GE/IDX WEB 4.0
GE-IDX Web 4.0 New User Front End Training

Course Descriptions

**Health Insurance Fundamentals:**
(On-line Learning on ULearn) Course provided by Office of Business Development

**GE-IDX Web 4.0 System Overview and Inquiry:**
(On-line Learning on ULearn) This course provides new users of GE-IDX Web 4.0 with an overview of basic system concepts, patient inquiry, and patient workflow. It defines the key elements of Web functionality such as the ‘Patient Banner’, ‘VTB/HTB’, ‘Patient Services’ screen. Also included is Patient Inquiry, Visit Inquiry, and the hold bill / alert concept, as well as instructions on obtaining Hospital and UMMG Policies and Procedures.

**Outline:**
1. About Patient Work Flow process
2. How to access Policies and Procedures
3. How to view patient data
   a. on the Patient Services screen
   b. through Patient Inquiry
4. About Hold Bill concepts
GE-IDX Web 4.0 Fundamentals:
(On-line Learning on ULearn) This course reviews basic system functionality such as logging in and out, navigating the system, requesting a chart and viewing patient financial documents scanned into the system.

Outline:
1. Login
2. Screen to Screen Navigation
3. Patient Services Overview
4. VTB, HTB, Banner, Workplace
5. Toolplace
6. Locking and Unlocking and IDX Session
7. Changing your password
8. Changing Organization, Group and HMO
9. Logging off
10. Patient Lookup
11. Selecting a patient previously accessed
12. Chart Request
GE-IDX Web 4.0 Provider Schedules Inquiry
(On-line Learning on ULearn) This course provides users with an understanding of viewing physician schedules on GE-IDX Web 4.0. It also defines key concepts in scheduling necessary in understanding provider schedules.

Outline:

GE-IDX Web 4.0 New User Front End Training Day 1
(Instructor-led learning)

Outline:
1. Patient Services and Inquiry Review
2. Scheduling concepts
3. Scheduling Appointments
   a. Review of the criteria screen
   b. Appointment Types
   c. Patient Preferences
   d. Appointment Setting
   e. ADF - Appointment Data Form
   f. Appointment List
4. Registration - Demographic Patient Information
   a. Explanation of all Registration Screens
5. Manage Insurance Information Concepts
   a. FSCs Concepts
   b. Contract Summary
   c. Contracted vs Non-Contracted FSCs
   d. Alternate Insurance
6. Open Referrals Concepts
   a. Creating an Open Referral
   b. Review of Referral Types, Rules and Policies

GE-IDX Web 4.0 New User Front End Training Day 2
(Instructor-led learning)

Outline:
1. Review of Day 1
2. Editing appointments
3. Linking Appointments, referrals and cases
   a. Before and After the Appointment is scheduled
4. Learning the XS action code process
   a. Appointments scheduled less than 14 days in the future
5. Cyclical Appointments
6. Provider Schedules
   a. Viewing
   b. Scheduling from
7. Bump list
GE-IDX Web 4.0 New User Front End Training Day 3
(Instructor-led learning)

Outline:
1. Review of Day 2
2. EDI-Eligibility
   a. Reviewing Eligibility Results and Benefits
   b. New Requests
3. Hospital Insurance Verification Process
   a. XN action code process
4. Appointment Manager
   a. Hospital Arrival Workflow discussion
5. Hospital Arrival Process
   a. ME – Marked Event
   b. XX action code process
6. Physician Practice Arrival Process
7. Walk-in / ABLEH Emergency Room
   a. ABLEH Emergency Room Arrival Process
   b. XR action code process
8. Front Desk
   a. Collecting Time of service payments
   b. Balancing and exiting batches

GE-IDX Web 4.0 New User Front End Training Day 4
(Instructor-led learning)

Outline:
This day is reserved to review materials, complete exercises and tests.
Glossary and Acronym Lists
### Glossary

#### TABLE 1. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Code - 1 Letter</td>
<td>One letter that is the abbreviation for an action in all IDX system applications. One letter action codes appear at the bottom of screens. Once the letter is entered, the system automatically executes the action. The user should not press the &lt;Enter&gt; key after typing the letter.</td>
</tr>
<tr>
<td>Action Code - 2 Letter</td>
<td>Two letters that are the abbreviation for an action or an action process in the VM/HPA application. Two letter action codes are entered at the Action prompts in the VM/HPA application. Once the letters are entered, the system automatically executes the action. The user should not press the &lt;Enter&gt; key after typing the letters.</td>
</tr>
<tr>
<td>Action Code Process</td>
<td>The stringing together of multiple two letter action codes in VM/HPA.</td>
</tr>
<tr>
<td>Admitting</td>
<td>The process followed when a patient arrives for an inpatient or outpatient visit.</td>
</tr>
<tr>
<td>Admission, Discharge, Transfer (ADT)</td>
<td>The former name of the VM part of the VM/HPA application.</td>
</tr>
<tr>
<td>Advanced Beneficiary Notice (ABN)</td>
<td>A notification to Medicare patients that certain procedures may not be covered by Medicare.</td>
</tr>
<tr>
<td>MS Action Code</td>
<td>Medicare Survey</td>
</tr>
<tr>
<td>Anne Bates Leach Eye Hospital (ABLEH)</td>
<td>An organization in the IDX system.</td>
</tr>
<tr>
<td>Application</td>
<td>The IDX term for a group of activities designed for a specific task such as scheduling patient appointments, processing physician and hospital billing and accounts receivable, managed care and processing referrals. Ex: Scheduling, BAR, MCA, VM/HPA.</td>
</tr>
</tbody>
</table>
### TABLE 1. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment</td>
<td>The information about a patient’s scheduled visit in the IDX Scheduling application. Some patient appointments are not scheduled in the IDX Scheduling application but their billing is processed in the IDX VM/HPA application. Surgery is an example of this.</td>
</tr>
<tr>
<td>Appointment Criteria</td>
<td>The information entered by the scheduler in the IDX system for an appointment. The information is based on the patient’s request.</td>
</tr>
<tr>
<td>Appointment Data Form (ADF)</td>
<td>The Scheduling application screen that designed for the capture of additional information specific to the appointment.</td>
</tr>
<tr>
<td>Appointment Type</td>
<td>The category which specifies the reason for the appointment. In the Scheduling application, this is also referred to as the Visit Type.</td>
</tr>
<tr>
<td>Arrived Appointment (ARR)</td>
<td>The appointment status that indicates the patient arrived for the appointment. Contains the date, time and initials of the person who arrived the appointment in the IDX system.</td>
</tr>
<tr>
<td>Batch</td>
<td>A group of related charges, payment or adjustment transactions.</td>
</tr>
<tr>
<td>Billing</td>
<td>The process of sending a claim form or statement for charges for medical services to the party responsible for payment.</td>
</tr>
<tr>
<td>Billing and Accounts Receivable (BAR)</td>
<td>The IDX application for tracking, monitoring and entering charges and billing for physician services.</td>
</tr>
<tr>
<td>Bottom Form</td>
<td>The form that appears at the bottom of a display. It usually is either a list of single letter action codes or several fields for data entry.</td>
</tr>
</tbody>
</table>
### Glossary and Acronym Lists

**TABLE 1. Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bumped Appointment (BMP)</td>
<td>The appointment status that indicates our facility removed the providers time slot from being a valid time for patient appointments and that an appointment had already been booked into that time slot. The <em>bumping</em> was accomplished in one of two ways: by editing the providers daily schedule or transferring a template to the provider’s daily schedule.</td>
</tr>
<tr>
<td>Bumped List</td>
<td>A list of bumped appointments.</td>
</tr>
<tr>
<td>Cancelled Appointment (CAN)</td>
<td>The appointment status that indicates the patient cancelled the appointment.</td>
</tr>
<tr>
<td>Capitation</td>
<td>The payment rendered for providing a specific menu of health services to a defined population over a set period of time. The provider usually receives, in advance, a negotiated monthly payment from the HMO. This payment rate is the same regardless of the amount of service rendered by the physician.</td>
</tr>
<tr>
<td>Chart Tracking (MTRK)</td>
<td>The IDX application for tracking, monitoring and entering patient medical charts.</td>
</tr>
<tr>
<td>Check In</td>
<td>The process followed when a patient arrives for a physician appointment.</td>
</tr>
<tr>
<td>Check Out</td>
<td>The process followed when a patient leaves the facility.</td>
</tr>
<tr>
<td>Claim</td>
<td>The document sent to an insurer to request payment. A claim may be sent electronically or printed on paper and mailed to the insurer.</td>
</tr>
<tr>
<td>Code Review</td>
<td>The code indicating the next date and action to be taken on a visit in PRS system.</td>
</tr>
<tr>
<td>Comment</td>
<td>See Note</td>
</tr>
<tr>
<td>Cyclical Appointment</td>
<td>An appointment that is part of a series of appointments which have the same provider, same department and same appointment type, but different dates and times.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Daily Schedule</td>
<td>The list of appointment and non-appointment time for one provider for one day. The Daily Schedule is created by the IDX system automatically from the provider’s Master Schedule.</td>
</tr>
<tr>
<td>Data Entry Field</td>
<td>A field on a screen that allows users to enter data. Data entry fields are either Dictionary, Free Text or Word Processing fields.</td>
</tr>
<tr>
<td>Default</td>
<td>The value or response to an IDX prompt if you do not make an entry. Default values are sometimes followed by the default symbol (=&gt;). If you do not enter a value after the symbol, the value after the symbol will be used by the system as your response to the prompt.</td>
</tr>
<tr>
<td>Default Value</td>
<td>The value that is the most frequent response to the prompt. Frequently it is preceded by the default symbol (=&gt;). Default values can be overwritten by the user.</td>
</tr>
<tr>
<td>Delete</td>
<td>To permanently remove entered data from the system.</td>
</tr>
<tr>
<td>Dictionaries</td>
<td>The building blocks of the IDX system. They store and organize information that otherwise would have to be entered in the system frequently.</td>
</tr>
<tr>
<td>Dictionary Entry</td>
<td>One logical unit of a dictionary. Ex: Each referring provider has one entry in the Referring Provider’s dictionary. That entry contains all the information about the referring provider that is in the IDX system.</td>
</tr>
<tr>
<td>Dictionary Field</td>
<td>A screen data entry field that only allows data from a dictionary entry.</td>
</tr>
<tr>
<td>Discharging</td>
<td>The process followed when a patient leaves the facility after an inpatient or outpatient visit.</td>
</tr>
<tr>
<td>Ellipsis</td>
<td>Three dots (...) that indicate there is another activity level associated with this activity or function. Ex: Dictionaries... indicates that once this function is selected, there are other choices for the user.</td>
</tr>
</tbody>
</table>
TABLE 1. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Day</td>
<td>The process of posting all the balanced financial transactions that were entered during the day and preparing all the daily operational reports.</td>
</tr>
<tr>
<td>End of Month</td>
<td>The process of closing the accounting period for the month and preparing all the analysis reports for the month.</td>
</tr>
<tr>
<td>Enterprise MRN</td>
<td>The unique number assigned by the IDX system to a patient. Formerly referred to as the UMMG number and may still be displayed on some screens with the label of UMMG.</td>
</tr>
<tr>
<td>File</td>
<td>To save your work and store it in the system. Usually this is accomplished by pressing the F10 key. In some cases, when the data in a screen is filed, it is date and time stamped with the user’s initials.</td>
</tr>
<tr>
<td>Final Verification</td>
<td>The designation that the insurance for a VM/HPA visit was verified by the check-in person.</td>
</tr>
<tr>
<td>Financial Status Classification (FSC)</td>
<td>A category of payment for the services rendered. FSCs include government funded programs (like Medicare), commercial insurance companies (like Aetna), HMOs (like ?) and self pay (for patients who do not have others paying for all or a portion of the charges). The same FSCs are used by the physician and hospital accounting systems.</td>
</tr>
<tr>
<td>First Available Search (FI)</td>
<td>A type of search for an appointment. Based on the information in the appointment criteria, the system displays providers and times that meet the criteria.</td>
</tr>
<tr>
<td>Flag</td>
<td>On the Hold Bill screen, the word Flag is equivalent to Hold Bill.</td>
</tr>
<tr>
<td>Free Text</td>
<td>Data that is entered in the IDX system that is not checked by the system for format or validity.</td>
</tr>
<tr>
<td>FSC Follow-Up Question</td>
<td>A sequence of FSC-specific questions that need to be answered for the charges to be billed to the insurer. The actual questions vary by FSC. They usually include certificate number and valid effective and expiration dates and subscriber information.</td>
</tr>
</tbody>
</table>
### TABLE 1. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Registration</td>
<td>The complete demographic and insurance information for a patient. See Mini Registration for the alternative type of registration</td>
</tr>
<tr>
<td>Guarantor</td>
<td>The person that is financially responsible for patient charges. If a patient has insurance, the guarantor is the party responsible after all insurance.</td>
</tr>
<tr>
<td>Header</td>
<td>The top portion of a screen, usually containing the patient name and other information.</td>
</tr>
<tr>
<td>Health Maintenance Organization (HMO)</td>
<td>An organization of health care personnel and facilities that provides a comprehensive range of health services to an enrolled population for a fixed sum of money paid in advance for a specified period of time. These health services include or exclude a wide variety of medical treatments and consults, inpatient and outpatient hospitalization, home health service, ambulance service and sometimes dental and pharmacy services.</td>
</tr>
<tr>
<td>Hold Bills</td>
<td>A mechanism to prevent a claim or patient bill to be produced for a VM/HPA visit. Hold Bills may be generated by the system or user applied.</td>
</tr>
<tr>
<td>Hospital Patient Accounting</td>
<td>The IDX application that bills</td>
</tr>
<tr>
<td>IDX Systems Corporation</td>
<td>The company from whom UMMG purchased the computer application for scheduling and managing the accounts receivable of patient appointments and billing. It is the company of choice at more than 2,065 customer sites serving more than 118,000 physician.</td>
</tr>
<tr>
<td>IDX System</td>
<td>The software from the IDX Systems Corporation. Also referred to as IDX. Ex: In IDX, a patient must be registered before any other actions can be performed.</td>
</tr>
<tr>
<td>Insurance Management System</td>
<td>The module used to enter registration level patient insurance data. It is used to assign FSCs and answer the Follow-Up Questions at the registration level.</td>
</tr>
</tbody>
</table>
### TABLE 1. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Verification</td>
<td>The process of obtaining or verifying a patient’s insurance for a specific appointment or visit.</td>
</tr>
<tr>
<td>Independent Practice Association (IPA)</td>
<td>A type of HMO.</td>
</tr>
<tr>
<td>Lag Days</td>
<td>The days between the discharge of a visit and the time when the claim or bill is eligible to be produced</td>
</tr>
<tr>
<td>Linked Appointment</td>
<td>The indication that one appointment has a relationship to another appointment. Linked appointments can be two or three appointments for one patient or for multiple patients.</td>
</tr>
<tr>
<td>Local Address</td>
<td>The address that the patient can be reached if different from the permanent address. Usually this is a Miami address when the permanent address is not within the Miami area or southern Florida area.</td>
</tr>
<tr>
<td>Lookup</td>
<td>The method by which the system searches the database for all data items beginning with the letters or numbers entered by the user in response to a prompt. The term is used for both patient data and dictionary data.</td>
</tr>
<tr>
<td>Marked Event</td>
<td>An event in the life of a VM/HPA visit that must be indicated as complete. The system automatically creates a Hold Bill for Marked Events that have not been completed.</td>
</tr>
<tr>
<td>Master Schedule</td>
<td>Schedules that reflect a provider’s usual schedule for each day of the week. It can contain exceptions for monthly or special recurring events. The information in Master Schedules create Daily Schedules.</td>
</tr>
<tr>
<td>Medical Record Number (MRN)</td>
<td>A unique number assigned to a patient in the IDX system. There are two types of MRNs: Enterprise MRN and Organization MRN.</td>
</tr>
<tr>
<td>Medicare Survey</td>
<td>A patient survey required for each visit for Medicare patients.</td>
</tr>
<tr>
<td>No-Show (NOS)</td>
<td>The appointment status that indicates a patient did not arrive for his/her appointment.</td>
</tr>
</tbody>
</table>
### TABLE 1. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note</td>
<td>A free text field in the IDX system to free text pertaining to a specific category or item. Also called a Comment on some IDX screens.</td>
</tr>
<tr>
<td></td>
<td>Ex: Registration General Comment for a note that pertains to the patient in general. Ex: Needs wheelchair.</td>
</tr>
<tr>
<td></td>
<td>Ex: The check number on a payment transaction.</td>
</tr>
<tr>
<td>Open Referrals</td>
<td>The IDX application for entering, tracking and monitoring patient referral data.</td>
</tr>
<tr>
<td>Organization</td>
<td>A University of Miami group.</td>
</tr>
<tr>
<td></td>
<td>Ex: University of Miami Medical Group, Anne Bates Leach Eye Hospital, Sylvester Comprehensive Cancer Center, Jackson Memorial Hospital Public Health Trust.</td>
</tr>
<tr>
<td>Organization MRN</td>
<td>The unique number assigned to the patient for each organization in the IDX system. The UMMG organization MRN is the same.</td>
</tr>
<tr>
<td>Paperless Collection System (PCS)</td>
<td>A process that facilitates the collection and monitoring of billing in the BAR application.</td>
</tr>
<tr>
<td>Patient Representative System (PRS)</td>
<td>A process that facilitates the collection and monitoring of billing in the VM/HPA application. Previously referred to as the Rep System or the Patient Rep System.</td>
</tr>
<tr>
<td>Patient Type</td>
<td>The former name of a VM/HPA Visit Type. The term Patient Type still appears on some screens.</td>
</tr>
<tr>
<td>Pending Appointment (PEN)</td>
<td>The appointment status that indicates a future appointment or one that has not been arrived, no-showed, cancelled or bumped.</td>
</tr>
<tr>
<td>Permanent Address</td>
<td>The location at which the patient can be contacted for correspondence and billing. The patient may also have a Local Address if he/she is not at the Permanent Address for the full year.</td>
</tr>
<tr>
<td>Plan</td>
<td>The name of the payors who will be billed for the charges on the Visit. Plans are attached to VM/HPA Visits and consist of FSCs and their Follow-Up Questions. There may be multiple Plans on a Visit.</td>
</tr>
</tbody>
</table>
**TABLE 1. Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan FSC</td>
<td>The FSC that is associated with a specific Plan. Each plan will be associated with only one FSC. One FSC may have one or multiple Plans associated with it.</td>
</tr>
<tr>
<td>Plan Follow Up Questions</td>
<td>A sequence of questions specific to the Plan that need to be answered for the charges to billed to the insurer. The actual questions vary by FSC. They usually include certificate number and valid effective and expiration dates and subscriber information. If the Plan FSC is a Registration FSC, the answers from the Registration FSC default into the answers of the Plan FSC.</td>
</tr>
<tr>
<td>Plan Profiles</td>
<td>The repository for detailed specific information about the Plan.</td>
</tr>
<tr>
<td>Proration</td>
<td>The process the VM/HPA application uses to calculate the expected payment for each plan on a visit.</td>
</tr>
<tr>
<td>Provider (Physician) Sponsored Network/Organization (PSN/PSO)</td>
<td>A type of HMO. A Managed Care network owned and operated by physicians or a combination of physician and other health care providers, such as hospitals.</td>
</tr>
<tr>
<td>Registration</td>
<td>The process of entering demographic and insurance information or the location of that data within the IDX system. There are two types of registration: Full and Mini. See above for definitions.</td>
</tr>
<tr>
<td>Registration Document</td>
<td>A printed form that summarizes a patient’s registration information.</td>
</tr>
<tr>
<td>Registration FSC</td>
<td>A FSC that is valid when a patient is registered and one that is the patient’s standard insurer or insurers. A patient may have multiple Registration FSCs. Registration FSCs do not include Research Studies, Workers Comp or other visit specific only insurance.</td>
</tr>
<tr>
<td>Reminder Appointment (REM)</td>
<td>An appointments that needs to be scheduled more than 180 days in the future. Used when a daily schedule has not been created for the date of the appointment.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rep System</td>
<td>See Patient Representative System.</td>
</tr>
<tr>
<td>Result Code</td>
<td>The code used in the PRS system to explain the action taken on the visit.</td>
</tr>
<tr>
<td>Sched</td>
<td>Short name for the IDX Scheduling application</td>
</tr>
<tr>
<td>Sched Link</td>
<td>A process that creates VM/HPA visits based upon the information in a patient’s IDX scheduled appointment.</td>
</tr>
<tr>
<td>Scheduling Registration</td>
<td>See Mini Registration</td>
</tr>
<tr>
<td>Security Plus</td>
<td>The IDX application that controls user access to data and functionality in the IDX system. The functionality includes IDX applications, functions, activities, action codes and transaction codes.</td>
</tr>
<tr>
<td>Selector List</td>
<td>A list of entries in the IDX system displayed to the user. The user highlights an entry and presses the &lt;Enter&gt; key to select an entry. Frequently entries must be selected before a one letter action code can be executed.</td>
</tr>
</tbody>
</table>
| Session                 | There are two definitions for this term depending upon context.  
1. A period of time used to group appointments in the Scheduling application. Valid sessions are AM, PM or Evening  
2. The period of time the user is logged into the IDX system. |
<p>| Stringing               | The shortcut into an activity or sub-activity. The string of a function and activity number or numbers separated by commas allows the user to reach the desired activity or sub-activity without going to each menu screen. |
| Subscriber              | The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or other health plan.                                                   |
| Summary Search (SU)     | A type of search for an appointment. Allows the user to view a provider’s schedule before selecting a time slot of an appointment.                                                             |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sylvester Comprehensive Cancer Center (UMHC)</td>
<td>An organization in the IDX system. Sylvester Comprehensive Cancer Center,</td>
</tr>
<tr>
<td>Time Slots</td>
<td>A period of time reserved for an appointment type. Time slots are defined in a provider’s master schedule.</td>
</tr>
<tr>
<td>Trigger Event</td>
<td>An event that triggers a visit to be placed on a PRS worklist.</td>
</tr>
<tr>
<td>University of Miami Medical Group</td>
<td>An organization in the IDX system.</td>
</tr>
<tr>
<td>Visit Management</td>
<td>The registration, insurance and bed assignment part of the VM/HPA application. Formerly call ADT.</td>
</tr>
<tr>
<td>Visit Type</td>
<td>There are two definitions for this term depending upon IDX application.</td>
</tr>
<tr>
<td></td>
<td>1. In VM/HPA, Visit Type is a category of hospital admission. It is the building block of the VM/HPA application. It was formerly called Patient Type.</td>
</tr>
<tr>
<td></td>
<td>Ex: Inpatient, Observation, Out Patient Clinic</td>
</tr>
<tr>
<td></td>
<td>2. In Scheduling, Visit Type is the former name for appointment type, the building block of the Scheduling application. When the words Visit Type display in the scheduling application, it means appointment type.</td>
</tr>
<tr>
<td></td>
<td>Ex: New Patient Visit, Follow-Up visit.</td>
</tr>
<tr>
<td></td>
<td><em>NOTE</em>: Scheduling Visit Types (appointment types) and VM/HPA Visit Types have no relationships to each other.</td>
</tr>
<tr>
<td>VM/HPA</td>
<td>The IDX application for tracking, monitoring and entering charges and billing for hospital services</td>
</tr>
<tr>
<td>Wait List</td>
<td>A list of patients who want to be notified of the availability of an earlier appointment time for a specific provider and appointment type.</td>
</tr>
<tr>
<td>Walk In Appointment</td>
<td>An appointment for a patient who presents at the clinic who does not have a previously scheduled appointment.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Word Processor Field</td>
<td>A field on the screen that allows the user to enter free text data.</td>
</tr>
<tr>
<td>Worklist</td>
<td>A list of visits to be worked on in the PRS system.</td>
</tr>
<tr>
<td>Z99</td>
<td>The self pay Plan that is automatically assigned by the IDX system as the last Plan on a Visit.</td>
</tr>
</tbody>
</table>
## Acronyms

