What's New with Physical Therapy Advantage v11
(current release 11.0.5.0)

GENERAL

Help Resources to ease the transition to Version 11:

- [What's New in Help for Version 11](#)

- Command Menu section

  o There are new Command Menu topics with interactive images to help you acclimate to Version 11.
  o Hover on an icon for a brief description or click on the icon for a link to more information.
  o Menu mapping tables below the image list each action, how it was performed in v10.6 and how it is performed in v11.

- **compulink** university

  o Look for this Compulink University icon on new and updated Help topics. It directs you to related courses on CU LMS.
  o Click on the '+' next to the image in Help to display the Program, Course ID and Course Name to search for in the Course Catalog.

'EHR Tour of the Version 11 Screens' in Compulink University LMS

- This new Program in CU LMS includes an overview of the Compulink-owned Exam Layouts for Version 11, as well as recordings for the individual screen tabs.
- Learn about the latest screens for your Advantage EHR from the designer.

New SHOWSCREEN Function for OpenOffice

- Offices interfacing with OpenOffice now have the ability to preview or edit documents generated from Functions or Data Mining/Query, before they are printed.
- Add the instruction -SHOWSCREEN- anywhere in your ODT document. Be sure to use this exact syntax.
- Select this document as the Output in your Function or Query.
- The results are combined into one large document and displayed on screen, allowing you to edit the merged text before printing or saving.

This instruction is ignored when printing documents from Patient or Exam.

Login and Security Enhancements

Login IDs
- The Position field in the Login IDs table has been changed to 'Role' and is now mandatory.
- The User is prompted to select their Role at Login if the field is empty in their Login ID record.

- Primary E-Mail is mandatory if the user is flagged for Learning Mgmt System 'Y' access to Compulink University LMS.

Scribes
- The Login ID Role 'Scribe' has special functionality related to medical records.
- Users assigned to this Role are prompted to identify the Provider they are scribing for at Login.
- Medical Records Functionality associated with Scribes:
    - If records the Scribe works on are not signed off, the Provider's name will appear on the Missing Signatures Report and Unsigned Medical Records Work List.
    - Encounter Favorites for that Provider's ID are available, along with the Favorites for all Providers.

Login Profiles

- A new consolidated Profile right named 'Ledger Charge Tables/Modifiers/POS/TOS' determines user access to Charge tables, Modifiers, Place of Service and Type of Service tables.

System Setup > System Administrator

Auto Login based on Window Login (SSON)

- A new System Administrator option called 'Allow Single Sign On' authenticates your Advantage users based on their Windows User Name and Password.
- If there is a match between the individual's Windows Login and the Advantage Login IDs table, they will be automatically logged into Advantage.
- The System Administrator must verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
- Be sure that the appropriate Login Profile Access Rights have been assigned to each User.
- Default is unchecked, to require each User to log in with their Advantage Login User Name and Password.

Audit Events are now automatic.

- The System Administrator Tab no longer includes options for disabling auditable events in the software such as User Log In/Log out/Session Time outs, PHI access, Medical Record sign off by Doctor or Technician, etc.

2015 PQR

The Compulink-owned EHR screens delivered with this exe have been updated for the 2015 Physician Quality Reporting codes.

You must add, delete or update the corresponding PQR entries in your Services table, with identical POST codes, for PQR Codes to post from EHR to the patient ledger. Click here for a short recording.

CMS is strongly recommending that all PQR codes be submitted with a charge amount of 1 penny (0.01).

- Go to the Medicare Fee Schedule(s) in your Services table and enter 0.01 in the CHARGE field for any new and all existing PQR Codes.
- If you also enter 999.99 in the ALLOWED amount, the penny will automatically adjust off during ledger posting, and your financial reports will not be inflated.
- **Advantage Master Users**
- Updates to previously delivered EHR tabs look at the HIDE attribute that is currently assigned to each tab.
- If you have the tab hidden and we update it, it remains hidden.
- You can unhide a tab at any time in the Screen Builder.

