



ChartMaker® Clinical Release Notes

ChartMaker® 2016 (fv6.2.4)

Please note that the ChartMaker Medical Suite can no longer be installed on computers using the Windows XP or Windows 2003 Server operating system. Since Microsoft has discontinued support for Windows XP in April 2014, and Windows 2003 Server in July 2015, we can no longer guarantee the stability of computers using this operating system, and recommend that you upgrade the operating system on any computers currently using Windows XP or Windows 2003 Server.

Added Features

- **Audit Trail** – The Audit Trail has been updated to track when an order has been uploaded to the PatientPortal. When the **Send Print Procedures and Send to PatientPortal** or **Send to PatientPortal** option is selected from the facesheet context menu for Procedures, and audit event will be created. When such an event occurs the Event column will display **Export**; the Group column will display **Order**; the Audit Trail Description will display the list of **Orders** separated by a semicolon; and the patient's **Account #** will be listed in the Metadata column.
- **Audit Trail** – The Audit Trail has been updated to track when a new patient is added in ChartMaker® Mobile (requires ChartMaker® Mobile version 6.2.4). When a new patient audit event occurs, the Event column will display **Added**; the Group column will display **Person**; the Audit Trail Description will display **Status**; and the patient's **Account #, Practice, and Mobile Username** (in comments) will be listed in the Metadata column.
- **Export Patient Data** – The **Document Type** field, in the Export Patient Data dialog, has been updated with a **Referral Summary** option that becomes available whenever the **Date Range** option is selected above. See Figure 1. When the Referral Summary is selected as the Document Type, the system will generate a Referral Summary note for each of the patients selected that have an open referral for the date range specified.

Name	Date of Birth	Account #
Duck, Daffy	2/1/1963	10102

Name	Date of Birth	Account #
Duck, Daffy	2/1/1963	10102

Figure 1 – Export Patient Data

Added Features (continued)

- The Facesheet – Health Alert** – The Health Alert button in the Facesheet has been updated so that whenever button becomes active (highlighted), indicating that a procedure is due per the Flow Sheets, you can now click the **Health Alert** button to access a Health Alerts dialog that will display the Flow Sheet name, and underneath any procedures that are due for that flowsheet. See Figures 2 and 3.



Figure 3 – The Facesheet – Health Alert Button

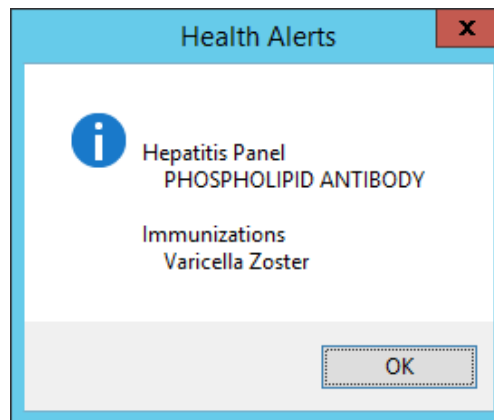


Figure 3 – Health Alerts

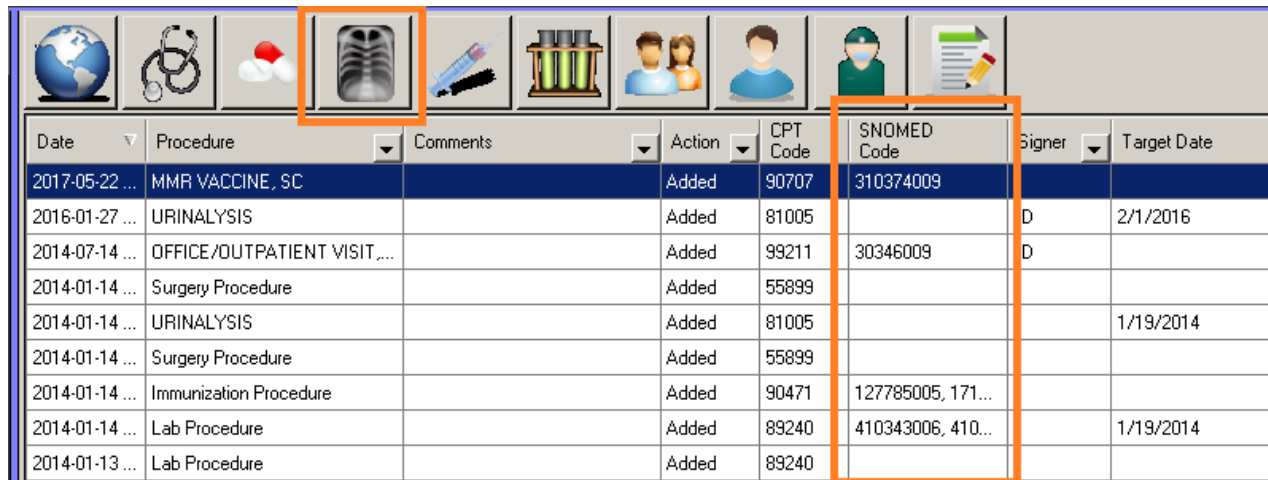
- History Tab** – The Global (**All**) and **Results** views of the History tab have been updated to display the LOINC codes in parentheses after the answers to screening questions in the Detail column, for the **Social, Psychological, and Behavioral, Quick Depression Assessment Panel (PHQ9)**, and **Generalized Anxiety Disorder (GAD7)** questionnaires. See Figure 4.

Date	Name	Detail	Action	Code	SNOMED Code	Signer	Type
2017-08-29 ...	Little interest or pleasure in doing thi...	Several days (LA6569-3)	Entered	44250-9			Value
2017-08-29 ...	Feeling down, depressed, or hopeles...	Several days (LA6569-3)	Entered	44255-8			Value
2017-08-29 ...	Patient Health Questionnaire 2 item (...)	2	Entered	55758-7			Value
2017-08-29 ...	What is the highest grade or level of ...	High school graduate (LA15564-0)	Entered	63504-5			Value
2017-08-29 ...	How many days of moderate to stren...	1	Entered	68515-6			Value
2017-08-29 ...	On those day that you engage in mo...	20	Entered	68516-4			Value
2017-08-29 ...	How often do you have a drink cont...	2-4 times a month (LA18927-6)	Entered	68518-0			Value
2017-08-29 ...	How many standard drinks containin...	1 or 2 (LA15694-5)	Entered	68519-8			Value
2017-08-29 ...	How often do you have 6 or more dri...	Less than monthly (LA18933-4)	Entered	68520-6			Value
2017-08-29 ...	Total score [AUDIT-C]	3	Entered	75626-2			Value
2017-08-29 ...	How hard is it for you to pay for the v...	Somewhat hard (LA22683-9)	Entered	76513-1			Value
2017-08-29 ...	Do you feel stress - tense, restless, n...	Only a little (LA22687-0)	Entered	76542-0			Value

Figure 4 – History Tab

Added Features (continued)

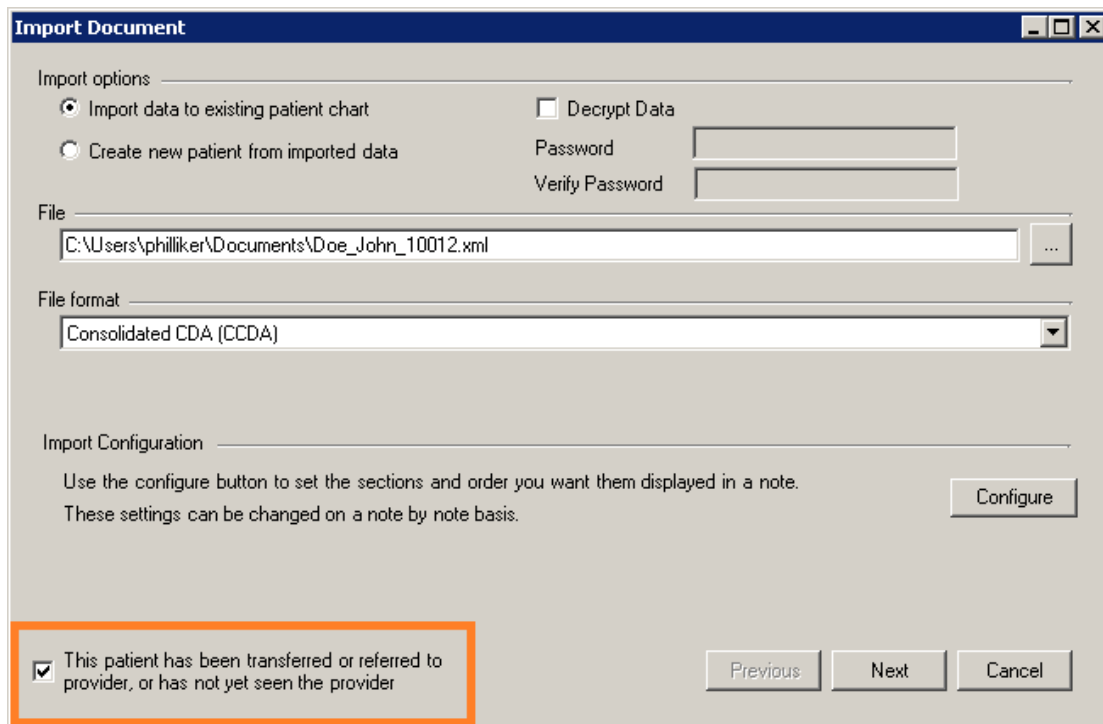
- **History Tab** – The **Procedures** view of the History tab has been updated with a **SNOMED Code** column that will display any SNOMED Codes attached to the corresponding procedure. See Figure 5.



Date	Procedure	Comments	Action	CPT Code	SNOMED Code	Signer	Target Date
2017-05-22 ...	MMR VACCINE, SC		Added	90707	310374009		
2016-01-27 ...	URINALYSIS		Added	81005		D	2/1/2016
2014-07-14 ...	OFFICE/OUTPATIENT VISIT,...		Added	99211	30346009	D	
2014-01-14 ...	Surgery Procedure		Added	55899			
2014-01-14 ...	URINALYSIS		Added	81005			1/19/2014
2014-01-14 ...	Surgery Procedure		Added	55899			
2014-01-14 ...	Immunization Procedure		Added	90471	127785005, 171...		
2014-01-14 ...	Lab Procedure		Added	89240	410343006, 410...		1/19/2014
2014-01-13 ...	Lab Procedure		Added	89240			

Figure 5 – History Tab – Procedures View

- **Import Patient Data** – The Import Document dialog (accessed via **Chart > Import > Patient data**) has been updated with a **This patient has been transferred or referred to provider, or has not yet seen the provider** option that allows you to track whether the patient has been transferred, referred, or never seen the provider when importing a document for a patient. See Figure 6. Whenever this option is selected, it will be counted toward any applicable Meaningful Use and MIPS 2018 performance measures.



Import Document

Import options

☒ Import data to existing patient chart ☐ Decrypt Data

☐ Create new patient from imported data Password

Verify Password

File

C:\Users\philliker\Documents\Doe_John_10012.xml

File format

Consolidated CDA (CCDA)

Import Configuration

Use the configure button to set the sections and order you want them displayed in a note.
These settings can be changed on a note by note basis.

☒ This patient has been transferred or referred to provider, or has not yet seen the provider

Previous Next Cancel

Figure 6 – Import Document

Added Features (continued)

- Import from HIE** – The Import Document from HIE dialog (accessed via **Chart > Import > From HIE**) has been updated with a **This patient has been transferred or referred to provider, or has not yet seen the provider** option that allows you to track whether the patient has been transferred, referred, or never seen the provider when importing a document from an HIE for a patient. See Figure 7. Whenever this option is selected, it will be counted toward any applicable Meaningful Use and MIPS 2018 performance measures.

Import Document from HIE

Select patient:

Name	Account/Ch.	DOB
Doe, Abbey	10041	2/19/1969
Doe, Carl	10056	3/25/1965
Doe, Flo	10038	2/13/1978
Doe, Jane M.	10040	3/3/2000
Doe, Jennifer C.	10009	9/27/1969
Doe, John	10012	8/10/1980
Doe, John	10003	10/16/1993
Doe, Jonah	10011	9/12/1956
Doe, Rene	10039	1/1/1966


Matching Results: 9

Search Column: Search Type:

☒ This patient has been transferred or referred to provider, or has not yet seen the provider

Previous Next Cancel

Figure 7 – Import Document from HIE

- Infobutton** – A new Infobutton dialog has been created that allows you to research and retrieve diagnostic and therapeutic information concerning a patient via MedlinePlus. The Infobutton dialog is accessed through the Chart menu when in a patient's chart (**Chart > Infobutton**), or via the  button located at the bottom-left of the decision support Alert Manager dialog. See Figure 8.

