ClinixPM Master Table Step by Step Training Guide

NOTE- This document is designed to help new users input data into their Master Tables in the order in which they need to be completed. Therefore, the order of the tables will not match the order in which they are listed in ClinixPM.

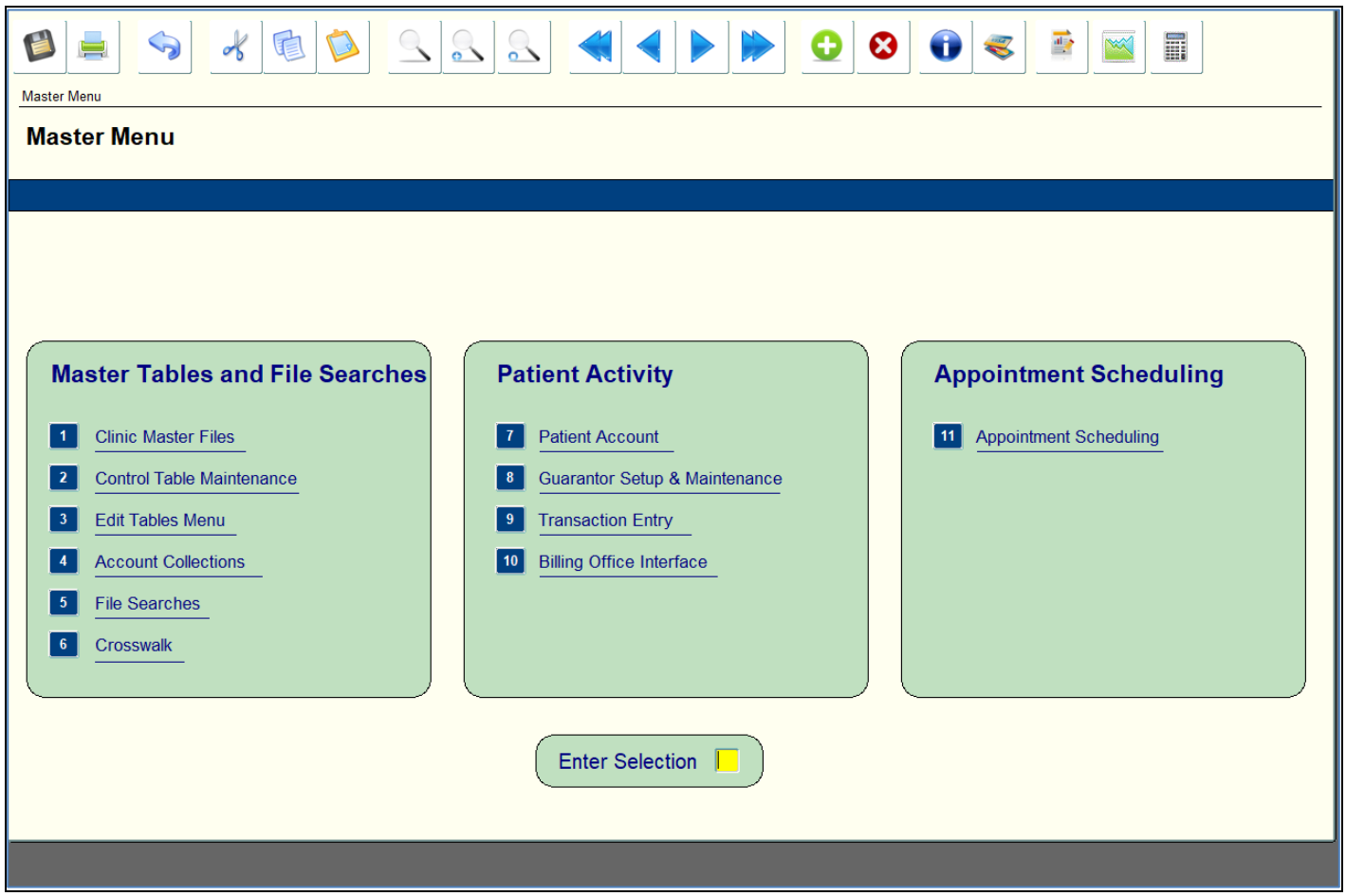
Table of Contents

Introduction: Clinix Master Files and Control Tables Functions

Choose Master Menu Selection 1 to access the **MASTER FILES** function screens in order to create, view and/or maintain files which are used to produce patient accounts, insurance master records, procedures, claims, statements and appointment schedules, and are used for reference during data entry and processing activities.

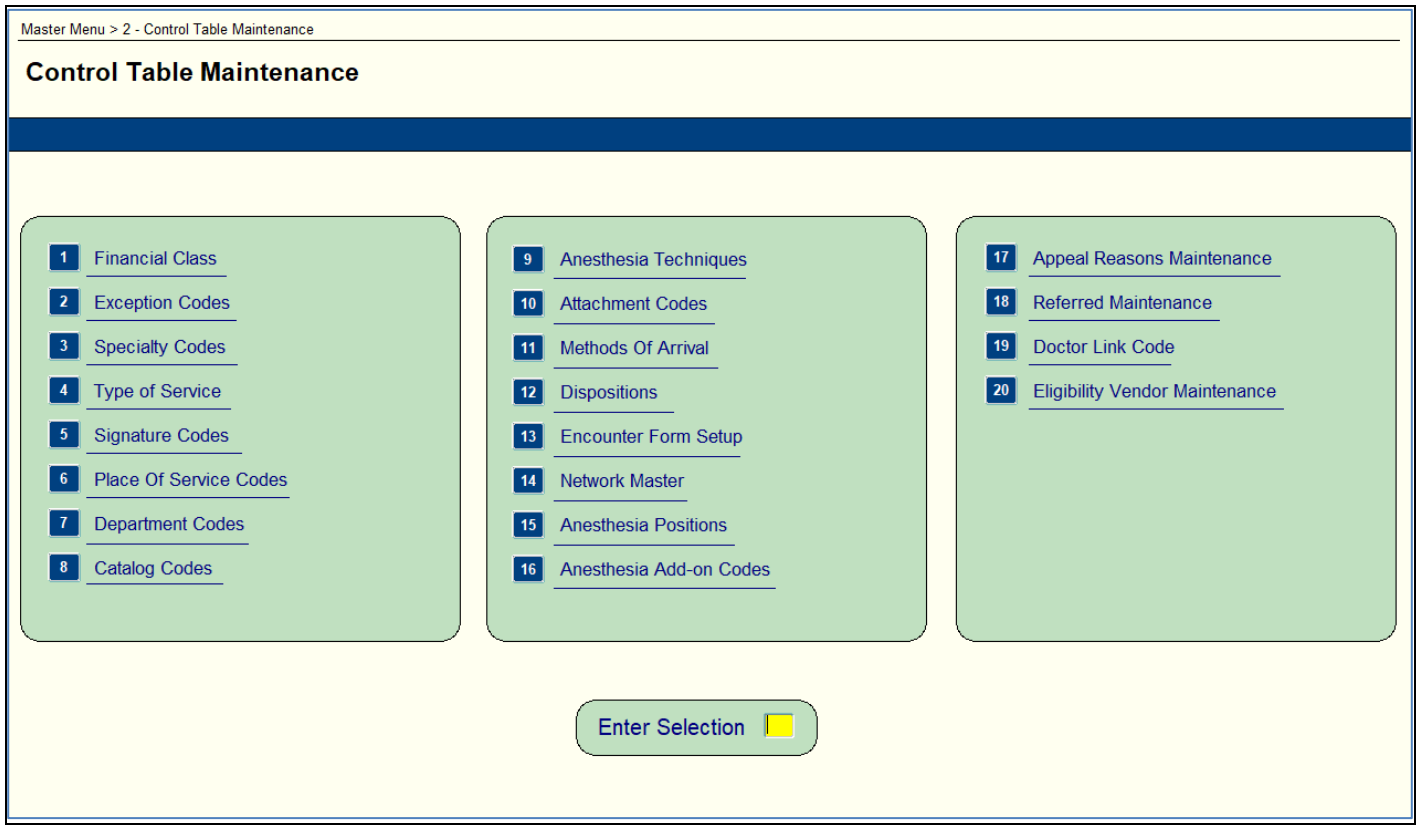
Choose Master Menu Selection 2 to access **CONTROL TABLES MAINTENANCE** in order to create, view and/or maintain tables which are used for reference during data entry and processing activities.

Each Master File or Control Table's purpose and field usage is outlined in the following Master Menus based on the format "Master Menu X.n" where "n" is the submenu number.



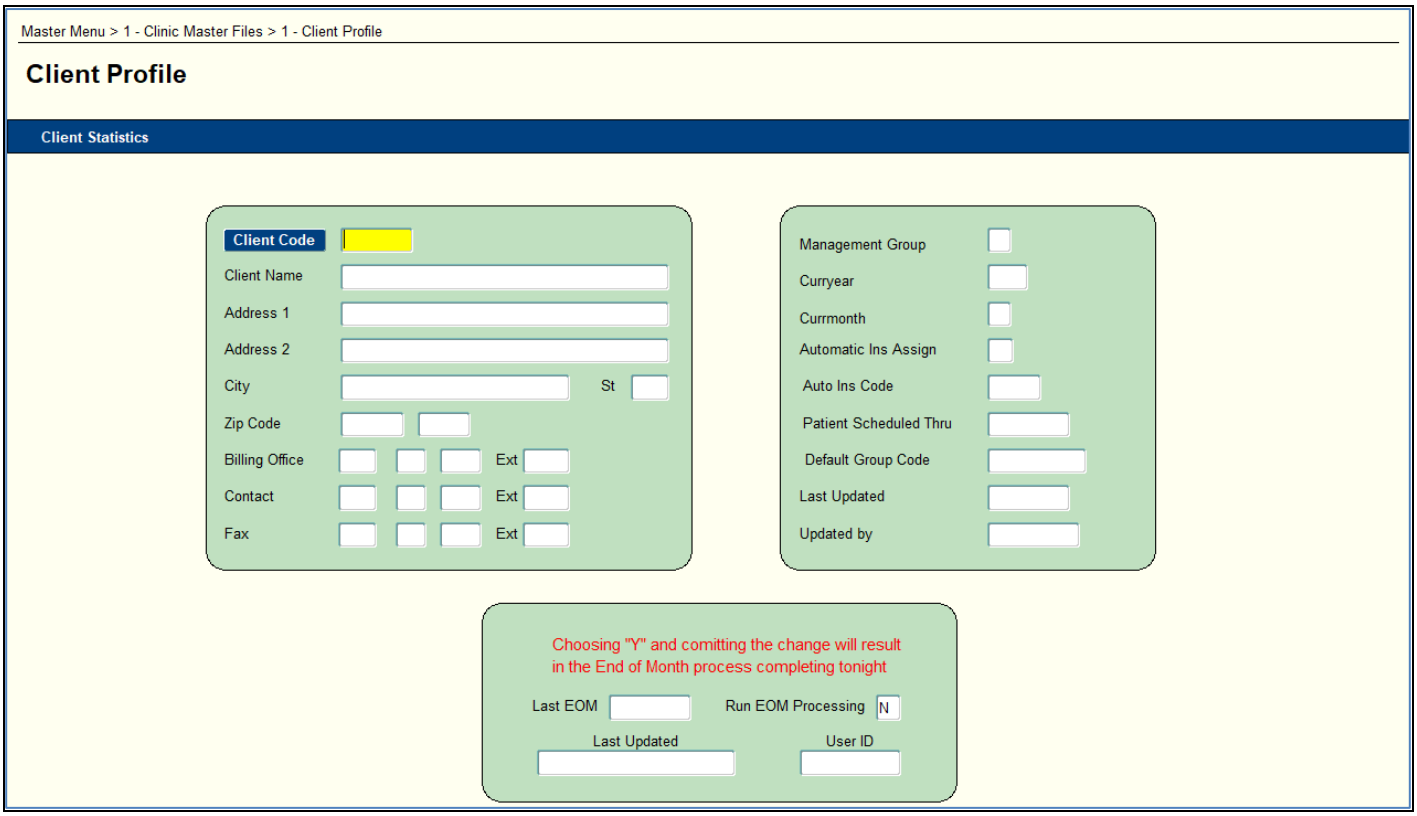

Master Menu > 1 - Clinic Master Files
Client Master Files
1 Client Profile
2 Doctor Master
3 Location Master
4 Insurance Master
5 Diagnosis Codes
6 Procedure Codes
7 Billing Messages
8 Management Group
9 Audit Trail
10 Provider Fee Schedules
11 Expected Payment Percentage
12 Expected Payment CPT Level
13 Bank Setup
14 Refund Check Register
15 Test Codes
16 Group Provider Numbers
17 Individual Provider Numbers
18 Action Codes
19 Managed Care Contract
20 User Level Security
21 Retail Sales
Enter Selection

Master Menu 2 – Table Codes Maintenance



Master Menu 1.1 Client Profile

Purpose: Used to create the control record that defines you as a Clinix client by identifying your overall system criteria. Fields utilized for this purpose are defined below.

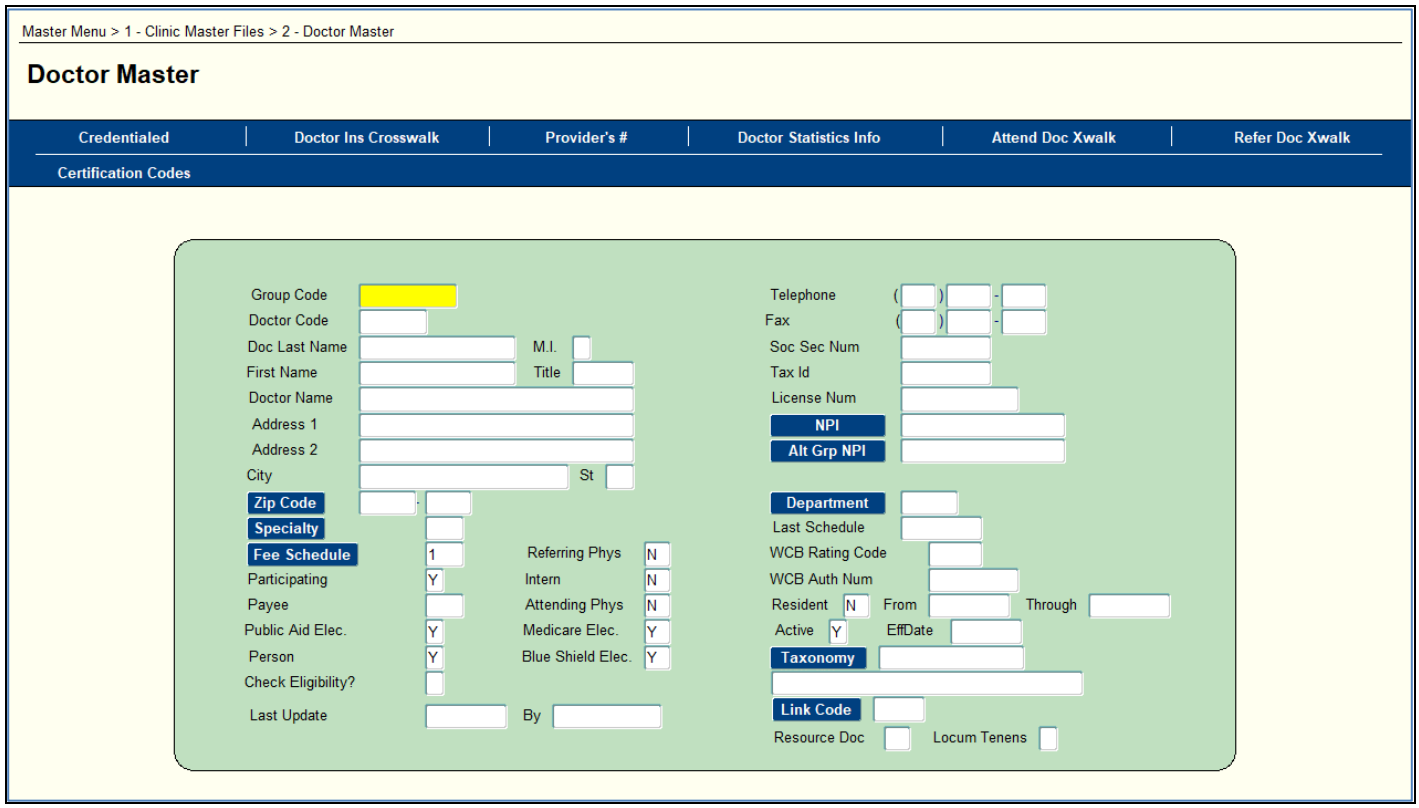


Master Menu 1.1 Client Profile	
Field Name	**Field Description**
Client Code	Behind the scenes code used by Programming. Client will never see this code. **MUST be different than database code.**
Client Name	Client's short name as will be used for identifying their database.
Address 1 and Address 2	This address does not appear anywhere, just FYI here.
City, State, and Zip Code	Enter the City, State, and Zip Code
Billing Office	Number Clinix staff should use to contact the client.
Contact	Additional number that can be used to contact the client; sometimes referred to as a back office line.
Fax	Fax number of Billing office
Management Group	**Always** a 'Y'
Curryear and Currmonth	Displays the current system month and year
Automatic Ins Assign	Enter Y if you want the system to automatically assign numeric Insurance key codes. Blank assumes No.
Auto Ins Code	Enter the number the system should auto assign after

Patients Scheduled Thru	Displays the latest date through which the appointment schedule is built
Default Group Code (Use the default Group Code Code if you only have one group in your database)	If client only has one group, the group should be entered.
Last Updated	This field will display the last date a changed was made.
Updated By	This field will display the last user that updated the form.
Last EOM	This field will display the date of the Last EOM. Note: A security must be set on MM1.21 for this feature.
Run EOM Processing	This field will default to an N. If client is set up as 'At Notification' for their EOM processing by entering a Y in this field it will set their EOM process to run that night. Note: A security must be set on MM1.21 for this feature.
Last Updated	This field will show the last date that the 'Run EOM Processing' flag was updated. Note: A security must be set on MM1.21 for this feature.
User ID	This field will show the last user that updated the 'Run EOM Processing' flag. Note: A security must be set on MM1.21 for this feature.

Master Menu 1.2 Doctor Master

Purpose: To define each doctor or provider of care within the group and input data needed for insurance claim filing and to define each referring physician to the group and input data needed for insurance claim filing. This record can also be used to define functional areas or resources such as Treadmill, X-ray, EKG, internal Lab, or others that can be used for scheduling purposes.

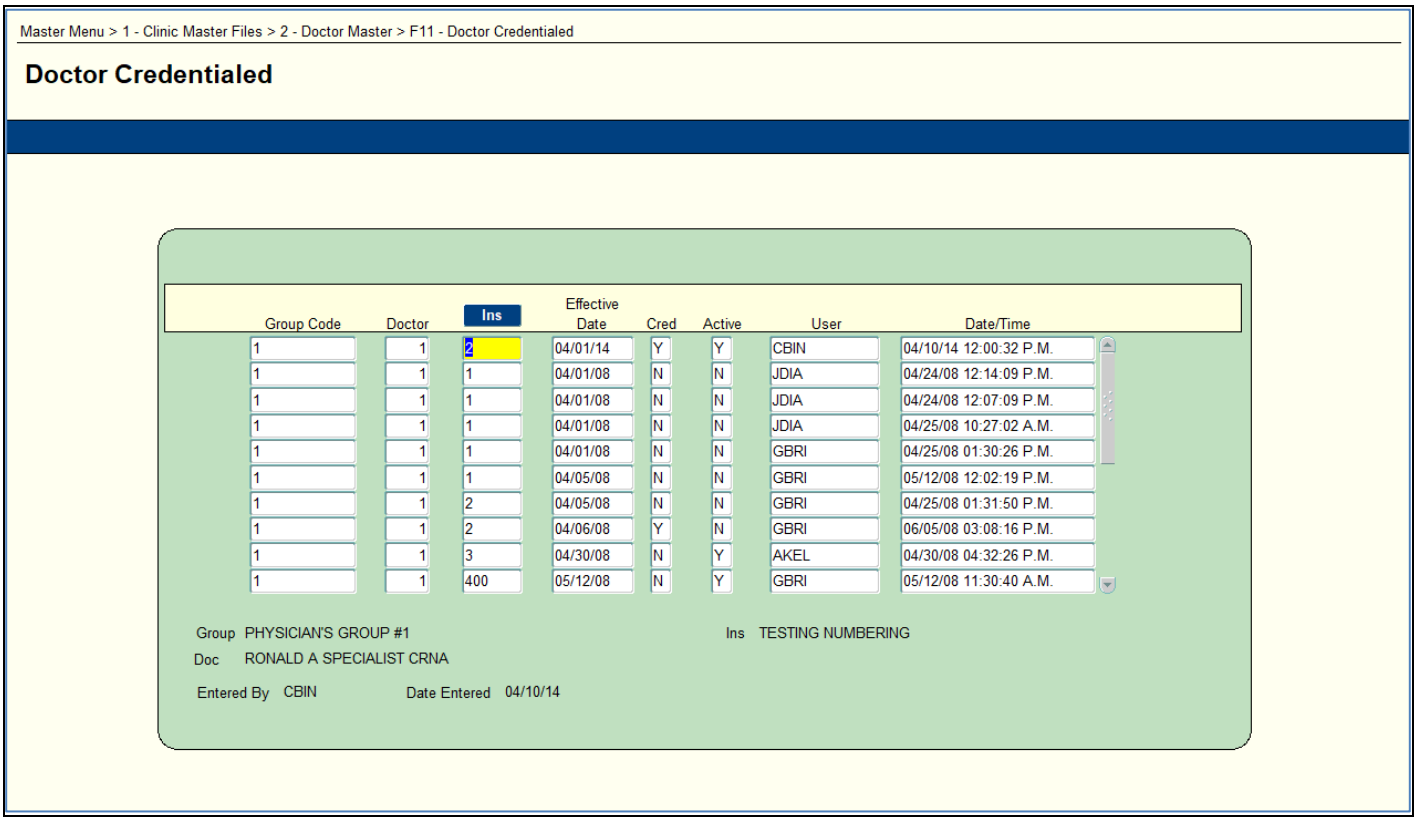


Master Menu 1.2 Doctor Master	
Field Name	**Field Description**
Group Code	Group specific for attending. Attending may also be marked as referring within the same specific group. If referring can be shared by more than one group, put referring in group All.
Doctor Code	Numeric only. May set system to auto assign but enter number for exceptions.
Doc Name and Title	Block 31 of CMS-1500
Address 1 and 2	Not needed
Zip Code, City and State	Self-explanatory
Telephone	FYI
Fax	FYI
SSN	May be used for claim depending (not required)
Tax ID	May be used for claim depending
License Number	Used primarily for Worker's Comp proprietary claims
NPI	National Provider Identification number. Select from LOV.
Alt Grp NPI	Can be used when a practice has two group numbers. If an NPI number is stored in the 'Alt Grp NPI' field this NPI will override the NPI that is stored in the Management Group, MM1.8. If this field is left blank, the insurance program will use the NPI number that is stored on MM1.8.
Department	Used for reporting
Last Schedule	Displays the date of the last built schedule
WCB Rating Code	Worker's comp related
WCB Auth Number	Worker's comp related

Specialty	Used in scheduling
Fee Schedule	Identifies the pricing the doctor uses.
Participating	Enter Y if Doctor Participating with Medicare
Payee	Illinois IDPA and PA Medicaid # used on claim
Public Aid Electric	Enter a 'Y' to file electronic, 'N' to file to paper, and 'H' to hold all Medicaid Claims.
Person	Enter 'Y' or leave blank if the referring doctor is a person. Enter 'N' if the referring doctor is a non-person indicating that the referral was a facility
Check Eligibility?	Enter 'N' to exclude provider from batch and real time eligibility check. Y or null assumes Yes.
Referring Physician	Enter Y if doc can be used as referring
Resident	No longer used
Intern	No longer used
Attending Physician	Enter Y if doc is attending
Medicare Electric	Enter a 'Y' to file electronic, 'N' to file to paper, and 'H' to hold all Medicare Claims
Blue Shield Elec.	Enter a 'Y' to file electronic, 'N' to file to paper, and 'H' to hold all Blue Shield Claims.
Active	Type N to deactivate doctor (Y does nothing)
Effective Date	Date doctor deactivate. Will not allow charges for DOS => effective date.
Taxonomy	Select from LOV
Link Code	This field can be utilized to link all Referring Physicians that belong to the same practice. There are several reports that the link code will display.
Resource Doctor	Type Y when you are setting up a resource, i.e., Treadmill, EKG. The Not Posted report will not include resource.
Locum Tenens	If a provider is performing Locum Tenens function, check this box for internal reporting only.
User name and Date	Auto stamps upon commit

Master Menu 1.2, F11-Doctor Credentialed

Purpose**:** This will allow users to hold claims, based on the insurance key code, when the doctor is not yet credentialed.



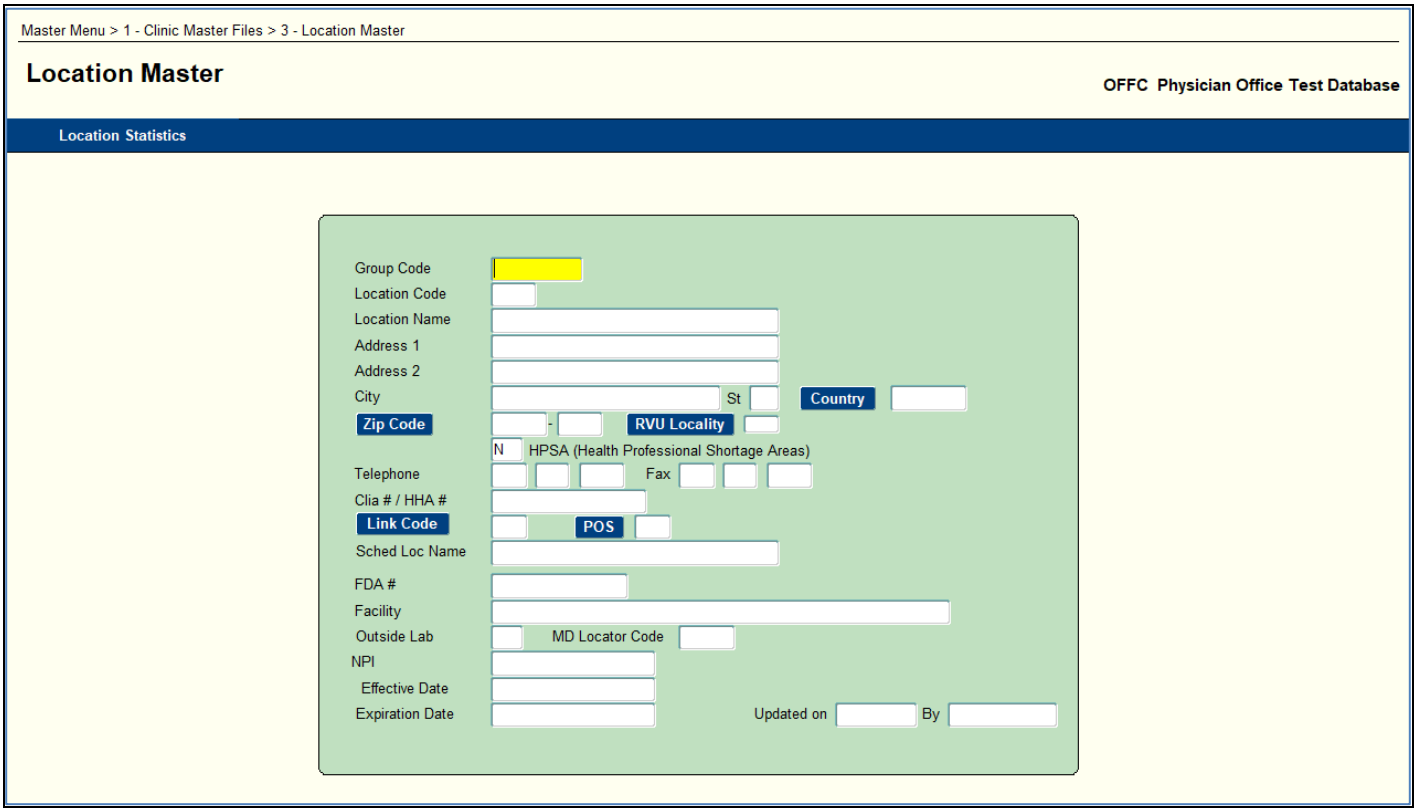
Master Menu 1.2, F11- Doctor Credentialed	
Field Name	**Field Description**
Group Code	This defaults from MM1.2- Doctor Master Record Maintenance
Doc	This defaults from MM1.2- Doctor Master Record Maintenance
Ins	Enter the insurance key code where the claims need to be put on hold
Effective Date	This is just for documentation purposes
Cred	An 'N' will prevent claims from opening for that provider for that carrier. When the doctor becomes credentialed, a new record will need to be entered with a 'Y' which will allow claims to begin opening for that provider for that carrier.
Active	A 'Y' will default to state this record is being utilized in insurance processing. If a doctor becomes credentialed the user will need to set this field to a 'N' and enter a new record with a 'Y' stating this provider can begin filing claims for a specific carrier
User	The system will automatically stamp the user id of the person entering/updating that record
Date/Time	The system will automatically stamp the date and time the record was entered and/or updated
Bottom of the screen:	
Group	FYI field- Shows the full name of the group
Doc	FYI field- Show the full name of the doctor
Ins	FYI field- Show the full name of the insurance carrier
Entered by	Shows the user who entered the original record
Date Entered	Shows the date the record was originally entered

Master Menu 1.3 Location Master

Purpose: To define each location the group provides services. This information is used in filing Insurance claims and to develop financial statistics.

- Note- Location Code Maintenance – Medloc (MM1.3) If you have the POS attached to a specific location on the Location Master Table and you do not have 1) the POS default set on the Batch Control screen or 2) a POS code set on a specific CPT code in the Procedure Master; then the POS from the Location Master will default at charge entry.

For full POS hierarchy information see announcement with effective date November 7, 2007 with the title 'Created a hierarchy to default the Place of Service (POS) from specific screens/forms within Clinix'



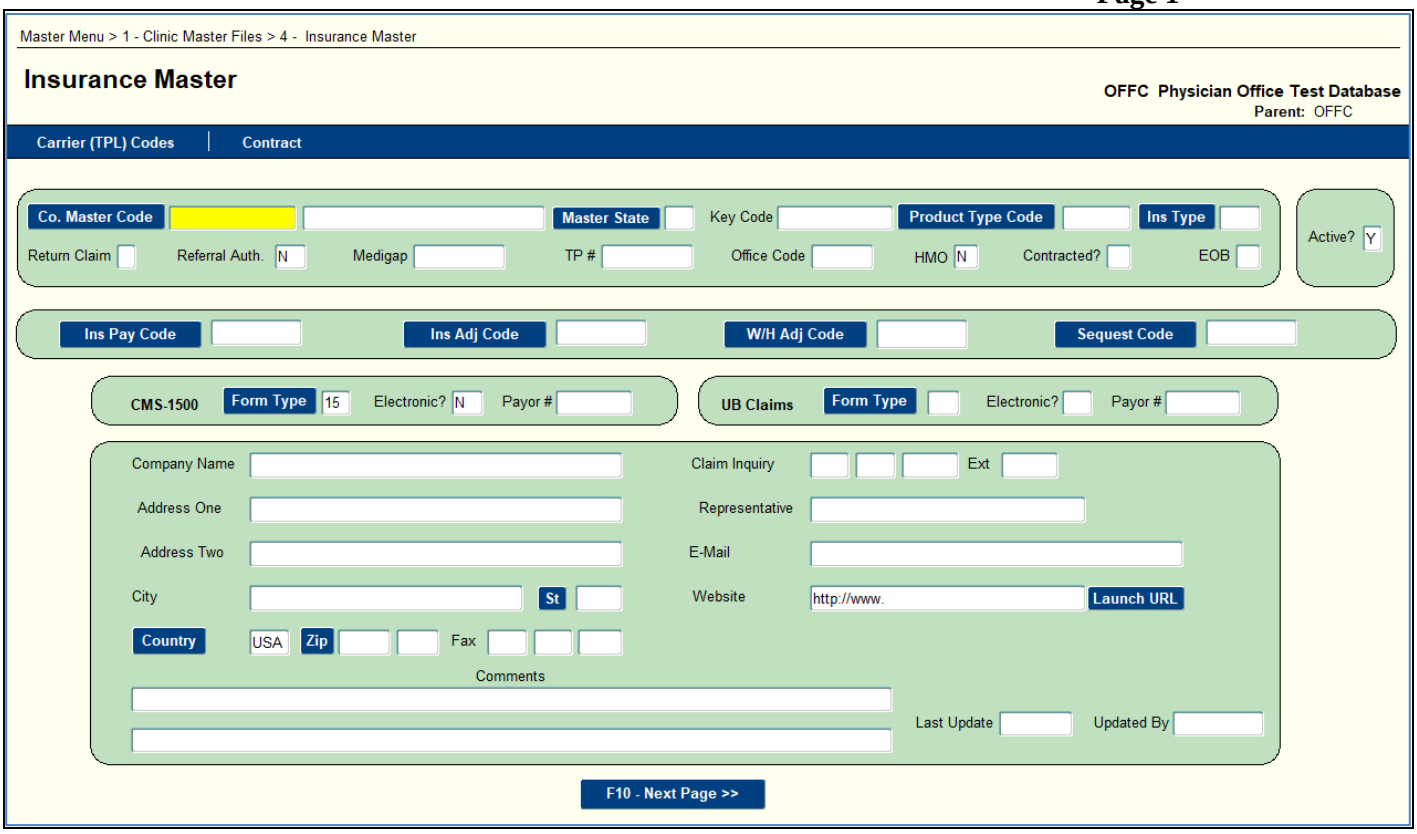
Master Menu 1.3 Location Master	
Field Name	**Field Description**
Group	Must be group specific.
Location Code	Must be numeric.
Location Name and Address	Block 32 of CMS-1500. Ins. Program must have an address for HIPAA. Put in additional 4 digits to zip code.
RVU Locality	Clinix will programmatically set this field when possible; however, we ask that you very every locality code.
HPSA(Health Professional Shortage Areas)	Y if qualified as an HPSA, or N or leave blank

Telephone	FYI only
Clia #/HHA #	Prints in Block 23 or 32 of CMS-1500. Insurance program determines placement dependent on carrier. Clia 3 represents Lab Certification HHA represents Home Health Agency certification
Link Code	Not used at this time
POS	If you have the POS attached to a specific location on the Location Master Table and you do not have 1) the POS default set on the Batch Control screen or 2) a POS code set on a specific CPT code in the Procedure Master; then the POS from the Location Master will default at charge entry.
Sched Loc Name	When data is entered into this field and saved, this field will pull into the drop down list for the Location Name in the parameter section of the Scheduling form.
FDA #	This field is used to store the: Mammogram FDA certification number prints in CMS-1500 block 32 or the Facility Number when required.
Facility	This field is only used for IDPA paper claims, Form HFS 2360. Enter name that should appear on HFS-2360 block 21 if different than what appears in Location Name above.
Outside Lab	Enter Y if CMS-1500 block 20 should be marked Yes
MD Locator Code	Please enter the Locator code for NY Medicaid or ID Medicaid
NPI	Location NPI field for block 32A on CMS-1500
Effective Date	Used for FYI
Expiration Date	Used for FYI

Master Menu 1.4 Insurance Master

Purpose: To define all insurance company master records that is used to file patient insurance claims.