Essentials Users – your tab is always replaced with the latest tab when you update your program file.

Compulink University LMS and Retirement of the Legacy Training Site
Due to recent updates performed by Cisco WebEx, the legacy training site we have been using to provide you with pre-recorded classes is no longer able to support the newer course formats. As a result, we have retired that site and will be solely using Compulink University LMS, our learning management system which was implemented last year.

To access CU LMS, your office must be running Advantage version 10.6 (or greater). This allows you to flag your Advantage users as students, by setting Learning Mgmt System to 'Y' in the Advantage Login IDs table. A student account is automatically created within approximately 45 minutes for that user on the compulinkuniversity.com website.

The "LEARN" command on the Advantage main menu takes you directly to the Compulink University Student Portal. Browser login at **http://compulinkuniversity.com** is available for Advantage Cloud clients, and anyone who would like 24/7 access to our extensive library of on-demand recordings. Compulink University LMS offers all of the newest recordings, and allows for a much simpler registration process, reporting on your staff activity, and the ability to bulk register your team for courses all at once.

Just getting started? **Click here for the Welcome to Compulink University LMS document**
Click here for our Training Page with additional details

Compulink University LMS Course Catalogs
(Click Here) for the latest on-demand course offerings available for registration on the CU LMS Course Catalog.

COMPULINK TABLE UPDATES

General Table Updates
Some tables have an 'Owner' column that identifies records as either 'U' for User or 'C' for Compulink. This allows us to pre-populate and update the tables with commonly used items so that you don't have to add them. Table updates are delivered automatically with our product exes, and never overwrite any entries that you add. For example, we periodically update the Owner 'C' records in the Diagnosis table.

Any diagnoses you have added to the table are not touched. Owner 'C' table records cannot be deleted by the User, but you can hide them from display in your drop-down lists.

Payors Updates
Clients running v10.6 and greater, who are current on support, may download Payors table updates directly from the Advantage software. These are also delivered with Product Exe updates. Click here for a list of the latest updates.

To download, go to UTILITY > LOOK-UP TABLES > FINANCIAL > PAYORS > COMPULINK UPDATE.

- There must be only one user logged into Advantage.
- Files are downloaded into the \Update folder in your Advantage product directory.
- The user must exit Advantage after download and re-start the software to force an update of those files. Once the process is finished, you will see your normal Login.
- New Payors come into your table 'Hidden'. Simply change the Hide flag to "N" to activate them
- Your 'user-owned' carrier records stay active unless you choose to hide them.

Scheduled File Updates

- Diagnostics:
  - Compulink-owned Payors table and Claim Edit Payors and Claim Edits updates download every 28 days at the end of Diagnostics.
  - Once the Diagnostic window closes, the files are extracted automatically.
  - The user does not have to exit the software.
  - The download takes place after auto-diagnostics as well.
- Using the look-up table's COMPULINK UPDATE command:
  - Individual table updates are available via the COMPULINK UPDATE command located near the respective look-up table in the Utility menu.
- Configuration File:
  - Your Advantage Configuration file is automatically downloaded approximately every 2 weeks.
  - If there is a problem with the automatic download, a message will pop up for the first User who logs in for the day.
  - This message will prompt them to notify their Administrator to download the Configuration file manually from the Utility > System Administrator menu. See the Help file for directions for the manual download.
  - *Related Courses on Compulink University LMS:*
    - *Program: Version 11 Enhancements*
    - *Course: PM_245 Version 11.0.5.0*

CUSTOMIZATION

Screen Builder options for Essentials Clients:
- Essentials Clients may now access the Screen Builder utility to:
  - Change the sort order of Tabs in a Layout.
  - Create their own Layouts using Compulink-owned tabs.
  - Hide screens.
- Only Advantage Master clients are able to design custom Tabs.

EDI

Batch Eligibility with Emdeon:
- Changes were made to improve readability of the Batch Eligibility Report.
- Payor Name and Emdeon Payor ID were also added.

