ChartMaker® Clinical Release Notes
ChartMaker® 2016 (fv6.2.2)

Please note that the ChartMaker Medical Suite can no longer be installed on computers using the Windows XP or Windows 2003 Server operating system. Since Microsoft has discontinued support for Windows XP in April 2014, and Windows 2003 Server in July 2015, we can no longer guarantee the stability of computers using this operating system, and recommend that you upgrade the operating system on any computers currently using Windows XP or Windows 2003 Server.

Added Features

- **Audit Trail –** The Audit Trail has been updated to track when implantable device information is added, edited, and deleted from the system. See Figure 1. When an implantable device event occurs the Event column will display **Created** or **Modified** depending upon the action; the Group column will display **Implantable**, the Audit Trail Description will detail at the end of the description whether the item was **Added**, **Deleted**, or **Updated**; and the **Account ID** and **Visit Date** will be listed in the Metadata column.

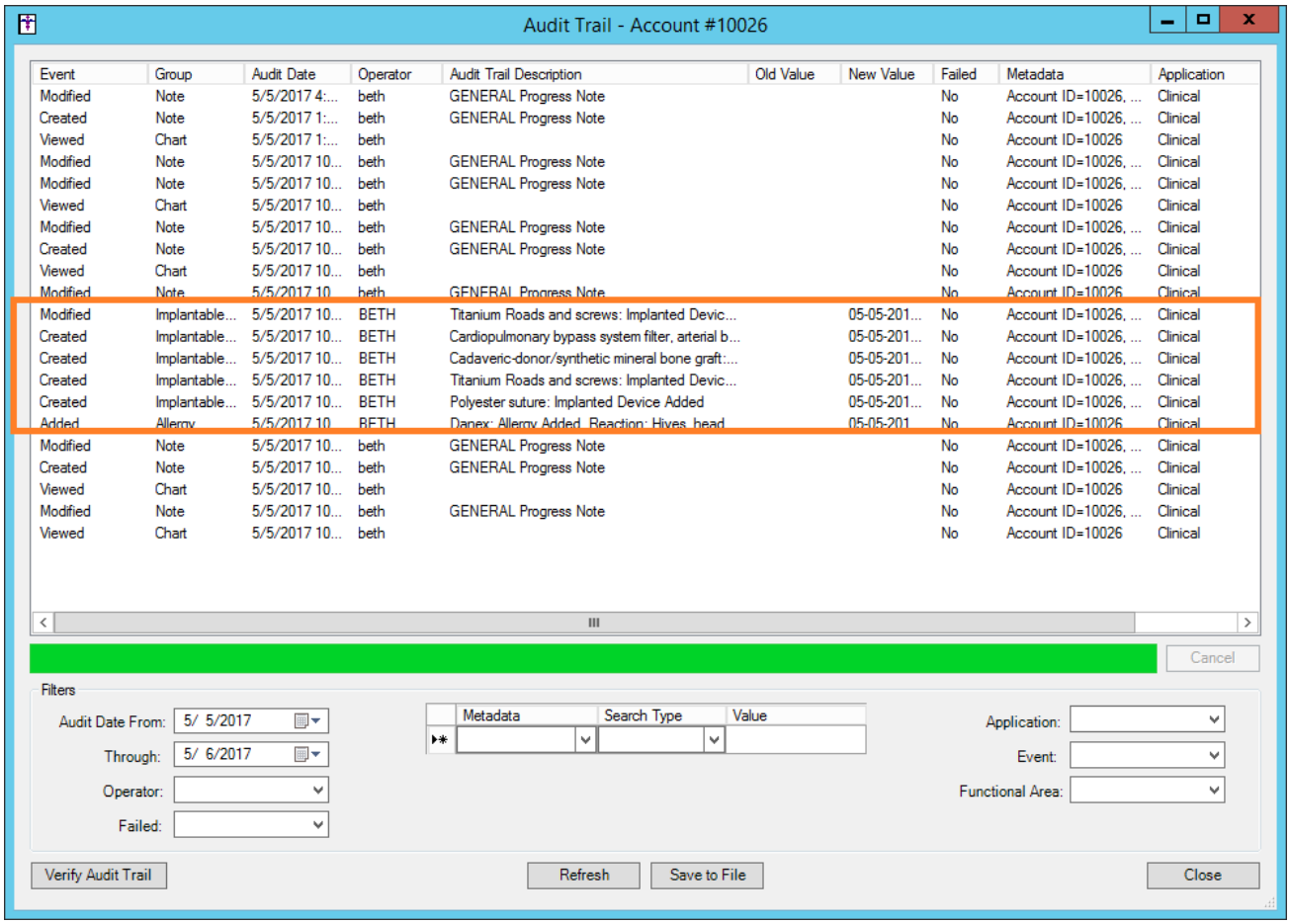


Figure 1 – Audit Trail

Added Features (continued)

- **Audit Trail –** The Audit Trail has been updated to track when Patient Health Information is added, edited, and deleted from the system. See Figure 2. When a Patient Health Information event occurs the Event column will display Added, **Modified**, **Import**, and **Deleted** depending upon the action; the Group column will display **PHI**; the Audit Trail Description will detail the item added, modified, imported, or deleted; the Old Value and New Value fields will display the items modified, **Marked** or **Unmarked**; and the **Account ID** and **Visit Date** will be listed in the Metadata column.

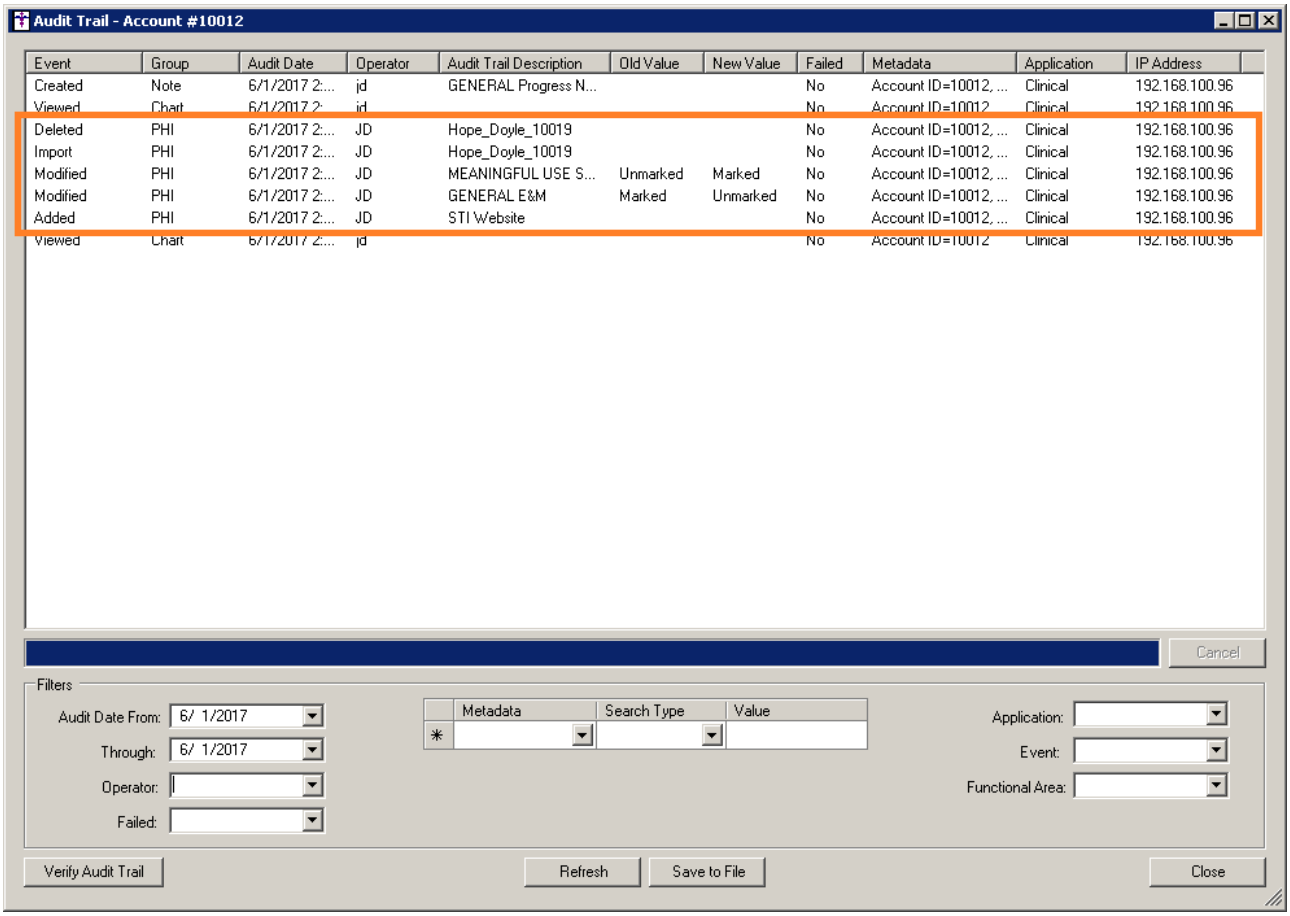


Figure 2 – Audit Trail

- **Audit Trail –** The Audit Trail has been updated to track RxCancel requests. See Figure 3. When a RxCancel is initiated and completed, the system will track the Event as **Modified**, the Group as **Medication**, include an Audit Trail Description of **Medication Canceled: [Medication Information]**, and list the Account ID and Visit Date in the Metadata column.

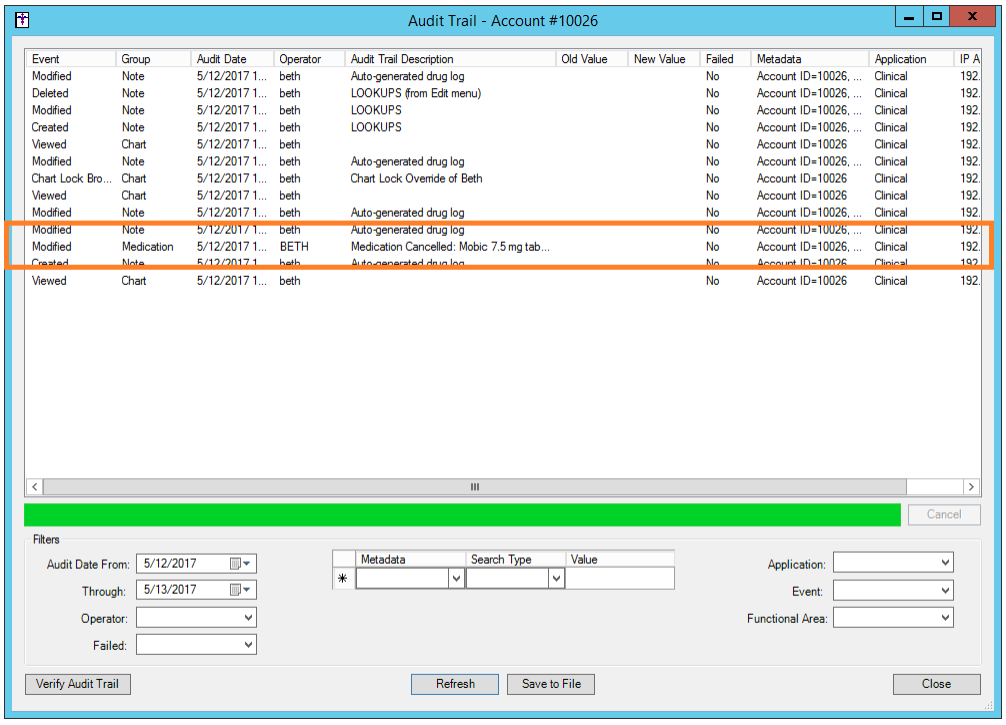


Figure 3 – Audit Trail

- **Direct Messaging – Manage Direct Addresses –** The **Direct Address Manager** dialog (accessed via **To-Do** > **Direct Messaging** > **Manage Direct Addresses...**) has been updated so that the Users will appear in alphabetical order allowing you to locate a specific user easily and more efficiently when managing addresses for users.

- **The Facesheet – Implanted Devices –** The Facesheet has been updated with an **Implantable Devices** section that will list any implantable devices that were added for the patient via the new Implantable Device button. If you click the asterisk (*) button next to the device, the context menu will display the information configured for that device. See Figure 4. You can also add a new Implantable Device button to a note by clicking the heading of this section, and then dragging and dropping to the location in the note where you want the button to appear.

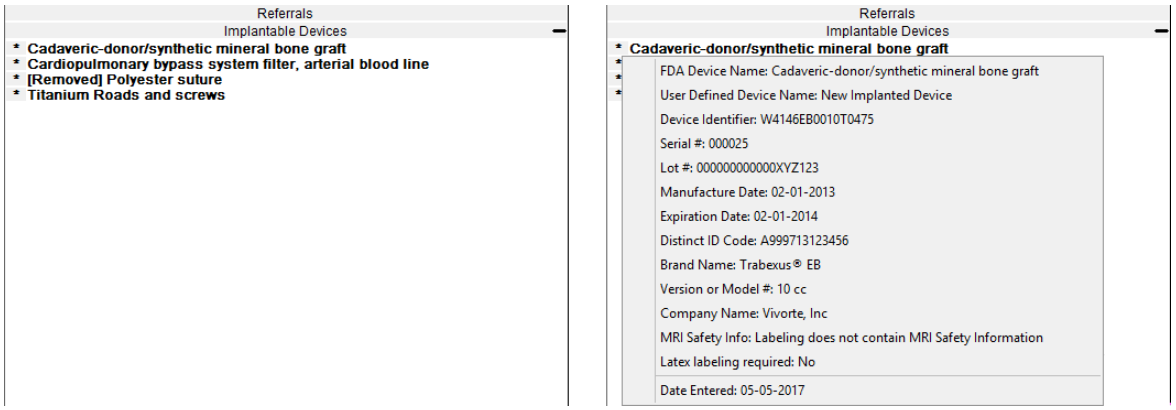


Figure 4 – The Facesheet – Implantable Devices

- **Import Patient Data –** The Import Document dialog (accessed via **Chart** > **Import** > **Patient data**) has been updated with the ability to validate the imported file when the **Consolidated CDA (CCDA)** file format is selected in the File format field. Do note, this validation will *not* be performed when **Healthcare Information Technology Standards Panel CCD/C32** or **ASTM Continuity of Care (CCR)** file format options are selected in the File format field.

  When a Consolidated CDA (CCDA) file format is selected, there is a three-step validation that is triggered once the **Next** button has been clicked.

  For the first step, the system will confirm that the file being imported is a valid XML document. If it is not, an error message will note that the document isn't valid, show the error found, and you will not be able to import the document.

  For the second step, the system will verify that the document is a valid CDA and only contains XML elements allowed by the CDA schema. If it is not, an error message will appear noting that the document isn't a valid C-CDA, and you will not be able to import the document. Likewise, the message dialog will also contain an optional Details button that will allows access to and display any errors found.

  The third step of the validation will only be triggered when the **Validate Document** option (enabled via an advanced preference) is checked. See Figure 5. When the Validate Document option is activated, the system will check the imported file for any implementation guide errors, and if any errors are detected a Validation Results dialog will appear indicating that there were errors. See Figure 6. You can view the error details by clicking the **Details** button, as well as continuing with the import by clicking the **OK** button.

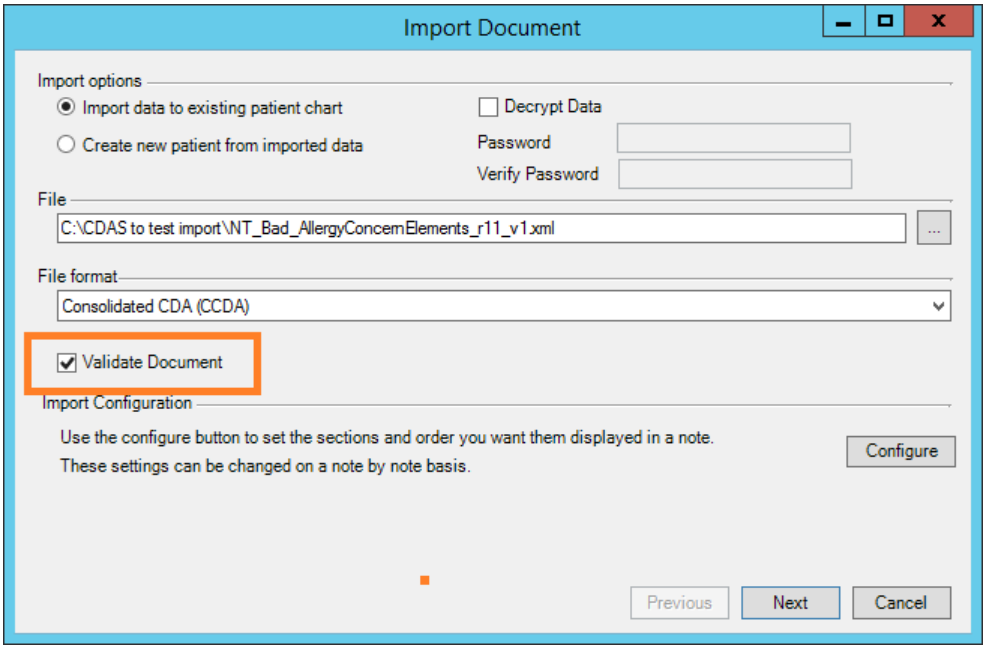


Figure 5 – Import Document

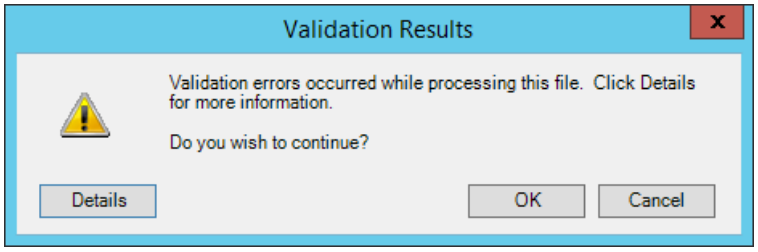


Figure 6 – Validation Results

Added Features (continued)

- **Meaningful Use Stage 2 2017 – Quality Measures –** The Meaningful Use Dashboard has been updated with the following Clinical Quality Measures (CQMs): **NQF0101 Screening for Future Fall Risk** and **NQFTBD Dementia: Cognitive Assessment**.

  The NQF0101 Screening for Future Fall Risk CQM will measure the percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period. The LOINC and SNOMED codes used in the **Falls Risk Assessment Form** screening will count toward the numerator and exceptions.

  The NQFTBD Dementia: Cognitive Assessment CQM will measure the percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period. The LOINC and SNOMED codes used in the **Blessed Orientation Memory Concentration Test (Cognitive Assessment)** screening will count toward the numerator and exceptions.

  See **The Note Tab – Screening – Falls Risk Assessment Form** and **The Note Tab – Screening – Blessed Orientation Memory Concentration Test (Cognitive Assessment)** entries below for further details on these new screenings.

- **Medication – Prescribe Medication–** The Prescribe Medication dialog have been updated so that whenever prescribing or renewing an oral liquid medication, the Dose Units field will be set to the oral form and will be locked, and the Dispense units will be set to Milliliter and will be locked. See Figure 7. This ensures that the correct Dose and Dispense units will be used when prescribing and renewing oral liquid medications per ONC requirements.

