



CGM MEDISOFT User's Guide

December 2024

CGM MEDISOFT

Practice Management and EHR

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Publication date

December 2024

Product

CGM MEDISOFT v29

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Preface

Where to Find Help

Online Help

Access the online Help screens to find detailed information on each feature in CGM MEDISOFT. Online Help is available in two different ways:

- **Context-Sensitive Help:** For help in a particular part of CGM MEDISOFT, click the area for which you need help and press F1. The help topic for that area will appear.
- **Main Help File:** To access the main help file, click the Help menu and click CGM MEDISOFT Help. The main help file will appear, displaying the Contents tab. Use the Contents tab to view categorized topics for CGM MEDISOFT. Use the Index and Search tabs to find out additional or specific information about CGM MEDISOFT.

Training

There are various training options available. Please contact your local Value-Added Reseller for information concerning these options.

Independent Value-Added Resellers

There are Value-Added Resellers in your area who are knowledgeable and efficient in selling, installing, troubleshooting, and supporting your CGM MEDISOFT program. Search the CGM MEDISOFT website at www.medisoftware.com for a reseller in your area.

CGM MEDISOFT Versions

CGM MEDISOFT comes in three versions:

Product	Features
Basic	Offers basic features for processing patient visits, claims, payments, and reporting.
Advanced	Offers all that Basic does but provides greater reporting power, the ability to process secondary claims, as well as sending patient statements and collections processing.

Product	Features
Network Professional	Offers all the features of Basic and Advanced, but enables you to integrate with an Electronic Health Records (EHR) system. In addition, with this version only, you can use a mobile device such as an iPad, Android tablet, or iPhone to connect to your practice data.

Chapter 1 - Navigating in CGM MEDISOFT

In this chapter, you will learn about the basics of navigating in CGM MEDISOFT, using the menus and keyboard shortcuts.

Toolbars

There are four toolbars that you use to help you navigate in CGM MEDISOFT.

Title Bar

The top bar on the screen is the Title bar and it displays the name of the active program and contains Minimize, Maximize, and Close buttons on the right side.

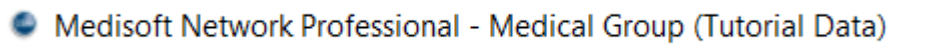


Figure 1. Title Bar

Menu Bar

Just below the Title bar is the Menu bar, which shows categories of activities available in CGM MEDISOFT. Click one of the headings, such as File, Edit, Activities, Lists, Reports, Tools, screen, and Help, to open a submenu with a list of all the options available in that category. For more information on each drop-down menu, see [“Menus” on page 3](#).

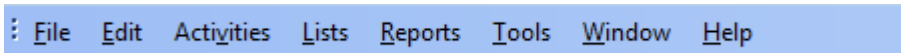


Figure 2. Menu Bar

Toolbar

Below the menu bar is the toolbar with an assortment of speed buttons (or icons) that are shortcuts to accessing options in CGM MEDISOFT.



Figure 3. Toolbar

Select the option you want by clicking the appropriate button. To see the function of the toolbar button, hover the mouse cursor over it. The value will appear.



Figure 4. CGM MEDISOFT toolbar with icon highlighted

Customizing the Toolbar

You can customize the toolbar to fit your needs. You can change the order of the buttons in the toolbar or remove them so they do not appear. You can create a new toolbar with only the buttons or file names that you want. In addition, you can move the toolbar to the top, bottom, or either side of the screen or return it to its original position and layout.

To customize the toolbar:

1. Right-click an open space on the toolbar and click **Customize**. The Customize screen appears.

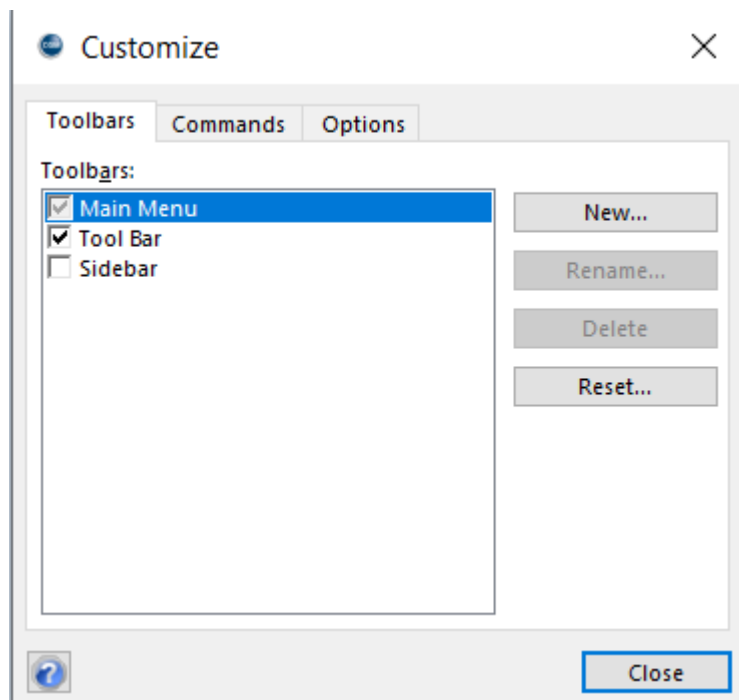


Figure 5. Customize screen

2. Use the options on the tabs to make your choices.
3. Click the **Close** button when you are done.

Shortcut Bar



Figure 6. *Shortcut Bar*

At the bottom of the screen, above the Status bar, is a shortcut bar that describes the available shortcut function keys available in the active screen. This bar may also be referred to as the “function help bar.”

Menus

There are eight drop-down menus from the menubar that have options that allow you to work in CGM MEDISOFT.

File Menu

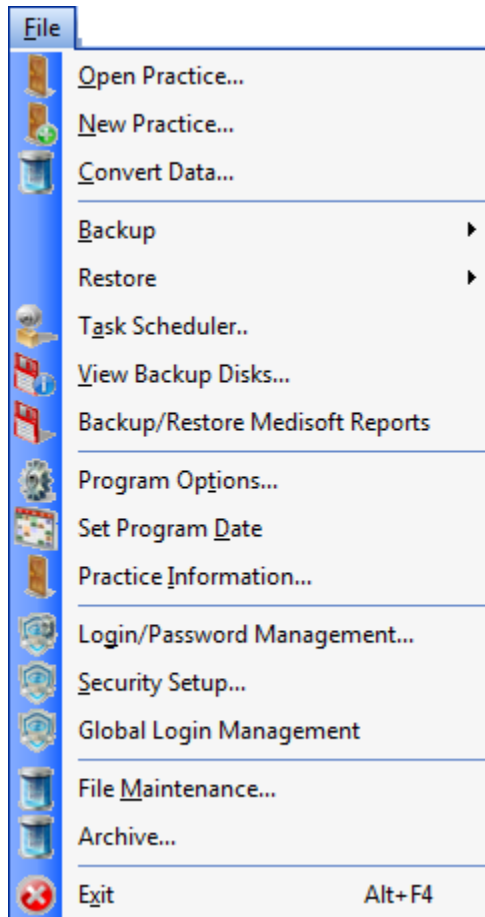


Figure 7. File menu

The File menu contains options for managing your practice files.

Edit Menu

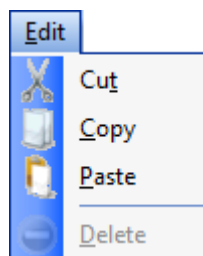


Figure 8. Edit menu

The functions of the Edit menu are Cut, Copy, Paste, and Delete.

Activities Menu

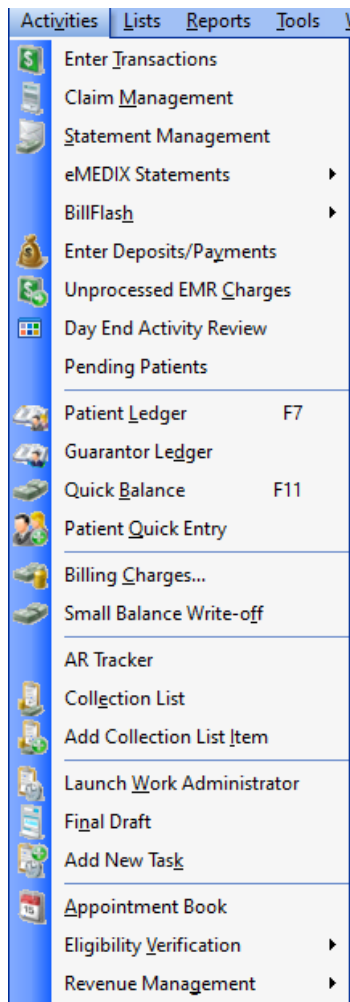


Figure 9. Activities menu

You will use the options on this menu for much of your daily routine. Here is where you enter transactions and payments, create claims, view balances, and open Office Hours.

Lists Menu

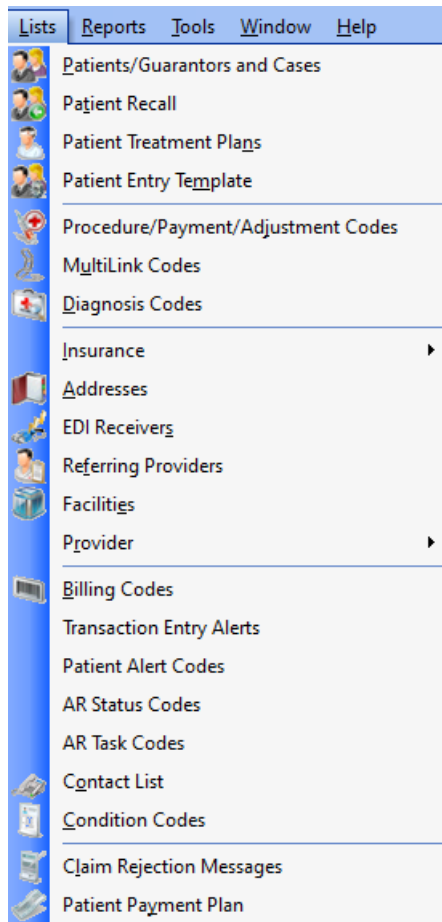


Figure 10. Lists menu

This menu provides access to the various list screens available in CGM MEDISOFT. Here is where you will set up your patients, providers, insurance companies, diagnosis codes, and other basic data you will need to file claims and send statements to patients.

Reports Menu

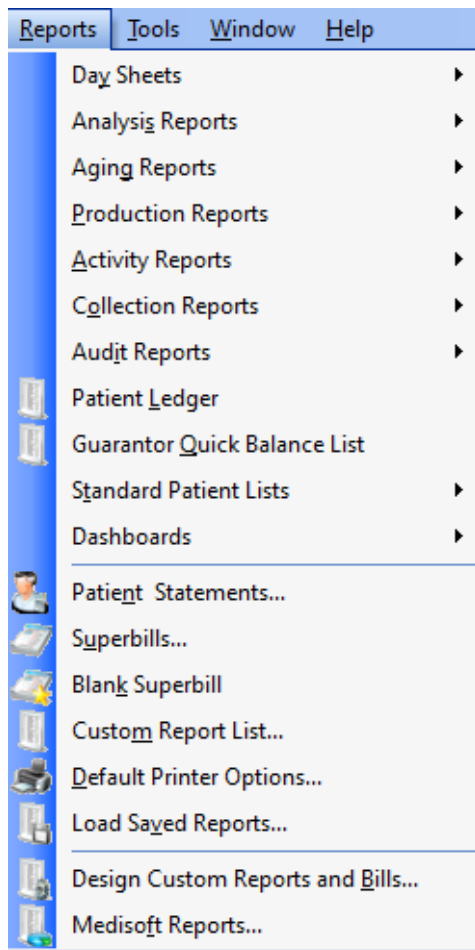


Figure 11. Reports menu

Reports within CGM MEDISOFT are accessible through the Reports menu. A wide variety of reports enable you to track your practice and see the state of your practice at any time.

Tools Menu

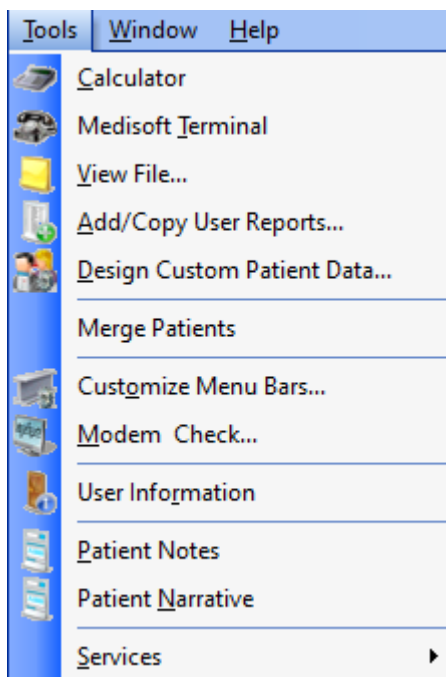


Figure 12. Tools menu

The options available in this menu help you access peripheral programs and information to help you manage your practice.

Window Menu

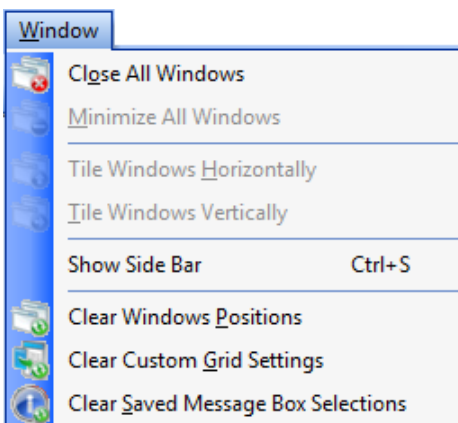


Figure 13. Window menu

This menu contains options that control the display of screens in CGM MEDISOFT.

Help Menu

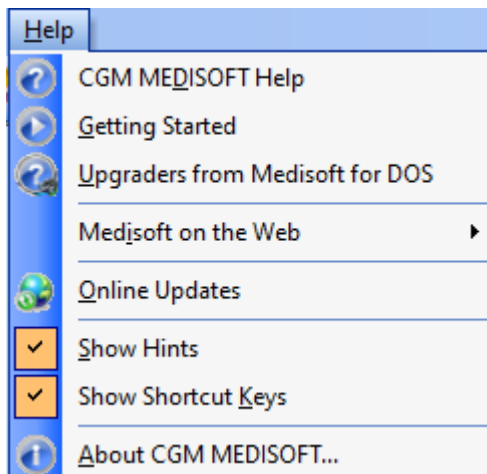


Figure 14. Help menu

The Help menu contains access to information on how to use CGM MEDISOFT, as well as how to register.

Keystrokes and Shortcuts

Special keyboard shortcuts reduce the number of times you have to click the mouse or press keys to accomplish a task.

Common Keystrokes

Keystroke	Action
F1	Opens Help files in most screens.
ESC	Closes or cancels the current function or screen.
F3	Saves whatever you are working on.
F6	Opens a search screen
F7	Opens the Quick Ledger screen. For more information on this screen, see “Quick Ledger” on page 109 .
F8	Opens a screen to create a new record.
F9	Opens a screen to edit the selected record.
F11	Opens the Quick Balance screen. For more information on this screen, see “Quick Balance ” on page 110 .
SPACEBAR	Toggles a check box (check/uncheck).
ENTER	Depends on settings in the Program Options screen. For more information, see “Program Options” on page 171 .
CTRL + S	Toggles the Sidebar display.
CTRL + X	Cuts the selected text.
CTRL + C	Copies the selected text.
CTRL + V	Pastes the text.
ALT + DOWN ARROW	Opens drop-down lists.

Keystrokes - List screens

Keystroke	Action
F2	Changes the value in the field.
F3	Saves the record.
F8	Creates a new record.
F9	Edits the selected record.

Keystrokes - Transaction Entry

Keystroke	Action
F2	Opens the MultiLink screen. For more information on this screen, see “MultiLink Codes” on page 59 .
F4	Opens the Apply Payment to Charges screen. For more information on this screen, see “Applying a Payment” on page 127 .
F5	Opens the Transaction Documentation screen.

Keystrokes - Eligibility

Keystroke	Action
F10	Opens the Eligibility Verification Results screen when Eligibility is enabled. For more information on this screen, see “Eligibility Verification” on page 143 .

Chapter 2 - CGM MEDISOFT at a Glance

This chapter provides a brief overview of the setup and use of CGM MEDISOFT, in the general order in which you will want to set up your practice. For instance, you will first want to enter basic information on your practice, such as practice name and address. Then, you'll move on to entering information on the physicians in your practice (Providers), the insurance carriers your patients have, and then diagnosis and procedure codes.

For more detail on each area of the program, use the following table:

For more information about setting up...	see...
your practice	“Creating a Practice and Setup Overview” on page 21 and “Entering Practice Information” on page 35 .
your providers	“Setting up Providers and Provider Classes” on page 41 .
referring providers	“Referring Provider Records” on page 45 .
insurance carriers	“Insurance Classes and Insurance Carriers” on page 49 .
facilities	“Facility Information” on page 53 .
addresses	“Attorney, Employer, or Other Addresses ” on page 55 .
procedure/payment/adjustment codes	“Procedure, Payment, Adjustment, and Diagnosis Codes” on page 57 .
diagnosis codes	“Diagnosis Codes” on page 65 .
patients	“Patients” on page 79 .

Setting up Your Practice Overview

You will first set up your practice. The Practice Information screen contains the basic information on your practice.

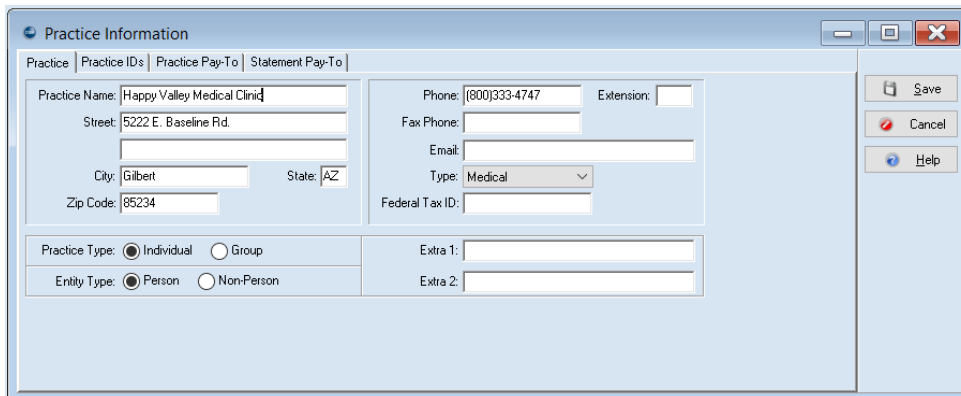
The screenshot shows the 'Practice Information' window with tabs for Practice, Practice IDs, Practice Pay-To, and Statement Pay-To. The 'Practice' tab is active. It contains fields for Practice Name (Happy Valley Medical Clinic), Street (5222 E. Baseline Rd.), City (Gilbert), State (AZ), Zip Code (85234), Phone ((800)333-4747), Extension, Fax Phone, Email, Type (Medical), and Federal Tax ID. There are also radio buttons for Practice Type (Individual, Group) and Entity Type (Person, Non-Person), and Extra 1 and Extra 2 fields. On the right, there are Save, Cancel, and Help buttons.

Figure 15. Practice Information screen

The Provider screen contains important information about the providers/physicians who are part of your practice.

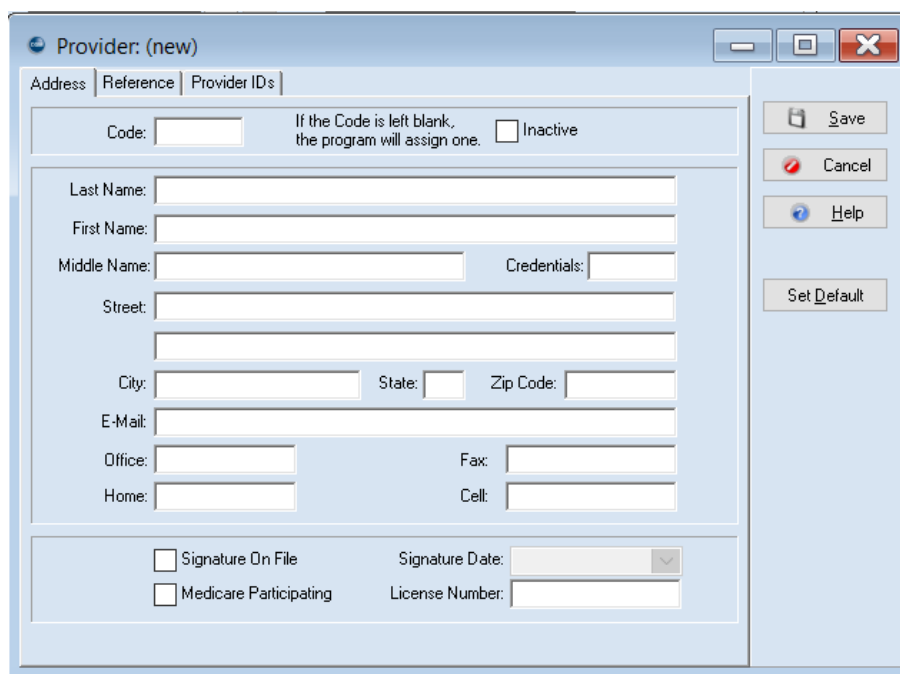
The screenshot shows the 'Provider: (new)' window with tabs for Address, Reference, and Provider IDs. The 'Address' tab is active. It contains fields for Code, Last Name, First Name, Middle Name, Credentials, Street, City, State, Zip Code, E-Mail, Office, Home, Fax, and Cell. There are also checkboxes for Signature On File, Medicare Participating, and an Inactive checkbox. A Signature Date dropdown and a License Number field are also present. On the right, there are Save, Cancel, Help, and Set Default buttons.

Figure 16. Provider screen

Each provider in the practice needs to have his or her own record set up in the database.

The Referring Provider screen contains information about the referring providers associated with your practice.

Figure 17. Referring Provider screen

You will use the Insurance Carrier screen to enter insurance carrier records. Keep a complete record of each of your insurance carriers so that claims will be filed properly.

Figure 18. Insurance Carrier screen

The Facility screen contains information about the labs and facilities associated with your practice. Use the fields on this screen to enter information that is specific to the facility for claim filing purposes.

The Addresses screen is used to enter address information important to your practice, such as addresses of attorneys, employers, or referral sources.

The Diagnosis List screen displays diagnosis codes that have been set up for the practice. You can also identify codes that are HIPAA Approved. Use diagnosis codes in patient records, as well as during transaction entry. These will be part of each claim that is filed.

Figure 19. Diagnosis screen

You will use the Procedure/Payment/Adjustment Code screen to enter and edit procedure codes.

Figure 20. Procedure/Payment/Adjustment screen

The Patient screen is the main space for entering/editing patient and information.

Patient / Guarantor: (new)

Payment Plan: Custom | **Name, Address** | Other Information

Chart Number: AR Status: ☐ Inactive

If the Chart Number is left blank, the program will assign one.

Last Name: Suffix:

First Name:

Middle Name:

Street:

City: State:

Zip Code: Country: USA

E-Mail:

Home: Work:

Cell: Fax:

Other:

PREVIOUS

Last Name: Suffix:

First Name:

Middle Name:

Street:

City: State:

Zip Code: Country:

Birth Date: Sex: Female Birth Sex:

Birth Weight: 0 Units:

Social Security: Entity Type: Person

Ethnicity: Language:

Death Date:

Race: ☐ American Indian or Alaska Native (I) ☐ Asian (A) ☐ Black or African American (B) ☐ Native Hawaiian or Other Pacific Islander (P) ☐ White (W) ☐ Other (E) ☐ Declined (7)

Save **Cancel** **Help** **Set Default** **Copy Address...** **Appointments** **View Statements** **CONNECTION Prefs** **CGM CONNECTION** **AR AutoRemind**

Figure 21. Patient/Guarantor screen

Entering Transactions and Payments

You enter charges via the Transaction Entry screen. You can also apply payments using this feature.

Transaction Entry

Chart: AGADW000 | Again, Dwight (3/30/1932) | MED01 .. | AET00 .. | Patient

Chart Number Name Date of Birth
 AGADW000 Again, Dwight 3/30/1932
 AUSAN000 Austin, Andrew 1/1/1950
 BORJ0000 Bordon, John 1/20/1972
 BRIEL000 Brimley, Elmo 9/29/1997
 BRIJA000 Brimley, Jay 1/23/1964
 BRISU000 Brimley, Susan 6/17/1964
 CATSA000 Catera, Sammy
 CLWIA000 Clinger, Wallace

Charges: \$210.00
 Adjustments: \$0.00
 Subtotal: \$210.00
 Payment: -\$119.00
 Balance: \$91.00
 Account Total: \$196.00
☒ Calculate Totals

Co-pay Overdue: \$20.00

Diag 2	Diag 3	Diag 4	1	2	3	4	Provider	POS	TOS	Allowed	M1	Co
11/21/2009	72052	1	80.00	80.00	847.2	346.9	REL	11	1	0.00		
11/21/2009	97010	1	10.00	10.00	847.2	346.9	REL	11	4	0.00		
3/9/2009	99213	1	60.00	60.00	847.2	346.9	REL	11	1	0.00		

Total Taxable Amount: 0.00

Payments, Adjustments, And Comments:

Date	Pay/Adj Code	Who Paid	Description	Provider	Amount	Check Number	Unapplied
12/4/2009	MP	MED01 Medicare-Primary	#23664	REL	-8.00		\$0.00
12/4/2009	COMMENT		Carrier: AET00 was billed	REL	0.00		\$0.00
11/21/2009	COMMENT		Carrier: MED01 was billed	REL	0.00		\$0.00

Figure 22. Transaction Entry screen

Generating Claims and Statements

Claims processing centers on the Claim Management screen from which you can create, edit, and print/send claims. CGM MEDISOFT also provides support for UB-04 claims.

Claim Management

Search: | Sort By: | List Only... | Change Status

Claim Number	Chart Num	Carrier 1	Status 1	Media 1	Batch 1	Bill Date 1	EDI Receiver 1	Carrier 2	Status 2
1	SIMTA000	AET00	Sent	Paper	1	12/3/2009			
2	AGADW000	MED01	Done	Paper	2	11/21/2009		AET00	Sent
3	BRIJA000	CIG00	Sent	Paper	4	3/25/2009		BLU01	Sent
4	BRISU000	CIG00	Done	Paper	5	12/5/2009		BLU00	Sent
5	WAGJE000	BLU00	Sent	EDI	0	6/1/2009	RM		
6	YOUUMI000	US000	Ready To Send	Paper	0				
7	AGADW000	MED01	Sent	Paper	7	12/6/2009			

Edit | Create Claims | Print/Send | Reprint Claim | Delete | Close

Figure 23. Claim Management screen

After you have created claims in CGM MEDISOFT, you can either print them from CGM MEDISOFT or file them electronically using Revenue Management (see [“Electronic Claims Processing” on page 143](#)), an integrated electronic claims filing application.

You can use the Statement Management screen (available in CGM MEDISOFT Advanced or Network Professional) to create billing statements for patients.

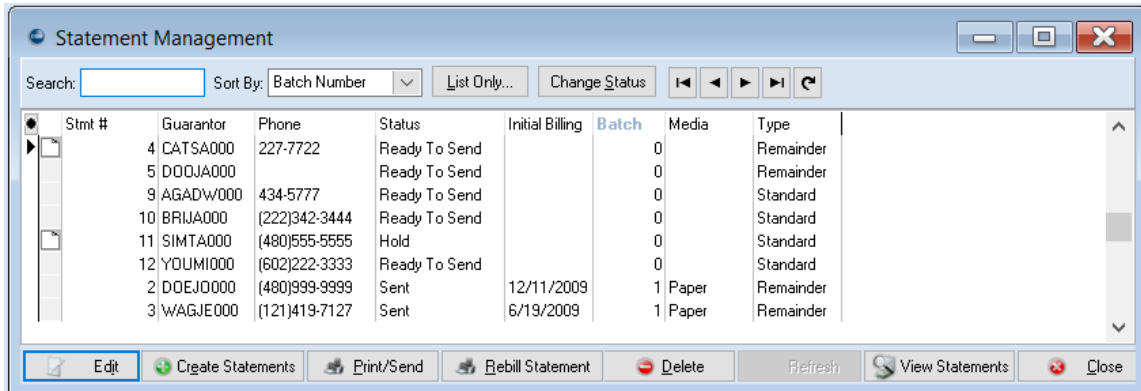


Figure 24. Statement Management screen

Chapter 3 - Creating a Practice and Setup Overview

In this chapter you will learn how to create a database for your practice and learn about program options.

Creating a Practice

The first step in setting up CGM MEDISOFT is creating the database that holds the data in your practice.

Creating the Practice Database

1. When you first open CGM MEDISOFT after installation, you must either create a new data set (if this is the first time you have ever installed CGM MEDISOFT) or convert previous CGM MEDISOFT data.

If you have been using CGM MEDISOFT Version 5.5x or 5.6x and above and have just installed Version 27, a message displays stating that data must be converted before you can access CGM MEDISOFT. If you have not already created a backup on your existing data, create a backup now. Then, click the **OK** button to perform the automatic conversion.

If you work with multiple practices, each will have to be converted.

2. If you choose to create a new data set, the Create a new set of data screen appears.

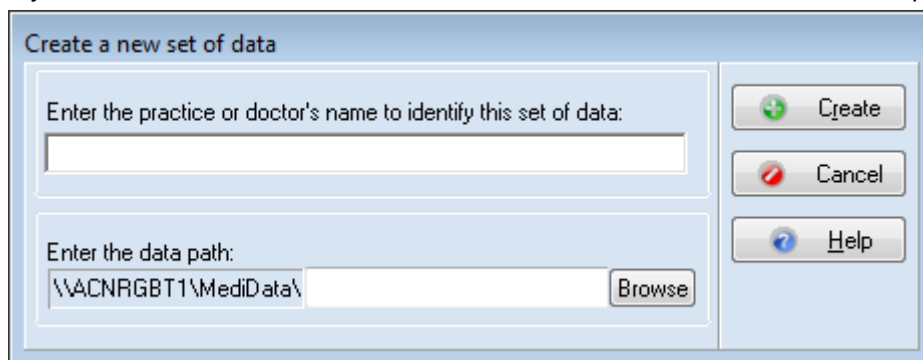


Figure 25. Create a new set of data

3. Fill in the practice name and the practice data path. The data path is the location within the MediData folder in which the practice data is stored.
4. When you click the **Create** button, the Practice Information screen appears. On this screen on the Practice tab, enter your basic practice information such as the name of the practice, address, and telephone number.

For more detailed information on this screen, see [“Entering Basic Practice Information” on page 35](#).

Creating Multiple Practices

It is not necessary to install CGM MEDISOFT for each new practice. When the first practice is set up, CGM MEDISOFT assumes there is only one practice and establishes a default directory for the data for that practice. Each time you set up an additional data set with totally unrelated patients and procedure files, you must create a different subdirectory. This establishes a completely separate database for the new practice.

Changing the Program Date

You can change the program date for back-dating a large number of transactions. This affects all dates in CGM MEDISOFT except the Date Created setting, which always reflects the System date.

Opening a Practice

To open a practice:

1. On the File menu, select the appropriate option.

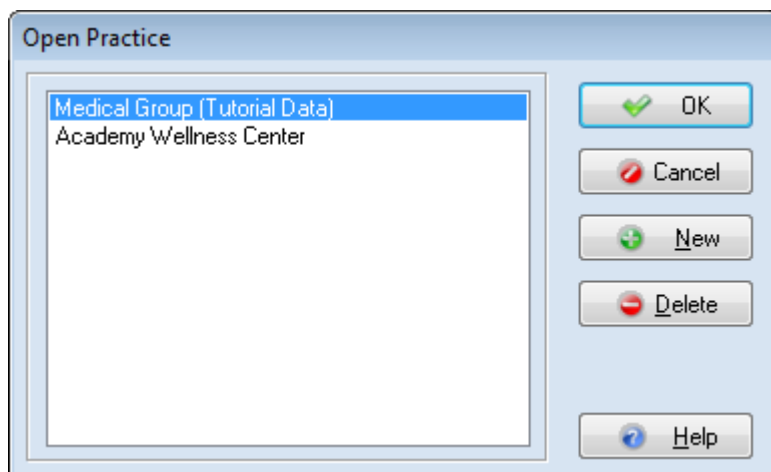


Figure 26. Open Practice screen

2. Choose the practice you want to open and click the **OK** button.

Setup Overview

Steps to setting up your basic practice can be found at [“Entering Basic Practice Information” on page 35](#).

Once you have created your practice database, the next step is to enter data into each of the different areas of CGM MEDISOFT, such as insurance carrier records in the Insurance Carrier screen, procedure codes in the Procedure, Payment, and Adjustment Codes screen, and so on.

Here is a sequence for practice setup that will help you enter your practice information in the most economical way.

- Creating rules overview
- Set up security
- Set up preferences
- Enter basic practice information
- Set up EDI Receivers for electronic claims and eligibility
- Enter insurance carrier records
- Enter facility records
- Enter provider records
- Enter referring provider records
- Enter other address records
- Enter procedure codes and multi-link codes
- Enter diagnosis codes
- Enter billing codes
- Enter guarantor and patient records

Keeping in mind your practice structure and your filing needs will help you set up your practice.

Creating Rules Overview

CGM MEDISOFT claim processing for both print and electronic claims depends on a series of flexible rules that you define. When setting up your practice, you will create a series of grid entries (rules) on the Practice IDs screen (see [“Entering a Practice IDs Rule” on page 35](#)) and Provider IDs screen (see [“Entering Provider IDs Rules” on page 43](#)). Depending on your practice, you may also use the Facility IDs screen (see [“Entering Facility Information” on page 53](#)) and Referring Physician IDs screens (see [“Entering Referring Provider Rules” on page 46](#)). These rules contain your basic practice information, such as group or individual NPI numbers, taxonomy, tax IDs, and claim filing status (group or individual). They also connect this information to the insurance companies that your patients use and the physicians in your practice.

You begin by creating rules for each provider on the Provider IDs screen and at least one rule on the Practice IDs screen. These rules will contain information that would apply to the most generic situations. Then, you will create other rules that apply to a specific insurance company, insurance category, facility, provider, and so on. See [“If you are a solo provider \(file claims as an individual\)” on page 24](#) and [“If you are a group \(file claims as a group\)” on page 26](#) for more detailed information.

