Health Information Management

Health Information Management

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Chapter 5 Grouper

Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications and vendor specifications provided by CMS, ONC and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

1.2 What's New

This section introduces the new features and improvements for the **Health Information Management application** for release Version 22.01. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 22.01 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact **Client Services** Support.

Charged CPT -- FA-12842

DESCRIPTION: Additions have been made to the Charged CPT screen to include the A/R Date, Service Date, and Item Number linked to each listed CPT.

DOCUMENTATION: See Charged CPT

Coder Name Pulls to Grouper -- FA-12912

DESCRIPTION: The coders name and login will automatically populate when **Finish** is selected from the action bar on the MR Grouper screen.

DOCUMENTATION: See Patient Summary 55

HIM Coding Worklist - New Options -- FA-12432

DESCRIPTION: A **Delete** option now appears next to the Coding Status field allowing users to remove the coding status and make the field blank again (e.g., if a coding status was added in error).

A **Coding Status History** option now appears on the action bar and may be used to view the history log. When viewing the Coding Status History log, **PDF** and **CSV** options are now available to generate a PDF or CSV report of the history log.

DOCUMENTATION: See Removing a Coding Status 48 and Coding Status History 49.

Chapter 2 Overview

Medical Records is a fully integrated application that allows for maintenance of complete and accurate records. The responsibility of receiving, coding, transcribing and provision of central files of Medical Records is easily facilitated throughout the system.

The reports generated from within the Medical Records application can be valuable administrative tools for planning and evaluating the hospital program as well as legal protection for the patient, hospital and physician. As the department receives and reviews medical reports, incomplete or inadequate records can be directed to responsible physicians or other parties for corrective action.

The Medical Records application facilitates the maintenance of indexes in a number of ways. These include patient indexes, disease indexes (filed according to the International Classification of Diseases, Ninth Revision, Clinical Modification), physician indexes and procedure indexes.

Features of the application include:

- Grouper
- APC Verification
- Transcription
- MR Electronic Signature
- Release of Information
- Chart Location
- State Abstracting
- Chart Deficiency
- Coding Interfaces
- Master Patient Index
- Over 100 different reporting options

Accessing the Medical Records Selection Screen

There are two ways to access the Medical Records application:

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records** or
Select **Web Client > System Menu > Hospital Base Menu > Lock onto Patient Account > Patient Functions > Medical Records**

The different functions of these screens will be discussed in later sections.

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY or YYMMDD to be used throughout the Medical Records and Electronic Signature applications. A TruBridge Representative should be contacted in order for the date format to be changed.*

NOTE: *Facilities outside of the United States may utilize a different address format to display in select HIM applications. The address may display the Province and Postal Code instead of the State and Zip Code when the Country Code field is set to another country code other than "US". A TruBridge Representative will need to be contacted in order for the foreign address fields to display.*

Chapter 3 Print Electronic Record

3.1 Overview

The Print Electronic Record application is designed for use by Health Information Management professionals. It allows users to print specific documents from a single, centralized area. Several tasks must be completed prior to using this application. The following information outlines the setup process and provides instructions for printing the Electronic Record.

3.2 Security

Access to Electronic Records is controlled using Employee Security Switch #105 within System Management. This switch grants the employee access to the entire Electronic Record and permission to print all documents within a chart.

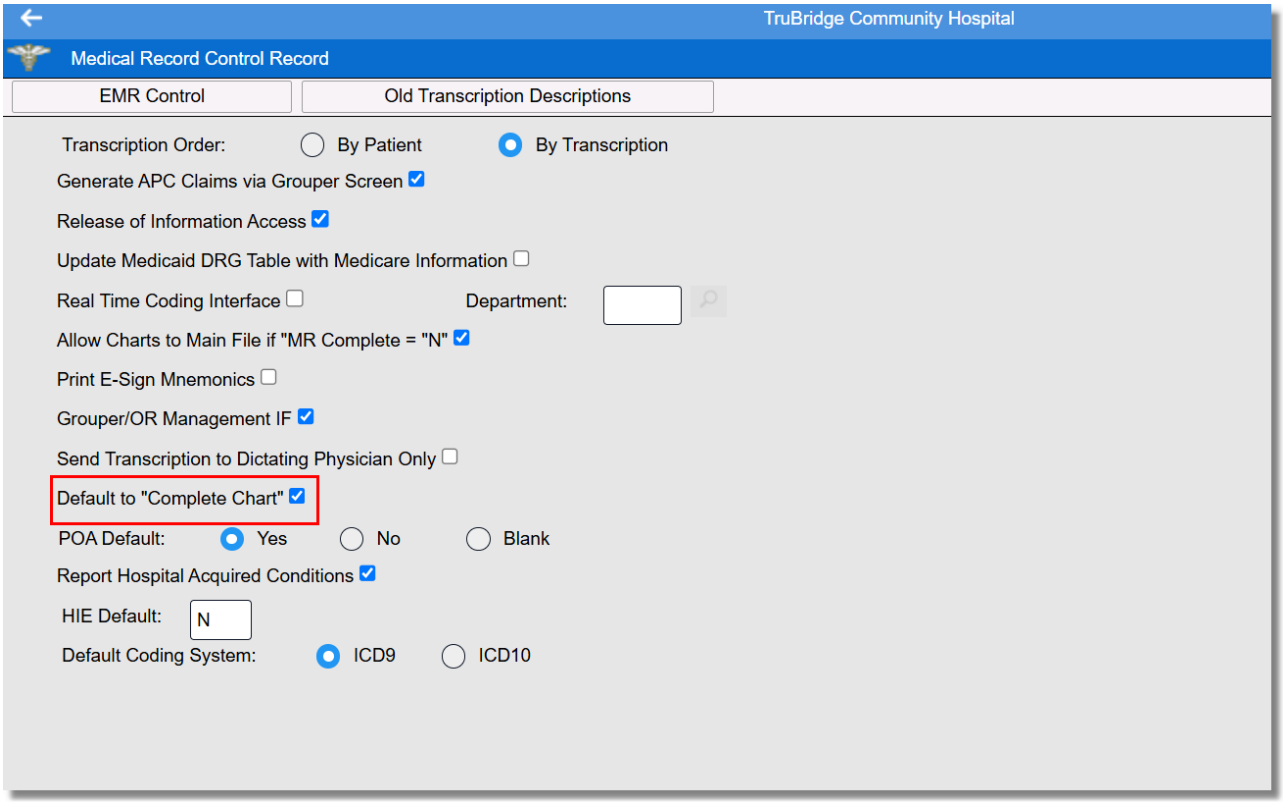
3.3 Table Maintenance

The following information explains the table maintenance that must be completed before using the Print Electronic Record application.

Medical Record Table

The Medical Record Control Record table allows health information mangers to set system-wide defaults and behaviors for the Medical Records application, to ensure consistency and automation for coding, transcription, and documentation.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Med Rec**



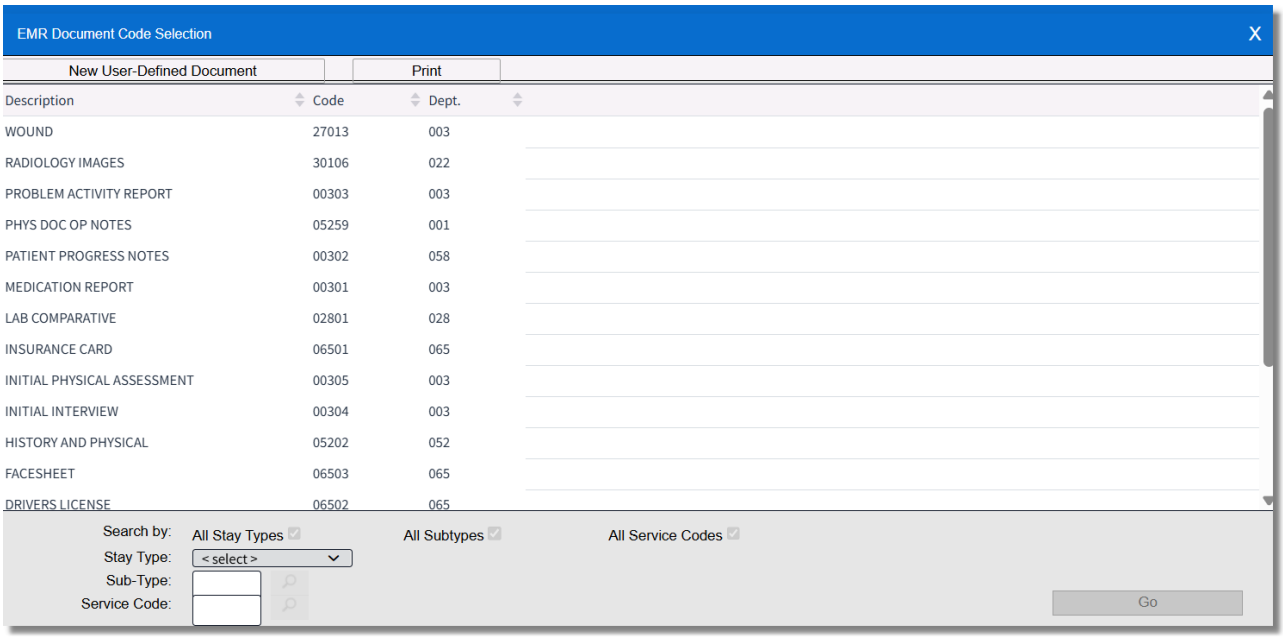
Medical Record Control Record

- **Default to "Complete Chart"**: Selecting this option will automatically check the Include box for Electronic Record documents to be printed. These documents are not associated with a document code and will be labeled as (*****). This applies to all documents that existed prior to the setup of the EMR Document Table.

EMR Document Code Table

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Med Rec** > **EMR Control** > **EMR Document Code Table**

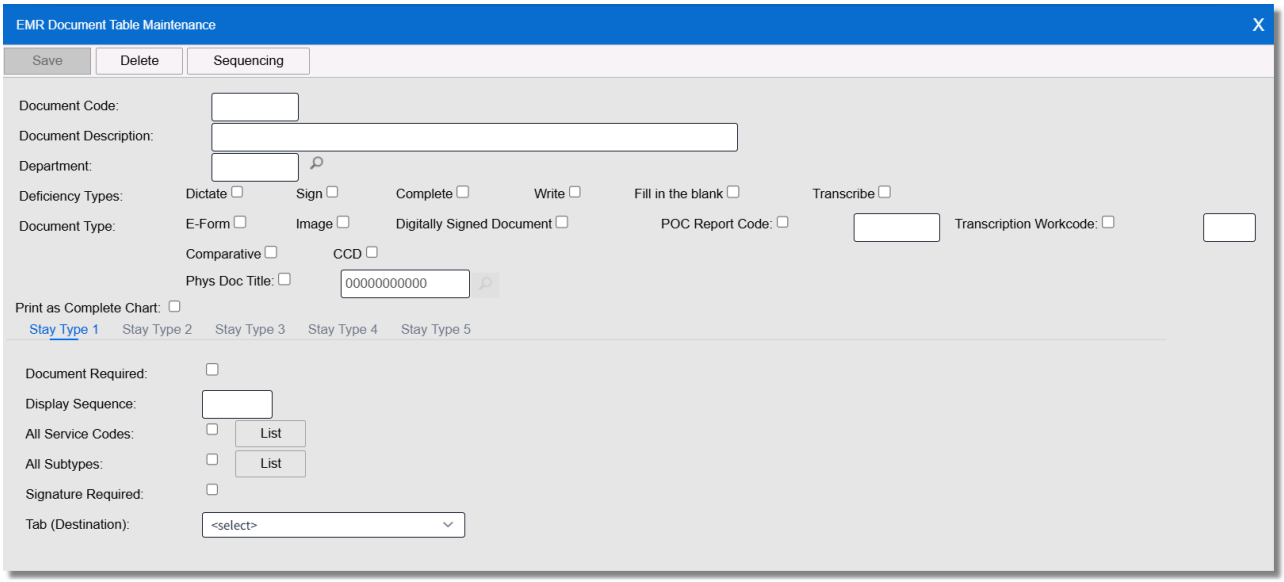
The EMR Document Code table is designed to create a unique code for each document that may be stored in a patient's electronic chart. Document codes can be configured either in this table or within the individual tables, as discussed later in this section. During the initial phase, this setup enables the electronic record to be compiled for printing. Document codes must be created for Point of Care, Lab, and Cardiology.



EMR Document Code Selection

- **New User-Defined Document:** Select this option to create a new Document Code.
- **Print:** Select this option to print a list of all Document Codes that are set up in the table.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Med Rec > EMR Control > EMR Document Code Table > New User-Defined Document**



EMR Document Table Maintenance

- **Document Code:** Enter a 5-digit code for this document. This will also serve as the barcode number used to scan documents on an account.

- **Document Description:** Enter the description used for this document. When deciding on description, enter one that will distinguish this from others. For example, for pathology images, Pathology should not be used. Set up one for Surgical Pathology, Pap Smears, etc.

- **Department:** Enter the Department number or select the magnifying glass for a lookup option. This is the department from which this document originated.

- **Deficiency Types:** Reserved for future use.

- **Document Types:** Select the single Type that corresponds with this document. This is used for the system to locate where the document is stored.
  - **E-Form:** Select this option if the document is an E-Form.
  - **Image:** Select this option if the document is an Image.
  - **Digitally Signed Document:** Select this option if the document is a Digitally Signed Document.
  - **POC Report Code:** If this option is selected, enter the code that will correspond with this document. This will be found in the Point of Care Control Maintenance table.
  - **Transcription Workcode:** If this option is selected, enter the Category code that is loaded in the corresponding Physician Headers table.
  - **Comparative:** Select this option if the document is a Cumulative. This field will look to the Department option above and will pull Cumulative reports associated with that department.
  - **Phys Doc Title:** If this option is selected, enter or select magnifying glass for a lookup option and the Physician Documentation Title that corresponds with this document code.

- **Print as Complete Chart:** Selecting this option will pre-select this Document Code to be included when choosing to print the Electronic Record.

- **Stay Type 1-5:** Reserved for future use.

The EMR Document Code can be added in the following tables.

Image Titles

Select **Web Client** > **Tables** > **Business Office** > **Titles**

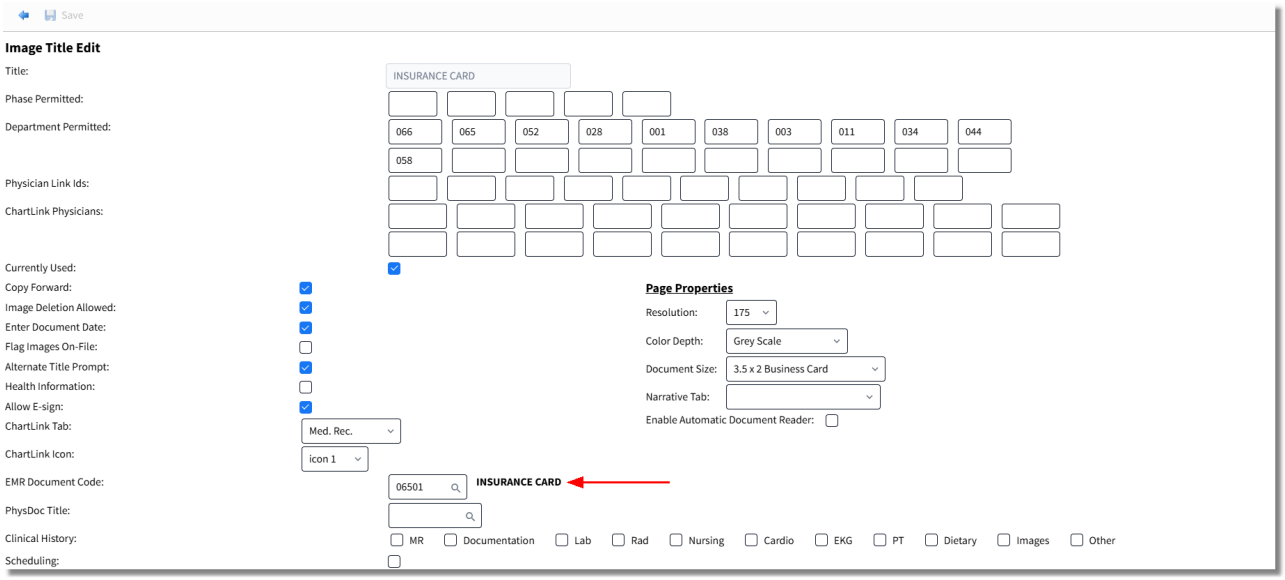


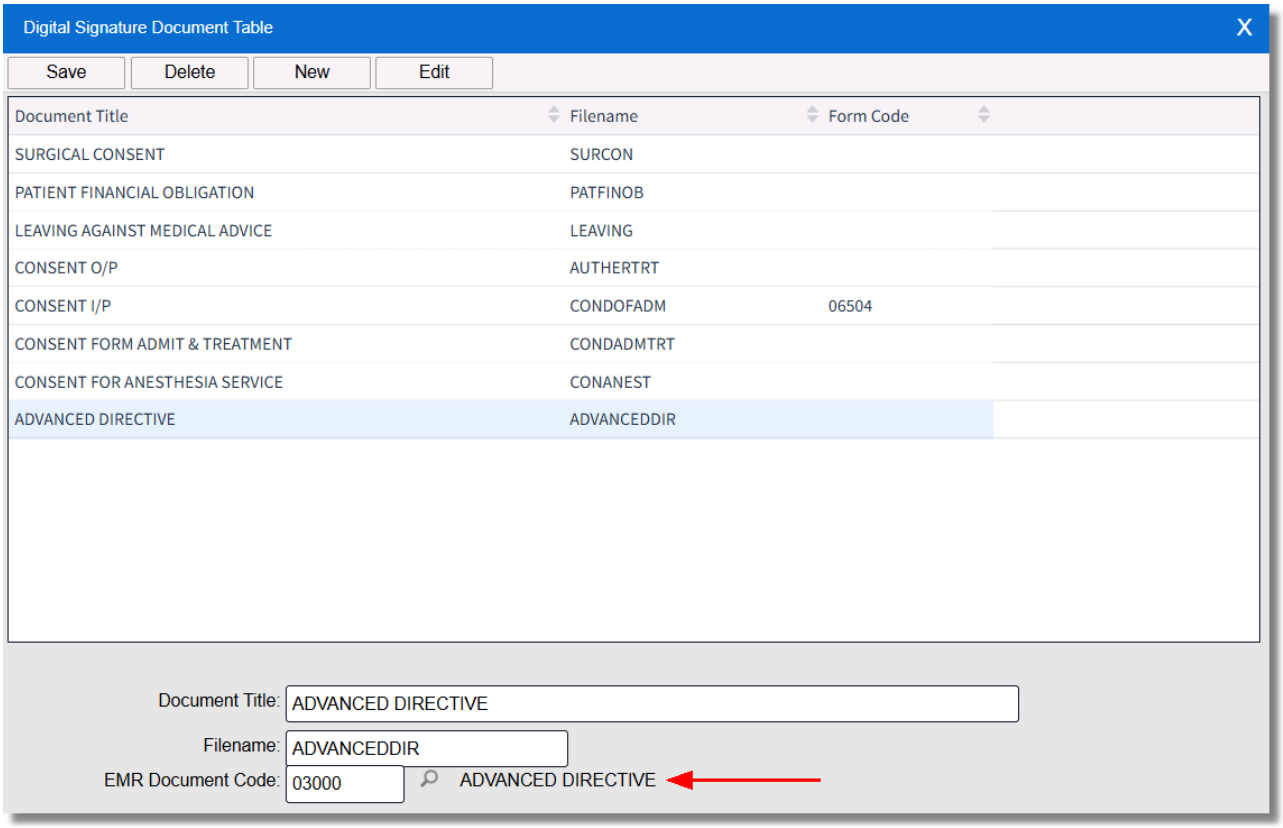
Image Title Maintenance

- **EMR Document Code:** Enter the code that corresponds to this image title. Select the magnifying glass to look up an existing EMR Document Codes or to add a new code.

NOTE: *The EMR Document Code field is not required for an image to be printed in the Electronic Record. However, if a code has been set up in the EMR Document Code table, it should be entered here.*

Digital Signature Document

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Dig Sig Doc**



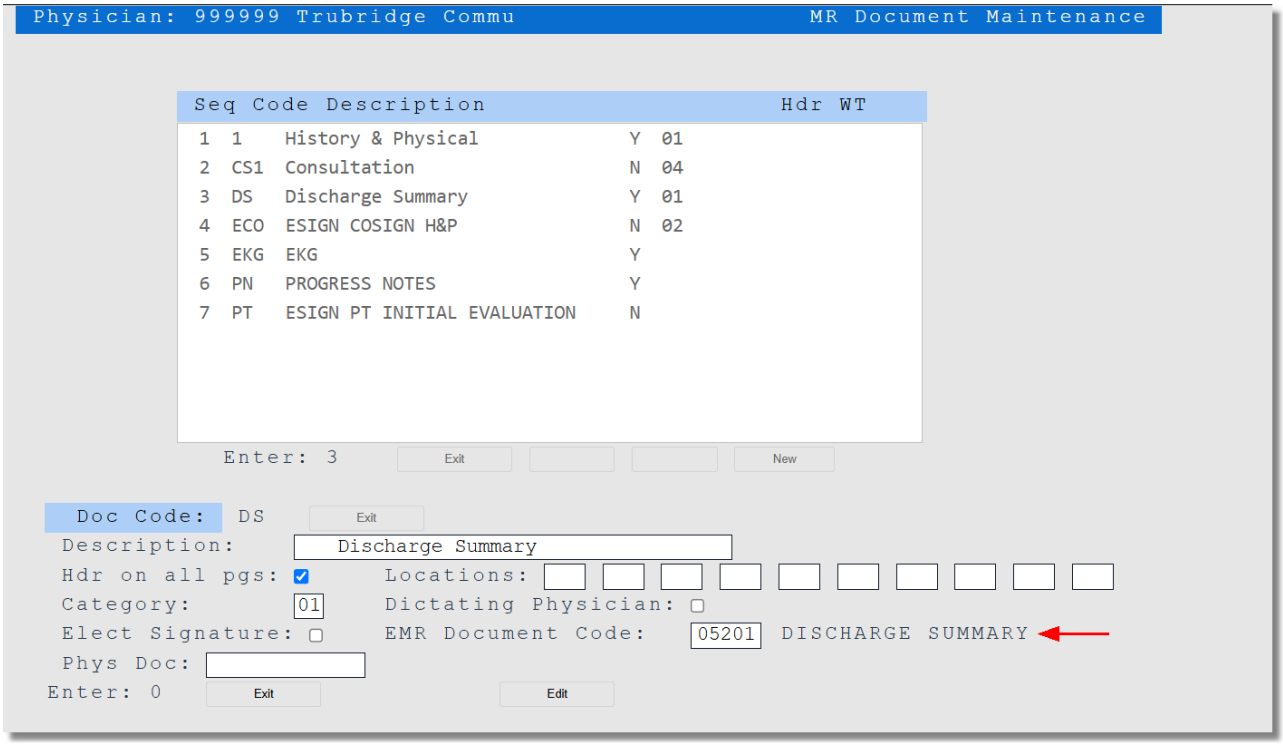
Digital Signature Document Table

- **EMR Document Code:** Enter the code that corresponds to the selected Digital Signature. Select the magnifying glass to lookup an exisiting EMR Document Codes or to add a new one.

NOTE: *The EMR Document Code field is not required for a digitally signed document to be printed in the Electronic Record. However, if a code has been set up in the EMR Document Code table, it should be entered here.*

Phys Header

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Phy Headers**



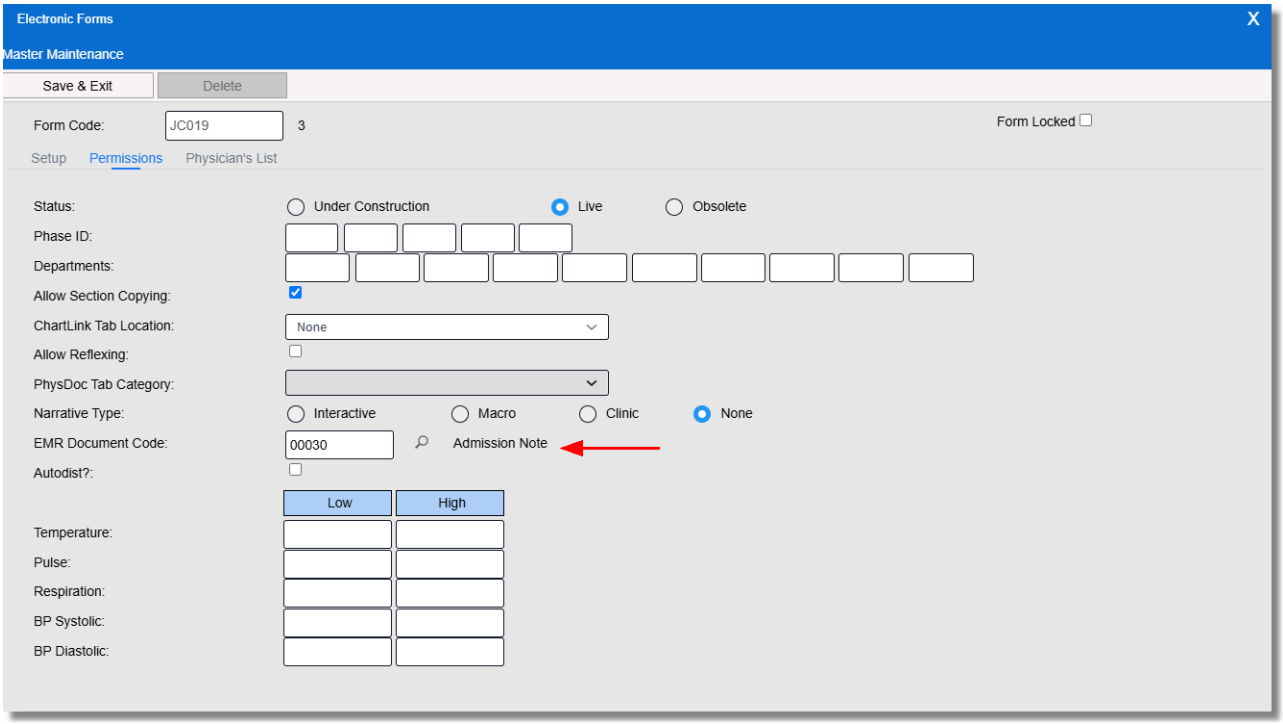
MR Document Maintenance

- **EMR Document Code:** Enter the code that corresponds to the physician. To look up an exisiting code, type a question mark (?) then press enter. This also allows a new document code to be entered.

NOTE: *The EMR Document Code field is not required for a Physician Header to be printed in the Electronic Record. However, if a code has been set up in the EMR Document Code table, it should be entered here.*

Electronic Form

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Elect. Forms > Title > Master > Permissions**



Master Maintenance

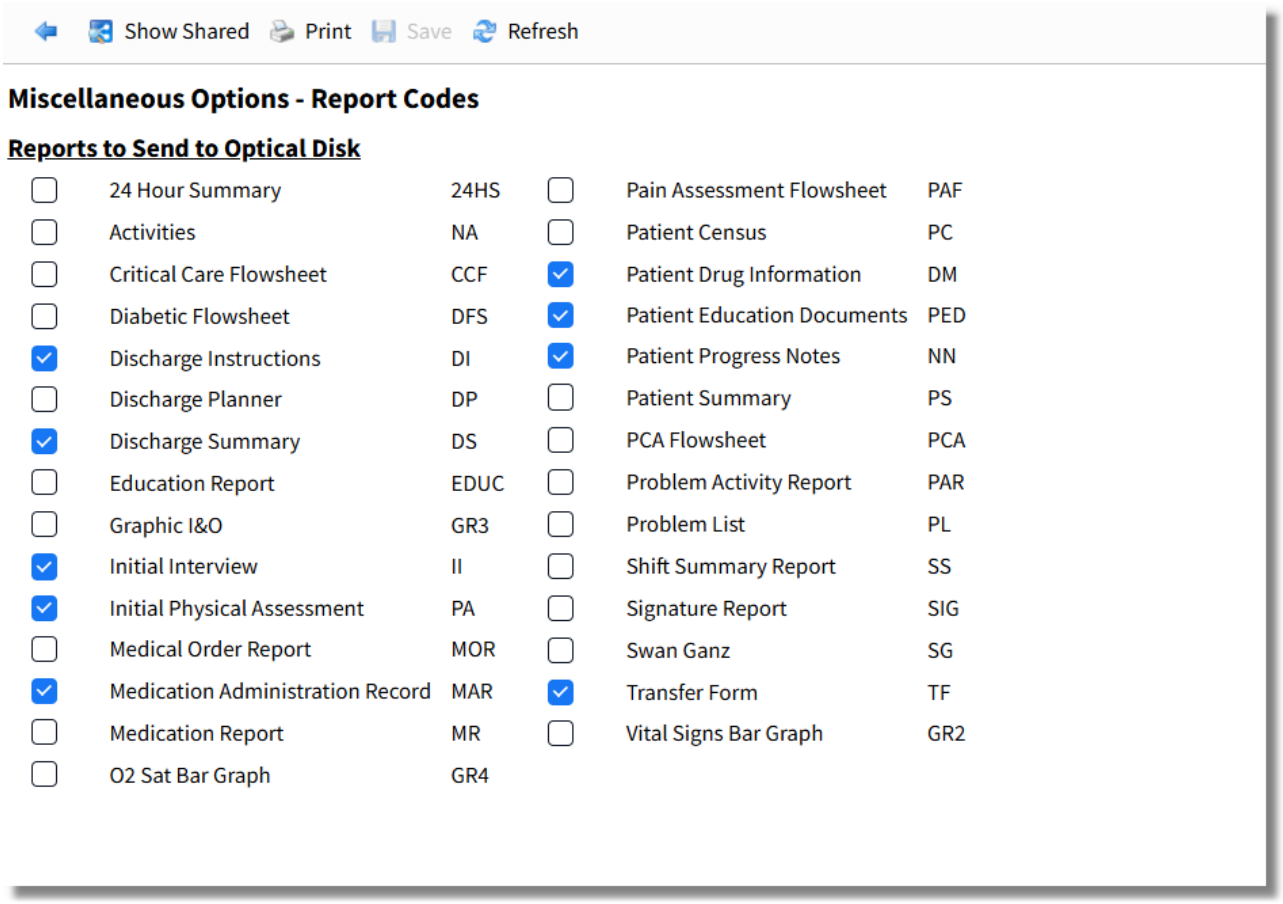
- **EMR Document Code:** Enter the code that corresponds to this electronic form. Select the magnifying glass to lookup exisiting EMR Document Codes or to add a new one.

NOTE: *The EMR Document Code field is not required in order for an electronic form to be printed in the Electronic Record. However, if a code has been set up in the EMR Document Code table, it should be entered here.*

Point of Care Control Maintenance

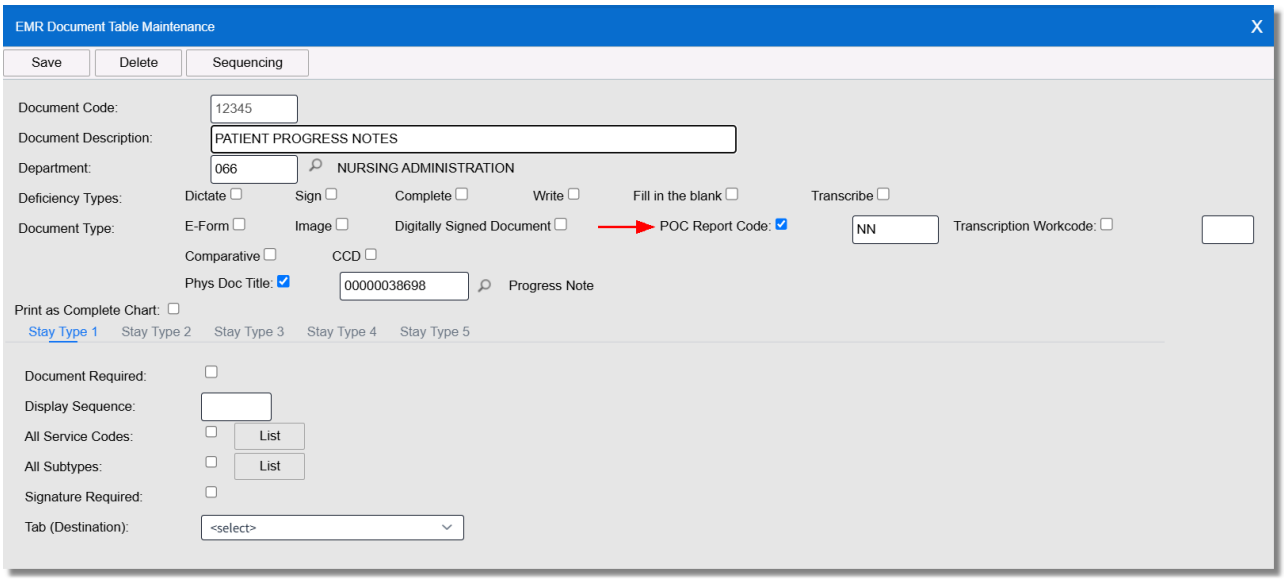
If the Document Type is Point of Care, the report displayed next to the selected report should be entered in the POC Report Code field within the EMR Document table. An EMR Document Code should not be set up for POC Report code FSR (Floor Stock Report).

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **Point of Care Control Maintenance** > **Page 2** > **Report to Send to Optical Disk**



Report Codes to Send to Optical Disk

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Med Rec > EMR Control > EMR Document Code Table**



EMR Document Table Maintenance

3.4 Using Print Electronic Record

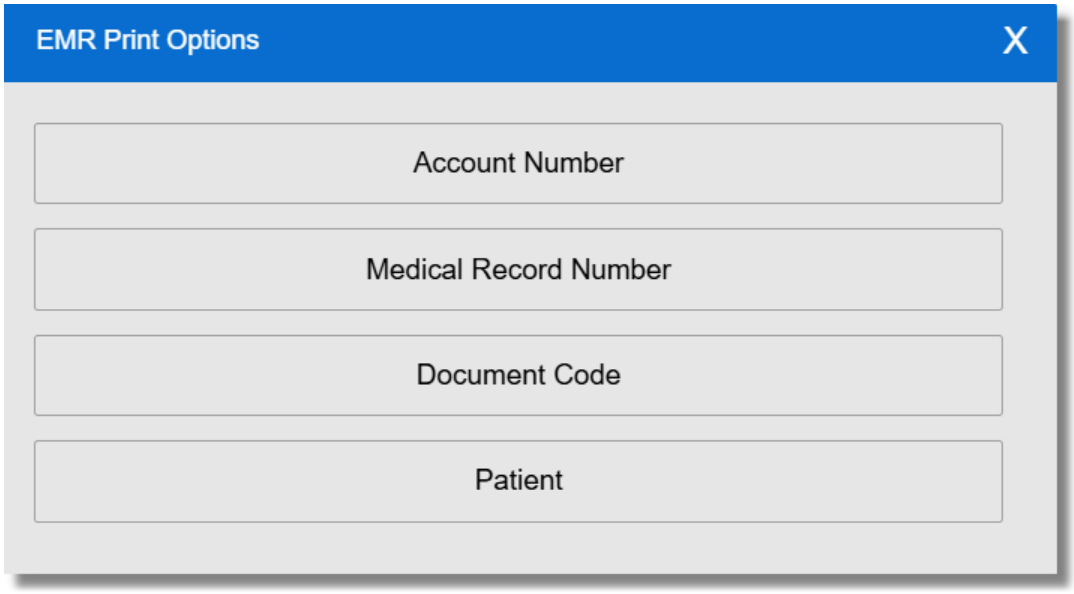
The Electronic Record can be printed by Account Number, Medical Record Number, Document Code, or Patient. There are three ways to access the Print Electronic Record option:

1. Master Selection
Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record**

2. Patient Account
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Print Electronic Record**

3. Patient Summary Screen
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Print Electronic Record**

All three paths will launch the EMR Print Options screen.



EMR Print Options

EMR Print Options

The following information outlines the options available within the EMR Print Options prompt.

Account

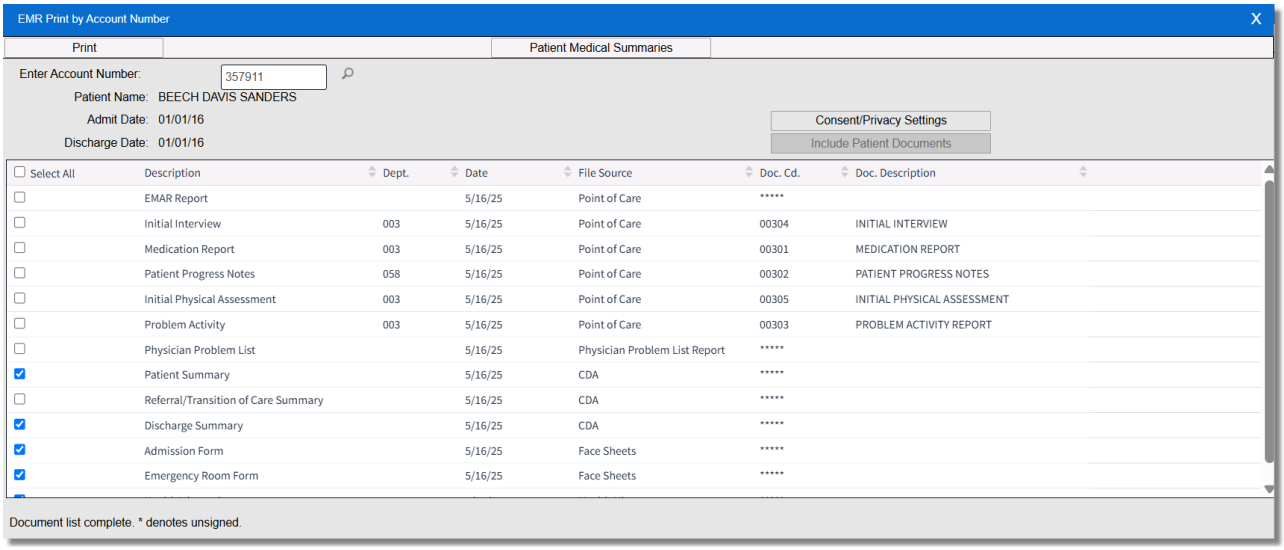
To print documentation for a single patient account, select **Account Number**.

From Master Selection

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number**

From Patient Account

Select **Web Client > System Menu > Hospital Base Menu > Patient Account > Medical Records > Print Electronic Record > Account Number**



EMR Print by Account Number

NOTE: *Selecting the **Restrict Payer Disclosure** field on the Guarantor/Ins tab of the Registration ADT screen will trigger a "Restrict Payer Disclosure" warning to display in red on the EMR Print by Account Number screen. The warning will also display on the Medical Records System screen. To access the Medical Records System screen, select Web Client > Application Drawer > System Menu > Hospital Base Menu > Enrer patient account > Medical Records.*

- **Print:** Once the desired documents are selected, they may be printed, viewed, faxed or emailed.
- **Patient Medical Summaries:** Please see Patient Medical Summaries - CCDA 40.
- **Enter Account Number:** Enter in the account number or select the magnifying glass to search for an account.
- **Patient Name:** Displays the selected Patient Name.
- **Admit Date:** Displays the patient's Admit Date.
- **Discharge Date:** Displays the patient's Discharge Date.
- **Consent /Privacy Settings:** Allows information regarding the patient's privacy to be captured. Please see Consent/Privacy Settings 38.
- **Include Patient Documents:** Based on settings in the EMR Documents table (located in the Medical Record Control table or Business Office tables) documents will be automatically selected to be printed as part of the "complete chart."

- **Include:** Select this option to choose documents for printing, viewing, faxing, or emailing documentation for.
- **Description:** Pulls the name of the documents that are linked to the selected account.
- **Dept.:** Pulls the Department from the Document Code table.
- **Date:** Displays the date the document was added to the patient's chart.
- **File Source:** Pulls the location from which the Document originated.

***NOTE**: Electronic File Management documents that have been deleted or moved to another account will be highlighted in red.*

- **Doc. Code:** Pulls the code that is associated with the EMR document. Documents that are not associated with a document code will be labeled (*****).
- **Doc. Description:** If a Document Code is associated with a document, the description from the EMR Document Code table will pull.

Medical Record Number

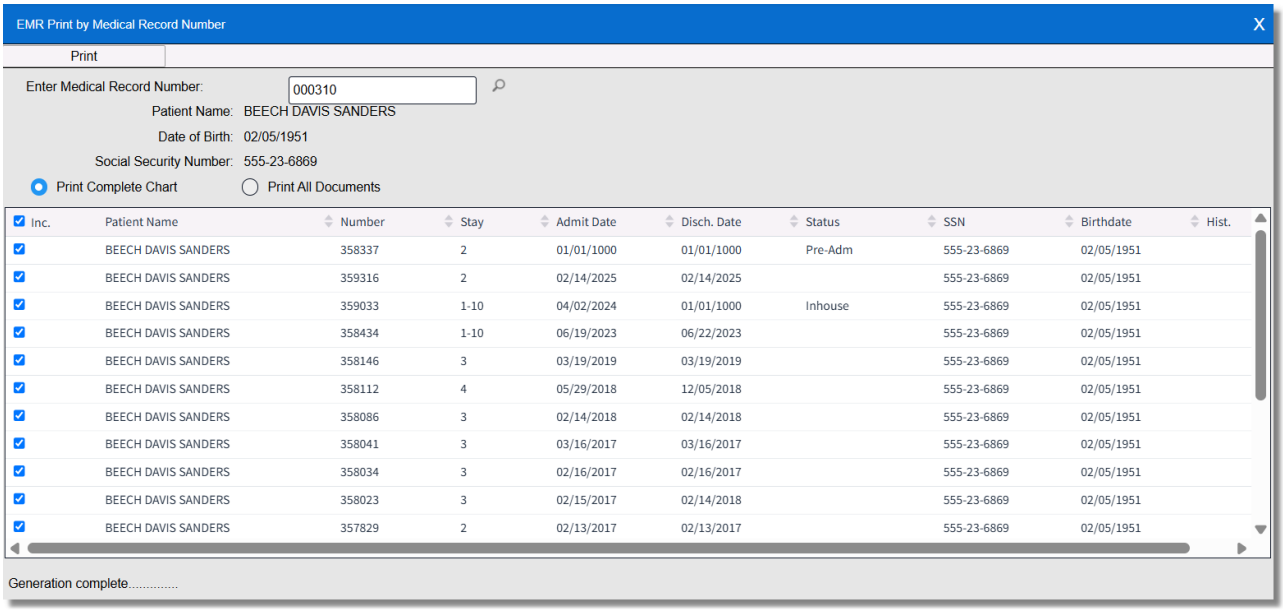
To print documentation for any Medical Record Number, select **Medical Record Number**.

From Master Selection

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Medical Record Number**

From Patient Account

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account** > **Medical Records** > **Print Electronic Record** > **Medical Record Number**



Print by Medical Record Number

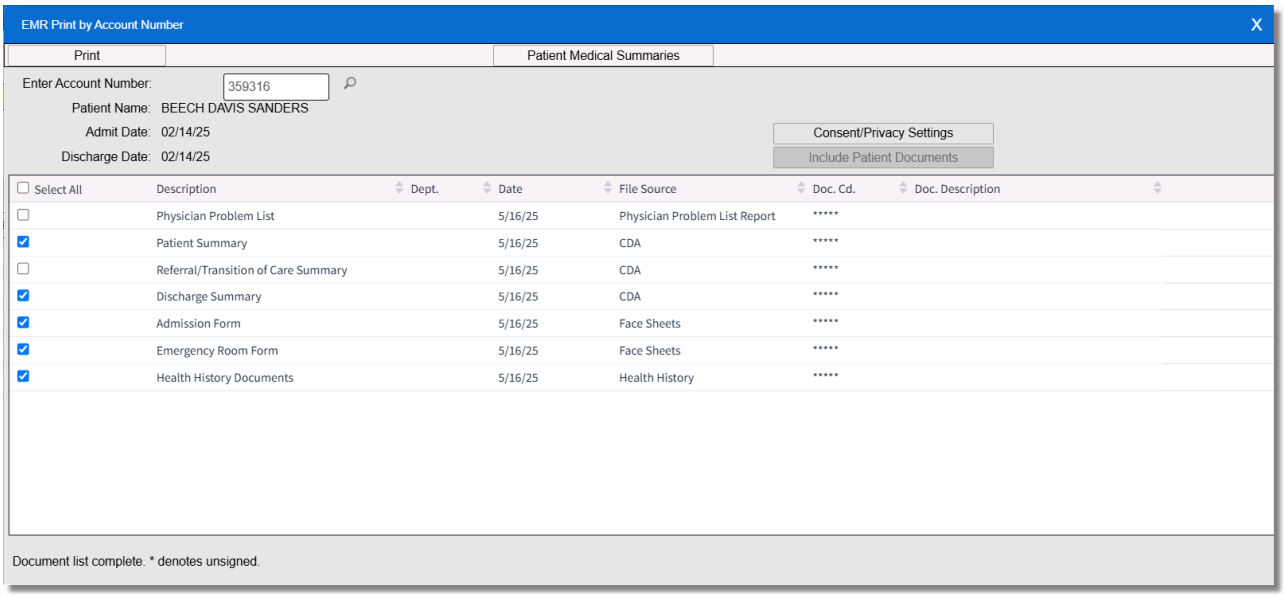
- **Print:** Once the desired documents are selected, they may be printed, viewed, faxed or emailed.
- **Enter Medical Record Number:** Enter in the Medical Record Number or select the magnifying glass to search for a patient within the Master Patient Index.
- **Patient Name:** Displays the Patient Name.
- **Date of Birth:** Displays the patient's Date of Birth.
- **Social Security Number:** Displays the patient's Social Security Number if the patient has a valid Social Security number rather than a system generated Social Security number.
- **Print Complete Chart:** This option will print all Complete Chart documents. This will default to selected.
- **Print All Documents:** This option will print Complete Chart documents as well as all other documents.
- **Include:** Displays the accounts selected for printing, viewing, faxing, or emailing documentation for. This will default to selected.
- **Patient Name:** Displays the Patient Name.
- **Number:** Displays the patient Account Number.
- **Stay:** Displays the patient's Stay Type.

- **Admit Date:** Displays the patient's Admit Date.
- **Discharge Date:** Displays the patient's Discharge Date.

NOTE: If the Admit Date or Discharge Date field is blank in the Registration and ADT screen on the account, the system will pull 1/01/1000 to these fields in Print Electronic Record.

- **Status**: Displays the status of the account.
- **SSN:** Displays the patient's Social Security Number if the patient has a valid Social Security number rather than a system generated Social Security number.
- **Birthdate:** Displays the patient's Date of Birth.
- **Hist.** Displays Hist for History accounts.

A specific account may be selected to show all documents associated with that account, as shown below. Select the **Account Number**.



EMR Print by Account Number

- **Print:** Once the desired documents are selected, they may be printed, viewed, faxed or emailed.
- **Patient Medical Summaries:** Please see Patient Medical Summaries - CCDA 40.
- **Enter Account Number:** Enter in the account number or select the magnifying glass to search for an account.
- **Patient Name:** Displays the selected Patient Name.
- **Admit Date:** Displays the patient's Admit Date.

- **Discharge Date:** Displays the patient's Discharge Date.
- **Consent /Privacy Settings:** Allows information regarding the patient's privacy to be captured. Please see Consent/Privacy Settings 38.
- **Include Patient Documents:** Based on settings in the EMR Documents table (located in the Medical Record Control table or Business Office tables) documents will be automatically selected to be printed as part of the "complete chart."
- **Select All:** Select this option to choose documents for printing, viewing, faxing, or emailing documentation for.
- **Description:** Pulls the name of the documents that are linked to the selected account.
- **Dept.:** Pulls the Department from the Document Code table.
- **Date:** Displays the date the document was added to the patient's chart.
- **File Source:** Pulls the location from which the Document originated.

***NOTE**: If utilizing Electronic Signature for Images and the image is signed, the File Source will display as "Signed Image Revision" along with the version number of the image such as 001.*

- **Doc. Code:** Pulls the code that is associated with the EMR document. Documents that are not associated with a document code will be labeled (*****).
- **Doc. Description:** If a Document Code is associated with a document, the description from the EMR Document Code table will pull.

Document

Document Code

To print documentation by Document Code, select **Document Code**. Using this option will allow all documents completed within a certain date range to print. Only documents associated with the selected Document Codes will print.

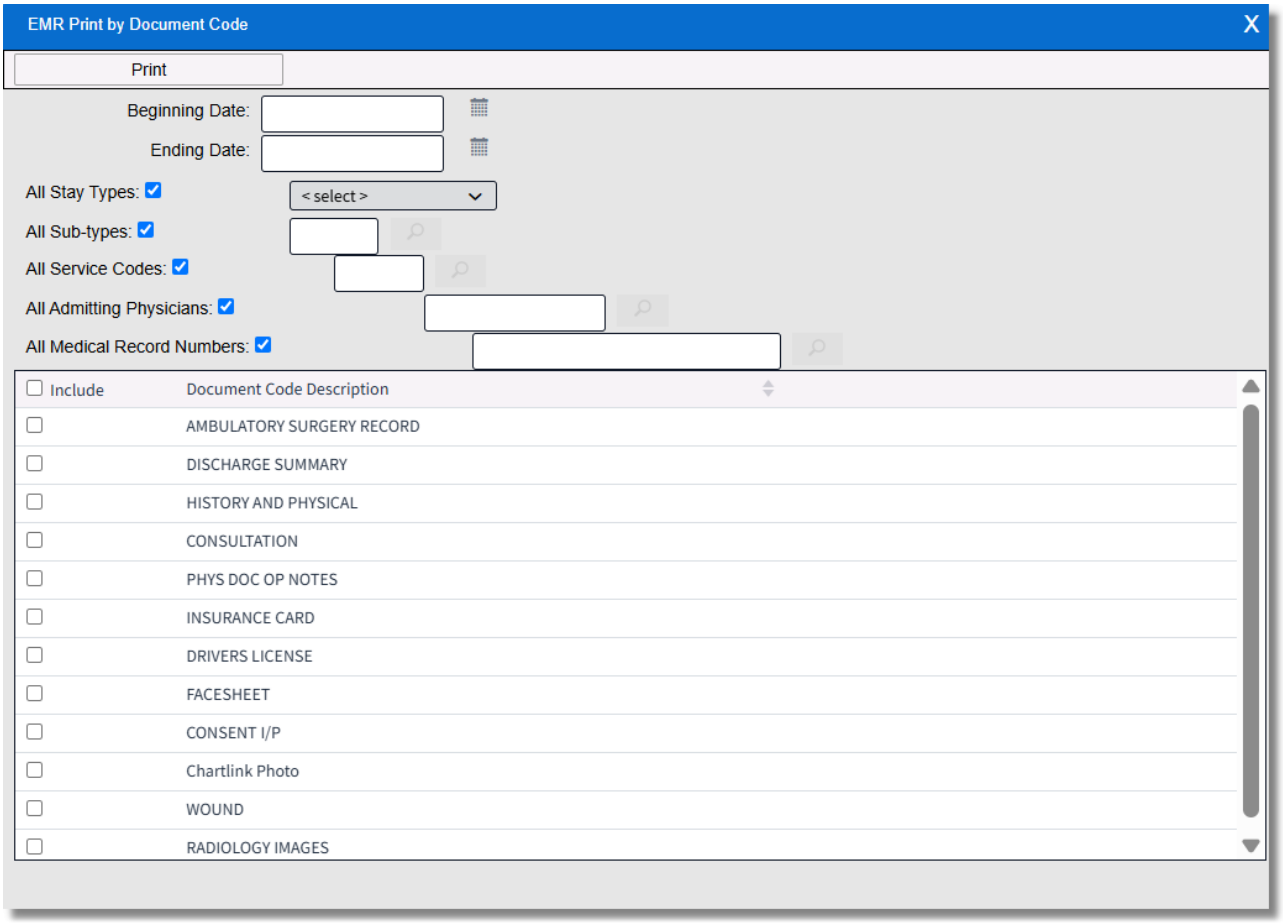
***NOTE**: Point of Care and Comparative Reports will not use the print by Document Code feature.*

From Master Selection

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Document Code**

From Patient Account

Select **Web Client > System Menu > Hospital Base Menu > Patient Account > Medical Records > Print Electronic Record > Document Code**



EMR Print by Document Code

- **Print:** Once the desired documents are selected, they may be printed, viewed, faxed or emailed.
- **Beginning Date:** Enter a Beginning Date. The drop-down option may be selected to display a calendar.
- **Ending Date:** Enter an Ending Date. The drop-down option may be selected to display a calendar.

NOTE: *The Beginning Date for a Document Code cannot precede the date of when that Document Code was set up.*

- **All Stay Types:** Select this option to filter by specific Stay Types. This option is selected by default.
- **All Sub-types:** Select this option to filter by specific Sub-Types. This option is selected by default.

- **All Service Codes:** Select this option to filter by specific Service Codes. This option is selected by default.
- **All Admitting Physicians:** Select this option to filter by specific Admitting Physicians. This option is selected by default.
- **All Medical Record Numbers:** Select this option to filter by specific Medical Record Numbers. This option is selected by default.
- **Include:** Select this option to choose documents for printing, viewing, faxing, or emailing documentation for.
- **Document Code Description:** All documents in the EMR Document Code table will be displayed.

Patient

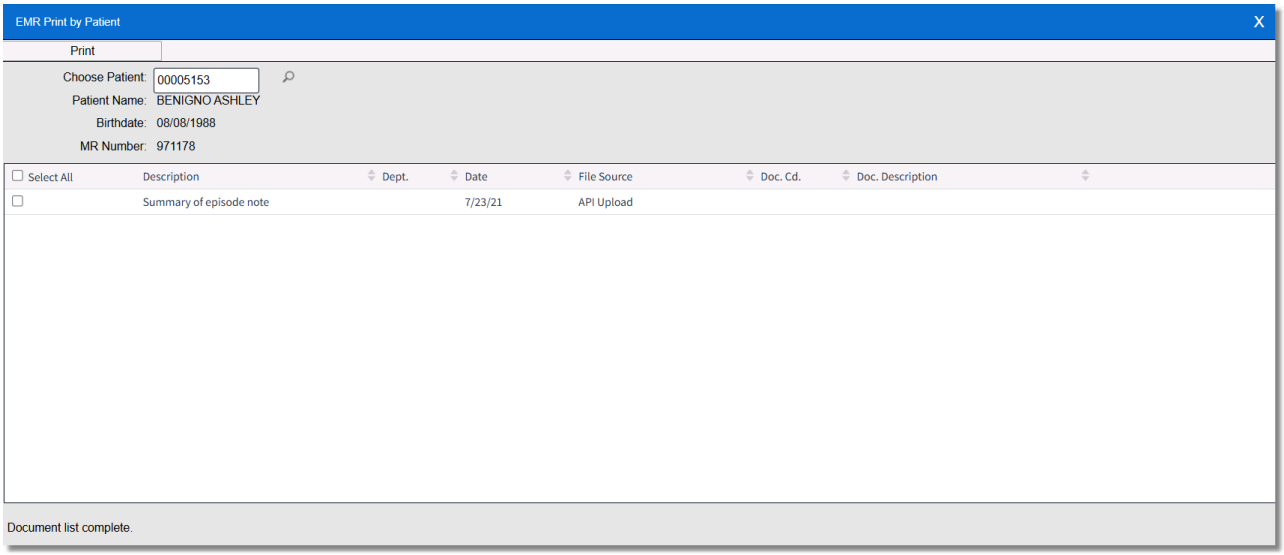
The Patient option within Print EMR shows documents linked to a patient from the Communications Center and the Document Management System (DMS). These documents are not linked to a specific account, but are instead linked with the patient's Profile.

From Master Selection

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Document Code**

From Patient Account

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account** > **Medical Records** > **Print Electronic Record** > **Document Code**



EMR Print by Patient

- **Print:** Once the desired documents are selected, they may be printed, viewed, faxed or emailed.
- **Choose Patient:** Enter the patient profile number, or select the magnifying glass icon to search for a patient in the Profile Listing.
- **Patient Name:** Displays the selected Patient Name.
- **Date of Birth:** Displays the patient's Date of Birth.
- **MR Number:** Displays the patient's Medical Record Number.
- **Select All:** Select this option to include all documents when printing. Documents may also be selected individually by selecting the check-box next to the document Description.
- **Description:** Pulls the name of the documents linked to the selected patient.
- **Dept.:** This field is not used at this time.
- **Date**: The date the document was linked to the patient.
- **File Source:** Pulls the location from which the Document originated.

***NOTE**: Electronic File Management documents that have been deleted or moved to another account will be highlighted in red.*

- **Doc. Code:** Pulls the code that is associated with the EMR document. Documents that are not associated with a document code will be labeled (*****).
- **Doc. Description:** If a Document Code is associated with a document, the description from the EMR Document Code table will pull.

Copy to Portable Media

The selected documentation can be provided to a patient electronically by selecting the **Portable Media** option.

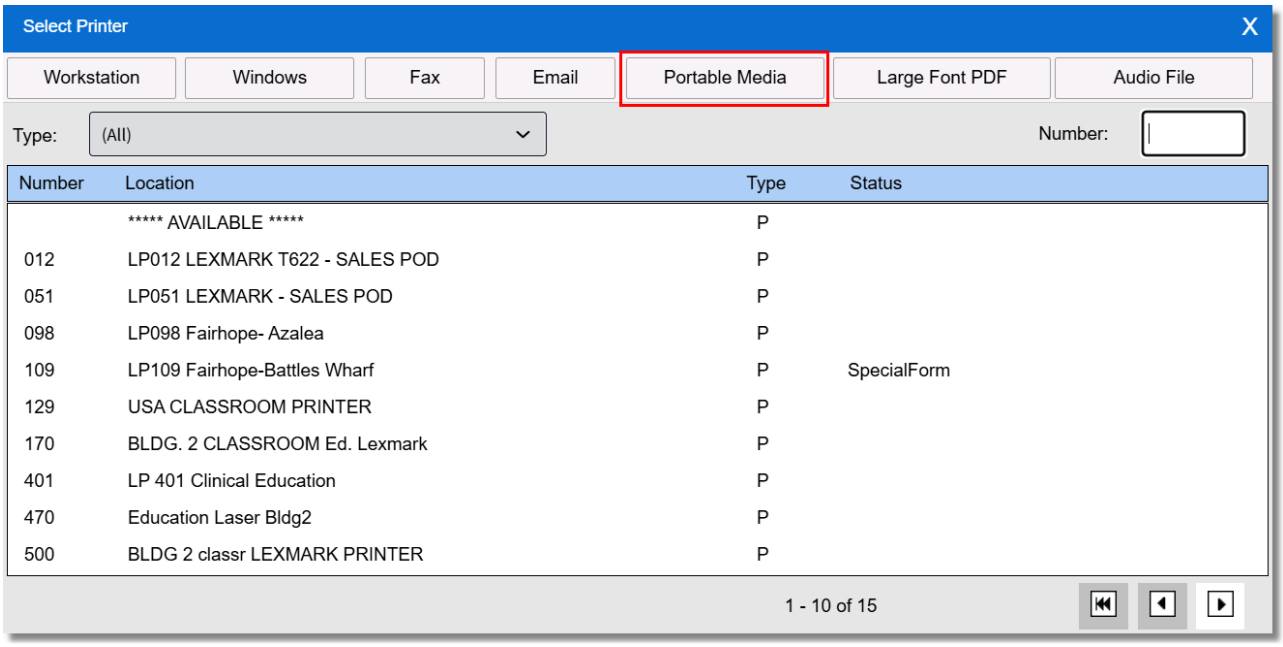
Encrypting Portable Media

From Master Selection

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Print** > **Portable Media**

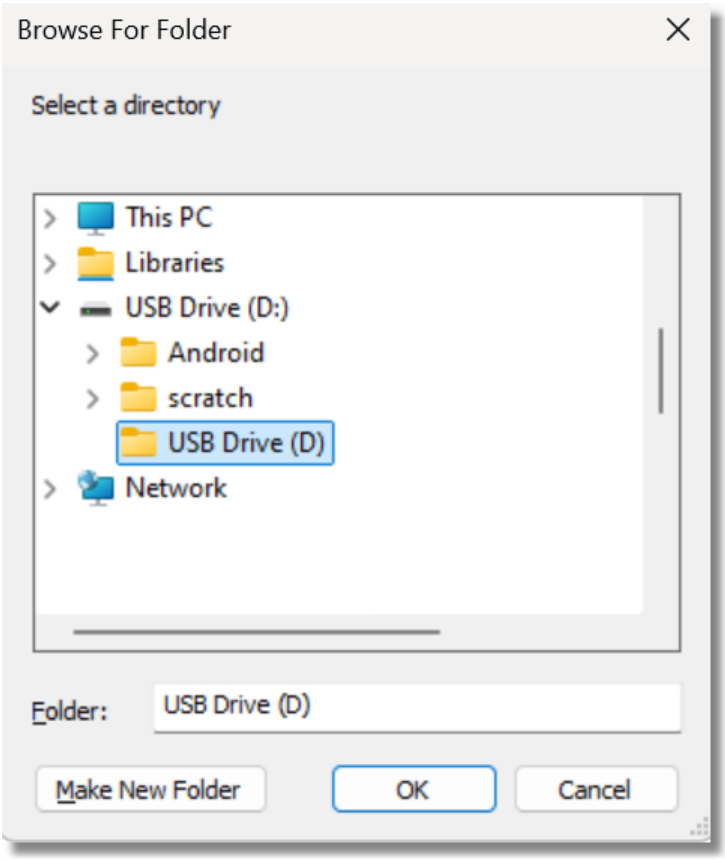
From Patient Account

Select **Web Client > System Menu > Hospital Base Menu > Patient Account > Medical Records > Print Electronic Record > Account Number > Print > Portable Media**



Select Printer

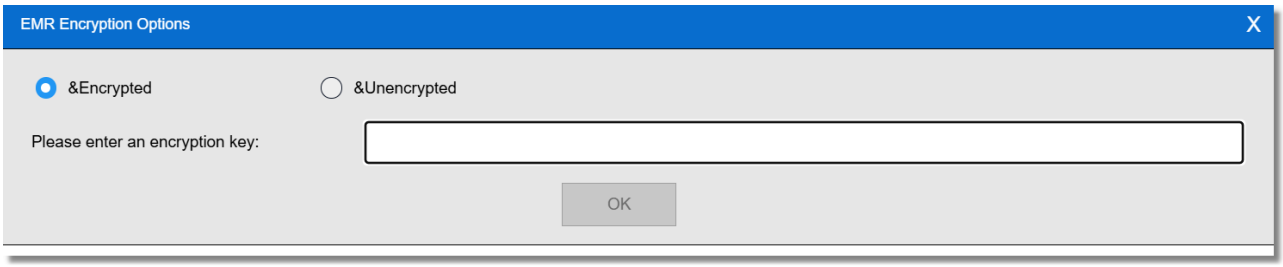
At this point select CD Drive or insert a Flash Drive to copy the media. The steps to download data to a CD vary depending on the operating system. Please refer to the document Instructions for Downloading to Portable Media, which provides detailed steps for Windows XP, Vista, and Windows 7 operating systems.



Browse for Folder

This will allow the hospital to encrypt data before providing it to the patient. Enter an encryption key as designated by the patient or hospital. The encryption key may be up to 32 characters in length.

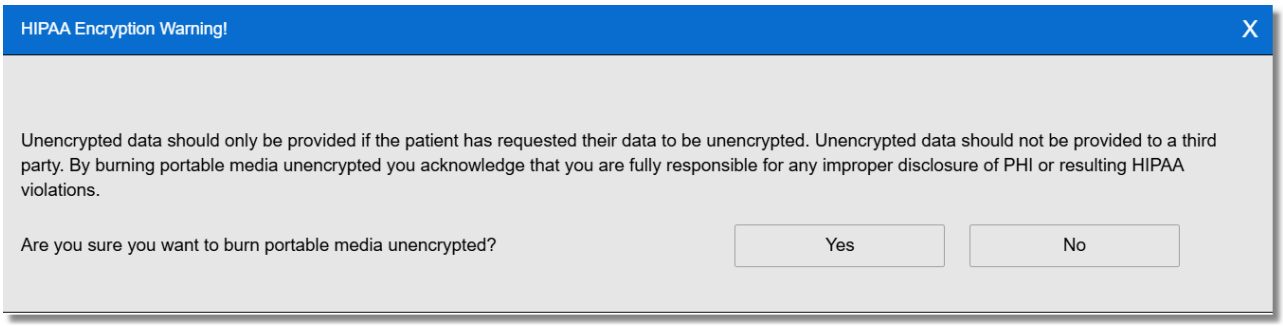
TruBridge recommends the encryption key be relayed verbally to the requestor and not documented along side the portable media.



EMR Encryption Key

The option to provide the data on portable media unencrypted is available; however, TruBridge recommends that this only be done if the patient specifically requests unencrypted information. If anyone other than the patient is requesting the data, the media should be encrypted to protect against potential HIPAA violations.

If Unencrypted is selected, the following warning will appear. Answering **Yes** to this prompt will allow the data to be copied to the portable media without encryption.

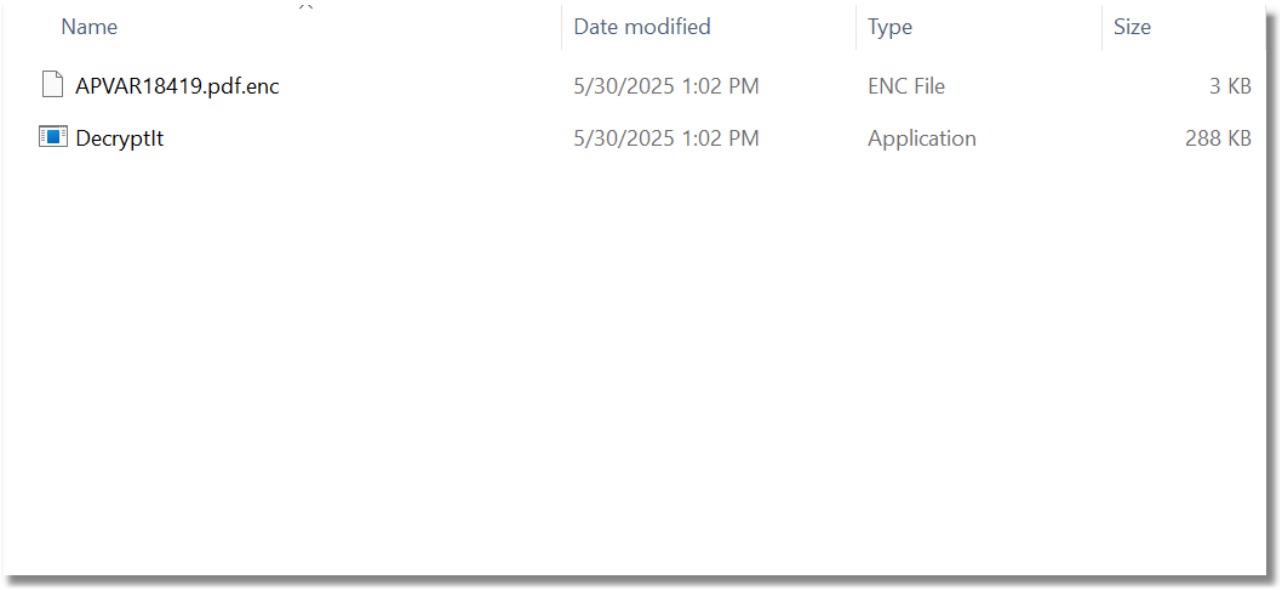


HIPAA Encryption Warning

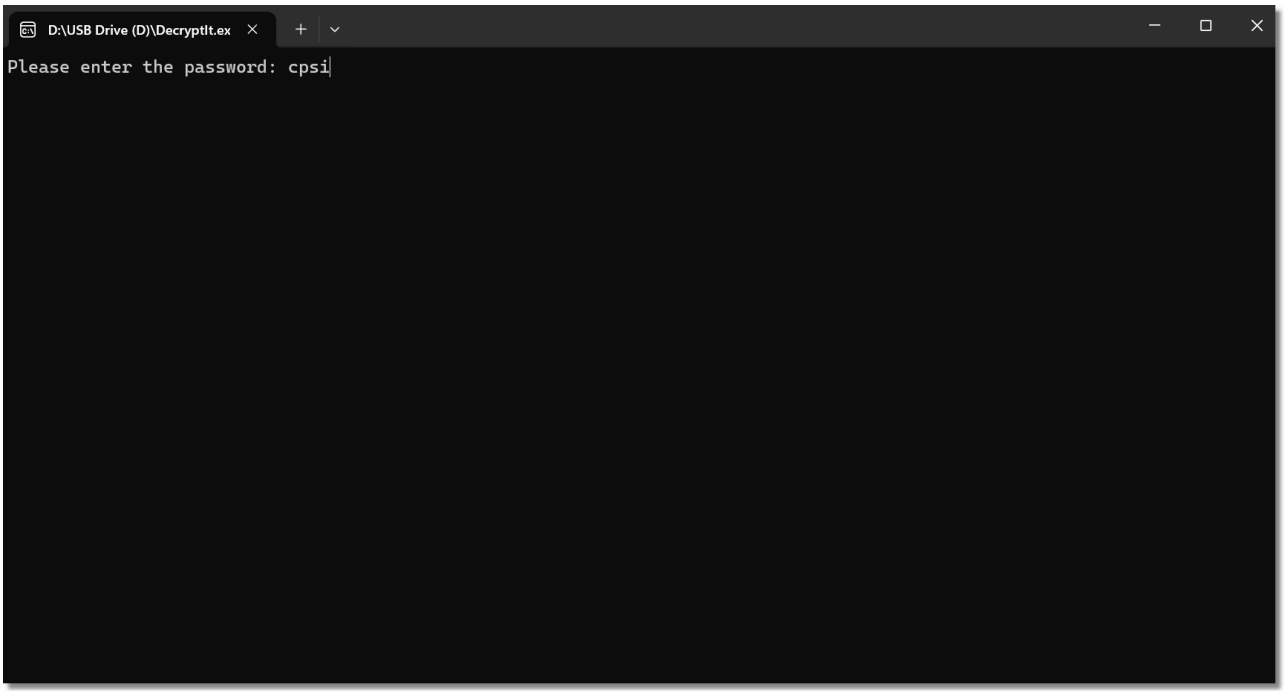
Retrieving Portable Media

Retrieving the file from Portable Media - Data Encrypted

When the patient inserts the Flash Drive in the PC, temporary files will display that cannot be read. To access the encrypted data, the patient must select the DecryptIt file and enter the encryption key provided by the facility.

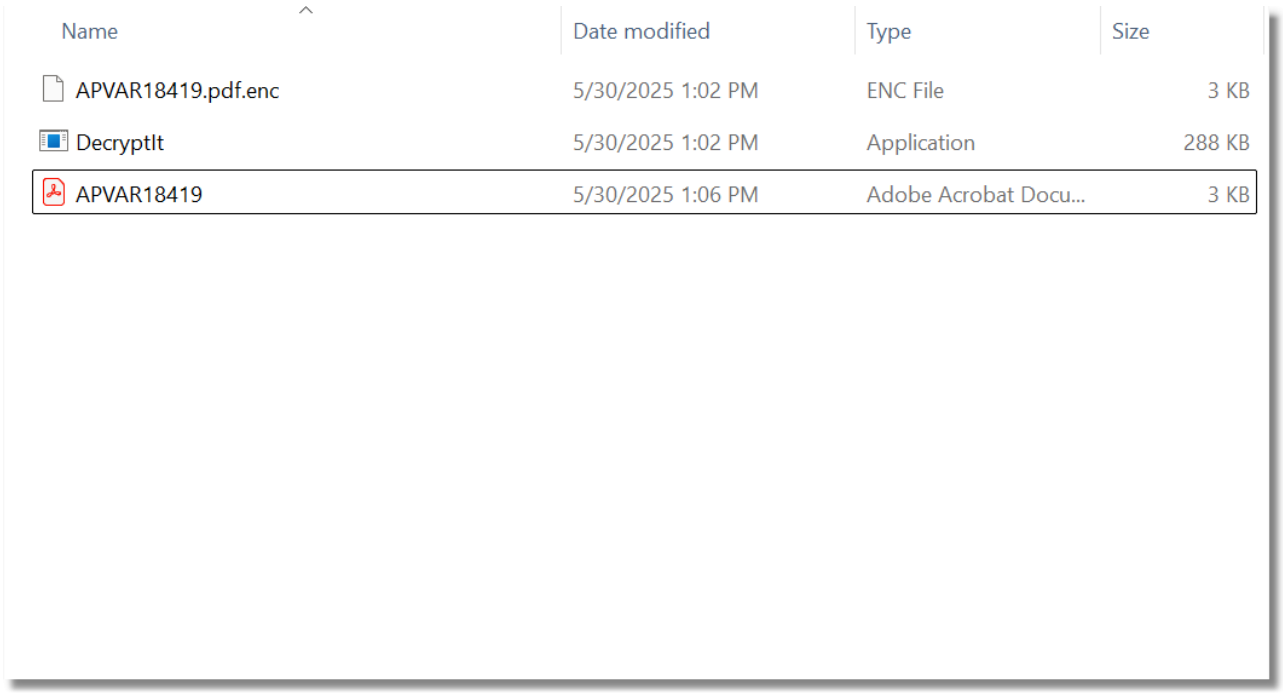


USB Thumb Drive Directory



DecryptIt.exe

At this point, a PDF file will be generated, allowing the patient to view their medical record using Adobe Reader or a compatible PDF viewer.

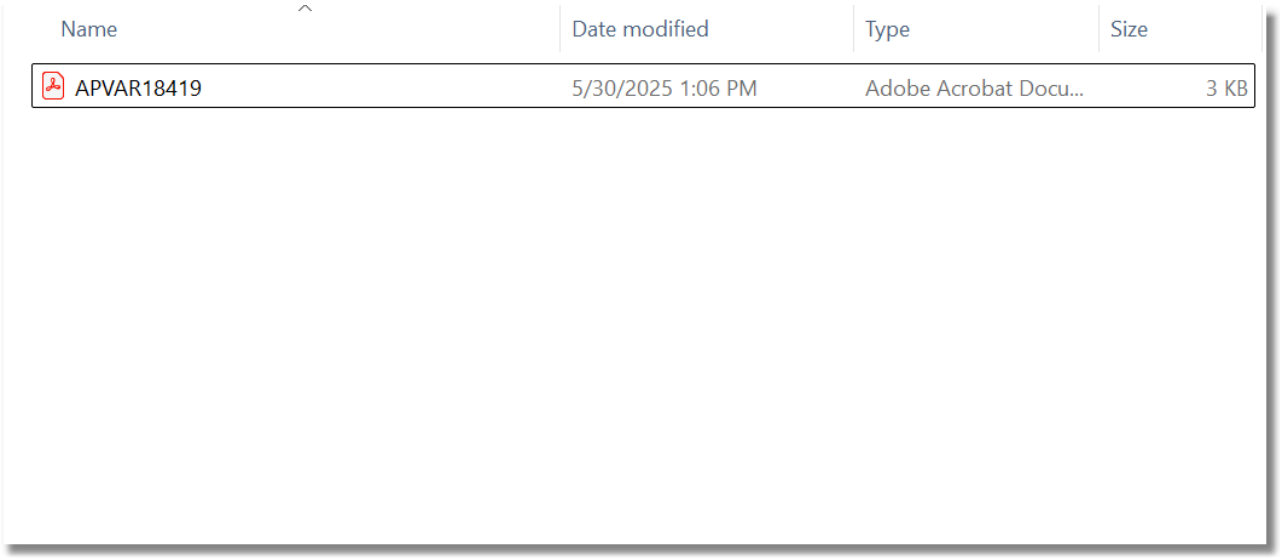


USB Thumb Drive Directory - Data Encrypted

NOTE: *If the Patient Summary is downloaded to Portable Media, it will automatically load and display once the encryption code is entered.*

Retrieving the file from Portable Media - Data Unencrypted

When the patient inserts the Flash Drive in the PC, the PDF file will be displayed, allowing the patient to view the medical record.



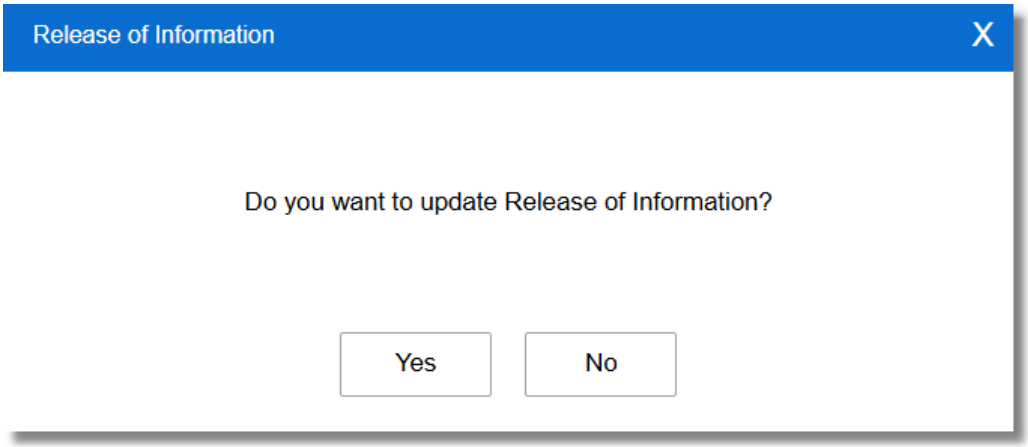
USB Thumb Drive Directory - Data Unencrypted

Updating ROI

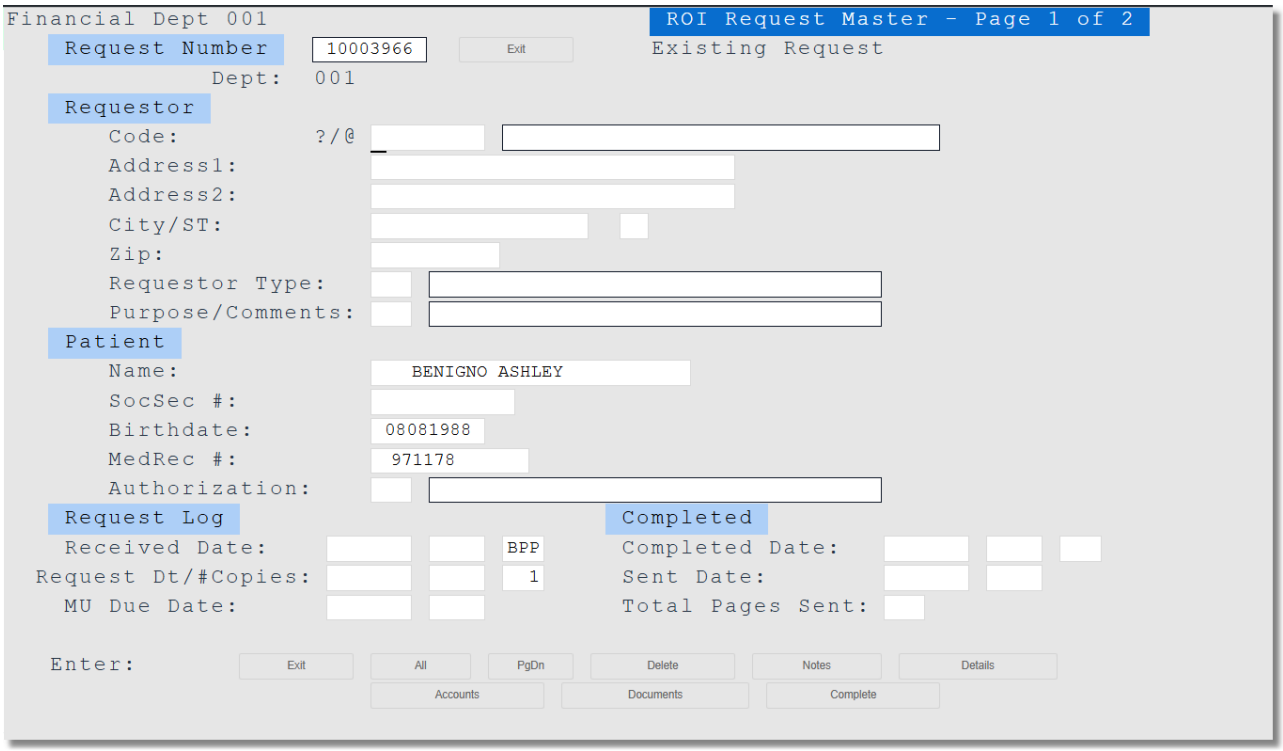
After printing the documents, the system will prompt to update the Release of Information module.

Answering **Yes** will bring up the ROI Request Entry screen. Selecting **No** will not update the ROI module. If answered **Yes**, the new request will be visible in the ROI History Log from the Medical Records application. Updating Release of Information will keep track of what was sent out, and the Authorization Code will pull over to the MU Statistics report to track compliance for Meaningful Use.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Document Code** > **Print Option** > **Print and Exit**



Release of Information



ROI Request Master

Updating Release of Information will create the following entries in the ROI History Log Detail:

- If using **Electronic Signature for Images** and a signed image is released, updating the Release of Information will create a request entrty in the ROI History Log with a Documents Requested Code of **SRV**, indicating the release of a signed image.

- If the **Patient Summary** or **Referral/Transition of Care Summary** is released, two request entries will be added to the ROI History Log:
  - The first entry is automatically created by the system, with a Documents Requested Code of **REF** for an Incomplete CCD or **CCD** fo a Completed CCD.

NOTE: An Incomplete CCD is defined as a Patient Summary or Referral/Transition of Care Summary that does not include Medications, Medication Allergies and Problems or an indication of none. A completed CCD is defined as a Patient Summary or Referral/Transition of Care Summary that has Medications, Medication Allergies and Problems or explicitly states none for each.

  - The second entry is a manual entry with a Documents Requested Code of **ABS,** indicationg the release of the Patient Summary or Referral/Transition of Care Summary.

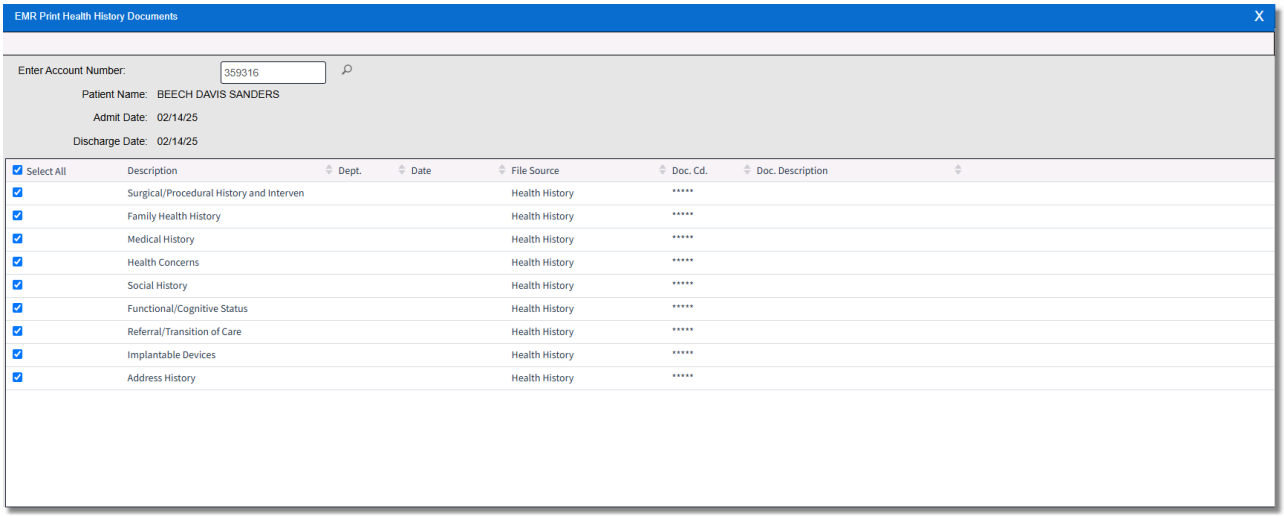
For more information, refer to the Release of Information 281 section of this user guide.

3.5 Health History Documents

Selecting the check-box next to Health History Documents within Print Electronic Medical Record will print all nine sections of the Health History Report at once, with a page break between each section.

To print a specific section(s), double-click the Health History Documents description. A new window will display, showing each individual section of the Health History Reports. Select the check-box next to each section that should be printed. Close the new window by selecting **X** to return to the Print EMR document selection window.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Double-Click Health History Documents**

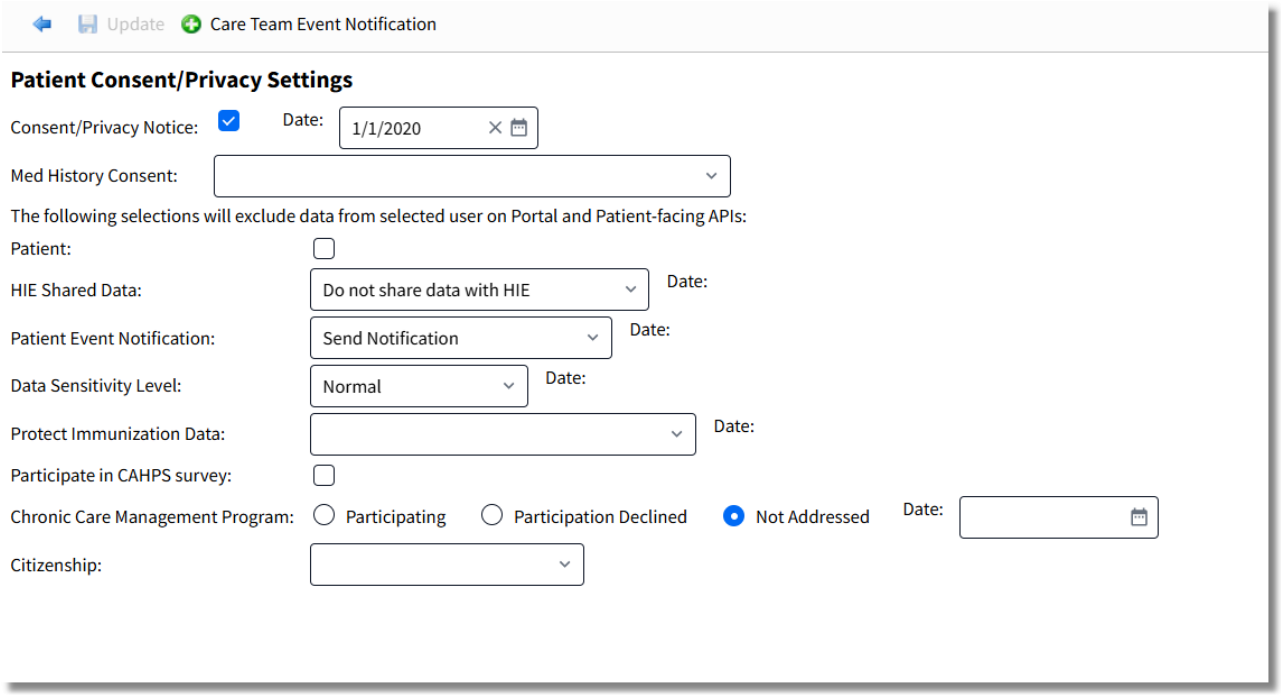


Print EMR - Health History Reports

3.6 Consent/Privacy Settings

The Patient Consent/Privacy Settings screen will allow information regarding the patient's privacy to be captured. There are various other locations in the system where this screen may be accessed.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Consent/Privacy Settings**



Consent/Privacy Settings

Below is an explanation of each field:

- **Consent/Privacy Notice and Date:** Pulls from the Person Profile. Indicates if the patient has signed a privacy notice and the date it was signed.

NOTE: *This field will only be available if the Census Behavior Control "Edit Consent/Privacy Notice" is set to allow.*

- **Med History Consent:** Select the code that represents the consent level to be utilized when retrieving medication history. This field will only be visible if the site has purchased E-Scribe. Select the drop-down box to see the listing. These categories are hard-coded.
  - No consent
  - Parental/Guardian consent from any prescriber
  - Consent given

NOTE: *This field will only be available if the Census Behavior Control "Edit Med History Consent" is set to allow.*

Effective April 5, 2021, the Information Blocking rule prohibits any action or practice that interferes with the access, exchange, or use of an individual's electronic health information (EHI). There are eight exceptions when interference with the access, exchange or use of an individual's EHI would not be considered Information Blocking. To avoid non-compliance, and potential non-compliance penalties, Healthcare providers should ensure that suppression of any patient EHI meets one of the documented exceptions. Questions concerning the Information Blocking rule, and the eight exceptions, may be answered on the ONC's FAQ web page.

The following selection will exclude data from selected user on Portal and Patient-facing APIs:

- **Patient:** Select this option to deny a patient from viewing the Patient Summary or Referral/Transition of Care documents within the Patient Portal. The default for this field is unchecked which allows the Patient Summary or Referral/Transition of Care documents within the Patient Portal to be viewed. This field may also be selected in HIR (Health Information Resource).

- **HIE Shared Data?:** Indicates whether the patient has designated the information from this account as being shareable. The default may be set up in the Medical Record Control Record in the Business Office tables. If this field is answered "Do not share data with HIE", the information will not be shared and therefore not transmitted to a RHIO. If this field is answered "Share data with HIE", the information from this account will be shared and transmitted to a RHIO. This field may also be answered "Share data in emergency only" which indicates no response or unknown. The information in this case will only be shared in the case of an emergency. A date will display next to this field to reflect the last time a change was made.

- **Patient Event Notification:** Indicates if a patient has opted in or out from having their Care Team members notified of their admission/discharge/transfer from a facility. The options for this field are **Send Notification** and **Do Not Send Notification**. When a new visit is created, this field will default to Send Notification. The Date next to this field will only be captured if this field is accessed or changed.

- **Data Sensitivity Level:** Indicates the sensitivity level of the patient's data. This field will default to **Normal**, but may also be set to **Restrictive**, or **Very Restrictive**. A date will display next to this field when it has been updated.

- **Protect Immunization Data:** Indicates if the patient's immunization data may be shared. The options for this field are **Y - Protect Data, do no share**, and **N - not protected, can be shared**. A date will display next to this field when it has been updated.

- **Participate in CAHPS survey:** When selected, indicates that the patient is willing to participate in the OAS CAHPS survey.

- **Chronic Care Management Program:** Select if the patient is participating in a Chronic Care Management program or not. If Participating or Participation Declined is selected, a date will also need to be added as to when the patient was asked. This field will default to Not Addressed.

- **Citizenship:** Select the patient's immigration status. The options are:
  - 01 US citizen
  - 02 Lawfully in U.S.
  - 03 Unlawfully in U.S.
  - 04 Declined to answer

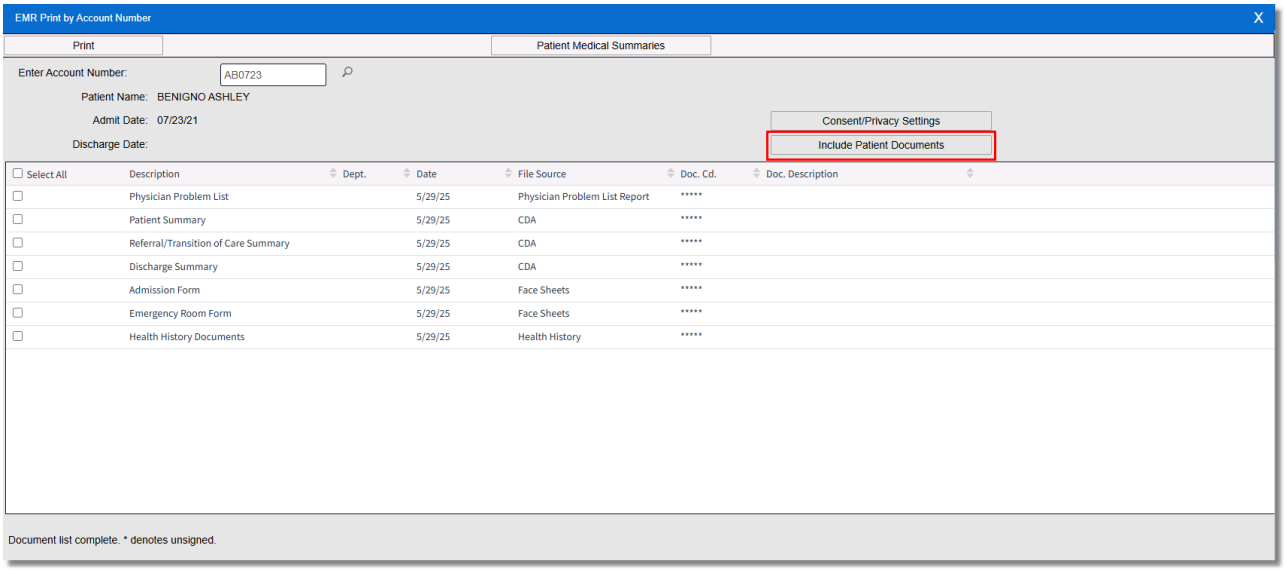
Select **Update** on the action bar once all necessary information has been captured. Select the **back arrow** to return to the Print Electronic Record screen.

Care Team Event Notification may be selected from the action bar and will display a listing of added physicians the patient has requested to be notified when they are admitted, discharged or transferred from the facility. Physicians may also be added, edited or deleted from this screen as well. For more information, refer to the Person Profile and Registration user guide.

3.7 Include Patient Documents

The **Include Patient Documents** option is available when printing EMR documents by Account 22 or Medical Record Number 24. Selecting this option will add all documents linked to the patient from the Communications Center and the Document Management System (DMS) to the current document list so the documents may be included when printing. These are the same documents displayed when printing EMR documents by Patient 29. These documents are not linked to a specific account, but are instead linked with the patient's Profile.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account or Medical Record Number**



EMR Print by Account

3.8 Patient Medical Summaries - CCDA

Please see the Patient Medical Summaries - CCDA user guide on TruLearn.

Chapter 4 HIM Coding Worklist

4.1 Overview

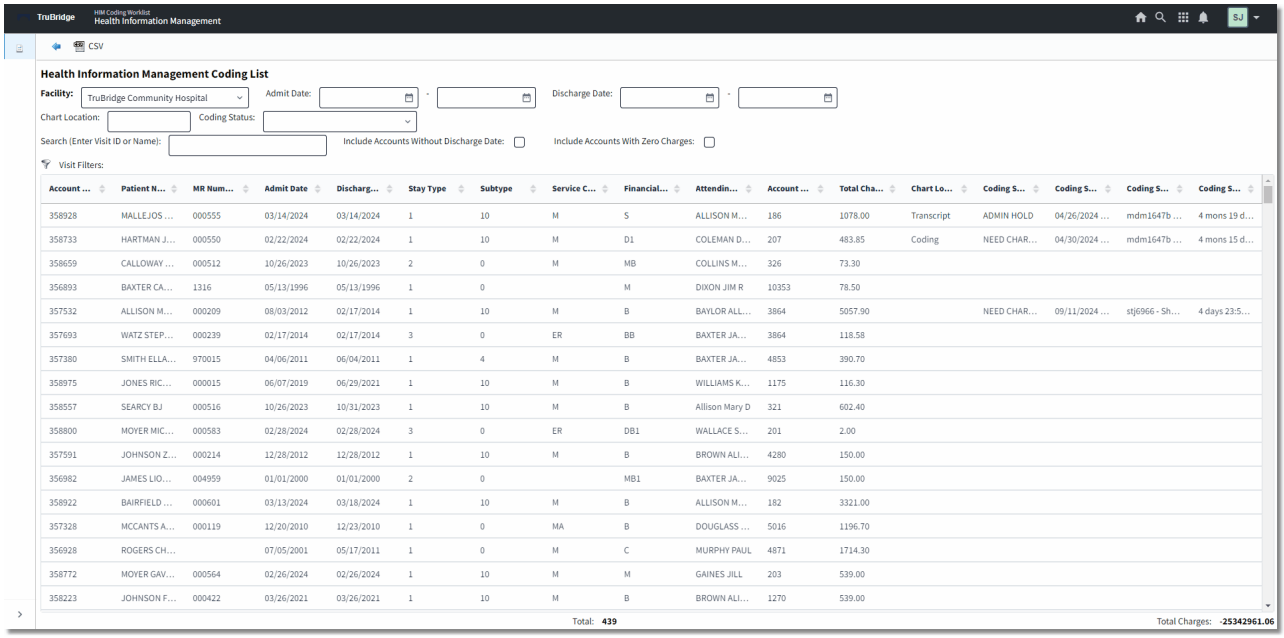
The HIM Coding Worklist offers a streamlined and effective solution for coding patient accounts. By utilizing a customizable, queue-based approach, the HIM Coding Worklist enhances and optimizes the medical records coding workflow.

4.2 HIM Coding List

The criteria that must be met to allow an account to drop into the HIM Coding Worklist are as follows:

- Have a Discharge Date
- No Contract Code
- No Medical Records Finish Date
- Total Charges Greater than $0

Select **Web Client** > **Application Drawer** > **HIM Coding Worklist**



HIM Coding List Screen

Below is an explanation of each column:

- **Account Number:** Pulls from Registration and ADT screen.
- **Patient Name:** Pulls from the Patient tab on the Registration and ADT screen.
- **MR Number (Medical Record Number):** Pulls from the Patient tab on the Registration and ADT screen.

- **Admit Date:** Pulls from the Stay tab on the Registration and ADT screen.
- **Discharge Date:** Pulls from the Stay tab on the Registration and ADT screen.
- **Stay Type:** Pulls from the Patient tab on the Registration and ADT screen.
- **Sub Type:** Pulls from the Patient tab on the Registration and ADT screen.
- **Service Code:** Pulls from the Patient tab on the Registration and ADT screen.
- **Financial Class:** Pulls from Guarantor/Ins tab on the Registration and ADT screen.
- **Attending Physician:** Pulls from Stay tab on the Registration and ADT screen.
- **Account Age:** Pulls the number of days since discharge.
- **Total Charges:** Pulls the total charges from the account detail.
- **Chart Location:** The current location of the patient's chart.
- **Coding Status:** The current coding status assigned to the patient's chart.
- **Coding Status Changed Date:** Pulls the current coding status was changed.
- **Coding Status Changed By:** Pulls the most current user login who assigned the current coding status to the patient's chart.
- **Coding Status Elapsed Time:** Pulls the length of time the current coding status has been assigned to the patient's chart.

Search Parameters

Various search parameters and filters are available on this screen.

- **Facility:** Users may select which specific facilities they wish to code in when working with multiple facilities.
- **Admit Date:** Dates may be entered to filter and display accounts admitted within a designated date range.
- **Discharge Date:** Dates may be entered to filter and display accounts discharged within a designated date range.
- **Chart Location:** Entering a specific Chart Location will display accounts currently assigned to that location through the Chart Location application.
- **Coding Status:** Choosing a specific Coding Status will display accounts assigned to that status.
- **Search (Enter Visit ID or Name):** Specific charts may be searched using either the patient account number or patient name.

- **Include Accounts Without Discharge Date:** This option may be selected to display accounts that have NOT been discharged. By default, the HIM Coding Worklist shows only accounts that have been discharged.
- **Included Accounts with Zero Charges:** This option may be selected to display accounts with zero-dollar charges. By default, the HIM Coding Worklist shows only accounts with charges.
- **Filter:** If wanting to further refine the list, Filter Builder queries may be created by selecting the  filter option. Please refer to the Filter Builder document for more information regarding how to add and/or create custom filters.

CSV Option

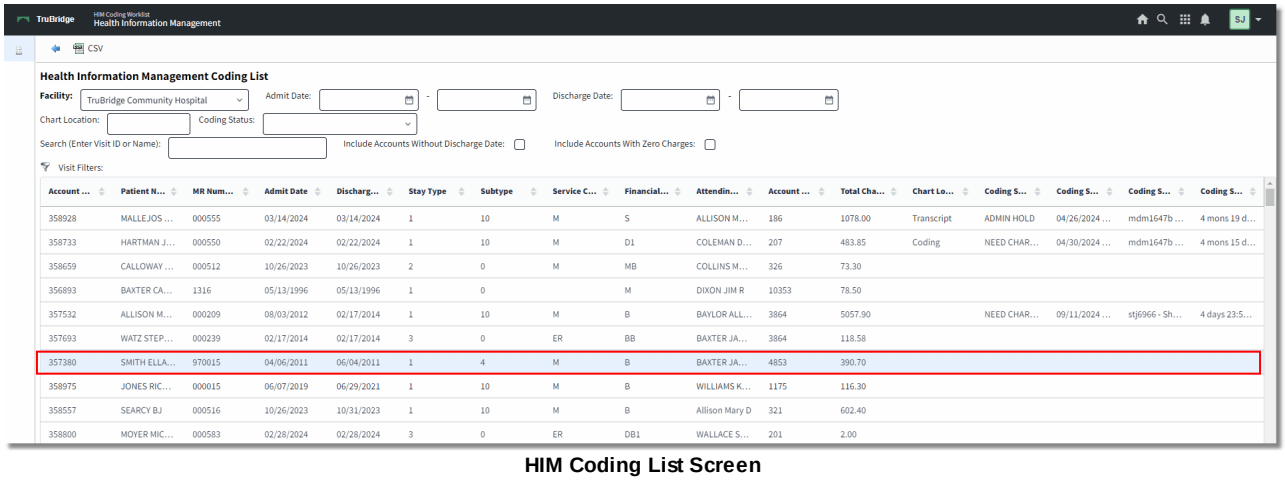
The 

CSV Option may be selected to take the information displayed on the screen and export it into Excel.

Totals

- **Total:** Displays the total amount of accounts listed on screen. This number will change if any search parameters are used.
- **Total Charges:** Displays the grand total for the charges listed on the screen. This number will change if any search parameters are used.

A specific account may be selected from the HIM Coding Worklist to display a patient's chart. To view the chart, select the patient's account.

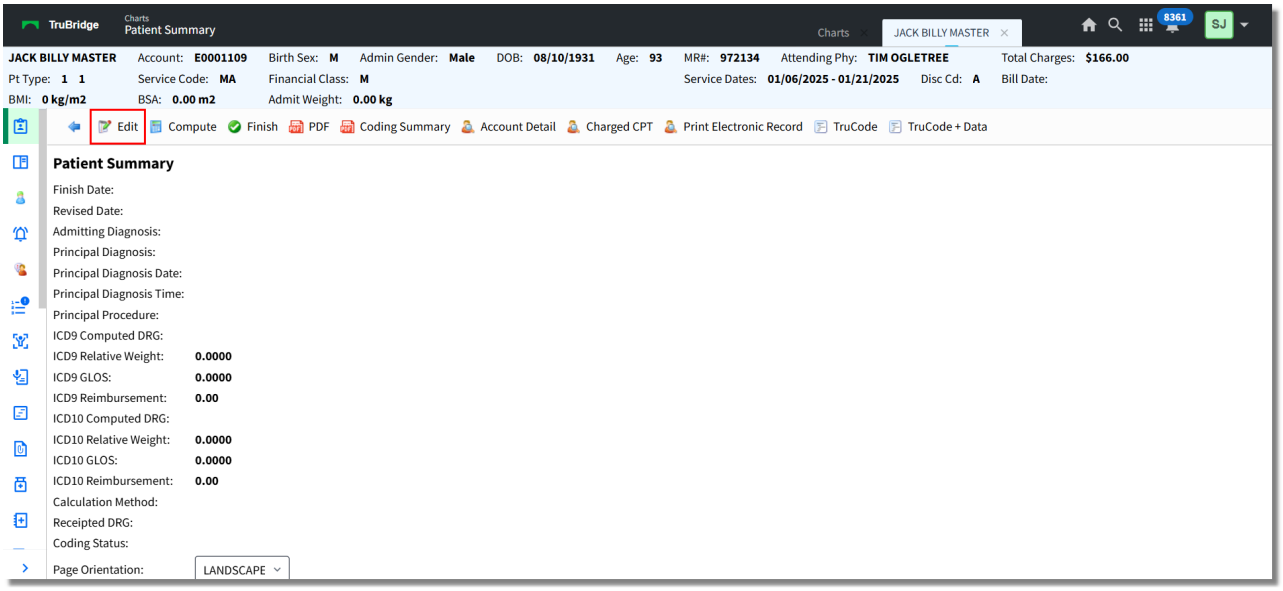


HIM Coding List Screen

4.3 Adding a Coding Status

The Coding Status may be updated from the Patient Summary screen once the patient's chart has been accessed from either the Medical Records main menu, the Home Screen, or the HIM Coding Worklist. To update the Coding Status select **Edit** from the Patient Summary.

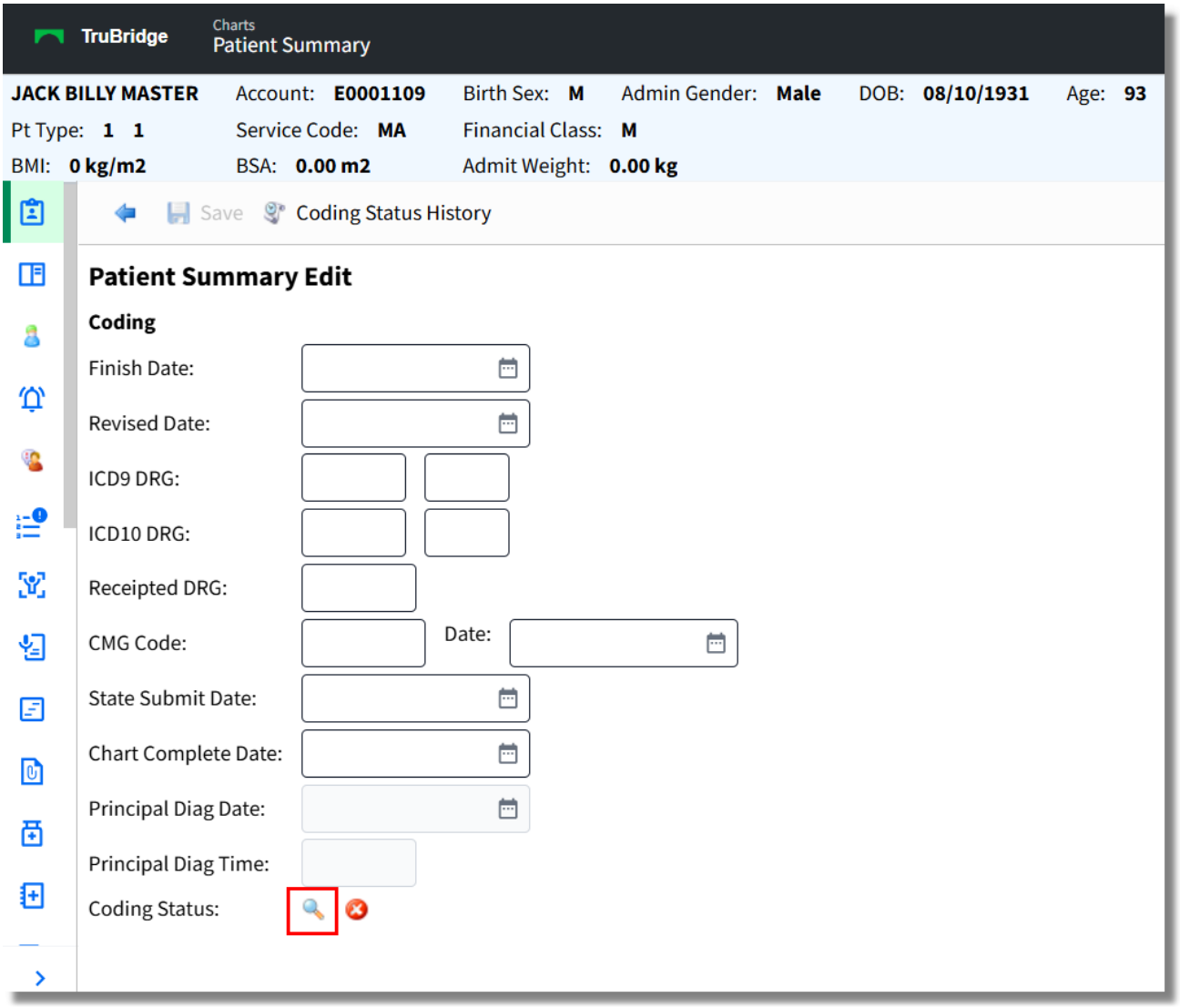
Select **Web Client** > **System Menu** > **Patient Account #** > **Medical Records** > **Grouper**



Patient Summary

Once Edit is selected, the Patient Summary Edit screen will display. To select a Coding Status, select the **magnifying glass** icon.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Edit**

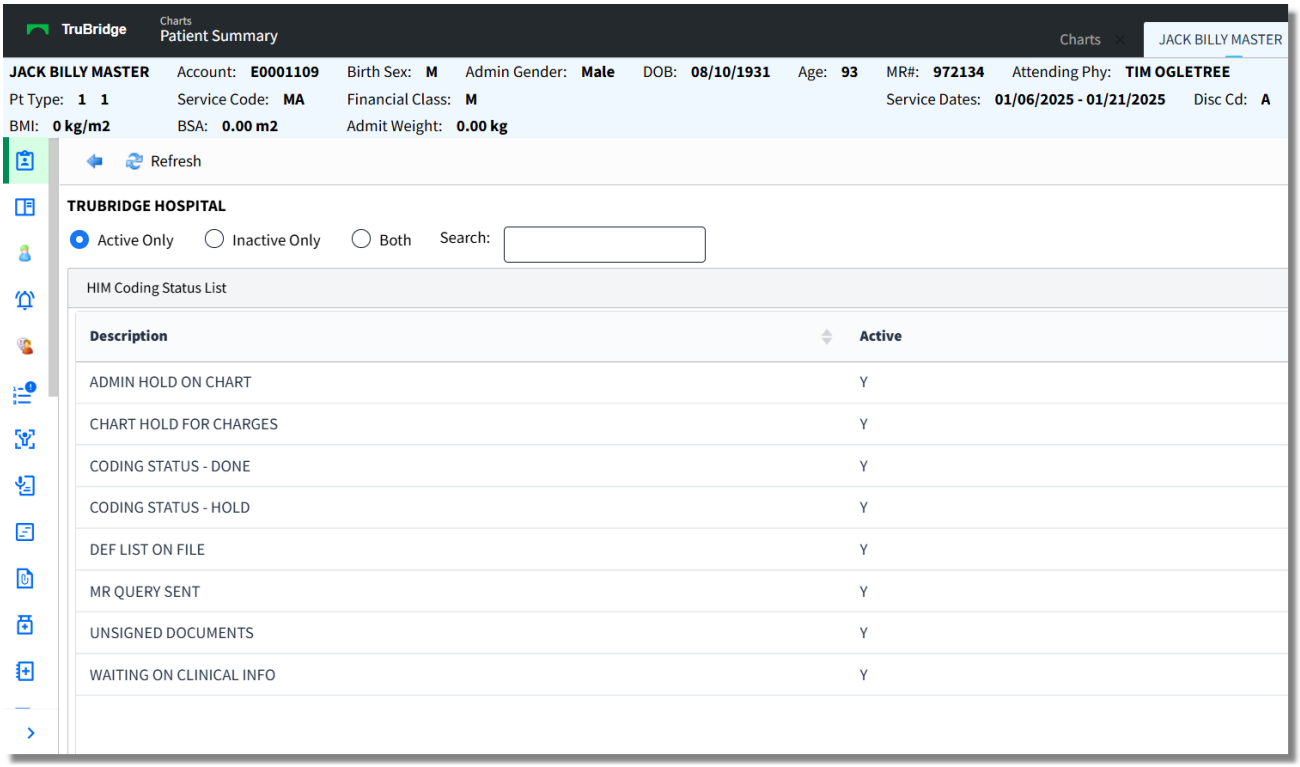


Patient Summary Edit

Once the magnifying glass icon is selected, the HIM Coding Status List will display. To add a coding status to the patient's chart, double-click on the applicable Coding Status.

NOTE: *The displayed statues are user-defined and set up in the Coding Status table. Please refer to the Table Maintenance - HIM User Guide for more information on how to add and/or edit Coding Statuses.*

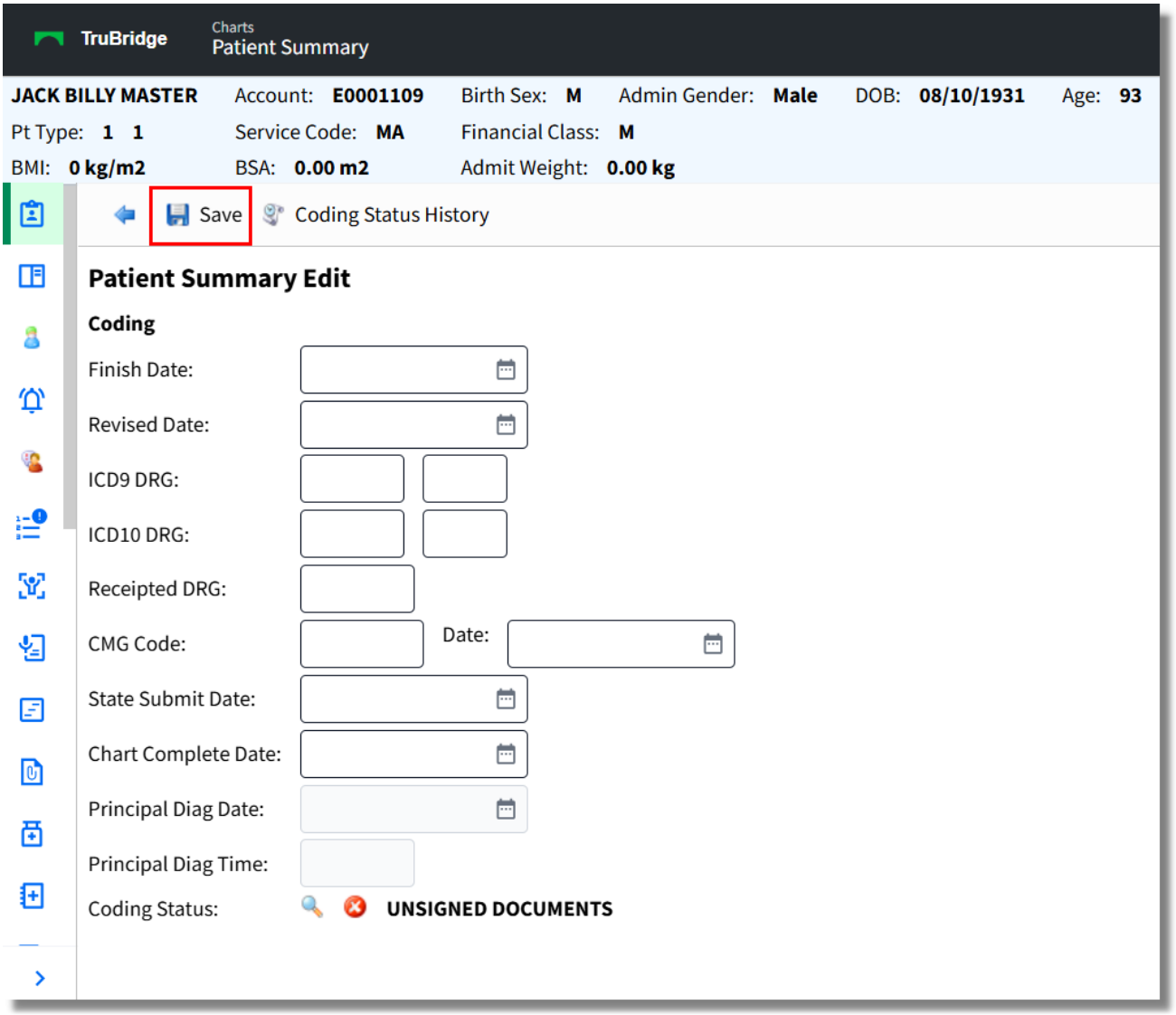
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Edit** > **Coding Status**



HIM Coding Status List

If any changes are made, select **Save**. Then select the **Back Arrow** to return to the Patient Summary screen.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Edit**

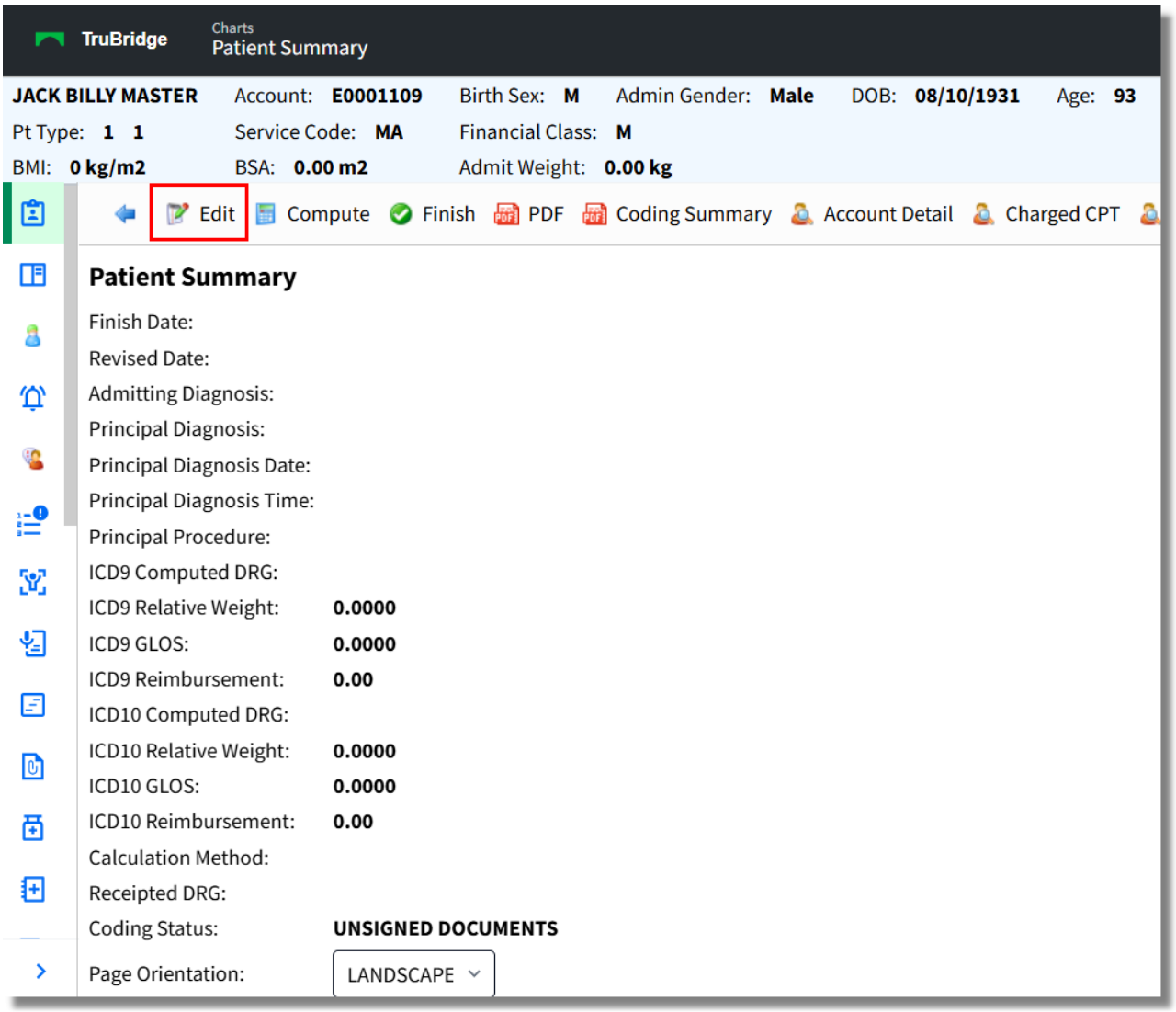


Patient Summary Edit

4.4 Removing a Coding Status

The Coding Status may be removed from the Patient Summary screen once the patient's chart has been accessed from either the Medical Records main menu, the Home Screen, or the HIM Coding Worklist. To remove the Coding Status select **Edit** from the Patient Summary.

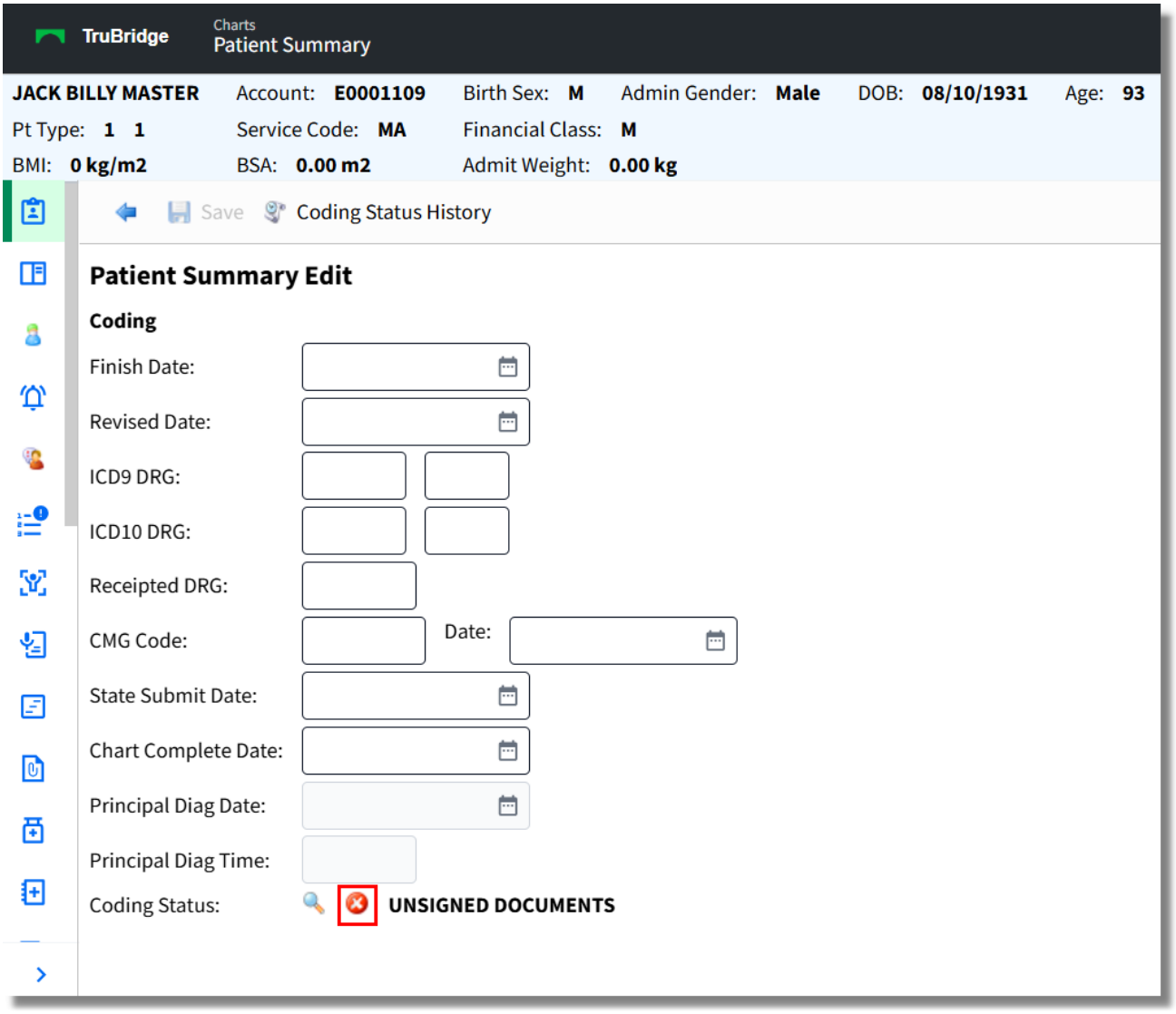
Select **Web Client** > **System Menu** > **Patient Account #** > **Medical Records** > **Grouper**



Patient Summary

Once Edit is selected, the Patient Summary Edit screen will display. To remove the Coding Status, select the **red 'X'** icon and then select **Save**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Edit**



Patient Summary Edit

Once **Save** is selected, the previously listed coding status will be removed from the Coding Status field.

