



Business Office Management Training Guide

**Integrating PTOS
(Physical Therapy Office System)**



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PTOS TRAINING AGENDA

Introduction to PTOS - Libraries

- (1) Remind NEW CLINICS of their responsibility in establishing these libraries...only one Referring Doctor and one Insurance Carrier is required to “open” libraries.
- (2) Procedure Code Library: Clinic Liaison & Janice Compton are responsible for development of their Charge Master - any questions regarding same are to be referred to them.
- (3) “Copy” Procedure Code function - example: copy PT codes to OT codes.

Patient Demographics

- (1) 2nd screen: State of Texas, Workers Compensation Claim number MUST be coded in the “ID #” field.
- (2) 3rd screen: “N/A” can no longer be entered in box 15 (required for W/C in TX) with PTOS-2000, must be handwritten onto HCFA.
- (3) Self Insured plans in the state of Texas: social security number MUST be coded in “ID #” field.

Daily Routine: *Prior to beginning PTOS -*

- (1) Enter fee amounts from Charge Master onto Charge Tickets & total each.
- (2) Run Tapes on: Charge Tickets (Superbills), Payments, & Adjustments
- (3) Complete Weekly Summary Report
 - Add charges of Daily Treatment Records (Itemized tape for grand total)
 - Add payments (Itemized deposit list and tape of checks)
- (4) Start PTOS & Verify System Date
- (5) Verify transaction entries against Charge tickets as each ticket is entered.
- (6) After entering transactions into PTOS
 - Select Option 7 (System Tasks) from Main Menu
 - Select Option 1 (Daily Tasks)
 - Select Option 1 (View)
- (7) Charge tape total should equal “TOTAL CHARGES”
- (8) Check tape total should equal “AMOUNT PAID”
- (9) Adjustment tape total should equal “ADJUSTMENTS”
- (10) Total visits should equal totals for Schedule Book, Sign In sheets and # of Charge Tickets

If reports #1 & 2 are desired, these MUST be run prior to printing the TRX report.

If balanced, = Print Option 3, Daily Transaction Report. This “Closes” the business day.

**If not in balance, = Go to back to Option 2) Enter & Adjust Transactions
“L)ist” transactions to verify against actuals.**

**KEEP THIS NUMBERED (*highlight the number*) DAILY TRANSACTION REPORT (TRX)
Information can be re-generated by using 6) OTHER LISTS and running 1) LIST OF TRANSACTIONS for that date.**

**Fax validated deposit slip(s), handwritten deposit slip(s) & Payment Report(s)
to the clinic’s Accounting Representative each day.**

Weekly Summary Reports

- (1) **Compare PTOS to Weekly Summary Report, NOT the other way around!**
- (2) **Must be faxed no later than 3pm CST on Monday - Goal: Friday, close of business.**

Insurance Billing

- (1) **Under 5)Patient Lists, run P)Pre-Billing edit:**
 - **Input pertinent information and C)ontinue.**
 - **This will print which claims could possibly be rejected due to lack of information.**
- (2) **Insurance billed once a week. Suggest Tuesday. Generate for ALL unbilled charges.**
- (3) **Copy scripts and notes to remit with paper claims.**
- (4) **If only bill Medicare once per month - be sure to include ALL account types EXCEPT Medicare. Most clinics do bill Medicare weekly.**
- (5) **Complete Secondary billing. Choose “S” for Secondary, enter starting and ending patient number, skip account type, location, charges and dates. Answer “Y” to “INCLUDE PREVIOUSLY BILLED CHARGES”, key to and from dates to bill, Bill “Paid Only” for Secondary or “All” to Rebill.**
- (6) **Must attach EOB from Primary when sending Secondary claims.**
- (7) **Everything in PTOS runs through Epson printer in Draft mode and 12 pitch. Be sure to check printer if you have been using WordPerfect, etc., and pitch has changed.**
- (8) **Claim folds to fit in right-sided window envelope. Fold in half, then at line above name.**

Transactions - Payment & Adjustment Posting

- (1) **Credits - non-cash transactions. If percent to bill patient is 20% and it is reduced with partner approval (after the fact), we can use a credit. Goes to patient balance.**
 - (2) **Debits - use for overpayment on account. Debit is positive number in PTOS. Use to clear a credit balance.**
- **Line Item as much as possible - most exact, includes patient payment.**
 - **Date Range for Medicare or other “lump” Payments.**
 - **Balance Forward only if Litigation and will zero account.**

After Line Item & Date Range entry, select S)ame patient & do L)ist to show how payment spreads.

Patient Statements

- (1) **After selecting 3) for Patient Billing,**
 - Always choose 1) = Patient - by Last Date Sent & Account Type**
- (2) **Always fill out “from” and “thru” dates to print on statements.**
- (3) **Statement folds to fit into left sided window envelope.**

Day Packs:

√ A copy of Daily Transaction Report (TRX)	√ Itemized Tapes for manual totals: Charges/Deposits
√ Payment Report (6-1-5-3) for that day	√ Copy of Deposit Slip & Bank Confirmation Slip
√ Daily Sign-In Sheet(s)	√ Original EOBs (optional)
√ Charge Tickets (yellow portion) with totaled charges	√ Copies of Checks and cash

Collection Notes - A)dditional Notes / Fourth Patient Screen

Use “2 Line” notes system at the start and after every follow-up entry.

- (1) Use first line of notes to record insurance verification information for reference. “Who, Where & How”; person spoken with, where are they located and how to get in touch with them. The line should end with initials of author.
- (2) Second line to be used as “tickler” for follow-up. Follow this format for all collection notes: YY/MM/WEEK i.e. 99/02/4 (for week of month follow-up is needed)

Work accounts with highest dollar: i.e. \$1000 and greater - first week, \$750 second week, \$500 third week and \$250 fourth week. If \$1000 and 0-30 days, check that claim was received and in line for payment.

Print Collection notes weekly:

- Option 5 from Main Menu (Patient Lists)
- Option “L” to list Notes
- “A” for additional notes, put Tickler date in “DESCRIPTION” field

Goal is 80 call backs per week from collection list and A/R.

<p>Goal: 6 calls per hour x 4 hours on Tuesday and Thursday 6 calls per hour x 2 hours on Wednesday and Friday</p>
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Office Efficiencies

Table of Contents/Chapters contained in the Business Office Policies and Procedures Manual.

Dealing with, but not limited to:

Month End Processing

A/R Management

Training Wrap Up, Evaluation of Training

Exit Evaluation & Wrap-up

THE 3 R'S

RESET, RE-AGE, RESTART

When data has been entered and the system is slow responding or improperly allocating the data, you can:

Reset Files:

Select Option 7, System Tasks

Select Option 8, Reset Files, press "C" for Continue

Re-Age for all patients:

*The Daily Transaction Report for that day **must** be printed before this is available.*

Select Option 4, Management Reports

Select Option 1, Aged Accounts Receivable

Select Option 1, Prepare A/R for All Patients

Re-Age for one patient:

Select Option 4, Management Reports

Select Option 1, Aged Accounts Receivable

Select Option 2, Prepare A/R for 1 Patient

Restart:

- Shut down PTOS system,
- Turn off the computer,
- And Restart everything again!

