

New Features of Centricity Business (Formerly IDX)
Version 5.0 Upgrade

This document contains a listing of all features that are part of the October 22 upgrade of Centricity Business. This document lists the module, title of the new feature, followed by a description of the new functionality and the benefit.

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Billing and Accounts Receivable (BAR)

Capture Ethnicity for Meaningful Use

Overview:

There are now five categories for data on race:

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or Other Pacific Islander
5. White

Instead of allowing a multiracial category, the Office of Management and Budget (OMB) adopted a standard of allowing respondents to select one or more races when they self-identify. There are now two categories for data on ethnicity:

1. Hispanic or Latino or Spanish Origin
2. Not Hispanic or Latino or Spanish Origin

Additionally, the new standards call for separate questions to be used, wherever feasible, for reporting race and ethnicity. The new Ethnicity dictionary (#14) is used to help capture and store patient ethnicity, and includes a registration storage location to store the data, and a claim form variable to support reporting. It also provides multiple table columns and claim form variables to allow for reporting of more than one race selection.

Benefits:

This feature provides the following benefits:

- Helps provide the ability to capture and report patient ethnicity in addition to race.
- Helps comply with meaningful use requirements from Medicare.
- Helps ensure that regulatory requirements are met.
- Provides a dictionary to store ethnicity.
- Provides a storage location to store the data.
- Provides a claim form to support reporting.

Budget Plan Enhancement

Overview

Maintaining budget plan eligibility and budget plan policy rules on the system helps facilitate putting patients on budget plans; collectors can quickly determine, based on the account balance, whether an account is eligible for a budget plan and what the monthly amount should be. The user can modify the monthly amount or number of months to come up with for the patient's monthly payment. These enhancements allow for an easier, faster, and more automated method of calculating and creating budget plans. This functionality is activated by using the new Budget Plans screens. Now, you can calculate everything based on the Current Statement balance instead of the Balance that was printed on the last

statement (as appeared on budget plan screen). The system uses the new value and the delivered rulesets use the BAR_L_BUDGET_PLAN.PROPOSED_PLAN_STMT_BAL.

Benefits

This feature provides the following benefits:

- Helps reduce self-pay A/R days.
- Helps establish a payment plan to avoid delinquent accounts.
- Helps support Low Touch Billing.

Detail Display for Multi-Selected Invoices

Overview

Previously, to view the detail of several invoices in Invoice Inquiry, you would multi-select the invoices and then select **D-View Detail**. The system would first display the detail of the most current invoice selected, then when you selected **OK**, the system would display the detail of the next invoice. This process would continue until the detail for each of the selected invoices had been displayed. In this release, you can select multiple invoices in Invoice Inquiry and then use the new **Z-Multi Inv Detail** action to display the details for the selected invoices on a single screen.

Benefits

Helps streamline process for viewing detail on multiple invoices

This feature helps reduce the total cost of ownership of the Billing & Accounts Receivable (BAR) application by providing users with an easy method for displaying invoice detail for multiple invoices on one screen when responding to billing inquiries.

Filter BAR Invoices for a TES Encounter

Overview

Several features have been added to Invoice Inquiry and TES Encounter/Transaction Inquiry to provide users with an easy method to identify the Billing & Accounts Receivable (BAR) invoices for a Transaction Editing System (TES) encounter. This can be helpful when patients contact the organization with questions about billing. Since an encounter can result in multiple invoices, users need to identify all invoices, as well as BAR and TES activity for transactions in a particular invoice.

Benefits

- Helps reduce the total cost of ownership of the BAR and TES applications by allowing users to filter the BAR Invoice Inquiry screen by invoices associated with a particular TES encounter, reducing the need for a user to manually research this information.
- Helps filter the applicable list of transactions in an encounter that the user needs to see.

Low Touch Metric Program

Overview

The Low Touch Metric Program allows you to gather baseline data for Low Touch metrics. This data can later be incorporated into the Client Metrics Program. There are standard SQL queries that are delivered in the upgrade.

Benefits

- Supports Low Touch Billing.
- Allows new queries to be run to measure the before and after effectiveness of various low touch billing added functionality.

Manual Payment Reversal and Reconciliation

Overview

When performing an invoice charge correction, the standard process posts a credit to the original invoice and creates a reversal invoice that has a negative charge (to back the charge out of the BAR reports) and a negative credit so that the balance of the invoice is 0.00. In both invoices, a FSC transfer to a designated Do Not Bill FSC is also performed. Charge correction reverses the payments in the original invoice and in the reversal invoice. If the payments are not carried forward to the new invoice (Charge and Payments Carry Forward method) at that time, the payments are in "limbo" as they need to be re-posted to an invoice or the batch will be out of balance. In BAR-only charge correction, the new invoice is immediately created and the payments can be reapplied or the user can apply the payments to other invoices if appropriate. In this release, a new action, **7-Reverse Payment**, allows users to specify a single invoice payment transaction (either invoice-level or line item) and reverse the payment activity. This allows the payment to be removed from one invoice and manually applied to another while maintaining a record of the payment.