Page 1

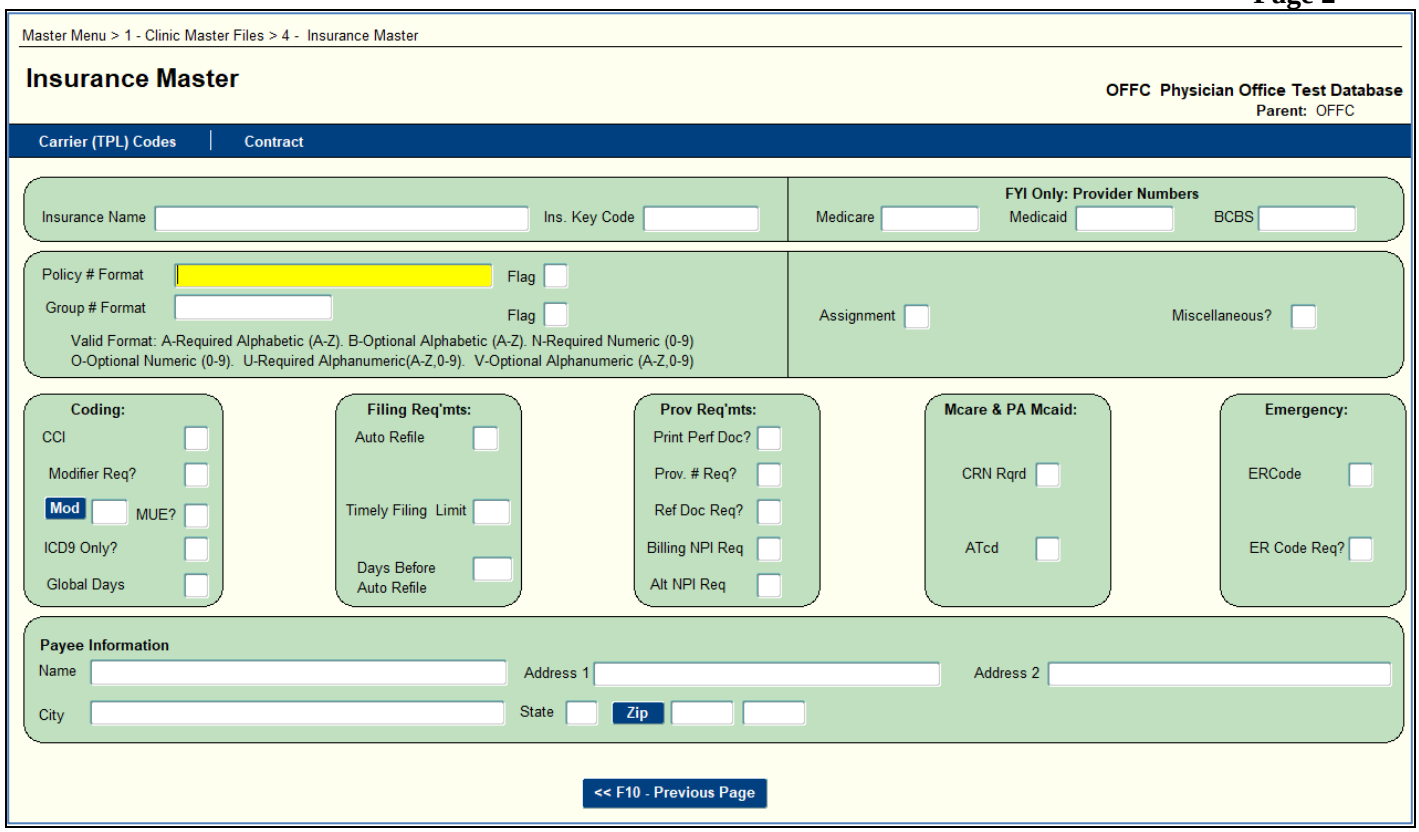


Master Menu 1.4 Insurance Master	
Field Name	**Field Description**
Company Master Code	Select from LOV. Must be a network that the payor is in, not to be used to store payors. (Think credentialing when deciding on a master code)
Master State	Only use if the carrier has different formatting by state.
Insurance Key Code	May be alpha or numeric, 5 character maximum
Product Type Code	Select from LOV, critical to payment posting reporting in the near future
Insurance Type	Select from LOV
Return Claim	Enter an R if you want the claim to drop to paper and be returned to the client. Enter an S if claim to be returned to client for signature only when claim had to drop to paper because it could not open electronically. Return or Signature will appear on the top of the claim as applicable.
Referral Auth	If this field is set to 'Y' the system will force the user to enter the referral/authorization when scheduling an appointment. NOTE- The 'Primary Physician' field on MM2.3 will need to be set to 'N' for this field to function correctly.
Medigap	By entering a medigap number, the system does not send a secondary claim but records that a medigap claim has been forwarded by the primary carrier.

TP #	Louisiana Medicaid number, BCBS of TN requires BSS, and TNcare requires 002. Any keycode with form type 64 must have either BL, HM, MB, or OF in the TP # field (medins) in order to go electronically. BL means blue shield. HM means blue care network. MB means Medicare advantage. OF means federal.
Office Code	Some Change Healthcare carriers still use this in addition to the payor #.
HMO	If the HMO flag is a Y, this means the payer is a medicare advantage plan and we will send code 16 (HMO medicare risk) instead of code MB (medicare part B) in the emc filing indicator (SBR09). The HMO flag is also tied to rejection 36 (MSP code missing) when the secondary payer is medicare part B and the MSP code is blank and the HMO flag is N or blank.
Contracted?	Enter Y if there is a contract with this product. In addition, if this field is marked with a 'Y' the adjustment will automatically be taken when posting insurance payments.
EOB	Enter a Y or P. If this field is marked with a 'Y', users will have the ability to enter the Allowed, Co insurance, Deductible, etc when posting insurance payments and a system generated EOB will generate. If this field is marked with a P, users will users will have the ability to enter the Allowed, Co insurance, Deductible, etc when posting insurance payments but a system generated EOB will not generate.
Active?	Enter N to deactivate this insurance record. The deactive flag prevents the user from manually entering this code from that point forward. It does not stop claims from generating for existing accounts.
Ins Pay Code	Select from LOV
Ins Adj Code	Select from LOV
W/H Adj Code	Select from LOV. If a payment is being manually posted to an insurance carrier that has a withhold adjustment entered, the system will deduct that withhold amount from the payment amount and post a withhold adjustment. NOTE- if this field is left null the offsetting adjustment will not be posted but the system will still deduct the withhold amount from the payment.
Sequest Code	Select from LOV or enter your Medicare sequestration code
CMS-1500 – Form Type	Form 15 should be used for Change Healthcare carriers. For direct carriers select correct form type from the LOV
Electronic?	Y will send claims electronically if Medicare, Medicaid, BC, RR directly; all other carriers via Change Healthcare when payor number is entered
Payor #	Find on the Change Healthcare web page. This number identifies for Change Healthcare where to forward the claim
UB Claims: Form Type	If an electronic UB04 claim is needed, enter the form type of UB.
Electronic?	Enter a 'Y' if a UB claim can be filed electronically.
Payor #	The appropriate Change Healthcare payor number must be entered. Note: Additional enrollment might be required for some insurance carriers. This will be noted on the Change Healthcare Payor List on their website - changehealthcare.com.
Company Name	Top of claim for mailing purposes
Address 1 & 2	Self-explanatory
Zip Code, City, and State	Self-explanatory

Country	Self-explanatory
Fax	Self-explanatory
Claim Inquiry	FYI
Representative	FYI- Open Claims Report #6946
Email	FYI
Website	Self-explanatory
Comments	Any comments for this key code record

Page 2



Master Menu 1.4 Insurance Master (continued)

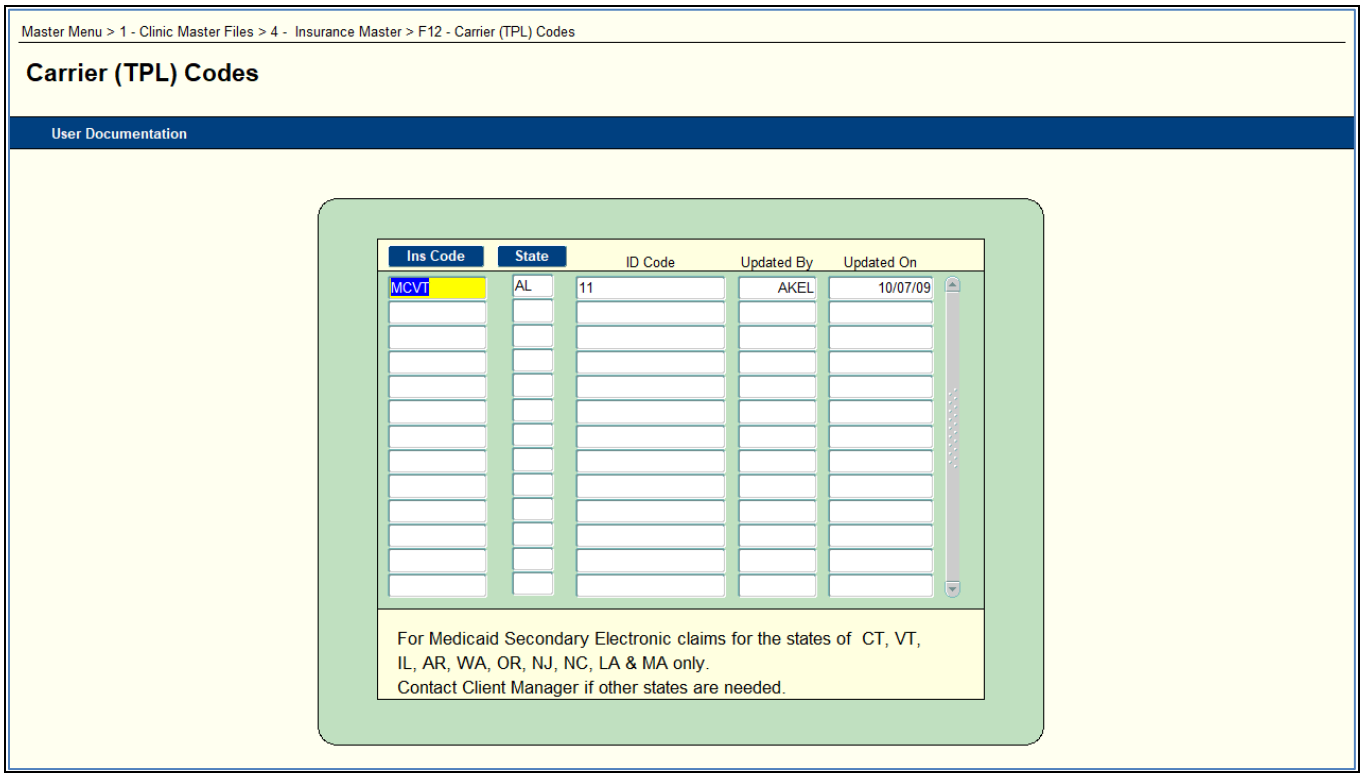
Master Menu 1.4 Insurance Master	Page 2
Field Name	**Field Description**
FYI Only: Provider Numbers	These fields will display the provider numbers
Policy # Format & Flag	Set parameters that users will have to follow when entering account policy numbers. CTR B for a list. Enter W for warning, V for validation.
Group # Format & Flag	Set parameters that users will have to follow when entering account policy numbers. CTR B for a list. Enter W for warning, V for validation.
Assignment	Enter Y to Accept Assignment, N for No. Block 27 of CMS 1500
Miscellaneous?	A 'Y' requires the user to enter the insurance name and address in the Misc. Medacins fields. An N prevents a user from entering the name and address on the Medacins screen. A null leaves the Mis. Medacins field optional.
Coding: CCI	Enter Y to active the Correct Coding Initiative edits.

Modifier Required?	Enter Y if required.
Mod	Enter the code at charge entry or enter the Modifier code to default at the time of charge entry.
MUE?	Definition- 'Maximum units of service that a provide would report under most circumstances for a single beneficiary on a single date of service.' Any charges entered where the units exceed the MUE maximum allowable will generate on our Batch Edit Report (5207).
ICD9 Only?	Enter a 'Y' if the insurance carrier will only accept ICD9 diagnosis codes after October 1, 2015.
Global Days	ClinixPM has defaulted this field to a 'Y' on all insurance carriers within your database. If you do not want a specific carrier to look at the global days and thereby notifying the user during charge entry, you will need to change this field to an 'N' and save. If this field is marked with a 'Y', when a charge is posted and the account number, date of service, and the procedure code conflict with another charge that has been posted or is still pending, the user will get a warning pop up. This warning is not a fatal warning and will allow the user to continue posting without taking any action. This is simply a warning message to notify the user of a potential problem that could result in denied claims.
Filing Req'mts: Auto Refile	This field will allow users to inform the system if a specific insurance carrier should not be considered when we run our automatic close and refile claims program based on the (med) option that has been put in place for a database. This field will only hold a 'Y' or 'N' value. Adding data into the this field will override the (med)options that have been set
Timely Filing Limit	Enter the number of days the carrier has set for their timely filing limit.
Days Before Auto Refile	This field will allow users to inform the system if a specific insurance carrier needs a different number of days set regarding when to close and refile claims based on the (med) option that has been put in place for a database. This field will only hold up to three (3) numeric characters. Adding data into the this field will override the (med)options that have been set
Provider Req'mts Print Perf Doc?	Enter N if this product only wants the attending doctor on the claim.
Prov. # Req?	This field will reject a claim if a provider # is missing for this product. Enter a G for group number, I for Individual number and B for both numbers. **Since we are sending NPI only to Medicare, Medicaid, and BCBS, if you want legacy numbers to print in addition to the NPI, a project must be entered for that payer. There are several Medicaid's who still want legacy numbers. Note: For BCBS policies that are filing through Emdeon, you will need to enter an 'N' in this field. If you are entering an 'I','G', or'B' on a carrier that is going through someone other than Emdeon, please call your Client Manager.**
Ref Doc Req?	Enter Y if the user must enter a referring doctor at charge entry. Not necessary for Specialty ED as the attending doctor defaults as the referring doctor
Billing NPI Req	If a specific insurance carrier requires something other than the NPI indicated on the Group Master, in block 33a, then users can set this field to allow an 'I' for Individual (NPI) or a 'G' for Group (NPI) to be used as

	the billable NPI. If the Insurance Master field is left blank the logic will go to the Group Master. Setup per ins if IT does not use NPI.
Alt NPI Req	If a specific insurance carrier requires the Group NPI number in both box 24J you will need to enter a 'G' in this field. If a specific insurance carrier requires nothing to print in this field you will enter an 'N'. If this field is left blank, the doctor's individual NPI number will print in block 24j. **The Group NPI number will also need to be in the 'NPI' field in the Management Group Profile Maintenance screen and the 'Use Group NPI' field will need to be set to 'Y' in MM1.8.**
Mcare & PA Mcaid CRN Rqrd	Medicare and PA Medicaid have Insurance Claim Numbers (ICN) that are needed for secondary EOBs. Entering Y in this field will require manual posted payments to enter a Claims Reference Number. (Remit program does not use this field, it always posts the ICN)
ATcd	Enter a Y if an attachment code is required when posting payments, necessary for PA Medicaid.
ED Specialty: ERCode and ER Code Req? Only applicable for Specialty ED clients.	Enter the letter O but no code if the user may enter an ER code at charge entry based on the procedure. Enter Y and no code if you want the field to be mandatory and you want the user to enter the code at charge entry. Enter a Y and the code if you want the field to be mandatory but the ER code to default the code entered on this table. You will not be able to access this field at charge entry. Enter an N if you do not want the user to access the field at charge entry as an ER code is never warranted for this carrier.
Payee Information	Name & address info for mailing insurance refund checks if different from Company Name & Address on Page 1.

Master Menu 1.4, F12 – Carrier (TPL) Codes

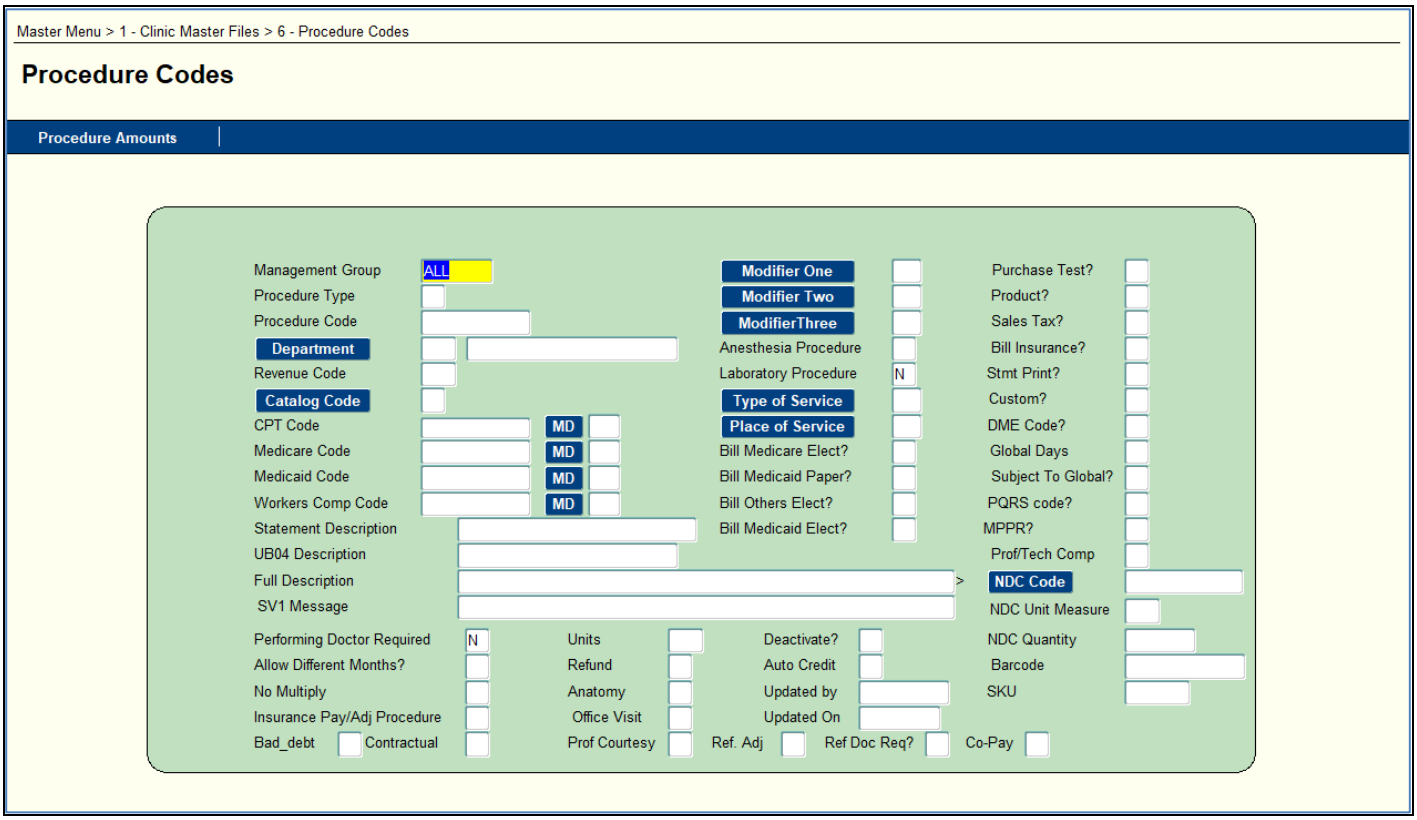
- Purpose: To allow a user to enter a TPL, Third Party Liability, code when a Medicaid secondary claim can be filed electronically.



Master Menu 1.4, F12 Carrier (TPL) Codes	
Field Name	**Field Description**
Ins Code	Enter the Keycode that files claims to Medicaid carrier requiring TPL code
State	Enter the State to define which Medicaid should include the TPL code
ID Code	Enter the TPL code Note: This applies only to the States of CT, VT, IL, AR, WA, OR, NJ, and LA at this time. If additional states are need contact your Client Manager
Updated By	System will automatically stamp the users name
Updated On	System will automatically stamp the date

Master Menu 1.6 Procedure Codes

- Purpose: This screen is used to input and maintenance all procedures performed by the group. It is also used to define payment and adjustment codes used in posting to patient accounts
- Note- Procedure Master – Medproc (MM1.6) If you have the POS attached to a specific CPT code on the Procedure Master and you do not have 1) the POS default set on the Batch Control screen; then the POS from the Procedure Master will default at charge entry.
    - For full POS hierarchy information see announcement with effective date November 7, 2007 with the title 'Created a hierarchy to default the Place of Service (POS) from specific screens/forms within Clinix'



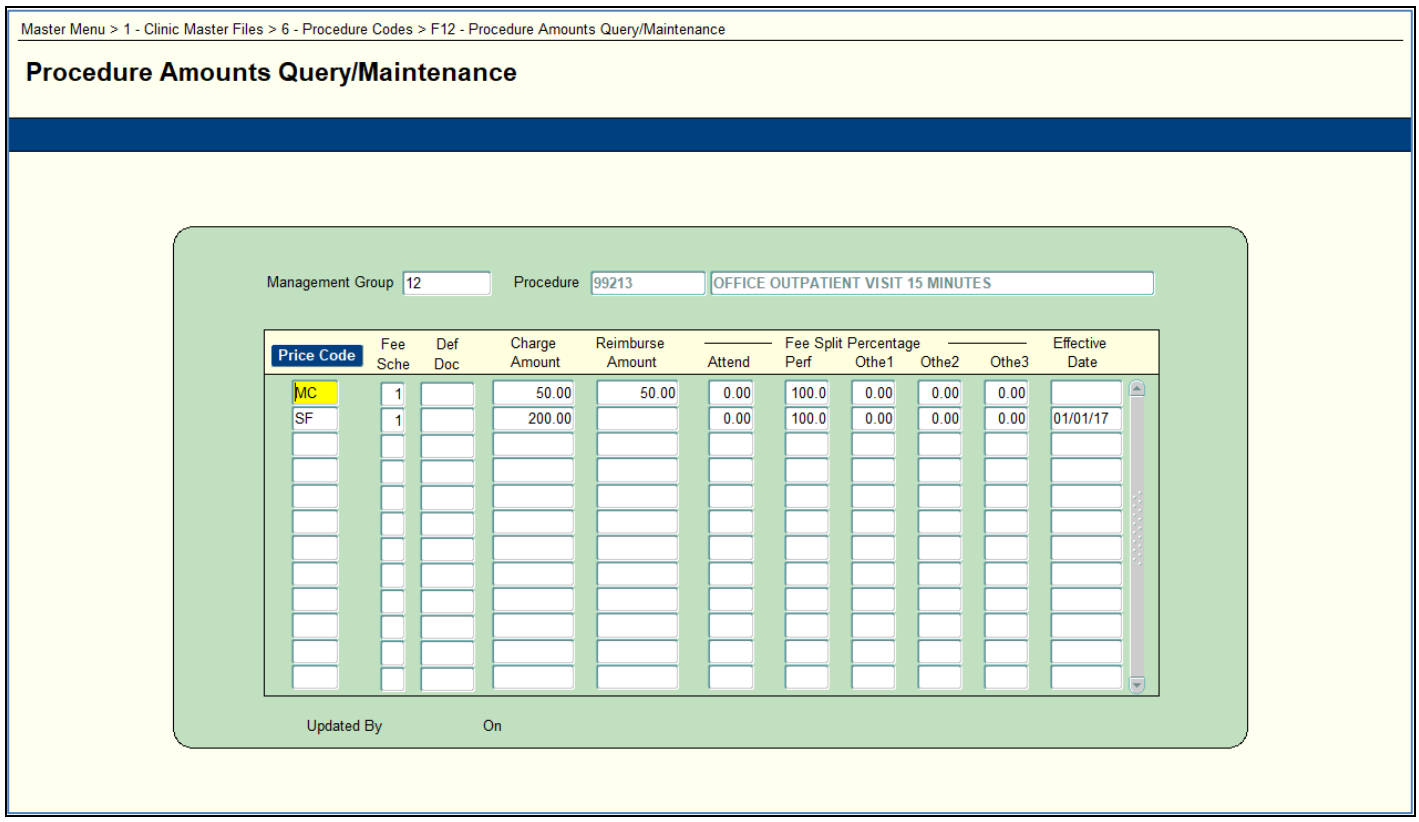
Master Menu 1.6 Procedure Codes	
Field Name	**Field Description**
Management Group	If there is more than one group, procedures can be loaded under group "ALL." If there is only one group, it can be group specific. If group "ALL" is used it will have to be set up in Master Menu 1.8. Table can be loaded with all charge codes from the AMA manual or from a spreadsheet supplied by the client with only the codes they use.
Procedure Type	**C** for charges, **A** for adjustments, **P** for paycodes.
Procedure Code	Free text for Paycodes and Adjustment codes. May use CPT code or free text for charges.
Department	See Department table. **Master Menu 2.7**
Revenue Code	Used for UB04 billing.

Catalog Code	See catalog code. **Master Menu 2.8**
CPT Code / Modifier	Must be the AMA code. / Enter a modifier if it should default for all insurance claims other than Medicare, Medicaid, or Worker's Comp. See those carriers listed separately below.
Medicare Code / Modifier	For carrier specific coding. / Enter a modifier if it should default for Medicare claims.
Medicaid Code / Modifier	For carrier specific coding. / Enter a modifier if it should default for Medicaid claims.
Worker's Comp Code / Modifier	For carrier specific coding. / Enter a modifier if it should default for Worker's Comp. claims.
Statement Description	Allows you to have a different description appear on the patient's statement verses the claim.
Performing Doctor Required?	Enter Y to force the user to enter the performing doctor code at charge entry. Enter N or leave null and the attending doc code will default into the performing doc field at charge entry.
Allow Different Months	Leave blank to restrict the "To date" field at charge entry to be in the same month as the "From date" for a service. Enter a Y to allow different months in From Date (DOS) and To Date.
No Multiply	Enter Yes if you don't want the price times the unit to multiply for total charge. Null field assumes yes.
Insurance Pay/Adj Procedure	Enter Y if the Paycode or Adjustment code represents an Insurance. This will tell the system to deduct the previous payment when creating a secondary claim.
Modifier 1,2,3	Defaults at charge entry for all carriers. If carrier specific, see above carrier code fields.
Anesthesia Procedure	Enter Yes if the charge is an anesthesia procedure.
Laboratory Procedure	Not used.
Type of Service	Will default at charge entry. No longer required in CMS-1500 Block 24 C. However; internal programming still requires the TOS. If the TOS is anything other than a 1 or 2, the CPT code will kick out in the upfront scrubber as needing a referring doctor.
Place of Service	If you have the POS attached to a specific CPT code on the Procedure Master and you do not have the POS default set on the Batch Control screen; then the POS from the Procedure Master will default at charge entry.
Bill Medicare Elect?	Null or Y assumes to bill this procedure to Medicare electronically. N will keep the procedure from going electronically. Enter an R to drop to paper and return to client.
Bill Medicaid Paper?	Null or Y will allow the procedure to bill on a paper claim. Enter an N to keep the procedure from printing on a Medicaid claim.
Bill Others Elect?	Used in Blue Shield and Emdeon electronic programs. Null or Y allows the procedure to bill electronically to other carriers besides Medicaid and Medicare. Enter an N to keep the procedure from billing electronically. Enter an R to drop to paper and return to the client.

Bill Medicaid Elect?	Null or Y assumes to bill this procedure to Medicaid electronically. N will keep the procedure from going electronically. Enter an R to drop to paper and return to client.
Purchase Test?	Enter a Y if this procedure is a purchased test. This is block 20 on the CMS paper form. It is also in production for emc claims. This is optional. The medoption is rptname=MEDCINS, option=3, which=8. If client desires to use purchase test, they must: 1. Set purchase test flag to Y on procedure code. 2. Purchase test charges MUST be posted to a separate location code from other charges. 3. The location master needs either a clia # or fda #. Purchase test charges will print on a separate claim from other charges. If a patient has more than one purchase test charge (different proc codes), each purchase test will print on a separate claim.
Bill Insurance?	Enter an N if this procedure should not bill on an insurance claim. Null presumes to bill the insurance.
Statement Print?	No longer used.
Custom?	Enter a Y in this field to identify procedure codes that should be disregarded when implementation of the AMA Annual updates occur.
DME Code?	Enter 'Y' if this is a DME charge code
Global Days	Enter 0, 10 or 90 depending on surgery
Subject to Global Days?	Enter a 'Y' if a specific code should be considered within the global period of another code. Enter 'N' if a specific code should NOT be considered within the global period.
PQRS Code?	Enter a 'Y' if the charge code is a CPT II code. Null or 'N' if the charge code is not a CPT II code.
MPPR	Enter 'Y' if code will be used in MPPR edit – see announcement dated 07/30/15
Prof/Tech Comp	For Reporting: Enter a P for Prof component or T for Tech component- specific to RVU reporting- null assumes global
NDC Code	When an NDC number is defaulted in this field, it will automatically populate to the charge line item when the code is posted.
NDC Unit Measure	default unit measure
NDC Quantity	default quantity
Barcode	If a specific code is marked with a 'Y' in the Product? field, you can scan the products barcode in this field. You can then use the barcode scanner to automatically populate the product when either creating an order or posting a product.
SKU	If needed, enter the SKU number of a product.
Statement Description	Procedure description for pt statement
UB04 Description	Used to print in block 43 on the UB04 form. If this field is left blank then the 'Full Description' field will print.
Full Description	Full description as provided by CPT source

Units	This field prints in the Unit block on CMS-1500. Null assumes this procedure represents one unit so one unit would default at charge entry and will appear on CMS-1500.
Deactive?	Enter a D to deactivate. This code will not be available for data entry when de-activated.
Refund	If your adjustment or paycode represent a refund, enter a Y. If refund is an adjustment, go to Auto credit field and enter an N.
Auto Credit	If adjustment code should not be a credit, as with refunds, enter an N. Null or Y will make all adjustments credits.
Anatomy	No longer used.
Bad Debt	For reporting. When applicable, enter an 'X' when loading an adjustment procedure code.
Contractual	For reporting. When applicable, enter an 'X' when loading an adjustment procedure code
Prof Courtesy	For reporting. When applicable, enter an 'X' when loading an adjustment procedure code
Ref Adj	For reporting. When applicable, enter an 'X' when loading a refund adjustment procedure code
Ref Doc Req?	Enter a Y if a referring doctor is required for this procedure. Null assumes a referring doctor is not required.
Co-pay	By entering a Y in this field you are identifying this paycode as a copay, which tells the system to not reset the account age regarding statement aging when this paycode is used for payment posted.
Office Visit	Enter a 'Y' when a procedure code is a true office visit. The field is used in the automated co-pay apply program when a payment code is also marked as 'Y' in the Co-pay field (see above). The Co-pay apply program will do the following: if a charge flagged as an office visit is posted for the same doctor and same DOS, apply the co-pay to that charge if no charge is posted for the same doctor and same DOS, list the co-pay on the unapplied report if only charges that are not flagged as an office visit are posted for same doctor and same DOS, apply the co-pay to the charge with the highest dollar value or amount.

Master Menu 1.6, F12 -Procedure Amounts Query and Maintenance

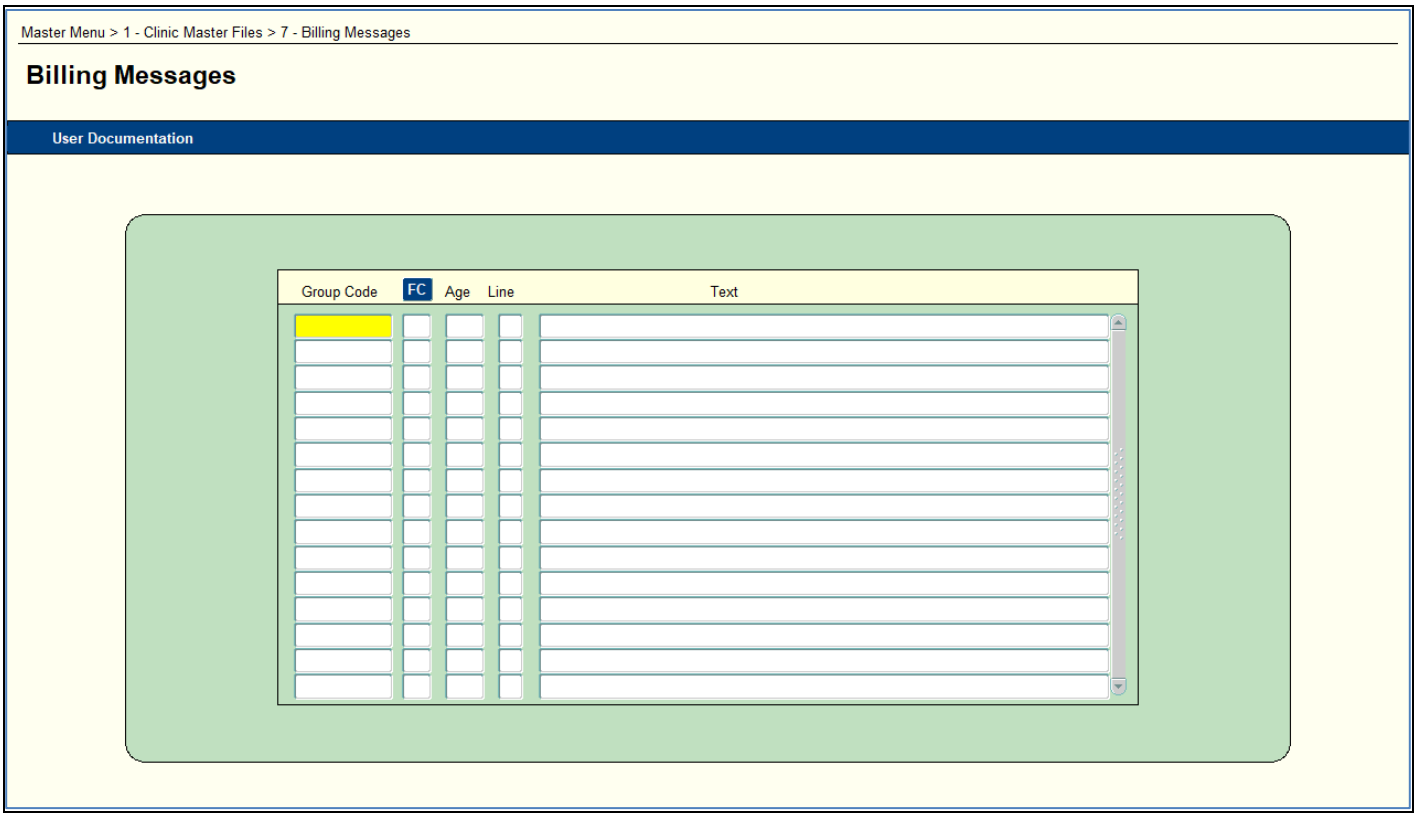


Procedure Amounts	Used to query and/or set prices for procedure codes
Management Group	Group brought forward from Procedure Maint screen
Procedure	Procedure code and name brought forward from Proc Maint screen
Price Code	Enter appropriate Price Code
Fee Sche(dule)	Enter Fee Schedule applicable to this Price Code
Def Doc	No longer used.
Charge Amount	Amount to charge for this procedure
Reimburse Amount	Expected reimbursable amount
Attend(ing) Dr	Percentage split to go to attending doctor
Perf(orming) Dr	Percentage split to go to performing doctor
Other1	Percentage split to go to other provider
Other 2	Percentage split to go to other provider
Other 3	Percentage split to go to other provider
Effective Date	Effective date for this charge/price code combination, if any

An alternative and quicker method to input the fee associated with each procedure code follows in Master Menu 1.10.

Master Menu 1.7 Billing Messages

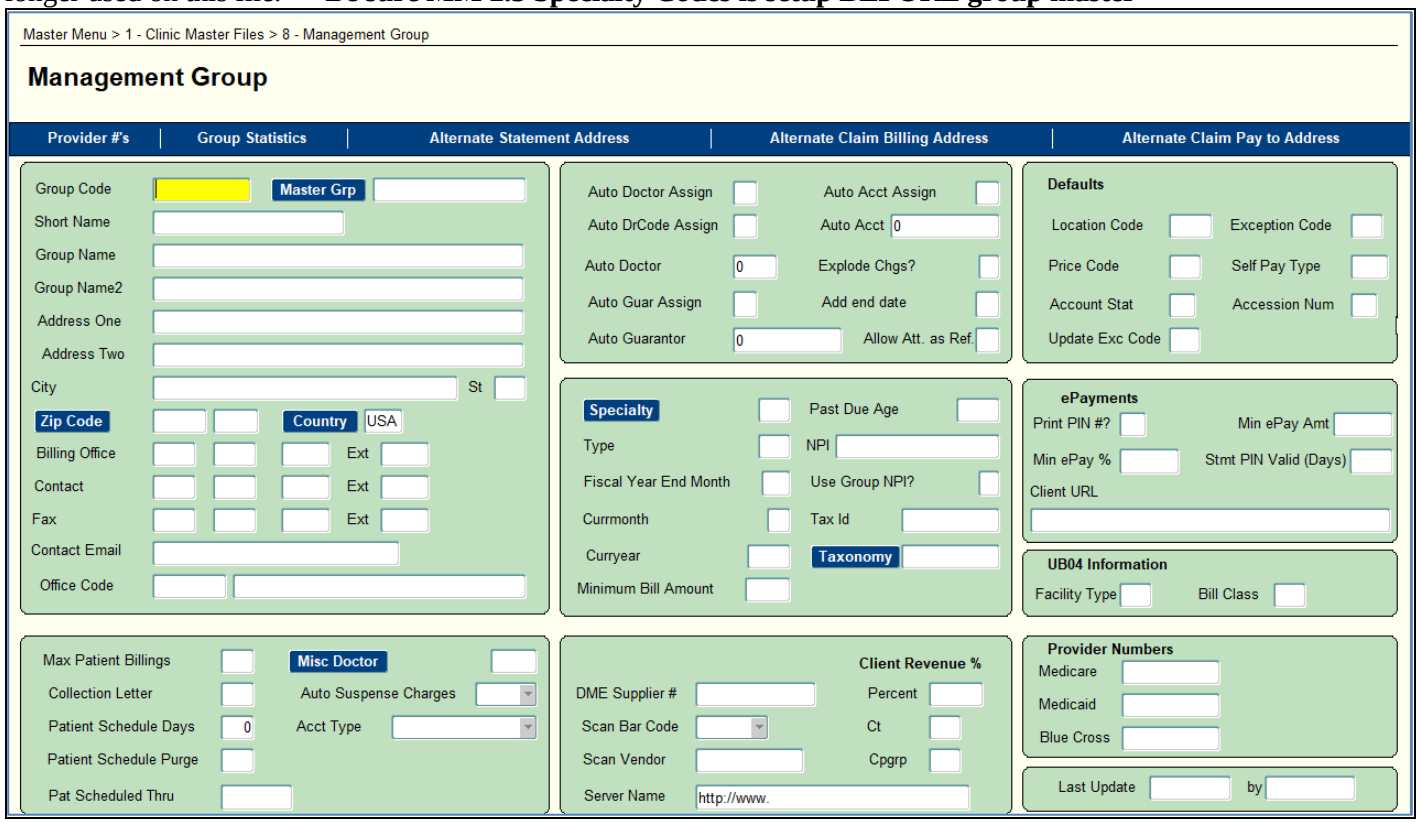
Purpose: To input and maintenance billing messages that appear at the bottom of the guarantor statement. The messages may be customized by the group for each financial class and by age of account**.**



Master Menu 1.7 Billing Messages	
Field Name	**Field Description**
Group Code	May use group all to print a message at the bottom of the statements for all groups
Financial Class	Enter the FN class warranting the message
Age	Enter the account age warranting the message. (Age 0= 1st statement)
Line	This is used to keep track of the message. This does not mean it will print on a separate line.
Text	The current statement will only allow 7 lines.

