ExamWRITER User's Guide

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Getting Started

1

In this chapter:

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Choosing ExamWRITER to record and store your electronic medical records (EMRs) is the first step in creating a fully automated medical practice. This guide will show you how to use ExamWRITER to create, modify, and view EMRs. For more information on how to use ExamWRITER from start to finish, watch the Start To Finish Overview video.

Finding More Information

For more information on getting help in ExamWRITER, watch the "Navigation and Help" video.

In addition to the *ExamWRITER User's Guide*, the following tools are available to you to help you better understand and use ExamWRITER:

- *Training Videos*. These Internet-based, prerecorded training videos should be viewed by all ExamWRITER users. Go to http://www.eyefinity.com/education-and-support/Support-Community.html and log into the Eyefinity Support Community to view ExamWRITER training sessions.
- *Eyefinity Support Community.* In this community, you can create and update support cases, access our growing knowledge base of information, ask questions and get answers from your peers, and contribute your ideas to improving Eyefinity products. Go to http://www.eyefinity.com/education-and-

support/Support-Community.html to access the Eyefinity Support Community.

- *Online Help.* To access online help for ExamWRITER, click **Help** on the ExamWRITER main window and select **Help Topics**. The ExamWRITER help system opens. You can also access online help by pressing the **F1** key anywhere in ExamWRITER.

ExamWRITER Overview

Your ExamWRITER software creates customized EMRs that manage all of your patient information in a secure database that is easy to modify and use. This section includes the following topics:

- Explanation of Interface Elements, 2
- Explanation of Navigation Schemes, 3

Explanation of Interface Elements

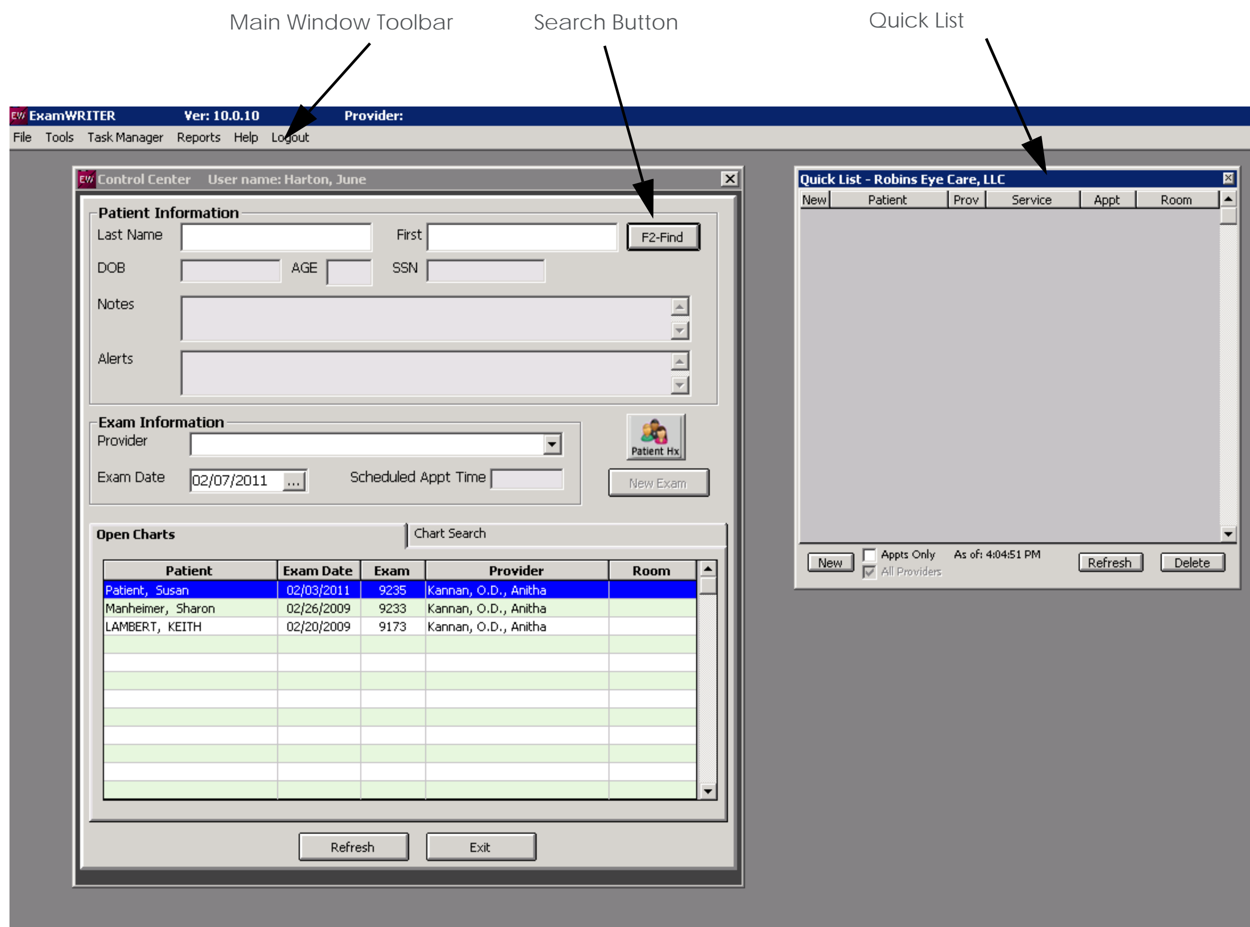

Figure 1-1: ExamWRITER Main Window, ExamWRITER Control Center, and Quick List

For information on the Red Flags Rule, watch the “Red Flags Rule” video.

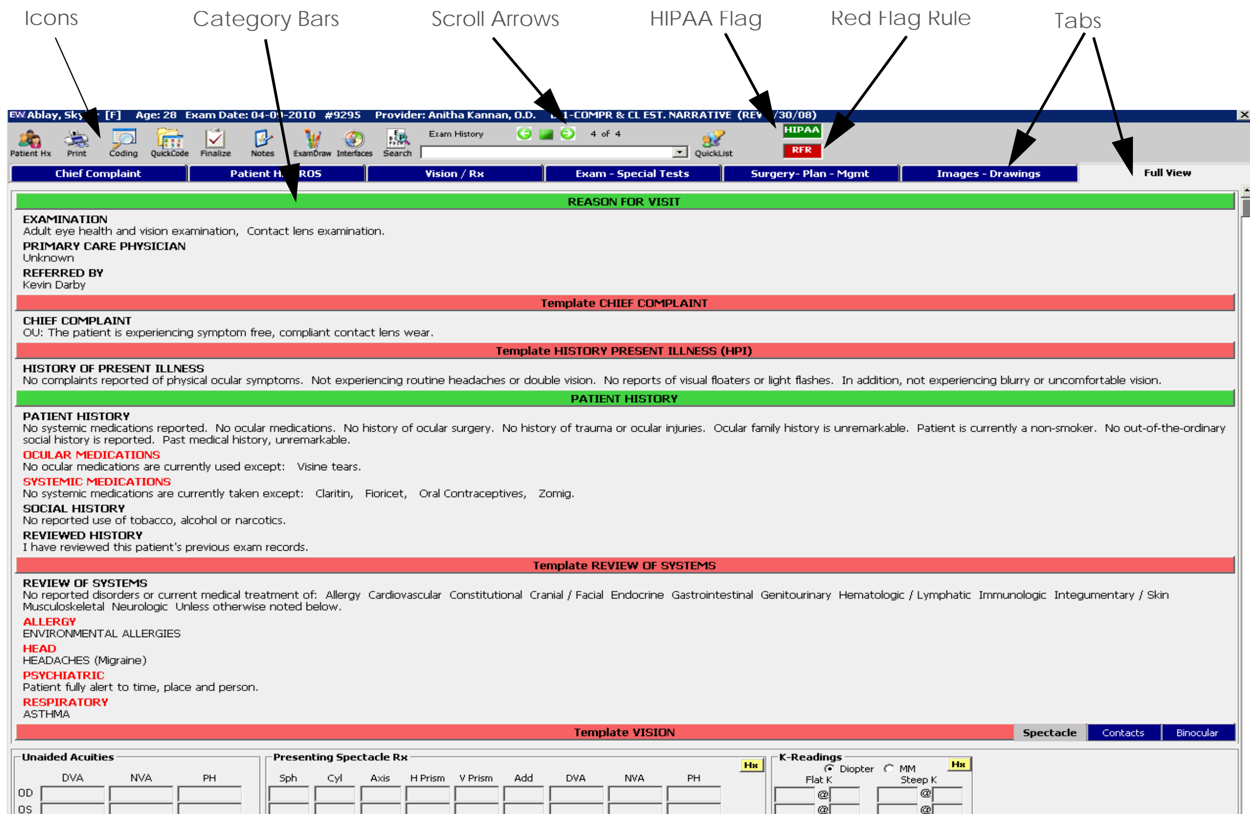

Figure 1-2: ExamWRITER Chart Window

Explanation of Navigation Schemes

For more information on navigating in ExamWRITER, watch the "Navigation and Help" video.

ExamWRITER has many unique navigation schemes. Eyefinity highly recommends familiarizing yourself with the ExamWRITER navigation schemes in order to more quickly and efficiently navigate through ExamWRITER and perform tasks.

This section tells you how to use the various navigation schemes in ExamWRITER, including how

- To open Administration (Standalone Users Only), 4
- To sort columns, 4
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- To search for patients and guarantors (F2), 7
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- To record medication orders (F6), 9
- To use the Task Manager (F7), 10
- To add and maintain list box selections (F12), 10

▶ To open Administration (Standalone Users Only)

If you are using the standalone version of ExamWRITER (without OfficeMate), then you will need to open Administration to complete many setup and reporting tasks.

1. Open Windows Explorer.
2. Navigate to the **OMATE32** or **OfficeMate** folder.
3. Select **EWHomeOffice.exe** and drag it to the desktop.
4. Double-click the **EWHomeOffice.exe** icon on the desktop.

▶ To sort columns

❖ Click on a column heading to sort the column in ascending order.

NOTE	Clicking on a column heading a second time will not sort the column in descending order.

– For example, in the ExamWRITER Control Center, you can click the **Patient** heading on the **Open Charts** tab and sort the Patient column in ascending order. Clicking on the Patient heading a second time will not sort the column in descending order.

▶ To use the right-click functionality

❖ Right-click throughout the ExamWRITER interface to open shortcut windows, process text files, add impressions and observations to an exam, and delete EMR text.

Throughout the ExamWRITER interface, there are many areas where you can right-click to open a shortcut window. In many places, you can also

right-click to open a window with menu options that are not available as menu options anywhere else in ExamWRITER.

- For example, in the ExamWRITER Control Center, you can right-click on **Open Charts** and select **Unlock Exam**. You can only unlock an exam by right-clicking on the open chart; there is no other way to unlock an exam.

NOTE	Only one person at a time should access a patient's exam record. If more than one person accesses the same exam record at the same time, data from that record will be lost!

- For example, in the ExamWRITER Control Center you can right-click on **Previous Exams** (if available) and select **Copy to New Exam**. You can only copy a previous patient exam to a new exam by right-clicking on the previous exam; there is no other way to copy the previous patient exam to a new exam.

NOTE	If there are no closed or finalized exams for a patient, then the patient will have no previous exams recorded in ExamWRITER.

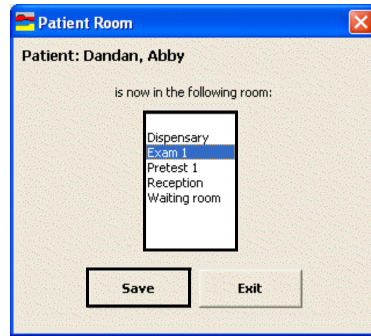
- For example, in the ExamWRITER Control Center Open Charts and Chart Search windows, you can right-click on a patient and select **Delete Exam** to delete a patient's exam record.
- For example, in the ExamWRITER Control Center Chart Search window, you can right-click on a patient and select **Un-Delete Exam** to restore a deleted exam record.
- For example, in the ExamWRITER Control Center Open Charts, Chart Search, and Previous Exams views, you can right-click on a patient and select **Change Provider/Exam Date** (or **Change Provider** in the Previous Exams view) to modify the patient's provider or exam date. Select a provider from the **Current Provider** drop-down menu to select a new provider for the patient. Select an exam date from the **Exam Date** calendar to change the exam date.

NOTE	You can only modify a patient's provider and exam date on the Chart Search tab and Previous Exams view if the exam is closed. You cannot modify a patient's provider and exam date on the Chart Search tab or Previous Exams view if the exam is finalized.

Change Provider
Exam No. 111
Patient Name Dubois, Nikki Q
Current Provider Miller, O.D., Michael
Exam Date 08/25/2006
Save Exit

- For example, in the ExamWRITER Control Center Open Charts window, you can right-click on a patient and select **Update Patient Room**, select

the room in the office where the patient is located, and click **Save** to denote this room on the ExamWRITER Control Center and Quick List.



– For example, in the ExamWRITER Control Center Chart Search window you can right-click on a patient's finalized exam and select **Patient Information** to open the Patient Information Center window and view the patient's demographic and medical information.

Throughout ExamWRITER you can record and process medical record information by clicking **Process**; you can add impressions and observations to an EMR by clicking a yellow **Observations** button. You can also right-click anywhere within these windows to record and save the medical record information and add impressions and observations.

– For example, in the Reason for Visit window, you can select Reason for Visit, Patient Profile, Failed Screening, and Expressing Interest check boxes and then right-click anywhere in the window to process and record the selected information in the EMR.

– For example, in the ACA RATIO Impressions/Observations window, you can select the **Calculated ACA** or **Graphical ACA** check box and then right-click anywhere in the window to add the selected item to the ACA Ratio Observations.

To delete text in an EMR, right-click on the text header and click **Yes**.

– For example, in the Chief Complaint tab, you can right-click a bold heading under Reason for Visit and delete the heading and its accompanying text.

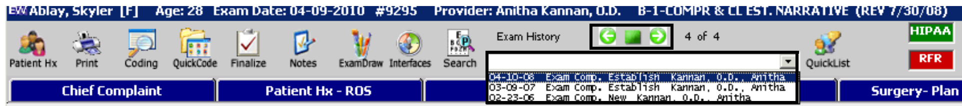
▶ To access previous patient exams

Use the green scroll arrows at the top of the ExamWRITER chart window to access previous patient exams.

- Click the green left scroll arrow on the ExamWRITER chart window to scroll through older patient exams.
- Click the green right scroll arrow on the ExamWRITER chart window to scroll through newer patient exams.
- Click the green square on the ExamWRITER chart window to return to the exam that you most recently opened.

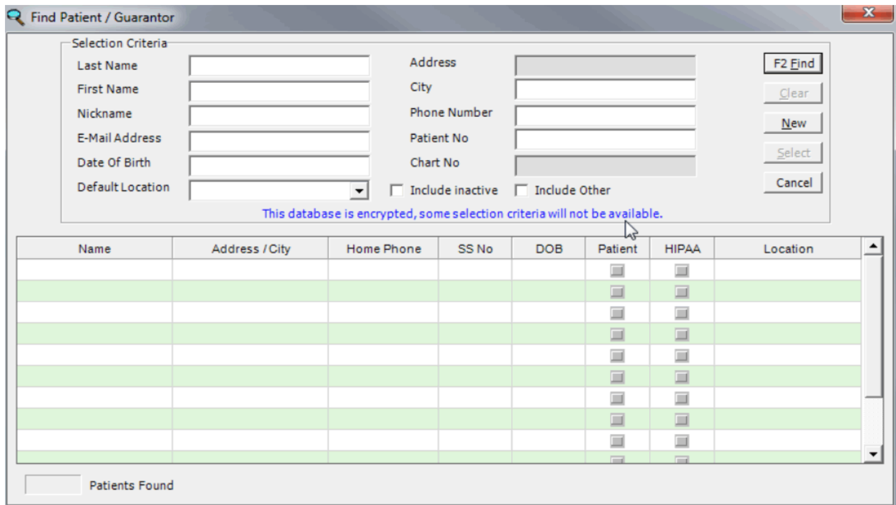
NOTE	You cannot modify or print the exams that you scroll though.

To open a previous exam from within a currently opened exam, select a date, primary procedure code, and provider from the **Exam History** drop-down menu on the ExamWRITER chart window.



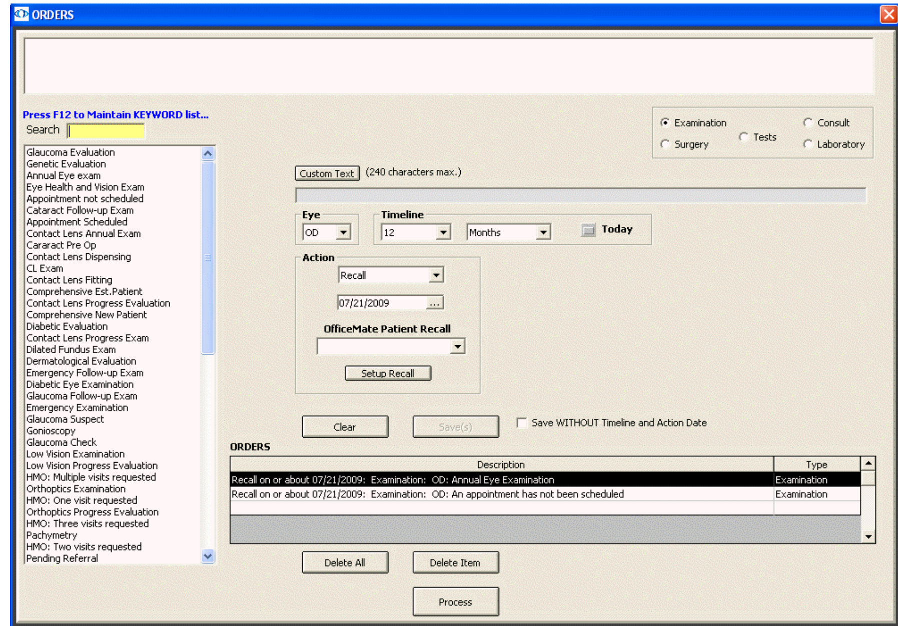
▶ To search for patients and guarantors (F2)

❖ Press the **F2** key in the Control Center window to open the Find Patient/Guarantor window and search for a patient or guarantor.



▶ To record orders (F3)

❖ Press the **F3** key anytime during an exam to open the Orders window and record a patient’s examination, surgery, test, consultation, and laboratory orders.

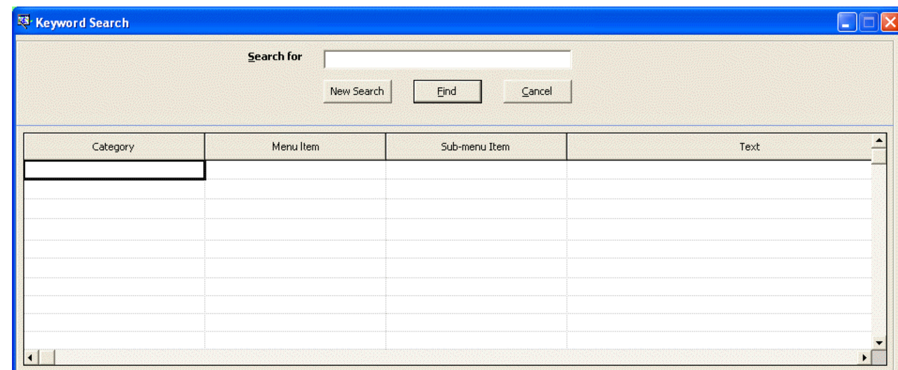


▶ To view and print a patient report (F4)

❖ Press the **F4** key anytime during an exam to open and print a compilation of a patient’s reported diagnoses. This report opens in your default word processing program as an .rtf formatted file.

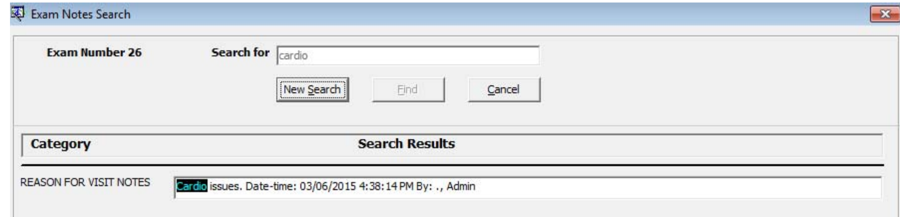
▶ To search in ExamWRITER (F5)

❖ Press the **F5** key anytime during an exam to open the Keyword Search window and search for information in ExamWRITER. For more information on searching in ExamWRITER, go to “Searching in ExamWRITER” on page 103.



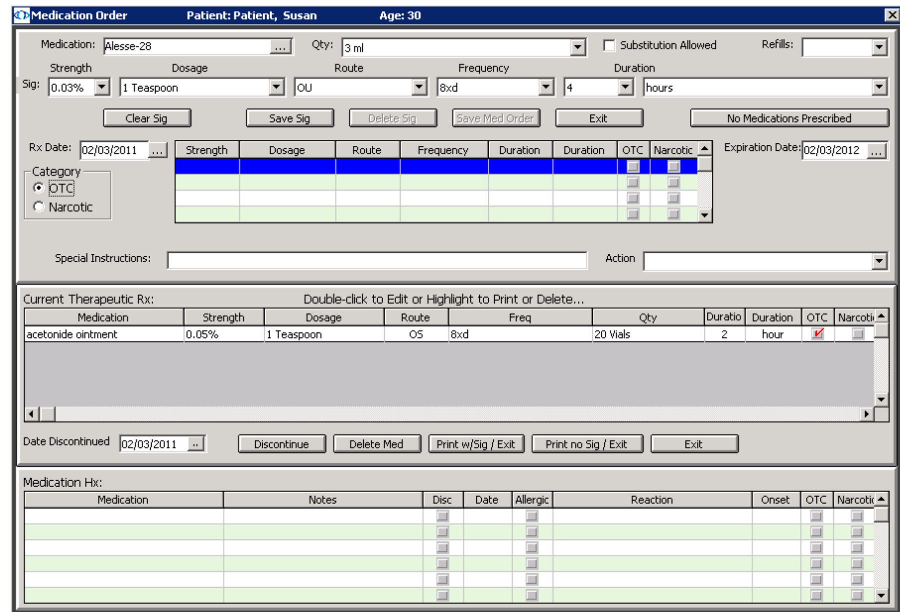
▶ To search for exam notes (Ctrl + F5)

❖ Press the **Ctrl** and **F5** keys anytime during an exam to search for recorded exam notes.



▶ To record medication orders (F6)

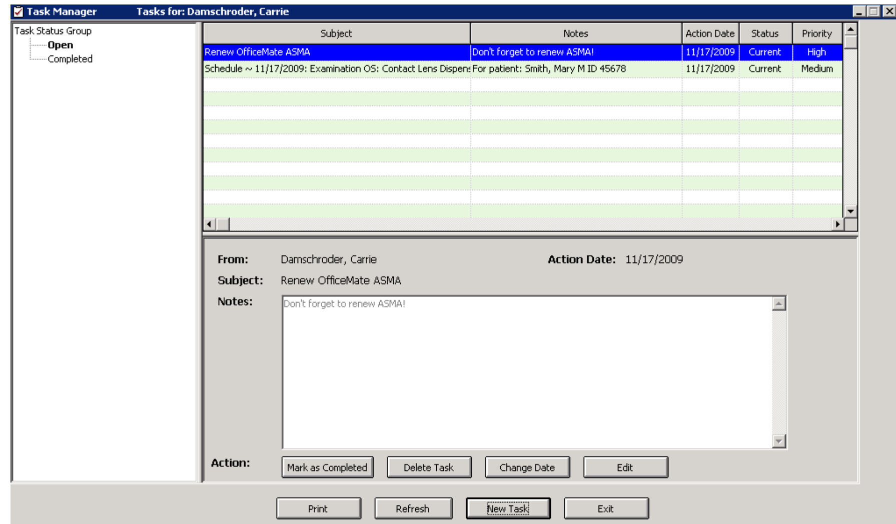
❖ Press the **F6** key anytime during an exam to open the Medication Order window and record a patient's prescription medication.



For more information on using the Task Manager, watch the "Task Manager" video.

▶ To use the Task Manager (F7)

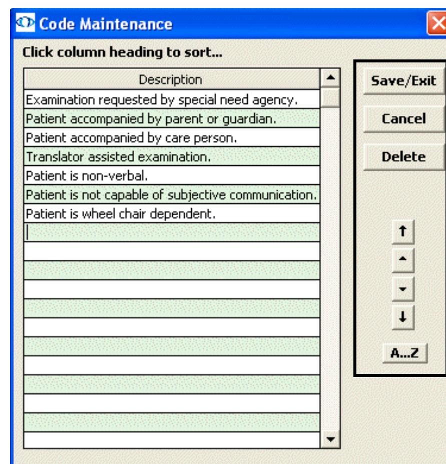
❖ Press the **F7** key anytime during an exam to open the Task Manager window and create, track, and assign tasks to specific providers and staff members.



▶ To add and maintain list box selections (F12)

❖ Press the **F12** key when your cursor is in a drop-down box to open a Code Maintenance window and add new items and resequence the selections.

– For example, press **F12** while your cursor is in the **Dosage** drop-down box in the Medication Order window. Type a dosage in the **Description** column and click **Save/Exit** to add the dosage to the drop-down menu selections or select a dosage and click **Delete** to delete the dosage from the drop-down menu selections. You can also move drop-down menu selections up or down one row at a time or to the top or bottom of the list by clicking the arrow buttons and you can alphabetize the selections by clicking **A...Z**.



Setting Up ExamWRITER

ExamWRITER offers many ways for you to customize your EMRs. Before you begin creating, modifying, and viewing EMRs, customize ExamWRITER by setting up your preferences, creating templates, and adapting correspondent, patient demographic, and medication information to your practice needs. If you are using the standalone version of ExamWRITER (without OfficeMate), you can also customize your business names and set up third party information, resources, list box selections, ZIP code shortcuts, recalls, service agreements, duplication fees, marketing groups and categories, locations, products, security preferences, and audit logs from within Administration. This section includes the following topics:

- Maintaining Business Names, 11
- Setting Up Insurance Codes, Modifiers, & Attributes, 12
- Maintaining Providers, Staff, & Other Resources, 23
- Customizing ExamWRITER, 31
- Maintaining Locations, 45
- Setting Up Security, 52
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- Creating and Modifying Templates, 88
- Customizing Exam Data, Exam Text, & Auto Letter Sequences, 92

NOTE	You cannot customize ExamWRITER when exam records are open. Close all exam records in the ExamWRITER chart window before customizing ExamWRITER in the ExamWRITER main window.

Maintaining Business Names

For more information on maintaining business names, watch the "Location Maintenance & Business Names" video.

1. On the OfficeMate Administration main window, click **Setup** and select **Business Names**.

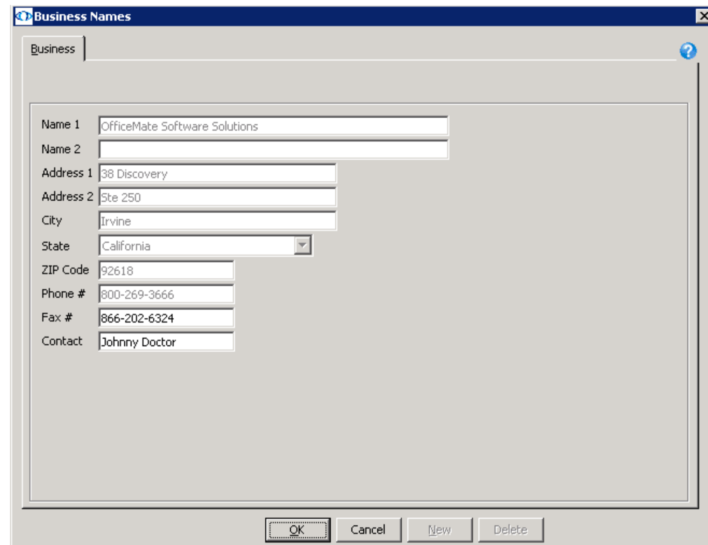
   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Business Names**.

   The Business Names window opens. If you are a single-location practice, your office address is displayed as the business location.

2. Update or add information in the **Fax #** and **Contact** text boxes.

NOTES	• If you submit ANSI insurance claims, you must type a contact name in the **Contact** text box. • You cannot modify your practice name, address, or phone number from within the Business Names window in Administration. If you need to modify this information, call Eyefinity at 800.369.3666.



3. Click **OK** to save the business name information and exit the Business Names window.

Setting Up Insurance Codes, Modifiers, & Attributes

This section tells you how to set up detailed codes that drive insurance billing, including how

- To open the Third Party Setup window, 13
- To add & modify procedure codes, 13
- To add & modify diagnosis codes, 14
- To add & modify procedure modifiers, 16
- To add & modify attributes, 16
- To add & modify additional attributes, 18
- To add & modify places of service, 19
- To set up lens power range codes, 21
- To set up SNOMED codes, 22

To open the Third Party Setup window

1. From the OfficeMate Administration main window, click **Setup**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Third Party Setup**.
2. Select **Third Party Setup**.

   The Third Party Setup window opens.

To add & modify procedure codes

Setting up procedure codes enables you to associate CPT codes, costs, and fees with services that you bill. For more information on setting up procedure codes, watch the "Procedure Codes" video.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to "To open the Third Party Setup window" on page 13.
2. Click **New Code** to create a new code.

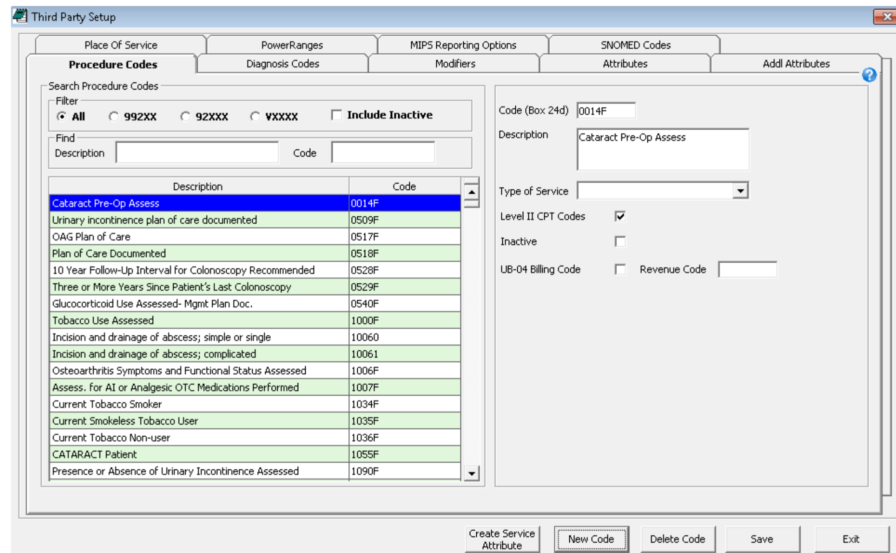
   OR

   Select a code from the list.
   - Select a **Filter** radio button to narrow the list of codes as needed.
   - Type a description or code in a **Find** field to narrow the list of codes as needed.
   - Select the **Include Inactive** check box to include inactive codes in the list as needed.
3. In the **Code (Box 24d)** field, type the CPT/HCPCS or carrier-specific code.
4. In the **Description** text box, type a short description for the code.
5. From the **Type of Service** drop-down menu, select a service type.
6. Select the **Level II CPT Codes** check box to designate the procedure code as a level II procedure code for the CMS Physical Quality Reporting System (PQRS).

   NOTES
   - For more information about the PQRS, go to the Centers for Medicare and Medicaid Services Web site at www.cms.hhs.gov.
   - After designating PQRS diagnosis codes and level II procedure codes and selecting to auto populate PQRS codes for select insurance companies, you will not receive a reminder on fee slips with level II procedure codes and $0 fees, and you will not receive the "Line Item cannot have ZERO" error in the Third Party Processing window. If all of the items on an insurance claim are level II procedure codes, then you can submit a $0 balance insurance claim. For more information on designating PQRS diagnosis codes, go to "To add & modify diagnosis codes" on page 14.
7. Select the **Inactive** check box if the procedure code is no longer in use.
8. Select the **UB-04 Billing Code** check box to designate the UB-04 as the suitable claim form for the procedure code if this code is a surgical procedure.

9. If you have designated the UB-04 as the suitable claim form for the procedure code, type the revenue code for the procedure code in the **Revenue Code** text box, if desired. The revenue code is populated in box 42 on the UB04 form.
10. If you want to assign a service an attribute to ensure that the service is assigned the correct insurance benefits, select the procedure code and click **Create Service Attribute**.

    The selected procedure code is now available under the Services Product Type (Exam Cat./Base category) on the Attributes tab. For more information on adding and modifying attributes, go to "To add & modify attributes" on page 16.
11. Click **Save** when you are finished.
12. Repeat steps 2–11 to add or modify additional procedures as needed.



13. Click **Exit** to close the Third Party Setup window.

▶ To add & modify diagnosis codes

For more information on setting up diagnosis codes, watch the "Diagnosis Codes" video.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to "To open the Third Party Setup window" on page 13.
2. Click the **Diagnosis Codes** tab.
3. Click **New Code** to create a new code.

   OR

   Select a code from the list.

   – Select a **Filter** radio button to narrow the list of codes as needed.

   – Type a description or code in a **Find** field to narrow the list of codes as needed.

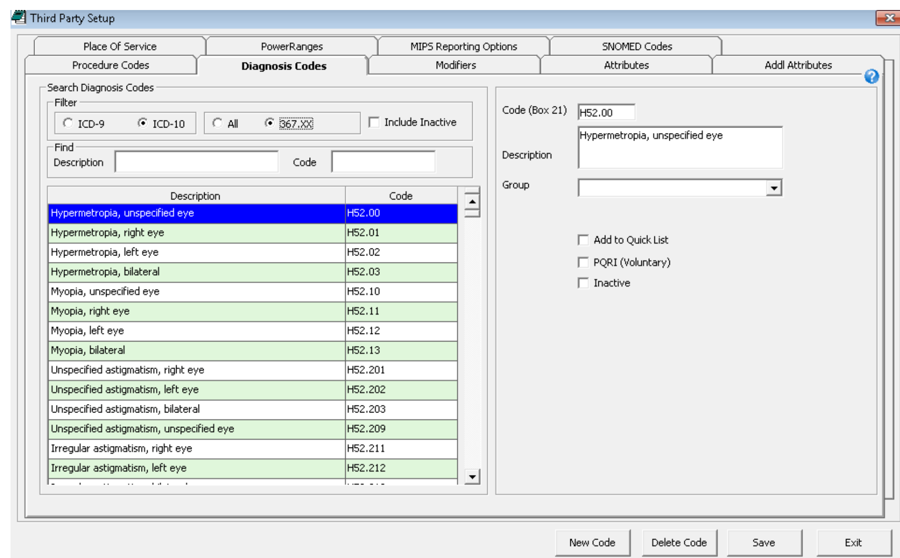
   – Select the **Include Inactive** check box to include inactive codes in the list as needed.
4. In the **Code (Box 21)** field, type the ICD-9 or ICD-10 code.

5. In the **Description** text box, type a short description for the diagnosis code.
6. From the **Group** drop-down menu, select a category for the diagnosis code.
7. Select the **Add to Quick List** to add the diagnosis code to the Quick List of frequently used codes.
8. Select the **PQRI (Voluntary)** check box if the diagnosis is designated as a PQRS measure.

NOTES

- For more information about the PQRS, go to the Centers for Medicare and Medicaid Services Web site at www.cms.hhs.gov.
- After designating PQRS diagnosis codes and level II procedure codes and selecting to auto populate PQRS codes for select insurance companies, you will not receive a reminder on fee slips with level II procedure codes and $0 fees, and you will not receive the “Line Item cannot have ZERO” error in the Third Party Processing window. If all of the items on an insurance claim are level II procedure codes, then you can submit a $0 balance insurance claim. For information on designating level II procedure codes, go to “To add & modify procedure codes” on page 13.

9. Select the **Inactive** check box if the diagnosis code is no longer in use.
10. Click **Save** when you are finished.
11. Repeat steps 3–10 to add or modify additional procedures as needed.



12. Click **Exit** to close the Third Party Setup window.

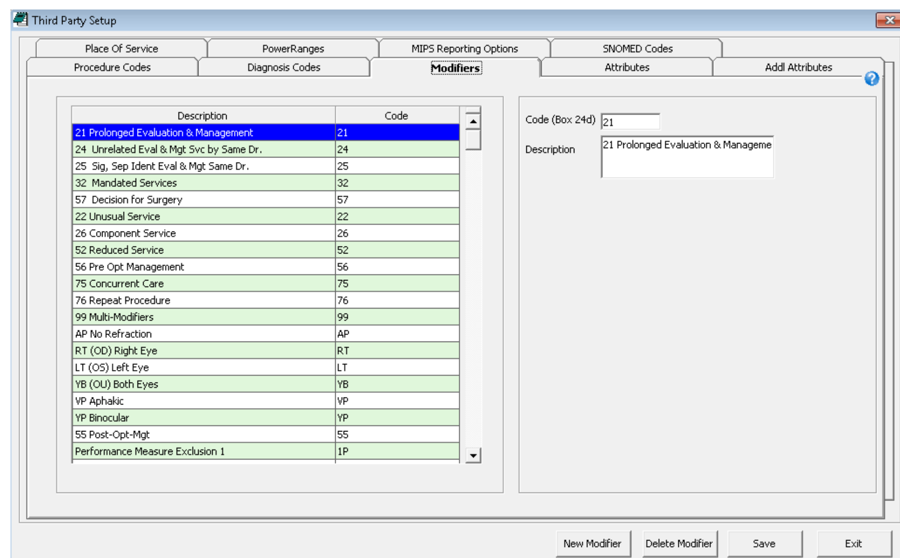
▶ To add & modify procedure modifiers

Modifiers provide extra descriptions about procedures and appear on insurance claims. Modifiers can be attached to services or selected on fee slips. For more information on setting up modifiers, watch the "Modifiers" video.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to "To open the Third Party Setup window" on page 13.
2. Click the **Modifiers** tab.
3. Click **New Modifier** to create a new code.

   OR

   Select a code from the list.
4. In the **Code (Box 24d)** field, type the procedure modifier code.
5. In the **Description** text box, type a short description for the modifier.
6. Click **Save** when you are finished.
7. Repeat steps 3–6 to add or modify additional procedures as needed.



8. Click **Exit** to close the Third Party Setup window.

▶ To add & modify attributes

For more information on setting up attributes, watch the "Attributes" video.

Attributes are the individual qualities and characteristics that define a product (e.g., color, material, lens type). Attributes are inherent to the product; add-ons are not attributes. For example, an ophthalmic lens may be described by the following attributes: a progressive lens type; plastic, high index material; transition gray in color; with a Crizal coating. Product attributes translate directly to billable codes on the CMS 1500 claim form and patient statement.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to "To open the Third Party Setup window" on page 13.
2. Click the **Attributes** tab.
3. Select an Attribute Category from the tree.Expand the category by clicking the **plus** (**+**) sign.

4. Click **New Attribute** to create a new attribute.

   OR

   Select an attribute from the list to modify it.

5. Select a procedure code from the **CPT** drop-down menu.

NOTES	
	• By default, the ophthalmic Lens Cat./Base attributes are not assigned CPT codes. Assign CPT codes to ophthalmic lenses on the Power Ranges tab. For information on assigning CPT codes to lens power ranges, go to “To set up lens power range codes” on page 21. • With services, several CPT codes can be associated to one attribute. Do not select a CPT for these types of services. For example, surgery should not have any CPT association. On each service product, associate the surgery attribute and select the appropriate CPT code at the product level.

6. In the **Cost** and **Fee** columns, type the additional cost and fee for the attribute.

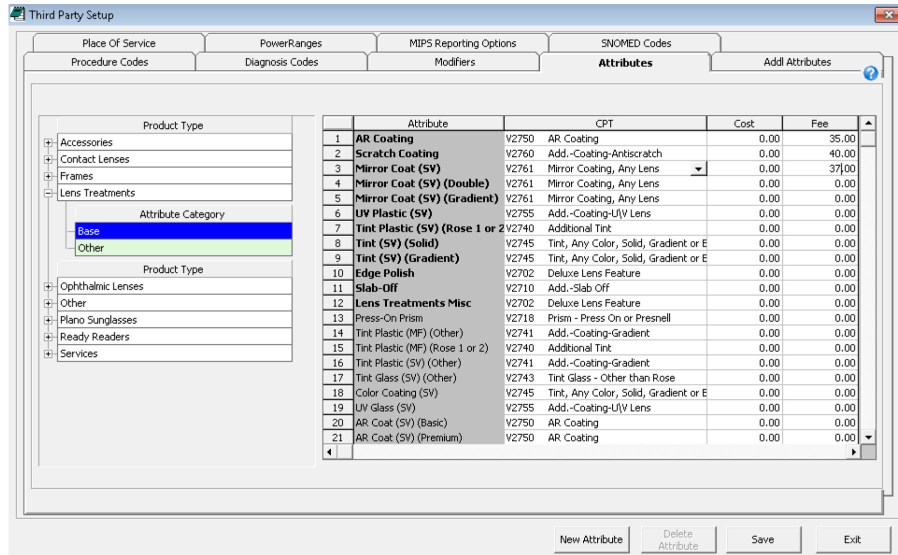
   OR

   For opthalmic material, color, or other attributes, type the additional fees associated with single-vision, bifocal, trifocal, and progressive lenses. If the fees are the same for each of these columns, enter the fee in the **All Fee** column only.

NOTES	
	• The cost and fee associated with the attribute are added to the base cost of the product set up in the Products & Services window. • If you are updating the cost and fee, the change will only apply to products that are created after the change is saved. For information on updating the attribute cost or fee for individual products, go to “To maintain product attributes” on page 274. For information on updating the attribute cost or fee for multiple products, go to “Updating Many Products & Services” on page 292. • If many of your costs and fees are the same, select a fee or cost, press **Ctrl+C** to copy, place your cursor in the next cell, and press **Ctrl+V** to paste. Once you copy a cost or fee, you can paste it many times. • The costs and fees significantly effect the general ledger and accounting.

7. Click **Save** when you are finished.

8. Repeat steps 4–7 to add or modify additional procedures as needed.



9. Click **Exit** to close the Third Party Setup window.

▶ To add & modify additional attributes

Often there are additional material or lab costs for high-power lenses, oversized lenses, and other prescription needs that need to be calculated into the patient's fee slip. By recording additional attribute information, you ensure that ExamWRITER automatically includes those fees on fee slips and insurance claims when they are applicable.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to "To open the Third Party Setup window" on page 13.
2. Click the **Addl Attributes** tab.
3. In the **Prism** group, enter the measurement range for each cost or fee point.
4. Type the **Prod Cost** and **Addl Fee** information for each measurement range.

NOTE	If you are updating the cost and fee, the change will only apply to products that are created after the change is saved. For information on updating the attribute cost or fee for individual products, go to "To maintain product attributes" on page 274. For information on updating the attribute cost or fee for multiple products, go to "Updating Many Products & Services" on page 292.

5. Repeat steps 3–4 for the **BF Add Power**, **TF Add Power**, and **Oversize** groups.
6. Click **Save** when you are finished.

   ExamWRITER confirms that you want to overwrite the pricing for these attributes on all ophthalmic lenses in the database.

7. Click **Yes** to confirm.

8. Click **Exit** to close the Third Party Setup window.

▶ To add & modify places of service

For more information on setting up places of service, watch the "Places of Service" video.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to "To open the Third Party Setup window" on page 13.
2. Click the **Place of Service** tab.
3. Click **New POS** to create a new place of service.

   OR

   Select a place from the list.
4. Enter the place of service location information in the appropriate fields:
   - Name 1 (Box 32)
   - Name 2
   - Address 1 (Box 32)
   - Address 2 (Box 32)
   - City (Box 32)
   - State (Box 32)
   - ZIP Code (Box 32)
5. Type the name of the primary contact person in the **Contact** field as needed.
6. Select the type of facility from the **Facility Type** drop-down menu.
7. Type the place's telephone number in the **Phone #** field as needed.
8. Type the place's fax number in the **Fax #** field as needed.
9. Type the place's NPI number in the **NPI # (Box 32a)** field.

10. Select a qualifier from the **Qualifier (Box 32b)** drop-down menu as needed.

NOTE	Ensure that you are selecting the appropriate qualifier description and ANSI code in the Qualifier (Box 32b) drop-down menu, as listed below: Blue Cross Provider Number - 1A Blue Shield Provider Number - 1B CHAMPUS Identification Number - 1H Clinical Lab. Improvement Amendment Number - X4 Federal Tax Payer's Identification Number - TJ Location Number - LU Medicaid Provider Number - ID Medicare Provider Number - 1C Provider Commercial Number - G2 Provider Plan Network Identification Number - N5 Provider UPIN Number - 1G State Industrial Accident Provider Number - X5 State License Number - 0B

11. Type the place's facility ID in the **Facility ID (Box 32b)** as needed.
12. Select the **Inactive** check box if the place is no longer active.
13. Click **Save** when you are finished.

14. Click **Exit** to close the Third Party Setup window.

▶ To set up lens power range codes

For more information on setting up lens power range codes, watch the “Power Ranges” video.

The Power Ranges tab allows you to assign CPT/HCPCS codes to specific power ranges for each ophthalmic lens type. The power ranges themselves (low sphere to high sphere and low cylinder to high cylinder) cannot be changed.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to “To open the Third Party Setup window” on page 13.
2. Click the **Power Ranges** tab.
3. Click **New** to set up a new power range.
4. Select a lens type from the **Lens Category** drop-down menu.

   The table on the left updates to reflect the power ranges that have been set up for the selected lens type.
5. Select a power range from the **Sphere** drop-down menu.
6. Select a procedure code from the **CPT/HCPCS Code** drop-down menu.
7. Type the additional cost and fee associated with the selected lens type and power range in the **Add to Base Cost** and **Add to Base Fee** fields.
8. Click **Save**.
9. Repeat steps 2–8 to add additional power ranges as needed.

NOTE	After you set the CPT/HCPCS code for a power range and lens type, you cannot modify it. You may, however, select the power range from the list, click **Delete** to remove that line, and then follow steps 2–8 to add a power range with the correct CPT/HCPCS code.

Third Party Setup

Procedure Codes | Diagnosis Codes | Modifiers | Attributes | Addl Attributes
Place Of Service | PowerRanges | MIPS Reporting Options | SNOMED Codes

Low Sph	High Sph	Low Cyl	High Cyl	CPT/HCPCS Code	Add Cost	Add Fee
0.00	4.00	0.00	0.00	V2200	0.00	0.00
4.12	7.00	0.00	0.00	V2201	0.00	0.00
7.12	99.00	0.00	0.00	V2202	0.00	0.00
0.00	4.00	0.12	2.00	V2203	0.00	0.00
0.00	4.00	2.12	4.00	V2204	0.00	0.00
0.00	4.00	4.12	6.00	V2205	0.00	0.00
0.00	4.00	6.12	99.00	V2206	0.00	0.00
4.12	7.00	0.12	2.00	V2207	0.00	0.00
4.12	7.00	2.12	4.00	V2208	0.00	0.00
4.12	7.00	4.12	6.00	V2209	0.00	0.00
4.12	7.00	6.12	99.00	V2210	0.00	0.00
7.12	12.00	0.12	2.00	V2211	0.00	0.00
7.12	12.00	2.12	4.00	V2212	0.00	0.00
7.12	12.00	4.12	6.00	V2213	0.00	0.00
12.12	99.00	0.00	99.00	V2214	0.00	0.00

Lens Category: Blended Bifocals

Low Sphere 0.00 | High Sphere 4.00 | Low Cyl 0.00 | High Cyl 0.00

CPT/HCPCS Code: V2200

Add to Base Cost: $5.00 | Add to Base Fee: $7.00

Export To Lenses

New | Delete | Save | Exit

10. To export the power range costs and fees to the products in ExamWRITER, perform the following steps:
    a. Select a lens type from the **Lens Category** drop-down menu.
    b. Click **Export to Lenses**.

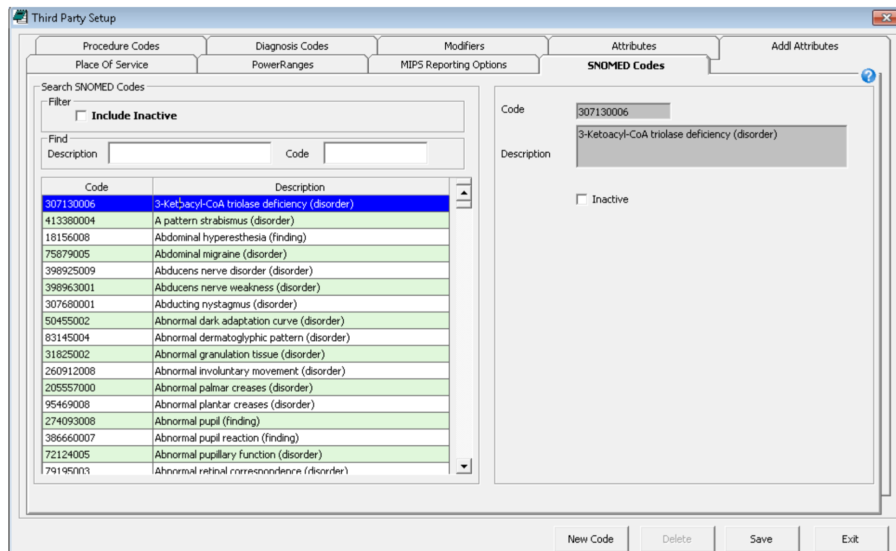
NOTE	The costs and fees exported will replace any existing power range costs and fees.

    c. Repeat steps a–b for each lens type as needed.
11. Click **Exit** to close the Third Party Setup window.

▶ To set up SNOMED codes

SNOMED codes are required for CPOE, health information exchange, lab results, and other meaningful use applications. Eyefinity has populated a list of SNOMED codes for you. You can add new SNOMED codes and delete SNOMED code that you have added, but you cannot edit the default SMNOMED codes.

1. Open the Third Party Setup window. For information on opening the Third Party Setup window, go to “To open the Third Party Setup window” on page 13.
2. Click the **SNOMED Codes** tab.
3. Click **New Code**.
4. Type the SNOMED number in the **Code** text box.
5. Type a name for the diagnosis in the **Description** text box.
6. Click **Save**.



7. Click **Exit** to close the Third Party Setup window.

Maintaining Providers, Staff, & Other Resources

This section tells you how to maintain resources, including how

- To modify or add provider information, 23
- To modify or add staff information, 26
- To modify or add referring doctors, 27
- To modify or add appointment schedule resources, 29
- To modify or add doctors to which your practice refers patients, 30

For more information on maintaining resources, watch the "Resource Setup" video.

▶ To modify or add provider information

NOTE	Many insurance companies and clearinghouses are no longer accepting claims with legacy numbers and prefer to rely on the NPI number. Check with your clearinghouse or insurance carriers to determine if you should include legacy numbers on your CMS 1500 or UB-04 claims.

1. On the OfficeMate Administration main window, click **Setup** and select **Resource Setup**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Resource Setup**.

   The Resources Setup window opens.
2. Click the **Provider** tab.
3. Click **New** to add a new provider.

   OR

   Select a provider from the table at the top of the window to modify a provider.

NOTE	You should only delete provider names if they are *not* linked to any records.

4. Type the provider's last name in the **Last Name (Box 33)** text box.
5. Type the provider's first name in the **First Name (Box 33)** text box.
6. Type the provider's middle name in the **Middle Name (Box 33)** text box.
7. Type the provider's phone and fax number in the **Phone # (Box 33)** and **Fax #** text boxes.
8. Type the login name in the **User ID** text box.
9. Select the default location for the provider or staff member from the **Default Location** drop-down menu.
10. Select a provider type from the **Provider Type** drop-down menu.
11. Type the provider's license number in the **License #** text box.

12. Type your individual provider NPI number in the **NPI Number (Box 24j)** text box.

NOTES	• You *must* record an NPI number for each provider. • If you are using the VSP Interface, the NPI number is required.

13. Type the HL7 identifier for the provider in the **HL7 Provider ID** text box, as needed.
14. Type your Department of Public Safety number, if required by your state, in the **DPS #** text box.

NOTE	The DPS number is printed on ExamWRITER medical prescriptions if you record it in the DPS # text box and it is required by your state.

15. Select the provider's speciality from the Speciality drop-down menu. The provider's speciality is included on continuity of care record (CCR) documents that you create in ExamWRITER.
16. If you want to enter HIPAA information, follow the instructions below:
    a. Type the EIN number in the **EIN Number** text box.

NOTES	• If the provider you selected in step 3 submits ANSI insurance claims, you must type a number in the **EIN Number** text box. • If you are using the VSP Interface, the EIN number is required.

    b. Select a date from the **Privacy Training Date** menu.
    c. Select the HIPAA Privacy Officer **Yes** radio button if the provider or staff member is a HIPAA Privacy Officer.
17. If you want to set up a commission for a provider or staff member, follow the instructions below:
    a. Select the Commissionable **Yes** radio button.
    a. Select **Gross%** or **Margin%** as a commission Method.
    b. Type the commission rate in the **Rate** text box.
    c. Type the special incentive amount in the **Spiff** text box, if applicable.

NOTES	• The gross percentage commission is based on the product gross minus write offs. • The margin percentage commission is based on product gross minus product cost and write offs.

18. If the doctor plans to process insurance claims, click the **Insurance Info** button and follow the instructions below:

    a. Select insurance companies to which the doctor plans to bill insurance claims from the **Insurance Company** drop-down menus.

    b. Type the insurance company PIN numbers in the **Pin #** column, as needed.

    c. Type the insurance company group numbers in the **Group #** column.

    d. Type the insurance company submitter IDs in the **Submitter ID** column, as needed.

    NOTES
    - If you are processing insurance claims through McKesson, type the billing ID and submitter ID that was assigned to you by McKesson in the **Submitter ID** column (as one number).
    - If you are processing VSP claims, you do not need to enter any information on the Insurance Information window for VSP.

    e. Click **OK**.

Duck Daisy Insurance Information

Insurance Company	Pin # (Box 24j/33b)	Group # (Box 33b)	Submitter ID (24j)
JFN Ansi Comm Max Allot	12334	1234	1234
JFN GW Medicare DB	4321	4321	4321
JFN Print Group Percent	5678	5678	5678
VSP			

OK | Cancel | Delete Line

19. If you want to save a default signature for the provider or staff member that will print on medical prescriptions, click **Browse**, navigate to the signature, and click **Open**.

    NOTES
    - Eyefinity recommends saving all signatures in the eDocuments folder.
    - All signatures must be saved using the JPEG graphic format.

20. Click **Save** to save the provider information and exit the Resources Setup window.

    NOTES
    - Before the provider can log into ExamWRITER, you must select the provider's security role(s) and initial password. For more information, go to "Assigning Roles and Passwords to Users" on page 63.
    - Before the provider can exchange secure message with patients or other providers, you must establish the provider's secure messaging account. For more information, go to "To edit provider portal settings" on page 336

▶ To modify or add staff information

1. On the OfficeMate Administration main window, click **Setup** and select **Resource Setup**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Resource Setup**.

   The Resources Setup window opens.

2. Click the **Staff** tab.
3. Click **New** to add a new staff member.

   OR

   Select a staff member from the table at the top of the window to modify a staff member.

NOTE	You should only delete staff member names if they are *not* linked to any records.

4. Type text in the text boxes.
5. Type the login name in the **User ID** text box.
6. Select the default location for the staff member from the **Default Location** drop-down menu.

7. If you want to enter HIPAA information, follow the instructions below:
   a. Type the EIN number in the **EIN Number** text box.
   b. Select a date from the **Privacy Training Date** menu.
   c. Select the HIPAA Privacy Officer **Yes** radio button if the provider or staff member is a HIPAA Privacy Officer.

8. If you want to set up a commission for a provider or staff member, follow the instructions below:
    a. Select the Commissionable **Yes** radio button.
    a. Select **Gross%** or **Margin%** as a commission Method.
    b. Type the commission rate in the **Rate** text box.
    c. Type the special incentive amount in the **Spiff** text box, if applicable.
9. Click **Save** to save the provider information and exit the Resources Setup window.

NOTE	Before the staff member can log into ExamWRITER, you must select the staff members security role(s) and initial password. For more information, go to "Assigning Roles and Passwords to Users" on page 63.

▶ To modify or add referring doctors

1. On the OfficeMate Administration main window, click **Setup** and select **Resource Setup**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Resource Setup**.

   The Resources Setup window opens.
2. Click the **Referring Dr.** tab.
3. Click **New** to add a new referring doctor.

   OR

   Select a referring doctor from the table at the top of the window to modify a referring doctor.
4. Type text into the text boxes.
5. Type the referring provider's NPI number in the **NPI Number (Box 17b)** text box.

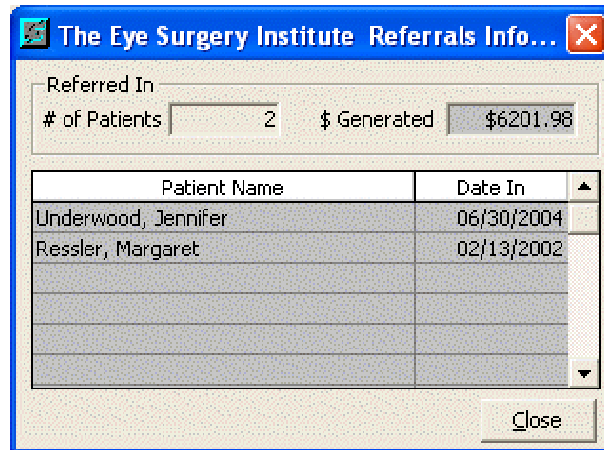
NOTE	You *must* record an NPI number for each referring doctor.

6. Select a qualifier from the **Qualifier (Box 17a)** drop-down menu.

> **NOTE** Ensure that you are selecting the appropriate qualifier description and ANSI code in the Qualifier (17a) drop-down menu, as listed below:
>
> Blue Shield Provider Number - 1B
> CHAMPUS Identification Number - 1H
> Employer's Identification Number - EI
> Location Number - LU
> Medicaid Provider Number - ID
> Medicare Provider Number - 1C
> Provider Commercial Number - G2
> Provider Plan Network Identification Number - N5
> Provider UPIN Number - 1G
> Social Security Number - SY
> State Industrial Accident Provider Number - X5
> State License Number - 0B

7. Type the other ID in the **Other ID (Box 17a)** text box.

8. Click **Referral History**, if active, to view the referral history information for a selected doctor.



9. Click **Save** to save the referring doctor information and exit the Resources Setup window.

▶ To modify or add appointment schedule resources

1. On the OfficeMate Administration main window, click **Setup** and select **Resource Setup**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Resource Setup**.

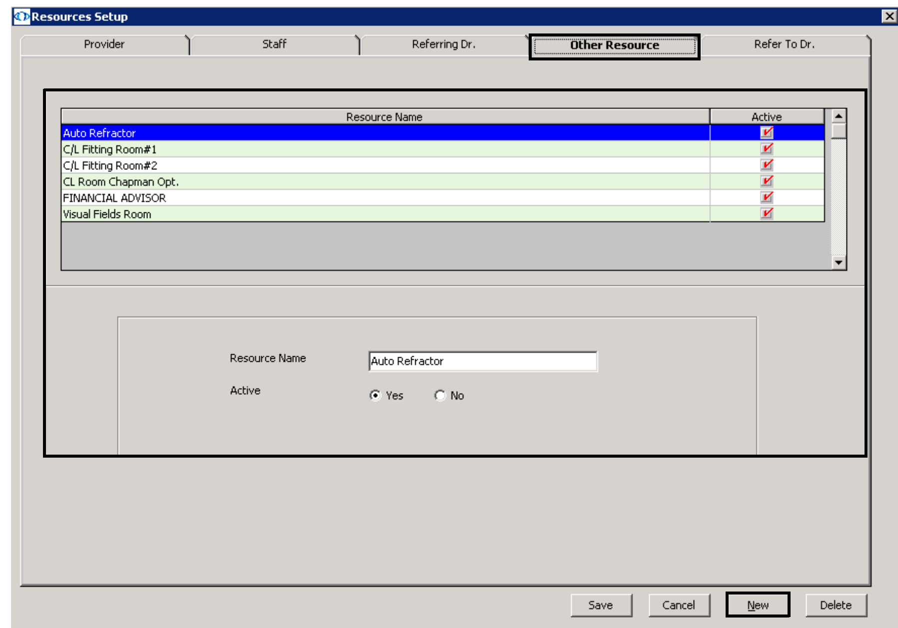
   The Resources Setup window opens.
2. Click the **Other Resources** tab.
3. Click **New** to add a new resource and type the resource name in the **Resource Name** text box.

   OR

   Select a resource from the table at the top of the window to modify a resource.

NOTE	You should only delete resources if they are *not* linked to any appointments.

4. Select the **Active** Yes or No radio button, depending on whether or not the resource is active or inactive.



5. Click **Save** to save the other resource information and exit the Resources Setup window.

▶ To modify or add doctors to which your practice refers patients

1. On the OfficeMate Administration main window, click **Setup** and select **Resource Setup**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Resource Setup**.

   The Resources Setup window opens.

2. Click the **Refer To Dr.** tab.
3. Click **New** to add a new doctor.

   OR

   Select a doctor from the table at the top of the window to modify a doctor.

4. Type text in the text boxes.

5. Select the **Active** Yes or No radio button, depending on whether or not the doctor is active or inactive.

6. Click **Save** to save the doctor information and exit the Resources Setup window.

Customizing ExamWRITER

Although you can customize ExamWRITER at any time, we suggest that you complete the customization instructions before you start using ExamWRITER to record and store EHRs. This section tells you how to customize ExamWRITER, including how

- To add list box selections, 32
- To modify list box selections, 33
- To add ZIP code shortcuts, 34
- To modify ZIP code shortcuts, 35
- To create new recall schedules, 36
- To modify recall schedules, 37
- To delete recall schedules, 38
- To create new service agreement renewal plans, 39
- To modify service agreement renewal plans, 40
- To delete service agreement renewal plans, 41
- To identify contact lens duplication fees, 42
- To maintain marketing groups, categories, & costs, 43

For more information on adding and modifying list box selections, watch the "List Box Selections" video.

▶ To add list box selections

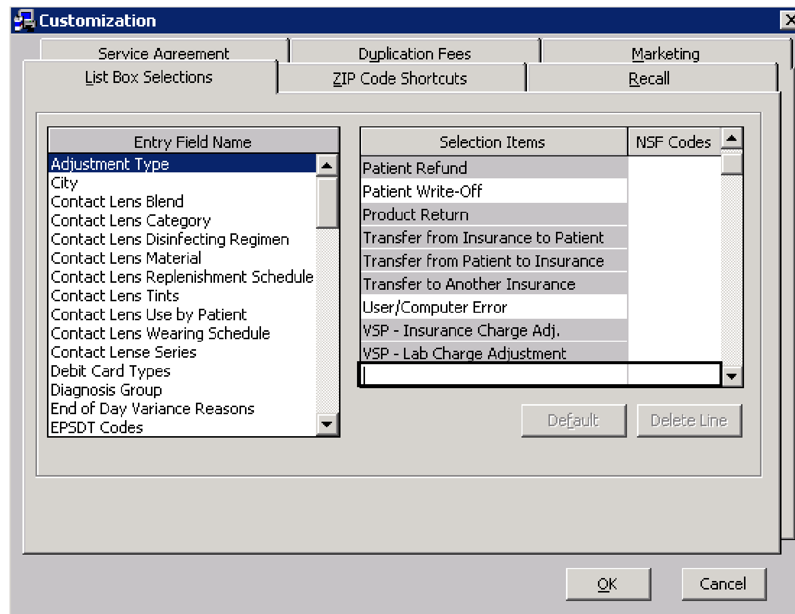
NOTE	You can add new selections to a list box while you are working in Administration by pressing the **F12** key any time your cursor is in a list box.

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Select an item in the **Entry Field Name** box.
3. Place your cursor in the first blank line at the bottom of the **Selection Items** box.



4. Type the new selection item or NSF code.

NOTE	• To make an item the default item in the list, select the item in the Selection Items box and click **Default**. • To deselect a default item in the list, select the default item in the Selection Items box and click **UnDefault**.