Benefits

Helps to reduce keystrokes and data entry errors

This feature helps reduce the total cost of ownership of the BAR and TES applications by providing an easy method to reverse payments from invoices. This helps to reduce the possibility of data entry errors during the reversal process, as well as to reduce the number of keystrokes for the user.

Patient Notification Method

Overview

On July 13, 2010 the federal government released the Final Rules implementing the American Recovery and Reinvestment Act of 2009 (ARRA) incentives for electronic health record (EHR) adoption. Customers who use EHRs will be required to meet Meaningful Use criteria to be eligible to receive EHR incentive payments specified in the Meaningful Use Rule. There are also future penalties for not meeting these objectives. The following EHR data is already available:

- Patient date of birth (DOB)
- Patient primary language
- Patient race
- Patient ethnicity
- Patient sex
- Patient's preferred method of notification

Standard storage locations and associated dictionaries already exist in Centricity Business Registration for DOB, language, race, and gender.

Benefits

This feature provides the following benefits:

- Helps identify the preferred method of communication for the patient.
- Helps allow you to be compliant with Meaningful Use Rule.
- Provides the ability to capture and report the patient ethnicity in addition to race.

Anesthesia Regulatory File (ANES)

Adding Effective Dates for Anesthesia Concurrency Modifiers

Overview

The Anesthesia module allows customers to define concurrency modifiers for concurrencies of 2, 3, or 4. Specific types of concurrencies such as Resident with Resident or Resident with CRNA can also be defined. However, an effective date for the modifiers was not available. If a modifier changed as of a certain date, only one modifier could be used in the Anesthesia module. Charges must be corrected in either the Transaction Editing System (TES) or via Charge Correction in Billing & Accounts Receivable (BAR). This is a manual process that can be time intensive, and could cause incorrect modifiers to be sent on billed claims. Components of the Anesthesia module have been updated to support Medicare Regulatory changes that affect reimbursement of teaching anesthesiologists who train physician residents in a single anesthesia case, or two concurrent anesthesia cases. For charges in cases performed after 1/1/2010, the **AA** modifier is used. For charges in cases performed before 1/1/2010, the **QK** modifier is used for concurrent procedures #2, #3, and #4. The **AA** modifier is used for an anesthesiologist alone, or an anesthesiologist directing a resident in a non-concurrent procedure. The **QK** modifier is used for an anesthesiologist directing two, three or four concurrent procedures. This feature allows for multiple entries of the same concurrency, with a unique effective date for which the modifiers are used.

This enhancement provides the following features:

- Allows a user to designate more than one set of concurrency modifiers for a given date, Financial Status Classification (FSC), and concurrency number.
- Allows a user to designate the *expiration date* of a set of concurrency modifiers for a given FSC and concurrency.
- Allows a user to designate the *effective date* of a set of concurrency modifiers for a given FSC and concurrency.
- The system can apply the correct concurrency modifier to a key in the Calculation report based on the *Key Start Date*.
- The system can post the correct concurrency modifier as applied in the Calculation Report to BAR or TES.
- The system can apply the correct concurrency modifier based on the *Invoice Start Date* when the Anesthesia Concurrency Modifiers are used.

Benefits

This feature provides the means to maintain multiple concurrency modifier entries for the same concurrency and Financial Status Classification (FSC) in the Anesthesia/Radiation Profile dictionary (#126). Entries are differentiated by effective and expiration dates. This avoids the need to manually correct charges when effective dates for modifiers change. The feature allows customers to submit Medicare anesthesia bills with the correct modifiers, thus helping to improve reimbursements.

Cross Application

Dictionary Lookup Field Improvements

Overview

A dictionary lookup field is one at which you press F4 or click a lookup button to select from a list of valid values that are stored in a dictionary. An example is the Relationship field that points to the Relationships dictionary for valid entries. Now when you do a lookup, the lookup window includes your most recently used values at the top. In addition, you do not need to delete the existing entry in a dictionary lookup field in order to do a lookup for a different value. These enhancements apply to the Advanced Web and Web Baseline user interfaces.

Benefits

- Helps reduce total cost of ownership by helping increase user efficiency.
- Helps reduce the number of times the user initiates a field lookup unsuccessfully.

Improvements in Readability of Disabled Field Text (Advanced Web)

Overview

In Advanced Web, readability of text in disabled fields and in disabled free text grid rows was improved.

Benefits

Helps improve the user experience with the system.

Helps reduce total cost of ownership by helping reduce the times the user pauses to read hard-to-read data.

Progress Indicator

Overview

The progress indicator is a small graphic with a rotating wheel that appears when the system is processing a request, to reassure you that the operation is underway and is not waiting for your input. For example, when you log into the system, a progress indicator appears as the system loads your default screen. This tells you to wait for the screen. And when you select a screen with a lengthy filtered grid, a progress indicator appears while the grid loads.

