Users Manual

HTN Inc.

The Health Transaction Network Inc.

HEALTHCARE ELECTRONIC RESOURCES ON-LINE

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1. Windows

In discussing the various features and functions of ***HERO*** this manual presumes a basic knowledge of the Microsoft Windows operating system. If you are already familiar with Windows, you may wish to skip this chapter. If, however, you are new to Windows, or wish to review the basic operating system elements, you are encouraged to read this chapter first.

1.1. The Windows Desktop

The Microsoft Windows operating system uses what is called a *graphical user interface*. This means that all functions are controlled from within Windows by manipulating graphical objects (icons, buttons, and individual windows) on the screen. The metaphor that Windows uses is that of a *desktop*. Like the surface of a desk, you can move work items around, bring new one onto it, and remove those that aren't needed.

- The **Menu Bar** lists the available menus. This is a list of commands that are available in a particular program. (The ***HERO*** **Menu Bar** will be discussed in detail later.)

- The **Horizontal** and **Vertical Scroll Bars** can be used to view unseen portions of a display if it doesn't fit within its window.

- The **Maximize Button** allows you to enlarge the application to full-screen size (e.g. fill the entire desktop). Once maximized, this button is replaced by the **Restore Button** that will reduce the application to its previous size.

- The **Minimize Button** allows you to reduce the window to a button in the taskbar.

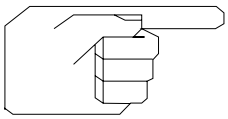
- The **Window Border** can be used to re-size the length or height of the window.

- The **Window Corners** can be used to re-size both the length and height of the window at the same time.

- The **Insertion Point** indicates where typed text will be inserted.

1.2. Mouse and Keyboard Techniques

In Windows there are two basic ways to navigate the screen and execute commands: either from the keyboard (using some combination of F-Keys, Speed Keys, and Arrow Keys) or with a pointing device (e.g. mouse). While it is possible to execute all Windows commands from the keyboard, (and this is sometimes the method of choice within applications that are keyboard intensive such as a text editor), it can be argued that the true power of Windows is realized when it is used in conjunction with a mouse. This is especially true of more sophisticated Windows applications that feature multiple windows, Button Bars, Tool Bars etc. that greatly increase speed and functionality with a few clicks of the mouse button.



The preferability of a mouse is especially true of *HERO* which utilizes powerful Module and Tool Bars to quickly enter, retrieve and transmit information.

Apart from speed issues there are other advantages. Mouse commands are fewer, more universal and easier to learn than their keyboard counterparts. The mouse works more or less the same way in *every* application and it requires only a handful of basic techniques to accomplish tasks. The functions are summarized below.

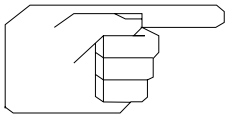
OPERATION	FUNCTION
Click	Quickly pressing and releasing the mouse button. Unless otherwise indicated this is always the *left* mouse button. Usually used to *select* (e.g. highlight or display) an item or position the cursor. An example of this would be clicking on a **Program Icon**. You often have to *select* an item before *choosing* it. (See next.)
Double-Click	Pressing and releasing the mouse button twice in rapid succession. Unless otherwise indicated this is always the *left* mouse button. Usually used to *choose* (e.g. execute) an item. An example would be double-clicking on a **Program Icon** to launch that application. It can also be used to access pick-lists based on the part of the program you are in at the time.
Right-Click	Quickly pressing and releasing the *right* mouse button. Usually to *select* specialized or context sensitive items. In ***HERO*** it is used to access pick-lists based on the part of the program you are in at the time.
Drag	Holding the left mouse button down while you move the mouse. Usually used to *move* an item or highlight an area. An example would be dragging a **Program Icon** from one group to another.
Drop	Releasing the mouse button after dragging.
Point	Moving the mouse until the mouse pointer rests on the chosen item.

1.3. Menu Commands

Windows commands can be issued by selecting then choosing an item listed on a *menu*. The menu titles related to the particular application are always listed on a menu bar along the top of the application.

Each of these titles can be selected by clicking on them to produce one or more vertical pull-down menus that become progressively more specific. Once the desired item is found, it can be selected with an additional click.

The keyboard alternative to this is to press **ALT** to highlight the menu bar, then use the left-right arrows to select the desired menu title. Once the tile is selected, the pull-down menu is opened by pressing **ENTER**. By using the up-down arrow keys the menu item is selected, then chosen by pressing **ENTER** once more.



A further alternative is to press ALT + [Underlined Letter] to access the Main Menu item, then press the underlined letters of the sub-menu choices to select further or execute your command.

1.4. Speed Keys

You will note as you examine menu items in Windows that certain entries have references to keys (or combinations of keys) next to them. For instance, in **Explorer**, if you open the **EDIT** menu, next to the item **COPY** is **Ctrl+C**. **Ctrl+C** in this case is a *speed key*, a key that when pressed will perform the same function as **EDIT ➔ COPY.**

Apart from speed keys *within* particular applications, there are also speed keys general to Windows that assist in opening, closing and switching application windows. These are summarized below.

SPEED KEY	OPERATION
ENTER	Choose highlighted object. If the highlighted object is a **Program Icon** then that application is opened. If the highlighted object is a menu item, then that command executed. The best way to think of **ENTER** is as the keyboard counterpart to double-clicking with the mouse.
ALT+F4	Close current window and exit program. If an application is active, **ALT+F4** will close it and return to the last application you used that is still open. If no other applications are active then Windows will shutdown altogether.
CTL+ESC	Activate the **Start Menu** The **Start Menu** is where you can launch any of your applications, By choosing from approiate Menu.
ALT+ESC	Cycle through open applications. This is another way of switching applications. **ALT-ESC** activates each open application in turn.
ALT+TAB	Cycle through open applications titles. This is another way to switch applications that is less intuitive than **ALT-ESC** but faster once you get used to it. With this speed key you *hold the* **ALT** *key down* while pressing **TAB** repeatedly to cycle through the titles of all open applications. When the desired application title is displayed you release the **ALT** key to activate that open application.

SPEED KEY	OPERATION
TAB	Cycle through fields. Inside any application with fields (e.g. the input forms in ***HERO***), **TAB** will advance the cursor to the next field.
SHIFT-TAB	Backward cycle through fields. Inside any application with fields (e.g. the input forms in ***HERO***), **SHIFT-TAB** will move the cursor to the previous field.
CTRL-F4	Close active window. If you have multiple windows open in an application such as ***HERO*** this will close the active one.
CTRL-F5	Cascade window. If you have multiple windows open in an application such as ***HERO*** this will arrange them in an overlapped cascade display.
CTRL-F6	Next window. If you have multiple windows open in an application such as ***HERO*** this will activate the next window.
ESCAPE	Cancel operation. Inside an application **ESCAPE** will cancel most operations and return you to the previous screen.

1.5. What's Next

Windows is a feature-rich operating system capable of many functions that are beyond the scope of this summary. Depending on the scope of your system (number of applications you run, multi-tasking needs etc.) you may want to explore Windows further through hands-on experimentation and reference to Windows documentation. At this point, however, you should possess enough of the basics to open, close, and switch between applications such as ***HERO***.

2. About HERO

HERO is a comprehensive practice management system designed to quickly process OHIP billing information, laboratory requisitions, scheduling and e-mail with a minimum of user input. This manual will provide a brief overview of the structure and command-set for ***HERO***, then explain all procedures in detail.

2.1. Network Services

HERO provides full network services to its subscribing physicians through the use of Remote Access Services (**RAS**) to its servers at the Facilities Management Centre. Once a subscribing physician is validated on the network, his or her transactions can be transmitted and received with a standard-type modem using asynchronous communications (ordinary analog phone lines), or with an Internet connection (e.g. cable or DSL).

The HERO network can best be thought of as a highly sophisticated mailbox (technically referred to as a " store and forward " design) that quickly routes transactions between the physician and the various government departments with whom s/he deals with on a daily basis.

2.2. Installation

All initial installations are performed by HERO personnel or their authorized representatives. All subsequent upgrades to the program will be made available through downloads from the HERO network directly to your computer.

Whether you are using a HERO provided computer, or have upgraded from an existing system, *all* hardware setup should be completed and tested before you use the program. This includes both the required and recommended items below, as well as the setup of doctors and communications in ***HERO*** itself (as described in Chapter 4: **System Setup**).

2.3. System Requirements

- ☑ Pentium 75 or better is recommended
- ☑ Microsoft Windows 95 or better
- ☑ 64MB RAM minimum
- ☑ 4GB hard disk minimum (at least 50MB available for HERO – some conditions may apply depending on the usage)
- ☑ Installed Hayes compatible modem (14.4 v32 bis or better is recommended) with access to an outside analog telephone line (dedicated or shared fax line recommended), and/or an Internet connection.
- ☑ A Windows-compatible pointing device (e.g. mouse)
- ☐ A magnetic card reader (Optional)

3. Overview

3.1. Conventions

Like all full Windows applications ***HERO*** supports *icons* or *custom buttons* (small representative pictures that can be clicked on with a mouse to select various functions). Wherever possible these icons will be reproduced in section headings and text for clarity.

EXAMPLE:

Click once to access Setup Utilities.

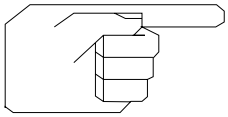
In this document all references to **Main Menu Bar** items will be capitalized, and connected to sub-menu choices by arrows. For example, to indicate selecting "File" in the **Main Menu Bar**, then selecting "Lists" from the pull-down menu that is opened, then selecting "Billing" from the next pull-down menu that is opened, the convention will be:

EXAMPLE: " Select FILE ➔ LISTS ➔ BILLING "

All references to keystrokes will be written in boldface and small caps.

EXAMPLE: " To proceed to the next field press **TAB**. "

Hints, comments etc. will be offset in boldface with the following graphic:

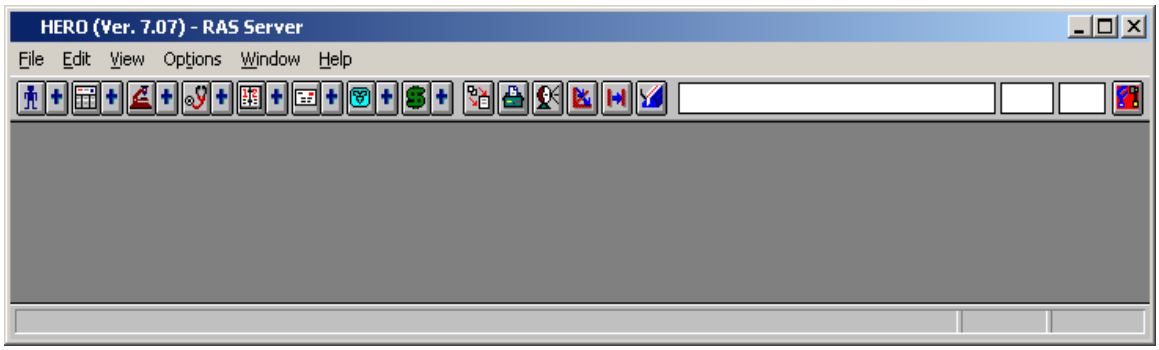


The Lookup feature on any field can be accessed by clicking once with the right mouse button on that field, or by double-clicking with left mouse button.

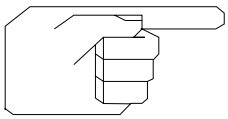
3.2. Running HERO

To launch ***HERO,*** double-click on the **HERO** shortcut (e.g. on your Windows desktop), or highlight it and press **ENTER**.

The main screen (illustrated below) should be displayed.



The top of the screen is comprised of two distinct areas: the **Main Menu Bar** and the **Tool Bar** respectively. You will note, as we discuss these areas individually, that there is a great deal of overlap between them. This *redundancy of function* allows you several different ways to perform the same task, based on where you are in the program at the time and individual preference. The blank area in the middle of the screen is the **HERO Client Area**, in which forms, records, etc. are placed, depending on the commands issued.



Generally speaking, the fastest and most intuitive way to perform most tasks is through the TOOL BAR (in concert with a CARD READER), and this is the recommended mode of input.

3.3. Main Menu Bar

The **Main Menu Bar** is the standard Windows pull-down type. That is to say it is a horizontal bar divided into menu titles. Each of these titles can be selected by clicking on them, to produce one or more vertical pull-down menus that may also lead to a cascading menu as indicated by the black triangle in the right margin. Once the desired item is found, it can be chosen by clicking or by pressing **ENTER**.

Alternatively, you can press Alt, followed by (or combined with) the underlined letter, i.e. File, Edit, View, Options, Window, Help, to open the desired menu, and then press the underlined letter (if applicable) to select the desired option within that menu. (Note that the underlining might not appear until you press Alt, depending on your Windows

configuration.) Or, press Alt, and then use the arrow keys to navigate within the menus, and then press **ENTER** to confirm the selected item.

You will note that many **Main Menu** items are accompanied by a reference to corresponding "Speed Keys" that will perform the same function with either an F-Key or a combination of keystrokes. Using our previous example, entering a new claim can also be accomplished by pressing **F3**.

FUNCTION/AREA	SPEED KEY
Help Contents (Help)	**F1**
Enter New Patient (File)	**F2**
Enter New Claim (File)	**F3**
Set for keyboard card-reader input (Edit)	**F4**
First Record (File)	**F5**
Prior Record (File)	**F6**
Next Record (File)	**F7**
Last Record (File)	**F8**
Lookup (File)	**F9**
Zoom (File)	**F10**
Okay (Edit)	**ENTER**
Cancel (Edit)	**ESC**
Undo (Edit)	**CTL+Z**
Cut (Edit)	**CTL+X**
Copy (Edit)	**CTL+C**
Paste (Edit)	**CTL+V**
Close Active (Window)	**CTL+F4**
Window Cascade (Window)	**CTL+F5**
Next (Window)	**CTL+F6**

An alternative method is to press ALT + [Underlined Letter] to access the Main Menu item, then press the underlined letters of the sub-menu choices to select further or execute your command.

EXAMPLE: To look up billing records via FILE➔ LISTS➔BILLING, press ALT-F, L, B.

Most of the specific items on the **Main Menu Bar** are dealt with in greater detail in the following sections, but to summarize their functions:

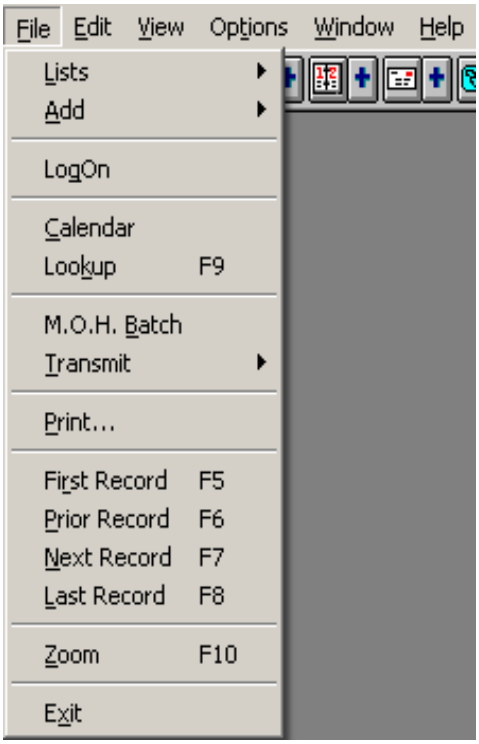
FILE

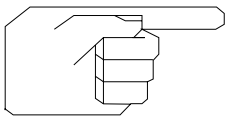
- Accesses List functions
- Add a particular item

- Logs on the doctor
- Accesses Pop-up Calendar
- Context sensitive lookup
- Batch Claims
- Manual Transmission

- Print Report

- First record
- Prior record
- Next record
- Last record
- Zoom view
- Exit program



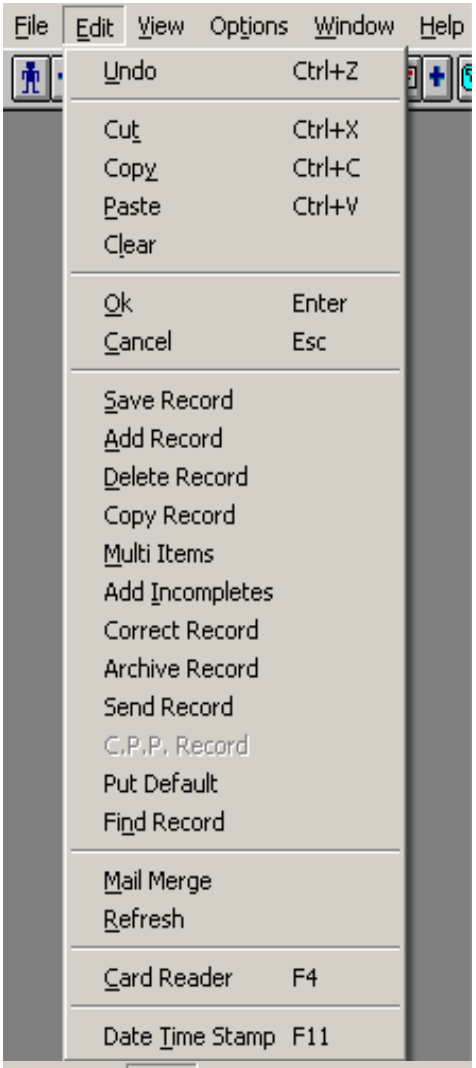


In pull-down menus, sometimes some of the entries are grayed out. Consistent with the Windows interface, only those items that are appropriate to the area of the program you are using will be displayed in a darker font.

EDIT

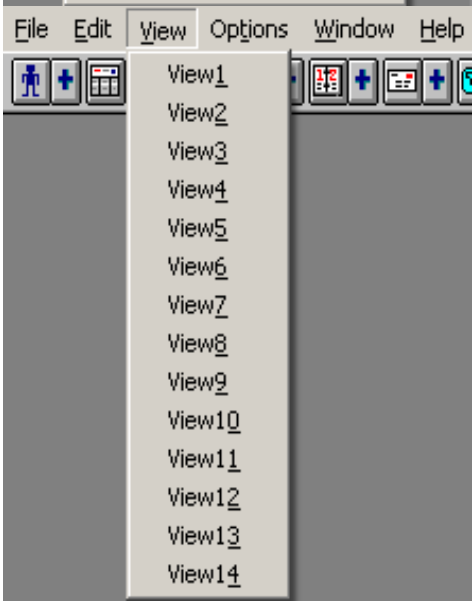
- Undo the last command
- Cut text to Clipboard
- Copy text to Clipboard
- Paste text from Clipboard
- Clear record

- Accept operation
- Cancel operation
- Save record
- Add record
- Delete selected record
- Copy selected record
- Multiple Item Entry
  - Add Incompletes
- Correct record
- Archive Record
- Transmit/Receive Records
- For Future Use
- Set Default Values
- Find record based on search string
- Prepare merge file
- Set automatic refresh
- Set for keyboard card-reader input
- Stamp current Date/Time in selected note field.



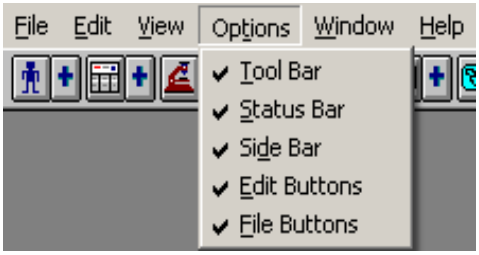
VIEW

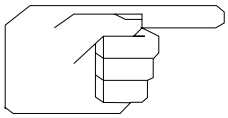
Allows the user to choose pre-selected views of the program.



OPTIONS

- Display/Hide Tool Bar
- Display/Hide Status Bar
- Display/Hide Side Bar
- Display/Hide Edit Buttons
- Display/Hide File Buttons

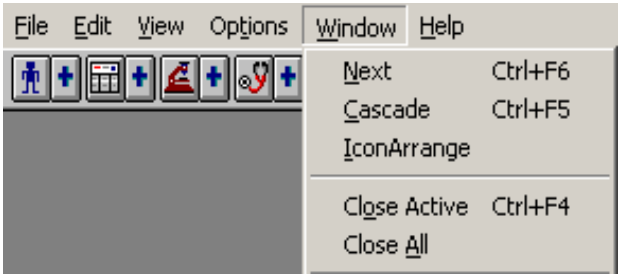




You will note in the preceding menu that all of the entries are accompanied by check marks. Consistent with the Windows interface, the program puts a check mark next to menu items that are currently active. In the case of the Options Menu, *all* items are initially checked by default.

WINDOW

- Next window
- Cascade display
- Custom arrange icons
- Close active windows
- Close all windows
- Also lists all open windows



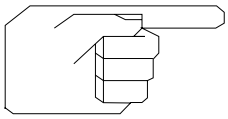
HELP

- Index of contents.
- Search for Help
- How-to information about Help
- Version information on ***HERO***

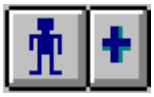
3.4. Tool Bar

The **Tool Bar** is a series of icons that are used to quickly access areas of ***HERO***. This includes patients, claims, appointments, payments, etc. These icons are designed to function like buttons which are " pressed " by clicking on them once. Some buttons are divided into two parts, a reference icon (denoted by a representative picture) and an

action icon (denoted by a “+” sign). The reference icon displays a list of existing items for purposes of editing or quick reference, the action icon allows an item to be quickly entered in that area.



You will notice that as you pass the cursor over each of the Tool Bar icons, a description of its function is displayed in the Status Bar (if it’s enabled) for easy reference.



List Add
Patient Records

The **Patient Records** icon allows you to list all patients by clicking on the left icon, or quickly add a new patient record by clicking on the right icon.

List Add
Doctor’s Claims

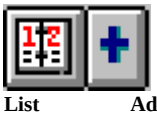
The **Doctor’s Claims** icon is used to provide a list of all claims for a particular doctor, or quickly add a new claim. The records are categorized by status, i.e. **Completed, Incompleted, Error, Rejected, Batched, Corrected, Reconciled**, and **Archived.** The initial view defaults to **Completed Claims.**

List Add
Doctor’s Laboratory Requisitions Reports

The **Doctor’s Laboratory Requisitions & Reports** icon is used to provide a list of all laboratory records and/or requisitions by physician, or quickly add a new lab requisition.

List Add
Doctor’s Encounter Records

The **Doctor’s Encounter Records** icon is used to provide a list of patient encounters by physician, or quickly add a new encounter.



List Add
Doctor’s Appointments

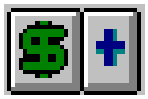
The **Doctor’s Appointments** icon is used to provide a list of all patient appointments by physician for the current date, week or month, or quickly add a new appointment. The default view would be the monthly view for the logged-on doctor for the current date.

List Add
Doctor’s E-Mail

The **Doctor’s E-Mail** icon is used to provide a list of all incoming and outgoing e-mail, or quickly compose a new e-mail message.

List Add Doctor's Batches/RAs

The **M.O.H Claims/Reconciliations** icon is used to provide a list of all MOH batches, all processed Remittance Advices (RAs), and all transmission events, or to create a new batch for transmission or process a received RA.



List Add Cash Receipts & Payments

The **Cash Receipts & Payments** icon is used to provide a list of all Private and Insured payments or to apply payment to an account.

Mail Merge

The **Mail Merge** icon is used to export selected patient records for purposes of merging form-letters in word processors such as Microsoft Word. The information exported is the primary doctor's information, the referring doctor's information and the patients demographic information.

Print Reports

The **Print Reports** icon is used to generate reports (to print, preview, or export). Depending on the area of the program you are using it will either give you a list of general reports or reports specific to a particular area (context sensitive).

Force a RAS Transmission

The **Force a RAS Transmission** icon allows you to manually transmit and receive claims, RAs, e-mail, OBEC, error reports, etc.

Close All Document

The **Close all Documents** icon closes all open windows/documents.

Go To Next Document

The **Go To Next Document** icon sets focus on the next open but inactive window/document.

Read Input From Keyboard Card-Reader

The **Read Input From Keyboard Card-Reader** icon prepares a screen (usually **New Patient** or **New Claim**) for input from a *keyboard/USB* card-reader.

Setup Utilities

The **Setup Utilities** icon is used to access *all* aspects of system administration. This includes creating a system password, entering doctors into the system, running periodic indexes, archives and purges etc.

You will notice that between **Close All Windows** and **Setup Utilities**, there are three blank fields. The first field is used to look up and display the name of the logged-in doctor. The second field displays the group number (or "0000" if the physician is not part of a group) and the third displays the *Alias* (if any). Aliases are usually assigned if the physician wishes to sub-divide the practice for accounting purposes (i.e. an alias of " INS " to track all privately insured billing, and " MOH " to track HCP/RMB/WCB claims.) Double-click to see a lookup for billing doctors or to log in a doctor.

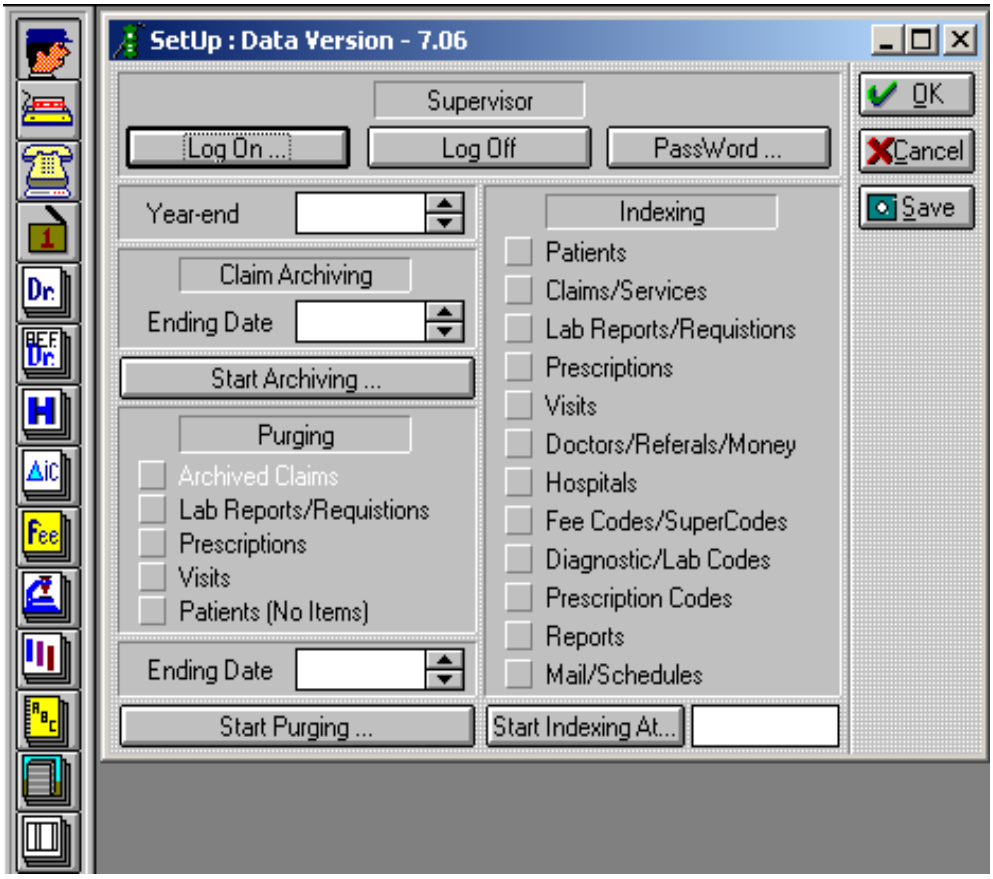
These fields may be blank if no doctor has been entered in the system, but normally will contain at least the logged-on doctor, and in fact *no* billing is possible without them. These will be covered in greater detail in Chapter 4: **System Setup**.

4. System Setup

Now that you have a general overview of the command keys and functions of ***HERO*** you are ready to set up your system. The hardware configuration should already have been performed, and is provided here for reference only. For the most part, setup will consist of customizing certain areas specific to your day-to-day practice.

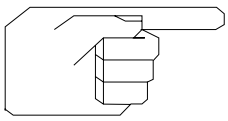
Setup Utilities

Click the **Setup Utilities** icon once to access Supervisor functions. Your screen should resemble the one below:



(For a complete discussion of the archiving, purging and indexing features, please refer to Chapter 12, **Maintenance**. **)**

You will note that the Supervisor screen is accompanied by a row of side buttons to the left. These represent a list of choices available from within that module, and they function exactly like the icons on the Tool Bar in that they can be "pressed" by clicking on them.



Side buttons are *context sensitive*: that is, they are different depending on the screen you have chosen. You will see as you work through the program that each module has its own side buttons that are logically consistent with its particular function.

1. **Security/General Maintenance**: Default view. General utilities including indexing, archiving and purging.

2. **Setup Serial Card Reader Dialog**: Set up the **HERO *SERIAL* Card Reader** for quick input. This area *doesn't* apply to keyboard/USB card-readers, which require no set up.

3. **Setup RAS Communications Dialog**: Set up communications with HERO.

4. **Setup Network Refresh Dialog**: Enable automatic screen refresh for remote stations.

5. **Add/Browse Doctors**: Enter or browse one or more *billing* physicians in the **Billing Doctors Lookup Table**. While several fields in this form can be edited, each new doctor entry requires a HERO unlock code.

6. **Add/Browse Referring Doctors**: Enter, browse and/or edit doctors in the **Referring Doctor Lookup Table.**

7. **Add/Browse Hospitals**: Enter, browse and/or edit hospitals in the **Hospital Lookup Table**.

8. **Add/Browse Diagnostic Codes**: Enter, browse and/or edit diagnostic codes in the **Diagnostic Code Lookup Table**.

9. **Add/Browse Fee Codes**: Enter, browse and/or edit fee codes in the **Fee Code Lookup Table.**

10. **Add/Browse Laboratory Codes**: Enter, browse and/or edit lab codes in the **Laboratories Lookup Table.**

11. **Add/Browse Patient Code Records**: Enter, browse and/or edit patient codes the **Patient Codes Lookup Table** for user-defined tracking purposes.

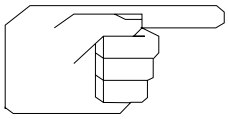
12. **Add/Browse Address Records**: Enter, browse and/or edit address records (i.e. templates such as " Toronto, ON ") in the **Address Records Lookup Table** for quick pasting into patient records.

13. **Add/Browse Insurer Records**: Enter, browse and/or edit private insurer the **Insurer Records Lookup Table** for quick pasting into a patient record.

14. **Add/Browse Reports**: Enter, browse and/or edit reports the **Reports Lookup Table**.

4.1. Security/General Maintenance

The Supervisor Password feature, if enabled, restricts access to key areas of ***HERO***, among them: adding, editing, and viewing doctor records; batching claims; and accessing reports. If *not* enabled there are *no* access restrictions in any of these areas.



The Supervisor password is an entirely *local* security feature and has no influence on the *network* password that allows you to transmit to and receive from the HERO network.

Password Click on this button, or highlight and press **ENTER**.

- You will be prompted to confirm that you wish to enter a password. Click on **Yes** to proceed or **Cancel** to return to the previous screen.

A security box will be displayed and you will be prompted to enter a new password.

- Enter your chosen password in the space provided. As you type the characters will only display as a row of asterisks. Press **ENTER** when finished.

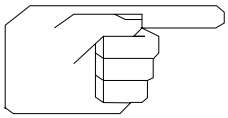
- You will be prompted to re-enter your password to ensure it was entered correctly. Re-type your password and press **ENTER**. You will then be returned to the **Setup** screen.

You may change the system password at any time in the future, simply by following the steps above. The only difference is, once the initial password has been entered, you will be prompted to enter it before being allowed to change it to something else. To *remove* password protection, leave the new password field blank.

Log On Click on this button, or highlight and press **ENTER**.

- When prompted, type in the system password, then click " **OK** " or press **ENTER**.

You now have access to all secure features in the program, and can continue with your setup.



If the Supervisor Password has been enabled, and a User attempts to access a secure feature without first logging on, the program will prompt entry of a Supervisor Password before proceeding.

4.2. Setup Serial Card Reader Dialog

This section allows you to view and/or edit the settings of a *serial* **Health Card Reader**. A serial card reader is one that plugs directly into a serial port in your computer. If you have a *keyboard/USB* card reader (that is, a card reader that is connected to a keyboard or USB port), no setup is required.

Click on this button.

The settings for the **Health Card Reader** are entered by HERO personnel, if necessary, during installation and *should not be modified without contacting HERO support*.

4.3. Setup RAS Communication Dialog

Click on this button.

This area is used to enable or disable Remote Access Services (RAS) and dedicate one (and *only* one) machine as the RAS server. The RAS server setting is configured by HERO personnel during installation and *should not be modified without contacting HERO support*.

You may elect to have system automatically transmit to the HERO network at random times throughout the day by clicking once on the **Schedule Transmissions** button. Notification of next transmission time shows on the Title Bar and is randomly set each tim you start HERO.

Otherwise the system will only transmit when you force a manual transmission. The proper credentials as provided by HTN must be entered in the **Username** and **Password** fields (Unlock code from HTN Support is required). **OBEC Frequency** determines the number of days HERO will look ahead in the scheduler for Health Number verification.

4.4. Setup Network Refresh Dlalog

This button enables local screen refresh. Characteristically it would be used in a local network setting where the physician wishes to periodically update his screen with patient arrivals etc.

4.5. Add/Browse Doctors

Billing physicians are initially entered into the system by HERO personnel during setup. New billing physicians may be entered at any time, but require an unlock code from HERO support and must be granted access permissions on the HERO network. These operations will ordinarily be performed by HERO personnel on-site or by contacting HERO support. For the most part, this area will be used to *edit* certain fields for existing doctors.

Click on this button.

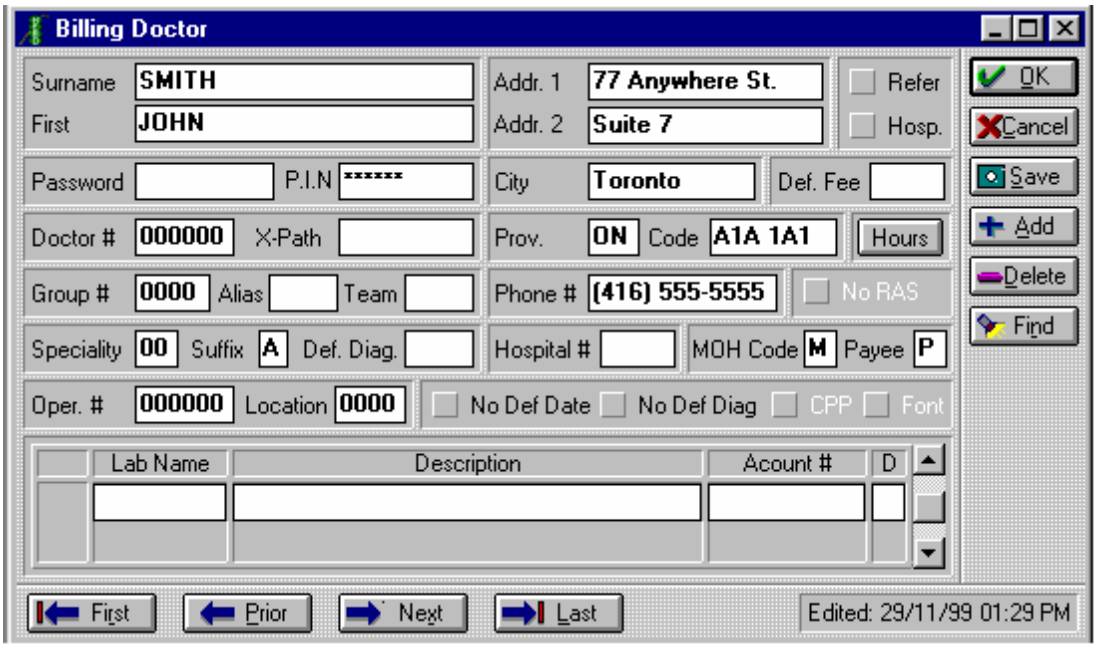
A blank **Billing Doctor** form will be displayed. Select an existing doctor by double clicking on the **Surname** field and selecting from the pick-list.