Master Menu 1.8 Management Group

Purpose: To define each group or entity that is a part of the client. Fields not defined are no longer used on this file. ****Be sure MM 2.3 Specialty Codes is setup BEFORE group master****



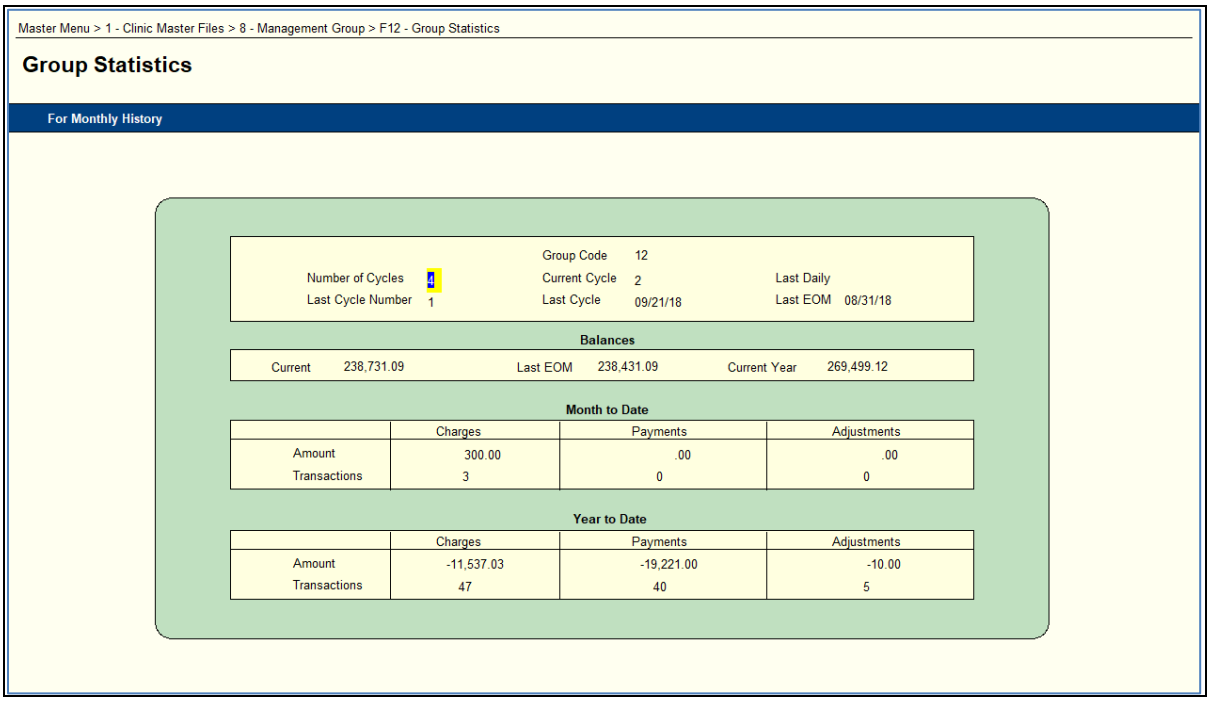
Master Menu 1.8 Management Group	
Field Name	**Field Description**
Group Code	Alpha 10 character max. Group code will appear on all reports and screens.
Master Group	To group like groups together for reporting. Click on Master Group button to access Master Group table for insert of a Master Group.
Short Name	Enter Group Short name. Displays on the new medinsguide form, see MM1.21, Insurance Name Conversion, CTRL A. Note: This is currently only being used by one client.
Group Name	Block 33 of CMS-1500 identifying where carrier is to send payment. Appears on Statement in the Remit and Return address field. Appears on reports and screens. Only room on CMS-1500 for 29 characters. Must be entered exactly as credentialed.
Group Name2	This field only appears on Statements. If you do <u>not</u> want this field to appear on statements, enter medoption: rptname= medptstm, options=N, whichop=O.
Address One Address Two	Block 33 of CMS-1500 identifying where carrier is to send payment. Appears on Statement in the Remit and Return

	address field. If return address is different, notify Operations. Operations will send return mail to the separate address. Reference Alt tabs on pages 34-35.
City, State and Zip Code	Enter the City, State and Zip Code+4 digits (required by 5010)
Billing Office	Top of Block 33 on CMS-1500 and on statements.
Contact	Additional number that can be used to contact the client; sometimes referred to as a back office line. Medoption available to print contact phone number from the Group Master instead of Billing Co. phone # on the bottom of the Patient Recall Letter. Medoption available to have contact phone number print on the statement rather than the Billing Co. phone #.
Fax	Fax number for client
Contact Email	Will print on patient's statement for optional method to contact office.
Office Code	Used for Internal reports. . (Billing co name is entered in Office Code)
Max Patient Billings/Dunnings	Limits how many dunnings the patients will receive without any new charge, payment or adjustment posting.
Collection Letter	The age that a pre-collect letter will be sent rather than a statement.
Patient Schedule Days	How far in advance do you want the system to generate a schedule. The default is 90 days. Starts at 0.
Patient Schedule Purge	Leave blank for no purge – enter number of days to keep schedule before purging
Patients Scheduled Thru	Displays the latest date through which the appointment schedule is built
Auto Suspend Charges	Used to hold charges in a file that are awaiting to be matched to demographics that will later download. Medoption must be set.
Account Type	EB = Encounter billed. Client creates a new account every time the patient is seen. AB = Account billed. Same account used for all visits.
Auto Doctor Assign	A Y will cause the doctor that is stored on Medacct to default at charge entry.
Auto Acct Assign	A Y will let the system auto assign but can be assigned manually when necessary ie company acct.
Auto DrCode Assign	A Y will let the system auto assign but can be assigned manually when necessary ie non- referring doctor .
Auto Account	Same as Auto Guarantor number.
Auto Doctor	Enter the number the system should auto assign after. Last number assigned will be stored here.
Explode Chgs?	Allows test codes to explode. Medoichge will display the exploding charges but the claim screen, Medoiin2 will not.
Auto Guar Assign	A Y will let the system auto assign but can be assigned manually when necessary ie company acct.
Add End Date	Always answer Y. This will then show the end date for a service with a range date on the description on the acct detail transaction, Medoichge.

Auto Guarantor	Enter the number the system should auto assign after. Last number assigned will be stored here.
Allow Att as Ref?	Allow attending dr to be referring dr – must be reflected on Dr Master as well.
Specialty	ED if Emergency Room Client, AN if Anesthesia Client, and UC if Urgent Care. Please note: Specialty ED or UC will always set the referring doctor to equal the attending doctor when the group specialty is ED or UC. Some insurance companies may require the PCP to also be the referring doctor. In this case you would not want to use ED or UC as the specialty. If any other type client, the client can choose the abbreviation. **Users can go ahead and enter the abbreviation in this field prior to setting it up in the Specialty table.**
Past Due Age	Will flag accounts with exception code PD. A report will generate listing all accounts where the patient OR insurance balance has reached the age listed in this field.
Type	Used by our insurance program(s) to identify the CMS-1500 Block 25- that requires a Federal Tax ID. The Type tells the Insurance program where to pull the tax ID: **CL**=Clinical- Insurance program will look for each individual doctor for tax id when needed. **CP**=Combined Practice- Insurance program will look at each Group for tax id when needed. **HB**=Hospital Based-Insurance program will look at each Group for tax id when needed. **SP**= Solo Practice – Insurance program looks at the one doctor for a tax id. Only use SP when the group is a one Doc practice.
NPI	If you have a Group NPI, enter it here.
Fiscal Year End Month	For reporting and system accumulation of totals.
Use Group NPI	If marked with a 'Y' (blank assumes 'Y'), the group NPI number will be used as the billing NPI. If there is not a group NPI number this field must to be marked with an 'N', so the Individual provider NPI number will be used as the billing NPI on your claims. Depending on how the field is marked that's what will print in block 33A and the individual NPI will always show in block 24J.
Curryear and Currmonth	Displays the current system month and year
Tax ID	Block 25 of CMS-1500; either uses this field for the EIN (Employee Identification Number) or uses Doc table for the SSN. See Type for usage; When type is CL it first looks to Meddoctr table, if not there it looks here.
Taxonomy	Enter a Group Taxonomy Code for any insurance company that may require the group taxonomy number to appear in box 33b on an insurance claim form. If there is a group taxonomy number entered in this field the number will print in 33b on the 1500 form. As of Nov. 15, 2007 this will only apply to VT Medicaid, CT Medicaid, Ladies First, and Community Health payer 62149. If this field is left blank then the taxonomy

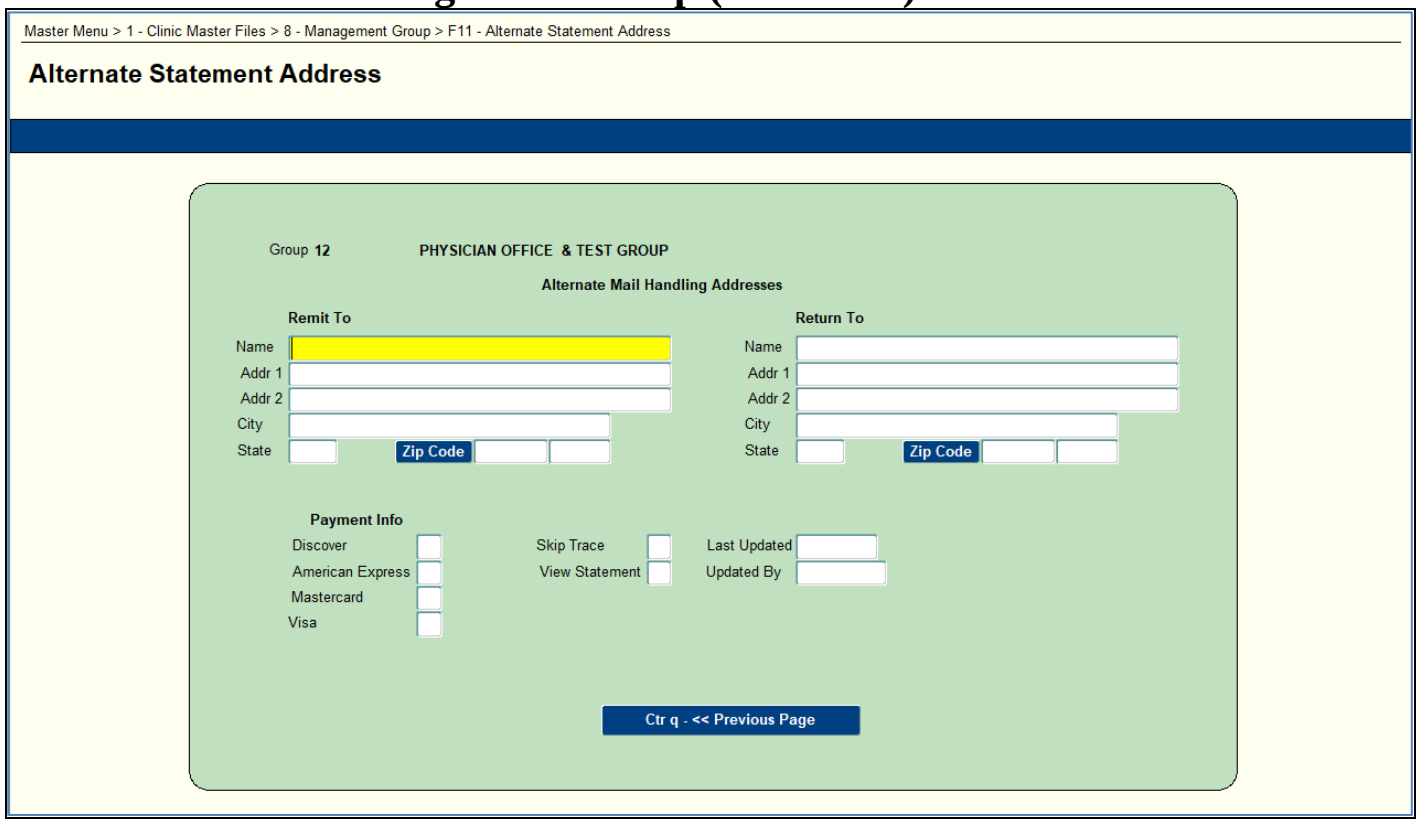
	number that is entered in the taxonomy field in the Doctor Master Record, MM 1.2 will print on the 1500 form.**NOTE**: In order for the group taxonomy code to print in block 33b your Client Manager will need to be notified for any carrier not mentioned above.
Minimum Bill Amount	Anything less than the amount entered in this field will not produce a statement.
DME Supplier Number	Provider number on DME claims. (Durable Medical Equipment)
Scan Bar Code	'Y' if using bar code on charge entry forms
Scan Vendor	If scanning vendor is known, enter name here
Server Name	If scan vendor server name is known, enter here
Client Revenue Percentage	
Percent	No longer used.
Ct	No longer used.
Cggrp	No longer used.
Defaults	
Location	Defaults at the time of charge entry.
Exception Codes	Defaults on Medacct.
Price Code	Defaults on Medacct.
Self-Pay	Defaults on Charge if pt doesn't have insurance
Account Status	A for active, W for wind down, I for inactive.
Accession Number	Y warns user to enter the number, M=Mandatory. Used for lab services billing tracking.
Update Exception Code	If this ='Y', then user can update exception code in medbchge and anebchge.
Print PIN Number	Users must enter a 'Y' to use the ePayment process. This field indicates to the application to print a PIN number on the patient's statements in order for them to make payments using a credit or debit card. Checks (ACH Transactions) will be added at a later date. Blank equals 'N'
Minimum ePayment Amount	This field is required if the 'Print PIN Number?' field is marked with a 'Y'. Users should enter the minimum amount allowed for a credit card payment. The amount must be between $1.00 and $99.00. Only whole dollars are allowed.
Minimum ePayment Percentage	Users can enter the minimum percentage that should be allowed for a credit card payment. If this field is entered but the 'Minimum ePayment Amount' field is left blank a warning will appear stating the minimum amount must be entered. If an arrangement has been made between the patient and the provider on what the patient's payments should be, then the payment amount that is stored on the Patient's Account (MM4-Minimum Pay field) will be displayed as the minimum payment in the ePayment forms. If the 'Minimum Pay' field on MM4 is zero, then the amount is calculated by multiplying the amount entered in the 'Minimum ePayment Percentage' field and the 'Statement Balance' value. This value is then compared to the 'Minimum

	ePayment Amount' field on MM1.8. The greater number is used as the minimum payment amount in the ePayment forms.
Statement PIN Valid (Days)	This field will automatically default to '27' whenever a user enters data into one of the fields listed above. Users are not able to update this field. The reason we use 27 days is a new statement is generated every 28 days plus for security reasons we want to limit the number of days that a PIN is valid.
Client URL	Users can enter their company web address. If populated, the web address listed will display on the statement as the website the patients should link to in order to pay their bill online. PLEASE NOTE- The customer is responsible to ensure their web site is working correctly. The customer is also responsible for adding a link on their web site that directs their patients to www.EZPayMed.com
UB04 Information	
Facility Type	This is concatenated with Bill Class and then a '1' to print at top-right of UB04 form in block "Type of Bill"
Bill Class	See Facility Type, above
Provider Numbers	FYI only. The Insurance program doesn't reference provider numbers from this table. If ins requires a legacy identifier (not use NPI) puts provider # in addition to NPI.
Last Updated	System will automatically stamp the system date when update was made.
Updated By	System will automatically stamp user that updated information.



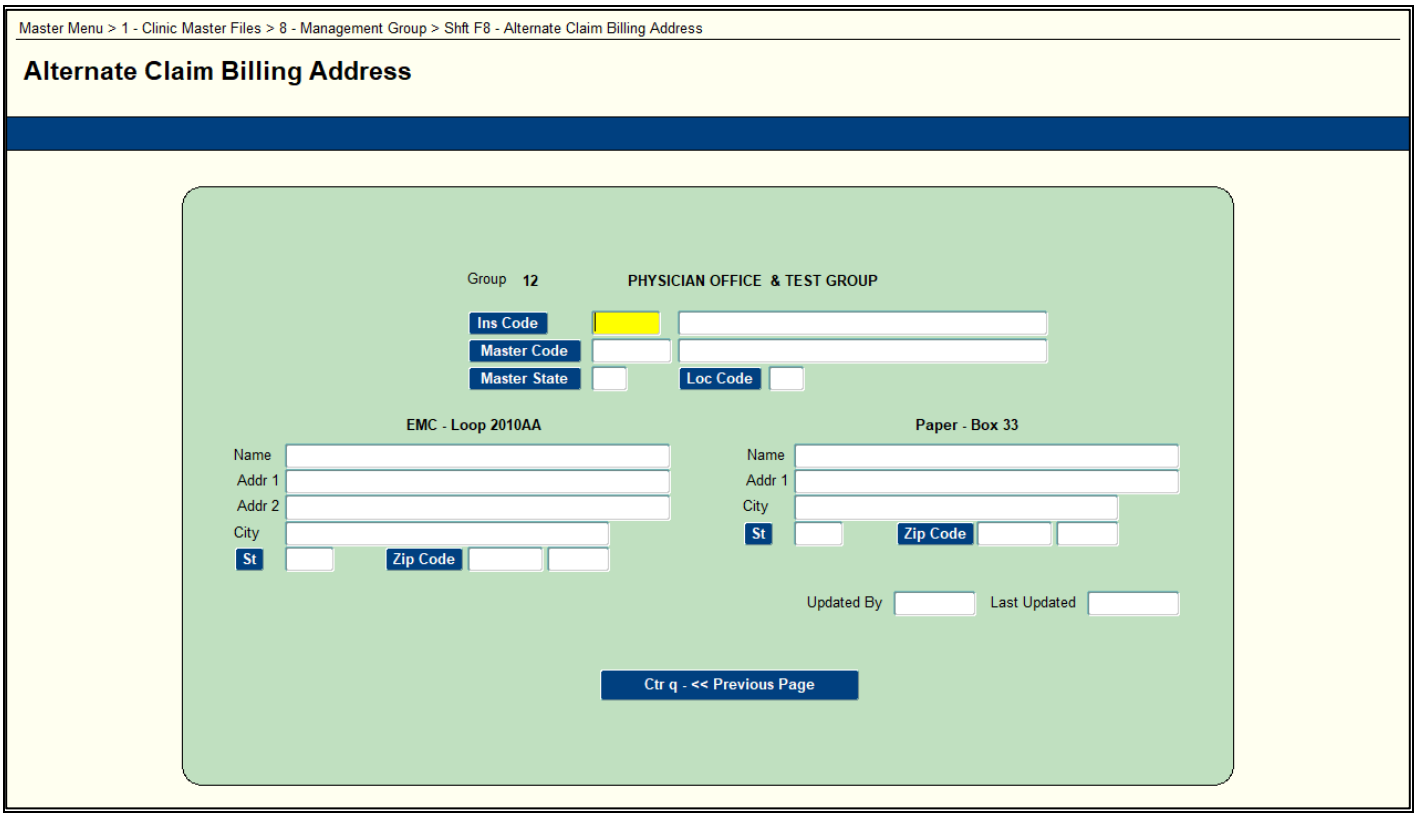
Group Statistics	Displays Statement and /or Collection Letter Billing Cycle information and current statistics for all providers in the Group.
Group	Identifies the Group you have accessed.
Number of Cycles	Identifies how many billing cycles the Group warrants. Statements cycles that run Friday nights will print the following Monday and be mailed Tuesday. If a claim is open, charges on that claim will not generate a cycle billing until the claim is closed. You cannot force a cycle billing for charges on an open claim. Statements that are RETURN coded or BAD ADDRESS statements/letters are returned to Paducah, then distributed and mailed to each client, at least twice a week.
Current Cycle	Billing Cycle the Group is currently set to
Last Daily	Not currently used.
Last Cycle Number	Previous billing cycle that generated statements and/or collection letters
Last Cycle	Displays run date of the last cycle.
Last EOM	Identifies Last day of Month that a Group generated a month end close
Balances, Current, Last End of Month, Current Year	Displays the current Balance, Balance as of Last End of Month, Balance as of Beginning of Current Fiscal Year. Displays month to date and year to date transaction data in dollar amount and number of transaction that comprises each area: charges, payments and adj.

Master Menu 1.8 Management Group (continued)



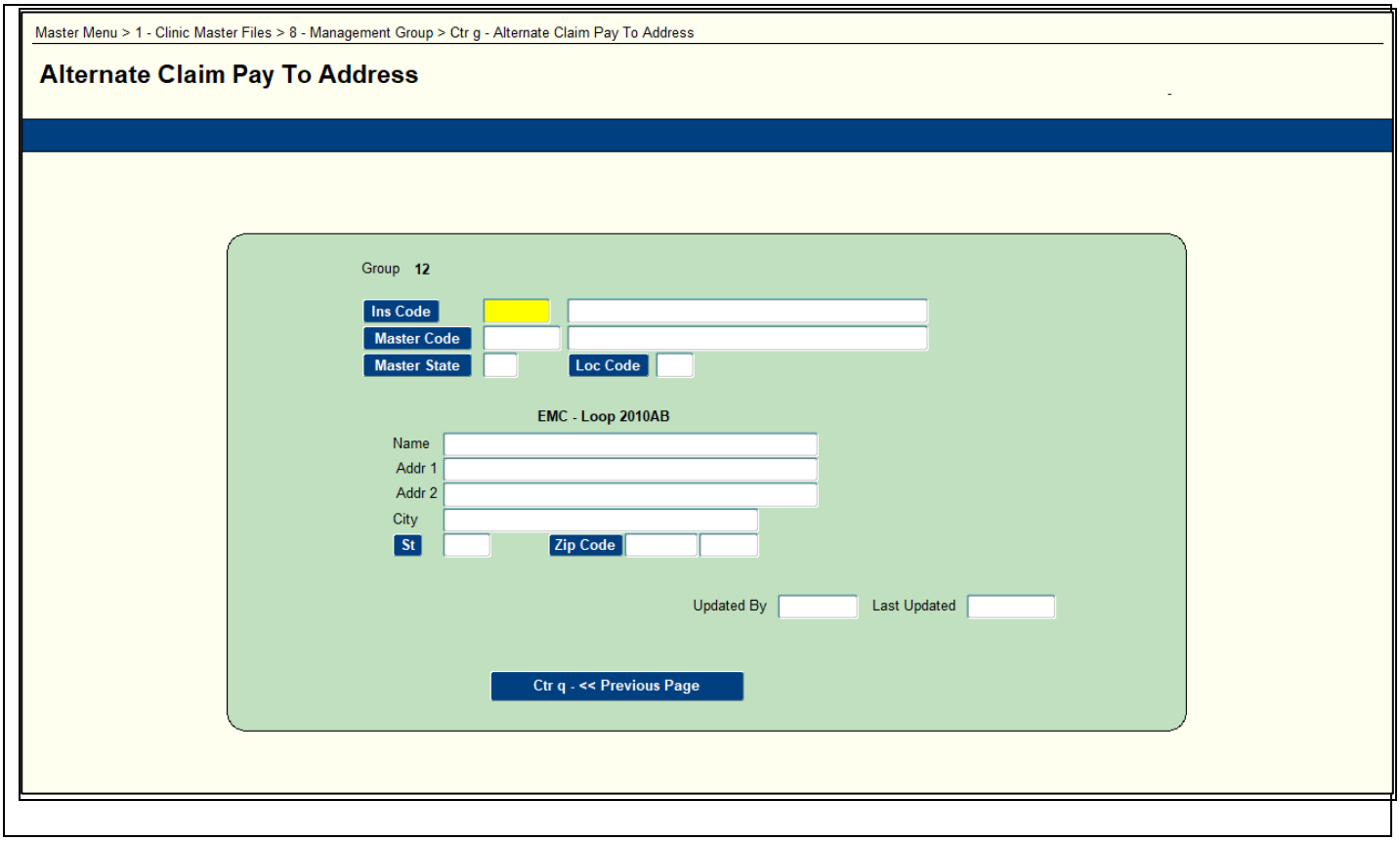
Alternate Statement Address	Will allow a user to modify information pertaining to patient statements.
Remit To	
Name	Enter if different than what is on MM1.8. Blank will default to information on MM1.8. This is where patient payments will be mailed to.
Addr1	Enter if different than what is on MM1.8. Blank will default to information on MM1.8
Addr2	Enter if different than what is on MM1.8, if applicable
City	Will default when zip code is entered
State	Will default when zip code is entered
Zip Code	Enter if different than what is on MM1.8
Return To	
Name	Enter if different than what is on MM1.8. Blank will default to information on MM1.8. This is where return statements will be mailed to.
Addr1	Enter if different than what is on MM1.8. Blank will default to information on MM1.8
Addr2	Enter if different than what is on MM1.8, if applicable
City	Will default when zip code is entered
State	Will default when zip code is entered
Zip Code	Enter if different than what is on MM1.8
Payment Info	
Discover	Enter a 'Y' if your office accepts this credit card. If 'Y' is entered, this credit card info will print on the patient's statement. Blank assumes No.
American Express	Enter a 'Y' if your office accepts this credit card. If 'Y' is entered, this credit card info will print on the patient's statement. Blank assumes No.
MasterCard	Enter a 'Y' if your office accepts this credit card. If 'Y' is entered, this credit card info will print on the patient's statement. Blank assumes No.
Visa	Enter a 'Y' if your office accepts this credit card. If 'Y' is entered, this credit card info will print on the patient's statement. Blank assumes No.
Skip Trace	This field can only be seen by Clinix staff. They will enter a 'Y' or 'N' depending on if a client is interested in this feature.
View Statement	This field can only be seen by Clinix staff. They will enter a 'Y' or 'N' depending on if a client is interested in this feature.
Last Updated	System will automatically stamp the system date when update was made.
Updated By	System will automatically stamp user that updated information.

Master Menu 1.8 Management Group (continued)



Alternate Claim Billing Address	
Ins Code	If applicable, enter the Insurance Code
Master Code	If applicable, enter the Master Code
Master State	If applicable enter the Master State
Loc	If applicable, enter the location
EMC- Loop 2010AA	If the group master has a PO Box entered as the billing address the user can keep the PO Box and enter a street address in the new Alternate Claim Billing Address Maintenance form. The claims program will still use the group master address as the billing address unless there is something entered in the Alternate Claim Billing Address Maintenance screen.
Paper- Box 33	If the group master has a PO Box entered as the billing address the user can keep the PO Box and enter a street address in the new Alternate Claim Billing Address Maintenance form. The claims program will still use the group master address as the billing address unless there is something entered in the Alternate Claim Billing Address Maintenance screen.
Update By	System will automatically stamp the system date when upate was made.
Last Updated	System will automatically stamp user that updated information.

Master Menu 1.8 Management Group (continued)

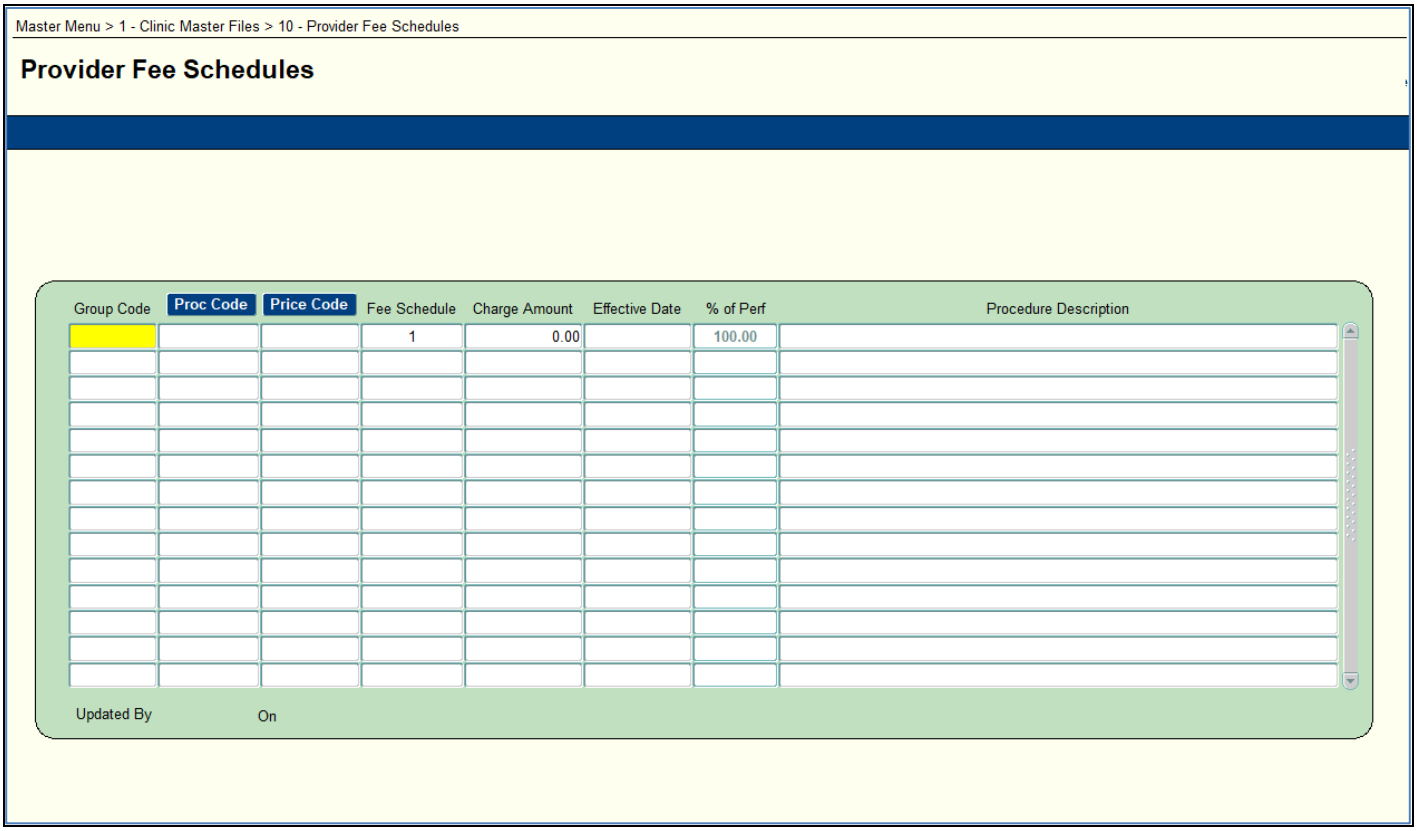


Alternate Claim Pay to Address	
Ins Code	If applicable, enter the Insurance Code
Master Code	If applicable, enter the Master Code
Master State	If applicable enter the Master State
Loc	If applicable, enter the location
EMC- Loop 2010AB	The pay to address is only needed if it's different from the billing address. However, if the pay to address needs to be a PO Box or Lock Box address the user can enter that address in the 'Alternate Claim Pay To Address Maintenance' form
Update By	System will automatically stamp the system date when update was made.
Last Updated	System will automatically stamp user that updated information.

Master Menu 1.10 Provider Fee Schedules

Purpose: This screen is used to input the fee that is to be charged with each procedure code for each group within the client database.

- NOTE: The client can supply Clinix with a spreadsheet containing the columns shown below and we will upload the data

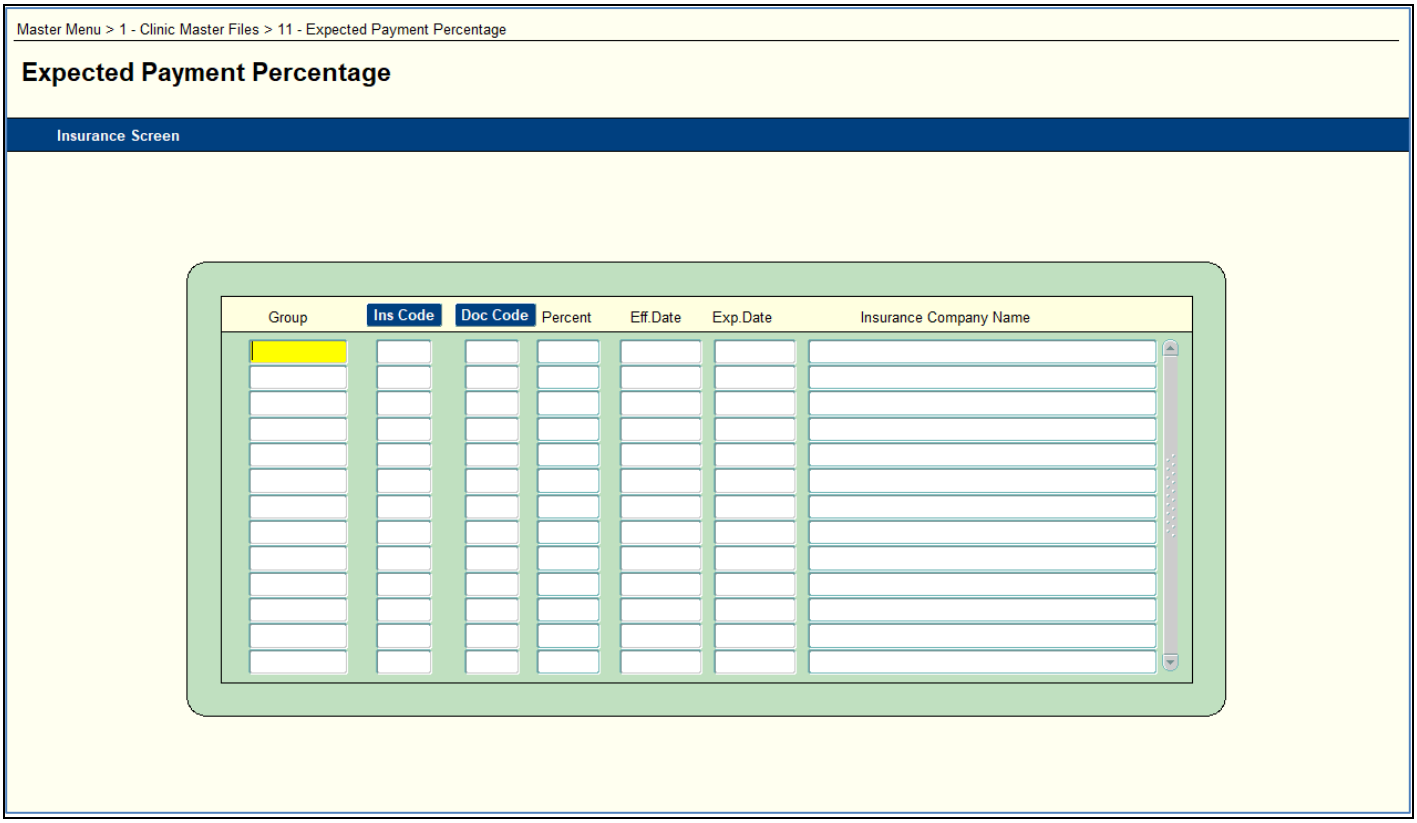


Master Menu 1.10 Provider Fee Schedules	
Field Name	**Field Description**
Group Code	Must be group specific
Procedure Code	Enter procedures warranting set fees. (May send excel file for loading if available.)
Price Code	Enter the Price Code as it relates to the charge. May use more than one price code.
Fee Schedule	If using more than one price within a price code, enter the appropriate fee schedule code. You may have up to 9 codes.
Charge Amount	Enter the few to charge for the procedure.
Effective Date	Leave blank on first entries to identify original price loaded into Clinix. (Unless a charge conversion takes place, then dates must be loaded on original entries.)
% of Perf	This defaults 100%.
Procedure Description	Defaults from procedure master.

Master Menu 1.11 Expected Payment Percentage

Purpose: This screen is used to identify insurance companies and what percentage of payment the group should receive. The report will print daily when a payment is posted for an insurance company that paid less or more than the percent indicated on this master file by looking at DOS.