When you create claims using Revenue Management, CGM MEDISOFT gathers data for each claim using these rules, looking first at rules that apply to an insurance company or provider. It will compare these rules against rules set up for facilities or referring physicians. The specific order in which CGM MEDISOFT analyzes rules follows the order of fields on the level it is working on. For instance, when looking at practice information, it will look first at Providers, then Insurance Carrier, and so on, moving from left to right on the grid.

For instance, if you are setting up a group practice with three physicians,

1. Create at least one rule on the Practice IDs screen for general information that is common to all claims. Apply this rule to all providers, all insurance companies, and all facilities (assuming you have no facilities associated with your practice or all facilities would use the same details). Include your group NPI, taxonomy, and tax ID numbers.
2. Second, create one rule on the Providers IDs screen for each provider (a total of three rules). You must include one rule for each provider on the Provider IDs screen since claim filing status (individual or group) is specified there. Each of these rules would be general and could apply to all insurance companies and facilities. Select Group for your claim type and select From Practice to pull NPI, taxonomy, and Tax IDs from the Practice IDs screen.

3. If one of the insurance companies requires a legacy identifier, create a second entry on the Practice IDs screen. By creating a second entry on this screen instead of the Provider IDs screen, you save time and effort. This one rule can be applied to all the providers at the practice level, instead of creating a rule for each provider at the provider level. To do this, for this second Practice IDs rule, select the *specific* insurance company and select *all* providers. Importantly, include your NPI, taxonomy, and Tax IDs since each rule needs to be complete. Finally, enter the legacy number the insurance company requires. When the application gathers claim data, it will select this row for the specific insurance company and pull the data for the claim.

If you are a solo provider (file claims as an individual)

As a solo provider, you have two options when entering key ID numbers, such as NPI, taxonomy, and tax ID/social security number.

- Enter this information at the practice level using the Practice IDs screen (see [“Entering a Practice IDs Rule” on page 35](#)). With this method, enter these numbers on the Practice ID screen. Then, select From Practice for all values on the Provider IDs screen (see [“Entering Provider IDs Rules” on page 43](#)).

Figure 27. New Practice ID screen

Enter this information at the provider level using the Provider IDs screen (see [“Entering Provider IDs Rules” on page 43](#)). In this case, on the Practice IDs screen, select None for NPI, taxonomy, tax ID/social security number, and so on, and enter a minimal amount of information. Then, on the Providers screen, specify your NPI, taxonomy, tax ID/social security number, and so on. Also,

select Individual for the File Claim as. The result will be the same and CGM MEDISOFT will correctly pull these IDs when filing claims.

The screenshot shows the 'New Provider IDs' screen. It has a light blue background and a white border. On the right side, there are three buttons: 'OK' (green checkmark), 'Cancel' (red X), and 'Help' (blue question mark). The main area contains several sections of radio buttons and text input fields. The first section has 'All' selected. The second section has 'Facility' selected. The 'File Claim As' section has 'Individual' selected. The 'From Practice' section has 'National Provider ID', 'Taxonomy', 'Tax Identifier', and 'Social Security Number' selected. The 'None' option is selected for 'Mammography Cert', 'Care Plan Oversight', and 'Legacy Identifier 1' through 'Legacy Identifier 3'. Each selected option has a corresponding text input field.

Figure 28. New Provider IDs screen

NPI Considerations

If you have the same pay-to address as your billing address, you can enter your NPI information on the Practice IDs screen. Then, select From Practice on the Providers IDs screen. This will ensure that the NPI number appears on all claims.

If you have different billing information and pay to information (see [“Entering Practice Information for a Billing Service” on page 36](#)), enter your NPI information on the Practice IDs screen. Also, enter any unique NPI on the Provider IDs screen.

If you have insurance companies that require mixed NPI numbers (some require individual while some require group), enter your *group* NPI number on the Practice IDs screen. Then, create several rules on the Provider IDs screen specific to the insurance companies that require mixed NPI numbers. For insurance companies that require the group NPI, select From Practice for the NPI number. This will pull that number from the Practice IDs screen. For insurance companies that require an individual NPI number, select National Provider ID and enter the number on the Provider IDs screen.

Insurance Company Considerations

You might only need one rule (grid entry). Most likely though, you will probably have at least one or more insurance companies that require different information. In that case, you must create other rules that are specific to that insurance company and the information needed, for instance a legacy qualifier such as a medicare number.

Each of these additional rules needs to be complete since the claims processing pulls all the information in a rule and not just one field. An incomplete rule (for instance, no NPI number) will leave fields empty in the claim, causing rejection. In the case of Figure , you would need to include the NPI number, Taxonomy number, and Social Security Number since those were included in the initial rule using the Provider IDs screen (see Figure 28). If you used the Practice IDs screen, you

could select From Practice for these numbers and you would not need to specify them on the Provider IDs screen since CGM MEDISOFT would pull these values from the Practice IDs screen.

If an insurance company requires taxonomy, you must create a rule on the Practice IDs screen for that insurance carrier and enter the taxonomy number there. Then, open the Insurance Companies screen and select the Send Practice Taxonomy in Loop 2000A checkbox. If your practice requires dual taxonomy, then you must also create a rule on the Provider IDs screen for that number, specifying the provider and insurance company.

Facility Considerations

If you have facilities attached to your practice, you must create rules on the Facility ID screen for any numbers that are specific to that facility. If you have entered a separate NPI number for a facility and need to send facility billing information, specify the type of facility and qualifier, including the unique facility NPI number. If this information is sent on the claim, select the Send Facility on Claim check box and do not include any other data.

Referring Physician Considerations

If your practice has referring physicians, create records for them on the Referring Physicians screen and use the Referring Physician IDs screen to enter any numbers unique to a referring physician.

If you are a group (file claims as a group)

First, complete at least one rule on the Practice IDs screen for the practice. Then, create at least one rule on the Provider IDs screen for each provider. Set your claim filing status on the Provider IDs screen by selecting Group for each provider in your practice.

The screenshot shows the 'New Provider IDs' screen. The 'File Claim As' section has 'Group' selected and highlighted with a red box. The 'Insurance Carrier' and 'Insurance Class' are both set to 'All'. The 'Facility' is set to 'All'. The 'From Practice' section has 'From Practice' selected for 'National Provider ID', 'Taxonomy', 'Tax Identifier', and 'Social Security Number'. The 'Legacy Identifier' section has 'None' selected for all three identifiers. The 'Mammography Cert' is set to 'None'. The 'Care Plan Oversight' is set to 'None'. The 'Legacy Identifier 1', 'Legacy Identifier 2', and 'Legacy Identifier 3' are all set to 'None'. The 'OK', 'Cancel', and 'Help' buttons are visible on the right side.

Figure 29. New Provider IDs screen with Group selected

If you have a provider that files claims using a personal NPI number for a specific insurance company, create an extra rule for this provider, specifying that particular insurance company. Enter the unique NPI number for that rule.

The screenshot shows the 'New Provider IDs' screen. It features a light blue background with various input fields and radio buttons. At the top, there are two rows of radio buttons for 'Insurance Carrier' and 'Insurance Class', both with 'All' selected. Below these are radio buttons for 'Facility' (with 'All' selected) and 'File Claim As:' (with 'Individual' selected). The 'National Provider ID' field is populated with '3453453454'. To its right, the 'ID Qualifier' dropdown is set to 'XX National Provider Identifier'. Further down, there are fields for 'Tax Identifier' and 'Social Security Number', both with 'From Practice' selected. At the bottom, there are several 'None' radio buttons for 'Mammography Cert', 'Care Plan Oversight', and three 'Legacy Identifier' fields.

Figure 30. New Provider IDs screen with NPI for specific insurance company

NPI Considerations

Enter your NPI information on the Practice IDs screen. Then, on the Provider IDs screen, select From Practice.

If you have insurance companies that require mixed NPI numbers (some require individual while some require a group), enter your *group* NPI number on the Practice IDs screen. Then, create several rules on the Provider IDs screen specific to the insurance companies that require mixed NPI numbers. For insurance companies that require the group NPI, select From Practice for the NPI number. This will pull that number from the Practice IDs screen. For insurance companies that require an individual NPI number, select National Provider ID and enter the number on the Provider IDs screen.

Insurance Company Considerations

If an insurance company requires dual taxonomy, you must create a rule on the Practice IDs screen for that insurance company and enter the taxonomy number there. Then, open the Insurance Companies screen and select the Send Practice Taxonomy in Loop 2000A checkbox.

Most likely though, you will probably have at least one or more insurance companies that require different information. In that case, you must create other rules that are specific to that insurance company and the information needed, for instance a legacy qualifier such as a medicare number,

as shown in Figure 31.

Figure 31. New Provider IDs screen, specific to an insurance company

Each of these additional rules needs to be complete since the claims processing pulls all the information in a rule and not just one field. An incomplete rule (for instance, no NPI number) will leave fields empty in the claim, causing rejection. In the case of Figure 31, you would need to include the NPI number, Taxonomy number, and Social Security Number since those were included in the initial rule using the Provider IDs screen (see Figure 30). If you used the Practice IDs screen, you could select From Practice for these numbers and you would not need to specify them on the Provider IDs screen since CGM MEDISOFT would pull these values from the Practice IDs screen.

Facility Considerations

If you have facilities attached to your practice, you must create rules on the Facility ID screen for any numbers that are specific to that facility. If you have entered a separate NPI number for a facility and need to send facility billing information, specify the type of facility and qualifier, including the unique facility NPI number. If this information is sent on the claim, select the Send Facility on Claim check box and do not include any other data.

Referring Physician Considerations

If your practice has referring physicians, create records for them on the Referring Physicians screen and use the Referring Physician IDs screen to enter any numbers unique to a referring physician.

Setting Program Options

The Program Options screen contains various default settings that affect operations in different parts of the program.

To open Program Options:

- On the File menu, click **Program Options**.

The screenshot shows the 'Program Options' dialog box with the 'General' tab selected. The dialog has a title bar with a close button. Below the title bar is a tabbed interface with tabs for 'General', 'Data Entry', 'Payment Application', 'Aging Reports', 'HIPAA', 'Color-Coding', 'Billing', 'Audit', and 'BillFlash'. The 'General' tab contains the following settings:

- ☒ Remind to Backup on Program Exit
- Max Automatic Backup Count: 3
- Backup Program: MBACKUP.EXE
- Command Line: (empty text box)
- Show Windows on Startup:
 - ☐ Patient List
 - ☐ Transaction Entry
- Data Version Number: 29
- Menu/Toolbar Options:
 - ☐ Hide Icons in Menus
- Calculate Patient and Statement Remainder Balances:
 - ☒ when Medisoft first opens
 - ☐ when Medisoft closes
 - ☐ None of the above
- Patient Remainder Balances may also be recalculated through File Maintenance.
- Account Alert Setting:
 - ☐ Patient Remainder Balance (value: \$0.00)
 - ☐ Delinquent on Payment Plan
 - ☐ Sent to Collections
 - ☐ Outstanding Co-payments
 - ☐ All of the above
- Other options on the right side of the tab:
 - ☒ Show Hints
 - ☒ Show Shortcuts
 - ☒ Enforce Accept Assignment
 - ☐ Print Report Title Page
 - ☐ Enable Electronic Prescribing
 - ☐ Use Server Time
 - ☐ Hide Inactive/Closed Items
 - ☐ Use Guarantor Ledger for Quick Ledger
 - ☐ Enable HL7 Triggers

On the right side of the dialog, there are three buttons: 'Save', 'Cancel', and 'Help'.

Figure 32. Program Options screen

TIP: For most users the default settings on the various tabs on the screen are sufficient for initial use. You can customize these settings at a later date.

- Each tab features settings for different functional elements in the application. For more information on the available options and settings, see:
- [“General Tab” on page 171](#)
- [“Data Entry Tab” on page 172](#)
- [“Payment Application Tab ” on page 172](#)
- [“Aging Reports Tab” on page 173](#)
- [“HIPAA Tab/ICD 10” on page 173](#)
- [“Color-Coding Tab ” on page 174](#)
- [“Billing Tab ” on page 174](#)
- [“Audit Tab ” on page 176](#)
- [“BillFlash Tab ” on page 178](#)

Chapter 4 - Security Setup Overview

Basic security in CGM MEDISOFT is practice-based, with each practice having various users and groups. Multiple practices require security setup for each database. Setting up security is a two-step process:

1. Create users, giving them a login name, password, and access level (1-5).
The access level determines which areas of the practice a user can access. Level 1 users have the most access, while Level 5 users have the least access.

When you create a new practice, a system/administrator **user with** a password with access level of 1(all access) is automatically created for you. The user name for this password is SYSTEM and the password is MEDISOFT1 (all capital letters).

Use these credentials to set up other users with user names and passwords. In addition, be sure to create a personal administrative password with access level of 1. Once this is created, eMDs recommends that you delete the automatically-created system password.

2. Assign permissions to users, using the five access levels.

Users upgrading

If you are upgrading to CGM MEDISOFT 27, the following rules apply:

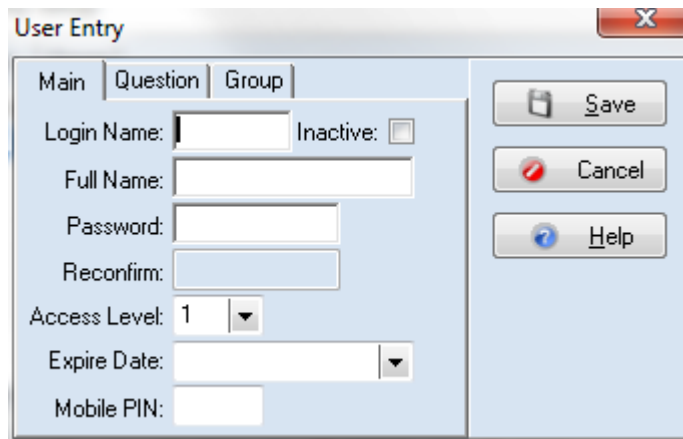
- If there is at least one active User with an Access Level of 1, then this new SYSTEM user will not be created.
- If a converted practice has no active Users with an Access Level of 1 or has no Users created at all, then the new administrative User with the Login Name of SYSTEM and the Password of MEDISOFT1 will automatically be created. That user's Access Level will be set to 1.
- If a current user has a password that is shorter than the new minimum length (now set with a default of 8 or the length the administrator determines), the user will be prompted to create a new password. The user must enter their old password and then they can create a new password that meets the new password minimum length and other requirements.
- Since current passwords were previously stored as all upper-case, after an upgrade, if a user logs in with a password that meets the minimum length requirement and is all upper-case, no prompt to change is necessary since it meets the new requirements. However, if a current password that meets minimum length requirements but contains any lower-case characters is used, this would no longer be a match and you'll be prompted to create a new password. Alternatively that user can log in with all capitals and then change it later if desired.

If you are deleting users and attempt to delete the last user with a Level 1 access, CGM MEDISOFT will present a warning message and prevent you from deleting that user.

Creating Users

You create users of the practice in the User Entry screen. To create a practice

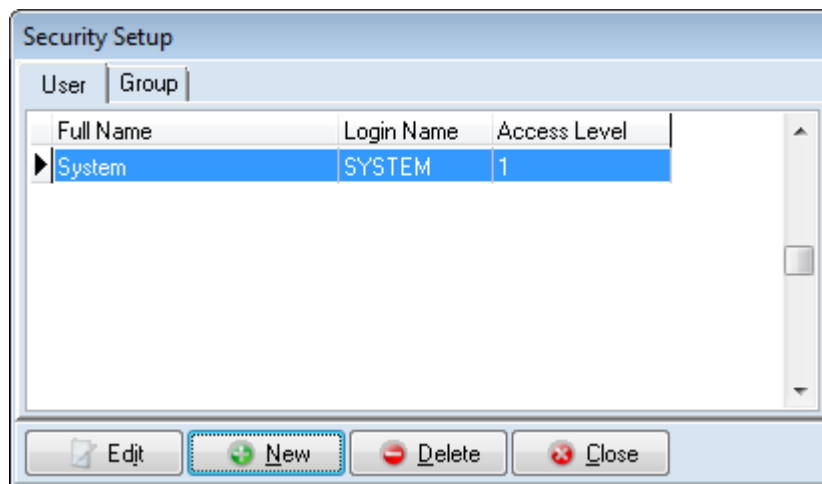
1. On the File menu, click **Security Setup**. The Security Setup screen appears. This screen shows you a list of all users.
2. Click the **New** button. The User Entry screen appears.



The User Entry screen is a dialog box with a title bar containing 'User Entry' and a close button. It has three tabs: 'Main', 'Question', and 'Group', with 'Main' selected. The 'Main' tab contains several input fields: 'Login Name' with an adjacent 'Inactive' checkbox, 'Full Name', 'Password', 'Reconfirm', 'Access Level' (a dropdown menu currently set to '1'), 'Expire Date' (a date picker), and 'Mobile PIN'. On the right side of the dialog, there are three buttons: 'Save' (with a floppy disk icon), 'Cancel' (with a red X icon), and 'Help' (with a question mark icon).

Figure 33. User Entry screen

3. Complete the fields on the screen.
Note that the password must be at least 8 characters in length and is case-sensitive.
4. Click the **Save** button. The Security Setup screen appears and shows you the new user.



The Security Setup screen is a window with a title bar 'Security Setup'. It has two tabs: 'User' and 'Group', with 'User' selected. Below the tabs is a table with three columns: 'Full Name', 'Login Name', and 'Access Level'. The table contains one row with the values 'System', 'SYSTEM', and '1'. Below the table is a list of buttons: 'Edit' (with a pencil icon), 'New' (with a green plus icon and a dotted border), 'Delete' (with a red minus icon), and 'Close' (with a red X icon).

Full Name	Login Name	Access Level
System	SYSTEM	1

Figure 34. Security Setup screen

Login/Password Management

Use Login/Password Management to set the requirements and application of login rights and password usage. For example, you can set the length of valid passwords (minimum of 8

characters), the valid time frame in which a password can be used before it has to be changed, how long a user has to wait before reusing a password, and so on.

Figure 35. Login/Password Management screen

Setting Permissions

NOTE: This is an Advanced or Network Professional feature.

The Permissions feature provides five levels of access to CGM MEDISOFT. Once you have created at least one user for your practice and logged into your practice using someone's login and password, the Permissions options will be available.

To set permissions:

1. On the File menu, click **Permissions**. The CGM MEDISOFT Security Permissions screen appears.
This screen comprises two sections:
 - The screen section displays all the areas of the practice for which security can be set up.
 - The Process section shows the individual elements, features, or screens that make up the selected area in the screen section.
Level 1 is for unlimited access and is designed to be used exclusively by the Supervisor or administrator to restrict access to CGM MEDISOFT. For Levels 2, 3, 4, and 5, the supervisor defines what access goes with each level and assigns users based on that.
2. Select a program area in the **screen** section. The options for that area appear in the **Process** section.
3. Select or clear check boxes for each option and level in the Process section of the screen.
4. Click the **Close** button when you are done.

The Security Supervisor, who has unlimited access and full control of security, can assign or remove rights for any level of security, with one exception. Level 1 access cannot be removed from any of the three options listed in the Process section of the Permissions screen when Security is selected in the screen section.

Chapter 5 - Entering Practice Information

Enter basic practice information that the system uses for reports, statements, and filing claims. Be sure to enter complete information so that your claims will be complete.

Entering Basic Practice Information

To enter practice information:

1. On the File menu, click **Practice Information**. The Practice Information screen appears.

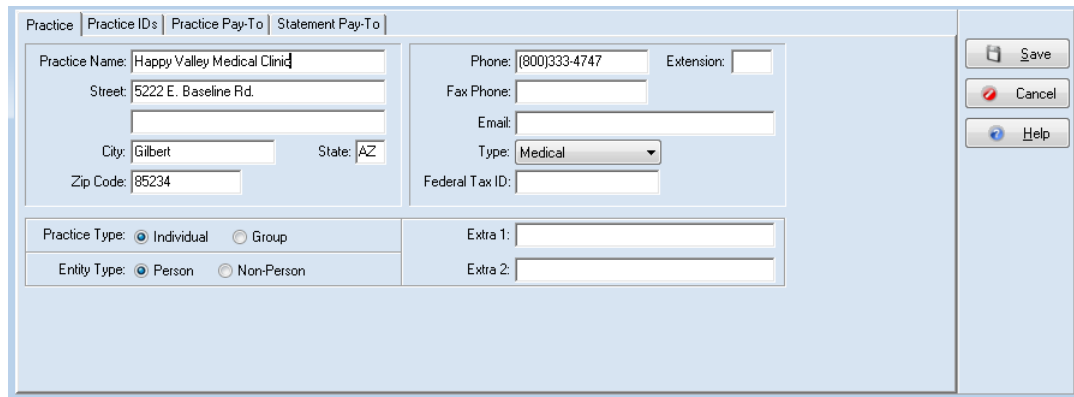


Figure 36. Practice Information screen

2. On the Practice tab, enter the contact information for the practice. The address must be a physical address, not a P.O. Box. If you have a P.O. Box to which payments are sent, that information will go in the Practice Pay-To tab.
3. From the Type list select your practice type.
When you select **Chiropractic**, the Level of Subluxation field appears in the Diagnosis tab of the Case screen for entering the level of subluxation. In addition, five treatment fields are displayed in the Miscellaneous tab of the Case screen.
4. In the Federal Tax ID field, enter the practice's federal tax ID.
5. From Practice Type, select **Individual** or **Group**.
6. From Entity Type, select **Person** or **Non-Person**.

NOTE: Extra 1 and Extra 2 are optional fields that may be used if a carrier requires extra data on a claim. They can hold up to 30 characters.

Entering a Practice IDs Rule

Use the Practice IDs tab and Practice IDs grid to enter or edit key data elements associated with your practice (tax ID/social security number, NPI, taxonomy, legacy numbers). You will set up at

least one rule on the Practice IDs grid and associate this information to all providers, insurance carriers, and all facilities. For more information on entering data on the IDs grid, see [“Creating Rules Overview” on page 23](#).

1. Select the **Practice IDs** tab. The Practice IDs tab appears.
2. Click the **New** button to create a new rule.

--OR--

To edit an entry, select the record on the grid and click the **Edit** button.

3. Select the **All**, **Provider**, or **Provider Class** button.
4. Select the **All** button to apply the rule to all providers associated with the practice.

To apply the rule to a specific provider, select the **Provider** button and click the magnifying glass to select the specific provider.

To apply the rule to a specific provider class, select the **Provider Class** button and click the magnifying glass to select the provider class.

5. Select the **All**, **Insurance Carrier**, or **Insurance Class** button.

Select the **All** button to apply the rule to all insurance carriers associated with the practice.

To apply the rule to a specific insurance company, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

To apply the rule to a specific insurance class, select the **Insurance Class** button and click the magnifying glass to select the insurance class.

6. Select either the **All** or **Facility** button.
7. Select National Provider ID and enter an NPI number to associate that NPI number with the rule.

TIP: if your practice has a group NPI number, enter it here. Then, if providers in your office need to file claims as individuals, you can create a rule for that provider using the provider's individual NPI number that you enter on the Provider IDs grid.

8. Select either **None** or **Taxonomy**.
9. Select the **Tax Identifier** button and enter the tax ID number to associate with the rule.
10. Select the **Social Security Number** button and enter the social security number to associate with the rule.
11. If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the Legacy Identifier 1 and 2 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
12. Click the **Save** button.

Entering Practice Information for a Billing Service

Billing Services

If you are a billing service, enter your client's information in the Practice tab. Enter your information in the Practice Pay-To tab. If you want to use CGM MEDISOFT to keep track of your own accounts

receivables, a separate database can be set up with each client listed as a patient. Separate procedure codes can be created to cover the various services of your billing service.

To set up a billing service:

1. On the File menu, click **Practice Information**. The Practice Information screen appears.
2. Select the **Practice Pay-To** tab.

The screenshot shows the 'Practice Pay-To' tab of the Practice Information screen. The form is divided into two main sections. The left section contains fields for Practice Name (Happy Valley Medical Billing), Street (1944 N. Kluge Dr.), Suite (8381), City (Gilbert), State (AZ), and Zip Code (85234). The right section contains fields for Phone ((480)480-4800), Extension (2222), Fax Phone ((480)480-4801), Extra 1, and Extra 2. On the right side of the form, there are three buttons: Save, Cancel, and Help.

Figure 37. Practice Information screen - Practice Pay-To tab

3. Enter the pay to information in the Practice Name, Street, City, State, Zip Code fields.
4. Click the **Save** button.

BillFlash Users

BillFlash is the online service available to you if you want to send your statements electronically. Once you enroll with BillFlash, you can create statements and upload them to BillFlash. BillFlash then takes care of printing and sending them to your patients.

If you use Bill Flash for electronic statement processing, complete the Statement Pay To tab. Data on this tab is used to create a separate pay-to address location for the statements, for instance, a PO Box instead of a physical address.

To complete the Statement Pay-To tab:

1. On the File menu, click **Practice Information**. The Practice Information screen appears.
2. Select the **Statement Pay-To** tab.

The screenshot shows the 'Statement Pay-To' tab of the Practice Information screen. The form is divided into two main sections. The left section contains fields for Practice Name, Street, City, State, and Zip Code. The right section contains fields for Phone, Extension, Fax Phone, Extra 1, and Extra 2. On the right side of the form, there are three buttons: Save, Cancel, and Help.

Figure 38. Practice Information screen - Statement Pay-To tab

3. Enter the pay to information in the Practice Name, Street, City, State, Zip Code fields.

NOTE: the Extra 1 and Extra 2 fields are only used if a carrier requires extra data on a claim.

4. Click the **Save** button.

EDI Receiver Records

The EDI Receiver screen displays parameters used for transmitting information to a clearinghouse.

To open the EDI Receiver screen:

- On the Lists menu, click **EDI Receivers**.

The settings in CGM MEDISOFT on the EDI Receiver screen are used for setting rules for electronic claims generation. The actual transmission of claims is done by Revenue Management. If you make changes on these tabs in CGM MEDISOFT, the changes flow automatically to Revenue Management, and changes made there are also transferred to CGM MEDISOFT.

When sending electronic claims, set up your clearinghouse or direct payers in Revenue Management. Once an EDI receiver is set up, Revenue Management will synchronize the EDI settings in CGM MEDISOFT. For users upgrading to CGM MEDISOFT 27, Revenue Management can use the existing settings for the payors set up on the EDI Receiver screen, but you will need to reconfigure receivers to work with Revenue Management.

The screenshot shows the 'EDI Receiver: (new)' window. It has a tabbed interface with 'Address' selected. The 'Address' tab contains the following fields and controls:

- Code:** A text field with a note: 'If the Code is left blank, the program will assign one.'
- Name:** A text field.
- Street:** A text field.
- City:** A text field.
- State:** A dropdown menu.
- Zip Code:** A text field.
- Inactive:** A checkbox.
- Phone 1:** A text field.
- Extension:** A text field.
- Phone 2:** A text field.
- Fax Phone:** A text field.
- E-Mail:** A text field.
- Web Address:** A text field.
- Contact:** A text field.
- Comment:** A text field.

On the right side of the window, there are three buttons: **Save**, **Cancel**, and **Help**.

Figure 39. EDI Receiver screen

Chapter 6 - Setting up Providers and Provider Classes

Set up your providers (physicians) in CGM MEDISOFT so you can add them to patient records and transactions entered. In this way their information will be put on claims.

Entering Provider Information

Enter provider records on the Providers screen. To do so:

1. On the Lists menu, point to Provider and click **Providers**. The Provider List screen appears. This screen shows you all of the providers currently set up in the practice.

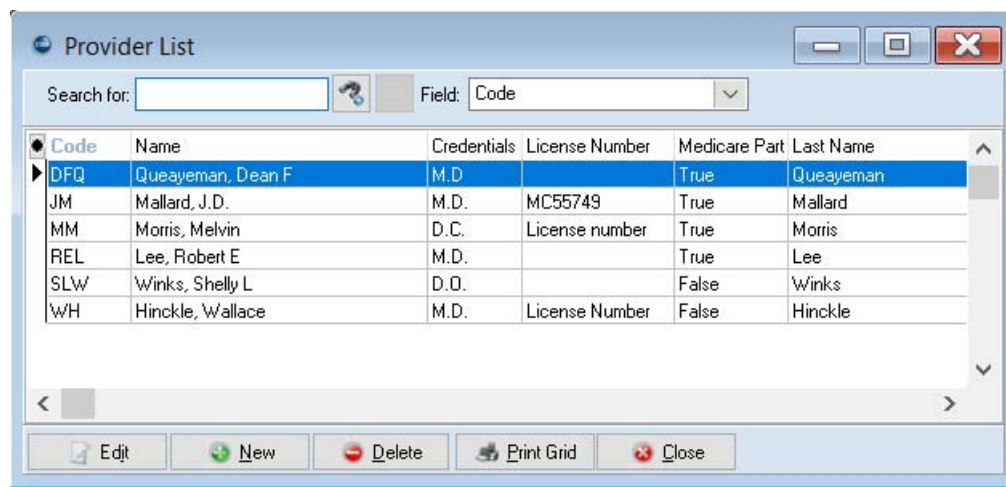


Figure 40. Provider List screen

2. Click the **New** button.

Provider: (new)

Address | Reference | Provider IDs

Code: If the Code is left blank, the program will assign one. ☐ Inactive

Last Name:

First Name:

Middle Name: Credentials:

Street:

City: State: Zip Code:

E-Mail:

Office: Fax:

Home: Cell:

☐ Signature On File Signature Date:

☐ Medicare Participating License Number:

Save Cancel Help Set Default

Figure 41. Provider screen

3. On the **Address** tab, enter demographic information for the provider such as last name, first name, title.
4. Options:

Select the Medicare Participating check box if the provider is considered a Medicare participating provider. A Medicare participating provider agrees to accept assignment on all Medicare claims for covered services and supplies. This field is generally used with electronic claims.

Select the Signature on File check box to indicate that the provider's signature is on file. Select this box if the provider has signed an agreement with Medicare to accept its charges and an affidavit is on file. If it is checked, the Signature Date field becomes active to display the date on which the signature was placed on file. Enter a date in this field.

5. In the License Number field, enter the provider's license number.
6. Click the **Save** button if you are finished with the record or click the Reference tab.

The Reference tab displays data and values before the data was converted to CGM MEDISOFT 27 and moved to the Provider IDs grid to create rules for claim creation. The tab shows data from the Default Pins and Default Group IDs tabs, which were replaced with the Provider IDs tab.

This tab is mostly used for reference purpose only. You can update data on this tab for your reference purposes, but none of this data is pulled for claim generation. The only field that still impacts claims is Provider Class.

7. Assign a provider to a provider class by clicking the Provider Class list and selecting a class.

NOTE: Provider classes are set up in the Provider Class screen.

When generating claims, you can use the provider class on the Practice IDs tab to limit a rule to a specific class of providers.

8. Click the **Save** button if you are finished with the record or select the Provider IDs tab.

Entering Provider IDs Rules

Use the Provider IDs tab to enter or edit key data associated with a provider (tax ID/social security number, NPI, taxonomy, legacy numbers). Set up at least one rule on the Provider IDs grid for each provider in your practice and associate this information to all insurance carriers or insurance classes and all facilities or a particular insurance carrier or an insurance class.

For information on creating these rules, see [“Creating Rules Overview” on page 23](#).

To enter rules for a provider:

1. Select the **Provider IDs** tab.
2. Click the **New** button to create a new rule.

--OR--

To edit a rule, select the record on the grid and click the **Edit** button.

3. Select either **All**, **Insurance Carrier**, or **Insurance Class**. Select a carrier or class if necessary.
4. Select either **All** or **Facility**. Select a facility if necessary.
5. Select either File Claim As **Individual** or File Claim As **Group**.
6. Select either From Practice or National Provider ID. Enter an ID if the NPI is for this provider only.
If you do not want to send an NPI number on a claim, select From Practice and then on the Practice IDs screen, create a matching entry for the provider in which you select None for the NPI option.
7. Select the From Practice button to pull the NPI number from the Practice IDs grid.

WARNING: By selecting From Practice for the NPI, it will put the Practice NPI in the Rendering Provider in Loop 2310.

8. Select either From Practice or Taxonomy.

If you do not want to send a taxonomy number on a claim, select From Practice and then on the Practice IDs screen, create a matching entry for the provider in which you select None for the Taxonomy option.

Select the From Practice button to pull the taxonomy number from the Practice IDs grid.

9. Select From Practice, Tax Identifier, or Social Security Number. Select From Practice to pull the tax ID/social security number from the Practice ID grid.
10. If you file mammography claims, select **Mammography Cert** and enter the certificate number to associate with the rule.
11. If you file laboratory claims using a CLIA number, select **CLIA** and enter the CLIA number to associate with the rule.

12. If your carrier requires a care plan oversight number, select **Care Plan Oversight**, enter the care plan oversight number, and select an ID qualifier to associate with the rule.
13. If needed, enter up to three legacy and qualifiers to associate with the rule using the Legacy Identifier 1, 2, and 3 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
14. Click the **Save** button.

Chapter 7 - Referring Provider Records

Many patient visits come to a practice as a result of a referral from another provider. When a patient is referred to your practice, create a record for the referring provider. Add data such as the Unique Physician Identification Number (UPIN), NPI, tax ID, and so on. In this record, you can link the provider to a particular insurance company/category, if needed.

Entering Referring Provider Information

1. On the Lists menu, click **Referring Providers**. The Referring Provider List screen appears.

Code	Name	Credentials	License Number	Medicare Part	Last Name
BR000	Brown, Drenthal	M.D.		True	Brown
CAR00	Carlson, Carl	M.D.		True	Carlson
PIE00	Pierce, Hawkeye	M.D.		False	Pierce
SCH00	Schneider, Judge			True	Schneider
TRA00	Trapper, John	M.D.		False	Trapper

Figure 42. Referring Provider List screen

2. Click the **New** button.

--OR--

Select a record on the Referring Provider List screen and click the **Edit** button.

3. On the Address tab, enter demographic information for the referring provider such as last name, first name, title.

Also, if you are sending electronic claims, select from the Specialty list the referring provider's special field of practice. If you need to use a specialty code that is different than the usual code, select "Not Listed" and enter your specialty code in the field that appears next to the Specialty list.

NOTE: This field is not used for sending paper claims unless you have modified your claim form to include this information.