DAILY BACKUP

System Support: 1-800-580-6285 Pat King Ext. 7073 Wayne Smith Ext. 7062

Back up each day before leaving using the 8 Zip Disks which are labeled "Mon." thru "Fri.", "EOM1", "EOM2" & "Clinic EOM".

☐ Insert correct Zip Disk in Zip Drive.

☐ Double click on the icon located on the Desktop labeled "Backup".

If you are not using Windows, choose your Backup PTOS menu item.

☐ All PTOS files will be copied to the Zip Disk.

☐ Upon completion of copy process, files are listed chronologically on your screen.

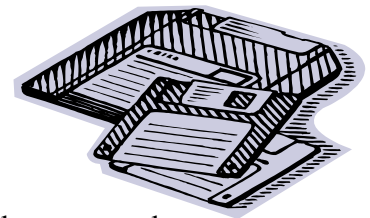
☐ Verify dates of "Patient.dbf" and "Trans.dbf". These dates should be the current date. If the dates are not correct (not the current date), call either Wayne or Pat to find out what is causing the problem.

☐ Put the Zip Disk in the fireproof safe.

END OF THE MONTH BACKUP

Same as above, but use "EOM" zip disks.

First make your daily backup, then insert your "EOM" zip disks and repeat above procedure.



CREATING CODE LIBRARIES - PROCEDURES

Begins with Option 7) System tasks, 4) Update Codes, 4) Procedure Codes, Enter new code and select A) Add new code.

Codes require discipline labeling for Medicare compliance.

- | | | |
|--|------------------------------|--|
| 1 - Modalities for Physical Therapy | 3 - Modalities for Speech | 5 - Modalities for Occupational Therapy |
| 2 - Evals and Tests - Physical Therapy | 4 - Evals and Tests - Speech | 6 - Evals and Tests - Occupational Therapy |

UPDATE PROCEDURE CODES						
PROCEDURE CODE						
DETAIL CODE	DATE	RVS/CPT from "Code" book	DESCRIPTION * (include time)	UNITS	AMOUNT	OLD AMT
# 1	D			1	XX.XX	
# 2						
# 3						
# 4						
# 5						
# 6						
# 7						
STATEMENT DESCRIPTION * (no time)						
CO-PAY	TOS 1	COST	TIME	UNITS		
PROCEDURE DETAIL CODES						
CODE 1	CODE 2	CODE 3	CODE 4	CODE 5	CODE 6	
TOTAL AMOUNT EXPECTED AMOUNT <i>(Blank except for WC & Medicare codes)</i>						
BILL TO P)atient ONLY, S)econd Insurance ONLY or Blank for ALL						
DATE OF LAST FEE CHANGE			LAST AMOUNT		0.00	
DATE OF PRIOR FEE CHANGE			PRIOR AMOUNT		0.00	
D)elate, C)opy to Another Procedure, M)ore or E)nd						

NOTE:

- DATE - a **"D"** is ALWAYS necessary for all procedure codes.
- DESCRIPTION and STATEMENT DESCRIPTION - Place an asterisk (*) in front all current CPT-4 codes,
- **USE DESCRIPTIONS FOUND IN CPT-4 CODE BOOK ~**
- **INCLUDE THE TIME OF THE PROCEDURE (15 MIN, 30 MIN, ETC.) ONLY IN THE DESCRIPTION FIELD.**
- TOS – **must be coded with the number "1"**, needed for electronic billing.
- BILL TO - Always leave blank

Use The "*" In Both Description Fields for Procedure Codes -

The "*" is a very useful tool in the tracking of current and outdated procedure codes. The "*" tags all of the procedure codes that are currently being used within the practice of the clinic. When setting up a new clinic, all procedure codes should have an "*" at the beginning of the description fields. The "*" is to be placed at the beginning of both the DESCRIPTION field and the STATEMENT DESCRIPTION field (leave the time off the STATEMENT DESCRIPTION field).

As the world of healthcare changes, so does treatment methodology and acceptable CPT codes. When changes occur, clinics must add or discontinue using procedure codes. This is where the "*" is useful in differentiating which codes are active and which are not. As codes are discontinued, clinics must modify the outdated procedure code by removing the "*". When charges are entered each day, insure that all of the charges have an "*" at the beginning of the description for each charge item and by scanning the daily transaction report.

The other feature of using the "*" is when a printout is needed of all currently used procedure codes. Enter an "*" on the line that states "Enter Description Or Leave Blank For All". The only procedures that print will be procedures that have this symbol. Never delete old codes!

OUTDATED PROCEDURE CODES ARE STILL TIED TO PATIENT RECORDS .

COPYING PROCEDURE CODES

- A. Run 6) Other Lists, 2) Procedure Codes, 2) All Codes.
- B. Using 1999 CPT-4 Code Book, update your internal codes by removing the "*" from deleted codes and ensuring that **ALL CURRENT** codes have an "*" in front of **BOTH** the DESCRIPTION & STATEMENT DESCRIPTION fields. You must ensure that only **CURRENT** codes are being used by your clinic.

NOTE:

If your state Worker's Comp requires outdated codes, you should have a separate procedure list for these codes which begin with: EX: 1WUS

Also, enter WC Fee Screen in "EXPECTED AMOUNT".

- C. To enter new codes -

- 7) System tasks,
- 4) Update codes,
- 4) Procedure codes

Following this example:

UPDATE PROCEDURE CODES						
PROCEDURE CODE 1WUS						
DETAIL						
CODE	DATE	RVS/CPT	DESCRIPTION	UNITS	AMOUNT	OLD AMT
#1	D	97035-US	*ULTRASOUND	1.00	20.00	
#2						
#3						
#4						
#5						
#6						
#7						
STATEMENT DESCRIPTION *ULTRASOUND						
CO-PAY	0.00	TOS	1	COST	TIME	0 UNITS 1.00
PROCEDURE DETAIL CODES						
CODE 1	CODE 2	CODE 3	CODE 4	CODE 5	CODE 6	
TOTAL AMOUNT 20.00 EXPECTED AMOUNT 15.50						
BILL TO Patient ONLY, Second Insurance ONLY OR Blank FOR ALL						
DATE OF LAST FEE CHANGE			LAST AMOUNT 0.00			
DATE OF PRIOR FEE CHANGE			PRIOR AMOUNT 0.00			
D)delete, C)opy to Another Procedure, M)ore or E)nd						

Page down,
type C)OPY TO ANOTHER PROCEDURE,
and make the following corrections:

Code: 1MUS

D 97035GP *Ultrasound 1 \$20

NOTE: All other fields are the same but you must add the allowed Medicare payment in "EXPECTED AMOUNT" field on lower right on this page - this amount can be found on the Geographic Practice Costs Indices which was mailed to your clinic on December 22, 1998. (Page down after adding "EXPECTED AMOUNT" and continue adding all Medicare codes)

For 1 & 2 Add the modifier (PT) GP

For 3 & 4 Add the modifier (Speech) GN

For 5 & 6 Add the modifier (OT) GO

Rerun 6, 2, 2 by C)ode and put in DESCRIPTION: "*"

- D. Double check all codes then fax a copy to your **Liaison!**

Now that your codes are up to date, there are further steps you must take to track the expected payment for all Medicare patients.

