What's New in Version 11.0.5.0 for Eyecare Advantage (rev 03/31/2015)

EDI

EDI PHI Security Enhancements:
- Due to HIPAA and Meaningful Use Stage 2 requirements, individual EDI files containing patient protected health information or PHI including electronic claims, remittance and eligibility files will no longer be saved in your Advantage product folder.
- You will need to run a one-time "Secure EDI Files" process to save important files and clean up your product folder by deleting files containing PHI.
- Going forward, EDI files will automatically be saved to a secure, encrypted table in your Advantage database.
- A new EDI Reports Viewer screen lets you browse new and historic files and reports, and will make your job easier! Otherwise, the changes to your daily process are MINIMAL.
- Details are available on the EDI Alerts page, in WebHelp and in the EDI Program in Compulink University LMS.
- *Related Courses on Compulink University LMS:*
    - *Program: EDI*
    - *Course: EDI_220 EDI PHI Security Enhancements*
    - *Course: EDI_225 EDI Reports Viewer*

GENERAL

Configuration File:
- Your Advantage Configuration file is automatically downloaded approximately every 2 weeks.
- If there is a problem with the automatic download, a message will pop up for the first User who logs in for the day.
- This message will prompt them to notify their Administrator to download the Configuration file manually from the Utility > System Administrator menu. See the Help file for directions for the manual download.
- *Related Courses on Compulink University LMS:*
    - *Program: Version 11 Enhancements*
    - *Course: PM_245 Version 11.0.5.0*

ICD-10

- *Related Courses on Compulink University LMS:*
    - *Program: ICD-10*
    - *Course ID: ICD_10_105 ICD-10 Introduction (available now)*
    - *Course ID: ICD_10_115 ICD-10 Action Plan (available now)*
    - *Course ID: ICD_10_120 ICD-10-CM Code Structure (available now)*
    - *Course: ICD_10_125 ICD-10 Advantage Configuration*
    - *Course: ICD_10_130 ICD-10 Software Utilization*

ICD Preference Flags have been removed:
- The ICD-10 Preview options have been removed from the Status Bar Software Settings menu.
    - When you right click on the status bar menu at the bottom of the screen, the "Diagnosis ICD Lookup Preference" and "EHR ICD-10 Simulation On/Off" no longer appear.
- Utility>System Administrator>Login>IDs.
    - The "ICD-9 Lookup Preference" field has been removed from this table. The software will now automatically default to either ICD-9 or ICD-10 based upon the designated start date in the primary Payor record.

ICD-10 Start Date (Utility>System Administrator>System Setup).

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- An ICD-10 Start date field was added to the Miscellaneous tab.
- This field should be left blank. The software will assume a start date of 10/01/15.
- If CMS should change the start date, you may enter that new start date in this field.