Entering Referring Provider Rules

Use the Referring Provider IDs tab and grid to enter or edit key data elements associated with a referring provider (NPI, taxonomy, legacy numbers). You will set up at least one entry (rule) on the Referring Provider IDs grid for each referring provider that works with your practice and associate this information to all insurance carriers or insurance classes or a particular insurance carrier or an insurance class. For more information on creating rules, see ["Creating Rules Overview" on page 23](#).

1. Select the **Referring Provider IDs** tab.

2. Click the **New** button to create a new grid entry.

--OR--

Select an entry on the grid and click the **Edit** button.

3. Select either **All**, **Insurance Carrier**, or **Insurance Class**.
4. Select either **Entity Type: Person** or **Entity Type: Non-Person**.
5. Select either **None** or **National Provider ID**.
6. Select either **None** or **Taxonomy**.
7. If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the Legacy Identifier 1 and 2 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
8. Click the **Save** button.

Chapter 8 - Insurance Classes and Insurance Carriers

Set up the insurance carrier records completely to ensure that your claims are processed in a timely manner. You can create insurance classes, into which you can group carriers based on a common feature. In addition, create your carrier records.

Insurance Classes

Use this screen to create insurance classes, such as Blue Shield or Medicare. Use these classes to group insurance carriers for easier reporting and payment posting.

To create insurance classes:

1. On the Lists menu, point to Insurance and click **Classes**. The Insurance Class List screen appears.

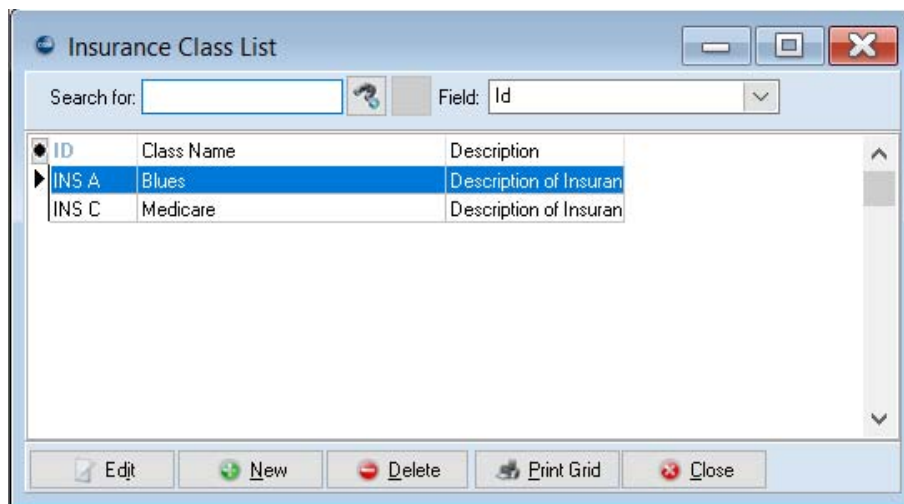


Figure 43. Insurance Class List screen

2. Click the **New** button.
3. Enter an ID, Name, and Description for the class.
4. Click the **Save** button.

Insurance Carriers

1. On the Lists menu, point to Insurance and click **Carriers**. The Insurance Carrier List screen appears.

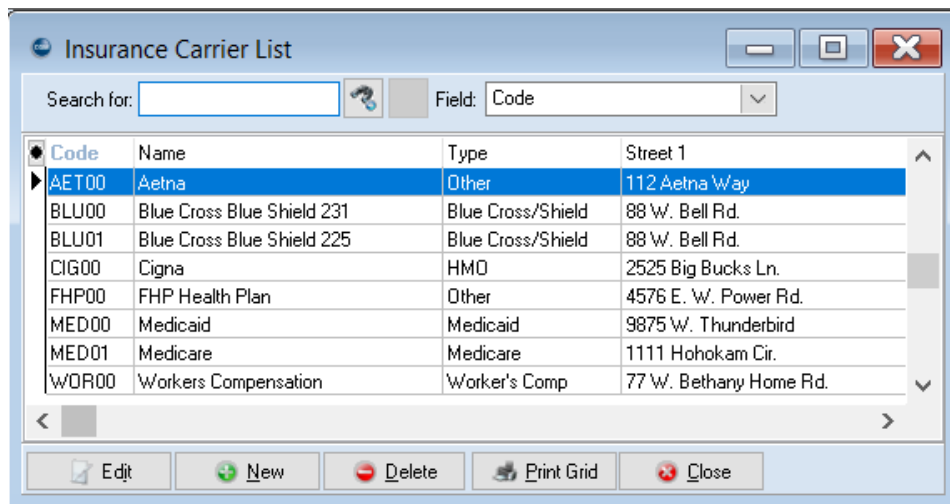


Figure 44. Insurance Carrier List screen

2. Click the **New** button.

--OR--

Select an entry on the Insurance Carrier List and click the **Edit** button.

3. Enter the carrier's information.
4. From the Class list, select an insurance class to assign to the carrier.
5. Select the **Options and Codes** tab.
6. From the Procedure Code and Diagnosis Code Set lists, select a procedure code set (1, 2, or 3) and a diagnosis code set (1, 2, or 3) to apply to the insurance carrier. CGM MEDISOFT gives you the ability to assign up to three codes to the same procedure. By using this field, the claims for each carrier can contain the correct code.
7. From the Patient, Insured, or Physician Signature on File lists, for each option select, Leave blank, Signature on file, or Print name.
These fields control what is printed in the signature Boxes 12, 13, and 31, respectively, on the CMS - 1500 claim form, if you are printing claims. These fields do not control whether anything is printed in these boxes, but what is printed. Whether anything prints is controlled by settings on the Case screen, Policy tab, Accept Assignment and Benefits Assigned field, and Provider screen, Address tab, Signature on File field.
The Signature on file option prints "Signature on File" (if the Signature on file field has been activated in the patient and provider records).
The Print name option prints the name of the patient, insured, or physician.
The Leave blank option prints nothing.
8. From the Print PINs on Forms list select PIN Only or Leave Blank. When setting up Medicare and Medicaid carriers for printed claims, select PIN Only; otherwise, select Leave Blank.
9. From the Default Billing Method 1, 2, and 3 lists, select either Paper or Electronic for handling primary (1), secondary (2), and tertiary (3) claims. Select Paper if claims are to be printed; select Electronic if claims are to be transmitted electronically.

10. In the Default Payment Application Codes box select default payment codes.
11. Select the **EDI/Eligibility** tab. The EDI/Eligibility tab is used for electronic claims.
12. In the Primary Receiver panel on the EDI Receiver list, select the EDI receiver you use when sending electronic claims for primary insurances. If you do not enter an EDI receiver in the EDI Receiver field, electronic claims will not be created or sent for this insurance company.
13. In the Claims Payer ID field, enter the payer ID for the insurance carrier. Refer to the enrollment information you received from the carrier/clearinghouse and look up the commercial identification number/ submitter identification numbers assigned to the insurance company by the clearinghouse.

If you use the eligibility verification service and want to verify eligibility with this insurance carrier, in the Eligibility Payer ID field, enter the payer ID (for some carriers, the eligibility payer ID is different from the payer ID). Refer to the enrollment information you received from the clearinghouse and look up the commercial identification number/ submitter identification numbers assigned to the insurance company by the clearinghouse.

From the Type list select a type for the insurance company.
14. Leave Alternate Carrier ID blank. Revenue Management will populate this field if needed.
15. If needed, select from the EDI Max Transactions list, a maximum number of transactions accepted by the carrier. This field is available for those carriers that limit the number of transactions per claim accepted electronically. If you submit more than the maximum number of transactions per claim, CGM MEDISOFT automatically splits the claim.
16. If the insurance carrier is used as both a primary EDI insurer and a Medigap insurer, in the EDI Extra 1/Medigap field, enter the Medigap number. The number entered is the COBA Medigap claim-based identifier received from the national Coordination of Benefits Contractor (COBC).
17. The EDI Extra 2 field is used by Revenue Management.
18. Select the Complimentary Crossover check box if you are filing complimentary crossover claims. Secondary insurance will not be sent in the claim file. However, CGM MEDISOFT will mark the secondary as sent. If you are sending Medigap claims, do not select this box.
19. Select the Delay Secondary Billing check box, if there is a secondary insurance company and you want to delay printing the secondary claim form until a response is recorded from the primary carrier. To print the secondary claim form at the same time the primary is printed, leave the box empty.
20. Select the Send Ordering Provider in Loop 2420E check box to send ordering provider information on an electronic claim.
21. Select the Send Practice Taxonomy in Loop 2000A check box to send taxonomy in Loop 2000A for electronic claims. Loop 2000A is usually used to report taxonomy for individual providers. Contact your carrier for more information on their taxonomy requirements.
22. Select the **Allowed** tab. This displays the amount last paid by the selected carrier for each procedure code available in CGM MEDISOFT. If you do not enter anything in this table, each time a carrier makes a payment on a particular procedure code, CGM MEDISOFT takes the amount paid plus any deductible and divides it by the established Service Classification percentage to arrive at the allowed amount.

This allowed amount is used when calculating the patient portion estimate of any procedure in the Transaction Entry screen. The existing allowed amount can be changed in the Transaction Entry screen by clicking the Allowed Amt column and entering the corrected amount.
23. Click the **Save** button.

Chapter 9 - Facility Information

Setup Scenarios

If you have a facility or a lab attached/affiliated with your practice, you will need to create a record for it. There are two components to the record: contact/demographic data entered on the Address tab and billing-specific information entered on the Facility IDs tab.

A facility or lab is a location to which mail might be sent or calls directed, that has a separate address from your practice.

Entering Facility Information

1. Click Lists and click **Facilities**. The Facility List screen appears.
2. Click the **New** button.

--OR--

Select a record on the Facility List and click the **Edit** button.

3. Enter contact data associated with the facility, including a name, address, telephone number.
4. If the facility is a lab, click the **Laboratory** button; if the facility is not, click **Facility**.

Entering Facility IDs Rules

Use the Facility IDs tab to enter or edit key data specific to the facility (NPI number, taxonomy number, CLIA number, legacy numbers). If your practice is associated with a facility or a lab, set up at least one rule on the Facility IDs screen and associate this information to a specific insurance carrier or an insurance class.

If you have entered a separate NPI number for your facility and need to send facility billing information for box 32 of the CMS 1500 form, specify the type of facility and qualifier along with the facility NPI number. If you need to send it on claims, select the Send Facility on Claim check box.

For more information on creating rules, see [“Creating Rules Overview” on page 23](#).

1. Select the **Facility IDs** tab. The Facility screen appears.
2. Click the **New** button to create a new rule.

--OR--

Select the record on the grid and click the **Edit** button.

3. Select either **All**, **Insurance Carrier**, or **Insurance Class**.

To apply the rule to a specific insurance carrier, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

To apply the rule to a specific insurance class, select **Insurance Class** and click the magnifying glass to select the insurance class.

4. To include facility information on a print or electronic claim, select the **Send Facility on Claim** box and select an ID Qualifier.
5. Select either **None** or **National Provider ID**. Select **National Provider ID** and enter an NPI number to associate the facility NPI number with the rule.
6. Select either **None** or **Taxonomy**.
7. Select either **None** or **CLIA**.
8. If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the Legacy Identifier 1 and 2 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
9. Click the **Save** button.

Chapter 10 - Attorney, Employer, or Other Addresses

The Address file is your address book in CGM MEDISOFT. It keeps the names, addresses, and phone numbers of important outside contacts, such as attorneys, employers, referral sources, and any other addresses you need.

The Address file will include all important contact persons whose phone, fax, cell, and e-mail numbers the practice needs.

The addresses maintained in CGM MEDISOFT are classified by “type” assigned to help you select them in a drop-down list. These types include: Attorney, Employer, Miscellaneous, and Referral Source.

To set up address records:

1. On the Lists menu, click **Addresses**. The Address List screen appears.
2. Click the **New** button on the Address List screen. The Address screen appears.
3. Enter a Code for a new address record or leave the field blank and let CGM MEDISOFT create a unique code.
4. Enter demographic data for the address.
5. From the Type list, select **Attorney, Employer, Miscellaneous, or Referral Source**.
6. Enter other demographic data such as phone numbers and email address.
7. Click the **Save** button.

Chapter 11 - Procedure, Payment, Adjustment, and Diagnosis Codes

In this chapter you will learn about entering procedure and diagnosis codes that are used when you enter charges for your patients.

Procedure, Payment, and Adjustment Codes

Procedure codes are used to communicate procedure information between patient, provider, and third-party payers.

The Procedure/Payment/Adjustment List screen shows what codes have been set up.

Code 1	Description	Amount	Type Description
17110	Wart Removal	\$15.00	Procedure charge
29130	App. of Finger Splint, Static	\$30.00	Procedure charge
43220	Esophageal Endoscopy	\$275.00	Procedure charge
70250	X-Ray, Skull, 4 Views	\$55.00	Procedure charge
70360	X-Ray, Neck	\$45.00	Procedure charge
71020	X-Ray, Chest, 2 Views	\$53.00	Procedure charge
71030	X-Ray, Chest, Min 4 Views	\$65.00	Procedure charge
71040	Contrast X-Ray of Bronchitis	\$50.00	Procedure charge

Figure 45. Procedure/Payment/Adjustment List screen

At the top of the screen, there are two fields to help you find a procedure code: Search for and Field. Field defaults to Type but you can change it to Code 1 or Description. If you are not sure of the complete code, description, or type, enter the first few letters or numbers in the Search for field. As you type, the list automatically filters to display records that match.

General Tab

Enter a new code number, description, and type in the General tab.

Procedure/Payment/Adjustment: Wart Remov...

General | Amounts | Allowed Amounts

Code 1: **17110** ☐ Inactive

Description: **Wart Remova]**

Code Type: **Procedure charge**

Account Code:

Type of Service:

Place of Service:

Time To Do Procedure: **0**

Service Classification: **A**

Don't Bill To Insurance:

Only Bill To Insurance:

Default Modifiers: ☐ ☐ ☐ ☐

Revenue Code:

Default Units: **0**

National Drug Code:

NDC Unit Price:

NDC Unit of Measurement:

Code ID Qualifier:

Purchase Service Amount:

CPT Description:

Alternate Codes

2: **17110**

3: **17110**

☒ Taxable ☐ Patient Only Responsible

☐ HIPAA Approved ☐ Purchased Service

☐ Require Co-pay

Figure 46. Procedure/Payment/Adjustment screen

Amounts Tab

The Amounts tab links to the Price Code field on the Account tab of the Case screen. CGM MEDISOFT Advanced and CGM MEDISOFT Network Professional allow 27 charge amounts for each code entered in CGM MEDISOFT. The applicable charge amount is selected in the Account tab of each patient's Case screen.

Allowed Amounts Tab (Advanced and CGM MEDISOFT Network Professional)

The Allowed Amounts tab keeps track of how much each insurance carrier pays for a particular procedure. CGM MEDISOFT calculates the allowed amount based on the amount paid, any applicable deductible, and the service classification. This amount is used in calculating the patient portion of any transaction entered in Transaction Entry.

MultiLink Codes

MultiLink Codes are groups of procedure codes combined as a single code. They are for procedures that are normally performed at the same time, for example, for a physical exam or a routine set of treatments.

There are two advantages to using MultiLinks:

- You reduce data entry time by creating several transactions at once with a single code.
- You reduce omission errors since you've already included all applicable codes in your MultiLink code.

To create MultiLink codes:

1. On the Lists menu, click **MultiLink Codes**. The MultiLink List screen appears.
2. Click the **New** button. The MultiLink Code screen appears.
3. Enter a Code and Description for the procedure.
4. Select the procedures for this code from the Link Code fields.
5. Click the **Save** button.

CPT Code Search

You can use the CPT Code search feature to search for CPT/Procedure codes and add them to your practice.

Note: This is an add-on feature to CGM MEDISOFT 22 and will work only for CGM MEDISOFT 22 and above. For information on purchasing CPT Code Search, contact your Value-Added Reseller. Once you purchase CPT Code Search, you must register it to activate it.

In addition, Internet is required to use CPT Code search.

With this feature, you can add either

- A single code--Find CPT button on the Procedure/Payment/Adjustment Code screen
- Multiple codes--Add CPT Codes button on the Procedure/Payment/Adjustment Code List screen

New CPT Code Search screen (single code search)

Use this screen to search for a CPT/Procedure code and add it to your practice.

Search For: Effective Date: 8/22/2017 ☐ Show Matches Only

- + 00000-0009T Category Temporary Codes
- + 00100-01999 Anesthesia
- + 05000-0526Z Category II Codes - Patient Management
- + 10000-1001Z Category II Codes - Patient History
- + 10021-69979 Surgery
- + 70010-79999 Radiology
- + 80047-89399 Pathology and Laboratory
- + 90281-99199 Medicine
- + 99000-99090 Miscellaneous Services
- + 99201-99499 Evaluation and Management
- + 99500-99602 Home Health and Home Infusion Procedures
- + 99605-99607 Medication Therapy Management Services
- + AAAAA-WZZZZ Custom Charting Codes (5 char minimum) by disease

Figure 47. CPT Code Search screen

The table below describes the fields and elements on this screen.

Element	Description
Search for	Use this field to type in characters that you want to search for.
Effective Date	Select an Effective Date for when the code will become active for your practice.
Show Matches Only check box	Select this check box if you want to see exact matches only.
Search button	Click this button to perform the search for the code you entered. When you click this button, the “tree” listing of codes in the code section will expand to show you the code you searched for.
OK button	Click this button to add the code to your list of Codes.
Cancel	Click this button to cancel your search and close the screen.

New CPT Code Search screen (multiple code search)

Use this screen to add more than one CPT code to your code set at once.

Figure 48. CPT Code Search screen (multiple code search)

The table below describes the fields and elements on this screen.

Element	Description
Search for	Use this field to type in characters that you want to search for.
Effective Date	Select an Effective Date for when the code will become active for your practice.
Show Matches Only check box	Select this check box if you want to see exact matches only.
Search button	Click this button to perform the search for the code you entered. When you click this button, the “tree” listing of codes in the code section will expand to show you the code you searched for.
Check boxes in grid	Select the check boxes in the grid for the codes you want to add. Selecting a check box for an entire group of codes will add the entire group to your database at one time.
Default values for selected codes section	

Element	Description
Type of Service	Enter the Type of Service that will apply to the selected codes.
Place of Service	Enter the Place of Service for the selected codes.
Revenue Code	Select a Revenue Code (if applicable) from the drop-down menu.
Modifiers	Enter the modifiers that will apply to the selected codes.
Taxable check box	Select the check box if the selected codes are taxable.
Select All button	Click this button to select all of the codes in the grid. In this way, you can add the codes at one time.
OK button	Click this button to add the codes to your list of Procedure Codes.
Cancel	Click this button to cancel your search and close the screen.

Procedures

Adding a new code on the Procedure/Payment/Adjustment Codes screen

To add a new code on the Procedure/Payment/Adjustment Codes screen

1. On the Lists menu, select Procedure/Payment/Adjustment Codes. The Procedure/Payment/Adjustment Codes screen opens.
2. Click the **New** button.
3. Click the **Find CPT** button. The CPT Code Search screen opens.
4. Enter the code you are searching for in the Search For field.
5. Click the **Search** button. The code will appear in the section below, with the code tree opening to show you the code and its description.
6. Highlight the code and click the **OK** button. The code will appear in the Procedure/Payment/Adjustment (new) screen.

Adding multiple codes from the Procedure/Payment/Adjustment List screen

To add multiple codes at once:

1. On the Lists menu, select Procedure/Payment/Adjustment Codes. The Procedure/Payment/Adjustment Codes screen opens.
2. Click the **Add CPT Codes** button. The CPT Code Search screen opens.
3. Enter a code to search for or use the code tree in the grid to find a group of codes to add.
4. Select the check boxes to the left of the codes you want to add.

5. Enter additional information for Type of Service, Place of Service, Modifiers, and so on as necessary.
6. Click the **OK** button. The codes will appear in the Procedure/Payment/Adjustment List screen.

Chapter 12 - Diagnosis Codes

Diagnosis codes describe the medical the reason(s) a service is provided. The procedure code tells what the physician did and the diagnosis code tells what the physician found.

To create a new Diagnosis Code

1. On the Lists menu, select **Diagnosis Codes**. The Diagnosis List window appears.

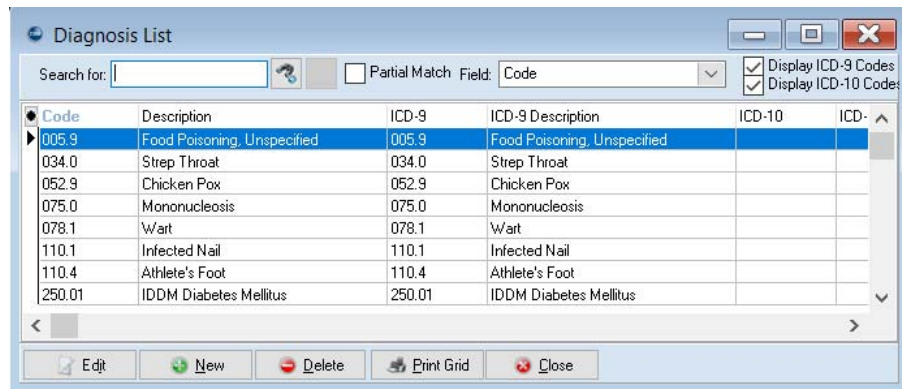


Figure 49. Diagnosis List window

2. Click **New**. The **Diagnosis** window appears.

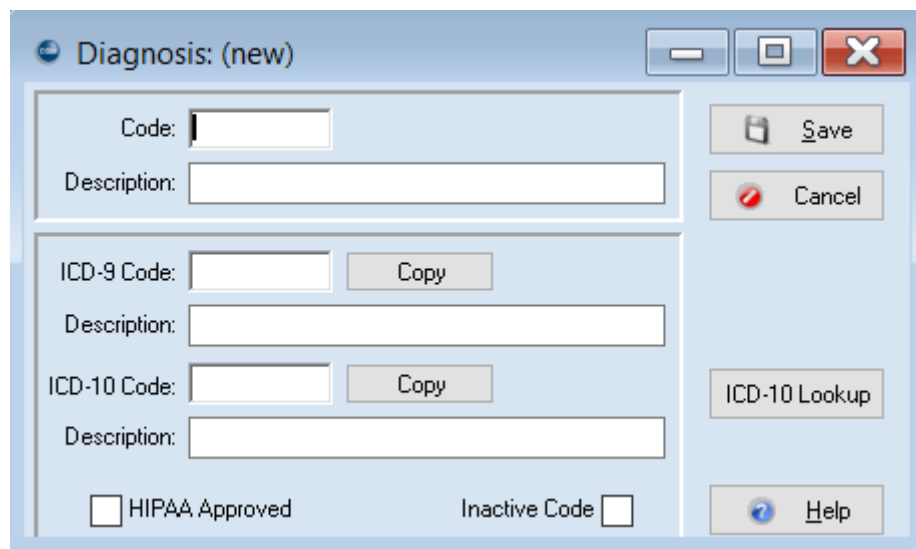


Figure 50. Diagnosis window

3. Enter the correct **Code** and a **Description**.
4. If necessary, enter **Alternate Code Sets**. YOU can use these for entering codes for different carriers but for the same diagnosis.
5. Click **Save**.

IMO - Enhanced ICD Search

The current ICD-10 code search tool for CGM MEDISOFT has been replaced by Intelligent Medical Objects® (IMO®).

You must be registered to use this feature. When you first use this feature, you'll see a screen for registration information. Enter the information you received from your Value-Added Reseller (VAR). The Account ID is case-sensitive

For the Value-added reseller: The Customer Account ID in Salesforce is the Customer Account ID in CGM MEDISOFT.

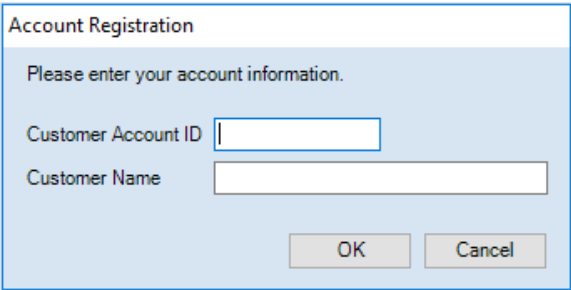
A dialog box titled "Account Registration" with a light blue background. It contains the text "Please enter your account information." followed by two input fields: "Customer Account ID" and "Customer Name". At the bottom right are "OK" and "Cancel" buttons.

Figure 51. Account Registration screen

When you click the ICD-10 Look up button on the CGM MEDISOFT Diagnosis (new) screen, the new search screen will open.

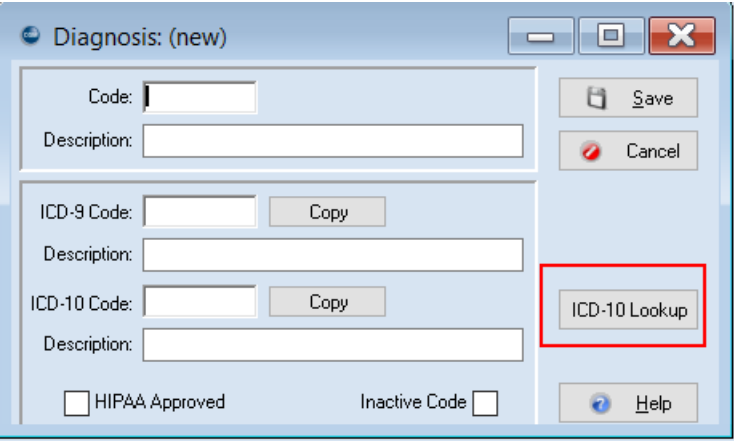
A dialog box titled "Diagnosis: (new)" with a light blue background. It contains several input fields and buttons. At the top, there is a "Code:" field and a "Description:" field. Below these are two sections for "ICD-9 Code:" and "ICD-10 Code:", each with a "Copy" button. At the bottom left are checkboxes for "HIPAA Approved" and "Inactive Code". On the right side, there are "Save", "Cancel", "ICD-10 Lookup" (highlighted with a red box), and "Help" buttons.

Figure 52. Diagnosis (new) screen

When you first open Diagnosis Code Search, it will appear like this:

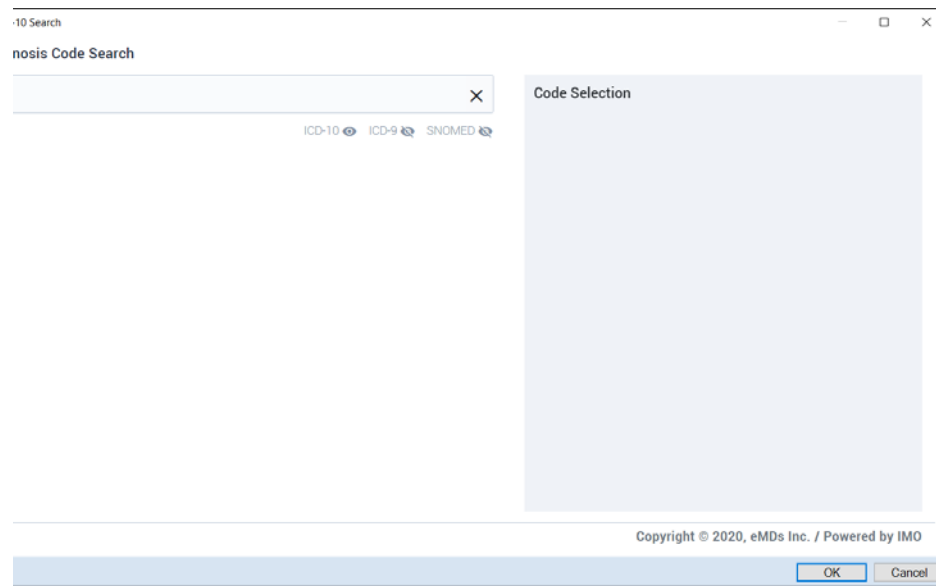


Figure 53. Diagnosis Code Search screen

Searching for and selecting codes

Searching for codes

Search for a code by entering the code description or part of the description. The type ahead search feature will display codes automatically after you have entered three characters. Then, either scroll through the list of results or continue to type in the description to refine the search.

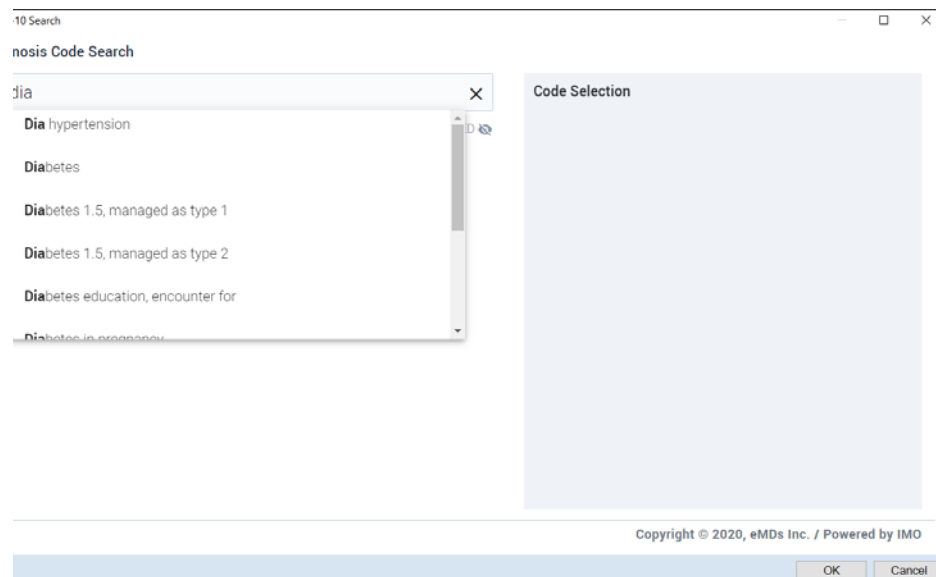


Figure 54. Diagnosis Code Search screen - type ahead results

You also can type a search term or partial search term (for instance, one or two characters) and press **Enter**.

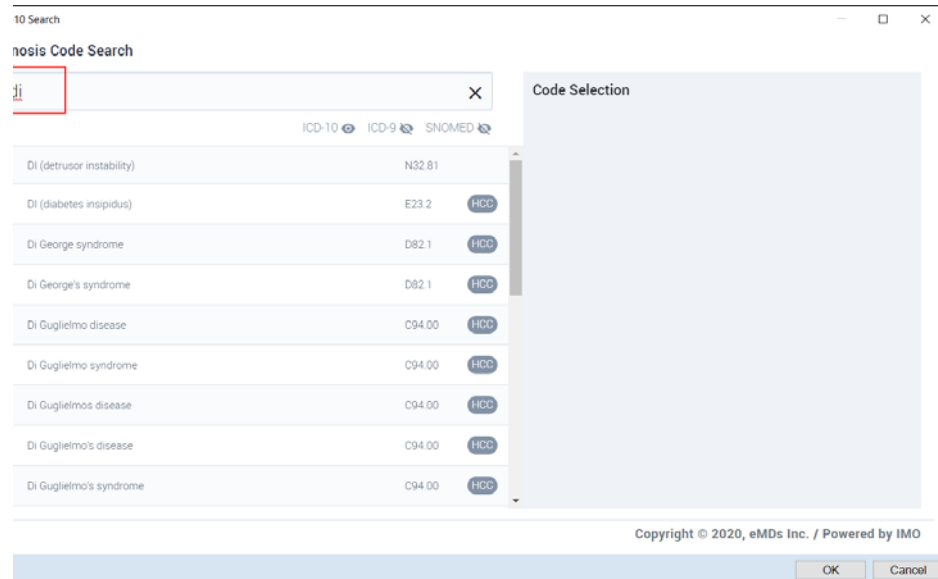


Figure 55. Diagnosis Code Search screen - Enter key pressed

Codes that were located appear in the section below the Search field. When the search results include a diagnosis with multiple ICD-10 codes, a plus sign (+) displays next to the diagnosis code.



Figure 56. Diagnosis Code Search screen - + sign highlighted

Selecting such a code by clicking the radio button to the left of it will display all diagnoses associated with that item.

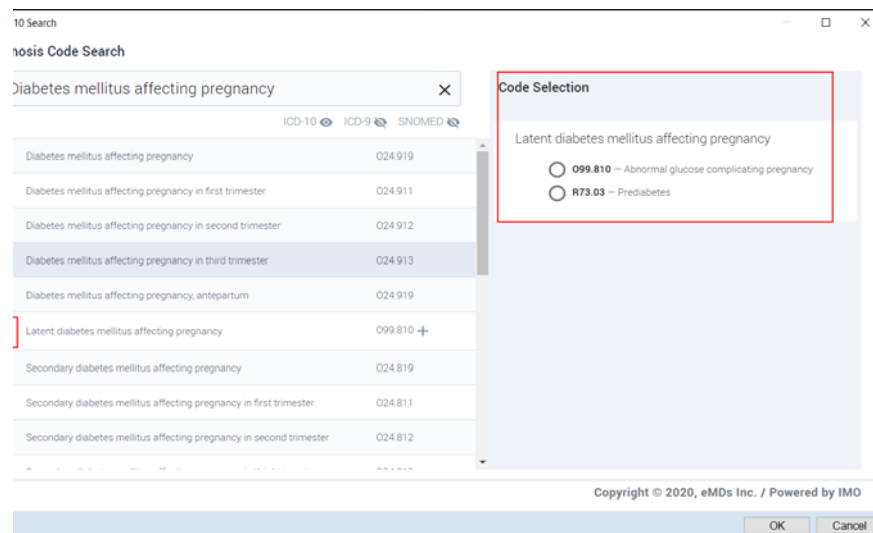


Figure 57. Diagnosis Code Search screen - Code Selection section highlighted

You can also hover over or click the plus sign (+) to display a screen that shows the **additional ICD-10 codes** for the diagnosis code.

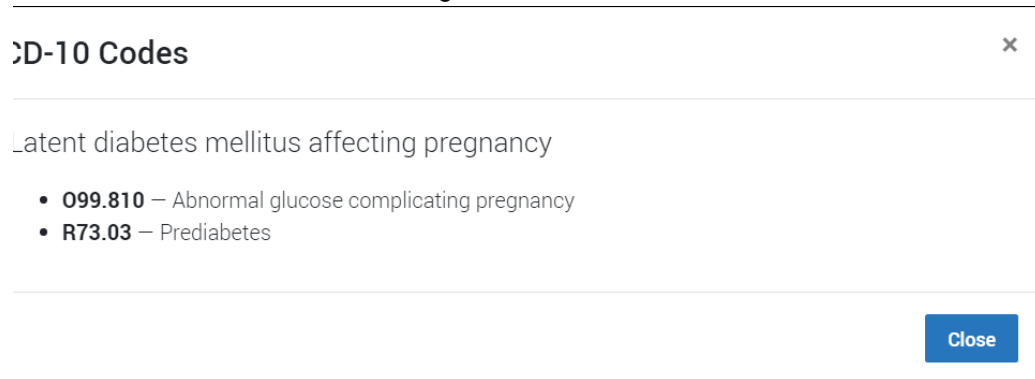


Figure 58. ICD-10 Codes modal

Selecting codes

To select a code, click the radio button to the left of the code in the main search section.