5. Click **OK** to save the new list box selection and exit the Customization window.

▶ To modify list box selections

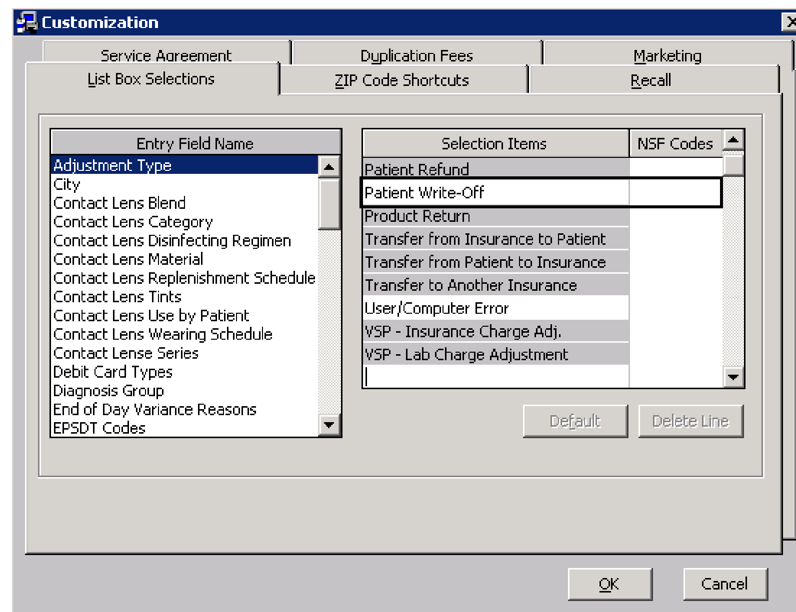
NOTE	You can modify list box selections while you are working in Administration by pressing the **F12** key any time your cursor is in a list box.

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Select an item in the **Entry Field Name** box.
3. Click the item that you want to modify in the **Selection Items** box.



4. Type your changes.

NOTE	• To make an item the default item in the list, select the item in the Selection Items box and click **Default**. • To deselect a default item in the list, select the default item in the Selection Items box and click **UnDefault**. • You should only delete list box selections if they are *not* linked to any records.

5. Click **OK** to save the modified list box selection and exit the Customization window.

For more information on adding and modifying zip code shortcuts, watch the "ZIP Code Shortcuts" video.

▶ To add ZIP code shortcuts

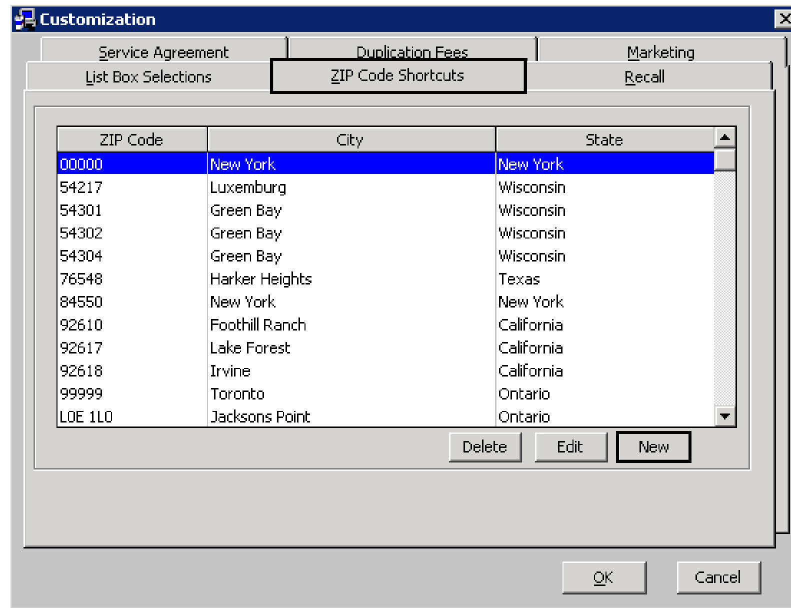
1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

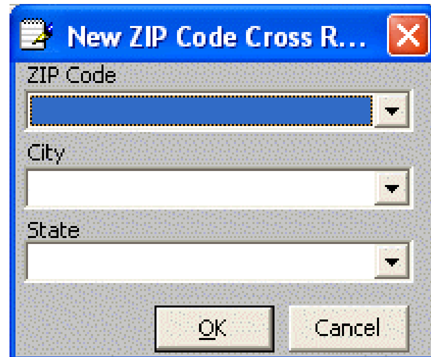
   The Customization window opens.

2. Click the **ZIP Code Shortcuts** tab.
3. Click **New**.



The New ZIP Code Cross Reference window opens.

4. Select a ZIP code, city, and state from the **ZIP Code**, **City**, and **State** drop-down menus.



NOTES	• If the ZIP code, city, or state that you want to add is not available in the drop-down menus, press the **F12** key to add it to the drop-down menus and click **OK**. • To add a ZIP code, city, or state as a default option, press the **F12** key; type or select the ZIP code, city, or state; click **Default**; and click **OK**.

5. Click **OK** to close the New ZIP Code Cross Reference window.
6. Click **OK** to close the Customization window.

▶ To modify ZIP code shortcuts

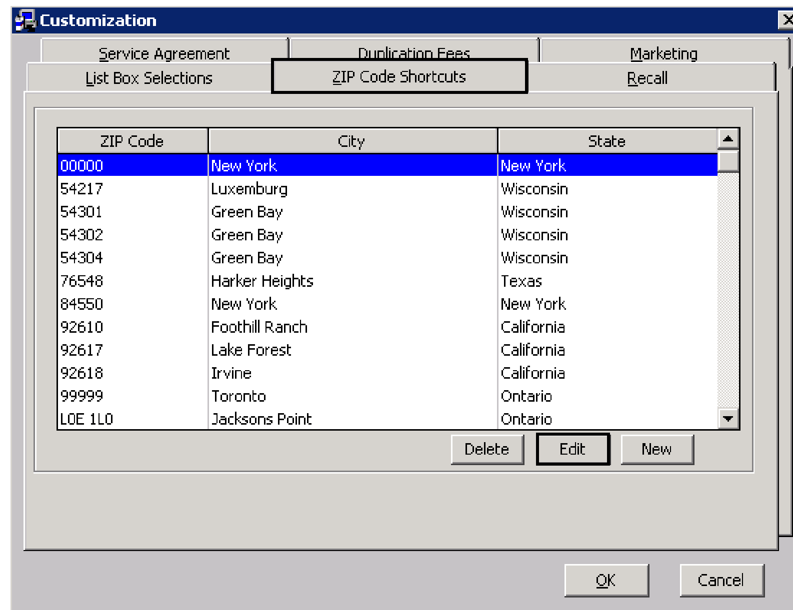
1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **ZIP Code Shortcuts** tab.

3. Click **Edit**.



The New ZIP Code Cross Reference window opens.

4. Select a ZIP code, city, or state from the **ZIP Code**, **City**, and **State** drop-down menus.
5. Press the **F12** key.

   The Maintain window opens.
6. Modify the ZIP code, city, or state and click **OK**.

NOTES	• To add a ZIP code, city, or state as a default option click **Default**. • To deselect a default ZIP code, city, or state, click **UnDefault**.

7. Click **OK** to close the New ZIP Code Cross Reference window.
8. Click **OK** to close the Customization window.

For more information on creating and modifying recall schedules, watch the "Recall Setup" video.

▶ To create new recall schedules

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Recall** tab.
3. Click **New Recall**.
4. Type the name of the new recall schedule in the **Recall Type** text box.
5. Type the number of months until the patient will be recalled in the **Months to Next Recall** text box.

6. Type the number of weeks or months between the patient's recall date and the notice that you are creating in the Renewal Notice Mailing Schedule **#** column.
7. Select **Month(s)** or **Week(s)** from the **Period** column drop-down menu.
8. Select **After** or **Before** from the **When** column drop-down menu.
9. Select the type of recall letter or postcard to print from the **Print Letters/Postcard** column drop-down menu.

NOTE	If there is no appropriate letter or postcard to select from the Print Letters/Postcard column drop-down menu, click **Compose Letter** to open CARE or the Maintain Documents window and compose a letter.

10. Repeat steps 3–9 to create additional new recall schedules.

    OR

    Click **OK** to close the Customization window.

NOTE	To insert a new blank line above a completed line, select the completed line that you want to insert a new blank line above and click **Insert Line**.

▶ To modify recall schedules

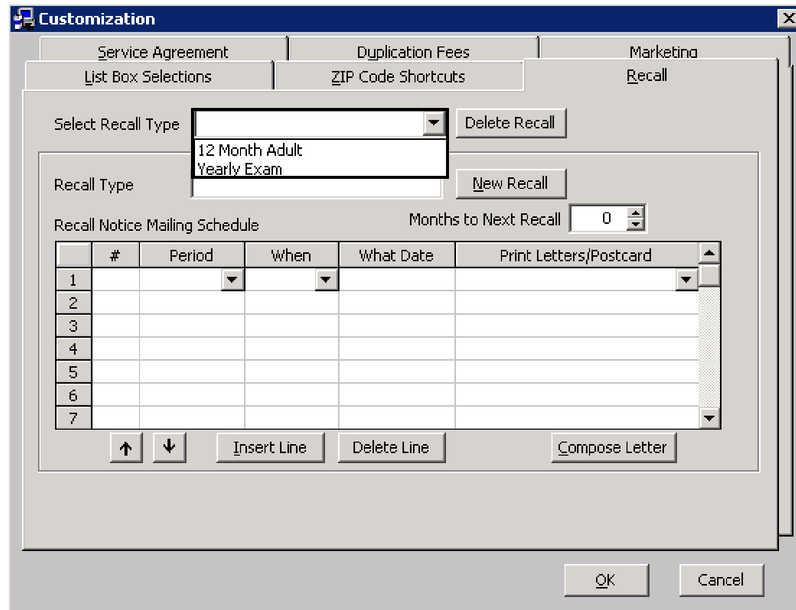
1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Recall** tab.

3. Select a recall type from the **Select Recall Type** drop-down menu.



4. Modify the **Recall Type** and **Months to Next Recall**.
5. See "To create new recall schedules" on page 36, steps 5–9, to modify the information in the **Recall Notice Mailing Schedule** table.
6. To delete a mailing schedule, select a line and click **Delete Line**.
7. To insert a new blank line above a completed line, select the completed line that you want to insert a new blank line above and click **Insert Line**.
8. Repeat steps 3–7 to modify additional recall schedules.

   OR

   Click **OK** to close the Customization window.

▶ To delete recall schedules

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

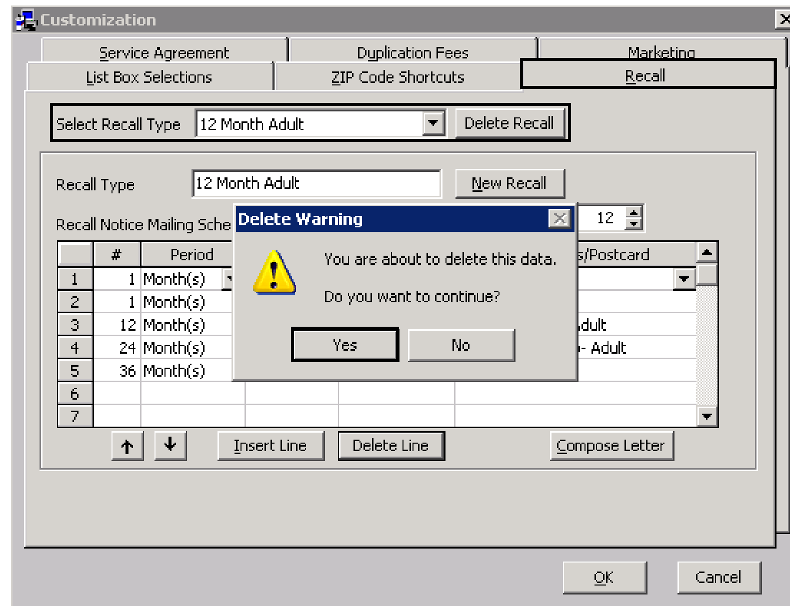
   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Recall** tab.
3. Select a recall type from the **Select Recall Type** drop-down menu.
4. Click **Delete Recall**.

   The Delete Warning window opens.

5. Click **Yes** to continue.



6. Click **OK** to close the Customization window.

For more information on creating and modifying service agreement renewal plans, watch the "Service Agreements & Duplication Fees" video.

To create new service agreement renewal plans

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

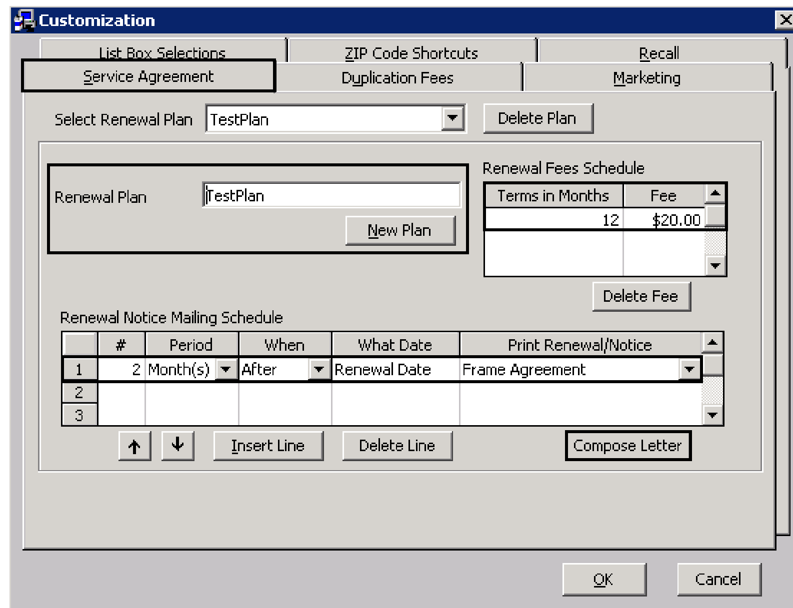
   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Service Agreement** tab.
3. Click **New Plan**.
4. Type the name of the new service agreement in the **Renewal Plan** text box.
5. Place your cursor in the Renewal Fees Schedule **Terms in Months** box and select the number of months for each renewal year you offer.
6. Place your cursor in the Renewal Fees Schedule **Fee** box and type the fee that corresponds to the renewal plan.
7. Type the number of weeks or months between the patient's renewal date and the notice that you are creating in the Renewal Notice Mailing Schedule **#** column.
8. Select **Month(s)** or **Week(s)** from the **Period** column drop-down menu.
9. Select **After** or **Before** from the **When** column drop-down menu.

10. Select the type of renewal letter or postcard to print from the **Print Renewal/Notice** column drop-down menu.

NOTE	If there is no appropriate letter or postcard to select from the Print Renewal/Notice column drop-down menu, click **Compose Letter** to open CARE or the Maintain Documents window and compose a letter.



11. Repeat steps 3–10 to create additional new renewal schedules.

    OR

    Click **OK** to close the Customization window.

NOTE	To insert a new blank line above a completed line, select the completed line that you want to insert a new blank line above and click **Insert Line**.

▶ To modify service agreement renewal plans

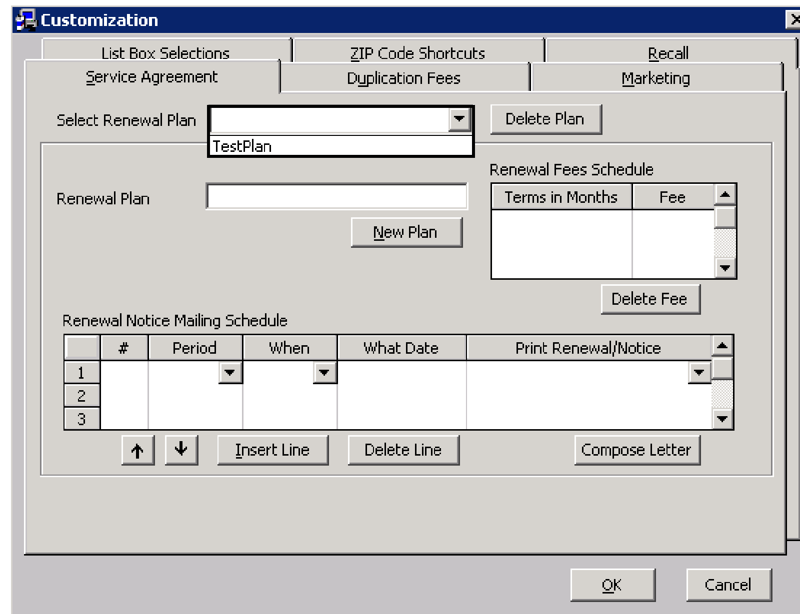
1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Service Agreement** tab.

3. Select a renewal type from the **Select Renewal Plan** drop-down menu.



4. Modify the **Renewal Plan**.
5. See "To create new service agreement renewal plans" on page 39, steps 5–10, to modify the information in the **Renewal Notice Mailing Schedule** table.
6. To delete a Renewal Fees Schedule Fee, select the fee that you want to delete and click **Delete Fee**.
7. To delete a mailing schedule, select a line and click **Delete Line**.
8. To insert a new blank line above a completed line, select the completed line that you want to insert a new blank line above and click **Insert Line**.
9. Repeat steps 3–8 to modify additional recall schedules.

   OR

   Click **OK** to close the Customization window.

▶ To delete service agreement renewal plans

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

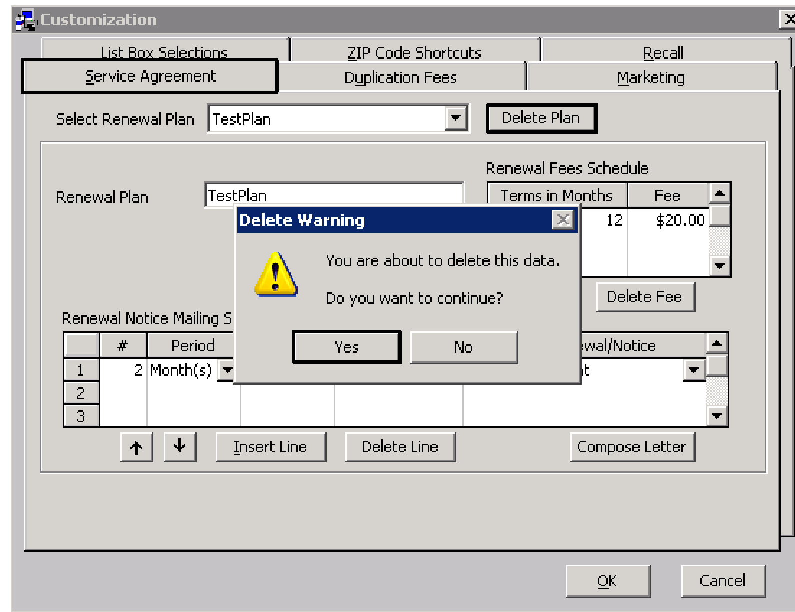
   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Service Agreement** tab.
3. Select a renewal type from the **Select Renewal Plan** drop-down menu.
4. Click **Delete Plan**.

   The Delete Warning window opens.

5. Click **Yes** to continue.



6. Click **OK** to close the Customization window.

For more information on identifying duplication fees, watch the "Service Agreements & Duplication Fees" video.

▶ To identify contact lens duplication fees

Identify duplication fees when a service agreement is used for contact lenses.

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

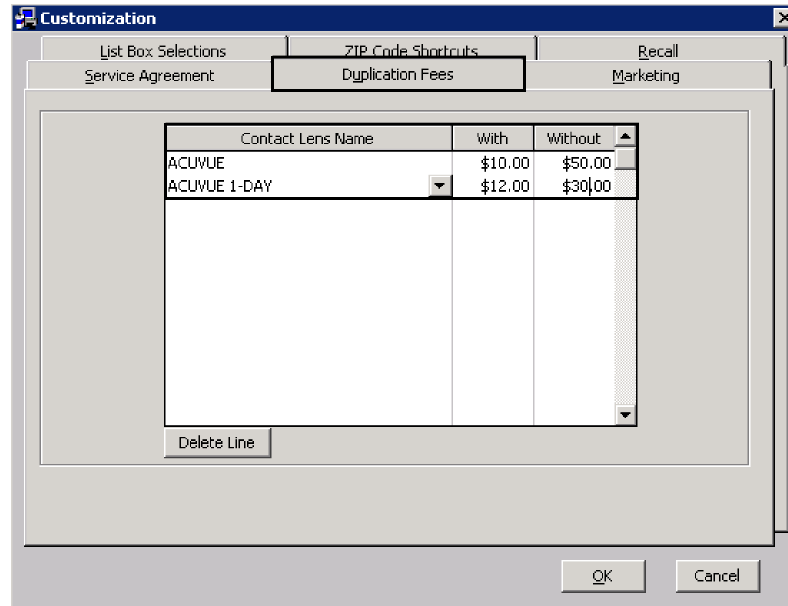
   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Duplication Fees** tab.
3. Select the contact lens from the **Contact Lens Name** column drop-down list.

NOTE	If there is no appropriate contact lens to select from the Contact Lens Name column drop-down menu, place your cursor in a blank row in the Contact Lens Name column and type a contact lens name. The contact lens name and fees are added to your list of products.

4. Type the patient's duplication fee with a service agreement in the **With** column.

5. Type the patient's duplication fee without a service agreement in the **Without** column.



6. Click **OK** to close the Customization window.

For more information on using the Marketing tab, watch the "Marketing" video.

▶ To maintain marketing groups, categories, & costs

1. On the OfficeMate Administration main window, click **Setup** and select **Customization**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Customization**.

   The Customization window opens.
2. Click the **Marketing** tab.
3. Select a marketing group and click **Delete** to delete the group or click **Edit** to edit the group's name.

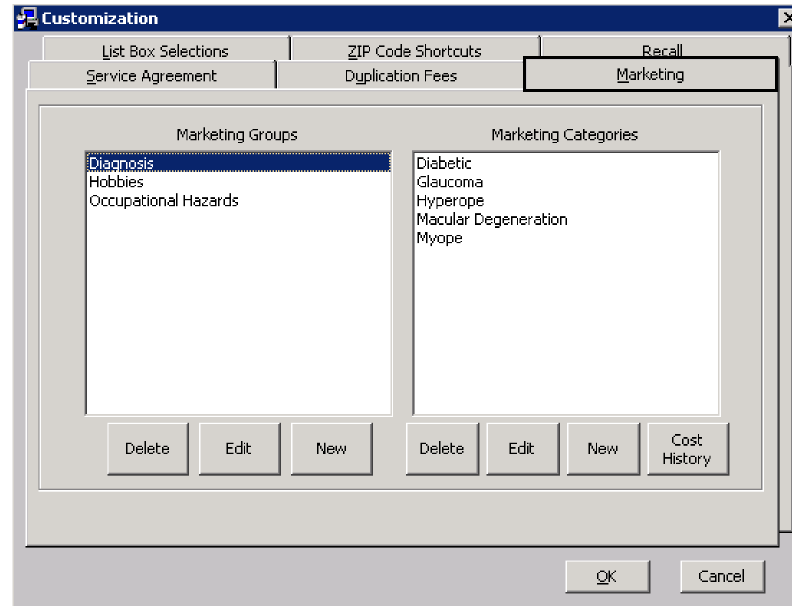
   OR

   Click **New** to add a new marketing group.

4. Select a marketing category and click **Delete** to delete the category or click **Edit** to edit the category's name.

   OR

   Click **New** to add a new marketing category to the marketing group.



5. To capture the marketing effectiveness of money spent on media sources, perform the following steps:

   a. Click **Cost History**.

   b. Type the monthly dollar amounts spent on media sources in the month columns.

Cost History

Year 2008

Glaucoma
Macular Degeneration

Totals

Marketing Group: SOURCE-TV

Marketing Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
ABC	1,200	0	1,200		5,000								7,400
CBS	1,200		1,000		10,000								12,200
NBC	500		0		0								500
FOX	300		0		0								300
Totals	3,200	0	2,200		15,000								20,400

OK Cancel

   c. Click **OK** to save the cost history.

6. Click **OK** to save the new marketing groups and categories and exit the Customization window.

Maintaining Locations

For more information on maintaining locations, watch the "Location Maintenance & Business Names" video.

This section tells you how to set up such locations as an administrative location, stores, distribution centers, and labs, that are internal to your practice, including how

- To open the Location Maintenance window, 45
- To maintain location information, 45
- To add a company lab to the vendor list, 52

▶ To open the Location Maintenance window

1. From the OfficeMate Administration main window, click **Setup** and select **Location Maintenance**.

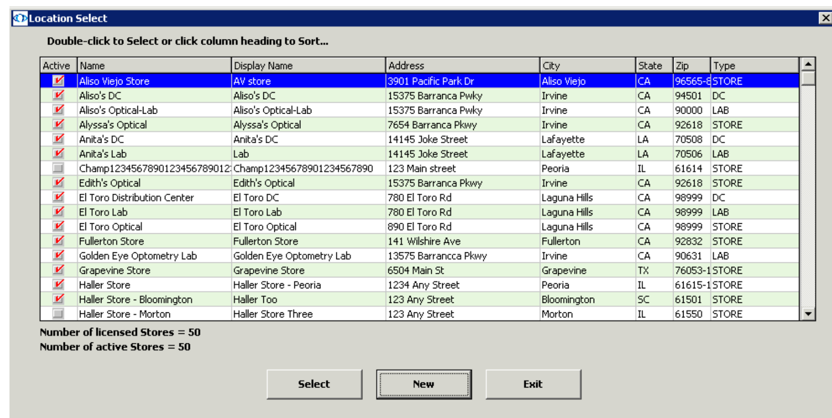
   OR

   From the ExamWRITER Administration main window, click **Activities** and select **Location Maintenance**.

   The Location Select window opens.

NOTE	Click on the column headings to sort the columns in ascending or descending order.

2. Complete one of the following tasks:
   - Click **New** to create a new location (if the number of active locations does not equal the number of licensed locations).
   - Double-click a location to modify it.
   - Highlight a location and click **Select** to modify it.



The Location Maintenance window opens. If you are a single-location practice, your office address is displayed as the administrative location.

▶ To maintain location information

1. Create a new location or select an existing location to edit in the Location Maintenance window. For information on creating a new location or opening

an existing location, go to "To open the Location Maintenance window" on page 45.

2. Enter the appropriate address and contact information for this location in the text boxes.

NOTES

- If you are using the VSP interface to send claims to VSP electronically, you must enter the same phone number that Eyefinity has on file for this location. If the phone number does not match Eyefinity's records, your claims will be rejected.
- If you are sending claims in the ANSI 5010 format, you must enter physical address and ZIP+4 information. Post office boxes and five-digit ZIP codes will result in claim errors.

3. If you are creating a new location, select a location type from the **Location Type** drop-down menu; otherwise, go to step 4.

NOTES	
	• Ensure that you have selected the correct location type for the new location. After saving the new location, you cannot modify the location type. The location types and definitions are listed below: – *Administration.* This location type can perform all set up functions record adjustments to the ledger, receive payments, schedule appointments, process third party insurance claims, create purchase orders, perform inventory functions, modify patient records, and create reports. This location type *cannot* perform end of day processes, create lab and Rx orders, create and edit fee slips, and record sales, although it can view lab and Rx orders. – *Location.* This location type can perform end of day processes, record adjustments to the ledger, receive payments, create lab and Rx orders, create fee slips, record sales, schedule appointments, process third party insurance claims, create purchase orders, perform inventory functions, modify patient records, and create reports. This location type *cannot* perform any set up functions. – *Distribution Center.* This location type can view lab and Rx orders, perform inventory functions, create purchase orders, and create reports. This location type *cannot* create lab or Rx orders, create fee slips, record sales, perform end of day processes, modify patient records, and perform any set up functions. – *Lab.* This location type can view lab and Rx orders, perform inventory functions, create purchase orders, modify patient records, and create reports. This location type *cannot* create lab or Rx orders, create fee slips, record sales, perform end of day processes, and perform any set up functions. • If a company lab and distribution center share a single location, create a single location in OfficeMate and select Lab from the Location Type drop-down menu. Setting up the lab and distribution center as a single location will enable you to more easily track products in transit and save steps in the ordering process.

4. Select the **Active** check box if the location is active, or leave the **Active** check box deselected if the location is not active.
5. Type a name in the **Display Name** text box. The name in the Display Name field displays on screen only and does not appear on patient statements or insurance claims.

6. If this is an administrative location and if you use Essilor Visioffice, type the password in the **Visioffice** text box to activate the ability to record Visioffice measurements on OfficeMate lab orders.
7. Select the location's region from the **Region** drop-down menu.

NOTE	Press the **F12** key when your cursor is in the Region drop-down box to open a **Maintain** window and add new regions to the drop-down menu selection.

8. Select a city from the **Default City** drop-down menu that will default on the Patient Demographic window when new patients are added at this location.
9. Select a state from the **Default State** drop-down menu that will default on the Patient Demographic window when new patients are added at this location.
10. If the location will be printing barcode labels, set the **Bar Code Output Path** by clicking the **...** (ellipsis) button and selecting a folder on the network.
11. Select a network printer that the location will use to print medical prescriptions from the **Medical Rx** drop-down menu.
12. Select a network printer that the location will use to print ophthalmic lens prescriptions from the **Oph Rx** drop-down menu.
13. Type the location's website address in the **Website** text box.
14. Type the location's tax identification in the **Tax ID** text box.

NOTE	The Tax ID is required for sales tax to be calculated and if you are using the VSP Interface.

15. Select appropriate tax locations from the **State Tax**, **County Tax,** and **Local Tax** drop-down menus.

16. Enter the **Claims Information** for this location:
    a. Select a qualifier from the **Qualifier (32b)** drop-down menu.

NOTE	Ensure that you are selecting the appropriate qualifier description and ANSI code in the Qualifier (32b) drop-down menu, as listed below: • Blue Cross Provider Number - 1A • Blue Shield Provider Number - 1B • CHAMPUS Identification Number - 1H • Clinical Lab. Improvement Amendment Number - X4 • Federal Tax Payer's Identification Number - TJ • Location Number - LU • Medicaid Provider Number - 1D • Medicare Provider Number - 1C • Provider Commercial Number - G2 • Provider Plan Network Identification Number - N5 • Provider UPIN Number - 1G • State Industrial Accident Provider Number - X5 • State License Number - 0B

    b. Type your facility ID in the **Facility ID (32b)** field.
    c. Type the facility's billing name in the **Billing Name (33)** field.
    d. Type your service facility NPI number (either your group NPI number or your provider NPI number) in the **NPI Num (33a)** field.

NOTES	• You *must* record an NPI number for each location. • If you are using the VSP Interface, the NPI number is required.

    e. Type the four-character code that represents they type of bill in the **Type of Bill UB04 FL4** field.

17. If you are integrating ExamWRITER with another practice management system, and your practice has purchased the HL7 Interface, enter the

information required by your practice management system in the **HL7 Integration** fields; otherwise, skip to step 22:

a. Type the name or number that identifies the location in the practice management system in the **Location ID** field.

NOTE	The Location ID must be the same as the location identifier used in the HL7 settings of the practice management system.

b. Select the **Production** radio button to run the interface in production mode or click the **Test** radio button to run the interface in test mode.

c. Type the control group identifier in the **Control Group** field, as needed.

d. Type the sending application identifier in the **Sending App** field, as needed.

e. Type the sending facility identifier in the **Sending Fac** field, as needed.

f. Type the receiving application identifier in the **Rec. App** field, as needed.

g. Type the receiving facility identifier in the **Rec. Fac.** field, as needed.

NOTES	• The Control Group, Sending App, Sending Fac, Rec App, Fac App., information comes from your practice management system's HL7 interface settings. Not all of these fields are required by all practice management systems. • The Charge Interface On check box is not functional at this time.

18. If you submit claims to VSP electronically, enter your Eyefinity login information in the **VSP Integration** fields; otherwise, skip to step 17:

    a. Type the username (Rid) that Eyefinity Customer Care gave to you in the **User ID** text box. The username is the same as your Eyefinity login ID.

    b. Type the password (Rpw) that Eyefinity Customer Care gave to you in the **Password** text box. The password is the same as your Eyefinity login password.

    c. Type the office ID (Oid) that Eyefinity Customer Care gave to you in the **Office Id** text box.

NOTE	Enter the office ID exactly as Eyefinity has printed it. Enter all leading zeros and include any spaces.

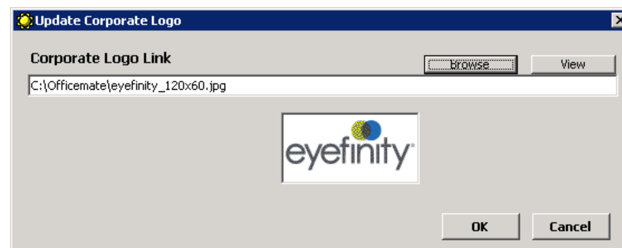
    d. Type "PROD" in the **Test/Prod** text box.

19. If you are using the OfficeMate Lab Interface, select the location's default lab from the **Default Lab** drop-down menu.

20. If you use the General Ledger Interface, type the location ID in the **G/L Location ID** text box.

NOTES	
	• The G/L Location ID may be any number of letters or numbers, but you must be consistent from location to location. The G/L Location ID must fit within the parameters for the location segment length that are established in the General Ledger Setup window. • The G/L Location ID field is not visible if the General Ledger Interface has not been enabled.

21. Click **Update Logo** to browse for and select a corporate logo. This logo appears on the Diabetic Letter and Glaucoma Letter. For more information about printing these letters, go to “Printing Diabetic Letters” on page 326 and “Printing Glaucoma Letters” on page 328.



22. Click **Save/Exit**.

NOTE	The Credit Card Processing button is disabled. This feature will be enabled in a future version of ExamWRITER.

▶ To add a company lab to the vendor list

NOTE	Adding a lab to the vendor list in this manner copies the address, phone, and contact information to the Vendor Maintenance window and allows the lab to be selected as the vendor on eyewear and contact lens orders.

1. Open a lab by selecting it from the Location Select window. For information on creating a new location or opening an existing location, go to "To open the Location Maintenance window" on page 45.
2. Click **Add to Vendor List**.

   A dialog box displays informing you that the lab has been added tot he vendor list.

NOTE	The Add to Vendor List button is not available on the Location Maintenance window when you initially create a lab. You must save the lab, exit the Location Maintenance window, and reopen the lab to enable the Add to Vendor List button.

3. Click **OK** to close the dialog box.
4. Close the Location Maintenance and Location Select windows.

Setting Up Security

For more information on setting up security preferences, watch the "Security" video.

This section tells you how to assign or modify security preferences, including how to change a user's password. Security is always active in ExamWRITER. Setting up security will take dedication and time, so be sure to set aside some planning and implementation time before you begin using ExamWRITER.

This section includes the following topics:

- Understanding Security, 52
- Creating, Modifying, & Copying Security Roles, 54
- Assigning Roles and Passwords to Users, 63
- Setting Up Security Preferences, 64

Understanding Security

Security is an important component in safeguarding patient data and complying with HIPAA rules and regulations. ExamWRITER requires that you set up security so that each user must log in to view or maintain patient information.

ExamWRITER leverages a role-based security system, which allows you to control how loosely or how tightly security is implemented in your practice.

A *role* is a job or a function within your practice. For example, front desk is a function within your practice that generally requires entering patient demographic data, scheduling appointments, receiving copayments, etc. You can easily think of a list of tasks within your own practice that the front desk role would need to perform as well as those of biller, office manager, and optician. ExamWRITER allows you to establish which sections of the software each role can access.

It is not uncommon for one person in your practice to fill multiple roles. For example, a single person in your practice may work in the capacity of front desk, biller, and optician. ExamWRITER allows you to assign multiple roles to each individual in your practice, thereby enabling users to access the various portions of the software that they need to perform their various job functions.

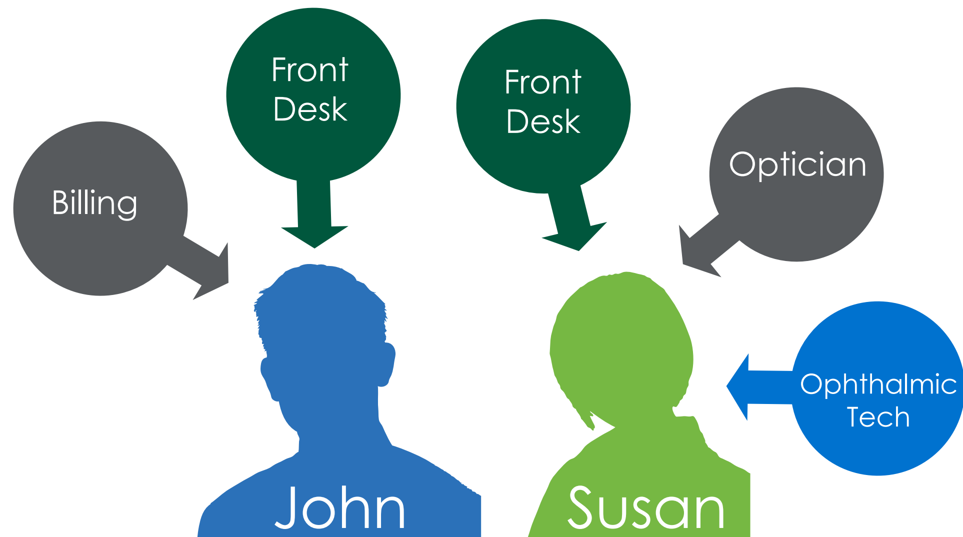


Figure 1-3: Security Roles. As illustrated here by John and Susan, multiple security roles can be assigned to each provider or staff member. The same security role can be assigned to multiple staff members when their duties overlap. In this case, both John and Susan are assigned to the Front Desk role. ExamWRITER comes preloaded with several security roles that you can customize to the needs of your practice.

Each security role is made up of building blocks, which determine which parts of the software a person with that security role can access and if the role can access, modify, or delete data. You might think of role details as all the various tasks that someone filling that role would need to perform.

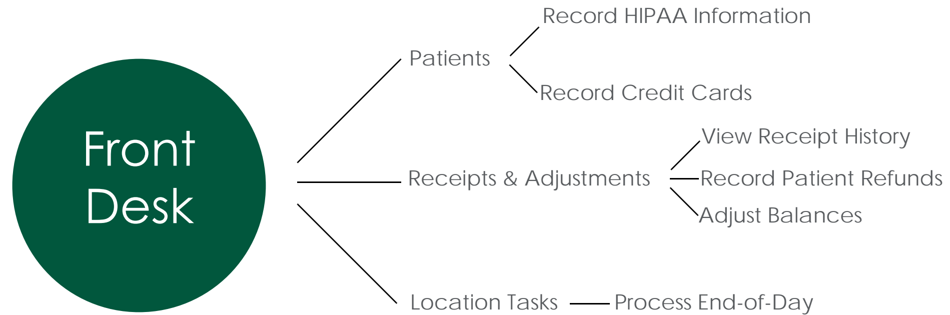


Figure 1-4: Security Role Details. The security role details are made up of building blocks that grant the user access to sections of the software, specific tasks, and levels of access. In this example, any users who are assigned the Front Desk security role can record HIPAA information, record credit cards, etc.

NOTE ExamWRITER makes setting up roles easy by including several sample roles. You can modify or delete the sample roles to your practice's needs.

For information on creating security roles, go to "Creating, Modifying, & Copying Security Roles" on page 54.

Creating, Modifying, & Copying Security Roles

For more information on setting up security preferences, watch the "Security" video.

ExamWRITER leverages a role-based security system, which allows you to control how loosely or how tightly security is implemented in your practice. Before proceeding any further, read "Understanding Security" on page 52. for a brief overview of role-based security.

This section tells you how to work with security roles in ExamWRITER, including how

- To create a role, 56
- To change the name of a role, 58
- To copy a role, 58
- To define role details, 59

NOTE If you upgraded from OfficeMate 9.5 or earlier or OfficeMate Enterprise 1.0 or 2.0, security roles are created based on your existing security settings. You may need to adjust the new security roles to ensure users have access to the appropriate functions.

If…	Then…
Security was OFF in your prior version of ExamWRITER	All users are assigned to the Admin Role, enabling them to access all areas of the software.
Security was ON and users' security included Access All	Those users are assigned to the Admin Role, enabling them to access all areas of the software.
Security was ON and users' security included limited access	A new security role is created for each user with limited access. The new role names are based on the users' names. The sample roles that are installed with OfficeMate are marked as inactive.

NOTES

- If your practice requires only minimal security, assign all users to Administration Role. Go to "Assigning Roles and Passwords to Users" on page 63 for more information.
- Prior to setting up security roles, complete each of the following tasks:
  - Ensure that all of your locations are set up. For more information on setting up locations, go to "Maintaining Locations" on page 45.
  - Ensure that your staff and provider(s) are set up with user IDs. For more information on setting up staff and provider user IDs, go to "Maintaining Providers, Staff, & Other Resources" on page 23.
  - Print a copy of the sample security roles to help you get started. Go to www.eyefinity.com/dam/eyefinity/documentation/OM/Security-Roles.pdf to download a list of the preinstalled sample roles. Remember, you can modify or delete the sample roles to your practice's needs.
  - Make a list of all of the jobs for which you and your employees are responsible (i.e., front desk tasks, optician, lab orders, medical technician tasks, contact lens orders, physical inventory, receiving purchase orders, pricing products, insurance processing, administration, recording exam records, etc.). These jobs will be your "roles" in ExamWRITER.
  - Write each employee's name next to the jobs for which they are responsible. If some employees are responsible for more than one job, write their names next to multiple jobs.

▶ To create a role

1. From the OfficeMate Administration main window, click **Setup** and select **Security**.

   OR

   From the ExamWRITER Administration main window, click **Activities** and select Security.
2. Click the **Role** tab.

NOTES

- ExamWRITER comes preloaded with example roles. Eyefinity highly recommends that you modify or copy these roles according to the needs of your practice. You are not required to use the sample roles, but rather they are there to help you get started with security roles.
- To delete an existing role that has not been assigned to any users, select the role and click **Delete**.

3. Create the role by performing the following steps:

1. Click the Ellipses (**...**) next to the Role text box.

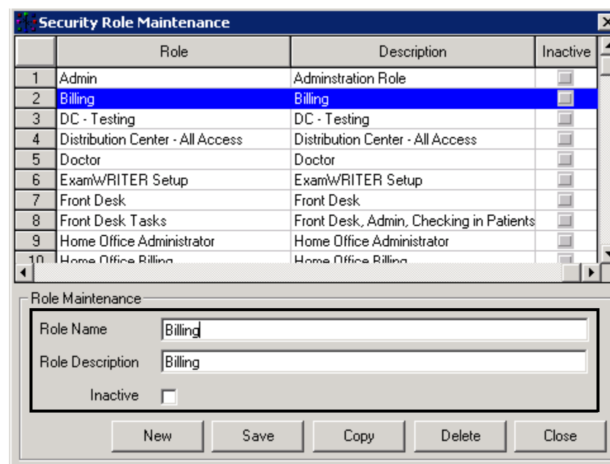
   The Security Role Maintenance window opens.

2. Type the name of a job function in the **Role Name** text box.

NOTE	When it comes to role names, think in general terms. Do not type the name of an employee who is responsible for the job or the exact title of people who hold that job. For example, type, “Front Desk Tasks,” *not* “Suzie’s Tasks.”

3. Type a description of the new role in the **Role Description** text box.

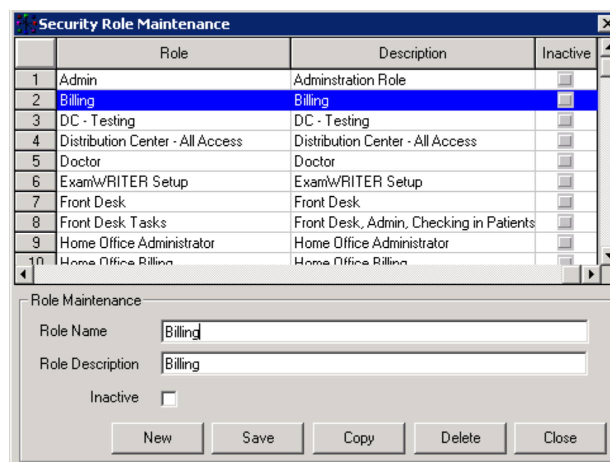
4. If you don’t want the role to be assigned to anyone yet, select the **Inactive** check box.



5. Click **Save**.

6. Repeat steps 2–5 to create roles for all of the job functions in your office.

7. Click **Close** to close the Security Role Maintenance window.



The roles that you created now appear in the Security Roles list on the left side of the Security window.

8. Continue by defining the role details. For information about defining role details, go to “To define role details” on page 59.

▶ To change the name of a role

1. From the OfficeMate Administration main window, click **Setup** and select **Security**.

   OR

   From the ExamWRITER Administration main window, click **Activities** and select Security.
2. Click the **Role** tab.

NOTES	• ExamWRITER comes preloaded with example roles. Eyefinity highly recommends that you modify or copy these roles according to the needs of your practice. You are not required to use the sample roles, but rather they are there to help you get started with security roles. • To delete an existing role that has not been assigned to any users, select the role and click **Delete**.

3. Click the Ellipses (**...**) next to the Rule text box.

   The Security Role Maintenance window opens.
4. Select the role that you want to modify from the list.
5. Type the new name of the role in the **Role Name** text box.

NOTE	When it comes to role names, think in general terms. Do not type the name of an employee who is responsible for the job or the exact title of people who hold that job. For example, type, “Front Desk Tasks,” *not* “Suzie’s Tasks.”

6. Type a description of the new role in the **Role Description** text box.
7. If you don’t want the role to be assigned to anyone yet, select the **Inactive** check box.
8. Click **Save**.
9. Repeat steps 4–8 to modify additional roles.
10. Click **Close** to close the Security Role Maintenance window.
11. Continue by defining the role details. For information about defining role details, go to “To define role details” on page 59.

▶ To copy a role

1. From the OfficeMate Administration main window, click **Setup** and select **Security**.

   OR

   From the ExamWRITER Administration main window, click **Activities** and select **Security**.

2. Click the **Role** tab.

NOTES	• ExamWRITER comes preloaded with example roles. Eyefinity highly recommends that you modify or copy these roles according to the needs of your practice. You are not required to use the sample roles, but rather they are there to help you get started with security roles. • To delete an existing role that has not been assigned to any users, select the role and click **Delete**.

3. Click the Ellipses (**...**) next to the Rule text box.

   The Security Role Maintenance window opens.
4. Select the role that you want to copy from the list.
5. Click **Copy**.

   The Copy a Security Role window opens.
6. Type the name of the new role in the **New Role Name** text box.

NOTE	When it comes to role names, think in general terms. Do not type the name of an employee who is responsible for the job or the exact title of people who hold that job. For example, type, “Front Desk Tasks,” *not* “Suzie’s Tasks.”

7. Type a description of the new role in the **Role Description** text box.
8. If you don’t want the role to be assigned to anyone yet, select the **Inactive** check box.
9. Click **OK**.
10. Repeat steps 4–9 to copy additional roles.
11. Click **Close** to close the Security Role Maintenance window.
12. Continue by defining the role details. For information about defining role details, go to “To define role details” on page 59.

▶ To define role details

Define the areas of access for a role by editing the role details. The role details determine which areas of the software a user can access and the levels of access. Think of role details as all the various tasks that someone filling that role would need to perform.

To define the areas of access for a role, you will select progressively narrower areas of the software and then select the actions the role can perform.

NOTES

- The areas of access that you assign to a role can be as broad or limiting as you desire.
- You can assign multiple functions to a role so that a single role can access various parts of the software.
- You can assign multiple roles to a user, so you don't need to squeeze all of an individual's access into one role.
- To delete an existing role's details that have not been assigned to any users, click **Delete**.
- Eyefinity recommends printing the Security Roles report to see how roles are broken down, gain an understanding of which tasks are found in the various sections of the software, and help you plan the roles needed for your practice:
  - To print Security Roles report, click **Print** on the Security window.
  - To print the sample roles that were preinstalled in your ExamWRITER software, go to www.eyefinity.com/dam/eyefinity/documentation/OM/Security-Roles.pdf.

1. From the OfficeMate Administration main window, click **Setup** and select **Security**.

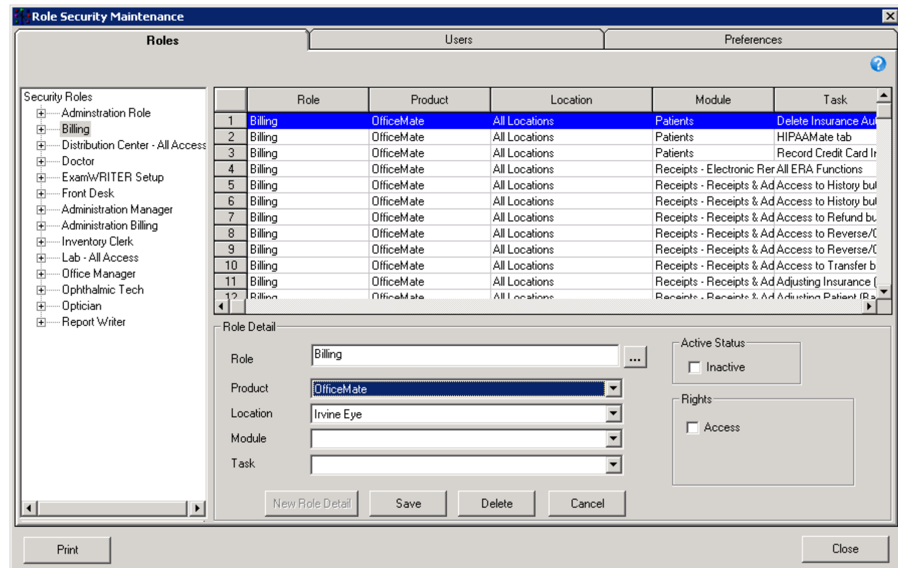
   OR

   From the ExamWRITER Administration main window, click **Activities** and select **Security**.
2. Click the **Role** tab.
3. Select a role from the **Security Roles** list on the left side of the window.
4. Click **New Role Detail** to create a new area of access.

   OR

   Select an existing detail from the list.

5. Select the software program that people using this role will need to access from the **Product** drop-down menu.



NOTE	The Product drop-down menu allows you to select the general area in which a person with this role would need access. Use the following table to help you decide which product to select.

Select this product…	If a person with this role…
OfficeMate	Performs general business tasks within the practice.
ExamWRITER	Performs tasks within the examination room or records diagnostic testing.
ReportWRITER	Performs tasks related to medical reports.
Administration	Performs tasks that require setting up or customizing the software.
Distribution Center	Performs tasks within an internal distribution center. Most practices will not use this option.
Lab	Performs tasks within an internal lab. Most practices will not use this option.
All Products	Requires blanket access to all programs.

Remember that you are able to assign multiple areas of access to a role and multiple roles to an individual staff member or provider, so you are able to assign access to multiple software products to an individual user.

6. Select the location that people using this role and product will need to access from the **Location** drop-down menu.

NOTES	
	• Most practices will not need to select a location; the location populates automatically when you make a selection from the Product drop-down menu. Only multilocation practices or practices with multiple internal labs or internal distribution centers need to select a location. • Multilocation practices will generally select All Locations for the sake of consistency. Select a specific location only if a particular store, lab, or distribution center must have a unique operating procedure.

7. Select the module in the product that people using this role and product will need to access from the **Module** drop-down menu.

NOTE	The module represents the specific area of the software that you want to allow individuals with this security role to access.

8. Select the task in the module that people using this role and product will need to access from the **Task** drop-down menu.

NOTE	The task represents the specific task that you want to allow individuals with this security role to access.

9. Select the **Access**, **Delete**, **Override**, and **Print** check boxes in the Rights box to select the level of access for the role.

NOTE The Rights represent the specific actions that you want to allow individuals with this security role to access.

Select this checkbox...	To allow users to...
Access	View, add, and modify information associated with the task.
Delete	Delete information (when deletion is possible).
Override	Access or perform specific functions in restricted areas after entering their password.
Print	Print items when possible within the task.

10. Select the **Inactive** check box in the Active Status box to deactivate the selected task, if desired.
11. Click **Save**.
12. Click **New Role Detail** and repeat steps 5–11 to record additional areas of access that someone with the selected role would need to carry our his or her duties.

Assigning Roles and Passwords to Users

Click the Users tab to assign users to the roles that you created. You can assign as many roles as desired to users. All users are initially assigned to a default administrator role, which allows them access to all products, modules, and tasks in all locations, until you modify their role assignments.

NOTE	If your practice requires minimal security, assign all users to Administration Role. The Administration Role requires users to log in with a username and password and allows them to access all areas of the software.

To assign roles to users, perform the following steps:

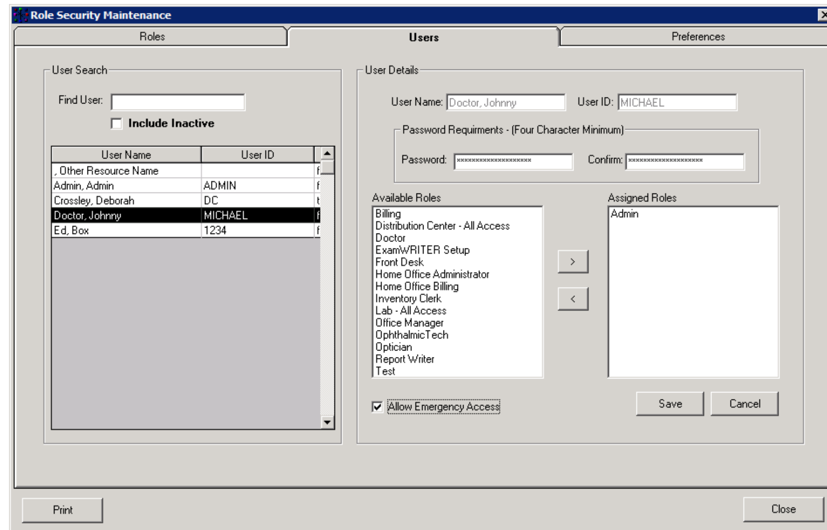
1. From the OfficeMate Administration main window, click **Setup** and select **Security**.

   OR

   From the ExamWRITER Administration main window, click **Activities** and select **Security**.
2. Click the **User** tab.
3. Select a user on the left side of the window; or, search for a specific user by typing all or part his or her name in the Find User text box. To find an inactive user, select the Include Inactive check box.
4. If a password does not exist for the user that you selected, type a password for the user in the **Password** and **Confirm** text boxes. The password must contain at least four characters.
5. Double-click the roles in the **Available Roles** box to move them to the Assigned Roles box and assign them to the user that you selected. You can also select the roles in the Available Roles box (press the **Ctrl** key to select multiple roles) and click the arrow button to move them to the Assigned Roles box and assign them to the user that you selected. If you assign multiple, overlapping roles to a user, the role with the highest level access will override the roles with lower levels of access. For example, if you assign one role to a user that allows him or her to print the schedule and one role that does not allow him or her to print the schedule, the user will be able to print the schedule.
6. Select the **Allow Emergency Access** check box to allow a user who does not normally have access to ExamWRITER to open patient exams in read-only mode in emergency situations.

NOTE	Emergency accesses are recorded in the Audit Log. for more information about the Audit Log, go to “Auditing Activities” on page 109.
7. Click **Save**.

8. Repeat steps 3–7 to assign all of your users roles.



Setting Up Security Preferences

Security preferences allow you to control, globally or by location, the amount of time a user may be inactive before being logged out of the software and establish which reports are secure. This section tells you how to set up security preferences including how

- To set up inactivity periods, 64
- To secure reports, 65

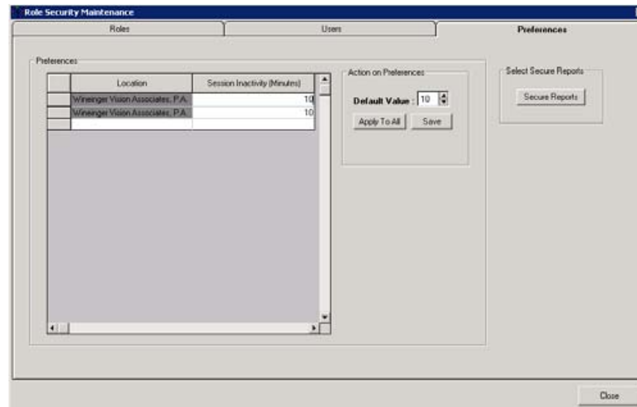
▶ To set up inactivity periods

1. From the OfficeMate Administration main window, click **Setup** and select **Security**.

   OR

   From the ExamWRITER Administration main window, click **Activities** and select **Security**.
2. Click the **Preferences** tab.
3. Place your cursor in the cell next to a location and type the number of inactive minutes after which you want users to be logged off ExamWRITER.
4. Repeat step 3 for each location; or, if you want all users to be logged off ExamWRITER after the same number of inactive minutes, type or select the default number of inactive minutes in the Default Value box and click **Apply To All**.

5. Click **Save**.



6. Click **Close** to close the Security window.

▶ To secure reports

1. From the OfficeMate Administration main window, click **Setup** and select **Security**.

   OR

   From the ExamWRITER Administration main window, click **Activities** and select **Security**.
2. Click the **Preferences** tab.
3. Click **Secure Reports** to restrict user access to reports.

   The Reports Security window opens.

4. Select the check box in the **Secure** column next to each report that you want to restrict access.

NOTES	
	• Selected reports can be viewed and printed only by users whose security roles include Secured Reports. • To allow a user to view and print secured reports create a role, or assign an existing role, that includes the ExamWRITER product, Reports module, and Secured Reports task.For more information about creating roles, go to “Creating, Modifying, & Copying Security Roles” on page 54. For information about assigning roles, go to “Assigning Roles and Passwords to Users” on page 63. • Deselected reports are not secured and can be viewed and printed by any user.

5. Click **OK** to close the Reports Security window.
6. Click **Close** to close the Security window.

Setting Up Preferences

This section tells you how to define and change preferences in ExamWRITER, including how

- To set up general preferences, 67
- To set up report settings preferences, 69
- To set up default preferences, 69
- To set up copy forward preferences, 72
- To set up Rx print option preferences, 73

NOTE	You can change your ExamWRITER preferences any time you are *not* in an exam record. Close all exam records in the ExamWRITER chart window before changing ExamWRITER preferences.

For more information on setting up preferences in ExamWRITER, watch the "Preferences" video.

▶ To set up general preferences

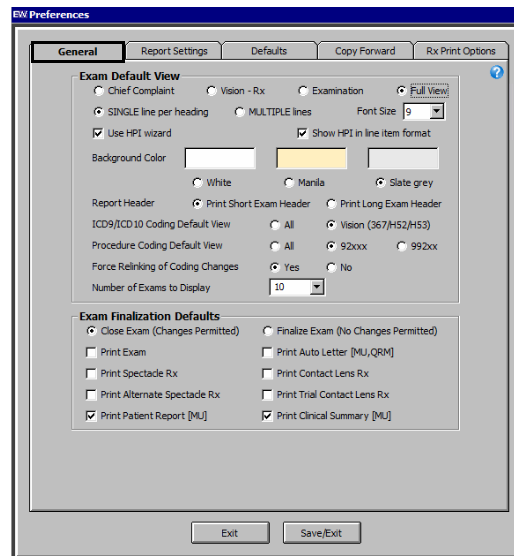
1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Preferences**.

   OR

   On the ExamWRITER Administration main window, click **Activities**, and select **Preferences**.

   The Preferences window opens.

2. Click the **General** tab.



3. Select the appropriate **Exam Default View** radio buttons:

   a. Select which tab initially displays when an exam is opened:

   – **Chief Complaint**

   – **Vision-Rx**

   – **Examination**

   – **Full View**

   b. Select how text displays on the exam:

   – **SINGLE line per heading** displays observations in paragraph form.

   – **MULTIPLE lines per heading** displays observations in a vertical list.

   The default views are Full Exam View and MULTIPLE lines.

4. If you want to use the HPI Wizard to more easily and accurately document HPI information, select the **HPI wizard** check box. If you select this check box, select the **Show HPI in line item format** check box if you want to document HPI information on an exam record in a vertical, multiline format

(leave the check box deselected if you want to document HPI information on an exam in a horizontal, narrative format).

The default preference does not have the HPI wizard check box selected.

5. Select an exam display font size from the **Font Size** drop-down menu.

   The default font size is 10.

6. Select the appropriate **Exam Background Color** of White, Manila, or Slate grey.

   The default exam background color is Slate grey.

7. Select the appropriate **Exam Report Format** to Print Short Exam Headers or Print Long Exam Headers.

   The default format is Print Long Exam Header.

NOTE	Printing a short exam header will print the patient's name, DOB, age, exam date, occupation, and chart number. Printing a long exam header will print the patient's name, DOB, age, exam date, occupation, social security number, chart number, address, and phone number.

8. Select a default ICD-9 or ICD-10 coding and default procedure coding view for the Diagnosis/Procedure Coding window from the **ICD9/ICD10 Coding Default View** and **Procedure Coding Default View** radio buttons.

   The default view is All.

9. Select the appropriate **Force Relinking of Coding Changes** radio button to open a window in the Diagnosis/Procedure Coding window to remind you to review linked codes. For more information about linking codes, go to "To link diagnosis codes to procedure codes" on page 311.

   The default selection is Yes.

10. Select how many exams to display in the Exam History drop-down menu on the ExamWRITER chart window from the **Number of Exams to Display** drop-down menu. This preference is especially helpful if you have patients with many exams over many years.

    The default selection is 10.

11. Select the appropriate **Exam Finalization Defaults** to Close Exam (Changes Permitted), Finalize Exam (No Changes Permitted), Print Exam, Print Auto Letter, Print Spectacle Rx, Print Contact Lens Rx, Print Alternate Spectacle Rx, Print Trial Contact Lens Rx, Print Patient Report, and Print Clinical Summary.

NOTES	• If you select Finalize Exam (No Changes Permitted), you cannot make changes to the exam after it is finalized and closed. You will only be able to add information to the exam in an addendum. • If you select Print Auto Letter and you are using ECR Vault, then the exam and auto letter is automatically saved in ECR Vault.

12. Click **Save/Exit** to save your changes and close the Preferences window.

▶ To set up report settings preferences

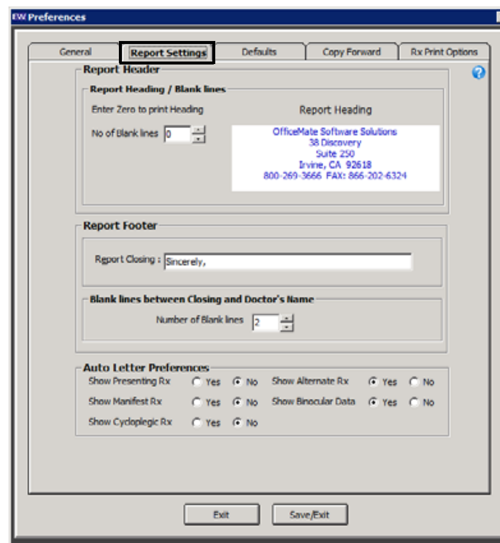
1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Preferences**.

   OR

   On the ExamWRITER Administration main window, click **Activities**, and select **Preferences**.

   The Preferences window opens.

2. Click the **Report Settings** tab.



3. Enter the number of blank lines that you want to appear in your report header.

NOTE	If you are not using your office stationary and you want to print a report heading, enter 0 as the number of blank lines.

4. Type the Report Closing that you want to appear in your report footer.
5. Enter the number of blank lines that you want to appear between the closing and doctor's name.
6. Select appropriate **Auto Letter Preferences** Yes or No radio buttons to display or hide the presenting Rx, manifest Rx, cycloplegic Rx, alternate Rx, and binocular data on auto letters.
7. Click **Save/Exit** to save your changes and close the Preferences window.

For more information on setting up preferences in ExamWRITER, watch the "Preferences" video.

▶ To set up default preferences

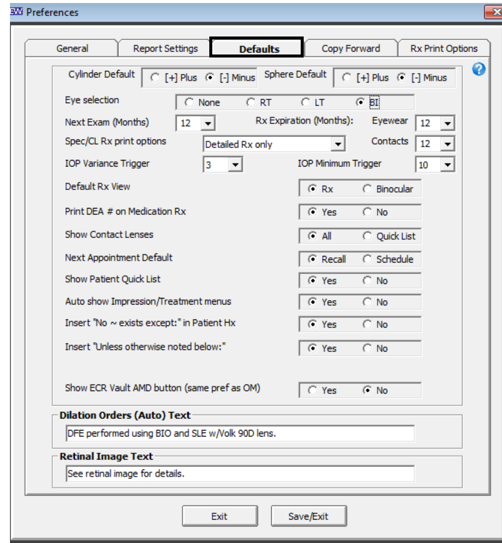
1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Preferences**.

