MedBASE
User's Manual

Mac

Table of Contents:

Introduction: 1
Getting Started: 1
Installing the Program 1
Starting the Program 1
Provider Menu 2
Choose… 2
Edit… 2
New… 3
Patient Menu 3
Select… 3
New… 5
Appointments 6
Summary 7
Labels 7
Review Claims 8
Import 8
Card Reader 9
Physician Menu 9
Select… 9
New… 10
Labels 10
Claim Menu 11
Select 11
New 13
Adjust 13
Verify 14
Direct 14
Summary 15
Service Codes 15
Process Menu 16
Bill… 16
Profile 17
Accounting 17
Accounts Receivable 18
Reconcile 18
Discrepancy 19
Archive 19

Preferences… 20

Menu....21
About MedBASE…....21
Help 21
Desk Accessories....21
File Menu....22
MedBASE License Agreement 23
Index....24

Introduction:

MedBASE is a versatile and powerful billing and office management database system originally designed for the Macintosh and commercially available since January, 1991. A PC-based version of MedBASE was developed and released in January, 1992, possessing the same features and "look and feel" as the Macintosh version. These programs are intended specifically for Ontario physicians (and other health professionals who submit patient billings to OHIP).

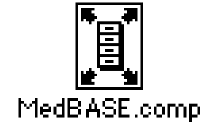
The MedBASE program makes full use of many of the intuitive tools characteristic of the Macintosh with the aim of providing a user-friendly environment for the operator. As with many Macintosh applications, a minimum of operator training is necessary for using the application, and the layout is designed to maximize efficiency and minimize operator error. The program can be used in conjunction with many of the available MACRO programs such as Macromaker® or AutoMac® for executing repetitive tasks.

This manual assumes that you are familiar with the Macintosh operating environment and are acquainted with the use of the mouse, Macintosh windows, and menu-driven commands. For new Macintosh users unfamiliar with this environment, we recommend reviewing the Macintosh Owner's Manual. Proper operation of the program requires that MedBASE be properly installed as described below. Desk accessories are fully operational in conjunction with MedBASE and the application is compatible with both Systems 6.0 and 7.0.

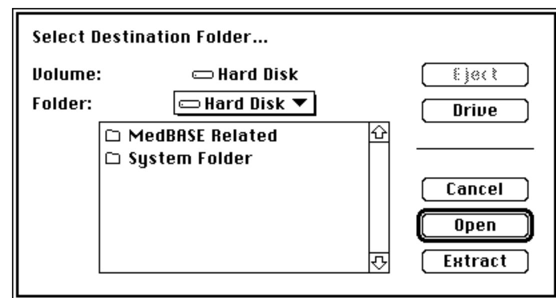
Because of the potential memory demands of a large database system, we recommend at least 2 MBytes of RAM with System 6.0 and preferably 4 MBytes of RAM with System 7.0. A hard disk with a capacity of at least 20 MBytes is recommended. MedBASE is compatible with all Macintosh computers from the older Mac Plus and SE models to the newer PowerBook, LC series, Centris and Quadra systems.

Getting Started:

Installing the Program:

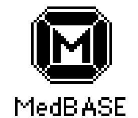


To install MedBASE, insert the diskette entitled "MedBASE 3.5 Program" into the floppy disk drive. This disk contains a file of the compressed code of the MedBASE application and related files. When the MedBASE.comp icon is double clicked, a dialogue box appears as shown at the top of the next column, prompting you to select a destination for the decompressed files. Click on the **Drive** button (or **Desktop** button in System 7.0) to select the hard disk on your computer and then click **Extract** to decompress the MedBASE files. When



decompression is complete, a new folder entitled "Billing Folder" will be present on the hard disk and will contain the MedBASE application as well as the MedBASE Databases and Submissions folders. Your MedBASE program is now installed.

Starting the Program:



MedBASE is accessed by simply double clicking on the MedBASE icon. If no providers (billing physicians), have been entered in the billing system, the user will be asked to enter the new Provider Information as described on Pages 2-3. After entering the Provider Information or with subsequent program use when only one provider is in the system, this provider will be selected automatically. If more than one provider is present, the Provider Browse Window will appear as shown below. This displays a listing of each of the providers in the system. Select the desired provider with the mouse

Select Provider and Close Window

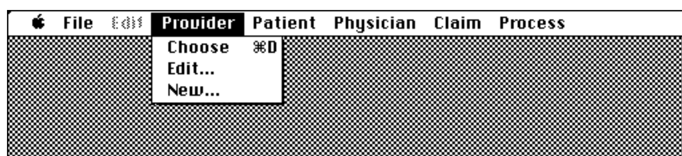
Surname	First Name	Billing
ALLISON	JAMES	0000-100008-13
LAWRENCE	TERRANCE	0000-224840-60

and then close the window by clicking in the close box in the top left corner or by hitting the escape key. If full password protection is active for the selected provider (see Page 3), a window will appear prompting you for the password. Enter the password in the blanked out boxes and click **OK**. If full password protection is not active, these steps are bypassed.

Enter Password for Provider:
DR. JAMES ALLISON
Password: ■■■■■■
OK

When a provider has been selected, only the active claims under him/her can be accessed. Also provider-specific are patient appointments, claim reviews, claim summaries, billing and reconciliation functions, accounting summaries, accounts receivable summaries, practice profiling and archiving. Full patient and referring physician listings are always accessible and these are not provider-specific. The ‘Current Provider’ is displayed at the bottom of the screen in the status bar as shown below.

Provider Menu



Choose…

The Choose… option allows you to change the active or 'Current Provider'. Upon selecting Choose… (or the keyboard equivalent, Command-D), the Provider Browse Window will again appear, similar to Startup. The desired provider can then be selected and the window closed. If full password protection is active, the operator will be prompted with the Password Window. After choosing the new provider, the status bar will be updated at the bottom of the screen.

Edit…

The Edit… option allows you to enter or change the information associated with each provider. If partial or full password protection is active, the password window will appear before editing is allowed. The Provider Information screen contains several fields as shown at the top of the next column. Fields marked with a * must be entered before any billing can be done for that provider. Fields marked with a † cannot be edited, once saved. In MedBASE, type is converted automatically to UPPER CASE (Exception - **Title**, see below).

A = alpha, N = numeric

Provider Information
Surname: ALLISON
First Name: JAMES
Title: MD, FRCP(C)
Address: TGH
200 ELIZABETH ST, TORONTO
Postal Code: M5G2C4
Pay Type: ◉ Pay Provider ○ Pay Subscriber
Group No: 0000 District Code: N
Billing No: 100008 Specialty No: 13
Change Password Delete Done

*** Surname**:

*** First Name**:

Title: Needed for direct billing letters (ie - Yours sincerely, J. Allison MD, FRCP(C)). Upper or lower case allowed (BSc, PhD, etc.)

Address: Needed for printing claim cards.

Postal Code: Format “ANANAN”.

*† **Group No.**: Enter the provider’s 4 digit group number or “0000”.

*† **Billing No.**: Enter the provider's 6 digit billing number. If an incorrect billing number is entered, a message "Invalid Input" will appear.

* **District Code**: Enter the District Code for the provider as outlined by OHIP.

*† **Specialty Code**: Enter either the specialty code (2 digit number) or for general practitioners, enter "00".

Change Password

If you click on the **Change Password** button, the password edit screen will appear displaying the password status and the current password.

Password Off
Partial Protection
Full Protection

Using the Password Pop-Up menu, you have 3 choices. If password protection is not desired, choose the **Password Off** option. To restrict access to the Process menu only, choose the **Partial Protection** option. To completely restrict access to a provider, choose the **Full Protection** option.

You may edit the password by typing in the password edit boxes. The password may be any combination of 6 alphanumeric characters.

<u>Important</u> - remember your password!

If either partial or full password protection is operative, you will be prompted for the password before being allowed to edit provider information.

Enter Password for Provider:
DR. JAMES ALLISON
Password: 0 0 0 0 0 0
Password Off
OK

Delete

Only providers without existing claims can be deleted. Clicking on the **Delete** button prompts the program to search the database for existing claims for this provider. If any are found, a warning message will appear "Cannot delete provider due to existing claims". If there are no existing claims, a message will appear asking to confirm if you wish to delete the provider. Click **Yes** to delete the provider or **No** to cancel.

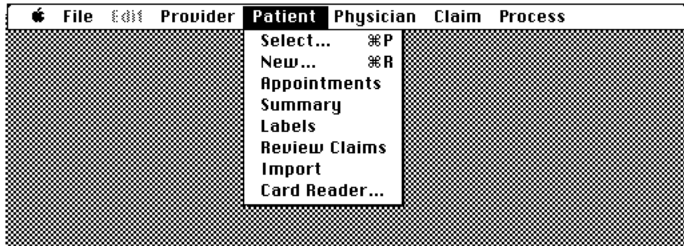
Done

Click the **Done** button to leave the Provider Information screen. Any changes will be saved.

<u>New…</u>

Select the New… menu option from the provider menu to enter a new provider. A blank Provider Information screen will then appear. Refer to the Edit menu option on Pages 2-3 for details regarding the Provider Information screen.

<u>Patient Menu:</u>



<u>Select…</u>

The Select… option allows you to select a patient for editing of patient information. Upon selecting Select… (or the keyboard equivalent, Command-P), the Patient Search… screen will appear as shown at the top of the next column.

Patient Search…
Search List by:
'Surname, First Name'
'Patient #'
OR
'10 Digit Health #'
Awaiting search criteria.
New
Cancel

By typing in either: (a) the Patient's **surname, first name** or any portion thereof, (b) the **Patient #**, or (c) the **10 Digit Health #**, the corresponding patient will be found almost immediately. If more than 1 patient matches the search criteria, as when a partial name is entered (eg - "FR"), then these patients will be displayed in a Patient Browse Window as shown below.

Select Patient and Close Window

Surname	First Name	Patient #	Health #
Cancel			
FRANCIS	CARL	10	2986763692
FRANKLIN	SIMON	82	1645369370
FREIDMAN	TED	38	6045706758
FROBISHER	EDITH	36	7712047096
FRONTENAC	JOSEPH	69	2837690235
FRYDRYCH	DAVID	138	6902357712

If the user leaves the Search Field blank and hits ‘Return’, then all patients in the database will be displayed in the Patient Browse Window. Clicking on the **New** button will allow you to enter a new patient as described on Page 5. Clicking on **Cancel** allows the user to exit without editing patient information. After selecting a patient, either through an exact match in the Patient Search routine or from the browse window, the Patient Information Screen will then appear, allowing you to edit patient information. This screen is shown at the top of the next page. Fields marked with an * are required for OHIP claims.

Patient #: Assigned by the program when a new patient is entered. It cannot be edited.

* **Health #:** Enter the patient’s 10 digit Health Number. If an incorrect health number is entered, a message "Invalid Input" will appear. Correct the health number or leave it blank to continue.

* **Version #**: If applicable, enter the version number (1 or 2 alphabetic characters).