### TABLE 2. Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Application</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADF</td>
<td>Sched</td>
<td>Appointment Data Form</td>
</tr>
<tr>
<td>ADT</td>
<td>VM/HPA</td>
<td>Admission, Discharge, Transfer</td>
</tr>
<tr>
<td>ABLEH</td>
<td>All</td>
<td>Anne Bates Leach Eye Hospital</td>
</tr>
<tr>
<td>ABN</td>
<td>All</td>
<td>Advanced Beneficiary Notice</td>
</tr>
<tr>
<td>ARR</td>
<td>Sched</td>
<td>Arrived Appointment Status</td>
</tr>
<tr>
<td>BAR</td>
<td>BAR</td>
<td>Billing and Accounts Receivable (IDX application)</td>
</tr>
<tr>
<td>BMP</td>
<td>Sched</td>
<td>Bumped Appointment Status</td>
</tr>
<tr>
<td>CAN</td>
<td>Sched</td>
<td>Cancelled Appointment Status</td>
</tr>
<tr>
<td>DOB</td>
<td>All</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>FSC</td>
<td>All</td>
<td>Financial Status Classification</td>
</tr>
<tr>
<td>HMO</td>
<td>All</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>IDX</td>
<td>All</td>
<td>IDX System Corporation or its software</td>
</tr>
<tr>
<td>IMS</td>
<td>All</td>
<td>Insurance Management System</td>
</tr>
<tr>
<td>IPA</td>
<td>All</td>
<td>Independent Practice Association</td>
</tr>
<tr>
<td>HB</td>
<td>VM/HPA</td>
<td>Hold Bill</td>
</tr>
<tr>
<td>HMO</td>
<td>All</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>HPA</td>
<td>VM/HPA</td>
<td>Hospital Patient Accounting</td>
</tr>
<tr>
<td>MCA</td>
<td>MCA</td>
<td>Managed Care Application (IDX application)</td>
</tr>
<tr>
<td>MRN</td>
<td>All</td>
<td>Medical Record Number</td>
</tr>
<tr>
<td>MTRK</td>
<td>Chart Tracking</td>
<td>Chart Tracking (IDX application)</td>
</tr>
<tr>
<td>NOS</td>
<td>Sched</td>
<td>No-Show Appointment Status</td>
</tr>
<tr>
<td>PCS</td>
<td>BAR</td>
<td>Paperless Collection System (IDX application)</td>
</tr>
<tr>
<td>PCE</td>
<td>All</td>
<td>The patient’s Primary Care Physician.</td>
</tr>
<tr>
<td>PEN</td>
<td>Sched</td>
<td>Pending Appointment Status</td>
</tr>
<tr>
<td>PRS</td>
<td>VM/HPA</td>
<td>Patient Representative System</td>
</tr>
<tr>
<td>PSN/PSO</td>
<td>All</td>
<td>Provider (Physician) Sponsored Network/Organization</td>
</tr>
<tr>
<td>Sch</td>
<td>Sched</td>
<td>Scheduling (IDX application)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Application</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>Sched</td>
<td>Sched</td>
<td>Scheduling (IDX application)</td>
</tr>
<tr>
<td>SSN</td>
<td>All</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>UMHC/SCCC</td>
<td>All</td>
<td>University of Miami Hospital and Clinics/Sylvester Comprehensive Cancer Center</td>
</tr>
<tr>
<td>UMMG</td>
<td>All</td>
<td>University of Miami Medical Group</td>
</tr>
<tr>
<td>VM</td>
<td>VM/HPA</td>
<td>Visit Management</td>
</tr>
</tbody>
</table>
University of Miami Clinical Enterprise Technologies

UMMG Policies and Procedures
Instructions to Download UMMG Policies & Procedures for ABLEH, UMHC/SCCC and UMMG Physician Practice

1. Open Internet Explorer.
2. At the address bar, type:

4. On the top of the page, under the Black bar that reads “University of Miami Medical Group” there is a gray bar, click on Employee Intranet.

5. A login screen window will appear. You must enter your Medical ID and password (this is the same ID and password to login to your computer and your email).
6. A menu will then appear where you will find UMMG Policies and Procedures, Business Tools and Calendar.

7. In the fourth bullet under UMMG Policies and Procedures you will find the Revenue Cycles Policies and Procedures for ABLEH, UMHC/SCCC and UMMG Practice Group. Click on the manual you need to view and/or print.

8. It will open with Adobe Acrobat Reader (if you do not have it installed in your computer, you can download it from www.adobe.com).

9. It will open the desired manual. You can print it or go to a specific topic by clicking on the navigation bar on the left hand side.
University of Miami Clinical Enterprise Technologies

JOB AIDES
PATIENT SERVICES WORKPLACE - After Patient has been selected FOR A USER WITH FULL ACCESS TO THE GE-IDX SYSTEM

JOB AID  Page 1 of 4

Banner and Patient Services Screen

- All other parts of the screen described on Page 3

Patient Name

Key Patient Registration Data

Other Patient Data Links

Chart Tracking

-> Described on Page 2

Patient Financial Summary Data and Links

Patient Last and Next Appointment data and links

Patient Appointment List and New Appointment links

Patient's Referral List link

Enter Hospital Action Codes here

2/27/2008 © 2008 University of Miami
## Patient Banner Described

### Field | Description
---|---
Patient Name | Patient’s name: Last, First
MRN | Patient’s enterprise medical record number
ABLE | Patient’s Ableh medical record (if the patient has one)
UMHC | Patient’s UMHC medical record (if the patient has one)
DOB | Patient’s birth date
Sex/Age | Patient’s sex: \( M = \) Male; \( F = \) Female; \( I = \) Indeterminate
then a slash and then patient’s age in years or months.
\( Y = \) age in years or \( M = \) age in months
Primary | Patient’s day telephone number from registration
FSC1/FSC 2 | Patient’s primary and secondary registration FSCs
CoPay PCP/Spec | Patient’s copays as entered in the primary FSC follow-up questions. The PCP copay is listed first and separated from the specialist’s copay by a slash
Cell/Beeper | Patient’s Cell/other telephone number from registration
PCP | Patient’s primary care physician
SP BAL A/U/P | Patient’s Self Pay balances, separated by slashes
\( A = \) Ableh self pay balance
\( U = \) UMHC self pay balance,
\( P = \) Physician self pay balance
Status | Patient Flags. Only the flags that are active for the patient display

---

2/27/2008 © 2008 University of Miami
### Key Patient Reg Info

<table>
<thead>
<tr>
<th>A</th>
<th>Key information</th>
<th>Patient's address, home and work phone numbers, email, insurance and last registration update data</th>
</tr>
</thead>
</table>

--> **Telephone Number relationships described on Page 4**

### Other Links

<table>
<thead>
<tr>
<th>B</th>
<th>Demographics</th>
<th>Link to Initial Registration screen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insurance</td>
<td>Link to display Manage Insurance Information screen (FSC list) with links to insurance actions</td>
</tr>
<tr>
<td></td>
<td>Eligibility List</td>
<td>Link to display list of patient's existing eligibility requests and results and has link to enter a new eligibility request</td>
</tr>
<tr>
<td></td>
<td>Enrollment</td>
<td>Link to display patient's MCA enrollment information</td>
</tr>
<tr>
<td></td>
<td>Patient Inquiry</td>
<td>Links to view HIPPA Screen, Appointments, Claims, Demo/Ins/Case, Enrollment, Hospital, Invoices, Documents, Eligibility List, Referrals, Customer Service, Visits, TES Inquiry and APC Summary Data</td>
</tr>
</tbody>
</table>

### Chart Tracking

<table>
<thead>
<tr>
<th>C</th>
<th>Chart Request</th>
<th>Link to request the patient's chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>View Chart</td>
<td>Link to display Chart Tracking information</td>
</tr>
<tr>
<td></td>
<td>Chart Transfer</td>
<td>Link to transfer a chart from one chart borrower to another</td>
</tr>
</tbody>
</table>

### FINANCIALS

<table>
<thead>
<tr>
<th>D</th>
<th>Current Stmt Balances</th>
<th>Displays patient self pay balances by Group. Some of this data is also in the Patient Banner.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check In</td>
<td>Link to check patient in for an appointment</td>
</tr>
<tr>
<td></td>
<td>Check Out</td>
<td>Link to check patient out from an appointment</td>
</tr>
<tr>
<td></td>
<td>Financial Inquiry</td>
<td>Link to display balances by Group, Insurance/Self Pay, Billed/Unbilled with links to view other financial details</td>
</tr>
<tr>
<td></td>
<td>Case List</td>
<td>Link to display patient's Case list</td>
</tr>
</tbody>
</table>

### APPOINTMENTS

<table>
<thead>
<tr>
<th>E</th>
<th>Last</th>
<th>Displays overview of patient's last appointment with link to view more details and ADF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Next</td>
<td>Displays overview of patient's next appointment with link to view more details and ADF</td>
</tr>
</tbody>
</table>

### REFERRALS

<table>
<thead>
<tr>
<th>F</th>
<th>Appointment List</th>
<th>Displays list of patient's appointments with links to display details, arrive/cancel/noshow, make a follow-up appt., change provider, link/unlink, move appt(s) and view attached document(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Appointment</td>
<td>Links to New appointment screen with patient name defaulted in</td>
</tr>
<tr>
<td></td>
<td>Referral List</td>
<td>Link to display list of patient's referrals with links to referral actions</td>
</tr>
</tbody>
</table>

### ACTION CODE

| H | Field in which to enter a hospital action code |

2/27/2008 © 2008 University of Miami
# VERTICAL TOOL BAR (VTB) LINKS

**Job Aid**

<table>
<thead>
<tr>
<th>Vertical Tool Bar List</th>
<th>Initial Display</th>
<th>Links or Initial Screen Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Services</td>
<td>Screen links &gt;&gt;</td>
<td>Demographics Insurance Eligibility List Enrollment Patient Inquiry</td>
</tr>
<tr>
<td>Appt Manager</td>
<td>HTB tabs &gt;&gt;</td>
<td>Appointment List New Appointment Provider Schedules Referral List Bump List Wait List Encounter Forms</td>
</tr>
<tr>
<td>Visit Manager</td>
<td>HTB tabs &gt;&gt;</td>
<td>Registration Demographics Insurance Quick Registration Appointment List Referral List Hold Bill Work List Charge Entry VM Reports Patient Reps</td>
</tr>
<tr>
<td>Front Desk</td>
<td>HTB tabs &gt;&gt;</td>
<td>Check Out Cash Drawer Front Desk Reports</td>
</tr>
<tr>
<td>Eligibility</td>
<td>HTB tabs &gt;&gt;</td>
<td>BAR</td>
</tr>
<tr>
<td>Open Referrals</td>
<td>HTB tabs &gt;&gt;</td>
<td>Add/Edit Referrals Referral Queue Definition Referral Manager</td>
</tr>
<tr>
<td>Forms</td>
<td>HTB tabs &gt;&gt;</td>
<td>BAR Forms Sched Forms Print/Demand Forms</td>
</tr>
<tr>
<td>Chart Tracking</td>
<td>HTB tabs &gt;&gt;</td>
<td>Chart Inquiry Chart Request Chart Transfer</td>
</tr>
<tr>
<td>Census/Admit</td>
<td>HTB tabs &gt;&gt;</td>
<td>VM Reports</td>
</tr>
<tr>
<td>Sched Reports</td>
<td>HTB tabs &gt;&gt;</td>
<td>Sched Standard Reports Sched Custom Reports Sched AES Reports Sched DBMS Reports</td>
</tr>
<tr>
<td>Case Mgmt</td>
<td>HTB tabs &gt;&gt;</td>
<td>Add/Edit/View Case Case Reports Case Maintenance Audit Trail</td>
</tr>
<tr>
<td>Fee Schedules</td>
<td>HTB tabs &gt;&gt;</td>
<td>B/AR Fee Schedule VM/HPA Fee Schedule</td>
</tr>
<tr>
<td>Dictionaries</td>
<td>HTB tabs &gt;&gt;</td>
<td>Inquiry BAR Dictionaries Sched Dictionaries VM/HPA Dictionaries Sched Dictionaries</td>
</tr>
<tr>
<td>Intranet</td>
<td>HTB tabs &gt;&gt;</td>
<td>Issues Reporting MIT IT Help Desk IDX Update Requests Patient Consolidation UM Websites UM Doctors UM HIPAA My UM</td>
</tr>
<tr>
<td>Internet</td>
<td>HTB tabs &gt;&gt;</td>
<td>Insurance Websites Other Websites ClienTell</td>
</tr>
<tr>
<td>Change Group</td>
<td>Screen</td>
<td>Change Group or HMO</td>
</tr>
<tr>
<td>Provider Schedules</td>
<td>Screen</td>
<td>Provider Schedule screen</td>
</tr>
<tr>
<td>MCA</td>
<td>HTB tabs &gt;&gt;</td>
<td>Enrollment</td>
</tr>
<tr>
<td>Visit Notes</td>
<td>Screen</td>
<td>Visit Notes for selected visit</td>
</tr>
</tbody>
</table>
Click on the button to access the appropriate patient data

OK and Cancel both display the screen from which you entered this activity

<table>
<thead>
<tr>
<th>Button</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>HIPAA Screen - displays Registration PHI (Protected Health Information screen)</td>
</tr>
<tr>
<td>A</td>
<td>Appointment - displays the Patient Appointment screen</td>
</tr>
<tr>
<td>C</td>
<td>Claims</td>
</tr>
<tr>
<td>D</td>
<td>Demo, Ins, Case Info - displays Reg Only, FSCs Only, Case Only or All</td>
</tr>
<tr>
<td>E</td>
<td>Enrollment - displays Enrollment screen for selection of MCA options</td>
</tr>
<tr>
<td>H</td>
<td>Hospital - after selecting a Hospital Group, displays patient's Account Level Inquiry for the Group</td>
</tr>
<tr>
<td>I</td>
<td>Invoices - after selecting BAR Group, displays patient's Invoice Inquiry</td>
</tr>
<tr>
<td>J</td>
<td>Documents - displays EDM (IMX) documents that have been linked to the patient</td>
</tr>
<tr>
<td>L</td>
<td>Eligibility List - displays Eligibility Request List</td>
</tr>
<tr>
<td>R</td>
<td>Referrals - displays patient's referrals</td>
</tr>
<tr>
<td>V</td>
<td>Visits - after selecting a Hospital Group, displays patient's visits</td>
</tr>
<tr>
<td>Y</td>
<td>TES Inquiry - after selecting BAR Group, displays TSEncounter/Transaction Inquiry screen</td>
</tr>
</tbody>
</table>
Appointment Manager Settings

---

**Header**

**Name** Enter name of new Provider Schedule setting

**Default** Click if this should be the default setting

**Date** Click the button before "Today" to have the Provider Schedule list the appointments for the current date each day ................. OR .................

Click the button after "Today" to list appointments for a specific date each time this Provider Schedule Setting is used. Then enter the date in the next field

---

**Session Options**

**Sort By:** Choose the default sort for the Appointment Manager List. You can also change the sort on the Appointment Manager screen. Options are: Time, Department, Location, Patient and Provider

**Appointment Times:** Specify the number of hours in the past and/or a number of hours in the future to display in the Appointment Manager list. Leave blank to display the entire day's appointments.

**Automatically refresh list every ___ minutes:** Check box to automatically refresh the appointments on the Appointment Manager List. Specify a refresh rate between 1 and 1000 minutes in the numeric text box.

**Display alert N minutes after arrival.** Leave blank. Feature not used currently.

**View Alert Categories.** Leave blank. Feature not used currently.

---

**Selection Criteria Steps**

1. Select the Dept/Prov button or the Location button
2. Select the Dept/Prov or Location to be included or excluded
3. Click the Incude or Exclude button
4. The criteria displays in the Criteria box
5. Click the OK button to save the criteria

---

Click the OK button to save the setting displayed

Click the Cancel button to exit without filing any changes.
GREETER
APPOINTMENT MANAGER
JOB AID

Modify filter settings by changing dates and sort

Click appointment's Time to access the appointment's ADF

Click appointment's Name to access the appointment's ADF

Click appointment's Appt No to Access Registration

IF YOU CLICK ANY OF THESE BY MISTAKE, CLICK THE CANCEL BUTTON ON THE SCREEN THAT DISPLAYS. THE APPOINTMENT MANAGER SCREEN WILL REDISPLAY.

GREETER STEPS
1. Find the appointment. If appt. is not on the screen, use the vertical scroll bar or change the sort to find appt. by time or provider
2. Click on the Provider Name to highlight the appointment
3. Click the Greeter clock in the appointment's Greeter column
4. The time displays in the Greeter column

Refresh screen and button
Use button to refresh the screen. Text above displays when the screen was last refreshed

Filter Setting Name (also in Banner)
Click the List button to select another setting

Click the icon in the appointment's Greeter Time column to have the system automatically time stamp the Greeter Time with the current time

Use the Vertical Scroll Bar to view more appointments

Refresh screen and button
Use button to refresh the screen. Text above displays when the screen was last refreshed

Filter Setting Name (also in Banner)
Click the List button to select another setting

Click the icon in the appointment's Greeter Time column to have the system automatically time stamp the Greeter Time with the current time

1. Find the appt.
2. Click on Provider Name
3. This symbol is the clock. Click it in the highlighted row
4. The time displays
PROVIDER SCHEDULE SETTINGS - NEW and EDIT

A. Header
- Name: Enter name of new Provider Schedule setting
- Default: Click if this should be the default setting
- Date: Click the button before "Today" to have the Provider Schedule list the appointments for the current date each day OR Insert date. Click the button after "Today" to list appointments for a specific date each time this Provider Schedule Setting is used. Then enter the date in the next field.

B. Session Options
- Sessions: Click one or more sessions to display on the Provider Schedule screen
- When I switch to Weekly Show __ Schedule(s): Enter the number (1-5) of schedules to display when a Weekly calendar is displayed. Usually, enter 5.
- Default Display options
  - Schedule List: Click this box to display a list of providers with schedules displayed on the Provider Schedules screen
  - Sort By: Choose the default sort for the Schedule List and schedules. You can also change the sort on the Provider Schedules screen. Options are: Department, Provider, Date, Percent Booked
  - Show: Specify the type of schedule to display: Daily, Weekly or Monthly
  - Hide Columns: Click this box to hide the schedule definition columns (Bkd/Total, Availability, Duration) for this setting.
  - Show ___ Schedule(s): Select the number (1-5) of schedules to be displayed on the Provider Schedule screen

C. Selection Criteria Steps
1. Select the Dept/Prov button or the Location button
2. Select the Dept/Prov or Location to be included or excluded
3. Click the Include or Exclude button
4. The criteria displays in the Criteria box
   - Repeat steps 2-4 until all criteria entered
5. Click the OK button to save the criteria

When the correct criteria displays in

D. Criteria selected displays in this box

Click the OK button to save the setting displayed

Click the Cancel button to exit without filing any changes.
PROVIDER SCHEDULE SETTINGS
JOB AID

**Name** of the current Provider Schedule setting

**Date:**
Click the button before “Today” to display the provider’s schedule for the current date each day

……………OR……………
Click the button after “Today” to list provider’s schedule for a specific date each time this Setting is used. Then enter the date in the next field.

**Session options:**
Click one or more sessions to display on the Provider Schedule screen

**Show**
1. Specify the number of schedules to show for this setting
2. Specify Daily, Weekly or Monthly type of schedule to display for this setting

**Hide Columns**
Click to hide the Bkd/Total, Availability and Duration columns

**When I switch to Weekly display**
Enter the number of schedules to display when a Weekly calendar is selected. **Recommendation:** 5

**Selection Criteria Steps**
1. Select the Dept/Prov button or the Location button
2. Select the Dept/Prov or Location to be included or excluded
3. Click the Incude or Exclude button
4. The criteria displays in the Criteria box
5. Click the **Default Setting** box to save setting as a default
6. Click the **Save** button to save the criteria

**Actions**
- **New** - Click to add a new setting
- **Delete** - Click to delete displayed setting

**Cancel** button - Click to exit without filing any changes

**OK** button - Click after adding a new setting or editing an existing setting. Make sure you clicked the **Save** button first if the criteria changed

Click **List button** to view a list of existing Provider Schedule settings

**Tabs**
(above the sort options)
- The **Appointment Manager** tab is used to add/edit Appointment Manager settings.
- The **Provider Schedules** tab is used to add/edit Provider Schedule settings.

**Criteria selected displays in this box**
## Provider Schedule Legend

### ATTACHMENTS

<table>
<thead>
<tr>
<th>Letter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Scheduling Comment attached</td>
</tr>
<tr>
<td>E</td>
<td>Eligibility Results attached</td>
</tr>
<tr>
<td>I</td>
<td>Invoices attached</td>
</tr>
<tr>
<td>L</td>
<td>Linked Appointments</td>
</tr>
<tr>
<td>R</td>
<td>Referrals attached</td>
</tr>
<tr>
<td>S</td>
<td>Case attached</td>
</tr>
<tr>
<td>W</td>
<td>Wait List</td>
</tr>
<tr>
<td>$</td>
<td>Copay or Outstanding Balance</td>
</tr>
</tbody>
</table>

### Status Legend

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARR</td>
<td>Arrived appointment</td>
<td>Green</td>
</tr>
<tr>
<td>BMP</td>
<td>Bumped appointment</td>
<td>Black</td>
</tr>
<tr>
<td>CAN</td>
<td>Cancelled appointment</td>
<td>Black</td>
</tr>
<tr>
<td>NOS</td>
<td>No Show appointment</td>
<td>Gold</td>
</tr>
<tr>
<td>PEN</td>
<td>Pending appointment</td>
<td>Dark Red</td>
</tr>
<tr>
<td>RSC</td>
<td>Rescheduled appointment</td>
<td>Dark Red</td>
</tr>
<tr>
<td>REM</td>
<td>Reminder appointment</td>
<td>Bright Rd</td>
</tr>
</tbody>
</table>

---

2/12/08 © 2008 University of Miami
### Schedule Control Legend

- **Show Schedule List**: Expanding view reveals MRN and Comment in box.
- **Hide columns Bkd/Total, Avl, and Dur**: Hide columns Bkd/Total, Avl, and Dur.
- **Hide blank rows**: Hide blank rows.