   OR

   On the ExamWRITER Administration main window, click **Activities**, and select **Preferences**.

   The Preferences window opens.

2. Click the **Defaults** tab.



3. Select the appropriate default **Cylinder Default Sign**.

   The default is [-] Minus.

4. Select the appropriate default **Sphere Default Sign**.

   The default is [-] Minus.

   Select

5. Select a default recall date from the **Next Exam (Months)** drop-down menu.

   The default is 12 months.

6. Select a default eyewear and contact lens Rx expiration date from the **Rx Expiration (Months)** drop-down menus.

   The defaults are 12 months.

7. Select the default spectacle and contact lens Rx print option from the **Spec/CL Rx print options** drop-down menu.

   The default is Wallet size Rx only.

8. Select an IOP variance range between 1 and 20 from the **IOP Variance Trigger** drop-down menu.

   If the most recently recorded IOP value in a patient's exam deviates from any IOP value in the patient's history more than the IOP variance trigger, it will be highlighted in red in the IOP table in the Exam - Special Tests tab. For more information on the IOP table in the Exam - Special Tests tab, go to "Recording & Modifying Tonometry Measurements" on page 268.

9. Select a minimum IOP trigger between 10 and 40 from the **IOP Minimum Trigger** field drop-down menu.

   If the most recently recorded IOP value in the patient's exam is greater than the trigger value, that cell in the IOP grid turns red.

10. Select the appropriate **Default Rx View**.

    The default is Rx.

11. Select the appropriate default **Print DEA # on Medication Rx** radio button.

    The default is Yes.

12. Select the appropriate default **Show Contact Lenses** radio button to choose whether you want to view all contact lenses or only the lenses that are in your Quick List in the Select Contact Lens window.

    The default is All.

13. Select the appropriate **Next Appointment Default** radio button to choose whether you want to assign a recall date or schedule an appointment in the Follow-Up window.

NOTES	• If you select **Recall**, the recall will be recorded in the EMR and OfficeMate. • If you select **Schedule**, the appointment will be recorded in the EMR, but no appointment will be scheduled in OfficeMate.

14. Select the appropriate **Show Patient Quick List** radio button to choose whether you want to always display or hide the Quick List.

    The default is Yes.

15. Select the appropriate **Auto show Impression/Treatment menus** radio button to choose whether you want to automatically open impression and treatment windows after selecting examination exceptions.

    The default is Yes.

16. Select the appropriate **Insert “No ~ exists except:” in Patient Hx** radio button to choose whether you want to automatically insert the “No ~ exists except:” text in the exam record when an exception is selected in the Patient History window.

    The default is Yes.

17. Select the appropriate **Insert “Unless otherwise noted below:”** radio button to choose whether you want to automatically select the “Unless otherwise noted below:” check box on the Patient History, Review of Systems, External Exam, Slit-Lamp Exam, and Routine Ophthalmoscopy windows

18. Select the appropriate **Show ECR Vault AMD button (same pref as OM)** radio button to choose whether you want to display the ECR AMD button in the Patient Demographics window in OfficeMate and on the exam chart window in ExamWRITER.

    The default is No.

19. Type the default **Dilation Orders (Auto)** in the text box.

    The default is DFE performed using BIO and SLE w/Volk 90D lens.

20. Type the default **Retinal Image** text in the text box.

    The default is See retinal image for details.

21. If you are using the standalone version of ExamWRITER (without OfficeMate) and a selected third party practice management software system, select the

On **Third Party Interface** radio button to export exam files to your BIDEAS folder or select the Off radio button if you do not want to export exam files to your BIDEAS folder.

22. Click **Save/Exit** to save your changes and close the Preferences window.

▶ To set up copy forward preferences

NOTES

- Exams and templates that were created using ICD-9 codes can be copied forward to new exams that use ICD-10 codes. If there is an exact correlation between ICD-9 codes copied forward and their ICD-10 counterparts, then the ICD-9 codes will be translated into ICD-10 codes in the new exams and templates. If there is *no* exact correlation between ICD-9 codes copied forward and their ICD-10 counterparts, then the ICD-9 diagnoses will be flagged as blue text in the exam so that you can manually re-code them as ICD-10 diagnoses them before billing the exam.
- If you are using ExamWRITER 10.6 or above and you copy forward an exam that was created before ExamWRITER 10.6, the selections you made during the previous exam in the Examinations, Impressions, Plans, Special Testing, and Surgery windows will *not* copy forward to the new exam.

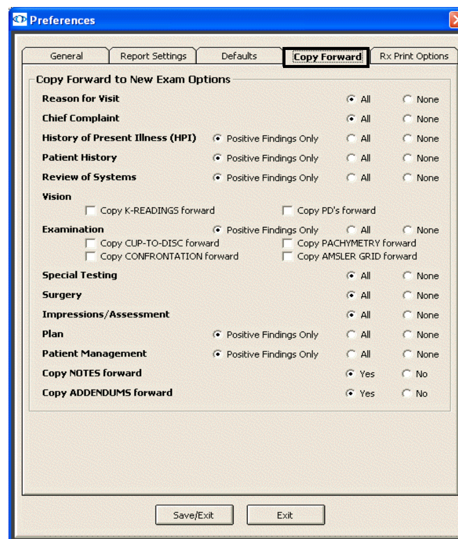
1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Preferences**.

   OR

   On the ExamWRITER Administration main window, click **Activities**, and select **Preferences**.

   The Preferences window opens.

2. Click the **Copy Forward** tab.



3. Select the appropriate **Copy Forward To New Exam Options** to copy former patient specific exam template information to a new patient exam.

4. Click **Save/Exit** to save your changes and close the Preferences window.

For more information on setting up preferences in ExamWRITER, watch the "Preferences" video.

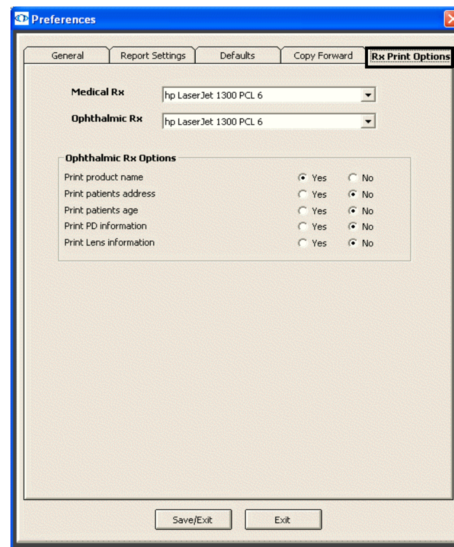
▶ To set up Rx print option preferences

1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Preferences**.

   OR

   On the ExamWRITER standalone main window, click **Tools** and select **Preferences**.

   The Preferences window opens.
2. Click the **Rx Print Options** tab.



3. Select the printer where you want to print medical prescriptions from the **Medical Rx** drop-down menu.
4. Select the printer where you want to print ophthalmic prescriptions from the **Ophthalmic Rx** drop-down menu.
5. Select appropriate **Ophthalmic Rx Options**.
6. Click **Save/Exit** to save your changes and close the Preferences window.

Setting Up Correspondent Information

This section tells you how to set up and maintain correspondent information in ExamWRITER, including how

- To modify or delete a correspondent, 74
- To create a new correspondent, 75

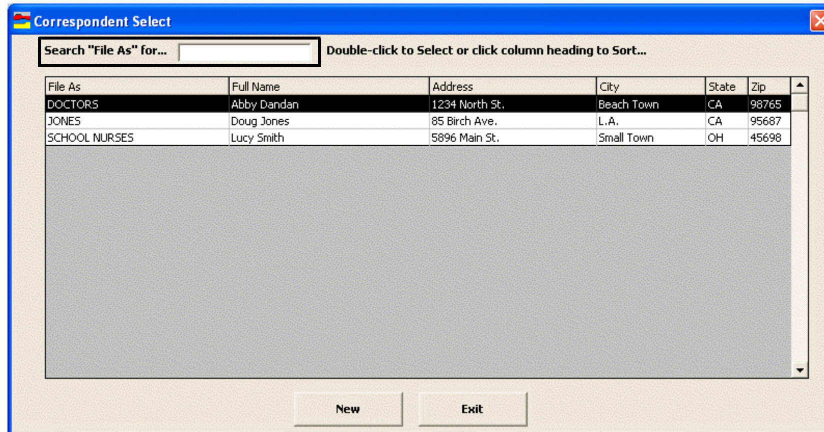
For more information on maintaining correspondents, watch the "Correspondent Maintenance" video.

▶ To modify or delete a correspondent

1. On the ExamWRITER main window, click **Tools** and select **Correspondent Maintenance**.

   The Correspondent Select window opens.

NOTE	To search for a correspondent, type text in the **Search "File As" for...** text box.



2. Double-click the correspondent you want to modify.

   The Correspondent Maintenance window opens.

3. Modify the correspondent and click **Save**.

   OR

   Click **Delete** to delete the correspondent from your database.

4. Click **Exit** to close the Correspondent Select window.

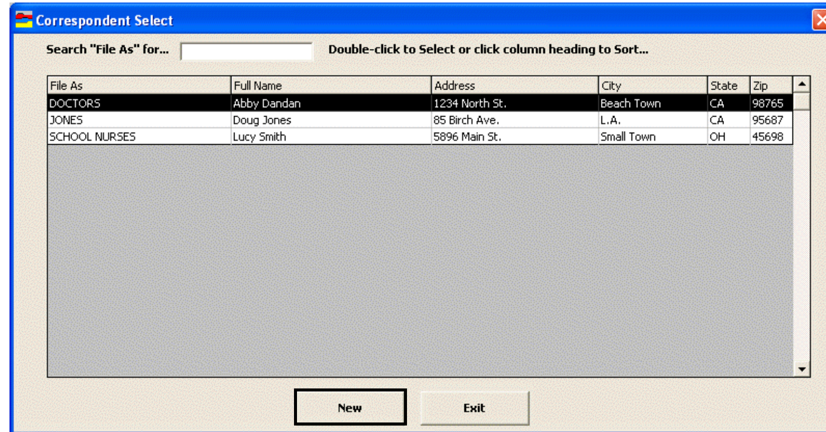
Correspondent Maintenance
File As: DOCTORS
Name: Abby Dandan
Address: 1223 North Street
Address 2:
City, State, Zip: Beach Town | CA | 92656
Phone: 789-789-7899 FAX: (852) 852-8522
Email: abby@dr.com
Salutation: Dr. Dandan
Exit | Delete | Save

▶ To create a new correspondent

1. On the ExamWRITER main window, click **Tools** and select **Correspondent Maintenance**.

   The Correspondent Select window opens.

2. Click **New** to add a new correspondent to your database.



   The Correspondent Maintenance window opens.

3. Type text into the fields and click **Save**.

NOTE	The text you type in the File As text box will determine what group this correspondent is filed with (for example, "School Nurses," "Doctors," or in alphabetical order by last name).

Correspondent Maintenance
File As DOCTORS
Name Abby Dandan
Address 1223 North Street
Address 2
City, State, Zip Beach Town CA 92656
Phone 789-789-7899 FAX (852) 852-8522
Email abby@dr.com
Salutation Dr. Dandan
Exit Delete Save

4. Click **Exit** to close the Correspondent Select window.

Setting Up Product and Service Information

This section tells you how to set up and maintain product and service information in the standalone version of ExamWRITER (without OfficeMate).

NOTE	Contact lens product information can also be accessed and modified from the Vision/Rx tab on the ExamWRITER chart window. Click the **Contacts** tab on the Vision bar and then click anywhere in the **Presenting Contact Rx** box to access the Contact Lens Presenting, Trial, and Final tabs. Select an OD or OS contact lens product name from the **Product Name** menu. The Select Contact Lens window opens. Click **Edit Product** to open the Products window and modify the contact lens product information.

For more information on maintaining products and services, see the "Maintaining Product & Service Information" chapter in the *OfficeMate Administration User's Guide* and the "Product Setup," "Product Maintenance," and "Services" videos.

1. On the Administration main window, click **Activities** and select **Product Maintenance**.

   The Products window opens.

NOTE	To add a new product or service, click **New Product**.

2. Select a product or service from the **Product Type** drop-down menu.
3. Select a product manufacturer from the **Manufacturer** drop-down menu or select a service **CPT** code radio button.
4. Type a product or service name in the **Product Name** text box.
5. Select the **Include inactive products** check box if you want to maintain product or service information for inactive products or services.
6. Click **F2-Find** to search for a product or service.

NOTE	To conduct an advanced search for a product, click **Advanced Search** to open the Find Product window and search for a product using additional criteria.

7. Double-click the product or service that you want to modify.

NOTE	You can drag and drop column headings to rearrange column views.

8. Select appropriate options from the drop-down menus and complete the necessary Additional Fees, HCFA - 1500 Additional Information, Notes, and other fields.

NOTES

- To copy product or service information to a new product or service style, click **Copy**.
- You must assign contact lenses to a lens category in order for them to appear in the Select Contact Lens window.

9. To record a CPT code, select a CPT code from the **CPT/HCPS Code** drop-down menu.

NOTE	• You must select CPT codes for your services before you code an exam in order for the service to appear in the Diagnosis/Procedure Coding window. • You can assign two CPT codes to ophthalmic lenses by recording a CPT code in the CPT/HCPCS Code text box in the Products tab and in the Product Code text box in the Product Details tab. If you assign two CPT codes to ophthalmic lenses, the codes recorded in the Product Code text box in the Product Details tab will override the codes in the CPT/HCPCS Code text box in the Products tab when you add the lenses to fee slips in OfficeMate. If you do not record a CPT code in the Product Code text box in the Product Details tab, the code in the CPT/HCPCS Code text box in the Products tab will appear on fee slips in OfficeMate.

10. Click the **Product Details** tab to modify product sizes, colors, and codes; print bar codes; and mark products as being discontinued.

11. Select a line in the table to modify product details already recorded.

NOTE	Select a line and click **Delete** to delete the line if it is *not* linked to a fee slip, Rx order, or purchase order.

12. Select the product's status:

   – Select the **Stock/Inline** radio button if the product is regularly kept in inventory at store locations and is available for sale.

   – Select the **Non Stock/Not Inline** radio button if the item is not regularly kept in inventory at the store locations, but is ordered from a vendor when a unit is sold.

   – Select the **Inactive** radio button if the product is not regularly kept in inventory at the store locations, nor is it ordered from a vendor when a

unit is sold. Items marked as inactive do not appear in product order search results.

- Select the **Discontinued** radio button if the product is no longer available. Items marked as discontinued do not appear in product order search results.
- Select the **Backordered** check box if the item is not currently available from the vendor or manufacturer and type the date in which the item is again expected to be available in the **ETA** text box. This date can also be entered on the Receive PO window. In the event two different dates are entered, the latest date is displayed.
- Select the **Display Sample** check box to indicate that there are sample or display units of this product. The minimum display quantity for the product is set to one. You can change the minimum sample quantity on the All Locations Inventory tab.

13. Type the product size information in the appropriate fields.The Product window displays the appropriate fields based on the type of product:
    - Contact lens: **BC**, **Dia**, **Sph**, **Cyl**, **Axis**, and **Add** text boxes.
    - Frames, plano sunglasses, and ready readers: **Eye**, **Bridge**, **Temple**, **DBL**, **A**, **B**, and **ED** text boxes.
    - Ophthalmic lenses: **Low Sphere**, **High Sphere**, **Low Cyl**, and **High Cyl** text boxes.
    - Accessories, lens treatments and other products do not require size information.
14. Type the base cost and base fee in the **Base Cost** and **Base Fee** text boxes.
15. Type the product code in the **Product Code** text box.
16. Type the UPC code in the **UPC Code** text box.
17. Type or select a color from the **Color** drop-down menu, if applicable.
18. If the product is an ophthalmic lens, select a code from the **Prod. CPT/HCPCS Code** drop-down menu.

NOTE	The code that you select will only be used if do *not* use Rx orders. If you use Rx orders, the CPT code will automatically be populated on the fee slip according to the prescription in the Rx order.

19. Select the product's attributes from the **Attributes** drop-down menus.

    The CPT/HCPCS Code, Product Cost, and Product Fee fields automatically populate based on the attribute selected. For information on associating procedure codes, costs, and fees with attributes, go to "To add & modify attributes" on page 16.

20. Repeat steps 18–19 to apply attributes to each of the products listed at the top of the window.

21. If the product is an opthalmic lens, click the **Additional Attributes** tab; otherwise, skip to step 27.

22. In the **Prism** group, enter the measurement range for each cost or fee point.

23. Type the **Prod Cost** and **Addl Fee** information for each measurement range.

24. Repeat steps 22–23 for the **Add Power** and **Oversize** groups.

25. Click the **VSP Product** tab.

26. Select options that apply to the lens from the **Vision Type**, **Material**, and **Lens** drop-down menus.

NOTE	Options may already be selected based on information recorded on the Products tab.

27. Select one of the following options:
    – **Save** to save the information and keep the Products window open.
    – **Save and New** to save the information and create a new product.
    – **Save and Exit** to save the information and close the Products window.

Maintaining Medication & Allergen Information

This section tells you how to maintain medication and allergen information in ExamWRITER, including how

- To maintain medication & allergen information, 82
- To add new medication & allergen information, 84
- To delete medication & allergen information, 86

NOTE	You can customize and maintain medication and allergen information at any time while you are recording information in an EMR. To access the Medication/Allergen Maintenance window from within an EMR, follow the instructions below: 1. Click the **Patient Hx – ROS** tab. 2. Click the **Patient History** bar. 3. Select the **Medications - Systemic/Ocular/Allergies [MU]** or **Allergens - Non Medication** check box and click **Process**. 4. Select a medication or allergen and click **Add/Edit Medication** or **Add/Edit Allergen** or right-click on a medication or allergen to customize or maintain it.

For more information on maintaining medication information, watch the "Medication Maintenance" video.

▶ To maintain medication & allergen information

1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Medication Maintenance**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Medication Maintenance**.

   OR

   On the ExamWRITER main window, click **Tools** and select **Medications Maintenance**.

   The Medication/Allergen Maintenance window opens with a list of the most commonly prescribed medications and allergens.

2. Type text in the **Name Search** text box to search for a medication or allergen.

   OR

   Select a group from the **Group to view** drop-down menu.

NOTE	Click on a column heading to sort the column in ascending order.

3. Double-click the medication or allergen that you want to modify.

   The medication or allergen information appears in the text boxes at the top of the window.

4. Click the **Yes** radio button to show the medication or allergen in the Quick List of medications and allergens.

   OR

   Click the **No** radio button to keep the medication or allergen in the database, but hide it in the Quick List.

5. Modify the **Category**, **Name**, **Generic**, **Indications**, **Group**, and **Default Values** information.

6. Click **Save** to save your changes and keep the window open.

   OR

   Click **Save/Exit** to save your changes and close the window.

▶ To add new medication & allergen information

1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Medication Maintenance**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Medication Maintenance**.

   OR

   On the ExamWRITER main window, click **Tools** and select **Medications Maintenance**.

   The Medication/Allergen Maintenance window opens with a list of the most commonly prescribed medications and allergens.

2. Click **New**.

3. Click the **Yes** radio button to show the medication or allergen in the Quick List.

   OR

   Click the **No** radio button to keep the medication or allergen in the database, but hide it in the Quick List.

4. Add information to the **Category**, **Name**, **Generic**, **Indications**, **Group**, and **Default Values** text boxes and drop-down menus.

5. Click **Save** to save your changes and keep the window open.

   OR

   Click **Save/Exit** to save your changes and close the window.

▶ To delete medication & allergen information

1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Medication Maintenance**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Medication Maintenance**.

   OR

   On the ExamWRITER main window, click **Tools** and select **Medications Maintenance**.

   The Medications Maintenance window opens with a list of the most commonly prescribed medications and allergens.

2. Type text in the **Name Search** text box to search for a medication or allergen

   OR

   Select a group from the **Group to view** drop-down menu.

NOTE	Click on a column heading to sort the column in ascending order.

3. Double-click the medication or allergen that you want to delete.

   The medication or allergen information appears in the text boxes at the top of the window.

4. Click **Delete**.

NOTE	Deleting a medication or allergen does not remove it from a patient record; instead, deleting a medication or allergen removes it from the ExamWRITER database.

5. Click **Exit** to close the window.

Creating and Modifying Templates

Eyefinity strongly recommends using templates to maintain complete EMRs, reduce repetitive data entries, and save time entering patient exam information into ExamWRITER. Create templates using text that you write repetitively 80 percent or more of your time. Each time that you use a template to launch an exam, all of the text that you saved in your template will automatically appear in the new EMR. You can create problem focused and procedure focused templates.

NOTES

- Templates using the narrative format display exam text on the ExamWRITER chart window in paragraphs.
- Templates using the line item format display exam text on the ExamWRITER chart window in separate vertical lines.

This section tells you how to create and modify templates in ExamWRITER, including how

- To create a new ExamWRITER template, 89
- To modify the name of an existing ExamWRITER template, 90
- To modify an existing ExamWRITER template, 91

For more information on creating and using templates, watch the "Templates" video.

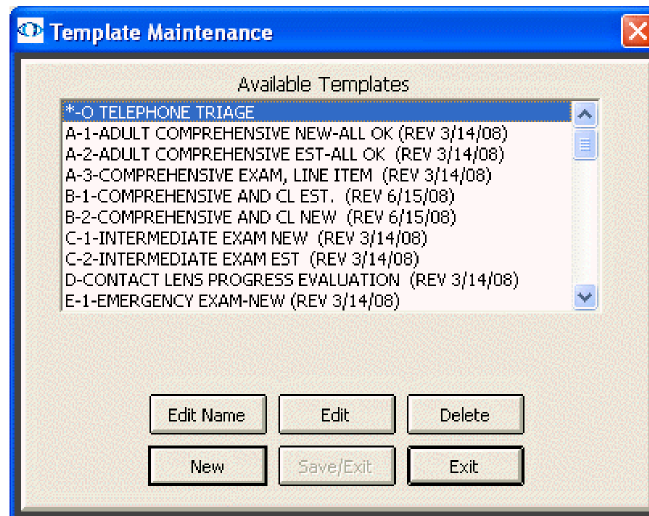
▶ To create a new ExamWRITER template

A new, blank template is a blank EMR with no patient name associated with it.

1. On the ExamWRITER main window, click **Tools** and select **Template Maintenance**.

   The Template Maintenance window opens.

2. Click **New**.

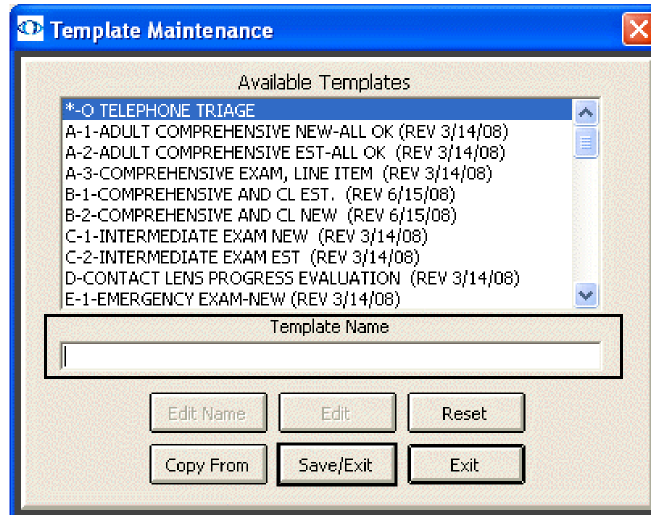


3. Type the name of the template in the **Template Name** text box.

4. If you want to copy an existing template to a new template, select an available template and click **Copy From**.

   OR

   Click **Save/Exit** to close the Template Maintenance window.



   A new exam template opens.

5. Add default exam information to the blank template using the instructions in "Creating & Opening Exam Records" on page 145.

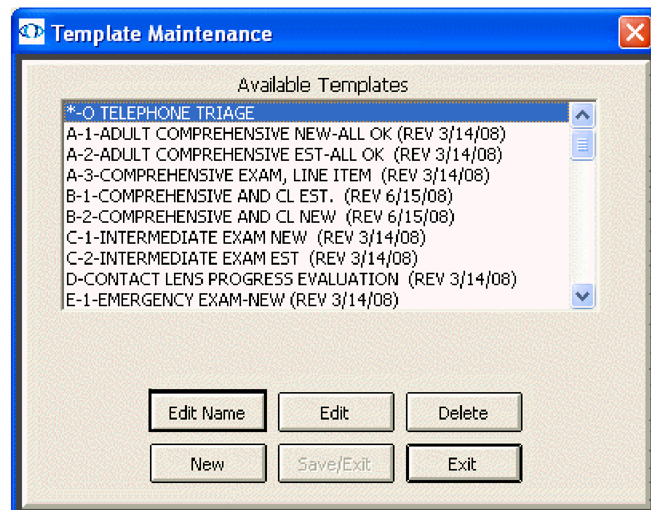
6. Click the **X** in the top right corner of the window to save and close the template.

▶ To modify the name of an existing ExamWRITER template

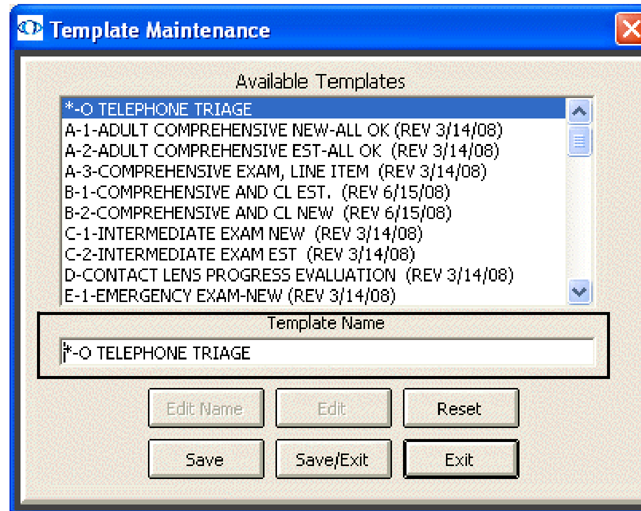
1. On the ExamWRITER main window, click **Tools** and select **Template Maintenance**.

   The Template Maintenance window opens.

2. Select one of the available templates and click **Edit Name**.



3. Modify the name of the template in the **Template Name** text box.



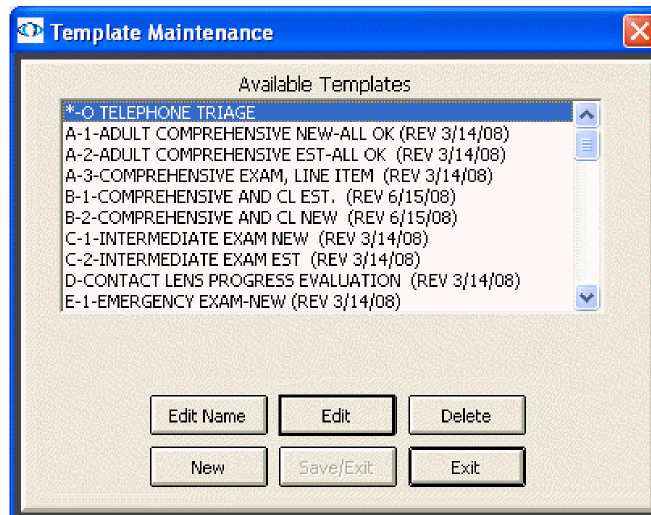
4. Click **Save/Exit** to close the Template Maintenance window.

▶ To modify an existing ExamWRITER template

1. On the ExamWRITER main window, click **Tools** and select **Template Maintenance**.

   The Template Maintenance window opens.

2. Select one of the available templates and click **Edit**.



   The template opens.

3. Add default exam information to the blank template using the instructions in "Creating & Opening Exam Records" on page 145.

4. Click the **X** in the top right corner of the window to save and close the template.

Customizing Exam Data, Exam Text, & Auto Letter Sequences

For more information on customizing exam data, watch the "Templates" and "Menu Editor" videos.

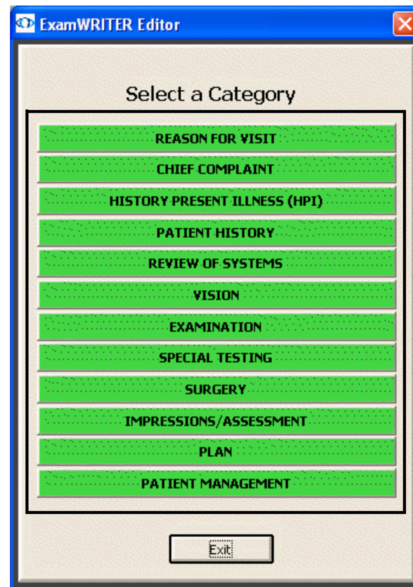
1. On the OfficeMate Administration main window, click **Setup**, select **ExamWRITER**, and select **Menu Editor**.

   OR

   On the ExamWRITER Administration main window, click **Activities** and select **Menu Editor**.

   The ExamWRITER Editor window opens.

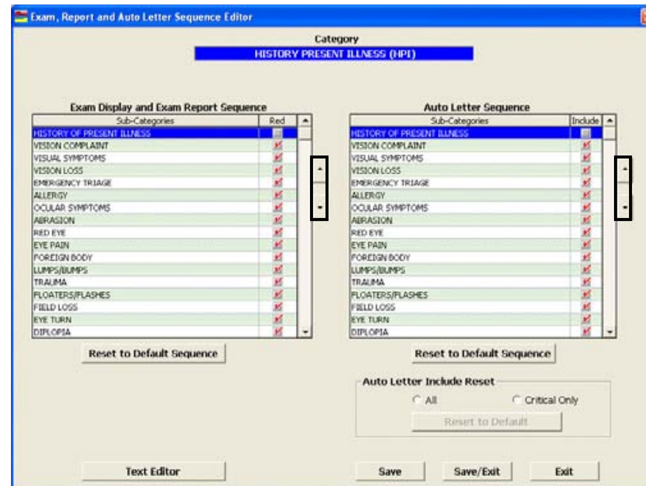
2. Select the category in which you want to customize exam data and auto letter sequences.



The Exam, Report and Auto Letter Sequences Editor window opens.

3. Modify the sequence of exams and auto letters using the arrow buttons on the right side of the Exam Display and Exam Report Sequence box and Auto Letter Sequence box.

NOTES	• You can only resequence subcategories within a selected category. • Editing subcategory sequences only modifies subcategories in current and new exams; resequencing modifications will *not* be visible in previous exams.



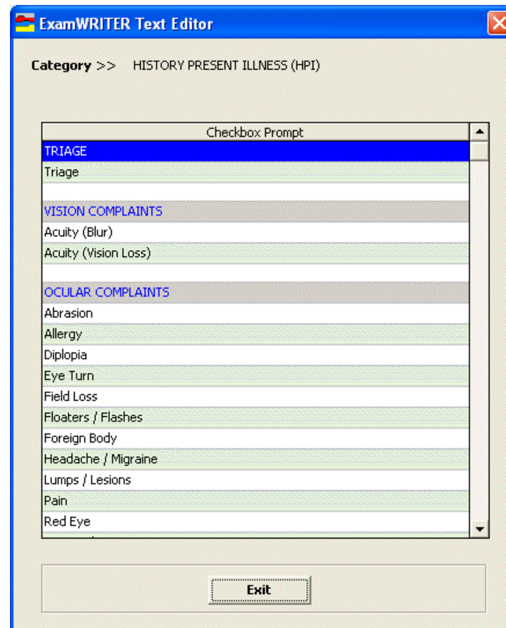
4. Select the **Red** check boxes in the Exam Display and Exam Report Sequence box to display subcategories in red text on the ExamWRITER chart window.
5. Deselect the **Include** check boxes in the Auto Letter Sequence box to exclude data from auto letters.

NOTES	• Click the **Reset to Default Sequence** buttons to reset the Include and Red check boxes to the default settings. • Select the appropriate **Auto Letter Include Reset** radio button to print all exam information or only critical exam information. The default format is Critical Only. Printing critical information will only print medical information in the category that appears in red text in the exam record.

6. Click **Text Editor** to customize descriptive exam text; otherwise, go to step 11.

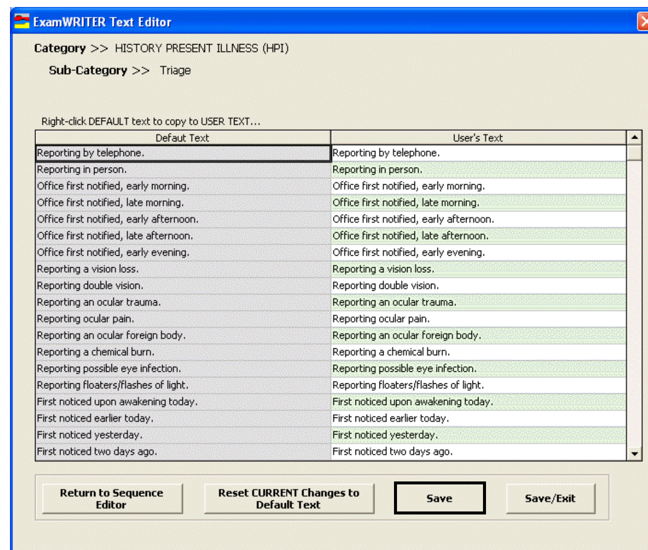
   The ExamWRITER Text Editor window opens.

7. Double-click a subcategory to customize the exam text within the category.



8. Double-click on a string of User's Text, modify the text, and click **Save**.

> **NOTES**
>
> - Modifying text within subcategories does not alter check box prompts in ExamWRITER windows; instead, it populates the Expanded Description text box in ExamWRITER windows with your modified subcategory text.
> - Editing text within subcategories only modifies text in current and new exams; text modifications will *not* be visible in previous exams.
> - Right-click on a string of Default Text and select **Copy Default Text** to copy the default text to the User's Text.
> - Click **Reset CURRENT Changes to Default Text** to reset the sequences to the default settings prior to clicking Save or Save/Exit. After you save the text, you cannot reset the modified text back to your default text.
> - Click **Return to Sequence Editor** to return to the Exam, Report and Auto Letter Sequence Editor window.



9. Click **Save/Exit** to close the ExamWRITER Text Editor window.
10. Double-click on another subcategory in the ExamWRITER Text Editor window and repeat step 8 and step 9 or click **Exit** to close the window.
11. Click **Save/Exit** to close the Exam, Report and Auto Letter Sequence Editor window.
12. Click **Exit** to close the ExamWRITER Editor window.
13. Close and reopen ExamWRITER to view your changes in the ExamWRITER chart window.

Using the Task Manager

You can create, track, and assign tasks to specific providers and staff members in ExamWRITER. If you record an exam with surgery, examination, test, consult, or laboratory orders and schedule an examination, the scheduled orders are displayed in the Orders To Be Scheduled window, which you can then post to the Task Manager. This section tells you how to use the Task Manager, including how

- To open the Task Manager, 96
- To add new tasks, 96
- To post scheduling tasks recorded in ExamWRITER, 97
- To update tasks, 98
- To change the date of tasks, 98
- To record completed tasks, 98
- To record open tasks, 99
- To delete tasks, 99
- To print the task list, 99

For more information on using the Task Manager, watch the "Task Manager" video.

▶ To open the Task Manager

❖ On the ExamWRITER main window, click **Task Manager** or press **F7** anywhere in ExamWRITER.

The Task Manager window opens.

NOTES

- Click **Refresh** to refresh the Task Manager.
- To sort the columns in the Task Manager, click the column headings.
- To display the tasks assigned to inactive users, ensure that the Allow Full Access to Task Manager check box is selected in the User Security window and select Show Inactive in the Task Manager. For more information on customizing security preferences, go to "Setting Up Preferences" on page 66.

▶ To add new tasks

1. Open the Task Manager window. For more information on opening the Task Manager, go to "To open the Task Manager" on page 96.
2. Click **New Task**.

   The New Task window opens.
3. Select a provider or staff member to whom you want to assign and send the task from the **Send To** drop-down menu.
4. Type or select a date for the task from the **Action date** field.
5. Type a task in the **Subject** text box.
6. Select a priority from the **Priority** drop-down menu.
7. Select the status (open or completed) of the task from the **Task Status Group** drop-down menu.

8. Type notes in the **Notes** text box, if necessary.

9. Click **Save**.

   After a task is assigned to a specific provider or staff member, the task is visible in the Task Manager window when the provider or staff member logs into ExamWRITER.

NOTE	To refresh the Task Manager after creating a task, click Refresh.

▶ To post scheduling tasks recorded in ExamWRITER

If you record an exam with surgery, examination, test, consult, or laboratory orders and schedule an examination, the scheduled orders are displayed in the Orders To Be Scheduled window in the Task Manager.

1. Open the Task Manager window. For more information on opening the Task Manager, go to "To open the Task Manager" on page 96.
2. Select the provider or staff member who you want to schedule the orders from the Send to drop-down menu.
3. Select the orders to schedule.
4. Click **Post**.

▶ To update tasks

1. Open the Task Manager window. For more information on opening the Task Manager, go to “To open the Task Manager” on page 96.
2. Select a task and click **Edit**.
3. Click **Forward** to forward the task to a new user, if desired.

   The From field displays the current user and the Send To field is blank.
4. Edit the task using steps 4–9 in “To add new tasks” on page 96.

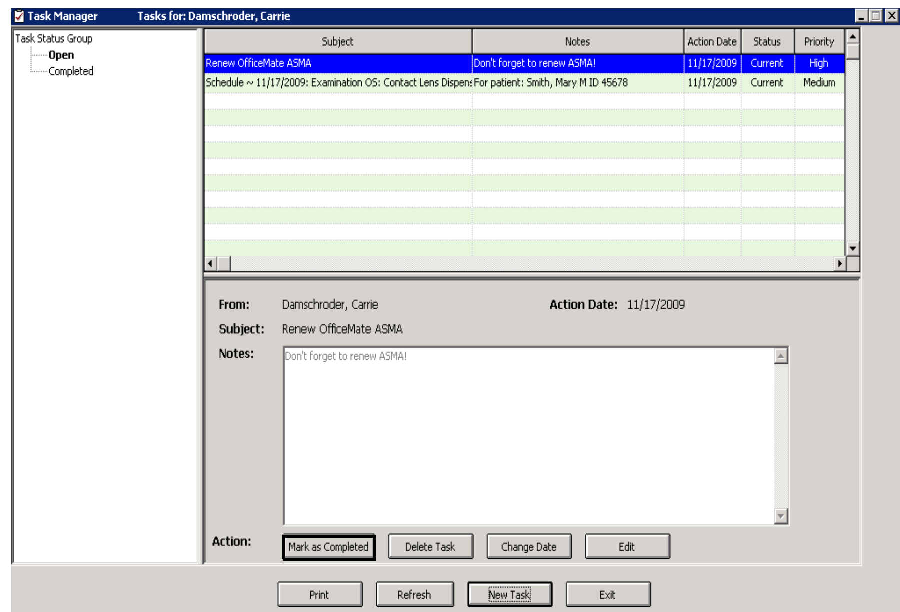
NOTE	To refresh the Task Manager after updating a task, click Refresh.

▶ To change the date of tasks

1. Open the Task Manager window. For more information on opening the Task Manager, go to “To open the Task Manager” on page 96.
2. Select a task.
3. Click **Change Date**.
4. Select a new date from the calendar and click **OK**.

▶ To record completed tasks

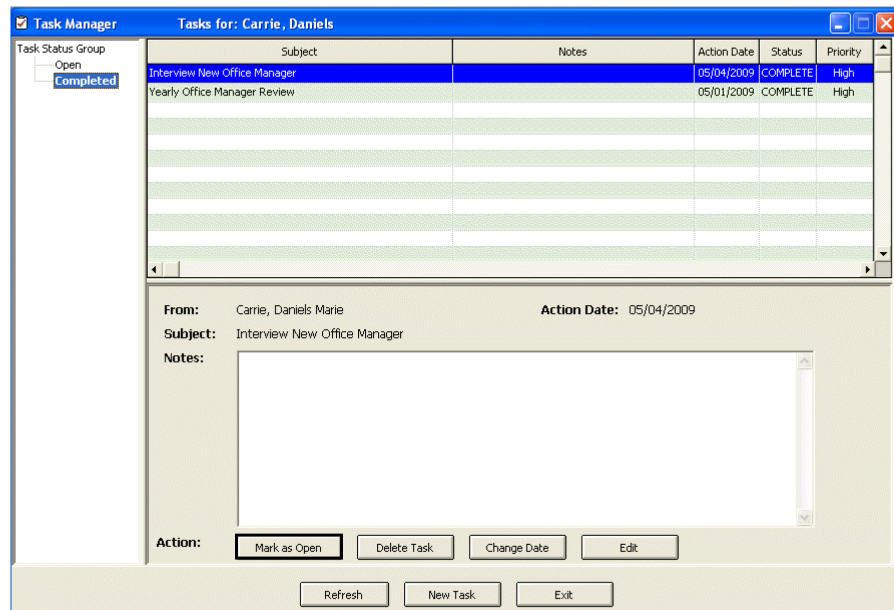
1. Open the Task Manager window. For more information on opening the Task Manager, go to “To open the Task Manager” on page 96.
2. Ensure that you are viewing the Open tasks.
3. Select an open task in the table.
4. Click **Mark as Completed**.



The task is moved from the Open tasks table to the Completed tasks table.

▶ To record open tasks

1. Open the Task Manager window. For more information on opening the Task Manager, go to “To open the Task Manager” on page 96.
2. Ensure that you are viewing the Completed tasks.
3. Select a completed task in the table.
4. Click **Mark as Open**.



The task is moved from the Completed tasks table to the Open tasks table.

▶ To delete tasks

1. Open the Task Manager window. For more information on opening the Task Manager, go to “To open the Task Manager” on page 96.
2. Select a task.
3. Click **Delete Task**.

   The Confirm Delete window opens.
4. Click **Yes**.

▶ To print the task list

1. Open the Task Manager window. For more information on opening the Task Manager, go to “To open the Task Manager” on page 96.
2. Click **Print**.

Using the Quick List

You can use the Quick List to view and access patient demographic and exam information. Patients are added to the Quick List each time you open their exams, when their appointments are scheduled on the current day, or when you modify their information in the Patient Information Center or Patient Demographics window on the current day. The Quick List can be very beneficial to network users

because every time a patient's record is accessed at one computer, it is added to the Quick List and can be accessed at other computers in the network. This section tells you how to use the Quick List, including how

- To open the Quick List, 100
- To add patients to the Quick List, 101
- To use the Quick List, 101
- To delete patients from the Quick List, 102

For more information on using the Quick List, watch the "Misc" video.

▶ To open the Quick List

Open the Quick List window using one of the following methods:

- Click the **QuickList** icon on the ExamWRITER chart window.
- Click **Tools** on the ExamWRITER main window toolbar and select **Show Patient Quick List**.

  The Quick List window opens.

NOTES

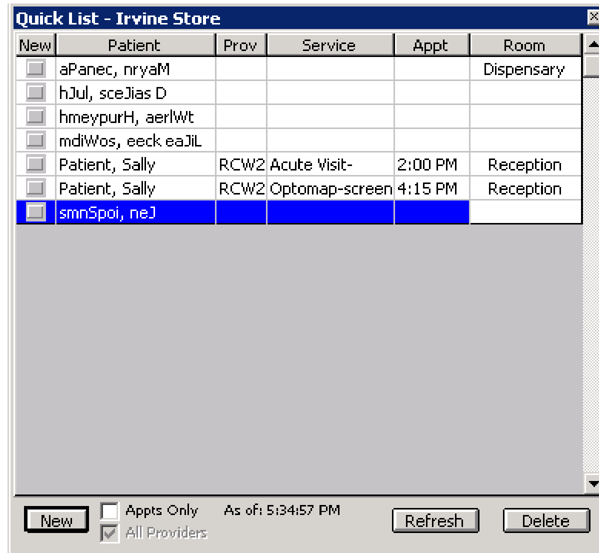
- The Quick List that is visible on the ExamWRITER chart window is for viewing purposes *only*; you cannot modify patient demographic information or create new exams from the Quick List in the ExamWRITER chart window.
- If you want the Quick List to display automatically when you open ExamWRITER, select the **Yes** radio button next to the Show Patient Quick List default system preference. For more information on modifying default ExamWRITER preferences, go to "To set up default preferences" on page 69.
- To sort the list by patient, phone number, or appointment, click on the column headings.
- When a patient's exam has been closed or finalized, the Room column automatically displays the text "CLOSED."
- The Prov column displays the provider's initials and provider ID (which is also displayed in the ID # box next to the provider's name on the Provider/Staff tab on the Business Names window).
- Although the Quick List automatically refreshes, you can click **Refresh** to refresh the Quick List manually.
- To display patients with appointments only, select the **Appts Only** check box and click **Refresh**.
- To display patients who are assigned to all providers, select the **All Providers** check box. To display patients who are assigned only to the provider logged into ExamWRITER, deselect the **All Providers** check box. The **All Providers** check box is *only* active when a provider is logged into ExamWRITER. Staff members logged into ExamWRITER will see all providers listed in the Quick List.

▶ To add patients to the Quick List

1. Click **Tools** on the ExamWRITER main window toolbar and select **Show Patient Quick List**.

   The Quick List window opens.

2. Click **New**.



   The Patient Demographic window opens.

3. Use the instructions in "To add new patient demographic information" on page 115 to add a new patient record.

   The patient appears in the Quick List after you click **OK** on the Patient Demographic window.

▶ To use the Quick List

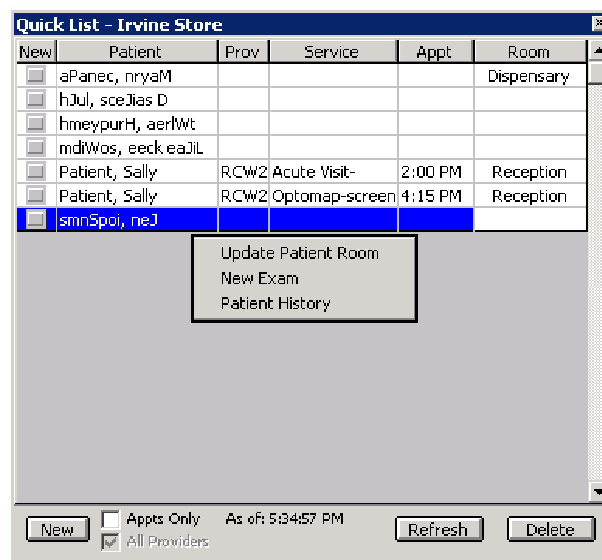
Use the Quick List in one of the following ways:

- Click on a patient's name in the Quick List window and drag and drop the patient on the **F2 - Find** button, **Last Name** text box, or **First** text box on the

ExamWRITER Control Center to populate the ExamWRITER Control Center with the patient's information.

- Drag and drop the patient on the **Patient Hx** icon on the ExamWRITER Control Center to open the Patient Information Center.
- Right-click on a patient's name and select **Patient History** to open the Patient Information Center and modify the patient's information.
- Right-click on a patient's name and select **New Exam** to begin creating a new exam record for the patient.
- Right-click on a patient's name and select **Room** to open the Patient Room window, select the room in the office where the patient is currently located, and click **Save** to denote the patient's location on the Quick List.

NOTE	To maintain a list of office room locations, open the Customization window in OfficeMate (or go to "To add and maintain list box selections (F12)" on page 10 if you are a standalone ExamWRITER user), click the **List Box Selections** tab, and modify the **Room** Entry Field Name.

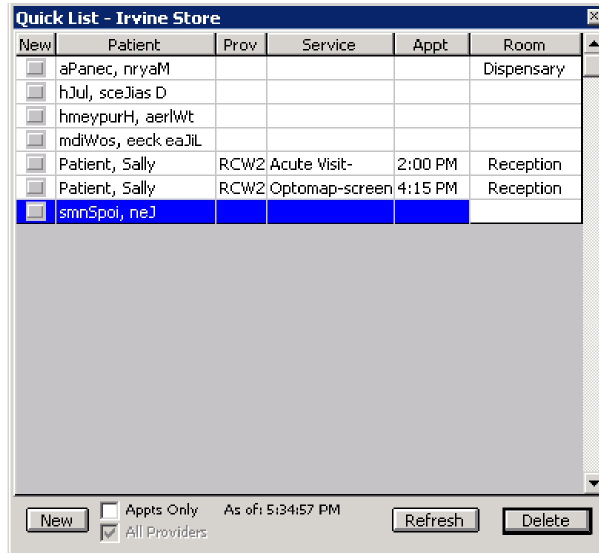


▶ To delete patients from the Quick List

1. Click **Tools** on the ExamWRITER main window toolbar and select **Show Patient Quick List**.

   The Quick List window opens.

2. Select the patient and click **Delete**.



The Remove Patient window opens.

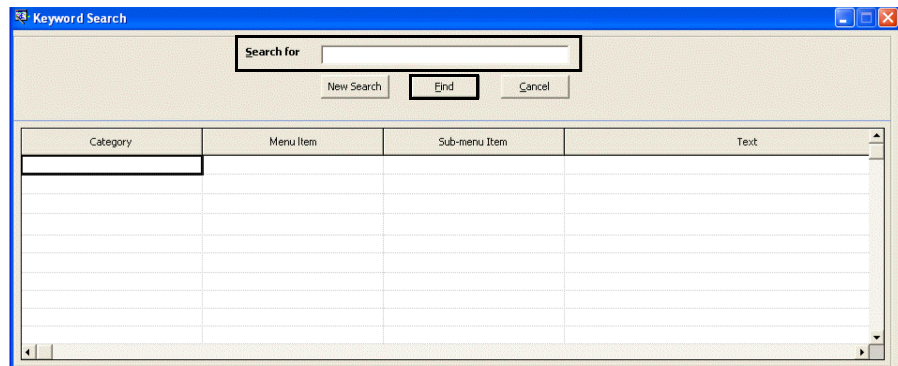
3. Click **Yes** to delete the patient from the Quick List.

Searching in ExamWRITER

1. On the ExamWRITER chart window, click the **Search** icon or press **F5**.

   The Keyword Search window opens.

2. Type the text that you want to search for in the **Search for** text box.
3. Click **Find**.



The results of your search are displayed.

4. Write down the Category, Menu Item, and Sub-menu Item of the text that you searched for and navigate to it.

NOTE	You cannot double-click on the search results to navigate to the text that you searched for. You also cannot print the search results.

5. Click **New Search** to start a new search or **Cancel** to close the Keyword Search window.

Searching for Patients & Creating Lists

For more information on searching for patients, watch the "Patient Search" video.

You can search for and create a patient list based on the following criteria: diagnosis, medication type and date, lab results, and demographics (age and gender). Search criteria can be included or excluded from the search.

1. Click **Tools** on the main window and select **Patient Search**.
2. Select your search criteria.

   You can search using any or all of these criteria: minimum/maximum age, gender, lab results, medication date, medication, diagnosis.

   To include lab results criteria, select the criteria and click **Add**. The selections will appear in the Lab Results criteria selection box.

To exclude...	Do this...
Age	Leave the default Min/Max Age values (0,99)
Medications (one or more)	Select the medication to exclude and check **NOT IN**
Medication Date	**Delete the dates** until **<Enter text here> displays**

3. Click **Search**.

   The list of patients and their data that meet the search criteria are displayed in the bottom of the window.

NOTES

- To clear all existing search criteria and return to default settings, click **Clear**. The Clear button does not clear dates from the Medication Date fields or the Medication List NOT IN box. To clear these fields, manually delete the dates and deselect the box respectively.
- To print your search results, click **Print** and select a provider. Printing your search results from your attestation period can be beneficial if you are ever audited as part of the EHR Incentive Program.

Search criteria

Search results

Setting Up Patient-specific Resources

For more information on the Reference and Guidelines window, watch the "Reference and Guidelines" and "Patient-Specific Education" videos.

You can set up and access patient-specific educational resources and links to disease management guidelines and associated material in the Reference and Guidelines window. The references you can construct include Web sites, programs, and documents that help patients keep up with the latest medical data available for their care.

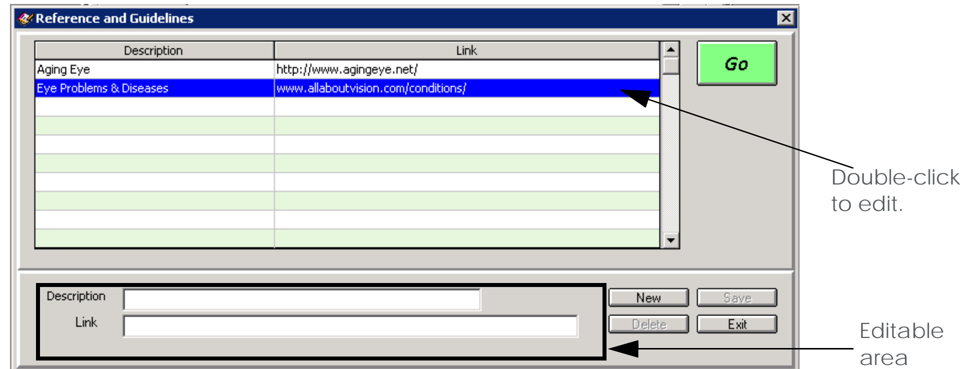
1. Print the patient's report (press **F4** from within the exam) to view a compilation of the patient's reported diagnoses and to determine the relevant educational material for the patient.
2. Click **Tools** on the main window and select **Reference and Guidelines**.

3. To add a new reference, click **New** and type a description and the Web site link.

   OR

   To modify a reference, double-click on a reference and modify the **Description** and **Link** fields.
4. Click **Save**.

To open the reference's Web site link, select the reference and click **Go**.



Setting Up Equipment Interfaces

For information about setting up and using equipment interfaces, refer to the *ExamWRITER Equipment Integration User's Guide* and watch the Equipment Integration Setup video.

If you are interested in purchasing the ExamWRITER Equipment Interface, go to www.eyefinity.com/electronic-health-records/examwriter/equipment.html to see if your diagnostic equipment is supported. For information on purchasing the equipment interface, contact Sales at 800.269.3666 or sales@eyefinity.com.

Verifying File Integrity

Protecting patients' health information through hash files helps your practice meet meaningful use criteria. To better understand meaningful use and its criteria, go to http://www.cms.gov/EHRIncentivePrograms/.

You can validate that no one has tampered with a file by generating and comparing hash values using the Process Hash File window. After you generate a hash value for a file, you can generate another hash value at a later time for the file and compare the two values. If the comparison is successful, the file is the same as the original file. If the comparison fails, the file has been changed.

This section tells you how to complete actions that validate the original contents of a file, including how

- To generate a hash value for a file
- To compare files

▶ To generate a hash value for a file

Generating a hash value for a file allows you to compare the file at a later date to verify the integrity of its contents.

1. Click **Tools** and select **Process Hash File**.

   The Process Hash File window opens.

2. Click **Browse** next to the File name to Generate Hash text box and select the file you that want to check.
3. Type a hash file name in the **Hash File Name** text box or click **Browse** and navigate to and select an existing hash file.
4. Click **Generate Hash** to create the hash value in the hash file that you specified.

   This value will also display in the Hash Value field.

5. Click **Exit** to close the Process Hash File window.

   You now have a hash value that you can compare with the current file. Go to "To compare files" on page 107 for more information.

▶ To compare files

Before you can compare files, a hash file must exist for the original file. For more information, go to "To generate a hash value for a file" on page 107.

1. Click **Tools** and select **Process Hash File**.

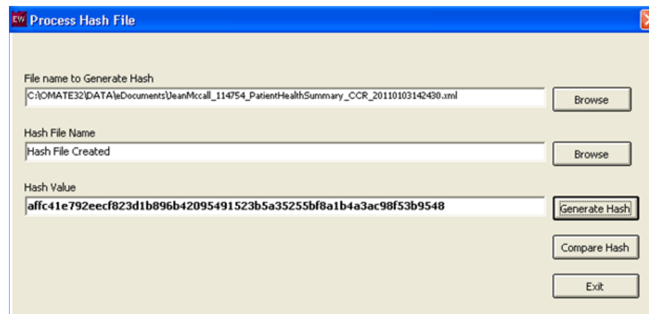
   The Process Hash File window opens.

2. Click **Browse** next to the File name to Generate Hash text box and select the file you that want to compare.
3. Click **Browse** next to the Hash File Name text box and navigate to and select an existing hash file with a hash value.
4. Click **Compare Hash**.

   A message will display at the bottom of the window indicating the success or failure of the file/hash comparison to the earlier file.

   "Compare Successful" indicates that the file is identical to when you first created the hash value for it. "Compare Failed" indicates that the new hash value created from the file does not match the earlier hash value, and the file has changed.

5. Click **Exit** to close the Process Hash File window.



Encrypting & Decrypting the Database

By default, OfficeMate/ExamWRITER encrypts patient and provider protected health information (PHI) in your database. If you need to disable or re-enable encryption, perform the following steps.

NOTE	Passwords are encrypted within the database regardless of whether the rest of the database is encrypted or not; this functionality requires no action on your part.

This section describes how

- To encrypt the database, 108
- To decrypt the database, 109

To encrypt the database

NOTES

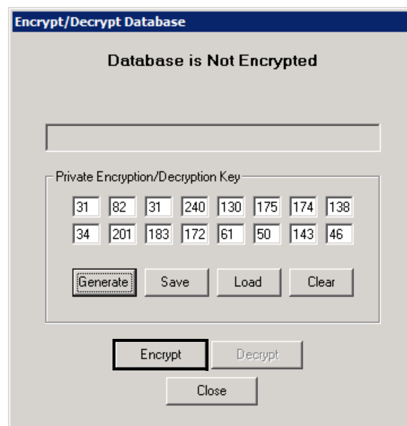
- You *must* back up your database prior to encrypting or decrypting it. If the encryption or decryption process is interrupted due to a power outage, disk failure, system error, or any other reason, the database will become irreparably damaged. Protect your practice: Back up your data!
- You cannot encrypt the database if any other users are logged in.

1. From OfficeMate Administration, click **Setup** and select **Encrypt/Decrypt Database**.

   OR

   From ExamWRITER Administration, click **Activities** and select **Encrypt/Decrypt Database**.

   The Encrypt/Decrypt Database window opens.
2. Click **Encrypt** to encrypt the database.



3. Click **Close** when the encryption process is completed.

To decrypt the database

NOTES

- You *must* back up your database prior to encrypting or decrypting it. If the encryption or decryption process is interrupted due to a power outage, disk failure, system error, or any other reason, the database will become irreparably damaged. Protect your practice: Back up your data!
- You cannot decrypt the database if any other users are logged in.

1. From OfficeMate Administration, click **Setup** and select **Encrypt/Decrypt Database**.

   OR

   From ExamWRITER Administration, click **Activities** and select **Encrypt/Decrypt Database**.

   The Encrypt/Decrypt Database window opens.
2. Click **Decrypt** to decrypt the database.
3. Click **Close** when the decryption process is completed.

Auditing Activities

The Audit Log Review window is a feature of that allows you to view the activities of the OfficeMate and ExamWRITER users in your practice, to track changes made to a particular patient's record, or view changes made to a specific exam. This section explains how

- Managing Auditable Transactions, 109
- Viewing & Printing Audit Logs, 110
- Understanding the Audit Log, 111

Managing Auditable Transactions

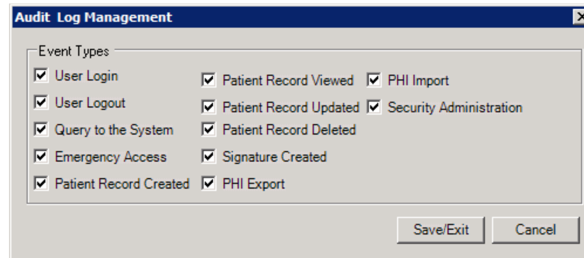
1. From OfficeMate Administration, click **Setup** and select **Audit Log Management**.

   OR

   From ExamWRITER Administration, click **Activities** and select **Audit Log Management**.

   The Audit Log Management window opens.

2. Select only the check boxes that correspond to the types of transactions that are important to your practice and deselect those that are unimportant.



NOTE

- Deselecting check boxes disables an audit trail from being created, and those transactions will not be auditable.
- Select only those transactions for which auditing is important to your practice. Each transaction that you select adds to the size of your database as each occurrence is recorded and timestamped.

3. Click **Save/Exit**.

Viewing & Printing Audit Logs

1. From OfficeMate Administration, click **Setup** and select **Audit Log Review**.

   OR

   From ExamWRITER Administration, click **Activities** and select **Audit Log Review**.

   The Audit Log Review window opens.

2. Select only the check boxes that correspond to the types of transactions that are important to your practice and deselect those that are unimportant.
3. Narrow your search results by typing or selecting the beginning and ending dates and times in the **Start Time** and **End Time** fields, as needed.
4. To see the activity of a specific user, type the user ID in the **User ID (Number)** text box. To determine the user ID, look at the Provider ID or Id# field on the Resource Setup window.
5. To see the activity on a specific patient, type the patient ID in the Patient ID (Number) text box. To determine the patient ID, look at the Patient ID field on the Patient Center window.
6. To see the activity on a specific exam, type the exam number in the Exam ID (Number) text box. To determine the exam number, look at the Exam History tab on the Patient Center window.
7. To see a specific type of activity, select an activity from the **Event Type** drop-down menu.
8. Narrow your search results by the completion or attempt of transactions:
   - Select the **Success** radio button to see only successfully completed transactions.
   - Select the **Failure** radio button to see only attempted transactions.
   - Select the **All** radio button to see all transactions.

9. Click **Search** to display the audit log transactions that match the search criteria. For a description of the information displayed in the audit log, go to "Understanding the Audit Log" on page 111.
10. Perform the following steps as needed:
    - Double-click an entry to view it in the Audit Log Entry window.
    - Click any column heading to sort in ascending order. Click twice to sort in descending order.
    - Click **Print** to print the audit log search results, as needed.
11. To verify that an audit log entry has not been tampered or forged, perform the following steps:
    a. Double-click an entry to view it in the Audit Log Entry window.
    b. Click **Validate**.

    ExamWRITER validates the information in the entry against the log hash file and displays true if the entry is valid or false if it appears the entry has been altered.

    c. Click **OK** to close the Integrity Check window.
    d. Click **Close** to close the Audit Log Entry window.

Understanding the Audit Log

Since the audit log offers a glimpse into transactions that are recorded in the OfficeMate/ExamWRITER database, some explanation is required in order for you to understand the information displayed in the audit log results.

Column	Description
logID	The log identification number. Each logged activity is recorded and number sequentially.
logTime	The date and time of the transaction.

Column	Description
userID	The provider or staff identification number. ExamWRITER assigns an ID number sequentially as each provider or staff member as they are added to the Resource Setup window. Cross-reference ID numbers in the Audit Log with the ID numbers in the Resources Setup window.
clientIP	The IP or IPv6 address of the workstation used to complete the transaction.
clientName	The name of the workstation used to complete the transaction.
eventTypeID	The identification number of the type of transaction performed. Refer to the next column for a description of the transaction.
eventDescription	A description of the transaction performed.
patientID	The patient identification number. ExamWRITER assigns an ID number sequentially as each patient as they are added to the Patient Demographics window. Cross-reference ID numbers in the Audit Log with the ID numbers in the Patient Center window. The Patient ID is 0 if the transaction did not involve a patient record.
examID	The exam number or chart number.ExamWRITER assigns an ID number sequentially as each exam is created. Cross-reference ID numbers in the Audit Log with the ID numbers in the Control Center window in ExamWRITER. The Exam ID is 0 if the transaction did not involve an exam.
description	A short description of the transaction including the name of the person completing the transaction and the name of the patient if applicable.
Result	A check mark means the transaction was completed successfully.
logHash	A string of characters that ExamWRITER uses to validate the integrity of the log entry.

Logging Out of ExamWRITER

1. Close any open windows within ExamWRITER.
2. Click **Logout** on the ExamWRITER main window toolbar.

   You are now logged out of ExamWRITER. The ExamWRITER Login window opens so that a new user can log into ExamWRITER.