See "Medicare Accounting"

MEDICARE ACCOUNTING

1. All Medicare patients must receive a new account number as of 99/01/01. We had hoped this could be an option but due to the limitations of PTOS for tracking the Medicare \$1500 cap, it will be necessary to give all Medicare patients a new account number for each year seen. Must retain the same # all year.
 - a) The first visit date will be the actual first visit date from the 98 account.
 - b) The 98 account should have a 98/12/31 discharge date but the therapist should not complete a DC summary until patient is actually discharged.
 - c) In the 98 account, add “98” after last name to remove any confusion on which is the active account.
 - d) Under Posting Note, add the patient’s old account # for referencing.
 - e) It is not necessary to set up a new chart, simply put both account #'s on the patient’s chart.
2. Medicare Patients in year 2000 – Acct. type “M9” ONLY, **even** with two insurances.
3. On the third screen of the patient’s demographics, add an approximate gross amount in the CHARGE LIMIT field. Estimate from \$2500 to \$3200 depending on specifics for your clinic. This will allow you to track the gross charges, and since Medicare will only pay 40-50% of gross charges, this will provide a second tracking mechanism for the \$1500 Medicare Allowed Charges.

NOTE: A report may be run in PTOS to help you track any patients who are approaching the Charge Limit that you set. This report is run from 5) Patient Lists, P2) Patients at charge limit.

4. It is also recommended that you run the Expected Payment Report that will be accurate until you receive the first payment on these accounts. 4) MANAGEMENT REPORTS, 1) AGED A/R, A) EXPECTED A/R BY ACCOUNT TYPE, and enter your Medicare Account Type(s). After payments are received, the total must be added to EXPECTED AMOUNT shown on report. Medicare allowed amount is tracked in Addl. Notes.
5. The Medicare disclaimer form is to be introduced to the patient when they are approaching the \$1500 Allowed Medicare Amount.

Your Procedure list has been updated, and the patient(s)’ account has been set up correctly, **NOW** you must ensure that the therapist(s) mark off the correct codes on your DTRs or charge tickets.

- a) On all charge tickets or DTRs, (except Worker’s Comp if they use outdated CPT-4 codes) use a black “Marks-A-Lot[®]” and cross out:
 - Joint Mobilization (97265)
 - Myofacial/soft tissue release (97250)
 - Manual traction (97122)
 - Regional/Supplemental Manipulation (97260 & 97261)
- b) Add “MA” - Manual Therapy under Constant Attendance Modalities

NOTE: We are continuing to work with PTOS and HCFA to determine how we will enter charges for Medicare Patients after the \$1500 cap is met, since Medicare requires that “21” code be inserted in condition codes Box 24-30 to signify the cap has been reached. We will send another memo as soon as this problem has been resolved.

If you have any questions, please contact your Liaison.

CHANGING FEES OF PROCEDURE CODES

Prior to changing fees* ~ Contact Liaison or Janice Compton - Revenue Management

* fee changes must be supported with EOBs of several account types that reflect 100% payment of charges.

1. Set the PTOS system date to the **last day** of the previous month
2. Go to Update Codes:
 - Main Menu- Option 7 - System Tasks
 - Option 4 - Update Codes
 - Option 4 - Procedure Codes
3. Type in the procedure code and press enter
4. Change the price
5. Press Page Down
6. Select M)ore from the menu at the bottom & type in the next procedure code to be changed
7. Re-age all accounts: Main Menu, 4) Management Reports, 1) Aged Accounts, 1) Prepare A/R
8. Reset files: Main Menu, 7) System Tasks, 8) Reset Files, C)ontinue
9. Exit the system - Sign back on to PTOS with the current date.

CREATING CODE LIBRARIES - PAYMENT/ADJUSTMENT

BAD	Bad Debt Write Off	PRO	Professional Discount/Courtesy Discount
COI	DO NOT USE (type this in description field) Does NOT apply to new clinics	SMW	Small Balance Write Off
CON	Contractual Write Off (use to adjust WC, Medicare and Managed Care)	SMD	Small Balance Debit
NCS	Non Covered Service (services not covered and unable to bill patient)	PRF	Patient Refund(Debit)/-Debit to Reverse
NEG	Negotiated Settlement (attorney)	IRF	Insurance Refund (Debit)/-Debit to Reverse
OON	Out of Network (able to bill out of network, receive payment for services and have to adjust off difference)	IOP	Ins Overpay - Refund when Request Received
PPD	Patient Paid		

CREATING CODE LIBRARIES - ACCOUNT TYPE

<p>BC - BLUE CROSS</p> <p>CL - COLLECTIONS – accounts sent to a collection agency</p> <p>DI - DUAL INSURANCE</p> <p>HP* - HEALTH PLANS (CONTRACTED) must start with an "H"</p> <p>HO - OUT OF NETWORK</p> <p>L - LITIGATION / LIEN (Must have Letter of Protection on File)</p> <p>M9 - MEDICARE 1999 – ANY and ALL M/C patients (The account number should be a new number assigned at the patient's first visit in 2000 whether or not the patient had been seen in the clinic prior)</p>	<p>N - MEDICAID</p> <p>PI - PRIVATE INSURANCE - must begin with "P" This includes University programs, etc.</p> <p>SP - SELF PAY</p> <p>V - MOTOR VEHICLE</p> <p>WC - WORKERS COMPENSATION</p> <p>XX - MEDICARE PRE-CERTIFICATION - ONLY</p> <p>ZZ - PAYMENT PLANS</p> <p>MS - ANY OTHER TYPE OF PAYOR</p>
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* - If you need to track a specific plan such as Kaiser, Cigna, Prucare, etc,
Start with H and add letter or number: Ex: HC - Cigna, or H1



DAY PACKS

1. Daily treatment records (yellow copies) for that day with itemized adding machine tape attached.
2. Daily appointment record or Sign-in sheet.
3. Copies of all checks received that day with itemized adding machine tape attached.
Make copies before separating from attached paperwork. Use the copies for posting payments (don't hold up daily deposits)
4. Validated and hand-written deposit slip for that day. If the hand-written slip is not validated, include a copy of the hand-written slip with the validation slip.
The deposit slip generated by PTOS will NOT help Accounting.
5. Payment report (6-1-5-3)

NOTE: ITEMS 4 & 5 ARE FAXED DAILY TO USPT ACCOUNTING REPRESENTATIVE

Informs Controller about a clinic's sources of money deposited which aids in monitoring a cash flow.

6. *Copy of Daily Transaction Report (TRX) *
7. *Original EOB's - remember, financial information cannot be kept in the chart. *

* - *Only 2 items in the day pack are **OPTIONAL**:*

Copies of the Daily Transaction Records

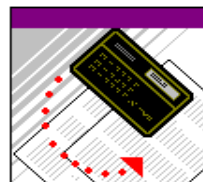
Put the TRX with the report number highlighted in date order in a binder. When the end of the month report is run, if something ends up out of balance, all the information is in one place.

Original Insurance EOBs.