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

New Claim Edits and more in version 11 to improve billing

View our recorded Webex training videos below. There are several options for accessing these recordings that include streaming, download, and MP4 if your computer/device supports this format.
Download
Streaming (11 minutes)
MP4 (11 minutes)

Payor table content updates to improve organization
- State-specific government payors like BC, BS, Medicaid and Medicare have been renamed starting with their full state name so they are now grouped together by State.
- Claim Edit Groups have been assigned to every Compulink-owned Payor to avoid or minimize rejections

New Form field default in Function>Activities>Insurance Billing
- The default for the Form field is now CMS1500. Previously the default was HCFA1500 thru 10.6.
- If you are used to selecting CMS1500 in the Form drop down, that is no longer necessary.
- If you have NOT been making a change here and just going with the default of HCFA1500, please note you will now need to select HCFA1500 from the Form drop down or you will not get any patients to bill out when you run a claim batch.

New Remittance Features in v11

FUNCTIONS AND QUERY

Payment Overdue Notices Indicator on the Patient Record:
▪ When a patient has received 1 or more Overdue Notices, you will see the notation of 'Overdue Reminders Sent: #' in the Account Responsible section of their Patient Demographic screen.

ICD-10

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

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

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

ICD-10 Table Changes:
▪ Insurance Payors (Utility>Look-up Tables>Financial>Payor Names)
  o A new field called "ICD 10 START" was added to the table.
  o For all Compulink-owned Payors, the ICD 10 START will be populated from the Emdeon Payer List based on the payer's ICD-10 readiness.
  o Run the Compulink Update command to stay current. (Utility>Look-up Tables>Financial>Payors>Compulink Update)
  o For all User-owned Payors, the ICD 10 START date defaults to 10/1/15 on new entries, and is assumed to be 10/1/15 on existing entries.
  o If you have a Payor that will not be ready to accept claims on that date, you may enter that individual Payor's Start date.

- o More guidance will be available on this as we get closer to the ICD-10 effective date.
- Assessment/Plan>By Diagnosis (Utility>Look-up Tables>EHR>Assessment/Plan>By Diagnosis).
  - o Added ICD-10 codes to the table.
- Diagnosis Name (Utility>Look-up Tables>EHR>Diagnosis>Name).
  - o The complete set of ICD-10 codes was appended to the table.
- Encounter Favorites (Utility>Look-up Tables>EHR>Encounter Favorites).
  - o A new "ICD-10 Diagnosis List" field was added.
  - o This list contains the "base" ICD-10 codes that will be used after the ICD-10 Start Date.
  - o When selecting an Encounter Favorite in the exam, the software will use the Start Date to determine if it should pull from the "ICD-9 Diagnosis List" or the "ICD-10 Diagnosis List."
- Bitmap Detail (Utility>Look-up Tables>EHR>Image>Bitmap Detail).
  - o A new "ICD-10 Code(s)" field was added.
  - o This list contains the "base" ICD-10 codes that will be used after the ICD-10 Start Date.
  - o When selecting a Bitmap in the Visual Documentation Engine, the software will use the Start Date to determine if it should pull from the "ICD-9 Code(s)" or the "ICD-10 Code(s)."
- Base Image (Utility>Look-up Tables>EHR>Image>Base Image).
  - o Some base images have Regions attached to them.
  - o Highlight a base image and click on Regions at the top.
  - o This will open a window with the image in the middle with all of the regions outlined, and the list of regions listed on the left.
  - o Double click on one of the regions on the left and the Area Edit window opens.
  - o The "ICD Keywords" field is where you can enter any keywords that you would like the software to look for when selecting the list of diagnosis codes to choose from when using the Visual Documentation Engine.
  - o The software will first look at the ICD-10 codes that are assigned in the Bitmap Image Detail table. These could be a list of 3 character "base" codes.
  - o From that list of diagnoses listed, it will then look to the "ICD Keywords" field for words that could help to narrow down that list of diagnoses to choose from.
  - o If the "ICD Keywords" field is empty, it will then look to the Region Name for words that could help to narrow down that list of diagnoses to choose from.
  - o When dropping a bitmap on the VDE, the ICD-10 list will be filtered down based on the keywords in the region you dropped it on.
- HCM Order Sets (Utility>Health Care Maintenance Rules>Diagnosis/Orderset Mapping).
  - o Added ICD-10 codes to the table.