Patient Information

Patient # 322
Health #: 7428758481 Version #: Q
Surname: SPENCER First: ANTHONY
Date of Birth (dd/mm/yy): 25/03/34 ◉ Male ○ Female
Ref Phys 052458 DR. H. JACKSON
Diag 428
Last Visit: 21/07/91
Admit Date: 17/07/91
Address: 3285 ST. CLAIR AVE. E.
SCARBOROUGH
ONTARIO
Phone (H): 416 265-3610
Postal Code: M1K1L5 Phone (B):
Identifier: CHF CABG
Reciprocal | Appointments | New Claim | Delete | Select | Done

Surname:

First Name:

* **Date of Birth**: Enter the patients date of birth in the form dd / mm / yy.

Sex: Choose male or female, by clicking the appropriate radio button. See Preferences section on Pages 20-21 for information about setting default values for patient sex.

Ref Phys

For patients with previous claims, the most recently entered referring physician will be indicated beside the **Ref Phys** button. For new patients, this field will be blank. To enter or change the referring physician for a given patient, either enter the physician number (if known) or click the **Ref Phys** button. Clicking on the **Ref Phys** button will bring up the Physician Search… screen as described on Page 9. The user may select a referring physician from the database or enter a new physician for the claim.

If automatic Referring Physician entry is chosen in the Preferences section (see Pages 20-21), then the referring physician on this screen will be the default entry for any new claim for this patient.

Diag Code

For patients with previous billings, the patient's most recent diagnosis code will be shown beside the **Diag Code** button. For new patients, this field will be blank. The diagnosis code can be entered or changed by typing in the 3 digit diagnosis code or by clicking the **Diag Code** button. The diagnosis code on the patient screen will be the default entry for new claims for a given patient. Clicking the **Diag Code** button will bring up the Diagnosis Code Browse Window.

Select Diagnosis and Close Window

Code	Diagnosis Description
428	Congestive heart failure, acute pulmonary edema
429	All other forms of heart disease
432	Intracranial hemorrhage
435	Transient ischemic attack (TIA)
436	Acute cerebrovascular accident (CVA, stroke)
437	Chronic cerebrovascular disease (old CVA), hypertensive encephalopa
440	Generalized arteriosclerosis, atherosclerosis
441	Aortic aneurysm (thoracic or abdominal, non-syphilitic)
443	Raynaud's disease, Buerger's disease, peripheral vascular disease, in
446	Polyarteritis nodosa, temporal arteritis
447	Other disorders of arteries
451	Phlebitis, thrombophlebitis
452	Portal vein thrombosis

To search for a given diagnosis (or portion thereof), use the **Find** (Command-F) and **Find Again** (Command-G) commands under the **Edit** menu. Once the desired Diagnosis Code is selected, close the window and the correct diagnosis code is entered. (**NOTE** - **Find** and **Find Again** are active whenever a browse window is open and may be used as an alternative searching tool).

Street Address:

City: See Preferences section on Pages 20-21 for information about setting default values for City.

Province: See Preferences section on Pages 20-21 for information about setting default values for Province.

Postal Code: Format “ANANAN”.

Phone (Home): Enter the patient’s area code and home phone number. See Preferences section on Pages 20-21 for information about setting default values for area code.

Phone (Work): Enter the patient’s area code and work phone number.

Identifier: Optional field (60 alphanumeric characters) used for indexing patients (ie - by diagnosis or other variable). Used as a marker for patient summaries and archiving.

For newly entered patients or those without billed claims, the message 'No Claims Entered' will be present in the information box. Otherwise, the **Last Visit** will be shown. **Last Visit** is useful for generating Patient Summaries (see Page 7) and for archiving (see Pages 19-20).

For patients whose last encounter was as an inpatient, the **Admit Date** will be shown. If the last encounter was as an outpatient, **Outpatient** will be shown. These fields cannot be edited.

Reciprocal

Clicking this button brings up the Out of Province screen as shown below. Used for billing out-of-province patients, this information is mandatory for all Reciprocal claims (see Pages 13 &14).

Out of Province
MS. T. MCCONNELL
Enter registration number: 34687964354
Province: New Brunswick
OK

Enter the appropriate registration number and select the correct province using the province Pop-Up menu. Click **OK** to continue.

Appointments

Clicking on the Appointments button will bring up a scrollable list of the active patient's appointments. If no appointments have been entered, a message will appear alerting the user to this. Otherwise, the Patient

Patient Appointments
For Mr. F. Berger...
27/02/92 13:00 CONSULTATION
09/03/92 09:00 EXERCISE TEST
Remove
Mark
Unmark
Process Appointments Print Done

Appointments screen will appear displaying a scrollable list of the appointments for that patient in chronological order. An appointment can be highlighted by clicking on it and can be deleted, 'marked' (ie - when confirming an appointment) or 'unmarked' by clicking on the **Remove**, **Mark** and **Unmark** buttons respectively. To add new appointments or edit existing appointments, click on the **Process Appointments** button. The Patient Appointments screen and Patient Information screen will be closed and the Appointments screen will appear (see Page 6). To print the appointment list for this patient, click on the **Print** button. Click on the **Done** button to exit.

New Claim

Clicking on the New Claim button brings up a new Claim Form screen for the active patient (see Page 11).

Delete

Only patients without existing claims can be deleted. Clicking on the **Delete** button prompts the program to search the database for existing claims for this patient. If any are found, a warning message will appear "Cannot delete patient due to existing claims". If there are no existing claims, a message will appear asking to confirm if you want to delete the patient. Click **Yes** to delete the patient or **No** to cancel.

Select

Clicking the **Select** button will bring up the Patient Search… screen as described on Page 3, allowing the user to either edit or view the information of another patient or to enter a new patient as described in the New menu option section below.

Done

Click the **Done** button to leave the Patient Information screen. Any changes will be saved.

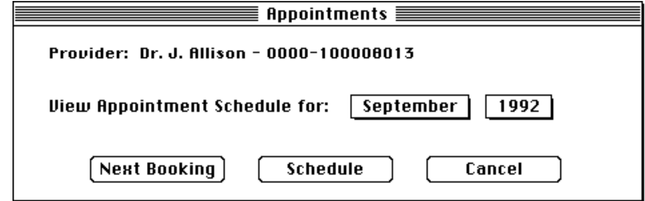
New…

New patients can be entered either by clicking the **New** button on the Patient Search… screen, by selecting the New… menu option from the Patient menu or by using the keyboard equivalent, Command-R. After selecting the New… menu option, a blank Patient Information screen will appear. Enter the Health #, Version # (if applicable), patient surname and given name. The program will then search for a patient with this Health # or name. If one already exists a message indicating the patient, Health # and date of birth will appear. If this is the same patient, a new patient entry will not be created. Otherwise, a new patient will be entered into the database. Default values for City, Province, Area Code and Patient Sex are also entered according to the Patient Preferences defined

in the Preferences section as described on Pages 20-21. The remaining patient data can then be entered on the Patient Information screen as described for the Select menu option. To cancel, hit 'Return' 4 times, leaving the **Health #**, **Version #**, **Surname** and **Given Name** fields blank. The new Patient Screen will be exited and the new patient entry will be deleted.

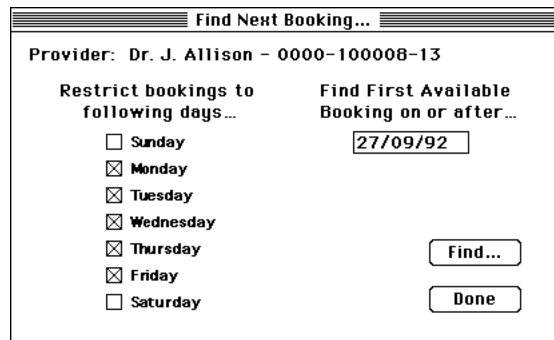
Appointments

Selecting the Appointments menu option from the Patient menu brings up the Appointments screen as shown below. Choose the month and year in which



you wish to process appointments from the respective pop-up menus. Click on the **Next Booking** button to view the Find Next Booking… screen as shown at the top of the next column. Click on the **Schedule** button to bring up the Monthly Appointments screen as shown in the next column on this page. Click on the **Cancel** button to exit.

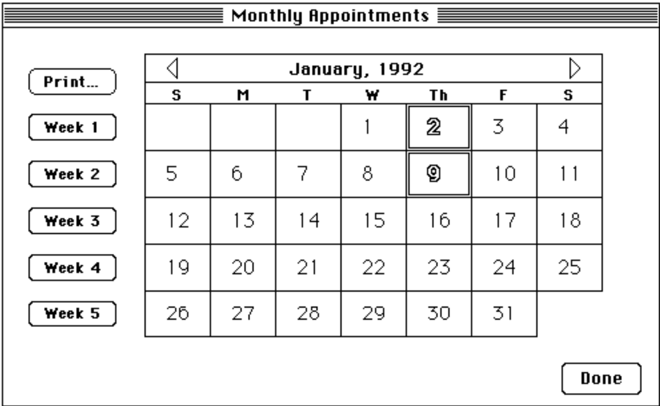
The Find Next Booking… screen allows you to find the next available appointment for the currently active provider, for a patient appointment or general entry (see Daily Appointments). For a given provider, bookings can be restricted to specific days of the week (ie - "office days") as shown on the left half of the screen.



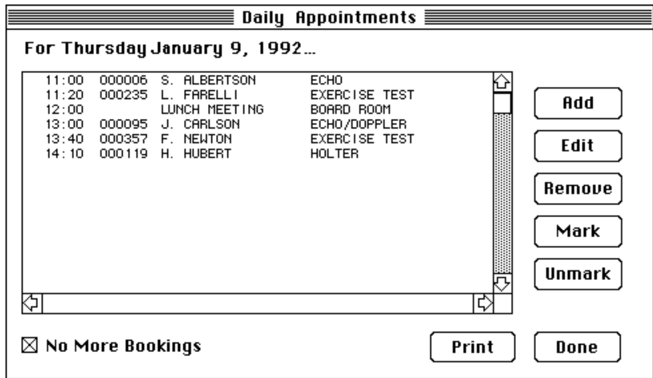
A starting date for the appointment search can be specified (the current date or the last date found is the default). Clicking on **Find…** initiates the search. Only "office days" of the week are checked and days that are flagged as "No More Bookings" on the Daily Appointments screen (see adjacent column) are ignored. The Daily Appointments screen for the "First Available Booking" day is then displayed. Exiting from the Daily Appointments screen returns

the user to the Find Next Booking… screen. Click **Done** to exit.