Modifying & Viewing Patient Information

2

In this chapter:

- Modifying & Viewing Patient Demographic Information, 113
- Creating Clinical Decision Support Rules & Patient Alerts, 117
- Viewing Exam History & Recording Patient Referrals to Other Providers, 120
- Viewing Glaucoma Elements, 122
- Viewing & Refilling Prescriptions, 124
- Viewing Spectacle Prescriptions, 125
- Viewing Contact Lens Prescriptions, 126
- Attaching Electronic Documents to Patient Records, 127
- Using Microsoft HealthVault, 131
- Creating Clinical Summary Documents, 136
- Viewing Correspondence History, 137
- Viewing Vital Signs, 138
- Printing Patient Welcome Forms, 139
- Recording Lab Results, 140
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NOTE To add a new patient to ExamWRITER, go to "Modifying & Viewing Patient Demographic Information" on page 113.

Modifying & Viewing Patient Demographic Information

This section tells you how to modify and view patient demographic information in ExamWRITER, including how

- To maintain patient demographic information, 114
- To add new patient demographic information, 115
- To modify & view demographic information in the Patient Information Center, 116

NOTE If you are an OfficeMate user, any modifications or additions that you make to patient demographic information in ExamWRITER will be reflected in OfficeMate. Likewise, any modifications or additions that you make to patient demographic information in OfficeMate will be reflected in ExamWRITER.

For more information on maintaining patient demographic information, watch the "Tools" video.

▶ To maintain patient demographic information

1. On the ExamWRITER main window, click **Tools** and select **Patient Demographic Maintenance**.

   The Find Patient/Guarantor window opens.

2. Enter text into the **Selection Criteria** text boxes to search for a patient.
3. Select the Include Inactive check box to include inactive patients and guarantors in the search results.
4. Select the **Include Other** check box to include the names of people who are neither patients nor guarantors, but are recorded in the database as other insured parties.
5. Click **F2 Find**.

NOTE	If your database is encrypted, PHI (protected health information) will be greyed out and not visible when you are searching for patients.

   A list of patients meeting your selection criteria is displayed.

NOTE	Click **Clear** to clear your search and start over.

6. Double-click on the patient that you want to modify.

   OR

   Click on the patient that you want to modify and click **Select**.

   The Patient Demographic window opens.

7. Modify the patient demographic information and click **Save/Exit**.

To add new patient demographic information

For more adding new patient demographic information, watch the "Tools" video.

1. On the ExamWRITER main window, click **Tools** and select **Patient Demographic Maintenance**.

   The Find Patient/Guarantor window opens.

2. Click **New**.

   The Patient Demographic window opens.

3. Type the new patient demographic information into the text boxes.

4. Click **Save/Exit**.

▶ To modify & view demographic information in the Patient Information Center

For more information on modifying patient demographic information, watch the "Patient Hx" video.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.

NOTE	If you have documented in OfficeMate that the patient's identity may have been stolen, a red "RFR" (Red Flags Rule) box appears in the upper right corner of the window to quickly indicate to you the identity theft status of the patient's security and identity information. This feature complies with the Federal Trade Commission (FTC) and the Nation Credit Union Administration (NCUA) to ensure the security and confidentially of your patients' information. Refer to the *OfficeMate User's Guide* to set up the Safeguard - Red Flags Rule feature. For additional information on the Red Flags Rule, watch the "Red Flag Rules Use" video.

2. Modify the patient demographic information in the text boxes, type notes in the **Notes** text box, and type medical alerts in the **Alert** text box, if desired.

For more information on photos and alerts watch the "Misc" video.

NOTE	Attach patient photos to patient records in the Patient Center in OfficeMate Administration.

3. Click **Save** to save modified information.

4. Click **Exit** to close the Patient Information Center window.

Creating Clinical Decision Support Rules & Patient Alerts

Implementing clinical decision support rules and tracking compliance with those rules helps your practice meet meaningful use criteria. To better understand meaningful use and its criteria, go to http://www.cms.gov/EHRIncentivePrograms/.

For more information on clinical decision support rules and patient alerts, watch the "Clinical Decision Support Setup" video.

When you finalize an exam, an alert can prompt you to take an action if the exam meets a condition (Clinical Decision Support or CDS rule). For information on how to finalize individual or multiple exams, go to "Finalizing EMRs" on page 379.

To set up an alert, set up a condition for the alert at the Clinical Decision Support Setup window. A condition consists of one or more criteria, such as a diagnosis code, and a requirement or action, such as patient education. If the criteria match a patient's problem list, medication list, demographics, or laboratory test results, the Patient Alert window opens when you finalize the exam.

NOTE	After upgrading to ExamWRITER 12.0, you must edit any ExamWRITER Clinical Decision Support templates that you created that contain ICD-9 codes and update them to include appropriate ICD-10 codes, instead. You do *not* need to edit any ExamWRITER Clinical Decision Support templates that Eyefinity created and that were provided to you within the program; those templates have already been updated to include appropriate ICD-10 codes.

1. Click Tools and select **Clinical Decision Support Setup**.

   The Clinical Decision Support Setup window opens.
2. To create a new condition, click **New** and type a name in the **Condition Name text box.**
3. Record one or more criteria.

NOTES	• Recording multiple criteria for a condition lowers the chance of receiving an alert, since the exam has to meet all of the criteria. Creating multiple conditions, each with fewer criteria, increases the chance of meeting criteria. • To clear all fields, click **Cancel**.
4. Type a requirement in the **Requirement** text box, such as an action to take.
5. Type a link to a link to a Web site, if desired.

6. Click **Save and Exit to save the condition and close the window**.

   After you create a condition, it is available from the Condition drop-down menu.

NOTE	To delete a condition, select the condition from the Condition drop-down menu and click **Delete**.

After you set up one or more conditions, if the patient's exam meets any of them, the Patient Alert window opens. If the exam meets multiple conditions, you will receive multiple alerts. Click **Go** to access any Web site listed, or click **OK** or **Next Alert**.

Viewing Exam History & Recording Patient Referrals to Other Providers

For more information on viewing exam history, watch the "Patient Hx" video.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.

2. Click the **Exam Hx** tab to view the patient's family members' exam history and the patient's exam history.

After recording referring provider information on the Exam Hx tab, you can create and print the Refer To Doctor Tracking report in OfficeMate that displays a list of patients to whom you have referred to other doctors, their referring provider, the doctor to whom you referred them, the date referred, and the expected and actual return dates.

NOTES

- The patient's family members' exam history is only available if you are an OfficeMate user and if the patient and his or her family members have OfficeMate patient records.
- If you have diagnosis codes recorded in previous exams that are outdated and no longer appear on the Diagnosis Codes tab on the Customization window, they will not appear in the Diagnosis/Problem List on the Patient Information Center window.
- To display PQRS procedure codes in the Procedures Performed table and keep track of PQRS reporting, select the **Show PQRI** check box.
- Click the **Info** buttons to view information from MedlinePlus Connect about the selected diagnosis codes.

3. To maintain the patient's problem list and add ICD-9 or ICD-10 codes documenting the patient's existing diagnoses, click **Maintain Problem List** and follow the instructions below:
   a. Search for a diagnosis code and double-click on it in the Diagnosis table.
   b. Record the diagnosis date, status, and status date.
   c. Click **Save** to add the diagnosis code to the Current Problem List table.
   d. Click **Save/Exit** to save the problem list and exit Problem List Maintenance window.

NOTES

- To delete an existing diagnosis code, select it from the Current Problem List table and click **Delete**.
- To modify the status of an existing diagnosis code, select it from the Current Problem List table, select a new status from the **Status** drop-down menu, select a status date from the Status date calendar, click **Save**, and then click **Save/Exit**.

Problem List Maintenance

Diagnosis code ICD-9 ICD-10
Search by: Code Desc.

ICD-9/10	Diagnosis
G43.D1	Abdominal migraine, intractable
G43.D0	Abdominal migraine, not intractable
H53.61	Abnormal dark adaptation curve
R25.0	Abnormal head movements
H02.516	Abnormal innervation syndrome left eye, unspecified eyelid
H02.515	Abnormal innervation syndrome left lower eyelid
H02.514	Abnormal innervation syndrome left upper eyelid
H02.513	Abnormal innervation syndrome right eye, unspecified eyelid
H02.512	Abnormal innervation syndrome right lower eyelid

Diagnosis H53.61 Abnormal dark adaptation curve
SNOMED
Diagnosis Date 03/24/2015 Exam
Status Active Status Date 03/24/2015
Save Delete Cancel

Current Problem List

ICD-9/10	SNOMED	Diagnosis	Onset	Status	Date
H18.059		Posterior corneal pigmentations, unspecified eye		Active	
H21.239		Degeneration of iris (pigmentary), unspecified eye		Active	
H40.1391		Pigmentary glaucoma, unspecified eye, mild stage		Active	
H35.352		Cystoid macular degeneration, left eye		Active	
H35.353		Cystoid macular degeneration, bilateral		Active	
H52.02		Hypermetropia, left eye		Active	
H52.11		Myopia, right eye		Active	
H52.4		Presbyopia		Active	

Save/Exit Exit

4. To record or update patient referral information, click **New Referral** or double-click on an existing referral and follow the instructions below:
   a. If you are recording a new referral, select the **Referring Provider**, **Refer to Provider**, **Reason**, **SNOMED**, **Referral Date**, and **Expected return date**.
   b. If you are updating an existing referral, select the **Actual return date** and select the **Specialist report received** check box.
   c. Click **Save**.
   d. If you want to save the patient's record to transmit later through secure messaging, click **Create CDA Transition of Care** and click **Exit**.

Patient Referral
Referring Provider: Dayton, Jr. O.D., Dan
Refer to Provider: Corneal Associates of Texas, — Maintain
Reason: Corneal consult
SNOMED: 183879000 — Private referral to ophthalmologist (procedure)
Referral Date: 04/12/2017
Expected return date: 04/26/2017
Actual return date — Create CDA Transition of Care — Specialist report received
Save — Delete — Exit

NOTE	To send the clinical summary, click the **eDocuments** tab, select the **CDA Export - Transition of Care** from the list of eDocuments. Select the **Provider** radio button and click **Secure Send**. The Secure Message window opens. Type the provider's email address or select it from the drop-down menu, type a Subject, and type a message, and click **Send**. Your message and the patient's CDA are sent securely.

5. Click **Exit** to close the Patient Information Center window.

Viewing Glaucoma Elements

For more information on viewing Glaucoma elements, watch the "Patient Hx" video.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.
2. Click the **Glaucoma Elements** tab.
3. Click the **Enter Hx** buttons to record historical Glaucoma elements. For information on recording these elements, go to "Recording & Modifying Target IOP Measurements" on page 271, "Recording & Modifying

Pachymetry Measurements” on page 272, and “Recording & Modifying Cup Disc Ratio Measurements” on page 274.

NOTES	
	• You cannot record pachymetry, CD ratio, and IOP observations after clicking the **Enter Hx** buttons on the Glaucoma Elements tab. To record observations for these elements, you must be in the patient’s exam record. • To delete a Glaucoma element value, right-click on it and click **Yes**. If you delete historical Glaucoma elements from the Patient Information Center, they will also be deleted in final exams.

4. Click the **Show Graph** buttons to view pachymetry, CD ratio, and intra-ocular pressure graphs.

NOTES	
	• The intra-ocular pressure graph is the default graph that is displayed. • You can only view graphical intra-ocular pressure measurement histories for Examination tests. You cannot view graphical intra-ocular pressure measurement histories for Pre-Test and Post-Dilation tests. • Click the **Copy to clipboard** icon to copy the Glaucoma element graph displayed to the clipboard and paste it into another document; click the **Print Preview** icon to preview the printed version of the graph; and click the **Print** icon to print the graph.

5. Click **Exit** to close the Patient Information Center window.

Viewing & Refilling Prescriptions

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.

2. Click the **Med/Surgical Hx** tab.

NOTE	To mark or unmark a medication or allergen as being discontinued, right-click on the medication or allergen in the Medication History, Medical Hx, Surgical Hx, Ocular Hx, or Ocular Surgical Hx table and select **Discontinue** or **Remove Discontinue**. Select a date from the **Date Discontinued** calendar and click **Save**. The discontinued date appears in the Date column in the Medication History window. You can also mark medications and allergens as being discontinued from the Patient Systemic Medications and Allergies, Patient Ocular Medications and Allergies, and Patient Allergens windows. For more information on marking medications as being discontinued from these windows, go to “Recording Patient History Information” on page 167.

3. Select the radio buttons above the Medication and Allergy History table to specify the amount and type of information you want to see in the table, such as to view all medications, view only medications or allergens, or view all or only active/inactive statuses.

4. Right-click on a current therapeutic Rx or click **Refill** to open the Medication Order window and refill a prescription. For more information on writing and refilling prescriptions, go to “Writing Medication Prescriptions” on page 291.

5. Click **Exit** to close the Patient Information Center window.

Viewing Spectacle Prescriptions

For more information on viewing spectacle prescriptions, watch the "Patient Hx" video.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.
2. Click the **Spectacle Rx** tab.
3. Select **Show ALL** to display all spectacle prescriptions or **Rx type** to display spectacle prescriptions by the Rx type from the Display Options radio buttons.
4. Select a prescription type from the **Select Rx type** drop-down menu.

NOTES

- To create a lab order (if one has not already been created) for a finalized exam, right-click on a finalized exam final or alternate Rx and select **Create Lab Order**. An addendum is created in the finalized exam noting that you have created a lab order.
- To successfully create a lab order for a finalized exam, you must open the Patient Information from the ExamWRITER Control Center (*not* from within an exam).

5. Click **Exit** to close the Patient Information Center window.

Viewing Contact Lens Prescriptions

For more information on viewing contact lens prescriptions, watch the "Patient Hx" video.

6. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.
7. Click the **Contact Lens Rx** tab.
8. Select a prescription type from the **Select Rx type** drop-down menu.
9. Select the **Show ALL** or **Rx type** Display Options radio button to display all contact lens prescriptions or display a specific type of prescription.
10. If you selected the Rx type Display Options radio button, select a prescription type from the **Select Rx type** drop-down menu.

NOTES

- To create a lab order (if one has not already been created) for a finalized exam, right-click on a finalized exam final or trial Rx and select **Create Lab Order**. An addendum is created in the finalized exam noting that you have created a lab order.
- To successfully create a lab order for a finalized exam, you must open the Patient Information from the ExamWRITER Control Center (*not* from within an exam).

11. Click **Exit** to close the Patient Information Center window.

Attaching Electronic Documents to Patient Records

NOTES

- In addition to attaching electronic documents to patient records in the Patient Information Center, you can also add, edit, delete, view, and print a list of electronic documents attached to a patient's exam record by clicking the **Images - Drawings** tab and then clicking the **Images, Drawing and Graphic** category bar on the ExamWRITER chart window.
- For information about sending clinical summaries to patients, go to "Giving Patients Access to their Clinical Data" on page 341.
- For information about sending clinical summaries to other providers, go to "Sending Clinical Information to Another Provider" on page 353.
- The following information pertains to ECR Vault users:
  - To scan documents, open the Patient Demographic window and click **ECR Scan** (or press **F9**) to open the ECR Capture window. For more information about scanning documents, refer to the *ECR Vault User's Guide*.
  - To search for and view documents, open the Patient Demographic window and click **ECR Retrieve** (or press **F10**) to open the ECR Vault Client window. For more information about searching for and viewing documents, refer to the *ECR Vault User's Guide*.
  - To locate the *ECR Vault User's Guide*, click **Start**, select **Programs**, select **Comsquared**, select **ECR Vault**, and select **ECR Vault User Guide.pdf**.

For more information on using eDocuments, watch the "Patient Hx" video.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.
2. Click the **eDocuments** tab.

3. Select the **All Exams** or **This Exam Only** Display Documents from radio button and click **Show eDocs** to display electronic documents from all exams or from the current exam only.

NOTES	• Double-click on a document to view or edit it. • To edit a document's information, select the document, click **Edit**, and review steps 5-10 below. • To delete an electronic document, select the document and click **Delete**. • To print a list of the patient's electronic documents, click **Print List**.

4. Click **Add** to add a new electronic document to the patient's record.

   The eDocuments Information window opens.

5. Select a document type from the **Document Type** drop-down menu.

NOTE	Press the **F12** key to open a **Code Maintenance** window add new items to or modify or delete existing items from the Document Type menu.

6. If you want to attach an electronic document to a specific exam record, select the **Attach Document to Exam** check box and select an exam.
7. If you want to add notes to the form, type them in the **Notes** text box.

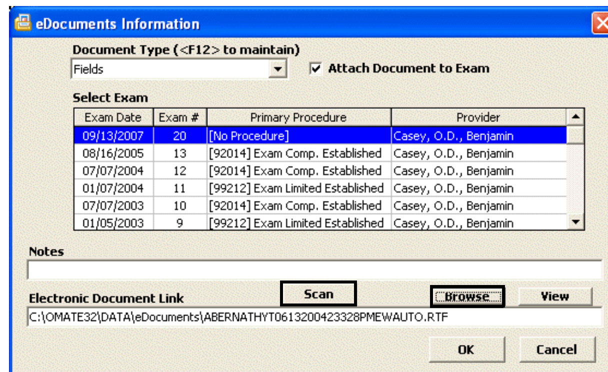
8. Click **Browse** to navigate to and select an electronic document to link to the patient’s record.

   OR

   Click **Scan** to scan documents directly into ExamWRITER and save them as an eDocument in the patient’s record.

   NOTES

   - Because all documents scanned directly into ExamWRITER must be saved as PDF files, you must have Adobe Reader installed on your computer. Go to www.adobe.com to download and install Adobe Reader for free.
   - Eyefinity does not recommend a specific scanner brand or model; you can use any scanner that can create an electronic document with the ExamWRITER eDocuments feature. For more information on scanners, go to article #000012869 in the Eyefinity Support Community, or consult your hardware technician.
   - Eyefinity does not support your hardware and highly suggests consulting your hardware technician before purchasing a scanner to use with your computer. For installation, support, and troubleshooting issues related to your scanner, contact the scanner’s manufacturer.



9. If you clicked Scan in step 8, follow the instructions below; otherwise, skip to step 10:

   a. Select the following Scan Options on the Scan Document(s) window:

      B/W if you want to scan the document in black and white.

      Greyscale if you want to scan the document in greyscale.

      Color if you want to scan the document in color.

      Duplex if you want to scan two sides of a document (and if it is supported by the scanner).

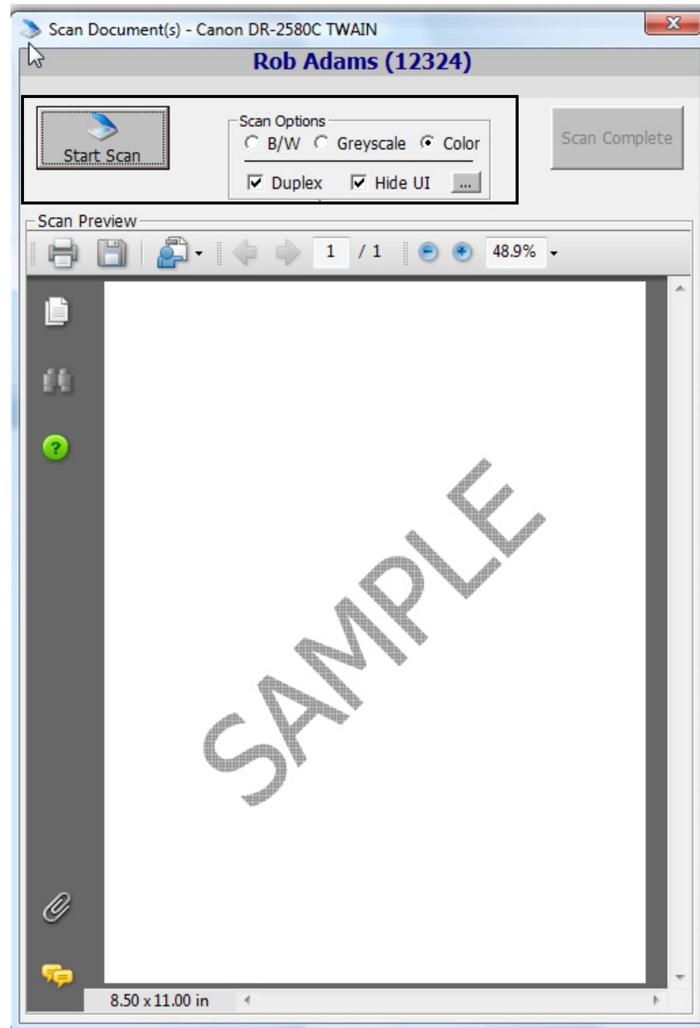
      Hide UI if you want to hide the scanner’s user interface. If you deselect this check box then the scanner’s interface will open with additional

scanning options. For information about these additional options, view the scanner's documentation.

b. Click the **...** (ellipse) button in the Scan Options box to open the Select Source window and select a scanner.

NOTE	If you select a different scanner from the one that is already displayed on the blue title bar in the Scan Document(s) window, the window will close and you will have to reopen it by clicking Scan on the eDocuments Information window.

c. Click **Start Scan** to scan the document.



d. Click **Scan Complete** after the document is finished scanning.

NOTE	Do *not* click the Save icon in the Scan Preview section of the Scan Document(s) window to save the document. You *must* click the **Scan Complete** button to properly save the document.

ExamWRITER automatically names the document using the current date

and saves it as a PDF file in the OMATE32\DATA\eDocuments or OfficeMate\DATA\eDocuments folder.

10. Click **OK**.

    Electronic documents are visible and accessible under the Images, Drawing and Graphics category bar on the Images - Drawings tab.

NOTE	The **Entered By** column is populated only if your ExamWRITER security is active.

11. Click **Exit** to close the Patient Information Center window.

Using Microsoft HealthVault

For more information on Microsoft HealthVault, go to www.HealthVault.com/Microsoft.

Microsoft HealthVault is a free service that provides a centralized place to store, access, and share a patient's health information with authorized users (patients, doctors, or others). Health information is entered by: typing, uploading, faxing, using a service, or through compatible devices.

Providing patients with timely electronic access to their health information helps your practice meet meaningful use criteria. To better understand meaningful use and its criteria, go to http://www.cms.gov/EHRIncentivePrograms/.

NOTE	If you have questions or issues with ExamWRITER's integration with Microsoft HealthVault, contact Eyefinity Customer Care at 800.269.3666 or officematesupport@eyefinity.com. Do *not* contact Microsoft Support with questions about ExamWRITER's integration with Microsoft HealthVault. If you have questions specifically about Microsoft HealthVault (and not ExamWRITER's integration with it), go to the HealthVault Solution Center, at http://support.microsoft.com/healthvault.

This section tells you how to use Microsoft HealthVault, including how

- To register your practice with Microsoft HealthVault, 131
- To register a patient with Microsoft HealthVault, 132
- To upload a patient's health information to HealthVault, 134
- To view a list of HealthVault patients that you have registered, 135

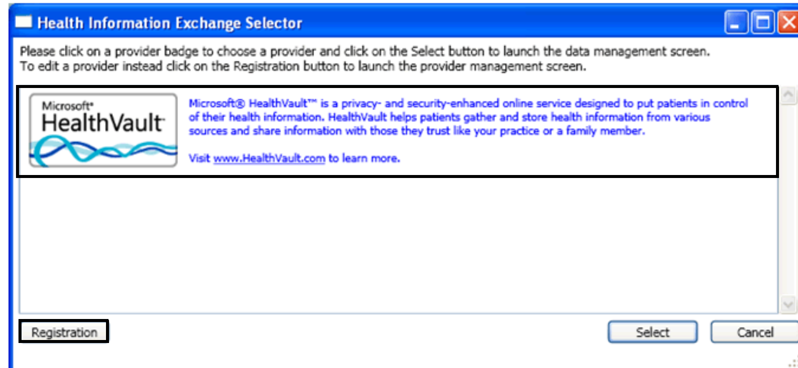
NOTE	Before you can upload a patient's health information, you must first: 1. Register your practice with HealthVault 2. Register the patient with HealthVault. 3. Have the patient sign into HealthVault using the ID code provided when the patient was registered.

▶ To register your practice with Microsoft HealthVault

1. Click **Tools** and select **HealthVault Registration**.

   The Health Information Exchange Selector window opens.

2. Select **HealthVault** and click **Registration**.



The Health Information Exchange - Register practice with Microsoft HealthVault window opens.

3. Complete all of the fields in the window. Modify or replace the sample text provided for some of the fields.

NOTE	Your logo must be a 120×60 pixel .JPEG file.

HealthVault Provider Registration
Practice Name
Logo
Browse...
Practice Description
Privacy Statement
<Sample>This practice adheres to all HIPAA guidelines to protect patient privacy and may use medical information about the patient in order to provide medical treatment and services. If you have any further questions regarding the Patient Privacy policy, please contact this practice.
Terms of Use
<Sample>
By using this service, you are agreeing to be bound by the service Terms and Conditions of Use, all applicable laws and regulations, and agree that you are responsible for compliance with any applicable local laws. If you do not agree with any of these terms, you are prohibited from using or accessing this service.
Authorization Reason
<Sample> This practice is requesting the patient's authorization to send their patient health record to HealthVault.
*Updates to provider information and logo typically will take about 30 minutes to be reflected on the web site.
Submit
Close

4. Click **Submit**.

   An information box opens with the message “Practice registration completed.”

5. Click **OK** and then click **Close**.

   The practice is now registered with HealthVault. If you have not yet registered the patient with HealthVault, go to “To register a patient with Microsoft HealthVault” on page 132. If you have already registered the patient with HealthVault, you are ready to upload a patient’s health information to HealthVault. For information on how to do this, go to “To upload a patient’s health information to HealthVault” on page 134.

NOTE	It can take up to 30 minutes for a registration or change to appear on the HealthVault Web site.

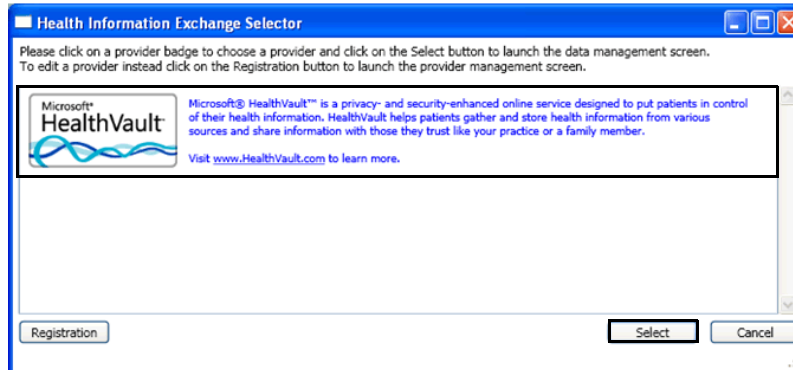
▶ To register a patient with Microsoft HealthVault

Registering the patient associates the practice with the patient’s account.

For more information on using eDocuments, watch the "Patient Hx" video.

1. Click the **eDocuments** tab in the Patient Information Center.
2. Select a document.
3. Click **Upload to HIE** to upload the document to the HealthVault HIE (Health Information Exchange).

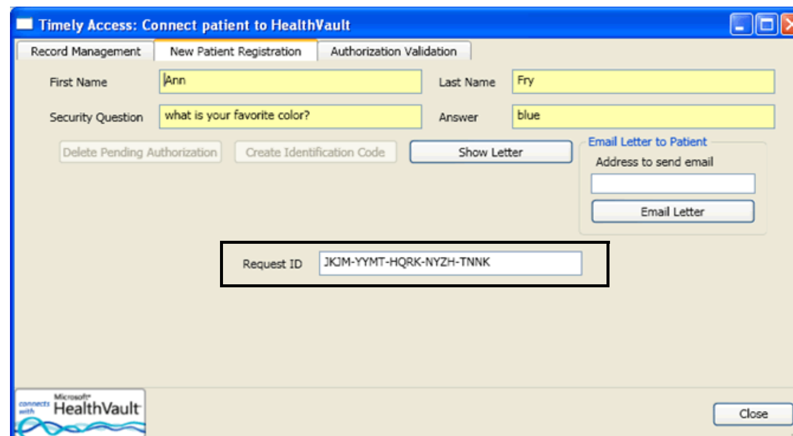
   The Health Information Exchange Selector window opens.
4. Select **HealthVault** and click **Select**.



   The Timely Access:Connect patient to HealthVault window opens on the Record Management tab.
5. Click the **New Patient Registration** tab.
6. Type a security question and answer in the **Security Question** and **Answer** fields.

   Create the security question and answer with the patient's input because the patient will need to answer this question in HealthVault to register his or her account and connect his or her account to your practice's account.
7. Click **Create Identification Code** to create a code to give to the patient.

   The patient will need this code to register the account and connect it to your practice's account. The identification code is added to a letter that you can also print and give to the patient so that he or she has detailed instructions on how to set up his or her HealthVault account.



8. Click **Show Letter** to view this letter and then click **Print** to print it or type the patient's e-mail address and click **Email Letter** to e-mail it.

9. If you need to delete a pending user registration, click **Delete Pending Authorization**.
10. Ask the patient sign into HealthVault using the ID code provided when the patient was registered.

    This authorizes the practice to upload the patient's health information.You are now ready to upload a patient's health information to HealthVault. For information on how to do this, go to "To upload a patient's health information to HealthVault" on page 134.

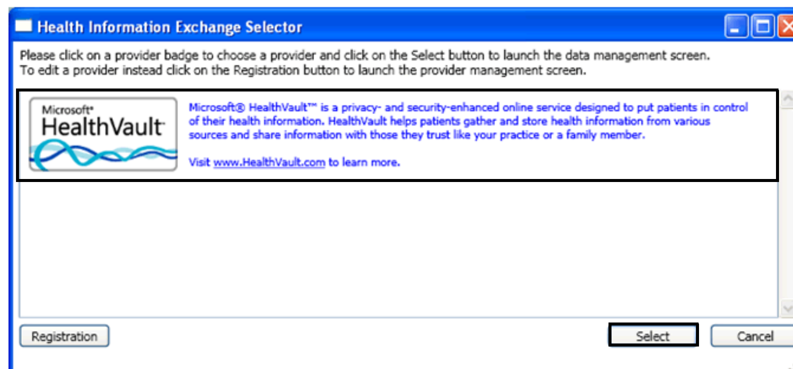
▶ To upload a patient's health information to HealthVault

For more information on using eDocuments, watch the "Patient Hx" video.

NOTE	Prior to uploading a patient's health information to Microsoft HealthVault, you must register your practice and the patient for a HealthVault accounts. The patient must then sign into HealthVault using the ID code provided when the patient was registered. To register for a HealthVault account, go to "To register your practice with Microsoft HealthVault" on page 131 or "To register a patient with Microsoft HealthVault" on page 132.

1. Click the **eDocuments** tab in the Patient Information Center.
2. Select a document.
3. Click **Upload to HIE** to upload the document to the HealthVault HIE (Health Information Exchange).

    The Health Information Exchange Selector window opens.
4. Select **HealthVault** and click **Select**.



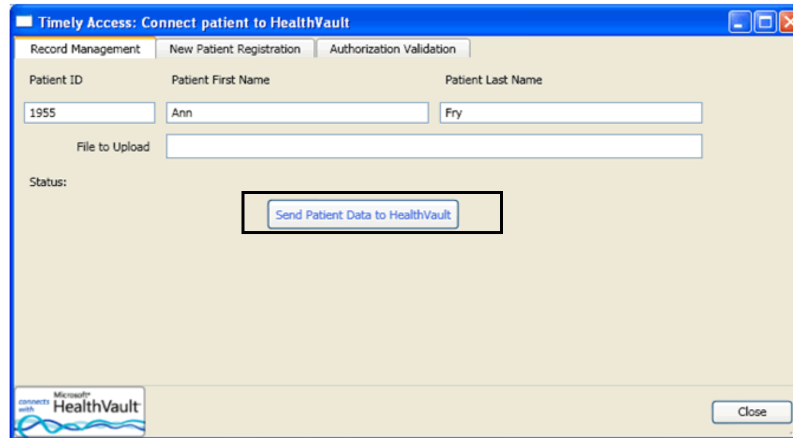
The Timely Access:Connect patient to HealthVault window opens on the Record Management tab with the patient's name, ID, and file name to upload already displayed.

5. Click **Send Patient Data to HealthVault**.

    The message "File successfully uploaded to HealthVault displays. If you did not yet register the patient, click the **New Patient Registration** tab to register the user before uploading the file. For information on registering new patients, go to "To register a patient with Microsoft HealthVault" on page 132.

6. Click **OK**.

   ExamWRITER uploads the selected document to HealthVault.



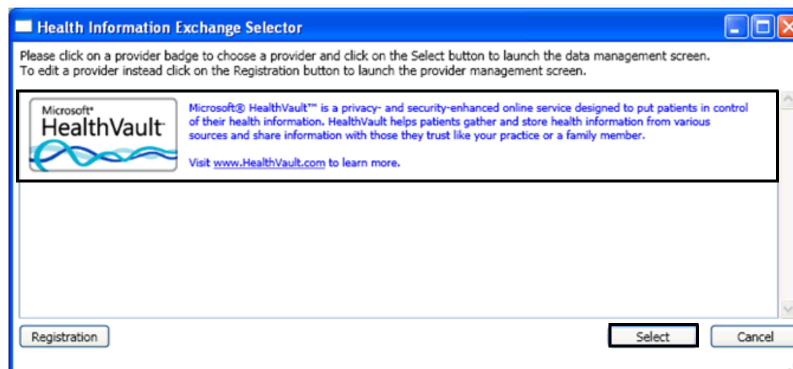
▶ To view a list of HealthVault patients that you have registered

For more information on using eDocuments, watch the "Patient Hx" video.

Viewing authorized patients that you have registered and unauthorized patients can help you troubleshoot.

1. Click the **eDocuments** tab in the Patient Information Center.
2. Select a document.
3. Click **Upload to HIE** to upload the document to the HealthVault HIE (Health Information Exchange).

   The Health Information Exchange Selector window opens.
4. Select **HealthVault** and click **Select**.

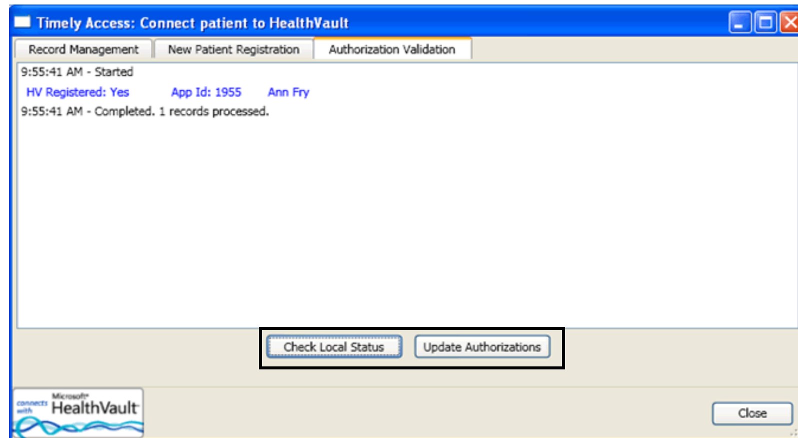


   The Timely Access:Connect patient to HealthVault window opens on the Record Management tab.
5. Click the **Authorization Validation** tab.
6. Click **Update Authorizations** to refresh your registration information.

   Any newly registered patients will be updated in HealthVault.

7. Click **Check Local Status**.

   The registered and unregistered patients are displayed. Users displayed in red text have not yet registered their account with their security question and answer and identification code and authorized your practice to connect to their HealthVault account. Users displayed in blue text have registered their account with their security question and answer and identification code and authorized your practice to connect to their HealthVault account.



Creating Clinical Summary Documents

Clinical summary documents are files that contain diagnostic test results (lab orders), diagnoses, medications, medication allergies and other elements recorded in a patient's exam and exam history. You can create clinical summary documents for patients or to exchange key clinical information and summary care records with patients and other providers.

Clinical summaries may be transmitted in two different formats. CDA (clinical document architecture) is becoming the preferred format, displacing CCR (continuity of care record). You may occasionally need to create CCRs for specific health information exchanges (HIEs), but CDAs are required for the secure messaging portal.

For more information on using eDocuments, watch the "Patient Hx" video.

NOTE	CCR documents do not contain 111.11 diagnosis codes, 11111 procedure codes, and PQRS codes.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.
2. Click the **eDocuments** tab.
3. Select the **Clinical Summary (open exam)** (if you are creating the clinical summary that is limited to the open exam) or **Patient Health History** (if you are creating a clinical summary the patient's history) radio button.
4. Select the **Patient Requested** check box if the patient requested the clinical summary.

5. Click **Create CDA** if you are sending the summary through the secure messaging portal, or click **Create CCR** is you sending the summary through a state exchange that requires the CCR format.

The clinical summary file appears and is also saved in the DATA\eDocuments folder. The file name contains the patient's name, patient number, the words "Clinical Summary," and the creation date.

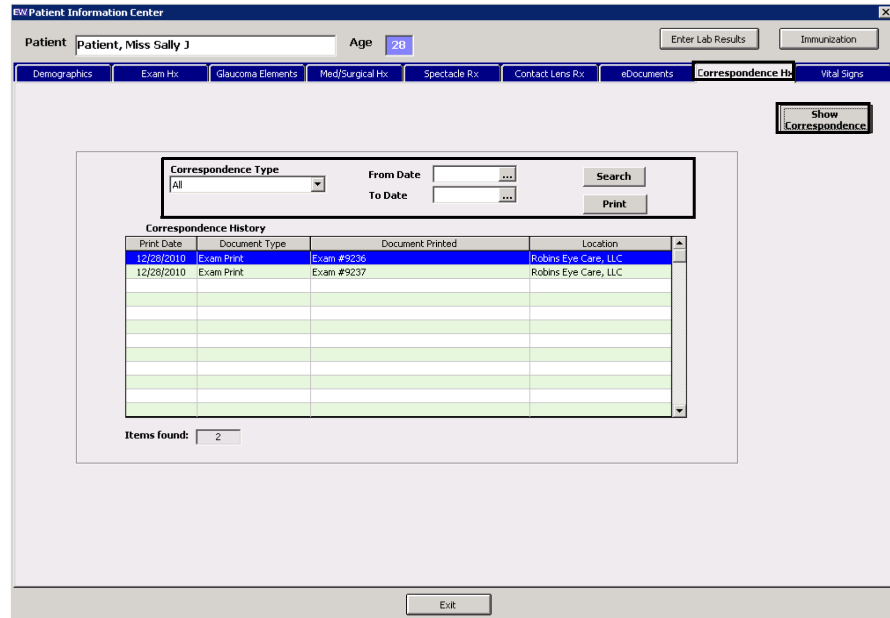
Viewing Correspon-dence History

For more information on viewing correspondence history, watch the "Patient Hx" video.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

   The Patient Information Center window opens.
2. Click the **Correspondence Hx** tab.
3. Select a correspondence type from the **Correspondence Type** drop-down menu.
4. Type or select dates in the **From Date** and **To Date** boxes.

5. Click **Search** to search for and display the correspondence history based on the parameters you specified in steps 3-4 or click **Show Correspondence** to view the list of correspondences.



6. Click **Print** to print the correspondence history, if desired.
7. Click **Exit** to close the Patient Information Center window.

Viewing Vital Signs

For more information on viewing vital signs, watch the "Patient Hx" video.

1. Click the **Patient Hx** icon in the top left of the ExamWRITER chart window or select a patient in the ExamWRITER Control Center window and click the **Patient Hx** icon.

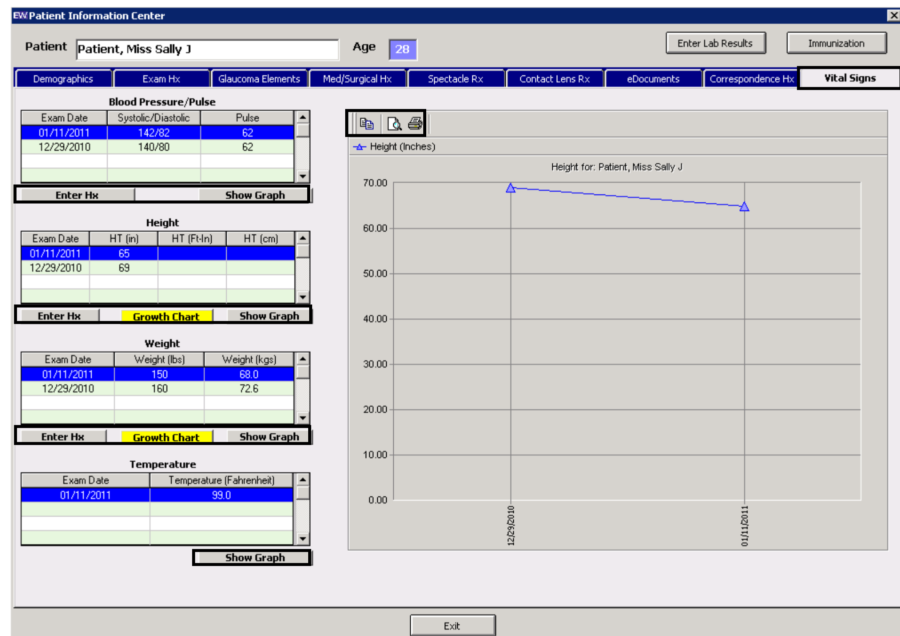
   The Patient Information Center window opens.
2. Click the **Vital Signs** tab.
3. Click the **Enter Hx** buttons to record historical blood pressure/pulse, height, and weight vital signs. For information on recording these elements, go to "Recording & Modifying Vital Signs " on page 277.

NOTES

- You cannot record blood pressure and pulse observations after clicking the **Enter Hx** buttons on the Vital Signs tab. To record observations for these vital signs, you must be in the patient's exam record.
- To delete a vital sign value, right-click on it and click **Yes**. If you delete historical vital signs from the Patient Information Center, they will also be deleted in final exams.

4. Click the **Show Graph** buttons to view blood pressure/pulse, height, weight, and temperature graphs.

NOTES	• The blood pressure/pulse graph is the default graph that is displayed. • Click the **Copy to clipboard** icon to copy the vital sign graph displayed to the clipboard and paste it into another document; click the **Print Preview** icon to preview the printed version of the graph; and click the **Print** icon to print the graph.



5. Click **Exit** to close the Patient Information Center window.

Printing Patient Welcome Forms

For more information on printing patient welcome forms, watch the "Tools" video.

The patient welcome form displays basic patient demographic and insurance information. A patient welcome form is printed for each patient with a confirmed appointment on a given day. Follow the instructions below to print patient welcome forms.

NOTE	ExamWRITER prints patient welcome forms only for appointments that have been confirmed in the OfficeMate Appointment Scheduler.

1. Click **Tools** on the ExamWRITER main window and select **Print Patient Welcome Forms**.

   The Print Patient Welcome Forms window opens.

2. Select your store from the **Location** drop-down menu if it is not selected already.

3. Type or select a date in the **Appointment Date** field.

4. Click **Print Patient Welcome Forms**.

   The Preview Window opens.

5. Complete one or more of the following tasks:

   – Click the **Print Report** icon to open the Print window and print the patient welcome forms.

   – Click the **Export Report** icon to open the Export window and choose a format and destination for your exported patient welcome forms.

NOTE	If you are exporting the report to a Microsoft Windows application, such as Excel, select the **MS Excel 97-2000 (Data Only)** format and **Disk file** destination in the Export window and click **OK**. Select the **Column width based on objects in the Details** radio button and *all* the check boxes in the Excel Format Options window and click **OK**.

6. Close the Preview Window.

7. Click **Exit** to close the Print Patient Welcome Forms window.

Recording Lab Results

You can record patients' lab results, which are included in clinical summary and patient health history CCR files, in the Lab Results window. For more information on creating CCR files, go to "Creating Clinical Summary Documents" on page 136.

For more information on recording lab results, watch the "Tools" video.

This section tells you how to record lab results, including how

- To record lab results manually, 141
- To import an electronic lab results file, 142

▶ To record lab results manually

For more information on recording lab results, watch the "Tools" video.

1. Click **Tools** on the ExamWRITER main window and select **Enter Lab Results**.

   OR

   Open the patient's Patient Information Center window and click **Enter Lab Results**.

   The Lab Test Results window opens.

   e. Click **New** in the middle of the window.

   f. Select the **Test Name**, **Test Type**, and **Code Type** from the drop-down menus and enter the **Code**.

   g. Select the **Order Link** by clicking the elopes (**...**) and selecting the exam where the lab tests were ordered.

   h. Record the lab details in the appropriate fields.

2. For each element reported on the lab result, perform the following steps:
   a. Click **New** at the bottom of the window.
   b. At minimum, type the **Element**, **Result Value**, and **UOM** (unit of measure).
   c. Select a **Test Date**.
   d. Click **Save** at the bottom of the window.

3. Click **Save** in the middle of the window.

▶ To import an electronic lab results file

1. Click the **Patient Hx** icon.
2. Click the **eDocuments** tab.
3. Click **Import Lab Results**.
4. Browse for the HL7 lab results file and click **Open**.

   The Importing Patient Match window opens and displays the name, date of birth, and gender of patient you have open in ExamWRITER and of the patient listed in the lab results file.

5. Verify that you are importing the correct patient's lab results.
   – Click **Import** if the patient matches.
   – Click **Select Another File** if the patient does not match.

   ExamWRITER displays the contents of the lab results file for your review.
6. Click **Import**.
7. On the Patient Information window, click **Enter Lab Results**.
8. Double-click the lab results listed under **Lab Order Results**.
9. Select the **Order Link** by clicking the elopes (**...**) and selecting the exam where the lab tests were ordered.
10. Click **Save**.

Managing Patient Immunization Information

You can manage a patient's immunizations, including any immunizations that you administered or information from an immunization card the patient may have provided, through the Immunization Administration window.

The information you record is included in clinical summary and patient health history CCR files created in the eDocuments tab. You can also register the immunizations with an immunization registry by sending a file in the HL7 2.3.1 format. Submitting electronic data to an immunization registry helps your practice meet meaningful use criteria. To better understand meaningful use and its criteria, see http://www.cms.gov/EHRIncentivePrograms/.

For more information on reporting immunization information, watch the "Immunization Registry Reporting" video.

1. In the Patient Information Center window, click **Immunization**.

   The Immunization Administration window opens.
2. Click **New**.
3. Record vaccines that the patient has previously had, filling out every field.

NOTE	Press **F12** to enter a new item for a drop-down menu.

4. Click **Save.**

   The vaccine is added to the Immunization History table.

NOTES	• To edit a saved vaccine, double-click the vaccine in the Immunization History table and modify the appropriate field. • To delete a vaccine, highlight the line in the Immunization History table and click **Delete**.

5. Record another vaccine or **Exit** to close the window.

For information on submitting immunization information to an immunization registry for a patient in OfficeMate Administration, refer to the *OfficeMate Administration User's Guide*, which is available from the Help menu within OfficeMate Administration.

Creating & Opening Exam Records

3

In this chapter:

- Creating New Patient Exam Records, 145
- Opening Saved Patient Exam Records, 153
- Finding & Changing Exam Information, 155
- Changing the Patient Name in an Exam, 156

Creating New Patient Exam Records

This section tells you how to create a new patient exam record in OfficeMate and ExamWRITER, including how

- To create a new exam record for a new patient using OfficeMate, 145
- To create a new exam record for a new patient using ExamWRITER, 148
- To create a new exam record for an existing patient using ExamWRITER, 150

For more information on using the Control Center, watch the "Control Center" video.

▶ To create a new exam record for a new patient using OfficeMate

1. Click the **Patients** icon in OfficeMate.

   The Find Patient/Guarantor window opens.

2. Click **New**.

   The Add New Patient Record window opens.

3. Follow the instructions in the "Creating, Modifying, & Deleting Patient Records" chapter in the *OfficeMate User's Guide* to record new patient

information in the Demographic, Insurance, Marketing, Notes, Recall, Financial Info, Correspondence Hx, HIPAA, and eDocuments tabs.

4. Click **ExamWRITER** or right-click on the Patient Demographic window's blue title bar and select **ExamWRITER** to open a new ExamWRITER EMR.

   The ExamWRITER Control Center window opens.

5. Click **New Exam**.

NOTE	If the patient record has notes and alerts recorded, click the **Show** buttons to view the patient notes and alerts.

6. Click **Create New Blank Exam**.

   OR

   Double-click on an available template.

For more information on creating and using templates, go to "Creating and Modifying Templates" on page 88 and watch the "Templates" video.

A new exam opens.

▶ To create a new exam record for a new patient using ExamWRITER

1. Complete the instructions in "Modifying & Viewing Patient Demographic Information" on page 113 to add new patient demographic information to the ExamWRITER database.
2. From the ExamWRITER Control Center, enter search information in the **Patient Information** text boxes and click **F2-Find**.

   If the Find Patient window opens with a list of patients meeting your selection criteria, go to step 3.

   If the ExamWRITER Control Center window opens, go to step 4.

NOTE	If the patient record has notes and alerts recorded, click the **Show** buttons on the ExamWRITER Control Center to view the patient notes and alerts.

3. Double-click on the patient for whom you want to create a new EMR.

   OR

   Click on the patient for whom you want to create a new EMR and then click **Select**.

   The ExamWRITER Control Center window opens.

NOTE	If the patient record has notes and alerts recorded, click the **Show** buttons to view the patient notes and alerts.

4. Click **New Exam**.

5. Click **Create New Blank Exam**.

   OR

   Double-click on an available template.

For more information on creating and using templates, go to "Creating and Modifying Templates" on page 88 and watch the "Templates" video.

A new exam opens.

▶ To create a new exam record for an existing patient using ExamWRITER

1. From the ExamWRITER Control Center, enter search information in the **Patient Information** text boxes and click **F2-Find**.

   If the Find Patient window opens with a list of patients meeting your selection criteria, go to step 2.

   If the ExamWRITER Control Center window opens, go to step 3.

NOTE	If the patient record has notes and alerts recorded, click the **Show** buttons on the ExamWRITER Control Center to view the patient notes and alerts.

2. Double-click on the patient for whom you want to create a new EMR.

   OR

   Click on the patient for whom you want to create a new EMR and then click **Select**.

   The ExamWRITER Control Center window opens.

NOTE	If the patient record has notes and alerts recorded, click the **Show** buttons to view the patient notes and alerts.

3. Click **New Exam** if there are no previous exams on file.

   OR

   Right-click on a previous exam and select **Copy forward to New Exam** to copy a patient's previous exam to a new exam.

NOTES

- If there are no closed or finalized exams for a patient, then the patient will have no previous exams recorded in ExamWRITER.
- Exams and templates that were created using ICD-9 codes can be copied forward to new exams that use ICD-10 codes. If there is an exact correlation between ICD-9 codes copied forward and their ICD-10 counterparts, then the ICD-9 codes will be translated into ICD-10 codes in the new exams and templates. If there is *no* exact correlation between ICD-9 codes copied forward and their ICD-10 counterparts, then the ICD-9 diagnoses will be flagged as blue text in the exam so that you can manually re-code them as ICD-10 diagnoses them before billing the exam.
- If you are using ExamWRITER 10.6 or above and you copy forward an exam that was created before ExamWRITER 10.6, the selections you made during the previous exam in the Examinations, Impressions, Plans windows will *not* copy forward to the new exam. You will need to reselect the correct information in these windows.

For more information on creating and using templates, go to "Creating and Modifying Templates" on page 88 and watch the "Templates" video.

4. Click **Create New Blank Exam**.

   OR

   Double-click on an available template.

   A new exam opens.

Opening Saved Patient Exam Records

1. If the patient has an open exam record, double-click the patient's name on the **Open Charts** tab on the ExamWRITER Control Center window; otherwise, go to step 2.

The saved patient exam opens.

For more information on opening exam charts, watch the "Opening the Chart" video.

NOTE To open a closed, finalized, or deleted exam record, click the **Chart Search** tab on the ExamWRITER Control Center, enter the appropriate date and status search criteria, and then double-click the patient's name.

2. If the patient does not have an open exam record, enter search information in the **Patient Information** text boxes in the ExamWRITER Control Center and click **F2-Find**.

   The Find Patient window opens with a list of patients meeting your selection criteria.

3. Double-click on the patient for whom you want to create a new EMR.

   OR

   Click on the patient for whom you want to create a new EMR and then click **Select**.

   The ExamWRITER Control Center window opens.

NOTE	If the patient record has notes and alerts recorded, click the **Show** buttons to view the patient notes and alerts.

4. Double-click on a previous exam.

NOTE	If there are no closed or finalized exams for a patient, then the patient will have no previous exams recorded in ExamWRITER

The saved patient exam opens.

Finding & Changing Exam Information

This section tells you how to find an exam and change the location and status in the standalone version of ExamWRITER (without OfficeMate).

1. On the Administration main window, click **Activities** and select **Find & Change Exams**.

   The ExamWRITER Find Exam window opens.

2. Enter search information in the **Find Charts by Patient** text boxes and click **F2-Find** or enter the appropriate date and status search criteria in the **Chart Search** fields and click **Search**.

3. Select an exam from the search results.
4. Change the provider, exam date, location, and status.
5. Click **Save**.

Changing the Patient Name in an Exam

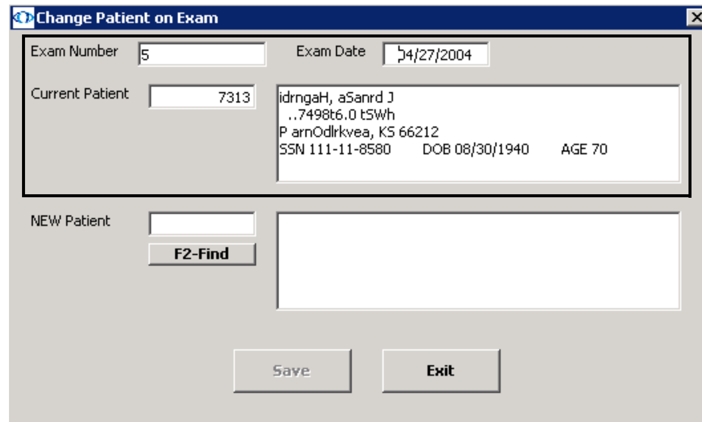
This section tells you how to change the name of a patient in an exam in the standalone version of ExamWRITER (without OfficeMate). You may need to change the name of a patient in an exam if you accidentally recorded an exam under the wrong patient name.

1. On the Administration main window, click **Activities** and select **Change Patient on Exam**.

   The Change Patient on Exam window opens.

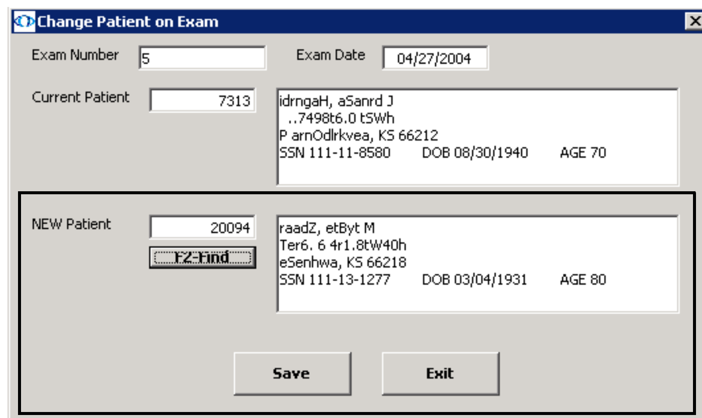
2. Type the exam number of the exam in which you need to change the patient's name in the **Exam Number** text box.
3. Place your cursor in any other text box in the window.

   The exam date, current patient's number on the exam, and current patient's demographic information is automatically populated in the top half of the window.



4. Click **F2-Find** and search for and select the correct patient under whom the exam should be recorded.

   The correct patient's demographic information is automatically populated in the bottom half of the window.
5. Click **Save**.



Recording Chief Complaint Information

4

For more information on recording reason for visit information, watch the "Open Chart Icons/Tabs - Reason for Visit" and "Chief Complaint - HPI" videos.

In this chapter:

- Recording Reason for Visit Information, 159
- Recording Chief Complaint Information, 162
- Recording History of Present Illness (HPI) Information, 163
- Modifying Chief Complain Information, 165

The ExamWRITER chart window is organized for you to follow the SOAP (Subjective, Objective, Assessment, Plan) methodology when you are entering information into an EMR. Click the **Chief Complaint** tab to enter subjective information into an EMR.

NOTE	To select Chief Complaint as your default exam view, go to "To set up general preferences" on page 67.

Recording Reason for Visit Information

NOTE	Press the **F12** key in the Occupation, Notes, Last Eye Exam, and Exam type boxes to open a Code Maintenance window and add descriptions to the fields. When you are adding exam types to the Exam type box, you must type a long and short description in the Code Maintenance window. For more information on using the Code Maintenance window, go to "To add and maintain list box selections (F12)" on page 10.

1. Click the **Chief Complaint** tab on the ExamWRITER chart window.
2. Click the **Reason for Visit** bar.

   The Reason for Visit window opens.

3. Click your cursor in the **Notes** text box to open a drop-down menu and select notes for the patient's record.

NOTE	To select multiple notes, left-click in the Notes text box and use the left button on your mouse to select multiple notes. After you have selected all of the patient's notes, right-click to insert the notes into the text box.

4. Click your cursor in the **Occupation** text box to open a drop-down menu and select the patient's occupation.

NOTE	To search for occupations in the Occupation field, click the drop-down arrow in the Occupation field, place your cursor in the text box, and type the first letter of the occupation. The drop-down menu advances to the occupations beginning with the letter that you typed in the text box.

5. Type or select the patient's last office visit date in the **Last Office Visit** text box.
6. Type or select the patient's last physical exam date in the **Last Physical Exam** text box.
7. If the patient completed his or her last eye exam at another practice, select the time period when the patient had his or her last eye exam from the **Last Eye Exam (elsewhere)** drop-down menu.
8. Select the exam technician from the **Exam Technician** drop-down menu.

NOTE	The Exam Technician menu is populated from the OfficeMate list of staff.

9. Click the **...** (ellipse) next to the **Primary Care Physician** text box to open the Primary Care Physician window and double-click the primary care physician.

NOTE	To add a new primary care physician to the Primary Care Physician window, click **New** and go to “Setting Up Correspondent Information” on page 73 for more information.

10. Click the **...** (ellipse) next to the **Other Physician** text box to open the Other Doctor window and double-click the other physician.

NOTE	To add a new physician to the Other Doctor window, click **New** and go to “Setting Up Correspondent Information” on page 73 for more information.

11. If you have not already select a referring provider in OfficeMate, select the **PCP** (primary care physician), **Other Physician**, or **None** radio button in the **Referred by** box.
12. Double-click exam types from the **Exam type** table to add them to the Selected Exam Types box.

NOTES

- You can only select six exam types (i.e., procedures) to add to the Select Exam Types box.
- To remove an exam type from the Selected Exam Types box, select the exam type and click the **Remove Item** arrow.
- To rearrange the exam types in the Selected Exam Types box, click the arrows to the left of the table. You can move exam types up or down one row at a time, move an exam type to the top of the list to make it the primary exam type (click the **Make Primary** arrow), or move an exam type to the bottom of the list.

13. Click **Process** or right-click anywhere in the Reason for Visit window.

Recording Chief Complaint Information

For more information on recording reason for visit information, watch the "Chief Complaint - HPI" video.

1. Click the **Chief Complaint** tab on the ExamWRITER chart window.
2. Click the **Chief Complaint** bar.

   The Chief Complaint window opens.
3. Select the appropriate complaint(s) in the box on the left side of the window.

NOTES	
	• To create and maintain complaints in the box on the left side of the window, place your cursor in the Search text box and press the **F12** key. • To search for complaints already in the box on the left side of the window, type text into the **Search** text box. • To include custom text, click **Custom Text** and type the custom text into the text box.

4. Select an eye from the **Eye** drop-down menu.
5. Choose the appropriate dates from the **Timeline** drop-down menus. If you want to select an exact date, click the **...** (ellipse) to open the calendar and select an exact date. If you want to select today's date, select the **Today** check box.

NOTE	
	If you want to include timeline information for custom text, select the **Include TIMELINE** check box.

6. Click **Save Item**.

NOTES	
	• To delete a chief complaint that you have saved in the Chief Complaint table at the bottom of the window, select the chief complaint and click **Delete Item**. • To delete all of the chief complaints that you have saved in the Chief Complaint table at the bottom of the window, click **Delete All**.

7. Click **Process**.

Recording History of Present Illness (HPI) Information

For more information on recording HPI information, watch the "Chief Complaint - HPI" video.

1. Click the **Chief Complaint** tab on the ExamWRITER chart window.
2. Click the **History of Present Illness (HPI)** bar.

   The History of Present Illness window opens.
3. Select the **ALL OK (Except)** check box and any appropriate **Triage**, **Vision Complaints**, **Symptoms**, and **Progress HPI** check boxes.

NOTES	
	• Select the **Triage**, **Vision Complaints**, **Symptoms**, and **Progress HPI** check box(es) only if there are exceptions to the patient's healthy medical history; otherwise, only select the **ALL OK (Except)** check box. • Blue text is a heading for the black or red text below it. • Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

4. Click **Process** or right-click anywhere in the History of Present Illness window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.

   NOTE If you select the **Common Ocular Complaints** check box and you are using the HPI Wizard, follow the instructions below to document the ocular complaints. To turn on the HPI Wizard and make the technician's job of documenting complaints worry-free, go to "To set up general preferences" on page 67.

   1. Search for and select a complaint in the box on the left side of the window (press the **F12** key to add a complaint to the box).
   2. Select an eye from the **Eye** drop-down menu.
   3. In the Keyword and Long Description text boxes, left-click to select the appropriate items from the drop-down menu list and then right-click to save your selections. To modify or add keywords and long descriptions, left-click in a Keyword text box and press the **F12** key.
   4. If you prefer to add custom text instead of using the HPI Wizard, click the **Custom Text** button and type the text in the **Custom text** box.
   5. Click **Save Item** to add the complaint to the Ocular Complaint table at the bottom of the window. To edit a saved complaint, click **Edit** and modify the text. To delete all complaints, click **Delete All**; or, to delete one complaint, select it and click **Delete Item**.
   6. After you have finished documenting all ocular complaints, click **Process**.

7. Select or deselect the appropriate check boxes and click **Process**.

Modifying Chief Complain Information

1. Click the **Chief Complaint** tab on the ExamWRITER chart window.
2. Click the **Reason for Visit**, **Chief Complaint**, and **History of Present Illness (HPI)** bars or click on a bold Reason for Visit, Chief Complaint, or History of Present Illness subheading in the ExamWRITER chart window and follow the instructions above for recording information in an EMR.

NOTES	
	• After you have finished recording Chief Complaint information in an EMR, the Reason for Visit, Chief Complaint, and History of Present Illness (HPI) bars change in color from orange to green. • All abnormal medical conditions appear in red text in the ExamWRITER chart window. All normal medical conditions appear in black text in the ExamWRITER chart window.

Recording Patient Hx – ROS Information

5

In this chapter:

For more information on recording patient history information, watch the "Patient History" video.

- Recording Patient History Information, 167
- Recording Review of Systems Information, 182
- Modifying Patient Hx – ROS Information, 183

The ExamWRITER chart window is organized for you to follow the SOAP (Subjective, Objective, Assessment, Plan) methodology when you are entering information into an EMR. Click the **Patient Hx – ROS** tab to enter subjective information into an EMR.

Recording Patient History Information

This section tells you how to record patient history information in ExamWRITER, including how

- To record ALL OK patient history, 167
- To record medical, surgical, and ocular history, 169
- To record systemic and ocular medications and allergies, 171
- To record nonmedication allergens, 174
- To record family ocular history, 177
- To record social history, 178
- To record developmental, spectacle, contact, low vision, reviewed, disposition, and orientation patient history, 180

▶ To record ALL OK patient history

1. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
2. Click the **Patient History** bar.

   The Patient History window opens.

3. Select the **Patient History** check box under the ALL OK heading to record that there are no exceptions to the patient’s healthy medical systems.

NOTE	Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

Patient History

ALL OK
PATIENT HISTORY

EXCEPT...
Medical/Surgical/Ocular
Medications - Systemic/Ocular/Allergies [MU]
Allergens - Non Medication
Family Ocular
Social [MU]
Developmental
Spectacles
Contacts
Low Vision
Reviewed [MU]

NEURO/PYSCH
Disposition
Orientation

*Green items indicate PQRI auto coding measures...