Alert Manager

Active Alerts | History

Pop-up Disabled	Alert Type	Rule	Rule Logic	Recommended Action	Date Occurred
<input checked="" type="checkbox"/>	Decision Support	For patients that were born in 1980	DOB >=#01/01/1980# and DOB <=#12/31/1980#		7/12/2017 1:37:34 PM
<input type="checkbox"/>	Decision Support	Patients that are older than 57, have an current diagnosis of influenza, and are currently taking Coumadin.	CurrentDxInfluenzaCD10 and CurrentMedCoumadin and AgeInYears > 57		9/10/2014 10:01:43 AM
<input type="checkbox"/>	Decision Support	Patients that are older than 57, have an current diagnosis of influenza, and are currently taking Coumadin.	CurrentDxInfluenzaCD10 and CurrentMedCoumadin and AgeInYears > 57		1/17/2014 10:36:02 AM


 OK Cancel

Figure 8 – Alert Manager

Added Features (continued)

Infobutton (continued)

After the Infobutton dialog has been accessed, you can then configure the various parameters to search, locate, save, and print applicable diagnostic and therapeutic information as needed. See Figure 9. In the Patient Search Criteria section of the Infobutton dialog, you can refine your search by the patient's **Age, Birth Date, Birth Sex, Race, Ethnicity, Sexual Orientation, Gender Identity**, as well as **Diagnoses, Medications, Procedures, and Lab Results**. When selecting diagnoses, medications, procedure, and lab results the corresponding drop-down lists will populate with information from the patient's chart.

After the search criteria has been selected, you can click the **Search** button, and the system will retrieve any applicable information from MedlinePlus. You can then scroll through the information in the various tabs below, click the various links in the pages as needed, and then once the desired information has been located, you can save or print that information using the corresponding buttons. Any information saved will appear as a hyperlink in the **Saved Information** section. You can then access that information as needed by double-clicking the link, and the information will open in a tab below. When that information is no longer needed, you can delete it by highlighting the item in the Saved Information section, and then clicking the **Delete** button.

The screenshot shows the Infobutton dialog box at the top. The 'Resource' is set to 'MedlinePlus'. Under 'Patient Search Criteria', several checkboxes are selected: 'Age: 37 years', 'Race: Black or African American...', 'Ethnicity: Hispanic or Latino', 'Sexual Orientation: Straight or heterose...', and 'Gender Identity: Identifies as Male'. Below this, a section for selecting diagnoses, medications, procedures, and lab results shows 'Diagnoses' selected with 'Essential (primary) hypertension' in the dropdown. A table below this shows a single entry: 'Diagnosis' with 'Essential (primary) hypertension'. A 'Search' button is at the bottom right of this section. To the right of the dialog box is the 'Saved Information' section, which contains a single link: 'High Blood Pressure'. Below the dialog box is a browser window showing the MedlinePlus website. The browser's title bar says 'High Blood Pressure'. The website header includes the NIH logo and 'U.S. National Library of Medicine'. The main content area features the MedlinePlus logo and a search bar with 'High Blood Pressure' entered. Below the search bar are links for 'About MedlinePlus', 'Site Map', 'FAQs', and 'Customer Support'. At the bottom of the website, there are links for 'Health Topics', 'Drugs & Supplements', 'Videos & Tools', and a language selector for 'Español'. A breadcrumb trail at the very bottom reads 'Home → Health Topics → High Blood Pressure'.

Figure 9 – Infobutton

- **Medications – Process Change Request** – The system has been updated to allow you to create and maintain user-defined Comments when processing change request denials as well as unmatched change request denials.
- **Medications – Process Refill Request** – The system has been updated to allow you to create and maintain user-defined Comments when processing refill request denials as well as unmatched refill request denials.

Added Features (continued)

- **Medication History** – The system has been updated with a Medication History dialog that allows you to import Medication History for a patient from the SureScripts Network into the patient's chart, and then reconcile that information with any medications currently in the patient's chart. The Medication History dialog is accessed through the Chart menu when in a patient's chart (**Chart > Medication History**). The medication history information is also available through the Medication History button in the Prescribe Medication dialog, however, you are not able to import and reconcile medications when accessing via the Prescribe Medication dialog, it is view only from this area.

Do note, to access Medication History for a patient, the patient must have given medication history consent and it must be configured in the Consent dialog for that patient (i.e., in **ID Tab > Consent** or **Medication History Consent** button in Prescribe Medication dialog).

When accessing the Medication History dialog, you may first receive a series of dialogs indicating that the system is gathering the information, or that the Medication History is pending for the patient. Likewise, you may also receive dialogs that indicate that there is no history information available for the patient, or that history information could not be retrieved. See Figure 10 for examples of these types of messages.

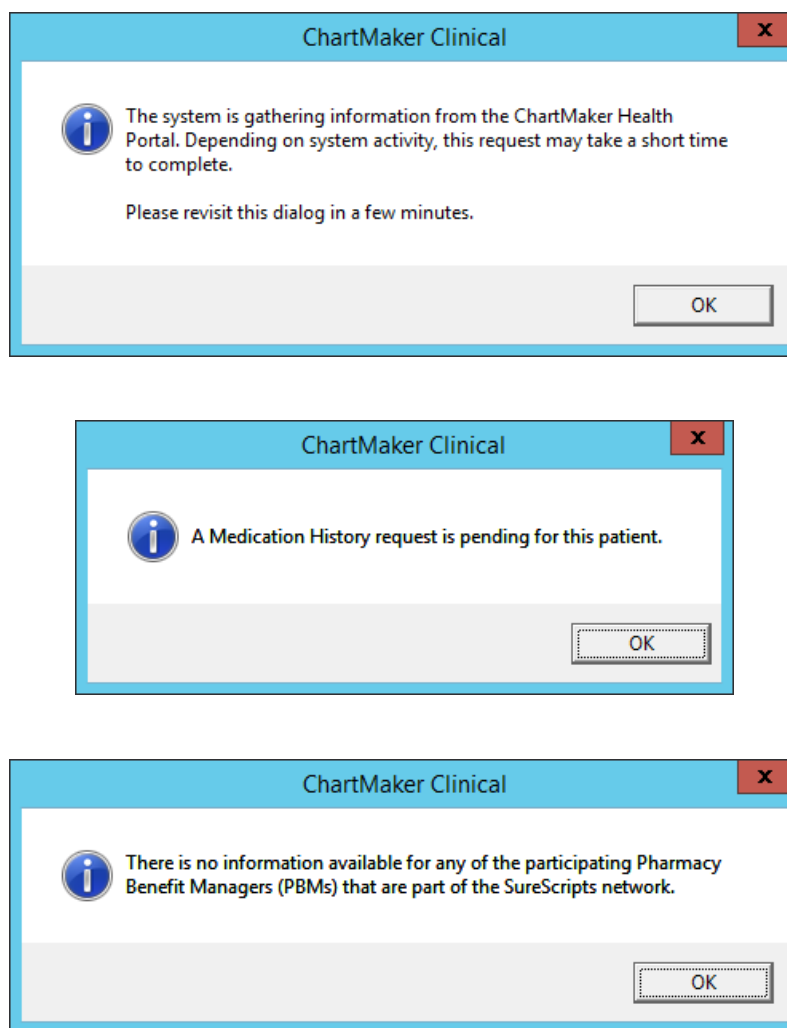


Figure 10 – ChartMaker Clinical – Medication History Messages

Added Features (continued)

Medication History (continued)

In the Medication History dialog, the patient basic demographic information will be listed, along with medication history for that patient. See Figure 11. Beside the Medication History title, at the top of the dialog, the number of medication occurrences will appear in parentheses.

At the bottom of the dialog there is a **Filter By** section that allows you filter the medication history by **Medication**, **Prescriber**, and **Last Fill Date**. After the filter items are configured as desired, simply click the **Filter** button. You can then view the medication by scrolling through the Medication section, **Reconcile** the medications, or **Print** the medication history. When reconciling and printing, only those medications that are included in the filter criteria will be included.

Medication History (54)

Consent: Ben Davidson
Date Received: 8/31/2017 11:50:14 AM

Patient -

Name:	SELENA KYLE
Gender:	F
Date of Birth:	10 / 11 / 1966
Address:	23230 PORT
City:	AKRON
State:	OH
Zip Code:	44306

Medication -

Drug Description:	LIFESCAN UNISTIK 2 LANCETS
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Disclaimer: Some information may not be available or accurate in this list, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient, non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

Filter By...

Medication: Prescriber:

Last Fill Date: 7/ 1/2015 to 8/31/2017

Figure 11 – Medication History

Added Features (continued)

Medication History (continued)

After the Reconcile button has been clicked, a Clinical Information Reconciliation (CIR) dialog will appear that allows you to view and reconcile the various medications, broken into the patient's Current Chart Medications, Available Medications from Surescripts Medication History, and a Final Merged List. Each list will show the available medication (name, start and last modified dates, last fill date, and sig information) detail. See Figure 12.

Medications in the Available Medications from Surescripts Medication History list are color-coded to denote the level of medication information available and the ability of importation. You can click the **Legend** option for a complete listing. Medications can be moved individually by clicking the **Add** button, or in bulk using the **Add All** button. Each medication also includes a **Skip** checkbox that can be manually selected, but will be turned on if the medication already exists, has an end date that has passed, or if there isn't enough information to import the medication. Medications that have been added will show in the Final Merged List and labels will be updated to show their status as added.

New medications added to the Final Merged List can be edited by using the **Change** button (except for controlled substances which cannot be changed during the import process). This will open the Prescribe Medication dialog with as much of the available information found in the Surescripts Medication History pre-filled. The Prescribe Medication dialog will also show the original name, dates, and text from the import at the bottom of the dialog for reference.

An added medication can be removed from the list and existing medications can be discontinued on either the final or current list. If a medication is discontinued, the End Medication dialog will appear and then the medication will be marked as ended.

After all the applicable medications have been reconciled, you can **Confirm** the import. The system will then import the medications in the Final Merged List, and after confirmation messages have been satisfied, you will return to the Clinical Information Reconciliation (CIR) dialog with the medication information updated. An Auto-generated drug log will be created listing the drug details for each medication imported. Likewise, the patient's facesheet will be updated with the medications imported, and the medications will appear in the patient's History tab.

The screenshot shows the 'Clinical Information Reconciliation (CIR)' dialog box. It has three tabs: 'Medications', 'No Diagnoses to Import', and 'No Allergies to Import'. The 'Medications' tab is selected. The dialog is divided into three main sections: 'Current Chart Medications', 'Available Medications from Surescripts Medication History', and 'Final Merged List'. The 'Current Chart Medications' section shows 'amoxicillin 500 mg capsule' as 'Active'. The 'Available Medications from Surescripts Medication History' section lists several medications with their status (Active) and a 'Skip' checkbox. The 'Final Merged List' section shows the medications that have been added to the patient's chart, including 'amoxicillin 500 mg capsule', 'ACTOS 15 MG TABLET', 'AMARYL 1 MG TABLET', and 'BUPROPION HCL 75MG TABLET'. At the bottom of the dialog, there are buttons for 'Discontinue', 'Add', 'Add All', 'Legend', 'Remove', 'Change', 'Confirm', and 'Cancel'.

Figure 12 – Care Plan Button

Added Features (continued)

- **The Note Tab – Care Plan** – A new **Care Plan** widget is available to add to chart note templates, via the Template Editor, that allows you to add Health Status, Impressions, Health Concerns, and Goals regarding a patient's health care. See Figure 13.



Figure 13 – Care Plan Button

When the Care Plan widget is accessed, a **Care Plan** dialog will appear allowing you to add, edit, and delete care plan information for the patient. See Figure 14.

The **Health Status** drop-down list will contain pre-configured status items along with the corresponding SNOMED codes. You can select an item or leave this field blank. When a health status is selected, it will appear in the History tab along with the SNOMED description and code.

The **Impressions** field allows you to enter any free-text impressions or assessments.

The **Heath Concerns** section allows you to add chart diagnoses that are of concern via the **Add Diagnoses** button, or additional health concerns in free-text format via the **Add Additional Health Concerns** button. When adding diagnoses, an Add Diagnoses as Health Concerns dialog will appear listing any active, inactive, or pre-existing diagnoses that are in the patient's chart; you can simply check any diagnoses you want to include as health concerns. When adding additional health concerns, an Add Health Concern dialog will appear allowing you to add a free-text description of the concern. After diagnoses and additional health concerns have been added, you can edit and remove items by highlighting the applicable items, and using the **Edit** and **Remove** button.