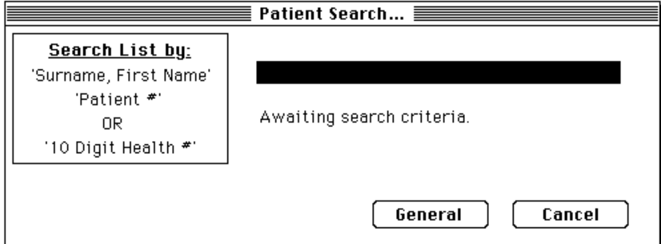
The Monthly Appointments screen displays the days of the selected month in a calender format. Days on which appointments have been scheduled are shown as an RXWOLQH. Days which have been flagged as "No More Bookings" are <u>underlined</u>. Clicking on the backward and forward arrows situated adjacent to the month and year brings up the previous and next months respectively.



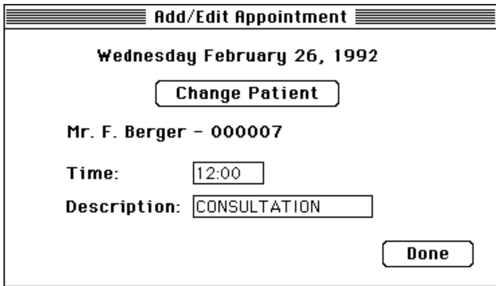
A weekly summary of appointments can be printed by clicking on the **Week 1…5** buttons for each week of the month. To view, add, edit or print the appointments for any given day of the month, simply click on that day on the calender. This will bring up the Daily Appointments screen as shown below. This screen displays a scrollable list of the appointments for that day in chronological order. An appointment can be highlighted by clicking on it and can be deleted, 'marked' (ie - when confirming an appointment) or 'unmarked' by clicking on the **Remove**, **Mark** and **Unmark** buttons respectively.



To add an appointment, click on the **Add** button. This brings up a modified Patient Search… screen with a **General** button rather than a **New** button as shown below.



The user can search for a specific patient or click on **General** to enter patients not yet in the database or non-patient activities such as meetings. After selecting a patient or 'General' entry, the Add/Edit Appointment screen will appear as illustrated below. For 'General' entries, the 'patient' field is editable. Enter the time of the appointment and a brief description (up to 15 characters) and click on **Done** to complete the entry and return to the Daily Appointments screen.



Similarly, to edit an appointment, click on the **Edit** button on the Daily Appointments screen. This will also bring up the Add/Edit Appointment screen and allow the user to change the patient by clicking on the **Change Patient** button or change the time or description as described above. If no more further appointments or bookings are desired for that day, then click on **No More Bookings**. When searching for the next available appointment, then days flagged as such will be omitted. To print a summary of the daily appointments, click on the **Print** button of the Daily Appointments screen. When the entries or changes for that day are complete, click on the **Done** button to return to the previous screen (Find Next Booking… screen or Monthly Appointments screen). Click on the **Done** button on the previous screen to complete appointment processing.

<u>Summary</u>

Selecting the Summary menu option from the Patient menu brings up the Patient List / Export screen as illustrated below. This screen allows the user to browse, print or export a summary for a subset of patients by specifying any or each of 4 parameters: **Sex**, **Age**, date of **Last Visit** and **Identifier**. A summary of 'J8' patients can also be generated (see Page 19 for details)

Patient List / Export

List Patients with the Following Characteristics:

Sex — Male patients only.
Age — Age greater than 70.
Last Visit — On or after Jan. 1, 1991.
Identifier — Includes 'CHF'.

Browse Print Export Done

Click the **Browse** button to view the patients who match the chosen criteria as shown below.

Scroll to View Matching Patients

Surname	First Name	Date of Birth	Identifier
BISHOP	SPENCER	17/03/30	CHF ANGINA DCM
HUANG	KAI-LEE	25/08/36	AMI ANGINA CHF CA
MCAFEE	DENNIS	06/11/30	CHF ANGINA CABG
PICKERING	ANTHONY	11/05/28	AMI CHF
SPENCER	ROY	09/09/34	CHF CABG
STONLEY	CECIL	25/03/34	CABG ANGINA CHF
UPSHAW	PATRICK	22/02/28	CHF HBP HCHOL DCM
WILSON	CHARLES	19/11/28	CHF AVR CABG AOS

Click the **Print** button to print the patient summary.

Click the **Export** button to export the patient information to a text file. This file can be used for importing patients into another MedBASE program or into other programs which accept a tab-delimited text file such as Microsoft Excel® or most word processing applications. The File Save dialogue window will appear prompting the user to 'Insert Export Diskette'. After the file has been successfully written, the diskette will be automatically ejected.

Click the **Done** button to exit this screen.

Labels

Patient labels can be printed using Avery AL-120 label sheets (14 labels per page) with a laser printer or with a non-laser printer equipped with a sheet feeder. After selecting the Labels menu option, the Print Patient Labels screen will appear as shown at the top of Page 8.

Print Patient Labels

Print List

83 ANDERSON, DIANE
91 AUSTIN, FRANK
74 BROWN, DAVID

Address Labels
Chart Labels

Add
Remove
Clear

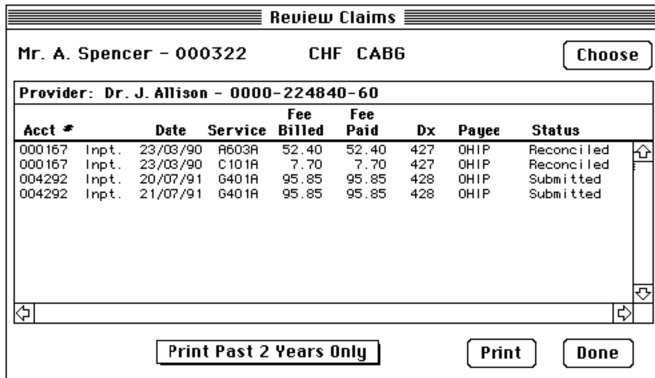
Start Position: 1
Number of Labels: 1

Print Done

Choose chart labels or address labels by clicking the appropriate radio buttons. Chart labels are useful both for patient charts and lab requisitions and contain detailed patient information. Clicking the **Add** button brings up the Patient Search… screen as described on Page 3. The selected patient is added to the print list. To remove a patient from the print list, highlight the patient in the print list and click the **Remove** button. To remove all names from the the print list, click the **Clear** button. The Start Position allows you to use a label sheet which has been partially used. For example, if the first 3 labels have been previously used, set the start position to '4' to use the remainder of the sheet. If more than 1 label per patient is desired, then set the Number of Labels accordingly. Click the **Print** button to print labels for patients in the print list. Click the **Done** button to exit.

Review Claims

The Review Claims menu option of the patient menu allows you to review all claim information for a particular patient. When a claim is open, selecting Review Claims will generate a claims review for the active patient only. Otherwise, the Patient Search… screen will appear and any patient can be selected. If there are no claims for this patient under the current provider, a message will appear stating that no claims



were billed. If there are claims entered, the Review Claims screen will appear with a scrollable list of claim information for the selected patient as shown at the bottom of the previous column. You may choose another patient for claims review by clicking the **Choose** button which will again bring up the Patient Search… screen. When printing, the user can choose

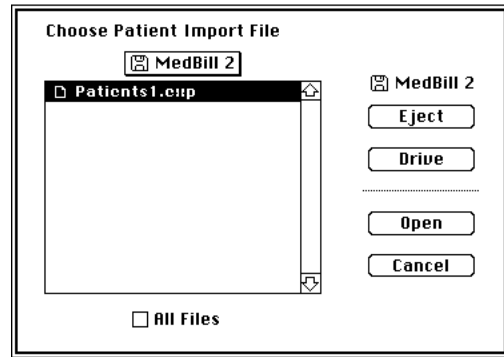
Print All Claims
Print Past 3 Years Only
Print Past 2 Years Only
Print Past Year Only

to print all claims or only the most recent ones as shown on the pop-up menu. The default is **Print Past 2 Years Only**. Click the **Print** button to print the claim review. Click the **Done** button to exit this screen.

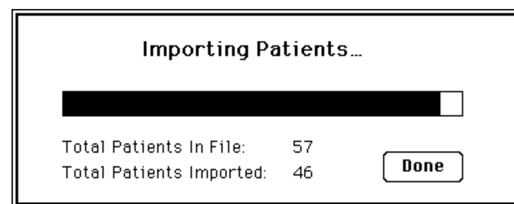
Import

The Import menu option allows you to import a group of patients from a file created by another MedBASE program. This menu option can also be used for importing patients from the 'Patient Set-Up File' supplied by OHIP (disk must first be sent to MedBASE Software Inc. for preparation).

After selecting Import, a file selection window will appear prompting you to choose the Patient Import file as shown below. Only files created by MedBASE using the Export option can be imported. Choosing a non-MedBASE file will result in a warning message and the file will not be imported.



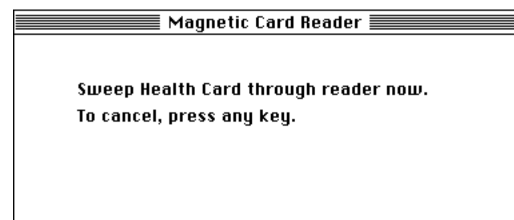
After selecting a valid Import file, the Importing Patients… screen will appear with a status bar indicating progress.



Duplicate patients will not be imported and the screen will indicate the total patients in the Import file and the total imported. Click the **Done** button to exit.

Card Reader…

New patient information can be entered and the information of existing patients can be updated with the use of a Magnetic Card Reader. Select the Card Reader menu option from the Patient menu. After selecting the Card Reader menu option, a Magnetic Card Reader dialogue screen will appear as shown below.

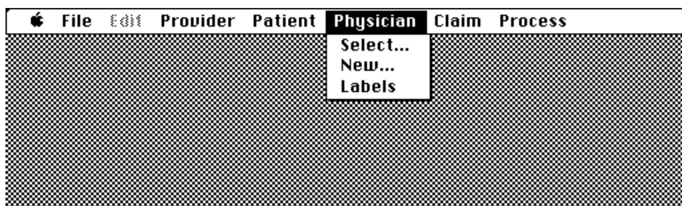


To cancel, press any key. To enter the patient information, run the Health Card through the card reader (magnetic strip down and back). As with new patients entered via the New… menu option, the program will search for a patient with a Health # or name matching that read from the magnetic strip of the Health Card. If an existing patient matches these parameters, then a message will appear

informing the operator as described in the New… menu option section. Information from the magnetic strip will be used to update the database only if the date of the card is newer than the date of previous cards used with MedBASE for this patient.

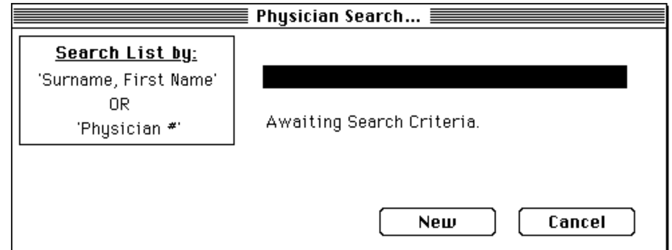
If the card is from a new patient, a new Patient Information Screen appears, displaying the Health #, Version #, patient surname, first name and initial, date of birth and sex as read from the magnetic strip, as well as the default values for City, Province and Area Code. The remaining patient data can then be entered on the Patient Information screen as described for the Select menu option.

