



To: All WRS Users  
From: WRS Development Team  
Date: 04/27/12  
Re: System Update to Waiting Room Solutions

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The WRS Development Team will be performing a software update to the Waiting Room Solutions System on or about April 27, 2012. This release will include the following:

**RVU Report**  [\(Click to View Video Release Note 1\)](#)

Medicare uses a physician fee schedule to determine payments for over 7,000 physician services. The fee for each service depends on its relative value units (RVUs), which rank on a common scale the resources used to provide each service. These resources include the physician's work, the expenses of the physician's practice, and professional liability insurance. To determine the Medicare fee, a service's RVUs are multiplied by a dollar conversion factor.

$$\begin{aligned} \text{Payment/RVU} &= \text{Payment per RVU} \\ \text{Total RVU} &= \text{RVU assigned to that CPT} \end{aligned}$$

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$$\text{Total RVU} \times \text{Payment per RVU} = \text{Payment}$$

Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes, range from those that require considerable amounts of physician time and effort, clinical staff, and specialized equipment, to those that require little if any physician time and minimal other resources. For each service, Medicare determines RVUs for three types of resources. Physician work RVUs account for the time, technical skill and effort, mental effort and judgment, and stress to provide a service. Practice expense RVUs account for the nonphysical clinical and nonclinical labor of the practice, as well as expenses for building space, equipment, and office supplies. Professional liability insurance RVUs account for the cost of malpractice insurance premiums.

Functionality has been added to view the RVU per CPT code under **Billing>Reports>Saved Reports>Activity Reports**. All Activity Reports run by CPT code will now show the payment per RVU.

Print

Print Filters?

DATE: 01/01/2012 - 01/31/2012

SUPERVISING PROVIDER:      RENDERING PROVIDER:      INSURANCE COMPANY:      HCPC CODE(S): All      LOCATION:      TYPE: Date Posted

Total Adjustments   
 Total Patient Transfers   
 Total Secondary Transfers   
 Total Tertiary Transfers   
 Transfer Back   
 Total Voids

Bad Debt     Balance Bill     Co-Insurance     Co-Insurance     Duplicate  
 Capitation     Co-Insurance     Co-Pay     Co-Pay     Global  
 Courtesy     Co-Pay     Deductible     Deductible     Void  
 Contractual     Deductible     Other     Other  
 Discount     Other  
 Interest  
 User Correction

Activity Report - Monthly Date Posted Activity Report by CPT


HCPC Code	# Of Charges	Payment/RVU	Total RVU	Amount Charged	True Charges	Amount Posted This Period	Interest	Deductible	Deductible	Deductible	Other	Global	Void	Amount Outstanding
[30901]CONTROL OF NOSEBLEED	1	26.92	2.86	\$288.03	\$288.03	\$-77.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$211.03
[31575]DIAGNOSTIC LARYNGOSCOPY	2	24.81	3.44	\$420.69	\$400.00	\$-170.69	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$250.00
[42700]DRAINAGE OF TONSIL ABSCESS	1	13.65	5.76	\$151.04	\$0.00	\$-78.63	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
[42826]REMOVAL OF TONSILS	1	6.11	7.62	\$46.53	\$0.00	\$-46.53	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
[69210]REMOVE IMPACTED EAR WAX	2	6.62	1.51	\$200.00	\$160.00	\$-20.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$180.00
[76536]US EXAM OF HEAD AND NECK	1	24.03	3.62	\$250.00	\$250.00	\$-87.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$163.00
[95117]IMMUNOTHERAPY INJECTIONS	6	10.60	0.35	\$22.25	\$0.00	\$-22.25	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
[99024]POSTOP FOLLOW-UP VISIT	3	0.00	0.00	\$30.00	\$0.00	\$-30.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
[99203]OFFICE/OUTPATIENT VISIT NEW	4	8.90	3.09	\$210.00	\$175.00	\$-110.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$100.00
[99204]OFFICE/OUTPATIENT VISIT NEW	3	21.54	4.72	\$975.00	\$935.00	\$-305.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$670.00
[99213]OFFICE/OUTPATIENT VISIT EST	6	14.17	2.07	\$790.00	\$670.00	\$-176.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$614.00
[99214]OFFICE/OUTPATIENT VISIT EST	3	11.55	3.06	\$511.02	\$415.00	\$-106.02	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$405.00
[99243]OFFICE CONSULTATION	1	5.68	3.52	\$20.00	\$0.00	\$-20.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
[99244]OFFICE CONSULTATION	1	27.66	5.20	\$143.82	\$0.00	\$-143.82	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
None	25	0.00	0.00	\$587.00	\$0.00	\$-557.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$30.00
				\$4,645.38	\$3,273.03	\$-1,949.94	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,623.03

Figure 1: Billing>Reports>Activity Report>RVU

### Diagnostic Imaging Report III

A new Diagnostic Imaging Report III note format has been added. This note allows practice users to specify the Place of Service, Date of Procedure, Performed By, and Requesting Provider, along with Findings, Indications and Impressions.