### ANDREW MD, GEORGE
**GENERAL MEDICINE**
**07/14/2006 Friday**

#### AM SOU

<table>
<thead>
<tr>
<th>Time</th>
<th>Bkd/Total</th>
<th>Avl</th>
<th>Dur</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00A</td>
<td>1/1 NPV</td>
<td>-</td>
<td>30</td>
</tr>
<tr>
<td>09:00A</td>
<td>0/1 PHY</td>
<td>1</td>
<td>60</td>
</tr>
</tbody>
</table>

**Slot Comment**: Do not overbook.

- **LANDERS, PAT 46 Y**: patient needs a wheelchair.
- **MACAULEY, ED 94 Y**: patient feels a relapse in pain.
- **SANDERSON**: scheduled.
- **BAXTER, STEVEN 30 D**: scheduled.
- **SIC 15**: allman, ronnie 60 y.
- **JENNING, SIC 15**: scheduled.
- **SALLMAN, RONNIE 60 Y**: scheduled.
- **COS 20**: scheduled.
- **Hilton, Kayla 13 Y**: referred from Dr. Jones.

#### PM SOU

<table>
<thead>
<tr>
<th>Time</th>
<th>Bkd/Total</th>
<th>Avl</th>
<th>Dur</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00N</td>
<td>0/0 UNA</td>
<td>-</td>
<td>60</td>
</tr>
</tbody>
</table>

**LUNCH**

- **FENNEY, KAYLA 13 Y**: patient needs a wheelchair.

---

**Patient**: MACAULEY, ED  
**MRN**: 170251  
**DOB**: 10/16/1921  
**Age**: 94  
**SSN**: 307-85-5346  
**H Phone**: 214-284-8775  
**W Phone**: 777-849-1772

**PSC 1**:  
**PSC 2**: NPV  
**Status**: PEN

**Comment**: patient needs a wheelchair.  
**Reason**: Duration: 60.

---

© 2008 University of Miami
PROVIDER SCHEDULE Screen

**PROVIDER SCHEDULES**

1. **Refer to the Provider Schedule Detail Job Aid** for a description of the contents of each provider schedule.

2. There are several options to increase the amount of schedule data that is displayed on the screen at one time:
   a. **The fewer the number of schedules displayed on the screen, the more detailed appointment data is displayed. Use the Show # Schedules field to change the number of schedules displayed.**
   b. **Click the Hide/Show VTB button hide or show the VTB**
   c. **Click the Hide/Show Schedule List button to hide the Schedule List**

---

### Schedule List

For each provider schedule displayed, the **Schedule List** displays each provider's name, department, date, and percent booked for that date. It will display up to 50 entries by using the vertical scroll bars.

1. **To display a daily schedule, click its row in the Schedule List.**
2. **The Schedule List displays when the Show/Hide Schedule List button is in the Show mode.**
3. **Click the Insert Schedule button** to insert a provider's schedule in the display.

### Buttons

**Buttons**

- Click to navigate backward or forward through the schedules
- Click to navigate backward or forward through provider's schedules
- Click to how or hide the session, slot, and appointment details
- Select an app't then click to display the Appointment Overview screen
- Select an app’t then click to arrive the appointment. Valid only for Professional
- Schedule a new appointment for the selected patient/appointment
- Insert a specific schedule to the Schedule List and display
- Access Appointment Tasks: Refer to Provider Schedules Appt Actions Job Aid
- Accesses Actions functionality: Refer to Provider Schedules Actions Job Aid
<table>
<thead>
<tr>
<th>Provider Schedules Appt Action button option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrive</td>
<td>Arrive the selected appointment</td>
</tr>
<tr>
<td>Cancel/Reschedule</td>
<td>Cancel and optionally reschedule the selected appointment</td>
</tr>
<tr>
<td>Noshow</td>
<td>Change the status of the selected appointment to noshow</td>
</tr>
<tr>
<td>Appointment Detail</td>
<td>Display the Appointment Detail screen</td>
</tr>
<tr>
<td>Appointment Data Form (ADF)</td>
<td>Display the ADF to update or add any additional information</td>
</tr>
<tr>
<td>Appointment Overview</td>
<td>Display the Appointment Overview screen to view and perform various functions</td>
</tr>
<tr>
<td>Visit Overview</td>
<td>Display the Visit Overview screen to perform any visit related task</td>
</tr>
<tr>
<td>Link Appointment</td>
<td>Display the Linked Appointments screen to add or edit linked appointments</td>
</tr>
<tr>
<td>Lin/Unlink Invoice</td>
<td>Display the Lin/Unlink Invoice screen to link or unlink invoices associated with the selected appointment</td>
</tr>
</tbody>
</table>
| Print Forms                                | Prints the Provider Schedule view exactly as it is displayed on the screen and other forms associated with the selected appointment  
**NOTE**: For best results, turn on the Internet Explorer **Print background colors and images** setting *(Tools/Internet/Options/Advanced)* and set the print layout option to Landscape |
<p>| View Documents                             | Displays the Document List screen to select EDM documents that are associated with the selected patient/appointment |
| Scan Documents                             | Display the Scan Documents screen to scan and index documents associated with the selected patient/appointment |
| Followup Appointment                       | Schedule a followup appointment for the selected appointment. The system automatically uses the patient data from the selected appointment to search for the followup |
| Cut                                        | Copies the appointment information and removes it from its current timeslot |
| Copies                                     | Copies the selected appointment information |
| Paste                                      | Pastes the appointment information in the new slot |</p>
<table>
<thead>
<tr>
<th>Provider Schedule Action button option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancel/Reschedule</td>
<td>Accesses the cancel/reschedule workflow</td>
</tr>
<tr>
<td>Followup Appointment</td>
<td>Schedules a follow-up appointment</td>
</tr>
<tr>
<td>Noshow</td>
<td>Changes the status of an appointment to no-show</td>
</tr>
<tr>
<td>Quick Appointment</td>
<td>Do not use</td>
</tr>
<tr>
<td>Add Time</td>
<td>Adds an appointment to the schedule by adding a non-clinic regular timeslot</td>
</tr>
<tr>
<td>Daily Schedules and Templates</td>
<td>Applies a template to the schedule</td>
</tr>
<tr>
<td>Slot Comment</td>
<td>Adds a slot comment to the schedule</td>
</tr>
<tr>
<td>Block Time</td>
<td>Blocks time in the schedule (cannot be undone)</td>
</tr>
<tr>
<td>Hold Time</td>
<td>Holds time in the schedule (can be released)</td>
</tr>
<tr>
<td>Release Time</td>
<td>Releases held time</td>
</tr>
<tr>
<td>Patient List</td>
<td>Lists patient appointments for the selected schedule</td>
</tr>
</tbody>
</table>
| Print                                  | Prints the Provider Schedule view exactly as it is displayed on the screen  
*NOTE*: For best results, turn on the Internet Explorer **Print background colors and images** setting *(Tools/Internet/Options/Advanced)* and set the print layout option to Landscape |
| View Legend                            | Views the Provider Schedule legend for attachments and status indicator |
| Cut                                    | Copies the appointment information and removes it from its current timeslot |
| Paste                                  | Pastes the appointment in the new slot |
Monthly Provider Schedule Legend

Clicking the title bar will select all days in the month.

Clicking a side panel will select all days in that week.

In Daily Schedules & Templates, day of month is multi-selectable.

Each day shows the percentage of allocated time that has been used by booked appointments, as well as the number of booked appointments. Yellow fill is a graphical representation of the percentage booked.

Clicking on Monday will select all Mondays in the month.

Overbooked

In Provider Schedules, days are non-selectable. Instead, day of month is a hyperlink to the Daily view.

This day has only non-clinic time allocated.

This day has no schedules.
# APPOINTMENT LINKING

## JOB AID

<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHERE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINKING NEW APPOINTMENTS TO EACH OTHER</td>
<td>“NEW APPOINTMENT” HYPERLINK IN THE PATIENT SERVICES SCREEN</td>
<td>You can link up to three (3) new appointments for the same or different patients. Notes: 1. When making new appointments, you cannot link them to existing appointments. 2. You cannot link appointments when scheduling a new appointment from the Provider Schedules</td>
</tr>
<tr>
<td>LINKING EXISTING APPOINTMENTS TO EACH OTHER</td>
<td>“APPOINTMENT LIST” FROM THE 1. HYPERLINK IN THE PATIENT SERVICES SCREEN 2. HTB TAB FROM THE APPOINTMENT MANAGER VTB</td>
<td>You can link up to three (3) existing appointments for the same or different patients</td>
</tr>
<tr>
<td>VIEWING LINKED APPOINTMENTS</td>
<td>FROM THE 1. APPOINTMENT LIST 2. APPOINTMENT MANAGER</td>
<td>Linked appointments have an ‘L’ in the Attach column</td>
</tr>
</tbody>
</table>
Note:
First Available Search will only return available appointment dates and times for the indicated appointment criteria.
First Available Search will not display any frozen slots nor booked appointments.
<table>
<thead>
<tr>
<th>AM SOL</th>
<th>Bkd/Total</th>
<th>Avl</th>
<th>Dur</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00A</td>
<td>1/1 NPV</td>
<td>-</td>
<td>30</td>
<td>keep morning light</td>
</tr>
<tr>
<td>09:00A</td>
<td>0/1 PHY</td>
<td>1</td>
<td>60</td>
<td>patient needs a wheelchair</td>
</tr>
</tbody>
</table>

- **ANDREW MD, GEORGE**
- **GENERAL MEDICINE**
- **07/14/2006 Friday**

Header: Dr. must approve all overbooking

% of Schedule or number/# of Appointments booked

Orange background indicates Schedule is over Threshold

Patient: MACALLEY, ED
- MRN: 170251
- DOB: 10/16/1921
- Age: 84
- SSN: 307-95-5346
- (H) Phone: 214-284-8775
- (W) Phone: 777-848-1772

FSC 11
- Type: NPV
- Status: PPV
- Comment: patient needs a wheelchair
- Reason: Time Held: tentative meeting w/ Dr. Strong
- Duration: 60

- **PM SOL**
- | Bkd/Total | Avl | Dur | Comment |
- |-----------|-----|-----|---------|
- | 12:00N    | 0/0 UNA  | 60  | LUNCH  |

- **Excluded appointment type**
- | Session, Location, Booked/Total, Slot Type, Availability, Duration, and Session Comment |
**Session Detail:**
Displays the following information:
- Provider’s name
- Department and Scheduling Location
- Number of Appointments booked for the selected date of service
- Percentage of schedule currently utilized
- Schedule Comments entered by the Master Scheduler
- Selected Session (i.e. AM, PM, or EVE)
- Scheduling location of selected session
- Number of appointment booked in session
- Percentage of scheduling currently utilized
- Session Comment entered by the Master Scheduler

**Note:** Selecting a new session will display information specific to newly selected session.
**Detail Search Legend**

**Slot Detail:**
Displays the following information:

**Slot Allocations**
The designated number of appointment types intended for the selected time slot.

**Comments** entered by the Master Scheduler.

**Freeze/Thaw/Hold:**
Displays the shift in appointment types in the release of a frozen or held time slot.

**Switch:**
Displays the shift in appointment types designated to occur a specified number of days prior to the date of service.

**Note:** Selecting a new slot will display information specific to newly selected slot.
**Appt - Patient:**

Displays the following information:
- Patient's Name
- Patient's UMMG MRN
- Patient's Age
- Patient's Work Tel. Number
- Patient's Home Tel. Number
- Appointment Type
- Appointment Status
- Reason for Appointment
- Appointment Duration

**Attachments:**

Attachment Type and Description

**Note:** Selecting a new appointment will display information specific to the newly selected appointment.
Full Registration Flow

1. Enter Patient's Data
2. Enter Demographic Data
3. Is this Patient the guarantor?
   - Yes: Enter General Comments
   - No: Enter Guarantor Data
4. Enter FSC Information
5. Enter Case Information
6. Registration Document
7. Done
## GE/IDX Patient Activity Codes

<table>
<thead>
<tr>
<th>Flag Category</th>
<th>Program</th>
<th>Program Owner</th>
<th>Flag</th>
<th>Flagging Authority/Access</th>
<th>May send to Collections?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Assistance Programs</strong></td>
<td><strong>PinnacleCare</strong> (Pinnacle patients list Patient Advocate as the guarantor, so all contact, including ClientTell reminders go to PA)</td>
<td>UMMG Business Development</td>
<td>P</td>
<td>Executive Medicine Program Office</td>
<td>NO</td>
</tr>
<tr>
<td><strong>(External/Contracted)</strong></td>
<td><strong>Flagship</strong></td>
<td>Executive Medicine Program Office</td>
<td>E</td>
<td>Executive Medicine Program Office/Privacy Office</td>
<td>NO</td>
</tr>
<tr>
<td><strong>MDMP</strong></td>
<td></td>
<td>Executive Medicine Program Office</td>
<td>E</td>
<td>Executive Medicine Program Office/Privacy Office</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Referring MD</strong></td>
<td></td>
<td>Executive Medicine Program Office</td>
<td>E</td>
<td>Executive Medicine Program Office/Privacy Office</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Service Assistance Programs</strong></td>
<td><strong>Miami Medicine Personalized Services Program - VIP</strong></td>
<td>Executive Medicine Program Office</td>
<td>E</td>
<td>Executive Medicine Program Office/Privacy Office</td>
<td>NO</td>
</tr>
<tr>
<td><strong>(Internal)</strong></td>
<td><strong>Miami Medicine Personalized Services Program – Donor</strong> (Once a patient signs the HIPPA form allowing Medical Development to contact them, they are statused as a D)</td>
<td>Medical Development</td>
<td>D</td>
<td>Med Dev/Privacy Office/PRO</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Bascom Palmer Donor</strong></td>
<td></td>
<td>Executive Medicine Program Office</td>
<td>E</td>
<td>Executive Medicine Program Office/Privacy Office</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Executive Medicine Program</strong></td>
<td></td>
<td>Executive Medicine Program Office</td>
<td>EM</td>
<td>Executive Medicine Program Office</td>
<td>NO</td>
</tr>
<tr>
<td><strong>International Patients</strong></td>
<td></td>
<td>International Health Center</td>
<td>I</td>
<td>IHC</td>
<td></td>
</tr>
<tr>
<td><strong>Medically Complex/CMS</strong></td>
<td></td>
<td>Pediatrics</td>
<td>M</td>
<td>CHDS-Pediatric Associates</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Students</strong></td>
<td></td>
<td>Medical Education</td>
<td>S</td>
<td>PRO</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Patient Financial Services - Internal</strong></td>
<td><strong>Collection Negotiations w/Pt Attorneys</strong> (Collection negotiations with patient’s attorney, when no legal action is being taken against UM, but attorney involved due to MVA or other accidents, Worker’s Comp, Product liability, etc.)</td>
<td>Patient Financial Services</td>
<td>L</td>
<td>PFS</td>
<td>NO</td>
</tr>
<tr>
<td>Office of Patient Protection - Internal</td>
<td>Risk Management</td>
<td>OPPRP</td>
<td>R</td>
<td>OPPRP/Billing Compliance</td>
<td>NO</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------</td>
<td>-------</td>
<td>---</td>
<td>--------------------------</td>
<td>----</td>
</tr>
<tr>
<td><strong>Disruptive Patient</strong> - (Patient has been determined to be disruptive in at least one clinic location, in accordance with the UMMG Disruptive Patient-Visitor Policy.)</td>
<td>OPPRP/PPAP</td>
<td>X</td>
<td>Dr. D. Thevenin's Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Terminated Patient</strong> - (Patient is TERMINATED FROM THE PRACTICE. Patients flagged with “T” are not to be SCHEDULED.)</td>
<td>OPPRP/PPAP</td>
<td>T</td>
<td>Dr. D. Thevenin's Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UM Employee</strong> - (When UM Employees or dependents call 305-243-CARE and agree to be coded, they are statused as “F” to expedite the visit process.)</td>
<td></td>
<td></td>
<td>F</td>
<td>PRO</td>
<td></td>
</tr>
</tbody>
</table>

| R | OPPRP/Billing Compliance | NO |
INSURANCE
Dictionary 19 Contains:
- Registration Level FSC's
- Invoice Level FSC's
- Contains Address Information for those Registration Level FSC's that have ONE claims address.

Dictionary 120 Contains:
- All 3rd Party Carrier Names and Billing Address
- Payors and Addresses
- Only used by Registration Level FSC's that do NOT have an address stored in Dictionary 19

**Use FSC:**
980-HMO Non-Contracted 1st
983-HMO Non-Contracted 2nd
981-HMO Non-Contracted Medicaid 1st
984-HMO Non-Contracted Medicaid 2nd
982-HMO Non-Contracted Medicare 1st
987-HMO Non-Contracted Medicare 2nd

**Use FSC:**
41-Commercial Primary 1st
42-Commercial Primary 2nd
43-Commercial Primary 3rd
49-Commercial Secondary 1st
44-Commercial Secondary 2nd
45-Commercial Secondary 3rd
94-Commercial Secondary/Supplemental to Medicare 1st
95-Commercial Secondary/Supplemental to Medicare 2nd
96-Commercial Secondary/Supplemental to Medicare 3rd
**Aetna IDX FSC Guide**

**New Aetna FSC for UM Employees**

Effective January 1, 2009, there will be new Aetna FSCs for University of Miami Employees and the respective plans they have chosen for the upcoming year.

### NEW (Effective 1/1/09)

<table>
<thead>
<tr>
<th>FSC</th>
<th>FSC Description</th>
<th>Plan</th>
<th>Plan Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7005</td>
<td>AETNA SELECT HMO1-UM EMP09</td>
<td>H708</td>
<td>AETNA SELECT HMO1-UM EMP09</td>
</tr>
<tr>
<td>7006</td>
<td>AETNA SELECT HMO 2-UM EMP09</td>
<td>H709</td>
<td>AETNA SELECT HMO 2-UM EMP09</td>
</tr>
<tr>
<td>5082</td>
<td>AETNA CHOICE POS II 600-UM EMP09</td>
<td>P582</td>
<td>AETNA CHOICE POS II 600-UM EMP09</td>
</tr>
<tr>
<td>5083</td>
<td>AETNA CHOICE POS II HRA-UM EMP09</td>
<td>P583</td>
<td>AETNA CHOICE POS II HRA-UM EMP09</td>
</tr>
</tbody>
</table>

