Provider QRG

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Open a Note

From Tracking

1. Access the Tracking window: **Clinical, Practice Management, or Billing tab > Schedule button > Tracking radio button.**
2. Select a patient.
3. Click the **Visit Status** drop-down and select from the list.
4. Click the **Patient Chart** button.
5. Click **Well Visits** or **Encounters**.
6. Select a note and click the **Open Note** button.

From the Patient Chart

1. Access the Patient Chart window: **Clinical, Practice Management, or Billing tab > Patient Chart button.**
2. Find the patient using the **Search** box.
3. Click **Well Visits** or **Encounters**.
4. Select a note and click the **Open Note** button.

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Review/Enter Visit Info

This section is optional depending on who is responsible for documenting this information per practice workflow.

Well Visit: Visit Info

1. From an open Well Visit Note, click **Visit Info**.
2. Review and make edits, as necessary, to the **Accompanied by** field.

3. *(Optional)* **Telehealth:** Complete the Telehealth fields:
    a. **Provider Location:** Click the drop-down arrow and select from the list.
    b. **Patient Location:** Click the drop-down arrow and select from the list.

    Note: Once the Provider Location and Patient Location fields are completed, the Place of Service field updates to **Telehealth.**

Encounter: Visit Info

1. From an open Encounter Note, click **Visit Info**.
2. Review and make edits, as necessary, to the **Accompanied by** field.
3. *(Optional)* **Independent historian:** Click the drop-down arrow and select from the list or click in the field and type who is providing patient history to the provider.
4. *(Optional)* **Assisted by translator:** Select the checkbox to indicate a translator assisted the provider.
5. *(Optional)* **Telehealth:** Complete the fields below
    a. **Provider Location:** Click the drop-down arrow and select from the list.
    b. **Patient Location:** Click the drop-down arrow and select from the list.

    Note: Once the Provider Location and Patient Location fields are completed, the Place of Service field updates to **Telehealth**.

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Review Vital Signs/ Review and Print Growth Charts

Review Vital Signs

From within the Patient Chart, Encounter or Well Visit Note, click **Vitals/Growth**. The most recent vital signs display in the **Vital Signs** section of the window.

Note: To view prior vital signs, click prior dates in the **Date/Time Taken** panel.

Review Growth Measurements

On the **Enter Vital Signs** tab, the most recent growth measurements display in the **Growth Measurements** section of the window.

Note: To view prior growth measurements, click the **Growth Measurements** tab.

Print Growth Charts

1. Click the **Growth Charts** tab.
2. In the **Chart type**: panel, click the **Incl Print** checkbox for the measurements to print.

    Note: You may choose up to four measurements to print on a single sheet of paper.

3. Review the defaulted **Age** radio button and **Source** drop-down.
4. Click the **Print** button.

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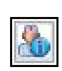
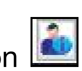
Add an Allergy

1. From within the Patient Chart, Encounter or Well Visit Note, click the **Allergies** button.
2. Click the **New** button.
3. Complete the fields below.
   a. **Subsection**: **Medication Allergy** is the default selection. To change, click the drop-down and choose from the list.
   b. **Status**: **Active** is the default selection. To change, select the **Tracking** or **Resolved** radio button.
   c. *(Optional)* **Onset date**: Defaults to the date you clicked the New button. To change, type a date or click the drop-down and select from the calendar.
   d. **Medication (required for Medication allergy)**:
      i. Type the full or partial name of the medication and click the **Ellipsis** button or press the **Enter** key.
      ii. Choose the medication from the list.
      iii. Click the **OK** button.

      Note: You do not need to select the correct form/strength of the medication.
   e. *(Optional)* **Allergy group**:
      i. Click the **Ellipsis** button.
      ii. Type the full or partial name of the allergy in the **Allergy Code** field.
      iii. Click the **Search** button.
      iv. Select the allergy and click the **Select** button.
   f. **Problem**:
      i. Type the full or partial name of the allergy and press the **Enter** key or click the drop-down arrow and choose the allergy from the list.
      ii. Click the **Select** button.
   g. *(Optional)* **ICD code**: Type the description or Code and press the **Enter** key or click the drop-down arrow and choose from the list.

      Note: This field will only be active for Non-Medication Allergies.
   h. *(Optional)* **Refer/coord**: Click the **Address book** button  or the **Patient Coordination** button  and select.

i. *(Optional)* **Stage/severity**: Click the drop-down arrow and select from the list.
j. *(Optional)* **Symptoms**: Click the drop-down arrow and select from the list.
k. *(Optional)* **Notes**: Type notes related to the allergy
l. **Visibility**: **Any staff member** is the default selection. To change, click the drop-down arrow and select from the list.