ICD-10 and Patient Exam:

- Exam date. The ICD-9/ICD-10 toggle is controlled by the Exam date.
  - o If the exam date is BEFORE the ICD-10 Start Date, ICD-9 codes will be used throughout the exam.
  - o If the exam date is ON or AFTER the ICD-10 Start Date, ICD-10 codes will be used throughout the exam.
  - o If the ICD-10 Start Date for the patient's Primary Payor is anything other than the 10/01/15 date, it will use that date to determine if it should use ICD-9 or ICD-10.
- Complaint
  - o There is a new accident button and memo field inside the Chief Complaint popup.
  - o Fill out the "Additional/Accident Details" field and click the button.

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

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

ICD-10 and Patient Ledger

- Adding a Diagnosis:
  - o In the patient ledger, the ICD-10 functionality is controlled by the From date or date of service.
  - o If the date of service (ledger from date) is BEFORE the ICD-10 Start Date, the diagnosis dropdown will only display ICD-9 codes.

- o If the date of service is ON or AFTER the ICD-10 Start Date, the dropdown will only display ICD-10 codes.
- Claim Sets.
  - o ICD-9 codes and ICD-10 codes can NOT be billed on the same claim set.
  - o When clicking on Service, the claim set will default to the previous claim set. If past the ICD-10 Start date, it will automatically create a new claim set for the current date of service.
- Claim screen.
  - o When adding a diagnosis on the expanded claim screen, the drop-down will display ICD-9 or ICD-10 based upon the date of service (ledger From date) on the ledger.

ICD-10 and Functions

- Function>Insurance Activities>Billing.
  - o ICD-9 and ICD-10 codes can NOT be billed on the same claim.
    - If the current date is after the ICD-10 start date, the claim validation will look for ICD-9 and ICD-10 codes that are on the same claim set, and will produce an error on the Claim Edit Error Report.
    - This claim validation will also take place on the patient ledger when clicking the "Claim Validate" button or when printing an individual claim.
  - o ICD Indicator.
    - When sending paper claims in a batch, or printing from the ledger, the software will look at the diagnosis codes on the claim set to determine the ICD Indicator in box 21.
    - If the claim set has ICD-9 codes, it will populate the field with a 9.
    - If the claim set has ICD-10 codes, it will populate the field with a 0.

LEDGER

Merchant Interface for Credit Card Transactions

- XCharge by OpenEdge is a cost-effective, secure and reliable gateway for processing credit card transactions.

- Clients using Advantage Version 10.6 and greater have access to the Advantage/XCharge interface.

Rx Discounts Pharmacy Discount Program
- Rx Discounts is a prescription discount program administered by MedImpact, the 4th largest pharmacy benefit manager in the United States.
- The Rx Discounts pharmacy network includes 62,000 pharmacies nationwide, including the big box retailers, every national drug store chain, and thousands of independent pharmacies.
- Rx Discounts runs the pharmacy loyalty programs for 1 out of 3 pharmacies in the country. This includes CVS, Rite Aid, Target and Kroger.

- Rx Discounts has unique programs for Medicare Part D and contracts with the major payors, such as Humana and United HealthCare 10.
- Providing this benefit to your patients is as easy as printing a receipt.

MEDICAL RECORDS

Adaptive Learning Functionality
- There is Usage Prioritization when you enter the Exam Diagnosis on the Plan tab.
- This functionality keeps track of all Diagnosis table entries selected by the current User.
- When clicking the drop down for Diagnosis Code or Description, the software first displays the top 10 table entries previously chosen by the user who is currently logged in, followed by the rest of the entries in the Diagnosis table.