NOTE: NOTIFY YOUR CLIENT MANAGER IF YOU DECIDE TO IMPLEMENT THIS OPTION

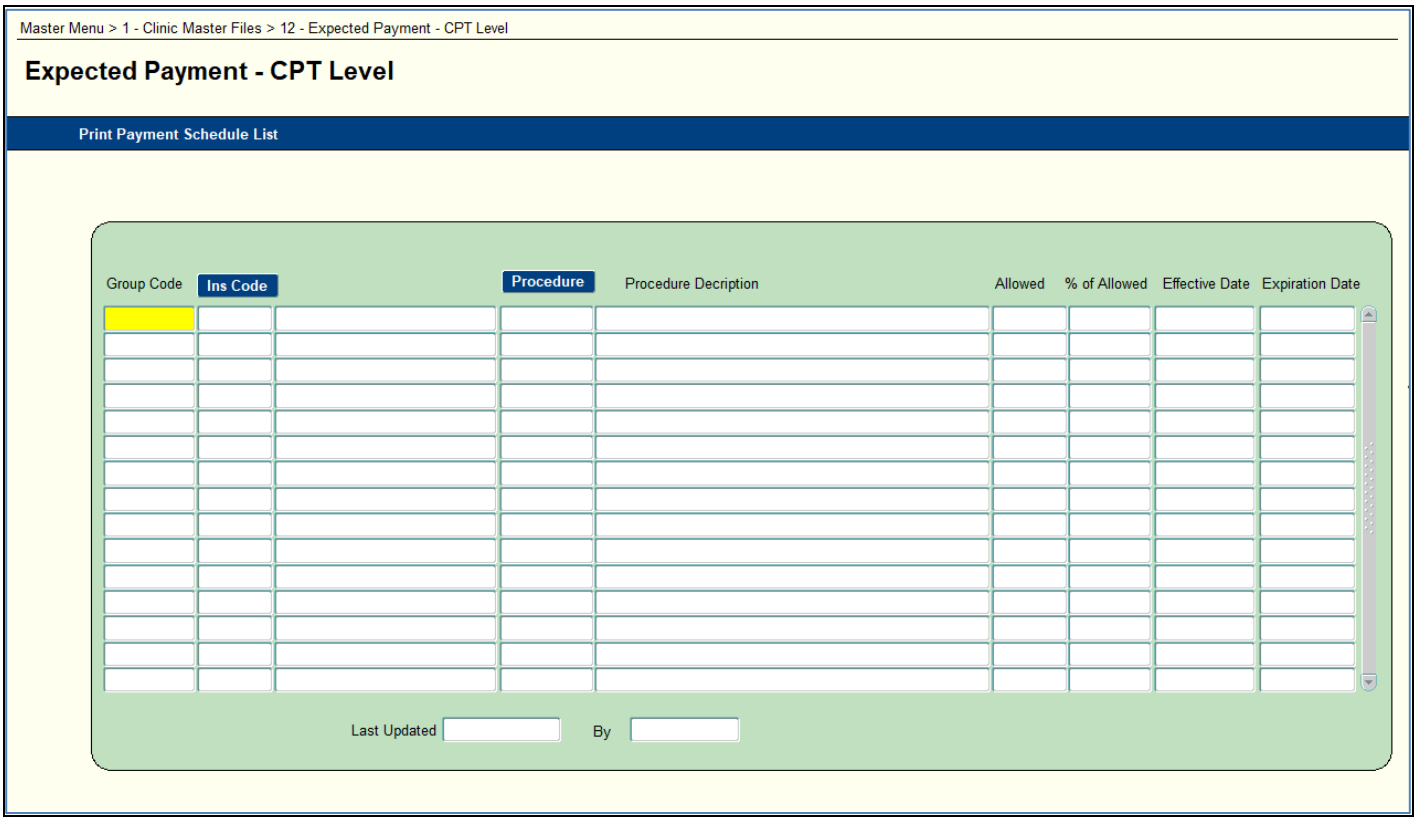


Master Menu 1.11 Expected Payment Percentage	
Field Name	**Field Description**
Group	When the contract is doctor specific, the insurance percentage must be entered by group. If the contract is for all doctors within a group, use ALL for the group code and enter the information in one record for that insurance company code.
Insurance Code	The Insurance Master File code (key code) that identifies the insurance company payments you want to report on.
Doctor Code	The Doctor Master File code that identifies the specific doctor if you need to track payments for certain doctors.
Percent	Percent of charge that payment is expected
Effective Date	Date of Service
Expiration Date	Date of Service
Insurance Company Name	Displays based on Insurance Code selected

Master Menu 1.12 Expected Payment –CPT Level

Purpose: To identify insurance companies and what dollar amount the group should receive for a specific procedure. This can be based on the payment posted or on the allowed amount entered at the time of payment posting. A medoption must be set to base the report on the allowed amount. When a payment or allowed amount falls above or below the pay amount entered on this Master File, an exception report will generate that day.

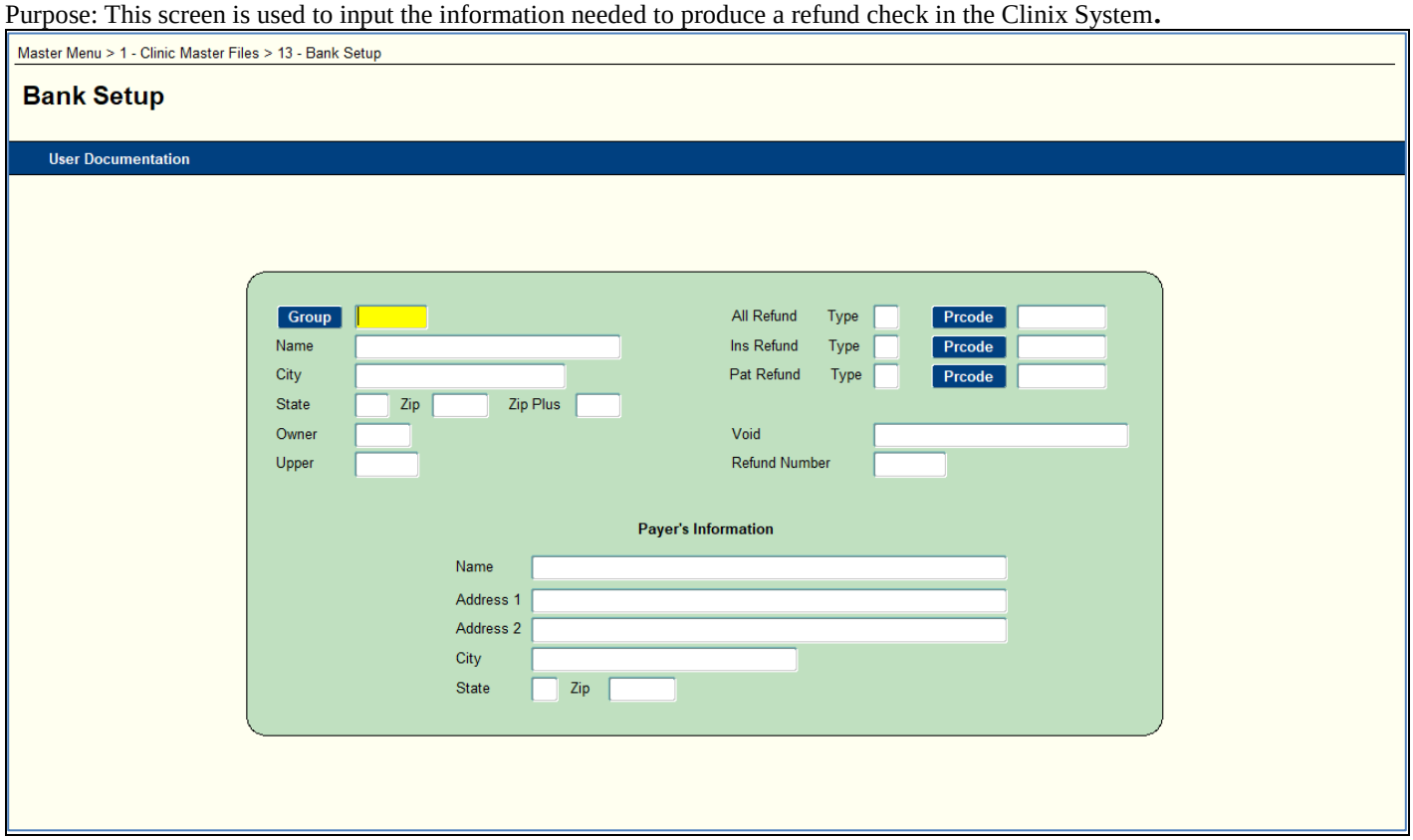
NOTE: NOTIFY YOUR CLIENT MANAGER IF YOU DECIDE TO IMPLEMENT THIS OPTION



Master Menu 1.12 Expected Payment – CPT Level	
Field Name	**Field Description**
Group	When the contract is doctor specific, the insurance percentage must be entered by group. If the contract is for all doctors within a group, use ALL for the group code and enter the information in one record for that insurance company code.
Insurance Code	The Insurance Key Code that identifies the insurance company payments you want to report on.
Procedure Code	The Procedure File code that represents the charge
Allowed	Allowed Amount
% of Allowed	Percentage of allowed for this Doctor/Insurance/CPT combination
Effective Date	Date of Service
Expiration Date	Date of Service

Master Menu 1.13 Bank Setup

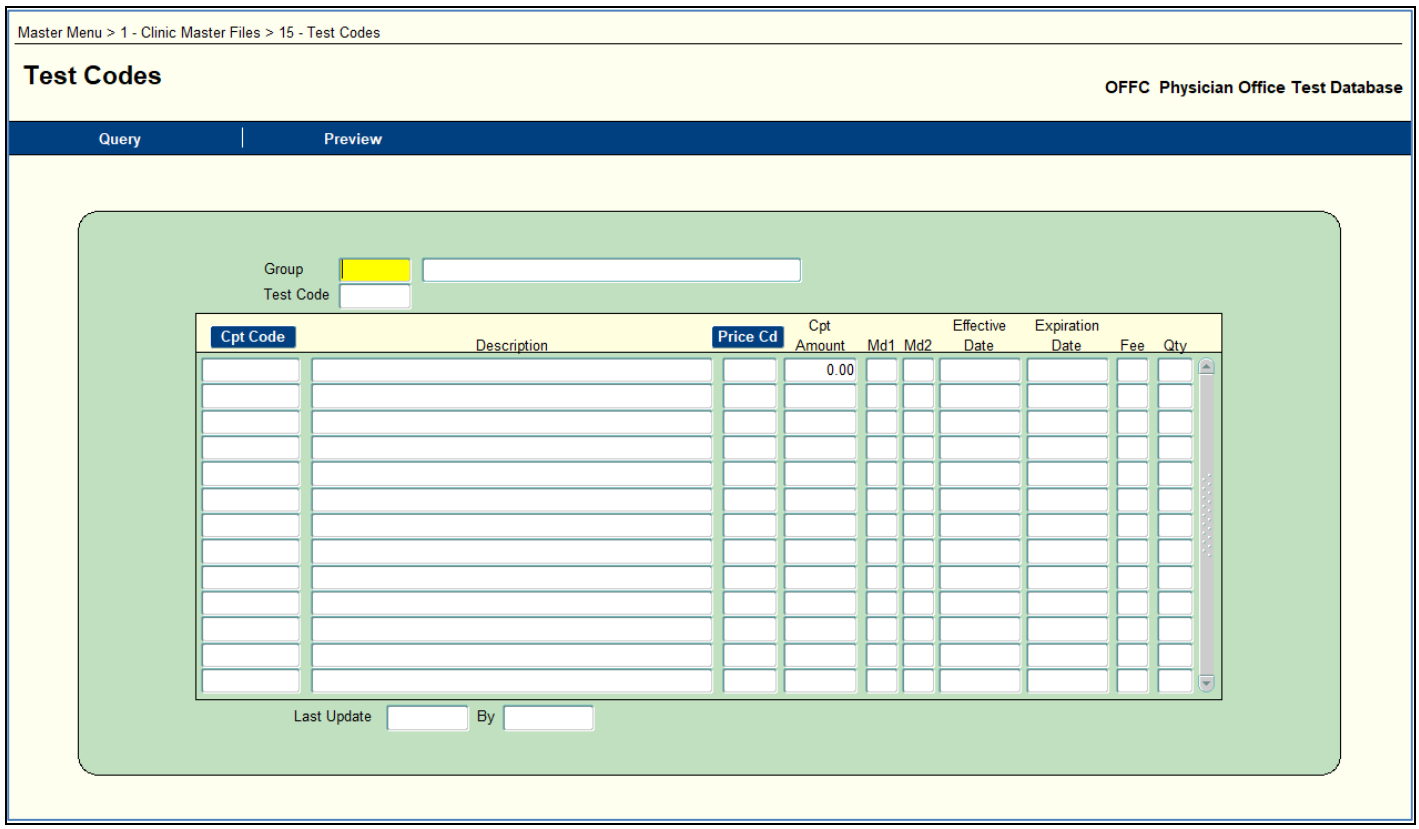
Purpose: This screen is used to input the information needed to produce a refund check in the Clinix System**.**



Master Menu 1.13 Bank Setup	
Field Name	**Field Description**
Group	Management Group Code
Name	Bank Name if not pre-printed on checks
City, State, Zip and Zip Plus 4	Bank City, State and Zip if not pre-printed on checks
Owner	Bank owner number if not pre-printed on checks
Upper	Bank routing number if not pre-printed on checks
All Refund Type	P or A, depending on acct practices
Prcode	Procedure Code that can be used for ALL refunds
Ins Refund Type	P or A, depending on acct practices
Prcode	Procedure Code used for only Insurance Refunds
Pat Refund Type	P or A, depending on acct practices
Prcode	Procedure Code used for only Patient Refunds
Void	If desired, enter “Void after XX days”
Refund Number	Starting number less one for refund checks to be issued to carrier – can leave this blank
Payer’s Information	Name and address to appear on check if other than name and address on group master. Put the word ‘BLANK’ in the payer name to leave the payer name and address blank on the check as pre-printed checks might already contain this information.

Master Menu 1.15 Test Codes

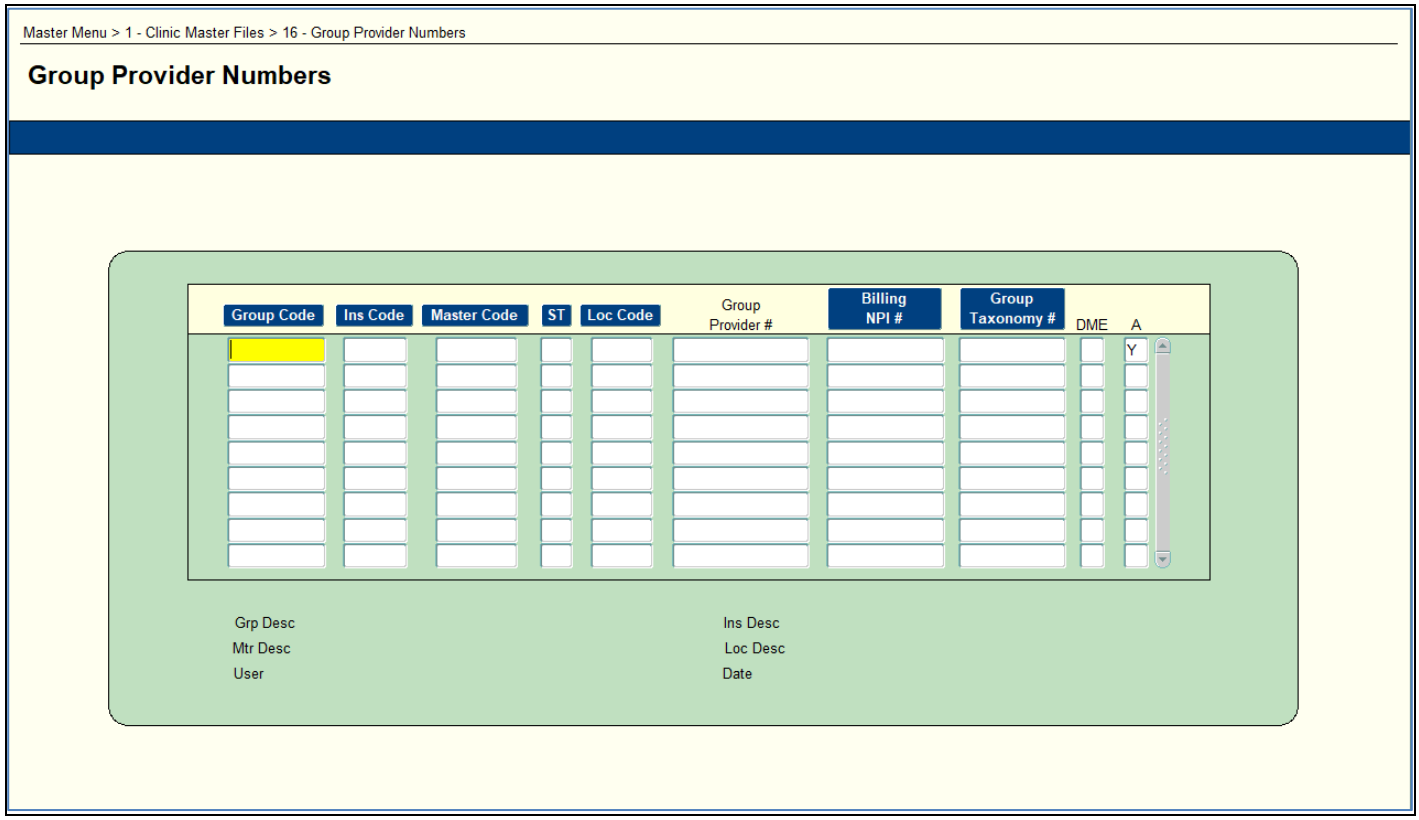
Purpose: This screen is used to define test or 'explode codes' that consist of multiple CPT codes. Each CPT code is defined and priced underneath the 'explode code'. Each explode code must be defined and total price entered in the Procedure Codes Maintenance screen**.**



Master Menu 1.15 Test Codes	
Field Name	**Field Description**
Group	Must be Group specific
Test code	Procedure code from Procedure Code Master File that will identify Test code
CPT code	List all CPT codes that should be associated with the Test Code
Description	Will default from Procedure Master File
Price Code	Select the Price Code to be used to apply the charge amount
CPT Amount	Type in the dollar amount of the code
Modifier1, Modifier 2	If modifiers are applicable, enter here. These modifiers will be used. Modifiers on Medproc will not be used even if these are null.
Effective Date	Date of service
Expiration Date	Date of service
Fee	Enter 1 unless you have multiple doctors in a group that have more than one fee schedule
Quantity	Number of units

Master Menu 1.16 Group Provider Numbers

Purpose: To define the Group Provider Numbers that are needed for filing insurance claims. The Provider Numbers may be entered for each unique Ins Key Code, or if several Ins codes need the same provider number, the provider number may be entered using the Master Code only.

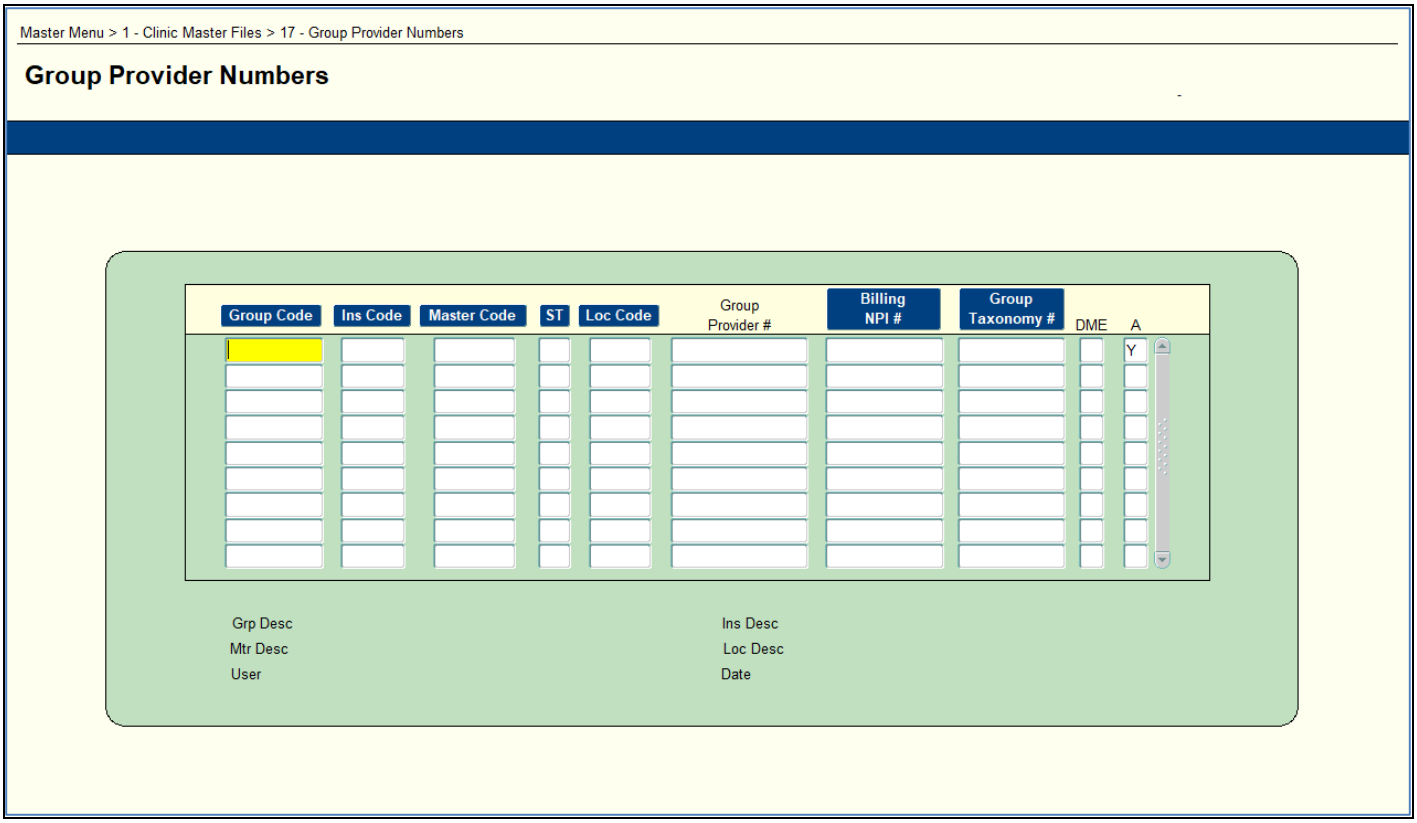


Master Menu 1.16 Group Provider Numbers	
Field Name	**Field Description**
Group Code	Group associated with provider number
Insurance Code	Only enter if Group Provider Number must be for a specific Key Code in the Insurance Master file. If Key Code is entered, the Master Code will automatically display
Master Code	If the Group Provider number can be used for all Key Codes that fall under a Master Code umbrella, enter the Master Code only.
State	Only enter if Group Provider Number is state specific
Location Code	Only enter if Group Provider Number is location specific
Group Provider Number	Number assigned by carrier to appear in block 33
Billing NPI #	This field can be used to enter an alternate Billing NPI that will display in Box 33a if different at the insurance level from the standard NPI.
Group Taxonomy #	This field can be used to enter an alternate Group Taxonomy code that will display in Box 33a if different at the insurance level from the standard Taxonomy code.

DME	If an insurance key code or insurance master should file on a DME claim with a different Billing NPI and/or Group Taxonomy you will enter a 'Y' in this field.
Active	Enter an "N" to de-activate a record. Records cannot be edited for audit trail purposes
Group, Insurance, Master and Location Description	Displays from Master Files
User name and Date	Auto stamps upon commit

Master Menu 1.17 Individual Provider Numbers

Purpose: To define the Doctor Provider Numbers which are needed for filing insurance claims. The Provider Numbers may be entered for each unique Ins Code, or if several Ins Codes need the same provider number, the provider number may be entered using the Master Code only.

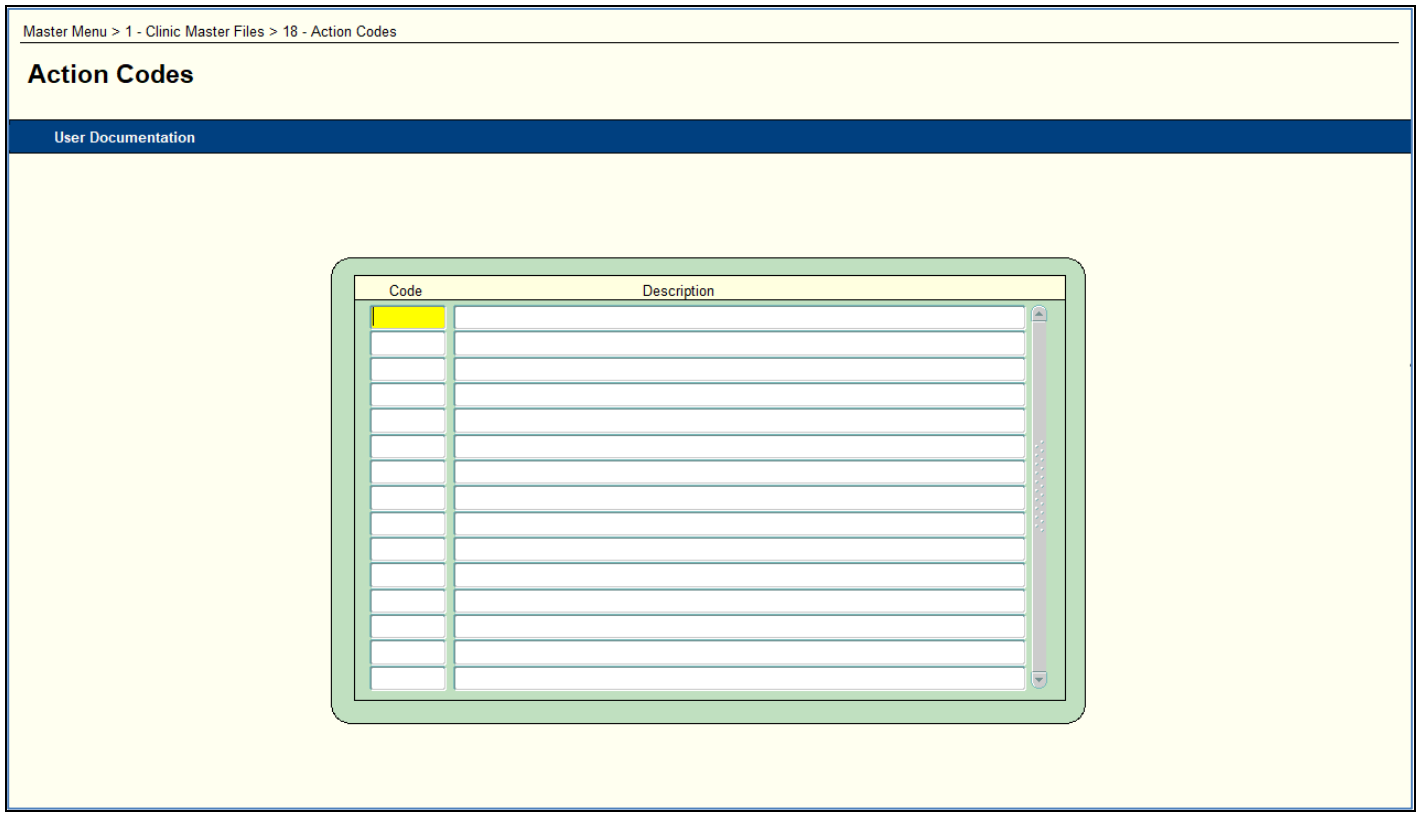


Master Menu 1.17 Individual Provider Numbers	
Field Name	**Field Description**
Group Code	Group associated with provider number
Doctor Code	Doctor code from Doctor Master File
Ins	Only enter if Doctor Provider Number must be for a specific Key Code in the Insurance Master file. If Key Code is entered, the Master Code will automatically display

Master Code	If the Doctor Provider number can be used for <u>all</u> Key Codes that fall under a Master Code umbrella, enter the Master Code only.
State	Only enter if Doctor Provider number is state specific
Location Code	Only enter if Doctor Provider Number is location specific
Individual Provider Number (24J)	Enter Doctor Provider Number if you want it to appear in block 24J of CMS-1500. Some states require additional information when loading referring docs that needs to be in either block 19 or 17 on the 1500 form. Users will need to load that information into this field and the system will pull it into the appropriate block. **24J (if populated) will print in block 17 for:** NY Medicaid, MS Medicaid, VA Medicaid, MA Medicaid, PA Medicaid, IN Medicaid, NC Medicaid, MT Medicaid, MI Medicaid (prov type plus 24J), and MI blue shield **24J (if populated) will print in block 19 for:** KY Medicaid and. SC Medicaid hmo Other states not listed will need to be programmed first to the appropriate box. *Some examples of state specific additional info-KY is Kenpac, NC is Access Number*
Individual Provider Number (33 PIN)	Enter Doctor Provider Number if you want it to appear in block 33 PIN of CMS-1500
Individual EMC Number	Only enter if Doctor Provider Number is different when filing and electronic claim
Provider Type	Enter if applicable
Biller Code	Enter if applicable
Tax Suffix	Enter if applicable
Active	Enter a D to de-activate a record. Records cannot be edited for audit trail purposes
Group, Insurance, Master, Location, Insurance Carrier, and Doctor Description	Displays from Master Files
User name and Date	Auto stamps upon commit

Master Menu 1.18 Action Codes

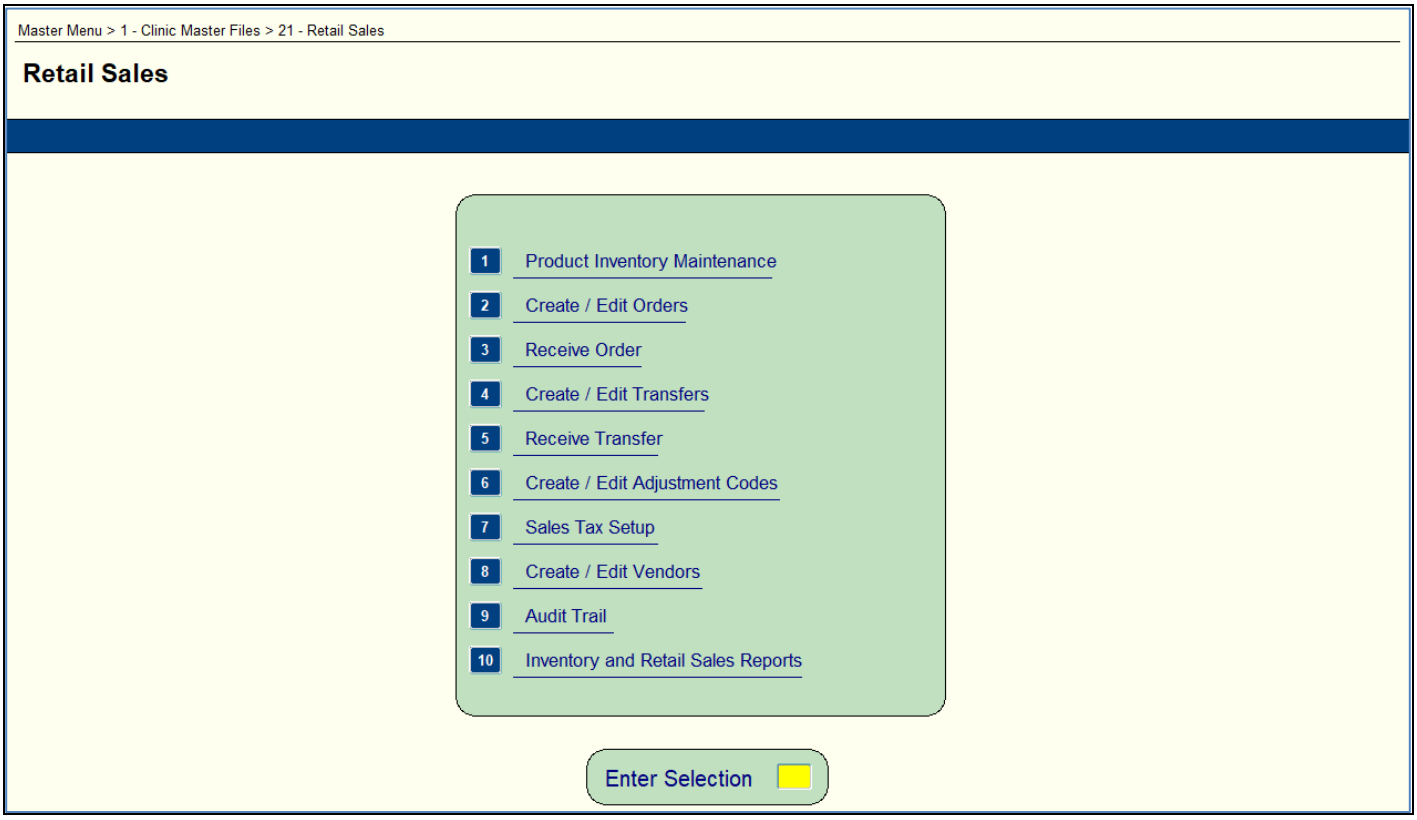
Purpose: Action Codes can be used when entering comments on Patient Accounts and are convenient for populating text without having to enter all the words. Code VERIF is used to pull information into Scheduling Report 8926 - Insurance Verification Report.



Master Menu 1.18 Action Codes	
Field Name	**Field Description**
Code	Action Code – alpha-numeric, 5 characters
Description	Enter the description of the action code

Master Menu 1.21 Retail Sales

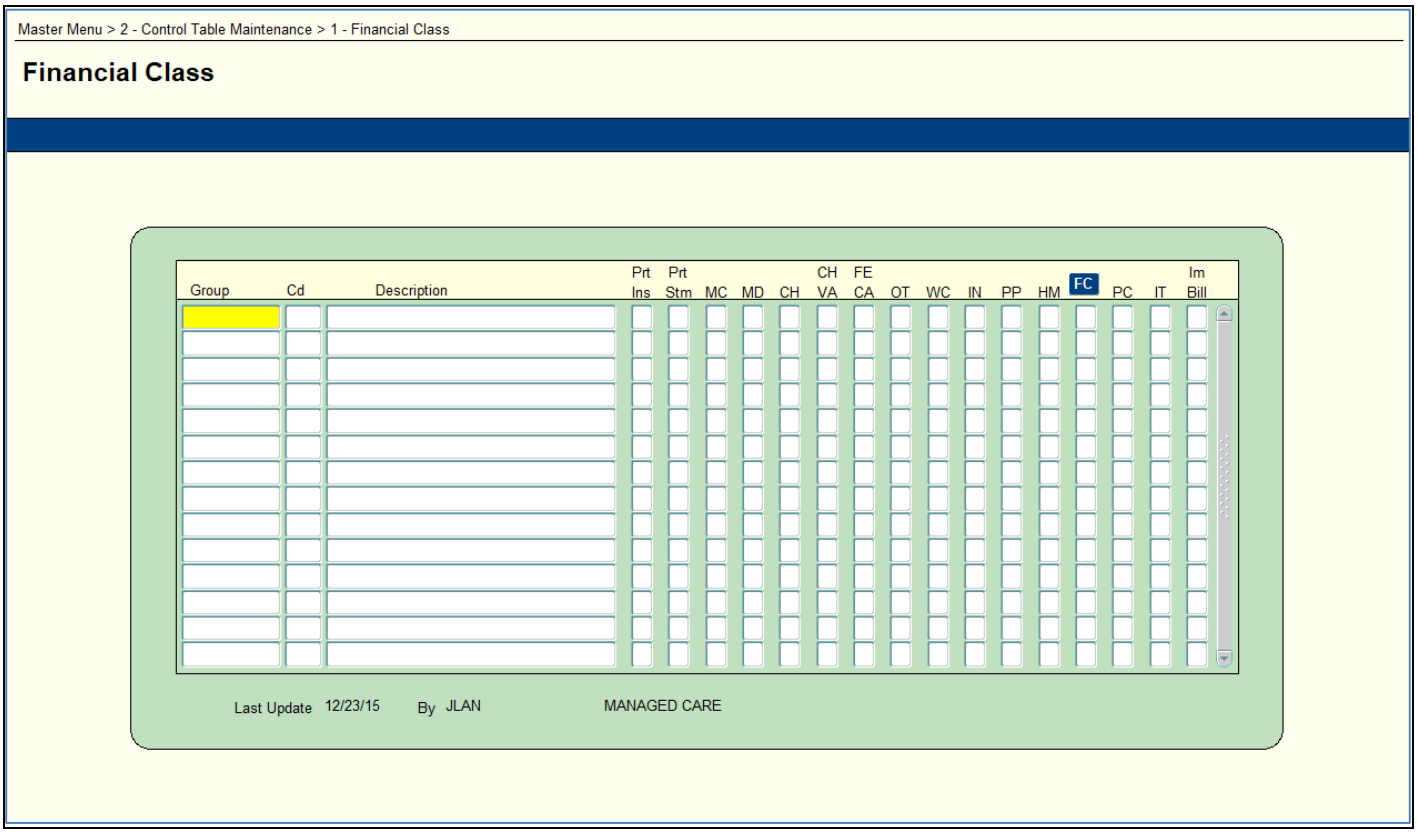
Purpose: These tables can be set up if a client wishes to post products and payments. Please contact your Client Manager before completing any retail sales tables to obtain a separate retail sales document. There are behind the scenes programming tasks that must be completed prior to posting products.



Master Menu 2.1 Financial Class

Purpose:

- Set up Financial Class Codes that will identify a patient's primary insurance and is used for reporting purposes and used in the creation of statements and insurance claims.
- Set up a Price Code to be used to identify procedure fees.
- Set up Insurance Types for Insurance claim billing and reporting.