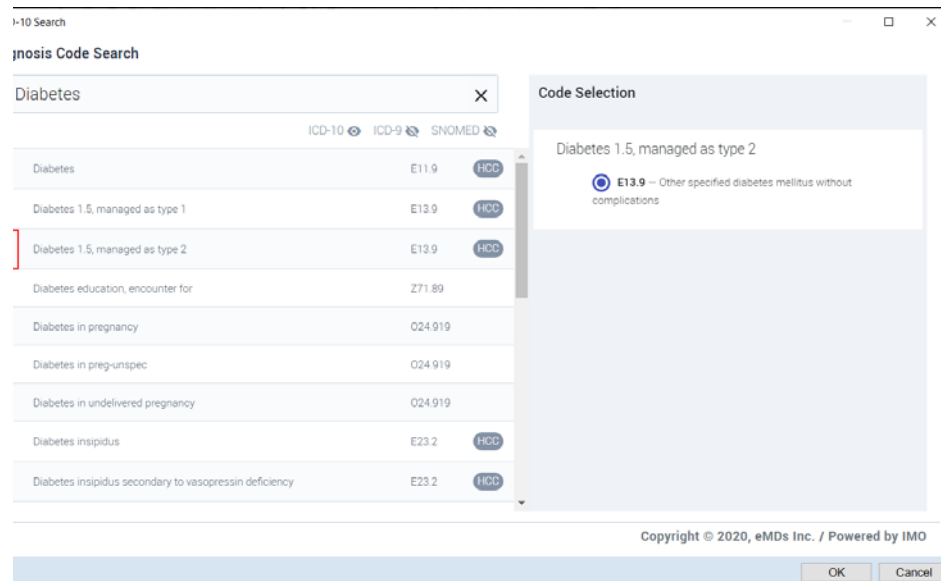


Figure 59. Diagnosis Code Search screen

The selected code will appear at the right in the Code Selection section, with the radio button selected there (if there is only one item for the selected code).

To add the code to your list of codes in CGM MEDISOFT, click the OK button in the bottom right. On the CGM MEDISOFT Diagnosis screen the Description, ICD-10 Code and Description fields will be populated.

Then, click the Save button on the Diagnosis screen in CGM MEDISOFT.

Note: if you enter an ICD-10 code in the CGM MEDISOFT New Diagnosis screen before you click the ICD-10 Lookup, the Search screen will be scoped to related items when you launch it.

For items that have multiple codes, when you click the radio button to the left of the item in the search, all codes for that item will appear in the Code Selection section on the right.

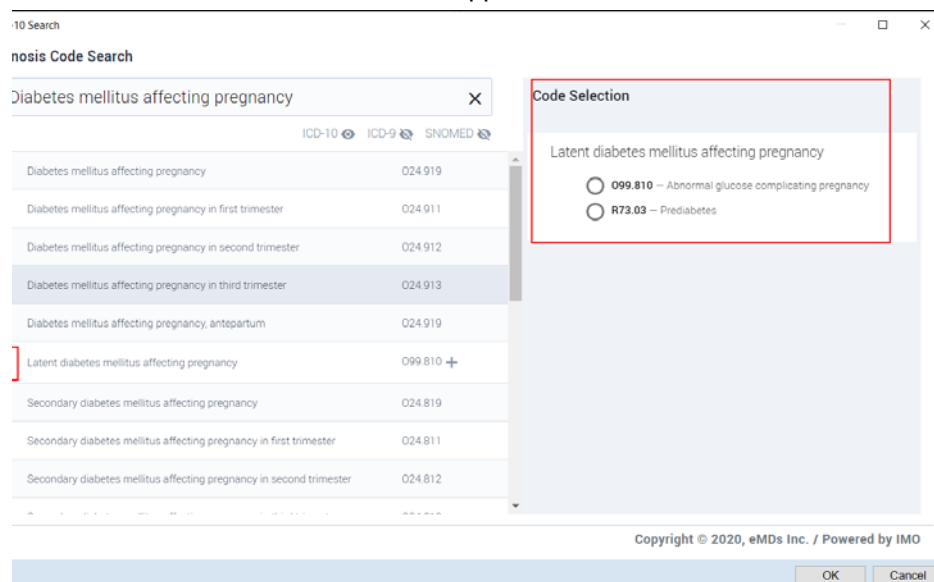


Figure 60. Diagnosis Code Search screen

In this case, to select a code, select one of the radio buttons in the Code Selection section. Then, click the OK button.

Note that you can add only one code at a time to your CGM MEDISOFT Diagnosis Code list.

To de-select a code, select a different radio button or click the Cancel button on the bottom right to close the Diagnosis Code Search screen.

Viewing and hiding code types

By default, only ICD-10 codes will display in the search results when opening the Diagnosis Code Search screen. However, you can choose to view ICD-9 and SNOMED codes by clicking the View (Show/Hide) icon shaped like an eye.

- The View (show) icon will display for code types that are marked for display.
- The View icon with a slash (hide) will display for code types that are hidden.



Figure 61. Code Types

When all code types are displayed, the screen will appear like this:

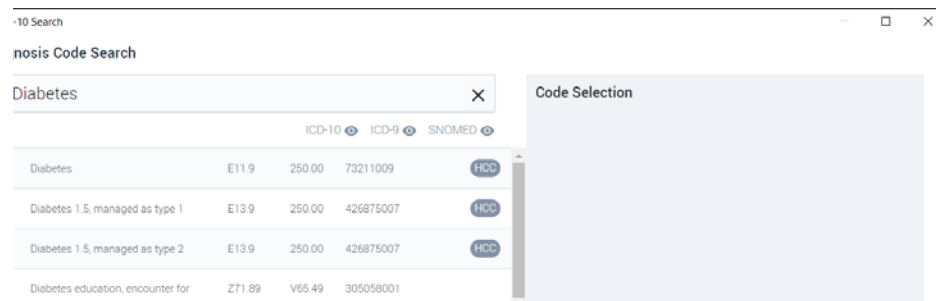


Figure 62. Diagnosis Code Search screen

Hovering over an ICD-10 code will display the information for that code.

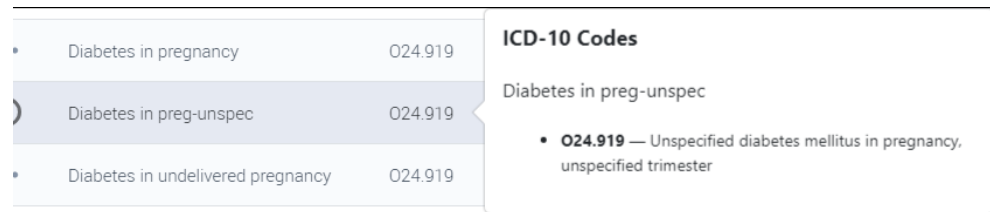


Figure 63. Diagnosis Code Search screen - hover over displayed

Click the ICD-10 code and a modal screen will open showing the information.

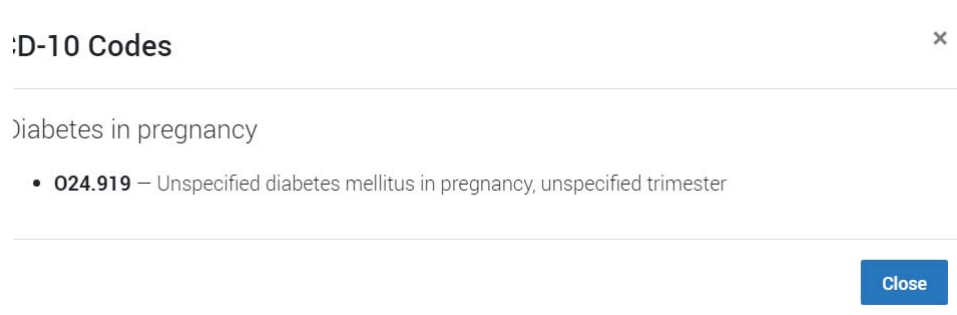


Figure 64. ICD-10 Codes modal

Viewing and selecting modifiers

The More Options button (ellipsis) indicates that there are modifiers available for the diagnosis code. The use of the term modifier refers to qualifying, or refining, the diagnosis code and has no impact on billing.

>10 Search

Diagnosis Code Search

Diabetes

ICD-10 ICD-9 SNOMED

Diagnosis Code	ICD-10	ICD-9	SNOMED	More Options
Diabetes	E11.9	250.00	73211009	More Options
Diabetes 1.5, managed as type 1	E13.9	250.00	426875007	More Options
Diabetes 1.5, managed as type 2	E13.9	250.00	426875007	More Options
Diabetes education, encounter for	Z71.89	V65.49	305058001	More Options

Code Selection

Figure 65. Diagnosis Code Search screen - with More Options button highlighted

Click the More Options button to open a screen that displays modifier groups that allow you to refine the search results.

Diagnosis Modifiers

Diabetes

Results (0)

Diabetes mellitus type

Diabetes mellitus long term insulin use

Diabetes mellitus complication status

Diabetes mellitus complication detail

Diabetic retinopathy severity

Proliferative retinopathy type

Diabetes mellitus macular edema

Laterality

Chronic kidney disease stage

Figure 66. Diagnosis Modifiers screen

When you select a modifier item in one of the category boxes, a more specific list of modifier results will display in the Results section. The system will hide all incompatible modifier items in the other modifier groups, as well as all items in the active modifier container. Only one selection per modifier group is allowed.

To de-select a modifier, click it again. All of the modifiers and categories will be restored.

Diagnosis Modifiers

Diabetes

Diabetes mellitus type

Diabetes mellitus complication status

Diabetes mellitus complication detail

Diabetic retinopathy severity

Results (118)

Select	Type 1 diabetes mellitus with ketoacidosis without coma	E10.10
Select	Type 1 diabetes mellitus with ketoacidotic coma	E10.11
Select	Type 1 diabetes mellitus with nephropathy	E10.21

Figure 67. Diagnosis Modifiers screen - Results highlighted

Note in the figure above that the selected item is now highlighted in light blue.

You can continue to make selections to narrow the results. For instance, after selecting type 1 or type 2 in the Diabetes mellitus type category box, selecting **without complication** from the **Diabetes mellitus complication status** box will reduce the results to a single item and **without complication** is also highlighted.

Diagnosis Modifiers

Diabetes

Diabetes mellitus type

Diabetes mellitus complication status

Results (1)

Select	Type 1 diabetes mellitus without complication	E10.9
--------	---	-------

Figure 68. Diagnosis Modifiers screen

Selecting modifiers

Click all necessary diagnosis modifiers in the category boxes to refine the search. Then, click the Select button in the Results section to select the desired code. You can select only one code.

Diagnosis Modifiers

Diabetes

Diabetes mellitus type

Diabetes mellitus complication status

Diabetes mellitus complication detail

Diabetic retinopathy severity

Diabetic nephropathy type

Diabetic nephropathy severity

Diabetic nephropathy stage

Results (118)

Select	Type 1 diabetes mellitus with ketoacidosis without coma	E10.10	HCC
Select	Type 1 diabetes mellitus with ketoacidotic coma	E10.11	HCC
Select	Type 1 diabetes mellitus with nephropathy	E10.21	HCC
Select	Type 1 diabetes mellitus with stage 1 chronic kidney disease	E10.22 +	HCC
Select	Type 1 diabetes mellitus with stage 2 chronic kidney disease	E10.22 +	HCC
Select	Type 1 diabetes mellitus with stage 3 chronic kidney disease	E10.22 +	HCC

Figure 69. Diagnosis Modifiers screen

Then, the Diagnosis Modifier screen will close and the selected code will display in the Code Selection section of the Diagnosis Code Search screen. If multiple codes appear, select the one you want in the Code Selection section.

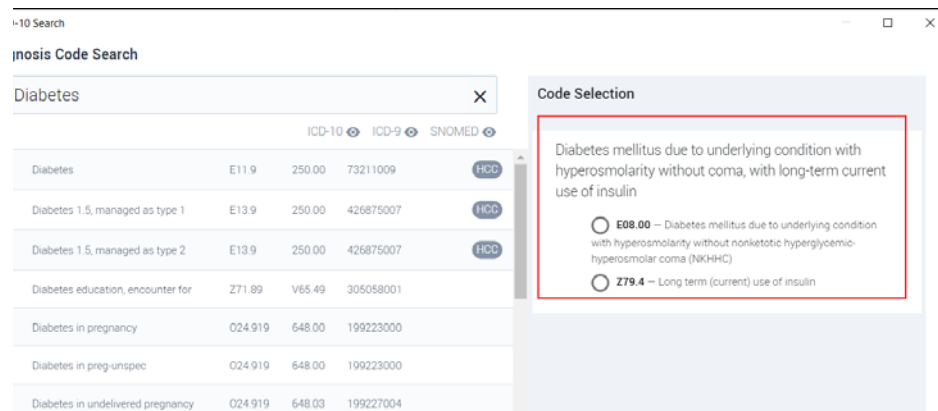


Figure 70. Diagnosis Code Search

Then, click the OK button to add the code on the Diagnosis (new) screen.

Finally, click the Save button on the CGM MEDISOFT Diagnosis screen.

Risk Score display

If an IMO diagnosis code has risk score results, an HCC (for Hierarchical Condition Categories) icon appears at the far right of the description. Hover your mouse pointer over this icon to display the risk results data. The data displays in two columns: **RxHCC Information** and **HCC Information**.

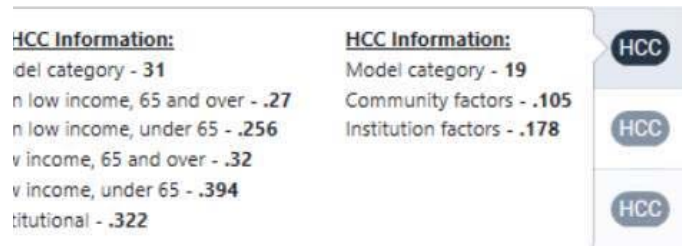


Figure 71. Diagnosis Code Search screen - Risk hover over

Although the HCC Risk Category information is displayed for some codes, this information is not included in nor automatically carried over to the Diagnosis Code list in CGM MEDISOFT. It is provided for information and not used elsewhere for a selected diagnosis.

Chapter 13 - Billing Code List

A billing code is a user-defined two-character alphanumeric code used in sorting and grouping patient records for billing purposes. A billing code range is a filter available in most reports printed in CGM MEDISOFT as well.

To enter a billing code:

1. On the Lists menu, click **Billing Codes**. The Billing Code List screen appears.

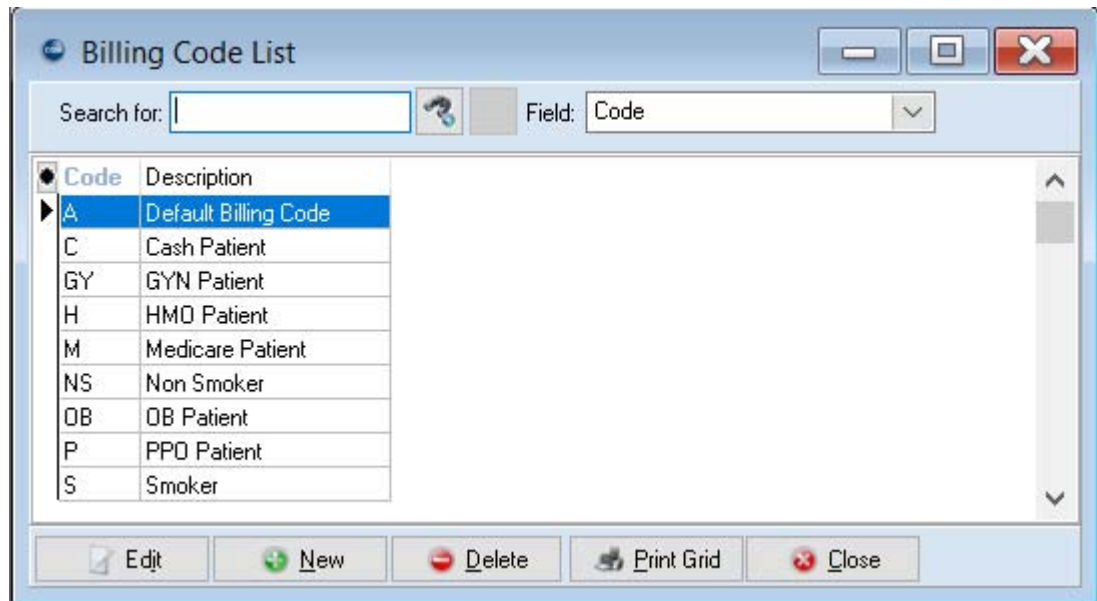


Figure 72. Billing Code List screen

2. Click the **New** button. The Billing Code screen appears.
3. Enter a Code and Description.
4. Click the **Save** button.

Chapter 14 - Contact List

NOTE: This is a CGM MEDISOFT Advanced and CGM MEDISOFT Network Professional feature.

The Contact List is available to track people with whom you have had contact during the course of business. On the Contact screen, you can add notes regarding your conversations with the contact to help you keep track of what was discussed and any conclusions or information shared during the conversation.

To add a contact:

1. On the Lists menu, click **Contact List**. The Contact List screen appears.
2. Click the **New** button. The Contact screen appears.
3. Select the Category for the new contact.
4. Enter information as necessary to complete your record.
5. Click the **Save** button.

Chapter 15 - Patients

One of the most important functions in getting your practice set up is entering patient data. Complete patient information is important for filing claims and processing statements to bill your patients.

Chart Number Considerations

Every patient or guarantor must have a chart number and be set up in the database before you can enter transactions for the patient. You can choose to allow CGM MEDISOFT to create your patients' chart numbers as you enter their records or you can use your own system.

- If you want CGM MEDISOFT to create your chart numbers, simply leave that field blank when you create a patient record.
- If you want to use your own system, complete the Chart field as you enter the new patient's information.

If you want to use numeric chart numbers only, open Program Options, select the Data Entry tab, and select the Use numeric chart numbers check box.

There is no need for corresponding numbers within a family; the number sequence has little bearing on grouping of patients. Each patient is set up individually in CGM MEDISOFT and individual bills are prepared for each guarantor.

Once assigned, the Chart Number cannot be changed. To correct a wrong chart number, you must delete the entire patient record and create a new one with the proper chart number.

All other data in the patient record can be modified.

Entering Patient Information

1. On the Lists menu, click **Patients/Guarantors and Cases**. The Patient List screen appears.
2. Click **New Patient**. The Patient/Guarantor screen appears.
3. On the Name, Address tab, enter all known or necessary information.

Tip: In CGM MEDISOFT Advanced and CGM MEDISOFT Network Professional, you can establish default information, applied to all new patient records. Enter the information that is the same for all of your patients, and then click Set Default. To remove your new default settings, hold down CTRL and the button name changes to Remove Default.

When you enter a Social Security number, CGM MEDISOFT checks through the patient records for any duplications. If a number you enter is a duplicate, CGM MEDISOFT displays the name and chart number of the patient having that Social Security Number.

4. Select the **Other Information** tab.

5. Complete the fields here.

If the patient's employer record has been set up in the Address file (see ["Attorney, Employer, or Other Addresses"](#) on page 55), select it on the Employer field.

If you want to create a new address record, place the cursor in the Employer field and press F8. The Addresses screen will appear.

6. Select the **Payment Plan** tab. Select a Payment Code to set up the payment terms for the patient.

Patient Alerts

You can create Patient "Alert Codes," which can be assigned to a patient from the patient level.

Each patient can have up to five Patient Alert Codes assigned to them, as well as one free-text alert. These alert codes are user-defined and user-created and can be assigned in the patient record. The Patient Alert Codes can be used as warning messages to the practice, assigning a status, as a reminder to the practice, categorize the patient into a group, and so on.

You can set up alerts to open on one or up to four screens in CGM MEDISOFT, based on selections you make when creating the alert:

- If the Display on New/Edit Transaction Entry is checked, a pop-up window will open with the alert(s) when the user creates or edits a transaction for the patient. The alerts will display immediately after the patient is selected.
- If the Display on New/Edit Patient is checked, a pop-up window will appear with the alert(s) when the user creates or edits a patient. The alerts will display immediately after the patient is selected.
- If the Display on New/Edit Case is checked, a pop-up window will appear with the alert(s) when the user creates or edits a case for the patient. The alerts will display immediately after a case is selected.
- If the Display on New/Edit Appointment in Office Hours is checked, a pop-up window will open with the alert(s) when the patient is selected on a new or edited appointment in Office Hours. The alerts will display immediately after the patient is selected.

Free text alert will display on all of the above.

If multiple Patient Alert Codes are chosen for a patient and that patient is chosen in one or more of the four optional pop-up areas of CGM MEDISOFT, all selected messages will appear in one window.

Patient Alerts list

Use this window to view, search for, and filter alerts that have been created. Use it also to create, edit, and delete existing alerts.

Code	Description
2	Patient still has Coventry. Do not bill for LABS.
3	Do not charge for lab work. Let Lab Corp charge.
5	Patient always pays in cash.
PA	Private Account

Figure 73. Patient Alerts List screen

The table below describes the elements on this screen.

Elements	Description
Search for	Enter a Code to search for. As you type characters, the grid will automatically filter.
? button	Click to open the Locate Patient Alert screen, which you can use for advanced searching.
Field	Select the type of data to search for, either Code or Description
grid	This shows you the list of codes. Note that in the Description column, you will only see the first line of an Alert Codes that have multiple lines in their Description fields.
Edit button	Click this button to edit a selected alert in the grid.
New button	Click this button to create a new alert.
Delete button	Click this button to delete a selected alert in the grid.
Print Grid button	Click this button to print the information in the grid.
Close button	Click this button to close the List screen.

Patient Alert Code Entry

Use this screen to create and edit alerts. You can give the alert a description and specify on which areas of CGM MEDISOFT you want the description/message to open.

Figure 74. Patient Alert Entry screen

The table below describes the elements on this screen.

Element	Description
Code 1	Use this field to enter a code for the alert, up to 9 characters.
Inactive	Select this check box to mark the alert as inactive.
Description	Use this field to enter a description of the code. This information will appear on the Alert Popup when it is triggered on one of the 4 screens. This field can be up to 70 characters.
Display on new/edit Appointment in Office Hours	Select this check box if you want this alert to display when a patient is selected in Office Hours appointments.
Display on new/edit Transaction Entry	Select this check box if you want this alert to display when a patient is selected in Transaction Entry.
Display when editing Patient Record	Select this check box if you want this alert to display when the patient's record is opened.
Display on new/edit Case	Select this check box if you want this alert to display when the patient is selected for the case.
Save button	Click this button to save the new alert or the changes for an edited alert.

Element	Description
Cancel	Click this button to close the window without saving the alert or changes to an alert.
Help	Click this button to open the Help for this screen.

Other Information tab

The Other Information tab of the Patient screen includes fields for up to five Patient Alert codes and one Free Text alert. Use these fields to select the codes or enter free text that you want to display when the patient is selected in the designated areas.

Figure 75. Patient screen - Other Information tab

In addition, there is an optional sixth, user-defined alert that is specific to that patient.

The drop-down arrow to the right of the Patient Alert Code field will display the list of existing alerts, as well as the settings of the check boxes for that alert.

Code	Description	Display in OH	Display in TE	Display in PE	Display in CE
1	PA	True	True	True	True
2	Private Account	True	True	True	True
3	Patient still has Coventry. Do not bill for LABS.	True	True	True	True
4	Do not charge for lab work. Let Lab Corp charge.	True	True	True	True
5	VIP Patient.	True	True	True	True
6	Patient always pays in cash.	True	True	True	True

Figure 76. Other Information tab - Patient Alert Codes section

Clicking the magnifying glass to the right of the Alert Code field will open a search window that you can use to find a particular code.

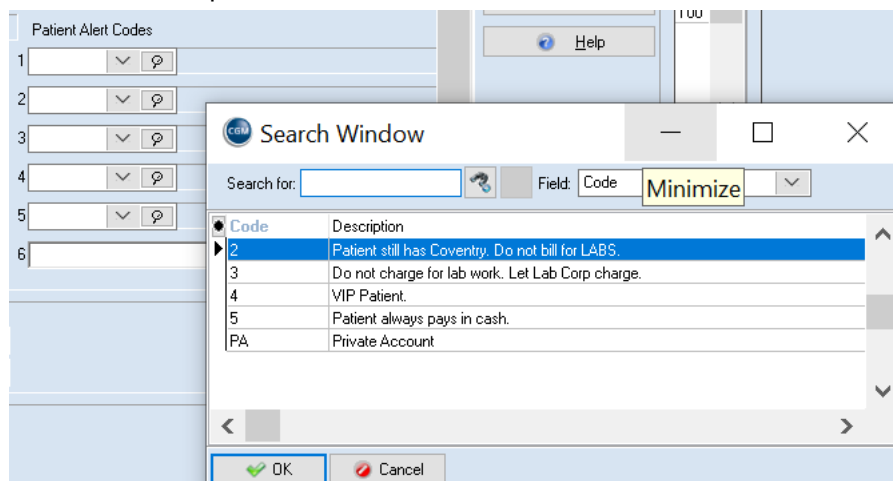


Figure 77. Search window

Patient Alert Code Messages screen

This screen will open when an alert is triggered for the patient.

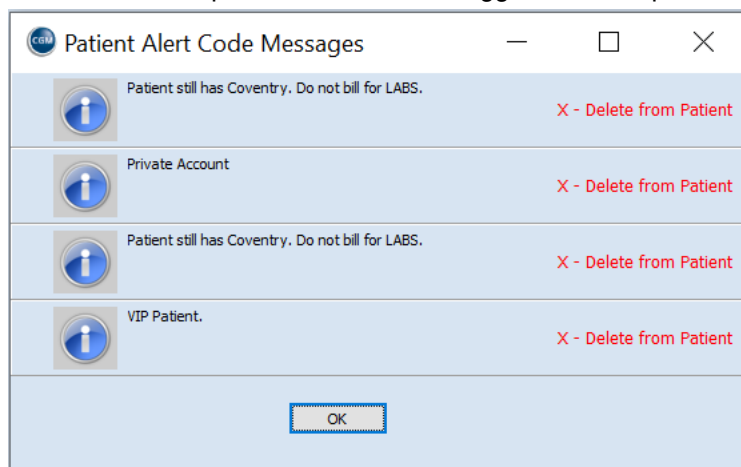


Figure 78. Patient Alert Message

When the alerts are displayed in the pop-up window, they display in the order of the code field in the patient.

The message will show ALL of the alerts specified for that patient in that area. For example: if you have 2 alerts flagged to display in Transaction entry and 1 to display in appointments, when you launch transaction entry for that patient, you will see the 2 transaction entry alerts; you will not see the one flagged for the appointment.

You have the option in certain places of deleting an alert from the patient's record. When you click on an alert, it will turn Red to indicate which one is selected to delete. If you click on it again to de-select it from deletion it will turn black again. If there are no red items, the cancel button will be removed.

When you do, the Cancel button will appear at the bottom of the screen.

- When you are done, click OK. Any codes you selected for deletion from the patient's record will be deleted and you can continue your work.

Click Cancel if you have clicked on the X to delete and change your mind to keep the alerts in the patient's record. Then, click OK to close the screen and continue your work.

Due to record-locking limitations, the Delete from Patient option on the pop-up window is not available when the pop-up displays when accessing the Patient or from Transaction entry.

Chapter 16 - Cases

Transactions in CGM MEDISOFT are generally case-based. A case is a grouping of procedures or transactions generally sharing a common treatment, facility, or insurance carrier. You can set up as many new cases as needed for your patients, depending on changes to their insurance, treatment, diagnosis, and so on. For instance, you are treating a diabetic patient regularly and he is injured on the job. His visits regarding the work-related injury should be kept in a Workers' Compensation case, totally separate from regular visits, for legal and reporting reasons. Ideally, you would have a case for each different malady from which the patient suffers. Then, you can pull up groupings of case visits to help you evaluate the patient's overall health status. By pulling a case that contains all diabetic treatments, one for high blood pressure, one for angina, and one for cancer, you get a better picture of the full range of health problems.

TIP: If a patient comes for a one-time treatment, you can create a transaction for that treatment without creating an entirely new case. Just select different diagnosis codes in Transaction Entry when creating the transaction.

Creating a Case

To create a new case for a patient:

1. On the Lists menu, click **Patients/Guarantors and Cases**. The Patient List screen appears.
2. In the top right of the screen, click **Case**. The buttons on the Patient screen change.
3. Click the **New Case** button. The Case screen appears.

Case: AGADW000 Again, Dwight [Broken Hand]

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | EDI | Custom One

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition

Case Number: 2

Description: Broken Hand

Global Coverage Unit: [dropdown]

Guarantor: AGADW000 | Again, Dwight

Marital Status: Married | Student Status: Non-student

Employment

Employer: READ | Really Useful Trucking Co.

Status: Full time

Retirement Date: [dropdown] | Work Phone: (602)457-3326

Location: [text] | Extension: [text]

Patient Information

Name: Again, Dwight | Home Phone: 434-5777

Address: 1742 N. 83rd Ave. | Work Phone:

Phoenix, AZ | Cell Phone:

85021 | Date of Birth: 3/30/1932

Save | Cancel | Help

View BF Strms

Eligibility...

Face Sheet

Set Default

Patient Intake

Patient Resp. Estimate

Estimate History

Case: 2

Figure 79. Case screen - Personal tab

CGM MEDISOFT will pull information from the patient's record into the case record automatically.

4. Complete the fields on each tab as is applicable for the new case. Be as complete as you can, since much of this information will be sent when you file claims.

Tab	Description
Personal	Use this to enter general information on the new case and employer information.
Account	Use this to enter the provider, referral, and attorney information set up in the Address file. Also enter billing and price codes and information on visit authorization, including the number of visits.
Diagnosis	Use this to enter diagnosis codes for this case.
Condition	Use this to enter information pertinent to the illness, pregnancy, or injury, and tracking of symptoms. Also enter dates relative to the condition, plus Workers' Compensation information.
Miscellaneous	Use this to enter supplemental information such as lab work charges, whether the lab is in-house or outside, Referral and Prescription Dates, Local Use A and Local Use B fields, case Indicator code, and prior authorization.
Policy 1, 2, 3	Use this to enter up to three insurance carriers for the patient, including policy and group numbers, and Insurance Coverage Percents by Service Classification (how much the carrier pays for certain types of procedures). The service percentage classification is tied to each procedure code. A Deductible Met check box is provided in the Policy 1 tab. When the patient meets his or her deductible obligation for the year, select this check box and the status is displayed in the patient account detail of the Transaction Entry screen. The three tabs have the same layout, except Policy 1 has fields for Capitated Plan and Co-Pay Amount and has the Deductible Met check box; Policy 2 has a field for Crossover Plan; and Policy 3 can be set up for tertiary or third-party involvement.
Medicaid and TRICARE	Use this to enter all submission numbers, reference, and data for each carrier. Also, enter branch of service information. Within the Medicaid and Tricare tab are EPSDT and Family Planning indicators, required submission numbers, and reference data for the case. It also includes service information for TRICARE claims.
Multimedia tab (Network Professional only)	Use this to add images to your patient records.

Tab	Description
Comment (Advanced and CGM MEDISOFT Network Professional)	Use this to enter notes to be printed on statements.
EDI	Use this to enter information for electronic claims specific to this case.

5. Click the **Save** button.

Copying a Case

In CGM MEDISOFT, you can copy an entire case to help save you time. To do so

1. On the Lists menu, click **Patient/Guarantor and Case**. The Patient List screen appears.
2. Highlight the patient whose case you want to copy. The existing cases for that patient appear in the right pane of the Patient screen.
3. Highlight the case you want to copy.
4. Click the **Copy Case** button.
5. The Case screen appears with the data copied.
6. Modify the case data for the new case.
7. Click the **Save** button.

Customizing the Case screen

In CGM MEDISOFT Advanced and CGM MEDISOFT Network Professional, you can customize the display of the tabs. If you do not need a tab, you can hide it.

1. With the Case screen open, right-click on any tab header. A list of the tabs appears. A check mark appears next to the tabs that are currently displayed .
2. Click one of the tabs to deselect it. The tab is now hidden.
3. To display the tab again, right-click any tab header.
4. Click the hidden tab to place the check mark on it. The tab appears again.

Scanning

You can scan insurance cards, and other documents, directly into CGM MEDISOFT.

Supported scanners

The scanning feature requires the use of a TWAIN-compatible scanner.

For reference, the following scanners were used in successful testing of the scanning feature. This is not an exclusive list and other TWAIN-compatible card scanners may also be compatible.

- ScanShell 800DX and 800DXN

- ScanShell 800N, 800R, 800NR
- ScanShell 1000N, 1000A, 1000NA
- ScanShell 2000N

- Ambir DS490
- Ambir DS687
- Ambir PS667
- Ambir PS600

- TTScanner

- Fujitsu 6130z

- Brother MFC 8680DN
- Canon PIXMA MX 452

Important notes:

- eMDs does not provide support for individual scanner hardware or software questions.
- if you are working with Terminal Services or a Remote Desktop Protocol, you will need additional software to connect a scanner to CGM MEDISOFT, such as TSscan. Also, eMDs recommends that you close CGM MEDISOFT prior to disconnecting a remote session.
- Be sure to set up and install the scanner on your computer or network before attempting to scan images from within CGM MEDISOFT.
- New installations may change the previously-selected scanner. Be sure to check which scanner is selected prior to performing a scan.

Scanning tips

- eMDs recommends that you use a dedicated insurance card scanner for scanning insurance cards.
- Since scanning images into your database will increase its size and possibly affect the performance of CGM MEDISOFT, use the lowest acceptable resolution and size for your images
- When using duplex, insert the insurance card slightly off the side rail (sometimes a ¼ to ½ inch). This will cause the duplex images to be centered on the scan page. Additionally, the card should be inserted with the long-edge into the scanner, usually upside down and top-in.

Case - Policy tabs

The Policy tabs have fields and options that allow you to scan insurance cards. Once the card is scanned, you can preview the front and back images for the card.

