select as many of these as are applicable to the patient chart.

Note: Abnormal findings are highlighted in bold.

- To include an entire sub-system as reviewed and normal, check the checkbox to the side of the sub-system name.
 - To unselect a subsystem, highlight the subsystem and press the F6 key.
 - When a finding is defined to allow Bilaterality, you may indicate that the finding is left, right, or bilateral.
7. Add notes to any of the entries as necessary by selecting the notes field alongside the symptoms you want to annotate. You can also select the notes icon () to access the Notes window where you can select predefined notes.
 8. <<New>> If appropriate, select the Lifelong column to set the finding as lifelong for this patient.
 9. Delete entries by checking the Delete (X) button.
 10. The count in the footer of the window indicates the E&M score.

Converting to Full Exam - General

Select the Convert to Full Exam button to convert the exam type you are using to the Full Exam - General exam type. This button is enabled only when it is possible to make this conversion. When converting from another exam type in this way, you will not lose information already charted. Please note that you must convert using this button. If you simply select the Full Exam - General exam type after you have started charting in another exam type, the information you have charted will be lost.

Enter the Review of Systems and Physical Exam Notes (ROS/PE)

This tab enables you to enter information about the review of systems and physical exam in a manner similar to writing a progress report. It is used instead of the ROS and PE tabs, rather than in addition to them.

- The left pane contains a list of the standard physical exam notes that you have created.
 - To create a new note, select the New button. Then enter a Name and any general Notes you want to include.
 - To use a note, select it from the list. This adds the general note text to the right pane.
- Use the right pane to enter text regarding this patient and this visit. Standard text can be added by selecting a predefined note from the left pane, and by typing directly into the notes field. You can also use a stylus to write or draw in this area.

Enter the Diagnosis (Dx Tab)

Use this tab to enter the patient's diagnosis. When you chart a diagnosis in a patient visit note, you may associate that diagnosis to a current or new problem for the patient.

The application may chart a diagnosis code automatically if your administrative super user has defined the necessary conditions. For example:

- A diagnosis code may be defined as 'lifelong'. This indicates that the diagnosis is one from which a patient will not recover or which cannot be corrected, removed, or any way resolved. When a diagnosis is defined as 'lifelong', then once that diagnosis has been charted for a patient, then the application will automatically chart that diagnosis in the patient's first visit note for any calendar year.
- A CC symptom may be associated with a diagnosis code. Then when the CC symptom is selected in a patient visit note, the diagnosis code is added to the Dx tab.
- An HPI description item may be associated with a diagnosis code. Then, when you select the history category and description item in a patient visit note, the diagnosis code is added to the DX tab.

Use the splitter bar to change the size of the display of the selected diagnoses. Simply select the splitter bar and drag it to the desired location.

Entering a Diagnosis

1. Select the Dx tab.
2. Enter a diagnosis by either:
 - Select a diagnosis. Choose from:
 - Patient's list, which includes all diagnoses that have been made for this patient by the provider. (A diagnosis code that has expired will display in italic. If you select an expired code, the application will prompt you to search for a current code. It will not prevent you from selecting the code.)
 - Frequently used Dx list, which includes all diagnoses that have been made by this provider. Diagnoses are sorted by frequency used.
 - Problems, which is the problem list from the patient's history. You can edit an item in the problem list.
 - Categories defined on the diagnosis charge ticket for your care team.
 - Enter a diagnosis using the search feature.
 - Add a diagnosis from the Common Problem Palette if applicable by selecting from Diagnosis Specific Plans or selecting the Palette icon ().3. When you have entered a diagnosis, it is listed in the Diagnosis section of the window.
 - a. Select the Type, such as differential, pre-op, or post-op, if desired.
 - b. Select the hyperlink to access the IMO Diagnosis Search window to review the code, if needed.

- c. Associate the diagnosis with a Problem, if desired, by selecting the Find icon. Then select a current problem from the list or select the New Patient Problem button to add a new problem for the patient.

When adding a new problem, select the Problem to which the diagnosis is associated. Then select an Onset time and the Status of the problem. Define whether there is a default association between the diagnosis and the problem.

- d. Add notes to any of the entries as necessary by selecting the notes field alongside the symptoms you want to annotate. You can also select the notes icon () to access the Notes window where you can select predefined notes.
 - e. If appropriate, the HCC score for the diagnosis code is displayed.
4. If needed, delete charted diagnosis code entries by selecting the Delete (X) icon.

Using ICD-10 Diagnosis Codes

Selecting an ICD-10 code actually selects both the ICD-10 code and its corresponding ICD-9 code and SNOMED code. The Dx tab displays the selected ICD-10 and ICD-9 code pair.

Selecting an ICD-10 Code from an ICD-9 Code

You may chart an ICD-10 code based on an ICD-9 code that already exists in the clinical note type window, such as the diagnosis charge ticket, patient list of previous diagnoses, or your frequently used diagnoses list, or common problem palette. When you select the ICD-9 code, the IMO Diagnosis Search window appears. It displays a list of possible ICD-10 codes for the ICD-9 code you selected. In the Find window, select the desired ICD-10 code with the appropriate modifiers/qualifiers. Then select the OK button to add the ICD-10 code to the patient visit note.

Entering an ICD-10 Code that Corresponds to Multiple ICD-9 Codes

There are instances in which a single ICD-10 code corresponds to multiple ICD-9 codes. For example, the ICD-10 code Z23, for Encounter for Immunization, corresponds with a large number of ICD-9 codes for individual vaccinations. Therefore, the application checks both the ICD-10 code and its corresponding ICD-9 code to identify a diagnosis. So if the ICD-10 code and corresponding ICD-9 both match a diagnosis that is already entered, the application will prevent you from adding that ICD-10/ICD-9 combination again. If the ICD-10 code matches a diagnosis already entered but the ICD-9 code does not, the application will allow you to enter that ICD-10/ICD-9 combination.

ICD-10 Codes without Corresponding ICD-9 Codes

While most ICD-10 codes correspond with an ICD-9 code, there are some codes in each code set that do not have a corresponding code in the other code set. If you are coding with ICD-10 and an entity (laboratory, registry, insurance payer, etc.) that will receive the code requires an ICD-9 code, then you must select an ICD-10 code that does have a corresponding ICD-9 code. The IMO Diagnosis Search window displays an IMO placeholder code when a diagnosis code does not have a corresponding code in the other code set. The placeholder codes are IMO0001 and IMO0002. The placeholder codes may appear in either the ICD-10 or the ICD-9 column of the IMO Diagnosis Search window.

Modifiers

The ICD-10 code that you select as the diagnosis is a combination of a base code, and one or more modifiers or qualifiers. The base code is identified by three alphanumeric characters followed by a decimal point. For example, M48. or S32. Modifiers and qualifiers are identified by alphanumeric characters following the decimal point.

Each modifier and/or qualifier increases the specificity of the code, and restricts the additional modifiers and qualifiers that may be selected. For example, M48.4 is less specific than M48.45, which is less specific than M48.45X, which is less specific than M48.45XA. Each time you select an option for a modifier/qualifier type, you determine the options available for the modifier/qualifier type that is the next level of specificity.

The options available for any modifier/qualifier type are determined by the options you have selected for other modifier/qualifier types. A given selection may expand or narrow the options available for another modifier/qualifier type.

If your selections result in a code that is too specific or that does not have the desired modifier options for the modifier/qualifier type, then you can go back to the next higher level, which is less specific. If needed, you can continue working back through the levels until you reach the base code.

Non-Specific Codes

An ICD-10 code may be either specific or non-specific. Non-specific codes are identified with the  icon.

Hierarchical Condition Category Coding

Hierarchical condition coding (HCC) is part of the CMS risk adjustment model. HCC scores are assigned to chronic diseases, such as diabetes and kidney disease, which are costly to treat. Higher scores indicate a higher cost to treat.

The application includes the HCC score for ICD-10 codes which have been assigned a score. When searching for a diagnosis code, the HCC column of the IMO Diagnosis Search window includes the score, if available. The HCC score is also displayed in the Dx tab for charted diagnosis codes.

You can use the HCC score to help ensure that you are charting the most accurate and specific diagnosis code for a patient. Remember that your visit note must include documentation supporting the charged diagnosis.

HCC scores do not affect how a claim is paid. Instead, the current year's HCC scores for your patient population are used to set your risk adjustment factor (RAF) for subsequent years.

The CMS risk adjustment model assigns a patient a risk factor based upon their chronic illness, other health conditions, and demographic details. The application does not calculate a patient's risk factor.

<<Revised>> Searching for an ICD-10 Code

The IMO Diagnosis Search window enables you to search for, view, and select ICD-10 diagnosis codes. You may search by term, ICD-10 code, or ICD-9 code. For each diagnosis, the window displays the ICD-10 and ICD-9 codes, SNOMED code, RAF score, and description.

1. Full Note Composer or other clinical note type window → Dx tab
2. In the Search field, select the Find  icon.
3. Search for the desired diagnosis by entering a search term or code in the search field. As you type, the diagnoses matching your entry are displayed in the left pane of the window.
 - A diagnosis code may be listed multiple times with different descriptions. This enables you to select the description you want in your visit note.
 - A diagnosis code may be associated with one or more extension diagnoses codes that identify conditions or manifestation causing, resulting from, or related to the diagnosis. Use the Down arrow () next to the description to expand the entry to show the extension codes. Extension codes are required for billing. When you select a diagnosis code with extension codes, all of the codes required for billing are selected.

4. Select the Modifier () icon to view additional information about the modifiers and qualifiers for the base code.

The modifier window displays a panel for each modifier/qualifier type, and the options for each type.

- Blue text identifies modifiers that you have selected.
 - Black text identifies other modifiers available for selection. The options that may be selected are determined by your other selections.
 - Grey text identifies modifiers that are available for the code, but are not available based up on your current selection.
- a. Select the modifier or modifiers desired.
 - Selections toggle on and off. So, to remove a selection, select it again.
 - As you select modifiers, the Terms section of the window displays a list of the diagnosis codes with your selected modifiers.
 - b. Select the desired diagnosis code from the list. This returns to the IMO Diagnosis Search window, with the selected code in the right pane of the window.
5. If desired, search for and select additional diagnosis codes. All selected codes are listed in the right pane of the window.
 6. Select the OK button to add the selected diagnosis codes to the Dx tab.

Reviewing a Previously Charted ICD-10 Code

There may be times when you want to review a previously charted ICD-10 code. If need, you may then select a different code or change the modifiers on the selected code.

1. Full Note Composer or other clinical note type window → Dx tab
2. In the charted diagnoses table at the top of the window, select the Diagnosis name hyperlink. This accesses the IMO Diagnosis Search window.
3. In the IMO Diagnosis Search window, you may:
 - Search for and select a different ICD-10 code.
 - Select the Modifier () icon to access the ICD-10 Detail Filter window to view additional information about the modifiers and qualifiers for the selected base code. In the ICD-10 Detail Filter window, you may:
 - Select the modifier or modifiers desired. Selections toggle on and off. So to remove a selection, click on it again.
 - Move back to a higher, less specific level, by selecting the Up Level () icon in the Root Code area at the top of the window. You may continue selecting this icon to up a level until you reach the most general level of the code. This will enable you to select an ICD-10, with modifiers/qualifiers that was not necessarily displayed in the List Editor window with your original selection criteria.
 - Return to your previous view, if needed, by selecting the Back () icon.
4. Once you selected the desired code, select the OK button to chart the complete ICD-10 diagnosis code and its description in the visit note. This replaces the originally charted diagnosis code.

Using the Info Button to Access Additional Information

Once you have entered a diagnosis, you may use the Info Button to access additional information from your patient education resources provider.

1. In the line item for the charted diagnosis, scroll to the far right and select the Info Button () icon in the Info column.
2. Your default browser will open to your patient education resources provider, and will display information about the selected diagnosis.

<<New>> Viewing the Patient's Diagnosis History by Hierarchical Condition Category

You may view the patient's past diagnoses by their hierarchical condition category (HCC) in the Community Model Diagnostic Categories window. This window displays for each category in the patient's history, the highest HCC score for an active diagnosis charted prior to the current calendar year, the highest HCC score for a diagnosis charged in the current calendar year, and the diagnosis code with the highest score if it has not yet been charted for the patient in the current year. This enables you to ensure that you have used the diagnosis code with the highest score at least once in the calendar year.

1. The Disease HCC Total field displays the total score for all the diagnosis codes entered in the visit note. If you have not yet entered a diagnosis code or the diagnosis codes entered do not have HCC scores, then the total will be 0.0
2. Select the Disease HCC Total hyperlink to access the Community Model Diagnostic Categories window where you can view the diagnostic categories for the diagnosis codes entered.
 - The window lists all the categories for which the patient has an active diagnosis.
 - For each category, if the patient's history includes an active diagnosis entered prior to the current year, then Active Patient History column will display the HCC score of the active diagnosis with the highest score.
 - The column identified by the year displays the HCC score of any diagnosis code entered for the patient in the current calendar year.
 - If the HCC score in the Active Patient History column is higher than the score in the 2019 column, then the diagnosis code with that score is displayed in the ICD10 column.
3. If you want to add the diagnosis code with the higher HCC score to the current visit note, select the checkbox in the Add To Note column.
4. Select the Submit button to add any selected diagnosis codes to the visit note.
5. Select the Close button to close the window and return to the Dx tab.

<<Revised>> Enter Prescriptions (Rx Tab)

The Rx tab and the SIG Writer window accessed from it provide comprehensive prescription writing capabilities to create and store drug and prescription information. They are also used to enter information about administered drugs.

The Visit Medication section at the top of the Rx tab displays the medications you prescribe or administer during this visit. If you have used a CPP entry in this visit note and that CPP included a prescription, then the drug and prescription details will be listed in this section when you access the Rx tab.

You may select a drug name in this list to edit the prescription until the prescription has been prescribed (either printed or sent electronically). You may also delete a prescription before it has been prescribed. You cannot edit or delete a prescription once it has been prescribed.

The Patient Medication section at the bottom of the tab displays the patient's medication history. You may refill, discontinue, or change a prescription for a medication in this section by selecting the Action (ⓘ ⓘ ⓘ) icon. It also enables you to access the medication Details and the PDR information and to print or reprint a prescription.

When a drug formulary has been downloaded or entered in the patient record, you can access the formulary using the Patient Formulary link. This link will be inactive when the patient record does not include a drug formulary. Formulary details include status, therapeutic code, and relative cost.

Medication Status

The Status column in the Visit Medication section displays the current status of the medications you have prescribed during the current visit. The status display refreshes when you either move to another tab and then back to the Rx tab or when you save the visit note.

The Status column in the Patient Medication section displays the final status of the medications in the patient's history.

The table below shows the status icons that may be displayed in the Status column and their meaning.

Type of Prescription			Meaning
Electronic	Printed or Faxed	Cancelled	
			Queued
			Sent
			Successful
			Error

<<Revised>> Chart a Prescription or Administered Medication

The basic process for charting a prescription is given below. Please see the Prescription section for more information on prescriptions, and for instructions on using the SIG Writer window for prescriptions, administered medications, and samples given.

1. Select the Rx tab.
2. Search for the medication you want to prescribe or administer.
 - a. Select the Prescribe button in the Medication SIG column header. This accesses the Select Drug window.
 - b. In the Select Drug window, search for the desired medication.
 - Medications are listed by name, strength, and form. The entry also includes the drug class.
 - Default SIGs matching your drug name are listed first and are shown with the Default SIG (D) icon. They are listed by the name of the default SIG, and also include the SIG details.
 - Medications in your most frequently used list are shown with the MFU (M) icon.
 - To access the medication details for a drug, select the Information (i) icon. You can then select any of the links to narrow your search.

- Select the Use Generic button to the right of drug name to select the generic form of the drug and strength.
 - The No eRx (🚫 No eRx) icon indicates that the drug cannot be electronically prescribed. Prescriptions must be printed.
 - Enter "AKA:" followed by a drug name to search for names of the drug.
 - Enter "Class:" followed by the name of the medication class to search for all drugs in that class.
 - Enter "NDC:" followed by the NDC number to search for the drug with that number.
 - Enter "RXN:" followed by the RxNorm code to search for drugs with that code.
- c. Select the desired medication to open the SIG Writer window.
- Note that the application automatically saves the visit note before opening the SIG Writer window.
3. Use the SIG Writer window to specify the details for the prescription or administered medication.

<<New>> Change the Pharmacy on Prescriptions

You may change the pharmacy on one or more prescriptions without opening the SIG Writer window.

1. In the Pharmacy column of the Visit Medication table, select the checkbox for each pharmacy that you wish to change.
2. Select the Change button.
3. Search for and select the desired Pharmacy. The patient's pharmacies are listed first. Search for other pharmacies by typing the pharmacy name or ZIP code.
4. The Pharmacy column displays the selected pharmacy for changed prescriptions.

Enter Services Performed (SP Tab) and Services Ordered (SO Tab)

The services performed (SP) tab and the services ordered (SO) tabs are both used to chart and order services. You chart information on these tabs in the same way. The difference in these tabs is in how the application handles the charges for the services.

Services entered in the SP tab are included on the superbill generated from the visit note. These services include services performed in your office. They may also include services performed by a third party, such as a laboratory, but for which you bill the patient and the patient's insurance payer.

Services entered in the SO tab are not included on the superbill generated from the visit note. These are services that are performed by third parties, such as laboratories, imaging centers, or other medical providers, who will bill the patient and the patient's insurance payer for their services.

Any procedure that is defined to generate an order is handled as a service order, including being submitted through a lab interface, whether entered on the SP or the SO tab. A procedure

is defined to generate an order in the Procedure Code window (accessed through the List Editor) by selecting the Generate Order checkbox. Procedures that are not defined to generate an order are not handled as a service order, whether entered on the SP or the SO tab.

Sort to Bottom of Display

Selected procedures are added to the charted procedures list at the top of the window as you select them. If desired, you may then highlight a charted procedure and use the Up and Down Arrow icons to change the order of the procedures in the list.

Your administrative super user may define a procedure code to always display at the bottom of the list of procedures charted in the SP or SO tab. A procedure code that is defined to sort to the bottom of the list will always display below all charted procedure codes that are not defined to sort to the bottom. If you select more than one procedure code that is defined to sort to the bottom, then the codes that are defined in this way are displayed in the order in which they were selected, but below any other charted procedures.

The application copies procedure codes from the visit note to the superbill in the same order as they are displayed in the clinical note type window.

Ordering Lab Tests

Please refer to the Lab Tests and Other Clinical Orders section for information and instructions on ordering a lab test using a laboratory interface.

Referrals as Services Ordered

Handling a referral to another physician or medical service provider as an order through a procedure note enables you to create the patient/provider tracking record and create the referral associated with that patient/provider tracking record.

The application includes system-defined dynamic procedure notes for referrals. Both the Create Referral and Patient Message Referral procedure notes create the patient/provider tracking record, if it does not already exist, and they both create a referral on that tracking record. The Patient Message Referral procedure note also generates a message to a staff member so that the staff member can make an appointment with the referred-to provider, decide whether or not to generate a referral letter or other document, and do anything else that might be needed.

Both the Create Referral and the Patient Message Referral procedure notes enable you to select a document to generate and send to the referred-to provider. If the application can automatically send the document to the referred-to provider, using either Direct messaging or fax, then it will do so. If the document cannot be sent automatically, then the application will either display the Send Documents window so that you can print the document or it will send a task message to a user so that user can generate and print the document. Your administrative super user will have configured whether the Send Documents window displays or a task message is sent.

When using the Create Referral or Patient Message Referral procedure note, it is important to understand that you can select a document as the default document for the patient/provider tracking entry and a document for the referral order. This gives you the ability to select different

documents for these two items. For example, you may select the checkout plan as the default document for the patient/provider relationship and select a referral letter for the referral order.

However, it is also possible for you to select the same document for both items. If you deliberately select the same document for both items, then the application will not include the default document for the patient/provider tracking relationship when you complete the visit note containing the referral order. Otherwise, the referred-to provider will be sent two copies of the same document.

Automatically Charted Procedures

The application may chart a procedure code automatically if your administrative super user has defined the necessary conditions. For example:

- An HPI description item may be associated with a procedure code. Then, when you select the history category and description item in a patient visit note, the procedure code is added to the SP or SO tab.
- An education form may be associated with a procedure code. Then when you select the education form from the Education Form slider, the application adds the associated procedure code to the SP tab.

Select the Procedure to be Performed or Ordered

1. Select the SP tab or SO tab.
2. Select a procedure code or procedure group from the patient's list, the frequently used orders lists, or via the search field. The service is added to the list of charted services.
3. Add notes to any of the procedures. If your User Setting is defined to copy procedure notes, then this may be populated by notes entered on the procedure in the Procedure window.
4. If you select a procedure code that is associated with a procedure note, the Procedure Note () icon is shown to the left of the procedure in the upper portion of the SP or SO tab.
 - a. Select the Procedure Note icon to open the procedure note, if desired.
 - b. If there is more than one procedure note associated with the procedure, then highlight the procedure note you want to use and select the OK button.
 - c. Complete the procedure note as appropriate.
5. If a reimbursement rule is associated with the patient's insurance payer and this procedure, you will see a red question mark against the associated procedure code. Select the question mark to display the message that was associated with the note.

Note: If you have not performed diagnosis association, the association with the rule is provisional, and will be confirmed when diagnosis association is performed.

- a. Select the Reimbursement Rule question mark () icon to access the Find Diagnosis Code window. The window will display only the diagnosis codes that have been defined as valid in the reimbursement rule.
- b. Either:
 - Select a diagnosis code that is valid for the procedure to chart the diagnosis. This removes the Reimbursement Rule question mark () icon from the charted procedure.

- Select the Ignore Reimbursement Rule button to ignore the rule and continue without a valid diagnosis code. This replaces the Reimbursement Rule question mark (?) icon in the charted procedure line with the Overwritten Reimbursement Rule (O) icon.
6. Select the Include checkbox if you want to include this procedure in the patient's surgical history.
 - The Include checkbox will be selected by default if your administrative super user has configured this procedure to be included in the surgical history. You may deselect the checkbox if desired.
 - When the Include checkbox is selected, the procedure is added to the patient's surgical history when you save and complete the note.

Modify the Procedure

Modify the procedure to enter additional information for a service ordered or provided. The Order tab appears in the window only if the procedure code has been defined as an order.

1. Select the procedure code hyperlink in the Test/CPT column to access the Modify Service Order window.
2. Specify a Quantity of units for the service. You can specify a quantity of 1 to 999.
3. Add up to four modifiers. You can enter the modifier code, or search for the modifier you need. Modifier codes must be separated with a semicolon (;).
4. The ABN Estimated Fee displays the total of the quantity times the procedure fee amount from the fee schedule.
5. Attachments, if any, will be available in the upper right corner.
6. Enter any Notes, if needed.
7. Select the Order tab to modify the service order, if need. This tab appears in the window only if the procedure code has been defined as an order.
8. Verify and enter the basic order information.
 - a. Define the Urgency of the service. By default, the urgency is Routine, but you can change this as needed.
 - b. Enter the name of Lab Technician if desired. This enables you to designate a draw technician associated with the specimen. It can be the name of anyone you want to be associated with the lab order, and does not have to be a user of the application.
 - c. Select or verify the Laboratory for the procedure. This will default to the laboratory associated with the procedure, if one has been defined. You can change it if, for example, the patient's insurance requires a different laboratory be used.
 - d. Select the Bill Type to identify how billing for the procedure will be handled.
 - Patient Bill: Laboratory will bill patient.
 - Insurance Bill: Laboratory will bill the insurance company.
 - Client Bill: Laboratory will bill clinic.
 - e. Select the PSC checkbox if the patient is going to the lab's patient service center to have the lab specimen collected.
 - f. If the patient is or must be fasting, select the Fasting checkbox.

- g. The Scheduled Order Date field populates with today's date. If the procedure is to be performed in the future, enter the date you want the procedure it to be performed.
 - h. The Due Date is calculated from the scheduled order date and the number of days until due defined for the procedure. You may change this date if desired.
 - i. Select the Actual Collection Date/Time if the specimen was collected in-house. Do not enter a collection date if the specimen is to be collected at the lab's patient service center.
9. Verify and enter message information, if needed.
 - a. The Patient Message checkbox is enabled only when the order date is in the future and is equal to or greater than the number of days prior defined for patient messages. Select the checkbox if you want to send a message to the patient, and modify the Days Prior to Order Date if needed.
 - b. The User Message checkbox is automatically selected if message defaults are defined for the procedure. Select the checkbox if you want to send a message to staff members, and modify the users to receive the message and the Days Prior to Order Date if needed.
 - c. The Overdue Message checkbox is automatically selected if message defaults are defined for the procedure. Select the checkbox if you want to send a message to staff members, and modify the users to receive the message and the Days Prior to Order Date if needed.
10. Complete the Order Recurrence information, if you want this test to be repeated.
 - a. Select the Order Recurrence hyperlink. This accesses the Order Recurrence window.
 - b. Select the radio button for the desired Scheduled Recurrence period (daily, weekly, etc.).
 - c. Select the appropriate Recurrence End.
 - If you want the test performed a certain number of times, select the End After radio button and then enter the number of occurrences desired.
 - If you want the test performed through a certain time period, select the End By radio button and then enter the end date of the time period.
 - d. Enter the Recurrence Pattern information. This information depends on your schedule recurrence selection.
 - e. Select the OK button to save the recurrence information, and return to the Modify Service Order window.
 - f. The recurrence information is displayed. You can change this information by selecting the Order Recurrence hyperlink. However, once you select the OK button to save the order information and close the Modify Service Order window, you can no longer change the recurrence information.
11. Select the Dx Association tab to associate a diagnosis with the procedure. The diagnosis codes and descriptions are listed in the Dx Association field. If you have already associated the procedure codes with the diagnosis codes, the associations are listed. You can also associate the codes in the window by selecting the field to the right of the diagnosis. Scroll bars appear and you can enter the required association.
12. Select the OK button to save the order information, and return to the Full Note Composer window.

<<Revised>> **Generate an Advance Beneficiary Notice (ABN) for a Procedure**

You must give an advance beneficiary notice (ABN) to a Medicare patient before performing a procedure or service that Medicare may not cover. When an ABN is needed, the patient must sign it prior to the procedure being performed. Otherwise, Medicare prohibits billing the patient if they deny the charge.

If your practice has purchased the optional clinical claims scrubbing functionality, then it may be configured to prompt you when an ABN is needed. The code scrubbing process only assesses the need for an ABN when the patient's insurance payer is configured with an ABN document formatting model.

If your practice has purchased an optional laboratory interface to Quest, then the application will generate an ABN form when you send the lab order.

Generate an ABN Using Reimbursement Rules

1. In the visit note, chart the diagnoses and procedures.
2. Select the Close icon to close the note.
3. Since you have not concluded the patient visit, mark the note as incomplete. You may also want to deselect options for creating the superbill, submitting electronic prescriptions, or submitting lab orders until you have concluded the visit.
4. In the Generate Documents Using Models field, select the ABN Form 2020v508 or ABN Spanish 2020v508.
5. Select the OK button to close the note and generate the selected document.
6. Open the incomplete note in Full Note Composer to complete the visit.

Generate an ABN Using Optional Claim Scrubbing

1. In the visit note, chart the diagnoses and procedures.
2. Select the Validate Codes () icon. This sends the diagnosis and procedure codes and other information to Alpha II for validation.
3. The Code Validation window opens to display any code scrubbing messages. If a line item rejection is received with a category ID of MN (for medical necessity), then an ABN is needed and no other validation information will be displayed for the procedure.
4. Select the Close button to close the Code Validation window and return to the Full Note Composer window.
5. When an ABN is needed, then the ABN Needed () icon displays in the ABN column of the charted procedures table.
6. Select the ABN Needed () icon to generate the ABN form.
7. The Generate Document window will open to display the generated ABN form.
8. Either:
 - Have the patient electronically sign and date the form.

- Print the form and have the patient sign and date the form.
9. Close the Generate Document window. This returns to the Full Note Composer window.
 10. The ABN Complete () icon now displays in the ABN column of the charted procedures table.

<<New>> *Generate an ABN Using an Optional Quest Interface*

1. In the visit note, chart the diagnoses and procedures.
2. Select the Save and Send Lab Orders () icon. This accesses the Patient Lab Order window.
3. When an ABN is needed, the Attachment window opens with the ABN.
4. Print the form and have the patient sign and date the form.
5. Close the Attachment window. This returns to the Patient Lab Order window.

Negation of a Procedure

There are circumstances under which you may decide not to perform or order a procedure that is otherwise the standard protocol. You can chart the procedure code and apply a negation reason to it. The negation reason identifies that the procedure was not performed and why not. This is useful for MIPS and other federal and state quality programs with established protocol for performing certain procedures.

Negation reasons are associated with SNOMED codes. The SNOMED is included in the patient visit note when the negation reason is used, and then included in the reporting for MIPS or other quality program.

Negated Procedures and Orders

A negated procedure entered in the SO tab will not generate an order even if the procedure is configured to do so.

Negated Procedures and Patient History

A negated procedure will be entered in the patient's history if the procedure is configured to do so. You should delete the procedure from the patient's history indicating that it was not performed.

Negated Procedures and Superbills

A negated procedure entered on the SP tab will not be included in the superbill generated from the visit note if you enter the negation reason before the superbill is created (i.e., before closing the visit note). If you enter the negation reason after the procedure has been included on the superbill, then you or your billing staff should remove the procedure from the superbill before filing a claim or billing the patient.

Negated Procedures and Document Formatting Models

A negated procedure will appear in document formatting models, including those used for the Visit Text tab, Review Past Notes, and One Page Summary, with the statement:

Procedure name was not performed/ordered because negation reason.

Negate a Procedure

Use the following process to negate a procedure that you have decided not to perform.

1. Full Note Composer or other clinical note type
2. Select the SO tab.
3. Select the desired procedure code in the usual manner.
4. In the charted procedure, select the Negation field and search for and select the desired negation reason.