ICD-10 Table Changes:
- Insurance Payors (Utility>Look-up Tables>Financial>Payor Names)
  - A new field called "ICD 10 START" was added to the table.
  - For all Compulink-owned Payors, the ICD 10 START will be populated from the Emdeon Payer List based on the payer's ICD-10 readiness.
  - Run the Compulink Update command to stay current. (Utility>Look-up Tables>Financial>Payors>Compulink Update)
  - For all User-owned Payors, the ICD 10 START date defaults to 10/1/15 on new entries, and is assumed to be 10/1/15 on existing entries.
  - If you have a Payor that will not be ready to accept claims on that date, you may enter that individual Payor's Start date.
  - More guidance will be available on this as we get closer to the ICD-10 effective date.
- Assessment/Plan>By Diagnosis (Utility>Look-up Tables>EHR>Assessment/Plan>By Diagnosis).
  - Added ICD-10 codes to the table.
- Diagnosis Name (Utility>Look-up Tables>EHR>Diagnosis>Name).
  - The complete set of ICD-10 codes was appended to the table.
- Encounter Favorites (Utility>Look-up Tables>EHR>Encounter Favorites).
  - A new "ICD-10 Diagnosis List" field was added.
  - This list contains the "base" ICD-10 codes that will be used after the ICD-10 Start Date.
  - When selecting an Encounter Favorite in the exam, the software will use the Start Date to determine if it should pull from the "ICD-9 Diagnosis List" or the "ICD-10 Diagnosis List."
- Bitmap Detail (Utility>Look-up Tables>EHR>Image>Bitmap Detail).
  - A new "ICD-10 Code(s)" field was added.
  - This list contains the "base" ICD-10 codes that will be used after the ICD-10 Start Date.
  - When selecting a Bitmap in the Visual Documentation Engine, the software will use the Start Date to determine if it should pull from the "ICD-9 Code(s)" or the "ICD-10 Code(s)."
- Base Image (Utility>Look-up Tables>EHR>Image>Base Image).
  - Some base images have Regions attached to them.
  - Highlight a base image and click on Regions at the top.
  - This will open a window with the image in the middle with all of the regions outlined, and the list of regions listed on the left.
  - Double click on one of the regions on the left and the Area Edit window opens.
  - The "ICD Keywords" field is where you can enter any keywords that you would like the software to look for when selecting the list of diagnosis codes to choose from when using the Visual Documentation Engine.
  - The software will first look at the ICD-10 codes that are assigned in the Bitmap Image Detail table. These could be a list of 3 character "base" codes.
  - From that list of diagnoses listed, it will then look to the "ICD Keywords" field for words that could help to narrow down that list of diagnoses to choose from.
  - If the "ICD Keywords" field is empty, it will then look to the Region Name for words that could help to narrow down that list of diagnoses to choose from.
  - When dropping a bitmap on the VDE, the ICD-10 list will be filtered down based on the keywords in the region you dropped it on.
- HCM Order Sets (Utility>Health Care Maintenance Rules>Diagnosis/Orderset Mapping).
  - Added ICD-10 codes to the table.

ICD-10 and Patient Exam:

- Exam date. The ICD-9/ICD-10 toggle is controlled by the Exam date.
  - If the exam date is BEFORE the ICD-10 Start Date, ICD-9 codes will be used throughout the exam.

- o If the exam date is ON or AFTER the ICD-10 Start Date, ICD-10 codes will be used throughout the exam.
- o If the ICD-10 Start Date for the patient's Primary Payor is anything other than the 10/01/15 date, it will use that date to determine if it should use ICD-9 or ICD-10.
- Complaint
  - o There is a new accident button and memo field inside the Chief Complaint popup.
  - o Fill out the "Additional/Accident Details" field and click the button.
  - o It will automatically add a diagnosis record, and copy the details to the Assessment field.
  - o Once you complete the exam and arrive on the Plan tab, you will need to edit the existing diagnosis record that was added, and complete the rest of the information.
- Diagnosis Assessment/Plan grid.
  - o Diagnosis name field: When entering diagnoses manually, "Unspecified" options will not be displayed. CMS suggests that each healthcare encounter should be coded to the level of certainty known for that encounter.
- Assessment and Plans.
  - o Double click in the Assessment or Plan field and they will only display items based upon the ICD-9/ICD-10 toggle.
- Forwarding the Diagnosis.
  - o The "Forward Last DOS" icon (blue circle arrow) will now display on the Diagnosis grid.
  - o Forwarding from ICD-9 to ICD-10.
    - If the exam date is ON or AFTER the ICD-10 Start Date, diagnoses will forward from ICD-9 to ICD-10.
    - If the ICD-10 Start Date for the patient's Primary Payor is anything other than the 10/01/15 date, it will use that date to determine if it should forward ICD-9 or ICD-10.
    - Single diagnosis.
      - Highlight an ICD-9 code from an exam date prior to the switch to ICD-10, click on the green circle arrow to forward. This will bring up a window for you to select the appropriate ICD-10 code.
  - o All diagnoses from the previous exam.
    - Click on the blue circle arrow to forward ALL of the ICD-9 codes from the previous exam to ICD-10 codes on the current exam. This will bring up a window for you to select the appropriate ICD-10 code.
    - Combination codes.
      - If 2 or more of the ICD-9 codes can be combined into 1 ICD-10 code, this will be done when using the "Forward Last DOS" icon.
      - Example: ICD-9 = 250.50, 362.05 and 362.07; when forwarded with blue arrow (after 10/1/2015) will come through with one ICD-10 = E11.331.
  - o If only one ICD-10 code matches the ICD-9 code that is being forwarded, the diagnosis selection window will be bypassed, and the new code will automatically forward.
    - Example: ICD-9 = 362.52; when forwarded ICD-10 = H35.32.
  - o If a "Side" or "Eye" was defined in the previous ICD-9 code, that will be used as a filter for the ICD-10 diagnoses that are available.
- Forwarding from ICD-10 to ICD-9.
  - o On the previous exam, ICD-10 codes were entered for the patient.
  - o Upon the next visit, the patient's Primary Payor has changed, and the ICD-10 Start Date for that Payor has not arrived yet.
  - o This means that the codes for this date of service must be in ICD-9, or the Payor will not accept the claim.
  - o When manually entering a diagnosis code, or using the Encounter Favorites and Visual Documentation Engine (VDE), the software will see the Payor Start date, and use the ICD-9 codes.
  - o When forwarding a previous diagnosis, the forward last date of service option is disabled, and you must forward one at a time.
    - If you click the icon, you will receive a message: Unable to forward ICD-10 codes back to ICD-9 as a GROUP. Please use Individual Forwarding Option!
  - o A diagnosis selection window will open for you to select the appropriate diagnosis if there is more than one code that matches.
  - o If only one ICD-9 code matches the ICD-10 code that is being forwarded, the diagnosis selection window will still come up, but the code is automatically selected/checked in the window. Hit Enter or click OK to forward the ICD-9 and bring up the diagnosis editing window.