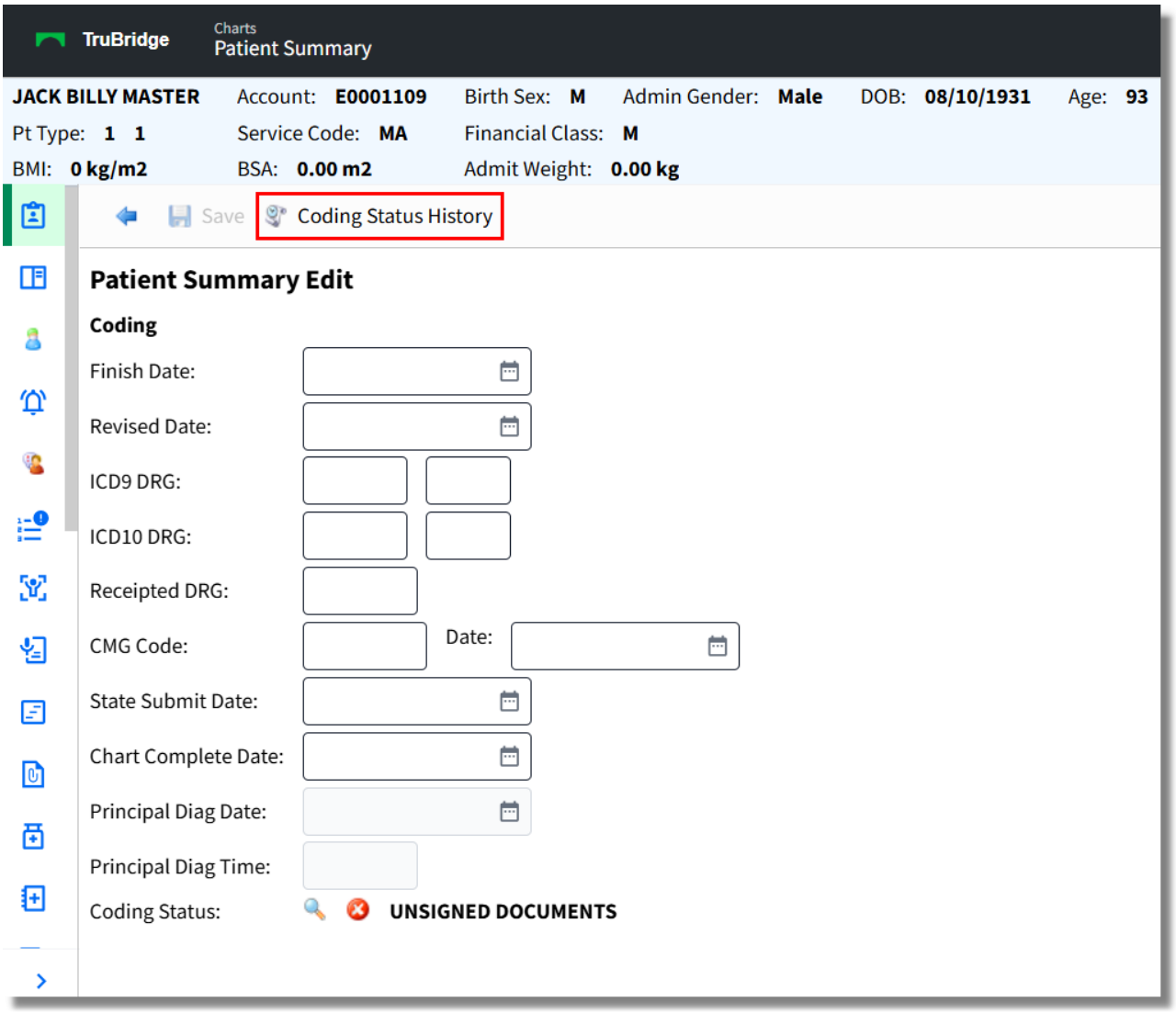
NOTE: *Each time the coding status is updated, a record of the change will be added to the Coding Status History will be recorded. Please refer to the* *Coding Status History* 49 *section for more information on Coding Status History.*

4.5 Coding Status History

The Coding Status History will update each time the coding status is changed. To access the history, select **Coding Status History** on the Patient Summary Edit screen.

***NOTE**: The words 'Coding Status' can also be selected to view the coding status history.*

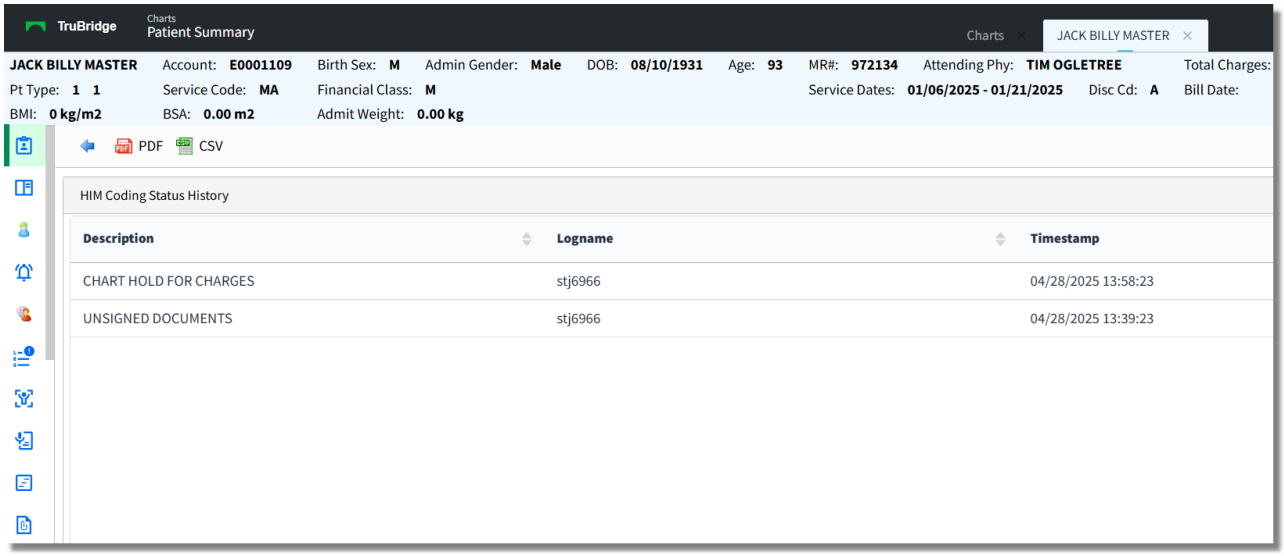
Select **Web Client** > **System Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Edit**



Patient Summary Edit

Once Coding Status History has been selected, a history of the coding status changes will display.

Select **Web Client** > **System Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Edit** > **Coding Status History**



HIM Coding Status History

Below is an explanation of each column:

- **Description:** Pulls the coding statuses assigned to the patient's chart.
- **Logname:** Pulls the user's login who assigned the coding status.
- **Timestamp:** Pulls the date and time the coding status was updated.

Below is an explanation of the options available on the Action Bar:

- **PDF:** Exports the HIM Coding Status History displayed in a printed format in Adobe Acrobat.
- **CSV:** Exports the HIM Coding Status History displayed into a comma-separated values (CSV) file, which can be opened in Microsoft Excel.

Chapter 5 Grouper

5.1 Overview

The Grouper is be used to code patient accounts within TruBridge EHR. It allows all diagnosis, procedure, and DRG reimbursement information to be entered and stored directly on the patient account.

There are two versions of the Grouper screen:

Medical Records Grouper
- Displays the coding information entered by the Medical Records.
- Information entered here will automatically copy to the Insurance Grouper.

Insurance Grouper
- Displays the diagnosis and procedure information originally entered by Medical Records.
- Information displayed here may be edited to change the diagnosis and procedure information that displays on the insurance claim.
- Changes made on the Insurance Grouper will not copy back to the Medical Records Grouper.

Depending on the user's assigned security, the Grouper screens may be view-only or allow maintenance access. The path to access Behavior Control rules for a login is: **Web Client > System Administration > Logins > select a Login > Behavior Controls**.

Listed below are the combinations of behavior controls that may be used to assign access to the Grouper.

- Coders that require view only access to the Medical Records Grouper should be given the following behavior controls.
  - **Code by HIM** set to **Allow**
  - No rule for **Edit HIM Diagnosis and Procedure Information** -or- **Edit HIM Diagnosis and Procedure Information** set to **Deny***

- Coders that require access to view and edit the Medical Records Grouper should be given the following behavior controls:
  - **Code by HIM** set to **Allow**
  - **Edit HIM Diagnosis and Procedure Information** set to **Allow***

- Coders that require access to view and edit the Medical Records Grouper AND access to view the Insurance Grouper should be given the following behavior controls:
  - **Code by HIM** set to **Allow**
  - **Edit HIM Diagnosis and Procedure Information** set to **Allow***
  - **Code by Insurance** set to **Allow**

- Coders that require access to view and edit BOTH the Medical Records Grouper AND the Insurance Grouper should be given the following behavior controls:
  - **Code by HIM** set to **Allow**
  - **Code by Insurance** set to **Allow**
  - **Edit HIM Diagnosis and Procedure Information** set to **Allow***
  - **Edit Non-HIM Diagnosis and Procedure Information** set to **Allow**

- If the user's login is not assigned to the Health Information Management role, additional Applications access must be assigned. The path to access the Application rules for a login is: **Web Client > Application Drawer > System Administration > Logins > select a Login > Applications**.
  - **Coding** set to **Allow**
  - **Health Information Management** set to **Allow**
  - **Table Maintenance** set to **Allow****

***NOTE**: The coding behavior control for Edit HIM Diagnosis and Procedure Codes is automatically set to Allow for users in the Health Information Management role by default.*

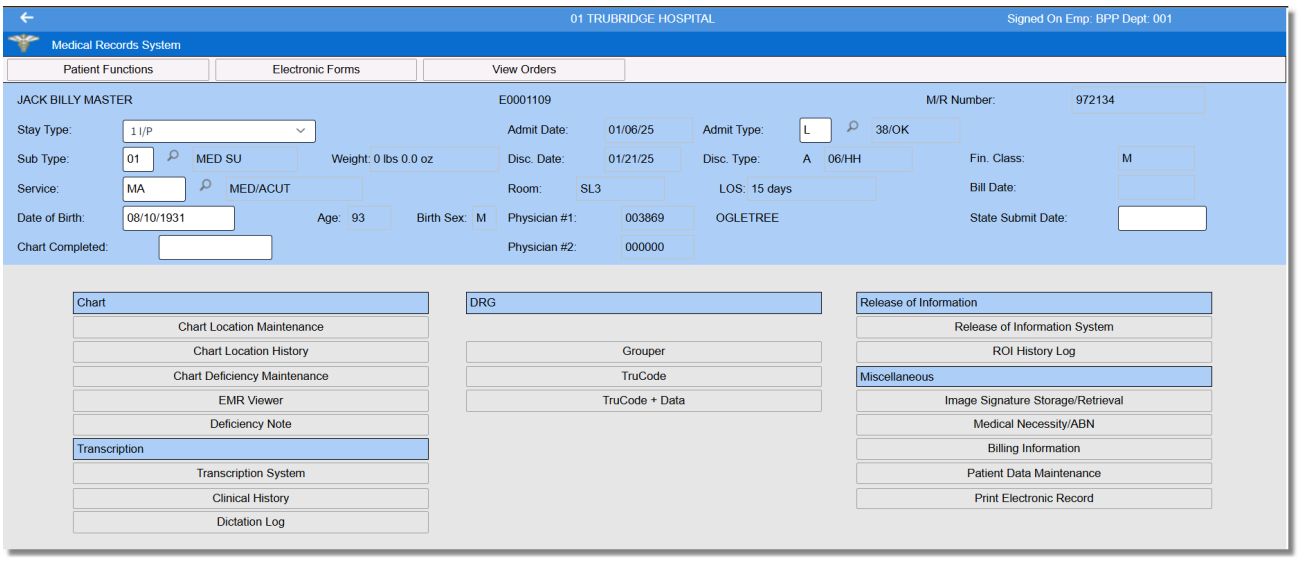
***NOTE:** Access to the Table Maintenance application is only necessary if the user needs the ability to edit the Medical Records or Insurance Grouper.*

5.2 Accessing the Grouper

There are currently two ways to access the Grouper. Once the Grouper has been access the Patient Summary screen will display.

The first option is to lock onto a patient account number and choose **Medical Records** from the Patient Functions menu then select **Grouper**. When choosing this option, coding may be updated for this particular account.

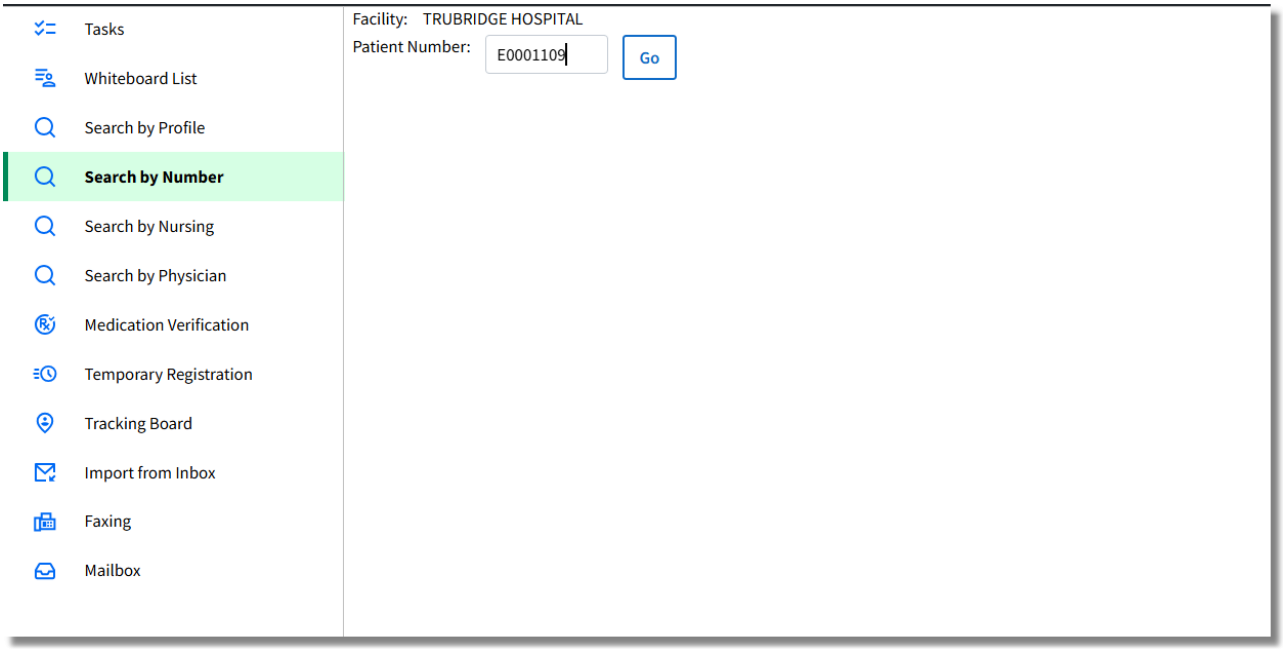
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper**



Medical Records System

The second option is to access the patient account from the Home Screen. This method should be used when coding multiple patient accounts at one time. From the Home Screen, select **Charts**, then choose the method to search for the correct patient chart (ex. Search by Number).

Select **Web Client** > **Charts** > **Navigation Panel** > **Search by Number** > **Patient Account #** > **Grouper**



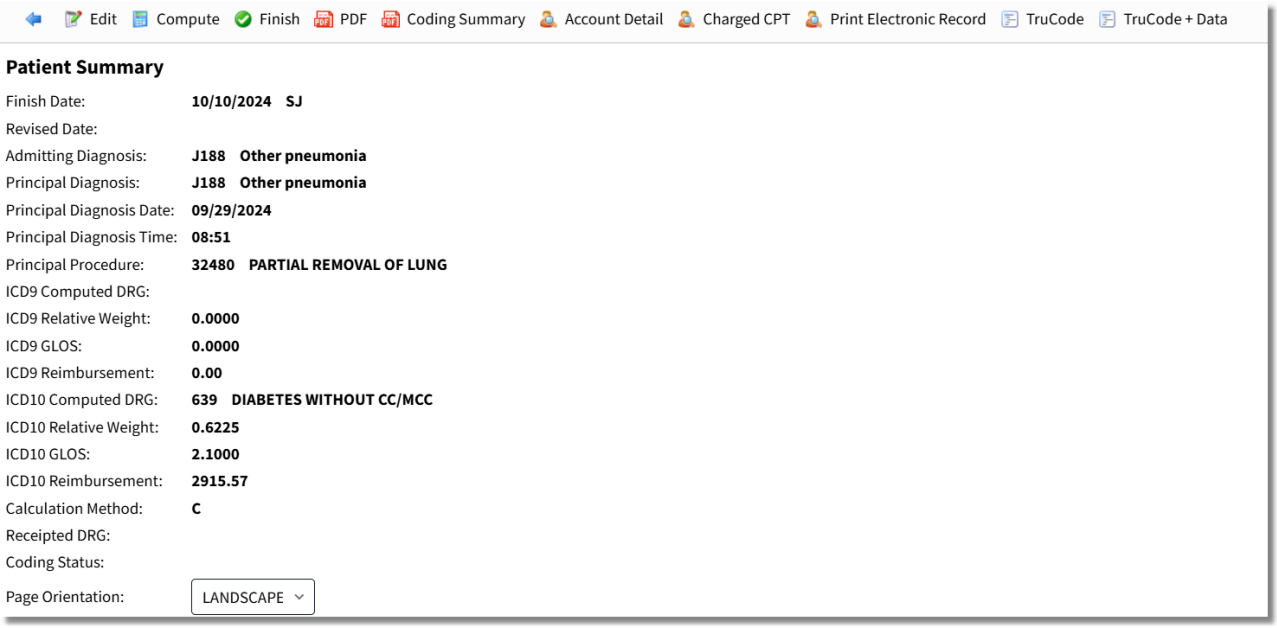
Charts - Search by Number

***NOTE**: The UBL must be assigned to the Health Information Management role in order to access the Grouper from the Home Screen.*

5.3 Patient Summary

Once the Grouper has been accessed from either the Medical Records main menu or Charts, the Patient Summary will be displayed. The Patient Summary provides a summary of the coding entered on the account. It also displays the Finish Date and Revised Date, as well as the Computed DRG, Calculation Method and Receipted DRG.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary**



Patient Summary

- **Finish Date:** Displays the date that coding was completed on the account. The Finish Date and Coder name and login will automatically populate when **Finish** is select from the action bar. This field directly affects the auto-generation of insurance claims. If the Insurance Company Table page 1, M/R Complete field is set to **Y**, a Finish Date will be required before the claim will be auto-generated. This field also prints on medical record and insurance reports.

- **Revised Date:** Displays the date that revisions were made after the Finish Date was populated. The Revised Date and Coder Initials will automatically populate when **Finish** is selected from the action bar and the Finish Date has been previously populated. This allows the original coder's name and login and date to be retained and give accountability for revisions.

- **Admitting Diagnosis:** If an admitting diagnosis code is entered on the Diagnoses screen, it will be displayed in this field. If not, the system will default to the code entered as the Principal Diagnosis.

- **Principal Diagnosis:** The principal diagnosis entered on the Diagnoses screen will be displayed in this field.

- **Principal Diagnosis Date**: After a the principal diagnosis is coded, the principal diagnosis date will default to the patient's admission date but may be updated by selecting Edit on the Patient Summary screen. The diagnosis onset date will be captured to meet the Meaningful Use Healthcare Survey requirement.

- **Principal Diagnosis Time**: After the principal diagnosis is coded, the principal diagnosis time will default to the patient's admission time but may be updated by selecting Edit on the Patient Summary screen. The diagnosis onset time will be captured to meet the Meaningful Use Healthcare Survey requirement.

- **Principal Procedure:** The principal procedure entered on the Procedures screen will be displayed in this field.

- **ICD9 Computed DRG:** Displays the DRG that is calculated using the official ICD-9 coding guidelines. The DRG may be computed by selecting **Compute** on the action bar.

NOTE: *A warning will appear if there is an interface between TruBridge EHR and any coding software. The interface information should be entered in AHIS page 6, M/R Code Finder field. When* ***Compute*** *is selected, the following warning will appear: "DRG and Reimbursement calculated through interface. Do you wish to continue?" A response of* ***Y*** *will continue with the calculation, and a response of* ***N*** *will stop the computation.*

- **ICD9 Relative Weight:** Displays the Relative Weight associated with the ICD-9 Computed DRG

- **ICD9 GLOS:** Displays the GLOS associated with the ICD-9 Computed DRG

- **ICD9 Reimbursement:** Displays the expected reimbursement associated with the ICD-9 Computed DRG

- **ICD10 Computed DRG:** Displays the DRG that is calculated using the official ICD-10 coding guidelines. The DRG may be computed by selecting **Compute** on the action bar.

- **ICD10 Relative Weight:** TDisplays the Relative Weight associated with the ICD-10 Computed DRG

- **ICD10 GLOS:** Displays the GLOS associated with the ICD-10 Computed DRG

- **ICD10 Reimbursement:** Displays the expected reimbursement associated with the ICD-10 Computed DRG

- **Calculation Method:** This field will display a **C** if the DRG is computed in TruBridge EHR using the Compute option. This field will display an **A** if the DRG Autocompute option is used to compute the DRG from the Medical Records Print Report Menu. This field will display an **I** if the DRG was brought into TruBridge EHR from an Interface.

- **Receipted DRG:** Displays the actual DRG paid by the intermediary and entered during receipt entry

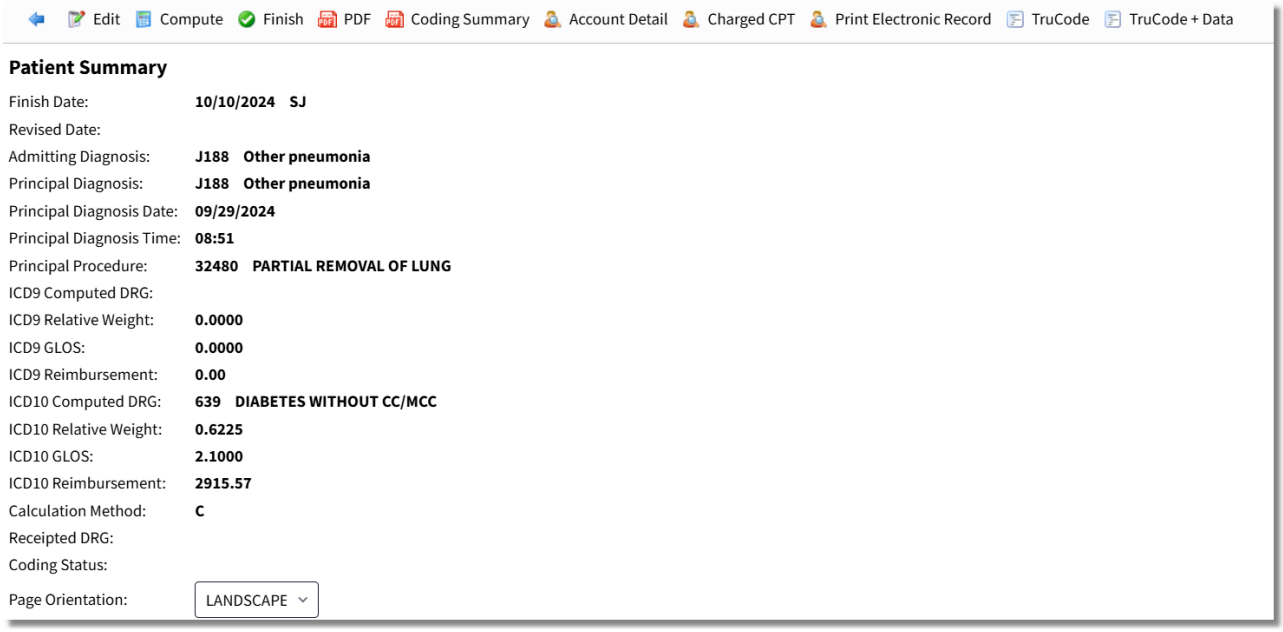
- **Coding Status:** Displays the current coding status assigned to the patient's chart.

- **Page Orientation:** Use the drop-down to select the orientation in which the Patient Summary will be printed in PDF format.
  - **Landscape**
  - **Portrait**

Edit

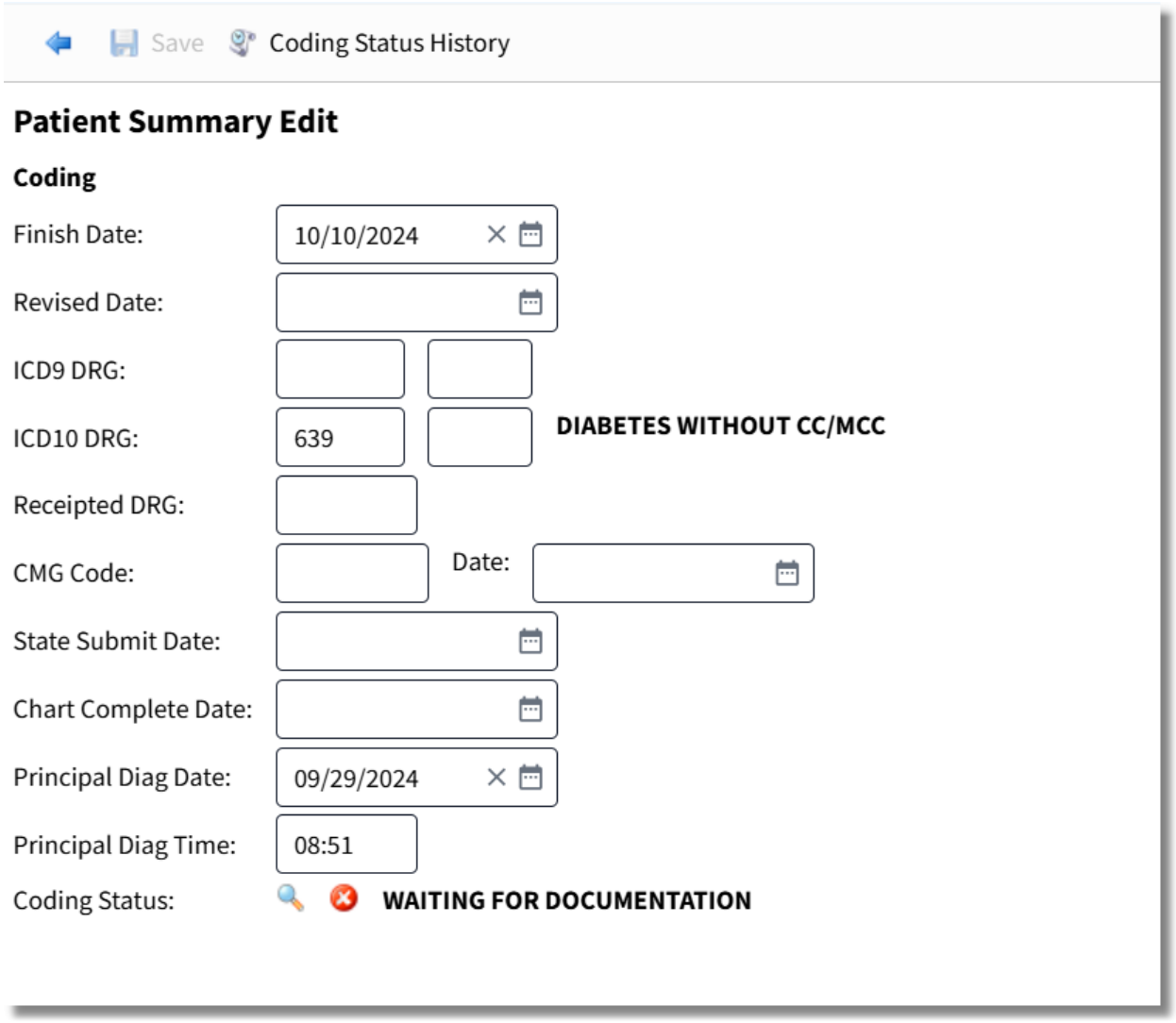
Some fields on the Patient Summary screen may be modified by selecting **Edit** on the action bar.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary**



Patient Summary - Edit

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary** > **Edit**



Patient Summary - Edit

The Finish Date, Revised Date, ICD-9 DRG, ICD-10 DRG and Receipted DRG may be changed on the **Patient Summary Edit** screen. It will also allow the Case Mix Group Code to be added.

- **CMG (Case Mix Group) Code/Date**: Aids in the filing of Inpatient Rehab PPS claims. The Date field is required by CMS. Enter the date of transmission of the IRF. This date will then be recoded in the Service Date/Assessment Date field on the UB04.
- **State Submit Date**: This field is used for New Jersey state abstracting.
- **Chart Complete Date**: This field is the date that all deficiencies were completed on the chart. For more information see Removing Deficiencies after Completion 241.
- **Principal Diagnosis Date**: This date will default to the patient's admission date, but may be changed here.

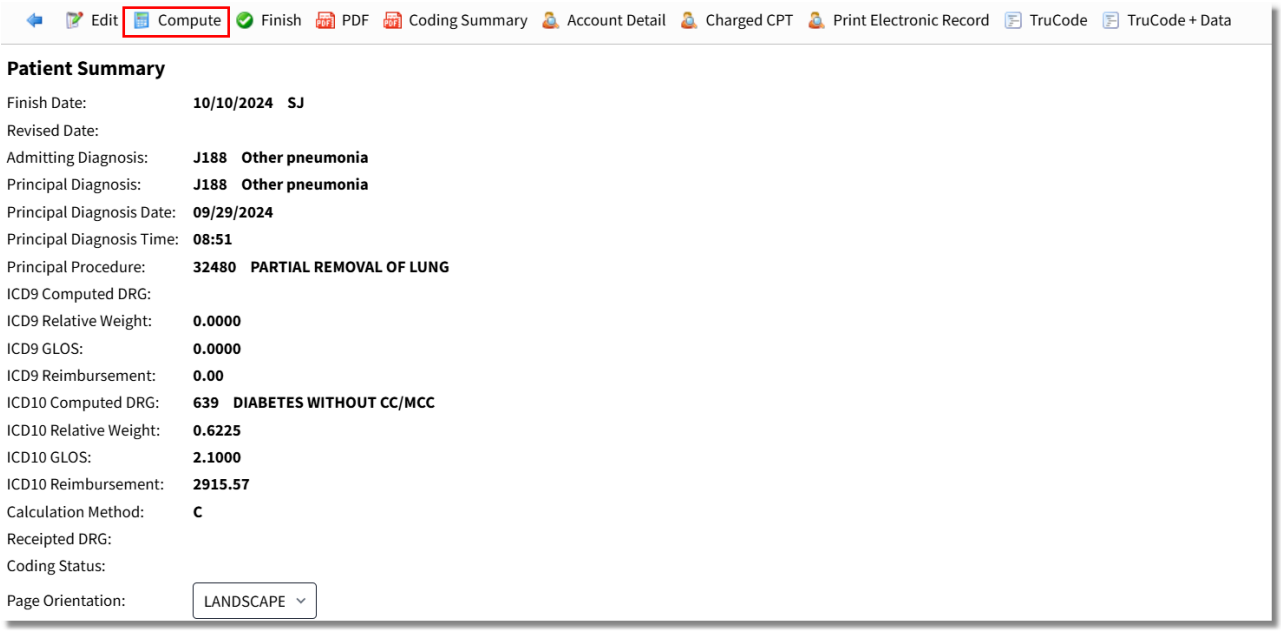
- **Principal Diagnosis Time:** This time will default to the patient's admission time, but may be changed here.
- **Coding Status:** This field is used to assign a Coding Status to the patient's chart. For more information see Adding a Coding Status 44 or Removing a Coding Status 48.

Once changes are made, select **Save** on the action bar. Select the **Back Arrow** to return to the Patient Summary screen.

Compute

The Compute option will calculate the DRG within TruBridge EHR and update the DRG field on the Patient Summary 55 screen. The Compute option may be selected from the Patient Summary, Diagnosis, and Procedures screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary** > **Compute**

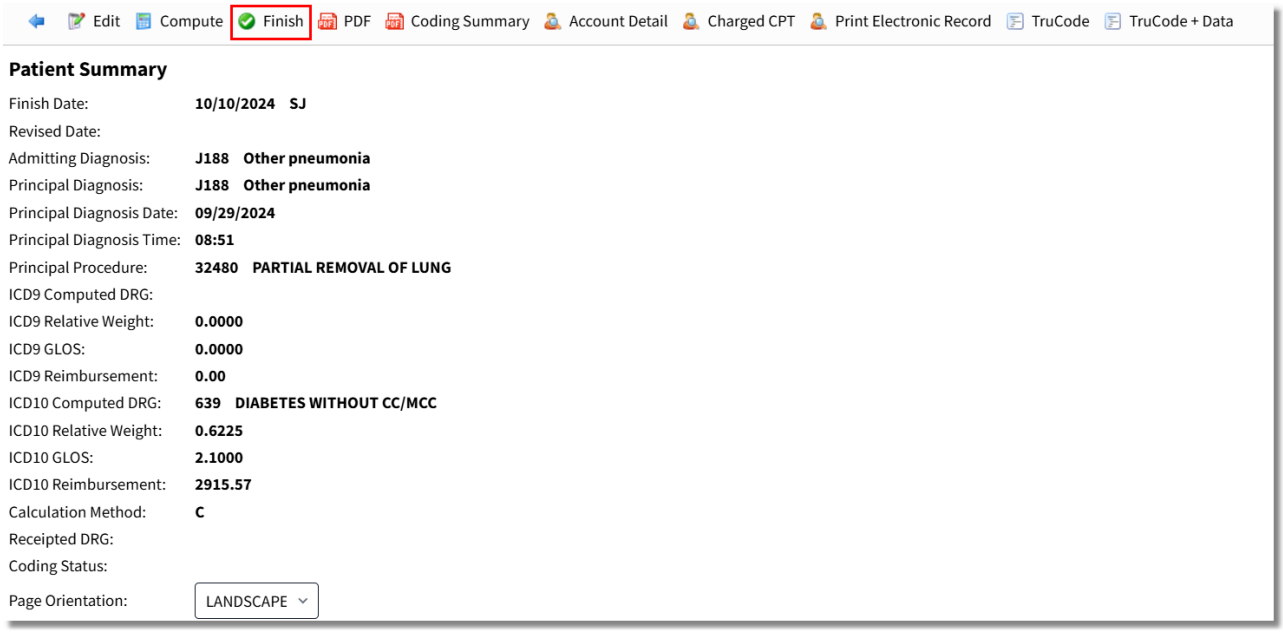


Patient Summary - Compute

Finish

The Finish option will populate the Finish Date and Coder Initials on the Patient Summary 55 screen. A Finished Date indicates that coding has been completed. If a Finish Date has already been populated, then the Revised Date and Coder Initials will be populated. The Finish option may be selected from the Patient Summary, Diagnosis, and Procedures screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary** > **Finish**



Patient Summary - Finish

APC Verify

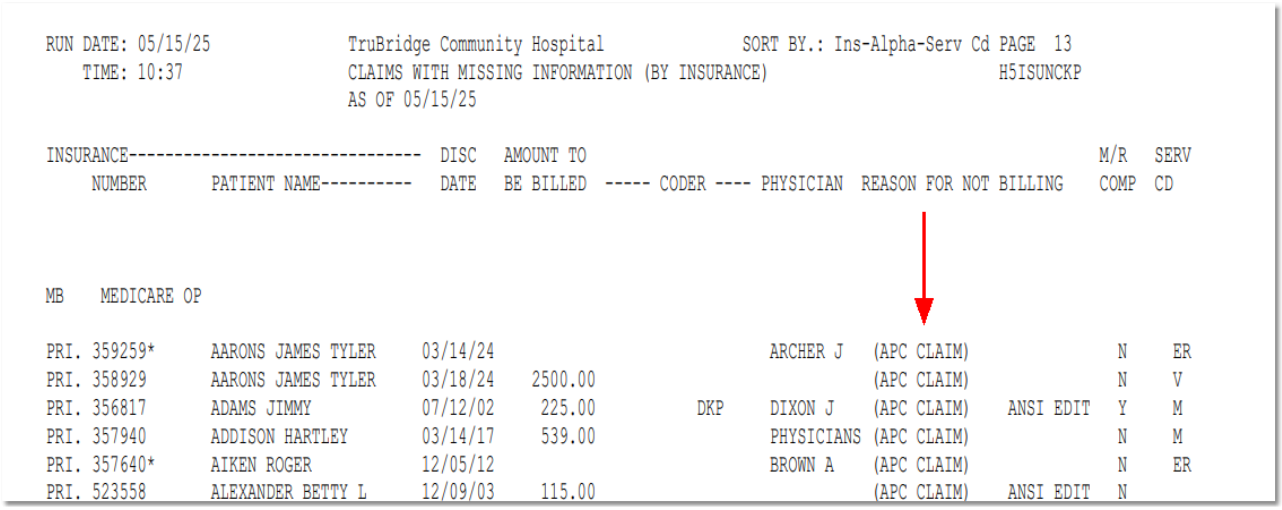
The APC Verify option will display when there is an APC claim at the Unchecked status present on the account. TruBridge recommends that Medical Records verify the CPT codes and Modifiers that are attached to the charges on insurance claims that will be reimbursed off of APC.

TruBridge EHR looks to the following table maintenance to determine if the claim is an APC claim.

- Insurance Company Table, Page 4 "APC Reimburse" set to **Y**

Medical Records may run the Claims with Missing Information Report to identify APC Claims that are at the Unchecked status that need to be reviewed. The Reason for Not Billing column on the report will display (APC Claim) on accounts that need to be reviewed. For more information on this report please see the HIM Print Reports User Guide.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **Page 2** > **Claims with Missing Information (I)**



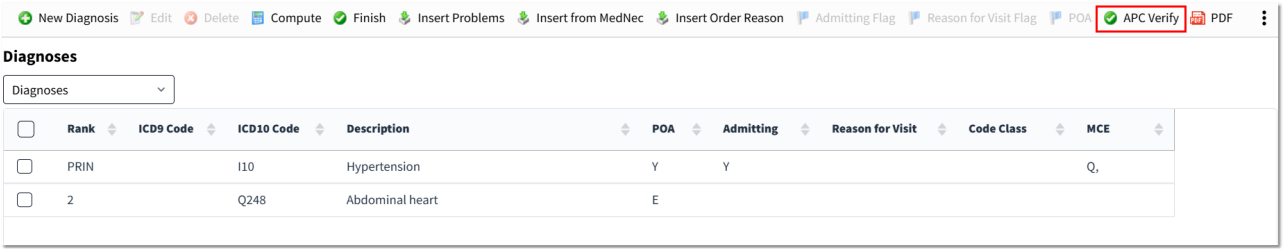
RUN DATE: 05/15/25 TruBridge Community Hospital SORT BY.: Ins-Alpha-Serv Cd PAGE 13
TIME: 10:37 CLAIMS WITH MISSING INFORMATION (BY INSURANCE) H5ISUNCKP
AS OF 05/15/25

INSURANCE NUMBER	PATIENT NAME	DISC DATE	AMOUNT TO BE BILLED	CODER	PHYSICIAN	REASON FOR NOT BILLING		M/R COMP	SERV CD
MB MEDICARE OP									
PRI. 359259*	AARONS JAMES TYLER	03/14/24			ARCHER J	(APC CLAIM)		N	ER
PRI. 358929	AARONS JAMES TYLER	03/18/24	2500.00			(APC CLAIM)		N	V
PRI. 356817	ADAMS JIMMY	07/12/02	225.00	DKP	DIXON J	(APC CLAIM)	ANSI EDIT	Y	M
PRI. 357940	ADDISON HARTLEY	03/14/17	539.00		PHYSICIANS	(APC CLAIM)		N	M
PRI. 357640*	AIKEN ROGER	12/05/12			BROWN A	(APC CLAIM)		N	ER
PRI. 523558	ALEXANDER BETTY L	12/09/03	115.00			(APC CLAIM)	ANSI EDIT	N	

Claims with Missing Information

After the account has been identified, the APC Verify option may be selected from the Grouper. This option will be available on the Patient Summary, Diagnosis and Procedures screens.

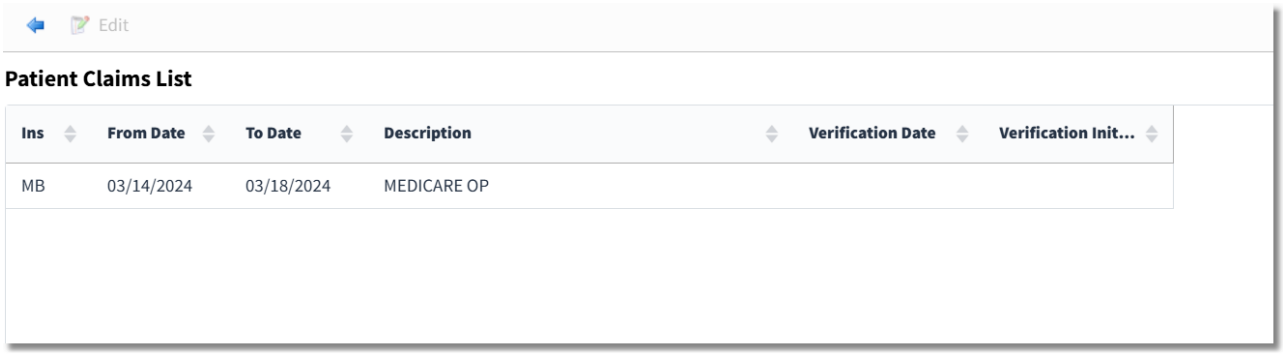
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



Diagnoses - APC Verify

Once selected, the Patient Claims List screen will display with the Claims that are set up to be reimbursed off APC. Select the claim, and then select **Edit** to verify the CPT codes and Modifiers that will pull to the insurance claim.

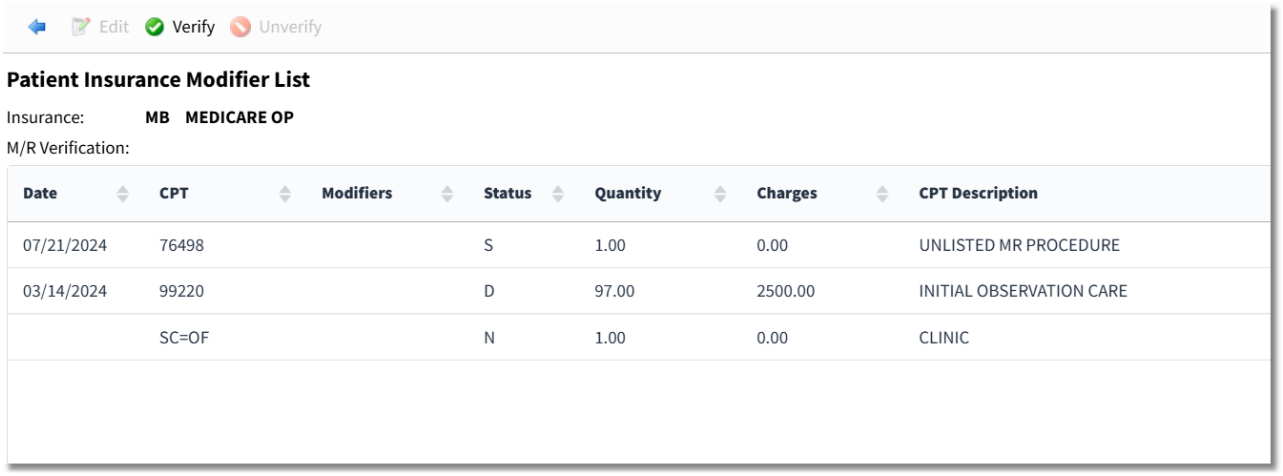
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **APC Verify**



Patient Claim List

The Patient Insurance Modifier List will display the Charges and their associated CPT codes and modifiers.

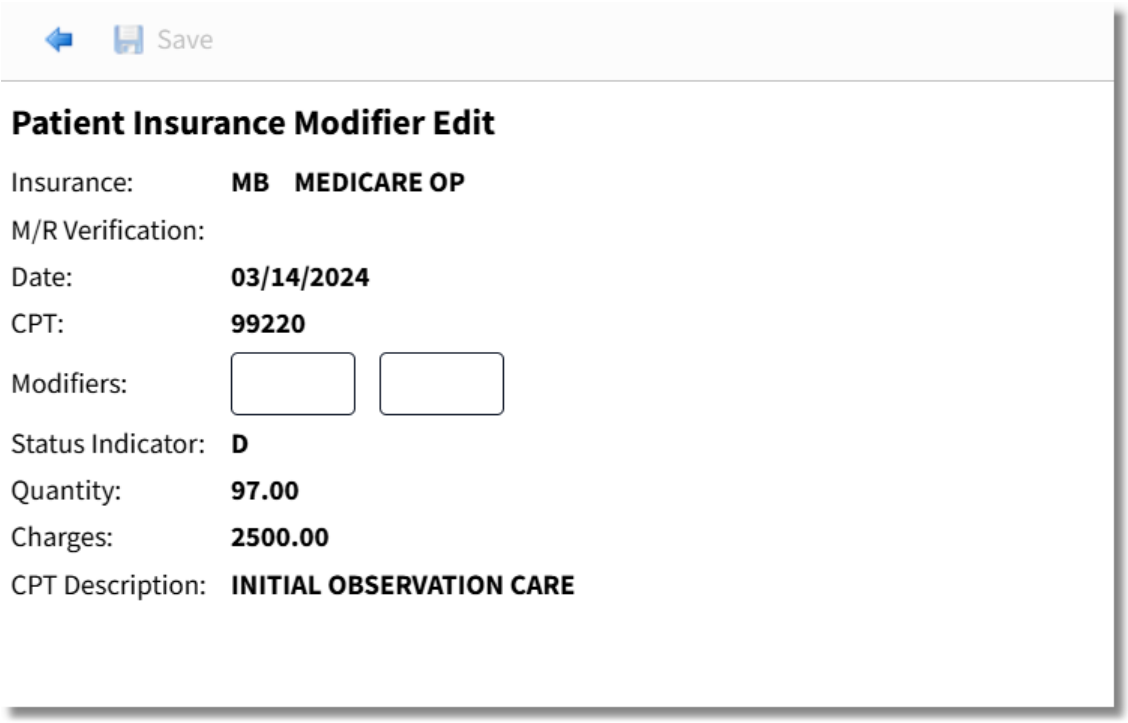
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **APC Verify** > **Select Claim** > **Select Edit**



Patient Insurance Modifier List

If a change needs to be made, select the charge and then select **Edit**. This will allow up to two modifiers to be edited or added.

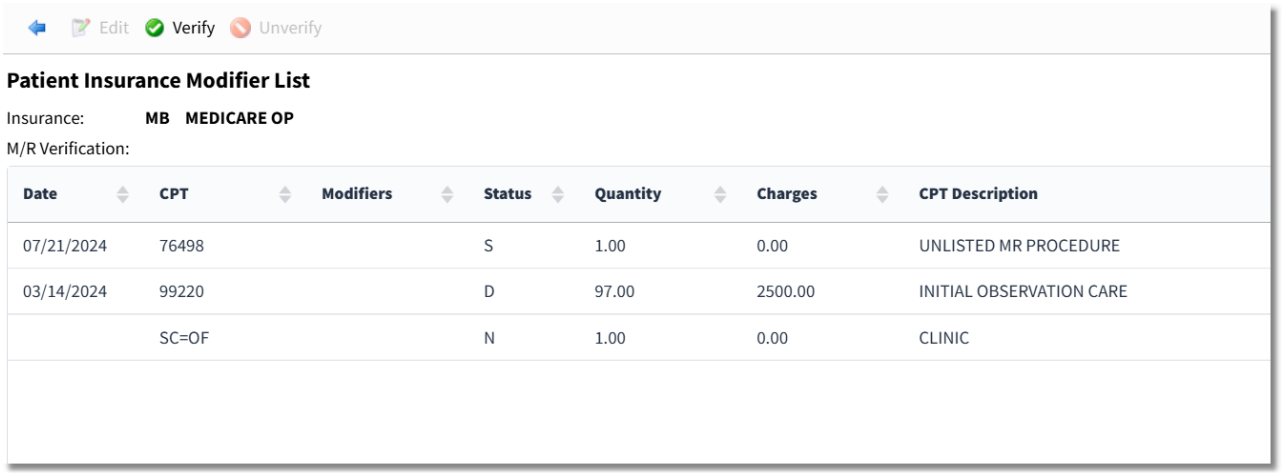
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **APC Verify** > **Select Claim** > **Select Edit** > **Select Charge** > **Select Edit**



Patient Insurance Modifier Edit

Select **Save** to keep any changes or select the Back Arrow to return to the Patient Insurance Modifier List.

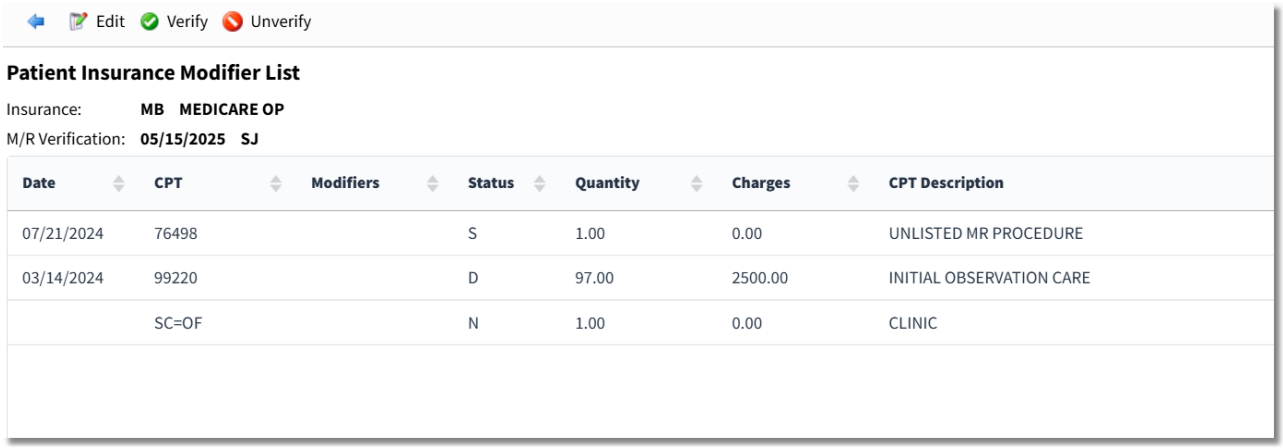
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **APC Verify** > **Select Claim** > **Select Edit**



Patient Insurance Modifier List

Once all CPTs and modifiers have been reviewed, select the **Verify** option. This will populate the M/R Verification Date and Coder Initials indicating that Medical Record has finished reviewing the charges.

Select **Web Client** > **Application Drawer** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **APC Verify** > **Select Claim** > **Select Edit** > **Verify**



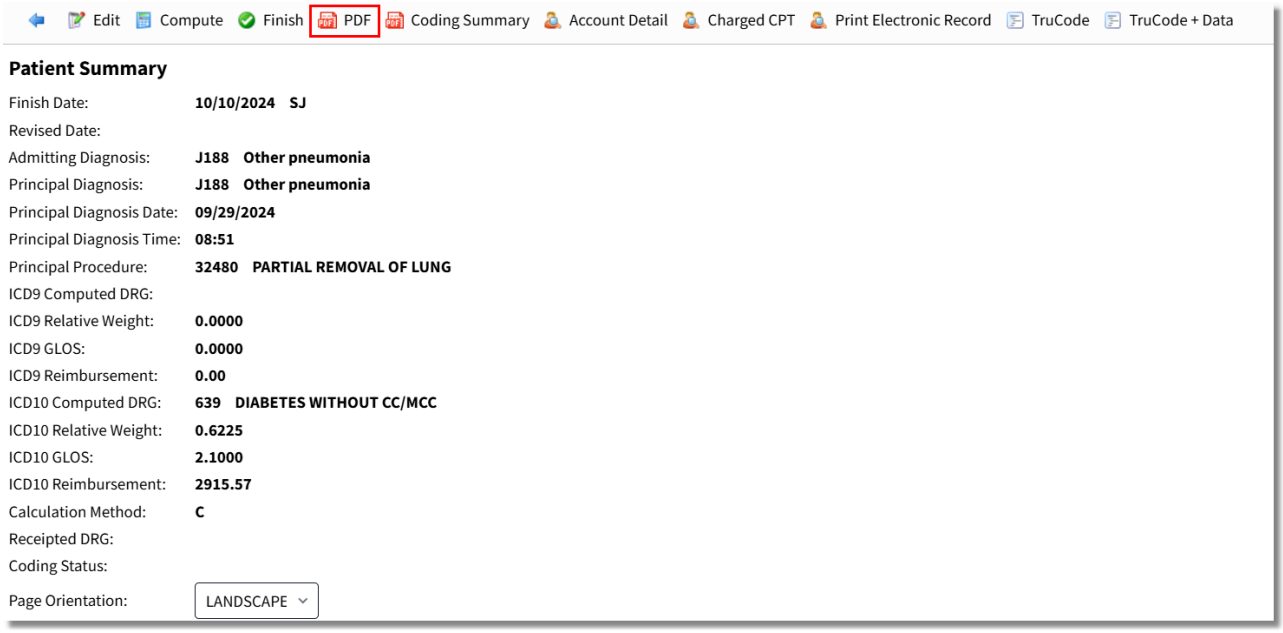
Patient Insurance Modifier List

The **Unverify** option may be used to remove the M/R Verification Date and Coder Initials.

PDF

The PDF option allow the screen displayed to open in Adobe®. This option is available on the Patient Summary 55, Diagnosis 72, Procedure 89, and Account Detail 67 screens.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Patient Summary**

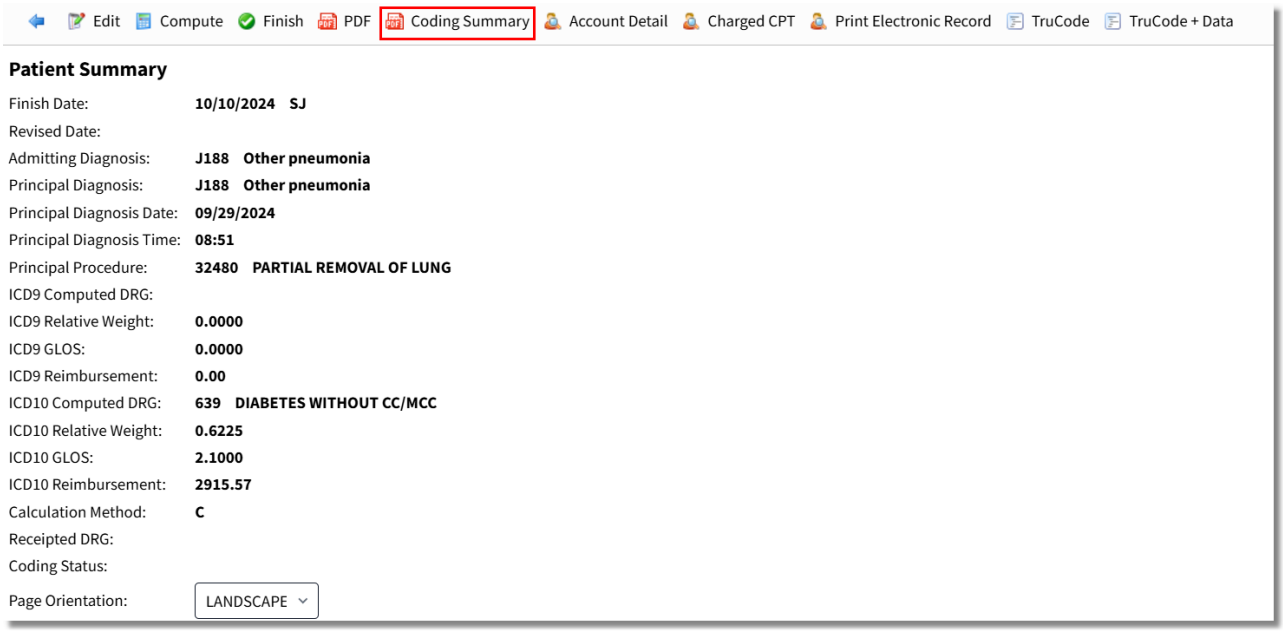


Patient Summary - PDF

Coding Summary

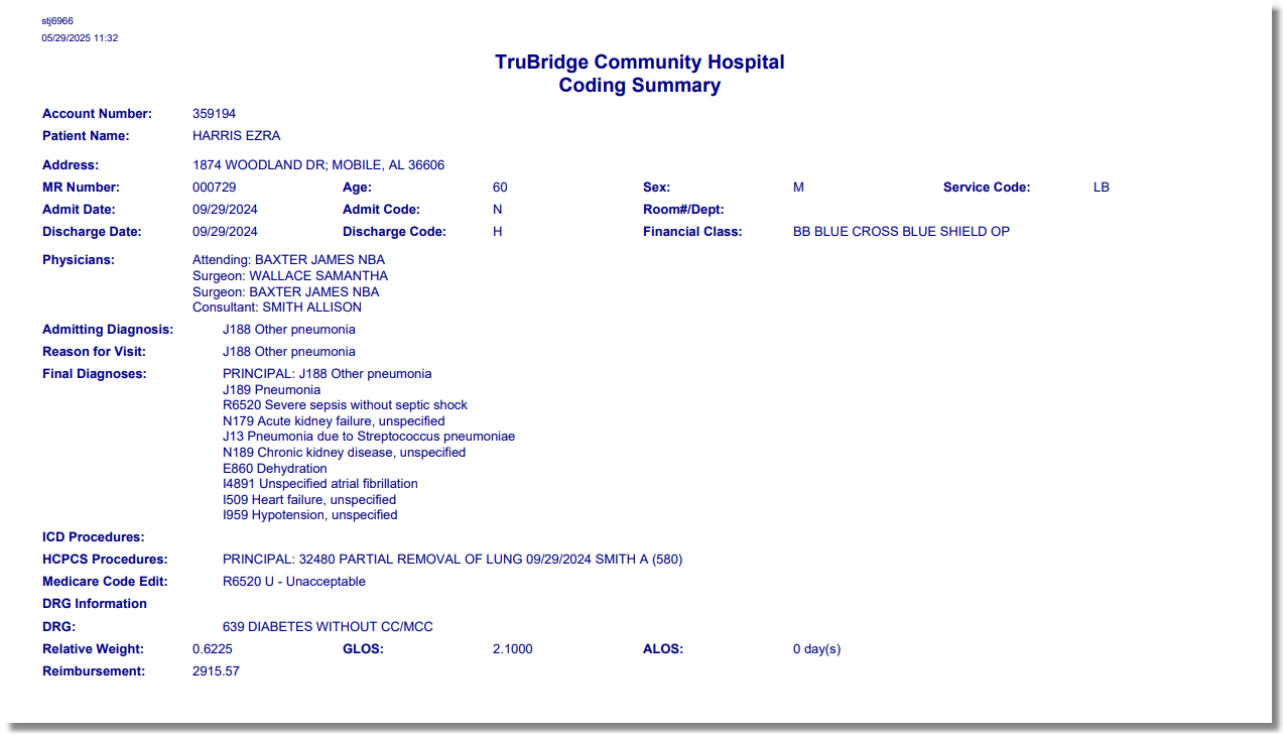
The Coding Summary option displays a PDF version of the summary of codes applied to the patient account. This option may be accessed from the Patient Summary 55 screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Patient Summary**



Patient Summary - Coding Summary

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Patient Summary Screen > Coding Summary**



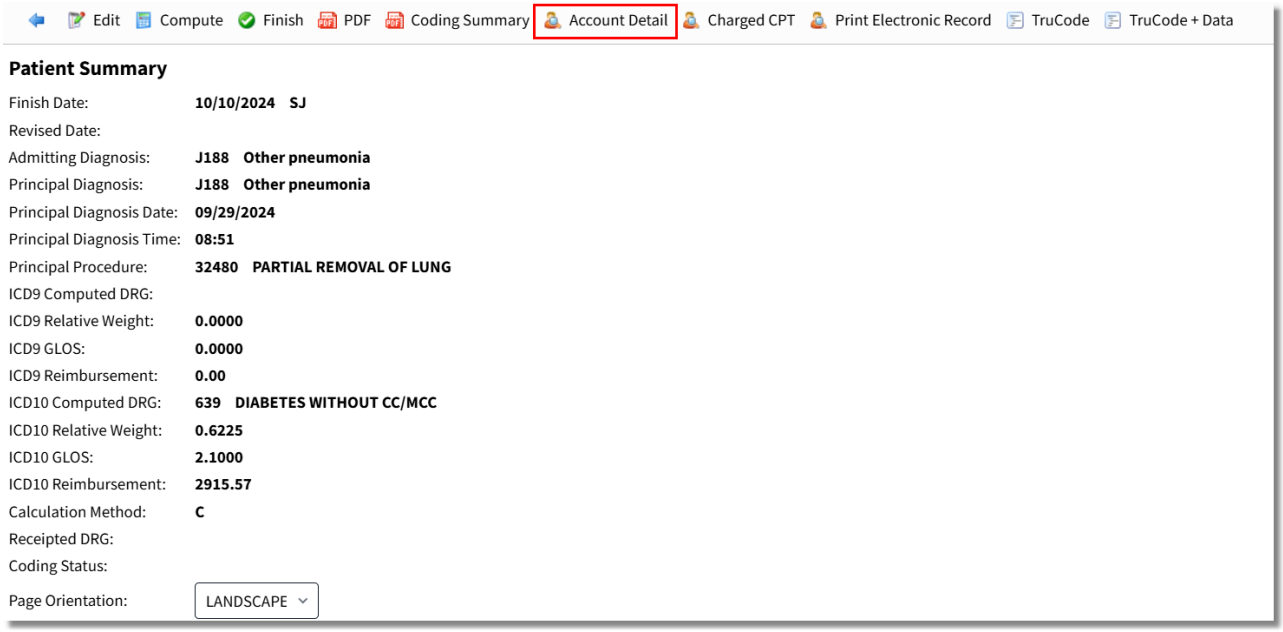
Account Detail

For more information please see the HIM Print Reports User Guide.

Account Detail

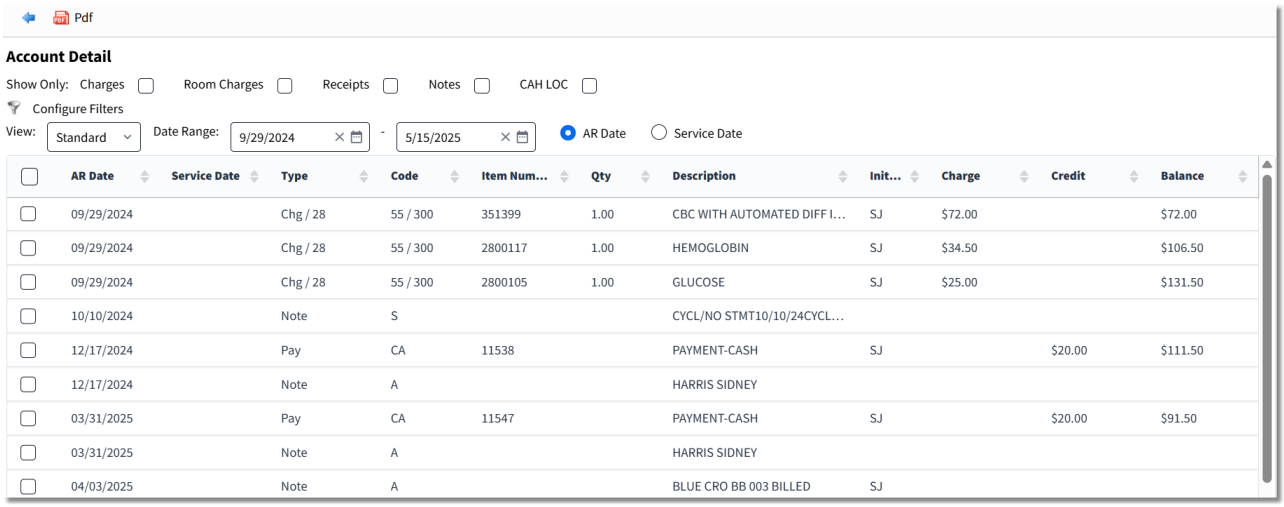
The Account Detail option allows the patient's Account Detail to be displayed. This option may be accessed from the Patient Summary 55, Procedures 89 and Charges 115 screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary**



Patient Summary - Account Detail

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Patient Summary Screen > Account Detail**



AR Date	Service Date	Type	Code	Item Num...	Qty	Description	Init...	Charge	Credit	Balance
09/29/2024		Chg / 28	55 / 300	351399	1.00	CBC WITH AUTOMATED DIFF I...	SJ	$72.00		$72.00
09/29/2024		Chg / 28	55 / 300	2800117	1.00	HEMOGLOBIN	SJ	$34.50		$106.50
09/29/2024		Chg / 28	55 / 300	2800105	1.00	GLUCOSE	SJ	$25.00		$131.50
10/10/2024		Note	S			CYCL/NO STMT10/10/24CYCL...				
12/17/2024		Pay	CA	11538		PAYMENT-CASH	SJ		$20.00	$111.50
12/17/2024		Note	A			HARRIS SIDNEY				
03/31/2025		Pay	CA	11547		PAYMENT-CASH	SJ		$20.00	$91.50
03/31/2025		Note	A			HARRIS SIDNEY				
04/03/2025		Note	A			BLUE CRO BB 003 BILLED	SJ			

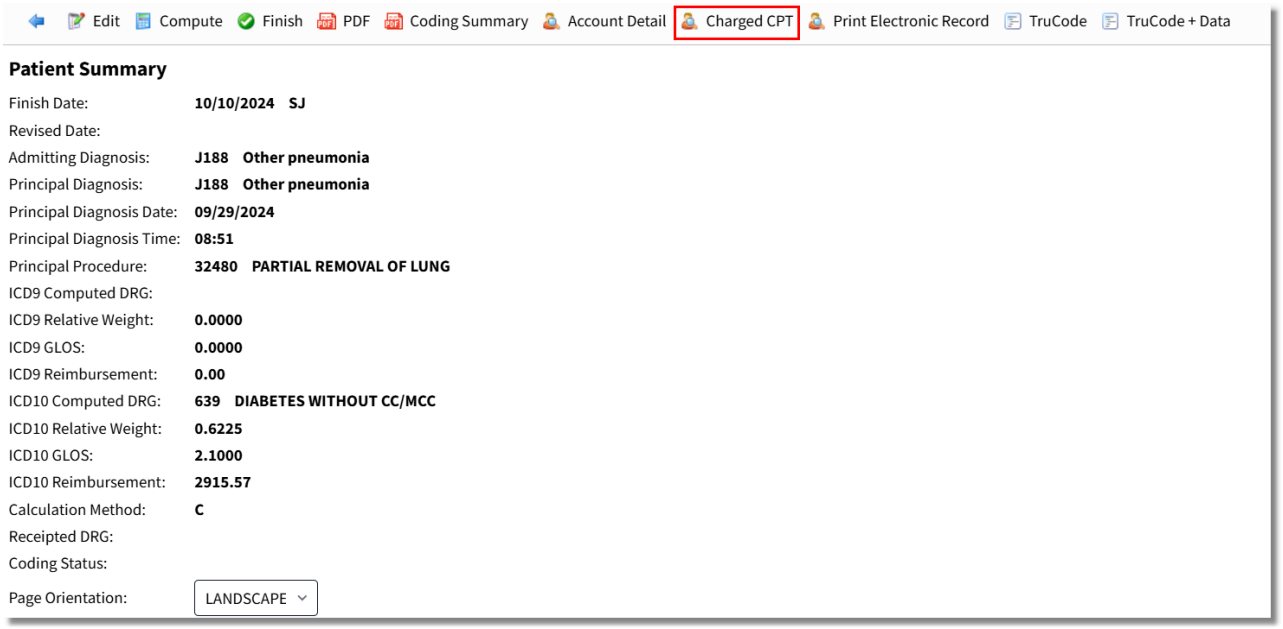
Account Detail

For more information please see the Charging User Guide.

Charged CPT

The Charged CPT screen displays charges that have been posted to the account that have a CPT code loaded on Page 1 of the Item Master. This screen may be accessed from the Patient Summary 55 and Procedures 89 screens.

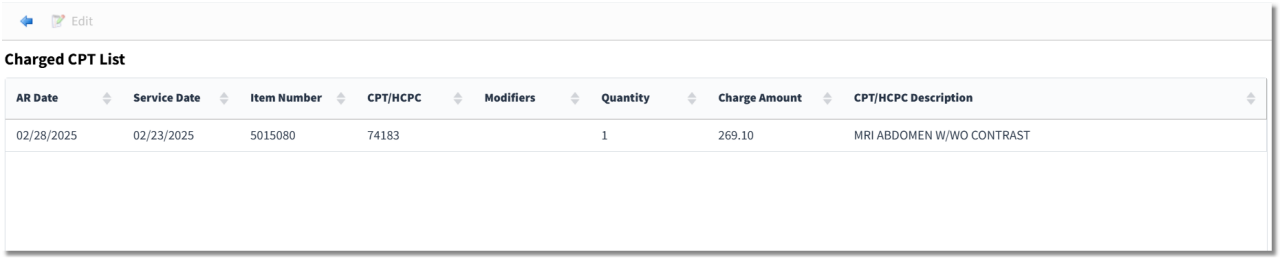
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Patient Summary**



Patient Summary - Charged CPT

This screen also displays the Modifiers that are attached to the CPT code. Modifiers can originate from Page 1 of the Item Master or be brought in from an encoder. Up to two modifiers can be brought in from an encoder, these modifiers may be edited from this screen. Modifiers may also be added manually from this screen.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary** > **Charged CPT**



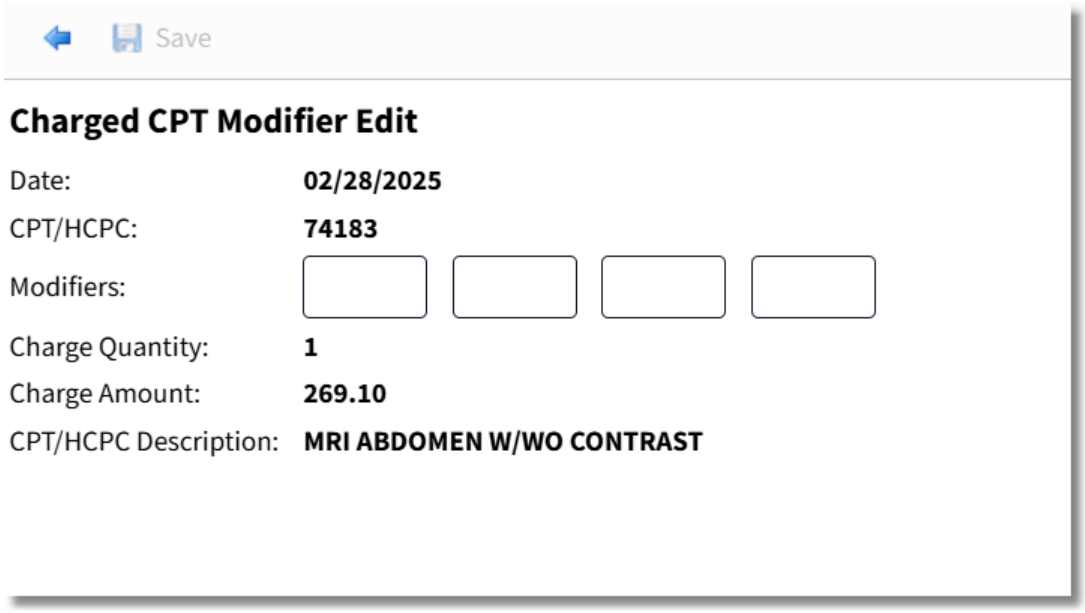
Charged CPT screen

The following information will display for each charge.

- **AR Date**: Displays the Accounts Receivable date associated with the charge.
- **Service Date:** Displays the Service date associated with the charge.
- **Item Number:** Displays the item number entered during charge entry on the patient account.
- **CPT/HCPC**: Displays the CPT loaded on Page 1 of the Item Master for this item number.
- **Modifiers**: Displays the modifiers from Page 1 of Item Master or modifiers that were brought in from an encoder.
- **Quantity**: Displays the quantity of the item that was charge.
- **Charge Amount**: Displays the dollar amount of the item that was charged.
- **CPT/HCPC Description**: Displays the description of CPT/HCPC code.

To edit or add modifiers, select a charge item, then select **Edit**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary** > **Charged CPT** > **Select Charge** > **Edit**



Charged CPT Edit screen

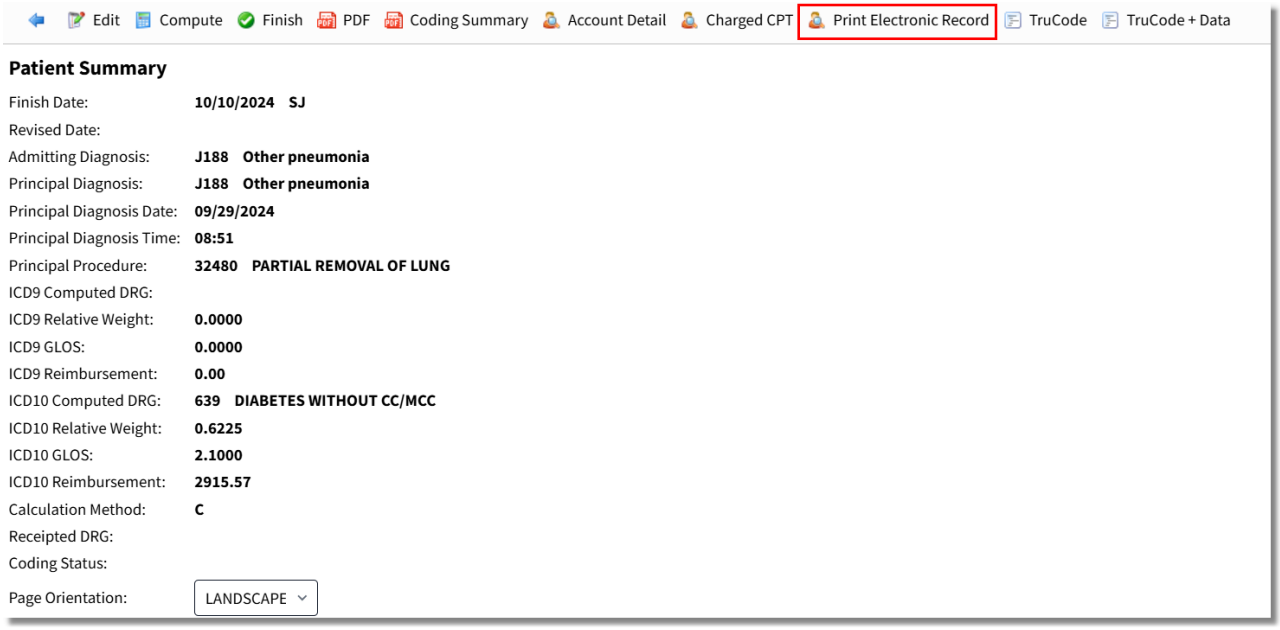
Existing modifiers may be edited or new modifiers may be entered. Up to four two digit modifiers may be added.

***NOTE**: If the modifier displayed is pulling from Page 1 of the Item Master, then it cannot be edited from this screen. If this is the case, the item will need to be backed off the account and the correct item will need to be charged.*

Print Electronic Record

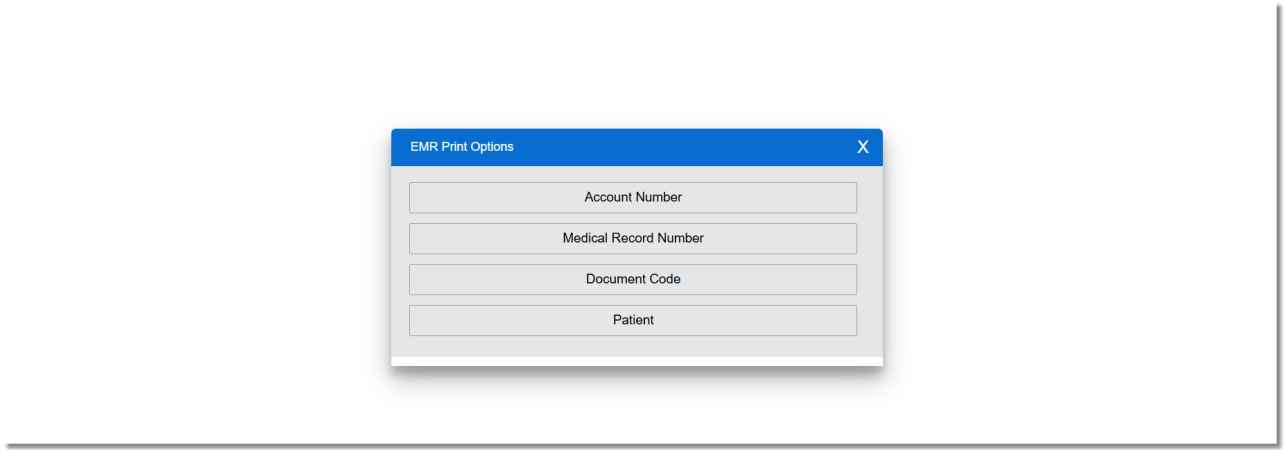
The Print Electronic Record option displays the patient's electronic record. This option may be accessed from the Patient Summary 55 screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Patient Summary**



Patient Summary

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Patient Summary > Print Electronic Record**



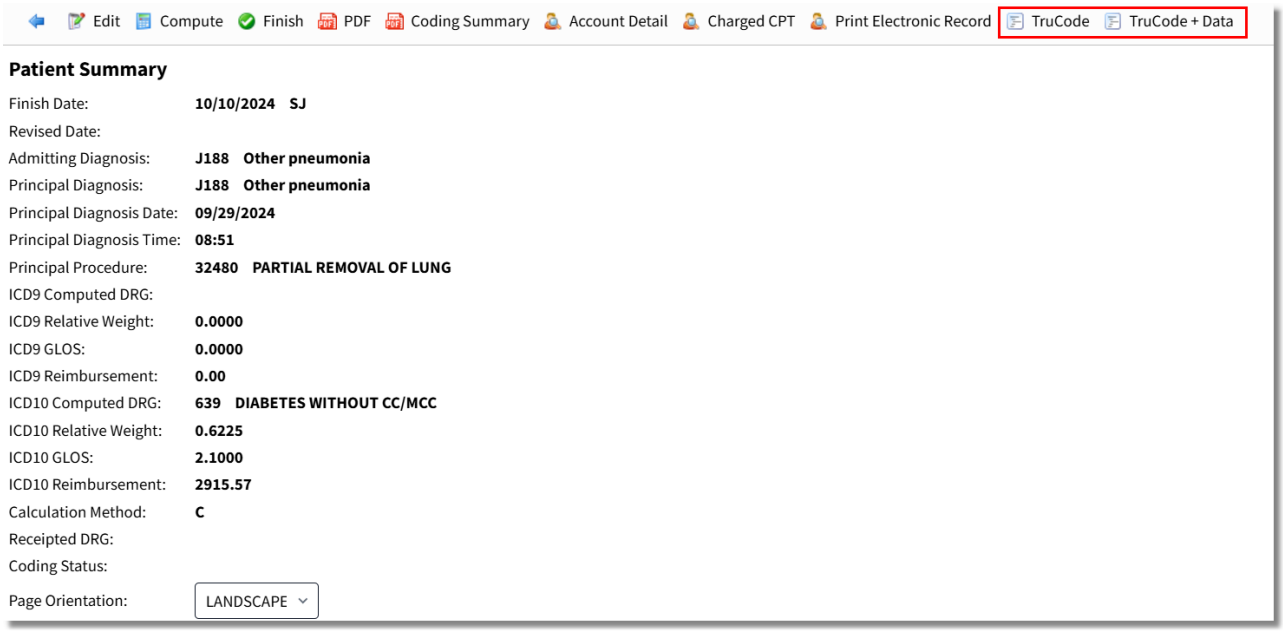
Print Electronic Record

For more information see Using Print Electronic Record 21.

Encoder Launch Point

Encoders can be launched from the Patient Summary 55 screen if they have been purchased.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Patient Summary**



Patient Summary

NOTE: Encoders *are purchased applications and must be activated before using this option.*

5.4 Diagnosis

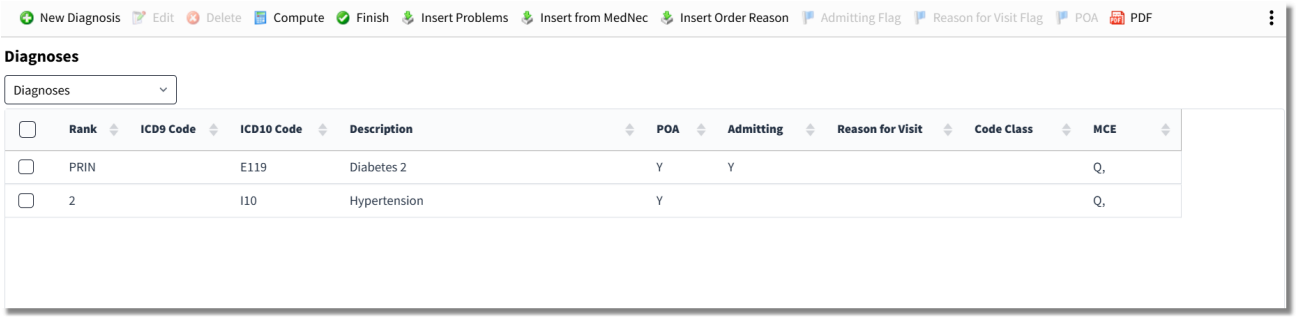
The Diagnoses screen allows Diagnosis information to be entered and stored on the account. The Diagnoses screen defaults with the Diagnoses option selected in the drop-down menu. The following options are available on the drop-down menu:

- **Diagnoses**: Allows diagnosis codes to be entered or edited.
- **Admitting Diagnosis**: Allows an Admitting diagnosis to be entered or edited. For more information please see the Admitting Flag 82 topic.
- **Reason for Visit**: Allows up to three Reason for Visit diagnoses to be entered or edited. For more information please see the Reason for Visit Flag 84 topic.
- **Insurance**: Allows diagnosis information to be edited for insurance billing purposes only. Changes made on this screen will not copy to the Diagnoses screen and will only affect the way diagnosis codes pull to the insurance claim.
- **Insurance Admitting**: Allows the admitting diagnosis information to be edited for insurance billing purposes only. Changes made on this screen will not copy to the Admitting Diagnosis screen and will only affect the way the admitting diagnosis code pulls to the insurance claim.

NOTE: *The Behavior Control* ***Code by Insurance*** *will give access to view the Insurance and Insurance Admitting options. The Behavior Control* ***Edit Non-HIM Diagnosis and Procedures***

***Codes** will allow the user to make changes to the Insurance and Insurance Admitting screens. For more information on these screens please refer to the Insurance User Guide.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



Diagnoses

If diagnosis codes have been added to the account, the existing diagnosis codes will display with the following information.

- **Rank:** Defines the rank of the diagnosis codes. A rank of PRIN indicates that the diagnosis is the Principal diagnosis.
- **ICD9 Code:** Displays the ICD-9 code selected on the Diagnosis List screen
- **ICD10 Code:** Displays the ICD-10 code selected on the Diagnosis List screen
- **Description:** Displays the diagnosis code description selected on the Diagnosis List screen
- **POA:** Displays the POA entered on the diagnosis detail screen. Valid codes are **E**, **N, U, W** or **Y.**

Y	Yes
N	No
U	Unknown
W	Clinically Undetermined
E	TruBridge code for Exempt from Reporting (Insurance)

***NOTE**: An E will make UB04 Locator 67 pull blank on the paper claim. If it is an electronic claim, it will pull a "1" to the electronic file, which means unreported/not used - exempt from POA reporting. "1" is not a valid code to be entered in the POA field.*

- **Admitting:** A **Y** will display in this column if the diagnosis code has been identified as the Admitting Diagnosis.
- **Reason for Visit:** A **Y** will display in this column if the diagnosis code has been identified as the Reason for Visit.

- **Code Class**: Displays applicable indicators of **C** for CC, **H** for HAC, and **M** for MCC
- **MCE's:** Displays any applicable Medicare Code Edits.

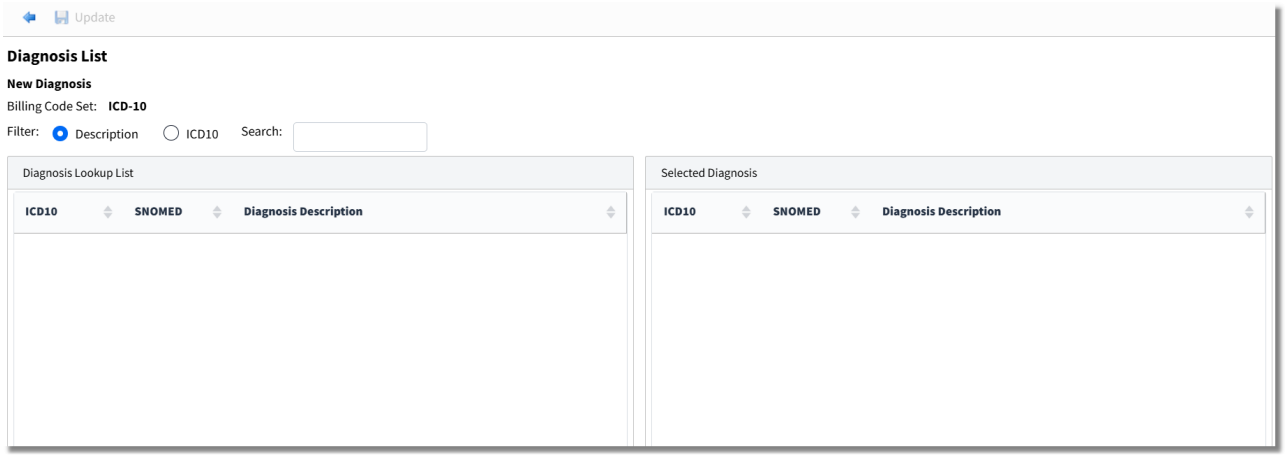
B	Newborn; Diagnosis to be used only for patients less than one year old
P	Pediatric; Diagnosis to be used only for patients less than 18 years old
M	Maternity; Diagnosis to be used only for patients between 12-55 years old
A	Adult; Diagnosis to be used only for patients more than 14 years old
F	Female; Indicates female-only diagnosis
M	Male; Indicates male-only diagnosis
U	Unacceptable; The reason (diagnosis) for admission to a healthcare facility is unacceptable
M	Manifestation condition; these codes can never be used as a principal diagnosis
Q	Questionable diagnosis for admission; the condition would not be expected to justify admission to a healthcare facility

For further definition of each MCE, the Edits 108 option may be selected.

New Diagnosis

To add diagnosis codes to an account, make sure that **Diagnosis** is selected from the drop-down menu. Then select **New Diagnosis.** The **Diagnosis List** screen will display.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Diagnosis** > **New Diagnosis**

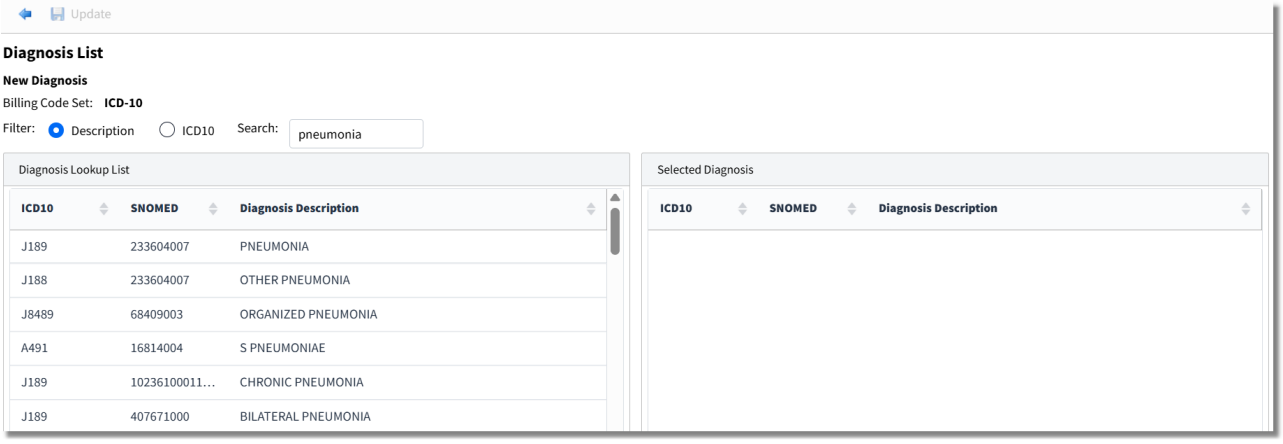


Diagnosis List

- **Billing Code Set:** Displays the code set currently accepted by the Financial Class. Typically, this will be ICD-10.
- **Filter:** Provides the ability to search for diagnosis code by Description or ICD-10.
- **Search:** Allows the ability to search by description or ICD-10, depending on the selection made in the Filter field.

Once the search criteria is entered the search results will display in the **Diagnosis Lookup List**. Double-click the desired code to move it to the **Selected Diagnosis** list.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Diagnosis** > **New Diagnosis**



Diagnosis List

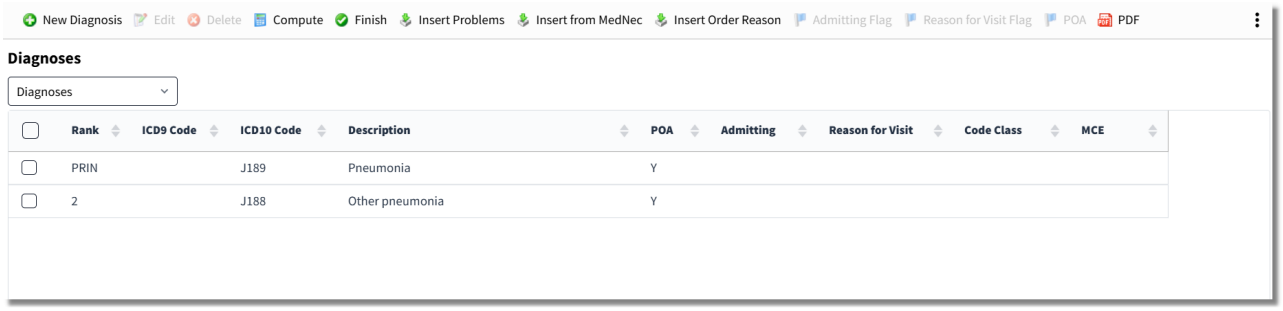
Selecting a diagnosis from **Diagnosis Lookup List** that has an asterisk (*) in any column will allow the best grouping for the diagnosis.

If a diagnosis code is added to the **Selected Diagnosis** list in error, double-click the code to remove it.

Duplicate Diagnosis cannot be entered. If a duplicate code is selected, the system will display a warning message: “Duplicate Code”.

Continue adding diagnosis codes until all the diagnoses are listed in the Selected Diagnosis list. When finished, select **Update**. The Diagnoses screen will then display.

Select **Web Client > Application Drawer > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Diagnosis**



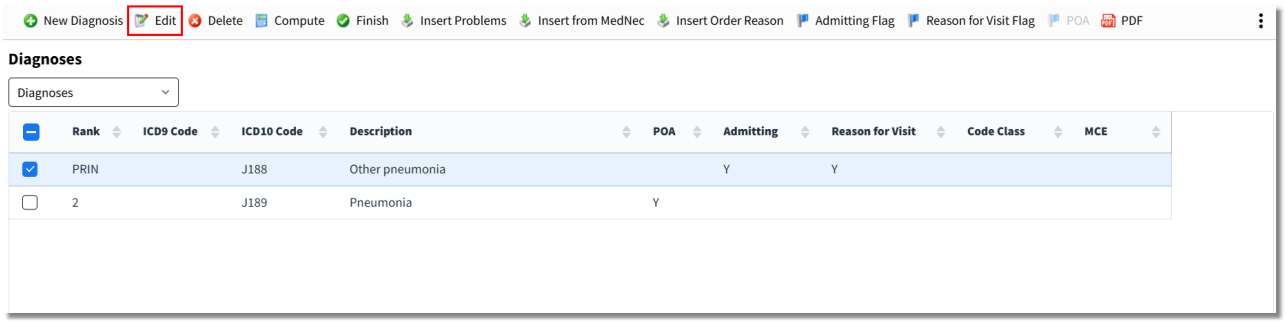
Diagnoses

***NOTE**: Facilities participating in the Electronic Case Reporting objective for Meaningful Use 3 may have a Case Report sent to a Public Health Agency when an Diagnosis entered here matches a diagnosis in the Trigger Code Table. Additional setup is required for this functionality. For more information please contact a TruBridge Support Representative.*

Edit

The Edit option allows the POA indicator and/or Rank to be changed on a single diagnosis code.

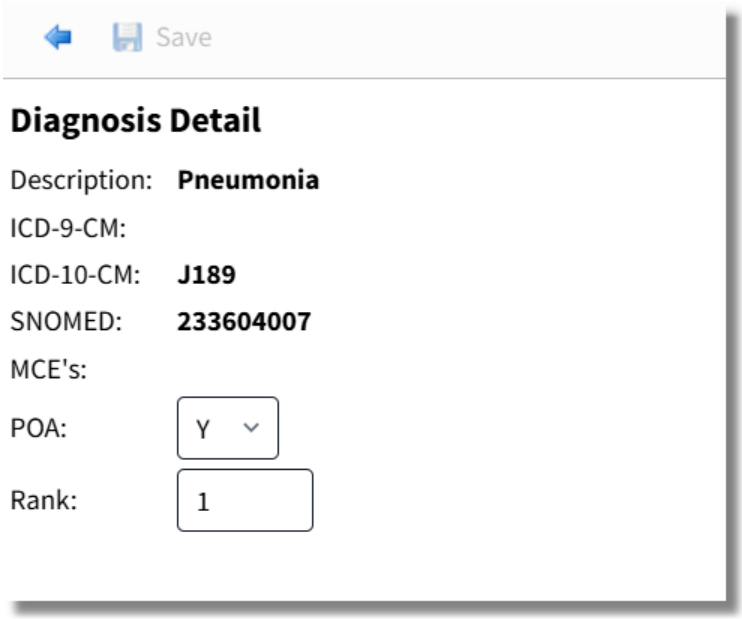
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnoses**



Diagnoses - Edit

Once **Edit** is selected the Diagnosis Detail screen will display.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Diagnosis** > **Select Code** > **Edit**



Diagnosis Detail

The following information will be displayed:

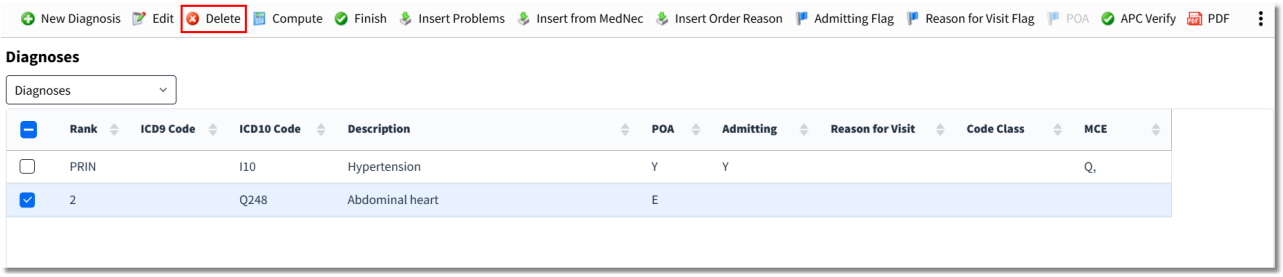
- **Description:** Displays the diagnosis code description selected from the Diagnoses screen.
- **ICD-9-CM:** Displays the ICD-9-CM code selected from the Diagnoses screen.
- **ICD-10-CM:** Displays the ICD-10-CM code selected from the Diagnoses screen.
- **SNOMED:** Displays the SNOMED code selected from the Diagnoses screen.
- **MCE's:** Displays any applicable Medicare Code Edits.
- **POA:** Indicates whether the condition was present at the time of admission. Select the valid code from the drop down menu. Valid codes are **E**, **N, U, W** or **Y.** A default value may be set up in the Medical Record Control Record within the Business Office tables. The default options are **Yes**, **No** or **Blank.**
- **Rank:** Determines the order in which diagnosis codes are displayed on the Diagnoses screen. This field defaults to the order in which each code is entered but can be adjusted. The diagnosis ranked as 1 will be considered the Principal Diagnosis and will list as PRIN on the Diagnoses screen.

If any changes are made, select **Save**, then select the **Back Arrow** to return to the Diagnoses screen.

Delete

The Delete option allows a diagnosis or procedure code to be removed. The Delete option may be selected from the Diagnosis and Procedures screens. To remove a code, select the diagnosis or procedure code from the list and then select **Delete**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Select Code** > **Delete**

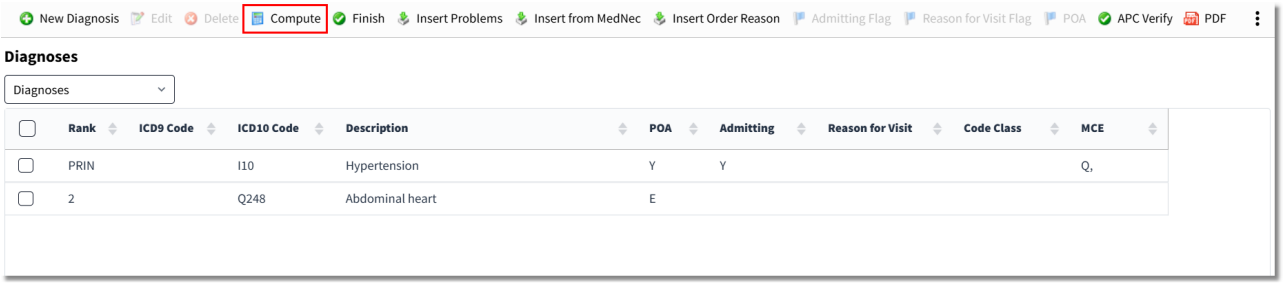


Procedure - Delete

Compute

The Compute option will calculate the DRG within TruBridge EHR and update the DRG field on the Patient Summary 55 screen. The Compute option may be selected from the Patient Summary, Diagnosis, and Procedures screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Compute**



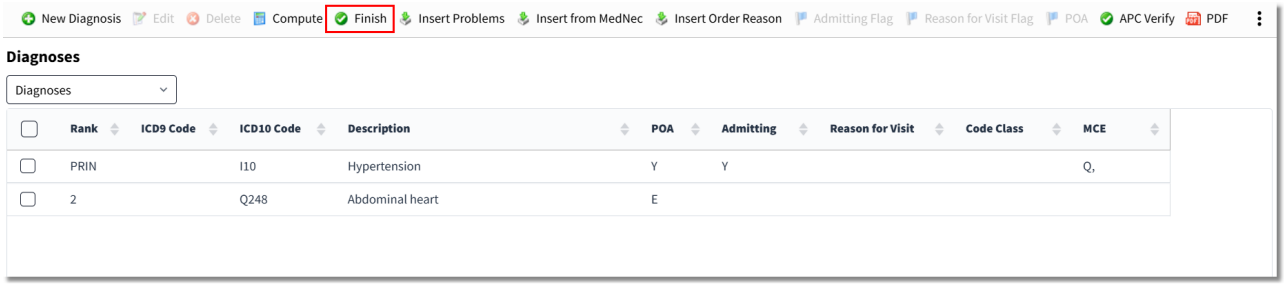
Diagnosis - Compute

For more information refer to the Compute 59 section.

Finish

The Finish option will populate the Finish Date and Coder Initials on the Patient Summary 55 screen. A Finished Date indicates that coding has been completed. If a Finish Date has already been populated, then the Revised Date and Coder Initials will be populated. The Finish option may be selected from the Patient Summary, Diagnosis, and Procedures screens.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnosis > Finish**



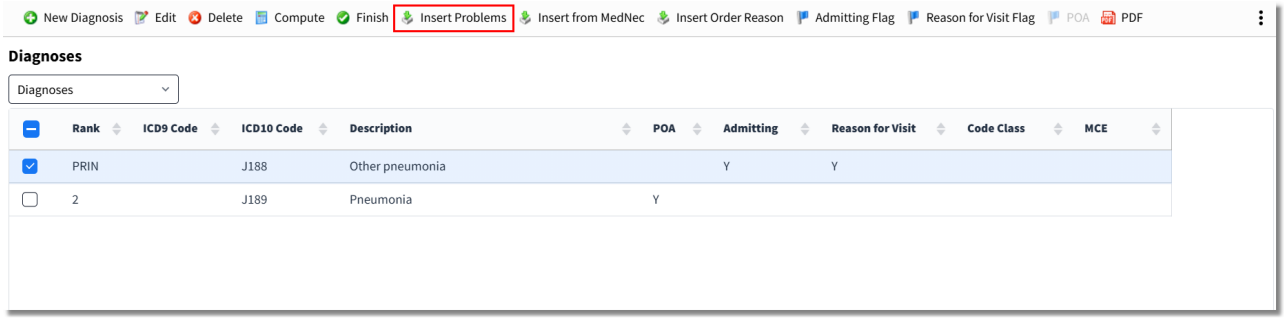
Procedure - Finish

For more information refer to the Finish 59 section.

Insert Problems

The Insert Problems option allows Diagnoses to be added from the Physician Problem List. From the Diagnosis screen, select **Insert Problems**.

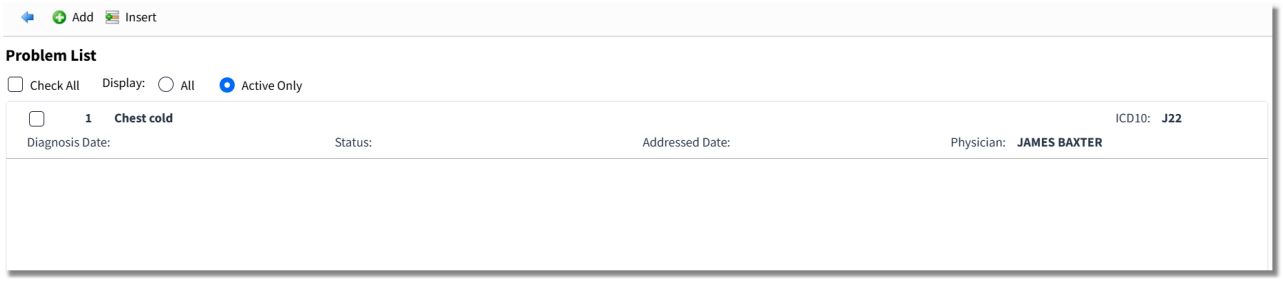
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnoses**



Diagnoses - Insert Problems

The Problem List will display, showing problems that have been previously entered for the patient.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Insert Problems**



Diagnoses - Insert Problems

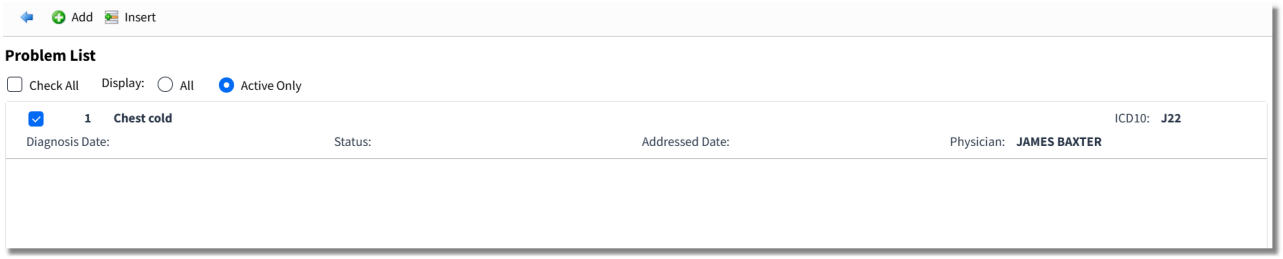
Select the check-box next to the diagnoses that should be added to the Diagnoses screen, or select the check-box next to the Check All option to include all diagnoses on the Problem List.

Once the diagnoses have been selected, chose **Insert** to add them to Diagnoses screen.

Additional problems may also be added to the Problem List from this screen by selecting **Add**.

For more information on adding problems to the Problem List, please see the Physician Problem List User Guide.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Insert Problems** > **Select Check-box**

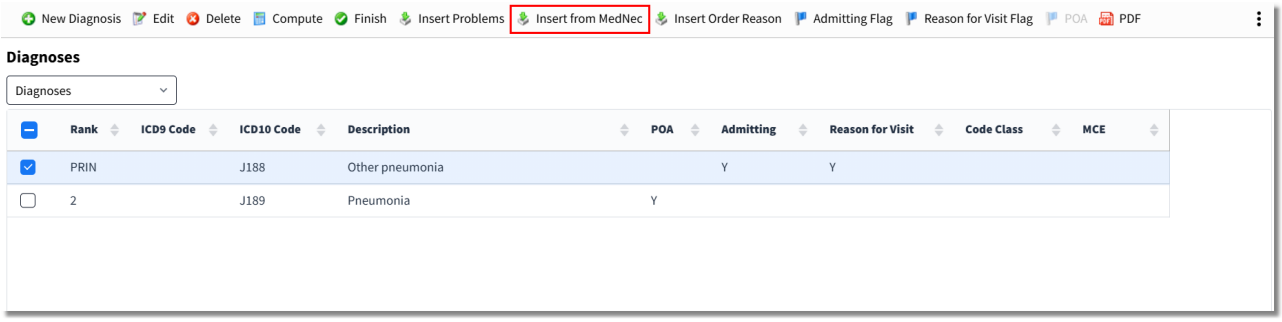


Diagnoses - Insert Problems

Insert from MedNec

The Insert from MedNec option allows Diagnoses to be added from the Medical Necessity application. From the Diagnosis screen, select **Insert from MedNec**.

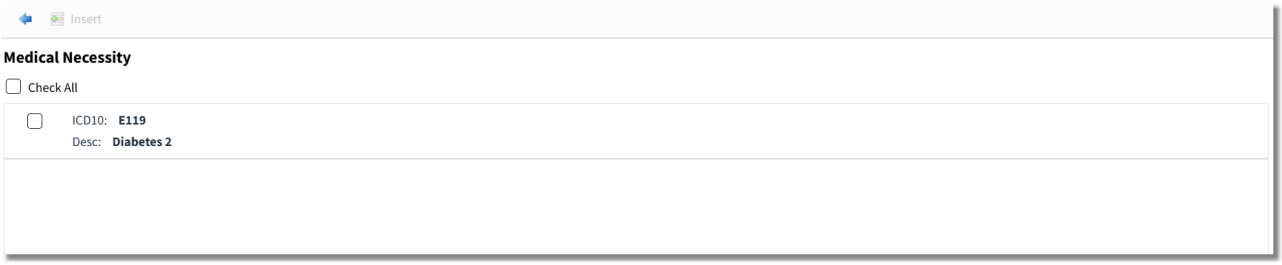
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnoses**



Diagnoses - Insert from MedNec

The Medical Necessity list will display diagnosis that have been used to check medical necessity for on the account.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Insert from MedNec**



Diagnosis - Insert from MedNec

Select the check-box next to each diagnosis that should be added to the Diagnoses screen, or select the check-box next to the Check All option to include all diagnoses listed on the screen.

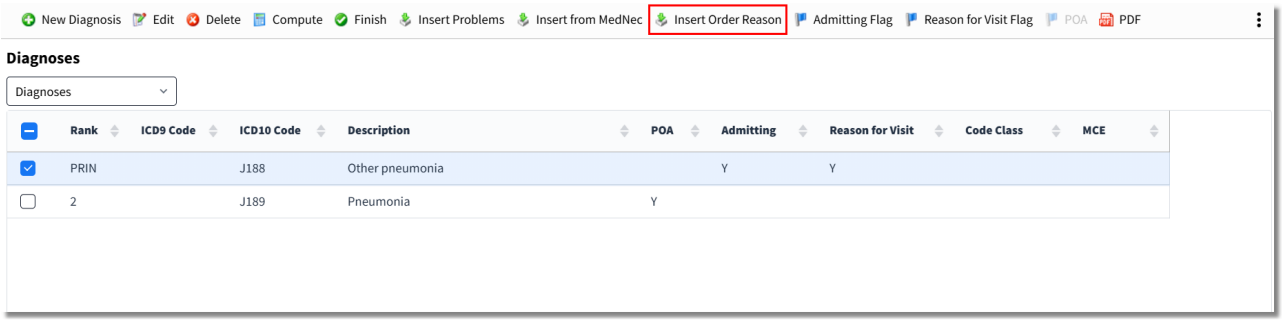
Once the diagnoses have been selected, select **Insert** to add them to Diagnoses screen. If a selected diagnosis is already coded on the Diagnosis screen, it will not be duplicated.

For more information on Medical Necessity, please see the Medical Necessity User Guide.

Insert Order Reason

When Future Orders are placed on an account, an Order Reason may be entered. The Insert Order Reason option allows the order reason to be added to the Diagnosis screen. From the Diagnosis screen, select **Insert Order Reason**.

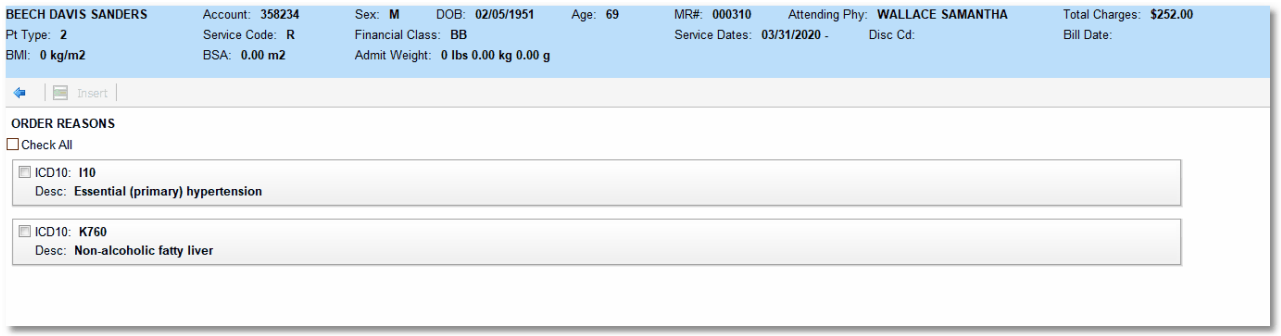
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnoses**



Diagnoses - Insert Order Reason

The Order Reason list will display diagnosis codes that were entered as the Order Reason on this account's released Future Orders.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Insert Order Reason**



Diagnosis - Insert Order Reason

Select the check-box next to each diagnosis that should be added to the Diagnoses screen, or select the check-box next to the Check All option to include all diagnoses listed.

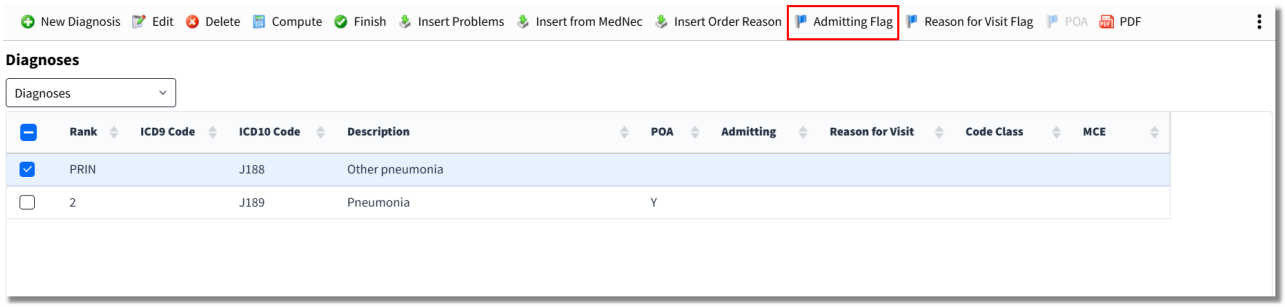
Once the diagnoses have been selected, select **Insert** to add them to Diagnoses screen. If a selected diagnosis is already coded on the Diagnosis screen, it will not be duplicated.

For more information on Future Orders, please see the Future Orders User Guide.

Admitting Flag

The Admitting Flag option allows a diagnosis to be marked as the Admitting Diagnosis. To assign the flag, select the appropriate diagnosis code, then select the **Admitting Flag** button.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



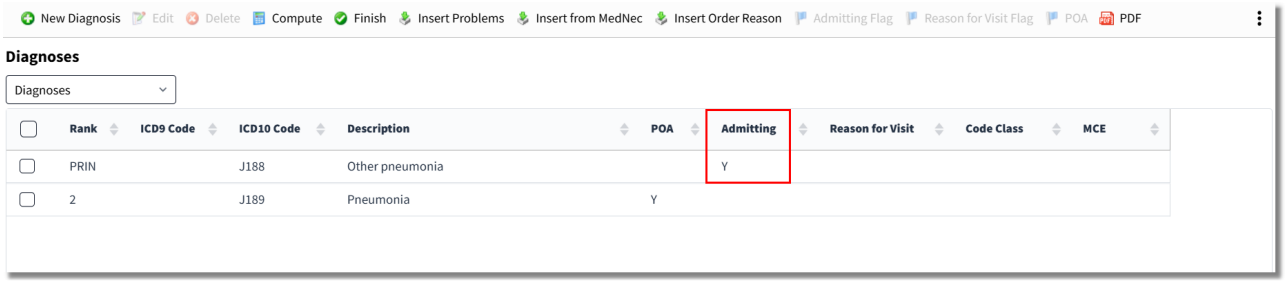
Diagnoses - Admitting Flag

When a diagnosis is flagged as the Admitting Diagnosis, a **Y** will pull to the Admitting column for that diagnosis. The diagnosis will also be added to the Admitting Diagnosis screen.

Only one Admitting Diagnosis may be identified at a time.

If a diagnosis has already been marked as the Admitting Diagnosis and the Admitting Flag option is selected, TruBridge EHR will remove the "Y" from the Admitting column, indicating that the diagnosis is no longer marked as the admitting diagnosis.

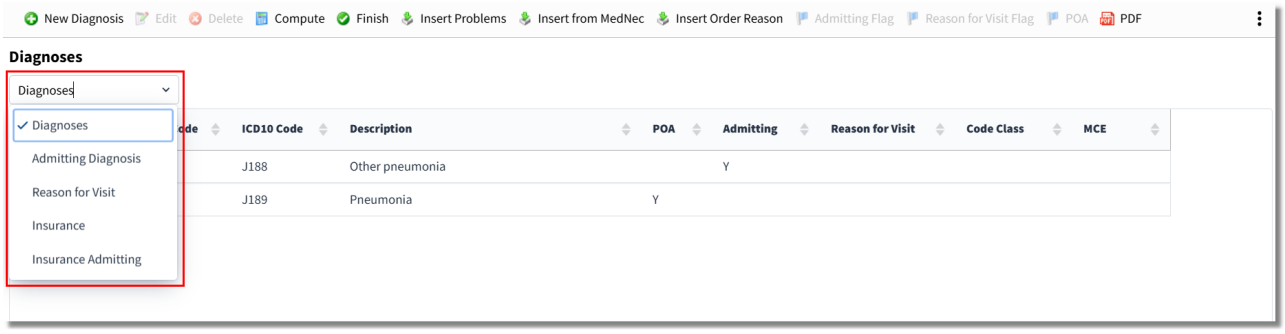
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



Diagnoses - Admitting Flag

The Admitting Diagnosis may also be added directly from the Admitting Diagnosis screen. To begin, select **Admitting Diagnosis** from the drop-down menu.

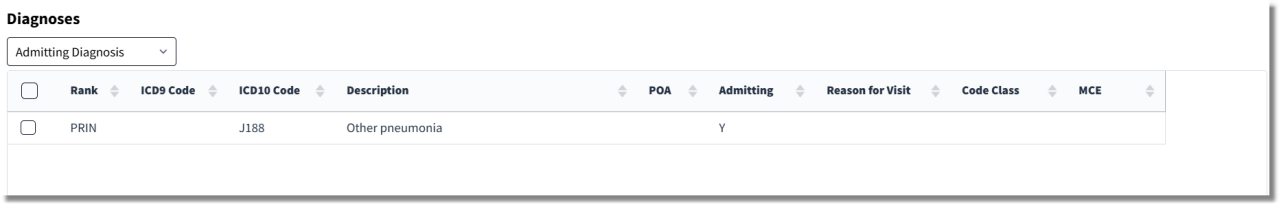
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



Diagnoses - Admitting Diagnosis Screen

The Admitting Diagnosis screen will display. From this scrreen, the admitting diagnosis can be added or edited from this screen using the same options available when adding a New Diagnosis 74 and Editing 76 an existing diagnosis.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Admitting Diagnosis**



Diagnoses - Admitting Diagnosis Screen

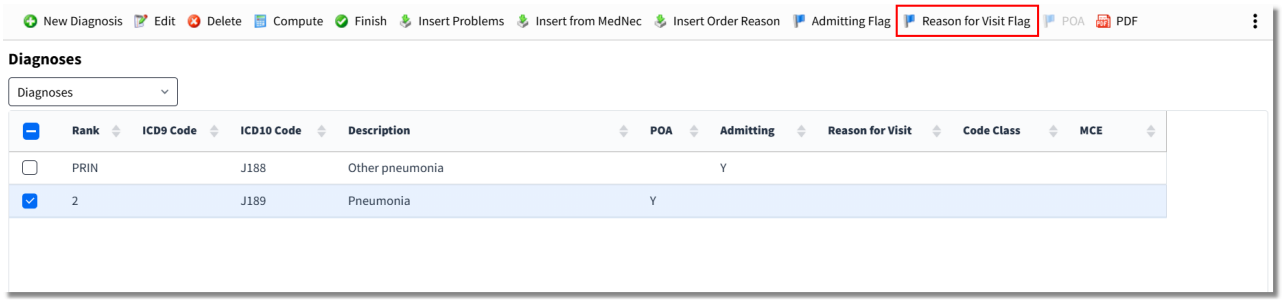
***NOTE**: Only one diagnosis may be listed as the admitting diagnosis; therefore, the option to add a New Diagnosis will not be accessible when an admitting diagnosis is already identified.*

***NOTE**: Facilities participating in the Electronic Case Reporting objective for Meaningful Use 3 may have a Case Report sent to a Public Health Agency when an Admitting Diagnosis entered here matches a diagnosis in the Trigger Code Table. Additional setup is required for this functionality. For more information please contact a TruBridge Support Representative.*

Reason for Visit Flag

The Reason for Visit Flag is used to identify multiple diagnoses as the Reason for Visit simultaneously. To begin, select the check-boxes beside each diagnosis codes—up to three diagnoses may be selected. After selecting the desired diagnosis, select **Reason for Visit Flag**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



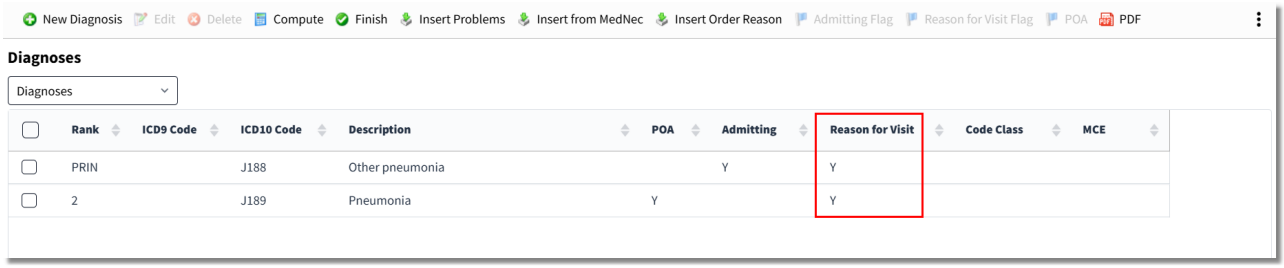
Diagnoses - Reason for Visit Flag

When flagged, a **Y** will pull in the Reason for Visit column for the diagnoses. These diagnosis will also be added to the Reason for Visit screen.

Up to three Reason for Visit diagnoses may be selected; therefore, the option to add a New Diagnosis will be disabled once three Reason for Visit diagnoses have been identified.

If a diagnosis has been marked as a Reason for Visit and the Reason for Visit Flag option is selected again, TruBridge EHR will remove the Y from the Reason for Visit column, indicating that the diagnosis is no longer designated as a Reason for Visit.