4. Click the **Save** button.

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Add a Medication

1. From within the Patient Chart, Encounter or Well Visit Note, click the **Medications** button.
2. Click the **New** button.
3. Complete the following fields.
    a. **Purpose**: **Med - reference only** is the default selection. To change, click the drop-down arrow and select from the list.
    b. *(Optional)* **DX**:
        i. Type the full or partial name of the diagnosis and press the **Enter** key or click the drop-down arrow and select the diagnosis from the list.
        ii. Click the **Select** button.
    c. **Type**: **Standard Medication** is the default selection. To change, click the drop-down arrow and select from the list.
    d. **Drug**:
        i. Type the full or partial name of the medication and press the **Enter** key or click the drop-down arrow and select the medication from the list.
        ii. Click the **OK** button.
    e. **Include in chronic medication list**: Click this checkbox if the medication is ongoing.
    f. **Rx start date**: Defaults to the date you clicked the New button. If unknown, highlight and click the **Delete** button or click the drop-down arrow and select **Clear**.
    g. *(Optional)* **Rx end date**: Date calculated using the Rx Start Date and Days Supply.
4. Click the **Save** button.

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Add a Problem

1. From within the Patient Chart, Encounter or Well Visit Note, click the **Problem List** button.
2. Click the **New** button.
3. Complete the fields below.
   a. **Status**: **Active** is the default selection. To change, select the **Tracking** or **Resolved** radio button.
   b. **Onset date**: Defaults to the date you clicked the New button. To change, type a date or click the drop-down and select from the calendar.
   Note: If the Onset Date is unknown, click the drop-down arrow and select **Clear** or highlight it and click the **Delete** key.
   c. **Problem**:
      i. Type the full or partial name of the problem and press the **Enter** key or click the drop-down arrow and select the problem from the list.
      ii. Click the **Select** button.
   d. *(Optional)* **ICD code**:
      i. Type the full or partial name of the diagnosis and press the **Enter** key or click the drop-down arrow and select the diagnosis from the list.
      ii. Click the **Select** button.
   e. *(Optional)* **Refer/coord**: Click the **Address book** button or the **Patient Coordination** button and select.
   f. *(Optional)* **Stage/severity**: Click the drop-down arrow and select from the list.
   g. *(Optional)* **Symptoms**: Click the drop-down arrow and select from the list.
   h. *(Optional)* **Quality of life**: Click the drop-down arrow and select from the list.
   i. *(Optional)* **Notes**: Type notes related to the problem.
   j. **Visibility**: **Any staff member** is the default selection. To change, click the drop-down and select from the list.
4. Click the **Save** button.

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Add History

Past Medical History

1. From within the Patient Chart, Encounter or Well Visit Note, click the **History** button.
2. Click the **Past Medical** tab.

Note: If previous past medical history was entered, the selections are displayed in the Past Medical window.

3. To see additional history questions, click the **Show all questions** checkbox.
4. Make the following selections.
    a. **+** (Positive): Click once.
    b. **-** (Negative): Click twice.
    c. **N/A**: Click three times. This sets the selected history question back to the N/A value.
5. Add to the Problem List.

    Note: If the history selection should be added to the list of problems, follow the steps below.

    a. Click the **Add** button .
    b. Select from the following on the **Warning** window.
        i. **New**: No entry exists in the Problem List, create a new problem.
        ii. **Attach**: An entry exists in the Problem List, attach to the existing problem.
        iii. **Cancel**: Cancel add or attach to a problem.
    c. Complete the information on the **Problem List** window (see **Add a Problem** section for additional information).

Family History

1. From within the Patient Chart, Encounter or Well Visit Note, click the **History** button.
2. Click the **Family** tab.
3. Confirm **Genetic mother** and **Genetic father**. If not selected, click the drop-down and choose from the list.

    Note: Genetic mother and Genetic father are entered and set in Clinical Contacts.

4. Click the **Add** button .
5. Complete the following fields.
    a. **Family Member**: Click the drop-down arrow and select from the list.
    b. **+/-**: Default to **+** (Positive). Click into the **+ / -** field to change the selection.
    c. **Problem**: Click the **Problem** button or type the full or partial name of the problem and click the **Search** button .
    d. *(Optional)* **SNOMED**: Field populated by the selected problem.
    e. *(Optional)* **Dx Age**: Click the drop-down arrow and select from the list.
    f. *(Optional)* **Notes**: Type notes related to the selected family member's problem.
6. Click the **Save** button .