### EXPIRED (Effective 12/31/08)

<table>
<thead>
<tr>
<th>FSC</th>
<th>FSC Description</th>
<th>PLAN</th>
<th>Plan Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5049</td>
<td>HUMANA COVFIRST1500-UM EMP08</td>
<td>P549</td>
<td>HUMANA COVFIRST1500-UM EMP08 2008</td>
</tr>
<tr>
<td>5042</td>
<td>HUMANA PPO 550- UM EMP08</td>
<td>P542</td>
<td>HUMANA PPO 550- UM EMP</td>
</tr>
<tr>
<td>6089</td>
<td>HUMANA HMO 2- UM EMP08</td>
<td>H689</td>
<td>HUMANA HMO 2- UM EMP 2008</td>
</tr>
<tr>
<td>6090</td>
<td>HUMANA HMO 1- UM EMP</td>
<td>H690</td>
<td>HUMANA HMO 1- UM EMP</td>
</tr>
</tbody>
</table>
OPEN REFERRALS
<table>
<thead>
<tr>
<th>Referral Type (D511)</th>
<th>MNE</th>
<th>Hospital Staff</th>
<th>Dr.’s Office Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>CHEM</td>
<td>Ex. Physician requesting 3 drug Chemo Therapy treatment: Floxuridine (FUDR), Leucovorin (Leuco) and (5FU). Patient is authorized for chemotherapy only. This referral type requires hospital authorization for at least one drug. If there are additional drugs to be administered with separate authorization numbers, those additional authorization should be entered in the CTU1 and CTU2 fields. Auth # = First drug authorization #. Covers Hosp? = Y Hospital Auth = Blank CTU1 = Second drug authorization (if applicable) CTU2 = Third drug authorization (if applicable)</td>
<td>Ex. Physician requesting 3 Chemo Therapy treatment: Floxuridine (FUDR), Leucovorin (Leuco) and (5FU). Patient is authorized for chemotherapy only. This referral type requires hospital authorization for at least one drug. If there are additional drugs to be administered with separate authorization numbers, those additional authorizations should be entered in the CTU1 and CTU2 fields. Auth # = First drug authorization #. Covers Hosp? = Y Hosp Auth = Blank CTU1 = Second drug authorization (if applicable) CTU2 = Third drug authorization (if applicable)</td>
</tr>
<tr>
<td>Consultation</td>
<td>CON</td>
<td>Ex. PCP refers patient to Dermatology physician; Dermatology physician refers patient to an Oncologist. Physician refers patient to a specialist and no other services are requested. This Referral type does not require HOSPITAL authorization. If the referring physician needs an authorization, create a new Open Referral. If test or other services are needed in addition to the Consult, use another Referral type or create another Open Referral. Appt. Types: NPV and CON Auth # = Target physician auth # Covers Hosp? = N Hosp Auth = Blank</td>
<td>Ex. PCP refers patient to Dermatology physician; Dermatology physician refers patient to an Oncologist. Physician refers patient to a specialist and no other services are requested. This Referral type does not require HOSPITAL authorization. If the referring physician needs an authorization, create a new Open Referral. If test or other services are needed in addition to the Consult, use another Referral type or create another Open Referral. Appt. Types: NPV and CON Auth # = Target physician auth # Covers Hosp? = N Hosp Auth = Blank</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>----------------------</td>
<td>------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Diagnostic- Nuclear Medicine** | DNUC | Ex: Physician requesting a Bone Density test.  
Ex: Physician requesting a Thallium Myocardial rest & stress test.  
Ex: PET Scan  
Patient is authorized for Diagnostic Nuclear Medicine only. This referral type requires physician and hospital authorizations. Note: If more than one physician Auth# is given for the Thallium test, a second referral must be created and linked to the Visit.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # | Ex: Physician requesting a Bone Density test.  
Ex: Physician requesting a Thallium Myocardial rest & stress test.  
Ex: PET Scan  
Patient is authorized for Diagnostic Nuclear Medicine only. This referral type requires physician and hospital authorizations. Note: If more than one physician Auth# is given for the Thallium test, a second referral must be created and linked to the Visit.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # |
| **Diagnostic- Cardiology** | DCAR | Ex: Stress Test  
Patient is authorized for Diagnostic Cardiology only. This referral type requires physician and hospital authorization.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # | Ex: Stress Test  
Patient is authorized for Diagnostic Cardiology only. This referral type requires physician and hospital authorization.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # |
| **Diagnostic- CT Scans** | DCTS | Ex: CT Scan  
Patient is authorized for Diagnostic CT Scan only. This referral type requires physician and hospital authorization.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # | Ex: CT Scan  
Patient is authorized for Diagnostic CT Scan only. This referral type requires physician and hospital authorization.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # |
<table>
<thead>
<tr>
<th>Referral Type (D511)</th>
<th>MNE</th>
<th>Hospital Staff</th>
<th>Dr.’s Office Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic- GI</strong></td>
<td>DGI</td>
<td>Ex: Sigmoidoscopy</td>
<td>Ex: Sigmoidoscopy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for Diagnostic GI only. This referral type requires physician and hospital authorizations.</td>
<td>Patient is authorized for Diagnostic GI only. This referral type requires physician and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td><strong>Diagnostic- Interventional</strong></td>
<td>DINT</td>
<td>Ex: Physician requesting a Chest Port Placement; Gastrostomy to check; Nephrostogram; Drainage Catheter C; Lumbar Epidural Steroid Injection.</td>
<td>Ex: Physician requesting a Chest Port Placement; Gastrostomy to check; Nephrostogram; Drainage Catheter C; Lumbar Epidural Steroid Injection.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for Diagnostic Interventional services only. This referral type requires physician and hospital authorizations.</td>
<td>Patient is authorized for Diagnostic Interventional services only. This referral type requires physician and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td><strong>Diagnostic- MRI</strong></td>
<td>DMRI</td>
<td>Ex: MRI</td>
<td>Ex: MRI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for MRI exclusively. This referral type requires physician and hospital authorizations.</td>
<td>Patient is authorized for MRI exclusively. This referral type requires physician and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diagnostic-</td>
<td>DOPH</td>
<td>Ex: Fundus Photography; Echography</td>
<td>Ex: Fundus Photography; Echography</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
<td>Patient is authorized for Diagnostic Ophthalmology only. This referral type</td>
<td>Patient is authorized for Diagnostic Ophthalmology only. This referral type</td>
</tr>
<tr>
<td></td>
<td></td>
<td>requires physician and hospital authorizations.</td>
<td>requires physician and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex: Fundus Photography; Echography</td>
<td>Ex: Fundus Photography; Echography</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for Diagnostic Ophthalmology only. This referral type</td>
<td>Patient is authorized for Diagnostic Ophthalmology only. This referral type</td>
</tr>
<tr>
<td></td>
<td></td>
<td>requires physician and hospital authorizations.</td>
<td>requires physician and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Diagnostic-</td>
<td>DRAD</td>
<td>Ex: Chest X-ray, lower lumbar</td>
<td>Ex: Chest X-ray, lower lumbar</td>
</tr>
<tr>
<td>Pathology/Lab</td>
<td></td>
<td>Patient is authorized for Diagnostic Radiology only. This excludes MRIs.</td>
<td>Patient is authorized for Diagnostic Radiology only. This excludes MRIs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physician requesting one or more radiology tests. This referral type requires</td>
<td>Physician requesting one or more radiology tests. This referral type requires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>physician and hospital authorization.</td>
<td>physician and hospital authorization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex: Chest X-ray, lower lumbar</td>
<td>Ex: Chest X-ray, lower lumbar</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for Diagnostic Radiology only. This excludes MRIs.</td>
<td>Patient is authorized for Diagnostic Radiology only. This excludes MRIs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physician requesting one or more radiology tests. This referral type requires</td>
<td>Physician requesting one or more radiology tests. This referral type requires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>physician and hospital authorization.</td>
<td>physician and hospital authorization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Diagnosis-</td>
<td>DIAG</td>
<td>Ex: Cardiology and CT Scan</td>
<td>Ex: Cardiology and CT Scan</td>
</tr>
<tr>
<td>other/multiple</td>
<td></td>
<td>Patient is authorized for multiple disciplines diagnostic test or for services</td>
<td>Patient is authorized for multiple disciplines diagnostic test or for services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>not covered by any other diagnostic referral type.</td>
<td>not covered by any other diagnostic referral type.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex: Cardiology and CT Scan</td>
<td>Ex: Cardiology and CT Scan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for multiple disciplines diagnostic test or for services</td>
<td>Patient is authorized for multiple disciplines diagnostic test or for services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>not covered by any other diagnostic referral type.</td>
<td>not covered by any other diagnostic referral type.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>DME</td>
<td>Ex: Cane or wheelchair&lt;br&gt;Patient is authorized for Durable Medical Equipment only. This referral type requires physician and hospital authorizations.&lt;br&gt;Auth # = Target physician auth #.&lt;br&gt;Covers Hosp? = Y if Auth # covers both physician and hospital&lt;br&gt;Covers Hosp? = N if separate Auth # for hospital&lt;br&gt;Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Ex: Cane or wheelchair&lt;br&gt;Patient is authorized for Durable Medical Equipment only. This referral type requires physician and hospital authorizations.&lt;br&gt;Auth # = Target physician auth #.&lt;br&gt;Covers Hosp? = Y if Auth # covers both physician and hospital&lt;br&gt;Covers Hosp? = N if separate Auth # for hospital&lt;br&gt;Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>ER</td>
<td>Ex: Patient arrives at Emergency Room.&lt;br&gt;Patient is authorized for Emergency services only. This referral type does require an authorization number, however there are instances that after the fact the carrier may provide an auth # that must be entered in IDX. In these cases, use the ER Referral Type.&lt;br&gt;Appt. Type: ER&lt;br&gt;Auth # = Target physician auth #.&lt;br&gt;Covers Hosp? = Y if Auth # covers both physician and hospital&lt;br&gt;Covers Hosp? = N if separate Auth # for hospital&lt;br&gt;Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>N/A</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Follow up Visits</td>
<td>FUP</td>
<td>Ex: Oncologist requests a follow up visit; PCP requesting a follow up visit with the Oncologist. Patient is an established patient who is returning for follow up visit(s) to see the same provider or one of the group providers within the same specialty. This referral type does not require HOSPITAL authorization. Authorization only obtained for the target physician. Appt. Types: FUV or variations of FUV. Not NPV Auth # = Target physician auth #. Covers Hosp? = N Hosp. Auth = Blank.</td>
<td>Ex: Oncologist requests a follow up visit; PCP requesting a follow up visit with the Oncologist. Patient is an established patient who is returning for follow up visit(s) to see the same provider or one of the group providers within the same specialty. This referral type does not require HOSPITAL authorization. Authorization only obtained for the target physician. Appt. Types: FUV or variations of FUV. Not NPV Auth # = Target physician auth #. Covers Hosp? = N Hosp. Auth = Blank.</td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Episode</td>
<td>HOP</td>
<td>Ex: Blanket referral for multiple Appointments/Visits on the same day. Restricted ONLY to the Admitting and Utilization Review (UMHC/SCCC and ABLEH) Patient is authorized for Outpatient Services not otherwise specified on any other Referral Type. All of the appointment/visits are covered by the same authorization number(s). Each appointment or visit does not require its own auth #. This referral type requires provider and hospital authorization. Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Ex: Blanket referral for multiple Appointments/Visits on the same day. Restricted ONLY to the Admitting and Utilization Review (UMHC/SCCC and ABLEH) Patient is authorized for Outpatient Services not otherwise specified on any other Referral Type. All of the appointment/visits are covered by the same authorization number(s). Each appointment or visit does not require its own auth #. This referral type requires provider and hospital authorization. Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital Covers Hosp? = N if separate Auth # for hospital Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>----------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>INP</td>
<td>Patient is authorized for In-Patient Admission stay. This referral type requires provider and hospital authorizations obtained by the UR nurse. Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital. Covers Hosp? = N if separate Auth # for hospital. Hosp Auth = Hospital Auth # if different from physician Auth #.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Observation</strong></td>
<td>OBS</td>
<td>Patient is authorized for Observation. This referral type requires provider and hospital authorizations obtained by the hospital designee. Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital. Covers Hosp? = N if separate Auth # for hospital. Hosp Auth = Hospital Auth # if different from physician Auth #.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Obstetrics</strong></td>
<td>OB</td>
<td>Ex: Occupational Therapy. Patient is authorized for Occupational Therapy only. This referral type requires provider and hospital authorization.</td>
<td>Ex: Occupational Therapy. Patient is authorized for Occupational Therapy only. This referral type requires provider and hospital authorization.</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>OT</td>
<td>Ex: Occupational Therapy. Patient is authorized for Outpatient Services not otherwise specified on any other referral type. All of the appointment/visits are covered by the same authorization number(s). Each appointment or visit does not require its own auth #. This referral type requires provider and hospital authorizations. Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital. Covers Hosp? = N if separate Auth # for hospital. Hosp Auth = Hospital Auth # if different from physician Auth #.</td>
<td>Ex: Occupational Therapy. Patient is authorized for Outpatient Services not otherwise specified on any other referral type. All of the appointment/visits are covered by the same authorization number(s). Each appointment or visit does not require its own auth #. This referral type requires provider and hospital authorizations. Auth # = Target physician auth #. Covers Hosp? = Y if Auth # covers both physician and hospital. Covers Hosp? = N if separate Auth # for hospital. Hosp Auth = Hospital Auth # if different from physician Auth #.</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>OUM</td>
<td>Ex: Psychiatrist or Psychologist</td>
<td>Patient is authorized for Outpatient Mental Health Services only. This referral type does not require hospital authorization. Authorization only obtained for the target provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N</td>
<td>Covers Hosp? = N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Blank</td>
<td>Hosp Auth = Blank</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td></td>
<td>Ex: Breast Biopsy</td>
<td>Patient is authorized for Outpatient Surgery. This referral type requires provider and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Pain Management</td>
<td>PAIN</td>
<td>Ex: Patient is authorized for Bier Block Auth</td>
<td>Ex: Patient is authorized for Bier Block Auth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Hospital Auth</td>
<td>Auth # = Hospital Auth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y</td>
<td>Covers Hosp? = Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Blank</td>
<td>Hosp Auth = Blank</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTU1= Second drug authorization (if applicable)</td>
<td>CTU1= Second drug authorization (if applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTU2 = Third drug authorization (if applicable)</td>
<td>CTU2 = Third drug authorization (if applicable)</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>----------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for Physical Therapy only. This referral type requires provider and hospital authorizations.</td>
<td>Patient is authorized for Physical Therapy only. This referral type requires provider and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>RAD</td>
<td>Patient is authorized for Radiation Therapy only. This referral type requires physician and hospital authorizations.</td>
<td>Patient is authorized for Radiation Therapy only. This referral type requires physician and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>ST</td>
<td>Ex: Physician is requesting Speech Therapy for stroke patient.</td>
<td>Ex: Physician is requesting Speech Therapy for stroke patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is authorized for Speech Therapy only. This referral type requires physician and hospital authorizations.</td>
<td>Patient is authorized for Speech Therapy only. This referral type requires physician and hospital authorizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auth # = Target physician auth #.</td>
<td>Auth # = Target physician auth #.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
<td>Covers Hosp? = Y if Auth # covers both physician and hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
<td>Covers Hosp? = N if separate Auth # for hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
<td>Hosp Auth = Hospital Auth # if different from physician Auth #</td>
</tr>
<tr>
<td>Referral Type (D511)</td>
<td>MNE</td>
<td>Hospital Staff</td>
<td>Dr.’s Office Staff</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| Therapeutic/DX      | TXIN| Ex: Physician requesting a Botox injection  
Patient is authorized for a diagnostic procedure only that it is not otherwise listed or patient is authorized only for the Therapeutic injection. This referral type requires physician and hospital authorization.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # | Ex: Physician requesting a Botox injection  
Patient is authorized for a diagnostic procedure only that it is not otherwise listed or patient is authorized only for the Therapeutic injection. This referral type requires physician and hospital authorization.  
Auth # = Target physician auth #.  
Covers Hosp? = Y if Auth # covers both physician and hospital  
Covers Hosp? = N if separate Auth # for hospital  
Hosp Auth = Hospital Auth # if different from physician Auth # |
University of Miami Medical Group Practice Locations
University of Miami Medical Center – Downtown Miami/Civic Center
Miami, Florida 33136
305-243-5757

UMHC/SCCC* (UM/Sylvester)
1475 NW 12th Avenue
Miami, Florida 33136
305-243-1000
800-545-2292

Anne Bates Leach Eye Hospital *
(Bascom Palmer Eye Institute)
900 NW 17th Street
Miami, Florida 33136
305-326-6000
800-329-7000

Bascom Palmer Eye Institute Retina Center at Naples
311 9th Street North
Naples, Florida 34102
239-659-3937

University of Miami Physicians – South Dade
Deering Medical Plaza
9380 SW 152nd Street
Miami, Florida 33176
305-243-4530

Bascom Palmer Eye Institute at Plantation *
1000 South Pine Island Road
Plantation, Florida 33324
954-465-2700

Bascom Palmer Eye Institute of the Palm Beaches
7108 Fairway Drive, Suite 340
Palm Beach, Florida 33418
561-515-1500

University of Miami Physicians at Boca
3858 FAU Boulevard
Boca Raton, Florida 33431
561-455-3627

UMHC/SCCC at Deerfield *
(UM/Sylvester at Deerfield Beach)
1192 East Newport entrance Drive, Suite 100
Deerfield Beach, Florida 33442
1-800-545-2292 or 305-243-1000

University of Miami Physicians at Coral Gables (Daystar)
5513 Merrick Drive
Coral Gables, Florida 33124
305-284-3333

University of Miami Physicians at Kendall
8932 SW 97th Avenue
Miami, Florida 33176
305-270-3400

University of Miami Physicians at Key Biscayne

General Internal Medicine
967 Crandon Boulevard
Key Biscayne, Florida 33149
305-243-7735

MDVIP at Key Biscayne
30 West Mashta Drive
Key Biscayne, Florida 33149
305-243-7934

University of Miami Physicians at Miami Beach
Cosmetic Center
Miami Heart Institute, Nichol Building
4701 N. Meridian Avenue, Suite 7450
Miami Beach, Florida 33140
305-534-5224

Department of Psychiatry
Mount Sinai Medical Center
4300 Alton Road
Miami Beach, Florida 33140
305-674-2194

University of Miami Physicians at Weston
Weston regional Health Park, Suite 317
2300 North Commerce Parkway
Weston, Florida 33326
954-384-8886

UMHC/SCCC at Miramar*
UM/Sylvester at Miramar
1951 SW 172nd Avenue, Suite 305
Medical Office Building
Miramar, Florida 33029

* Hospital location or a division of a University of Miami hospital location
## Medical Center Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC EAST</td>
<td>1666 NW 10th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>ACC WEST</td>
<td>1611 NW 12th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>AIDS CLINICAL RESEARCH CENTER (ELLIOTT BUILDING)</td>
<td>1801 NW 9th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>ALAMO</td>
<td>1611 NW 12 Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>AMBULATORY CARE CENTER</td>
<td>1611 NW 12th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>BATCHELOR CHILDREN’S RESEARCH INSTITUTE</td>
<td>1580 NW 10th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>BREAST HEALTH CENTER (DIAGNOSTIC TREATMENT CENTER, 1ST FLOOR)</td>
<td>1611 NW 12th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>UNIVERSITY OF MIAMI HOSPITAL</td>
<td>1400 NW 12th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>COMPREHENSIVE AGING CENTER/PSYCHIATRY (SIERON BUILDING)</td>
<td>1425 NW 10th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>DERMATOLOGY CLINIC (EDELMAN BUILDING)</td>
<td>1444 NW 9th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>DIABETES RESEARCH INSTITUTE</td>
<td>1450 N.W. 10th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>DIALYSIS CENTER, PEDIATRIC OUTPATIENT (HOLTZ CENTER, EAST TOWER)</td>
<td>1611 NW 12th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>FOX CANCER RESEARCH BUILDING</td>
<td>1550 NW 10th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>GLASER MEDICAL RESEARCH BUILDING</td>
<td>1600 NW 10th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>HOLTZ CENTER FOR MATERNAL AND CHILD HEALTH (EAST TOWER)</td>
<td>1611 NW 12th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>Name</td>
<td>Address</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>LOIS POPE LIFE CENTER</td>
<td>1095 NW 14th Terrace Miami, FL 33136</td>
</tr>
<tr>
<td>MAILMAN CENTER FOR CHILD DEVELOPMENT</td>
<td>1601 NW 12th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>MIAMI VETERANS AFFAIRS MEDICAL CENTER</td>
<td>1201 NW 16 Street Miami, FL 33125</td>
</tr>
<tr>
<td>MAGNETIC RESONANCE CENTER, (JOSEPH APPLEBAUM DIAGNOSTIC IMAGING CENTER) (UMHC/SCCC APPLEBAUM)</td>
<td>1115 NW 14th Street Miami, FL 33136</td>
</tr>
<tr>
<td>NATIONAL PARKINSON FOUNDATION</td>
<td>1501 NW 9th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>PARK PLAZA EAST</td>
<td>901 NW 17th Street Miami, FL 33136</td>
</tr>
<tr>
<td>PARK PLAZA WEST</td>
<td>1611 NW 10th Avenue Miami, FL 33101</td>
</tr>
<tr>
<td>PROFESSIONAL ARTS CENTER (PAC)</td>
<td>1150 NW 14th Street Miami, FL 33136</td>
</tr>
<tr>
<td>R. BUNN GAUTIER BUILDING</td>
<td>1011 NW 15th Street Miami, FL 33136</td>
</tr>
<tr>
<td>REHABILITATION CENTER</td>
<td>1600 NW 10th Avenue Miami, FL 33136</td>
</tr>
<tr>
<td>ROSENSTIEL MEDICAL SCIENCE BUILDING</td>
<td>1600 NW 10th Avenue Miami, FL 33136</td>
</tr>
</tbody>
</table>
ARRIVAL of HOSPITAL VISITS
Appointment Arrival for Hospital Visit Admission


Date: October 10, 2008
Author: UMCET Training Department
Introduction

The Sched Link is a feature of the GE-IDX Web 4.0 application that functions to automatically create a visit in Visit Management for any appointment scheduled for a hospital location once the appointment is due to occur within 14 days. As such, the arrival of these appointments will route the user to Visit Management.

The arrival of hospital visits from the Appointment Manager is known as the XX Action Code process. The result of the XX Action Code Process is the simultaneous arrival of the appointment and the admission of the visit. This manual provides a detailed outline of the screens encountered in during the hospital arrival process.
1. From the Appointment Manager on the Vertical Toolbar, select the appointment to be arrived.

2. Click the “Check In” button at the bottom of the screen.

3. The Visit Overview will display (See Figure 2).

4. At the Action Code field type “ME”.

FIGURE 1

FIGURE 2
5. The Marked Event (ME) screen will display (See Figure 3). On this screen it is important to note whether or not the patient’s insurance has been verified. In addition, pay particular attention to any notes in the Notes columns for Insurance Verified. Such notes may affect the arrival of the selected appointment.

6. If there are no pending insurance matters, Click “Ok” at the bottom of this screen.

FIGURE 3
7. The Visit Overview screen will display (See Figure 4).

8. At the Action Code field. Type “XX”.

**FIGURE 4**
9. The patient’s registration data (RE) will display (See Figure 5). Use the page navigator arrows to validate all registration data.

10. Click “Ok” at the bottom of this screen.
11. The Visit lookup Screen will display (See Figure 6). The visit to be arrived should be highlighted.

12. Click “OK” at the bottom of the screen.

FIGURE 6
13. The Edit Visit (EV) screen will display (See Figure 7). Make certain that the accurate information has been entered in the Alternate Ins. Coverage field. Use the page navigator arrows to view the following screens: Admission Diagnosis, Injury Info, and Advanced Directive.

14. Click “OK” at the bottom of the screen.

FIGURE 7
15. The Insurance Plans associated with the selected visit will display. This is the IV Screen. Make certain that the visit is designated to be billed to the correct insurance plan or alternate insurance.

FIGURE 8
16. A window will display the following question: “Is this Final Verification?” (See Figure 9). Respond to this question “Yes”.

FIGURE 9
17. The following screen will display indicating that the visit has been final verified (See Figure 10). Make certain that the box Next to Final Verification beneath the insurance plans has been marked with a checkmark.

18. Click “OK” at the bottom of the screen.

**Figure 10**
19. If the patient is not insured through Medicare the following window will display (See Figure 11). If the patient does not have Medicare, respond “No” to not continue with the Medicare Survey. If the patient is insured through Medicare, the Medicare Survey (MSP) will display.

**FIGURE 11**
20. After the MSP or once the MSP has been bypassed, the Visit Notes (NA) will display (See Figure 12). Pay particular attention the visit notes since this information may affect the arrival of the selected visit.

21. Click “OK’ at the bottom of the screen.
22. The Alerts/Hold Bill (HB) will display (See Figure 13). Hold bills prevent claims and patient bills from being sent with incomplete information. Hold bills are defined for specific users to work. The first few letter of most Hold Bill descriptions designate the department responsible for correcting the error or omission that created the Hold Bill. The user arriving the selected the visit must work all applicable Hold Bills.
   
   a. To work a specific Hold Bill, select the Hold Bill to be worked, and then click the “Work” button at the bottom of the screen.

23. Click “OK” at the bottom of the screen.

FIGURE 13
24. The Demand Form (DF) screen will display (See Figure 14). Users may print any form pertaining to the patient’s appointment indicated on this screen.
   a. To print a form, click the box next to the form description so that a checkmark appears in the box, then click on Action Code P – Print a Form. A printer device name must be specified in order to print a form.

25. Click “OK” at the bottom of the screen.

FIGURE 14
26. The visit Overview screen will display (See Figure 15).

27. Click “OK’ at the bottom of the screen.

**FIGURE 15**

![Image of the appointment manager](image)

28. The system will return to the Appointment Manager (See Figure 16). The previously selected visit will now appear in ARR status indicating that the appointment has been arrived.