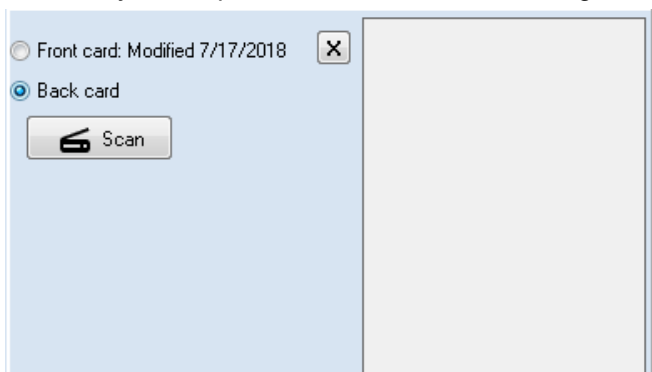


Figure 80. Case - Policy tab

The table below describes the fields and buttons on this section.

Element	Description
Front Card radio button	Select this button to scan or view the front of the insurance card.
Back Card radio button	Select this button to scan or view the back of the insurance card.
Delete icon	Click this icon to delete the selected scan. Note: These icons only appear when there is a scan for the front or back card or both.
Scan button	Click this button to scan a card or load an image from a file. Clicking this button will open the Multimedia Entry modal. This button will be disabled if there are already two images (one for front and one for back) scanned for the policy and case. If you need to change the card, first delete the existing scans and then you will be able to scan the new card.
Preview area	This area shows you a preview of the card. This area is gray when no image is selected. Clicking the image will display the image in the multi-media modal.

Scanning tip

If you accidentally scan an insurance card to the wrong insurance policy and no longer have access to the card, you can use the following steps to move the scans from one Policy tab to the other.

1. Open the case and the Policy tab that has the wrong scan.

2. Select the Front Card.
3. Double-click the scan in the preview pane. This will open the Multimedia entry screen.
4. Click the **Save to File** button.
5. Give the scan a name and save it.
6. Click **Cancel** on the Multimedia Entry screen.
7. Select the Policy tab where you want the scan to be saved.
8. Select the Front Card radio button and click **Scan**. The Multimedia Entry screen opens.
9. Click the **Load from File** button.
10. Find the file you saved and click Open.
11. Click **Save**. The scan appear on the Policy tab.
12. Click **Save** on the Case screen.
13. Repeat for the Back Card scan.
14. On the Policy tab that has the wrong scan, click the X button next to Front Card and Back Card to delete the incorrect scans.

Multimedia Entry screen

You can also use the Multimedia Entry modal to scan an image into CGM MEDISOFT from within the screen.

The table below describes the elements on this screen.

Element	Description
Description	Use this field to enter a description of the image you are scanning. Note: if you open this screen from a Policy tab, the description will be either “front card” or “back card”, depending on which radio button is selected on the Policy tab.
Note	Use this field to enter a note on the image you are scanning. The information you enter here will not appear on the Policy tab but will be available if you double-click the image preview on the Policy tab.
Show on Patient Screen	Select this check box if you want to scan to appear as a thumbnail on the right side of the Patient’s record. Note: this check box is hidden when you open the Multimedia Entry screen from the Policy tab. Scans made from the Policy tab are for insurance cards only.

Element	Description
Scanner Name	Use the drop-down to select a scanner. Only the last-used scanner (per Windows user) will appear when you open the Multimedia Entry modal and use the drop-down. To get a full list of scanners, click the Refresh Scanners button. This drop-down will be empty until you click the Refresh Scanners button. At that time, a list of scanners will appear. Once you have scanned and saved, the scanner name will automatically appear in the drop-down. Note: scanners must be installed or set up prior to using this feature. For a list of supported scanners, see “Supported scanners” on page 89.
Refresh Scanners button	Click this button to refresh the list of scanners that will appear in the Scanner Name drop-down.
Disable duplex check box	Select or clear this check box when using a duplex scanner to choose single sided or duplex scanning. If the system can detect your scanner only allows single sided this will be disabled. If you clear this check box, the scanner will scan both sides of the document and create a single image with both sides. if you opened the Multimedia Entry modal from a Policy tab, the combined image will be placed in the selected option on the Policy tab, either front card or back card.
Color radio button	Select this option if you want to scan in color. Note: scanning in color can increase the size of the image file. For best contrast and readability, color is the best scanning method.
Black White radio button	Select this radio button if you want to scan in black and white.
Resolution	Use this field to select the resolution. Note: higher resolutions will create larger image files. eMDs recommends that you use the lowest setting that creates an acceptable image.
Scan button	Click this button to scan the image. The completed, scanned image will appear in the preview area below.

Element	Description
Zoom in	Click this button to zoom in on the scanned image in the preview area. This is for viewing only. You cannot save the zoomed image.
Zoom out	Click this button to zoom out on the scanned image in the preview area. This is for viewing only. You cannot save the zoomed image.
Crop Picture	Click this button to crop the scanned image. You must select the area to be cropped before clicking this button.
Rotate Right 90	Click this button to rotate the image right 90 degrees.
Rotate Left 90	Click this button to rotate the image left 90 degrees.
Flip Horizontal	Click this button to flip the image horizontally.
Flip Vertical	Click this button to flip the image vertically.
Image area	This section of the screen shows you the scanned image.
Image thumbnail	The image thumbnail appears to the right of the image preview area.
Print Image	Click this button to print the image on paper.
Save to File	Click this button to save the image as a file on your computer.
Load from File	Click this button to load an image saved on your computer into the image area. In this way, you can insert a saved image into your patient's record. The following image formats are supported: • bmp • jpg • tif • gif • png Note: The Load from File button will remain active after you scan a document from the Multimedia Entry screen. Consequently, eMDs recommends that you save any scan prior to using the Load from File feature/button.

Element	Description
Save button	Click this button to save the image in CGM MEDISOFT. • If you were scanning from the Case-Multimedia tab, your image will appear on the list of images on the Case-Multimedia tab. • If you were scanning from a Policy tab, the image will appear on the Policy tab. Images are only saved to the case once when the Case is saved.
Cancel button	Click this button to undo any scan or changes to a scanned image and close the screen.
Help button	Click this button to open the Help file for this screen.

Procedures

Note: the steps may vary depending on your scanner. For some scanners you must place your document on the scanner and for others you can “feed” your documents to the scanner.

Scanning from a Policy tab

To scan an insurance card from a Policy tab:

1. In CGM MEDISOFT, open the case and select the appropriate Policy tab.
2. Select either Front card or Back card.
3. Place the card on the scanner.
4. Click the **Scan** button. The Multimedia Entry screen opens.
5. Enter any note and select a scanner.
6. Complete the options and click the **Scan** button. The image will preview in the Viewing area.
7. Manipulate the image as necessary and click the **Save** button.

Deleting an image on a Policy tab

To delete a scanned card on a Policy tab:

1. Click the X icon to the right of the front card or back card radio button.
2. Click **Yes** to confirm.

Chapter 17 - Transaction Entry Alerts

Transaction Entry Alerts enable you to have messages appear when you save transactions during transaction entry or while posting unprocessed charges from the Edit screen, allowing you to scrub the claim immediately while the transaction is still open. You can create message using a variety of data in CGM MEDISOFT and have them appear when a transaction is saved. Multiple messages can be triggered simultaneously and will all appear in a new popup screen.

For instance, you may want to alert:

- When a certain procedure code is present at the same as another procedure and should not be billed together.
- When an admin procedure code is missing and should be billed with another transaction on the same bill.

Transaction Entry Alert List screen

This screen shows you a list of the Transaction Entry Alerts that have been created.

The table below gives a description of the elements on this screen.

Element	Description
Grid Layout button (top left)	Click this button to modify the list of fields that appear in the List grid. This option is available for all versions of CGM MEDISOFT, including CGM MEDISOFT Basic.
Search for	Enter the information you want to search for. As you type, the list will filter. This search is like all others in CGM MEDISOFT and is a 'Starts with' search.
? button	Click this button to open the Locate Transaction Entry Alert screen, which you can use to perform a search. For more information, see "Locate Transaction Entry Alert screen" on page 100.
Partial Match check box	Select this check box if you want CGM MEDISOFT to search for partial matches to the item in the Search for box. This is a 'Contains' search which looks for a partial match anywhere in the selected field.

Element	Description
Field (Procedure Code/Message drop-down)	Select either Procedure Code or Message to specify the type of information you want to search for. The column header of the field that you select here will change to a blue color in the grid column header to show you which field is being searched in.
Grid	The grid area shows you the details of each message that has been created. By default, only active records appear. To modify the columns in the grid, click the black dot at the top left of the grid. This will open the Grid Columns screen. If multiple items were selected for a criterion, you can see them in the columns. You can double-click an item in the grid to open the Transaction Entry Alert screen for that item.
Edit button	Click this button to edit an existing alert. Highlight the alert you want to edit and click Edit. This button will be disabled if no alerts have been created or the user does not have Edit permission. If you attempt to edit an alert at the same time as another user, you will receive a notice.
New button	Click this button to open the Transaction Entry Alert screen, on which you can create a new message. For more information, see “Transaction Entry Alerts screen” on page 101. This button will be disabled if the user does not have New permission.
Delete button	Click this button to delete an existing alert. You will see a confirmation screen before the alert is deleted. This button will be disabled if no alerts have been created or if the user does not have Delete permission.

Element	Description
Print Grid button	Click this button to print the grid section of the Transaction Entry Messages List screen. This button will be disabled if no alerts have been created. Important: The fields Diagnosis, Modifier, and Other Procedure(s) will appear as either 0 or 1 when you print the grid, where 0 means Missing and 1 means Present. Tip: as with any report with many columns that cannot easily fit on a printed page, you may want to print in Landscape format and limit the columns to the most important for easier viewing. Note: The Permission to print the grid is controlled by the Reports/Print Grid permission.
Import button	Click this button to import a set of alerts from another practice. When you click the button, the Open screen will open. For more information, see “Import Alerts” on page 103 .
Export button	Click this button to export the active alerts to another practice. When you click the button, the Save As screen will open. Enter a name for the file and select a folder on the computer where the file will be placed. Note that extension of the file will be *.TEA.
Close button	Click this button to close the screen.

Right-click menu

There is a right-click menu on the Transaction Entry Alerts List screen that you can use to perform actions on a selected item in the list.

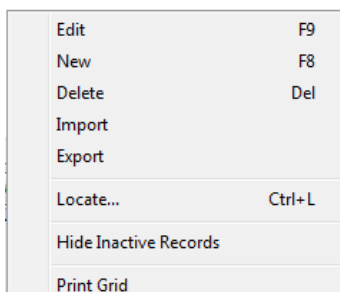


Figure 81. Right-click menu

The table below describes the options on this menu.

Option	Description
Edit	Select this option if you want to edit the selected alert.
New	Select this option if you want to create a new alert.
Delete	Select this option if you want to delete the selected alert.
Import	Select this option to import alerts into your practice.
Export	Select this option to export alerts from your practice to a file.
Locate	Select this option if you want to locate a term or information in the list of alerts. Selecting this option will open the Locate Transaction Entry Alert screen, which you can use to locate the term. For more information on this screen, see “Locate Transaction Entry Alert screen” on page 100 .
Show Inactive Records	Select this option if you want to see alerts that have been marked as Inactive.
Print Grid	Select this option if you want to print the list of alerts. The fields Diagnosis, Mod(ifier), and Other Procedure(s) will appear as either 0 or 1 when you print the grid, where 0 means Missing and 1 means Present. Note: The permission to print the grid is controlled by the Reports/Print Grid permission.

Locate Transaction Entry Alert screen

This screen will open when you select Locate on the Right-click menu or when you click the ? button on the Transaction Entry Alerts List screen. Use this screen to locate a term or information in the list of alerts.

Figure 82. Locate Transaction Entry Alert screen

The table below describes the elements on this screen.

Element	Description
Field Value	Enter the value you want to locate in the list.

Element	Description
Case-sensitive	Select this check box if you want the search to be case-sensitive.
Exact Match	Select this radio button if you want to find an exact match for the value entered in the Field Value field.
Partial Match at Beginning	Select this radio button if you want to find items that partially match the beginning of the value entered in the Field Value field.
Partial Match Anywhere	Select this radio button if you want to find items that partially match anywhere with the value entered in the Field Value field.
Fields	Select the field on the List screen that you want the search to look for matching items.
First button	Click this button to start the search for the first matching value.
Next button	Click this button to find subsequent matches.
Cancel	Click this button to cancel the search and close the screen.

Transaction Entry Alerts screen

Use this screen to create or edit alerts. Once you save an alert, it will appear on the Transaction Entry Alerts List screen.

Note: if you are using keyboard controls to navigate through the fields on this screen, be sure to use the Tab key to advance. If you use the Enter key on any field other than the Message field, it will cause the data to be saved and close the screen.

The table below describes the elements on this screen.

Element	Description
Message	Use this field to enter the message you want to appear on the popup when this alert is triggered. This is a required field. Messages appear in the Transaction Entry Alert pop-ups in alphabetical order, with numbers and special characters appearing first. So, for example, if you want a certain message to always appear first in the list of messages, you could place a 1 or an asterisk at the beginning of the message.
Inactive check box	Select this check box if you want this alert to be inactive. It will no longer appear in the Transaction Entry Alert List screen by default and will no longer provide an alert message.
Insurance	Use the Lookup button to select Insurances to trigger a message. You can select one or more insurances. To clear the Insurance field, click the X icon to the right.

Element	Description
Insurance Class	Use the Lookup button to select Insurance Classes to trigger a message. You can select one or more classes. To clear the Insurance Class field, click the X icon to the right.
Insurance priority check boxes	Select which insurance priorities will apply to this alert. • If an insurance carrier or insurance class is selected, at least one check box must be selected. • If one or more insurance carriers or insurance classes are selected AND no priority check box is selected, all three will be selected by default. • If you clear the insurance carrier and/or insurance class data, the check boxes will NOT be cleared automatically.
Facility	Use the Lookup button to select Facilities to trigger a message. You can select one or more facilities. To clear the Facility field, click the X icon to the right.
Assigned Provider	Use the Lookup button to select Assigned Providers to trigger a message. You can select one or more providers. To clear the Assigned Provider field, click the X icon to the right.
Attending Provider	Use the Lookup button to select Attending Providers to trigger a message. You can select one or more providers. To clear the Attending Provider field, click the X icon to the right.
Procedure Code	Use the Lookup button to select Procedure Codes to trigger a message. You can select one or more codes. To clear the Procedure Code field, click the X icon to the right. You can also type a code or codes into this field.
Modifier	Enter any modifiers that you want to trigger a message.
Alert when information is all missing/any present	Select if you want the alert to be triggered by the presence or absence of the modifier. Alerts will trigger is ALL of the items are missing or if ANY of the items is present.
Diagnosis	Use the Lookup button to select Diagnosis Codes to trigger a message. You can select one or more codes. To clear the Diagnosis Code field, click the X icon to the right.
Alert when information is all missing/any present	Select if you want the alert be triggered by the presence or absence of the diagnosis code. Alerts will trigger is ALL of the items are missing or if ANY of the items is present.
Alert when other procedures are missing/ present	Select if you want the alert be triggered by the presence or absence of additional procedures codes.

Element	Description
Procedure Code	Use the Lookup button to select Procedure Codes to trigger a message. You can select one or more codes. To clear the Procedure Code field, click the X icon to the right.
Modifier	Enter any modifiers that will trigger a message. The Modifier field is enabled only when the 'present' radio button is selected AND one or more procedures are selected. If a modifier is selected and then the radio button is changed to 'missing', the data is removed from the field and it is disabled.
Diagnosis	Use the Lookup button to select Diagnosis Codes to trigger a message. You can select one or more codes. To clear the Diagnosis Code field, click the X icon to the right. The Diagnosis Code field is enabled only when the 'present' radio button is selected AND one or more procedures are selected. If a code is selected and then the radio button is changed to 'missing', the data is removed from the field and it is disabled.
Save button	Click this button to save the information for this alert.
Cancel button	Click this button to discard any changes or new information and close the screen.
Help button	Click this button to obtain help for this screen.

Note: Although there is no multi-select on the fields in this screen, you can select items one at a time from list and then repeat as needed, or you can manually type in codes and separate them with a comma.

Rules examples:

- All the fields for the alert rules are AND conditions. So if you have an Insurance listed as part of a rule AND two Procedure codes, your transactions/charges must have BOTH that Insurance AND one of the Procedure codes. This is true of all other fields, EXCEPT when both Insurance Code and Insurance Class have an entry. In that case, it is an OR condition. That is, only ONE of them needs to be part of the transaction/charge.
- When entering multiple items in any field where the alert is looking for the codes to be present: the alert will appear when ANY of the codes are present. For example, you create an alert with the following Procedure codes entered in the upper section of the screen: 99213,99214,99214,99215. An alert will be triggered if your charges have ANY of these codes.
- If you enter the following Diagnosis codes in the top section with the All Missing radio button selected: E10.8, I73.9. An alert will be triggered only if your charges are missing both (**all**) of these diagnosis codes. If one is present it will not trigger.
- When you add something in the Other procedure section at the bottom of the screen, an alert will be triggered when your charges meet the criteria in the top section AND this section.

Import Alerts

Use the Open screen to import a set of rules from another practice or computer. When the screen opens, search for a file that has the extension *.TEA

Select the file to import and click Open.

Note: If you import rules from one practice to another practice that does not contain some of the codes selected in a rule, the rule will import but would not fire when entering charges. You will need to 'fix' the rule in the new practice. Example. Practice A exported rules that have a rule for CPT 99213 and Attending provider ABC. Rules are imported to Practice B that does not have provider ABC. If the rule applies to Practice B, change the provider code to one that is in this practice or remove it to apply to all.

Transaction Entry Alert pop-up

Alerts will compare transactions with the same Document/Superbill number against the rules. When the conditions for a message are met when you are saving a transaction (either a new transaction or one that you have added items to, or edited), or posting unprocessed charges, the message is triggered and appears on the screen when saved. If multiple messages are met, you will see all of them on the message screen.

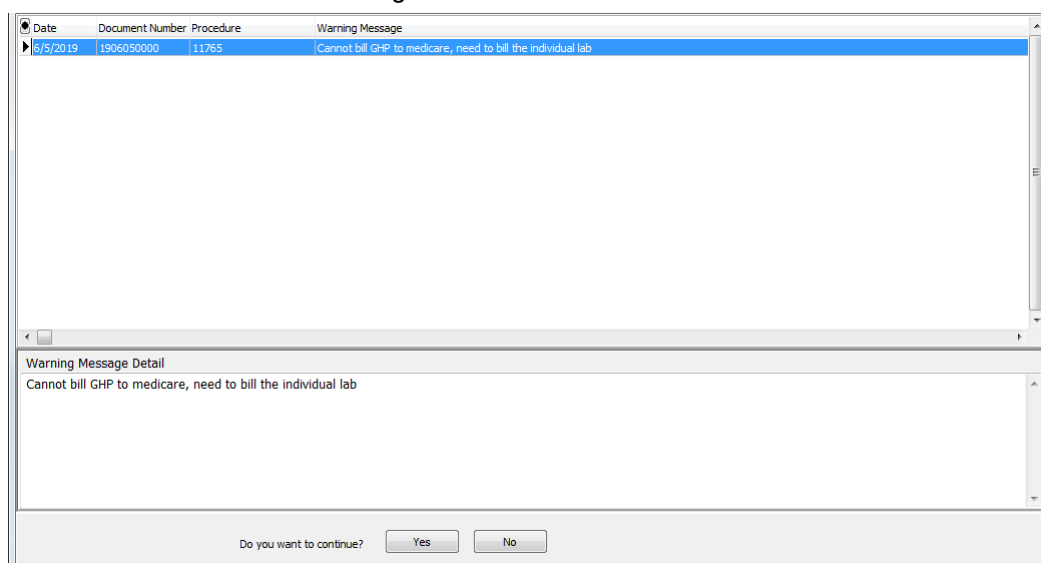


Figure 83. Transaction Entry Alert pop-up

The table below describes the elements on this screen.

Element	Description
Date column	This column shows the date of the transaction/service line from Transaction Entry.
Document Number column	This column shows the document number/Superbill associated with the transaction/service line in Transaction Entry.
Procedure column	This column shows the procedure codes associated with the message. Multiple codes may appear here. The presence of indicates that there are more codes than can fit in the column. You can widen the column if necessary to see all the codes.

Element	Description
Warning Message column	This column displays the text of the message that was activated. Messages will appear in alphabetical order based on the first letter of the message.
Memo field	This field shows you the selected message in full.
Yes button	Click Yes to continue saving the transaction.
No button	Click No to return to the Enter Transactions screen so you can make changes.

Note: a hover over will display the entire text of the message when you move the cursor over the message line.

Rules

All of the criteria for a rule must be met before a pop-up will appear.

If multiple rules are met, all of the messages will appear on the same pop-up in alphabetical order

If you add a line item to an existing transaction, the new line item and other line items with the same document number will be checked for messages.

For Procedure codes that are assigned for Patient Only Responsible, the alert will not appear if that procedure code is part of the alert and there is an Insurance Code or Class.

Tip: if you want alerts to appear for patient responsible amounts, leave the Insurance Class and Code fields empty.

Regarding Diagnosis codes, CPT Modifiers, and Other Procedure:

- If the Diagnosis or Modifier is set for "Any Present" and there are multiple values in the alert, then just one needs to be present
 - If the Diagnosis or Modifier is set for "All Missing" and there are multiple values in the alert, then ALL values need to be missing.
-

If you are not displaying Document Number or Superbill number at the top of Transaction entry, this feature will still work since each transaction is assigned a document number in the database. You may want to add the Document number field to the charges grid to more easily see which transactions are tied to the same document number.

Chapter 18 - Entering Transactions

Use the Transaction Entry screen to enter charges for procedures performed on patients. You can also enter co-payments here or adjustments to the patient's bill. When you open the screen and select a Chart (patient) and case number, CGM MEDISOFT automatically collects information from the patient and case records and displays it in the screen. The top right section of the screen shows you the patient's balance, insurance information, and aging.

CGM MEDISOFT is an Open Item Accounting program, meaning that transactions entered are marked when paid but remain on the active ledger as long as the case is active. There is no clearing of the ledger and bringing up a total to start a new month, as with a balance forward program.

To open Transaction Entry:

1. On the Activities menu, click **Enter Transactions**. The Transaction Entry screen appears.
2. Select or enter a Chart (patient). The screen fills with patient information, including a Case number.

You can choose a default for the case number that appears on the Data Entry tab in Program Options.

3. If necessary, change the case number.
4. To add a new charge, click the **New** button in the Charges section of the screen.
5. Select a Procedure and complete the remainder of the fields on the new charge line. Some of the information will be filled in automatically.
6. Enter further charge lines as necessary.
7. If you need to enter a patient's co-payment or other payments/adjustments, click the **New** button in the Payments, Adjustments, and Comments section of the screen.
8. Select a Pay/Adj Code and complete the line.
9. To apply this payment to a charge, click the **Apply** button. The Apply Payment to Charges screen appears.
10. Click in the This Payment check box and enter the amount to be applied.
Option: Use the Apply to CoPay or Apply to Oldest buttons to automatically apply the payment.
11. Click the **Close** button. Note that the Unapplied amount on the payment line changes.

WARNING: eMDs recommends that you apply all payments and adjustments to charges. Failure to do so results in other parts of CGM MEDISOFT not functioning properly, i.e., remainder billing and the delay secondary billing feature (Advanced and CGM MEDISOFT Network Professional), to name only two. In addition, some report results will be incomplete or inaccurate.

12. Click the **Tax** button if you need to add sales tax to the charges.
13. Click the **Note** button if you need to add further detail for a charge line. This may include detail for claims.
14. Click the **Save Transactions** button.

Unprocessed Transactions

The Unprocessed Charges screen provides an interface between an Electronic Medical Records (EMR) service and CGM MEDISOFT via McKesson Practice Interface Center (see “[McKesson Practice Interface Center \(MPIC\)](#)” on page 187) or a mobile device (CGM MEDISOFT Network Professional only). Transactions that come from the EMR appear here in an unposted state. As long as they are unposted, they will not be part of patient accounts and you cannot file claims on them or bill patients for them.

To open this screen:

1. On the Activities menu, point to Unprocessed Transactions and click **Unprocessed EMR Charges**. The Unprocessed Charges screen appears with a list of transactions that have yet to be posted.

ID	Post	Transaction Status	Chart Number	Case	Provider	Date	From	Diagnosis Code_1	Diagnosis Code_2	Diagnosis Code_3	Diagnosis
696c9f	☐	x	PALT1000	-1 JM	3/9/2007	E 416.0					
a0017f	☐	x	JACTH000	-1 JM	3/9/2007	E 110.4					
432a9f	☐	✓	AGADw000	17 JM	3/9/2007	E 535.5					
440a6f	☐	x	PETMO000	18 JM	3/9/2007	E 708.9					
d67edf	☐	✓	BRIJA000	3 JM	3/9/2007	E 786.09					
5c168f	☐	✓	BRIJA000	3 JM	3/9/2007	E 786.09					
2c2b9f	☐	✓	BRIJA000	3 JM	3/9/2007	E 786.09					

☒ Align Dx Codes during Posting

Refresh Edit Help Post Close

Figure 84. Unprocessed Charges screen

If there is a red or yellow x in the Transaction Status column for a line, click the **Edit** button to open the details and see the problem with the transaction. A red x indicates an error with the transaction that will likely cause it to fail claim scrubbing. A yellow x indicates a warning, such as a mismatch in an ICD code set version.

Any notes associated with a transaction, usually coming from a mobile device, will appear as an icon in the unlabeled column.

2. Select the check boxes in the **Post** column for the transactions you want to post.
3. Click the **Post** button to update your patients' accounts.

Chapter 19 - Quick Ledger and Quick Balance

In this chapter you will learn about the Quick Ledger and Quick Balance features in CGM MEDISOFT.

Quick Ledger

NOTE: This is an Advanced and CGM MEDISOFT Network Professional feature.

The Quick Ledger gives a quick reference for transaction and other information in the patient's account. There are two types of Quick Ledgers in CGM MEDISOFT: the Patient Ledger and the Guarantor Ledger.

The Patient/Quick Ledger displays transaction information and account totals for individual patients. The Patient Ledger is the default ledger.

To open the Patient Ledger:

- On the Activities menu, click **Patient Ledger**.

The Guarantor Ledger provides the same information as the Patient Ledger but allows you to view guarantor totals as well.

To get quick and easy access to a patient's ledger from almost anywhere in CGM MEDISOFT, press **F7** or click the Quick Ledger speed button.

To open the Guarantor Ledger:

- On the Activities menu, click **Guarantor Ledger**.

While no new transactions can be made in the ledger itself, you can edit and print the ledger and gain valuable detail on patient accounts.

You can change responsibility for a selected transaction in the Quick Ledger screen. Right-click a transaction to change its responsibility between insurance carriers or from an insurance to the patient. This feature lets you skip entering the zero-dollar insurance payment to indicate that no payment is coming from the insurance carrier.

Click the **Edit** button or press **F9** to open the Transaction Entry screen where charges, payments, and adjustments can be reviewed and edited, as needed. Both the Patient and the Guarantor Ledgers let you view the notes entered for transactions and also add a note.

Click the **Payment Detail** button to display all payments/adjustments made toward a specific charge.

TIP: If you click the **Quick Statement** button, you will print statements from the Reports menu. If you click **Statement**, you will print statements from Statement Management. For more information in creating and printing statements, see [“Creating Statements” on page 119](#).

Quick Balance

NOTE: This is an Advanced and CGM MEDISOFT Network Professional feature.

The Quick Balance is a summary of all remainder charge totals for a selected guarantor record.

To open the Quick Balance screen:

- On the Activities menu, click **Quick Balance**.

Chart Number	Patient Name	Amount
--------------	--------------	--------

Guarantor Remainder Total: \$

Print Close View Statements

Figure 85. Quick Balance screen

If the record selected is a guarantor's record, the Quick Balance screen displays each patient for whom the guarantor is responsible and the total qualifying remainder charges for each. If the record selected is not a guarantor's record, you will see a listing of all the selected patient's balances.

TIP: If you click the **Print** button in Quick Balance, you will print statements from the Reports menu. For more information in creating and printing statements, see ["Creating Statements" on page 119](#).

Chapter 20 - Creating Claims

In the chapter you will learn how to create claims in CGM MEDISOFT.

Claim Management

This section explains briefly how to manage claims in CGM MEDISOFT and includes creating, editing, printing/reprinting, and listing claims, as well as changing claim status.

The Claim Manager's Job

To help you better understand the function of claim management, consider this shipping analogy. Whereas Cases are containers filled with claims for specific diagnoses, claim management is the process by which the cases are checked, sorted, and delivered. In other words, claim management is the process of making sure all shipments are correct, ready to be sent, and shipped to the right companies (insurance carriers).

The Claim Manager (the person performing claim management) checks the claims, makes sure the boxes are properly marked, and sends them on their way. The Claim Manager determines whether the shipment goes by truck (paper claims) or by air (electronic claims). When a box is returned (rejected claim), the Claim Manager makes whatever changes are necessary (with help from the EOB or Audit/Edit Report) and ships the box again (resubmits the claim).

One person sees and treats the patients; another person enters data from the superbill (see ["Superbill" on page 188](#)) to begin the billing process. Once all the data has been entered, it must go through the Claim Manager's office before being sent to an insurance carrier.

The Claim Manager focuses on three principal areas, not necessarily sequential: review, batch, and final review.

- **Watchdog:** The Claim Manager is, first of all, the watchdog of the claims. The Claim Manager checks each claim and verifies the numbers, having the authority to edit the claim and make needed changes. If there is something in the claim that should go to a different carrier than indicated, or if the EDI receiver information is incomplete, the Claim Manager corrects the record. The Claim Manager also has access to the insurance carrier records and checks the billing date and how the claim is to be sent, either by paper or electronically. Then, the Claim Manager can indicate the status of the claim.
- **Batch 'em up!** The function of creating claims serves to group claims that are headed to the same destination. The Claim Manager gathers and sorts by range of dates or chart numbers. Transactions can be selected that match by primary carrier, Billing Code, case indicator, or location. Random Billing Code numbers can be selected. The Claim Manager can also indicate a minimum dollar amount for creating the claims, eliminating claims too small to be worth billing.
- **Reviewer:** There is also a List Only button that allows the Claim Manager to retrieve claims that match certain criteria that have been determined. The List Only Claims That Match screen is a "show me" screen that lets the Claim Manager review all that is in CGM MEDISOFT.

Besides these three focus areas, the Claim Manager also has responsibility to mark claims that are paid and those that are rejected.

- **Marking paid claims:** The date of submission in the Claim Management screen indicates when the claims were shipped or transmitted. Claims are marked under the designation of “Sent” and the date is automatically inserted. The claims stay in Claim Management marked as “Sent” until they are manually changed in the Claim edit screen as having been received and dispatched by the carrier. When a payment is received, use the EOB to enter all payments through transaction entry.
- **Handling rejected claims:** When a paper claim is rejected for payment by the insurance carrier, the Claim Manager can change the payment status in the Claim Management screen from “Sent” to “Rejected.”

Creating Claims

To perform claim management functions, use the Claim Management screen. Here is where you create, edit, and print claims. Claims that will be sent electronically are created here but sent with Revenue Management, an integrated application that will send claims and receive payments. For more information on Revenue Management, see [“Electronic Claims Processing” on page 143](#).

To create claims:

1. On the Activities menu, click **Claim Management**. The Claim Management screen appears.

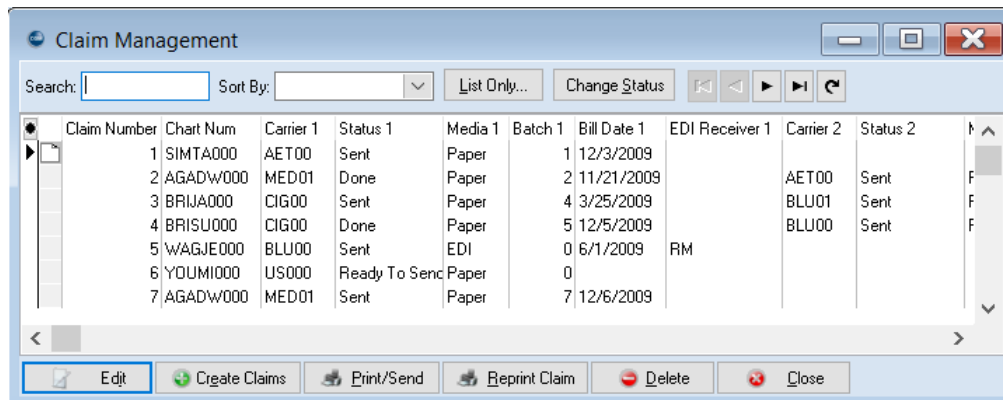


Figure 86. Claim Management screen

2. Click the **Create Claims** button. The Create Claims screen appears.
3. Use the fields on this screen to filter the ranges of dates, chart numbers, insurance carriers, and so on.
4. Click the **Create** button. The Claim Management screen appears and displays the claims that were created.

Editing Claims

If a claim is rejected by the carrier, you will have to edit it so that it contains all of the information that the carrier wants.

To edit a claim:

1. On the Activities menu, click **Claim Management**. The Claim Management screen appears.

- Highlight the claim you want to edit and click the **Edit** button. The Claim screen appears with the claim detail.

Figure 87. Claim screen

The Claim screen has several tabs that contain the information for the claim.

Tab	Description
Carrier 1, 2, 3	Use this tab to change the Claim Status, Billing Method, and the insurance carrier or EDI Receiver.
Transactions	Use this tab to see all of the transactions that are part of the selected claim. You can split, add, or remove transactions here.
Comment	Use this tab to place whatever comments you feel are necessary concerning this claim and/or any transactions relating to it. If you have CGM MEDISOFT Advanced or CGM MEDISOFT Network Professional, these notes will appear as a note icon in the Claim Management screen.
EDI Note	Use this tab to add information for EDI notes.

- Revise the information on the tabs as necessary.
- Click the **Save** button.

Printing Claims

If you print and send paper claims to clearinghouses and carriers, use the printing feature on the Claims Management screen.

- On the Activities menu, click **Claim Management**. The Claim Management screen appears.
- Click the **Print/Send** button. The Print/Send Claims screen appears.