Clinical Claim Scrubbing

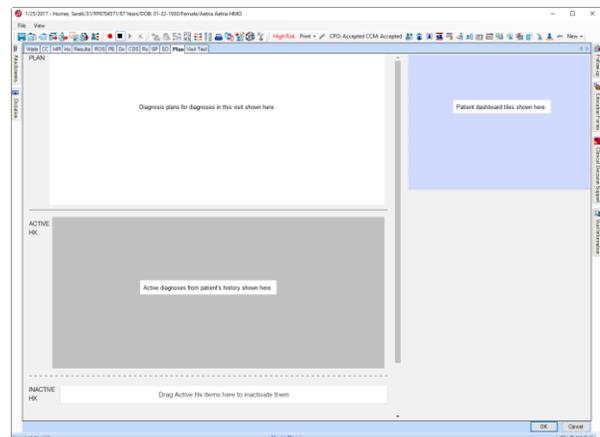
If your practice has purchased the optional clinical claims scrubbing functionality, you can perform that scrubbing now by selecting the Validate Codes icon () on the toolbar.

Please see the Clinical Claims Scrubbing for more information and instructions.

Enter the Plan (Plan Tab)

The Plan tab is a summary of the information and instructions that should be printed and given to the patient at the end of the visit. The Plan tab itself is divided into four sections:

- Plans for the diagnoses charted in this visit
- Patient dashboard for a selected diagnosis plan
- Active diagnoses from the patient's history
- Inactivate history drop space



The application automatically saves the visit note when you select the Plan tab, even if you do not make any entries in the tab.

Note: Only visit notes created in the 2016 version or later display the plan using the diagnosis plans. Visit notes created prior to the 2016 version display in the classic plan format. If you prefer to use the classic plan in new visit notes, you may select the Classic Plan hyperlink at the bottom of the window. You cannot switch between the Plan formats in a given visit note once you have made any entry in either format.

Diagnosis Plans

The Plan area of the tab includes a plan definition tile for each diagnosis charted in the visit note. Each tile contains the diagnosis plan definition for the charted diagnosis. A diagnosis plan definition contains sections for the information typically given to patients for the specified diagnosis. This may include things like diet and nutrition, exercise or physical activity, screenings and tests, medication, and vaccinations. An information section may enable you to select one or more options or enter free text.

The information sections in each plan tile are determined by the plan definition associated with the diagnosis code. The application includes system-defined diagnosis plan definitions for several diagnoses. Your administrative super user may define additional diagnosis plan definitions for your practice. A diagnosis that is not associated with a specific plan definition uses the system-defined Generic diagnosis plan definition.

The system-defined NOS (not otherwise specified) diagnosis plan definition is included on all visit notes. The NOS plan definition includes general plan notes, patient instructions, diet, exercise, and follow-up information for the patient. The NOS plan definition also includes internal notes that are not included in the plan information given to the patient. The plan notes, patient instructions, and internal notes sections use the General Note functionality. Text is limited to 8k, and images and inking are not supported.

You can use the NOS plan definition for any information not specified in a diagnosis plan definition, or you can use the NOS plan definition instead of using a diagnosis plan definition or definitions. Plan information entered into earlier versions of the application and pulled into a new visit via the Follow Up slider will appear in the system-defined NOS plan.

When a visit includes more than one diagnosis, then the plan definitions for the diagnoses may duplicate information. To avoid duplicate or seemingly contradictory information for the patient, you may want to complete the plan tile for the primary diagnosis first. Then review the information sections of any additional diagnosis plan tiles and the NOS plan tile, and complete any other information sections needed.

Patient Dashboard

A diagnosis plan may be associated with a patient dashboard configuration. The dashboard displays on the right when the diagnosis plan is selected. This enables you to view the patient information defined in the dashboard configuration.

A patient dashboard configuration may include a variety of patient medical information as well as demographic, appointment, and visit information. Your administrative super user will define dashboard configurations that display information pertinent for the diagnoses covered by a diagnosis plan or plans.

Active Diagnosis History

The active diagnosis history area of the Plan tab lists the active diagnoses and problems from the patient's history. These diagnosis and problem tiles are read-only, and for informational purposes only. You can, however, drag an active problem or diagnosis from the patient's history into the Inactive Hx box, which is the fourth and bottom area of the tab. Dragging a diagnosis or problem tile into this area inactivates the problem or diagnosis in the patient's history as of the current date.

Using the Plan Tab

1. Select the Plan tab.
2. Complete plan information for a diagnosis.
 - a. Select a plan tile by clicking in the center of the tile or on the drop-down arrow ().
 - Notice that when you select a diagnosis plan, the dashboard associated with that plan opens in the right side of the window.
 - b. From the list of information items, select the desired item.
 - c. Complete the plan by entering a description and notes or by selecting one or more items.
 - d. Select the OK button on the right of the diagnosis tile once you have completed all plan entries for the diagnosis.
 - e. Repeat for each diagnosis for which you want to enter plan information.
3. To view and revise a previous plan for the patient and the diagnosis:
 - a. Select the Previous Plan button in the diagnosis plan tile.
 - b. Select the desired plan.
 - c. Update or add information as desired.
4. Once you have entered information for a diagnosis plan, you can toggle between the Expand and Collapse hyperlinks to display more or less of the plan information in the tile.
5. To save your entries as defaults for the diagnosis plan, select the Save New Plan Defaults button in the diagnosis plan tile. The new defaults apply only to you. The defaults are not changed for any other users.
6. To exclude a diagnosis from the plan, unselect the checkbox in the colored bar on the left of the diagnosis plan tile. An excluded diagnosis will not be included in the Visit Text tab.
7. Review the active diagnoses from the patient's history, if desired. If appropriate, you may inactivate a diagnosis by selecting the diagnosis tile, and dragging it to the Inactive Hx area. (Please note that the status change is made and saved in the history immediately. This change is made even if you close the visit note without saving.)

Pasting Graphics in the Patient Instructions and Plan Notes Fields

You may paste graphics into the Patient Instructions and Plan Notes fields in the NOS plan. You cannot paste graphics into any other diagnosis plan.

Inked Entries in the Patient Instructions and Plan Notes Fields

You may use inking in the Patient Instruction and the Plan Notes fields in the NOS plan and other diagnosis plans that include these fields. However, the inking will not display in these fields in the visit note window. The image of the inked entry does appear in the Attachment Editor window and in generated documents.

Review the Visit Note (Visit Text Tab)

The Visit Text tab displays the information from the current patient visit note as it appears in Review Past Notes. You can edit the visit note text in the Visit Text tab in the following ways.

- Use the text tool bar to change the font, size, and appearance of the text. Select the text that you want to format, and then select the button for the desired change.
- Following each section of the visit note is an Editable Comment field. You may enter additional text in these fields. The information you enter here will be stored in the Notes field of the appropriate tab.
- Other text in the visit note cannot be edited directly from the Visit Text tab. To add to or change any of the information, you must make or change the appropriate entries in the other tabs of Full Note Composer or Superbill Composer.

Use the Refresh button to refresh the content of the tab with any updates made in other tabs.

Note: The Visit Text tab uses the formatting model functionality, which uses the Window's default printer definition to determine text layout. Therefore, when using the Visit Text tab, your default printer must be configured as an existing printer on your network. Visit Text will perform poorly if the default printer is not available or invalid.

Enter Confidential Information (Confidential Tab)

The Confidential tab enables you to enter confidential comments in a patient visit note. Information entered in the Confidential tab can only be accessed by those users to whom you have explicitly given permission. If you have a default list of providers and care teams that have access to your confidential comments, those users are defaulted to having access when you create a new confidential comment. You can add to or remove users from this list if desired.

Once a confidential note has been entered on a patient visit note, the list of users with access to that information cannot be edited.

1. Full Note Composer or other clinical note type → Confidential tab
2. Verify or modify the Providers and/or Care Teams with Access to the confidential comments.
3. Select the Ink or Text radio button to identify how you will enter the comments.
4. Write or type the comments in the notes field.

Enter an Assessment Form (Assessment Tab)

The Assessment tab is not standard in any clinical note type window. Your administrative super user must add the Assessment tab to a clinical note type window definition in order for you to use this functionality. The tab may be added to any user-defined clinical note type window or to a copy of system-defined clinical note type, such as Full Note Composer.

You must begin the visit note in a clinical note type window that includes the Assessment tab. Once a visit note has been created, you cannot open it in another clinical note type window.

The Assessment tab enables you to select and complete a specific assessment form. The application a number of system-defined assessment forms. Your administrative super user may have defined additional custom assessment forms.

System-defined assessment forms include the items to be assessed, the assessment method (such as a rating, or yes/no entry), and, if part of the assessment, an overall score.

When you chart an assessment, you may also want to chart the procedure code for that assessment in the SP tab so that a charge is included on the superbill for the visit. Your administrative super user may have associated a procedure code with some or all of your assessment forms. When a procedure code is associated with an assessment form, then charting the assessment form in a visit note also automatically charts the associated procedure code on the SP tab.

An assessment form may also be used to document information for one or more procedures. In this case, a radio button or checkbox in the assessment may be associated with a procedure code. When you select the radio button or checkbox, the application charts the associated procedure code in the SP or SO tab of the visit note. An assessment form may also include a procedure find field that enables you to select a procedure code. This may also be configured to chart the selected procedure code in either the SP or SO tab.

An assessment form may also have a radio button or checkbox associated with a diagnosis code. When you select the radio button or checkbox, the application charts the associated diagnosis code in the Dx tab of the visit note. An assessment form may also include a diagnosis find field that enables you to select a diagnosis code. This may also be configured to chart the selected diagnosis code in the Dx tab.

Custom assessment forms may be defined to allow multiple instances of an assessment form in a single visit note. This enables, for example, assessments of multiple wounds or limbs. When an assessment form is defined to allow multiple instances in a single visit note, then it will also create a title based on information entered into the assessment form. This enables you to distinguish the different assessments in the visit note.

When you add an assessment form to a visit note, the tab displays a list of previously completed assessments using the same form. You can then select any previously completed assessment to review the contents of the form. Note, however, that this does not work for assessment forms that are defined to allow multiple instances of the same form in a single visit. These assessment forms have dynamic titles, which the application cannot identify when you add a new instance of the assessment form to a visit note.

When viewing previously completed assessment forms, you cannot make changes to the assessment information that was charted in a previous patient visit note.

You can use the Follow-Up slider to add a new instance of an assessment form to the current visit note. The new instance of the form is added with the previously charged information prepopulated. You can make changes to this information in the new instance of the form. You can also review, but not change, the previously charted assessment.

You must use the Follow-Up slider to view previously completed assessments that use an assessment form defined to allow multiple instances of the same form in a single visit. Selecting the assessment form from the Follow-Up slider enables you to select the specific instance of the form that you want to review and reassess.

<<New>> Procedure Codes for Depression Screening Results

The add-in utility Depression Screening Note Processor enables the appropriate procedure code for remission of depression to be automatically added to a patient's visit note when the following conditions are met:

- The patient's score on the first PHQ-9 assessment must be 9 or greater, and
- A second PHQ-9 assessment is completed within 11 to 13 months of the patient's first PHQ-9 assessment.
- Then:
 - If the patient's score on the second assessment is between 0 and 5, the application adds the G9509 code to the SP tab.
 - If the patient's score on the second assessment is 5 or greater, the application adds the G9510 code to the SP tab.

Charting an Assessment

1. Select the Assessment Form tab.
2. Select the New button to add a new assessment.
3. In the Find window, select the desired assessment form.

This displays the assessment form in the primary pane. The form itself is listed in the top left pane, and the completion date, which is today's date, is listed in the lower left pane.

Any previously completed assessments using the same form are also listed in the lower left pane by date. Select the date to view the information in the previously completed form.

4. Complete the assessment by selecting the appropriate radio buttons, checkboxes, or entry fields.

If the assessment includes an overall score, you will see that score calculated at the bottom of the form.

If the assessment form is defined to allow multiple instances, then the assessment form name in the top left pane will change based on the information you enter. The name will change when you save the visit note or when you add another assessment form.

5. Repeat to complete an additional form. If the assessment form is defined to allow multiple instances, then you may select the same form again if needed.

Deleting an Assessment

You can delete a current assessment from a visit note. When you delete the current form, any previously completed assessments using the same form will be removed from the tab. This simply removes them from the current display. Previously completed assessments are still in the database.

1. Full Note Composer or other clinical note type window
2. Select the Assessment tab.
3. Select the desired assessment in the top left pane.
4. Select the Delete button.

Viewing Assessment Changes to a Completed Visit Note

Once a visit note has been marked as completed, then the application stores each changed version of an assessment form in the visit note. Use this process to view a previous version of a completed assessment.

1. Select the Assessment Form tab.
2. Highlight the desired assessment form in the upper left pane of the tab.
3. In the lower left pane, select the Number of Addenda for the desired visit date. This is selectable only when a previous version of the assessment form was saved.
4. The View Assessment Form Addendums window opens.
 - a. In the left pane, select the date and time of the completed form you wish to view.
 - b. In the right pane, review the assessment form with the content saved on the selected the date and time. This previously saved content is read only.
 - c. Select the Close button to close this window and return to the Assessment Form tab.

Enter General Notes (General Notes Tab)

The General Notes tab enables you to enter text or ink notes that you want to include in the patient visit note. Information entered in this tab appears in the CC/HPI section of the Visit Text tab, Review Past Notes, and One Page Summary.

You can simply type or ink in the text area of the window to enter a note for the patient. Or you may select a general note that saved for reuse. When you use a general note, you may modify the text for this use if needed.

Enter a Note for the Patient

1. Either:
 - Select the Ink radio button to enter the note using the stylus.
 - Select the Text radio button to enter the note using the keyboard.
2. In the text area, enter the desired information.
3. Use the text formatting icons to format the text as desired.

Create a New General Note

Use this process to create a general note that can be used now and in the future.

1. Select the Text radio button.
2. Select the User to be associated with the general note.
3. Select the New button.
4. Enter a Name for the note.
5. Enter the text of the Note.

Note: Use Ctrl+Enter to insert a blank line within or at the end of a note.

Select a General Note for Use

1. Select the Text radio button.
2. In the User field, select the user whose notes you want to view or leave blank to view all notes.
3. Select the link for the desired general note.
4. In the text area, make any desired changes to the general note.

Modify an Existing General Note

Use this process to make changes to the text of a general note.

1. Select the Text radio button.
2. In the User field, select the user whose notes you want to view or leave blank to view all notes.

3. Highlight the desired note, and then select the Modify button.
4. Edit Name and Notes fields as desired.

Enter Case Information (Case Mngt Tab)

The Case Management tab only displays if a patient case is associated with the patient and visit. Information in the Case Management tab on Full Note Composer enables you to track a patient case through multiple patient visits. Although a new patient visit note is created for each visit, the information in the patient case tab is retained throughout each visit until the case is explicitly closed.

1. Select the Case Mngt tab.
2. Complete the information on the tab as appropriate.

Please refer to the Case Management section for more information.

Enter an E&M Code

The Evaluation and Management (E&M) window enables you to review the parameters that have been included in a patient visit note prior to filing a claim for the visit and confirm or select a level of care. If you have not already entered an E&M code in the patient visit note, the entries on this tab will determine the appropriate code and recorded in the SP tab of Full Note Composer or other clinical note type window when you select the OK button to close the window.

To access the Evaluation and Management window, select the E&M icon () from the toolbar in Full Note Composer or other clinical note type window. Please refer to the Evaluation & Management section for more information.

Print Patient Information

You may choose to print patient information at this stage.

1. Select the Print icon from the patient visit note. This opens the Review Past Notes window for the current visit note.
2. Select the Review Past Notes tab you want to print, and then select the Print button.
Note: If you want to print information from more than one tab, you will have to print each tab separately.

Close the Visit Note

Select the Close () icon or the OK button to close the patient visit note. This accesses the Visit Checkout window. The Visit Checkout window enables you to control the status of the visit note and items associated with it. The status of the visit note may be complete or incomplete. The items associated with the note include the superbill; the appointment; any prescriptions, lab orders, advanced beneficiary notices, and documents that need to be generated; and the routing for approval if needed.

E&M Warning Message

A warning message is displayed at checkout when an E&M code has not been selected. However, if the patient visit note does not contain any services performed (procedure codes entered on the SP tab), then this warning message is not displayed.

Modifier Required Warning Message

Your administrative super user may configure procedure codes to display a warning message when the code requires a modifier. This message appears with the E&M warning message.

The modifier required warning appears only when the patient's insurance payer and plan requires a modifier on a procedure code charted in the visit note, and only when you select the option to complete the visit note.

Prescriptions and Orders Warning Message

If you entered prescriptions or orders in the visit note and have not yet submitted or printed them, then a yellow warning message will appear at the top of the Visit Checkout window.

Superbill Status Settings

A superbill is created when the clinical note type window used to create the visit note includes Services Performed (SP). The superbill includes data from the patient visit, such as the diagnoses and procedures if they were included in the visit. It also includes patient demographic information and fees information, if defined.

A patient visit note will be associated with a superbill if the clinical note type window includes an SP (services performed) tab. The visit note may be associated with more than one superbill if, for example, the visit note includes site-specific procedures or procedures covered by an alternative insurance payer. The list of superbills at the top of the window displays the superbill status for each superbill associated with the visit note.

Select the icon for the desired superbill status, or search for and select another superbill status.

- Preliminary (): Indicates that coding is not yet complete.
- Ready to Review (): Indicates that codes are entered, but the superbill should be reviewed by the billing staff to ensure it is complete and correct prior to processing.
- Ready to Submit (): Indicates that the coding requires little or no review by the billing staff prior to processing.

Note: When the Save as Complete Note radio button is selected, then the superbill status defaults to the provider's status default as defined in the Provider window.

You can review the superbill by selecting the superbill.

To create another superbill, select the New Superbill button in the list of superbills.

Appointment Status

The Set Appointment Status field enables you to set any appointment status that you prefer. There is also a Ready to Discharge button which enables you set the appointment status as Ready to Discharge with a single selection.

If the appointment status has already been changed to Discharged, marking the visit note as Complete does not change the appointment status.

Prescriptions

If a prescription has been included in the patient visit note, the Mark Prescriptions Ready to Prescribe checkbox is enabled. This checkbox is deselected while the status of the visit note is incomplete. You may select the checkbox to submit electronic prescriptions if desired. When you change the status of the visit note to complete, this checkbox is automatically selected.

If the patient has an associated pharmacy, and the pharmacy can accept electronic prescriptions, the prescription will be transmitted to the pharmacy when the note is closed. (This checkbox will not be selected and the prescription will not be transmitted if the prescription has already been transmitted to the pharmacy.)

Note: Compound, and complex drugs may not be transmitted electronically. Controlled substances may be sent electronically only if you are using the optional EPCS functionality.

If there is no associated pharmacy, the pharmacy cannot accept electronic prescriptions, or the type of prescription cannot be transmitted electronically, then the prescription will be available for printing from the patient Checkout window available from the Desktop. If the prescription has already been printed (from within Full Note Composer), you can uncheck this box and the prescription will not be available on the checkout window.

You cannot mark the patient visit note as complete until associated prescriptions are marked as ready to prescribe.

Lab Service Orders

If lab services were ordered and the lab requires a requisition, then the Print Requisition checkbox will be active. Select the box to print the requisition. If the lab does not require a requisition or if no lab services were ordered, the checkbox will be inactive.

If a lab order has been included in the patient visit note, the Mark Lab Orders Ready to be Sent checkbox is checked. This checkbox will not be selected if the lab order has already been transmitted to the lab.

If instead, you want to send a lab order message to a staff member to have the order completed, then select the Send Order Task Message To checkbox, and then select a recipient of the message.

Dictation

Dictation files cannot be exported, by the Export Dictation job or manually, until they have been marked as ready to transcribe. When a patient visit note includes dictation, the Voice Dictation Ready to Transcribe checkbox will be active. Select this checkbox if the dictation is complete and ready for transcription. Deselect the checkbox if the dictation is not ready for transcription.

You cannot mark the patient visit note as complete until the associated dictation file is marked as ready to transcribe.

Advance Beneficiary Notice

If a procedure provided required an advance beneficiary notice, and that notice was generated and signed by the patient, select the ABN Complete checkbox. This checkbox will already be selected, if the ABN was marked as complete within Full Note Composer. When the ABN Complete checkbox is selected, either here or within Full Note Composer, then it is also marked as completed on the superbill. This notifies the billing staff that the required paperwork is complete so that they know how to process the insurance claim.

Patient Case

If the patient visit note is associated with a patient case, you have the option of closing the case by selecting the Close Case checkbox. If you select the Close Case checkbox, then this patient case will no longer be available to be associated with additional patient visit notes. Before the case is closed, the system performs a validation check to make sure that all visit notes that relate to the case have been closed.

If the patient visit note is not associated with a patient case, the Close Case checkbox is inactive.

Clinical Summary

You may indicate that the patient declined the patient plan or other clinical summary. This may be an important indicator for MIPS or other clinical quality programs which expect a clinical summary to be given to the patient for each visit.

Document Generation

If required, generate a document, such as a referral letter, a disability letter, or a worker's compensation form, from a format defined in your system. You may generate documents using either document formatting models or rich text format (.rtf) or Microsoft Word™ documents as models. Documents generated using the document formatting models will generate more quickly than documents generated using Word document models.

Select the radio button for the type of document model you want to use, and then select the desired document formats using the search icon. The document generates and displays in a separate window, if using document formatting models, or in Word, if using Word document models. Using either method, you can edit the generated document if required. If you do edit the document, you must save it in the document generation window or in Word, depending on the method used. Otherwise, the originally generated document is attached to the visit.

Note: If a reimbursement rule was associated with the patient visit note, this field will automatically include any documents that were associated with the rule.

Visit Note Status

Select the radio button to indicate if the patient visit note will be saved as Incomplete or Complete.

- An Incomplete note is not finalized, and may still be edited and updated. To add or edit information, open the incomplete note. As the note has not been completed, edited information overwrites current information.
- A Complete note is finalized. This option will be disabled if you do not have the security rights needed to complete a visit note. Once a visit note is complete, you can add new information or make changes, but edits are identified as addendums. The new data is appended to the note; changed information is indicated with strikethrough text. The original information is not deleted; it displays as strikethrough text in OPS and RPN.

Forward the Note for Approval

Some users' names may have been set up to require a supervisor cosignature on patient visit notes. The cosignature may be mandatory or optional.

- When you close a note as Incomplete, you have the option of forwarding a message to one or more supervisors for cosignature. This option would usually be used if you require the supervisor to update information and complete the note.
- When you close a note as Complete, and you have been set up with Optional cosignature, you can choose whether to forward the note for cosignature.
- When you choose to close a note as Complete, and you have been set up with Mandatory cosignature, you must forward the note for cosignature before you can complete the note.
- You can request a message when the note has been approved. If you check the request checkbox, the application automatically sends you a message when the note has been marked as Approved.

Prescription Alert Summary

Surescripts requires that a summary of prescription information be displayed when closing a visit note or completing a prescription refill message. All providers are displayed the prescription summary for all visit notes and refill messages.

When you write one or more prescriptions from within Full Note Composer or other clinical note type window, a prescription alert message is displayed when you select the Submit Prescriptions  icon or close the patient visit note. The message tells you which prescriptions are being submitted electronically through Surescripts, which are being faxed through the fax service, and it gives you the option of printing any other prescriptions. Full details of each prescription are shown.

1. Review the prescriptions to verify they are correct before sending. You should check:
 - Drug description including the medication name, strength, strength unit of measure, and dosage form
 - Patient directions including the dose, dose unit, route of administration and frequency
 - Quantity to be dispensed including the corresponding dispense unit of measure
 - Notes written to the pharmacist
 - Number of authorized refills
2. If available, select printing options.
3. Select the Print Upon Completion checkbox if any prescriptions need to be printed.
4. Select the OK button to submit electronic prescriptions and print prescriptions not being sent electronically.

Visit Note Approval

Approve a Visit Note from the Note Approval Window

The Note Approval window enables you to approve a patient visit note without accessing Full Note Composer or other clinical note type window. The Note Approval window displays the patient visit note in One Page Summary format. It also includes the functionality from the Visit Checkout window. Thus, in addition to approving the visit note, you can save the note as complete or incomplete, forward the note to another provider for approval, view the list of superbills associated with the visit note, and set the superbill status.

It is important to recognize that when you access the Note Approval window for a patient visit note, the application considers the patient visit note open and locks it so that other users cannot access and change it.

1. Either:
 - Desktop → Visit Note entry → More Options menu → Note Approval
 - Visit Center → Complete hyperlink
2. Review the visit note displayed in the bottom portion of the window.
3. If appropriate, select the Change Billing Provider to Me checkbox.
4. Select the Complete Note radio button.
5. Select the desired Superbill Setting radio button to define the status of the associated superbill.
6. Approve the visit note:
 - If no changes are needed in the visit note, select the OK button. Then, at the confirmation message, select the Yes button.
 - If changes are needed in the visit note, select the Complete in FNC button to open the patient visit note in Full Note Composer or other clinical note type window. You can then make any needed changes to the patient visit note.

Approve Multiple Visit Notes from the Visit Center Window

You can approve multiple visit notes at once through the Visit Center window. Before you approve a visit note, you should review it, either in Full Note composer or another clinical note type window or in the Note Approval window.

The visit notes must be completed in order to be approved in this manner. If a visit note is incomplete or if it does not need to be approved, then a small red square appears in the top right of the checkbox column field.

1. Desktop menu → Visit Center
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox in the far left column for each visit note that you want to approve.
4. Select the Approve button.

Open and Edit a Completed Visit Note

When a user selects a completed visit note to open it, a popup message warns the user that the visit note is completed. The user may then cancel if they do not want to open a completed visit. This warning can be important when providers typically open the patient's most recent visit note for review before starting the visit note for today's visit. This warning can help prevent a provider from accidentally adding information from today's visit into the old note as an addendum.

When this warning is used, rendering or the billing provider on the visit note may open and edit the completed visit note. Any edits will be identified as addendums. A user who is not the rendering or the billing provider on the visit note can only open the completed visit note in read-only mode. The user will not be able to make any edits.

If your practice wants to allow someone other than the rendering or billing provider to edit completed visit notes, then your administrative super user may change the completed note warning message status for the practice. This allow users with clinical access, other than rendering or billing provider on the visit note, to edit a completed visit note. It also prevents the completed visit note warning message from displaying when any user opens a completed visit note.

PDR Network for Drug Information

You may access the PDR Network website to view drug information when reviewing a patient's medication history or past prescriptions and when writing a prescription. In most cases, you access the PDR Network by selecting the PDR () icon. This opens your web browser to the PDR Network page for the drug.

<<Revised>> Access the PDR Network for Medication or Prescription History

1. Either:
 - Full Note Composer or other clinical note type → Rx tab
 - Full Note Composer or other clinical note type → Hx tab → Medication History category
 - Patient History → Medication History category
2. Select the Action (  ) icon for a medication, then select the PDR option.
3. In the PDR Brief window, you may:
 - Select the Full Prescribing Information hyperlink. Your default browser will open to the PDR Network, and will display information about the selected medication.
 - Select the Patient Drug Info hyperlink. Your default browser will open to the PDR Network, and will display patient information about the selected medication. You may print this information if desired.
 - Select the Medications in PDR Therapeutic Class Your default browser will open to the PDR Network, and will display information for the medication therapeutic class.

Access the PDR Network when Searching for a Medication

1. Full Note Composer or other clinical note type → Rx tab
2. In the Drug field, enter all or part of the name of the desired drug and press the Tab key or select the Find icon.
3. In the Find Dispensable Drug window, select the PDR Search button located to the right of the Drug field.
4. Your default browser will open to the PDR Network, and will display a list of medications matching your search criteria.
5. Select the desired medication link to access information about the medication.

<<Revised>> Access the PDR Network When Writing a Prescription

1. Full Note Composer or other clinical note type → Rx tab
2. In the Drug field, search for and select the desired medication.
3. In the SIG Writer window, PDR information displays at the bottom of the window for approximately 15 seconds.
4. You may:
 - Select the Full Prescribing Information link. Your default browser will open to the PDR Network, and will display information about the selected medication.
 - Select the Patient Drug Info printer link. Your default browser will open to the PDR Network, and will display patient information about the selected medication. You may print this information if desired.
 - If available, select the PDR Discount link. Your default browser will open to the PDR Network, and will display a pharmacy discount card that you may print for the patient.
 - Select the Medications in PDR Therapeutic Class Your default browser will open to the PDR Network, and will display information for the medication therapeutic class.
5. Once the PDR information has closed, you may access it again by clicking on the PDR button at the bottom of the SIG writer window.

Prescriptions

This section includes general information about prescriptions and instructions for writing and refilling prescriptions.

When you select a medication on the Rx tab of Full Note Composer or another clinical note type window, that medication is then displayed in the SIG Writer window so that you can create a prescription. You may write a new prescription for the medication, refill a previously written prescription for that medication, or use a default SIG for that medication to write the prescription. All default SIGs for the selected drug are listed when the SIG Writer window is accessed. The SIG Writer window is also used to document medication samples that you give to a patient and to document a medication that you administer rather than prescribe.

You may also refill a prescription from a prescription refill request message and from the Patient History window.

When you write or refill a prescription, you can print the prescription, transmit it electronically if your practice uses the Surescripts electronic clearinghouse, or fax it if your practice uses the optional faxing service. To transmit a prescription electronically or by fax, the prescription must be associated with a pharmacy that is associated with either the Surescripts or Fax clearinghouse.

Prescription Regulations

It is the responsibility of the prescribing provider to comply with all state and federal regulations for prescriptions and electronic prescribing.

Sequence Numbers on Printed Prescriptions

Federal regulations require a unique sequence number on all printed prescriptions. The application assigns prescription sequence numbers by practice, not by individual provider.

The sequence number is assigned to the prescription when it is printed. When a prescription is reprinted, it is assigned a new sequence number. The sequence number appears on the printed prescription, in the prescription entry in the patient's medication history, and in the audit trail. The prescription entry in the patient's medication history will contain multiple prescription sequence numbers if the prescription was printed more than one time.

Printing a Copy of a Prescription

You can, if needed, print a copy of a previously printed or electronically transmitted prescription. However, the pharmacy cannot dispense the medication from the printed copy of the prescription. The DEA requires that the printed copy of the prescription include the watermark "Copy only – Not valid for dispensing." The application includes this watermark when you print any previously printed or electronically submitted prescription.