**FIGURE 16**

![Image of the new user training](image)

1. Log in to the IDX system.
2. At the Patient Services Screen, select the HPA Worklists menu option from the vertical toolbar.
### Visit Management Inquiry Action Codes for Front End Users

<table>
<thead>
<tr>
<th>Action Code</th>
<th>Action Code Name</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP</td>
<td>Inquire Patient</td>
<td>Highest level of inquiry. Initial Action Codes are for IDX applications. Able to access up to 43 types of VM/HPA (H – Hospital Action Code) inquiry of user has security access. The same functionality as Patient Inquiry</td>
</tr>
<tr>
<td>RI</td>
<td>Registration Inquiry</td>
<td>Demographic data only</td>
</tr>
<tr>
<td>II</td>
<td>IMS Inquiry</td>
<td>Registration-level insurance (FSC) data</td>
</tr>
<tr>
<td>LK</td>
<td>Lookup/Link Sched Appt</td>
<td>View which Sched appointments are linked to a specific VM/HPA visit</td>
</tr>
<tr>
<td>VI</td>
<td>Visit Inquiry</td>
<td>Visit data, visit plan data, claim and aging data, transaction data, and Notes A –E. Action Code VI may only be accessed through Action code PB – Patient Billing</td>
</tr>
<tr>
<td>PI</td>
<td>Plan Inquiry</td>
<td>Plan and detail Profile data for all plans on a visit. May only access Action Code IP through Action Code PI</td>
</tr>
<tr>
<td>AI</td>
<td>Admission Inquiry</td>
<td>Admission data including bed information for inpatient visits</td>
</tr>
<tr>
<td>DI</td>
<td>Discharge Inquiry</td>
<td>Discharge data</td>
</tr>
<tr>
<td>SC</td>
<td>Show cancelled visits</td>
<td>Displays all VM/HPA visits that were cancelled for a specific patient</td>
</tr>
</tbody>
</table>
### Transfer History Categories

<table>
<thead>
<tr>
<th>Transfer Action Code</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>TP</td>
<td>Transfer Visit Type</td>
</tr>
<tr>
<td>TL</td>
<td>Transfer Nurse Station/Location</td>
</tr>
<tr>
<td>TA</td>
<td>Transfer Attending and Service</td>
</tr>
<tr>
<td>FT</td>
<td>Fix Transfer data when initial pre-admit or admit was incorrect</td>
</tr>
<tr>
<td>TR</td>
<td>Revenue FSC Transfer</td>
</tr>
<tr>
<td>TH</td>
<td>To view or print the history of the above transfers</td>
</tr>
</tbody>
</table>

### Accommodation Types

<table>
<thead>
<tr>
<th>Names</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Private Room</td>
</tr>
<tr>
<td>S</td>
<td>Semi-Private Room</td>
</tr>
<tr>
<td>I</td>
<td>Intensive Care</td>
</tr>
<tr>
<td>H</td>
<td>Hotel (for family members who stay in a room with a patient)</td>
</tr>
</tbody>
</table>

### VI – Section Code – Initial Screen Fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit Level</td>
<td>Displays demographic and high level Visit accounts receivable Information. This information is also displayed on the PB (Patient Billing Action Code) screen.</td>
</tr>
<tr>
<td>Claim Level</td>
<td>Displays billed, payment, adjustment, balance, and claim information by FSC. This information is also displayed using Action Code P – Plan Summary within Action Code PB</td>
</tr>
<tr>
<td>Transaction Level</td>
<td></td>
</tr>
<tr>
<td>Notes A (NA)</td>
<td>Front End notes</td>
</tr>
<tr>
<td>Notes B (NB)</td>
<td>Medical Records and Utilization review notes</td>
</tr>
<tr>
<td>Notes C (NC)</td>
<td>Back End notes</td>
</tr>
<tr>
<td>Notes D (ND)</td>
<td>Notes the IDX System put on the visit</td>
</tr>
<tr>
<td>Notes E (NE)</td>
<td>Displays Notes A – D</td>
</tr>
<tr>
<td>Registration Notes</td>
<td>Displays registration General Comments</td>
</tr>
</tbody>
</table>
ELECTRONIC DATA INTERCHANGE (EDI)

ELIGIBILITY
Acknowledgments

Developed by Casi Computer Advisory Services.
Edited by the University of Miami, Business Information Management Systems Training Department

Copyright Notice

Copyright © 2008 University of Miami. All rights reserved.

The information contained in this document is the confidential property of the University of Miami.

No part of this document may be reproduced in any form, by photostat, microfilm, xerography, or any other means, or incorporated into any information retrieval system, electronic or mechanical, without the written permission of the copyright owner. Inquired regarding permission for use of material contained in this document should be addressed to: Business Information Management Systems, University of Miami, 1150 N.W. 14th Street, Suite 100, Miami, FL 33136.
Eligibility is the process of verifying a patient's insurance with an insurance payor. Eligibility can be performed by:
- calling the payor,
- having the system automatically send and receive the necessary patient insurance information electronically. This method is called Electronic Data Interchange (EDI) Eligibility.

**NOTE:** Eligibility does not take the place of obtaining referrals and going through the insurance verification process. These tasks must be completed also.

The University has agreements with most of the large volume insurers to perform EDI Eligibility. As of February, 2008, eligibility requests can be submitted via EDI to the following insurers:

- Aetna
- Avmed
- BC/BS
- Cigna
- Humana
- JMH Health Plan
- Neighborhood Health Partnership
- United Healthcare
- Medicare
- Medicaid

Any insurance payer not listed above has to be checked manually or as you do in your current process.

The rest of this document describes the steps to perform EDI Eligibility verification.

The system stores all the EDI eligibility requests and replies as they occur. They are available for viewing on the system for a year.

The University's policy is that if a patient's eligibility with an insurer has been verified within the last month and the patient is active with the insurer, you do not have to verify the insurance again. For example,

1. The patient has Avmed as her insurer. Someone verified her insurance on March 5th using the system's Eligibility functionality. The patient is covered by the insurer.
2. It's now March 20th and you have to verify the patient's insurance with Avmed. You do not have to send another request to Avmed because within the last month, her insurance was verified with Avmed.

**Note:** For the rest of the document, EDI Eligibility will be referred to as Eligibility because that is how it is referred to in the system.
If the patient has an EDI Eligibility insurer, the steps to verifying EDI Eligibility are:

1. Has a request been sent within the last month to the insurer and the patient is covered?
2. If yes, then update the current appointment with the information on the Outcome of that request.
3. If no, then
   a. Send a request to the insurer
   b. If the patient is insured, use the side-by-side screen to view the variances between the insurer's patient data and our system's patient data.
   c. View the patient's benefits
   d. If the information needs to be added back to the patient's demographic or insurance data in the system, edit Registration or Insurance and make the necessary updates.
   e. File the variants and mark the request as Reviewed and assign an Outcome

An EDI eligibility request was submitted for patient Test,Yamile for her Cigna insurance. Cigna returned the results.

You need to review the benefits and results, update Yamile's demographic and/or insurance data in the system and enter an Outcome in the system.

Access to the Eligibility List is from the Patient Services screen.

**NOTE:** The Eligibility List is also access by clicking on the VTB Open Referrals tab and in the Actions button on the Appointment List, Appointment Manager, New Appointment and Insurance Management screens.

1. Click the Eligibility List link.

Eligibility Request List screen displays.
The Eligibility Request List contains all the Eligibility Requests that have been requested for the patient.

The columns are:
- **FSC** = FSC Number
- **Insurance** = Payor
- **Req’d** = Date request was sent
- **Status** = Response we received from the payor
- **Var** = Difference, if any, are noted with a diamond
- **Rej** = A rejection code if the request was rejected
- **Outcome** = Comment assigned to the request after it has been reviewed
- **Rev’d** = Reviewed date
- **By** = Initials of the user who reviewed the request

2. Select the request for this month.
3. Click the **Results** button to view the results.

The Side-by-Side screen displays the eligibility results.
The **Eligibility Benefits** screen displays.

All the benefit types the patient has under their health plan are displayed.

You can scroll up or down to view the desired benefit.

5. Click the **Expand** button to view more details about the patient's benefits.

The **Expanded Benefit** screen displays.

6. Select a specific benefit.

7. Click the **Detail** button to view more information about the specific benefit you selected.
A Benefit Detail screen displays. This screen shot shows the Benefit Detail - Deductible screen.

8. Click the Edit button If any of the patient information from the payor needs to be added back to the patient's account (either to the Insurance or Demographics).

9. Select the type of information that needs to be updated in the system:
   - Demographics
   - IMS
   - Plan
   - NOTE: Do not use the Insurance option

The selected Edit Registration screen will display for you to update the patient's information in the system. When you click OK on a Registration screen, you are returned to this screen to make additional updates.

10. Click the OK button when all the updates to the patient's demographics and insurance have been made.

The Eligibility Benefits screen redisplays.

You can continue to select different benefits, view the details and update the system if appropriate.

11. Click the OK button when you are done viewing the patient's benefits and updating the system.

The Side-by-Side screen redisplays.

Continued on Next Page
There are two remaining results screens that need to be reviewed

12. Click on the Page > arrow button to see the Eligibility Results - Subscriber/Family screen.

The Eligibility Results - Subscriber/Family screen.

The Subscriber/Family screen is the second screen in the Eligibility Results.
This screen displays the subscriber's and dependant's information

13. Click on the Page > arrow button to see the Eligibility Results - Payor screen.

Continued on Next Page
The Payor screen is the last screen in the Eligibility Results. This screen displays the payor's information. Also displayed is information such as the group name and plan type.

14. Click the < Page arrow button twice to return to the Side-by-Side screen. The Side-by-Side screen redisplays.

15. Click in the check off the boxes next to the highlighted items as the first step to filing the variants.

**NOTE:** The insurance and the FSC Follow Up Questions still need to be updated.
16. Click the Review button.
The Outcome is determined by the status received from the payor and the patient's benefits.
The Eligibility Verification Outcomes popup box displays.

17. Click the appropriate outcome. Options are:
- Covered with Limitation
- Eligible
- Hospital Benefits only
- Not Eligible
- Terminated
- Wrong FSC

18. Click the OK button in the popup box to accept the selected Outcome.
The Eligibility Request List redisplay:

The Outcome you assigned, your initials and date are displayed on the Side-by-Side screen.

19. Click the OK button to return to the Patient Services screen.

Continued on Next Page
Scenario B

You have to verify eligibility for patient Test, Yamile for her Cigna insurance. You need to determine if any requests have been submitted for the month of the appointment.

A request has not been submitted to Cigna for the month of the appointment. Therefore you have to make a new eligibility request.

Access

Access to the Eligibility List is from the Patient Services screen.

Scenario B

1. Click the Eligibility List link.

Eligibility Request List screen displays.

You view the list of previous requests and see that a request has not been submitted for the month.

2. Click the New button.

Continued on Next Page
The Eligibility Request - Select Insurance screen displays

3. Check the Send request for multiple insurances box if you are requesting new eligibility requests for multiple insurance carriers.
   Leave the Send request for multiple insurances box unchecked if you are requesting a new eligibility for only one insurance carrier.

*NOTE: Keep in mind that not all insurance carriers are not available through EDI Eligibility.*

4. Click the box to the left of the insurance(s) for which you want to request EDI eligibility.

This is a screen shot of the same screen with eligibility requests from two insurers

5. Click the OK button to continue.

The system sends the request to the insurer(s). In a matter of seconds you are notified of the results.

Continued on Next Page
While you are waiting for the results, a message displays on the screen.

Message:
Waiting 90 seconds. Press any key to stop waiting.

Note: If you leave this screen you will not get a notification.

Once the response is received a pop up box displays **Reply Received**.

6. Click the **OK** button in the pop up box.

The **Eligibility Results - Patient Demo/Insurance** screen displays.

At this time you need to check the benefits and enter an outcome for the request.

**>> Refer to Scenario A for instructions.**
Insurance Payers on Eligibility

The insurance payers listed below are the ones that will be available as of May 1, 2007 through eCommerce Eligibility:

- Aetna
- Avmed
- BC/BS
- Cigna
- Humana
- JMH Health Plan
- Neighborhood Health Partnership
- United Healthcare
- Medicare
- Medicaid

Any insurance payer not listed on this list will have to be checked manually or as you do in your current process.
The following are the Eligibility status and their meaning:

1. **Active** = Covered
2. **Inactive** = Not Covered at the time
3. **Mix** = Inactive & Active at the same time, in essence, patient has SOME coverage
4. **Rejected** = Payor’s Gateway down or No match

**Please note that the status and outcomes are two different things. The status you get back from the payor and can not change and the outcome is assigned by the employee who reviews the results.**

The following are the Outcomes and their meaning:

**Eligible**
- Patient is active and eligible
- Depending on the appt type, additional intervention may be required by agent
- **Response: Active**

**Wrong FSC**
- when the results is a different health plan or product/group in IDX
- the agent must terminate the current FSC and add a new FSC according to new benefits
- **Response: Active**

**Covered w/ Limitations**
- Patient is active, but policy may exclude certain services or have pre-existing clauses/conditions
- Patient is active, but benefits for a particular service are exhausted (i.e., mammograms)
- The agent must make the determination specific to the appt type
- **Response: Active and/or Mixed**

**Not Eligible**
- When the clearing house can’t find, locate or match the member to any health plan
- **Response: No Response or Rejected**

**Terminated**
- When the clearing house identifies the member as terminated and includes a termination date
- **Response: Inactive**

**Hospital Benefits Only**
- When a health plan covers hospital benefits only
- No professional services are covered by the plan
- **Response: Active and/or Mixed**

**Please refer to your departmental Policies & Procedures to make the final determination on which action to take.**
SUBJECT: CHECKOUT: CASH CONTROL PROCESS

PURPOSE: To ensure that the appropriate person reconciles all Time of Service (TOS) payments (cash, checks, or credit card payments) taken during the checkout process with the amounts entered into the IDXE Front Desk Module.

POLICY: The designated cashier(s) will post TOS payments while the patient is on-site and provide the patient with an automated receipt. This policy applies to all Patient Financial Services staff working in Clinic Registration areas. This includes individuals working at the following UMHC locations:

- OPD1
- MOHS
- Head and Neck Clinic
- SCCC and Radiology Registration areas
- Cardiology Clinic
- General Medicine Clinic
- Radiation Oncology Clinic

PROCEDURE:

1. The checkout person will itemize and total all charges including ancillary services if applicable (self-pay patients only).
2. A follow-up appointment will be scheduled for the patient if necessary.
3. All Cashiers must pick up a Bank Bag from the main cashier office prior to the start of their shift.
4. The following steps must be taken when collecting Time of Service (TOS) payments.
   - The TOS payment must be entered into the IDXE system.
   - The payment amount and pay-code must be noted on the Cash Log Report.
   - The second copy of the system-generated receipt must be given to the patient.
   - The cashier/checkout person will supply the patient with the designated patient copy of the voucher.

   The cashier/checkout person will attach the top copy of the receipt to the billing office copy of the voucher. Note: If an error is made during the posting of TOS payments using the Front Desk Module, or if there is a printer jam, the following steps must be taken:
If the receipt has already been generated, the cashier must maintain both copies of the receipt (including a crumpled receipt from a printer jam) and re-post the TOS payment in IDXe.

Once the correct receipt is printed, the second copy will be given to the patient, and the original copy of the correct receipt will be attached to both copies of the incorrect receipt.

The three cash receipt sections will be attached to the patient’s voucher. At the end of the day, before closing the batch, the incorrect entry/entries for the day must be deleted from the batch before the batch proof is printed.

5. At the end of the business day, the cashier or designated checkout person will:

Access Function 25/Activity 2 (Cash Drawer) in order to balance the Open batch.

Perform the cash reconciliation process by entering all actual numbers of invoices and dollar amounts in the Control Section of the Cash Drawer screen using the completed Cash Log Report.

Print a Batch Proof by entering an < L > in the Action: field.

If the checkout batch has balanced, enter < X > to close the batch.

If the checkout batch does not balance, review the batch proof to find the error.

Take the appropriate steps to balance the batch. If applicable, submit an Over/Short Report.

If changes were made to balance the batch, print the Batch Proof again showing a balanced batch. This batch proof will display all transactions entered in the Front Desk Module (including any deletions).

Prepare the deposit information as follows:

- Each cashier must make a copy of all checks received for the day (including traveler’s checks).
- Run three “totals” tapes –
  - One for all cash collected and
  - Two for all checks collected (one tape goes in the Brinks Bag and one tape goes with the Gables One deposit information).
- Complete a deposit slip reflecting the totals for the cash and checks. List “regular” checks on one line and traveler’s checks on a separate line on the deposit slip.
- Place all cash, original checks, the cash total tape, one copy of the check total tape and the white copy of the deposit slip in the Brinks Bank Bag. Staple the pink copy of the deposit slip to the outside of the Brinks Bag. The front of the bag must be completely filled out (dated, cash and total check amounts, BPEI and Bank address) and the control portion of the bag must be torn off and included with the deposit information for Gables One. (See # 6)
Place the *Brinks Bank Bag* in the Cashier’s Bank Bag and deliver to the safe in the main Cashier’s office at the end of the day.

Prepare deposit information for the Gables One Billing office by attaching the yellow copy of the deposit slip to the other copy of the check total tape, *Brinks Bag* control copy, check copies, cash log report and batch proof. Make one copy of the above information and keep on-file for 30-days in the clinic.

A batch summary for the credit card payments and batch settlements must be generated and placed in a dated envelope along with the credit card transactions.

At the end of the day, place the cashier’s bank bag (*with the Brinks bag*), in the appropriate vault in the main cashier’s office. Place all paperwork (batch proof, yellow deposit slip, etc…) in an inter-office envelope addressed to Jose Miranda, and place in the Gables pick up box directly outside the cashier’s office on the first floor.

The cashier/checkout person must take the following steps to ensure that all vouchers are completed and accounted for:

- Review that all vouchers have been completed with diagnosis, procedure code(s), and charge code(s), and that the appropriate secondary forms, insurance card copies, and paper authorization/referral forms have been attached to the voucher.
- Place all vouchers in their appropriate bin (by Provider, in patient alpha order). This group of vouchers will be placed in the PIP designated area along with any pertinent paperwork (copies of insurance cards, etc.).
- Any missing vouchers must be logged on the *Missing Voucher Report* and the Voucher Custodian must be notified for the appropriate follow-up action. (As described in the Voucher Control Policy and Procedure).
- All Secondary encounter forms must be sequentially placed in a bin for reconciliation purposes. If any Secondary Encounter Forms are missing, they must be entered on the *Discrepancy Log* for supervisory follow-up.
SUBJECT:  CASH CONTROL PROCESS FOR TIME OF SERVICE (TOS) REFUNDS

PURPOSE:  The purpose of this policy is to ensure that TOS refunds are issued to patients under UMMG specified circumstances and the refund transaction and the refunded cash are accounted for in the IDX system.

POLICY:  The cashier/checkout person must document all refund transactions for TOS payments using the IDXe Front Desk Module. In addition, TOS refunds will only be issued on-site under the UMMG specified circumstances. This policy applies to all Patient Financial Services staff working in Clinic Registration areas. This includes individuals working at the following UMHC locations:

- OPD1
- MOHS
- Head and Neck Clinic
- SCCC and Radiology Registration areas
- Cardiology Clinic
- General Medicine Clinic
- Radiation Oncology Clinic

PROCEDURE:

1. The cashier/checkout person can issue a TOS payment refund under the following circumstances:
   - If a patient has made a TOS payment prior to seeing the provider and chooses to leave before being seen.
   - If a provider notifies the front desk that he/she cannot see the patient for some reason and the patient has already made the TOS payment.

2. The cashier/checkout person will take the following steps when issuing a TOS refund:
   - Ask the patient for the copy of the system-generated receipt.
   - Ask the patient to sign and date the returned receipt before issuing the refund.
   - Provide the patient with the correct refund amount.

At the end of the business day:
   - Note the Invoice Number on the receipt.
   - Retrieve the voucher and attach both portions of the receipt to the voucher.
   - Enter the appropriate status to the patient’s visit.
   - Access the open batch in the Cash Drawer screen.
At the **Action** prompt, enter `<D>` **(delete transaction)**.

Enter the Invoice number.

At the **Delete this Transaction** prompt, enter `<Y>`.

Use the `<F10>` key to file this transaction.

Use Function 1 in Appointment Scheduling to edit the patient’s “arrived” visit.

Change the status from **“Arr”** (**Arrived**) to **“Pen”** (**Pending**) and then status the appointment as **“Can”** (**Canceled**). Use the appropriate dictionary entry for the reason for cancellation.

Reschedule the appointment, if needed.

**Note:** Follow the current process for returning money on-site to patients. If the patient paid by check; return the check to the patient. If the patient paid by credit card, run the credit through the credit card machine and have the patient sign the credit slip. Provide a copy of the credit slip to the patient and attach the original copy to the “returned” front desk receipt and voucher.

At the end of the business day, print the batch proof. The batch proof will show the deleted transaction and make the adjustment to the batch total. The batch should be in balance with the actual amount of cash collected.

Provide the batch proof and all vouchers with the attached receipts to the appropriate person based on the departmental policies and procedures for submitting vouchers (encounter forms) to the billing office.

**The IDX system is not available**

Ask the patient for the copy of the handwritten receipt.

Ask the patient to sign and date the handwritten receipt **before** issuing a refund.

Retrieve the voucher and attach two portions of the handwritten receipt to the voucher.

Make a notation on the voucher indicating the reason for the refund.

Submit all vouchers to the Voucher Custodian.

Once the system is available, the appropriate person will enter all TOS payments, minus any refunds, into the IDXe system.
SUBJECT: CASH CONTROL PROCESS FOR SYSTEM DOWNTIME

PURPOSE: The purpose of this policy is to ensure that receipts can be accounted for when the department operates during system downtime.

POLICY: The cashier/checkout person must perform the “UMMG approved” downtime process related to the issuance of receipts for Time of Service (TOS) payments. This policy applies to all Patient Financial Services staff working in Clinic Registration areas. This includes individuals working at the following UMHC locations:

- OPD1
- MOHS
- Head and Neck Clinic
- SCCC and Radiology Registration areas
- Cardiology Clinic
- General Medicine Clinic
- Radiation Oncology Clinic

PROCEDURE:

1. All hospital administrators must obtain and store in a secured place, a pre-numbered, three-part receipt book for each site to use in case of system downtime. These receipts should be pre-printed with the appropriate logo.

2. If system downtime occurs, the following steps must be taken to ensure that all TOS payments collected are accounted for with minimal disruption to the patient flow process:
   - Cashier/checkout personnel will notify their immediate supervisor when system downtime occurs.
   - The supervisor will obtain the cash receipt book and note the next blank receipt (and number) available for use.
   - Cashier/checkout staff will be given the cash receipt book to use until the system is available.

3. The steps that the cashier/checkout staff must take to reconcile all TOS payments with copies of the receipt are:
   - A receipt will be completed manually for each TOS payment collected and the second part will be provided to each patient during system downtime.
   - The cashier/checkout person will note the payment amount, the pay-code, and the receipt number on the Cash Log Report (to be used for balancing batches at the end of the business day).
   - The cashier/checkout person who issues the receipts will maintain the top portion of the receipts.
If the system is unavailable for an entire business day

The cash reconciliation process must be performed with the handwritten receipts and signed off by the supervisor.

The cashier/checkout person must account for each pre-numbered receipt and provide a written explanation for any missing receipts.

The supervisor will investigate the cause of any missing receipt(s) to ensure that the explanation is within the hospital’s policies for the cash reconciliation process.

The top portion of all handwritten receipts will be attached to the vouchers to be used for data entry once the system is available.

A copy of the Cash Log Report will also be submitted to the designated person entering the TOS payments into the system. This report will provide the payment posting person with the information required for entering the correct pay-codes and dollar amounts once the system becomes available.

Note: If the system is down for an entire business day and TOS payments cannot be entered until the following day, it may be appropriate to have the billing office payment poster enter the previous day’s TOS payments using Front Desk Function 25/Activity1.
SUBJECT: VOUCHER CONTROL USING THE APPOINTMENT VOUCHER REPORT

PURPOSE: The purpose of this policy is to ensure that the appropriate person accounts for all vouchers (encounter forms) including “reprints” created by the Encounter Form Generator (EFG).