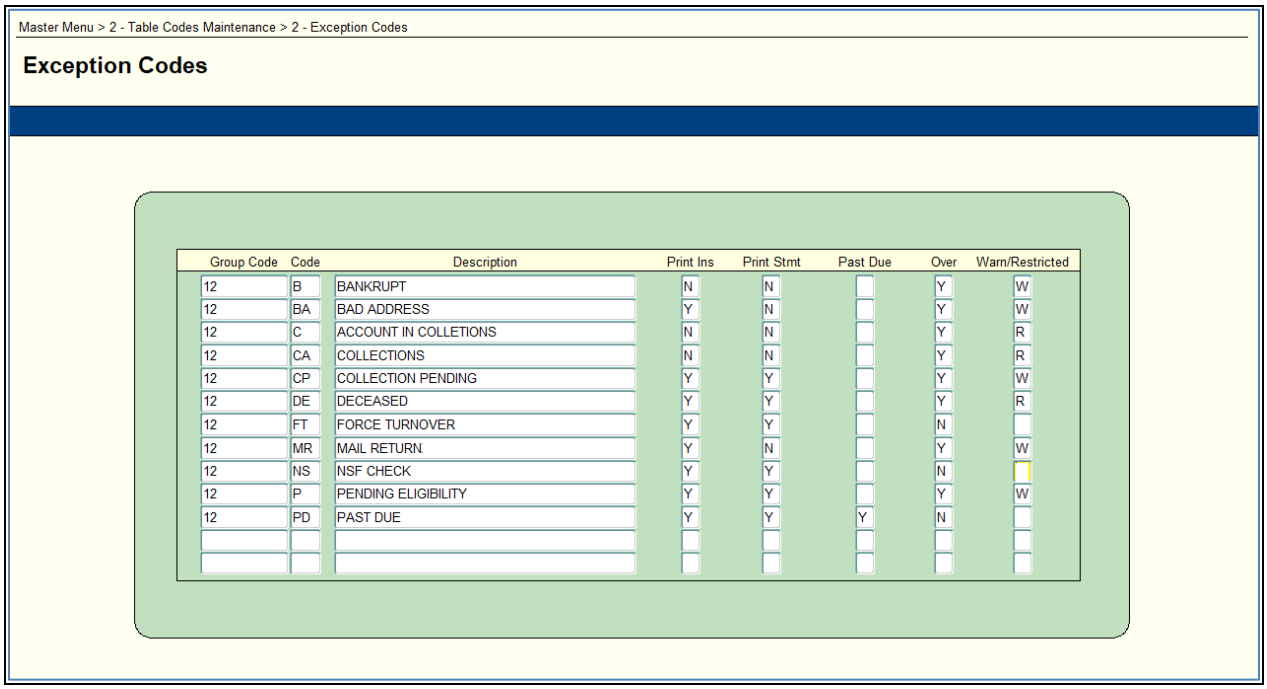


Master Menu 2.1 Financial Class	
Field Name	**Field Description**
Group	Must be group specific.
Code (“Cd”)	May be alpha or numeric, 2 characters.
Description	Free text
Print Insurance (“Prt Ins”)	IT driven not FN class. (Y or N)
Print Statement (“Prt Stm”)	IT driven not FN class. (Y or N)
MC,MD,CH,CHVA,FECA (black lung,) OT (Other):	Identifies which box to be checked on CMS-1500 Block 1 and used for Insurance program. X should go under the appropriate column except for BCBS, use a B under OT instead of X.
Worker’s Compensation	Identifies that code as WC for Insurance program specifics and demographic interfaces
Industrial Medicine	Not used at this time
Private Pay	Various Clinix programs need to know which codes are self-pay.
Health Maintenance	Not used at this time
Financial Class	X if it’s a Fin Class code.
Price Code (Fee Schedule)	PP is used for encounter billed accounts for the CPS logic. The PP is used to know that an account using our CPS logic has gone to Patient pay. If all insurances have paid, then we look for a record where the PP =X to know what FC code to set the CPS field with on that patient so that it is Patient Pay. If

	there is more than one record in the FC table marked with PP=X for that group, then we get the default for Patient Pay in the group master on page 3.
Insurance Type	X if it's an Insurance Type.
Im Bill	Y if Immediately send bill to patient

Master Menu 2.2 Exception Codes

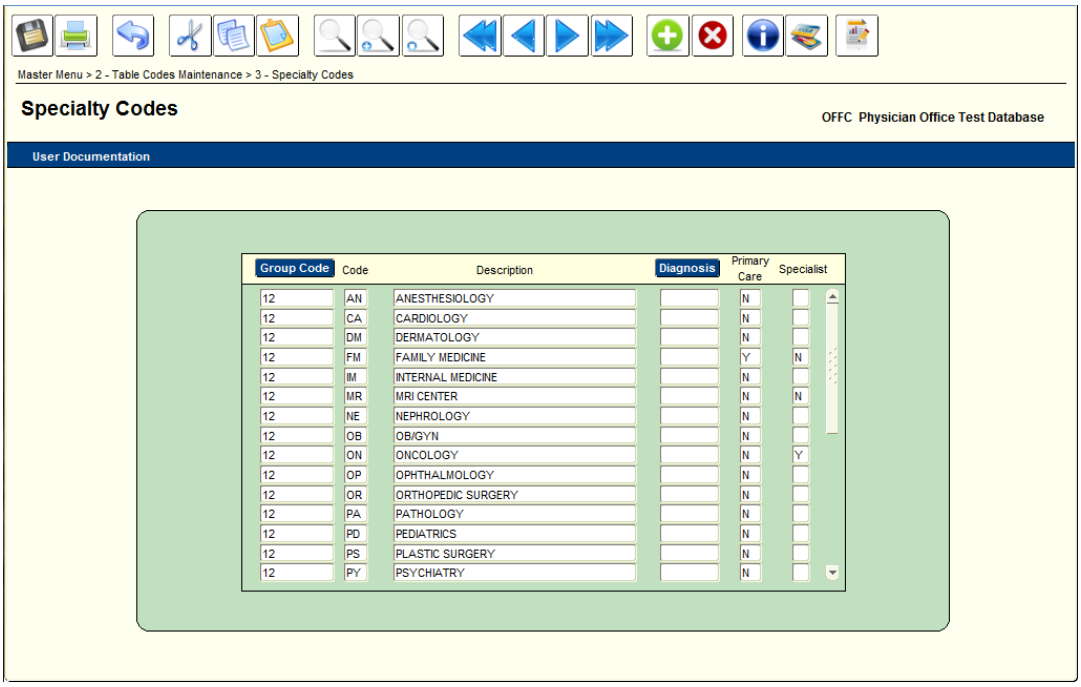
Purpose: Can be used to note specifics about an account and may be used to prevent the generation of a claim or statement. May also be used to cause an appointment scheduler to override, bring the accounts exception to the scheduler's attention. Can also be used as a means to identify the status of the account regarding user activity.



Master Menu 2.2 Exception Codes	
Field Name	**Field Description**
Group Code	Group specific
Code	Alpha or numeric, 2 characters
Description	Free text
Print Insurance ("Prt Ins")	Enter N to prevent claim generation
Print Statement ("Prt Stmt")	Enter N to prevent statement generation
Past Due	Enter Y for the exception code designated to use when acct age is past due
Scheduling Override ("Over")	This field will need a 'Y' entered if you want to receive a popup message when an appointment is being booked for a patient that has an exception code attached to their account. This will alert you that an action may need to take place before the appointment is booked. If the exception code does not need an alert enter an 'N' in this column.
Warn/Restricted	This is a required field if there is a 'Y' in the Over field. The options are 'W' Warn or 'R' for Restrict. For the W it will allow a user to bypass the popup and book the appointment and for an R the user will not be able to bypass the popup and complete the appointment unless there is a privilege set on MM1.28.

Master Menu 2.3 Specialty Codes

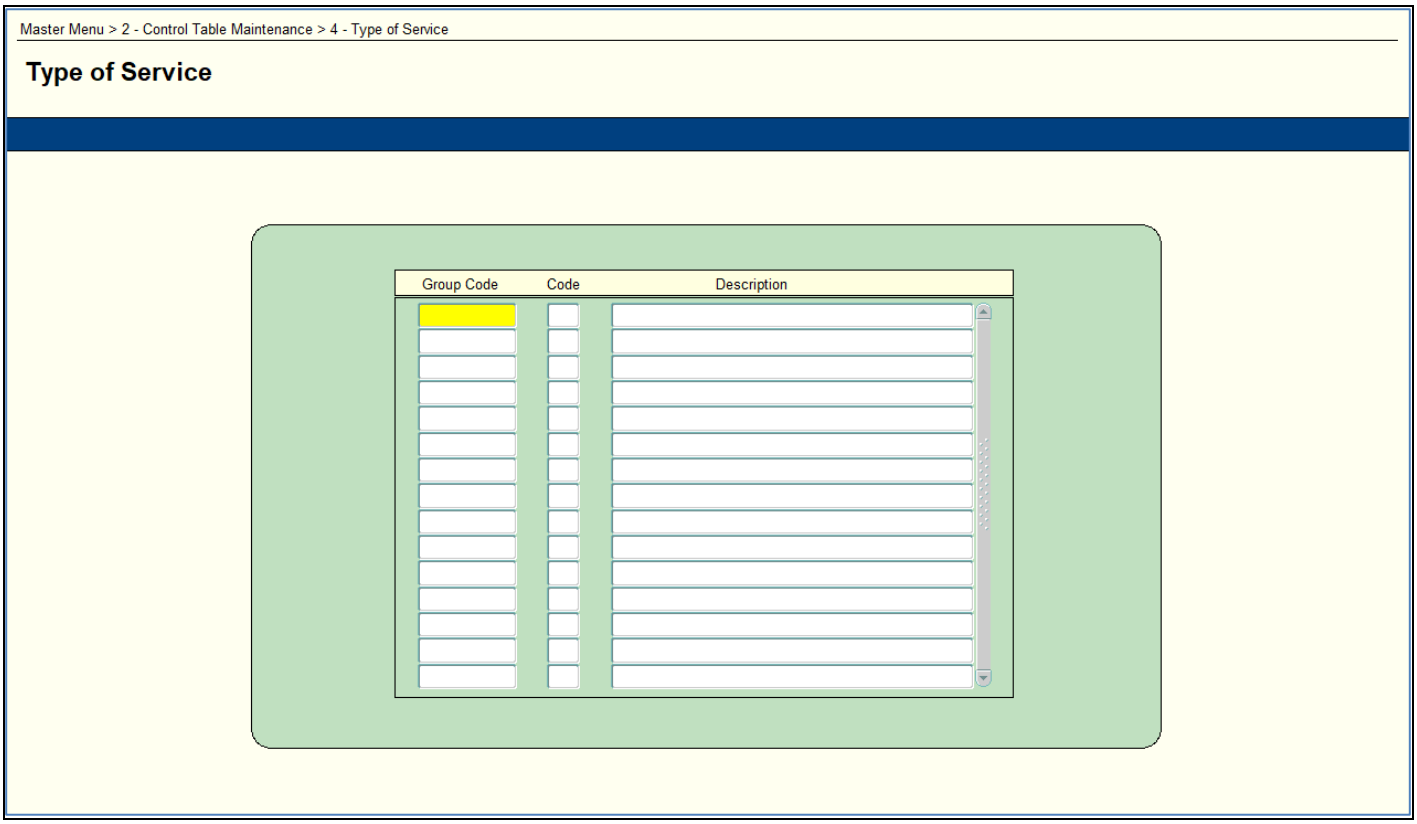
Purpose: Used to identify special needs required for certain services and for reporting. Also used in conjunction with appointment scheduling functions.
Note: Anesthesia clients must enter AN, Emergency Department must enter ED.



Master Menu 2.3 Specialty Codes	
Field Name	**Field Description**
Group Code	Must be group specific.
Code	Can be alpha or numeric. Only AM, Ambulance, AN, Anesthesiology and ED, Emergency Department, and UC if Urgent Care. Please note: Specialty ED or UC will always set the referring doctor to equal the attending doctor when the group specialty is ED or UC. Some insurance companies may require the PCP to also be the referring doctor. In this case you would not want to use ED or UC as the specialty. Codes are predefined, 2 characters.
Description	Free text.
Diagnosis	Not used
Primary Care	Used to note that the specialty is a primary care. A 'Y' will cause the authorization/referral check to bypass. Only "N" if pre-certs are required.

Master Menu 2.4 Type of Service

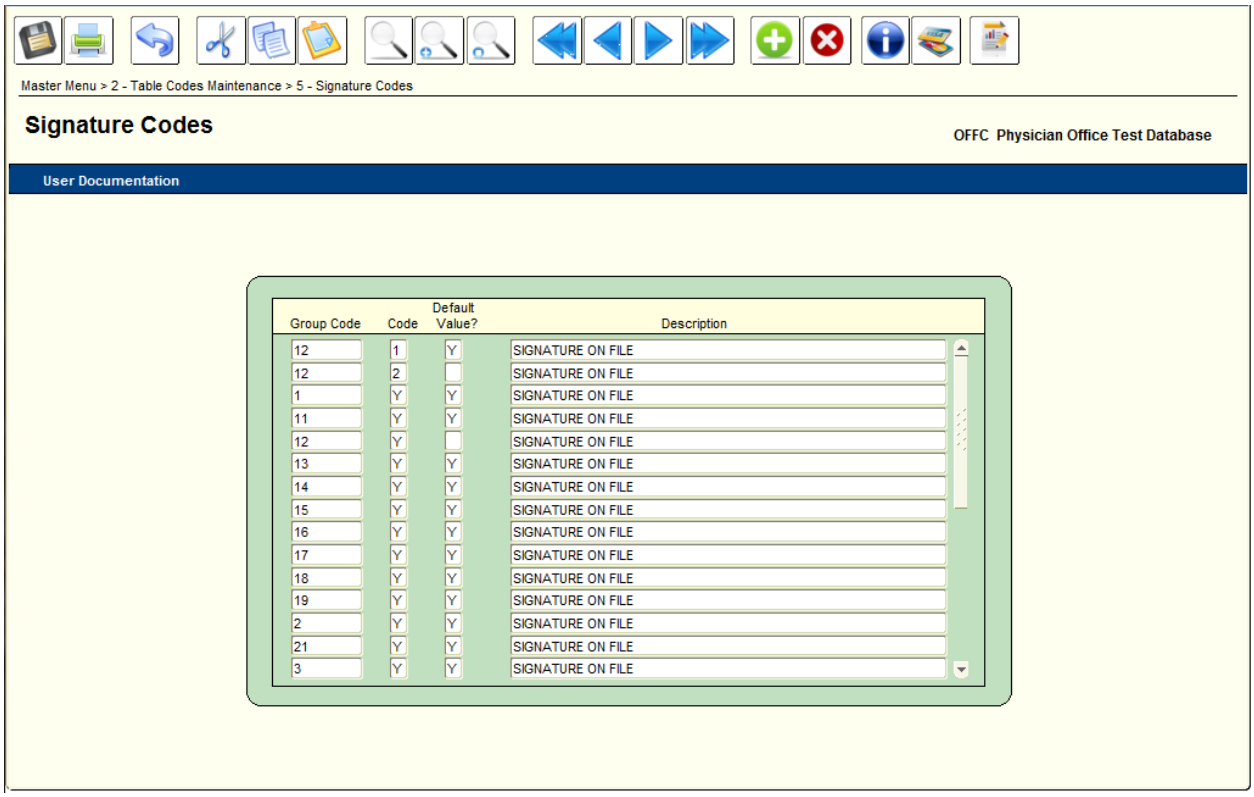
Purpose: Used for CMS-1500 billing



Master Menu 2.4 Type of Service	
Field Name	**Field Description**
Group Code	Must be group specific
Code	No longer required in CMS-1500 Block 24 C. However; internal programming still requires the TOS. If the TOS is anything other than a 1 or 2, the CPT code will kick out in the upfront scrubber as needing a referring doctor. Enter codes obtained from CMS-1500 billing guide.
Description	From CMS-1500 billing guide

Master Menu 2.5 Signature Codes

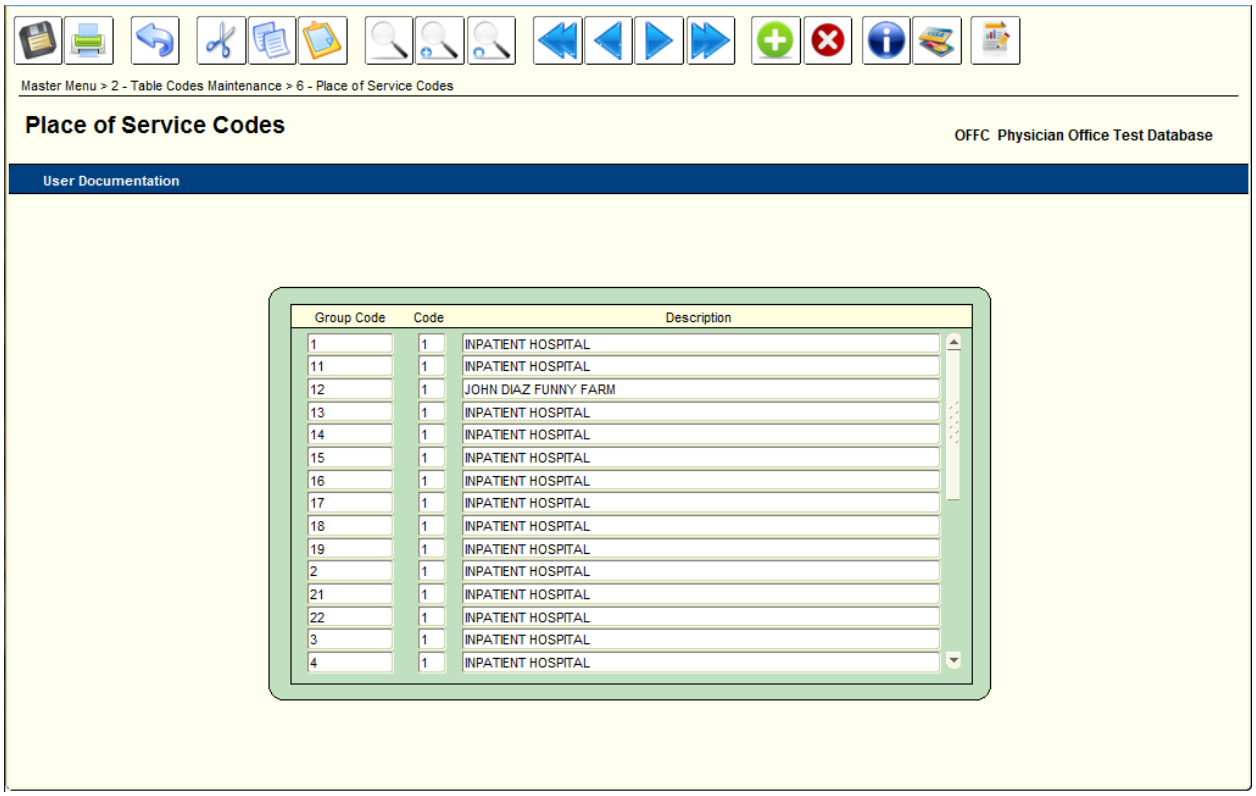
Purpose: Used for CMS-1500 billing. Accepted instead of written signature on claim.



Master Menu 2.5 Signature Codes	
Field Name	**Field Description**
Group	Must be group specific
Code	Code can be alpha or numeric, 1 character. Code represents the description you want to appear on CMS-1500 blocks 12 & 13.
Default Value?	If Y, that description code will default.
Description	“Signature on File” most commonly used.

Master Menu 2.6 Place of Service Codes

Purpose: Used for CMS-1500 Billing



Master Menu 2.6 Place of Service Codes	
Field Name	**Field Description**
Group Code	Must be group specific
Code	CMS-1500 Block 24-B. Enter codes obtained from CMS-1500 billing guide.
Description	From CMS-1500 billing guide

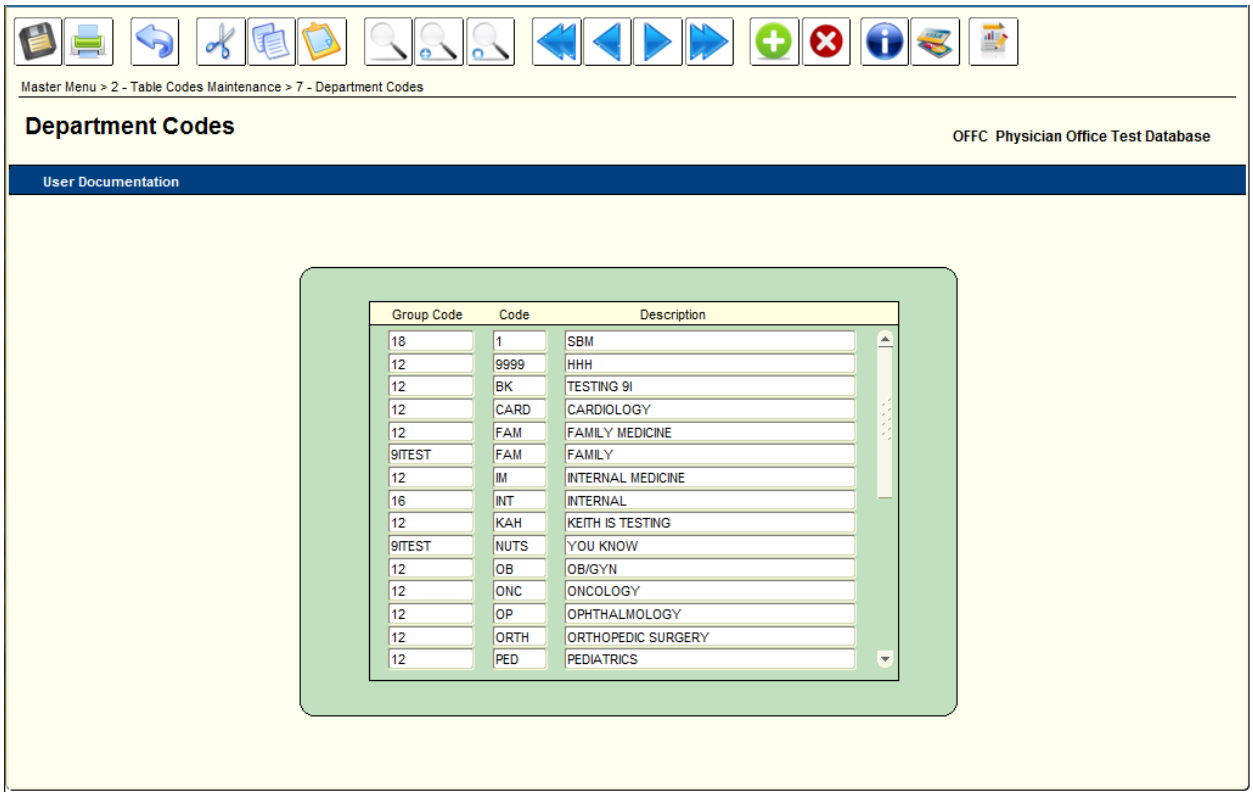
Master Menu 2.7 Department Codes

Purpose: This form can be used in a number of ways:

- The reception screen to pull appointments by department if you want all doctors within one department.
  - User may choose to print the appointments based on the Appt Department
- In charge load interfaces to determine if a particular group has a certain Dept code to assign a location.

Used to group ‘like’ doctor

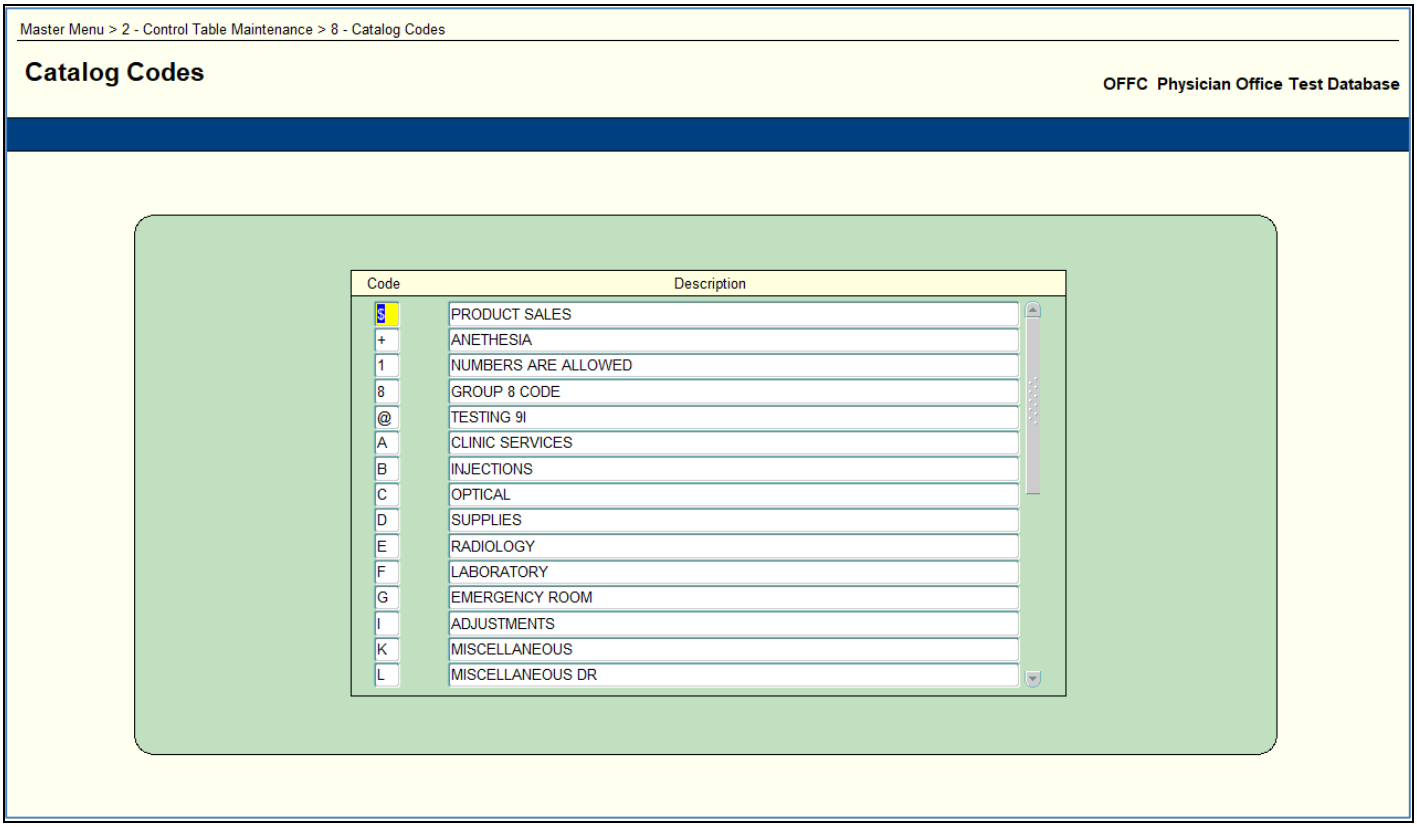
Used to group ‘like’ procedure codes in order to produce reports by department



Master Menu 2.7 Department Codes	
Field Name	**Field Description**
Group Code	Must be Group Specific
Code	User Defined can be alpha or numeric. Used in the Doctor and Procedure Master in order to group for reporting, 4 characters.
Description	Free text.

Master Menu 2.8 Catalog Codes

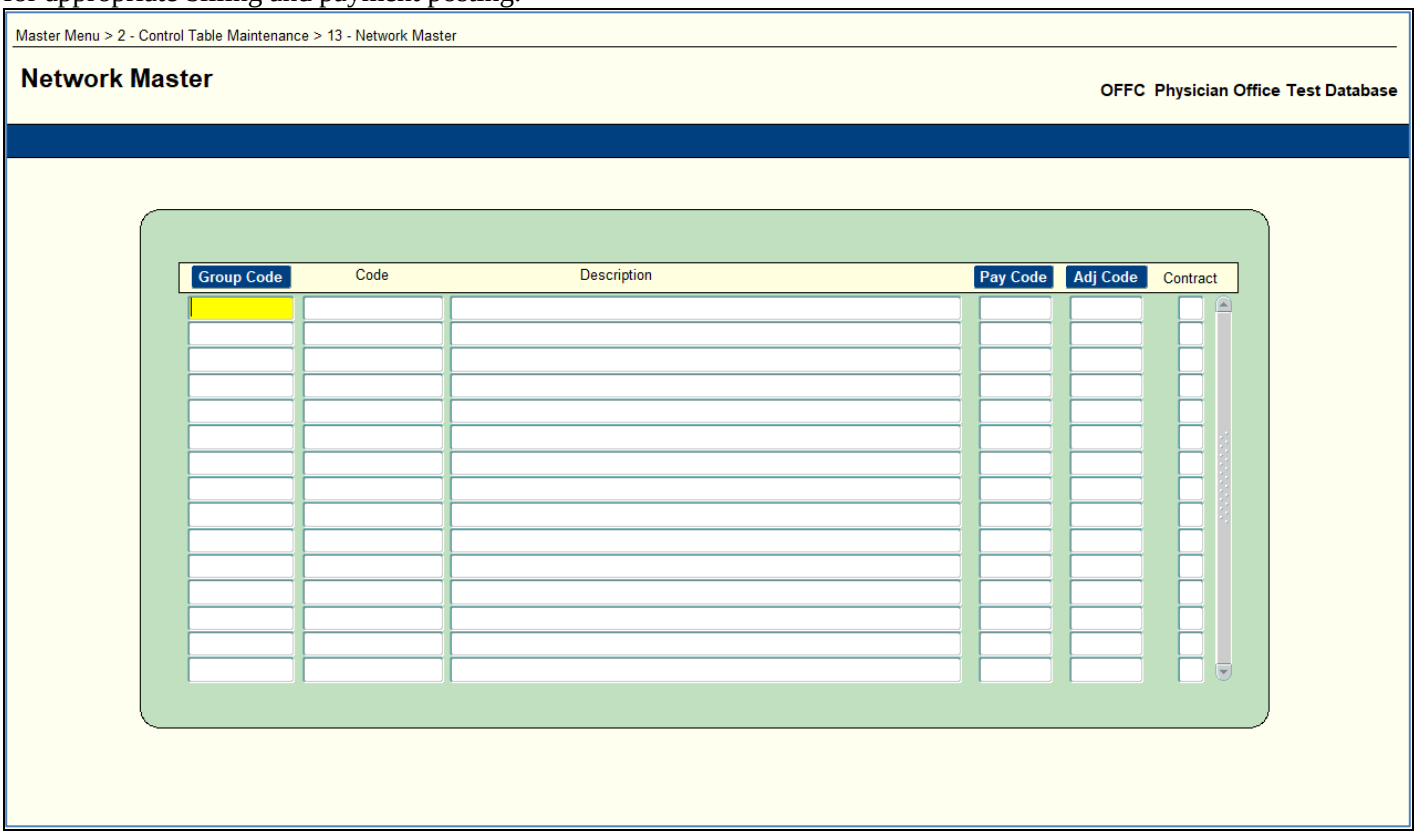
Purpose: To define like procedure codes into categories for reporting purposes.



Master Menu 2.8 Catalog Codes	
Field Name	**Field Description**
Code	Must be 1 character, alpha or numeric. Used in the Procedure Master in order to group for reporting on like procedures.
Description	Free text.

Master Menu 2.13 Network Master

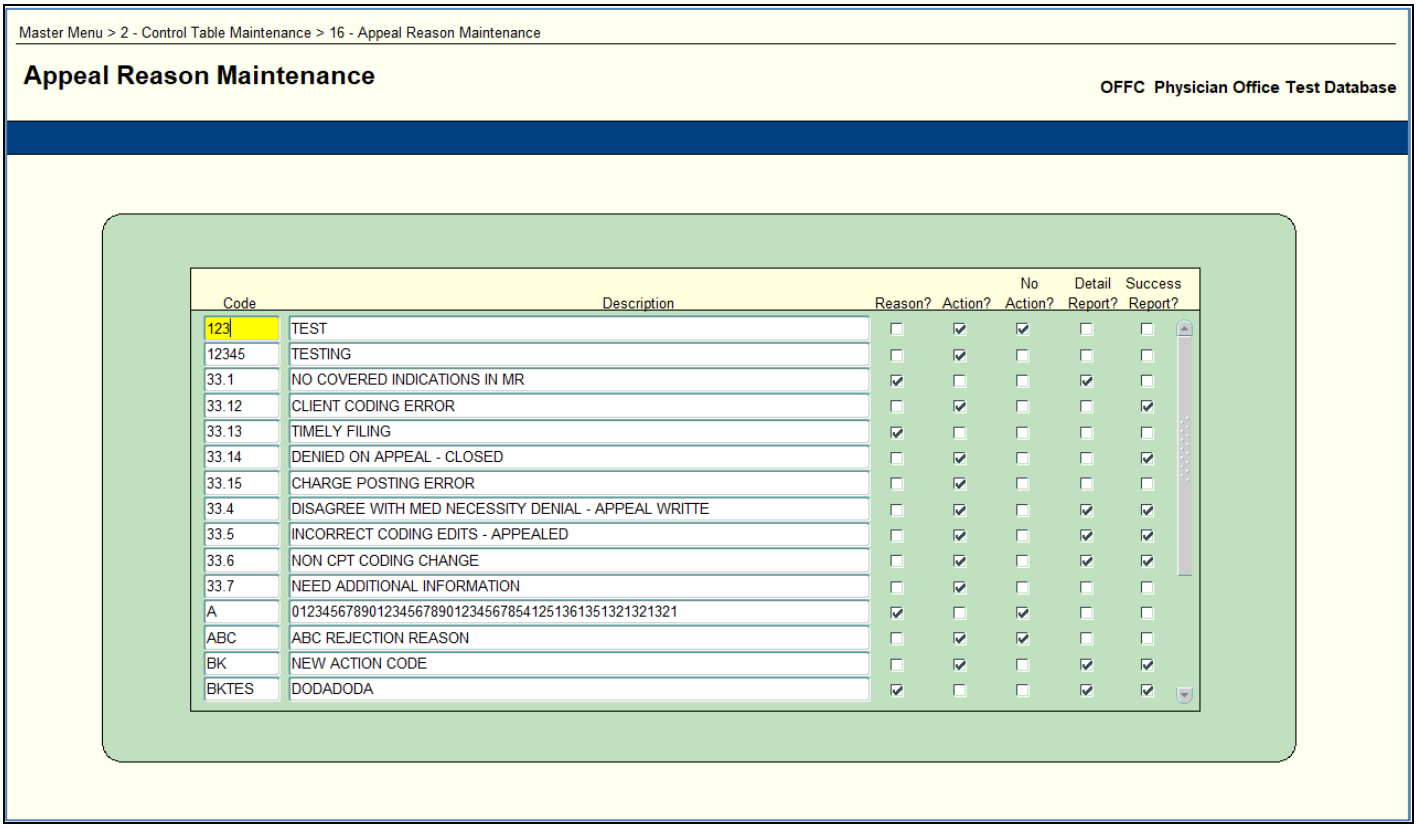
Purpose: To set up Insurance Networks to be linked to patient's insurance record, identifying the Provider Network for appropriate billing and payment posting.



Master Menu 2.13 Network Master	
Field Name	**Field Description**
Group Code	Group specific
Code	Alpha or numeric code to identify a network
Description	Free Text
Pay Code	Identifies pay code used to post Network payments
Network Adj Code	Identifies adjustment code used to post Network adjustments
Contract	Set this field to Y if the carrier is contracted and the adjustment should be calculated for the difference in the charge verses the allowed amount. Null or N in this field indicates not contracted and no adjustment will be calculated.

Master Menu 2.16 - Appeal Reason Maintenance

Purpose: To setup the reasons as to why a charge needs to be reviewed and the action codes that indicate what is required for a charge based on the review.

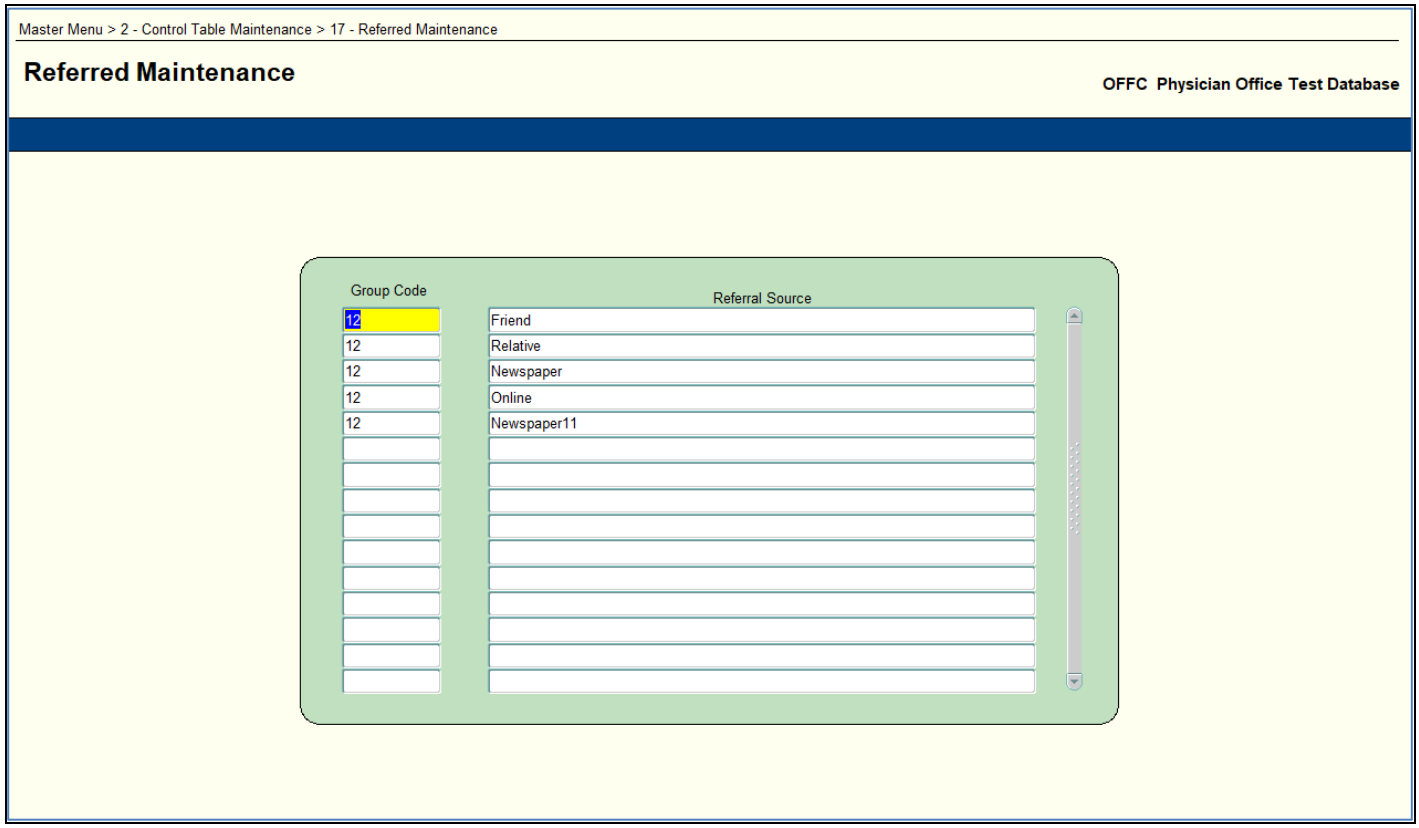


Master Menu 2.16 Appeal Reason Maintenance	
Field Name	**Field Description**
Code	Enter a user defined code that is up to 5 characters long using number, letters and/or symbols. ***Please note- Clinix is reserving the code '*****' as an internal code that will used in specific instances that will be explained later in this document.*
Description	Enter the description with a 50 character max
Report?	If the code entered is a reason why the charge needs to be reviewed the 'Reason' check box should be selected.
Action?	If the code entered is an action that should be taken after reviewing the charge the 'Action' check box should be selected.
No Action?	If no action is required based on the review of a charge, users can select 'No Action'. **Please note- 'No Action' can only be selected if 'Action' is checked
Detail Report?	If the 'Detail Report?' box is checked any charges that have been appealed using that particular code will be included on the 'Detailed Appealed Listing' report, report number 24141. This listing shows all charges that have been appealed

	during the current post month and year. Charges that have been appealed during the current fiscal year using this code will be included on the summary 'Detailed Appeal Listing – Totals by Appeal Code'.
Success Report?	If the 'Success Report?' box is checked any charges that have been appealed using that particular code will be included on the 'Appeals by Insurance Company-Success Report' report, report 24141. This listing shows all charges that have been appealed that have had no response, i.e., insurance payment or subsequent denial, from the insurance carrier to which the appeal was made. The appealed items will remain on this report until a response from the insurance carrier has been received. After a response is received, the appealed item will appear on the listing one more time for the current post month/year and then drop off.