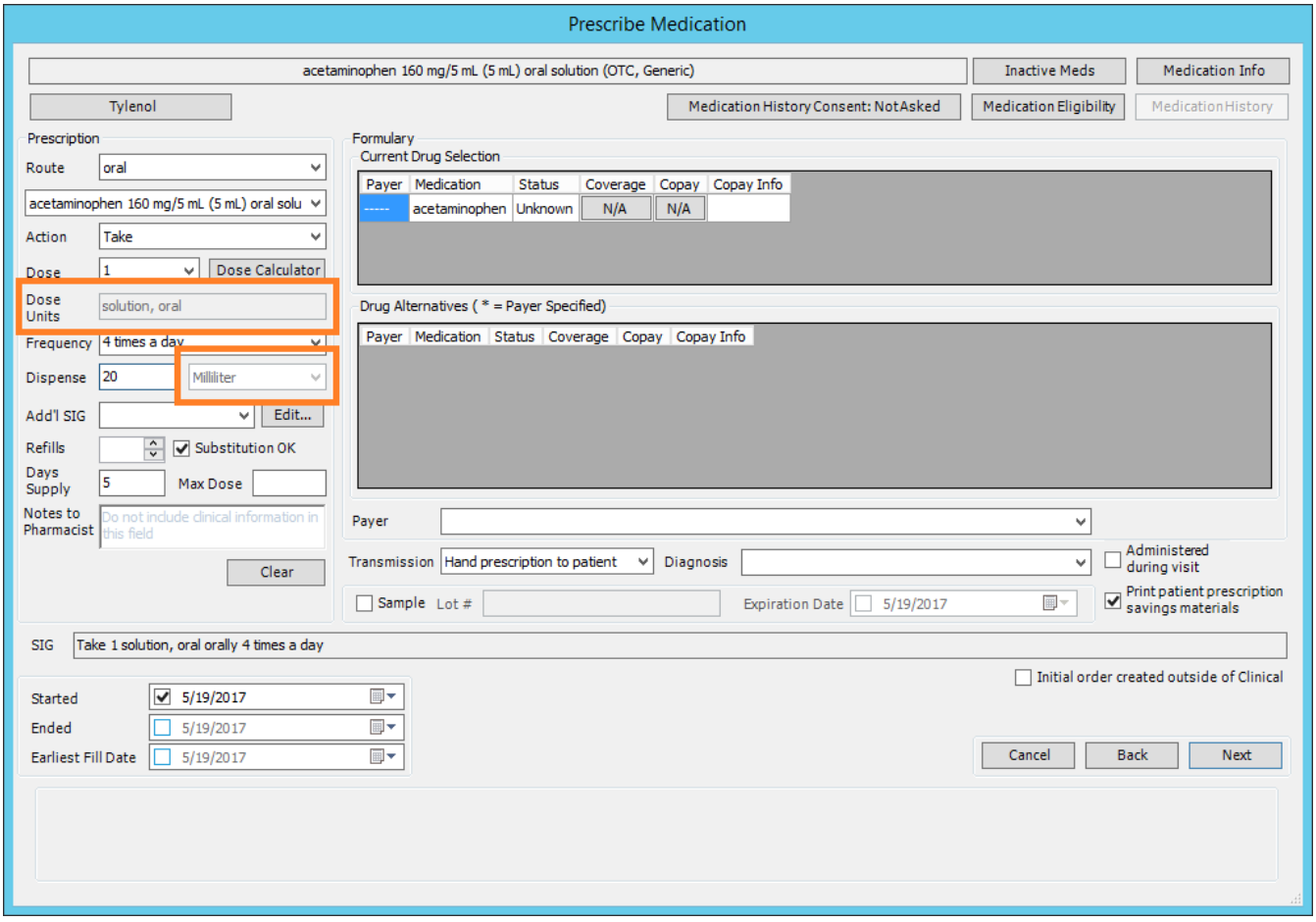


Figure 7 – Prescribe Medication

- **Medication – Rx Cancel –** The system has been updated so that whenever a medication is canceled via the **Cancel Prescription** option in the context menu for the medication in the facesheet, the system will generate an Auto-generated drug log in the patient's chart containing the patient's name, chart number, DOB, Sex, the canceled medication information, cancel date, who canceled the medication, as well as any drug interaction comments. See Figure 8.

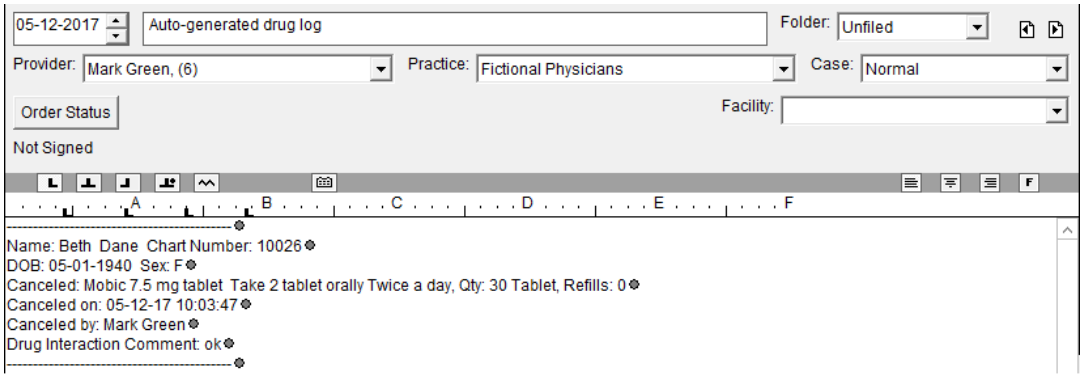


Figure 8 – Auto-generated drug log — Canceled Medication

- **MIPS Dashboard –** The system has been updated with a **MIPS Dashboard** that will allow MIPS Eligible Clinicians (ECs) to report their MIPS quality measures with ease. ECs can track their progress throughout their MIPS performance period and make any necessary corrections before submitting their data. See Figure 9.

  When you access the MIPS Dashboard (**Reports** > MIPS **Dashboard**), you can select, add, edit, and delete various **Configurations** where you set the eligible clinicians and the various parameters for each of the four categories for of the MIPS program: **Quality**, **Advancing Care Information**, **Improvement Activities**, and **Cost**. Do note that the Cost category is not available for 2017.

  After a Configuration is set up and selected, you will have access to each of the categories to select various parameters for those categories, as well as calculate scores based on the parameters set and your data entered to date. Each of the categories will have a last calculated/modified date so you will easily know if you need to run these again. Likewise, you can also view MIPS Requirements and the system will calculate an Estimated MIPS total composite score.

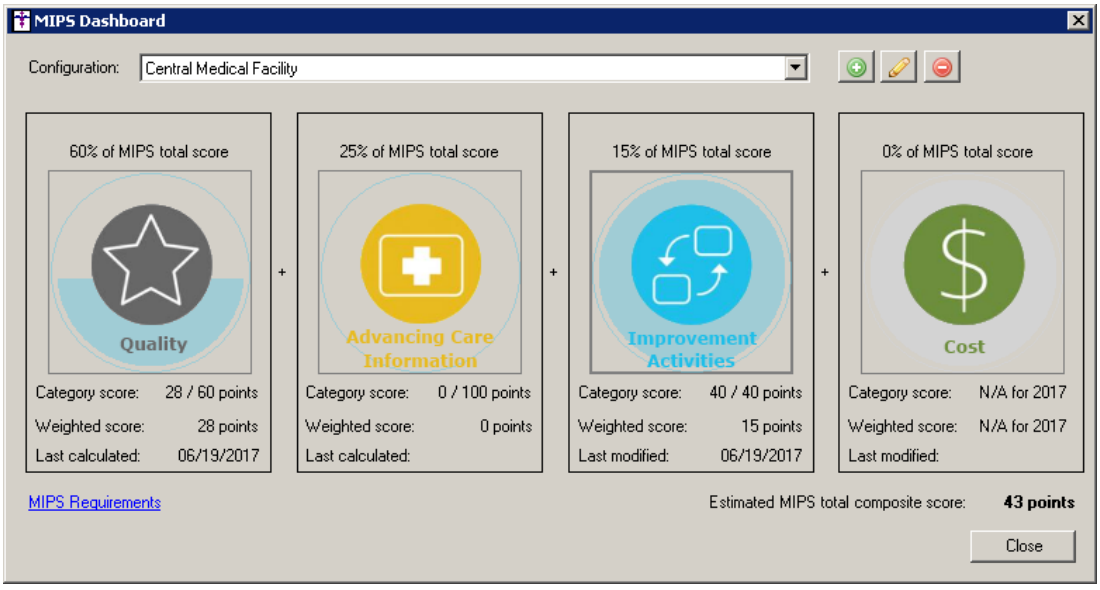


Figure 9 – MIPS Dashboard

MIPS Dashboard (continued)

Prior to configuring and running any data in the MIPS Dashboard you must select a **Configuration** in the corresponding field. Configurations can be added by clicking the **Add** button to the right of this field. Likewise, you can edit and delete a configuration by selecting the desired Configuration, and then clicking the **Edit** or **Delete** button to the right.

In the MIPS Dashboard Configuration dialog, you can enter a **Configuration** name, select the **Performance period** (which needs to be 90 days or more), select the **Eligible clinicians (NPI)** (which needs to be a single clinician, or all clinicians in the practice), and then select the parameters for the **Quality Reporting**, **Advancing Care Information Exemption**, and **Improvement Activity Adjustments**. See Figure 10. Do note, that by default, Quality Reporting is weighted as 60%, Advancing Care Information (ACI) as 25%, and Improvement Activity (IA) is 15%. If a user is configured to be exempt from reporting for ACI, the Quality category will be weighted as 85% and ACI will be 0% and disabled.

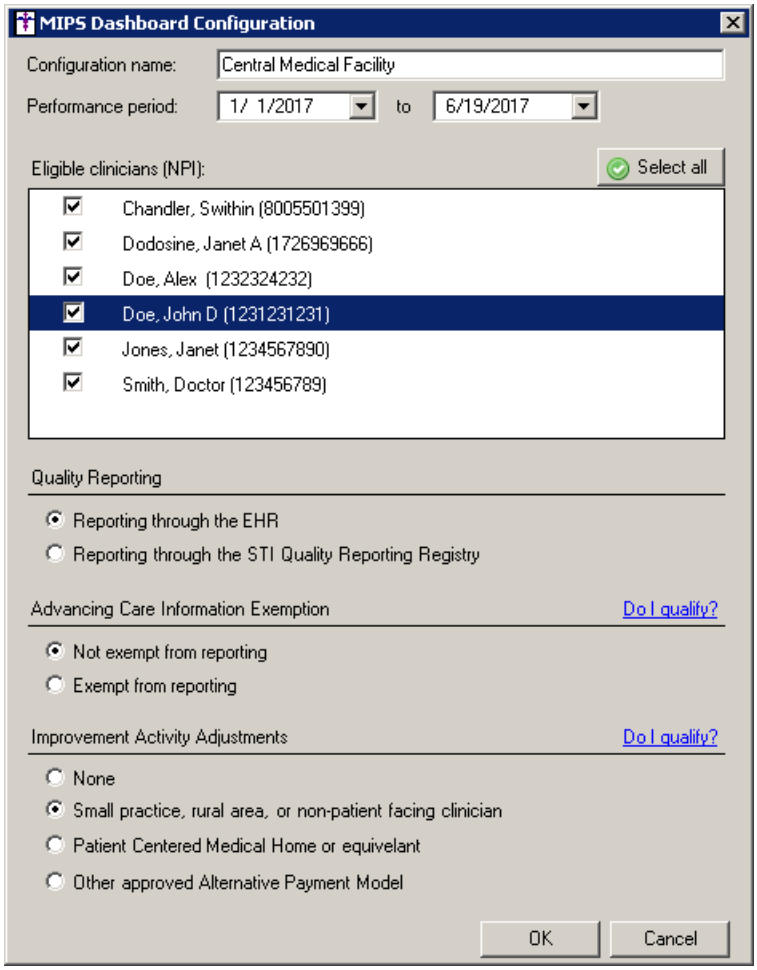


Figure 10 – MIPS Dashboard Configuration

MIPS Dashboard (continued)

Once a configuration is selected in the MIPS Dashboard, you can access the Quality Measures dialog to select the quality measures for your performance period, calculate your estimated score, run a reconciliation report, and generate a file for submission by clicking the **Quality** button.

In the Quality Measures dialog, in the left pane, the existing 29 quality measures will be listed, like the Meaningful Use Dashboard, but here are recategorized as **Outcome Measures**, **High Priority Measures**, or **Other Measures**. See Figure 11. You can select as many measures as desired, however, at least one outcome or high priority measure must be selected. The selected measures will appear in the right pane as a single row for each selected measure. Once the applicable measures are selected, you can calculate your estimated score by clicking the **Calculate** button, and after the system is done collecting and running data for the performance period, a **Total score** will appear at the bottom. After the total score has been calculated you can run a **Reconciliation Report** and **Generate Files for Submission** via the corresponding buttons at the bottom of the dialog. Clicking the **OK** button will save the selected quality measures and maintain any scores.

When calculating quality measure scores, the standard Numerator and Denominator information will be displayed along with a percentage result and a final score. The score starts as a base 3 points for all measures. If the measure has 20 or more in the denominator and at least 1 patient is marked as having Medicare as an insurance during an encounter, the measure is eligible for additional benchmark points. Benchmark points are determined by information provided by CMS, however, not all quality measures have a benchmark. Double clicking a row within the grid will display the benchmark breakdown and bonus points if they exist.

Only the top 6 best performing measures will be counted in the score, if more than 6 measures are calculated. Measures that are not included in the score will be marked with a gray background and reordered to the bottom of the grid. The top 6 measures are then eligible for 1 additional bonus point each for submitting through an EHR (for a maximum of 6 points). One outcome or high priority measure is required, however for each additional outcome 2 bonus points are awarded and 1 for each additional high priority measure (for a maximum of 6 points). Double clicking a row within a grid will also show the bonus points awarded.

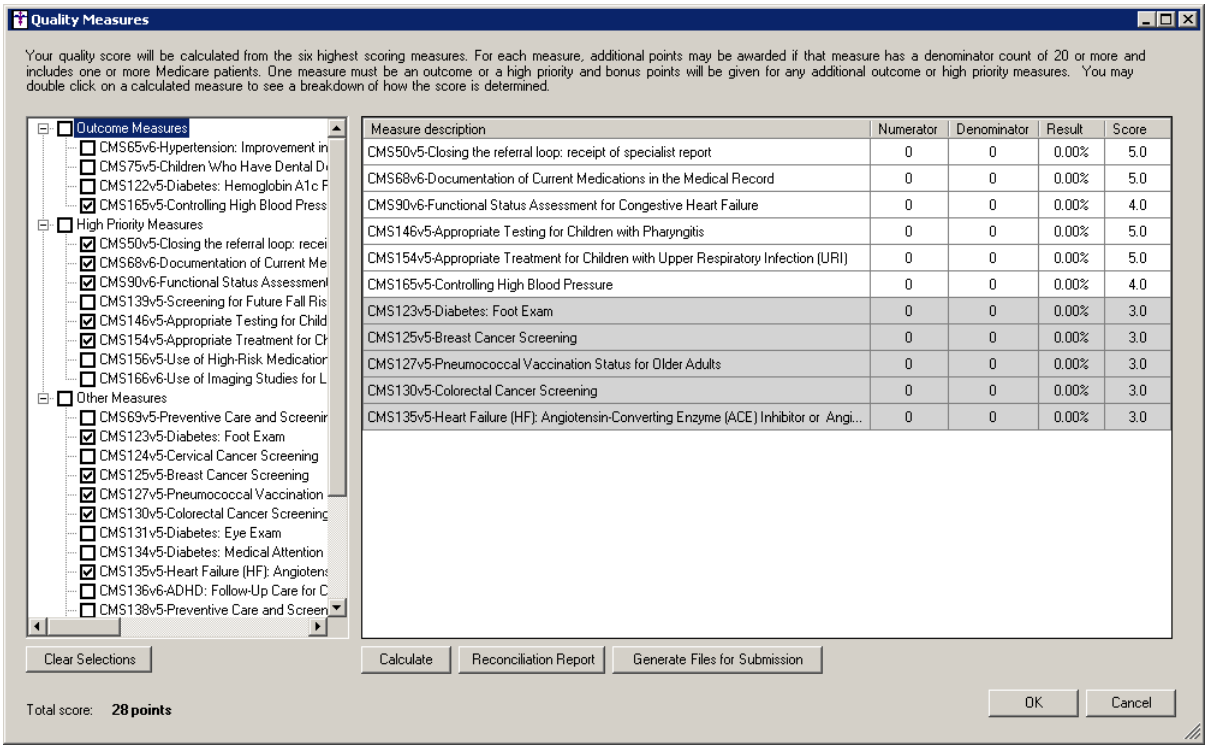


Figure 11 – MIPS Dashboard Configuration

When generating files for submission, as QRDA file will be generated that will include **all** measures that are selected, not just the 6 top performing measures.

If the total score is greater than 60, a warning text will appear indicating that the final score is capped. Clicking the **OK** button will automatically update the main dashboard view with the final capped score and the weighted score and update the total MIPS score.

If you chose to use the **Reporting through the STI Quality Reporting Registry** option in the MIPS Dashboard Configuration dialog (see figure 10 above), when you click the Quality button in the MIPS Dashboard, a Quality Score dialog will appear allowing you to manually enter the Quality score from the registry. See Figure 12.

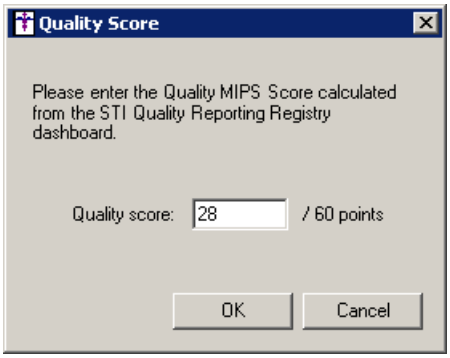


Figure 12 – MIPS Dashboard Configuration

With a configuration is selected in the MIPS Dashboard, you can access the Advancing Care Information dialog to select the Advancing Care Information (ACI) options for your performance period, calculate your estimated Base Score, Performance Score, and Bonus Points, run a reconciliation report for your Performance Score, and Print your Performance Score information by clicking the **Advancing Care Information** button.

The Advancing Care Information dialog is broken up into three areas for **Base Score**, **Performance Score**, and **Bonus Points**. See Figure 13. The Base Score ***must*** be completed before any other section of the ACI will count. Performance and Bonus sections will automatically be in a disabled state (although measures can be calculated but will show as gray rows and their score will not be added to the total) if Base Score credit is not awarded, and warning text will appear at the bottom to indicate that base credit was not met.

In the Base Score section, you must first check the **Performed a security risk analysis** option, followed by getting a 1 in the numerator after calculating the 3 base performance measures. You also have the option to select **Include controlled substances in the E-Prescribing measure**. As an exemption, a user with less than 100 in the denominator for E-Prescribing will count even if they do not have at least 1 in the numerator. To run the base performance measures, click the corresponding **Calculate** button. Once these conditions are met, the rest of the dialog will be enabled.