Process

4. Click **Process** or right-click anywhere in the Patient History window.

   The Patient History window opens. If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

5. Deselect check boxes, if necessary, or choose the appropriate button at the bottom of the window to reset or deselect the patient history ALL OK check boxes or add custom text.

NOTES

- If you click **UNSelect All**, all of the patient history ALL OK check boxes are deselected.
- If you click **Reset**, all of the patient history ALL OK check boxes are selected.

6. Click **Process**.

▶ To record medical, surgical, and ocular history

7. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
8. Click the **Patient History** bar.

   The Patient History window opens.

9. Select the **Medical/Surgical/Ocular** check box.

NOTE	Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

Patient History
ALL OK
PATIENT HISTORY
EXCEPT...
Medical/Surgical/Ocular
Medications - Systemic/Ocular/Allergies [MU]
Allergens - Non Medication
Family Ocular
Social [MU]
Developmental
Spectacles
Contacts
Low Vision
Reviewed [MU]
NEURO/PYSCH
Disposition
Orientation
*Green items indicate PQRI auto coding measures...
Process

10. Click **Process** or right-click anywhere in the Patient History window.

    The Medical History window opens. If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

11. Select the **Medical Hx**, **Ocular Hx**, **Systemic Surgery**, or **Ocular Surgery** radio button to record history associated with those areas.

12. Select the appropriate text in the box on the left of the window.

NOTES	• To create and maintain keywords, place your cursor in the Search text box and press **F12**. • To search for keywords, type text in the **Search** text box. • To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and select the **Include Timeline** check box if you want to include timeline information. • To clear selections, click **Clear**.

13. If necessary, select an eye from the **Eye** drop-down menu.

14. If necessary, select dates from the **Timeline** drop-down menus.

15. Click **Save(s)**.
16. Repeat steps 12–15, as necessary, until all history information is saved in the table at the bottom of the window.

NOTES	• To discontinue an item saved in the table at the bottom of the window, select it and click **Discontinue** Item. • To delete an item saved in the table at the bottom of the window, select it and click **Delete Item**. • To delete all items saved in the table at the bottom of the window, click **Delete All**.

17. Click **Process**.

▶ To record systemic and ocular medications and allergies

1. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
2. Click the **Patient History** bar.

   The Patient History window opens.

3. Select the **Medications - Systemic/Ocular/Allergies [MU]** check box.

NOTE	Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

Patient History

ALL OK
☑ PATIENT HISTORY

EXCEPT...
☐ Medical/Surgical/Ocular
☐ Medications - Systemic/Ocular/Allergies [MU]
☐ Allergens - Non Medication
☐ Family Ocular
☐ Social [MU]
☐ Developmental
☐ Spectacles
☐ Contacts
☐ Low Vision
☐ Reviewed [MU]

NEURO/PYSCH
☐ Disposition
☐ Orientation

*Green items indicate PQRI auto coding measures...

Process

4. Click **Process** or right-click anywhere in the Patient History window.

   The Patient Systemic Medications and Allergies window opens. If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

5. Select the **Systemic** or **Ocular** radio button to record history associated with those areas.

6. Double-click the medication name in the table at the top of the window.

NOTES

- To search for a specific medication, begin typing it in the **Name Search** text box.
- To search for unknown medications, click **Unknown Medications**.
- To add or edit medications, right-click on the medication or click **Add/Edit Medication**. For information on adding and editing medications, go to "Maintaining Medication & Allergen Information" on page 81.
- If the patient is not taking any medications, click the appropriate **No Medications [MU]** button to add the text "No reported medications" to the table in the bottom of the window.

7. If you are participating in the CMS Physician Quality Reporting System (PQRS), record medication verification by selecting one of the following radio buttons:
   - **Meds Documented**. This selection will autocode G8427, indicating that you met the performance measure.
   - **Meds Not Documented**. This selection will autocode G8428, indicating that you did *not* meet the performance measure.
   - **Incomplete list**
   - **Not Eligible**. This selection will autocode G8430, indicating a exception to meeting the measure.

   The PQRS procedure code associated with your selection is recorded in the Diagnosis/Procedure Coding window on the Procedures tab. For more information about recording procedure codes, go to “To select procedure codes” on page 306.
8. To record a medication as discontinued, select the medication in the table at the bottom of the window, click **Discontinue medication**, select a date from the **Discontinue Date** calendar, and click **Save**.

   The medication’s status is marked as discontinued and it is removed from the list of medications. To unmark a medication as being discontinued, go to “Viewing & Refilling Prescriptions” on page 124.
9. To denote if the patient is allergic to a medication, select the **Allergy** check box next to the medication in the table at the bottom of the window, click in the blank text box in the Reaction window, select as many reactions as necessary, right-click in the Reaction window, select an onset date from the Onset calendar, and click **Save**.

NOTE	If the patient does not have any medication allergies, click **No Medication Allergies [MU]** to add the text “No known medication allergies” and a check box in the Allergy column to the table in the bottom of the window.

10. To document that a medication reconciliation was performed, and to help your practice meeting meaningful use criteria, click **Transition of Care Medication Reconciliation [MU]**.

11. To delete a medication, select the medication in the table at the bottom of the window, click **Delete medication**, and click **Yes**.

12. Click **Save/Exit**.

▶ To record nonmedication allergens

1. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
2. Click the **Patient History** bar.

   The Patient History window opens.

3. Select the **Allergens - Non Medication** check box.

NOTE	Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

Patient History
ALL OK
PATIENT HISTORY
EXCEPT...
Medical/Surgical/Ocular
Medications - Systemic/Ocular/Allergies [MU]
Allergens - Non Medication
Family Ocular
Social [MU]
Developmental
Spectacles
Contacts
Low Vision
Reviewed [MU]
NEURO/PYSCH
Disposition
Orientation
*Green items indicate PQRI auto coding measures...
Process

4. Click **Process** or right-click anywhere in the Patient History window.

   The Patient Allergens window opens. If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

5. Double-click the allergen name in the table at the top of the window.

NOTES

- To search for a specific allergen, begin typing it in the **Name Search** text box.
- To add or edit allergens, right-click on the allergen or click **Add/Edit Allergen**. For information on adding and editing allergens, go to “Maintaining Medication & Allergen Information” on page 81.
- If the patient does not have any known allergens, click **No known Allergens** to add the text “No known non-medication allergens” to the table in the bottom of the window.

6. If you are participating in the CMS Physician Quality Reporting System (PQRS), record medication verification by selecting one of the following radio buttons:
   – **Verified Medications**
   – **Meds listed, not verified**
   – **Incomplete list**
   – **Not available to verify**

   The PQRS procedure code associated with your selection is recorded in the Diagnosis/Procedure Coding window on the Procedures tab. For more information about recording procedure codes, go to “To select procedure codes” on page 306.
7. To record an allergen as discontinued, select the allergen in the table at the bottom of the window, click **Discontinue allergen**, select a date from the **Discontinue Date** calendar, and click **Save**.

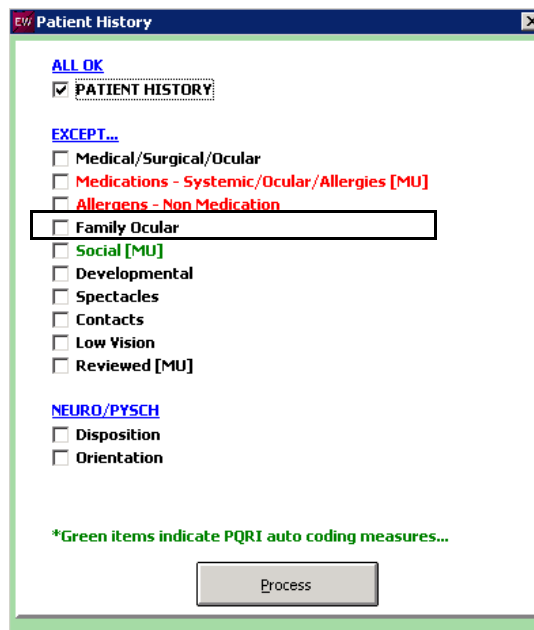
   The allergen’s status is marked as discontinued and it is removed from the list of allergens. To unmark a allergen as being discontinued, go to “Viewing & Refilling Prescriptions” on page 124.
8. To document that a medication reconciliation was performed, and to help your practice meeting meaningful use criteria, click **Transition of Care Medication Reconciliation [MU]**.
9. To delete an allergen, select the allergen in the table at the bottom of the window, click **Delete allergen**, and click **Yes**.
10. Click **Save/Exit**.

▶ To record family ocular history

1. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
2. Click the **Patient History** bar.

   The Patient History window opens.
3. Select the **Family Ocular** check box.

NOTE	Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.



4. Click **Process** or right-click anywhere in the Patient History window.

   The Ocular Family History window opens. If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.
5. Select the **Ocular** or **Systemic** radio button to record family history associated with those areas.
6. Select the appropriate text in the box on the left of the window.

NOTES	• To create and maintain keywords, place your cursor in the Search text box and press **F12**. • To search for keywords, type text in the **Search** text box. • To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and select the **Include Timeline** check box if you want to include timeline information. • To clear selections, click **Clear**.

7. Select a family member from the **Family Member(s)** box.
8. If necessary, select an eye from the **Eye** drop-down menu.

9. Select dates from the **Timeline** drop-down menus.

10. Click **Save Item**.

11. Repeat steps 12–10, as necessary, until all family history information is saved in the table at the bottom of the window.

> **NOTES**
>
> - To discontinue an item saved in the table at the bottom of the window, select it and click **Discontinue** Item.
> - To delete an item saved in the table at the bottom of the window, select it and click **Delete Item**.
> - To delete all items saved in the table at the bottom of the window, click **Delete All**.

12. Click **Process**.

▶ To record social history

1. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
2. Click the **Patient History** bar.

   The Patient History window opens.

3. Select the **Social [MU]** check box.

NOTES	• Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded. • Green text signifies that the item is associated with a PQRS procedure code or MIPS measure.

4. Click **Process** or right-click anywhere in the Patient History window.

   The Social History window opens. If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

5. Record the patient's smoking status using the check box at the top of the window or the radio buttons in the **Tobacco Use [MU]** box. If the patient is a smoker, you *must* select the patient's tobacco use and either the **Counseling Intervention Recommended** or **Pharmaceutical Intervention Recommended** check box to meet meaningful use criteria.

6. Record the patient's alcohol use, narcotic use, sexually transmitted disease status, blood transfusion status, and birth order.

7. If desired, type text into the **Custom Text** text box.

NOTE
- To delete an item saved in the Social History Reported box at the bottom of the window, select it and click **Remove Item**.
- To delete all items saved in the Social History Reported box at the bottom of the window, click **Clear All**.

8. Click **Process**.

▶ To record developmental, spectacle, contact, low vision, reviewed, disposition, and orientation patient history

9. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
10. Click the **Patient History** bar.

    The Patient History window opens.

11. Select the **Developmental**, **Spectacles**, **Contacts**, **Low Vision**, **Reviewed [MU]**, **Disposition**, and **Orientation** check boxes.

NOTES	• Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded. • Blue text is a heading for the black or red text below it. • Select the **Reviewed [MU]** check box to record medication reconciliation to meet meaningful use criteria.

Patient History

ALL OK
PATIENT HISTORY

EXCEPT...
Medical/Surgical/Ocular
Medications - Systemic/Ocular/Allergies [MU]
Allergens - Non Medication
Family Ocular
Social [MU]
Developmental
Spectacles
Contacts
Low Vision
Reviewed [MU]

NEURO/PYSCH
Disposition
Orientation

*Green items indicate PQRI auto coding measures...

Process

12. Click **Process** or right-click anywhere in the Patient History window.

    Depending on the boxes that you checked, various windows will open with additional check boxes.

13. Select or deselect the appropriate check boxes and click **Process**.

NOTES	• To record selected information for the right, left, or both eyes, first click **OD**, **OS**, or **OU** and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**. • To clear previous selections on the form, click **Reset Form**. • If a Current Information window opens, choose the appropriate button at the bottom of the window to add, edit, save, redo, or delete the previously entered text.

Recording Review of Systems Information

For more information on recording ROS information, watch the "Review of Systems (ROS)" video.

1. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
2. Click the **Review of Systems** bar.

   The Review of Systems window opens.
3. Select the **ALL OK** and appropriate **Except** check boxes.

NOTE

- Select the **Except** check box(es) only if there are exceptions to the patient's healthy medical systems; otherwise, only select the **ALL OK** check box.
- Blue text is a heading for the black or red text below it.
- Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

Review of Systems
ALL OK
Review of Systems
EXCEPT...
Allergy
Cardiovascular
Constitutional
Endocrine
Gastrointestinal
Genitourinary
Ears, Nose, Mouth, Throat
Hematologic/Lymphatic
Immunologic
Integumentary (Skin)
Musculoskeletal
Neurological
Psychiatric
Respiratory
Reviewed
Process

4. Click **Process** or right-click anywhere in the Review of Systems window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.
5. Select or deselect the appropriate check boxes and click **Process**.

NOTES

- To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**.
- To clear previous selections on the form, click **Reset Form**.
- If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

Modifying Patient Hx – ROS Information

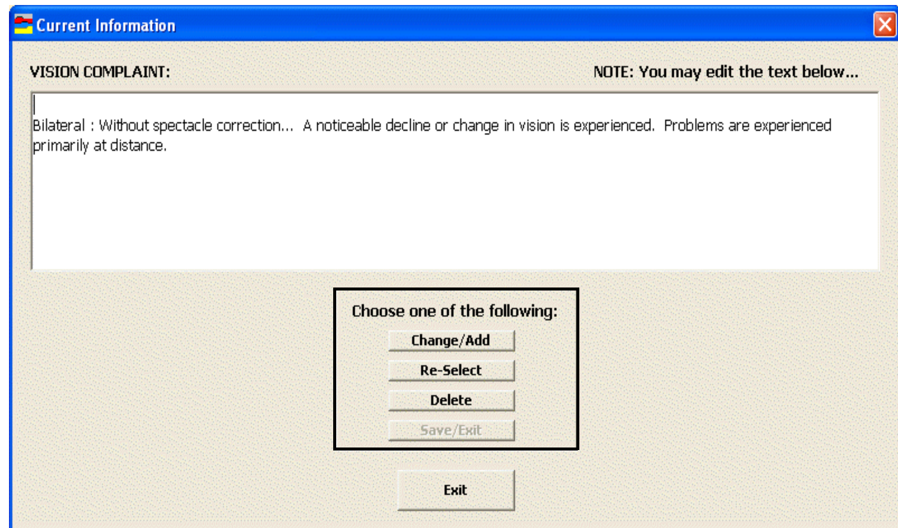
1. Click the **Patient Hx – ROS** tab on the ExamWRITER chart window.
2. Click the **Patient History** and **Review of Systems** bars and follow the instructions above for recording information in an EMR.

   OR

   Click on a bold subheading in the ExamWRITER chart window.

   The Current Information window opens.
3. Choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

NOTES	• If you click **Change/Add**, your previous selections are still selected and you can change or add to them. • If you click **Re-Select**, your previous selections are deleted and you must reselect new information.



NOTES	• After you have finished recording patient Hx – ROS information in an EMR, the Patient History and Review of Systems bars change in color from orange to green. • All abnormal medical conditions appear in red text in the ExamWRITER chart window. All normal medical conditions appear in black text in the ExamWRITER chart window.

Recording Vision/Rx Information

6

In this chapter:

- Recording Ancillary Testing Information, 185
- Recording Spectacle Vision/Rx Information, 187
- Recording Contact Lens Vision/Rx Information, 215
- Recording Binocular Vision/Rx Information, 239

The ExamWRITER chart window is organized for you to follow the SOAP (Subjective, Objective, Assessment, Plan) methodology when you are entering information into an EMR. Click the **Vision/Rx** tab to enter objective information into an EMR.

Recording Ancillary Testing Information

For more information on recording ancillary testing information, watch the "Refraction" video.

This section tells you how to record ancillary testing information in ExamWRITER, including how

- To record ancillary testing information, 185
- To modify ancillary testing information, 186

▶ To record ancillary testing information

1. Click the **Vision/Rx** tab on the ExamWRITER chart window.
2. Click the **Vision** bar.

   The Vision/Rx window opens.

3. Select the appropriate **Other Vision Tests** check boxes.

NOTE	• Blue text is a heading for the black or red text below it. • Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

4. Click **Process** or right-click anywhere in the Vision/Rx window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.

5. Select or deselect the appropriate check boxes and click **Process**.

NOTES	• To record selected information for the right, left, or both eyes, first click **OD**, **OS**, or **OU** and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**. • To clear previous selections on the form, click **Reset Form**. • If a Current Information window opens, choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

▶ To modify ancillary testing information

1. Click the **Vision/Rx** bar and follow the instructions above for recording information in an EMR.

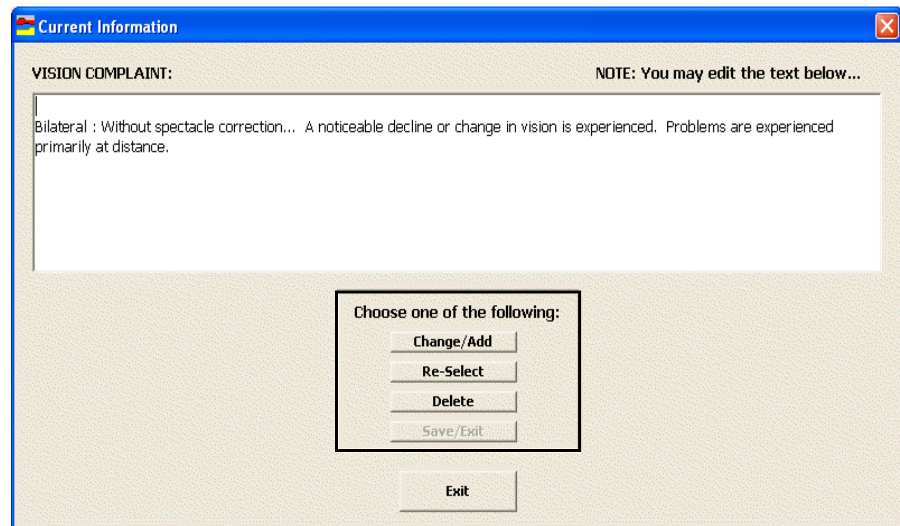
   OR

   Click on a bold subheading in the ExamWRITER chart window.

   The Current Information window opens.

2. Choose the appropriate button at the bottom of the window to change, add, reselect, or delete the previously entered text.

NOTES	• If you click **Change/Add**, your previous selections are still selected and you can change or add to them. • If you click **Re-Select**, your previous selections are deleted and you must reselect new information.



Recording Spectacle Vision/Rx Information

This section tells you how to record spectacle vision and prescription information in ExamWRITER, including how

- To record and modify unaided acuities, 188
- To record and modify the presenting spectacle Rx, 189
- To record and modify the objective spectacle auto refraction Rx , 192
- To record and modify the objective spectacle retinoscopy Rx, 193
- To record and modify the subjective spectacle manifest Rx, 195
- To record and modify the subjective spectacle cycloplegic Rx, 197
- To record and modify the final spectacle Rx, 199
- To record and modify the alternate spectacle Rx, 203
- To view the spectacle history, 207
- To record and modify keratometry readings, 208
- To view keratometry reading history, 210
- To record and modify pupillary distance measurements, 211
- To record and modify a vertex distance measurement, 212
- To record and modify a working distance measurement, 213
- To record and modify a spectacle base curve measurement, 214

To record and modify vision and prescription spectacle information in an EMR, click the **Vision/Rx** tab on the ExamWRITER chart window and then click the **Spectacle** tab on the Vision bar.

For more information on recording spectacle vision information, watch the "Refraction" video.

▶ To record and modify unaided acuities

1. Click in the **Unaided Acuities** box in the top left of the Vision/Rx ExamWRITER chart window.

   The Unaided Visual Acuities window opens.

2. Click on the appropriate measurements to add them to the **OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements into the **OD**, **OS**, and **OU** text boxes.

3. If you want to add visual acuity impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The VISUAL ACUITY Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

5. Click **Save/Exit**.

For more information on recording and modifying the presenting spectacle Rx, watch the "Vision Tests - Presenting Documentation - Binocular" video.

▶ To record and modify the presenting spectacle Rx

1. Click in the **Presenting Spectacle Rx** box in the top middle of the Vision/Rx ExamWRITER chart window.

   The Rx window opens.

   OR

   Click the **Presenting** tab on the Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Spectacle – Presenting OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Spectacle – Presenting OD**, **OS**, and **OU** text boxes.

NOTES

- You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes.
- If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. Select the prescription's usage from the **Usage** drop-down menu.
5. Select the Rx date from the **Rx Date** drop-down menu.
6. Click the **BPD** or **MPD** radio button and then click your cursor in a **Dist** or **Near** text box to open the Pupillary Distance window and record pupillary distance measurements.
7. If you want to copy the presenting prescription to the subjective manifest prescription, click **Copy to Manifest** and go to "To record and modify the subjective spectacle manifest Rx" on page 195.
8. If you want to copy the presenting prescription to the objective retinoscopy prescription, click **Copy to Obj. Retin** and go to "To record and modify the objective spectacle retinoscopy Rx" on page 193.
9. If you want to copy the presenting prescription to the final prescription, click **Copy to Final** and go to "To record and modify the final spectacle Rx" on page 199.

10. If you want to create multiple presenting spectacle prescriptions, click **New Rx** and follow the steps above to create additional presenting spectacle prescriptions.

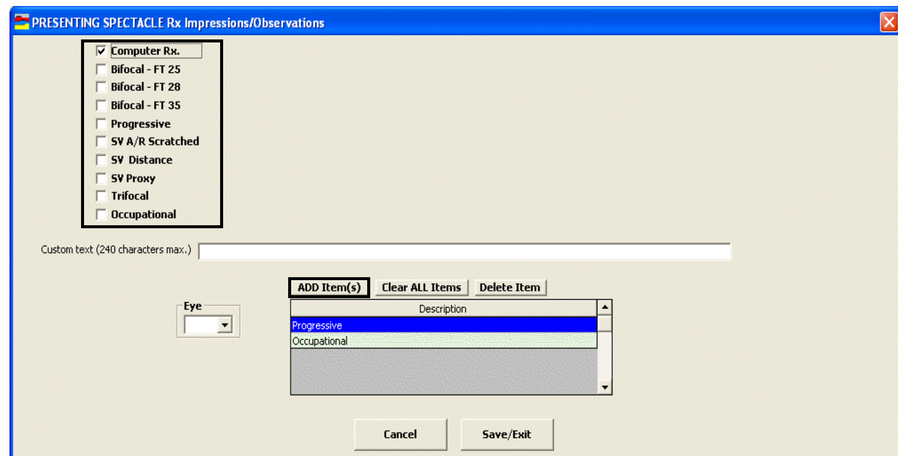
NOTES	• Click the arrows under **#/of** to view other presenting spectacle prescriptions. • If you are an OfficeMate user, click the arrow buttons in the OfficeMate Eyewear Order window to view the multiple prescriptions.

11. If you want to add presenting spectacle prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 13.

    The PRESENTING SPECTACLE Rx Impressions/Observations window opens.

12. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



13. Click **Save/Exit**.
14. Click **Save/Exit** to close the Rx window.

▶ To record and modify the objective spectacle auto refraction Rx

1. Click in the **Auto Refraction** box in the middle left of the Vision/Rx ExamWRITER chart window.

   The Rx window opens.

   OR

   Click the **Obj – Auto Ref.** tab on the Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Spectacle – Auto Refraction OD** and **OS** text boxes.

   OR

   Type the appropriate measurements in the **Spectacle – Auto Refraction OD** and **OS** text boxes.

NOTES

- You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes.
- If you want to make the OD and OS prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.

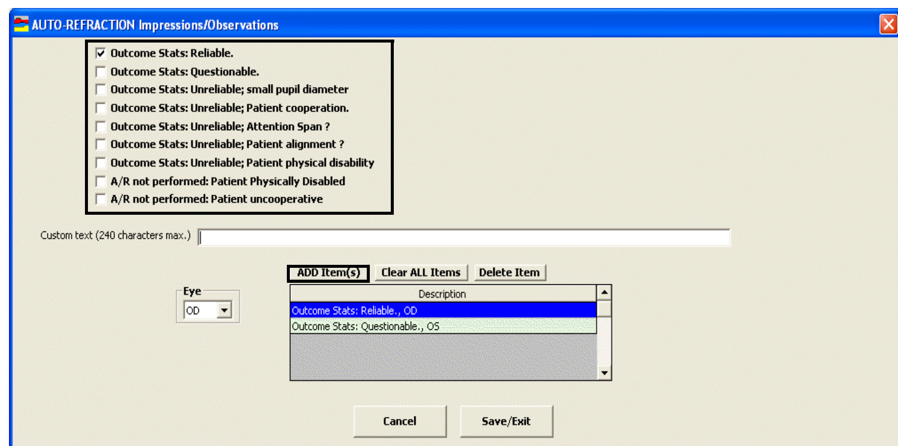
4. Click the **BPD** or **MPD** radio button and then click your cursor in a **Dist** or **Near** text box to open the Pupillary Distance window and record pupillary distance measurements.

5. If you want to add autorefraction spectacle prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 8.

   The AUTO-REFRACTION Impressions/Observations window opens.

6. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



7. Click **Save/Exit**.
8. If you want to copy the autorefraction prescription to the subjective manifest prescription, click **Copy to Manifest** and go to "To record and modify the subjective spectacle manifest Rx" on page 195.
9. Click **Save/Exit** to close the Rx window.

▶ To record and modify the objective spectacle retinoscopy Rx

1. Click in the **Retinoscopy** box in the middle of the Vision/Rx ExamWRITER chart window.

   The Rx window opens.

   OR

   Click the **Obj-Retin.** tab on the Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Spectacle – Retinoscopy OD** and **OS** text boxes.

   OR

   Type the appropriate measurements in the **Spectacle – Retinoscopy OD** and **OS** text boxes.

NOTES

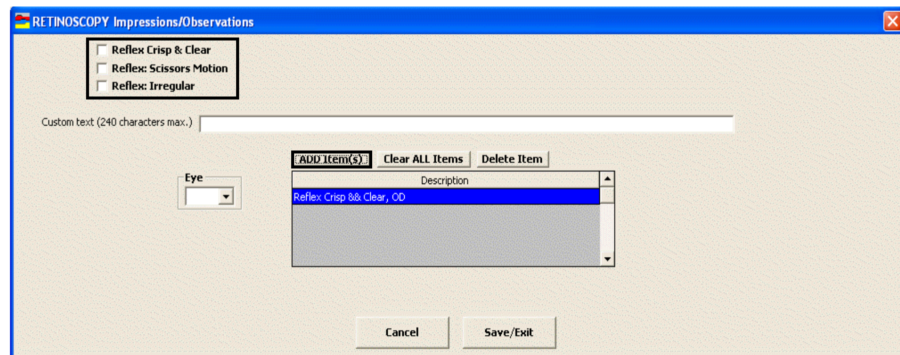
- You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes.
- If you want to make the OD and OS prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. Click the **BPD** or **MPD** radio button and then click your cursor in a **Dist** or **Near** text box to open the Pupillary Distance window and record pupillary distance measurements.
5. If you want to add retinoscopy spectacle prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 8.

   The RETINOSCOPY Impressions/Observations window opens.

6. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



7. Click **Save/Exit**.
8. If you want to copy the retinoscopy prescription to the subjective manifest prescription, click **Copy to Manifest** and go to "To record and modify the subjective spectacle manifest Rx" on page 195.
9. Click **Save/Exit** to close the Rx window.

▶ To record and modify the subjective spectacle manifest Rx

1. Click in the **Manifest** box in the middle left of the Vision/Rx ExamWRITER chart window.

   The Rx window opens.

   OR

   Click the **Sub-Manifest** tab on the Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Spectacle – Manifest OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Spectacle – Manifest OD**, **OS**, and **OU** text boxes.

NOTES	
	• You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes. • If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button. • To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. Click the Show Binocular **Yes** radio button to display or record binocular measurements.

NOTE	To record binocular measurements, click in a Binocular text box and follow the instructions in "Recording Binocular Vision/Rx Information" on page 239.

5. Click the **BPD** or **MPD** radio button and then click your cursor in a **Dist** or **Near** text box to open the Pupillary Distance window and record pupillary distance measurements.
6. If you want to add subjective response spectacle prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 9.

   The SUBJECTIVE RESPONSES Impressions/Observations window opens.

7. Select the appropriate check boxes and click **ADD Item(s)**.

> **NOTES**
>
> - To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
> - To add custom text, select the appropriate check box and type text in the **Custom text** box.
> - To clear all items from the Description list, click **Clear ALL Items**.
> - To delete an item from the Description list, select the item and click **Delete Item**.

8. Click **Save/Exit**.
9. If you want to copy the manifest prescription to the cycloplegic prescription, click **Copy to Cyclo.** and go to "To record and modify the subjective spectacle cycloplegic Rx" on page 197.
10. If you want to copy the manifest prescription to the final prescription, click **Copy to Final** and go to "To record and modify the final spectacle Rx" on page 199.
11. Click **Save/Exit** to close the Rx window.

▶ To record and modify the subjective spectacle cycloplegic Rx

1. Click in the **Cycloplegic** box in the middle right of the Vision/Rx ExamWRITER chart window.

   The Rx window opens.

   OR

   Click the **Sub-Cyclo.** tab on the Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Spectacle – Cycloplegic OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Spectacle – Cycloplegic OD**, **OS**, and **OU** text boxes.

NOTES	
	• You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes. • If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button. • To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. Click the Show Binocular **Yes** radio button to display or record binocular measurements.

NOTE	
	To record binocular measurements, click in a Binocular text box and follow the instructions in "Recording Binocular Vision/Rx Information" on page 239.

5. Click the **BPD** or **MPD** radio button and then click your cursor in a **Dist** or **Near** text box to open the Pupillary Distance window and record pupillary distance measurements.
6. If you want to add cycloplegic spectacle prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 9.

   The CYCLOPLEGIC ORDERS Impressions/Observations window opens.

7. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

8. Click **Save/Exit**.
9. If you want to copy the presenting prescription to the subjective manifest prescription, click **Copy to Manifest** and go to “To record and modify the subjective spectacle manifest Rx” on page 195.
10. If you want to copy the presenting prescription to the final prescription, click **Copy to Final** and go to “To record and modify the final spectacle Rx” on page 199.
11. Click **Save/Exit** to close the Rx window.

▶ To record and modify the final spectacle Rx

1. Click in the **Final Spectacle Rx** box in the bottom left of the Vision/Rx ExamWRITER chart window.

   The Rx window opens.

   OR

   Click the **Final** tab on the Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Spectacle – Final OD**, **OS**, and **OU** and text boxes.

   OR

   Type the appropriate measurements in the **Spectacle – Final OD**, **OS**, and **OU** text boxes.

NOTES	• You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes. • If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button. • To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. Select the prescription's usage from the **Usage** drop-down menu.

NOTE	The usage is copied to the OfficeMate Rx and is printed on the prescription.

5. Select the prescription and expiration dates from the **Prescription Date** and **Expiration Date** drop-down menus.

6. Click the Show Binocular **No** radio button and follow the instructions below to record lens product information and Rx lab order options:
   a. Type a product code into the OD **Product Code** text box or click the **?** to open the Find Product window and search for a product.
   b. Type a product name into the OD **Product Name** text box or click the **?** to open the Find Product window and search for a product.
   c. Select an OD lens category from the **Category** drop-down menu.
   d. Select an OD lens material from the **Material** drop-down menu.
   e. If you want to make the OS lens information the same as the OD information, click the **=** button; otherwise, repeat steps a –d for the OS fields.
   f. Select a lens color from the **Color** drop-down menu.
   g. Select a lens density from the **Density** drop-down menu and select the **Solid** or **Gradient** radio button.
   h. If the lens is uncut, select the **Uncut Lens** check box.
   i. Select add-ons from the **Product Add-Ons** box (hold down the Shift or Ctrl key to select multiple add-ons at the same time) and click the right arrow to move the selected add-ons to the **Add-ons selected** box.
   j. Type special instructions for the lab in the **Special Instructions to Lab** text box.
   k. Type Rx notes in the **Rx Notes** text box. These notes will print on the ExamWRITER Rx. An Rx Notes flag is displayed on the ExamWRITER chart window, notifying you that there are Rx notes; click this flag to view the notes.

NOTE	Lab order options are transferred to OfficeMate to enhance communication between the doctor and technical staff.

7. Click the Show Binocular **Yes** radio button to display or record binocular measurements.

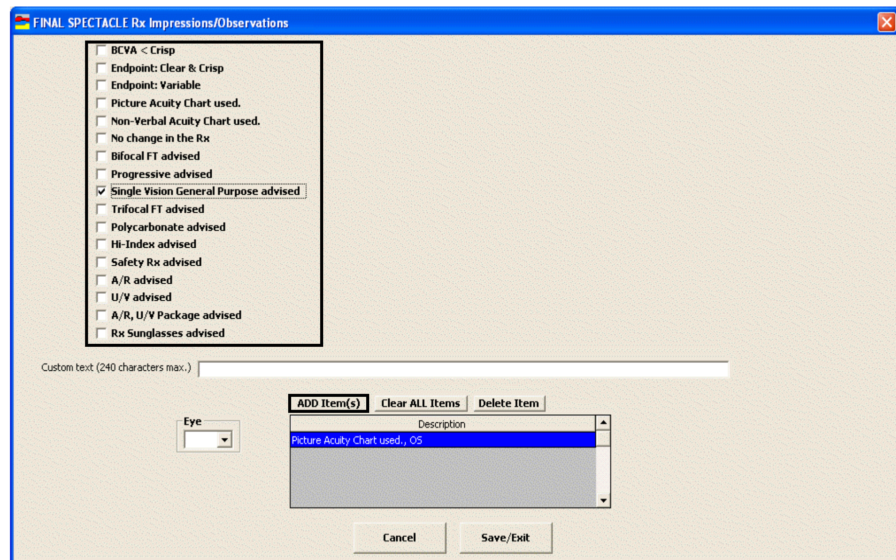
NOTE	To record binocular measurements, click in a Binocular text box and follow the instructions in "Recording Binocular Vision/Rx Information" on page 239.

8. Click the **BPD** or **MPD** radio button and then click your cursor in a **Dist** or **Near** text box to open the Pupillary Distance window and record pupillary distance measurements.
9. If you want to add final spectacle prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 12.

   The FINAL Rx Impressions/Observations window opens.
10. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.



11. Click **Save/Exit**.

12. Click **Create Lab Order** or **Update Lab Order** to create or update the final spectacle lab order.

    An Rx number appears in the Lab Order text box. The Rx information is transferred to OfficeMate. The charges are not created until you record and invoice the Rx order in OfficeMate.

NOTE	If you click Clear after creating or updating a lab order, the Rx in OfficeMate is not removed.

13. If you want to copy the final prescription to the alternate prescription, click **Copy to Alt. Rx** and go to "To record and modify the alternate spectacle Rx" on page 203.
14. Click **Print Rx** to print the final Rx.
15. Click **Save/Exit** to close the Rx window.

▶ To record and modify the alternate spectacle Rx

1. Click in the **Alternate Spectacle Rx** box in the bottom right of the Vision/Rx ExamWRITER chart window.

   The Rx window opens.

   OR

   Click the **Alternate** tab on the Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Spectacle – Alternate OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Spectacle – Alternate OD**, **OS**, and **OU** text boxes.

NOTES	• You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes. • If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button. • To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. Select the prescription's usage from the **Usage** drop-down menu.

NOTE	The usage is copied to the OfficeMate Rx and is printed on the prescription.

5. Select the prescription and expiration dates from the **Prescription Date** and **Expiration Date** drop-down menus.

6. Click the Show Binocular **No** radio button and follow the instructions below to record lens product information and Rx lab order options:
   a. Type a product code into the OD **Product Code** text box or click the **?** to open the Find Product window and search for a product.
   a. Type a product name into the OD **Product Name** text box or click the **?** to open the Find Product window and search for a product.
   b. Select an OD lens category from the **Category** drop-down menu.
   c. Select an OD lens material from the **Material** drop-down menu.
   d. If you want to make the OS lens information the same as the OD information, click the **=** button; otherwise, repeat steps 6a–6c for the OS fields.
   e. Select a lens color from the **Color** drop-down menu.
   f. Select a lens density from the **Density** drop-down menu and select the **Solid** or **Gradient** radio button.
   g. If the lens is uncut, select the **Uncut Lens** check box.
   h. Select add-ons from the **Product Add-Ons** box (hold down the Shift or Ctrl key to select multiple add-ons at the same time) and click the right arrow to move the selected add-ons to the **Add-ons selected** box.
   i. Type special instructions for the lab in the **Special Instructions to Lab** text box.
   j. Type Rx notes in the **Rx Notes** text box. These notes will print on the ExamWRITER Rx. An Rx Notes flag is displayed on the ExamWRITER chart window, notifying you that there are Rx notes; click this flag to view the notes.

NOTE	Lab order options are transferred to OfficeMate to enhance communication between the doctor and technical staff.

7. Click the Show Binocular **Yes** radio button to display or record binocular measurements.

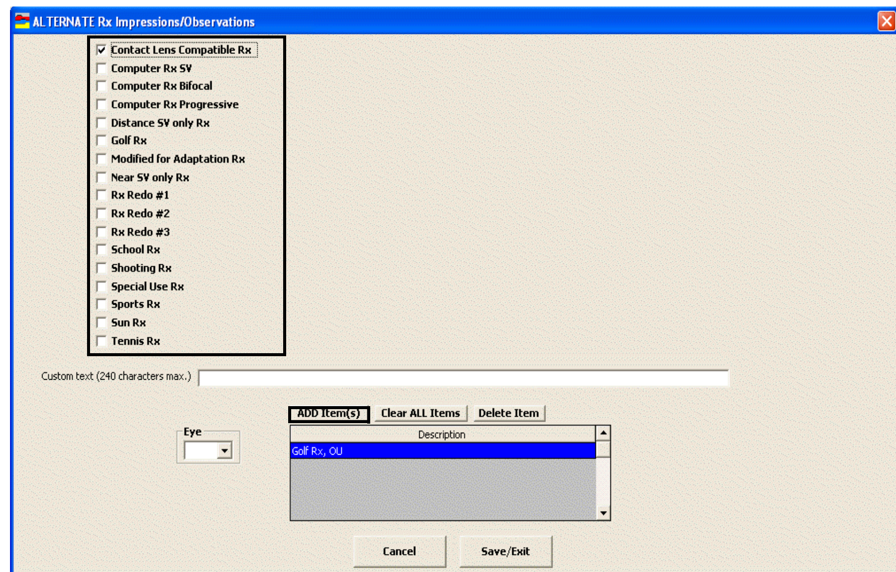
NOTE	To record binocular measurements, click in a Binocular text box and follow the instructions in "Recording Binocular Vision/Rx Information" on page 239.

8. Click the **BPD** or **MPD** radio button and then click your cursor in a **Dist** or **Near** text box to open the Pupillary Distance window and record pupillary distance measurements.
9. If you want to add alternate spectacle prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 12.

   The ALTERNATE Rx Impressions/Observations window opens.
10. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.



11. Click **Save/Exit**.

    Click **Create Lab Order** or **Update Lab Order** to create or update the alternate spectacle lab order.

    An Rx number appears in the Lab Order text box. The Rx charges are transferred to OfficeMate where they are automatically priced when the Rx is recorded in OfficeMate.

NOTE	If you click Clear after creating or updating a lab order, the Rx in OfficeMate is not removed.

12. If you want to create multiple alternate spectacle prescriptions, click **New Rx** and follow the steps above to create additional alternate spectacle prescriptions.

NOTES

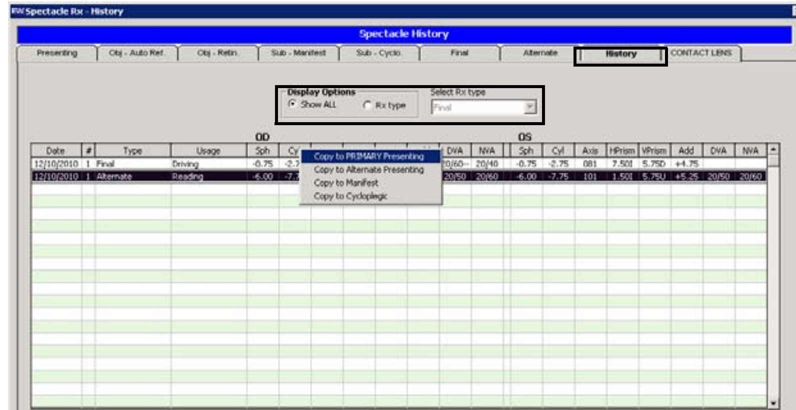
- Click the arrows under **#/of** to view other alternate spectacle prescriptions.
- If you are an OfficeMate user, click the arrow buttons in the OfficeMate Eyewear Order window to view the multiple prescriptions.

13. Click **Save/Exit** to close the Rx window.

▶ To view the spectacle history

1. Click the yellow Hx button in the top right of the Vision/Rx ExamWRITER chart window or click the History tab on the Rx window.
2. Select **Show ALL** to display all spectacle prescriptions, or **Rx type** to display spectacle prescriptions by the Rx type from the Display Options radio buttons and select an Rx type from the **Select Rx type** drop-down menu.

3. Right-click on a prescription and select a copy option to copy the selected prescription to another prescription.



To record and modify keratometry readings

NOTE	Click the yellow **Hx** button in the K-Readings box in the top right of the Vision/Rx ExamWRITER chart window to view the patient's keratometry readings history in a list and in a graph. For more information on viewing the patient's keratometry readings history, go to "To view keratometry reading history" on page 210.

1. Click in the **K-Readings** box in the top right of the Vision/Rx ExamWRITER chart window.

   The Keratometry window opens.

2. Click on the blue slider bar to add measurements to the OD and OS text boxes.

   OR

   Type the appropriate measurements in the OD and OS text boxes.

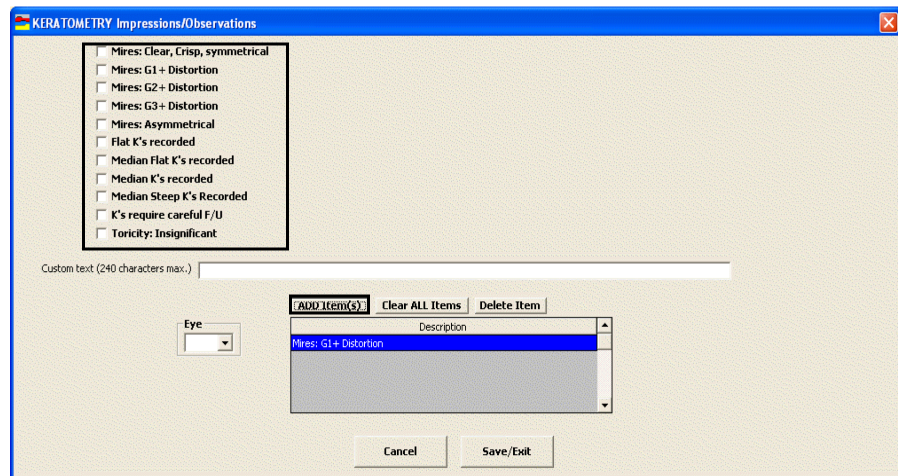
NOTES	• You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes. • Click **OD-Not Recorded** and **OS-Not Recorded** to document unrecorded keratometry measurements.

3. If you want to add keratometry impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The KERATOMETRY Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



5. Click **Save/Exit**.

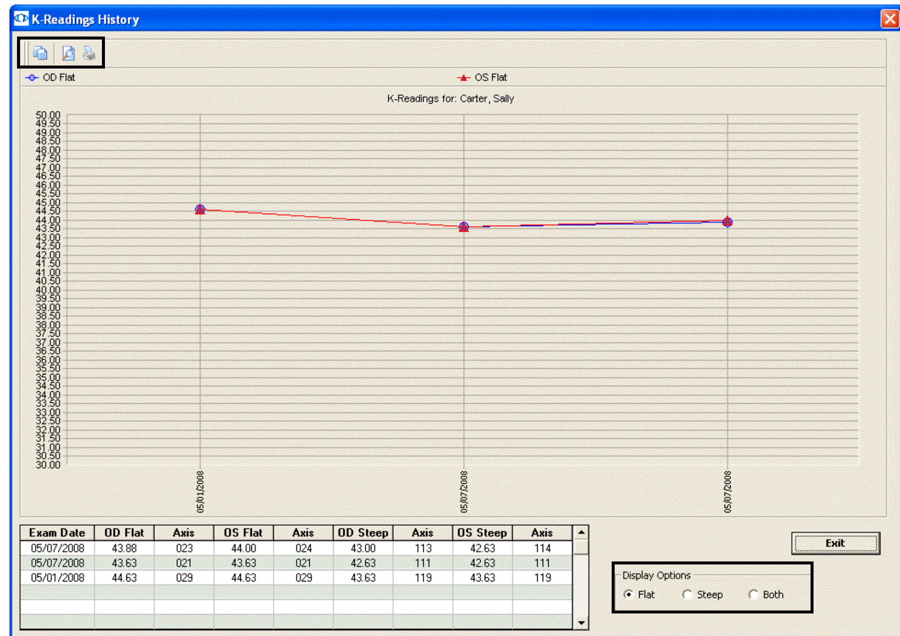
▶ To view keratometry reading history

1. Click the yellow **Hx** button in the K-Readings box in the top right of the Vision/Rx ExamWRITER chart window.

   The K-Readings History window opens.

2. Select the **Flat**, **Steep**, or **Both** radio button to change the display of the graph.

3. Click the icons at the top of the window to copy the graph to the clipboard or print the graph.



Exam Date	OD Flat	Axis	OS Flat	Axis	OD Steep	Axis	OS Steep	Axis
05/07/2008	43.88	023	44.00	024	43.00	113	42.63	114
05/07/2008	43.63	021	43.63	021	42.63	111	42.63	111
05/01/2008	44.63	029	44.63	029	43.63	119	43.63	119

4. Click **Exit** to close the K-Readings History window.

▶ To record and modify pupillary distance measurements

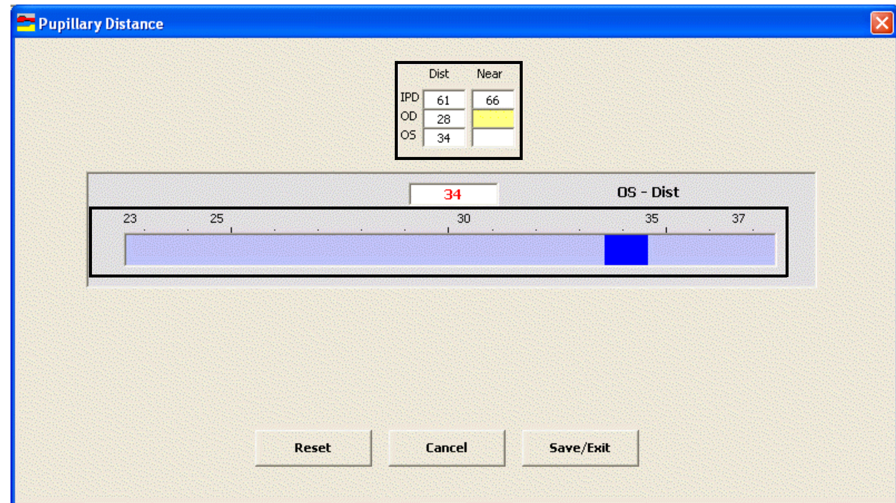
1. Click in the **PD** box in the top right of the Vision/Rx ExamWRITER chart window.

   The Pupillary Distance window opens.

2. Click on the blue slider bar to add measurements to the **IPD**, **OD**, and **OS** text boxes.

   OR

   Type the appropriate measurements in the **IPD**, **OD**, and **OS** text boxes.



NOTE	You do not need to click on an IPD, OD, or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the IPD, OD, and OS text boxes.

3. Click **Save/Exit**.

▶ To record and modify a vertex distance measurement

1. Click in the **Vertex Dist** box in the top right of the Vision/Rx ExamWRITER chart window.

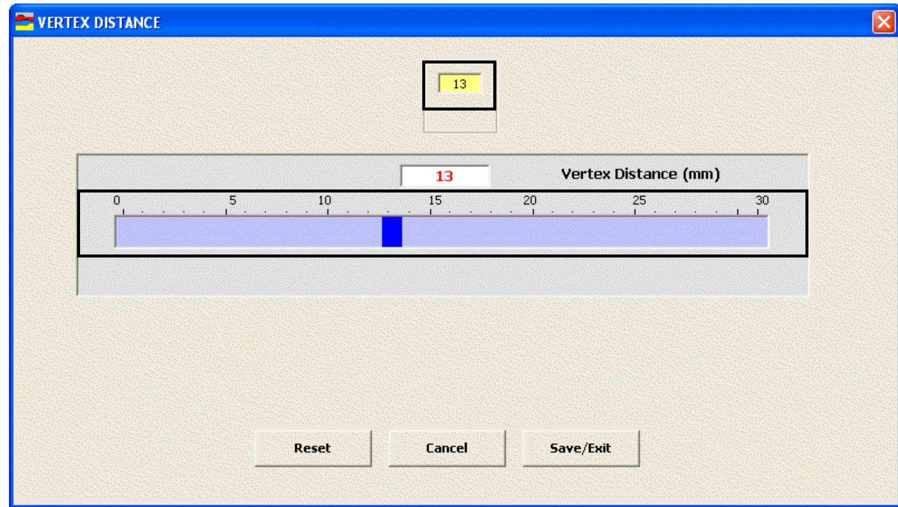
   The VERTEX DISTANCE window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTE	The default vertex distance measurement is 13mm. If you click **Reset**, the default vertex distance measurement will be displayed.



3. Click **Save/Exit**.

▶ To record and modify a working distance measurement

1. Click in the **Work Dist** box in the top right of the Vision/Rx ExamWRITER chart window.

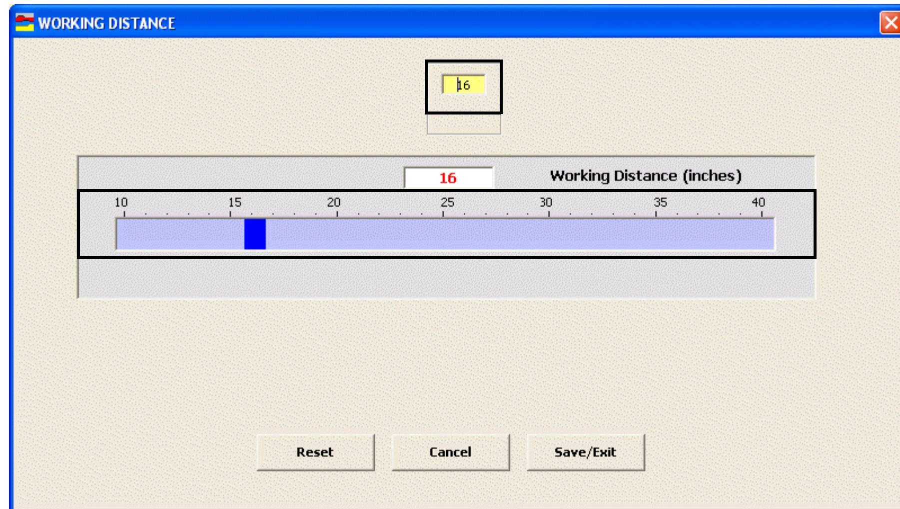
   The WORKING DISTANCE window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTE	The default working distance measurement is 16 inches. If you click **Reset**, the default working distance measurement will be displayed.



3. Click **Save/Exit**.

▶ To record and modify a spectacle base curve measurement

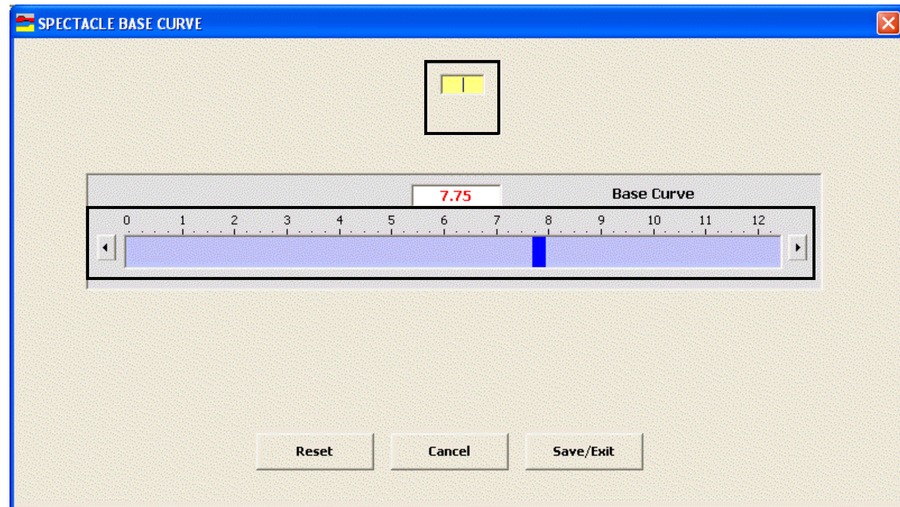
1. Click in the **Spec BC** box in the top right of the Vision/Rx ExamWRITER chart window.

   The SPECTACLE BASE CURVE window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.



3. Click **Save/Exit**.

NOTES

- After you have finished recording Vision/Rx information in an EMR, the **Vision** bar changes in color from orange to green.
- All abnormal medical conditions appear in red text in the ExamWRITER chart window. All normal medical conditions appear in black text in the ExamWRITER chart window.

Recording Contact Lens Vision/Rx Information

This section tells you how to record contact lens vision and prescription information in ExamWRITER, including how

- To record and modify the presenting contact lens Rx, 216
- To record and modify the trial contact lens Rx, 221
- To record and modify the sphere – cylinder contact lens ORx, 227
- To record and modify the sphere contact lens ORx, 229
- To record and modify the final contact lens Rx, 232
- To view the contact lens history, 238

To record and modify Vision/Rx contact lens information in an EMR, click the **Vision/Rx** tab on the ExamWRITER chart window and then click the **Contacts** tab on the Vision bar.

For more information on recording contact lens vision information, watch the "Refraction" video.

To record and modify the presenting contact lens Rx

1. Click in the **Presenting Contact Rx** box in the top left of the Vision/Rx ExamWRITER chart window.

   The Contact Lens Rx - Presenting window opens.

   OR

   Click the **Presenting** tab on the Contact Lens Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Contact Lens Rx – Presenting OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Contact Lens – Presenting OD**, **OS**, and **OU** text boxes.

NOTES

- You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes.
- If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. Click the ellipse (**...**) next to the OD and OS **Product Name** boxes to select contact lens product names.

   The Select Contact Lens window opens.

NOTES	
	• To view all contact lens products in your ExamWRITER database, select **Show ALL**. To view only the products that you previously designated as the most commonly used products and assigned to your Quick List in the Products window, deselect **Show ALL**. To set up a preference for displaying all contact lenses or only those in your Quick List, go to "To set up default preferences" on page 69. • To find a specific contact lens product in your ExamWRITER database, type the product name in the **Search** text box. • To view a specific contact lens category, select the category from the **Lens Category** drop-down menu. You must assign contact lenses to a lens category in order for them to appear in the Select Contact Lens window and be selected for an Rx. To assign contact lenses to a lens category go to "Setting Up Product and Service Information" on page 76.

4. Select the appropriate product name, click **Search** to search for a specific product with the measurements you recorded (if applicable), and double-click on the appropriate product details line in the bottom part of the

window to add the contact lens product name, tint, and lens (if applicable) to the presenting contact lens prescription.

OR

Select the appropriate product name and click **Product Name Only** to add only the product name to the presenting contact lens prescription.

NOTES

- If the contact lens product does not have any item details recorded, clicking the Search button will yield no results in the bottom part of the window.
- Click **Clear Rx** to delete the measurements from the Select Contact Lens window and record new measurements or leave the boxes empty.
- To add or edit a contact lens product, select the appropriate product name and click **New Product** or **Edit Product**. The Products window opens. For more information on adding and editing contact lens products, see "Setting Up Product and Service Information" on page 76.

NOTE If you select a rigid, single-vision contact lens from the Select Contact Lens window, you will be able to view and record rigid sphere information. If you select a rigid, multifocal lens from the Select Contact Lens window, you will be able to view and record rigid bifocal information. Appropriate Rx fields are displayed for each lens category that you select.

5. Select OD and OS blends from the **Blend** drop-down menus (rigid lenses only).
6. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the OD and OS **Underlying Conditions** drop-down menus.
7. Select the prescription's usage from the **Usage** drop-down menu.
8. Select OD and OS tints from the **Tint** drop-down menus (rigid lenses only).
9. Select a lens wear schedule from the **Wear Schedule** drop-down menu.
10. Select a lens replenishment schedule from the **Replenishment** drop-down menu.
11. Select a disinfecting regimen from the **Disinfecting** drop-down menu.
12. Select the **DOT** None, OD, or OS button (rigid lenses only).
13. If you are conducting a monovision contact lens fitting, select the near eye from the **Monovision** drop-down menu.
14. If you want to copy the presenting prescription to the trial prescription, click **Copy to Trial Rx** and go to "To record and modify the trial contact lens Rx" on page 221.
15. If you want to copy the presenting prescription to the final prescription, click **Copy to Final Rx** and go to "To record and modify the final contact lens Rx" on page 232.
16. If you want to create multiple presenting contact lens prescriptions, click **New Rx** and follow the steps above to create additional presenting contact lens prescriptions.

NOTES	• Click the arrows under **#/of** to view other presenting contact lens prescriptions. • If you are an OfficeMate user, click the arrow buttons in the OfficeMate Soft Order or Hard Lens Order window to view the multiple prescriptions.

17. If you want to add presenting contact lens prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 13.

    The PRESENTING CL Rx Impressions/Observations window opens.

18. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

19. Click **Save/Exit**.
20. Click **Save/Exit** to close the Rx window.

To record and modify the trial contact lens Rx

1. Click in the **Trial Rx** box in the middle left of the Vision/Rx ExamWRITER chart window.

   The Contact Lens Rx - Trial window opens.

   OR

   Click the **Trial** tab on the Contact Lens Rx window.

NOTE	To view or record patient or Rx notes, click **Show Notes** or **Show Rx Notes**. If you record Rx Notes, a flag is displayed on the ExamWRITER chart window notifying you that there are Rx notes; click this flag to view the notes. To copy notes from the Notes text box to the Rx Notes text box, click **Rx Notes=Notes**. The notes that you typed in the Notes text box will transfer to the Rx Notes text box and replace any previously recorded notes in the Rx Notes text box.

2. If you want to copy the most recent final spectacle Rx from a prior exam (if one does not exist in the current exam) that appears at the bottom of the window to the current trial Rx, click **Copy Final Spec to Trial**.

3. Click on the blue slider bar or on the measurement buttons to add measurements to the **Contact Lens Rx - Trial OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Contact Lens Rx - Trial OD**, **OS**, and **OU** text boxes.

NOTES

- You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes.
- If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

4. Click the ellipse (**...**) next to the OD and OS **Product Name** boxes to select contact lens product names.

   The Select Contact Lens window opens.

NOTES	
	• To view all contact lens products in your ExamWRITER database, select **Show ALL**. To view only the products that you previously designated as the most commonly used products and assigned to your Quick List in the Products window, deselect **Show ALL**. To set up a preference for displaying all contact lenses or only those in your Quick List, go to "To set up default preferences" on page 69. • To find a specific contact lens product in your ExamWRITER database, type the product name in the **Name Search** text box. • To view a specific contact lens category, select the category from the **Lens Category** drop-down menu. You must assign contact lenses to a lens category in order for them to appear in the Select Contact Lens window and be selected for an Rx. To assign contact lenses to a lens category go to "Setting Up Product and Service Information" on page 76.

5. Select the appropriate product name, click **Search** to search for a specific product with the measurements you recorded (if applicable), and double-click on the appropriate product details line in the bottom part of the

window to add the contact lens product name, tint, and lens (if applicable) to the trial contact lens prescription.

OR

Select the appropriate product name and click **Product Name Only** to add only the product name to the trial contact lens prescription.

NOTES

- If the contact lens product does not have any item details recorded, clicking the **Search** button will yield no results in the bottom part of the window.
- Click **Clear Rx** to delete the measurements from the Select Contact Lens window and record new measurements or leave the boxes empty.

Select Contact Lens

Search ☑ Show ALL   Lens Category (All)

Product Name	Fee Slip Description	Lens Category	Tint
Actifresh 400	Actifresh 400	Soft Sphere Disposable	
Acuvue	Acuvue	Soft Sphere Disposable	
Acuvue 1 Day Moist	Acuvue Moist	Soft Sphere Disposable	
Acuvue 2	Acuvue 2	Soft Sphere Disposable	
Acuvue 2 Colors Opaque	Acuvue 2 Colors	Soft Sphere Disposable	
Acuvue 2 Colours Enhancers	Acuvue 2 Colours Enhancer	Soft Sphere Disposable	
Acuvue Advance	Acuvue Advance	Soft Sphere	
Acuvue Advance for Astigmatism	Acuvue Advance for Astigmatism	Soft Toric	
Acuvue Bifocal	Acuvue Bifocal	Soft Bifocal	
Acuvue Oasys	Acuvue Oasys	Soft Sphere	
Acuvue Oasys for Astigmatism	Acuvue Astigmatism	Soft Toric	
Acuvue One Day	Acuvue One Day	Soft Sphere Disposable	
Acuvue Toric	Acuvue Toric	Soft Toric	
Air Optix	Air Optix	Soft Sphere	

Product Name Only

BC Dia Sph Cyl Axis   Search   Clear Rx

BC	Dia	Sph	Cyl	Axis	Add	Color	Product Code	OnHand	Discontinued
8.30	14.00	Plano							☐
8.70	14.00	Plano							☐

Items found = 2

Edit Product   New Product   Exit

NOTES	• To add or edit a contact lens product, select the appropriate product name and click **Edit Product**. The Products window opens. For more information on adding and editing contact lens products, see "Setting Up Product and Service Information" on page 76. • If you select a rigid, single-vision contact lens from the Select Contact Lens window, you will be able to view and record rigid sphere information. If you select a rigid, multifocal lens from the Select Contact Lens window, you will be able to view and record rigid bifocal information. Appropriate Rx fields are displayed for each lens category that you select.

6. If you want to automatically apply vertex corrections to the trial contact lens Rx, follow the instructions below:
   a. Record the patient's vertex distance. For more information on recording the vertex distance, go to "To record and modify a vertex distance measurement" on page 212.
   b. Click **Apply Vertex Correction** to automatically correct the sphere and cylinder fields if they are at or above +/- 4 diopters.
   c. Manually round the corrected sphere and cylinder measurements because they are not automatically rounded.
7. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the OD and OS **Underlying Conditions** drop-down menus.
8. Select OD and OS tints from the **Tint** drop-down menus (rigid lenses only).
9. Type an OD and OS quantity in the **Quantity** text box.
10. Select OD and OS blends from the **Blend** drop-down menus (rigid lenses only).
11. Select a lens wear schedule from the **Wear Schedule** drop-down menu.
12. Select a lens replenishment schedule from the **Replenishment** drop-down menu.
13. Select the **DOT** None, OD, or OS button (rigid lenses only).
14. If you are conducting a monovision contact lens fitting, select the near eye from the **Monovision** drop-down menu.
15. Select the prescription and expiration dates from the **Rx Date** and **Expiration Date** drop-down menus.
16. If you want to copy the trial prescription to the final prescription, click **Copy to Final Rx** and go to "To record and modify the final contact lens Rx" on page 232.

NOTE	If you copy the trial prescription to the final prescription, it will become the *primary* final prescription.

17. If you want to create multiple trial contact lens prescriptions, click **New Rx** and follow the steps above to create additional trial contact lens prescriptions.

NOTES

- Click the arrows under **#/of** to view other trial contact lens prescriptions.
- If you are an OfficeMate user, click the arrow buttons in the OfficeMate Soft Order or Hard Lens Order window to view the multiple prescriptions.

18. If you want to add trial contact lens prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 20.

    The CONTACT LENS TRIAL Impressions/Observations window opens.

19. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

20. Click **Save/Exit**.

21. Click **Create Lab Order** or **Update Lab Order** to create or update the trial contact lens lab order.

    An Rx number appears in the Lab Order text box. The Rx charges are transferred to OfficeMate where they are automatically priced when the Rx is recorded in OfficeMate.

NOTE	If you click Clear after creating or updating a lab order, the Rx in OfficeMate is not removed.

22. Click **Save/Exit** to close the Rx window.

▶ To record and modify the sphere – cylinder contact lens ORx

1. Click in the **Sph/Cyl ORx** box in the middle left of the Vision/Rx ExamWRITER chart window.

   The Contact Lens Rx – Sphere-Cylinder ORx window opens.

   OR

   Click the **Sph-Cyl ORx** tab on the Contact Lens Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Contact Lens Rx – Sphere-Cylinder ORx OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Contact Lens Rx – Sphere-Cylinder ORx OD**, **OS**, and **OU** text boxes.

NOTES

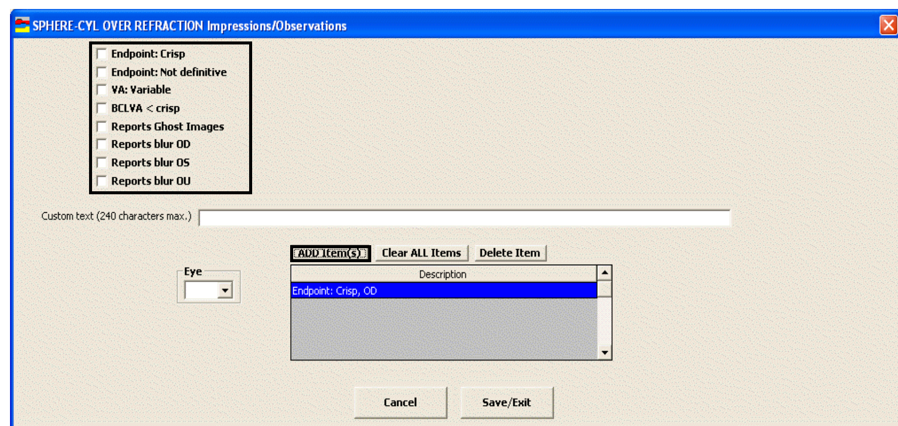
- You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes.
- If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. If you are conducting a monovision contact lens fitting, select the near eye from the **Monovision** drop-down menu.
5. If you want to add spherical cylinder over refraction contact lens prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 8.

   The SPHERE-CYL OVER REFRACTION Impressions/Observations window opens.

6. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



7. Click **Save/Exit**.
8. Click **Save/Exit** to close the Rx window.

▶ To record and modify the sphere contact lens ORx

1. Click in the **ORx** box in the middle of the Vision/Rx ExamWRITER chart window.

   The Contact Lens Rx – Sphere ORx window opens.

   OR

   Click the **Sph ORx** tab on the Contact Lens Rx window.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the **Contact Lens Rx – Sphere ORx OD**, **OS**, and **OU** text boxes.

   OR

   Type the appropriate measurements in the **Contact Lens Rx – Sphere ORx OD**, **OS**, and **OU** text boxes.

NOTES

- You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes.
- If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
4. If you are conducting a monovision contact lens fitting, select the near eye from the **Monovision** drop-down menu.
5. If you want to copy the spherical ORx prescription to the trial prescription, click **Copy to Trial Rx** and go to "To record and modify the trial contact lens Rx" on page 221.

6. If you want to create multiple spherical over refraction contact lens prescriptions, click **New Rx** and follow the steps above to create additional spherical over refraction contact lens prescriptions.

NOTES	• Click the arrows under **#/of** to view other spherical over refraction contact lens prescriptions. • If you are an OfficeMate user, click the arrow buttons in the OfficeMate Soft Order or Hard Lens Order window to view the multiple prescriptions.

7. If you want to add spherical over refraction contact lens prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 10.

   The SPHERICAL OVER REFRACTION Impressions/Observations window opens.

8. Select the appropriate check boxes and click ADD Item(s).

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

9. Click **Save/Exit**.
10. Click **Save/Exit** to close the Rx window.

▶ To record and modify the final contact lens Rx

1. Click in the **Final Contact Rx** box in the bottom left of the Vision/Rx ExamWRITER chart window.

   The Contact Lens Rx - Final window opens.

   OR

   Click the **Final** tab on the Contact Lens Rx window.

NOTE	To view or record patient or Rx notes, click **Show Notes** or **Show Rx Notes**. If you record Rx Notes, a flag is displayed on the ExamWRITER chart window notifying you that there are Rx notes; click this flag to view the notes. To copy notes from the Notes text box to the Rx Notes text box, click **Rx Notes=Notes**. The notes that you typed in the Notes text box will transfer to the Rx Notes text box and replace any previously recorded notes in the Rx Notes text box.

2. Click on the blue slider bar or on the measurement buttons to add measurements to the Contact Lens Rx – Final OD, OS, and OU text boxes.

   OR

   Type the appropriate measurements in the Contact Lens Rx – Final OD, OS, and OU text boxes.

NOTES

- You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes.
- If you want to make the OD, OS, and OU prescriptions the same measurement, click the **=** button.
- To clear all visual acuities previously recorded for an Rx, click **Clear VAs**.

3. Click the ellipse (**...**) next to the OD and OS **Product Name** boxes to select contact lens product names.

   The Select Contact Lens window opens.

NOTES	
	• To view all contact lens products in your ExamWRITER database, select **Show ALL**. To view only the products that you previously designated as the most commonly used products and assigned to your Quick List in the Products window, deselect **Show ALL**. To set up a preference for displaying all contact lenses or only those in your Quick List, go to "To set up default preferences" on page 69. • To find a specific contact lens product in your ExamWRITER database, type the product name in the **Name Search** text box. • To view a specific contact lens category, select the category from the **Lens Category** drop-down menu. You must assign contact lenses to a lens category in order for them to appear in the Select Contact Lens window and be selected for an Rx. To assign contact lenses to a lens category go to "Setting Up Product and Service Information" on page 76.

4. Select the appropriate product name, click **Search** to search for a specific product with the measurements you recorded (if applicable), and double-click on the appropriate product details line in the bottom part of the

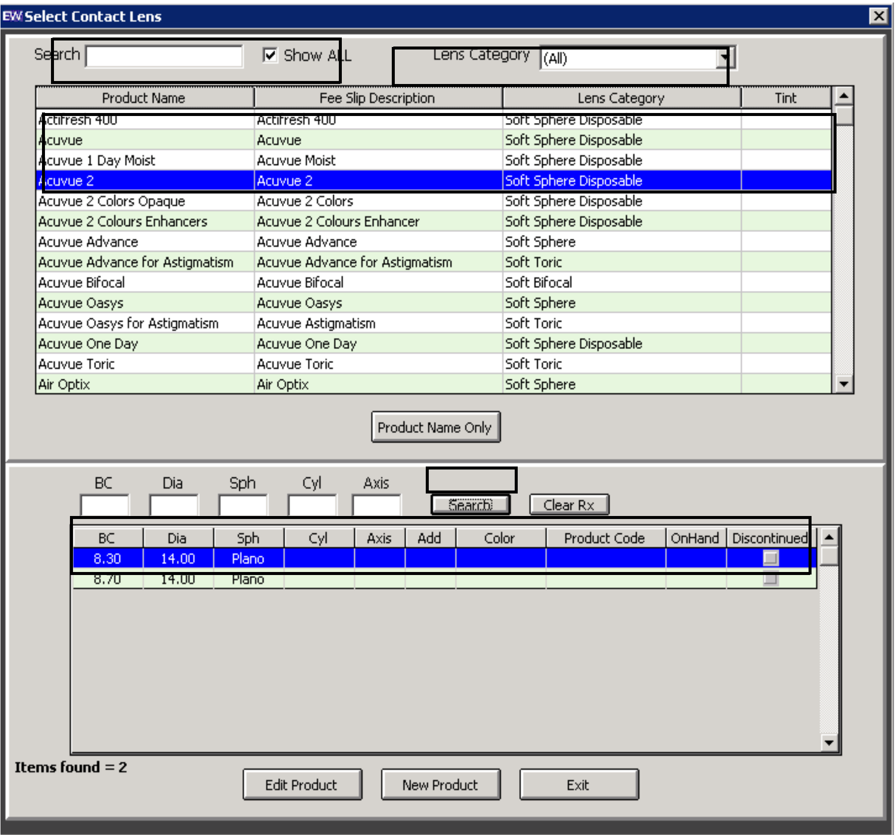
window to add the contact lens product name, tint, and lens (if applicable) to the final contact lens prescription.

OR

Select the appropriate product name and click **Product Name Only** to add only the product name to the final contact lens prescription.

NOTES

- If the contact lens product does not have any item details recorded, clicking the **Search** button will yield no results in the bottom part of the window.
- Click **Clear Rx** to delete the measurements from the Select Contact Lens window and record new measurements or leave the boxes empty.



NOTES	• To add or edit a contact lens product, select the appropriate product name and click **Edit Product**. The Products window opens. For more information on adding and editing contact lens products, see "Setting Up Product and Service Information" on page 76. • If you select a rigid, single-vision contact lens from the Select Contact Lens window, you will be able to view and record rigid sphere information. If you select a rigid, multifocal lens from the Select Contact Lens window, you will be able to view and record rigid bifocal information. Appropriate Rx fields are displayed for each lens category that you select.

5. If the patient has a nonprescription underlying condition, select **Balance Lens**, **No Lens**, **Not Recorded**, or **Prosthesis** from the **Underlying Conditions** drop-down menu.
6. Select OD and OS tints from the **Tint** drop-down menus (rigid lenses only).
7. Type an OD and OS quantity in the **Quantity** text box.
8. Select the prescription's usage from the **Usage** drop-down menu.
9. Select OD and OS blends from the **Blend** drop-down menus (rigid lenses only).
10. Select a lens wear schedule from the **Wear Schedule** drop-down menu.
11. Select a lens replenishment schedule from the **Replenishment** drop-down menu.
12. Select a disinfecting regimen from the **Disinfecting** drop-down menu.

NOTE	• The Disinfection information that is recorded on the Contacts (Care Regimen) window will print on the first final Rx. Selections from the Disinfecting drop-down menu on the Contact Lens Rx - Final window will print on the second and any subsequent final prescriptions. • Only the disinfecting information that is recorded for the most recently saved final Rx is displayed under the Plan category bar on the Surgery - Plan - Mgmt tab.

13. Select the **DOT** None, OD, or OS button (rigid lenses only).
14. If you are conducting a monovision contact lens fitting, select the near eye from the **Monovision** drop-down menu.
15. Select the prescription and expiration dates from the **Rx Date** and **Expiration Date** drop-down menus.
16. If you want to add final contact lens prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 17.

    The FINAL CL Rx Impressions/Observations window opens.

17. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

18. Click **Save/Exit**.

19. Click **Create Lab Order** or **Update Lab Order** to create or update the final contact lens lab order.

    An Rx number appears in the Lab Order text box. The Rx charges are transferred to OfficeMate where they are automatically priced when the Rx is recorded in OfficeMate.

NOTE	If you click Clear after creating or updating a lab order, the Rx in OfficeMate is not removed.

20. Click **Print Rx** to print the final Rx.
21. If you want to create multiple final contact lens prescriptions, click **New Rx** and follow the steps above to create additional final contact lens prescriptions.

NOTES

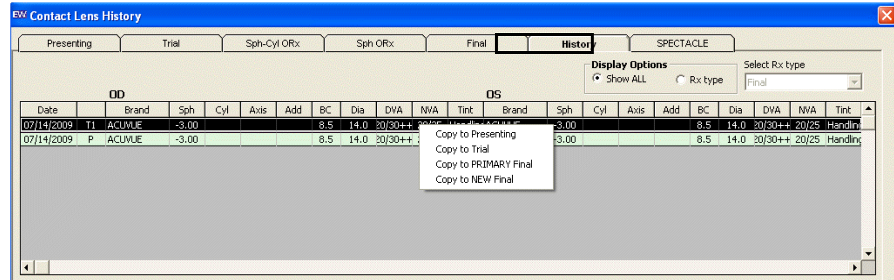
- Click the arrows under **#/of** to view other final contact lens prescriptions.
- If you are an OfficeMate user, click the arrow buttons in the OfficeMate Soft Order or Hard Lens Order window to view the multiple prescriptions.

22. Click **Save/Exit** to close the Rx window.

▶ To view the contact lens history

❖ Click the yellow **Hx** button in the top middle of the Vision/Rx ExamWRITER chart window or click the **History** tab on the Contact Lens Rx window.

Right-click on a prescription and select a copy option to copy the selected prescription to another prescription.



NOTES

- After you have finished recording Vision/Rx information in an EMR, the Vision bar changes in color from orange to green.
- All abnormal medical conditions appear in red text in the ExamWRITER chart window. All normal medical conditions appear in black text in the ExamWRITER chart window.

Recording Binocular Vision/Rx Information

This section tells you how to record binocular vision and prescription information in ExamWRITER, including how

- To record and modify distance cover test measurements, 239
- To record and modify near cover test measurements, 241
- To record and modify near point convergence measurements, 243
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- To record and modify phoria near measurements, 255
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- To record and modify relative accommodation measurements, 261
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To record and modify binocular vision and prescription information in an EMR, click the **Vision/Rx** tab on the ExamWRITER chart window and then click the **Binocular** tab on the Vision bar.

For more information on recording binocular vision information, watch the "Refraction" video.

▶ To record and modify distance cover test measurements

1. Click in the **Cover Test - Distance** box in the top left of the Vision/Rx ExamWRITER chart window.

   The COVER TEST – DISTANCE window opens.

2. Select the appropriate test from the **Test** drop-down menu.
3. Select the appropriate **ESO**, **Ortho**, **EXO**, **Base Up**, or **Base Dn** radio button.
4. Select the appropriate **Phoria** or **Tropia** radio button.
5. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTES

- You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes.
- Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric cover test distance information.

6. If you want to add distance cover test binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 8.

   The COVER TEST DISTANCE Impressions/Observations window opens.

7. Select an appropriate etiology from the **Etiology** drop-down menu, then select the appropriate check boxes, and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

8. Click **Save/Exit**.

To record and modify near cover test measurements

1. Click in the **Cover Test - Near** box in the top left of the Vision/Rx ExamWRITER chart window.

   The COVER TEST – NEAR window opens.
2. Select the appropriate test from the **Test** drop-down menu.
3. Select the appropriate **ESO**, **Ortho**, **EXO**, **Base Up**, or **Base Dn** radio button.
4. Select the appropriate **Phoria** or **Tropia** radio button.

5. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTES

- You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes.
- Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric cover test near information.

6. If you want to add near cover test binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 8.

   The COVER TEST (NEAR) Impressions/Observations window opens.

7. Select an appropriate etiology from the Etiology drop-down menu, then select the appropriate check boxes, and click ADD Item(s).

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

8. Click **Save/Exit**.

▶ To record and modify near point convergence measurements

1. Click in the **NPC** box in the top left of the Vision/Rx ExamWRITER chart window.

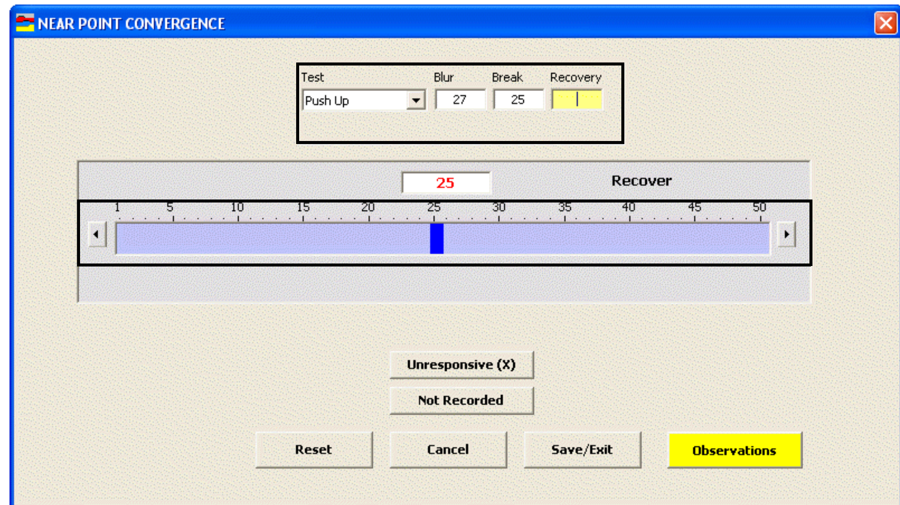
   The NEAR POINT CONVERGENCE window opens.

2. Select the appropriate test from the **Test** drop-down menu.

3. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.



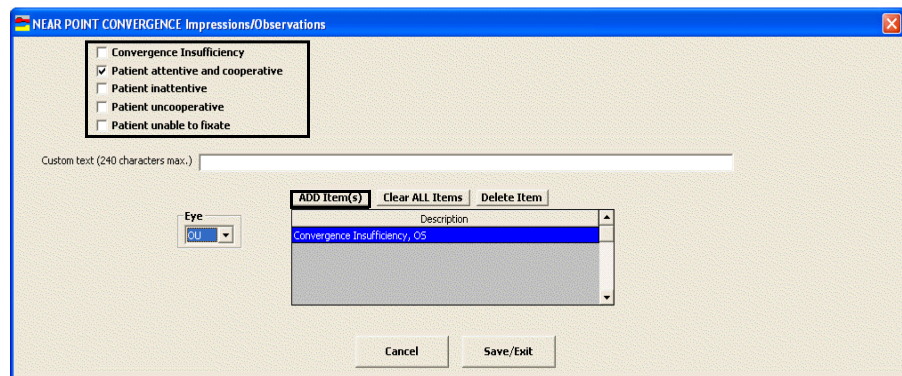
NOTES	• You do not need to click on a Blur, Break, or Recovery text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the Blur, Break, and Recovery text boxes. • Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric near point convergence information.

4. If you want to add near point convergence binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 6.

   The NEAR POINT CONVERGENCE Impressions/Observations window opens.

5. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



6. Click **Save/Exit**.

▶ To record and modify fusion measurements

1. Click in the **Fusion** box in the top left of the Vision/Rx ExamWRITER chart window.

   The FUSION window opens.

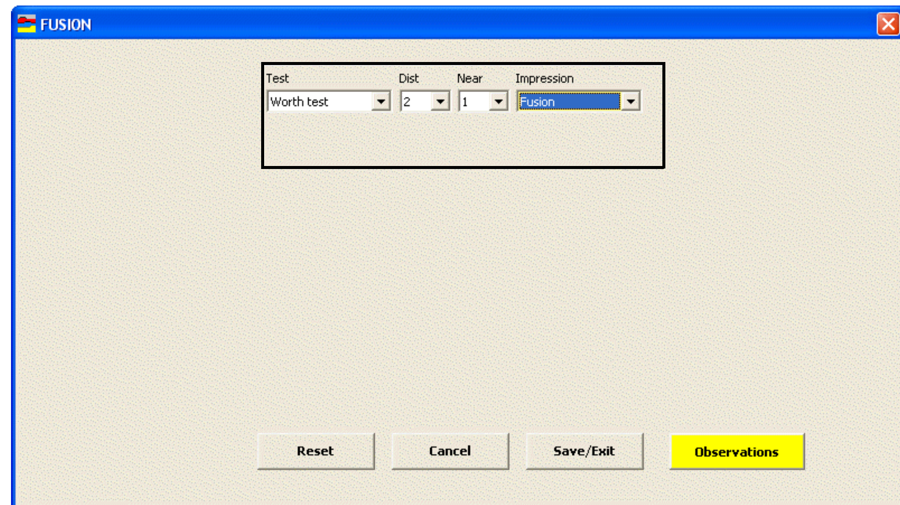
2. Select the appropriate test from the **Test** drop-down menu.

NOTE	Press the **F12** key in the Test drop-down menu to open a Code Maintenance window and add tests to the drop-down menu.

3. Select the distance measurement from the **Dist** drop-down menu.
4. Select the near measurement from the **Near** drop-down menu.

5. Select an impression from the **Impression** drop-down menu.

NOTE	If Worth Test is selected from the Test drop-down menu and 4 is selected from the Dist and Near drop-down menus, the Impression drop-down menu autopopulates with Fusion.



6. If you want to add fusion binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 8.

   The FUSION Impressions/Observations window opens.

7. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

8. Click **Save/Exit**.

To record and modify aniseikonia measurements

1. Click in the **Aniseikonia** box in the top middle of the Vision/Rx ExamWRITER chart window.

   The ANISEIKONIA window opens.

2. Select the appropriate vertical and horizontal distance and near measurements from the drop-down menus.

3. If you want to add aniseikonia binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The ANISEIKONIA Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

5. Click **Save/Exit**.

To record and modify stereopsis measurements

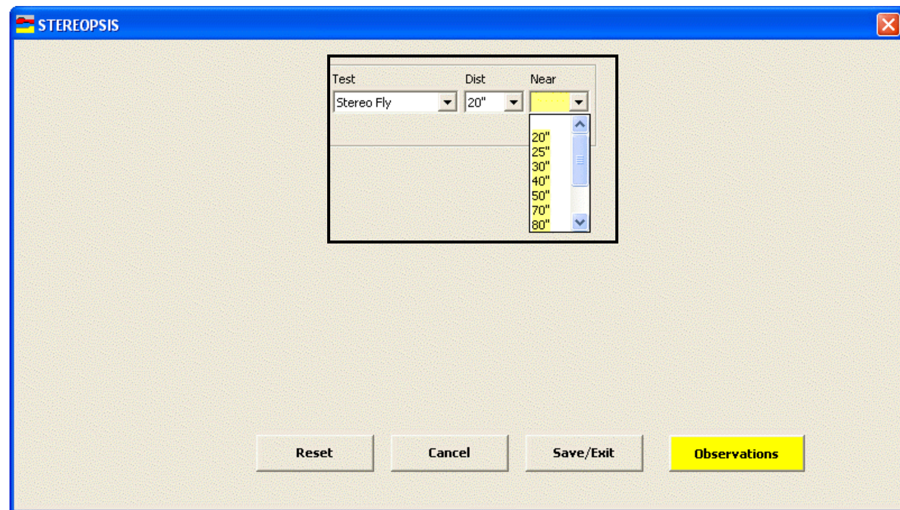
1. Click in the **Stereopsis** box in the top middle of the Vision/Rx ExamWRITER chart window.

   The STEREOPSIS window opens.

2. Select the appropriate test from the **Test** drop-down menu.

NOTE	Press the **F12** key in the Test drop-down menu to open a Code Maintenance window and add tests to the drop-down menu.

3. Select the distance measurement from the **Dist** drop-down menu.
4. Select the near measurement from the **Near** drop-down menu.

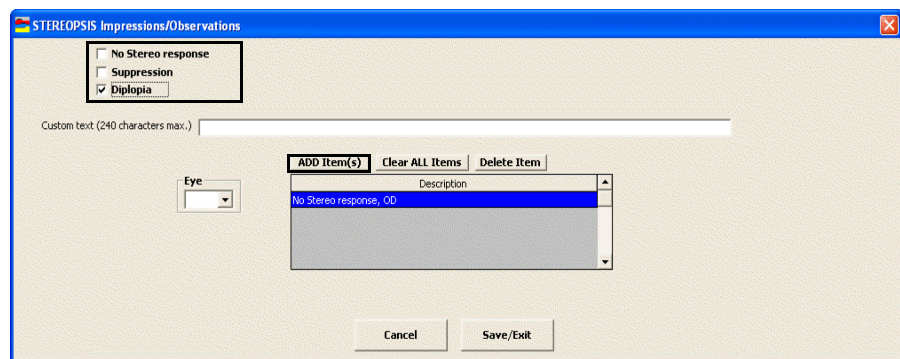


5. If you want to add stereopsis binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 7.

   The STEREOPSIS Impressions/Observations window opens.

6. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



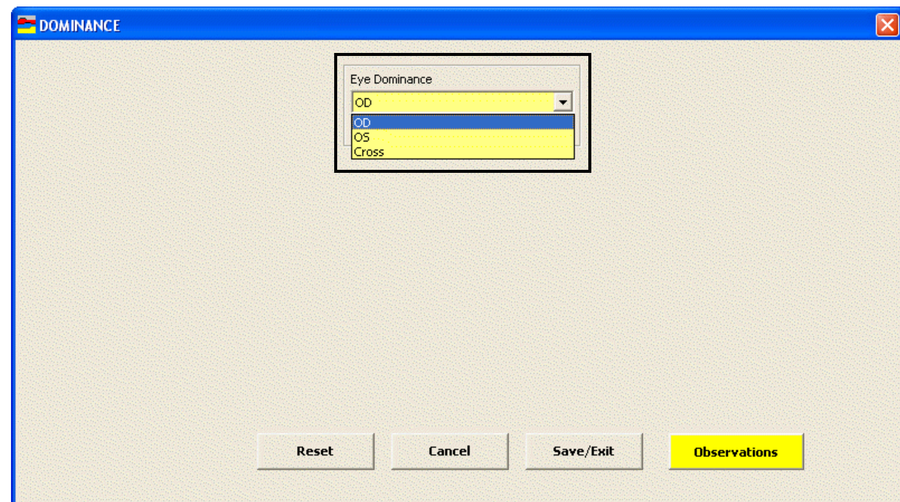
7. Click **Save/Exit**.

▶ To record and modify eye dominance

1. Click in the **Dominance** box in the top middle of the Vision/Rx ExamWRITER chart window.

   The DOMINANCE window opens.

2. Select the appropriate eye dominance from the **Eye Dominance** drop-down menu.

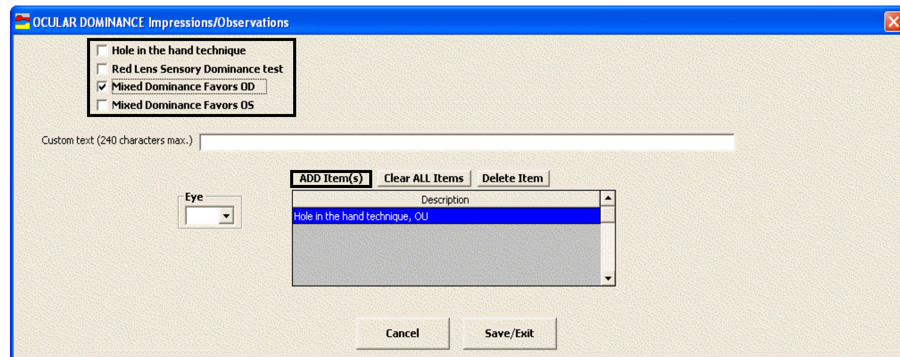


3. If you want to add eye dominance binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The OCULAR DOMINANCE Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



5. Click **Save/Exit**.

▶ To record and modify near point accommodation measurements

1. Click in the **NPA** box in the top middle of the Vision/Rx ExamWRITER chart window.

   The NEAR POINT ACCOMMODATION window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

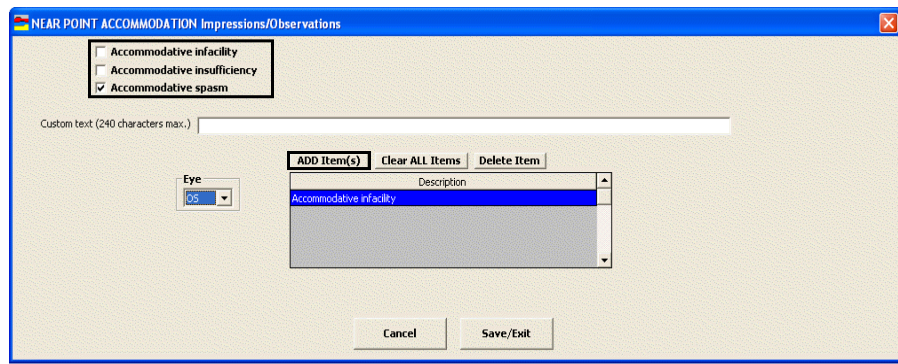
NOTES	
	• You do not need to click on an OD, OS, or OU text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD, OS, and OU text boxes. • Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric near point accommodation information.

3. If you want to add near point accommodation binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The NEAR POINT ACCOMMODATION Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



5. Click **Save/Exit**.

▶ To record and modify phoria distance measurements

1. Click in the **Phoria - Distance** box in the top middle of the Vision/Rx ExamWRITER chart window.

   The PHORIA - DISTANCE window opens.

2. Select the appropriate test from the **Test** drop-down menu.

NOTE	Press the **F12** key in the Test drop-down menu to open a Code Maintenance window and add tests to the drop-down menu.

3. Select the appropriate **ESO**, **Ortho**, **EXO**, **Base Up**, or **Base Dn** radio button.

4. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

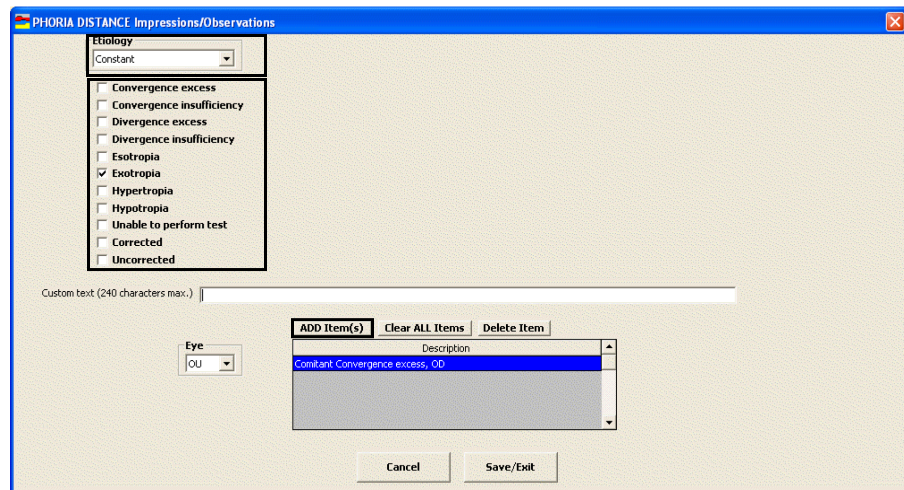
NOTE	
	• You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes. • Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric phoria distance information.

5. If you want to add phoria distance binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 7.

   The PHORIA DISTANCE Impressions/Observations window opens.

6. Select an appropriate etiology from the **Etiology** drop-down menu, then select the appropriate check boxes, and click **ADD Item(s)**.

NOTE	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



7. Click **Save/Exit**.

▶ To record and modify phoria near measurements

1. Click in the **Phoria - Near** box in the top middle of the Vision/Rx ExamWRITER chart window.

   The PHORIA - NEAR window opens.

2. Select the appropriate test from the **Test** drop-down menu.

NOTE	Press the **F12** key in the Test drop-down menu to open a Code Maintenance window and add tests to the drop-down menu.

3. Select the appropriate **ESO**, **Ortho**, **EXO**, **Base Up**, or **Base Dn** radio button.

4. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTES	• You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes. • Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric phoria near information.

5. If you want to add phoria near binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 7.

   The PHORIA NEAR Impressions/Observations window opens.

6. Select an appropriate etiology from the **Etiology** drop-down menu, then select the appropriate check boxes, and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

7. Click **Save/Exit**.

▶ To record and modify vergence measurements

1. Click in the Vergence box in the top right of the Vision/Rx ExamWRITER chart window.

   The VERGENCE window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTES	
	• You do not need to click on a BI (Divergence) or BO (Convergence) text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the BI (Divergence) and BO (Convergence) text boxes.
	• Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric vergence information.

3. If you want to add vergence binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The VERGENCE Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

5. Click **Save/Exit**.

▶ To record and modify an AC/A ratio measurement

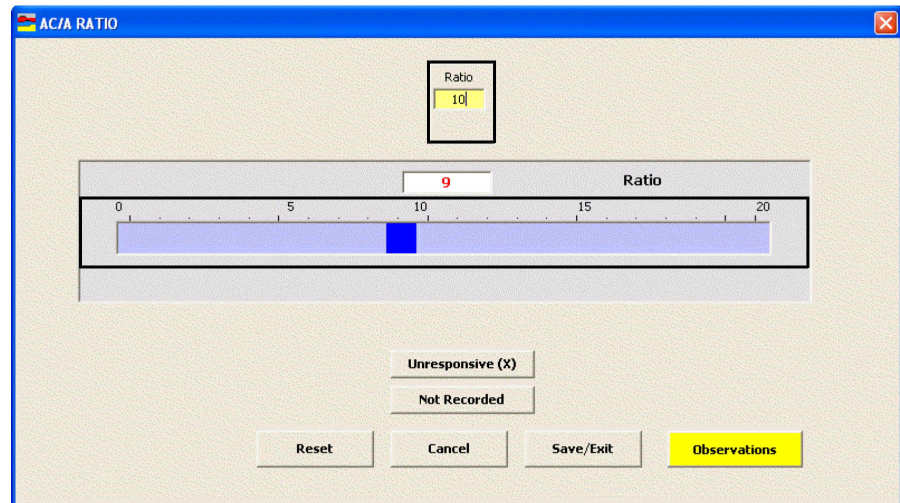
1. Click in the **AC/A Ratio** box in the top right of the Vision/Rx ExamWRITER chart window.

   The AC/A RATIO window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.



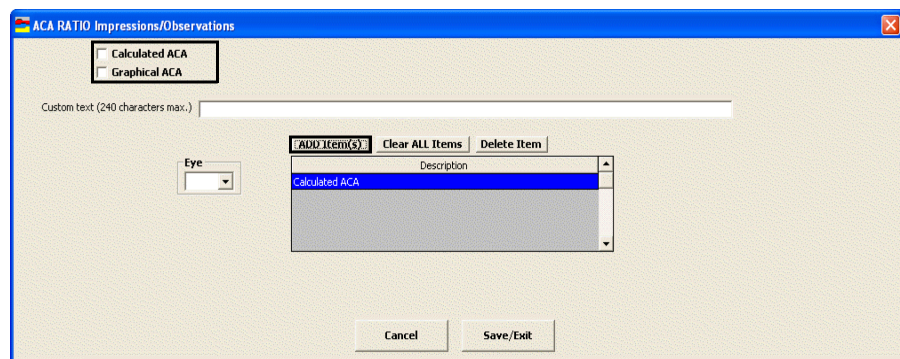
NOTE	Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric AC/A ratio information.

3. If you want to add AC/A ratio binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The ACA RATIO Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



5. Click **Save/Exit**.

▶ To record and modify relative accommodation measurements

1. Click in the NRA/PRA box in the top right of the Vision/Rx ExamWRITER chart window.

   The RELATIVE ACCOMMODATION window opens.

2. Select the appropriate **(-) Minus**, **Plano**, or **(+) Plus** radio button.

3. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTES	
	• You do not need to click on an NRA or PRA text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the NRA and PRA text boxes. • Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric relative accommodation information.

4. If you want to add relative accommodation binocular prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 6.

   The NEGATIVE RELATIVE ACCOM Impressions/Observations window opens.

5. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

6. Click Save/Exit.

▶ To record and modify a binocular cross cylinder measurement

1. Click in the BXC/14B box in the top right of the Vision/Rx ExamWRITER chart window.

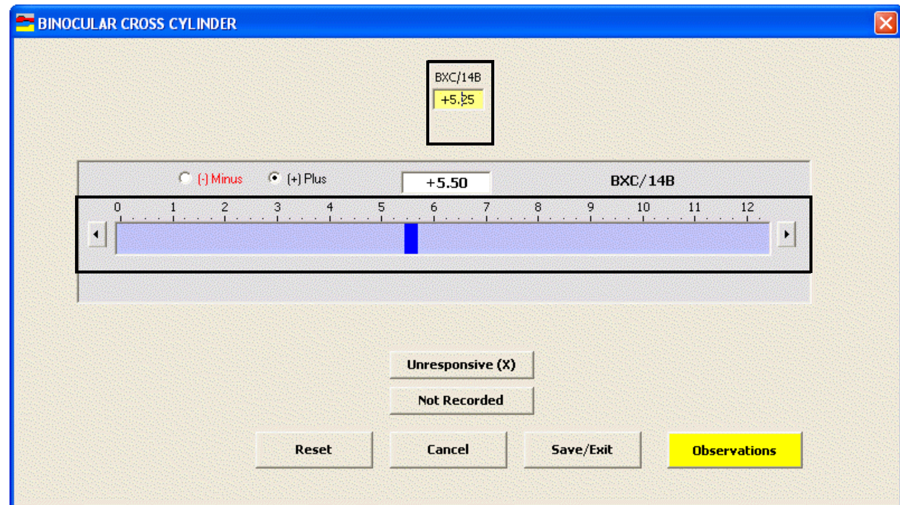
   The BINOCULAR CROSS CYLINDER window opens.

2. Select the appropriate **(-) Minus** or **(+) Plus** radio button.

3. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.



NOTE	Click **Unresponsive (X)** and **Not Recorded** to record nonnumeric binocular cross cylinder information.

4. If you want to add binocular cross cylinder prescription impressions and observations to the EMR, click **Observations**; otherwise, go to step 6.

   The BXC Impressions/Observations window opens.

5. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

6. Click **Save/Exit**.

NOTES	• After you have finished recording Vision/Rx information in an EMR, the **Vision** bar changes in color from orange to green. • All abnormal medical conditions appear in red text in the ExamWRITER chart window. All normal medical conditions appear in black text in the ExamWRITER chart window.

Recording Examination & Special Testing Information

7

For more information on recording examination information, watch the "Examination" video.

In this chapter:

- Recording & Modifying Tonometry Measurements, 268
- Viewing Tonometry Measurement History, 270
- Recording & Modifying Target IOP Measurements, 271
- Recording & Modifying Pachymetry Measurements, 272
- Viewing Pachymetry Measurement History, 273
- Recording & Modifying Cup Disc Ratio Measurements, 274
- Viewing Cup Disc Ratio Measurement History, 276
- Recording & Modifying Vital Signs , 277
- Recording Retinal Image Information, 280
- Recording & Modifying Dilation Orders, 281
- Recording & Modifying Confrontation Fields, 282
- Recording & Modifying Amsler Studies, 282
- Recording Examination Information, 283
- Recording Special Testing Information, 285
- Modifying Examination & Special Testing Information, 286

The ExamWRITER chart window is organized for you to follow the SOAP (Subjective, Objective, Assessment, Plan) methodology when you are entering information into an EMR. Click the **Exam - Special Tests** tab to enter objective information into an EMR.

Recording & Modifying Tonometry Measurements

NOTES	
	• You can record up to ten tonometry measurements in each EMR. • Click the yellow **Hx** button in the IOP grid on the ExamWRITER chart window to view the patient's IOP history in a list and in a graph. • You can quickly view in red highlights if an IOP value in the IOP table is greater than 20 or if the most recently recorded IOP value deviates from any IOP value in the patient's history more than the IOP variance trigger. For more information on setting up the IOP variance trigger, go to "To set up default preferences" on page 69.

1. Click on a blank line in the **IOP** grid in the top left of the Examination ExamWRITER chart window to add a new measurement.

   OR

   Click on an existing line in the **IOP** grid in the top left of the Examination ExamWRITER chart window to modify or delete a measurement.

   The Tonometry window opens.
2. Click **Goldmann**, **Applanation**, **Non-Contact**, **ICare Rebound**, or **TonoPen**, **Digital**, or **Pascal Tonometer** to add the appropriate test to the **Test** text box.

3. Click on the blue slider bar to add a measurement to the yellow highlighted text box or modify a measurement in the yellow highlighted box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTES	• You do not need to click on the OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes. • Click **OD – Not Recorded** and **OS – Not Recorded** to record nonnumeric tonometry information. • If you want to delete the measurement, type 0 in the **OD** and **OS** text boxes and click **Save/Exit**; otherwise, go to step 4.

4. If you want to adjust the time, type numbers in the **Time** text box; otherwise, the current time will be recorded.
5. Select an appropriate tonometry category from the **Category** drop-down menu.

NOTE	If you select **Examination** from the Category drop-down menu, you can view highlighted OD and OS measurements that were used to compute the adjusted IOP in the IOP grid. You can also view the adjusted IOP in the Adjusted IOP boxes in the Pachymetry box if pachymetry measurements are recorded. To record pachymetry measurements, go to “Recording & Modifying Pachymetry Measurements” on page 272.

6. If you want to add tonometry impressions and observations to the EMR, click **Observations**; otherwise, go to step 8.

   The INTRA OCULAR TENSIONS Impressions/Observations window opens.

7. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

8. Click **Save/Exit** to close the INTRA OCULAR TENSIONS Impressions/Observations window.
9. Click **Save/Exit** to close the Tonometry window.

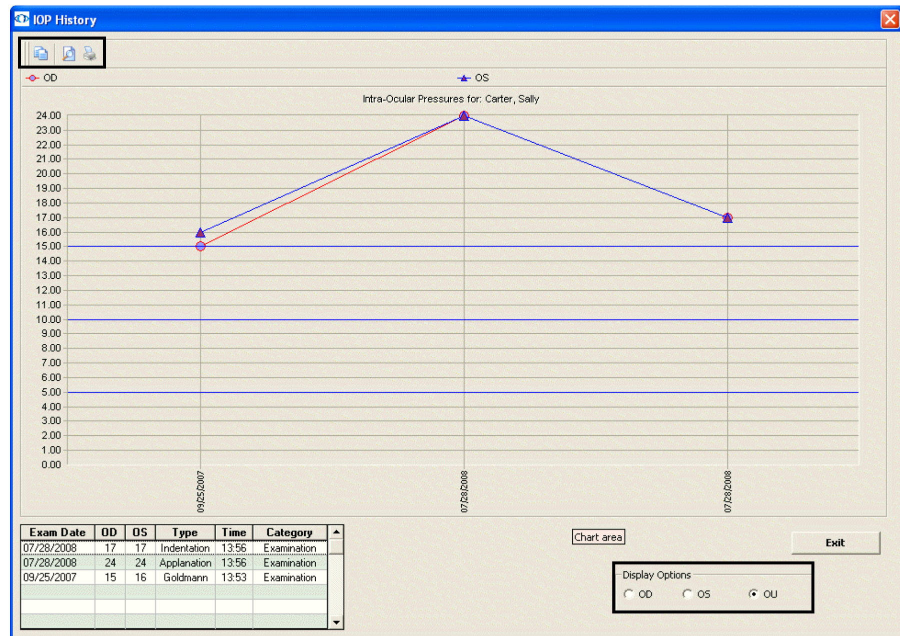
Viewing Tonometry Measurement History

NOTE	
	You can only view graphical tonometry measurement histories for Examination tests. You cannot view graphical tonometry measurement histories for Pre-Test and Post-Dilation tests.

1. Click the yellow **Hx** button in the IOP box in the top right of the Exam - Special Tests ExamWRITER chart window.

   The IOP History window opens.
2. Select the **OD**, **OS**, or **OU** radio button to change the display of the graph.

3. Click the icons at the top of the window to copy the graph to the clipboard or print the graph.



4. Click **Exit** to close the IOP History window.

Recording & Modifying Target IOP Measurements

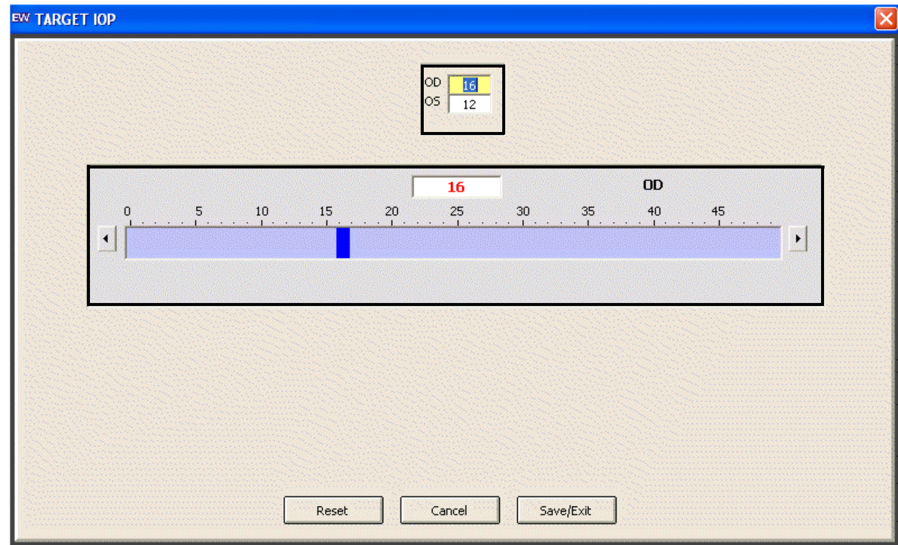
1. Click in the **Target IOP** box in the top left of the Exam - Special Tests ExamWRITER chart window.

   The TARGET IOP window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.



NOTE	You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes.

3. Click **Save/Exit**.

Recording & Modifying Pachymetry Measure-ments

NOTES	• Click the yellow **Hx** button in the Pachymetry box on the ExamWRITER chart window to view the patient's pachymetry history in a list and in a graph. For more information on viewing the patient's pachymetry history, go to "Viewing Pachymetry Measurement History" on page 273. • If you selected **Examination** from the Tonometry Category drop-down menu and you record pachymetry measurements, you can view the adjusted IOP in the Adjusted IOP boxes in the Pachymetry box. To record tonometry measurements, go to "Recording & Modifying Tonometry Measurements" on page 268.

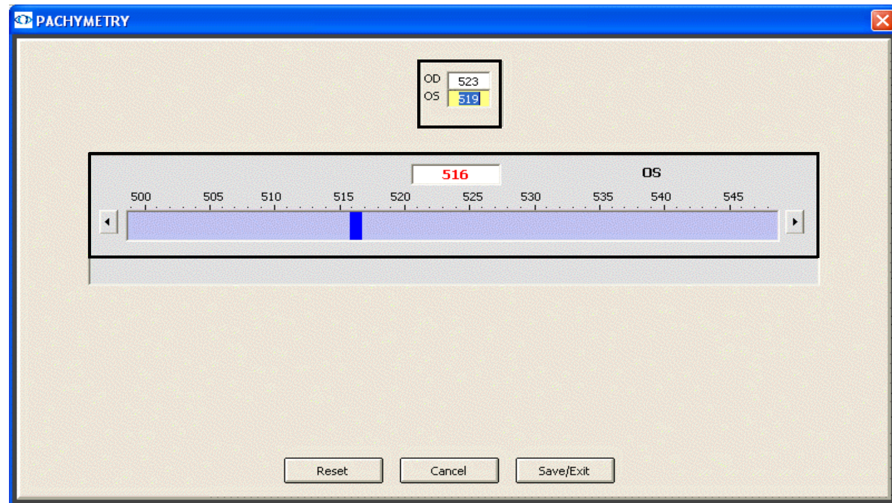
1. Click in the **Pachymetry** box in the top middle of the Exam - Special Tests ExamWRITER chart window.

   The PACHYMETRY window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.



NOTE	You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes.

3. If you want to add pachymetry impressions and observations to the EMR, click the **Exam - Special Tests** tab, click the **Special Testing** category bar, select **Pachymetry**, select appropriate check boxes, and click **Process**. For more information on recording pachymetry impressions, go to “Recording Special Testing Information” on page 285.
4. Click **Save/Exit**.

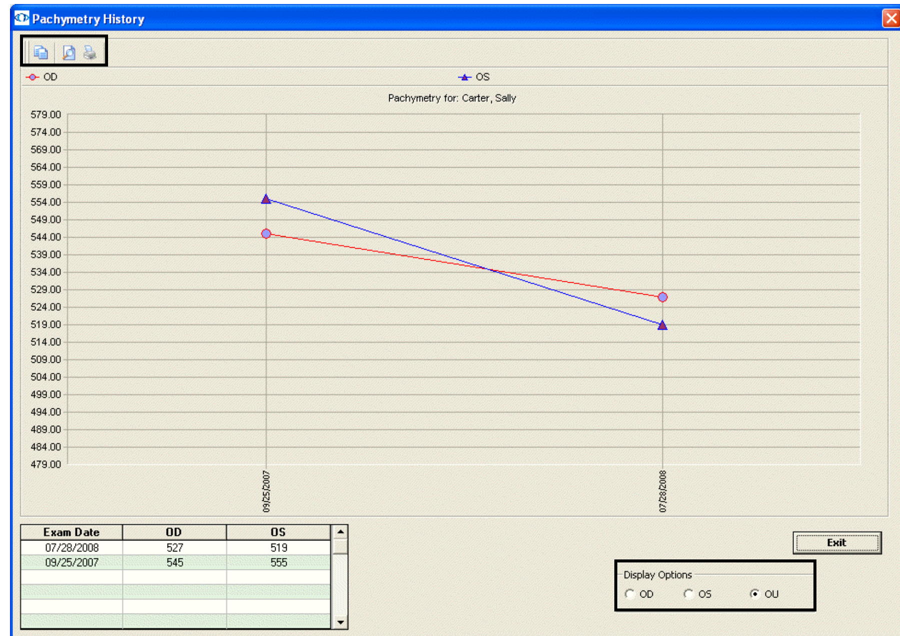
Viewing Pachymetry Measurement History

1. Click the yellow **Hx** button in the Pachymetry box in the top middle of the Exam - Special Tests ExamWRITER chart window.

   The Pachymetry History window opens.
2. Select the **OD**, **OS**, or **OU** radio button to change the display of the graph.

NOTE	To copy forward historical pachymetry values to a new exam, right-click on a pachymetry value in the table at the bottom of the window and select **Copy Forward**.

3. Click the icons at the top of the window to copy the graph to the clipboard or print the graph.



4. Click **Exit** to close the Pachymetry History window.

Recording & Modifying Cup Disc Ratio Measurements

NOTE	Click the yellow **Hx** button in the CD Radio box on the ExamWRITER chart window to view the patient's CD ratio history in a list and in a graph.

1. Click in the **CD Ratio** box in the top middle of the Examination ExamWRITER chart window.

   The CUP DISC RATIO window opens.

2. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

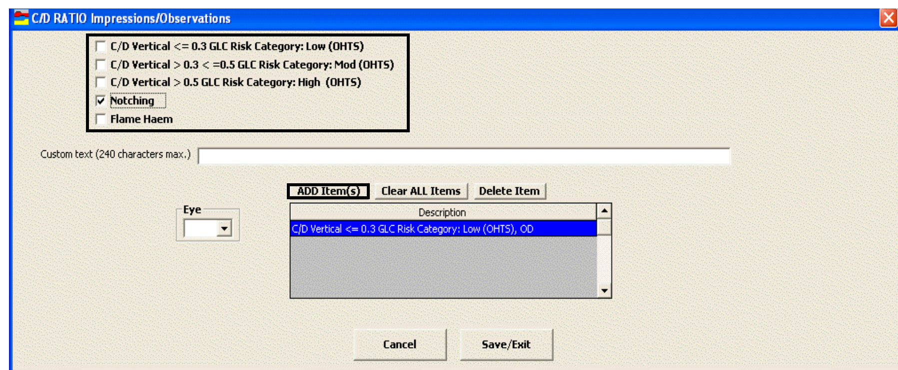
NOTE	You do not need to click on an OD or OS text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the OD and OS text boxes.

3. If you want to add cup disc ratio impressions and observations to the EMR, click **Observations**; otherwise, go to step 5.

   The C/D RATIO Impressions/Observations window opens.

4. Select the appropriate check boxes and click **ADD Item(s)**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.



5. Click **Save/Exit**.

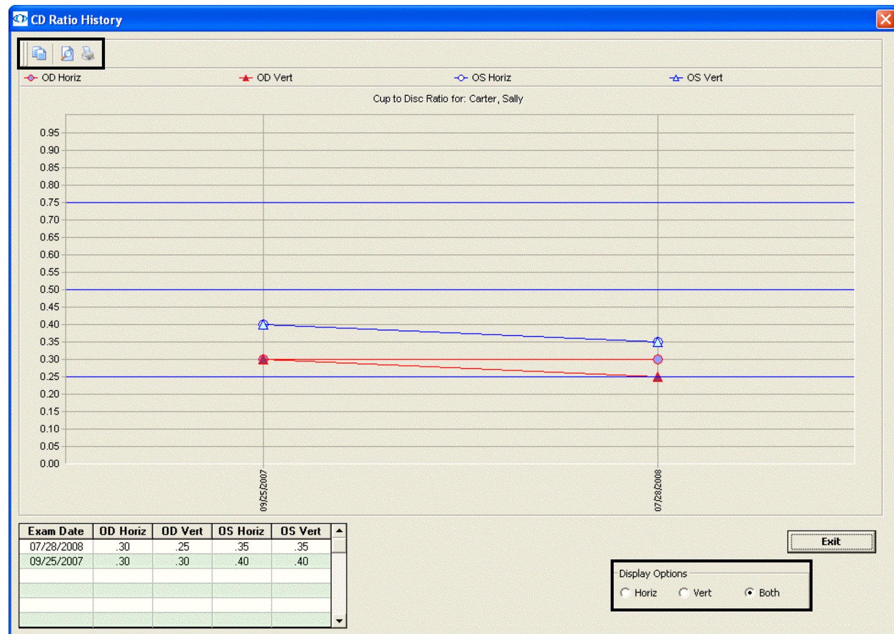
Viewing Cup Disc Ratio Measurement History

1. Click the yellow **Hx** button in the CD Ratio box in the top middle of the Exam - Special Tests ExamWRITER chart window.

   The CD Ratio History window opens.

2. Select the **OD**, **OS**, or **OU** radio button to change the display of the graph.

3. Click the icons at the top of the window to copy the graph to the clipboard or print the graph.



4. Click **Exit** to close the CD Ratio History window.

Recording & Modifying Vital Signs

1. Click the **Vital Signs** button in the top middle of the Exam - Special Tests ExamWRITER chart window.

   The Vital Signs window opens.

2. Click in the **Blood Pressure**, **Pulse**, **Height (inches)**, **Weight (pounds)**, and **Temperature** boxes.

3. Click on the blue slider bar to add a measurement to the yellow highlighted text box.

   OR

   Type the appropriate measurement in the yellow highlighted text box.

NOTES

- You do not need to click on the Systolic, Diastolic, or Pulse text box and then click on the blue slider bar each time that you add measurements to the text boxes. Simply click on the blue slider bar, and your cursor automatically tabs through the yellow highlighted text boxes in the normal prescription writing process and adds measurements to the Systolic, Diastolic, and Pulse text boxes.
- Select one of the following options to autocode the correct PQRS procedure codes in the exam.
  - Select **Urgent or Emergent** or **Patient Refused** to autocode the G9745 PQRS procedure code in the exam.
  - Select **Active Diagnosis of Hypertension** to autocode the G9744 PQRS procedure code in the exam.
  - If abnormal blood pressure readings are documented (>=120 or >=80) and you select **Referred to Alternative/Primary Care Provider**, the G8950 PQRS procedure code will autocode in the exam. Additionally, the BP measurements and field in the exam will be highlighted red.
  - If abnormal blood pressure readings are documented (>=120 or >=80) and you do *not* select **Referred to Alternative/Primary Care Provider**, the G8952 PQRS procedure code will autocode in the exam. Additionally, the BP measurements and field in the exam will be highlighted red.

4. If you want to add blood pressure and pulse impressions and observations to the EMR, click **Observations**; otherwise, go to step 6.

   The BP/PULSE Impressions/Observations window opens.

5. Select the appropriate check boxes, click **ADD Item(s)**, and then click Save/Exit.

NOTES	
	• To modify the time, type numbers in the **Time** text box. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

6. Click **Save/Exit**.

   After you record the patient's height and weight, the patient's BMI is automatically calculated.

   NOTES

   - To view a graph displaying the patient's historical vital signs, click the **Hx** buttons. Click the **Copy to clipboard** icon to copy the vital signs graph displayed to the clipboard and paste it into another document; click the **Print Preview** icon to preview the printed version of the graph; and click the **Print** icon to print the graph.
   - To view the patient's growth charts from ages 2 through 20, click the **Growth Chart** buttons. Click the **Copy to clipboard** icon to copy the growth chart graph displayed to the clipboard and paste it into another document; click the **Print Preview** icon to preview the printed version of the graph; and click the **Print** icon to print the graph.

7. Click **Exit** to close the Vital Signs window.

Recording Retinal Image Information

NOTE To record default retinal image text, go to "To set up default preferences" on page 69.

❖ Click **Retinal Image** in the top middle of the Examination ExamWRITER chart window to automatically record the location of the retinal image that you defined in your default preferences.

For information on modifying your default retinal image text, go to "To set up default preferences" on page 69. For information on attaching a retinal image to the EMR as an eDocument, go to "Attaching Electronic Documents to Patient Records" on page 127.

Recording & Modifying Dilation Orders

For more information on recording dilation orders, watch the "Examination" video.

NOTES

- Dilation orders do not copy forward to new exams.
- To record default dilation orders, go to "To set up default preferences" on page 69.

1. Click **Auto** in the top middle of the Examination ExamWRITER chart window to automatically record the dilation orders that you defined in your default preferences. If you want to modify the dilation orders, go to step 2.
2. Click **Dilation** in the top middle of the Examination ExamWRITER chart window.

   The DILATION ORDERS window opens.
3. Select the appropriate check boxes and click **ADD Item(s)**.

   NOTES

   - To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
   - To add custom text, select the appropriate check box and type text in the **Custom text** box.
   - To modify the time, type numbers in the **Time** text box.
   - To clear all items from the Description list, click **Clear ALL Items**.
   - To delete an item from the Description list, select the item and click **Delete Item**.

DILATION ORDERS:

DFE performed using BIO and SLE w/Volk 90D lens
Proparacaine local anesthesia
Paremyd
Tropicamide .5%
Tropicamide 1%
Tropicamide .5% / Phenylephrine
Tropicamide 1% / Phenylephrine
Phenylephrine 2.5%
Tropicamide 1% / Phenylephrine 10%
Cyclomydril
Cyclopentolate .5%
Cyclopentolate 1%
Homatropine 5%
Mydriacyl
Mydriacyl / NeoSynephrine
Punctal occlusion
Redropped, 5 minutes
Dilation reversed
Cautioned, post dilation
INDIRECT using 14D lens
INDIRECT using 20D lens
INDIRECT using 28D lens
INDIRECT using 30D lens
INDIRECT using Pan Retinal 2.2
INDIRECT using Scleral depression
SLE using Volk 60D lens
SLE using Volk 78D lens
SLE using Volk 90D lens
SLE using Superfield
MIRROR SLE using Goldmann 3 mirror
MIRROR SLE using Panfundusopic lens
Monocular Indirect Ophthalmoscopy performed
Pupils dilated: Fully
Pupils dilated: Not Fully
Pupils dilated: Poorly
Pupil dilation not ordered
Patient denied dilation.
Patient denied Optomap.
Contraindicated-anatomical.
Contraindicated-IOP.
Contraindicated-IOL.
Contraindicated-patient safety.
Dilation is contraindicated.

Custom text (240 characters max.)

ADD Item(s) | Clear ALL Items | Delete Item

Eye: OD
Time: 06:03 PM

Description
Cyclopentolate .5%, OU @06:03 PM

Cancel | Save/Exit

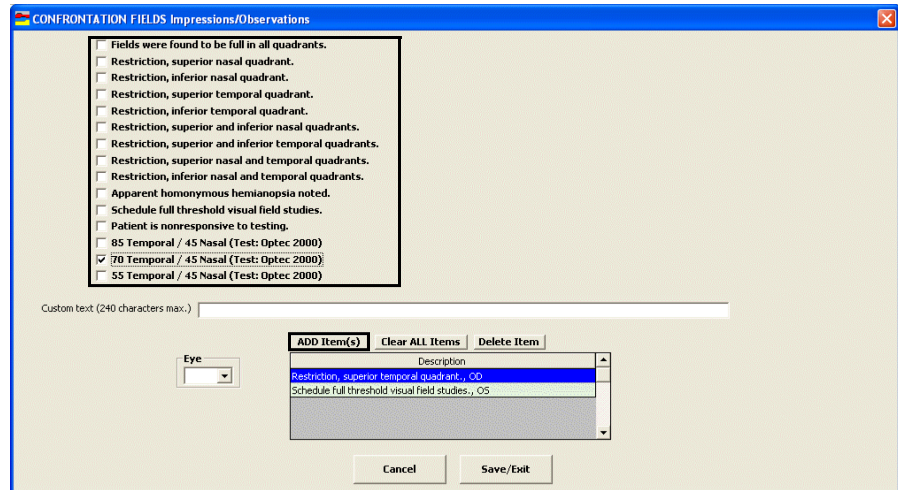
4. Click Save/Exit.

Recording & Modifying Confrontation Fields

1. If you detect a scotoma in a patient's eye, click the **OD** and **OS** boxes in the green grid below the Confrontations button in the top right of the Examination ExamWRITER chart window to document where the scotoma appears in the patient's visual field.
2. Click **Confrontations** in the top right of the Examination ExamWRITER chart window.

   The CONFRONTATION FIELDS Impressions/Observations window opens.
3. Select **Fields were found to be full in all quadrants** or any other check boxes and click **ADD Item(s)**.

> **NOTES**
> - To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
> - To add custom text, select the appropriate check box and type text in the **Custom text** box.
> - To clear all items from the Description list, click **Clear ALL Items**.
> - To delete an item from the Description list, select the item and click **Delete Item**.



4. Click **Save/Exit**.

Recording & Modifying Amsler Studies

1. If you detect a scotoma in a patient's eye, click the **OD** and **OS** boxes in the green grid below the Amsler Studies button in the top right of the Examination ExamWRITER chart window to document where the scotoma appears in the patient's visual field.
2. Click **Amsler Studies** in the top right of the Examination ExamWRITER chart window.

   The AMSLER STUDIES Impressions/Observations window opens.

3. Select **Amsler: Negative** or any other check boxes and click **ADD Item(s)**.

NOTES	
	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, select the appropriate check box and type text in the **Custom text** box. • To clear all items from the Description list, click **Clear ALL Items**. • To delete an item from the Description list, select the item and click **Delete Item**.

4. Click **Save/Exit**.

Recording Examination Information

1. Click the **Examination** bar on the Exam - Special Tests tab in the ExamWRITER chart window.

   The Examination window opens.

2. Select the appropriate **External Exam OK**, **Anterior Segment OK**, and **Routine Ophthalmoscopy OK** check boxes and any appropriate **Ocular Conditions** and **Except** check boxes.

Examination

EXTERNAL EXAM
WNL
EXCEPT...
EOM
Eyelashes
Eyelids
Eyelid Lesions
Lacrimal System
Pupils
Neurology
Headache
Orbit
Head and Neck
Systemic
Visual Efficiency

ANTERIOR SEGMENT
WNL
EXCEPT...
Cornea
Conjunctiva
Conjunctival Growths
Sclera
Chamber
Iris
Lens
Pseudo-aphakia

POSTERIOR SEGMENT
WNL
EXCEPT...
Vitreous
Optic Nerve
Macula
Retina
Retina - Vascular
Choroid

OCULAR CONDITIONS
Abrasion
Allergy
Amblyopia
Cataract
Contact Lenses
Dry Eye
Foreign Body
Glaucoma
Glaucoma Suspect
Keratoconus
Low Vision
Nystagmus
Ocular Albinism
Red Eye
Refractive Surgery
Trauma/Burn Center
Uveitis
Vision Loss

Process

NOTES

- Select the **Except** check box(es) only if there are exceptions to the patient's healthy examination; otherwise, only select the **ALL OK** check boxes.
- Blue text is a heading for the black or red text below it.
- Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.
- Green text signifies that the item is associated with a PQRS procedure code or MIPS measure.

3. Click **Process** or right-click anywhere in the Examination window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.

4. Select or deselect the appropriate check boxes and click **Process**.

NOTES

- To record selected information for the right, left, or both eyes, first click **OD**, **OS**, or **OU** and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**.
- To clear previous selections on the form, click **Reset Form**.
- If a Current Information window opens, choose the appropriate button at the bottom of the window to add, edit, save, redo, or delete the previously entered text.

Recording Special Testing Information

For more information on recording special testing information, watch the "Special Testing - Surgery" video.

1. Click the **Special Testing** bar on the Exam - Special Tests tab in the ExamWRITER chart window.

   The Special Testing window opens.

2. Select the appropriate **Anterior Segment**, **Posterior Segment**, **Fields**, **Sensorimotor**, **Ultrasound**, **Screening Tests**, and **Other Tests** check boxes.