Physician Menu:



Select…

The Select… option allows you to select a referring physician for editing of physician information. Upon selecting Select…, the Physician Search… screen will appear as shown below.

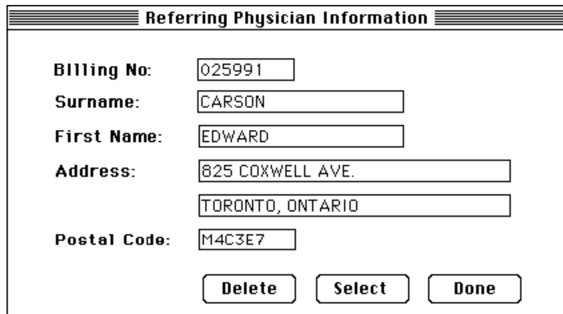


By typing in either: (a) the referring physician's **surname, first name** or any portion thereof, or (b) the **Physician #**, the corresponding physician will be found almost immediately. If more than 1 physician matches the search criteria, as when a partial name is entered (eg - "M"), then these referring physicians will be displayed in a Referring Physician Browse Window as shown below.

Select Physician and Close Window

Surname	First Name	Billing #
Cancel		
MALKIN	GEOFFREY	163618
MICHAELS	TREVOR	225029
MICHENER	JILLIAN	201855
MORRISON	BRIAN	133678
MUSTER	JONATHON	231142

If the user leaves the Search Field blank and hits ‘Return’, then all referring physicians in the database will be displayed in the Referring Physician Browse Window. Clicking on the **New** button will allow you to enter a new referring physician as described on Page 10. Clicking on **Cancel** allows the user to exit without editing physician information. After selecting a physician , either through an exact match in the Physician Search routine or from the browse window, the Referring Physician Information Screen will then appear, allowing you to edit physician information as shown at the top of Page 10.



Fields marked with an * are required for OHIP claims.

* **Billing #:** Enter the referring physician's 6 digit billing number. If an incorrect billing number is entered, a message "Invalid Input" will appear.

Surname:

First Name:

Address: Required for Physician Address Labels.

Postal Code: Format "ANANAN". Required for Physician Address Labels.

Delete

Only referring physicians without existing claims can be deleted. Clicking on the **Delete** button prompts the program to search the database for existing claims for this referring physician. If any are found, a warning message will appear "Cannot delete physician due to existing claims". If there are no existing claims, a message will appear asking to confirm if you want to delete the physician. Click **Yes** to delete the patient or **No** to cancel.

Select

Clicking the **Select** button will bring up the Physician Search… screen as described on Page 9, allowing the user to either edit or view the information of another physician or to enter a new physician as described in the New menu option section below.

Done

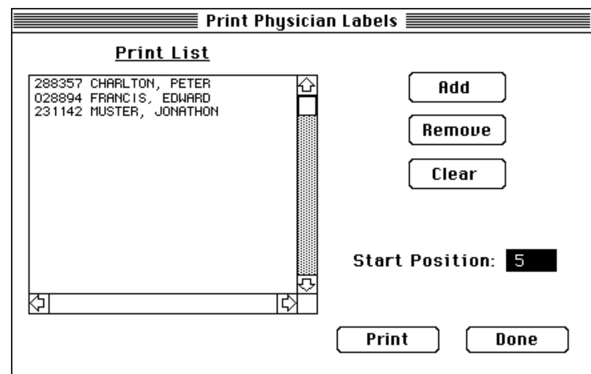
Click the **Done** button to leave the Referring Physician Information screen. Any changes will be saved.

New…

New referring physicians can be entered either by clicking the **New** button on the Physician Search… screen or by selecting the New… menu option from the Physician menu. After selecting the New… menu option, a blank Referring Physician Information screen will appear. Enter the referring physician's OHIP billing number. If this field is left blank, and 'Return' is hit, a new referring physician is not entered and the screen is exited. If an entry is made, the program will then search for this number in the Referring Physician database. If one already exists, a message indicating this will appear and the screen is exited. If this is a new and valid number, the remaining referring physician data can then be entered on the Referring Physician Information screen as described for the Select menu option.

Labels

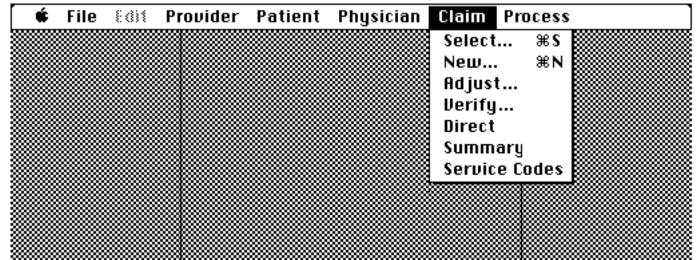
Referring physician address labels can also be printed using Avery AL-120 label sheets with a laser printer or a non-laser printer equipped with a sheet feeder. After selecting the Labels menu option, the Print Physician Labels screen will appear as shown at the top of the next column.



Clicking the **Add** button brings up the Physician Search… screen as described on Page 9. After selecting the desired physician, the physician is added to the print list. To remove a physician from the print list, highlight the physician in the print list and click the **Remove** button. To remove all names from the the print list click the **Clear** button. The start position allows you to use a label sheet which has been partially used, as described in the Patient Labels section on Pages 7-8. Click the **Print** button

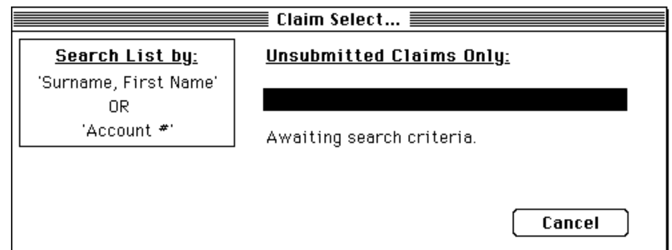
to print address labels for physicians in the print list. Click the **Done** button to exit.

Claim Menu:



Select…

The Select… menu option allows the user to select a claim for editing of claim information. If there are no unsubmitted claims for the current provider, a alert message will appear indicating this. Otherwise, choosing Select… (or the keyboard equivalent, Command-S), brings up the Claim Select… screen as shown below. Only unsubmitted claims (ie - Status = 'Saved') for the active provider can be accessed.



By typing in either: (a) the patient's **surname, first name** or any portion thereof, or (b) the claim **Account #**, the corresponding claim will be found almost immediately. Searching on Account # will yield only one match (if found). If searching on the patient's name, then often, more than 1 claim will match the search criteria, and these claims will be displayed in a Claim Browse Window as shown below, displaying the claims in order of Account Number.

Select Claim and Close Window

Patient Name	Account #	Patient #	Service Date
Cancel			
M. ELMORE	6189	3351	20/01/92
M. ELMORE	6191	3301	17/01/92
M. ELMORE	6520	3660	14/03/92
M. ELMORE	6610	3660	18/03/92

If the user leaves the Search Field blank and hits 'Return', then all Unsubmitted Claims will be displayed in the Claim Browse Window for the active provider. Clicking on **Cancel** allows the user to exit without entering the Claim Form screen. Otherwise, the Claim Form screen will appear as shown below. A given claim account contains anywhere from 1 to 8 claim items. After selecting the desired claim and closing the window, the Claim Form screen will appear allowing you to edit claim information.

Claim Form

Account # 7000

DR. J. ALLISON - 0000-224840-60 — Provider

34 — MR. W. BISHOP — Patient

028428 — DR. F. HORTON — Ref Phys

428 — Diag Code

Bill Code	#	Unit Fee	Fee Billed	Service Date
A605A	1	105.40	105.40	13/03/93
G313A	1	8.80	8.80	13/03/93
				/ /
				/ /
				/ /
				/ /
				/ /
				/ /

Claim ID: HOSP

Hospital #: 1302

Adm. Date (dd/mm/yy): 13/03/93

OHIP — Print

Saved — Cancel

☐ Manual Review — OK

Account #: This is the claim account number assigned by the program. This number should be recorded with any hard copy billing records or slips and is used by the program for identifying claims. This field cannot be edited.

Provider

To change the provider for this particular claim, click the **Provider** button. This will bring up the Provider Browse Window and the desired provider can be selected (full password protection will require entry of the appropriate password). Close the Provider Browse Window after making the selection. This will change the provider on the Claim Form screen but does not change the current provider in the Status Bar.

Patient

To change the patient for this particular claim, either enter the patient number (if known) or click the **Patient** button. Clicking the **Patient** button will bring up the Patient Search… screen as described on Page 3. The user may select another patient or enter a new patient for the claim.

Ref Phys

To enter or change a referring physician for the claim, either enter the physician number (if known) or click the **Ref Phys** button. Clicking on the **Ref Phys** button will bring up the Physician Search… screen as described on Page 9. The user may select a referring physician from the database or enter a new physician for the claim.

If automatic referring physician entry is activated (see Preferences section on Pages 20-21), then the default referring physician (see Page 4) will be automatically entered when a new claim is created.

Diag Code

For patients with previous billings, the patient's most recent diagnosis code will already be entered as the default. The diagnosis code can be entered or changed by typing in the 3 digit diagnosis code or by clicking the **Diag Code** button. Clicking the **Diag Code** button will bring up the Diagnosis Code Browse Window.

Select Diagnosis and Close Window

Code	Diagnosis Description
428	Congestive heart failure, acute pulmonary edema
429	All other forms of heart disease
432	Intracranial hemorrhage
435	Transient ischemic attack (TIA)
436	Acute cerebrovascular accident (CVA, stroke)
437	Chronic cerebrovascular disease (old CVA), hypertensive encephalopa
440	Generalized arteriosclerosis, atherosclerosis
441	Aortic aneurysm (thoracic or abdominal, non-syphilitic)
443	Raynaud's disease, Buerger's disease, peripheral vascular disease, in
446	Polyarteritis nodosa, temporal arteritis
447	Other disorders of arteries
451	Phlebitis, thrombophlebitis
452	Portal vein thrombosis

See Page 4 in the Patient Select… section for more information on diagnosis code entry.

Claim ID: An optional field, claim ID can be useful for identifying or separating groups of claims (ie - different clinics, office vs. hospital practice, etc). When printing claim summaries, claim ID can be used to identify groups of claims (see Page 15). If not needed, simply leave the field blank.

Hospital #: You must enter the hospital or facility number as necessary. See Preferences section on Pages 20-21 for information about setting default values for Hospital #.

Admit Date: An admission date must be entered for hospital inpatients. If automatic Admission Date entry is activated in the Preferences section (see Pages 20-21), then the admission date of the most recent claim will be automatically entered for new claims on the same patient. This is a useful feature for patients with long-term hospitalizations.

Bill Code: A valid OHIP service code (format "ANNNA") must be entered here. If an incorrect service code is entered a message "Invalid Input" will appear. Up to 8 service codes can be entered per claim. All codes must end in the suffix A, B or C.