POLICY: The appropriate hospital person (Voucher Custodian) must print the Appointment Voucher Report on a daily basis to perform the voucher reconciliation process.

PROCEDURE:

1. Once all vouchers have been printed for the following day’s patient visits, the control copy for each voucher will be immediately sent to the designated hospital’s Voucher Custodian.

   Note: The Voucher Custodian should be a person who does not handle cash. Cashier/checkout personnel assigned to track and account for vouchers can assist the Voucher Custodian on a daily basis but the Voucher Custodian should be responsible for ensuring that all vouchers (printed and downtime vouchers) can be accounted for on a routine basis.

2. On a daily basis, the Voucher Custodian will print the Appointment Voucher Report by following the guidelines for printing an AES report (See Attachment A).

3. The Voucher Custodian will count all vouchers received from relevant areas and compare the total with the total number of voucher numbers printed on the report. All vouchers reprinted must be accounted for and attached to the original voucher it replaced.

4. If the total number of vouchers (including reprints) received by the Voucher Custodian equals the total number of voucher numbers printed on the report, then the reconciliation process is complete.

   Note: Excluding System Downtime, all scheduling departments must create a visit in the IDXe system for each patient appointment, including “Walk-In” patients, and print a voucher using EFG. The practice of printing vouchers not linked to a visit created in Appointment Scheduling (blank vouchers) will not be allowed unless there is a system downtime period.

5. If the total number of vouchers received by the Voucher Custodian does not equal the total number of voucher numbers printed on the report, the following steps must be taken:

   Either review the Missing Voucher Report submitted by the appropriate cashier/checkout person or complete the Missing Voucher Report.

   Begin the research process for retrieving the missing voucher(s) by contacting the clinic to verify if the voucher was kept in error.

   If the voucher cannot be located at the clinic, the following steps must be taken:
University of Miami Medical Group  
Policies and Procedures Manual

- Make a copy of the control portion of the voucher.
- Retain this copy for appropriate follow-up.
- Remit the control portion of the voucher to the appropriate contact person (clinic manager or physician’s secretary) with a written request for the voucher or an explanation if the voucher is missing.

If the voucher cannot be located, the physician should review the control portion of the voucher to determine if the patient was seen.

If the patient was seen by the provider:

- The physician must complete and sign the Control portion of the voucher.
- The Control copy must be returned to the Voucher Custodian immediately.
- The Voucher Custodian should prepare a separate batch for this control copy(s) and submit to the charge entry staff for data entry processing.

Note: This copy should be retained with the appropriate Appointment Voucher Report.

If the patient was not seen by the provider:

- The physician must note on the control portion of the voucher that the provider did not see the patient.
- If the patient visit has not been appropriately “statused”, it should be brought to the attention of the supervisor.

It is the responsibility of the Voucher Custodian to ensure that all control copies of the voucher sent for follow-up are returned to the Voucher Custodian with an explanation and/or the missing voucher.

All research mechanisms used by the Voucher Custodian must be documented in writing and submitted to management.

6. On a daily basis, the Voucher Custodian must run the Post-Arrival Status Changes Report for the previous day’s appointments and confirm that any changes to a visit status are within the hospital’s policies related to patient visit status changes.

Effective Date:  
Approved By:

Approved Date:  
Revised Date:
SUBJECT: VOUCHER CONTROL PROCESS FOR SYSTEM DOWNTIME

PURPOSE: The purpose of this policy is to ensure that vouchers can be accounted for when the department operates during system downtime.

POLICY: The appropriate hospital person must perform the “UMMG approved” downtime process to complete the reconciliation process for all printed vouchers.

PROCEDURE:

1. All entities using EFG must print their vouchers at least one business day prior to the scheduled appointment date. This process will ensure that any downtime that may occur on a given day will have a minimal impact on daily operations.

2. In order to minimize any adverse impact to the operational flow of patient visits during system downtime, it is imperative that a designated manager in each area print the equivalent of one business day’s vouchers and store those vouchers in a secured location to be used only during downtime situations. Additionally, it is the responsibility of each manager to maintain an internal log of the system-generated “downtime” voucher numbers in order to be able to reconcile those vouchers when used during system downtime.

3. Every manager will remove the control copy of the “downtime” vouchers and submit them along with the log to the Voucher Custodian.

4. If there are “Walk-In” patients who arrive to see a provider during system downtime, the following steps must be taken to accurately track the patient’s visit:
   
   Inform the designated manager that the clinic is experiencing system issues and must resort to the Downtime Policy and Procedure for voucher control.

   In chronological order, use the preprinted vouchers and note the voucher number, patient’s name and Date of Birth on the internal log.

   Manually enter the patient’s name, date of birth, telephone numbers and other pertinent patient demographic information on the “Header” portion of the voucher.

   Once the system is available, take all vouchers that contain the manually written data and enter those patients into the IDX Appointment Scheduling Application using Function 6 Schedule a Walk-In Patient. This function will create an appointment for the patient who was seen and automatically arrive the visit in IDXe.

   Ensure that a complete patient registration (new or update) is performed in the system for all patients seen during system downtime.

   Note the visit number on each voucher for all patients seen during system downtime. This process will ensure that the charge entry personnel can use the visit number to
allow the system to automatically complete some “header” information in the TES Encounter/Transaction Entry screen (for professional billing purposes only).

The Voucher Custodian must:

1. Ensure that all “system downtime” vouchers are accounted for and submitted by all clinic sites to the Voucher Custodian for processing.

2. Reconcile all other vouchers (that were printed in advance of any system downtime) using the Appointment Voucher Report.
SUBJECT: VOUCHER CONTROL PROCESS FOR VOUCHERS DEMANDED IN ERROR

PURPOSE: The purpose of this policy is to ensure that vouchers can be accounted for when a user(s) from one department accidentally demands a voucher for a visit that has been scheduled for another department.

POLICY: Any user who chooses an incorrect visit number to demand a voucher must retain the incorrect voucher and notify the supervisor. In turn, the supervisor will notify the appropriate person in the department incorrectly chosen and forward that voucher to the appropriate person.

PROCEDURE:

1. If a voucher is demanded by a user, it is imperative that the correct visit number/date is chosen to ensure that the department has the correct voucher for clinical and billing information.

2. If an incorrect visit number has been selected and the user demands a voucher, the voucher must be given to the user’s supervisor. The correct visit must then be selected and a voucher demanded for the correct visit.

3. The supervisor will immediately notify the appropriate person for the department where the voucher was demanded, and forward that voucher to the appropriate person in order to allow that department to account for every printed voucher.

Effective Date: Approved By:
Approved Date: Revised Date:
SUBJECT: COLLECTION OF CO-PAYMENTS

PURPOSE: To ensure that all UMMG Clinics are properly collecting co-payments for patients

POLICY: To ensure the UMMG Clinics are collecting co-payments per the insurance contract.

PROCEDURE:

1. Request the co-payment as indicated on the patient’s insurance card and/or deductible for each applicable patient prior to providing the service.
2. Write the amount and type of collection (cash, check, and/or credit card) on the voucher.
3. If site is using IDX “Front Desk”, post the payment to the arrived visit.
   a. Provide receipt to the patient from IDX System per Policy and Procedure for Front Desk.
4. Place the monies in a locked box or lockable drawer.

Effective Date: Approved By:
Approved Date: Revised Date: 07/99, 08/26/03
SUBJECT: ADVANCED DEPOSITS

PURPOSE: To Establish A Uniform Guideline for Receipt of Advanced Deposits from Patients.

POLICY: Advanced Deposits shall be deposited upon receipt and posted to the patient account using Paycode 14.

PROCEDURE:

The Cashier shall:

1. Collect the monies from the patient.
2. Restrictively endorse all checks (as required).
3. Issue the patient a pre-numbered receipt evidencing the collection and stating that any monies left over shall be distributed to outstanding balances.
4. Prepare a deposit transmittal (using a split deposit, if appropriate).
5. Place monies in a locked drawer or safe for pick up by Brinks.

The Payment Poster shall:

1. Post the payment to the patient account using Paycode 14.
2. Enter the check number and the amount of the check.
3. When filed, this action generates an invoice number which should be shown on the encounter form, if available.
SUBJECT: PAYMENTS ON ACCOUNT

PURPOSE: To Establish A Procedure For Payment Collection For Services Rendered At An Earlier Date.

POLICY: All clinical areas shall attempt to collect patient payments upon check-out.

PROCEDURE:

The Cashier shall:
1. Collect payment for prior services rendered.
2. Issue patient a pre-numbered receipt for payment on account.

If a patient has an outstanding balance on his/her account, and no payment arrangement has been established, one should be set up at that time. (See Policy/Procedure Budget Plan Arrangement)

NOTE: Patients are responsible for the following:
[1] Co-payments
[2] Deductibles
[3] Non-covered services

Effective Date: Approved By:
Approved Date: Revised Date:
Front Desk Web 4.0
About this Manual

This IDX Training Manual is written to give you a step-by-step guide for your classroom training and a handy reference for your daily work. The list of features in this manual help you use it more effectively.

Objectives and Summaries - The manual contains class lesson objectives which provide you with the overall goals you will achieve by the end of the course. The manual contains a summary for your review at the end of each lesson.

Practice Sessions - Most modules end with a practice session to help you practice the skills you learned in the lesson. Your instructor will be available to assist you if you need it during the exercises.
Introduction

Class Objectives

After completing this training class, you will be able to:

- Identify the different Payment Codes (Paycodes) used in Front Desk;
- Complete the Batch Form;
- Enter Patient and Header information;
- Enter Payment information;
- Make Corrections
- Print a Batch Proof (Physician Payments Only)
- Balance and exit a batch.
Introduction to Front Desk

Welcome to the Front Desk course. This module was designed to allow users the ability to post patient payments (i.e., payments on invoice, copayments, and advanced deposits) at the front end. All patient payments received at the time of service will first be posted through Front Desk. Payments posted using Front Desk will immediately reduce our accounts receivable as they are being posted real-time in B/AR (Billing and Accounts Receivable).

Hospital Non-Service payments are not posted real-time. Examples of these types of payments are transportation charges, postage, etc.

Payments, such as copayments, advanced deposits, and time of service payments (TOS) are received in advance of charges being posted to the system; therefore, Front Desk is used as post these payments prior to the respective charges being entered.

This course and manual will provide you with the information needed to post patient Time of Service (TOS) payments made at our clinics at Check-In or Check-Out.

Your trainer will lead you through the material. Throughout the training, we will use presentations, on-line demonstrations, and hands-on exercises.
**Terminology**

Time of Service (TOS) Payments are payments collected at the time of the visit. These are in the form of copayments, payments on invoice (payments on visit) or advanced deposits.
**Dictionaries**

IDX uses dictionaries in the applications to expedite data entry and ensure standardized data for reporting purposes.

Dictionary entries can be accessed by using the name, number or mnemonic of the entry. If you do not know any of these, you can also type a `<?>` to do a lookup to the entire dictionary.

The following is a list of dictionaries that are used in the Post Receipts function:

**Dictionary Description:**

**Group** The IDX BAR application can segregate receivables into several groups. Most of UMMG receivables will be in BAR Group 3.

**Division** An IDX Division is equivalent to a clinical department. All divisions are stored in dictionary #102.

**Billing Area** An IDX Billing Area is a specialty within a department. This is known in PBS as a division. All Billing Areas are stored in dictionary #202.

**Location (POS)** Location or Place of Service codes are a HCFA requirement. These include inpatient, outpatient, doctor’s office, etc. All locations are stored in dictionary #100.

**Facility** The facility is the site where the patient was seen for services, such as JMH or Jackson Towers. All facilities are stored in dictionary #101.

**Provider** The provider or physician who rendered the services. Must be a billing provider. All UMMG providers/physicians are stored in dictionary #3.

**FSC** is a mnemonic for Financial Status Classification. It determines who gets billed for services rendered, for example, Medicare, Medicaid or Self Pay. FSCs are stored in dictionary #19.

**Payment Codes** A payment code, also called a paycode, is a code that is used to post a transaction in the system. The payment code tells the system how to process the transaction and how to report the transaction in daily and month end reports. B/AR Paycodes match up to their corresponding FSCs.
Payment Codes

The following payment codes (Paycodes) are used for Physician Front Desk payments.

12 – Patient Payment on Invoice Used to post a deductible, coinsurance, or Self Pay payment paid in the form of cash or check against a charge for services rendered on that specific day.

14 – Advanced Deposit Used to post a Self Pay Advanced Deposit paid in the form of cash or check against a charge for a future service.

15 - Copayment Used to post a Self Pay Managed Care Copayment paid in the form of cash or check against a charge for services rendered on that specific day.

33 – Credit Card (CC) Visa/Mastercard (M/C) Payment on Invoice Used to post a deductible, coinsurance, or Self Pay Payment paid using Visa or M/C against a charge for services rendered on that specific day.

34 – (CC) Visa-M/C Advanced Deposit Used to post a Self Pay Advanced Deposit paid using Visa or M/C against a charge for a future service.

35 – (CC) Visa – M/C Copayment Used to post a Self Pay Managed Care Copayment paid using Visa or M/C against a charge for services rendered on that specific day.

36 – (CC) AMEX – Payment on Invoice Used to post a deductible, coinsurance, or Self Pay payment paid using American Express against a charge for services rendered on that specific day.

37 – (CC) AMEX Advanced Deposit Used to post a Self Pay Advanced Deposit paid using AMEX against a charge for a future service.

38 – (CC) AMEX Copayment Used to post a Self Pay Managed Care copayment paid using AMEX against a charge for services rendered on that specific day.

56 – (CC) Discover Payment on Invoice Used to post a deductible, coinsurance, or Self Pay payment using Discover against a charge for services rendered on that specific day.

57 – (CC) Discover Advanced Deposit Used to post Self Pay Advanced Deposit using Discover against a charge for future service.

58 – Discover Copayment Used to post a Self Pay Managed Care copayment paid using Discover against a charge for services rendered on that specific day.

67-(CC) Care Credit Advance Deposit Used to post a Self Pay Advance Deposit using a Care Credit card against a charge for future services.

66-(CC) Care Credit Payment on Invoice Used to post a Self Pay payment using Care Credit card against a charge for services rendered on that specific day.

8000- HPA Non-Provider Payment Used for hospital staff to post Hospital TOS payments that do not require a professional fee. This paycode should always be entered with $0.00 payment amount.
HPA Payment Codes

The following payment codes (Paycodes) are used for Hospital Front Desk payments.

90611 – PT Cash/Check Paym Visit Used to post a deductible, coinsurance, or Self Pay payment paid in the form of cash or check against a charge for services rendered on that specific day.

90610 – PT Cash/Check Adv Deposit Used to post a Self Pay Advanced Deposit paid in the form of cash or check against a charge for a future service.

90510 - PT Cash/Check Copay Used to post a Self Pay Managed Care Copayment paid in the form of cash or check against a charge for services rendered on that specific day.

90522 – PT Credit Card (CC) VISA/MC Paym Visit Used to post a deductible, coinsurance, or Self Pay Payment paid using Visa or M/C against a charged for services rendered on that specific day.

90521 – PT CC VISA/MC Adv Deposit Used to post a Self Pay Advanced Deposit paid using Visa or M/C against a charge for a future service.

90520 – PT CC VISA/MC Copay Used to post a Self Pay Managed Care Copayment paid using Visa or M/C against a charge for services rendered on that specific day.

90622 – PT CC AMEX Paym Visit Used to post a deductible, coinsurance, or Self Pay payment paid using American Express against a charge for services rendered on that specific day.

90621 – PT CC AMEX Adv Deposit Used to post a Self Pay Advanced Deposit paid using AMEX against a charge for a future service.

90620 – PT CC AMEX Copay Used to post a Self Pay Managed Care copayment paid using AMEX against a charge for services rendered on that specific day.

90722 – PT CC DISC Paym Visit Used to post a deductible, coinsurance, or Self Pay payment using Discover against a charge for services rendered on that specific day.

90721 – PT CC DISC Adv Deposit Used to post Self Pay Advanced Deposit using Discover against a charge for future service.

90720 – PT CC DISC Copay Used to post a Self Pay Managed Care copayment paid using Discover against a charge for services rendered on that specific day.

90822- PT CC CARE Paym Visit Used to post a Self Pay payment using Care Credit card against a chage for services rendered on that specific day.

90821- PT CC CARE Adv Deposit Used to post a Self Pay Advance Deposit using a Care Credit card against a charge for future services.

90820- PT CC CARE Copay Used to post a Self Pay Copayment paid using a Care Credit Card against a charge for services rendered on that specific day.
Accessing the Front Desk Module

To access Front Desk, first select your patient from the Patient Services screen or the Appointment Manager, then select the Front Desk option from the vertical toolbar.

Select the Check-Out tab that displays in the horizontal tab to branch to the Batch control Form to enter TOS Payments.
Module Summary

- Time of Service (TOS) payments, Payment on Invoice, Advanced Deposits, and Copayments are entered through the Front Desk application.
- Front is used to post payments prior to their respective charges being posted to the system.
- Time of Service payments for the Professional and Hospital components immediately reduced the accounts receivable as they are posted real-time.
- Hospital Non-service payments are not posted real-time.
- Time of Service payments are collected at the time of visit and may be in the form of Copayments, Patient Payments on Invoice, Advanced Deposits, and Hospital non-service payments.
- A hospital non-service payment consists of moneies collected that are part of the services provided during the visit (e.g. postage, transportation, etc.)
- Advanced deposits are monies paid in advance for services to be rendered in the future.
- All BAR and HPA payments collected require that an appointment and/or visit is linked to the payment.
Practice Exercise

1. What are Time of Service (TOS) payments?
2. What is an Advanced Deposit?
3. What payment code would be used to post a copayment for the physician paid in cash?
Completing the Batch Form

Batch Overview

Payments are entered into the system in groups called *batches*. A batch is a group of payments that are similar in some way.

The first step in entering payments into the Front Desk module is to create a new payment batch through the batch control form. In order to do this, sign into Front Desk. This screen must be completed prior to entering payments. The Batch Form is a fixed screen. Use the appropriate keys to move around the batch control form.

The Batch Form identifies the batch. It allows you to enter batch identification information. Each batch is unique. Only the user assigned to the batch will be able to access the batch for editing information.
Batch Form

Below is a sample of the Front Desk Batch Form:

When you enter Front Desk, Check Out, the system will display the Batch Control Form. Type a <G> at the Batch prompt in order to generate a new batch number and <T> to enter the date of collection.

All of the fields on this screen are required.

The DESCRIPTION FIELD HAS A REQUIRED FREE TEXT FORMAT:

FD DIV MM/DD

The FORMAT is FD (Front Desk), which will default in your batch description form, space, DIV (User's Division Mnemonic), space, MM/DD (Month/Day). Use a two digit format for both the month and day.

- Please refer to the Division Mnemonic table on the next page to look up your division code.
- *Any deviation from this pre-determined format will result in an error message*
Division/Department Mnemonic

Anne Bates Leach Eye Hospital/ABLEH
Anesthesiology /ANES
CHDS /CHDS
Dermatology/ DERM
Diabetes Research Institute/ DRI
Family Medicine /FAM
Medicine /MED
Neurology/ NEUR
Neurosurgery / NSURG
OB/GYN /OB
Ophthalmology /OPT
Orthopedics/ORTH
Otolaryngology /OTO
Pathology / PATH
Patient Financial Services / PFS
Pediatrics / PED
Psychiatry / PSY
Radiation Oncology / RONC
Radiology / RAD
Rehabilitative Medicine / RMR
Surgery / SURG
Urology / URO

The description field holds up to 20 characters, 12 of which are required; additional information may only be entered **after** the required format. **No special characters such as** dashes, periods or slashes may be used.
Steps to complete the Batch Form:

1. Type `<G>` at the Batch prompt to Generate a new batch. If you are returning to an open batch, Click List button to see a list of open batches. the press the Tab key.

2. Type `<T>` at the collection date field to populate the date or click on the calendar button to select a date. the press the Tab key.

3. Enter `<FD DIV MM/DD>` in the Description Field. Refer to the table in the proceeding page for your Division Mnemonic.

4. Click `<OK>` to File and Save the Batch Form and move to the Check Out Screen.
Posting Payments to your Batch

You will now complete the Patient Header information and begin entering your transaction.

Posting the TOS Payments:

1. At the **Patient prompt**: Since your patient was previously selected, press the `<tab>` key. Only appointments which have been arrived will appear on the next screen.

2. Select an appointment by highlighting the appointment you wish to select and press the `<OK>` button.
NOTE! Advanced Deposits cannot be linked to a visit as these are payments for future services.

If you are posting an advanced deposit, click OK without selecting an appointment t3. At Invoice field: Type <G> to generate a new invoice number. (If you are posting to a previous date of service, click list button to see a listing of Patient Invoices.

4. Complete the Header information (if not already defaulted by the selection of the appointment).

5. Press <Tab> at the Diagnosis and Procedure code fields.

DO NOT enter Diagnosis or Procedure code information.

6. Click the list button or the Paycode at the BAR Payment Code: field. (The list button will provide you with a list of all codes that may be used at this prompt.)
B/AR Paycodes

- Select the appropriate paycode and click the <OK> button.
7. At **Payment Amount**: Enter the amount of the payment. The amount will then default in the **Post to Inv:** field.

8. At **Comment**: enter a comment concerning the payment, for example, the check number or credit card authorization number.

**A COMMENT SHOULD ALWAYS BE ENTERED**

**DO NOT ENTER CREDIT CARD NUMBERS ON THIS FIELD!**

To record a check number in the Comment Field, use the following format:

**CHK#** or **CK#** prior to the check number.

To record a credit card authorization number in the Comment Field, use the following format:

**AUTH#** prior to the authorization number.

To record a payment made in cash, enter **CASH** in the Comment Field.
If a Hospital payment needs to be posted in addition to the physician payment complete the following steps:

**For TOS payments:**

1. At Hospital Org: enter the hospital group number (ABLEH is group 2, and UMHC/SCCC is group 11)

2. At the Hospital Vis: click the list button to select the appropriate Hospital Visit that is to be linked to this payment. The following screen will appear
3. At the HPA PAY CODE field click the selector list button to view a list of possible HPA Paycodes. The following screen will appear:

HPA Payment Codes

![HPA Payment Codes](image)

Highlight the appropriate paycode and click “Select”.

4. At the Payment Amt field: Enter the HPA payment amount.

*Please note that hospital Time of Service (TOS) payments must always be linked to a visit in Visit Management

**For OLD payments that belong to the previous computer system:**
1. At Hospital Org: enter the hospital group number (preceded by the letter O) (ABLEH is group 02, and UMHC/SCCC is group 011)
2. At the Hospital Vis: type the admission/episodic number that belongs to the payment being posted. Precede this number by A for ABLEH or U for UMHC.
**If no hospital TOS payment is required, press the <TAB> key to skip all HPA fields.**

5. The Non Service Payment field: This field is used to post non-service (non-hospital service payments such as valet parking, pharmacy, transportation, etc.) to the system. To post a Non Service Payment enter a check mark then at this field then press the tab key. The screen below should appear automatically:

**Non-Service Payments**

![Non-Service Payments Screen]

**Items in this screen are prefixed with the hospital abbreviation, for example: UMHC Transportation, or ABLEH Pharmacy, etc.**

**Your instructor will distribute a list of items that are considered “Non Service”.**

**DO NOT PRESS Click OK at this screen.** It will file the payment without printing a receipt.
*DO NOT PRESS <Cancel> at this screen. It will cancel the entire transaction.