Benefits

- Helps keep users from cancelling a system operation and having to restart it
- Helps reduce total cost of ownership by avoiding unnecessary repetition of system processing
- Helps reduce unnecessary calls to customer IT departments from users wondering if the system is working

Red Flags Rule

Overview

The Centricity Business Red Flags Rule has been created to meet the regulatory requirement for prevention of identity theft as defined by the FTC. The screens and fields added to the registration process allow you to confirm the patient's identity and flag the patient for identity confirmation from a picture ID on the next patient visit. With the Red Flags Rule, you can:

- Challenge and confirm the identity of patients using a standard set of data elements.
- Set a picture ID status that prompts you to confirm the patient's identification via a picture ID the next time the patient presents.
- Store the following new data elements:
 - . Picture ID status
 - . Challenge question
 - . Challenge question answer
 - . Registration update source
 - . Picture ID source
 - . Picture ID confirmation date/time
 - . Picture ID status explanation
 - . Challenge results
- Provide a passive warning in the registration screens to indicate picture ID status requirements.
- Allow for the use of Enterprise Task Manager (ETM) to track red flags follow up activities (optional).

The Red Flags Rule introduces two new screens, Red Flags Challenge

Set Up screen, and Red Flags Rule Challenge screen, that can be copied into the custom registration form and then customized to meet workflow requirements. These screens contain all of the Red Flags Rule data elements, and are part of the registration process. Five new dictionaries were created to control field values and display in the Red Flags Challenge screen.

Benefits

This feature addresses the following benefits:

- Helps you meet the FTC regulatory requirement through the use of standard data elements, rather than a fully custom solution.
- Provides a standard set of data elements for you to work with.

Social Security Number Masking and Lookup

Overview

The display of Social Security numbers in the system can present opportunities for patient identity theft and compromise patient privacy. The Social Security Number (SSN) Masking feature allows you to mask (hide with X's) all or part of SSNs on screens and reports. For example, when masked, an SSN of 999-87-6543 appears as XXX-XX-XXXX or XXX-XX-6543. The user can see the full SSN while typing it in, but once the patient record is filed, the SSN is masked. If you mask SSNs, you can allow certain users to use the **S-View SSN #** action to view the full SSN if needed. You can also restrict users from looking up patients by SSN. This enhancement applies to the Advanced Web, Web Baseline, and character-based user interfaces.

Benefits

- Potentially improves patient trust and satisfaction by better securing personal information that may be used for identity theft
- Helps reduce the total cost of ownership by helping decrease the potential for legal liability related to identity theft

Database Management System (DBMS)

Ability to Access the Error Trap from DBMS

Overview

With this release, new DBMS F7/A10 provides access to the Caché error trap. Prior to this release, only GE staff could access the error trap. This feature improves your ability to research issues, and lets you forward error information directly from the system via e-mail.

Benefits

- Gives you the ability to provide additional information about errors when you report issues to your staff or to GE. This capability could help expedite resolution of your issues.
- Helps reduce total cost of ownership.

Caché Job Exam Tool

Overview

If you are a Caché SQL user with system-level privileges, you can use this new activity to examine Caché processes from within DBMS.

Benefits

This feature provides the following benefits:

- Lets Caché SQL users with system-level privileges examine Caché processes from within DBMS.
- Helps reduce total cost of ownership.

Dictionary to Manually Track Customizations

Overview

You can use the new Client Customization Tracking dictionary (#35244) to manually keep track of customizations made to your system. Knowing the details, status, and history of customizations made to your system can help you in maintaining your customizations, and in testing with ongoing projects and upgrades. You can add previous customizations and new customizations into this dictionary.

Benefits

Provides a central point of customization information

Effective Date Requirement for Dictionary Entry Deactivations/Activations

Overview

In Enterprise Dictionaries or application-specific dictionary activities like BAR Dictionaries, you must now specify an Effective Date when you deactivate or reactivate a dictionary entry. This helps ensure that Night Jobs can recognize the current status of a dictionary entry. There is one caveat for forms that tie lookups to a date on the screen. If you accept the default of today's date for a dictionary entry deactivation, that entry will still be available for the user to select if the date on the screen is prior to today's date.

Benefits

Helps prevent incorrect system reactivation/deactivation of dictionary entries.

Enterprise Dictionary Entry Variants Audit Trail

Overview

A variant is an alternate definition of one or more Enterprise dictionary fields (data fields) that change (vary), based on the value of one or more predetermined dictionary fields (breakdown fields). Changes made to dictionary variants are now audited.

Benefits

Helps you keep track of changes to dictionary variants.

Enterprise Rulesets New Features

Overview

Several features have been added to rulesets to make working with Enterprise rulesets easier, and more efficient. Features span coding efficiencies for improved performance, new dictionary fields, new ruleset header screens, and multi-line assignment rules.

Benefits

This combination of features helps to streamline the workflow for rulesets.

- Generated code for each ruleset promotes efficiency.
- Ruleset header screens provide one organized location to update ruleset headers.
- Dictionary fields enable the capture and storage of ruleset data in logs that can be queried, and the storage of aliases that can be used across a ruleset.
- Multi-line assignment rules provide a user interface (UI) that makes it possible to write and store lengthy, more complicated rules.