3. Select **Paper** and click the **OK** button. The Open Report screen appears.

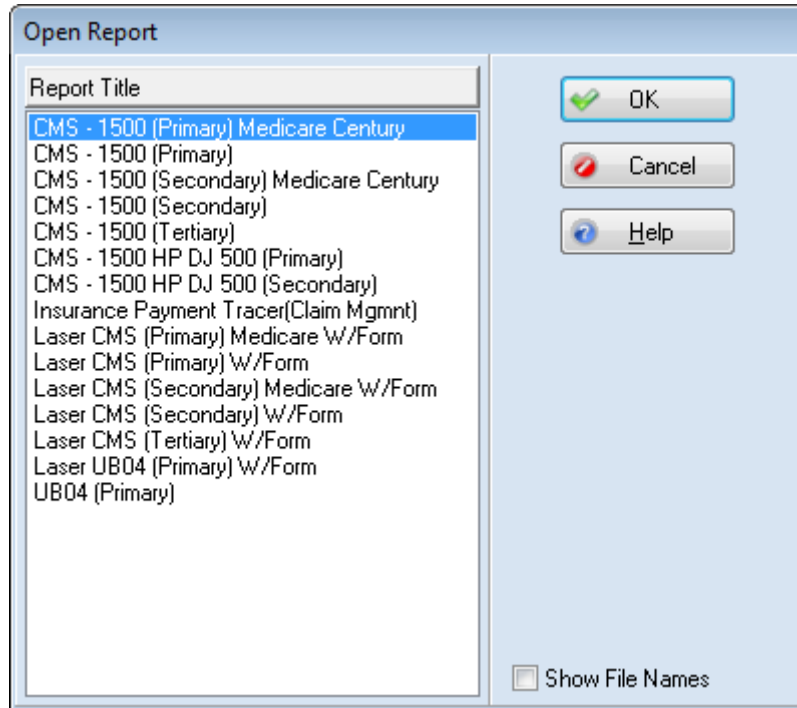


Figure 88. Open Report screen

4. Select which form you want to print on and click the **OK** button. The Print Report Where? screen appears.

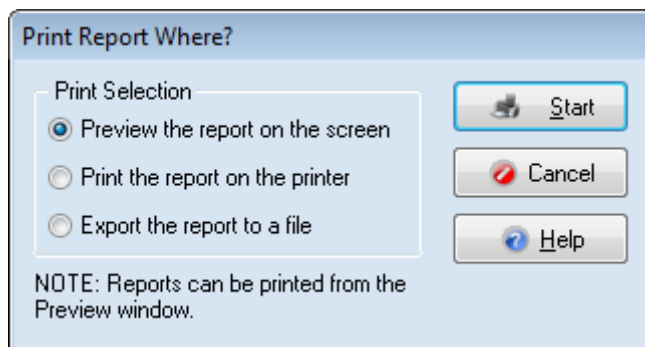


Figure 89. Print Report Where? screen

5. Select your option and click the **Start** button. The Data Selection Questions screen appears.

Figure 90. Data Selection Questions screen

6. Make your selections for the various ranges and click the **OK** button.
7. The Status of the claims will be updated to Sent on the Claim Management screen.

Troubleshooting Insurance Claims

Claim Form Not Centered

If your insurance claims are printing off-center, you can fix this with the following steps:

1. On the Reports menu, click **Design Custom Reports and Bills**. The CGM MEDISOFT Report Designer opens.

2. On the File menu of CGM MEDISOFT Reports Designer, click **Open**. The Open Report screen appears.

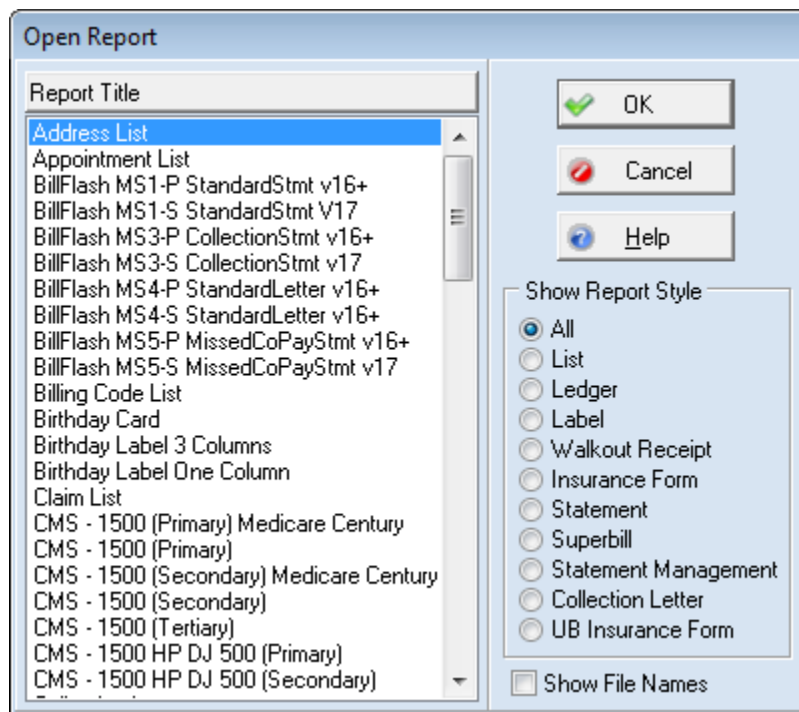


Figure 91. Open Report screen

3. Select the report form you use and click the **OK** button. The form opens.

4. On the File menu, click **Report Properties**. The Report Properties screen appears.

Figure 92. Report Properties screen

5. In the Form Offset section of the screen, adjust the form as necessary from the top and/or left margins. The form is moved in increments of one hundredth of an inch.
6. Click the **OK** button.
7. Save the report and close CGM MEDISOFT Reports Designer.

Reprinting Claims

You can reprint claims if there is a problem with some of those that printed. To do so, follow the steps above on printing claims, except select Reprint Claim instead of Print/Send. See [“Printing Claims” on page 113](#).

Changing Claim Status

In the Claim Management screen, all submitted claims are automatically marked Sent with an indication of the method of submission. There may be occasions when you need to change this status, for instance, if you need to resend them from Revenue Management.

Entire Batch

If the status of an entire batch needs to be changed, you can change all the claims at once.

1. Highlight one of the claims on the Claim Management screen and note the number listed in the Batch 1 column.
2. Click **Change Status**. The Change Claim Status/Billing Method screen appears.

Figure 93. Change Claim Status/Billing Method screen

3. Select **Batch** and enter the batch number from the Batch 1 column in the Claim Management screen.
4. Choose the appropriate buttons in the Status From and Status To sections.
5. Click the **OK** button.

Selecting Multiple Claims

1. When only one or a few claims within the same batch or claims from multiple batches need a status change, on the Claim Management screen, hold down the CTRL key and click each claim that needs the status changed. Note that the selected claims do not need to have the same claim status, but they will all change to the same status when you complete this procedure.
2. Click the **Edit** button.
3. In the Change Claim Status/Billing Method screen, click **Selected Claim(s)**
4. Select the appropriate buttons in the Status From and Status To sections.
5. If you have chosen claims with varying statuses, select **Any status type** in the Status From section.
6. Click the **OK** button.

Chapter 21 - Creating Statements

In this chapter you will learn how to create statements for billing your patients and updating them on charges to their accounts.

Statement Management

NOTE: This is an Advanced and CGM MEDISOFT Network Professional feature.

This section explains briefly how to manage statements within the Statement Management screen and includes creating, editing, printing/reprinting, and listing statements, as well as changing statement status.

You can use Statement Management to create, bill, and rebill statements all from one place. You can also view information about the statement, such as the guarantor, the status, the initial billing date, and the type. You can also generate statements to track missed copays.

Creating Statements

When you want to bill your patients, create statements. You can print your statements to paper or you can use BillFlash to send them electronically. BillFlash will print and send your statements to your patients for you.

1. On the Activities menu, click **Statement Management**. The Statement Management screen appears. For more information on BillFlash, see [“BillFlash Users” on page 37](#).

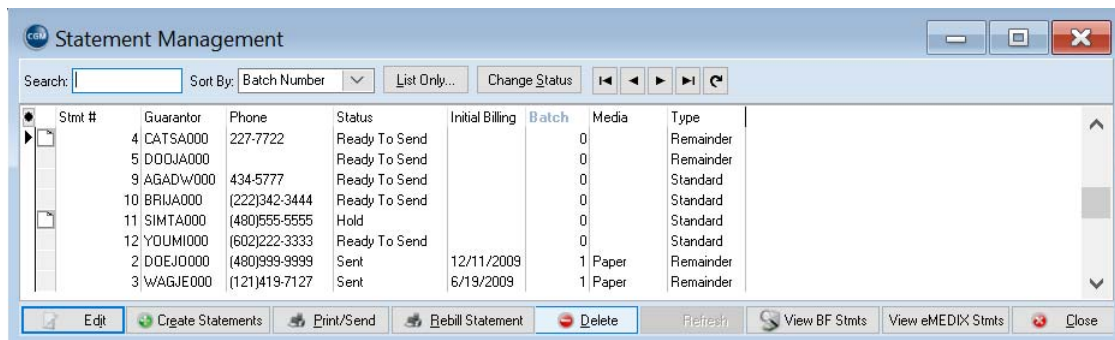


Figure 94. Statement Management screen

2. Click **Create Statements**.
3. Enter ranges of transaction dates and/or chart numbers to control which statements are created, as well as other data for filtering the data.
4. Click the **Create** button. The system tells you how many statements were created.
5. Click the **OK** button. The new statements appear on the Statement Management screen.

Editing Statements

1. On the Statement Management screen, highlight a specific statement.
2. Click the **Edit** button. You can modify general statement information, the transactions that appear on the statement, and any comments attached to the statement. When you make changes in the Statement edit screen, you modify only that statement and do not affect the defaults for other statements.

Figure 95. Statement screen

The Statement screen has three tabs that contain the information for the claim.

Tab	Description
General	Use this tab to change the Claim Status, Billing Method, and the billing date.
Transactions	Use this tab to see all of the transactions that are part of the selected statement. You can split, add, or remove transactions here.
Comment	Use this tab to place whatever comments you feel are necessary concerning this statement and/or any transactions relating to it.

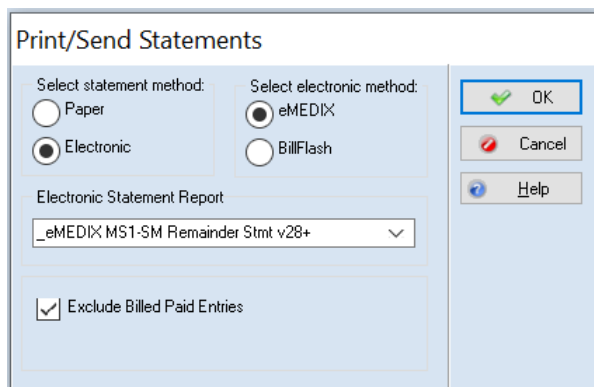
3. Revise the information on the tabs as necessary.
4. Click the **Save** button.

Printing Statements

If you print and send paper statements to your patients, use the printing feature on the Statement Management screen.

1. On the Activities menu, click **Statement Management**. The Statement Management screen appears.

- Click the **Print/Send** button. The Print/Send Statements screen appears.



Print/Send Statements

Select statement method:

☐ Paper

☒ Electronic

Select electronic method:

☒ eMEDIX

☐ BillFlash

Electronic Statement Report

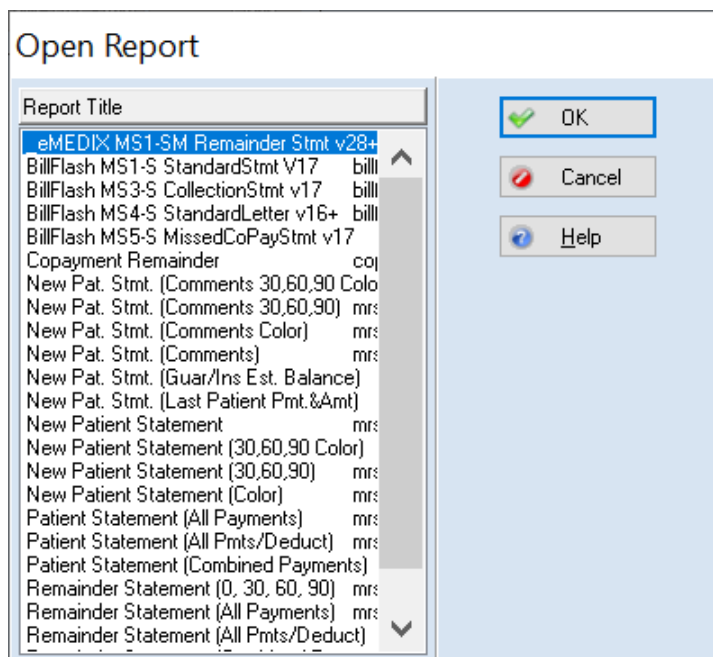
_eMEDIX MS1-SM Remainder Stmt v28+ ▼

☒ Exclude Billed Paid Entries

OK Cancel Help

Figure 96. Print/Send Statements screen

- Select Paper and click the **OK** button. The Open Report screen appears.



Open Report

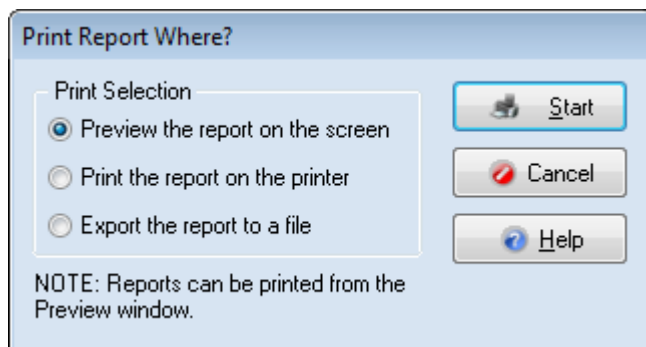
Report Title

eMEDIX MS1-SM Remainder Stmt v28+
 BillFlash MS1-S Standard Stmt v17 billi
 BillFlash MS3-S Collection Stmt v17 billi
 BillFlash MS4-S Standard Letter v16+ billi
 BillFlash MS5-S Missed CoPay Stmt v17
 Copayment Remainder
 New Pat. Stmt. (Comments 30,60,90 Color)
 New Pat. Stmt. (Comments 30,60,90) mrs
 New Pat. Stmt. (Comments Color) mrs
 New Pat. Stmt. (Comments) mrs
 New Pat. Stmt. (Guar/Ins Est. Balance)
 New Pat. Stmt. (Last Patient Pmt.&Amt)
 New Patient Statement mrs
 New Patient Statement (30,60,90 Color)
 New Patient Statement (30,60,90) mrs
 New Patient Statement (Color) mrs
 Patient Statement (All Payments) mrs
 Patient Statement (All Pmts/Deduct) mrs
 Patient Statement (Combined Payments)
 Remainder Statement (0, 30, 60, 90) mrs
 Remainder Statement (All Payments) mrs
 Remainder Statement (All Pmts/Deduct)

OK Cancel Help

Figure 97. Open Report screen

4. Select which form you want to print and click the **OK** button. The Print Report Where? screen appears.



Print Report Where?

Print Selection

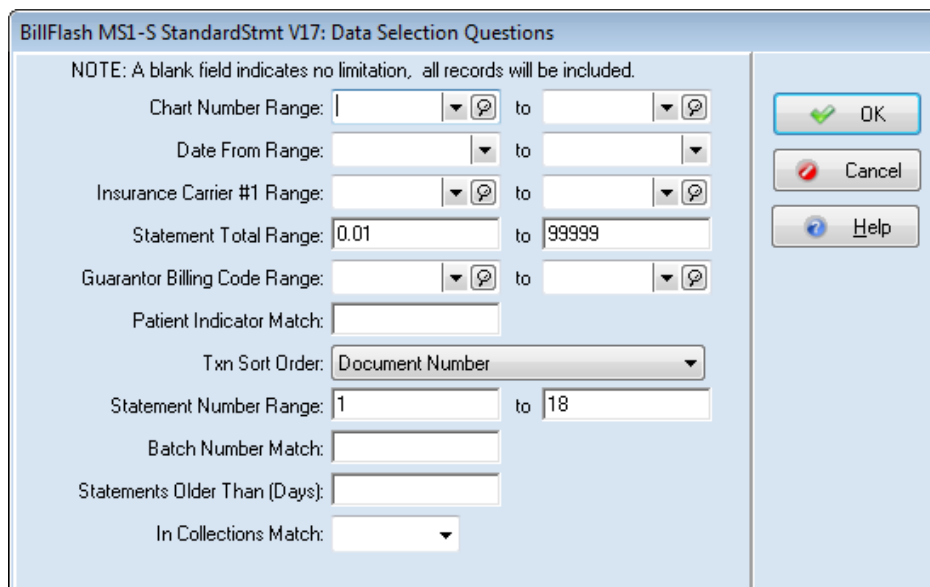
- ☒ Preview the report on the screen
- ☐ Print the report on the printer
- ☐ Export the report to a file

NOTE: Reports can be printed from the Preview window.

Start Cancel Help

Figure 98. Print Report Where? screen

5. Select your option and click the **Start** button. The Data Selection Questions screen appears.



BillFlash MS1-S StandardStmnt V17: Data Selection Questions

NOTE: A blank field indicates no limitation, all records will be included.

Chart Number Range: [] to []

Date From Range: [] to []

Insurance Carrier #1 Range: [] to []

Statement Total Range: 0.01 to 99999

Guarantor Billing Code Range: [] to []

Patient Indicator Match: []

Txn Sort Order: Document Number

Statement Number Range: 1 to 18

Batch Number Match: []

Statements Older Than (Days): []

In Collections Match: []

OK Cancel Help

Figure 99. Data Selection Questions screen

6. Make your selections for the various ranges and click the **OK** button.

- The Status of the claims will be updated to Sent on the Statement Management screen.

Reprinting Statements

If necessary, you can reprint statements without regard to their status. To reprint an entire batch, the status must be changed for the batch.

Changing Statement Status

In the Statement Management screen, all submitted statements are automatically marked Sent with an indication of the method of submission. There may be occasions when you need to change this status.

Statements sent electronically through BillFlash get a report that marks each statement as either accepted or rejected.

Entire Batch

If you need to change the status of an entire batch, you can change all the statements at once.

- On the Statement Management screen, highlight one of the statements and note the number listed in the Batch column.
- Click **Change Status**. The Change Statement Status/Billing Method screen appears.

Figure 100. Change Statement Status/Billing Method screen

- Select the **Batch** button and enter the batch number from the Batch column in the Statement Management screen.
- Select the appropriate buttons in the Status From and Status To sections.
- Click the **OK** button.

Selecting Multiple Statements

- When only one or a few statements within the same batch or statements from multiple batches need a status change, on the Statement Management screen hold down the CTRL key and

- click each statement that needs the status changed. Note that the selected statements do not need to have the same status, but they will all be changed to the same status.
- Click the **Edit** button. The Change Statement Status/Billing Method screen appears.
- Select **Selected Statement(s)**.
- Select the appropriate buttons in the Status From and Status To sections.
- If you have chosen statements with varying statuses, choose **Any Status Type** in the Status From section.
- Click the **OK** button.

Billing Cycles

The cycle billing feature lets you print statements every certain number of days. If you want to print statements every 30 days, you can set up a billing cycle of that length.

Follow these steps to set up a billing cycle:

- On the File menu, click **Program Options**. The Program Options screen appears.
- Select the **Billing** tab.
- Select the **Use Cycle Billing** check box.

The screenshot shows the 'Program Options' window with the 'Billing' tab selected. The 'Use Cycle Billing' checkbox is checked and highlighted with a red box. The 'Cycle Billing Days' field is set to 0. Other options include 'Standard Statement Detail Only', 'Remainder Statement Detail Only', 'Add Copy's to Remainder Statements', 'Create statement billing notes', 'Create claim billing notes', 'Statement Billing Note Code', 'Claim Billing Note Code', and 'Quick Formats'.

Figure 101. Program Options screen - Billing tab

- Enter a number in Cycle Billing Days. The number of days indicates the length of your billing cycle.
- Click the **Save** button.

Now, after you click Print/Send on the Statement Management screen, CGM MEDISOFT will automatically print statements based on the Next Statement Date of each statement. If the Next Statement Date is on or before the current date, the statement prints. If you have never printed statements with the billing cycle turned on, statements are printed according to the Last Statement Date stored in the statement record. If the Last Billing Date plus the billing cycle interval is on or before the current date, the statement prints.

NOTE: Statements might not print if they are filtered out by report selection questions or by predefined statement processing rules.

The program updates the statement's Next Statement Date for the next time you process statements.

Troubleshooting Statement Printing

Patient Remainder Statements

NOTE: This is an Advanced and CGM MEDISOFT Network Professional feature.

If you are having trouble printing patient remainder statements, check to be sure the following items have been performed:

- The patient has insurance coverage. This is indicated in the patient Case screen, Policy 1 tab, Insurance 1 field (also Policy 2 and Policy 3 tabs if there is secondary and/or tertiary coverage).
- A charge has been posted in the patient case.
- A claim has been created.
- An insurance payment or adjustment has been posted, applied, and marked as Complete to the account for each applicable carrier.

Chapter 22 - Applying Deposits/Payments

NOTE: Deposits/Payments is an Advanced and CGM MEDISOFT Network Professional feature.

Although you can enter payments in transaction entry for patient copays, you can also enter payments using Deposit/Payment. This option makes creating a deposit list and applying payments, especially payments from insurance carriers, an easy process. The advantage to this option is that you can apply a payment toward several cases and charges from the same screen.

Entering a Payment

To enter a payment:

1. On the Activities menu, click **Enter Deposits/Payments**. The Deposit List screen appears.

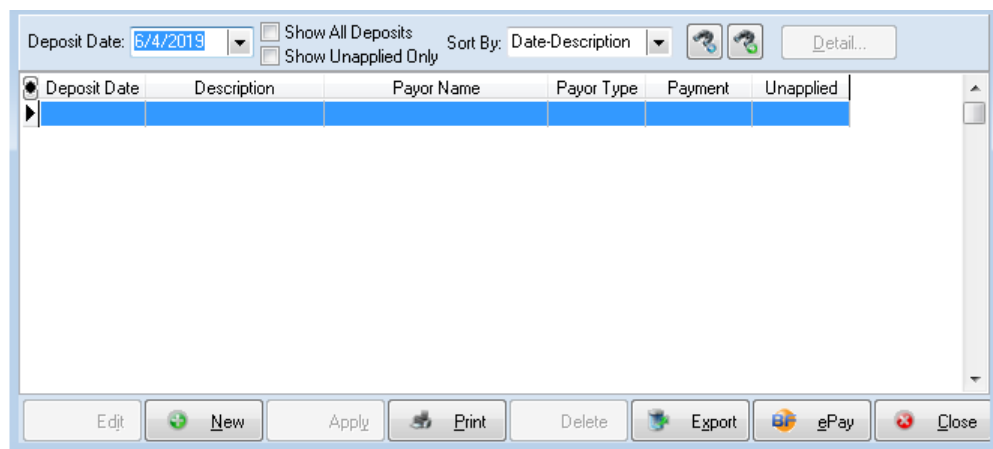


Figure 102. Deposit List screen

2. Click the **New** button. The Deposit (new) screen appears.
3. Select the appropriate Payor Type. Depending on your selection, the fields on the screen will change.
4. Complete the remaining fields as necessary, specifying the insurance or patient who paid.
5. Click the **Save** button. The new payment appears on the Deposit List screen and is highlighted. It is now available to be applied to charges.

Applying a Payment

1. On the Activities menu, click **Enter Deposits/Payments**. The Deposit List screen appears.

TIP: To save time and increase work efficiency, you can close a case after applying payment by right-clicking the line item in the grid and then selecting Close Case.

2. Highlight a payment and click the **Apply** button. The Apply Payment/Adjustments to Charges screen appears.
3. Select the patient chart number (if you have chosen an insurance payment)
4. Apply the portion of the payment to the applicable charge(s).
5. Click the **Save Payments/Adjustments** button.

TIP: If you select the Print Statement Now check box and click the **Save Payments/Adjustments** button, you can print statements from Statement Management.

6. If you need to apply payments from the same deposit to another patient record, select the next patient chart number and continue making payment applications.
This screen is also tied to the Payment Application tab of Program Options. Unless deactivated, all payment applications are automatically checked as paid in full by the payer, allowed amounts are calculated on all charges, and any charges over the calculated allowed amounts are automatically entered in the Adjustment field. You can open and change Program Options that are applicable to this screen by clicking Options in the bottom left of the screen

TIP: Be sure to click the **Save Payments/Adjustments** button before closing this screen or transactions cannot be created.

7. Click the **Close** button.

EOB Payments

Part of the payment structure to a healthcare office from an insurance carrier involves a check and an Explanation of Benefits. Widely known throughout the industry as the EOB, it lists claims for which payment is being made and, in some cases, an explanation of what is not being paid and why.

Not every insurance claim that is filed with a carrier is paid in full. It may be that payment is 80 percent of the claim or it may be 50 percent. Other times a claim may be totally or partially disallowed. The EOB explains in these cases. Normally, the part that is not paid by the carrier is picked up by a secondary carrier or charged back to the patient.

When a payment is received, a transaction must be entered to offset the charges. This is done by creating a deposit in the Deposit List screen. If the payment covers several charges, distributing a payment to specific charges can be handled by clicking Apply. Then, select the patient records and claims to be paid and designate how much goes to each.

Managed Care

One of the important sources of patients and income in many practices are managed care organizations. An HMO or PPO provides a list of patients who have selected your practice as their primary care provider. Payment is made to your practice on a per-patient basis, regardless of whether the patient ever visits the office. When a patient does come in for treatment, he or she pays a set co-pay amount.

The co-pay is charged only by the primary care facility or the facility to which the patient is referred by the primary care facility. After a patient's visit to the physician's office, a claim is filed and sent to the carrier. When the EOB is returned, there is seldom a payment included, since payment is made under the capitation program for managed care organizations.

Capitation Payment

The basis for capitation payments is to provide healthcare for a fixed cost, irrespective of the amount of service required by each individual patient. This is done in connection with the managed healthcare services such as HMOs and PPOs. There is no direct relationship between the capitation payment received by the practice and the number of patients covered by the plan who actually visit the practice for treatment. Capitation payments are not posted to patient accounts but are entered in the Deposit List screen. If it is necessary to zero out a patient account, create a zero deposit for the carrier. For each patient covered by the capitation payment who has an outstanding balance, zero out the account by entering the remainder in the Adjustment field. When it is applied, the payment shows as zero and the patient's balance shows as a write off in the Adjustment field in the Transaction Entry screen.

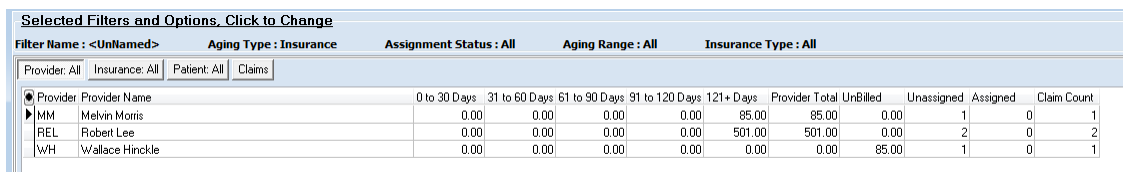
ePayments

If you have enrolled with BillFlash and patients are making payments online directly to BillFlash, you can download these payments to your practice by clicking ePay on the Deposit List screen. CGM MEDISOFT will capture these payments and display them in the Deposit List screen. Then, you can apply them to charges.

Chapter 23 - AR Tracker

AR Tracker ties together AR management into one cohesive workflow. It provides advanced filtering to track and collect Insurance and patient balances.

This is the main screen for the AR Tracker feature. It displays the filter settings, and the grid shows you the information that meets the filter settings.



The screenshot shows the AR Tracker interface. At the top, there's a header "Selected Filters and Options. Click to Change". Below it, filter settings are displayed: Filter Name: <Unnamed>, Aging Type: Insurance, Assignment Status: All, Aging Range: All, Insurance Type: All. Below the filters are four tabs: Provider, Insurance, Patient, and Claims. The "Provider" tab is selected, showing a grid of data. The grid has columns for Provider, Provider Name, and various aging ranges (0 to 30 Days, 31 to 60 Days, 61 to 90 Days, 91 to 120 Days, 121+ Days), followed by Provider Total, UnBilled, Unassigned, Assigned, and Claim Count. Three providers are listed: MM (Melvin Morris), REL (Robert Lee), and WH (Wallace Hinckle).

Provider	Provider Name	0 to 30 Days	31 to 60 Days	61 to 90 Days	91 to 120 Days	121+ Days	Provider Total	UnBilled	Unassigned	Assigned	Claim Count
MM	Melvin Morris	0.00	0.00	0.00	0.00	85.00	85.00	0.00	1	0	1
REL	Robert Lee	0.00	0.00	0.00	0.00	501.00	501.00	0.00	2	0	2
WH	Wallace Hinckle	0.00	0.00	0.00	0.00	0.00	0.00	85.00	1	0	1

Figure 103. AR Tracker screen

When you select AR Tracker for the first time, it displays the default filter selections of All. In addition, you can save filter selections and settings on the AR Tracker Filters screen.

Sorting grid columns

You can sort the grid information by a certain column simply by clicking the column header. An icon will appear, showing you which column the data is sorted by and whether the sorting is ascending or descending.

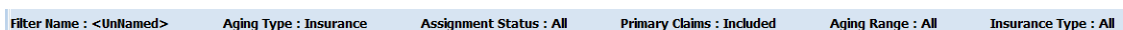
Changing grid columns

You can change which columns appear on the grid. To do so, click the black dot at the left of the column headers. This will open the Grid Columns screen.

Use the buttons to add or remove fields and click the OK button when you are done.

Filter detail

Below the filter link is the filter detail, which shows you how the grid information has been filtered.



The screenshot shows the Filter detail screen. It has a header "Filter Name: <Unnamed>". Below it, filter settings are displayed: Aging Type: Insurance, Assignment Status: All, Primary Claims: Included, Aging Range: All, Insurance Type: All.

Filter Name: <Unnamed>	Aging Type: Insurance	Assignment Status: All	Primary Claims: Included	Aging Range: All	Insurance Type: All
------------------------	-----------------------	------------------------	--------------------------	------------------	---------------------

Figure 104. Filter detail

Drilling down

You can drill down to several levels using the four tabs in the lower top section.

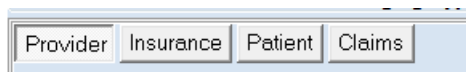


Figure 105. Drill-down tabs

The level will appear indented after you select it.

Double-clicking a grid item will change the level to the right in the list of tabs. You will see that change of level in the indented tab. The benefit of double-clicking is that new level will show you only the items that pertain to the line item you double-clicked.

For instance, double-clicking on Melvin Morris in the image below will show you the Insurance level for only Melvin Morris.

Selected Filters and Options. Click to Change

Filter Name : <Unnamed> Aging Type : Insurance Assignment Status : All

Provider Insurance Patient Claims

Select	Provider	Provider Name	0 to 30 Days	31 to 60
☐	MM	Melvin Morris	\$15.00	
☐	REL	Robert Lee	\$0.00	
☐	WH	Wallace Hinckle	\$85.00	

Figure 106. AR Tracker - Provider level

Once you double-click, you will see the image below. Note that the insurance is only for Melvin Morris and the Provider Level filter link shows you the provider's code, indicating the list is filtered by that provider.

Selected Filters and Options. Click to Change

Filter Name : <Unnamed> Aging Type : Insurance Assignment Status : All

Provider: MM Insurance: All Patient: All Claims

Select	Insurance	Insurance Name	Insurance Phone	0 to 30 Days
☐	AET00	Aetna		
☐	CIG00	Cigna		

Figure 107. AR Tracker - Insurance level filtered by provider

Claims drill-down

When you select the Claims tab and select a line item, the detail for the line item will appear in a second grid below.

Selected Filters and Options. Click to Change

Filter Name : <Unnamed> Aging Type : Insurance Assignment Status : All Aging Range : All Insurance Type : All

Provider: All Insurance: All Patient: All Claims

Chart Number	Patient Name	Patient Date Of Birth	Claim Number	Insurance	Insurance Phone	Policy Number	Group Number	First Date Of Service	Claim Amount	Claim Status 1	Claim Status 2
AGADW000	Dwight Aglin	3/30/1932	7	MED001	(800)999-9999	780340761	23c	9/3/2009	\$105.00	Sent	Done
BRLA000	Jay Bimley	1/23/1964	3	CIG00	234-6678	98547377	12d	3/25/2009	\$35.00	Sent	Sent
SMTA000	Tanus Simpson	4/4/1968	1	AET00	(602)333-3333	GG93-GKTA	99999	12/3/2009	\$336.00	Sent	Done
YOUNI000	Michael Youngblood	7/5/1962	6	US000		USAA236678	258B	8/22/2009	\$85.00	Ready to Send	Done

0 to 30 Days	31 to 60 Days	61 to 90 Days	91 to 120 Days	121+ Days	Aging Total	Unbilled	Assigned	UnAssigned	Claims
\$0.00	\$0.00	\$0.00	\$0.00	\$586.00	\$586.00	\$85.00	0	4	4

Chart Number	Claim Number	Date From	Procedure Code	Provider	Days_Aged	Days To File	Pri Amount	Remainder	M1	M2	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4	Diagnosis Code 5
AGADW000	7	9/3/2009	73130	REL	3467		\$45.00	\$55.00			959.4				
AGADW000		7/9/2009	99213	REL	3467		\$60.00	\$60.00			959.4				

100%

Figure 108. AR Tracker with claim detail

Viewing transactions not assigned to claims

If you want the AR Tracker to show you transactions that have not yet been added to a claim, select the No Claim check box on the AR Tracker Filters screen.

The screenshot shows the 'AR Tracker Filters' screen. At the top, there is a section for 'Existing Filters' with a dropdown menu and a search icon. Below this, there are two main filter categories: 'Aging Type' and 'Insurance'. Under 'Aging Type', there are radio buttons for 'Insurance' (selected) and 'Patient'. Under 'Insurance', there are checkboxes for 'Primary', 'Secondary', 'Tertiary', and 'No Claim'. The 'No Claim' checkbox is highlighted with a red rectangle.

Figure 109. AR Tracker Filter screen

These claims will then appear in the grid and the Claim Number will be NONE.

