

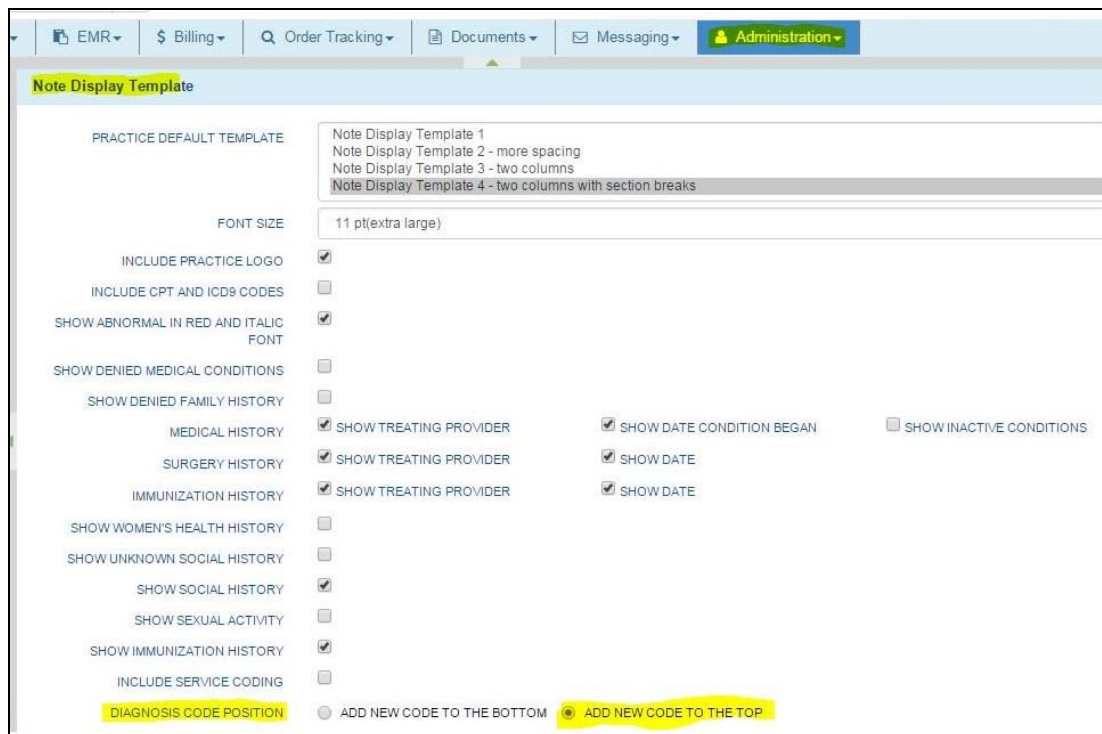
To: All WRS Users  
From: WRS Development Team  
Date: 06/02/2015  
Re: WRS Health System Update

The following functional changes have been made to the WRS Health system. Please review to ensure that your practice is aware of the upcoming changes.

## Assessment Options

Several options have been added that offer practices the ability to customize content within the Assessment section of their notes. Note that this affects all note types, as applicable.

- (a) **Order of Diagnosis on Note** - allows for the practice to determine if new diagnoses will appear at the top or bottom of the Diagnosis List. This option can be specified under **Administration>EMR Setup> Note Display Template**. This is a practice-level setting, so changes will affect all notes, for all practice providers, going forward.



The screenshot displays the 'Note Display Template' configuration interface. At the top, there is a navigation bar with tabs for EMR, Billing, Order Tracking, Documents, Messaging, and Administration. The main content area is titled 'Note Display Template' and contains several sections of settings:

- PRACTICE DEFAULT TEMPLATE:** A dropdown menu with options: Note Display Template 1, Note Display Template 2 - more spacing, Note Display Template 3 - two columns, and Note Display Template 4 - two columns with section breaks.
- FONT SIZE:** A text input field containing '11 pt(extra large)'.
- INCLUDE PRACTICE LOGO:**
- INCLUDE CPT AND ICD9 CODES:**
- SHOW ABNORMAL IN RED AND ITALIC FONT:**
- SHOW DENIED MEDICAL CONDITIONS:**
- SHOW DENIED FAMILY HISTORY:**
- MEDICAL HISTORY:**  SHOW TREATING PROVIDER,  SHOW DATE CONDITION BEGAN,  SHOW INACTIVE CONDITIONS
- SURGERY HISTORY:**  SHOW TREATING PROVIDER,  SHOW DATE
- IMMUNIZATION HISTORY:**  SHOW TREATING PROVIDER,  SHOW DATE
- SHOW WOMEN'S HEALTH HISTORY:**
- SHOW UNKNOWN SOCIAL HISTORY:**
- SHOW SOCIAL HISTORY:**
- SHOW SEXUAL ACTIVITY:**
- SHOW IMMUNIZATION HISTORY:**
- INCLUDE SERVICE CODING:**

At the bottom, the **DIAGNOSIS CODE POSITION** section is highlighted in yellow. It contains two radio button options:  ADD NEW CODE TO THE BOTTOM and  ADD NEW CODE TO THE TOP.

Once the setting is selected, all newly selected diagnoses in the note will load in the "top" position in the diagnosis listing. Note that this setting change will not affect notes that have been signed previously.

E&M Advice					
CURRENT NOTE ASSESSMENTS					
<input type="checkbox"/>	Code	Problem	Status	Plan	Order
<input type="checkbox"/>	388.30	Tinnitus	new		1
<input type="checkbox"/>	389.9	UNSPECIFIED HEARING LOSS	unchanged		2
<input type="checkbox"/>	487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFESTATIONS	stable		3
<input type="checkbox"/>	380.22	OTHER ACUTE OTITIS EXTERNA	unchanged		4

**(b) Include Diagnosis in Note** - allows providers to indicate which diagnoses should be included when selecting **View Note**. These selections will also determine which diagnoses will auto populate under **Create New Claim**.

E&M Advice					
CURRENT NOTE ASSESSMENTS					
<input type="checkbox"/>	Code	Problem	Status	Plan	Order
<input type="checkbox"/>	388.30	Tinnitus	new		1
<input type="checkbox"/>	389.9	UNSPECIFIED HEARING LOSS	deteriorated		2
<input type="checkbox"/>	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE,	improving		3
<input type="checkbox"/>	401.1	BENIGN ESSENTIAL HYPERTENSION	unchanged		4

*TIP- This allows practices to keep a "list" of patient problems in that note, but only view/bill for the problems that were addressed during that specific visit. In the past, those diagnoses would have been deleted from the note, and re-entered at a later encounter, as applicable. The option allows the "problem list" to always be available, even if some of the diagnoses shown were not pertinent to the visit.*

HISTORIES & HABITS	Review of System
<p><b>Medical History:</b> Allergic rhinitis Atrial fibrillation Emphysema Heart attack High blood pressure [hypertension] Hypothyroid CYST OF THYROID , Doctor: Gordon, Lawrence High blood pressure [hypertension], Doctor: Gordon, Lawrence Sciatica [Reviewed] <b>Surgery History:</b> bowel exploration, Gordon, Lawrence, 04/01/2011, north shore hospita <b>Family History:</b> Father: Atrial fibrillation , Circulatory system disorder , Depression , Headache [Reviewed] Father: Asthma, High cholesterol, Smoking <b>Immunization History:</b> Hep A, adult WAPSHARE, JAMES IG, unspecified</p>	<p><b>General:</b> <i>WDWN, no apparent distress</i> <b>Eyes:</b> <i>intermittently complains of irritation;</i> <b>Skin:</b> <i>denies rash, itching, ulcers/growths, excess scarring, bleeding problem, dryness, suspicious lesions</i> <b>Neurologic:</b> <i>+syncope (all the time); denies weakness; previously complained of paresthesias (at night);</i></p>
	PHYSICAL EXAM
	<p><b>MSK:</b> <b>Head and neck:</b> <i>+flex: 45; ext: 45; R. lat. bend: 40; L. lat. bend: 40; R. rot: 70; L. rot: 70 (deg.) (test test test);</i></p>
	ASSESSMENT & PLAN
	<p><b>Tinnitus (new)</b></p> <p><b>Unspecified hearing loss (deteriorated)</b></p>
	SIGNATURE