The entry of a claim item into the Claim database depends on the presence of a non-blank Bill Code. To **delete** a claim item, simply erase the Bill Code. On re-opening the Claim Form Window for that account, that claim item will be deleted.

To review billing information for a specific service code, select the Service Codes option from the Claim Menu (see Page 15).

#: The number of services for each bill code are entered in this field. For anesthetists' (C suffix) and assistants' (B suffix) fees, the # of base units are entered automatically. For these fees, the user should then add on the # of time units.

For other fees, if no entry is made, '1' is assumed. For expandable codes such as hospital visits, a # > 1 refers to visits on consecutive days starting with the Service Date.

Unit Fee: The unit fee for the specified billcode is entered automatically. The unit fee can be changed by manually entering a fee and hitting 'Return'.

For special visit fees, the unit fee entered will equal the greater of either the base fee or the product of the fee billed on the immediately preceding item (assessment or consultation) multiplied by the percentage shown below.

Fee Code	Percentage	Base Fee
_991A	30%	$9.50
_993A	30%	$14.30
_995A	30%	$14.30
_997A	50%	$22.00

Fee Billed: The fee billed is automatically calculated and entered (equals the product of the number of services and the unit fee). The fee billed can be changed by manually changing the unit fee and hitting 'Return'.

Service Date: The date on which the service was rendered is entered here. If 'Automatic Date Entry' is checked off in the Preferences section (see Pages 20-21) and a value has been entered for the default date, then this date will be automatically entered in the first date field. If 'Automatic Date Entry' is checked off but the default date has been left blank, then either the admission date or the current date (if admission date is blank) is automatically entered for the first claim item. For subsequent claims items, the service date for the previous claim item is automatically entered. This feature can be disabled by unchecking 'Automatic Date Entry' in the Set Preferences screen in the Preferences section. When disabled, the service date must be manually entered.

OHIP
Reciprocal
WCB
Direct

Use the Pop-Up menu (see adjacent figure) to select the claim billing type. OHIP is the default.

Status: The claim status, Not Saved or Saved, is displayed at the bottom of the Claim Form screen.

Manual Review: The Manual Review checkbox should be checked for claims designated as requiring manual review by OHIP.

Print

The **Print** button allows you to print an OHIP card, Reciprocal Billing card or Workman's

Compensation Board (WCB) card for the current claim. Before printing, the user will be prompted that all changes must be saved.

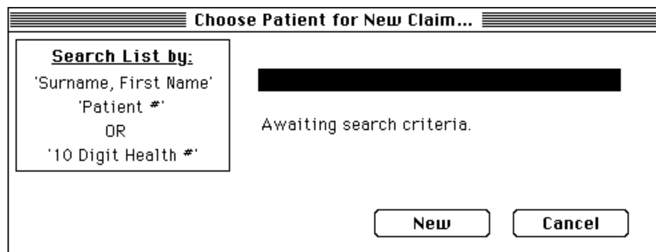
Claims with a Direct claim billing type cannot be printed directly from the Claim Form screen. See the section on **Direct** claims on Page 14 for details about printing invoices for directly billed patients.

The **Cancel** button allows you to leave the claim edit screen without saving any changes made. A message window will appear asking you to confirm that this is what you intend to do.

Clicking the **OK** button will leave the claim edit screen and save any changes.

New…

Selecting the New… menu option from the claim menu (or entering the keyboard equivalent, Command-N), brings up a screen identical to the Patient Search… screen (described on Page 3) but with the heading "Choose Patient for New Claim…" as shown below.

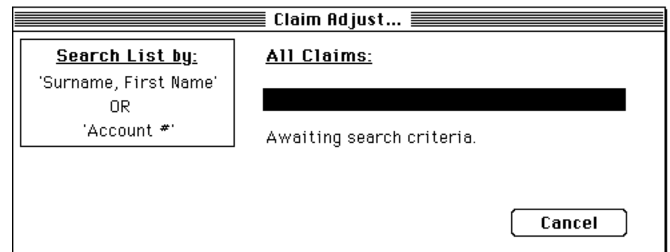


The user can select a patient from the database or enter a new patient. A new Claim Form screen will then come up for this patient with the current provider as the default provider. The most recent diagnosis code of the selected patient is entered as well. The default referring physician is blank. Data is entered in the fields as described for the Select… menu option. Values for Referring Physician, Hospital # and Admit Date will appear as specified in the Set Preferences screen as described in the Preferences section on Pages 20-21. Details of Claim Form entry are described under the Select… menu option.

Adjust…

The Adjust menu option of the Claim menu is used for making changes to claims that have already been submitted. To avoid conflicts with OHIP, only certain fields can be edited, once claims have been submitted.

After selecting Adjust, the Claim Adjust… screen will appear as shown below. Unlike the Claim Select… screen, this screen allows you to access all claims for the active provider (ie - unsubmitted, submitted, discrepant and reconciled claims).



As with Claim Select…, typing in either: (a) the patient's **surname, first name** or any portion thereof, or (b) the claim **Account #**, will bring up the the Claim Browse Window if more than 1 claim matches the search criteria or the Adjust Claim… screen if only 1 claim matches the criteria.

The data that can be edited on the Adjust screen status includes Health #, Version #, Date of Birth, Fee Paid, Claim Status (ie - Saved, Submitted, Discrepancy, or Reconciled) and Billing Type (ie - OHIP, Reciprocal, WCB or Direct). The Adjust Claim… screen is useful for performing manual reconciliation for directly billed claims as well as for correcting and resubmitting rejected machine-readable claims. OHIP claims with incorrect Health #, Version # or Date of Birth are not processed and a paper listing of these is sent back to the provider monthly on an OHIP Error Report. This information can be corrected on the Adjust Claim… screen and the claim can then be re-submitted by simply changing the status to Saved from Submitted. The claim account will be automatically included in the next billing submission. The Adjust Claim… screen is shown below.

Adjust Claim...

Account # 4292
Provider: DR. J. ALLISON - 0000-224840-60
Patient: 322 MR. ANTHONY SPENCER
Health #: 7428758481 Version #: Q
D.O.B. (dd/mm/yy): 25/03/34

Bill Code	#	Unit Fee	Fee Billed	Fee Paid	Service Date	Status
A605A	1	105.40	105.40		17/07/93	Saved
C602A	1	17.10	17.10		18/07/93	Saved
C608A	1	17.10	17.10		19/07/93	Saved
C101A	1	7.70	7.70		19/07/93	Saved
					/ /	
					/ /	
					/ /	
					/ /	

Saved
OHIP
Choose
Done

Change the data for Health #, Version # and Date of Birth as necessary. Enter or change the fee paid as necessary for the appropriate claim items.

Saved
Submitted
Discrepancy
Reconciled

You can use this Pop-Up menu to change the claim status for all of the items in the claim. If discrepancy is chosen, a warning message will appear, asking if you want to change the status of all claim items to "Discrepancy".

OHIP
Reciprocal
WCB
Direct

You can use this Pop-Up menu to change the billing type for all of the items in the claim.

Clicking the **Choose** button will bring up the Claim Adjust… screen allowing you to select another claim for adjustment. Click the **Done** button to exit.

Verify…

The Verify… option of the Claim menu is used to check all unsubmitted OHIP, Reciprocal and WCB claims belonging to the current provider for errors. The errors checked for include:

Service code excluded from machine-readable input.
Diagnosis code required for this service code.
Referring physician required for this service code.
Hospital number required.
Admission date required.
Service date is after submission date.
Service date is more than 6 months old.
Service date is after admission date.
Missing Health number for this patient.
Missing date of birth for this patient.
Reciprocal Claims require a specified province.
Reg# for <province> must be __ digits
Manual review required for this claim.

If errors are found an error report window will appear as shown below. Click **Print** to print a report of these errors. Errors can then be corrected by selecting the corresponding claim accounts using the Select… menu option on the Claim menu. Click **Done** to exit.

Verification Complete: 6 errors found.

Acct#	Service	Date	Error
000175	A605A	18/04/91	Diagnosis code required
000175	C602A	19/04/91	Diagnosis code required
000176	A603A	25/04/91	Service date after admission date
000177	A605A	04/05/91	Referring physician required
000178	A603A	09/11/90	Service date more than 6 months old
000179	A603A	09/04/91	Missing OHIP & Health number

Print Done

NOTE - Only one error is reported for any claim item. It is advisable to reverify after correcting the first batch of errors before proceeding with billing to ensure that a second unrecognized error was not present.

Direct

Use the Direct option of the claim menu to print an invoice or statement of account for patients who are billed directly. If no unsubmitted Direct claims are available, a message will appear, alerting you to this. Otherwise, the Patient Browse Window will appear, showing only patients with unsubmitted Direct claims by the current provider. Select the patient for whom you wish to print a Direct billing invoice and close the window.

When preparing an invoice, it is important to have an explanation for each Service Code so that the patient understands what he is being billed for. For all service codes with blank description fields, a Service Code screen will appear as shown below. Enter a description and click **OK** to confirm and continue.

Service Code: A605

Enter a description for this service code…

CONSULTATION

OK

All unsubmitted directly-billed claim items will be included on the statement and may come from several claim accounts. The Direct billing statement of account will then be printed. It may be advisable to use the provider's letterhead for this report. After the statement is printed, a message will appear asking if you wish to change the status for these claims to 'submitted'. It may be useful to do this to mark that these accounts have been invoiced. However, if the user wishes to send another statement for the same claim accounts, it will be necessary to revert the claim status back to 'Saved' using **Adjust…** (see Page 13).

Summary

The Summary option of the claim menu is used for printing a summary for a defined subset of claims for a particular provider. These claims can be defined by a date range or account range. The date range can be used for detailed daily, weekly or monthly claim summaries. The account range is useful for verifying entered data against original data (keeping track of the accounts entered in a given time period). The summary can be limited to any or all statuses of claims (ie - Unsubmitted, Submitted, Discrepant, Reconciled) and can be limited to claims with a specific Service Code or Claim ID (see Page 12). The generated report details all of the mandatory claim and patient data for each claim item as well as totals. After selecting the Summary menu option, the Claim Summary screen will appear.

Claim Summary

Choose Provider DR. J. ALLISON - 0000-100008-13

Acct # Range: 1 to 7012

Date Range: (dd/mm/yy) 01/01/93 to 29/09/93

Include…

☒ Unsubmitted Claims

☒ Submitted Claims

☒ Discrepant Claims

☒ Reconciled Claims

Limit Claims By…

Service Code: Z442A

Claim ID:

Order… ◉ By Account # ○ Alphabetically

Print Done

To change the provider (the current provider is the default) click the **Choose Provider** button. The Provider Browse Window will appear and the desired provider can be selected (full password protection will require entry of the appropriate password). Click on the appropriate check boxes to include any or all claims according to claim status. The user can specify a specific Service Code and/or

Claim ID to limit the claim summary to claims matching that code / ID. To print the summary, click the **Print** button. Click the **Done** button to exit.