The Performance Score section contains a Submitted data for immunization registry reporting option that allows you to indicate immunization registry use for 10 points. In addition, 6 measures can be calculated for an additional 0 to 10 points each, two of which are worth double points, where scoring is based on the performance percentage per CMS requirements and guidelines. Once the applicable options are selected, you can calculate your estimated score by clicking the **Calculate** button, and after the system is done collecting and running data for the performance period, the results and applicable scores will appear in the corresponding columns in the grid. After the scores have been calculated, you can run a **Reconciliation Report** and **Print** the results via the corresponding buttons.

MIPS Dashboard (continued)

The Bonus Points section has a Submitted data to one or more public health or clinical data registries option that is worth 5 points. Likewise, you may also receive 10 points by making any selection in the ACI Bonus tab of the Improvement Activities dialog which will be described further below.

The final score (points) is listed at the bottom as a breakdown of Base Score plus the Performance Score plus any Bonus Points.

Clicking the **OK** button will save any calculated scores and selections, and will automatically update the MIPS Dashboard view and the Estimated MIPS total composite score.

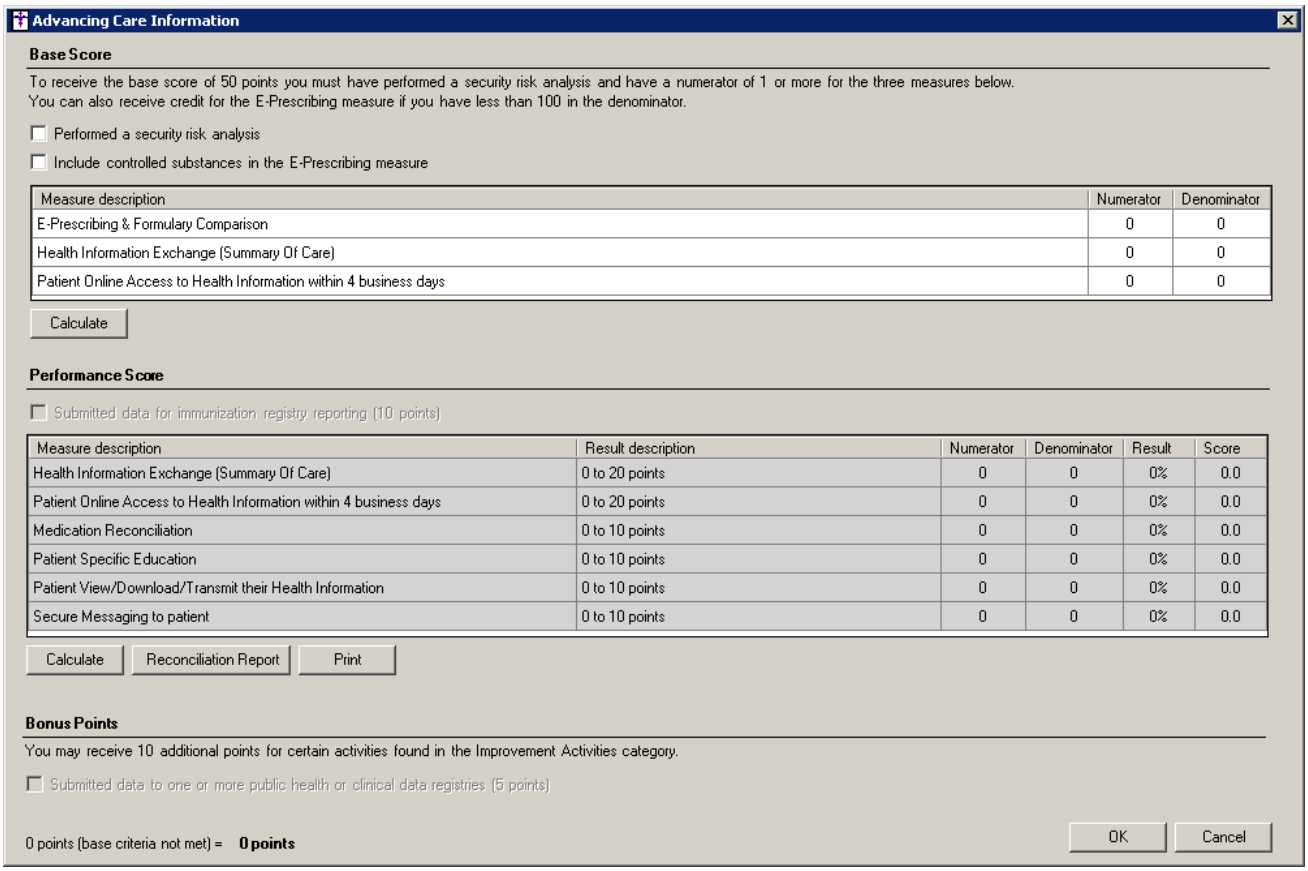


Figure 13 – Advancing Care Information

MIPS Dashboard (continued)

With a configuration is selected in the MIPS Dashboard, you can access the Improvement Activities dialog to select an improvement activities that you qualify for during your performance period, by clicking the **Improvement Activities** button.

The Improvement Activities dialog is broken into three tabs: **ACI Bonus**, **High Weighted**, and **Medium Weighted** activities. See Figure 14. Each tab will display the applicable list of activities with a link for **More Information** and a **Yes**/**No** selection drop-down box. High Priority activities are worth 20 points and medium weight are worth 10 points.

If you chose the **Small practice, rural area, or non-patient facing clinician** option in the Improvement Activity Adjustments section of the MIPS Dashboard Configuration dialog, you will receive double points for each selection. If you selected the **Patient Centered Medical Home or equivalent** option, you will receive full credit automatically (40 points), but can still make other choices. If you selected the Other approved Alternative Payment Model, you will receive half credit (20 points) automatically.

If you make any selection from the ACI Bonus section, 10 points will be given to the ACI total.

The **Total score** (capped at 40 points) is listed at the bottom. Clicking the **OK** button will save any selections and scores, and will automatically update the MIPS Dashboard view and the Estimated MIPS total composite score.

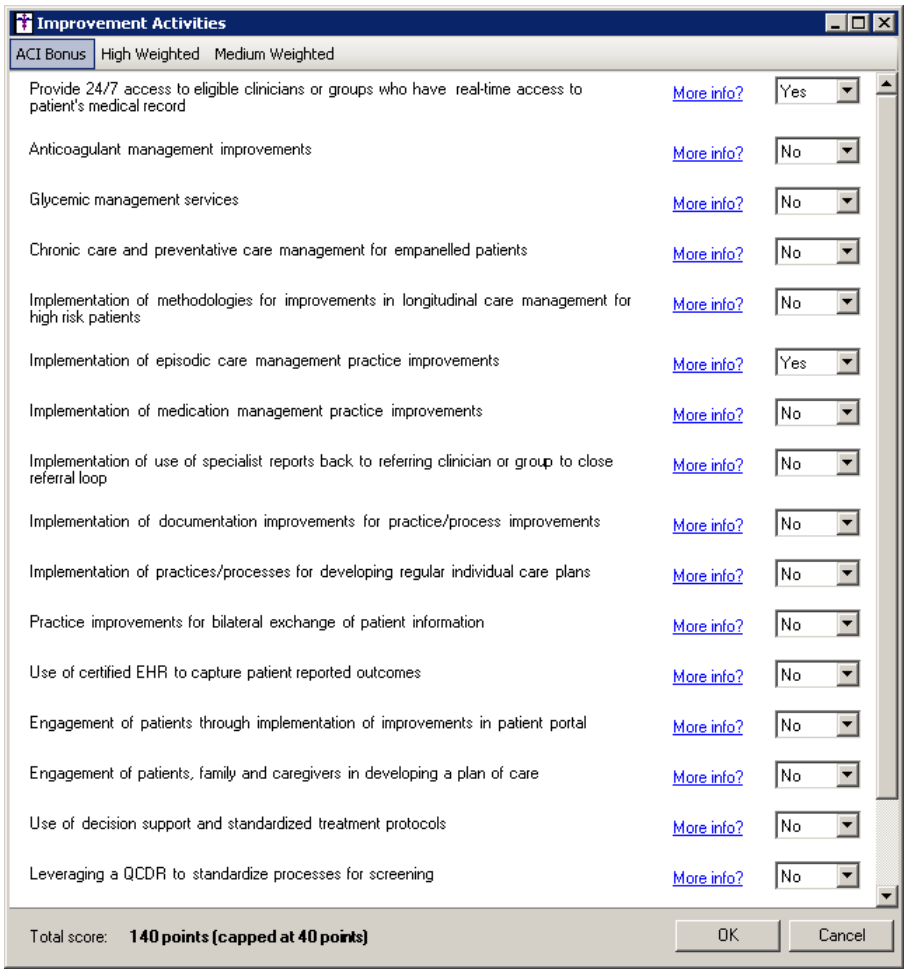


Figure 14 – Improvement Activities

- **The Note Tab – Allergies –** The Active Allergies dialog has been redesigned so that the **Reaction SNOMED** field precedes the **Reaction** field. See Figure 15. Whenever SNOMED codes are added in the Reaction SNOMED field for an allergy, the descriptions for the selected SNOMED codes will automatically be added, or appended if there is existing information, to the Reaction field. You can then modify the text in Reaction field as needed.

- **The Note Tab – Allergies –** The Active Allergies dialog has been updated with a **Display in list format** option that allows you to determine whether you want the allergy information to appear in list format, or paragraph format, in the chart note. See Figure 15. If the Display in list format option is checked, the configured allergy information will appear in list format in the note, if this option is not checked, it will appear in paragraph format.

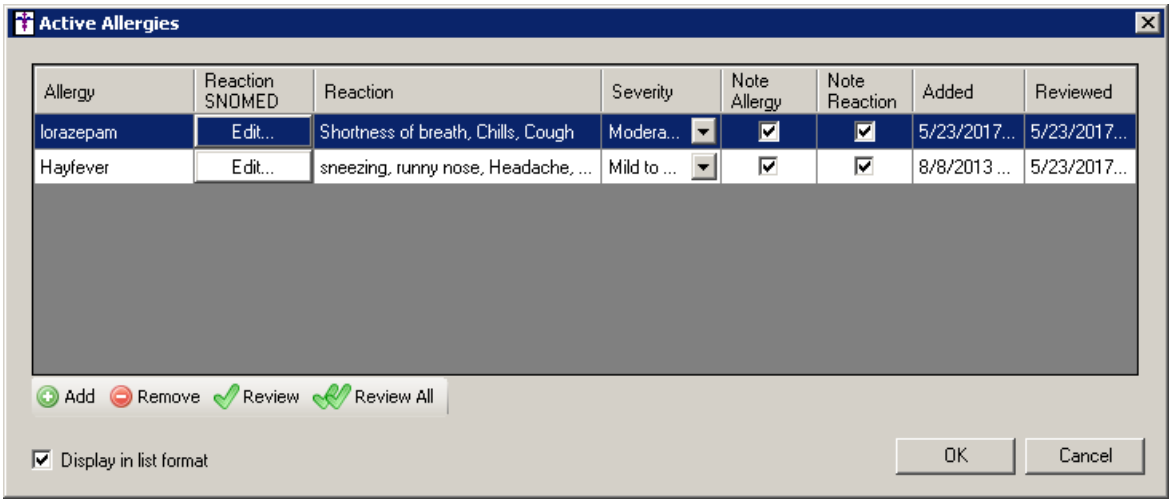


Figure 15 – Active Allergies

- **The Note Tab – Allergies –** The system has been updated so that the allergic reaction configured for an allergy will be outputted in the chart note. See Figure 16.



Figure 16 – Note – Allergies

- **The Note Tab – Implantable Device –** The system has been updated to allow you to add information for implantable devices, with the additional ability to retrieve device information from the FDA based on the Device UID, for those templates that have the new **Implantable Device** button. See Figure 17.

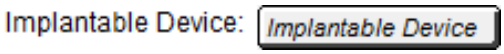


Figure 17 – Implantable Device Button

When the Implantable Device button is clicked, the **Implantable Devices** dialog will appear allowing you to add, edit, and delete implantable device information for the patient. See Figure 18.

In the **Device List** section of the dialog, any implantable devices that have been entered for the patient will appear. If the information for the device was received from the FDA, a bullet mark will appear in the FDA column, and the Name column will contain the FDA Device Name. If the information for the device was manually entered, the FDA column will be blank for the device, and the Name field will contain the User-defined Device Name.

When adding a new implantable device, in the Device Details section, you can enter a **User-defined Device Name** if manually entering a device; or you can enter or paste the **Device UDI** into the corresponding field, and then click the **Verify UDI with FDA** button to retrieve device information from the FDA.

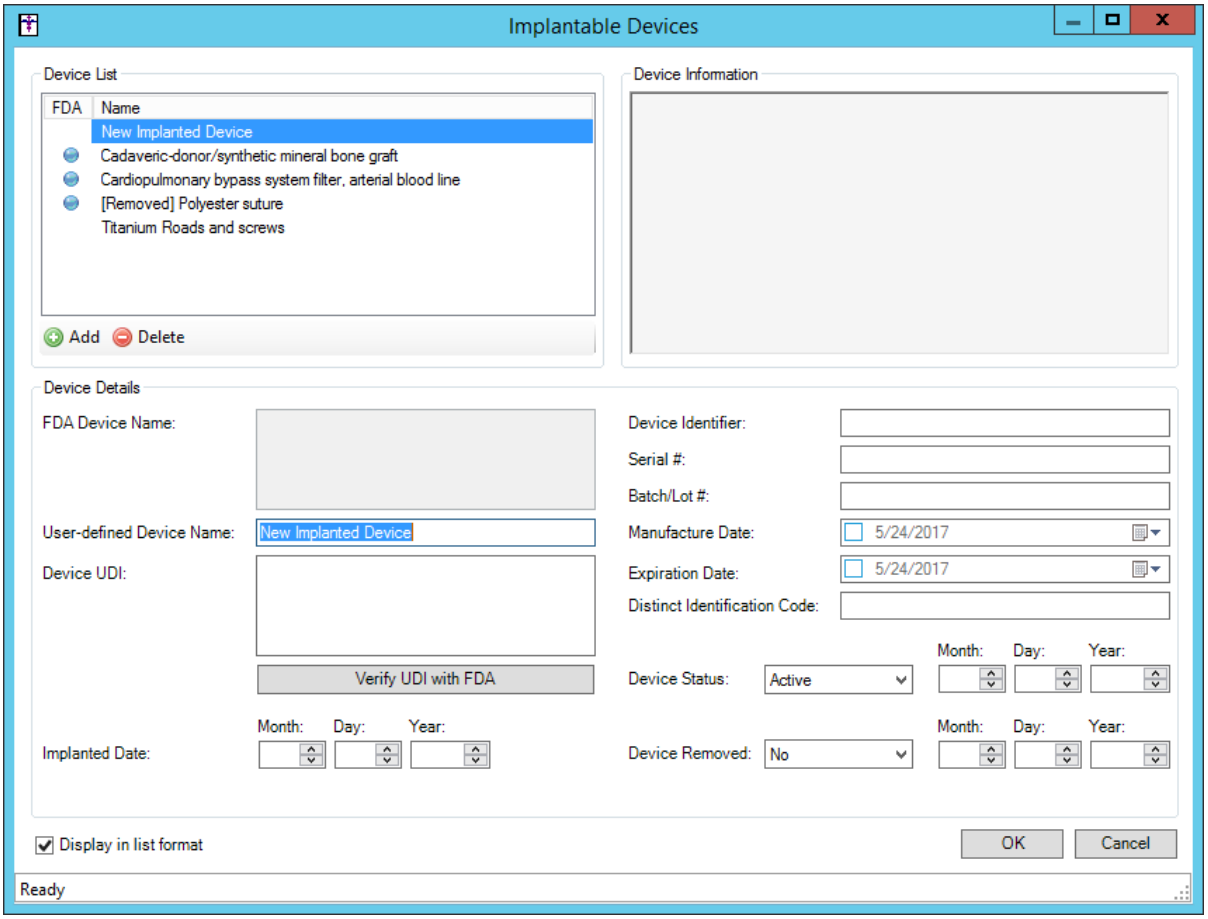


Figure 18 – Implantable Devices

The Note Tab – Implantable Device (continued)

If a Device UDI is entered and validated, the system will populate the Device Information section, along with the **FDA Device Name**, **Device Identifier**, **Serial #**, **Batch/Lot #**, **Manufacturer Date**, **Expiration Date**, and **Distinct Identification Code** fields with information pertaining to the device you are adding. See Figure 19. You are not allowed to modify this information. However, you can click the **Refresh FDA Data** button to query the FDA database to see if any information has been added or changed.

If a Device UDI is not available, or is not valid, you can manually enter information into the aforementioned fields, except the FDA Device Name, as needed.

Once the FDA data is retrieved, or manually entered if no UDI is available, you can enter an **Implanted Date**, and then configure the **Device Status** and **Device Removed** information and any corresponding dates, as needed.

The **Display in list format** option that allows to determine whether you want the implanted device information to appear in list format, or paragraph format, in the chart note. If the Display in list format option is checked, the configured implant information will appear in list format in the note, if this option is not checked, it will appear in paragraph format.

When the **OK** button is clicked, the information will be displayed in the chart note, and the information will be tracked in the Audit Trail, as well as in the History tab for the patient.

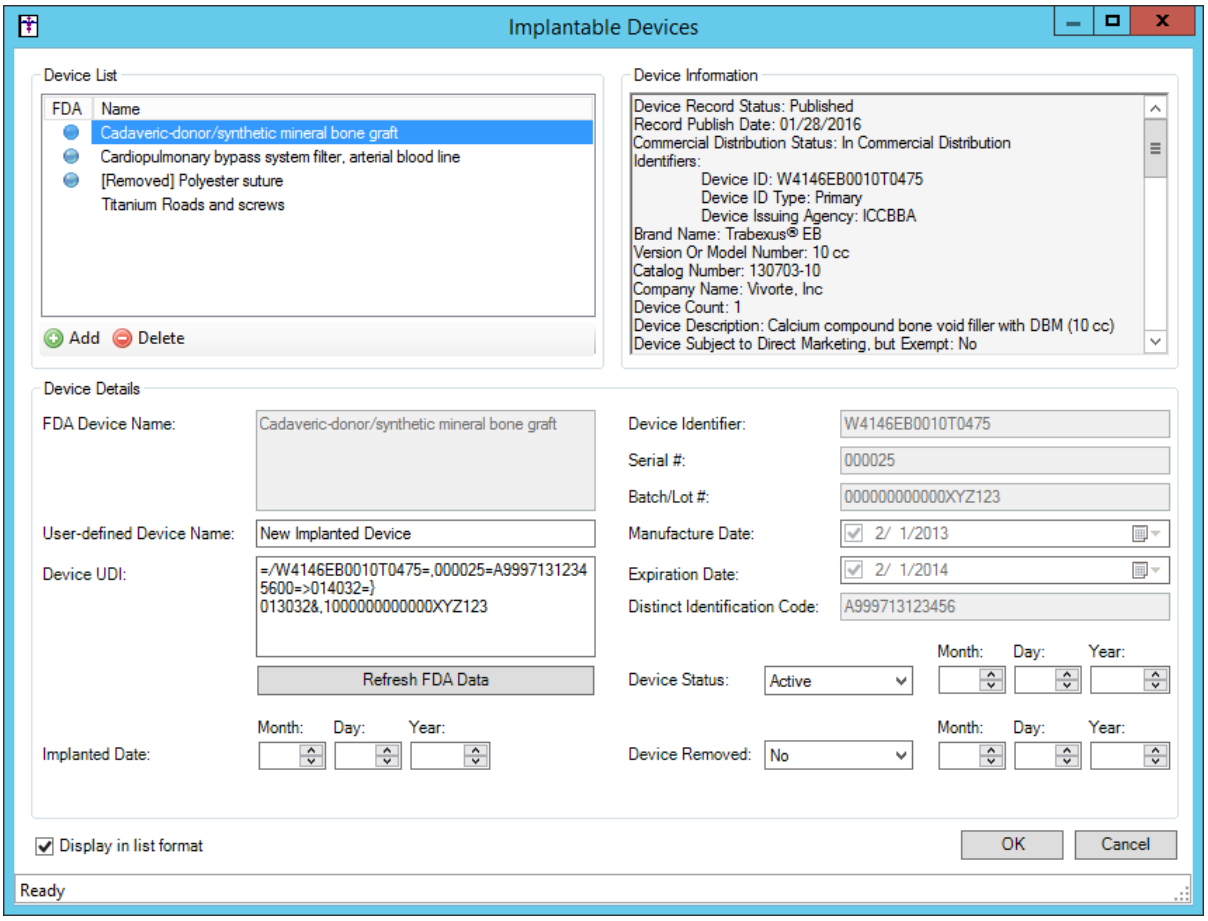


Figure 19 – Implantable Devices – FDA Device Information

Added Features (continued)

- **The Note Tab – Order Procedure – Immunizations –** The program has been updated so that the latest immunization codes from the CDC are being used when configuring immunization information.