GlobalDoc Enhancements

Overview

Enhancements were made to DBMS (Database Management System) Global Documentation to improve search capabilities. You can now search web-based GlobalDoc by package and/or class name, dictionary, table, and table.column, as well as global. In addition, you can set up access to web-based DBMS GlobalDoc for a server that has multiple instances of Caché running.

Benefits

Improves access to DBMS GlobalDoc.

Patient Confidentiality Module Improvements

Overview

Improvements were made to the DBMS Patient Confidentiality module to expand logging and improve the usefulness of the report.

Benefits

Helps reduce the total cost of ownership by auditing additional key user activities so you can better protect patient data.

Uploading Dictionary Variant Information

Overview

Previously, DBMS did not provide the ability to upload dictionary variant data from an input file. You can use the Dictionary Variant Upload Utility feature to upload dictionary variant data from an input file. To use the utility, you first create a spreadsheet or flat file with the information to be uploaded and save it (as a flat file, if you used a spreadsheet) in a location accessible by your Centricity Business applications. You can then use the utility to:

- Create a variant upload definition
- Verify the contents of your input file
- Execute the data upload, in both test mode and live
- Review the error lists generated by each data upload run

Benefits

This feature provides the following benefits:

- Helps streamline the process of uploading dictionary variant data.
- Helps reduce the total cost of ownership.

Electronic Data Interchange (EDI)

Full Run BAR and HPA EOBs

Overview

The Full Run EOB (F43/A2/A24) feature for Billing & Accounts Receivable (BAR) and Hospital Patient Accounting (HPA) lets you view EDI Explanation of Benefit (EOB) runs, and print run data for runs that are completed, or have fatal edits. A new selector screen allows you to choose the form, and print it. A generator has been added to allow you to generate full run EOB forms. This feature is similar to the EOB File Inquiry (F43/A2/A3) used by BAR customers in the past. The Full Run EOB format is more flexible. You can continue to use your existing EOBs, or redefine the EOB formats to use the new Full Run EOB format. The Full Run EOB format is new for HPA customers, who can define Full Run EOB formats for use now.

Benefits

This feature allows you to print data from EOB runs.

Update Eligibility Name Variances

Overview

An eligibility request sends the patient name stored in your database. However, the name on file at the carrier's sight might not match the name you have on file. You can set up your system to produce the error message, *Patient sent in this response does not match the patient sent in the request.*, and allow users to update the patient name. This feature delivers software to allow you to update a patient name when there is a variance. You can set up this feature using existing tools: Eligibility Crossmap, Payer Categories dictionary (#30147).

Benefits

This feature allows you to update variant patient names in the Eligibility Results screen.

Eligibility

Audit Trails for Eligibility Modules

Overview

Audit Trails have been added to the Eligibility Modules: System Setup, Requests, Crossmap, and Grouped Requests. The Audit Trails let you capture the initials, and any values that were going to be filed into the Insurance Management System (IMS) FSC Follow up questions, Plan Follow up questions, or into a Managed Care (MCA) Contract. New selector screens and action code dictionaries have been created for each of the audit trail modules. Each audit trail also has a data file (global) and an index (global). This feature was included as part of the EDI Eligibility File for Centricity Business version 4.3.

Benefits

This feature allows you to capture Eligibility changes in an audit trail, and identify the users who have made the changes.

Duplicate Checking in DBMS Grouped Eligibility Request Definitions

Overview

When DBMS type, Grouped Eligibility Request Definitions are run for some payers, customers do not want to see *all* service dates for which requests were made. However, other customers need to see all the dates for which requests were made. This feature delivers a screen update that allows you to turn on/off duplicate checking in DBMS type, Grouped Eligibility Request Definitions. This feature was included as part of the EDI Eligibility File for Centricity Business version 4.3.

Benefits

This feature allows customers to streamline the production of eligibility requests by turning on duplicate checking.

Eligibility Reports

Overview

Four new reports have been added to Eligibility Reports (F43/A3/A12):

- Utilization Rate Report (A9) - measures the rate at which an organization is verifying eligibility for arriving patients. The goal is to increase the overall verification and utilization rates.
- Automation Rate Report (A10) - measures the percentage of interactive (manual) requests versus automated grouped requests (GERD), and the percentage of requests filed back into the system without user intervention (auto file rate).
- Frequency Report (A11) - displays the number of Eligibility Requests that fall under the *too frequently requested* umbrella. Helps to highlight potential workflow issues by user, department, location, and payer.
- Results Variance Audit Report (A12) - Lets you capture the initials of a user, and audits columns that have been changed by displaying the old value, and new value of entries that would be filed in any one of the following areas:
 - . Insurance Management System (IMS) Financial Status Classification (FSC) Follow up questions
 - . Patient Accounting (HPA) Plan Follow up questions
 - . Managed Care Application (MCA) Contracts

All customers must be using Centricity Business Eligibility to use these reports. Centricity Business v4.3 customers must have installed the v4.3 5010 Upgrade File and the v4.3 5010 Regulatory Change File. Centricity Business v4.0 customers must have the v4.3 Supplemental File installed, as well as the v4.0 5010 Upgrade File and the v4.0 5010 Regulatory Change File. Refer to the *EDI Eligibility Verification Reports Guide* for a detailed description of each report.