Figure 14 – Care Plan

Added Features (continued)

The Note Tab – Care Plan (continued)

The **Goals** section allows you to add, edit and remove health goals for the patient via the **Add Goal**, **Edit**, and **Remove** buttons. When adding and editing goals, the Add Goal dialog will appear allowing you to select from user-created list of common goals, or to enter or modify a free-text goal for the patient. See Figure 15. Likewise, the **Initiated By** field allows you to associate who initiated the goal: **Provider**, **Patient**, or **Both**. Common goals can be maintained via the Goal Maintenance dialog accessed by **Edit** button. Goals added in the Goals Maintenance dialog can be shared with other users in the system, as desired. When a new goal is added, it will appear in the patient's History tab with the text of the goal.

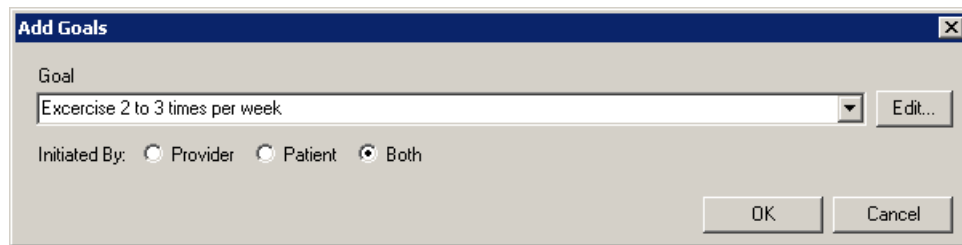


Figure 15 – Add Goals

In addition, in the **Note output** field you can determine how this information is outputted to the note. You can choose to output the configured information in **List format**, **Paragraph format**, or **No Output**.

When creating a note with a Care Plan button, if the patient already has a Care Plan from a previous note, all the previously entered information will automatically be pulled into the new note. When opening the Care Plan dialog, you can view, edit, and remove items done previously. A patient will only have one active care plan at any time, and this information will be included when generating Transition of Care documents for the patient.

- **The Note Tab – Diagnosis** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2017 – Sept 30, 2018** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30 2016 code set, the Oct 1, 2016 – Sept 30 2017 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when adding or editing a diagnosis in the chart note, the system will default to the code set based on the **Note Date** to ensure that the proper ICD codes for that date are selected.
- **The Note Tab – Educational Materials** – The system has been updated so that whenever you have saved education materials from MedlinePlus for a patient, and that patient is registered with the PatientPortal, the links to those web documents will be included in the Educational Materials section of the Clinical Summary that is sent to portal when the applicable note is signed, or if that note is manually sent to the portal by right-clicking the note and selecting **Send to PatientPortal**. When the links are clicked when viewing the Clinical Summary in PatientPortal, the exact documents that the provider selected will open.

Added Features (continued)

- **The Note Tab – Implantable Device** – The FDA Device Name field in the Implantable Devices dialog has been renamed to **Device Name**. Also, the District Identification Code field has been renamed to **HCT/P Distinct ID Code**. See Figure 16.

The screenshot shows the 'Implantable Devices' dialog box. The 'Device List' on the left contains a table with columns 'FDA' and 'Name'. The first row is selected and highlighted in blue: 'Cadaveric-donor/synthetic mineral bone graft'. Below the list are 'Add' and 'Delete' buttons. The 'Device Information' section on the right displays various fields: 'Device Record Status: Published', 'Record Publish Date: 01/28/2016', 'Commercial Distribution Status: In Commercial Distribution', 'Identifiers: Device ID: W4146EB0010T0475, Device ID Type: Primary, Device Issuing Agency: ICCBBA', 'Brand Name: Trabexus® EB', 'Version Or Model Number: 10 cc', 'Catalog Number: 130703-10', 'Company Name: Vivorte, Inc', 'Device Count: 1', 'Device Description: Calcium compound bone void filler with DBM (10 cc)', and 'Device Subject to Direct Marketing, but Exempt: No'. The 'Device Details' section at the bottom contains several input fields: 'Device Name' (highlighted with an orange box), 'Device Identifier' (W4146EB0010T0475), 'Serial #' (000025), 'Batch/Lot #' (00000000000XYZ123), 'Manufacture Date' (2/ 1/2013), 'Expiration Date' (2/ 1/2014), 'HCT/P Distinct ID Code' (A999713123456, highlighted with an orange box), 'Device Status' (Active), 'Device Removed' (No), 'Implanted Date' (Month, Day, Year), and 'Device UDI' (=/W4146EB0010T0475=,000025=A99971312345600=>014032=)013032&100000000000XYZ123). There are also 'Add', 'Delete', 'Refresh FDA Data', 'OK', and 'Cancel' buttons. A status bar at the bottom left says 'Ready'.

Figure 16 – Implantable Devices

- **The Note Tab – Order Procedure – Immunizations** – The program has been updated to ensure that the latest CVX codes and CVX mappings, per the latest CDC guidelines, are used for immunization procedures.

Added Features (continued)

- **The Note Tab – Patient Assignment** – The program has been updated with the ability to enter and capture patient assignment information for incoming transition of care patients to ensure that the **Importing Transition of Care into Patient's Chart** and **Clinical Information Reconciliation** performance measures are calculated correctly for Meaningful Use Stage 3 and MIPS 2018 via the Patient Assignment button. See Figure 17.


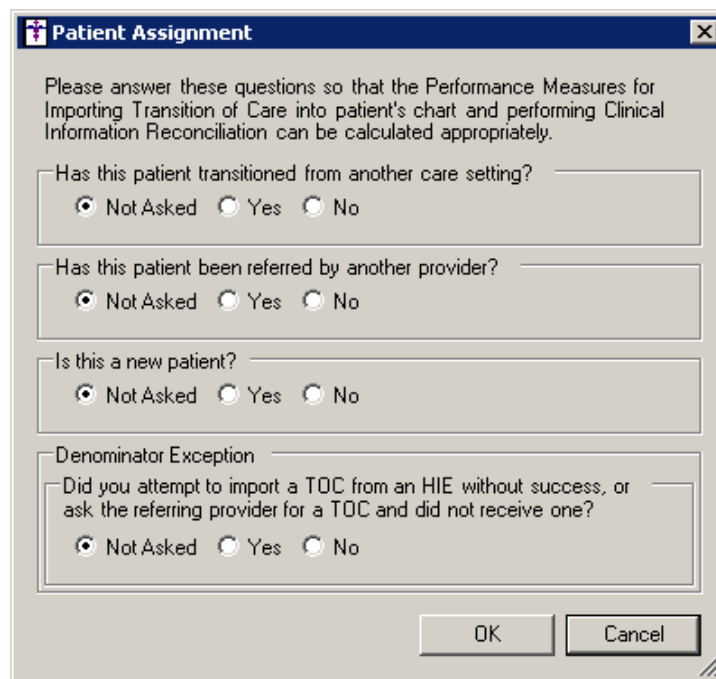
Patient Assignment: 

Figure 17 – Patient Assignment Button

Once the Patient Assignment button has been clicked the Patient Assignment dialog will appear allowing you to answer four questions regarding the patient's transition of care and whether a Denominator Exception has been performed. See Figure 18. To edit patient assignment information, you must access the chart in which the original note was entered.

When Patient Assignment information is entered, it will be counted toward any applicable Meaningful Use Stage 3 and MIPS 2018 performance measures.



The dialog box is titled "Patient Assignment" and contains the following text: "Please answer these questions so that the Performance Measures for Importing Transition of Care into patient's chart and performing Clinical Information Reconciliation can be calculated appropriately." It features four sections, each with a question and three radio button options: "Not Asked", "Yes", and "No".

- Has this patient transitioned from another care setting?
☒ Not Asked ☐ Yes ☐ No
- Has this patient been referred by another provider?
☒ Not Asked ☐ Yes ☐ No
- Is this a new patient?
☒ Not Asked ☐ Yes ☐ No
- Denominator Exception
Did you attempt to import a TOC from an HIE without success, or ask the referring provider for a TOC and did not receive one?
☒ Not Asked ☐ Yes ☐ No

At the bottom right are "OK" and "Cancel" buttons.

Figure 18 – Medication Reconciliations

- **The Note Tab – Screening – Social, Psychological, and Behavioral** – The question under the **Education** category (What is the highest grade or level of school you have completed or the highest degree you have received?), and the first question under the Social Connection and Isolation category (Are you now married, widowed, divorced, separated, never married or living with a partner?), have been updated with a **Declined to specify** option. Any answer that is tagged as **Declined to specify** will output to the note and will also appear in the History tab.
- **The Note Tab – Signature Widget** – The system has been updated to allow those users accessing the ChartMaker Medical Suite applications in a Cloud environment to capture signatures using a Topaz Signature Device. Be aware that an Advanced Preference needs to be configured prior to use, and other setups may be required to enable this functionality.

Added Features (continued)

- **Patient-Generated Health Data** – The Patient-Generated Health Data dialog has been updated with a Date Added column so you can easily see when data was entered for the patient. See Figure 19. Likewise, using the **Add** button, the title of the dialog accessed has been changed from Add Health Data to **Add Health Data Website**; and the URL field, in legacy versions of this dialog, has been renamed **Website**.

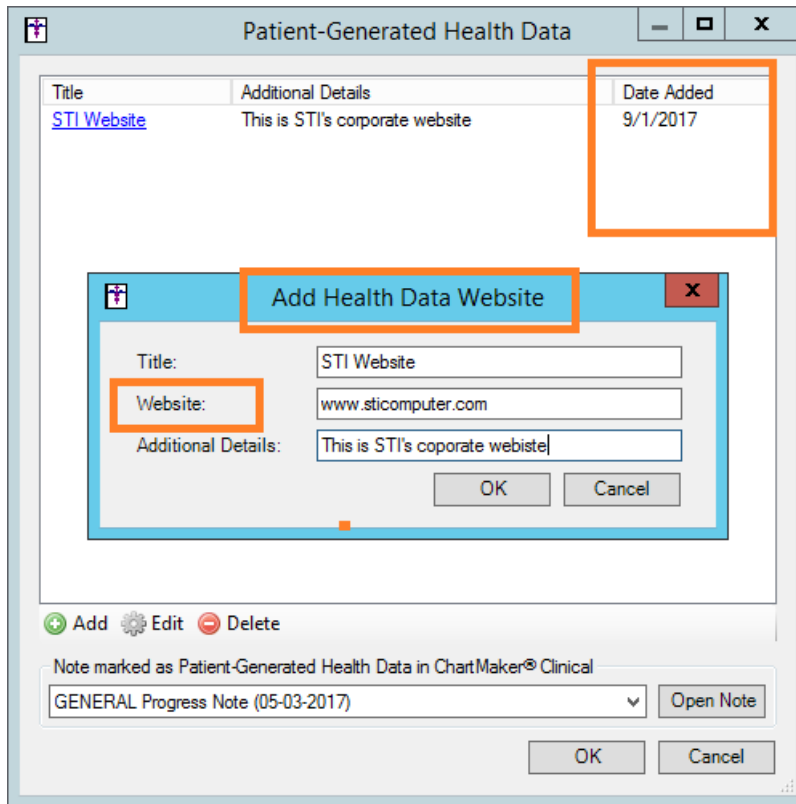


Figure 19 – Patient-Generated Health Data

- **System Tables – Diagnosis Search** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2017 – Sept 30, 2018** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30 2016 code set, the Oct 1, 2016 – Sept 30 2017 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog via the **Edit > System Tables** menu, the system will default to the code set based on the current day's date.

Added Features (continued)

- System Tables – Mobile – Mobile Administration** — The **Audit** tab, in the Mobile Administration dialog, has been updated to track to when a new patient is created in ChartMaker® Mobile (requires ChartMaker® Mobile version 6.2.4). See Figure 20. When a new patient audit event occurs, the Activity Type column will display **New Patient**, and the Additional Info column will display the patient's **Date of Birth** and the **Practice** to which the patient was added.