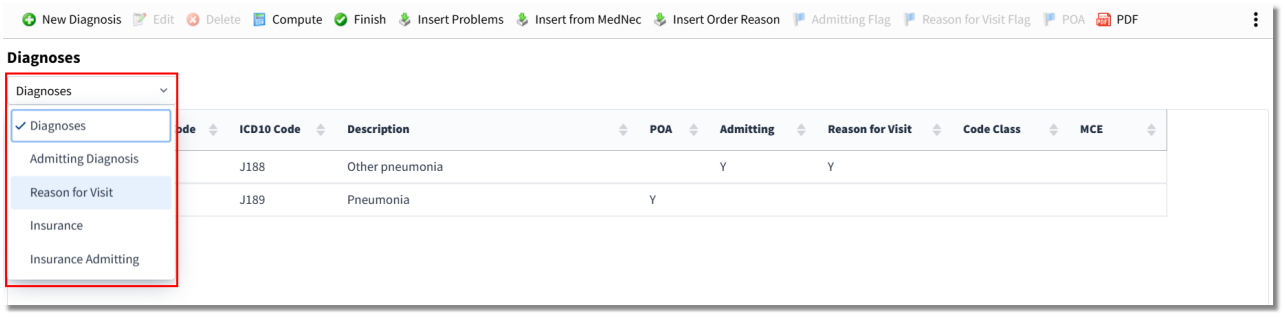
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



Diagnoses - Reason for Visit Flag

The Reason for Visit diagnoses may also be added separately from the Reason for Visit screen. To begin, select **Reason for Visit** from the drop-down menu.

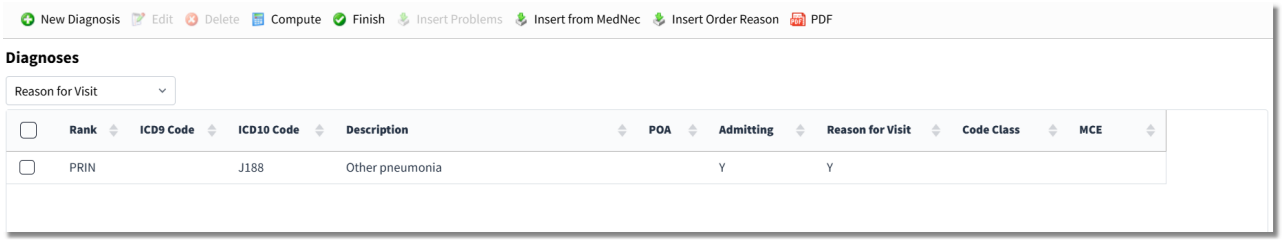
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnosis**



Diagnoses - Reason for Visit Screen

The Reason for Visit screen will display. Diagnoses can be be added or edited on this screen using the same options available for adding a New Diagnosis 74 and Editing 76 an existing diagnosis.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnosis > Reason for Visit**

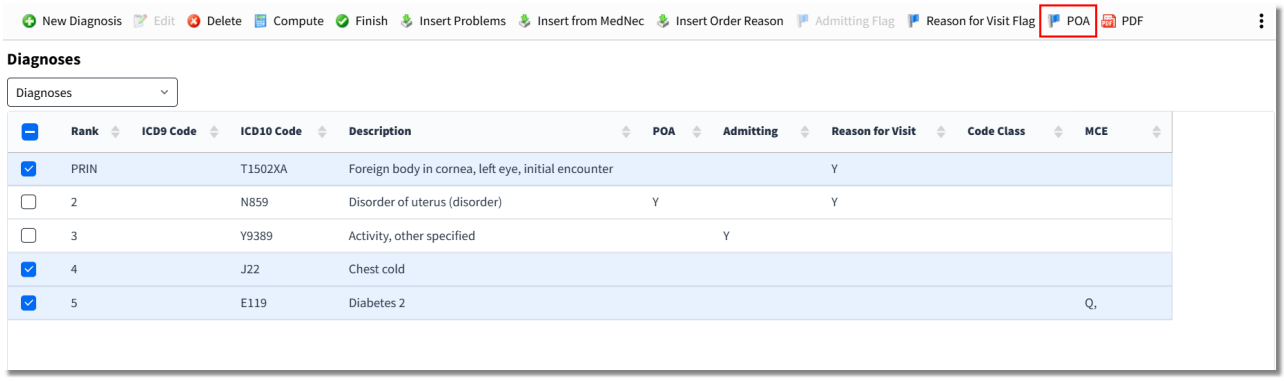


Diagnoses - Reason for Visit Screen

POA Flag

The POA Flag option allows the Present on Admission (POA) indicator to be updated on multiple diagnoses at one time. This option will become accessible when more than one diagnoses is selected on the Diagnoses screen. To select multiple diagnoses, select the check-boxes beside each diagnosis codes. After the diagnoses are selected, choose the **POA** Flag button.

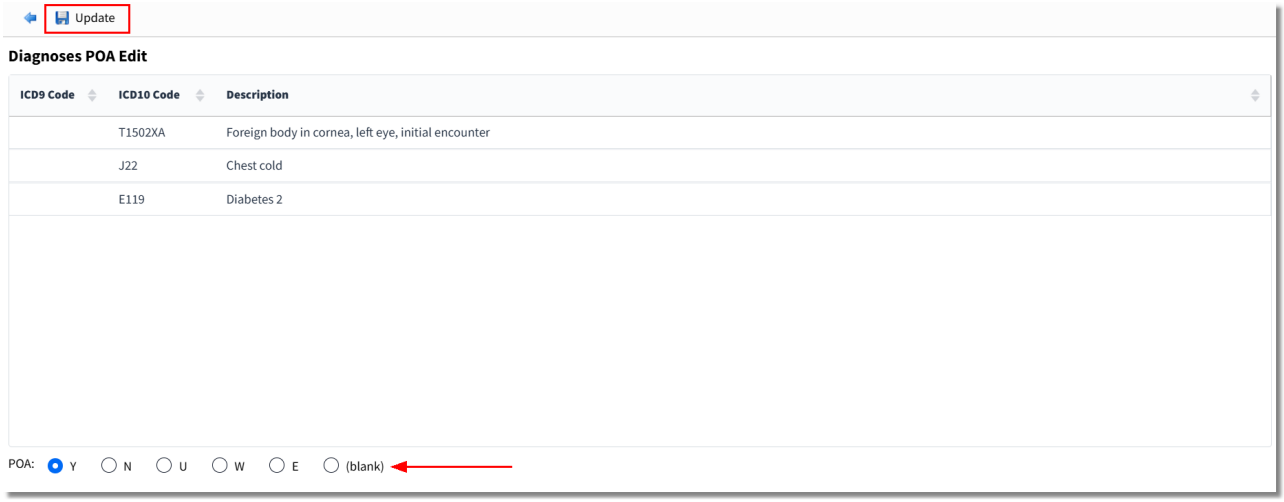
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis**



Diagnoses - POA Flag

The Diagnoses POA Edit screen will display. The top portion of the screen shows the selected diagnosis codes. Select the radio button next to the appropriate POA indicator for the selected diagnoses, then select **Update**.

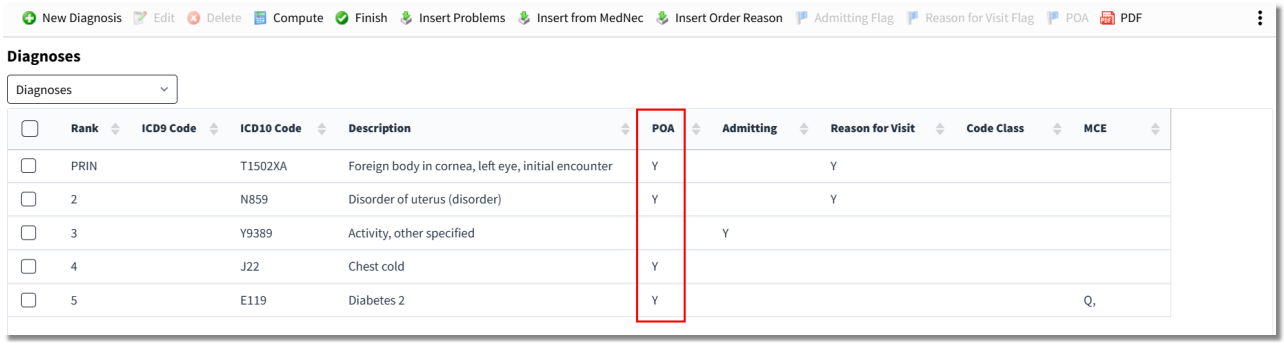
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Diagnosis** > **Select Codes** > **POA**



Diagnoses - POA Edit

The POA column will be updated for the selected diagnosis codes.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnosis**

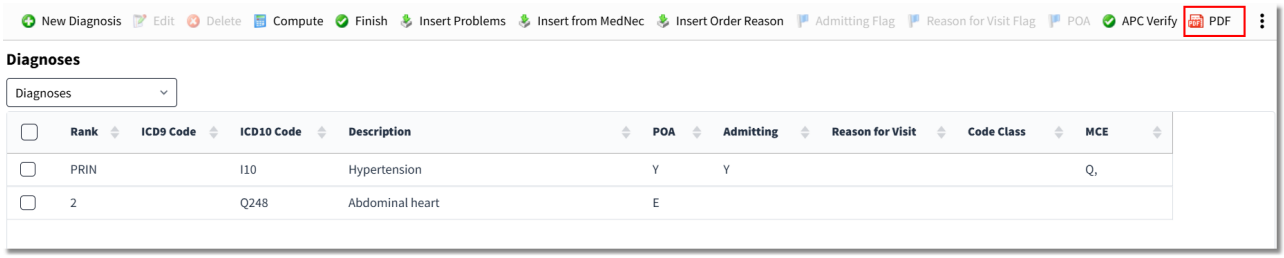


Diagnoses - POA Column

PDF

The PDF option allow the screen displayed to open in Adobe®. This option is available on the Patient Summary 55, Diagnosis 72, Procedure 89, and Account Detail 67 screens.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnosis > PDF**

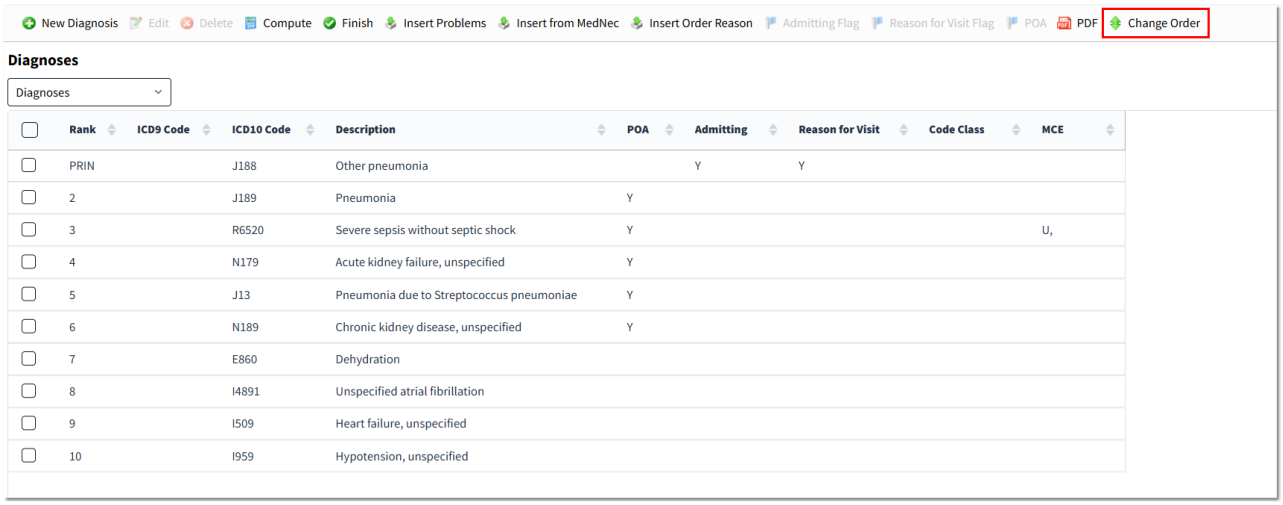


Diagnosis - PDF

Change Order

The Change Order option will allow directional tools to be used to rearrange the order of the diagnosis codes. This option may be selected from the diagnosis and procedure screens.

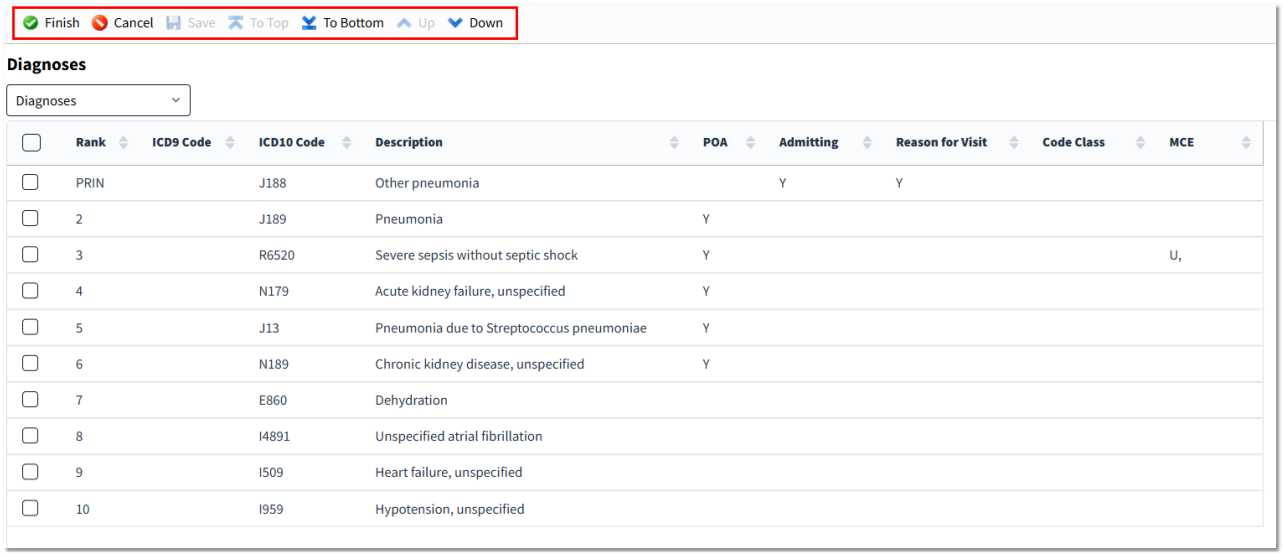
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Diagnosis > Change Order**



	Rank	ICD9 Code	ICD10 Code	Description	POA	Admitting	Reason for Visit	Code Class	MCE
☐	PRIN		J188	Other pneumonia		Y	Y		
☐	2		J189	Pneumonia	Y				
☐	3		R6520	Severe sepsis without septic shock	Y				U,
☐	4		N179	Acute kidney failure, unspecified	Y				
☐	5		J13	Pneumonia due to Streptococcus pneumoniae	Y				
☐	6		N189	Chronic kidney disease, unspecified	Y				
☐	7		E860	Dehydration					
☐	8		I4891	Unspecified atrial fibrillation					
☐	9		I509	Heart failure, unspecified					
☐	10		I959	Hypotension, unspecified					

Diagnoses - Change Order

After selecting the **Change Order** option the action bar will display a new toolbar. To change the order of the codes, select the code then use the directional tools to move the code to the top or bottom of the list or Up or Down a single line in the list. Select **Save** to keep the changes, or select **Cancel** to exit the toolbar without saving. The Finish 78 option may also be selected from the toolbar.



	Rank	ICD9 Code	ICD10 Code	Description	POA	Admitting	Reason for Visit	Code Class	MCE
☐	PRIN		J188	Other pneumonia		Y	Y		
☐	2		J189	Pneumonia	Y				
☐	3		R6520	Severe sepsis without septic shock	Y				U,
☐	4		N179	Acute kidney failure, unspecified	Y				
☐	5		J13	Pneumonia due to Streptococcus pneumoniae	Y				
☐	6		N189	Chronic kidney disease, unspecified	Y				
☐	7		E860	Dehydration					
☐	8		I4891	Unspecified atrial fibrillation					
☐	9		I509	Heart failure, unspecified					
☐	10		I959	Hypotension, unspecified					

Diagnoses - Change Order

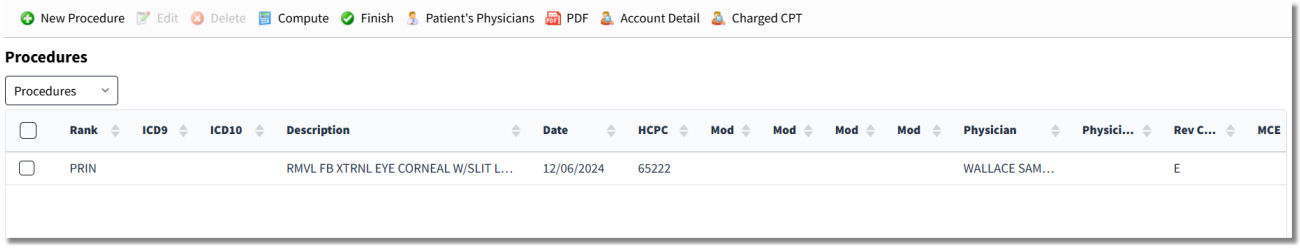
5.5 Procedures

The Procedures screen allows procedure information to be entered and stored on the account. By default, the Procedures option is selected in the drop-down menu. The drop-down menu includes the following options:

- **Procedures**: Allows procedure codes to be entered or edited.
- **Insurance**: Allows procedure information to be edited specifically for insurance billing purposes. Changes made on this screen will not copy to the Procedures screen and will only affect how procedure codes pull to the insurance claim.

NOTE: *The ability to view procedures under the Insurance option is controlled by the Behavior Control* ***Code by Insurance****. The ability to make changes to procedures under the Insurance option is controlled by the Behavior Control* ***Edit Non-HIM Diagnosis and Procedures Codes****. For more information on these screens, please refer to the Insurance User Guide.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures**



Procedures

If procedure codes have been added to the account, the existing procedure codes will display with the following information.

- **Rank:** Indicates the rank of the procedure codes. A rank of PRIN indicates that the procedure is the Principal procedure.
- **ICD9 Code:** Displays the ICD-9 code associated with the procedure.
- **ICD10 Code:** Displays the ICD-10 code associated with the procedure.
- **Description:** Displays the procedure code description selected on the Procedure List screen
- **Date:** Displays the date the procedure was performed. This date is entered on the Procedure Detail screen.
- **HCPC:** Displays the HCPC code selected on the Procedure List screen.
- **Mod (Modifier) 1-4:** List any modifier(s) entered on the Procedure Detail screen
- **Physician 1-2:** Displays the physician(s) associated with the Procedure Detail screen
- **Rev Cntr (Revenue Center):** Indicates the revenue center entered on the Procedure Detail screen
- **MCE's:** Displays any applicable Medicare Code Edits

F Female; Indicates female-only procedure

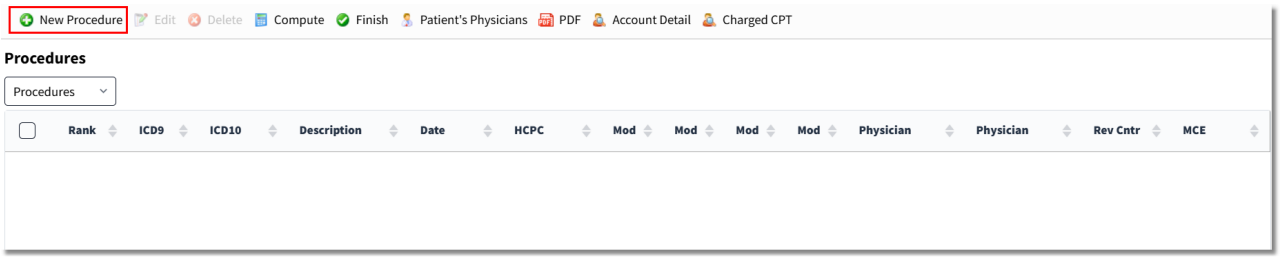
M Male; Indicates male-only procedure

For further definition of each MCE, the Edits 108 option may be selected.

New Procedure

To add procedure codes to an account, select **New Procedure**.

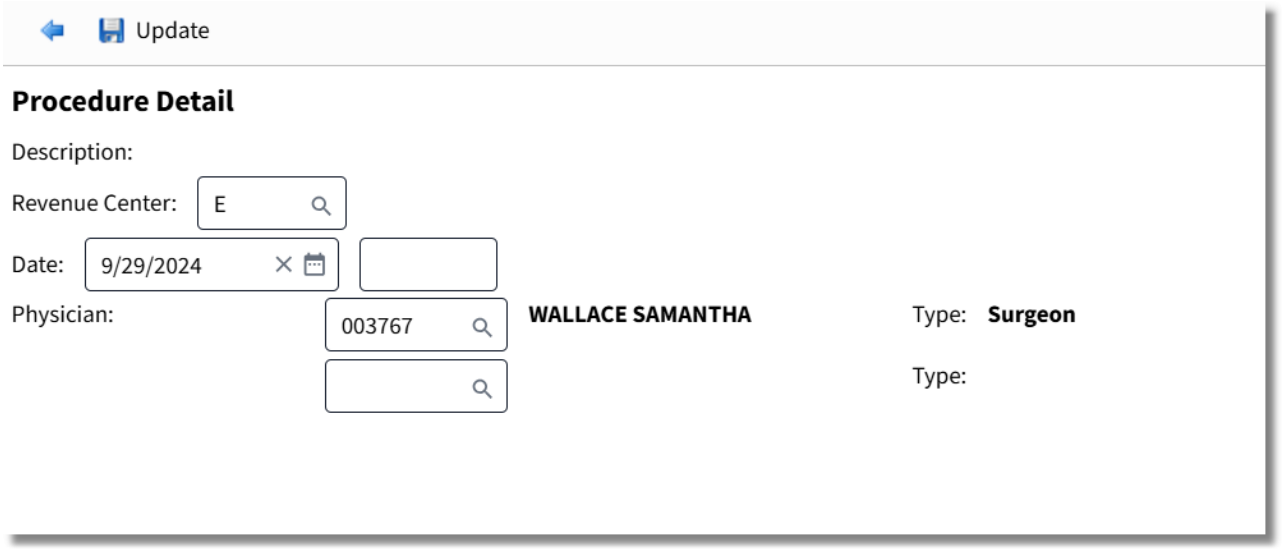
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures**



Procedures

The Procedure Detail screen will display. Information entered on this screen will apply to all the procedure codes selected from the Procedure List.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **New Procedure** > **New Procedure**



Procedure Detail

The following fields are available on this screen:

- **Revenue Center:** Used to designate the place of service where the procedure was performed. When entering the code associated with where the service was incurred, TruBridge EHR will pull the HCPC to the correct line on the insurance claim.

NOTE: *Setup is required to make this happen, for more information please see the additional documentation on Revenue Centers.*

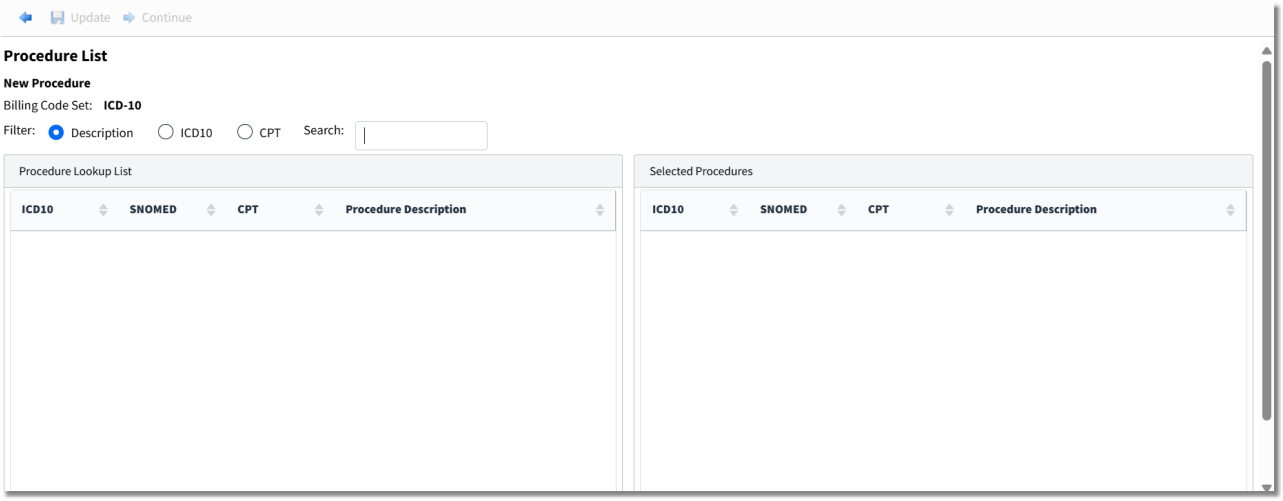
- **Date:** The date the procedure was performed. A **Date Picker** is available for ease of entry.

- **Physician:** These fields reference the physician(s) who performed the procedure. Up to two physicians can be associated with each procedure. Select the **magnifying glass** icon to display the Patient's Physician List. Double-click the correct physician. If the physician is not listed, use the Add and Add Type options to update the list, see Patient's Physicians 97 for more details.

NOTE*: The Attending, Primary, Secondary, and ER physician's will automatically pull to this list from the Census screens. If the surgeon is also the Attending physician, then the Attending physician will need to be added again with the Type set to Surgeon.*

Once the fields have been addressed, select **Update**. The Procedure List will display.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Procedures** > **New Procedure** > **Update**



Procedure List

- **Billing Code Set:** Displays the code set currently accepted by the Financial Class. Typically, this will be ICD-10.

- **Filter:** Provides the ability to search for procedure codes by Description or ICD-10.

- **Search:** Allows the ability to search by description, ICD-10 or CPT, depending on the selection made in the Filter field.

Once the search criteria is entered, the search results will display in the **Procedure Lookup List**. Double-click the desired code to move it to the **Selected Procedures** list.

Selecting a Procedure from the Procedure Lookup List that has an asterisk "*" in any column will allow the best grouping for the procedure to be selected.

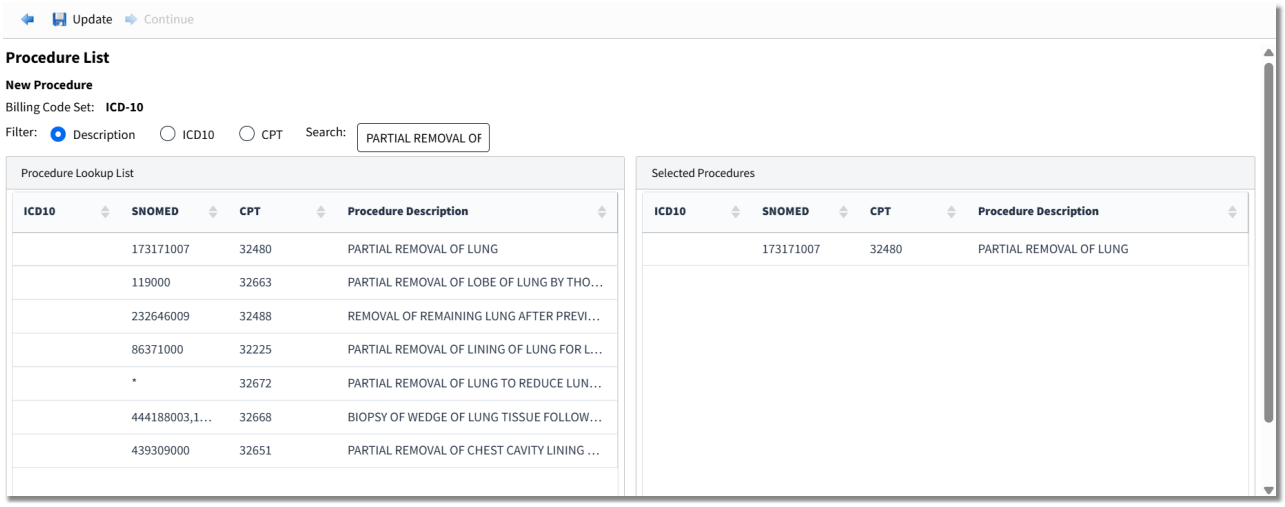
If a procedure code is added to the Selected Procedures list in error, double-click the Procedure code to remove it from the list.

Continue adding the procedure codes until all the procedures are displayed in the Selected Procedures list.

***NOTE**: If a procedure occurred on a different date, at a different place of service (Revenue Center) or involves a different Physician, it must be added separately.*

After all codes have been added, select **Update** to return to the procedures screen.

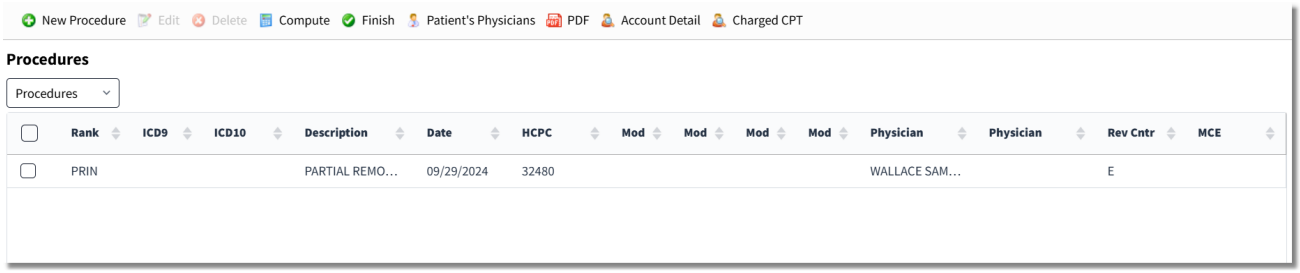
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **New Procedure** > **Update**



Procedure List

The coded procedure will list on the Procedure screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Procedures**

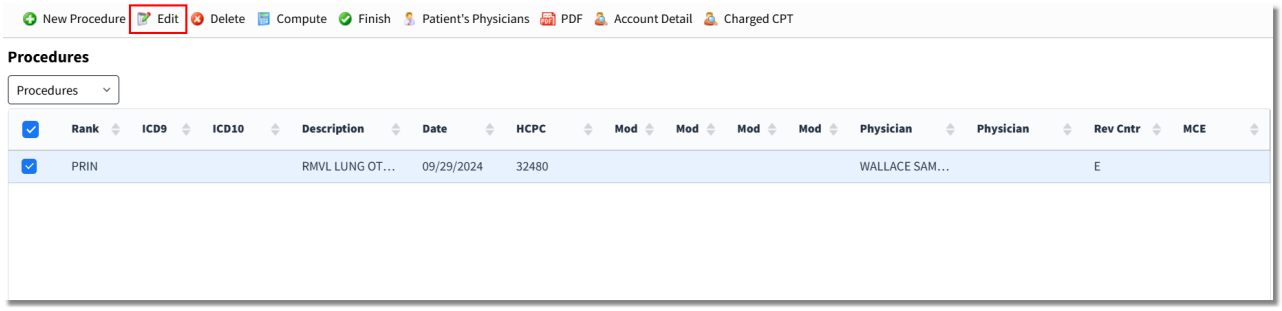


Procedures

Edit

The Edit option allows the Revenue Center, Procedure Date, and/or Physician(s) to be updated on a single procedure code. It also allows up to four modifiers to be added to a HCPC procedure code.

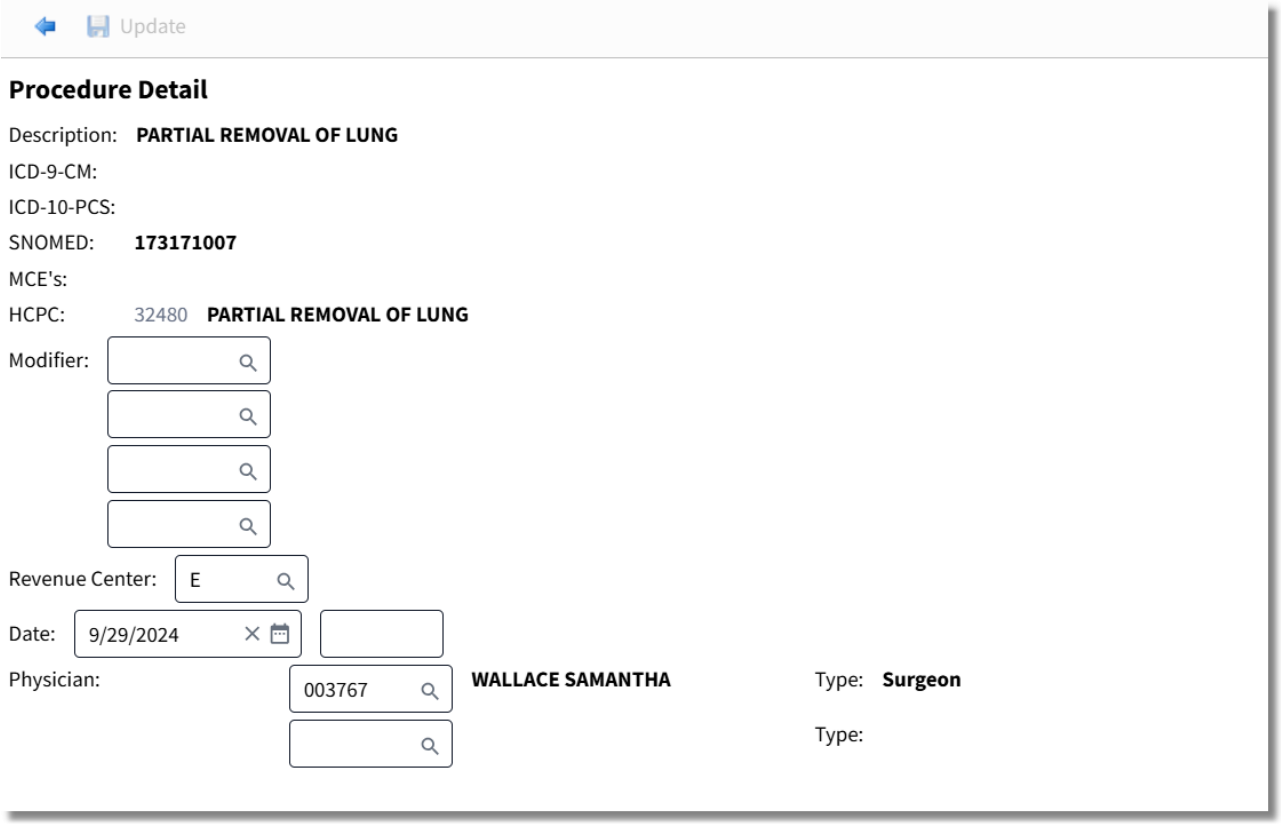
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Procedures**



Procedures

Once **Edit** is selected the Procedure Detail screen will display.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Select a Code** > **Edit**



Procedure Detail

The following information will display:

- **Description:** Displays the procedure code description selected from the Procedure screen.
- **ICD-9-CM:** Displays the ICD-9-CM code selected from the Procedure screen.
- **ICD-10-CM:** Displays the ICD-10-CM code selected from the Procedure screen.
- **SNOMED:** Displays the SNOMED code selected from the Procedure screen.
- **MCE's:** Displays any applicable Medicare Code Edits.
- **HCPC:** Displays the CPT code selected from the Procedure screen.
- **Modifier:** Up to four modifiers may be entered for the HCPC Procedure code.
- **Revenue Center:** Used to designate the place of service where the procedure was performed. When entering the code associated with where the service was incurred, TruBridge EHR will pull the HCPC to the correct line on the insurance claim.

NOTE: *Setup is required to make this happen, for more information please see the additional documentation on Revenue Centers.*

- **Date:** Allows the procedure date to be updated.
- **Physician (s):** Allows the Physicians associated with the procedure to be updated.

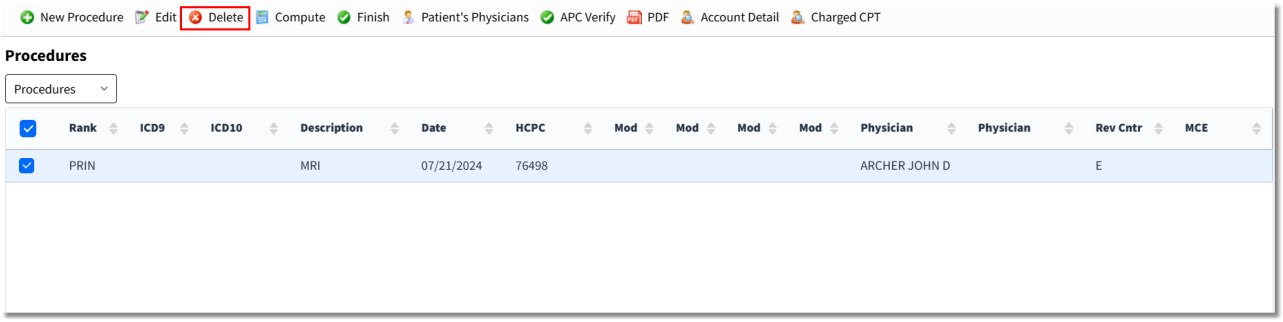
If any changes are made, select **Save**, then select the **Back Arrow** to return to the Diagnoses screen.

NOTE*: The Time option may also be accessed from the Procedure Detail screen. See the Time 102 section for additional information.*

Delete

The Delete option allows a diagnosis or procedure code to be removed. The Delete option may be selected from the Diagnosis and Procedures screens. To remove a code, select the diagnosis or procedure code from the list and then select **Delete**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedure** > **Select Code** > **Delete**

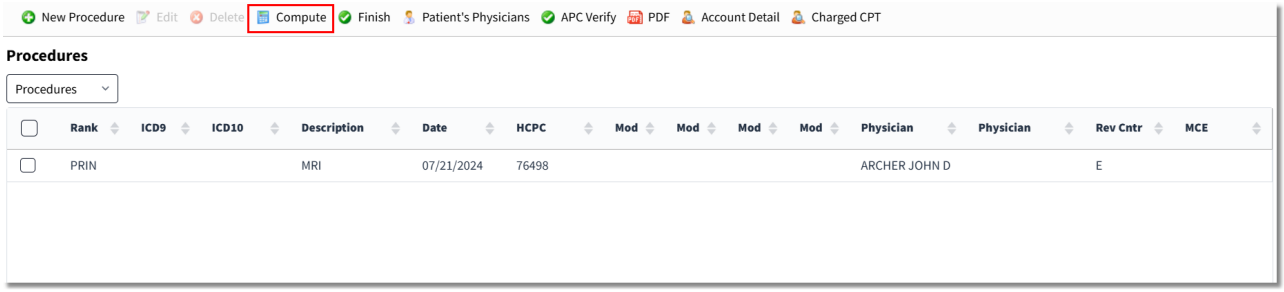


Procedure - Delete

Compute

The Compute option will calculate the DRG within TruBridge EHR and update the DRG field on the Patient Summary 55 screen. The Compute option may be selected from the Patient Summary, Diagnosis, and Procedures screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Compute**



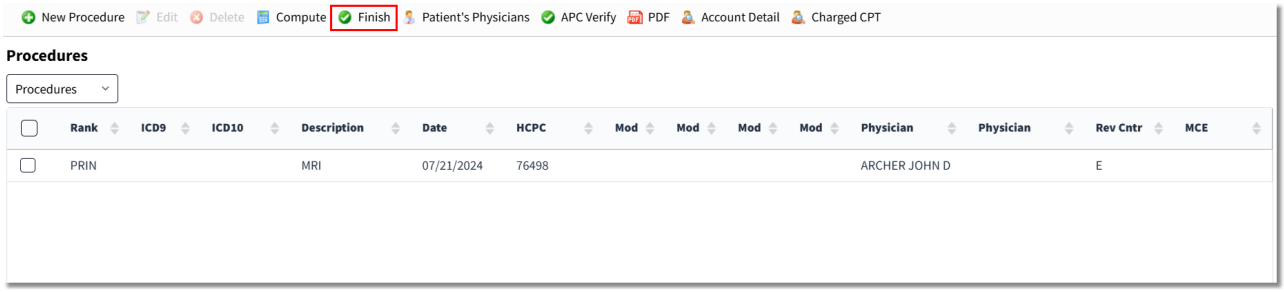
Procedure - Compute

For more information refer to the Compute 59 section.

Finish

The Finish option will populate the Finish Date and Coder Initials on the Patient Summary 55 screen. A Finished Date indicates that coding has been completed. If a Finish Date has already been populated, then the Revised Date and Coder Initials will be populated. The Finish option may be selected from the Patient Summary, Diagnosis, and Procedures screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Finish**



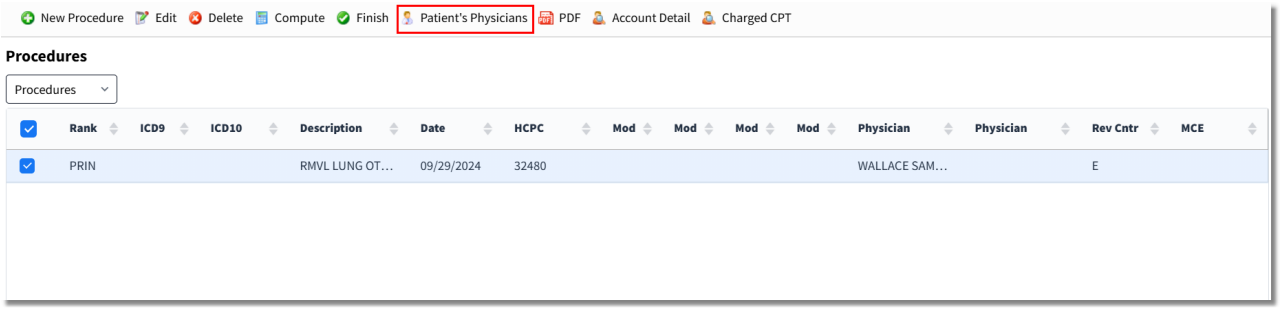
Procedure - Finish

For more information refer to the Finish 59 section.

Patient's Physicians

The Patient's Physician screen displays a list of physicians associated with the account. It can be accessed by selecting the Patient's Physician option on the Procedures screen. The list can also be updated when adding a physician to a New Procedure 91 or Editing 94 an exiting procedure.

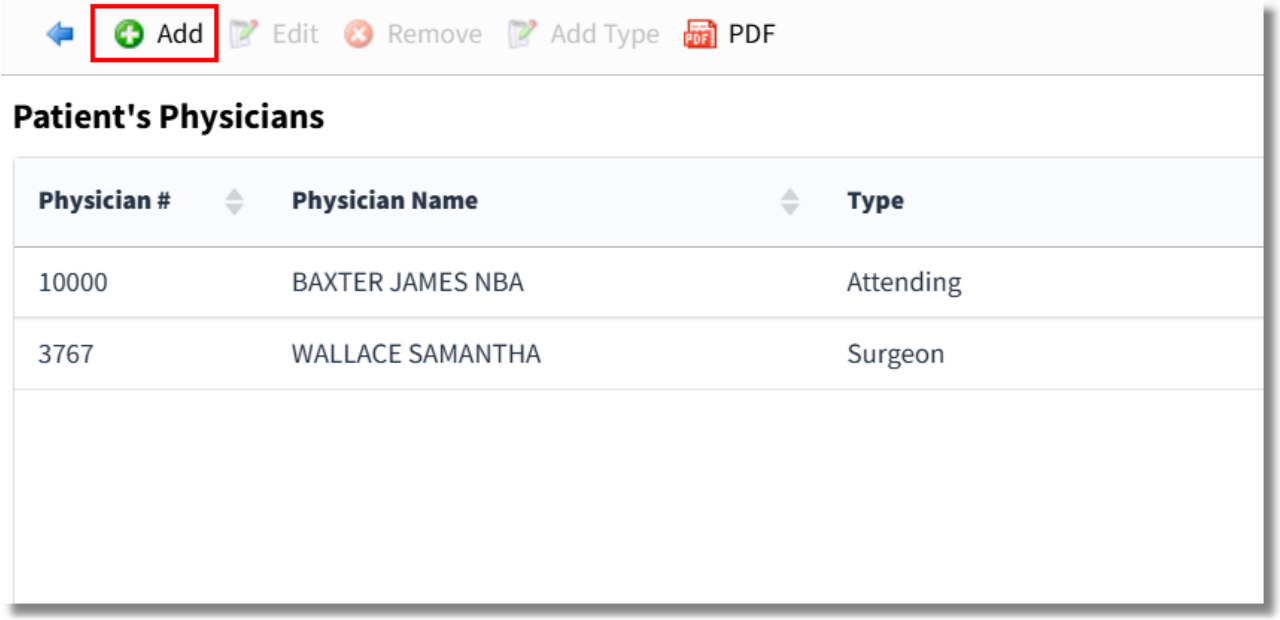
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures**



Procedures

When the screen is accessed, the Physician Number, Name and Type will be listed.

Select **Web Client** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Patient's Physician**



Patient's Physicians

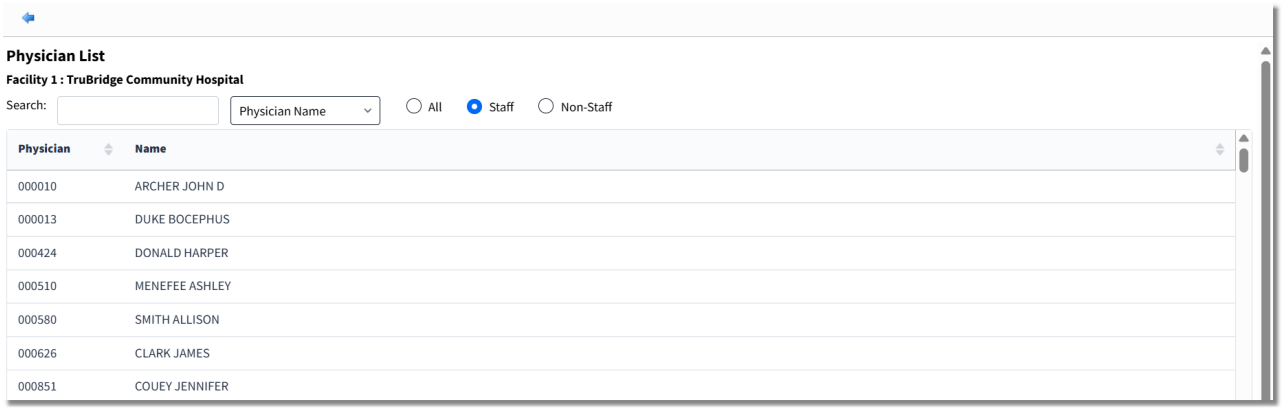
- The Attending, Primary, and Secondary physician will pull from the Stay tab on the Census screen. The ER physician is pulled from the ER Log on the Census screen.
  - The Attending and ER physicians may be edited directly from the Patient's Physicians screen.
  - The Primary and Secondary physicians must be edited from the Census screen.
  - Only one Attending may be assigned per account. If the correct Attending is not listed in the drop-down menu, remove the existing Attending physician before adding the new Attending physician.

- Consulting physicians entered from Point of Care Demographics or Clinical Information will automatically pull to the Patient's Physician list. These consulting physicians cannot be edited or removed from this screen.

- If a Hospitalist already exists on the Patient's Physicians list and another Hospitalist is added, the system will rename the existing Hospitalist as the Hospitalist of Record and label the newly added physician as the Hospitalist. Multiple Hospitalist of Record may be listed on the Patient's Physicians list; however, only one physician will be designated as the Hospitalist.

To add a physician to the list select **Add**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Patient's Physician** > **Add**

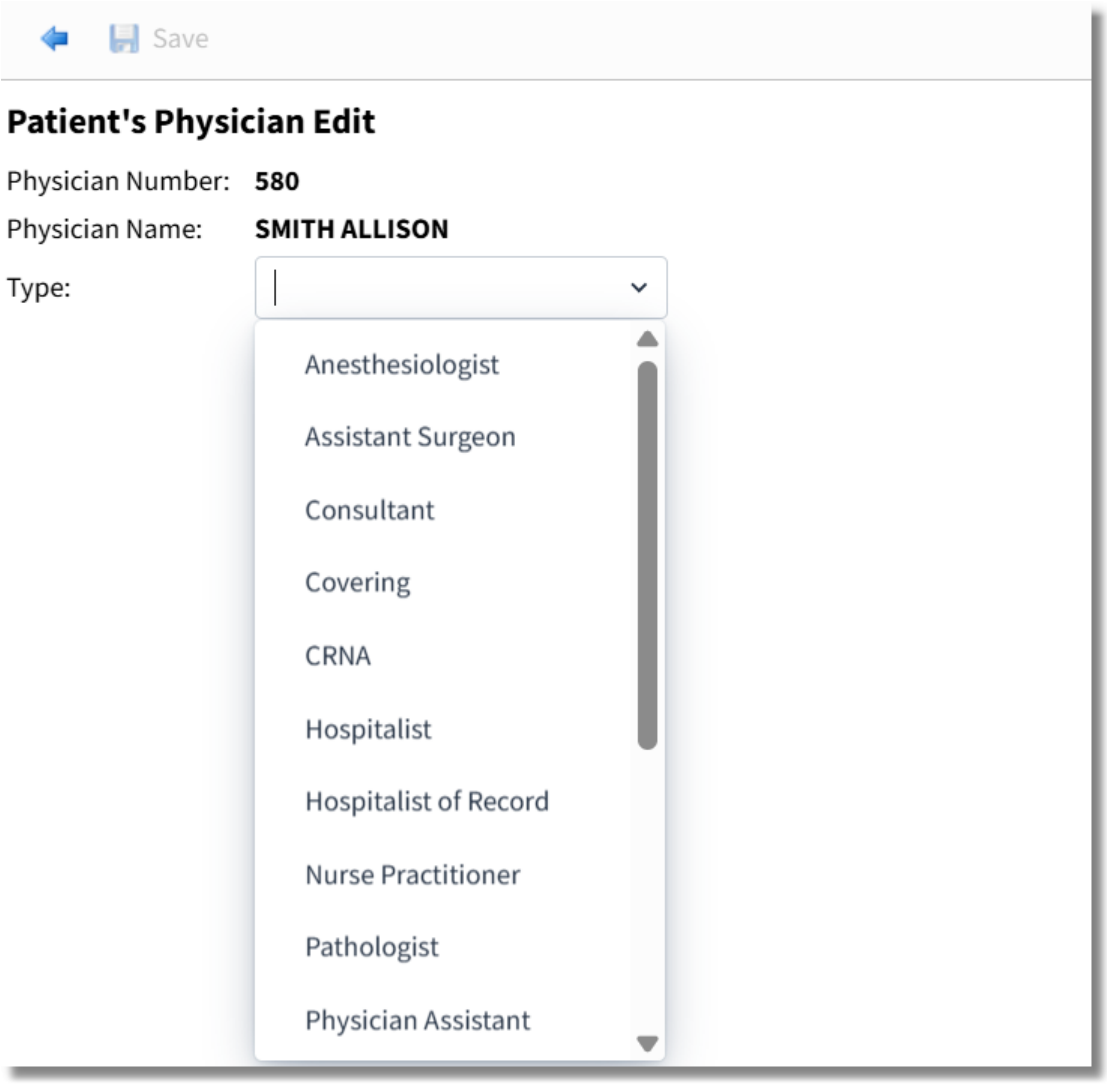


Physician Lookup

The Physician lookup will display. Search options are available to find physicians by Name or Number. Additionally, there is also a radio button to search from either the Staff or Non-Staff physicians.

Once the correct physician is found, double-click their name from the list. The Patient's Physician Edit screen will display. Select the appropriate Type from the drop-down menu.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Patient's Physician** > **Add** > **Select Physician**



Patient's Physician Edit

The following Types are are available to choose from:

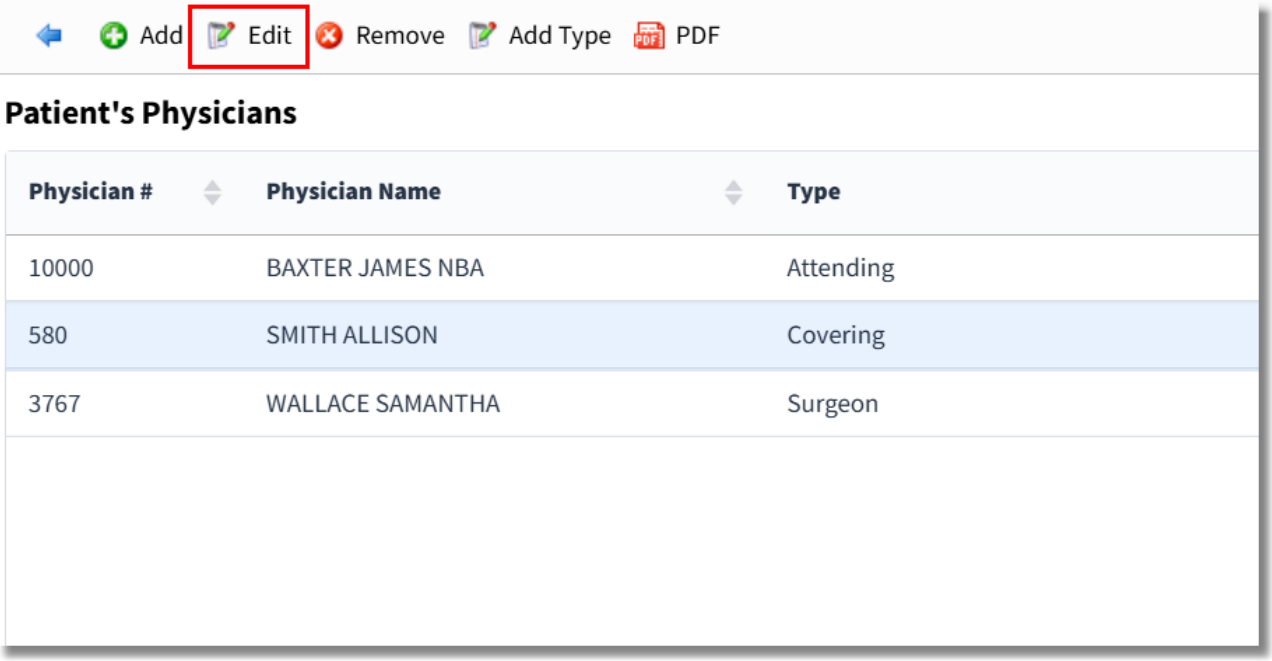
- Anesthesiologist
- Assistant Surgeon
- Attending
- Consultant
- Covering
- CRNA
- ER Physician 1
- ER Physician 2
- ER Physician 3
- ER Physician 4
- Hospitalist
- Hospitalist of Record

- Nurse Practitioner
- Pathologist
- Physician Assistant
- Radiologist
- Resident
- Surgeon

After selecting a Type, select **Save** and then the **Back Arrow** to return to the Patient's Physician screen.

The Edit option will allow the type to be updated on a physician that is already listed.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Patient's Physician**

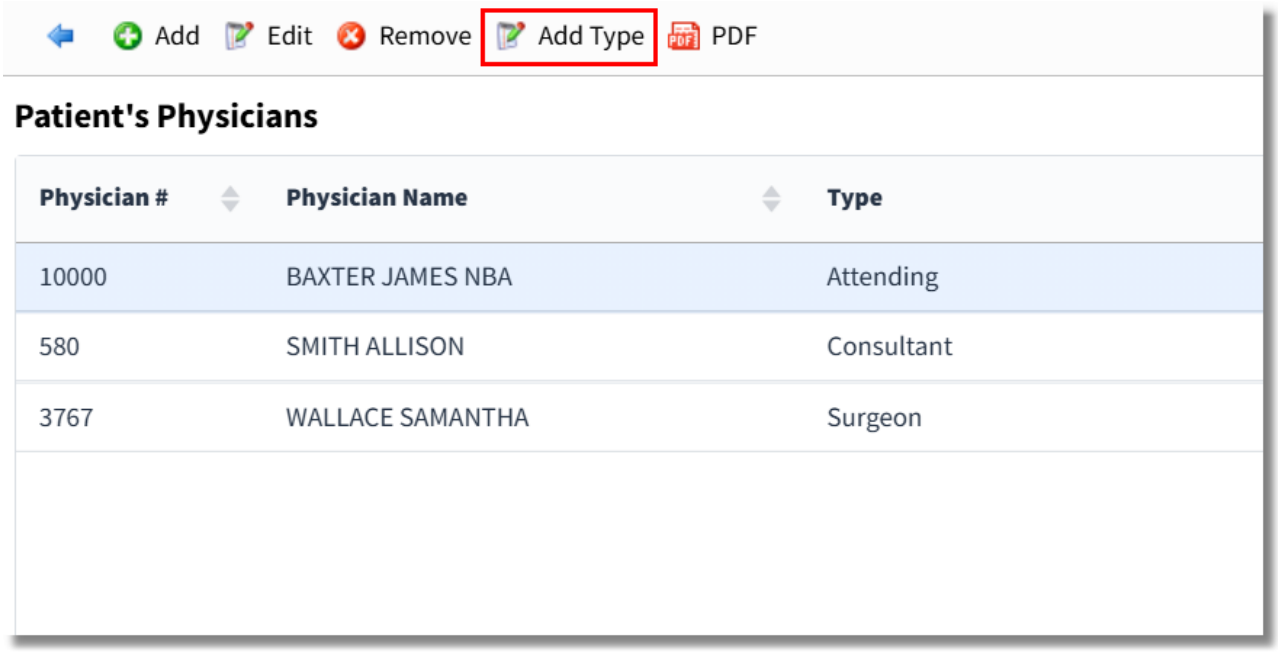


Patient's Physicians

When **Edit** is selected, the Patient's Physician Edit screen will display. Choose a different **Type** from the drop-down menu, then select **Save** to apply the changes. Use the **Back Arrow** to return to the Patient's Physician screen.

The **Add Type** option may used to list a physician that is already displayed again using a different physician type. For example, if the Attending physician is also the Surgeon, the Add Type may be used to list the Attending physician again, but with the Type as Surgeon.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **Patient's Physician**



Patient's Physicians

When Add Type is selected, the Patient's Physician Edit screen will display. Choose a different Type from the drop-down menu, then select **Save** to keep the changes. Use the **Back Arrow** to return to the Patient's Physician screen. The physician will be listed again, with the additional Type.

***NOTE**: The PDF option may also be accessed from the Procedure Detail screen. See the PDF 105 section for additional information.*

Time

The Time option is utilized with the Point of Care and OR Management applications. When selected, it displays the Start and Stop times for procedures brought over from the patient's Flowsheet. This option can be used to verify procedure start and stop times and to post level based charges on the account.

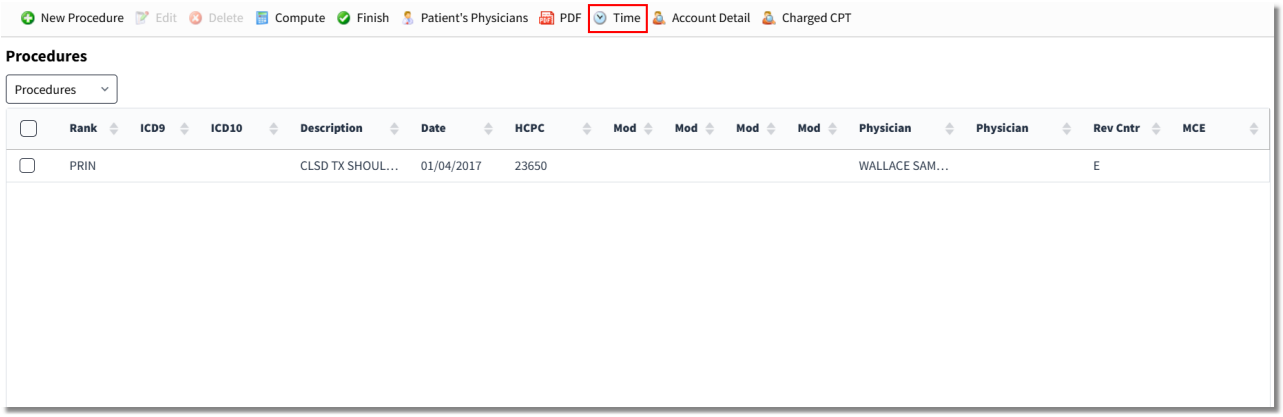
The following table maintenance must be in place in order for the Time option to display:

- AHIS, page 8 must have "Auto Charging for OR Mgt" set to **Y**.
- Medical Record Control Table must have the "Grouper/OR Management IF" field checked.
- The CPT Code table must have the procedure must have a Charge Level Code loaded in the CPT Code table.
- The Charge Level Table must also be set up.

***NOTE**: The above table maintenance only outlines the table maintenance necessary to utilize the Time option. The Time option is used with the Point of Care and OR Management applications and these application may require additional table maintenance. Please contact a TruBridge representative before making changes to any of these tables.*

The **Time** option may be selected from the Procedures List screen or by selecting a procedure code and accessing the Procedure Edit screen.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures**



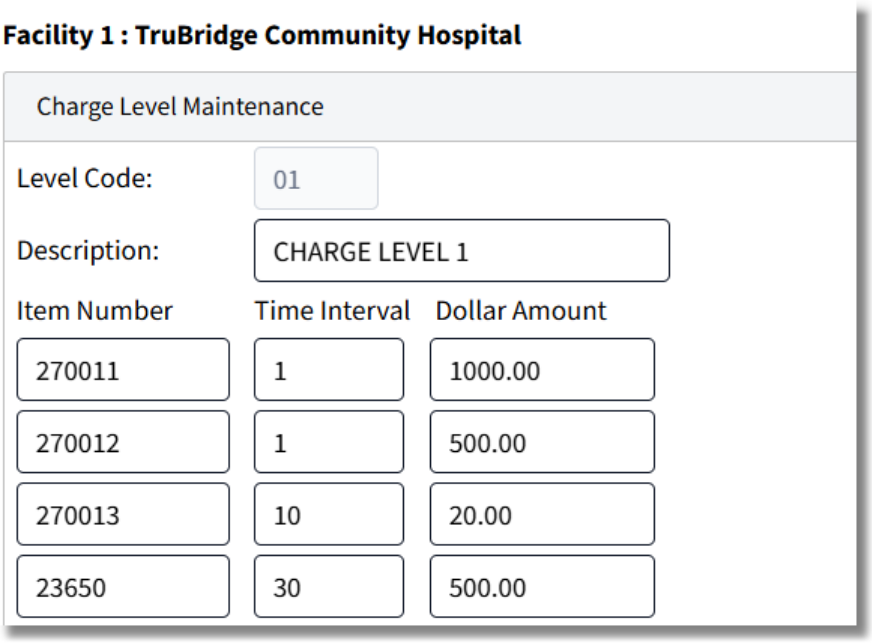
Grouper - Time

Once selected, the procedure start and stop times may be edited. A Post option is also available, which post charges to the patient's Account Detail based on the set up of the Charge Level Table and the length of the procedure.

***NOTE**: The option to Post is only available when the Time option is selected from the Procedures List screen. If the Time option is selected after choosing a specific procedure code only the procedure start and stop times may be updated.*

When posting charges, TruBridge EHR will reference the Charge Level Table for the Level Code associated with the procedure code. The Charge Level table is maintained within Table Maintenance.

Select **Web Client** > **Tables** > **Business Office** > **Charge Level Table** > **Select a Code**



Charge Level Table

TruBridge EHR will use the total procedure time entered on the Time screen, along with the information in the Charge Level Table, to determine which charges to post.

The system evaluates the Charge Level Table sequentially:
1. It will look to the first item entered in the Charge Level Table, and
2. If the first Time Interval is not long enough to cover the total procedure time, TruBridge EHR will charge the first item as well as the second item.
3. If the total for the time intervals from the first item and second item are not long enough to cover the total procedure time, TruBridge EHR will charge the first, second and third item.

TruBridge EHR will continue to charge each item in the table until the total procedure time has been charged. If TruBridge EHR reaches the last item listed in the table and the total procedure time has not yet been charged then the last item will be charged multiple times.

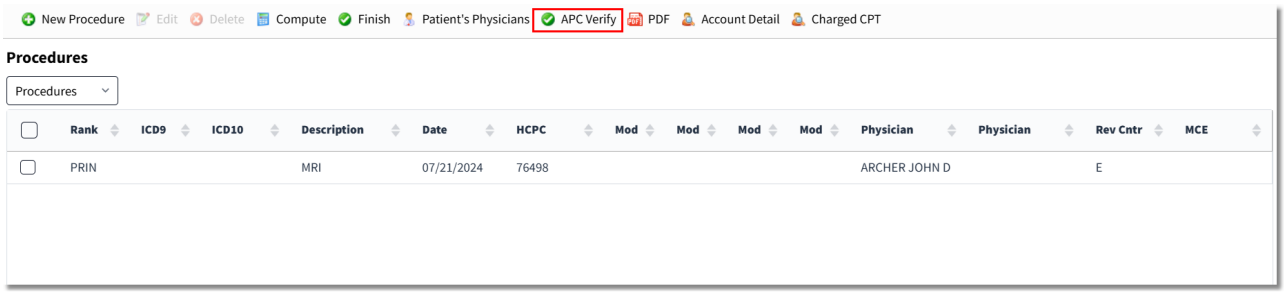
For example, based on the table set up on in the image above if the total procedure time is 55 minutes the following would be charged on the patient's account.

Item 270011	Quantity 1	$1000.00
Item 270012	Quantity 1	$500.00
Item 270013	Quantity 10	$200.00
Item 23650	Quantity 30	$500.00

APC Verify

The APC Verify option will display when there is an APC claim at the Unchecked status present on the account. The APC Verify option will be available on the Patient Summary, Diagnosis and Procedures screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedures** > **APC Verify**



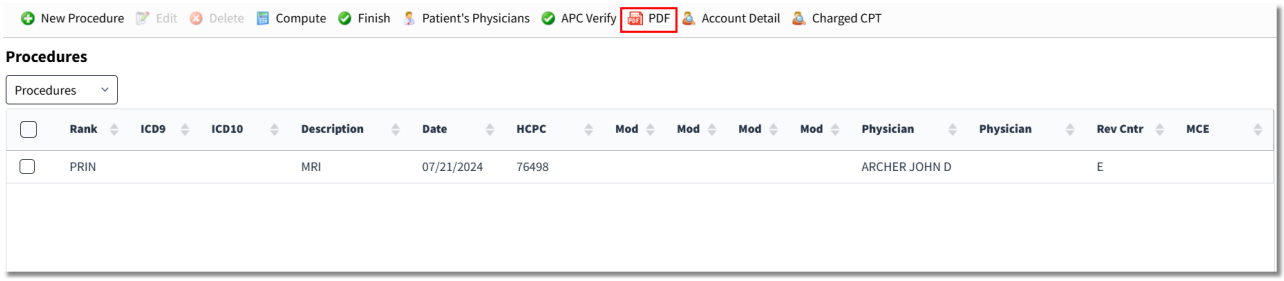
Procedure - APC Verify

For more information refer to the APC Verify 60 section.

PDF

The PDF option allow the screen displayed to open in Adobe®. This option is available on the Patient Summary 55, Diagnosis 72, Procedure 89, and Account Detail 105 screens.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedure** > **PDF**

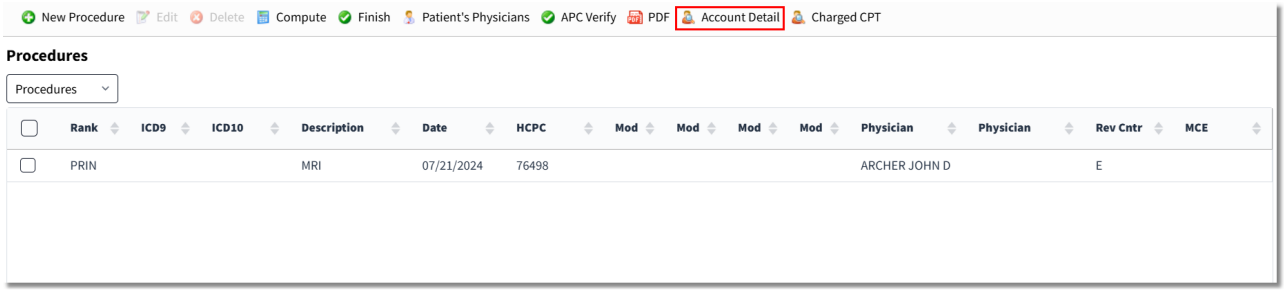


Procedure - PDF

Account Detail

The Account Detail option allows the patient's Account Detail to be displayed. This option may be accessed from the Patient Summary 55, Procedures 89 and Charges 115 screens.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Procedures > Account Detail**



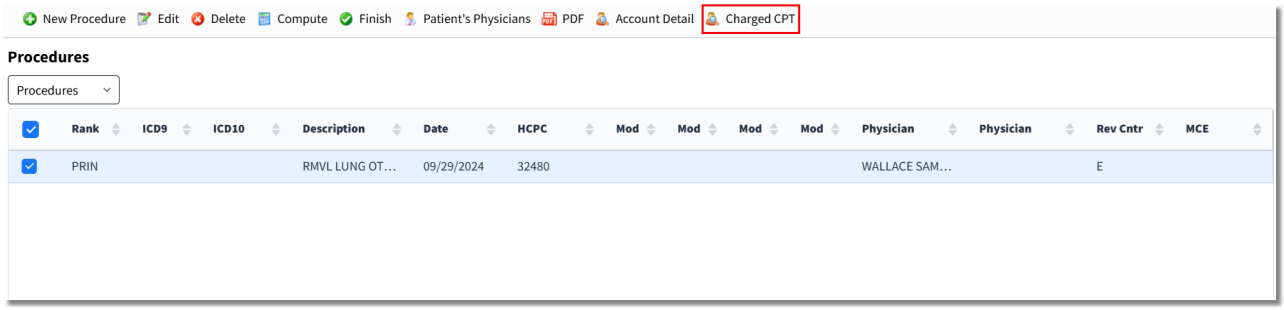
Procedure - Account Detail

For more information refer to the Account Detail 67 section.

Charged CPT

The Charged CPT screen displays charges that have been posted to the account that have a CPT code loaded on Page 1 of the Item Master. This screen may be accessed from the Patient Summary 55 and Procedures 89 screens.

Select **Web Client > Application Drawer > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Procedures > Charged CPT**



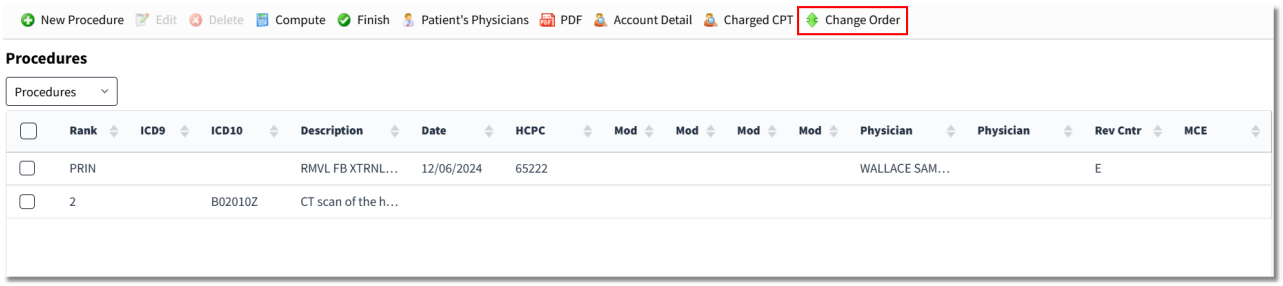
Procedure - Charged CPT

For more information refer to the Charged CPT 68 section.

Change Order

The Change Order option will allow directional tools to be used to rearrange the order of the procedure codes. This option may be selected from the diagnosis and procedure screens.

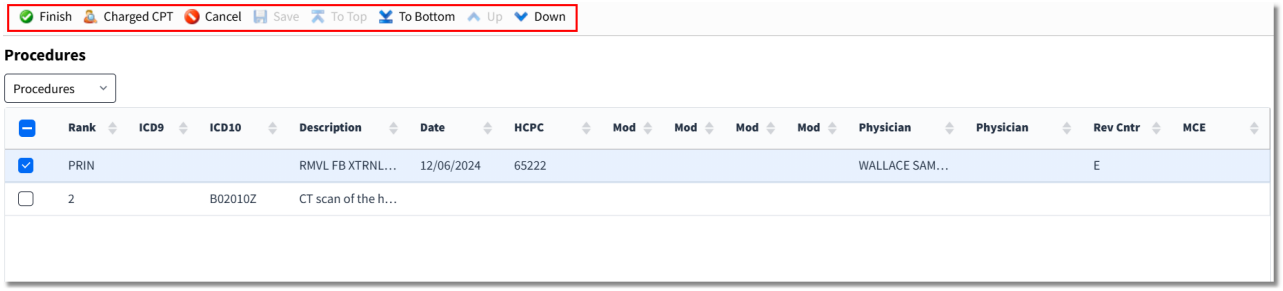
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedure**



Procedure - Change Order

After selecting the **Change Order** option the action bar will display a new toolbar. To change the order of the codes, select the code then use the directional tools to move the code to the top or bottom of the list or Up or Down a single line in the list. Select **Save** to keep the changes, or select **Cancel** to exit the toolbar without saving. The Finish 97 option may also be selected from the toolbar.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Procedure** > **Change Order**

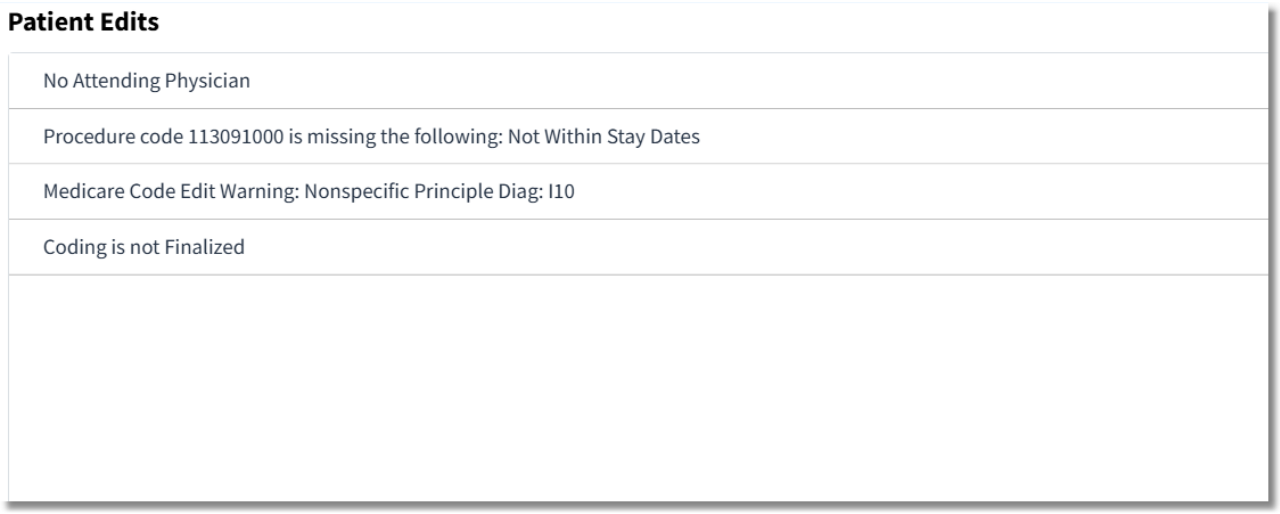


Procedure - Change Order

5.6 Edits

The Edits option will display possible coding errors.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Edits**



Edits

The following edits will be tracked via this screen

- Medicare Code Edits for Diagnoses
  - This Diagnosis is just for Males
  - This Diagnosis is just for Females
  - This Diagnosis is just for Newborns
  - This Diagnosis is just for Ages 0-7
  - This Diagnosis is just for Adults
  - This Diagnosis is just for Maternity Age
  - Nonspecific Principle Diagnosis

- Medicare Code Edits for Procedures
  - This Procedure is just for Males
  - This Procedure is just for Females

- Procedure Code Edits
  - Procedure Code missing Surgeon
  - Procedure Code missing date
  - Procedure Date not within Stay Dates

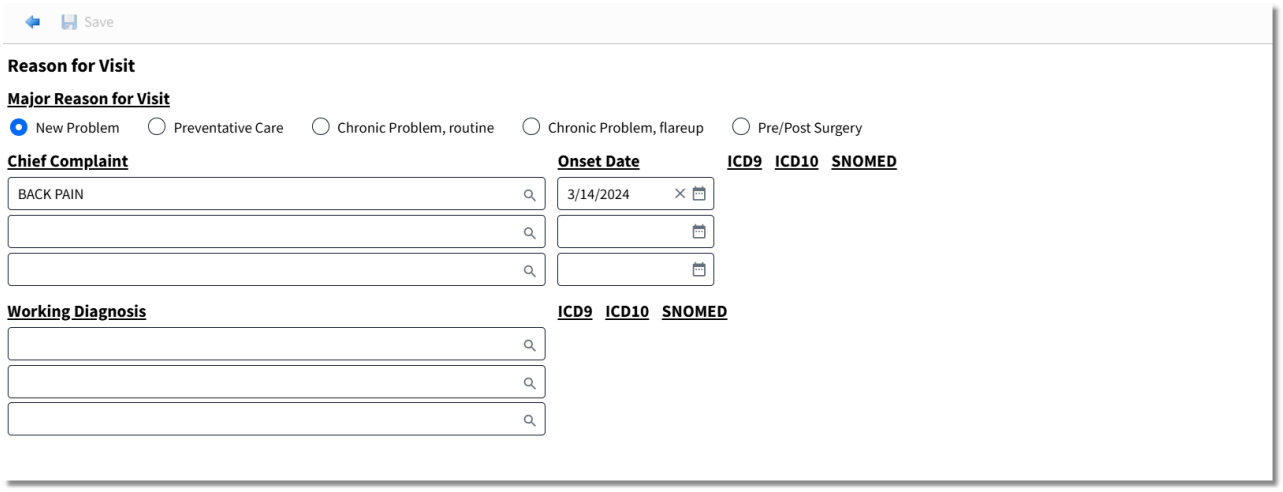
- Other
  - Coding not finalized
  - Attending Physician Blank

5.7 Chief Complaint

Selecting Chief Complaint will display the Reason for Visit screen. This screen allows the Chief Complaint — originally entered on the Clinical Tab in the Census screens — to be viewed and/or edited.

NOTE**: The ability to edit the Chief Complaint field is controlled by the **Behavior Control "Access Chief Complaint Fields".

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Chief Complaint**



Chief Complaint

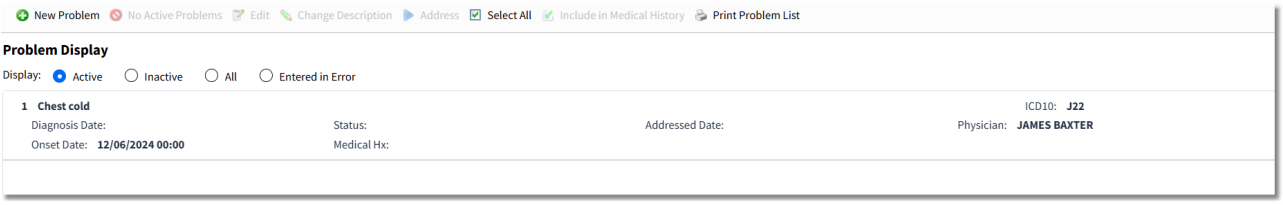
***NOTE:** For more information, please refer to the Clinical Section in the Person Profile and Registration User Guide.*

***NOTE**: Facilities participating in the Electronic Case Reporting objective for Meaningful Use 3 may have a Case Report sent to a Public Health Agency when a Working Diagnosis or Physician Admit Reason entered here matches a diagnosis in the Trigger Code Table. Additional setup is required for this functionality. For more information please contact a TruBridge Support Representative.*

5.8 Problem List

This Problem List option allows the Physician Problem List to be accessed by administrative staff such as coders, utilization review and medical records personnel.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Problem List**



Problem List

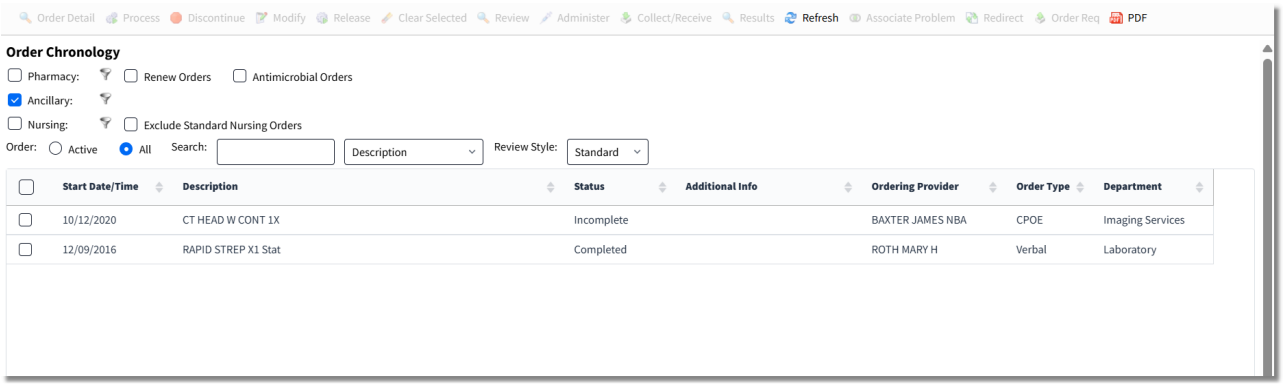
NOTE: *For more information, please refer to the Problem List User Guide.*

NOTE*: Facilities participating in the Electronic Case Reporting objective for Meaningful Use 3 may have a Case Report sent to a Public Health Agency when a Problem (diagnosis) entered here matches a diagnosis in the Trigger Code Table. Additional setup is required for this functionality. For more information please contact a TruBridge Support Representative.*

5.9 Order Chronology

The Order Chronology screen allows access to order details on a patient's account.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Order Chronology**



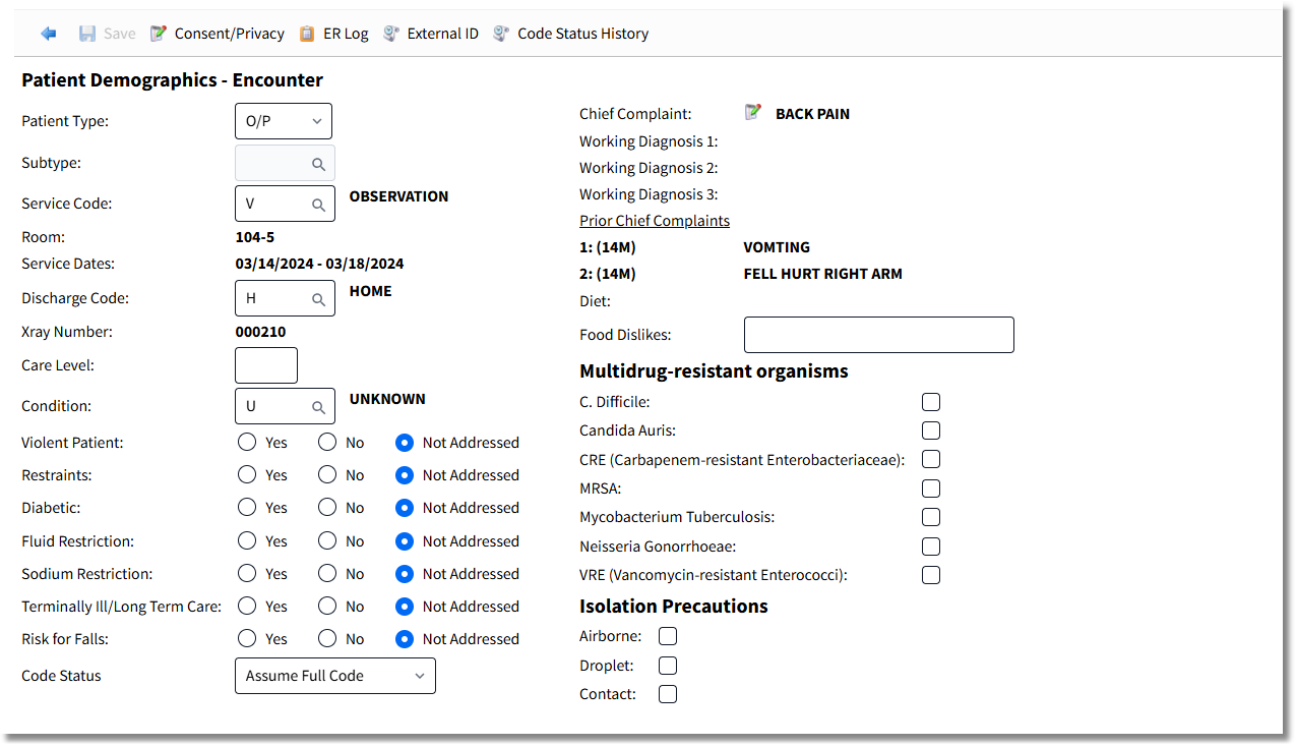
Order Chronology

NOTE: *For more information, please refer to the Order Chronology User Guide.*

5.10 Demographics

The Demographics option allows demographic information entered at the time of Registration to be viewed/edited by Medical Records.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Demographics**



Demographics

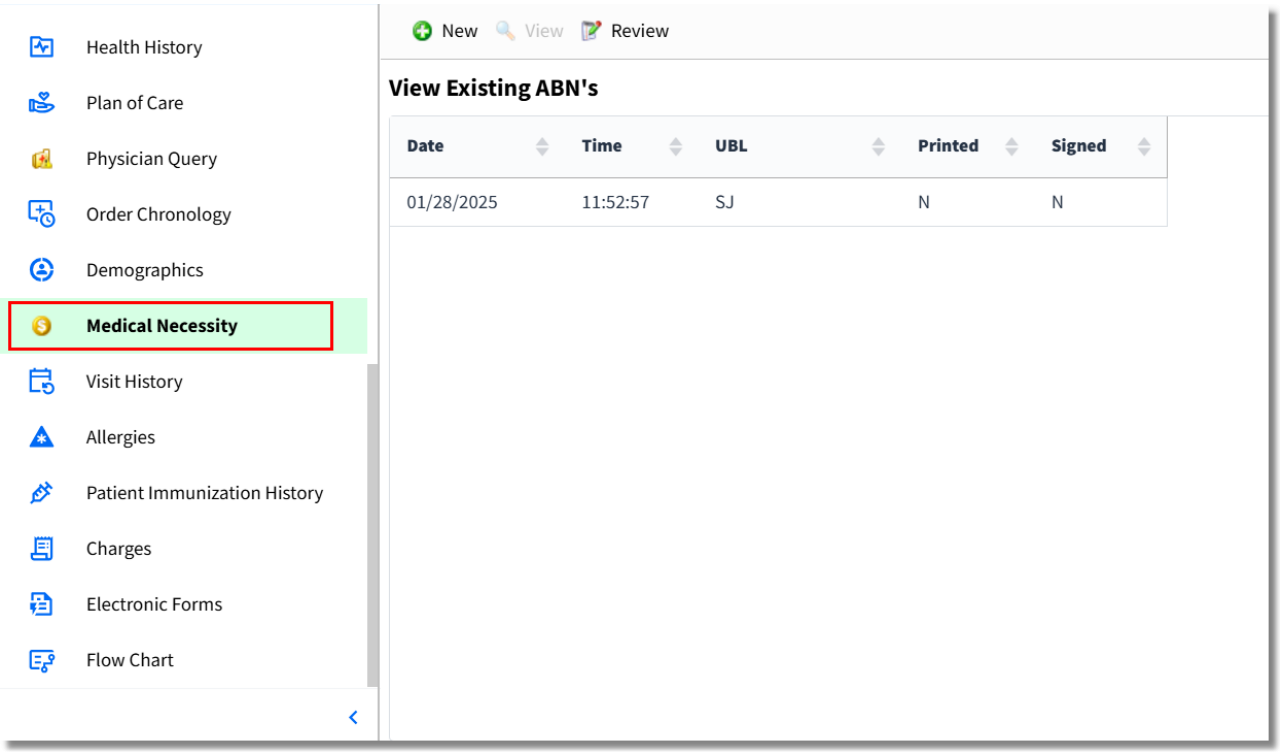
NOTE: *For more information, please refer to the Encounter section of the Demographics User Guide.*

5.11 Medical Necessity

The Medical Necessity option allows new medical necessity checks to be performed and existing medical necessity checks to be reviewed. Medical Necessity may be accessed from within the Grouper or the Medical Records System.

Grouper

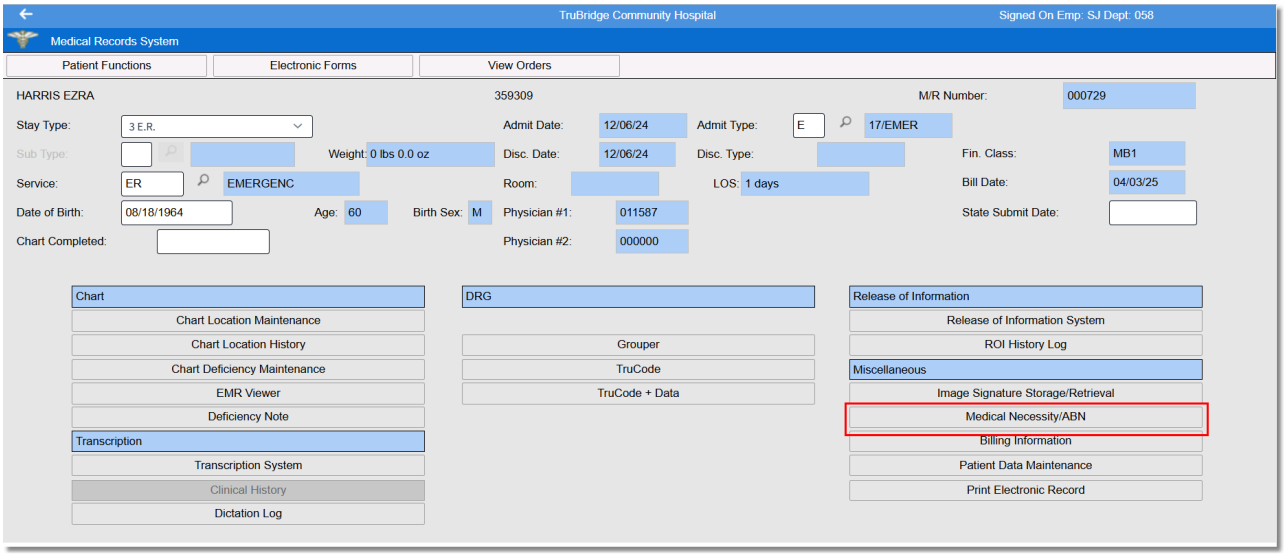
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Medical Necessity**



Grouper - Medical Necessity

Medical Records System

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Medical Necessity/ABN**



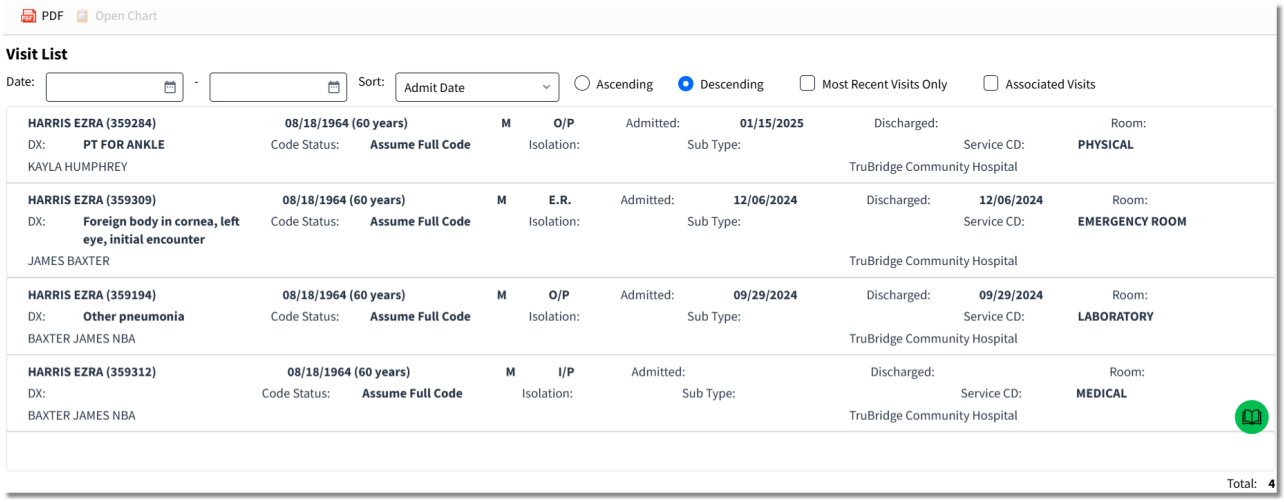
Medical Records System

NOTE: *For more information, please refer to the Medical Necessity User Guide.*

5.12 Visit History

The Visit History option allows access to view all the past patient visits. The listing will include visits from all shared Account Receivables. The display may be filtered and sorted in various display options.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Visit History**



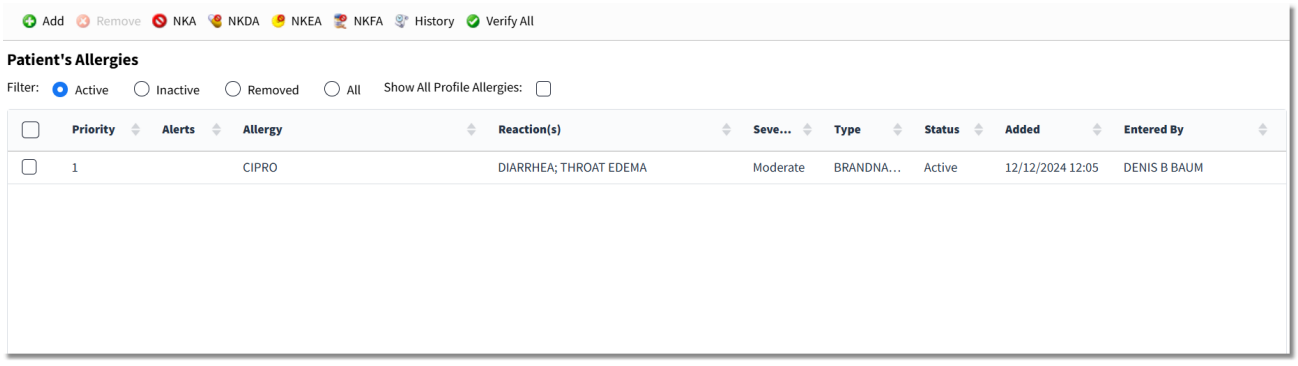
Visit History

NOTE: *For more information, please refer to the Visit History User Guide.*

5.13 Allergies

The Allergies option is used to add allergies for medication, food and environmental allergens. Reactions for each allergy may be entered. Information entered in the Allergies tab will copy forward to future visits so information only needs to be entered initially. Allergies are checked for interactions when placing orders for medications. They also display in the demographics information for quick reference.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Allergies**



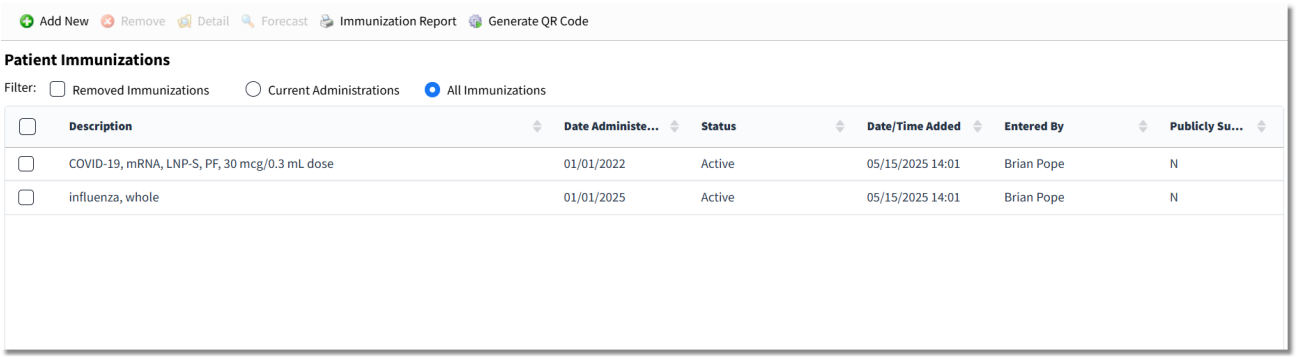
Allergies

NOTE: *For more information, please refer to the Allergies User Guide.*

5.14 Patient Immunization History

Patient Immunization History option is an electronic record of a patient's immunizations. If ordered and administered through TruBridge EHR, immunizations will automatically pull over to the immunization record. The user will also have the ability to select an immunization and add the vaccine information manually. These immunizations will be saved within the electronic record and the patient's profile.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Patient Immunization History**



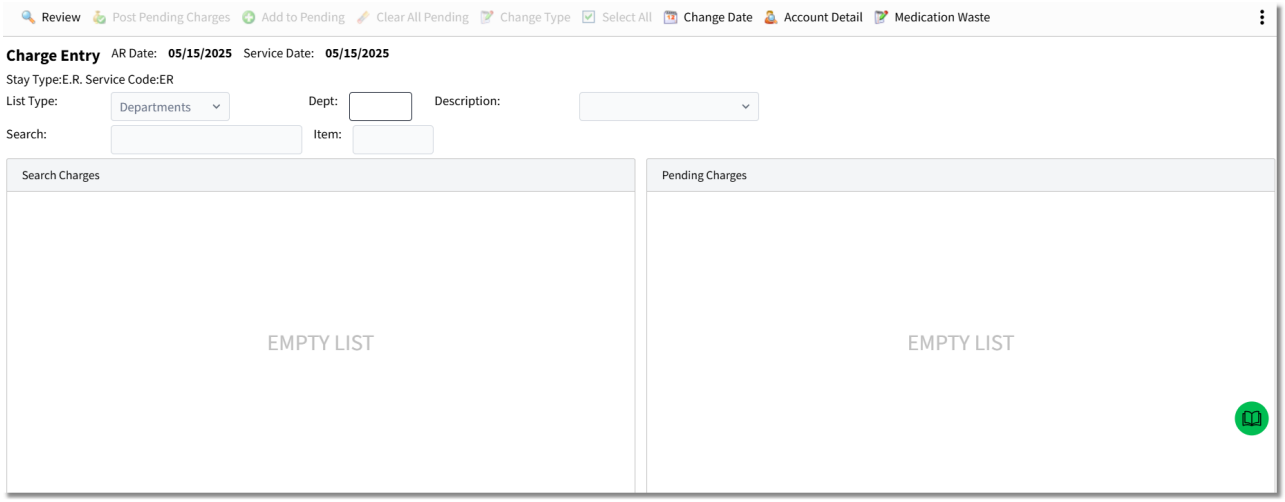
Patient Immunization History

NOTE: *For more information, please refer to the Patient Immunization History User Guide.*

5.15 Charges

The Charges option allows charges to be entered for the patient's account. Existing charges may also be viewed from this screen by selecting the Account Detail option.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Charges**



Charge Entry

NOTE: *For more information, please refer to the Charging User Guide.*

Chapter 6 Query

6.1 Overview

The Physician Query option allows communication between the Health Information Management (HIM) department and Physicians. Any user with access to the Grouper option may view a query; however, a user must be assigned to the HIM role to have the ability to create a new Query or edit an existing query.

TruBridge strongly recommends using Physician Documentation Instructions when entering a query. Using Instructions will allow the HIM department to monitor queries using the Query Review Report. If instructions are NOT utilized, the Query Review Report may not be used to track queries.

6.2 Query Instructions

Using Physician Documentation Instructions when entering a new query enables the query to be tracked on the Query Review Report. In additional to supporting reporting, these instructions serve as a templates, to promoting standardization and efficiency throughout the query process.

Instructions may be setup within Table Maintenance or when entering a new query. To create a new instruction from Table Maintenance, select **Physician Documentation Instructions** from the Clinical Table Maintenance screen.

Select **Web Client** > **Tables** > **Clinical**

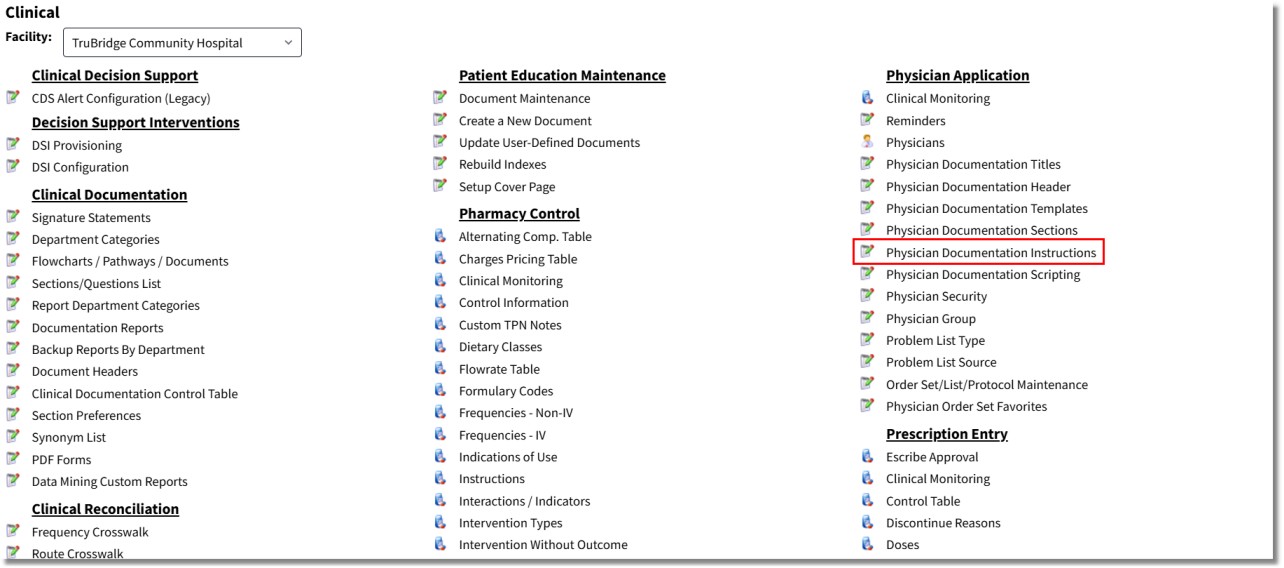


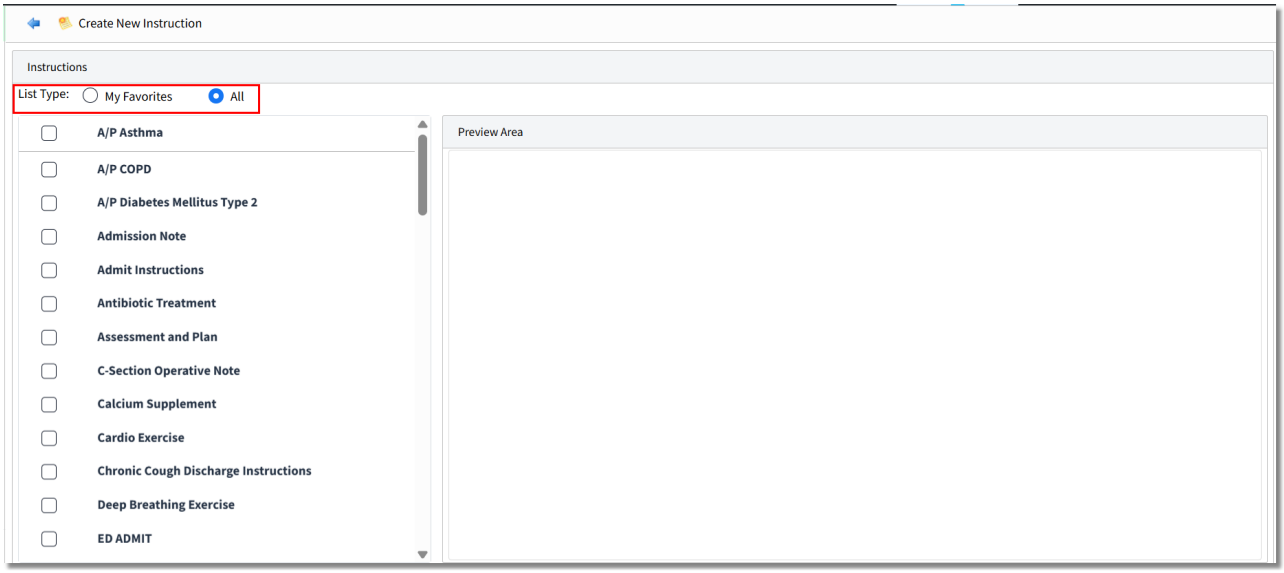
Table Maintenance - Clinical

The Instruction List screen will display.

The **List Types** option allows existing Instructions to be searched using the following filters.

- **My Favorites**: Displays instructions marked as favorites by the logged-in user. Favorites are specific to each login.
- **All**: Displays all the Instructions that have been created in the Physician Documentation Instructions table.

Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions**

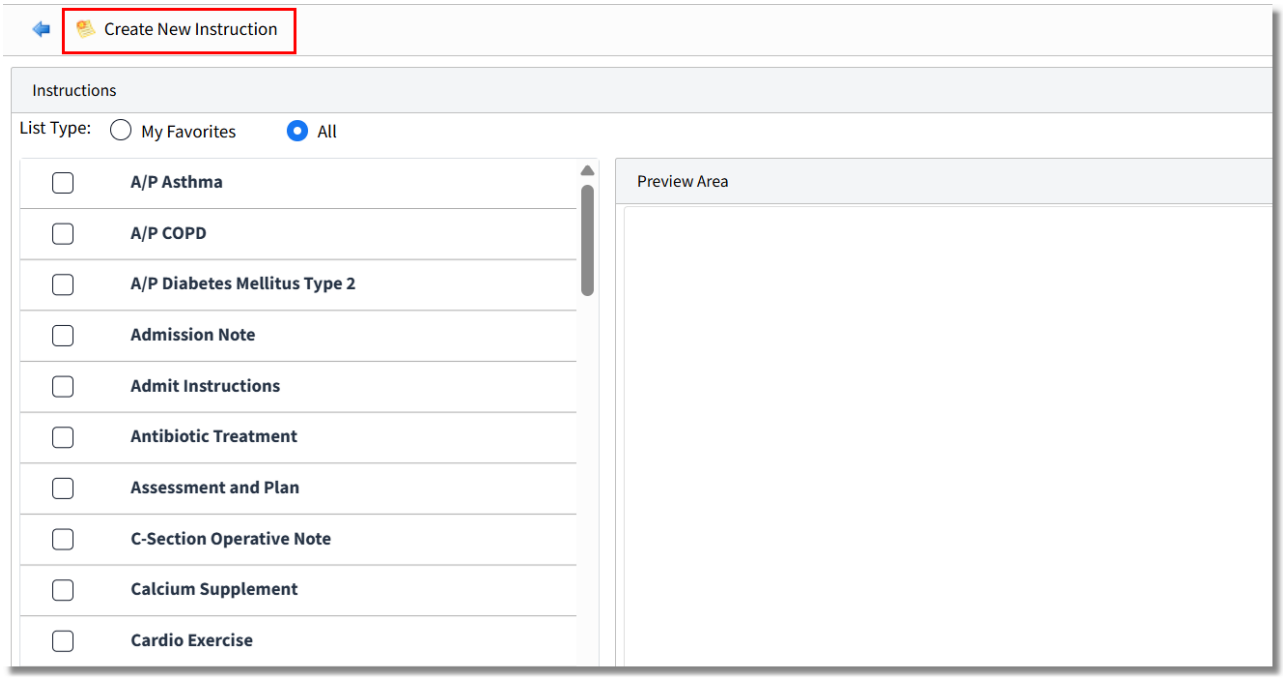


Instructions List

Create New Instruction

To create a new Instruction, select **Create New Instruction**.

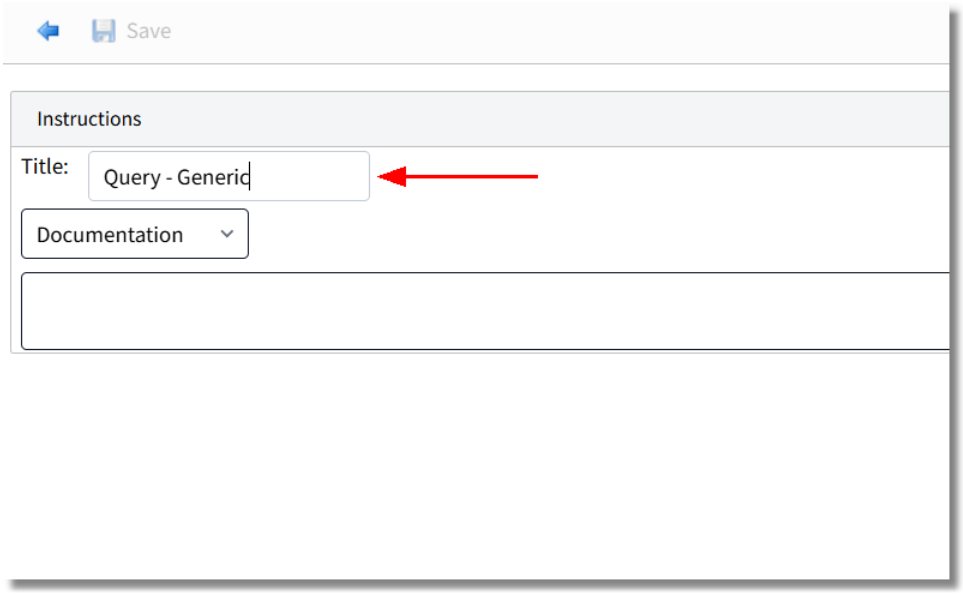
Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions**



Create New Instructions

Enter a Title for the new instruction. TruBridge recommends beginning the title with "Query -" followed by a brief description of the title, as several applications share the Physician Documentation Instructions table.

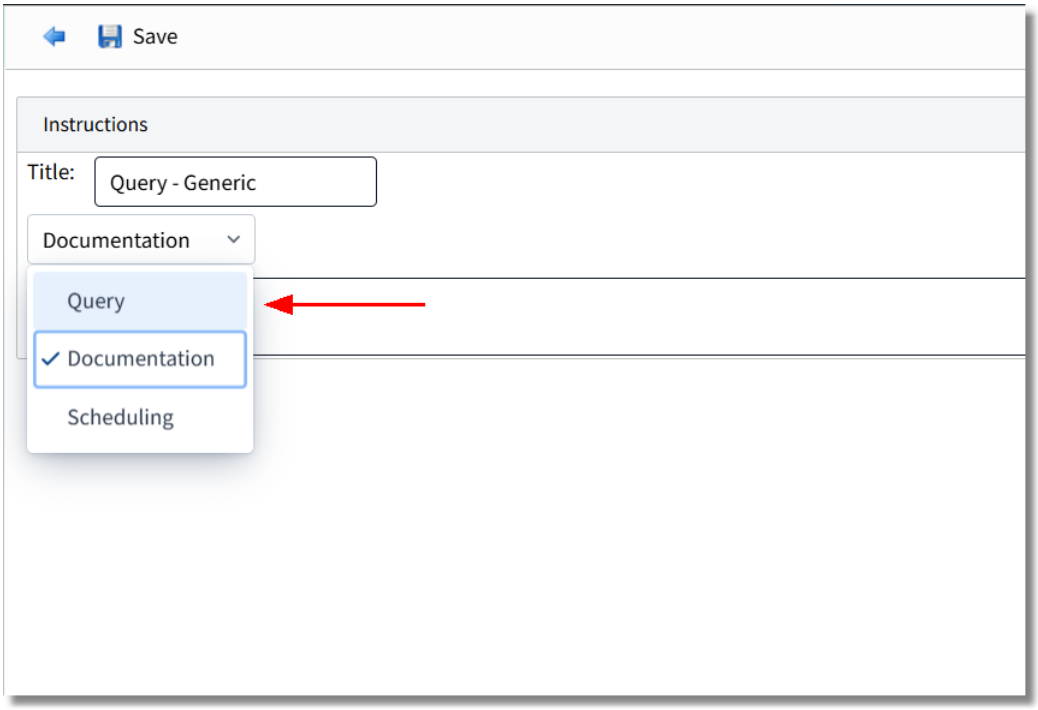
Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Create New Instruction**



Instruction Title

An instruction Type must be selected. From the drop-down, select **Query**.

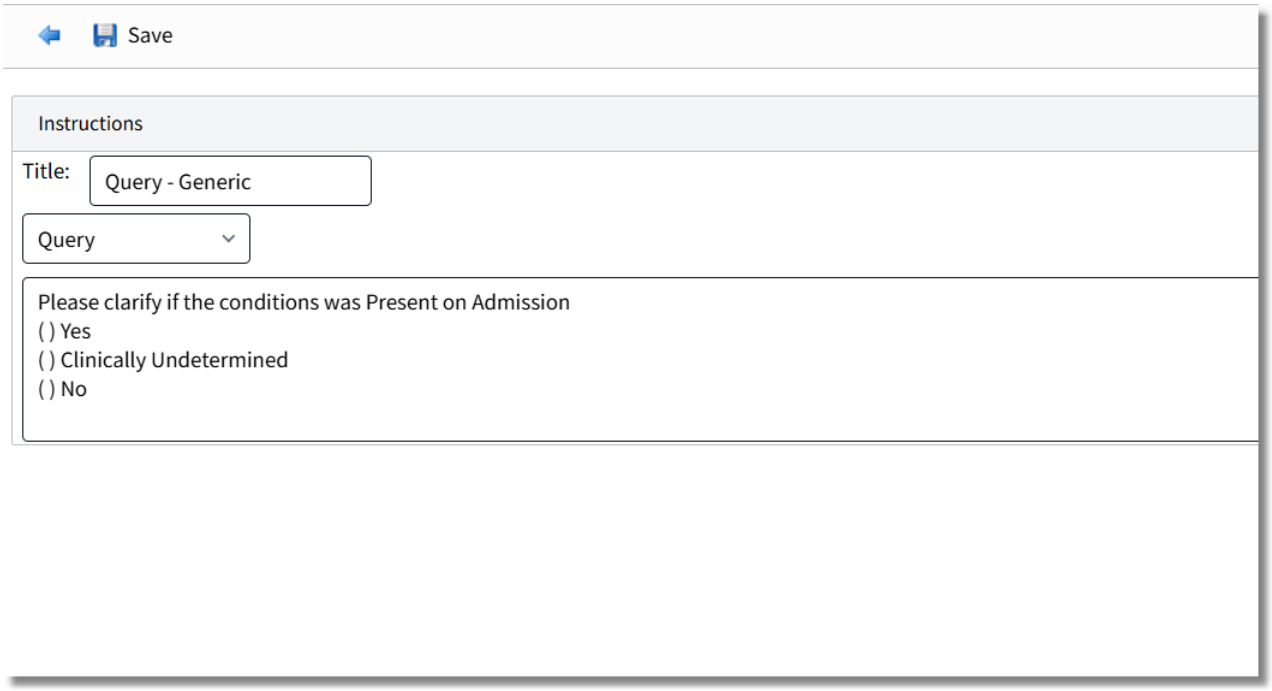
Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Create New Instruction**



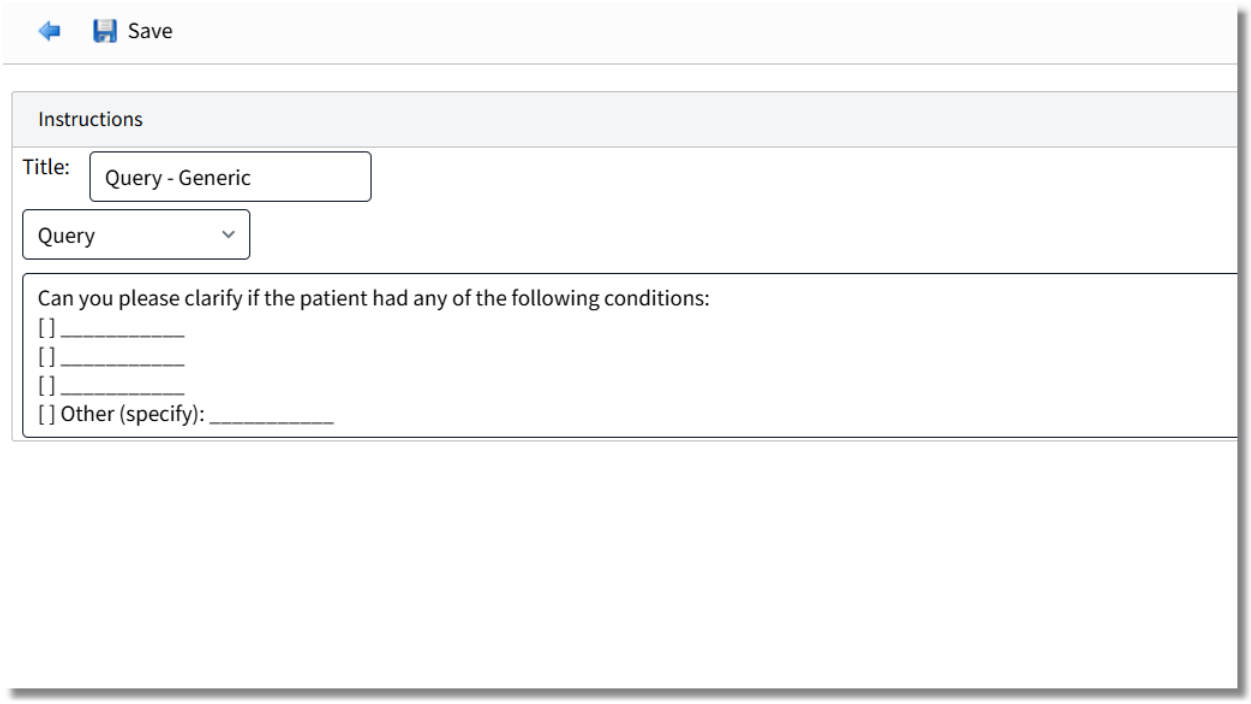
Instruction Type

In the **Text Box**, enter the text that should display each time this instruction is used. If the instructions includes questions and possible responses, TruBridge recommends using parentheses **( )** to indicated responses with only one possible response, and brackets **[ ]** to indicate responses that may have multiple responses. Refer to the images below examples of each.

Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Create New Instruction**



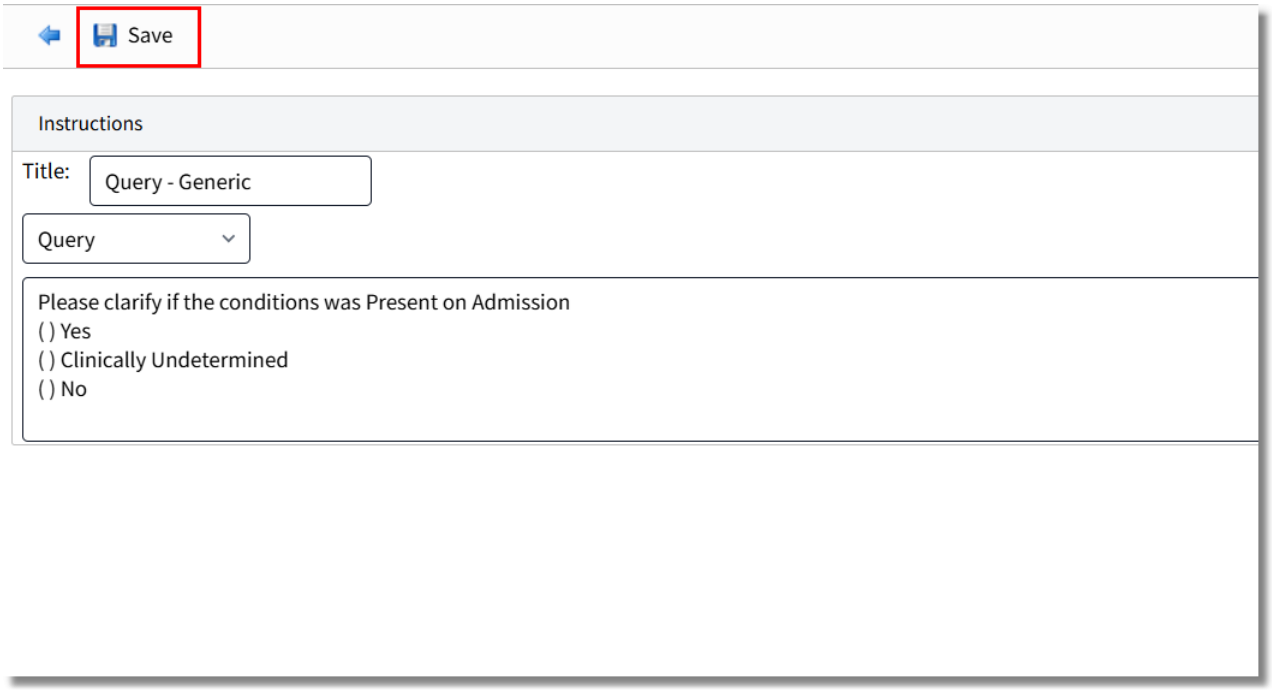
Instruction Text - Parentheses



Instruction Text - Brackets

Once the setup is complete, select **Save**. The Back Arrow can be used at any time to return to the Instruction List screen.