14. Press the <Tab> key to return to the batch control form.

15. At Print Receipt: Type <Y> to print a patient receipt.

16. Receipt Copies: Enter the number of receipts you want to print.

17. Click the <OK> button to file and save the information.
18. Type your receipt printer device name (if not already displayed).

19. Click the <OK> button to print the receipt.

20. You are ready to enter the next payment.
Front Desk Receipt

![Receipt Image]

- **Appointment Number**
- **BAR Payment**
- **HPA Payment**
- **Non Service Payment**
- **Batch Number**
Entering a Hospital Payment that does not require Physician Payment

A scenario may exist where a Hospital Payment is collected for the visit, and not a physician payment. If this scenario is encountered, the following instructions must be followed:

1. At the **BAR Pay Code** field enter paycode 8000 for **HPA Non-Provider Payment**.

2. At the **Payment Amt** field a **$0.00** payment will default.

3. At the Hospital Org: for TOS payments enter the hospital group number (ABLEH is group 2, and UMHC/SCCC is group 11) or for OLD payments enter the hospital group number (preceded by letter O).

4. Continue entering all pertinent information for either the Times of Service or OLD payment as detailed in the previous sections for the respective payment.
**Entering a Payment for a Non-Billing/Unknown Provider**

On occasion a TOS payment needs to be posted for services rendered by a non-billing provider or a unknown provider. The table below lists three types of non-billing/unknown providers and when to use them.

<table>
<thead>
<tr>
<th>TABLE 1.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABLEH</strong></td>
</tr>
<tr>
<td>ABLEH, PROVIDER</td>
</tr>
<tr>
<td>OPHTHAMOLOGY, PROVIDER</td>
</tr>
<tr>
<td>ANESTHESIOLOGY, PROVIDER</td>
</tr>
<tr>
<td><strong>UMHC/SCCC</strong></td>
</tr>
<tr>
<td>UMHC, PROVIDER</td>
</tr>
<tr>
<td>MEDICINE, CARDIOLOGY PROVIDER (9018)</td>
</tr>
</tbody>
</table>
TABLE 1.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type of Provider</th>
<th>Example of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEDIATRICS,CARDIOLOGY PROVIDER</td>
<td>Physician Interpreting the results is unknown</td>
<td>Use this provider to post payment for Pedi-Cardiology when the reading provider at the time of posting the payment is unknown.</td>
</tr>
<tr>
<td>(9017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RADIOLOGY,PROVIDER (8888)</td>
<td>Physician Interpreting the results is unknown</td>
<td>Use this provider to post payment for Radiology when the reading provider at the time of posting the payment is unknown.</td>
</tr>
</tbody>
</table>
Front Desk Corrections

Several situations may arise where corrections need to be made to the batch. For example, printing a receipt to an incorrect printer, the receipt printer jamming, posting an incorrect payment on the physician or hospital side, posting a payment to the wrong patient, etc.

Correcting transactions in Front Desk:

Scenario A

If the correction is being posted to the same patient, and all header information is correct, follow these steps:

1. Recall the patient with the incorrect transaction.

   Note: Once you have selected the appropriate appointment from the appointment selector screen, the system will refer to the invoice previously generated for that appointment and populate all previously entered header information. Do not generate a new invoice number.

2. Press the <Tab> key to reach the BAR Pay Code prompt.

3. Repost all applicable transactions with the previously used paycodes

4. Repost the previously entered amounts with a negative sign in front of the amount to cancel the incorrect posting.

5. In the comment field enter the type of correction you are making. (EX.”Wrong paycode” or “Wrong Amount”, etc.)

6. File the correction. This will cancel the transaction that was incorrect.

7. Recall the patient again, select the same invoice and post the correct transaction.
Scenario B

If you are making the correction because you posted to an incorrect patient, follow these steps:

1. Recall the patient with the incorrect transaction.
   
   **Note:** Once you have selected the appropriate appointment from the appointment selector screen, the system will refer to the invoice previously generated for that appointment and populate all previously entered header information. Do not generate a new invoice number.

2. Press `<Tab>` to reach the **BAR Pay Code** prompt

3. Repost all applicable transactions with the previously used paycodes

4. Repost the previously entered amounts with a **negative** sign in front of the amount to cancel the incorrect posting.

5. In the comment field enter the type of correction you are making. (EX. “Incorrect Patient”)

6. File the correction. This will cancel the transaction that was incorrect.

7. Select the patient that should receive credit for this payment and proceed to post accordingly.

Scenario C

**If the correction is at the header level, follow these steps:**

1. Recall the patient with the incorrect transaction.
   
   **Note:** Once you have selected the appropriate appointment from the appointment selector screen, the system will refer to the invoice previously generated for that appointment and populate all previously entered header information. Do not generate a new invoice number.

2. Press `<Enter>` to reach the **BAR Pay Code** prompt

3. Repost all applicable transactions with the previously used paycodes
4. Repost the previously entered amounts with a **negative** sign in front of the amount to cancel the incorrect posting.

5. In the comment field enter the type of correction you are making. (EX. “Incorrect Header”)

6. File the correction. This will cancel the transaction that was incorrect.

7. Recall the patient again. Generate a new invoice, do not post to the previously created invoice.

8. Populate the correct header information and proceed to post accordingly.
Check Out Grp: 3 Per: 0818 Batch: 216 [0-8CD] 18001272 - NON SERVICES FEES

Non Service Payments

<table>
<thead>
<tr>
<th>Non Serv Fnd</th>
<th>Amount</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$0.00</td>
<td>02/09/2009</td>
<td>2:23PM</td>
</tr>
<tr>
<td>2</td>
<td>$4.00</td>
<td>02/09/2009</td>
<td>2:24PM</td>
</tr>
<tr>
<td>3</td>
<td>$2.00</td>
<td>02/09/2009</td>
<td>2:24PM</td>
</tr>
</tbody>
</table>

Total Non Service Payments: $16.00

Note: Non-Service payments do not post Real-time, therefore you will see your original entry. In order to correct, post the original amount with a negative in front of the amount on the second line to total a Non Service payment of $0.00.
Module Summary

- The first screen in Front Desk is the “Batch Control Form” which identifies the batch.
- The batch description field has a required format that must be used to identify the batch, i.e. FD DIV MM/DD.
- Payments such as copays and payment on invoice must be linked to the correct appointment and/or visit.
- Advanced Deposits will never be linked to an appointment/visit because they are for services to be performed in the future.

At the Comment: field, **NEVER** enter a patient’s credit card number. Only enter the credit card authorization number. This field is also used to record check numbers and cash transactions.
Practice Exercise

1. What is purpose of the Batch Control Form?
2. What is the required format of the Batch Description: field?
3. What may NEVER be entered in the Comment: field?
Exiting a Payment Batch

1. Click the <Cancel> button to exit the batch once all payments have been entered for the day.

2. A message displays "Out of balance," notifying you that the batch is out of balance has been placed on hold. Press the <Tab> key or click the <OK> button.
Balancing the Batch

Overview

The Front Desk module, allows you to post payments to the system prior to charges being entered.

So far, we have created the batch and entered payments. At the end of the day, we are going to balance our batch.

Balancing a Payment Batch

1. Clear your screen.
2. Select the **Front Desk** option from the Vertical Toolbar.
3. Click on the **Cash Drawer** tab on the Horizontal Toolbar.

The following section outlines the Cash Drawer Screen required fields.
**Cash Drawer Required Fields**

The following fields are required in the Cash Drawer Screen:

- **Initials** User initials automatically default.
- **Batch** The Open Batch number will default.
- **Created** The Creation date of the batch will default.
- **Description** The Batch Description will default.
- **Number of Invoices** Enter the total number of invoices created in the Check Out Batch.
- **Advanced Dep Units 14** Enter the total number of Advanced Deposit payments entered, in Units, using Paycode 14 (Cash/Check)
- **Advanced Dep Units 34** Enter the total number of Advanced Deposit payments, in Units entered, using Paycode 34. (Visa – M/C)
- **Advanced Dep Units 37** Enter the total number of Advanced Deposit payments entered, in units, using Paycode 37. (AMEX).
- **Advanced Dep Units 57** Enter the total number of Advanced Deposit payments entered, in Units, using Paycode 57. (Discover).
- **Advanced Dep Units 67** Enter the total number of Advanced Deposit payments entered, in Units, using Paycode 67. (Care Credit)
- **Copayments Units 15** Enter the total number of Copayments entered, in Units, using Paycode 15 (Cash/Check)
- **Copayments Units 35** Enter the total number of Copayments entered, in Units, using Paycode 35. (Visa – M/C)
- **Copayments Units 38** Enter the total number of Copayments entered, in Units, using Paycode 38. (AMEX)
- **Copayments Units 58** Enter the total number of Copayments entered, in Units, using Paycode 58 (Discover)
- **Pmt on Invoice Units 12** Enter the total number of Payments on Invoice entered, in Units, using Paycode 12. (Cash/Check)
- **Pmt on Invoice Units 33** Enter the total number of Payments on Invoice entered, in Units, using Paycode 33 (Visa – M/C)
Pmt on Invoice Units 36 Enter, the total number of Payments on Invoice entered, in Units, using Paycode 36 (AMEX)

Pmt on Invoice Units 56 Enter, the total number of Payments on Invoice entered, in Units, using Paycode 56 (Discover)

Pmt on Invoice Units 66 Enter, the total number of Payments on Invoice entered, in Units, using Paycode 66 (Care Credit)

Advanced Dep $ 14 Enter the total dollar ($) amount of Advanced Deposit payments entered, using for Paycode 14 (Cash/Check)

Advanced Dep $ 34 Enter the total dollar ($) amount of Advanced Deposit payments entered, using for Paycode 34 (Visa – M/C)

Advanced Dep $ 37 Enter the total dollar ($) amount of Advanced Deposit payments entered, using for Paycode 37 (AMEX).

Advanced Dep $ 57 Enter the total dollar ($) amount of Advanced Deposit payments entered, using for Paycode 57 (Discover).

Advanced Dep $ 67 Enter the total dollar ($) amount of Advanced Deposit payments entered, using Paycode 67 (Care Credit).

Copayments $ 15 Enter the total dollar ($) amount of Copayments entered, using Paycode 15 (Cash/Check)

Copayments $ 35 Enter the total dollar ($) amount of Copayments entered, using Paycode 35 (Visa – M/C)

Copayments $ 38 Enter the total dollar ($) amount of Copayments entered, using Paycode 38 (AMEX)

Copayments $ 58 Enter the total dollar ($) amount of Copayments entered, using Paycode 58 (Discover)

Pmt on Invoice $ 12 Enter the total dollar ($) amount of Payments on Invoice entered, using Paycode 12 (Cash/Check)

Pmt on Invoice $ 33 Enter the total dollar ($) amount of Payments on Invoice entered, using Paycode 33 (Visa – M/C)

Pmt on Invoice $ 36 Enter the total dollar ($) amount of Payments on Invoice entered, using Paycode 36 (AMEX)

Pmt on Invoice $ 56 Enter the total dollar ($) amount of Payments on Invoice entered, using Paycode 56 (Discover)
**Pmt on Invoice $ 66** Enter the total dollar ($) amount of Payments on Invoice entered, using Paycode 66 (Care Credit).

**HPA S's** Enter the total dollar amount of Payments entered for the Hospital.

**Non Service S's** Enter the total dollar amount of Non-Service payments entered for the Hospital.

**Controls Ok?** Enter <Y> to tell the system to reconcile the batch by comparing the Actual numbers against the Control totals.
Show Payment Detail For BAR Paycode: This field allows the user to branch to a summary screen listing all invoices posted to the batch using a specific paycode.

1. For a list of BAR paycodes, click on the list button at the prompt.
2. Once you are done viewing the details for the BAR Paycode, click on the <OK> button to branch back to the Cash Drawer screen.

To print a detail of all of your transactions for BAR, use action code “L” Print Batch Proof at the action prompt from the Cash Drawer screen. Please refer to page 44 of this manual for instructions on how to print the batch proof.
Show Payment Detail HPA Payments?

1. Check off the box and press the <Tab> Key to print a detail summary of all the transactions posted to the batch for HPA payments.

2. The system will ask for the device name, enter your standard printer device name and click on the <OK> button to print the summary.

3. If you want to view the information on the screen, clear the Device: field and then press the <OK> button.

4. Once you are done viewing or printing the transaction details, click on the <OK> button to return to the Cash Drawer screen.
Show Payment Detail Non-Service Payment?

1. Check off the box and press the <Tab> Key to print a detail summary of all the transactions posted to the batch as Non-Service payments.

2. The system will ask for the device name, enter your standard printer device name and click on the <OK> button to print the summary.

3. If you want to view the information on the screen, clear the Device: field and then press the <OK> button.

4. Once you are done viewing or printing the transaction details, click on the <OK> button to return to the Cash Drawer screen.

**Action:** At the Batch Action field, Click the list button to see all available options. Refer to page 43 for all available action codes at this prompt.

Remember to first print the Batch Proof <L> then EXIT your Batch <X> once it has been balanced.

**ONLY BATCHES THAT ARE IN BALANCE ARE CLOSED USING ACTION CODE <X> EXIT BATCH.** If the batch is not in balance the system will automatically place your batch on HOLD.
Front Desk – Check Out Action Codes

There are several action codes available in the Cash Drawer Check Out Screen. These are all discussed below.

**A** - **Add/Edit Registration** This action takes you to the Add/Edit Activity in Registration where you can edit an existing account.

**C** – **Charge Correction** This action is not available through Front Desk.

**D** – **Delete Transaction** This action should not be used through Front Desk.

**E** – **Enter Charges** This action is not available through Front Desk.

**X** - **Exit Batch** This action allows you to properly exit the batch and allows it to be processed by Night Jobs.

**F** – **Financial Comments** This action takes you to the Financial Comments Screen to add/edit a patient's financial comments. (Please note these comments are only regarding financial information and should not be used for insurance verification.)

**G** – **General Comments** This action takes you to the General Comments Screen to add/edit a patient's General comments. This action takes you to the General Comments Screen to add/edit a patient's General comments. (Please note these comments are only relating to information to assist the patient and should not be used for insurance verification.)

**H** – **Hold Batch** This action allows you to place a batch on hold and then exit the batch. Batches on hold will not be processed by Night Jobs. Out of balance batches will automatically be placed on hold.

**Q**- **Inquiry** This action brings you into full Invoice Inquiry, where you can inquire into patient accounts.

**I** – **Insurance Claim Request** This action should not be used through Front Desk.

**Y** – **Invoice Split** This action should not be used through Front Desk.

**M** – **Move Invoices** This action should not be used through Front Desk.

**L** – **Print Batch Proof** This action prints a batch proof detailing the transactions in a batch. A batch proof can be used to reconcile out of balance batches. The batch proof details BAR transactions entered, not HPA.

**T** – **Temporarily Exit Batch** Using this action to exit a batch will automatically bring up the same batch next time you enter Front Desk, Cash Drawer.
Printing the Batch Proof

If your batch is out of balance, the batch proof will allow you to view, on paper, all of the transactions you have entered. It provides you a detailed listing of all items entered in the batch.

The number of items in any given batch should be kept to a manageable number so to allow for balancing and locating errors in entry in minimal time.

1. At the **Batch**: Type `<L>` to Print Batch Proof.

2. Press the `<OK>` button.

3. **At the Print Transactions: First to Last =>** Press the `<Enter>` key to accept the default.

4. At the **Device**: type your printer Device name if it does not appear. If no device name is entered, the proof will scroll on your screen. You will have to repeat this process.

5. Click `<OK>` to print.
Module Summary

- The module used to balance the payment batch is known as Cash Drawer.
- The following fields: Initials, Batch, Created, and Description default into the Cash Drawer screen.
- The system only displays three Control totals in units and $ for the BAR Pay-code. Once the first three have been entered, the system will scroll the cursor up so that additional control totals may be entered for the remaining paycodes in the batch.
- You may print the Batch Proof by using Action Code “L”.
**FRONT DESK PAYCODES**

<table>
<thead>
<tr>
<th>Method of Payment</th>
<th>Form of Payment</th>
<th>Paycode Description</th>
<th>B/AR Paycode</th>
<th>HPA Paycode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash/Check</td>
<td>Cash/Check</td>
<td>Payment on Invoice</td>
<td>12</td>
<td>90611</td>
</tr>
<tr>
<td>Cash/Check</td>
<td>Cash/Check</td>
<td>Advance Deposit</td>
<td>14</td>
<td>90610</td>
</tr>
<tr>
<td>Cash/Check</td>
<td>Cash/Check</td>
<td>Co-Pay</td>
<td>15</td>
<td>90510</td>
</tr>
<tr>
<td>Credit Card</td>
<td>American Express (AMEX)</td>
<td>Payment on Invoice</td>
<td>36</td>
<td>90622</td>
</tr>
<tr>
<td>Credit Card</td>
<td>American Express (AMEX)</td>
<td>Advance Deposit</td>
<td>37</td>
<td>90621</td>
</tr>
<tr>
<td>Credit Card</td>
<td>American Express (AMEX)</td>
<td>Co-Pay</td>
<td>38</td>
<td>90620</td>
</tr>
<tr>
<td>Credit Card</td>
<td>Discover</td>
<td>Payment on Invoice</td>
<td>56</td>
<td>90722</td>
</tr>
<tr>
<td>Credit Card</td>
<td>Discover</td>
<td>Advance Deposit</td>
<td>57</td>
<td>90721</td>
</tr>
<tr>
<td>Credit Card</td>
<td>Discover</td>
<td>Co-Pay</td>
<td>58</td>
<td>90720</td>
</tr>
<tr>
<td>Credit Card</td>
<td>Visa/Master Card</td>
<td>Payment on Invoice</td>
<td>33</td>
<td>90522</td>
</tr>
<tr>
<td>Credit Card</td>
<td>Visa/Master Card</td>
<td>Advance Deposit</td>
<td>34</td>
<td>90521</td>
</tr>
<tr>
<td>Credit Card</td>
<td>Visa/Master Card</td>
<td>Co-Pay</td>
<td>35</td>
<td>90520</td>
</tr>
<tr>
<td>Care Credit</td>
<td>CC Care Credit</td>
<td>Advance Deposit</td>
<td>67</td>
<td>90821</td>
</tr>
<tr>
<td>Care Credit</td>
<td>CC Care Credit</td>
<td>Payment on Invoice</td>
<td>66</td>
<td>90822</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Provider Payment</td>
<td>8000</td>
<td></td>
</tr>
</tbody>
</table>
University of Miami Medical Group

Voucher and Cash Control Flow

Designated person prints IDX-generated four-part Encounter Forms (Vouchers) the day prior to patients’ scheduled visits.
1st part: Patient Copy
2nd part: Billing Office Copy
3rd part: Hospital/Technical Copy
4th Part: Control Copy

Control copies go to the custodian in charge of Voucher control.

Front Desk personnel receive the remaining multi-part Vouchers.

(Upon patient arrival), Appropriate Staff member statuses patient appointment as “Arrived” in IDX system.
Note: By the end of each Clinic season, all patient visits must be appropriately statuses as:
1. No Show,
2. Cancelled, or
3. Rescheduled.

Voucher forms given to the treating Provider.

Voucher must be Cashed and signed by Treating Provider.

Voucher delivered to Cashier.

Cashier posts at Time of Service (TOS) copayments in the Front Desk module.

Front Desk Module-generated receipt given to patient.

Voucher Complete?
Voucher Flow

Page 3

Cashier:
1. Prints Batch Proof (displays all transactions entered in Front Desk Module)
2. Prepares deposit slip for total collections
3. Makes copy of deposit slips
4. Places money & original deposit slip in a Brinks sealed-envelope
5. Prepares UIMSS transmittal, and attaches a copy of the deposit slip to the original UIMSS Transmittal

Cashier submits to the Voucher Custodian for Review:
1. Vouchers with Batch Cover Sheet
2. Appointment Voucher Report
3. Missing Voucher Report with explanation (if applicable)
4. Front Desk Batch Proof Report
5. Over/Short Report (if applicable)
6. Signed UIMSS Transmittal with the colored copy of the Deposit Slip

Custodian:
1. Reconciles all vouchers (including reprints) to the Appointment Voucher Report
2. Certifies Reconciliation Process by Signing and Dating Appointment Voucher Report
3. Submits Appointment Voucher Report and all vouchers to Billing Department for Charge Entry Process
4. Generates, on a daily basis, the Post-Arrival Status Changes Report for the previous day’s appointments and confirms that any changes to a visit status are within the departmental policies related to patient visit status changes.
5. Any deviations from departmental policies must immediately be brought to management’s attention
UMMG - MISSING VOUCHER REPORT

Department: _________________________
Scheduling Location: _________________________
Appointment Date: ______________

<table>
<thead>
<tr>
<th>PROVIDER NAME:</th>
<th>PATIENT’S INITIALS:</th>
<th>VISIT NO.:</th>
<th>COMMENTS:</th>
<th>DATE RESOLVED/RCD.:</th>
<th>BATCH NO.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 3/6/2009
<table>
<thead>
<tr>
<th>EFG VOUCHER NO.:</th>
<th>DATE VOUCHER USED:</th>
<th>PROVIDER NAME:</th>
<th>PATIENT'S NAME:</th>
<th>PATIENT'S DOB:</th>
<th>CASH RECEIPT NO.(if applicable):</th>
<th>COMMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
AMBULATORY PATIENT ACCESS SCENARIO
Ambulatory Patient Access Scenario

New Features 4.0 for Character Cell 3.0 to Web 4.0

University of Miami
Business Information Management Systems
Acknowledgments

Developed by Casi Computer Advisory Services.
Edited by the University of Miami, Business Information Management Systems Training Department

Copyright Notice

Copyright © 2008 University of Miami. All rights reserved.

The information contained in this document is the confidential property of the University of Miami.

No part of this document may be reproduced in any form, by photostat, microfilm, xerography, or any other means, or incorporated into any information retrieval system, electronic or mechanical, without the written permission of the copyright owner. Inquired regarding permission for use of material contained in this document should be addressed to: Business Information Management Systems, University of Miami, 1150 N.W. 14th Street, Suite 100, Miami, FL 33136.
All the functionality that you currently use is available in the Web 4.0 version of the system.

The main differences are:
- how you access the screens
- pressing the **TAB** key instead of the **Enter** key for movement from field to field within a screen
- clicking the **OK** button to file the data on the screen(s) instead of pressing the **F10** key
- clicking the **Cancel** button to leave a screen without filing any changes instead of pressing the **F7 Q** buttons

Additionally, there are several new features that will be described.