Reprinting an Electronically Submitted Prescription

When a prescription fails to print or to transmit electronically correctly, then you may reprint the prescription. The DEA requires that you identify the reason for reprinting the prescription.

When the prescription was originally printed, the DEA requires that the reason for reprinting be included on the reprinted prescription.

When the prescription was originally submitted electronically, the DEA requires that the following information be included in the reprinted prescription:

- That the prescription was originally transmitted electronically
- The name of the pharmacy the prescription was originally sent to,
- The date and time of the transmission, and
- An indication that the transmission failed.

When you reprint a prescription that was submitted electronically, the application defaults the following message as the reprint reason. You can add to this message if desired.

ePrescribed transmission failed. The prescription was originally transmitted electronically to *PharmacyNameandNumber*. Transmitted at *MM/DD/YYYY HH:MM*.

Earliest Fill Date

The start date on a prescription is the earliest date that a pharmacy may fill the prescription. The earliest fill date is important for controlled substances, particularly Schedule II drugs since refills are prohibited for these drugs. The earliest fill date ensures that multiple prescriptions for a drug are treated as separate dispensing documents, not refills of an original prescription.

Each separate prescription must contain written instructions indicating the earliest date on which a pharmacy may fill each prescription. By default, the start date on a prescription is the date the prescription is written. You may change this date if needed or desired.

Regulations for the State of Ohio

The Administered Medication Detail Log and the Prescription Detail Log reports serve as the paper Record Administration required by the Ohio Board of Pharmacy in accordance with OAC 4729-5-01 (N). The information for these reports is pulled from the SIG Writer and Full Note Composer or Superbill Composer. The provider identified in these reports is the rendering provider identified in the patient visit note. The person identified as administering or prescribing the medication is the user who is signed into the application when the data is entered into the patient visit note. Therefore, in order to maintain the appropriate legal records required by Ohio state law, users must be logged in to the application under their own login when entering prescription and administered medication data in order for these reports to populate the correct administrator of the medication.

Surescripts Requirements

NDC Number Required for Electronic Prescribing

The Surescripts pharmacy clearinghouse requires that a national drug code (NDC) number be included on all electronic prescriptions, except prescriptions for supply items, such as syringes. The First Databank drug database used by the application includes NDC numbers for medications and also identifies supply items.

However, not all medications in the drug database have an NDC number. The application will not allow medications without an NDC number to be electronically prescribed because Surescripts would reject the prescription.

When writing a prescription and selecting a medication, the Find Dispensable Drug window displays the NDC number of the medication. If the NDC column in window is empty, then the medication cannot be electronically prescribed.

If you attempt to electronically prescribe a medication that does not have NDC number, the application displays a warning message in the Unified Summary window. You can either print the prescription that you have written or you can edit the prescription to select a form of the medication that does include an NDC number.

Pharmacy Instructions

Surescripts allows you to enter free text notes and instructions to the pharmacy. These notes and instructions are intended for you to communicate pertinent information that is related to the prescription, but that **is not** part of the prescription itself. You may enter notes and instructions in the Pharmacy Instruction field in the SIG Writer window.

It is very important that you use the Pharmacy Instruction field appropriately. Inappropriate notes, such as information that conflicts with the structured prescription, may cause problems or delays in filling the prescription and may cause patient safety risks.

The tables below give examples of appropriate and inappropriate use of the pharmacy instructions. Remember that pharmacy instructions are not necessary. You should include these only when appropriate.

Appropriate Pharmacy Instructions

Type of Instruction or Information	Example
Inform a mail order pharmacy of the need for bridge, vacation, lost, stolen, replacement supply.	This is another 90 tabs for a vacation override. Additional amount - pills were destroyed.
Request that the label be in the patient's preferred language.	Please label in Spanish.

Type of Instruction or Information	Example
Request expedited pick-up time, delivery, or to inform the patient when ready.	Please deliver to patient today.
Counsel patient on therapy, indication, use, and other related information.	Please advise patient not to drink alcohol while taking this medication.
Request flavoring of the medication.	May add flavoring, preferably bubble gum.
Identify the number of prescriptions for the patient.	1 of 3 Rx
Other related information intended for the pharmacist without a structured field.	Patient prefers only XYZ manufacturer brand.

Inappropriate Pharmacy Instructions

Type of Instruction or Information	Example
Identifying information for the patient, provider, or pharmacy.	PT DOB: XX-XX-XX Prescribed by: Dr. XYZ NPI: 123456789.
Drug name or description.	Metoprolol Tartrate 50 mg oral tablet.
Directions for the patient.	Follow up after course
Diagnosis or indication.	Benign Hypertension 401.9
Quantity or quantity unit of measure, or potency unit code.	QS for 3 Bottle 90 days supply

Prescribing or Refilling Controlled Substances

The prescribing of controlled substances is regulated by the Drug Enforcement Administration (DEA). It is your responsibility as a provider to be aware of, to understand, and to comply with all DEA requirements for prescribing, printing prescriptions for, and submitting electronically prescriptions for controlled substances.

- General information about prescribing controlled substances is available from the DEA website at <http://www.deadiversion.usdoj.gov/21cfr/21usc/index.html>.
- Information about EPCS regulations is available from the DEA website at <http://www.deadiversion.usdoj.gov/e-comm/e-rx/index.html>.

Medications defined as controlled substances by the Drug Enforcement Agency (DEA) are identified as a controlled substance in the drug database supplied by First DataBank. First DataBank does not identify as controlled substances other medications that are defined as controlled substances by a particular state. Your administrative super user may define medications as controlled substances at the state level. The application recognizes those medications as controlled substances, based on the patient's or the pharmacy's address, when you print the prescription or send it electronically.

Printed Prescriptions for Controlled Substances

When printing a prescription for a controlled substance, the DEA requires that you physically sign it (wet signature, not electronic). If the prescription is for a Schedule III – V medication, the DEA allows you to give the signed prescription to the patient or fax it to the pharmacy. If the prescription is for a Schedule II medication, the DEA requires that you give the signed prescription to the patient.

Your administrative super user may have defined a specific prescription format for printed prescriptions for controlled substances. The controlled substance format may be defined practice-wide and for individual providers. If a controlled substance prescription format is defined, then it will be used for all controlled substance prescriptions.

Electronically Submitting Prescriptions for Controlled Substances

DEA requirements for electronically prescribing controlled substances (EPCS) include identity proofing the provider and enabling two-factor authentication when submitting prescriptions. Aprima's identity authentication services vendor is IdenTrust. The IdenTrust certificate satisfies the identity-proofing requirement, and the HID Approve mobile app or the security device provides the two-factor authentication.

Therefore, in order to use the application's EPCS functionality, you, the provider, must have registered with IdenTrust, downloaded the HID Approve app to your cell phone or received your security device, and activated your security certificate on one or more PCs. (Please refer to the IdenTrust Certification Process document for more information and instructions.) You must also have been set up for the EPCS functionality in your Aprima database.

In compliance with the DEA regulations, the application prevents any prescription for a Schedule I through Schedule V medication from being sent electronically if you are not properly set up for the EPCS functionality. If you are not set up for EPCS, then you must print prescriptions for controlled substances.

When using the EPC functionality, you must electronically sign each controlled substance prescription using the HID Approve app or security device and the password associated to it. You cannot have another user perform the signing process for you. You are required to keep the HID Approve app or security device in your possession and you must not share your password for the app or device with anyone. Failure to keep the app or device and password secure may result in the loss or suspension of your DEA registration.

You, as the person to whom the security certificate and the HID Approve app or security device have been issued, must maintain exclusive use of your security device. Your digital security certificate and the HID Approve app or the security device together are a legal form of identification, similar to your passport or driver's license. Like your passport or driver's license, they

cannot be used by or transferred to another person. Under the IGC certificate policy, IdenTrust has the authority to revoke the certificate in a case of loss or disclosure of the private key (password) to anyone other than you.

Audit and Reporting Regulations

The DEA requires that each location where providers will use EPCS functionality must designate at least two individuals to manage access control to the Aprima application and EPCS functionality. At least one of the designated individuals must be a provider who is authorized to issue controlled substance prescriptions and who has obtained a two-factor authentication credential from IdenTrust. The other individual may also be a provider or may be a clinical administrator.

These designated individuals and all providers using EPCS services are required by the DEA to generate and review reports on EPCS activity on a regular basis, and to take prompt action on any irregularities or possible security breaches identified.

The administrator must generate the eRx Audit Daily Summary report every day to identify potential security incidents regarding the issuance or records of controlled substance prescriptions, such as an attack on the application or unauthorized access to the application. When the administrator identifies a potential incident, the administrator must notify both Aprima Medical Software, Inc. and the DEA within one business day of the potential incident.

Each provider must generate the eRx Medication Audit report for their controlled substance prescriptions once a month. The provider must review the report to verify that all prescriptions attributed to the provider were written and submitted by the provider.

Aprima automatically generates these reports on your behalf, and sends the generated report to the appropriate users in a message. The application generates the eRx Audit Daily Summary report each morning for the previous day's EPCS activity, and sends it to all users in the system-defined Clinical Administrators user group. The application generates the eRx Medication Audit report for each provider on the first of the month for the previous month's EPCS activity. It also generates this report for a provider when the provider's EPCS functionality is revoked. The application sends each provider's report to the provider. Administrators and providers must complete the message to signify that they have reviewed the report.

IMPORTANT: Should either report fail to generate automatically, these users are responsible for generating and reviewing the report in the timeframe required by the DEA.

Pharmacies for EPCS

An electronic prescription for a controlled substance may only be dispensed by a pharmacy that is certified for EPCS. A pharmacy may accept electronic prescriptions, but not be certified to accept and process electronic prescriptions for controlled substances. The Find Pharmacy window displays the pharmacy's electronic prescribing services in the Service Level Code column. If this column includes 'Controlled Substance (EPCS),' then the pharmacy accepts electronic prescriptions for controlled substances.

Electronically Submitting a Previously Printed or Phoned Prescription

The DEA prohibits the electronic submission of a prescription for a controlled substance if that prescription has already been printed. Once a prescription has been printed, the application prevents any attempt to electronically submit it.

The DEA does allow you to submit an electronic prescription for a controlled substance after you have phoned the prescription to the pharmacy. The DEA requires that you include the following text in the pharmacy notes of the prescription submitted electronically.

Emergency Cover Prescription - Do Not Fill

The application includes a system-defined general note with this required text. The general note has the general note type EPCS.

Number of Refills Allowed for Controlled Substances

Prescriptions for schedule III, IV, and V medications may include up to four refills. Prescriptions for schedule II medications cannot include any refills. However, a prescription for a schedule II medication may be refilled when requested by the patient or the patient's pharmacy.

Refills for Controlled Substances

You cannot refill a prescription for a controlled substance originally written by another provider. You must write a new prescription for the medication. If you receive an electronic refill request for a controlled substance prescription written by another provider and you want to refill the prescription, then you must select the "Deny with New" option, and then write a new prescription for the medication.

Prescriptions for Opioid Addiction Treatment

The DEA requires that prescriptions for opioid addiction treatment medications include the Narcotics Addiction DEA Number (NADEAN) for the medication. Include the NADEAN in the pharmacy instructions. The application includes a system-defined general note enables you to easily enter this number. The NADEAN general note has the general note type EPCS.

Prescriptions for GHB Drug Products

The DEA requires that prescriptions for GHB drug products be issued for legitimate medical purposes, and that the purpose be identified in the prescription. Include the reason for the prescription in the pharmacy instructions. The application includes a system-defined general note enables you to easily enter this reason. The GHB Reason general note has the general note type EPCS.

Prescription Drug Monitoring Programs

Many states are implementing prescription drug monitoring programs to monitor prescriptions for controlled substances. The intent of these programs is to help providers and pharmacies identify patients who are at risk of substance abuse.

Appriss Health is working with the National Association of Boards of Pharmacy (NABP) to develop the PMP Gateway to the various state prescription drug monitoring databases. At this time, the NABP is integrated with approximately 40 states which may connect to the PMP Gateway. A list of participating states is available from the NABP website at <https://nabp.pharmacy/initiatives/pmp-interconnect/>.

If your practice has purchased this optional functionality, then you can access your state's prescription drug monitoring data from the Rx tab in Full Note Composer or another clinical note type and from prescription refill messages. The application displays the information directly from the state database. This information is reported to the state by pharmacies. The information displayed is not downloaded into your database.

Appriss only displays information from states with which you have registered with the state pharmacy board for their prescription drug monitoring program.

Information is matched by patient name. If patient name used by the pharmacy is different from the patient name in your database, then information for the patient may not be found.

<<Revised>> **Accessing Prescription Drug Monitoring Information from Patient Visit Note**

1. Full Note Composer or other clinical note type → Rx tab
2. Select the State Controlled Rx Hx link.
3. The Appriss Health State Controlled Substance window displays:
 - The state or states from which data was requested.
 - The name of the patient for which data was requested.
 - A list of prescriptions for monitored drugs. Entries include the medication name and strength, the date the prescription was filled, the quantity prescribed, and other information about the prescription.

Accessing Prescription Drug Monitoring Information from Prescription Refill Message

1. Message window for prescription refill message
2. Select the State Controlled Rx Hx button.
3. The Appriss Health State Controlled Substance window displays:
 - The state or states from which data was requested.
 - The name of the patient for which data was requested.
 - A list of prescriptions for monitored drugs. Entries include the medication name and strength, the date the prescription was filled, the quantity prescribed, and other information about the prescription.

Audit Information

MIPS and other quality programs may include measures related to prescription monitoring. Participation or auditing may require that you show that you accessed the prescription drug monitoring information for a patient. You, or your administrative super user, may do this in the Audit Trail window by searching for the word "Appriss" in the Description field. The audit trail entry includes the date and time the request was made, the user, the patient, and the report ID from Appriss.

Prescribing or Refilling an Obsolete or Retired Medication

When you write a new prescription or attempt to refill a prescription for a medication that has a status of Obsolete or Retired, the application will present a warning message telling you that the medication is obsolete or retired. You can cancel the prescription or refill, and then write a prescription for a different medication. Or you can choose to continue, and your prescription or refill will be submitted electronically or printed, as appropriate.

When you choose to write or refill a prescription for an obsolete or retired medication, an entry is written in the Audit Trail.

<<Revised>> Formulary and Patient Medication Benefit Check from Surescripts®

When the patient's insurance payer or plan has an associated formulary, you can view the formulary information from the Rx tab of Full Note Composer or other clinical note type window and from the SIG Writer window.

- On the Rx tab, select the Formulary Information link. This link will be active only when formulary has been downloaded for the patient.
- In the SIG Writer window, the Formulary pane displays the information.
 - The Rx Benefits link displays the date formulary information was received. Select the link to access information about the pharmacy benefits manager (PBM) and formulary.
 - The PBM and formulary name is displayed beneath the Rx Benefits link. If the patient has more than one PBM, the PBMs will be available for selection in this field.
 - Medications in the formulary are listed with their formulary status.

In some cases, you may receive Patient Medication Benefit Check (PMBC) in addition to the standard formulary information. Surescripts' PMBC program is a real-time transaction-based communication between the application, Surescripts, and the patient's-PBM that provides you with patient-specific drug cost and coverage information while you are charting a prescription.

The standard formulary and PMBC both provide information about the patient's formulary, coverage, and copays. But, the information they provide is at different levels.

- Formulary information is at the insurance plan-level. It tells you the drug's formulary status, medication alternatives, coverage factors, and copay details.
- PMBC information is patient, drug, and pharmacy specific. This includes specific, point-in-time cost for the selected medication and pharmacy, and costs for alternative medications,

types of pharmacy (retail, mail order, specialty), and days supply (such as 90 days). This gives you a more accurate estimate of the patient's out-of-pocket cost than the standard formulary information.

Please refer to the Using the PMBC Information While Charting a Prescription section for more information about PMBC and instructions for using the functionality.

Pharmacy Coupons

ScriptSave® electronic pharmacy coupons are automatically added to new prescriptions when the patient does not have prescription benefits, and therefore, does not have formulary information. When a coupon is available for a medication and the patient qualifies, the coupon is sent with the electronic prescription or included on the printed prescription. No action is required from you to add the coupon or to include it in the prescription.

Pharmacy on a Prescription

When you write a prescription, the pharmacy that is identified in Patient Demographics is automatically populated in the SIG Writer. If more than one pharmacy is identified in Patient Demographics, then the first one in the list is populated in the SIG Writer. If the pharmacy is listed with the Surescripts pharmacy clearinghouse or the Fax clearinghouse, you can select the Prescribe Items () icon to send the prescription to the Surescripts clearinghouse or to fax it directly to the pharmacy associated with the fax service. The visit note is automatically saved prior to submitting the prescription. Or, if you prefer, you can choose to send the prescriptions when you close the visit note.

Prescriptions that are not associated with a pharmacy or are associated with a pharmacy that is not listed with the pharmacy clearinghouse must be printed.

<<Revised>> Chart an Administered Medication

Administered medications are charted from the SIG Writer window. You enter the details for an administered medication in the Rx and Hx tabs of Full Note Composer or other clinical note type window, just like the details of a prescription. However, no prescription is generated; therefore, no prescription can be submitted electronically or printed for the administered medication.

When you administer a drug for which a National Drug Code (NDC) number is required, you can select the CPT code associated with the NDC number. The selected procedure code is added to the SP tab of Full Note Composer. The CPT code will have been associated with the NDC number by your administrative super user.

You can edit the information in an administered medication until the visit note is saved. Once the visit note is saved, you can delete an administered medication and re-enter the information, but you will not be able to edit the information.

1. Full Note Composer or other clinical note type window → Rx tab
2. Search for the desired medication.
 - a. Select the Prescribe button in the Medication SIG column header. This accesses the Select Drug window.
 - b. Search for and select the desired medication. This accesses the SIG Writer window.
3. In the SIG Writer window, review the drug screening and patient formulary information.
 - a. The Drug Screening pane lists the high-level categories for any warnings at the top of the pane. Select the Expand () icon to open the Drug Screening window and review the full text of all warnings.

If you are using ActX, the message "ActX results available below" appears at the top of the Drug Screening pane when an alert is received. Scroll to the bottom of the pane to review the alert.
 - b. The Formulary pane displays the date the formulary was downloaded, the patient's PBM and formulary name, and any available alternative medications are listed with their formulary status. To see additional information, select the Expand () icon.
4. In the SIG Writer window, select the Administered checkbox. This opens the Administered popup window.
5. In the Administered popup window:
 - a. Enter the Site where the medication is given.
 - b. Enter the manufacturer's lot number in the Lot # field.
 - c. Select the name of the Manufacturer of the medication.
 - d. Select the Funding Source if applicable.
 - e. Enter the Expiration Date of the medication.
 - f. Enter the Initials of the person who administered the medication.
 - g. The Administered Date and Time default to today's date and the current time. You may change these if needed.
 - h. Select the OK button to save the entries and return to the SIG Writer window.

To reopen the Administered popup window, select the Expand () icon in the Administered panel in the top right of the SIG Writer window.
6. Enter the Dose, Unit measure, and Route.
 - a. Selecting any of these fields accesses a popup window where you can quickly select each item.

To search for a specific entry, select the blank line at the top of the desired pane, then type the first letter or letters of the desired entry.
 - b. Select the OK button to return to the SIG Writer window.
7. Select a medication Category, if desired. The category may be used to filter in the patient's medication history.
8. Select the diagnosis code in the Dx field that you want to associate with the medication. This field displays the diagnosis codes you selected on the Dx tab.

9. Select the associated CPT code if appropriate. This is the procedure code that is associated with the NDC number.
10. Enter Authorization information if needed. This is the authorization number from the insurance payer authorizing the medication.
11. Enter an Internal Notes if needed.
12. Select the Save button to close the SIG Writer window and save the administered medication information.

<<Revised>> Write a New Prescription

1. Full Note Composer or other clinical note type window → Rx tab
2. Search for the desired medication.
 - a. Select the Prescribe button in the Medication SIG column header. This accesses the Select Drug window.
 - b. Search for and select the desired medication. This accesses the SIG Writer window.
3. In the SIG Writer window, review the drug screening and patient formulary information.
 - a. The Drug Screening pane lists the high-level categories for any warnings at the top of the pane. Select the Expand  icon to open the Drug Screening window and review the full text of all warnings.

If you are using ActX, the message “ActX results available below” appears at the top of the Drug Screening pane when an alert is received. Scroll to the bottom of the pane to review the alert.
 - b. The Formulary pane displays the date the formulary was downloaded, the patient's PBM and formulary name, and any available alternative medications are listed with their formulary status. To see additional information, select the Expand  icon.
4. Enter the prescription details for the drug, by selecting the dosage amount and measure, route, frequency, and number of days.
 - a. Selecting any of these fields accesses a popup window where you can quickly select each item.

To search for a specific entry, select the blank line at the top of the desired pane, then type the first letter or letters of the desired entry.

Note: When you enter a number of refills, you are authorizing the pharmacy to fill the original prescription plus the number of refills indicated. So, if you write a prescription for three refills, the pharmacy will dispense to the patient a total of four times.
 - b. Select the OK button to return to the SIG Writer window.
5. Enter the numeric quantity to be dispensed. The quantity is automatically calculated for pills, tablets, and liquids. It is not calculated for other forms.

Quantity is required for printed and electronic prescriptions. If you do not enter the quantity, then a warning message is displayed when you attempt to save the prescription.
6. If needed, enter instructions for the patient within the prescription line.
 - a. Select the Insert Text  icon to enter text before any prescription detail entry.

- b. Type the instructions to the patient.
- c. Enter any additional instructions in the Instructions field.

The number of characters available for the prescription is automatically calculated as you add information, and it is displayed in the upper right corner of the window.

7. By default, the Start Date is entered as today's date, and the estimated End Date is calculated based on the prescription details you have completed. You may edit these dates if required.

Note that the Start Date is the earliest date that the prescription may be filled by a pharmacy.

8. Select the Unit of Measure if not preselected by the medication selection. This is the unit of measure in which the prescription will be filled. The NCPDP code for this unit of measure will be transmitted to Surescripts for electronic prescriptions.

If no NCPDP code is associated with the unit of measure, the application identifies it as 'unspecified' when submitting electronically. When the prescription is submitted, the application will display a warning message that the unit of measure is unspecified, but you may still submit the prescription.

9. Select a medication Category, if desired. The category may be used to filter prescriptions in the patient's medication history.
10. The Prescriber is the rendering provider on the patient visit note.
11. When a Supervising Provider is entered on the visit note, it will be populated here.
12. Select the Dispense as Written checkbox if appropriate.
13. Select the Chronic Medication checkbox if this is a maintenance medication that a patient takes for a chronic condition.
14. Select the Include Monograph checkbox, if you want to include the drug monograph as an education form. Information about the drug is listed in the Education Forms section of the Plan tab.
15. Select the diagnosis code in the Dx & Problems field that you want to associate with the medication. This field displays the diagnosis codes you selected on the Dx tab.
16. Select the Pharmacy, if the prescription will be sent electronically or faxed.
 - When one or more preferred pharmacies are identified in the patient's demographic record, the first pharmacy listed populates in this field.
 - Select the pharmacy name to see other pharmacies in the patient's record.
 - To search for a pharmacy not in the patient's record, select the Delete (✕) icon to remove the prepopulated pharmacy. Then search for and select the desired pharmacy.
 - Search for a pharmacy using the name, street address, city, or ZIP code or any combination of these items. If the pharmacy, street, or city name is more than one word, then include the full name within double quotes. For example, "Rite Aid", "Oak Lawn", or "San Antonio".
17. Enter any Pharmacy Instructions if needed. Pharmacy instructions are sent to the pharmacy with electronic prescriptions. Instructions are limited to 210 characters.
18. Select the associated CPT code if appropriate. This is the procedure code that is associated with the NDC number.

19. Enter Authorization information, if needed. This is the authorization number from the insurance payer authorizing the medication
20. Enter an Internal Notes if needed.
21. Select the Save button to close the SIG Writer window and save the prescription.

Using the PMBC Information While Writing a Prescription

The Surescripts Patient Medication Benefit Check (PMBC) functionality provides you with patient-specific drug cost and coverage information while you are charting a prescription in the SIG Writer window. The PMBC information tells you how much the patient will have to pay for the selected medication and days supply at the pharmacy identified in the prescription.

Because you have accurate cost information at the time you are charting the prescription, you can discuss the cost and the benefits of the medication with the patient.

If PMBC information is not available from the patient's PBM, then the standard formulary information for the patient is available.

Surescripts Disclaimer

Actual pricing may vary depending on plan structure, deductibles, previous payments, future claims and prior authorizations. Information provided may not include possible drug interactions or other safety alerts.

Prescription Benefits and Formulary Downloads

You must use the Surescripts prescription benefits and formulary functionality in order to use the PMBC functionality.

You must have current prescription benefits and formulary information downloaded for a patient in order for the application to process PMBC request. This is because the prescription benefits information identifies the patient's pharmacy benefits manager (PBM). It is the PBM that provides the PMBC information.

Information Needed for Cost Determination

The patient's cost and coverage are determined by the patient's PBM based on the following information in the prescription.

- Pharmacy
- Medication
- Days supply
- Quantity
- Unit of measure

<<Revised>> Understanding the Transmission of PMBC Data

The application sends information from the prescription to the PBM via Surescripts.

The application sends the initial PMBC data transmission to Surescripts when the minimal data is available. The minimal data needed is the medication, the PBM, and the pharmacy.

The application identifies that another transmission is needed when you add or change any of the information needed for cost determination. Then, it waits for a period of inactivity (no entries or changes) to request the cost and coverage information again.

As the application receives PMBC responses, it displays the cost and coverage information in the Formulary pane of the SIG Writer window.

The status of the formulary transmission is indicated by the color bar on the left of the Formulary pane.

- Yellow indicates not enough information for the request. You must select a PBM, pharmacy, or both.
- Blue indicates that the request is in progress; waiting on response.
- Green indicates that the response has been received.
- Red indicates an error occurred in sending or receiving.

<<Revised>> Using the PMBC Information

To receive PMBC information, you must first enter the information needed for cost determination. You will have selected the medication to access the SIG Writer window. In most cases the patient's PBM and preferred pharmacy are automatically selected. But, in some cases, you will have to select a PBM or pharmacy.

If not all the cost information is available when you access the SIG Writer window, then it displays the standard formulary information for the patient. Once you enter all the necessary information, any PMBC information received replaces the standard formulary information.

You may also enter the frequency and days to calculate the days supply, and enter the quantity and unit of measure. These additional details enable the PBM to respond with more specific cost and coverage information for the patient.

The alternative medication list in the Formulary section of the SIG Writer window displays both the standard formulary and PMBC information, once it has been received. Alternative medications from PMBC appear at the top of the list and include a copay amount. Alternative medications from the formulary are listed below the PMBC information and include a formulary status.

Formulary 

[Rx Benefits: 06/26/2018](#)

RXHUBPBM (PLANA) 

hydrocodone 5 mg-acetaminophen 300 mg tablet

On Formulary/Preferred 1

Alternatives

oxycodone-acetaminophen 5 mg-300 mg tablet
Preferred 1

acetaminophen 120 mg-codeine 12 mg/5 mL (5 mL) oral solution
Preferred 1

acetaminophen 120 mg-codeine 12 mg/5 mL oral solution
Preferred 1

acetaminophen 240 mg-codeine 24 mg/10 mL (10 mL) oral solution
Preferred 1

acetaminophen 300 mg-codeine 15 mg tablet
Preferred 1

Standard Formulary Only

Formulary 

[Rx Benefits: 06/26/2018](#)

RXHUBPBM (PLANA) 

On Formulary/Preferred 1

Mail: \$115 Qty:30 Cvs Caremark Inc (Mail Order) (Restrictions)

Mail: \$115 Qty:90 #3980958 (Restrictions)

Alternatives

DRUG C

\$18.08 ... (Restrictions)

oxycodone-acetaminophen 5 mg-300 mg tablet
Preferred 1

acetaminophen 120 mg-codeine 12 mg/5 mL (5 mL) oral solution
Preferred 1

acetaminophen 120 mg-codeine 12 mg/5 mL oral solution
Preferred 1

acetaminophen 240 mg-codeine 24 mg/10 mL (10 mL) oral solution
Preferred 1

PMBC and Standard Formulary

Remember when reviewing the information that the formulary status and copay information at the top of the pane is for the medication and quantity currently selected in the SIG Writer window. The list of alternatives includes each alternative medication and its formulary status or copay information.

The Formulary pane has several links to additional information you can review.

- Select a pharmacy link to change the Pharmacy selected in the SIG Writer for the prescription. Please note that selecting a different type of pharmacy (for example, changing a retail pharmacy to a mail order pharmacy) does not change any of the other prescription information. You may also have to change the days supply to match the formulary requirements.
- Select a medication from the Alternatives list to change the medication selected in the SIG Writer for the prescription.

- Select the Expand () icon to access the Formulary Information window. This window displays additional details about the pharmacy and medication alternatives. Selecting an alternative from this window returns to the SIG Writer window, and changes the pharmacy and/or medication selected for the prescription.
- The Formulary Information window has expand () and contract () icons that enable you to increase or decrease the amount of information displayed in each section of the window.
- Select the Rx Benefits link to access the Rx Benefits Coverage window. This window displays the standard formulary information details.

<<Revised>> Write a Prescription Using a Default SIG

You may write a prescription by selecting a default SIG from the Rx tab of Full Note Composer or other clinical note type window. The default SIGs that are available to you are determined by the KDB configuration associated with your provider record or, for non-provider users, with your user setting definition.

When you search for a medication, the Find Dispensable Drugs window displays default SIGs for that medication at the top of the list. They are identified by the Default SIG () icon.

Selecting a default SIG accesses the SIG Writer window. All the prescription details (amount, unit, route, frequency, etc.) defined in that default SIG are populated on the SIG Writer window. You may edit any details as needed and enter any additional information needed.

<<Revised>> Chart Samples Given

Chart sample medications given to a patient in the SIG Writer window as you would chart a prescription. Your practice may choose to simply chart details for samples given, or to print a prescription for the samples. Your administrative super user will have defined this in the Practice Settings. Regardless, the samples are charted in the same manner.