A screen resembling the one below will be displayed.

The doctor's **Doctor #**, **Group #, Specialty, Operator #** and **P.I.N.** will be grayed out pursuant to HERO security locks. All other fields, however, can be edited at any time.

The **X-Path** field allows customization of Fee and Diagnostic Codes for an individual doctor.

The **Alias** field allows you to enter one or more tag names for a particular doctor. This is especially useful if a doctor wishes to have an intuitive reference for tracking income based on the different activities. You can enter the same doctor into the **Billing Doctor Lookup Table** multiple times with different aliases. (Contact HERO support for an unlock code to enter multiple aliases.)



The **Team** field is used primarily for hospitals or clinics that wish to track the schedules of various physicians who may not necessarily belong to a billing group (i.e. a pediatrics team). As outlined in the chapter dealing with scheduling, this allows for the lookup of the next available appointment for a *team* member as opposed to a particular physician.

Billing Suffix refers to the default suffix a doctor will be billing with. Ordinarily this is "A" but if the doctor is primarily in the role of assistant/technician, the default suffix would be "B", or if the doctor is primarily in the role of anesthetist, the default suffix would be "C". When the **Billing Code Lookup Table** is accessed during billing, the pointer automatically goes to the first record with the appropriate suffix.

A **Hospital #** can be entered if it would be normally associated with this Doctor, and you wish to use it as a default.

The **Def Diag** field can be entered if there is a default Diagnostic Code that would be normally associated with this Doctor. By default, a claim will use the last diagnostic code used for the patient being claimed unless an √ is placed in the box beside **No Def. Diag.**. A √ in the box beside **No Def. Date** will use current date for all entries, otherwise, the last date selected will be used.

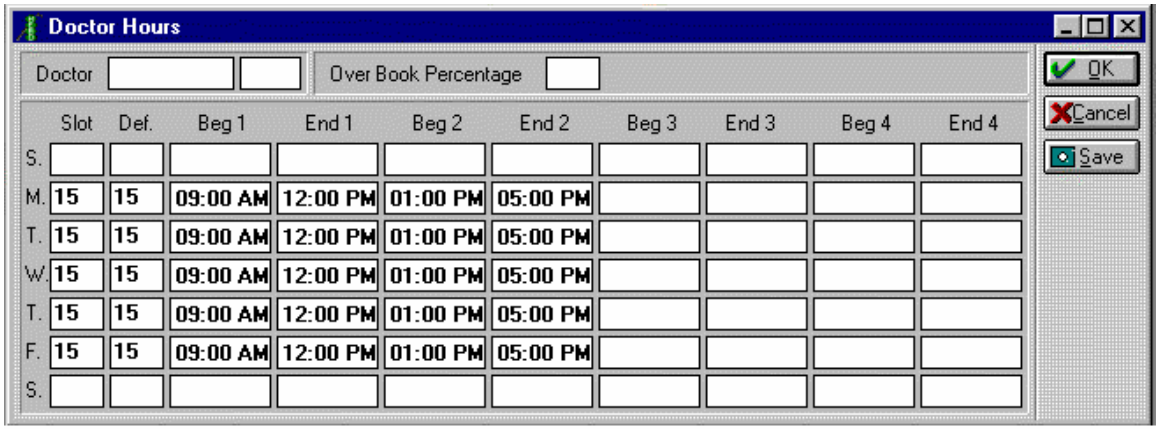
The **Def Fee** field can be entered if there is a default Fee Code that would be normally associated with this doctor.

The next fields allow you to enter address information. This information will automatically be pasted in to invoices etc.

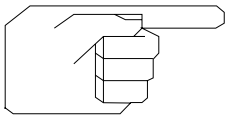
The **Hours** button allows you to set the doctor's available hours, and **must be set** before you can use the scheduler.

- Click once on the **Hours** button.

A screen resembling the one below will be displayed.



Over Book Percentage allows entry of multiple appointments in the same time-slot *over and above its normal capacity* without flagging a conflict. (For example: given the values in our illustration, the normal capacity of a 15-minute time-slot would be one 15-minute appointment. An over book value of 100 would allow two fifteen-minute appointments in the same time-slot, 200 would allow three appointments and so on.)



Notwithstanding the value entered in Over Book Percentage, the scheduler *will* allow you to force an appointment into a full time-slot after alerting you to the conflict.

Slot refers to the default *time-slots* that will be displayed on the calendar. These can be set to individual values for any given day.

Def. refers to the default *length of appointment* for a patient. These can be set to individual values for any given day.

The individual times of availability can be set by entering new values in the appropriate box in the calendar grid. You may enter up to four separate times of availability per day. These times should be logically sequenced and non-overlapping. These fields accept common abbreviations such as " 1P " for 1:00 PM. To blank a field, position the cursor in

the desired field and press the space bar, or press the **DELETE** key, and press **TAB** to advance the cursor to the next field.

- When finished, click on **OK** to save your changes and return to the **Billing Doctor** form.

The **No RAS** check box disables RAS communication for that physician (as would be the case for a physician who was using the system for scheduling only, or a locum doing disk billing instead of EDT), and can only be altered by contacting HERO Support.

The lower section allows entry of laboratories to which the doctor subscribes, with the *default* laboratory being designated by clicking once in the **D** column. This list becomes the lookup table used when lab requisitions are entered. To change the default, position the cursor in the **D** column to the right of the desired lab and double-click.

- When finished, click on the **OK** button to save your work and exit this screen.

4.6. Add/Browse Referring Doctors

For certain types of bill codes (i.e. consultations) a referring doctor number must be provided, otherwise OHIP will reject the claim. The **Add/Browse Referring Doctors** button is used to enter the name and number of a referring physician. This information can later be quickly accessed and pasted in from the **Referring Doctor Lookup Table** when you are generating a bill that requires it.

If you wish to enter a referring doctor:

Click on this button.

An input screen is displayed. **Surname, First Name,** and **Doctor #** *must be entered*. You may also enter telephone and address information for future reference.

- Using the navigation methods outlined above, enter the information in the appropriate fields.

- When finished, click on the **OK** button, or highlight **OK** and press **ENTER**, to save your work and exit this screen.

4.7. Add/Browse Hospitals

Every hospital and institution in Ontario has a unique four-digit institution code, which is required for billing encounters done in hospitals and institutions. The **Add/Browse Hospitals** button is used to enter this institution code number and description for your future reference. This information can later be accessed from the **Hospital Lookup Table** when you are generating a bill that pertains to a hospital visit.

If you wish to enter a hospital:

Click on this button.

An input screen is displayed with two fields: **Description**, and **Hospital #**. In the **Hospital #** field, enter a 4-digit Master Number assigned by MOH. You can also add a Service Location Indicator, if necessary (optional). Valid SLIs are HDS (Hospital Day Surgery), HED (Hospital Emergency Department), HIP (Hospital In Patient), HOP (Hospital Out Patient), and HRP (Hospital Referred Patient). However, when entering an SLI in HERO, only enter the last two letters (not the "H"), e.g. DS, ED, IP, OP, or RP. For example, you might enter something like "1234IP" or "5678OP" or "9999" in the Code field.

- Using the navigation methods outlined above, enter the information in the appropriate fields.
- When finished, click on the **OK** button, or highlight **OK** and press **ENTER**, to save your work and exit this screen.

4.8. Add/Browse Diagnostic Codes

HERO comes with its own database of standard MOH Diagnostic Codes that can be accessed via the **Diagnostic Code Lookup Table**. In the event that MOH creates new codes you may wish to update the existing database manually. The purpose of **Add/Browse Diagnostic Codes** then is to allow you to update the database in this fashion between standard updates received through the HERO network.

If you wish to add a Diagnostic Code:

Click on this button.

An input screen is displayed with two fields: **Code**, and **Description.**

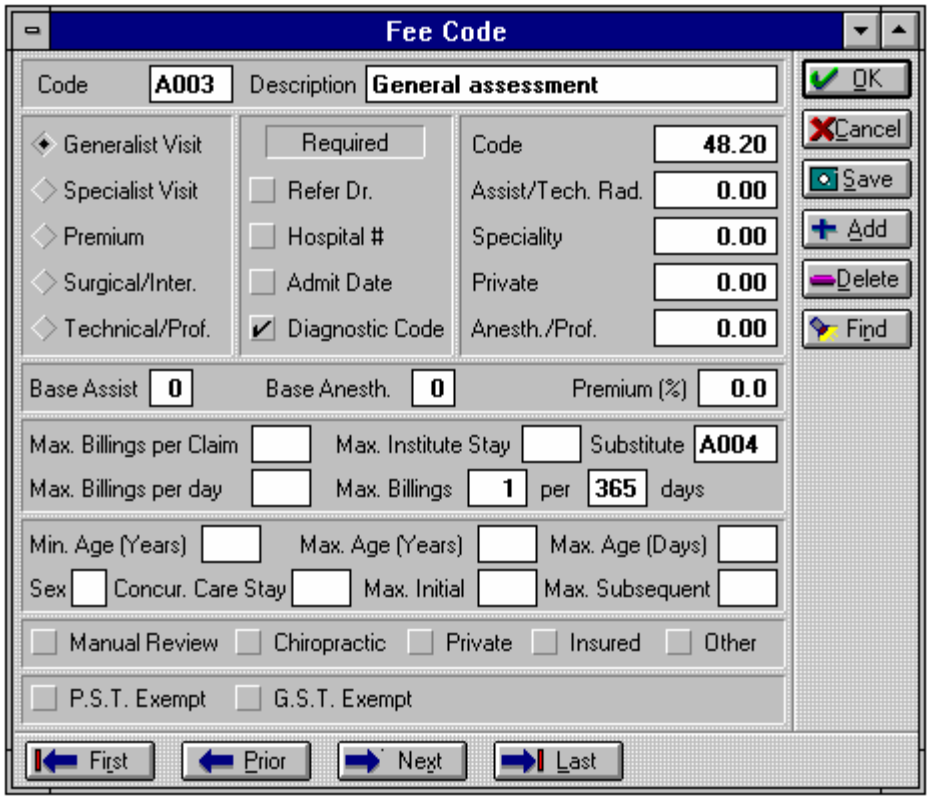
- Using the navigation methods outlined above, enter the information in the appropriate fields.
- When finished, click on the **OK** button, or highlight **OK** and press **ENTER**, to save your work and exit this screen.

4.9. Add/Browse Fee Codes

HERO comes with its own database of standard OHIP Billing Codes that can be accessed via the **Fee Code Lookup Table**. The purpose of **Add/Browse Fee Codes** is to allow you to manually update this database between standard updates received through the HERO network, or to enter custom codes for private or insured billing.

Click on this button.

An input screen, resembling the illustration below, is displayed.



The top line displays the **Code** and **Description** of the particular fee. The next two columns refer to the *type* of claim (Generalist Visit, Specialist Visit etc.) and the additional information that the system will require to complete the claim (Referring Doctor, Hospital # etc.). The third column displays the fee schedules based on the service provided. The appropriate values are itemized below:

- **Code** will be entered for all MOH claims with an “A” suffix.
- **Assist/Tech.Rad** will be entered for all MOH claims with a “B” suffix.
- **Specialty** will be entered for all MOH claims with an “A” suffix where **Code** is “0”.
- **Private** will be entered when the claim is flagged as a private claim.
- **Anaesth/Prof.** will be entered for all MOH claims with a “C” suffix.

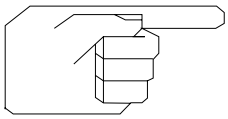
Base Assist and **Base Anesthetist** refers to the default number of units allowable for the particular claim.

Premium % refers to the percentage of preceding service items that will be calculated. Always add 100, for example, for a 50% premium, enter “150”. (An example of this would be a **E410** ***After Hours Premium - 12am-7am*** in which a value of 150 indicates that 50% of the total preceding service items in a given claim will be added.)

The next two sections (four lines) contain various fields that represent the *business rules* of the claim. In our example the claim can only be submitted once per year, and if a second billing is attempted it will suggest replacing it with an **A004** ***General Re-Assessment***.

The next row allows the flagging of a claim in various ways. For instance, if you wished to be automatically prompted to enter a Manual Review note, you would click once on the **Manual Review** check box. The other boxes, which would prompt you for various reports or entries related to the type of claim, are reserved for future development and should not be checked at this time.

The final two check boxes are only active when preparing a *private or insured* claim. By default all private or insured claims will calculate and add *both* PST and GST. If you wish to exempt a particular private or insured claim from PST and/or GST, click the appropriate box.



For the most part it is advisable to leave the values in the existing Fee Code database in their default state, as they subscribe to current MOH specifications. However, you may wish to add custom codes for private or insured billing or enter private values for MOH codes that may be billed privately.

- Using the navigation methods outlined above, enter the information in the appropriate fields.

- When finished, click on the **OK** button to save your work and exit this screen.

4.10. Add/Browse Laboratory Codes

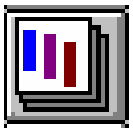
This area is used to add *new* lab codes to an **existing** laboratory. This would characteristically involve new or amended codes, specific to one of the ***HERO*** trade partner laboratories that are included in the laboratory requisition template.

Click on this button.

A popup screen of existing labs is displayed. Double-click on the desired lab and enter the new code information in the appropriate boxes. Click on **OK** to exit the form and save your entry.

4.11. Add/Browse Patient Code Records

HERO allows you to track particular areas of interest through user-defined patient codes. There are three such fields available in the **Patient Information Screen** (**Code 1** through **Code 3** respectively) and though information can be entered manually, it is advisable to create lookup tables for consistency. For instance, if you wished to track a risk factor such as smoking in **Code 1** you could do so through the following steps.



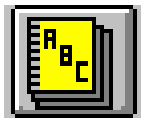
Click on this button.

- Click once on the **Code 1** diamond if not already selected.
- Type " Non-Smoker " in the **Code** field.
- Click once on **Save**, then once on **Add**.
- Type " < 1 Pack Per Day " in the **Code** field.
- Repeat the process until all relevant codes have been entered then click once on **OK** to save your entry and exit the screen.

Thereafter, when entering a new patient, or updating a patient record, you can enter the appropriate code by double clicking on the **Code 1** field and selecting from the pick-list.

4.12. Add/Browse Address Records

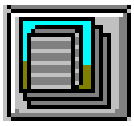
When entering patient information, certain fields, such as city and province, can be repetitive and time-consuming to enter manually. A preferable method is to construct a pick-list of cities, and provinces, and/or their postal codes that can be quickly pasted in by double clicking on the **City** or **Province** field.



Click on this button, enter the city, province, and postal code desired, click on **Save** and **Add** for subsequent entries, then click on **OK** to save the last entry and exit the screen.

4.13. Add/Browse Insurer Records

This area is used to add information about *private* insurance companies that can be pasted into a patient record and into all privately insured claims and related reports such as statements and invoices.



Click on this button, enter the appropriate information, click on **Save** and **Add** for subsequent entries, then click on **OK** to save the last entry and exit the screen.

4.14. Add/Browse Reports

This area is used to add a report into your HERO database, for example a customized report created for you by HTN.

Click on this button, enter the appropriate information, click on **Save** and **Add** for subsequent entries, then click on **OK** to save the last entry and exit the screen.

4.15. Other Defaults

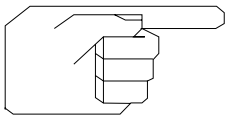
Several defaults are not located in the setup screen but are assigned in the particular areas where they occur. This includes patient chart numbers and several notes fields. Defaults in data fields (i.e. **Chart Number**) are set by positioning the cursor in the field, entering the data you wish to be the default and clicking on **EDIT ➔ PUT DEFAULT**. Defaults in notes fields (i.e. **Note 1** or **Note 2** in a patient record) are set by positioning the cursor in the note field, double-clicking to access the **Lookup:Defaults** table, clicking on **Add**, typing in the desired text, and saving the default under a unique name (notes fields support multiple defaults). These defaults are outlined throughout the manual (and are listed in the index under the "Settings Notes Defaults" heading).

5. Registration and Encounters

In this chapter we will discuss the mechanics of entering patients and generating claims using ***HERO***. Before we examine these options in detail, however, it will be necessary to launch ***HERO*** and log on a doctor. (***HERO*** supports multiple physicians and/or one physician will several aliases, on either a standalone machine or a local area network, which necessitates this step.)

HERO is usually launched via a shortcut on the Windows desktop, e.g. by double-clicking on it, or by highlighting it and pressing **ENTER**.

- Position the cursor on the long blank field in the upper-right corner of the screen to select a doctor. Double-click or right-click once to access the **Billing Doctor Lookup Table**.



There are several alternatives to right-clicking to access a Lookup Table. They include double-clicking, pressing F9, and selecting FILE ➔ LOOKUP in the Main Menu.

- Select a doctor either by highlighting the name and double-clicking, or highlighting and clicking once on the **OK** button.

This is the standard way to enter the program. You are now ready to register patients and generate claims.

As is true of all Windows software, there is a multitude of ways to perform *any* function in ***HERO***, and this is especially true of billing and patient records. Generally speaking, data is entered three ways:

1) *Manually* (typing in the information)

2) *Card-swipe* (using a magnetic card reader to bring in the information)

3) *Lookup tables* (using lookup tables to paste in information already stored in the system)

To successfully process a claim two conditions must be met: the patient must be *registered* (who was he or she), and there must be a record of the *encounter* (what happened). *Registration* occurs when you enter a patient into the patient database.

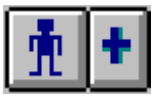
Similarly, an *encounter* occurs when you record a contact, complete with all data required by OHIP, between doctor and patient on a given service date.

5.1. Registering Patients

New patients can be entered into the system prior to billing (although, as we shall see, *core MOH* patient information is automatically saved when you enter a claim for a new patient in the billing area). The advantage to entering patient data first is that much more detailed information (i.e. address, telephone numbers, private insurance information etc.) can be recorded in this area. Additionally, if you wish to set default chart numbers, you must use the patient area to do so.

5.1.1. Patient Chart Numbers

If you wish to have chart numbers automatically assigned to patients you must enter a default in the patient information area.



Click once on the **Add Patients** icon.

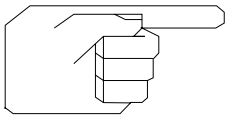
The **Patient Information - New Information** screen will be displayed.

- Enter a value of up to eight digits in the **Chart #** field (i.e. " 00000001 ").
- In the **Main Menu** select **EDIT ➔ PUT DEFAULT**. Click on **Yes** when prompted to overwrite the previous default.
- Click on **Cancel** to exit the **Patient Information - New Information** screen (the default information will already have been recorded).

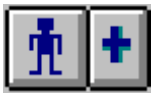
Chart numbers will be assigned in sequence, starting with the default starting number, every time you save a new patient entry.

5.1.2. Setting Notes Defaults

You may optionally enter one or more defaults for **Note 1** and **Note 2** in the patient record. This is handy if you have repetitive text that you would prefer to select and paste in when appropriate.



Although this is a discussion of setting defaults in the patient record, most notes-type fields in the program support this feature. This includes the new record form for Encounters, Appointments, and Mail.



List Patients **Add Patients**

Click once on the **Add Patients** icon.

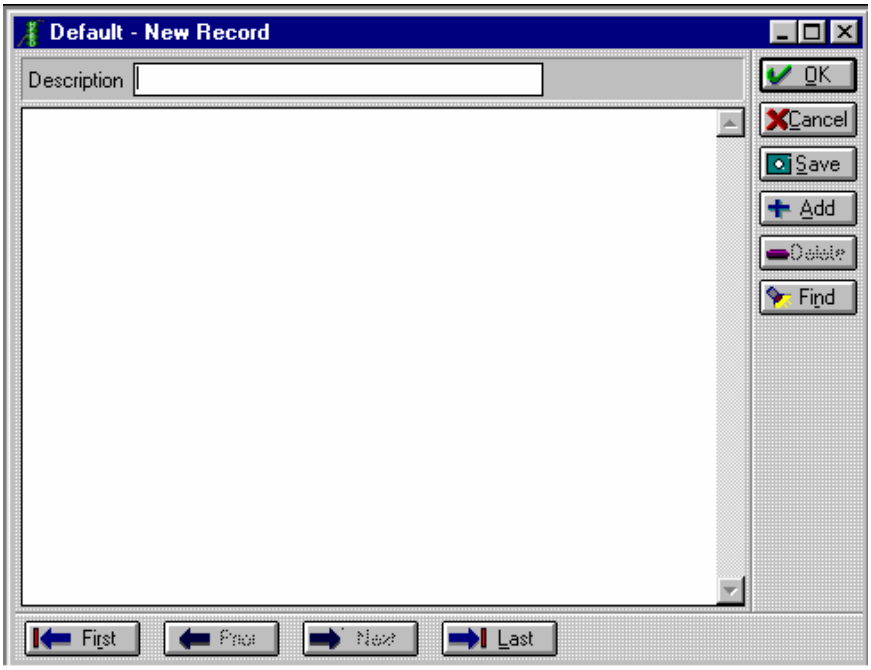
The **Patient Information - New Information** screen will be displayed.

- Click on the radio-button of the notes field (**Note 1** or **Note 2**) where you want to place the default text.
- Place the cursor in the notes field and double-click.

The **Lookup:Defaults** table will be displayed.

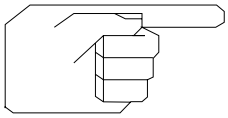
- Click on the **Add** button.

A screen resembling the illustration below will be displayed.



- Enter the desired text in the notes field. (This field will support up to 32K or 16 pages of text.)
- Enter a unique description for this template. (Notes defaults support multiple templates that can be applied as necessary.)

- To save this template but remain in the screen, click on **Save**.
- To save this template then add another, click on **Add**.
- To save this template and exit the screen, click on **OK**.
- To apply this template, double-click in the appropriate notes field to access the **Lookup:Defaults** table and select the template by double-clicking on the item. The text will be pasted in automatically.
- Click on **Cancel** to exit the **Patient Information - New Information** screen.



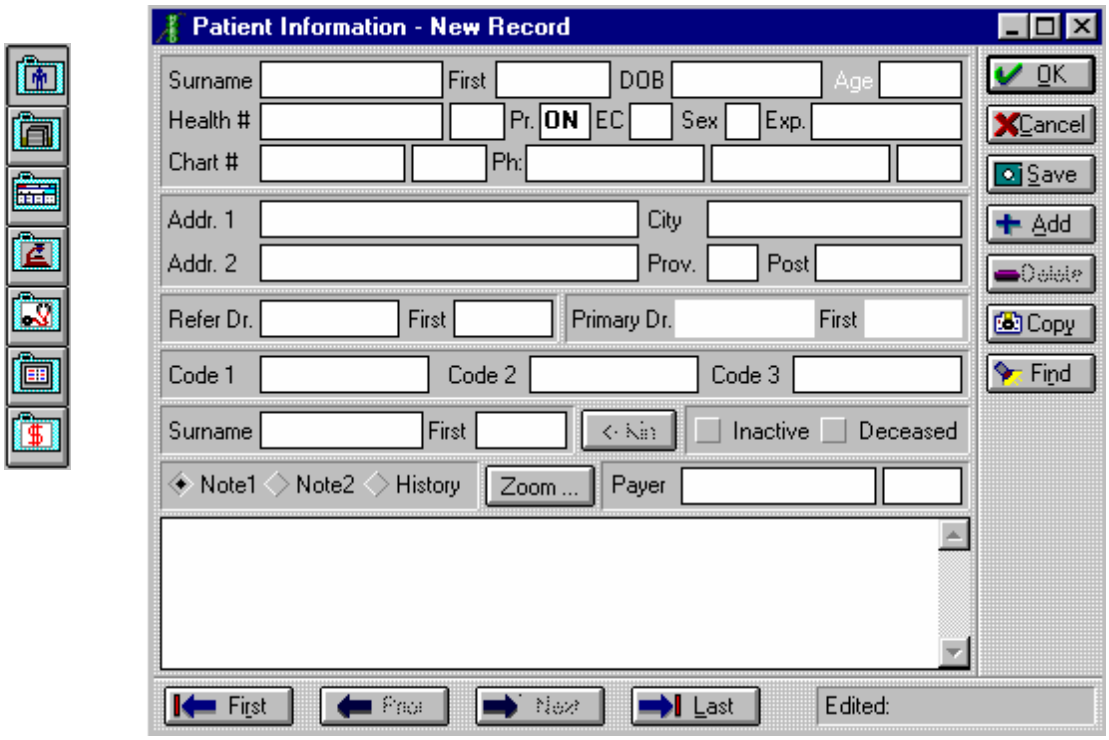
New notes defaults can also be set up on the fly while using an existing patient record.

5.1.3. Adding New Patients

To register a patient:

Click once on **Add Patients**.

The **Patient Information - New Record** screen, resembling the one below, should be displayed.



Consistent with the ***HERO*** interface, the patient area defaults to **Patient Information - New Record** with side-buttons that can be clicked on to access related patient information (i.e. billing, appointment records etc.). The necessary fields for generating a complete claim are: **Surname**, **First Name**, **Birthdate**, **Health Number**, **Province**, **Version Code** (if applicable), **Sex** and **Expiry Date** (if applicable). Most of this *core MOH* information can be typed in manually or brought in automatically by swiping a health card through a magnetic card reader. **Age** is calculated automatically by HERO on an ongoing basis. **EC** eligibility code is determined by the MOH during an OBEC cycle.

If using a magnetic card reader that connects via a keyboard or USB port, the **Read Input From Card-Reader** icon must be clicked first. If using a magnetic card reader that connects via a serial port, this is not necessary.

To advance the cursor from one field to another you may either click on each desired field in turn or press **TAB**.

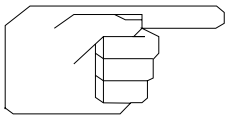
You will note next there are fields for chart number, phone numbers, and address. You may fill these in for purposes of your own record keeping. (If chart numbers have been set to a default, they will be pasted in when you save the record.) The **Refer Dr.** field may be entered at this time if you wish this information defaulted into every subsequent bill you generate for this patient. To enter a referring doctor, double-click on the **Refer Dr.** field and select from the pick-list. If you need to add a new referring doctor, click on the **Add** button on the list form and enter the appropriate information. **Primary Dr.** may be used in offices with more than one Dr. to indicate the primary physician. To enter a primary doctor, double-click on the **Primary Dr.** field and select from the pick-list. (The **Primary Dr.** will automatically default to the logged-in doctor, if applicable.)

The fields **Code 1, Code 2,** and **Code 3** are customizable to your particular needs. If, for instance, you wished to track a particular set of patient characteristics you would dedicate one of the code fields to that and make entries accordingly. To enter a code, double-click on the **Code 1, Code 2,** or **Code 3** field and select from the pick-list. If you need to add a code, click on the **Add** button on the list form and enter the appropriate information.

Double clicking on the next of kin Surname field and selecting from the pick-list. Will enter Next of Kin information.

The next two fields **Note 1** and **Note 2** are for any notes, miscellaneous comments etc. To enter, edit or view information in either note field click on the appropriate diamond.

The final notes field, **History** is *read-only* in this form. It contains a compilation of all entries made into the history fields of corresponding claims for this patient, and is presented in reverse chronological order. (Entering history notes in the billing area is covered later in this chapter.) This is extremely useful for reviewing anecdotals, ongoing notes etc. attached to claims.



Notes-type fields in *HERO* generally have the following characteristics:

- **If there is any information in the field, the title of the field is displayed in blue.**
- **To enter, edit or view the information on a larger area, click once on the Zoom button.**
- **Each note field can contain up to 32K (16 pages) of text.**

The **Payer** field is for use with private claims, when the patient may not be the person billed (i.e. a child whose parent is billed). Any entry made in this field will be the default payer when a private claim is entered for this patient.

When input has been completed, there are a number of options for saving the entry, depending upon what you want to do next.

- To save the entry and exit the **Patient Information - New Record** screen, click on the **OK** button.

- To save the entry but keep the **Patient Information - New Record** screen active, click on the **Save** button.

List Claims **Add Claims**

To generate a claim with this patient's information already pasted in, click on the **Save** button, then click on the **Add Claims** button.

- To save the entry and add a new patient, click on the **Add** button.

5.1.3.1.Error Checking

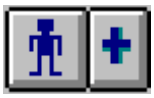
The program ensures that the core information of the patient record has been properly entered before proceeding. If Surname**, First Name, Birthdate, Health #, Province** or **Sex** haven't been entered; or the **Health #** is invalid, or already entered in the system, the program will prompt you to make the necessary additions or corrections.

5.1.4. <u>Editing Patient Information</u>

Periodically, you may find it necessary to update existing patient information either in the main patient information area (i.e. change of address) or in one of the other areas attached to the form (i.e. add or edit private insurance information).

There are two ways to edit patient information from within the patient information area.

5.1.4.1.New Patient Screen



Click once on **Add Patients**. The **Patient Information - New Record** screen will be displayed.

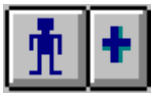
List Patients Add Patients

- Double-click on the **Surname**, **Health #** or **Chart #** fields select the appropriate record from the **Lookup: Patients** list and double clicking on it.

- Edit the record as necessary.

- Click on **Save** to save your work and remain in the form, or **OK** to save your work and exit the form.

5.1.4.2.Patient Lists



List Patients Add Patients

Click once on **List Patients**. An alphabetical patient list will be displayed.

- Locate and highlight the desired record by scrolling down (clicking and holding the down-arrow on the scroll-bar to the right of the list) or by typing in (part of) the patient's surname, phone number, chart number, or health number in the appropriate field below the list.

- Once the desired record is highlighted, double-click on it. A **Patient Information** screen will be displayed, with the current patient information pasted in.

- Edit the record as necessary.

- Click on **Save** to save your work and remain in the form, or **OK** to save your work and exit the form.

5.1.4.3.Associated Patient Information

Associated areas for a patient are available by accessing the **Patient Information** record, using either of the methods described above, and clicking on the appropriate side button. These side-buttons, and their functions, are listed below.

Patient Demographic Information (Default).

Patient's Insurer Information: allows you to browse, add and edit private insurance companies associated with the patient.

List Patient's Services: provides a list of all service items for the patient. Individual service items can be browsed/edited by double clicking on them.

List Patient's Lab Req's/Reports: provides a list of all lab items for the patient. Individual items can be browsed/edited by double clicking on them.

List Patient Encounters: provides a list of all patient encounters. Individual encounters can be browsed/edited by double clicking on them.

List Patient Appointments: provides a list of all patient appointments. Individual appointments can be browsed/edited by double clicking on them.

List Patient Financial Statements: provides a list of all patient financial statements, cross-referenced by type. Individual claims, payments etc. can be browsed/edited by double clicking on them.

5.1.5. Deleting Patient Records

There are some instances where it may be necessary to delete a patient record. Typically, this would be the case if a patient has been double entered into the system without a health number (the system will not allow double entry of a health number). You may delete a patient record *only* if the record has no subordinate items attached (i.e. claims, appointments etc.) If there are items attached you must first access those items and re-assign them to another patient or delete them.

To delete a patient record:

- Access the **Patient Information** record, using either of the methods described above.
- *While that record is open* click once on the **Delete** button.
- Click on **Yes** when you are prompted to confirm deletion.

5.1.6. Printing Patient Information

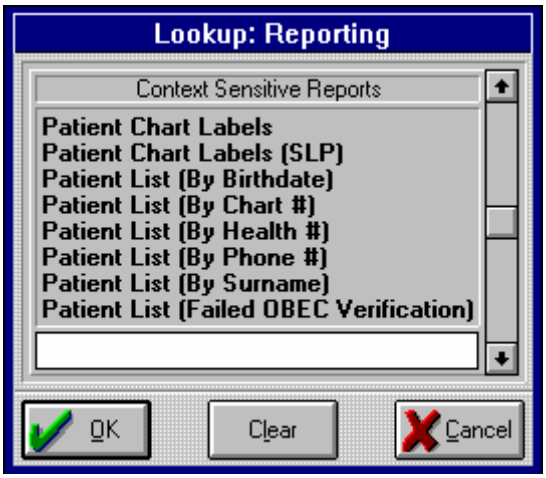
Various *context-sensitive* reports are available in this area. This is a subset of the full report list, containing only those reports that are relevant to this area. (For a more detailed discussion of ***HERO*** reports, please refer to Chapter 13: **Reports.)**

Print Reports

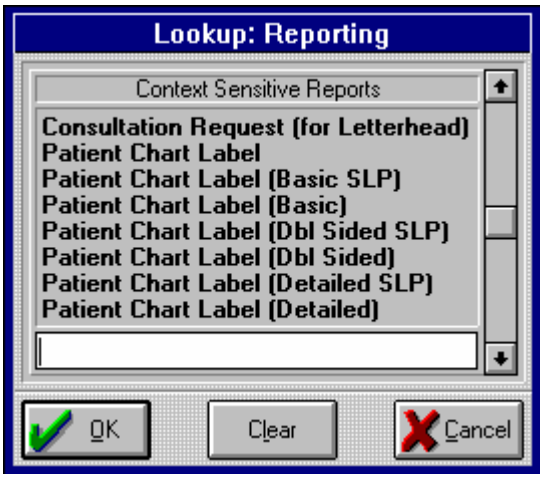
The **Print Reports** icon is used to print reports. By clicking on it while the area is active, it will either display a list of context-sensitive reports for the area, or, if only one report is available, display the print dialogue screen for that report.

Some samples of available reports for patient information, are shown below:

Patient List
(Patient Demographic)

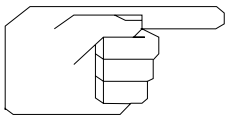


Individual Patient Record
(Looked up or newly saved)



- To select a report, scroll down using the scroll-bar to the right of the list if necessary, and double-click the desired item.
- Select a printer other than default if necessary.
- Enter a **From** and **To** date if necessary (as would be the case if you wished to generate a monthly report and want the balance adjusted accordingly). Otherwise the report will default to beginning of time to the present.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the report output before printing.
- Click on **OK** to proceed.

Depending on the options selected, the report will either print out immediately or after a preview and print command.



Other reports are available in areas accessed through the side-buttons, but are covered in their own chapters. For instance, *all* reports associated with private billing (invoices, receipts, statements etc.) are dealt with exhaustively in Chapter 7: Private Billing.

5.2. Generating Claims

List Claims **Add Claims**

All claims are entered in the **Patient Claim: New Record** screen, which is accessed either by clicking on the **Add Claims** button or swiping a health card.