- Example: ICD-10 = H35.32; when forwarded ICD-9 = 362.52.
- Encounter Favorites:
  - Items used to filter the diagnoses list.
    - The software uses the name of the Encounter Favorite as keywords to search for the closest diagnoses (left/right/OD/OS/OU). If RT or LT was used in the name, it will be recognized as right or left in the search.
    - The software will pull either ICD-9 or ICD-10 diagnoses based upon the exam date or the ICD-10 Start date on the patient's Primary Payor.
- Visual Documentation Engine (VDE).
  - If the exam date is ON or AFTER the ICD-10 Start Date, diagnoses attached to bitmap images will default to ICD-10.
  - If the ICD-10 Start Date for the patient's Primary Payor is anything other than the ICD-10 Start Date, it will use that date to determine if it should default to ICD-9 or ICD-10.
- Smart Functions
  - Automatically adding a diagnosis.
    - If you have a smart function attached to a button that will automatically add a diagnosis record, the software will automatically prompt you to select which ICD-10 diagnosis you would like to add. It is converting the ICD-9 code that is built into the smart function, to a list of ICD-10 codes to select from.
    - You will also be reminded once daily that you also have the option of using Encounter Favorites and the Visual Documentation Engine for higher efficiency.
- Fees command.
  - Added Auto-creation of PFSH ICD-10 ExamDiag records as needed, based upon the ICD10PFSH table.
  - This table indicates what History related ICD-10 records should be added if the Exam Health History contains Significant positive indication of a disorder already recorded.
  - This will take place automatically when clicking on the Fees command.
  - Example: Make sure the client is a smoker indicated in the Health History, and add this diagnosis in ICD10 mode: H35.32. Click the Fees command. An additional diagnosis of Z72.0 Tobacco use will appear.
  - When clicking on Fees, these historical codes will always be listed at the bottom of the diagnosis order, so they will NEVER default onto the charges.

ICD-10 and Patient Ledger
- Adding a Diagnosis:
  - In the patient ledger, the ICD-10 functionality is controlled by the From date or date of service.
  - If the date of service (ledger from date) is BEFORE the ICD-10 Start Date, the diagnosis dropdown will only display ICD-9 codes.
  - If the date of service is ON or AFTER the ICD-10 Start Date, the dropdown will only display ICD-10 codes.
- Claim Sets.
  - ICD-9 codes and ICD-10 codes can NOT be billed on the same claim set.
- Claim screen.
  - When adding a diagnosis on the expanded claim screen, the drop-down will display ICD-9 or ICD-10 based upon the date of service (ledger From date) on the ledger.