1. Full Note Composer or other clinical note type window → Rx tab
2. Search for the desired medication.
 - a. Select the Prescribe button in the Medication SIG column header. This accesses the Select Drug window.
 - b. Search for and select the desired medication. This accesses the SIG Writer window.
3. In the SIG Writer window, review the drug screening and patient formulary information.
 - a. The Drug Screening pane lists the high-level categories for any warnings at the top of the pane. Select the Expand () icon to open the Drug Screening window and review the full text of all warnings.

If you are using ActX, the message "ActX results available below" appears at the top of the Drug Screening pane when an alert is received. Scroll to the bottom of the pane to review the alert.

- b. The Formulary pane displays the date the formulary was downloaded, the patient's PBM and formulary name, and any available alternative medications are listed with their formulary status. To see additional information, select the Expand  icon.
4. Select the Sample Given checkbox. This opens the Sample Given popup window.
5. In the Sample Given popup window:
 - a. Enter the manufacturer's lot number in the Lot # field.
 - b. Select the name of the Manufacturer of the medication.
 - c. Enter the Expiration Date of the medication.
 - d. Select the OK button to save the entries and return to the SIG Writer window.

To reopen the Sample Given popup window, select the Expand  icon in the Administered panel in the top right of the SIG Writer window.
6. Enter the prescription details for the drug, by selecting the dosage amount and measure, route, frequency, and number of days.
 - a. Selecting any of these fields accesses a popup window where you can quickly select each item.

Note: When you enter a number of refills, you are authorizing the pharmacy to fill the original prescription plus the number of refills indicated. So, if you write a prescription for three refills, the pharmacy will dispense to the patient a total of four times.
 - b. Select the OK button to return to the SIG Writer window.
7. Enter the numeric quantity to be dispensed. The quantity is automatically calculated for pills, tablets, and liquids. It is not calculated for other forms.

Quantity is required for printed and electronic prescriptions. If you do not enter the quantity, then a warning message is displayed when you attempt to save the prescription.
8. If needed, enter instructions for the patient within the prescription line.
 - a. Select the Insert Text  icon to enter text before any prescription detail entry.
 - b. Type the instructions to the patient.
 - b. Type the instructions to the patient.
 - c. Enter any additional instructions in the Instructions field.

The number of characters available for the prescription is automatically calculated as you add information, and it is displayed in the upper right corner of the window.
9. By default, the Start Date is entered as today's date, and the estimated End Date is calculated based on the prescription details you have completed. You may edit these dates if required.
10. Select the Unit of Measure if not preselected by the medication selection.
11. Select a medication Category, if desired. The category may be used to filter prescriptions in the patient's medication history.
12. The Prescriber is the rendering provider on the patient visit note.
13. When a Supervising Provider is entered on the visit note, it will be populated here.

14. Select the Chronic Medication checkbox if this is a maintenance medication that a patient takes for a chronic condition.
15. Select the Include Monograph checkbox, if you want to include the drug monograph as an education form. Information about the drug is listed in the Education Forms section of the Plan tab.
16. Select the diagnosis code in the Dx & Problems field that you want to associate with the medication. This field displays the diagnosis codes you selected on the Dx tab.
17. Select the associated CPT code if appropriate. This is the procedure code that is associated with the NDC number.
18. Enter an Internal Notes if needed.
19. Select the Save button to close the SIG Writer window.

<<Revised>> Write a Complex Prescription

A complex prescription is one that includes varying doses for a single medication. This may also be referred to as a stepped or tapered prescription since the dose increases or decreases over a period of time.

When you select a dosing suggestion for a complex prescription that includes varying doses for a single medication, the prescription details for the first part of the complex prescription will be populated. However, the subsequent parts of the complex prescription cannot be automatically populated due to a limitation in the dosing suggestion information available from First DataBank. You must enter the details for each subsequent part of the prescription in the Pharmacy Instructions field.

A complex prescription should not include refills. This is because the final dose of a complex prescription is either greater than or less than the initial dose. If the patient needs to continue the medication, you must determine the dosage needed at that time.

Use Additional Functionality

The SIG Writer window includes additional functionality that you may use when writing a prescription.

Use a Dosing Suggestion

Select the Dosing Suggestion icon () in the SIG Writer window to review common dosage information. The drug dosage suggestion information is from First DataBank, who obtains the information from the manufacturing pharmaceutical companies. Suggestions are provided for conditions for which the drug is commonly used and age ranges. (Age range suggestions, when provided, are only available for patients 15 to 64 years old.) Dosage suggestions assist you in selecting the most appropriate dose, route, frequency, and duration combination.

The default prescription order, as defined by the manufacturer, is listed first. Common conditions and therapies are then listed alphabetically.

When you select a dosing suggestion, the prescription details populate in the SIG Writer window. When you select a dosing suggestion for a complex prescription that includes varying doses for a single medication, the prescription details for the first part of the complex prescription will be populated. You must enter the details for each subsequent part of the prescription in the Pharmacy Instructions field.

<<Revised>> **Calculate Dosage**

Use the optional dosing calculator to determine the dosage for the medication strength and form selected. For pediatric patients, the weight or weight and height may be needed. A banner error message may appear until you select the dose and frequency.

1. In the SIG Writer, select any of the prescription details to access the popup window.
2. Select the Dosage link. This opens the Calculate Dosing window.
3. Review the General Dosing Information. This includes the suggested dose in milligrams (MG) and the conversion of MG to the dosage form of the selected medication.
4. Weight and Height will be prepopulated if entered in the Vitals tab of the visit note. Enter these amounts if they are not prepopulated.
5. Enter the desired dose, in MG, in the Dosing Information field. The conversion of MG to the dosage form of the selected medication is shown in the field below.
6. Select the Close button to return to the SIG Writer window.
7. Enter the remaining prescription details. When the dose and frequency fall within the dosing recommendation, the warning will be removed.

Auto-Calculate Quantity

The quantity to be dispensed may be automatically calculated by the application based on the prescription details you enter or you may enter the quantity directly. Auto-calculation is the default when you access the SIG Writer window to write a new prescription, and the quantity is calculated as you enter the prescription details.

You can toggle the auto calculation function on and off by selecting the Auto button next to the quantity field. You can override the calculated quantity simply by entering an amount in the quantity field.

Select a Reason for PRN in a Prescription

When prescribing a medication with a frequency of PRN, you may identify the reason for prescribing the medication as needed. The application includes a number of system-defined reasons, and you can define additional reasons if desired.

1. In the SIG Writer window, enter the dosage and route in the usual manner.
2. Leave the Frequency field empty.
3. Select the PRN checkbox. This enables the PRN reason column beneath the checkbox.
4. Select the PRN reason.

<<Revised>> Review Formulary Information

If your practice uses Surescripts for electronic prescribing, you can download a patient's prescription benefits and formulary information. Once a patient's information has been downloaded, formulary information and therapeutic alternatives, if any, are shown in the Formulary pane of the SIG Writer window.

- The Rx Benefit field contains the selected benefits payer. If the patient has benefits from more than one payer, the Find icon will include a red checkmark, and you can select another payer from the Find Patient Rx Eligibility window.
- Rx Benefits link displays the date the information was obtained. The more recent the date, especially if within the same calendar month, the greater the likelihood that the information is current. The older the date, the greater the possibility that the information may not be current. Most coverage plans are only good for one year, so if the date is a year or more in the past, then the information is likely no longer valid
- Formulary Status displays the status of the medication currently selected in the SIG Writer. Select the link for additional information.
- Copay Retail displays the patient's copay amount for retail pharmacies. Select the link for additional information.
- Copay Mail displays the patient's copay amount for mail order pharmacies. Select the link for additional information.
- Any available alternative medications are listed with their formulary status and copay amounts. To use an alternative, select the desired medication from the list.
- To see additional information, select the Expand () icon.

<<Revised>> Complete a Medication Consent Form

Your administrative super user can configure the application so that you are presented with a patient consent form when writing a prescription for a medication that requires a signed consent, such as a psychotropic medication. This enables you to easily document the symptoms to be addressed by the medication, and to obtain the patient's signature on the consent form.

1. Full Note Composer or other clinical note type window → Rx tab
2. Search for and select the desired Drug.
3. In the SIG Writer window, enter the prescription details in the usual manner.
4. Select the Consent button to complete the medication consent form. This button is available only when patient consent is required.
 - a. Select the appropriate How Discussed radio button to identify how you discussed the medication with the patient.
 - b. Enter the Symptoms to be addressed by the medication.
 - c. Select the Save button to return to the SIG Writer window.
5. When you have completed the prescription for this medication, select the OK button to close the SIG Writer window.
6. On the Rx tab, select another medication if you wish to write another prescription.

7. Continue charting the visit in the usual manner.
8. When you have finished charting, select the Close () icon or the OK button to close the clinical note type window. This accesses the Visit Checkout window.
9. In the Visit Checkout window, select the Mark Prescriptions Ready to Prescribe checkbox.
10. Complete the other checkout information as appropriate, and then select the OK button.
11. If the Prescription Alert window appears, select the OK button to print the prescription.
12. The visit note will save, the window will close, the prescription will print, and the medication consent form will generate.
13. In the Generate Document From Template window, either:
 - Select the specific `{{Signature}}` field to be signed.
 - Select the Sign Document button to enter a single signature to sign all signature fields in all documents.
14. In the signature window, enter the signature.

The signature window displayed depends upon the type of signature pad or computer being used. Below are two examples. The window title depends on the signature field name if signing a specific field or is Enter Your Signature if signing all fields at one time.

 - a. Have the patient sign in the window using the tablet PC, data entry pad, or signature pad.
 - b. Select the OK button to return to the Generate Document From Template window
15. From the File menu, select the Save option to save the document with the signature, and attach it to the patient visit note.

<<Revised>> Add a Pharmacy to the Patient's Default Pharmacy List

When writing a prescription for a patient, you can add a pharmacy to the patient's list of pharmacies simply by selecting the desired pharmacy and then completing the prescription. A patient's list of pharmacies is created on the Pharmacy tab of the Patient Demographics window and is displayed in the Pharmacy field in the SIG Writer window.

Note that a pharmacy added to the patient's list from the SIG Writer window will not appear in the default list of the Pharmacy field until the Full Note Composer and other clinical note type window has been closed and reopened. Also, if the Patient Demographics window is open at the time you add a pharmacy to the list from the SIG Writer, the added pharmacy will not appear in the Patient Demographic window until that window has been closed and reopened.

Using the Most Frequently Used Pharmacy List

By default, the pharmacies that are displayed when writing a prescription for a patient are the pharmacies associated with the patient record (Patient Demographics window Pharmacy tab). These are the pharmacies that the patient has identified that he or she uses. However, in some instances, a provider usually works with one or a small number of pharmacies, and so pharmacies are not identified in individual patient records. In this circumstance, your administrative super user or you, if you have the needed security access, can define your pharmacy list preference in the user settings associated with your provider record.

The pharmacy list is available in the SIG Writer window when writing a new prescription or a refill for a prescription. You can expand the search to include all pharmacies if desired, whether the initial search is by most frequently used or by the patient's list.

<<Revised>> Repeating a Prescription in a Visit Note

The SIG Writer window contains a Repeat SIG field that enables you to create multiple copies of the prescription in a visit note. Select the dropdown menu to add a copy of the prescription.

- 0: This is the default selection. It results in a single instance of the prescription charted in the visit note.
- X1: This selection creates one copy of the prescription. This results in two instances of the prescription charted in the visit note. The copy's start date is one day after the stop date of the initial instance of the prescription.
- X2: This selection creates two copies of the prescription. This results in three instances of the prescription charted in the visit note. The first copy's start date is one day after the stop date of the initial instance of the prescription. The second copy's start date is one day after the stop date of the first copy (that is, the second instance) of the prescription. You cannot create more than two copies of a prescription.

The start date on a prescription is the earliest date that a pharmacy may fill the prescription. The earliest fill date is important for controlled substances, particularly Schedule II drugs since refills are prohibited for these drugs. The earliest fill date ensures that multiple prescriptions for a drug are treated as separate dispensing documents, not refills of an original prescription. Each separate prescription must contain written instructions indicating the earliest date on which a pharmacy may fill each prescription.

You, as prescribing provider, are responsible for complying with all state and federal regulations for prescriptions and electronic prescribing. Please check with your state's pharmacy board and/or other regulatory agencies regarding regulations on giving a patient multiple prescription for a medication at one time and on future dating prescriptions. This functionality cannot be used for maintenance medications.

Edit a Prescription

You can edit a prescription to change the dosage or the frequency of the medication, and thus, the estimated ending date of the prescription. You can only edit a prescription while it is active; that is, it has a remaining amount of medication and an ending date in the future (the ending date cannot be empty or none. You cannot edit a prescription that has passed its ending date or that has been discontinued.

When you edit a prescription, the original prescription is discontinued with the discontinued reason "Has been revised". The ending date of the original prescription is the date you edit it. A new prescription is written for the original medication, but with the new dosage and/frequency and the new ending date. The new prescription is not sent electronically to the pharmacy or printed.

You may edit a prescription in the Patient History window or in Full Note Composer or another clinical note type window. When you edit a prescription from the Patient History window, then the application creates a new visit note with the visit type of Rx Change Visit.

<<Revised>> Edit a Prescription

1. Either:
 - Full Note Composer or other clinical note type window → Rx tab
 - Patient Demographics → Patient menu → History → Medication History category
2. In the Patient Medication list, select the Action (ⓘ ⓘ ⓘ) icon for the prescription you want to edit.
3. From the popup Action menu, select the Change option.

This option is available only for prescriptions that meet the requirements for editing.
4. In the SIG Writer window, select the Prescriber.
5. The window displays the details of the original prescription. You may change:
 - Dose: Increase or decrease the dose amount. The Estimated End Date changes as you change the dose.
 - Frequency: Increase or decrease the frequency. The Estimated End Date changes as you change the frequency.
 - Estimated End Date
 - Chronic Medication: Change the medication from or to a chronic, maintenance medication for the patient.
6. Enter new Patient Instructions if desired.
7. Select the OK button to save the changes and return to the Full Note Composer window.

Signing EPCS Prescriptions

Signing Prescriptions when Using Replication

You can only sign an electronic prescription for a controlled substance while your laptop or tablet PC is connected to the network and has access to the domain name service (DNS). Therefore, if you are using the replication functionality on your laptop or tablet PCs, then you may enter prescriptions for controlled substances while you are disconnected from the network. But, you cannot send those prescriptions while disconnected. To sign and submit the prescriptions electronically, you must connect to the network. Then open each visit note containing a controlled substance prescription and submit the prescription electronically. This will initiate the signing process described below.

<<Revised>> Using the HID Approve Mobile App or Hybrid Token Security Device to Sign a Prescription

The application works with the HID Approve mobile app and the IdenTrust Hybrid Token security device. Both the mobile app and the device enable two-factor authentication. You may use either form when signing a prescription.

When using the HID Approve mobile app on your cell phone or other mobile device, your phone will receive a prompt for authentication. You will swipe to approve or decline the prescription, and then enter your password.

When using the Hybrid Token device, there are two forms of authentication. The first form of authentication is to use the device by plugging it into a USB port on your PC, and entering your device password. In this form, the device serves as one factor of authentication, and the password as the second factor of authentication. To use this form of two-factor authentication, your IdenTrust security certificate must be activated on the PC you have the device plugged into.

The second form of authentication is to use the device as a one-time-password (OTP) generator. You will use this form of authentication when you use a PC that does not have a USB port or that does not have your IdenTrust security certificate activated on it. To use this form of two-factor authentication, you will enter your OTP password, and then press the button on the device to generate an OTP PIN, which you must also enter. The OTP password is one factor of authentication, and the OTP PIN is the second factor of authentication.

<<Revised>> **Signing a Prescription from a Visit Note**

Use this process to sign a new or refilled prescription from a visit note.

1. In the SIG Writer window, complete the prescription in the usual manner.
2. In Full Note Composer or other clinical note type window, begin the submission process for the prescriptions by either:
 - Selecting the Submit Prescriptions  icon.
 - Selecting the OK button to save and close the visit note. Then in the Visit Checkout window, select the Mark Prescriptions Ready to Subscribe checkbox, and then select the OK button.
3. In the Prescription Alert window, select the Mark Ready to ePrescribe (EPCS) checkbox for each controlled substance prescription you want to submit.

Note: The DEA requires that you, as the provider, select this checkbox for each prescription. This cannot be automatically set by the application or be performed by another user.

4. Select the radio button for the EPCS PIN Type.
 - USB: Select this radio button if you have your security device plugged into a USB port on the computer.
 - OTP: Select this radio button if your security device is not plugged in and you are using the one-time-password password generated by that device.
 - HID Phone: Select this radio button if you are using the HID Approve mobile app.
5. Either:
 - For USB: In the USB Password field, enter the password for your security device.
 - For OTP: In the OTP Password field, enter the OTP password for your security. Then push the button on your device to generate a code. Enter that code in the OTP PIN Code field.
 - For HID Approve: When your phone receives the prompt, swipe to Accept the prescriptions. Then enter your password.

<<Revised>> **Signing a Prescription from a Refill Message**

Use this process to sign a refill prescription from an electronic or a manual prescription refill request message.

1. In the Message window, enter the prescription and other message information in the usual manner.
2. Select the Complete button to complete the message and begin the submission process for the prescription.
3. In the Prescription Alert window, select the Mark Ready to ePrescribe (EPCS) checkbox for each controlled substance prescription you want to submit.

Note: The DEA requires that you, as the provider, select this checkbox for each prescription. This cannot be automatically set by the application or be performed by another user.

4. Select the radio button for the EPCS PIN Type.
 - USB: Select this radio button if you have your security device plugged into a USB port on the computer.
 - OTP: Select this radio button if your security device is not plugged in and you are using the one-time-password password generated by that device.
 - HID Phone: Select this radio button if you are using the HID Approve mobile app.
5. Either:
 - For USB: In the USB Password field, enter the password for your security device.
 - For OTP: In the OTP Password field, enter the OTP password for your security. Then push the button on your device to generate a code. Enter that code in the OTP PIN Code field.
 - For HID Approve: When your phone receives the prompt, swipe to Accept the prescriptions. Then enter your password.

<<Revised>> **Signing a Prescription from a the Patient History**

Use this process to sign a refill prescription from the Patient History window.

1. Patient History window → Medication History category
2. For the desired medication, select the Refill button.
3. In the SIG Writer window, enter the prescription and other message information in the usual manner.
4. In the Patient History window, select the OK button. This begins the submission process for the prescriptions.
5. In the Prescription Alert window, select the Mark Ready to ePrescribe (EPCS) checkbox for each controlled substance prescription you want to submit.

Note: The DEA requires that you, as the provider, select this checkbox for each prescription. This cannot be automatically set by the application or be performed by another user.

6. Select the radio button for the EPCS PIN Type.
 - USB: Select this radio button if you have your security device plugged into a USB port on the computer.
 - OTP: Select this radio button if your security device is not plugged in and you are using the one-time-password password generated by that device.
 - HID Phone: Select this radio button if you are using the HID Approve mobile app.
7. Either:
 - For USB: In the USB Password field, enter the password for your security device.
 - For OTP: In the OTP Password field, enter the OTP password for your security. Then push the button on your device to generate a code. Enter that code in the OTP PIN Code field.
 - For HID Approve: When your phone receives the prompt, swipe to Accept the prescriptions. Then enter your password.

Monitor EPCS Activity

The DEA requires that practices and providers using EPCS functionality closely monitor all EPCS activity. There are two primary monitoring requirements.

- One or more of the designated individuals who are responsible for EPCS access control must perform daily monitoring of all EPCS activity. This is done with the eRx Audit Daily Summary report.
- Each provider using EPCS functionality must monitor their own activity at least once a month, within seven business days of the end of the month. This is done with the eRx Medication Audit report.

To make monitoring your EPCS activity easier, the application automatically generates the reports used for daily and monthly monitoring, and sends the generated reports to the appropriate user or users in an attachment message.

The application also includes the eRx Audit report, which is an all-inclusive listing of everything that happens with EPCS data. The eRx Audit report is intended for use when something in the eRx Audit Daily Summary report or the eRx Medication Audit report indicates the need for further investigation. This report contains more information and more detail than either of those reports. By default, the application is not configured to generate the eRx Audit report automatically.

Reporting Incidents

When you determine that the issuance or records of controlled substance prescriptions have been compromised or could have been compromised, then you must report this to both the DEA and to Aprima within one business day. In general, you should report security incidents that represent successful attacks on the application or other incidents in which someone gains unauthorized access.

Automatic Report Generation

The application generates the eRx Audit Daily Summary report at 1:00 a.m. for the previous day's activity. The report is generated every day, including weekends and holidays. The application attaches an Excel file of the generated report to a message and sends that message to the Clinical Administrators user group. At least one person responsible for EPCS access control must review each day's report on the day it is generated. Therefore, it is important that you grant the members of this group security rights to view and complete messages sent to the group. You may also grant a user access to the user group's messages even if the user is not a member of the group. It is also important for members of this user group or other users responsible for the group's messages to include the necessary filtering criteria for these messages in a message filter.

The application generates the eRx Medication Audit report at 1:00 a.m. on the first of each month for the previous month's activity. The application generates this report for each provider who has been granted EPCS rights. The report will not generate automatically on the first of the month for a provider whose EPCS rights have been revoked. When the application generates the monthly report, it attaches an Excel file of the generated report to a message and sends that message to the provider. The provider must review each month's report within seven days of the end of the previous month. Therefore, it is imperative that providers include the filtering criteria for these messages in a message filter.

The application also automatically generates the eRx Medication Audit report at the time a provider's EPCS rights are revoked. The application attaches an Excel file of the generated report to a message and sends that message to the provider. The provider must review the report within seven days of its generation.

These EPCS reports are automatically generated by the EPCS Report Scheduler job and the EPCS Report Scheduler and EPCS Schedule Report eRx Audit Daily Summary job schedules. You cannot inactivate or change these job schedules.

IMPORTANT: There are circumstances in which jobs fail or fail to complete correctly. If for any reason the eRx Audit Daily Summary report is not generated automatically, then it is the responsibility of the clinical administrator designated to manage access control to generate and review the report within the DEA's defined timeframe. If for any reason the eRx Medication Audit report is not generated for a provider, then it is the responsibility of that provider to generate and review the report within the DEA's defined timeframe.

Report Messages

The application generates a message each time any of the EPCS reports is generated, whether generated by the scheduled job or generated by a user. The message includes an Excel file of the generated report.

When the eRx Audit Daily Summary report is generated by the job, the application sends the message containing the Excel file to the Clinical Administrators user group. Users who are in this user group must have security rights to view and complete messages sent to the group. It is also important for members of this user group to include filtering criteria for these messages in a message filter.

When the eRx Medication Audit report is generated by the job, the application sends a message to each provider who has been granted EPCS rights. It is important that providers include filtering criteria for these messages in a message filter.

When any of the EPCS reports is generated by a user, the message is sent to that user. The message is automatically completed when it is sent. This is done so that the user does not have to search for, open, and complete the message. It is assumed that the user reviewed the report when they generated it, either to view it or to print it.

Messages for the EPCS reports, whether generated automatically by the application or generated by a user, cannot be deleted. The Excel files attached to these messages cannot be deleted or changed.

When the eRx Audit Daily Summary report is generated by the scheduled job, the message has a message type of Attachment and message subtype of Scheduled Report. When the eRx Medication Audit report is generated by the scheduled job, the message has a message type of Attachment and message subtype of EPCS. When a user generates any of the EPCS reports, the message has a message type of Attachment and message subtype of EPCS.

Excel Files of the Reports

The Excel files generated of the reports contain the data that is included in the printed report. They do not contain the additional detail that may be accessed when viewing the report within the application.

You can sort, filter, and format the data in the Excel file, but you cannot change or delete any of the data in the file. Attempts to change or delete data are not saved, and do not modify the file attached to the message. You cannot delete the file attached to the message.

Prescription Validation Errors

Below is a partial list of electronic prescription validation messages that may be displayed when you select the Submit Prescriptions  icon or on the Consolidated Summary window when you close the patient visit note. This list is not complete; the list only includes those validation messages that may require additional explanation.

Validation is also performed when the electronic prescription is actually submitted, and when the prescription is received by the Surescripts electronic pharmacy clearinghouse. Messages generated from these validations are displayed in the Track Prescriptions window.

Prescription

Message	Explanation and Instructions
Unknown drug class cannot be ePrescribed.	The drug schedule is not identified in the First DataBank drug database. Therefore, the drug cannot be electronically prescribed. This prescription must be printed.

Message	Explanation and Instructions
Controlled drug cannot be ePrescribed.	The application is not yet certified to submit electronic prescriptions for controlled substances. This prescription must be printed.
Multiple SIG Detail records not supported.	Compound medications and stepped prescriptions cannot be electronically prescribed. This prescription must be printed.
Medication cannot be ePrescribed because drug direction is empty.	There are no prescription details. You must enter the details in order to electronically prescribe.
SIG Patient Directions cannot be blank.	There are no prescription details. You must enter the details in order to electronically prescribe.
Prescription quantity not valid for ePrescribing.	The Quantity must be a numeric value, and cannot be blank.
NDC required for non-supply ePrescribe.	The First Databank drug database does not contain an NDC number for the medication. An NDC is required to submit the prescription to Surescripts. This prescription must be printed.

Clearinghouse/Partner

Message	Explanation and Instructions
Electronic pharmacy clearinghouse is inactive.	Your Surescripts clearinghouse record is not active. You must activate the record in order to electronically prescribe.

Pharmacy

Message	Explanation and Instructions
Pharmacy not set.	No pharmacy was selected at the time the medication was prescribed. You may Cancel, and then edit the prescription to add the pharmacy. Once the prescription has been printed or sent, it can no longer be edited.

Message	Explanation and Instructions
Pharmacy not configured for ePrescribing.	The pharmacy is either not configured for electronically prescribing or is configured for fax-only, and your practice is configured to not send to fax-only pharmacies. You may Cancel, and then edit the prescription to select a different pharmacy. Or you may print the prescription.

Prescriber

Message	Explanation and Instructions
Provider is not licensed for ePrescribing.	Your Provider record does not contain an Aprima license. Your administrative super user must set up your Provider record.
Provider has not been set up for ePrescribe.	Your Provider record is not set up for electronic prescribing. Your administrative super user must set up your Provider record.
Surescripts ePrescribe directory entry not located for Provider.	Your database is not in synch with the Surescripts provider directory. Your administrative super user must: <ul style="list-style-type: none"> • Make sure all provider ID number are correctly entered. • Run the eRx: Poll Mailbox for Prescriber Updates. • Verify the job successfully completed. Then wait 10 minutes for the webservice to complete and respond. • Run the eRx: Process Pharmacy/Prescriber Messages job.
Surescripts ePrescribe directory not completed for Provider.	Surescripts does not have complete information for the provider. Contact Support for assistance.
Provider NPI does not pass Lunh Digit Check (n).	The NPI in your Provider record is incorrect. Your administrative super user must correct your record.

Supervising Provider

Message	Explanation and Instructions
Supervising Provider NPI does not pass Lunh Digit Check (n).	The NPI in your supervising provider's Provider record is incorrect. Your administrative super user must correct this record.

Practice

Message	Explanation and Instructions
Practice is not licensed for E-prescribing.	Your electronic prescribing asset is not set up correctly. Please contact Support for assistance.

Patient

These are warning messages, not error messages. You may send the prescription with this warning. However, an Rx error message will then be generated. You must locate the error message in the Message Center or on your Desktop, and correct the problem and then resend or print the prescription.

Message	Explanation and Instructions
Patient's ANSI gender code is required.	The patient record either does not include the patient's gender or the gender record does not include an ANSI code. Correct the gender information Patient window. Correct the ANSI code for the gender in the Gender window (List Editor → Demographics → Gender).
Patient's ANSI gender code is too long (maximum length allowed for ePrescribing is 1 character).	Correct the ANSI code for the gender in the Gender window (List Editor → Demographics → Gender).

<<Revised>> Create a Default SIG

You can create a default SIG for a medication and dosage that you frequently prescribe or administer. Then you can use that default SIG to quickly write a prescription for the medication for a particular patient. When you use a default SIG, you can change the prescription details as needed.

When you create a default SIG, it is associated with the KDB configuration defined in your provider record or, for non-provider users, your user setting definition.

1. Enter the prescription details as described in the Write a New Prescription section above.
 - You can also use the Sample Given or Administered options for a default SIG.
 - If the default SIG is for an administered medication, you can select the Associated CPT code as described in Administered Medication section above.
 - Information in the Start and End Date, the Provider, and the Pharmacy fields will not be saved as part of the default SIG.
 - If the default SIG is for a compounded medication, use the Pharmacy Instructions field to enter the compounding instructions.
2. To save the prescription as a default, select the Default SIG button. Enter a name for the default SIG, and an ID if desired.
3. Enter any other information needed to prescribe the medication for the patient, and then select the Save button.

<<New>> Change Prescription Request from the Pharmacy

A pharmacy may send you an electronic request to change a prescription for a patient. There are three basic reasons for a change request from a pharmacy. The pharmacy may request:

- An authorization number for a prescription requiring prior authorization.
- To substitute a generic form of the prescribed medication.
- To substitute a different medication, either brand name or generic, that has the same or similar purpose of the originally prescribed medication, but that is not in the same medication class.

Process a Change Request for an Authorization Number

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. Verify the patient, pharmacy, and provider information at the top to the message tab.
3. If desired, select the Forward For Prescription Review To checkbox, and then select the provider to whom to forward the message.
4. If desired, select the Rx Benefits link to view the patient's formulary and benefits information.
5. In the Change Prescription section, you may either:
 - Select the Authorization Number radio button, and then enter the authorization number provided by the insurance payer or pharmacy benefits manager (PBM).

- Select the Deny radio button, if the insurance payer or PBM denied the authorization or if you declined to request authorization.
6. Enter any additional information in the Note To Pharmacy field.
 7. Select the Complete button to complete the message and send the appropriate message back to the pharmacy.