(A card-swipe usually brings up a new claim record with core MOH information pasted in unless you are in a **Patient Information - New Record** screen, in which case it will paste the information into that form. However, if desired, your ***HERO*** can be configured to *always* bring up a **Patient Information - New Record** screen whenever a card is swiped.)

The **Add Claims** button has *context-sensitive* capability, which means it, will paste in core MOH patient information if another screen (such as patient information or scheduling) is active. We have already seen one such example in the previous section.

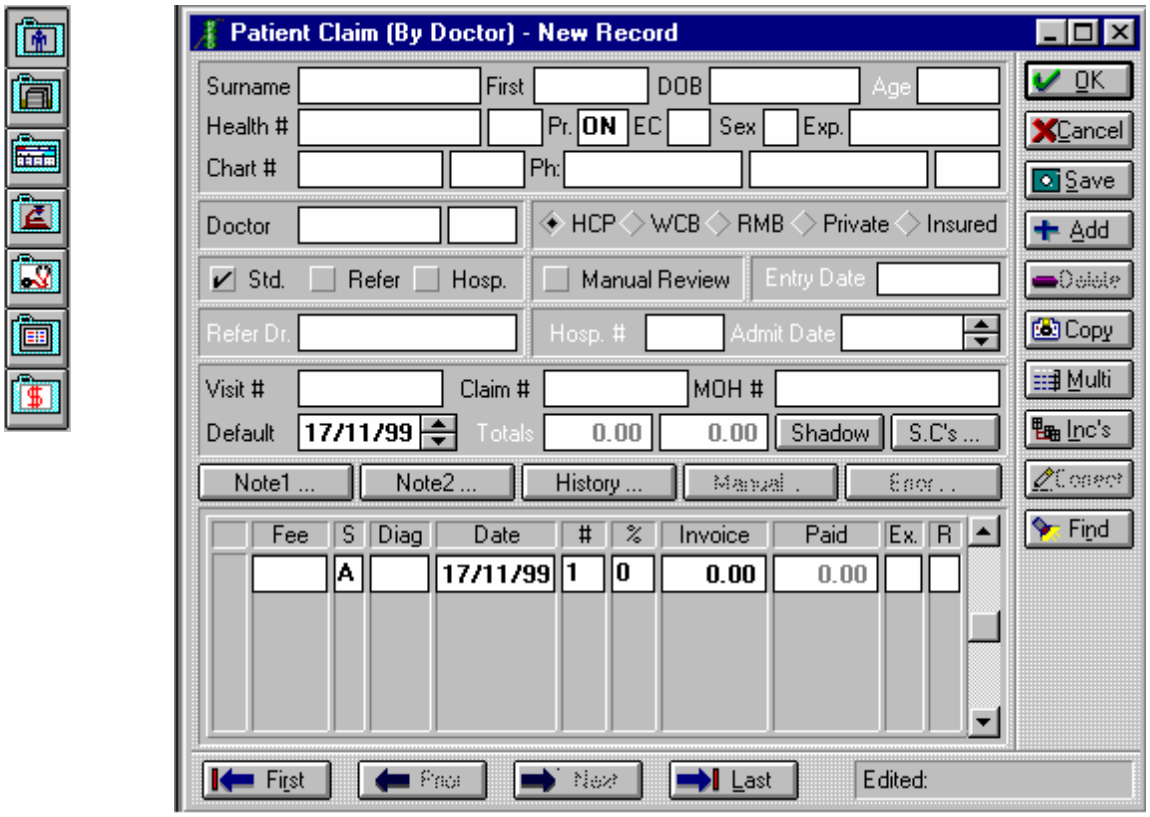
Read Input From Card-Reader

(If using a keyboard type magstripe reader, the **Read Input From Card-Reader** icon must be clicked first.)

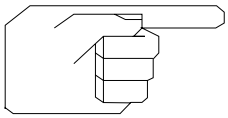
5.2.1. The New Claim Form

A screen, resembling the one below should be displayed. You may enter claims for a new (unregistered) patient or for a patient already entered into the system.

If a card is swiped, the **Surname**, **First Name**, **Birthdate**, **Health Number**, **Province**, **Version Code** (if applicable), **Sex** and **Expiry Date** (if applicable) will be filled in automatically. If the patient is already in the database and a discrepancy exists (such as new version code), you will be prompted to update the information.



If a card is *not* swiped (Add **Claim** button is pushed) the **Surname**, **First Name**, **Birthdate**, **Health Number**, **Province**, **Version Code** (if applicable), **Sex** and **Expiry Date** (if applicable) will be blank. For a *new* patient, this information must be entered manually. If the patient is already in the database, the information can be pasted in by double clicking on the **Surname**, **Health #** or **Chart #** fields, selecting the appropriate record from the **Lookup: Patients** list and double clicking on it.



If you in any other area of the program with a patient record active (i.e. Patient Schedule, Patient Encounter etc.) and click on the Add Claim icon, the core patient information will automatically be pasted into the form.

In either case the logged-on doctor and default date will be pasted in. (The billing date defaults to the *last* date entered, and is pasted into all service items in the claim. The default date can be changed, as can the individual dates on the service items.)

The screen is divided into sections. These divisions, in fact, are determined by the logic of the program.
For instance, the top section is comprised of biographical information about the patient, pasted in from a card swipe, an existing patient record, or manually entered in this form. The **Doctor** and **Alias** fields reside in their own section because they are drawn from only one place, the **Billing Doctor Lookup Table**.

The next section is devoted to billing *classifications.* They are, respectively:

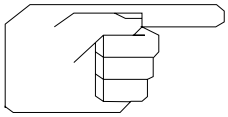
HCP : Health Care Provider — OHIP
WCB: Workman's Compensation Board
RMB: Reciprocal Medical Bill
Private: Private
Insured: Private Insurance Companies

These buttons are *mutually exclusive*, which means selecting one automatically disables all the others.

The next section deals with the *type* of encounter. It is defaulted to **Standard**. You will note that the next two sections are grayed out and that entries cannot be made in them. This is because, by definition, Standard Encounters require neither a referring doctor or any institutional information. The next button, **Refer**, is pressed in the case of a **Referred Consult**, and once clicked, will allow input into the **Refer Dr.** field (which will no longer be grayed out).

The next button, **Hosp**, is pressed in the case of a Hospital Encounter, where a hospital number and/or admission date will be required. The section containing **Hosp. #** and **Admit Date** will no longer grayed out and will accept input to those fields.

Referred Consult and **Hospital Encounter** are *not* mutually exclusive and are in fact quite a common combination. Therefore they can be pressed individually or together.



This is the essence of the " smart form " feature. Throughout the form, as you select the *classification* and *type* of bill you wish to generate, the program makes the necessary fields available for input, grays out unnecessary fields, and disables contradictory buttons.

This section contains the button for **Manual Review**. This button can be pushed in combination with any valid combination of billing classification and type, and indicates to OHIP that there is something unusual about this bill and that they should defer processing it pending receipt of supporting documentation from your office. Some examples of this would be:

⇨ If the Fee Code is one that *always* requires an explanatory letter before OHIP will process the claim. Two examples of this are K001A (detention) and K101A (detention with a patient while in an ambulance).

⇨ If there were unusual circumstances that required the doctor to submit fee codes that would not normally be submitted. For example, if a surgeon uses more than one assistant for a particular surgery, the second assistant will require a letter from the surgeon justifying his or her participation in order for OHIP to process the bill.

⇨ If the doctor sees the same patient twice in one day, OHIP tends to reject the second bill in the absence of a letter of explanation. Another variation of this is billing both a **WCB** and **HCP** visit for the same patient on the same day.

When you elect to submit a manual review, a note field pops up into which you may enter your notes. These notes can be printed out when the claim is batched (you are prompted at batch time) or any time thereafter by accessing the **Financial Reports** area.

The next four fields: **Refer Dr., Hosp. #, Admit Date** and **Visit #,** are *contingent* fields that depend on choices made regarding billing type.

Visit #, Claim # and **MOH #** are tracking fields that are generated automatically at different stages of processing: The claim number when you first save the bill, the MOH number when **HERO** has processed a Remittance Advice file containing that bill.

The **Default** field defaults to the last billing date entered, and is pasted into all service items in the claim. The default date can be changed, as can the individual dates on the service items.

Totals displays the sum of all billed service items for the claim, and all remittances against the claim respectively.

The [Shadow] button is for specialized use by Doctors in remote locations.

The [S.C's ...] button allows you to create and retrieve custom combinations of Fee Codes that recur on a regular basis. The mechanics of adding and pasting in a SuperCode is discussed later in this chapter.

The next two fields **Note 1** and **Note 2** are for any notes, miscellaneous comments etc. To enter, edit or view information in either note field click on the appropriate button.

The final notes field, **History** is a special field for entering anecdotals, comments etc. that you wish compiled into the patient record.

The **Manual Review** button allows you to edit any manual review notes already entered on this claim for this patient.

The box near the bottom of the form allows the entry one or more service items in the claim. The entry fields include **Fee Code, Billing Suffix, Diagnostic Code** and **Date** (these are the basic fields that will be dealt with in detail later in this chapter).

The **#** field allows for the entry of *units*—some types of claims (i.e. some surgical procedures) are structured in 15 minute units.

The **%** field allows for the entry of a percentage of the claim, if it was split between (say) insured and private billing.

The **Invoice** field displays the value of the claim once it is entered.

The following two fields display information *after* the reconciliation is run. **Paid** displays the actual amount paid, **Ex.** is reserved for error codes and will only contain a code if the claim was rejected.

R allows you to archive your claim. This is usually used to reconcile a claim that has been paid less than requested by OHIP.

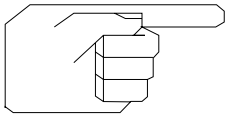
The bottom row of buttons are for navigating through all billing records for this patient in full-screen mode.

5.2.2. Types of Encounters

In this section we will examine the following types of encounters in detail:

- ⇨ Standard Encounters
- ⇨ Referred Consults
- ⇨ Hospital Encounters
  - 🗀 Individual Billing
  - 🗁 Same fee codes on Multiple Dates
- ⇨ Reciprocal Billing

All encounters begin the same way, with the entry of biographical information in the first section of the **Patient Claim [by Doctor] New Record** form, as outlined in the previous section.



Private and Insured type claims require some initial setup in other areas of the program, and contain reporting and accounting features outside the scope of MOH billing. A complete discussion of these modules is contained in Chapter 7: Private Billing and **8: Insured Billing.**

5.2.2.1.Standard Encounters

Standard Encounters, as the name suggests, are the most straightforward type of claim, typically an OHIP or Workman's Compensation Board bill that requires neither a referring doctor nor any institutional information.

Examples of this would be a patient's visit to a General Practitioner's office (A007A and G010A), a housecall to a patient's home (A001A and B990A), a follow-up WCB visit (A004A and G372A), or, in the case of specialists, those visits such as partial assessments and general re-assessments where OHIP does not require a referring doctor number.

To generate a Standard Claim:

- Access the **Patient Claim [by Doctor] New Record**.

- Enter patient biographical information. Or, for non-patient specific claims (e.g. Primary Care Incentive Payments), enter the Health # as 0000000000. You can make up ANY values for patient name (e.g. "Incentive Payments") birth date (e.g. January 1, 2000), and sex.

- The **Doctor** field should contain the billing physician for this case. If the incorrect physician is entered, double-click on the Doctor field. When the **Lookup:Billing Doctors Table** is displayed, select the correct physician by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

- Select either **HCP** (OHIP) or **WCB** (Workman's Compensation Board).

- Do not click on **Manual Review** unless there are special circumstances regarding the claim that will require a written explanation to OHIP before it can be processed.

- The **Default** field defaults to the last billing date entered, and is pasted into all service items in the claim. The default date can be changed, as can the individual dates on the service items. Accept the default date or change it by entering a new date or double-clicking on the field a selecting a new date from a popup calendar.

- The **Patient Claim [by Doctor] New Record** form automatically defaults to a Standard Claim configuration, so accept the remaining defaults.

- The lower right hand section of the screen is the box for inputting Diagnostic and Fee codes. The cursor should be automatically placed in the **Fee** (Billing Code) field.

There are several ways to enter a Fee Code. If you already know the appropriate code you can just type it in. If, however, you don't, you can look up then paste in the appropriate code by accessing a **Lookup Table**.

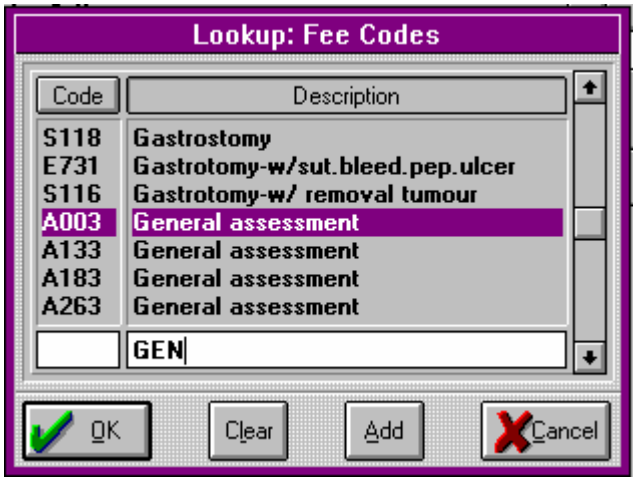
- Double-click on this field, click once with the right mouse button, or press **F9**.

The **Fee Code Lookup Table** is displayed. The fastest way to select a Fee Code, is by *progressive search*. Suppose you wish to enter the Fee Code for General Assessment:

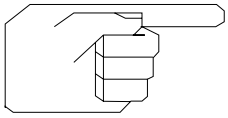
- Click once *below* the **Description** column.

- Type the letters "GEN" in the field below the **Description** column.

The cursor moves to the first record that matches the string, *progressively*, as you enter successive letters. When you arrive at the desired record (usually between two and four keystrokes) you can enter it into your claim.



- Click once on the **OK** button or double-click on the highlighted entry to enter this Fee Code item into your claim.



The context-sensitive Lookup feature is available throughout the program. The *quickest* way to access a Lookup Table is to double-click on the appropriate field, but it can also be accessed by clicking once with the right mouse button, or pressing F9. The *progressive search* feature is available on all Lookup Tables.

If your claim requires a Diagnostic Code:

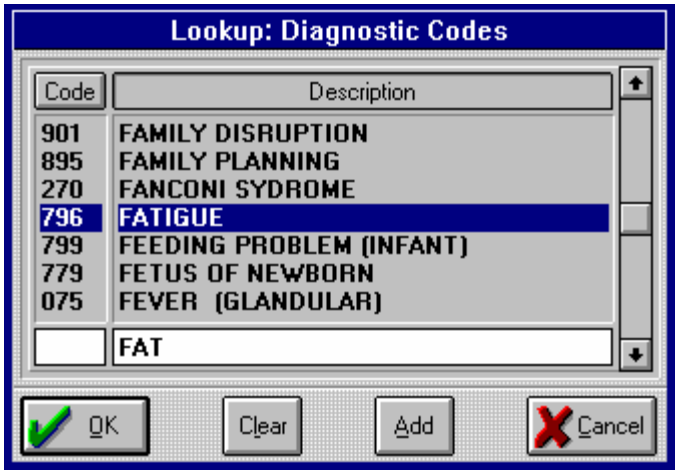
As with the Fee Code, there are several ways to enter a Diagnostic Code. If you already know the appropriate code you can just type it in. If, however, you don't, you can look up then paste in the appropriate code by accessing a **Lookup Table**.

- Double-click on this field, click once with the right mouse button, or press **F9**.

The **Diagnostic Code Lookup Table** is displayed. Once again we will use *progressive search* to locate a code. Suppose you wish to enter the Diagnostic Code for fatigue:

- Click once on the field *below* the **Description** column.

- Type the letters "FAT" in the field below the **Description** column.



The cursor moves to the first record that matches the string, *progressively*, as you enter successive letters. When you arrive at the desired record (usually between two and four keystrokes) you can enter it into your claim.

- Click once on the **OK** button or double-click on the highlighted entry to enter this Diagnostic Code item into your claim.

The **Date** field defaults to the date displayed in the **Default** field. This date can be changed individually if necessary (i.e. if you have multiple service items on different dates).

- Accept the default date or change it by typing in a new date or double-clicking on the field and selecting a new date from a popup calendar.

- If you wish to enter additional service items, click once on the down-arrow on the scroll bar to the right of the billing area or press the down-arrow key once, then repeat the above steps.

- To save the entry and exit the billing screen, click on the **OK** button.

- To save the entry but keep the billing screen active, click on the **Save** button.

- To save the entry and add a new claim, click on the **Add** button.

5.2.2.2.Referred Consults

The Referred Encounter type includes those Fee Codes that must be accompanied by a referring doctor number in order for OHIP to process the bill. As a general rule the following Fee Codes require a referring doctor number:

⇨ Consultations (A005A, A135A, A315A)
⇨ Limited Consultations (A675A, A385A, A545A)

⇨ Repeat Consultations (A006A, A036A, A196A)
⇨ Referred diagnostic/laboratory services

To generate a Referred Consult Claim:

- Access the **Patient Claim [by Doctor] New Record** and enter patient biographical information.

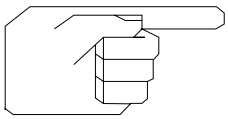
- The **Doctor** field should contain the billing physician for this case. If the *incorrect* physician is entered, double-click on the **Doctor** field. When the **Lookup:Billing Doctors Table** is displayed, select the correct physician by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

- Select either **HCP** (OHIP) or **WCB** (Workman's Compensation Board).

- In the next section, click once on **Refer**. You will note that the **Refer Dr.** field below is no longer grayed out.

- Do not click on **Manual Review** unless there are special circumstances regarding the claim that will require a written explanation to OHIP before it can be processed.

- In the **Refer Dr.** field enter the referring doctor's name by accessing the **Lookup:Referring Doctor Table.** This is accomplished by double clicking on the field, clicking once with the right mouse button, pressing **F9**, or clicking once on the **Find** button.



If the referring doctor in question hasn't yet been entered in the LOOKUP:BILLING DOCTORS Table, click once on the ADD button. The REFERRING DOCTOR - NEW RECORD Table will be displayed. Enter the doctor's surname, first name and unique six-digit number, then click once on OK to save the entry. The PATIENT CLAIM [BY DOCTOR] NEW RECORD will be re-displayed. Repeat the previous step to access the LOOKUP:BILLING DOCTOR Table and select the new entry.

- Select the referring doctor by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

- The referring physician has been pasted into the Refer Dr. field.

- Add Fee Code and Diagnostic Code information using the steps outlined in the ***Standard Encounters*** section.

- To save the entry and exit the billing screen, click on the **OK** button.

- To save the entry but keep the billing screen active, click on the **Save** button.

- To save the entry and add a new claim, click on the **Add** button.

5.2.2.3.Hospital Encounters

Hospital Encounters include work done at hospitals, long-term care homes, and any other institutions that have a unique four-digit code. As mentioned before, selecting this option does not necessarily preclude *also* selecting the **Referred Consult** option.

In this section we will also examine the program's ability to generate the same Fee Codes over multiple dates. Although this feature is not *restricted* to the Hospital Encounter Option it is most commonly used in this context, when the doctor will be performing repetitive tasks at a hospital or institution.

5.2.2.3.1.🗀 Individual Billing

To generate a Hospital Encounter Claim:

- Access the **Patient Claim [by Doctor] New Record** and enter patient biographical information.

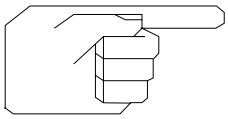
- The **Doctor** field should contain the billing physician for this case. If the *incorrect* physician is entered, double-click on the **Doctor** field. When the **Lookup:Billing Doctor Table** is displayed, select the correct physician by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

- Select either **HCP** (OHIP) or **WCB** (Workman's Compensation Board).

- In the next section, click once on **Hospital**. You will note that the **Hosp #** and **Admit Date** fields are no longer grayed out.

- Do not click on **Manual Review** unless there are special circumstances regarding the claim that will require a written explanation to OHIP before it can be processed.

- In the **Hosp #** field enter the unique four-digit institution code by accessing the **Lookup:Hospitals Table**. This is accomplished by double clicking on the field, clicking once with the right mouse button, or pressing **F9**.



If the hospital or institution hasn't yet been entered in the LOOKUP:HOSPITAL Table, click once on the ADD button. The HOSPITAL - NEW RECORD Table will be displayed. Enter the unique four-digit number and a description, then click once on OK to save the entry. The PATIENT CLAIM [BY DOCTOR] NEW RECORD will be re-displayed. Repeat the previous step to access the LOOKUP:HOSPITAL Table and select the new entry.

- Select the hospital by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

The unique four-digit code has been pasted into the **Hosp #.** field.

- Add Fee Code and Diagnostic Code information using the steps outlined in the ***Standard Encounters*** section.

- To save the entry and exit the billing screen, click on the **OK** button.

- To save the entry but keep the billing screen active, click on the **Save** button.
- To save the entry and add a new claim, click on the **Add** button.

5.2.2.3.2.🗁 Same Fee Codes on Multiple Dates

A common type of encounter is that where a doctor records the same Billing and Diagnostic Codes for the same patient over multiple days. Examples would be weekly visits to a Nursing Home (W002A) or daily hospital rounds to visit an in-patient (C002A). Once again, *Hospital Encounters is not the only option in which this feature can be used*, it is merely the most common. You could enter all service items in one claim and adjust the dates manually but a quicker method is to use the **Copy** command.

To generate multiple Hospital Encounter Claims for the same patient:

- Create a simple Hospital Encounter Claim per instructions in the previous section.
- Add Fee and (if necessary) Diagnostic Codes for one or more service items for the *first* date. (*Important: Enter only service items for one date, and ensure they are all for the same date.*)

When the bill is complete press the **Save** button to save your work, but remain within this screen.

Press the **Copy** button once.

- Click on the desired dates from the popup calendar to select the other dates for the claims. You may use the adjacent arrow keys to select other months if desired.
- Click on **OK** once all dates have been selected.
- You will be prompted with the number of claims that will be entered. Click on **Yes** to accept or **Cancel** to cancel the operation.

The claims for the desired dates will be saved.

The **Multi** button operation is similar to **Copy** but will enter *multiple copies of the selected service item into a single claim* rather than generating multiple claims.

5.2.2.4.Reciprocal Billing

Reciprocal, or out-of-province, billing allows you to generate bills for those medically insured patients who live in Canada, with the exception of Quebec. The billing and Diagnostic Codes used for reciprocal billing are the same as those used for billing Ontario residents. In fact the only two essential differences are an entry in the **Province** field and clicking on the **RMB** (Reciprocal Medical Billing) button in the **Patient Claim [by Doctor] New Record** form.

To generate a Reciprocal Billing Claim:

- Access the **Patient Claim [by Doctor] New Record.** Enter patient biographical information *manually* (out-of-province cards *cannot* be swiped .)

- In the **Province** field double-click to access the **Lookup:Provinces Table**.

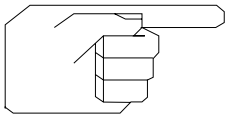
- Select the appropriate province by highlighting and double clicking or clicking once on the **OK** button.

The correct province abbreviation is pasted into the **Province** field.

- The **Doctor** field should contain the billing physician for this case. If the *incorrect* physician is entered, double-click on the **Doctor** field. When the **Lookup:Billing Doctor Table** is displayed, select the correct physician by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

- The **RMB** (Reciprocal Medical Billing) radio button will automatically be selected when you change the province entry to anything but Ontario.

The Reciprocal Medical Billing classification precludes neither the Referred Consult nor the Hospital Encounters option.



The program will only accept registration numbers that are of a specified length for each province. As such, if it is refusing entry, it is possible there is an error in either the Health # field or the Province field.

- If appropriate, click on the **Refer** and/or **Hosp.** checkboxes and enter the relevant information per instructions in the ***Referred Consult*** and/or ***Hospital Encounters*** sections.

- Add Fee Code and Diagnostic Code information using the steps outlined in the ***Standard Encounters*** section.

- To save the entry and exit the billing screen, click on the **OK** button.

- To save the entry but keep the billing screen active, click on the **Save** button.

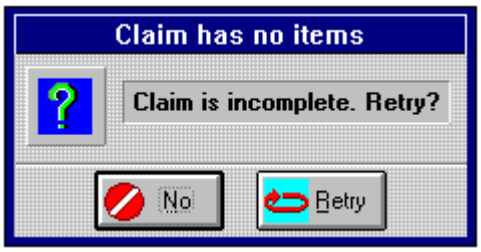
- To save the entry and add a new claim, click on the **Add** button.

5.2.3. Error Checking

When you attempt to save a claim, one of three things will happen:

1. If there is a missing, invalid or duplicated field in the *core* information, the program will flag it as such and prevent the claim from being saved. This includes basic fields such as **Surname, First Name, Birthdate, Health #, Province** and **Sex** You may at that point elect to **Retry** (fix the error) or **Cancel** to exit without saving.

2. If there is missing required *billing* information such as **Fee Code** or fields required by the *type* of **Fee Code** you have chosen such as **Hospital #, Admit. Date, Refer #** and/or **Diagnostic Code**, the program will flag it. At that point you may either edit the entry or save it as is.



   Without further editing it will be placed in the **Incomplete Claims List**, *and will not be batched until it is corrected*. (For further details on editing claims please refer to Section 5.2.5: **Editing A Claim**)

3. If the claim satisfies the error-checking routines of the program it will be placed in the **Complete Claims List** and will be included in the next batch for transmission.

5.2.4. SuperCodes

In most practices there are combinations of Fee Codes that recur on a regular basis. One example of this would be B991 (Housecall) and A007 (Intermediate Assessment). Rather than input these codes manually each time, you could create a *SuperCode* that would automatically paste them in each time it was retrieved.

5.2.4.1.Adding a SuperCode

- Access the **Patient Claim [by Doctor] New Record** form.

Click once on the **SuperCodes** button located just above the **Fee** and **Diagnostic Codes** table in the lower-right section of the form.

The **Lookup:SuperCodes Table** is displayed.

Click once on the **Add** button to create a SuperCode.

The **SuperCode-New Record Table** is displayed.

Selecting the Fee Codes (and, if required, Diagnostic Codes) that will comprise the SuperCode is basically the same operation as selecting Fee Codes for the **Patient Claim [by Doctor] New Record** form.

- In the **Code** field enter a unique name (can be any combination of letters and numbers) that will identify the code.

- In the **Description** field enter a short description of the code.

The rest of this Table is identical to the **Fee Code** and **Diagnostic Code Table** in the **Patient Claim [by Doctor] New Record** form, and follows the same rules of selection.

- Place the cursor in the **Fee** field either by clicking on it or pressing **TAB**.

- Right-click or double-click to access the **Lookup: Fee Codes** Table.

- Select a Fee Code by highlighting the appropriate item and either double-clicking or pressing **ENTER**.

The appropriate Fee Code will be pasted into the first line of the Table.

- If a Diagnostic Code is necessary, advance the cursor to the **Diag** field and, using the above steps, paste it in.

- To enter a second Fee Code press the **DOWN-ARROW** key once and repeat the above procedure.

- When all the required codes have been entered press **OK** to save your entries and exit the screen.

5.2.4.2.Using A SuperCode

- Using either the Quick Entry or Manual Entry option, access the **Patient Claim [by Doctor] New Record** form.

- If the basic patient information isn't already pasted in (i.e. if you are using manual entry), enter it, then advance the cursor to the **SuperCodes** button.

Click once on the **SuperCodes** button located just above the **Fee** and **Diagnostic Codes** table in the lower-right section of the form.

The **Lookup:SuperCodes Table** is displayed.

- Select a SuperCode by highlighting the appropriate item and either double-clicking or pressing **ENTER**.

All Fee and Diagnostic Codes contained in the SuperCode are pasted into the **Patient Claim [by Doctor] New Record** form.

5.2.5. Editing A Claim

Claims *that have not already been batched* can be edited at any time. (For a complete discussion of adjusting claims after they have been batched please refer to Chapter 6: **Transmitting, Receiving and Adjusting MOH Files**.) These claims are located in either the **Complete Claim** or **Incomplete Claim** areas.

To access these areas:

List Claims **Add Claims**

Click once on **List Claims**. The **Billing Records** screen, defaulted to the **HCP/WCB/RMB** (MOH type billing) view of the **Complete Claims List**, is displayed.

The **Complete Claims List** is displayed by default. A **Complete Claim** is any encounter that satisfies the error-checking routines of the ***HERO*** program and is ready for batching.

An **Incomplete Claim** is any encounter that *does not* satisfy the error-checking routines of the ***HERO*** program and will not be transmitted unless it is edited to satisfy the error checking routines.

- Click on these side-buttons to access either a list of **Complete** or **Incomplete** claims.

- Select the claim by double clicking on it.

The **Patient Claim** screen is displayed.

- Edit information by clicking on the appropriate field and either overwriting it or re-selecting from a pick-list. Enter missing information (i.e. Billing Code, Diagnostic Code, field required by the Billing Code), if necessary.

- Click on **OK** when finished.

If the edited claim satisfies the error-checking routines of the program it will remain in (or be moved to) the **Complete Claims** area, if it does not, and there is no further editing, it will remain in (or be moved to) the **Incomplete Claims** area.

5.2.5.1.Associated Patient Information In Claims

Associated areas for a patient are available by clicking on the appropriate side button, while a **Patient Claim** is active. These side-buttons, and their functions, are identical to those found in the **Patient Information** area. For further details on browsing or editing associated areas, please refer to Section 5.1.4.3 **Associated Patient Information**.

5.2.6. Deleting a Claim

- Access the claim using the steps outlined above

The **Patient Claim** screen is displayed.

- Click on the **Delete** button.

- Click on **OK** when you are prompted to confirm deletion.

5.2.7. Printing Claim Information

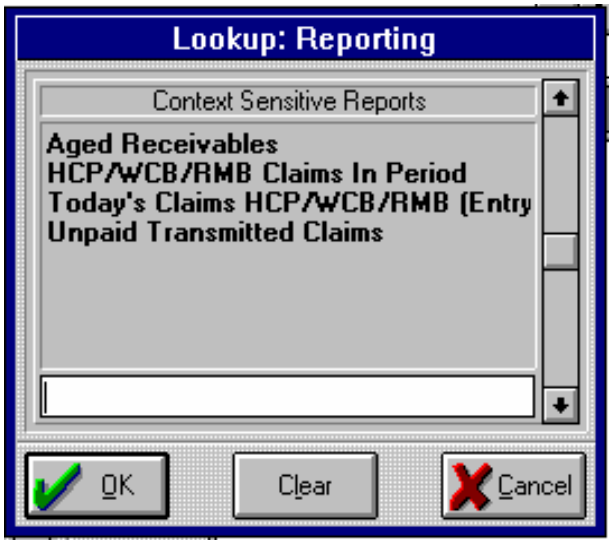
Several *context-sensitive* reports are available in this area. This is a subset of the full report list, containing only those reports that are relevant to this area. (There are numerous other reports available in the General Reports area. For a more detailed discussion of ***HERO*** reports, please refer to Chapter 13: **Reports.)**

List Claims **Add Claims**

Click once on **List Claims**.

Print Reports

The **Print Reports** icon is used to print reports. By clicking on it while the area is active, it will either display a list of context-sensitive reports for the area, or, if only one report is available, display the print dialogue screen for that report.



- To select a report, scroll down using the scroll-bar to the right of the list if necessary, and double-click the desired item.
- Select a printer other than default if necessary.
- Enter a **From** and **To** date if necessary (as would be the case if you wished to establsih date parameters for a **HCP/WCB/RMB Claims In Period** report). Otherwise the report will default to beginning of time to the present.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the report output before printing.
- Click on **OK** to proceed.

Depending on the options selected, the report will either print out immediately or after a preview and print command.

6. Transmitting, Receiving and Adjusting MOH Files

HERO allows you to transmit your claims (via modem or Internet) to the HERO network, where they in turn are forwarded to the Ministry of Health (hereafter referred to as MOH). By a similar process, you will receive remittance advices as soon as they are provided to the HERO network by MOH. You will be notified by e-mail when this occurs.

In this chapter we will discuss:

- ⇨ The transmission cycle
- ⇨ Batching and transmitting claims
- ⇨ Processing Remittance Advices
- ⇨ Post-Batch adjustment of claims
  - ⇨ Rejected Claims (Payment Discrepancies)
  - ⇨ Reconciled Claims (Payment Discrepancies)
  - ⇨ Batched Claims (Error Reports received on paper)
  - ⇨ Error Claims (Error Reports received by EDT)
- ⇨ Printing Financial Reports
- ⇨ Undoing batches and claims

6.1. The Transmission Cycle

In order to put the mechanics of transmitting, receiving and adjusting claims into context it is important to understand the overall transmission cycle. This is the path your data follows from initial transmission to final reconciliation based on HERO reports.

The following scenario tracks the progress of a batch of claims. There are three distinct levels of error-checking within the cycle — the ***HERO*** program level, the HERO Network level, and the ***Ministry of Health (MOH)*** level — and the particular status of any claim depends on whether it contained any errors, and, if so, what level of error-checking flagged it. *All* of the variations will be dealt with later in the chapter, but for now let's summarize the simplest form of transmission cycle.

1. Your claims are transmitted to ***HERO Network Services.*** Only claims that contain the necessary basic billing information, and are free of internal conflicts are transmitted.

2. HERO processes the claims and submits them to MOH.

3. MOH processes the claims, checking them against a much more extensive database containing, among other things, the names, birth dates and Health Card numbers of every resident in Ontario. MOH then transmits a record of payment

(the RA file) back to HERO. Claims that have tripped a demographic error (i.e. incorrect Health Card number) are returned to the physician as ***error reports*** **and are** *not contained* **in the RA file.**

4. HERO processes the MOH RA file and directs individual RA files to the appropriate doctor's " out-box " on the HERO network where they are automatically downloaded for reconciliation processing during the next transmission session.

The balance of this chapter is devoted to examining each phase of the transmission cycle in detail. You are encouraged to refer back to the summary if any particular operation seems unclear to you in terms of the " big picture. "

6.2. Batching Claims

Once claims have been entered, before they can be transmitted they must be " batched ", that is, translated into MOH file format and marked as ready for transmission.

To batch claims:

Click once on the **Add Batch** icon.

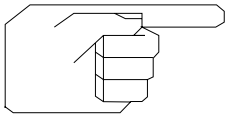
The **Batch** screen is displayed. It consists of a display area at the top, rows of command buttons, and a list of all billing doctors at the bottom.

Bill Claims takes all outstanding selected claims, translates them into MOH input code, then generates an MRI (Machine Readable Input) file that is stored on your hard drive and flagged as ready for transmission.