Social History

1. From within the Patient Chart, Encounter or Well Visit Note, click the **History** button.
2. Click the **Social** tab.

   Note: If previous social history was entered, the selections display in the Social window.
3. To see additional history questions, click the **Show all questions** checkbox.
4. Make the following selections.
   a. **+** (Positive): Click once.
   b. **-** (Negative): Click twice.
   c. **N/A**: Click three times. All history questions not selected will begin with the N/A value.

Newborn History

1. From within the Patient Chart, Encounter or Well Visit Note, click the **History** button.
2. Click the **Newborn** tab.

   Note: If previous newborn history was entered, the selections display in the Newborn window.
3. To see additional history questions, click the **Show all questions** checkbox.
4. Make the following selections.
   a. **+** (Positive): Click once.
   b. **-** (Negative): Click twice.
   c. **N/A**: Click three times. All history questions not selected will begin with the N/A value.

Birth Info

1. From within the Patient Chart, Encounter or Well Visit Note, click the **History** button.
2. Click the **Birth Info** tab.

   Note: Always follow your Practice policy on what information to complete in the fields below.
3. Complete the fields below.
   a. *(Optional)* **Birth time**: Type a time or click the up/down arrows to change the time.
   b. **Part of multiple birth**: Click the checkbox if part of a multiple birth.
   c. **Apgars**: Click in the field and type the Apgars score.
   d. **Gestational Age**: Click the drop-down arrow and select from the list
   e. **Synagis indicated**: Click the checkbox if Synagis indicated.
   f. **Type of delivery**: Click the drop-down arrow and select from the list.
   g. **Feeding**: Click the drop-down arrow and select from the list.
   h. **Infant blood type**: Click the drop-down arrow and select from the list.

i. **Coombs**: Click the drop-down arrow and select from the list.
j. **Hearing screen**: Click the drop-down arrow and select from the list.
k. **Newborn screen #**: Click in the field and type the Newborn screen number.
l. **Adopted/at**: If adopted, click the checkbox and enter the age in months of adoption in the months field.
m. **Birth Location**:
    i. **Birth place**: Click the drop-down arrow and select from the list.
    Note: If the birth place is not in the list, type in the blank text field below the **Birth place** field.
    ii. **County**: Click the drop-down arrow and select from the list.
    iii. **City / State**: Click the drop-down arrow and select from the list.
    iv. **Country**: Click the drop-down arrow and select from the list.
n. **Birth Measurements**:
    i. **Units**: **Inches / lbs** is the default selection. Select the **cm /kg** radio button to view metric units.
    ii. **Length**: Type a number or click the drop-down and select from the number pad.
    iii. **Weight**: Type a number or click the drop-down and select from the number pad.
    iv. **Head Circum**: Type a number or click the drop-down and select from the number pad.
o. **Discharge Measurements**:
    i. **Discharge date**: Type a date or click the drop-down and select from the calendar.
    ii. **Length**: Type a number or click the drop-down and select from the number pad.
    iii. **Weight**: Type a number or click the drop-down and select from the number pad.
    iv. **Head Circum**: Type a number or click the drop-down and select from the number pad.

Maternal/Pregnancy History

1. From within the Patient Chart, Encounter or Well Visit Note, click the **History** button.
2. Click the **Maternal/Pregnancy** tab.
   Note: Always follow your Practice policy on what information to complete in the fields below.
3. **Maternal Blood Type / Tests**: Complete the fields below.
   a. **Blood type**: Click the drop-down arrow and select from the list.
   b. **Indirect Coombs**: Click the drop-down arrow and select from the list.
   c. **Hep B surface antigen**: Click the drop-down arrow and select from the list.
   d. **RPR/VDRL**: Click the drop-down arrow and select from the list.
   e. **Rubella**: Click the drop-down arrow and select from the list.
   f. **HIV status**: Click the drop-down arrow and select from the list.
   g. **Group B strep**: Click the drop-down arrow and select from the list.

h. **Amnio/CVS testing**: Click the drop-down arrow and select from the list.

4. **Family of Origin:** Complete the fields below.
   a. **Marital status at birth/adoption**: Click the drop-down arrow and select from the list.
   b. **Parent relationship at birth/adoption**: Click the drop-down arrow and select from the list.
   c. **Mother's maiden name**: Click in the field and type the mother's maiden name.
   d. **Mother's ethnicity**: Click in the field and type the mother's ethnicity.
   e. **Fathers ethnicity**: Click in the field and type the father's ethnicity.

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Encounter Documentation

Encounter: Select a Diagnosis Template

1. From an open Encounter Note, click **Detail Exam**.
2. From **All templates**, click the drop-down arrow or begin typing the template name and select from the list.
3. Click **OK** to apply the template.