- **The Note Tab – Order Procedure – Immunizations –** The Order Procedure dialog has been updated with a **NDC Code** field and a **CVX Code** field, for immunization procedures, allowing you to select the proper codes when configuring immunization information. See Figure 20. The NDC field drop-down will contain any NDC codes that were configured in the procedure file, and will default the NDC code that was tagged as the primary in the procedure file. Primary NDC codes will be designated with a **(P)** after the code. The CVX code will also default from the procedure file. When a NDC code is configured with the immunization it, along with the CVX code, will be included in the immunization file sent to applicable immunization registries.

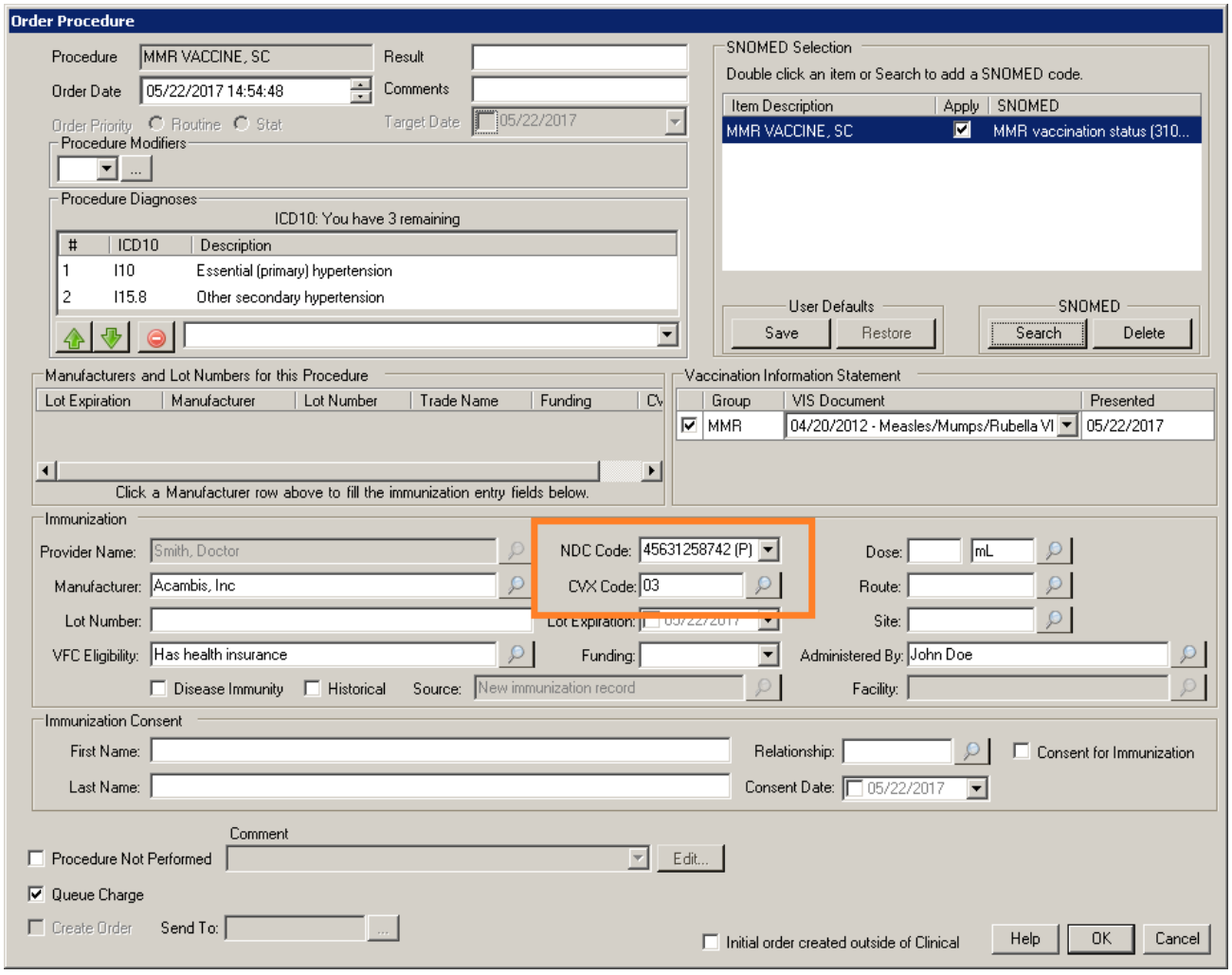


Figure 20 – Order Procedure

- **The Note Tab – Order Procedure – Immunizations – DelVAX –** The DelVAX program has been updated to be compliant with the CDC HL7 2.5.1 v1.5 format.

- **The Note Tab – Order Procedure – Immunizations – NJIIS –** The NJIIS program has been updated to include a PD1 Segment in the immunization file, regardless of whether consent information is entered.

- **The Note Tab – Patient Health Information –** The Note tab context menu has been updated with an **Add Patient Health Information** option that allows you to add external files to the patient's chart that will be marked as a patient health information record. See Figure 21. When adding files the functionality is similar to using the Add Existing File option.

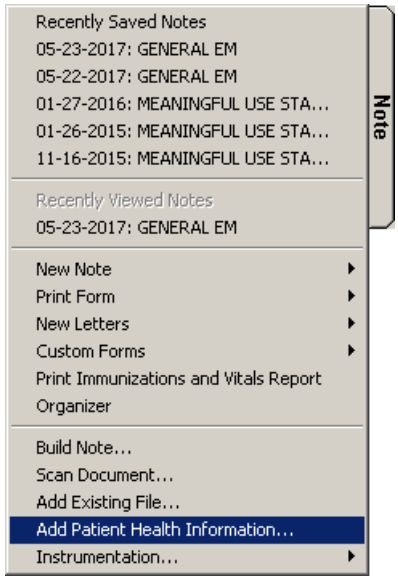


Figure 21 – The Note Tab Menu

- **The Note Tab – Screening – Falls Risk Assessment Form –** The Screening dialog has been updated with a **Falls Risk Assessment Form** questionnaire that is accessed by clicking the corresponding button at the top of the dialog. See Figure 22. After the questionnaire is accessed, you can configure the answers for the various questions. Do note if the answer to the second question (**Is the patient ambulatory?**), is anything other than **Yes** or **blank** (unanswered), the assessment questionnaire sections below will be grayed out and no score will be given. Likewise, if the answer to the third question (**Screening not done for medical reason**), is **Yes**, the assessment questionnaire sections below will be grayed out and no score will be given.

  If you click the **Balance** link you are provided with additional information on how to access the patient for the questions in that section.

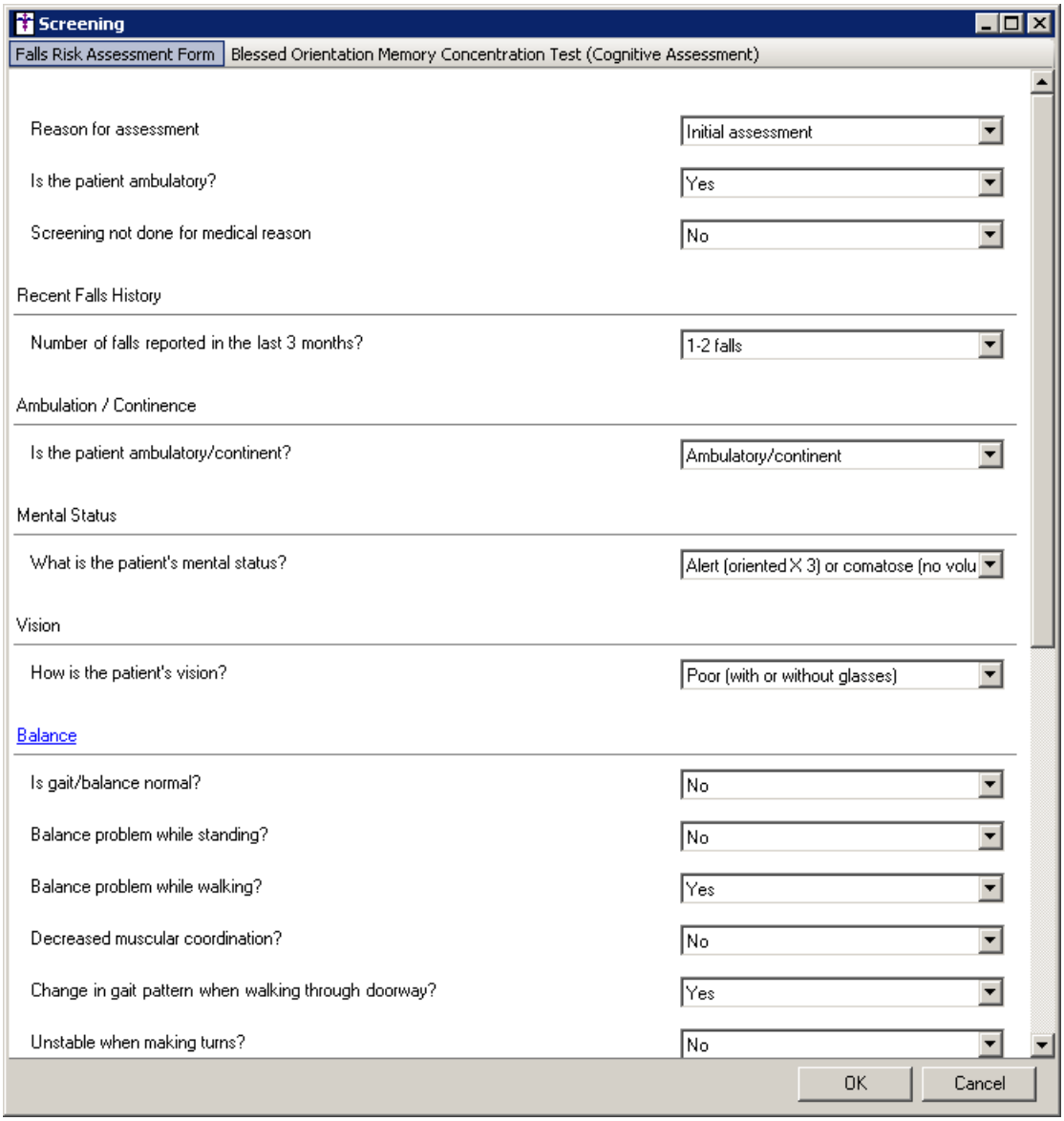


Figure 22 – Screening – Falls Risk Assessment Form

The Note Tab – Screening – Falls Risk Assessment Form (continued)

The **Medication** link provides access to a list of medications to consider while answering the questions in that section of the questionnaire. See Figure 23. While the **Predisposing Conditions or Diseases** link provides access to a list of conditions and diseases to consider when answering the question for that section.

The various assessment questions have a measured **Total Score** based on the answered questions allowing you to quickly determine if the patient is "at risk" for future falls and thereby offer further testing or treatment as needed. If you click the **Total Score** link, additional information is provided about how the scoring is conducted.

In addition, you can determine how this information is outputted to the note. You can choose only to output only the **Title**, to output the configured information in **List** format, or to output the configured information in **Paragraph** format. When information is configured in the Screening dialog, the applicable LOINC and/or SNOMED codes will be attached to the options selected and will be used to access any applicable Meaningful Use quality measures. Likewise, the information will also appear in the History tab for the patient.

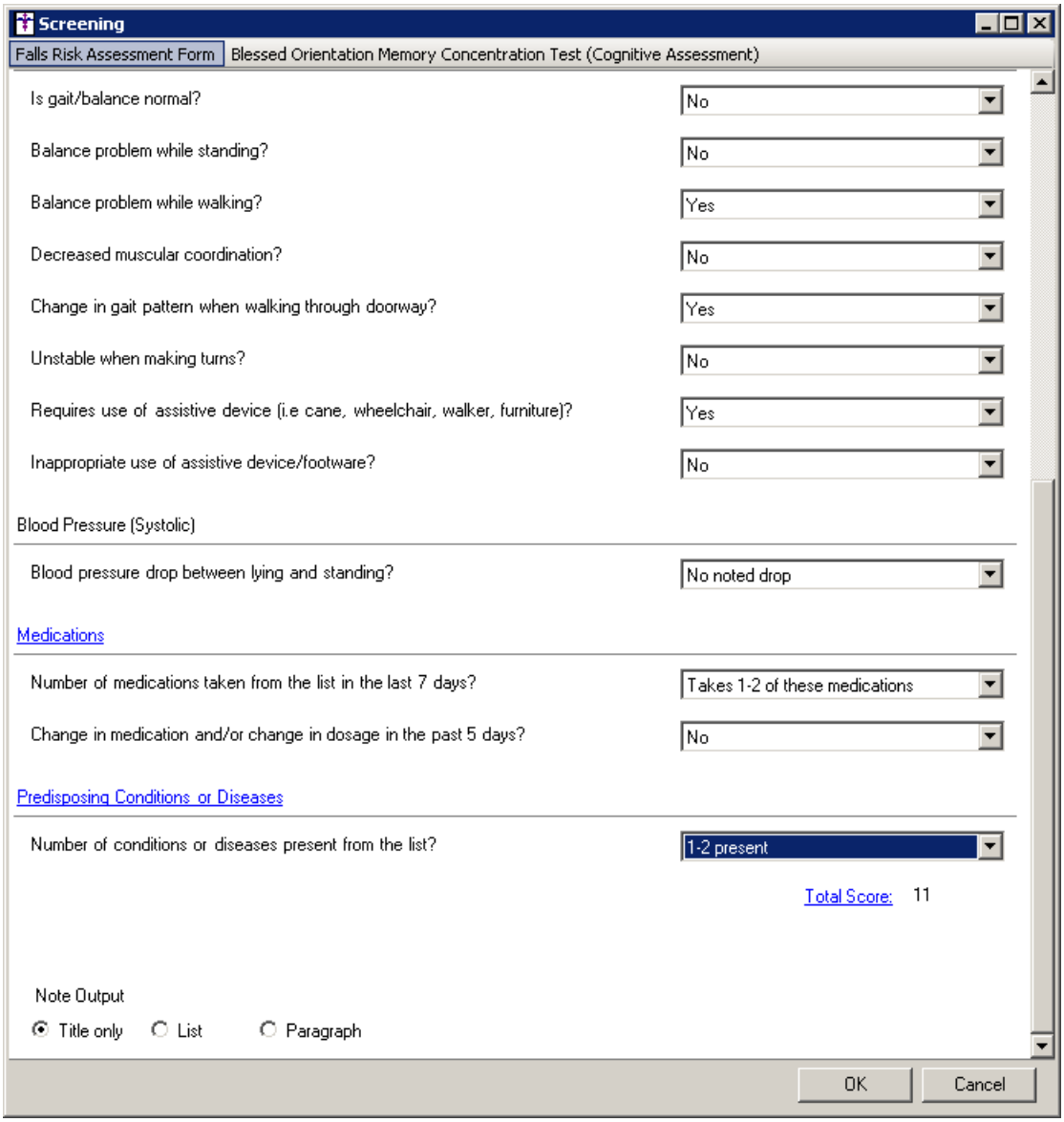


Figure 23 – Screening – Falls Risk Assessment Form

- **The Note Tab – Screening – Blessed Orientation Memory Concentration Test (Cognitive Assessment) –** The Screening dialog has been updated with a **Blessed Orientation Memory Concentration Test (Cognitive Assessment)** questionnaire that is accessed by clicking the corresponding button at the top of the dialog. See Figure 24. After the questionnaire is accessed, you can configure the answers for the various questions. Do note if the answer to the first question (**Screening not done for medical reason**), is **Yes**, the assessment questionnaire sections below will be grayed out and no score will be given. Likewise, if the answer to the second question (**Screening not done for patient reason**), is anything other than **Yes** or **blank** (unanswered), the assessment questionnaire sections below will be grayed out and no score will be given.

  The **Repeat the memory phrase...** link provides access to detailed information on how to score this aspect of the questionnaire.

  The various assessment questions have a measured **Total Score** based on the answered questions allowing you to quickly determine if the patient assessment is consistent with dementia and thereby offer further testing or treatment as needed. If you click the **Total Score** link, additional information is provided about how the scoring is conducted.

  In addition, you can determine how this information is outputted to the note. You can choose only to output only the **Title**, to output the configured information in **List** format, or to output the configured information in **Paragraph** format. When information is configured in the Screening dialog, the applicable LOINC and/or SNOMED codes will be attached to the options selected and will be used to access any applicable Meaningful Use quality measures. Likewise, the information will also appear in the History tab for the patient.