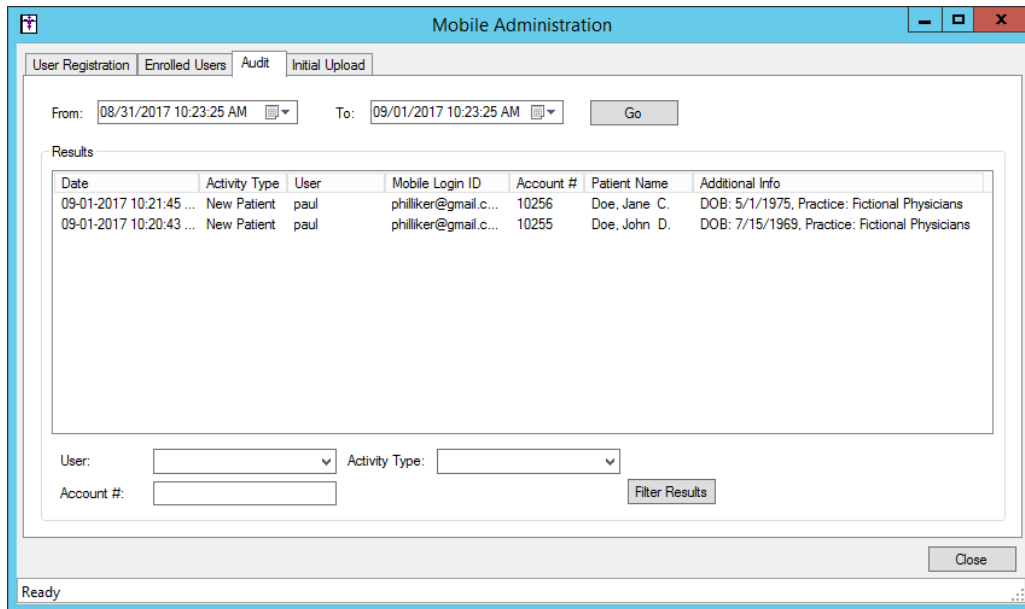


Figure 20 – Mobile Administration – Audit

- System Tables – Mobile – New Patients** — A **New Patients From ChartMaker® Mobile** dialog has been created to easily view all patients that were created in ChartMaker® Mobile (requires ChartMaker® Mobile version 6.2.4). See Figure 21. When new patients are added through the mobile app, they are given a status of NPI (New Patient Incomplete Information), and need to be activated in Practice Manager prior to processing any pending charges. Patients will remain listed in this dialog until their status has been updated in Practice Manager.

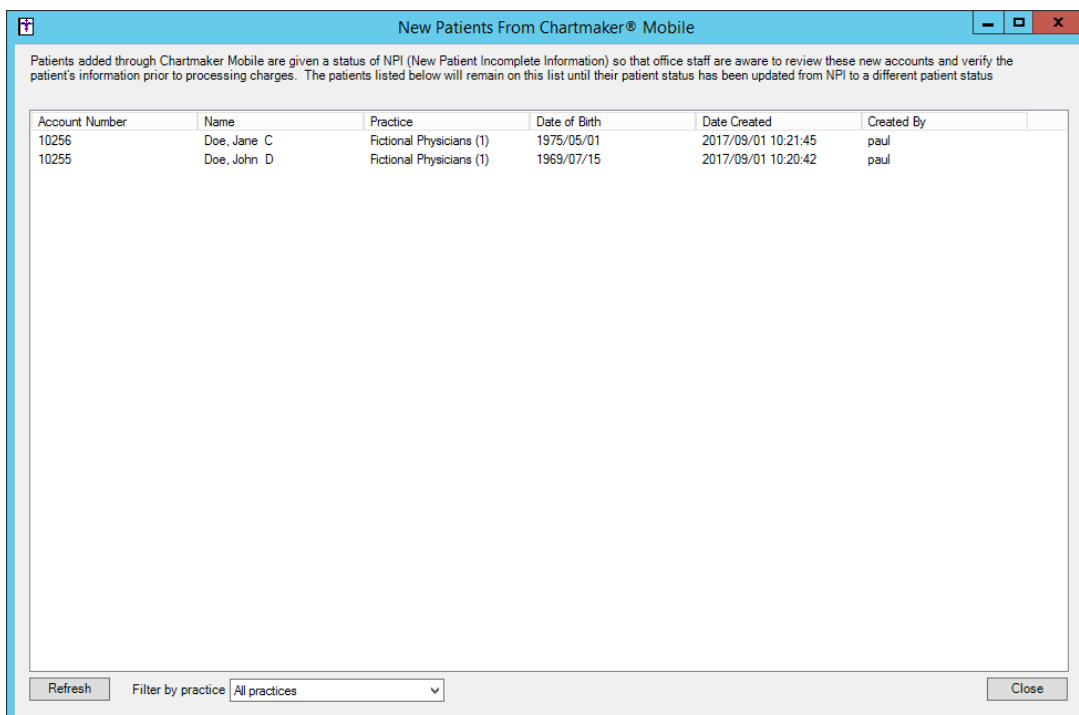


Figure 21 – Mobile Administration – Audit

Added Features (continued)

- **Template Editing – Care Plan** – The Template Editor has been updated with the ability to add a **Care Plan** widget to a template that will allow you to add health related information such as health status, impressions and concerns, as well as goals for a patient. See Figure 22.



Figure 22 – Care Plan Button

- **Template Editing – Patient Assignment** – The Template Editor has been updated with the ability to add a Patient Assignment button to a template. The Patient Assignment button lets you to track patient assignment information for incoming transition of care patients to ensure that the **Importing Transition of Care into Patient's Chart** and **Clinical Information Reconciliation** performance measures are calculated correctly for Meaningful Use Stage 3 and MIPS 2018. See Figure 23.

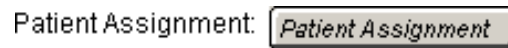


Figure 23 – Patient Assignment Button

When the Patient Assignment button is added to the template you can access the Patient Assignment dialog that allows you to add a **Heading** that will be displayed prior to the **Patient Assignment** button. See Figure 24.

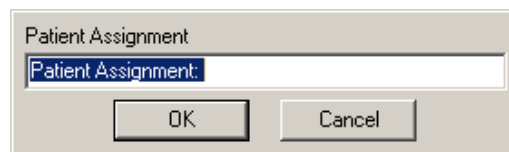


Figure 24 – Implantable Device

SureScripts® E-Prescribing Best Practice Guidelines

Below are best practices that have been developed to assist in the construction of complete, non-contradictory, and clear patient directions:

Ensure that Directions are complete and accurate

- All information in the Sig must be accurate, complete, and include all the required components written in the following order: action, dose, dose units, route, frequency, and finally auxiliary information.
 - The exception to this syntax is Sigs which simply state "Take/Use as Directed/Instructed as per manufacturer labeling."
- Information within the Sig must not conflict with itself

Example: Use **"Take 1 tablet by mouth daily"** instead of just **"Daily."**

Always qualify "...as Directed" with a source

- Statements such as "Take as directed" and "Use as instructed" should only be used when followed by a source that clearly dictates to the patient where or from whom they can obtain the specific directions.
- If a Sig builder tool is used, ensure that prescribers enter the specific source of the instruction after selecting the "Take/Use as directed/instructed" option before they can proceed with finalizing the e-prescription.

Example: Use **"Use as instructed per instructions on package"** instead of **"Use as instructed."**

Always qualify "PRN (as needed)" with an indication

- The use of "PRN" (i.e. "as needed") should only be used in conjunction with an indication.
- For all other non-PRN directions, inclusion of an indication is also recommended; alternatively, there is also a designated structured field for Diagnosis, in which ICD-10 codes may be used to communicate the appropriate diagnosis or indication relevant for the prescribed product
- If a Sig builder tool is used, ensure that the Sig builder tool requires prescribers to enter the specific indication or conditions for PRN use if the prescriber selects a "PRN" frequency

Example: Use **"Take 1 tablet by mouth every 4 hours as needed for mild to moderate pain"** instead of **"Take 1 tablet by mouth every 4 hours as needed."**

Always specify the Duration of Therapy for Acute Treatments

- Duration of therapy should **only** be specified for medications for acute treatments with a defined length of therapy, e.g., antibiotics.

Avoid Abbreviations, Acronyms or Symbols

- ISMP (Institute for Safe Medication Practices) provides the complete list of *Error-Prone Abbreviations, Symbols, and Dose Designations* that should never be used in a prescription
- If the use of Latin abbreviations is desired, the system should include the ability to expand Latin abbreviations into plain English text via keystroke accelerators. The expanded text form of the Sig should be displayed to the prescriber to ensure correct transition from abbreviations to full text

Example: Use **"Instill 1 drop into both eyes once daily"** instead of **"1 gtt ou qd."**

Never Truncate or Split Directions between multiple fields

- If the patient directions are being transmitted exceeds the 140-character limit, it should be communicated by other means, e.g. as a fax or printed handout
- Sig information should **not** be written into the Notes field if it exceeds the 140-character limit.

Send only Patient Directions (Sig) within the Directions field

- The Sig should not contain information for which another designated field exists in the SCRIPT standard (e.g. the Sig should never include the quantity, drug name, NDC or RxCUI values, or Notes to pharmacists, etc.)

Example: Use **"Take 1 tablet by mouth once daily"** instead of **"Take 1 tablet by mouth once daily. Dispense #30, 3 Refills, Thank you."**

Do not include Clinical or Prescription Information in the Notes field.

- The Notes field be used to contain information related to, but not part of the prescription. While clinical and prescription information should appear in the designated fields for these data elements, not in the Notes field.

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input.

(1) Guidelines that apply to name, strength, dosage form, and quantity of drug prescribed as well as the directions for use (the “Sig”)

- Drug names should be spelled out in full, avoiding the use of abbreviations.
 - While it might be possible to make the case that abbreviations save time in the world of paper prescriptions, no such time savings accrue in the electronic world in which the prescriber simply picks a medication from a drug database.
 - Abbreviations can lead to a misinterpretation of the prescriber’s intent, which can result in medication errors.
 - Examples:
 - Use “Hydrochlorothiazide 50 mg” instead of “HCTZ 50 mg.”
 - Use “Zidovudine 300 mg” instead of “AZT 300 mg.”
- Drug descriptions should include complete name, strength, strength units and dosage form information (if applicable) in the same exact order, and all should appear in one drug description field.
 - Not doing so causes problems in pharmacies due to missing data components.
 - It is preferred that either the generic or the brand name be used in the drug description, but not both. Using both unnecessarily complicates the information in the drug description field.
 - Examples:
 - Use “Doxycycline Monohydrate 50 mg oral capsule” instead of “Doxycycline caps.”
 - Use “Ciprofloxacin 500 mg tablet” instead of “Ciprofloxacin tablet 500 mg.”
 - Use “Atorvastatin calcium 20 mg tablet” or “Lipitor 20 mg tablet” instead of “Lipitor (Atorvastatin calcium) 20 mg tablet.”
 - Drug descriptions for generic products should use the naming conventions found in the Food and Drug Administration’s “Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations.”
 - This helps pharmacists to accurately choose the product to be dispensed when brand names are not used.
 - Examples:
 - Use “Glipizide 10mg tablets, extended release” instead of “Glipizide TAB OSM 24 10mg.”
 - Drug strength information should be consistent across all fields in which it appears.
 - The strength in the drug description should match that in the drug strength field.
 - Drug strength units in the drug description should match those in the drug strength units field. Drug strength units should not be sent in the drug strength field.
 - Example of improper use: The drug description is “Amoxicillin 500 mg oral capsule” and the drug strength field contains the value of “250.”
- Dosage form codes should match the forms sent in drug description fields.
 - Example of improper use: The drug description is Amoxicillin 500 mg capsule and the dosage form code field contains “10,” which is the NCPDP code that stands for tablet.
- All orders should be written using metric measurements of weight (e.g., mg, gm and kg) and volume (e.g., ml).
 - The apothecary and avoirdupois systems of weights and volumes are no longer considered appropriate in the world of pharmaceuticals.
 - Example: Use “Aspirin 81 mg” instead of “Aspirin 1 ¼ grains.”
- A zero should be used before a decimal (use 0.X mg instead of .X mg), but not after (use X mg instead of X.0 mg).
 - Trailing zeros are particularly dangerous in that they can lead to ten-fold overdoses. Thus, trailing zeros should never be used.
 - Examples:
 - Use “Digoxin 0.25 mg” instead of “Digoxin .25 mg.”
 - Use “Haloperidol 5 mg” instead of “Haloperidol 5.0 mg.”
- Arabic (decimal) numerals are preferable to Roman numerals, and in some instances it is preferable for numbers to be spelled out.
 - Example: Use “Aspirin 325 mg” instead of “Aspirin V grains.”
- Other specific abbreviation issues:
 - The term “microgram” can be abbreviated as “mcg,” but it should not be abbreviated as “ug,” which can easily be mistaken for the abbreviation for “mg,” standing for “milligram.”
 - The word “unit” should be spelled out and never abbreviated as “U” or “u.”
 - “M” should not be used as an abbreviation for thousands (e.g., 5 M units), as it has been mistaken as meaning one million.
 - Do not use commas when expressing thousands as they might be misinterpreted as periods.