EOBs can be kept in individual Pendaflex folders for major carriers. Smaller payors can be kept in alpha folders or an alpha file sorter with the latest date on top and then moved to a Pendaflex folder if they become a major payor. Keep for 6 months and then move to a file box leaving most current 6 months in the file.

DAILY ROUTINE

- I. Total all charges on charge tickets, run itemized tapes of charge tickets, cash and checks
- II. Complete Weekly Summary Report
- III. Using PTOS:
 - Enter all charges
 - Run Daily Transaction Report (TRX)
 1. Select Option 7 (System Tasks) from the Main Menu
 2. Select Option 1 (Daily Tasks)
 3. Select Option 1 (View on Screen), Enter 3 times, *look for possible errors here*
 4. If everything is correct, E)nd and select Option 3 (Print New and Deleted Transactions)
 5. Option 1, press enter 3 times and type C)ontinue
 - Enter all payments and adjustments
 - Run Daily Transaction Report (AGAIN) ~
 1. Select Option 7 (System Tasks) from the Main Menu
 2. Select Option 1 (Daily Tasks)
 3. Select Option 1 (View on Screen), Enter 3 times, *look for possible errors here*
 4. If everything is correct, E)nd and select Option 3 (Print New and Deleted Transactions)
 5. Option 1, press enter 3 times and type C)ontinue
 6. Ensure all totals balance to the Weekly Summary Report



DAILY ROUTINE - CONT.

- IV. Complete deposit slip(s) (one each for PT and OT, for tracking separately)
- V. Run Payment Report (one each for PT and OT, for tracking separately)
 - Select Option 6 (Other Lists) from the Main Menu
 - Select Option 1 (Transaction List)
 - Select Option 5 (Payments)
 - Complete the date fields for the date payments were entered, enter through all other fields
 - Press “Page Down” key
 - Select Option 3 - All payments and C)ontinue to print
- VI. Fax validated and handwritten deposit slip(s) and Payment Report(s) to USPT Acct. Representative

PLACE ORIGINAL DAILY TRANSACTION REPORTS (TRXS) WITH REPORT # HIGHLIGHTED IN A BINDER.

WEEKLY ROUTINE

- I. Fax Weekly Summary Report each Monday no later than 3:00 p.m. CST.
Goal: end of the day Friday (Saturday - if open)
- II. Reset System files in PTOS - MAIN MENU, OPTION 7, OPTION 8, C)ONTINUE
- III. Run these lists (located under OPTION 5 - PATIENT LISTS) on Friday to work the following week:
 - 2 RETURN TO DOCTOR - Patients are returning to the referring physician—notes need to be completed and sent to referring physician.
 - 9 REMAINING VISITS - Report for less than 4 remaining visits means that either patient needs another prescription, authorization for more visits from the insurance company, or is ready to be discharged.
 - A AUTHORIZATION DATE - *RE*-authorization date from the insurance company required, need reauthorization in order to continue to be paid for seeing the patient.
 - L NOTES - Using tickler system (Option 5, L, A, and in D)escription - YY/MM/Week) for A/R follow-up, pulls up accounts that need follow-up the following week.
 - P2 PATIENTS AT CHARGE LIMIT - Patients are at the charge limit allowed by the insurance carrier. Financial counseling is scheduled if the patient continues treatment beyond charge limit.

WEEKLY SUMMARY REPORT

Weekly Summary Reports ~

- numbers on weekly summary are taken from manual totals, nothing entered in or taken from the computer.
- are to be completed **DAILY** by each clinic.
- each column must be totaled for each week before faxing to the home office.
- are due in the home office no later than 3:00 pm CST, Monday.
- Faxed to (713) 297-7090

WEEKLY SUMMARY IS TOTALED AT MONTH END & INCLUDED WITH MONTH END PACKET!

~ The Weekly Summary Report is Also Faxed At The End Of The Month ~

WEEKLY SUMMARY REPORT - Column Headings

P.T. Visits -

Daily Treatment Records (SuperBills) added up for patient visits, also available from the Sign-in sheet. This documents the total visits for that day. If the clinic sees 20 patients in one day and 5 of those were new patients, record 20 in this column and 5 in the New P.T. column (should match # of visits as printed on Daily Transaction Report).

Total P.T. Charge -

Total sum of charges taken from adding machine tapes.
(should match total charges as printed on Daily Transaction Report)

New P.T. -

How many of the patients seen were **new** patients?
(should match total new visits as printed on Daily Transaction Report)

O.T. Visits, Total O.T. Charge, New O.T. -

Collect from same sources as P.T.

NS (No Show) -

Patients who did not show up for their scheduled appointment and you were unable to contact them to reschedule the appointment during the **current** week.

C (Cancellation) -

Patients who cancel their appointment and are unable to reschedule **within the same week** as the missed appointment.

RS (Reschedule) -

Patient is one that was unable to keep the appointment, but you were able to reschedule the appointment for **the same week** as the missed appointment.

Daily Collections -

Add up checks/cash received for that day.
(should match total payments as printed on Daily Transaction Report)

MTD Collections -

Cumulative figure for the month to date. **DO NOT** include \$ amount from previous month!

No Charge Patients -

Number of patients seen but not charged. Must record amount of charges on right side.
Includes Medicare prior to certification – Charges must be recorded also.

Out of Clinic Visit -

How many patients seen at facility other than office? (usually a contract) Need a sign-in sheet for therapist to take with them, only proof they have of actually seeing the patient.

Out of Clinic Charge -

How much was charged for patients seen outside of the office?

PATIENT RECORDS

FILE FOLDER



I. Label –

1. End tab: **99**

J
O
N

Label = Last Name, First Name, MI, Account # & Account type
Dr. Name

EX: **Jones, John E. 100923 HP**
Dr. Donald Jackson

2. File folder with 2 clips:

Left hand side: Top to Bottom

- Intake: Referral Form
- Pt. Info
- Consent to Treat
- Ins. Verification
- Copy of Ins. Card
- Copy of Driver's License or Picture ID
 - Therapist can identify for lawsuit deposition or patient is gone for a long time and returns
 - Often required by collection agency if acct. goes to collection

II. NO FINANCIAL INFORMATION IN THE CHART (except as part of Intake package)

III. ID - (Driver's license or picture ID)

- A. Customers have to show ID when cashing a check at other places.
- B. If multiple therapists and one need to fill in for another, he/she can identify the patient easier.
- C. If PT has to do a deposition 2 or 3 years later helps to identify the patient for the therapist.
- D. If the account is turned over to collection agency, most require a picture D/L.

IV. Insurance cards -

- A. Address on the back is not always correct.
- B. Get the correct claim mailing address when calling to verify insurance.
- C. Insurance companies merging, changing address, etc.

V. Consent form (has been tested in a court of law) -

- A. Patient must sign in all four (4) places.
- B. Payment portion - They sign to acknowledge it was explained.
- C. Give a copy to the patient if they have to go on a payment plan.

VI. Filing items in charts -

- A. When filing, try to keep "like" items together. Latest date on top.
- B. Progress notes also go on right side of folder along with discharge.
(Therapist/Partner's decides location of medical record items in chart)

OTHER FOLDER INFORMATION

- 3 If return patient is Worker's Comp, in therapy for the same injury and using the same claim number, use the same account number.
- 3 If any of the above info is different, use a 2nd acct. number.