Benefits

These new reports help you gather statistics about the efficiency of your Eligibility system, and also help to meet meaningful use requirements.

Eligibility Summary Alternate View

Overview

This enhancement for Grouped Eligibility Requests is accessible from the Eligibility Summary list.

Alternate View - displays alternate views of the Eligibility Summary list. These views help users and managers quickly identify any remaining work, as well as work that has been completed. The new **Alt View** action is a toggle that moves from views of uncompleted work, to views of completed work, to the standard Eligibility Summary view.

- The first time you select **V-Alt View**, new columns appear that indicate how much work remains to be completed (default).
- The second time you select **V-Alt View**, new columns appear indicating how much work has been completed.
- The third time you select **V-Alt View**, the standard Eligibility Summary columns reappear. The Alternate Views serve as productivity measures. You can view completed and uncompleted work, and make determinations about your organizational needs. This feature was included as part of the EDI Eligibility File for Centricity Business version 4.3.

Benefits

This feature helps to streamline Eligibility processes, and potentially indicate where more staff might be needed.

Eligibility Turnaround Time (TAT) Request/Response Monitoring Tool

Overview

The Eligibility Turnaround Time (TAT) Request/Response Monitoring Tool lets you monitor the time taken by Eligibility Requests that are being sent, and Eligibility Responses that are being received within the system. It shows the times for individual (real-time) and grouped transactions going out of and coming into the system. The list can be ordered by request date (default is chronological order), and filtered by any column in the list. A list of details about transactions, including number and percentage of defects is available on the Transaction Defect Rate. CORE® is the Committee on Operating Rules and Information Exchange, and was established by CAQH (<http://www.caqh.org/benefits.php>) with the vision of "*giving providers access to eligibility and benefits information before or at the time of service using the electronic system of their choice for any patient or health plan.*". GE as a software vendor, is a certified CORE member. The Transaction Defect Rate screen of the Eligibility Turnaround Tool is a result of CORE Phase I measurements. Phase I is a measurement of the turnaround time of a transaction - the time lapse between when the transaction is sent and the response is received. For a real time transaction, *90% of responses should be received in 20 seconds or less*. For a grouped transaction, the GE measurement is based on a *4 hour return time*. The report shows a defect if the real-time return time (RT) took greater than 20 seconds or the group return time (GT) took longer than 4 hours. There are a lot of different rules and different phases to CORE. The GE EDI 270/271 Eligibility Transaction has only gone through Phase I, so the report is specific to the Phase I quality measurement. This feature was included as part of the EDI Eligibility File for Centricity Business version 4.3.

Benefits

The Request Response Monitoring tool provides the times required to send an Eligibility Request and receive an Eligibility Response that can help you gauge the efficiency of exchanges with your trading partner. The Transaction Defect Rate screen of the monitoring tool provides defect information that can help you gauge the efficiency of transaction processing within your organization.

Eligibility Variance List

Overview

Several new Eligibility reports have been created to help customers be more efficient, and streamline workflows. The Eligibility Variance List provides the means for users to view variances for a selected payer, date range, and Eligibility 271 Response column. You can view the responses in a selector list. This feature was included as part of the EDI Eligibility File for Centricity Business version 4.3.

Benefits

The Eligibility Variance List helps customers view variances in selected columns of the Eligibility 271 Response that were filed into the Insurance Management System.

My Eligibility Request Summary (for Managers)

Overview

The My Eligibility Request Summary (F43/A3/A23) allows a manager to view the requests made by his or her direct reports. When a manager is set up in the My Eligibility Request List Managers dictionary (#30802), and specifies direct reports, the manager can view the request status totals of all direct reports from this front-end screen. Select the action, **D-Detail** to drill down to details about a specific users' productivity. If a manager is entered in dictionary #30802, but has not designated direct reports, all managers and users' requests appear in this front-end screen. If you are not a manager, you cannot access this screen. This feature was included as part of the EDI Eligibility File for Centricity Business version 4.3.

Benefits

This feature helps to streamlines operations by allowing managers a way to view eligibility request/response productivity for a selected group of direct reports.

Performance Improvements for Grouped Eligibility Requests

Overview

Several behind the scenes updates have been made to the code that supports Grouped Eligibility Requests:

- Single query to retrieve pre-admission patients
- Single query to get grouped eligibility request records
- Moved the holiday check to a Caché class/table
- Efficiencies in weekend and holiday queries; now one query to retrieve visit skip day settings and one query for appointment skip day settings. Previously, each setting had two queries.

- Ensure that grouped request advanced filters are executed once
- Additionally, a new field was added to Grouped Eligibility Request Definition Visit screen. The field, **Send a request for each visit** determines whether to loop through all visits for a patient, to see if there was already a request on another visit with the same plan. If the flag is set to **Y** (yes), then a new request is sent for the visit in context. If the Flag is set to **N** (no), then the system loops through other visits with the same plan and skips the visit in context if a request was already sent for one of the other visits. This feature was included as part of the EDI Eligibility File for Centricity Business version 4.3.