Select **Web Client > Tables > Clinical > Physician Documentation Instructions > Create New Instruction**

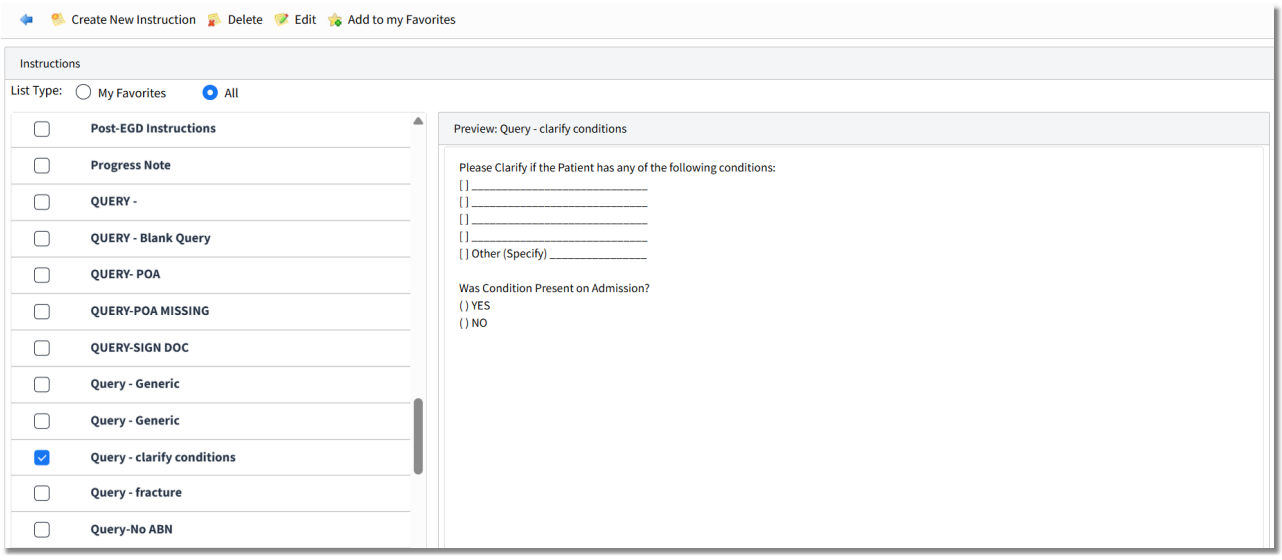


Instruction Text - Parentheses

Edit Existing Instruction

To edit an existing instruction, select the check box next to the title on the Instruction List screen. Once an instruction is selected, several options become available.

Select **Web Client > Tables > Clinical > Physician Documentation Instructions**

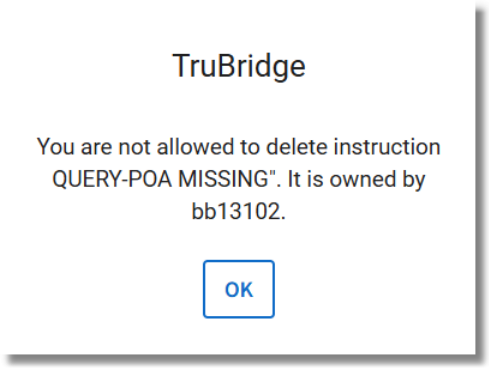


Instructions List

Delete

The **Delete** option allows an Instruction to be removed. An Instruction can only be deleted by the login that initially created it. If a different login attempts to delete the instruction, the following message will display:

Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Select Instruction** > **Delete**

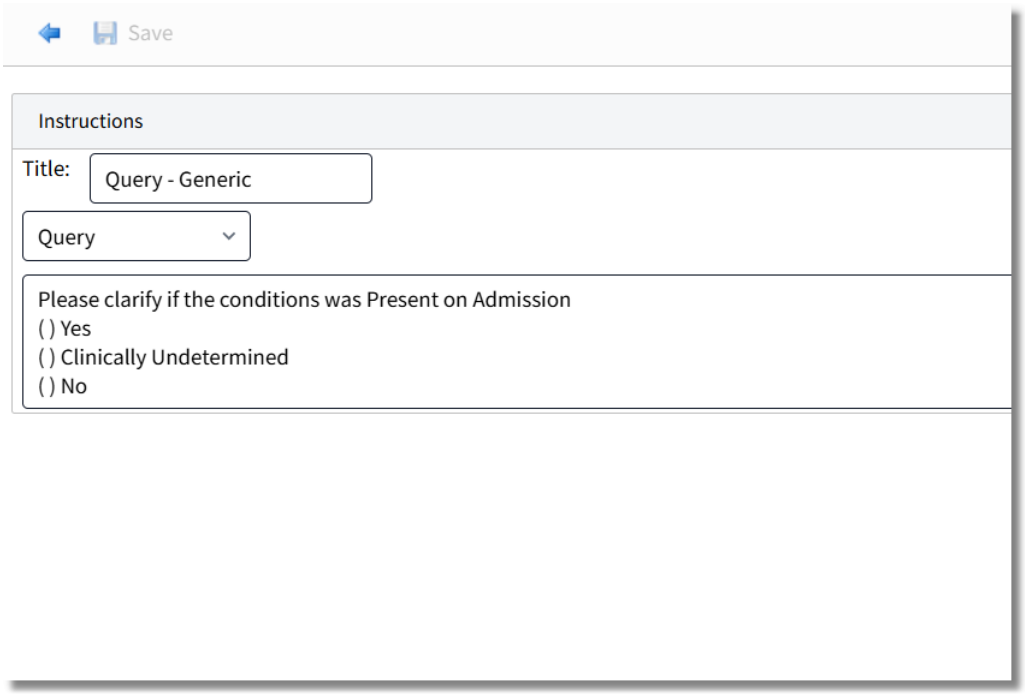


Delete Message

Edit

The **Edit** option allows an Instruction to be modified. An Instruction can only be edited by the login that originally created it. Once Edit is selected, the Instruction's title, type and text can be updated. To apply the changes made, select **Save**.

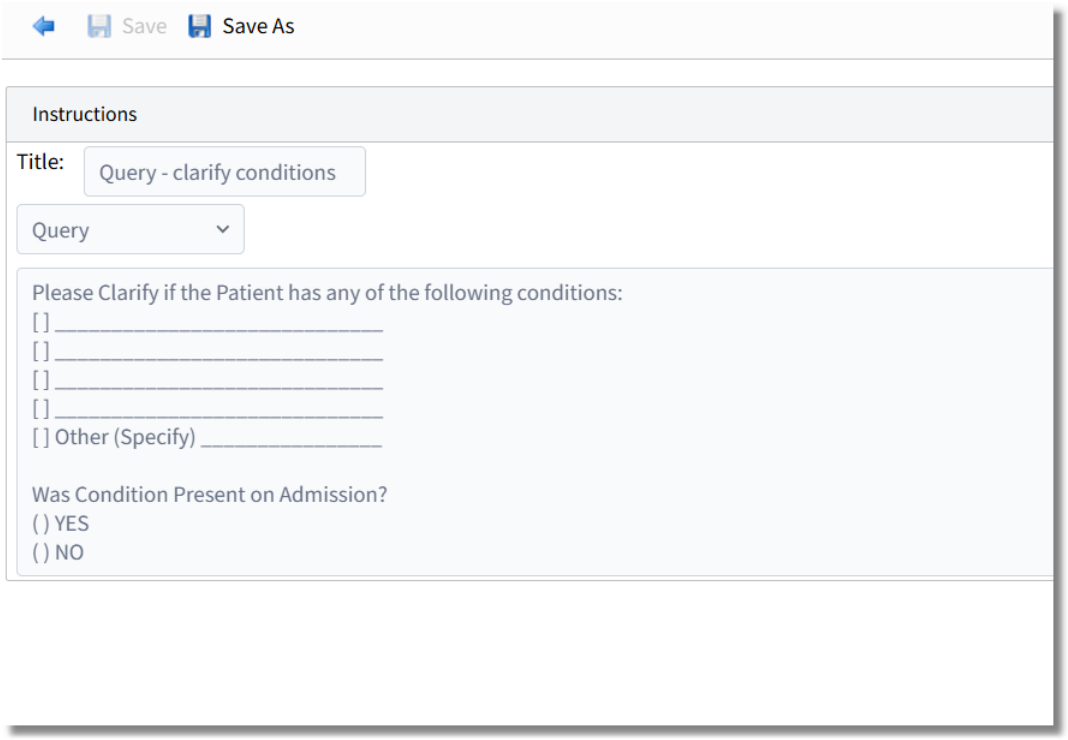
Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Select Instruction** > **Edit**



Edit

If the Edit option is selected by a login that did not create the instruction, the Text Box will be inaccessible, and the **Save As** option will be available.

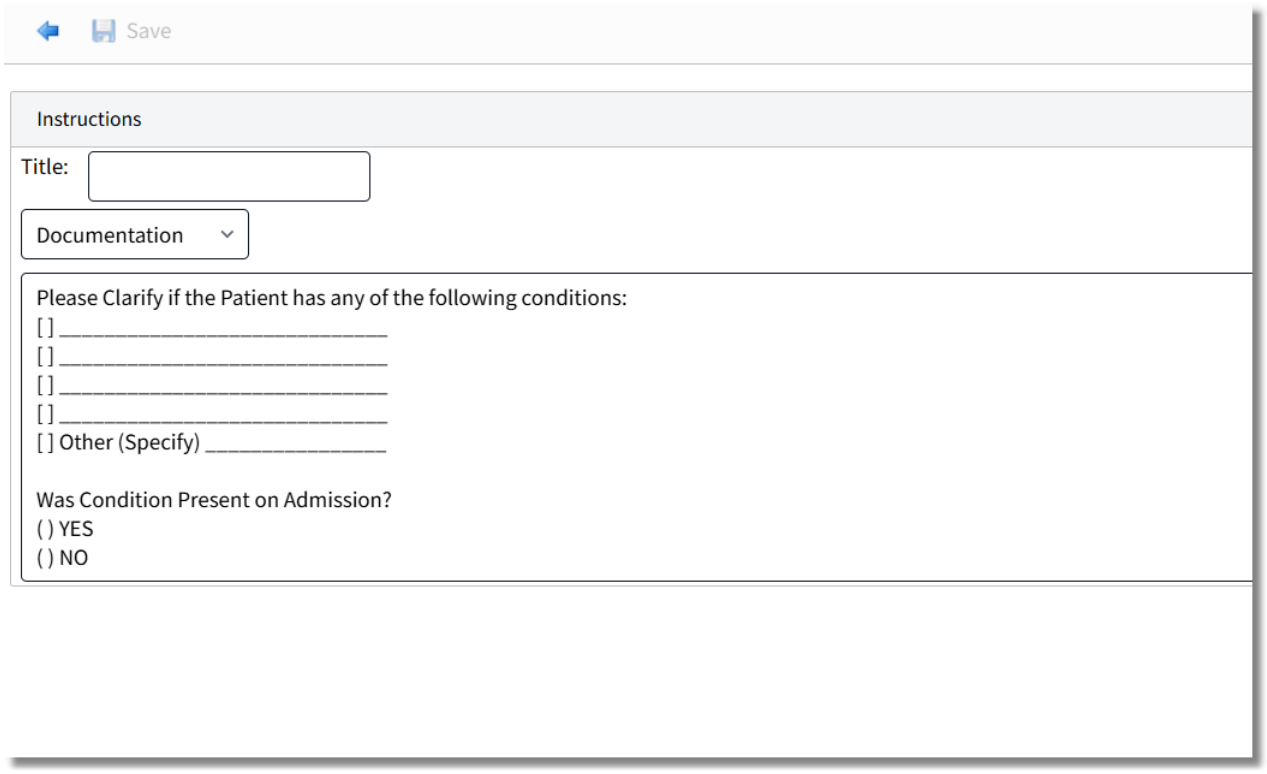
Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Select Instruction** > **Edit**



Edit - Save As

The **Save As** option allows a copy of the Instruction to be saved under the current login, enabling it to be edited. After selecting Save As, the Title and Instruction Type must be updated.

Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Select Instruction** > **Edit** > **Save As**



Edit - Save As

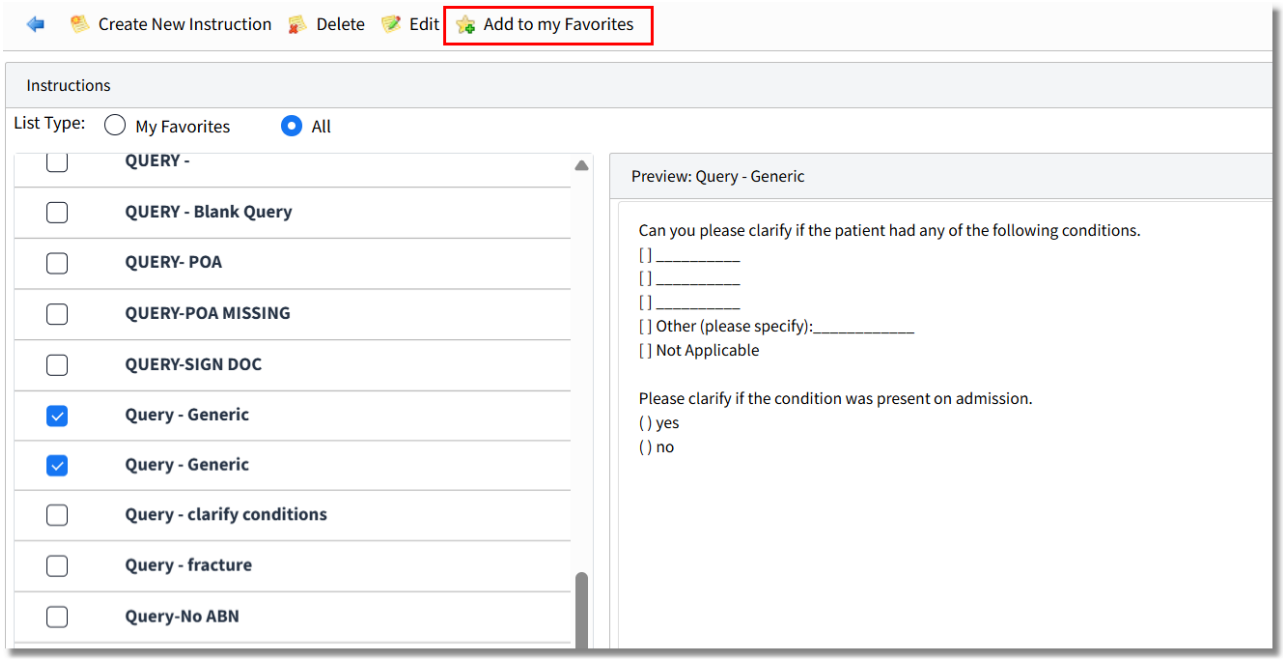
Once all information has been updated, select **Save**. The Back Arrow can be used at any time to return to the Instruction List screen.

Add to my Favorites

Add to my Favorites

The **Add to my Favorites** option allows an Instruction to be displayed in the **My Favorites** list when searching for Instructions. The My Favorites list is login specific and can be used both in Table Maintenance and when inserting Instructions into a query.

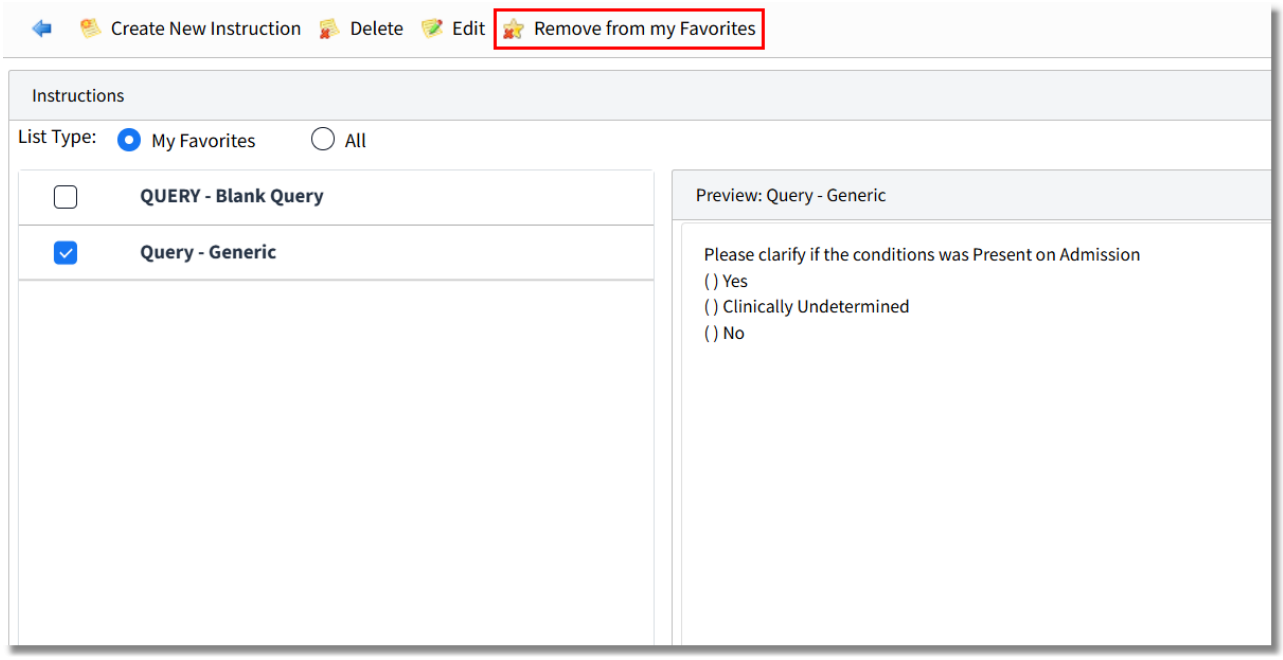
Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Select Instruction** > **Add to my Favorites**



Instructions List - Add to Favorites

If the selected Instruction is already part of the login's **My Favorites** list, this option will change to **Remove from my Favorites**. Selecting Remove from my Favorites will remove the Instruction from the **My Favorites** list for that login.

Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Instructions** > **Select Instruction** > **Remove from my Favorites**



Instructions List - Remove from my Favorites

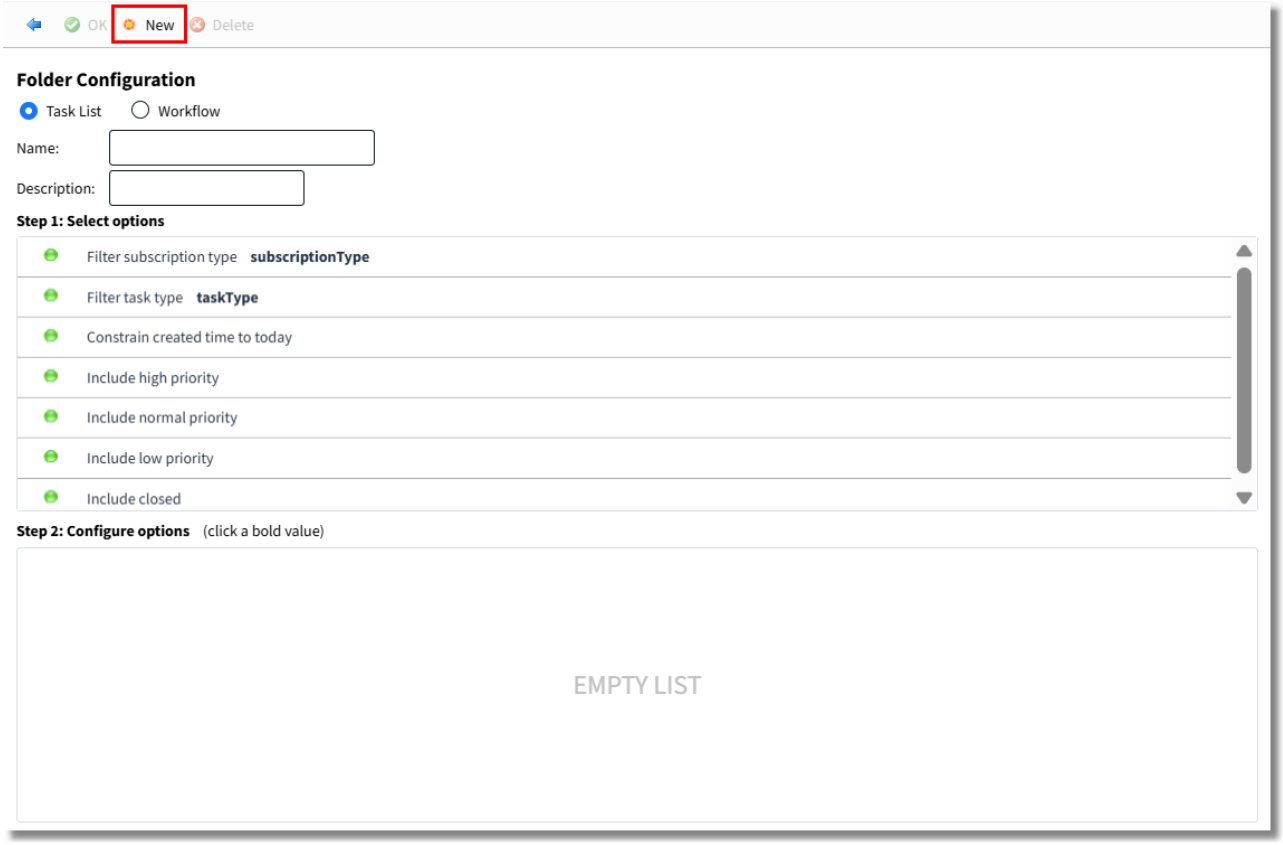
6.3 Creating Query Folders

Folders can be added to the Home screens of providers and HIM staff to provide quick access to existing Physician Queries. Query folders are user-specific and must be set up individually on the Home screen of each user who requires access.

Physician Queries from HIM

To create a folder for physician to receive queries from HIM staff, select **New**.

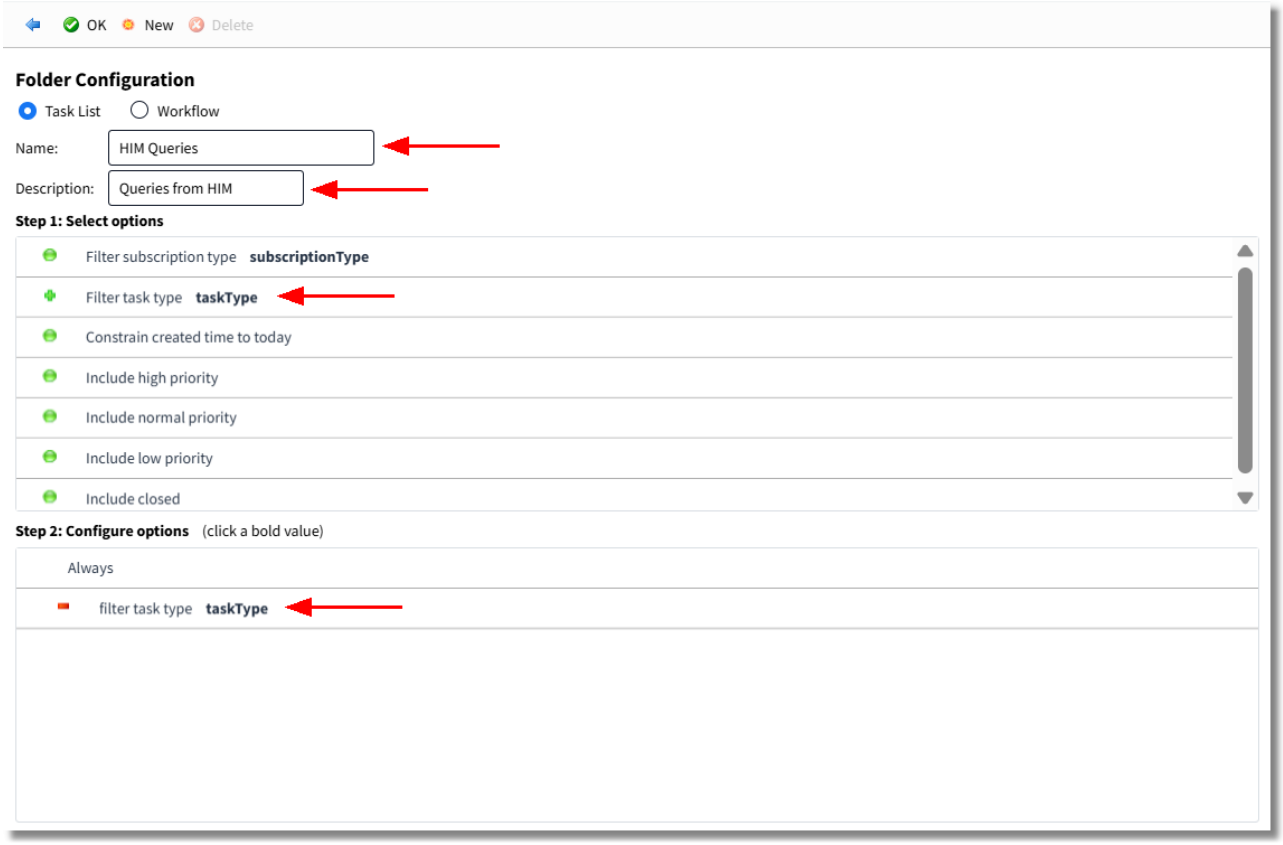
Select **Web Client** > **Home Screen** > **Tasks** > **New**



Folder Configuration

The Folder Configuration screen will display. To configure the folder, follow the steps below:

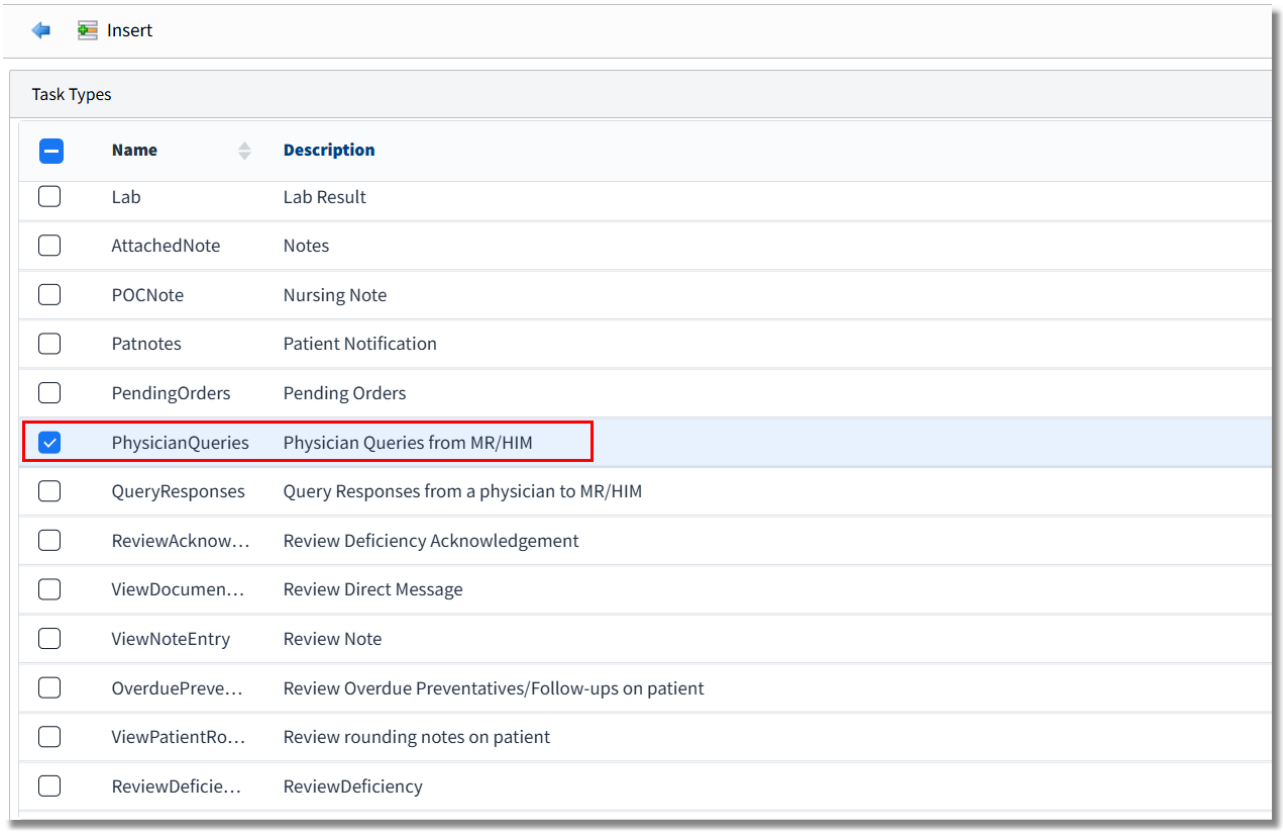
Select **Web Client** > **Home Screen** > **New** > **Tasks** > **Folder Configuration**



Folder Configuration - New

- Enter a **Name** for the folder. This name will appear as the label next to the folder icon on the Home screen.
- Enter a **Description** for the folder. The description will be displayed in the right-hand window after the folder is selected on the Home screen.
- Enter the **Filter Task Type** for the folder. In the **Step 1: Select options** section, select the green button next to **Filter task type**.
- Configure **Task Type** for the folder. In the **Step 2: Configure options** section, select the bold lettering **taskTypes** label. The Task Types list will display.

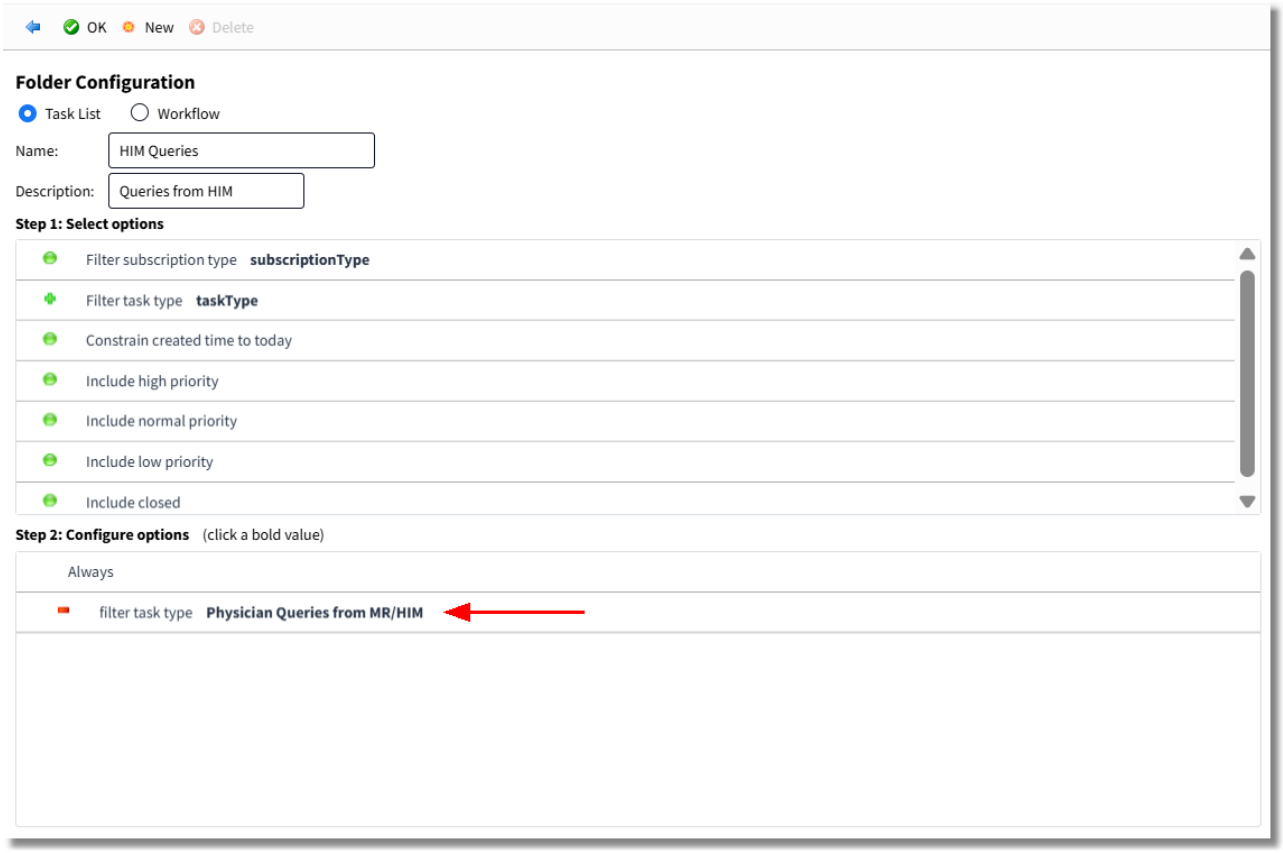
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration** > **Task Types**



Task Types

- Select **Physician Queries from MR/HIM**, then select **Insert**. The selected task type will then display on the Folder Configuration screen.

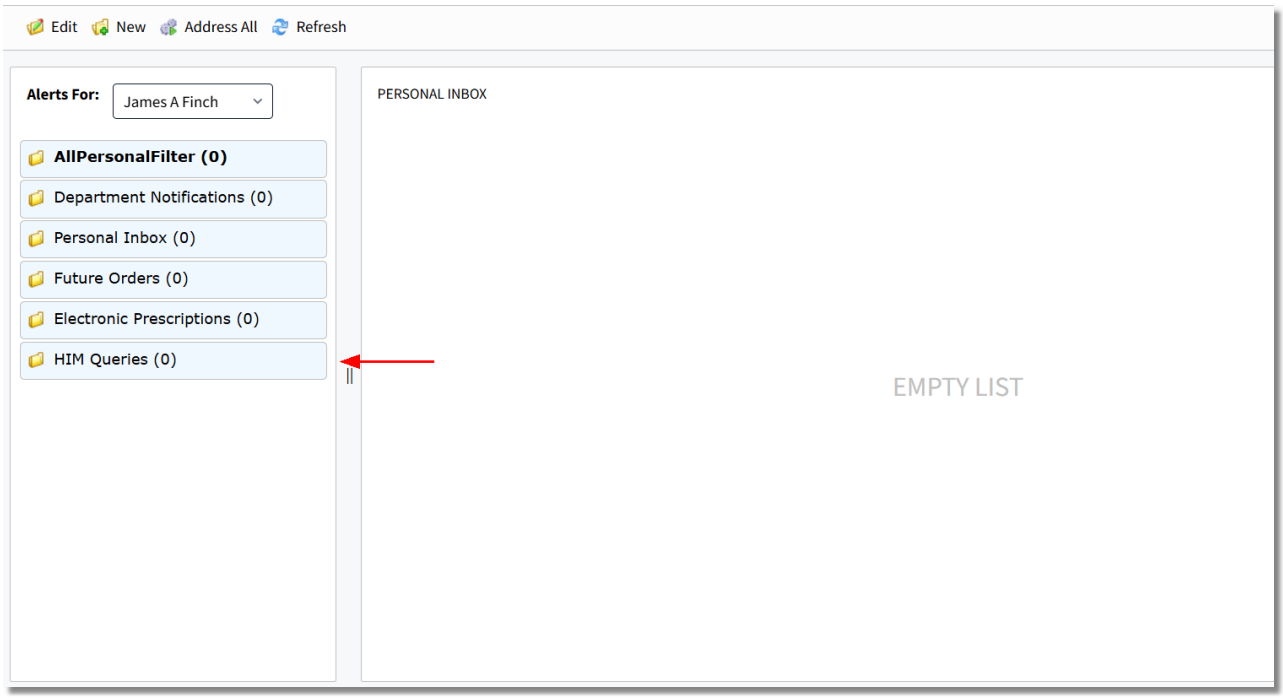
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration**



Folder Configuration - New

- Once the task type filter is set, select **OK** from the action bar, and then select the **back arrow** from the action bar to return to the Home screen.

Select **Web Client** > **Home Screen** > **Tasks**

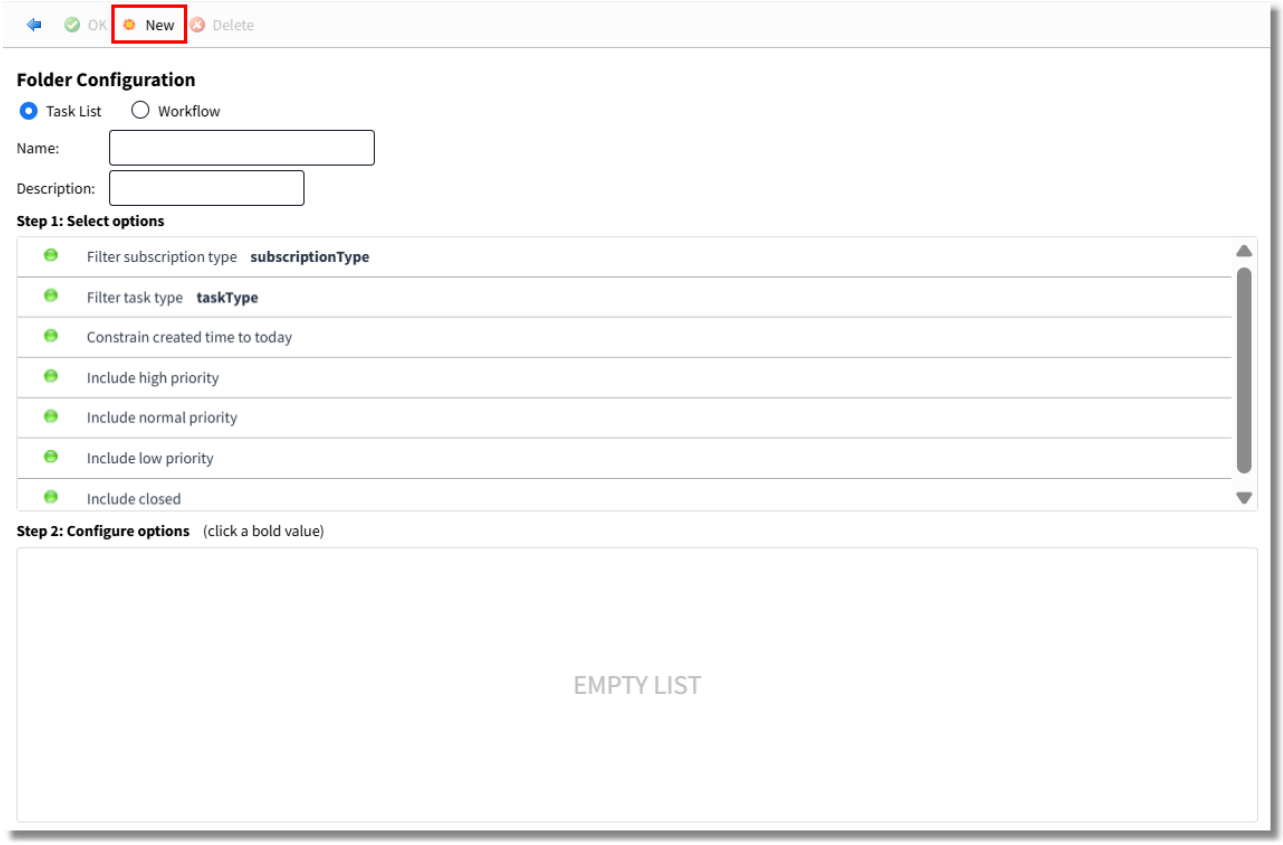


Home Screen - Tasks

Physician Query Responses

To create a folder for HIM staff to receive physician responses, select **New**.

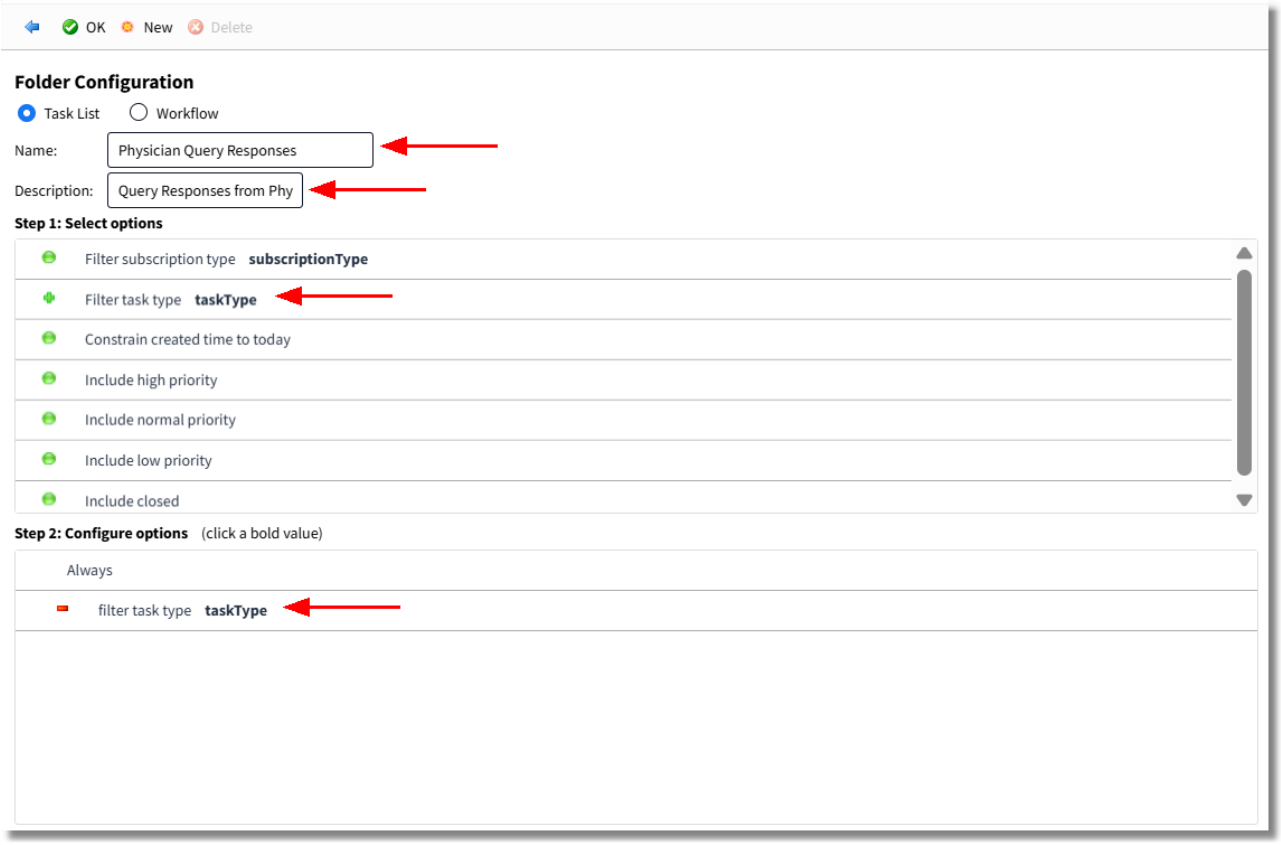
Select **Web Client** > **Home Screen** > **Tasks** > **New**



Folder Configuration

The Folder Configuration screen will display. To configure the folder, follow the steps below:

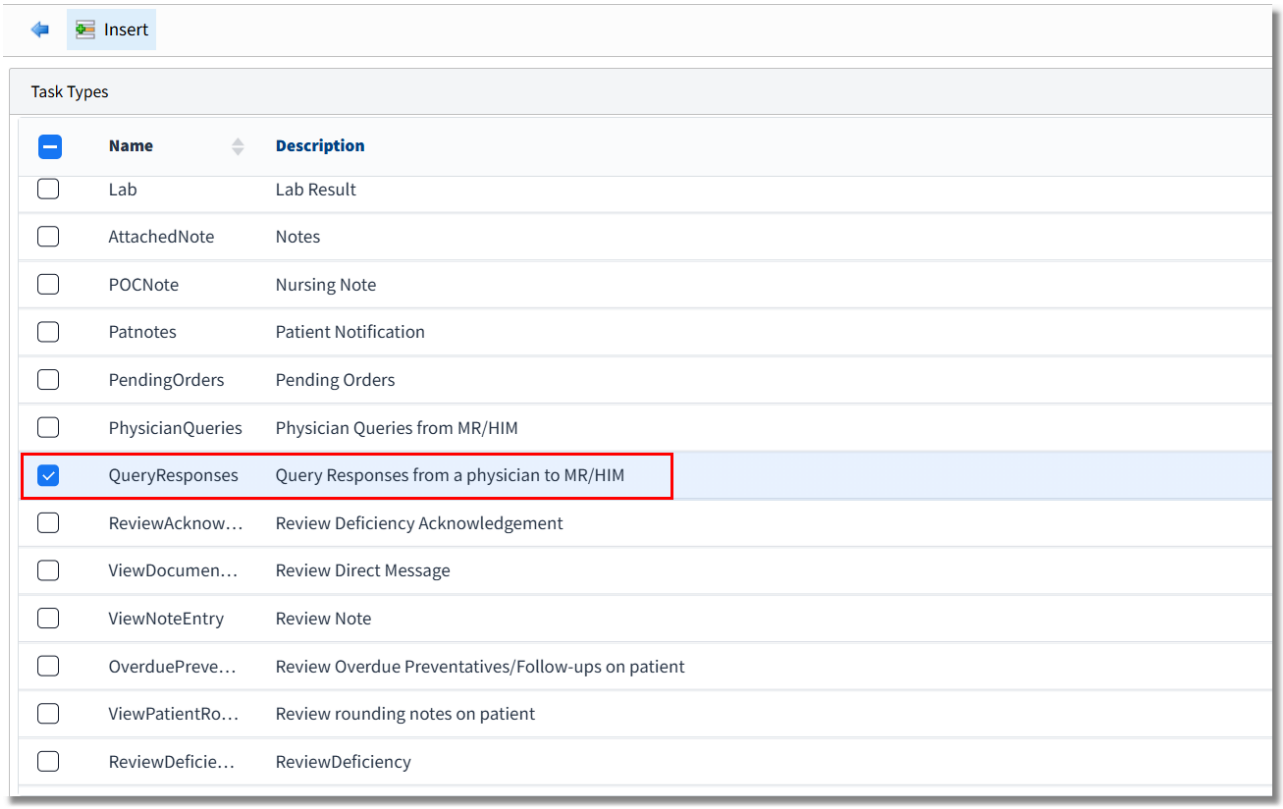
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration**



Folder Configuration - New

- Enter a **Name** for the folder. This name will appear as the label next to the folder icon on the Home screen.
- Enter a **Description** for the folder. The description will be displayed in the right-hand window after the folder is selected on the Home screen.
- Enter the **Filter Task Type** for the folder. In the **Step 1: Select options** section, select the green button next to **Filter task type**.
- Configure **Task Type** for the folder. In the **Step 2: Configure options** section, select the bold lettering **taskTypes** label. The Task Types list will display.

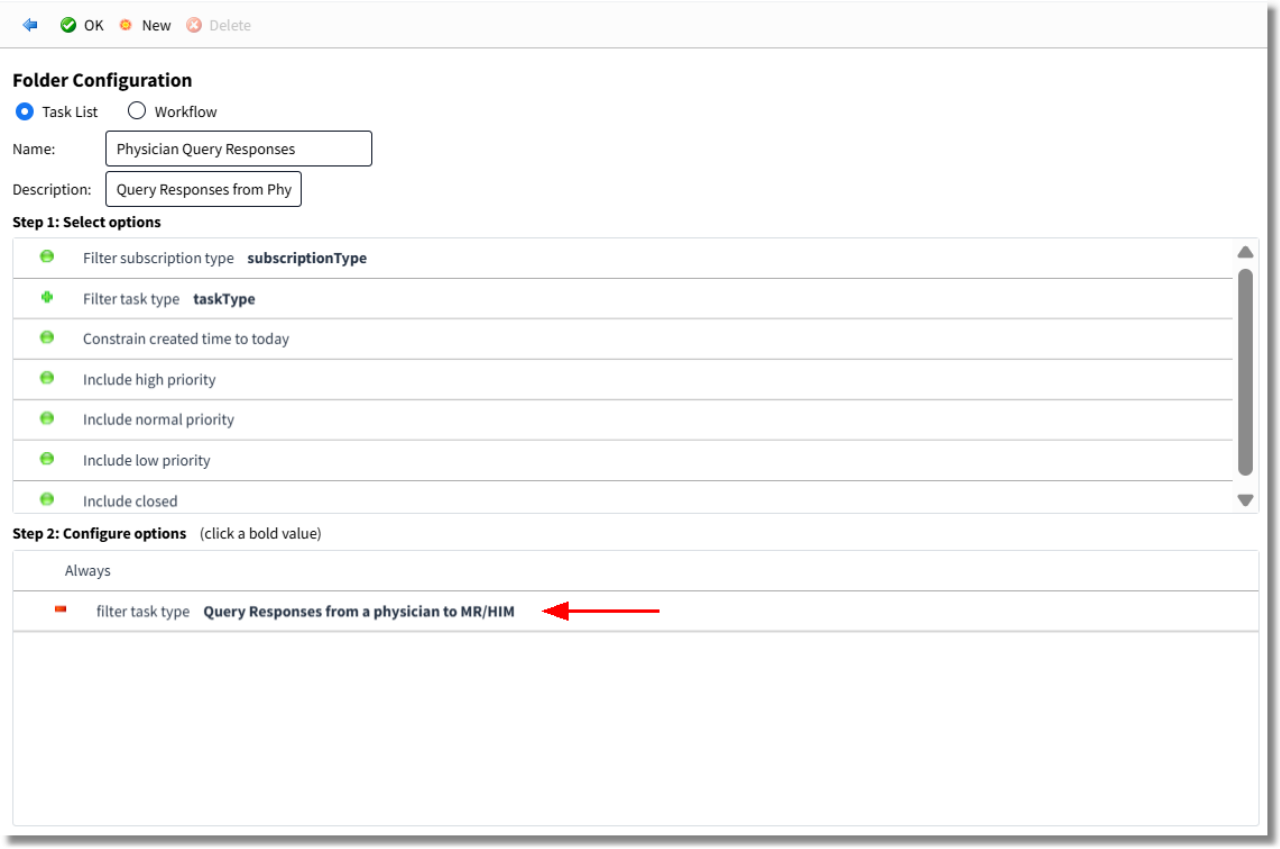
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration** > **Task Types**



Task Types

- Select **Query Responses from a Physician to MR/HIM**, then select **Insert**. The selected task type will then display on the Folder Configuration screen.

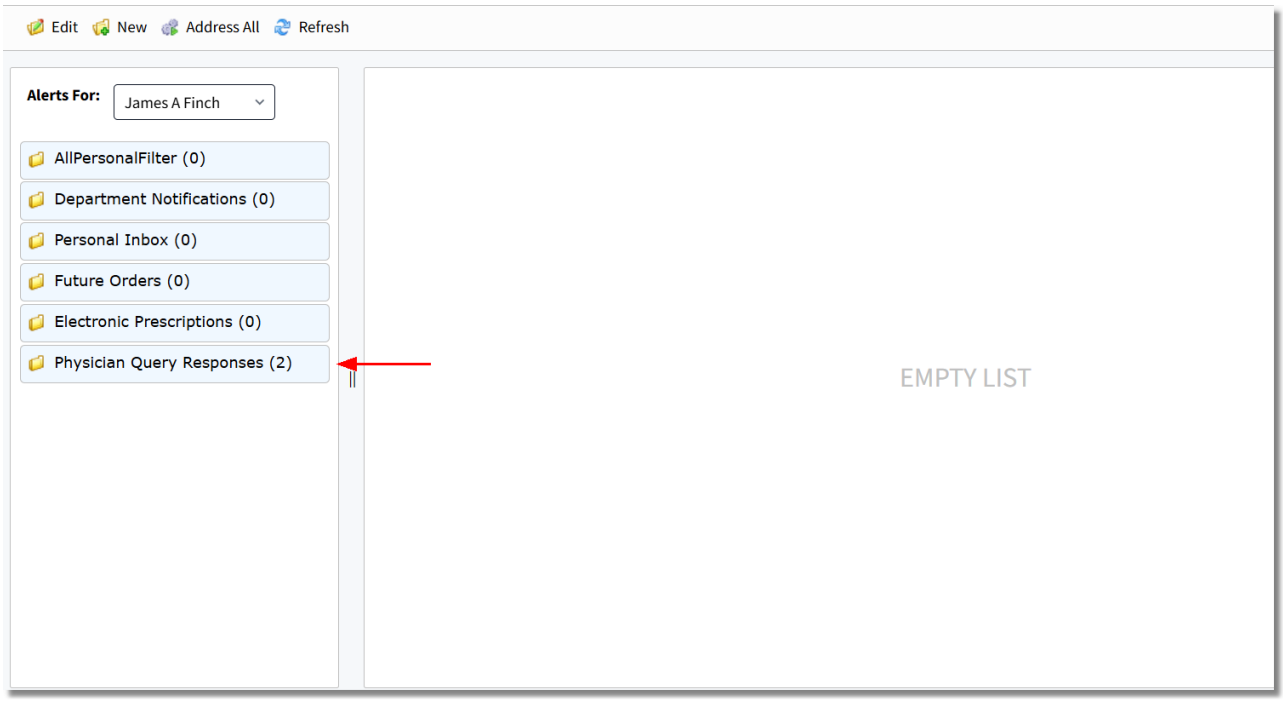
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration**



Folder Configuration - New

- Once the task type filter is set, select **OK** from the action bar, and then select the **back arrow** from the action bar to return to the Home screen.

Select **Web Client** > **Home Screen** > **Tasks**



Home Screen - Tasks

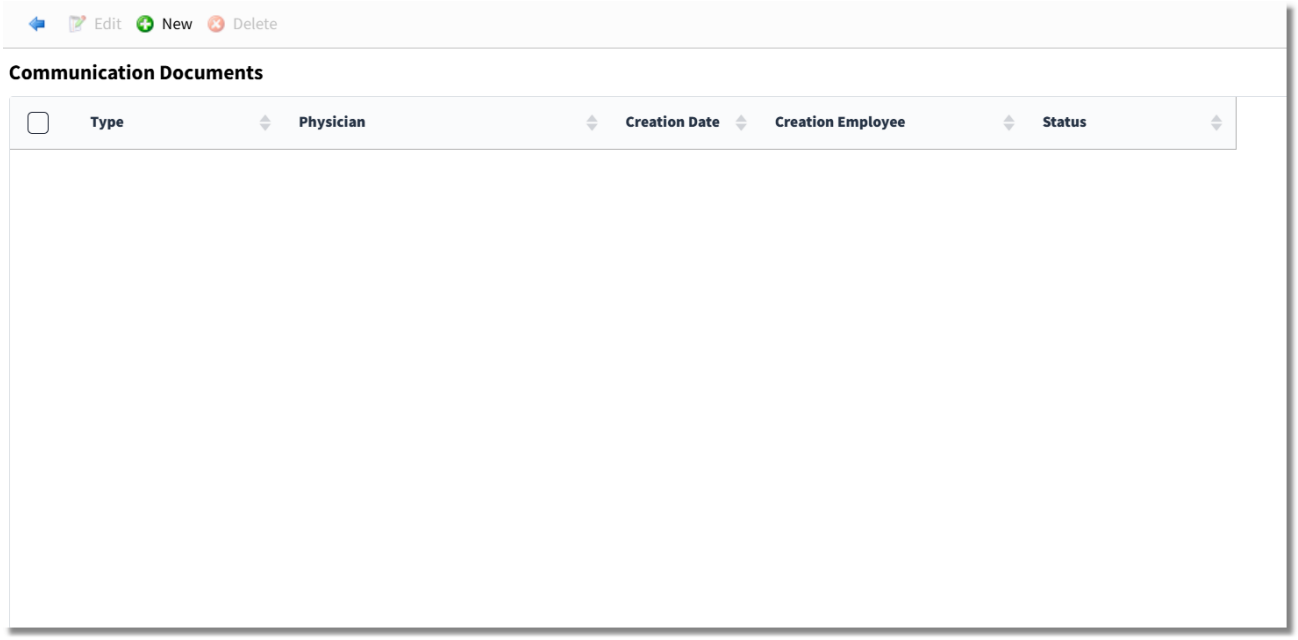
***NOTE**: In addition to having the folder for Query Responses, the user's Login must also be in the Health Information Management role in order to receive query responses from the physician.*

6.4 Query Procedures

Sending a Query to a Physician

To send a query to a physician, select **Physician Query** from the Grouper and select **New**.

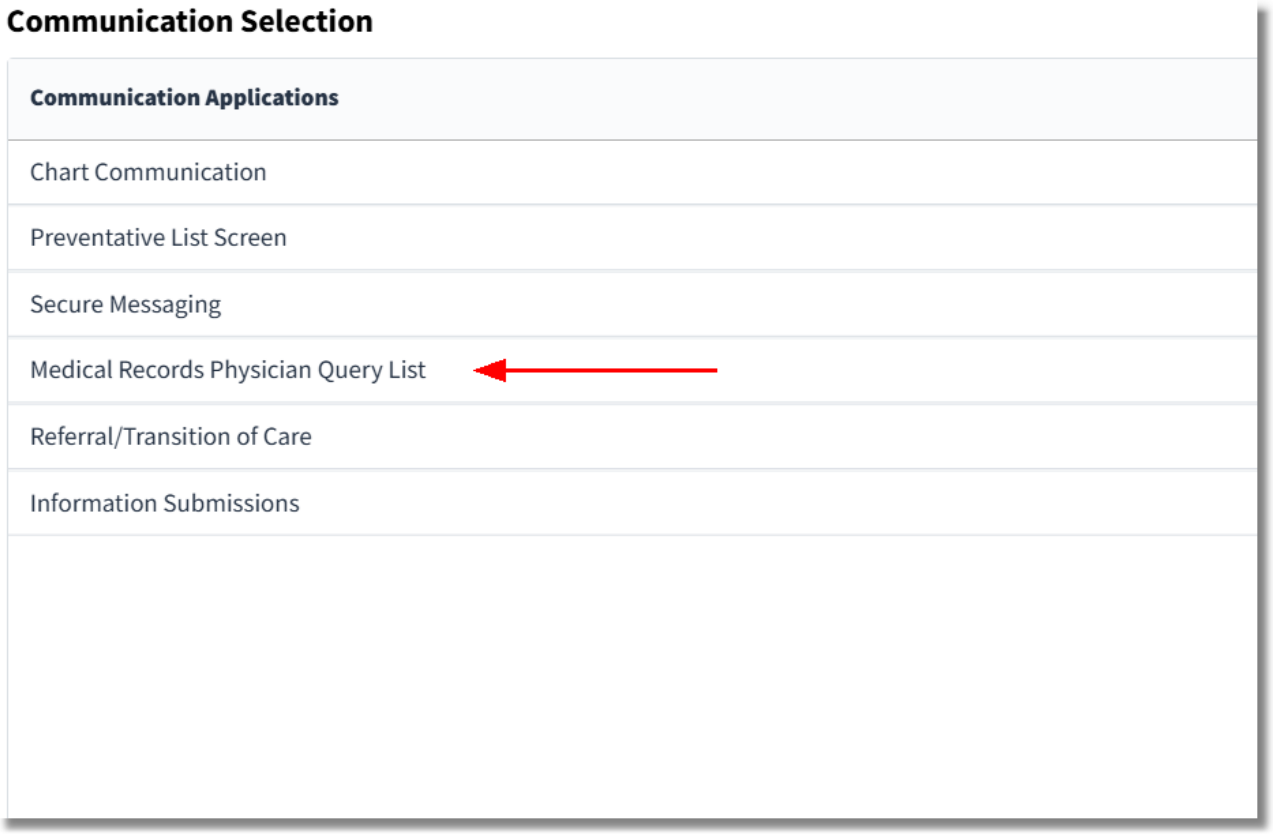
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Physician Query**



Communication Documents

The Communications Selection screen will display. Select **Medical Records Physician Query List**.

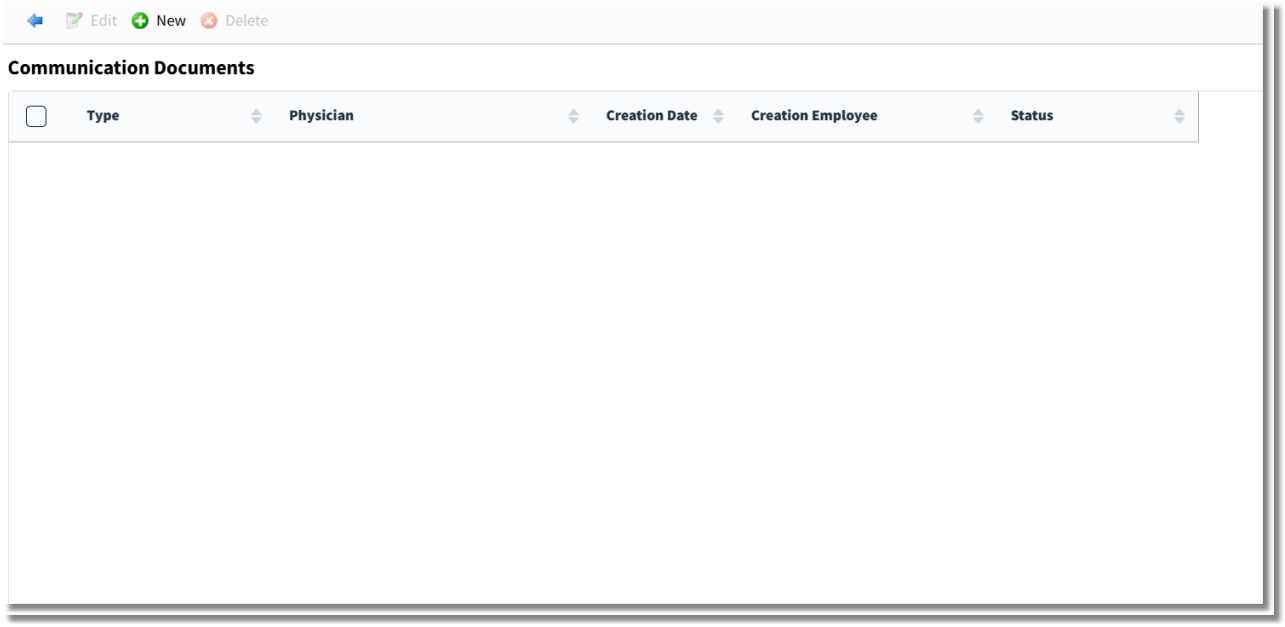
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Navigation Panel > Physician Query > Medical Records Physician Query List**



Communication Selection

The **Communication Documents** screen will appear, displaying any existing queries. Existing queries can be edited by highlighting the desired query and selecting **Edit** on the action bar, or by double-click the query. To create a new query, select **New** on the action bar.

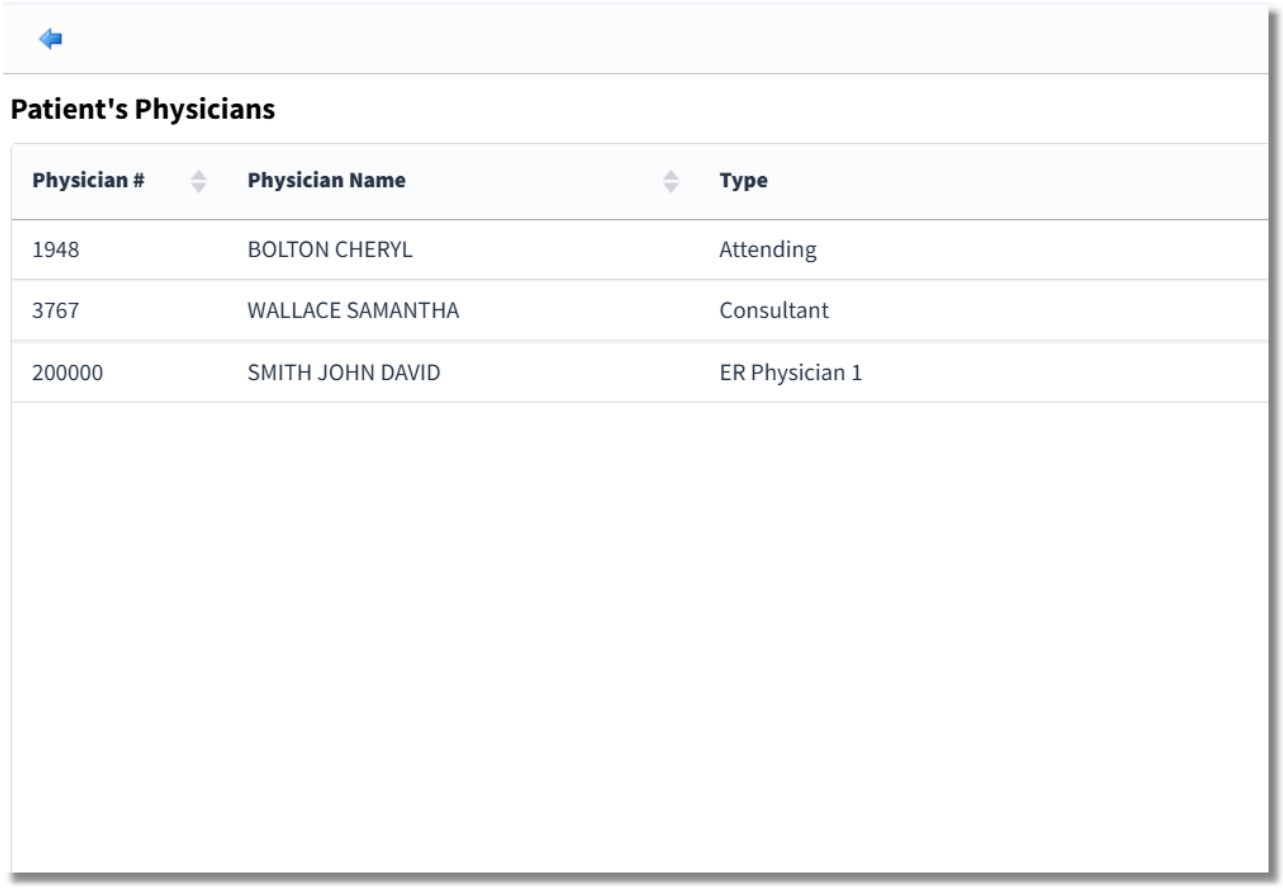
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Physician Query** > **New** > **Medical Records Physician Query List** > **New**



Communication Documents

Once **New** is selected, the Patient's Physician List will display. Select the physician to whom the query will be sent. If the desired physician is not listed, they must be added to the Patient's Physician List. Refer to the Patient's Physicians 97 section for more information.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Physician Query** > **New** > **Medical Records Physician Query List** > **New** > **Patient's Physicians**

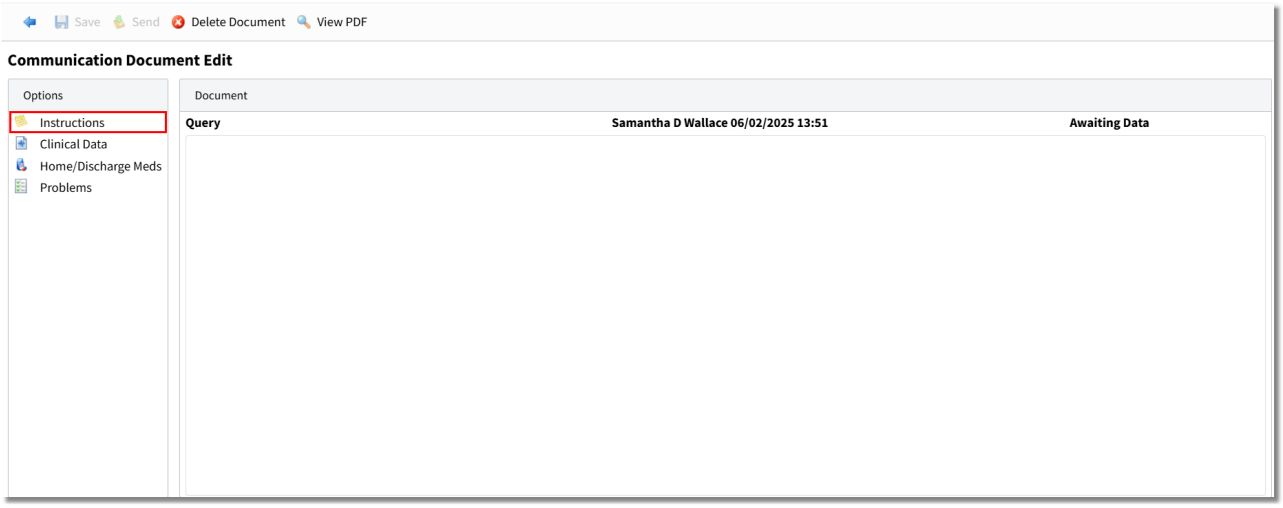


Patient's Physicians

The Communication Document Edit screen will display. In the Document section of the screen, the selected physician's name will be displayed along with the creation date and time of the query. The query status will display as Awaiting Data**.**

The Document section of the Communication Document Edit screen is a free-text field. However, TruBridge strongly recommends inserting an Instruction into every query to ensure it can be tracked on the Query Review report. To insert an Instruction, select **Instructions** from the Options section.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Physician Query** > **New** > **Medical Records Physician Query List** > **New** > **Select Physician** > **Instructions**



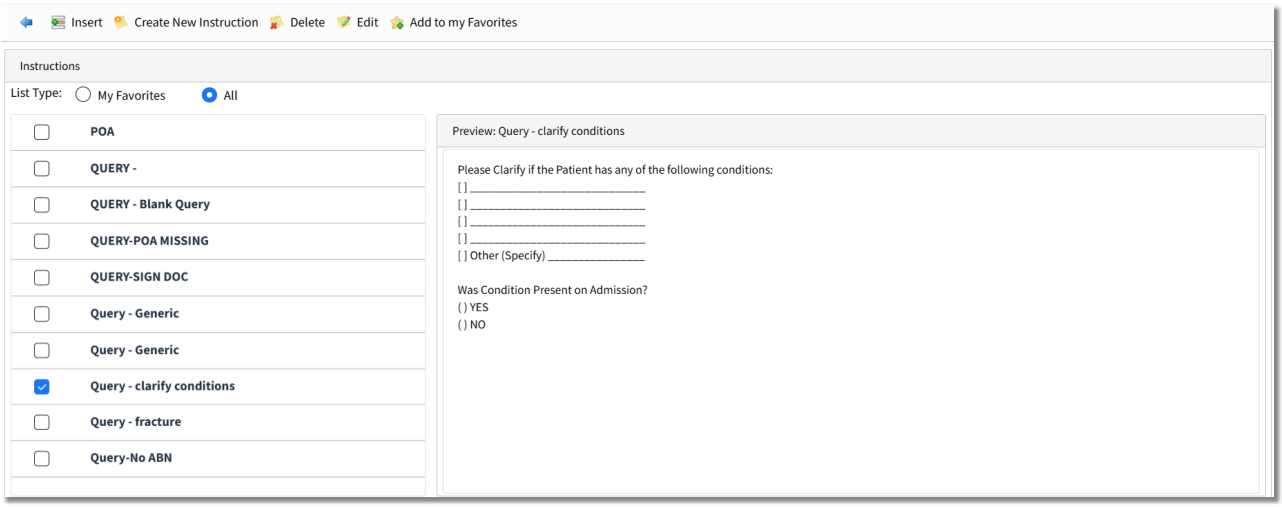
Communication Document Edit

The Instructions screen will display a list of all exiting Physician Documentation Instructions. The List Types option allows users to filter the list using the following options:

- **My Favorites**: Displays Instructions that have been marked as favorites by the current user. Favorites are specific to each login.
- **All**: Displays all the Instructions that have been created in the Physician Documentation Instructions table.

Once the Instruction is selected from the list, a preview of the Instruction will display.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Physician Query** > **New** > **Medical Records Physician Query List** > **New** > **Select Physician** > **Instructions** > **Select Instruction**



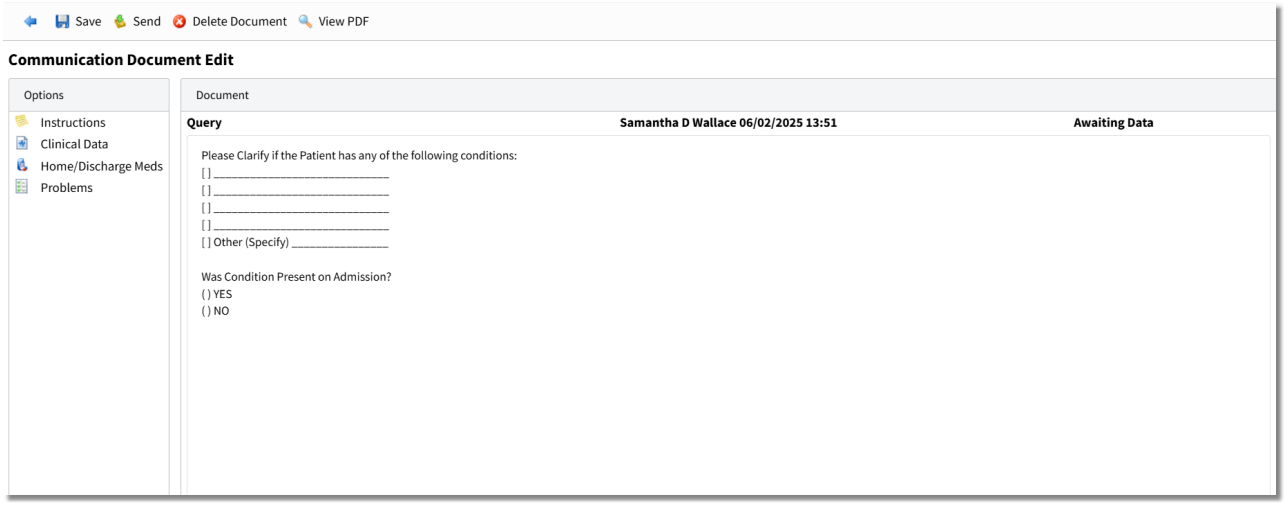
Instructions

The following option are available on the toolbar:

- **Insert**: Copies the selected Instruction into the query.
- **Create New Instruction**: Allows the creation of a new Instruction to be added to the Physician Documentation Instructions table. Once selected, the process is the same as creating an Instruction through Table Maintenance. Please see the Create New Instruction 118 section for more information.
- **Delete**: Deletes the selected Instruction. Only the login that originally created the Instruction may delete it. If a different login attempts to delete the Instruction, a warning will display the login that created it.
- **Edit**: Enables editing of the Instruction. You may update the Instruction Title, Type, and Text. After making changes, select **Save**.
- **Add to my Favorites**: Adds the Instruction to the user-specific **My Favorites** list for easier access during searches in Table Maintenance or when inserting Instructions into a Query. If the Instruction is already in the user's **My Favorites**, this option will change to **Remove from my Favorites**. Selecting this will remove the Instruction from the list.

To copy the Instructions to the query, select **Insert**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Physician Query** > **New** > **Medical Records Physician Query List** > **New** > **Select Physician** > **Instructions** > **Select Instruction** > **Insert**



Communications Document Edit

After the Instruction has been inserted, the Instruction may be customized and additional information can be added.

To insert information from the patient's chart, the following options are available:

- **Clinical Data:** Allows the ability to insert clinical data related to the visit.
- **Home/Discharge Meds:** Allows the ability to insert the patient's home and discharge medications.
- **Problems:** Allows ability to insert from the Patient Problem List

NOTE: *Refer to the Notes User Guide for more details on these options.*

Once all information has been added to the query, select an option on the action bar.

- **Save:** Saves the query on the patient account. The query will status will be **Awaiting Data**, indicating it has been created but not sent to the Physician.
- **Send:** Saves the query on the patient's account and sends it to the physician. The status will update to **Awaiting Physician**.
- **Delete Document:** Deletes the query.
- **View PDF:** Displays the document in PDF format.

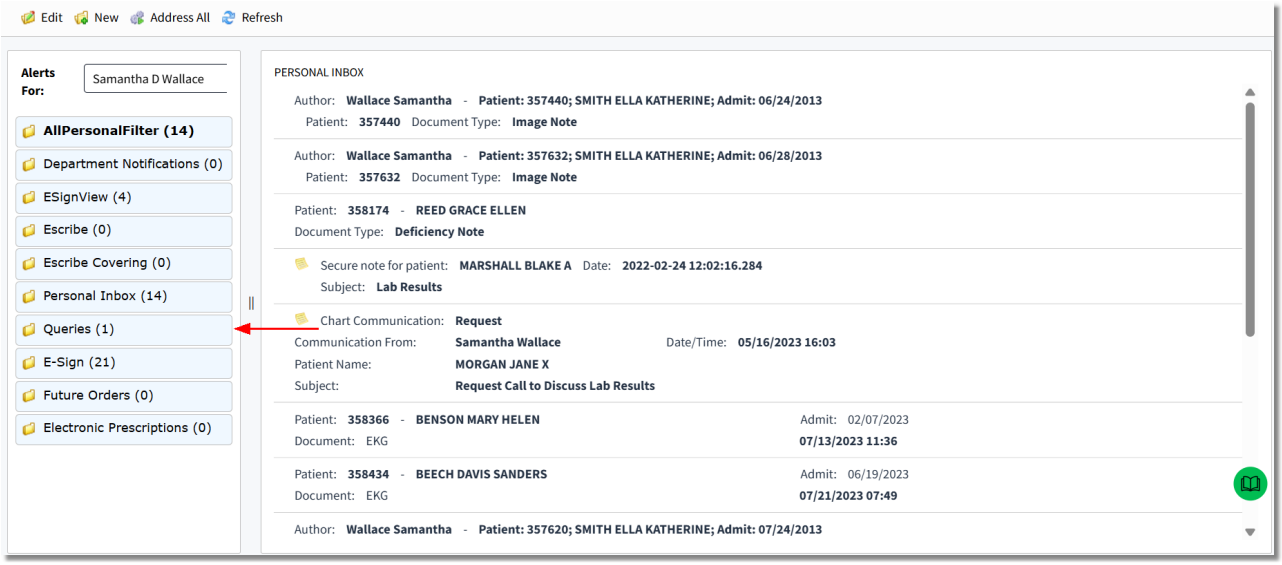
Physician Procedures

Once a query has been sent to the physician, it may be accessed from the physician's Home Screen or from the patient's chart. The process for viewing and signing the query is the same regardless

how the Home Screen is accessed. If the Queries folder is not displayed, it will need to be created. Refer to the Creating Query Folders 128 section for more information.

Home Screen

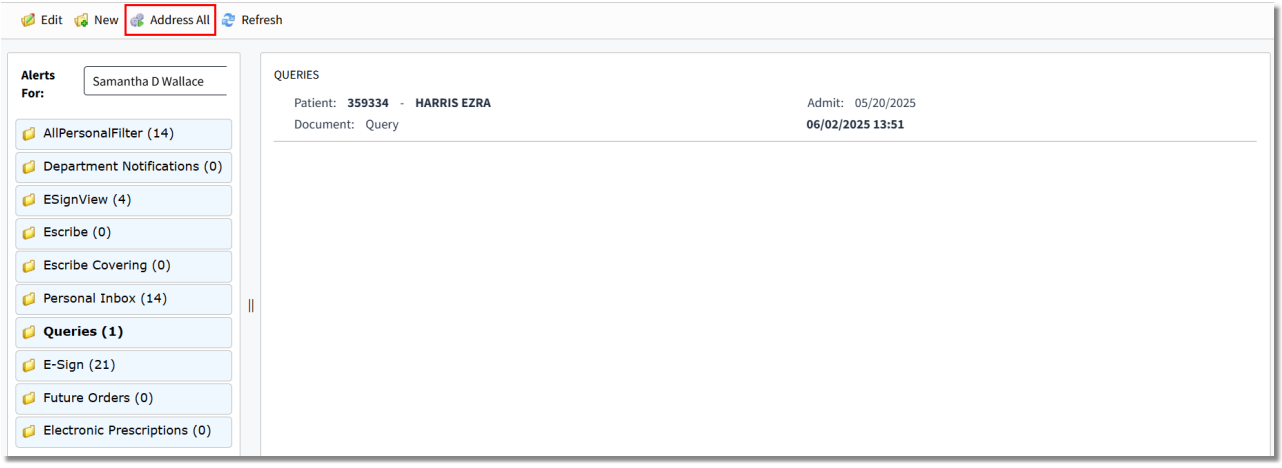
Select **Web Client** > **Home Screen** > **Tasks**



Home Screen - Tasks

The **Address All** option can be selected to view and sign all listed queries at once.

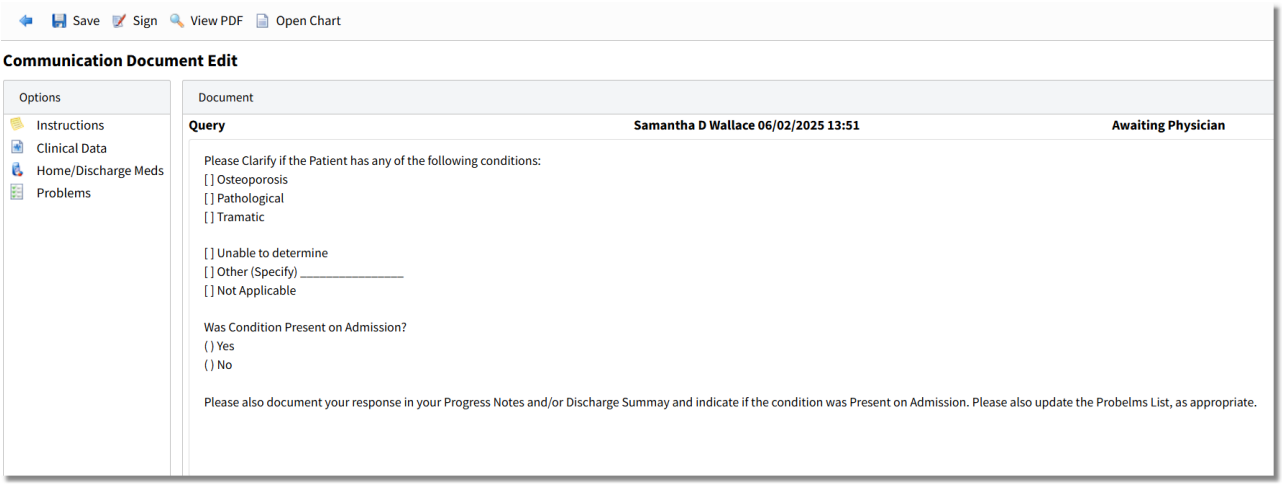
Select **Web Client** > **Home Screen** > **Tasks** > **Query Folder** > **Address All**



Home Screen - Queries

To view and sign a single query, double-click the desired query. It will open with a status of **Awaiting Physician**.

Select **Web Client** > **Home Screen** > **Tasks** > **Query Folder** > **Double-Click Query** > **Communication Document Edit**



Communication Document Edit

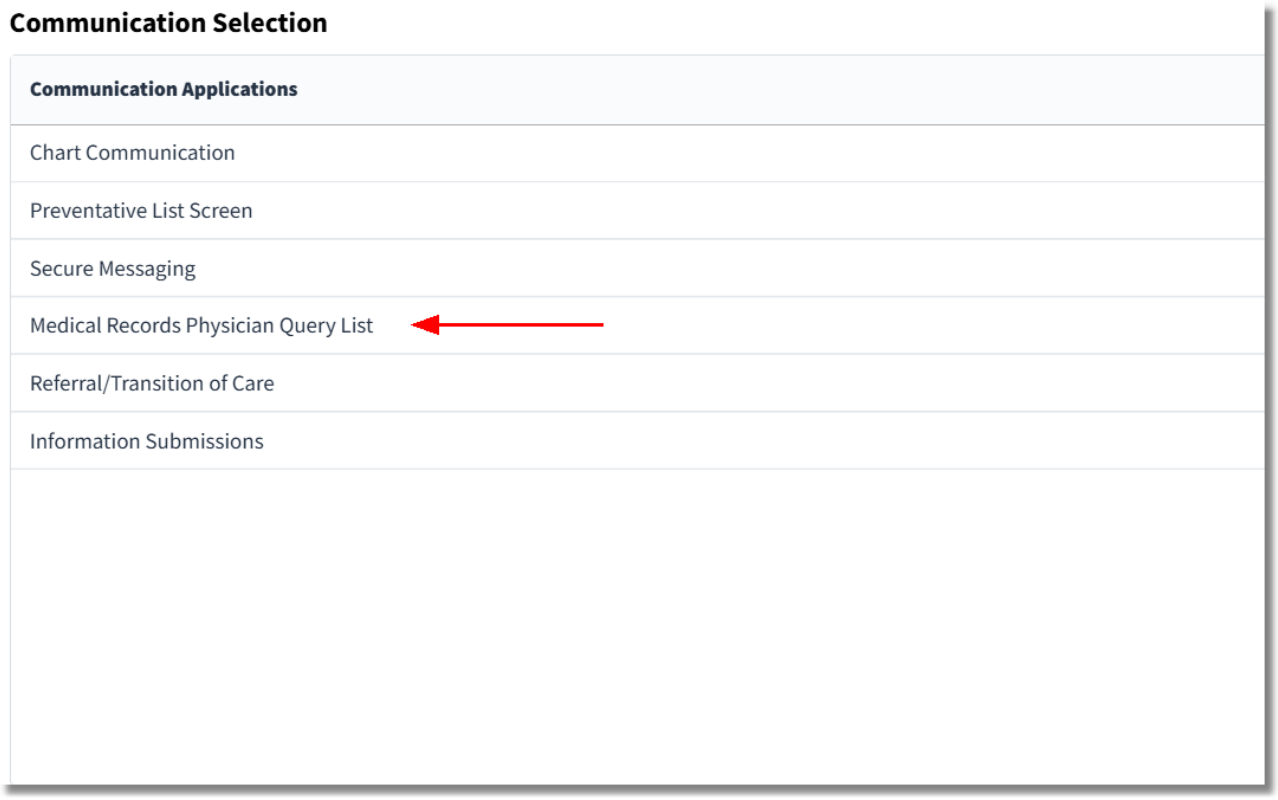
Once the query has been updated, the following options are available:

- **Save:** Saves any changes made to the query.
- **Sign: Saves the** physician's changes and electronically signs the document. The system will prompt for the physician to enter their **Passphrase**. After entering the passphrase, select **Accept** from the action bar. Once signed, the query is sent to the **Medical Records Query Responses** folder on the Home Screen with a status of **Awaiting Coder**.
- **View PDF:** Displays the document in PDF format.
- **Open Chart:** Opens the patient's chart for review or additional documentation.

Patient's Chart

The physician may also address the query by accessing the **Communications** application from the patient's chart. Once the Communication Selection screen displays, select **Medical Records Physician Query List**.

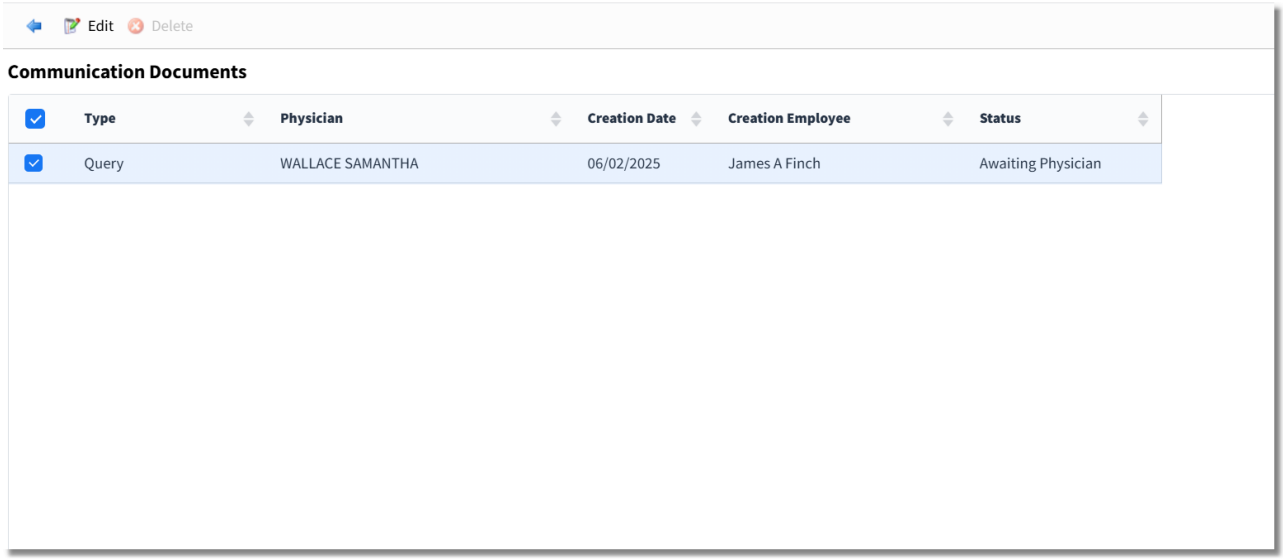
Select **Web Client > Charts > Navigation Panel > By Account Number > Communications**



Communication Selection

The Communication Documents screen will display all queries for the selected patient. Queries with a status of **Awaiting Physician** may be addressed and signed by the physician. Queries with any other status are view-only for the physician.

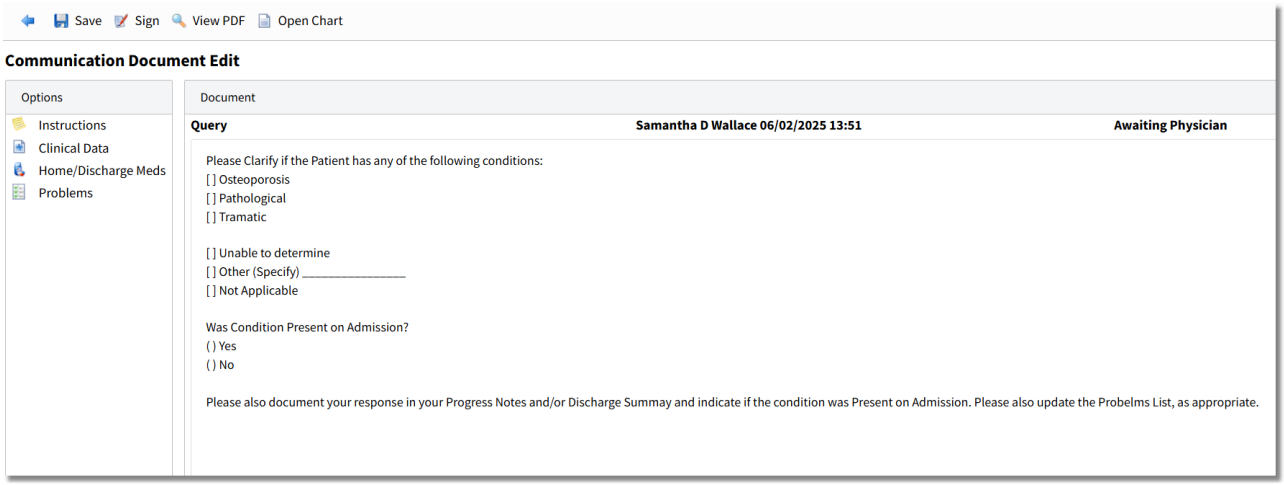
Select **Web Client > Charts > Navigation Panel > By Account Number > Communications > Medical Records Physician Query List**



Communication Documents

To view and/or sign the query, double-click the desired query from the list.

Select **Web Client > Charts > Navigation Panel > By Account Number > Communications > Medical Records Physician Query List > Double-Click Query**



Communication Document Edit

Once the query has been updated, the following options are available.

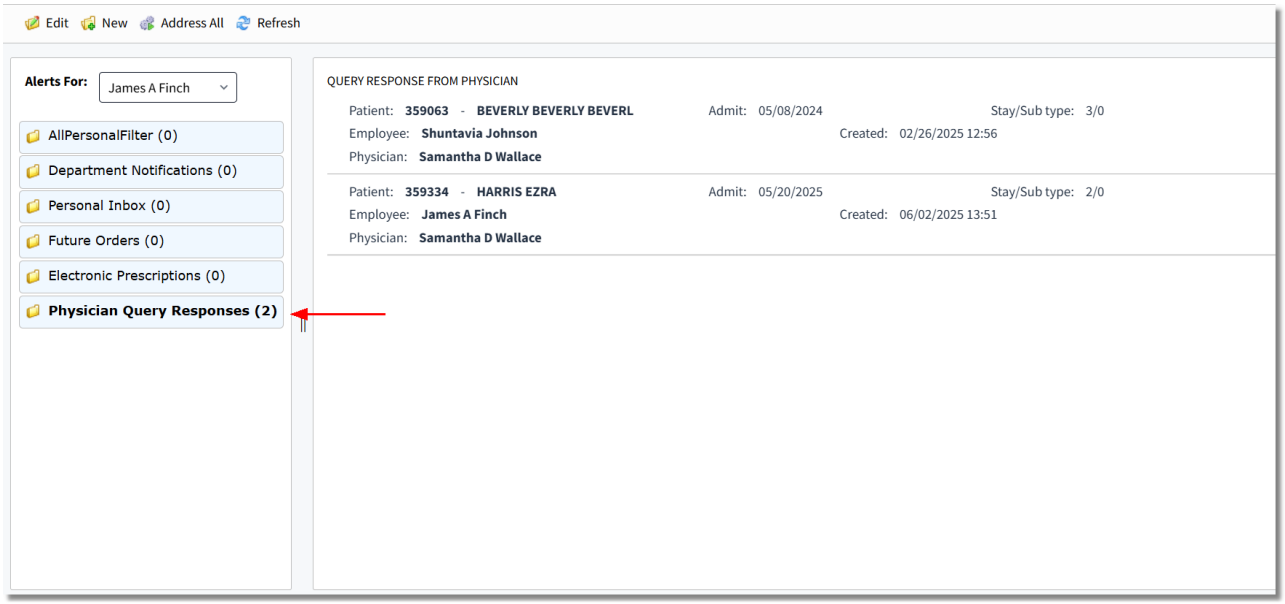
- Once the query has been updated, the following options are available:
- **Save:** Saves any changes made to the query.

- **Sign: Saves the** physician's changes and electronically signs the document. The system will prompt for the physician to enter their **Passphrase**. After entering the passphrase, select **Accept** from the action bar. Once signed, the query is sent to the **Medical Records Query Responses** folder on the Home Screen with a status of **Awaiting Coder**.
- **View PDF:** Displays the document in PDF format.
- **Open Chart:** Opens the patient's chart for review or additional documentation.

HIM Acknowledgement Procedures

Once the query is signed, it may be accessed from the HIM staff's Home screen or from the patient's chart. If the Query Responses folder is not displayed, it will need to be created. Refer to the Creating Query Folders 133 section for more information.

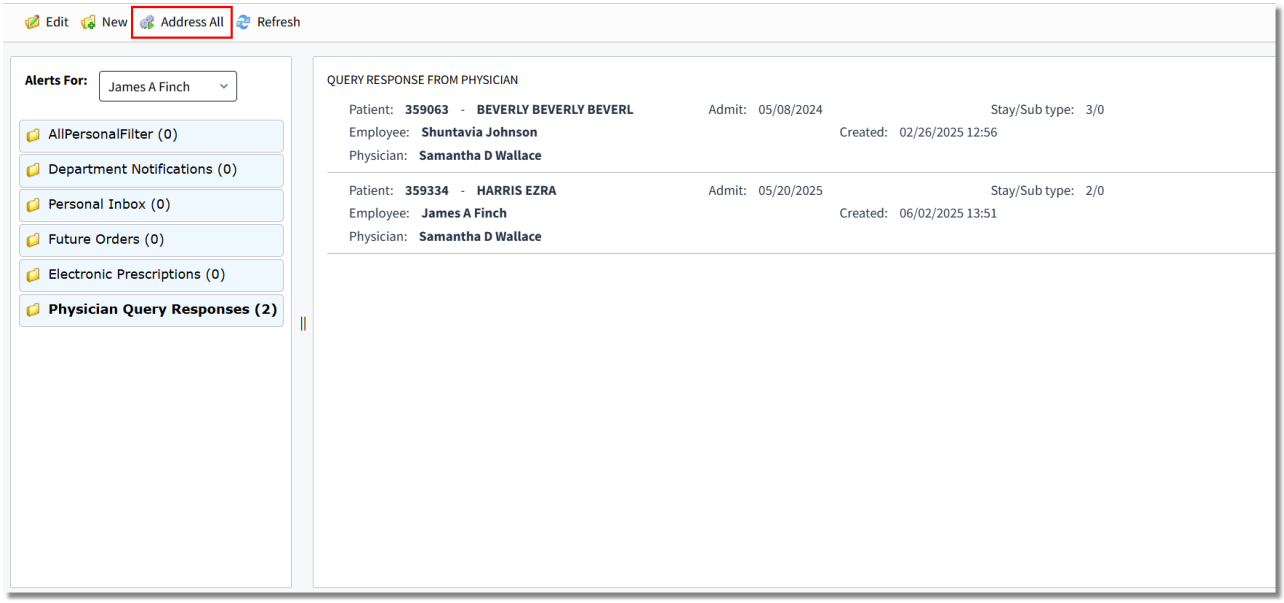
Select **Web Client** > **Home Screen** > **Tasks**



Home Screen - Query Responses

The **Address All** option can be selected to view and acknowledge all queries listed.

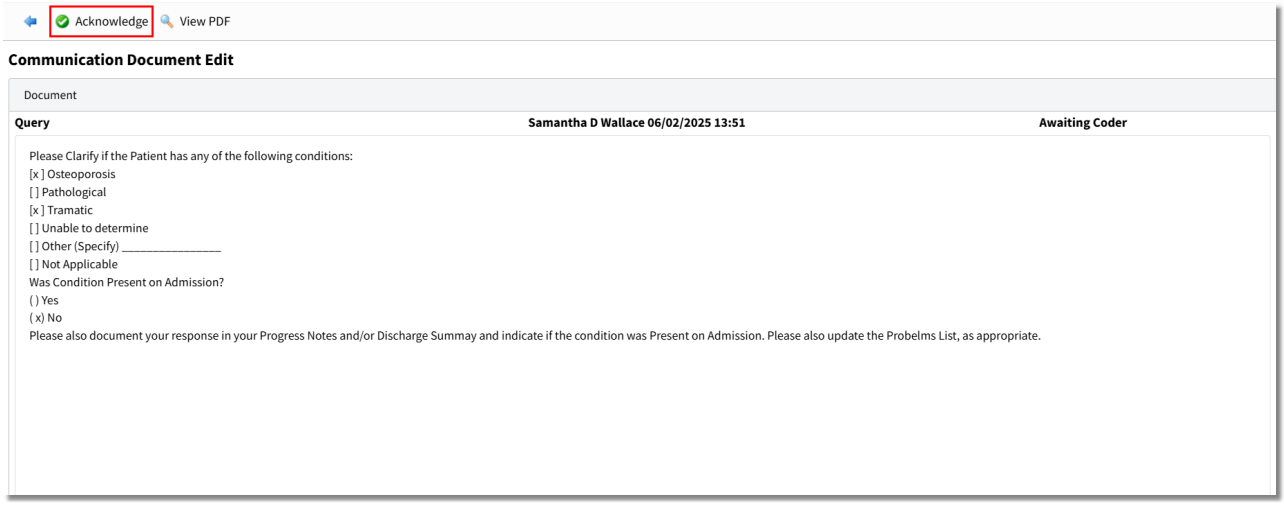
Select **Web Client > Home Screen > Tasks > Query Response Folder > Address All**



Home Screen - Query Responses

To view and acknowledge a single query, select the query. It will be displayed on the screen with a status of **Awaiting Coder**.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account Number > Medical Records > Grouper > Physician Query**



Communication Document Edit

The following options are available on the action bar:

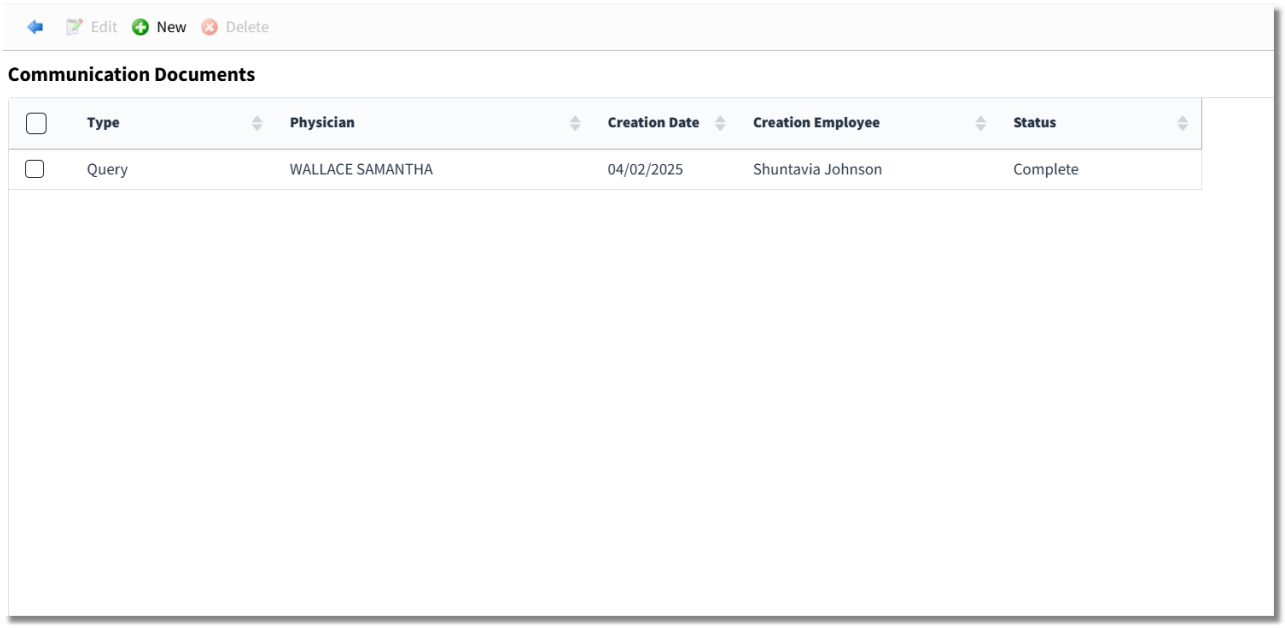
- **Acknowledge:** Confirms that Health Information Management has reviewed the query. The query will be removed from the Medical Records Query Responses folder, and its status will be updated to **Complete**.

- **View PDF:** Displays the document in PDF format.
- **Open Chart:** Opens the Grouper screens for the patient associated with the query.

Viewing a Query on a Selected Patient

Queries can be viewed from the Communication Documents screen or, if acknowledged, from the Print Electronic.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Grouper** > **Navigation Panel** > **Physician Query**



Communication Documents

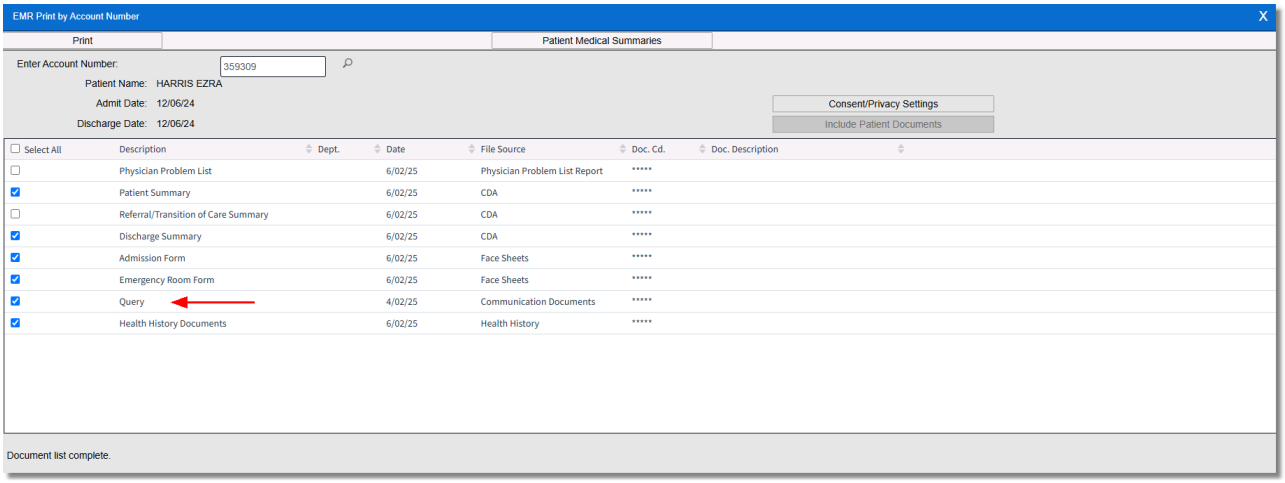
The following information is displayed with each query:

- **Type:** Displays the type of communication document.
- **Physician:** Displays the physician to whom the query was sent.
- **Creation Date:** Displays the date the query was created.
- **Creation Employee:** Displays the employee who created the query.
- **Status:** Displays the current status of the query. The possible statues are:
  - **Awaiting Data:** The query has been created but has not yet been sent to the physician.
  - **Awaiting Physician:** The query has been sent to the physician but has not been signed.
  - **Awaiting Coder:** The query has been signed by the physician but has not yet been acknowledged by Health Information Management.
  - **Complete:** The query has been acknowledge by Health Information Management.

To view or edit an existing query, highlight the query and select **Edit** from the action bar, or double-click the query. Only queries with a status of **Awaiting Data** can be edited. Queries with a status of **Awaiting Coder** status can be **Acknowledged** once selected. Queries with a status of **Awaiting Physician** can also be deleted by selecting the query and selecting the **Delete** option from the action bar.

Once a query has been signed, it will display in the Electronic Record.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number**



Print EMR - Query

Chapter 7 Transcription

7.1 Overview

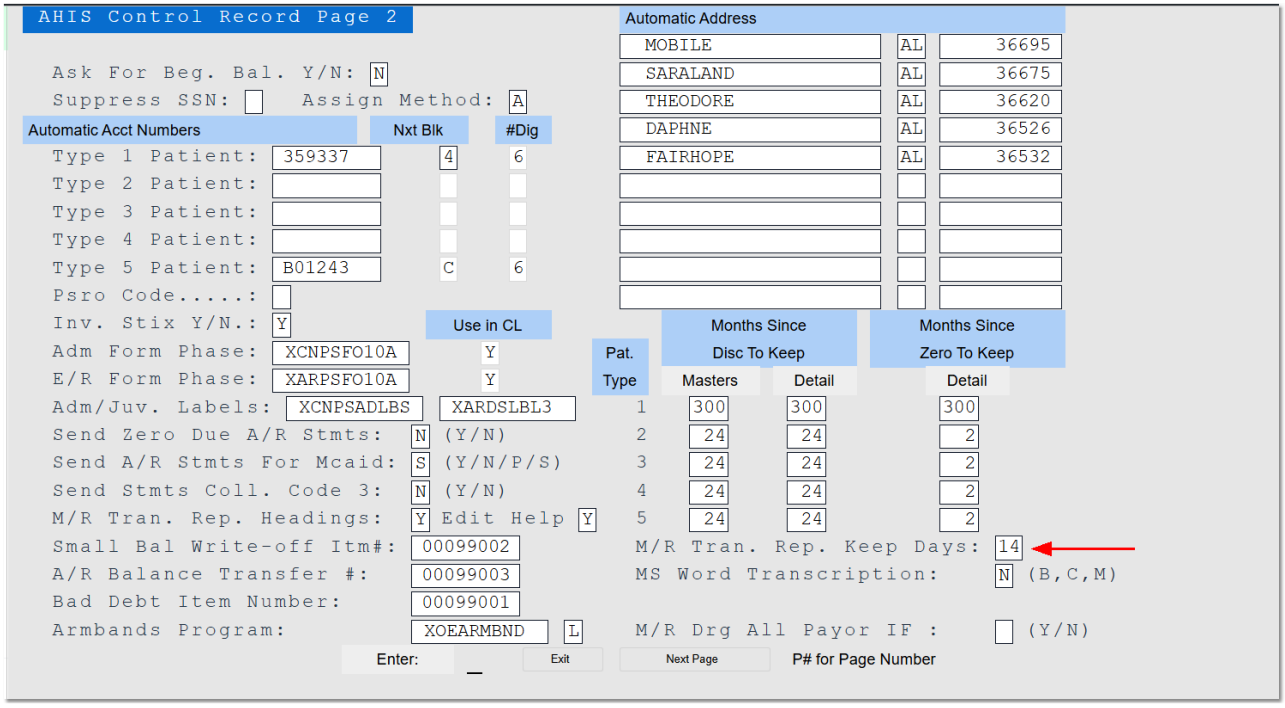
The Transcription system provides an efficient and effective means of transcribing patient records. It provides flexibility to accommodate several types of documents that may be transcribed for each physician.

7.2 Table Maintenance

There are several tables within Patient Accounting that will need to be set up before transcribing a report to a patient's account.

AHIS

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **AHIS** > **Page 2**



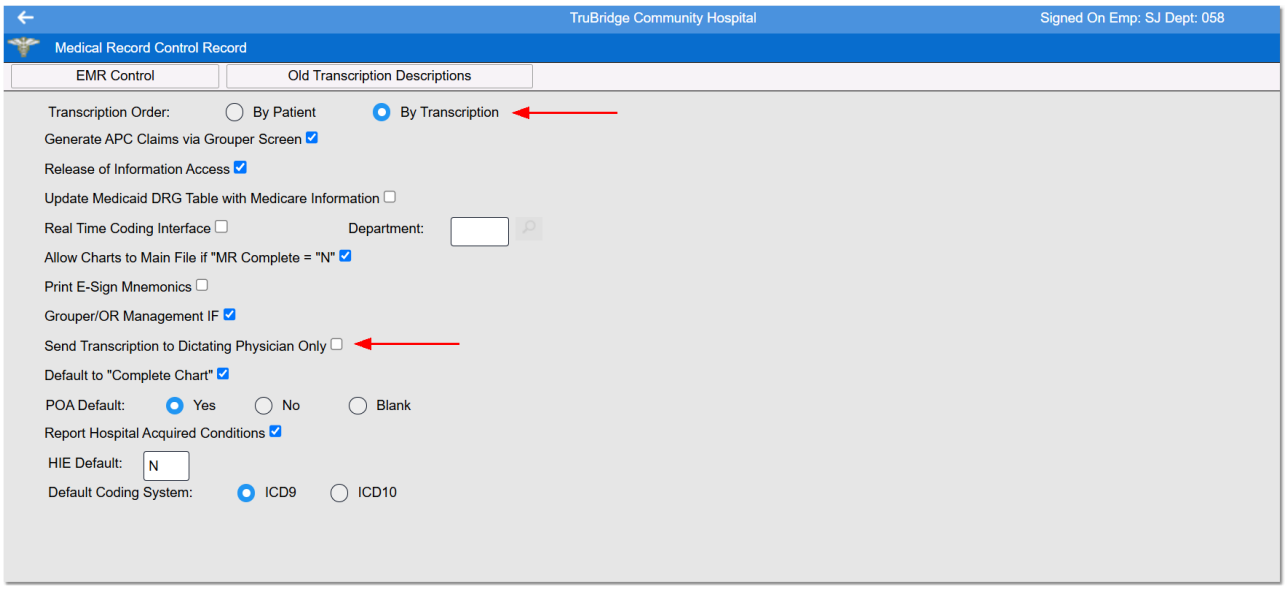
AHIS Control Record - Page 2

- **M/R Tran. Rep. Keep Days:** Controls the number of days a transcription document remains on the patient's account. If a facility has purchased an Archival Data Repository drive, the transcription document will remain on the account under Clinical History and may be viewed or printed. A number from one to 99 may be entered in this field. TruBridge recommends this field be set to 14 days.

NOTE: *Documents requiring multiple signatures will not move to Clinical History until all required signatures have been obtained.*

Medical Records Control Information Table

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Med Rec**



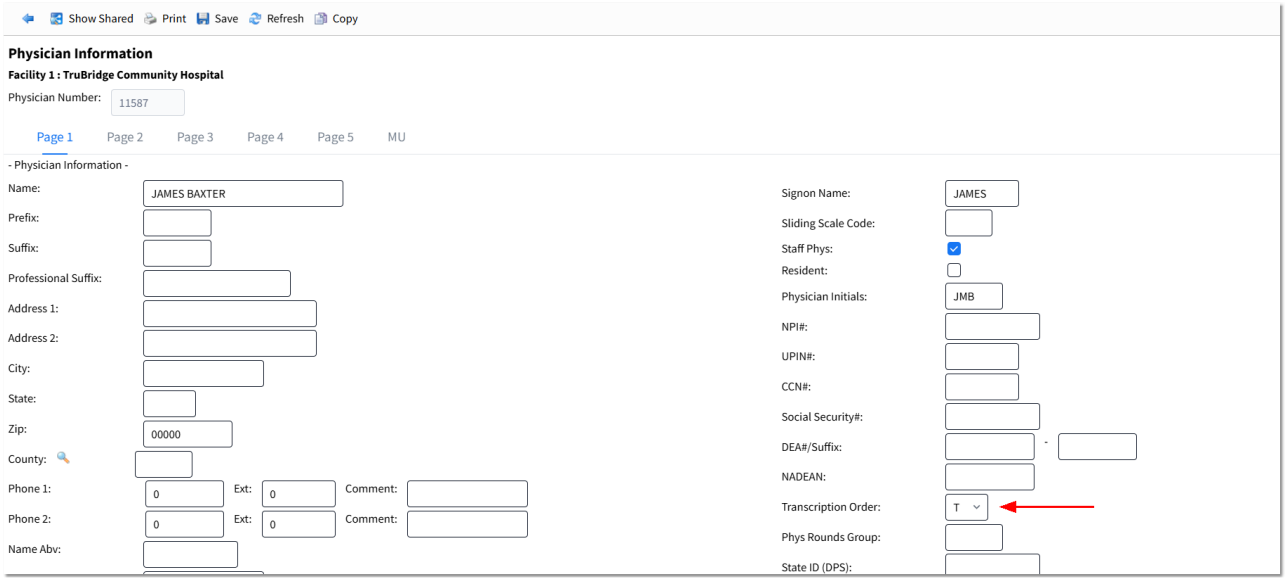
Medical Record Control Record

- **Transcription Order (By Patient/By Transcription):** This field determines the order of selections when using the mass entry feature of Transcription.
  - If **By Transcription** is selected, the system will first prompt for the Transcription Document Types (e.g., History & Physical, Discharge Summary, etc.), followed by Patient Selection from the Current Patient Index.
  - If **By Patient** is selected, the selection order will be reversed, prompting for the patient first, then the document type.

- **Send Transcription to Dictating Physician Only:** If this option is selected and the transcription header is setup for Dictating Physician (located in the Physician Headers 157 table), then only the dictating physician will pull to the Medical Record Transcription Document Options screen. If this option is left blank, all physicians on the account will be displayed.

Physician Table

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select Physician**

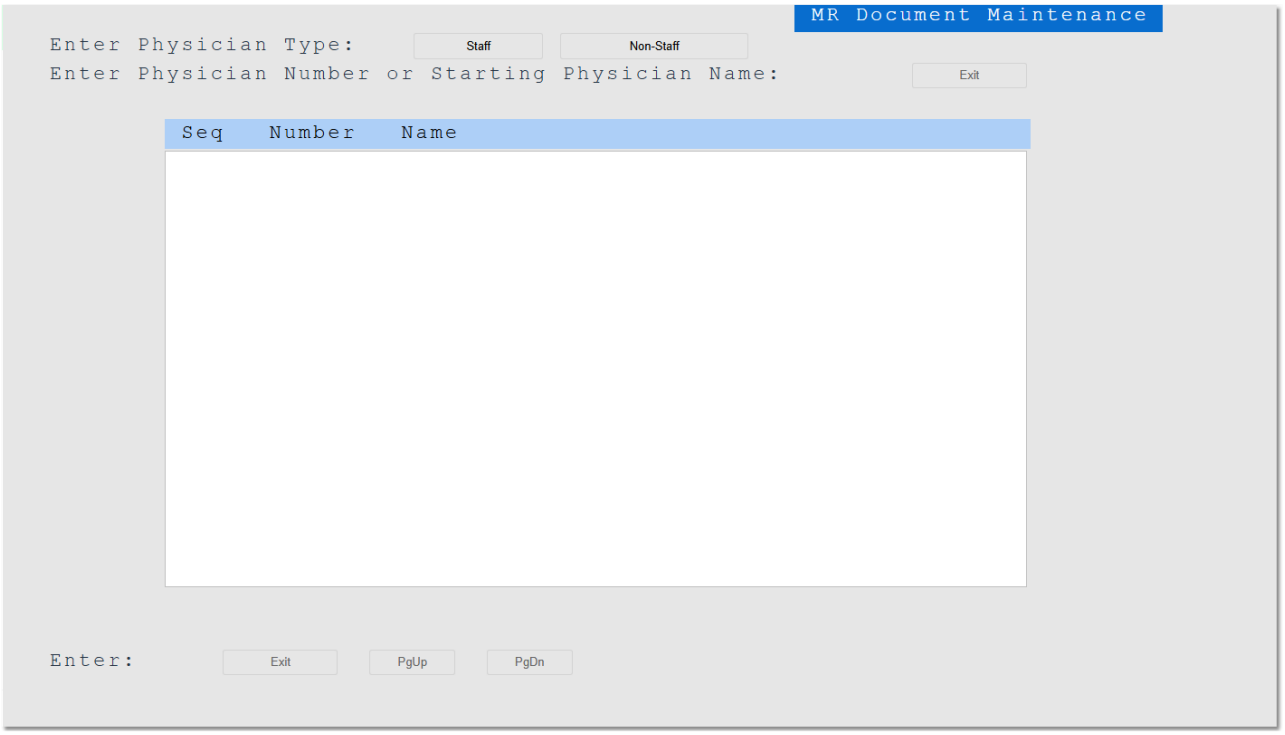


Physicians - Page 1

- **Transcription Order: (P/T):** This field overrides the Transcription Order setting in the Medical Records Control Information Table for the selected physician.
  - If **T** is selected, the system will first prompt for the Transcription Document Types (e.g., History & Physical, Discharge Summary, etc.), followed by patient selection from the Current Patient Index.
  - If **P** is selected, the system will reverse this order, prompting for the patient first, then the document type.

Physician Headers

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Phy Headers**



MR Document Maintenance

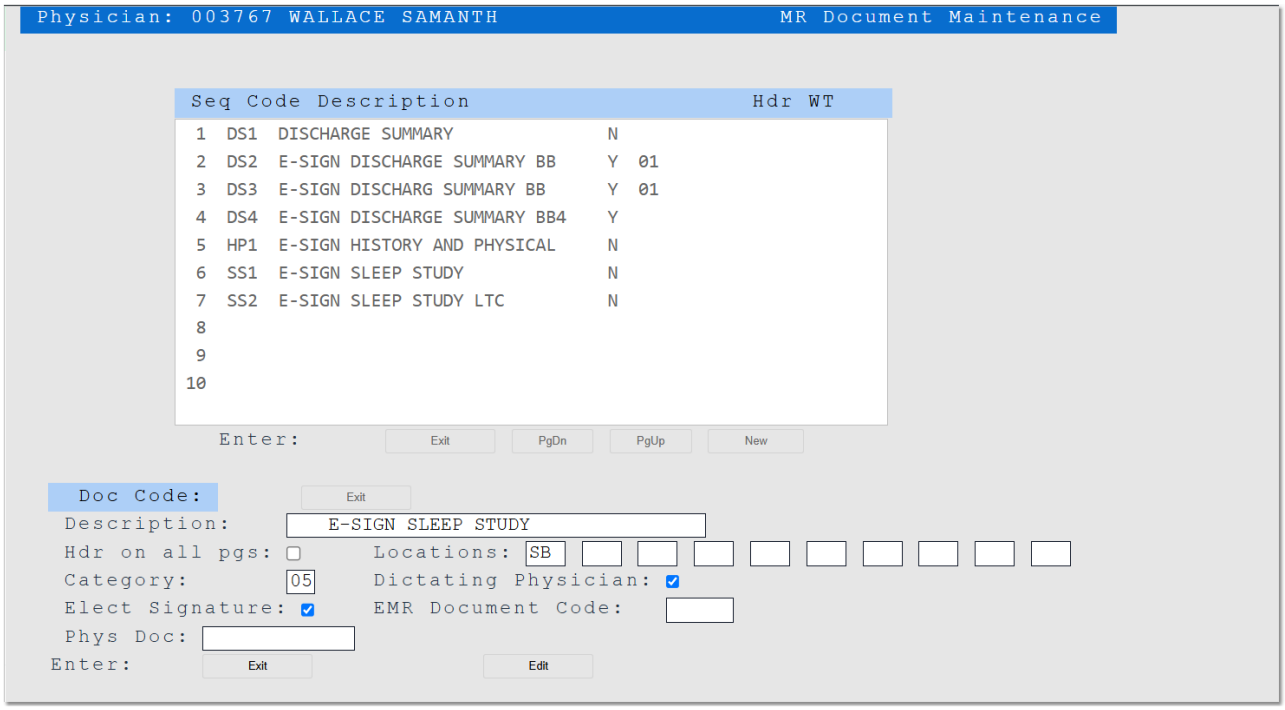
Once the physician type is selected, it will be necessary to enter the physician name or number.

NOTE: *Transcription document formats intended for use by most physicians can be set up globally by accessing the hospital number (Physician Number 999999) and setting up the appropriate document formats.*

After selecting the appropriate physician, any existing document formats will be displayed. The system will prompt to either:

- Select **N**ew to create a new document format, or
- Enter a sequence number to edit an existing format.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Phy Headers** > **Physician** > **"N"ew**



MR Document Maintenance

- **Doc Code:** A user-defined code can be used as a quick indexing feature. For example, HP1 might represent the first History and Physical for this physician.

- **Description:** Enter the name of the document (up to 30 characters). This description will appear in various screen listings and selection menus.

- **Hdr on all pages:** This applies only to sites using TruBridge Word Processing. In Microsoft Word, this can be controlled using **File > Page setup > Different First Page**
  - Enter **Y** to print the physician's header on every page of the document.
  - Enter **N** to print the header on the first page only.

- **Category:** This is a required free-text field for all MR transcription headers. This category code should be entered in the Transcription Workcode field in the EMR Document Table when assigning document codes to physician headers for MR transcription.

NOTE: *For consistency and compatibility with future software development, TruBridge recommends the use of the dictation "worktype" that the physician utilizes when dictating a report, as the basis for this code.*

- **Elect Signature:** Set this field to **Y** if this physician will electronically sign the transcribed document.

- **Locations:** Enter up to ten locations to which the document will be sent automatically. These codes must be defined in the Report Location Table 184.

- **Dictating Physician:** Enter **Y** if the dictating physician should always receive a copy of the document.

- **EMR Document Code:** Enter the code that corresponds to this physician header. Typing a "**?**" and selecting Enter will open a lookup window, allowing the user to search for existing document codes or create a new document code.

NOTE*: The EMR Document Code field is not required for a* physician header *to be print in the Electronic Medical Record. However, if a code has been set up in the EMR Document Code table, it should be entered here.*

Once the above prompts have been completed, the document can be edited using Microsofr Word or TruBridge Word Processing, depending on how transcription will be utilized. Setup instructions will vary depending on the word processing platform used for transcription. For detailed guidance, refer to the Setting Up Physician Headers 159 section.