ALL OTHERS:

If patient returns with different injury (or if they've not been seen within 60 days), use same chart, but use a different account number. Put colored sheet of paper over old info in the chart and begin new information.

Put a new label on chart, and write up above label old account number and injury (i.e. 100001 - 97 elbow). This is because info could have changed but need to retain original info for 5 years.

In PTOS, add "97 Elbow" to the right of the last name to differentiate accounts:

100001 Andrews 97 elbow, John (old account - don't use)

100005 Andrews, John (this is current account)

TIERED FILING SYSTEM

TIERED SYSTEM - can be on one shelf in small clinic or on 3 shelves.

A. Active

Charts - separate sections:

//Today //This Week //Previous Week

- When appointment made, pull charts from "Previous Week" and put into today. Or, if the patient has already been here this week, pull from "This Week" and put into "Today".
- At end of day, file "Today" charts back into "This Week" section if patient is returning.
- After pulling charts for Friday, if there are folders left over in previous week, find out why the patient was not seen. Possibly someone was on vacation, or gone back to the doctor. Any charts left after determining who has gone on vacation or back to the doctor, ask the PT if he/she wants to call the patient, wants the Office Manager to call, or if the patient needs to be discharged.

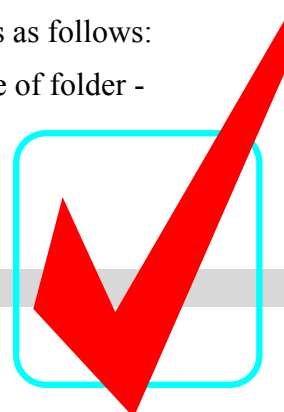
B. Discharged

Put discharged patient charts in a the designated filing areas as follows:

Discharged with Open Balance: use this code on outside of folder -

means complete medically

Discharged with 0 (zero) Balance: Add 0 below code



CLINIC FORMS

SIGN-IN SHEET

MEDICARE REQUIRES SIGN-IN!

Put the sign in number of patient in the upper corner of charge ticket (DTR), if a DTR doesn't come back from the therapist, you can quickly identify which patient you need the PT to finish with by putting them in numeric order and checking the Sign-in sheet for the patient listed by the missing number.

Make sure patients sign in and out because actual time in clinic is very effective for insurance/charge support.

CREDIT FORM

1. We **don't** keep other people's money. Refund by EOM. Follow procedure in P&P manual, pp. 95-98
2. Patient refund - if less than \$10, call patient and give them the option to come in to get a money order. (*Don't pay patient with cash out of petty cash*) - Costs approx. \$24 to process a check request.

PAYMENT/ADJUSTMENT CODES

(Refer to Policies & Procedures Manual for all adjustment codes.)

- NEG** old litigation accounts-offer a discount and may get the attorney to pay even if not settled before 2 years. P&P manual contains a write-off form - cover yourself by getting it signed.
- BAD** document the financial need; i.e. Medicaid card and filed to Medicaid; sent to collections, or W-2 form (below poverty level)
- SM** Balances below \$25 with partner approval costs too much to continue to bill - costs between \$25-\$35 to send a statement for \$10, \$15, \$25 or below for small-medium to medium business office.

In a 4" Binder, assemble four tabs- Collections, Courtesy Discount, Bad Debit, & Refunds

MAINTAIN ALL DOCUMENTATION FOR THESE CONCERNS IN THIS BINDER

NOTE:

1. Don't report in the notes what shows up in the transactions, i.e. "write-off" or "Patient Pd \$50" Any other helpful financial information should be recorded in the patient's notes section.
2. If printing patient statement for research, change the standard print options to say 'NO' to "INCLUDE PATIENT HAS BEEN BILLED STATEMENT IN SYSTEM". Printing same statement several times and system will be out of balance a penny or two.

MISCELLANEOUS

Can't say "We'll write off the deductible or co-pay or accept only what the insurance will pay".
Say "We'll see you for \$(*) a visit." *Partner needs to agree to any discounting.

APPOINTMENT SCHEDULE

1. Schedule new patient evals on Tuesday and Thursday if possible - takes one hour with therapist. Ask them to come in 15-20 minutes early for appointment to fill in paperwork. This leaves more time on M-W-F for all other appointments.
2. Tell them that after first visit that you will schedule them for regular visits M-W-F. Work with therapist to cluster appointments so you can keep a consistent block of time, usually two hours when they can work on marketing efforts with referring physicians.

APPOINTMENT BOOK

1. Mark appointment book:

V - Visits – total visits for the day, new and returning patients

NP - New Patient - a circle in red or purple to the right of the name

CX - Cancel (Canceled and could not reschedule for the current week) - try to reschedule for later in the same day if possible

NS - No Show (patient did not show up for appointment and were unable to contact to reschedule during the current week)

RS - Reschedule (Patient unable to keep appointment but were able to reschedule for current week)

At the bottom of each day's schedule, the following letters should be placed vertically to record totals (have a stamp made to stamp on the bottom of the appt. book)

If this image is copied and sent to a stamp producing business, a stamp can be made from it!	V	Visits
	NP	New Patients
	CX	Cancellations
	NS	No Shows
	RS	Rescheduled

These totals will be transferred to the Weekly Summary Report at the end of the day.

3. Each **new** patient should have 4 lines in the appointment book:

Name

Phone #

Who referred

Body part



4. All other patients:

Name

Phone # (at least on the first visit for the week)

MONTHLY COLLECTIONS

- ☎ Concentrate 90% of the effort on the accounts that will yield 90% of the revenue.
- ☎ Each account must have a viable phone contact every 30 days.
- ☎ Legal accounts and litigation - contact attorneys every month to keep on top of the status of the settlement. The month that follow-up calling is missed, the case will be settled and the patient paid.

WEEK	FOCUS ON ACCOUNTS. . .
1	\$1,000 & higher (then follow-up the 4 th week if no action)
2	\$750 & higher
3	\$500 & higher
4	\$250 & higher
	Below \$250 when there is time



ADVANCED COLLECTIONS

Insurance requires the patients to be responsible for their own care.

As providers, we *must* involve the patients also.

I. Patient Involvement

- A. The **first** visit you need to discuss the patient's financial responsibilities with them.
 1. Inform the patient of their benefits, what is covered, excluded, limits, etc.
- B. Co-pays/deductibles collected by the last visit of each week.
 1. Insurance Verification defines patient responsibility.
 2. Insurance providers' contacts and phone numbers are important.
- C. Insurance Denials ~
 1. Check with insurance provider for reason for denial.
 - a) If information is missing from the patient, get information or missing form.
 2. Appeals ~
 - a) What is the time limit for the appeals process?
 - b) Write letters with a copy sent to the patient.
- D. Patients who do not pay or pay inconsistently ~
 1. Meet with the patient face to face to set up financial arrangements.
 2. Suggest putting the balance on their credit card.
 - a) Patient Statements - send out consistently, the same day each month.
 - b) Medicare billing to arrive by 1st of the month. If paid 2x a month, insure the bill arrives by the 15th.
 - c) Phone patient if payment is not received.
- E. Meet with patient on discharge to arrange for payment of any balance remaining after insurance payment.
 1. Payment Plan vs. Credit Card - offer 10% balance reduction if the patient will use a credit card.