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

(2) Issues related specifically to the Sig field or directions for use.

- The directions for use should not be split between the Sig and Notes fields.
 - Depending upon the design of the pharmacy system and/or the effectiveness of the training of pharmacy personnel, splitting directions between the Sig and Notes fields can result in part of the directions being missed, thereby preventing complete directions from being conveyed to patients. Patients may experience significant negative therapeutic outcomes when this occurs.
 - Examples of improper use:
 - Sig field—"Take one tablet daily," Notes field—"Take only on Monday, Wednesday and Friday." NOTE: This is an actual example from a warfarin e-prescription, which if not taken according to the complete directions, could possibly result in serious patient harm.
 - Sig field—"Dissolve one tablet under the tongue every 10 minutes for chest pain," Notes field—"Call physician immediately if relief is not obtained after three doses."
 - Sig field—"Apply and rub well into affected area twice a day," Notes field—"Discontinue use and call physician if rash worsens."
 - Sig field—"One drop to eye having surgery three times daily," Notes field—"Start two days prior to surgery."
- Information in the Sig field should not conflict with information in the Notes field.
 - Conflicting information in these fields usually requires pharmacists to contact prescribers to ascertain their actual intent with respect to the directions, which compromises the efficiencies related to e-prescribing.
 - Inconsistent information in the Sig versus the Notes fields can result in incorrect directions being conveyed to patients.
 - Example of improper use: Sig field—"1 cap orally 3 times a day", Notes field—"One capsule by mouth daily."
- Care must be taken so that Sigs are not truncated because important information can be lost.
 - Example of improper use: "Take 1 tablet once a month in the am 1 hr before eating or drinking, with 1 C water. Remain upright x 1 hour and nothing by mouth, then resu"
- Sig information should be clinically correct.
 - Example: Use "Amoxicillin 500 mg Oral Capsules"—Sig "One capsule three times a day" instead of "500 caps 3 times a day."
- Directions for use should be spelled out clearly in proper English.
 - Since the pharmacist must interpret—and nearly always writes—the label in English, the use of abbreviations (particularly Latin) or symbols is unnecessary and discouraged because it can lead to medication errors.
 - Example: Use "Take 1 tablet by mouth twice a day" instead of "1 T PO BID."
- Information in the Sig field should be limited to the Sig.
 - Quantity to be dispensed should not be placed in the Sig field.
 - Example: Use "One capsule by mouth three times daily" instead of "One capsule by mouth three times daily – Disp # 30."
 - Duration of therapy should not be placed in the Sig field.
 - Example: Use "One capsule by mouth four times daily" instead of "One four times daily – Disp 10 day supply."
 - Drug description should not be placed in Sig field.
 - Example: Use "One capsule by mouth at bedtime" instead of "One by mouth at bedtime– Paxil CR 20 mg."
 - Example of improper use:
 - "One drop to eye having surgery three times daily. Start two days prior to surgery. May substitute Acular LS, Xibrom, or Voltaren if less expensive." (i.e., the indication of alternative approved drugs "May substitute Acular LS, Xibrom, or Voltaren if less expensive" should be placed in the Notes field.)
- Sigs should be complete, properly formatted, and not repeated.
 - Sig should be complete.
 - □ Example: Use "Apply topically to forearm three times a day" instead of "Topical each day."
 - Sig should be properly formatted.
 - □ Example: Use "Take one capsule three times a day" instead of "1 3 times a day."
 - Sig should not be repeated.
 - □ Example: Use "Take one capsule daily" instead of "1 PO QD – Take one tablet every day."
- The inclusion of the intended use or the indication for the medication in the directions for use is helpful to patients, pharmacists and other prescribers, and is strongly encouraged.
 - Intended use can help patients to organize and better understand their medications and why they are taking them.
 - Including the indication in the Sig field can help prevent dispensing errors, and it provides pharmacists with a foundation for patient counseling and medication therapy management.
 - Other prescribers may find the indication helpful when a patient brings their medication bottles with them to office visits.
 - Example: "Take according to instructions in dosepack for poison ivy rash."

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

- The instruction “take as directed” is rarely appropriate and should be avoided by prescribers.
 - Such an instruction assumes an understanding on the part of the patient that may not exist, and even if it does, will very likely be short lived.
 - Using the term “take as directed” provides little information upon which the pharmacist can base their counseling of the patient.
- (3) Proper use of the Notes field (referred to as “free text” in the NCPDP SCRIPT Standard).
- Prescription information that has a designated, standardized data field should not be placed in the Notes field.
 - For example, neither the drug name, strength nor quantity should be placed in the Notes field because there are specific fields in the NCPDP SCRIPT Standard for these data elements. This is important because if this information isn’t placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
 - Clinical information that has a designated, standardized data field should not be placed in the Notes field.
 - As with prescription information, the clinical information should appear in the designated fields for these data elements. This is important because if this information isn’t placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
 - Reserve use of the Notes field for information related to, but not part of, the prescription.
 - For example, a comment such as: “Please have the patient call the office when they have finished taking this prescription” would be an appropriate use of the Notes field.
 - To reiterate, as mentioned above, the directions for use should not be split between the Sig and Notes fields nor should the information in the Sig field conflict with information in the Notes Field.
 - The former can lead to critical information being missed by pharmacy personnel and possibly not being transmitted to the patient, and the latter normally requires pharmacists to contact the prescriber to clarify their intent, thereby compromising the potential efficiencies of e-prescribing.
- (4) Refills authorized, if any
- Although allowed both by convention and NCPDP SCRIPT, the indication of “PRN” (refill as needed) is not considered to be good practice and should be discouraged.
 - Example: Use “Refill 11 times” instead of “Refill PRN.”
- (5) Other items unique to electronic prescribing.
- Representative NDC number requirements.
 - Representative NDC numbers, which contain 11 digits, must be correct, as incorrect representative NDC numbers may cause drug identification problems in the receiving pharmacies.
 - Representative NDC numbers must be current and included in e-prescription messages unless the items do not have assigned NDCs.
 - Quantity Qualifiers must be correctly associated with drug descriptions.
 - Correct mapping procedures are available in the Units of Measure table, which can be found in the NCPDP External Code List and the Surescripts Implementation Guides.
 - Where possible, quantities should reflect the actual metric quantity to be dispensed.
 - Example: Use “Amoxicillin 250mg/5ml, 150 ml” instead of “Amoxicillin 250mg/5ml, 1 bottle.”
 - The use of “ZZ”, “EA” and “00” should be limited to instances in which none of the available qualifiers in the Units of Measure table can be applied.
 - ☐ Examples of improper use: Drug description—Amoxicillin 500 mg Oral Capsule, Quantity 30 and Quantity Qualifier sent “ZZ”—mutually defined, “EA”—each or “00”—unspecified instead of “AV”—capsules.

Category III—Prescription Common Mistakes

Even though providers using the ChartMaker Medical Suite strive to be accurate in entering information for E-prescription, there are common mistakes made that can easily be corrected. Please read through the examples below in order to understand E-prescription best practices.

(1) Incorrect or incorrectly formatted SIG

This occurs when the appropriate dose is entered incorrectly. The following examples demonstrate typical errors:

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category III—Prescription Common Mistakes (continued)

Drug Description	SIG	Notes	Nomenclature Description	Comment
Combivent 20 mcg-100 mcg/actuation Aerosol Inhaler	Spray 1 aerosol with adapter (gram) puff(s) 4 times a day		Incorrect or incorrectly formatted SIG	"1 aerosol" is not an appropriate dose for Combivent
Advair HFA 115 mcg-21 mcg/actuation Aerosol Inhaler	Take 2 aerosol with adapter (gram) puff(s) twice a day		Incorrect or incorrectly formatted SIG	"2 aerosol" is not an appropriate dose for Advair HFA
ProAir HFA 90 mcg/actuation Aerosol Inhaler	Take 2 puffs puff(s) q 4-6 hrs prn cough or wheeze or before exercise		Incorrect or incorrectly formatted SIG	Part of the patient instructions are duplicated
Proctosol HC 2.5 % Rectal Cream	Apply 1 cream (gram) rectally 4 times a day		Incorrect or incorrectly formatted SIG	"1 cream" is not an appropriate dose for Proctosol
dicyclomine 10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Three times a day	prn as directed	Incorrect or incorrectly formatted SIG	SIG should be free of all extraneous characters All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Lotrel 5 mg-10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Daily	Name Brand Medically Nec.	Incorrect or incorrectly formatted SIG; Conflicting or Supplementary Drug Substitution information in the Notes	SIG should be free of all extraneous characters All Drug Substitution information should be sent in its designated field; No parts of the Drug Substitution information should be in the Notes
Suprax 400 mg capsule	Take 1 capsule (hard, soft, etc.) orally qd		Incorrect or incorrectly formatted SIG; Incorrect, Missing or Incomplete Dosage Form sent in Drug Description	SIG should be free of all extraneous characters - Suprax 400mg is not available in capsule form; Appropriate dosage form: Oral Tablet

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category III—Prescription Common Mistakes (continued)

(2) Incomplete SIG

The following examples indicate incomplete SIG:

Drug Description	SIG	Comment
Suprep 17.5 gram-3.13 gram-1.6 gram Oral Solution	Take 1 solution, reconstituted, oral orally As Needed	SIG should include the dose, route and frequency of the prescribed medication
Coumadin 4 mg tablet	Take 2 tablet orally as directed	SIG should include the dose, route and frequency of the prescribed medication
Zithromax Z-Pak 250 mg tablet	Take 1 tablet orally As Directed	SIG should include the dose, route and frequency of the prescribed medication

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category III—Prescription Common Mistakes (continued)

(3) Conflicting or Supplementary SIG information included in the Notes

Drug Description	SIG	Notes	Comment
nystatin 100,000 unit/gram Topical Ointment	Apply 1 ointment (gram) topically Twice a day	FOR CORNER OF LIP	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
metformin 500 mg tablet	Take 1 TABLET orally bid	*take 1 tablet daily for 1 month, then increase to 1 tablet twice a day	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Augmentin 875 mg-125 mg tablet	Take 1 tablet orally Every 12 hours	x 5 days	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Mobic 7.5 mg tablet	Take 1 tablet orally twice a day	as needed	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes

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ChartMaker® Mobile Release Notes

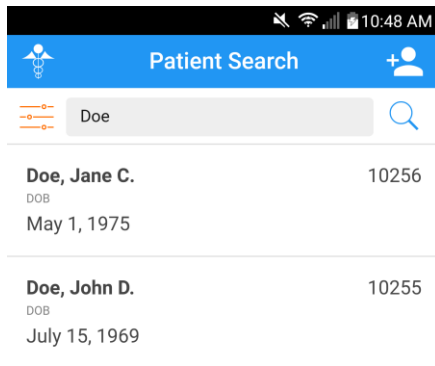
ChartMaker® 2016 (fv6.2.4)

ChartMaker Mobile 6.2.4 Enhancements

Patient

- **Patient – Patient Search** – The Patient Search screen, accessed via Charge Capture or Patient, has been updated with an Add Patient  button, that allows you to add a new patient in ChartMaker® Mobile. See Figure 1.

After the  button has been tapped, a New Patient screen will appear allowing you to enter the patient's name, date of birth, birth sex, and the practice they are associated with. See Figure 2. The **First Name**, **Last Name**, **Date of Birth**, **Birth Sex**, and **Practice** information is required when adding a new patient.

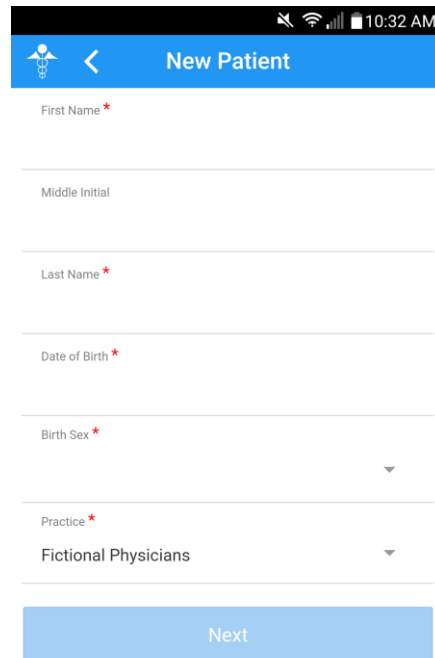


The Patient Search screen shows a search bar with the text "Doe" and a magnifying glass icon. Below the search bar, there are two patient entries. Each entry displays the patient's name, DOB, and a unique ID.