Special Testing

Anterior Segment
- Corneal Topography - 92025
- CL Treatment of Ds - 92071/72
- External Photos - 92285
- Gonio, Scheie - 92020
- Schaeffer - 92020
- Spaeth - 92020
- OCT, Anterior Seg - 92132
- Biometry - 92136
- Provocative - 92140
- Specular Microscopy - 92286

Posterior Segment
- Angiography, Fl - 92235
- Indocyanine - 92240
- Extended Oph, initial - 92225
- Sub - 92226
- Optomap - 92250
- OCT, NFL - 92133
- Retina - 92134
- Ophthalmodynamometry - 92260
- Remote Imaging, detect - 92227
- Manage - 92228
- Retinal photo - 92250

Fields
- General - 92083
- Glaucoma - 92083
- Neurological - 92083
- Single stimulus - 92081
- Suprathreshold - 92082

Sensorimotor
- Color Vision - 92283
- Orthoptics - 92065
- Sensorimotor - 92060

Ultrasound
- A-Scan - 76511
- w/IOL - 76519
- B-Scan - 76512
- Pachymetry - 76514
- UBM - 76513

Screening Tests
- Color Vision Screening
- Field Screening - S9986
- Retinal Screening - S9986
- SLO Screening - S9986
- Topography Screening - S9986

Other Tests
- Glare
- PAM
- Tear Test
- Vital Dye
- Wavefront
- Microbiology

Process

NOTES
- Blue text is a heading for the black or red text below it.
- Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

3. Click **Process** or right-click anywhere in the Special Testing window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.

4. Select or deselect the appropriate check boxes and click **Process**.

NOTES
- To record selected information for the right, left, or both eyes, first click **OD**, **OS**, or **OU** and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**.
- To clear previous selections on the form, click **Reset Form**.
- If a Current Information window opens, choose the appropriate button at the bottom of the window to add, edit, save, redo, or delete the previously entered text.

Modifying Examination & Special Testing Information

1. Click the **Examination** and **Special Testing** bars and follow the instructions above for recording information in an EMR.

   OR

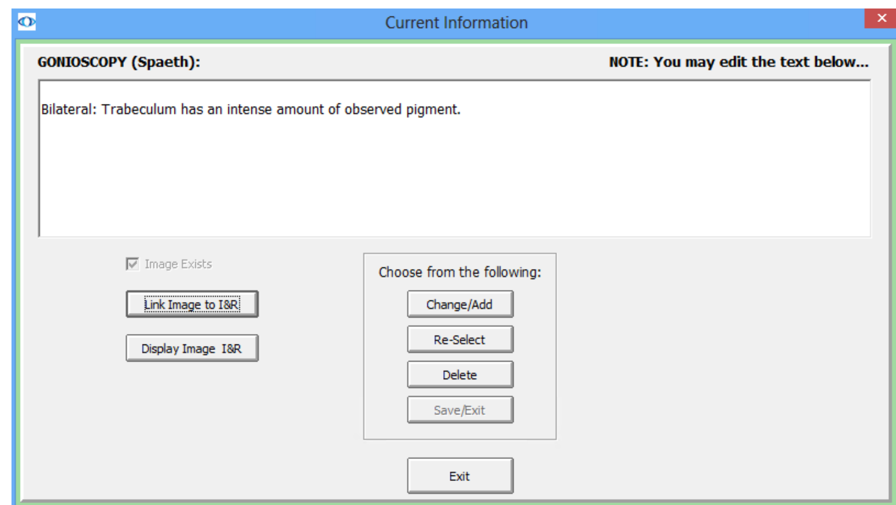
   Click on a bold subheading in the ExamWRITER chart window.

   The Current Information window opens.

2. If you want to link an image to the interpretation and report, click **Link Image to I&R** and select the image to which you want to link from your eDocuments folder.

NOTES	• You can link to .bmp, .jpg, .gif, and .png images. • Click **Display Image I&R** to view the linked image.

3. Choose the appropriate button at the bottom of the window to add, edit, save, redo, or delete the previously entered text.



NOTES	• After you have finished recording Examination information in an EMR, the Examination and Special Testing bars change in color from orange to green. • All abnormal medical conditions appear in red text in the ExamWRITER chart window. All normal medical conditions appear in black text in the ExamWRITER chart window.

Recording Surgery, Plan, & Management Information

8

In this chapter:

- Recording Surgery Information, 287
- Recording Impressions & Assessments, 288
- Recording Plan Information, 290
- Writing Medication Prescriptions, 291
- Recording Contact Lens Care Regimes, 293
- Recording Patient Management Information, 295
- Assigning Orders to Patients, 296
- Modifying Plan Management Information, 298

The ExamWRITER chart window is organized for you to follow the SOAP (Subjective, Objective, Assessment, Plan) methodology when you are entering information into an EMR. Click the **Surgery - Plan - Mgmt** tab to enter assessment and plan information into an EMR.

Recording Surgery Information

For more information on recording surgery information, watch the "Special Testing - Surgery" video.

1. Click the **Surgery - Plan - Mgmt** tab on the ExamWRITER chart window.
2. Click the **Surgery** bar.

   The Surgery window opens.

3. Select the appropriate **Conjunctiva**, **Cornea**, **Injections**, **Intraocular**, **Lacrimal**, **Laser**, **Lens**, **Lids/Lashes**, and **Other** check boxes.

Surgery

Conjunctiva
- Biopsy - 68100
- FB Removal - 65205
- FB, embedded - 65210
- Incision and drainage - 68020
- Laceration - 65270
- Pterygium - 65420
- w/graft - 65426
- Tissue glue - 65286

Cornea
- Debridement - 65435
- Diagnostic scrape - 65430
- Excision of lesion - 65400
- FB Removal - 65220
- FB w/slit lamp - 65222
- Laceration - 65280
- Refractive
- Stromal puncture - 65600
- Tissue glue - 65286

Injections
- Subtenon - 67515
- Subconjunctival - 68200

Intraocular
- FB Removal - AC - 65235

Lacrimal
- Dilation, punctum - 68801
- Lacrimal canaliculi probe - 68840
- Naso-lacrimal probe - 68810
- Punctum closure, plug - 68761
- thermal - 68760

Laser
- Trabeculoplasty - 65855
- Capsulotomy - 66821
- Adhesions - 65860
- Iridotomy/iridectomy - 66761

Lens
- Cataract - 6698x
- IOL, secondary - 6698x

Lids/Lashes
- Drainage of abscess - 67700
- Destruction of lesion - 67850
- Excision of lesion - 67840
- FB Removal - 67938
- Chalazion - 6780x
- Epilation - 67820

Other
- Anterior - 6xxxx
- Posterior and EOM - 6xxx

Process

NOTES
- Blue text is a heading for the black or red text below it.
- Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

4. Click **Process** or right-click anywhere in the Surgery window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.

5. Select the appropriate check boxes and click **Process**.

NOTES
- To record selected information for the right, left, or both eyes, first click **OD**, **OS**, or **OU** and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**.
- To clear previous selections on the form, click **Reset Form**.
- We recommend that you select the **Electronic signature** check box to electronically sign each operative report.

Recording Impressions & Assessments

For more information on recording impressions and assessments, watch the "Impression/Assessment - Plan (Therapeutic Rx)" video.

1. Click the **Surgery - Plan - Mgmt** tab on the ExamWRITER chart window.
2. Click the **Impressions/Assessment** bar.

   The Impressions/Assessment window opens.

3. Select the appropriate **External Exam**, **Vision Impressions**, **Anterior Segment**, **Routine Ophthalmoscopy**, and **Ocular Conditions** check boxes.

Impressions/Assessment

EXTERNAL EXAM
- EOM
- Eyelashes
- Eyelids
- Eyelid Lesions
- Lacrimal System
- Pupils
- Neurology
- Orbit
- Head and Neck
- Systemic
- Visual Efficiency

VISION IMPRESSIONS
- Refractive
- Binocular Vision
- Contact Lenses

ANTERIOR SEGMENT
- Cornea
- Conjunctiva
- Conjunctival Growths
- Sclera
- Chamber
- Iris
- Lens
- Pseudo-aphakia

POSTERIOR SEGMENT
- Vitreous
- Optic Nerve
- Macula
- Retina
- Retina - Vascular
- Choroid

OCULAR CONDITIONS
- Abrasion
- Allergy
- Amblyopia
- Cataract
- Contact Lenses
- Dry Eye
- Foreign Body
- Glaucoma
- Glaucoma Suspect
- Keratoconus
- Low Vision
- Nystagmus
- Ocular Albinism
- Red Eye
- Refractive Surgery
- Trauma/Burn Center
- Uveitis
- Vision Loss

Process

NOTES

- Blue text is a heading for the black or red text below it.
- Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

4. Click **Process** or right-click anywhere in the Impressions/Assessment window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.

5. Select the appropriate check boxes and click **Process**.

NOTES

- To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes.
- To add custom text, select the appropriate check box and type text in the **Custom text** box.
- To clear all items from the Description list, click **Clear ALL Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.

6. Click **Save/Exit**.

Recording Plan Information

For more information on recording plan information, watch the "Special Testing - Surgery" video.

1. Click the **Surgery - Plan - Mgmt** tab on the ExamWRITER chart window.
2. Click the **Plan** bar.

   The Plan window opens.

3. Select the appropriate **External Exam**, **Vision Impressions**, **Anterior Segment**, **Prescription Pad**, **Routine Ophthalmoscopy**, and **Ocular Conditions** check boxes.

Plan

EXTERNAL EXAM: EOM, Eyelashes, Eyelids, Eyelid Lesions, Lacrimal System, Pupils, Neurology, Orbit, Head and Neck, Systemic, Visual Efficiency

VISION PLAN: Spectacle Rx, Contact Lenses, Contact Lens Care

ANTERIOR SEGMENT: Cornea, Conjunctiva, Conjunctival Growths, Sclera, Chamber, Iris, Lens, Pseudo-aphakia

PRESCRIPTON PAD: Medication Rx

POSTERIOR SEGMENT: Vitreous, Optic Nerve, Macula, Retina, Retina - Vascular, Choroid

OCULAR CONDITIONS: Abrasion, Allergy, Amblyopia, Cataract, Contact Lenses, Dry Eye, Foreign Body, Glaucoma, Glaucoma Suspect, Keratoconus, Low Vision, Nystagmus, Ocular Albinism, Red Eye, Refractive Surgery, Trauma/Burn Center, Uveitis, Vision Loss

Process

NOTES

- Blue text is a heading for the black or red text below it.
- Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.
- To write medication prescriptions, go to "Writing Medication Prescriptions" on page 291.
- To record contact lens care regimes, go to "Recording Contact Lens Care Regimes" on page 293.
- To print prescriptions, go to "Recording Patient Management Information" on page 295.

4. Click **Process** or right-click anywhere in the Plan window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.

5. Select the appropriate check boxes and click **Process**.

NOTES	• To record selected information for the right, left, or both eyes, first select **OD**, **OS**, or **OU** from the **Eye** drop-down menu and then select the appropriate check box(es) for the right, left, or both eyes. • To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**. • To clear previous selections on the form, click **Reset Form**.

Writing Medication Prescriptions

NOTE	Press the **F6** key anytime during an exam to open the Medication Order window and record a patient's prescription medication.

1. Click the **Surgery - Plan - Mgmt** tab on the ExamWRITER chart window.
2. Click the **Plan** bar.

   The Plan window opens.
3. Select the **Medication Rx** check box and click **Process**.

4. Enter text in the text boxes in the Medication Order window and select options from the drop-down menus.

NOTES

- If the patient's medical history has been entered into the EMR, it appears in the Medication Hx grid at the bottom of the window.
- The expiration date automatically populates to one year from the date of the order for all refill medication orders. You can only record a medication's expiration date in ExamWRITER 8.0 exams and higher. You cannot record a medication's expiration date when you refill a medication order that was recorded in an exam created with ExamWRITER 7.4.1 or below.

5. To taper a medication frequency, follow the instructions below and then go to step 7; otherwise, go to step 6.
   a. Select the highest frequency from the **Frequency** drop-down menu and click **Save Sig**.
   b. Select the second highest frequency from the **Frequency** drop-down menu and click **Save Sig**.
   c. Select and save frequencies until you have entered all medication frequencies.
6. Click **Save Sig**.
7. Click **Save Med. Order** to add the medical prescription to the Current Therapeutic Rx table.

8. Click **Print w/Sig/Exit** to print the medical prescription with a provider's signature and exit the Medication Order window.

   OR

   Click **Print no Sig/Exit** to print the medical prescription without a provider's signature and exit the Medication Order window.

NOTES	• For more information on printing a provider's signature on medical prescriptions, go to "To modify or add provider information" on page 23. • Some states require an original signature on medical prescriptions. Check with your state regulatory agency to find out if printing a signature on prescriptions is legal in your state.

Recording Contact Lens Care Regimes

1. Click the **Surgery - Plan - Mgmt** tab on the ExamWRITER chart window.
2. Click the **Plan** bar.

   The Plan window opens.
3. Select the **Contact Lens Care** check box and click **Process**.

   The CONTACTS (Care Regimen) window opens.

4. Click the text boxes to select lens care solutions and cleaning instructions from the drop-down menus and click **Save Item**.

NOTES

- To create and maintain the lens care solution and cleaning instruction menus, press the **F12** key. For more information on using the F12 key, go to "To add and maintain list box selections (F12)" on page 10.
- To add custom text, type text into the **Custom text** box and click **Save Item**.
- To clear all items from the Description list, click **Clear All Items**.
- To delete an item from the Description list, select the item and click **Delete Item**.
- The Disinfection information that is recorded on the Contacts (Care Regimen) window will print on the first final Rx. Selections from the Disinfecting drop-down menu on the Contact Lens Rx - Final window will print on the second and any subsequent final prescriptions.
- Only the disinfecting information that is recorded for the most recently saved final Rx is displayed under the Plan category bar on the Surgery - Plan - Mgmt tab.

5. Click **Save/Exit**.

The contact lens care regime is displayed on the ExamWRITER chart window and printed on the contact lens Rx.

Recording Patient Management Information

For more information on recording patient management information, watch the "Patient Management (Task Manager)" video.

1. Click the **Surgery - Plan - Mgmt** tab on the ExamWRITER chart window.
2. Click the **Patient Management** bar.

   The Patient Management window opens.
3. Select the appropriate **Counseling/Education** and **Exam Time/Recall** check boxes.

NOTES	• Blue text is a heading for the black or red text below it. • Red text signifies that the corresponding check box has been previously selected and information relating to that text has been previously recorded.

4. Click **Process** or right-click anywhere in the Patient Management window.

   Depending on the boxes that you checked, various windows will open with additional check boxes.
5. Select the appropriate check boxes and click **Process**.

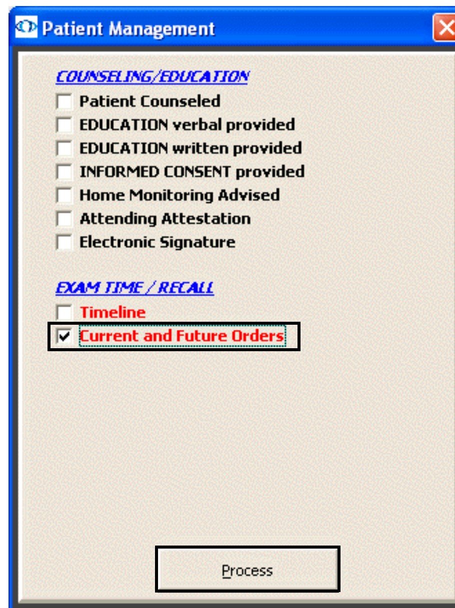
NOTES	• To add custom text, first select the appropriate check box(es), then click **Custom Text**, type the text, and click **OK**. • To clear previous selections on the form, click **Reset Form**.

Assigning Orders to Patients

NOTES	
	• Press the **F3** key anytime during an exam to open the Orders window and record a patient's examination, surgery, test, consultation, laboratory, and immunization orders. • If you record an exam with surgery, examination, test, consult, laboratory, or immunization orders and schedule an examination, the scheduled orders are displayed in the Orders To Be Scheduled window. For more information on scheduling orders in the Task Manager, go to "Using the Task Manager" on page 96.

1. Click the **Surgery - Plan - Mgmt** tab on the ExamWRITER chart window.
2. Click the **Patient Management** bar.

   The Patient Management window opens.
3. Select the **Current and Future Orders** check box and click **Process**.



   The Orders window opens.
4. Select the appropriate **Examination**, **Surgery**, **Tests**, **Consult**, **Laboratory**, or **Immunization** radio button to record orders for those items.
5. Select orders in the box on the left of the Orders window.

NOTES	
	• To create and maintain orders, place your cursor in the Search text box and press the **F12** key. • To search for orders, type text into the **Search** text box. • To add custom text, click **Custom Text** and type text in the text box.

6. Select an eye from the **Eye** drop-down menu.
7. Choose the appropriate dates from the **Timeline** drop-down boxes. To record an order for today, select the **Today** check box.

8. Select an action from the **Action** drop-down menu and a date from the calendar.

NOTES	• If you select **Recall** from the Action drop-down menu, the recall will be recorded in the EMR and OfficeMate. • If you select **Schedule** from the Action drop-down menu, the appointment will be recorded in the EMR, but no appointment will be scheduled in OfficeMate. • To record a default action for patients' next appointments, go to "To set up default preferences" on page 69.

9. If you are an OfficeMate user and you have recalls and the patient's recall type set up in OfficeMate, select a recall type from the **OfficeMate Patient Recall** drop-down menu.

NOTE	To set up recall types and schedules, click **Setup Recall** and select recall types from the **Recall Type** drop-down menus. To change the recall date, type or select the number of months until the next recall in the **Months to Recall** text box or type or select a recall date in the **Next Recall** text box. Click **Save** to save the new recall type and schedule.

10. If you want to save the order without the timeline and action date, select the **Save WITHOUT Timeline and Action Date** check box.

11. Click **Save(s)**.

12. Repeat steps 4–11 for each recall reason and date.

NOTE	To discontinue an order, select the order and click Discontinue Item. Select the date on which the order was discontinued and click Save.

13. Click **Process**.

Modifying Plan Management Information

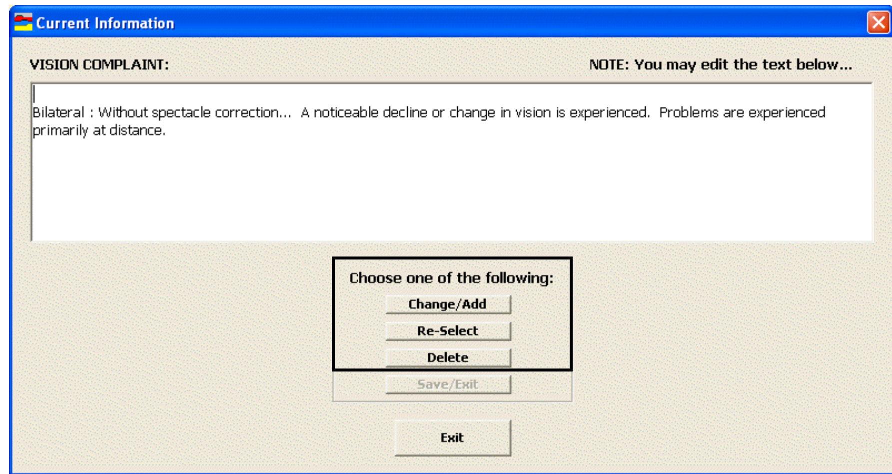
1. Click the **Surgery, Impressions**/ **Assessment**, **Plan**, and **Patient Management** bars and follow the instructions above for recording information in an EMR.

   OR

   Click on a bold subheading in the ExamWRITER chart window.

   The Current Information window opens.

2. Choose the appropriate button at the bottom of the window to add, edit, save, redo, or delete the previously entered text.



NOTES	• After you have finished recording Plan - Management information in an EMR, the Surgery, Impressions/Assessment, Plan, and Patient Management bars change in color from orange to green. • All abnormal medical conditions appear in red text in the ExamWRITER chart window. All normal medical conditions appear in black text in the ExamWRITER chart window.

Selecting Diagnosis & Procedure Codes

9

In this chapter:

- Using Quick Code, 301
- Selecting Diagnosis and Procedure Codes, 302

Using Quick Code

For more information on using Quick Code, watch the "Coding the Exam - Using Quick Code" video.

Use ExamWRITER's Quick Code function to accurately and automatically determine the level of medical code documentation (based on the *Evaluation and Management Services Guide* by the Centers for Medicare & Medicaid Services (CMS)) needed for billing purposes on new exams. The check box selections that you record in a patient's exam record that relate to 99xxx procedure codes are tallied and recorded in the Documented Elements row on the E&M Quick Code Check window.

1. Click the **Quick Code** icon in the top left of the ExamWRITER chart window.

   The E&M Quick Code Check window opens.

E & M Quick Code Check

You may click on the column headings to obtain more information or to document additional elements.

Established Patient

	Coding Required		History			Exam	Medical Decision	
	Level	E&M Code	HPI	ROS	PFSH	Phys Exam	Diag/Mgmt	Risk
SELECTED ->	1	99211	0	0	0	0	0	None
	2	99212	1+	0	0	1+	1	Minimal
	3	99213	1+	1	0	6+	2	Low
	4	99214	4+	2+	1	9+	3	Moderate
	5	99215	4+	10+	2	14+	4	High
	Documented Elements		19	13	5	12	3	Low

Coding for E&M Code 99211 - Satisfied

Based on the elements documented you may choose an alternate E&M code.

Close Coding

2. Note the appropriate code for billing purposes.

   The lowest level of code that you have selected (as denoted by purple boxes) is what you are able to bill a patient. To meet CMS guidelines, you cannot bill a level 5 E&M code unless all of the boxes in the level 5 row are purple. For example, if there is a purple HPI box in the level 2 row and purple ROS, PFSH, Phys Exam, Diag/Mgmt, and Risk boxes in the level 5 row, you

must bill the level 2 E&M code unless you document additional HPI elements to create a purple HPI box in the level 5 row.

NOTES

- Grey boxes denote elements that you have not documented or coding levels that you have not reached.
- Green rows denote the coding level that you have already selected in the Diagnosis/Procedure Coding window (if applicable).
- A red E&M Code box denotes an alternate E&M code that you can bill based on elements that you have already documented (if applicable).
- Purple boxes denote coding levels that you have reached.

3. If an insufficient number of elements were documented in the exam, click the heading of the insufficient aspect to go to the insufficient portion of the exam and add the necessary information. See “Creating & Opening Exam Records” on page 145 for more information on adding exam information.

   To meet CMS guidelines, you must document two out of three areas (History, Exam, and/or Medical Decision) for established patients. To meet CMS guidelines, you must document all three areas (History, Exam, and Medical Decision) for new patients; new patients are patients who have not been seen in your practice in at least three years.

NOTES

- If you click the **HPI** (History of Present Illness), **PFSH** (Past, Family, and/or Social History), or **Diag/Mgmt** headings, windows open for you to select and process exam information. See “Creating & Opening Exam Records” on page 145 for more information on adding exam information.
- If you click the **ROS** (Review of Systems) or **Phys Exam** headings, a **Quick Code Review** window opens. Click **Process** to select and process exam information. See “Creating & Opening Exam Records” on page 145 for more information on adding exam information.
- If you click the **Risk** heading, the **Risk Factors** window opens for you to select a risk factor.
- Click **Coding** and open the Diagnosis/Procedure Coding window and record and modify coding information.

Selecting Diagnosis and Procedure Codes

This section tells you how to assign billing codes to exams, including how

- To select diagnosis codes, 303
- To select procedure codes, 306
- To link diagnosis codes to procedure codes, 311

▶ To select diagnosis codes

For more information on selecting diagnosis and procedures codes, watch the “Coding the Exam - Using Quick Code” video.

1. Click the **Coding** icon in the top left of the ExamWRITER chart window.

   The Diagnosis/Procedure Coding window opens.

2. Click the **Diagnosis** tab.

   The diagnosis codes are automatically displayed in the Selected Diagnosis table for the impressions that you recorded in the exam. They are based on the patient’s primary insurance carrier’s setup options in the Insurance Billing Initial Setup window in Administration.

   – If the insurance carrier is set up to use ICD-9 codes, then only those version codes will be available to select.

   – If the insurance carrier is set up to use ICD-10 codes, then only those version codes will be available to select.

   – If the patient does not have a primary insurance carrier and the visit date is prior to October 1, 2015, then only ICD-9 codes will be available to select.

   – If the patient does not have a primary insurance carrier and the visit date is on or after October 1, 2015, then only ICD-10 codes will be available to select.

For additional information on ICD-10 codes, go to www.cms.gov/ICD10.

NOTES	
	• If you receive a No Data error when you open the Diagnosis/Procedure Coding window, click **OK** and see “Setting Up Product and Service Information” on page 76 to add services to your exam. • By default, the ICD-9 codes displayed are 367.xx and the ICD-10 codes displayed are H52.x and H53.x (refractive error codes) in numerical order. To view all of the diagnosis codes, click the **All** radio button in the **View Diagnosis** box.

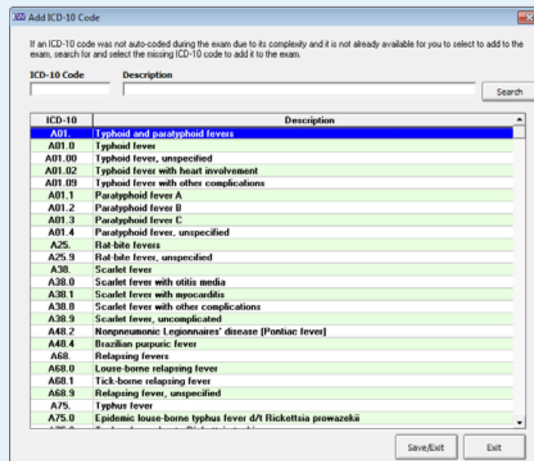
3. Double-click diagnosis codes to add them to the **Selected Diagnosis** table.

   OR

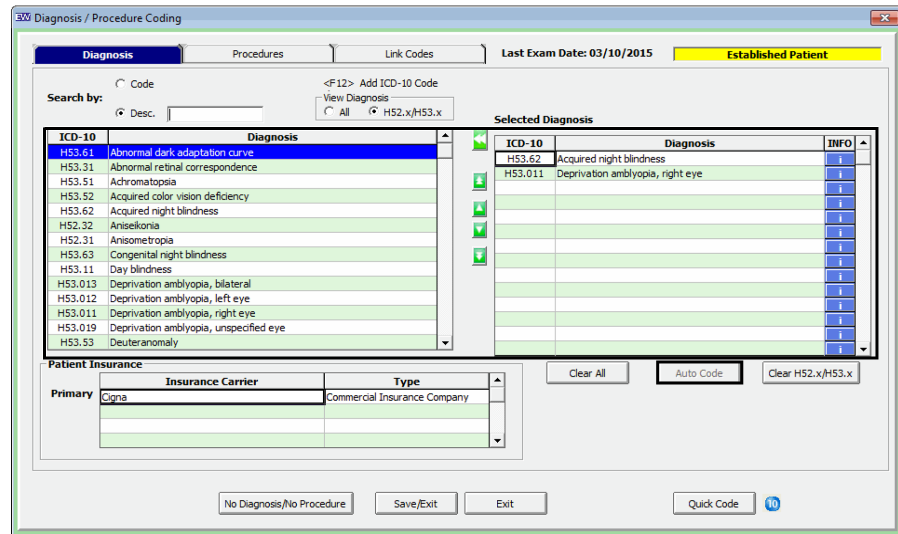
   Click **Auto Code** to automatically populate the Selected Diagnosis table.

NOTES

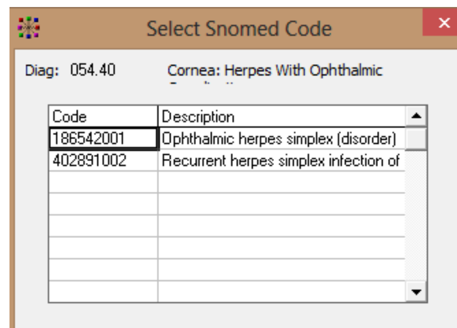
- Click the **Info** buttons to view information from MedlinePlus Connect about the selected diagnosis codes.
- To remove 367.xx ICD-9 codes that were automatically populated in the Selected Diagnosis table, click **Clear 367.xx**. To remove H52.x and H53.x ICD-10 codes that were automatically populated in the Selected Diagnosis table, click **Clear H52.x/H53.x**.
- If an ICD-10 code was not auto-coded during an exam due to its complexity and it is not already available for you to select to add to the exam, press **F12** and then search for and select the missing ICD-10 code to add it to the exam.



- If you copied forward a version 7.x exam, click **Clear All** and then click **Auto Code** to populate the Selected Diagnosis table with codes from the previous and new exam records.
- If you copied a version 6.4 or below exam forward, you must rerecord the impressions in the exam record in order to automatically assign diagnosis codes in the exam record.If you copied forward a previous exam, the diagnosis codes recorded are *not* copied forward unless they were automatically coded in the exam.
- If there are no diagnosis and procedure codes to record for this exam, click **No Diagnosis No Procedure Codes**.
- Click **Quick Code** to open the E & M Quick Code Check window and reference quick code information. For information on the E & M Quick Code Check window, go to "Using Quick Code" on page 301.



4. If multiple SNOMED codes are associated with a selected diagnosis code, double-click the code and select the appropriate SNOMED code.



5. If you want to delete the diagnosis codes from the Selected Diagnosis table and manually record the codes and modifiers, follow the instructions below; otherwise, go to step 5:
    a. Click **Clear All**.
    b. Select modifiers for the diagnosis codes that you are going to use from the **Modifier** drop-down menus.
    c. Double-click on the appropriate diagnosis codes to move the selected codes and modifiers to the Selected Diagnosis table.
6. Click the arrows to the left of the table to rearrange or delete the codes in the Selected Diagnosis table. You can move codes up or down one row at a

time, move a code to the top of the list to make it the primary diagnosis code, or move a code to the bottom of the list.

NOTE	Any diagnosis code that you move into the first priority on the Diagnosis window will automatically appear in the DIAG1 column on the Link Codes tab. After making changes (even automatic ones) to the diagnosis code selected in the DIAG1 drop-down menu, you should still review the selections in the DIAG2, DIAG3, and DIAG4 drop-down menus, if necessary, and ensure that they are in the correct priority order.

7. If this is a VSP exam, select the appropriate **VSP EHM** check boxes to participate in the Eye Health Management program.

NOTE	The VSP EHM check boxes may already be selected based on the findings recorded in the exam or from the patient's history.

The EHM information, associated ICD-10 codes, and dilation information are sent when the claim and order are transmitted to VSP.

8. Click **Save/Exit**.

NOTE	Although you can select an unlimited number of diagnosis codes in ExamWRITER, only the codes listed in the first six rows of the Selected Diagnosis table will appear on the ExamWRITER chart window and transfer to OfficeMate.

▶ To select procedure codes

For more information on automatically recording PQRS codes in exams, watch the "Auto PQRS" video.

1. Click the **Coding** icon in the top left of the ExamWRITER chart window.

   The Diagnosis/Procedure Coding window opens.

NOTES	• You must select CPT codes for your services before you code an exam in order for the service to appear in the Diagnosis/Procedure Coding window. If you receive a No Data error when you open the Diagnosis/Procedure Coding window, click **OK** and see "Setting Up Product and Service Information" on page 76 to add services to your exam. • Click **Quick Code** to open the E & M Quick Code Check window and reference quick code information. For information on the E & M Quick Code Check window, go to "Using Quick Code" on page 301.

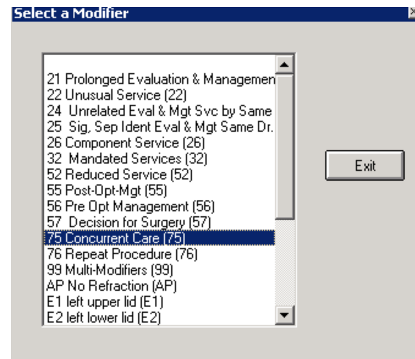
2. Click the **Procedures** tab.

   The procedure codes are automatically displayed in the Selected Procedures table based on the patient's primary insurance carrier's preferences and your exam selections.

NOTE	
	• In order to comply with the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and support the CMS Physician Quality Reporting System (PQRS), PQRS procedure codes automatically populate on the Procedures tab when associated diagnoses are recorded in the exam. • If you copy forward a previous exam that contains PQRS procedure codes to a new exam, *only* 1036F and 4004F, are copied forward. • The *only* procedure codes that are copied forward to new exams are 92012–92015, 92310, 99211–99215, and S0620. • If you upgraded from a previous version of ExamWRITER to ExamWRITER 12.0, you must create new services in the Products window and select the appropriate new level II procedure code from the CPT drop-down menu for those services in order for the procedure codes to automatically populate in ExamWRITER. You must also complete this task before you can record the new level II procedure codes on fee slips in OfficeMate. For more information on creating new services in the Products window, go to “Setting Up Product and Service Information” on page 76. • By default, the procedure codes displayed are S-Codes and 92xxx (nonmedical or “wellness visit” codes) in numerical order. To view all of the procedure codes, click the **All** radio button in the View Procedures box. To view the 992xx (evaluation/management (E/M) or “sick eye visit”) procedure codes, click the **992xx** radio button in the View Procedures box. To view only the PQRS procedure codes, click the PQRI check box. • Click the **Show Quick List** check box to view only the services that you frequently use. For more information on adding services to your Quick List, go to “Setting Up Product and Service Information” on page 76.

3. If you want to add modifiers to procedure codes, right-click in the **Mod1** and **Mod2** columns next to procedures that you want to select and then click a modifier in the Select a Modifier window.

NOTES	• You must select a modifier in the Mod1 column before you can select a second modifier in the Mod2 column. • Modifiers do not transfer to OfficeMate fee slips or CMS 1500 forms.



4. Double-click procedure codes to add them to the **Selected Procedures** table.

   OR

   Click **Auto Code** to automatically populate the Selected Procedures table.

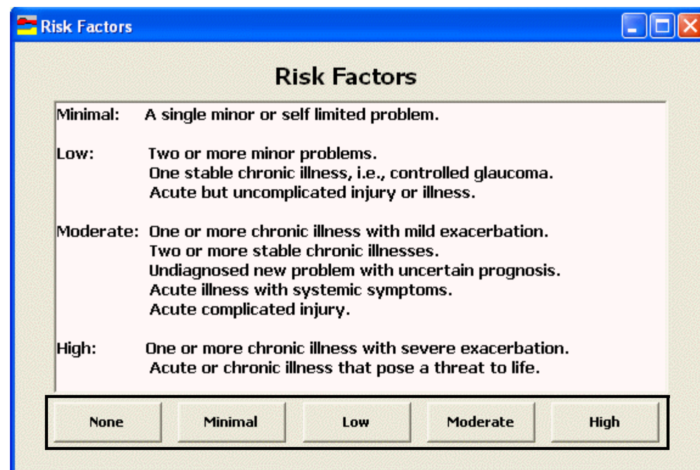
NOTES

- As a reminder, you must select CPT codes for your services *before* you can manually or automatically add procedure codes to an exam. For more information on selecting CPT codes for services, go to "Setting Up Product and Service Information" on page 76.
- For the auto code feature to work properly with unilateral procedure codes (92226, 92135, 76519, 92225, and 92235), you must ensure that separate unilateral procedure codes for each eye are set up in the Customization window (Procedure Codes tab) in OfficeMate or ExamWRITER (for example, 92226 RT and 92226 LT) prior to coding exams. For the auto code feature to work properly with surgical procedure codes (67850, 68200, 68810, 67515, and 65860), you must also ensure that the procedure codes are set up in the Customization window. Then, you must open the services in the Products window and select the appropriate right or left eye modifier for the procedure code. For more information on selecting modifiers in the Products window, go to "Setting Up Product and Service Information" on page 76.
- To remove PQRS procedure codes that were automatically populated in the Selected Procedures table, click **Clear PQRI**.
- If there are no diagnosis and procedure codes to record for this exam, click **No Diagnosis No Procedure Codes**.

5. If you want to delete the procedure codes from the Selected Diagnosis table and manually record the codes and modifiers, follow the instructions below; otherwise, go to step 5:
   a. Click **Clear All**.
   b. Select modifiers for the procedure codes that you are going to use from the **Modifier** drop-down menus.
   c. Double-click on the appropriate procedure codes to move the selected codes and modifiers to the Selected Procedures table.
6. Click the arrows to the left of the table to rearrange or delete the codes in the Selected Procedures table. You can move codes up or down one row at a time, move a code to the top of the list to make it the primary procedure code, or move a code to the bottom of the list.
7. Click **Save/Exit**.

NOTE	Only the first 20 procedure codes selected in a new exam and listed in the Patient Open Charges window will transfer to a patient's fee slip. If you do not want to post these charges, select them and click Close out.

If you selected 992xx procedure codes and have not yet assigned a risk factor to your medical decisions, the Risk Factors window opens. Click **None**, **Minimal**, **Low**, **Moderate**, or **High** to record a risk factor.



If you select a 992xx procedure code, the E & M Quick Code Check window automatically opens so that you can reference quick code information. For more information on using the Quick Code feature, go to "Using Quick Code" on page 301.

▶ To link diagnosis codes to procedure codes

You can link up to four diagnosis codes to each procedure code for insurance billing purposes. Linked diagnosis and procedure codes and insurance carriers are transferred to OfficeMate fee slips and to CMS 1500 forms/ANSI insurance claims.

NOTE	To set up a preference to remind you to review linked codes, go to "To set up general preferences" on page 67.

With the ability to link diagnosis and procedure codes together, you can now bill different codes to different insurance carriers, depending on the insurance carrier's rules and plans.

1. Click the **Coding** icon in the top left of the ExamWRITER chart window.

   The Diagnosis/Procedure Coding window opens.
2. Ensure that diagnosis and procedure codes are selected on the Diagnosis and Procedures tabs. For more information on selecting diagnosis codes, go to "To select diagnosis codes" on page 303. For more information on selecting procedure codes, go to "To select procedure codes" on page 306.

NOTE	The first diagnosis code that you select on the Diagnosis tab is the default diagnosis code that is linked to procedure codes.
3. Click the **Link Codes** tab.
4. Select a procedure.
5. Select diagnosis codes from the **DIAG** drop-down menus to link them to the procedure.

6. To associate an insurance carrier with a procedure, follow the instructions below; otherwise, skip this step:
   a. Select a procedure.
   b. Double-click on an insurance carrier.

NOTES

- To associate the patient's primary insurance carrier with all procedures, click **Apply Insurance**.
- To remove an insurance carrier from association with a procedure code, click **Remove Insurance**.

Printing EMRs, Recalls, Reports, & Letters

10

In this chapter:

- Printing EMRs, 313
- Printing Recall Correspondences, 314
- Creating & Printing the Exam Analysis Report, 324
- Printing Diabetic Letters, 326
- Printing Glaucoma Letters, 328

Printing EMRs

NOTES	
	• The EMRs open and print using Microsoft Word. You can modify the EMRs and send the records to e-mail and fax recipients using Microsoft Word tools. Before sending the EMRs via e-mail and fax, ensure that you are complying with HIPAA guidelines. • To print an ExamDRAW drawing, go to "Using ExamDRAW" on page 371. • To record default printing options, go to "To set up default preferences" on page 69.

For more information on printing from ExamWRITER, watch the "Printing from ExamWRITER" video.

1. Click the **Print** icon in the top left of the ExamWRITER chart window.
2. Select one of the following options from the drop-down list:
   - **Exam** to print the entire exam.
   - **View Exam** to view a screenshot of the entire printed exam.
   - **Auto Letter [MU, QRM]** to view and print an automatically generated exam letter.

NOTE	Select a correspondent from the **Correspondent Select** window before viewing the Auto Letter.

   - **Formal Health Record** to view and print a formal health record for the patient that contains information about every exam related to the patient.

NOTE	Select a correspondent from the **Correspondent Select** window before viewing the Formal Health Record.

   - **Spectacle Rx** to print the spectacle prescription.
   - **Alternate Rx** to print the alternate prescription.
   - **Contact Lens Rx** to print the contact lens prescription.
   - **Trial Contact Rx** to print the trial contact lens prescription.
   - **Patient Report [MU 1 only]** to print the eyecare report.
   - **Clinical Summary [MU 1 only]** to print a summary that contains the Patient Report and clinical summary CCR information.

Printing Recall Correspondences

You can print recall correspondences any time that it is convenient. Follow the instructions below

- To print recall correspondence, 315
- To print a list of patients that you want to recall, 318
- To print labels for patients that you want to recall, 321

▶ To print recall correspondence

NOTE	Print recall correspondence using 8½” × 11” paper stock or office letterhead, or postcard stock with four cards on 8½” × 11” sheets.

1. Click **Tasks** on the OfficeMate main window toolbar and select **Correspondence [MU]**.

   OR

   Click **Activities** on the ExamWRITER Administration main window and select **Correspondence**.

   The Process Recalls window opens.

NOTES	• Click **History** to view the recall correspondence printing history. • Click **Printer Setup** to set up the printer or select a printer other than the default ExamWRITER printer.

2. Select a location for which you want to print recall correspondences from the **Location** drop-down menu.
3. Select a communication preference for the recall correspondences from the **Communication Preference** drop-down menu. To select communication preferences for patients, go to “Modifying & Viewing Patient Demographic Information” on page 113.

4. Type or select dates in the **Selection Range From** and **To** boxes and click **Start Selection** to find patients in the selected date range to whom you can send recall correspondences.

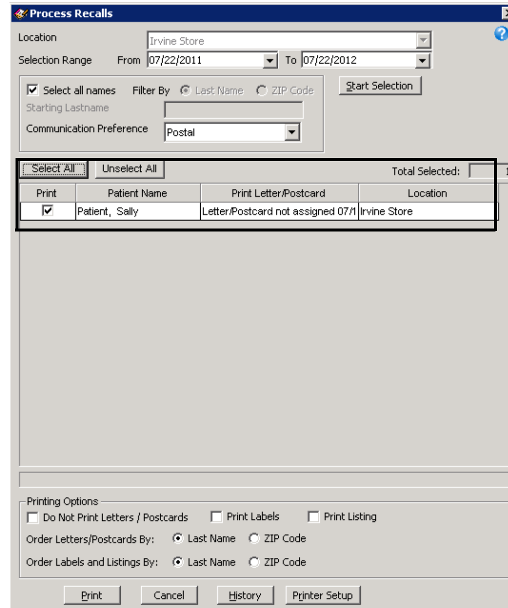
NOTE	To further narrow your selection, deselect the **Select all names** check box, select a filter option from the **Filter By** radio buttons, and type a letter (if you are filtering patients by last name) or number (if you are filtering patients by ZIP code) in the **Starting Last Name** or **Starting Zip Code** text box to print recall correspondence for patients meeting your selection criteria. For example, if you type "G" in the Starting Last Name text box, ExamWRITER will print recall correspondences for patients with last names that begin with G–Z.

A list of patients meeting your selection criteria is displayed.

5. Select or deselect patients by clicking the check box in the **Print** column.

NOTE	You can also click **Select All** to select all patients or **Unselect All** to deselect all patients.

6. Select the **Last Name** or **ZIP Code** Order Letters/Postcards By radio button to sort the recall correspondences that you are printing by last name or ZIP code.



7. Click **Print** to print the recall correspondences.

   The Report Printer Selection window opens. Click one of the following buttons:

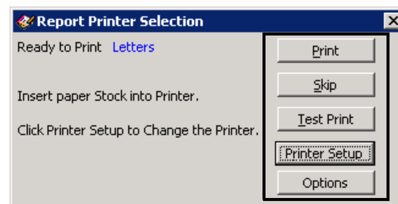
   – **Print** to print the recall correspondences for the selected patients.

   – **Skip** to skip the current print selection and go to the next print selection.

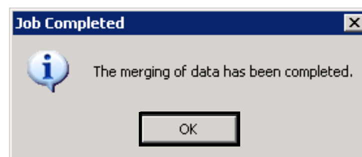
   – **Test Print** to print a sample recall correspondence.

   – **Printer Setup** to set up the printer.

   – **Options** (for postcards) to select a printing method.

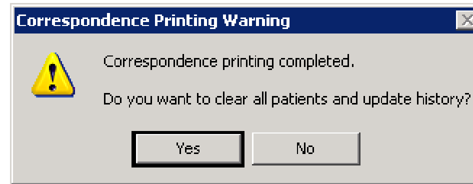


8. Click **OK** in the Job Completed window.



The Correspondence Printing Window opens.

9. Click **Yes** in the Correspondence Printing Warning window if you are finished printing this group of recall correspondence and you want to update the patient demographic information and recall history.



▶ To print a list of patients that you want to recall

NOTE	Print lists using 8½” × 11” paper stock.

1. Click **Tasks** on the OfficeMate main window toolbar and select **Correspondence [MU]**.

   OR

   Click **Activities** on the ExamWRITER Administration main window and select **Correspondence**.

2. Select **Recall**.

   The Process Recalls window opens.

NOTES	• Click **History** to view the recall correspondence printing history. • Click **Printer Setup** to set up the printer or select a printer other than the default ExamWRITER printer.

3. Select a location for which you want to print a recall list from the **Location** drop-down menu.

4. Select a communication preference for the recall list from the **Communication Preference** drop-down menu. To select communication preferences for patients, go to “Modifying & Viewing Patient Demographic Information” on page 113.

5. Type or select dates in the **Selection Range From** and **To** boxes and click **Start Selection** to find patients in the selected date range to include in the recall list.

NOTE	To further narrow your selection, deselect the **Select all names** check box, select a filter option from the **Filter By** radio buttons, and type a letter (if you are filtering patients by last name) or number (if you are filtering patients by ZIP code) in the **Starting Last Name** or **Starting Zip Code** text box to include patients meeting your selection criteria. For example, if you type "G" in the Starting Last Name text box, ExamWRITER will include patients with last names that begin with G–Z.

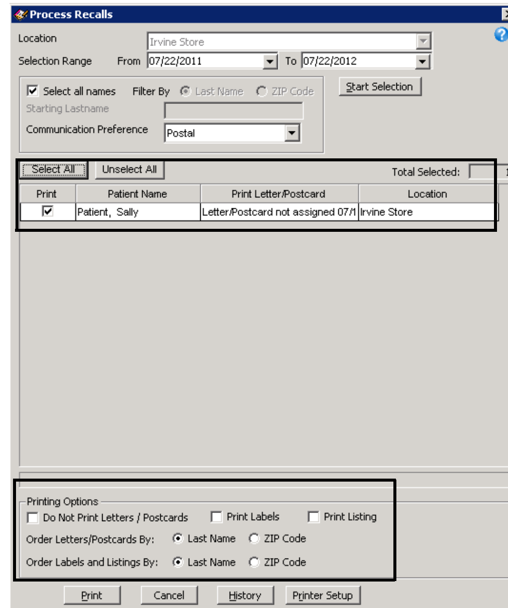
A list of patients meeting your selection criteria is displayed.

6. Select or deselect patients by clicking the check box in the **Print** column.

NOTE	You can also click **Select All** to select all patients or **Unselect All** to deselect all patients.

7. Select the **Print Listing** check box and select the **Last Name** or **ZIP Code** Order Labels and Listings By radio button to sort the recall list that you are printing by last name or ZIP code.

8. Select the **Do Not Print Letters/Postcards** check box.



9. Click **Print** to print the recall list.

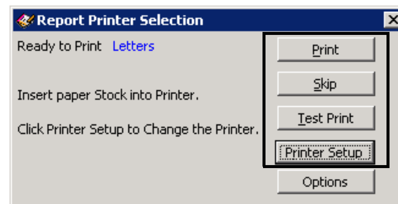
   The Report Printer Selection window opens. Click one of the following buttons:

   – **Print** to print the recall list for the selected patients.

   – **Skip** to skip the current print selection and go to the next print selection.

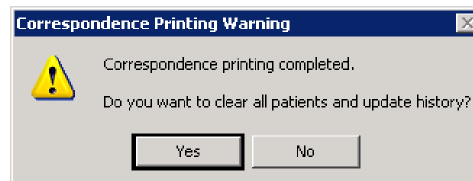
   – **Test Print** to print a sample recall list.

   – **Printer Setup** to set up the printer.



   The Correspondence Printing Window opens.

10. Click **Yes** in the Correspondence Printing Warning window if you are finished printing this recall list and you want to update the patient demographic information and recall history.



▶ To print labels for patients that you want to recall

NOTE	Print labels using Avery 5260 compatible white rectangular labels.

1. Click **Tasks** on the OfficeMate main window toolbar and select **Correspondence [MU]**.

   OR

   Click **Activities** on the ExamWRITER Administration main window and select **Correspondence**.

2. Select **Recall**.

   The Process Recalls window opens.

NOTES	• Click **History** to view the recall correspondence printing history. • Click **Printer Setup** to set up the printer or select a printer other than the default ExamWRITER printer.

3. Select a location for which you want to print recall labels from the **Location** drop-down menu.

4. Select a communication preference for the recall labels from the **Communication Preference** drop-down menu. To select communication preferences for patients, go to “Modifying & Viewing Patient Demographic Information” on page 113.

5. Type or select dates in the **Selection Range From** and **To** boxes and click **Start Selection** to find patients in the selected date range for whom you can print recall labels.

> **NOTE** To further narrow your selection, deselect the **Select all names** check box, select a filter option from the **Filter By** radio buttons, and type a letter (if you are filtering patients by last name) or number (if you are filtering patients by ZIP code) in the **Starting Last Name** or **Starting Zip Code** text box to print recall labels for patients meeting your selection criteria. For example, if you type “G” in the Starting Last Name text box, ExamWRITER will print recall labels for patients with last names that begin with G–Z.

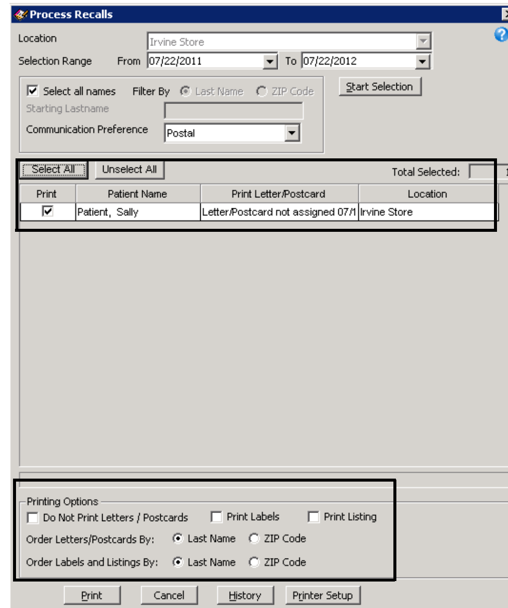
A list of patients meeting your selection criteria is displayed.

6. Select or deselect patients by clicking the check box in the **Print** column.

> **NOTE** You can also click **Select All** to select all patients or **Unselect All** to deselect all patients.

7. Select the **Print Labels** check box and select the **Last Name** or **ZIP Code** Order Labels and Listings By radio button to sort the recall labels that you are printing by last name or ZIP code.

8. Select the **Do Not Print Letters/Postcards** check box.



9. Click **Print** to print the recall labels.

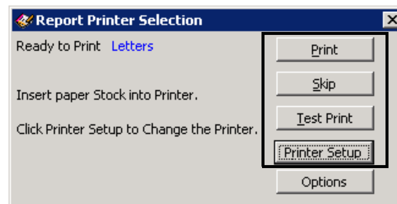
   The Report Printer Selection window opens. Click one of the following buttons:

   – **Print** to print the recall labels for the selected patients.

   – **Skip** to skip the current print selection and go to the next print selection.

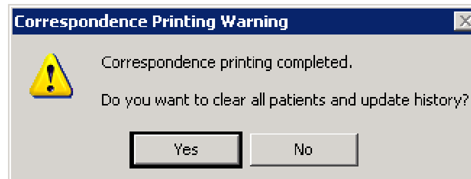
   – **Test Print** to print a sample recall label.

   – **Printer Setup** to set up the printer.



   The Correspondence Printing Window opens.

10. Click **Yes** in the Correspondence Printing Warning window if you are finished printing this group of recall labels and you want to update the patient demographic information and recall history.



Creating & Printing the Exam Analysis Report

1. Open the Exam Analysis window:
   a. From the OfficeMate main window, click **Reports**, select **ExamWRITER**, and then select **Exam Analysis**.
   b. From the ExamWRITER Administration window, click **Reports** and select **Exam Analysis**.

   The Exam Analysis window opens.
2. Narrow your report results by selecting a date range and report criteria:
   a. Type the beginning in the **From Date** field.
   b. Type the ending date in the **Thru Date** field.
   c. Select a location from the **Location** drop-down menu, as needed, to pull data for a single location.
   d. Select a provider from the **Provider** drop-down menu, as needed, to pull data for a single provider.
3. Select a **Major Sort Sequence** option:
   – Select the **Location** radio button to sort the data by location and then by provider.
   OR
   – Select the **Provider** radio button to sort the data by provider only.
4. Select either the **Detailed** or **Summary** radio button.
5. Select a **Report Output** option:
   – Select the **Printer** radio button to preview and print the report.
   OR
   – Select the **Export** radio button to export the data as an XLS spreadsheet file.

6. Click **Continue** to create the report or click **Exit** to cancel.

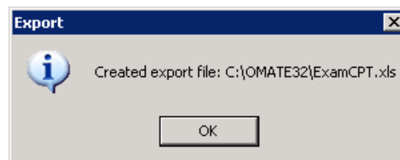
If you selected the Print radio button, the Preview window opens, where you can complete one or more of the following tasks:

– Click the **Print Report** icon to open the Print window and print the report using the current report printer.

– Click the **Export Report** icon to open the Export window and choose a format and destination for your exported report.

NOTE	If you are exporting the report to a Microsoft Windows application, such as Excel, select the **MS Excel 97-2000 (Data Only)** format and **Disk file** destination in the Export window and click **OK**. Select the **Column width based on objects in the Details** radio button and *all* the check boxes in the Excel Format Options window and click **OK**.

If you selected the Export radio button, the report is exported as an XLS spreadsheet file and saved on the server’s hard drive in the OMATE32 folder.



Printing Diabetic Letters

You can automatically generate and print a detailed routing slip for diabetes exams.

NOTES

- Ensure that you have the following location data recorded in Administration so that it populates in the letter:
  - Corporate Logo
  - Website

  For more information on recording location data, go to "To maintain location information" on page 45.
- Ensure that you have the following physician data recorded in the exam so that it populates in the letter:
  - Primary Care Physician and/or
  - Other Physician

  For more information on recording physicians in exams, go to "Recording Review of Systems Information" on page 182.
- The following additional data, if recorded in ExamWRITER, will also populate in the letter:
  - Patient name, address, DOB, and home phone number
  - Exam date
  - Blood pressure
  - Visual acuity
  - Recall date
  - CPT codes
  - Diabetes ICD-10 code

1. Click the **Print** icon in the top left of the ExamWRITER chart window.

2. Select **Diabetic Letter**.

   The Diabetic Patient Eye Examination Report opens.

Big Eye Center

Diabetic Patient Eye Examination Report www.msn.com

Family / General Practice Physician	
Name:	Ferit Furball MD
Address:	
Phone:	
Fax:	

Other Coordinating Physician	
Name:	Bruce Apeman MD
Address:	
Phone:	
Fax:	

Patient			
Name:	Michae	DOB:	04/23/1967
Address:	927 Oak Avenue	Phone:	

Eye Examination Date: 05/26/2017

BP: 111/70 mm/Hg

Best Corrected Distance Visual Acuity: OD: 20/25 OS: 20/20

Dilated Fundus Examination:
- ☐ Performed
- ☐ Patient Declined
- ☐ Contraindicated - Reason: ______

Diabetic Retinopathy Detection:
- ☐ Detected. Requires monitoring. No treatment indicated.
- ☐ Detected. Requires further testing &/or treatment.
- ☐ Other diabetic ocular complication(s) detected. Comments: ______

Imaging Performed:
- ☐ Optomap
- ☐ OCT
- ☐ Other: ______

Diabetes Control & Care Coordination Information: ☐ Discussed

Patient Recall Scheduled: 12/26/2017 (no. of days, weeks, months, years)

CPT Code: 99202 92004 Other: 3044F G8785

Mellitus Diagnosis ICD 10 Code: ______

Dr. Name: Dan Dayton, Jr. O.D. (Print) ______ (Signature) **Date:** ______

Note: If faxed, this report must include the HIPAA Privacy Rule fax cover sheet

Printing Glaucoma Letters

You can automatically generate and print a detailed routing slip for glaucoma exams.

NOTES

- Ensure that you have the following location data recorded in Administration so that it populates in the letter:
  - Corporate Logo
  - Website

  For more information on recording location data, go to "To maintain location information" on page 45.
- Ensure that you have the following physician data recorded in the exam so that it populates in the letter:
  - Primary Care Physician and/or
  - Other Physician

  For more information on recording physicians in exams, go to "Recording Review of Systems Information" on page 182.
- The following additional data, if recorded in ExamWRITER, will also populate in the letter:
  - Patient name, address, DOB, and home phone number
  - Exam date
  - IOP
  - CD radio
  - Recall date
  - CPT codes
  - Glaucoma ICD-10 code

1. Click the **Print** icon in the top left of the ExamWRITER chart window.
2. Select **Glaucoma Letter**.

   The Glaucoma Eye Examination Report opens.

Big Eye Center

Glaucoma Eye Examination Report

Family / General Practice Physician	
Name:	Dr. Syed Ahmad
Address:	
Phone:	
Fax:	

Other Coordinating Physician	
Name:	Dr. Alene Betancourt
Address:	
Phone:	
Fax:	214 328 0798

Patient			
Name:	Russell Marr	DOB:	
Address:		Phone:	

Eye Examination Date: 06/05/2017

Best Corrected Distance Visual Acuity: OD: ______ OS: ______

Intraocular Pressure (mm/Hg): OD: NR OS: 11

Optic Nerve Head Cup/Disk Ratio: OD: H NR V NR OS: H .35 V .35

Optic Nerve Head Photos: ☐ Photos Taken

Video Field Defect: OD: ☐ New ☐ Stable ☐ Worse OS: ☐ New ☐ Stable ☐ Worse

Nerve Fiber Layer Defect: OD: ☐ New ☐ Stable ☐ Worse OS: ☐ New ☐ Stable ☐ Worse

Glaucoma Detected: ☐ Suspect ☐ Under Management

Glaucoma Medication(s) & Dosage: ______

Patient Recall Scheduled: 06/11/2013

Comments: ______

CPT Code: ______ 92014 **Other:** G8785

Glaucoma Code: H40.1112 Primary open-angle glaucoma, right eye, moderate stage

Dr. Name: Dan Dayton, Jr. O.D. ______ **Date:** ______
Print Signature

Note: If faxed, this report must include the HIPAA Privacy Rule fax cover sheet

Sending Secure Messages

11

In this chapter:

- Understanding the Terminology, 332
- Setting up the Secure Messaging Portal, 333
- Logging into the Secure Messaging Portal, 341
- Giving Patients Access to their Clinical Data, 341
- Understanding Patient Access, 346
- Sending Clinical Information to Another Provider, 353
- Managing Your Own Provider Portal Account, 356
- Managing Other Provider Portal Accounts, 359
- Managing Patient Portal Accounts, 364

For more information on sending secure messages, watch the "Secure Messaging" and "Provide Patient Access" videos.

The secure messaging portal enables you to give patients secure access to their health records, send patient data to a receiving provider during a transition of care, and send and receive secure messages.

The secure messaging portal also allows you to set up a secure mailbox for each provider in your practice. The mailbox, or provider portal, is similar to many web-based email programs. Messages look like email messages and patient records look like email attachments. The closed architecture of the system makes it secure and HIPAA compliant; however, messages that you receive from patients are not completely private; any provider in your practice may see them.

Understanding the Terminology

While secure messages bear a resemblance to email, the two are not compatible. Understanding the technical differences between the two is not necessary, but it is important to understand some of the terminology used to distinguish secure messages. Use the table below to learn a few important terms.

Term	Definition
direct	*The protocol used to send secure messages.* You may sometimes see secure messages referred to as direct messages.
patient portal	*The patient's inbox.* The patient portal is a web application that allows the patient to view his or her latest clinical summary, download the summary or send the summary via secure message to another provider. The patient can also send secure messages to and receive secure messages from the practice provider.
provider portal	*The provider's inbox.* The provider portal is a web application allows the provider to send secure messages to patients and other providers, see any message sent by a patient to the practice, and see any secure message sent directly to the provider.
secure message	*An encrypted message sent from a person with a verified security certificate.* The message may contain a health-related question or a clinical summary.
security certificate	*An invisible electronic certificate that shows that a message came from a verified source.* Obtaining a security certificate is a one-time process that verifies your practice account was established by a real person.

Setting up the Secure Messaging Portal

The secure messaging portal enables you to set up a secure mailbox address for each provider in your practice. The secure mailbox addresses are significantly different than the insecure email addresses your providers already have.

You can set up the secure messaging portal directly within ExamWRITER. There are three basic steps required to set up the portal:

1. Configure the portal.
2. Register users.
3. Register the practice.

The portal is set up for your entire practice regardless of how many offices operate within your practice. This section tells you how to set up the secure messaging portal, including how

- To open the Secure Messaging Portal Setup window, 333
- To edit practice portal information, 334
- To edit practice hours, 336
- To edit provider portal settings, 336
- To save the portal settings and register, 337
- To establish provider direct mailbox passwords, 339
- To establish a direct messaging security certificate, 340

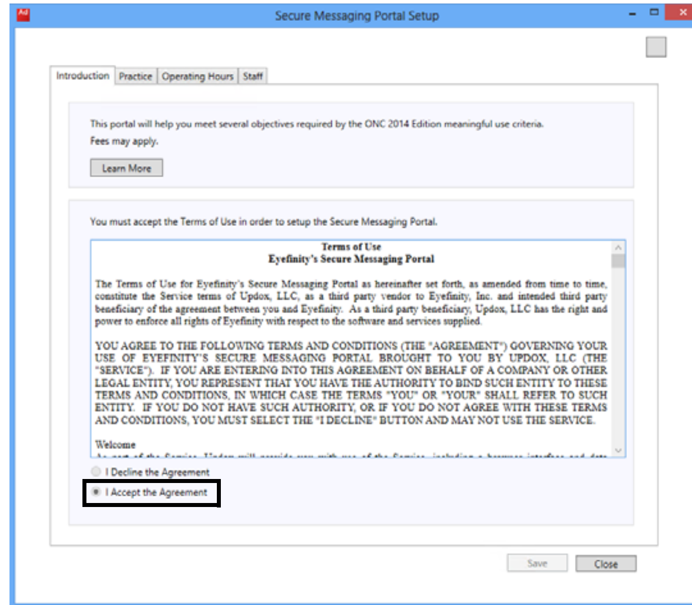
NOTE	Here are some tips to help you configure the portal and add provider accounts. These tips also appear throughout the instructions in this section.
	• Choose a standard naming convention for the Direct Mailbox that identifies the provider. Here are some suggestions:
	  – First initial, last name (e.g., *jdoctor*)
	  – First name, period, last name (e.g., *johnny.doctor*)
	• Use your email address as your temporary administrator user name. If you forget your administrator password, instructions on how to reset it will be sent to your email address. You can also open the Secure Messaging Portal Setup window and click on the Staff tab to view your administrator password.
	• Choose a standard temporary password for all providers and staff.
	• Send an email to each provider detailing the URL of the provider portal, and their username, temporary password, and direct mail address.

▶ To open the Secure Messaging Portal Setup window

1. In OfficeMate Administration, click **Setup**.
2. Select **ExamWRITER** and select **Setup Secure Messaging Portal**.

   The Secure Messaging Portal Setup window opens and displays important information about the costs associated with the portal.

3. Click **Learn More** to find out about the different pricing options for secure messaging.
4. Click the **I Accept the Agreement** radio button.



▶ To edit practice portal information

1. Open the Secure Messaging Portal Setup window. For more information, go to "To open the Secure Messaging Portal Setup window" on page 333.
2. Click the **Practice** tab.

   The first time the Practice tab opens, it displays the practice information that appears on the Business Names window.
3. Edit the practice information as needed.