Process a Change Request for a Change in Medication

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. Verify the patient, pharmacy, and provider information at the top to the message tab.
3. If desired, select the Forward For Prescription Review To checkbox, and then select the provider to whom to forward the message.
4. If desired, select the Rx Benefits link to view the patient's formulary and benefits information.
5. In the Change Prescription section, review the original prescription and the comments from the pharmacy explaining the reason for the requested change.
6. In the Change Prescription section, you may either:
 - Select the Deny radio button, and then select the appropriate reason for denying the medication change request.
 - Select the radio button for the medication prescription requested by the pharmacy. This discontinues and cancels the original prescription, and sends the prescription requested.
 - Select the Other button to select a different medication, and access the SIG Writer to enter the desired prescription. This discontinues and cancels the original prescription, and sends the prescription requested.
7. Enter any additional information in the Note To Pharmacy field.
8. Select the Complete button to complete the message and send the appropriate notification back to the pharmacy.
9. If the prescription is for a controlled substance and you are using the optional EPCS functionality, then the Prescription Alert window will open and you must enter your EPCS signature information.

<<New>> View the Fill History for a Prescription

When a pharmacy fills a prescription you have written, the pharmacy may send you the fill history for the prescription. The fill history for a single prescription is the same information as a patient's electronic medication history, except that the information received is only for the one prescription.

The application displays prescription fill history information in the Import Medication Hx window, just as it displays downloaded electronic medication history information. You may access the information from the Patient History window or from Full Note Composer or other clinical note type window. When medication history has been downloaded or fill history has been received, the Import Medication History icon appears with a checkmark .

Please refer to the Import a Patient's Electronic Medication History section of this guide for more information on viewing and importing medication history and prescription fill history.

You will only receive prescription fill history for prescriptions you have written since upgrading to Aprima v18.1. Use the electronic medication history download to receive fill history information for older prescriptions.

<<Revised>> Discontinue a Prescription

When you discontinue a medication that has previously been prescribed for a patient, you must enter a discontinue reason code to identify why the medication is being discontinued and enter the date on which the medication is discontinued. You may also enter additional comments regarding the discontinuation of the medication. The selected reason and comment can be reviewed later in the Medication Detail window.

When a medication is discontinued because of an allergic reaction, you may enter the patient's reaction.

When discontinuing a prescription, you may also send a cancellation notification to the pharmacy if the prescription was electronically prescribed.

A medication is considered active through and including the date on which it is discontinued.

1. Either:
 - Full Note Composer or other clinical note type window → Rx tab
 - Full Note Composer or other clinical note type window → Hx tab → Medication History
 - Patient Demographics () → Patient → History → Medication History
2. In the list of medications for the patient, locate the medication you want to discontinue.
Note: You may need to select a different medication filter if you cannot locate the medication you are looking for.
3. Select the Action (  ) icon for a medication for the desired medication.
4. Select the D/C option from the Action menu. This accesses the Discontinue window.

5. Select the End date.
6. Select the Reason field for discontinuing the medication.
7. If the discontinue reason code is Allergic Reaction, enter the patient's reactions to the medication.
 - a. In the popup window, select the patient's reaction or reactions.
 - b. Select the Save button to close the window.
8. If appropriate, send a cancellation message to the pharmacy.
 - a. Select the Cancel checkbox.
 - b. Select the Pharmacy to which to send the notification. This may be the pharmacy to which the prescription was originally sent, or the pharmacy that actually filled the prescription, if different.
 - c. Select the Provider authorizing the cancellation.
 - d. Select the Supervising Provider, if the authorizing provider requires a supervising provider.
 - e. Select the provider's Service Site.
9. Select the Save button to discontinue the medication.

<<Revised>> Refill a Prescription

You may refill a prescription from the medication history on the Hx tab or from the Rx tab of Full Note Composer or other clinical note type windows or from the medication history in the Patient History window.

When you issue a prescription refill prior to the end date of the original prescription, the original prescription is discontinued with the reason code Refilled.

1. Either:
 - Full Note Composer or other clinical note type window → Rx tab
 - Full Note Composer or other clinical note type window → Hx tab → Medication History
2. Select the Action () icon for the medication you want to refill.

If you want to refill multiple prescriptions, select the checkboxes for the desired prescriptions, and then select the Action button for one of them.
3. Select the Refill option from the Action menu.
4. Either:
 - If all the information for the prescription is available, then the prescriptions is added to the Visit Medication section of the Rx tab.
 - If any information is needed for the prescription, then the SIG Writer window opens. Complete the prescription in the usual manner. The prescription is then added to the Visit Medication section of the Rx tab.

Pharmacy Default on Prescription Refills

When refilling a prescription through the Hx tab of Full Note Composer or other clinical note type window, the application verifies the pharmacy to which the original prescription was sent. It then may default a pharmacy for the refill based on the following:

- If the original pharmacy is still in the patient's list of pharmacies (Patient Demographics → Pharmacy tab), then the original pharmacy defaults to the refill.
- If the original pharmacy is no longer in the patient's list of pharmacies, then no pharmacy is identified by default on the refill. The Pharmacy field will be blank, and you must select a pharmacy if sending electronically.
- If the original prescription did not identify a pharmacy, then the refill defaults to the first pharmacy in the patient's list of pharmacies.

Process Prescription Refill Messages

There are two types of prescription refill messages: user-generated and electronic. You can create a prescription refill message when a patient phones your office requesting prescription refills. When a patient calls the pharmacy requesting a refill, the pharmacy can send you an electronic refill messages through the pharmacy clearinghouse. Pharmacy-generated electronic refill request messages are sent to the provider (if possible) based on the provider's DEA number.

When you refill a prescription from a user-generated or pharmacy-generated refill message, the application creates a visit note on which the refill is charted. If you select a supervising provider in the refill message, then the visit note that is created is sent to that supervising provider for approval. No superbill is created from the visit note for the refill.

When you issue a prescription refill prior to the end date of the original prescription, the original prescription is discontinued with the reason code Refilled.

Drug screening is performed when refilling a prescription from a message, and warning messages will appear as appropriate.

When refilling a prescription from an electronic prescription refill request, the application compares the NDC number of the requested medication to the medication being prescribed.

- If the NDC number in the electronic refill request does not match any prescription in the patient's history, then the message defaults to denied. The provider must write a new prescription if one is appropriate.
- If the NDC number in the electronic refill request matches a prescription in the patient's history and that prescription was written to allow substitutes, then a refill may be made for any of the generic equivalents to the identified medication.
- If the NDC number in the electronic refill request matches a prescription in the patient's history and that prescription was marked 'dispense as written', then the refill may only be made only for the identified medication.

Icons for Additional Functionality

The following icons enable to access additional information and functionality.

Icon	Function
	Medication History
	Find Dispensable Drug
	Find Default SIG
	Delete
	Drug Screening Alerts
	Drug Formulary
	Electronic Prior Authorization.

Refill Request Details

Electronic prescription refill messages display details received from the pharmacy. This includes details about the:

- Medication prescribed
- Medication dispensed
- Pharmacy and pharmacy notes
- Patient
- Prescriber

Drug Formulary Information

The application initiates a drug formulary request when an electronic prescription refill request is received from Surescripts or when a user creates and sends a manual prescription refill message. Refill messages display the Formulary status and the most recent download date for the prescription benefits information. The refill message does not display the formulary alternatives. You must select the medication hyperlink to access the SIG Writer window if you want to review the formulary details.

Electronic Refills and Controlled Substances

Drug Enforcement Agency (DEA) regulations allow pharmacies to request refills for controlled substances electronically. If you are using the application's electronic prescribing of controlled substances (EPCS) functionality, then you may submit the refill electronically.

If you are not using the EPCS functionality, then you cannot submit a refill electronically. Therefore, when you receive an electronic refill request for a controlled substance, you must process that refill request by denying it. There are two options for denying an electronic refill request for a Schedule III, IV, or V drug: you can deny the refill and complete the message, or you can deny the refill with a new prescription to follow. For a Schedule I or II drug, you must deny the refill and complete the message. Once you deny the electronic refill request for a controlled substance, you can, if desired, write a refill for the prescription and print the prescription for the patient.

Medications defined as controlled substances by the DEA are identified as a controlled substance in the drug database supplied by First DataBank. First DataBank does not identify medications that are defined as controlled substances by an individual state, rather than the DEA. Therefore, your administrative super user must identify in your database any medications defined as controlled substances by your state. This enables the application to recognize them in order to prevent them from being sent electronically and to print them using your controlled substance prescription format.

If the medications are not identified as state-defined controlled substances, then you are responsible for remembering to print the prescription rather than submitting it electronically. If you have a specific prescription format that is different from your regular prescription format, you will have to handwrite prescriptions for state-defined controlled substances.

Electronic Refill Response Expectations

It is important that you respond promptly to electronic refill requests received from pharmacies. The Surescripts electronic pharmacy clearinghouse requires that electronic refill request be responded to within 48 hours. Surescripts will suspend electronic refill requests for any provider who receives at least ten electronic refill requests a month and who fails to respond to any of these requests within at least 48 hours.

A pharmacy may send a second, or even third, request for a prescription refill if you do not respond promptly. Each request sent by the pharmacy is considered a separate item to which the pharmacy and Surescripts expect a response, even if the requests are for the same patient and medication. By responding promptly, you can reduce the number of duplicate requests sent by pharmacies. A response to an electronic refill request does not have to be authorization to refill the prescription. A denial, of any type, is a valid response.

Warning Messages on Prescription Refill Messages

Electronic and user generated prescription refill messages include a warning message box which may display any of the following messages when there is a problem with the requested refill.

- Warning: Unable to match requested refill with medication history for the patient.
- Warning: Requested medication being refilled was Discontinued. Reason: *discontinue reason*.
- Warning: Requested medication being refilled is obsolete. *Details from requested prescription*.
- Warning: A prescription within the same drug class was prescribed after the date of the requested medication being refilled. *Details from requested prescription*.

Prescription Refill Messages for Inactive Patients

You may occasionally receive a prescription refill request for a patient whose record has been inactivated. A patient record may be inactive with a status of Inactive or Deceased. When you open the prescription refill message, the application will display a popup message stating that the patient is inactive. You may then decide how you want to handle the request. The application does not prevent you from refilling the prescription, if that is what you want to do.

Create a Refill Message

You can create a prescription refill request message when a patient phones your office requesting a refill. You can then send the message to the provider who will authorize the refill.

1. Desktop → New → Rx Refill Request Message
2. Search for and select the Patient requesting the refill.
The patient's primary provider (PCP) and phone number are populated in the message. You can get additional phone numbers by hovering the cursor over the patient's name.
3. The message Urgency defaults to "routine". You may change this if needed.
4. Enter a Due Date for the completion of the refill and message.
5. In the Assign To field, search for and select the provider or other clinician who will receive and process the refill. You may send the message to more than one person or a group if needed.
6. The Reason field is prepopulated with "Refill Request". You may change or add to this as needed.
7. In the Provider field, search for and select the provider responsible for the prescription. This will be prepopulated if you selected a provider in the Assign To field in step 5.
8. In the Pharmacy field, search for and select the pharmacy at which the patient wants to receive the prescription.
This will default to the first pharmacy listed in the Patient Demographics if any pharmacies have been identified for the patient.

9. Enter the medication or medications the patient wants refilled. There are two ways to enter a medication:
 - Type any text in the Medication Requested field. Use this when the medication cannot be identified. This can be the purpose of the medication, a description of the medication, or any other identifying information that the patient can provide.
 - Select the Medication History icon () to search the medication history for the desired medication.
 - a. In the Filter field, select the medication history filter you wish to use.
 - b. Use the Select button to select a medication to be refilled. You may select any number of medications.
 - c. Select the Close button to return to the message window.
10. Enter a Comment regarding the medication if desired.
11. Repeat steps 9 and 10 to enter additional medications if desired.

<<Revised>> Complete a User-Generated Refill Message

You may display refill messages on the Desktop or use the Message Center to review them. Message entries displayed on the Desktop include the patient's name and phone number and the message reason. These instructions start from the Desktop window.

You can process a prescription refill request by refilling the requested prescription, by writing a prescription for a different medication, or by denying the refill. When a refill request message includes more than one prescription, you can process each prescription individually.

1. Desktop → Message Time Stamp or More Options icon () → Process Rx Refill Message
2. Patient information appears at the top of the Refill Request tab.
3. The Pharmacy field contains the pharmacy selected when the request was made. You can change this if needed. If the prescriptions will be sent electronically, all prescriptions will be sent to this pharmacy.
4. The Provider field contains the name of the provider selected when the request was made. You can change this if needed.
5. The Service Site is the selected provider's default service site. This service site will be used on the visit note created for the refill. You can change this if need.
6. To identify a supervising provider in the visit note, select the desired provider in the Supervisor field.
7. The message contains a section for each medication requested. Process each medication. Drug screening begins running in the background once a medication is fully identified. While the screening process runs, the In Process () icon displays just below the requested medication name. Once the screening is complete, either the Alerts () icon or No Alerts () icon appears. Select the Alerts () icon to review the drug screening alerts.

- To refill the requested medication or to write a prescription for a different medication:
 - a. Either:
 - Select the Refill Prescription link to refill the requested prescription.
 - Select the Medication History icon () to search the medication history for another prescription for the same or a different medication. Then, select the Refill button for the desired prescription.
 - Search for and select a Drug to write new prescription for the same or a different medication.
 - Search for and select a Default SIG if desired. This field is enabled only when there are default SIGs available for the requested medication.
 - b. In the SIG Writer window, either:
 - Enter or confirm the prescription details and select OK.
 - To change the strength or form (tablet, liquid, etc.) of the medication, select the medication name link. Then select the desired medication.
 - To change to another medication with the same ingredient, select the medication name link. Then select the desired medication.
 - c. In the Message window, enter any Internal Comments if desired.
 - d. Select the Accept radio button to accept the refill request.
 - e. Select the 'Print When Message is Completed' checkbox if a printed prescription is needed. When not selected, the prescription will be submitted electronically to the identified pharmacy.
 - Select the Deny radio button to deny the refill request.
8. Repeat step 7 for each medication requested.
 9. If the visit note created for the refill needs to be approved by a supervising provider:
 - a. Select the 'Forward Note for Prescription Review to' checkbox.
 - b. Select the desired supervising provider.
 10. Select the Send Response Upon Completion checkbox if you want to send a response to person who requested the refill. If desired, you can select another recipient.
 11. When you have processed all the medications, select the Complete button to complete the message.

Complete an Electronic Refill Message

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. Verify that the correct patient is identified in the Patient field.

If the application cannot automatically match the patient identified in the refill request to a patient in the database, then you may make this match. If you can match the patient to a patient in your database, then you will be able to refill the prescription as long as the medication and its NDC match a prescription in the patient's history.

3. In the Medication section, you may:
 - Select the Refill Prescription link to refill the requested prescription.
 - Select the Medication History icon () to search the medication history for another prescription for the same or a different medication. (Note: Do not go into Review Past Notes, Full Note Composer, or Superbill Composer to review the medication history while processing a refill.)
 - Select the Drug Selection () icon to write new prescription for the same or a different medication.
 - Select the Default SIG () icon if desired. This field is enabled only when there are default SIGs available for the requested medication.
 - Review the drug screening warnings, if any. Drug screening begins running in the background once a medication is fully identified. While the screening process runs, the In Process () icon displays just below the requested medication name. Once the screening is complete, either the Alerts () icon or No Alerts () icon appears. Select the Alerts () icon to review the drug screening alerts
 - Select the Drug Formulary () icon to review the patient's formulary information.
4. Select the radio button for the action you want to take:
 - Accept Request: Select to refill the prescription. You must also enter a Number of Refills Authorized.
 - Deny with a New Prescription to Follow: Select to send a message to the pharmacy denying the requested refill, and notifying them that another prescription will be sent. This is appropriate if you want to prescribe a different medication.
 - Deny Request: Select to send a message to the pharmacy denying the requested refill.
5. If the visit note created for the refill needs to be approved by a supervising provider:
 - a. Select the 'Forward Note for Prescription Review to' checkbox.
 - b. Select the desired supervising provider.
6. Select the "Send Response Upon Message Completion" checkbox in order to send a reply to the pharmacy.
7. Select the Complete button to complete the message, and send the appropriate message back to the pharmacy.

Deny the Refill with a New Prescription to Follow

You can use this procedure for a Schedule III, IV, or V drug when you wish to refill the prescription or write a new prescription for a different drug.

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. Verify that the correct patient is identified in the Map to Patient field.
3. When the requested drug matches a drug in the patient's history, it will automatically match. The Rx reference number will be populated in the Comments section of the message.
4. Verify that the Deny with New radio button is selected.
5. Enter an explanation for the denial in the Comments To Pharmacy text box. This is required. Under some circumstances, the application is able to determine the reason for denying the prescription and populates the Comments field for you. If not, you must enter a comment.
6. Either write a prescription for a different medication or print the refill.
 - To write a new prescription for a medication that is not a controlled substance, select the desired Drug, and complete the prescription details in the usual manner.
 - To print the refill prescription for the controlled substance, verify that the checkbox for Print When Message is Completed. This causes the prescription to print.
7. Select the Complete button to complete the message, and send the appropriate message back to the pharmacy.

Deny the Refill

You must use this procedure for Schedule I and II drugs. You can also use it to simply deny the refill for a Schedule III, IV, or V drug. You can, if desired, write a refill for the prescription from the patient history and print the prescription for the patient.

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. Verify that the correct patient is identified in the Map to Patient field.
3. When the requested drug matches a drug in the patient's history, it will automatically match. The Rx reference number will be populated in the Comments section of the message.
4. Select the Deny radio button. When you complete the message, this will send a message to the pharmacy denying the requested refill.
5. Enter an explanation for the denial in the Comments To Pharmacy text box. This is required. Under some circumstances, the application is able to determine the reason for denying the prescription and populates the Comments field for you. If not, you must enter a comment.
6. Select the appropriate Reason for the denial.
7. Select the Complete button to complete the message, and send the appropriate message back to the pharmacy.

Track Prescriptions

The Track Prescriptions window displays the status of all prescriptions that have been printed, transmitted electronically, or faxed. It lists visit date, patient, provider, medication, and pharmacy name.

The ePrescribed column indicates whether the transmission was successfully transmitted and processed. There are four possible states:

- Yes: This includes the date and time of transmission.
- No
- Failed
- Queued: This means the script is awaiting transmission. You will probably see this only if your eRx Send Job is scheduled to run infrequently.

The Note column, when populated, will usually contain a reason for the failure of an electronic prescription. These notes are similar to the reasons that appear in the ePrescribe Warning message.

The Ready column indicates whether the prescription has been marked as ready to prescribe.

The Message Type column identifies whether the prescription is new or a refill.

The Message ID column contains the Surescripts ID for the prescription. This is the same ID that appears in the Surescripts Admin Console. This ID is useful for Support when troubleshooting a problem with a prescription.

When a prescription is faxed, the Faxed column will contain Yes (mm/dd/yy), where mm/dd/yy is the date the prescription was faxed. When a prescription is printed, the Printed column will contain Yes (mm/dd/yy), where mm/dd/yy is the date the prescription was faxed. These columns will be blank if the prescription was not faxed or printed.

You can filter the list if required to find specific items. You can print the contents of the window by selecting the Print option on the File menu.

Transmission of Electronic Prescriptions

When an electronic prescription fails because it times out, the application makes three more attempts to send that prescription before the prescription fails completely. Please allow time for the system to attempt to resend the failed message.

While the application makes these subsequent attempts, the Track Prescriptions window may show the prescription with a number of different states in the ePrescribed column. These states may include Failed, Queued, or specific error message. If the final attempt to send the prescription fails, then ePrescribe column displays 'No' and the Note column displays 'Transmission Error'.

You should not do anything for these prescriptions until you see 'Transmission Error' in the Notes column. This is because the prescription may be successfully sent during one of the subsequent attempts. 'Transmission Error' indicates that the prescription has truly failed to transmit.

When the Track Prescription window displays 'Transmission Error', you must check the Message Center window for the actual error message. From the Message Center window, you can attempt to send the prescription again, or you can complete the message with a 'Do Nothing' status and call the prescription into the pharmacy. Please see the instructions below.

If a prescription continues to fail after resending it, please contact Support with the ID number of the patient as well as the entire error message being received in the Message Center for further review.

View the Status of Prescriptions

1. Tools → Track Rx
2. Enter one or more search criteria from date, patient, provider, and pharmacy.
3. If an error is indicated, information about the error will appear in the Notes column. Use this information to correct the error. There are a number of reasons a prescription cannot transmit, including:
 - Pharmacy is not selected
 - Pharmacy is not configured for ePrescribing
 - Prescribing provider is not enrolled to ePrescribe with this clearinghouse
 - User defined drug cannot be ePrescribed
 - Medication cannot be ePrescribed because drug name is too long
 - Compound/complex drug cannot be ePrescribed
 - Unknown drug class cannot be ePrescribed
 - Controlled drug cannot be ePrescribed
 - Prescription quantity is not valid for ePrescribing

Prescription Management Services from Surescripts®

The Surescripts electronic pharmacy clearinghouse offers several services that help you manage patients' prescriptions. These include:

- Electronic prior authorization of prescriptions
- Medication Management
- Specialty patient enrollment

Please note that Surescripts's prescription management services are relatively new. Not all services are available from all pharmacy benefits manager (PBM) organizations and/or pharmacies. Services may not be available in all locations.

To use any of these services for a patient, the patient must have granted you permission. This permission must be set in the Patient window's Additional tab by selecting the eMed Hx Request Consent checkbox. The patient's full physical address must also be entered in the patient record. The address cannot be a Post Office box.

These services also require that the patient's prescriptions benefits and formulary information must have been received. If your practice is using the Surescripts electronic benefits, formulary, and medication history functionality, then this information is usually downloaded by a job each night. If your practice is not currently using this functionality, you must begin using the electronic benefits and formulary download functionality in order to use the medication management functionality. (It is not necessary to use the medication history functionality.)

The nightly job that downloads medication benefits and formulary obtains this information for patients who have appointments scheduled for the next day. It is important to recognize that the job can only download information for patients who meet the download criteria. The patient's name, date of birth, gender, and full physical address must be entered in the patient's record. In addition, a provider with an SPI number must be associated with the appointment.

Information for all of these services is displayed in the Review Electronic Prior Authorization/Medication Management window. Information may also be displayed elsewhere, depending on the service. The information displayed in the Review Electronic Prior Authorization/Medication Management window is from the Surescripts clearinghouse. This information is not in your database.

Electronic Prior Authorization of Prescriptions

Electronic prior authorization of prescriptions is available through the Surescripts electronic pharmacy clearinghouse. Electronic prior authorization (ePA) enables providers or other clinical users to send an authorization request when prescribing a medication. Then, if prior authorization is needed for the medication, an authorization questionnaire is returned. The provider or other clinical user can complete the questionnaire to obtain the authorization results.

Please note that prior authorization information is obtained from the pharmacy benefits manager (PBM) organization responsible for the patient's prescription benefits and formulary. Please also note that some PBMs only cover certain types of pharmacies, such as only mail order pharmacies or only retail pharmacies. If the PBM identified for the patient does not cover the pharmacy on the prescription, then the electronic prior authorization functionality may be triggered when not needed or not triggered when needed.

Electronic prior authorization is available only from the PBM organizations that have been certified for this service by Surescripts. If the PBM for the patient is not certified, then the electronic prior authorization functionality will not be triggered for the patient even if prior authorization is needed for the medication. You may access a list of the payers and PBMs certified by Surescripts on their website at <https://surescripts.com/network-connections/payers-and-pbms/>

Identifying that Prior Authorization is Appropriate

When you enter a prescription for a medication for a patient, the application uses the patient's prescription benefits and formulary information to determine whether a prior authorization is needed. Generic versions of a medication may not need a prior authorization even though the brand name medication does. In this instance, the application will only identify a prior authorization as needed for the brand name when you specify 'dispense as written' (DAW) on the prescription.

When the application determines that the medication needs prior authorization, then the application enables the ePA icon in the SIG Writer window or the prescription refill message. The application also displays a warning message that the medication needs prior authorization when you close the SIG Writer window or submits the prescription from the message. The enabled ePA icon and the warning message both serve to notify you that a prior authorization is needed so that you can take action if desired.

For example, you may want to explain to the patient that there will be a delay in the pharmacy filling the prescription or that the patient may have to pay more for the medication in order to get it quickly. Or, you may want to review the patient's insurance formulary and prescribe another medication instead so that prior authorization is not needed.

If you do not want the prior authorization warning message to display (and want to rely on the enabled ePA icon alone), then your administrative super user may modify your user settings definition to turn off the warning message. The instructions for changing this setting are in the Warning Message for ePA Appropriate section of the *Administrative User's Guide*.

Send a Prior Authorization from a Visit

The application uses the patient's prescription benefits information to determine whether prior authorization may be needed for a medication.

1. In the SIG Writer window, chart a prescription in the usual manner.
2. Check the status of electronic prior authorization icon.
 - When the electronic prior authorization icon () has a red arrow, then a request will be sent. The application has determined that a prior authorization may be needed. You may select the icon to deactivate it if you do not want to send the request.
 - When the electronic prior authorization icon () has a blue arrow, the request will not be sent. Either the application has determined that prior authorization is not needed or it cannot make a determination. You may select the icon to change it to red if you want to send a request even though the application did not identify the need for a request. However, you should only do this when you know that authorization is required.
3. Select the OK button to save the prescription and return to the Full Note Composer or other clinical note type window.
4. A warning message displays reminding you that prior authorization is needed, and asking you to confirm the prescription for the medication.
 - Select Yes if you want to prescribe the medication. This returns to the Full Note Composer or other clinical note type window. The application will send the prior authorization request.
 - Select No to return to the SIG Writer window. You can review the patient's formulary information, and if desired, write a prescription for a different medication.
5. When you submit the prescriptions electronically, either when closing the visit note or by selecting the submit electronic prescriptions () icon, then any prior authorization requests are also sent.

Review or Send a Prior Authorization Request from Medication History

You can review the status of a patient's prior authorization requests from the patient's history. Then, if desired, you can select the ePA status icon to access a window displaying more information from Surescripts.

You can send a prior authorization request for a medication listed in the patient's history. The following information must be available in order to request prior authorization:

- Dosage
- Route
- Frequency
- Days supply
- Quantity

1. Patient History → Medication History category
2. In the medication line, the ePA column displays an icon with the status of the prior authorization request.
 -  Prior authorization has never been requested. Select the icon to send a prior authorization request.
 - a. In the popup confirmation message, select the Yes button.
 - b. On the Patient History window, select the OK button to send the request.
 -  Prior authorization is complete. No further action is needed. You may select this icon to send a new prior authorization request.
 - a. In the popup confirmation message, select the Yes button.
 - b. On the Patient History window, select the OK button to send the request.
 -  Request for prior authorization has been sent, and waiting for response from the clearinghouse or PBM.
 -  Prior authorization is pending action. Select the icon to view additional information and determine the action needed (such as responding to a questionnaire).
 -  An error occurred in the transmission of the request or response. Select the icon to view additional information.

Send a Prior Authorization Request from a Refill Message

You can send a prior authorization request when you refill a prescription from an electronic or user-created prescription refill message.

1. Desktop → Message Time Stamp or More Options icon () → Process Rx Refill Message
2. As you process a medication in the message, check the status of electronic prior authorization icon.
 - When the electronic prior authorization icon () is active and has a red arrow, then a request will be sent. The icon will be active when the application determines that a prior authorization may be needed. You may select the icon to deactivate it if you do not want to send the request.
 - When the electronic prior authorization icon () is inactive and has a grey arrow, the request will not be sent. The icon will be inactive when the application determines that prior authorization is not needed or cannot make a determination. You may select the icon to activate it if you want to send a request even though the need for one was not identified by the application.
3. Continue processing the refill message in the usual manner. See the Process Prescription Refill Messages section for more information.

Review Electronic Prior Authorization Responses

The PBM sends responses to your providers' prior authorization requests through Surescripts. Surescripts refers to these responses as tasks because you must process each response in order to fully complete your providers' prior authorization requests.

The PBM's response may inform you that the authorization is not needed or that authorization has been granted based on the information in the original request. When the PBM needs additional information for the authorization, then the PBM's response includes an online questionnaire for you to complete. You must acknowledge the PBM's response regardless of what that response is.

After completing a questionnaire, the PBM will send a response informing you whether the prescription is authorized or denied. Again, you must acknowledge the PBM's response regardless of what that response is.

Acknowledging a response from a PBM indicates that you accept the outcome of the provider's prior authorization request. Acknowledging a response eliminates any possibility for you to appeal the response electronically. You can, however, manually appeal. Your appeal must include the PA Case ID.

The Worklist tab of the window displays a list of responses to requests for prior authorization for prescriptions. You can review the responses and complete questionnaires to obtain authorization. The list of responses and the questionnaires are displayed from the Surescripts clearinghouse. This information is not in your database.

By default, the Worklist displays responses for the last 30 days. You can change the filtering and date range if desired.

You can select a response task to review the history of the prior authorization request and its response. If desired, you may cancel a prior authorization request that is still in progress.

1. Either:
 - Desktop menu → Review Electronic Prior Authorization/Medication Management
 - Patient toolbar → ePA icon ()
 - Desktop window's Electronic Prior Authorization control
2. Select the providers or patients whose requests you want to review.
 - When accessed from the Desktop menu, select the Providers or Patients radio button, and then select the desired providers or patients.
 - When accessed from the Patient toolbar, then only the selected patient's requests may be viewed.
 - When accessed from the Electronic Prior Authorization control on the Desktop window, then you can select only the providers desired.
3. Select the Prior Authorization radio button.
4. Select the Worklist tab to display the responses that need to be reviewed.
5. Select the Refresh button to refresh the list if needed.

6. Select the down arrow on the Filtering Options bar to select another filter.
7. In the Task column, select a hyperlink to access the response from Surescripts and the PBM. The types of responses are:
 - Complete PA Form: You must complete the prior authorization questionnaire.
 - Acknowledge Approval: You must acknowledge the authorization approval message.
 - Acknowledge Denied: You must acknowledge the authorization denied message.
 - Acknowledge PA Not Needed: There is an authorization not needed message to acknowledge.
 - Complete Prior Auth Criteria with PDR: The PBM does not support Surescripts' electronic prior authorization questionnaire. But, you may access the PDR Network website, where you can complete an interactive PDF questionnaire form.
8. Use the appropriate process below to acknowledge the response.