ICD-10 and Functions

- Function>Insurance Activities>Billing.
  - ICD-9 and ICD-10 codes can NOT be billed on the same claim.
    - If the current date is after the ICD-10 start date, the claim validation will look for ICD-9 and ICD-10 codes that are on the same claim set, and will produce an error on the Claim Edit Error Report.
    - This claim validation will also take place on the patient ledger when clicking the "Claim Validate" button or when printing an individual claim.
  - ICD Indicator.
    - When sending paper claims in a batch, or printing from the ledger, the software will look at the diagnosis codes on the claim set to determine the ICD Indicator in box 21.
    - If the claim set has ICD-9 codes, it will populate the field with a 9.

- If the claim set has ICD-10 codes, it will populate the field with a 0.

MEANINGFUL USE

Data Mining > Reminder option

- Some clients send reminders for preventative care using the Data Mining/SQL Query tool.
- If the Reminder option is checked and you have selected an Output of 'Letter', the patients included in the operation are counted in the Numerator.
- This records a PHI Audit Event '65 – MU Additional Communication' that is evaluated by Meaningful Use reporting for Stage 1 Menu 4 Patient Reminders and Stage 2 Core 12 Reminders for Preventative/Follow Up Care.
- *Eligible Providers who use this option to send Reminders for Preventative/Follow-Up Care acknowledge that they understand the functionality and are responsible for its correct use in the event of a Meaningful Use audit.*
- *Related Courses on Compulink University LMS:*
  - *Program: Meaningful Use*
  - *Course: MU_416b Meaningful Use Stage 1: Menu 4 Patient Reminders*
  - *Course: MU_511b Meaningful Use Stage 2: Core 12 Patient Reminders*

Patient Opt Out Portal:
- A check-mark in this new field indicates that the patient does not want to be sent communications from their provider to the Patient Portal at mysecurehealthdata.com.
- Per CMS, patients who Opt Out are counted in the Numerator for reporting the following MU Objectives: Stage 1 Core 11 Patient Electronic Access, Stage 1 Core 12 Clinical Summaries, Stage 2 Core 7 View Download Transmit, Stage 2 Core 8 Clinical Summaries.
- *Related Courses on Compulink University LMS:*
  - *Program: Meaningful Use*
  - *Course: MU_410b Meaningful Use Stage 1: Core 11 Patient Electronic Access*
  - *Course: MU_411b Meaningful Use Stage 1: Core 12 Clinical Summaries*
  - *Course: MU_506b Meaningful Use Stage 2: Core 7 Patient Online Access*
  - *Course: MU_507b Meaningful Use Stage 2: Core 8 Clinical Summaries*

Utility>System Administrator>System Setup
- On the Miscellaneous tab, a new "MU Reminder Threshold" field was added.
- The default MU Reminder Threshold is '0', indicating that all Appointment Communications are for care the patient is scheduled to receive.
- A MU Threshold of 90 days tells the software that patients sent a communication for an appointment more than 90 days from today, are getting a reminder for preventative care.
- When running the Appointment Communication function, it will record a PHI Audit Event '66 – MU Appointment Communication' that is evaluated by Meaningful Use reporting for Stage 2 Core 12 Reminders for Preventative/Follow Up Care.
- *Eligible Providers who use this option to send Reminders for Preventative/Follow-Up Care acknowledge that they understand the functionality and are responsible for its correct use in the event of a Meaningful Use audit.*
- *Related Courses on Compulink University LMS:*
  - *Program: Meaningful Use*
  - *Course: MU_511b Meaningful Use Stage 2: Core 12 Patient Reminders*

MEDICAL RECORDS

Continuity of Care Documents:
- The patient's Social Security Number will no longer be used as the Patient ID on the CCDA documents.

- The Location's NPI number, plus the patient unique number will now be used.
- If the NPI number is not available, it will use the last 4 digits of the patient's Social, plus the patient unique number.
- If the Social is not available, the section will be marked as unknown (UNK).
- *Related Courses on Compulink University LMS:*
  - *Program: Version 11 Enhancements*
  - *Course: PM_245 Version 11.0.5.0 Changes*