Patient Name	DOB	ID
Doe, Jane C.	May 1, 1975	10256
Doe, John D.	July 15, 1969	10255



Figure 1 – Patient Search



The New Patient screen displays a form with the following fields: First Name (required), Middle Initial, Last Name (required), Date of Birth (required), Birth Sex (required), Practice (required), and Fictional Physicians. A "Next" button is located at the bottom of the form.

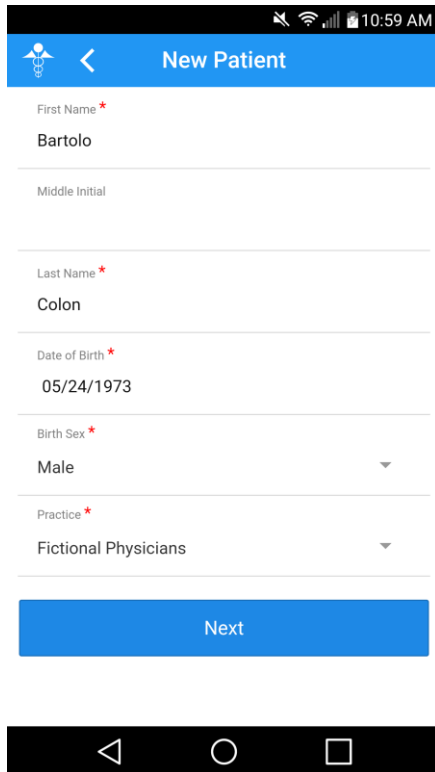


Figure 2 – New Patient

Patient (continued)

Patient – Patient Search (continued)

After the applicable information is entered for the patient, you can tap the Next button. See Figure 3. The system will check for any duplicate patients, and if there are similar patients, an **Existing Patients Found** message will appear displaying the similar patients. See Figure 4. You can then tap **Continue** to continue adding the patient as entered, or tap **Cancel** to go back to the New Patient screen and modify the patient's information, or go back to the Patient Search screen to access the correct patient.

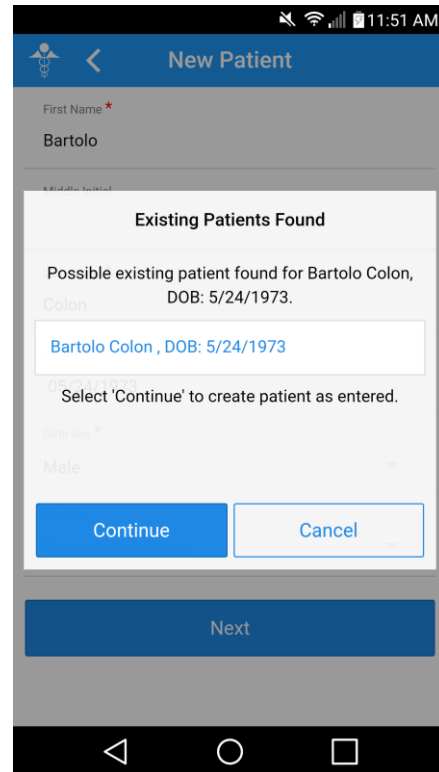


The screenshot shows the 'New Patient' form with the following fields and values:

- First Name: Bartolo
- Middle Initial: (empty)
- Last Name: Colon
- Date of Birth: 05/24/1973
- Birth Sex: Male
- Practice: Fictional Physicians

A blue 'Next' button is located at the bottom of the form.

Figure 3 – New Patient (Configured)



The screenshot shows the 'New Patient' form with an 'Existing Patients Found' modal overlay. The modal displays the following information:

- Existing Patients Found
- Possible existing patient found for Bartolo Colon, DOB: 5/24/1973.
- Bartolo Colon , DOB: 5/24/1973
- Select 'Continue' to create patient as entered.

The modal includes 'Continue' and 'Cancel' buttons. The 'Next' button from the form is visible below the modal.

Figure 4 – Existing Patients Found

Patient (continued)

Patient – Patient Search (continued)

After the Continue button has been tapped, the configured patient information will appear for confirmation. See Figure 5. If everything is correct, you can tap the **Confirm** button to add the patient. The patient will then be created, and you will then be able to enter a charge, add another patient, or search for a patient by tapping the appropriate link below. See Figure 6. Do note, that when new patients are added through ChartMaker® Mobile, they are given a status of NPI (New Patient Incomplete Information), and their status will need to be activated in Practice Manager prior to processing any pending charges.

10:59 AM

New Patient

Please review the following information. Go back to make changes or select 'Confirm' to add the patient to your practice.

Chart Number
10271

First Name
Bartolo

Middle Initial

Last Name
Colon

Date of Birth
5/24/1973

Birth Sex
Male

Practice
Fictional Physicians

Cancel Confirm

Figure 5 – New Patient (Confirm)

10:59 AM

New Patient

Patient was created successfully.

Bartolo Colon

Account Number
10271

Date of Birth
May 24, 1973 (44 years)

Birth Sex
Male

[Enter Charge](#)

[Add Another Patient](#)


[Patient Search](#)



Figure 6 – New Patient (Added)

Charge Capture

- **Charge Capture – Charge History & Charge Details** – The Charge Capture functionality has been updated with a new **Charge History** screen that appears once a patient has been accessed via the Patient Search screen, and allows you to add a new charge, view the details of previously sent charges, or to copy a charge that had been previously sent from ChartMaker® Mobile. See Figure 7. When entering the Charge History screen the patient name will appear at the top, a **New Charge** link will then appear, and then a Sent Charges section that will contain any previously sent charges from ChartMaker® Mobile. In the Sent Charge section you can either view the charge details for a previously sent charge, and/or copy a previously sent charge.

If you click the **New Charge** option, you will enter the Charge Capture screen and you can enter the charge capture information as in previous versions.

If you want to copy a previously sent charge, simply tap the  icon next to the corresponding charge in the Sent Charges section. Do note, that if the patient does not previously sent charges a message will appear in this section indicating that no mobile charges have been entered for this patient.

To view the details of a previously sent charge, tap the applicable charge and the Charge Details screen will appear displaying the charge details for that charge capture. See Figure 8. In the Charge Details screen you can add a new charge by tapping the  icon, or copy the currently selected charge by tapping the  icon. Likewise, a **Copy Charge** link and a **New Charge** link will appear below the charge details information.

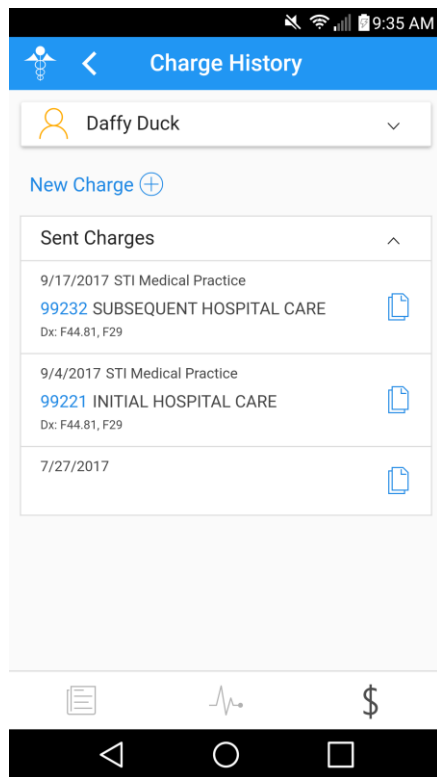


Figure 7 – Charge History

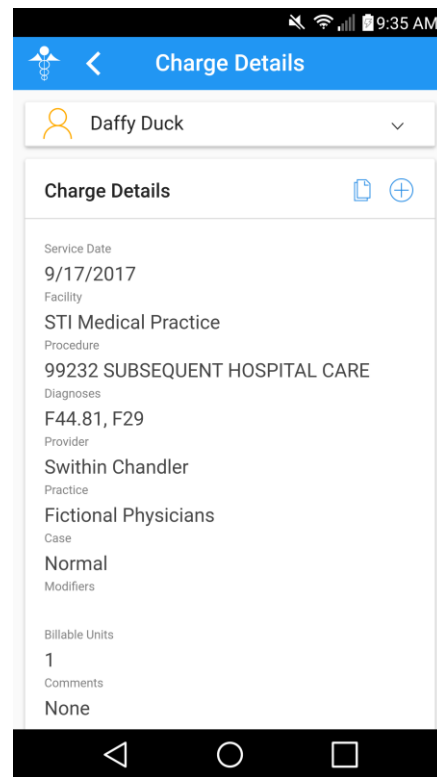

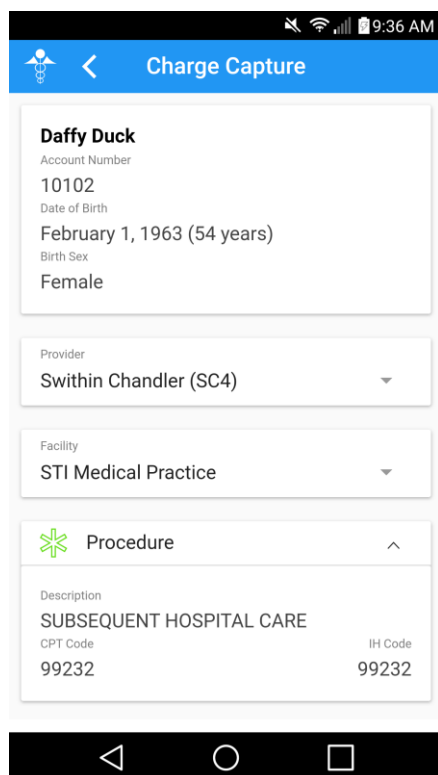


Figure 8 – Charge Details

Charge Capture (continued)

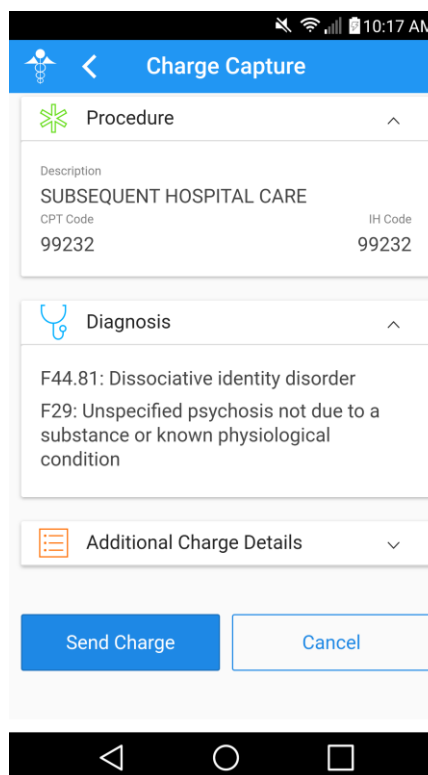
Charge Capture – Charge History & Charge Details (continued)

When copying charges from within the Charge History or Charge Details dialog, after tapping the  icon, you will then enter the Charge Capture screen where the procedure and the diagnoses from the previous charge will be populated in the corresponding fields. See Figure 9 and 10. The provider will default to the user logged in, if that user is a provider. If the user logged in is not a provider, and has previously sent charges, the provider from the previous charge will be populated. If the user logged in is not a provider, and has not previously sent charges, the Provider field will be blank and will need to be configured. The Service Date for the copied charge will default to today's date, and the Practice will default based on user access and preference. Comments will not be copied. You can add and modify the charge information as needed.




The screenshot shows the 'Charge Capture' screen at 9:36 AM. At the top is a blue header with a back arrow and a medical icon. Below it is a white box for patient information: 'Daffy Duck', 'Account Number 10102', 'Date of Birth February 1, 1963 (54 years)', and 'Birth Sex Female'. Below this is a 'Provider' dropdown menu showing 'Swithin Chandler (SC4)'. Then a 'Facility' dropdown menu showing 'STI Medical Practice'. At the bottom is a 'Procedure' section with a green asterisk icon, containing 'Description: SUBSEQUENT HOSPITAL CARE', 'CPT Code: 99232', and 'IH Code: 99232'. The bottom of the screen shows standard Android navigation icons.