Continuity of Care Documents:
- The patient's Social Security Number will no longer be used as the Patient ID on the CCDA documents.
- The Location's NPI number, plus the patient unique number will now be used.
- If the NPI number is not available, it will use the last 4 digits of the patient's Social, plus the patient unique number.
- If the Social is not available, the section will be marked as unknown (UNK).
- *Related Courses on Compulink University LMS:*
  - o *Program: Version 11 Enhancements*
  - o *Course: PM_245 Version 11.0.5.0 Changes*

Diagnosis Assessment/Plan grid:
- Diagnosis Name field

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

Encounter Favorites:

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

Encounter Favorites - Smart Functions:

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

Encounter Favorites – new Default option

- By creating 'DEFAULT' encounter favorites, you can auto populate Tabs upon first access to the tab by a provider.
- An Encounter favorite must exist with the name 'DEFAULT' for each particular tab. These can be configured for All providers or specific IDs.
- The software looks for the DEFAULT specific to the logged in provider first. If no matching entry exists, the software will use the general/non provider-specific DEFAULT Encounter Favorite.
- There is a Compulink-owned Default Encounter Favorite delivered as part of the Version 11 update.
- To disable this from populating data fields automatically as you add new medical records, go to UTILITY > LOOK-UP TABLES > EHR > ENCOUNTER FAVORITES.
- Use SEARCH to locate the 'Default' record, edit and change the Hide field to 'Y', and then Save.

Exam Goal Updates

Goal records for previous dates of service are now editable in the medical record for updating information such as 'Achieved' Date. Entries in the Goals table can be attached to HCM Order Sets. When you add a Goal that has an order set attached, the associated actions are displayed and can be quickly added to the exam. **Click here for a short recording.**

1. Go to Utility > Health Care Maintenance Rules/Orders > Order Sets. Create a Goal Set/Order Set and attach individual actions to it as detail records.
2. Next to the Look-up Tables for EHR and select the Goal Names table.
3. Edit a Goal and use the drop-down in the Goal Set/Order Steps field to assign the Order Set.

When you add this Goal in the patient's exam and save the record, you'll be presented with a 'Select Order Set' window. Select the orders you need and click OK. The Objectives/Goal Steps appear below the Goal area. Double click on a Goal to display its assigned steps.

General Changes for less screen clutter

- Vertical scroll bars are no longer displayed in grids, unless there is sufficient text in the field to require scrolling.
- Custom numeric fields that have never been touched will display no digits. Manual entry of 0., 0.0, or 0.00 will force display of the zero value.
- Patient Menu items are only displayed if the User has access rights to that area of the software.
- If, for example, a user does not have access rights to Appointments or Ledger, those icons will not appear in the menu when they are logged in.
- The new Save/Add icon may be used to Save and go immediately into Add of another record in a PopUp EHR Add window, such as the Diagnosis grid in the Plan tab. This saves time when adding multiple records.

- This new Search icon may be used to find Text within the medical record.
- Click on the icon and choose 'Text Within Record'.
- A window opens with a prompt to Enter Text for Search. Enter a word, sentence fragment, etc., then click OK, or hit Enter.
- The exam record is converted to document format, based on document name that is assigned to this Layout in the 'Complete Doc' field Screen Builder.
- If a match is found, the document is displayed with your search text highlighted in yellow.

Images
- Effective with Version 11.0.4.6 and greater, if there is a problem with the image imported or scanned into the medical record, the tab will open instead of returning an error, with a placeholder in the image box displaying the notation 'bad image'.

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

Medications:
- Prescription: Effective with Version 11.0.4.6 and greater, prescriptions printed for the states of Missouri and Washington have been updated to meet state requirements.

Medline Plus the National Institutes of Health's website of information about diseases, conditions, and more in easy to understand language.