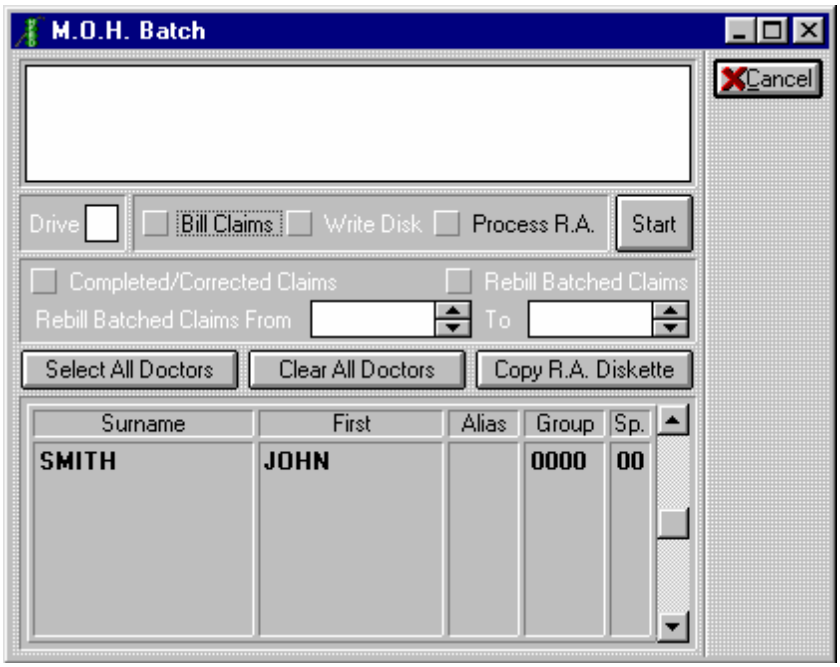
Process RA processes the remittance advice (RA) file downloaded from the HERO network. This option will be dealt with in the next section.

You may select one or more of the following claim types:

- **Complete/Corrected Claims** will batch all Completed Claims and Corrected Claims for transmission.
- **Rebill Batched Claims** will batch *previously transmitted but to date unreconciled* claims for transmission.



When using Rebill you must enter a From and To date in the fields below it. This sets the date parameters (i.e. all claims within these dates) that will be batched.



- Click once on **Bill Claims**.
- If this batch will be sent on disk (e.g. for a locum) instead of by EDT, click once on **Write Disk**, and make sure the correct floppy disk drive (e.g. A) is selected under **Drive**.
- Select the doctor(s) whose claims you wish to batch by clicking on the name.
- Select the type of claim you wish to batch/copy by clicking on the **Complete**/ **Corrected Claims** or **Rebill Batched Claims** buttons.
- Click on the **Start** button.

There should be a rolling display of the batched items. When batching is completed a message will appear asking if you wish to print a batch report (Post-Batch Preparation). This is a detailed report of all batched claims that can be very useful in day-to-day tracking. (If you elect *not* to print a Post-Batch Summary at the time of batching, but require it at a later date, you can access it through the **Financial Reports** area. For details, please refer to Section 6.7: **Financial Reports**.)

- Select **Yes** or **No** to complete the operation.

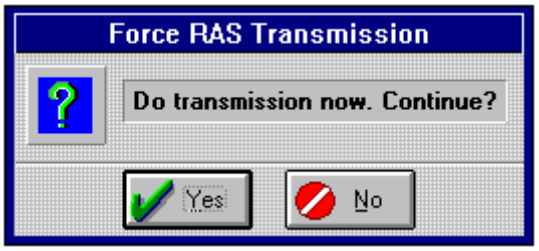
Depending on the options selected, all claims in the **Complete/Corrected Claims** or **Rebill Batched Claims** area at the time of batching will be moved to **Batched Claims**.

6.3. Transmitting Claims

Transmissions of all data (i.e. claims, e-mail etc.) occur in one of two ways: manual or scheduled. NOTE: Transmissions do *not* include billing for doctors that use disk billing (e.g. locums) instead of EDT.

6.3.1. Manual Transmissions

Click once on the **Transmit** button.



The **Force RAS Transmission** dialogue box will be displayed.

Click once on the **Yes** button to force transmission, or **No** to cancel the operation.

Scheduled Transmissions

HERO contains an optional internal scheduler feature that allows periodic automatic transmissions to the HERO network.

To enable the scheduled transmission feature:

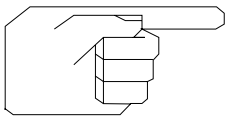
Click the **Utilities** icon. The **Setup** screen should be displayed with a number of side-buttons to the left indicating various setup areas.

Setup
Utilities

Click on the **Setup Communications** button.

- Click once on the box adjacent to **Schedule Transmissions**. A checkmark should appear, indicating you have enabled this feature.

The transmission will be scheduled for random times throughout the day. On the machine designated as the RAS server, you will note at the top of the screen a message indicating the next scheduled transmission time. **HERO** will transmit all batches claims automatically on that time without further operations.



Scheduled transmissions will only occur if HERO is active. You can, of course, leave HERO running in the background while using another Windows application such as your word processor.

6.3.2. Transmission Events

Whether manual or scheduled, transmission will follow a set sequence of events that can be monitored on the Status Bar at the bottom of your main HERO window.

- **Dial, Connect** The computer will connect to the HERO network, either through a modem over a phone line, or using the Internet.

- **Authentication** Remote Access Services (RAS) will then authenticate your account on the network, checking, among other things, doctor or group number and password.

- For each doctor in your database (enabled for EDT transmission):

  - **Reception** All RA files, batch acknowledgments, error reports, incoming e-mail etc., not already received, will be downloaded at this time. The particular files, as they are downloaded, will be displayed at the bottom of the screen.

  - **Transmission** All batched claims, outgoing e-mail etc. will be transmitted to the HERO network. The particular files, as they are transmitted, will be displayed at the bottom of the screen.

  Once the transmission has been completed, the message "Processing for doctor successfully completed" will be displayed, and then HERO will continue the transmission for the next doctor (if applicable).

- **Hang Up** The computer will disconnect from the HERO network.

6.4. Processing Remittance Advices

As outlined in the previous section, ***HERO*** will automatically download all outstanding items—including RA files—at the time of transmission. (An e-mail message will always advise you when the current RA file has been downloaded.) Once downloaded, the RA file ***must be processed*** in order to reflect payments and rejections from the MOH. Any time *after* processing, complete financial summary reports may be generated.

To process Remittance Advices:

List Batch **Add Batch**

Click once on the **Add Batch** icon.

- Click once on the **Process RA** button.

- Select (highlight) **one** doctor.

- Click on Start.

There should be a rolling display as the remittance advice records are reconciled with billed claims. There will then be notification that the processing has finished, and a series of prompts to print various financial reports. You may elect to print some, all or none of

these reports at this time. (These reports can be accessed through the **Financial Reports** area. For details, please refer to Section 6.7: **Financial Reports**.)

6.5. RA Rules

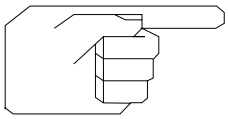
After the RA file had been processed a number of things happen, which we will examine in the following sections in detail. Briefly, however, these are the changes that occur.

- All claims that were fully paid, or overpaid, are moved from **Batched Claims** to **Archived Claims**.
- All claims with at least one *unpaid* service item are moved from **Batched Claims** to **Rejected Claims**.
- All claims with at least one *underpaid* service item are moved from **Batched Claims** to **Reconciled Claims**.

There are also a series of messages from OHIP copied to your system that can be viewed and/or printed by selecting **MOH Messages** from the report lookup after RA processing.

6.6. Post-Batch Adjustment Of Claims

After receiving Remittance Advice files you will want to adjust *payment discrepancies* so as to resubmit them or write them off (**Rejected Claims**, **Reconciled Claims**). Similarly, after receiving *error reports* you will want to edit errors for re-transmission or archiving.



***Payment discrepancies* occur when the MOH office declines payment of a particular claim, usually because it conflicts with billing guidelines. These items are included in the RA files. *Error reports* occur when there is a demographic error, such as incorrect birthdate or Health Card number. These reports are usually forwarded to you directly by EDT (or by mail).**

6.6.1. Rejected Claims (Payment Discrepancies)

After a RA file is processed, all claims containing at least one ***unpaid*** service item are moved from **Batched Claims** to **Rejected Claims** automatically. You can either reconcile the outstanding amount and archive the claim (recommended), or delete the claim.

Generally you should not modify a Rejected claim (except to archive it, as described below). Rejected claims cannot be resubmitted. Instead of making corrections to a Rejected claim, you can make a *new* claim to replace it (and archive or delete the original claim).

6.6.1.1.Archiving a Rejected Claim

List Claims **Add Claims**

Click once on **List Claims**.

Click on the **Rejected Claims** side-button once to view the **Rejected Claims List**.

- Select the claim by double clicking on it.

The **Patient Claim (Rejected)** screen is displayed.

The lower right hand section of the screen is the box for inputting Diagnostic and Billing Codes. The cursor should be automatically placed in the **Fee** (Billing Code) field.

- Click on the **R** (for Reconciled) field of all service item's once, or press any key to enter an "R".

- Press **OK** to return to the Claims List.

That item should no longer be displayed in the **Rejected Claims List** but should have been moved to the **Archived Claims List**.

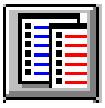
6.6.2. Reconciled Claims (Payment Discrepancies)

After a RA file is processed, all claims containing at least one ***underpaid*** service item are moved from **Batched Claims** to **Reconciled Claims** automatically. The exclusive purpose of this area is to allow you to examine these items before archiving them.

Reconciled claims cannot be resubmitted. Instead of making corrections to a Reconciled claim, you can make a *new* claim to replace it (and archive the original claim).

To archive a Reconciled Claim:

Click once on **List Claims**.



Click on **Reconciled Claims** side-button once to view **Reconciled Claims List**.

- Select the claim by double clicking on it.

The **Patient Claim (Reconciled)** screen is displayed.

The lower right hand section of the screen is the box for inputting Diagnostic and Billing Codes. The cursor should be automatically placed in the **Fee** (Billing Code) field.

- Click on the **R** (for Reconciled) field of all service item's once, or press any key to enter an "R".

- Press **OK** to return to the Claims List.

That item should no longer be displayed in the **Reconciled Claims List** but should have been moved to the **Archived Claims List**.

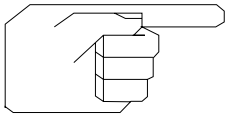
6.6.3. Correcting Or Reconciling Claims (Error Reports)

Periodically the MOH office may send you an error report indicating a problem with a particular claim or batch of claims. Usually this involves a demographic error, such as incorrect birthdate or Health Card number. *These claims are not included in the RA File* and must be either corrected or reconciled manually.

6.6.3.1.Correcting a Claim from a Paper Error Report

Click once on **List Claims**.

Click on the **Batched Claims** side-button once to view the **Batched Claims List**.



The Batched Claims area contains *all* batched items.

- Using the error report as a guide, select the claim by double clicking on it.

The **Batched Claim** screen is displayed.

Click once on the **Correct** button.

- Add or edit the information in this record per accompanying notation in the error report.
- Click on **OK** when finished.

If the corrected claim satisfies the error-checking routines of the ***HERO*** program it will be moved from **Batched Claims** to **Corrected Claims**. If it does not, and there is no further editing, it will be placed in the **Incomplete Claims** area.

6.6.3.2.Correcting a Claim in Error Claims Bin (for EDT enabled Doctors only)

List Claims Add Claims

Click once on **List Claims**.

Click on the **Error Claims** side-button once to view the **Error Claims List**.

- Select a claim by double clicking on it. Click on the Error button (in blue) to see what the problem was.

Click once on the **Correct** button.

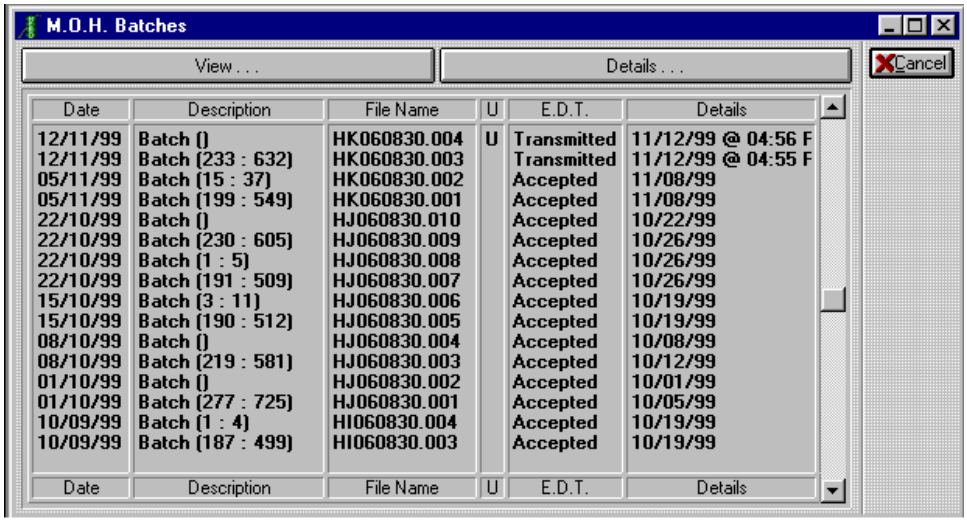
- Add or edit the information in this record per accompanying notation in the error report.
- Click on **OK** when finished.

If the corrected claim satisfies the error-checking routines of the ***HERO*** program it will be moved from **Error Claims** to **Corrected Claims**. If it does not, and there is no further editing, it will be placed in the **Incomplete Claims** area.

6.7. Financial Reports

Financial reports are accessed through the **List MOH Claims/Reconciliations** area. Click once on this button.

A screen resembling the one below is displayed. The default view is a list of **MOH Batches**, but other reports are available by clicking on the side-buttons to the left of the list.



Date	Description	File Name	U	E.D.T.	Details
12/11/99	Batch ()	HK060830.004	U	Transmitted	11/12/99 @ 04:56 F
12/11/99	Batch (233 : 632)	HK060830.003		Transmitted	11/12/99 @ 04:55 F
05/11/99	Batch (15 : 37)	HK060830.002		Accepted	11/08/99
05/11/99	Batch (199 : 549)	HK060830.001		Accepted	11/08/99
22/10/99	Batch ()	HJ060830.010		Accepted	10/22/99
22/10/99	Batch (230 : 605)	HJ060830.009		Accepted	10/26/99
22/10/99	Batch (1 : 5)	HJ060830.008		Accepted	10/26/99
22/10/99	Batch (191 : 509)	HJ060830.007		Accepted	10/26/99
15/10/99	Batch (3 : 11)	HJ060830.006		Accepted	10/19/99
15/10/99	Batch (190 : 512)	HJ060830.005		Accepted	10/19/99
08/10/99	Batch ()	HJ060830.004		Accepted	10/08/99
08/10/99	Batch (219 : 581)	HJ060830.003		Accepted	10/12/99
01/10/99	Batch ()	HJ060830.002		Accepted	10/01/99
01/10/99	Batch (277 : 725)	HJ060830.001		Accepted	10/05/99
10/09/99	Batch (1 : 4)	HI060830.004		Accepted	10/19/99
10/09/99	Batch (187 : 499)	HI060830.003		Accepted	10/19/99
Date	Description	File Name	U	E.D.T.	Details

6.7.1. Post-Batch Summary

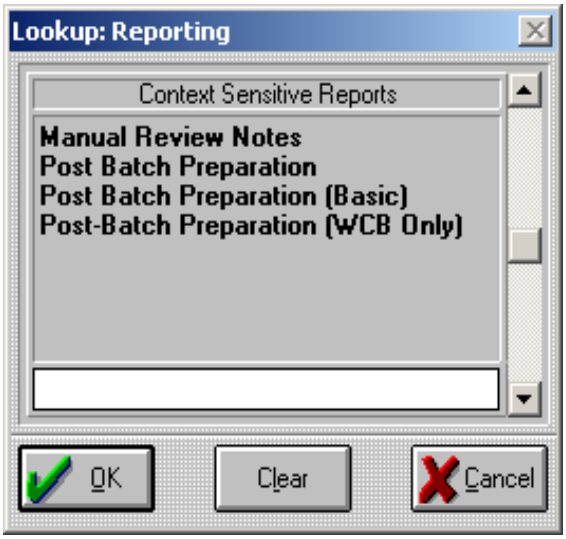
MOH Batches

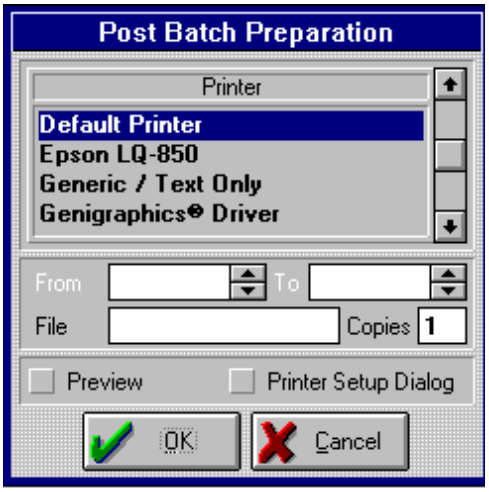
Click once on the **M.O.H. Batches** icon if not already activated. (it is the default). A screen resembling the one above should be displayed.

- Select the desired batch by clicking on it once to highlight it.

Print Reports

While the item is highlighted, click once on the **Print Reports** button and screen below will appear. Highlight report required, then click Ok.





- Select a printer other than default if necessary.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the report before printing.
- Click on **OK** to proceed.

Depending on the options selected, the report will either print out immediately or after a preview and print command.

6.7.2. RA Reports

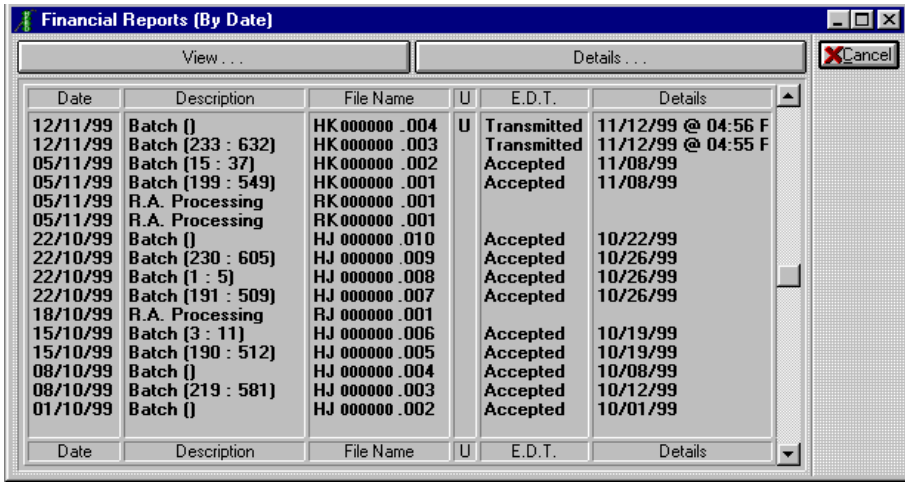
RA Reports are created from MOH source data and are thus handled a little differently than other reports in the program.

Financial Reports (By Date)

Financial Reports (By Type)

Click once on either the **Financial Reports (By Date)** or **Financial Reports (By Type)**.

In our example we are using **Financial Reports (By Date)**. A screen resembling the one adjacent should be displayed.



- Select the desired **R.A. Processing** item by clicking on it once to highlight it.
- For R.A. files, the **View** button is not active (An R.A. in its raw form is not easily understood without an MOH Technical Reference guide)

Print Reports

While the item is highlighted, click once on the **Print Reports** button and select the desired option from a list of context sensitive reports.

6.8. UNDOING Batches and Claims

There may be circumstances where it is necessary to undo a batch or a RA process. Typically this would occur when the process was interrupted for some reason (power failure, system error) or a certain batch file needed to be recalled for editing.

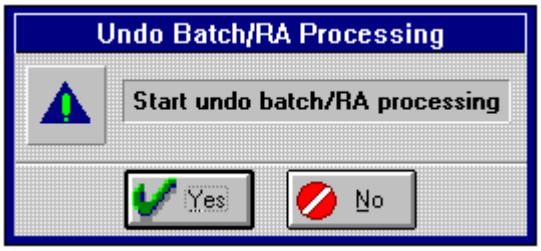
Click once on the **List MOH Claims/Reconciliations** icon.

Financial Reports (By Date)

Financial Reports (By Type)

Click once on either the **Financial Reports (By Date)** or **Financial Reports (By Type)**.

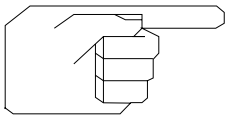
- Select the desired RA file or batch file by clicking on it once to highlight it.
- While the file is highlighted click on **FILE ➔ LISTS ➔ UNDO BATCH/RA**.



You will be prompted to accept the UNDO procedure for that file.

- Click on **Yes** to proceed, or **No** to cancel the process.

There will then be a rolling count as individual items are processed. If a RA has been processed, all claims associated with it will be moved back to the **Batched Claims** area. If a batch file has been processed, all claims associated with it will be moved from the **Batched Claims** area to the **Complete** and/or **Corrected** area.



Undoing batches, especially R.A.'s should be done with extreme caution. The date order for R.A.'s is critical, and should be performed sequentially from the most recent to the oldest.

7. Private Billing

Private billing encompasses any claim that does not fall within the guidelines of OHIP, WCB or Reciprocal jurisdictions, or any claim billed to a patient who is ineligible for the aforementioned health insurance services, where the payer is either the patient or another designated *individual* (i.e. the parent of a minor child). Unlike OHIP, WCB or Reciprocal billing, the responsibility for calculation, collection and reconciliation of receivables is the physician's. This necessarily implies an internal accounting capability not ordinarily required in other forms of billing.

In this chapter we will discuss the following:

- ⇨ Initial Setup
  - Fee Codes
  - Default Payer
- ⇨ Creating a claim
  - Generating an invoice
- ⇨ Entering payments against claims
  - Generating a receipt
- ⇨ Reviewing the status of payer accounts
  - Generating a Statement of Account
- ⇨ Reviewing privately billed claims
  - Generating financial reports
- ⇨ Writing off outstanding claims through reconciliation

7.1. Initial Setup

7.1.1. Fee Codes

Private claims, by definition, are not tied to MOH fee code structure. Individual physicians can create their own fee codes for non-MOH procedures and/or assign a different fee amount for MOH procedures rendered privately. Custom fee codes can be added and existing fee codes edited at any time, but it is a good practice to have the most frequently used fee codes in place before private billing begins.

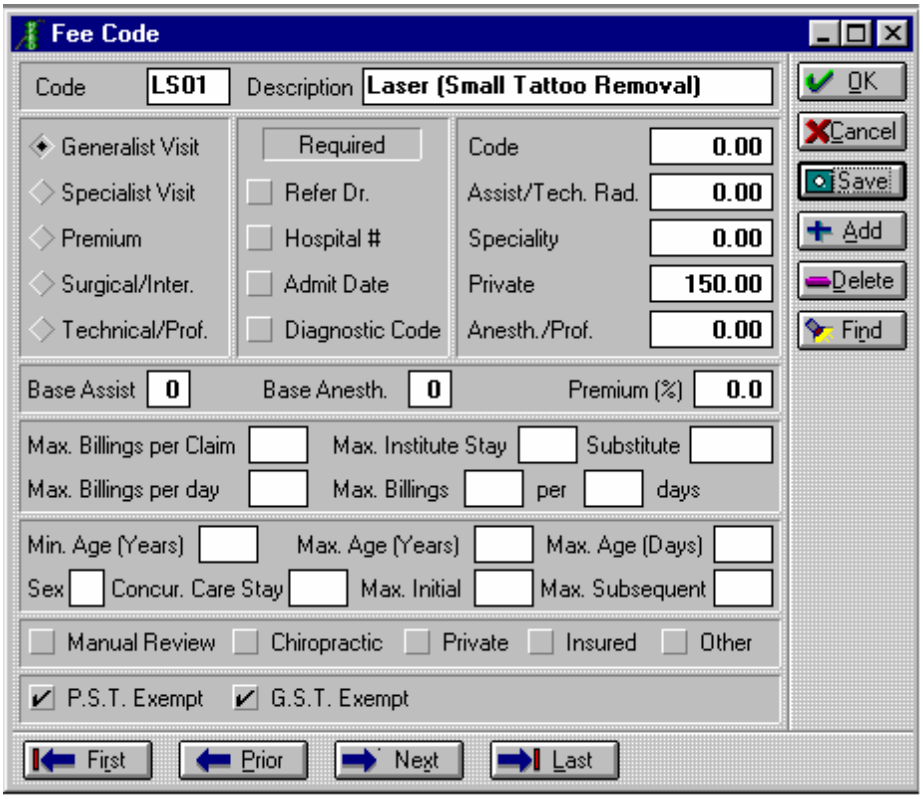
7.1.1.1.Adding A Custom Fee Code

Setup Utilities

Click the **Utilities** icon.

Click on the **Add/Browse Fee Codes** side-button.

The **Fee Code—New Record** screen is displayed. For the most part, creating a new Fee Code for private billing is straightforward. In the example below the physician has added a code for small tattoo removal.



To add a new Fee Code:

- Type in a unique code in the **Code** field. In our example, all private laser procedures have been assigned an “LS” prefix to set them off from regular MOH codes (which are constructed of one letter prefix and three numbers).

- Type in a description.

- Enter a fee amount in the **Private** field. This is the amount that will be entered when you create a private claim.

At the bottom of the form there are two check-boxes, which apply only to private or insured billing: **PST Exempt** and **GST Exempt**. If left unchecked, both PST and GST will be calculated on this Fee Code if used to generate a private or insured bill.

- If you do *not* want PST and/or GST added, click on the appropriate check-box(es).

- To save the entry and exit the **Fee Code—New Record** screen, click on the **OK** button.

- To save the entries but keep the Fee Code—New Record screen active, click on the **Save** button.

- To save the entry and add a new Fee Code, click on the **Add** button.

7.1.1.2.Editing A Fee Code

In order to use an existing MOH code for private billing, a billing amount must be entered in the **Private** field and GST and PST settings verified.

To edit an existing Fee Code:

- Access the **Fee Code—New Record** screen using the steps outlined in the previous section.

- Double-click in the **Code** field to bring up the **Lookup:Fee Codes** table.

- Locate the appropriate code by scrolling down or typing in the Fee Code in the field under the **Code** column. Highlight and double-click on the entry to paste the information into the form.

In our example below an A001 code (Minor Assessment) has been modified to allow private billing.

- Enter a fee amount in the **Private** field. This is the amount that will be entered when you create a private claim.

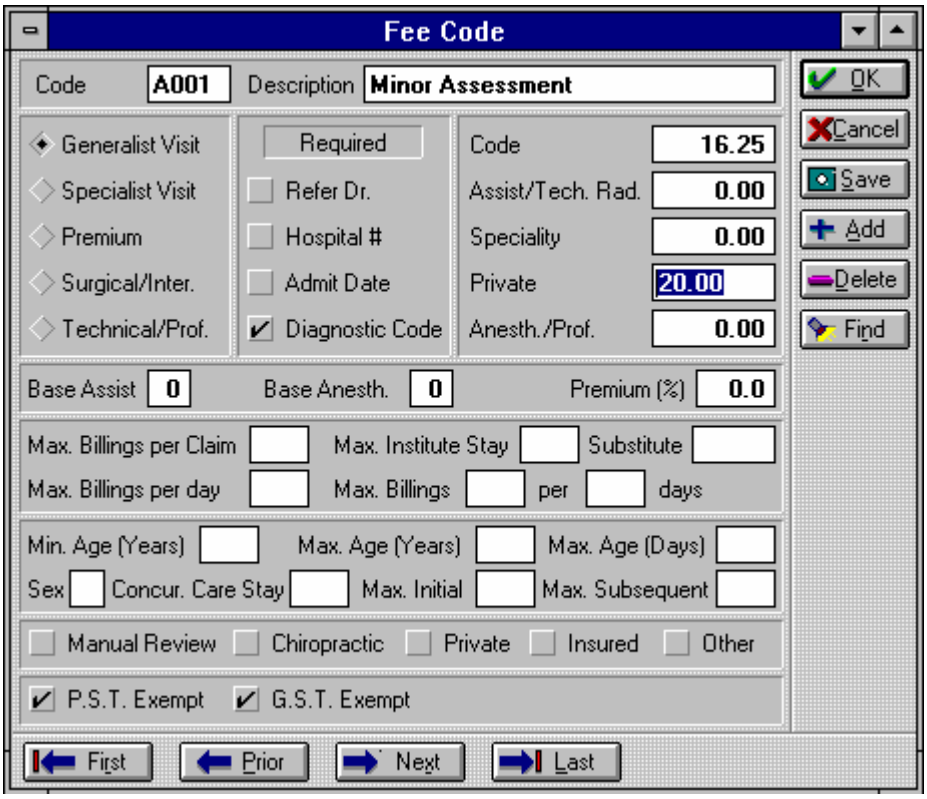
If **PST Exempt** and **GST Exempt** are left unchecked, both PST and GST will be calculated on this Fee Code if used to generate a private or insured bill.

- If you do *not* want PST and/or GST added, click on the appropriate check-box(es).

- To save the entry and exit the **Fee Code—New Record** screen, click on the **OK** button.

- To save the entry but keep the **Fee Code—New Record** screen active, click on the **Save** button.

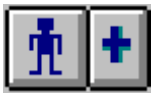
- To save the entry and add a new Fee Code, click on the **Add** button.



7.1.2. Default Payer

In a private billing situation the patient is usually the one invoiced. However, there are cases where another individual (i.e. the parent of a minor child) needs to be designated as the payer. While this can be done when the claim is being created, it is preferable to set it up as default in the **Patient Information** screen.

- If both the patient and payer haven't been entered in the patient database, do so before proceeding. (For a full discussion of adding patients please see **Chapter 5: Registration and Encounters**.)



List Patients Add Patients

Click once on **List Patients**. An alphabetical patient list will be displayed. Locate and highlight the desired record by scrolling down (clicking and holding the down-arrow on the scroll-bar to the right of the list) or by typing the first few letters of the patient's surname in the field below the list.

- Once the desired record is highlighted, double-click on it. A **Patient Information** screen will be displayed, with the current patient information pasted in.

- Double-click on the **Payer** field to bring up the **Lookup:Patients** table.

- Locate the appropriate patient by scrolling down or typing in first few letters of the patient's surname in the **Surname** field. Highlight and double-click on the entry to paste the information into the form.

- To save the entry and exit the **Patient Information - New Record** screen, click on the **OK** button.

- To save the entry but keep the **Patient Information - New Record** screen active, click on the **Save** button.

- To save the entry and add a new patient, click on the **Add** button.

7.2. Creating A Private Claim

List Claims Add Claims

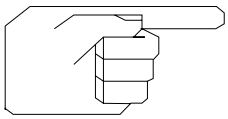
Click once on **Add Claims**.

- Enter patient biographical information. If the patient is already in the database, the information can be pasted in by double clicking on the **Surname**, **Health #** or **Chart #** fields, selecting the appropriate record from the **Lookup:Patients** list and double-clicking on it.

- The **Doctor** field should contain the billing physician for this case. If the *incorrect* physician is entered, click on the **Doctor** field with the right mouse button. When the **Lookup:Billing Doctors Table** is displayed, select the correct physician by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

- Click once on the **Private** radio-button.

- The selection radio-buttons are replaced with two fields to identify the **Payer**. This defaults to the selected patient, but if this is to be billed to someone else (i.e. a parent) this should be changed accordingly. (NB: Default can be set on the Patient Information screen.)



To bill a non-private claim after selecting this option, click once on the Other button to restore defaults.

- The **Default** field defaults to the last billing date entered, and are pasted into all service items in the claim. The default date can be changed, as can the individual dates on the service items. Accept the default date or change it by entering a new date or double-clicking on the field a selecting a new date from a popup calendar.

- Enter notes-type information in **Note 1**, **Note 2** and/or **History** as necessary.

The lower section of the screen is the box for inputting Diagnostic and Fee codes. The cursor should be placed in the **Fee** (Fee Code) field.

- If you know the Fee Code you can enter it manually. Alternatively, double-click on this field, or press F9.

The **Fee Code Lookup Table** is displayed.

- Locate the appropriate code by scrolling down or typing in the description in the field under the **Description** column. Highlight and double-click on the entry to paste the information into the form.

It is often unnecessary to enter a Diagnostic Code in a private claim. However, if your claim requires one:

- Click once on the **Diag** field.

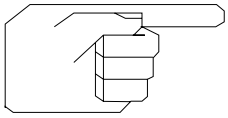
- If you know the Diagnostic Code you can enter it manually. Alternatively, double-click on this field, or press F9.

The **Diagnostic Code Lookup Table** is displayed.

- Locate the appropriate code by scrolling down or typing in the description in the field under the **Description** column. Highlight and double-click on the entry to paste the information into the form.

The **Date** field defaults to the date displayed in the **Default** field. This date can be changed individually if necessary (i.e. if you have multiple service items on different dates).

- Accept the default date or change it by typing in a new date or double-clicking on the field and selecting a new date from a popup calendar.



Some practices offer discounts, promotionals for certain elective private procedures. You can use the % field to discount a fee amount. For instance, to record a 30% discount, you would enter 70 in the % field.

- If you wish to enter additional service items, click once on the down-arrow on the scroll bar to the right of the billing area or press the down-arrow key once, then repeat the above steps.

- To save the entry and exit the billing screen, click on the **OK** button.

- To save the entry but keep the billing screen active, click on the **Save** button.

- To save the entry and add a new claim, click on the **Add** button.

The claim has been entered and can be reviewed in the **Private Billing** section of **Billing Records** (see section: **Reviewing Privately Billed Claims**).

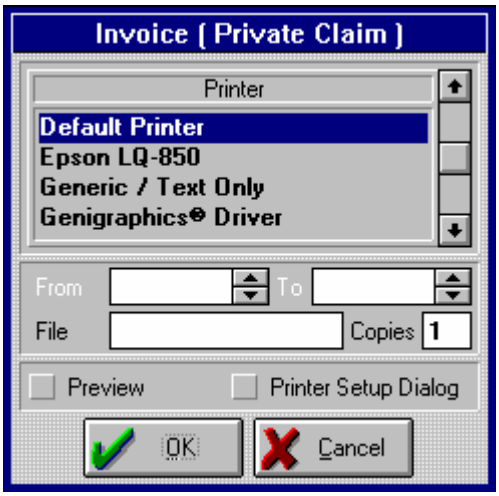
7.2.1. Printing An Invoice

It is often advisable to provide privately billed patients with an invoice at the end of their visit. ***HERO*** allows you to generate an invoice as soon as you have entered and saved a claim.

- Be sure the printer is on-line and connected properly to your computer.

- If you have just completed the claim you wish to invoice, press **Save** to save entry. If you do not have the appropriate claim open, open the claim using the steps outlined in **Reviewing Privately Billed Claims** (Section 7.5).

While the claim is open, click once on the **Print** icon.



- The report dialogue box will be displayed (because there is only one context-sensitive report in this area, the report pick-list is bypassed)
- Select a printer other than default if necessary.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the invoice before printing.

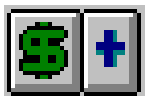
- Click on **OK** to proceed.

Depending on the options selected, the invoice will either print out immediately or after a preview and print command.

7.3. Entering Payments Against Claims

Payment can be applied to an account at any time in the program, however it is common to accept payment at the end of the patient visit.