Master Menu 2.17 Referred Maintenance

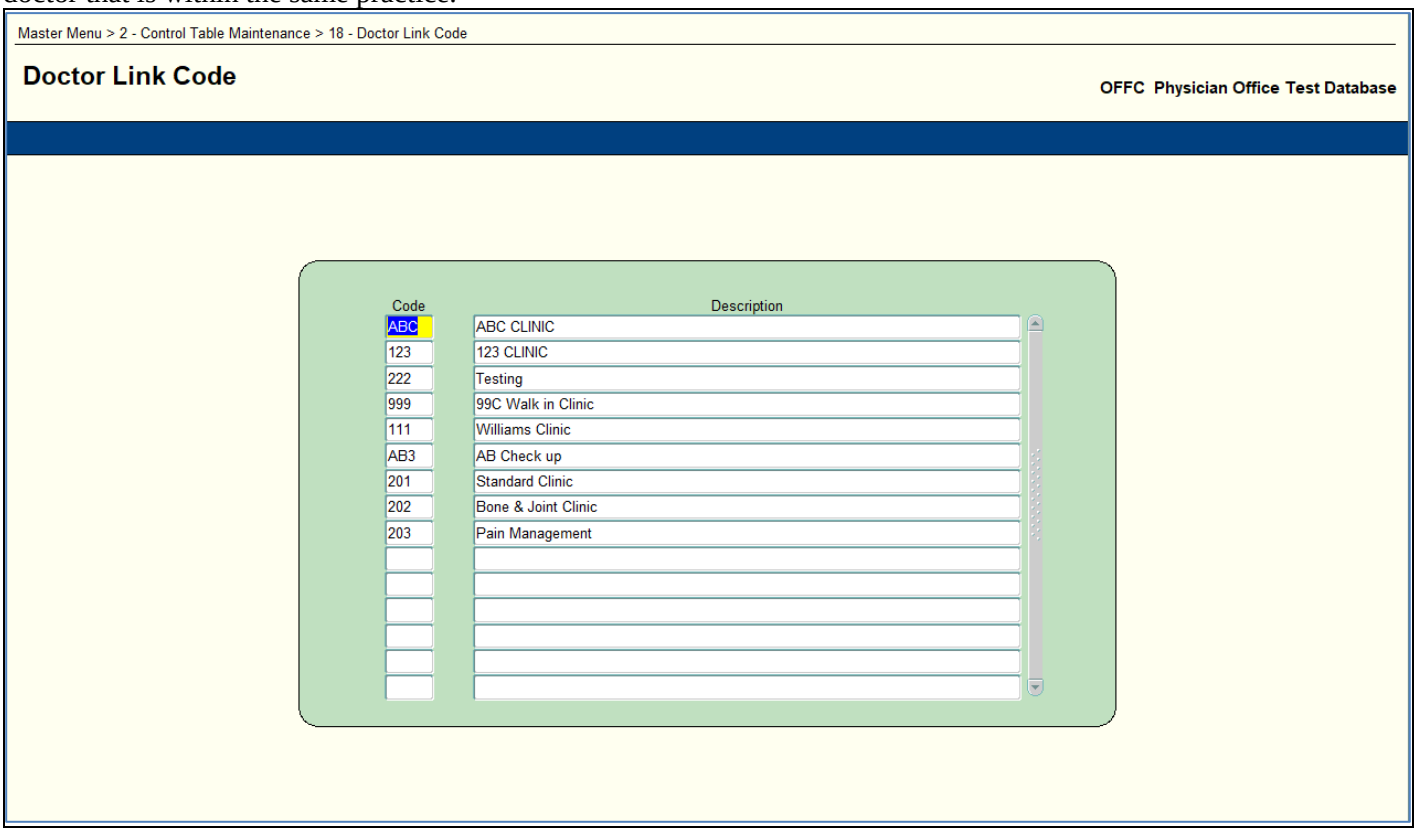
Purpose: To document and track the source in which the patient was referred to the practice. This field is located on the 'Patient Account' MM7.



Master Menu 2.17 Referred Maintenance	
Field Name	**Description**
Group Code	Enter the group code in which this referral pertains to. Enter for each group, if needed.
Referral Source	Free text up to 20 characters, the source of the referral.

Master Menu 2.18 Doctor Link Code

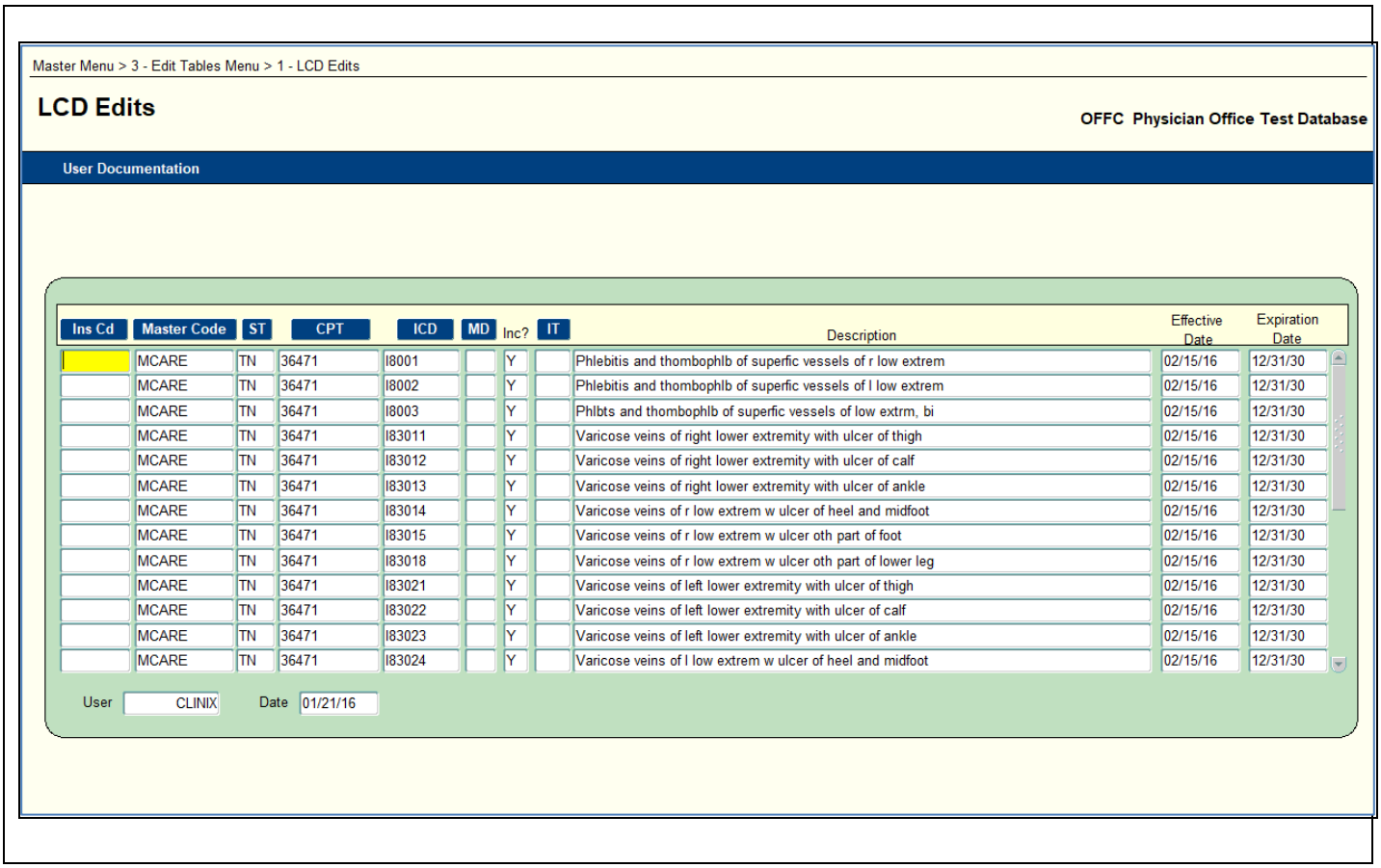
Purpose: To create a link code that can be added to referring doctors. The link code can be attached to each referring doctor that is within the same practice.



Master Menu 2.18 Doctor Link Code	
Field Name	**Field Description**
Code	This can be alpha or numeric. This code will be entered in the Link Code field on MM1.2.
Description	Free Text. This field is where the name of the practice will be entered that needs to be grouped by the Link Code.

Master Menu 3.1 LCD Edits

Purpose: Used to define CPT/ICD code pairs that can be associated with specific modifiers by insurance company. Can define inclusions as well as exclusions.
Note: Once a CPT code has been identified as an inclusion LMRP code pair, all possible CPT/ICD-9 code pairs must be listed for that CPT code.
Note: To identify a CPT/Modifier combination that is inclusive, you may list a CPT without a diagnosis. This relationship is only for inclusive CPT/Modifier combinations. It does not work for Exclusions.

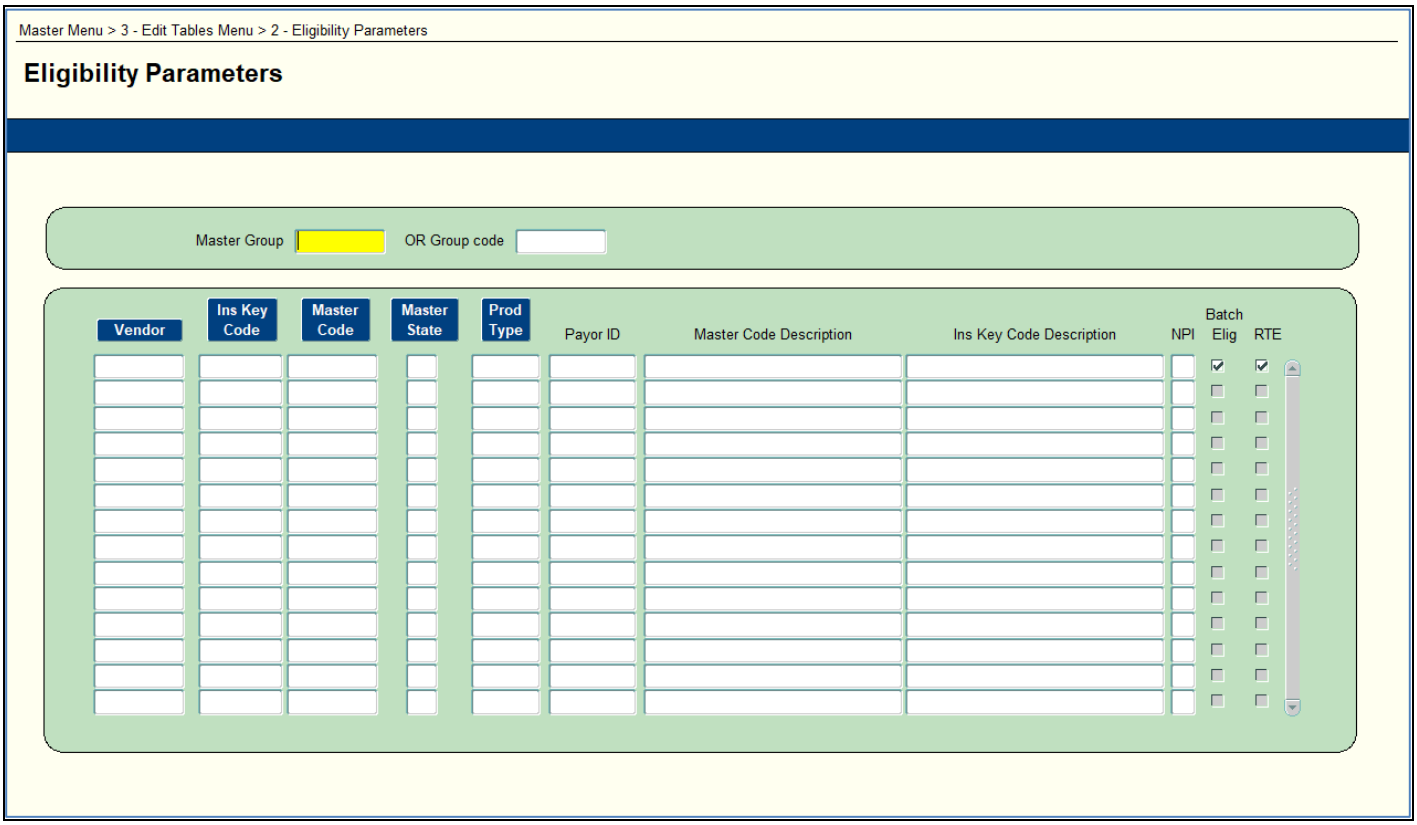


Master Menu 3.1 LCD Edits	
Field Name	**Field Description**
Ins Code	Enter the Insurance Company Key Code if the edit is Key Code specific.
Master Code	Enter the Master code if the edit applies to all payors identified with this Master code in the Insurance Master File.
State	Enter the State only if the edit is state specific
CPT	Enter the CPT that applies to this LMRP edit
ICD	Enter the diagnosis code that applies to this LMRP edit
MD	Enter the modifier if applicable that applies to this LMRP edit in relation to the ICD-9 and CPT code.
Inc?	Enter Y to indicate that the LMRP edit record is an Inclusion, which indicates the ICD-9/ CPT code pair can be billed. Enter N to indicate that the LMRP edit record is an Exclusion, which indicates the ICD-9/ CPT code pair are not to be billed.
IT	This field is used for interface edits only. This field is used to mark exceptions rather than cause a fatal error. Enter an Insurance Type to override the charge transaction insurance type. This flags the user that the charge has an LMRP edit that needs correcting.
Description	Description populated by ICD code

Effective Date	Date of Service when the edit becomes effective
Expiration Date	Date of Service when the edit should no longer be considered.

Master Menu 3.2 Eligibility Parameters

Purpose: To list the insurance carriers that should be considered for batch or real time eligibility checks through Passport. The eligibility checks will be based off of the appointment scheduler and the insurance key codes or insurance master codes that have been manually setup.

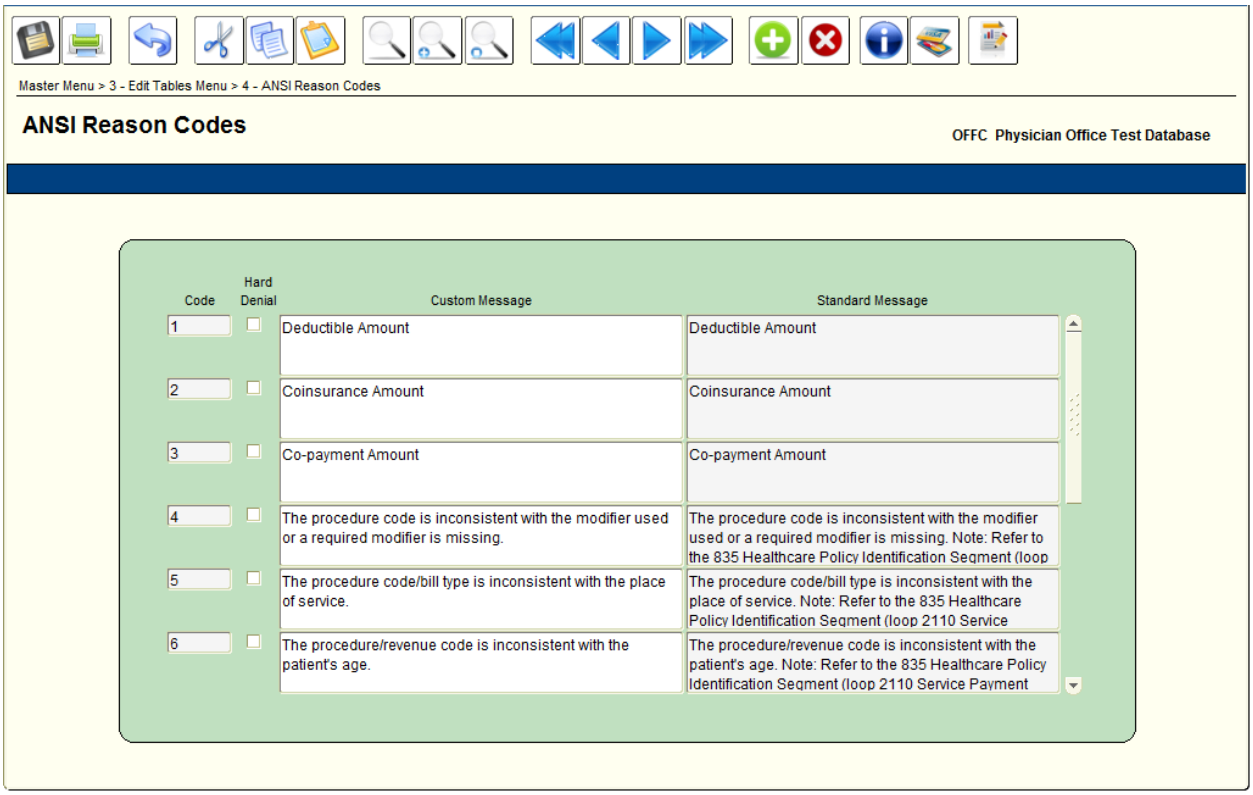


Master Menu 3.2 Eligibility Parameters	
Field Name	**Field Description**
Master Group – OR Group Code	Enter Master group OR Group Code to specify which group's accounts the batch eligibility processing program will use
Insurance Key Code	Only enter if the batch eligibility program should check for that specific Key Code in the Insurance Master file. If Key Code is entered, the Master Code will automatically display
Master Code	If the batch eligibility program can be used for all Key Codes that fall under a Master Code umbrella, enter the Master Code only.
Master State	Enter if only applicable for records for a specific state
Product Type	Select the product type that suits the inquiry
Payor ID	Enter the Payor ID according to the Passport payer list. This is an alpha/numeric field that can allow for up to 10 characters.

Master Code Description	Populated based on the Master Code entered. This field will display the description of the 'umbrella' as shown on the Insurance Master Record.
Ins Key Code Description	Populated based on the Insurance Key Code entered. This field will display the company name as shown on the Insurance Master Record
NPI	For clients that send batch eligibility files to Passport, the program is currently setup to send the Group NPI; however, some insurance carriers require patient eligibility to be checked against the Individual Provider's NPI. When an 'I' is entered in the NPI field, the application will pull the Individual NPI instead of the Group NPI.
Batch Elig	Check mark this field if the corresponding insurance should be checked through batch eligibility
RTE	Check mark this field if the corresponding insurance should be checked through Real Time Eligibility

Master Menu 3.4 ANSI Reason Codes (Smart Denials)

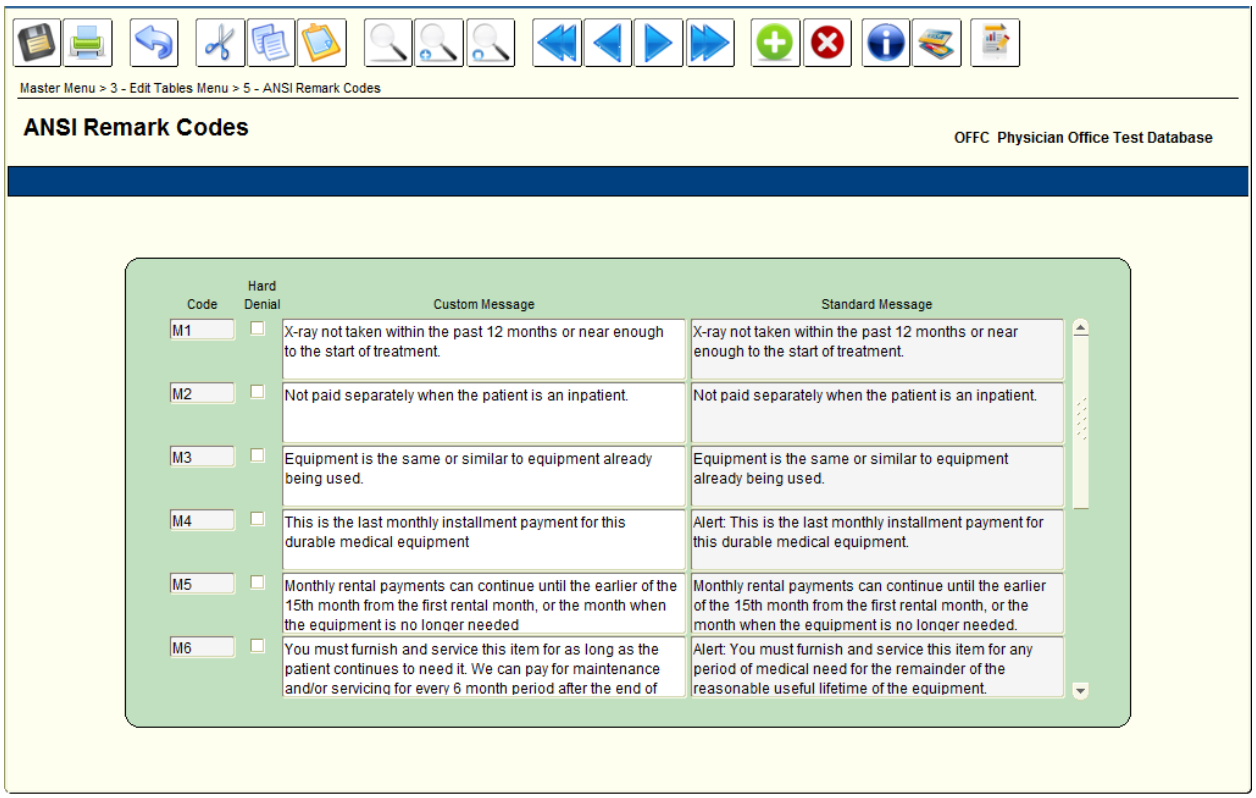
Purpose: Provide a more efficient and effective method for automating the process to close and deny a claim, and immediately bill the patient when the carrier denies payment due to patient responsibility. These denials are often referred to as ANSI Hard Denial codes.



Master Menu 3.4 ANSI Reason Codes	
Field Name	**Field Description**
Code	ANSI Reason Code populated by Clinix
Hard Denial	Check this box if you want this Reason to result in a "Hard Denial" which will close the claim and make it patient responsibility
Custom Message	Allows client to customize the denial message. This message will print on the statement.
Standard Message	Populated by Clinix. Not printed anywhere at this time.

Master Menu 3.5 ANSI Remark Codes (Smart Remarks)

Purpose: Provide a more efficient and effective method for automating the process to close and deny a claim, and immediately bill the patient when the carrier denies payment due to patient responsibility. These denials are often referred to as ANSI Hard Denial codes.



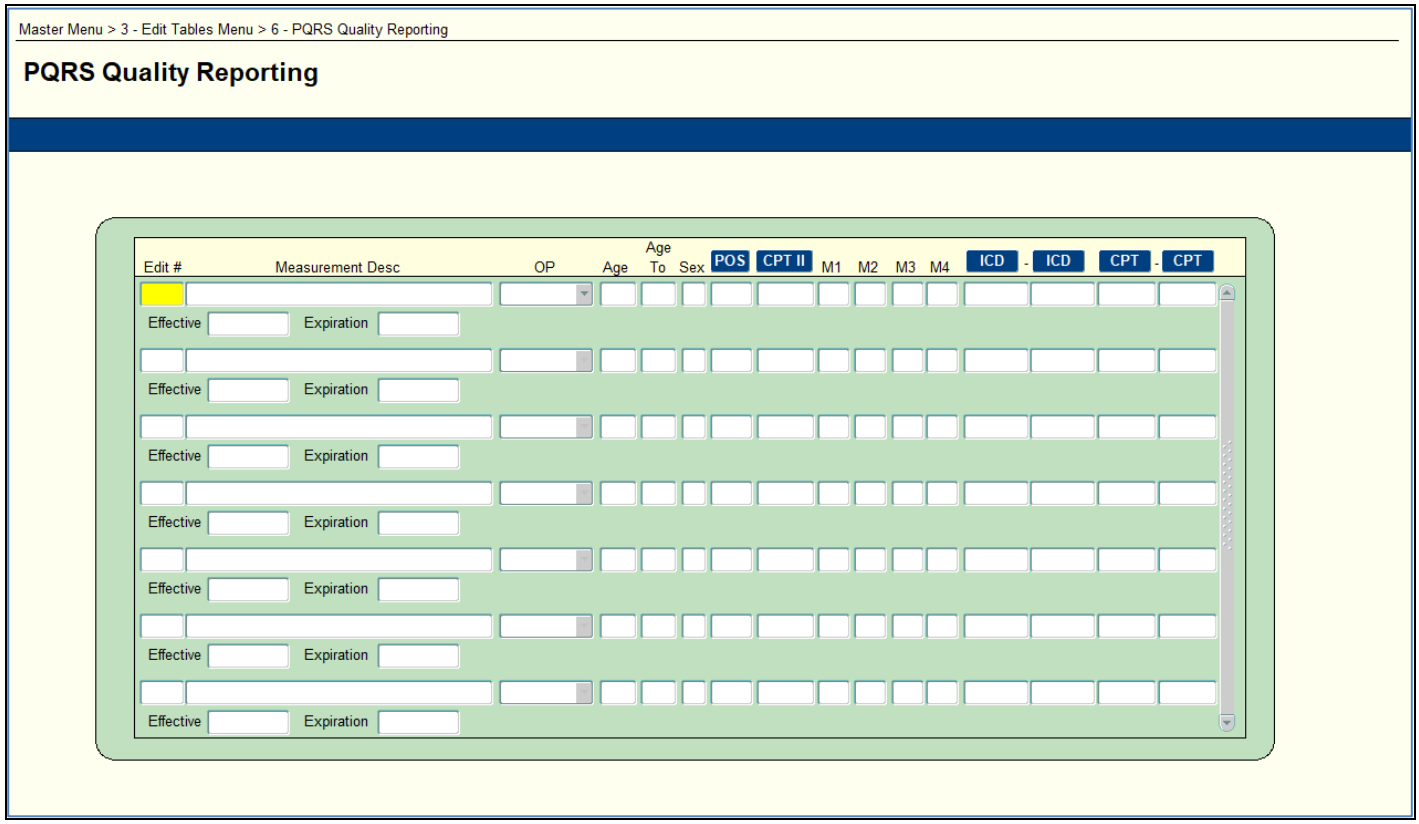
Master Menu 3.5 ANSI Remark Codes	
Field Name	**Field Description**
Code	ANSI Remark Code populated by Clinix
Hard Denial	Check this box if you want this Reason to result in a “Hard Denial” which will close the claim and make it patient responsibility
Custom Message	Allows client to customize the denial message. Not used at this time
Standard Message	Populated by Clinix. Not printed anywhere at this time.

Master Menu 3.6 PQRS Quality Reporting

Purpose: This screen will enable users, which participate in the PQRS reporting program, to develop a PQRS Measurement Edit table specific to their individual practice. Entries into this table will be used to identify charges that qualify for the PQRS program and alert clients that they have an opportunity to enter CPT II codes along with the qualifying encounter charge that is being posted.

- All CPT II codes that are being posted must have a zero dollar value and must appear with the qualifying CPT code on the insurance claim.

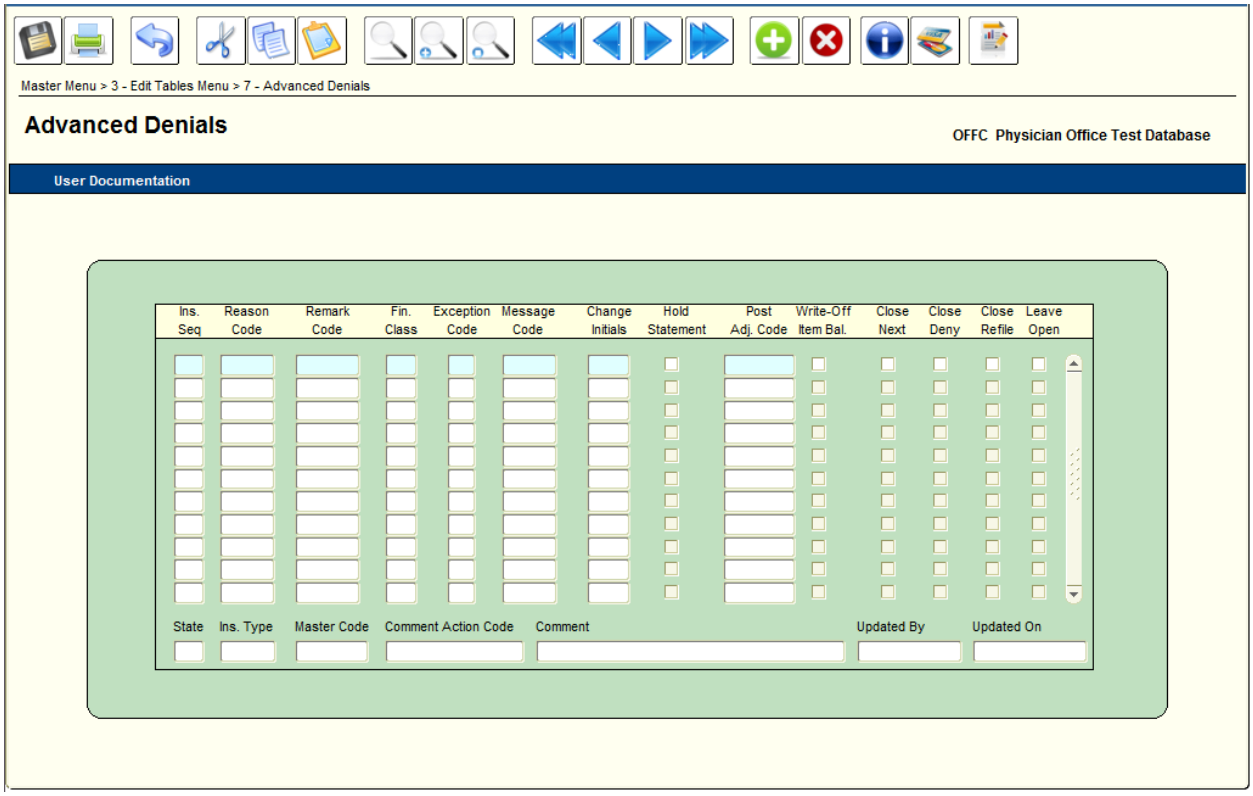
- NOTE: The Procedure Maintenance master table has been enhanced so PQRS edits can be identified. If a database(s) already has any CPT II code(s) loaded, Clinix has automatically performed these actions for you. If you are manually entering the CPT II codes designated by CMS the following steps will need to be taken:
  - Mark these codes with a 'Y' in the 'PQRS Code' field to allow the insurance program to file the zero charge(s) on a claim.
  - Enter a zero (0) dollar amount for each CPT II code so it can be billed correctly to the carrier.
  - Mark the field labeled 'Bill Medicare Elect' with a 'Y'
  - Mark the fields listed below with a 'N'
    - 'Bill Medicaid Elect'
    - 'Bill Others Elect'
    - 'Bill Medicaid Paper'
- NOTE: An addition to the Batch Edit Report, report number 5207, has been created to show the CPT and ICD pairs that are eligible for the PQRI program based on the edits that have been manually entered in MM15.9.
  - It is advised that users should do their own 'test' by entering charges without the CPT II code to be sure that they have the measurement entered correctly AND that we are editing for that measurement accurately.



MM3.6 PQRS Quality Reporting	
Field Name	**Field Description**
Edit #	Enter the PQRS Measurement number that is provided by CMS
Measurement Desc	Type the description of the Measurement Edit
OP	Using the drop down OP field, choose the appropriate choice for the age definition
Age	Enter the beginning age if using an age range or the specific age associated with the edit
Age To	Enter the ending age in the age range if applicable
Sex	Enter a sex (M/F) if applicable
POS	Enter a POS if applicable
CPT II	Enter a valid CPT II code
M1, M2, M3, and M4	Enter a valid PQRS Modifier if applicable
ICD	Enter the first valid ICD code of the range (if a range is applicable) or if you are using a single ICD code
ICD	Enter the last valid ICD code of the range (if a range is applicable)
CPT	Enter the first valid CPT I code of the range (if a range is applicable) of if you are using a single CPT I code
CPT	Enter the last valid CPT I code of the range (if a range is applicable)
Effective	Enter the effective date of the PQRS Measure
Expiration	Enter the expiration date of the PQRS Measure if applicable

Note: This form will allow a user to insert, update, and delete records whenever necessary.

Master Menu 3.7 Advanced Denials

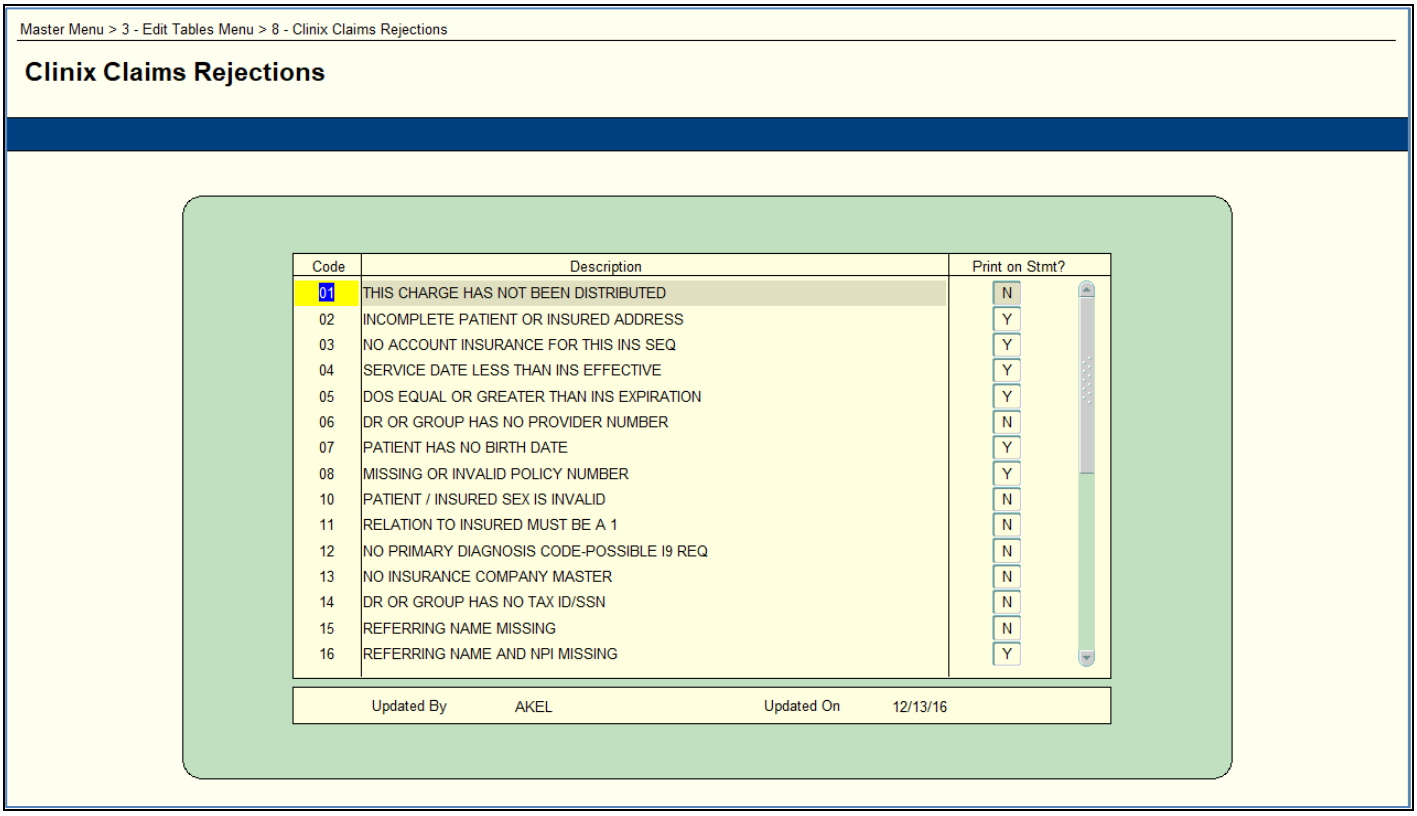


Master Menu 3.7 Advanced Denials	
Field Name	**Field Description**
Parameters:	**The following define the factors that need to be in place for the related actions to occur.**
Ins Seq	Enter the Insurance Sequence: 1= primary, 2=secondary, 3=tertiary. The related action will only occur when the defined ANSI is posted to a charge with the Ins. Seq defined in this field. This is a required field.
Reason Code	ANSI Reason code requiring an action to occur
Remark Code	ANSI Remark code requiring an action to occur. If both are posted against a charge, the Reason code will take precedence.
State	If the action is only to be taken for the specific state that is defined on the Insurance Master Record, enter the state abbreviation here. Either Ins. Type and/or Master code must be defined.
Ins. Type	If the action is only to be taken for the specific Insurance Type as defined on the Insurance Master record, enter the insurance type here. Either Ins. Type and/or Master code must be defined.
Master Code	If the action can be taken only for specific Insurance Company Master codes as defined in the Insurance Master record, enter the Company Master code here. Either Ins. Type and/or Master code must be defined.
Related Actions:	**The following define the actions that can be taken:**

	(Note: Any actions that update the Patient Account will also create an FM Audit trail record)
Fin. Class	Enter a Financial class if you want the patient account's Financial class to be updated when the related ANSI is posted. This does not validate the relation to the Price Code. This is not advised.
Exception Code	Enter an Exception code if you want the patient's account to be updated with an Exception code. If the account already has an exception code, this program will override that exception code.
Message Code	Enter a Message Code if you want the next statement generated to include a message code. If the account already has a Message code, this program will override that Message code. This program also will default Message Count 1.
Change Initials	Enter up to 3 alpha or numeric characters to have the program update the Initials field on the Patient Account.
Hold Statement	Select this field if you need the account to be flagged with a Hold Statement. This will update the patient account with a Hold Statement = Y.
Post Adj. Code	Enter the adjustment code that the program should use if you need the program to write-off the item balance when the ANSI code is posted.
Write-Off Item Bal.	Select this field if you need the program to write-off the item balance when the ANSI code is posted.
Claim Status	**You must select one of the following:**
-Close Next	The claim will be set to file to the next sequence.
- Close Deny	The claim will be set as Deny = Y and bill the patient for the balance.
-Close Refile	The claim will be set to close and refile to the same sequence.
-Leave Open	The claim will remain open.
Comment Action Code	Enter the Account Comment Action code that you want to be entered on the patient's Account Comment screen based on the ANSI code posted.
Comment	Enter the comment that you want the program to enter on the Patient's Account Comment screen based on the ANSI code posted.
Updated by	This field defaults the user who is entering or updating the Advance Denial record
Updated On	This field will default the date that the Advance Denial record was entered or updated.