II. Profiling Insurance Company - Bottom line is to **GET THE MONEY!**

- A. Develop a positive relationship with the claims staff. Be polite but **persistent**.
 - Is the staff effective? Can they see or do anything for you beyond their computer screen?
 - Develop awareness by staying on top of outstanding claims.
 - Keep a list of current direct phone and fax numbers.
 - Ask for the address to mail claims; both the P.O. Box & a physical address
 - in case of the need to send a certified letter.
 - Mail insurance claims on Tuesday.
- B. Follow-up on claims within 14-15 days of filing to ensure claim was received.
- C. Ask major payors about their claim process - what can be done to prevent future denials?
- D. Denials/Delays ~
 1. Review EOB whenever denied, contact insurance company to understand why the claim was denied.
 2. Speak to person who denied claim to find out why specifically they denied it.
 3. Contact Claims Examiner or Supervisor for phone appeal on denial.
 4. Develop a positive relationship with claims examiner.
 5. If no results, go up the chain of command, all the way to CFO/CEO if necessary!
 6. Identify the problem - don't waste time talking to someone who never gets results.
 7. Send a copy of any correspondence to patient, insuring patient involvement.
 8. Is the problem resolved? When *exactly* will the claim be processed? **Never** finish talking to the insurance company without knowing exactly when a check will be sent.
 9. Check claim payment contract agreement with group insurance. If insurance not moving on claim as per agreement with group insurance, may need to have patient work with you and with employer's Human Resources Department to require insurance company to honor their agreement.
 10. Take delay of payments/denials as *personal* - what could you have done better to receive payment?
 11. Challenge why they need another paper claim.

III. Know Your Resources

- A. Worker's Compensation is governed by state boards.
- B. Know if the employer for the group insurance is self-insured.
- C. Contact group's Human Resources if problems arise with payments.

What is the time frame within which the claims are to be paid?

>> To Get Complete Answers - Ask Complete Questions! <<

ENTERING PATIENT INFORMATION



Helpful Hints

Enter all dates in PTOS system with **YYYY/MM/DD** format (2000/01/25).

Up and **Down** arrows on the keyboard move from field to field.

Left and **Right** arrows move the cursor left or right in a field.

Page up/Page down keys go to the previous or next screen.

Use **Caps Lock** to enter all information into data entry fields.

F1 Key - when used in a data entry field shows appropriate codes.

Ctrl Y - Deletes all information in a field or line. Must be at the start of the field.

P - After the patient name or address has been entered, using P in the Payor or Insured Name field will default the patient information into those fields.

PA - When the payor name, address, etc. has been entered, using PA in the Insured Name field will default the payor information into those field.

EMP - When the employer name, address, etc. has been entered, using EMP in the Insured Name field will default the employer information into those fields.

ENTERING PATIENT INFORMATION ~ PRIVATE INSURANCE

Patient Screen 1

PATIENT # 100001	OFFICE # 1	DR APPT. 2000/06/05	When is the patient's NEXT Dr.'s Appt.?
FRST NAME DIANE	EDIT	DATE INJUR 2000/01/04	
LAST NAME TABONE	THERAP KA	FIRST VIS 2000/01/30	
ADDRESS 263 MEANDERING WAY	ACC TYPE PI	BIRTH 1971/10/30	
LINE 2	PAT SEX F	DISCHARGE / /	
CITY HOUSTON	ST TX ZIP 77042	SORT DATA 00/01/30	
PAYOR TABONE, FRANK	Whenever only one line is available for a name, always put last name first, first name last.	HOME PHONE 713 6236694	
ADDRESS 263 MEANDERING WAY		WORK PHONE 713 2978700	
LINE 2		INJURY AREA BACK	
CITY HOUSTON	ST TX ZIP 77042	ACCIDENT RELATED O	
EMPLOYER CHILI'S RESTAURANT		EMPLOYMENT RELATED N	
ADDRESS 7777 SOUTH WEST FREEWAY		SSN # 233-71-4632	
CITY HOUSTON	ST TX ZIP 77042	OCCUP MANAGER	
REFERRAL DR JACKSON, DONALD MD.	When entering a new referral, after returning to this screen the cursor jumps to "Office #". Page down and use "Revise" to return to ICD-9 code.	PIN# 111111	
PRIMARY DR		PIN#	
ADMIT COND - - - -	DISCRG COND - - - -		
ICD9 847.2	DX SPRAIN/STRAIN, LUMBAR - 847.2		
ICD9	DX		
ICD9	DX		
ICD9	DX		

C)ontinue, R)evise, N)otes, T)ransactions, S)chedule, J)ump to next or E)nd

NOTES:

EDIT - INPUT THE LETTER "Y" TO GENERATE A CHARGE TICKET/SUPERBILL FOR NEXT VISIT USING THE "SUPERBILL" ICON ON THE DESKTOP

SORT DATA - DATE AUTHORIZATION WAS RECEIVED BY CARRIER - YY/MM/DD FORMAT

ACCIDENT RELATED - "A" FOR AUTO, "O" FOR "OTHER" IF IT WAS AN ACCIDENT, LEAVE BLANK FOR DEGENERATIVE OCCURRENCE.

Patient Screen 2

PATIENT # 100001	PATIENT NAME TABONE, DIANE	ACCOUNT TYPE PI
PRIMARY INSURANCE AETN AETNA INSURANCE COMPANY	PHONE 8005806285	
ADJUSTER	INSURED NAME TABONE, FRANK	
GROUP# F3424	ADDRESS 263 MEANDERING WAY	
ID# 749623324	CITY HOUSTON	ST TX
EMPLOYER FEDERAL EXPRESS	ZIP 77042	PHONE 713 8982600
PATIENT RELATION TO INSURED 2	ACCEPT ASSIGNMENT Y	BDATE 1969/09/23 SEX M
SECOND INSURANCE		
ADJUSTER	INSURED NAME	
GROUP#	ADDRESS	
ID#	CITY	ST
EMPLOYER	ZIP	PHONE
PATIENT RELATION TO INSURED	ACCEPT ASSIGNMENT	BDATE / / SEX
DEDUCTIBLE AMOUNT 0.00	2ND DEDUCTIBLE 250.00	DATE 2001/01/01
PCT TO BILL PATIENT 10	PAYMENT PLAN AMOUNT 0.00	
2ND PCT TO BILL PT 0	AUTO-ADJ A% 0.00	AUTO-ADJ B% 0.00
START DATE FOR 2ND % / /	RE-AUTHORIZATION DATE 2000/05/20	
CALC % OF EXPECTED AMT (Y/N)	ALLOWED VISITS 12	
CO-PAY BILLING N	REMAINING VISITS 12	
CO-PAY AMOUNT 0.00	ATTORNEY	

C)ontinue, R)evise, N)otes, T)ransactions, S)chedule or E)nd

NOTES:

ADJUSTER - ALWAYS LEAVE THIS FIELD BLANK AND RECORD ADJUSTER NAME IN THE "NOTES"

DEDUCTIBLE AMOUNT - HOW MUCH OF THE PATIENT'S DEDUCTIBLE IS LET TO BE MET.