**Jace Test,**  
23 year old female,  
DOB: Mar 23, 1989



Clinical Date  
Apr 27, 2012 to Apr 27, 2012

View Note  
Patient Instructions  
View All Notes  
Templates

Diagnostic Imaging Report

ALL NOTES  
CURRENT NOTE

Diagnostic Imaging

Note Sign off  
 Private Visit  
Sign Note

**DIAGNOSTIC IMAGING**

Place of Service: Goshen    1 Harriman Drive  
Goshen, NY 10924-1234

Date of Procedure: 4/27/2012

Performed by: Doctor Test

Requesting Provider: Physicians Assistant

Procedures:  
Type CPT Code / Description to search    Add Procedure

Findings: normal

Indications: chronic sinusitis

Impression: noted ethmoid sinusitis

Save

Figure 2: EMR>Diagnostic Imaging Report III

**Test, Jace** Fax Note Print & Close Window

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Date: Apr 27, 2012 WRS Training and Implementation Practice  
 DOB: 03/23/1989, 23 year old Female 1 Harriman Drive, Goshen, NY 10924-1234  
Tel: (845)294-8749 Fax: (845)294-8749

**DIAGNOSTIC IMAGING**

**PLACE OF SERVICE:**  
 1 Harriman Drive  
 Goshen, NY 10924-1234

**DATE OF PROCEDURE:** 4/27/2012

**PERFORMED BY:** Doctor Test

**REQUESTED BY:** Physicians Assistant

**FINDINGS:** normal

**INDICATIONS:** chronic sinusitis

**IMPRESSION:** noted ethmoid sinusitis

**SIGNATURE**

This note has not yet been signed.  
 If required, you can [add an addendum](#) to it.  
 If required, you can [add a patient annotation](#) to it.

Figure 3: EMR>Diagnostic Imaging Report III>View Note

## Note Display Templates

Through EMR Setup>Note Display Templates, the addition of "Include service coding" allows for Service Coding to be added into a Global Template and allows Service Coding to be added to the viewed/printed/faxed note.

Font size: 9 pt(default size) ▼

Include practice logo:

Include CPT and ICD9 codes:

Show abnormal in red and italic font:

Show Denied Medical Conditions:

Show Denied Family History:

Past Medical History: Show Treating Provider  Show Date Condition Began

Surgery History: Show Treating Provider  Show Date

Immunization History: Show Treating Provider  Show Date

Show Unknown Social History:

Show Social History:

Show Immunization History:

Include Service Coding:

Figure 4: EMR Setup>Note Display Templates

**Template Preview**

Name: tester2  
 Note Format: Visit Note II  
 Author:  
 Created on: 1:35:52 PM Apr 27 2012

**HISTORIES & HABITS**  
**Past Medical History:** No Past Medical History on Record  
 No denied Medical History on Record  
**Surgery History:** appendectomy  
 prostate  
**Family History:** No Family History on Record  
 No denied Family History on Record

**PROCEDURES**  
 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity  
 Audiogram without tympanogram

**ORDERED TESTS**  
 Ct sinuses c- -- CT of sinuses. Dx. Sinusitis.


Figure 5: Allows for populatuion of service coding into a Global Template

*Printed 5:51 PM Apr 27 2012, User Location: ENT SPECIALTY CARE*

**HISTORIES & HABITS**  
**Past Medical History:** DVT  
 Emphysema  
 Heart attack  
 No denied Medical History on Record  
**Surgery History:** APPENDECTOMY  
**Family History:** No Significant Family History  
 No denied Family History on Record

**CURRENT MEDICATIONS**  
 Toprol XL 100 mg 24 hr Tab ( Take 1 tablet(s) by ORAL route , per day )  
 Clarinex 5 mg Tab ( Take 1 tablet(s) by ORAL route , per day , for 90 days ) -- ON DESENSITIZATION  
 Coumadin 1 mg Tab ( PID or PQ )

**ALLERGIES**  
 Sulfa(Sulfonamide Antibiotics) -- rash  
 Flonase -- Moved from Medications

**ASSESSMENT & PLAN**   
 Unspecified hearing loss (new)  
 Plan: [92557] Audiogram without tympanogram


**PROCEDURES**   
 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity.  
 Audiogram without tympanogram  
Related Diagnosis:

Figure 6: View Note with service coding