Master Menu 3.8 Clinix Claims Rejections

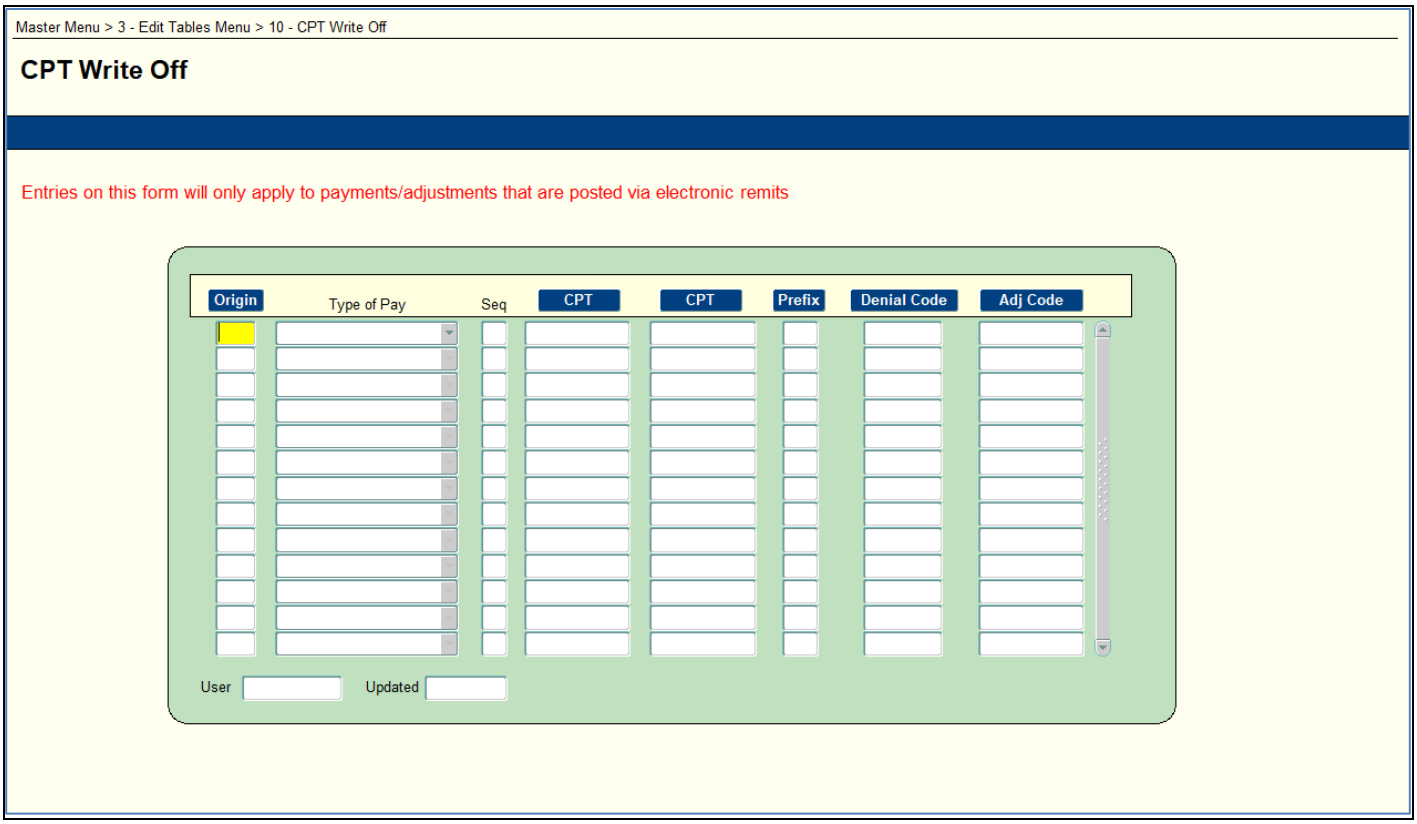
Purpose: This screen will enable users to choose if they want the charge that is attached to an Insurance Rejection Code to print on a patient's statement. **Note:** These rejection codes are attached to charges that did not meet necessary criteria in our upfront insurance scrubber, which are stored on MM 5.5 or report 3991, Claims Rejections



MM3.8 Clinix Claims Rejections	
Field Name	**Field Description**
Code	This is the insurance rejection code. Note: these are standard codes that are assigned by Clinix.
Description	Description of the insurance rejection
Print on Stmt	If a 'Y' is entered in this field, the charge that is attached to the rejection code will print on the patient's statement, not the rejection itself. **Note**: By printing the charge on a patient statement, it will not correct the insurance rejection. The charge will continue to have the rejection attached to it until the error is corrected by the user. If an 'N' is entered, the charge that is attached to the rejection code will not print on a patient's statement.
Updated By	The system will automatically stamp the User ID that updated the line item.
Update On	The system will automatically stamp the date the update occurred

Master Menu 3.10 – CPT Write Off

Purpose: This will give users the ability to enter a CPT code or a group of CPT codes that an insurance company is never going to allow. When entries are made on this form, the ERA posting will automatically perform the write off at the time an ERA is being posted. Note: This will not apply to manual posting of insurance payments.

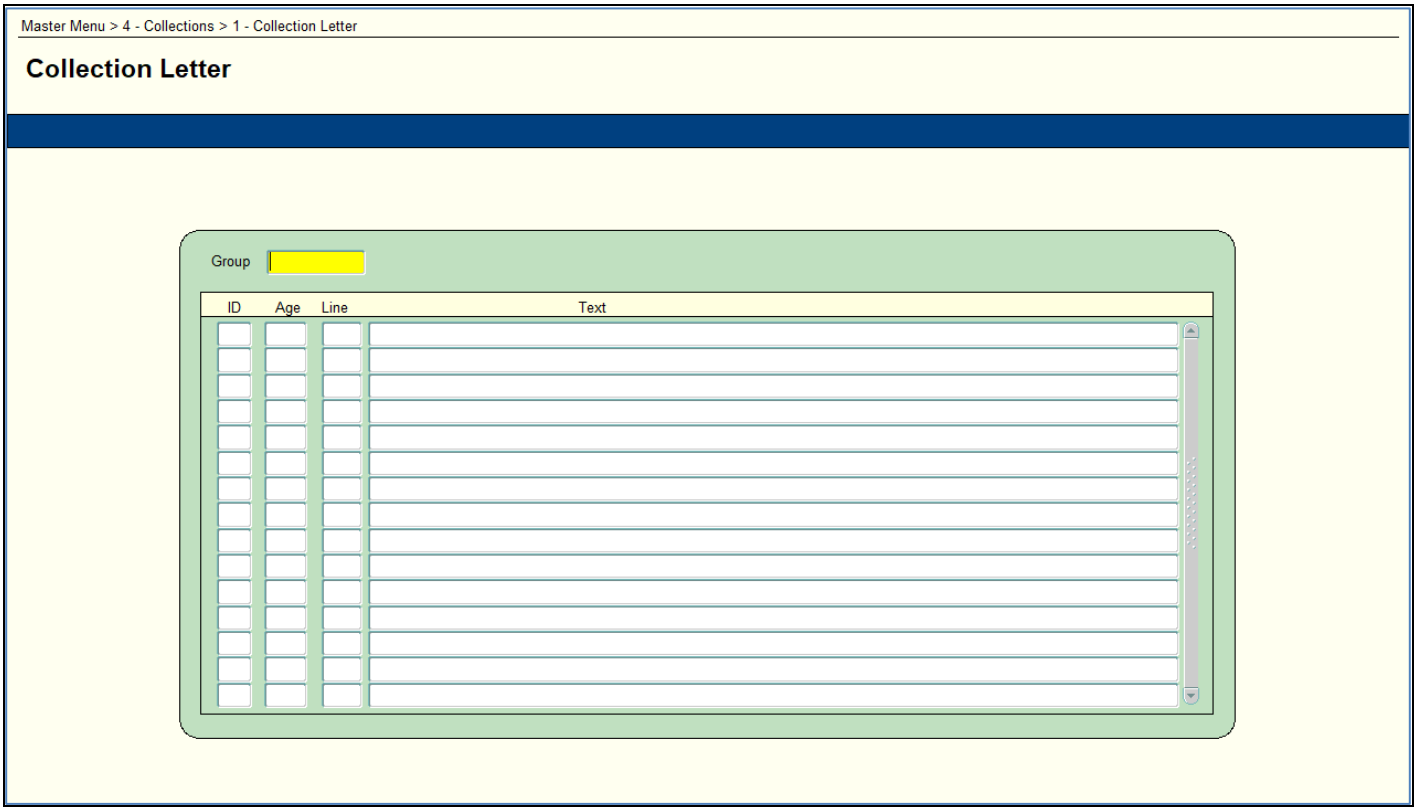


MM3.10 CPT Write Off	
Field Name	**Field Description**
Origin	Enter one of the following: State, WB if Emdeon, DM if Durable Medical, or RR if Railroad Medicare
Type of Pay	Choose either, MC – Medicare, MA – Medicaid, BS – Blue Shield, BC – Blue Cross, or CO - Commerical
Seq	Enter the sequence of the insurance record
CPT	Enter the CPT code that needs to be adjusted off at time of ERA posting.

CPT	Enter either the same CPT as entered in the first CPT field or an ending CPT if a range of CPT codes needs to be adjusted off at the time of ERA posting.
Denial Code	Enter the ANSI denial code associated with the adjustment
Adj Code	Enter the adjustment code associated with the adjustment.

Master Menu 4.1 – Collection Letter

Purpose: To create or edit a letter to be generated when an account reaches the age to generate a collection letter. May also be used to create or edit a letter to be generated at any time by a user for collection or other informational purposes**.**



Master Menu 4.1 Collection Letter	
Field Name	**Field Description**
Group	Group specific
ID	ID number for this particular letter
Age	Statement age at which this letter is automatically generated by Clinix
Line	This is used to keep track of the message. This does not mean it will print on a separate line
Text	Free text.

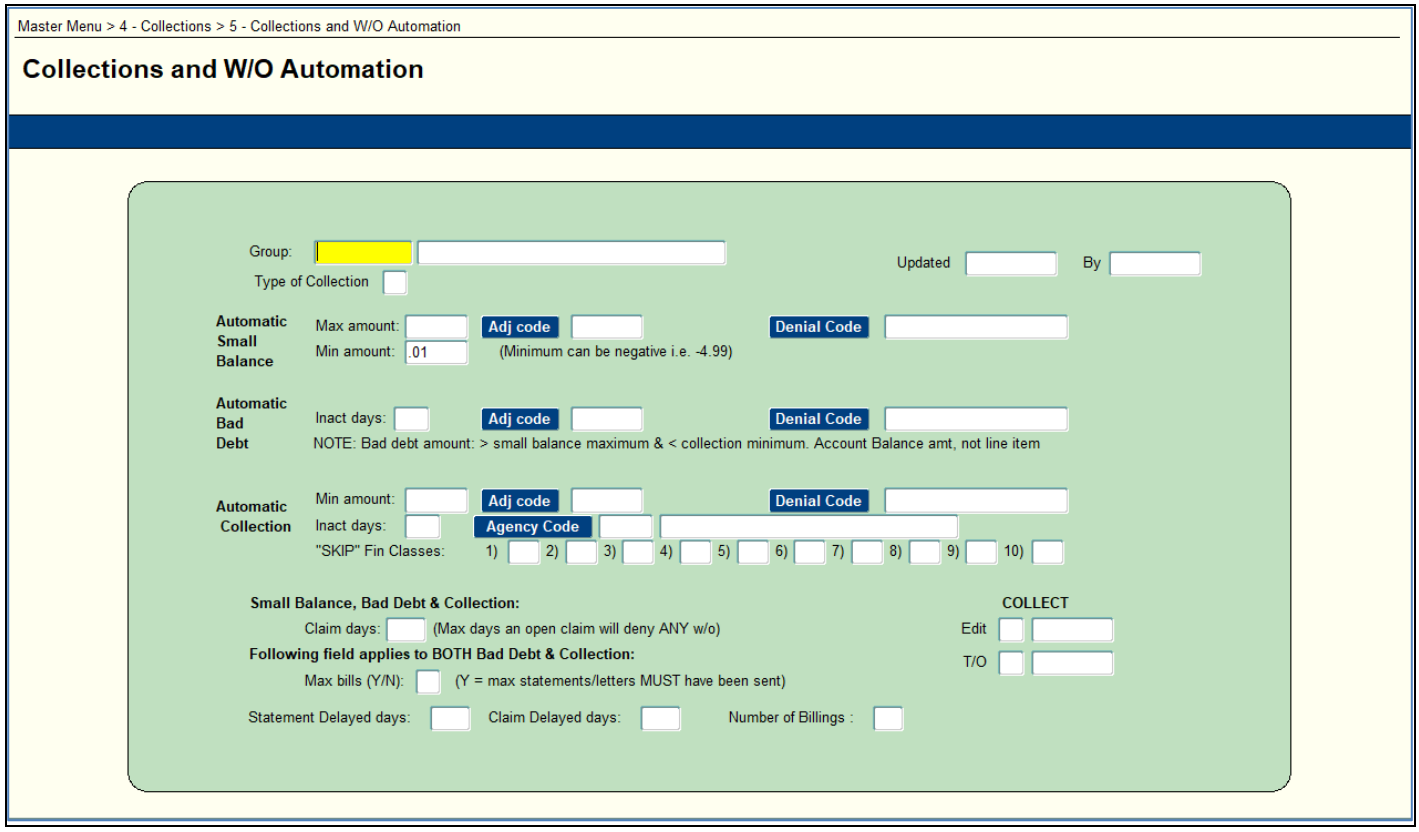
Master Menu 4.5 Collections and W/O Automation

Purpose: To allow the user to define the necessary parameters for establishing the Small Balance, Bad Debt and Collection Write-Offs.

Note: This screen can be used to setup Account Collections or Partial Collections

Note: The automated small balance write off program waits until the last entry (charge, payment or adjustment) is at least 45 days old before it makes a small balance write off as the standard rule. If a client would like a different date range a medoption can be set:
Rptname: Autosmallwo
Frmname: Enter the # of days you want to use as the minimum wait period if other than the standard 45 days
Opt: W
WhichOP: M

These are the field descriptions associated with Small Balance, Bad Debt, and Account Collection Write-off:



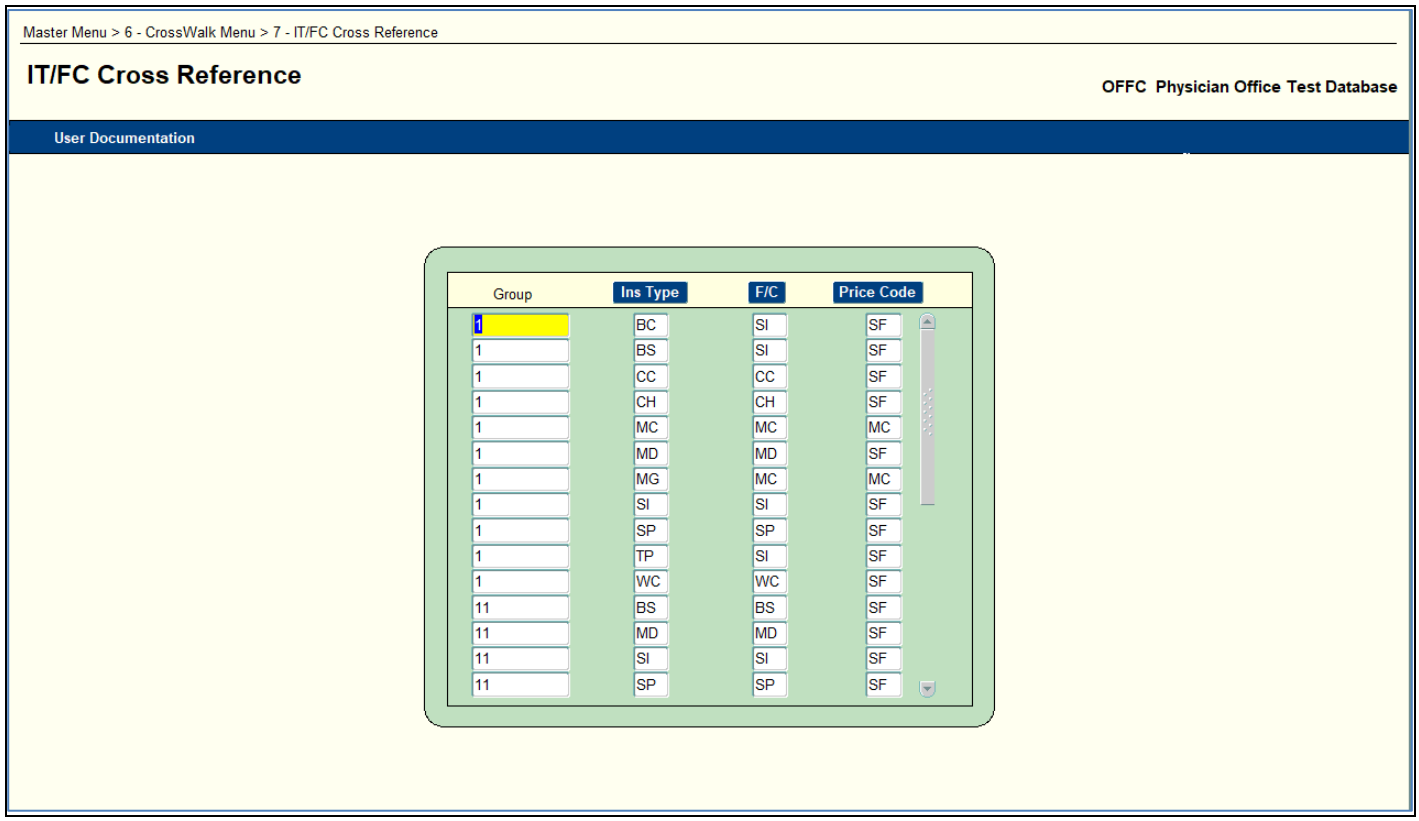
Master Menu 4.5 Collections and W/O Automation	
Field Name	**Field Description**
Group	Group Specific
Type of Collection	Enter an 'A' if the collection program should look for accounts to qualify only when the entire account balance meets the criteria. If an existing client is changing the type of collection program that is being run this will need to be

	set programmatically so please contact your client manager.
Automatic Small Balance:	
Maximum amount	Specify the maximum amount to be treated as small balance (i.e. 4.99)
Adjustment code	Select from Small Balance Adj code LOV
Denial Code	Code to be placed in the claim denial reason when claims are closed (i.e. SBWO)
Minimum amount	Can be negative
Automatic Bad Debt:	
Inactive Days	Number of days that must pass since last transaction (chg, payment, adj) before the balance is considered a bad debt (i.e., 120)
Adjustment Code	Select from Bad Debt Adj code LOV
Denial Code	Code to be placed in the claim denial reason when claim is closed (i.e. BDWO)
Automatic Collection:	
Minimum Amount	Minimum amount that will be considered for the collection process (i.e. 25.00)
Adjustment Code	Select from Collection Adj code LOV to be used for the collection (i.e. CA)
Denial Code	Code to be placed in the claim denial reason when claim is closed (i.e. COLAG)
Inactive Days	Number of days that must pass since the last transaction (chg, payment, adj) before the balance is considered for collections
Agency Code	Enter code from LOV, Ctrl F. F8 will take you to a split screen used for two agencies
Skip Financial Classes	Enter up to 10 FN classes that should be omitted from the collection process
Claim Days	Maximum days that a claim can be open and deny any of the w/off.
Max bills	Enter Y for maximum statement/letters must have been sent to be considered for bad debt and collections (not small balance)
Statement Delayed days	This field allows you to delay a collection w/off from occurring until set number of days has passed since the last statement was generated
Claim Delayed days	This field allows you to delay a collection w/off from occurring until set number of days has passed since the last claim was generated.
Number of Billings	This field defines the number of bills that must be generated before a charge will be considered as eligible for partial collection.

Edit and Edit Date	This is used by the Account Collection Program to verify that a group is ready to have the edit program run. The edit program will flag the accounts that are eligible for collection based on the parameters that have been entered. Users will only be able to enter a 'Y' in this field. The field remains a 'Y' until the edit program runs. The program will then remove the 'Y' but retain the date as a reference. If a 'Y' is entered again before the T/O (turnover) occurs, additional accounts will be added to the T/O and an additional edit report will generate listing just those added accounts.
T/O and T/O date	This is used by the Turn Over program which performs the write offs and creates the collection file and/or report. Users will only be able to enter a 'Y' in this field. This field remains a 'Y' until the T/O program runs. The program will then remove the 'Y' but retain the date for reference

Master Menu 6.7 IT/FC Cross Reference

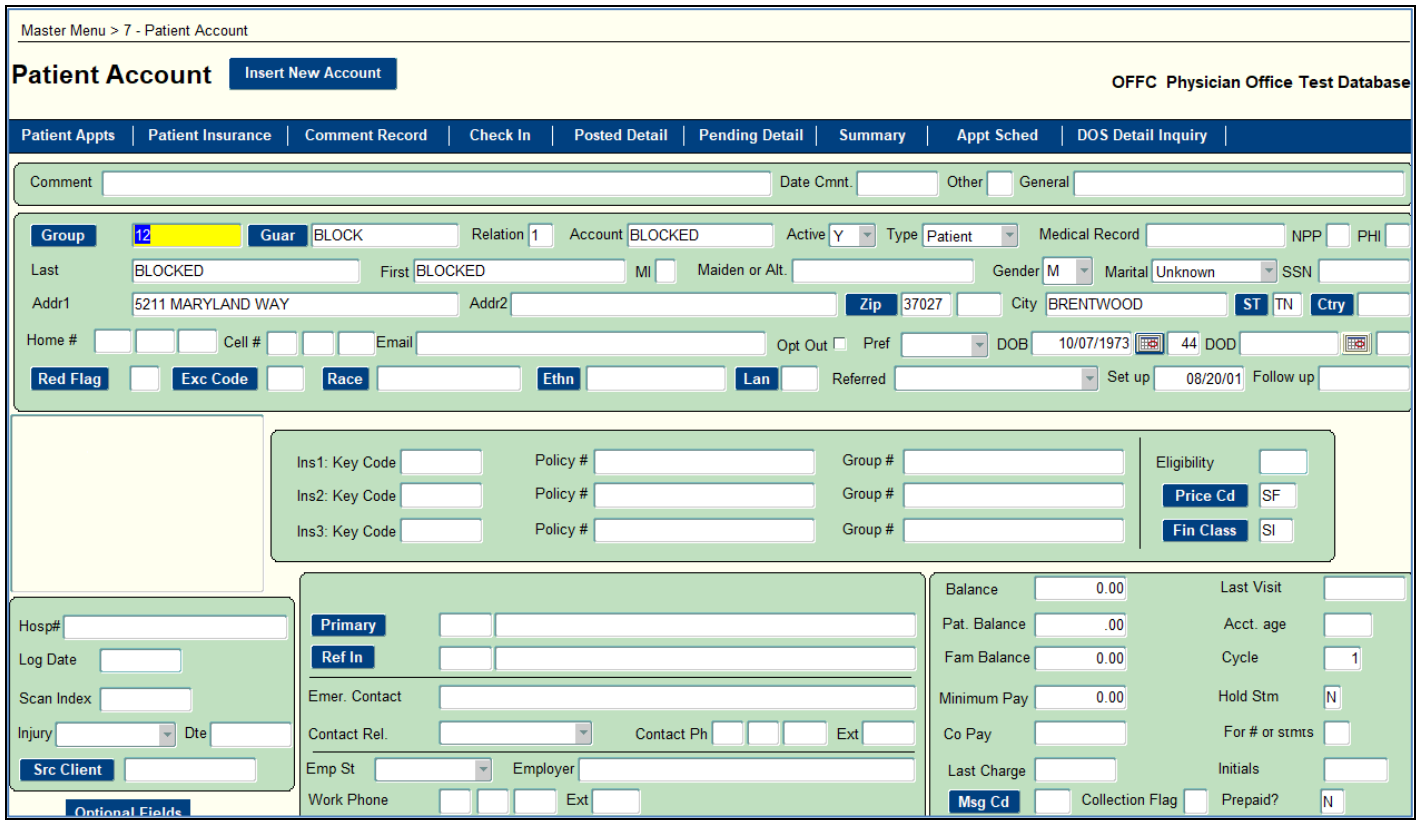
Purpose: For the purpose of cross walking the Financial Class to the Insurance Type to the Price Code for demographic and Medptdemo assignment.



Master Menu 6.7 IT/FC Cross Reference	
Field Name	**Field Description**
Group	Group specific
Insurance Type	List from MM10,1
Financial Class	List from MM10,1. Only used for reporting purposes.
Price Code	List from MM10,1 as applicable

Master Menu 7 – Patient Account - Setting up a BLOCKED account

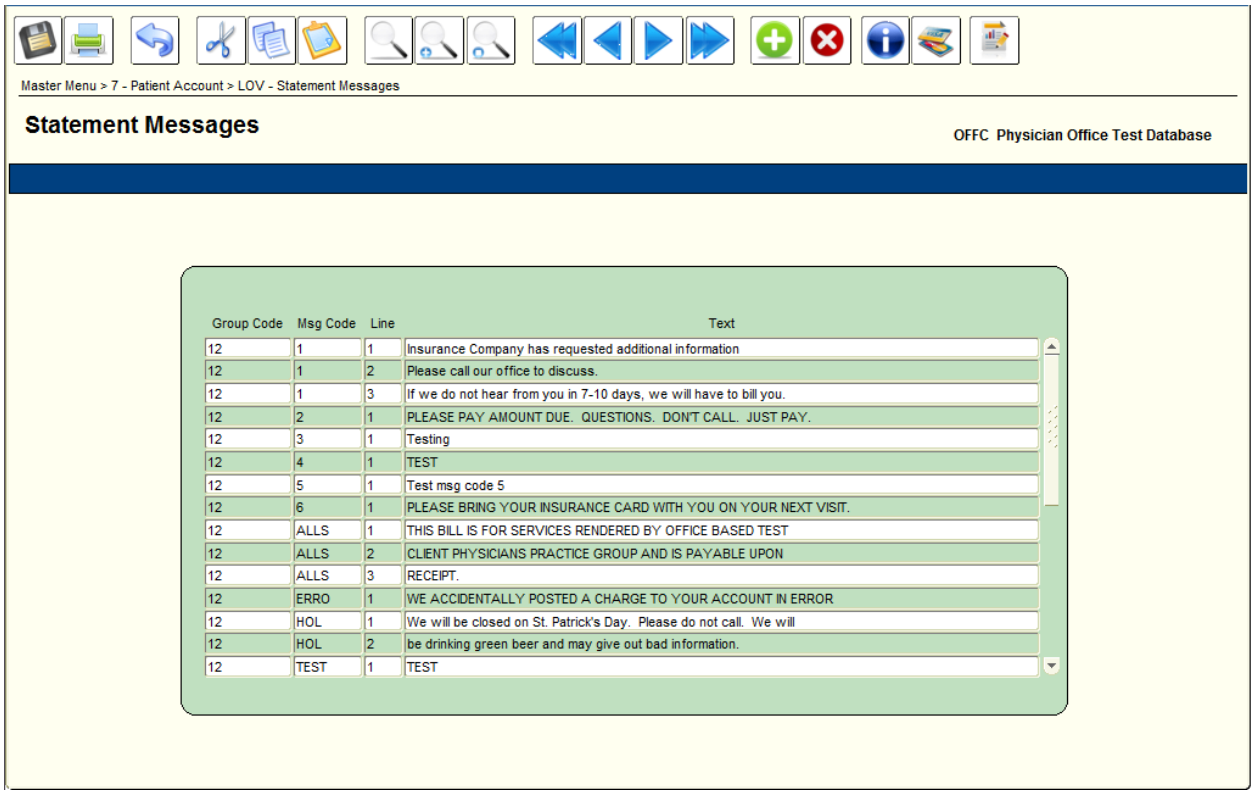
Purpose: If client will be using the appointment scheduling system, a BLOCKED account should be created in order to use the block/unblock feature.



When setting up this guarantor/patient, be sure the *Account Number* is entered as BLOCKED. The name can be anything.

Master Menu 7 – Patient Account – Message Code

Purpose: Setup codes for messages to appear on guarantor's statement. If a message uses the code ALLS, it will appear on every patient account statement every time. Other codes can be limited as to how many times they occur by putting a number in the small count field next to the Msg Cd.

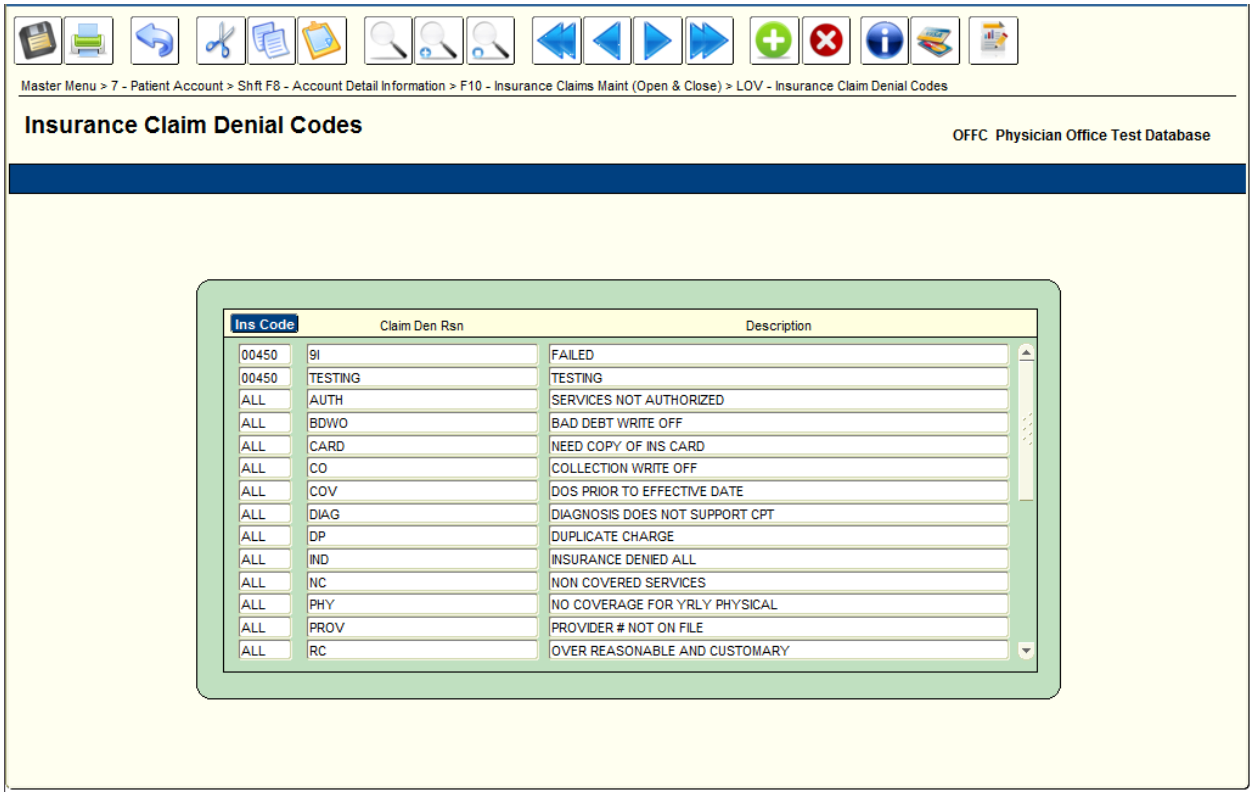


Master Menu 7  Statement Messages	
Field Name	**Field Description**
Group Code	Group specific
Msg Code	Message Code, alpha-numeric, 4 characters
Line	This is used to keep track of the message. This does not mean it will print on a separate line. You will need to add a blank line in between each paragraph for the letter to look nice.
Text	Free text

Master Menu 7 – Patient Account – Insurance Claim Denial Codes

Purpose: To print information for a guarantor in the body of a statement with ***Claim Status*** in front. This only prints if a Medoption is set and this code has a 'Y' in the Print on Stmt box.

NOTE: To reach this screen, go to MM4-Patient Account, press F2 (the first account you come to in the group will be fine), then click **Posted Detail**, then click **Ins Claim Maintenance** and then click **Reason**

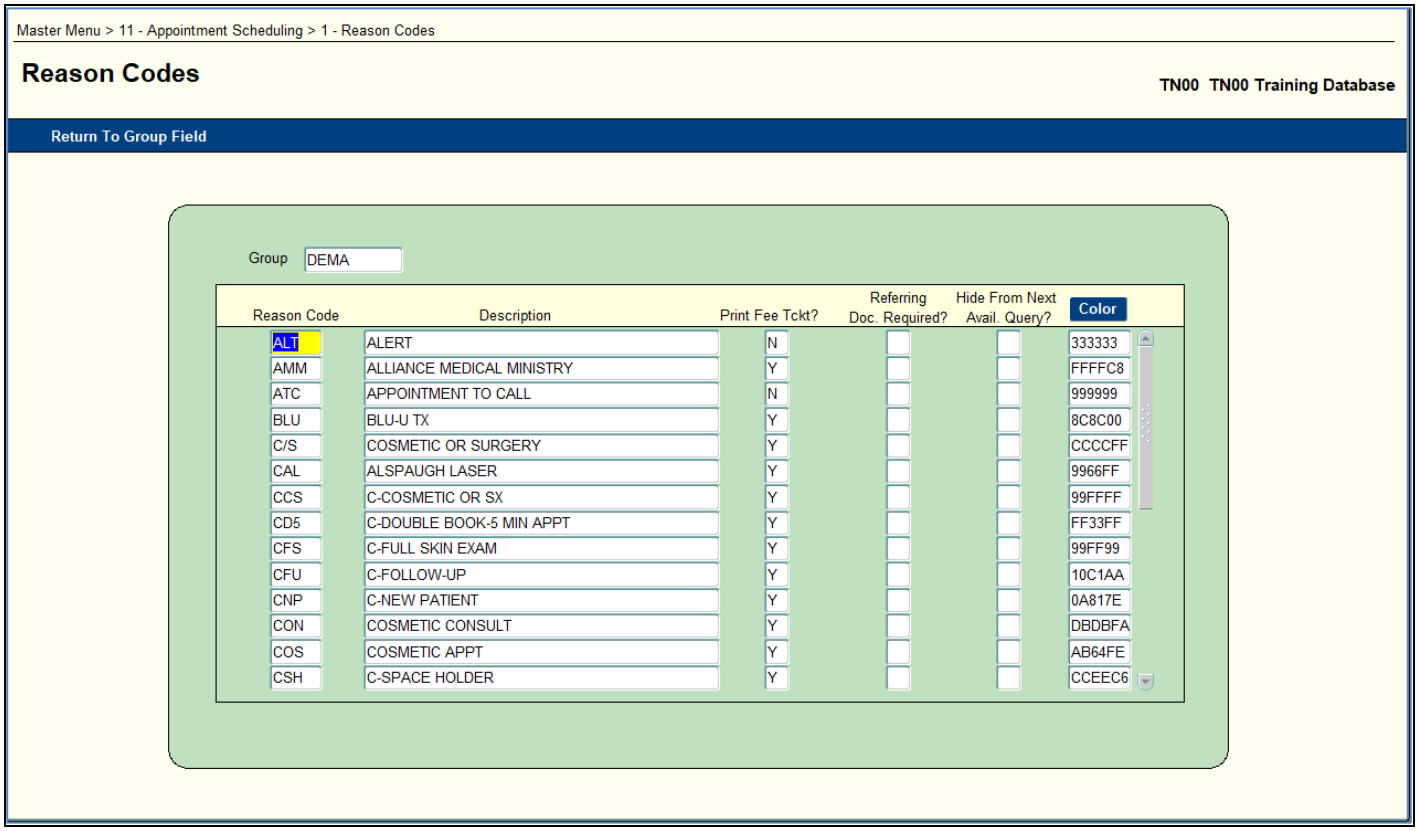


Master Menu 7 Insurance Claim Denial Codes	
Field Name	**Field Description**
Ins Code	Can be for ALL insurance companies or for specific Ins Key Codes
Denial Reason	Reason Code, alpha-numeric, 20 characters
Description	Text description of reason for denial
Print on Stmt?	Y if reason is to print on statement, N if not. The denial code will only print if the account is using the old statement program or if the account is a 'Z' (company) account and the correct medoption is set.