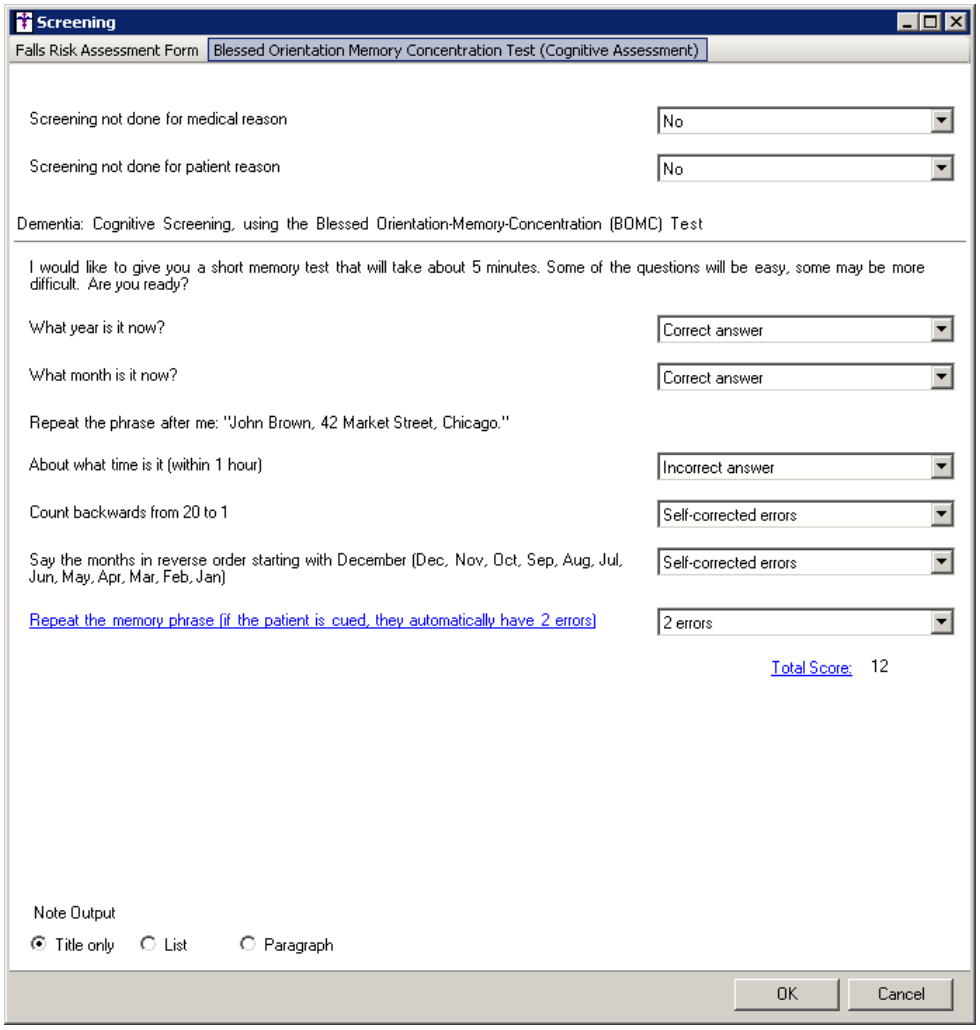


Figure 24 – Screening – Blessed Orientation Memory Concentration Test (Cognitive Assessment)

- **The Organizer – Patient Health Information –** The Organizer has been updated with a **Patient Health Info** column that will display **Yes** when a chart item has been tagged as Patient Health Information. See Figure 25. Likewise, the right-click context menu has been updated with a **Mark as Patient Health Information** option that allows you to tag any non-form chart notes as Patient Health Information.

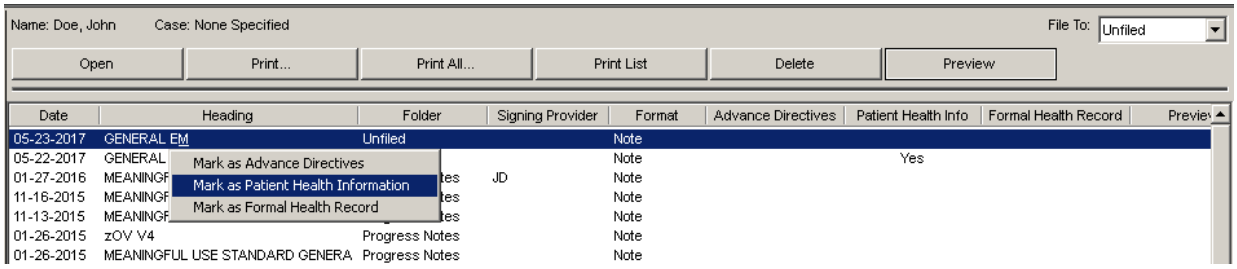


Figure 25 – The Organizer

- **Patient Health Information –** The system has been updated with a **Patient Health Information** dialog that allows you to add and maintain external links to a patient's health information, as needed. See Figure 26. In addition, the Patient Health Information dialog will include a listing of all chart notes that have been tagged as Patient Health Information in the Clinical application, allowing you to select and open those notes.

  To access the Patient Health Information dialog for a patient, open the patient's chart, and then click **Chart** > **Patient Health Information**. You can then **Add**, **Edit**, and **Delete** external links for patient health information using the corresponding buttons, or access any chart notes that were marked as patient health information.

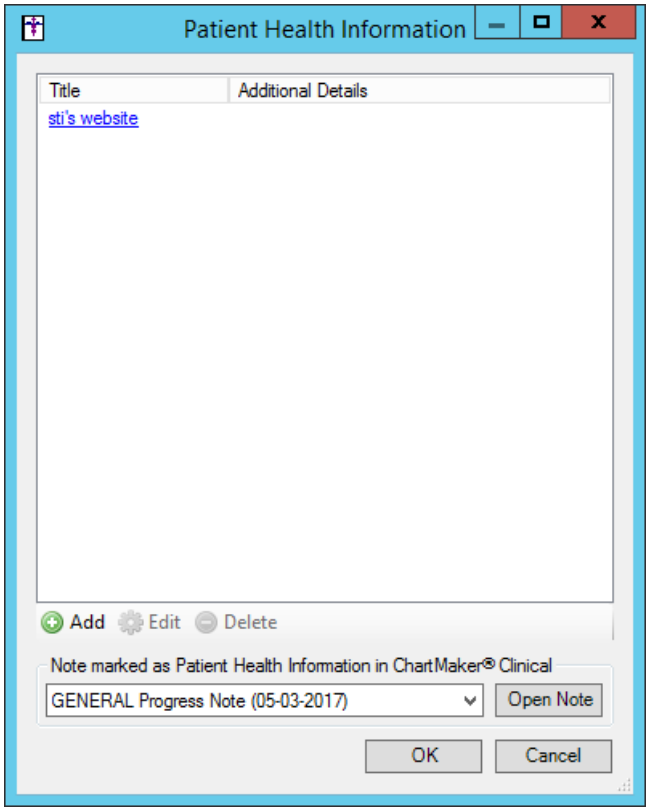


Figure 26 – Patient Health Information

- **Scan Management – Patient Health Information –** The Scan Management dialog has been updated with a **Scan as Patient Health Information** option that allows you to tag scanned documents for a patient as Patient Health Information. See Figure 27.

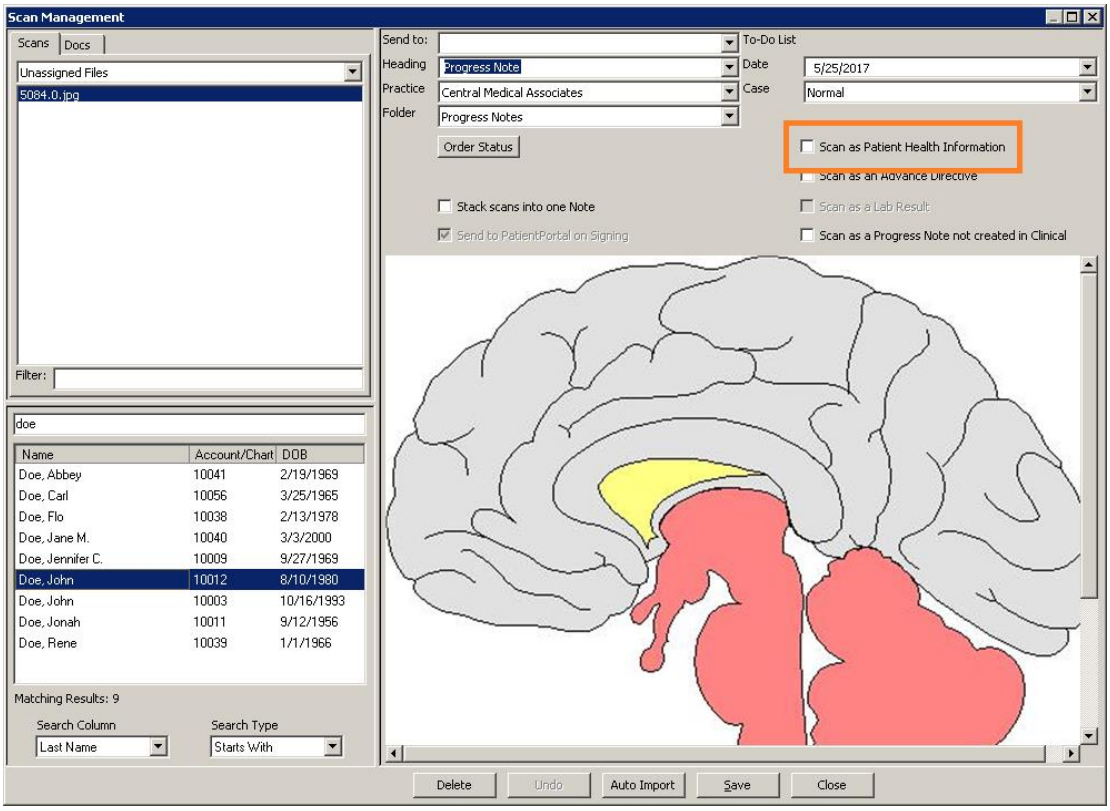


Figure 27 – Scan Management

- **Template Editing – Implantable Device –** The Template Editor has been updated with the ability to add an Implantable Device button to a template that will allow you to add information for implantable devices with the additional ability to retrieve device information from the FDA based on the Device UID. See Figure 28.

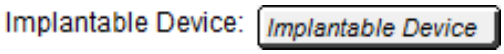


Figure 28 – Implantable Device Button

When the Implantable Device button is added to the template you can access the Implantable Device dialog that allows you to add a **Heading** that will be displayed prior to the Implantable Device button. See Figure 29.

Do note, that this new Implantable Device button does not replace the Implant button from previous versions. The new Implantable Device works independently of the Implant button; however, the new button also introduces additional features, specifically the ability to retrieve device information from the FDA, as opposed to entering all data manually. You can use both buttons simultaneously, or use your preferred button depending on your needs and the functionality needed.

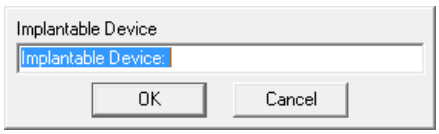


Figure 29 – Implantable Device

Added Features (continued)

- **Template Editing – Screening –** The Screening Selection dialog (accessed via the Screening button), has been with two new screenings: a **Falls Risk Assessment Form**, and a **Blessed Orientation Memory Concentration Test (Cognitive Assessment)** screening. See Figure 30. You can view each screening questionnaire, by highlighting the applicable screening, and clicking the **Preview** button. Do note, that for any existing Screening buttons in chart templates, the new screenings will appear in the **Unused screenings** section, and will need to be activated for those buttons, as needed. Any new Screening button added to a chart template will have all screenings activated, and you can modify the position, as well as remove any screenings that are not needed for that button.

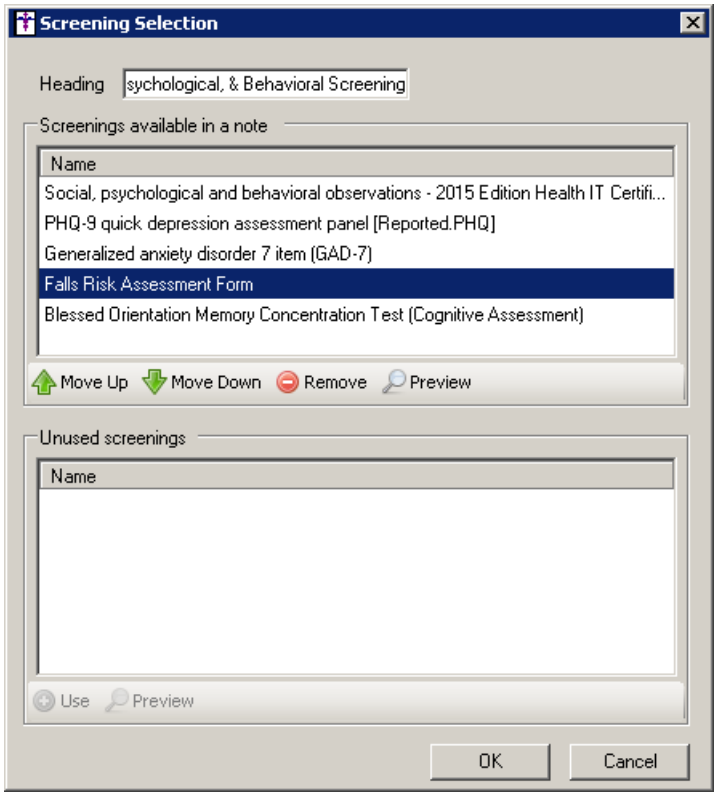


Figure 30 – Screening Selection

Addendum

SureScripts® E-Prescribing Best Practice Guidelines

Below are best practices that have been developed to assist in the construction of complete, non-contradictory, and clear patient directions:

Ensure that Directions are complete and accurate

- All information in the Sig must be accurate, complete, and include all the required components written in the following order: action, dose, dose units, route, frequency, and finally auxiliary information.
    - The exception to this syntax is Sigs which simply state "Take/Use as Directed/Instructed as per manufacturer labeling."
- Information within the Sig must not conflict with itself

Example: *Use "**Take 1 tablet by mouth** daily" instead of just "Daily."*

Always qualify "…as Directed" with a source

- Statements such as "Take as directed" and "Use as instructed" should only be used when followed by a source that clearly dictates to the patient where or from whom they can obtain the specific directions.
- If a Sig builder tool is used, ensure that prescribers enter the specific source of the instruction after selecting the "Take/Use as directed/instructed" option before they can proceed with finalizing the e-prescription.

*Example: Use "Use as instructed **per instructions on package**" instead of "Use as instructed."*

Always qualify "PRN (as needed)" with an indication

- The use of "PRN" (i.e. "as needed") should only be used in conjunction with an indication.
- For all other non-PRN directions, inclusion of an indication is also recommended; alternatively, there is also a designated structured field for Diagnosis, in which ICD-10 codes may be used to communicate the appropriate diagnosis or indication relevant for the prescribed product
- If a Sig builder tool is used, ensure that the Sig builder tool requires prescribers to enter the specific indication or conditions for PRN use if the prescriber selects a "PRN" frequency

*Example: Use "Take 1 tablet by mouth every 4 hours as needed **for mild to moderate pain**" instead of "Take 1 tablet by mouth every 4 hours as needed."*

Always specify the Duration of Therapy for Acute Treatments

- Duration of therapy should **only** be specified for medications for acute treatments with a defined length of therapy, e.g., antibiotics.

Avoid Abbreviations, Acronyms or Symbols

- ISMP (Institute for Safe Medication Practices) provides the complete list of *Error-Prone Abbreviations, Symbols, and Dose Designations* that should never be used in a prescription
- If the use of Latin abbreviations is desired, the system should include the ability to expand Latin abbreviations into plain English text via keystroke accelerators. The expanded text form of the Sig should be displayed to the prescriber to ensure correct transition from abbreviations to full text

Example: *Use "**Instill 1 drop into both eyes once daily**" instead of "1 gtt ou qd."*

Never Truncate or Split Directions between multiple fields

- If the patient directions are being transmitted exceeds the 140-character limit, it should be communicated by other means, e.g. as a fax or printed handout
- Sig information should **not** be written into the Notes field if it exceeds the 140-character limit.

Send only Patient Directions (Sig) within the Directions field

- The Sig should not contain information for which another designated field exists in the SCRIPT standard (e.g. the Sig should never include the quantity, drug name, NDC or RxCUI values, or Notes to pharmacists, etc.)

*Example: Use "**Take 1 tablet by mouth once daily**" instead of "Take 1 tablet by mouth once daily. Dispense #30, 3 Refills, Thank you."*

Do not include Clinical or Prescription Information in the Notes field.

- The Notes field be used to contain information related to, but not part of the prescription. While clinical and prescription information should appear in the designated fields for these data elements, not in the Notes field.

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input.

(1) Guidelines that apply to name, strength, dosage form, and quantity of drug prescribed as well as the directions for use (the "Sig")

- Drug names should be spelled out in full, avoiding the use of abbreviations.
  - While it might be possible to make the case that abbreviations save time in the world of paper prescriptions, no such time savings accrue in the electronic world in which the prescriber simply picks a medication from a drug database.
  - Abbreviations can lead to a misinterpretation of the prescriber's intent, which can result in medication errors.
  - Examples:
    - Use "Hydrochlorothiazide 50 mg" instead of "HCTZ 50 mg."
    - Use "Zidovudine 300 mg" instead of "AZT 300 mg."
- Drug descriptions should include complete name, strength, strength units and dosage form information (if applicable) in the same exact order, and all should appear in one drug description field.
  - Not doing so causes problems in pharmacies due to missing data components.
  - It is preferred that either the generic or the brand name be used in the drug description, but not both. Using both unnecessarily complicates the information in the drug description field.
  - Examples:
    - Use "Doxycycline Monohydrate 50 mg oral capsule" instead of "Doxycycline caps."
    - Use "Ciprofloxacin 500 mg tablet" instead of "Ciprofloxacin tablet 500 mg."
    - Use "Atorvastatin calcium 20 mg tablet" or "Lipitor 20 mg tablet" instead of "Lipitor (Atorvastatin calcium) 20 mg tablet."
    - Drug descriptions for generic products should use the naming conventions found in the Food and Drug Administration's "Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations."
  - This helps pharmacists to accurately choose the product to be dispensed when brand names are not used.
  - Examples:
    - Use "Glipizide 10mg tablets, extended release" instead of "Glipizide TAB OSM 24 10mg."
    - Drug strength information should be consistent across all fields in which it appears.
  - The strength in the drug description should match that in the drug strength field.
  - Drug strength units in the drug description should match those in the drug strength units field. Drug strength units should not be sent in the drug strength field.
  - Example of improper use: The drug description is "Amoxicillin 500 mg oral capsule" and the drug strength field contains the value of "250."
- Dosage form codes should match the forms sent in drug description fields.
  - Example of improper use: The drug description is Amoxicillin 500 mg capsule and the dosage form code field contains "10," which is the NCPDP code that stands for tablet.
- All orders should be written using metric measurements of weight (e.g., mg, gm and kg) and volume (e.g., ml).
  - The apothecary and avoirdupois systems of weights and volumes are no longer considered appropriate in the world of pharmaceuticals.
  - Example: Use "Aspirin 81 mg" instead of "Aspirin 1 ¼ grains."
- A zero should be used before a decimal (use 0.X mg instead of .X mg), but not after (use X mg instead of X.0 mg).
  - Trailing zeros are particularly dangerous in that they can lead to ten-fold overdoses. Thus, trailing zeros should never be used.
  - Examples:
    - Use "Digoxin 0.25 mg" instead of "Digoxin .25 mg."
    - Use "Haloperidol 5 mg" instead of "Haloperidol 5.0 mg."
- Arabic (decimal) numerals are preferable to Roman numerals, and in some instances it is preferable for numbers to be spelled out.
  - Example: Use "Aspirin 325 mg" instead of "Aspirin V grains."
- Other specific abbreviation issues:
  - The term "microgram" can be abbreviated as "mcg," but it should not be abbreviated as "ug," which can easily be mistaken for the abbreviation for "mg," standing for "milligram."
  - The word "unit" should be spelled out and never abbreviated as "U" or "u."
  - "M" should not be used as an abbreviation for thousands (e.g., 5 M units), as it has been mistaken as meaning one million.
  - Do not use commas when expressing thousands as they might be misinterpreted as periods.