Selected Filters and Options. Click to Change

Filter Name : <UnNamed> Aging Type : Insurance Assignment Status : All Primary Cl

Provider	Insurance:	Patient: All	Claims	Claim Number	Policy Number
☐	YOKCL000	Cletus Yokel		NONE	5642324
☐	BORJO000	John Bordon		NONE	7405842
☐	CLIWA000	Wallace Clinger		10	
☐	CLIWA000	Wallace Clinger		11	
☐	CLIWA000	Wallace Clinger		12	
☐	BRIJA000	Jay Brimley		NONE	98547377
☐	BRIJA000	Jay Brimley		3	98547377

Figure 110. AR Tracker screen

AR Tracker Filters screen

Use this screen to set up and save filtering options for your AR tracking.

To open this screen, click the link in the top section of the AR Tracker screen.

The screenshot shows the 'AR Tracker Filters' screen. It has a top section for 'Existing Filters' with a dropdown and 'Save'/'Delete' buttons. Below this, there are sections for 'Aging Type' (Insurance/Patient), 'Insurance' (Primary/Secondary/Tertiary/No Claim), and 'Starting Level' (Provider, Aging Range, Insurance Type). There are also sections for 'Assignment Status' (Unassigned/Assigned), 'Task Due Date Range', and 'Date of Service'. On the right side, there is a list of filters to include or exclude, such as Insurance, Insurance Class, Patient, Guarantor, Patient Billing Code, Case Billing Code, Procedure Code, Diagnosis, Provider, and Facility. Each filter has a checkbox and a red 'X' icon. At the bottom right, there are buttons for 'Apply', 'Clear', 'Help', and 'Done'.

Figure 111. AR Tracker Filters screen

The table below describes the fields and options on this screen.

Element	Description
Existing Filters	Use this field to select an existing filter. This field will be disabled until you have saved a filter.
Save button	Click this button to save the filter. You will see the Save AR Filter screen on which you can enter a name for your new filter.
Delete button	Click this button to delete the existing filter.
Aging Type	Select Insurance or patient. Depending on your selection, the options on the screen will change.
Insurance check boxes	Select which insurances you want to include. You can select as many as you want. Selecting No Claim will enable you to see transactions that have not yet been assigned to a claim. These items will appear on the grid with a Claim Number of NONE. <u>Note: if you de-select all of the values, the filter will run the Primary insurance by default.</u>
Statement Type	Select either Remainder or Statement for this field. <u>This field will not appear when you select Insurance for the Aging Type.</u>
Starting Level	Select the starting level for the filter.
AR Status	Select an AR Status for this filter.
Aging Range	Select the aging range that you want to see.
Insurance Type	Select an Insurance Type for this filter. <u>This field will not appear when you select Patient for Aging Type.</u>
Patient AR Status	Select an AR Status for the patient.
Assignment Status	Select one of the assignment statuses.
AR Task	Select an AR Task for this filter.
Assigned to	Use the drop-down to assign a user to the task.
Task Due Date Range	Enter a range in these two fields for due date.
Over Due check box	Select this check box if you want overdue tasks to appear.
Date of Service From	Select a beginning date for this filter.
Date of Service To	Select an end date for this filter.

Element	Description
Date Created From	Select a beginning date for creating the claim.
Date Created To	Select an ending date for creating the claim.
Last Bill Date From	Select a beginning last billed date for this filter.
Last Bill Date To	Select an ending last billed date for this filter.
Total Amount Due	Enter a total amount due range in the two fields.
Insurance	Use this field to select which insurance you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field. This field will be disabled when you select Patient for Aging Type.
Insurance Class	Use this field to select which insurance class you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field. This field will be disabled when you select patient for Aging Type.
Patient	Use this field to select which patients you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field.
Guarantor	Use this field to select which guarantors you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field. This field will be disabled when you select Insurance for Aging Type.

Element	Description
Patient Billing Code	Use this field to select which Billing Codes you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field.
Case Billing Code	Use this field to select which Billing Codes you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field.
Procedure Code	Use this field to select which Procedure Codes you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field.
Diagnosis	Use this field to select which Diagnosis Codes you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field.
Rendering Provider	Use this field to select which Rendering Providers you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field.
Facility	Use this field to select which facilities you want to include. - Click the green Plus icon to include or exclude this filter. When the filter is excluded, the Plus icon will appear gray. - Click the red X icon to clear the field.
Apply button	Click this button to apply the filter. The results will appear in the AR Tracker screen.
Clear button	Click this button to clear the screen and create a new filter.
Help button	Click this button to open the online Help.

Element	Description
Close button	Click this button to close the screen.

Workflow

To use the AR Tracker feature:

1. Select AR Tracker from the Activities menu. The AR Tracker screen opens.
2. Click the link in the top section to open the AR Tracker Filters screen.
3. Select an existing filter or click Clear to create a new filter.
4. Make your selections for filtering information. You can save your settings by clicking Save.
5. Click Apply to run the filter. The results will appear in the AR Tracker screen.

AR Tracker field detail

The table below describes the fields and options on the AR Tracker screen.

Element	Description
Current filter link	This link shows you the current filter being used. Click this link to open the AR Tracker Filters screen.
Filter level tabs	These four tabs allow you to drill-down to different levels of detail. The currently-displayed tab appears indented.
Grid section The information on the grid will vary depending on your filter selections. Use the grid to collect the information you need for collecting bills. You can drill down to different tabs by either clicking the tabs or double-clicking a line item in the grid.	
Footer section	The footer at the bottom of the screen gives you totals for each column.

Right-click menu

When you right-click on a grid line on the AR Tracker screen, this menu appears. The options are described in the table below:

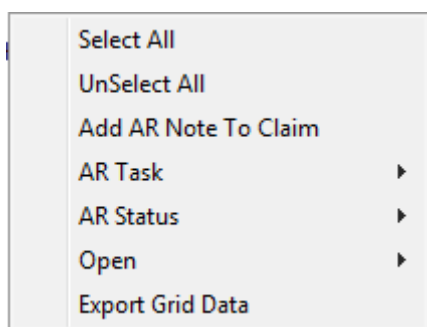


Figure 112. Right-click menu

The available options will depend on which level is in view.

Option	Description
Select All	Click this to select all items on the grid.
UnSelect All	Click this to clear all items on the grid.
Add AR Note to Claim/Statement	Click this option to open the AR Note screen, on which you can add a note to the AR Management Status screen. Note that you can select more than one claim or statement and add the AR Note to them simultaneously by holding the Shift key (for a range of claims/statements) or Ctrl key (for non-contiguous claims/statements) and selecting this option.
AR Task (for all selected)	You have two options on the sub-menu: • Assign Task: Click to open a screen on which you can assign a task to the claim or statement. • Remove Task: Click this option to remove tasks from an insurance or statement. Note that you can select more than one claim or statement and add the AR Task to them simultaneously by holding the Shift key (for a range of claims/statements) or Ctrl key (for non-contiguous claims/statements) and selecting this option.

Option	Description
AR Status (for all selected)	You have four options on the sub-menu: • Assign Claim/Statement AR Status: Click to assign the claim or statement an AR status using the Assign AR Status screen. • Assign Patient/Claim AR Status: Click this option to assign an AR status to a patient using the Assign AR Status screen. • Remove Claim/Statement AR Status: Click this option to remove the claim or statement AR status. • Remove Patient/Claim AR Status: Click this option to remove the patient or claim AR status. Note that you can select more than one claim or statement and add the AR Status to them simultaneously by holding the Shift key (for a range of claims/statements) or Ctrl key (for non-contiguous claims/statements) and selecting this option.
Open Patient	There are two options on the sub-menu: • Open Patient: Click to open the patient's record in the Patient/Guarantor screen. • Open Insurance: Click to open the insurance record in the Insurance Carrier screen.
Export Grid Data	Select this option to export the data in the grid to a file that you can move to another computer.

After you select an option, the information on the AR Tracker will refresh automatically.

Chapter 24 - Managing Small Balance Write-Offs

In this chapter you will learn about writing off balances that you know will never be paid.

Small Balance Write-off

This feature lets you automatically write off remainder balances of a certain amount. The balance written off is the patient remainder balance. You can write off small remainder balances as a batch in the Small Balance Write-off screen or for one patient at a time in the Apply Charges/Adjustments to Payments screen.

Writing off a Balance

1. On the Activities menu, click **Small Balances Write-off**. The Small Balance Write-off screen appears.

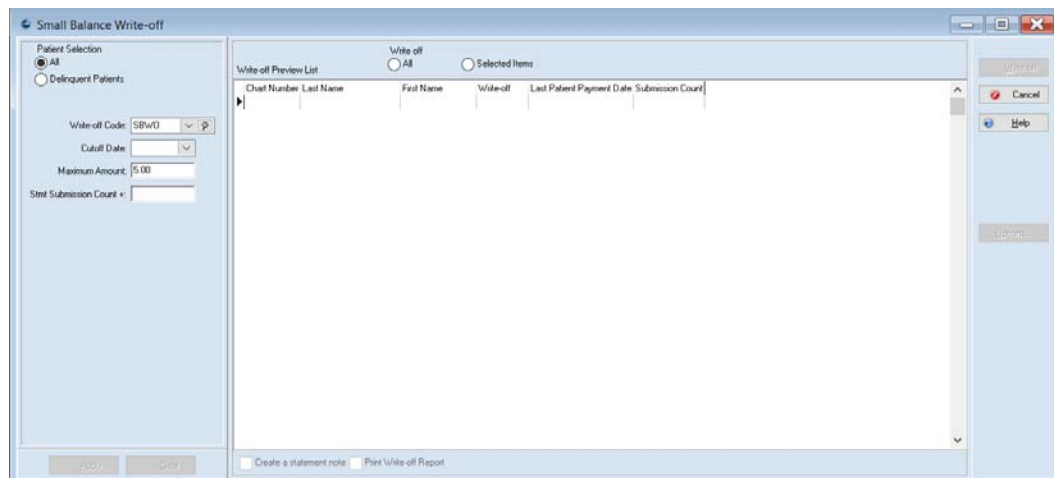


Figure 113. Small Balance Write-off screen

2. In the lefthand section of the screen, enter criteria for the type of remainder balances you want to write-off and click the **Apply** button. In the right hand section, a list of the patients who meet the criteria appears in the Write-off Preview List. The default is set to write off all records in the list. You can select individual records to write off by clicking on the record. Multiple records can be selected by pressing the CTRL key and clicking the record.
3. Click **Write off** to write off the selected remainder balances.

Use the Stmt Submission Count + field to define a maximum amount of times that you want to send a statement before writing off the balance. Once this number is met, the small balance is written off. CGM MEDISOFT selects patients whose statements have been sent (submission count) more than the value entered in the field. Once this number is met, the small balance is written off. This field works in conjunction with the other fields on this screen. If a value is entered in this field, the balance is only written off if it meets the criteria for this field (completed the statements) and the other fields such as Maximum Amount field. For instance, if you enter 3 in this field and 10 in the Maximum Amount field, small balances would be written off after three statements are sent and if the balance is under \$10.00.

When CGM MEDISOFT writes off the remainder balances, it updates a number of other areas of the database. Write-off entries are created and applied to all patient responsible charges associated with the selected patient. CGM MEDISOFT also updates the associated Collection List items, refreshing balances and marking zero balances as deleted. After a remainder balance write off, statements are changed to the status of Done and a note is added to the write-off entries.

Chapter 25 - Using Electronic Services

This chapter gives a brief overview of the electronic services available in CGM MEDISOFT.

Electronic Claims Processing

Electronic claims send your insurance claims online either directly to the insurance carrier or to a clearinghouse, which then sends the claims to the insurance carrier. CGM MEDISOFT currently ships with Revenue Management, an integrated component that installed when you installed CGM MEDISOFT. To launch Revenue Management

- On the Activities menu, point to Revenue Management, and click **Revenue Management**.

Statement Processing

You can send statements electronically through BillFlash, the web-based company that is set up to process CGM MEDISOFT electronic statements. Statements sent electronically through BillFlash get an instant response report that tells what information was sent. BillFlash will receive your statement data and then print and send statements to your patients. BillFlash can also receive payments from patients and you can download them to CGM MEDISOFT and apply them to patient accounts.

Eligibility Verification

The Eligibility Verification feature lets you check a patient's insurance coverage online. Revenue Management conducts eligibility verification behind the scenes.

Eligibility Verification Setup

Before you can perform eligibility requests electronically, you must make sure certain information is in your practice records. Use the following table to help you verify your records are complete.

Field(s) to complete	Screen or tab on which the field is located
Practice Tax ID	Practice Information screen, Practice IDs rules

Field(s) to complete	Screen or tab on which the field is located
Tax ID	Providers screen, Provider IDs tab (if this value is different from the Practice Tax ID above)
Claims Payer ID	Insurance Carriers screen, EDI/Eligibility tab
Last Name, First Name, Date of Birth, Gender, Social Security Number	Patient/Guarantor screen, Name/Address tab
Assigned Provider	Patient/Guarantor screen, Other Information tab
Insurance, Policy Holder, Relationship to Insured, Policy Number.	Case screen, Policy tabs
Assigned Provider	Case screen, Account tab

You must also apply security to your practice and create at least one user. For more information on CGM MEDISOFT security, see [“Security Setup Overview” on page 31](#).

Eligibility Verification Results

There are multiple places in CGM MEDISOFT from which you can make eligibility verification requests: the Eligibility Verification Results screen, the Patient List screen, Office Hours, and the Task Scheduler screen. The type of eligibility inquiry you make, either real-time or scheduled, depends on the screen from which you are making the request.

Eligibility Verification Results

If you access this screen from the Activities menu, it will automatically show the last inquiry made for each patient. You can also set it to show all inquiries.

To make a real-time eligibility inquiry from the Eligibility Verification Results screen:

- Highlight the patient and click the **Verify** button.

Patients

To make a real-time eligibility inquiry for a specific patient:

1. Right-click the patient's case in the Patient List and click **Eligibility Verification**.
2. The Eligibility Verification Results screen appears.
3. Click the **Verify** button to make the inquiry.

TIP: Press F10 to launch the Eligibility Verification Results screen to verify a patient's eligibility.

Task Scheduler

You can use the Scheduled Tasks feature to schedule a daily time to send a batch of eligibility inquiries. To schedule a batch,

1. On the Activities menu, point to **Eligibility Verification** and click **Schedule**. The CGM MEDISOFT Task Scheduler screen appears.
2. Click the **New** button. The Select Type screen appears.
3. Select **Eligibility**.
4. Click the **OK** button. The Select Practice screen appears.
5. Select the practice and click the **OK** button. The New Eligibility Task screen appears.
6. Complete the options and click the **Save** button. The new task appears on the CGM MEDISOFT Task Scheduler screen.

The task will automatically make inquiries for patients scheduled in the appointment grid up to a week in advance.

Chapter 26 - Scheduling Appointments

In this chapter you will learn about Office Hours and some of the basic features available for creating and managing patient appointments.

Office Hours Overview

Office Hours is an appointment scheduling program that helps keep track of appointments for your practice. It is automatically installed with CGM MEDISOFT.

Starting the Program

- On the Activities menu, click **Appointment Book**.

Office Hours Setup

There are several sections of the program that must be set up before you start scheduling.

1. First, set up provider records. If you are booking appointments for lab work or therapy, each of those technicians will have a provider number and schedule and so will each office member whose schedule will be included in the Office Hours program.
2. Set up your patient records.
3. Create your resource records. You can include all treatment apparatuses in this list, as well as consultation and treatment rooms, so that you do not double-book a room or equipment.
4. Set up program options, such as establishing appointment length, creating whatever views you need for viewing multiple columns at once, and deciding how much information you want displayed in your appointment blocks in the appointment grid.
5. Set up breaks and recurring breaks, to show lunch hour, set coffee-type breaks, seminars, and so on.
6. Set up security.

Using Office Hours

Entering a New Appointment

You can enter a new appointment on the Appointment Grid that opens when you start Office Hours. To create a new appointment

1. Select a provider in the provider field in the top right of the grid.
2. Double-click the timeslot for which you want to enter an appointment. The New Appointment Entry screen appears.

TIP: If you want to set up an appointment for someone who is not a patient and has no chart number, skip the Chart field and enter the person's name in the Name field. Enter all other necessary information. You can also print the appointment list showing blank appointments and manually write in appointments. Also, If a patient's case has an Authorized Number of Visits set on the Account tab of the Case screen, the program will warn you when the patient approaches the maximum number of authorized visits.

3. In the Chart field, type or select the patient's chart number.
4. Select a value for the Resource field.
5. Enter any notes about the appointment in the Note field. If you want to create a new line in the note, press CTRL + ENTER.
6. In the Case field the newest case entered for the patient appears. To change the case to which the appointment is tied, click the arrow to select the case.

Tip: You can right-click the field to create a new case, edit the selected case, or copy the selected case.

7. Select a value for the Reason field.
8. Enter the appointment length of time in the Length field. Enter the date in the Date field.
9. Enter the time in the Time field.
10. Select a button for the Status of the appointment. The default value is Unconfirmed.
11. If necessary, click Need Referral to indicate the patient does not have a referral for his or her visit.
12. If the patient must make a co-payment, click **Enter Copay**. This will open the Enter Copay screen on which you can enter the patient's co-payment.
13. Click the **Save** button. The appointment appears on the Appointment Grid.

Find Open Time

You can use the Find Open Time feature to have the program search for the next available opening for an appointment. To do so

1. On the Edit menu, click **Find Open Time**. The Find Open Time screen appears.
2. Complete the fields and click the **Search** button. Office Hours shows you the next available time on the grid.

Go To Date

If you need to locate a date that is a given length of time in the future, use the Go To Date screen. To do so

1. From the Edit menu, click **Go to Date**. The Go to Date screen appears.
The date that defaults in the Date From field is the date that is currently selected in the calendar. If you want to change the date in the Date From field, replace it by either highlighting and typing in a new date, or click in the field or on the down arrow to the right of the field and the calendar opens.
2. Enter a number in one of the selection boxes to indicate how far in the future you need to make the appointment. For example, if you need an appointment in six months, type the number 6 in the Months field.
3. Click the **Go** button.

Wait List

The Wait List is available to track any unexpected patients who need to be seen that day. If no openings are available when patients call in, you can put them on the Wait List. If a time slot becomes available, you can use the Wait List to help you determine whom to call first for that opening.

Moving a Patient from the Wait List to an Open Appointment

1. On the View menu, click **Wait List**. The Wait List screen appears.
2. Use the Search/Sort by fields to search for a record. Select the field by which you want to search in Sort by and then enter the value for which you want to search in Search.
3. Select the **Provider**.
4. Choose a patient from the list and click and drag their name to an open time slot in the Appointment Grid.

Adding a Patient to the Wait List

To create a new entry for the Wait List:

1. On the View menu, click **Wait List**. The Wait List screen appears.
2. Click the **New** button in the Wait List. The New Wait List Appointment screen appears.
3. Select a patient in the Chart Number field. The patient's name and phone number are automatically entered in those fields when you tab past them.

NOTE: Entering a phone number here does not store that number in the patient's record. To include a phone number in the patient's permanent record, enter the phone number in the Patient/Guarantor screen. You can move the cursor back to the Name field, and then press F9 to edit the patient record.

4. Complete the remaining fields on the New Wait List Appointment screen.
5. Click the **Save** button.

Editing an Appointment

To edit an appointment:

1. Double-click the appointment or right-click the appointment and click **Edit** from the drop-down menu. The Edit Appointment screen appears.
2. Make the changes you want.
3. Click the **Save** button.

Changing a Telephone Number or Cell Phone

If you update a patient's appointment with a new telephone number, you can also update all future appointments with the new phone number. When you enter the new phone number and click, the following screen appears:

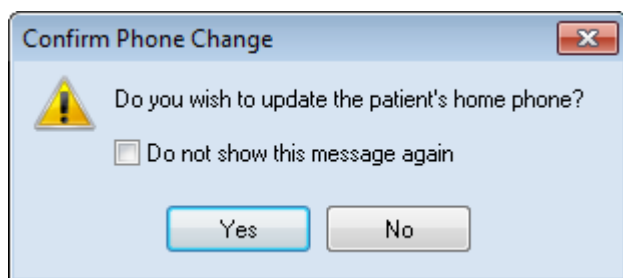


Figure 114. Confirm Phone Change screen

- If you click the **Yes** button, all future appointments are updated.
- If you select the **Do not show this message again** check box, the Confirm Phone Change screen will not appear in the future when you change other telephone numbers; the system will automatically update the phone number.
- If you click the **No** button, the patient's phone number for all future appointments will remain the old phone number.

Changing Other Information

If the field has an arrow key, you can click the arrow and then select from the drop-down list. If the field has a Search icon, you can click the icon and search for the corrected information.

Viewing Scheduled Appointments

You can view all the appointments scheduled for a patient.

1. On the Lists menu, click **Patient List**. The Patient List screen appears.
2. Highlight the patient whose appointments you want to view and click **Edit Patient**. The Patient/Guarantor screen appears.

3. Click the **Appointments** button on the right. The Scheduled Appointments screen appears.

Name	Date	Length	Provider	Resource	Repeat
Collins, Anorie L	9/21/2012	15	DS		No Repeat

Figure 115. Scheduled Appointments screen

- Click **Show all appointments** to view all appointments for this patient.
- Click the **Edit** button to edit the selected appointment.
- Click the **New** button to create a new appointment.
- Click the **Delete** button to delete the selected appointment.
- Click the **Print** button to print the appointments in the grid.
- Click the **Close** button to exit the screen.

Viewing Future Appointments

You can see the future appointments for each patient. Future appointments can be scheduled for up to a year in advance. When you open the Future Appointments screen, however, only the next 60 days of appointments, based on the current system date, will appear. The future appointments that appear in this screen will change as the system date advances.

Using the Future Appointment List screen

1. Right-click the patient's appointment on the Appointment Grid and click **Future Appointments**. The Future Appointments List screen appears. It will show you appointments for this patient for the next 60 days.

Chart Number	Case Number	Name	Date	Time	Length	Provider	Resource
COLAN000	1	Collins, Anorie L	9/21/2012	8:00 am	15 DS		

Figure 116. Future Appointment List (next 60 days screen)

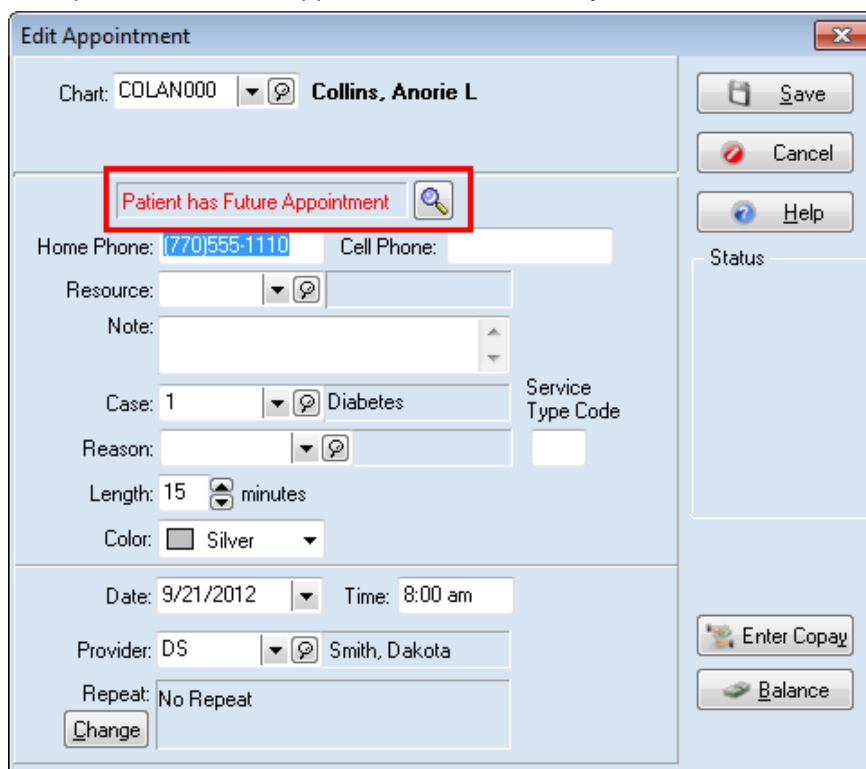
2. Click the **Print Grid** button to print the list or click the **Close** button to exit.

Using the Edit Appointment screen

CGM MEDISOFT will also notify you if the patient has future appointments scheduled when you open the Edit Appointment screen.

1. From the Appointment grid, right-click an appointment and click **Edit**.
2. Press **Tab** to move the cursor to the Home Phone field.

3. If the patient has future appointments scheduled, you will see the notification on the screen.



The screenshot shows the 'Edit Appointment' window for patient Collins, Anorie L. (Chart: COLAN000). A red box highlights a notification that says 'Patient has Future Appointment' with a magnifying glass icon. The window contains various appointment details: Home Phone (770)555-1110, Cell Phone, Resource, Note, Case (1 Diabetes), Reason, Length (15 minutes), Color (Silver), Date (9/21/2012), Time (8:00 am), Provider (DS Smith, Dakota), and Repeat (No Repeat). On the right side, there are buttons for Save, Cancel, Help, Status, Enter Copay, and Balance.

Figure 117. Edit Appointment screen with future appointment notification

4. Click the magnifying glass to open the Scheduled Appointments screen.

You can see all of the patient's appointments from this screen. You are not limited to the next 60 days.

Rescheduling an Appointment

You can reschedule an appointment by opening it and changing its status to Rescheduled. The Wait List will open, allowing you to find an open appointment time for the patient.

To reschedule an appointment:

1. On the Appointment grid, right-click the appointment and click **Rescheduled**. The Wait List screen appears.

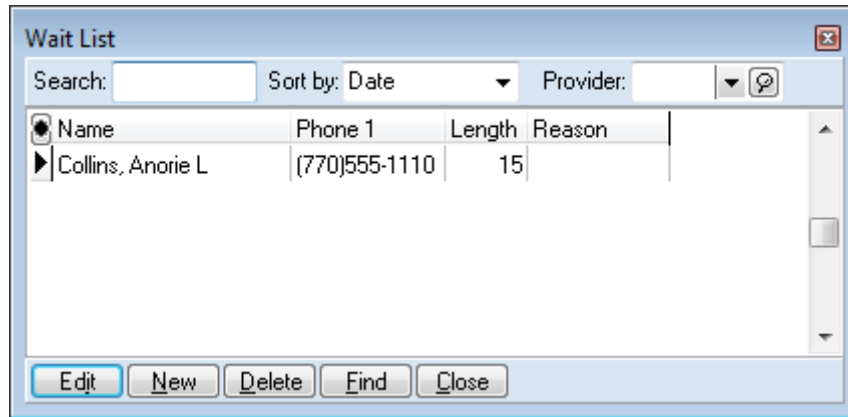


Figure 118. Wait List screen

2. On the Wait List screen, click the **Find** button. The Find Open Time screen appears.
3. On the Find Open Time screen, select/modify criteria for selecting a new appointment.
4. Click the **Search** button. The Confirm screen appears.
5. On the Confirm screen, select one of these options
 - Click **Yes** to set the appointment.
 - Click **No** to reject the appointment.
 - Click **Retry** for the next available appointment.

Moving/Deleting an Appointment

Moving an Appointment

To move an appointment, select one of the following methods:

Drag and Drop (changing to same day only):

1. Click the appointment and hold the mouse button down.
2. Move the cursor to the new appointment time.
3. Release the mouse button.

Using accelerator keys:

1. Highlight the appointment by clicking the grid cell.
2. Press ALT + X to cut the appointment.
3. Move to the new date on the Appointment Grid.
4. Click the new appointment time.
5. Press ALT + V to paste the appointment in the new location.

Using the Speed menu:

1. Highlight the appointment by clicking the grid cell.
2. Right-click the mouse and click **Cut**.
3. Move to the new date or new time.

4. Click the new appointment time.
5. Right-click the mouse and click **Paste**.

Using the Edit menu:

1. Highlight the appointment by clicking the grid cell.
2. On the Edit menu, click **Cut**.
3. Move to the new date.
4. Click the new appointment time.
5. On the Edit menu, click **Paste**.

Deleting an Appointment

To delete an appointment

1. Highlight the appointment on the grid by clicking it.
2. Right-click and click **Delete**.

NOTE: When you delete an appointment to which a numbered superbill is attached, the superbill is also deleted. The number may be released for reassignment.

Recalling Patients

The Patient Recall List screen displays all patients who have been set up for appointment recalls. The recall list provides staff a list of patients who need to be contacted for various reasons, for instance, contacting a patient regarding a follow-up visit or paying a bill.

This screen is for information purposes only and it does not integrate with any other part of Office Hours.

To open the Patient Recall List:

1. On the Lists menu, click **Patient Recall**. The Patient Recall List appears.

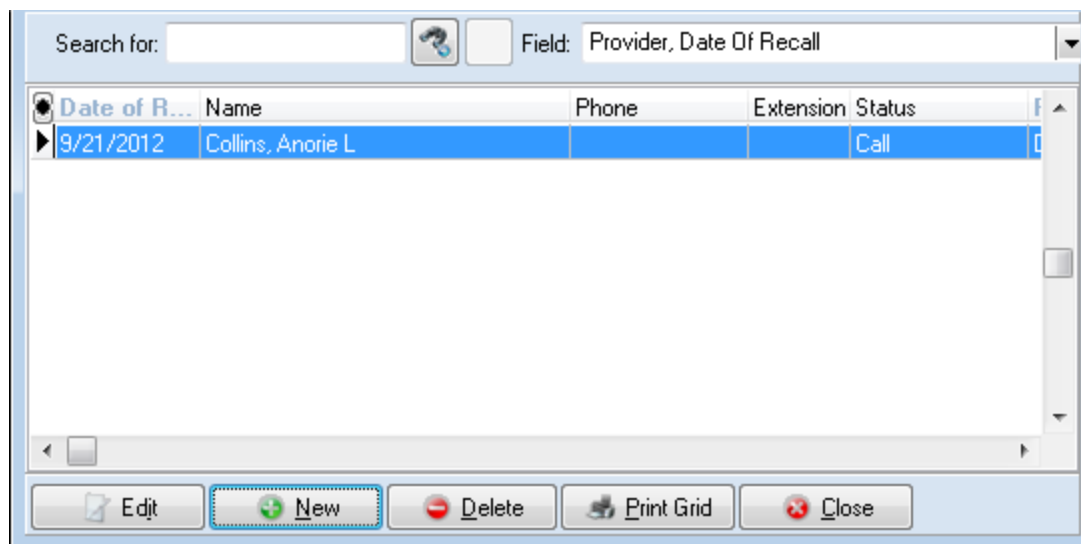


Figure 119. Patient Recall List screen

This screen is different from the other lists because you can search for a record by its date. When using the date as a search parameter, there are various date formats you can use. The following table explains the formats that are acceptable to use when searching.

2. From this screen, you can
 - Click the **New** button to add a new entry.
 - Click the **Edit** button to update an existing entry.
 - Click the **Delete** button to remove an entry.
 - Click the **Print Grid** button to print a list of patients on this list.

Setting Program Options

There are several options you can choose from. You can access Program Options from the Program Options option on the File menu.

Options tab

Figure 120. Program Options - Options tab

Set the starting and ending appointment times for the practice. Enter the Starting Time and Ending Time, breaking it down by hour and minutes. Standard appointment Intervals can be established by scrolling with the up and down arrows.

You can also set colors to distinguish appointments, breaks, and conflicts. Make decisions concerning all the other default settings in this tab.

Designate one of the reports in the Speed Report box and it will automatically print when you click the Print speed button.

You can now choose to use Deposit Entry or Transaction Entry when entering a copay. To use Transaction Entry rather than Deposit Entry, click the Use transaction Entry to Make Copays check box.

Multi Views tab

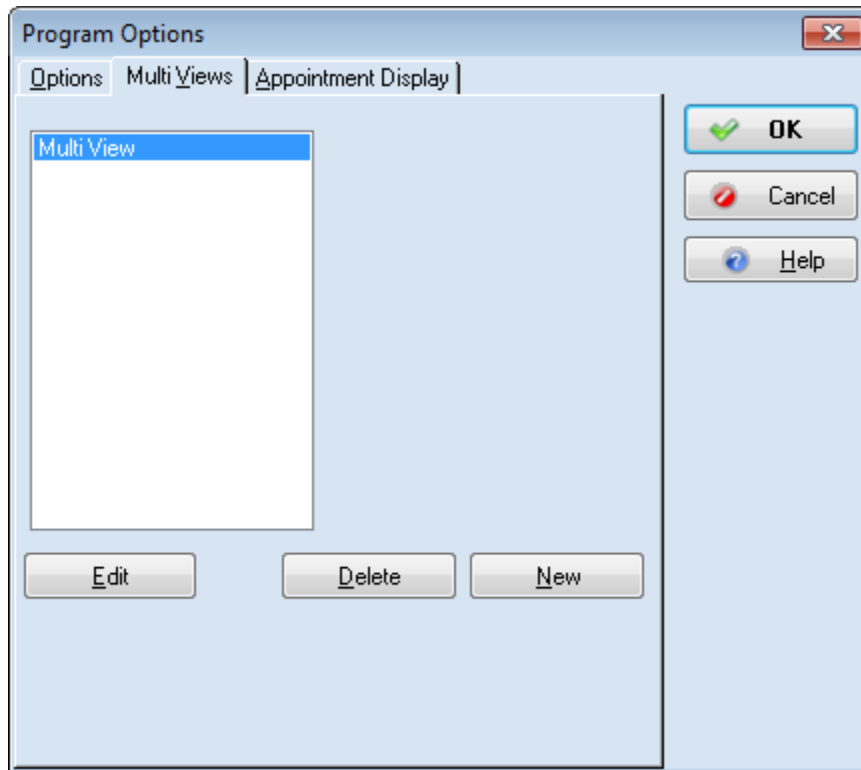


Figure 121. Program options - Multi Views tab

Office Hours provides one Multi View setup, which automatically includes all providers and all resources, each with its own column. You can create as many Multi Views as you need in the Multi Views tab.

The open data entry field lists all Multi Views that have been set up. This is where you can group providers and/or resources (rooms or facilities scheduled for appointments) in any combination desired, or modify or delete existing multiple view setups. Click the New button to set up a new Multi View (select a view and click the Edit button to make changes).

In the New View screen, assign a name for the new view. For the first column, indicate the type (Provider or Resource), the Code (provider number or resource code), then the width of the column (in pixels). Set up each column you want in the view and click the Close button when finished.