Setting Up Physician Headers

As desired, the hospital name, address and patient demographic identifiers may be setup within a header or footer. Any text that will pull to patient transcription documents should be setup in the body of the document. To control the pages the header information will pull to may be accomplished in MSWord by selecting the following path: File/Page setup/Different First Page. This should be done first so that header information will not be lost. Next, the Font Type and Size should be set and lastly Tabs can be set up leaving 22 spaces for a name. When editing is completed, exit by using the TruBridge toolbar (**Save/Exit**). A list of transcription patient identifiers that may be used in the document header is listed below. Transcription headers must contain either **PATNUM** or **PATMRNUM**.

NOTE: *These headers may only be created from a TruBridge PC and Microsoft Word must be turned on through the Options menu.*

Identifiers:	Demographics:	Identifiers:	Demographics:
DCTNAME Field Length: 40	Dictating Phy Electronic Sig. Name	PATSEX Field Length: 1	Patient's Sex
DICTDATE Field Length: 8	Dictation Date	PATSS Field Length: 9	Pt's Social Security Number
DICTNAME Field Length: 40	Dictating Physicians Name For Digital Signature Documents this will pull the Admitting Employee's Name	PATTYPE Field Length: 1	Patient Type
DICTTIME Field Length: 5	Dictation time	PHYS1ABR Field Length: 10	Attending Phy. Short Description

FAMPHYSABR Field Length: 10	Fam. Phy. Short Desc	PHYS1NAME Field Length: 40	Attending Phy. Name
FAMPHYSNAME Field Length: 40	Family Phy. Name	PHYS1NUM Field Length: 6	Attending Phy. Num.
FAMPHYSNUM Field Length: 6	Family Phy. Number	PHYS2ABR Field Length: 10	2ND Phy. Short Desc.
PATADMIT Field Length: 8	Admit Date	PHYS2NAME Field Length: 40	Second Phy. Name
PATAGE Field Length: 3	Patient's Age	PHYS2NUM Field Length: 6	Second Phy. Number
PATBDAY Field Length: 8	Birthday	RADCRED Field Length: 20	Physicians Credentials
PATDISCHARGE Field Length: 8	Discharge Date	SERVTYPE Field Length: 1	Service Type
PATFC Field Length: 3	Patient's Fin. Class	SIGNDATE Field Length: 8	Signature Date
PATMRNUM Field Length: 11	Medical Record Number	SUBTYPE Field Length: 2	Patient's Subtype
PATNAME Field Length: 23	Patient's Name	TRANSDATE Field Length: 8	Transcribed Date
PATNUM Field Length: 6	Patient's Number	TRANSINIT Field Length: 3	Transcriptionist's Initials
PATPHONE Field Length: 10	Patient's Phone Number	TRANSTIME Field Length: 5	Transcribed Time
PATROOM Field Length: 4	Room Number	XRAYNUM Field Length: 11	X-ray Number
PATADDR Field Length: 21	Patient's Address	PATCITY Field Length:14	Patient's City
PATSMOKER Field Length:1	Smoker	DICTINITS Field Length:3	Dictating Physician's Initials
PATSTATE Field Length: 2	Patient's State	<<COSIGNATURE_ PENDING>>	Physician Security field 4
<<REPDIST>>	Report Distribution		

Medical Records Transcription Identifiers

NOTE: *Exceeding the "Field Length" for any identifier may result in hang-ups with the PrintRTF as well as Physician E-Sign.*

- *When correcting an identifier, it should be completely deleted and retyped.*
- *TruBridge recommends placing the physician's credentials in the Signature field of the Physician Security table page 1. This will allow the credentials to pull with the physician's name when*

using the DCTNAME mnemonic. An example would be Daniel E Smith, MD. The Credentials field in the Physician Security table page 1 should be reserved for the physician's specialty such as Radiologist, Chief of Staff etc.

- *TruBridge recommends sites that copy others on their documentation, place the <<REPDIST>> identifier within the document to list other physicians where the report was distributed.*

Identifiers:	Demographics:	Identifiers:	Demographics:
DCTNAME Field Length: 40	Dictating Phy Electronic Sig. Name	PDISCHARGE Field Length: 8	Discharge Date
ORDERNUM Field Length: 5	Order Number	PMEDREC Field Length: 11	Patient Medical Record Number
P1ABR Field Length: 10	Attending Physician Short Description	PNAME Field Length: 23	Patient Name
P1NAME Field Length: 40	Attending Physician Name	PNUM Field Length: 6	Patient Number
P1NUM Field Length: 6	Attending Physician Number	PROOM Field Length: 4	Patient Room Number
P2ABR Field Length: 10	Second Physician Short Description	PSEX Field Length: 1	Patient Sex
P2NAME Field Length: 40	Second Physician Name	PTYPE Field Length: 1	Patient Stay Type
P2NUM Field Length: 6	Second Physician Number	RADCRED Field Length: 20	Physicians Credentials
P3ABR Field Length: 10	Referring Physician Short Description	REPORTLOC Field Length: 2	Report Location
PADMIT Field Length: 8	Admit Date	SIGNDATE Field Length: 8	Signature Date
PAGE Field Length: 3	Patient Age	TRANSDATE Field Length: 8	Transcription Date
PDISCHARGE Field Length: 8	Patient Financial Class	TRANSIN Field Length: 3	Transcription Initials
PATPHONE Field Length: 10	Patient Phone Number	TRANSTIME Field Length: 5	Transcription Time
PBDAY Field Length: 8	Patient Birth date	XRAYNUM Field Length: 11	X-ray Number
<<COSIGNATURE_PENDING>>	Physician Security field 4		

Order Entry Transcription Identifiers

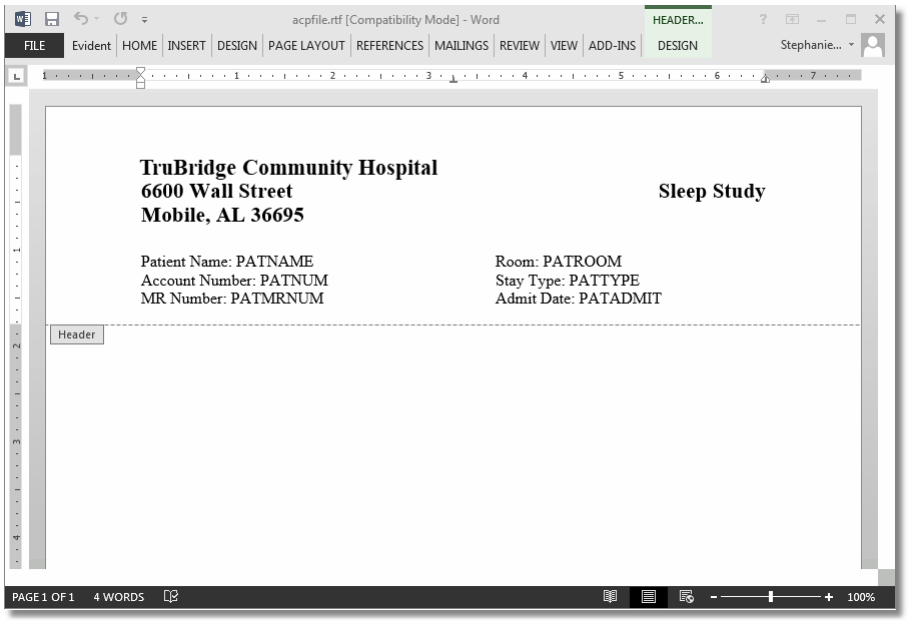
NOTE: *The mnemonic XRAYNUM only works in conjunction with the Order Entry application.*

NOTE: *TruBridge recommends placing the physician's credentials in the Signature field of the Physician Security table page 1. This will allow the credentials to pull with the physician's name when using the DCTNAME mnemonic. An example would be Daniel E Smith, MD. The Credentials field in the Physician Security table page 1 should be reserved for the physician's specialty such as Radiologist, Chief of Staff etc.*

The following is an example of a transcription header document for a Discharge Summary containing identifiers. Information must be entered into each Word transcription header document. After selecting **E**dit, MS Word will open. Headers may be setup by selecting **View/Header and Footer** from the toolbar. The hospital's address and patient identifiers should be entered as desired, using MS Word commands. Fonts should be set up in the header, text and footer. The default is 10. To create a body of text for the Word transcription header document, double click below the completed header to edit the body or select **Close** on the Header/Footer toolbar. After completing setup for the transcription header, select **Save/Exit** on the TruBridge toolbar.

NOTE: *To view Header/Footer as part of the document, select* ***View/Page Layout*** *or* ***Print Layout****. To view only text body, select* ***View/Normal****. When viewing using Page Layout or Print Layout, the Header will appear as shaded. To edit the Header, double click within the shaded area.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Phy Headers** > **Select Physician** > **Select Document** > **Edit**



Physician Header

NOTE: *The headers, once created, are located in /usr/mr. Facilities with multiple companies will need different directories set up. Please contact an TruBridge representative for assistance.*

Normals are used in Medical Record Transcription to reduce the number of unnecessary keystrokes. A Normal is used when there is a standard Letter/text that will be utilized on a regular basis. After creating the Normal in Word, select **File** from the toolbar, then **Save As**. The file should be named as desired. At this point, **Abort/No Save** should be selected since the Normal will not be saved again through TruBridge EHR.

After accessing the Word Transcription document in which to copy the Normal, select **Insert/File**. Once the Normal is accessed, edited and completed, then select **Save/Exit**, which will bring the document back into TruBridge EHR.

There are three steps that must be completed to set up transcription documents for TruBridge Word Processing. T hospital name, transcription document title, and transcription document body must be setup.

The transcription document title is setup in the document "**CAT", where "**" signifies the two characters that are used in the Category of Document Maintenance field. These are also set up in the library /usr/mr.

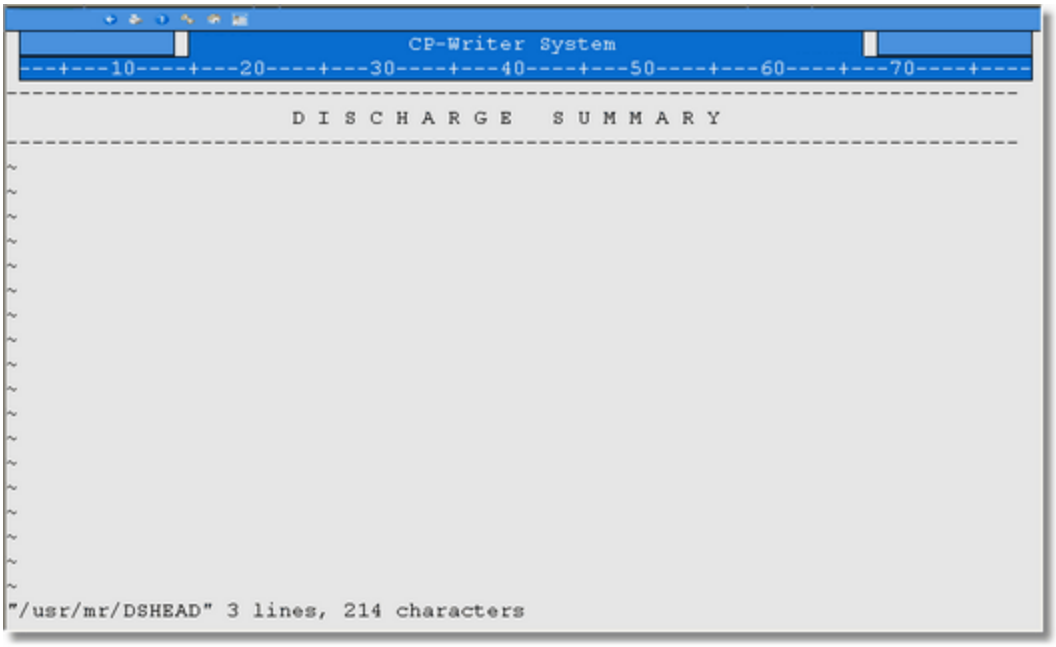
The document body is set up in **Physician Headers** in the Business Office Tables. See figure 3.5.

Upon selecting **N**ew to create a new document, the following prompts must be answered:

- **Doc Code:** This code is a hospital-defined code and may be used as a quick indexing feature. For example, H01 could be the first History and Physical for this physician.
- **Description:** This is the name of the document, up to 30 characters in length. This description will be used in various screen listings.
- **Hdr on all pgs:** Selecting this field will allow this physician's header to print on every page, and leaving this field blank will only allow the header to print on the first page.
- **Category:** This field is utilized by the system when TruBridge Word Processing is used. It should be answered as **HP**, **DS**, **RD**, **OP**, etc. The system uses the category to pull an appropriate category header from the "/usr/mr" directory in Word Processing. While it is a hospital-defined field, there should be a category header document created that corresponds to the category entered. The category header documents should follow the "**CAT" naming convention, in the "/usr/mr" directory, where the "**" signifies the two characters that are used in this Category field. For example, if the document created was a History & Physical, HP could be loaded in this field. In the "/usr/mr" directory, a document named HPCAT should be setup.

Once the above prompts have been answered, the available options are **0** to Exit, **D** to Delete or **E** to Edit the document using TruBridge Word Processing to enter text and document formats to be used when transcribing. The screen below gives an example of a format that could be used for a Discharge Summary using TruBridge Word Processing.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Phy Headers** > **New** > **Edit**



CP-Writer System

Normal documents should be set up in the "**/usr/mr**" directory. Each normal should contain a separate document. After normals are set up, they may be read into a transcription document using text editor commands.

NOTE: *Refer to the Word Processing User Guide for instructions on editing and using "read" commands in text editor.*

7.3 Transcribing Patients

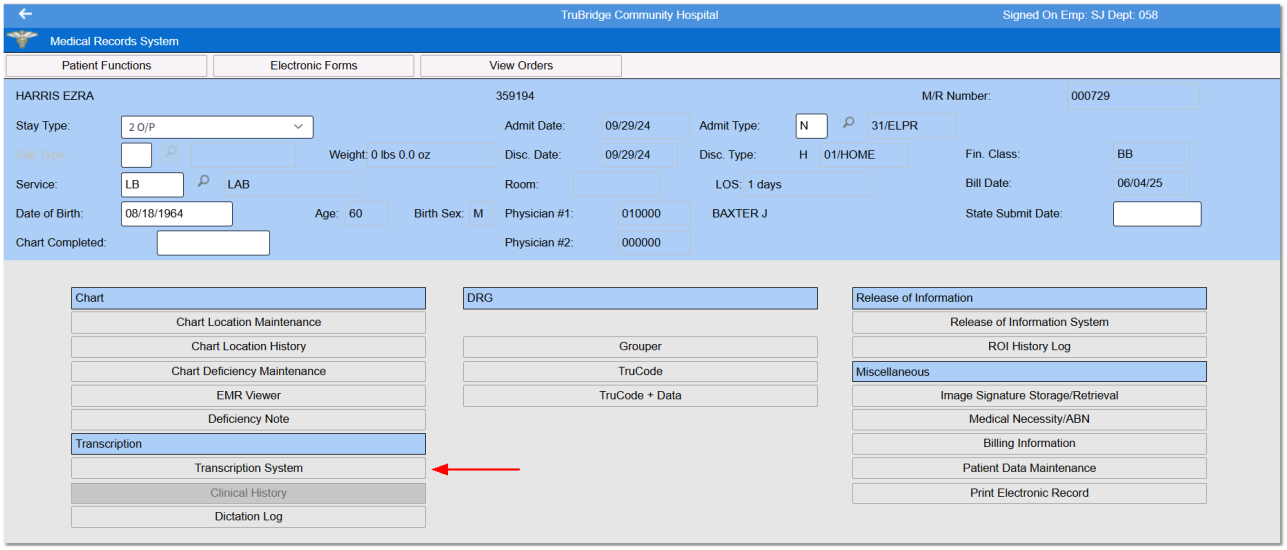
Once all physician headers and category documents are set up, the Transcription application may be used.

There are two methods for accessing transcription:
1. By Patient Account 165 - Allows a transcription to be entered for one specific patient at a time.
2. Mass Entry 169 - Enables transcriptions to be entered for multiple patients.

Transcribing By Patient Account

To transcribe for a selected patient, lock onto the patient's account and select the Transcription System to view existing transcription documents or create new documents.

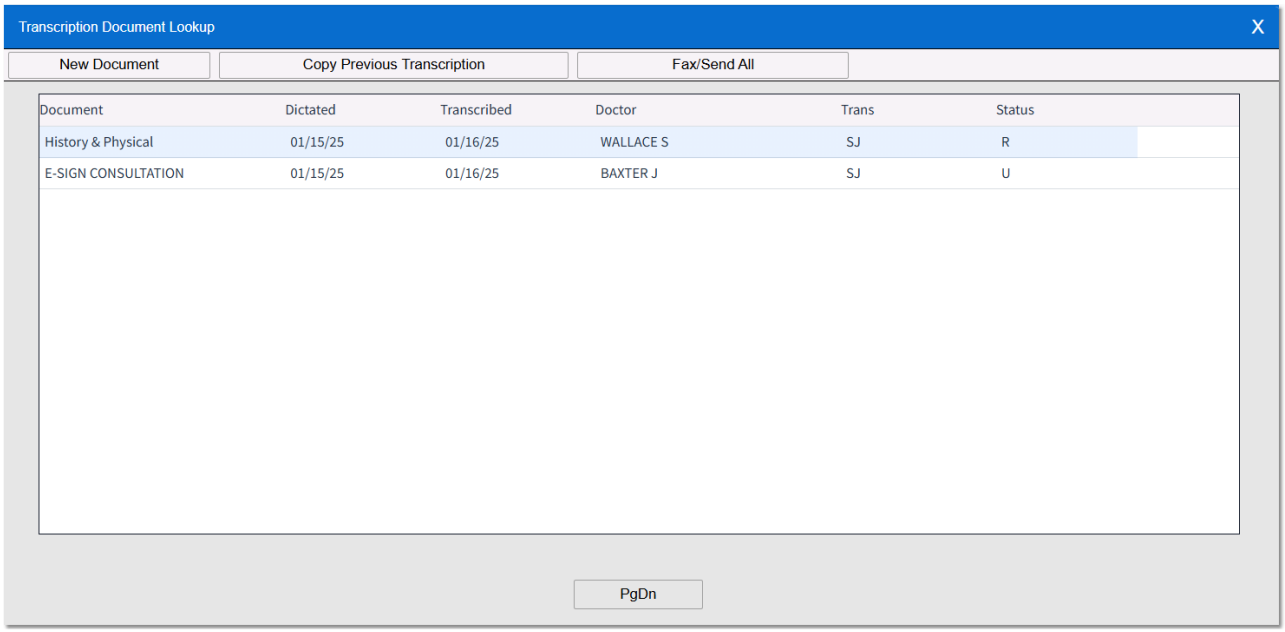
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Patient Account #** > **Medical Records**



Medical Records System

After selecting **Transcription System**, the following menu will display. Select **New Document** to create a new transcription entry. Any existing documents for the patient will also be displayed for review or selection. Select **Copy Previous Transcription** to allow an existing transcription document to be copied over to a new patient's account.

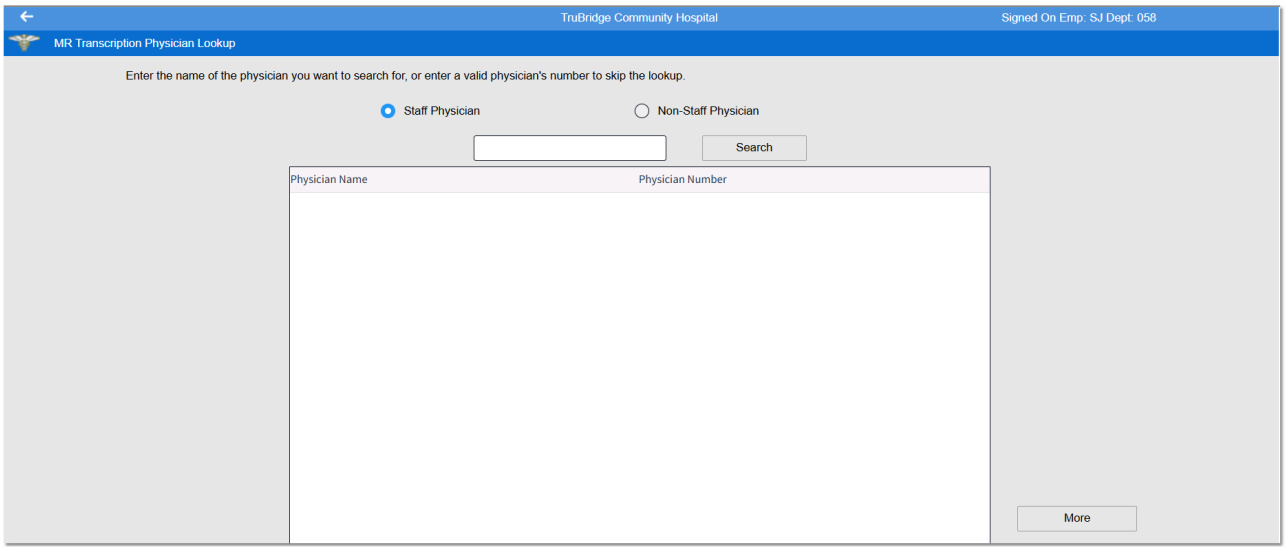
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Patient Account #** > **Medical Records** > **Transcription System**



Transcription Document Lookup

Upon selecting **New Document**, the following screen will appear:

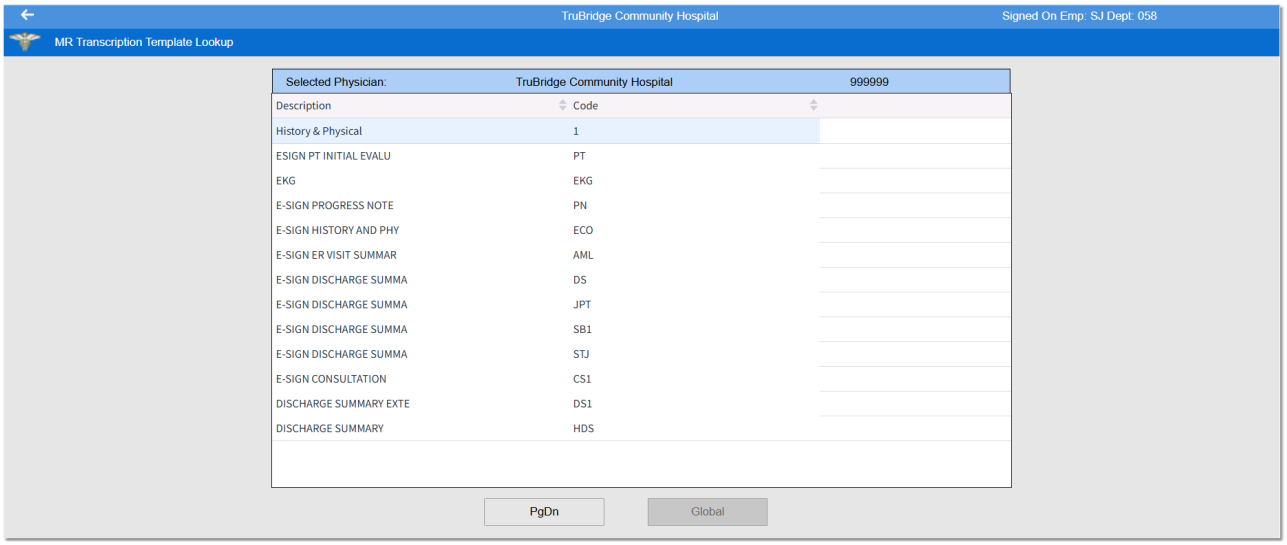
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Patient Account #** > **Medical Records** > **Transcription System** > **New Document**



MR Transcription Physician Lookup

An index of Staff or Non-Staff physicians is available for selecting the dictating physician. Once selected, the physician's document formats that were previously set up will display. Transcribers may choose from one of the physician's formats or select **Global,** which will display all document formats set up for the Hospital number (Physician number 999999).

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Patient Account #** > **Medical Records** > **Transcription System** > **New Document** > **Physician**



MR Transcription Template Lookup

Selecting a template allows transcription using either Microsoft Word or TruBridge Word processing, depending on the facility's set up.

Facilities using MS Word will see the header information and any predefined text from the document format setup automatically populate into the transcription document.

Facilities using TruBridge Word processing will find information from the documents, “MRHEAD”, “**CAT” (“**” signifies the 2-character category), and the physician formats pulling into the transcription document.

Transcribing Using Mass Entry Transcription System

The mass entry transcription system allows more efficient data entry for multiple documents associated with a selected physician. It allows transcription by physician, organized by either by patient or by transcription document type.

After selecting a physician, the system will prompt for either the physician's transcription document type or a patient name—depending on the Transcription Order setting in either the Medical Records Control Information or the Physician table.

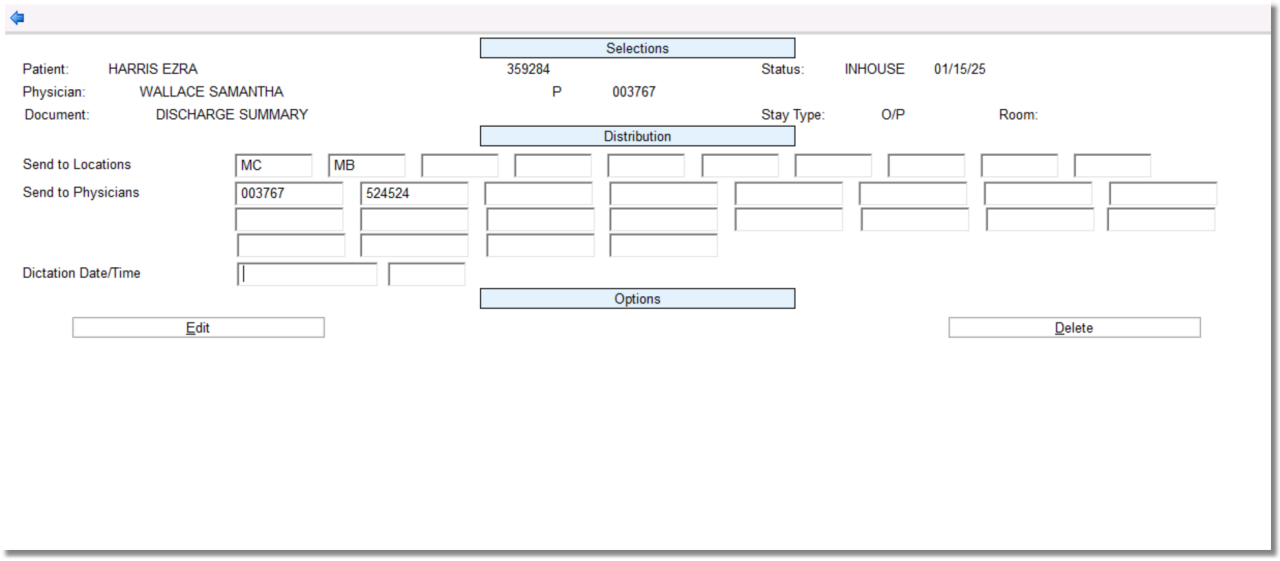
- If the Transcription Order is set to **T**, after selecting the physician, the transcription document must be selected before accessing the patient.
- If the Transcription Order is set to **P**, after selecting the physician, the patient must be selected and then the physician's transcription document type.

After selecting the patient and the transcription document to be transcribed, select **Edit** to edit the document.

In order to have the Dictation Date and Time pull into the mnemonics **DICTDATE** and **DICTTIME** in the document, they must be entered into this field prior to selecting Edit. Upon completion, the transcriptionist should exit the document appropriately by using the TruBridge Toolbar (**Save/Exit**).

NOTE: *If utilizing Physician Documentation, a dictation date and time must be entered prior to selecting* ***Edit****.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **MR Transcription System** > **Transcription Type** > **Patient Account #**



MR Transcription Document Options

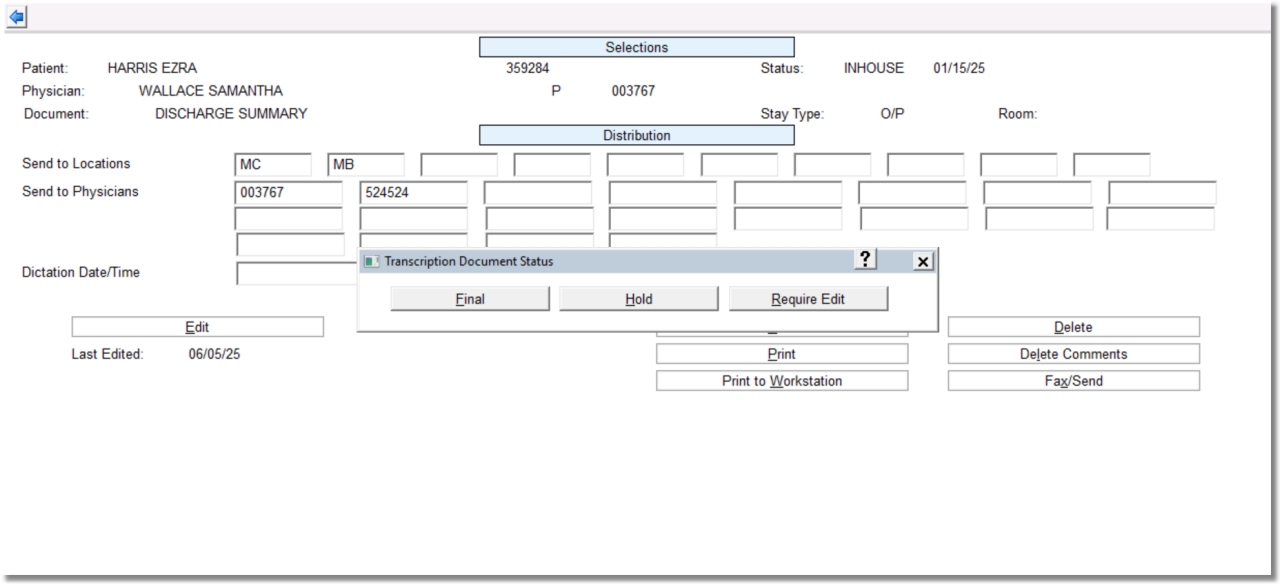
The last date the transcription was edited will show up on this screen beside the Edit option. This will allow the original transcription date to remain on the Medical Records screen while still keeping track of when a document is edited.

Additional Locations and Physicians may also be entered to change/add locations and physicians for the automatic distribution of the document by entering this information into these fields.

When exiting the MR Transcription Document Options screen, a transcription status needs to be assigned.

- Select **Final** to indicate it is finalized. This will also automatically send a copy of the document to the Physician if the Physician Security Table is set to **P** or **B**.
- Select **Hold** to indicate the transcription has not been completed.
- Select **Require Edit** for E-Sign documents if additional information or clarification is needed from the provider.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **MR Transcription System** > **physician** > **Transcription Type** > **Patient Account #**

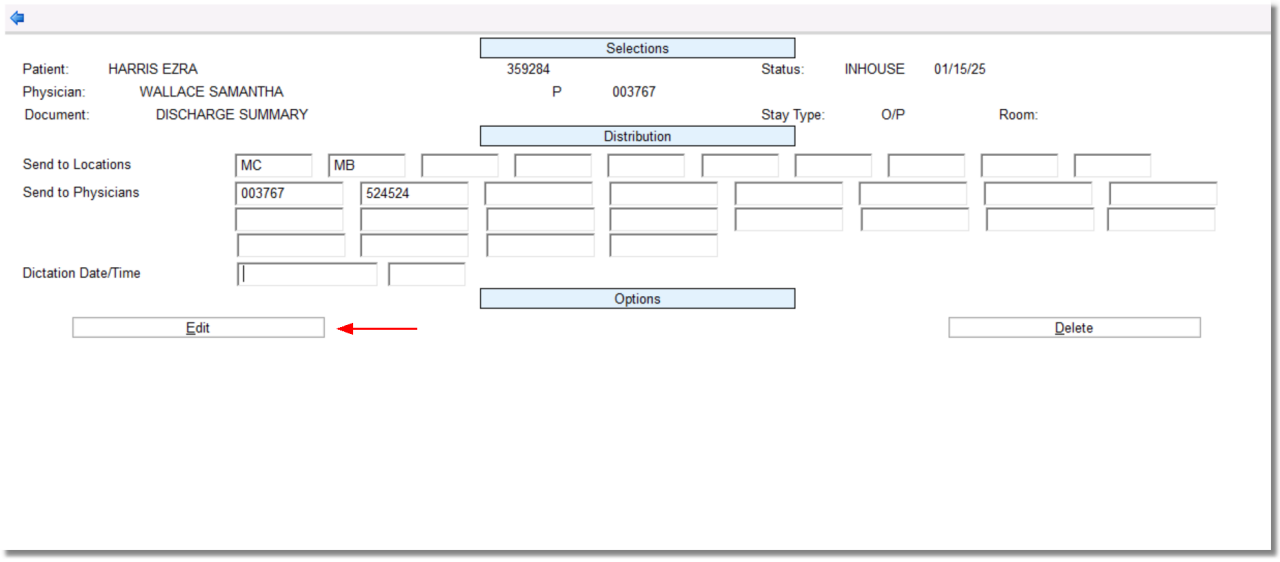


MR Transcription Document Options

Transcribing a Document

After selecting the transcription document, select **Edit** to access Microsoft Word to begin transcribing.

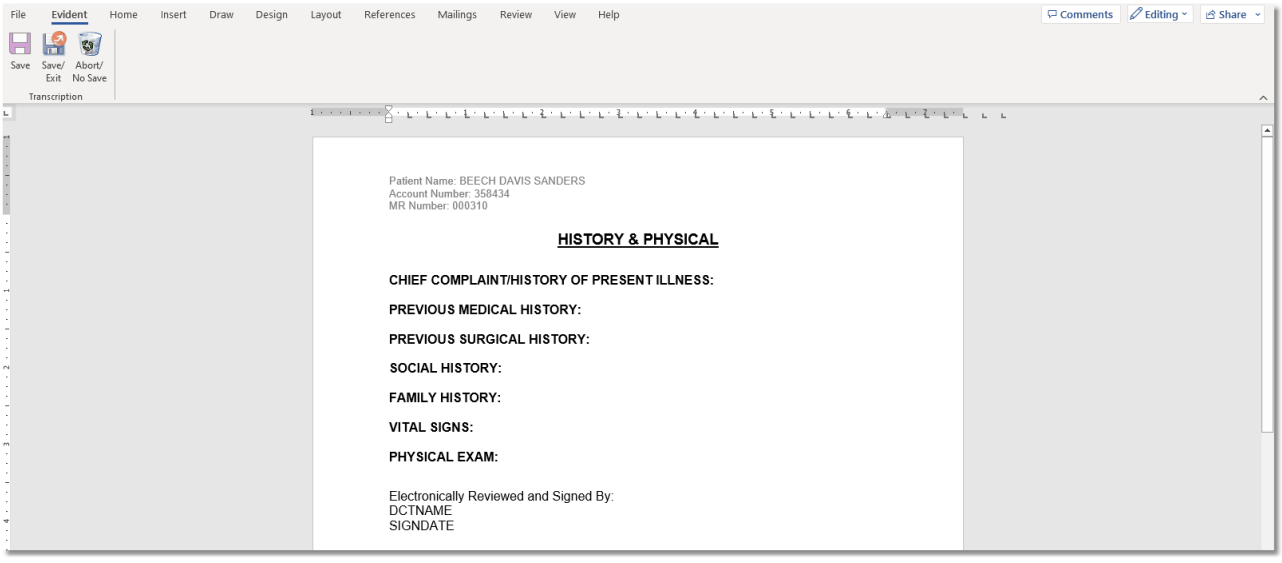
Select **Web Client** > **System Menu** > **Patient Account #** > **Medical Records** > **Transcription System** > **Select Document**



MR Transcription Document Options

Once Microsoft Word has opened, begin transcribing the dictation.

Select **Web Client** > **System Menu** > **Patient Account #** > **Medical Records** > **Transcription System** > **Select Document** > **Edit**



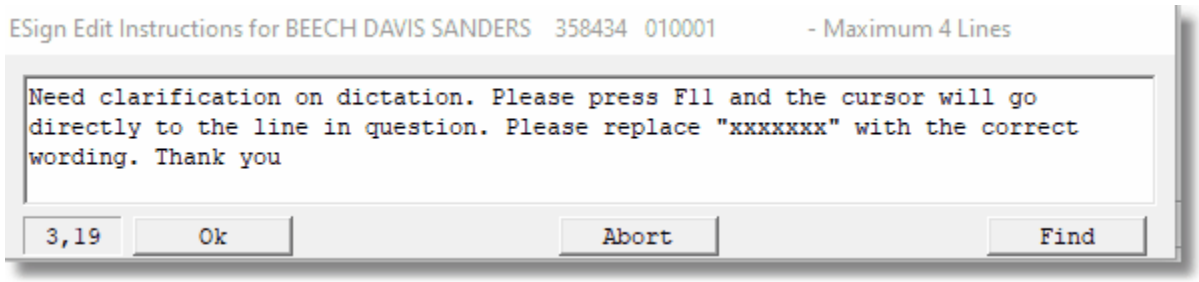
Transcription Document

Once the dictation has been transcribed select **Save/Exit.** The Document Options screen will then display, selecting the **Back Arrow** will provide the transcriptionist with three options.

Transcription Document Status

The following options available:

- **Final:** This option places the transcribed document in the provider's queue to sign and distributes a copy for each physician and location set to receive a preliminary copy of the document.
- **Hold:** This would indicate that a partial transcription has been completed, but not in its entirety. This will not place the document in the provider's queue. The transcription will display with a status of **H** to signify the report is incomplete and should not be distributed or printed. The transcription will pull to the E-Sign Deficiency report as being on hold.
- **Require Edit:** This option will indicate that the transcriptionist was unable to understand some of the dictation and/or needs some further clarification from the provider. Once this option is selected, Notepad will open and the transcriptionist will be able to enter a note for the provider. This note will automatically open when the provider selects this document to view or edit from the e-sign queue. Shown below is an example of the edit box that appears once this option is selected:



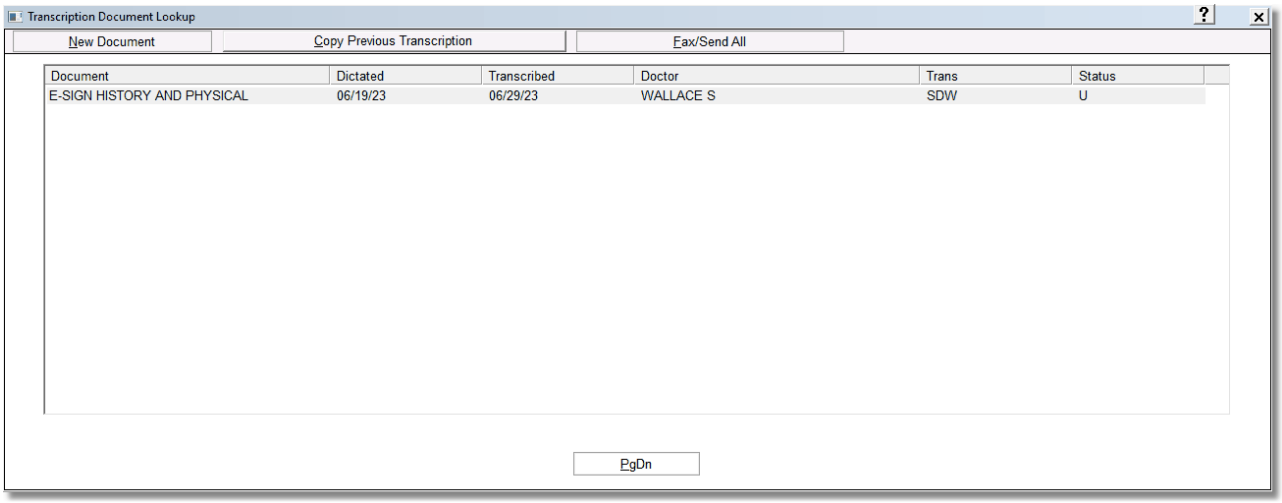
ESign Edit Instructions

Entering **xxxxxxx** (7 lowercase x's) in the place of the misunderstood terminology will prevent the physician from successfully signing the document electronically. Therefore, it is necessary to let the provider know to remove these symbols before exiting.

Creating a Stop Code will also make it easier for the provider to go directly to the space in the document requiring attention. To set up the code, place the cursor in the document exactly where the physician should go, and select **Ctrl-F9**. Then the provider can enter **F11** and the cursor will go to this space.

Once a selection has been made on this screen the transcribed document will have a status of **U**-Unsigned, as shown below.

Select **Web Client** > **System Menu** > **Patient Account #** > **Medical Records** > **Transcription System** > **document**

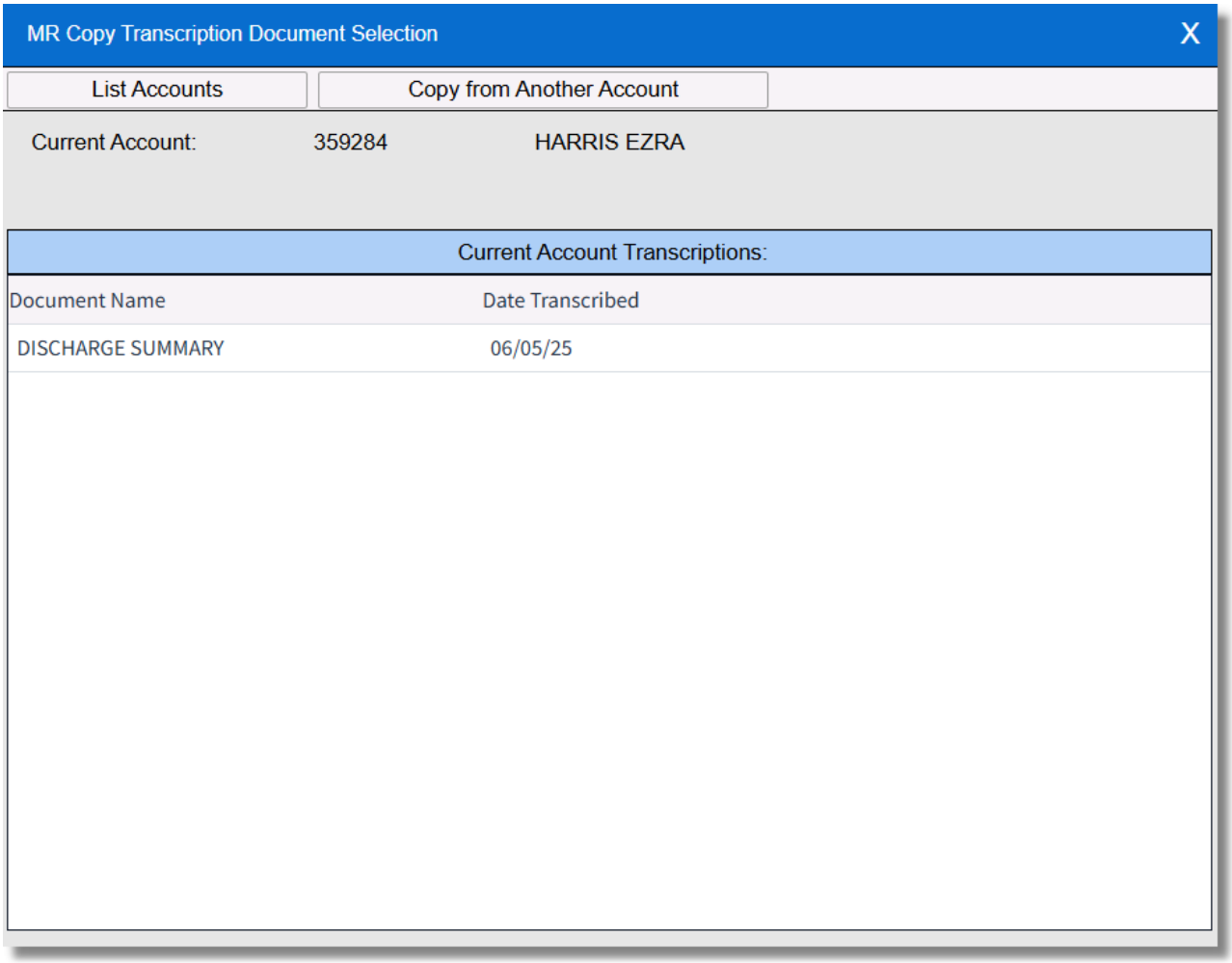


Transcription Document Lookup

Copy Existing Transcriptions to New Patient Accounts

If the patient has a previous transcription on file, the **Copy Previous Transcription** option becomes available. If any exist, current transcriptions will display.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Transcription System** > **Copy Previous Transcription**

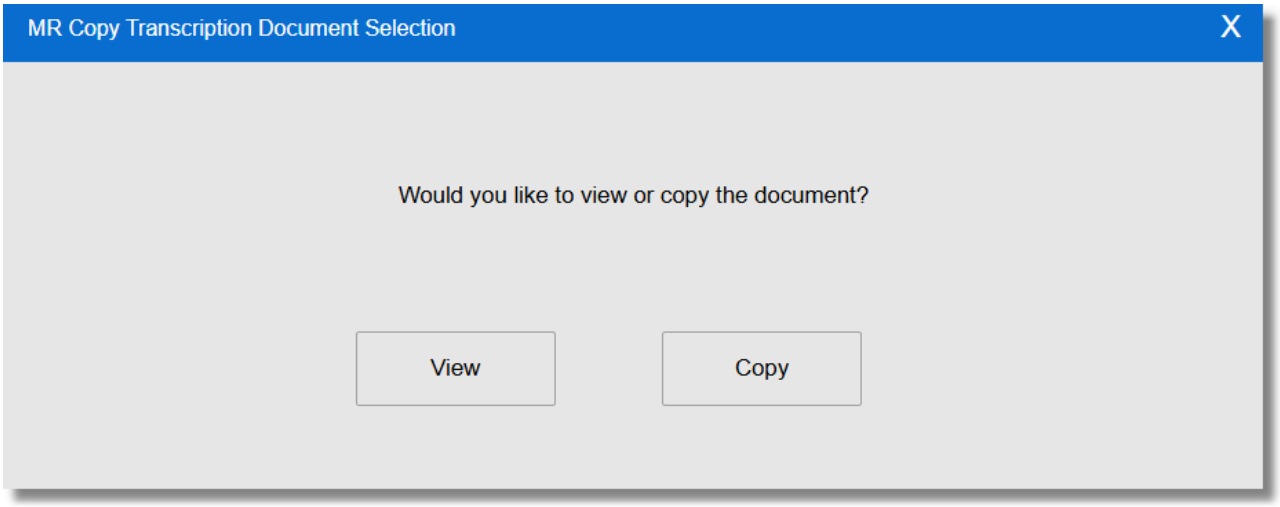


MR Copy Transcription Document Selection

- To display Existing documents on existing accounts enter in the account (if known) or select **List Accounts**. A list of accounts based on the same Social Security Number will display. If there is no Social Security Number in the new account to reference, a list of accounts based on the date of birth and the same name will pull to the screen.

After an account is selected, existing transcribed documents will be displayed. When the desired document is selected, two options will be listed: **V**iew and **C**opy

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Transcription System** > **Copy Previous Transcription** > **Select Document**



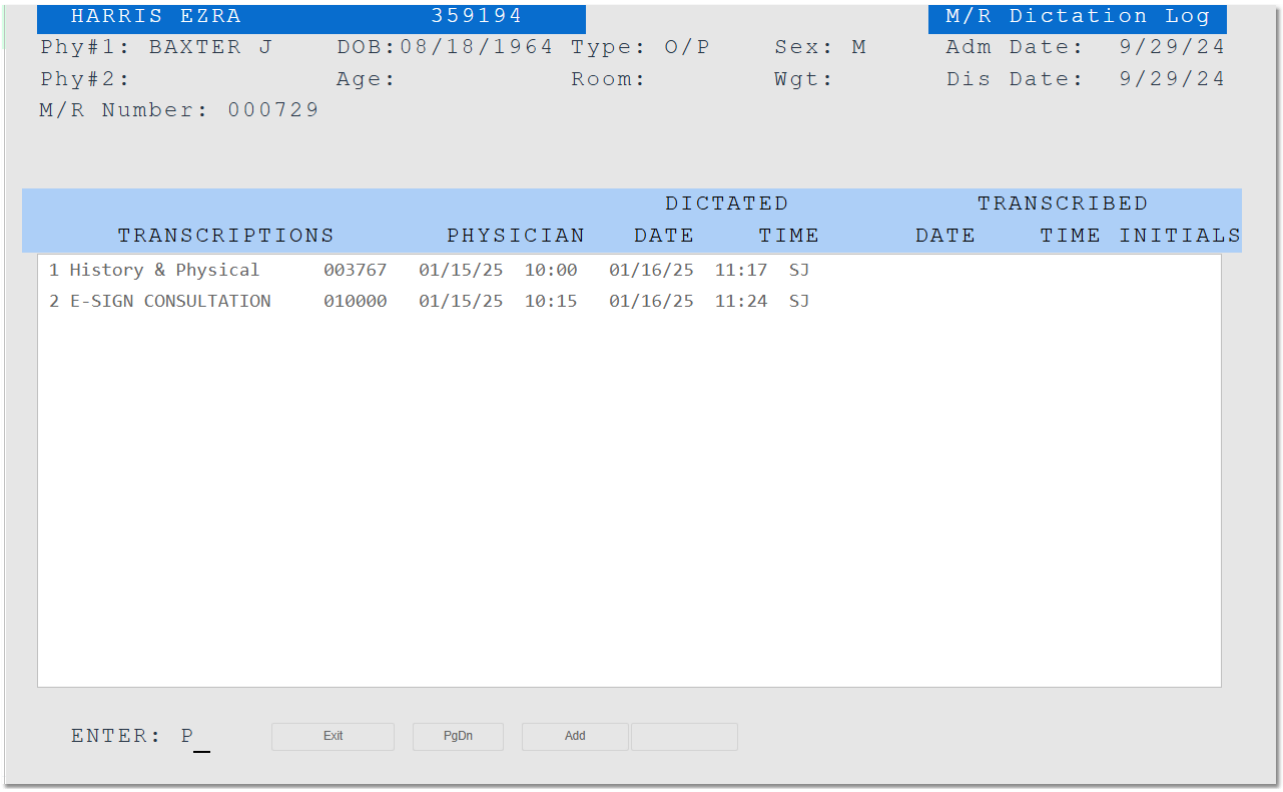
MR Copy Transcription Document Selection

- To view the document, select **View** and it will display on the screen.
- To copy the document, select **Copy** and it will be saved to the PC's hard drive in the CPSI folder and titled **copytrans.rtf**. Once the document has been copied, start a **N**ew transcription document in the new account. Once Microsoft Word is opened, select **Insert** on the toolbar, then **File**. Go to the PC's hard drive and select the **CPSI** folder and then the **copy-trans** file.

Dictation Log

The Dictation Log records the dates and times each transcription document is dictated and transcribed, providing a clear audit trail for documentation activity.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Dictation Log**

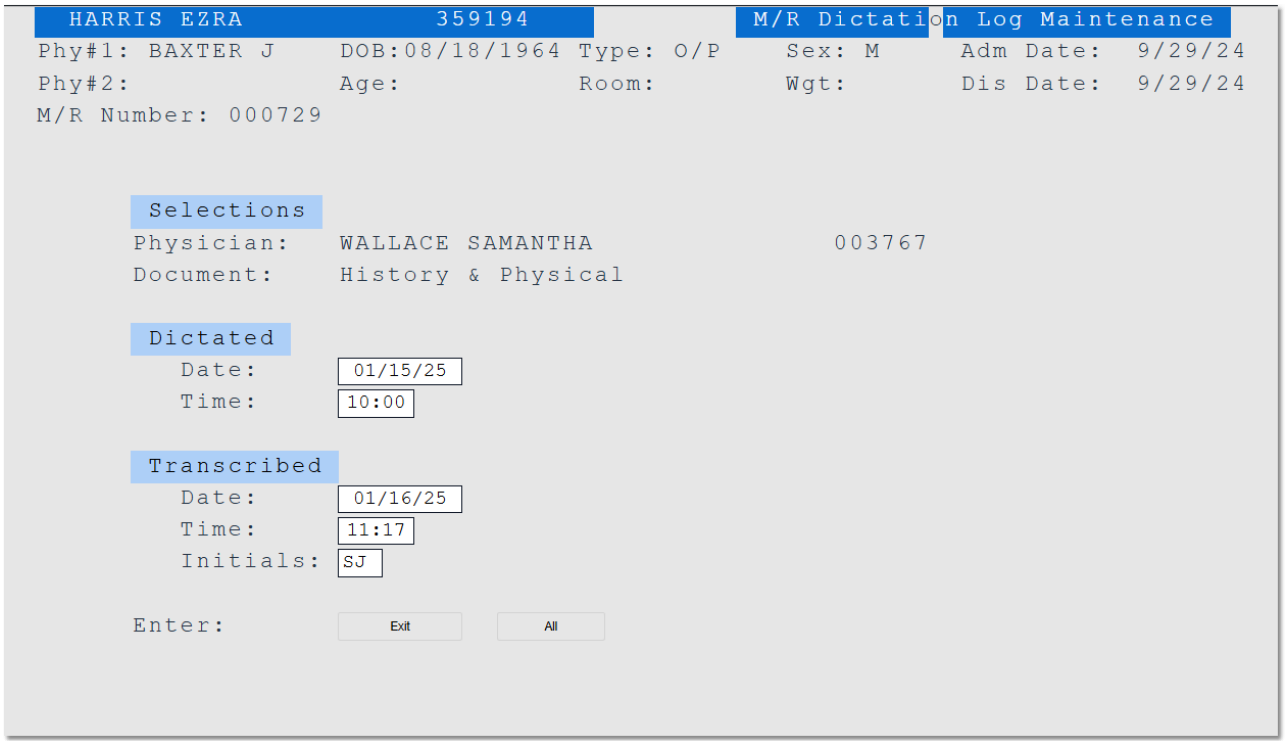


M/R Dictation Log

The Transcribed Date, Time and Initials are automatically recorded a transcription document is transcribed. The Dictated Date and Time are pulled from the Dictation Date/Time field on the MR Transcription Document Options page. To add or update the Dictation Date and Time for a document that has already been transcribed, select the document's sequence number and enter the Dictated Date and Time in the appropriate fields.

To enter a Dictation Date and Time on a document that has not been transcribed, from the bottom of the Dictation Log screen, select **Add**.

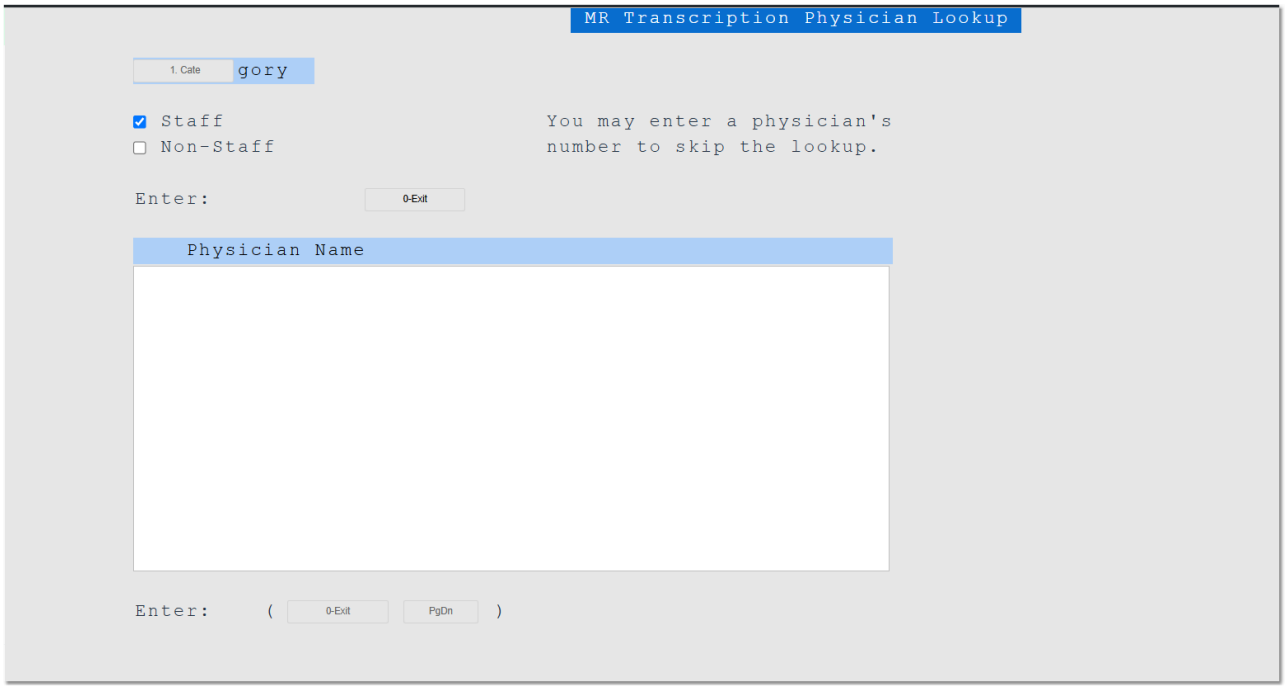
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Dictation Log** > **Transcription**



M/R Dictation Log Maintenance

An index of Staff or Non-Staff physicians may be accessed to select the dictating physician. Enter the physician's number or part of the physician's name.

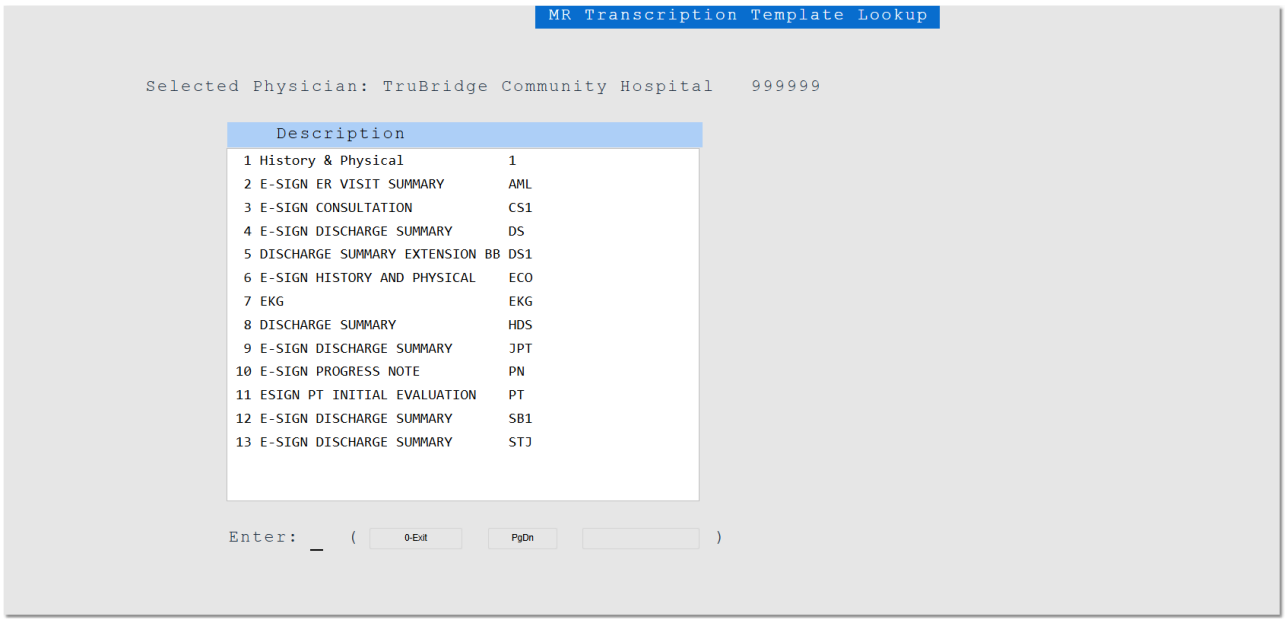
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Dictation Log** > **"A"dd**



MR Transcription Physician Lookup

After selecting the physician, a list of document formats for the physician will display.

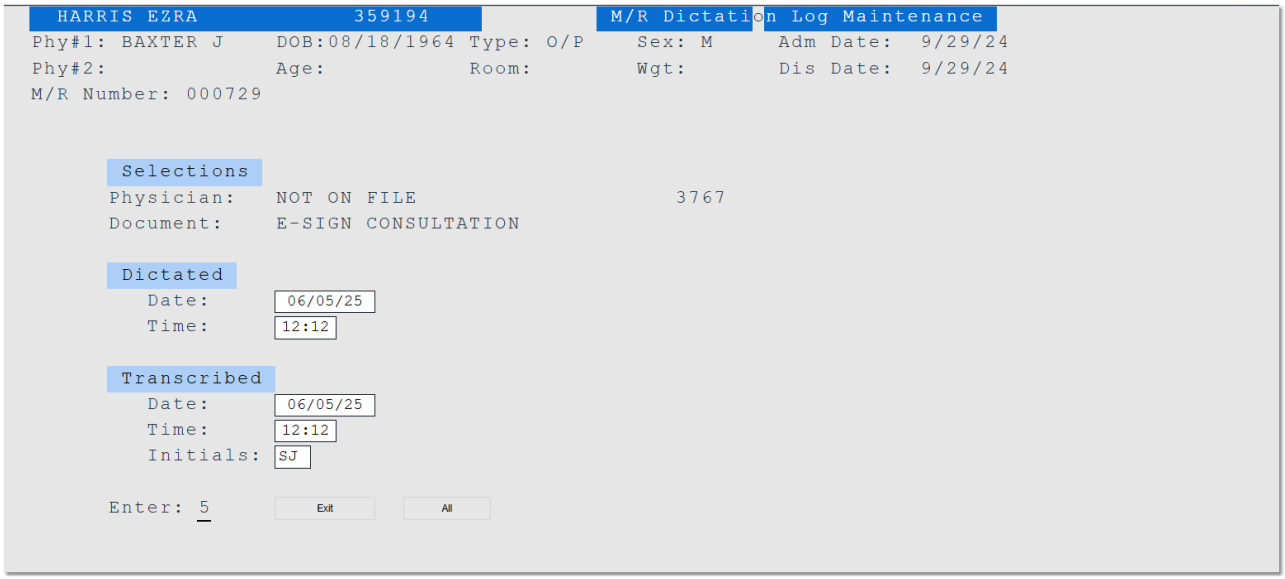
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Dictation Log > "A"dd > Physician**



MR Transcription Template Lookup

Select the appropriate document type.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Dictation Log > "A"dd > Physician > Transcription template**



M/R Dictation Log Maintenance

The Dictated Date and Time may be entered here. The document name and physician will appear under the list of transcriptions but the transcribed date will remain blank until the document is transcribed.

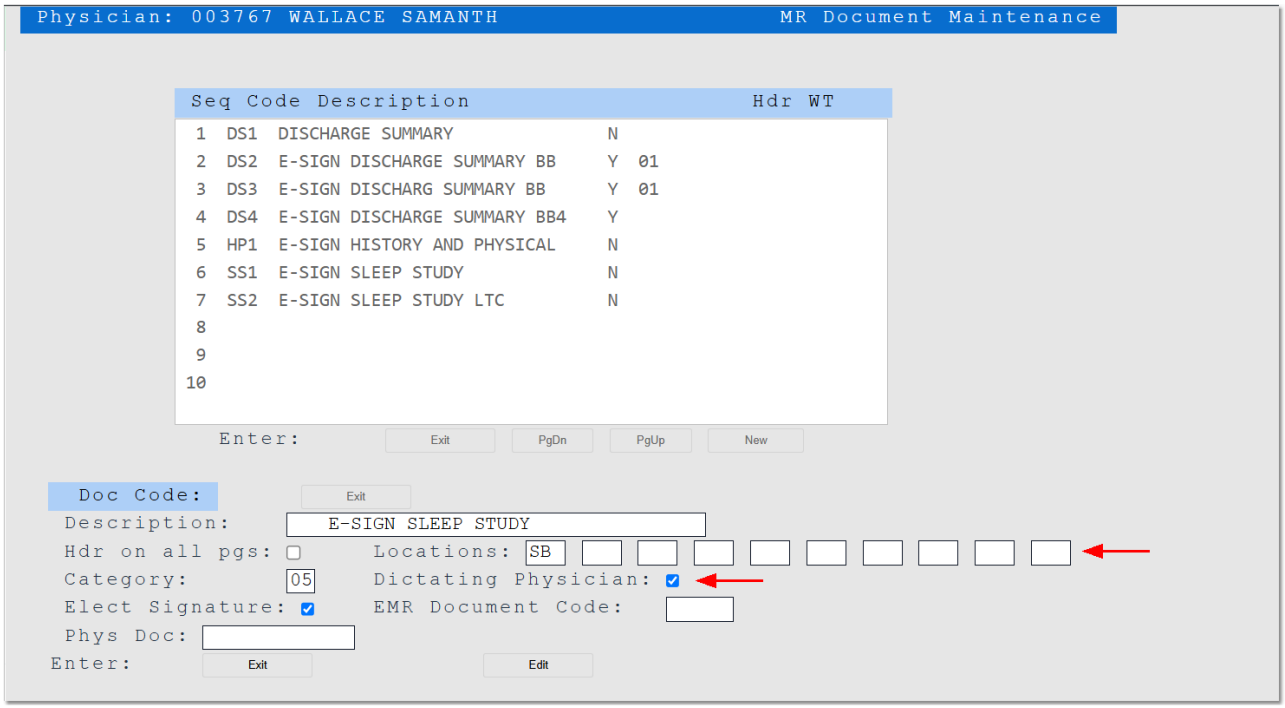
7.4 Report Distribution for Transcription Documents

A distribution mechanism exists for Medical Records transcription documents. Documents are automatically distributed when **Final Transcription** status is selected. To enable this functionality, several tables will need to be set up to designate distribution locations.

Physician Headers Table

The following fields in the Physician Headers table muse be set up to enable report distribution.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Phy Headers > Physician > "N"ew**



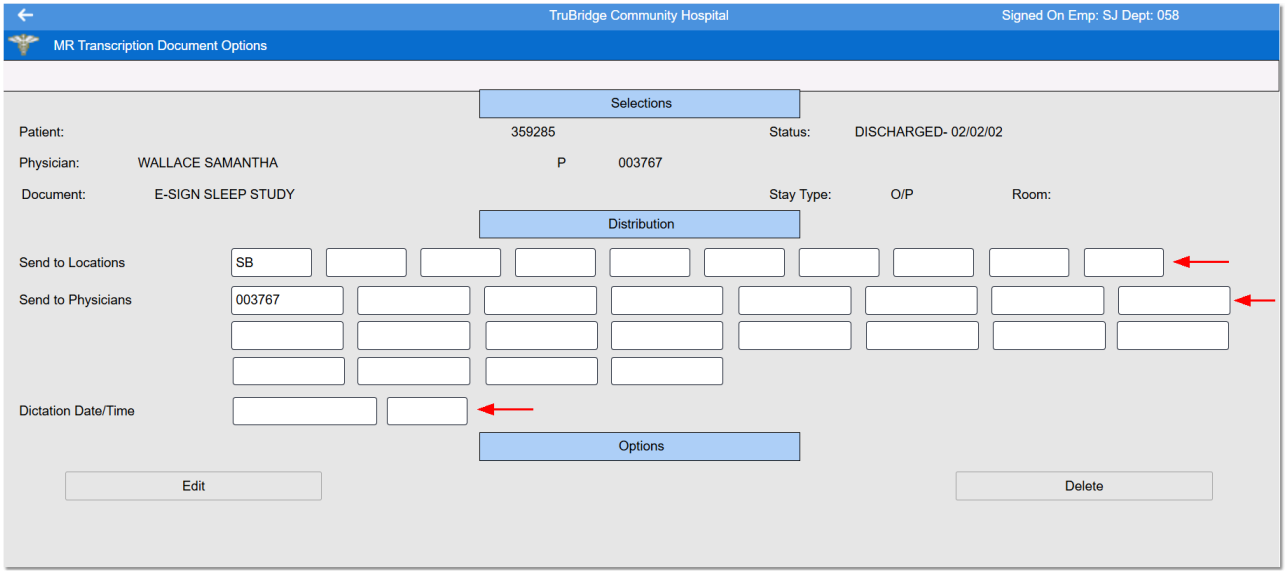
MR Document Maintenance

- **Locations:** Allows up to 10 locations to be entered for this physician. These locations determine where the transcription document will be automatically sent upon finalization.
- **Dictating Physician:** Selecting this field prevents the dictating physician from receiving a distributed copy of the transcription. If this option is not selected, the physician will not pull to the "Send to Physician" field on the MR Transcription Document Options screen (shown below).

MR Transcription Document Options

The following fields must be set up in the MR Transcription Document screen for distribution of transcription documents.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Transcription System** > **Select Document**



MR Transcription Document Options

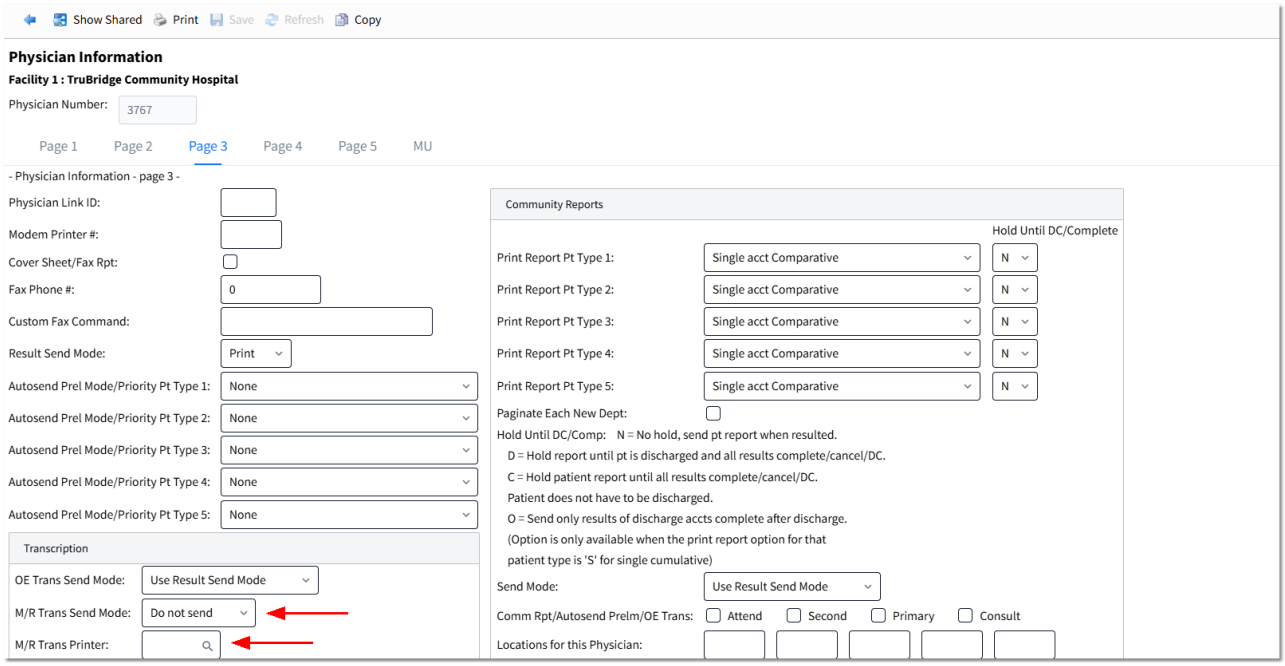
- **Send to Locations:** Pulls any locations entered in the Physician Header table. Locations can also be added or deleted.
- **Send to Physicians:** Pulls all dictating physicians listed on the Stay tab on the Registration and ADT screen, as well as physicians entered in the MR Grouper screen. Physician numbers can be added or deleted if needed.
- **Dictation Date/ Time:** Enter the Dictation Date and Time in this field to ensure they populate on the transcribed document. The mnemonics **DICTDATE** and **DICTTIME** must be inserted into the header format for this information to appear correctly.

NOTE: *The mnemonic* ***<<REPDIST>>*** *may be placed in the physician header to automatically pull: locations listed in the* ***Send to Locations*** *field and the physicians listed in the* ***Send to Physicians*** *field. This distribution information will be applied: when the transcriptionist marks the document as Final, or when the dictating physician electronically signs the document.*

Physician Table

The following fields must be set up in the Physicians table for distribution of transcription documents.

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select Physician** > **Page 3**



Physicians Table - Page 3

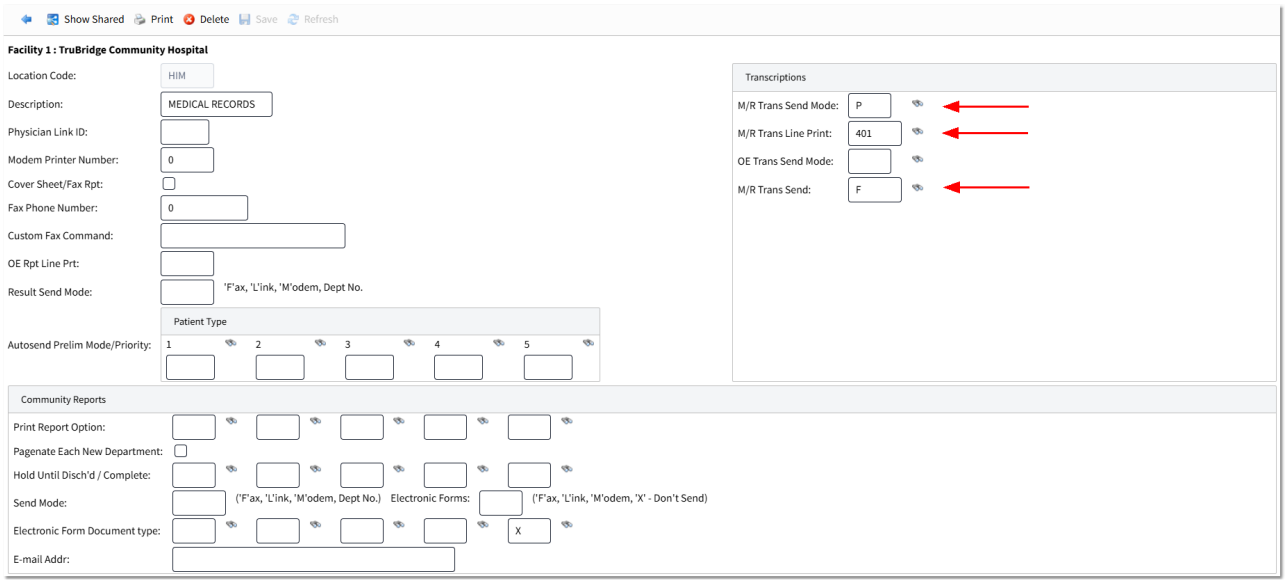
- **M/R Trans Send Mode:** Indicates the mode for sending transcribed documents to this physician. The options available in the drop-down are:
  - **Fax:** Sends the transcribed document using the number entered in the **Fax Phone #** field.
  - **Link:** Sends the transcribed document using the Physician Link entered in the **Physician Link ID** field.
  - **Modem:** Sends the transcribed document using the number entered in the **Modem Printer #** field.
  - **Print:** Sends the transcribed document using the line printer loaded in the **M/R Trans Line Print** field.
  - **Don't Send:** The transcribed document will not send to this physician.

- **M/R Trans Line Print:** Allows a line printer to be entered for transcriptions to be printed to for this physician.

Report Location Table

The following fields must be set up in the Report Location table for distribution of transcription documents.

Select **Web Client** > **Tables** > **HIM** > **Report Locations** > **Select Location**



Report Location - Page 1

- **M/R Trans Send Mode:** Indicates the mode for sending transcribed documents to this location. The options available via the **binocular icon**, include:
  - **F - Fax:** Sends the transcribed document using the number entered in the **Fax Phone Number** field.
  - **L - Link:** Sends the transcribed document using the Physician Link entered in the **Physician Link ID** field.
  - **M - Modem:** Sends the transcribed document using the number entered in the **Modem Printer Number** field.
  - **P - Print:** Sends the transcribed document using the line printer loaded in the **M/R Trans Line Print** field.
  - **X - Don't Send:** The transcribed document will not send to this location.

- **M/R Trans Line Print:** Allows a line printer to be entered for transcriptions to be printed to for this location.

- **M/R Trans Send: Indicates** when transcription documents should be distributed to this location. The options available are:
  - **P (Preliminary):** Sends a copy of the document when the document is transcribed.
  - **F (Final):** Sends a copy of the document when the document is signed.
  - **B (Both):** Sends a copy of the document when the document is transcribed and when the document is signed.

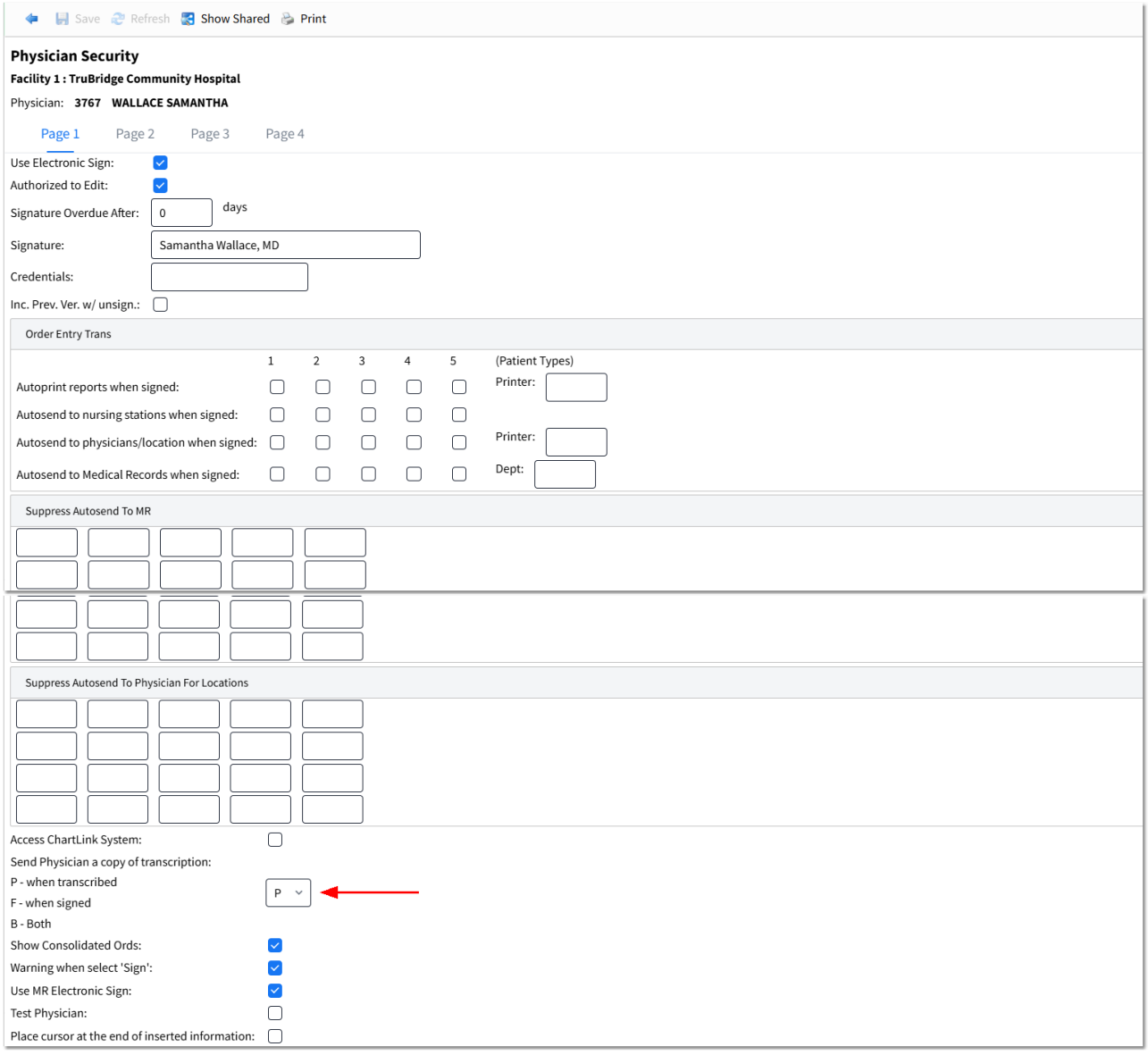
NOTE: *The system recognizes the Report Location Code "**HIM**" as the Health Information Management department for the purpose of auto-distributing documents. If "HIM" has values*

entered in both the M/R Trans Send Mode field and the M/R Trans Line Print fields, documents will be automatically sent to this location—regardless of whether "HIM" is listed as a location in the Physician Headers table. For all other locations, the destination must be entered in the Physician Headers table for the documents to be sent.

Physician Security Table

The following fields must be set up in the Physician Security table for distribution of transcription documents.

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Select Physician**



Physician Security - Page 1

- **Send Physician a copy of transcription:** This field determines when a copy of the transcription will be sent to the physician. The available options in the drop-down menu are:
  - **P:** Sends a preliminary report to the physician at the time of transcription.
  - **F:** Sends the report after it has been signed.
  - **B:** Sends the report both at the time of transcription and after it is signed.

Chapter 8 HIM Electronic Signature

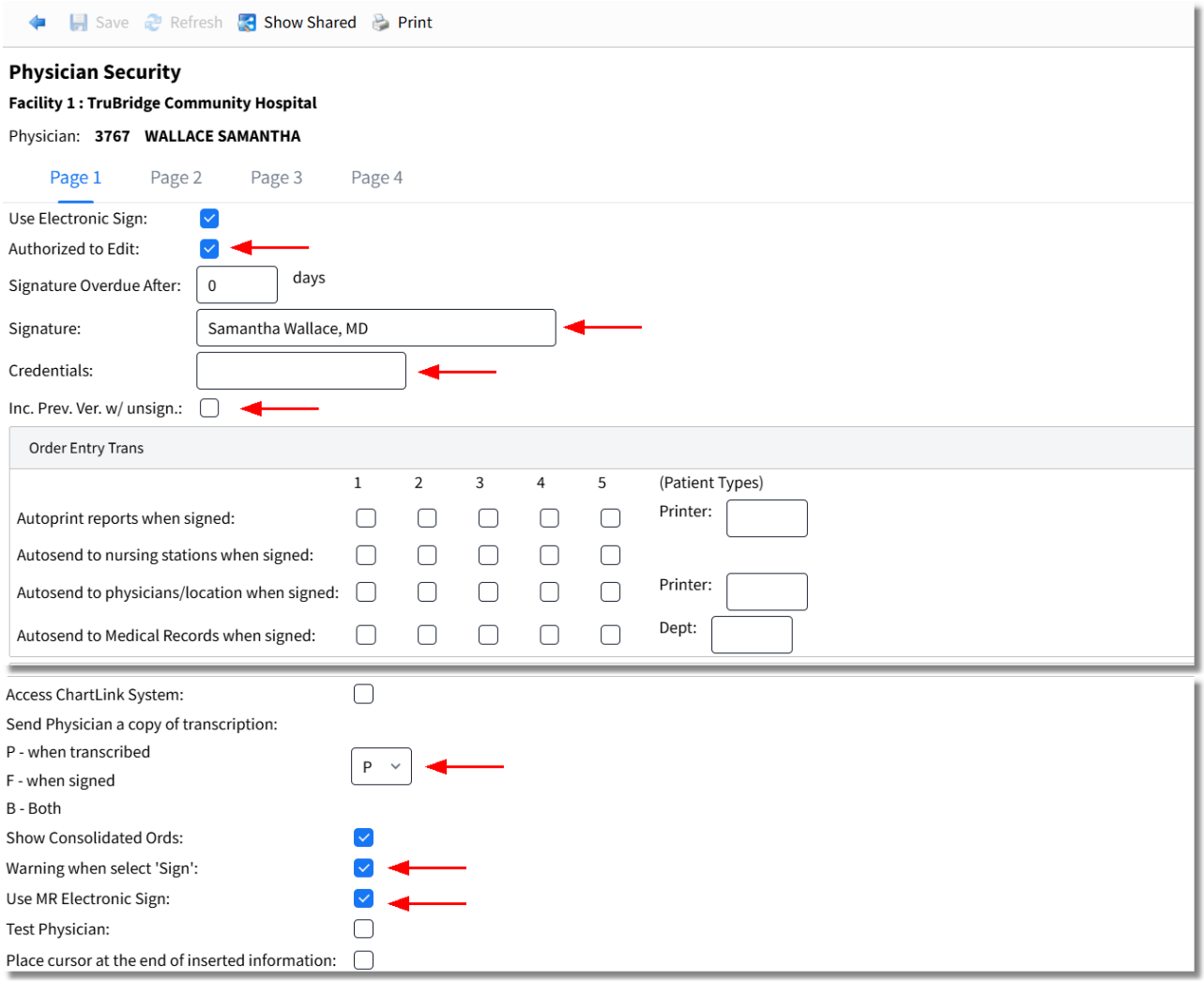
8.1 Overview

The Electronic Signature feature allows a physician to automatically apply an electronic signature to transcribed documents within the TruBridge EHR system.

8.2 Table Maintenance

Physician Security Table

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Select Physician** > **Page 1**



Physician Security - Page 1

- **Authorized to Edit:** Gives the physician the ability to edit transcribed documents when using the Electronic Signature feature.

***NOTE**: The Authorized to Edit feature is not currently supported in TruBridge EHR Web Client.*

- **Signature:** Displays the signing physician's signature. Enter the physician's name exactly as it should appear for the Electronic Signature. The mnemonic for this field in transcribed documents is **DCTNAME**, which should be set up in the document header.

- **Credentials:** Displays the signing physician's credentials. The mnemonic for this field in transcribed documents is **RADCRED**, which should be set up in the document header.

***NOTE:** The Credentials field in the Physician Security table page 1 should be reserved for the physician's specialty such as Radiologist, Chief of Staff, etc. TruBridge recommends entering the physician's credentials directly in the Signature field on Page 1. This ensures the credentials will pull with the physician's name when using the DCTNAME mnemonic. (e.g., Samantha Wallace, MD).*

- **Inc. Prev. Ver. w/ unsign,:** When selected, the Electronic Signature screen will default to **All**, displaying all versions of unsigned electronic signature documents. If not selected, it defaults to **Current**, showing only the most recent version of each unsigned document.

***NOTE**: The Include Previous Version with Unsign feature is not currently supported in TruBridge EHR Web Client.*

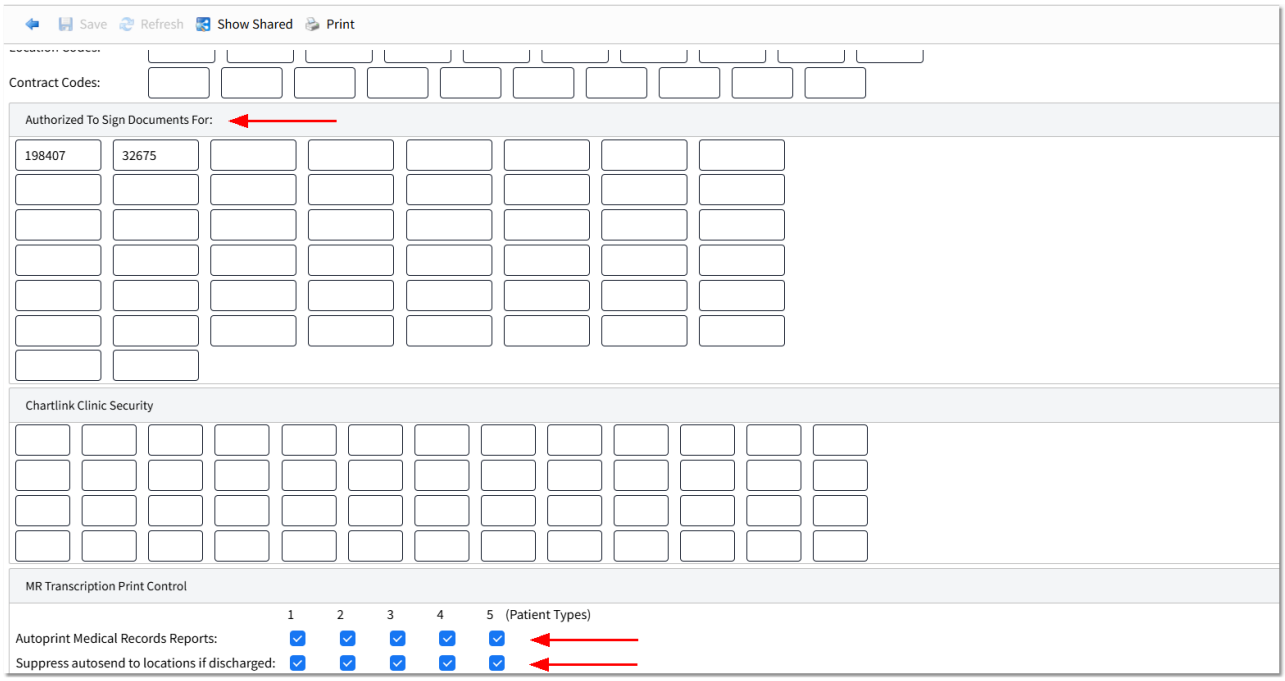
- **Send Physician a copy of transcription:** This field determines when a copy of the transcription will be sent to the physician. The available options in the drop-down menu are:
  - **P:** Sends a preliminary report to the physician at the time of transcription.
  - **F:** Sends the report after it has been signed.
  - **B:** Sends the report both at the time of transcription and after it is signed.

- **Warning when select 'Sign':** Select this field to prompt a warning when a physician attempts to sign a document without first viewing or editing it. The warning message will display: "Are you sure you want to sign documents w/o viewing or editing?"

***NOTE**: The Warning when Select Sign feature is not currently supported in TruBridge EHR Web Client.*

- **Use MR Electronic Sign?:** Enables the MR Electronic Signature feature for the selected physician.

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Select Physician** > **Page 2**



Physician Security - Page 2

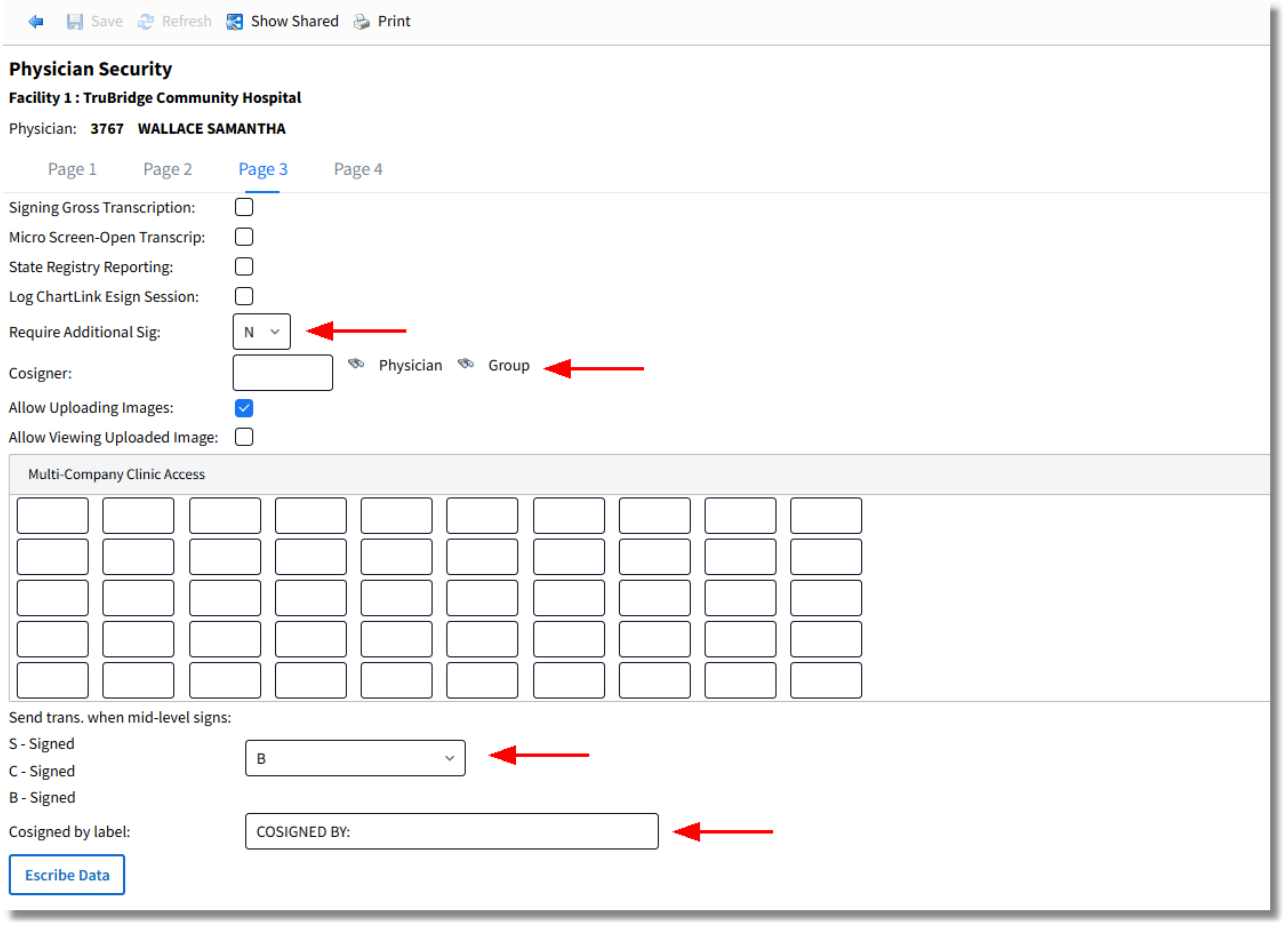
- **Authorized to Sign Documents For:** Allows this provider to electronically sign documents on behalf of other providers. Enter the physician numbers for which this provider is authorized to sign. Once set up, the provider will be able to view unsigned documents for the listed physician numbers by using the **Covering** filter in the E-sign folder on the Tasks screen. For additional details, refer to the Provider E-Sign Procedures 194 section.

NOTE: *Please refer to JCAHO standards and CMS Conditions of Participation for guidelines on the circumstances and mechanisms under which one Licensed Practitioner could authenticate for another Licensed Practitioner.*

- **Autoprint Medical Records Reports:** Select the applicable Stay Types for reports to automatically distribute for physicians using electronic signature, based on the associated table setup.

- **Suppress autosend to locations if discharged:** Select the applicable Stay Types for which automatic distribution of documents should be suppressed when the patient has been discharged.

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Select Physician** > **Page 3**



Physician Security - Page 3

- **Require Additional Sig? Y/N/P:** Allows a provider to require a co-signer for any orders, transcriptions, and verbal/telephone orders they initiate. If **P** is selected from the drop-down menu, a list of providers available to co-sign the transcription will be presented during the Electronic Signature process, but selecting a provider from the list is optional.

- **Cosigner:** Enter the supervising physician's number. This ensures the supervising physician pulls to the top of the physician list for the mid-level to select from.

NOTE: *Any co-signing physician will see a list of documents from all mid-level providers they are responsible for co-signing. These documents will display in the co-signing physician's queue, separate from their regular electronic signature documents, when they log into the electronic signature.*

- **Send trans. when mid-level signs?:** This field determines when a transcription is auto-distributed after Electronic Signature. It should be set only for physicians or providers (NOT requiring a co-signature) with mid-levels working under their supervision. This field works in conjunction with the existing report distribution fields and settings for both order entry and medical records transcriptions. The available options are:

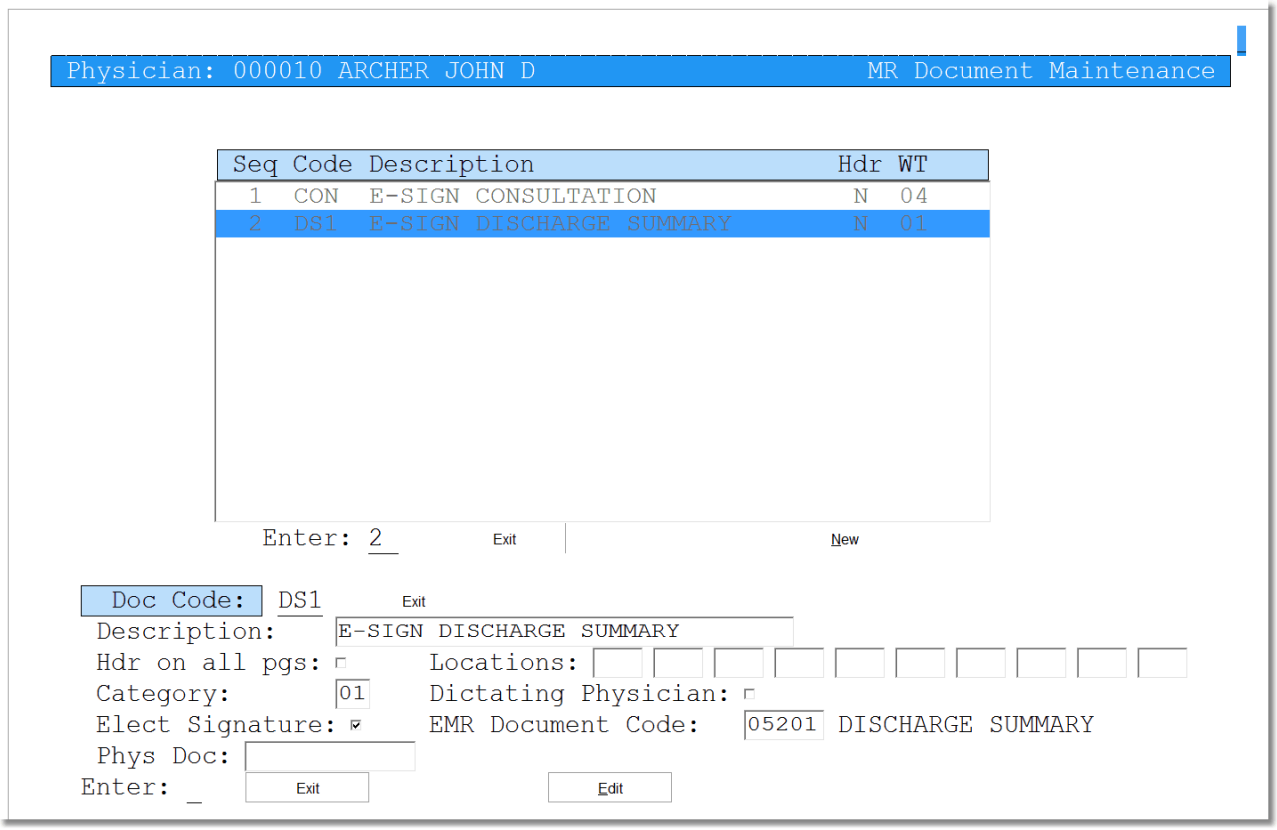
- **S -** The transcription will be auto-distributed when the mid-level signs the document (first signature).
- **C -** The transcription will be auto-distributed after the supervising physician co-signs the document (second signature).
- **B -** The transcription will be auto-distributed twice: once after the mid-level signs and again after the supervising physician signs.

- **Cosigned by label:** The text entered in this field will pull to any transcription that uses the **<<COSIGNATURE_PENDING>>** mnemonic. This label is used in conjunction with a co-signing supervising physician. If the Cosigned by label has the following phrase "Electronically Reviewed and Signed by:", when the co-signing physician (e.g. John Doe, MD) signs a document previously signed by the mid-level provider, the transcription will display: "*Electronically Reviewed and Signed by John Doe, MD*."

NOTE: *The co-signing physician's credentials will pull from page 1 of the Physician Security table.*

Physician Headers Table

Select **Web Client** > **System Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Phy Headers**



MR Document Maintenance

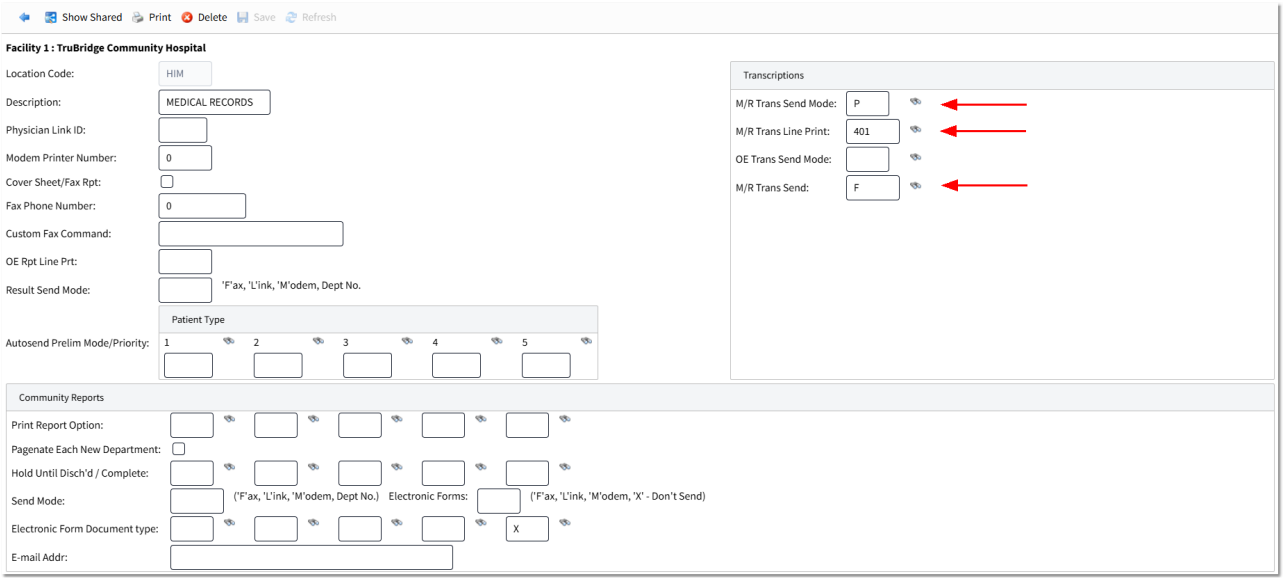
- **Elect Signature:** Select this field if this physician will electronically sign this transcribed document.

- **Locations:** Enter up to 10 locations to which the document will be sent automatically. Enter codes set up in the Report Locations table.

- **Dictating Physician:** Select this field if the dictating physician should always get a copy of the document. This is a required field when using auto distribution.

Report Location Table

Select **Web Client** > **Tables** > **HIM** > **Report Locations** > **Select Location**



Report Location - Page 1

- **M/R Trans Send Mode:** Indicates the mode for sending transcribed documents to this location. The options available via the **binocular icon**, include:
  - **F - Fax:** Sends the transcribed document using the number entered in the **Fax Phone Number** field.
  - **L - Link:** Sends the transcribed document using the Physician Link entered in the **Physician Link ID** field.
  - **M - Modem:** Sends the transcribed document using the number entered in the **Modem Printer Number** field.
  - **P - Print:** Sends the transcribed document using the line printer loaded in the **M/R Trans Line Print** field.
  - **X - Don't Send:** The transcribed document will not send to this location.

- **M/R Trans Line Print:** Allows a line printer to be entered for transcriptions to be printed to for this location.

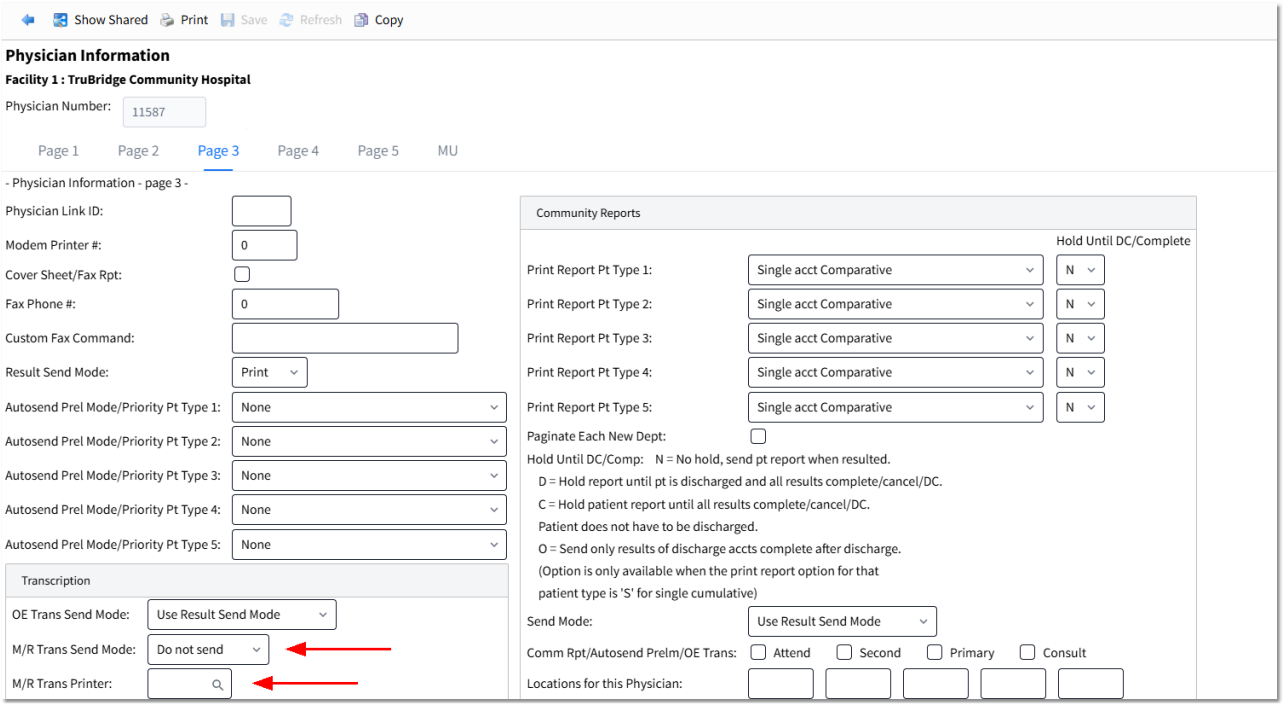
- **M/R Trans Send: Indicates** when transcription documents should be distributed to this location. The options available are:
  - **P (Preliminary):** Sends a copy of the document when the document is transcribed.
  - **F (Final):** Sends a copy of the document when the document is signed.

- **B (Both):** Sends a copy of the document when the document is transcribed and when the document is signed.

NOTE: *The system recognizes the Report Location Code "**HIM**" as the Health Information Management department for the purpose of auto-distributing documents. If "HIM" has values entered in both the M/R Trans Send Mode field and the M/R Trans Line Print fields, documents will be automatically sent to this location—regardless of whether "HIM" is listed as a location in the Physician Headers table. For all other locations, the destination must be entered in the Physician Headers table for the documents to be sent.*

Physician Table

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select Physician** > **Page 3**



Physician Table - Page 3

- **M/R Trans Send Mode:** Indicates the mode for sending transcribed documents to this physician. The options available in the drop-down are:
  - **Fax:** Sends the transcribed document using the number entered in the **Fax Phone #** field.
  - **Link:** Sends the transcribed document using the Physician Link entered in the **Physician Link ID** field.
  - **Modem:** Sends the transcribed document using the number entered in the **Modem Printer #** field.
  - **Print:** Sends the transcribed document using the line printer loaded in the **M/R Trans Line Print** field.
  - **Don't Send:** The transcribed document will not send to this physician.

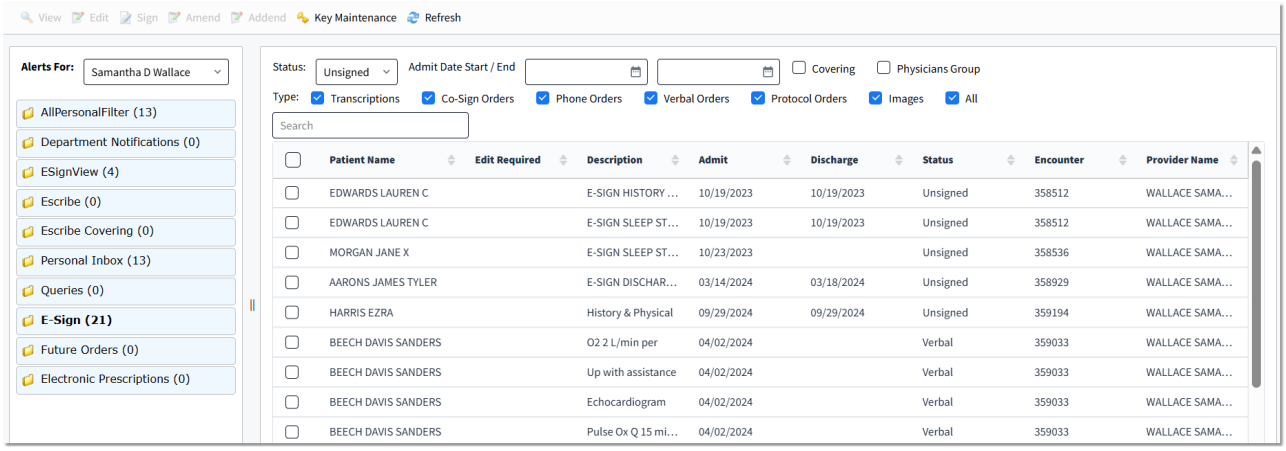
- **M/R Trans Line Print:** Allows a line printer to be entered for transcriptions to be printed to for this physician.

8.3 E-Sign Transcribe Documents Procedures

Provider E-Sign Procedures

Providers can access their e-sign documents through the E-Sign folder located on the Tasks screen.

Select **Web Client** > **Charts** > **Tasks** > **E-Sign Folder**



E-Sign Folder

Filters

Filters are available to customize the document list. The following filters may be applied:

- **Status**: Select Unsigned, Signed, or All to display documents based on signature status.
- **Admit Date Start/End**: Enter an admission date range to display accounts admitted within a specific time period.
- **Covering**: Displays documents that the provider is authorized to sign on behalf of another provider. For more details, refer to the Signing for Other Providers 197 section.
- **Physicians Group**: Displays orders sent to the physician group by a mid-level provider that require co-signature. Mid-level providers have the ability to send orders to an individual physician or a physician group. If sent to a group, once any provider in the group signs the order, it is removed from all other providers' queues.
- **Type**: Select the type of e-sign documents to display. Options include: Transcriptions, Co-Sign Orders, Phone Orders, Verbal Orders, Protocol Orders, Images, and All.

Document List

The following information will display for each document:

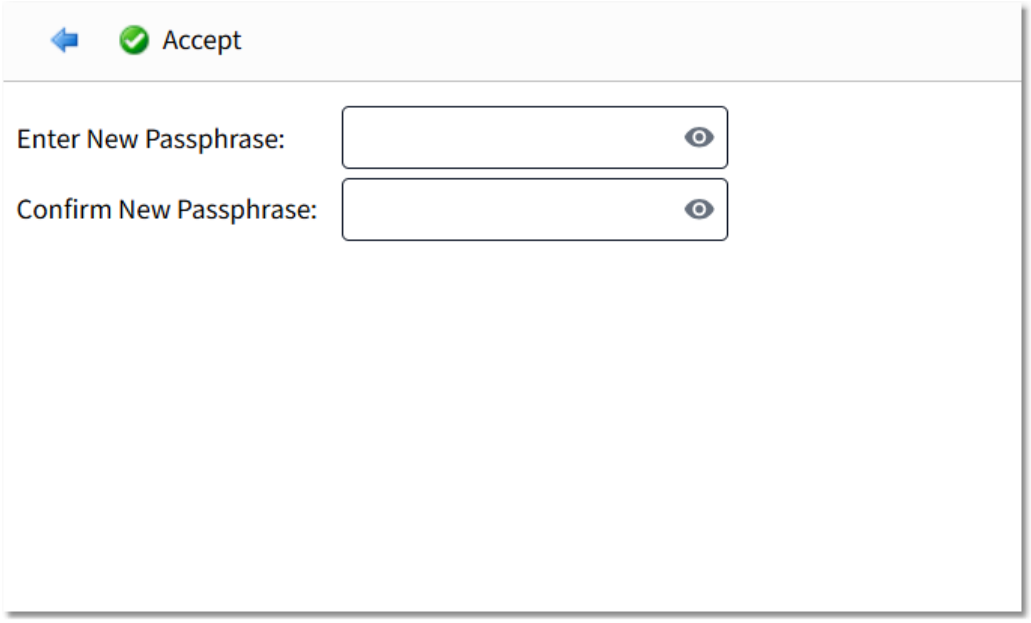
- **Patient Name**: Displays the patient's full name.

- **Edit Required**: A **Y** will appear if the document requires an edit from the transcriptionist. When these documents are viewed or edited, the transcriptionist's message will display in a pop-up box. If the transcriptionist has entered seven lower case x's (e.g., xxxxxxx) in the document, these must be removed before the provider can electronically sign.
- **Description**: Displays the name of the document.
- **Admit**: Displays the patient's admission date.
- **Discharge**: Displays the patient's discharge date.
- **Status**: Displays the current status of the document. Possible statuses include:
  - Cosign
  - Amended
  - Addended
  - Unsigned
  - Signed
- **Encounter**: Displays the patient's account number.
- **Provider Name**: Displays the name of the provider the document was sent for signing.

Column headings can be selected to sort the documents by that category. The order of the columns may also be rearranged by dragging and dropping them in the desired position.

Creating or Changing a Passphrase

If this is the provider's first time using e-sign, a passphrase will need to be created. A passphrase is a separate password used to electronically sign all documents. To create or update a passphrase, select **Key Maintenance**.



Passphrase

Enter the desired passphrase. It must be at least 10 characters in length and include at least one uppercase, one lowercase and one number. After entering the passphrase in both the **New** and **Confirm** fields, select **Accept**. A **Success!** prompt will display once the passphrase has been accepted.

E-signing Documents

To electronically sign a document, the provider should ensure the Status filter is set to Unsigned. Select the check-box next to each documents that need to be addressed, then choose one of the following options:

- **View**: Selecting View will display the document in PDF format. The following options will become available on the Action Bar:
  - **Sign**: Electronically signs the document.
  - **Edit**: Opens the document in Microsoft Word, allowing the provider to make changes prior to signing. For more information, see the detailed Edit description below.
  - **Return**: Sends the document back to the transcriptionist for editing. When selected, a Return Message box displays, allowing the provider to enter instructions letting the transcriptionist know what needs to be edited. After entering the message, select Return. The document will be sent to the transcriptionist's return queue and will remain unsigned until the transcriptionist makes the changes and sends the document back to the provider to sign.
  - **Hold**: Leaves the document unsigned and returns the provider to the document list.
  - **Cancel**: Leaves the document unsigned and returns the provide to the document list.

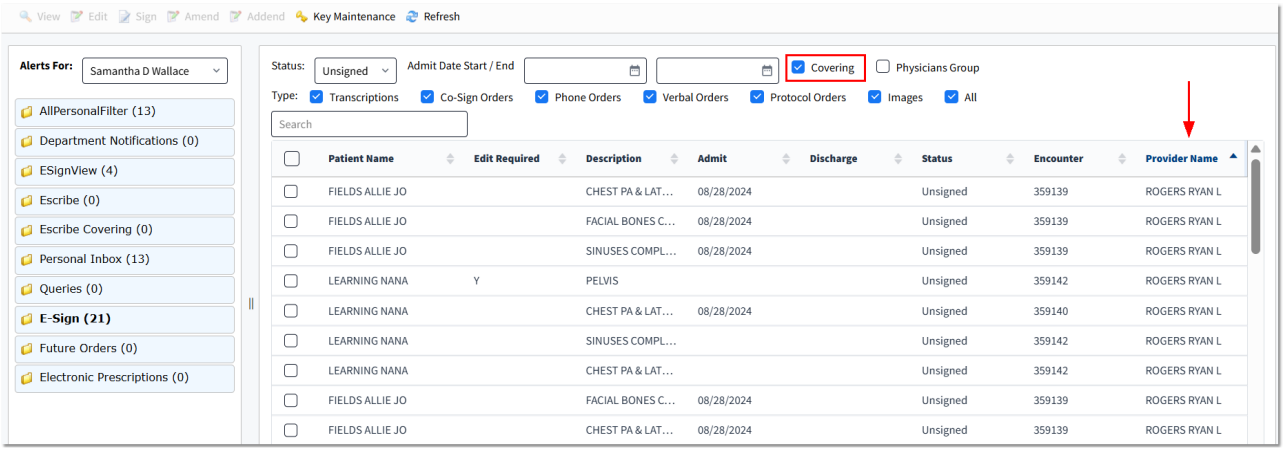
- **Edit**: Selecting Edit opens the document in Microsoft Word, allowing the provider to make changes before signing. The following options will become available on the Action Bar:
  - **Save:** Saves any changes made to the document.
  - **Save/Sign:** Saves the changes and electronically signs the document.
  - **Save/Hold:** Saves the changes and returns the provider to the document list. The document remains unsigned.
  - **Edit/Return:** Returns the document to the transcriptionist for editing. A Return Message box will display, allowing the provider to enter instructions for the required changes. After entering the message, select **Return**. The document will be sent to the transcriptionist's return queue and will remain unsigned until the requested edits are completed and the document is returned for signature.
  - **Abort/No Save:** Exits the documents without saving any changes.
  - **Exit E-Sign:** Closes the document without electronically signing it. A prompt will appear indicating that no changes will be saved. Select **Yes** to proceed or **No** to return to the document.

- **Sign**: Signs the selected document without opening it for viewing.

Signing for Other Providers

Providers may be granted the ability to electronically sign documents on behalf of another provider. This access must be granted in the Physician Security table. For setup instruction, refer to the Physician Security Table 187 section. Once access is granted, the provider will be able to view unsigned documents for the listed physician numbers using the **Covering** filter in the E-sign folder on the Tasks screen. The **Provider Name** field displays the name of the provider the document is being signed on behalf of.

Select **Web Client** > **Charts** > **Tasks** > **E-Sign Folder** > **Covering**



E-Sign Folder - Covering

Using Co-Sign

TruBridge EHR provides the ability to co-sign transcription documents, as well as verbal and telephone orders, initiated by mid-level providers (e.g., Nurse Practitioner or Physician Assistants). This functionality allows for a second co-signature for documents or orders that require additional authentication.

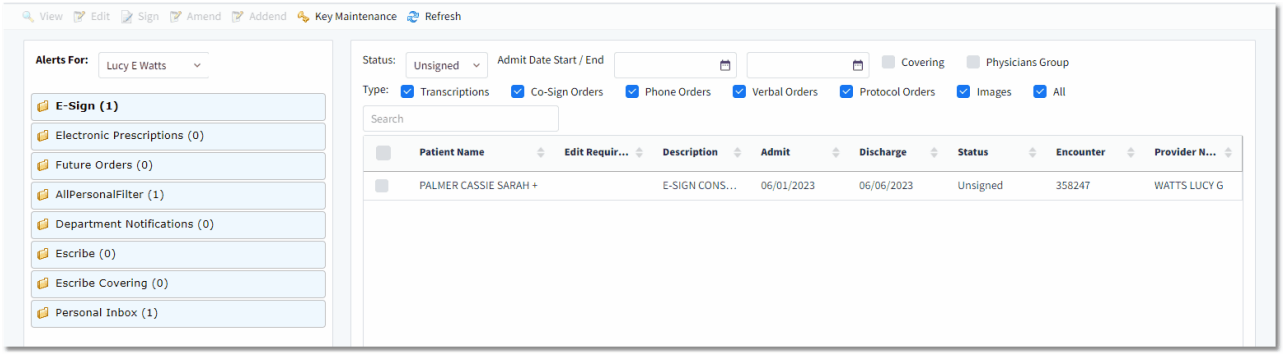
The mnemonic **<<COSIGNATURE_PENDING>>** must be inserted into any transcription header (order entry or medical records) to enable co-signature functionality. This mnemonic pulls information from the co-signing provider's information, including the Cosigned by Label, Signature, and Credentials (from the Physician Security table), and the Date and Time the document was signed.

If the dictating provider does not require a co-signature, the mnemonic will not remain unfulfilled. Instead, it will be automatically removed from the document once the provider signs. This allows the mnemonic to be included in any e-sign header, without having to create a separate header for providers that require co-signatures.

NOTE: *TruBridge recommends entering the provider's credentials in the Signature field on page 1 of the Physician Security table. This ensures that credentials will pull alongside the provider's name when using the* ***DCTNAME*** *mnemonic. Example: Daniel E Smith, MD. The Credentials field on page 1 of the Physician Security table should be reserved for the provider's specialty, such as Radiologist or Chief of Staff.*

Mid-level providers who require co-signatures will receive the relevant documents in their e-sign queue.

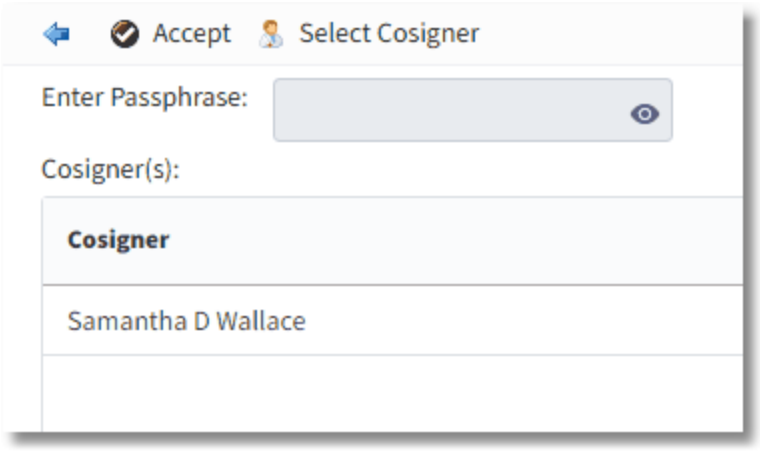
Select **Web Client** > **Home Screen** > **Tasks** > **E-Sign**



Electronic Signature

- Select the document, then select an option to **View**, **Edit**, or **Sign**. If Sign is selected, the provider will be prompted to enter their passpharse and select a co-signing provider.