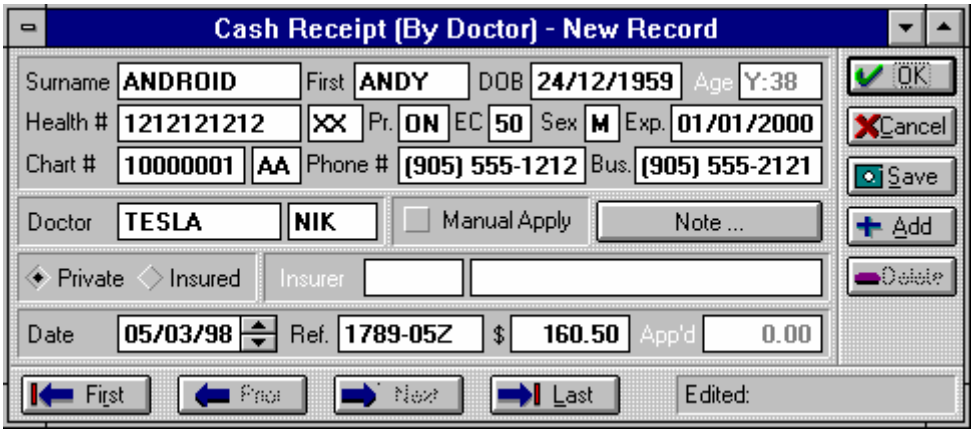
- If you have just completed the claim you wish to invoice, press **Save** to save entry. If you do not have the appropriate claim open, open the claim using the steps outlined in the **Reviewing Privately Billed Claims** (Section 7.5).



List Payments Add

While the claim is still open click once on the **Add** Payment icon. A screen resembling the one below will be displayed.

The screen should contain all the core patient information from the claim, as well as the default date.



- By default, payments are applied to the *oldest* outstanding items first so an accurate aged receivable can be derived.

- Click on **Note** if you wish to enter comments. (These comments will appear on the printed receipt.)

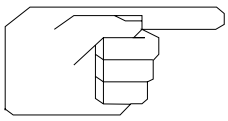
- The **Private** radio-button should be selected. Accept this default.

- Adjust the **Date** if necessary using the side-arrows to advance or go back on the date, or by double clicking or right clicking on the field and selecting the correct date from a Pick-List.

- Enter a **Reference** if desired, (i.e. a cheque number).

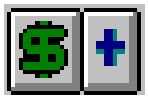
- Enter the amount paid in the **$** field.

- If you wish to print a receipt, click on **Save** to save the payment record but leave the form active. Otherwise, click on **OK** to save the record and exit the form.



This method should *always* be used to apply payments to Private Claims. *Do not* attempt to enter values directly in the patient's billing record, as this will cause discrepancies in the financial statement reports.

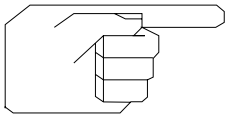
7.3.1.1.Manual Apply of Payment to Specific Claims



List Add Payments

While the claim is still open click once on the **Add** Payment icon. A screen resembling the one above will be displayed.

- Click **Manual Apply** box
- Enter the amount paid in the **$** field and in the **App'd** Field, Click on OK and you will be back to the Claim.
- Go to Claim, Enter payment in the **Paid** column
- Put a **"R"** beside each Item on claim, then Click OK. This will apply payment to this specific claim only, and moved to the **Archived Claims**



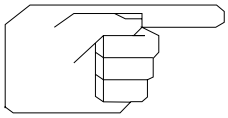
This method described in Section 7.3 is the preferred method to use when applying payments to Private Claims. *Do not* attempt to enter values directly in the patient's billing record, as this will cause discrepancies in the financial statement reports.

7.3.1.2.Printing A Receipt

While the receipt is open, click once on the **Print** icon. The report dialogue box will be displayed (because there is only one context-sensitive report in this area, the report pick-list is bypassed)

- Select a printer other than default if necessary.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the receipt before printing.
- Click on **OK** to proceed.

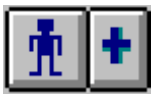
Depending on the options selected, the receipt will either print out immediately or after a preview and print command.



A payment can also be applied in the Payer Statement area. See the next section for details.

7.4. Reviewing Status Of Payer Accounts

You will, from time to time, wish to review the status of payer accounts. The most expeditious way to do this is through **Patient Records**.



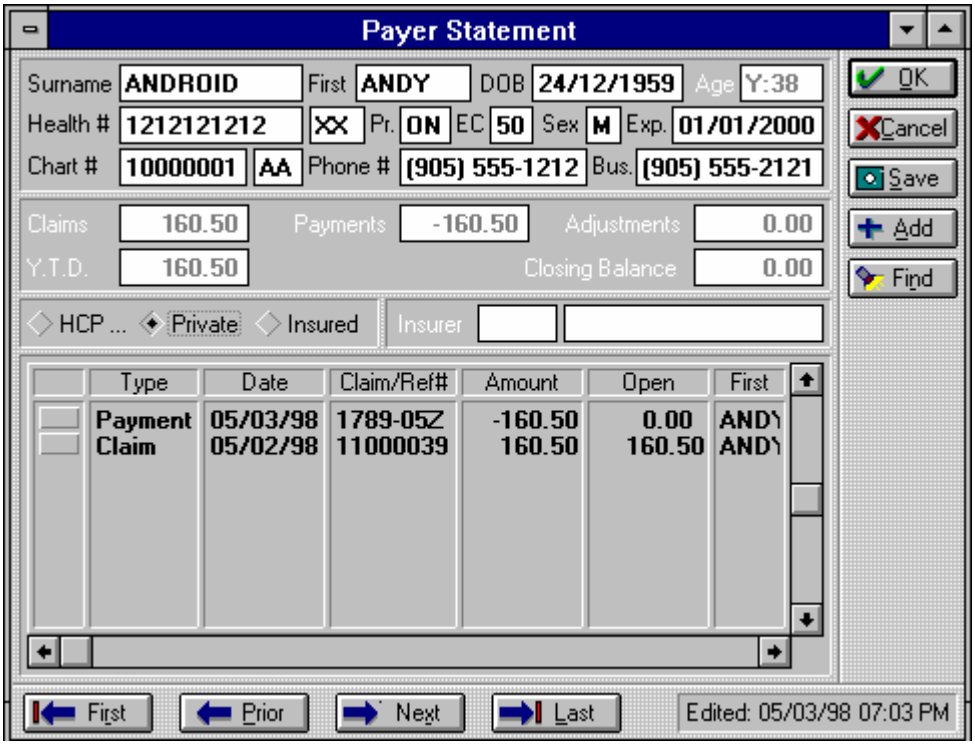
List Patients Add Patients

Click once on **List Patients**. An alphabetical patient list will be displayed. Locate and highlight the desired record by scrolling down (clicking and holding the down-arrow on the scroll-bar to the right of the list) or by typing the first few letters of the patient's surname in the field below the list. Double-click to access the **Patient Record** screen.

Click on the **Patient's Financial Statements** side-button.

The **Payer Statement** screen, resembling the one below, will be displayed.

The default view of the **Payer Statement** is **HCP/WCB/RMB** (MOH type billing). To view private transactions, click once on the **Private** radio-button.



The **Payer Statement** features a line-item transaction list pertaining to the type of claims selected (in this case private), summarized for convenience across the top of the screen. Double clicking on it can access detailed information on any item.

7.4.1. Applying A Payment

A payment can be applied from the **Payer Statement** screen. This would be the preferred method if payment is received some time after the fact or if you were processing a number of different patients' payments in a batch and wished to quickly generate receipts and patient statements on the fly.

- Following the steps outlined above, access the **Payer Statement** for the desired patient.
- Click once on the **Add** button.

The **Cash Receipt by Doctor—New Record** screen will be displayed.

- Following the steps outlined in Section 7.3, enter the necessary information to complete the receipt, save, and print if necessary.

7.4.2. Printing A Statement Of Account

A Statement of Account can be printed from this area. This is a " balance forward " type of report that can be set to desired time parameters (i.e. monthly). This provides patients with a summary of their private billings and applied payments and the outstanding balance owed.

- Following the steps outlined above, access the **Payer Statement** for the desired patient. (Ensure the **Private** radio-button is selected.)

While the form is open, click once on the **Print** icon. The report dialogue box will be displayed (because there is only one context-sensitive report in this area, the report pick-list is bypassed)

- Select a printer other than default if necessary.

- Enter a **From** and **To** date if necessary (as would be the case if you wished to generate a monthly report and want the balance adjusted accordingly). Otherwise the report will default to beginning of time to the present.

- Set number of copies if necessary.

- Click once on **Preview** if you wish to view the receipt before printing.

- Click on **OK** to proceed.

Depending on the options selected, the Statement of Account will either print out immediately or after a preview and print command.

7.5. Reviewing Privately Billed Claims

As is the case with MOH claims, Private claims are stored in different areas in **Billing Records**, depending on their status. These areas, and the status they reflect, are summarized below:

- All outstanding claims that have satisfied the error-checking routines of the program are located in **Complete Claims**.

- All outstanding claims that have *not* satisfied the error-checking routines of the program (i.e. missing fee code), but have been saved anyway, are located in **Incompleted Claims**.

- All claims paid in full or written off are located in **Archived Claims**.

To review the status of individual outstanding Private claims:

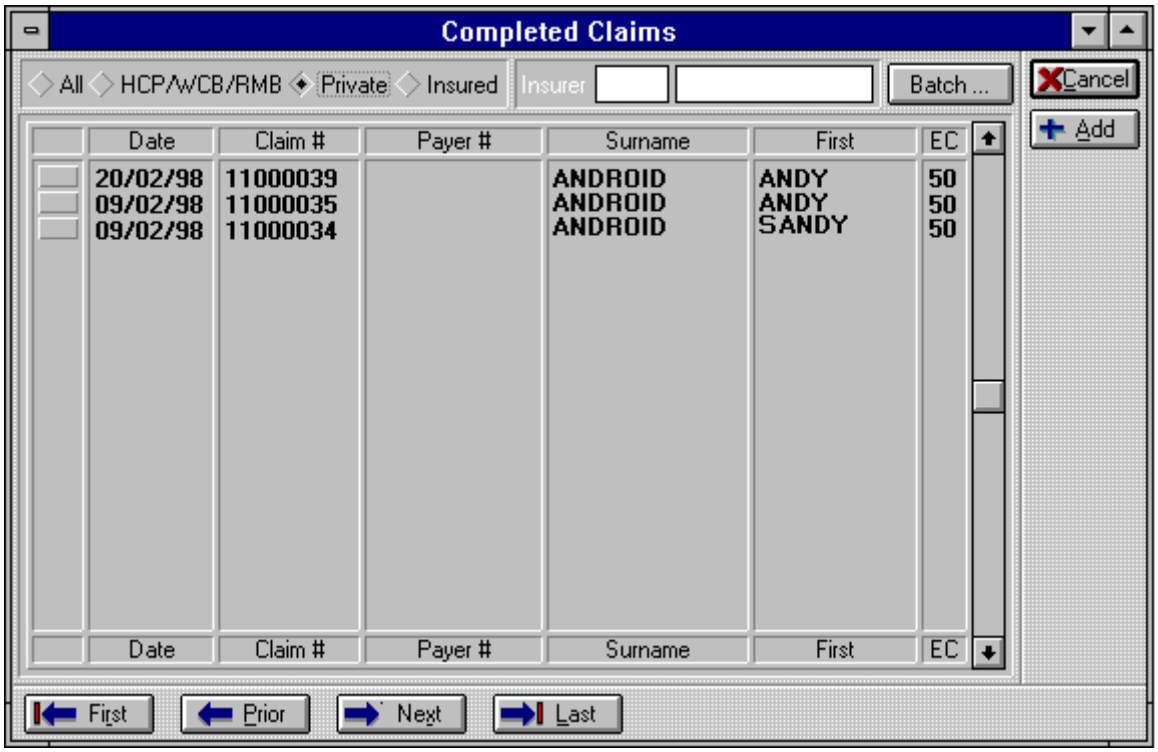
List Claims Add Claims

Click once on the **List Claims** icon.

The **Billing Records** screen, defaulted to the **HCP/WCB/RMB** (MOH type billing) view of the **Complete Claims List**, is displayed.

- To change the view, click once on the **Private** radio button.

A list of Completed Private Claims, resembling the one below, should be displayed.



- Select the claim you wish to view by highlighting it and double clicking. The **Patient Claim (Completed)** form for this claim is displayed. You may view, edit or delete this record.

The side-buttons on the left of the screen indicate the various areas into which claims are put depending on their status.

Click on **Incomplete Claims** side-button once to view **Incomplete Claims List**. Select the claim you wish to view by highlighting it and double clicking.

The **Patient Claim (Incompleted)** form for this claim is displayed. You may view, edit or delete this record. (The usual practice is to complete the claim by adding missing information such as the Fee Code, then saving. If the claim then satisfied the program's error-checking routines, it is moved to the **Completed** area.)

Click on **Archived Claims** side-button once to view **Archived Claims List**. Select the claim you wish to view by highlighting it and double clicking.

7.5.1. Financial Reports

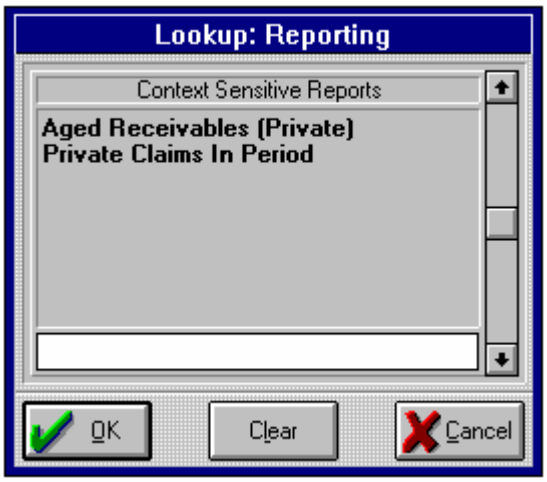
Several financial reports are available in the **Billing Records** area to provide quick summaries of account status with all privately billed patients.

List Claims Add Claims

Click once on the **List Claims** icon.

- Click once on the **Private** radio-button.

While the screen is active, click once on the **Print** icon. A **Lookup:Reporting** table, resembling the one below, should be displayed.



The available reports in this section include Aged Receivables and a list of all private claims in period.

- Select the desired report by highlighting and double clicking on it.
- Select a printer other than default if necessary.
- Enter a **From** and **To** date if necessary (as would be the case if you wished to set date parameters for the **Private Claims In Period** report). Otherwise the report will default to beginning of time to the present.

- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the receipt before printing.
- Click on **OK** to proceed.

Depending on the options selected, the report will either print out immediately or after a preview and print command.

7.6. Reconciliation

It is possible in the **Patient Claim** screen to " write off " outstanding claims, or remaining balances on claims when these amounts, for whatever reason, become uncollectable, or if discounts apply. Once reconciled, an **Adjustment** entry is added to the patients **Payer Statement** and the claim is archived.

- Access the **Patient Claim** record containing the claim you wish to reconcile, using either the **Payer Claim** screen (see Section 7.4) or **Billing Records** list (see Section 7.5).
- Click once on the **R** field (rightmost in the Fee and Diagnostic Code row) *for all service items contained in the bill*. An "R" should be entered in that field.
- Click once on **OK** to save the change and exit the screen.

The claim has been adjusted an equivalent amount to the outstanding balance and is archived.

8. Insured Billing

Insured billing encompasses any claim that does not fall within the guidelines of OHIP, WCB or Reciprocal jurisdictions, or any claim billed to a patient who is ineligible for the aforementioned health insurance services, where the payer is a *private insurance company*. Unlike OHIP, WCB or Reciprocal billing, the responsibility for calculation, collection and reconciliation of receivables is the physician's. This necessarily implies an internal accounting capability not ordinarily required in other forms of billing.

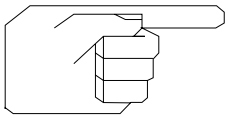
In this chapter we will discuss the following:

- ⇨ Initial Setup
  - Assigning Insurance Companies
  - Fee Codes
- ⇨ Creating a claim
  - Generating an invoice
- ⇨ Entering payments against claims
- ⇨ Reviewing the status of payer accounts
  - Generating a receipt
  - Generating a Statement of Account
- ⇨ Reviewing insured claims
  - Generating financial reports
- ⇨ Writing off outstanding claims through reconciliation

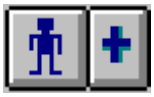
8.1. Initial Setup

8.1.1. Assigning Insurance Companies

Before insured billing can be done for a particular patient, the program needs to know the insurance company or companies that are providing the coverage. This is accomplished by associating one or more insurance companies with the patient's record.



This operation assumes that the insurance company or companies have already been entered into the general database. For a complete discussion of entering new insurance companies please refer to Chapter 4, Section 13: Add/Browse Insurer Records.

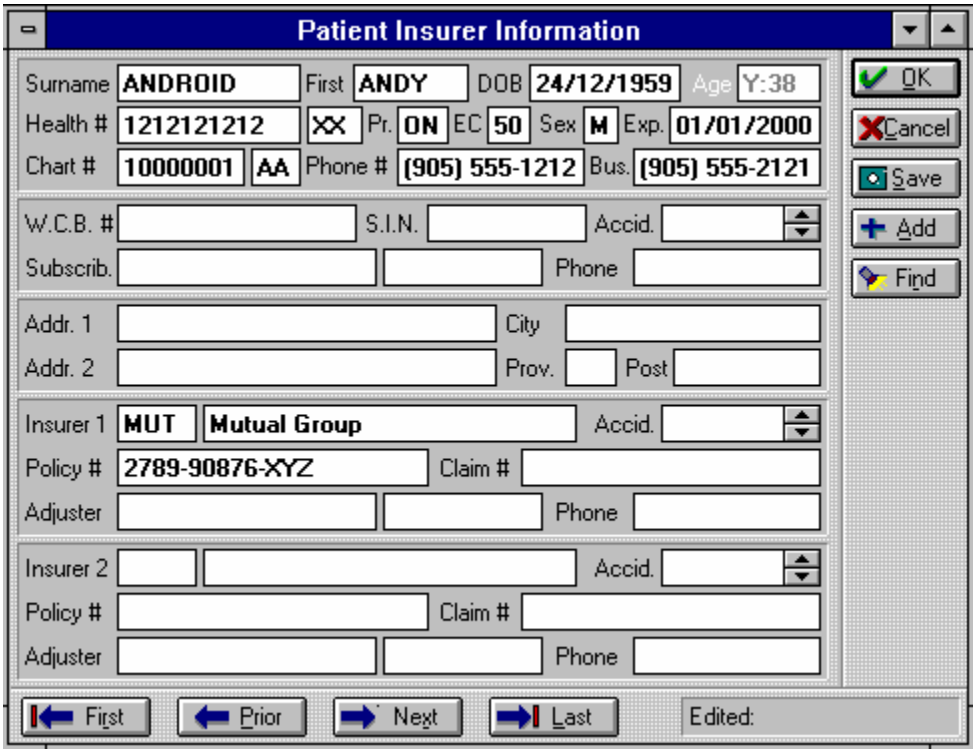


List Patients Add Patients

Click once on **List Patients**. An alphabetical patient list will be displayed. Locate and highlight the desired record by scrolling down (clicking and holding the down-arrow on the scroll-bar to the right of the list) or by typing the first few letters of the patient's surname in the field below the list.

- Once the desired record is highlighted, double-click on it. A **Patient Information** screen will be displayed, with the current patient information pasted in.

Click once on the **Patient's Insurer Information** side-button. The screen, resembling the one below will be displayed. (The illustration is truncated in the interests of space: the actual form can contain four separate private insurance entries.)



- Double-click on the **Insurer 1** field (or the next available **Insurer** field for multiple entries) to access the **Lookup:Insurers** table.

- Locate and highlight the desired record by scrolling down (clicking and holding the down-arrow on the scroll-bar to the right of the list) or by typing the first few letters of the insurance companies code in the field below the list.

- Once the desired record is highlighted, double-click on it. The information pertaining to the selected insurance company will be pasted in.

- Enter specific information (i.e. **Policy #**, **Accident Date**, **Adjuster**), as necessary.

- To save the entry and exit the **Patient's Insurer Information** screen, click on the **OK** button.

- To save the entry but keep the **Patient's Insurer Information** screen active, click on the **Save** button.

- To associate another insurance company, double-click on the next available **Insurer** field and repeat the steps outlined above.

8.1.2. Fee Codes

Insured claims can be tied to MOH fee code structure or calculated against custom fee codes for non-MOH procedures supported by the private insurance carrier. Custom fee codes can be added and existing fee codes edited at any time, but it is a good practice to have the most frequently used fee codes in place before insured billing begins.

8.1.2.1.Editing A Fee Code

Many insurance carriers tie their fee-schedules to the MOH fee code structure. In these cases, little editing is required of the existing MOH fee code involved, *except to insure that PST and/or GST calculation is enabled or disabled as required*.

To edit an existing Fee Code:

Setup Utilities

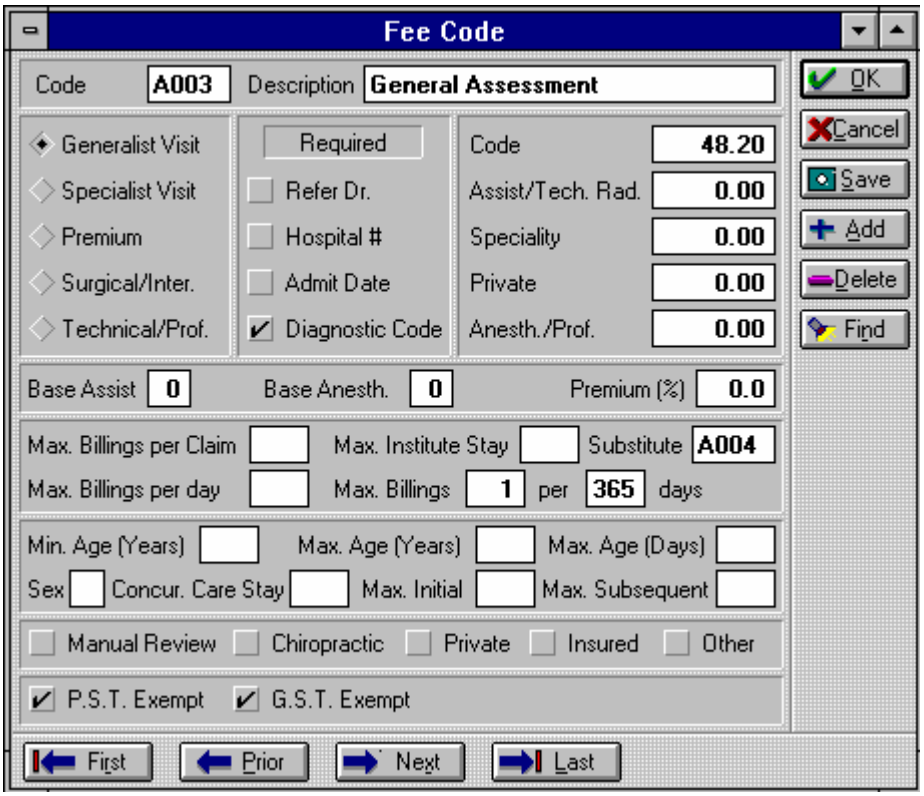
Click the **Utilities** icon.

Click on the **Add/Browse Fee Codes** side-button.

- Double-click in the **Code** field to bring up the **Lookup:Fee Codes** table.

- Locate the appropriate code by scrolling down or typing in the Fee Code in the field under the **Code** column. Highlight and double-click on the entry to paste the information into the form.

In our example below an A003 code (General Assessment) has been modified to allow insured billing. Unlike private claims there is no need to enter a separate value: *the amount entered in the* **Code** *field is the one pasted into an insured claim*.



If **PST Exempt** and **GST Exempt** are left unchecked, both PST and GST will be calculated on this Fee Code if used to generate a private or insured bill.

- If you do *not* want PST and/or GST added, click on the appropriate check-box(es).

- To save the entry and exit the **Fee Code—New Record** screen, click on the **OK** button.

- To save the entry but keep the **Fee Code—New Record** screen active, click on the **Save** button.

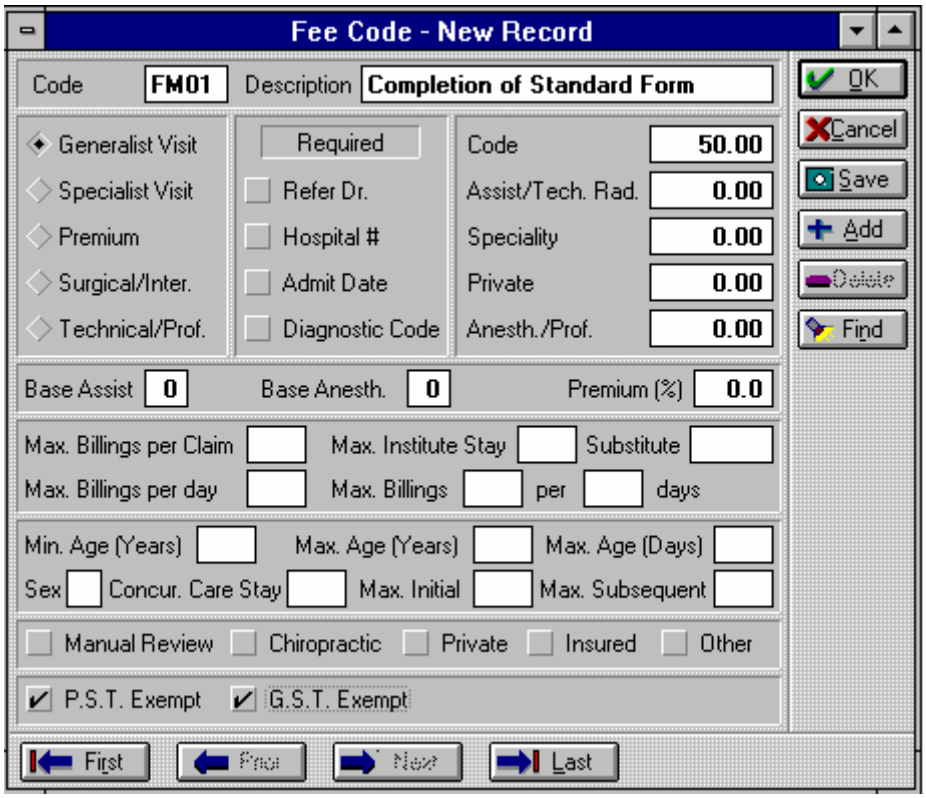
- To save the entry and add a new Fee Code, click on the **Add** button.

8.1.2.2.Adding A Custom Fee Code

In the event that the private insurance carrier supports non-MOH procedures, or maintains a fee schedule or business rules different from MOH, it is necessary to create custom fee codes for the procedures involved.

- Access the **Fee Code—New Record** screen using the steps outlined in the previous section.

The **Fee Code—New Record** screen is displayed. For the most part, creating a new Fee Code for insured billing is straightforward. In the example below the physician has added a code for completing an insurance form.



To add a new Fee Code:

- Type in a unique code in the **Code** field. In our example, all insurance forms have been assigned an "FM" prefix to set them off from regular MOH codes (which are constructed of one letter prefix and three numbers).

- Type in a description.

- Enter a fee amount in the **Code** field. This is the amount that will be entered when you create an insured claim.

  At the bottom of the form there are two check-boxes, which apply only to private or insured billing: **PST Exempt** and **GST Exempt**. If left unchecked, both PST and GST will be calculated on this Fee Code if used to generate a private or insured bill.

- If you do *not* want PST and/or GST added, click on the appropriate check-box(es).

- To save the entry and exit the **Fee Code—New Record** screen, click on the **OK** button.

- To save the entry but keep the **Fee Code—New Record** screen active, click on the **Save** button.

- To save the entry and add a new Fee Code, click on the **Add** button.

8.2. Creating An Insured Claim

List Claims **Add Claims**

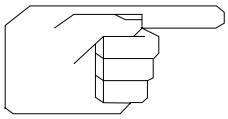
Click once on **Add Claims**.

- Enter patient biographical information. If the patient is already in the database, the information can be pasted in by double clicking on the **Surname**, **Health #** or **Chart #** fields, selecting the appropriate record from the **Lookup:Patients** list and double-clicking on it.

- The **Doctor** field should contain the billing physician for this case. If the *incorrect* physician is entered, click on the **Doctor** field with the right mouse button. When the **Lookup:Billing Doctors Table** is displayed, select the correct physician by highlighting the name and double-clicking, or highlighting and clicking on the **OK** button.

- Click once on the **Insured** radio-button. If the patient has only one insurance company associated it will be pasted in by default. If there are more than one insurance company associated, the **Lookup:Insurers** table will be displayed, and the correct company can be selected by double clicking on it.

- The selection radio-buttons are replaced with two fields to identify the insurance company code and full name.



To bill a non-insured claim after selecting this option, click once on the Other button to restore defaults.

- The **Default** field defaults to the last billing date entered, and are pasted into all service items in the claim. The default date can be changed, as can the individual dates on the service items. Accept the default date or change it by entering a new date or double-clicking on the field a selecting a new date from a popup calendar.

- Enter notes-type information in **Note 1**, **Note 2** and/or **History** as necessary.

The lower right hand section of the screen is the box for inputting Diagnostic and Fee codes. The cursor should be placed in the **Fee** (Fee Code) field.

- If you know the Fee Code you can enter it manually. Alternatively, double-click on this field, or press F9.

The **Fee Code Lookup Table** is displayed.

- Locate the appropriate code by scrolling down or typing in the description in the field under the **Description** column. Highlight and double-click on the entry to paste the information into the form.

If your claim requires a Diagnostic Code:

- Click once on the **Diag** field.

- If you know the Diagnostic Code you can enter it manually. Alternatively, double-click on this field, press F9, or click once on the **Find** button.

The **Diagnostic Code Lookup Table** is displayed.

- Locate the appropriate code by scrolling down or typing in the description in the field under the **Description** column. Highlight and double-click on the entry to paste the information into the form.

The **Date** field defaults to the date displayed in the **Default** field. This date can be changed individually if necessary (i.e. if you have multiple service items on different dates).

- Accept the default date or change it by typing in a new date or double-clicking on the field and selecting a new date from a popup calendar.

- If you wish to enter additional service items, click once on the down-arrow on the scroll bar to the right of the billing area or press the down-arrow key once, then repeat the above steps.

- To save the entry and exit the billing screen, click on the **OK** button.

- To save the entry but keep the billing screen active, click on the **Save** button.

- To save the entry and add a new claim, click on the **Add** button.

The claim has been entered and can be reviewed in the **Insured Billing** section of **Billing Records** (see Sectio8.4: **Reviewing Insured Claims**).

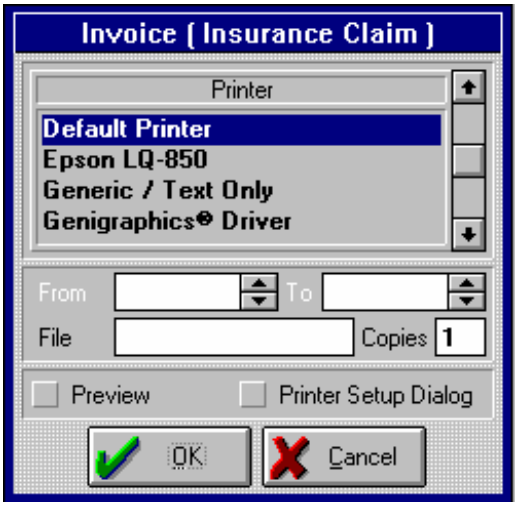
8.2.1. Printing An Invoice

HERO allows you to generate an invoice as soon as you have entered and saved a claim.

- Be sure the printer is on-line and connected properly to your computer.

- If you have just completed the claim you wish to invoice, press **Save** to save entry. If you do not have the appropriate claim open, open the claim using the steps outlined in **Reviewing Insured Claims** (Section 8.4).

While the claim is open, click once on the **Print** icon.



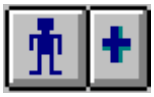
- The report dialogue box will be displayed (because there is only one context-sensitive report in this area, the report pick-list is bypassed)
- Select a printer other than default if necessary.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the invoice before printing.

- Click on **OK** to proceed.

Depending on the options selected, the invoice will either print out immediately or after a preview and print command.

8.3. Reviewing Status Of Payer Accounts

You will, from time to time, wish to review the status of payer accounts. The most expeditious way to do this is through **Patient Records**.



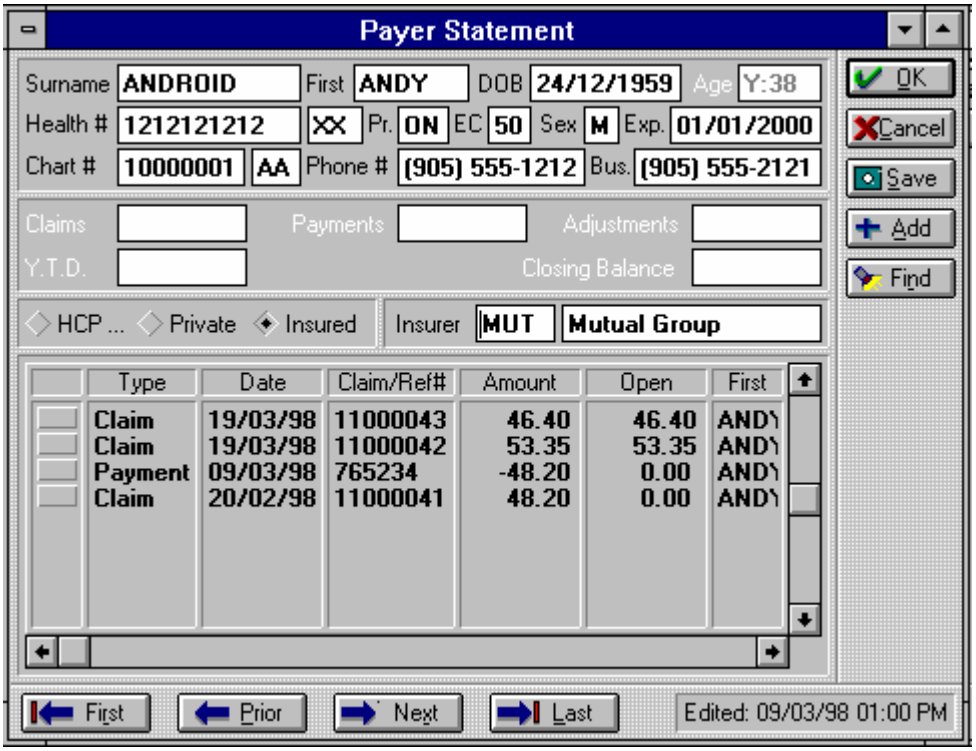
List Patients Add Patients

Click once on **List Patients**. An alphabetical patient list will be displayed. Locate and highlight the desired record by scrolling down (clicking and holding the down-arrow on the scroll-bar to the right of the list) or by typing the first few letters of the patient's surname in the field below the list.

Click on the **List Patient's Financial Statements** side-button.

The **Payer Statement** screen, resembling the one below, will be displayed.

- Click once on the **Insured** radio-button. If the patient has only one insurance company associated it will be pasted in by default. If there are more than one insurance company associated, the **Lookup:Insurers** table will be displayed, and the correct company can be selected by double clicking on it.



The **Payer Statement** features a line-item transaction list pertaining to the type of claims selected (in this case insured), summarized for convenience across the top of the screen. Double clicking on it can access detailed information on any item.