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

(2) Issues related specifically to the Sig field or directions for use.

- The directions for use should not be split between the Sig and Notes fields.
  - Depending upon the design of the pharmacy system and/or the effectiveness of the training of pharmacy personnel, splitting directions between the Sig and Notes fields can result in part of the directions being missed, thereby preventing complete directions from being conveyed to patients. Patients may experience significant negative therapeutic outcomes when this occurs.
  - Examples of improper use:
    - Sig field—"Take one tablet daily," Notes field—"Take only on Monday, Wednesday and Friday." NOTE: This is an actual example from a warfarin e-prescription, which if not taken according to the complete directions, could possibly result in serious patient harm.
    - Sig field—"Dissolve one tablet under the tongue every 10 minutes for chest pain," Notes field—"Call physician immediately if relief is not obtained after three doses."
    - Sig field—"Apply and rub well into affected area twice a day," Notes field—"Discontinue use and call physician if rash worsens."
    - Sig field—"One drop to eye having surgery three times daily," Notes field—"Start two days prior to surgery."
- Information in the Sig field should not conflict with information in the Notes field.
  - Conflicting information in these fields usually requires pharmacists to contact prescribers to ascertain their actual intent with respect to the directions, which compromises the efficiencies related to e-prescribing.
  - Inconsistent information in the Sig versus the Notes fields can result in incorrect directions being conveyed to patients.
  - Example of improper use: Sig field—"1 cap orally 3 times a day", Notes field—"One capsule by mouth daily."
- Care must be taken so that Sigs are not truncated because important information can be lost.
  - Example of improper use: "Take 1 tablet once a month in the am 1 hr before eating or drinking, with 1 C water. Remain upright x 1 hour and nothing by mouth, then resu"
- Sig information should be clinically correct.
  - Example: Use "Amoxicillin 500 mg Oral Capsules"—Sig "One capsule three times a day" instead of "500 caps 3 times a day."
- Directions for use should be spelled out clearly in proper English.
  - Since the pharmacist must interpret—and nearly always writes—the label in English, the use of abbreviations (particularly Latin) or symbols is unnecessary and discouraged because it can lead to medication errors.
  - Example: Use "Take 1 tablet by mouth twice a day" instead of "1 T PO BID."
- Information in the Sig field should be limited to the Sig.
  - Quantity to be dispensed should not be placed in the Sig field.
    - Example: Use "One capsule by mouth three times daily" instead of "One capsule by mouth three times daily – Disp # 30."
  - Duration of therapy should not be placed in the Sig field.
    - Example: Use "One capsule by mouth four times daily" instead of "One four times daily – Disp 10 day supply."
  - Drug description should not be placed in Sig field.
    - Example: Use "One capsule by mouth at bedtime" instead of "One by mouth at bedtime– Paxil CR 20 mg."
  - Example of improper use:
    - "One drop to eye having surgery three times daily. Start two days prior to surgery. May substitute Acular LS, Xibrom, or Voltaren if less expensive." (i.e., the indication of alternative approved drugs "May substitute Acular LS, Xibrom, or Voltaren if less expensive" should be placed in the Notes field.)
- Sigs should be complete, properly formatted, and not repeated.
  - Sig should be complete.
    - Example: Use "Apply topically to forearm three times a day" instead of "Topical each day."
  - Sig should be properly formatted.
    - Example: Use "Take one capsule three times a day" instead of "1 3 times a day."
  - Sig should not be repeated.
    - Example: Use "Take one capsule daily" instead of "1 PO QD – Take one tablet every day."
- The inclusion of the intended use or the indication for the medication in the directions for use is helpful to patients, pharmacists and other prescribers, and is strongly encouraged.
  - Intended use can help patients to organize and better understand their medications and why they are taking them.
  - Including the indication in the Sig field can help prevent dispensing errors, and it provides pharmacists with a foundation for patient counseling and medication therapy management.
  - Other prescribers may find the indication helpful when a patient brings their medication bottles with them to office visits.
  - Example: "Take according to instructions in dosepak for poison ivy rash."

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

- The instruction "take as directed" is rarely appropriate and should be avoided by prescribers.
    - Such an instruction assumes an understanding on the part of the patient that may not exist, and even if it does, will very likely be short lived.
    - Using the term "take as directed" provides little information upon which the pharmacist can base their counseling of the patient.

(3) Proper use of the Notes field (referred to as "free text" in the NCPDP SCRIPT Standard).

- Prescription information that has a designated, standardized data field should not be placed in the Notes field.
    - For example, neither the drug name, strength nor quantity should be placed in the Notes field because there are specific fields in the NCPDP SCRIPT Standard for these data elements. This is important because if this information isn't placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
- Clinical information that has a designated, standardized data field should not be placed in the Notes field.
    - As with prescription information, the clinical information should appear in the designated fields for these data elements. This is important because if this information isn't placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
- Reserve use of the Notes field for information related to, but not part of, the prescription.
    - For example, a comment such as: "Please have the patient call the office when they have finished taking this prescription" would be an appropriate use of the Notes field.
- To reiterate, as mentioned above, the directions for use should not be split between the Sig and Notes fields nor should the information in the Sig field conflict with information in the Notes Field.
    - The former can lead to critical information being missed by pharmacy personnel and possibly not being transmitted to the patient, and the latter normally requires pharmacists to contact the prescriber to clarify their intent, thereby compromising the potential efficiencies of e-prescribing.

(4) Refills authorized, if any

- Although allowed both by convention and NCPDP SCRIPT, the indication of "PRN" (refill as needed) is not considered to be good practice and should be discouraged.
    - Example: Use "Refill 11 times" instead of "Refill PRN."

(5) Other items unique to electronic prescribing.

- Representative NDC number requirements.
    - Representative NDC numbers, which contain 11 digits, must be correct, as incorrect representative NDC numbers may cause drug identification problems in the receiving pharmacies.
    - Representative NDC numbers must be current and included in e-prescription messages unless the items do not have assigned NDCs.
- Quantity Qualifiers must be correctly associated with drug descriptions.
    - Correct mapping procedures are available in the Units of Measure table, which can be found in the NCPDP External Code List and the Surescripts Implementation Guides.
    - Where possible, quantities should reflect the actual metric quantity to be dispensed.
        - Example: Use "Amoxicillin 250mg/5ml, 150 ml" instead of "Amoxicillin 250mg/5ml, 1 bottle."
    - The use of "ZZ", "EA" and "00" should be limited to instances in which none of the available qualifiers in the Units of Measure table can be applied.
        - Examples of improper use: Drug description—Amoxicillin 500 mg Oral Capsule, Quantity 30 and Quantity Qualifier sent "ZZ"—mutually defined, "EA"—each or "00"—unspecified instead of "AV"—capsules.

Category III—Prescription Common Mistakes

Even though providers using the ChartMaker Medical Suite strive to be accurate in entering information for E-prescription, there are common mistakes made that can easily be corrected. Please read through the examples below in order to understand E-prescription best practices.

(1) Incorrect or incorrectly formatted SIG

This occurs when the appropriate dose is entered incorrectly. The following examples demonstrate typical errors:

Category III—Prescription Common Mistakes (continued)

Drug Description	SIG	Notes	Nomenclature Description	Comment
Combivent Respimat 20 mcg-100 mcg/actuation Aerosol Inhaler	Spray 1 aerosol with adapter (gram) puff(s) 4 times a day		Incorrect or incorrectly formatted SIG	"1 aerosol" is not an appropriate dose for Combivent
Advair HFA 115 mcg-21 mcg/actuation Aerosol Inhaler	Take 2 aerosol with adapter (gram) puff(s) twice a day		Incorrect or incorrectly formatted SIG	"2 aerosol" is not an appropriate dose for Advair HFA
ProAir HFA 90 mcg/actuation Aerosol Inhaler	Take 2 puffs puff(s) q 4-6 hrs prn cough or wheeze or before exercise		Incorrect or incorrectly formatted SIG	Part of the patient instructions are duplicated
Proctosol HC 2.5 % Rectal Cream	Apply 1 cream (gram) rectally 4 times a day		Incorrect or incorrectly formatted SIG	"1 cream" is not an appropriate dose for Proctosol
dicyclomine 10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Three times a day	prn as directed	Incorrect or incorrectly formatted SIG	SIG should be free of all extraneous characters All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Lotrel 5 mg-10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Daily	Name Brand Medically Nec.	Incorrect or incorrectly formatted SIG; Conflicting or Supplementary Drug Substitution information in the Notes	SIG should be free of all extraneous characters All Drug Substitution information should be sent in its designated field; No parts of the Drug Substitution information should be in the Notes
Suprax 400 mg capsule	Take 1 capsule (hard, soft, etc.) orally qd		Incorrect or incorrectly formatted SIG; Incorrect, Missing or Incomplete Dosage Form sent in Drug Description	SIG should be free of all extraneous characters - Suprax 400mg is not available in capsule form; Appropriate dosage form: **Oral Tablet**

Category III—Prescription Common Mistakes (continued)

(2) Incomplete SIG

The following examples indicate incomplete SIG:

Drug Description	SIG	Comment
Suprep 17.5 gram-3.13 gram-1.6 gram Oral Solution	Take 1 solution, reconstituted, oral orally As Needed	SIG should include the **dose, route and frequency** of the prescribed medication
Coumadin 4 mg tablet	Take 2 tablet orally as directed	SIG should include the **dose, route and frequency** of the prescribed medication
Zithromax Z-Pak 250 mg tablet	Take 1 tablet orally As Directed	SIG should include the **dose, route and frequency** of the prescribed medication

Category III—Prescription Common Mistakes (continued)

(3) Conflicting or Supplementary SIG information included in the Notes

Drug Description	SIG	Notes	Comment
nystatin 100,000 unit/gram Topical Ointment	Apply 1 ointment (gram) topically Twice a day	FOR CORNER OF LIP	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
metformin 500 mg tablet	Take 1 TABLET orally bid	*take 1 tablet daily for 1 month, then increase to 1 tablet twice a day	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Augmentin 875 mg-125 mg tablet	Take 1 tablet orally Every 12 hours	x 5 days	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Mobic 7.5 mg tablet	Take 1 tablet orally twice a day	as needed	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes

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Schedule

- **Schedule – Appointment Details – Patient Details –** The Patient Details section of the Appointment Details screen has been updated to display all primary phone numbers in the patient's account, allowing you to easily access that information should you need to contact the patient to reschedule or cancel an appointment, or for any other reason regarding their healthcare. See Figure 1.

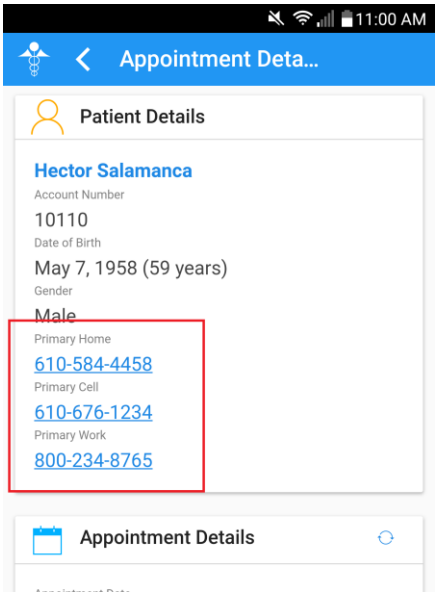


Figure 1 – Schedule – Appointment Details – Patient Details

- **Schedule – Appointment List –** The appointment Schedule screen has been updated to display the number of appointments that are in the current appointment list being displayed. The number of appointments will appear above the Filter button. See Figure 2.

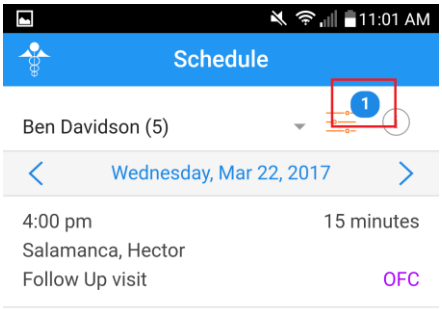


Figure 2 – Schedule – Appointment List

Patient

- **Patient – Patient Details –** The Patient Details screen has been updated to display any Reaction and Severity for Allergies when configured for a patient. See Figure 3.

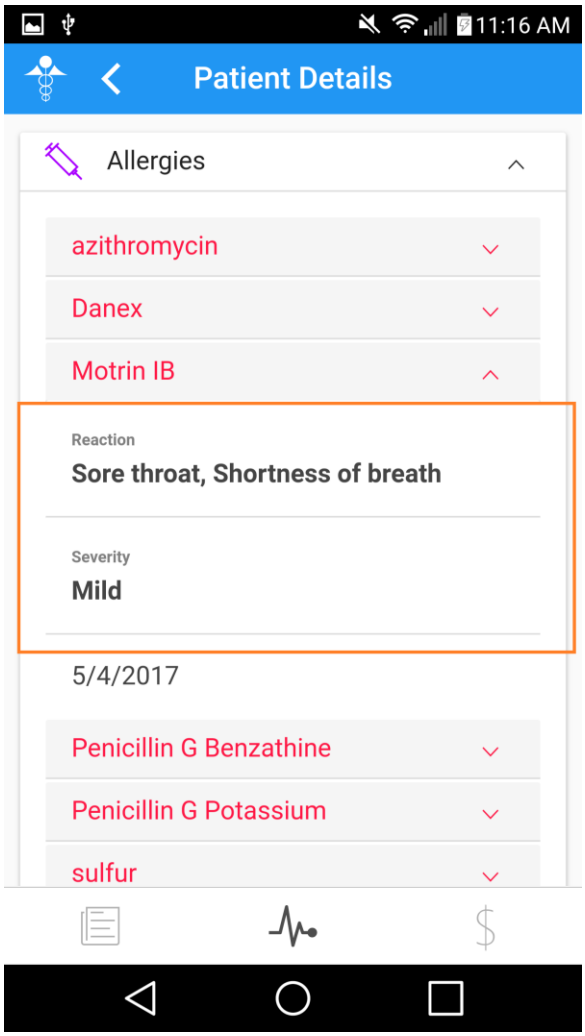


Figure 3 – Patient Details – Allergies

Charge Capture

- **Charge Capture –** The Charge Capture user-interface has been updated with several small modifications to enhance the user-experience, making the screens more consistent, clear, and easier to maneuver. Back and close buttons have been added where applicable, option verbiage has been updated where needed, and spacing and overall aesthetic concerns have been addressed to give an improved mobile experience.

- **Charge Capture – Enter Diagnosis** – The **Enter diagnosis** functionality in the Charge Capture screen has been enhanced to allow you to easily select and search for diagnoses for the patient. You can now select from recently used diagnoses (**Recent Dx**), select from the active, inactive, and pre-existing diagnoses from the patient's facesheet (**Facesheet Dx**), and search for any diagnosis in the system (**Dx Search**), to configure current diagnoses for the charge you are capturing. Any of these methods can be used in conjunction when entering diagnoses, and the selected diagnoses (up to five) will be queued in **Dx Review** area where you can confirm your diagnostic selections.

  After you have accessed the Charge Capture area, you can tap the **Enter diagnosis** link (see Figure 4), and you will default to the Recent Dx screen. See Figure 5. You can then toggle between the **Recent Dx** (the compass icon), **Facesheet Dx** (the stethoscope icon), **Dx Search** (the magnifying glass icon), and **Dx Review** (the paper airplane icon) by tapping the applicable icon below.

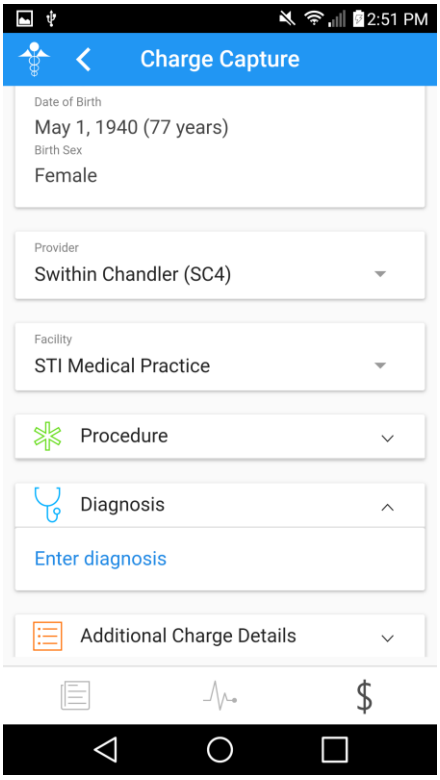


Figure 4 – Charge Capture

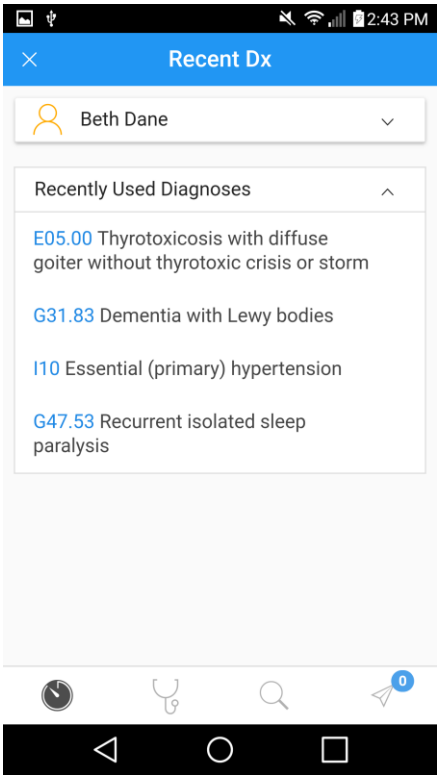


Figure 5 – Recent Dx

Charge Capture – Enter Diagnosis (continued)

To select a diagnosis in the Recent Dx and Facesheet Dx screens, tap the diagnosis you wish to add, and a check will appear next to the diagnosis, and the Dx Review icon will keep a tally of the number of diagnoses you have selected. See Figure 6.