Figure 9 – Charge Capture




The screenshot shows the 'Charge Capture' screen at 10:17 AM. It has the same blue header and patient information box as Figure 9. Below the facility dropdown is a 'Diagnosis' section with a blue medical icon, containing 'F44.81: Dissociative identity disorder' and 'F29: Unspecified psychosis not due to a substance or known physiological condition'. Below this is an 'Additional Charge Details' dropdown menu. At the bottom are two buttons: 'Send Charge' (blue) and 'Cancel' (white with blue border). The bottom of the screen shows standard Android navigation icons.

Figure 10 – Charge Capture

- **Charge Capture – Patient Search** – The Patient Search screen, accessed via Charge Capture or Patient, has been updated with an Add Patient  button, that allows you to add a new patient in ChartMaker® Mobile. The Add Patient functionality works the same whether accessed via Charge Capture, or via Patient. See the **Patient – Patient Search** entry above for more information.

Rounds

- **Rounds** – A new Rounds option is available that allows access to a Rounding List where you can view a hospital rounds patient list for each separate facility, and/or hospital, outside of your office, that you see patients. The hospital rounding list is based on information added in the Patient Hospitalization dialog in Practice Manager (accessed via the **Hospitalization** button in the **Patient** screen). Any patient with an open hospitalization record (where a **Discharge Date** *has not been entered* in the Patient Hospitalization dialog), will be displayed for each applicable facility. The Rounding List will display the patient's name, date of birth, admission date, and room number, as well as giving you the option to copy a previous charge, add a new charge, or access to a Rounding Details screen where you indicate that a patient has been **Skipped** (for those patients where a charge has not been entered for the current day), view visit details, and view any charges that have been sent for visit.

The Rounds option can be accessed via the Home screen in ChartMaker Mobile or via the Mobile menu accessed by tapping the  icon located in the top left the screen. See Figure 11 and 12.

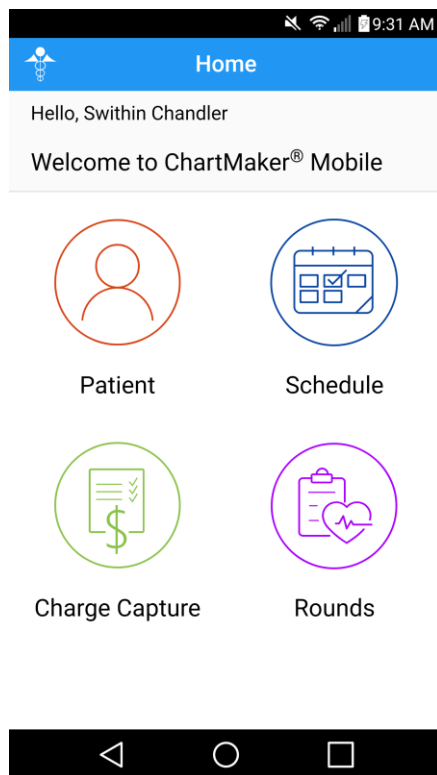


Figure 11 – Mobile Home

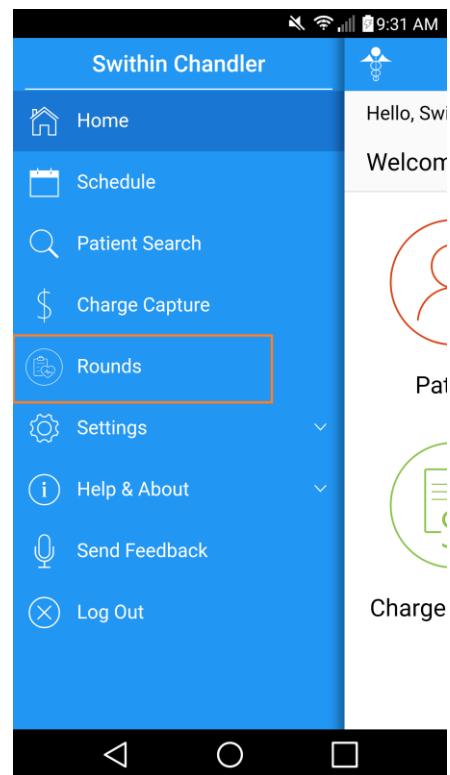






Figure 12 – Mobile Menu




Rounds (continued)

Rounds (continued)

After the Rounds option has been tapped, a **Census** screen will appear displaying each facility, the total number of patients within each facility, and the number of patients seen and/or skipped out of that patient total for each facility. See Figure 13. To access the Rounding List for a facility, simply tap the applicable facility in the Census screen.

In the Rounding List screen the facility and each applicable patient will be listed along with their date of birth, admission date, and room number for the date range listed in below the facility name. See Figure 14. You can tap the **From** and **To** date to modify the date range as needed. Likewise, you can tap the  icon to order the patients by Admitted Date, Name, or Room Number, as well as filter by Practice and/or Provider. The number of patients for the date range and filtered patients will appear above the  icon.

Any patient that has an  icon next to their name have been skipped, and any patient that has an  icon next to their name has had a charged entered for the current date for the selected facility and is considered to have been seen. Patients without an icon next to their name have been neither skipped, nor had a charge entered, and therefore are considered not seen.

In the Rounding List you can copy a previously sent charge for a patient by tapping the  icon, enter a new charge for the patient by tapping the  icon, or accessing the Rounding Details screen for the patient by tapping the  icon.

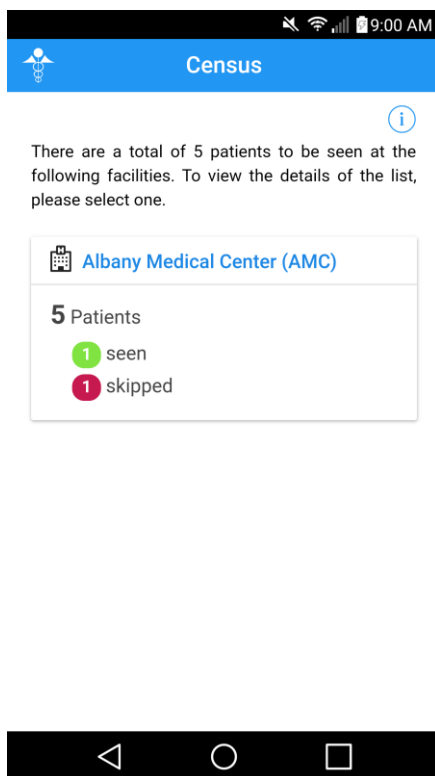


Figure 13 – Census

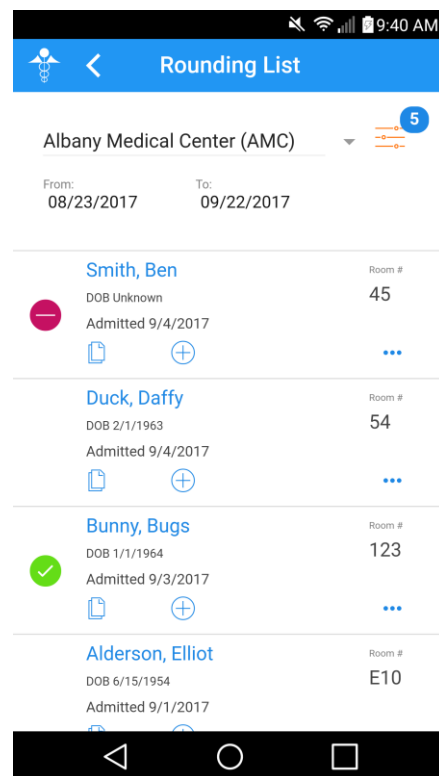



Figure 14 – Rounding List

Rounds (continued)

Rounds (continued)

When copying a charge, a **Copy a sent charge** screen will be displayed with a list the five (5) most recent charges sent from ChartMaker® Mobile. See Figure 15. You can then tap the  icon next to the charge you want to copy. You will then enter the Charge Capture screen where the procedure and the diagnoses from the previous charge will be populated in the corresponding fields. The provider will default to the user logged in, if that user is a provider. If the user logged in is not a provider, and has previously sent charges, the provider from the previous charge will be populated. If the user logged in is not a provider, and has not previously sent charges, the Provider field will be blank and will need to be configured. The Service Date for the copied charge will default to today's date, and the Practice will default based on user access and preference. Comments will not be copied. You can add and modify the charge information as needed.

When adding a charge, you will access the Charge Capture screen and the Provider field will default as described when copying a charge, the Facility field will default to the facility from the Rounding List, and the Service Date will default to today's date. You can add and modify the charge information as needed.

When accessing the Rounding Details screen, the patients name will appear at the top of the screen, if you tap their name the drop-down will display their Account Number, Date of Birth, and Birth Sex. The next section will display a Skipped option that you can turn on or off by using the corresponding slider. See Figure 16. Or, if a charge has been sent for this patient for today's date, this section will state **Charges sent**, and the Skipped option will not be available. The **Visit Details** and any **Sent Charges** will then be listed. If any charges have been sent, you can copy any of the charges if needed.

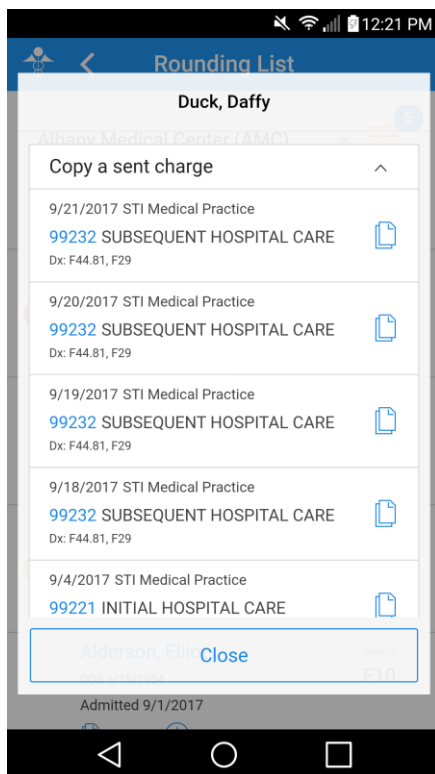


Figure 15 – Rounding List – Copy a sent charge

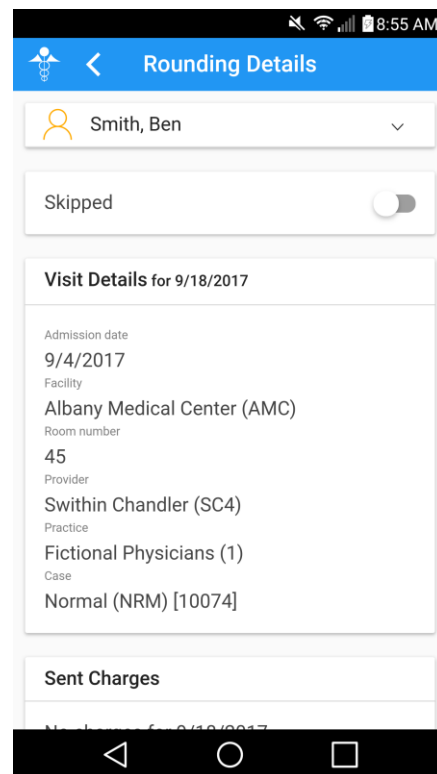


Figure 16 – Rounding Details



ChartMaker® Practice Manager Release Notes

ChartMaker® 2016 (fv6.2.4)

Please note that the ChartMaker Medical Suite can no longer be installed on computers using the Windows XP or Windows 2003 Server operating system. Since Microsoft has discontinued support for Windows XP in April 2014, and Windows 2003 Server in July 2015, we can no longer guarantee the stability of computers using this operating system, and recommend that you upgrade the operating system on any computers currently using Windows XP or Windows 2003 Server.

Administration

- **Administration – Diagnosis Search** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2017 – Sept 30, 2018** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30 2016 code set, the Oct 1, 2016 – Sept 30 2017 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog via the **Administration** menu, the system will default to the code set based on the current day's date.
- **Administration – Mobile – Mobile Administration** – The **Audit** tab, in the Mobile Administration dialog, has been updated to track to when a new patient is created in ChartMaker® Mobile (requires ChartMaker® Mobile version 6.2.4 due to be released 09/15/2017). See Figure 1. When a new patient audit event occurs, the Activity Type column will display **New Patient**, and the Additional Info column will display the patient's **Date of Birth** and **Practice** to which the patient was added.