8.3.1. Applying A Payment

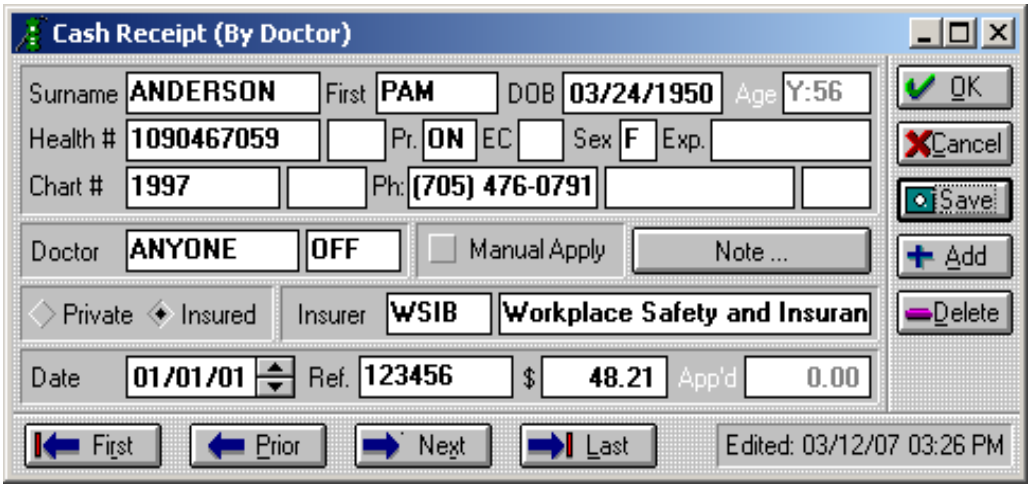
A payment can be applied from the **Payer Statement** screen. This would be the preferred method if payment is received some time after the fact or if you were processing a number of different payments in a batch and wished to quickly generate receipts and statements on the fly.

- Following the steps outlined above, access the **Payer Statement** for the desired patient.

List Payments Add

Click once on the **Add a Cash Receipt or Payment** button.

The **Cash Receipt by Doctor—New Record** screen will be displayed.



- By default, payments are applied to the *oldest* outstanding items first so an accurate aged receivable can be derived.

- The **Insured** radio-button, and the correct insurance company, should already be selected. Accept these defaults. Or, double-click (or right-click, or press F9) in the **Insurer** field, and the **Lookup:Insurers** table will be displayed, and the correct company can be selected by double clicking on it.

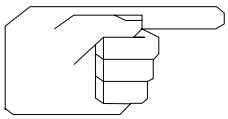
- Click on **Note** if you wish to enter comments. (These comments will appear on the printed receipt.)

- Adjust the **Date** if necessary using the side-arrows to advance or go back on the date, or by double clicking or right clicking on the field and selecting the correct date from a Pick-List.

- Enter a **Reference** if desired, (i.e. a cheque number).

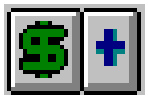
- Enter the amount paid in the **$** field.

- If you wish to print a receipt, click on **Save** to save the payment record but leave the form active. Otherwise, click on **OK** to save the record and exit the form.



This method should *always* be used to apply payments to Insured Claims. *Do not* attempt to enter values directly in the patient's billing record, as this will cause discrepancies in the financial statement reports.

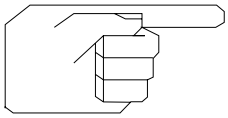
8.3.1.1. Manual Apply of Payment to Specific Claims



List Add Payments

Open the insured claim. While the claim is still open click once on the **Add** Payment icon. A screen resembling the one above will be displayed.

- Click **Manual Apply** box
- Enter the amount paid in the **$** field and in the **App'd** Field, Click on OK and you will be back to the Claim.
- Go to Claim, Enter payment in the **Paid** column
- Put a **"R"** beside each Item on claim, then Click OK. This will apply payment to this specific claim only, and moved to the **Archived Claims**



This method described in Section 8.3 is the preferred method to use when applying payments to Private Claims. *Do not* attempt to enter values directly in the patient's billing record, as this will cause discrepancies in the financial statement reports.

8.3.2. Printing A Receipt

While the receipt is open, click once on the **Print** icon. The report dialogue box will be displayed (because there is only one context-sensitive report in this area, the report pick-list is bypassed)

- Select a printer other than default if necessary.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the receipt before printing.
- Click on **OK** to proceed.

Depending on the options selected, the receipt will either print out immediately or after a preview and print command.

8.3.3. Printing A Statement Of Account

A Statement of Account can be printed from the **Payer Statement** area. This is a " balance forward " type of report that can be set to desired time parameters (i.e. monthly). This provides a summary of insured billings and applied payments for the patient in the period and the outstanding balance owed.

- Following the steps outlined above, access the **Payer Statement** for the desired patient.

While the form is open, click once on the **Print** icon. The report dialogue box will be displayed (because there is only one context-sensitive report in this area, the report pick-list is bypassed)

- Select a printer other than default if necessary.

- Enter a **From** and **To** date if necessary (as would be the case if you wished to generate a monthly report and want the balance adjusted accordingly). Otherwise the report will default to beginning of time to the present.

- Set number of copies if necessary.

- Click once on **Preview** if you wish to view the report output before printing.

- Click on **OK** to proceed.

Depending on the options selected, the Statement of Account will either print out immediately or after a preview and print command.

8.4. Reviewing Insured Claims

As is the case with MOH claims, Insured claims are stored in different areas in **Billing Records**, depending on their status. These areas, and the status they reflect, are summarized below:

- All outstanding claims that have satisfied the error-checking routines of the program are located in **Complete Claims**.

- All outstanding claims that have *not* satisfied the error-checking routines of the program (i.e. missing fee code), but have been saved anyway, are located in **Incompleted Claims**.

- All claims paid in full or written off are located in **Archived Claims**.

To review the status of individual outstanding Insured claims:

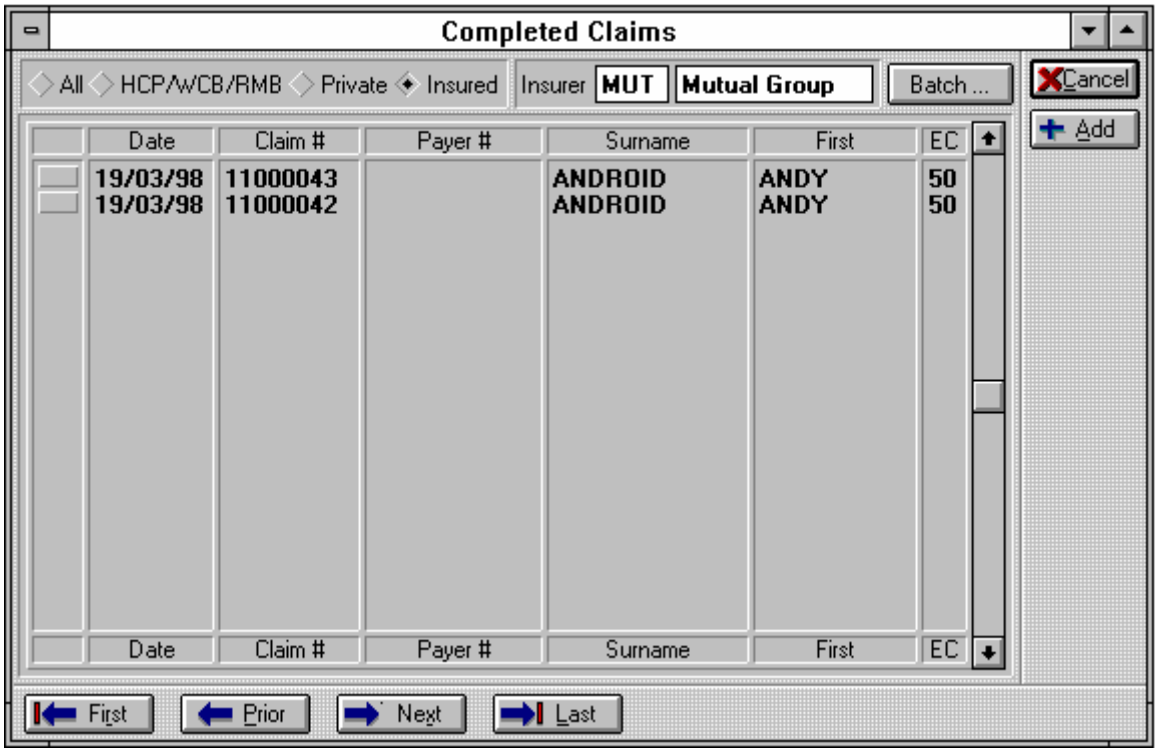
List Claims Add Claims

Click once on the **List Claims** icon.

The **Billing Records** screen, defaulted to the **HCP/WCB/RMB** (MOH type billing) view of the **Complete Claims List**, is displayed.

- Click once on the **Insured** radio-button. If the patient has only one insurance company associated it will be pasted in by default. If there are more than one insurance company associated, the **Lookup:Insurers** table will be displayed, and the correct company can be selected by double-clicking on it.

A list of Completed Insured Claims, resembling the one below, should be displayed.



- Select the claim you wish to view by highlighting it and double clicking. The **Patient Claim (Completed)** form for this claim is displayed. You may view, edit or delete this record.

The side-buttons on the left of the screen indicate the various areas into which claims are put depending on their status.

Click on **Incomplete Claims** side-button once to view **Incomplete Claims List**. Select the claim you wish to view by highlighting it and double clicking.

The **Patient Claim (Incompleted)** form for this claim is displayed. You may view, edit or delete this record. (The usual practice is to complete the claim by adding missing information such as the Fee Code, then saving. If the claim then satisfied the program's error-checking routines, it is moved to the **Completed** area.)

Click on **Archived Claims** side-button once to view **Archived Claims List**. Select the claim you wish to view by highlighting it and double clicking.

8.4.1. Financial Reports

Several financial reports are available in the **Billing Records** area to provide quick summaries of account status with specific or all insurance companies.

List Claims Add Claims

Click once on the **List Claims** icon.

- Click once on the **Insured** radio-button. If the patient has only one insurance company associated it will be pasted in by default. If there are more than one insurance company associated, the **Lookup:Insurers** table will be displayed, and the correct company can be selected by double-clicking on it.

While the screen is active, click once on the **Print** icon. A **Lookup:Reporting** table, resembling the one below should be displayed.

The available reports in this section include Aged Receivables either for all insurance companies or the one selected, and a list of all insured claims for the selected company.

- Select the desired report by highlighting and double clicking on it.
- Select a printer other than default if necessary.
- Enter a **From** and **To** date if necessary (as would be the case if you wished to set date parameters for the **Privately Insured Claims In Period** report). Otherwise the report will default to beginning of time to the present.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the report output before printing.
- Click on **OK** to proceed.

Depending on the options selected, the report will either print out immediately or after a preview and print command.

8.5. Reconciliation

It is possible in the **Patient Claim** screen to " write off " outstanding claims, or remaining balances on claims when these amounts, for whatever reason, become uncollectable, or if discounts apply. Once reconciled, an **Adjustment** entry is added to the patients **Payer Statement** and the claim is archived.

- Access the **Patient Claim** record containing the claim you wish to reconcile, using either the **Payer Statement** screen (see Section 8.3) or **Billing Records** list (see Section 8.4).
- Click once on the **R** field (rightmost in the Fee and Diagnostic Code row) *for all service items contained in the bill*. An "R" should be entered in that field.
- Click once on **OK** to save the change and exit the screen.

The claim has been adjusted an equivalent amount to the outstanding balance and is archived.

9. HERO Mail

HERO allows you to create, edit, transmit and receive e-mail to and from HERO Customer Service.

In this chapter we will discuss:

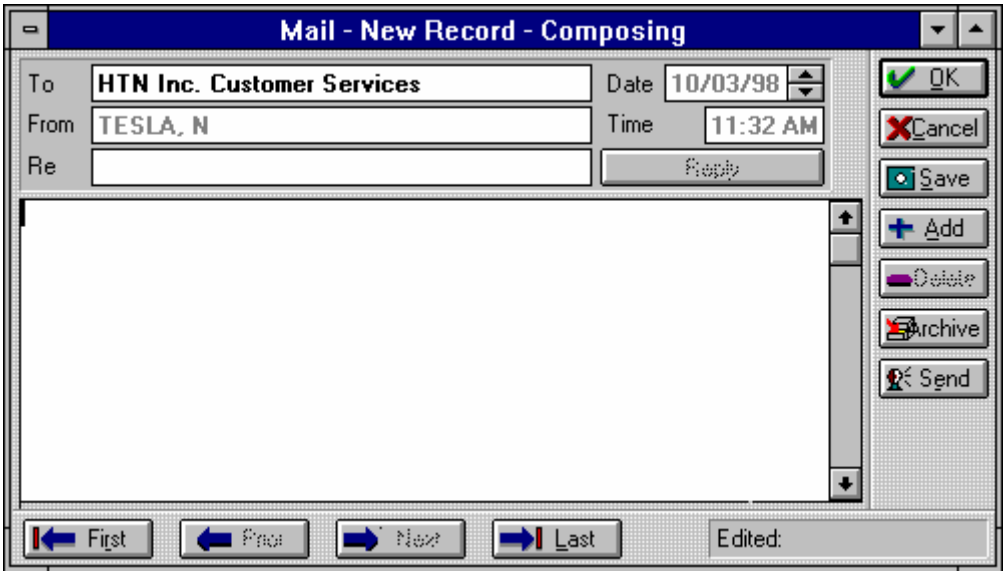
- ⇨ Creating an outgoing e-mail message
- ⇨ Editing or deleting an outgoing e-mail message
- ⇨ Reading and responding to incoming e-mail messages
- ⇨ Archiving and deleting messages
- ⇨ Accessing all types of mail

9.1. Outgoing E-Mail Messages

9.1.1. Creating Messages

List Mail Add Mail

Click once on the **Add Mail** icon. A screen resembling the one below will be displayed.



The **To** field defaults to HERO Customer Service.

***HERO* mail is only for messages between you and HTN Support.**

The **Date** and **Time** field defaults to the current date and time and cannot be modified.

The **From** field defaults to the logged-on doctor and cannot be modified.

The **Re** field should contain the subject of the message (50 characters).

The memo field at the bottom of the form contains the body of the message and has a capacity of 32K (16 pages) of text.

- Using the guidelines above, type in the summary and body of the message.
- To save the message, *without marking it for transmission*, click on **Save** (save message but remain in the screen, or **OK** (save the message and exit the screen). Typically, this would be a message you haven't completed, or wish to edit further before sending.
- To mark the message for transmission, click once on the **Send** button, then click once on **OK** to save the message and exit the screen.

All messages marked for **Send** will be sent on the next scheduled transmission or during the next forced transmission. (For further information on the HERO transmission cycle see Chapter 6: **Transmitting, Receiving And Adjusting MOH Files**.)

HERO subscribers are strongly urged to use the HERO Mail feature to transmit support issues whenever possible. A detailed response can be sent back, usually within one business day, that will save time and eliminate the " fax loop " that many such questions inevitably involve.

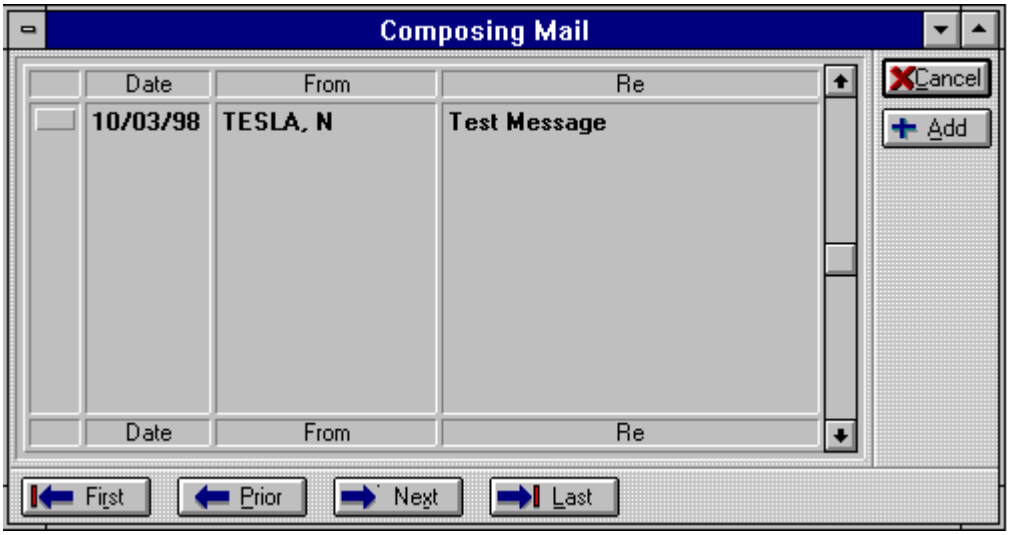
9.1.2. Editing or Deleting Messages

All outgoing messages not marked for send can be edited or deleted at any time.

List Mail Add Mail

Click on the **List Mail** icon once. The **Mail** screen, defaulted to **Unread Mail**, will be displayed.

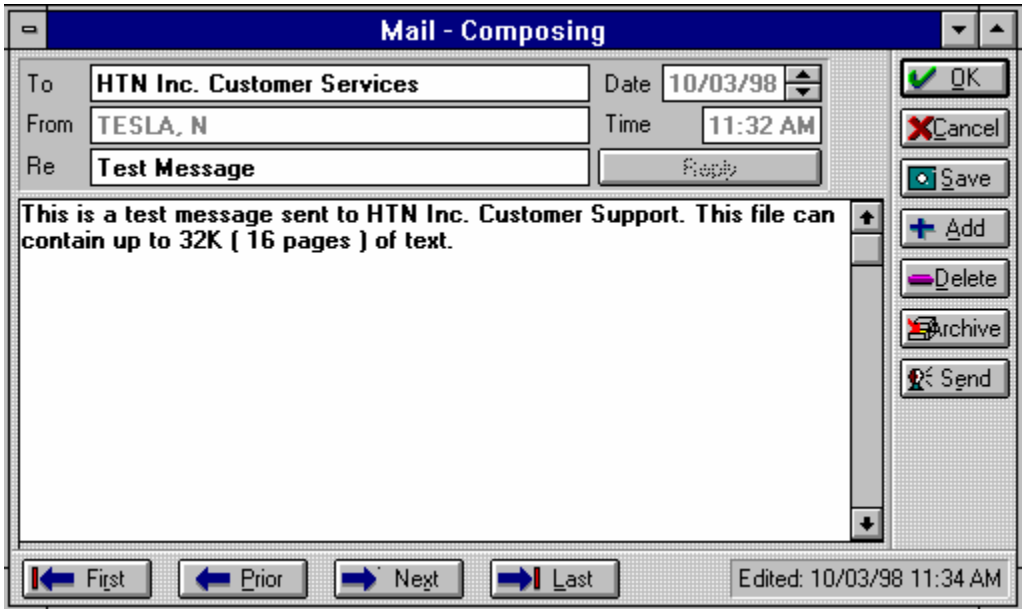
Click on the **Composing Messages** side-button. A screen resembling the one below will be displayed.



A list of all messages is displayed. To access a message double-click on the appropriate item. A screen resembling the one below will be displayed.

- You may edit all available fields and/or text following the guidelines contained in the previous section. When finished, you can either save it for further editing or mark for send.

- To delete a message, click once on the **Delete** button on the right side of the form. A dialogue will prompt you for confirmation. Click on **OK** to delete. This message will have disappeared from the **Composing Mail** list once you exit the form.



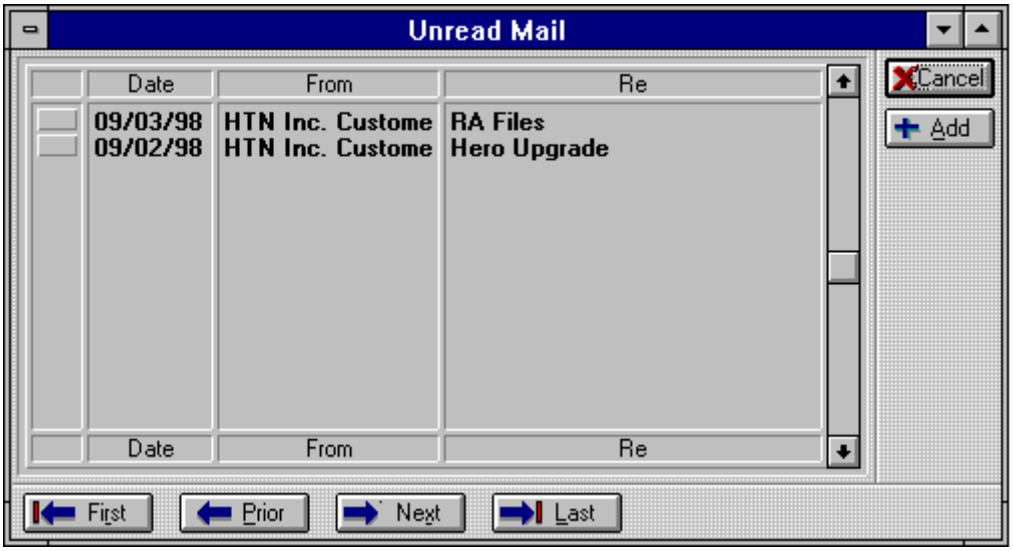
9.2. Incoming E-mail Messages

As we have seen in the previous section, all mail is referenced through the **Mail** screen and it's associated side-buttons. This allows you to compose, read, respond to and archive messages quickly.

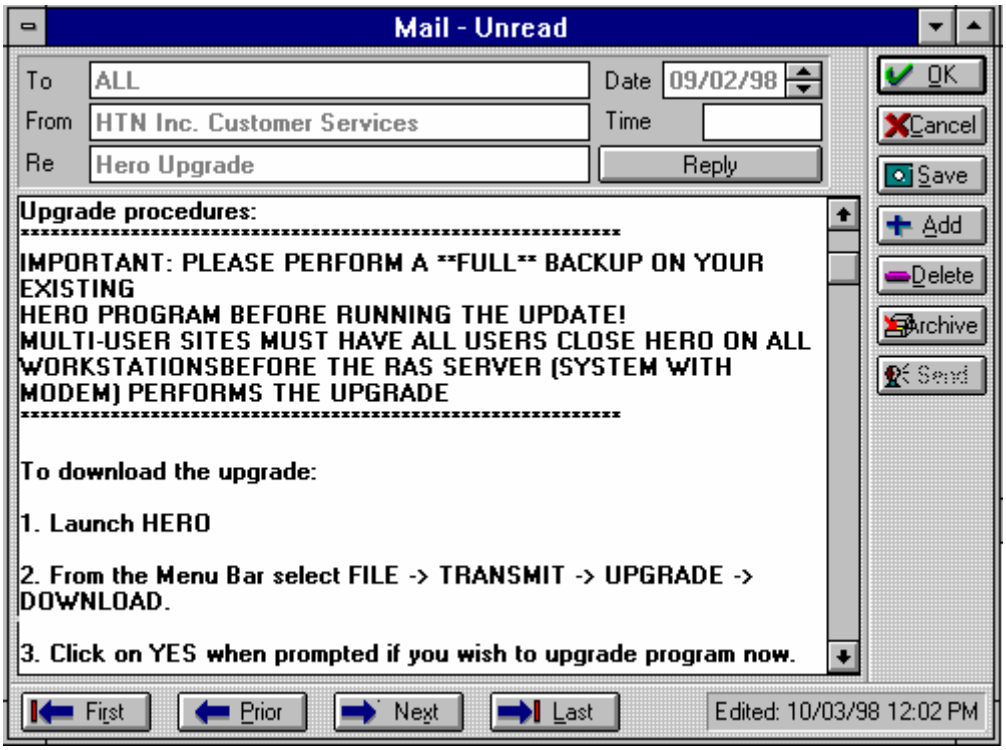
To read new mail:

List Mail Add Mail

Click on the **List Mail** icon once. The **Mail** screen, defaulted to **Unread Mail**, will be displayed.



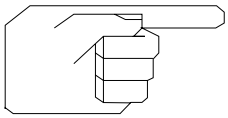
A list of all unread messages is displayed. To access a message double-click on the appropriate item. A screen resembling the one below will be displayed.



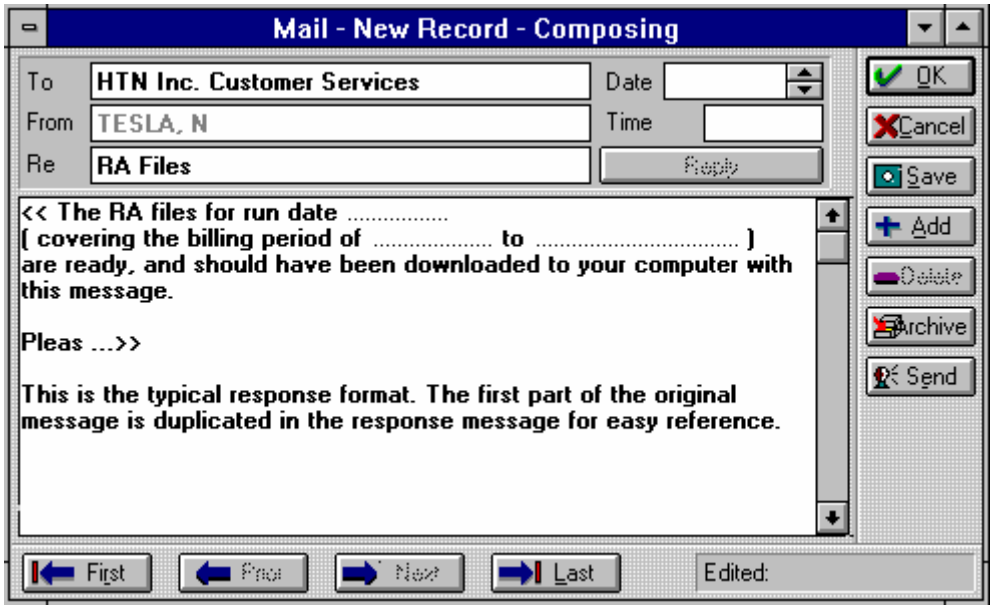
- To delete a message, click once on the **Delete** button on the right side of the form. A dialogue will prompt you for confirmation. Click on **OK** to delete. This message will have disappeared from the **Composing Mail** list once you exit the form. Alternatively, you may simply click on **OK** to exit the form and it will automatically be moved into the **Read Mail** bin.

- To archive the message (remove the message from the **Unread Mail** bin but store it in the **Archive** bin for future reference) click once on the **Archive** button.

- To reply to a message, click once on the **Reply** button. A screen resembling the one below will be displayed. You will note that the first part of the original message is pasted into the reply for easy reference (once you are using e-mail extensively it is easy to forget the particular message that was responded to). The original text (consistent with conventions on the Internet, CompuServe etc.) is surrounded by " << >> " signs to demarcate it. The body of the response is added underneath.



The Reply paste may be highlighted and deleted if you feel its inclusion in the reply is unnecessary, or you wish to recover some message space.



- Once you have composed your reply you may save it without sending (**Save** and/or **OK**) or mark it for send (**Send** button).

9.3. Types of Mail

As we have already seen, different types of mail can be viewed by clicking on the **Mail** button and clicking on the various side-buttons. What follows is a summary of the location of all types of mail.

List Mail **Add Mail**

Click on the **List Mail** icon once. The **Mail** screen, defaulted to **Unread Mail**, will be displayed.

9.3.1. Side Buttons

List all **Unread Mail** (default).

List all **Read Mail**.

List all **Composing Mail** (saved but unsent).

List all **Sent Mail** (includes all transmitted mail and mail ready for transmission).

List all **Archived Mail**.

9.4. Printing E-Mail Lists

You can print detailed lists of e-mail by status, based on the type of mail you are viewing. (For a more detailed discussion of ***HERO*** reports, please refer to Chapter 13: **Reports**.)

- Using the steps outlined above access the e-mail list by clicking on the **Mail** button and select the type of e-mail by clicking on the appropriate side-button.

Print Reports

While the area is active, click once on the **Print Reports** icon.

- Select a printer other than default if necessary.
- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the report output before printing.
- Click on **OK** to proceed.

Depending on the options selected, the report will either print out immediately or after a preview and print command.

10. Appointment Scheduler

HERO contains a full-featured appointment scheduler that allows physicians to book patient appointments in an intuitive " day book " format. The scheduler supports multiple physicians; user-defined slot-lengths, configurable appointment lengths and available times; conflict-checking, over-booking, automated re-booking and status tracking (i.e. " To Confirm, Confirmed, Arrived, Completed, No Show and Reschedule "). Schedule information can be viewed several ways including the day-book interface itself (by appointments only or time-grid) and in patient information as a sequential list for that patient. All appointment views support appropriate reports.

In this chapter we will discuss:

- ⇨ Creating appointments
  - 🕮 Simple appointments
  - 🕮 Conflict-checking and overbooking (forced appointments)
  - 🕮 Recurring (multiple) appointments
- ⇨ Viewing/editing appointments
  - 🕮 Viewing appointments
  - 🕮 Modifying/deleting appointments
  - 🕮 Rebooking appointments (follow-up visits)
- ⇨ Printing appointments

10.1. Doctor Available Hours

Before the appointment scheduler can be used for a particular doctor, that doctor's available hours must be set up in the system setup area. For further details please see Chapter 4: **System Setup**.

10.2. Creating Appointments

10.2.1. Simple Appointments

Appointments can be created either by pressing the **New Appointment** button or through the day-book screen.

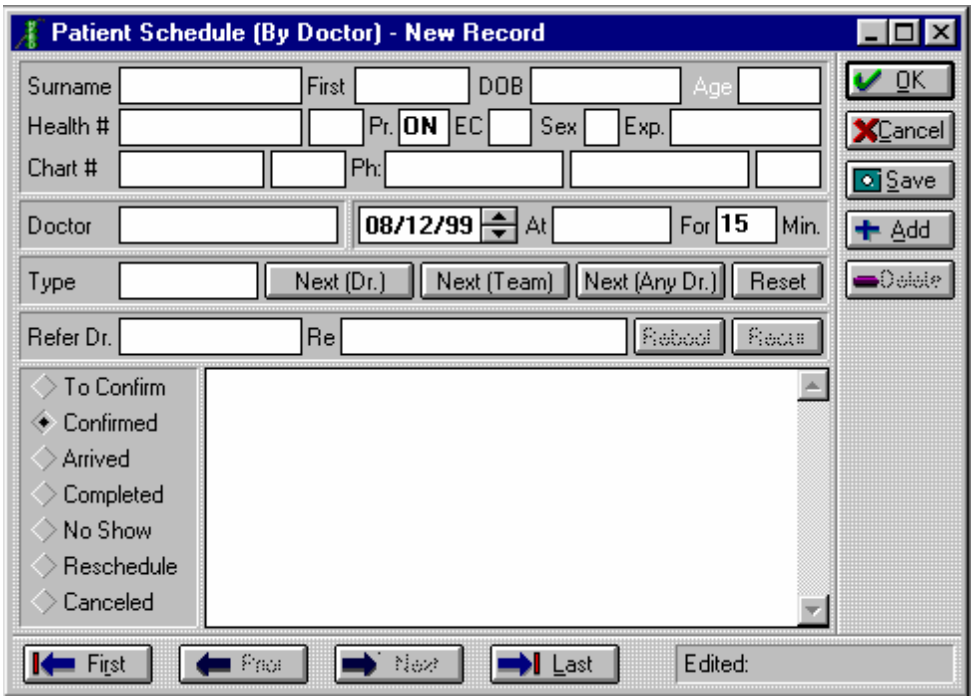
10.2.1.1.New Appointment Button Method

List Appts Add Appts

Click once on the **Add Appointment** button. The **Patient Schedule (By Doctor) New Record** screen will be displayed.

- Select a patient by double-clicking on the **Surname** field and selecting from a pick-list.

The patient's name, and other relevant information will be pasted in.



The **Doctor** field defaults to the logged-on doctor. You may select another doctor, if necessary, by double-clicking on this field and selecting from a pick-list.

The **Date** field defaults to the current date. This can be modified by either using the up-down arrows on the right, or double-clicking on the field to access a calendar and select another date.

The **At** field refers to the time of the appointment. You may either type in a time using standard abbreviations (i.e. " 1P " for 1:00 PM) or double-click on the field to view the available times. Double-click on the desired time to paste it in.

The **For** field represents the length of the appointment and defaults to the value entered for that doctor in system setup. It can be modified by typing in a new value.

Type allows the selection of various classes of appointment (i.e. annual physicals).

The next series of buttons (**Next (Dr.), Next (Team), Next (Any Dr.), Reset**) allows you to step through the next available appointment either for the logged-on doctor, members of the doctors " team ", or *any* doctor in the database. (For a full discussion of assigning doctors to teams please refer to Chapter 4: **System Setup**, Section 5.) The **Reset** button restores the time to the original default.

The **Re** field should contain a brief description of the nature of the appointment (50 characters).

Rebook allows you to add a second appointment for the patient after saving the original. It is a quick way to schedule a follow-up type appointment.

Recur allows you to book multiple recurrent appointments for the same patient.

The memo field at the bottom of the form can be used to enter a detailed description of the appointment, notes etc. It has a capacity of 32K (16 pages) of text.

To the left of the memo field is a series of radio buttons that can be clicked to reflect the *status* of the appointment. It defaults to **Confirmed**. This feature is especially useful for tracking such events as the arrival of patients or **No Shows**, which can quickly be referred to in the patient information screen. Most of the buttons are self-explanatory with the exception of **Arrived** and **Reschedule**.

Arrived can be clicked if you wish to track patients as they arrive for their appointments. This is especially useful on a local area network where the physician is monitoring arrivals remotely. (To use this option, the remote PC would need to have **Local Screen Refresh** enabled. Please refer to Chapter 4 : **System Setup**, Section 4, for details.)

Reschedule is a way of flagging appointments that need to be rescheduled. Typically, this would occur in a busy practice where the assistant doesn't have time to reschedule the appointment at the time, but wishes to refer to it later.