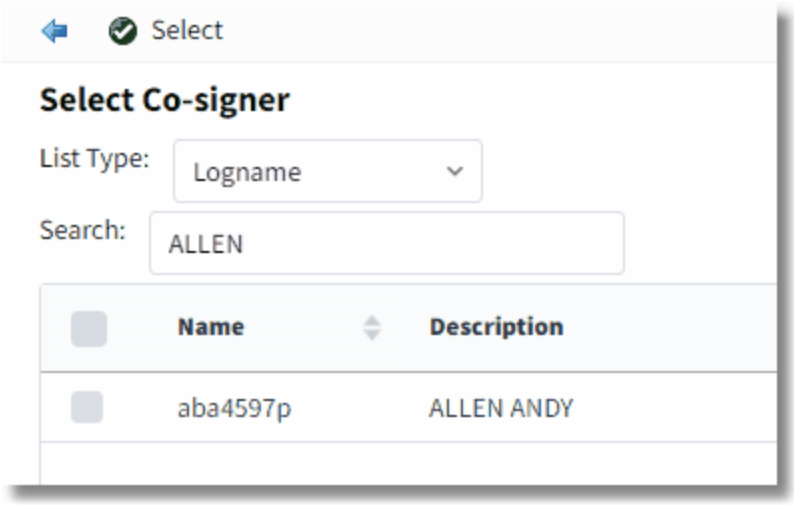
Select **Web Client** > **Home Screen** > **Tasks** > **E-Sign** > **Select Document** > **Sign**



Passphrase & Cosigner

- A default co-signing provider will display in the **Cosigner** box. This value is pulled from the Cosigner field on page 3 of the Physician Security table for the mid-level provider. If a different provider will be co-signing the document, select the **Select Cosigner** option to choose an alternative.

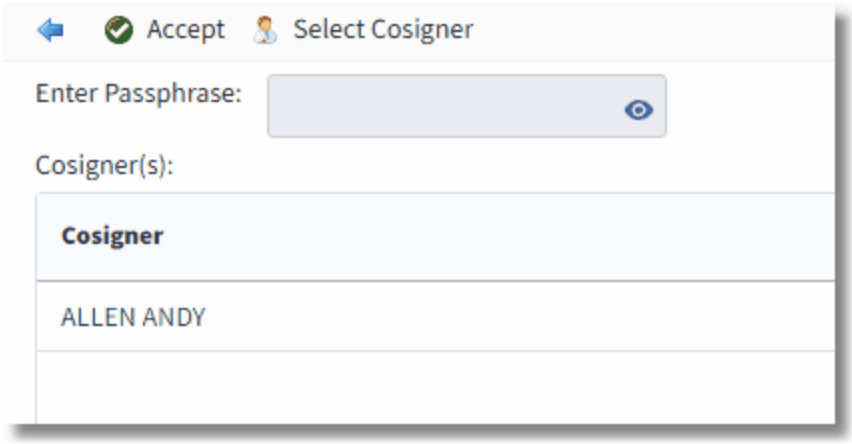
Select **Web Client** > **Home Screen** > **Tasks** > **E-Sign** > **Select Document** > **Sign** > **Select Cosigner**



Select Co-Signer

- Once selected, the new co-signer will appear in the **Cosigner** box. Enter the **Passphrase**, then select **Accept** to sign the document and send it to the co-signing provider.

Select **Web Client** > **Home Screen** > **Tasks** > **E-Sign** > **Select Document** > **Sign** > **Select Cosigner** > **Select Provider** > **Select**

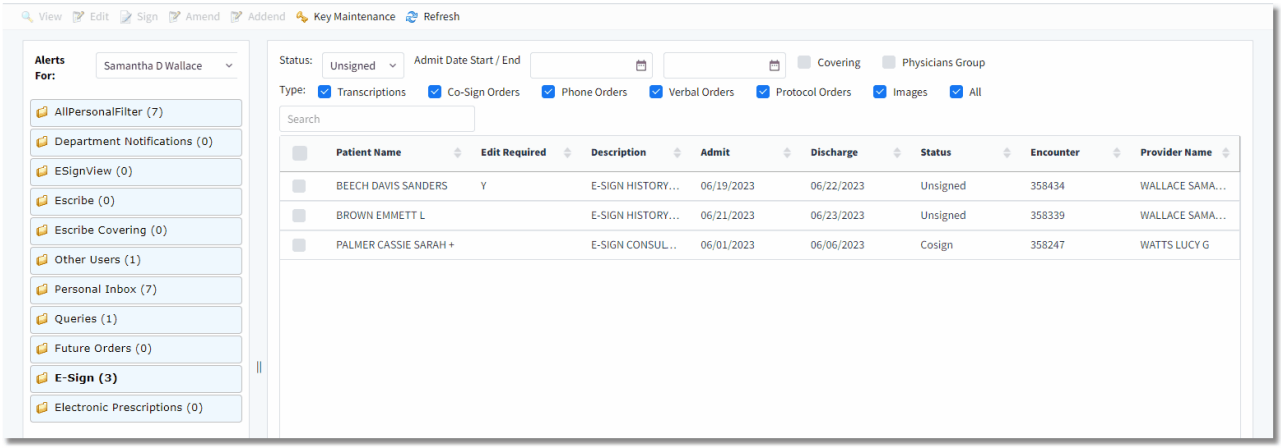


Passphrase & Cosigner

- When the document is signed by the mid-level, the **DCTNAME** mnemonic will populate their signature from page 1 of the Physician Security table. The **RADCRED** and **SIGNDATE** mnemonic may also be used to display the mid-level's credentials and signature date, respectively.

Documents requiring a co-signature will display with a status of **Cosign** in the co-signing provider's e-sign queue.

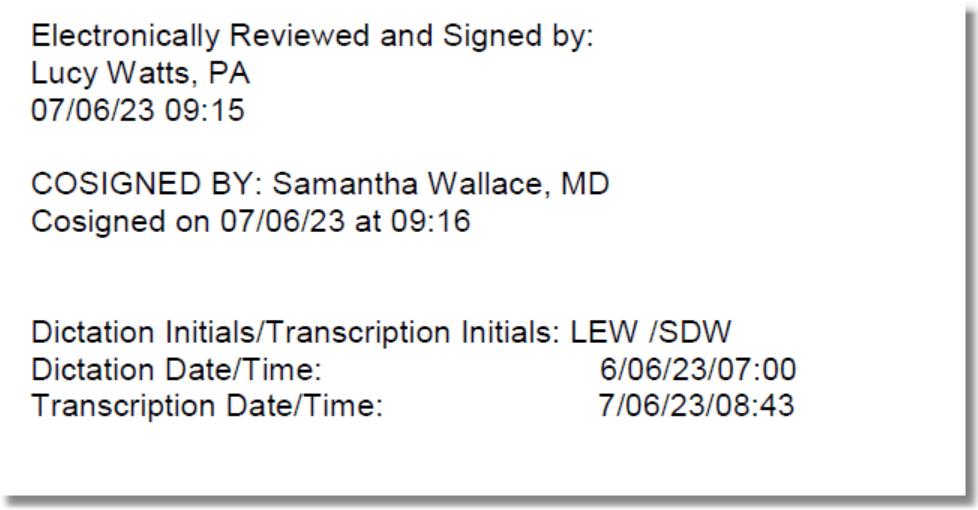
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Electronic Signature**



Electronic Signature

- After the document is signed, the **<<COSIGNATURE_PENDING>>** mnemonic will be fulfilled using information from pages 1 and 3 of the Physician Security table for the co-signing provider.

Select **Web Client** > **System Menu** > **Patient Account** > **Medical Records** > **Transcription System** > **Document** > **View**

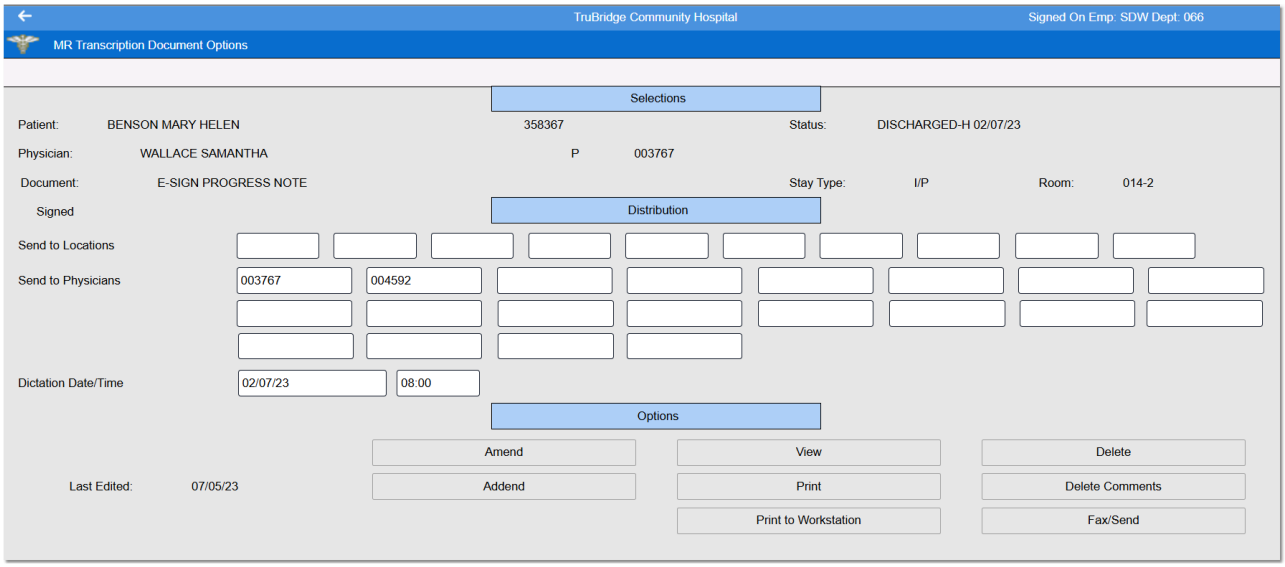


Transcribed CoSigned Document

8.4 Accessing a Signed Document

After a document is e-signed by a provider, it will have a status of **S-Signed** in the Transcription Document lookup. Once the document is selected, the Edit option will no longer be available. Instead, the options will include **Amend** or **Addend**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Transcription System** > **Select Document**



MR Transcription Document Options

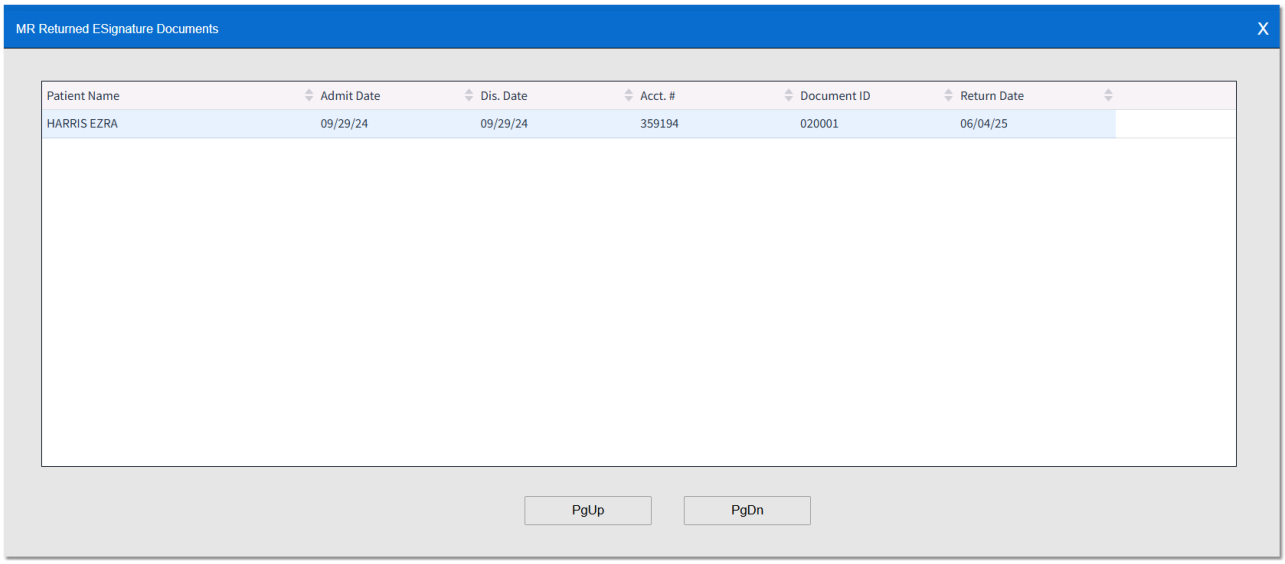
- **Amend:** This option opens the previously signed document for review and corrections while preserving the original document as the first version. When a signed document is amended, its status reverts to unsigned. The transcriptionist must add the mnemonics **DCTNAME** and **SIGNDATE** to the bottom of the document, so that when it returns back to the provider's queue and is e-signed again, it will display a second signature and date.

- **Addend:** This option brings the previously signed document for editing and the addition of new information, while preserving the original document as the first version. The transcriptionist must add the mnemonics **DCTNAME** and **SIGNDATE** to the bottom of the document, so that when it returns back to the provider's queue and is e-signed again, it will display a second signature and date.

8.5 Documents Returned to the Transcriptionist

If a provider uses the **Return** (or **Edit/Return)** option while reviewing unsigned documents in the E-sign folder, the document will be placed in the transcriptionist's queue. When accessing **Returned MR ESignature Documents**, a display screen will lists all documents returned by the providers.

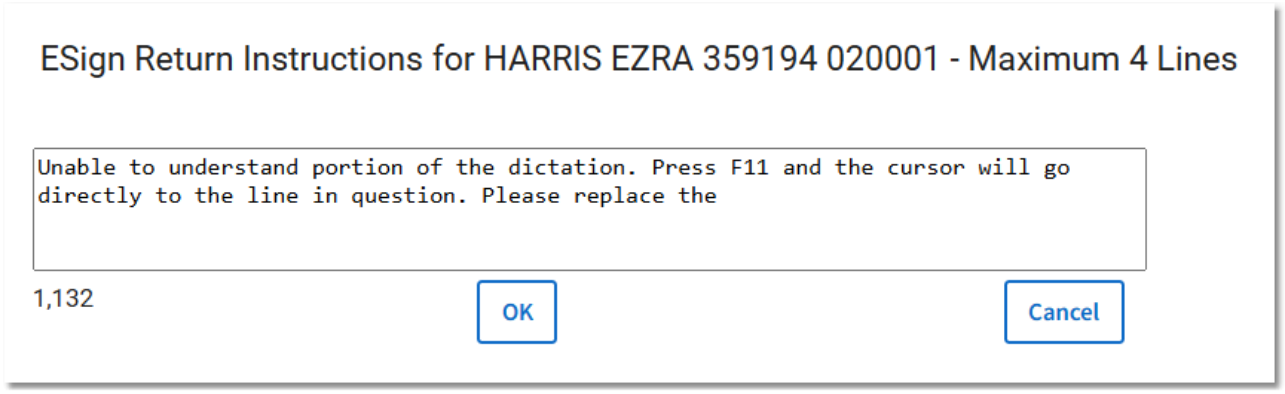
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Returned MR ESignature Documents**



MR Returned ESign Documents

After selecting a document, an edit box will open displaying the provider's instructions.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Returned MR ESignature Documents** > **Select Document**



ESign Edit Instructions

After selecting **Ok**, select **Edit** from the transcription screen to make any updates to the document. When editing is complete, select **Save/Exit** from the TruBridge toolbar. The transcriptionist will then select the **Back Arrow** and be prompted to select a status: **Final**, **Hold** or **Require Edit**. After making the desired selection, the cursor will return to the **Returned MR E-Signature Documents** screen, allowing the transcriptionist to proceed with editing the next returned document.

Chapter 9 E-Sign Scanned Documents

9.1 Overview

E-Signing scanned documents enables images scanned through batch scanning to be electronically signed and stored within a patient's account. Once signed, the image will be visible on the File List tab in Electronic File Management. To enable E-Signing for scanned documents, please contact a TruBridge Financial Support to activate this feature.

9.2 Table Maintenance

Image Title Table

Before E-Signing scanned images can begin, the Allow E-Sign field must be selected in the Image Title Table for every Image Title that may be eligible for e-signature.

Select **Web Client** > **Tables** > **Business Office** > **Titles** > **Select Existing Title**

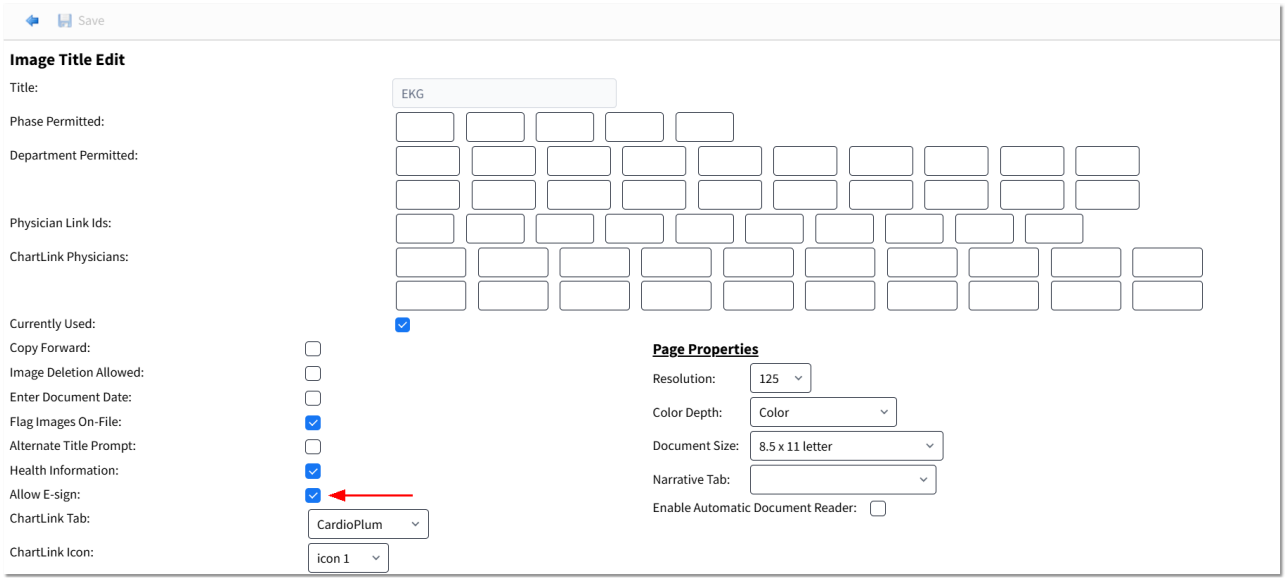


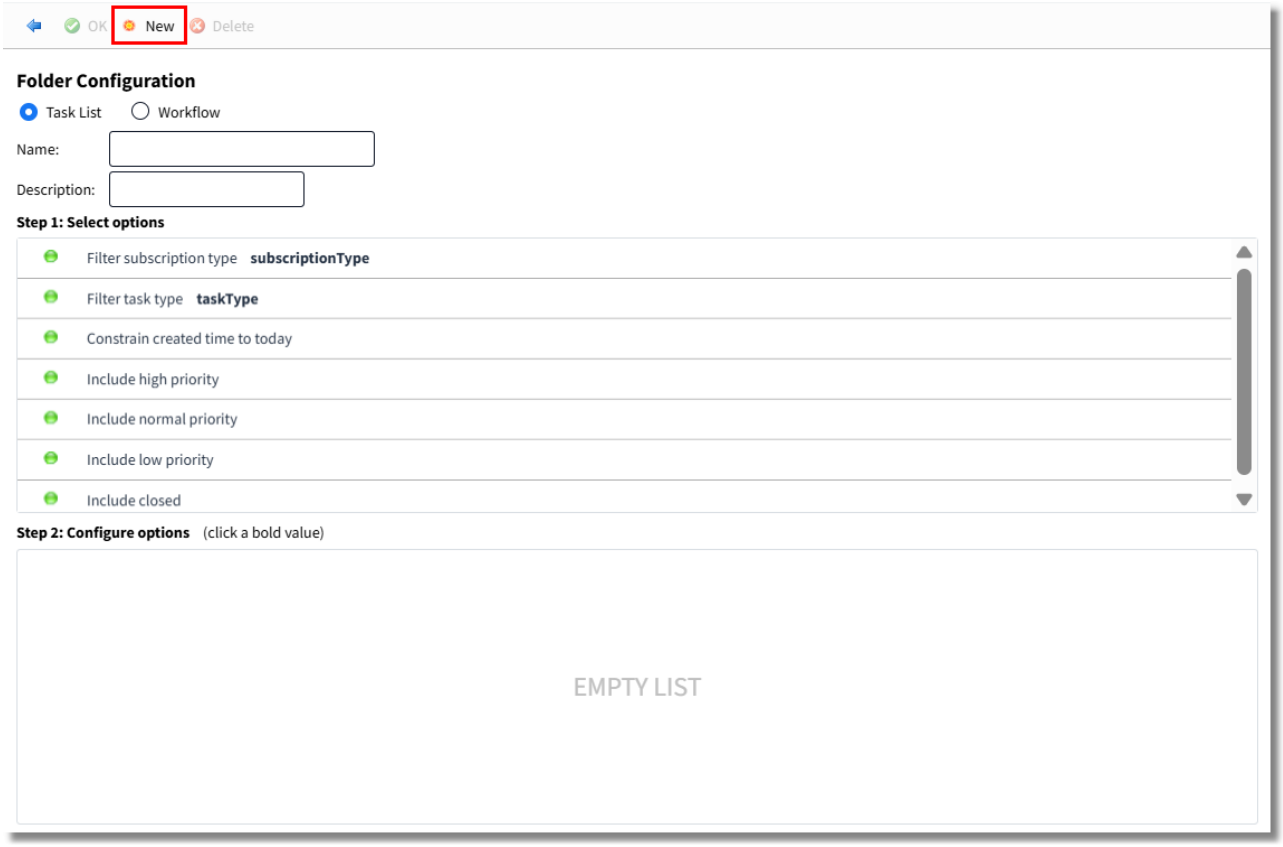
Image Title Maintenance

9.3 ESignView Folder Setup

When scanned documents are assigned, employees can locate them in the ESignView folder on the Tasks screen. Providers may use either the ESignView folder or the E-Sign folder to review or sign scanned documents. If the ESignView folder is not present on the Tasks screen, it can be added by creating a new folder.

To add the ESignView folder to an employee's or provider's Tasks screen, select **New**.

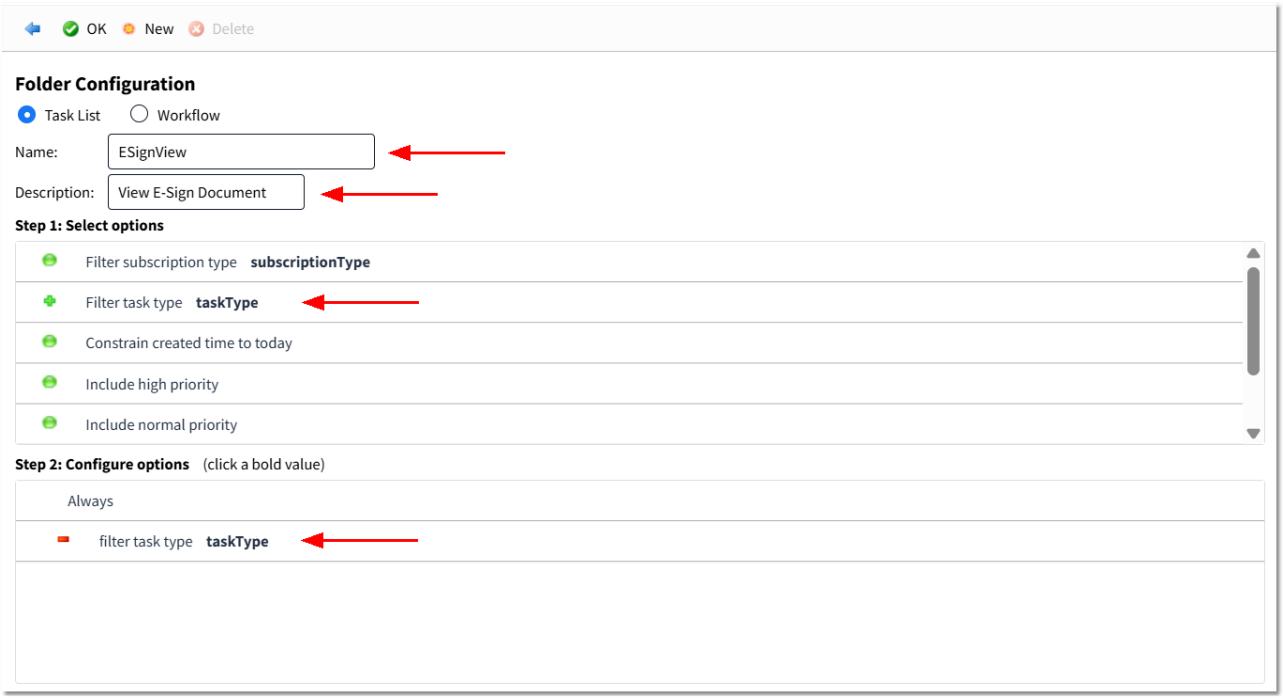
Select **Web Client** > **Home Screen** > **Tasks** > **New**



Folder Configuration

The Folder Configuration screen will display. To configure the folder, follow the steps below:

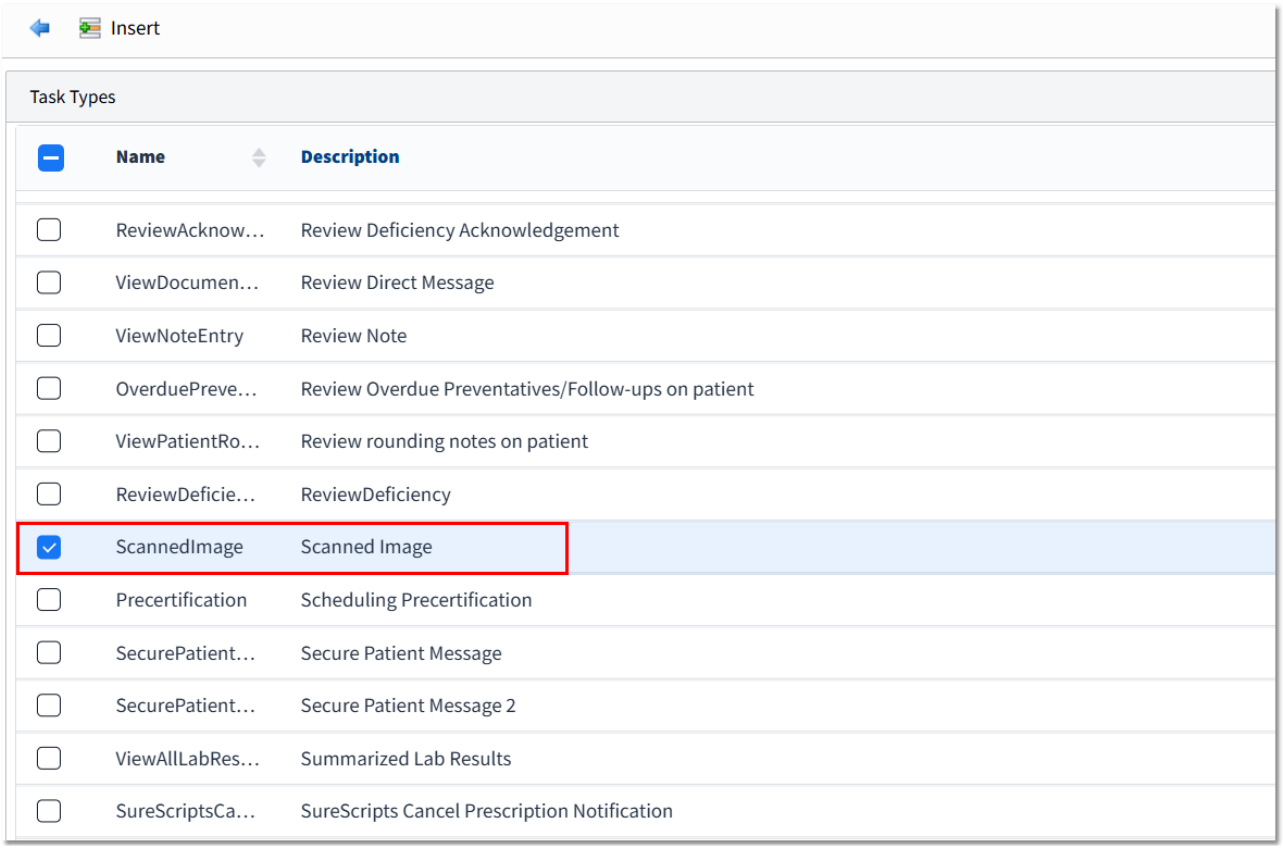
Select **Web Client** > **Home Screen** > **New** > **Tasks** > **Folder Configuration**



Folder Configuration - New

- Enter a **Name** for the folder. This name will appear as the label next to the folder icon on the Home screen.
- Enter a **Description** for the folder. The description will be displayed in the right-hand window after the folder is selected on the Home screen.
- Enter the **Filter Task Type** for the folder. In the **Step 1: Select options** section, select the green button next to **Filter task type**.
- Configure **Task Type** for the folder. In the **Step 2: Configure options** section, select the bold lettering **taskTypes** label. The Task Types list will display.

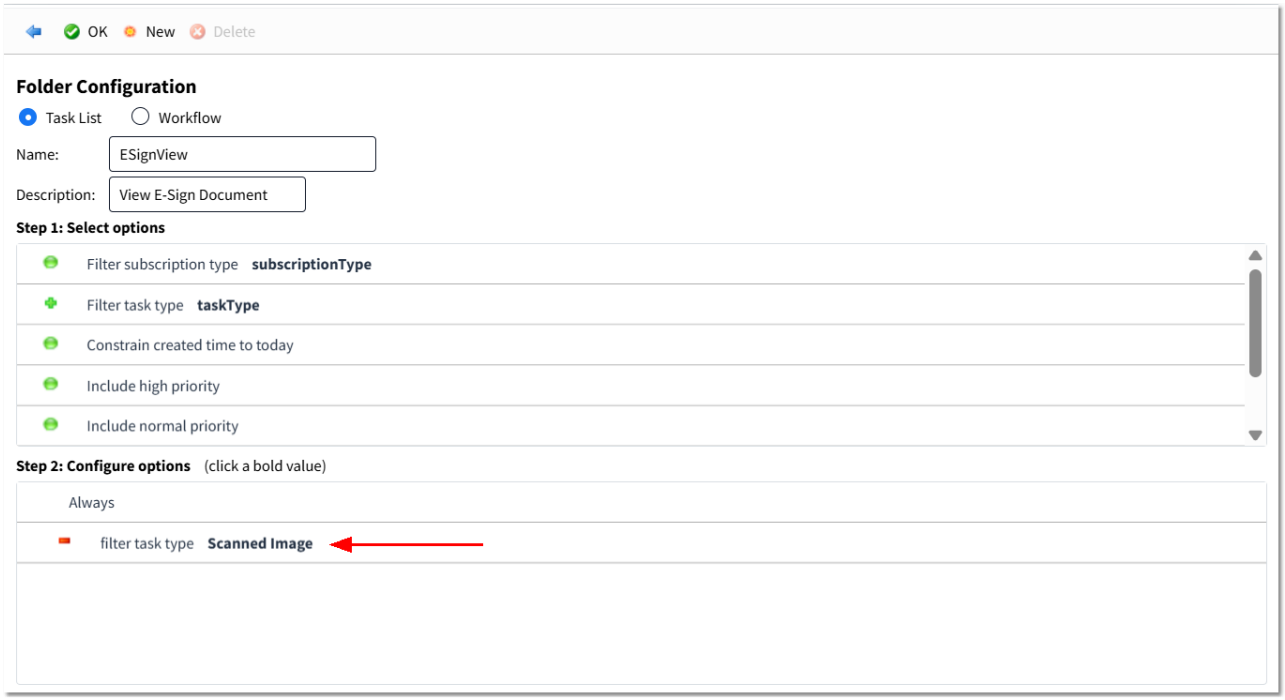
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration** > **Task Types**



Task Types

- Select **ScannedImage**, then select **Insert**. The selected task type will then display on the Folder Configuration screen.

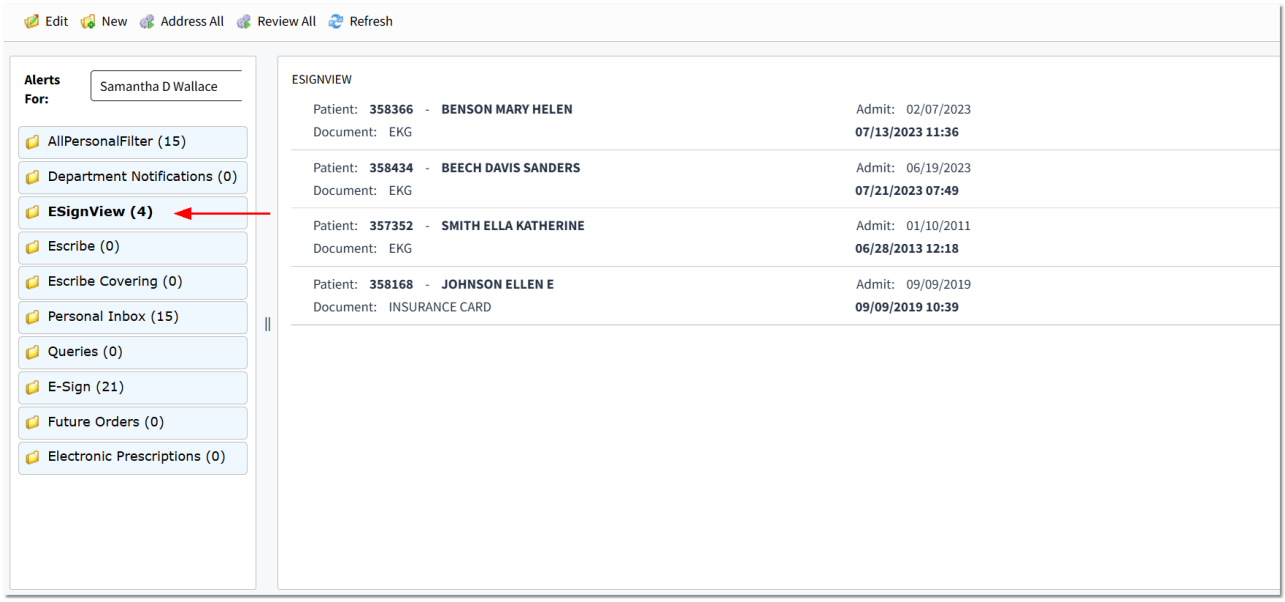
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration**



Folder Configuration - New

- Once the task type filter is set, select **OK** from the action bar, and then select the **back arrow** from the action bar to return to the Home screen.

Select **Web Client** > **Home Screen** > **Tasks**

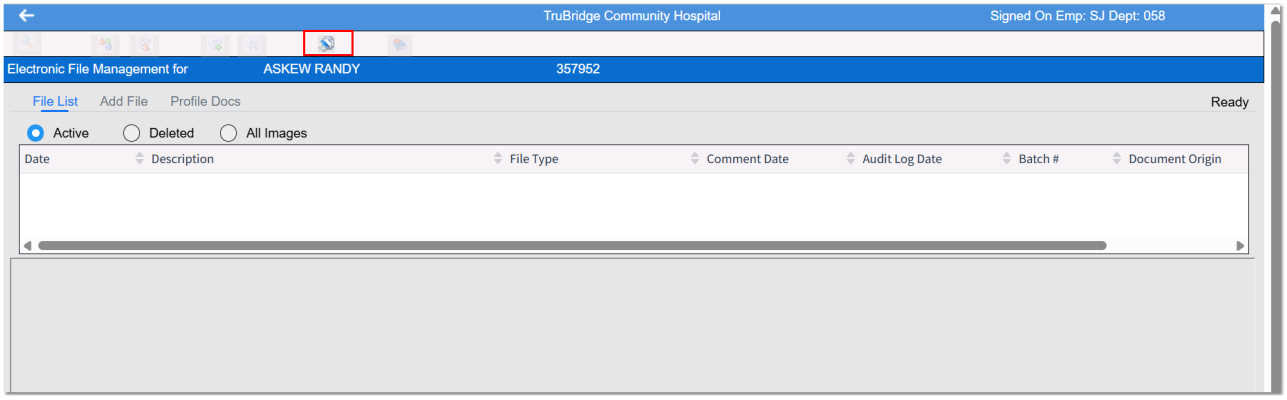


Home Screen - Tasks

9.4 Batch Scanning

Documents must be scanned onto the account using batch scanning. For detailed instructions, please refer to the Batch Scanning section of the Electronic File Management 19 User Guide.

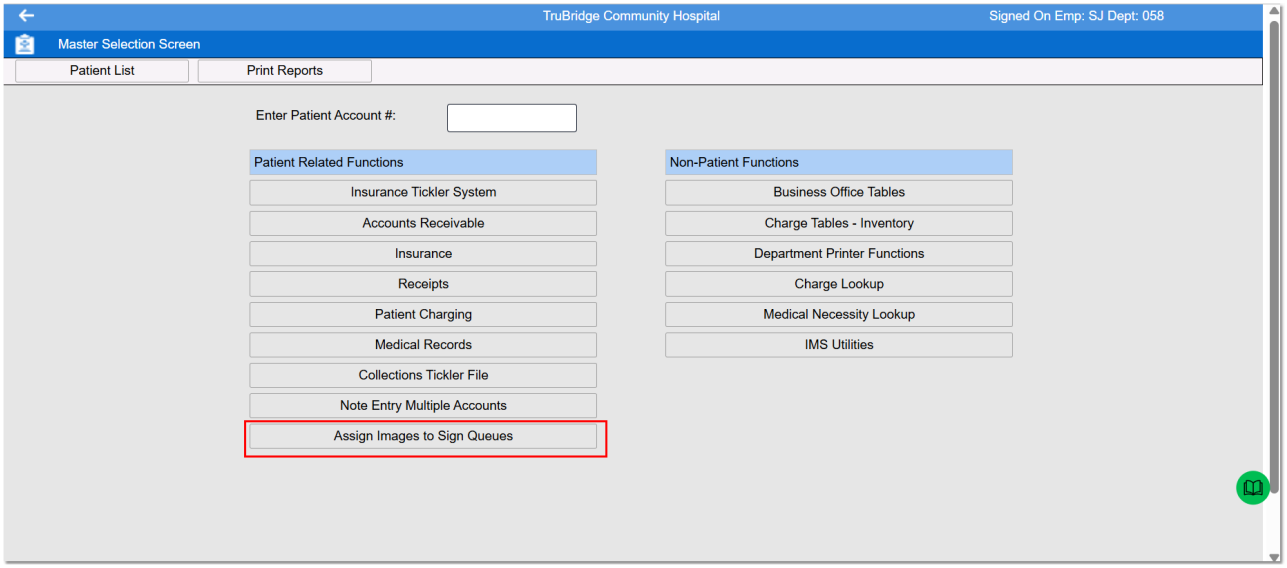
Select **Web Client > System Menu > Patient Account # > Electronic File Management**



Electronic File Management

Once a document has been batch scanned, it will be placed in the **Assign Images to Sign Queues**.

Select **Web Client > System Menu > Master Selection > Assign Images to Sign Queues**



Assign Images to Sign Queues

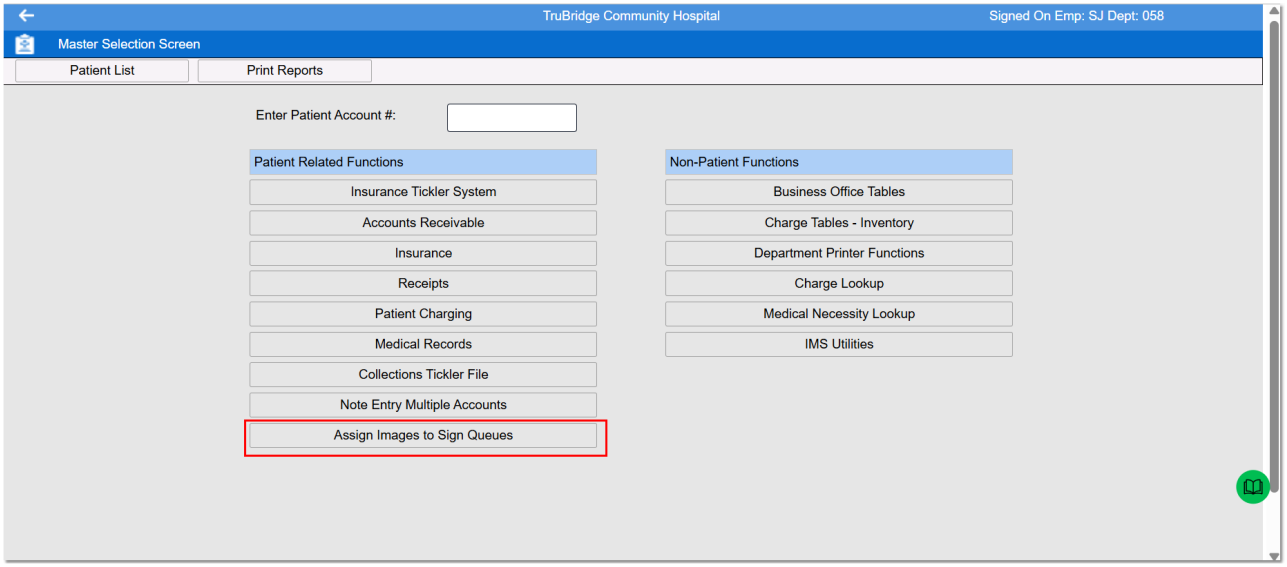
9.5 Assigning E-Sign Scanned Documents

The following steps outline how to assign a scanned image to an employee or provider for E-Signing.

Select **Assign Images to Sign Queues** to assign the documents.

NOTE: *To access the Assign Images to Sign Queues option, the Allow Changing Scanned Documents security switch must be set to* ***Y*** *on page 2 of Employee Security table .*

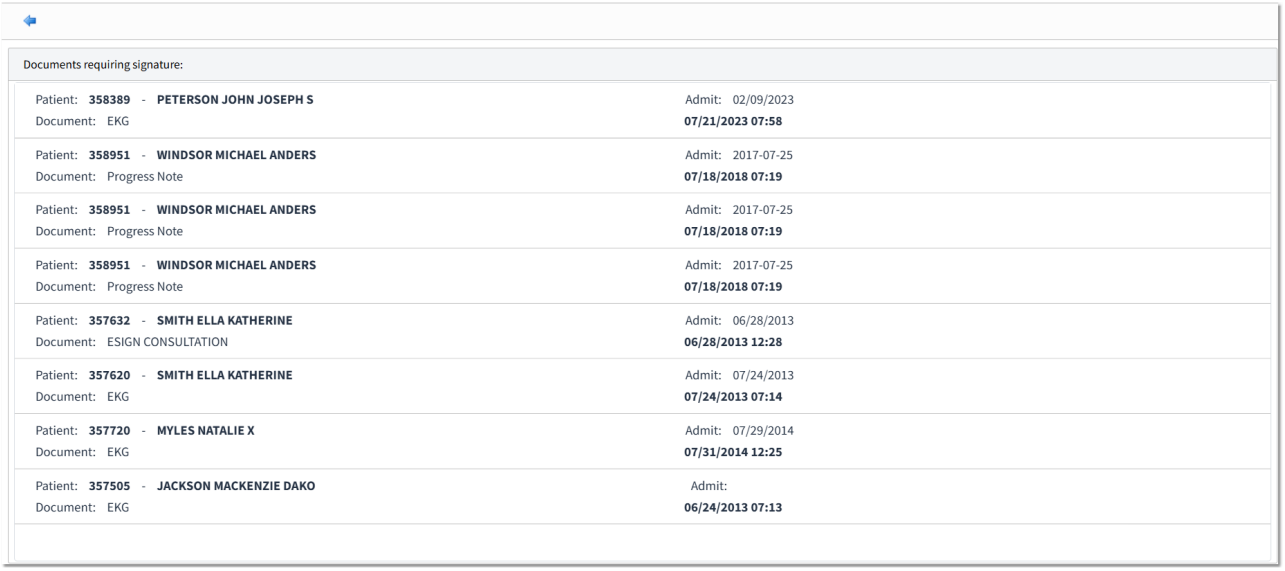
Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues**



Assign Images to Sign Queues

Once Assign Images to Sign Queues is selected, the Document Requiring Signature screen will display.

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues** > **Document Requiring Signature**

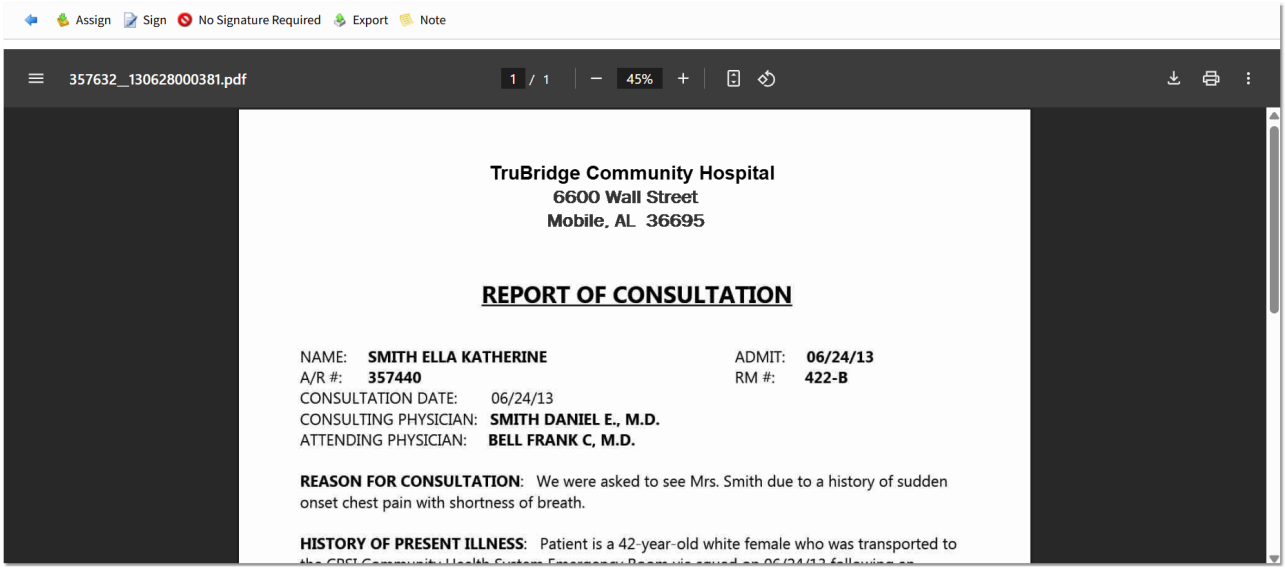


Assign Images to Sign Queues

The following information will be displayed for each scanned document: Account Number, Patient Name, Admit Date, Document Title and the Date and Time the document was scanned.

Select the scanned document that needs to be assigned for electronic signature.

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues** > **Document Requiring Signature** > **Select Scanned Document**



Assign Images to Sign Queues

When a scanned document is selected, the following options will appear on the Action Bar:

- **Back Arrow**: Returns to the previous screen, displaying the list of scanned documents awaiting assignment.
- **Assign:** Allows an employee or provider to be assigned to the scanned document for electronic signature. Once assigned, the document will appear in the employee's or provider's E-Sign folder.
- **Sign:** Enables the employee or provider to electronically sign the scanned document.

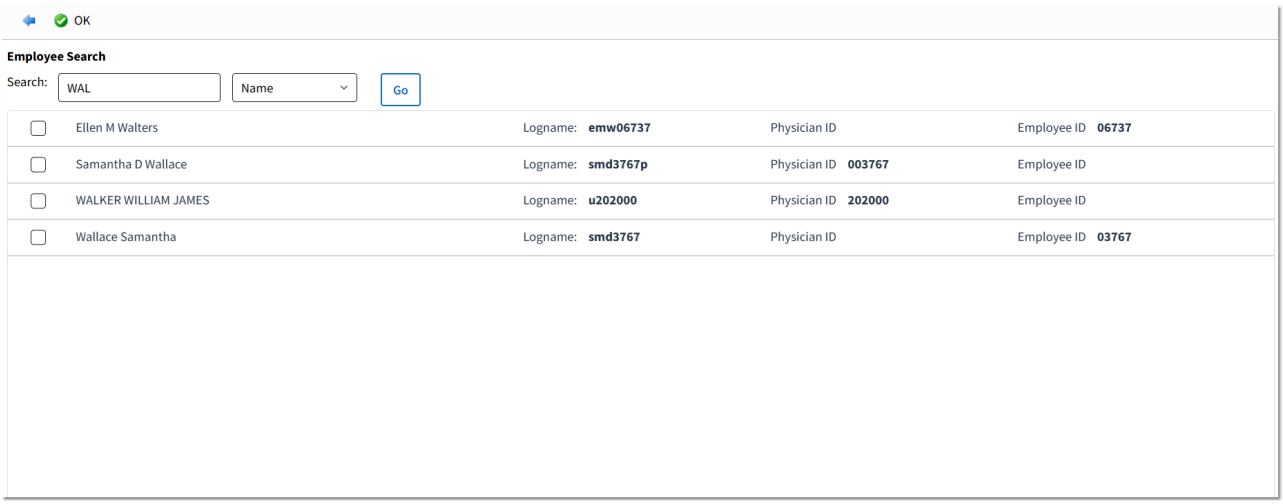
NOTE: *Detailed instructions for signing scanned documents can be found in the* *Procedures for E-Signing Scanned Documents* 214 *section.*

- **No Signature Required:** Marks the document as not requiring a signature. It will be saved accordingly and will not be sent to an employee or provider's E-Sign folder.
- **Export:** Reserved for future use.
- **Note:** Allows a note to be sent to an employee or provider with the scanned document attached.

NOTE: *Instructions for entering and viewing notes are provided in the* *Note* 223 *section.*

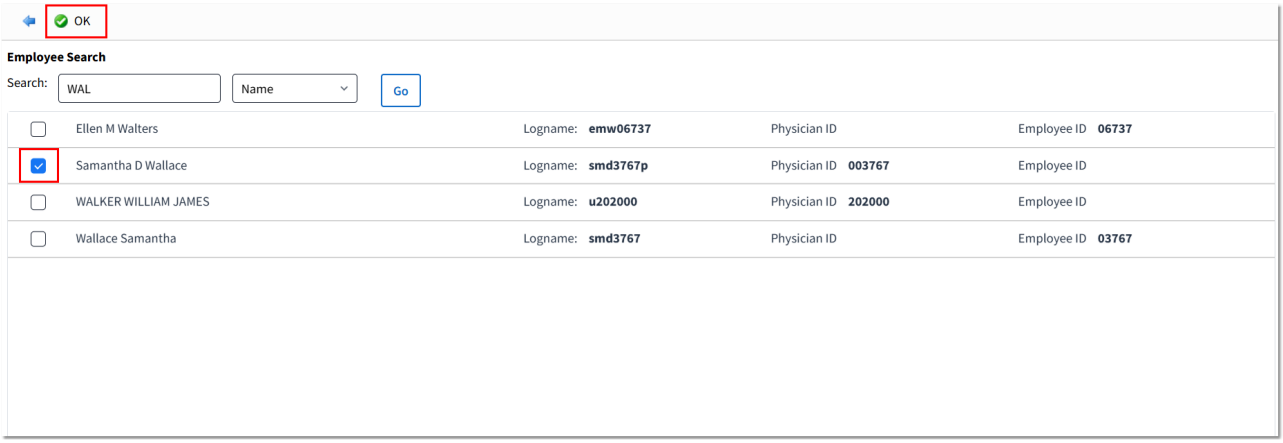
Select **Assign** to choose the employee or provider who will be signing the document. An employee's or provider's first or last name can be entered into the Search to narrow the list. Use the Search Type drop-down menu to search by Employee ID, Log Name, Name or Physician ID. By default, the search is set to Name.

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues** > **Document Requiring Signature** > **Select Scanned Document** > **Assign**



Assign Images to Sign Queues

Once the name of the employee or provider has been located, select the check-box next to the Login and then select **OK** on the action bar to assign the document.



Assign Images to Sign Queues

The document will be sent to a folder on the employee's or provider's **Tasks** screen. Once assigned, the document will be removed from Assign Images to Sign Queues.

NOTE: *The* ***Electronic File Management Audit Log*** *will be updated with the date, time and the name of the employee who assigned the document. The* ***EPHI Audit Log*** *will also be updated, indicating that Image Storage was accessed during the assignment process.*

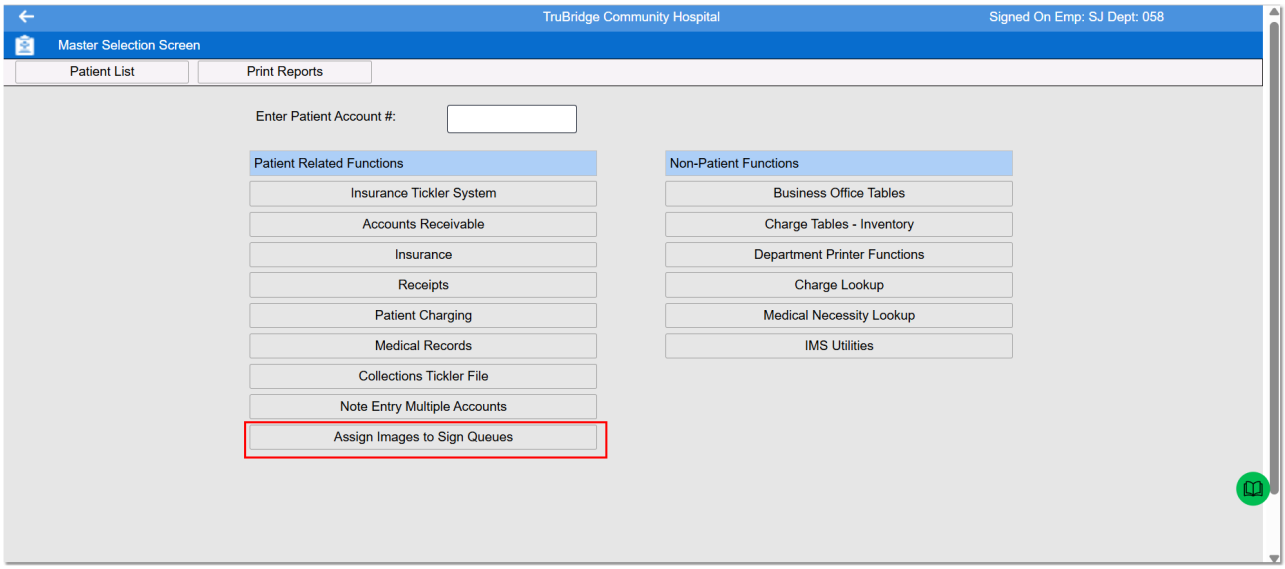
9.6 Setting up a Passphrase

Before a document can be E-Signed, a passphrase must be set up either from the Assign Images to Sign Queues screen or within the E-sign folder on the Tasks screen. For instructions on setting up a passpharases from the E-Sign folder and additional provider e-sign procedures, refer to the Provider E-Sign Procedures 194 section of this User Guide.

The steps below explain how to set up a passphrase from the Assign Images to Sign Queues screen.

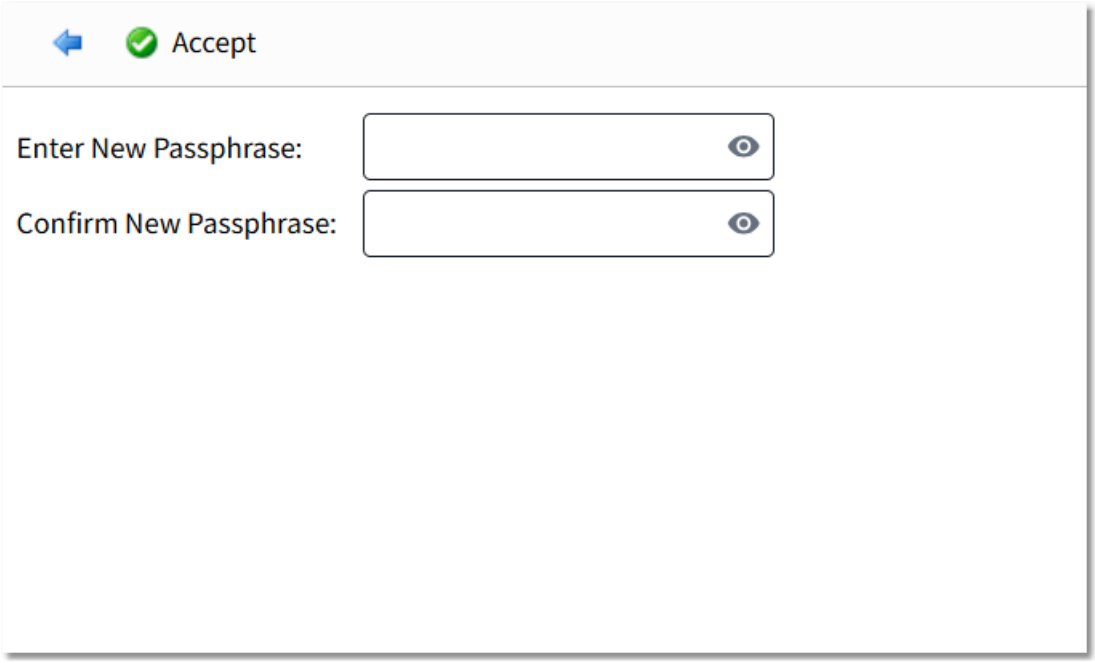
NOTE: *Passphrases can only be created for employees or providers currently signed in to the TruBridge EHR.*

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues**



Assign Images to Sign Queues

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues** > **Navigation Panel** > **Key Maintenance**



Key Maintenance

Enter the passphrase that the signed-on employee or provider will use. The passphrase must be at least 10 characters long and include one uppercase letter, one lowercase letter and one number.

After entering and confirming the passphrase, press the **Enter** key, then select **Accept** on the Action Bar. If the passphrase is entered correctly, a confirmation box will display with "**Success!**". Select **OK** to close the message.

9.7 E-Sign Scanned Documents Procedures

There are four ways a scanned document may be E-Signed:

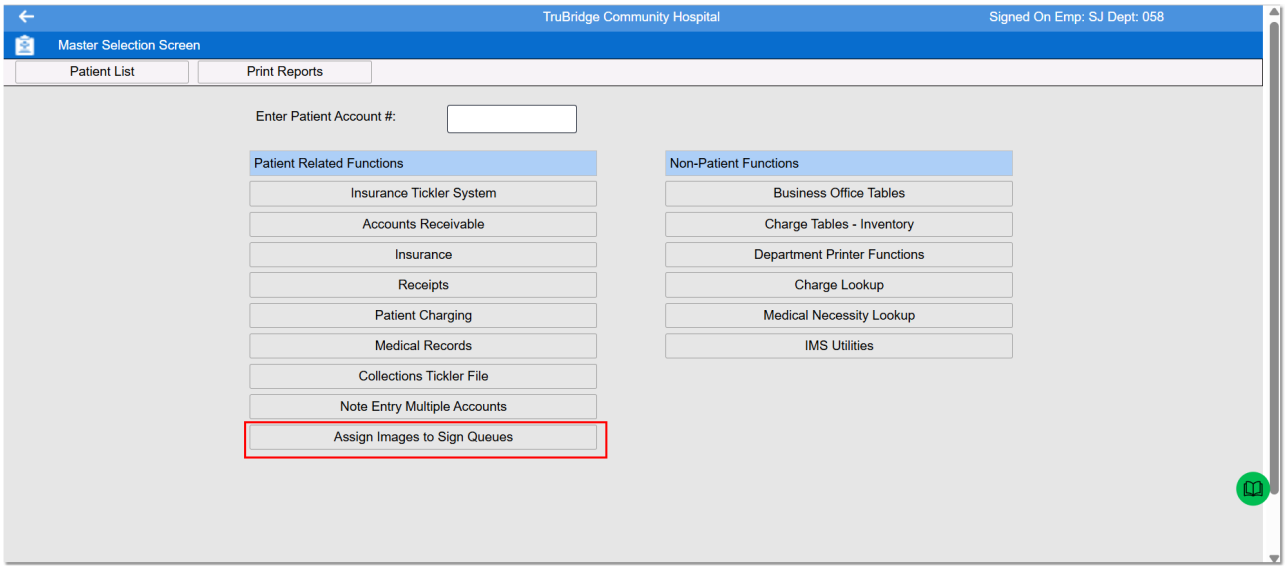
1. Assign Images to Sign Queues option
2. Electronic Signature for Images
3. ESign View folder on the Tasks screen.
4. The provider's E-Sign folder on the Tasks screen.

Assign Images to Sign Queues

To E-sign a scanned image using the **Assign Images to Sign Queues** option, follow the steps below:

From the Master Selection screen, select **Assign Images to Sign Queues**.

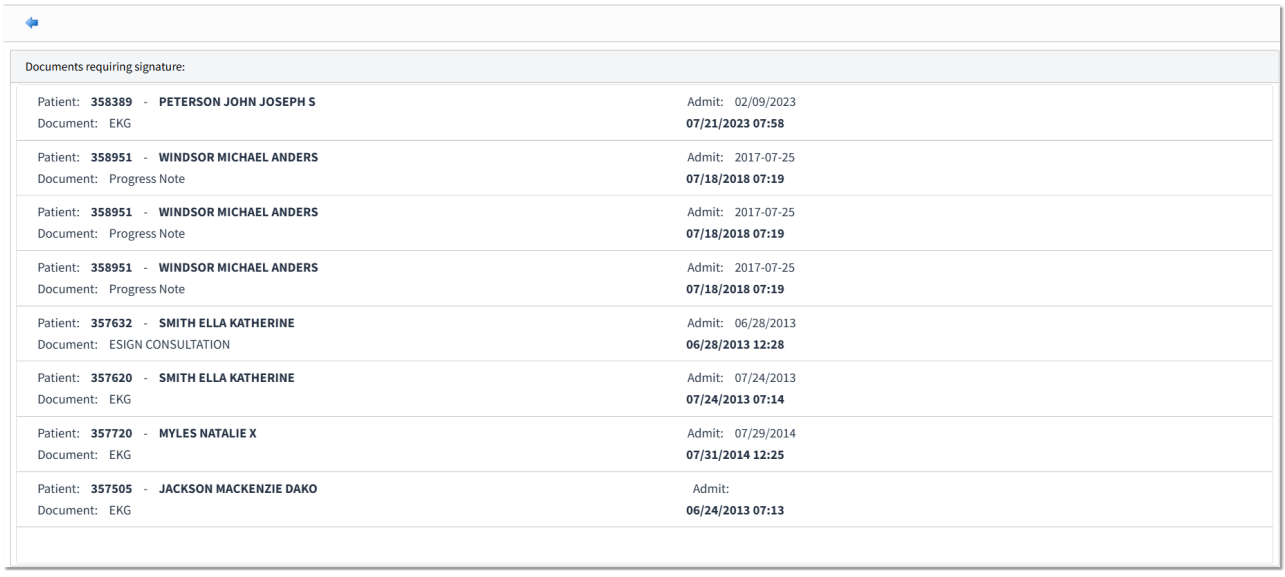
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection**



Assign Images to Sign Queues

Once Assign Images to Sign Queues has been selected, a list of scanned documents requiring a signature will be displayed. Select the scanned document to be e-signed.

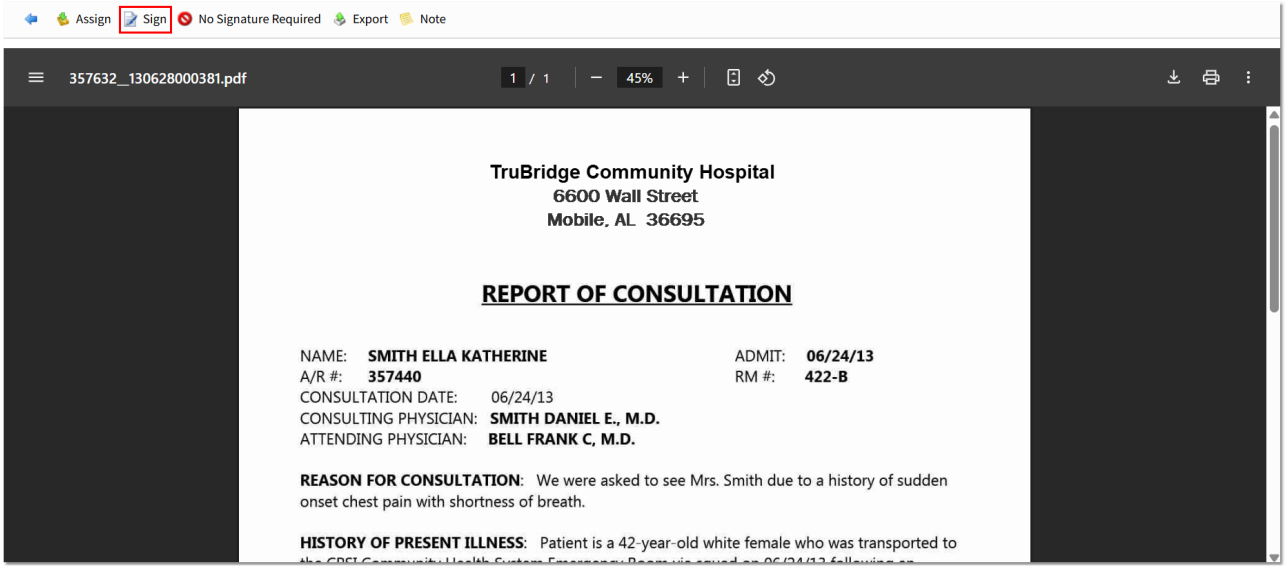
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Assign Images to Sign Queues**



Assign Images to Sign Queues

The scanned document will be displayed on the screen. If the scanned document was sent in error, select **No Signature Required** to remove it from the queue. Otherwise, select **Sign** on the action bar to proceed with the E-Sign.

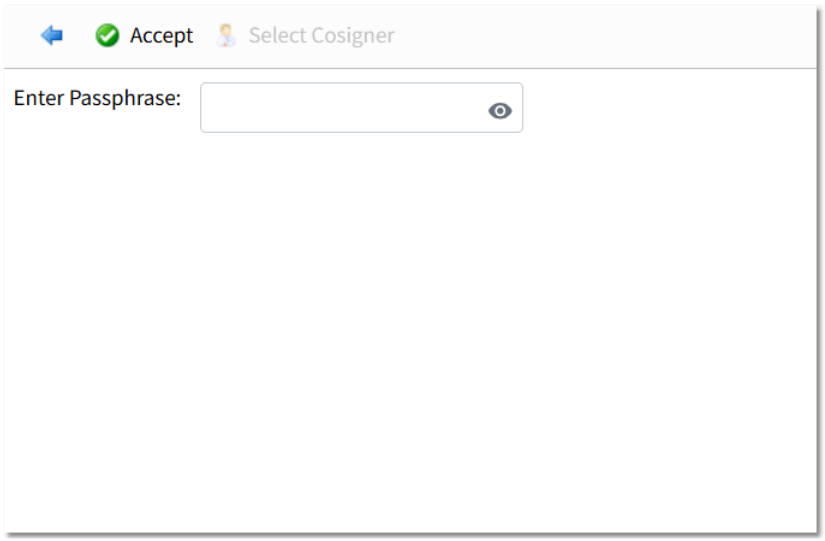
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Select Scanned Document**



Assign Images to Sign Queues

The system will prompt to enter the passphrase set up by the employee or provider. Type in the passphrase and press the Enter key, then select **Accept** on the action bar to complete the singature.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Select Scanned Document** > **Sign**



Electronic Signature - Passphrase

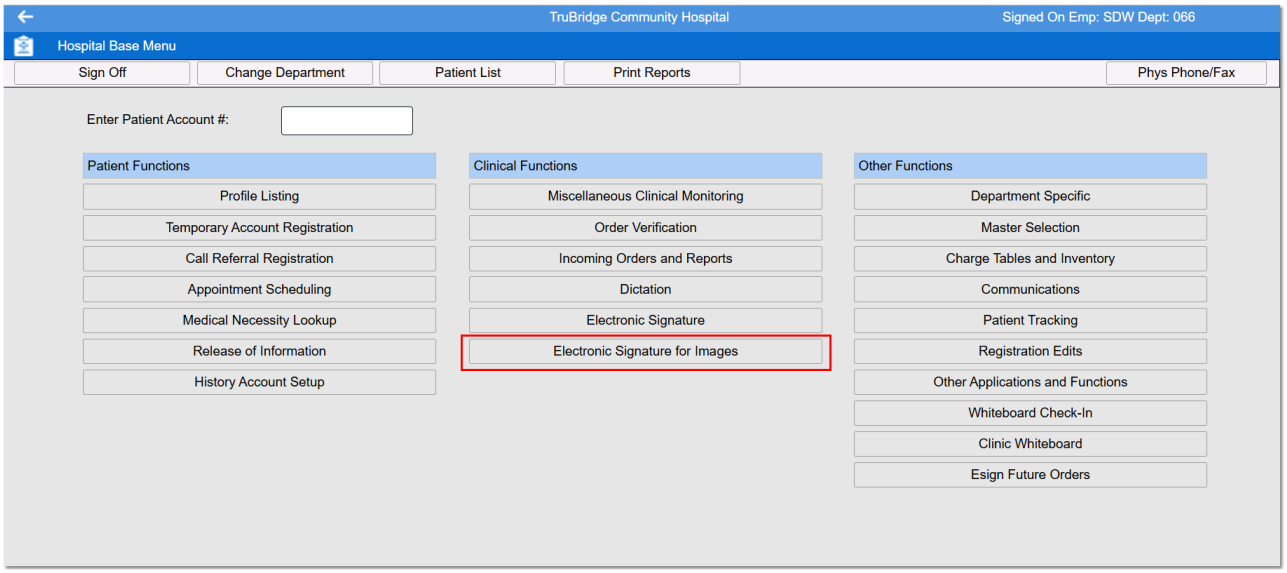
After the scanned document has been signed, it will be removed from the employee or provider's E-Sign queue.

Electronic Signature for Images

To E-sign a scanned document using the **Electronic Signature for Images** option, follow the steps below:

From the Hospital Base menu, select **Electronic Signature for Images**.

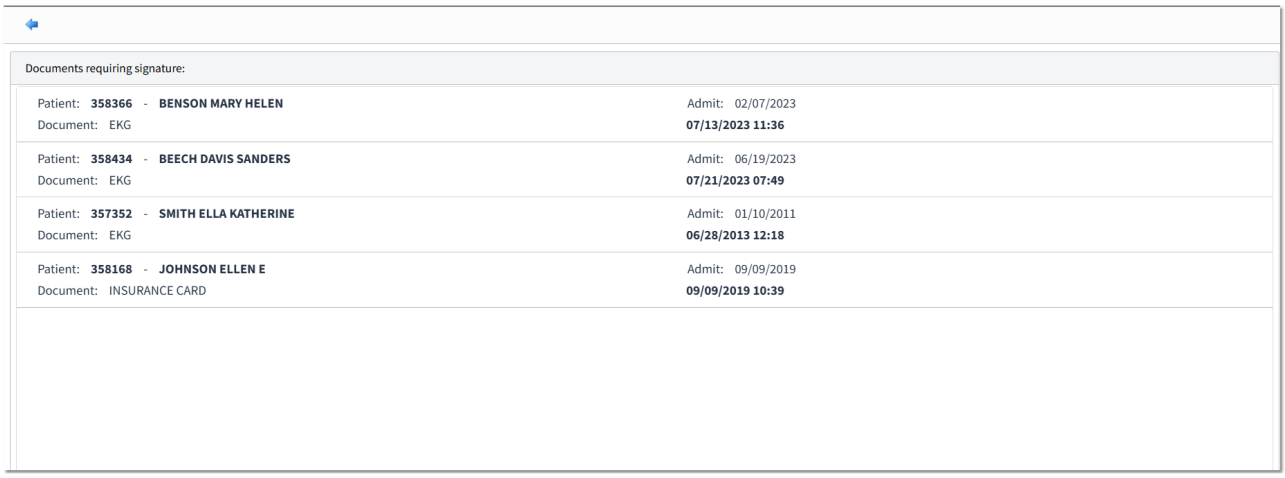
Select **Web Client** > **System Menu** > **Hospital Base Menu**



Hospital Base Menu

A list of scanned documents requiring e-signature will be display. Select the scanned document to be e-signed.

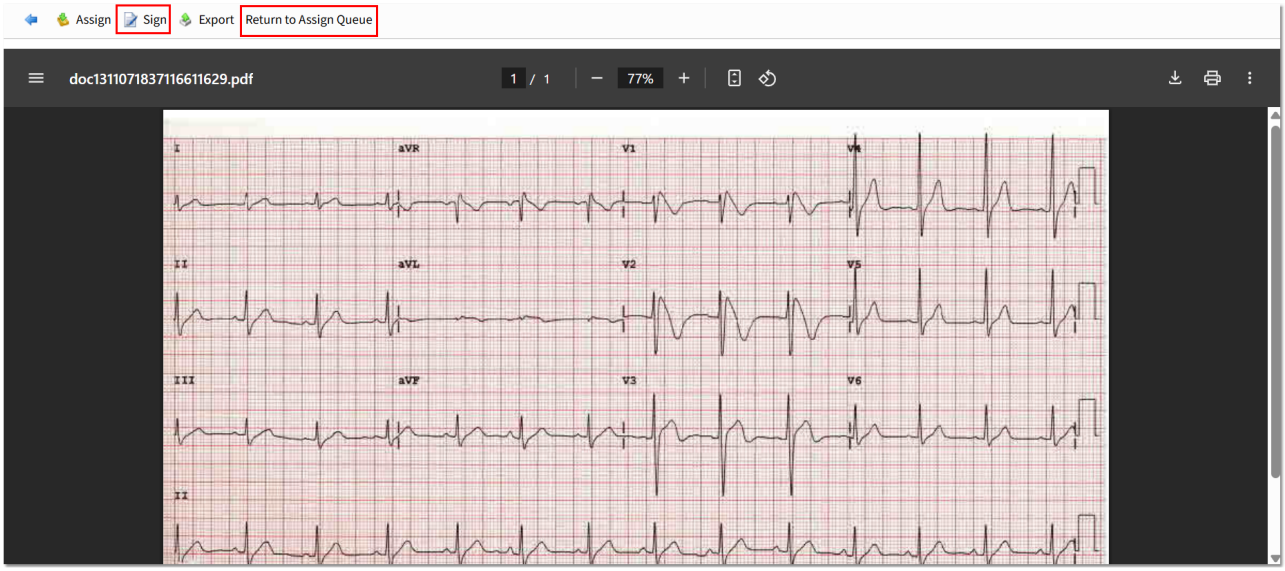
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Electronic Signature for Images**



Assign Images to Sign Queues

The scanned document will be displayed on the screen. If the scanned document was sent in error, select **Return to Assign Queue** on the action bar to return the scanned document to the Assign Images to Sign Queues. To sign the scanned document, select **Sign** on the action bar.

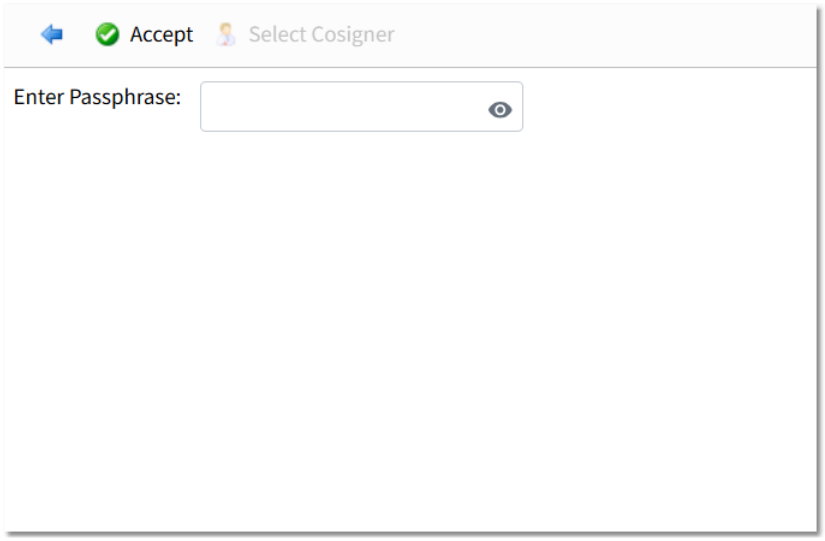
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Electronic Signature for Images** > **Select Scanned Document**



Assign Images to Sign Queues

The system will prompt to enter the passphrase set up by the employee or provider. Type the passphrase, press the Enter key, then select **Accept** on the action bar.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Electronic Signature for Images** > **Select Scanned Document** > **Sign**



Electronic Signature - Passphrase

After the scanned document has been signed, it will no longer show in the employee's or physician's E-Sign queue.

***NOTE**: The Electronic Signature behavior control **AllowRememberPassphraseOneHour,** when set to allow, allows the passphrase to be entered once per electronic signature session. After the passphrase is entered, the system will remember it for 60 minutes.*

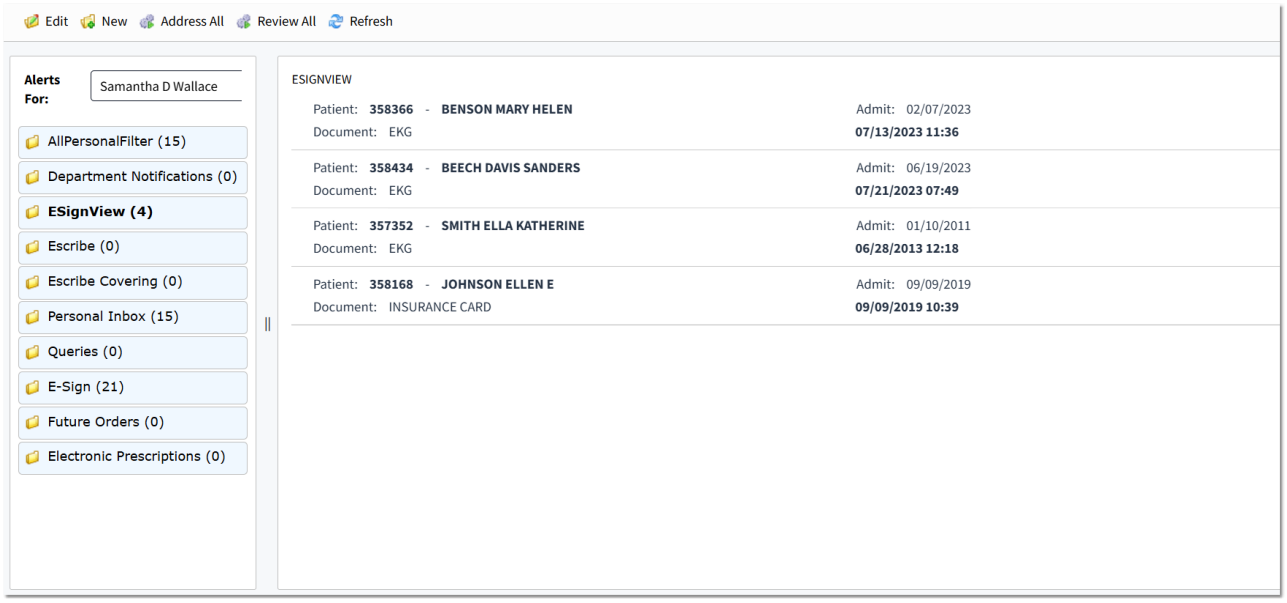
Tasks Screen

When scanned documents are assigned, employees will find them in the **ESignView** folder on the Tasks screen. Providers may use either the **ESignView** folder or the **E-Sign** folder to sign scanned documents. For information on signing scanned documents using the E-Sign folder, see the Provider E-Sign Procedures 194 section.

This section will cover signing from the ESignView folder. If the ESignView folder is not displayed, it will need to be created. Refer to the ESignView Folder Setup 203 section for more information.

From Web Client, select the **Home Screen** then select **Tasks**.

Select **Web Client** > **Home Screen** > **Tasks** > **ESignView Folder**



ESign View Folder

The following options are available to select which scanned documents to sign:

- **Address All**: Select this option to view and sign all scanned documents listed.
- **Address Selected**: To sign multiple specific documents, hold down the Ctrl key and select each desired scanned documents. Once all the scanned documents have been selected, the **Address All** option will then change to **Address Selected**. Select **Address Selected** to sign the chosen documents.
- **Review All**: Allows all scanned documents to be viewed before signing. If multiple documents are selected, this option will then change to **Review Selected**.

To view and sign one scanned document at a time, select the scanned document to be e-signed. Once a document is selected it will display on the screen. To sign the scanned document, select **Sign** on the action bar.

If the scanned document was sent in error, select **Return to Assign Queue** on the action bar to return the scanned document to the Assign Images to Sign Queues.

The system will prompt to enter the passphrase set up by the employee or physician. Type in the passphrase and select the Enter key, then select **Accept** on the action bar. After the scanned document has been signed, it will no longer show in the employee or physician's E-Sign folder.

Signing for Other Physicians

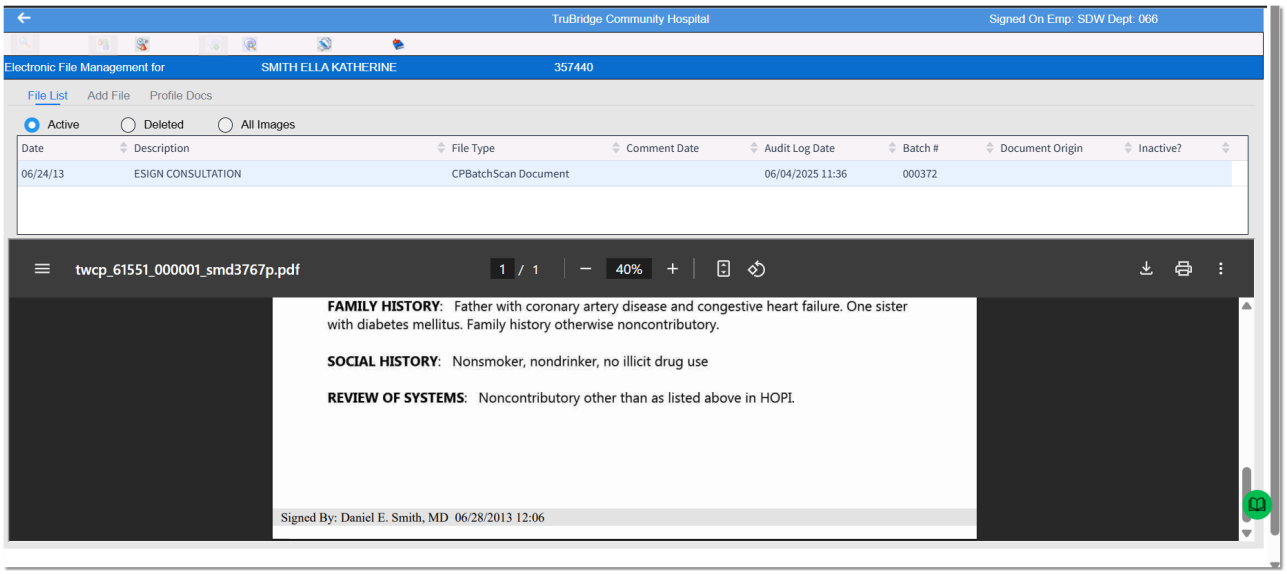
Providers have the ability to electronically sign scanned documents on behalf of another physician. To enable this functionality, the **Authorized to Sign Documents for** field on page 2 of the Physician Security Table must be set appropriately. For detailed instuctions, refer to the Signing for Other Providers 197 section.

NOTE: *Please refer to JCAHO standards and CMS Conditions of Participation for guidelines on the circumstances and mechanisms under which one Licensed Practitioner could authenticate for another Licensed Practitioner.*

9.8 Viewing a Signed Scanned Document

To view an electronically signed scanned document, access Electronic File Management from the patient's account and select the document. The electronic signature will display at the bottom of each page, along with the date and time the document was signed.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Electronic File Management** > **Double-click Document**

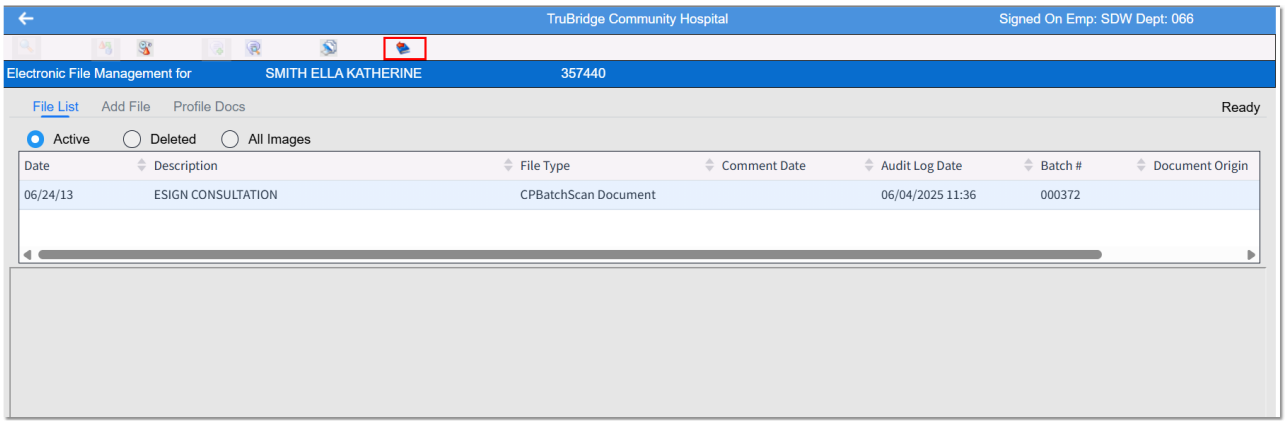


Electronic File Management

NOTE: *The **Electronic File Management Audit Log** will be updated when a document is signed with the date, time and the signing employee or physician's name.*

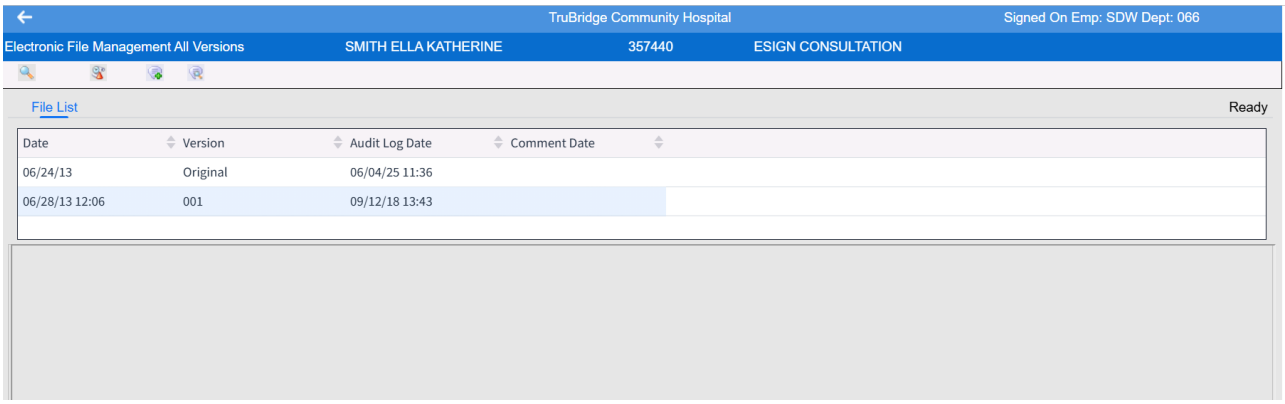
Once a document has been signed, all versions of the document can be viewed or printed. Select the signed document, then select the **Versions** icon.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Electronic File Management > Select Document > Versions Icon**



Electronic File Management File List

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Electronic File Management > Select Document > All Versions**



Electronic File Management All Versions

- **Date:** Displays the date the original document was attached to the account, or the date and time when other versions of the document were signed.
- **Version:** Displays the version number of the document.
- **Audit Log Date:** Displays the date and time recorded in the audit log for the document.
- **Comment Date:** Displays the date a comment was added to the document.

9.9 Note

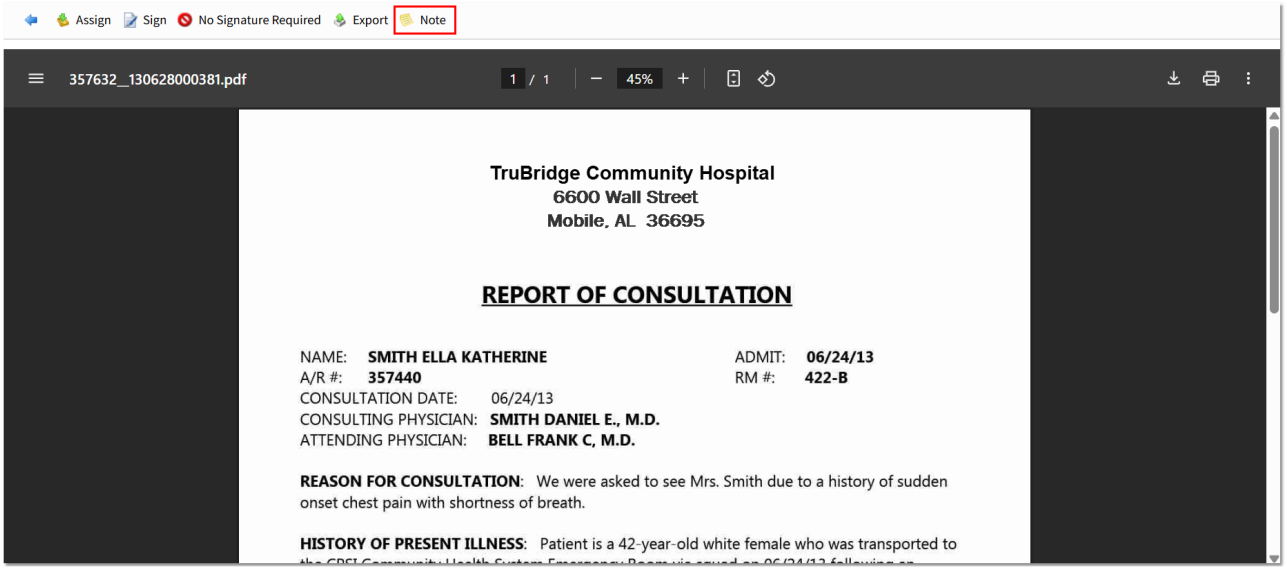
The Notes option in Assign Images to Sign Queues can be used as a communication tool between employees and providers.

Sending a Note

To begin, access **Assign Images to Sign Queues** and select a scanned document.

When the scanned document displays, select **Note** on the Action Bar to view a list of all employee and providers.

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues** > **Select Document**

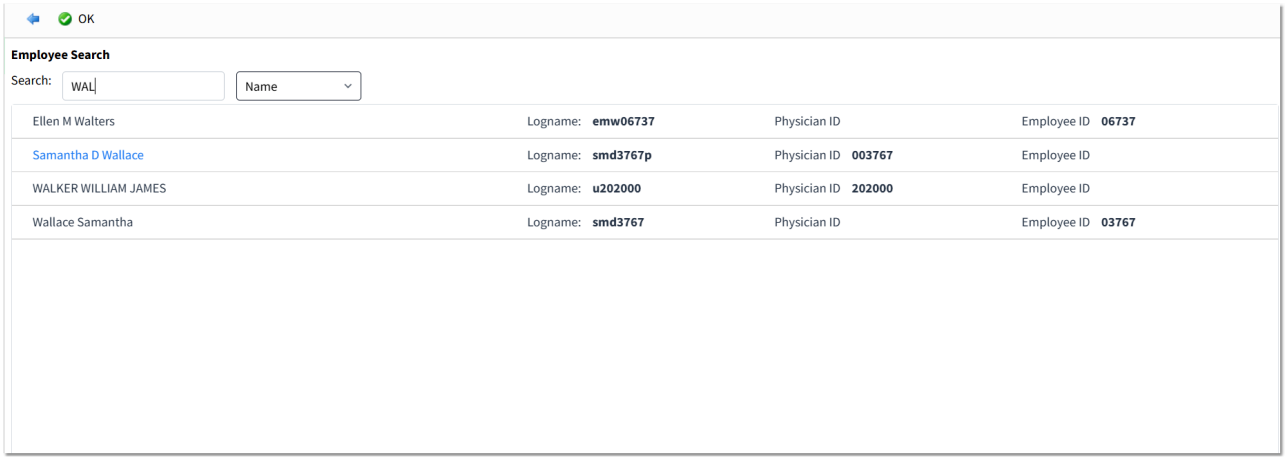


Assign Images to Sign Queues

An employee's or provider's first or last name can be entered into the Search field to narrow the list of logins. The Search Type drop-down allows searching by Employee ID, Log Name, Name or Physician ID, with Name set as the default.

Once the correct employee or provider is located, double-click their login.

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues** > **Select Document** > **Note**



Assign Images to Sign Queues

Enter the content of the note. To review the scanned document attached to the note, select **View Attachment**. Once the note is complete, select **Send** to submit it.

Select **Web Client** > **System Menu** > **Master Selection** > **Assign Images to Sign Queues** > **Select Document** > **Note** > **Select Recipient** > **OK**

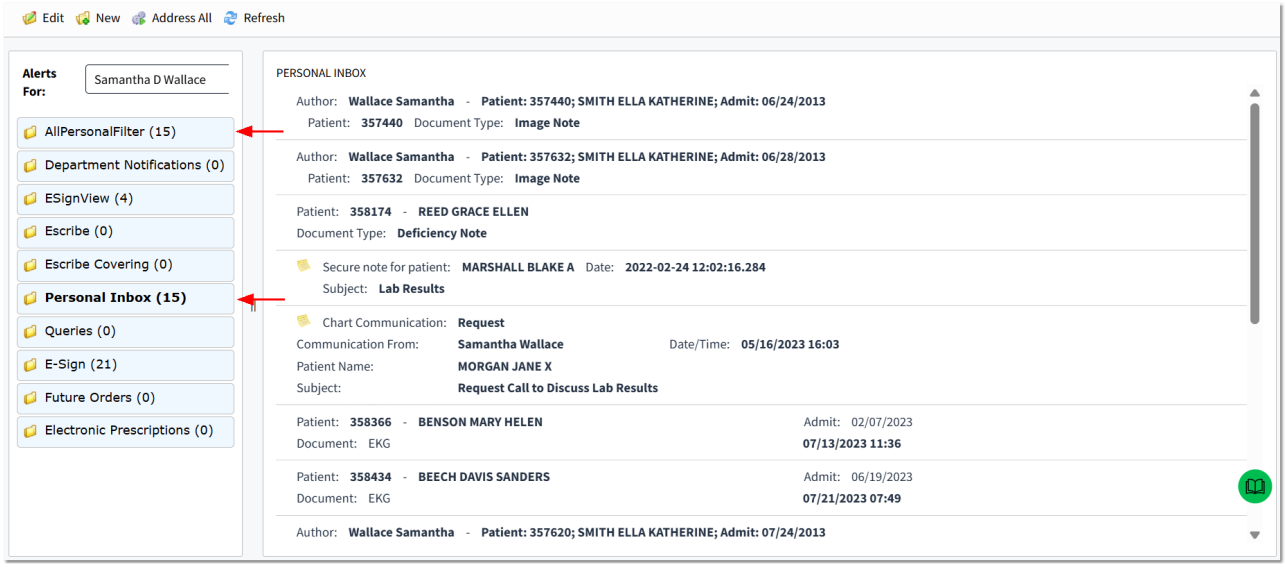
Assign Images to Sign Queues

The document will be sent to the employee's or provider's **Personal Inbox** on the Home Screen.

Viewing a Note

A note can be viewed from the **Personal Inbox** on the Tasks screen. Additionally, employees and providers can access Notes through the **AllPersonalFilters** folder located on the Tasks screen.

Select **Web Client** > **Charts** > **Tasks** > **Personal Inbox**

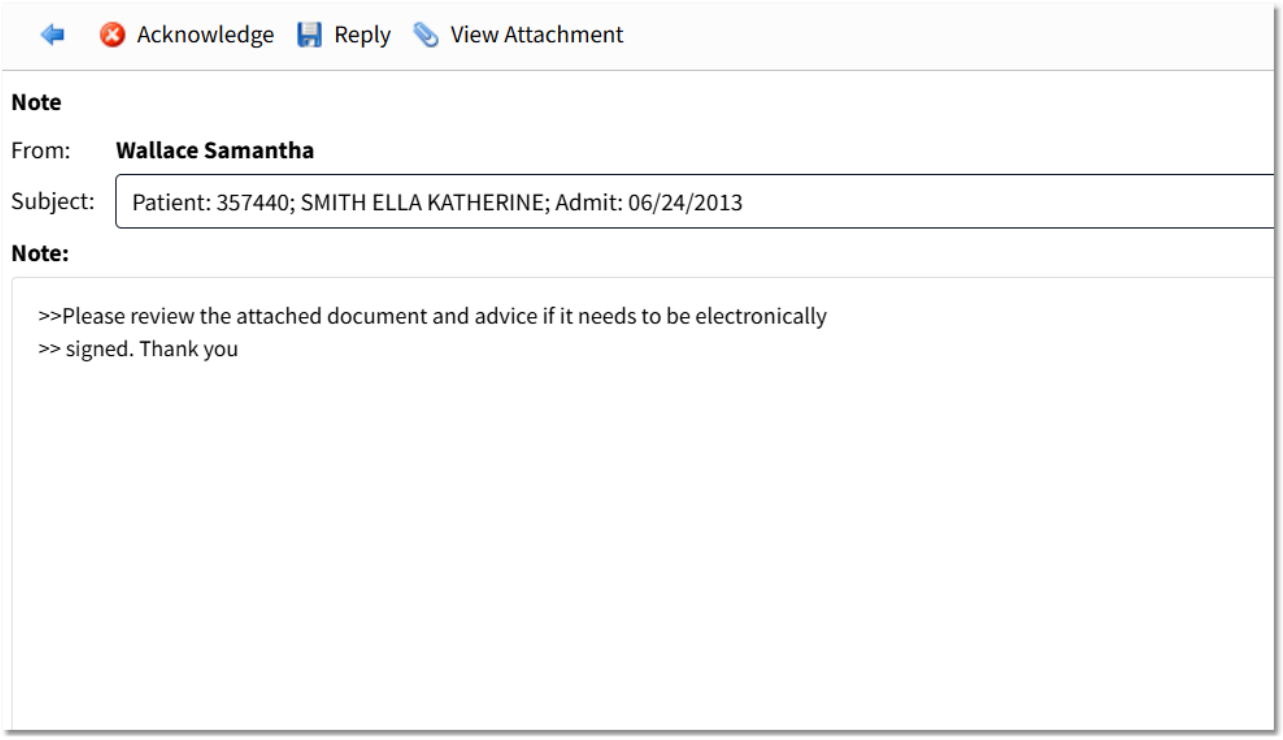


Home Screen - Tasks

The **Address All** option allows you to address all notes listed. To select multiple notes, hold down the Ctrl key while clicking each desired notes. Once all notes have been selected, the Address All option will change to **Address Selected**. Select **Address Selected** to view the chosen notes.

To view a single note at a time, select the note.

Select **Web Client** > **Charts** > **Tasks** > **Personal Inbox** > **Address Selected**



Assign Images to Sign Queues

When a note is selected, the following options display on the Action Bar:

- **Acknowledge:** Allows the employee or provider to confirm they have viewed and read the note. An acknowledgment note will be sent to the **Chart Review** folder of the note's sender.
- **Reply:** Enables the employee or provider to send a reply directly to the sender of the note.
- **View Attachment:** Provides the option to view the scanned document attached to the note.
- **Back Arrow :** Returns to the previous screen, displaying the list of notes.

Chapter 10 Chart Location

10.1 Overview

The primary purpose of the Chart Location application is to enable the Medical Records department to track and identify the location of every patient's chart. This application is only effective if all updates and chart location changes are made promptly.

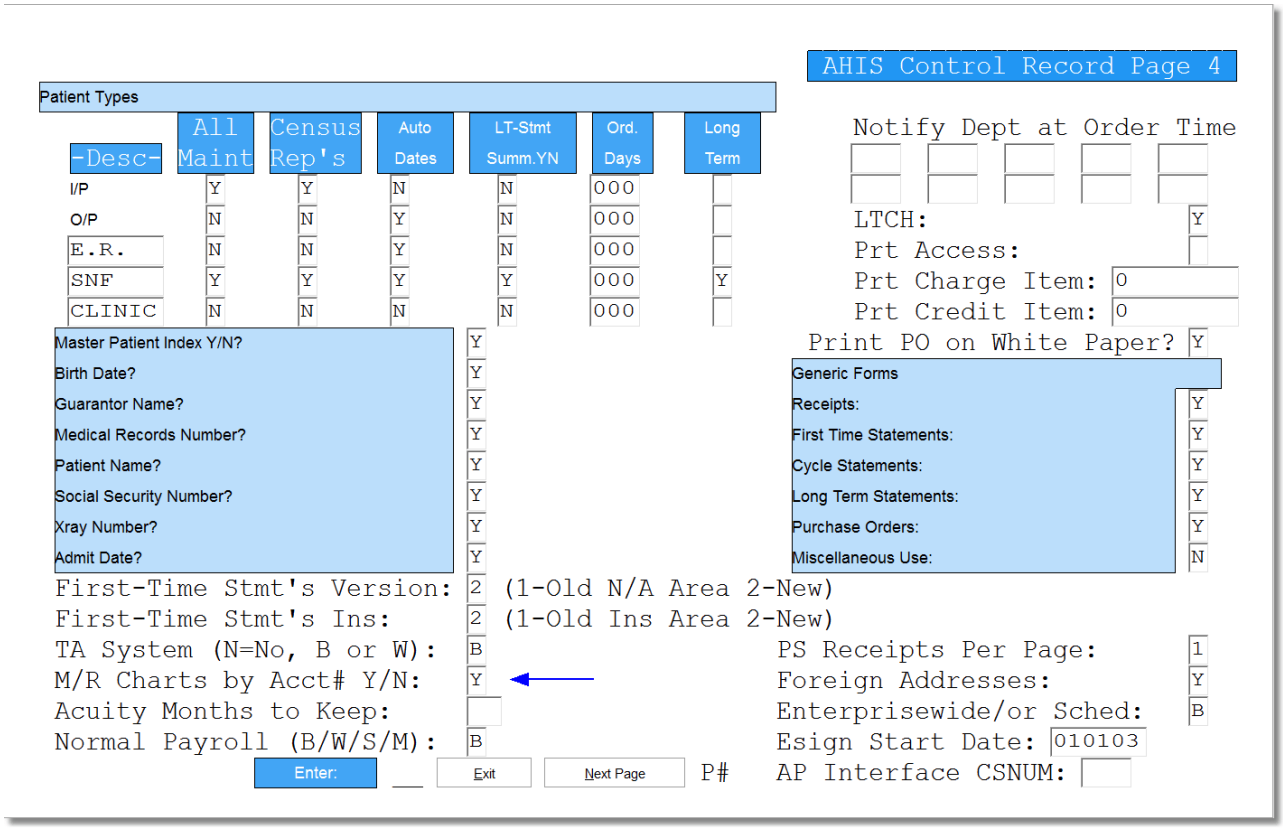
There are two ways to enter chart locations. The first is by a selected patient number and the second is through mass entry. Both ways are discussed in the following pages.

10.2 Setting Up Chart Location

AHIS

There are a few fields in AHIS that should be set up for Chart Tracking.

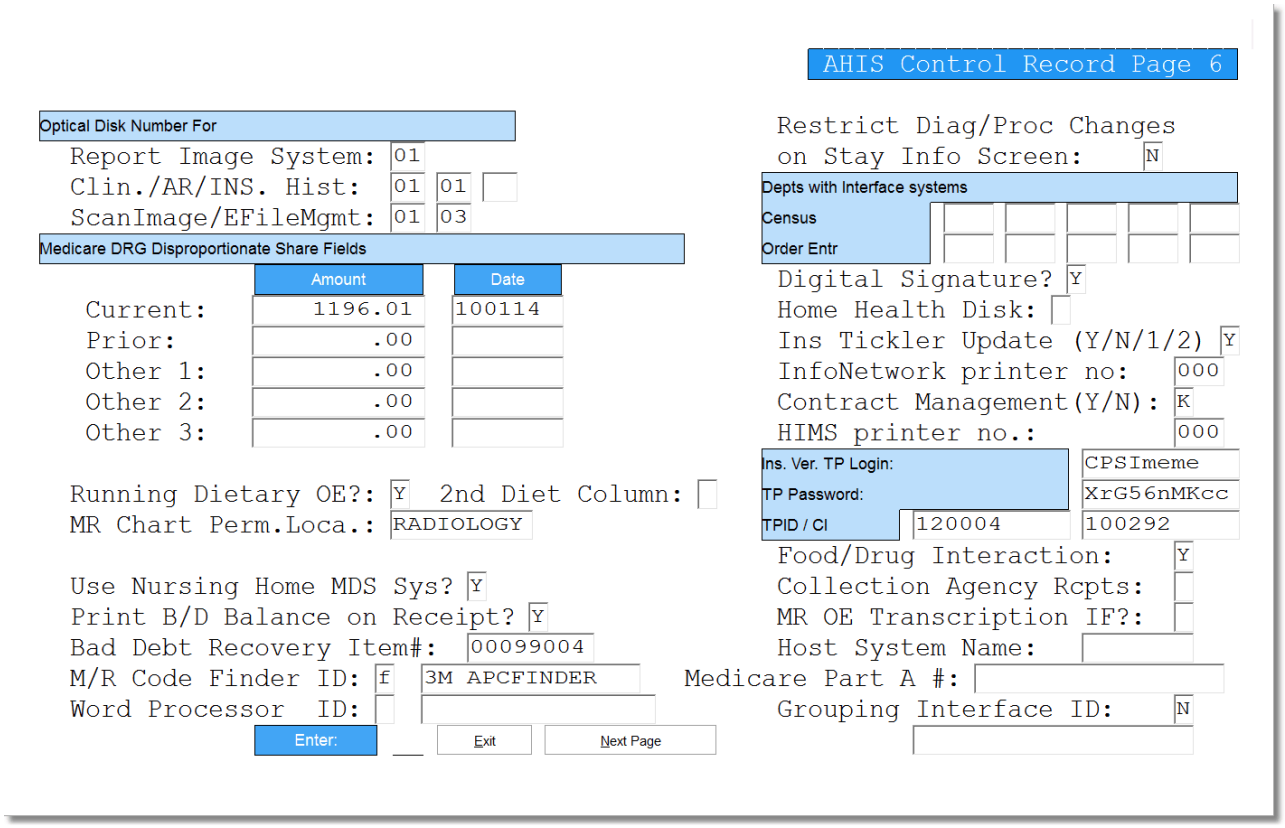
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **AHIS** > **Page 4**



AHIS Control Record, Page 4

- **M/R Charts By Acct# Y/N:** Either Medical Record number or Account number may be used to track patient account charts. If the Medical Record number is used, the location entered for tracking will display on all accounts that have the same medical record number. If an Account number is used, the location entered for tracking will only display on the Account number that was entered. The default for this field is **N**, which will track by Medical Record number. To change this field, please contact a TruBridge Financial Software Support Representative.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **AHIS** > **Page 6**



AHIS Control Record, Page 6

- **MR Chart Perm. Loca.:** This field is the name of the M/R Chart permanent location. This field will display the location of the chart when returned to Medical Records.

When a chart is moved to this permanent location within Chart Tracking, the system will check for deficiencies. If any exist, the system will flash “Chart Deficiency” and will not allow the chart to be transferred to this location.

Chart/Film Locations Table

Access **MR Chart Locations** within the HIM Table Maintenance to set up the codes for maintaining chart locations within the TruBridge EHR system. The codes may be up to three characters in length.

Select **Web Client** > **Tables** > **HIM** > **MR Chart Locations** > **Select Code**

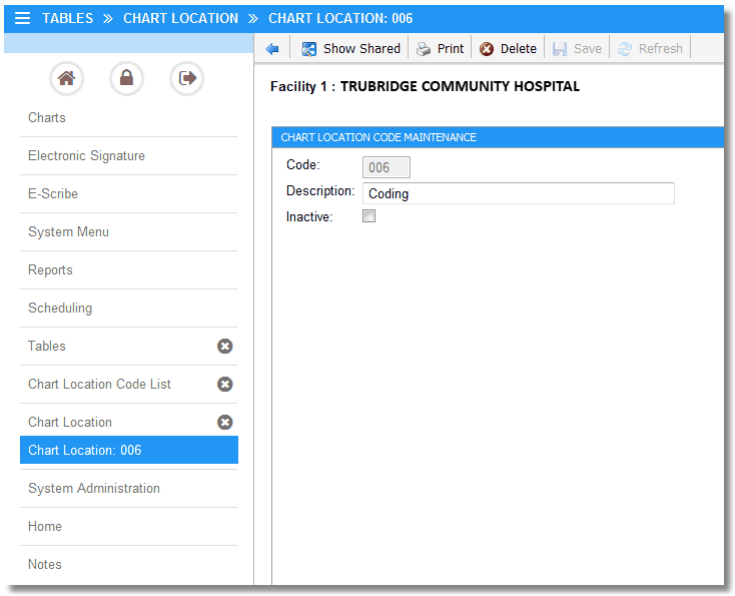
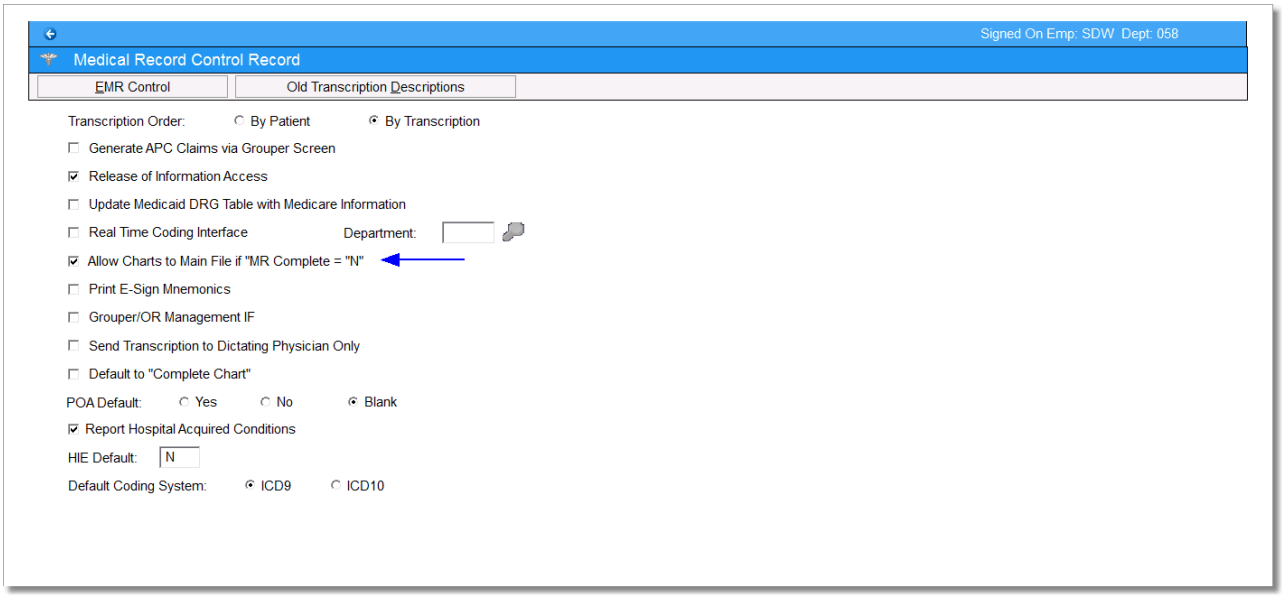


Chart Location Maintenance

Medical Records Control Inforamtion Table

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Med Rec**



Medical Record Control Record

- **Allow Charts to Main File if "MR Complete = N":** Select this option if Charts are allowed to go to the Main-File if the Medical Records Grouper screen has not been completed. Leave this field blank to prevent charts from going to the Main-File until coding is completed.

10.3 Chart Location for a Selected Patient

Entering a Location for a Selected Patient

To enter chart locations for a selected patient, lock onto the patient from the Hospital Base Menu or Master Selection screen to access the Patient Functions screen.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Chart Location Maintenance**

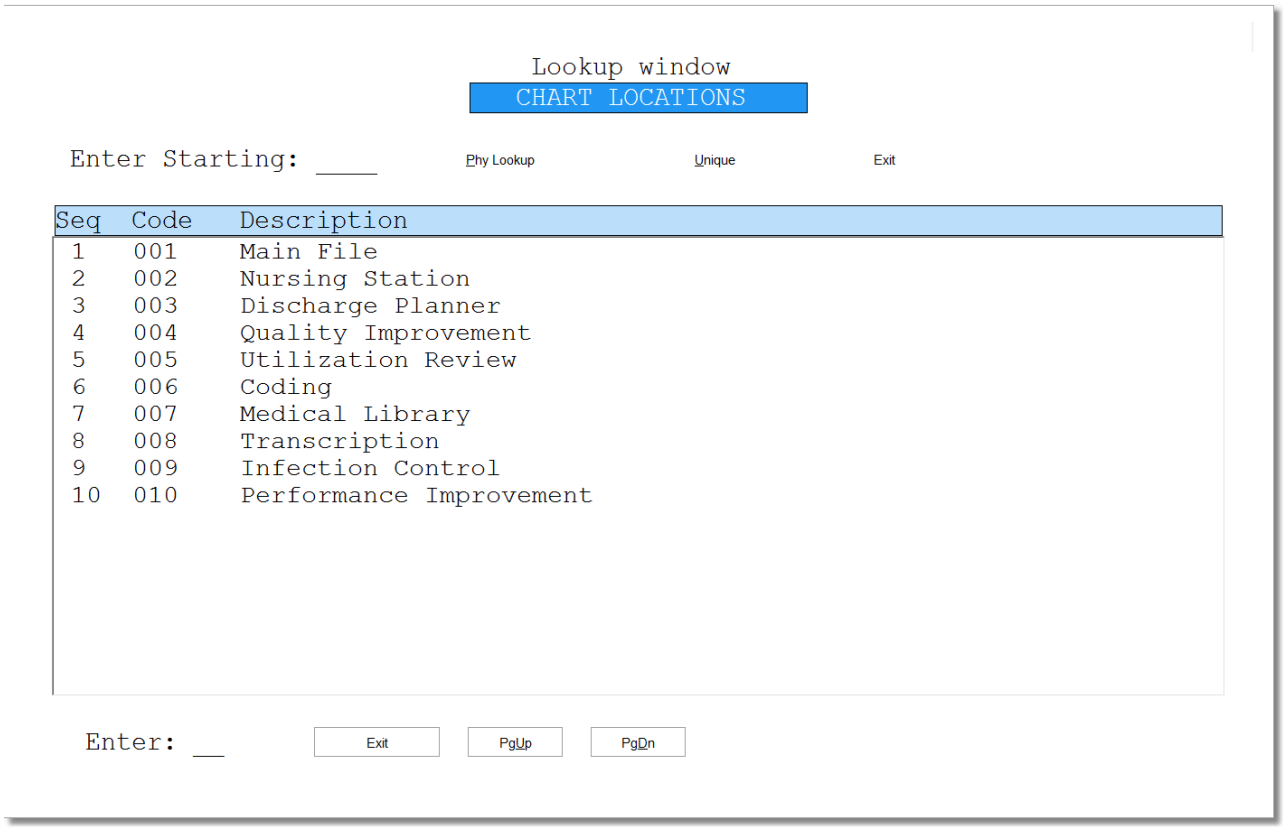


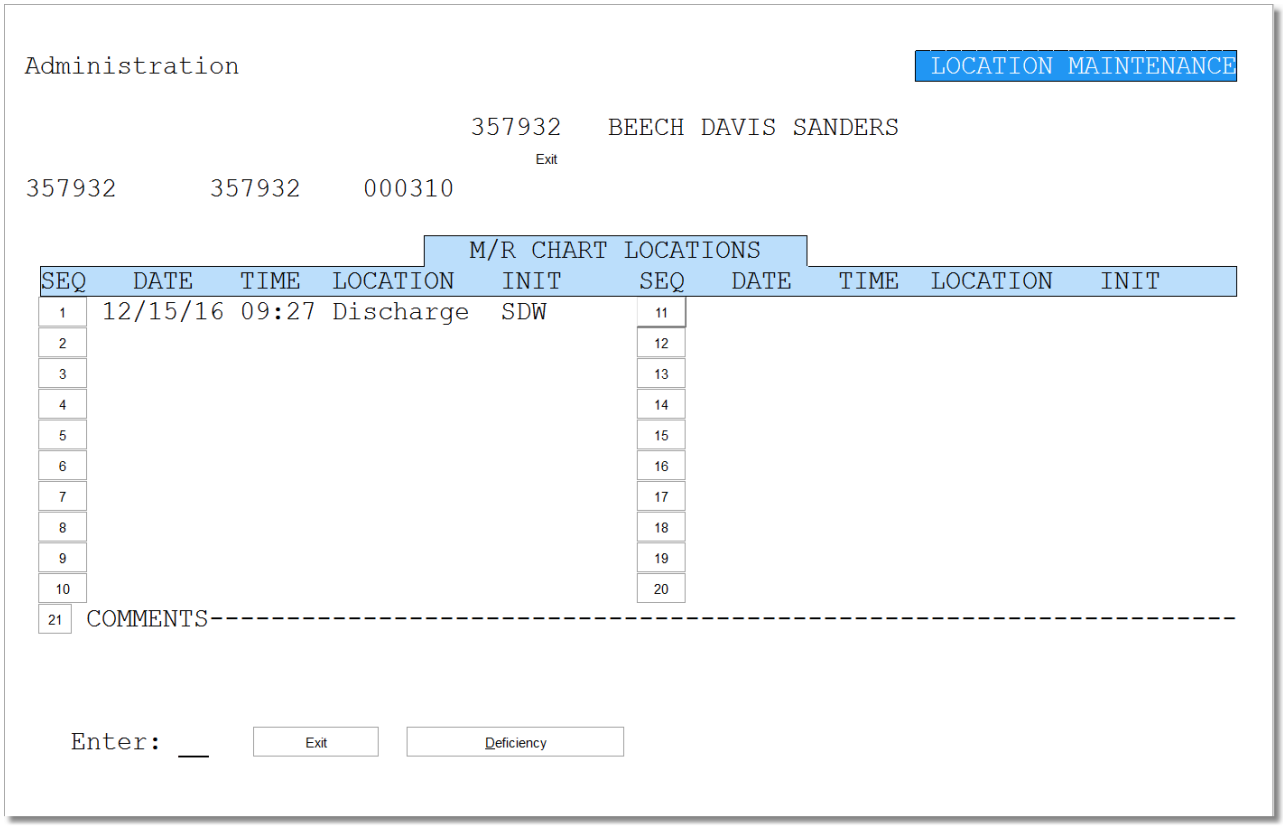
Chart Locations

If the Chart Location Code is known, it may be entered at the Enter Starting prompt. If not, there is a Physician Lookup that may be accessed by entering a **?** at the Enter Starting prompt. To enter the location of the patient's chart, enter the sequence number at the bottom of the screen. A location that is not listed may also be entered by using the ***** Unique option and then entering a location. The system date and time along with the Chart Location will be recorded. If using Employee Sign On, the employee initials will appear in Chart Location History.

Viewing a Location for a Selected Patient

To view the location of a chart for a selected patient, lock onto the patient from the Hospital Base Menu or Master Selection screen to access the Patient Functions screen.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Chart Location History**



Location Maintenance

The Location History will display a maximum of 20 past/present locations. This screen will display the chart's location, including the date and time that the location entry was made. Field 21 is a comment line that may be used for notes or comments concerning the chart.

Chart locations and comments may be corrected by entering, from the bottom of the screen, the sequence number of the item to be corrected. Once the cursor is on the selected field, the data may be re-keyed with the new information. To delete an entire line, enter the sequence number of the line to be deleted, enter the pound sign (#) and press Enter. Selecting **D**eficiency at the bottom of the screen will display the Chart Deficiency Maintenance screen for the selected patient.