Benefits

These features help to improve the response time of grouped eligibility requests.

Enterprise Wide Scheduling (EWS)

Color Coding for Appointment Type Categories in Provider Schedules (Advanced Web)

Overview

The color coding for appointment type categories lets you easily identify the appointment type (category), by color, in provider schedules during scheduling. The background of the appointment information is colored according to the color selected. To use this functionality you need to select a color from the lookup at the **Background Color** field in the Appointment Type Categories dictionary (#313), and assign a category at the **Reporting Category** field for each appointment type at the department and provider level on the New/Edit Appointment Type screen.

Benefits

This feature lets schedulers quickly and easily identify the types of appointments being scheduled by assigning each appointment type category a specific color, which is displayed in provider schedules.

Confirmation and Add to Wait List Screen Changes (Advanced Web)

Overview

The Advanced Web Confirmation screen allows you to easily view additional information about the appointment being scheduled, and perform actions against the appointment or the patient. The **Wait List** action lets you manually add eligible appointments to the Wait List, edit the appointment being scheduled, or undo an appointment previously added to the Wait List. Additionally, during the scheduling process, if appointments are eligible for the Wait List, the Add to Wait List screen appears. You can select which appointments to add to the Wait List and add a comment. An appointment is eligible for the Wait List depending on the number of days entered in the Sched Profile question, "*After how many days prompt for the Wait List:*"

Benefits

This feature provides the following benefits:

- Automates the workflow allowing you to add appointments to the Wait List during scheduling.
- Alerts you to which appointments can be added to the Wait List based on the date criteria.

Followup Appointment Indicator (Advanced Web)

Overview

Previously, when you scheduled a followup appointment from another appointment there was no indication that a followup appointment was made. With the followup appointment indicator functionality, when a followup appointment is made from another appointment an "F" will appear in the attachments column on all scheduling screens. The Appointment History section of the Appointment Detail screen for the appointment used to create the followup displays generated text indicating a followup appointment was made, by whom, and when it was made. The Appointment History for the followup appointment also displays this information with the exception of by whom.

Benefits

This feature provides the following benefits:

- Easy recognition that a followup appointment was scheduled from the appointment you are viewing.
- Followup appointment information displays in the appointment history.
- The Audit Trail tracks the followup appointment action and the source appointment of the followup action.

Stretch Controls for EWS Screens

Overview

In Enterprise-Wide Scheduling (EWS), several screens have been enabled with stretch controls that allow the screens to expand or collapse when browser window size is increased or decreased. These controls allow for resizing, when possible, to make the most use of the whitespace in the browser when the browser is maximized.

Benefits

The automatic resizing of the screen helps to: ▪ Streamline the user workflows ▪ Reduce total cost of ownership by allowing the user access to as much information as possible to complete tasks quickly

Time Stamp Changes in Appointment Manager (Advanced Web)

Overview

The Appointment Manager grid on the Appointment Manager screen has two new columns. The **Pt Out** column replaces **Time Out**. **Pt In** replaces **Time MD** which is the time the appointment was marked as seen by the provider. This enables you to see the different times associated with the patient and provider in Appointment Manager.

Benefits

This feature helps you easily track the status of the patient in Appointment Manager. You can see if a patient is waiting or being seen by the provider.

ICD-10

BAR Updates for ICD-10

Overview

Billing & Accounts Receivable (BAR) accommodates the input and display of ICD-10 diagnosis and patient reason for visit codes. The system then uses these codes to complete system processes. BAR accepts ICD-9s or ICD-10s based on the service date of the invoice. Organizations are responsible for meeting the ICD-10 compliance date of October 1, 2013.

Benefits

- Helps satisfy the regulatory requirements for ICD-10.
- Allows organizations to continue normal processes and workflows that meet all ICD-10 requirements.

Dictionary #47204 and the Preprocessing Utility

Overview

The Centers for Medicare & Medicaid Services (CMS) provide ICD-10 files containing new ICD-10 codes, *maintenance files*, *crosswalk files*, and *alternate files*. Before these CMS files can be uploaded into your Centricity Business ICD-CM Diagnosis (#36) or ICD-PCS Procedures (#144) dictionaries, the CMS files must be properly formatted. The ICD-10 Dictionary Upload Preprocessor dictionary (#47204), the Preprocessor Utility, and the existing Dictionary Upload Tool help you to format and load these files into your Centricity Business dictionaries (#36 and #144).

Benefits

This feature helps you ready your system for processing ICD-10 diagnosis and ICD-PCS procedure codes. The feature helps satisfy the regulatory requirements for ICD-10.

EWS Updates for ICD-10

Overview

Enterprise-Wide Scheduling (EWS) accommodates for the input and display of ICD-10 diagnosis. The system then uses these codes to complete system processes.

Benefits

Helps satisfy the regulatory requirements for ICD-10 Organizations will be able to continue normal processes and workflows that meet all ICD-10 requirements.