- The Compulink-owned medical record screens are configured for quick access to the Medline Plus database.
- The Info icon can be found on the exam screen grids for Diagnosis, Medications and Tests.
- This is a quick way to provide educational resources to your patients, and build your library of resources for future use.

Right Click Options

- When you right click on a data field with a look-up table, the 'View Lookup List Entries' command opens the table enabling the user to add new items and assign them a display order.
    - Effective with Version 11.0.4.6 and greater, this option is available in many fields with multi-column tables, such as Diagnosis and Test Name.
    - Replaces the previous option to 'View Lookup Table Name' that displayed the table name but did not allow editing.
    - This is different from the Add to Lookup List option that adds what you have typed in the field to the table without a display order.

Sign Off

- EHR Pop-Up Messages at Sign-Off:
  - Encounter Favorites and the Visual Documentation Engine are both great time savers for documentation.
    - If the Provider hasn't used these efficiency tools in the last month, a reminder appears at Sign-Off.

PATIENT RECORDS

Patient and Exam screen menu items are only displayed if the active user has access rights to these items

- For example, if the user who is logged in does not have access rights to Appointments or Ledgers, those icons will not appear in the menu.

The Demographic Screen has been redesigned with less clutter
- Patient, Account Responsible, Contact information and Appointment History are consolidated in a single screen tab.
- Only information that you need to see on a consistent basis is displayed, unless you are in Add or Edit mode.
- Italicized labels identify the data elements associated with Meaningful Use documentation and reporting.
- The Account Responsible section of the Compulink-owned Patient screen now has DOB and Sex fields. When adding an insurance record, choosing 'Account Responsible' as the Insured party will populate the insured's Birth and Gender fields required for claims.
- Active Field: This patient field may be unchecked when the patient record is inactive and being maintained for historical information. Inactive patients are ignored by the Recall function. Adding new Exam records is prohibited when the patient is inactive.

Create Family Accounts with Separate or Shared Ledgers
- There are now two Add > Family options available.
- In both cases, the new patient is assigned the Location, Last Name, Address, Home Phone and Account Responsible information from the account where they are added.
- With Family (Separate Ledger), each patient has a separate Account Number and an individual Ledger.
- With Family (Shared Ledger), the new patient is added to the displayed patient's account and shares their Ledger.

Deleting Patient Records
- Deleted Patient Information is recorded in the PHI Audit Event Log.
- To view the patient information, go to Report > System Admin. > PHI Audit Event Log.
- Look for the Category 'PHI Deleted Information'. The log will display a record for each data element deleted.

- You may not delete a patient who has existing Medical Records.
- The message 'You may not delete a patient who has existing Medical Records!' will appear if you attempt to do so.
- 'You must manually Delete those first!' will appear if you attempt to do so.
- This requires the User to first go through the EHR Delete process, which ensures all necessary auditing of deleted EHR records takes place.

E-Mail:
- You can now send a non-PHI E-Mail Message directly from the Patient screen with PRINT > E-MAIL TO PATIENT.

Gender Default Has Been Removed:
- In response to client requests, the patient Sex field no longer defaults to 'F' when adding new patients.

Insurance Card Scanner:
- Effective with Version 11.0.4.6 and greater, if there is a problem with the card image scanned, the insurance record will open instead of returning an error, with the notation 'bad image' in the image box.

New Tabs

- The Address History Tab may be used to store the patient's previous residences, Occupation and Industry.

- The Interest Tab is used to identify and monitor a patient's interest in the goods and services you provide.

Opt Out Portal:
- A check-mark in this new field indicates that the patient does not want to be sent communications from their provider to the Patient Portal at mysecurehealthdata.com.
- *Related Courses on Compulink University LMS:*
  - o *Program: Version 11 Enhancements*
  - o *Course: PM_245 Version 11.0.5.0 Changes*

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

Patient Tracking > Goto command

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

Print > Audit Report

- This command replaces the Patient History > Communication and Access commands.

- The report generated includes Views, Queries, Changes to Data and Communication outputs from the patient's record.