10.4 Chart Location for Mass Entry

Entering a Location Using Mass Entry

The Mass Entry option should be used when there are a large number of charts that need locations entered.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Chart Location Mass Entry**

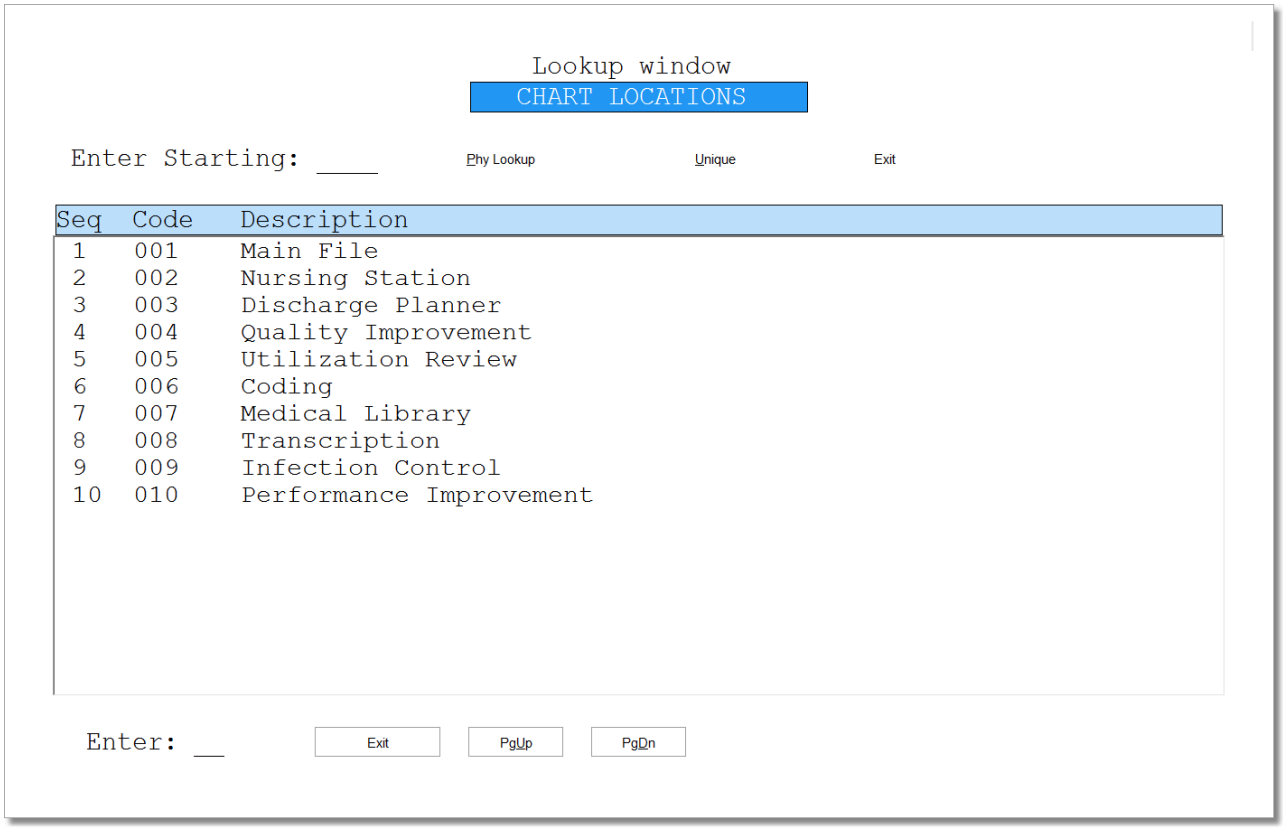
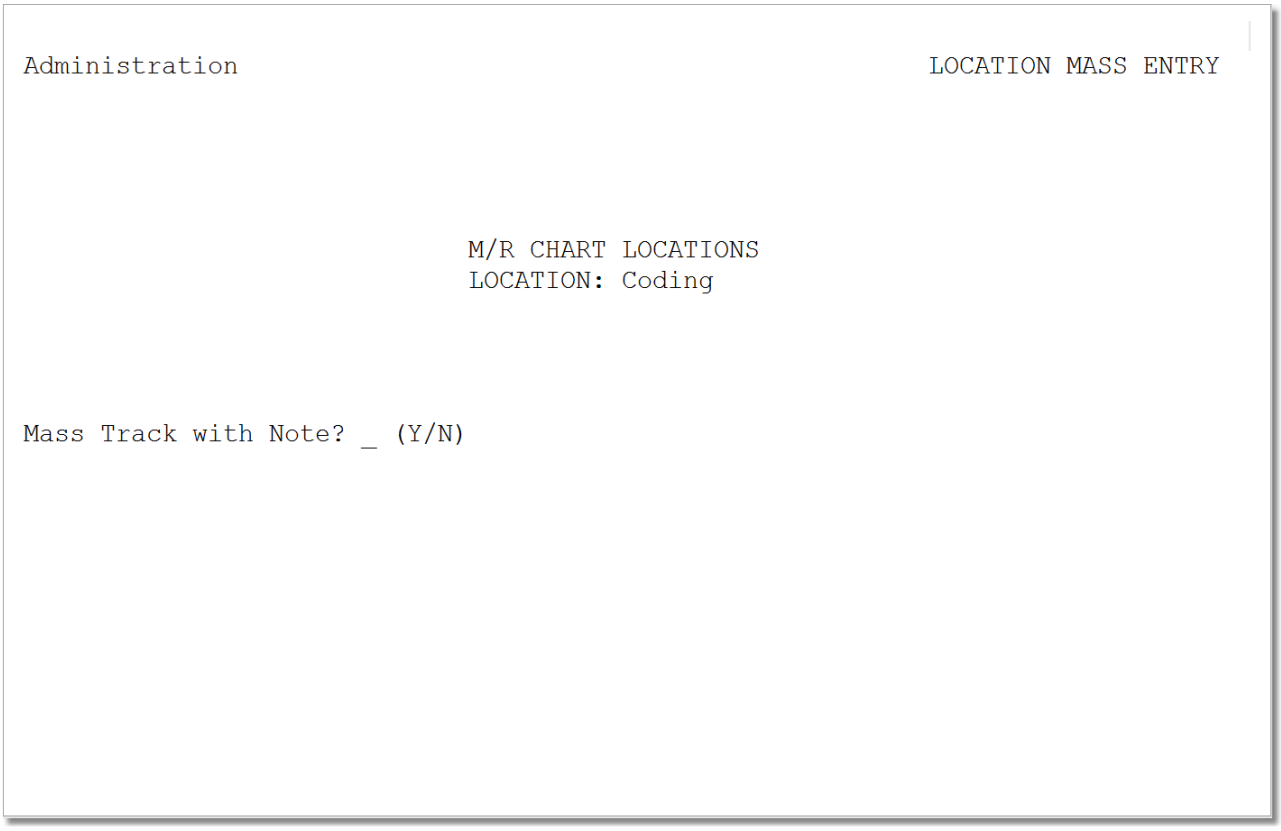


Chart Locations

If the Chart Location Code is known, it may be entered at the Enter Starting prompt. If not, there is a Phy Lookup that may be accessed by entering a **?** at the Enter Starting prompt. To enter the location of the patient's chart, enter the sequence number at the bottom of the screen. A location that is not listed may also be entered by using ***** Unique and then entering a location. The system date and time along with the Chart Location will be recorded. If using Employee Sign On, the employee initials will appear in Chart Location History.

After entering a location, the following screen will appear:

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Chart Location Mass Entry** > **Sequence #**



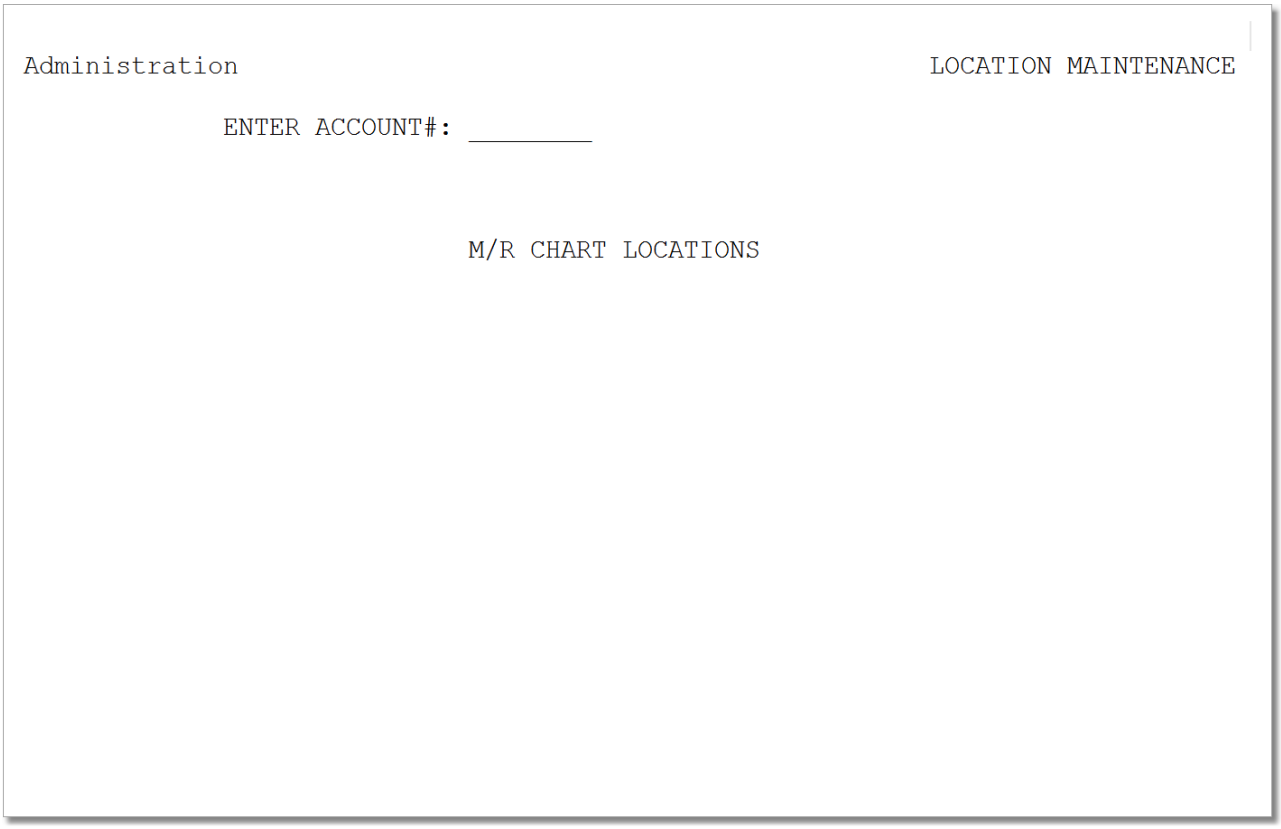
Location Mass Entry

The system will prompt, "Mass Track with Note? (Y/N)". If the prompt is answered with a **Y**, the system will allow a comment to be entered. The comment that is entered will update to all of the accounts put into this location.

The system will then prompt for either a M/R Number or an Account Number, depending on how Medical Records Chart Tracking is set in AHIS page 4. Multiple numbers may be entered for this location. After entering either a M/R or Account number, the prompt “Okay?” will appear. If the number entered is correct, Enter through this field; otherwise, enter an **N** and the cursor will allow the number to be re-entered. If the number does not exist, the message “This account is not on file, create chart record?" will appear. Selecting **NO** will take the cursor back to the beginning of the line so another number can be entered. Selecting **YES**, the chart location system will track a chart with a Medical Record number or Account number that does not exist. When finished entering all numbers, type **0** to return to the Medical Records menu. To enter another location for charts, select **Chart Location Mass Entry**.

Viewing a Location using Mass Entry

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Chart Location Maintenance**



Location Maintenance

The system will prompt for either the Account number or Medical Record number, depending on how Medical Records Chart Tracking is set in AHIS page 4, M/R Charts by Acct# field. The only difference between chart location maintenance for multiple charts and chart location history for a selected patient is the number of steps to get to the Location Maintenance screen. This mass entry option aids in time efficiency when doing maintenance. The Location History will display a maximum of 20 past/present locations. This screen will display the chart's location, including the date, time and employee initials that the location entry was made. The employee must be using Employee Sign On in order for their initials to appear. Also, these initials cannot be over-keyed. Field 21 is a comment line that may be used for notes or comments concerning the chart. This field cannot be accessed unless there is a location listed in fields 1-20.

Chart locations and comments may be corrected by entering, from the bottom of the screen, the sequence number of the item that needs correcting. Once the cursor is on the selected field, the data may be re-keyed with the new information. To delete an entire line, enter the sequence number of the line to be deleted, enter the pound sign (#) then press Enter. Selecting **D**eficiency at the bottom of the screen will display the Deficiency Maintenance screen for the selected patient.

Purging Chart Locations

The system will run a purge program daily on chart locations. The system will look to the last location entry on the chart. If the location is not the permanent storage location loaded in AHIS page 6, MR Chart Perm.Loca field, it will skip this chart and move to the next patient's chart to determine if it needs to be purged. If the last location is the permanent location, and it has been there less than 30 days then it will skip to the next patient's chart. If the chart has been in the permanent location longer than 30 days, it will purge the patient's chart from the location file. If there is no location entered on the chart, the system will purge the chart from the location file.

NOTE: *When a chart is moved to the permanent location within Chart Tracking, the system will check for deficiencies. If any exist, the system will flash "Chart Deficiency" and will not allow the chart to be transferred to this location.*

Chapter 11 Chart Deficiency

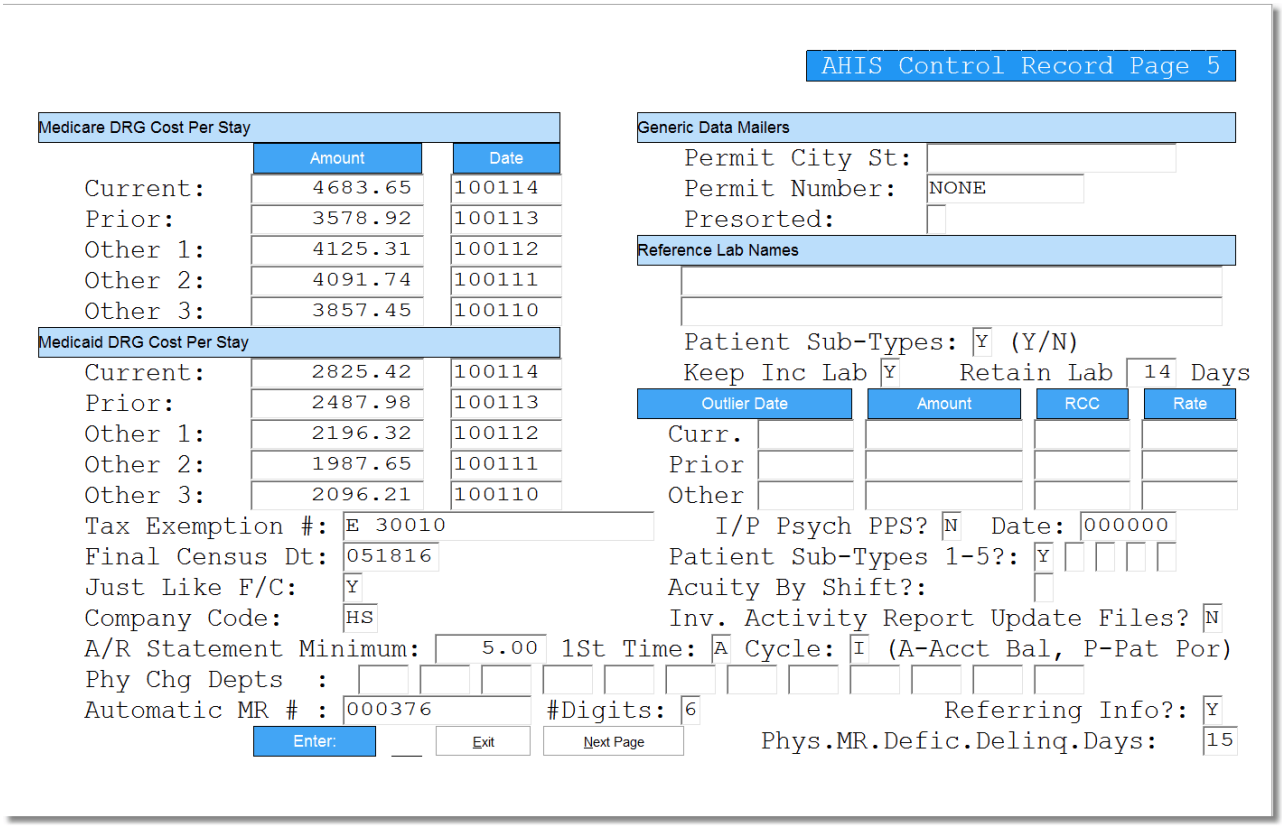
11.1 Overview

The primary use of the Chart Deficiency system is to provide Medical Records with a useful and efficient method of detecting chart deficiencies and discrepancies. The system is a very useful tool in communicating with physicians or employees on chart deficiencies in which they are responsible. In addition to this, the deficiency reports will note the action that should be taken to correct the deficiency(s).

11.2 Setting Up Chart Deficiency

AHIS

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > AHIS > Page 5**

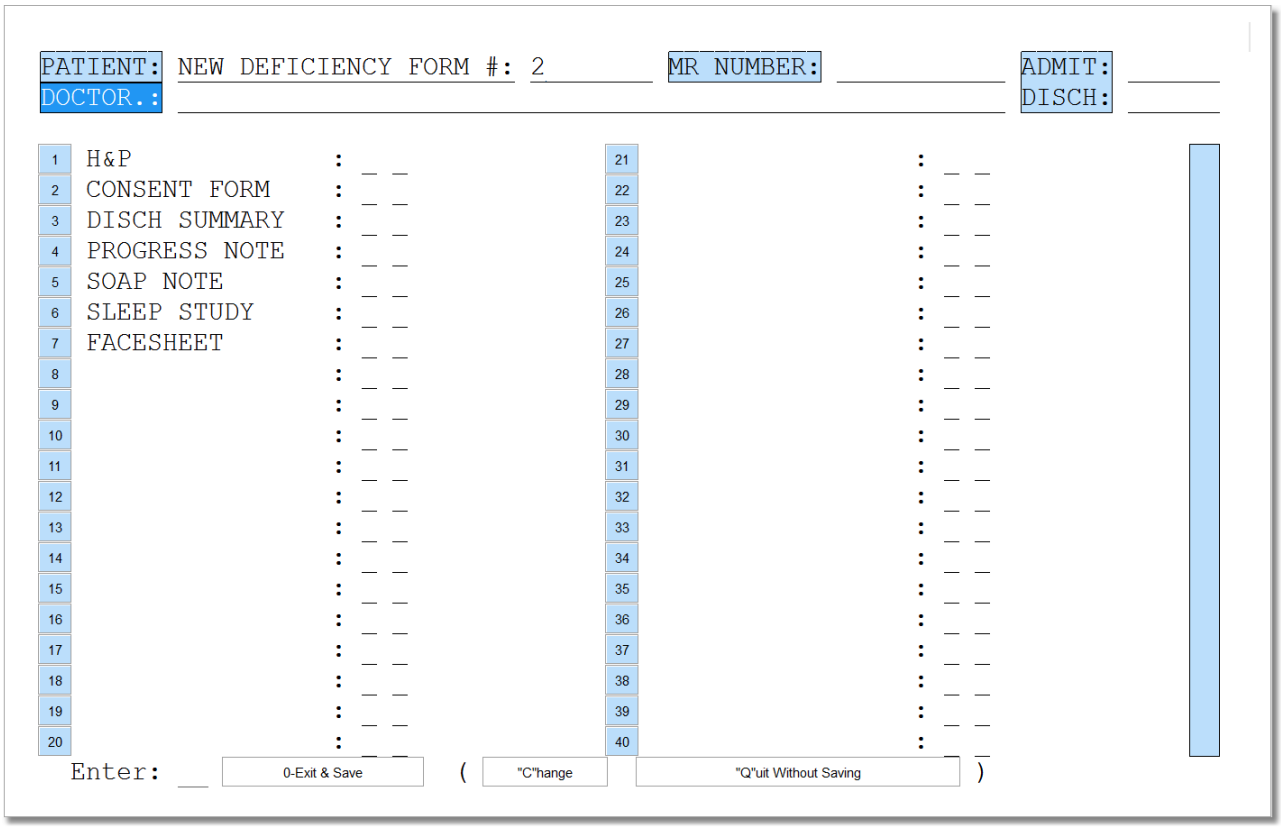


AHIS Control Record, Page 5

- **Phys. MR. Defic. Delinq. Days:** This is the number of days from the discharge date that a deficiency will be considered delinquent. When printing deficiency letters, a physician will receive a letter if the Medical Records are incomplete for a patient that has been discharged over the number of days loaded. Also, this number defines the aging columns in the Deficiency Report by Physician/Employee.

Deficiency Forms

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Deficiency Setup**



New Deficiency Form

The Chart Deficiency System will allow nine different forms to be set up. Numbers one through nine identify the different forms. Each form has 40 fields in which the description for possible deficient areas may be entered.

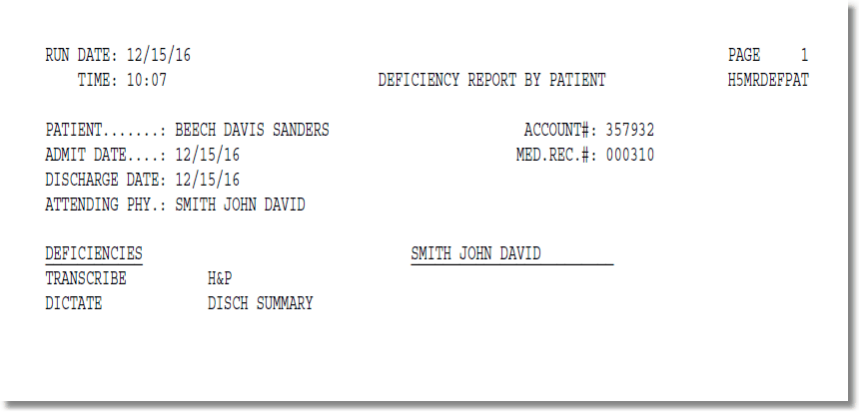
After accessing this screen, the prompt "New Deficiency Form #" will display. The number of the form to be setup should be entered. When the number has been selected, the cursor will stop at each field allowing a description to be entered. If a form has previously been setup, when the form number is entered, the system will display those deficiency descriptions already setup and changes may be made. If a field needs to be deleted, entering the pound sign (#) in the first character of the field will delete the line. To delete an entire form, each field will have to be deleted.

After entering all deficiencies, enter **0** and Enter to move the cursor to the bottom of the screen. From there, **C**hange may be selected to make changes to the deficiencies, **0** may be entered to save and exit out of the form, or **Q**uit Without Saving may be entered to exit out of the form without saving the changes made.

11.3 Deficiency Procedures

Deficiencies for a Selected Patient

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Chart Deficiency Maintenance** > **Form #** > **Print**


RUN DATE: 12/15/16 PAGE 1
TIME: 10:07 DEFICIENCY REPORT BY PATIENT H5MRDEFPAT

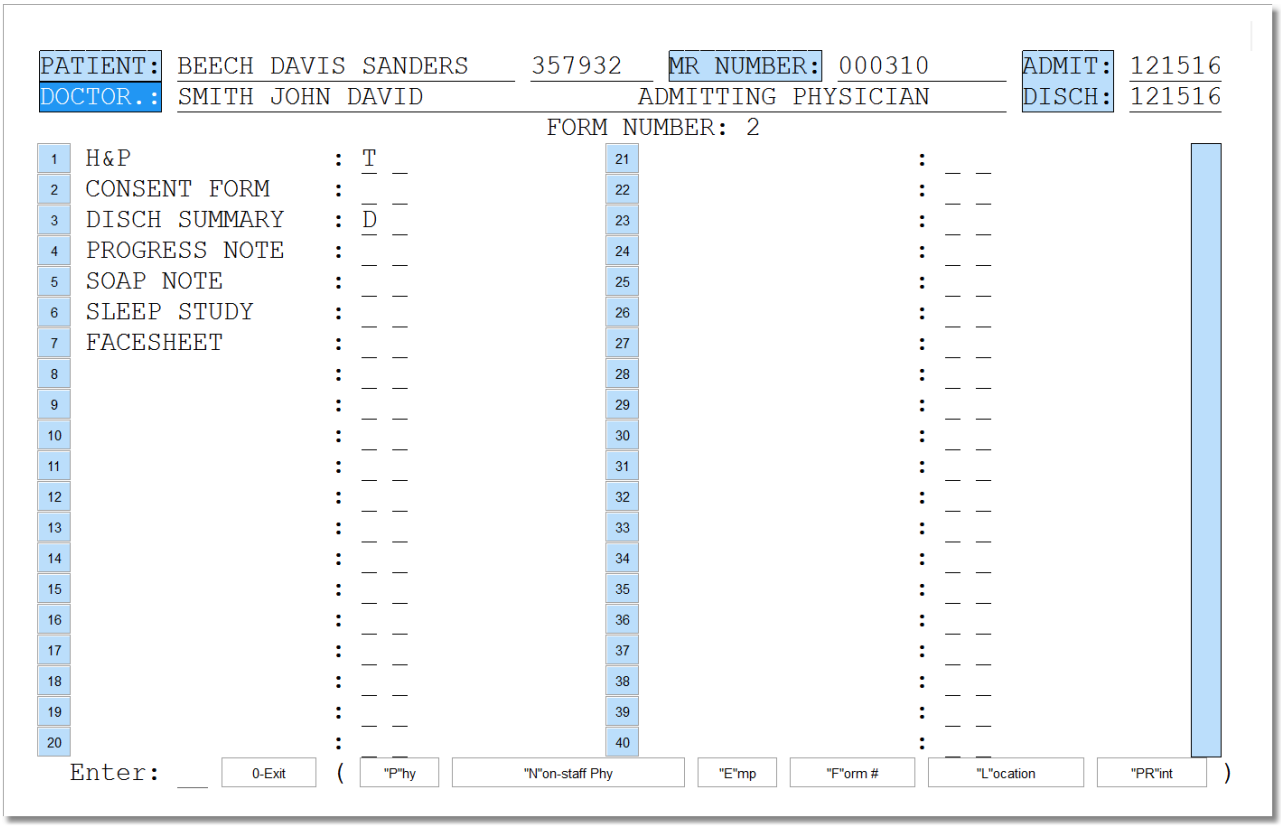
PATIENT.....: BEECH DAVIS SANDERS ACCOUNT#: 357932
ADMIT DATE....: 12/15/16 MED.REC.#: 000310
DISCHARGE DATE: 12/15/16
ATTENDING PHY.: SMITH JOHN DAVID

DEFICIENCIES SMITH JOHN DAVID
TRANSCRIBE H&P
DICTATE DISCH SUMMARY

Deficiency Form List

If a deficiency form has already been entered for this patient, the form number will appear. If a deficiency form has not been entered for this patient, it will display “NONE FOUND”. Select the form number to be used to enter deficiencies. Once the desired form displays, the actions needed to complete the patient’s chart may be entered. The needed information may be from the patient’s attending physician, a hospital employee or any additional physicians.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Chart Deficiency Maintenance** > **form**



Deficiency Maintenance

The system defaults to the attending physician and will display his or her name at the top of the screen. If a deficiency needs to be entered on another physician or employee, enter **P** for Physician, **N** for Non-staff physician or **E** for Employee, from the bottom of the screen. This will display a lookup list in which part of the name may be entered for faster access. The name of the chosen physician or employee will display on the top of the screen next to “Doctor”.

One of the following codes may then be entered on any of the deficiency lines:

- **C** Complete
- **S** Signature
- **D** Dictation
- **T** Transcription
- **W** Write

NOTE: *The first column next to each deficiency description is where the attending physician deficiencies are recorded. The second column is where any other physician or employee deficiencies are recorded.*

Another form number may be entered for this patient by entering **F** for Form # at the bottom of the screen. To access Chart Location, enter **L** for Location at the bottom of the screen.

When **PR**int is selected, the system will prompt for a print option to be chosen. Then the system will prompt “PRINT FOR ALL PHYSICIANS/EMPLOYEES?: (Y/N)”. If **N** is selected the system will prompt “ENTER P-PHYSICIAN OR E-EMPLOYEE” (P/E/0)”. Depending on the response to this prompt, the system will then prompt either “Enter Physician Number” or “Enter Employee Number”.

Entering Deficiencies for Several Patients

The Mass Entry feature of the deficiency system is used when there are several different patients that have deficiencies that need to be entered. This will allow greater accessibility when entering deficiencies on multiple patients. To enter deficiencies for multiple patients, Select Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records > Mass Entry of Deficiency.

After entering the patient’s account number, if a deficiency form has already been entered, the form number will appear. If one has not been entered, “NONE FOUND” will display. Select the form number to be used to enter deficiencies. Once the desired form displays, the actions needed to complete the patient’s chart may be entered. The needed information may be from the patient’s attending physician, a hospital employee or any additional physicians.

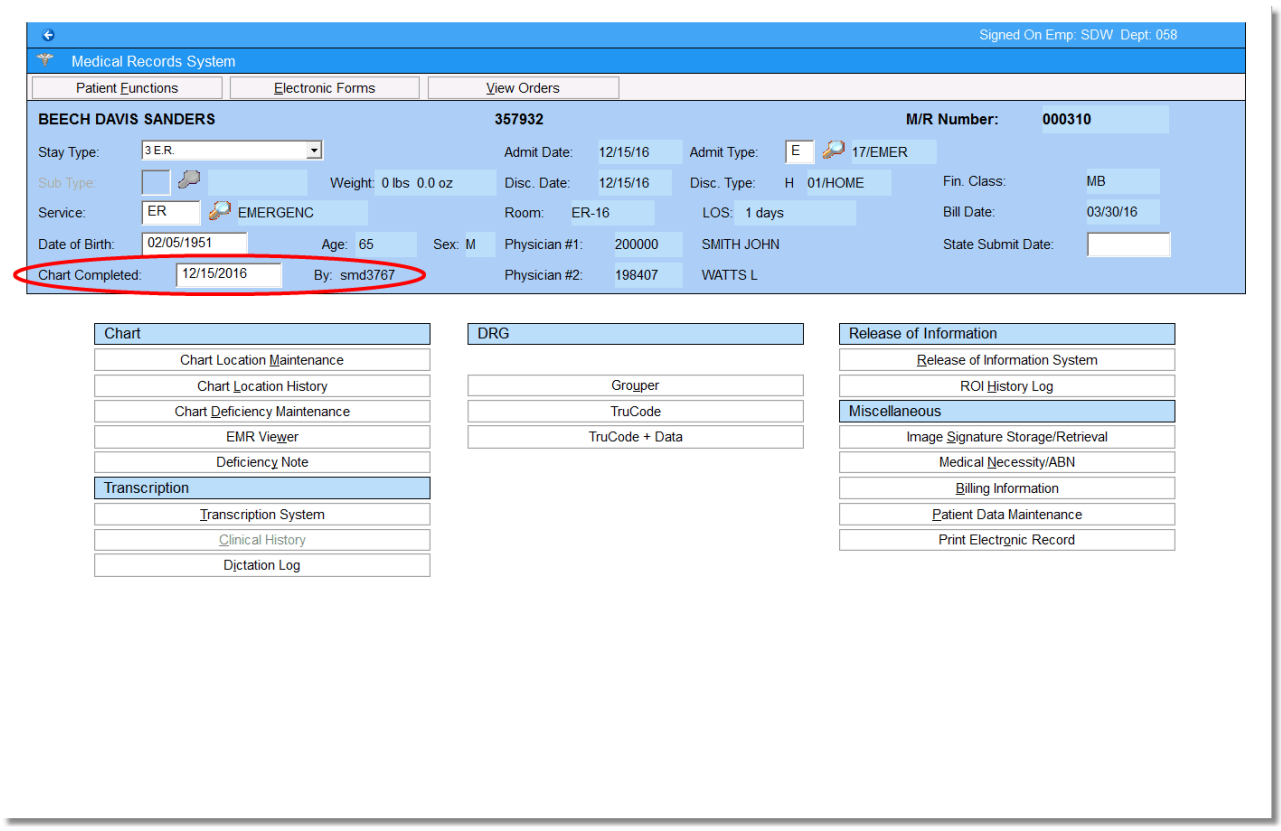
Removing Deficiencies after Completion

When a deficiency has been completed for a physician or employee, it is necessary to remove the deficiency from the Chart Deficiency screen. This will remove it from all deficiency reports and will prevent a physician from getting a deficiency letter. Once the chosen form is selected, if the physician is the Attending doctor, enter the sequence number of the deficiency that was completed. By entering the pound sign (#) it will remove the deficiency. If the completed deficiency was by another doctor or employee, the cursor will take you to the next column and allow you to change or enter the pound sign (#) to remove the deficiency.

All deficiencies for a particular physician may be removed at once from a single form. Entering a pound sign (#) at the bottom of the screen will remove all deficiencies for the selected physician. To remove the Attending Physician’s deficiencies, type the pound sign (#) at the bottom of the screen. To remove another physician or employee’s deficiencies, select the physician by entering a **P**, **N** or **E** at the bottom of the screen (the name will appear next to “Doctor” at the top of the screen) and type the pound sign (#) at the bottom of the screen.

Once all deficiencies for a particular chart have been removed, a Chart Completed date may be added to the account. When the Chart Completed date is entered, the system will display the User ID associated with the User Base Login of the employee entering the date.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records**



Medical Records System

Deficiency Letters to Physicians

Deficiency Letters may be printed for physicians to remind them of deficiencies that are delinquent. The deficiency delinquent days are determined by AHIS page 5, Phys.MR.Defic.Delinq.Days. Physicians will receive a letter when the number of days since discharge has reached the number entered in this field.

Deficiency Letters are set up in Word Processing using CP-Writer. Before doing any maintenance to Deficiency Letters that are setup in CP-Writer, verify that the TruBridge Word Processor is not set to Microsoft Word for Windows. To do this, select **Tools, Options** and **Programs.** Make sure Local Word Processor is set to **None.** Knowledge of TruBridge Word Processing is required when modifying the letters. Consult the TruBridge Word Processing User Guide or a Financial Software Support Representative for assistance.

The Deficiency Letter should be titled **DEFLETTER** and it is typically in the library **/usr/mr**. The library may be changed to another directory if there are disc space issues. Facilities with multiple companies would need to have a directory set up for each company's transcribed documents. Contact a TruBridge representative to have this setup completed.

The letter uses four identifiers to pull data from the system. Identifier ****NAME** will pull the physician name from the Name field under Physician Group Information in the Physician table. The identifier ****DATA** will pull patient information, along with areas of deficiency. This information will include

Patient Name, Account Number, Medical Record Number, Discharge Date, number of days since discharge that the chart has been deficient, the Deficiency, what is needed to complete the deficiency, Chart Location and number of days the chart has been in the listed location. The identifier ****NAME2** will pull the physician's name from the Name field in the Physician Table. The identifier ****PHAD** will pull the physician's address from the Physician Table. The identifier ****PHYSG** will pull the physician's name loaded in the Physician Security Table, Signature field (Path: Special Functions > System Management > root password > System Security > Physician Security).

***NOTE**: Refer to the Deficiency Letter to Physician section of the HIM Print Reports user guide regarding how to print the Deficiency Letter to Physicians.*

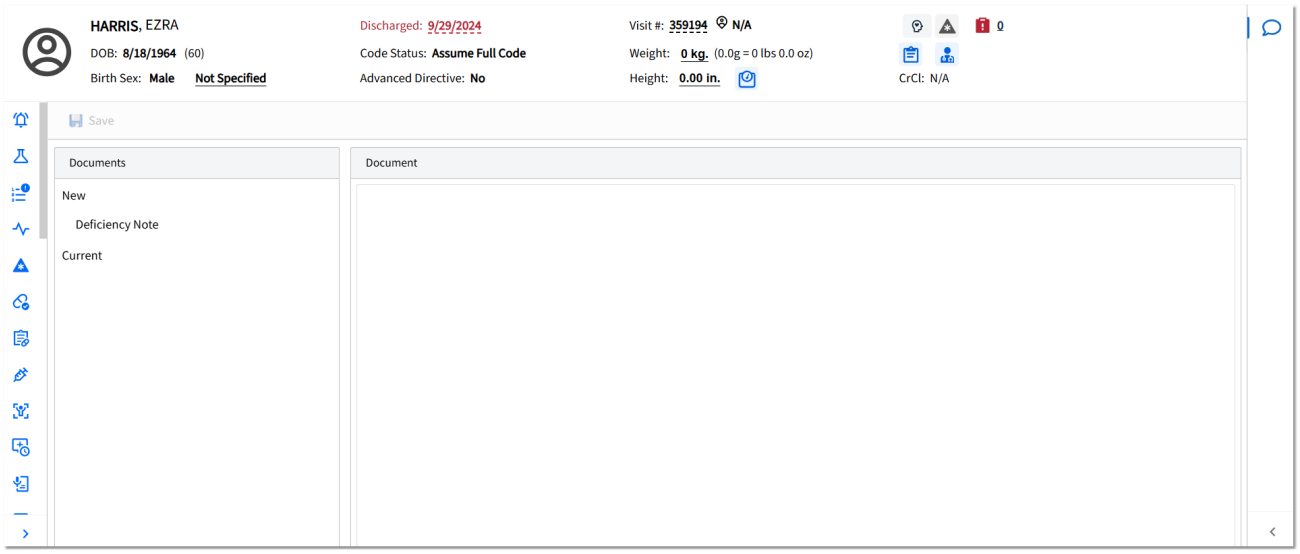
Chapter 12 Deficiency Note

12.1 Overview

The Deficiency Note option allows communication between the Health Information Management department and the Physician.

Select **Deficiency Note** to view an existing note or to create a new deficiency note on a patient account.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Deficiency Note**

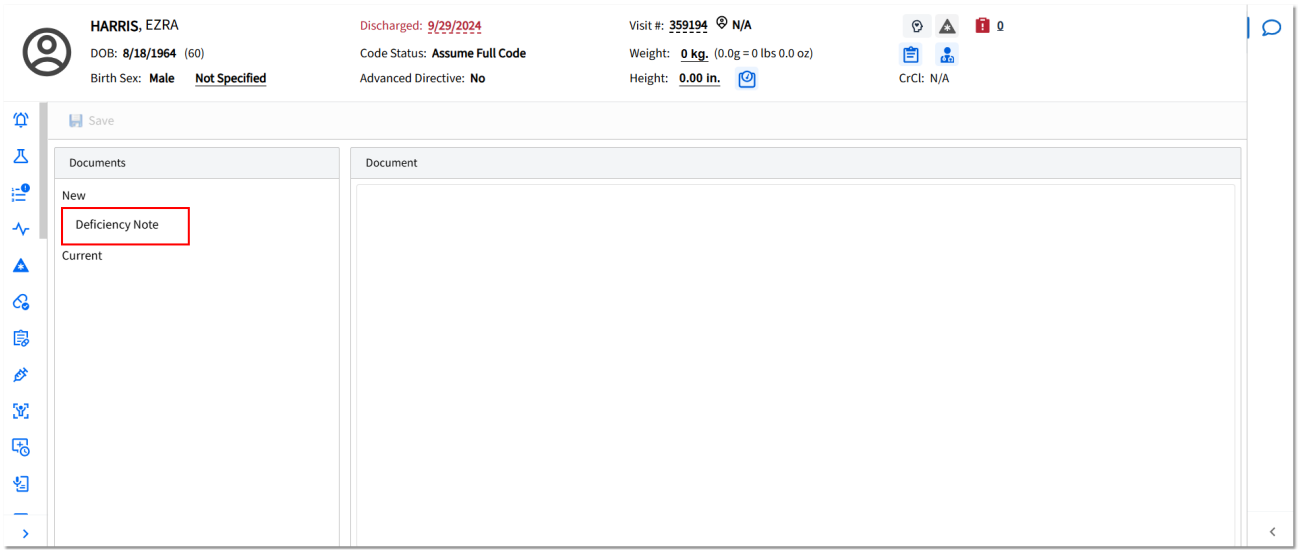


Deficiency Note

12.2 Sending a Deficiency Note

To create a new deficiency note, select **Deficiency Note**.

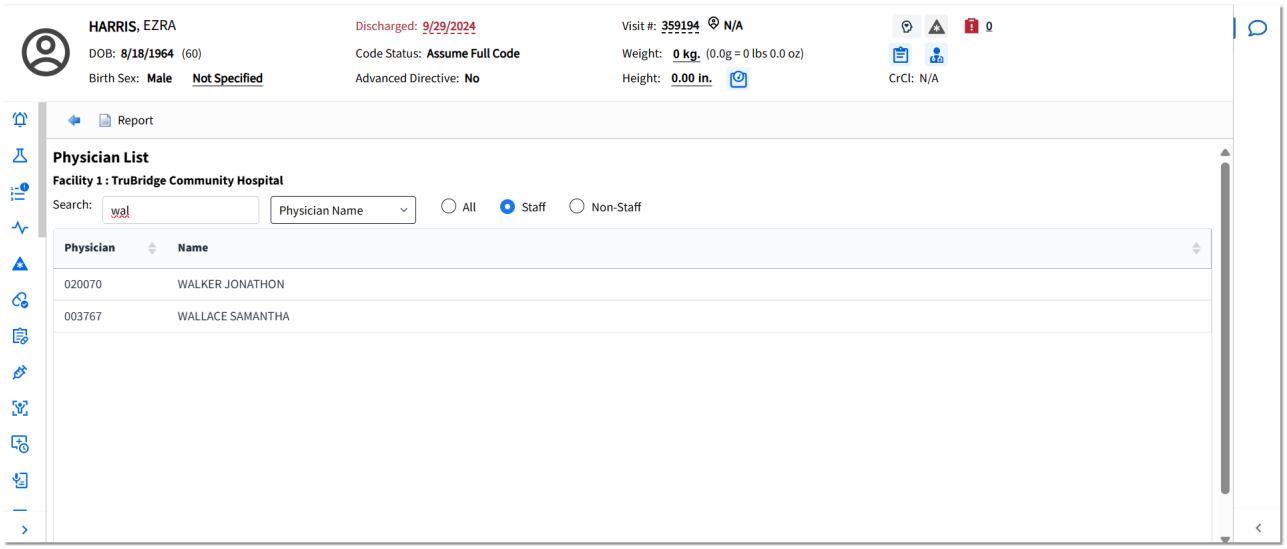
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Deficiency Note**



Deficiency Note

Once **Deficiency Note** is selected, a physician look up screen will display. Search for the physician by name or number, once the results are displayed, double-click the desired physician name.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Deficiency Note**> **Deficiency Note**

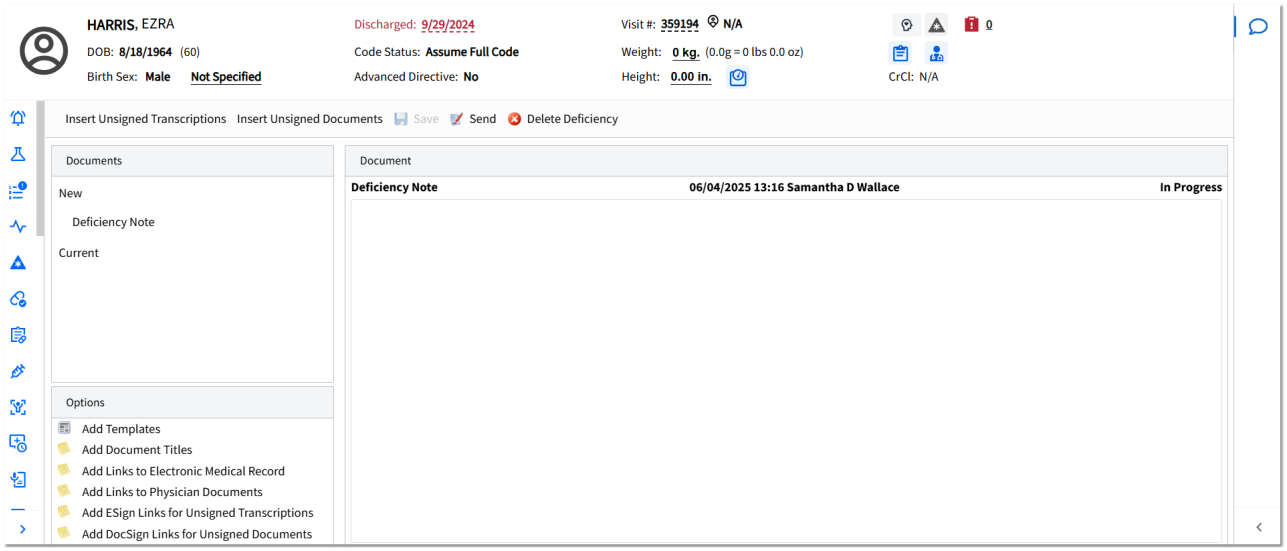


Search by Physician Name

Once a physician is selected, their name will display along with the creation date and time of the deficiency note. The status of the deficiency note will display as **In Progress.**

The **Document** section is free-text field where relevant note content can be entered.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Deficiency Note**> **Deficiency Note**



Deficiency Note

Once the physician has been selected, the following options become available from the action bar:

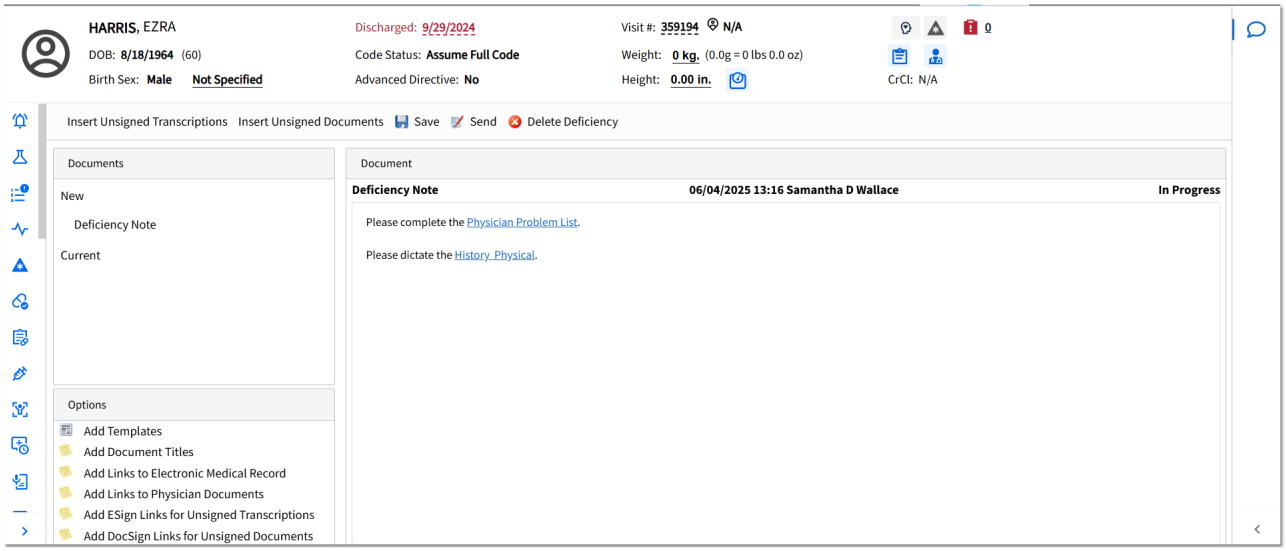
- **Insert Unsigned Documents:** Automatically inserts all unsigned images assigned to the selected physician on the patient's account.
- **Insert Unsigned Transcriptions:** Automatically inserts all unsigned Medical Records and Radiology transcriptions for the selected physician on the patient's account.

The **Options** section allows users to insert information into the deficiency note document. The available options are:

- **Add Template:** Allows ability to insert a prepared Physician Documentation template and enter documentation prompted by the template.
- **Add Document Titles:** Allows the ability to insert titles listed in the Physician Headers table.
- **Add Links to Electronic Medical Record:** Allows the ability to insert links to documents listed in Print Electronic Record section on the patient's account.
- **Add Links to Physician Documentation:** Allows the ability to insert links to Physician Documentation documents signed by the selected physician on the patient's account.
- **Add Esign Links for Unsigned transcriptions:** Allows the ability to insert unsigned Medical Records and Radiology transcriptions for the selected physician on the patient's account.
- **Add DocSign Links for Unsigned Documents:** Allows the ability to insert unsigned images assigned to the selected physician on the patient's account.

NOTE: *For more information on physician documentation templates and documents, refer to the Notes user guide.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records** > **Deficiency Note**> **Deficiency Note**



Deficiency Note

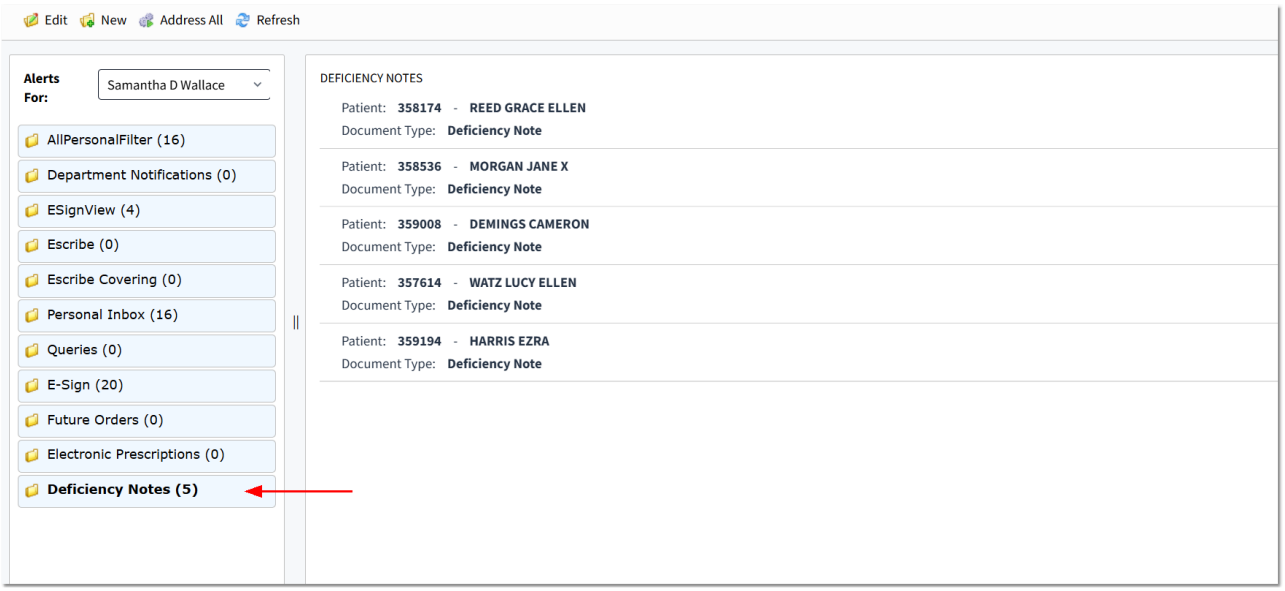
Once all information has been added to the deficiency note, select an option on the action bar. The following options are available:

- **Save:** Saves the deficiency note to the patient account. The note will remain in a status of **In Progress**, indicating it has been created but not yet sent to the Physician.
- **Send:** Saves the deficiency note to the patient's account and sends it to the physician. The status will update to **Sent to Physician**.
- **Delete Document:** Permanently deletes the deficiency note.

12.3 Physician Procedures

Once a deficiency note has been sent to the physician, it can be accessed from the physician's Tasks screen. If the Deficiency Note folder is not displayed, it will need to be created. Refer to the Deficiency Note Folder 251 section for more information.

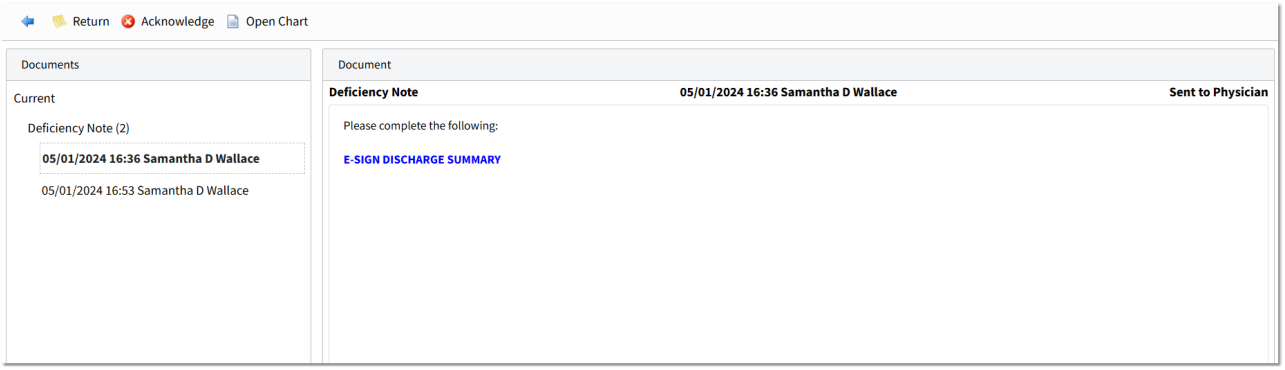
Select **Web Client** > **Home Screen** > **Tasks** > **Deficiency Notes Folder**



Home Screen, Deficiency Notes

- The **Address All** option can be selected to view and sign all deficiency notes listed.
- To view and sign a single deficiency note, select the individual note. The deficiency note will be displayed on the screen with a status of **Sent to Physician**.
- If a document link was included in the note, it can be accessed by double-clicking the link. Once all information in the deficiency note has been addressed, select the appropriate option on the action bar to proceed.

Select **Web Client** > **Home Screen** > **Tasks** > **Deficiency Notes Folder** > **Select Deficiency Note**



Deficiency Note

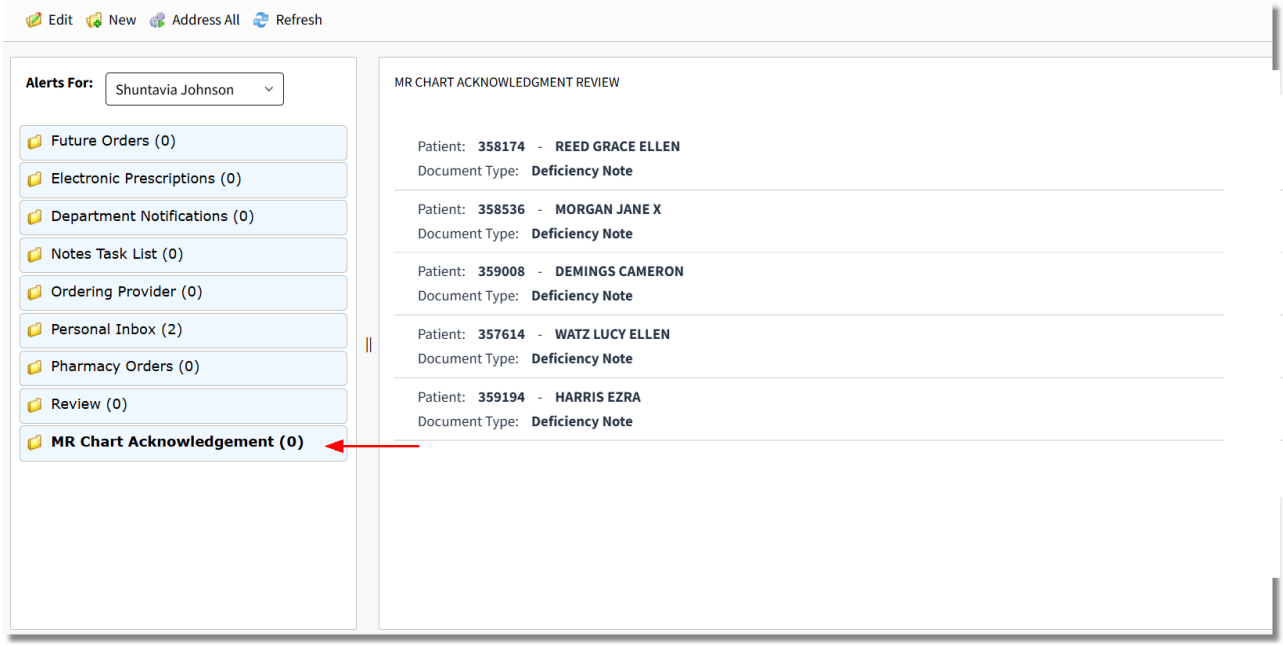
- **Return:** The physician selects this option to enter a note for the Health Information Management department. The deficiency note is then sent to the **Chart Acknowledgment Review** folder located on the Tasks screen.

- **Acknowledge:** The physician selects this option to acknowledge receipt and completion of the deficiency note. Once acknowledged, the note is also sent to the **Chart Acknowledgment Review** folder on the Tasks screen.

12.4 HIM Acknowledgement Procedures

Once the deficiency note is either **acknowledged** or **returned** by the physician, it will be sent to the **Medical Records Chart Acknowledgment Review** folder located on the Tasks screen.

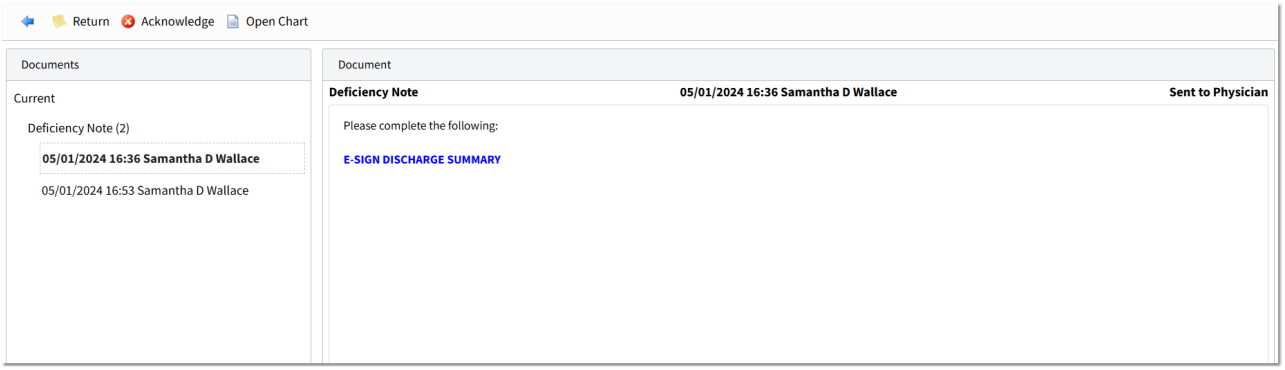
Select **Web Client** > **Home Screen** > **Tasks** > **Chart Acknowledgment Review Folder**



Home Screen, Chart Acknowledgment Review

- The **Address All** option may be selected to view and acknowledge all deficiency notes listed at once.
- To view and acknowledge a single deficiency note, select the individual note. The deficiency note will then be displayed on the screen.

Select **Web Client** > **Home Screen** > **Tasks** > **Deficiency Notes Folder** > **Select Note**



Deficiency Note

- **Acknowledge:** Selecting this option confirms that Health Information Management has reviewed the deficiency note. Once acknowledged, the note will be removed from the Chart Acknowledgment Review folder.

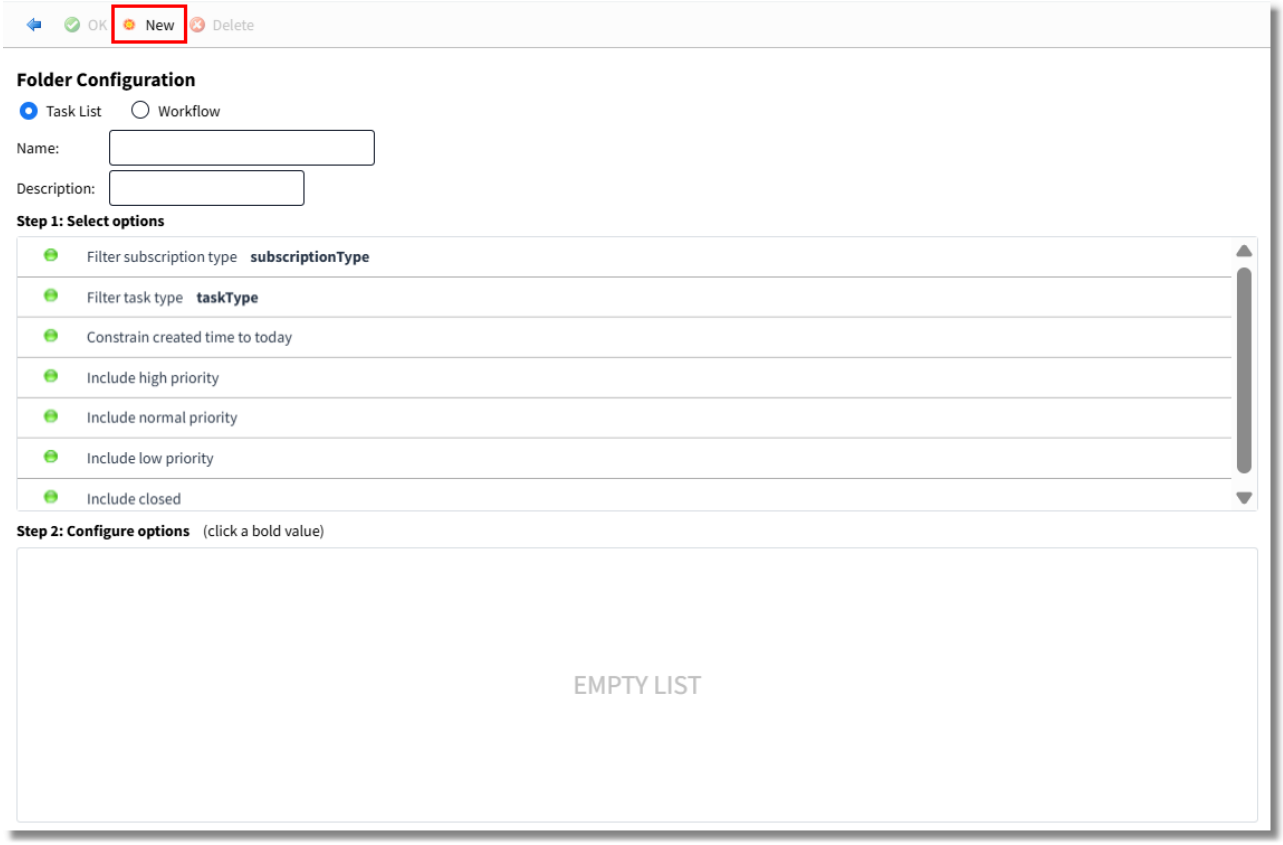
12.5 Deficiency Note Folder Setup

Deficiency Note Folder

When Deficiency Notes are sent to a provider, they will appear in the **Deficiency Note** folder on the Tasks screen. If the Deficiency Note folder is not present on the Tasks screen, it can be added by creating a new folder.

To add the Deficiency Note folder to a provider's Tasks screen, select **New**.

Select **Web Client** > **Home Screen** > **Tasks** > **New**



Folder Configuration

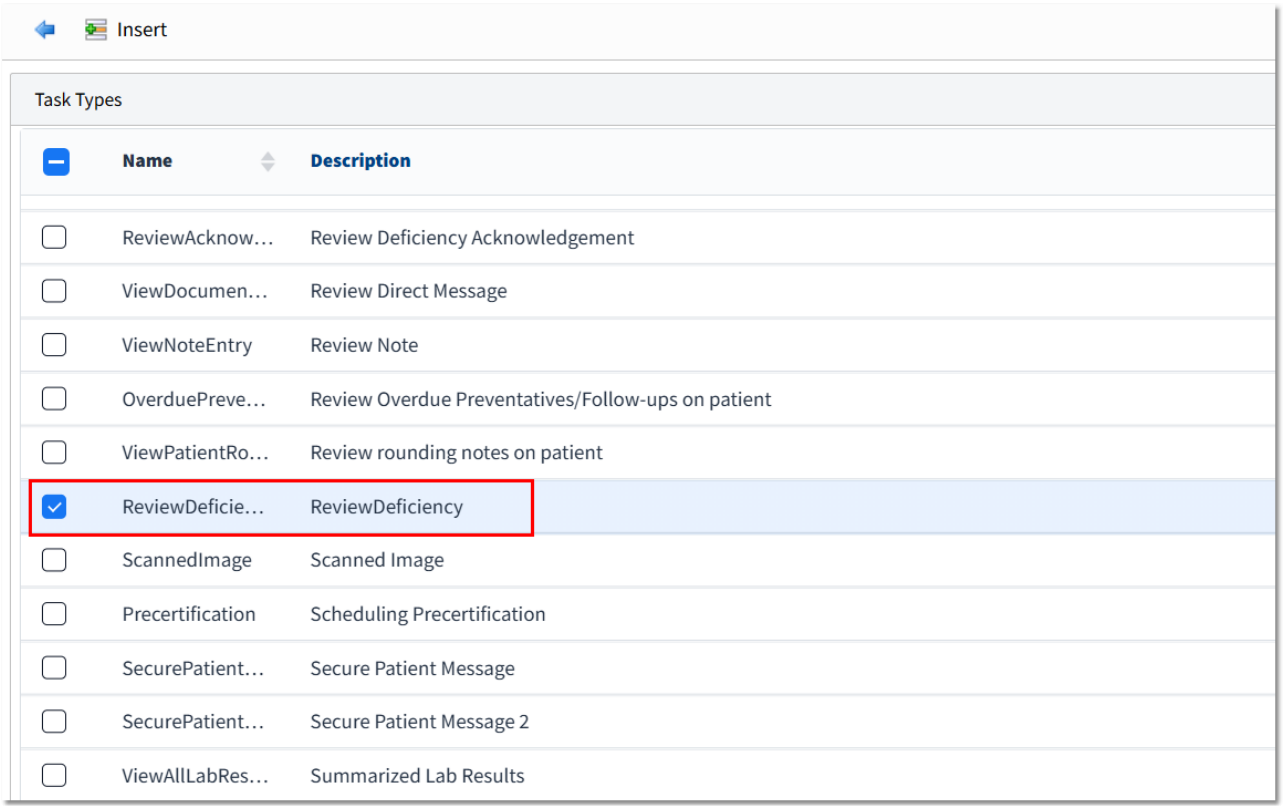
The Folder Configuration screen will display. To configure the folder, follow the steps below:

Select **Web Client** > **Home Screen** > **New** > **Tasks** > **Folder Configuration**

Folder Configuration - New

- Enter a **Name** for the folder. This name will appear as the label next to the folder icon on the Home screen.
- Enter a **Description** for the folder. The description will be displayed in the right-hand window after the folder is selected on the Home screen.
- Enter the **Filter Task Type** for the folder. In the **Step 1: Select options** section, select the green button next to **Filter task type**.
- Configure **Task Type** for the folder. In the **Step 2: Configure options** section, select the bold lettering **taskTypes** label. The Task Types list will display.

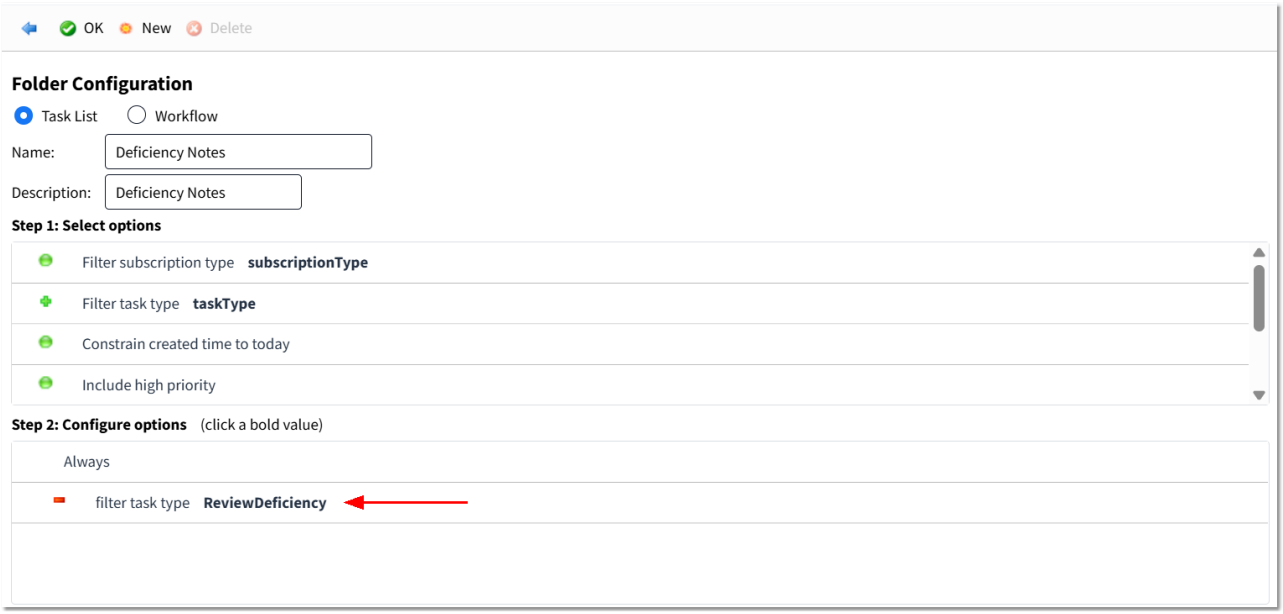
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration** > **Task Types**



Task Types

- Select **ReviewDeficiency**, then select **Insert**. The selected task type will then display on the Folder Configuration screen.

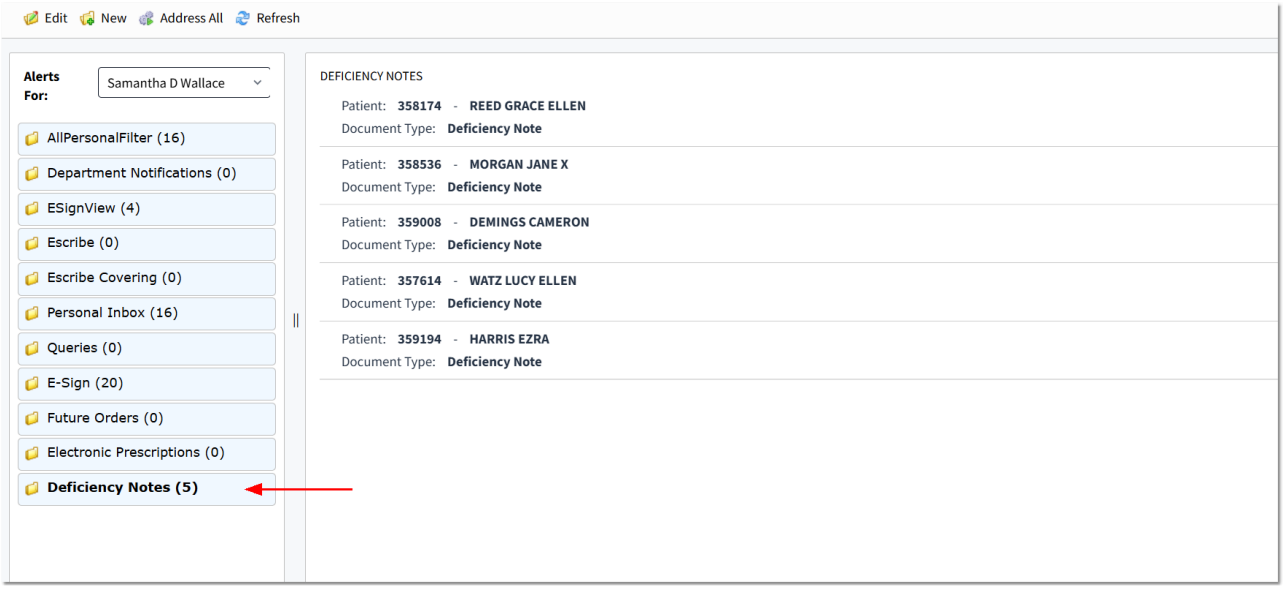
Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration**



Folder Configuration - New

- Once the task type filter is set, select **OK** from the action bar, and then select the **back arrow** from the action bar to return to the Home screen.

Select **Web Client** > **Home Screen** > **Tasks**



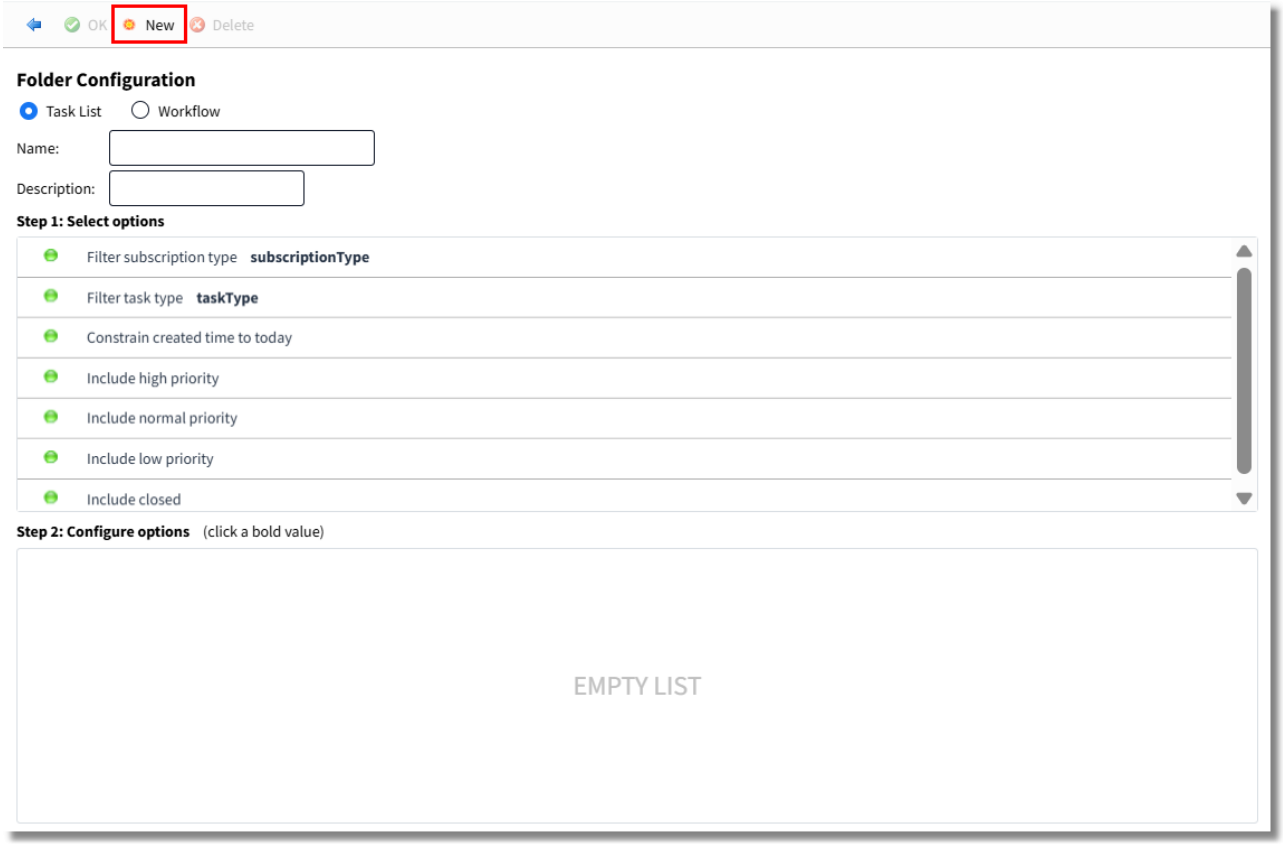
Home Screen - Tasks

Chart Acknowledgement Review Folder

When Deficiency Notes are sent to a provider, they will appear in the **Deficiency Note** folder on the Tasks screen. If the Deficiency Note folder is not present on the Tasks screen, it can be added by creating a new folder.

To add the Deficiency Note folder to a provider's Tasks screen, select **New**.

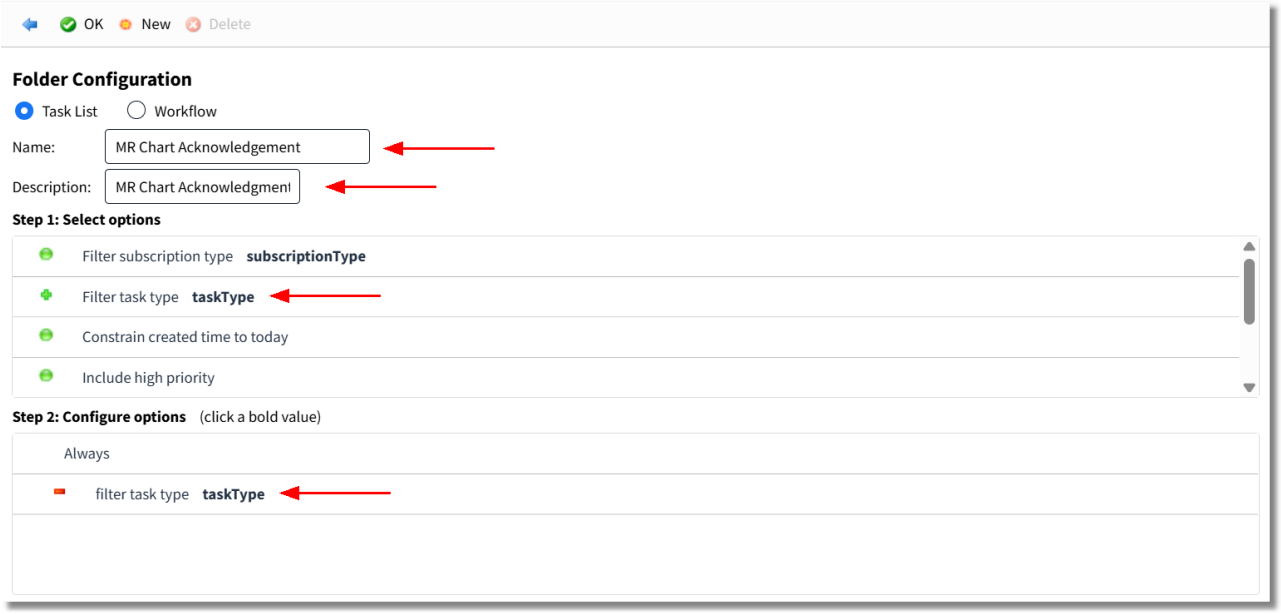
Select **Web Client** > **Home Screen** > **Tasks** > **New**



Folder Configuration

The Folder Configuration screen will display. To configure the folder, follow the steps below:

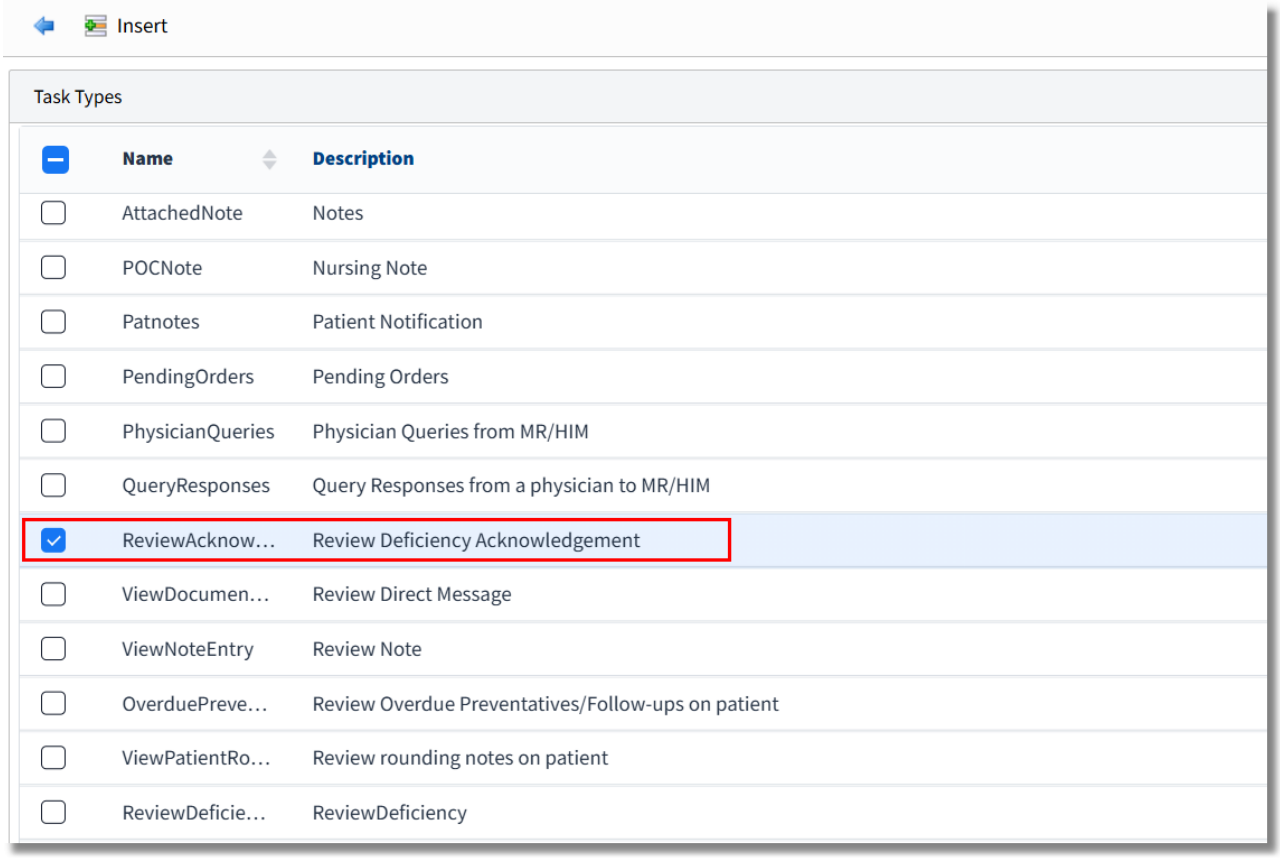
Select **Web Client** > **Home Screen** > **New** > **Tasks** > **Folder Configuration**



Folder Configuration - New

- Enter a **Name** for the folder. This name will appear as the label next to the folder icon on the Home screen.
- Enter a **Description** for the folder. The description will be displayed in the right-hand window after the folder is selected on the Home screen.
- Enter the **Filter Task Type** for the folder. In the **Step 1: Select options** section, select the green button next to **Filter task type**.
- Configure **Task Type** for the folder. In the **Step 2: Configure options** section, select the bold lettering **taskTypes** label. The Task Types list will display.

Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration** > **Task Types**



Task Types

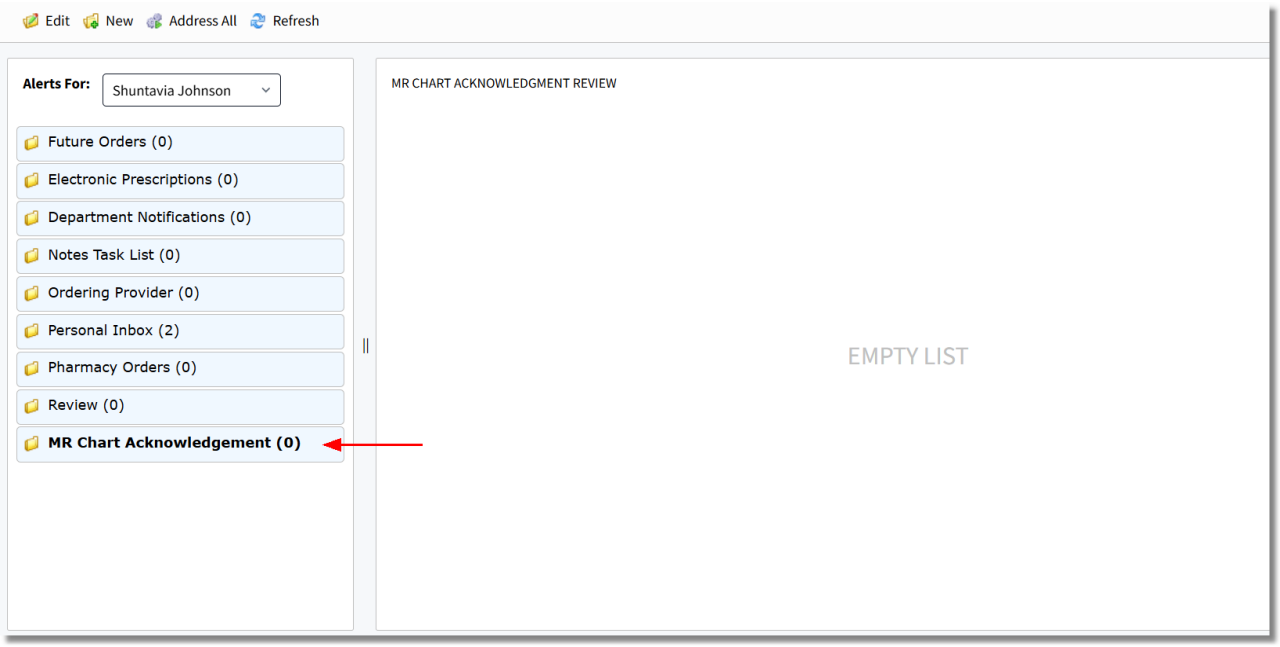
- Select **ReviewAcknowledgment**, then select **Insert**. The selected task type will then display on the Folder Configuration screen.

Select **Web Client** > **Home Screen** > **Tasks** > **New** > **Folder Configuration**

Folder Configuration - New

- Once the task type filter is set, select **OK** from the action bar, and then select the **back arrow** from the action bar to return to the Home screen.

Select **Web Client** > **Home Screen** > **Tasks**



Home Screen - Tasks

Chapter 13 EMR Viewer

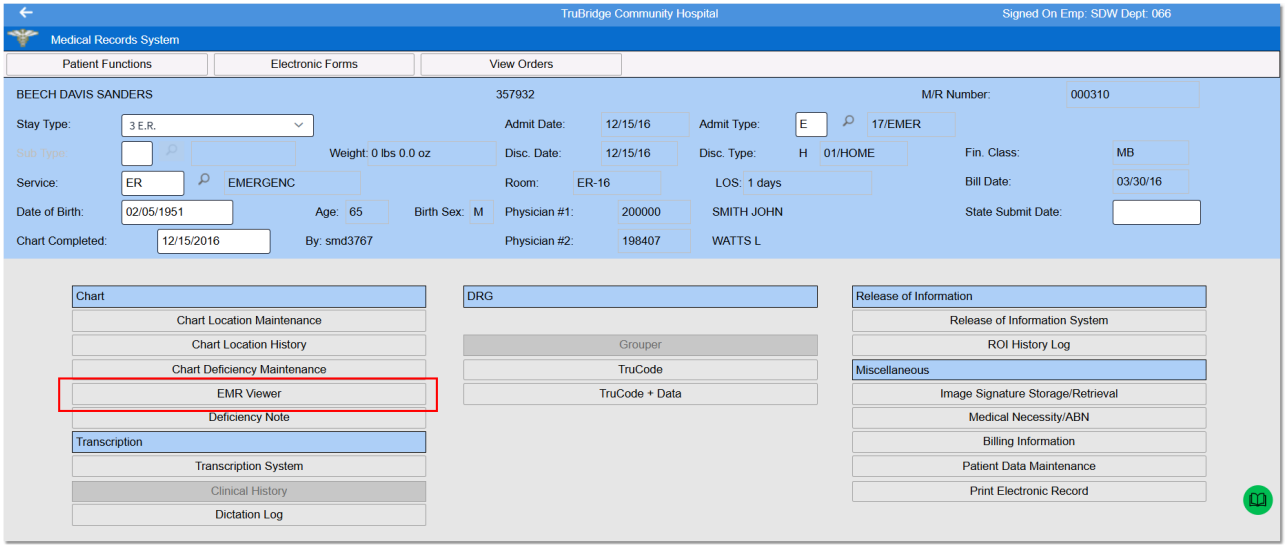
13.1 Overview

The option to view the patient's chart is available from the patient's Medical Records menu. Selecting the **EMR Viewer** option will launch the user straight to the Patient Chart. This view-only access is intended Medical Records staff and supports accurate coding on accounts.

13.2 EMR Viewer Option

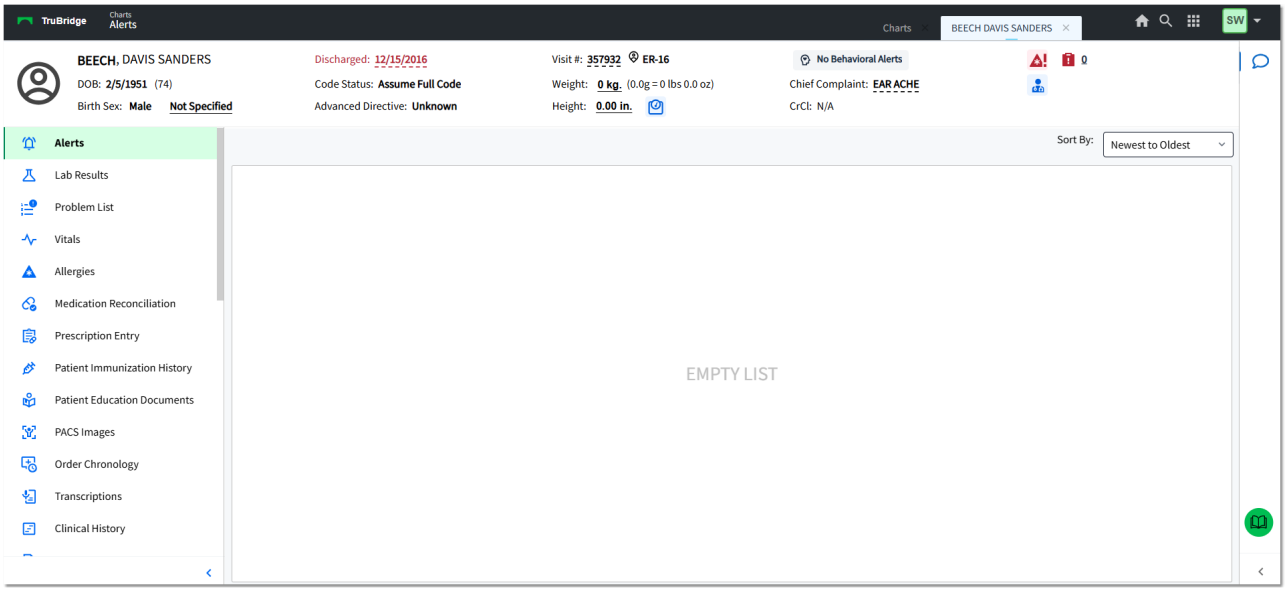
Once the EMR Viewer option is accessed the patient's chart becomes available. Please refer to the Patient Chart User Guide's for more information.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient Account #** > **Medical Records**



Medical Records System

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > EMR Viewer**



EMR Viewer

Chapter 14 Master Patient Index

14.1 Overview

The primary objective of the Master Patient Index is to provide the Medical Records Department with a complete system that will store and index patient records in an efficient manner. Once all indexes have been entered into the system, the department may retrieve the following and other data on a patient's past stays:

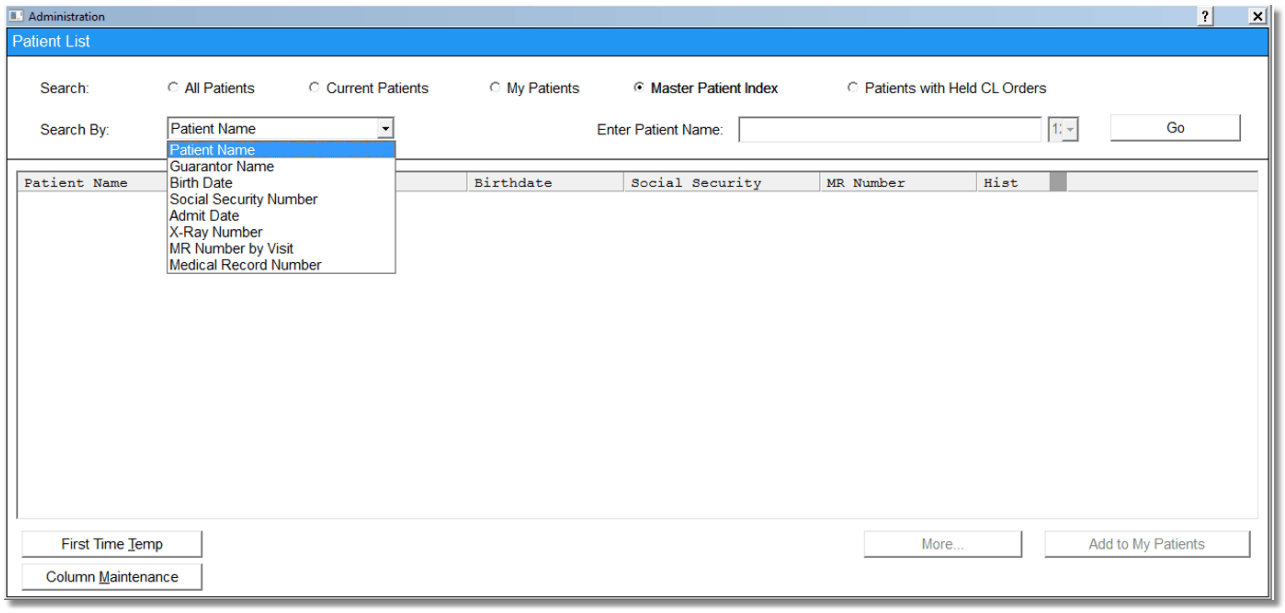
Patient Name
Expired Date
Patient Account Number(s)
Patient Birth Date
Patient Stay Type
Patient Social Security Number
Patient Service Type
Medical Records Number
Account Information
Admission date
Clinical Notes
Mammo Information
Discharge Date
Physician
Top 5 Diagnoses and Procedures
DRG Code
Stored Images
Guarantor Information
X-Ray Number
Clinical History
Balance
Age
Chart Location

The Master Patient Index enables the hospital to do away with the manual card index system and utilize a fully automated system for accessing patient information. Each time a patient is registered, the account will appear in the Master Patient Index immediately.

14.2 Accessing the Master Patient Index

This option provides multiple indexes to search for a patient. When selecting one of these options, the system will prompt for a starting name, number or date, depending on which index is selected.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient List** > **Master Patient Index**

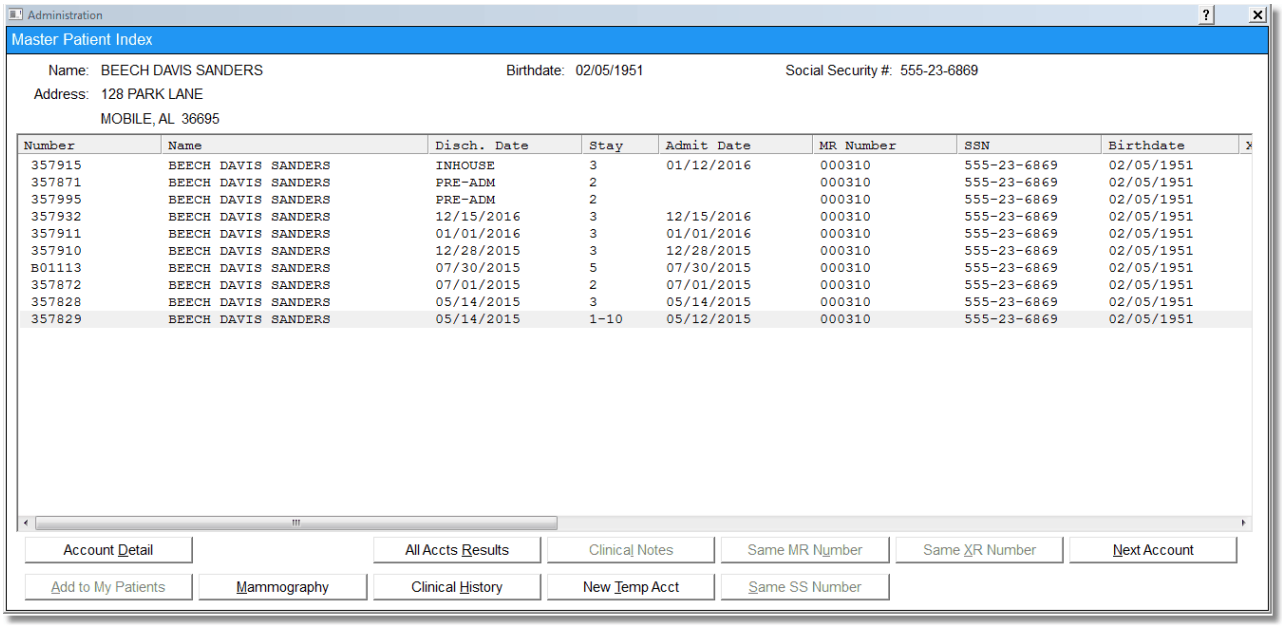


Patient List

By entering the last name and first character of the first name, the index will display the first match found and all other matches alphabetically. Any name that has “Multi” listed in the Acct# column will have multiple accounts for that name listed. To have all accounts display under one name for a particular patient, the Name, Birth Date and Social Security Number must match. Otherwise, there will be a separate entry for each listing. If an account listed has been purged from a hospital’s Accounts Receivable, the account will list “His File” to the right of the M/R#, indicating it is now a history file.

After selecting the patient’s sequence number, the following screen will display. Patient names that have “Multi” for Acct. # will display all hospital stays for that patient listing, as in the example below.

Select **Web Client > System Menu > Hospital Base Menu > Patient List > Master Patient Index > Patient Name**



Master Patient Index

The Admit Date, Patient Name, Account Number, Patient Social Security Number, MR Number and History will display at the top of the screen.

Once in the index, the system will display the following for each account across the top of the screen.

- Acct Number
- Name
- Discharge date
- Stay Type
- Admit Date
- Medical Record Number
- Prior MR#
- Social Security Number
- Birthdate
- XRay
- Chart Location
- Service Type
- Age
- Physician
- AR Balance
- Guarantor
- Same Address?
- Comments?
- Image?

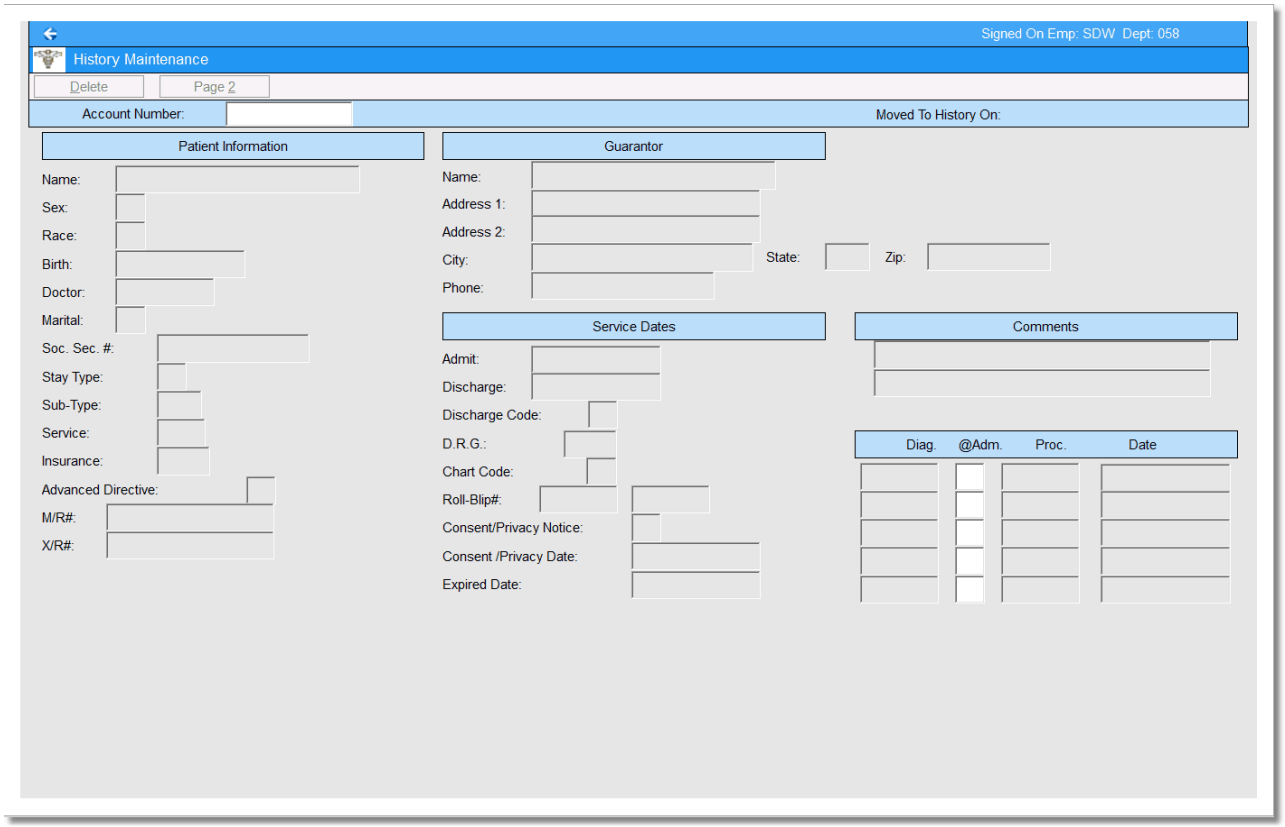
Options at the bottom of the screen are as follows:

- **Account Detail:** If there are multiple accounts, a specific patient number may be entered or press Enter to scroll through the account details of the oldest account through the most recent account. If an account has been purged from the hospital's Accounts Receivable, then lock onto that account and select **A/R History Detail**.
- **Add to My Patients:** The system will add the account selected to a lookup option under My Patients.
- **Mass Changes:** The system will allow the following information to be mass changed on patient accounts: Patient Last Name, Patient First Name, Patient Middle Name, Current Name, Date of Birth, Social Security Number, Expiration Date and Medical Record Number.
- **Mammography:** This allows viewing of the mammography data for the patient.
- **All Accts Results:** The system will display all account results for any or all of the following departments: Laboratory, Radiology, Rehab Services, Cardiopulmonary, Central Supply, Outpatient Clinic and Dietary.
- **Clinical History:** If a facility has installed an Archival Data Repository permanent storage drive, any Medical Records Transcription documents or Order Entry Results may be viewed and printed. If an account does not have any data in Clinical History, "NO HISTORY ON FILE" will display.
- **Clinical Notes:** This is where clinical notes may be viewed for a patient. This option will prompt for a department or **A**ll. After a department is selected, the option to **V**iew, **P**rint or print to a **W**orkstation printer may be selected.
- **New Temp Acct:** Select this option to start a temporary account registration using previous account's information for this patient.
- **Same MR Number:** Select this option to display other accounts with the same Medical Record Number.
- **Same SS Number:** Select this option to display other accounts with the same Social Security Number.
- **Same XR Number:** Select this option to display other accounts with the same X-Ray Number.
- **PACS:** Select this option to view PACS images entered on these accounts.
- **Next Account:** After this is selected, the system will display the next patient in the alphabetic display.

14.3 Setting Up a History Account

If a manual card index system is in place, the account numbers may be entered into the TruBridge EHR System to utilize a fully automated system. This will create an account in the MPI but will not be listed in the hospital's Accounts Receivable.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **History Account Setup**



History Maintenance

- **Account Number:** Enter the patient's account number assigned for that particular stay. Typing the number 1 and pressing Enter will assign the next account number available.
- **Just Like Number:** If the patient has an existing account number on the system, the Just-Like feature may be utilized. To do this, when prompted for "Just-Like Number", enter the patient's current account number in this field. The system will then copy the data from the existing record into this new record. If this is done, the cursor will go directly to the "Doctor" field. The information in all fields should be verified and changed if needed.
- **Moved To History On:** This is the date that the account was purged from the hospital's Accounts Receivable. Leave blank when setting up a history account.

- **Patient Information**
  - **Name:** Enter the patient's last name, first name and middle initial in all uppercase letters. No punctuation marks should be entered. Patients with a title such as JR or MD, should be entered with the title after the patient's middle initial.
  - **Sex:** Enter **M** for male, **F** for female or **U** for unknown for the patient's sex.
  - **Race:** Enter the facility-defined character denoting the patient's race.
  - **Birth:** Enter the patient's Birth Date in MMDDYYYY format. For example, April 11, 1955 should be entered as 04111955. Once the date is entered, the age will calculate and appear to the right.
  - **Doctor:** Enter the patient's Attending physician number.
  - **Marital:** Enter the patient's marital status. One of the following codes may be entered:

    S = Single **X** = Separated
    M = Married **U** = Unknown
    D = Divorced **P** = Life-Time Partner
    W = Widowed
  - **Soc. Sec.#:** Enter the patient's Social Security Number. Do not separate the numbers with punctuation marks.
  - ***NOTE:*** *If there is a match for the social security and name or the name and date of birth on the newly created history account, the account will be attached to an existing profile. Otherwise, a new profile will be created.*
  - **Stay Type:** Enter the patient's Stay Type. Stay Type **1**=Inpatient, Stay Type **2**=Outpatient, and Stay Type **3, 4** and **5** are facility-defined.
  - **Sub-Type:** Enter the patient's facility-defined Sub Type.
  - **Service:** Enter the patient's Service Code for this particular stay. Contact Data Processing for a list of facility-defined codes.
  - **Insurance:** Enter the Insurance Financial Class code that represents the patient's primary insurance carrier. Examples include: **M**-Medicare Inpatient, **MB**-Medicare Outpatient, **X**-Medicaid Inpatient, **XB**-Medicaid Outpatient, **B** - Blue Cross Inpatient, **BB**-Blue Cross Outpatient.
  - **Advanced Directive:** Enter **Y** if the patient has an Advanced Directive (such as a living will) or **N** if not applicable.
  - **M/R#:** Enter the patient's Medical Record number.
  - **X/R#:** Enter the patient's X-Ray number if applicable.

- **Guarantor**
  - **Name:** Enter the Guarantor's last name, first name and middle initial in all uppercase letters. No punctuation marks should be entered. If the patient is the guarantor, enter an **S** and the patient's name will pull to this field.
  - **Address 1:** Enter the guarantor's street address or Post Office Box number.
  - **Address 2:** Enter the guarantor's apartment or suite name and number.
  - **City/State/Zip:** Enter the guarantor's City and State and the five or 9-digit Postal Zip code. No punctuation marks should be entered.
  - **Phone:** Enter the guarantor's telephone number including area code. No punctuation marks should be entered.

- **Service Dates**
  - **Admit:** Enter the patient's Admit Date. It should be entered in MMDDYY format.
  - **Discharge:** Enter the patient's Discharge Date. It should be entered in MMDDYY format.
  - **Discharge Code:** Enter the patient's Discharge Code. Contact Data Processing for a list of facility-specific codes.
  - **D.R.G.:** Enter the DRG that the hospital was reimbursed by Medicare or any other insurance company that pays by DRG.
  - **Chart Code:** Enter the facility-defined chart code.
  - **Roll-Blip#:** This is where the microfilm Roll and Blip numbers may be entered if a facility retains hospital records on microfilm.
  - **Consent/Privacy Notice:** Enter **Y** if the patient has signed the Consent/Privacy notice, enter **N** if not applicable.
  - **Consent/Privacy Date:** Enter the date the Consent/Privacy notice was signed.
  - **Expired Date:** Enter the date the patient expired in this field. It should be entered in MMDDYYYY format.

- **Comments:** These Comment lines may be used to enter facility-defined information for the patient account.

- **Diag.:** Up to 25 Diagnosis codes may be entered for the patients stay.

- **@Adm.:** This field is used to specify whether or not the illness was present at the time of admission. Valid codes are **E**, **N, U, W** or **Y.**

- **Proc.:** Up to 25 Procedure codes may be entered for the patient's stay.

- **Date:** Enter the date the procedure listed in the previous column was performed.

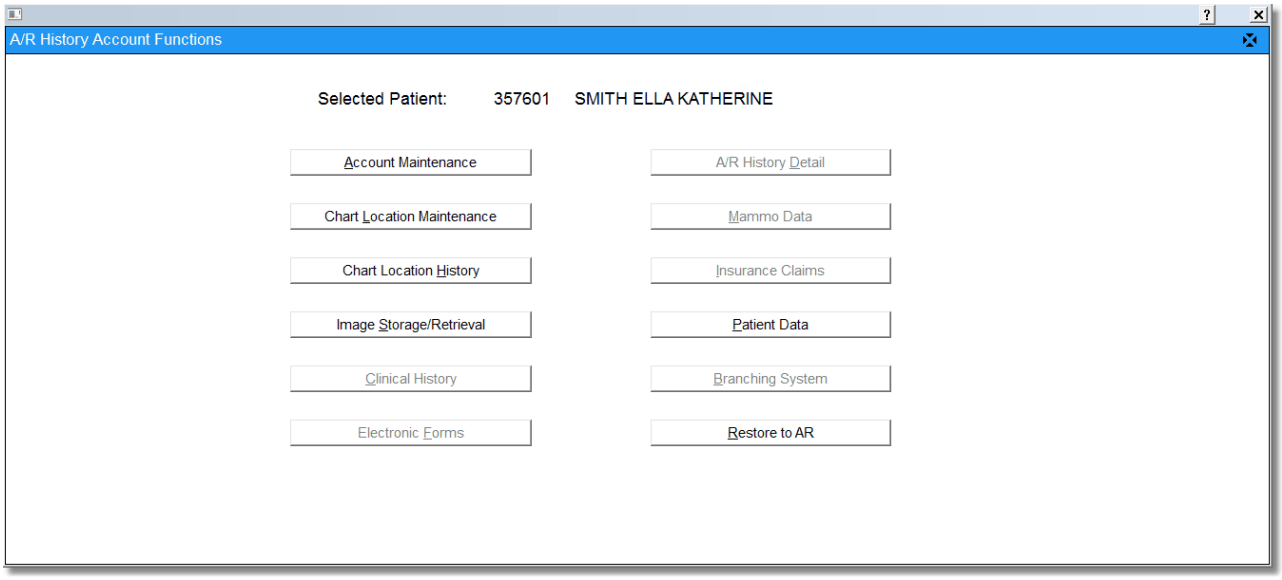
Select **Delete** to delete the account. Select the left arrow at the top of the screen or press the **ESC** key on the keyboard to exit.

14.4 Accessing a History Account

When selecting a history account (setup through History Account Setup or purged from a hospital's Accounts Receivable), the following screen will display.

NOTE: *A history account will display an "H" to the left of the account number when viewing through the Master Patient Index.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Patient List** > **Master Patient Index** > **Patient Name**



A/R History Account Functions

- **Setup New Account:** This option will access the Patient Registration screen and will setup an active account for the selected patient.
- **Account Maintenance:** This option will access the History Maintenance screen for the selected account.

NOTE: *The Soc. Sec # field cannot be accessed on a History account.*

- **Chart Location Maintenance:** This option will access the Chart Location Maintenance screen, where a chart location may be entered for the selected account.
- **Chart Location History:** The Chart Location History screen will show where a patient's chart is currently located and will display a maximum of 20 past/present chart locations.
- **Image Storage/Retrieval:** This option will display the Image Storage/Retrieval menu. From this menu, stored documents may be viewed and new documents may be stored.

- **Clinical History:** This option will display any Medical Records Transcription documents or Order Entry Results that have been purged from a hospital's Accounts Receivable. The information may be viewed or printed. This option is only available if a facility has an Archival Data Repository permanent storage drive.

- **A/R History Detail:** This option will display the Patient's Account Detail. This option is only available if a facility has an Archival Data Repository permanent storage drive.

- **Mammo Data:** This option will allow viewing of Mammography Data for the selected patient.

- **Insurance Claims:** This option will display any UB04's and/or 1500's (Form Codes U and J) that have been purged from the hospital's Accounts Receivable. When selecting this option from a PC, the insurance claim may be viewed or printed. Also, this may only be utilized if a facility has an Archival Data Repository permanent storage drive.

- **Patient Data:** This option will allow the Medicare Questionnaire and Patient Data Screens to be viewed or printed for the selected patient. When prompted "Enter Type:", **CP** may be entered to access the Medicare Questionnaire and Trauma Questionnaire.

- **Restore to AR:** For sites with ADR, this option allows a History Account to be restored to A/R for the purpose of posting receipts to the account without having to set up a new account. When the history account is restored to A/R, the account number, demographic information and previously purged Account Detail are restored. The account will have to once again meet the purge parameters before returning to the history file. At that point, the previously purged account detail will be updated with the new purged detail. The demographic information for the restored account will pull from the account's associated profile.

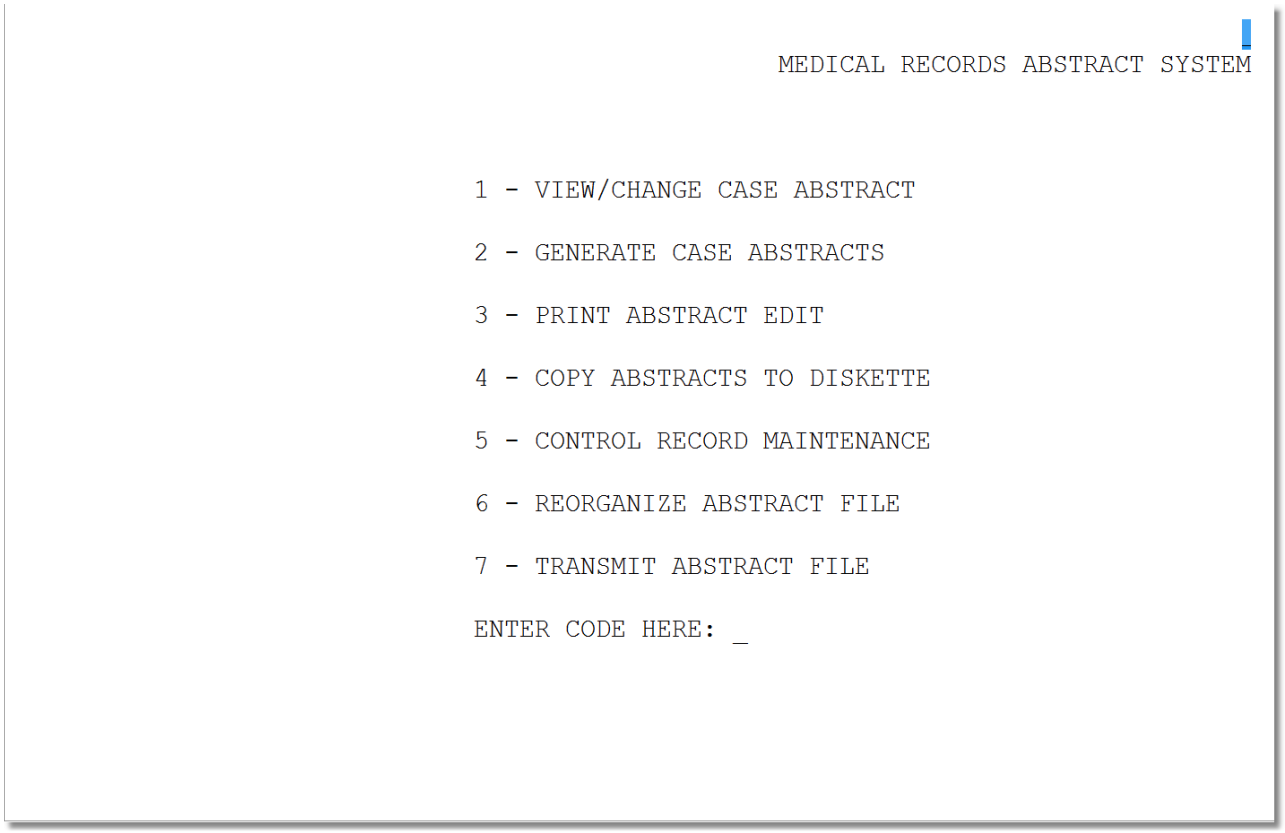
NOTE: *This option also puts a note on the account that states "History Acct Restored to AR." This note must be removed to allow deletion of the restored account.*

Chapter 15 State Abstracting

15.1 Overview

The primary use of the Medical Record Abstracting application is to allow hospitals to provide certain organizations with specific types of data within a given date range. These organizations manipulate this data and generate statistical information useful in many types of reporting.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **Page 2** > **Abstracting System #1**

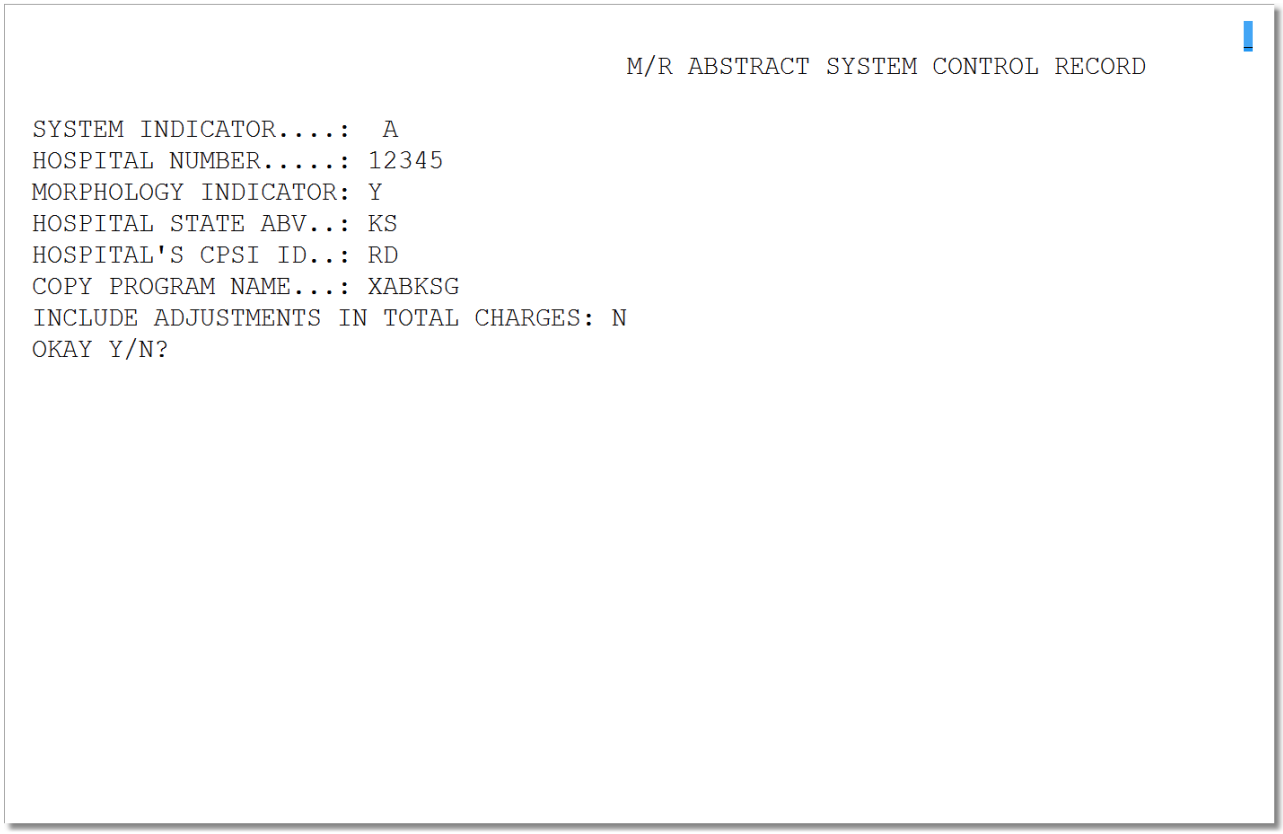


Medical Records Abstract System

15.2 Setting Up Abstracting

Prior to using the Abstracting system, some setup should be performed through Control Record Maintenance.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **Page 2** > **Abstracting System #1** > **Control Record**



M/R Abstract System Control Record

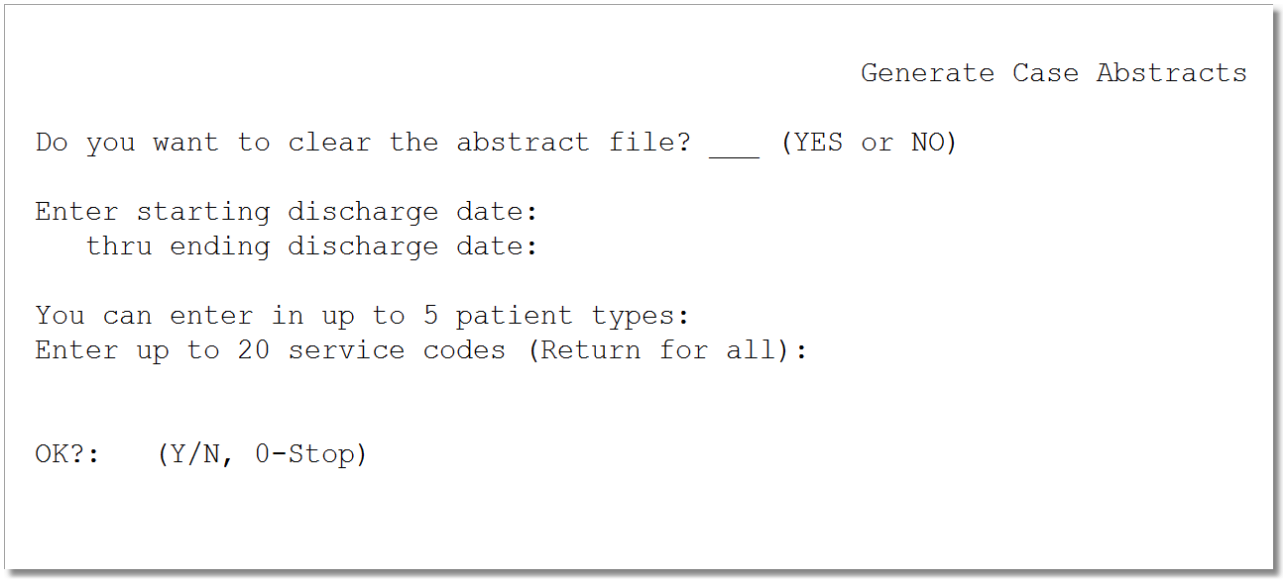
- **System Indicator:** This indicates the type of computer system being used. The system will automatically default to the correct system type.
- **Hospital Number:** This is the number assigned to a facility by HCIA.
- **Morphology Indicator:** This field should always be answered **N**.
- **Hospital State Abv:** Enter the hospital's 2-character state abbreviation code.
- **Hospital's CPSI ID:** Enter the 2-digit hospital code assigned by TruBridge. This code may also be found in the AHIS Control Table, page 5.
- **Copy Program Name:** This program copies the abstract file to diskette. This program name is assigned by TruBridge.

- **Include Adjustments in Total Charges:** When answered **N**, it will exclude any adjustment charges from the patient's total charges in the abstracting file. If answered **Y**, the adjustments will be included in the patient's total charges. To determine if a charge is an adjustment charge, the item's Summary Charge Code Table has field 13, Adjustment Charge, set to **Y**.

- **Okay Y/N:** If the above prompts are answered correctly, enter **Y**. Enter **N** to change any options.

15.3 Generating Case Abstracts

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **Page 2** > **Abstracting System #1**> **Generate Case Abstracts**



Generate Case Abstracts

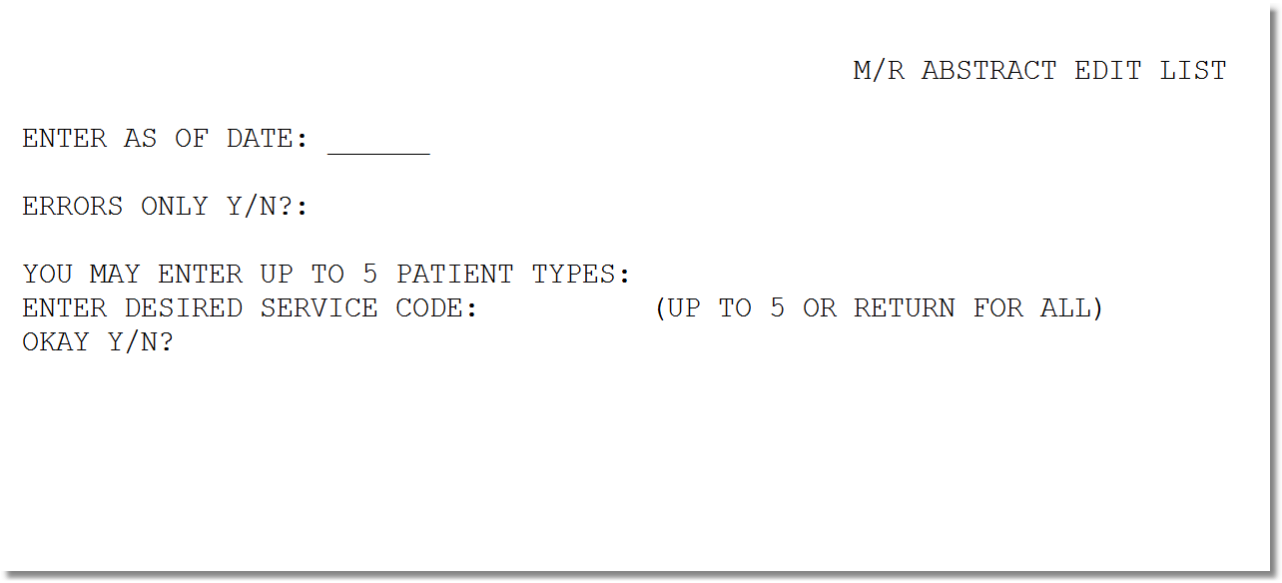
The system will display "Do you want to clear the abstract file? (YES or NO)". If answered **Yes**, all abstracts that have previously been generated will be removed and the abstract file will only contain the information that will be generated. If answered **No**, any previous abstracts in the abstract file will remain.