Complete a Prior Authorization Questionnaire

The PBM's prior authorization questionnaire and your answers to it are displayed from the Surescripts clearinghouse. This information is not in your Aprima database.

A questionnaire or other response task is locked while you are working on it so that no other user can access it. You can save your answers and release the task if you are unable to complete the questionnaire. You or another user can complete the questionnaire at a later time. Saving your answers does not submit them to the PBM.

A questionnaire will timeout and be automatically released if you do not complete it within one hour. Any answers that have not been saved are lost when a questionnaire times out.

1. Access the Review Electronic Prior Authorization/Medication Management window, and review the prior authorization responses.
2. In the Task column, select the Complete PA Form hyperlink to complete a questionnaire.
3. The Information tab contains the deadline for replying to the questionnaire. It may also contain contact information for the PBM or the insurance payer. The Patient Information and Provider Information tabs contain data that was sent in the initial request.
4. Select the Start button to begin the questionnaire.
5. For each question, answer the question and then select the Next button.
 - The question number and the percentage complete appear beneath the patient's name, just above the question.
 - Use the Back button to return to a previous question if needed.
 - Use the Save button to save your answers if you need to complete the questionnaire later. Saving does not submit your answers to the PBM.
 - Use the Release button to release the questionnaire so that another user can access it.
6. When you have answered all questions, select the Submit button.

Complete a Prior Authorization with PDR

Some PBMs do not support Surescripts' electronic prior authorization questionnaire. In this case, you will receive a task titled 'Complete Prior Auth Criteria with PDR'. This task message includes a hyperlink that enables you to access the PDR Network website, where you can complete an interactive PDF questionnaire form.

The PDR Network is not part of the Surescripts ePA functionality. The PBM will contact you directly, either by fax or by phone, with their response once you complete the questionnaire.

Note that the hyperlink to the PDR Network is only active for 24 hours. Once the link expires, you must complete the PBM's paper form, and fax it to the PBM directly.

1. Access the Review Electronic Prior Authorization/Medication Management window, and review the prior authorization responses.
2. In the Task column, select the Complete Prior Auth Criteria with PDR hyperlink to open the message.
3. In the message, scroll to Outcome Statements section. This is at the bottom of the message.
4. Select the View PA Form hyperlink.

This opens default internet browser, which displays an interactive PDF that looks like the paper form used by the PBM. This window is not part of the Aprima application or the Surescripts ePA functionality.

5. Complete the form in the browser window.
6. Either:
 - Select the Submit () icon to send the completed form electronically. The PDR Network will fax your completed form to the PBM for you.
 - Select the Print () icon to print the completed form. Then, you must fax the form to the PBM.
7. Close the browser window to return to the ePA task message in Aprima.
8. Select the Mark PA Complete button.

Acknowledge an Approval

1. Access the Review Electronic Prior Authorization/Medication Management window, and review the prior authorization responses.
2. In the Task column, select the Acknowledge Approval hyperlink.
3. Review the information to determine whether the PBM made changes, such as the number of refills or the days supply.
4. If there is an Attachment tab, select it. Then select the Accept and Download button to download the attachment.
5. Select the Acknowledge button.

Acknowledge or Appeal a Denial

1. Access the Review Electronic Prior Authorization/Medication Management window, and review the prior authorization responses.
2. In the Task column, select the Acknowledge Denied hyperlink.
3. Review the information on the denial.
4. If there is an Attachment tab, select it. Then select the Accept and Download button to download the attachment.
5. Either:
 - Select the eAppeal button if available and if you want to appeal the denial. Go to the next step.
 - Select the Acknowledge button. This completes the process.
6. When you select the eAppeal button, the Appeal window appears. The prior authorization case ID assigned by the PBM is displayed at the top of the window to the right of the patient's name and the medication.
7. In the PA Note field, type any information you want to provide about why you are appealing the denial.
8. Select the Appeal button to send the appeal information to the PBM.

Acknowledge that Prior Authorization is not Needed

1. Access the Review Electronic Prior Authorization/Medication Management window, and review the prior authorization responses.
2. In the Task column, select the Acknowledge PA Not Needed hyperlink.
3. Select the Outcome Statements tab to review the information, then select the Acknowledge button.

Review Previous Electronic Prior Authorization Cases

The Task History tab of the Review Electronic Prior Authorization window displays a list of previously worked response tasks. You can review the response tasks to make sure that questionnaires have been completed and all responses have been acknowledged. By default, the Task History tab displays responses for the last 30 days. You can change the filtering and date range if desired.

You can select a response task to review the history of the prior authorization request and its response. If desired, you may cancel a prior authorization request that is still in progress.

All response task information is displayed from the Surescripts clearinghouse, and is not stored in your Aprima database.

1. Either:
 - Desktop menu → Review Electronic Prior Authorization/Medication Management
 - Patient toolbar → ePA icon ()
 - Desktop window's Electronic Prior Authorization control
2. Select the providers or patients whose requests you want to review.
 - When accessed from the Desktop menu, select the Providers or Patients radio button, and then select the desired providers or patients.
 - When accessed from the Patient toolbar, then only the selected patient's requests may be viewed.
 - When accessed from the Electronic Prior Authorization control on the Desktop window, then you can select only the providers desired. You cannot select patients.
3. Select the Task History tab to display previous response tasks.
4. Select the Refresh button to refresh the list if needed.
5. Select the down arrow on the Filtering Options bar to select another filter.
6. To review the history of a response task, select the ePA Case hyperlink.
7. The response task details include the:
 - Patient's name
 - Medication
 - Status
 - PA Case ID
 - Action required
 - List of actions taken with their status, recipient, and responded date.
8. A completed questionnaire is indicated by a blue Completed icon next to the action entry. You can select this icon to review the questions and answers.
9. If desired, select the Cancel button to cancel a prior authorization request that is in progress.

Medication Management

(Please note that as of the publication date, Surescripts is piloting medication management with the CVS | Caremark, ExpressScripts, and Prime PBMs in Alabama, Florida, and North Carolina only. In addition, medication information is provided only for diagnoses of hyperlipidemia, hypertension, and diabetes.)

Medication management provides you with information about your patients' adherence with their prescriptions during and in-between patient visits. The prescription adherence information comes from the patient's pharmacy benefits manager (PBM) and/or insurance payer.

There are several different types of medication management messages. The table below lists the types of messages and gives a description and example of each.

Surescripts sends medication management messages to the provider identified in the Patient window's Practice Provider field. If you have not selected a practice primary provider for a patient, then no provider in your practice will receive medication management messages for that patient.

The medication management messages that you receive for a patient include medications prescribed by any provider, not just by your practice's primary provider for the patient or by other providers in your practice.

Current medication management messages are available in the Review Electronic Prior Authorization/Medication Management window. A message is current for 30 day, or until the expiration date defined by the PBM if less than 30 days, or until you take action on the message.

There are several ways in which you can access the Review Electronic Prior Authorization/Medication Management window. You can access this window:

- From the Desktop menu. This accesses messages for all patients.
- From the Desktop window using the Electronic Prior Authorization desktop control. This accesses messages for all patients. (Please refer to the *General User's Guide* for instructions on configuring your Desktop window.)
- From the Patient menu in the Patient Demographics window. This accesses only the messages for the specific patient.
- From the Rx Summary slider in a patient visit note. This accesses only the messages for the specific patient.

Please note that medication management messages are sent from the pharmacy benefits manager (PBM) organization responsible for the patient's prescription benefits and formulary. Medication management messages are available only from the PBM organizations that have been certified for this service by Surescripts. If the PBM for the patient is not certified, then the medication management functionality will not be enabled for the patient.

Types of Medication Management Messages

Message Type	Description	Example
Medication Adherence	An adherence message, as indicated by claim activity, is sent when a patient is not taking the medication as frequently as prescribed.	ABC Health Plan records indicate this patient may have discontinued taking Lipitor as instructed. Please discuss adherence with your patient.
High-Risk Medication	A high-risk medication (HRM) message occurs when a patient has been prescribed a drug that is considered high-risk due to the potential for side-effects where alternative drug therapies exist. These messages are classified as an "Urgent Message".	<p>ABC Health Plan records indicate this patient has been prescribed glyburide which is considered to be a high risk medication in the elderly causing prolonged hypoglycemia. Please evaluate the risk and benefit of continuing use.</p> <p>ABC Health Plan records indicate this patient has been prescribed glyburide which is considered to be a high risk medication in the elderly causing prolonged hypoglycemia. Please consider prescribing a safer alternative to this medication, if appropriate. Alternatives: glipizide, glimepiride.</p>
Missing Medication	A missing medication is a medication that is expected based on a patient's diagnosis codes or existence of another drug.	ABC Health Plan records indicate this patient may benefit from a statin. Please evaluate the use of a statin for a diabetic patient.

Message Type	Description	Example
Proportion of Days Covered (PDC)	<p>The PDC calculation is based on the fill dates and days supply for each fill of a prescription. PDC is defined as the total numbers of days with possession of medication in a period of time.</p> <p>A PDC ratio will be provided by the PBM/payer on a monthly basis for cholesterol, diabetes and hypertension regardless if the PDC is below or above 80%.</p> <p>PDC ratios are categorized as:</p> <ul style="list-style-type: none"> • Lowest ratio <= 60%, color red • Lowest ratio > 60% and < 80%, color orange • Lowest ratio >= 80%, color green 	

Medication Management Information in the Rx Summary Slider

The Rx Summary slider in Full Note Composer or other clinical note type window can display information about the patient's medication management messages. To display this information, your administrative super user must have configured the Rx Summary slider to include the medication management information, and configured the clinical note type window you are using to include the Rx Summary slider.

The Medication Management section of the Rx Summary slider lists the medication management messages available for the patient. A red Flag () icon is displayed next to any messages that are marked as urgent or are about a high-risk medication. You can select a medication management message hyperlink or the View All Messages hyperlink to access the Review Proportion of Days Covered window, where you can view the message and the patient's medication adherence profile.

The Medication Management section of the Rx Summary slider also contains a Medication Adherence Summary icon. This icon displays the patient's medication adherence percentage. The medication adherence percentage is the PDC ratio, which is based on the fill dates and days supply for each fill of a prescription. If the patient is prescribed more than one medication for which a PDC ratio is available, then the patient's lowest PDC ratio is displayed. The color of the Medication Adherence Summary icon is based on the PDC ratio:

- <= 60% is red

- > 60% to < 80% is orange
- >= 80% is green

You can select the Medication Adherence Summary icon to access the Review Proportion of Days Covered window, where you can view the message and the patient's medication adherence profile.

In the Review Proportion of Days Covered window, you can select the Patient Information tile to display the medication adherence profile in a different format.

View Medication Management Messages

You may view medication management messages in the Review Electronic Prior Authorization/Medication Management window. The information in this window is displayed from the Surescripts clearinghouse. This information is not in your database.

1. Either:
 - Desktop menu → Review Electronic Prior Authorization/Medication Management
 - Patient toolbar → ePA icon ()
 - Desktop window's Electronic Prior Authorization control
2. Select the providers or patients whose requests you want to review.
 - When accessed from the Desktop menu, select the Providers or Patients radio button, and then select the desired providers or patients.
 - When accessed from the Patient toolbar, then only the selected patient's requests may be viewed.
 - When accessed from the Electronic Prior Authorization control on the Desktop window, then you can select only the providers desired.
3. Select the Worklist tab.
4. Select the radio button for the messages to display.
 - Both displays electronic prior authorization messages and medication management messages.
 - Prior Authorization displays only electronic prior authorization messages.
 - Medication Management displays only medication management messages.
5. Select the Refresh button to refresh the list if needed.
6. Select the down arrow on the Filtering Options bar to select another filter.
7. In the Task column, select a hyperlink to access the medication management message from Surescripts and the PBM.
8. The message displays information about the medication and a summary of other messages available for the same patient.
9. If desired, you may respond to the message. Responding removes it from the worklist.

<<Revised>> Specialty Patient Enrollment

Some medications require that the patient be enrolled with a specialty pharmacy before the prescription can be filled. Surescripts's specialty patient enrollment (SPE) service enables you to complete the enrollment form from within the application. SPE is currently a pilot program which interacts with one specialty pharmacy for rheumatology medications.

When you electronically submit a new prescription, Surescripts determines whether the medication requires a specialty pharmacy enrollment. When a medication does require enrollment, then Surescripts's sends you an enrollment questionnaire. You or another clinical user can complete the questionnaire to enroll the patient with the specialty pharmacy.

There are no responses to completed specialty medication enrollment questionnaires. Completing the questionnaire is all that is needed.

Complete a Specialty Enrollment Questionnaire

The specialty enrollment questionnaire and your answers to it are displayed from the Surescripts clearinghouse. This information is not in your Aprima database.

A questionnaire is locked while you are working on it so that no other user can access it. You can save your answers and release the task if you are unable to complete the questionnaire. You or another user can complete the questionnaire at a later time. Saving your answers does not submit them to the specialty pharmacy.

A questionnaire will timeout and be automatically released if you do not complete it within one hour. Any answers that have not been saved are lost when a questionnaire times out.

1. Access the Review Electronic Prior Authorization/Medication Management window, and review the specialty enrollment responses.
2. In the Task column, select the Complete Specialty Enrollment Request hyperlink to complete a questionnaire.
3. Review the patient and medication information to ensure it is correct.
4. Select the Please Select an Enrollment Form button to display a list of the available forms.
 - Select the enrollment form appropriate for your patient's condition, if available.
 - If no specific form is available for the patient's condition, then select the general form.
5. Select the Start Enrollment button to display the enrollment form.

Some questions may contain information from the patient's chart. If any of this information is incorrect, you must correct the information in the patient's record or visit notes. Then, you can complete the enrollment form.

6. For each question, answer the question and then select the Next button.
 - Use the Back button to return to a previous question if needed.
 - Use the Save button to save your answers if you need to complete the questionnaire later. Saving does not submit your answers to the specialty pharmacy.

7. When you have answered all questions, the Summary page is displayed.
 - a. Review the information.
 - b. If any correction are needed, select the Edit Page button. Make the correction, then select the Next button to continue reviewing the summary.
 - c. When all information is correct, select the Send to Pharmacy button.
8. A popup window will display asking you to confirm the submission.
 - Select the Submit button to send the information to the specialty pharmacy. You cannot change the information once you have submitted it.
 - Select the Cancel button to cancel the submission. This returns to the questionnaire window where you may change any information.

Procedure Notes

You can use procedure notes to enter information about a procedure to be ordered, how a procedure was performed, or the results of a procedure. A procedure note enables you to reuse a common set of information, while providing an easy way to update specific data for each patient. There are many situations that require a standard format of a note regarding a procedure where the only differences between one use and another are variable information, such as location, quantity, or measurement. You can create a procedure note template that defines all the common information regarding the procedure, yet allows you to complete variable information in certain fields. For example, part of a procedure note for one patient may read: "...following that with 9cc of bupivacaine 0.25%." For another patient, the procedure note may be similar, but read: "...following that with 12cc of bupivacaine 0.20%."

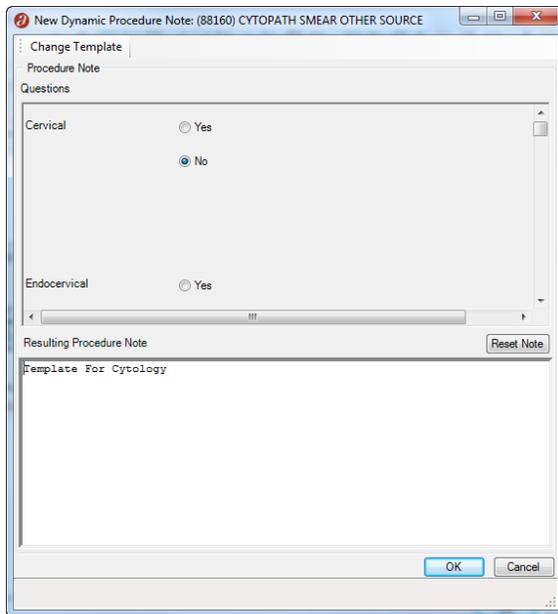
There are two types of procedure notes. Standard procedure notes are the most structured; dynamic procedure notes are more flexible. A standard procedure note requires that you make a single entry for each variable; a dynamic procedure note enables you to make entries for only those variables that apply to the situation and to select multiple responses when needed. A standard procedure note allows static text introducing or surrounding the variables. A dynamic procedure note allows a brief natural language phrase introducing each variable. A dynamic procedure note may be associated with an action or actions, such as sending a message or generating and sending a document, that are to take place when the dynamic procedure note is used.

Both standard and dynamic procedure notes may be used for documenting services performed, ordering clinical services, and entering test and other procedure results. The structure of standard procedure notes is appropriate for lab tests that are typically ordered through a laboratory interface and which always require the same variables, such as the location from which the specimen was collected, the collection technique, etc.

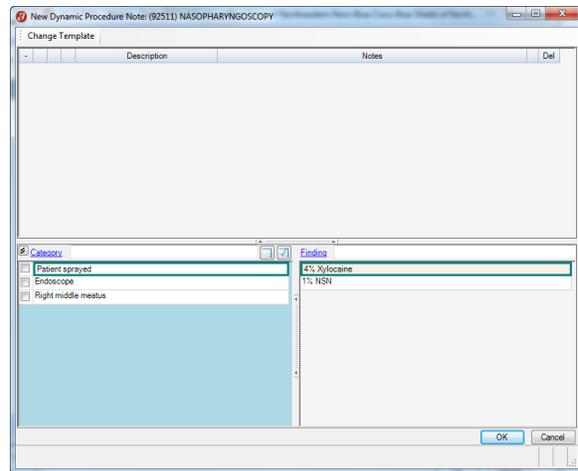
Dynamic procedure notes for clinical orders are generally used for procedures, such as x-rays or MRIs or lab tests performed in-house, which are not sent to a laboratory through an interface. You can also use procedure notes to order a referral to a specialist or consulting physician, durable medical equipment, physical therapy, or other types of services. The procedure note enables you to enter any details needed, such as the views for an x-ray, when creating the order for a specific patient.

Dynamic procedure notes for results are also generally used for tests and procedures which are not sent to a laboratory through an interface and for which results are not received through an interface. This may include such things as x-rays, MRIs, or physical therapy evaluations, which generate qualitative results and interpretations. The procedure note enables you to easily enter the results, and later review them, in a structured, yet flexible, manner.

Below are samples of the interface you will see for standard procedure note for a cytology test and a dynamic procedure note for a nasopharyngoscopy.



Standard Procedure Note



Dynamic Procedure Note

A dynamic procedure note may also trigger actions that the application automatically takes when you use the procedure note. Actions include creating various types of messages and generating documents that are then printed, faxed, or sent by Direct messaging. A procedure note may include one or more actions. Messages are sent to someone in your practice, such as a nurse, medical technician, so that they can complete some task, such as administering a vaccination, obtaining a specimen, or processing an insurance authorization request. Documents may be generated for any purpose, such as referral letters, consultation reports, or C-CDA or continuity of care documents. Once documents are generated, the application can print them or send them to external physicians, medical service providers, or other entities.

The dynamic procedure note's definition determines when the action is triggered. The trigger may be when you save the patient visit note, send the order, close the clinical note type window, or complete the patient visit note.

You can access procedure notes from within Full Note Composer or another clinical note type window when entering a procedure code in either the SP or SO tabs. When a procedure note has been defined for a procedure, the Procedure Note icon () appears next to the charted procedure.

You must select the procedure code to which the procedure note is associated in order to use the procedure note to complete the order or to enter the results once they are received. So, to use dynamic procedure notes for clinical service orders, you must know how your administrative super user has defined your procedure notes so that you start by ordering the correct procedure.

Procedure notes for referrals, DME orders, physical therapy, and similar services may be associated with specific CPT and HCPCS procedure codes. Or your administrative super user may have created a generic custom procedure code for each of the services, and associated a procedure note with the custom procedure code only. So for example, you may place all DME orders by selecting a custom DME order procedure code, and then entering all the details for the equipment and its specifications in the procedure note.

Complete a Standard Procedure Note

1. Full Note Composer or other clinical note type window → SP or SO tab
2. Select the desired procedure to be provided or ordered.
3. Select the Procedure Note icon ()
4. If there is more than one procedure note associated with the procedure, then highlight the procedure note you want to use and select the OK button.
The Questions section of the window then displays the data fields for the selected procedure note.
5. Enter the patient data in the data fields as appropriate.
The Resulting Procedure Section of the window displays the standard text of the note. It is updated with the patient's data as you make entries.
6. If needed, select the Reset Note button to delete all entries so that you can start again.
7. Select the OK button to close the window and add the patient data to the patient chart.

Complete a Dynamic Procedure Note

1. Full Note Composer or other clinical note type window → SP or SO tab
2. Select the desired procedure to be provided or ordered.
3. Select the Procedure Note icon ()
4. If there is more than one procedure note associated with the procedure, then highlight the procedure note you want to use and select the OK button.
5. The Procedure Note window displays the categories and their findings for the completion of the order and for any message or document to be generated and sent. If there is more than one procedure note associated with the procedure, you may choose a different procedure note by selecting the Change Template button at the top of the window.

6. In the Procedure Note window's Category pane, select the checkbox for the item you want to document.
7. In the KDB Finding pane, either:
 - Select the finding for the selected category item.
 - Select the <Find> listing or the Find () icon to search for an item not in the list. This option is available only when the finding is an item in the database, such as user, provider, or medical service provider.

This adds the selected category and finding to the Dynamic Procedure Note section in the top of the window.

8. Repeat steps 6 and 7 to enter all appropriate categories and findings.
9. Select the OK button to close the window and add the patient data to the patient chart.

Procedure Sets

A procedure set is a special type of custom procedure code that enables you to group multiple procedures that are frequently performed together. Your administrative super user may have defined one or more procedure sets for your practice.

A procedure set is selected like any other procedure code in Full Note Composer or other clinical note type window. This simplifies entry in the patient visit note. Be aware, however, that when a procedure set is used, then only the procedure set code and description appear in the SP or SO tab, and in Review Past Notes, One Page Summary, and any clinical reports. The codes and descriptions for the individual procedures in the procedure set do not appear.

When a procedure set is entered in a patient visit, the superbill created from that patient visit contains all the procedures in the procedure set. Thus, the superbill and subsequent claim contain all the information needed for billing. The procedure set code and description do not appear in the superbill, claim, or financial reports; the individual procedure codes in the set do.

Provider EPCS Rights

Providers must be specifically granted the security rights for electronic prescribing of controlled substances (EPCS). To obtain these rights, a provider must obtain an IdenTrust security certificate and the HID Approve application for their cell phone or other mobile device. The rights may be granted within Aprima. Please refer to the *Provider Setup for EPCS* document for more information and instructions.

Please see the Using the Hybrid Token Security Device to Sign a Prescription section of this guide for more information about this device and its use.

Provider Identity Validation

The Surescripts pharmacy clearinghouse requires that providers undergo identity validation in order to use any Surescripts services, including electronic prescribing, electronic prior authorization, immunization registry reporting, etc. Direct messaging functionality, whether from Surescripts or Nitor, also requires identity validation. Identity validation or identity proofing is a process by which a third-party organization verifies that a person is who they claim to be. Various forms of identity proofing are commonly used for such things as applying for or renewing a driver's license, applying for loan or credit card, and being hired by a new employer.

The identity proofing process is initiated within the application. This is a two part process. The first part of the process verifies that you are a licensed physician or other healthcare provider, and the second part of the process verifies your identity.

If you are already using Surescripts services, then you do not need to complete the identity proofing process in order to continue using your current services. However, you will need to complete the identity proofing process in order to begin using any additional Surescripts services. You only need to perform the identity proofing one time, unless your name or NPI changes.

Note: It is important to understand this identity proofing process is for general Surescripts services and for Direct messaging. This process is not sufficient for electronic prescribing of controlled substance (EPCS). Please see the Electronic Prescribing of Controlled Substances section of this document for more information about the identity proofing requirement for that functionality.

You, the provider, must perform the identity proofing process. It can be performed by anyone else on your behalf. If you have the necessary security rights, then you can perform the process within the Provider window. The instructions for that method are in the Provider Identity Proofing section of the *Administrative User's Guide*.

If you do not have security rights to the Provider window, then an administrative super user may initiate the process from the Provider window. This sends a message to you, and you can then complete the process from the Message window. Use the process below to complete your identity proofing process from a task message.

Process the Identity Proofing Task Message

You, the provider, must perform this process. You cannot have another user perform it on your behalf.

1. Select the provider identity verification email from the Desktop or Message Center.
2. In the Message window, select the Validate Provider tab.
3. Select the Validate Provider Identity button. This accesses the Identity Validation window.
4. Read the Provider Legal Disclosure statement, then select the I Agree checkbox.
5. Verify that your first and last name and your NPI number are correct. . If not, cancel this process. Have your administrative super user correct the information before continuing.
6. Select the Validate Identity Now radio button.

7. Select the OK button. This sends your identifying information to NPPES.
 - If all your information is confirmed by NPPES, then the Personal Identity Information window appears. Go to step 6.
 - If your information is confirmed by NPPES but inactive, then the Find NPPES Validation window opens and displays an entry for you. This entry is shown in italics. Please take a screen shot showing the entry, and then send it to Support. They will contact NPPES to determine whether the entry is incorrectly inactive. You cannot continue with this process until Support has addressed the problem.
 - If your information cannot be confirmed by NPPES, then the Identity Validation window closes, and you are returned to the message window. Please contact Support, explain what happened and include your name and individual NPI number. Support will contact NPPES so that they can update their database. You cannot continue with this process until Support has addressed the problem.
8. The Personal Identity Information window appears enabling you to enter the personal information needed to start the identity proofing process with the credit reporting company. The information you enter is not stored in the database. It is simply passed to the credit reporting company to start the process.
 - a. Enter your home address, Social Security number, date of birth, and your driver's license information.
 - b. Select the OK button.
9. The Questionnaire Web Browser window displays the questions that you must answer for identity proofing. Complete the information as required, and then select the Close button.
10. Select the Complete button to close and complete the message.

Public Health Registry Reporting

Public health registry reporting is used for specialized health registries and for syndromic surveillance. Reporting to these registries may be required for MIPS and other quality programs.

If you report to a public health agency or specialized registry, then your administrative super user will have configured the HL7 partner and jobs needed for the interface. For most interfaces, information or CCDA files are generated and sent when you complete patient visit notes.

Referrals

The application includes functionality for both inbound and outbound referrals. An inbound referral is when a patient is referred to you by another provider. An outbound referral is when you refer a patient to another provider or a medical services provider (such as an imaging center, physical therapy center, etc.) The application also includes functionality to record and track patient relationships with other providers who are involved in the patient's care.

Since inbound and outbound referrals have both clinical and practice management aspects and since tasks related to referrals may be performed by clinical or office staff, most of the referral functionality is explained in the *General User's Guide*. Please refer to the Referrals, Referral Tracking, and Patient/Provider Tracking section of the *General User's Guide* for more information.

Inbound referrals are identified in patient visit notes in the Visit Information slider. Referring provider information entered in the Visit Information slider is included in the superbill generated from the visit. The referring provider information is then included in the insurance claim generated from the superbill. Please refer to the Begin a New Visit Note section of this guide for more information about how the referring provider is entered in the Visit Information slider.

You can order an outbound referral to another provider in the same way you place an order for any other medical service or lab test. Please refer to the Lab Test and Other Clinical Orders section of this guide for more information and complete instructions.

Document Generation for Referrals and Patient/Provider Relationships

When an inbound referral, an outbound referral, or other patient/provider relationship exists for a patient, you may associate one or more document formatting models with that referral or relationship. This enables you to easily generate documents for another provider when completing a visit note for the patient. When you generate the documents, you can:

- Send the documents as an encrypted file if you are using the optional Direct messaging functionality and if the provider record for the recipient includes the provider's Direct address.
- Fax the documents if you are using an optional fax service and if the provider record for the recipient has a phone number with a phone type of Fax.
- Print the documents.
- Save the documents as a file.

The application tries to send the documents using the most direct method with the least amount of work from you. So, the application will send the documents by Direct messaging if possible. If not, then it will send the documents by fax if possible. If not, then you must either print the documents or save them to file.

Document Generation from Visit Note Summary

When you close and complete a patient visit note, you can generate documents for providers to whom you have referred the patient or with whom the patient has a relationship.

You cannot generate documents when closing and saving an incomplete visit note.

1. Full Note Composer or other clinical note type window
2. Chart the visit in the usual manner.
3. Select the OK button to save and close the note.
4. In the Visit Checkout window, select the Complete Note radio button.

5. Select the OK button.
6. In the Unified Summary window, the Patient/Provider Summary section lists the providers with whom the patient has a relationship.
7. The Formatting Model/CDA column lists any documents associated with the provider relationship.
 - Use the Find () icon to search for and select a document formatting model you want to generate.
 - If desired, select the Delete () icon to remove all the documents for a provider that you do not wish to send to.
8. Select the OK button to access the Send Documents window.

Please note that if you are using the optional Direct messaging or fax functionality, and you have a Direct address or fax number entered for the provider identified in step 6, then the application immediately sends the document to that provider. This completes this process. Otherwise, continue with the next step to complete this process.
9. The Send Documents window displays information for the first provider in the list. Complete the information needed to create and send the documents to this provider.
10. The Provider radio button is selected and the Provider and Description fields are populated with the name of the first provider in the list. These items cannot be changed.
11. The Disclosed By field is populated with the name of the rendering provider on the visit note. This cannot be changed.
12. Select the Disclosure Reason.
13. Select the desired Send Type radio button. This defaults to the most direct method, but you may change it if desired.
 - The selected Send Type determines which of the remaining fields are enabled and which are required.
 - When generating documents for multiple recipients, the application attempts to send documents to the second and any additional recipients using the Send Type selected and any additional information entered for the first recipient.
14. The Subject field is enabled when Direct Message or Fax is selected. Enter a brief subject message. This will be used for the Direct message or fax to this provider recipient and to any subsequent provider recipients.
15. The Message field is enabled when Direct Message or Fax is selected. Enter a brief message. This will be used for the Direct message or fax for this provider recipient and for any subsequent provider recipients.