Service Codes

Selecting the Service Codes option of the claim menu will allow you to examine or edit the fees, OHIP

Service Code Info

Service Code: R554 | Choose Service Code

Description:

Fee - A: $270.70 * Fee - B: $9.57 † Fee - C: $11.04

Edit Service Fees

☐ Consecutive Day Billing
☐ Manual Review Required
☐ Non-machine Readable
☒ Diagnosis Required
☐ Admission Date Required
☐ Must Indicate In/Outpatient
☐ Referring Physician Required
☐ Hospital # Required

* 3 Assistant Base Units.
† 4 Anesthetist Base Units.

OK

requirements or service description for a given service code. After selecting Service Codes, the Service Code Info screen will appear as shown above. For anesthetists' and assistants' fees, the appropriate base units are displayed at the bottom of the screen. To examine or edit a different service code, enter the first 4 characters of the service code (minus the A,B or C suffix). The service code information will then appear for the entered service code. Alternatively, click the **Choose Service Code** button to bring up the Service Code Browse Window as shown below, allowing the user to select a service code from the list.

Select Service Code and Close Window

Service Code	Description
A604	GENERAL REASSESSMENT
A605	CONSULTATION
A606	RE-CONSULTATION
A608	PARTIAL ASSESSMENT
A613	GENERAL ASSESSMENT
A614	GENERAL RE-ASSESSMENT
A615	CONSULTATION
A616	REPEAT CONSULTATION
A618	PARTIAL ASSESSMENT
A623	GENERAL ASSESSMENT
A624	GENERAL REASSESSMENT
A625	CONSULTATION
A626	RE-CONSULTATION

To edit the service code fees, click on the Edit Service Fees button. This will bring up the Edit Service Code Fees screen as illustrated below. The user will not be able to alter certain service codes because they are invalid (ie - A603B is initially blank and a fee cannot be assigned to it). In addition, the base fees for assistants' and anesthetists' fees cannot be edited.

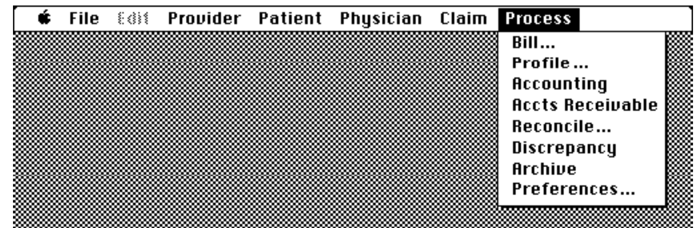
Edit Service Code Fees

Enter New Service Code Fees for A603 in spaces below:

A603A: $53.10
A603B:
A603C:

User-Defined Fees - 25 non-OHIP, non-machine-readable codes are included in the MedBASE fee schedule and are numbered from I001A to I025A. The assignment and usage of these fees is at the discretion of the user. Their initial value is $1.00 and this can be edited as described above. These codes cannot be included with an OHIP submission but can be used in any Direct billing claim. These fees can be used for services not covered by OHIP such as insurance forms, administration fees and disposable items.

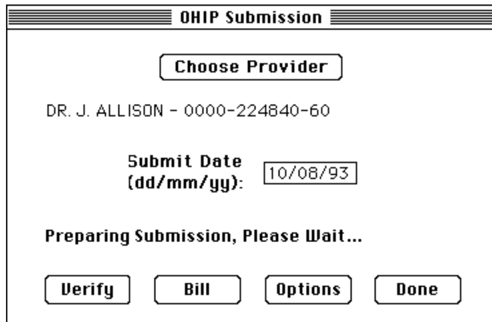
Process Menu:



Partial password protection limits access to the Process menu. When partial password protection is active, the selection of any option from the Process menu or changing providers while within a Process menu option will require entry of the appropriate password before proceeding.

Bill…

The Bill… option of the Process menu is used for creating a machine-readable file for submission to OHIP. This option is also useful for verifying submissions and for reprinting billing summaries and 'unsubmitting' OHIP submissions. After selecting Bill…, the OHIP Submission screen will appear.



Choose Provider

Click this button to change the provider for whom you wish to bill (the current provider is the default). The Provider Browse Window will appear and the desired provider can be selected (full or partial password protection will require entry of the appropriate password). The current provider in the Status Bar will not be changed.

Submit Date: The current date will appear as the default in this field. To change this date, simply enter a different date. This date will entered on the submission diskette.

Verify

For convenience, submissions can be verified for errors from either the OHIP Submission screen by clicking on the **Verify** button or by selecting the **Verify…** menu option from the Claim menu. See the section describing the **Verify…** menu option on Page 14 for further details about verification of claims.

With group submissions, all of the group providers can be verified with 'one click' when done from the OHIP Submission screen. When verification is done from the Claim menu, only claims for the 'Current Provider' are checked, regardless of whether the provider is part of a group or not.

If errors are found during verification, they should be corrected before proceeding with the submission. Click **Done** to return to the OHIP Submission screen.

Bill

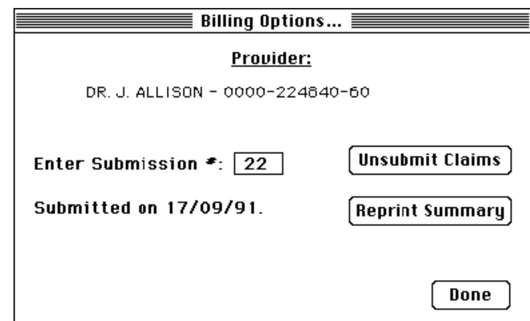
Click on the **Bill** button when you are satisfied that the OHIP submission is error-free. All unsubmitted OHIP, Reciprocal and WCB claims belonging to the active provider will be processed. OHIP claims without a valid Health # will not be submitted. If the provider belongs to a group (ie - Group # not '0000'), then the user is given the option of billing all providers from that group. Alternatively, each provider in the group can be billed separately and multiple diskettes submitted. Click on **Yes** or **No** as desired.

After processing is complete, a machine-readable ASCII file will be created and a file save window will appear with a prompt to insert the OHIP submission diskette. Insert the diskette and click **Save**. The file will be saved on the diskette and a duplicate copy will also be saved in the MedBASE Submissions folder on the hard disk. The diskette will be ejected and a prompt will then appear asking whether you wish to print a Billing Summary. Click **Yes** or **No** as desired. Be sure to record the number of Claims and Records. The OHIP Submission screen will then be exited.

It is advisable to check all submission diskettes to ensure that a submission file is present. Duplicates from the MedBASE Submissions folder can be copied onto a new diskette if necessary.

Options

Clicking on the **Options** button will bring up the Billing Options… screen as shown below. This screen is useful for reprinting previous billing summaries and 'unsubmitting' previously submitted OHIP submissions



When OHIP submission files are created by MedBASE, they are assigned sequential numbers (001, 002, 003, etc.) as required by OHIP. These submission #'s are also the last 3 characters of the submission filename. When a valid submission # is

entered, the date of submission will be displayed on the screen and this becomes the 'active submission'.

If, for some reason, the user has made an error in the OHIP submission and wishes to 'undo the submission', this can be done by clicking on the **Unsubmit Claims** button. The status of all the claims from the 'active submission' will be changed to Saved (= 'Unsubmitted'). These claims can be submitted again later using the **Bill** button as described in the previous section.

Clicking on the **Reprint Summary** button will produce an OHIP Billing Summary for the 'active submission'. This is useful when during the actual submission procedure, the user failed to turn the printer on or had printer-related problems. If any claims from the 'active submission' were later resubmitted in a different batch, then claim or record counts may be inaccurate. Click on **Done** to exit and return to the OHIP Submission screen.

Done

Click on this button to exit the OHIP Submission screen.

Profile

Selecting the Profile option of the Process menu will allow you to print a detailed summary or "practice profile" of a particular provider's billings broken down according to specific service codes billed over a specified date range. Details of the # of times billed, total fees billed, total fees paid, and last date billed will be displayed for each service code billed during the specified date range. This report is useful for analyzing patterns of practice and changes thereof. After selecting the Profile menu option, the Practice Profile screen will appear as shown below. To change the provider (the current provider is the

Practice Profile

Choose Provider

DR. J. ALLISON - 0000-100008-13

Date Range: (dd/mm/yy) 01/04/92 to 30/04/92

Print Done

default) click the **Choose Provider** button. The Provider Browse Window will appear and the desired provider can be selected (full or partial password protection will require entry of the appropriate password). The default date range is from the first to the last day of the previous month. This can be edited as desired. To print the Practice Profile report, click the **Print** button. Click the **Done** button to exit.

Accounting

Selecting the Accounting option of the Process menu will allow you to print a accounting summary which indicates the # of services, fee billed, fee paid, accounts receivable, over-payments and write-offs for a particular provider over a specified date range. A breakdown is also given according to claim status (ie - saved, submitted, discrepancy and reconciled). After selecting Accounting, the Accounting Summary screen will appear as shown at the top of

the next page. To change the provider (the current provider is the default) click the **Choose Provider** button. The

Accounting Summary
Choose Provider
DR. J. ALLISON - 0000-100008-13
Acct # Range: 1 to 211
Date Range: (dd/mm/yy) 01/02/90 to 31/01/91
Print Done

Provider Browse Window will then appear and the desired provider can be selected (full or partial password protection will require entry of the appropriate password).

The accounting summary can be defined according to an account # range and a date range. The default account # range includes the entire range of claim accounts in the database. This can changed as is desired. More commonly, the date range is used to delimit the accounting summary (ie - for monthly statements or year-end statements). The default date range is from the first to the last day of the previous month. This can be edited as desired. To print the Accounting Summary report click the **Print** button. Click the **Done** button to exit.

Accts Receivable

Selecting the Accts Receivable option of the claim menu will allow you to print an Accounts Receivable list as of any specified date broken down according to # of days past due. After selecting Accts Receivable, the Accounts Receivable screen will appear as shown below.

Accounts Receivable
Choose Provider
DR. J. ALLISON - 0000-100008-13
30 days past due
Print Accounts Receivable
list as of 15/05/92
Print Done

To change the provider (the current provider is the default) click the **Choose Provider** button. The Provider Browse Window will appear and the desired provider can be selected (full or partial password protection will require entry of the appropriate password). The default date is the current date and this is the date generally used for generating a list of 'Outstanding Transactions' (ie - current Accounts Receivable). When a prior listing of Accounts Receivable is required, (usually for Financial Statements at fiscal year-end), the desired

All claims
30 days past due
60 days past due
90 days past due
120 days past due

date can be entered in this field. Use the adjacent Pop-up menu to select the desired date threshold for the Accounts Receivable list. To print the Accounts Receivable report, click the **Print** button. Click the **Done** button to exit.