Only the indicated diagnoses will show under **View Note**, or **Create New Claim**, for that visit. All diagnoses will appear when the next new note is created for that patient.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										FROM MM DD YY		TO MM DD YY		\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind. 9		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		22. RESUBMISSION CODE		ORIGINAL REF. NO.					
A.	388.30	B.	389.9	C.		D.		E.		23. PRIOR AUTHORIZATION NUMBER											
E.		F.		G.		H.		I.													
I.		J.		K.		L.															
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPBDT Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER													
1																					

(c) **Disable Auto populate Plan** - The new option allows practices to disable the auto population of default **Plan** (text) when a given diagnosis code is used.

E&M Advice								
CURRENT NOTE ASSESSMENTS						Save	Delete	Print
<input type="checkbox"/>	Code	Problem	Status	Plan	Order	<input type="checkbox"/>	Include in Note	
<input type="checkbox"/>	388.30 E	Tinnitus	unchanged		1	<input checked="" type="checkbox"/>		
<input type="checkbox"/>	389.9 E	UNSPECIFIED HEARING LOSS	deteriorated		2	<input checked="" type="checkbox"/>		
<input type="checkbox"/>	250.00 E	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE,	improving	continue on diet regiment, check glucose nightly, exercise as instructed	3	<input checked="" type="checkbox"/>		
<input type="checkbox"/>	401.1 E	BENIGN ESSENTIAL HYPERTENSION	unchanged		4	<input checked="" type="checkbox"/>		

Practices can change this setting under **Administration>EMR Setup>Note Display Template>Diagnosis Plan Text Carryover**, unchecking the box if they wish to disable auto population of default **Plans**. This is a practice-level setting, so changes will affect all notes, for all practice providers, going forward.

### Important Note to Prescribing Providers & Staff

WRS Health was recently warned by SureScripts (our eRx network provider) that prescribers are making a common error and adding incorrect content to the **ADDITIONAL INSTRUCTIONS** and **NOTES TO PHARMACIST** when generating **prescriptions**.

Drug : prednisone 10 mg tablet S

Start Date: 05/29/2015 End Date:

e.g. 1 tablet

Route:

Every:   hours  times/day  other freq/interval

For:  days

Quantity:  Qualifier: Tablet

**Additional Instructions:** additional and/or explanatory information regarding the prescription itself, and is in

Refills:

Dispense As Written

**Note to Pharmacist:** convey information directly to the Pharmacist, that are not intended to be seen by the patient or placed on the prescription label. This could include

When entering required prescription information (**Drug Name, Route, Quantity, Refills**) the user is also able to enter free text under the **ADDITIONAL INSTRUCTIONS** and **NOTES TO PHARMACIST** fields. There are fields designed to contain *only* specific information regarding that prescription:

- **ADDITIONAL INSTRUCTIONS** should be used to add additional and/or explanatory information regarding the prescription itself; and is intended to be formatted on the prescription label. This can include titrating dose information, instructions, warnings, etc. (limit 140 characters)
- **NOTES TO PHARMACIST** should be used to convey information directly to the Pharmacist. Information that is *not* intended to be seen by the patient and/or placed on the prescription label. This can include a prior authorization number, confidential information to the pharmacist, etc. (limit 210 characters)

SureScripts will no longer allow incomplete, or incorrectly populated prescriptions, to be transmitted via eRx. It is important that all prescribers follow these instructions carefully. Failure to do so may result in prescriptions that are unable to be electronically transmitted.

## Appointment Search Information

Functionality has been added to display billing-related information under **Appointment Search**. A checkbox called **Billing Information** has been added under **Scheduler>Appointment Search**. Selecting this box will enable billing-related information to display during an **Appointment Search**. This **Billing Formation** includes: **COPAY** (primary insurance), **PREVIOUS BALANCE**, **AUTHS (Authorizations)** and **REFERRALS**. Items include hyperlinks to detailed information, as applicable.