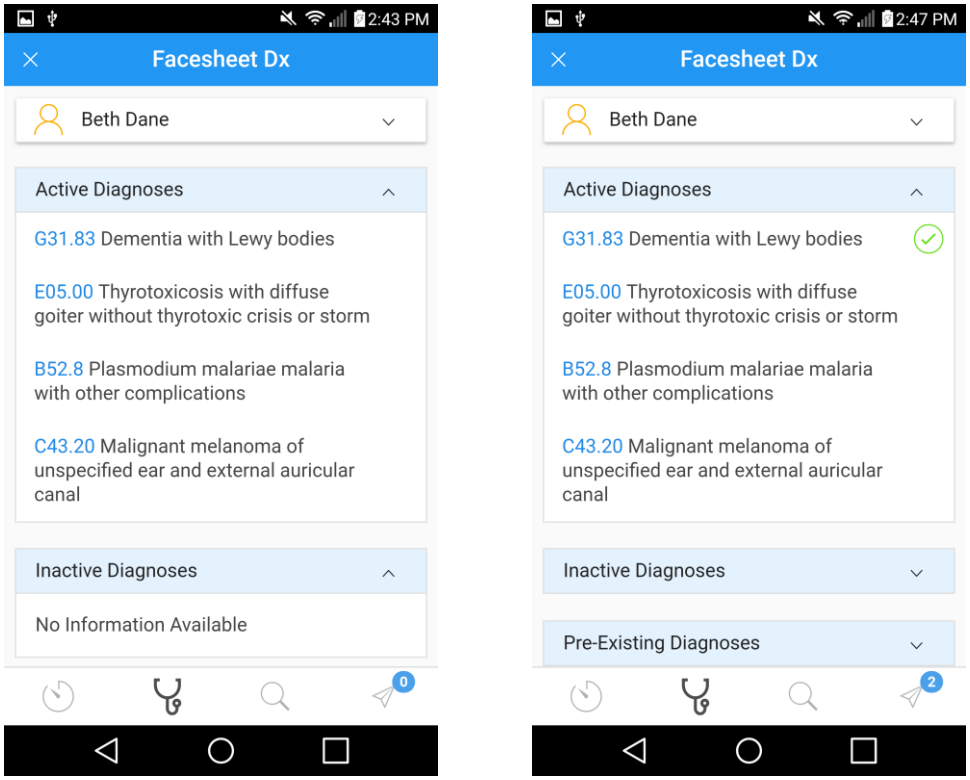


Figure 6 – Facesheet Dx

When you click **Dx Search** icon you will enter the Dx Search screen where you can search diagnostic codes by ICD10 **Description**, or by ICD10 **Code**. You can toggle between these options by tapping the **Search By** button to the left of the **Search** field. See Figure 7.

You can then enter a description or code in the Search field, or you can tap through the diagnostic tree below to find the applicable diagnosis.

When entering a description or code in the **Search** field, the system will narrow the diagnostic tree based on your search criteria. See Figure 8. You can then tap through the various diagnostic categories until you locate the billable diagnosis code you want to select. See Figures 9 and 10. As when selecting diagnoses in the Recent Dx and Facesheet Dx screens, when you select a diagnosis in the Dx Search screen a check will appear next to the diagnosis, and the Dx Review icon will keep a tally of the number of diagnoses you have selected.

Charge Capture – Enter Diagnosis (continued)

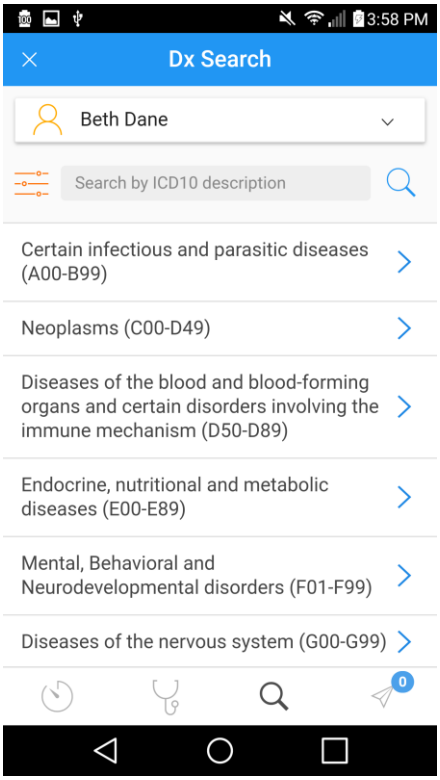


Figure 7 – Dx Search

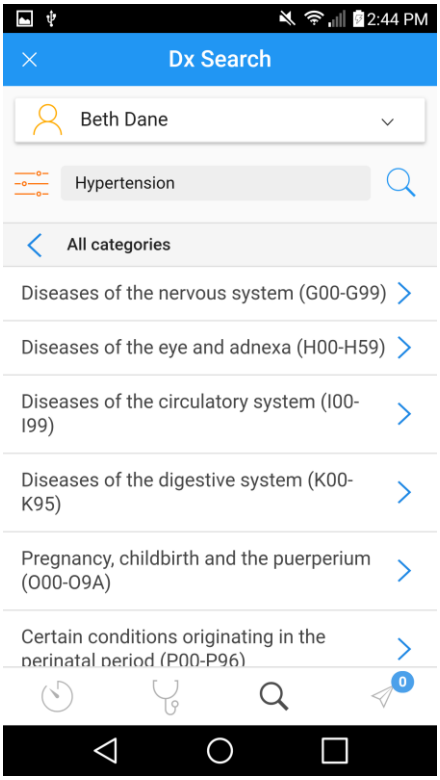


Figure 8 – Dx Search with Description

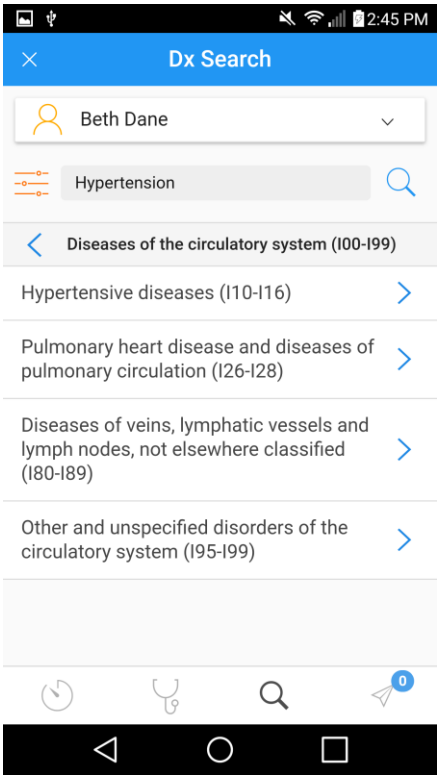


Figure 9 – Dx Search – Toggling Categories

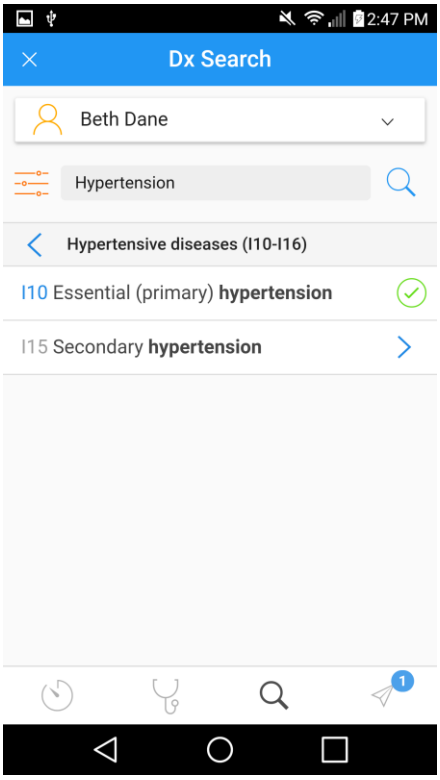


Figure 10 – Dx Search – Selected Dx

Charge Capture (continued)

Charge Capture – Enter Diagnosis (continued)

After all the applicable diagnoses have been selected in the Recent Dx, Facesheet Dx, and/or Dx Search screens, you can click the **Dx Review** icon to go to the Dx Review screen to review and finalize your diagnostic selections. See Figure 11. In the Dx Review screen you can remove any diagnoses that you do not want to include with the charge by tapping the **Trash** button next to diagnosis. Once all diagnoses have been reviewed, click the **OK** button to add the selected diagnoses to the charge capture. Those diagnoses will then appear in the Diagnosis area of the Charge Capture screen. See Figure 12.

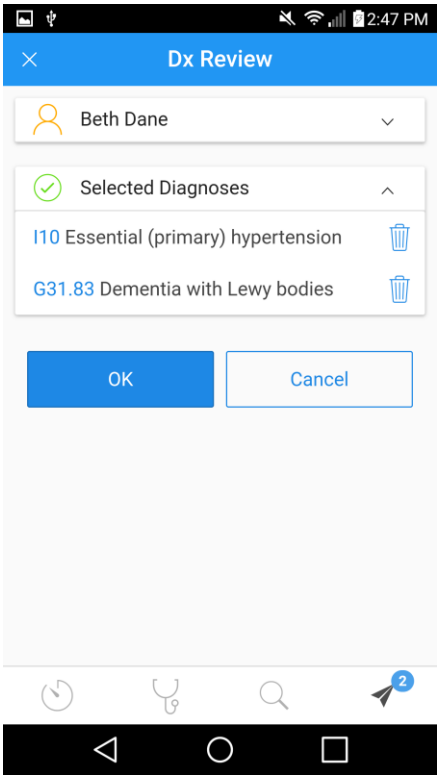


Figure 11 – Dx Review

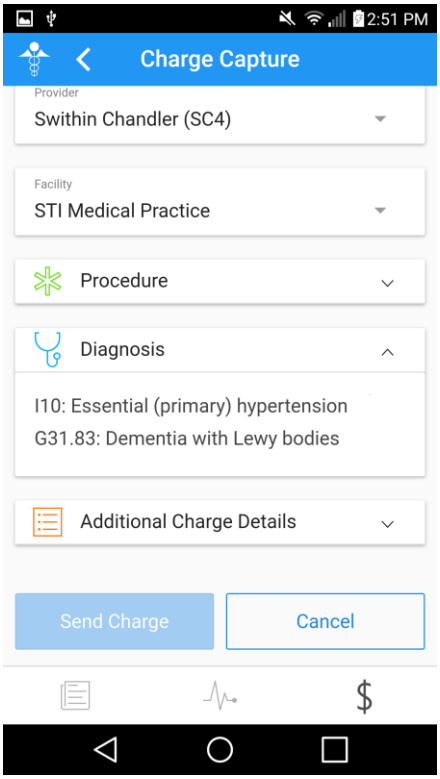


Figure 12 – Charge Capture

- **Charge Capture – Enter Procedure** – The **Enter procedure** functionality in the Charge Capture screen has been enhanced to allow you to easily select and search for procedures for the patient. You can now select from a practice-level **Procedure List**, or search for any procedure in the system (**Procedure Search**), to configure a procedure for the charge you are capturing. Practice-level procedure lists are maintained via **Settings** > **Procedure List**. You can create a single list, or multiple lists, per your office's needs.

  After you have accessed the Charge Capture area, you can tap the **Enter procedure** link (see Figure 13), and the **Procedure List** screen will default. See Figure 14. You can then select a procedure in the **Procedure List** (star icon) screen, or search for a procedure in the **Procedure Search** (the magnifying glass icon) screen by tapping the applicable icon below.

  In the **Procedure List** screen, you can toggle the various procedure lists open and closed by tapping the corresponding **arrow** button to the right of each of the lists. Once the applicable procedure is located, simply tap it to select it.

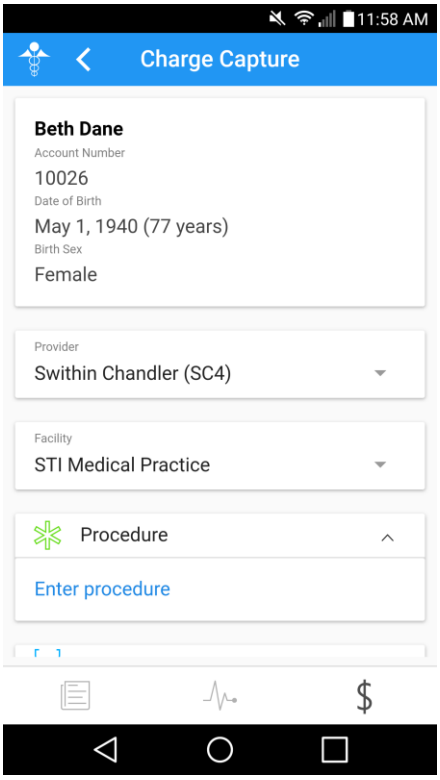


Figure 13 – Charge Capture

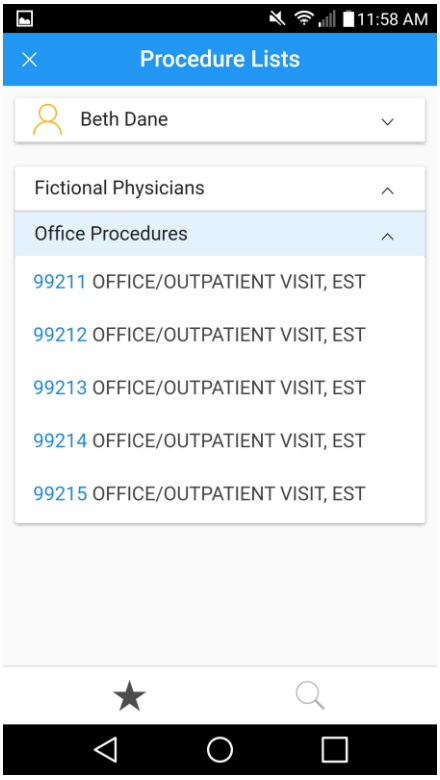


Figure 14 – Procedure Lists

When you click **Procedure Search** icon you will enter the Procedure Search screen where you can search procedure codes by **Description**, or by **CPT Code**. You can toggle between these options by tapping the **Search By** button to the left of the **Search** field. See Figure 15.

When entering a description or code in the **Search** field, the system will display any procedures that contain any of the description or code based on your search criteria. See Figure 16. You can then scroll through the list, and once the applicable procedure is located, tap that procedure to select it.

After the procedure has been selected it will appear in the Procedure section of the Charge Capture screen. See Figure 17.

Charge Capture – Enter Procedure (continued)

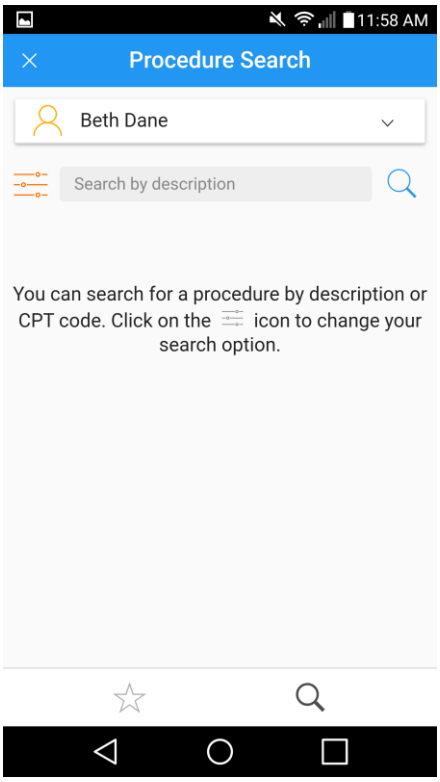


Figure 15 – Procedure Search

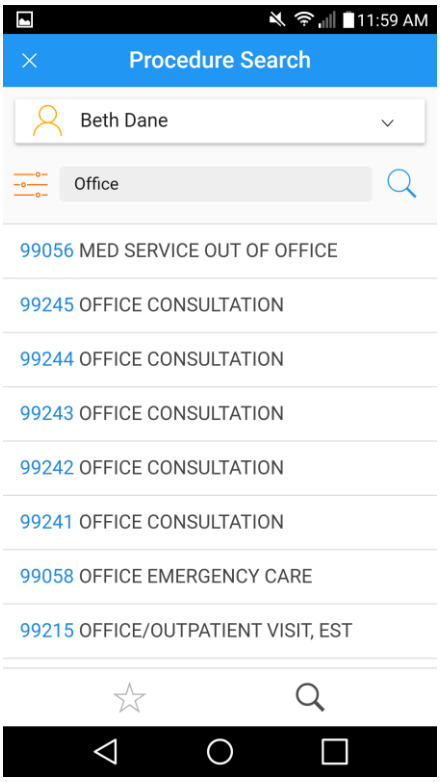


Figure 16 – Procedure Search with Search Criteria

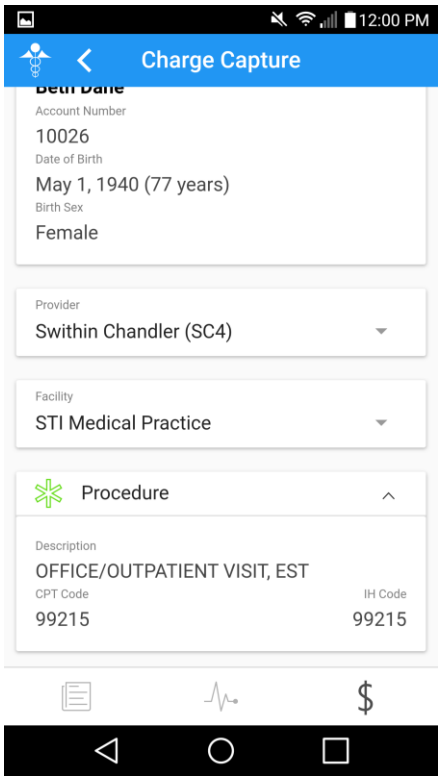


Figure 17 – Charge Capture with Procedure Selected

- **Settings – Procedure Lists** – To assist you in easily and efficiently selecting procedures for charge capture, the system has been updated with the ability to create practice-level **Procedure Lists** via the Settings submenu. See Figure 18.

  Once the Procedure Lists area has been accessed, you can create and maintain procedure lists. In the Procedure Lists screen, you will see any practices that have procedure lists configured. To maintain an existing procedure list, select the applicable list under the practice name. See Figure 19. To create a new procedure list, select the **Create List** option.

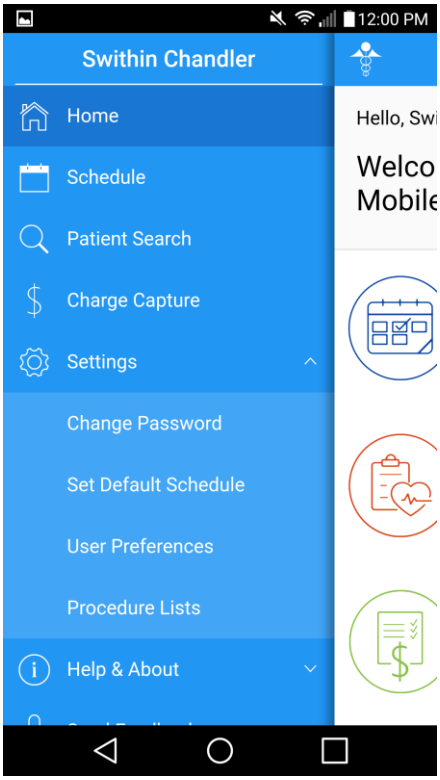


Figure 18 – Menu – Settings – Procedure Lists

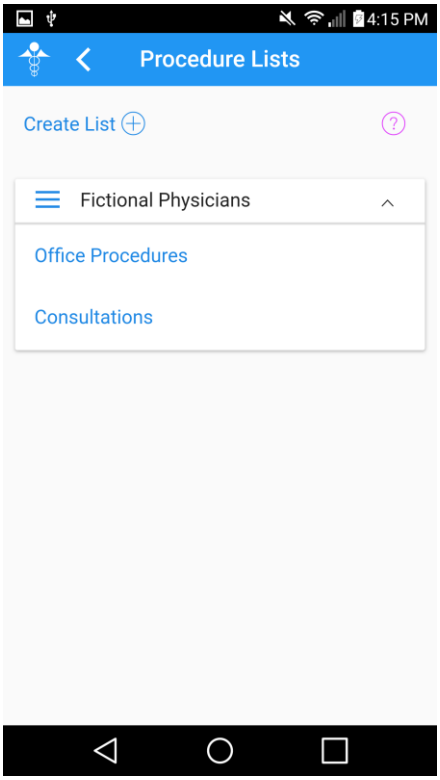


Figure 19 – Procedure Lists

When creating a new procedure list, you can select which practices you want the list to be available for, and then tap the **Create** button. See Figure 20. In the Edit Procedure List screen, you can then enter or modify a **List Name**, and then add procedures by selecting the **Add Procedure** option. See Figure 21. When the Add Procedure option is selected, you can search for and select the applicable procedures to add to the list in the Procedure Search screen. See Figure 22.