The screenshot shows the 'Mobile Administration' window with the 'Audit' tab selected. It displays a table of audit results for 'New Patient' events. The table has columns for Date, Activity Type, User, Mobile Login ID, Account #, Patient Name, and Additional Info. Two entries are shown for 09-01-2017. Below the table are filters for User, Activity Type, and Account #, along with a 'Filter Results' button. The status bar at the bottom indicates 'Ready'.

Date	Activity Type	User	Mobile Login ID	Account #	Patient Name	Additional Info
09-01-2017 10:21:45 ...	New Patient	paul	philliker@gmail.c...	10256	Doe, Jane C.	DOB: 5/1/1975, Practice: Fictional Physicians
09-01-2017 10:20:43 ...	New Patient	paul	philliker@gmail.c...	10255	Doe, John D.	DOB: 7/15/1969, Practice: Fictional Physicians

Figure 1 – Mobile Administration – Audit

Administration (continued)

- **Administration – Mobile – New Patients – A New Patients From ChartMaker® Mobile** dialog has been created to easily view all patients that were created in ChartMaker® Mobile (requires ChartMaker® Mobile version 6.2.4 due to be released 09/15/2017). See Figure 2. When new patients are added through the mobile app, they are given a status of NPI (New Patient Incomplete Information), and need to be activated in Practice Manager prior to processing any pending charges. Patients will remain listed in this dialog until their status has been updated in Practice Manager.

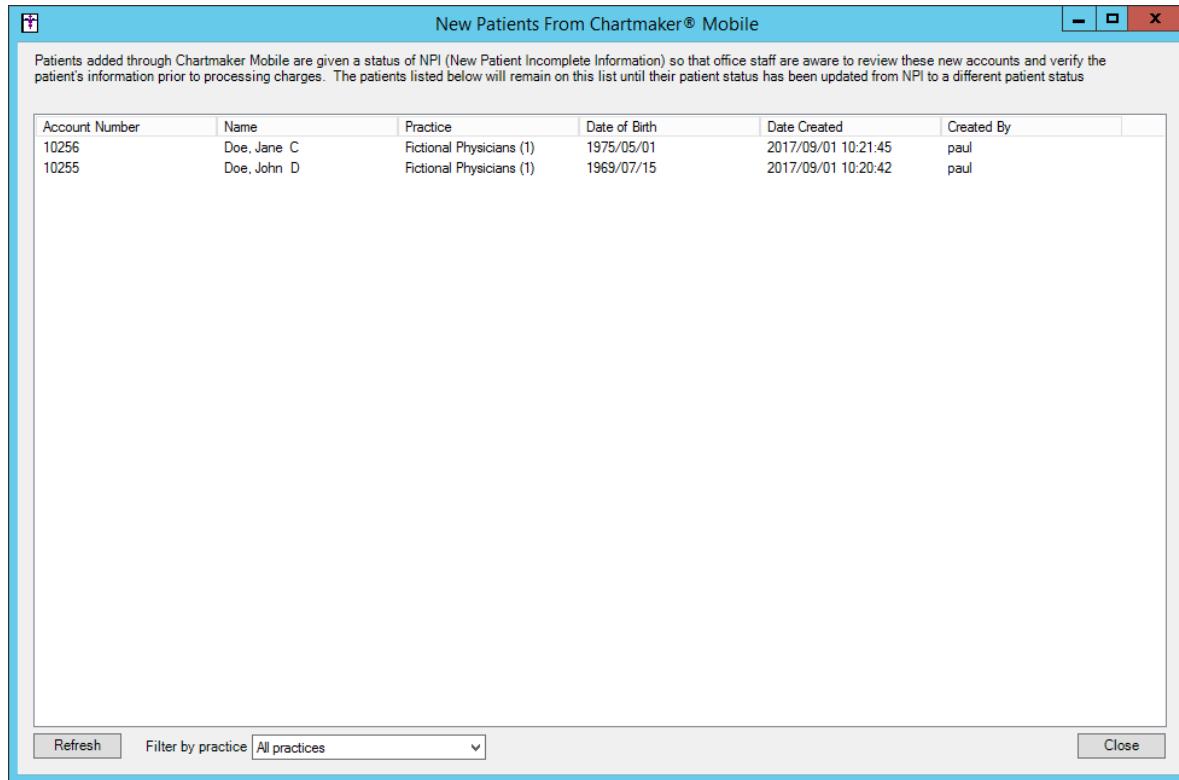


Figure 2 – New Patients From ChartMaker® Mobile

- **Administration – Utilities – Audit – Audit Trail** – The Audit Trail has been updated to track when a new patient is added in ChartMaker® Mobile (requires ChartMaker® Mobile version 6.2.4 due to be released 09/15/2017). When a new patient audit event occurs, the Event column will display **Added**; the Group column will display **Person**; the Audit Trail Description will display **Status**; and the patient's **Account #**, **Practice**, and **Mobile Username** (in comments) will be listed in the Metadata column.

Charge

- **Charge – Enter a Charge** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2017 – Sept 30, 2018** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30 2016 code set, the Oct 1, 2016 – Sept 30 2017 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when entering charges, the system will default to the code set based on the service **Start Date** to ensure that the proper ICD codes for that date are selected.
- **Charge – Edit a Charge** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2017 – Sept 30, 2018** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30 2016 code set, the Oct 1, 2016 – Sept 30 2017 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when editing charges, the system will default to the code set based on the service **Start Date** to ensure that the proper ICD codes for that date are selected.

Clinical

- **Clinical – Immunization** – The program has been updated to ensure that the latest CVX codes and CVX mappings, per the latest CDC guidelines, are used for immunization procedures.

Patient

- **Patient – Case – Diagnosis** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2017 – Sept 30, 2018** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30 2016 code set, the Oct 1, 2016 – Sept 30 2017 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when entering or editing patient information, the system will default to the code set based on the current day's date.
- **Patient – Case – Hospitalization** – The Patient Hospitalization dialog has been updated so that when adding or editing hospitalization information, the **Facility** for the hospitalization record is required. When adding or editing a hospitalization record for the patient, if a facility is not entered and you click the **Add to List** button, a warning message will appear prompting you to enter a facility. See Figure 3. You will not be able to add or update the hospitalization record until the facility is entered.

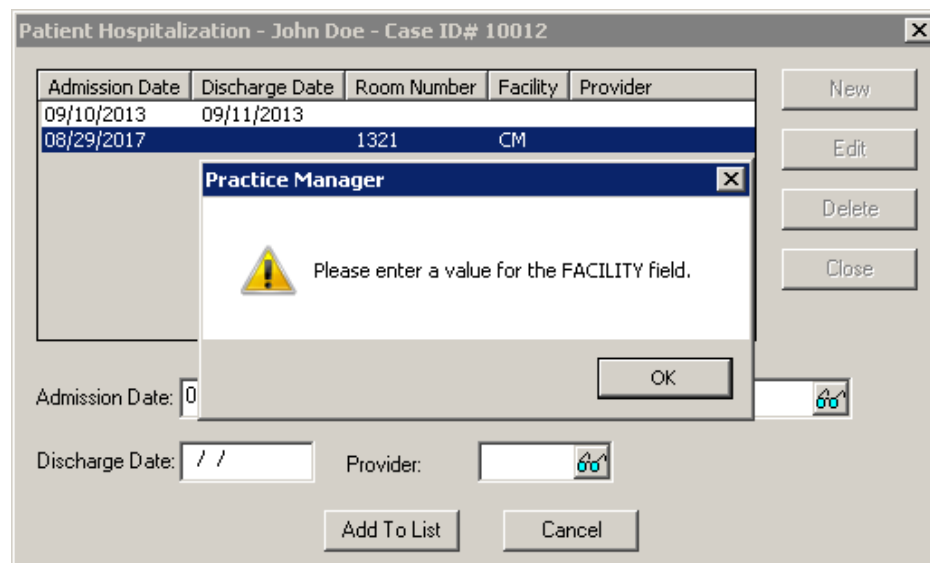


Figure 3 – Patient Hospitalization — Facility Warning

Addendum

Insurance Billing Updates Reminder

In the version 4.1 release of Practice Manager, there was an important enhancement that was made to the Insurance Billing screen to alert you whenever a new insurance billing update is available. Once alerted you can then download these updated billing components at your convenience. **Do note that if you are running the 4.1 version of Practice Manager, the update process needs to be performed on the server.**

In the version 4.2 release of Practice Manager, the system was updated so that billing components reside on each individual workstation. **Therefore, if you are running the 4.2 version or higher of Practice Manager, the update process (described below) will need to be initiated for each workstation that will be doing insurance billing.** If the updates are not downloaded and registered on each workstation that will be doing insurance billing, then claims generated for those workstations may be denied if they are not updated.

- **Insurance Billing Updates** – The Insurance Billing tab has been updated with an Update button that allows you to download the latest insurance billing components if new components are available. See Figure A1. An Update button is available in both the Manual Billing and Automatic Billing sub-tabs and will become highlighted to alert you when new billing components are available.

Mode	Form	Description
<input type="checkbox"/> Paper	CMSBSPA	CMS1500 for BSPA (N)
<input type="checkbox"/> Paper	CMSIBC	CMS1500 for PA IBC Product Line (N)
<input type="checkbox"/> Paper	CMS1500	CMS1500 Red Form (N)
<input type="checkbox"/> Paper	HPARTPPA	Health Partners Philadelphia, PA (N)
<input type="checkbox"/> Paper	MCDPPA	PA Medicaid (CMS1500)(N)
<input type="checkbox"/> Paper	MCRPPA	Pennsylvania Medicare (N)
<input type="checkbox"/> Electronic	DEMCD_P5	Delaware Medicaid Prof. 837 (ANSI 5010 A1)
<input type="checkbox"/> Electronic	MDMCD_P5	Maryland Medicaid Prof. 837 (ANSI 5010 A1)
<input type="checkbox"/> Electronic	NEIC_P4	NEIC (WEBMD) Prof. 837 (ANSI 4010 A1)
<input type="checkbox"/> Electronic	NEIC_P5	NEIC (WebMD) Prof. 837 (ANSI 5010 A1)
<input type="checkbox"/> Electronic	NJMCD_P5	New Jersey Medicaid Prof. 837 (ANSI 5010 A1)
<input type="checkbox"/> Electronic	PABSKA_P4	PA BS Keystone/AmeriHealth Prof. 837 (ANSI 4010 A1)
<input type="checkbox"/> Electronic	PABSKA_P5	PA BS Keystone/AmeriHealth Prof. 837 (ANSI 5010 A1)
<input type="checkbox"/> Electronic	PABS_P4	Pennsylvania Blue Shield Prof. 837 (ANSI 4010 A1)
<input type="checkbox"/> Electronic	PABS_P5	Pennsylvania Blue Shield Prof. 837 (ANSI 5010 A1)

Figure A1 – Insurance Billing – Manual Billing

Once the download is initiated by clicking the **Updates** button, another dialog will appear confirming that you want to download and install the latest billing updates. See Figure A2.

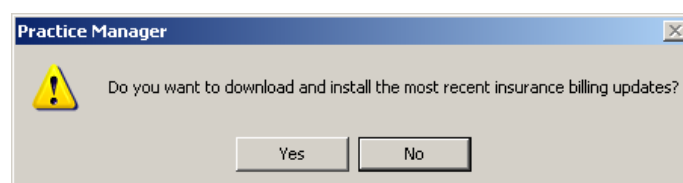


Figure A2 – Insurance Billing Updates Download

Insurance Billing Updates Reminder (continued)

Once the **Yes** button is clicked the insurance billing updates will start to download and the following message will appear in Figure A3. Do note that once the billing updates are initiated by a user, the Updates button will disable for all users and other users who try to initiate the download will receive a message stating that updates have started from another machine. Once the updates have been downloaded you will be prompted to install the updates, as well as to close out of the Practice Manager application to ensure a successful update.

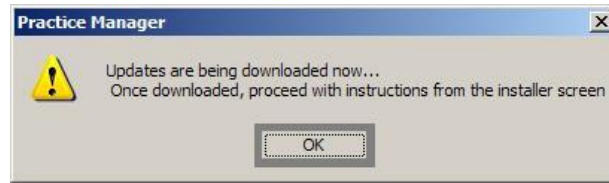


Figure A3– Insurance Billing Updates Download Confirmation

Once the updates have been successfully downloaded and installed, log back into Practice Manager and be sure to register the Billing Component Manger (Add-Ins > Insurance Billing > Billing Component Manager).

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