Reconcile

The Reconcile option of the Process menu is used to reconcile previously billed claims from a OHIP Remittance Advice (RA) Diskette. After selecting Reconcile, the file selection window will appear. Insert the OHIP RA diskette and select the RA file (should begin with a "P" as per the new OHIP format). Click **Open** to continue or **Cancel** to abort the reconciliation. If you select a file which is not an OHIP remittance advice file an error message will appear. If a proper file has been selected the file will be read and the diskette ejected. If the provider on the diskette is not the current provider and full or partial password protection is active for this provider, then the user will be prompted for the appropriate password. The Reconciliation Summary screen will appear as shown below.

As a default, the claim item will be reconciled if the fee paid is within $1.00 of the fee billed. Otherwise, the claim item will be marked as a discrepancy. The underpayment and overpayment limits may be edited as desired.

OHIP Reconciliation

OHIP Reconciliation in progress

Accept underpayment if within $ 1.00
Accept overpayment if within $ 1.00

Records	Reconciled	Discrepancies	Prev. Processed	Not Found
133	127	5		1

Continue...

Click the **Continue…** button to proceed with the reconciliation. The Reconciliation Summary screen will show the progress of the reconciliation both in the form of a status bar and in the table, indicating the total # of records, # reconciled, # of discrepancies, # previously processed and # not found (ie - on the RA diskette but not in the database and usually the result of manual card submissions). When the reconciliation is completed a prompt will appear asking whether you wish to print the Reconciliation Summary reports. Click **Yes** or **No** as desired.

These reports include:

(1) Reconciliation Totals and List of Discrepancies.

(2) Summary of Claim Items 'Not Found' (if applicable).

(3) Message from the Ministry of Health (includes OHIP Threshold Summary).

The # of outstanding claim items and 'J8' payments will be shown at the bottom of the first report. J8 refers to 'good faith' payments made by OHIP for patients with incorrect Version #'s or expired Health #'s. 'J8' will be added to the patient's identifier field allowing a printout of these patients using the Summary option of the Patient menu (see Page 7).

Click **Done** to exit the Reconciliation Summary.

Discrepancy

Selecting the Discrepancy option of the Process menu will allow you to edit any discrepant claims for the current provider. An alert message will appear informing the user of the number of discrepant claims (if any). If discrepant claims exist, then the Claim Browse Window will appear, displaying all discrepant claims for the current provider

Selecting the desired claim and closing the window brings up the Discrepancy Audit screen as illustrated below. An explanatory code is displayed in the lower portion of the Discrepancy Audit screen giving the reason for the discrepancy and below this, the current status of this claim is shown (initially will be 'Discrepancy' as shown in the figure below).

Discrepancy Audit

Account #: 4292 Patient #: 322

Patient: SPENCER, ANTHONY

	Billed	Paid
Service Date	17/07/93	17/07/93
Service Code	C603A	C602A
# of Services	1	1
Fee	52.40	16.70

Choose
Adjust
Reconcile

Explanatory Code HA
Admission assessment claimed by another physician.

Status = 'Discrepancy'
Done

If you do not wish to challenge OHIP and decide to accept the lesser amount paid, simply click the **Reconcile** button. This will change the status of the claim to 'Reconciled' as shown in the next illustration below. Clicking on the **Unreconcile** button will revert the status back to 'Discrepancy'.

If you decide to dispute the fee paid with OHIP, you will be required to submit on paper, a Remittance Enquiry form with a written explanation. Leave the information on the Discrepancy Audit screen unchanged for now.

Later, after you have received additional fees for the disputed claim, you will want to edit the fee paid on this claim. Simply click on the **Adjust** button. This will allow you to edit the fee paid field as shown below. Then enter the new fee and hit 'Return'. Click the **Reconcile** button to reconcile the claim, saving the new fee paid.

Discrepancy Audit

Account #: 4292 Patient #: 322

Patient: SPENCER, ANTHONY

	Billed	Paid
Service Date	17/07/93	17/07/93
Service Code	C603A	C602A
# of Services	1	1
Fee	52.40	16.70

Choose

Adjust

Unreconcile

Explanatory Code HA

Admission assessment claimed by another physician.

Status = 'Reconciled'

Done

Clicking the **Choose** button brings up the Claim Browse Window again, allowing you to select another discrepant claim. To exit, click on the **Done** button.

Archive…

The Archive… option of the Process menu is used to remove a batch of claims, patients and appointment records from their active databases. In general, this feature is useful only after a provider has been using the program for an extended period of time (ie - 2 years or more) and wishes to remove records to optimize program speed and performance.

We would recommend the following guidelines for archiving:

(1) Keep claim records from the current and previous fiscal year in the active database to maintain accuracy of accounting functions. Claims older than this can be archived if necessary. For example, if the current date is September 1, 1993 and the provider's fiscal year runs from February 1 - January 31, then an archive date of January 31, 1992 can be used.

(2) Use the same archive date for claims and patients. Hence, using the above archive date, only patients whose last visit was before January 31, 1992 will be archived. If a different archive date is used for patients, then many of the patient records will not be removed because of existing active claims.

(3) Patient records can be individually restored at any time. Claims and appointment records cannot be easily restored. Be absolutely certain before proceeding with archiving.

(4) Past appointment records are of little use for most users. To optimize appointment processing, we would advise archiving appointments booked before the current month. For example, if the current date is September 15, 1993, choose an archive date of August 31, 1993 for appointments.

Selecting the Archive… option will bring up the Archive / Restore screen as shown below. Only claim and appointment records relating to the current provider can be archived. Any patient can be archived as long as there are no active claims relating

Archive / Restore

Provider: DR. J. ALLISON - 0000-224840-60

Archive Date: 31/12/91

☒ Claims Reconciled as of Archive Date

☒ Patients Inactive as of Archive Date

☐ Appointments Booked before Archive Date

Restrict to Patients with Identifier… EXPIRED

Archiving Patient database.

Restore Patient | Archive | Done

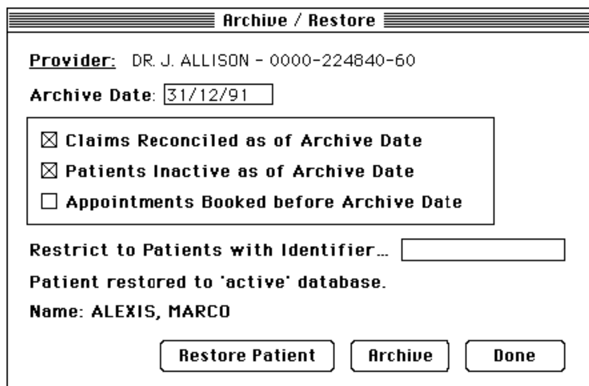
to that patient. Enter the desired archive date. Click the appropriate check boxes to archive claims, patients and/or appointment records. The user can choose to archive only a subset of patients (and their corresponding claims) by specifying a descriptor that must part of the patient's identifier field. Click on the **Archive** button to begin. When archiving is complete, an alert message will indicate the number of patient, claim or appointment records archived.

Select Patient to be Restored to Active Database

Surname	First Name	Patient #	Health #
ABOUSSAFY	WILFRED	561	4255333470
AHMED	FAISAL	567	2734011196
AIKMAN	STEWART	90	7534969592
ALEXIS	MARCO	502	1330522390
ALEXOPOULOS	STEVE	645	5396841552
ALIFERIS	ALKIVIADIS	368	8731943851
ALLEYNE	JUDIE	298	2720400999
ALLISON	LUELLA	494	8223846273
ANTONIADIS	SOFIA	500	1462264175
ARMANIOUS	EZZAT	95	7791878015
ARVANITIS	NORMA	372	8447116776
AVGERIS	DESPINA	379	7712047096
AYRES	REG	568	2837690235

Occasionally, the user may wish to restore a previously archived patient back to the active patient database. This can be done by clicking on the

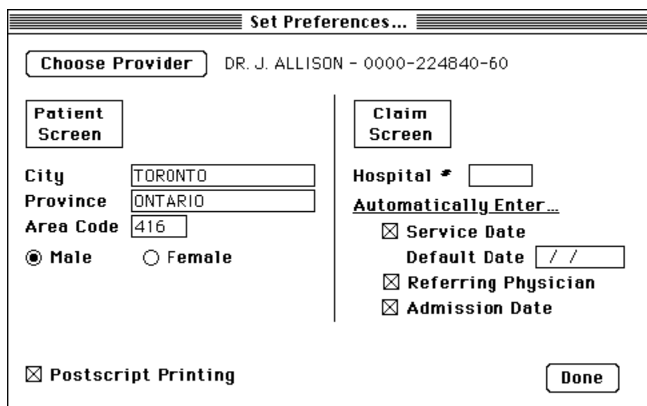
Restore button. This will bring up a Patient Browse Window as shown at the bottom of the previous column. Select the patient to be restored and close the window. If the patient has already been re-entered into the active patient database, the archived record will not be restored to avoid duplicate entries. Otherwise, a message will appear indicating that the patient has been restored, as shown below.



Click the **Done** button to exit.

Preferences…

Selecting the Preferences… option of the Process menu will bring up the Set Preferences Screen as illustrated below.



Preferences can be used to set default values that are automatically entered for the specific fields shown on the screen, when a new patient entry or new claim entry is created. For new claims, the user may also choose whether to automatically enter the service date, referring physician and/or admission date.

If a specific default date is specified, this date will be automatically entered for the service date on new claims. This is useful for billing a batch of claims where the services were rendered on the same day. If a default date is not specified, then the current date will be entered for outpatients and the admission date for hospital inpatients. For further details regarding automatic date entry, see Service Date in the Select… section of the Claim menu on Pages 11-12. If automatic referring physician entry is selected, then the most recent referring physician for that patient (as indicated on the Patient Information screen - see Page 4) will be entered. For automatic admission date entry, the admission date of the previous claim for that patient will be entered.

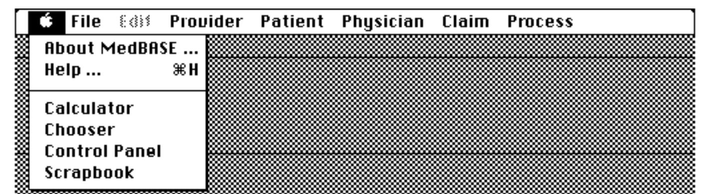
These preference selections are provider-specific and the values used depend on the provider that is active when a new patient or claim entry is created. Editing these default values will affect only new records. Previously entered information will not be affected.

To change the default values for another provider, click the **Choose Provider** button. The Provider Browse Window will appear and the desired provider can be selected (full or partial password protection will require entry of the appropriate password).

If a Postscript (or related) printer is used, click on the **Postscript Printing** checkbox. Failing to do so may result in malalignment of patient or physician labels during label printing.

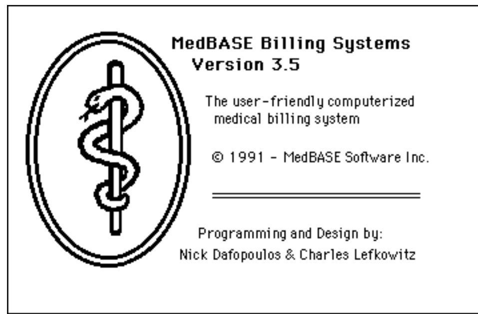
Click the **Done** button to exit.