Text Messaging

- Use PRINT > TEXT MESSAGE from the Demographic screen to send a text message to the cell phone number in the patient's record.
- This command lets you easily send a text up to 80 characters to your patient.
- The 'From' address in the message is the e-mail assigned to the patient's Location in the Location Details table.
- There are 60 major cell phone carriers recognized and the software will add other carriers automatically, based on the cell phone number.

REPORTS

Beta Reports (new to Version 11.0.4.6)
- We are excited to offer BETA Reports for Compuink Advantage and are soliciting your detailed feedback to improve your reporting experience.
  - o You'll find them on the Report menus, low on the menu list, with a title starting with "~BETA".
  - o Example: Report > Financial > Analysis > ~BETA Office Production w Inline Adjustments.

- To provide feedback, please follow these simple instructions:
  - o Run the report.
  - o If you see an issue or have a suggestion, contact us by E-MAIL at betareportfeedback@compulinkadvantage.com.
  - o In the subject line include "BETA Report Feedback"
  - o Your e-mail should include the report Name and Pre-Release Version from page 1 of
  - o the report.
- TELL US:
  - o Something you really like in the report: Be sure to tell us what you LIKE!
  - o Issue or Problem: Make a detailed description of the issue or screen shot.
  - o Suggestion: Describe it and how it would improve the usefulness of report.

Updates:
- Charge Collection Analysis:

- o Percent of net charge paid by payment source was added to the bottom of the report. (Report > Financial > Analysis)
- Production Analysis by Charge. (Report > Financial > Analysis)
  - o Charge Detail now includes Refund information.
  - o Summary by Charge now includes a "NET CRED" (Net Credits) column.

New:
- PQR Compliance 2015 report is now available. (Report > Financial > Acct Management)

TABLE UPDATES

Location Details Table
- The following fields were increased in size: Name (60 char), Street (55 char), City (30 char), Zip (15) and Letterhead 1-6 (80 char).

  Country Field
- A new field has been added to indicate the Country that the office is located in.
- This is required for HIPAA 5010 compliance. It is also used for CCD Documents, Cancer Registry files, and HL-7 Interfaces.

  Direct E-Mail field:
- This new field was added for transport of electronically secure messages.
- This is your office's Direct E-Mail address for incoming CCD documents and other PHI. It is not the same as standard e-mail.
- Direct-E-Mail is used by several Meaningful Use objectives related to electronic exchange of patient information with other providers and registries.

Post Code fields in Compulink-owned Table Entries

- Users may now access the Post Code field in the EHR Surgery Names, Test Names, and Treatment Names tables to use their own Service table Post Codes.

Provider Table
- A new Suffix field was added.
- MI was changed to Middle Name and expanded to 25 characters.
- The following fields were increased in size: Last (60 char), First (35 char), Degree (10 char) and Salutation (10 char).

  Direct E-Mail field:
- This new field was added for transport of electronically secure messages.
- This is not the same as standard e-mail. Instead, it is this Provider's incoming E- Mail address used for secure transmission of patient information, such as CCD Documents.
- Direct E-Mail is required for Meaningful Use Stage 2 measures. Often related to transitions of care in and out of the practice.

Referral Sources

- MI was changed to Middle and expanded to 25 characters.
- The following fields were increased in size: Salutation (10 char), First (35 char), Last(60 char) and Degree (10 char).

Direct E-Mail field:

- Direct E-Mail is used to transport electronically secure messages.
- This is not the same as standard e-mail. Instead, it is the Referral Source's outgoing E-Mail address, use when selecting this menu option in medical records: M.U. > Send CCD To Referral via Direct E-Mail.

On-Demand Table Updates (Claim Edits, Payors, etc.):

- Effective with Version 11.0.4.6, once you select COMPULINK UPDATE, you will be asked to 'Press Yes to confirm your desire to download the tables'.
- If you have accessed the Update option in error, you can now select 'No' to cancel the operation.