A starting discharge date and ending discharge date should be entered. The patient Stay Type codes to be generated in the file should also be entered. Up to 20 service codes may be selected. Enter through the field if all service codes should be included. The system will then generate all discharges within the given time frame.

15.4 Printing Case Abstracts

The abstract edit may be printed to pull all patients that have been generated for a given month or to pull just patients that have abstract edit errors within a given month.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **Page 2** > **Abstracting System #1** > **Print Abstract File**



M/R Abstract Edit List

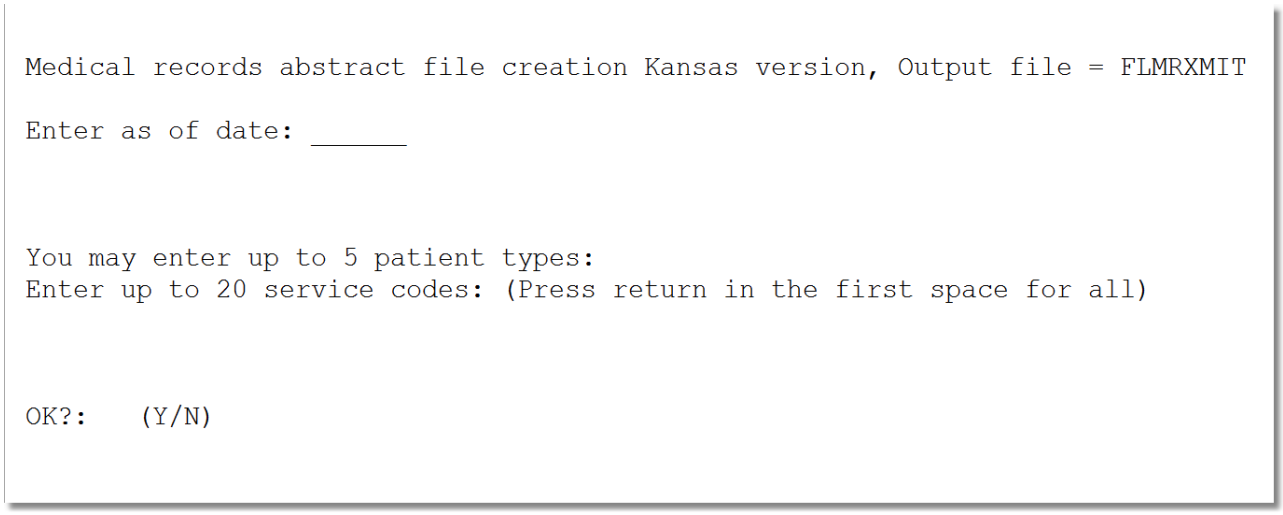
- **Enter As Of Date:** The date entered should be the last day of a given month. The report will only pull patients with a discharge date in the month entered.
- **Errors Only Y/N:** If answered **Y**, only abstracts with errors in the given month will print to the edit report. If answered **N**, all patients with a discharge date in the month entered will print to the edit report.
- **You May Enter Up to 5 Patient Types:** Enter the patient Stay Types that should be included in the edit report.
- **Enter the Desired Service Code:** Enter up to 5 Service codes to be included in the edit report. Only patients with the service codes entered will pull to the edit report. If all service codes should be included on the report, Enter through this field.

The message, “Next Record Has Error(s)”, will display before each record that needs to be corrected. Each error will be marked with three asterisks (“***”) before the field description. These corrections should be made through “View/Change Case Abstract”, which will be discussed in the next section.

15.5 Copying Case Abstracts to Diskette

At the end of each month, before generating for the next month, the case abstracts may be copied to a disk and sent to the professional health study group.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **page 2** > **Abstracting System #1** > **Copy Abstracts to Diskette**



Copy Abstracts

- **Enter As Of Date:** Enter the appropriate date in MMDDYY format.
- **You May Enter Up to 5 Patient Types:** Enter the appropriate Stay Types to be abstracted.
- **Enter Desired Service Code:** Enter the appropriate service code or press Enter to include all service codes.
- **Enter Service Codes to Exclude:** Enter the appropriate service code or press Enter to include all service codes.

15.6 Reorganizing the Abstract File

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **Page 2** > **Abstracting System #1**> **Reorganize Abstract File**

```
Evident Community Hospital                          REORGANIZE M/R ABSTRACT FILE

ENTER DROP DATE: _______      (ALL DISCHARGES THRU THIS DATE WILL BE PURGED)

ARE YOU SURE YES OR NO?
```

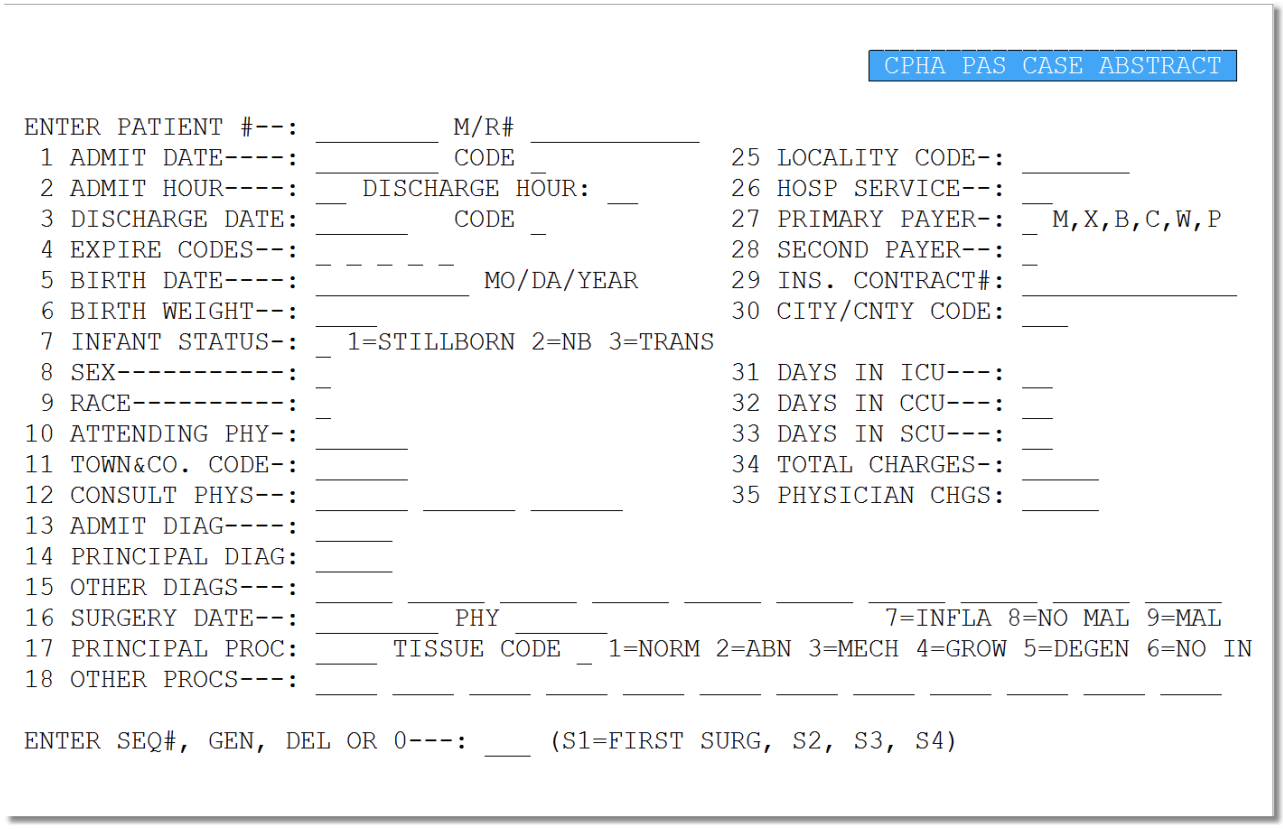
Reorganize M/R Abstract File

The abstract files should be reorganized once a month. The reorganize program purges the file of all data up to the date entered as the drop date. When generating case abstracts, if the prompt “Do You Wish to Clear File?” is answered **NO**, any old data that was generated will be retained in the file. It is recommended that the reorganize feature be used to purge any old data for months that abstracts have been completed.

Editing and Viewing Case Abstracts

To view or make corrections to a case abstract, from the Medical Records Abstract System, select **View/Change Case Abstract**. Enter the account number of the patient to view. If the account number entered is not in the case abstract system, it will display “New” next to the patient name. Otherwise, if the account number entered was included in the generation of case abstracts, it will display “Existing” next to the patient name. Any changes that are made here will be over-written if the case abstracts are regenerated, and the prompt is answered **YES** to clear the abstract file.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Print Reports** > **Medical Records** > **Page2** > **Abstracting System #1** > **View/Change Case Abstract**



CPHA PAS Case Abstract

- **Admit Date, Code:** This is the patient's Admit date and Admit code and will pull from Stay tab on the Registration and ADT screen.
- **Admit Hour, Discharge Hour:** This is the hour the patient was admitted and discharged and will pull from Stay tab on the Registration and ADT screen.
- **Discharge Date, Code:** This is the patient's discharge date and discharge code and will pull from Stay tab on the Registration and ADT screen.
- **Expire Codes:** There are 5 available spaces in this field, into any of which an asterisk ("*") may be placed. The position of the asterisk ("*") determines the type of Expire Code:
  - Position 1 Died
  - Position 2 Autopsy
  - Position 3 In OR
  - Position 4 Post Operative
  - Position 5 Coroner's Case

If a patient has a Discharge Code of 20, the system will automatically pull an asterisk ("*") to the first position. The other positions must be entered manually.

- **Birth Date:** This is the patient's birth date and will pull from Patient tab on the Registration and ADT screen.

- **Birth Weight:** If the patient is a newborn, this is the birth weight and will pull from Clinical tab on the Registration and ADT screen if the patient's admit date and birth date are the same.

- **Infant Status: 1**=Stillborn **2**=NB **3**=Trans If the admit date and birth date are the same, the system will pull a **2** in this field. A status of **1** or **3** can be entered in this field if applicable.

- **Sex:** This is the patient's gender. A code of **1** or **2** will automatically pull from Patient tab on the Registration and ADT screen.
  - 1 Male
  - 2 Female
  - 3 Unknown
  - 4 Male Verified
  - 5 Female Verified

- **Race:** This is the patient's race code. If the letter in parenthesis is entered on Patient tab on the Registration and ADT screen, the corresponding number will automatically pull:
  - 1 (W)hite
  - 2 (B)lack
  - 3 (A)sian
  - 4 American (I)ndian
  - 5 (H)ispanic
  - 6 (M)ulti-racial
  - 7 (O)ther
  - X (U)nknown

- **Attending Phy:** This is the patient's Attending physician. This pulls from Stay tab on the Registration and ADT screen.

- **Town&Co Code:** This code must be entered manually. A facility's professional health study group supplies this code.

- **Consult Phys:** This field will hold three physician numbers and pulls the physicians from the Medical Records Grouper screen. If a physician has a type **S** loaded for surgeon, that physician will not pull to this field.

- **Amit Diag:** This is the patient's admitting diagnosis and pulls from field 8 of the Medical Records Grouper screen

- **Principal Diag:** This is the patient's principal diagnosis and pulls from field 21 of the Medical Records Grouper screen.

- **Other Diags:** This is the patient's secondary diagnoses and pulls from fields 22 – 30 of the Medical Records Grouper screen.

- **Surgery Date, Phy:** The surgery date and physician will pull from field 31, page 2 of the Medical Records Grouper screen. The physician number will pull from fields A – J, page 2 of the Medical Records Grouper screen, depending on what number is loaded in the "Phy" column for the procedure.

- **Principal Proc, Tissue Code:** This is the patient's principal procedure and pulls from field 31, page 2 of the Medical Records Grouper screen. The valid tissue code may be entered in the second part of this field. Valid codes are:
  1 NORM
  2 ABN
  3 MECH
  4 GROW
  5 DEGEN
  6 NO IN
  7 INFLA
  8 NOMAL
  9 MAL

- **Other Procs:** These are the patient's secondary procedures. There are 12 procedure code fields that pull from fields 32-40 of the Medical Records Grouper screen. If the procedure codes are not relating to the principal procedure or another procedure code, then **S2**, **S3** or **S4** may be entered at the bottom of the screen and the procedure code(s) can be entered in either field 17 or field 18. When entering S2, S3, or S4, the date and physician will have to be entered for this surgery, along with the principal procedure or other procedure.

- **Locality Code:** This is the patient's zip code. It pulls from Patient tab on the Registration and ADT screen. There must be two spaces before the zip code to create a 7-character field.

- **Hosp Service**: This 2-character field must be entered manually.

- **Primary Payor:** This is the patient's primary financial class and pulls the first character of the financial class from Guarantor/Ins tab on the Registration and ADT screen.

- **Second Payor:** This is the patient's secondary financial class and pulls the first character of the financial class from Guarantor/Ins tab on the Registration and ADT screen.

- **Ins. Contract#:** This is the patient's contract number from the primary financial class.

- **City/Cnty Code:** This is the patient's city/county code. It pulls from Patient tab on the Registration and ADT screen.

- **Days in ICU:** This 2-character field must be manually entered.

- **Days in CCU:** This 2-character field must be manually entered.

- **Days in SCU:** This 2-character field must be manually entered.

- **Total charges:** This is the total charges on the patient's account detail at the time of generation. If "Include Adjustments in Total Charges" in the Abstract System Control Record is set to **N**, any adjustment charges on the patient account will not be included in the Total Charges.

- **Physician Chgs:** This is the total of physician charges on the patient's account detail at the time of generation.

15.7 Transmit Abstract File

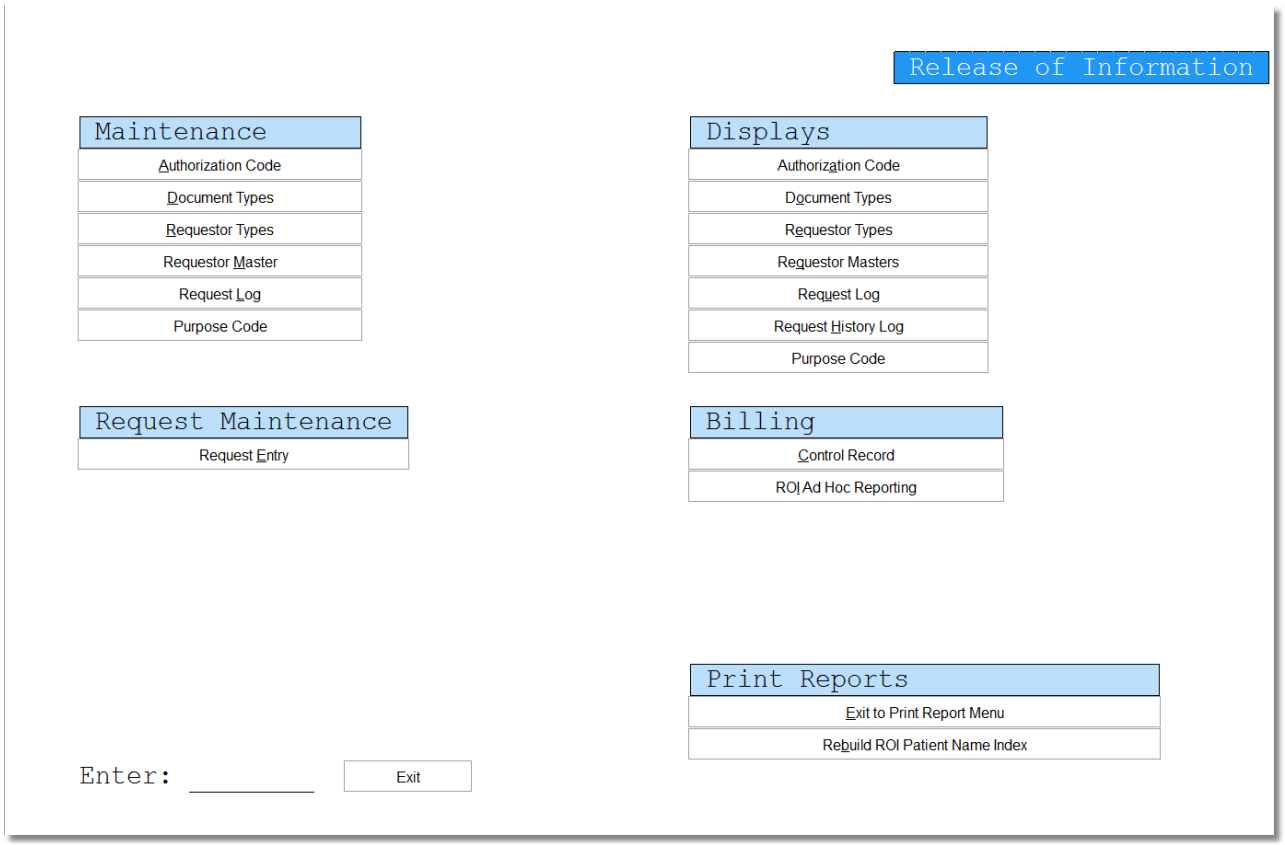
This option is used for custom file transmissions. Selecting **Transmit Abstract File**, will transmit case abstracts.

Chapter 16 Release of Information

16.1 Overview

Release of Information may be accessed through the Medical Records application. This has been developed for use by Medical Records for tracking disclosures of confidential patient information out side TPO (Treatment, Payment and Healthcare Operations). Clinical departments may access Release of Information from the Hospital Base Menu.

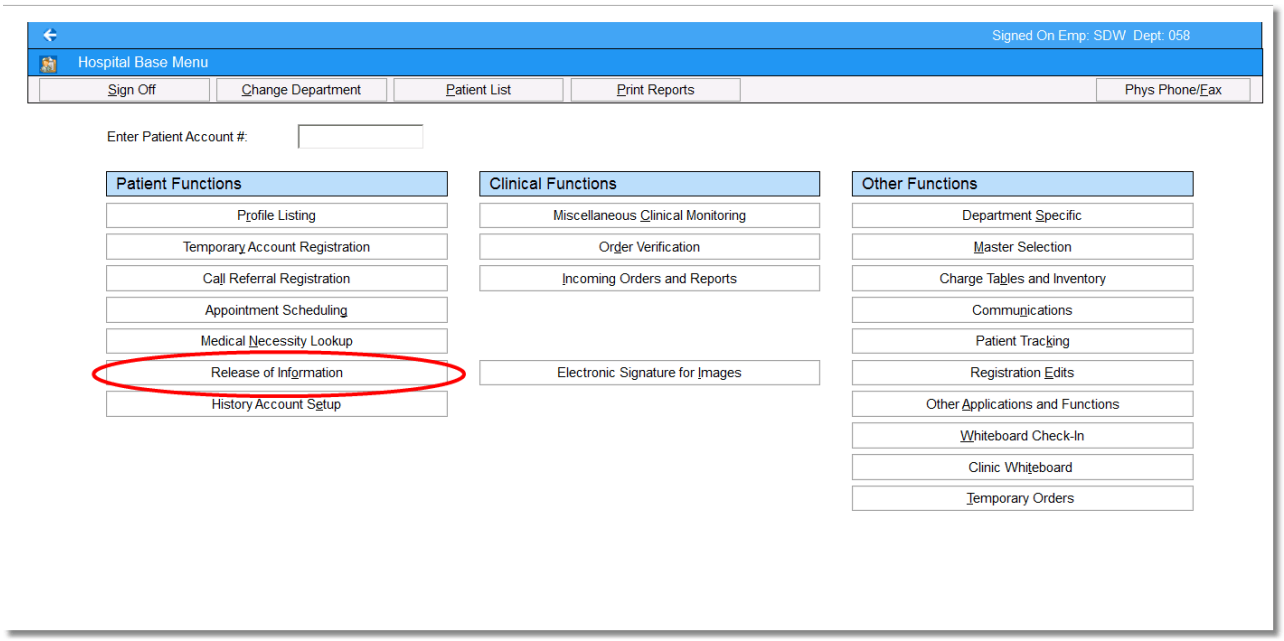
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information**



Release of Information

ROI Access for Clinical Departments

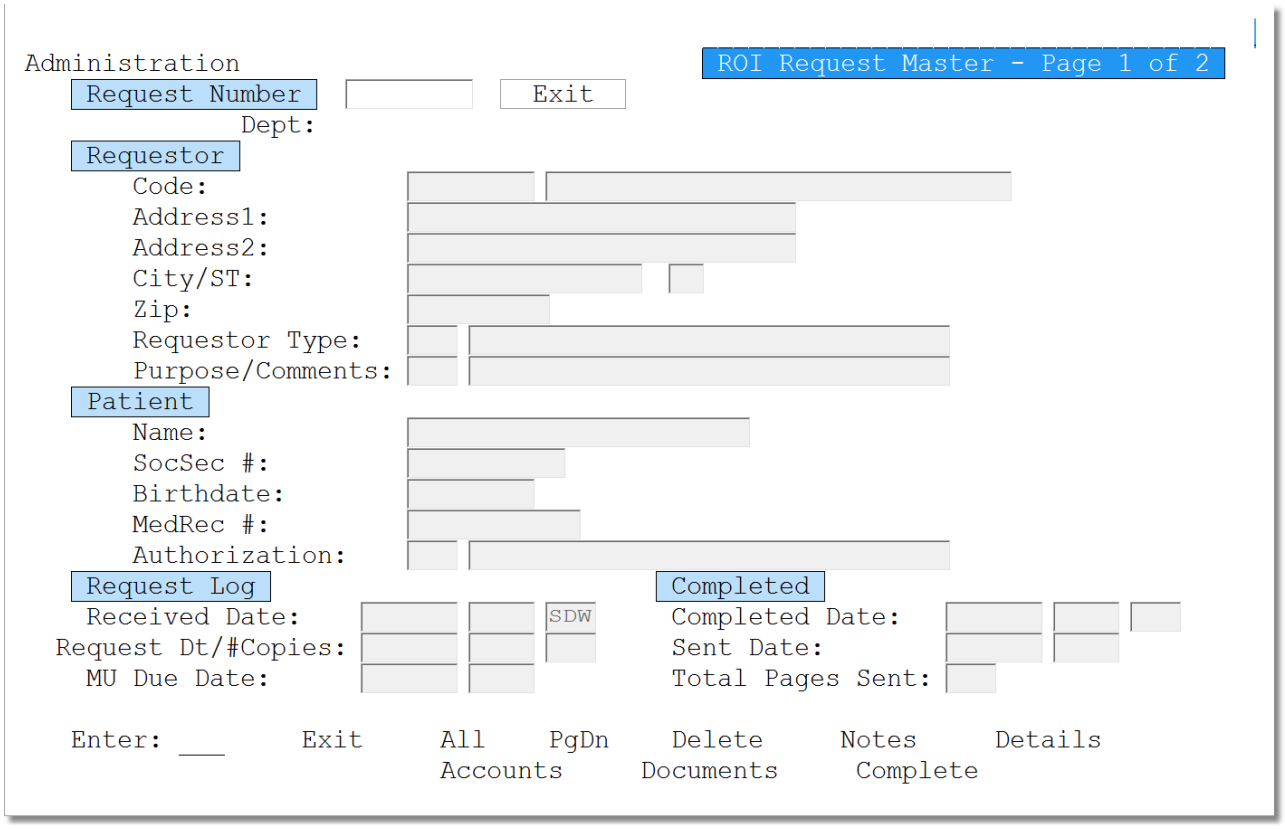
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Release of Information**



Hospital Base Menu

Select **Release of Information** from the Hospital Base Menu to access the ROI Request Master. This option allows Clinical Departments the ability to enter a new ROI request without giving the ability to view other requests. Once this option is selected, a new request may be entered.

Select **Web Client > System Menu > Hospital Base Menu > Release of Information > Request Number**



ROI Request Master, Page 1

16.2 Maintenance

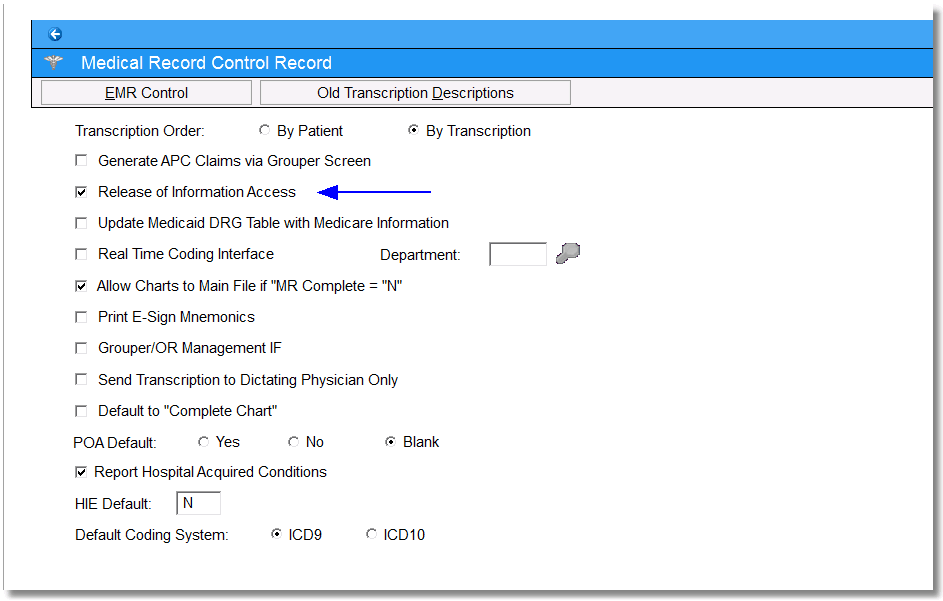
Overview

Before utilizing the Release of Information feature, maintenance must be performed prior to setting up a request. This would include creating authorization codes, document types and requestor types. The following options must be established prior to entering a request.

Medical Record Control InformationTable

Before utilizing the Release of Information feature, it must be turned on in the Medical Record Control Table.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Med Rec**



Medical Record Control Record

- **Request of Information Access:** Selecting this field gives access to the Release Of Information Application.

Authorization Codes

Authorization Code is used to set up facility-defined authorization codes. These codes may be used to identify special authorization needs, failure to meet department policy standards, the lack of a signed authorization, etc. The Authorization Code may be up to three digits in length and may be an alpha or numeric code. This option allows for the initial setup of the code and description. The description may be up to 32 characters in length. Entering a **?** will display a lookup window by code or description. Entering a **D** will delete the code.

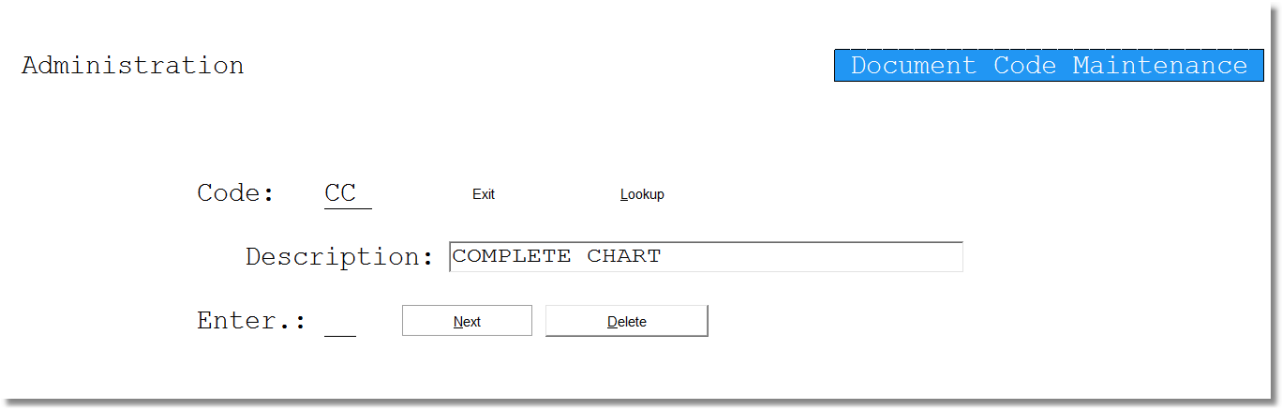
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Authorization Codes**

Authorization Code Maintenance

Document Types

Document Types are used to set up facility-defined codes that represent documents or information being requested. The document type may be up to three digits in length and may be an alpha or numeric code. The document description may be up to 32 characters in length. Entering a **?** will display a lookup window by code or description. Entering **D**elete will delete the code.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Document Types**

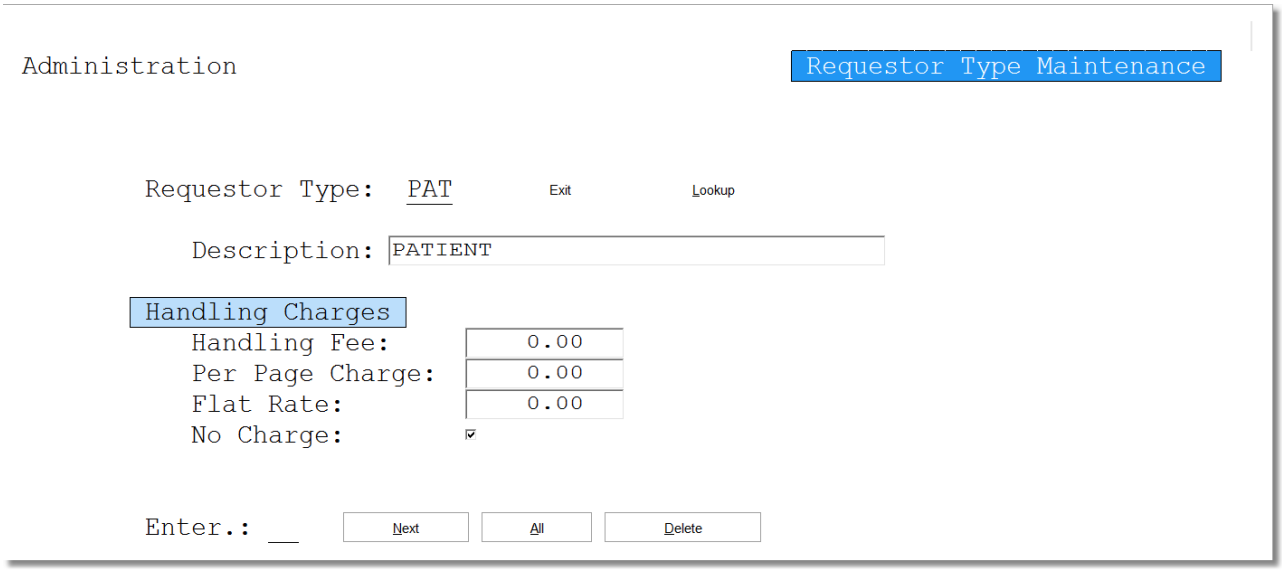


Document Code Maintenance

Requestor Types

Requestor Types are used to distinguish the type of requestor and to provide the system with the charge information necessary to calculate a billing amount. This code may be up to three characters in length and may be an alpha or numeric code. The requestor type description may be up to 32 characters in length. Entering a **?** will display a lookup window by code or description.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Requestor Types**



Requestor Type Maintenance

Upon setting up the Requestor type, additional information may be added that will be used in the billing for the request.

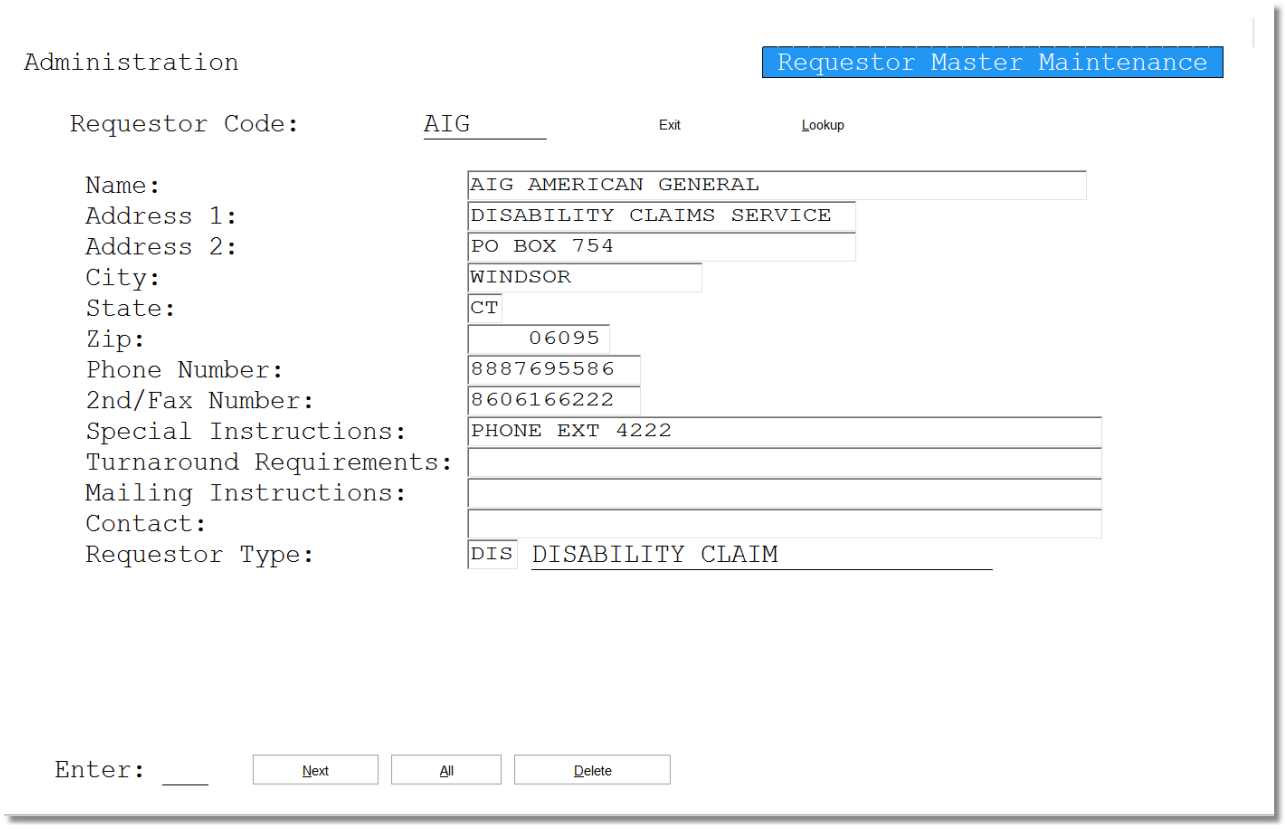
- **Handling Fee:** If a handling fee applies for this type of request it should be noted in this field. This amount will automatically be applied to a request of this type.
- **Per Page Charge:** If a charge is applied per the number of copies then it should be loaded in this field. This amount will be multiplied by the number of pages per request.
- **Flat Rate:** If a flat rate applies to the request type it should be loaded in this field. This amount will automatically be applied to a request of this type.
- **No Charge:** If there are no charges associated with completion of a specific request type, this field should be selected. If this field is marked, all requests with this Requestor Type will always have a Request Status of No Charge. These Requests statuses will never be listed as Incomplete, Sent, Complete, Billed or Paid, but will pull to the appropriate reports.

Entering **D**elete will delete the code. Entering **A**ll will access all fields.

Requestor Master

Each company, organization or person requesting information should be set up in the Requestor Master Maintenance. This code may be up to eight characters in length and may be an alpha or numeric code. Entering a **0** will return the cursor to the Release of Information main menu. Entering a **?** will display a lookup window by code or description of all previously established Requestor codes

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Requestor Master**



Requestor Master Maintenance

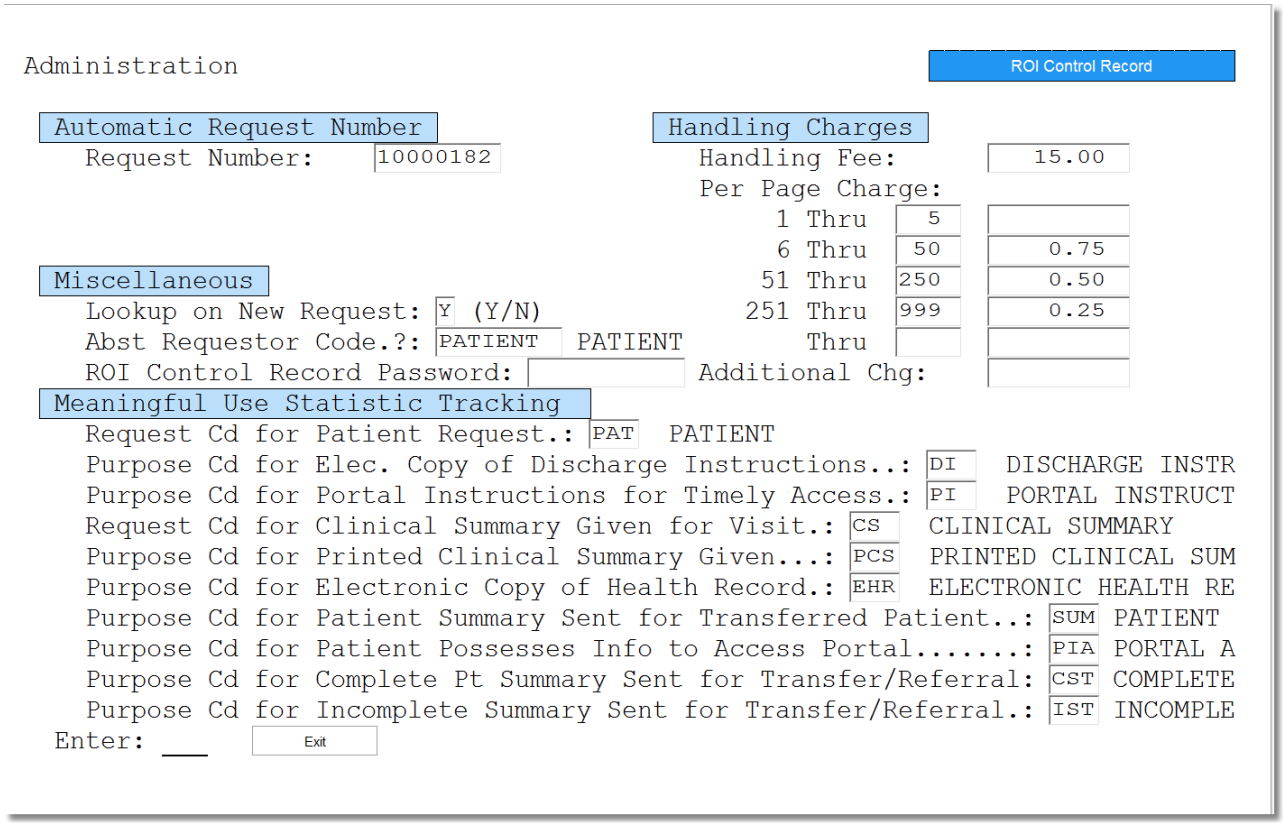
- **Name and Address Information:** Enter the name and address information for this requestor.
- **Phone Number:** Enter the phone number of the requestor.
- **Phone Number:** Enter a second phone number for the requestor.
- **Special Instructions:** This field is informational and any special instructions that apply to this requestor should be noted in this field (e.g., “All requests must be prepaid.”).
- **Turnaround Requirements:** This field is informational and may be used for special instructions regarding the turnaround time and special requirements for this requestor (e.g., “Contractual agreement to complete requests in 10 days.”).
- **Mailing Instructions:** This field is informational and may be used for any mailing instructions that apply to this requestor (e.g., “Must be shipped via UPS.”).
- **Contact:** The contact for this requestor should be entered.
- **Requestor Type:** The type of request, as defined in the Requestor Types table, should be entered in this field. This code will be used to determine the charges that will apply to this request for billing purposes.

Entering **A**ll will access all fields within the table. Entering **DEL**ete will delete the requestor.

Control Record

The Control Record provides the charge information necessary to calculate a billing amount for each request. These rates are used for every request unless different rates are loaded on a requestor type. The system will keep track of any unpaid requests and keep track of the turnaround time between release and payment.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Control Record**



ROI Control Record

- **Request Number:** This field contains the last request number that was used. When auto-assigning a request number, the system will assign the next available number to the request.
- **Handling Fee:** If a standard handling fee applies for all requests, it should be noted in this field. This amount will automatically be applied to all requests that do not have handling fees loaded for the Requestor Type.
- **Per Page Charge:** This field should be utilized if a specific dollar amount is charged up to a certain number of pages. Then each additional page number range will have a different dollar amount loaded. When this field is used, the rates apply to all requestor types that do not have this information loaded on the Requestor Type Maintenance.

- **Additional Charge:** This field should be loaded with any additional charge amount that needs to be added in addition to the existing charges.

- **Lookup on New Request:** This field will control which screen is accessed upon choosing Request Entry. Setting this field to **N** will access the Request Master page. Setting this field to a **Y** will allow for the lookup of previous requests prior to entering a new one. This setting will display the Request Log Search Screen.

- **Abst Requestor Code?:** Enter the Requestor Master Code that will be used in tracking the disclosure of State Abstracting information.

- **ROI Control Record Password:** A password may be entered in this field using alpha or numeric characters for additional security. Once this has been entered, the system will prompt for this password when accessing the ROI Control Record.

Meaningful Use Statistic Tracking

- **Request Cd for Patient Request:** Enter the Requestor Types Code that will be used in tracking patient Release of Information request.

- **Purpose Cd for Elec. Copy of Discharge Instructions:** Enter the Purpose Code that will be used in tracking the disclosure of Electronic copies of Discharge Instructions sent from Point of Care.

- **Purpose Cd for Portal Instructions for Timely Access:** Enter the Purpose Code that will be used in tracking the disclosure of Portal Instructions for Timely Access.

- **Request Cd for Clinical Summary Given for Visit:** Enter the Requestor Types Code that will be used in tracking the disclosure of the Patient Summary from Medical Practice EMR.

- **Purpose Cd for Printed Clinical Summary Given:** Enter the Purpose Code that will be used in tracking the disclosure of the Printed Patient Summary from Medical Practice EMR.

- **Purpose Cd for Electronic Copy of Health Record:** Enter the Purpose Code that will be used in tracking the disclosure of the Electronic Copy of Health Records.

- **Purpose Cd for Summary Sent for Transferred Patient:** Enter the Purpose Code that will be used in tracking the disclosure of the Summary Sent for Transferred Patients from Point of Care.

- **Purpose Cd for Patient Possesses Info to Access Portal:** Enter the Purpose Code that will be used in tracking the disclosure of the Patient Possesses Information to Access the Patient Portal sent from registration.

- **Purpose Cd for Complete Pt Summary sent for Transfer/Referral:** Enter the Purpose Code that will be used in tracking the disclosure of the Summary Sent for Transferred/Referred Patients. A completed Patient Summary is one that has Medications, Medication Allergies and Problems or an indication of none.

- **Purpose Cd for Incomplete Pt Summary sent for Transfer/Referral:** Enter the Purpose Code that will be used in tracking the disclosure of the Summary Sent for Transferred/Referred Patients.

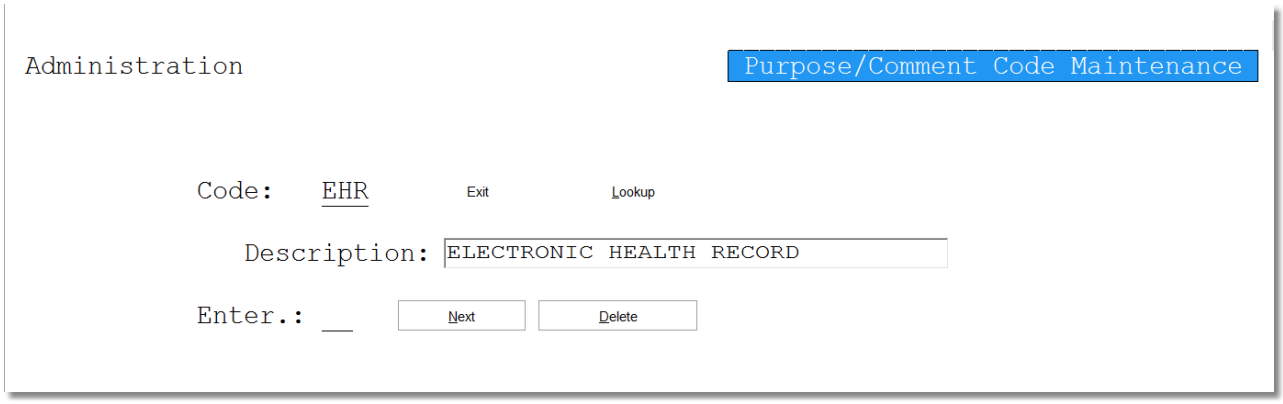
An Incomplete Patient Summary is one that does not have Medications, Medication Allergies and Problems or an indication of none.

NOTE: *For Meaningful Use sites, the correct Meaningful Use Statistic Tracking code(s) must be loaded on the corresponding ROI request in order for the account to pull to the Meaningful Use Phase Statistics report under the appropriate objective.*

Purpose Code

Purpose Code is used to set up facility-defined purpose codes. This code may be up to three characters in length and may be an alpha or numeric code and is used when creating a new request. Entering a **?** will display a lookup window by code or description. Entering a **D** will delete the code.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Purpose Code**



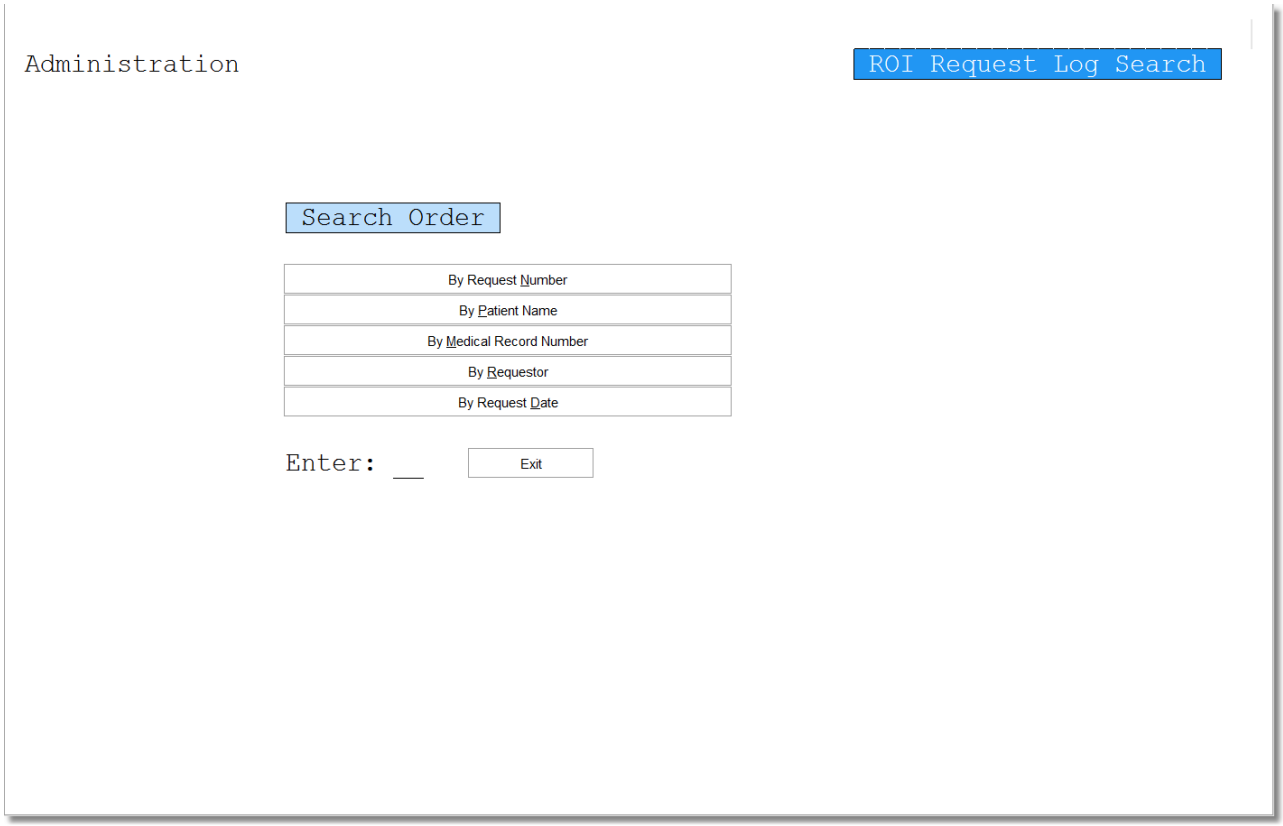
Purpose/Comment Code Maintenance

16.3 ROI Procedures

Request Maintenance

This option will allow for the entry or search of a request. Depending on how the Control Record is set, choosing this option will either display the Request Log Search or the Requestor Master. This option should be selected when setting up a new request. By accessing the Request Log Search first, the Medical Records staff has the ability to determine if this request has been setup on a prior occasion. Below are the options that will display:

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Request Entry**

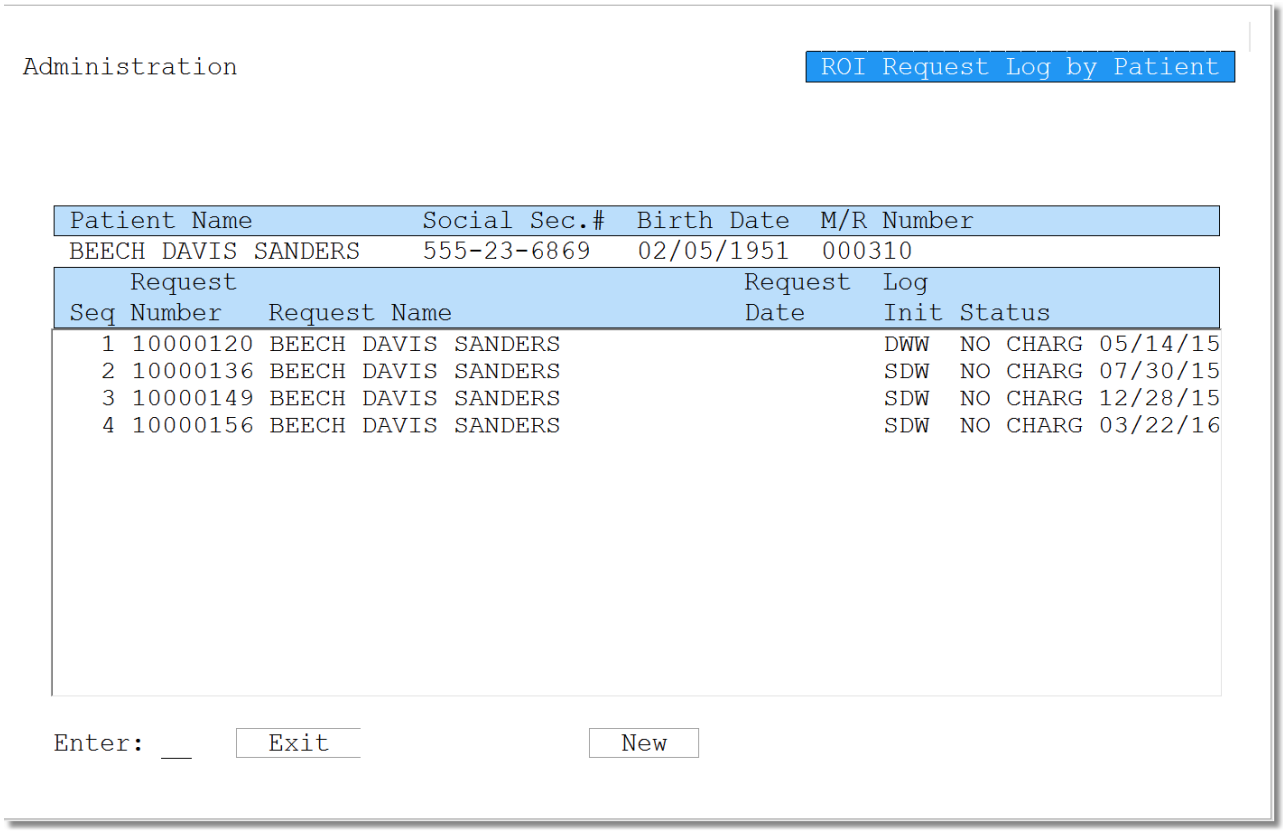


ROI Request Log Search

- **By Request Number:** This option will display all requests that have been set up. The system will prompt for a beginning request number. By entering through the starting request number, all requests will be displayed. Selecting **N**ew will allow for the entry of a new request.
- **By Patient:** This option will display the MPI lookup and allow for the selection of a patient. Once the patient is chosen it will display all requests. Selecting **N**ew will allow for the entry of a new request.
- **By Requestor:** This option will allow for the selection of a Requestor by name or code. Once the appropriate Requestor is chosen, all requests for the chosen requestor will be displayed. Selecting **N**ew will allow for the entry of a new request.
- **By Request Date:** This option will prompt for a begin date. Once the date is entered, the system will display all requests in ascending chronological order beginning with the date entered. Selecting **N**ew will allow for the entry of a new request.

Selecting the desired patient will display all of the requests that have been entered for that patient.

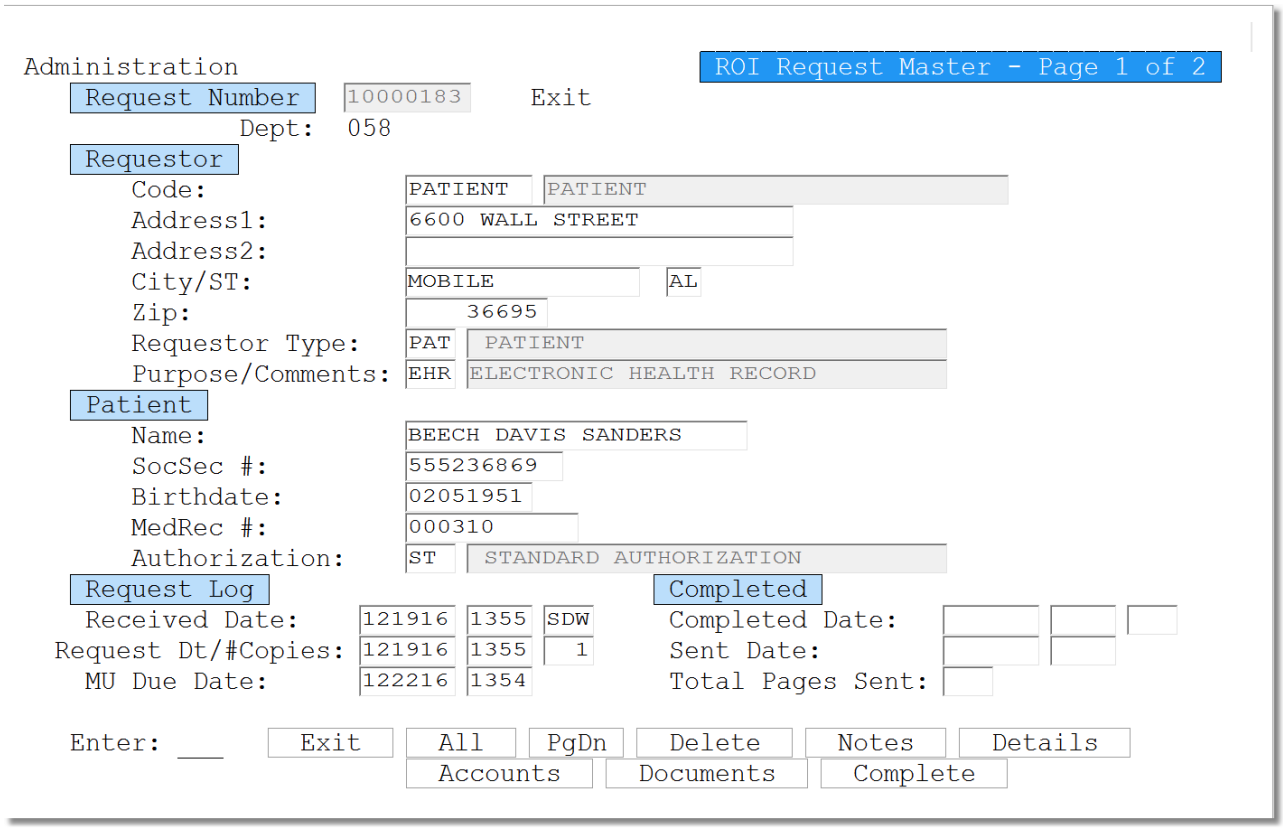
Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records > Release of Information > Request Entry > By Patient Name > sequence number**



ROI Request Log by Patient

If an existing request is not found, select **N**ew at the bottom of the screen to create a new request. The Request Master screen will then be accessed.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records > Release of Information > Request Entry > By Patient Name > "N"ew**



ROI Request Master - Page 1

NOTE: *If the Control Record is set to* ***N****, not allowing for Request Lookup, this screen will be directly accessed when Request Entry is chosen.*

NOTE: *For Meaningful Use sites, if a patient requests an electronic copy of Discharge Instructions at the time of discharge from the floor, ROI will be automatically updated from Point of Care. ROI Request Detail Maintenance will be updated with the account number, discharge date (if applicable), admit date, document code, description, pull date and initials.*

When setting up a new request, this screen must be completed prior to selecting accounts and the appropriate documents. Entering a period (**.**) and then pressing Enter will display the next available request number, which is stored in the Control Record. The following is an explanation of the fields:

Requestor

- **Requestor Code:** This field designates the Requestor. Entering a **?** will display the Requestor lookup. Entering an @ will allow for a free-form text field. This will be beneficial for patients or walk-ins.

- **Address Information:** Address information for the Requestor selected will pull from the Requestor Table. If a new Requestor was entered free-form, then this information should be entered.

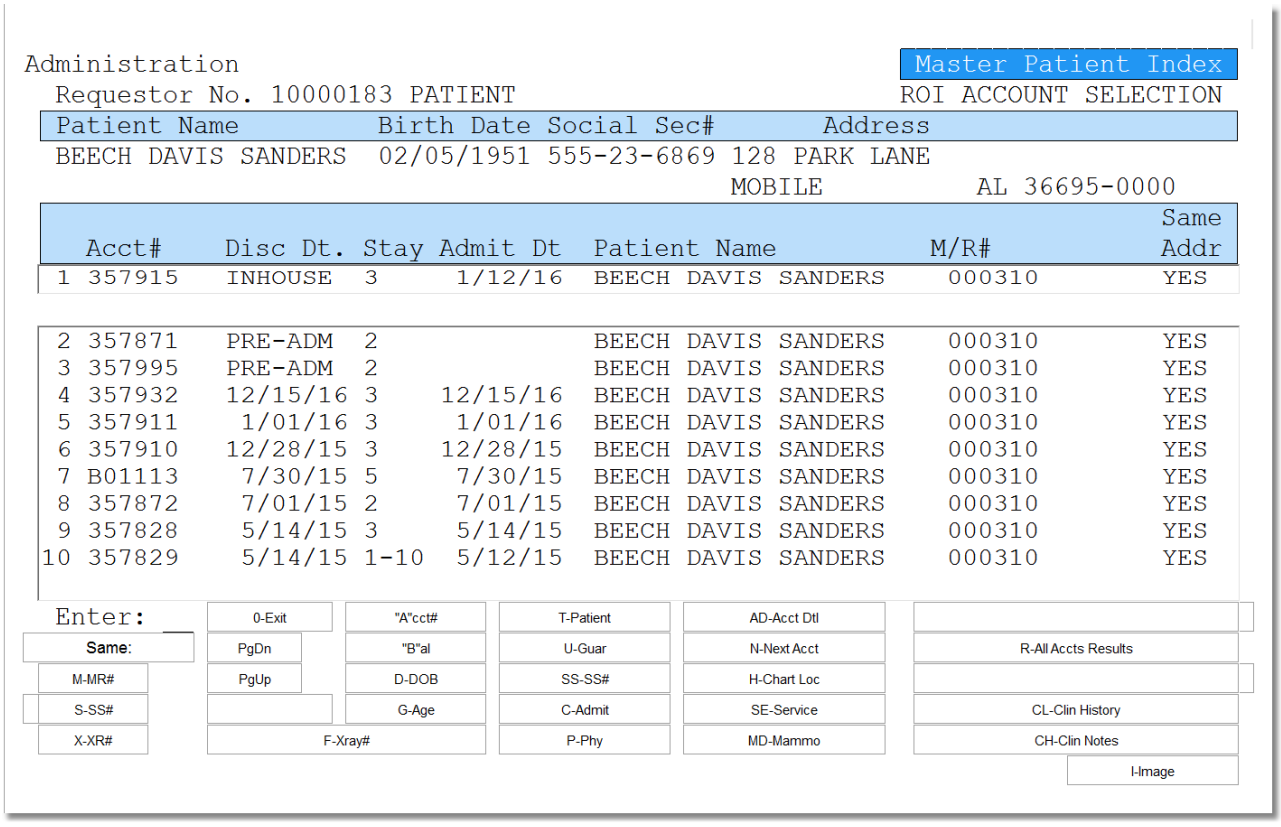
- **Requestor Type:** This field will pull from the Requestor Master Maintenance screen if one applies to this requestor. A lookup is provided that allows for a change in the requestor type. This field will determine how this request is billed.

- **Purpose/Comments:** The purpose of the request may be loaded in this field. This field is informational only and will pull to the Request History Log.

Patient

- **Name:** This field will allow for the selection of patient accounts included in this request. Entering a **?** will display the MPI Search Indexes. Once the appropriate search method is chosen, in order to select the necessary accounts, chose the sequence number that applies to those accounts. By accessing the accounts, an asterisk (*****) will appear next to those account numbers that the system is attaching to this request.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Request Entry**



Master Patient Index

Once the account(s) are selected, the Social Security Number, Birthdate and Medical Record Number will automatically pull from the Patient tab on the Registration and ADT screen.

- **Authorization:** The correct authorization code should be loaded in this field. Enter a **?** to access the lookup table or enter a @ to enter a free-form code.

Request Log

- **Received Date:** The date the request is received should be loaded in this field. The current time will pull next to the received date but may be overkeyed. If utilizing Employee Sign On, the initials of the person entering the request will pull next to the received time.

- **Request Date:** The date of the request should be loaded in this field. The current time will pull next to the request date but may be overkeyed.

- **Number of Copies:** The number of copies for this request should be loaded in this field. The system defaults to a 1.

- **MU Due Date:** The date will default to three days from the current date. The current time will pull next to the MU due date. Both fields may be overkeyed.

NOTE: *The MU Due Date only auto populates if the request is created from the Release of Information application using the Request Entry option.*

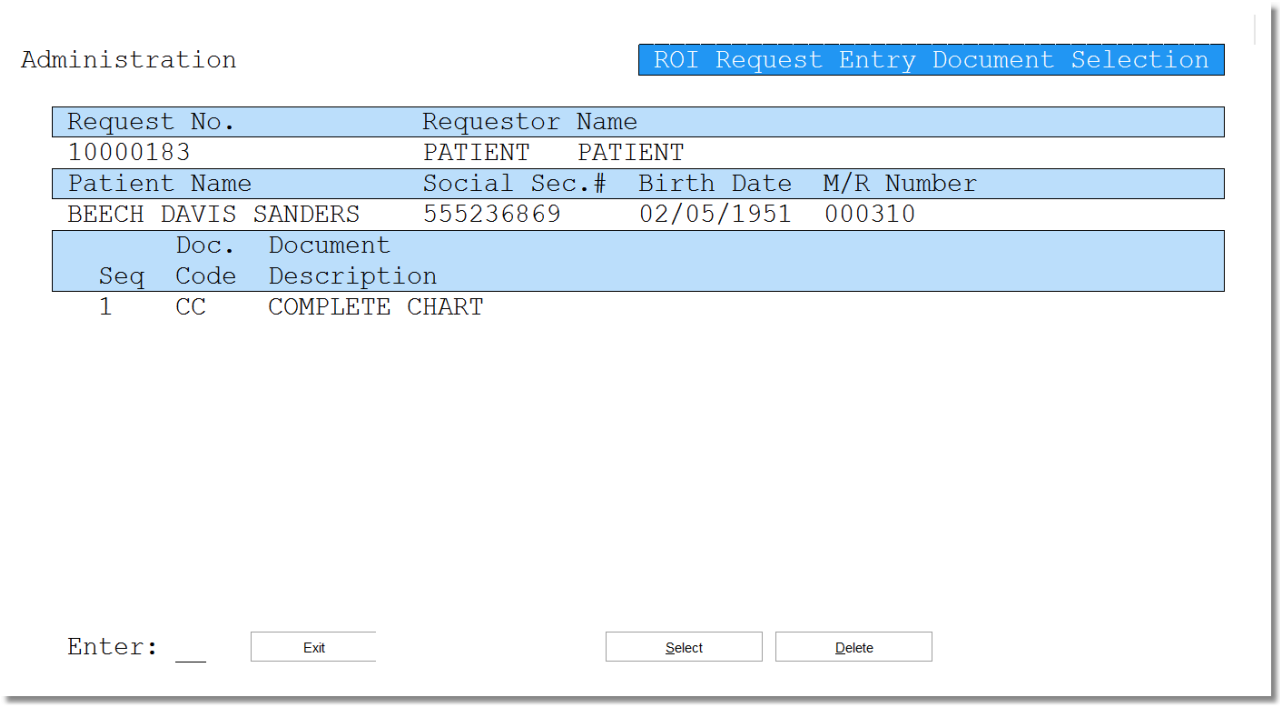
At the bottom of the screen, several other options are available:

- **ACC**ounts will allow patient accounts to be added or deleted from those previously selected in the (Patient) Name field.

- **DEL**ete will allow ROI requests to be deleted. However, once a request has a date loaded in the Completed Date field of the Request Entry, deletion is not possible. A warning message appears stating, “Unable to delete completed request. Press enter to continue.”

- **DOC**uments will allow the user to choose the documents requested. Entering **DOC** will display the following screen.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records > Release of Information > Request Entry > DOCuments**

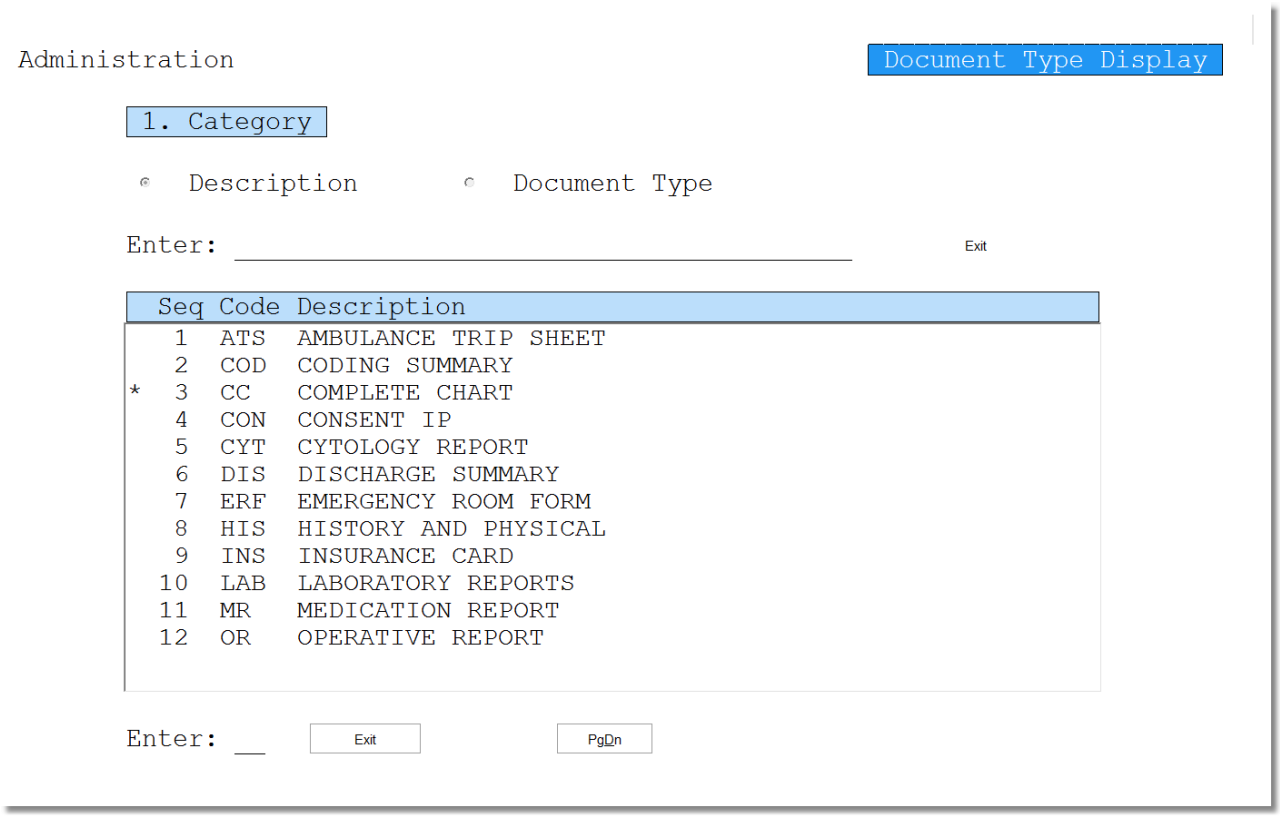


ROI Request Entry Document Selection

Select will allow requested documents to be chosen. If the document code is not known, entering a **?** will access a lookup window.

The lookup window will display by description or document type. Choosing the sequence number of the desired document will place an asterisk (*****) next to the selection.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records > Release of Information > Request Entry > DOCuments > "S"elect**

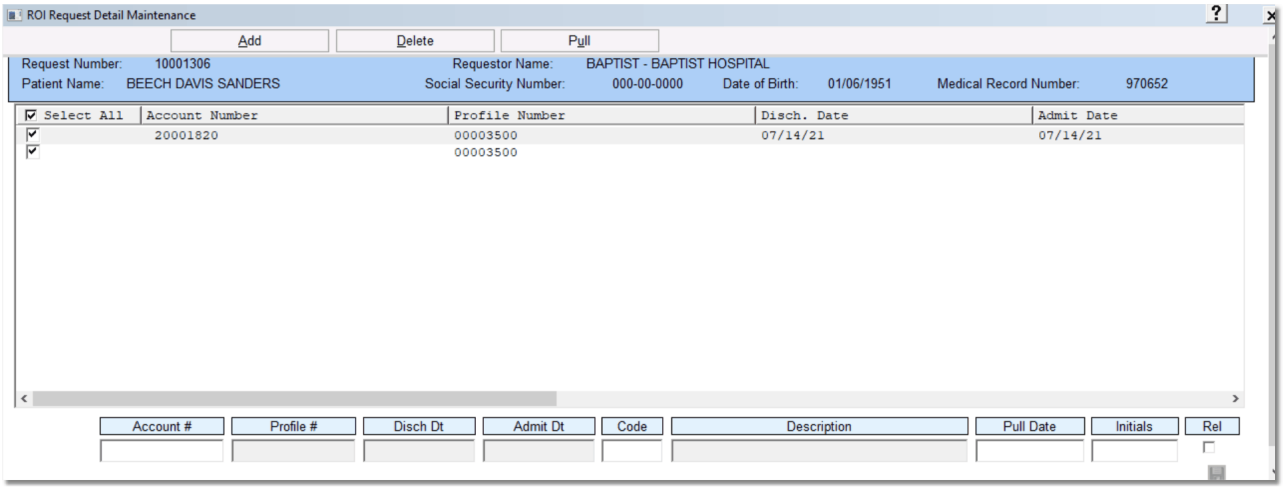


Document Type Display

When this screen is exited, the documents will be added to the details page of the request. When the user selects **DET**ails from page 1 of the Request Master, the system will display all accounts and documents requested.

The Details page contains all accounts and documents being requested. If an account or document needs to be added or deleted, it can be done on this page by entering **A**dd or **D**elete.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Request Entry** > **DETails**



Request Detail Maintenance

To record the Pull Date and Initials on a document, select the check-box next to the document or use the **Select All** option to choose all documents in the list. Then select **Pull**. Verify the Pull Date and Initials displayed in the edit row at the bottom of the screen. The Rel option may also be selected indicating that the documents were released to an individual or organization. Once the information is verified, select the **Save** disc.

***NOTE**: Documents that only display with a Profile Number were printed using the Print EMR by Patient 29 or the Include Patient Documents 40 options in Print EMR.*

The **Add** option will allow a document to be added to the ROI Request. Once selected, complete the information in the edit row at the bottom of the screen, then select the Save disc. The **Delete** option will allow a document to be removed from the ROI request. When finished, select the **X** in right corner of the Details screen to close it.

When exiting the above screen, the system will prompt, “Update Request as Complete?”. By answering **Y** this will prevent requests from pulling to the Incomplete Request Report, and will also flag this request as being ready for billing. If this prompt is answered **Y**, the system will return to page 1 of the Request Master.

Completed

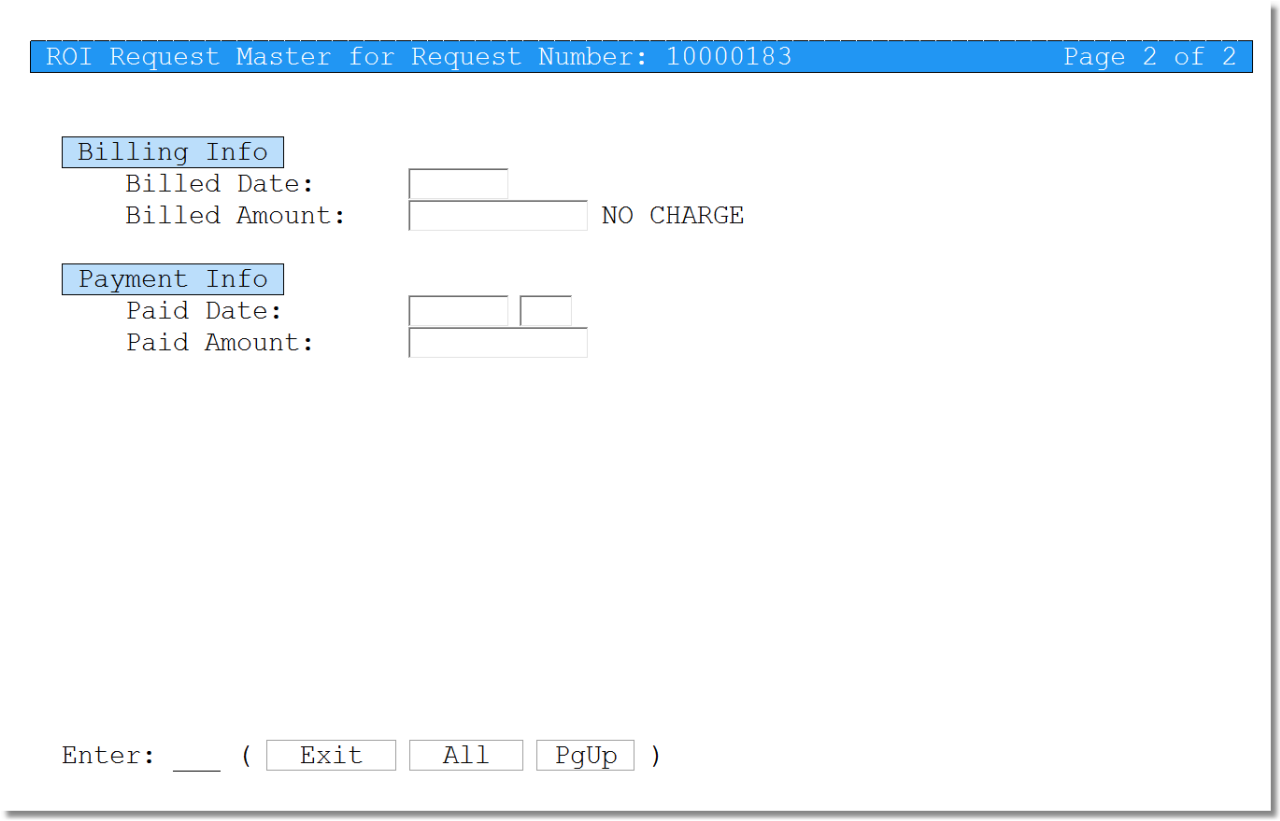
- **Completed Date:** The date the request was completed. The current time will pull next to the completed date but may be overkeyed. Once a date is entered in this field, the request status will move from Incomplete to Complete. If utilizing Employee Sign On, the initials of the person completing the request will pull next to the completed date.

- **Sent Date/Time:** This is the date and time the request was sent to the Requestor. Once a date is entered in this field, the request status will move from Complete to Sent.

- **Total Pages Sent:** The total number of copies contained in the request should be loaded in this field. The system will use the number loaded in this field to apply to the amount that will be billed to the Requestor.

The second page of the Request Master contains the billing and payment information. This page will automatically calculate the billed amount based on the requestor type for the request, once the request is marked as Complete. The system will look at the requestor type to see how the billed amount should be calculated. Once this screen is accessed the calculation will occur. This is the only field that will automatically enter information. All other information must be keyed.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Request Entry** > **PgDn**



ROI Request Master, Page 2

- **Billed Date:** The date the requestor was billed. Once a date is entered in this field, the request status will move from the Sent to the Billed status.
- **Billed Amount:** The system will automatically calculate the billed amount based on the Requestor type and the total pages sent.
- **Paid Date:** The date the payment for the request is received, and the initials of the person that accepted the payment, should be loaded in this field. Once a date is entered into this field, the request status will move from the Billed to the Paid status.

- **Paid Amount:** The total payment amount received on this request should be loaded in this field.

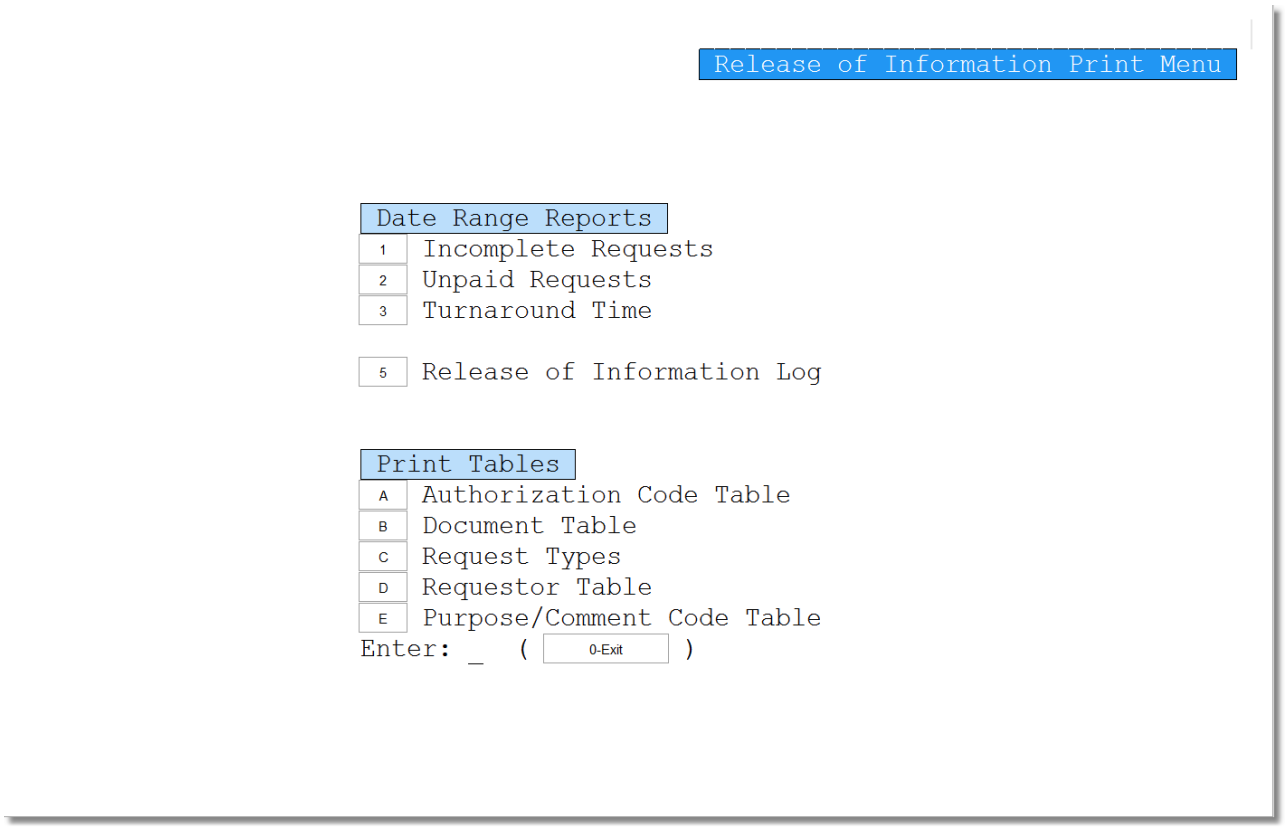
NOTE: *If the Request Type for this entry has the No Charge field selected in the Request Type Table, the Request Status will always be listed as No Charge. These Requests statuses will never be listed as Incomplete, Sent, Complete, Billed or Paid, but will pull to the appropriate reports.*

16.4 Printed Reports

Overview

To access the reports for Release of Information, select **Exit to Print Report Menu** from the Release of Information Main Menu. Once this option is chosen, the screen below will be displayed.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Exit to Print Report Menu**



Release of Information Print Menu

The Print Tables section provides a listing of all codes set up in the Maintenance section for each facility defined table.

Incomplete Requests Reports

The Incomplete Request report will provide a list of all requests that have not been marked as Complete.

How to Print

1. Select **Exit to Print Reports** from the Release of Information Main Menu.

2. Select **Incomplete Requests**.

3. Select a print option.

   System prompts, “Starting Received Date:” and “Ending Received Date:”

4. Enter a Received Date range or press Enter to pull for all dates.

   System prompts, “Requestor Code:”

5. Enter a specific Requestor Code, or a **?** to access the lookup window for Requestor Codes, or enter a @ to enter a free form Requestor Code. Pressing Enter will pull all codes.

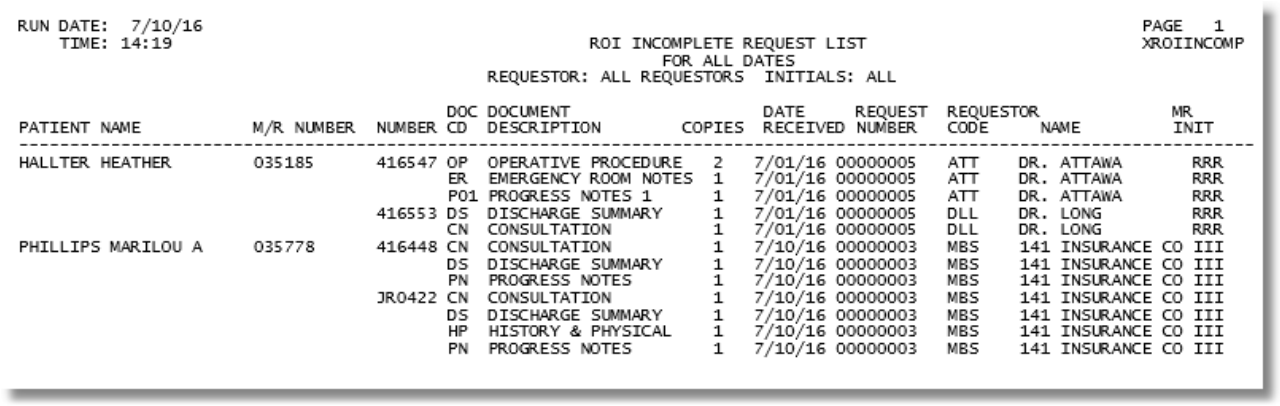
   System prompts, “Log Initials:”

6. Enter the initials of the person that entered the request, or press Enter for all.

Description and Usage

The Incomplete Request report will provide a list of all requests that have not been marked as Complete. This report should be used as a work list to pull the necessary documents being requested. This report will allow for the entry of a beginning and ending received date, requestor code and log initials. This report may be printed for specific dates or codes or by all.

Incomplete Requests



RUN DATE: 7/10/16 TIME: 14:19 — PAGE 1 — XROIINCOMP

ROI INCOMPLETE REQUEST LIST
FOR ALL DATES
REQUESTOR: ALL REQUESTORS INITIALS: ALL

PATIENT NAME	M/R NUMBER	NUMBER	DOC CD	DOCUMENT DESCRIPTION	COPIES	DATE RECEIVED	REQUEST NUMBER	REQUESTOR CODE	NAME	MR INIT
HALLTER HEATHER	035185	416547	OP	OPERATIVE PROCEDURE	2	7/01/16	00000005	ATT	DR. ATTAWA	RRR
			ER	EMERGENCY ROOM NOTES	1	7/01/16	00000005	ATT	DR. ATTAWA	RRR
			P01	PROGRESS NOTES 1	1	7/01/16	00000005	ATT	DR. ATTAWA	RRR
		416553	DS	DISCHARGE SUMMARY	1	7/01/16	00000005	DLL	DR. LONG	RRR
			CN	CONSULTATION	1	7/01/16	00000005	DLL	DR. LONG	RRR
PHILLIPS MARILOU A	035778	416448	CN	CONSULTATION	1	7/10/16	00000003	MBS	141 INSURANCE CO	III
			DS	DISCHARGE SUMMARY	1	7/10/16	00000003	MBS	141 INSURANCE CO	III
			PN	PROGRESS NOTES	1	7/10/16	00000003	MBS	141 INSURANCE CO	III
		JR0422	CN	CONSULTATION	1	7/10/16	00000003	MBS	141 INSURANCE CO	III
			DS	DISCHARGE SUMMARY	1	7/10/16	00000003	MBS	141 INSURANCE CO	III
			HP	HISTORY & PHYSICAL	1	7/10/16	00000003	MBS	141 INSURANCE CO	III
			PN	PROGRESS NOTES	1	7/10/16	00000003	MBS	141 INSURANCE CO	III

Listed below is an explanation of each column.

- **Patient Name:** Pulls from the ROI Request Master, page 1.
- **M/R Number:** (Medical Record Number)**:** Pulls from the ROI Request Master, page 1.
- **Number:** The patient account numbers loaded on the request.
- **Doc Cd** (Document Code)**:** The documents selected on the request.
- **Document Description:** The description of the requested Document Code.
- **Copies:** The number of copies requested pulls from the ROI Request Master, page 1.
- **Date Received:** Pulls from the ROI Request Master, page 1.
- **Request Number:** Pulls from the ROI Request Master.
- **Requestor Code:** Pulls from the ROI Request Master, page 1.
- **Name:** The name of the requestor associated with the Requestor Code.
- **MR Init:** The initials of the person who received the request pulls from the ROI Request Master, page 1.

Unpaid Requests Reports

The Unpaid Request report will provide a list of all requests that have been completed and have a Billed Date and Amount, but have not yet received payment for the request.

How to Print

1. Select **Exit to Print Reports** from the Release of Information Main Menu.
2. Select **Unpaid Requests**.
3. Select a print option.

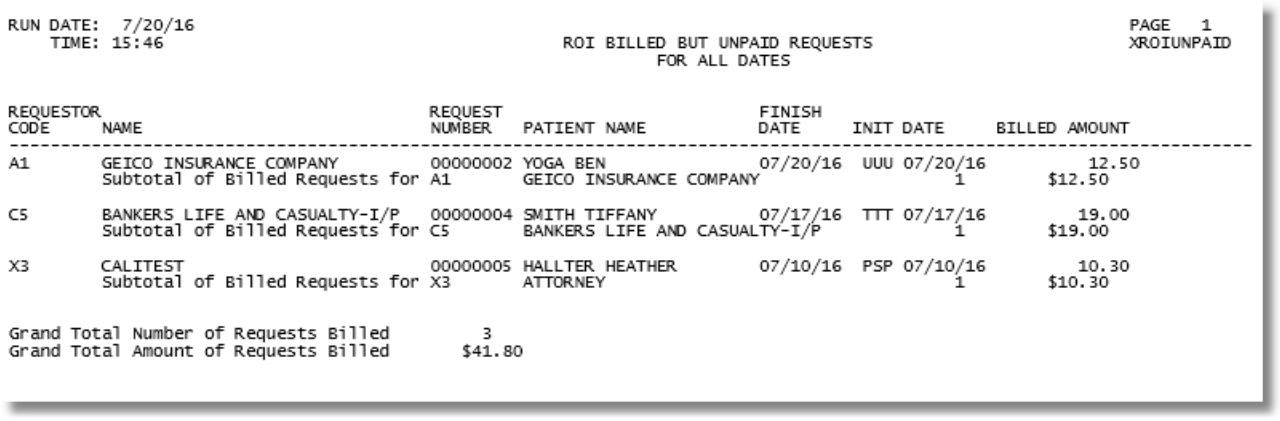
   System prompts, “Starting Billed Date:” and “Ending Billed Date:”

4. Enter a Billed Date range or press Enter to pull for all dates.

Description and Usage

The Unpaid Request report will provide a list of all Completed requests that have been marked with a Billed Date and Amount yet have not received payment for the request. Requests with a Billed Date that fall within the Billed Date range entered will pull to the report. The report will subtotal by Requestor Code. Once a Paid Date and Amount is entered on page two of the Request Master this request will no longer pull to the Unpaid Requests Report.

Unpaid Requests



RUN DATE: 7/20/16 TIME: 15:46 — ROI BILLED BUT UNPAID REQUESTS FOR ALL DATES — PAGE 1 XROIUNPAID

REQUESTOR CODE	NAME	REQUEST NUMBER	PATIENT NAME	FINISH DATE	INIT	DATE	BILLED AMOUNT
A1	GEICO INSURANCE COMPANY	00000002	YOGA BEN	07/20/16	UUU	07/20/16	12.50
	Subtotal of Billed Requests for A1		GEICO INSURANCE COMPANY			1	$12.50
C5	BANKERS LIFE AND CASUALTY-I/P	00000004	SMITH TIFFANY	07/17/16	TTT	07/17/16	19.00
	Subtotal of Billed Requests for C5		BANKERS LIFE AND CASUALTY-I/P			1	$19.00
X3	CALITEST	00000005	HALLTER HEATHER	07/10/16	PSP	07/10/16	10.30
	Subtotal of Billed Requests for X3		ATTORNEY			1	$10.30

Grand Total Number of Requests Billed 3
Grand Total Amount of Requests Billed $41.80

Listed below is an explanation of each column.

- **Requestor Code:** Pulls from the ROI Request Master.
- **Name:** The name of the requestor associated with the Requestor Code.
- **Request Number:** Pulls from the ROI Request Master.
- **Patient Name:** Pulls from the ROI Request Master, page 1.
- **Finish Date:** The Completed Date pulls from the ROI Request Master, page 1.
- **Init:** The initials of the person who completed the request pulls from the ROI Request Master, page 1.
- **Date:** The Billed Date pulls from the ROI Request Master, page 2.
- **Billed Amount:** Pulls from the ROI Request Master, page 2.

Turnaround Time

The Turnaround Time Report contains turnaround times in days for dates Received, Completed, Sent, Billed and Paid.

How to Print

1. Select **Exit to Print Reports** from the Release of Information Main Menu.
2. Select **Unpaid Requests**.
3. Select a print option.

   System prompts, “Starting Date:” and “Ending Date:”

4. Enter a Billed Date range or press Enter to pull for all dates.

   System prompts, “Date to use for Date Range:”

5. The options are Received Date, Complete Date, Sent Date, Billed Date and Paid Date.

   System prompts, “Requestor Code: (Enter for All):”

6. Enter a desired Requestor Code or Enter to have all codes print to report.

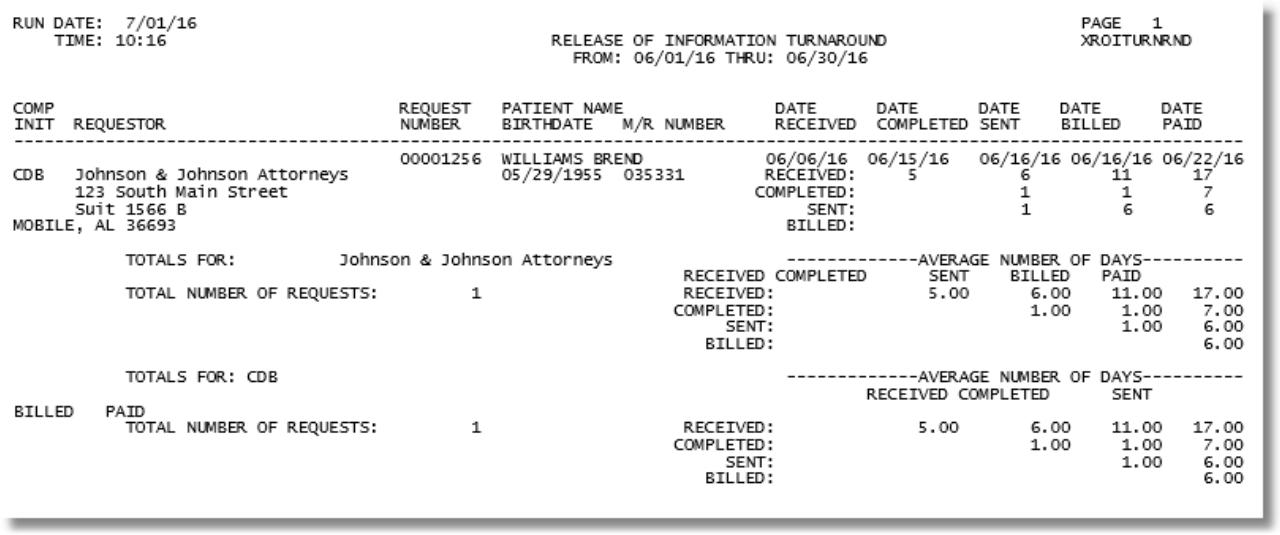
   System prompts, “Completed By Initials: (Enter for All):”

7. Enter a desired Initials or Enter to have all initials print to report.

Description and Usage

The Turnaround Time Report calculates the number of days between the statuses of the request. This report may be run for all Requestors Codes or for a specific code. The report may also be delimited by selecting specific initials associated with the requests. This report will aid in estimating the time it takes to complete a request from the received date to the paid date.

Turnaround Time



```
RUN DATE:  7/01/16                                                              PAGE   1
    TIME: 10:16                          RELEASE OF INFORMATION TURNAROUND      XROITURNRND
                                           FROM: 06/01/16 THRU: 06/30/16

COMP                                 REQUEST   PATIENT NAME              DATE      DATE      DATE    DATE      DATE
INIT  REQUESTOR                      NUMBER    BIRTHDATE   M/R NUMBER    RECEIVED  COMPLETED SENT    BILLED    PAID
-------------------------------------------------------------------------------------------------------------------
                                     00001256  WILLIAMS BREND            06/06/16  06/15/16  06/16/16 06/16/16 06/22/16
CDB   Johnson & Johnson Attorneys              05/29/1955  035331        RECEIVED:      5         6        11       17
      123 South Main Street                                            COMPLETED:                1        1        7
      Suit 1566 B                                                          SENT:                 1        6        6
MOBILE, AL 36693                                                         BILLED:

           TOTALS FOR:          Johnson & Johnson Attorneys                    -------------AVERAGE NUMBER OF DAYS----------
                                                                    RECEIVED COMPLETED      SENT    BILLED   PAID
           TOTAL NUMBER OF REQUESTS:         1                      RECEIVED:                5.00      6.00    11.00   17.00
                                                                   COMPLETED:                          1.00     1.00    7.00
                                                                        SENT:                                      1.00    6.00
                                                                      BILLED:                                              6.00

           TOTALS FOR: CDB                                                  -------------AVERAGE NUMBER OF DAYS----------
                                                                                   RECEIVED COMPLETED      SENT
BILLED   PAID
           TOTAL NUMBER OF REQUESTS:         1                      RECEIVED:              5.00       6.00    11.00   17.00
                                                                   COMPLETED:                          1.00     1.00    7.00
                                                                        SENT:                                      1.00    6.00
                                                                      BILLED:                                              6.00
```

Listed below is an explanation of each column.

- **Comp Init:** The initials of the person who completed the request pulls from the ROI Request Master, page 1, field 20.
- **Requestor:** Pulls from the ROI Request Master, page 1.
- **Request Number:** Pulls from the ROI Request Master.
- **Patient Name:** Pulls from the ROI Request Master, page 1.

- **Birthdate:** Pulls from the ROI Request Master, page 1.
- **M/R Number (Medical Record Number):** Pulls from the ROI Request Master, page 1.
- **Date Received:** Pulls from the ROI Request Master, page 1.
- **Date Completed:** Pulls from the ROI Request Master, page 1.
- **Date Sent:** Pulls from the ROI Request Master, page 1.
- **Date Billed:** Pulls from the ROI Request Master, page 2.
- **Date Paid:** Pulls from the ROI Request Master, page 2.
- **Received:** Pulls the number of days between Date Received and each of the other statuses.
- **Completed:** Pulls the number of days between Date Completed and Date Sent, Date Billed, and Date Paid.
- **Sent:** Pulls the number of days between Date Sent and Date Billed and Date Paid.
- **Billed:** Pulls the number of days between Date Billed and Date Paid.

Release of Information Log

The Release of Information Log will provide a list of all requests for a patient.

How to Print

1. Select **Exit to Print Reports** from the Release of Information Main Menu.
2. Select **Release Of Information Log**.

   System prompts, “Medical Record Numbers:”
3. Up to 40 numbers may be entered.

   System prompts, “Starting and Ending Received Dates”:
4. Enter specific dates or press Enter for all.

   System prompts, “Complete Status”.
5. Enter **C**omplete, **I**ncompleted, or Enter for All.

   System prompts, “Paid Status”.
6. Enter **P**aid, **U**npaid or Enter for All.

   System prompts, “Include Payment Info”.

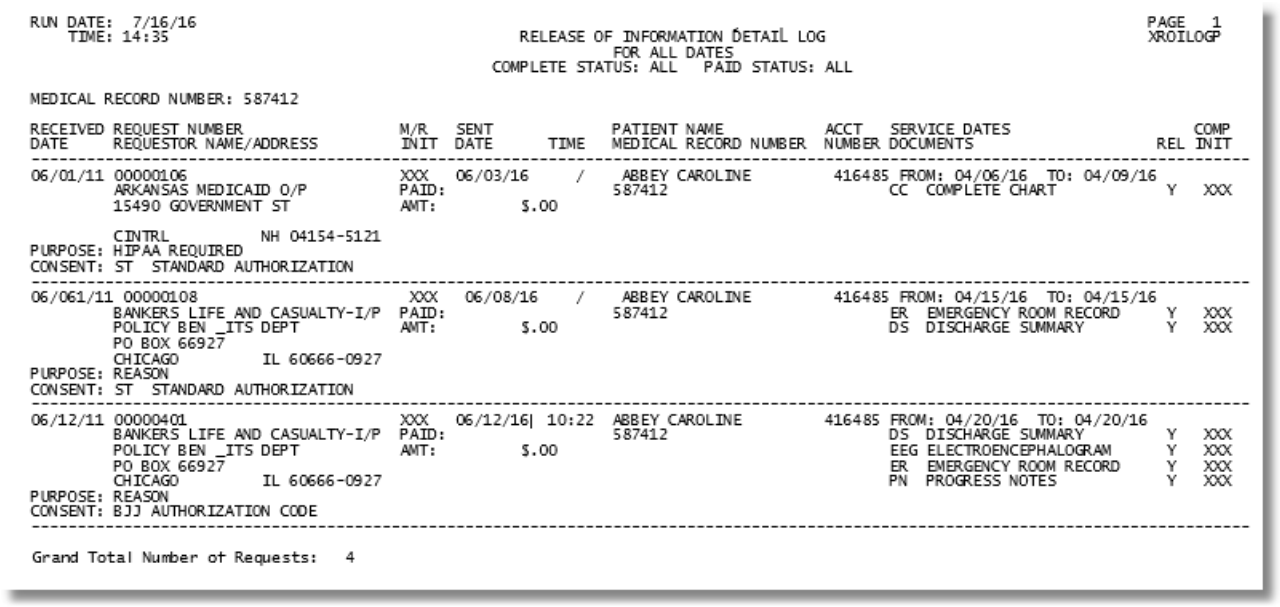
7. Select this field to include payment information.

8. Select a print option.

Description and Usage

The Release of Information Log will provide a list of all requests for a patient. This report will provide the received date, the requestor name and address, the request number, the date sent, patient's name and medical record number, account numbers associated with each request, the service dates of each account, the documents requested, the released information and the employee's initials that entered and released the request. Also included will be the purpose and consent code of each request. It is optional to include the payment information.

Release of Information Log



```
RUN DATE:  7/16/16                                                                                                    PAGE   1
    TIME: 14:35                                  RELEASE OF INFORMATION DETAIL LOG                                XROILOGP
                                                        FOR ALL DATES
                                            COMPLETE STATUS: ALL   PAID STATUS: ALL

MEDICAL RECORD NUMBER: 587412

RECEIVED REQUEST NUMBER                M/R   SENT                  PATIENT NAME          ACCT   SERVICE DATES                    COMP
DATE     REQUESTOR NAME/ADDRESS        INIT  DATE      TIME        MEDICAL RECORD NUMBER NUMBER DOCUMENTS                     REL INIT
-------------------------------------------------------------------------------------------------------------------------------------
06/01/11 00000106                      XXX   06/03/16     /       ABBEY CAROLINE        416485 FROM: 04/06/16  TO: 04/09/16
         ARKANSAS MEDICAID O/P         PAID:                      587412                       CC  COMPLETE CHART              Y   XXX
         15490 GOVERNMENT ST           AMT:          $.00
         CINTRL          NH 04154-5121
PURPOSE: HIPAA REQUIRED
CONSENT: ST  STANDARD AUTHORIZATION
-------------------------------------------------------------------------------------------------------------------------------------
06/061/11 00000108                      XXX   06/08/16     /       ABBEY CAROLINE        416485 FROM: 04/15/16  TO: 04/15/16
         BANKERS LIFE AND CASUALTY-I/P PAID:                      587412                       ER  EMERGENCY ROOM RECORD      Y   XXX
         POLICY BEN _ITS DEPT          AMT:          $.00                                      DS  DISCHARGE SUMMARY          Y   XXX
         PO BOX 66927
         CHICAGO         IL 60666-0927
PURPOSE: REASON
CONSENT: ST  STANDARD AUTHORIZATION
-------------------------------------------------------------------------------------------------------------------------------------
06/12/11 00000401                      XXX   06/12/16| 10:22  ABBEY CAROLINE        416485 FROM: 04/20/16  TO: 04/20/16
         BANKERS LIFE AND CASUALTY-I/P PAID:                      587412                       DS  DISCHARGE SUMMARY          Y   XXX
         POLICY BEN _ITS DEPT          AMT:          $.00                                      EEG ELECTROENCEPHALOGRAM       Y   XXX
         PO BOX 66927                                                                          ER  EMERGENCY ROOM RECORD      Y   XXX
         CHICAGO         IL 60666-0927                                                         PN  PROGRESS NOTES             Y   XXX
PURPOSE: REASON
CONSENT: BJJ AUTHORIZATION CODE
-------------------------------------------------------------------------------------------------------------------------------------

Grand Total Number of Requests:   4
```

Listed below is an explanation of each column.

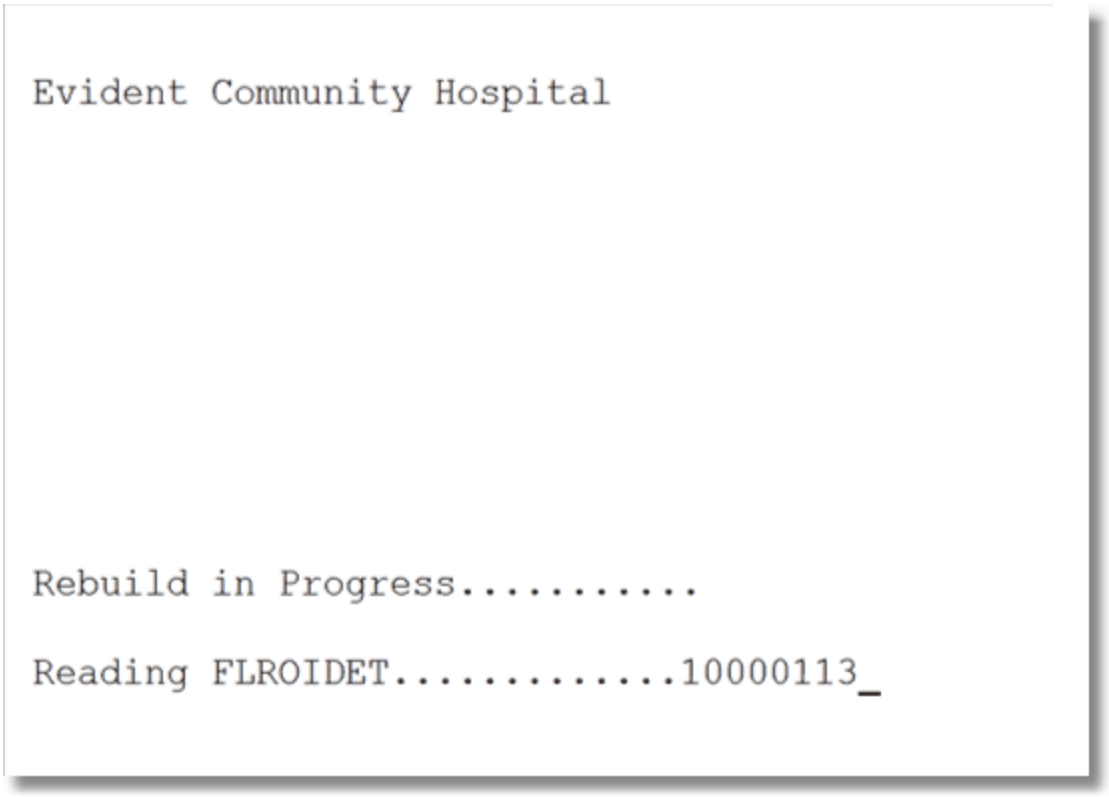
- **Received Date:** Pulls from the ROI Request Master, page 1.
- **Request Number:** Pulls from the ROI Request Master.
- **Requestor Name/Address:** Pulls from the ROI Request Master, page 1.
- **M/R Init:** The initials of the person who received the request pulls from the ROI Request Master, page 1.
- **Sent Date:** Pulls from the ROI Request Master, page 1.
- **Time:** Pulls from the ROI Request Master, page 1.
- **Patient Name:** Pulls from the ROI Request Master, page 1.

- **Medical Record Number:** Pulls from the ROI Request Master, page 1.
- **Acct Number:** If the document on the request is associated with a specific visit, then the patient's account number will display in this column. If the document on the request is not associated with a specific visit, then the patient's profile number will display in this column.
- **Service Dates:** The service dates or each patient account.
- **Documents:** The code and description of the requested documents.
- **Rel (Release):** Indicates if the document was released.
- **Comp Init:** The initials of the person who completed the request pulls from the ROI Request Master, page 1.
- **Purpose:** The Purpose/Comments pulls from the ROI Request Master, page 1.
- **Consent:** The Authorization Code and Description pulls from the ROI Request Master, page 1.

Rebuild ROI Patient Name Index

The rebuild of the ROI Patient Index option is a way to correct the index when patients are not displaying or printing to the ROI reports. For example, if patient requests, such as those which are at the Completed status, are unable to be viewed in Request History Log, then a rebuild of the ROI Patient Index would be needed. This rebuild should be run to capture any changes made in the MPI, and can be run as often as needed.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Print Reports** > **ROI Patient Name Index**



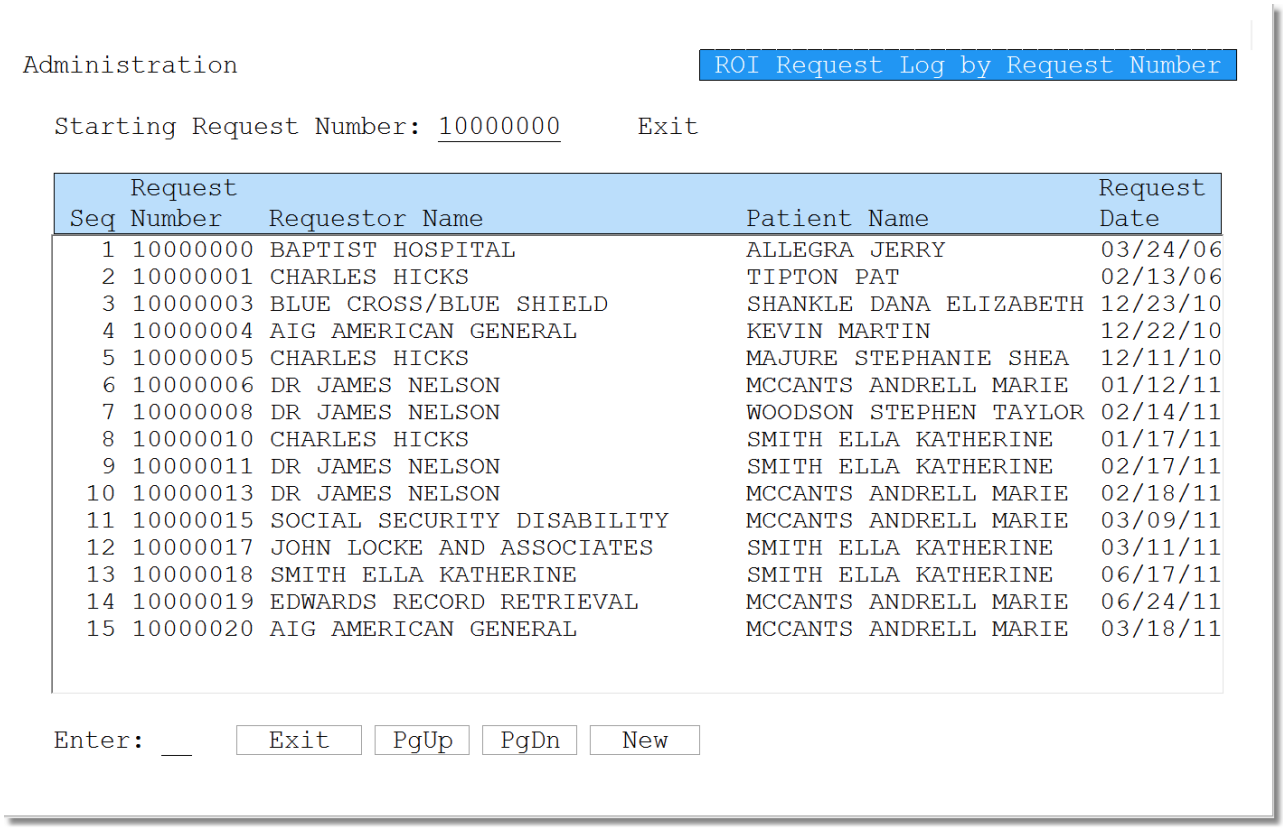
Rebuild Patient Name Index

Request Log

The Request Log will display options available for a Request Log Search.

Select a sequence number to choose a search order for requests. As shown below, **By Request Number** was selected.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Request Log** > **By Request Number**



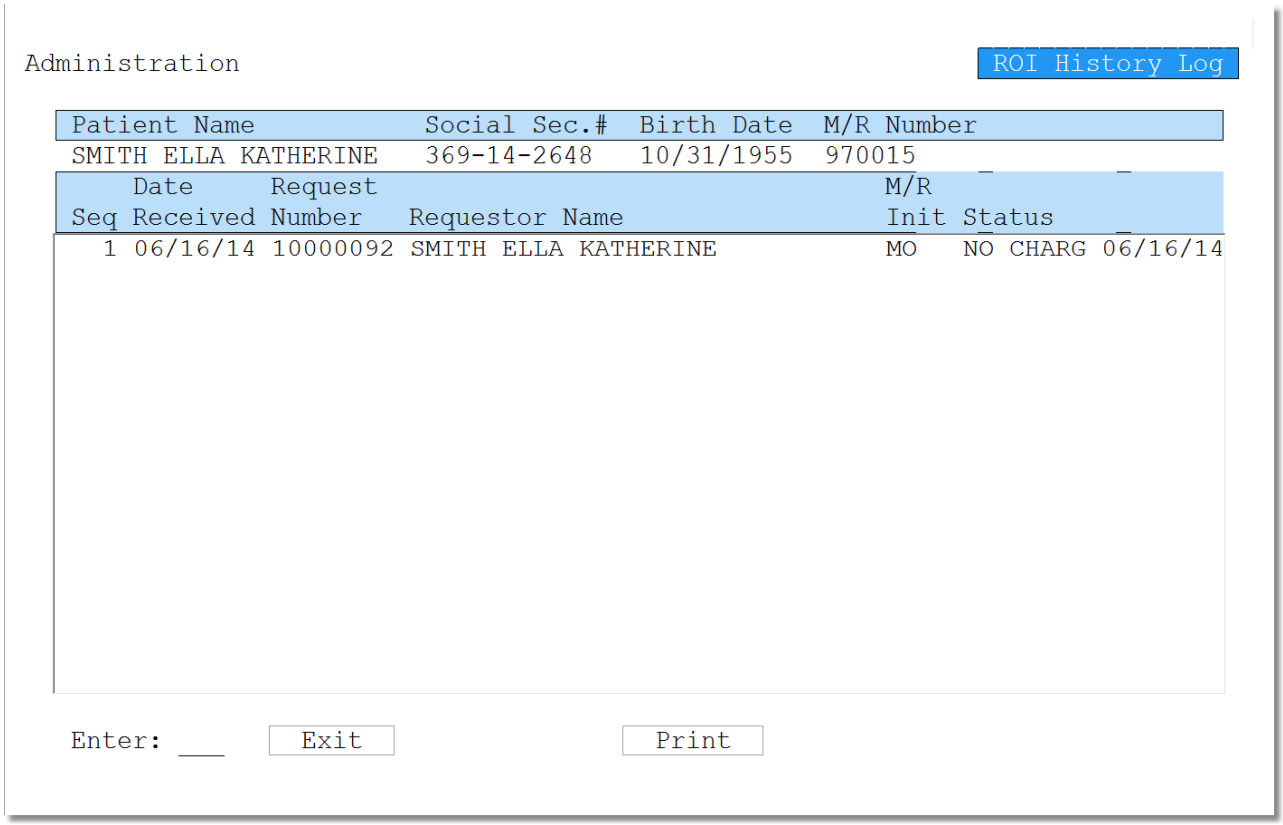
ROI Request Log by Request Number

Once the requests are accessed by any of the above search options, maintenance may be performed on an existing request, or a new request can be entered.

Displays

- **Authorization Code:** Choosing this option will display all authorization codes that have been established. This will display by description or code order.
- **Document Types:** This option will display all document types that have been established. This will display by description or code order.
- **Requestor Types:** This option will display all requestor types that have been established. This will display by description or code order.
- **Requestor Maintenance:** This option will display all requestors that have been established. This will display by description or code order.
- **Request Log:** This option will allow a search to be conducted by Request Number, Patient Name, Medical Record Number, Requestor or Request Date.
- **Request History Log:** This option will allow a search to be conducted by Patient name or Medical Record Number. Once the patient is chosen all requests for that patient will be displayed.

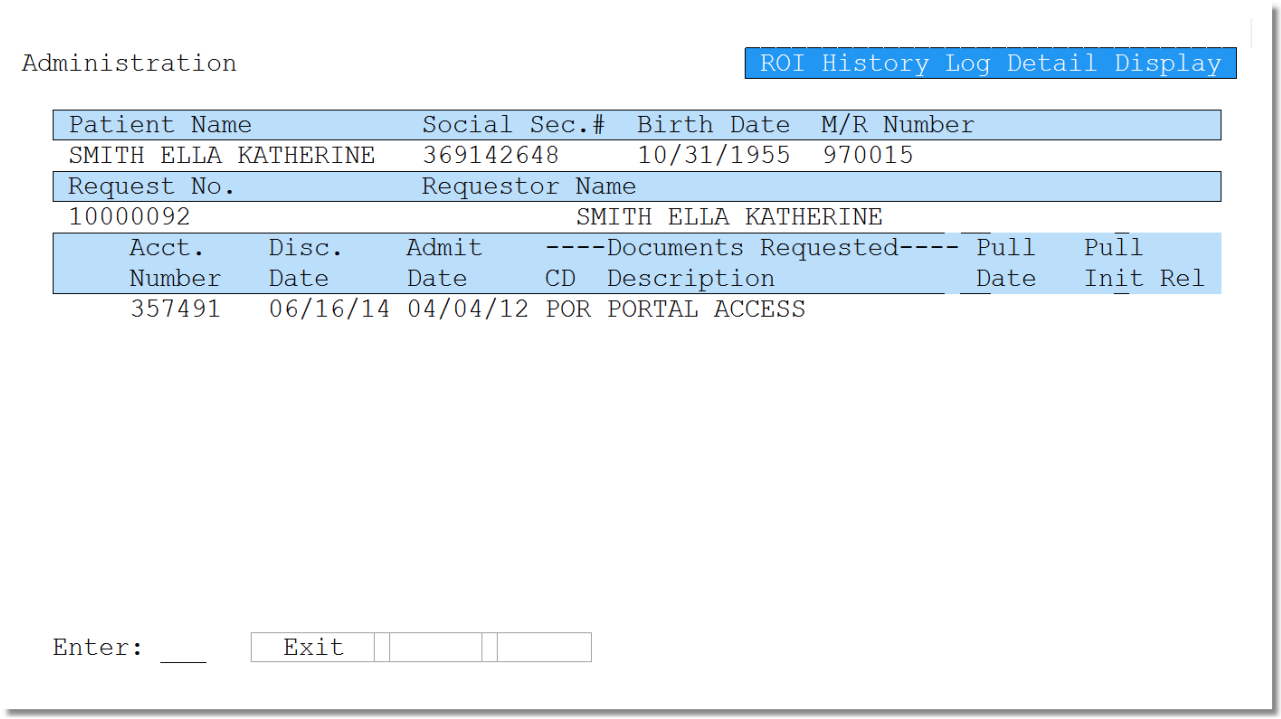
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Release of Information** > **Request History Log**



ROI History Log

Selecting the desired request will then allow for the details of that particular request to be displayed. The History Log may also be printed from this screen by selecting **P**rint.

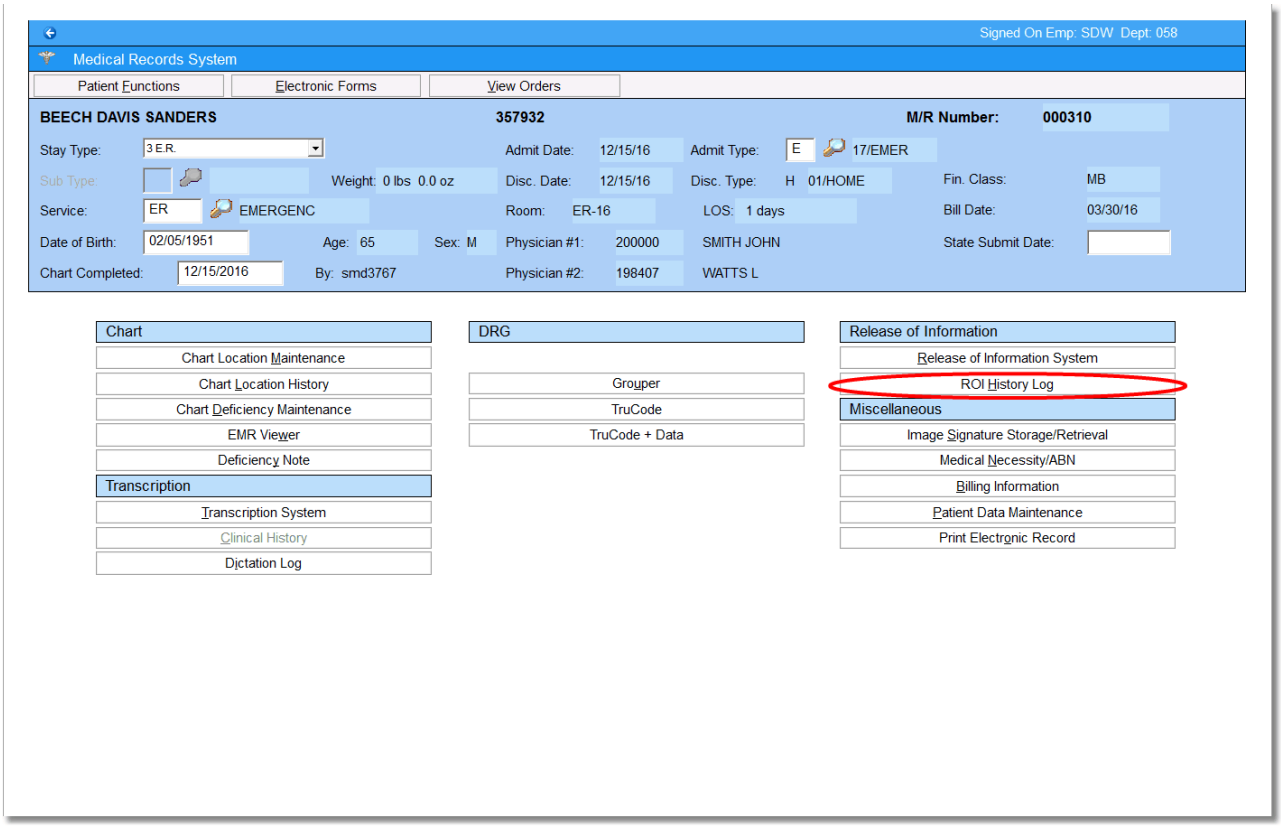
Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Medical Records > Release of Information > Request History Log > Sequence Number**



ROI History Log Detail Display

The ROI History log may also be accessed from the patient's Medical Record screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records**



Medical Records

Select **ROI History Log**, to display all requests for this patient. The History Log may also be printed from this screen.