Column	Type	Code	Width
▶			

Figure 122. New View tab

If you want to add a column between columns that have already been created, place your cursor where you want the new column and click Insert.

These views can be also edited or reverted to default views through the View menu.

Appointment Display tab

Program Options

Options | Multi Views | Appointment Display

Information to be displayed in the appointment grid

Row 1: Name

Row 2:

Row 3:

Row 4:

Row 5:

Figure 123. Appointment Display tab

In the Appointment Display tab, you can specify up to five rows of information to display in the grid for an appointment. Be aware that the length of the appointment determines how much data is actually displayed on the grid. An appointment must be at least 75 minutes long to display five rows of information.

Chapter 27 - Reports

In this chapter you will learn about reports in CGM MEDISOFT.

Reports Overview

CGM MEDISOFT offers flexible reporting options. You can run reports in CGM MEDISOFT by selecting various reports from the Reports menu. In addition, you can launch the CGM MEDISOFT Reports application (for CGM MEDISOFT Advanced and CGM MEDISOFT Network Professional only) and complete all reporting tasks there. The CGM MEDISOFT Report application offers several key features not available when running reports from the Reports menu, including different reports and features to enhance productivity.

Report Procedures

Viewing a Report

You can view or preview a report before printing or exporting it. For example, you could preview a Patient Aging report before printing it to make sure that you have selected the most appropriate data criteria. After previewing, you can export or print the report.

To view a report:

1. On the Reports menu, select the report you want to view. The Print Report Where? screen appears.
2. Select **Preview the report on the screen**.
3. Click the **Start** button. Depending on the report selected, the Data Selection Questions screen or the Search screen opens.
4. Select ranges and then click the **OK** button. The report appears.

NOTE: For some reports that use a different format, such as statements, the controls in this screen are slightly different and include a Save Report to Disk option.

Printing a Report

To print a report:

1. On the Reports menu, select the report you want to print. The Print Report Where? screen appears.
2. Select **Print the report on the printer**.
3. Click the **Start** button. Depending on the report selected, the Data Selection Questions screen or the Search screen opens.
4. Select ranges and click the **OK** button. The Print screen appears.
5. Click the **OK** button.

Exporting a Report

You can export a report into another format. For example, you could export a Patient Aging report to a Microsoft Excel spreadsheet.

To export a report:

1. On the Reports menu, select the report you want to export. The Print Report Where? screen appears.
2. Select **Export the report to a file** and click the **Start** button. The Save As screen appears.
3. Select a file format for exporting and a destination.
4. Click the **Save** button. The Search screen or the Data Selections Questions screen appears (depends on the report or statement selected).
5. Select appropriate criteria and click the **OK** button. The report is exported.

Searching for a Specific Detail in a Report

Once you have generated a report, you can further refine the report and search for a more detailed data element. When using this feature, you essentially re-run a report using more specific data criteria.

To refine your data criteria and search for specific data:

1. View a report. See [“Viewing a Report” on page 161](#).
2. Click the **Search** button. The Search screen appears.
3. Select specific data ranges.
4. Click the **OK** button. The report displays using the new search criteria.

Available Reports

Not only does CGM MEDISOFT build an accounts receivable file and handle statements, insurance claims, and electronic billing, it also provides a variety of reports that can give you a better understanding of the day-to-day workings of your practice.

Among the reports generated within CGM MEDISOFT are Day Sheets, Analysis Reports, Aging Reports, Productivity Reports (Network Professional), Activity Reports (Network Professional), Collection Reports (Advanced and CGM MEDISOFT Network Professional), Audit Reports, Patient Ledger Report, Guarantor Quick Balance List (Network Professional only), and Standard Patient List Reports.

You can also print a title page that shows all the filters used in preparing the report.

Day Sheets

Day Sheets are available in three reports.

Report	Description
Patient	Lists each patient's name, showing all transactions and a summary of activities for the day.
Procedure	Breaks down by procedure code the activities of the day, summarizing patients treated for each procedure.

Report	Description
Payment	Shows the payments made on the requested day and the charges to which the payments are applied.

Analysis Reports

Report	Description
Billing/Payment Status Report (Advanced and CGM MEDISOFT Network Professional)	Provides a thumbnail sketch of the current billing and payment status of each claim. The report shows what has been billed and not billed, what is delayed for some reason, if the carrier is not responsible or has refused the claim, or if the claim is paid in full. An asterisk (*) next to an amount indicates that the entity has paid all it is going to pay; and the balance, if any, should go to the next responsible payer.
Insurance Payment Comparison (Network Professional only)	Compares the payment records of all carriers in the practice.
Practice Analysis	Summarizes the activity of a specified period (for example, a month), listing each procedure performed, the number of times it was performed, and the total dollar amount generated by each procedure. It shows the average charge, includes any costs involved with that procedure, and calculates the net monetary effect on the practice's income.
Insurance Analysis (Advanced and CGM MEDISOFT Network Professional)	Summarizes all claims filed by category (Primary, Secondary, and Tertiary). Claims totals are shown for charges and insurance payments in both dollar amount and percentage.
Referring Provider Report (Advanced and CGM MEDISOFT Network Professional)	Shows which patients were referred by other practices and the percentage each referral contributes to the overall referred income of the practice, as of the date of that report. The report also includes the UPIN of the referring provider. By blanking out the Referring Provider range in the Data Selection Questions screen, a report can be generated showing what percentage of the entire practice has been referred.

Report	Description
Referral Source Report (Advanced and CGM MEDISOFT Network Professional)	Assembles the patient list by source (other than provider) and shows how much revenue comes from each source, allowing the practice to identify those sources that send profitable referrals and/or limit those that are costly or nonproductive. This is another report for tracking the source of patients who come to the practice. For the report to work, however, all referral sources must be entered in the Address Book. A source can be an attorney, a hospital, friends, other patients, or anything else. Most new patient application forms include the inquiry "How did you hear about us?"
Facility Report (Network Professional only)	Tracks patients who are seen at different facilities. The Facility Report assembles the patient list by facility and shows how much revenue comes from each facility, helping you identify which generates the most money.
Unapplied Payment/Adjustment Report (Advanced and CGM MEDISOFT Network Professional)	Shows any payment or adjustment that has an unapplied amount and where the transaction can be found.
Unapplied Deposit Report (Advanced and CGM MEDISOFT Network Professional)	Shows all deposits that have an unapplied amount.
Co-Payment Report (Advanced and CGM MEDISOFT Network Professional)	Shows all patients who have co-payment transactions. It shows the amount of the required co-payment, how much was applied, and what was left unapplied. If a patient does not have any co-payment transactions, he or she is not included in the report.
Outstanding Co-Payment Report (Advanced and CGM MEDISOFT Network Professional)	Shows all patients who have outstanding co-payment transactions. The report shows the Co-payment amount expected, the actual amount paid, and the amount due. If a patient has no outstanding co-payment transactions, he or she is not included in the report.
Appointment Eligibility Analysis - Detail Report	Shows patients with appointments whose eligibility has been checked, based on criteria entered. It includes detail about the patients, their appointment date and time, the provider name, and reason code. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.

Report	Description
Appointment Eligibility Analysis - Summary Report	Shows a summary of appointments whose eligibility has been checked, based on criteria entered. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.
Electronic Claims Analysis - Detail Report	Shows the status of claims, providing a summary of total claims and those that have been filed electronically or by paper. It includes the percentage of claims filed electronically. In addition, it shows detail such as the billing date, insurance carrier, sequence, claim number, patient chart and name, and the status of the claim. It is an ARRA report designed for showing that the practice is sending claims electronically.
Electronic Claims Analysis - Summary Report	Shows the status of claims, providing a summary of total claims and those that have been filed electronically or by paper. It is an ARRA report designed for showing that the practice is sending claims electronically.

Aging Reports

Report	Description
Patient Aging	Shows patient aging. Default aging criteria is based upon the number of days between the creation of the transaction or claim and the date of the report you are generating. The columns break down the amounts due that are 30, 60, and 90+ days old. Aging is from actual date of the transaction, so it reflects the true age of the account. The aging criteria and columns can be altered in Program Options. This report includes all unapplied amounts in the totals. The Date filter has been removed as it would return invalid values.
Patient Remainder Aging (Advanced and Network Professional only)	Has the same format as the Patient Aging, but there is a key difference in how it works. A charge does not show up on the Patient Remainder Aging report until all insurance responsibility has been marked complete.
Patient Remainder Aging Detail (Advanced and Network Professional only)	Has the same criteria as Patient Remainder Aging Detail. However, it also lists each insurance company on the patient's account and the date the insurance payment was marked complete.
Insurance Aging and Summary	Track aging of claims filed with insurance carriers. The summary versions are similar but no patient information is included.

Production Reports

NOTE: This is a Network Professional only feature.

Report	Description
Production by Provider, Procedure, and Insurance and Summary	Gives incoming revenue information for each provider, procedure, or insurance carrier, respectively.

Activity Reports

NOTE: This is a Network Professional only feature.

Report	Description
Daily/Monthly Activity Report	Presents financial activity based on the date range selected. The report displays the total number and the total amounts of the charges, payments, and adjustments entered during a date range. The report also details the net effect of the financial information entered on the Accounts Receivable balance for the day/month.
Activity Summary by Provider/Insurance and Procedure	Breaks down financial activity by day or month. The summary reports summarize financial information entered for each provider/procedure or insurance carrier, respectively.

Collection Reports

NOTE: This is an Advanced and CGM MEDISOFT Network Professional feature.

Report	Description
Patient Collection Report	Contains information based on statements marked Sent in the Statement Management screen, showing what has not been paid, statement date, and so on. Also, select this Patient Collection Report to generate the report with statement notes included.
Insurance Collection Reports	Shows the claim data, what amount is outstanding, and so on. These reports also offer variants that include claim notes.
Patient Collection Letters	Printed in preparation of collection letters. It contains information from the collection list and is used to help evaluate collections.
Collection Tracer Report	Reports how many collection letters have been sent and when. Each time collection letters are printed, CGM MEDISOFT, by default, keeps track of each letter sent.

Audit Reports

Report	Description
Audit Generator	Creates a data audit report that contains only the information you want included in the report. This report is intended as a protection for the practice to keep track of changes made and by whom. Some PHI (personal health information) will be included in the Data Audit Report no matter what selections are made or excluded in the Program Options screen or the Audit Generator. NOTE: This report does not support printing a report title page even if the Print Report Title Page option was set in the Program Options screen.
Login/Logout	This report allows you to track login/logout activity in the practice, including the user name and machine name of each login, along with a date and time stamp.

Chapter 28 - Program Options

This chapter gives a brief overview of the different program options available in CGM MEDISOFT.

General Tab

The General tab has options for backups, which are an essential part of maintaining computer-generated billing programs, and general default settings, such as which screen to open on startup, and several options to show or hide data.

Program Options

General | Data Entry | Payment Application | Aging Reports | HIPAA | Color-Coding | Billing | Audit | BillFlash

☒ Remind to Backup on Program Exit Max Automatic Backup Count: 3

Backup Program: MBACKUP.EXE

Command Line:

Show Windows on Startup:

☐ Patient List

☐ Transaction Entry

Data Version Number: 29

Menu/Toolbar Options:

☐ Hide Icons in Menus

☒ Show Hints

☒ Show Shortcuts

☒ Enforce Accept Assignment

☐ Print Report Title Page

☐ Enable Electronic Prescribing

☐ Use Server Time

☐ Hide Inactive/Closed Items

☐ Use Guarantor Ledger for Quick Ledger

☐ Enable HL7 Triggers

Calculate Patient and Statement Remainder Balances:

☒ when Medisoft first opens

☐ when Medisoft closes

☐ None of the above

Patient Remainder Balances may also be recalculated through File Maintenance.

Account Alert Setting

☐ Patient Remainder Balance \$0.00

☐ Delinquent on Payment Plan

☐ Sent to Collections

☐ Outstanding Co-payments

☐ All of the above

Save Cancel Help

Figure 124. Program Options screen - General tab

Data Entry Tab

The Data Entry tab gives you many options for various sections of CGM MEDISOFT.

Figure 125. Program Options screen - Data Entry tab

In the Global section, you can indicate whether to use the ENTER key to move between fields, to force payments to be applied, and to multiply unit times amount. When the Suppress UB04 Fields check box is selected, UB-04 fields do not appear throughout CGM MEDISOFT.

In the Patient section, you can choose to use numeric chart numbers (the default is to use an alphanumeric code) and/or have CGM MEDISOFT automatically hyphenate Social Security numbers. The Patient Quick Entry Default list and the Use Quick Entry for New Patient/Case F8 and Use Quick Entry for Edit Patient/Case F9 check boxes provide setting options for the Patient Quick feature, which provides a custom method for creating records.

Payment Application Tab

NOTE: This is an Advanced and CGM MEDISOFT Network Professional tab.

In the Payment Application tab, you can establish default settings that affect payments when you apply them to patient balances.

Figure 126. Program Options screen - Payment Application tab

If you choose to accept the default settings, any amount applied to a charge is automatically marked as paid by that particular payee, the allowed amount is automatically calculated, and the difference between the calculated allowed amount and the practice charge is offset in the Adjustment column. In addition, any claim that has received payment from all responsible payers is automatically marked “Done.”

In the lower half of the screen, select default billing codes to be applied when using this feature.

Aging Reports Tab

The Aging Reports tab lets you alter the starting date for patient aging reports and to redefine aging columns for both patient and insurance aging reports.

HIPAA Tab/ICD 10

The HIPAA tab offers features designed to help protect patient information from unauthorized access.

The Auto Log Off check box is designed to protect your data files from unauthorized tampering. Select the check box and then enter a number of minutes (up to 59) in the field. With Auto Log Off activated, any time CGM MEDISOFT remains unused for the amount of time designated, it locks the practice and requires re-entry of a password to access CGM MEDISOFT again.

If you select this check box and have not used the Security Setup feature in CGM MEDISOFT, a message pops up telling you that security has to be set up before the backup will function. For more information on security, see [“Security Setup Overview” on page 31](#).

When the Warn on Unapproved Codes check box is selected, CGM MEDISOFT alerts you if a code entered or selected is non-HIPAA compliant. This warning pops up every time you save transactions and CGM MEDISOFT finds a code that has not been marked HIPAA compliant.

Color-Coding Tab

NOTE: This is an Advanced and CGM MEDISOFT Network Professional tab.

Transactions

If you want to use color coding for transactions in Transaction Entry and Quick Ledger, select the Use Color Coding check box.

Select colors for each of six types of transactions: unsaved, no payment, partially paid, overpaid charge, unapplied payment, and overapplied payment. These colors appear in both screens, letting you know at a glance the status of the transaction.

Patients

This feature, called patient flagging, lets you color code patient records to alert you to various situations when viewing records.

The patient flag colors in the Program Options screen are fixed and cannot be edited. In the box to the right of a color box, assign your own description to that flag color. To activate the edit boxes, select Use Flags.

Patient flags are connected to patient records in the Other Information tab of the Patient/Guarantor screen as you edit or set up a new patient record.

Billing Tab

NOTE: This is an Advanced and CGM MEDISOFT Network Professional feature.

Statements

Options in the Statements section deal with billing cycles. If you want to use billing cycles when sending statements, select the Use Cycle Billing checkbox. If you choose to use cycle billing, be sure to enter a cycle billing days interval (for example., every 30 days). For more information on billing cycles, see [“Billing Cycles” on page 124](#). Statements sent through BillFlash are also affected by the billing cycle.

The Add Copays to Remainder Statements is used to add missed copays (when patients do not immediately pay their copay), to the patient's Copay Remainder statement.

Program Options

General | Data Entry | Payment Application | Aging Reports | HIPAA | Color-Coding | **Billing** | Audit | BillFlash

Statements: ☐ Use Cycle Billing Cycle Billing Days: 0
☐ Standard Statement Detail Only
☐ Remainder Statement Detail Only
☐ Add Copay's to Remainder Statements

Billing Notes: ☐ Create statement billing notes Statement Billing Note Code:
☐ Create claim billing notes Claim Billing Note Code:

Quick Formats: ☐ Use Statement Management for Quick Statements
Receipt:
Statement:
Face Sheet:
Quick List:

Save Cancel Help

Figure 127. Program Options screen - Billing tab

Billing Notes

When you select Create statement billing notes, CGM MEDISOFT adds a note to statements when printed. Be sure to select a default note in the Statement Billing Note Code field.

When you select Create claim billing notes, CGM MEDISOFT adds a Comment transaction line in both Transaction Entry and Quick Ledger whenever a claim is billed. The note includes the carrier name, date billed, claim number, and the name of the provider associated with the claim. Be sure to select a default Claim Billing Note Code.

Audit Tab

The Audit tab lists all tables available in the database. The tables you choose here become available in the Audit Generator when preparing the Data Audit Report.

Program Options

General | Data Entry | Payment Application | Aging Reports | HIPAA | Color-Coding | Billing | **Audit** | BillFlash

NOTE: By leaving or unchecking any of the following tables you will be turning off all audits for that table. Perform audits on these tables

Medisoft Tables

	Update	Delete
Address	☐	☐
Allowed Amount	☐	☐
Billing Code	☐	☐
Case	☐	☐
Contact	☐	☐
Custom Case Data	☐	☐
Custom Patient Data	☐	☐
Deposit	☐	☐
Diagnosis	☐	☐
Electronic Receivers	☐	☐
Insurance Carriers	☐	☐
Multilink	☐	☐
Patient / Guarantor	☐	☐
Patient Recall	☐	☐
Procedure Code	☐	☐
Providers / Referring Providers	☐	☐
Transaction	☐	☐
Treatment Plan	☐	☐
Treatment Plan Procedure	☐	☐

Office Hours Tables

	Update	Delete
Appointments	☐	☐
Reasons	☐	☐
Resources	☐	☐
Superbills	☐	☐
Wait	☐	☐

☒ ARRA Audit

Figure 128. Program Options screen - Audit tab

eMEDIX tab

Use this tab to enter defaults for eMEDIX Statements. Account login information, messages, credit cards accepted, other options will be entered here by the user for transmitting with the statements to eMEDIX.

The screenshot shows the 'Program Options' window with the 'eMEDIX' tab selected. The window has a tabbed interface with tabs for General, Data Entry, Payment Application, Aging Reports, HIPAA/ICD-10, Color-Coding, Billing, Audit, eMEDIX, eMEDIX Estimate, and BillFlash. The eMEDIX tab contains the following fields:

- Credit Cards Accepted:** A text input field.
- Shading:** A text input field.
- eMEDIX Account:**
 - Web service User: 1232123
 - Web service Password: 123123213
 - Submitter ID: 123123213
 - TPID: 12312321312
- Service Message:** A text input field.
- Statement Messages:**
 - Top: A text input field.
 - 1: A text input field.
 - 2: A text input field.
 - 3: A text input field.
 - 4: A text input field.
 - 5: A text input field.

On the right side of the window, there are buttons for Save, Cancel, and Help.

Figure 129. eMEDIX tab

eMEDIX Estimate tab

Use this tab to enter a message to appear on estimates. The Website URL field is optional and can be used if sending the patient to a website for patient education or for collecting possible deposits/prepays for the proposed procedures. This will print on the Estimate.

The screenshot shows the 'Program Options' window with the 'eMEDIX Estimate' tab selected. The window has a tabbed interface with tabs for General, Data Entry, Payment Application, Aging Reports, HIPAA/ICD-10, Color-Coding, Billing, Audit, eMEDIX, eMEDIX Estimate, and BillFlash. The eMEDIX Estimate tab contains the following fields:

- Website URL:** A text input field.
- Patient Estimate Message:** A large text area containing a pre-defined message:

Based on your coverage and our contract with your insurance company we are providing this good faith estimate of your financial responsibility. This amount is not the final bill, which may be more or less, depending on the final determination of coverage and other factors such as service dates, unknown or unexpected costs or procedures performed, complications or special circumstances which may occur that are unknown at this time. This good faith estimate is given to you as a courtesy to allow for planning your payment.

On the right side of the window, there are buttons for Save, Cancel, and Help.

Figure 130. eMEDIX Estimate tab

BillFlash Tab

The BillFlash tab allows you to control some of the information that appears on the statements you send electronically via BillFlash, the web based company that is set up to process electronic statements in CGM MEDISOFT.

Program Options

General | Data Entry | Payment Application | Aging Reports | HIPAA | Color-Coding | Billing | Audit | **BillFlash**

Credit Cards Accepted ☒ Visa ☒ MasterCard ☒ Discover ☒ American Express

Credit Card Security Code Message
3-4 Digit Sec. Code

Service Message For Billing Inquiries Call:

Paper Color: ☒ White ☐ Blue ☐ Red ☐ Green

Print Optional Sections: ☒ Summary ☒ Aging

Statement Messages
Top:
1:
2:
3:
4:
5:

Save Cancel Help

Figure 131. Program Options screen - BillFlash tab

Chapter 29 - Backup and Restore Data

In this chapter you will learn how to back up and restore data using both the regular and hot backup/restore features.

Backing Up Your Data

Making regular backups is essential to good maintenance of your data.

Best Practice--consider backing up data files every day so you can restore lost data to the most recent date before the files were damaged or corrupted. If you are working with multiple practices, each practice will have its own set of backup files. Doing your backups within the CGM MEDISOFT program is a dependable method.

Important! Prior to making a backup, you must stop the MPIC service and the Mobile service. Follow these steps to stop those services.

1. Click the **Start** button.
2. Enter services in the Search programs and files field.
3. Press **Enter**. The Component Services screen appears.
4. Click Services (local). The list of services appears.
5. Find McKesson MSL Mobile Api Server. Right-click and select Stop.
6. Find MPICservice. Right-click and select Stop.
7. Launch CGM MEDISOFT, open your practice, and make a backup.
8. Return to the Component Services screen and restart McKesson MSL Mobile Api Server and MPICservice.

To make a backup:

1. On the File menu, point to Backup, and click **Backup Data**.
2. Click the **OK** button on the warning message. The CGM MEDISOFT Backup screen appears.
3. Complete the fields on the screen.
4. Click the **Start Backup** button.
5. Click the **OK** button on the message that the backup is complete.

Restoring Your Data

You will very seldom have to restore a backup. It is only necessary if the data becomes corrupted or you have to print reports that are no longer accessible because of the addition of new data. eMDs highly recommends that you create a new backup of your current data **BEFORE** you restore your backup. You may need this backup to restore your files to their current state.

To restore a backup:

1. On the File menu, point to Restore, and click **Restore Backup**.
2. Click the **OK** button on the warning message. The CGM MEDISOFT Restore screen appears.
3. Select a backup on the list of existing backups or click **Find** to find a different backup.
4. Click the **Start Restore** button. A confirmation screen appears.
5. Click the **OK** button. The backup is restored.
6. Click the **OK** button.
7. Click the **Close** button on the CGM MEDISOFT Restore screen.

Making a Hot Backup

This feature is for CGM MEDISOFT Network Professional only.

Hot Backup allows you to make a backup of your data while other users are still working in the practice. Hot Backup will ensure that processes are completed before creating the backup. Once the backup is complete, you will be logged out of CGM MEDISOFT and must log back in to resume work.

To make a hot backup:

1. On the File menu, point to Backup, and click **Hot Backup**. The CGM MEDISOFT Hot Backup screen appears.
2. Complete the fields on the screen.
3. Click the **Start Backup** button.
4. Click the **OK** button on the message that the backup is complete.

Restoring Your Hot Backup

You will very seldom have to restore a hot backup. It is only necessary if the data becomes corrupted or you have to print reports that are no longer accessible because of the

addition of new data. eMDs highly recommends that you create a new backup of your current data **BEFORE** you restore your backup. You may need this backup to restore your files to their current state.

To restore a hot backup:

1. On the File menu, click **Restore**.
2. Click **Hot Restore**.
3. Click the **OK** button on the warning message. The CGM MEDISOFT Hot Restore screen appears.
4. Select a backup on the list of existing backups or click the **Find** button to find a different backup.
5. Click the **Start Restore** button. A confirmation screen appears.
6. Click the **OK** button. The backup is restored.
7. Log back into CGM MEDISOFT.

Chapter 30 - Merge Patients

CGM highly recommends that you make a full backup prior to merging patients! In addition, be sure to process any Unprocessed Transactions for the patient whose record you are merging to another patient record. If you interface with an EHR, do not allow other users to add appointments for the source patient while a merge is in process.

In addition, CGM recommends that:

- No other users are accessing the source or target patient while the merge is in process.
- Close the Patient list and Office Hours prior to merging patients.

You can now merge two patient records if there are duplicates in your system. When you merge, the following data will be merged:

- All Cases (and all information inside those cases including images) from the Move From (source) patient will be added to the Move Into (target) patient so that the Move To (target) patient has any original cases, as well as the ones added via the merge.

Warning note: Potentially, now that cases have been moved, the 'last used' case on the Move To (target) patient will be different.

- Everything in Transaction Entry (all transactions--charges, payments, adjustments, statements, and claim notes, etc.) will now be associated with the Merge To (target) patient
- All claims from the Move From (source) patient will now be associated with the Move TO (target) patient
- All Statements from the Move From (source) Patient will now be associated with the Move To (target) patient
- All appointments will be moved to the Move To (target) patient
- **Phone numbers in appointments/recalls/waitlist:** if the numbers in the most current appointment are the same as the numbers in the FROM patient, all appointments will have the number of the TO patient when merged.
- If there are "one-off" phone numbers in the most recently added appointment of the FROM patient, where a number was changed in that appointment so it differs from the one(s) in the patient record, the merge will place that number in all appointments of the From patient once merged. The Waitlist and Recall will also have these number(s) after the merge.
- If there are no appointments for the FROM patient and the patient is on the Waitlist or has a Recall set and there are one-off numbers in FROM patient in Waitlist or Recall. after the merge the numbers in the Waitlist and Recall are left as they were entered in Waitlist and Recall on the FROM patient
- All AR tracker items (tasks, status, notes, etc., will be moved).
- All Archived records are merged
- Final Draft: **No changes will be made during the merge.**

If you have any Final draft documents, you will need to manually change the file name of any documents saved with the From patient to the TO patient.

Final draft documentation Information or document text will NOT be changed during the merge. You must do this after the merge has taken place.

- If the Move From Patient (source) was a Guarantor or Policy Holder for any other patient, the Move To (target) patient will be replaced in those patients' corresponding fields.

What will not be merged

Demographic data (name, address, telephone number, etc.) will NOT be moved between patients. The system assumes that the Move To patient's demographics are correct and the most current.

It is recommended to do the merge when others are not using the system, However, if you do a merge while other users are in the system, you may encounter an error during the Merge because another user has a record in use/locked:

- If there is an issue anywhere during the merge, you will need to fix the issue and start again. Otherwise, the Merge From patient will still exist and there will still be entries in tables not processed with the old patient until you finish the process.

Refresh

The Patient List and Office Hours grids do not refresh automatically after the merge. Consequently, if someone is merging, other users may still see that patient on the list until they close and reopen the list. Be sure to instruct them to refresh the Patient List.

If the Patient List is open and cursor focus is on the move FROM patient and the user opens the Patient ledger, the ledger will open with the chart of the patient who is no longer there and the name of first patient in the patient list. In this case, simply pick another patient or close the list and reopen to refresh

Merging Patients and Interfaces with CGM MEDISOFT

If you are merging patients and use an EHR: CGM MEDISOFT does not send a Merge HL7 message, so with some EHRs there is some pre- or post-work that needs to be done.

For all EHRs:

The CGM MEDISOFT Office side needs to communicate with the EHR side to no longer use the source patient to send charges.

If your EHR has a merge option, it should be done immediately after merging in Medisoft. No one else in the system should be doing any activities involving the Merge From or To patients while the merge is in process.

If your EHR does not have a merge option, mark the From [patient inactive](#) in the EHR or do whatever process is applicable in that clinical system so that chart is no longer used to send charges

If there is a patient already in Unprocessed Charges before the merge, and then the merge is performed, the merge process will update the chart in Unprocessed with the Merge TO chart and, in most cases, will work as normal and can be posted. However, if the name, date of birth, or SSN are different between the patient in Unprocessed (the original FROM patient) and the current patient record (the Merged TO patient), there will be a mismatch error and that charge cannot be

posted. That charge will have to be manually added in Transaction Entry and deleted from Unprocessed Transactions.

To avoid this, check Unprocessed Transactions prior to doing a merge and post the charges prior to the merge.

The most likely scenario for this is if there was a From patient who got married and the TO patient was added with the married/different name.

The table below describes the steps to perform (if any) for each EHR.

Interface	Actions necessary
CGM APRIMA	Use the Patient Merge feature in CGM APRIMA to merge the same two patients. For more information, see the CGM APRIMA Online Help topic "Merging Patient Records."
CGM MEDISOFT EHR (Clinical)	Use the Patient Merge feature in CGM MEDISOFT EHR (Clinical) to merge the same two patients. For more information, see the online Help topic in CGM MEDISOFT EHR (Clinical): "Merge Patients Utility."
Plus	<u>Appointments/Demographics</u> Nothing needs to be done. Any existing appointments for the FROM patient get updated with the TO patient and the highest case updates.
CGM MEDISOFT Mobile	CGM eMDs recommends that you do not do a merge while anyone is using these patients on a mobile device

Merge Patient Warning message

This message reminds you of the changes to your patient records that will be made when you merge patients. Click Yes to proceed.

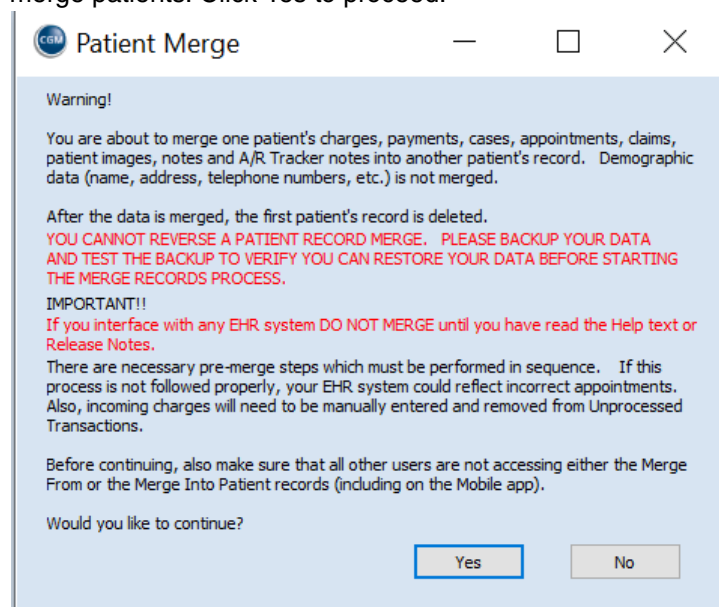


Figure 132. Merge Patient Warning message

Merge Patient screen

Use this screen to select the patient records that you want to merge.

- In the Merge From Patient field, select the record that you want to be merged with the Merge Into Patient field. The Merge From Patient record will be DELETED when the process is complete.
- In the Merge Into Patient field, select the record that will receive data from the Merge From Patient record. This record will be RETAINED in CGM MEDISOFT after the process is complete.

CGM Patient Merge

Merge From Patient:

Merge Into Patient:

By clicking MERGE NOW I acknowledge that:

- * I have confirmed there is a current and verified backup which can be restored if the merge needs to be reversed.
- * If this practice interfaces with an EHR, all steps outlined in Help/Release Notes for pre-merge requirements have been completed.
- * I have verified no other users are working in or have the MERGE FROM or MERGE INTO Patients open in any place on the system or in the mobile app.

Once the merge process has begun, if you receive a message 'current record in use this process cannot complete', that indicates someone is accessing the patient. You must get the other Users out of this patient and repeat the merge. Depending on what record was locked, a partial merge could have been done and if you do not complete a successful merge, your MERGE FROM patient has only been partially merged.

Merge Now Cancel

Figure 133. Merge Patient Utility screen

If you leave either field blank, you will receive an error message if you try to proceed.

Click Merge Now to merge the records.

NOTE: CGM highly recommends that you make a backup BEFORE you merge records. In addition, process any Unprocessed Transactions for the FROM patient and close Office Hours.

Glossary

This section defines terms used in the CGM MEDISOFT v29.

Care Plan Oversight Number

This is the number physicians have if they have supervision of Medicare patients under the care of hospices or home health agencies that require complex or multidisciplinary care.

CLIA Number

This is Clinical Laboratory Improvement Amendment Number. This number is required for all laboratory claims.

EDI Receivers

These are the organizations to which you send claims or eligibility requests.

EOB

An EOB is one or more ready-to-mail forms containing claim-specific information. Each form lists the carrier's payments, allowances, and insurance filing activity. EOBs are used mainly to inform secondary carriers of the payments and disallowances posted to a claim by the claim's primary carrier.

Insurance Class

Insurance classes enable you to categorize insurance carriers into groups.

Legacy identifier

This refers to a provider number or identification number other than NPI, such as a BCBS provider number, Unique Provider Identification Number (UPIN), Medicare number or Medicaid number.

Level One user

This is a user with the highest access level in CGM MEDISOFT, often an administrator.

List screen

These are screens that show lists of information, such as providers, insurance carriers, and so on. From these screens you can select an item to edit or create a new item for the list.

Mammography Certificate Number

The Mammography Certification Number is assigned to a provider certified to perform a mammography and is required on all mammography claims.

McKesson Practice Interface Center (MPIC)

This is an interface application that can be installed and configured to connect CGM MEDISOFT with other applications.

National Provider ID

This refers to a unique number for a physician or practice that identifies them.

Open Item Accounting

A type of accounting where charges and payments for patients remain on the books and are not lumped together at the end of a fiscal period or year.

Provider Class

The provider class is a way of categorizing providers into groups.

Quick Ledger

The Quick Ledger is a feature of CGM MEDISOFT that gives a quick reference for transaction and other information in the patient's account.

Revenue Management

This is the application that is bundled with CGM MEDISOFT that enables a user to transmit claims and eligibility payments electronically.

Rules

Rules are logic patterns set up in CGM MEDISOFT to ensure that claims are processed correctly for providers and practices based on requirements set by the government and insurance carriers.

Superbill

The superbill is designed to be a physician's worksheet. The superbill displays a list of what procedures can be performed by the provider and the diagnoses related to it displayed in a list format.

Taxonomy Number

This is a number that specifies the type of practice the physician is in, for example, family practice or emergency medicine

UB-04

This is a form used by institutions to file claims to insurance carriers.

Unique Physician Identification Number (UPIN)

The Unique Physician Identification Number (UPIN) is a number assigned to physicians and others who are enrolled in the Medicare Program.

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