Note: To comply with HIPAA requirements, you must not include any patient identifying protected health information in the Subject or Message fields. This might include, but is not limited to, patient name, date of birth, procedures, or diagnoses.
16. The Fax Number field is enabled only when Fax is selected. The field is populated with the fax number from the provider record and cannot be changed.
17. When sending a fax, select the Service Site if needed to determine the fax cover sheet options available.
18. When sending a fax, select a Cover Sheet if desired. This will be used for the fax to this provider recipient and to any subsequent provider recipients.

19. When saving to a file:
 - a. Enter a File Name. This will be the name of the zipped file created of the document or documents. It is not the name of the document or documents contained in the zipped file.
 - b. Select the Browse button, the browse to the file location in which you want to save the file. If needed, you may change the file name in the browse window.
 - c. Select the Save button to save the zipped file.
20. Select the button to complete the document generation. The button name changes based on the Send Type selected.
 - When sending by fax or Direct message, the documents for the first recipient are generated and sent. Documents for any other recipient providers which can be sent by the same method are also automatically generated and sent without further action needed from you.
 - If documents are needed for a provider who does not have a Direct address or fax number, then you must complete the information on this window to print or create a file for those documents.

Replication

The application is designed to work on a wireless network, updating the primary database with clinical information input via your notebook or tablet PC. Depending on your practice, there may be occasions when you are offsite and offline, but still need be able to review and enter patient data. This is enabled by the replication functionality. If your practice chooses to use the replication functionality, then your administrative super user will have configured your PC for replication.

Replication is the ability for the application to maintain a subset of current data as a copy (or cache) on your PC, and to synchronize that data with the primary database on the server when you reconnect your PC with the network. The data entered or changed on the primary database is replicated to your PC, and data entered or changed on your PC is replicated to the primary database on the server.

Replication copies the following data associated with the named providers.

- Clinical information for a patient who has an appointment scheduled for a date and time within the defined time window. An appointment within the defined time window will not be replicated if there is a completed visit note associated with that appointment. (Note that group appointments and their associated patients are not replicated.)
- Clinical information for a patient who has an incomplete visit note that is not associated with a scheduled appointment. Information is not replicated if the visit note is completed.
- Clinical information for a patient who has an active external patient record. Information is not replicated if the external patient record includes a discharge date that is in the past.
- Clinical information for a patient who has a visit note requiring co-signing and approval by a supervising provider.
- Clinical information for a patient who is associated with an incomplete message to or from the provider.

- All incomplete messages that are associated with the users defined on the machine.

The replication database on your PC is updated automatically each time a wireless connection to the primary database is enabled. The data continues to update as long as the connection to the network is maintained.

The amount of patient data that is replicated is determined by parameters that are defined by your administrative super user. These parameters include appointments within a defined number of hours, the number of hours to retain patient data after a visit note is completed, and the maximum size of attachments to be replicated.

If your replication database becomes large, then you may find it more difficult to work with. The application may respond slowly when you search for patients, visit notes, messages, or other items. It will also take longer to replicate with the master server when you are retaining a large amount of data in the replication database.

To keep your replication database a reasonable size, you should make sure that you are not replicating unnecessary data. To do this:

- Complete visit notes promptly. Patient data continues to replicate as long as a visit note remains incomplete.
- Complete messages promptly. Patient data continues to replicate as long as any message for the patient is incomplete.
- Enter discharge dates in external patient records. Patient data continues to replicate when there is no discharge date.

There are a number of restrictions to the functionality available on tablet and laptop PCs when replicating with the application database on the server. These are explained below.

Duplicate Patient Records

The most common use of replication is to create and complete visit notes and messages for patients whose records already exist in your practice database and which have been replicated to your PC's database. However, there may be times when using replication that you need to create a visit note for a new patient. You must use care when creating patient records using replication.

When you create a new record enter at least three of the following data items. This enables the application to search for and identify possible duplicates. Remember, the application is only able to search the patient records that have been replicated to your PC.

- First name
- Last name
- Date of birth
- Social Security number
- Driver's license number

When you create a patient record on your replicated database, do not create or have someone else create another patient record for that patient on the main database. Instead, you must replicate your PC with the server database in order to get the your new patient record in the main database. If patient records are created on both your replication client PC and on the main database, then those patient records are duplicates with some information on one record, and other information on the other record.

Printed Prescriptions

When using your PC in replication mode (not connected to the network), you cannot print prescriptions because the application cannot generate the correct sequential prescription number.

Financial Information on Replication PCs

Superbills Not Generated in Replication Mode

Charting a patient visit notes does not trigger the generation of a superbill for the visit charges when the PC is in replication mode. Instead, the visit note is uploaded to the database the next time the PC replicates with the server. The application then generates or modifies the associated superbill in the database on the server.

Superbills created at the time of replication are put in a financial batch that is owned by and named with the billing provider on the visit note. The posting date for the batch is the date on which the PC replicates with the server. All superbills created by the replication process are put into this batch, regardless of the service date on the visit.

Superbills that are updated by replication as a result of changes to the visit note are updated in the batch containing the original superbill. This is subject the normal rules for synchronizing visit notes and superbills and for open, completed, and closed batches.

The superbills will then be downloaded to the replication PC the next time the PC replicates with the server. Please note that superbills will be read-only while the PC is in replication mode.

Superbills are Read-Only in Replication Mode

When using replication mode, all superbills in the PC's local database are read-only. You cannot add to or change the information in any superbill. You must either wait until your PC is connected to the network to make changes to the superbill, or you must notify your billing staff of any changes required in the superbill.

Superbill Entries in Visit Billing Messages are Read-Only in Replication Mode

When using replication mode, the superbill entries in visit billing messages are read-only. You may make changes to the patient visit note through the visit billing message, but you cannot make changes to the entries on the associated superbill. You must either wait until your PC is connected to the network to make changes to the superbill entries, or you must notify your billing staff of any changes required in the superbill.

Financial Functionality Disabled in Replication Mode

When using replication mode, you only have access to the financial data that is available in your PC's local database. Only a portion of financial information is replicated, so the information in local database is incomplete. The information may also be out of date, depending on changes made in the server database since your PC was last replicated. Therefore, the financial information available to you while in replication mode is always suspect and will not balance with the financial information on the server database.

Because the financial information in the PC's local database is incomplete, financial functionality is disabled when working in replication mode. This includes:

- Superbills and superbill entries in visit billing messages are read-only, and cannot be edited or changed.
- Payments are read-only, and cannot be entered, changed, voided, or reversed.
- The Billing menu is disabled, and all functionality from that menu is disabled.

Reports Contain Limited Data in Replication Mode

A report that you generate while in replication mode only contains the data available in the PC's local database. This means that reports generated during replication mode will contain different results than the same report generated with the same filtering criteria from the server database.

This affects all reports, but it is particularly important for financial reports. The financial reports will only contain data previously replicated to the PC's local database. Only a portion of the financial information is replicated, so the information was incomplete at the time it was replicated. Also, the PC's local database will not include financial data for any visit notes charted while in replication mode since superbills are not generated and financial functionality is disabled while in replication mode. Therefore, the financial information available to you while in replication mode is always suspect and will not balance with the financial information on the server database.

System Settings

It is recommended that system settings, such as security setting and user groups, not be created, deleted, or changed on a replication PC. This may result in duplicate system settings on the master server, and then on other replication PCs.

Restricted Chart and Visit Note Access

A patient's record may be restricted at the chart or visit level. When access is restricted, only those users who are explicitly given access rights to either the entire chart or to specific visits will be allowed access. This enables you to restrict access to records for patients who are also staff members, family of staff, prominent in the community, etc.

When a patient's entire chart is restricted, users who are not specifically granted access to the chart cannot access the Patient Demographics window, One Page Summary, or Review Past Notes for the patient or any of the patient's visit notes in either Full Note Composer or another clinical note type window. When a patient visit note is restricted, users who are not specifically granted access to that visit note cannot access the visit note or any information in it in either Full Note Composer or other clinical note type window.

It is important to understand the difference between restricted chart and visit access and the visit type 'Private'. Restricted chart and visit access is intended to restrict user – and thus provider and staff member – access to the patient's record. The Private visit type is intended to identify patient visit notes that are to be kept confidential from people external to your practice, such as a patient's parents or spouse. All provider and non-provider users with access to patient visit notes can access private visit notes.

Both restricted chart and visit access and the private visit type are used to filter the information that is displayed in Review Past Notes and One Page Summary. The difference here is that any provider or non-provider user who has access to clinical information may choose to display or not display information from private visits in Review Past Notes and One Page Summary. In contrast, when a patient visit note or a patient chart is restricted, providers and non-provider users who do not have access to the restricted chart or restricted visit note can see that the chart or visit note exists, but they cannot access any information from it.

It is also important to understand the difference between restricted visit access and confidential information in a visit note. When access is restricted on a patient visit note, then access to the entire visit note and all the information in it is restricted to specified users. When information has been entered in the Confidential tab on the Full Note Composer or Superbill Composer windows, then only the information entered in the Confidential tab is restricted to specified users. Please see the "Confidential Information in a Visit Note" section for more information on this new functionality.

By default, all patient charts and patient visit notes are not restricted. Thus all users with clinical access rights can access any patient chart or visit note.

Emergency Access to Restricted Charts and Visit Notes

Because there may be a time when a provider who does not have access to a restricted chart or visit note does need to review the information in that chart or visit note, the application includes a security item, named Emergency Chart Access, which grants specific users or user groups the right to "break the glass" on a restricted chart or visit note to gain one time emergency access to that chart or visit note. It is recommended that you grant at least one user emergency chart access security rights if you anticipate that restricted chart or visit note access will ever be used.

When a user with emergency chart access security rights accesses a restricted chart or visit note, access is limited to that user on the computer which they are using until they close the application. This means that access is not granted to any other users. It is granted only to the specific user who breaks the glass. Access is only granted to that user on the computer being used at the time the user breaks the glass. If the user logs into the application on another computer, the user will not have access to the restricted chart or visit note from that computer. Once the user closes the application on the computer from which the user broke the glass, the user no longer has access. When the user logs back into the application, even on the same computer, the user will not have access to the restricted chart or visit note.

Two things happen anytime a user breaks the glass on a restricted chart or visit note. The first thing is that the action is recorded in the audit trail. The entry includes the user who breaks the glass, the patient, the visit note or notes to which access is granted, and the date and time access is requested. Another entry is made in the audit trail when the user logs out of the application, and is once again restricted from access. This creates a permanent record of the emergency access granted to a restricted patient chart or visit note.

The second thing that happens when a user breaks the glass is that an emergency chart access message is sent to the defined recipients of this type of message. The message includes the user who breaks the glass, the patient, the visit note or notes to which access is granted, the date and time access is requested, and the reason the user enters for breaking the glass. This message is sent automatically by the application; it is not sent by the user who breaks the glass and that user cannot modify the message or its recipients. This ensures that someone or some group of people in your practice is always notified when emergency access is granted to a restricted patient chart or visit note. It is recommended that you define at least one user to be the recipient of emergency chart access messages if you anticipate that restricted chart or visit note access will ever be used.

Restrict an Individual Patient Visit Note

1. Either:
 - Full Note Composer or other clinical note type window → Visit Information slider
 - Patient Demographics → New menu → Full Note Composer or other clinical note type window → Visit Information
2. In the Visit Note Access field, select the users and user groups to whom you want to grant access for this particular visit note. All other users will be restricted.

Restricted Visit Note Access when Searching for a Visit Note

When a patient visit note has been restricted, all users — both with access to the chart and without access to the chart — will be able to search for and see the visit note listed when searching for a visit note. A user who does not have access to the visit note will receive the "Access to visit note is restricted" message when selecting the visit note from the Visit Center window, Existing Incomplete Notes window, or any other window that displays hyperlinks to the patient visit note.

Restricted Visit Note Display in FNC or Other Clinical Note Type Window

When you access a visit note for a patient with one or more restricted visit notes, the Full Note Composer or other clinical note type window will display a message advising you that the patient's chart includes restricted information that is not displayed.

The Rx Summary slider in the Full Note Composer and other clinical note type windows also includes a message in red text advising you that some restricted information is not displayed.

Restricted Visit Note Display in One Page Summary

One Page Summary displays a warning message at the top of the window when a visit is restricted.

A user who has emergency chart access rights can access Review Past Notes in order to gain access to the restricted visits if necessary.

Restricted Visit Note Display in Review Past Notes

Review Past Notes lists unrestricted and restricted patient visit notes. Restricted notes are identified by the visit date in red and the description 'Restricted Visit Note'. When a user who does not have access to the restricted visit selects the restricted visit entry, the visit information pane displays the message 'Restricted Visit' and no information from the visit note is displayed.

When a user who does not have access to the restricted visits selects the visit note date link, the "Access to visit note is restricted" message is displayed. This is explained above in the Restricted Visit Note Access when Searching for a Visit Note section.

The Emergency Access icon () appears in the toolbar when the user has emergency chart access rights. The user can select this icon to access the restricted visits. Instructions for gaining access are in the Accessing a Restricted Patient Chart section below.

Accessing a Restricted Patient Chart

If you have been granted emergency chart access security rights and you attempt to access a patient chart that is restricted, the Emergency Chart Access window is displayed. This window enables you to break the glass on the patient chart so that you can then access patient and patient visit note information.

To break the glass and gain access, you must enter your reason for doing so in the comment field and then select the OK button. The reason you enter will be included in the message that is sent users who are responsible for monitoring emergency access activity and in the audit trail entry.

Accessing a Restricted Patient Visit Note

If you have been granted emergency chart access security rights and you attempt to access a patient visit note that is restricted, the Emergency Chart Access window is displayed. This window enables you to break the glass on the patient visit note so that you can then access it.

To break the glass and gain access, you must enter your reason for doing so in the comment field and then select the OK button. The reason you enter will be included in the message that is sent users who are responsible for monitoring emergency access activity and in the audit trail entry.

Review Past Notes

Review Past Notes enables you to review all the visit notes, both complete and incomplete, that have been saved for a patient and all admissions to external sites (these are called treatment events). It also enables you to access messages, attachments to visit notes, and lab results.

Visit notes are listed by date. Each visit note includes summary information, plan information, attachments, prescription information, and other details from the note. In addition to the information charted in the note itself, the summary information includes the note status, billing provider, rendering provider (if different), approving provider (if required), and the date and time stamp of when the note was last saved.

Completed notes include the rendering provider's signature. If approval of the note was required, the approving provider's signature is also included. The date and time stamp of the signatures is provided.

Review Past Notes uses the document formatting model functionality to display information. The document formatting model functionality enables your administrative super user – or you, if you have the necessary security access – to define the format of the Review Past Notes document and the content fields that it contains. This enables, for example, establishing different Review Past Notes documents for different providers, care teams, or other user groups.

Note: Your Windows default printer must be configured as an existing printer on your network. This is because the formatting model functionality uses the default printer definition to determine text layout. Therefore, Review Past Notes will perform poorly if the default printer is not available or invalid.

Access Review Past Notes from:

- More Options icon () → Review Past Notes
- Patient Demographics → Patient → Review Past Notes
- Review Past Notes icon ()

Information Categories

The left pane of the Review Past Notes window lists categories of information. Many categories also include subcategories. The subcategories that are listed may depend upon the information charted in the patient's visit notes.

For example, the Message category lists as subcategories the message types assigned to the messages in the patient's chart. The Attachments category lists as subcategories the attachment types assigned to attachments in the patient's chart.

The Results category lists all lab test and imaging results that have an attachment type of Lab Results or Radiology Results. The Results category also lists any structured data imported through a lab interface, regardless of the attachment type. The Attachments category lists all other attachments.

By default, the Visits By Diagnosis category lists subcategories of the active diagnoses in the patient's chart. To include inactive diagnoses, you must create a formatting model for use with Review Past Notes that includes inactive diagnoses.

The Visits by Related Case category lists subcategories of patient cases, if any.

Admissions to external sites, such as hospitals or nursing homes, that are entered into the External Patients List are included in Review Past Notes. These admissions appear in the Treatment Events category. The detail line has the type "Hospital Admission". The detail view in the bottom of the window contains all details from the entry.

Select the desired category or subcategory, and a list of items for that category appear in the top pane.

Clinical Note Type Display

When viewing the Visit Note category, all system-defined and custom clinical note types are identified in the Data Type column. For more information about clinical note types, please see the Custom Clinical Note Type Windows section.

Access the Clinical Note Type Window

Select the date link for a visit note to open that note in Full Note Composer or other appropriate clinical note type window.

Patient Care Console

You can access the Patient Care Console from the Review menu. The Patient Care Console displays the repeating procedures in effect for the patient and the clinical decision support rules that apply to the patient.

Generate Documents

You can generate documents using information from a patient visit note by selecting Review → Generate Documents or the Generate Documents () icon.

View Attachments

Attached documents and images appear in the note viewer section of the window. When an attachment group contains multiple documents or images (such as several scanned pages in a letter or the front and back of an insurance card), you can easily access the Attachment window to view and edit any of the items in the attachment group. Simply select the Multiple Document Viewer link. (This link will appear only when there are multiple documents or images in the attachment.)

Attachments from a Health Data Exchange

You may choose to enroll with the optionally purchased CommonWell® Health Alliance health data exchange. CommonWell enables you to link a patient record in your database with a person enrolled in the CommonWell health data exchange through one or more other participating physicians or medical services providers. Once you have linked your patient record with a CommonWell person record, then you may view and download documents from other physicians or medical services providers who also participate with CommonWell and who have also provided services to that person.

The linking of the patient record and the downloading of documents will be done by your front desk staff when a patient checks in for an appointment. When the front desk staff downloads documents for a patient, those documents will be in the Attachments section of Review Past Notes.

You must view all documents downloaded from CommonWell, and approve or delete them.

Addendums to Completed Visit Notes

When a completed patient visit note is changed, the change is marked as an addendum to the note. By default, addendums are not identified in the Review Past Notes display. Instead, Review Past Notes simply displays the current information in the visit note. If you want addendums identified as such in Review Past Notes, you must create a formatting model for use with the new Review Past Notes functionality that includes addendums.

Messages

Use the RPN Viewing Options to define the types of messages to include in Review Past Notes. You can include all message types, or you can select the specific types of messages you want to include.

Visit Types

By default, Review Past Notes includes only standard visits. You may include Lab Visits, Private Visits, Refill Visits, and Strike Out Visits if you choose. The RPN viewing options enable you to select the visit types to be included or excluded from Review Past Notes.

When a patient has a visit note with the visit type private visit, the title bar of the window will include the phrase 'Private Visits Filtered' or the phrase 'Private Visits Included', depending on whether your RPN viewing options are set to exclude or include private visits. When you exclude private visits, then no information from the private visit will appear in Review Past Notes. When you include private visits, information from the private visit is included and is identified by the phrase "Information from Private Visit".

Bilateral Physical Exam Results

Descriptions of bilateral symptoms and findings in a physical exam are grouped into "left" and "right" sentences. All findings for the left are grouped together, followed by all findings for the right. A finding that is marked as 'both' in the physical exam will appear twice; once with the findings for the left and once with the findings for the right.

When the symptom description in the knowledge database includes a caret symbol (^), then the "left" or "right" identifier is inserted at the location of the caret. For example, "The ^ shoulder has no" is written as the "The left shoulder has no" or "The right shoulder has no." When the symptom description does not include a caret symbol, then the "left" or "right" identifier is inserted before the description. For example, "upper arm" will be written as "left upper arm" or "right upper arm."

Confidential Information

By default, confidential information is not displayed in Review Past Notes. You may choose to include this information. Including confidential information will include your confidential information and confidential information to which other providers have granted you access.

To include confidential information, you must create a formatting model for use with the new Review Past Notes functionality that includes inactive diagnoses.

Private Visits

When a patient has a visit note with the visit type private visit, the title bar of the window will include the phrase 'Private Visits Filtered' or the phrase 'Private Visits Included', depending on whether your RPN viewing options are set to exclude or include private visits. When you exclude private visits, then no information from the private visit will appear in Review Past Notes. When you include private visits, information from the private visit is included and is identified by the phrase "Information from Private Visit".

Printing and Sending Documents

You can print and send visit notes, attachments, and generated documents from RPN. The Print button sends the selected item directly to the printer. The Send button opens the Send Documents window where you can fax the document or send it by Direct message. When you select the Print button, the application assumes that you are printing for your own use, and it does not record the release of patient information. When you select the Send button, the application does create a record of the release, and you must enter the recipient, a disclosure reason, and the provider authorizing the release.

When you select a visit to print or send, the application generates a document using the complete chart print definition for viewing visit notes in Review Past Notes. If you selected the Print button, the generated document is discarded after it is printed. If you selected the Send button, the generated document is saved as an attachment. Then, when you complete the send process, the application creates a record of the disclosure.

The formatting model used for viewing visit notes in the Review Past Notes window and the chart print definition used for printing Review Past Notes are configured independently, but they are both defined in the User Settings window, Clinical Note Types tab.

The complete chart definition uses a document formatting model to format the visit information. The default document formatting models for viewing Review Past Notes and for the complete chart print definition for printing Review Past Notes contain the same information, but the formats are slightly different to account for differences between online viewing and hard copy prints.

If you choose to customize the content of Review Past Notes, it is recommended that you use the same formatting model for viewing Review Past Notes and for the complete chart print definition used for printing Review Past Notes.

Refresh Button

Select the Refresh button to update the visit notes, attachments, messages, and other information available through the window. This is helpful if other users may be adding or changing information while you are reviewing a patient's chart.

Viewing Options

Viewing option filters for Review Past Notes determine the patient chart information that is displayed in the Review Past Notes window, and how that information is displayed. You may define viewing option filters for your own use or that are available to all users, depending on your security permissions.

Once you select a viewing options filter, you can select another filter but you cannot return to using no filter.

1. Review Past Notes
2. In the Viewing Options, select the Find () icon.

3. Select the New button to access the RPN Viewing Options window.
4. Enter a Name for the viewing options filter.
5. Select the radio button indicating who can use the viewing options filter.
 - Available to Anyone: The filter will be available to all users.
 - Just for Me: The filter is available only to you.
6. Select the radio button for the Initial RPN Category Selection. This selection determines what appears first in the Category pane of the Review Past Notes window.
 - All Interactions
 - Visit Note
 - Message
 - Attachment
 - Results
7. If desired, select one or more patient visit types to be included in Review Past Notes. By default, visits with the standard visit type are always included. (Please see the Visit Types section for more information.)
8. Select the Include Inactive Dx in Categories checkbox if you want the diagnosis category to include inactive diagnoses.
9. Select the appropriate radio button for the billing providers whose visit notes you want to view.
 - Me: Select this radio button to view only the visit notes for which you are the billing provider.
 - Billing Providers: Select this radio button to view visit notes from one or more providers. Then select the provider or providers whose notes you wish to include, or leave the field empty to view the visit notes for all providers.
10. Select the appropriate radio button for the rendering providers whose visit notes you want to view.
 - Me: Select this radio button to view only the visit notes for which you are the rendering provider.
 - Rendering Providers: Select this radio button to view visit notes from one or more providers. Then select the provider or providers whose notes you wish to include, or leave the field empty to view the visit notes for all providers.
11. Select the message types that you want to include.
 - Show All Types: All message types are included. This is the default.
 - Show Only: Select this radio button to view only specific message types. Then select the message types that you wish to include.
12. In the Medication Hx Filter field, select the filter you want to use for medication history in Review Past Notes.
13. In the Problem Hx Filter field, select the filter you want to use for problems in Review Past Notes.

Multiple Document Viewer

When an attachment group contains multiple documents or images (such as several scanned pages in a letter or the front and back of an insurance card), you can now easily access the Attachment window to view and edit any of the items in the attachment group.

1. Review Past Notes
2. Select the Multiple Document Viewer link. (This link will appear only when there are multiple documents or images in the attachment.)
3. The Existing Attachment window initially displays with the first document or image in the attachment group. To select another document or image:
 - a. Select the Select Attachments slider.
 - b. Select the desired document or image.

Signature Pad

Providers may be required to enter their signature when logging into the application. Your signature is then used for patient visit notes, printed prescriptions, and other documents. You may enter your signature using a data entry pad or one of the supported Topaz signature pads if you are not using a tablet PC. To use a data entry pad or signature pad, you must first configure the pad you are using.

Signature Pad Configuration

To use the signature capture functionality, you must configure the type of signature pad that you are using. You may use a tablet PC, data entry pad, or one of the supported Topaz signature pads.

1. Tools → Configure My Signature Pad
2. In the Configure Signature Pad window, select the radio button for the type of signature pad you are using.
 - Select the Use Tablet Inking Style radio button if you are using a tablet PC or a data entry pad.
 - Select the radio button for the correct model if you are using a Topaz signature pad.

Time-Based Billing

Time-based billing is used for services that are billed based on the time spent. A calculation is used to determine the number of units based on the time spent. The time-based billing functionality can be used for physical therapy, behavioral health, and other services for which a single, simple calculation is used to determine the time to units.

The time-based billing functionality cannot be used for anesthesia billing or other services in which more complex calculations are needed for the first unit and subsequent units for a single procedure code. Time-based billing is not used to determine the appropriate Evaluation and Management (E&M) code when the level of care is based on time rather than documentation.

If your practice performs services which are billed based on time spent, then your administrative super user will have enabled time-based billing and configured the rules on the appropriate amount allowed schedules for the applicable procedures.

When you perform a service which is billed based on time spent, you must enter the actual start and end times for the procedure in the patient visit note. You may enter default start and end times in the Visit Information slider, if there is only one time-based procedure in the visit note or if all the time-based procedures in the visit note happen concurrently. If there are multiple time-based procedures in the visit, then you should enter the start and end times for each time-based procedure in the Modify Service window.

When a patient visit note contains more than one time-based procedure, then you can either use the default start and end times for all of the procedures, or you can enter specific start and end times for each procedure. You cannot mix the two options. You cannot use the default start and end time for one procedure, and a specific start and stop time for another procedure. The application will warn you that there is conflict when you close the visit note. This is explained in the Conflicts Between Procedure-Specific and Default Start and End Times section below.

Enter the Start and End Times for a Procedure

Use this process to enter the start and end time for a time-based procedure when the patient visit includes more than one procedure or the entire visit is longer than the time spent on the procedure itself.

1. Full Note Composer or other clinical note type window → SP tab
2. Search for and select the desired procedure code.
3. Select the procedure code hyperlink in the Test/CPT column to access the Modify Service Order window.
4. In the Modify Service Performed window, select the Billable Time hyperlink.
5. In the Billable Time Tracker window, enter the start and stop times.
 - a. Enter the actual Start Time in hours and minutes.

Note: If you have entered a default start and end time in the Visit Information slider, that information is displayed here and the Apply Default Start/End Time checkbox is selected. Deselect this checkbox to enter and use information here.

- b. Enter the actual End Time in hours and minutes.
 - c. The Segment Time is calculated.
 - d. Enter any Notes, if needed.
 - e. Repeat for each segment of time spent.
 - f. The Total Time is calculated.
 - g. Select the OK button to return to the Modify Service Performed window.
6. Select the OK button to return to the clinical note type window.
 7. Finish charting the patient visit note in the usual manner.

Enter the Default Start and End Times for a Visit

Use this process to enter the start and end times for a procedure when the time spent on the visit and on the procedure itself are the same.

1. Full Note Composer or other clinical note type window
2. Select the Visit Information slider.
3. In the Default Start Time field, select the checkbox and then enter the start time for the procedure.
4. In the Default End Time field, select the checkbox and then enter the end time for the procedure.
5. Finish charting the patient visit note in the usual manner.

Conflicts Between Procedure-Specific and Default Start and End Times

It is important to understand that the application uses the start and end time associated with the procedure when creating the superbill for a visit note. So, if you enter a start and end time on the specific procedure code, the application uses those entries. The application only associates the default start and end times, from the Visit Information slider, with the procedure code when you have not entered specific start and end times for the procedure. However, because you can enter a default start and end time on the Visit Information slider in a visit note and you can enter a specific start and end time on the procedure itself, you may accidentally have conflicting start and end times in a visit note.

When you save and close a visit note, the application verifies that the default start and end times and the start and end times for the specific procedure are the same. The application displays a warning message if you have entered default start and end times in the Visit Information slider and you have entered start and end times for the specific procedure or procedures in the Billable Time Tracker window and those start and end times do not match.

1. In the patient visit note window, select the OK button to save and close the visit note.
2. In the Visit Checkout window, select the OK button.

3. If the default start and end times and the procedure-specific start and end times do not match, the application displays a warning message and asks if you want to apply the default times to the time-based procedure code or codes.
 - To apply the default start and end time from the Visit Information slider to all the time-based procedures, select the Yes button.
 - To use the procedure-specific start and stop times from the Billable Time Tracker window, select the No button.

Please note that selecting the No button does not remove the default start and end times from the Visit Information slider. To avoid this warning message in the future, you can unselect the checkboxes for the default start and end times in the Visit Information slider.

Transportation Billing

Please see the Transportation Billing section under Practice Management for more information and for setup instructions. The transportation billing functionality must be set up in order for you to use it in a patient visit note.

The transportation billing rule is used for routine transportation services. The transportation billing rule cannot be used for ambulance services.

Use this process to enter odometer readings for transportation services if this functionality has been enabled for your practice. Odometer readings are entered on a specific procedure.

Time-based rules and the transportation rule based on odometer readings are both used to calculate units. If odometer reading information is entered for a procedure which has a time-based billing rule, the odometer reading is used to calculate the units because the mileage rule is the most specific rule.

Enter the Odometer Readings for a Procedure

1. Full Note Composer or other clinical note type window → SP tab
2. Search for and select the desired procedure code.
3. Select the procedure code hyperlink in the Test/CPT column to access the Modify Service Order window.
4. In the Modify Service Performed window, select the Odometer Reading hyperlink.
5. In the Odometer Record window, enter the start and stop milages.
 - a. Enter the Odometer Start in whole miles.
 - b. Enter the Odometer End in whole miles.
 - c. The Segment Miles are calculated.
 - d. Enter any Notes, if needed.
 - e. Repeat for each driving segment.
 - f. The Total Miles are calculated.