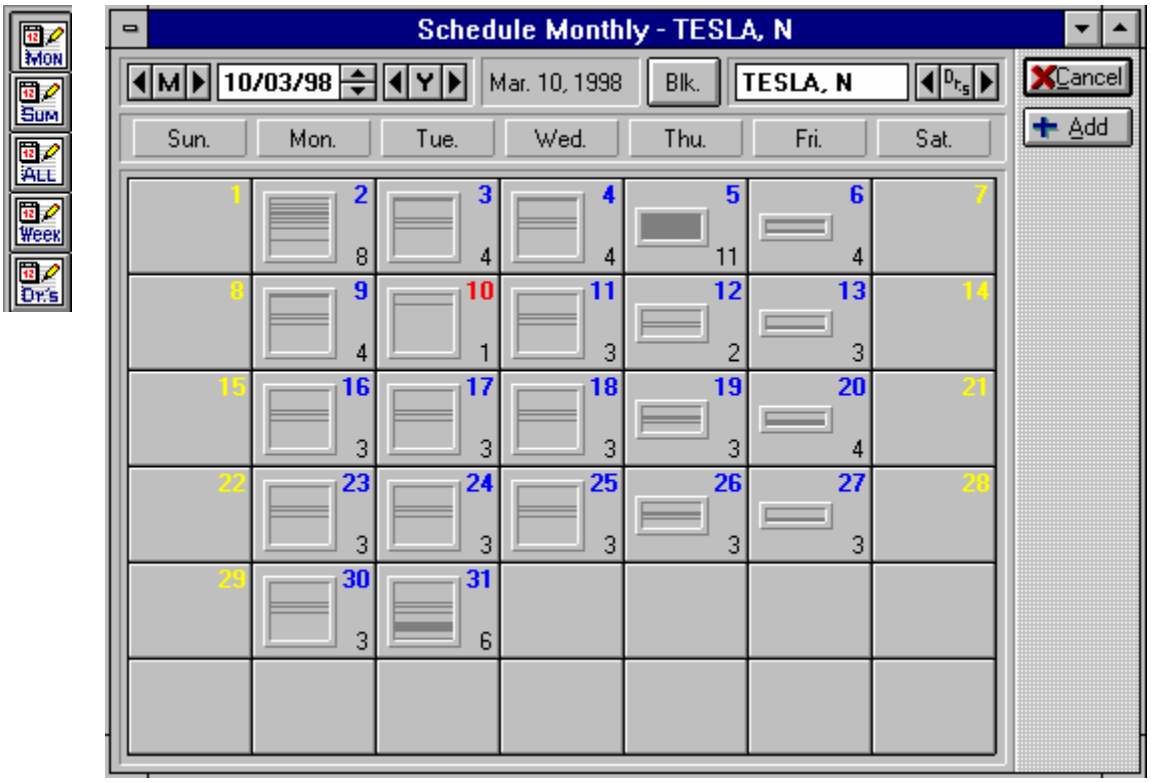
- Once you have entered the appropriate appointment information click once on **Save** (save but remain in the form) or **OK** (save and exit the form).

10.2.1.2.Day Book Method

A quick and centralized method of booking appointments for several patients is to work directly out of the day-book screen.

List Appts **Add Appts**

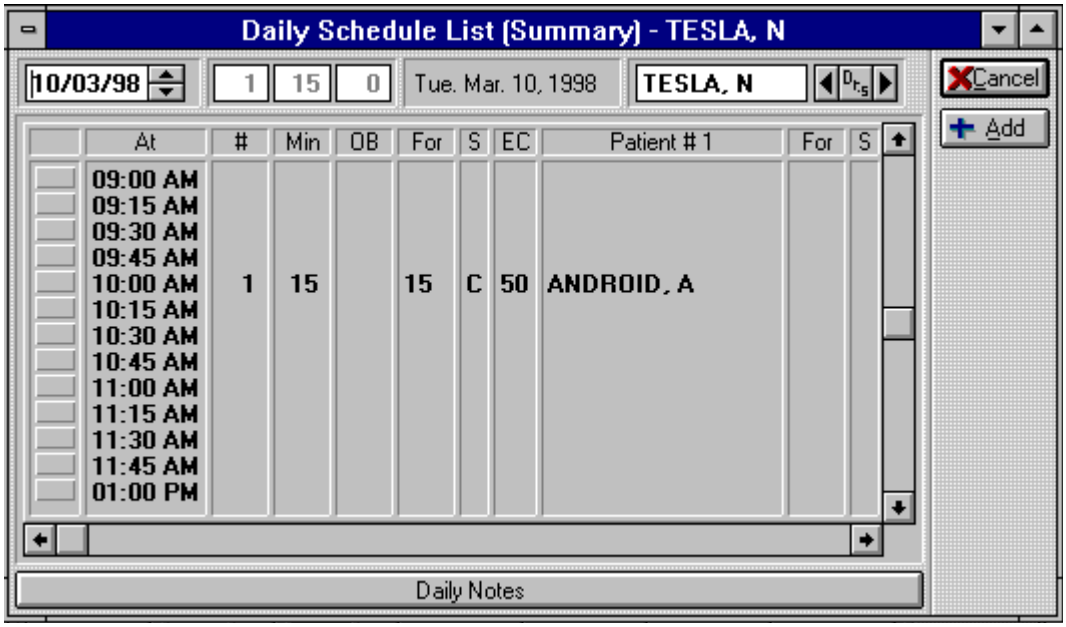
Click once on the **List Appointments** button. A screen resembling the one below will be displayed.



A month view is displayed with quick reference information. The size of the box for any particular day represents the portion of the day that the Physician is setup for appointments. The number at the bottom right corner of the day shows the number of appointments booked for the day, and the grey lines in each day box show the approximate "weight" of bookings and approximate time of day locations.

Double click on the day you wish to book an appointment(s), or select the day and click on the side bar button:

A screen resembling this one will be displayed.



The **Date** field defaults to the current date. This can be modified by either using the up-down arrows on the right, or double-clicking on the field to access a calendar and select another date.

This button will allow you to scan through bookings for various physicians on a multi-doctor site.

A list of all appointments for the current date is displayed, by time-slot, with number of bookings for each time slot (#), minutes booked in time slot (Min), over booked minutes (OB), length of the appointment (For), appointment status (S), OHIP Eligibility Code (EC), the patient name (Patient # x) for up to six patients in any time slot.

At the bottom of the screen is the **Daily Notes** button. Click once on this to access a notepad type screen where you can enter any notes specific to appointments for that day. It has a capacity of 32K (16 pages) of text.

To book a simple (i.e. not overbooked) appointment double-click on a blank time-slot.

You will be prompted to confirm that you wish to add an appointment for the selected date and time. Click on **Yes** to proceed. The **Patient Schedule (By Doctor) New Record** screen, as described in the previous section, will be displayed with the date and time already pasted in.

- Select a patient by double-clicking on the **Surname** field and selecting from a pick-list. Click on the appropriate status radio-button if necessary and add any required notes.

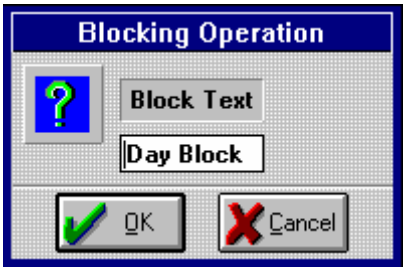
- Once you have entered the appropriate appointment information click once on **Save** (save but remain in the form) or **OK** (save and exit the form). If you click on **OK** you will be returned to the day book where you can quickly enter the next appointment.

10.2.2. Day Blocking / Blocking Unavailable Times

It may be periodically necessary to block unavailable times (i.e. when the doctor is in the operating room) that do not occur consistently enough to warrant adjusting the doctor's available hours (for a complete discussion of setting available hours please refer to Chapter 4: **System Setup.**)

To block an entire day:

In the ***MONTH*** view of Appointment scheduler, click once on the day you wish to select for blocking, and then click on the Blk. button show here.



This prompt will appear. You may enter any text to indicate the block reason (e.g. Holiday, etc.) or accept the default "Day Block" and click once on **OK**
The text you enter will be placed on the selected day in the ***MONTH*** view of Appointment Scheduler.

To block an unavailable time:

- Using one the methods outlined above, access the **Patient Schedule (By Doctor) New Record** form.

- Leave the patient information section (i.e. **Surname** etc.) *blank*.

- The **Doctor** field defaults to the logged-on doctor. Select another doctor, if necessary, by double-clicking on this field and selecting from a pick-list.

- The **Date** field defaults to the current date. Modify it if necessary by either using the up-down arrows on the right, or double-clicking on the field to access a calendar and select another date.

- The **At** field refers to the start time of the unavailable block. You may either type in a time using standard abbreviations (i.e. " 1P " for 1:00 PM) or double-click on the field to view the available times. Double-click on the desired time to paste it in.

- The **For** field represents the length of the unavailable and defaults to the value entered for that doctor in system setup. Modify it by typing in a new value.

- Enter a brief description of the block (i.e. " Operating Room ") in the **Re** field. This will show up both on the **Daily Schedule List** and any reports generated. **You must enter/modify text in at least one field (e.g. For, Re, Notes, etc.) in order to avoid HERO treating the entry as incomplete.**

- Once you have entered the appropriate appointment information click once on **Save** (save but remain in the form) or **OK** (save and exit the form).

You will be prompted to accept the entry as a blocking appointment.

- Click on **Yes** to accept, **No** to exit the form altogether, or **Cancel** to return to the **Patient Schedule (By Doctor) New Record** form

The blocked time will appear on the **Daily Schedule List** as a series of line-items in the appropriate time-slots marked **Blocked:[Re]** (for example: Blocked:Operating Room).

10.2.3. Conflict-Checking and Overbooking

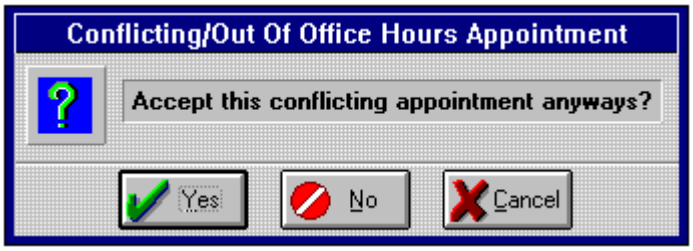
In some practices it is common to overbook appointments, that is, force more appointments into the same appointment time than actual time available, to maximize a physician's efforts and eliminate potential slack-time. An overbook percentage can be set up as a default, as described in Chapter 4: **System Setup**, which simply means the conflict-checking mechanism will not flag a potential conflict until that percentage is exceeded. However, an appointment can be forced into any appointment time by simply over-riding the conflict warning.

10.2.3.1.The Conflict-Checking Mechanism

Whenever you attempt to *enter* an appointment by double-clicking on an existing appointment, the program will present these choices:

At that time you may elect to click on **Cancel** to select another appointment time, **View** to view the appointment, or **Add** to force the appointment into that time.

Whenever you attempt to *save* an appointment that conflicts with an existing appointment, exceeds the overbook percentage default, or falls outside of the doctor's available hours, the program will flag the conflict:



At that time you may elect to click on **Cancel** to select another appointment time, **No** to cancel the appointment altogether, or **Yes** to accept the overbook and force the appointment into that time.

10.2.4. Recurring Appointments

Recurring appointments, as the name suggests, are appointments that occur more than once at a defined interval (i.e. daily, weekly etc.). Appointments of this type can be quickly created in ***HERO***.

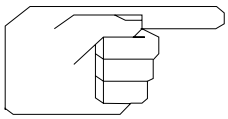
- Create a new appointment using the guidelines contained in the **Simple Appointments** section. (This will be the first appointment in the series.)

- Click once on **Save** to save the appointment but remain in the form. You will note as soon as the appointment is saved, the **Recur** button is no longer grayed out. Click once on the **Recur** button.

The **Recurring Appointment** screen will be displayed. In our example we have added 26 additional Bi-weekly appointments on Tuesdays beginning March 3, 1998 and ending March 3, 1999. This is accomplished by clicking on the **Bi-Weekly** radio button, clicking once on the **Tuesday** check box, and by double-clicking on **End Date** to display a calendar and select the date.

The **Occurrences** field will automatically register the number of additional appointments. This field can be changed by typing in a new value, and the dates will be adjusted accordingly.

The **Conflict Check** option will enable conflict-checking for all recurring appointments if it is clicked (it displays a check mark when active). Otherwise all appointments will be forced automatically.



Please check all recurring appointments—especially with reference to Occurrences—before saving. See <u>Modifying/Deleting Appointments</u> in the next section for the quickest way to delete appointments.

The **Recurring Appointment** form contains " smart fields " that are enabled or disabled based on the combination you employ. For instance, if you select **Daily**, all available days of the week will be checked automatically, if you select **3 Months**, all days of the week will be grayed out.

- To save your work, and create the appointments, click once on **OK**.

10.3. <u>Viewing/Editing Appointments</u>

There are several ways to view appointments, depending upon whether you prefer to group them by time (the day book) or by patient (patient records). In either case, the appointments can be accessed in full detail and modified.

10.3.1. Viewing Appointments

10.3.1.1.Day Book

As we have already seen, the day book contains a list of all appointments for the current date. The particular views of the day book are determined by the side-buttons on the form. Whichever view you choose, double-clicking on the desired entry will display the full appointment details for that patient, which can then be modified accordingly.

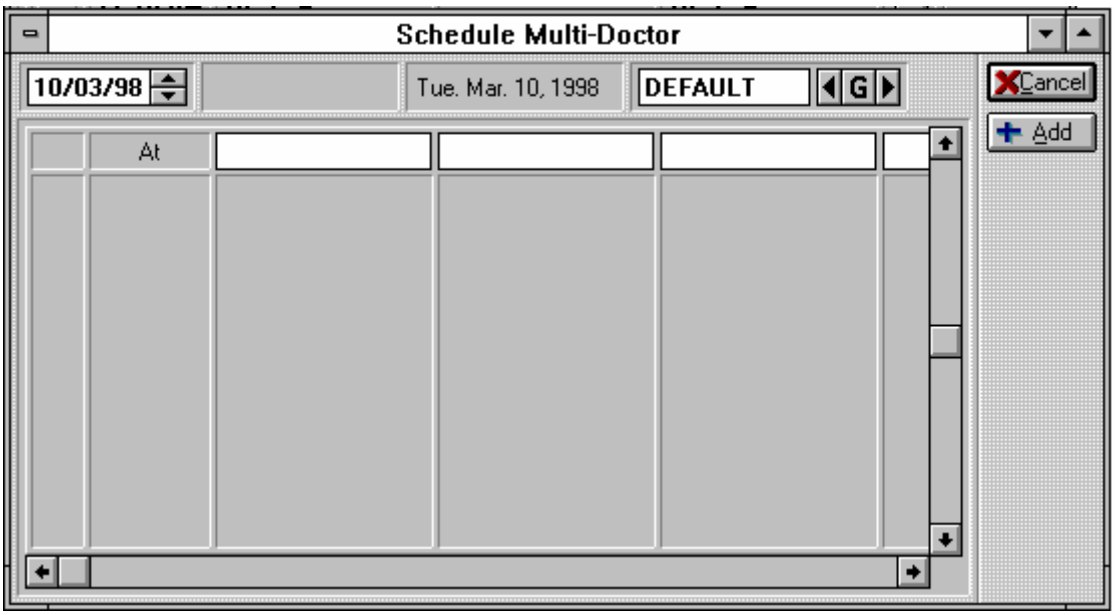
The default view is **Month**, showing a calendar view as described earlier in this chapter.

The **Summary** view is a time-grid with summary patient information showing all appointments and open time slots.

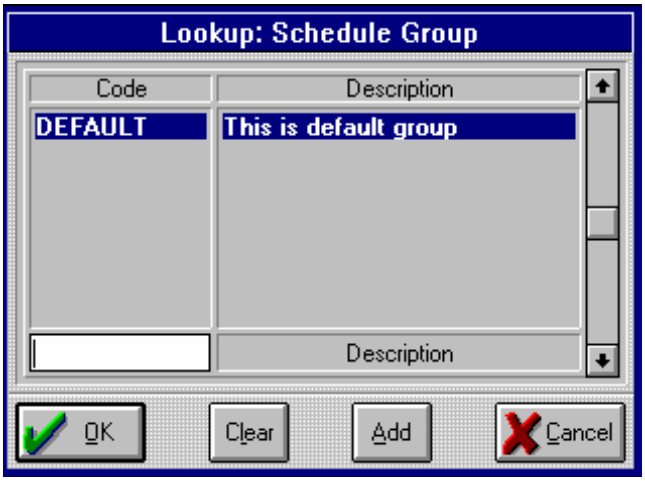
The **Detailed** view shows only those slots that contain appointments.

The **Week** view will show all appointments for the week. Patient initials are used instead of full names.

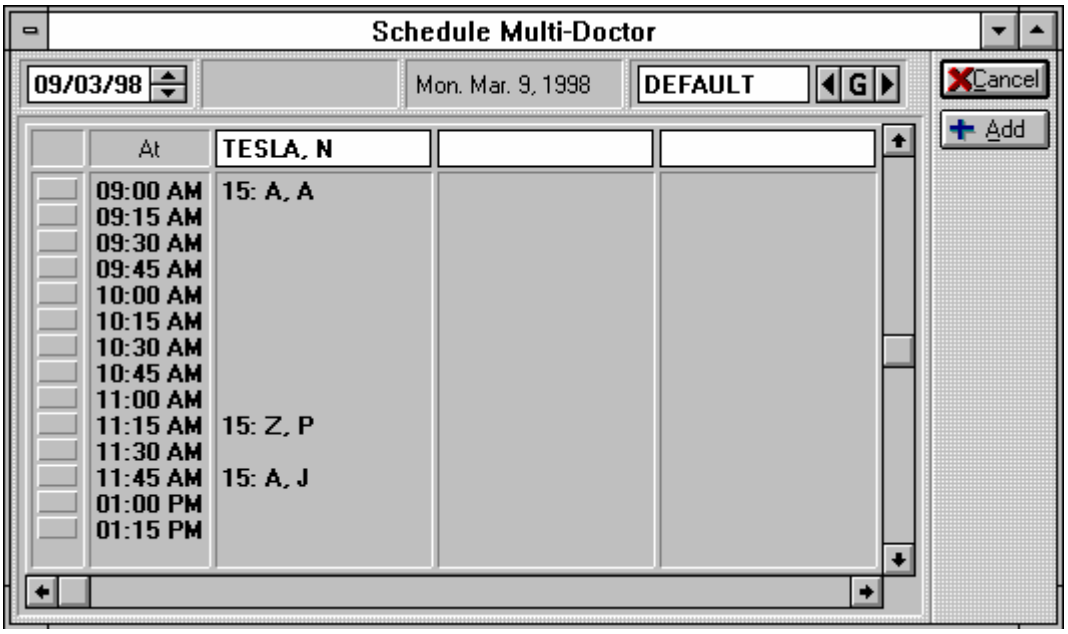
The **Dr.'s** view will show schedules for multiple doctors, displayed in selectable groupings.



Use this button in **Dr's** view to select a defined grouping or doctors.



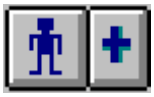
- To define a grouping, double click on the group name field to the left of the **G** button, and select **Add** to enter a new group name. Use the **Default** group to include doctors you wish displayed by default when selecting **Dr's** view.
- Double click on any of the blank white fields and select a doctor from the lookup list for membership in the current grouping. The following is a sample of what you will see:



- You may have up to ten doctors in any group, and any number of groups.

10.3.1.2.Patient Records

To view the appointments for a particular patient:

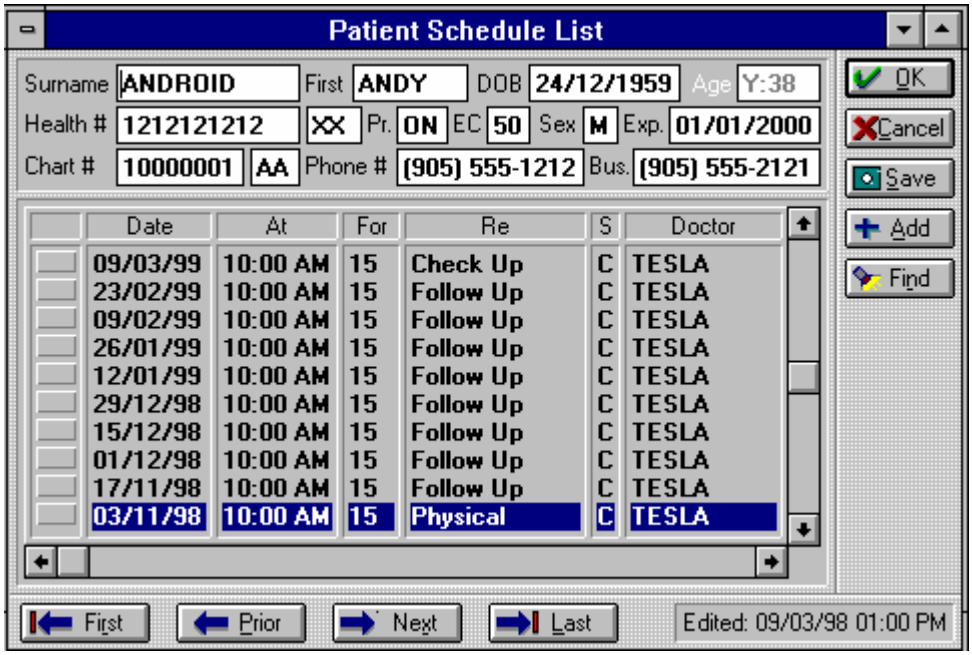


List Patients **Add Patients**

Click once on the **List Patients** icon.

The **Patient Information** screen is displayed by default.

- Click once on the **List Patient's Appointments** side-button. A screen resembling the one below will be displayed.



- To view full appointment details, double-click on the desired item.

10.3.2. <u>Modifying/Deleting Appointments</u>

10.3.2.1.Modifying Appointments

- Using one of the methods in the previous section, access the desired appointment.

- Using the guidelines contained in the **<u>Simple Appointments</u>** section, modify the **Date**, **At**, **For**, **Re**, memo and status fields as required. In most instances you will be using this feature to change the date or time of an appointment, or to update the status (i.e. record a **No Show**).

- Once you have edited the appropriate appointment information click once on **Save** (save but remain in the form) or **OK** (save and exit the form).

10.3.2.2.Deleting Appointments

- Using one of the methods in the previous section, access the desired appointment. (In the event of a recurring appointment, the quickest method is to access records through patient information.)

- Click once on the **Delete** button. You will be prompted to confirm deletion. Click once on **OK**.

- If the appointment is a recurring appointment, and some of those occurrences are in the *future* (on or after the current date), you will be asked if you want to delete all future occurrences of that appointment as well. You can select **Yes** or **No**.

10.3.3. Rebook

The rebook feature allows you to quickly enter a single follow-up appointment. Typically this would take the form of an annual checkup, six-month follow-up and so on.

- Using one of the methods in the previous section, access the desired appointment.

- Click once on the **Rebook** button. A pick-list of available times will be displayed.

The **On** field defaults to the current date. This can be modified by either using the up-down arrows on the right, or double-clicking on the field to access a calendar and select the desired date.

- After selecting the date, select an appointment time by highlighting the appropriate slot.

- Click once on **OK** to save the entry and create the rebooked appointment.

10.4. Printing Appointments

Appointment lists can be printed out either in summary or detailed format. The summary report contains only the line-item appointments, patient name, length of appointment etc., printed out in a " day-book " format. The detailed report includes any notes entered in the appointment record and the daily notes.

Click once on the **List Appointments** button.

While the **Daily Schedule List** is open, click once on the **Print** icon. A **Lookup:Reporting** table, resembling the one below should be displayed.

- Select the desired report by highlighting and double-clicking on it.
- Select a printer other than default if necessary.

Enter a **From** and **To** date if necessary (as would be the case if you wished to print schedule reports for multiple dates). Otherwise the report will default to the date selected on the **Daily Schedule List**.

- Set number of copies if necessary.
- Click once on **Preview** if you wish to view the receipt before printing.
- Click on **OK** to proceed.

Depending on the options selected, the report will either print out immediately or after a preview and print command.

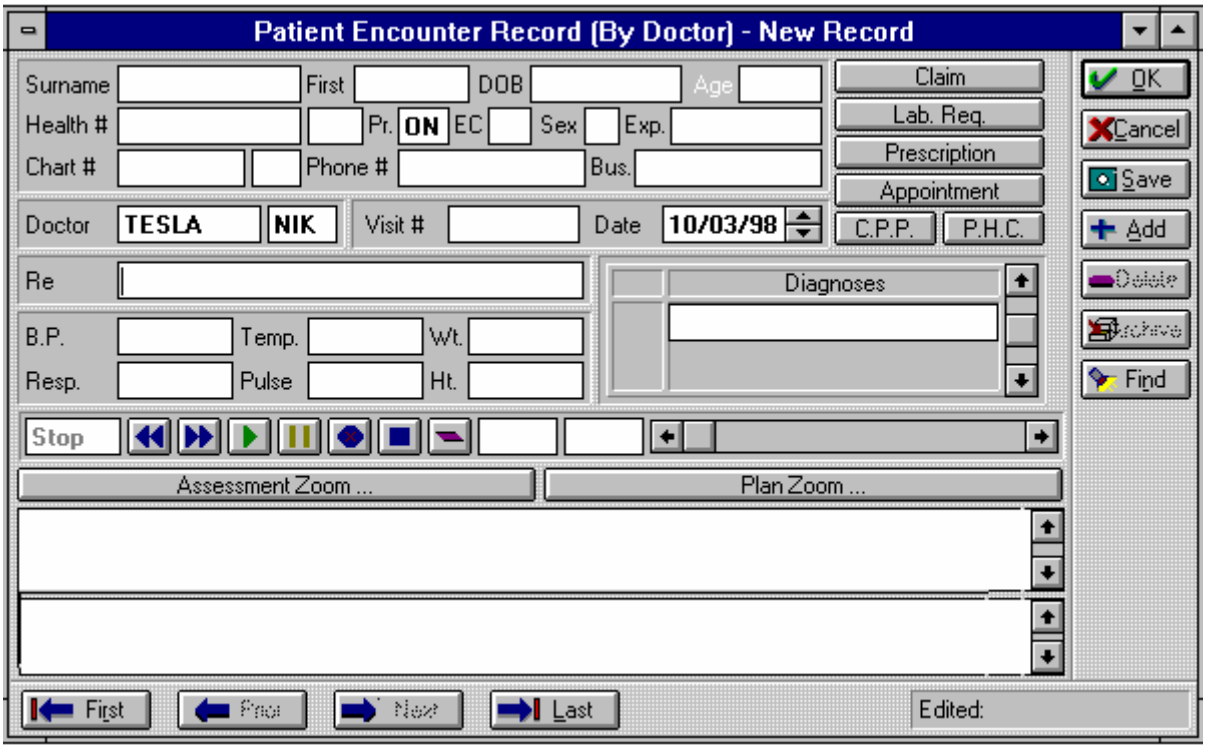
11. Patient Encounter Records

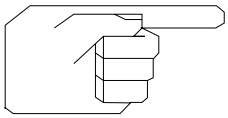
In addition to being a comprehensive billing system, ***HERO*** is also a medical record database that allows the physician to record patient encounters, track progress, generate reports etc. With the installation of optional hardware, a doctor can even voice-record his notes and have them transcribed later.

11.1. Adding A Patient Encounter Record

Click on the **Add Encounter** icon.

A screen resembling the illustration below will be displayed.





If you are in any other area of the program with a patient record active and click on the Add Encounters icon, the core patient information will automatically be pasted into the form.

For the most part, you will be recording encounters with patients who are already registered in the system. (Even if this is their first encounter, it is likely that you will already have swiped their Health Card or manually entered a claim.) You may however enter new patients in this area—the core patient information is automatically saved in the database.

11.1.1. Record Patient Encounter Using Health Card

- Swipe the Health Card.

Read Input From Card-Reader

(If using a keyboard type magstripe reader, the **Read Input From Card-Reader** icon must be clicked first.)

The **Surname, First Name, Birthdate, Health Number, Province,** and **Sex** are all entered automatically, and you may then optionally complete the rest of the form.

11.1.2. Record Patient Encounter Using Lookup Table

- Access the **Lookup:Patients** table by double clicking or right clicking in the **Surname** field, or pressing **F9**.

The **Lookup:Patients** List is displayed.

- Select the desired patient by highlighting and either double clicking on the item or pressing **ENTER**.

The patient's **Surname, First Name, Birthdate, Health Number, Province,** and **Sex** are all entered automatically per the information stored in the database. (**Chart #** and **Phone #'s** will also be pasted in if already entered in the database.)

The **Doctor**, **Alias**, **Visit #**, and **Date** fields will have been pasted in automatically. You may edit the **Doctor** or **Alias** by accessing the **Lookup:Billing Doctors List** and selecting another. You may edit the **Date** field either by manually entering another date or using the up or down arrows to advance or go back one day at a time.

11.1.3. Entering Patient Notes

Below the basic patient information is a series of icons resembling the command buttons on a tape-recorder, and underneath them a large **Notes** field. (For a full description of the voice recording features please refer to the following section: **Voice Recording And Transcription**.)

- To enter patient notes click once on the upper-left corner of the **Notes** field and type in the text.
- Click on **OK** to exit the screen and save the entry.

11.1.3.1.Putting Defaults

You may enter text defaults in the notes field—i.e. headings, categories etc.—that will be automatically pasted in to all new encounter notes thereafter.

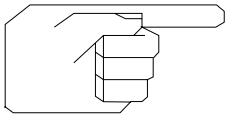
To put defaults:

- Open a *blank* **Patient Encounter Record**.
- Enter the default text in the **Notes** field of a new encounter record.
- From the **Main Menu** select EDIT ➔ PUT DEFAULT. Click on **OK** when prompted to overwrite the previous default.

You may change defaults at any time by editing the default text and repeating the above process.

11.2. Voice Recording And Transcription

The **Patient Encounter Records** module has a voice recording feature that makes it especially useful to physicians who want to record their notes on the fly and have them transcribed later.



The voice recording option requires special hardware to run. You may install any MPC-compatible card (WaveForm) to enable this feature.

11.2.1. Recording Patient Notes

- Using the steps outlined above, enter the basic patient information.

The command buttons for the voice recording feature are as follows:

- Click on the **REC** button once to record. Speak at a normal volume.
- When you have finished recording press the **Stop** button once.
- Click on **OK** to exit the screen and save the entry.

11.2.2. Transcribing Patient Notes

Once a Patient Encounter Record has been saved with a voice-recorded entry, it can be transcribed at any time, after which the original voice recording can either be retained for future reference or deleted.

Click on the **List Encounters** icon.

As the name suggests, the **Patient Encounter Records** are contained in this area, subdivided into **Completed** and **Archived**. The list defaults to **Completed** and the **Archived** area can be are accessed by clicking on appropriate side-button to the left of the main screen.

- Select the desired record by highlighting and double clicking or pressing **ENTER**.

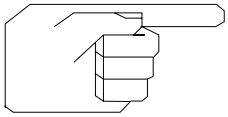
The **Patient Encounter (By Doctor)** screen is displayed, with the details of the selected patient.

To transcribe the voice recording:

- Advance the cursor to the voice recording section by clicking in the **Notes** area once.
- Click once on the **Play** button.

- Click once again in the **Notes** area and begin typing. You may use the mouse to **Pause, Rewind** and/or **Fast Forward** by clicking on the appropriate button.

- When you are finished, and satisfied with the transcription, you may delete the voice entry by clicking on the **Delete** button in the voice recording bar. *This will not effect your written entries*. You will be prompted to confirm the deletion. If you select YES the voice entry will be deleted.



Voice entries tend to take up significant amounts of disk space. Unless you have a specific reason for retaining a particular voice entry you are encouraged to delete them once you have transcribed their contents.

12. Maintenance

For the most part ***HERO*** is a self-regulating system, which means that record maintenance is largely automatic. There are a few functions in the program, however, that require the discretion of the user and are thus set to be performed manually.

In this chapter we will discuss the following:

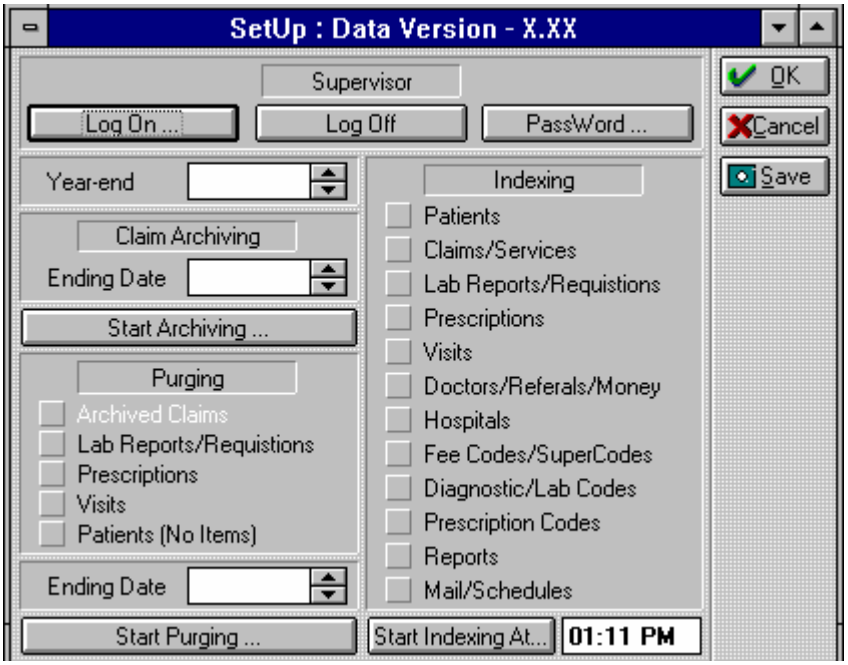
- ⇨ Indexing
- ⇨ Remote upgrades
- ⇨ Backing up data

12.1. Indexing

In managing its various databases ***HERO*** makes extensive use of *indexes*, specialized files that greatly enhance the ability of the program to access records quickly. As databases become larger and the numbers of transactions multiply, however, these index files can become inaccurate. It is a good idea therefore to rebuild these files periodically through indexing.

Setup Utilities

Click the **Utilities** icon once to access Supervisor functions. Your screen should resemble the one below:



To index immediately:

- ***Before proceeding ensure that no one else is using the program. HERO should be closed on all computers except the server.***

- Select the desired database files by clicking once in the appropriate box beside the name. A check mark denotes the selection.

- When all files are selected click once on the **Start Indexing** button on the lower right portion of the screen.

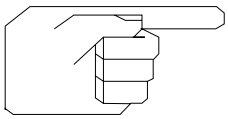
- At this point a dialogue-box is displayed, advising you that this process could take some time depending on the number of files selected and their size, and prompting you to confirm that you wish to index at this time. Select **Yes**.

- A prompt will indicate the database files that are being indexed, followed by notification when indexing is complete.

To index at a particular time:

- Select the desired database files by clicking once in the appropriate box beside the name. A check mark denotes the selection.

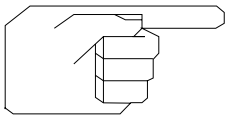
- Enter a time in the **Start Indexing At** field by typing in the time with standard abbreviations (i.e. " 10P " for 10:00 PM), then click once on the **Start Indexing At** button.



You can index ALL files on your RAS Server using the Main Menu bar selection: File ➔ Lists ➔ Index All. This is the preferred method.

12.2. Remote Upgrades

As improvements and new features are incorporated in ***HERO***, version upgrades of the software are periodically released. These upgrades are stored in special " out-boxes " on the HTN Network and can be downloaded using methods similar to a normal transmission. Subscribers will be notified of each new upgrade, and provided with summary instructions on download procedure, via e-mail.

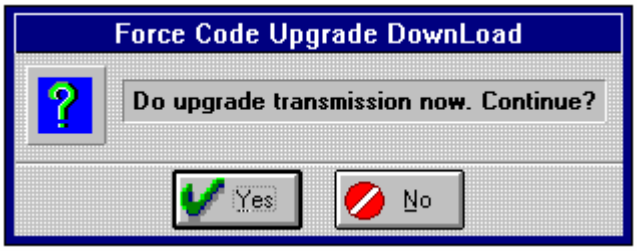


Before proceeding, run a full backup of your existing HERO program. **The upgrade program is fully tested and reliable, but it is always good policy to back up mission-critical data before running any major procedure.**

12.2.1. Manual Upgrade

- If you are running ***HERO*** on a local area network, ensure that no one else is using the program.