ICD Crosswalk Codes

Overview

All eligible visits or charges will be coded with ICD-10 codes as of October 1, 2013. However, there may be payers who are not ready to accept claims coded with ICD-10 as of the 10/1/2013 implementation date, and may continue to only be able to accept claims coded with ICD-9 code set(s). GE uses the General

Equivalence Mappings (ICD-10-PCS to ICD-9-CM procedure code) file to obtain the list of alternate ICD-9 crosswalk codes for those 5% of ICD-10 codes that have multiple crosswalk options. When you load the GEMs file, the system loads the alternate/possible ICD-9 codes into ICD-PCS dictionary (#144), in the **ICD-CM Crosswalk (Alternates)** field. The system then uses alternate **ICD-10 Effective Date** fields to enable a visit or charge coded with ICD-10 to be crosswalked back to ICD-9 for a specific payer. Functionality in coding screens crosswalk the ICD-10 codes on the VM visit to the appropriate ICD-9-CM procedure codes. In addition, claim form logic enables sending or printing crosswalked ICD-9-CM procedure codes on a claim.

The crosswalking method will look to these alternate **ICD-10 Effective Date** fields on each plan assigned to the visit based on the following hierarchy:

1. Insurance Companies stored in the Plan Master, for the plan(s) assigned to the visit.
2. Plan codes assigned to the visit.
3. FSC of the Plan(s) assigned to the visit

Benefits

Helps to ensure appropriate ICD codes are selected for claim submission

This feature is used to handle scenarios where claims with ICD-9 diagnosis and procedure codes may still be required by payers. Helps satisfy the regulatory requirements for ICD-10.

SIU Interface Updates for ICD-10

Overview

When updating the standard 8.4 System Interface Utilities (SIU) Interfaces, three areas were considered:

- SIU Standard Code (routines)
- SIU Non-Standard Forms Definition Language (FDL)
- Older Interfaces

Benefits

- These features ensure that SIU Interfaces continue to work when ICD-10 codes are implemented.
- These features help satisfy the regulatory requirements for ICD-10.

Transaction Editing System Updates for ICD-10

Overview

The Transaction Editing System (TES) accommodates for the input and display of ICD-10 diagnosis codes. This system then uses these codes to complete system processes. The system accepts ICD-9s or ICD-10s based on the service date of the invoice.

Organizations are responsible for meeting the ICD-10 compliance date of October 1, 2013.

Benefits

Helps satisfy the regulatory requirements for ICD-10 Organizations will be able to continue normal processes and workflows that meet all ICD-10 requirements.

Updating Centricity Business for ICD-10

Overview

On January 16, 2009, the Center for Medicare & Medicaid Services (CMS) issued a Final Rule that mandates the adoption of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) by October 1, 2013. This date has been tentatively moved forward to October 1, 2014. The shift to ICD-10 is intended to be a significant enhancement in the coding and classification of diagnoses and inpatient hospital procedures. This CMS adoption provides U.S. healthcare organizations with the opportunity to adopt the same platform already used by many industrialized nations such as the United Kingdom, France, Australia, Germany, and Canada. ICD-10 affects several of the Ambulatory and Hospital products in the Centricity Business suite:

- Advance Beneficiary Notice (ABN)
- Anesthesia
- Billing & Accounts Receivable (BAR)
- Electronic Data Interchange (EDI)
- Electronic Document Management (EDM)
- Enterprise-Wide Scheduling (EWS)
- Managed Care Application (MCA)
- Patient Accounting (HPA) and Combined Business Office (CBO)
- Ambulatory Payment Classifications (APC)
- Diagnostic Related Groups (DRG)
- Patient Protocol Manager (PPM)
- Payer Contracts Module (PCM)
- Transaction Editing System (TES)
- Visit Management
- Ambulatory Visit Management (AVM)
- Enterprise Visit Management (EVM)
- Medical Records (MR)

Changes are backward compatible to version 4.3 for most applications. In addition to the application changes, the ICD-CM Diagnosis dictionary (#36) has undergone updates to accommodate storage of both ICD-9 and ICD-10 codes. The ICD-PCS Procedures dictionary (#144) has undergone similar updates to allow for storage of both ICD-9 and ICD-10 procedure codes. Dictionary #144 changes primarily affect MCA, DRG, VM (EVM, AVM), MR, and HPA/CBO. The GE Healthcare (GEHC) strategy to help customers migrate from ICD-9 to ICD-10 encompasses the following areas of scope:

- Dictionary strategy - diagnoses (dictionary #36) and procedures (dictionary #144) continue to be managed through the existing dictionaries.
- User Interface (UI) strategy - forms, screens, and grids where you enter or view diagnoses and procedures have been updated to accommodate ICD-10.

- Output considerations - reports, claims, and interfaces that have diagnoses and procedures have been updated to accommodate ICD-10.
- Input considerations - inbound interfaces have been examined and updated for ICD-10.
- Conversion strategy - updates have been made so that you can move from ICD-9 to ICD-10, and support both schemes during an indefinite transition period.

Benefits

- All updates help to satisfy the regulatory need to input, process, and display ICD-10 codes in the proper manner.
- Centricity Business applications can continue to function after the updates go into effect.