- g. Select the OK button to return to the Modify Service Performed window. Note that the Quantity field now displays the number of units equal to the total miles.
6. Select the OK button to return to the clinical note type window. Note that the Qty field for the procedure now displays the number of units equal to the total miles.
7. Finish charting the patient visit note in the usual manner.
8. Select the Vist Text tab to view the milage segments and total on the procedure.

Vaccine Administration Record

A patient's vaccine administration record can be accessed from the History window and from Full Note Composer or other clinical note type window. Vaccinations may be entered, viewed, and printed from the vaccine administration record.

The vaccine administration record displays and prints in a format similar to the standard vaccine administration records for children and adults created by the Immunization Action Coalition and distributed by the Centers for Disease Control and Prevention's (CDC). The application uses antigens, types of vaccines, and vaccines to chart vaccinations on the vaccine administration record in a manner that corresponds with how they are identified on the CDC vaccine administration record.

- An antigen record identifies an antigen or antigens for an infectious disease.
- A vaccine usually corresponds to an infectious disease; however, there are some vaccines that correspond to multiple diseases, such as the Diphtheria, Tetanus, Pertussis vaccine. A vaccine may be associated with more or more antigens.
- A type of vaccine represents a form of medication that may be used to administer the vaccination. A type of vaccine may be associated with one or more antigens which are administered together in a single medication.

Below is the Immunization Action Coalition's and CDC's sample vaccine administration record showing the relationship between vaccines and types of vaccines.

(Page 1 of 2)

Vaccine Administration Record for Children and Teens

Patient name: Emily Jacobs
 Birthdate: 6/2/2005
 Chart number: _____

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VIS) to the child's parent or legal representative and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine ¹	Date given (month/yr)	Funding Source (FS, P) ²	Site ³	Vaccine		Vaccine Information Statement (VIS)		Vaccinator ⁴ (signature or initials & title)
					Lot#	MR.	Date on VIS ⁴	Date given ⁴	
Hepatitis B ⁵ (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM. ⁷	HepB	6/2/2005	F	RT	0651M	MERK	7/11/01	6/2/05	JTA
	Pediarin	8/2/2005	F	RT	635A1	GISK	7/11/01	8/2/05	DCP
	Pediarin	10/2/2005	F	RT	712A2	GISK	7/11/01	10/2/05	DCP
	Pediarin	12/2/2005	F	RT	712A2	GISK	7/11/01	12/2/05	DLW
DTPa-HepB-IPV (Pediarin) Diphtheria, Tetanus, Pertussis ⁶ (e.g., DTaP, DTaP/Hib, DTaP-HepB-IPV, DT, DTaP-IPV/Hib, Tdap, DTaP-IPV, Td) Give IM. ⁷	Pediarin	8/2/2005	F	RT	635A2	GISK	7/30/01	8/2/05	DCP
	Pediarin	10/2/2005	F	RT	712A2	GISK	7/30/01	10/2/05	DCP
	Pediarin	12/2/2005	F	RT	712A2	GISK	7/30/01	12/2/05	DLW
	DTPa-Hib	9/2/2006	F	RA	P0897A	SPI	7/30/01	9/2/06	RLV
DTPa	DTPa	8/2/2010	F	RA	326-812	SPI	5/17/02	8/2/10	JTA
Haemophilus influenzae type b ⁸ (e.g., Hib, Hib-HepB, DTaP-IPV/Hib, DTaP-IPV/Hib) Give IM. ⁷	Hib	8/2/2005	F	LT	4A244AA	SPI	12/16/98	8/2/05	DCP
	Hib	10/2/2005	F	LT	4A244AA	SPI	12/16/98	10/2/05	DCP
	Hib	12/2/2005	F	LT	4A244AA	SPI	12/16/98	12/2/05	DLW
	DTPa-Hib	9/2/2006	F	RA	712AA	SPI	12/16/98	9/2/06	RLV
Polio ⁹ (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV) Give IPV SC or IM. ⁷ Give all others IM. ⁷	Pediarin	8/2/2005	F	RT	635A2	GISK	1/1/00	8/2/05	DCP
	Pediarin	10/2/2005	F	RT	712A2	GISK	1/1/00	10/2/05	DCP
	Pediarin	12/2/2005	F	RT	712A2	GISK	1/1/00	12/2/05	DLW
	IPV	8/2/2010	F	RA	44569-8	SPI	1/1/00	8/2/10	DCP
Pneumococcal	PCV7	8/2/2005	F	LT	489-835	WYE	9/30/02	8/2/05	DCP

Handwritten notes:
 - DTPa-HepB-IPV (Pediarin)
 - DTPa-Hib (TnHib): 2 lot #, 2 different VIS
 - Pediarin: 3 different VIS dates

When an antigen is associated with more than one type of vaccine, then the application's vaccine administration record will include a row for each vaccine associated with the antigen. As you enter the information needed to chart the vaccination in one row, that same information will appear in all the related rows. You may edit the information in the related rows if needed.

When you access the vaccine administration record for a patient, the application uses the patient age to determine whether the adult or pediatric vaccine types are appropriate. You can access both the adult and the pediatric vaccines for an adult patient. You can access only the pediatric vaccines for a child.

Note: If, when charting a vaccination in an adult vaccine administration record, the procedure code selected is associated with a type of vaccine that is only associated with a pediatric vaccine administration, you will not be able to chart the vaccination on the adult vaccine administration record. You may do any of the following:

- Select a pediatric vaccine administration record that contains the vaccine.
- Delete the selected procedure code, and then select a procedure code that is associated with a vaccine included in the adult vaccine administration record.
- Save and close the patient visit note. Then, modify the adult vaccine administration record to include the desired vaccine. (You must have the required security rights to make this change, or have an administrative super user make the change.) Then reopen the patient visit note to continue charting the vaccination.

If a charted vaccination included only the vaccine, but not the vaccine type, then the application will display a string of asterisks (****) in the Vaccine Type field to indicate the information is not available. If the charted vaccination included only the vaccine type, but not the vaccine, then the application will display a string of asterisks (****) in the Vaccine field to indicate the information is not available.

Recurring Immunizations

Your administrative super user can identify vaccine types, such as flu vaccines, that are recurring. When a type of vaccine is identified as recurring, then when you record a vaccine for a patient in the Vaccine Administration Record, a new empty row will be created for that vaccine. This enables you to enter multiple instances of a vaccine that may be given multiple times.

Allergy Checking for Vaccinations

You or your administrative super user can associate a vaccine with the procedure code used to order that vaccination so that the application performs the drug allergy portion of drug screening when you chart the vaccination in a patient visit note. This enables identifying patients who are known to be allergic to the vaccine. The drug screening that is performed for vaccinations is limited to drug allergies; it does not include drug-to-drug interactions or other precautions.

Charting a Vaccination

The on-screen and print format of the pediatric and adult vaccine administration records is similar to the format of the CDC vaccine administration record form. The vaccines and vaccine type combinations that appear on the vaccine administration records are defined by your practice.

The application uses the patient age to determine whether adult or pediatric vaccine types are appropriate. You can access both the adult and the pediatric record for an adult patient. You can access only the pediatric record for a child.

You can record a vaccination in the vaccine administration record in a patient visit note, vaccine administration message, or in the patient's history, from the Patient History window. When you enter vaccination through Full Note Composer or other clinical note type window, an entry for the vaccination is made in the services performed (SP) tab when the administered date is the same as the visit date. The CPT code used for the order is defined on the type of vaccine (Tools → List Editor → Vaccinations → Type of Vaccine). Please note that you should enter only historical vaccination information through the Hx tab or Patient History window. Administered vaccinations should be entered through the SP tab or vaccine administration message. This ensures that complete information is transmitted to the vaccine registry.

When you record a vaccination in a visit note or vaccine administration message, the fields required for vaccine registry reporting are identified as required. Administered, refused, and contraindicated vaccinations are reported to registries and have required data. The required fields for these vaccinations are displayed with a double border. If you enter some, but not all, of the information for a vaccination in the vaccine administration record, then a warning message is displayed in the yellow warning bar at the top of the window. You may close the patient visit note as incomplete, but you cannot complete it until all the vaccination information is entered. This enables you to have someone else, such as a nurse or medical technician, complete the information for the vaccination.

Refusal of Vaccination

When a patient refuses a vaccination, you may select the reason for the refusal. The reason is included when vaccination information is sent to a registry. Refusal reason information may only be entered for vaccinations charted after upgrading the 2014 version of the application.

Entering a refusal reason on a vaccination in the Vaccine Administration Record automatically enters a negation reason on the procedure code for the vaccination in the visit note.

History Source

All immunization registries require a historical information code. However, many registries only accept code 01 (Historical Information - Source Unspecified) and code 00 (New Immunization Record). Before using any of the other available codes, it is recommended that you verify the codes accepted by your state or local registry.

Completion Status

The vaccination completion status indicates the status of the vaccination order. The status is included when vaccination information is sent to a registry.

Status	Use and Meaning
Complete	Vaccination administered.
Not Administered	Vaccination not administered because either the patient has evidence of immunity or the vaccination is contraindicated for the patient. If contraindicated, you must also enter information about the contraindication.
Partially Administered	Only part of the vaccination was administered.
Refused	Patient refused the vaccination. You must also enter a refusal reason.

Additional Information

You may enter additional information about the vaccination, including contraindications, reactions to the administration, previous immunity, and special indications for a vaccination. This information is included when vaccination information is sent to a registry.

Reporting to an Immunization Registry

Immunization registries require that certain information be included when reporting an administered, refused, or contraindicated vaccination. If your practice has an interface for reporting immunization information to an immunization registry, then the application will indicate the fields required for administered and contraindicated vaccinations and for historical vaccination entries. Whether in a patient visit note, Patient History, or a vaccine administration message, you must enter all required information in order to save the vaccination entry.

Below are some of the items required by registries. This is not a complete listing of all required fields.

- VFC Eligibility: This is required for pediatric vaccinations only and only if participating in a Vaccines for Children program. Must be identified by a CDC-defined code accepted by the state or local registry.
- History source: Must be identified by a CDC-defined code accepted by the state or local registry. Many only accept code 00 (New Immunization Record) and 01 (Historical Information - Source Unspecified).
- Completion status: Must be identified by a CDC-defined status. This must be 'Complete' for the vaccine information to be transmitted to the registry.
- Dose: Must be numerical only.
- Units: Such as cc or mL.
- Funding Source: Must be identified by a CDC-defined code.

- Route: Must be identified by the CDC defined route name and valid ANSI code.
- Site: Must be identified by the CDC defined site name and valid ANSI code. Site is not required if the route is 'PO' or 'NS'.
- Manufacturer: Must be identified by the CDC defined manufacturer name and short name.
- Refusal reason: Required if the vaccination is refused. Must be identified by a CDC-defined code.

Information is transmitted to most immunization registries through a clearinghouse. Immunization information is transmitted to the clearinghouse when a patient visit note is marked as completed or when you save information in the Patient History window. The clearinghouse transmits immunization information to registries on the schedule defined by the individual registry. Most registries receive information once a day, but some receive information less frequently.

Charting an Administered Vaccination

This is the basic process for charting a vaccination that you administer to the patient.

1. Full Note Composer or other clinical note type window → SP tab
2. Select the procedure code for the immunization.
If the selected procedure code is associated with more than one type of vaccine, then the Find Type of Vaccine window displays the associated types of vaccine. Select the desired type of vaccine.
3. Select the Vaccination icon () to access the vaccine administration record where you can enter the vaccination details.
The vaccine associated with the selected CPT code is highlighted in yellow. Other vaccinations that are due for the patient are highlighted in blue.
4. If desired, select the radio button for the Form Type age group desired. The application selects the default vaccine administration record based on the patient's age.
5. If desired, use the Form Name field to select a different vaccine administration record.
The form itself appears in the bottom pane of the window.
6. If desired, select the 'Display All Immunization History Records' checkbox to display all immunizations from the patient's record, even if they are not included in the selected vaccine administration record.
7. If desired, select the 'Hide Unadministered Vaccines' checkbox to display only those vaccines that the patient has received.
8. If desired, select the 'Display Strikout Entries' checkbox to display entries that have been struck from the patient's vaccination history.
9. If desired, select the 'Display Time of Administration' checkbox to display the time. The time defaults to system time when the procedure code was selected. You can change this time if needed.
10. To chart the vaccination:
 - a. Enter the Admin Date.
 - b. Select a VFC (Vaccines for Children Program) eligibility code, if appropriate.

- c. The Completion Status of the vaccination order is assigned by the application as the order progresses.
 - d. If there are contraindications, select the Contraindications (C) icon, and then:
 1. In the Contraindications, Precautions, Immunities, and Indications window, enter the Contraindication Effective Date. This is the date on which you determine there is a contraindication for this vaccination. This is needed only for a contraindication.
 2. Enter the Contraindication Expiration Date for the vaccination if appropriate. This could be, for example, the expected delivery date if the contraindication is pregnancy. This is needed only for a contraindication.
 3. Select the Contraindication.
 4. If the patient has a reaction when you administer the vaccination, select the Reaction.
 5. If the patient has prior immunity, select the appropriate source of evidence in the Immunity field.
 6. If there is a specific reason for administering the vaccination, select the appropriate reason in the Indication field.
 7. Select the OK button to return to the Vaccine Administration Record window.
 - e. Enter the appropriate details. (Some of this information may default if set up by your administrative super user.)
 - Dose: This must be numeric only.
 - Units: This is the abbreviation for the units in which the dose is given, such as mL.
 - Funding source
 - Route
 - Site
 - Lot number
 - Vaccine manufacture
 - Expiration date
 - Date on VIS (vaccine information sheet)
 - Date the VIS was given to the patient
 - Initials of the person administering the vaccination
 - f. Enter a Note if needed.
11. If the patient refuses a particular vaccine:
 - a. Select the Admin Date.
 - b. If needed, select the Vaccine Type.
 - c. In the Refusal column, select the patient's reason for refusing the vaccine.
 12. To enter a previously administered vaccine in the patient's history:
 - a. Select the Input History button.
 - b. In the Vaccine History window, select the Type of Vaccine.

- c. Enter the Administered Date. You may enter an approximate date or time period.
 - d. Select the Vaccine.
 - e. Select the Historical Source.
 - f. Enter a Note if needed.
 - g. Select the OK button to return to the Vaccine Administration Record.
13. Print the vaccination record if desired.
- a. Select the Print button.
 - b. Accept the default Header Definition, or search for and select the desired header for the vaccine administration record.
 - c. Either:
 - Select the Show Printer Window checkbox to access the Print window.
 - Select the Print Preview checkbox to preview the report
 - d. Select the OK button.

Charting a Vaccination Using a Clinical Decision Support Rule

Charting a vaccination through the vaccine administration record will action a clinical decision support rule that is due for that vaccine. However, you may also begin by reviewing the clinical decision support rules that are due for the patient.

1. Full Note Composer or other clinical note type window → Clinical Decision Support slider
2. For the vaccination that is due, select the Action button.
3. Select the SP radio button, and then select the OK button.
4. Select the Vaccination icon () to access the vaccine administration record where you can enter the vaccination details as described above.

<<Revised>> Charting a Vaccination Using a Barcode Scanner

You may use a barcode scanner to import vaccine details into the vaccine administration record when charting an administered immunization.

The process for entering by barcode scanner is basically the same as regular charting, but you do not have to manually enter many of the details.

Some vaccines are packaged in multiple vials that must be combined before the vaccine can be administered. For these vaccines, you must scan the barcode on the vial containing the active ingredients, not the vial containing the diluent.

Important: The barcode scanner acts as an extension of the keyboard. The scanner captures characters as if you typed them on keyboard. Therefore, it is important that once you engage the scanner, you do not use the keyboard until you complete the scan. Any characters typed on the keyboard are interpreted as part of the scanned information, and they will prevent the scanned information from being interpreted correctly. If the scan does not work, it may be that a key was accidentally pressed and a character entered. Try scanning the vial again.

1. Full Note Composer or other clinical note type window → SP tab
2. Select the procedure code for the immunization.
3. Select the Vaccination icon () to access the Vaccine Administration Record window where you can enter the vaccination details.
4. Select the desired vaccine administration record.
5. To chart the vaccination:
 - a. Select the Barcode Scanning Form () button. This opens the Scan Vaccine Barcode window.

Start this process only when you are ready to scan the vaccine. Do not use the keyboard or attempt to access any other window within the application or any other application once you access the Scan Vaccine Barcode window.
 - b. Using your bar code scanner, scan the bar code on the vaccine vial.
 - c. When the bar code has been read, the Scan Vaccine Barcode window populates with information for the vaccine. This information includes the vaccine name, type of vaccine, NDC number, manufacturer, lot number, and expiration date.
 - d. If more than one type of vaccine is associated, then a popup will display the types of vaccine. Select the correct type of vaccine.
 - e. Enter the Vaccine Administration information, if not defaulted. This includes:
 - Dose (Units are identified by the scan.)
 - Site
 - Route
 - Completion status (Defaults to Complete by the scan.)
 - Initials of the person administering the vaccination
 - Funding source
 - VFC (Vaccines for Children Program) eligibility code, if appropriate
 - Contraindication, if any
 - f. Enter the Vaccine Information Sheet (VIS) information. This includes:
 - VIS publication date
 - Date the VIS was given to the patient
 - g. Select the OK button to close the Scan Vaccine Barcode window.
6. If you did not perform step 2, then the Find Procedure window opens. Select the procedure code for the immunization.
7. In the Vaccine Administration Record window, enter additional vaccinations, or select the OK button to save the information and close the window.

Vaccine Administration Messages

Vaccine administration messages are used to request that a staff member administer a vaccination that has been ordered by a provider. The user who receives the vaccine administration message can document the vaccination details in the message. When the user completes the message, the vaccination details are then added to the patient's chart.

Most vaccine administration messages are generated automatically by a dynamic procedure note that has been used to create the order for the vaccination. (Please see the Lab Test and Other Clinical Orders section for information about dynamic procedure notes and the messages created by them.) Vaccine administration messages may also be created by users. When a user creates a vaccine administration message, it must be associated with a patient visit note that includes an order for a vaccination.

Creating a Vaccine Administration Message

1. Either:
 - Desktop → New → Vaccine Administration Message
 - Patient Toolbar → New → Vaccine Administration Message
2. Select the Urgency level appropriate for the messages action.
3. Enter a Due Date if desired. This is the date the message's action is to be completed.
4. In the Assign To field, select the user or users to receive the message.
5. Enter the text of the message in the Reason or Task field.
6. In the Vaccine Order Information section, select the date of the patient visit that contains the order for the vaccination that you want administered to the patient.

Charting a Vaccine in a Vaccine Administration Message

1. Desktop → Message Time Stamp or More Options icon () → Process Message
2. In the Message window, select the Vaccine Administration tab.
3. The Vaccine Administration tab displays the vaccine administration record, which you can use in the same manner as when it is displayed in Full Note Composer, another patient visit window, or the Patient History window.
4. Select the Complete button to complete the message, and to add the vaccination details to the patient's chart.

Entering a Vaccination in the Patient History

You can enter a vaccination that the patient received in the past in the patient's immunization history. The Patient History window uses the same vaccination administration as Full Note Composer and other clinical note type windows.

1. Patient Demographics → Patient menu → History
2. Select the Immunization History category to access the vaccine administration record where you can enter the vaccination details.

3. If desired, select the radio button for the Form Type age group desired. The application selects the default vaccine administration record based on the patient's age.
4. If desired, use the Form Name field to select a different vaccine administration record. The form itself appears in the bottom pane of the window.
5. If desired, select the 'Display All Immunization History Records' checkbox to display all immunizations from the patient's record, even if they are not included in the selected vaccine administration record.
6. If desired, select the 'Hide Unadministered Vaccines' checkbox to display only those vaccines that the patient has received.
7. If desired, select the 'Display Strikout Entries' checkbox to display entries that have been struck from the patient's vaccination history.
8. If desired, select the 'Display Time of Administration' checkbox to display the time. The time defaults to system time when the procedure code was selected. You can change this time if needed.
9. To enter the vaccination, select the Input History button.
10. In the Vaccine History window, enter the vaccine details:
 - a. Select the Type of Vaccine.
 - b. Enter the Administered Date.
 - c. Select the Vaccine.
 - d. Select the Historical Source of the vaccine information.
 - e. Enter a Note if needed.
 - f. Select the OK button to add the vaccination to the patient's history and return to the vaccine administration record.
10. Print the vaccination record if desired.
 - a. Select the Print button.
 - b. Accept the default Header Definition, or search for and select the desired header for the vaccine administration record.
 - c. Either:
 - Select the Show Printer Window checkbox to access the Print window.
 - Select the Print Preview checkbox to preview the report
 - d. Select the OK button.

Importing Immunization History

If your practice has purchased the optional immunization history interface, then you can request a patient's immunization history from your immunization registry. The information from the registry includes the following for each immunization that has been reported to them:

- Dosage
- Unit of measure
- Funding source

- Manufacturer
- Vaccination site
- Vaccination rout
- VFC eligibility

When viewing the patient's immunization history, you may choose to import items into the patient's chart within the database. Remember that the immunization history information is received from the registry, and that the registry received the information from the providers who administered and reported each immunization. Aprima has no control over the information received.

When you import an item from the electronic immunization history, the application maps it to an item in the patient's immunization history in the database. If no corresponding item exists, the application creates a new entry in the database. Once you have imported an item, it is a permanent part of the patient's record in the same way as any item you had entered.

If desired, you may choose to update the immunization history item in the database with the history item from the electronic immunization history. For example, you may choose to update the item if the patient provided some information about an immunization received in the past, you can update that historical entry with details from the immunization registry. When you update an item with information from the immunization registry, the original item in the patient's history is inactivated and a new item is created with the information from the registry.

The Import Immunization History window contains four panes. The Received History pane in the top left lists the immunization history items received from the registry. The Immunization History pane on the right displays the list of items that you have identified to add to the patient's immunization history in the database. Beneath each of these panes is a smaller pane that displays detailed information about the item selected in the upper pane.

Import the History

1. Full Note Composer or other clinical note type window → SP tab → Vaccination icon (📄📅)
2. Select the Get Record From Registry button. (Note that this button is available only if you have the necessary interface with the registry.)
3. Either:
 - If this is the first time you have requested immunization history for this patient, then you must match the patient to the correct patient record in the registry. Go to step 4.
 - If your patient record has already been matched to a record in the registry, then the patient's immunization history will be retrieved and displayed. Go to step 5.
4. The Multiple Patients Found From Immunization Registry Request window displays if you must match your patient record to the correct patient record in the registry.

Information from the patient record in your database is shown on the left side of the window. Patient records from the registry are shown on the right. The list includes patients with the same first and last name, date of birth, and gender. The entries also include their address information.

- a. Select the correct patient entry from the registry's list.

- b. Select the OK button. This matches your patient record to the registry's patient record. Then, the patient's immunization history will be retrieved and displayed.
5. In the Import Immunization History window, review the information received and confirm it with the patient.
6. To map an item, highlight the desired item in the Received History pane and drag it to the Immunization History pane and drop it on the corresponding item or the Add New Hx item.
7. To map several items at a time, in the Received History pane, select the checkboxes for the items you want to import.
 - Use the Select All icon () to select all items.
 - Use the Clear All icon () to deselect all selected items.
8. Select the Add Hx icon () to import the selected items.
9. The imported items will appear in the Immunization History pane. Items imported and mapped are displayed in blue text. Items that are in the patient's history, but that have not been mapped to an electronic immunization history item are displayed in black text.
10. If needed, you can undo an import by selecting the item and then selecting the Unlink icon (). This removes the link to the item in the Immunization History pane. If the item was mapped to an existing item in the patient's medication history, that item remains in the history and is displayed in black text.
11. To replace an item in the patient's history with new or additional information from the registry:
 - a. Select the checkbox for the desired item in the eRx History pane.
 - b. Select the item in the Received History pane to be updated.
 - c. Select the Replace button.
12. Once you have reviewed electronic history items, you should mark them as reviewed whether you import them or not. Then you will not have to review the same items over and over.
 - a. Select the checkboxes for the desired items, and then select the Mark as Reviewed () icon.
 - b. If needed, select a reviewed item or items, and then select the Mark as Unreviewed () icon.
13. You can change the items displayed or the order in which they are displayed using the icons in the toolbar. These icons toggle.
 - Show reviewed items () / Hide reviewed items ()
 - Show inactive items () / Hide inactive items ()
 - Sort by date () / Sort by name ()
14. If desired, you can display lines between items in the Received History pane and the items in the Immunization History pane to which they are mapped.
 - Use Diagonal lines ()

- Use Stepped corner lines ()
- Use No lines ()

15. When you have made all the desired imports, select the OK button to save the information to the patient's record.

Vaccination Reminders

ConnectiveRx, the parent company for the Physicians' Desk Reference (PDR), also provides vaccination reminders. The reminders are based on the patient's immunization history, age, and gender. Reminders are displayed at the bottom of the Vaccine Administration Record window.

This functionality is enabled by default. If you do want to review the vaccination reminders, your administrative super user may inactivate this functionality.

Vitals and Observations

Observation Charting

The Observation tab for clinical note type windows enables you to enter and view observation findings in patient visit note using a simple flowsheet view. In the Observation tab, you can select one or more observation templates containing the observation items which you are monitoring for the patient.

Observations included in an observation template and charted in a patient visit note through the Observation tab are displayed in the Patient Results window like lab test results and other observation results.

Observation Template Use

When charting a visit note, you may select the observation template or templates that are appropriate for the patient visit. An observation template is a set of vitals measurements, lab tests, and/or other observation items that can be used to enter observation findings and results in a flowsheet format.

A lab template is a type of observation template, and you can display lab templates in the Observation tab. Be aware, however, that if you enter lab test results in a lab template through the Observation tab, you will not be able to see the normal minimum and maximum values and the result does not appear in red when it is out of the normal range. It is recommended that if you enter lab test results through the Observation tab, you review them using the Results tab or the Patient Results window.

Observation Time Period

You can select the time period which you want to review. Today's observations are always displayed, regardless of the time period selected.

Observation Graphs

Observation items that are defined with a data type of 'metric' can be displayed on a graph, like vital signs and lab results. When an observation item in a template can be graphed the item name is displayed as a hyperlink. Select the hyperlink to display the Graph window with the observation item's findings plotted on the graph.

Use the Observation Tab to Chart Observations

1. Clinical note type containing Observation tab
2. Select the Observation tab.
3. In the top left of the tab, select the time period for results.
4. Display the desired observation template.
 - a. Select the New button.
 - b. Search for and select the desired observation or lab template.
 - c. Select the OK button to display the selected template in the Observation tab.
5. Repeat step 4 to select an additional template if desired. If you selected more than one, the templates are listed in the left panel.
6. To remove a template, select the Delete button.

Deleting a template removes it from the display. Prior entries in the template and entries made today and saved remain saved in the database even when the template is deleted from the display.
7. In the left panel, select the template you wish to display. A column appears for today's observation findings and results.
8. To enter observation:
 - a. Select the field for today's date in the row for the desired observation.
 - b. Enter the finding or result.
9. Repeat step 8 for each observation in the template.
10. To enter another set of observations for the visit:
 - a. Select the New Observation button. Another column with today's date is displayed. Note that the time of each observation set is now displayed with the date.
 - b. Select the field for today's date in the row for the desired observation.
 - c. Enter the finding or result.
 - To copy the previous entry, press the asterisk (*) key in the top right of the numerical keypad on a standard keyboard or press the Shift+8 keys.
 - To copy the entire column of previous entries, press the CTRL+* keys or the CTRL+Shift+8 keys. Note that this completes only the empty fields. Any field already containing an entry will not be overwritten.
11. To delete a set of observations:
 - a. Select any field in the column you want to delete.
 - b. Select the Delete Observation button.

Vitals Defaults

Creating Observation Default Settings

When you create an observation default settings template, you can define whether the vitals are reviewed as a table or as a flowsheet, the measurement units in which they are displayed, the normal conditions for measuring standard vitals, and the specialized vital entries to be captured and displayed.

1. Either:
 - Full Note Composer → Vitals tab → Defaults find control → New button
 - Superbill Composer → Vitals tab → Defaults find control → New button
 - List Editor () → Clinical → Observation Default Settings
2. Select the New button.
3. Enter an ID and Notes if desired.
4. Enter a Name for the default settings.
5. In the Customize Controls field, search for and select an observation custom panel if desired. The custom observation panel includes any specialized vital measurements that you want to display in the Vitals tab.

Please see Create an Observation Custom Panel below for more information on how to create a custom observation panel.

6. Select the Enter Metric checkbox if you want to enter vitals using metric values.
7. Define how vital measurements will be displayed for review.
 - Unselect the Review as Flow checkbox to display the vital measurements as a list. This displays only the measurements entered in the current visit note.
 - Select the Review as Flow checkbox to display the vital measurements as a flowsheet. This will display the measurements entered in the current visit note and measurements from previous visits if available.
8. Define the type of units used to display the vitals measurements. This controls the display of the measurement, regardless of the units used to enter the measurement.
 - Select the Auto radio button to display the measurement in the units in which it was entered.
 - Select the Metric radio button to display all measurements in metric units.
 - Select the English radio button to display all measurements in standard U.S. units.
 - Select the Both radio button to display both metric and standard U.S. units.
9. Select the With Percent checkbox if you want to display the percentile for weight, height, and head circumference for pediatric patients. BMI will also display as a percentage.
10. If you selected the Review as Flow checkbox in step 7, then define the previous vital measurements to be displayed by either:
 - Selecting the Maximum Items Returned to always display a specific number of previously entered vital measurements.

- Entering a Timespan to display all the vital measurements entered in that timespan. For example, you may want to display all the vitals for the previous six months or year.
11. In the standard vitals area, select the data entry options that you want to include as defaults. You may enter any or all of the following.
- Weight condition (clothed, unclothed, etc.)
 - Temperature method
 - Respiratory rate condition
 - Heart rate position, location, and regularity
 - Blood pressure location and position
12. If in step 4 you selected a customized control panel, then in the custom vitals area, select the data entry options that you want to include as defaults.