When the procedures are selected, they will be added to the **Procedures** list in the Edit Procedure List screen. See Figure 23. In the Edit Procedure List screen, you can add additional procedures by clicking the **Add Procedure** option. You can remove any added procedures that you do not want to include in the list by tapping the **Trash** button next to procedure. Once all procedures have been selected for the list, you can tap the **Save List** option. To remove the list, you can tap the **Delete List** option.

When procedure lists have been created, they will appear in the Procedure List screen when entering a procedure for charge capture for the applicable practices.

Settings – Procedure Lists (continued)

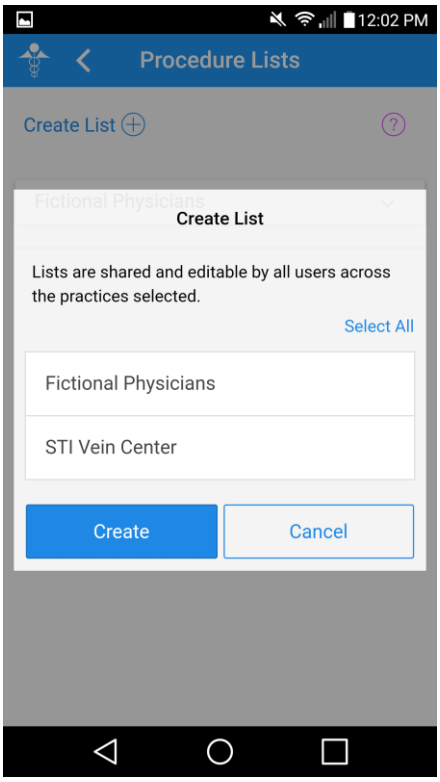


Figure 20 – Create List

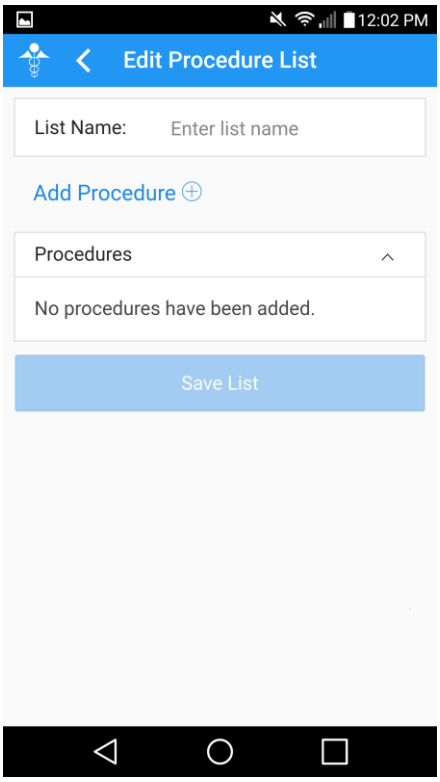


Figure 21 – Edit Procedure List

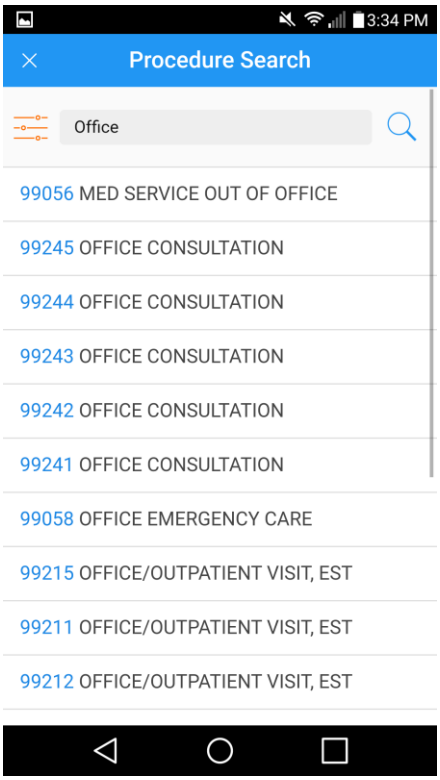


Figure 22 – Procedure Search

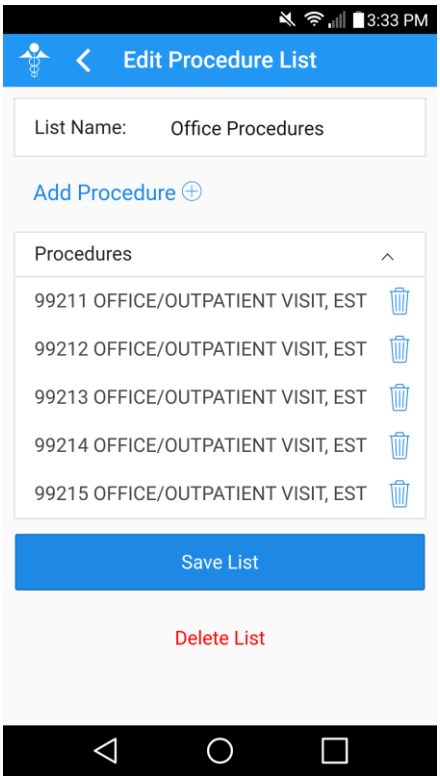


Figure 23 – Edit Procedure List with Procedures Selected

Please note that the ChartMaker Medical Suite can no longer be installed on computers using the Windows XP or Windows 2003 Server operating system. Since Microsoft has discontinued support for Windows XP in April 2014, and Windows 2003 Server in July 2015, we can no longer guarantee the stability of computers using this operating system, and recommend that you upgrade the operating system on any computers currently using Windows XP or Windows 2003 Server.

General

- **PCADMIN –** The Practice Manager Administration (PCADMIN) Tool icon has been updated to include an **ADM** above the handshake icon to easily distinguish it from the Clinical and Practice Manager icons on your desktop. See Figure 1.

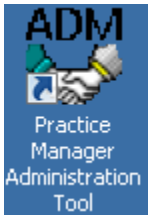


Figure 1 – PCADMIN Icon

Charge

- **Charge – Custom** – A new Charge Custom Field, **Primary ICN Number (20021)**, has been added to the Add Extended Data dialog, allowing you to enter the primary ICN number for the charge when it is needed for billing secondary insurances electronically. See Figure 2.

  This information is added by clicking the **Custom** button, when entering or editing a charge, then in the Charge Custom Fields dialog clicking the **Add** button, then in the Add Extended Data dialog selecting **Text** in the Type field, selecting **Primary ICN Number (20021)** in the Description field, and then entering the **Primary Insurance ICN Number** in the Value field.

  When information is configured and saved in this area, a REF*F8 segment will be created in the 2330B loop of the Change Healthcare (NEID _P5) billing file containing the Primary ICN Number.

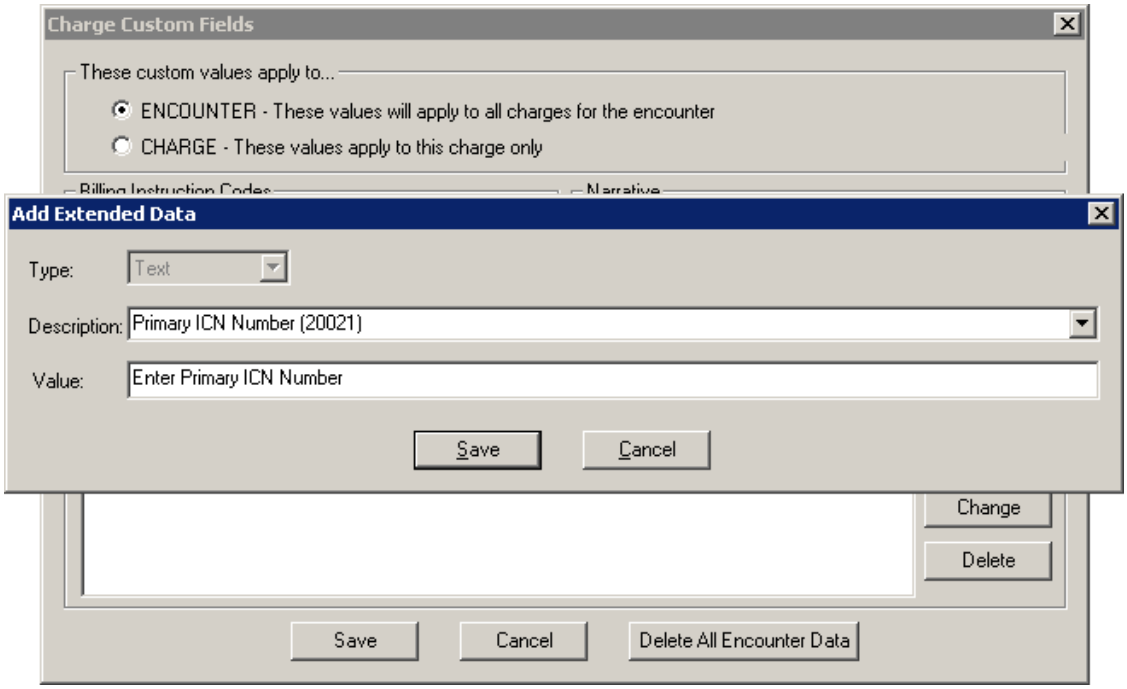


Figure 2 – Charge – Charge Custom Fields – Add Extended Data

Clinical

- **Clinical – Immunization** – The program has been updated so that the latest immunization codes from the CDC are being used when configuring immunization information.

- **Clinical – Immunization** – The DelVAX program has been updated to be compliant with the CDC HL7 2.5.1 v1.5 format.

- **Clinical – Immunization** – The NJIIS program has been updated to include a PD1 Segment in the immunization file, regardless of whether consent information is entered.

- **Clinical – Immunization** – The Immunization dialog has been updated with a **NDC Code** field and a **CVX Code** field, allowing you to select the proper codes when configuring immunization information. See Figure 3. The NDC field drop-down will contain any NDC codes that were configured in the procedure file. When entering a new immunization entry in the Immunization tab of the Clinical screen, the NDC code that was tagged as the primary in the procedure file will default into the NDC Code field. If the immunization procedure was entered as a charge in the Charge screen, the NDC Code field will contain the NDC code selected there and you can modify this field as needed. Primary NDC codes will be designated with a **(P)** after the code. The CVX code will also default from the procedure file. When a NDC code is configured with the immunization it, along with the CVX code, will be included in the immunization file sent to applicable immunization registries.

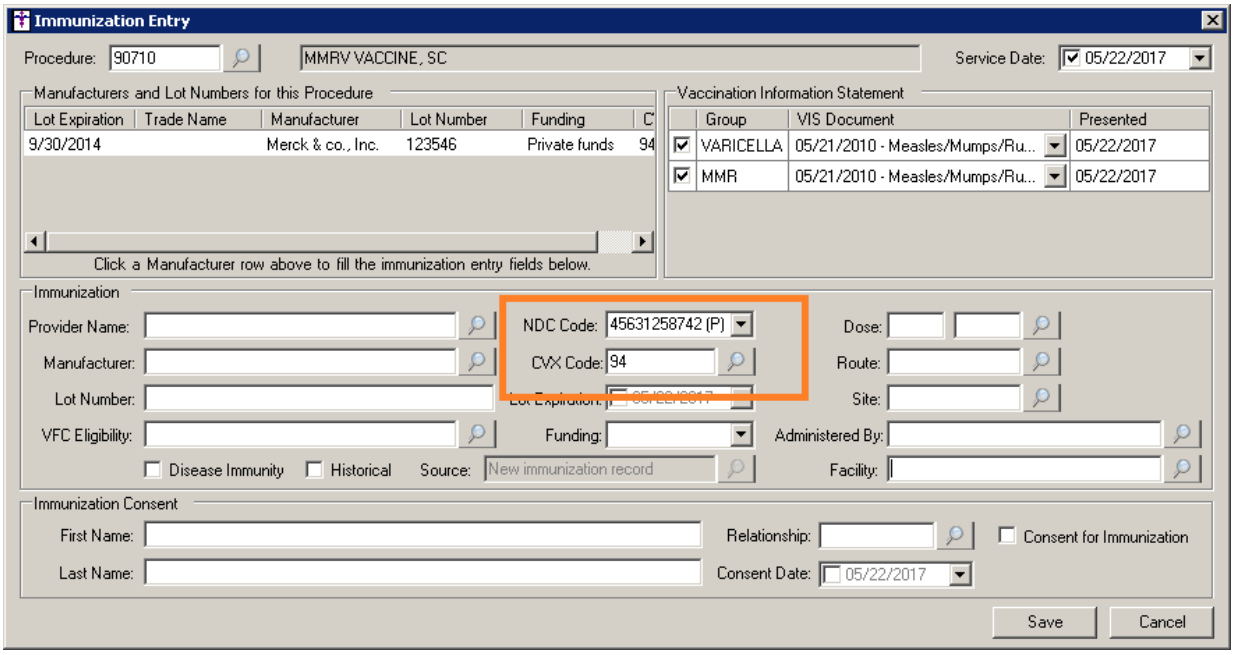


Figure 3 – Immunization Entry

Addendum

Insurance Billing Updates Reminder

In the version 4.1 release of Practice Manager, there was an important enhancement that was made to the Insurance Billing screen to alert you whenever a new insurance billing update is available. Once alerted you can then download these updated billing components at your convenience. **Do note that if you are running the 4.1 version of Practice Manager, the update process needs to be performed on the server.**

In the version 4.2 release of Practice Manager, the system was updated so that billing components reside on each individual workstation. **Therefore, if you are running the 4.2 version or higher of Practice Manager, the update process (described below) will need to be initiated for each workstation that will be doing insurance billing.** If the updates are not downloaded and registered on each workstation that will be doing insurance billing, then claims generated for those workstations may be denied if they are not updated.

- **Insurance Billing Updates** – The Insurance Billing tab has been updated with an Update button that allows you to download the latest insurance billing components if new components are available. See Figure A1. An Update button is available in both the Manual Billing and Automatic Billing sub-tabs and will become highlighted to alert you when new billing components are available.

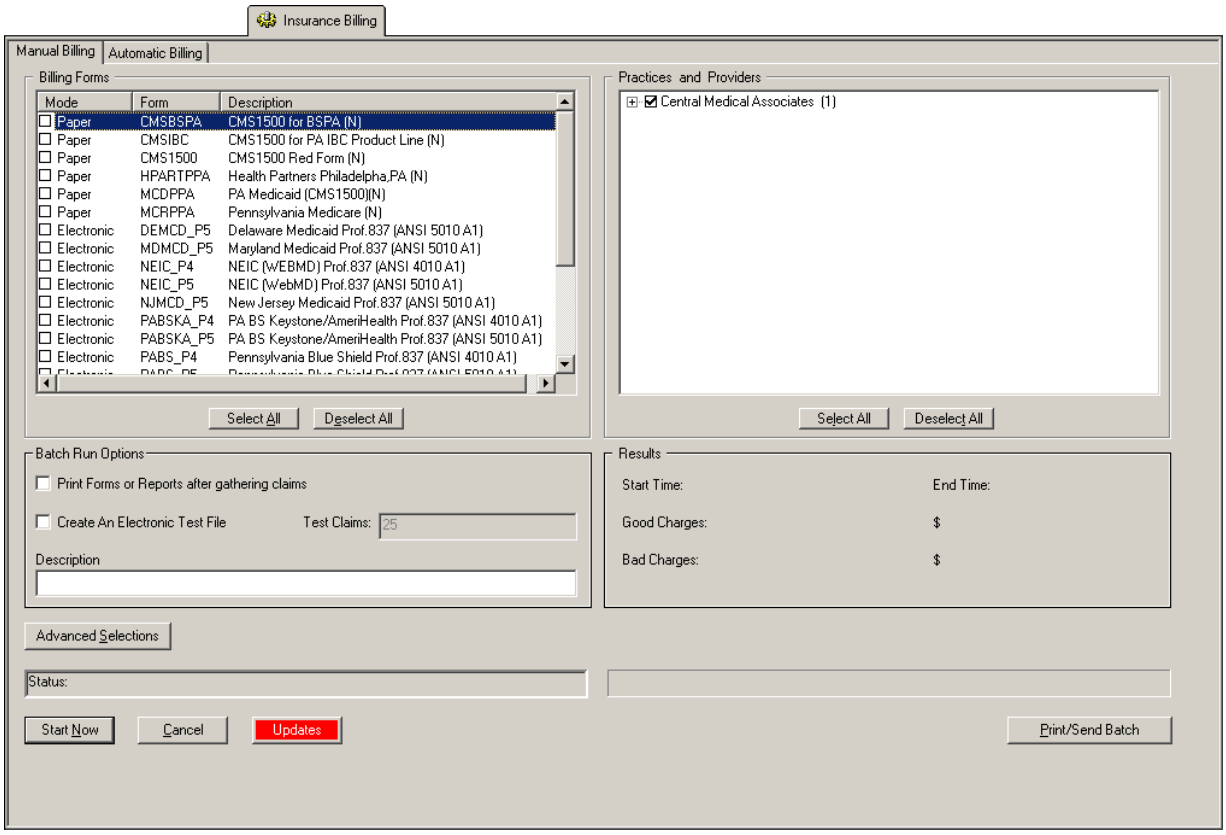


Figure A1 – Insurance Billing – Manual Billing

Once the download is initiated by clicking the **Updates** button, another dialog will appear confirming that you want to download and install the latest billing updates. See Figure A2.

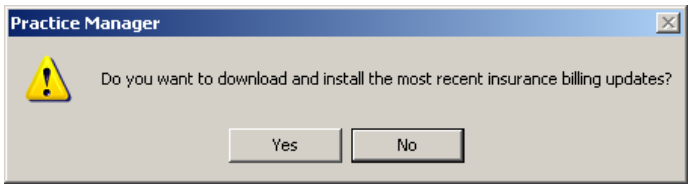


Figure A2 – Insurance Billing Updates Download

Once the **Yes** button is clicked the insurance billing updates will start to download and the following message will appear in Figure A3. Do note that once the billing updates are initiated by a user, the Updates button will disable for all users and other users who try to initiate the download will receive a message stating that updates have started from another machine. Once the updates have been downloaded you will be prompted to install the updates, as well as to close out of the Practice Manager application to ensure a successful update.

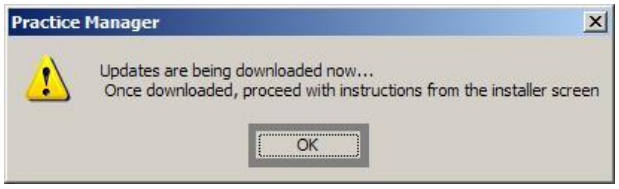


Figure A3– Insurance Billing Updates Download Confirmation

Once the updates have been successfully downloaded and installed, log back into Practice Manager and be sure to register the Billing Component Manger (Add-Ins > Insurance Billing > Billing Component Manager).

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