Diagnosis Assessment/Plan grid:
- Diagnosis Name field
  - This field was expanded to accommodate a multiple keyword search. Type in more than one word, hit the down arrow, and the list will be filtered by the matching keywords.
  - This keyword search used to look in the "Short Description" field in the diagnosis table, but will now look in the "Long Description" field. This will increase the number of keywords that can be matched.
  - It will search each word individually and find the best results. For example if you type 'eye right cyst' it will find the codes that match the 3 words regardless of order.
- Forwarding the Diagnosis.
  - The "Forward Last DOS" icon (blue circle arrow) will now display on the Diagnosis grid.
- *Related Courses on Compulink University LMS:*
  - *Program: Version 11 Enhancements*
  - *Course: PM_245 Version 11.0.5.0 Changes*

Encounter Favorites:
- If a Login ID was assigned to the Encounter Favorite, it will display after the name (E.F. name – ID)
- Check boxes to select items.
  - After choosing an Encounter Favorite, the Select Diagnosis window opens and there are now check boxes to allow you to select multiple diagnoses.
- The directions at the bottom of the window were updated.
- Items used to filter the diagnoses list.
  - The software uses the name of the Encounter Favorite as keywords to search for the closest diagnoses (left/right/OD/OS/OU).
  - If RT or LT was used in the name, it will be recognized as right or left in the search.
- The name of the Encounter Favorite that was selected will display at the top of the Diagnosis Selection window.
- Appending or replacing data manually entered.
  - If a data field already contains data, the information pulled in using the Encounter Favorite will append to the end of that existing data, and not replace it.
  - If the data field contains the "Default or Normal" value, then that value will be replaced by the data from the Encounter Favorite.
- *Related Courses on Compulink University LMS:*
  - *Program: Version 11 Enhancements*
  - *Course: PM_245 Version 11.0.5.0 Changes*

PQR Tab Updates
- The Compulink-owned PQR 2015 tab has been updated for three additional measures:
- 110: Preventative Care and Screening: Influenza Immunization.
- 111: Pneumonia Vaccination Status for Older Adults.
- 317: Preventative Care and Screening: High Blood Pressure and Follow Up.
- *Related Courses on Compulink University LMS:*
  - *Program: Version 11 Enhancements*
  - *Course: PM_245 Version 11.0.5.0 Changes*

Smart Functions:
- Encounter Favorite button (purple star).

- o If the exam is NOT in edit mode and you click the Encounter Favorite button (purple star), it will automatically put the exam in edit mode and bring up the list of Encounter Favorites to select from.
- ▪ *Related Courses on Compulink University LMS:*
  - o *Program: Version 11 Enhancements*
  - o *Course: PM_245 Version 11.0.5.0 Changes*

Video Files:
- ▪ You are now able to import the following types of video files into the patient exam: WMV, Mpeg, MP4, and MOV.
- ▪ *Related Courses on Compulink University LMS:*
  - o *Program: Version 11 Enhancements*
  - o *Course: PM_245 Version 11.0.5.0 Changes*

PATIENT

Opt Out Portal:
- ▪ A check-mark in this new field indicates that the patient does not want to be sent communications from their provider to the Patient Portal at mysecurehealthdata.com.
- ▪ *Related Courses on Compulink University LMS:*
  - o *Program: Version 11 Enhancements*
  - o *Course: PM_245 Version 11.0.5.0 Changes*
  - o *Program: Meaningful Use*
  - o *Course: MU_410b Meaningful Use Stage 1: Core 11 Patient Electronic Access*
  - o *Course: MU_411b Meaningful Use Stage 1: Core 12 Clinical Summaries*
  - o *Course: MU_506b Meaningful Use Stage 2: Core 7 Patient Online Access*
  - o *Course: MU_507b Meaningful Use Stage 2: Core 8 Clinical Summaries*

Opt Out Reminders:
- ▪ A check-mark in this new field indicates that the patient wants to be excluded from Appointment Communications and Patient Recall reminders.
- ▪ These functions will bypass the patient, even if they have an appointment scheduled or recall pending.
- ▪ *Related Courses on Compulink University LMS:*
  - o *Program: Version 11 Enhancements*
  - o *Course: PM_245 Version 11.0.5.0 Changes*

Patient Tracking > Goto command
- ▪ Highlight a patient name in the Tracking window and choose 'Goto' to move to their patient record.
- ▪ The Tracking window remains open and the selected patient record is displayed behind it.
- ▪ *Related Courses on Compulink University LMS:*
  - o *Program: Version 11 Enhancements*
  - o *Course: PM_245 Version 11.0.5.0 Changes*