2ND DEDUCTIBLE - WHEN DOES THE PATIENT'S DEDUCTIBLE BEGIN AGAIN?

AUTHORIZATION DATE - WHEN IS IT NECESSARY TO CONTACT THE CARRIER FOR ADDITIONAL AUTHORIZATION?

CO-PAY BILLING - "Y" IS NECESSARY IF PATIENT HAS A SPECIFIC "CO-PAY AMOUNT"

Patient Screen 3 – Private Insurance

PATIENT # 100001	PATIENT NAME TABONE, DIANE	ACCOUNT TYPE PI
POSTING NOTE 10% COPAY	CHARGE LIMIT 0.00	
DEFAULT DX 1	DEFAULT POS 11	DISC INFORMATION
NOTES LINE 1	Put total gross charges here for M9 patients	
NOTES LINE 2		
BOXES FOR HCFA-1500	BOX15 / /	
BOX 1 (1-7) 5	BOX 8 (S,M,O) M	BOX16 FROM / / TO / /
	(E,F,P) E	BOX18 FROM / / TO / /
BOX 10B (STATE)	BOX20 (Y/N) N	
BOX 10D	BOX22	
	BOX23 97-789658	
BOX 19		
ADDITIONAL BOXES FOR UB92	PRINT DATES IN UB92 BOX 84 (y/n)	
BOXES 24-29 - - - - -	VISIT REV CODE = "0" OR "1" (420/421)	
BOXES 32A-36A - - - - -	PRINT "A3" IN BOXES 39-41 (y/n)	
BOXES 32B-36B - - - - -		
	PT	OT
		SP
BOX 63 CODES		
BOX 80 & 81 CODES - - - - -		
		PRESS "F2" FOR HELP
R)evise, N)otes, T)ransactions, S)chedule or E)nd		

NOTES:

- POSTING NOTE** – INFORMATION THAT WILL BE DISPLAYED AT THE TOP OF THE PATIENT’S TRANSACTION SCREEN
- DEFAULT DX** - RELATES TO ICD-9 ENTRIES IN THE FIRST SCREEN
- Box 20** – ALWAYS “N” FOR OUTSIDE LAB CHARGES
- Box 23** – PLACE CLAIM/REFERRAL NUMBER IN THIS SPACE

Patient Screen 4 - Notes

100001	TABONE, DIANE	ADDITIONAL PATIENT NOTES
LINE 1	JOHN WAVERS @ AETNA INSURANCE 8002549635	
LINE 2	99/05/3	
LINE 3		
LINE 4		
LINE 5		
LINE 6		
LINE 7		
LINE 8		
LINE 9		
LINE 10		
LINE 11		
LINE 12		
LINE 13		
LINE 14		
LINE 15		
LINE 16		
LINE 17		
LINE 18		
LINE 19		
LINE 20		
N)ext, P)revious, T)ransactions, Copy Notes 1) or 2), R)evise or E)nd		

NOTES:

- LINE 1** – WHO, WHERE AND HOW
 - LINE 2** – TICKLER DATE – YY/MM/WEEK (SINGLE DIGIT FOR WEEK, 1-2-3-4)
- MAIN MENU: USE OPTION 5 – PATIENT LISTS, OPTION L – NOTES,
 “A” FOR ADDITIONAL NOTES AND
 TYPE THE TICKLER DATE IN “DESCRIPTION” FIELD TO GENERATE THIS REPORT.

ENTERING PATIENT INFORMATION ~ WORKER'S COMPENSATION

Patient Screen 1

PATIENT # 100003	OFFICE # 1	DR APPT. 2000/05/12
FRST NAME LISA	EDIT	DATE INJUR 2000/04/12
LAST NAME KOEHLER	THERAP KA	FIRST VIS 2000/04/12
ADDRESS 13559 WILLOW BEND	ACC TYPE WC	BIRTH 1960/03/21
LINE 2	PAT SEX F	DISCHARGE / /
CITY HOUSTON	ST TX ZIP 77043	SORT DATA 00/05/12
PAYOR		HOME PHONE 713 5562623
ADDRESS		WORK PHONE 713 2977210
LINE 2		INJURY AREA KNEE
CITY	ST TX ZIP	ACCIDENT RELATED O
EMPLOYER MEMORIAL HOSPITAL		EMPLOYMENT RELATED Y
ADDRESS 2300 MEMORIAL BLVD		SSN # 236-74-7270
CITY HOUSTON	ST TX ZIP 77056	OCCUP NURSE
REFERRAL DR MOORE, STEPHEN MD.		PIN# 112355
PRIMARY DR		PIN#
ADMIT COND - - - - -	DISCRG COND - - - - -	
ICD9 717.41	DX LATERAL MENISCUS, BUCKET HANDLE TEAR - 717.41	
ICD9	DX	
ICD9	DX	
ICD9	DX	

C)ontinue, R)evise, N)otes, T)ransactions, S)chedule, J)ump to next or E)nd

NOTES:

PAYOR NAME/ADDRESS - WORKER'S COMPENSATION - THESE FIELDS ARE LEFT BLANK!



Patient Screen 2

PATIENT # 100003	PATIENT NAME KOEHLER, LISA	ACCOUNT TYPE WC
PRIMARY INSURANCE LIBE LIBERTY MUTUAL		PHONE 8002638400
ADJUSTER	INSURED NAME MEMORIAL HOSPITAL	
GROUP# M7286-09	ADDRESS 2300 MEMORIAL BLVD	
ID# 236747270	CITY HOUSTON	ST TX
EMPLOYER MEMORIAL HOSPITAL	ZIP 77056	PHONE 713 2977100
PATIENT RELATION TO INSURED 4	ACCEPT ASSIGNMENT Y	BDATE / / SEX
SECOND INSURANCE		
ADJUSTER	INSURED NAME	
GROUP#	ADDRESS	
ID#	CITY	ST
EMPLOYER	ZIP	PHONE
PATIENT RELATION TO INSURED	ACCEPT ASSIGNMENT	BDATE / / SEX
DEDUCTIBLE AMOUNT 0.00	2ND DEDUCTIBLE 0.00	DATE / /
PCT TO BILL PATIENT 0	PAYMENT PLAN AMOUNT 0.00	
2ND PCT TO BILL PT 0	AUTO-ADJ A% 0.00	AUTO-ADJ B% 0.00
START DATE FOR 2ND % / /	RE- AUTHORIZATION DATE 2000/05/12	
CALC % OF EXPECTED AMT (Y/N)	ALLOWED VISITS 12	
CO-PAY BILLING	REMAINING VISITS 12	
CO-PAY AMOUNT 0.00	ATTORNEY	

C)ontinue, R)evise, N)otes, T)ransactions, S)chedule or E)nd

NOTES:

INSURED NAME - FOR W/C, THIS IS ALWAYS THE NAME OF THE EMPLOYER

Patient Screen 3 - Worker's Comp

PATIENT # 100003	PATIENT NAME KOEHLER, LISA	ACCOUNT TYPE WC
POSTING NOTE WORKER'S COMP	CHARGE LIMIT	0.00
DEFAULT DX 1	DEFAULT POS 11	DISC INFORMATION
NOTES LINE 1		
NOTES LINE 2		
BOXES FOR HCFA-1500	BOX15 / /	
BOX 1 (1-7) 7	BOX 8 (S,M,O) S	BOX16 FROM / / TO / /
	(E,F,P) E	BOX18 FROM / / TO / /
BOX 10B (STATE)		BOX20 (Y/N) N
BOX 10D		BOX22
		BOX23 9B-1109926
BOX 19		
ADDITIONAL BOXES FOR UB92		PRINT DATES IN UB92 BOX 84 (y/n)
BOXES 24-29 - - - - -		VISIT REV CODE = "0" OR "1" (420/421)
BOXES 32A-36A - - - - -		PRINT "A3" IN BOXES 39-41 (y/n)
BOXES 32B-36B - - - - -		
	PT	OT
BOX 63 CODES		SP
BOX 80 & 81 CODES - - - - -		
		PRESS "F2" FOR HELP
R)evise, N)otes, T)ransactions, S)chedule or E)nd		

NOTES:

Box 15 - For W/C CLAIMS IN TEXAS, "N/A" MUST BE HANDWRITTEN IN THIS BOX ON THE HCFA FORM

Patient Screen 4

100003	KOEHLER, LISA	ADDITIONAL PATIENT NOTES
LINE 1	CHERYL LONG @ LIBERTY MUTUAL 8002638400	
LINE 2	00/06/2	
LINE 3		
LINE 4		
LINE 5		
LINE 6		
LINE 7		
LINE 8		
LINE 9		
LINE 10		
LINE 11		
LINE 12		
LINE 13		
LINE 14		
LINE 15		
LINE 16		
LINE 17		
LINE 18		
LINE 19		
LINE 20		

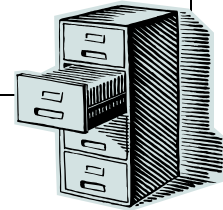
NOTES:

- LINE 1** - THE FIRST LINE OF THE NOTES INCLUDES THE PERSON, COMPANY AND PHONE NUMBER CONTACTED FOR INSURANCE OR TREATMENT VERIFICATION. **Who, Where, and How?**
- LINE 2** - THE DATE SHOWN ON LINE 2 IS AN EXAMPLE OF A TICKLER DATE FOR ACCOUNT FOLLOW-UP.
EXAMPLE ABOVE SHOWS FOLLOW-UP THE 2ND WEEK OF JUNE.
MAIN MENU: USE OPTION 5 – PATIENT LISTS,
OPTION L – NOTES,
"A" FOR ADDITIONAL NOTES AND
TYPE THE TICKLER DATE IN "DESCRIPTION" FIELD TO GENERATE THIS REPORT.

ENTERING PATIENT INFORMATION ~ LITIGATION

Patient Screen 1

PATIENT # 100009	OFFICE # 1	DR APPT. 2000/06/20
FRST NAME LITA	EDIT	DATE INJUR 2000/05/19
LAST NAME FRALEY	THERAP KA	FIRST VIS 2000/05/20
ADDRESS 1100 FAIRVIEW	ACC TYPE L	BIRTH 2000/11/14
LINE 2	PAT SEX F	DISCHARGE / /
CITY HOUSTON	ST TX ZIP 77011	SORT DATA 00/05/20
PAYOR LEE, STEPHEN ATTY	HOME PHONE 713 9638400	
ADDRESS 2611 POST OAK BLVD	WORK PHONE 713 2171468	
LINE 2	INJURY AREA NECK	
CITY HOUSTON	ST TX ZIP 77049	ACCIDENT RELATED O
EMPLOYER INEXS	EMPLOYMENT RELATED N	
ADDRESS 1950 POST OAK BLVD, STE 2150	SSN # 241-68-7459	
CITY HOUSTON	ST TX ZIP 77056	OCCUP INTERPRETOR
REFERRAL DR SMITH, JOHN M.D.	PIN# 111111	
PRIMARY DR	PIN#	
ADMIT COND - - - - -	DISCRG COND - - - - -	
ICD9 847.0	DX SPRAIN/STRAIN, NECK - 847.0	
ICD9	DX	
ICD9	DX	
ICD9	DX	



NOTES:

PAYOR - THE NAME AND ADDRESS OF THE ATTORNEY IS USED IN THIS AREA

Patient Screen 2

PATIENT # 100009	PATIENT NAME FRALEY, LITA	ACCOUNT TYPE L
PRIMARY INSURANCE		
ADJUSTER	INSURED NAME	
GROUP#	ADDRESS	
ID#	CITY	ST
EMPLOYER	ZIP	PHONE
PATIENT RELATION TO INSURED	ACCEPT ASSIGNMENT Y	BDATE / / SEX
SECOND INSURANCE		
ADJUSTER	INSURED NAME	
GROUP#	ADDRESS	
ID#	CITY	ST
EMPLOYER	ZIP	PHONE
PATIENT RELATION TO INSURED	ACCEPT ASSIGNMENT	BDATE / / SEX
DEDUCTIBLE AMOUNT 0.00	2ND DEDUCTIBLE 0.00	DATE / /
PCT TO BILL PATIENT 100	PAYMENT PLAN AMOUNT 0.00	
2ND PCT TO BILL PT 0	AUTO-ADJ A% 0.00	AUTO-ADJ B% 0.00
START DATE FOR 2ND % / /	RE- AUTHORIZATION DATE 2000/06/20	
CALC % OF EXPECTED AMT (Y/N)	ALLOWED VISITS 12	
CO-PAY BILLING N	REMAINING VISITS 12	
CO-PAY AMOUNT 0.00	ATTORNEY LEE, STEPHEN ATTY	
C)ontinue, R)evise, N)otes, T)ransactions, S)chedule or E)nd		

NOTES:

PCT TO BILL PATIENT 100 - PATIENT IS RESPONSIBLE FOR 100%

ATTORNEY - USE UPDATE REFERRAL CODES TO ENTER ATTORNEYS, MORE INFORMATION CAN BE INCLUDED

SUPERBILLS

The Superbill program, which is used to print the header information on the daily treatment records, is **NOT** located under the PTOS program. Follow the commands listed here to create pre-printed SuperBills whenever necessary.

In PTOS: Main Menu

- Option 1 - Patient Data
 - Page down once to Office # and then Enter to the Edit field.
 - Input the letter "Y" in the Edit field and press the Page down key.
 - Select "E" for End and "Stop System".
- Change the paper in the printer to Daily Treatment Records.
 - From the Desktop, double click on the Superbill icon.
 - Input the date to be printed on the Superbill (YY/MM/DD format).
 - Sort by Patient and type the letter "C" to Continue.
- The boxes that must be filled in by hand are "New Patient/ Return Patient", "PT or OT" and "In Clinic"

After the Superbills have been run, the letter "Y" is automatically deleted from the Edit field. It must be added again to the Patient Data each time a Superbill is needed.