   Note: The exam populates Normal and Abnormal findings according to the selected encounter template.
4. To make changes, click in the **NL / ABNL** column field.

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Well Visit Documentation

Well Visit: Detail Exam

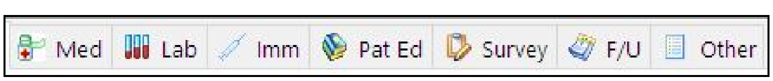
1. From an open Well Visit Note, select **Detail Exam**.

   Note: The exam populates Normal findings according to the selected well template.
2. To make changes, click in the **NL / ABNL** column field.

Create Orders/Add Tasks

Add a Task from the Order Worksheet

1. From within an Encounter, click the **Orders** button, or from within a Well Visit, click the **Plan/Orders** button. The Worksheet Summary populates by the template and by what is entered into each tab of the worksheet:

2. To add a task for **Medications**:
   a. Click the **Med** tab.

   b. Type the full or partial name of the medication and click the **Ellipsis** button.
   c. Select the diagnosis from the **Choose Primary Diagnosis** window.
   d. Click the **OK** button or **Cancel** if not selecting a diagnosis.
   e. Choose the medication from the list. If the medication is not available in the **Matching Favorites** list, click the **Master List** tab and select.
   f. Click the **OK** button.
   g. Complete the **Prescription Writer** window.
   h. Select the **Send**, **Print**, or **Save** button.
3. To add a task for a **Lab**:
   a. Click the **Lab** tab.
   b. If the lab is listed, select the **Add** checkbox.
   c. If the lab is not listed:
      i. Click the **Add** button .
      ii. Type the test name in the **Diagnostic Test Name** field.
      iii. Select the test.
      iv. Confirm the **Department**. Click the drop-down arrow if you need to change it.
      v. Confirm that the **Add** checkbox is selected.
      vi. Click the **Save** button .
   d. Repeat the above procedures to add other diagnostic tests.
   e. Click the **Create** button.
   f. Click the **OK** button to create a task for the diagnostic test.
4. To add a task for an **Immunization**:
   a. Click the **Imm** tab.
   b. If the vaccine is listed, click the radio button in the **Tdy** column.
   c. If the vaccine is not listed:
      i. Click the **Add** button.
      ii. Type the name of the vaccine in the **Vaccine Name** field.
      iii. Select the vaccine.
      iv. Confirm the **Department**. Click the drop-down arrow if you need to change it.
      v. Click the **Save** button.
   d. Repeat the above procedures to add other vaccines.
   e. Click the **Create** button.

   f. Click the **OK** button to create a task for the vaccine.

5. To add a task for **Patient Education**:
   a. Click the **Pat Ed** tab.
   b. If the Patient Education is listed, select the **Add** checkbox.
   c. If the Patient Education is not listed:
      i. Click the **Add** button.
      ii. Type the name of the document in the **Resource Name/Location** field.
      iii. Select the document.
      iv. Confirm the **Department**. Click the drop-down arrow if you need to change it.
      v. Click the **Save** button.
   d. Repeat the above procedures to add other patient-education documents.
   e. Click the **Create** button.
   f. Click the **OK** button to create a task for the patient-education document.
6. To add a task for a **Survey**:
   a. Click the **Survey** tab.
   b. If the survey is listed, select the **Add** checkbox.
   c. If the survey is not listed:
      i. Click the **Add** button.
      ii. Type the name of the survey in the **Survey Name** field.
      iii. Select the survey.
      iv. Confirm the **Department**. Click the drop-down arrow if you need to change it.
      v. Click the **Save** button.
   d. Repeat the above procedures to add other surveys.
   e. Click the **Create** button.
   f. Click the **OK** button to create a task for the survey.
7. To add a task for **Follow-up**:
   a. Click the **F/U** tab.
   b. If a follow-up is listed, select the **Add** checkbox.
   c. If a follow-up is not listed:
      i. Click the **Add** button.
      ii. Type the reason for the follow-up in the **Schedule: Next Visit / Appt. Reason** field.
      iii. Confirm the **Department**. Click the drop-down arrow if you need to change it.
      iv. Click the **Save** button.

d. Repeat the steps to add other follow-up appointments
e. Click the **Create** button
f. Click the **OK** button to create a task for a follow-up.