- In the Main Menu, click on **File ➔ Transmit ➔ Upgrade ➔ Download**.



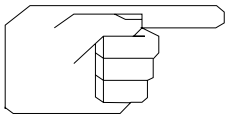
You will be then be prompted to proceed with the upgrade. Click on **Yes** to continue.

The program will then initiate a cycle similar to the normal transmission of claims. (For a full discussion of the normal transmission cycle please refer to Chapter 6: **Transmitting, Receiving and Adjusting MOH Files**.) If there are any claim batches, e-mail etc. pending they will be processed normally. The program will then download the upgrade file (HTNUDnnn.EXE—where nnn represents the version number). Depending on your connection speed, this file may take up to 15-25 minutes to download. Once the download has completed, the program will terminate the transmission normally.

- Once the download is complete, exit ***HERO*** and restart the program.

On restarting ***HERO*** you may hear a series of beeps as new files are being copied to the program directory. This will create a slightly longer than normal delay in launching the program.

Once the program is launched, the new version number should be displayed across the top of the screen. You will then receive a message "Found database structure(s) to be upgraded. Continue?" Select **Yes** to proceed.



Database structure changes will only modify certain aspects of the way your data is stored. *It will not affect the data itself.*

As the data structures are being modified there will be an ongoing display. Once the display is clear, the modifications will be complete and your program will be ready to use.

12.3. Back Up Data

Although ***HERO*** is very reliable in terms of storage and retrieval of patient information, corruption can occur due to power-failures, Windows-level system crashes etc. so it is always a good idea to back up important data.

Backups can be made onto some kind of portable physical media e.g. removable hard disk, CD, DVD, HD-DVD, Blu-Ray DVD, floppy disk, ZIP disk, USB memory/jump drive, tape, or even sent over a network (e.g. the Internet). For more information on available backup devices, contact your hardware distributor.

The final responsibility for setting up and maintaining a backup regime rests with the user.

12.4. Claim Archiving

HERO can automatically archive claims for you. There are two ways to do this:

1. Make sure a doctor is logged on. Then, in the Claim Archiving section of the SetUp window, select an Ending Date, and then select Start Archiving.

   Only claims of status Reconciled will be archived, and only claims for the logged-in doctor/alias will be archived, and only claims *before* the Ending Date selected will be archived. Those claims will have their status changed to Archived.

2. Make sure a doctor is logged on. Open a list of the doctor's claims (see the relevant manual section for more information). Make sure the claim type is set to "HCP/WCB/RMB". Set the claim status to Error, Rejected, Batched, or Reconciled. Then select **FILE ➔ LISTS ➔ ARCHIVE STALE CLAIMS** in the Main Menu.

   Only *stale-dated* claims (older than 6 months) of the selected type and status will be archived. Those claims will have their status changed to Archived.

12.5. Purging

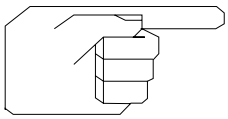
HERO can automatically purge (delete) old data from your database, in order to reduce the size of your database, and reduce clutter. However, government regulations generally require you to maintain medical records for a certain length of time (e.g. 10 years), so *be careful what you purge!* It is recommended that you perform a back up (see the manual section on backing up data) before purging data.

To purge data, make sure a doctor is logged on. Then, use the Purging section of the SetUp window. You can purge:

- Archived Claims (contact HTN to enable this feature)
- Lab Requisitions
- Prescriptions
- Visits (Encounters)
- Patients who have "No Items" (e.g. no other records attached to them such as Appointments, Claims, Payments, Encounters, etc.)

Select which of the above items to purge. Then select an "Ending Date". Only items *before* the selected date will be deleted. Then select "Start Purging".

13. Reports



This section is intended to provide a general overview of the reporting features in *HERO*.

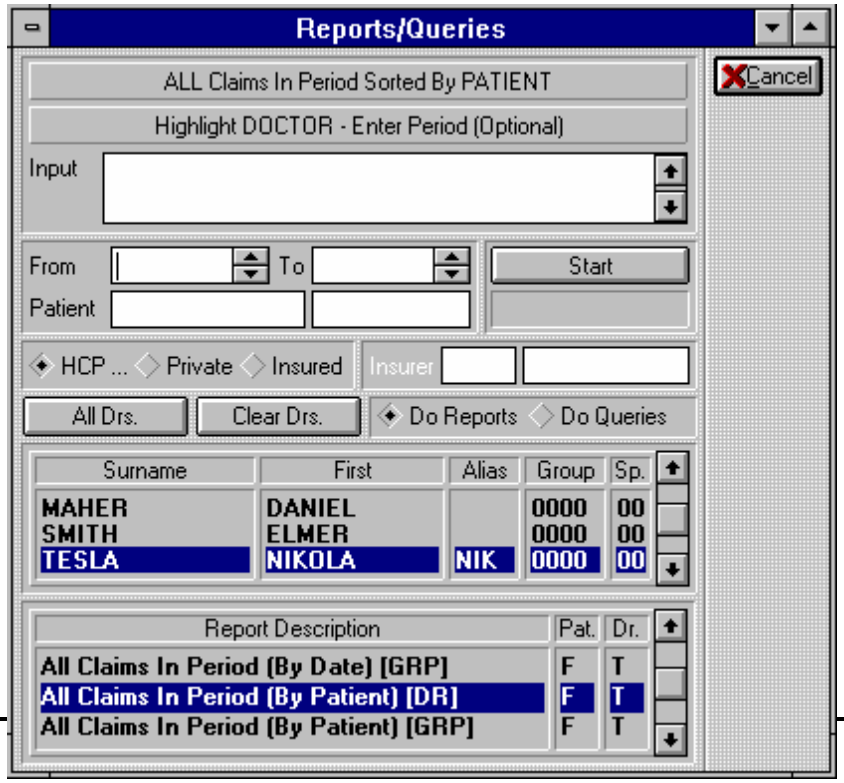
The ability to generate reports is very important. Apart from providing summary information about patients, billing activity, scheduling etc., it also allows you to maintain a " paper-trail " of important transactions, thus providing another type of backup.

13.1. Accessing Reports

Print Reports

The **Print Reports** icon is used to print reports. Depending on the area of the program you are using, it will either access a list of all generic reports, or a subset of reports specific to a particular area.

13.1.1. The Reports Menu



If no specific area of the program is active, the **Report** screen will be displayed. This is a line item list of all generic reports in the program, sorted alphabetically.

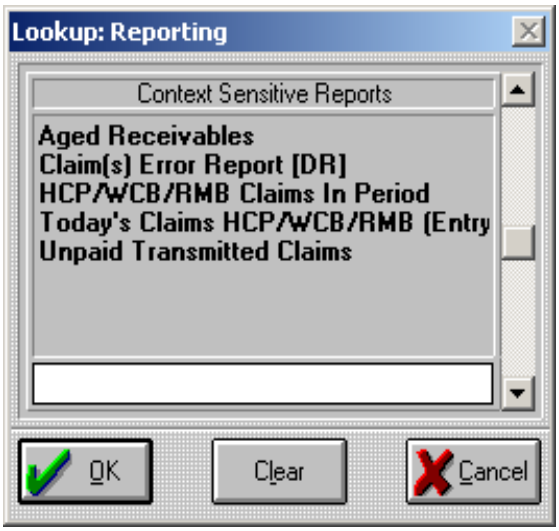
To select a report, scroll down using the scroll-bar to the right of the list, and click once to highlight.

The top two lines of the form display information and instructions pertaining to the report selected (in our example: **All Claims In Period (By Patient) [DR]**). Because many of these reports require, or optionally allow, *parameters* (i.e. which doctor, for which dates, for which patient etc.) it is advisable to read these lines carefully before proceeding.

For instance, in our example, you are required to highlight a doctor (by clicking once on the appropriate name) and may optionally enter the period using the **From** and **To** fields (either by typing in the dates, using the arrows to increase or decrease the date, or by double-clicking on the field to access a **Lookup:Calendar** and selecting the correct date). By default, the period is from the beginning of time to the present.

- To start printing, click once on the **Start** button. (For print options, please refer to Section 13.1.3).

13.1.2. Context-Sensitive Reports



If a specific area of the program is active (e.g. patient records, billing, schedule, etc.), a list of *context-sensitive* reports will be displayed. This is a subset of the full list, containing only those reports that are relevant to the particular area you are using.

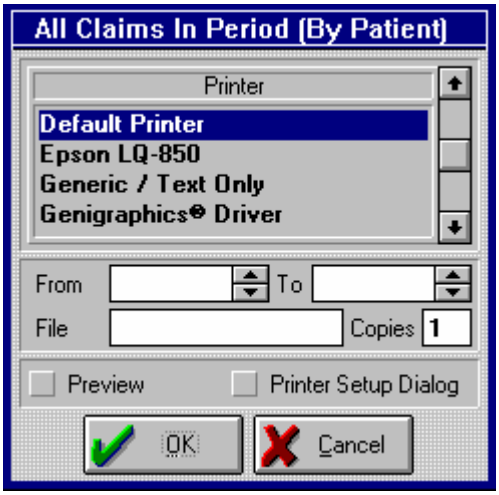
In our example the **Complete Claims List (All)** is active. Clicking on the **Print Reports** icon yields a list of reports that would logically be printed while the user was in this area.

Unlike the full reports menu, most of the parameters are entered automatically in context-sensitive reports. For instance, in the **HCP/WCB/RMB Claims In Period** report the doctor entry (the physician's claims that are being reported on) defaults to the logged-on doctor.

- To select a report, scroll down using the scroll-bar to the right of the list if necessary, and double-click the desired item. (For print options, please refer to the next section).

13.1.3. Print Options

Whether you access a report from the **Reports Menu** or from a context-sensitive area, there are several options you can choose at print time. Certain options depend on the type of report, but all are summarized in this section.



When you select a report, a dialogue box is displayed with the name of the selected report displayed across the top.

- You may accept the default printer or direct the print job to another printer by clicking on the appropriate entry.

- If appropriate you may alter the date parameters in the **From** and **To** fields. (If *not* appropriate these fields will be grayed out.)

- If you wish to direct the print job to a *file* as opposed to a printer, type in the file name and directory if necessary. (By default the file would be placed in the ***HERO*** root directory, which is usually `C:\HTN`.) This will create a *text-only* file (no bitmaps or formatting) that could be used for inclusion into a larger document.

- If you wish to print more than one copy, enter the number of copies in the **Copies** field.

- The **Preview** checkbox allows you to preview the report on the screen before (or instead of) printing. Click once in this box to enable the preview feature. If you choose to preview the report, you can then print by clicking once on the printer icon at the bottom of the screen.

- The **Printer Setup** checkbox allows you to review and/or edit the printer settings before the print-job is sent to the printer (does not work if “Default Printer” is selected on the printer list).

14. Overnight Batch Eligibility Check (OBEC)

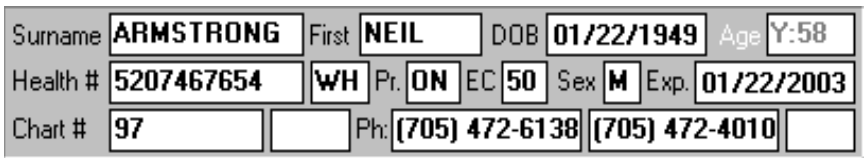
OBEC is a system you can use to tell if a patient's health card number and version code are valid *before* you provide services to that patient. This can save you time in tracking down unpaid claims. OBEC is only available for Ontario health cards.

Before you can use OBEC, it must be activated. Contact HTN to activate your OBEC service. Also, for OBEC to be useful, you should do your HERO transmission often (e.g. every day). Otherwise, your OBEC responses may be outdated by the time you receive them. Plus, for OBEC to be most useful, you should do your scheduling (appointments) in HERO, so that HERO knows which patients need to be OBEC verified. For more information on transmissions and scheduling, see the appropriate manual sections.

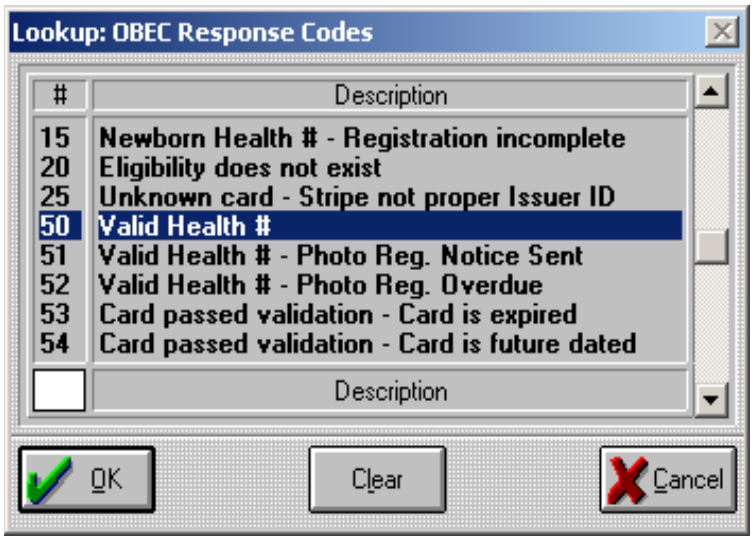
Whenever you add or modify an Ontario health card number or version code (for a new patient or an existing patient) in your database, an OBEC request is automatically generated (in order to check if the new health card number and/or version code are valid). Also, OBEC requests are automatically generated for all patients who have an appointment coming up in the next few days (except for patients who have already received an OBEC response in the past 30 days). The exact number of days (usually 3) depends on your "OBEC Frequency" in your "SetUp Communications" window (see the appropriate manual section for more information).

When an OBEC request is generated, it will automatically be sent on your next transmission. Within approximately one day after that, an OBEC response will be received (usually on your subsequent transmission). The OBEC response can be viewed in several places:

- In any record window where a patient is specified (e.g. patient, appointment, claim, payment, encounter, etc.), the second line of the window contains a field called "EC" (eligibility code) which indicates that patient's latest OBEC response, if available. In the example below, Neil Armstrong's OBEC response is 50:



  To find out the meaning of the OBEC response code, double-click or right-click (or press F9, or type any text) in the EC field, and a "Lookup: OBEC Response Codes" dialog box will open:

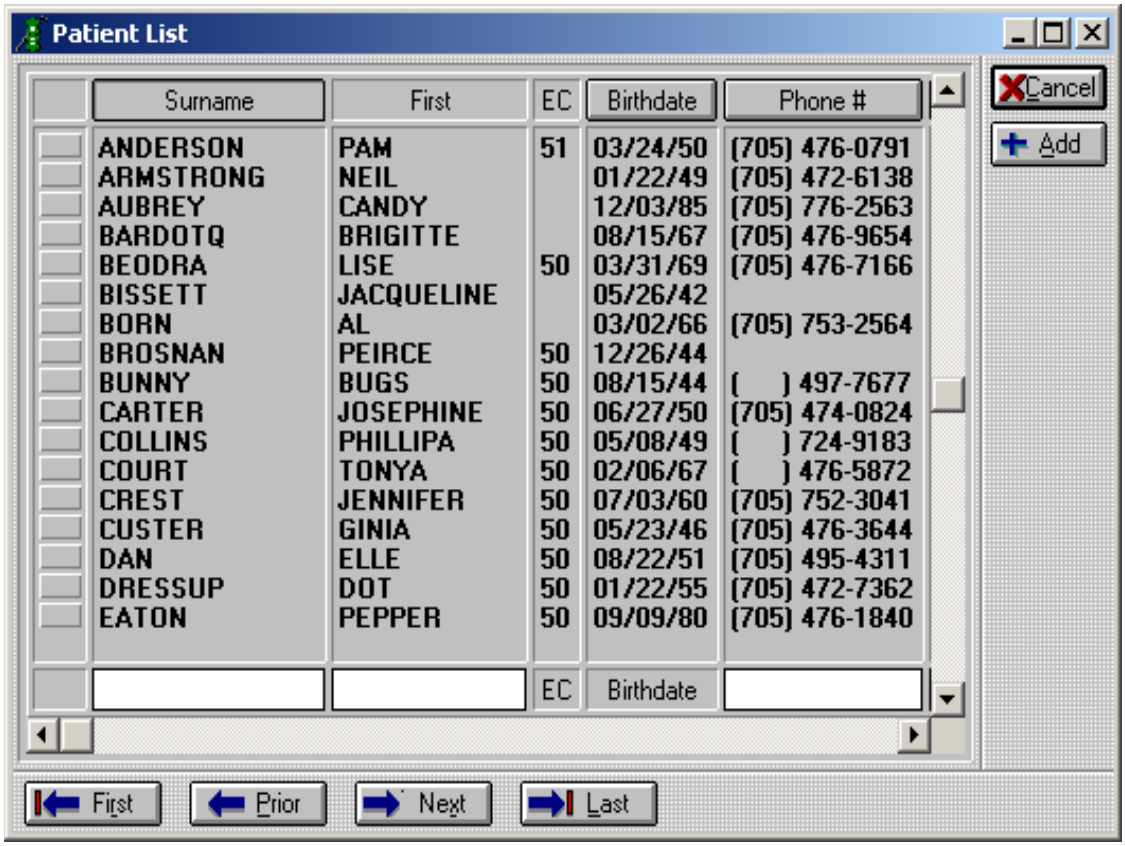


In this case, 50 means that Neil Armstrong's health card number (and version code) are valid.

- In the "Daily Schedule List (Summary)" window (see the manual section on "Appointment Scheduler" for more information), to the left of each "Patient" field there is a field called "EC" which displays the latest OBEC response for that patient.

- Some reports may contain OBEC responses. For example, "Patient List (Failed OBEC Verification)", run from any Patient List window. Also, when OBEC responses are received (during a transmission), HERO will ask if you want to "Print them now?" See the manual section on "Reports" for more information.

- In any Patient List window, the third column is "EC", which displays the latest OBEC response for each patient:



Surname	First	EC	Birthdate	Phone #
ANDERSON	PAM	51	03/24/50	(705) 476-0791
ARMSTRONG	NEIL		01/22/49	(705) 472-6138
AUBREY	CANDY		12/03/85	(705) 776-2563
BARDOTQ	BRIGITTE		08/15/67	(705) 476-9654
BEODRA	LISE	50	03/31/69	(705) 476-7166
BISSETT	JACQUELINE		05/26/42	
BORN	AL		03/02/66	(705) 753-2564
BROSNAN	PEIRCE	50	12/26/44	
BUNNY	BUGS	50	08/15/44	( ) 497-7677
CARTER	JOSEPHINE	50	06/27/50	(705) 474-0824
COLLINS	PHILLIPA	50	05/08/49	( ) 724-9183
COURT	TONYA	50	02/06/67	( ) 476-5872
CREST	JENNIFER	50	07/03/60	(705) 752-3041
CUSTER	GINIA	50	05/23/46	(705) 476-3644
DAN	ELLE	50	08/22/51	(705) 495-4311
DRESSUP	DOT	50	01/22/55	(705) 472-7362
EATON	PEPPER	50	09/09/80	(705) 476-1840
		EC	Birthdate	

- When viewing your Patient List, there are 5 different categories of lists you can use:

Lists all patient records (regardless of OBEC status).

Lists only patient records with invalid health card numbers (bad OBEC response).

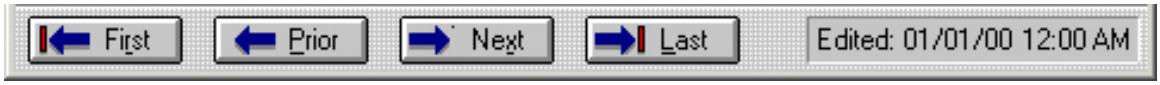
Lists only "OBEC Pending" patients, i.e. patients for whom an OBEC request has been generated, but no response has been received yet.

Lists only patient records with outdated version codes (bad OBEC response).

Lists only incomplete patient records, i.e. missing critical information (e.g. health card number, birth date, sex).

15. File Buttons

At the bottom of any record window in HERO (e.g. Patient, Appointment, Claim, Payment, etc.), there's an optional bar at the bottom called the File Buttons which looks like this:



The File Buttons are only visible if "File Buttons" is enabled in the Options menu (see the manual section on "Menu Commands").

The File Buttons include four buttons: First, Prior, Next, and Last. These buttons let you navigate among a list of items. That list is determined by the context from which the current window was opened. For example:

- If the current window is a Patient window which was launched from a list of ALL patients in your database, then the File Buttons will allow you to navigate among ALL patients in your database. For example, First will jump to the first patient in your database, Prior will jump to the previous patient in your database, Next will jump to the next patient in your database, and Last will jump to the last patient in your database.

- If the current window is a Patient window which was launched from a list of only INCOMPLETE patients in your database, then the File Buttons will allow you to navigate only among all INCOMPLETE patients in your database. For example, First will jump to the first INCOMPLETE patient in your database, Prior will jump to the previous INCOMPLETE patient in your database, Next will jump to the next INCOMPLETE patient in your database, and Last will jump to the last INCOMPLETE patient in your database.

- If the current window is an Appointment window which was launched from a list of appointments for a particular doctor (or a "Schedule Multi-Doctor" window), then the File Buttons will allow you to navigate among ALL appointments for the selected doctor. For example, First will jump to that doctor's first appointment, Prior will jump to that doctor's previous appointment, Next will jump to that doctor's next appointment, and Last will jump to that doctor's last appointment.

- If the current window is an Appointment window which was launched from a Patient Schedule List, then the File Buttons will allow you to navigate among ALL appointments for the selected patient. For example, First will jump to that patient's first appointment, Prior will jump to that patient's previous appointment, Next will jump to that patient's next appointment, and Last will jump to that patient's last appointment.

- The same applies to any other list of patients, appointments, claims, payments, etc.

On the right side of the File Buttons is a field that says "Edited". This field indicates the date and time when the open record was last modified.

16. Tracking Batches, Claims, and RAs

Below is a summary of the billing cycle in HERO. Generally, these rules apply to HCP/WCB/RMB claims submitted by EDT. They do *not* necessarily apply to Private, Insured, or disk-submitted claims.

1. You enter claims into your database. Generally, their status will be Completed (or first Incomplete, and then later change to Completed when you fill in the missing information). Or, if a claim has already been batched (e.g. its status is Batched or Error) and you modify it, its status will change to Corrected. (Remember to check your Incomplete claims often, e.g. every day, to ensure that an incomplete claim does not get "forgotten".)

2. When you make a batch, all claims of status Completed and Corrected will be batched (in two separate batches), and their status will be changed to Batched. Remember to make batches often, e.g. every day.

3. On your list of batches (see the manual section "Financial Reports"), the latest batches should appear at the top. The "E.D.T." fields will be blank.

4. When you do your next transmission (see the manual section "Transmitting Claims"), all batches that have not yet been sent will be sent. On your list of batches, their "E.D.T." status will become "Transmitted". Remember to do transmissions often, e.g. every day.

5. Within about a day or two, a batch acknowledgment will be created for each batch, indicating if the batches were accepted or rejected.

6. On your next transmission, you will receive any batch acknowledgments that you have not already received. On your list of batches, the "E.D.T." status will change to "Accepted" or "Rejected". If a batch is more than a few days old and its "E.D.T." status does not say "Accepted", then do a transmission, and if it still doesn't say "Accepted", then contact HTN.

7. If any claims are returned as error, this will generally happen within a few days, and you will probably receive them on your next transmission (you will be informed when error claims are received). The status of those claims will change (e.g. from Batched) to Error. Be sure to check your Error Claims bin often (e.g. every day or after every transmission). Correct all error claims (for resubmission) as soon as possible (see the manual section "Correcting a Claim in Error Claims Bin").

8. Any claim that is not returned as error (see above) should appear in your Remittance Advice (RA) files (see below) within a month or two (after you

transmit it). If any claim sits in your Batched bin for more than a couple of months, *first make sure that you have processed all of your RAs* (see below), and if the claim is still in the Batched Bin, then contact HTN immediately. All service items become stale-dated (cannot be paid) 6 months after the service date, so *don't delay!*

9. Around the beginning of each month, you should receive (during your regular transmission) an RA for each doctor/group, and each one should come with an e-mail (see the manual section "HERO Mail") informing you that you have received the RA. If you have not received an RA within approximately 10 days of the beginning of the month, then do a transmission, and if you still have not received an RA, contact HTN.

   The RA generally contains all claims that were *transmitted* in the 1-month period ending on the previous month's cutoff date. For example, claims that were transmitted between the January and February cutoff dates should appear in the March RA (which is sent out in early March, and the payment is made around the middle of March). The "cutoff" date is usually officially the first business day on or after the 18th of each month, but for EDT billing, the actual cutoff date is often much later, sometimes even approaching the end of the month. For more information, contact MOH.

10. For each RA received, process it as soon as possible (see the manual section "Processing Remittance Advices"). The RA will show up on your list of RAs (see the manual section "Financial Reports"), but *only after you process the RA.*

11. All claims that appear in an RA file will have their status changed (e.g. from Batched) to Rejected, Reconcile, or Archived (see the manual section "RA Rules").

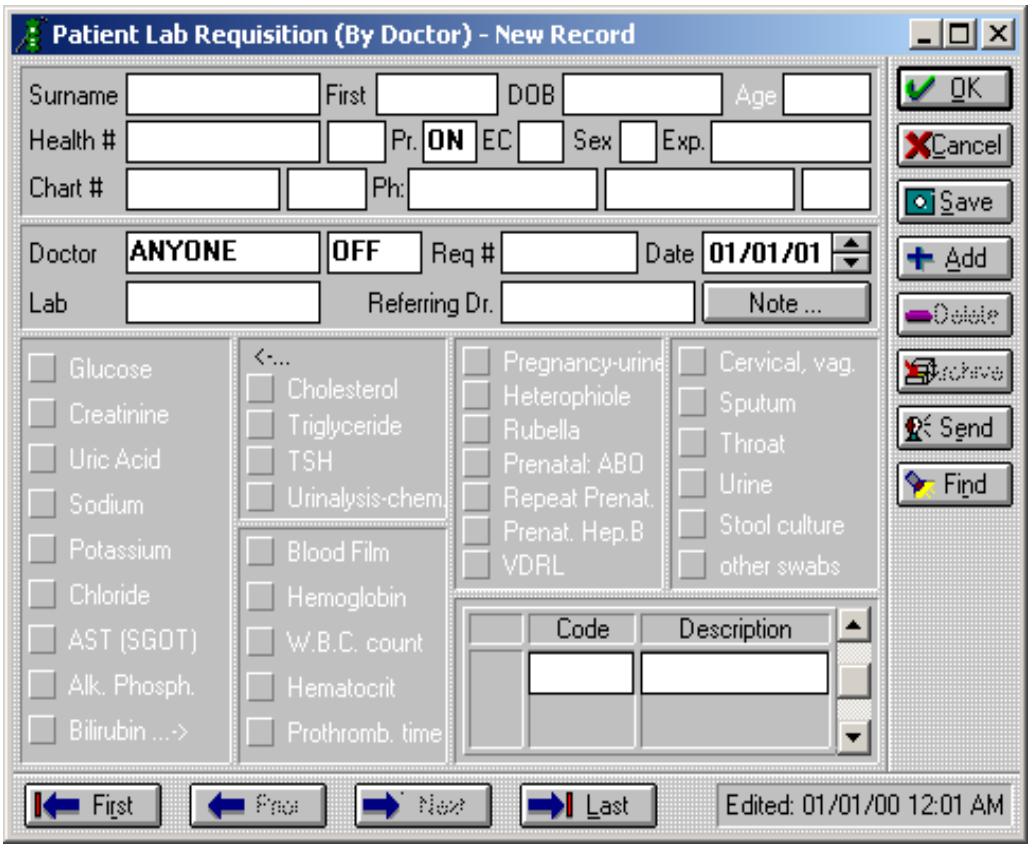
12. For all claims in the Rejected and Reconcile bins, you should archive or delete them (see the manual section "Post-Batch Adjustment Of Claims").

17. Lab Requisitions

17.1. Creating Lab Requisitions

List **Add**
Doctor's
Laboratory
Requisitions
Reports

Click once on the **Add Laboratory Requisition** icon. A screen resembling the one below will be displayed.



The **Surname**, **First Name**, **Birthdate**, **Health Number**, **Province**, **Version Code** (if applicable), **Sex** and **Expiry Date** (if applicable) will be blank. For a *new* patient, this information must be entered manually. If the patient is already in the database, the information can be pasted in by double clicking on the **Surname**, **Health #** or **Chart #**

fields, selecting the appropriate record from the **Lookup: Patients** list and double clicking on it.

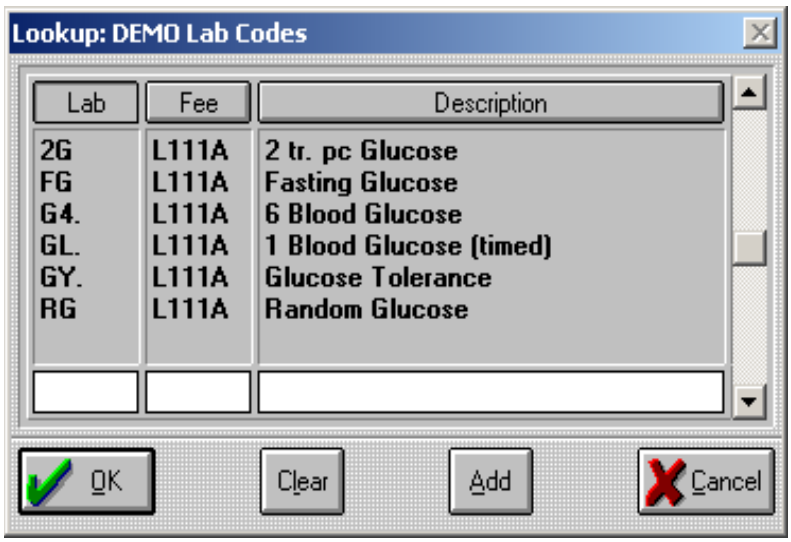
The logged-on doctor and date will be pasted in, but they can be changed.

Select a lab by double clicking in the **Lab** field and selecting the desired record from the **Lookup: Laboratories** list and double clicking on it.

You can select a referring doctor (optional) by double-clicking in the **Referring Dr.** field and selecting the desired record from the **Lookup: Referring Doctors** list and double clicking on it.

The **Req #** is a unique 8-digit identifier (e.g. 00000001) which will automatically be assigned when the Lab Requisition is first saved, and cannot be manually modified.

Once a lab has been selected, you can select the tests to be performed. Click on a test, and a Lookup dialog box will open:



Select the desired test and then select **OK**.

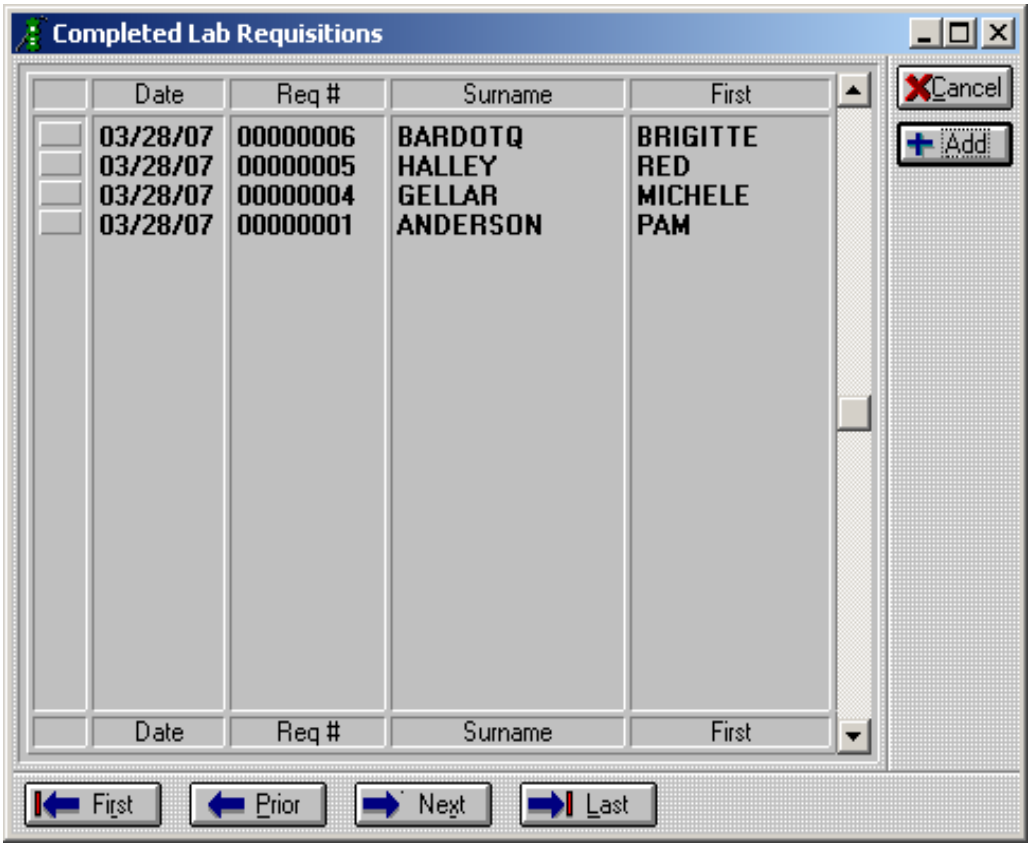
- To save the lab requisition, click on **Save** (save message but remain in the screen, or **OK** (save the message and exit the screen). Typically, this would be a lab requisition you haven't completed, or wish to edit further.

- To mark the lab requisition for transmission, click once on the **Send** button, then click once on **OK** to save the message and exit the screen. NOTE THAT THE LAB REQUISITIONS ARE NOT SENT AUTOMATICALLY! YOU MUST SEND THEM MANUALLY.

17.2. Editing or Deleting Lab Requisitions

List **Add**
Doctor's
Laboratory
Requisitions
Reports

Click on the **List Laboratory Requisitions** icon once. The **Lab Requisitions** screen, defaulted to **Completed Lab Requisitions**, will be displayed.



A list of lab requisitions is displayed. To access a message double-click on the appropriate item.

- You may edit all available fields and/or text following the guidelines contained in the previous section. When finished, you can either save it for further editing or mark for send.

- To delete a lab requisition, click once on the **Delete** button on the right side of the form. A dialogue will prompt you for confirmation. Click on **OK** to delete. This message will have disappeared from the lab requisitions list once you exit the form.

Side Buttons

List all **Completed Lab Requisitions** (default), i.e. those that have at least one lab test selected.

List all **Incompleted Lab Requisitions** (no lab tests selected).

List all **Printed Lab Requisitions** (this feature is unavailable).

List all **Sent Lab Requisitions**. This means that someone clicked on the **Send** button; this does *not* necessarily mean that the lab requisitions have actually been sent.

List all **Reported Lab Requisitions** (this feature is unavailable).

List all **Archived Lab Requisitions**.

List all **Unread Lab Reports** (this feature is unavailable).

List all **Unprinted Lab Reports** (this feature is unavailable).

List all **Read & Printed Lab Reports** (this feature is unavailable).

List all **Stat Lab Reports** (this feature is unavailable).

List all **Normal Lab Reports** (this feature is unavailable).

List all **Abnormal Lab Reports** (this feature is unavailable).

List all **Archived Lab Reports** (this feature is unavailable).