One of the main new features of the 4.0 version of the system is the Appointment Manager screen. It is a screen from which you can manage the appointments for the current day. From this screen, you will time stamp the greeter, arrival and check out times. You can also make a followup appointment from this screen.

This scenario will demonstrate the basic functionality of a new patient's first appointment, arrival, check out, making a follow-up appointment, requesting a chart and viewing patient inquiry.

The patient's name is Louisa Test. Her insurance is Cigna HMO. Therefore, we will have to check her eligibility, create a referral and link the referral to the appointment.

The scenario is divided into functional sections to make it easy for your future reference.

This scenario was created in a test environment. Therefore, some of the data, like the availability of a provider for a same day appointment, may not mimic the live environment.

Let's Get Started - Please turn the page
Louisa Test has a rash on her arm that is very red and itching very badly. She has been referred by her PCP, Dr. Carmen E. Gonzalez, for a consult with Dr. Kirshner in the Dermatology department. She would like the first available appointment.

1. Logon to system

   NOTE: The contents of the Vertical Tool Bar (VTB) varies based on your security

   A screen displays with just the VTB populated.

2. Click on the VTB Patient Services option

3. Enter TES, LOU, the patient name lookup criteria, in the Name field.

   NOTE: All of your current patient name lookup methods are available in the Web 4.0.

4. Press the Tab key
The Patient Selection screen displays with all the patients who meet the criteria of TES, LOU.

None of the patients are possible matches.

5. Click the New Reg button to register Louisa as a new patient.

The first screen of the Add/Edit Registration screens displays with TES, LOU defaulted in the Patient field.

6. Enter the patient data in this screen the same way that you currently do.

REMEMBER:
- Press the Tab key to move from field to field
- When you click the OK button, all the Reg screens will be saved (just like F10)

HINTS:
- Click on the List buttons next to some of the data fields to select options Ex: Sex
- Required fields have a pale yellow background Ex: Rel to Guar
- Click on the Page arrow buttons to navigate from page to page

The following screens show all the demographic data entered for Louisa Test.
Overview

The following screens are the demographic screens with Louisa Test's data. The screens are presented in the order that they displayed on the screen during data entry using the Tab key.

General Patient Information screen

Patient Employment Information

Next of Kin/Emergency Information

Continued on Next Page
6. Click the **OK** button after you have completed entering all the patient's demographics.

The **Registration Documents** screen displays.

To print a document, select it. Then click the **OK** button. A printer device screen displays for you to enter the printer name. Then click the **OK** button to print the form.

7. Click the **OK** button to complete the demographic portion of the new patient entry.

The **Manage Insurance Information** screen screen displays.
Overview

To continue with our scenario, the Manage Insurance Information screen automatically displays after the demographic information has been entered. It is the initial insurance screen that displays.

Steps (cont.)

8. Click the **Add** button to add Louisa's insurance.

The **Select Insurance** screen displays

9. Type first few letters of the FSC name (CIGNA).

10. Click the **List** button to display FSC options based on partial FSC name

11. Select the **CIGNA HMO** row

12. Click the **OK** button in the popup box

13. Click the **OK** button for the entire screen

Continued on Next Page
The **Insurance Information** screen displays. The name of the FSC is displayed at the top.

14. Enter Louisa's data in the FSC followup questions. Enter data as you entered it in the registration screens. The colors and List buttons work the same way.

The next two screens show all the data that was entered in the FSC Followup Questions.

15. Click the **OK** button when add the data has been entered.

**HINTS**
Press the **Tab** key to get to the next field or use the up and down arrow or the **PgUp** and **PgDn** keys on your keyboard to scroll to more questions.

When you get to the last field in the grid, the next FSC Followup Question displays.

**Continued on Next Page**
The Manage Insurance Information screen redisplay showing Louisa's insurance. Now let's check her eligibility status electronically with Cigna Insurance.

**L - Eligibility List**

NOTE: Although you want to check eligibility now, you cannot use the L - Eligibility List link on this screen because the insurance has not been filed yet. After the insurance has been filed, you are able to use the L - Eligibility List link to display the patient's Eligibility List.

16. Click the **OK** button to return to the Patient Services screen.

The Patient Services screen displays.

**Patient Banner includes demographic and insurance data**

Key patient information

**Continued on Next Page**

>> Refer to Patient Services Job Aid for a description of the Patient Services screen.
16. Click the **Eligibility List** button

The **Eligibility Request List** screen displays. This screen lists all previous eligibility requests. Since Louisa is a new patient, there are no previous eligibility requests in the system.

17. Click the **New** button to initiate an eligibility request.

The **Eligibility Request - Select Insurance** screen displays

18. Click the **OK** button to accept the default information.

Continued on Next Page
The Eligibility Request - Benefit Type screen displays

19. Click the OK button to accept the default information.

The system electronically contacts the insurance company to obtain Louisa’s information and current status.

**NOTE:** The following screen has been modified from an eligibility response from a real patient because TEST, LOUISA is not a real patient. Therefore, some of the data on the screen does not match Louisa’s registration and insurance information that has just been entered. Per HIPAA requirements, the unique real patient identifiers have been overlaid with Louisa’s data.

This is the first screen in the Eligibility Results. The middle column lists the information that was sent to the payor. The right-hand column list the information the payor sent back. The fields with the blue background indicate discrepancies that need to be worked.

20. Work the discrepancies and fill out the outcome field according to instructions in the Eligibility packet
21. Click the OK button when complete.

Continued on Next Page
The Manage Insurance Information screen redisplay.

22. Click the OK button to return to the Patient Services screen.

The Registration Documents screen displays to give you the opportunity to print documents again.

Use the previously described steps to print if needed.

23. Click the OK button to return to the Patient Services screen. Louisa's registration and insurance information displays in the banner and the detail of the screen.
**Scenario**

Before you make the appointment, create the referral so that you can link the referral easily when making the appointment.

Louisa tells you that she has a referral from her PCP to see Dr. Kirsner for 3 visits.

The Patient Services screen is displayed and your patient, Louisa Test, has been accessed.

---

**The Patient Services screen displays**

1. Click the Referral List hyperlink. This hyperlink accesses the Referral List screen which lists all of the patient's referrals. It is wise to check to see if the patient has a referral before creating a new one. Since this is a new patient, the referral list will be blank. New referrals can be created from the Referral List screen using action code N.

The Referral List screen displays.

2. Click the N - New/Edit Referral button.

The Add/Edit Referrals screen displays.

---

**Continued on Next Page**
The Add/Edit Referrals screen with Louisa's data entered through the Referral Type field

Steps

3. Enter referral data as you currently do.

REMEMBER: - Press the Tab key to move from field to field
- When you click the OK button, all the Referral screens will be saved (just like F10)

After you enter the Referral Type of Consult, the Consult screen displays.

The Add/Edit Referrals Consult screen.

Complete the form as you currently do remembering to use the Tab key to go from field to field.

When you press the Tab key to exit from the last field, the Referring To screen displays automatically.

Continued on Next Page
4. Complete the form as you currently do.

5. Click the OK button when complete.
A popup message box displays the message that the referral has been filed

6. Click the OK button
Immediately another popup message box displays that the Rule Bank has been applied to status and that the referral status has been changed from Pending to Approved.

7. Click the OK button

Continued on Next Page
Then the Referral List screen redisplays with the newly created referral at the top. The Referral List screen redisplays with the newly created referral visible at the top of the screen.

8. Click the OK button to return to the Patient Services screen.
Scenario

Now that the patient has been registered, the insurance verified and a referral created, it's time to make the appointment.

The Patient Services screen is displayed and your patient, Louisa Test, has been accessed.

The appointment is a first available New Patient Visit (NPV) appointment type with Dr. Kirsner.

The Patient Services screen displays

1. Click the **New Appointment** hyperlink.

   The **New Appointment** screen displays with Louisa's name defaulted into the **Patient** field.

2. Enter the appointment data in this screen the same way that you currently do.

   **REMEMBER:** - Press the **Tab** key to move from field to field

   **>> Refer to New Appointment Screen Job Aid for a description of this screen.**

Continued on Next Page
As soon as an **Appointment Type** is entered, the **New Appointment - Referral/Copay** screen displays.

3. Click on the **Referral No. List** button to display Louisa's referrals.

The Referrals screen displays with a list of Louisa's referrals.

4. Select the referral. Since Louisa only has one referral, the system preselects it for you.

5. Click the **OK** button.

An popup box displays to alert you to the number treatments left and pending on the referral.

6. Click the **OK** button.

The **New Appointment - Referral/Copay** screen redisplayes with the referral number in the **Referral No.** field.
7. Click the **OK** button
The **New Appointment** screen redisplay.
The **New Appointment - First Available** screen displays.

8. Enter **T** in the date field to change the date to search for an appointment from Today and forward.
When you press the **Tab** key, the date changes to today's date. There is no more data to enter.
9. Click the **Next** button.
The **First Available Selection** screen displays.

Continued on Next Page

10. Select a time slot
11. Click the **Next** button

The ADF screen displays

12. Enter the ADF data in this screen the same way that you currently do.

In the required **Appt Contact #** field, you have options for data entry:
   a) enter a 10 digit number with no hyphens
   b) click on the list button to the right of the telephone number to select one of the patient's registration telephone numbers
   c) enter:
      @D for the Patient's daytime phone number as entered in the patient's registration screen
      @E for the patient's evening phone number or as entered in the patient's registration screen
      @O for the patient's other phone number as entered in the patient's registration screen

**REMEMBER:** - Press the **Tab** key to move from field to field.

13. Click the **Save** button when all the data has been entered.

The **Confirmation** screen displays.

Continued on Next Page
Steps (cont.)

14. Reconfirm the appointment with Louisa by reading the appointment data on the screen to her.

Now print an Encounter Form for the visit. The system prints encounter forms for all appointments if the appointment is booked at least one day in advance of the appointment.

Since Louisa's appointment is a 'same day' appointment, you need to print the Encounter Form for the visit.

15. Click the **HTB Encounter Form** tab.

*Note: This tab also appears above the Patient Services screen.*
**Ambulatory Scenario - Printing an Encounter Form**

**Scenario**
In preparation for Louisa's arrival, print the encounter form.

**Steps**

The **Demand Encounter Forms** screen displays with Louisa's name in the **Patient** field.

1. Press the **Tab** key to accept the default name.

A bottom form displays with key patient information for you to validate that you have selected the correct patient.

2. Click the **OK** button.

**HINT:** If the default name is incorrect, enter a new patient name lookup, the patient selection screen displays, select the correct patient and then you will be returned to this screen with the correct patient's name in the **Patient** field.

**Continued on Next Page**
3. Click the **Appointment** field’s **List** button to display a list of the patient’s appointments.

4. Select the correct appointment.

**NOTE:** Since Louisa has only one appointment, it is already selected (as indicated by the blue background)

5. Click the **OK** button.

The **Demand Encounter Form** screen redisplays with the cursor in the **Encounter Forms Format** field.

6. Click the **Encounter Forms Format List** button

---

**Continued on Next Page**
The Background Printer/Record Room Locations popup box displays.

7. Select the Demand Encounter Forms form.
8. Click the OK button.

The Demand Encounter Form screen redisplay.

9. Click the OK button

The Device Code screen displays.

Continued on Next Page
10. Enter the printer device name in the **Device** field.
11. Press the Tab key.
12. Click the **OK** button.
   The form will print.

The **Demand Encounter Forms** screen redisplay

12. Click the **Cancel** button to return to the **Patient Services** screen

**NOTE**: Click the **OK** button to print another **Demand Encounter Form**.
Ambulatory Scenario - Appointment Manager

Scenario

Louisa has arrived for her appointment.
The Greeter will greet her.
A Front Desk staff member process her arrival.
She will then see Dr. Kirsner.
Her check out time will be recorded.
She will pay her copay.
Dr. Kirshner wants to see her in one month.
She will make a followup appointment to see the doctor in approximately 30 days (T+30).

Workflow

The workflow for time stamping greeter, arrival and check out times is different in the Web 4.0 than your current functions and activities in the system.

To make the process more efficient and reduce the chances of working on the wrong patient, you will use the Appointment Manager.

The Appointment Manager is a list of patients who have appointments for a specific date for one or more departments, locations and/or providers.

Below is a screen shot of the Appointment Manager for the Dermatology department for 2/13.

Using this screen, you will perform the time stamp the appointment with the Greeter Time, Arrival Time and Time Out.

You will make a follow-up appointments using one of the options in the Action button.

You will perform the Front Desk activities of Check Out, Cash Drawer and printing a batch report from the VTB Front Desk option.

>> Refer to the Appointment Manager Job Aid and the Appointment Manager Settings Job Aid for an explanation of all the fields and options in the Appointment Manager screens.

Continued on Next Page
Access

Access to the **Appointment Manager** is from the **VTB Appt Manager** option as shown in the screen shot above.

The first time you enter the **Appointment Manager**, you will have to create a setting. The setting defines which appointments display on your Appointment Manager screen.

The **Appointment Manager Settings** screen shown below has been set up to display all the appointments for the current day for the Dermatology department.

>> Refer to the **Appointment Manager Settings Job Aid** for an explanation of all the fields and options in the screen.
Ambulatory Scenario - Greeter Time

Scenario
The Greeter will greet Louisa and record the time in the system.

Steps

1. Find Louisa's appointment in the Appointment Manager screen.

2. Click Louisa's Greeter time button.

The Appointment Manager screen redisplays with the time in the Greeter column for Louisa's appointment.

NOTE: Be careful that you click the correct patient's Greeter Time button. Only a supervisor or manager can change the time if you clicked the wrong patient.

HINTS:
1. To make sure you click the correct Greeter Time button, you can highlight the appointment first. Then it will be easier to know which row in which to click the Greeter time.
2. Click in the black text of the appointment to select it.
   - Clicking in the first column, the time, displays the appointment ADF.
   - Clicking in the second column, the name, displays the patient's registration and insurance data
   - Clicking in the fifth column, the name, displays the Appointment Detail screen.
   - This screen displays the appointment's audit trail and information about its attachments. Ex: referrals, linked appointments, eligibility requests, etc.
**Scenario**

The Front Desk staff person who processes Louisa's arrival will time stamp the arrival in the system.

**Steps**

1. Find Louisa's appointment in the Appointment Manager screen.

   ![Appointment Manager Screen](image)

   **1. Louisa's Arrival Time button**

2. Click Louisa's **Time Arr** button.

   The **Appointment Manager** screen redisplays with the time in the **Time Arr** column for Louisa's appointment.

   ![Appointment Manager Screen](image)

   **Louisa's Arrival Time**

**NOTE:** Be careful that you click the correct patient's **Time Arr** button.

**HINTS:**

1. To make sure you click the correct Greeter Time button, you can highlight the appointment first. Then it will be easier to know which row in which to click the Greeter Time.

2. Click in the black text of the appointment to select it.
   - Clicking in the first column, the time, displays the appointment ADF.
   - Clicking in the second column, the name, displays the patient's registration and insurance data.
   - Clicking in the fifth column, the name, displays the Appointment Detail screen.
   - This screen displays the appointment's audit trail and information about its attachments. Ex: referrals, linked appointments, eligibility requests, etc.
**Scenario**

The Front Desk staff person who processes Louisa's check out will time stamp the check out time in the system.

1. Select Louisa's appointment
2. Click the **Time Stamp** button

**Steps**

3. Select the **Out** option.

The **Appointment Manager** screen redisplayes with the current time in the Time Out column.

- **2. Time Stamp button**
- **Louisa's Check Out Time**
Scenario

Louisa is at Check out and says that Dr. Kirsner wants her to come back in a month for a Follow Up appointment (FUV).

Access

A fast and efficient way to make a follow up appointment is from the Appointment Manager.

From the **Patient Access** screen, click the **VTB Appt Manager** option.

**NOTE:** A new appointment can also be made by clicking the New Appointment link from the Patient Services screen or from provider’s schedule.

Steps

The **Appointment Manager** is a list of patients who have appointments for a specific date for one or more departments, locations and/or providers.

Below is a screen shot of the Appointment Manager for the Dermatology department for 2/13.

>> Refer to the Appointment Manager Job Aid and the Appointment Manager Settings Job Aid for an explanation of all the fields and options in the Appointment Manager screens.

1. Select Louisa’s appointment
2. Click the **Actions** button.
3. Select the **Followup Appointment** option from the popup screen.

Continued on Next Page
The New Appointment screen displays with data defaulted into the fields of the new appointment.

For Louisa, two changes have to be made to the defaults: the only change to the defaults that has to be made is to change the appointment type from NPV to FUV for the followup appointment.

- Change the appointment type from NPV to FUV
- Change the From Date to T+30.

4. Use the Tab key to get to the Appt Type field.
5. Enter FUV in the Appt Type field
6. Press the Tab key

The New Appointment Referral/Copay screen displays.

The process of selecting the referral is the same process as you used for Louisa's first appointment.

9. Tab to the Referral No. field.
10. Click the List button to select referral for the appointment.

The Referral List screen displays.
7. **Tab** to the Referral No. field
8. Click the **Referral No.** List button

The list of Louisa's referrals displays.

9. Select the referral to link to this new appointment.
10. Click the **OK** button.

A referral message displays informing you of the number of treatments left and the number of pending appointments.

12. Click the **OK** button.
The New Referral screen redisplays with the referral number in the Referral No. field.

11. Click the OK button.

The New Appointment screen redisplays.

12. Enter T+30 in the From Date field

13. Click the Next button

The New Appointment - First Available Search screen displays.

Continued on Next Page

**Steps (cont.)**

14. Select an appointment slot

15. Click the **Next** button

The ADF screen displays.

---

14. Slot selection

15. **Next** button

16. Enter appointment data. Remember to use the Tab key to navigate to the next field.

17. Click the **Save** button when all data has been entered.

The **Appointment Confirmation** screen displays.

---

Continued on Next Page
The Appointment Confirmation screen.

Steps (cont.)

18. Click the **OK** button

The Appointment Manager screen redisplays.
Scenario
Louisa is at the Check Out desk and needs to pay her copay.

All the functionality that you currently use is available in the Web 4.0 version of the system. The main differences are the access to Check Out, using the mouse and using the Tab key to navigate from field to field.

Access
Access is from the Vertical Tool Bar (VTB) Front Desk option.

NOTE: We have accessed Louisa from the Patient Services screen before selecting Front Desk. When the Check Out screen displays, her name will default in the patient name field.

Steps
1. Click on Front Desk in the Vertical Tool Bar (VTB)
The Front Desk Horizontal Tool Bar (HTB) screen displays.

2. Click on the Check Out tab.
The Cash Drawer Batch Header screen displays.

Continued on Next Page
3. Fill out the fields in this screen the same way that you fill them out currently.

4. Click the OK button.

The Check Out screen displays with Louisa's name defaulted in the Patient field.

**NOTE:** If you entered this without having preselected the patient checking out, you can enter a standard lookup for the patient in the Patient field and the system will display the Patient Selection screen for you to select the patient.

5. Press the Tab key to exit from the Patient field.

The patient's Appointment List displays for you to select an appointment to which the copay will be linked.

6. Select the appointment that will be linked to the copay.

The Check Out screen redisplay.
The Check Out screen. After a slight pause, a copay message displays because, based on the copay information entered in the FSC Follow Up Questions, the system has determined the copay for the appointment.

7. Click the OK button in the message box after reading the copay amount.

8. Enter data in the fields the same way that you currently do.

After you press the Tab key to exit from the Procedure field, a message displays telling you that the procedure has been approved for the charge and the dollar amount of the charge.

9. Continue to enter data in all the appropriate fields.
5. Click the **OK** button after all data has been entered.

A message displays with the invoice number that the system applied the payment to.

**The following invoice has been filed:**

16762421

Then system will prompt you for a device on which to print a receipt.

The **Device** screen displays.

6. Enter the printer name in the **Device** field. Then **Tab** through the rest of the fields, entering data when appropriate.

7. Click the **OK** button.

The receipt prints on the designated printer.

---

**Steps**

**(cont.)**

4. **Check Out** data fields

5. **OK** button

6. Printer data fields

5. **OK** button

6. **Device** data fields

---

Continued on Next Page
The Check Out screen redisplayed without any patient information. It is ready for you to enter another Front Desk Check Out payment.

This is the only Check Out payment for you to post at this time. Exit to balance your batch in Cash Drawer.

8. Click the **Cancel** button to exit from the screen.
   A message displays telling you that the batch is out of balance and has been put on Hold.

The Front Desk initial screen displays with the Front Desk HTB and a patient banner.

9. Select another **HTB Front Desk** activity or select any **VTB** option.
Scenario

It is the end of the day and you need to balance your Check Out batch.

Access

Access is from the Vertical Tool Bar (VTB) Front Desk option.

Steps

1. Click on Front Desk in the Vertical Tool Bar (VTB)

The Front Desk Horizontal Tool Bar (HTB) screen displays.

2. Click on the Cash Drawer tab.

The Cash Drawer Batch Information screen displays.

Continued on Next Page
The **Cash Drawer Batch Information** screen.

Your initials default in the **Initials** field.

**Steps (cont.)**

3. Press the **Tab** key to advance to the Batch field.
4. Click the **Batch List** button to display your batches in a popup box.

5. Select the batch to be balanced.
6. Click the **OK** button in the popup box. The screen redisplayes.

**Continued on Next Page**
7. Fill out the fields in this screen the same way that you fill them out currently.

   NOTE: Remember to use the Tab key to navigate from field to field.

8. Click the Actions button if you need to enter batch defaults and additional control totals.

A bottom form displays.

5. Enter default information if appropriate

9. Enter Hash Range, Procedure Prefix and Suffix and First Procedure if appropriate.

10. Click the Next button to enter batch defaults and additional control totals.

The Cash Drawer Control Total Summary screen displays.

---

Continued on Next Page
11. Fill out the fields in this screen the same way that you fill them out currently.

12. Click the Previous button to return to the Batch Information screen,

The Batch Information screen displays.

13. Enter Y in the Controls OK? Field to indicate that all the control totals have been entered correctly.

14. View the screen to see if the system found any variances between the controls you entered and the actuals that are the totals of the individual transactions that you entered. If there were discrepancies, work them the same way that you have been working them.

Continued on Next Page
If there were no discrepancies and your batch is in balance,

**HINT:** If you need to resolve variances, printing a Batch Proof can help you find the variances.

15. Enter **L** in the **Action** field to print a batch proof.

16. Click the **OK** button.

The **Device** screen displays.

17. Enter the name of the printer in the **Device** field.

18. Click the **OK** button.
A screen displays with information about the batch printing and asks if you want to queue the report.

19. Press the **Enter** key to print the report immediately. The report prints.
20. The **Batch Information** screen redisplays.

21. Enter `X` in the **Action** field to exit from **Cash Drawer**.
22. Click the **Cancel** button.

The initial **Front Desk** screen redisplays.

---

**Steps**

(cont.)