Menu:



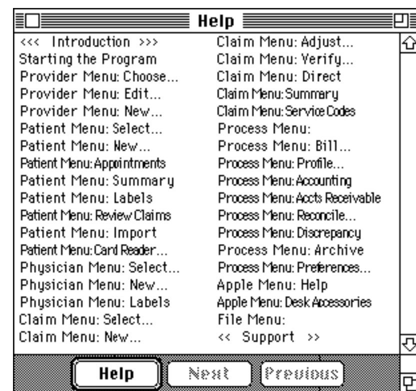
About MedBASE…

About MedBASE… brings up the



Help…

Selecting the Help… menu option from the Menu brings up the on-line Help Screen as illustrated below. The on-line Help Screen contains essentially the same information that is outlined in the MedBASE 3.5 Manual and is similarly organized according to menu items. To select a topic, click on the desired topic and then click on the **Help** button at the bottom of the screen. The **Next** and **Previous** buttons bring the next and previous topics respectively. Click in the close box in the top left hand corner to exit.



Desk Accessories…

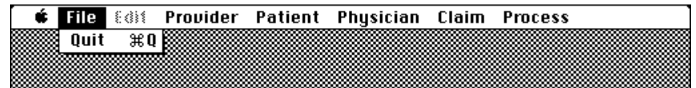
The desk accessories are files that are installed within the operating system of the Macintosh. These files reside in the **Apple Menu Items** Folder (in System 7.0) or are installed into the system with the **Font/DA Mover®** (in System 6.0 or less). The Calculator can be useful when entering claims. The Control Panel can contain any number of 'devices' such as screen savers, font managers, as well as the basic control files for general Macintosh functions, mouse, keyboard, monitors, etc. The Chooser is used to select the output device (generally the printer, ie - LaserWriter or StyleWriter).

For those with System 6.0, a shareware Control Panel device entitled **Max Files** (© Copyright 1990, Siemens Gammasonics Inc.) is automatically installed into your System Folder. Use this utility to set the maximum # of open files to at least 80 to ensure optimal database operations. An inadequate value for maximum # of open files may result in problems when printing reports, particularly when working in MultiFinder. The computer must be restarted for these changes to take effect. For those

with System 7.0, the maximum # of open files are regulated automatically during computer operation.

File Menu:

The File menu contains one option… **Quit** (or the keyboard equivalent, Command-Q). This allows you to quit the program.



For technical advice and support, call MedBASE Software Inc. at:

Phone and FAX line - ***416-778-5852***
Emergency Service **-** ***416-417-2743***

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Index:

About MedBASE........ 21
Accounting Menu Option........ 17
Accounting Summary........ 17, 18
Accounting Summary screen........ 17, 18
Accounts Receivable........ 18
Accounts Receivable report........ 18
Accounts Receivable screen........ 18
Accts Receivable Menu Option........ 18
Add/Edit Appointment screen........ 7
Address Labels........ 8
Adjust… Menu Option........ 13
Adjust Claim… screen........ 14
Admission date........ 4, 12, 13, 14, 20, 21
Analyzing patterns of practice........ 15
Anesthetists' fees........ 12, 15
Appointments........ 5, 6, 7
Appointments Menu Option........ 6
Appointments screen........ 5, 6
Archive date........ 19, 20
Archive Menu Option........ 19
Archive / Restore screen........ 20
Archiving appointments........ 19, 20
Archiving claims........ 19, 20
Archiving patients........ 19, 20
Assistants' fees........ 12, 15
AutoMac®........ 1
Automatic Date Entry........ 12, 20
Base units........ 12, 15
Bill Code........ 12
Billing Number........ 2, 10
Billing Options… screen........ 17
Billing Summary........ 16, 17
Billing Summary, reprinting of........ 17
Billing type........ 13, 14
Bill… Menu Option…........ 16
Calculator........ 21
Card Reader… Menu Option........ 9
Changing Password........ 2
Changing Billing type........ 14
Changing Claim status........ 13, 14
Changing Fee paid........ 13, 14, 19
Changing Maximum Open Files........ 21
Chart Labels........ 8
Choose… Menu Option (Provider)........ 2
Chooser........ 21
Claim Adjust… screen........ 13, 14
Claim Browse Window........ 11, 13, 19
Claim Form screen........ 5, 11, 12, 13
Claim ID........ 12, 15
Claim Menu........ 11
Claim Select… screen........ 11
Claim Status........ 11, 13, 14, 15, 17, 19
Claim Summary screen........ 15
Control Panel........ 21
Daily Appointments screen........ 6, 7
Date threshold........ 18
Default date........ 12, 18, 20
Default date range........ 18
Deleting a Provider........ 3
Deleting a Patient........ 5
Deleting a Referring Physician........ 10
Deleting a Claim Item........ 12
Desk Accessories........ 21
Diagnosis codes........ 4, 12, 13, 14
Diagnosis Code Browse Window........ 4, 12
Direct billing Statement of Account........ 14, 15
Direct claim billing........ 2, 13, 14, 15, 16
Direct Menu Option........ 14
Disabling Password........ 2
Discrepancy Menu Option........ 19
Discrepancies........ 14, 15, 18, 19
Discrepancy Audit screen........ 19
Discrepancy Summary........ 15
District Code........ 2
Edit… Menu Option (Provider)........ 2
Edit Menu (Find, Find Again)........ 4
Edit Service Code Fees screen........ 15, 16
Edit Service Fees........ 15, 16
Editing Provider Information........ 2
Expandable codes........ 12
Exporting Patient data........ 7, 8
Fee billed........ 12, 17, 18

Fee paid 13, 14, 17, 18, 19
File Menu.. 22
Find Command.. 4
Find Again Command 4
Find Next Booking… screen 6, 7
First Available Booking..................................... 6
Font-DA Mover... 21
Getting started 1
Good faith payments 19
Group Number.. 2
Health Card 9
Health Number....................3, 5, 9, 13, 14, 16, 19
Health Number, invalid 3, 16, 19
Help Menu Option 21
Help Screen 21
Hospital number... 12, 14
Identifier 4, 7, 20
Import Menu Option 8
Importing Patients… screen 8
Installing the Program 1
Introduction 1
J8 payments 7, 19
Keyboard equivalents 2, 3, 5, 11, 13, 22
Labels, malalignment of.................................... 21
Labels Menu Option (Patient) 7
Labels Menu Option (Physician)........................ 10
Last Visit 4, 7, 19
License Agreement... 23
List of Discrepancies (Reconciliation report) 19
Machine-readable input, excluded from 14
MACRO programs... 1
Macromaker®.. 1
Magnetic Card Reader 9
Manual reconciliation....................................... 13
Manual Review 13, 14
Max Files®.. 21
MedBASE Databases folder............................... 1
MedBASE Submissions folder 1, 16, 17
Memory requirements 1
Message from the Ministry of Health................ 19
Microsoft Excel® 7
Monthly Appointments screen............................. 6
New claim, creating a................................... 5, 13
New… Menu Option (Claim) 13
New… Menu Option (Patient) 5
New… Menu Option (Provider)......................... 3
New… Menu Option (Referring Physician) 10
Next booking 6, 7
Not found - claims 18
Not found - claims, summary of 19
Number of services 12
Office days... 6
OHIP billing cards.. 13
OHIP Error Report 13
OHIP RA diskette 18
OHIP Remittance Advice 18
OHIP Service codes........................12, 14, 15, 16
OHIP Submission diskette........................... 16, 17
OHIP Submission file 16, 17
OHIP Submission file - duplicate................ 16, 17
OHIP Submission screen 16, 17
Optimizing performance 19
Out of Province screen 5
Outstanding transactions 18, 19
Overpayments 17, 18
Password Protection, full ....
1, 2, 3, 11, 15, 16, 17, 18, 21
Password Protection, partial.................................
2, 3, 15, 16, 17, 18, 21
Password Protection, setting 2, 3
Patient Information screen................ 3, 4, 5, 9, 21
Patient Browse Window......................... 3, 14, 20
Patient Appointments screen 5
Patient Import file 8
Patient Labels.. 7, 8
Patient List / Export screen 7
Patient Menu.. 3
Patient Search… screen...........3, 5, 6, 7, 8, 11, 13
Patient Set-Up File... 8
PC-based version 1
Physician Menu.. 9
Physician Search… screen.................. 4, 9, 10, 12
Postscript printing 21
Practice Profile report 17

Practice Profile screen 17
Preferences 4, 5, 12, 13, 20
Preferences… Menu Option 20
Previously processed claims 18
Printing direct invoices 14
Printing OHIP billing cards 13
Printing Reciprocal billing cards 13
Printing WCB billing cards 13
Print Patient Labels screen 8
Print Physician Labels screen 10
Process Menu 16
Profile Menu Option 17
Provider Browse Window 1, 2, 11, 15, 16, 17, 18, 21
Provider Information screen 2, 3
Provider Menu 2
Quit Menu Option 22
RA (Remittance Advice) file 18
Reciprocal Claims 5, 13, 14, 16
Reciprocal billing cards 13
Reciprocal Medical Billing 5, 13, 14, 16
Reconcile Discrepant Claim 19
Reconcile… Menu Option 18
Reconciliation by diskette 18
Reconciliation Summary reports 19
Reconciliation Summary screen 18, 19
Reconciliation Totals 18, 19
Referring Physician address labels 10
Referring Physician Browse Window 9
Referring Physician Information screen 9, 10
Remittance Enquiry 19
Reprinting a billing summary 17
Restoring patient records 19
Resubmission in batch 17
Resubmitting individual claims 14
Review Claims Menu Option 8
Review Claims screen 8
Select… Menu Option (Claim) 11
Select… Menu Option (Patient) 3
Select… Menu Option (Referring Physician) 9
Service Codes 12, 14, 15, 17
Service Code Browse Window 15
Service Code Info screen 15
Service Code screen for Direct Billing 14
Service Codes Menu Option 15
Service Date 12, 13, 14, 20

Set Preferences screen................................ 13, 20
Setting default values 4, 5, 12, 13, 20
Special visit fees... 12
Specialty Code 2
Starting the Program 1
Status bar.. 2, 8, 16, 18
Submission number 17
Submit Date 16
Summary Menu Option (Patient)......................... 7
Summary Menu Option (Claim) 15
Summary of Claim Items 'Not Found'................ 19
System requirements 1
Technical advice and support 22
Underpayment... 18
Unsubmitting claims.. 17
Unit Fee 12
User-Defined Fees... 16
Verification of claims 14, 16
Verify… Menu Option 14
Verification Screen.. 14
Version Number........................3, 5, 9, 13, 14, 19
WCB billing cards 13
WCB claims.. 13, 14, 16
Workman's Compensation Board 13
Write-offs 17