- The dictionary changes have been implemented to allow both ICD-9 and ICD-10 codes to be used during the transition period.
- These features help satisfy the regulatory requirements for ICD-10.

Updating Dictionaries #36 and #144 for ICD-10

Overview

To allow customers to support both ICD-9 and ICD-10 diagnosis and procedure codes, updates have been made to dictionaries #36 and #144. The names of the dictionaries have also been changed to reflect the new functionality, as follows:

- Icd-CM Diagnosis dictionary (#36)
- Icd-Pcs Procedures dictionary (#144)

Benefits

This feature helps satisfy the regulatory requirements for ICD-10. The feature allows customers to update to ICD-10 diagnosis and procedure codes. It also allows customers to continue using ICD-9 codes until a specified cut-off date.

- The name of dictionary #36 has been changed from **Icd-9-Cm Diagnosis** to **Icd-CM Diagnosis**, and accommodates both ICD-9 and ICD-10 codes.
- The name of dictionary #144 has been changed from **Icd9-Cm Procedures** to **Icd-Pcs Procedures**, and accommodates both ICD-9 and ICD-10 codes. Several concepts and related tasks describe the specific dictionary changes.

Transaction Editing System (TES)

Deleting TES Encounter Deletes Associated Transactions

Overview

Previously, TES required users to delete all transactions tied to an encounter before the encounter could be deleted. In this release, the system can be set up to automatically delete underlying transactions when an encounter is deleted. You cannot delete an encounter if any of the following are true: (these rules are not new; they have been in place for prior releases as well)

- Any or all of the underlying transactions have been extracted from the system.
- The encounter has one or more transactions in a batch that is on Hold (either the encounter and all of its transactions are in that batch, or the encounter is in two batches and one of those is on Hold).

Benefits

Helps Promote Greater Efficiency in Encounter Deletion Process

- Helps make it easier and faster for users to delete charges submitted against an incorrect patient or to back out interface loads.
- Helps provide more reliable method for deleting the appropriate encounter and transactions.

Edit Placed on Encounter When Error Occurs During Nightly Edit Evaluation

Overview

Previously, if an error occurred during the Nightly Edit Evaluation (NEE), the NEE would crash and the user had no clear way to know what caused the problem or what needed to be resolved. In this release, when an error occurs during the Nightly Edit Evaluation (NEE), the NEE continues on. In addition, the system can be set up to place an edit on the encounter that caused the error.

Benefits

Crash Recovery for the Nightly Edit Evaluation (NEE)

- Allows the Nightly Edit Evaluation (NEE) to record an encounter error and then continue on.
- Helps identify encounters that need to be resolved due to an error during the Nightly Edit Evaluation (NEE).

Filter BAR Invoices for a TES Encounter

Overview

Several features have been added to Invoice Inquiry and TES Encounter/Transaction Inquiry to provide users with an easy method to identify the Billing & Accounts Receivable (BAR) invoices for a Transaction Editing System (TES) encounter. This can be helpful when patients contact the organization with questions about billing. Since an encounter can result in multiple invoices, users need to identify all invoices, as well as BAR and TES activity for transactions in a particular invoice.

Benefits

- Helps reduce the total cost of ownership of the BAR and TES applications by allowing users to filter the BAR Invoice Inquiry screen by invoices associated with a particular TES encounter, reducing the need for a user to manually research this information
- Helps filter the applicable list of transactions in an encounter that the user needs to see

Maximum Number of Transactions to Load Locally

Overview

This feature allows you to set the maximum number of transactions to load locally.

Benefits

Helps provide flexibility for each organization to decide the maximum number of transactions they want to load locally.

Performance Tracking for TES Manual Entry and Nightly Edit Evaluation

Overview

Previously, there was not a way to determine if any task during Transaction Editing System (TES) manual entry or the Nightly Edit Evaluation (NEE) was taking longer than expected. In this release, you can collect data for key steps in the TES manual entry process or the Nightly Edit Evaluation (NEE) process

that exceed time limits (thresholds) you have defined. By having these times recorded, if there is an area that is taking longer than expected, those events can be examined more closely. Elapsed time can be captured for these steps in the TES manual entry process or the NEE process:

- Edit evaluation
- Master edit evaluation
- Encounter workfile filtering
- Transaction workfile filtering
- Edit action processing
- Overall encounter processing times

Benefits

This feature helps identify areas of the TES manual entry process or the NEE process that are taking longer than expected so those areas can be reviewed and resolved.

Shortcut to Dictionary Lookup from TES System Manager Utilities

Overview

You can use the **J-Jump To** action from the TES System Manager Utility activities to look up a specific dictionary entry for the activity you are on.

Benefits

Provides a quick way to look up a specific dictionary entry using the name, mnemonic, or number.

Shortcut to TES Inquiry from the Encounter Selector

Overview

From the TES Encounter Selector on the TES Encounter/Transaction Editing screen, you can use the **H-TES Inquiry** action to jump to the TES Encounter/Transaction Inquiry screen for the selected patient.

Benefits

Provides a quick way to switch over to the TES Encounter/Transaction Inquiry screen for the selected patient.