8. To add a task for **Other** orders that cannot be created from the tabs of the Order Worksheet:
   a. Click the **Other** tab.
   b. If other tasks are listed, select the **Add** checkbox.
   c. If the task is not listed:
      i. Click the **Add** button.
      ii. Type a description of the task in the **Task Name/Description** field.
      iii. Confirm the **Task Type** or click the drop-down arrow and choose another from the list.
      iv. Confirm the **Due Date**. To change it, type a date or click the drop-down and select from the calendar.
      v. *(Optional)* **ICD-10**: Used only when billing for the task. Type the ICD-10 or click the drop-down arrow to search.
      vi. *(Optional)* **CPT(s)**: Used only when billing for the task. Type the ICD-10 or click the drop-down arrow to search.
      vii. Confirm the **Department**. Click the drop-down arrow if you need to change it.
      viii. Click the **Save** button.
   d. Repeat the above procedures to add other follow-up appointments.
   e. Click the **Create** button.
   f. Click the **OK** button to create the Other tasks.

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Code and Finalize a Note

Well Visit: Assessment

1. From within the Well Visit Note, click **Assessment**.
2. **ICD-10 Description/ICD-10:**
   a. Type the full or partial name of the diagnosis and press the **Enter** key or click **Search** to search for and select the code.
   b. Repeat steps above for any additional diagnosis codes.
   Note: Select the checkbox in the **Add PL** column if the diagnosis should be added to the patient's Problem list. Click the **Yes** or **Yes + Details** to Confirm.

Well Visit: Code a Note

1. From within the Well Visit Note, click **Coding**.
2. Confirm the **Visit type**. To change it, click the radio button for **Estab**, **New pt** or **Consult.**
3. Click the **Use Suggested** button.
4. If there were abnormal findings, select the **Abnormal Findings** checkbox.
5. Review the CPT Codes in the coding grid located in the lower section of the Coding Window.
6. Add additional CPT codes, if necessary.
   a. Click a Category button.
   b. Double click a CPT code to select it

      Note: If the CPT code was not found in the Category, click the **Lookup CPT** button and select the **Complete** and **Master** radio buttons to expand the search.
   c. Repeat for additional CPT codes.
7. Assign diagnosis codes to the corresponding CPT codes.
   a. **DX1, DX2, DX3, DX4**: Click the drop-down arrow and select from the list.
8. *(Optional)* **Billing Status:** Click the drop-down arrow and select Ready to Bill.

Encounter: Assess/Plan

1. From within the Encounter Note, click **Assess/Plan**.
2. **ICD-10 Description/ICD-10:**
   a. Type the full or partial name of the diagnosis and press the **Enter** key or click **Search** to search for and select the code.
   b. Repeat steps above for any additional diagnosis codes.

      Note: Select the checkbox in the **Add PL** column if the diagnosis should be added to the patient's Problem list. Click the **Yes** or **Yes + Details** to Confirm.
3. **Problem Status**: Click the drop-down arrow and select from the list.
4. **Assessment:** Review and make changes as needed.
5. **Plan:** Review and make changes as needed.
6. **Patient Instructions:** Review and make changes as needed.

Encounter: Code a Note

1. From within the Encounter Note, click **Coding**.
2. Confirm the **Visit type**. To change it, click the radio button for **Estab** or **New Pt.**
3. Review the **Tracked Time** and **MDM** coding calculation information.

4. Select the E/M Code to apply to the visit by clicking the **Add Suggested Code** button.
5. Review the CPT Codes in the coding grid located in the lower section of the Coding Window.
   a. Add additional CPT codes, if necessary, using one of the following methods:
      i. Enter the CPT code in the **Add CPT Code** field, and press Enter on your keyboard to add it to the coding grid.
      ii. Click the **ellipsis** to search for and select a CPT code.
      iii. Select the **Categories** radio button, choose a category and double-click the code to apply it.
6. Assign diagnosis codes to the corresponding CPT codes
   a. **DX1, DX2, DX3, DX4**: Click the drop-down arrow and select from the list.
7. *(Optional)* **Billing Status:** Click the drop-down arrow and select Ready to Bill.

Finalize a Note

1. From within the Encounter or Well Visit Note, click the **Summary** button.
2. Review the Note.
3. *(Optional)* **Patient Exit Note**: Click the **Patient Exit Note** tab.
   a. Click the **Rebuild Summary** button.
   b. Click the **Print Note** button to print.
4. *(Optional)* **Note Reviewed by:** Click the drop-down arrow and select from the list.
   Note: If the practice or state requires a percentage of Notes charted by mid-levels or medical students to be reviewed, and the reviewer is visible on a note, select the reviewer.
5. Click the **Finalize** button.
6. Click **OK** to finalize the note or **Cancel** if you are not prepared to finalize.

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