Master Menu 11.1 Reason Codes

Purpose: To enter or update Appointment Reason Codes which are assigned to schedule time slots to determine what type of appointments can be booked in the slots.

- Notes: In order to make the reason codes useable and easy to maintain, it is recommended that you make the codes as open and general as possible, e.g., *NEW* for a New Patient.



Master Menu 11.1 Reason Codes	
Field Name	**Field Description**
Group	Group specific
Reason Code	Alpha-numeric, 3 character maximum
Description	Free text
Print Fee Ticket?	Option to print encounters for this type of appointment. Blank is same as Y.
Referring Doc Required?	Y if Referring doctor required for this appt type. Default is blank (N).
Hide from next available query?	Enter Y to hide from next booking query
Color	Select the LOV to manually choose an individual colors for a specific Appointment Reason Codes

Master Menu 11.2, F6 – Template Application

Purpose: To establish or update schedule slots for the actual times and periods for which appointments can be booked during a schedule session.

- Notes:
  - If you are creating doctor schedules before using the system to book appointments for the first time, inform your Client Service Manager that you have created the doctor schedules. They will need to instruct the system to run the program that actually creates your scheduling "book." This program is usually run after hours, so the schedule will be available the next day. If you have modified an existing schedule, the changes will be available the next day.

With this scheduling template you can build daily templates using any naming convention that will easily apply to a specific practice.

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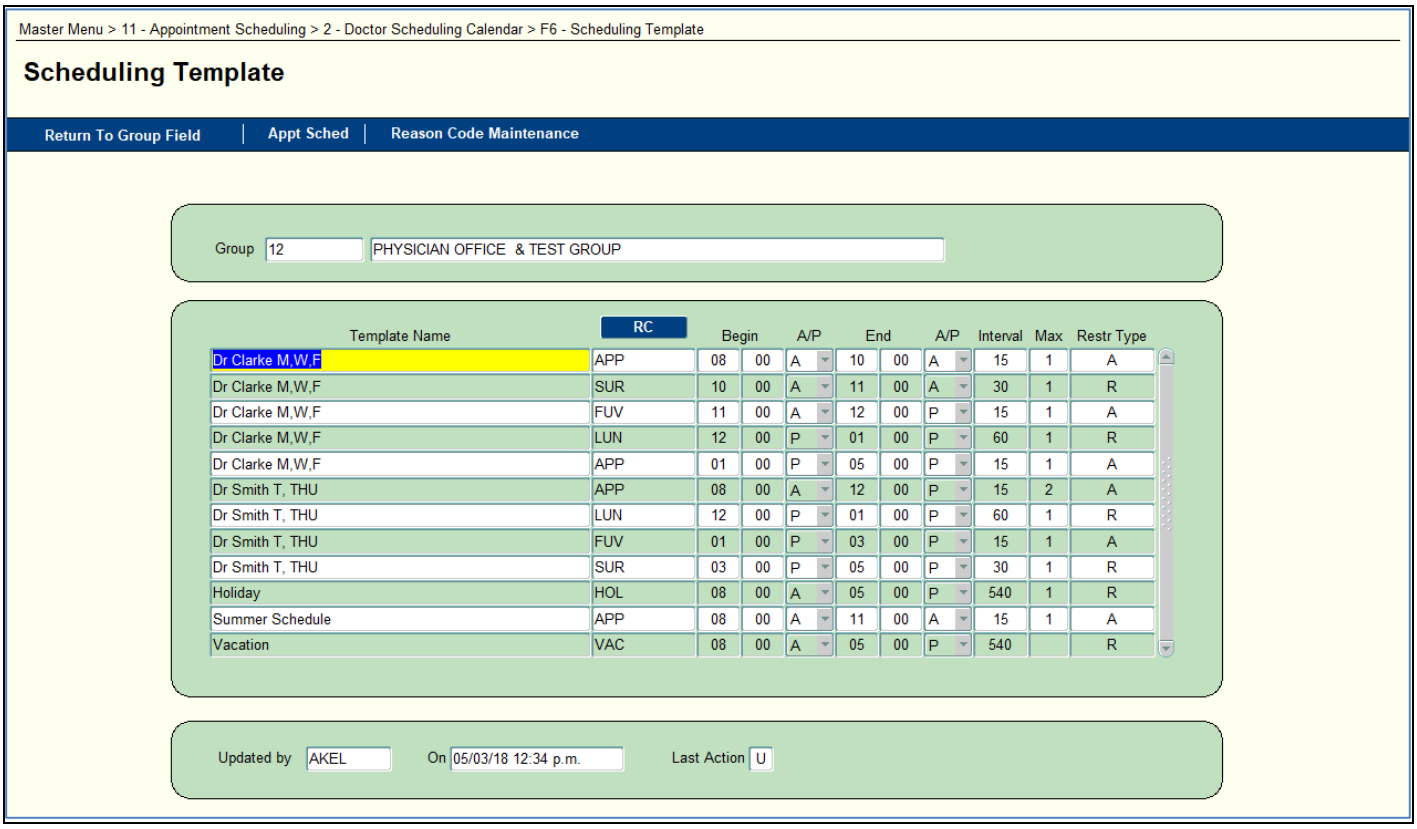
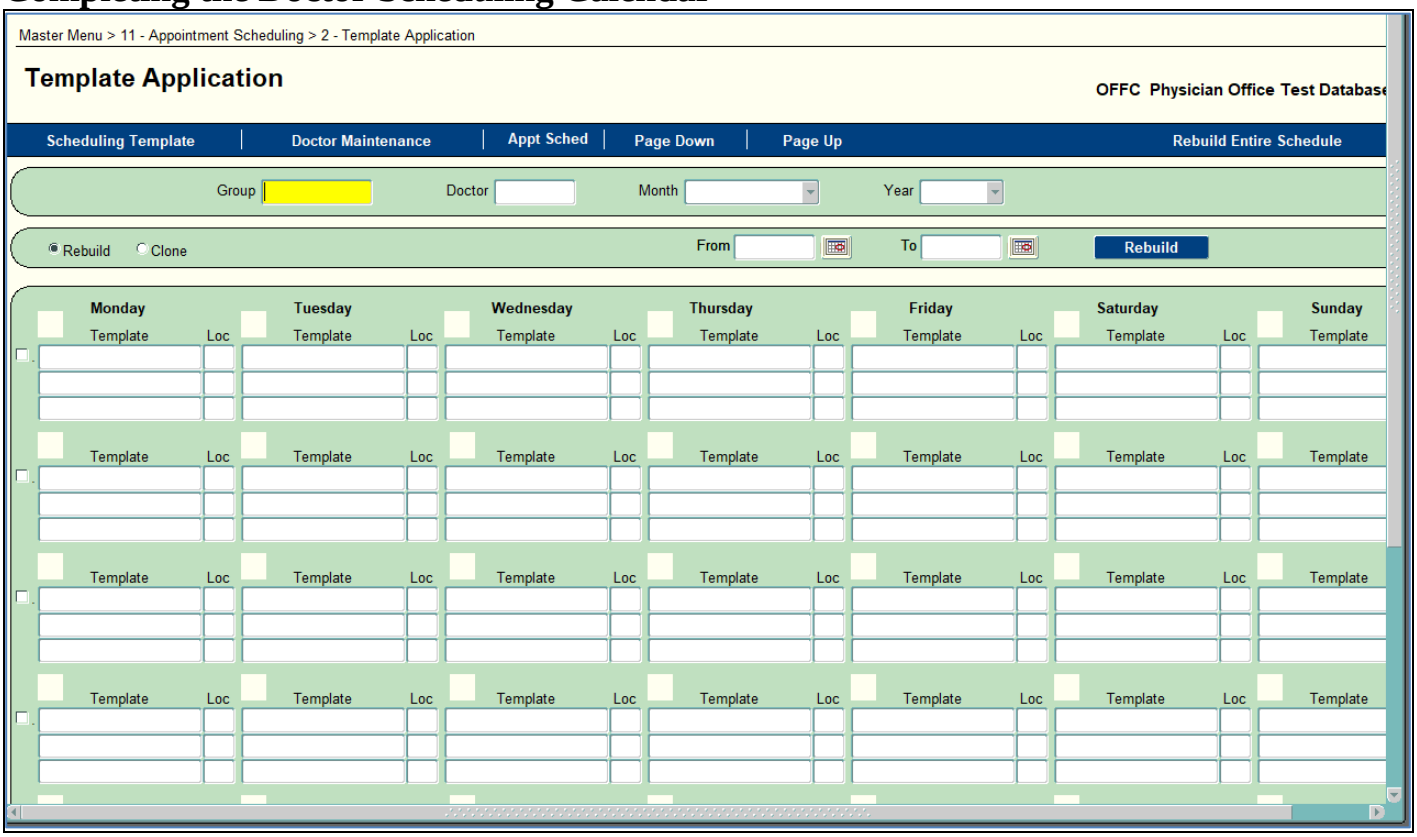


Master Menu 11.2, F6 Scheduling Template	
Field Name	**Field Description**
Group	Group specific
Template Name	This is a free text field which will allow 40 characters. Enter the template name that will have a clear meaning to a specific practice.
Reason Code	Enter the appointment reason code that you would like to attach to the template name.
Begin	Enter the hour and minute when slot should begin e.g., 0830 for 8:30
A/P	Enter the beginning time: A for A.M., P for P.M.
End	Enter the hour and minute when slot should end e.g., 0830 for 8:30
A/P	Enter the ending time: A for A.M., P for P.M.
Interval	Enter the length of slot, in number of minutes, if the slot will be used to book more than one appointment. The system defaults the length of the slot assuming one appointment
Maximum	Enter the number of appointments allowed during the slot, system assumes 1 appointment per slot
Restricted Type	Enter the code for the restriction on what type of appointment can be booked in the slot, see below for choices: A = Accept any appointment type which means the scheduler can override the reason code when booking an appointment N = No Appointments may be booked R = Only allows the scheduler to book appointments for the type specified in the Reason Code field E = Allow the scheduler to book any type of appointment except the type specified in the Reason Code field C = On call day for the doctor (the scheduler uses this as a reminder to keep the schedule light) **NOTE-Any reason code that has a restriction of 'N' or 'E' will NOT show on the schedule**

Completing the Doctor Scheduling Calendar



Once the Scheduling Template has been completed and saved, the template will need to be applied to the calendar.

NOTE: This form is automatically in a query/search mode.

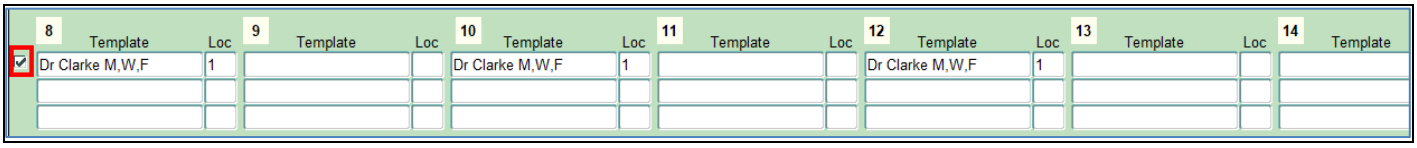
1. Enter the Group Code
2. Enter the Doctor, Month, and Year to apply a template to, F2
3. Click on the day of the month where the template needs to be applied. To view the template use Ctrl F when the cursor is in the field where the template needs to be applied; the list of the templates will appear in a pop-up screen.
4. Select the template that needs to be applied by double clicking on the template or using the F4 function key. This will insert the template into the Doctor Scheduling Calendar.
5. Enter the location for the template
6. Down arrow if additional templates are needed and repeat the process.
7. Save
8. Continue the same steps for each day where a template needs to be applied.

Cloning

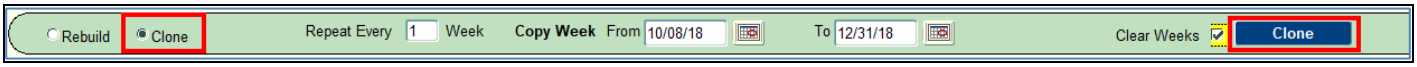
The Clone feature enables you to copy one or more pre-defined weeks. Doctor schedules that consistently follow a pattern are created once and then can be cloned into future months.

How to Clone a Template

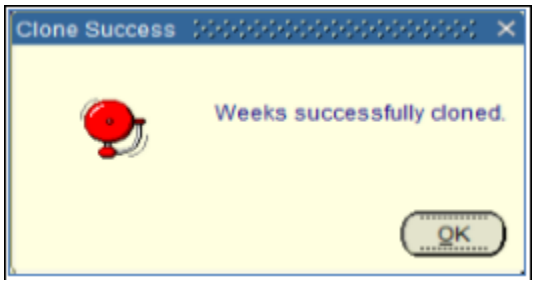
1. Click the check box next to the week you want to clone.



2. Click the Radio button at the top of the screen next to the word Clone. The fields shown below will appear.
    - **Copy Week**
    - **Repeat Every __Week:** Enter the amount of weeks that this schedule should be repeated (e.g every 1 week, every 2 weeks, etc)
    - **From:** Enter the date cloning is to begin
    - **To:** Enter the date cloning is to end
    - **Clear Weeks:** Select this if there is an existing template already in place within the time frame selected for cloning and you want to clear the existing template. This will clear the existing template and replace it with the one that is being cloned.



3. Click on the Clone button after all selections are made.
4. Once the calendare has been successfully cloned, a confirmation notice will display.

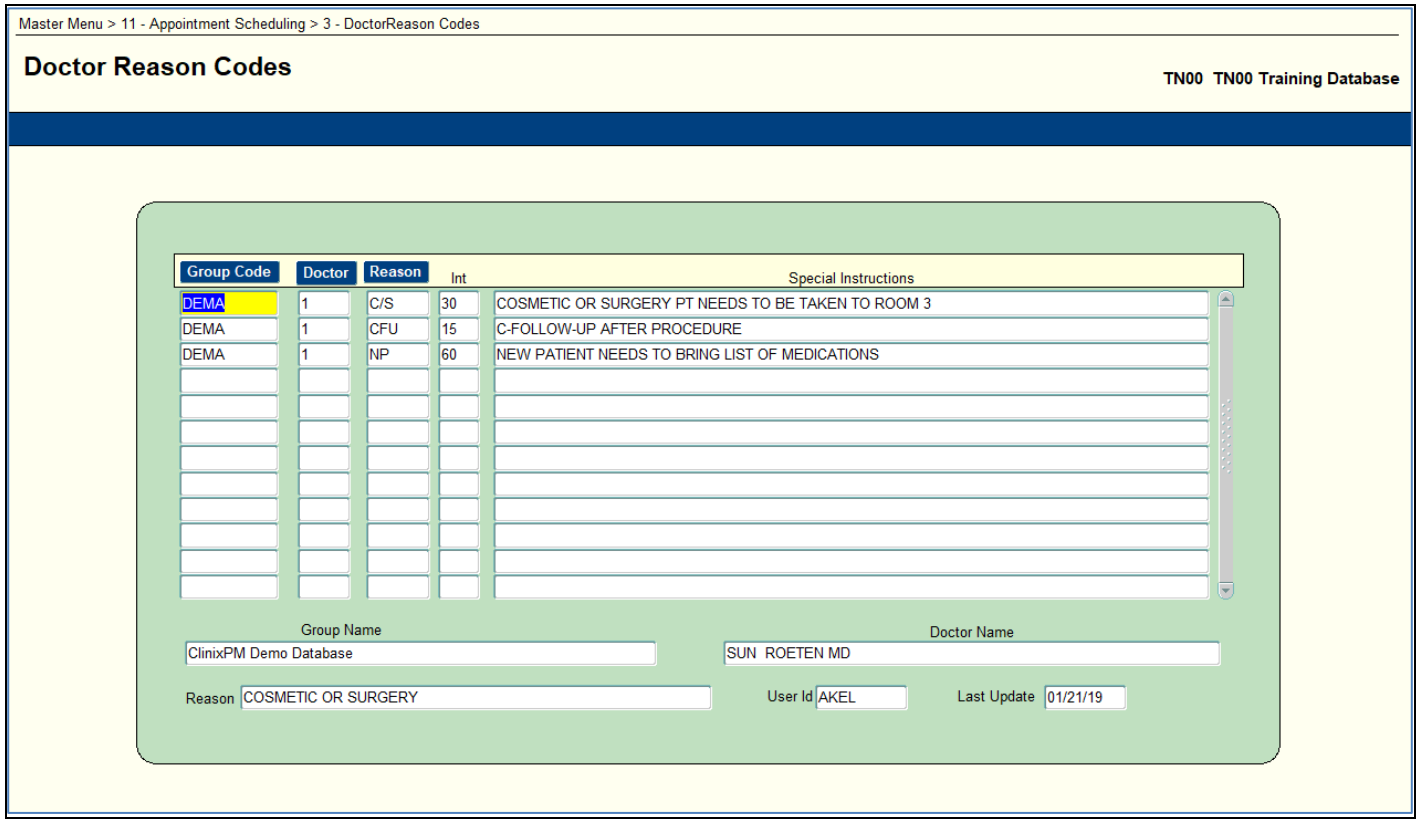


5. Click on the OK button to refresh the calendar and display the month the copy state date begins. For example; If you used the first week in April as the basis for the cloning, and entered May 15, 2018 as the start date for the cloned schedule, a calendar refresh will bring you to May 2018. This will allow you to view the beginning month of the cloned template.

Note: When the calendar is complete, you can rebuild the entire schedule and begin booking appointments. This is done by clicking on the Rebuild Entire Schedule text in the blue bar above the calendar. If you do not rebuild the template, at the time of a change, the schedule will automatically rebuild overnight.

Master Menu 11.3 Doctor Reason Codes

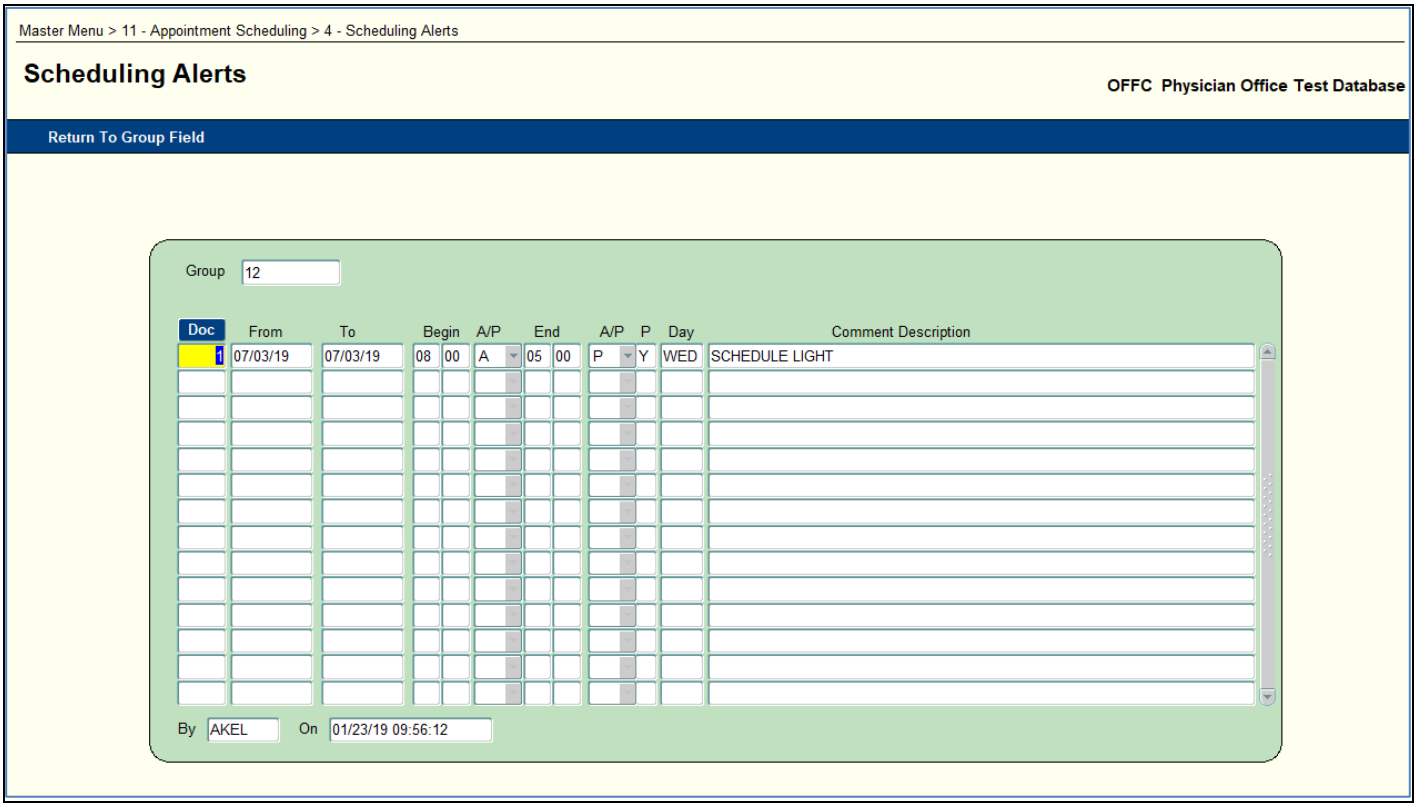
Purpose: To enter or update Doctor Reason Codes which are used to issue special instructions, based on appointment reason that will appear in the Comment section of the General Appointment Booking screen when appointments are made. These instructions will also appear on the doctor's schedule**.**



Master Menu 11.3 – Reason Codes by Doctor	
Field Name	**Field Description**
Group Code	Group specific
Doctor	Select from Doctor Master File
Reason	Enter Reason code to be displayed in a popup box when booking appointments. Alpha-numeric, 3 characters. If used as a "sticky cursor," this reason will populate the Rsn code at the bottom of the General Appt Booking screen (medapgen)
Int	Specify an appointment interval time, if needed
Special Instructions	These instructions will populate the Comment section at the bottom of Medapgen screen.

Master Menu 11.4 – Scheduling Alerts

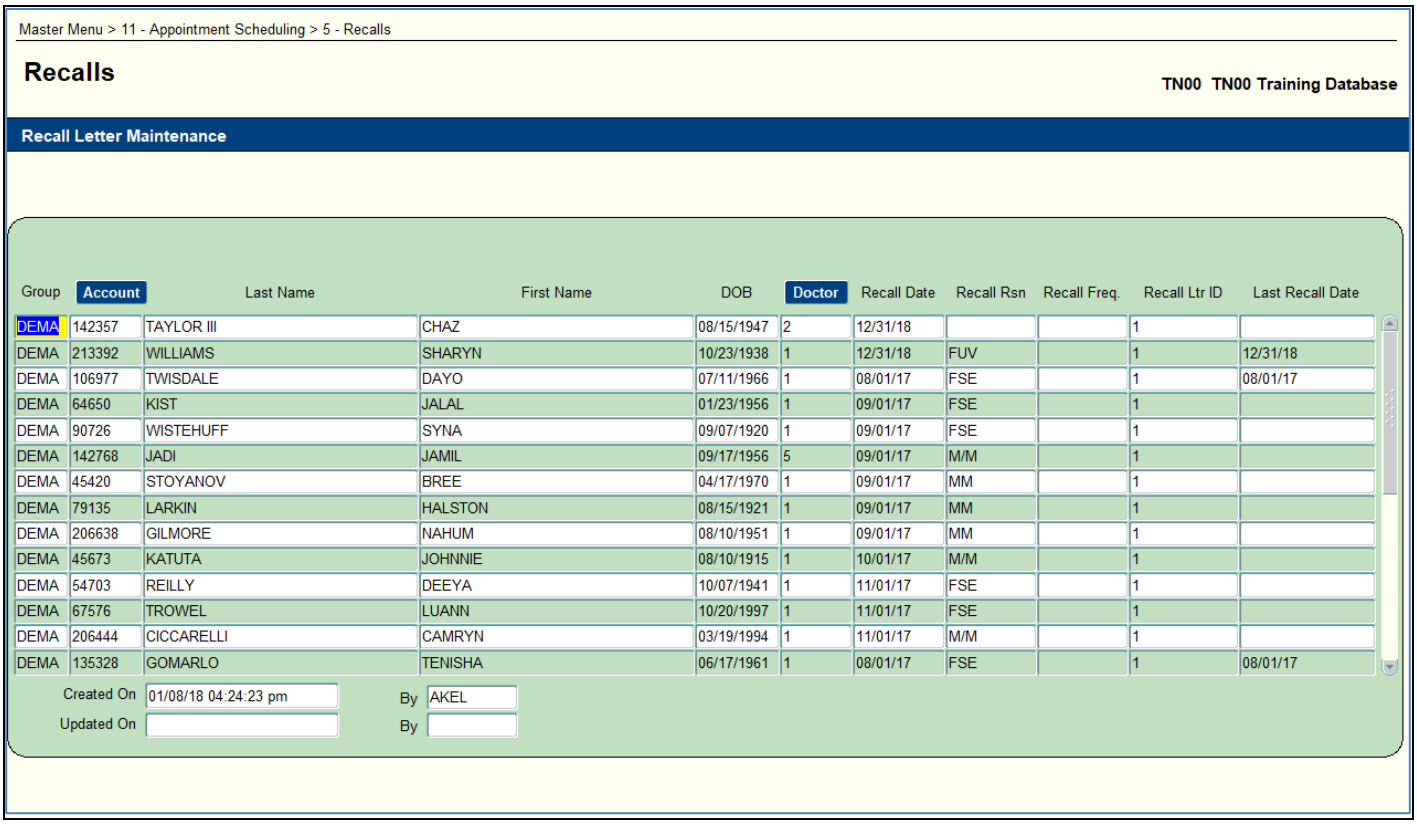
Purpose: This form can be utilized to set up any scheduling alerts that you may want to flag on a specific doctor on a specific day. For example; Doctor 1 may want a light schedule because he has a meeting that day. When this is set there will be a red indicator box on the scheduler screen for that day. You can hover over the red box to see the scheduling alert.



Master Menu 11.4 – Scheduling Alerts	
Group	Group Specific
Doc	Enter Doctor number the alert needs to be attached to
From	Enter the date the alert needs to begin
To	Enter the date the alert needs to go through
Begin	Enter the begin time for the alert
A/P	Select A for AM or P for PM
End	Enter the end time for the alert
A/P	Select A for AM or P for PM
P	No longer used
Day	Enter the Day of the week for the alert or leave blank if multiple days
Comment Description	Enter the alert that is needed

Master Menu 11.5 - Recalls

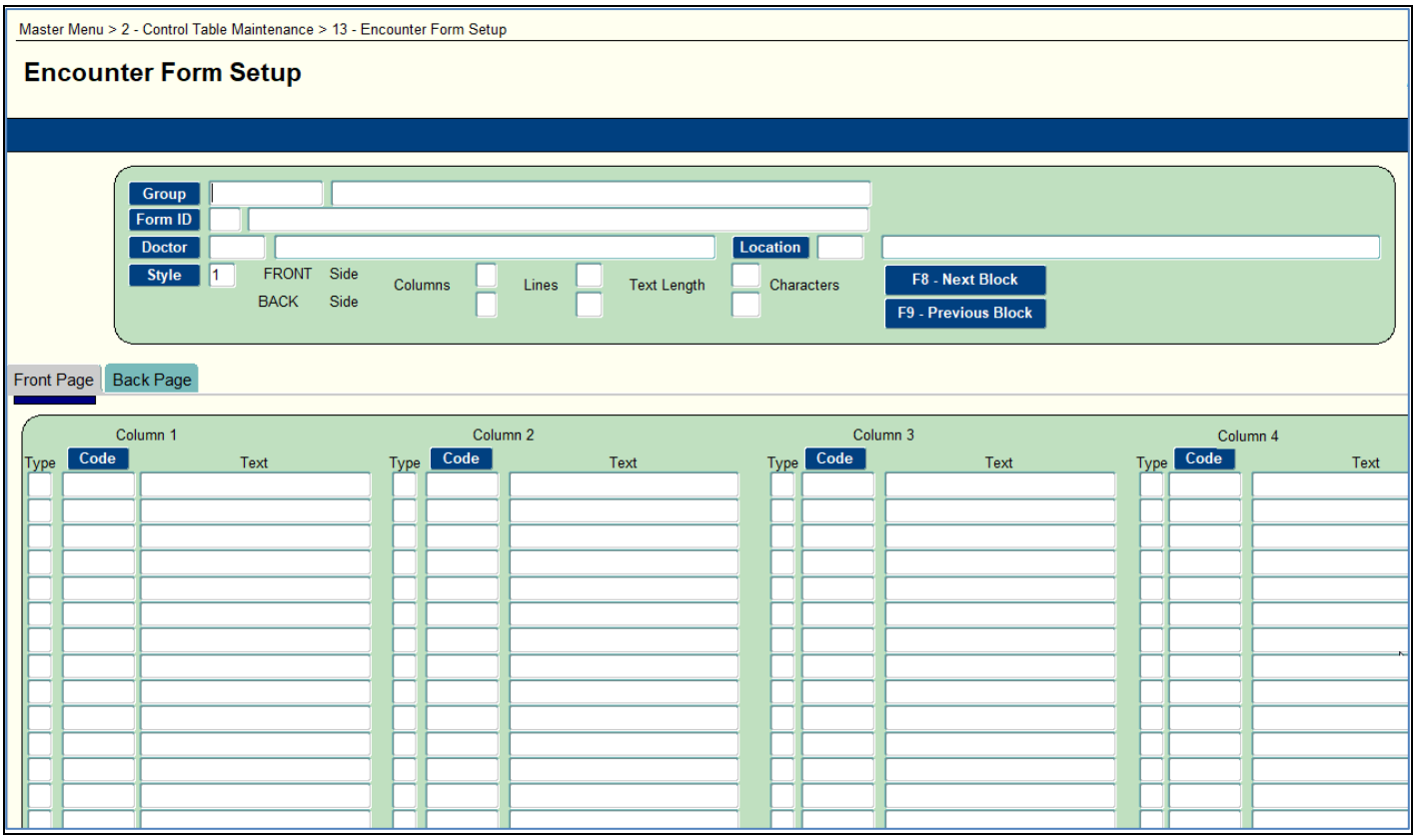
Purpose: A patient recall is a communication to a patient, reminding the patient that it's time to schedule an appointment. You can have the system generate recall notice letters or recall notice address labels on a regular basis.



Master Menu 11.5 – Recalls	
Field Name	**Field Description**
Group	Group specific
ID	Recall Letter ID number; alpha-numeric, 2 characters
Line	Sequential line number to appear on letter (1 for first line, 3 to skip a line, etc.). You will need to add a blank line in between each paragraph for the letter to look nice.
Text	Enter "Dear *Name" to have the Dear salutation and the responsible party name print. Enter "Estimado *Name" for the Spanish version. "Dear" is a suggested salutation but can be substituted. If the user wishes to have the Guarantor addressed instead of the patient, they need to enter 'Dear *Guarname'.

Master Menu 11.13 Encounter Form Setup

Purpose: Establish and maintain Encounter forms (Fee Tickets) for recording procedures rendered at time of service.

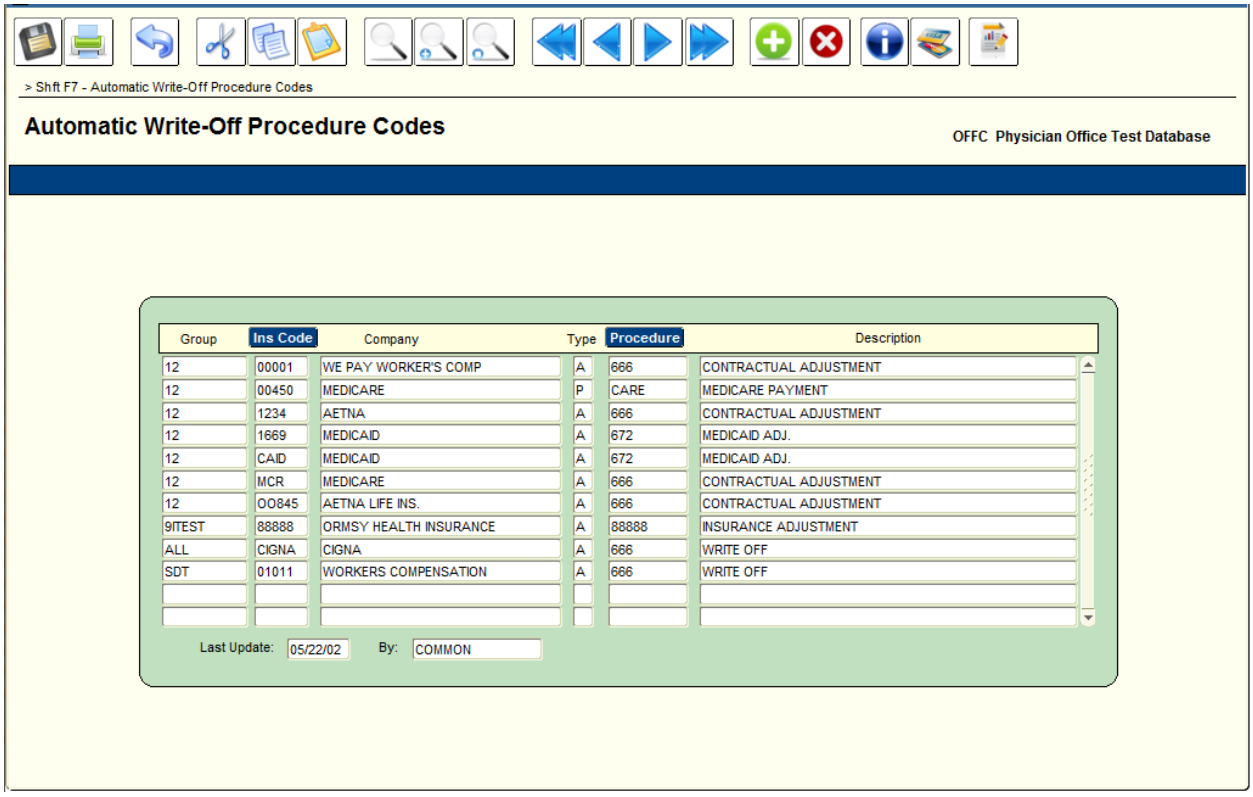


Master Menu 11.13 Encounter Form Setup	
Field Name	**Field Description**
Group	Enter Group ID (group-specific)
Form ID	Enter 2 character user-defined Form Id
Doctor	Leave blank for all drs, or enter specific dr number
Location	Leave blank for all locations, or enter specific location number
Style	Select from LOV
Front Page, Back Page	Click appropriate side of form
Columns, Lines, Text Length, and Characters	Informational fields that displays preset parameters based on the "Style" and "Side" of the encounter form the user is displaying
Col	Defines which column of the form data belongs with (based on max number of columns allowed). Controls placement of columns on the encounter form
Line	Enter sequential line number of the text (based on max number of lines allowed). Controls placement of text on the encounter form

Shade	Leave blank or press Ctrl-‘O’ to shade “Text”
Font	Leave blank or press Ctrl-‘B’ to bold “Text”
Type	Enter ‘P’ for procedure code, ‘D’ for diagnosis code, ‘B’ for blank, ‘H’ for heading
Code	Enter procedure code or diagnosis code (determined by value entered in “Type”
Text	Enter text (Based on “text length” parameter displayed)

Master Menu MM-Shift F7 – Automatic Write-off Procedure Codes

Purpose: When you need to write off the remaining balance after a payment has been made by an insurer, e.g., Workers Comp or Medicaid, because the patient is not to be billed.



Master Menu Shift-F7	
Field Name	**Field Description**
Group	Group specific or group ‘ALL’ can be used on this form when the w/off should be performed for all groups in the database
Ins Code	Insurance Key Code
Company	Populated from Ins Key Code
Type	‘A’ for adjustment, ‘P’ for Payment
Procedure	Adjustment or Payment code

Description	Populated from Procedure