NOTES	• Fields marked in red contain errors. You need to correct these errors before you can save the practice information. • The practice information appears on the portal page for your patients to see. • Editing the information on this window does not change the information on the Business Names window. To change the information on the Business Names window, contact Eyefinity at 800.942.5353. • If you are part of a multilocation practice, enter the information for the home office.

4. Type the first 5 digits of the practice's **ZIP Code**.
5. Type the practice's 10-digit **Phone Number** and **Fax Number** without dashes, parentheses, spaces, or other characters.
6. Type the practice's general-purpose **Email Address**. This email address appears on the portal page with the practice's contact information.

7. Select the **Time Zone** of the practice's home office.
8. Type a brief description of your practice in the **About Us Text** field.
9. Type a **Direct Subdomain** that identifies your practice.

NOTES

- The direct mail address consists of a mailbox, a subdomain, and a domain. Your direct mail addresses will look similar to this:

  johnnydoctor@joeseyecare.eyefinitydirect.com

  mailbox subdomain domain

- The mailbox portion of the address is setup on the Staff tab. The mailbox identifies the individual provider. Once this is set, you cannot change it, even if the provider's name changes.
- The subdomain identifies your practice. Once this is set, you cannot change it, even if the practice name changes.
- The domain identifies the secure messaging platform. This cannot be customized.
- The subdomain may contain alphanumeric characters only and is not case sensitive. Do not use spaces. After you establish the subdomain, do *not* change it, as changing it will adversely affect your meaningful use counts.
- The direct mail address is long; however, patients will not need to type it to send you secure messages.

10. Continue to "To edit practice hours" on page 336.

To edit practice hours

NOTE	The hours of operation appear on the practice's portal page. The hours are informational only and are not required to use the secure messaging portal.

1. Open the Secure Messaging Portal Setup window. For more information, go to "To open the Secure Messaging Portal Setup window" on page 333.
2. Click the **Operating Hours** tab.
3. Select the **Start** and **End** times for each day the practice is open.
4. Continue to "To edit provider portal settings" on page 336.

To edit provider portal settings

1. Open the Secure Messaging Portal Setup window. For more information, go to "To open the Secure Messaging Portal Setup window" on page 333.
2. Click the **Staff** tab.

   The tab displays providers listed in the Resources Setup window.

NOTES	• Once you save a provider's First Name, Last Name, and Direct Mailbox, you should not edit this information in the portal. • Set up a direct mail box for each provider in the practice. Multiple providers cannot share a direct mailbox.

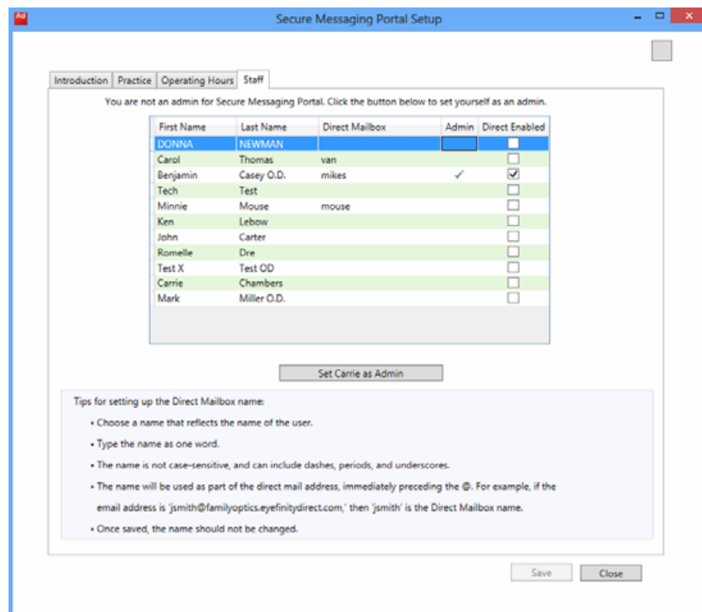
3. Select the **Direct Enabled** check box for each provider who needs a secure mailbox. Deselect the check box for any provider who has left the practice.

4. Type a **Direct Mailbox** name for each provider for whom the Direct Enabled check box is selected.

NOTE	• Choose a standard naming convention for the Direct Mailbox that identifies the provider. Here are some suggestions: – First initial, last name (e.g., *jdoctor*) – First name, period, last name (e.g., *johnny.doctor*) • Direct Mailbox names are not case sensitive and can include underscores, dashes, and periods. Do not use spaces. • Once this is set, you should not change it.

5. If you are not already set up as an administrator and want to set yourself up as someone who will have administrative rights to change the portal settings, click the **Set 'User' as Admin** button.

NOTES	• Assign admin rights to the people who will be setting up and maintaining the portal settings. Most likely, this will be the office managers. • If you are already assigned administrator rights and you no longer want to be an administrator, click the **Set 'User' as Regular User** button to remove your administrative rights.



6. Continue to "To save the portal settings and register" on page 337.

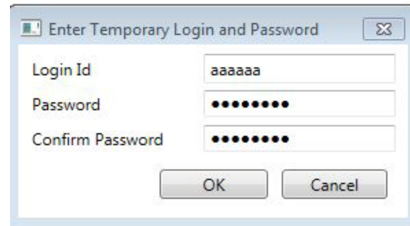
▶ To save the portal settings and register

1. Open the Secure Messaging Portal Setup window. For more information, go to "To open the Secure Messaging Portal Setup window" on page 333.
2. Edit or update the information on the Practice, Operating Hours, and Staff tabs as needed.

3. Click **Save**.

   If you have previously saved your portal settings and established an administrator user name and password, go to “To establish provider direct mailbox passwords” on page 339.

   If this is the first time you have saved your portal settings, you’re prompted to enter an email address as a temporary admin username and a password.



4. Type your **Email Address**.

NOTE	Your email address will be used as your username to log in and set up the provider portal. This email address may also be used to recover your admin password.

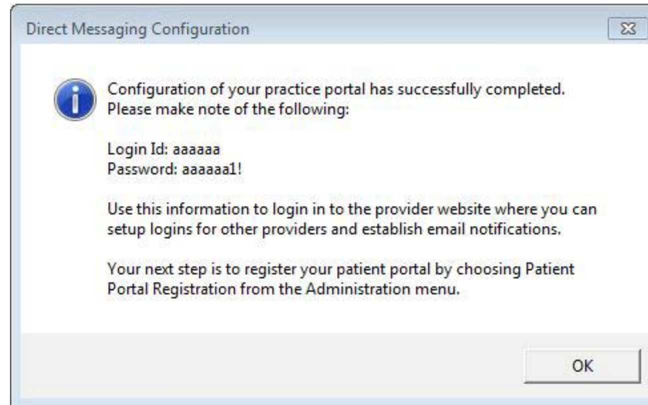
5. Choose a **Password**. Re-enter the password and click **OK**.

NOTES	• The password you enter here will be used to log in and set up the provider portal, and is not the password to your email account. • The email address and password are used to create an administrator account for the secure messaging portal. You will use this account to create initial passwords for each of your providers.

   The information is transmitted to the portal. The portal checks to see if your subdomain is available and sets up your practice’s account. If your subdomain is already taken you will need to choose another one.

6. Note the username and password that you entered. You will need this information to initiate the providers' passwords.

NOTE	If you forget the username and password, you can open the Secure Messaging Portal Setup window and click on the Staff tab to view this information.



7. Continue to "To establish provider direct mailbox passwords" on page 339.

▶ To establish provider direct mailbox passwords

Whether you're setting up your practice for the first time or adding a provider to your staff, you need to establish an initial password for the provider's account.

1. Open your web browser and go to https://eyefinityew.com.
2. Log in with an administrator's username and password.

NOTE	The administrator usernames and passwords were established when the portal was initially setup. After the providers' passwords are initiated, the providers selected as admins will also be able to administer the portal. If you forget your username and password, you can open the Secure Messaging Portal Setup window and click on the Staff tab to view this information.

3. Click **Configure** (gear icon) and select **Manage Users**.
4. Follow the on-screen instructions to establish the providers' logins and passwords.

NOTES	• Passwords must be at least 8 characters and contain at least one number and one special character. • Choose a common temporary password to make communicating account information with providers easier.

5. Notify the providers individually of their user names and passwords.
6. If this is the first time you have setup the secure messaging portal, continue to "To establish a direct messaging security certificate" on page 340.

To establish a direct messaging security certificate

Obtaining a security certificate is a one-time process for your entire practice that verifies your account was established by a real person.

1. Log into Administration as a person who is assigned the admin role.

NOTE	You can verify which people are assigned the admin role on the Staff tab of the Secure Messaging Portal Setup window.

2. Click **Setup**, select **ExamWRITER**, and select **Launch Practice Registration**.

   The Practice Registration page opens.

3. Follow the on-screen instructions to verify your practice's identity.

> **NOTE** The certificate process requires that you authenticate the identity of a provider in your practice.
>
> - Enter your Individual Provider NPI number *or* SSN in the Government ID section.
> - Enter a home or cell phone number for an automatic call back with a confirmation code, answer knowledge questions, *or* enter a valid personal credit card number in the Financial/Utility ID section. If you enter a credit card number, the name on the credit card must be the same as the provider name associated with the government ID. The credit card will not be charged; it is used only to establish the provider's identity.
>
> This authentication helps the system establish that you are a real person before issuing a secure certificate.

The certificate should take only a few minutes to process. While the certificate is processing, providers can send messages to patients within the practice, but they cannot send messages to providers outside of it.

Checking the security certificate status

Usually, the system processes your security certificate in a matter of minutes. Occasionally, the process may take a few hours. While the certificate is processing, providers can send messages to patients within the practice, but they cannot send messages to providers outside of it. To check the status of your practice's security certificate, perform the following steps:

1. In Administration, click **Setup**, select **ExamWRITER**, and select **Check Practice Vetted Status**.

   The Direct Messaging Status dialog box opens and displays the status of your practice's security certificate.

2. Click **OK**.

Logging into the Secure Messaging Portal

The secure messaging provider portal looks like many web-based email programs. There are, however, some notable differences:

- You will see the messages sent to all providers in your practice. While the message you send are secure, they are not private. Other providers in your practice will see your messages.
- You can send messages only to other providers who have a secure direct messaging account. These accounts are different then their standard email addresses. You cannot send a secure message to a insecure email address.

To log in, perform the following steps:

1. Open your web browser and go to https://eyefinityew.com.
2. Log in with your username and password.

NOTES	• Your initial password was established by the person who initiated your account. If you forget your username and password, you can open the Secure Messaging Portal Setup window and click on the Staff tab to view this information. You can change your password by logging into the portal, clicking **Menu**, **Tools**, and then selecting **Change Password**. • For more information about managing your account, go to “Managing Your Own Provider Portal Account” on page 356.

Username
Username
Password
Forgot password
****
LOGIN

Once you are logged in, you can review and send secure messages.

Giving Patients Access to their Clinical Data

You can give patients access to their clinical summary information through the secure messaging portal. In most cases, you will want to provide patients access to their clinical summary immediately to satisfy meaningful use requirements. Additionally, inform your patients that they will receive an email with instructions for accessing their clinical summary and encourage them to do so.

This section tells you how to give a patient access to his or her clinical data, including how

- To create a clinical summary document, 342
- To preview the clinical summary document, 344
- To send the clinical summary to the patient, 345

NOTE	You can also send .RTF (rich text format) files through the secure messaging portal that patients can view in their portals. Sending these file types, however, will not satisfy meaningful use requirements.

▶ To create a clinical summary document

1. Open the patient's exam.
2. Click **Patient Hx**.
3. Click the **Demographics** tab and verify the patient's **Name**, **Date of Birth**, and **E-Mail Address**.

NOTE	Patients are not required to have e-mail addresses recorded in the Patient Demographics window in order for you to send them secure messages and for them to view the in the patient portal. If the patient does not have an e-mail address, you will have to go to the provider portal and print out the patient's portal access information to give to them.

4. Click the **eDocuments** tab.
5. Select the **Clinical Summary (open exam)** radio button.
6. Select the **Patient Requested** check box.

7. Click **Create CDA**.

The Edit Clinical Summary window opens. The Original Document section reflects all of the data in the clinical summary that is capable of being shared with the patient. The Final Document section reflects only the data that you have selected to share with the patient. By default, all of the data is selected.

8. To exclude certain data, deselect the appropriate check boxes in the **Original Document** section.

NOTE	You may also deselect the check boxes in the Final Document section, but if you need to reselect them, you will need to select the check boxes in the Original Document section.

Figure 11-1:The Edit Clinical Summary window enables you to select which clinical data you want to include in the file. Notice that Problems is deselected in the Original Document, so it no longer appears in the Final Document.

9. Once you have selected only the data that you want to send the patient, click **Save**.
10. Click **OK** to dismiss the success message.

    The Patient Electronic Documents list refreshes and displays the clinical summary document that you created at the top.

▶ To preview the clinical summary document

1. Double-click the clinical summary document in the Patient Electronic Documents list.

   The eDocuments Information window opens.
2. Click **View**.

   The CDA Viewer window opens and displays the clinical summary as the patient would see it.

3. Click the links in the **Table of Contents** to navigate the clinical summary as needed.

CDA Viewer

Clinical Visit Summary

Patient	John Patient		
Date of birth	January 13, 1980	Sex	Male
Race		Ethnicity	Not Hispanic or Latino
Language	eng		
Contact info	Irvine, CA 92606 Telecom information not available.	Patient IDs	
Document Id	0896b207-57ac-432a-84bb-7622e3fafd2a		
Document Created:	January 28, 2014, 10:56:10		
Author	Johnny Doctor, OfficeMate Software Solutions		
Contact info	38 Discovery Irvine, CA 92618 Tel: (949) 390-8320		
Encounter Id	45447cce-0e28-46c6-b14c-f088904c50cd		
Encounter Date	From January 21, 2014		
Encounter Location	OfficeMate Software Solutions 38 Discovery Irvine, CA 92618 Telecom information not available.		
Document maintained by	OfficeMate Software Solutions		
Contact info	38 Discovery Irvine, CA 92618 Tel: (949) 390-8320		

Table of Contents

- Chief Complaint / Reason for Visit
- Social History
- Active Medications
- Allergies, Adverse Reactions, Alerts
- Immunizations
- Clinical Instructions and Patient Decision Aids
- Vital Signs
- Problem List
- Laboratory Tests and Values / Results
- Procedures
- Administered Medications
- Functional and Cognitive Status
- Plan of Care

4. Click the **×** to close the window when you're finished.

▶ To send the clinical summary to the patient

1. Select the clinical summary from the **Patient Electronic Documents** list.
2. Select **Patient** from the **Send To** radio buttons.

3. Click **Secure Send**.

4. Click **OK** to dismiss the message confirmation.

   The patient will receive an email explaining that new records are available from your practice. If the patient has not logged into the secure messaging portal before, he or she will receive a second email explaining how to log in for the first time. If the patient does not have an e-mail address, go to the provider portal and print out the patient's portal access information to give to them.

5. Encourage the patient to log into the portal and review the clinical summary.

Understanding Patient Access

This section is intended to help you understand what the patient sees when he or she receives a clinical summary or secure message from you. Because meaningful use Stage 2 measures count whether a patient actually views the clinical summary, you will need to encourage patients to view their records within a few days.

Refer to the following topics if a patient asks a question about the secure messaging portal:

- Activating the Patient Account, 347
- Changing Patient Account Settings, 349
- Viewing Clinical Summaries, 349
- Sending Clinical Summaries to Other Providers, 351
- Downloading Clinical Summaries, 352
- Sending Secure Messages, 352

NOTE	If the patient does not receive the activation email or is locked out of the patient portal, you may reset the patient's password and send a new activation. For more information, go to "Managing Patient Portal Accounts" on page 364.

Activating the Patient Account

ExamWRITER uses the patient's name, date of birth, and email address to create the secure messaging account. Verify this information on the Demographics tab before sending a clinical summary. To create a patient's account, you must send a clinical summary.

NOTE	Patients are not required to have e-mail addresses recorded in the Patient Demographics window in order for you to send them secure messages and for them to view the in the patient portal. If the patient does not have an e-mail address, you will have to go to the provider portal and print out the patient's portal access information to give to them.

The first time you send a patient a clinical summary, the patient will receive two emails: the first email notifies the patient that a document is available to review, and the second tells the patient how to activate an account.

To activate the account, the patient must complete the following steps:

1. Click the link in the activation email.

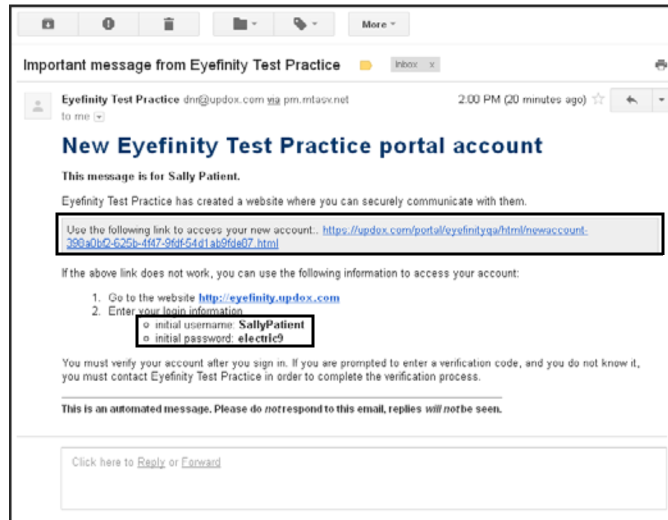
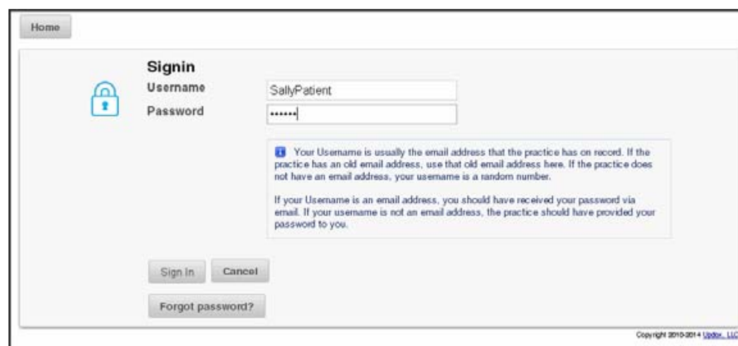


Figure 11-2:The activation email includes a unique link for the patient to activate a secure messaging account. The email also includes a username and initial password.

2. Click **Click Here to sign In**.

3. Type the **Username** and **Password** that were indicated on the activation email and click **Sign In**.



4. For added security, type your **Date of Birth** and click **Verify**.

Changing Patient Account Settings

The first thing the patient should do when after activating the account is change the settings under My Profile.

1. Click **My Profile**.
2. Edit the **User Name**, **Email Address**, and **Password** as needed.
3. Click **Update**.

Figure 11-3:Changing the settings under My Profile is not required, but patients can enhance the security of their own records by changing their usernames and passwords.

Viewing Clinical Summaries

Patients may view clinical summaries under the Records tab. When a patient views a clinical summary, it is reflected in the provider's meaningful use Stage 2 report. To view the clinical summary, the patient must perform the following steps:

1. Click the **Records** tab.

   The Records tab displays the most recent clinical summaries.

2. Click **View**.

Sally Patient
Send Message | My Profile | Sign Out

Home | Messages | Records

My Records

Continuity of Care Documents (CCD) and Continuity of Care Records (CCR) are two different file formats for representing patient health data. They are often used when transferring patient information from one computer system to another.

Your records are typically available in 2 formats:
- as a data file (in XML format), which you can download and provide to other practices or upload to a personal heath record (such as Microsoft HealthVault)
- as a human readable report (in HTML format), which you can read yourself

Message from your doctor:
Please find attached the Clinical Summary for your latest exam

Continuity of Care Document (CCD) — *Eyefinity Test Practice has not yet provided a CCD record for you.*

Continuity of Care Record (CCR) — *Eyefinity Test Practice has not yet provided a CCR record for you.*

Consolidated Clinical Document Architecture (CCDA) — View | Download text | Download data | Transmit
from 2014-02-13 2:00:19 pm

Continuity of Care Document - C32 Standard (C32) — *Eyefinity Test Practice has not yet provided a C32 record for you.*

Display audit trail

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The clinical summary opens in a new tab.

Clinical Visit Summary

Created On: February 13, 2014

Patient:	Sally Patient	**MRN:**	
Birthdate:	September 14, 1982	**Sex:**	Female
Guardian:		**Next of Kin:**	

Table of Contents

- Chief Complaint / Reason for Visit
- Social History
- Active Medications
- Allergies, Adverse Reactions, Alerts
- Immunizations
- Clinical Instructions and Patient Decision Aids
- Vital Signs
- Problem List
- Laboratory Tests and Values / Results
- Procedures
- Administered Medications
- Functional and Cognitive Status
- Plan of Care

Chief Complaint / Reason for Visit

No chief complaints / reasons for visit to show.

Social History

No social history to report.

Active Medications

No medications to show.

Allergies, Adverse Reactions, Alerts

No medical allergies to show.

Immunizations

3. Click the links in the table of contents as needed to jump to different sections of the clinical summary.

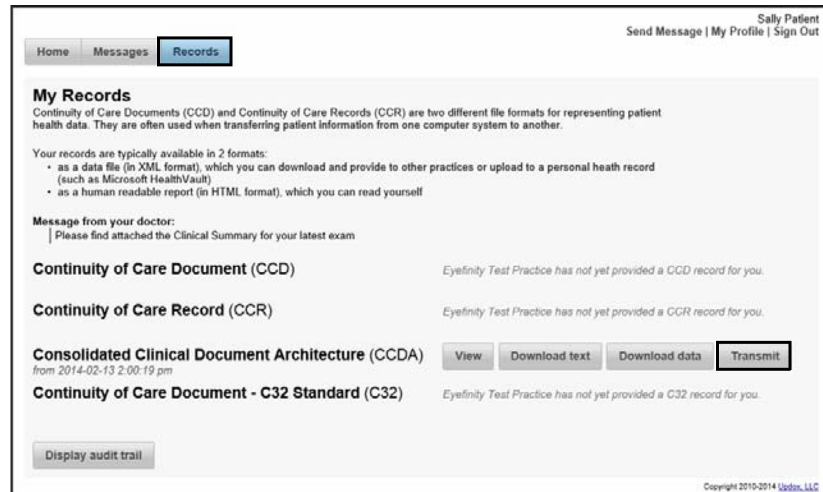
Sending Clinical Summaries to Other Providers

Patients may transmit their clinical summaries to other providers. When a patient transmits a clinical summary, it is reflected in the provider's meaningful use Stage 2 report.

NOTES	• The recipient must have a direct email address. The clinical summary cannot be sent to conventional email addresses. • Your practice must have established a security certificate before the patient will be able to transmit clinical summaries to other providers. For more information about this one-time process, go to "To establish a direct messaging security certificate" on page 340

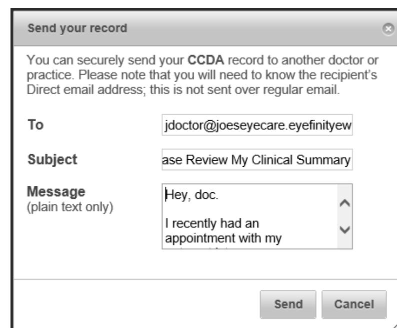
To transmit the clinical summary, the patient must perform the following steps:

1. Click the **Records** tab.
2. Click **Transmit**.



The Send Your Record window opens.

3. Type the recipient's direct email address in the **To** field. If the recipient does not have a direct email address, the clinical summary will not be sent.
4. Type a **Subject** and a **Message** and click **Send**.



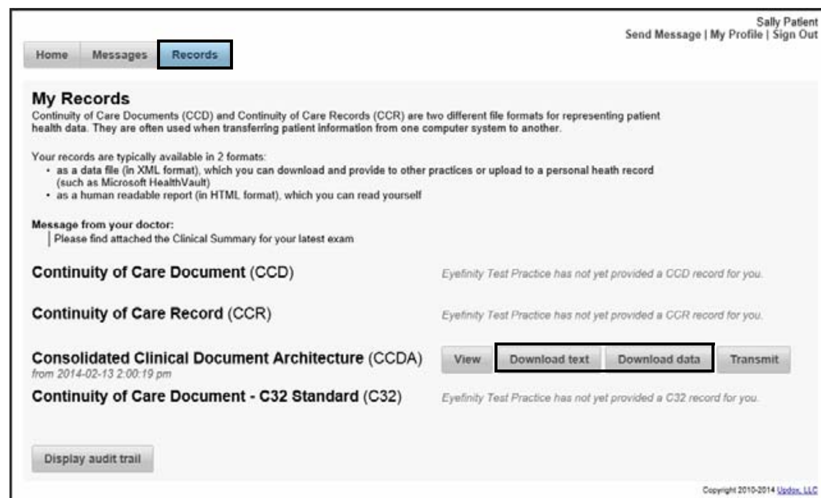
Downloading Clinical Summaries

Patients download their clinical summaries to their computer. When a patient downloads a clinical summary, it is reflected in the provider's meaningful use Stage 2 report.To download the clinical summary, the patient must perform the following steps:

1. Click the **Records** tab.
2. Click **Download Text** to download a styled clinical summary that looks like the clinical summary you see when you click View.

   OR

   Click **Download Data** to download an unstyled data file.



Sending Secure Messages

1. Click **Send Message**.
2. Type the **Subject** and the **Message** and click **Send**.

The message is sent to the provider.

Sending Clinical Information to Another Provider

You can send clinical information via direct message to providers to whom you refer a patient. There are two steps in this procedure:

1. Create the transition of care document in ExamWRITER.
2. Securely send it from ExamWRITER.

This section explains how.

NOTES	
	• Your practice must establish a security certificate before you will be able to exchange direct messages with a provider outside of your practice. For more information, go to "To establish a direct messaging security certificate" on page 340. • You may send a direct message to a provider with a direct messaging address. The provider's direct messaging address must be supported by a DirectTrust accredited agent. For example, the ExamWRITER secure messaging portal is supported by Updox. For a list of DirectTrust accredited agents, go to http://www.directtrust.org/accreditation-status.

▶ To create the transition of care document

1. Open the patient's exam.
2. Click **Patient Hx**.
3. Click the **Exam Hx** tab.
4. Click **New Referral**.

   The Patient Referral window opens.
5. Select a **Referring Provider** and a **Refer To Provider**.

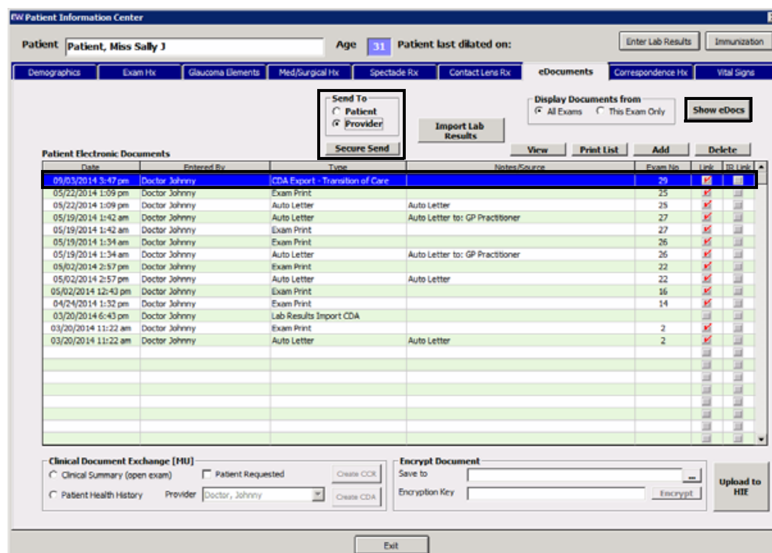
NOTE	Click **Maintain** to verify that the referred provider has a valid email address recorded.

6. Select a **SNOMED** that best explains the reason for the referral.
7. Select an **Expected Return Date** if needed.
8. Click **Save**.
9. Click **Create CDA Transition of Care**.
10. Click **Exit** to close the Patient Referral window.

11. Continue by sending the transition of care document. For more information, go to “To send the transition of care document” on page 354.

▶ To send the transition of care document

1. Create the referral and transition of care document. For more information, go to “To create the transition of care document” on page 353.
2. Click the **eDocuments** tab.
3. Click **Show eDocs**.
4. Select the CDA transition of care from the list of eDocuments.
5. Select **Provider** from the **Send To** radio buttons and click **Secure Send**.

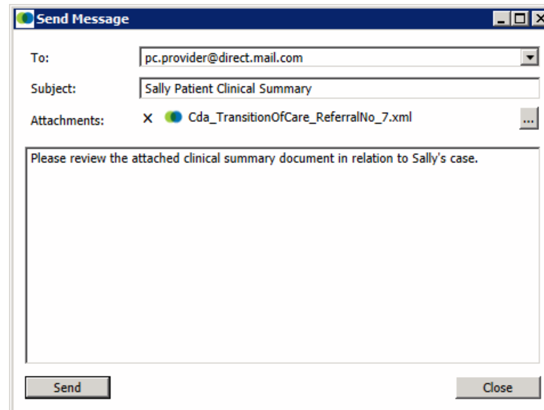


The Secure Message window opens.

6. Type the provider’s direct mail address or select it from the drop-down menu.

NOTE	The provider’s direct message address must be supported by a DirectTrust accredited agent. For example, the ExamWRITER secure messaging portal is supported by Updox. For a list of DirectTrust accredited agents, go to http://www.directtrust.org/accreditation-status.

7. Type a **Subject**, type a short message, and click **Send**.



Your message and the patient's CDA are sent securely.

Managing Your Own Provider Portal Account

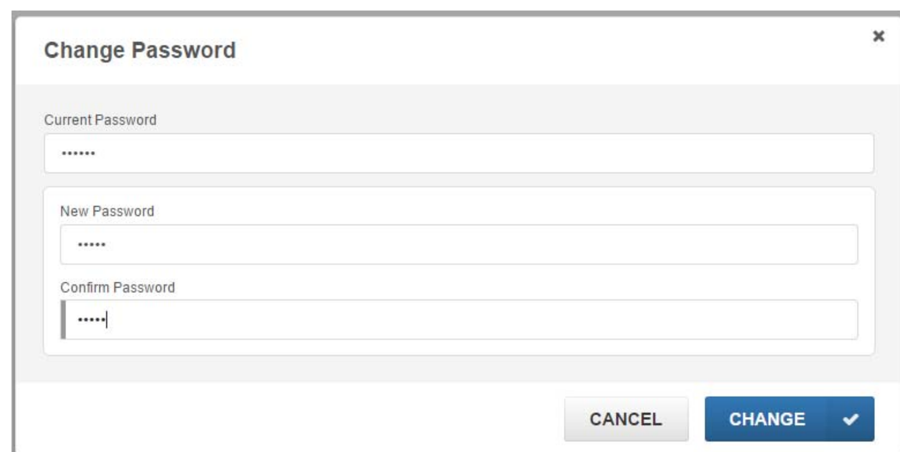
You can manage various aspects of your provider portal account. This section tells you how to manage your account, including how

- To change your password, 356
- To change your display name, 356
- To change your message signature, 357
- To change your provider portal settings, 358
- To change your email and text message notifications, 358

▶ To change your password

NOTE	If you modify your username or password in your portal account, then it will not match what is displayed on the Staff tab in the Secure Messaging Portal Setup window in OfficeMate/ExamWRITER.

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Tools** and select **Change Password**.
4. Type your **Current Password**.
5. Type your **New Password**.
6. Type your new password again in the **Confirm Password** field.
7. Click **Change**.



▶ To change your display name

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Profile** at the bottom of the menu.

4. Type your name as you want it to display in messages that you send in the **First Name**, **Middle Name**, and **Last Name** text boxes.

5. Click **Save**.

▶ To change your message signature

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Profile** at the bottom of the menu.
4. Type the signature that you want to display at the bottom of all of your outbound secure messages in the **Message Signature** text box.

5. Click **Save**.

To change your provider portal settings

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Profile** at the bottom of the menu.
4. Click **Settings**.

NOTE	Eyefinity recommends that you not change the Direct Address.

5. Change the viewing items settings to adjust the number of messages that appear on each page and the size and contrast of text.

6. Click **Save**.

To change your email and text message notifications

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Profile** at the bottom of the menu.
4. Click **Settings**.

5. Select the **Secure Messages** check box to receive notifications about messages sent to your mailbox.
6. If you wish to receive notifications by email, type your **Email Address**.
7. If you wish to receive notifications by text message, type your **Text Number**.

NOTE	Check with your carrier to determine your text message and data rates.

8. Click **Save**.

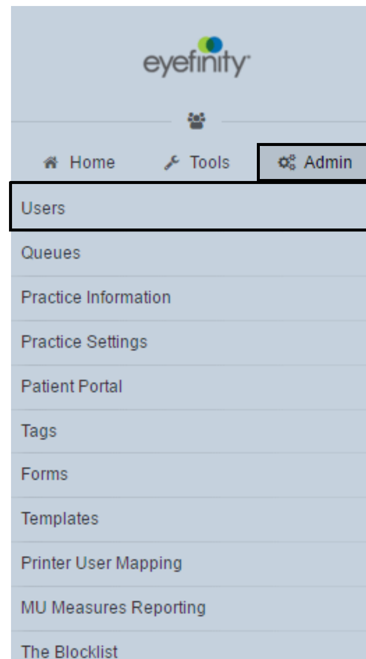
Managing Other Provider Portal Accounts

As an administrator, you can manage the portal accounts of the providers in your practice. This section tells you how to manage provider accounts, including how

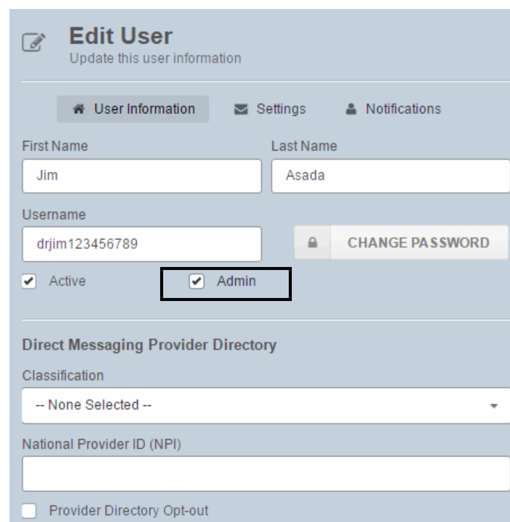
- To assign admin rights to another provider, 360
- To change a provider's display name, 361
- To change a provider's username and password, 362
- To manage the practice portal profile, 364

▶ To assign admin rights to another provider

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Admin** and select **Users**.



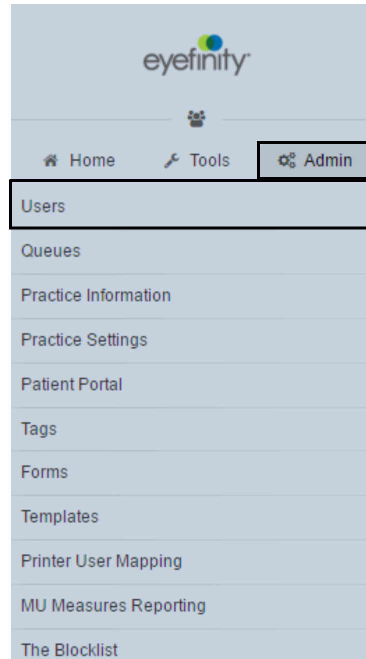
4. Select the user you want to edit.
5. Select the **Admin** check box to enable the provider to administer portal settings and other provider accounts.



6. Click **Save**.

▶ To change a provider's display name

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Admin** and select **Users**.



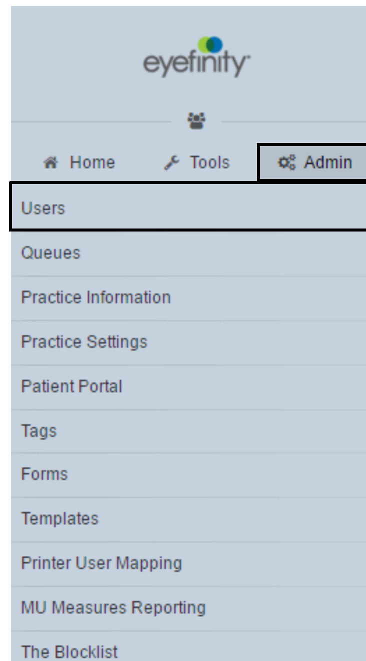
4. Select the user you want to edit.
5. Type the provider's name as it should appear in messages the provider sends in the **First Name** and **Last Name** text boxes.

6. Click **Save**.

▶ To change a provider's username and password

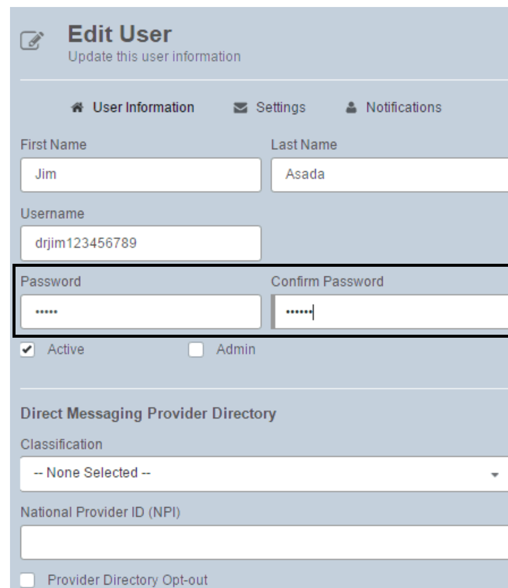
NOTE	If you modify a username or password in your portal account, then it will not match what is displayed on the Staff tab in the Secure Messaging Portal Setup window in OfficeMate/ExamWRITER.

1. Log into the provider portal.
2. Click **Menu**.
3. Click **Admin** and select **Users**.



4. Select the user you want to edit.
5. Type a new **Username**, if needed.
6. Click **Change Password**, if needed.

7. Type a new, temporary password in the **Password** and **Confirm Password** text boxes.



8. Click **Save**.

▶ To manage the practice portal profile

NOTES

- Do *not* change the settings on the Patient Portal window's General tab. Changing these settings will adversely affect your meaningful use counts.
- You can update the about, hours, and portal accounts information through the Secure Messaging Portal Setup window in OfficeMate Administration.

Managing Patient Portal Accounts

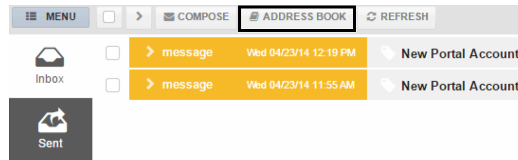
As a provider, you can manage the portal accounts of patients in your practice. This section tells you how to manage patient accounts, including how

- To update a patient's email address, 365
- To reset a patient's password, 366
- To resend a patient's account information, 367

To update a patient's email address

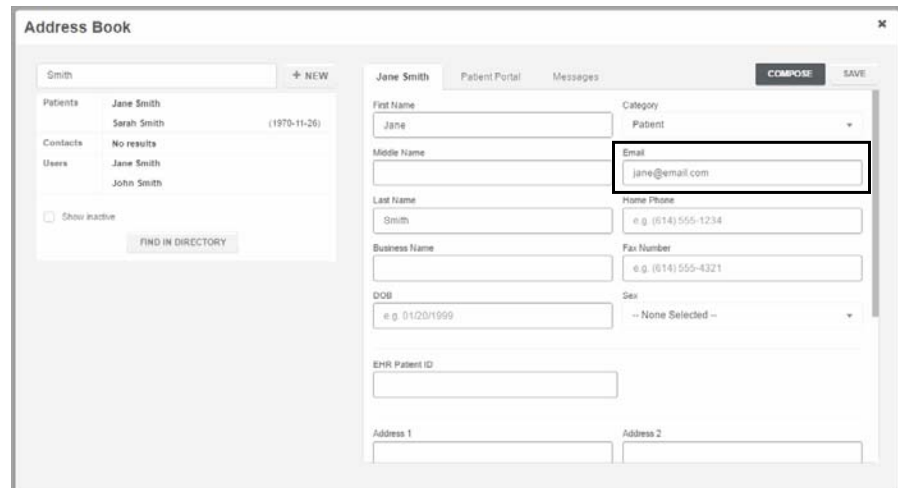
NOTE	You must also update the patient's address in the Patient Demographic window in OfficeMate/ExamWRITER.

1. Log into the provider portal.
2. Click **Address Book**.



3. Search for and select the patient you want to edit.

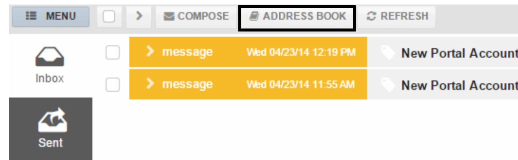
4. Type the patient's new email address in the **Email** text box.



5. Click **Save**.

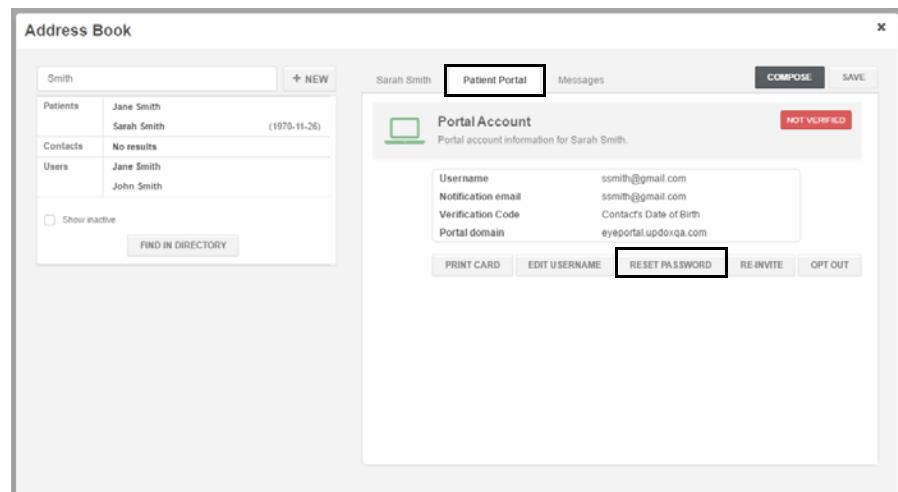
▶ To reset a patient's password

1. Log into the provider portal.
2. Click **Address Book**.



3. Search for and select the patient you want to edit.

4. Verify the patient's email address is correct.
5. Click the **Patient Portal** tab.
6. Click **Reset Password** to reset the patient's password and resend account activation instructions to the patient.



7. Click **Save**.

▶ To resend a patient's account information

If a patient did not receive or accidentally deleted the portal activation email, you can resend the activation from within the provider portal. To resend the activation email, you must reset the patient's password. For more information, go to "To reset a patient's password" on page 366.

Creating, Modifying, & Viewing Exam Notes

12

For more information on adding notes, watch the "Creating Notes or Addendums" video.

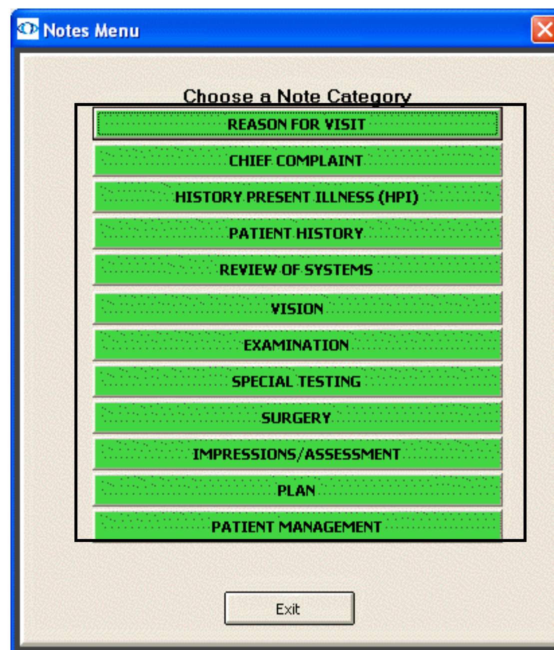
In this chapter:

- Creating Exam Notes, 369
- Searching for Exam Notes, 370

Creating Exam Notes

1. Click the **Notes** icon in the top middle of the ExamWRITER chart window.

   The Notes Menu window opens.



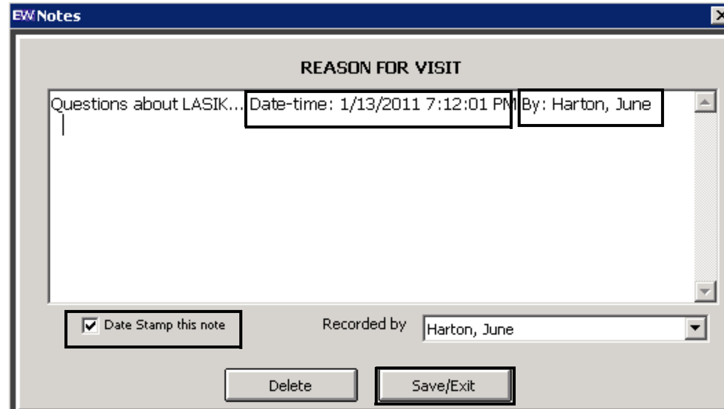
2. Click a note category.

   The Notes window opens.

3. Type your notes.
4. Select the **Date Stamp this note** check box if you want the date and time you recorded the note to appear in the note. If you select **this check box**, the person displayed in the Recorded by field will also appear in the note.
5. Select the name of the person recording the note from the **Recorded by** drop-down menu.

6. Click **Save/Exit** or click **Delete** to delete the note.

   If you selected Date Stamp this note in step 4, a time stamp of when the note was recorded and who recorded the note is appended to the text of the note.



Searching for Exam Notes

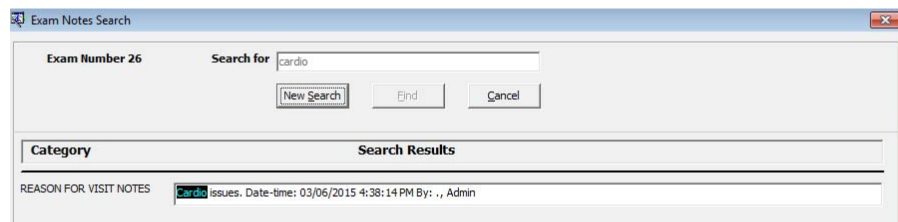
1. Press **Ctrl** + **F5**.

   The Exam Notes Search window opens.

2. Type search words in the **Search for** text box and click **Find**.

   Your search results are displayed.

3. Click **New Search** to conduct a new search.



Using ExamDRAW

13

In this chapter:

- Explanation of Interface Elements, 371
- Creating & Modifying Exam Drawings, 372
- Deleting Exam Drawings, 377

For more information on using ExamDRAW, watch the "ExamDRAW" video.

Explanation of Interface Elements

Figure 8-1 depicts the ExamDRAW window interface elements.

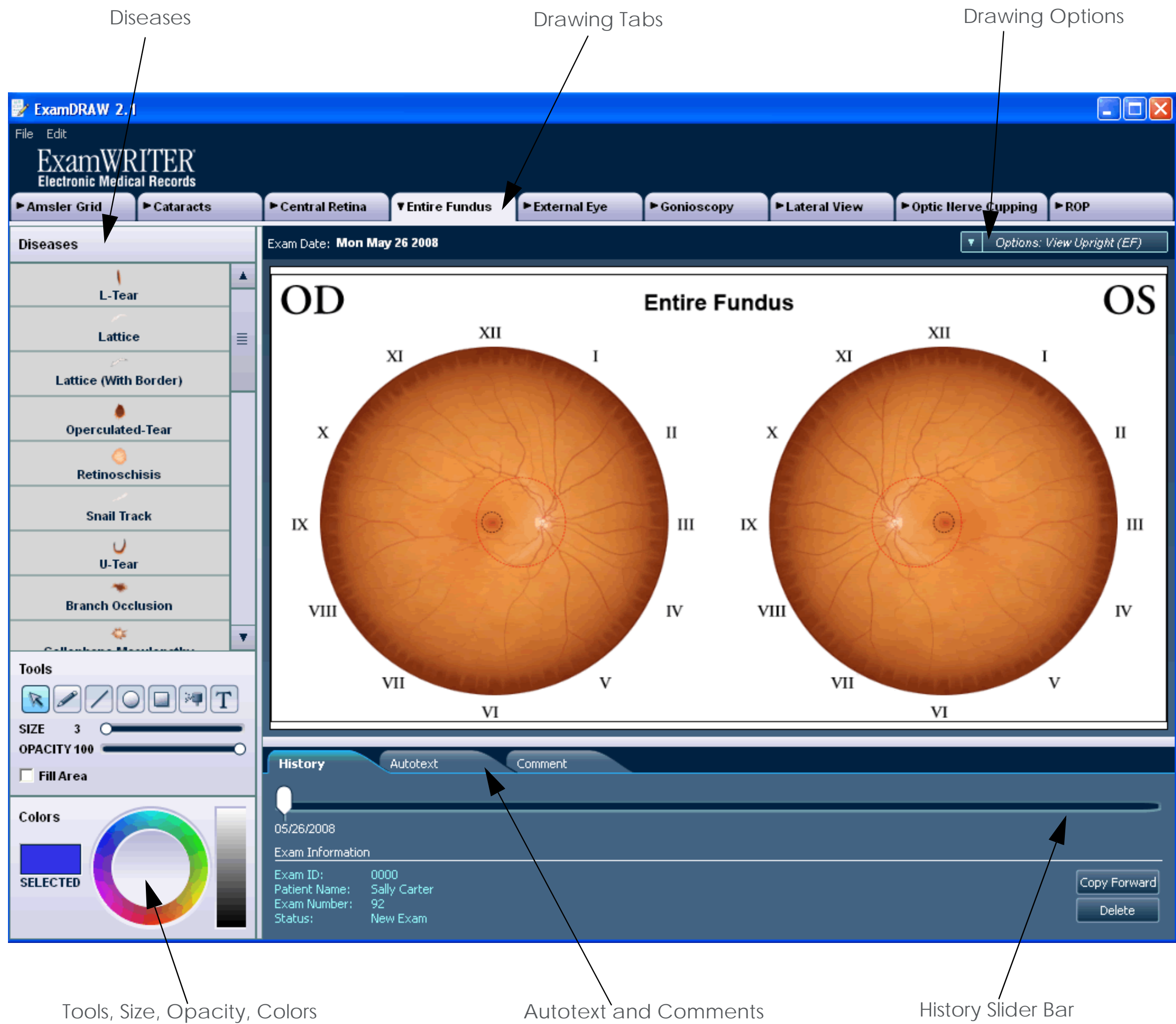


Figure 13-1: ExamDRAW Interface Elements

Creating & Modifying Exam Drawings

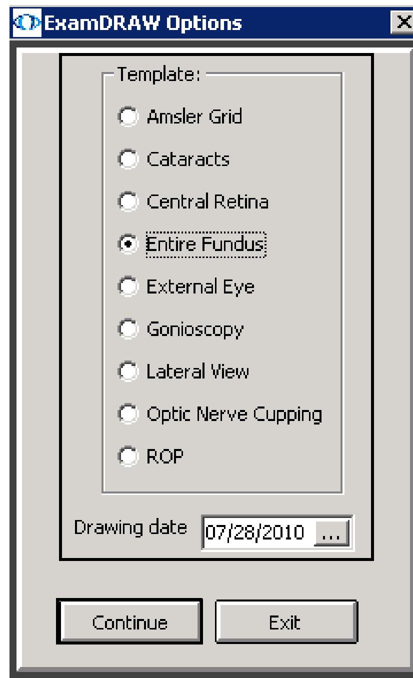
1. Click the **ExamDRAW** icon in the top middle of the ExamWRITER chart window.

   The ExamDRAW Options window opens.

2. Select a template.

NOTE	You can only use each ExamDRAW template once per day per patient exam. For example, you can create a drawing using the amsler grid template and a separate drawing using the cataracts template in the same patient exam on the same day, but you cannot create two drawings using the amsler grid template in the same patient exam on the same day.

3. Select the drawing date from the Drawing date calendar.
4. Click **Continue**.



The ExamDRAW window opens.

5. If you want to copy the drawing from a previous date forward to the current date to modify and record it on the current date, ensure that you are on the History tab at the bottom of the window and click **Copy Forward**.

NOTE	To view a historical record of a patient's drawings, move the white slider bar on the History tab at the bottom of the window to the desired date on the timeline or press your keyboard's left and right arrow keys.

6. If you want to add auto text to the drawing and the Autotext tab when you add a disease, click **File in the top left corner of the window**, select

Configure, and follow the instruction below; if you have already defined your auto text drawing options, skip this step.

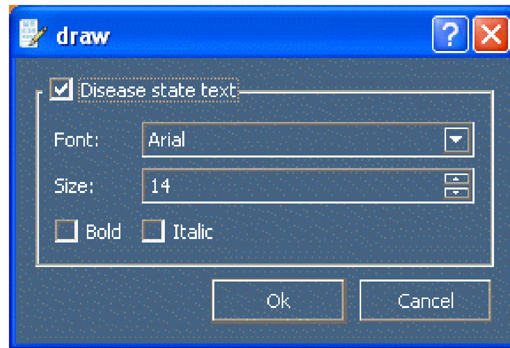
a. Ensure that the **Disease state text** check box is selected to insert auto text on the drawing.

b. Select a font style from the **Font** drop-down menu.

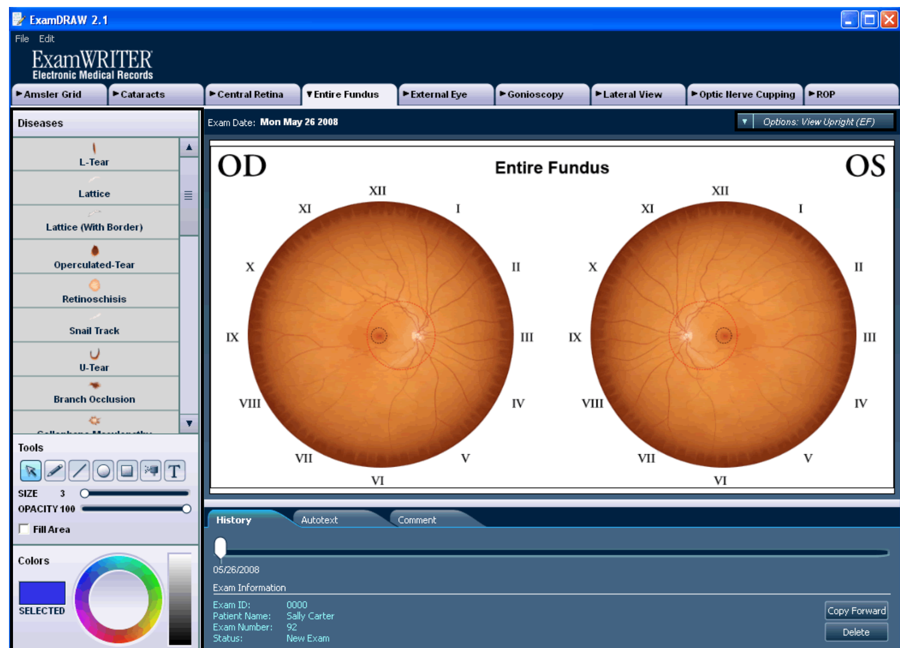
c. Type or select a font size from the **Size** menu.

d. Select the **Bold** and **Italic** check boxes, if desired.

e. Click **OK**.



7. Select the **Diseases**, **Tools**, **Size**, **Opacity**, and **Colors** that you want to use on the left side of the window.
8. If you are creating a central retina or entire fundus drawing and you want to draw on an inverted image, select **Inverted** from the **Options** drop-down menu in the top right corner of the window.
9. If you are creating an external exam drawing and you want to modify the size of the pupils, select a size from the **Options** drop-down menu in the top right corner of the window.

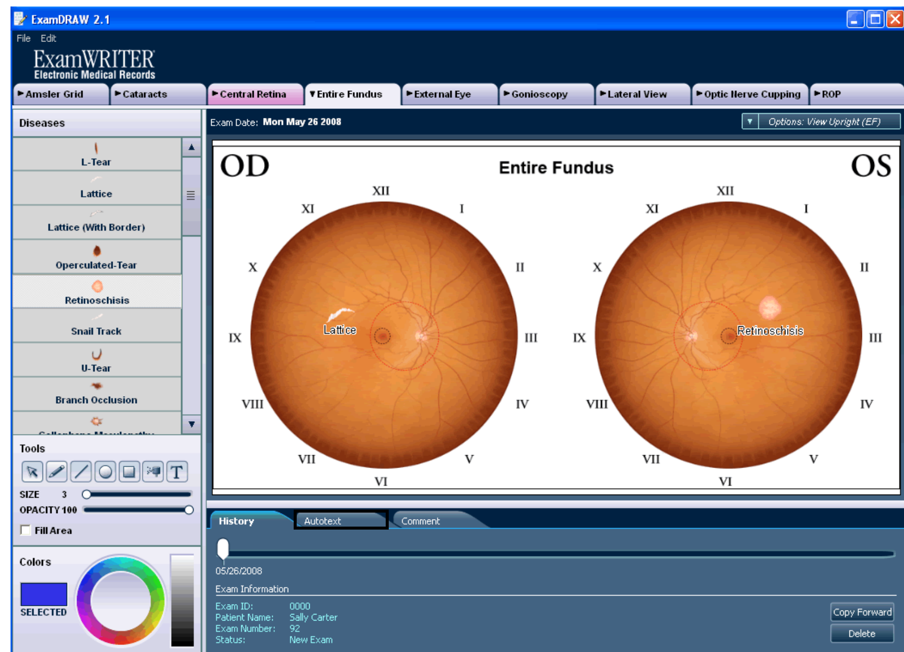


10. Draw on the eyes.
    a. Select a disease from the **Disease** column on the left side of the window.
    b. If the disease has a drop-down menu, select the most appropriate option.
    c. Click on the eyes to indicate where the disease is present.

    Auto text is automatically added to the Autotext tab at the bottom of the window when you add a disease to a drawing. The retina location is documented in Disc Diameters and clock position on the Autotext tab for central retina and entire fundus drawings. If you do not want to use the auto text, deselect the check box next to the auto text on the Autotext tab. You can use the text tool (the **T** icon) to add your own text to the drawing. To add comments to the auto text that appears when you draw on the eye, click the

Autotext tab, double-click in the **Comments** column next to the auto text, and type your comments.

NOTES	
	• To undo, redo, or clear changes that you have made to a drawing, click **Edit in the top left corner of the window** and select **Clear Changes**, **Undo**, or **Redo**. • To delete diseases or text that you have placed on the eyes, left-click on the disease or text and select **Delete**. • To record sizes and grades in a cataract drawing, click the **Cataracts** tab at the bottom of the Cataracts tab. • To record grades in a gonioscopy drawing, click the **Gonioscopy** tab at the bottom of the Gonioscopy tab. • To record C/D ratios in an optic nerve cupping drawing, click the **Optic Nerve Cupping** tab at the bottom of the Optic Nerve Cupping tab. • A dotted line defines where the central retina stops and the periphery starts on the Entire Fundus tab. Diseases recorded within the dotted line are also documented in the Central Retina tab and vice versa. • After you have recorded a drawing using a template and saved it, the tab denoting that template turns green. If you have recorded a drawing using a template but have not saved it, the tab denoting that template turns pink.

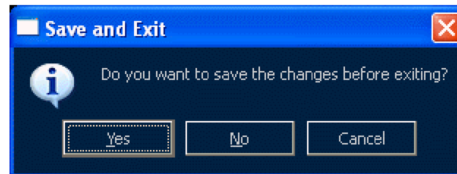


11. Click the **Comments** tab at the bottom of the window to add general comments to the drawing.
12. Click the tabs at the top of the ExamDRAW window to create other drawings.

13. Click the **X** in the top right corner of the window to save the drawing and exit ExamDRAW.

    The Save and Exit window opens.

14. Click **Yes** to save the drawing(s).



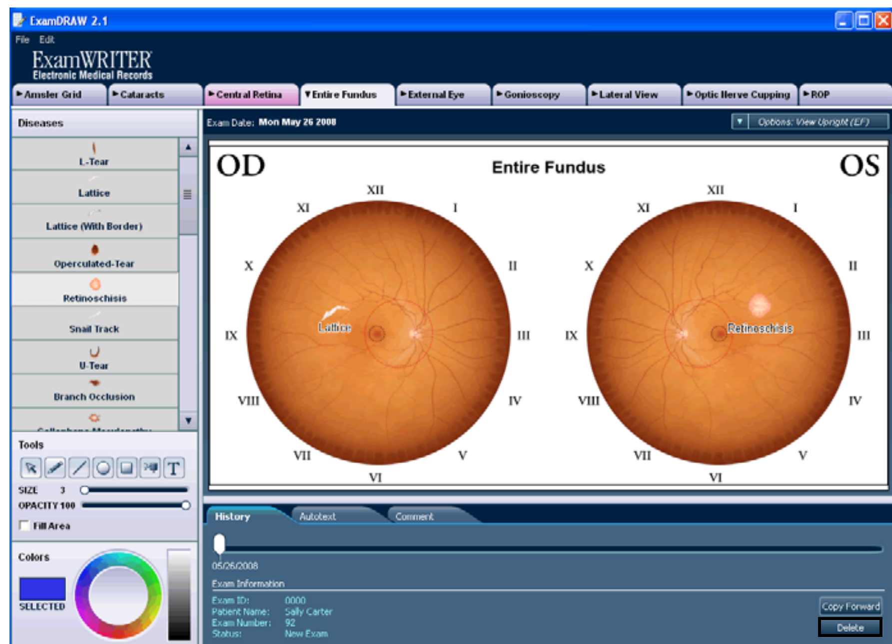
ExamDRAW drawings are visible and accessible under the Images, Drawing and Graphics category bar on the Images - Drawings tab in ExamWRITER.

Deleting Exam Drawings

1. Click the **Images - Drawings** tab on the ExamWRITER chart window.
2. Click on an ExamDRAW drawing under the Images, Drawing and Graphics category bar.

   The ExamDRAW window opens.

3. Click **Delete** in the bottom right corner of the window to delete the drawing.



Finalizing EMRs

14

For more information on closing and finalizing EMRs, watch the "Closing and/or Finalizing" video.

In this chapter:

- Finalizing Individual EMRs, 379
- Finalizing Multiple EMRs, 382

When you finalize an exam (EMR), an alert can prompt you to take an action if the exam meets a condition (Clinical Decision Support or CDS rule). For information on how to set patient alerts, see "Creating Clinical Decision Support Rules & Patient Alerts" on page 117.

Finalizing Individual EMRs

NOTES

- You *must* click the **Coding** icon in ExamWRITER, verify or add diagnosis and procedure codes on the Diagnosis/Procedure Coding window, and click **Save/Exit** before ExamWRITER will allow you to finalize an exam. If you have automatically recorded procedure codes in the exam, but the "Coding is Incomplete, Click Continue to Code Exam." message appears, then you have not saved the codes in the Diagnosis/Procedure Coding window and you must do so before finalizing the exam. For more information on verifying and adding diagnosis and procedure codes in exams, go to "Selecting Diagnosis and Procedure Codes" on page 302.
- You cannot close or finalize any exams that were copied forward that contain items in blue text. The blue text indicates that you copied ICD-9 codes forward and there was no exact correlation between those codes and their ICD-10 counterparts. You must remove the items in blue text in the exam and reselect them using ICD-10 codes.

1. Click the **Finalize** icon in the top left of the ExamWRITER chart window.

   The Exam Finalization window opens.

2. If the **Exam Review** indicates that the coding is incomplete, click **Continue**; otherwise, select the **Activities** that you want to perform:

Recording billable exams and printing auto patient reports, auto letters, and clinical summaries helps your practice meet meaningful use criteria. To better understand meaningful use and its criteria, see http://www.cms.gov/EHRIncentivePrograms/.

   – Select **Print Exam** to print the exam.
   – Select **Print Spectacle Rx** to print the spectacle Rx.
   – Select **Print Contact Rx** to print the contact lens Rx.
   – Select **Print Patient Report [MU]** to print the eyecare report.
   – Select **Exam is Billable/Reportable [MU]** if the exam is billable and should be documented as a reportable exam for meaningful use measures.

NOTE	Deselect Exam is Billable/Reportable [MU] if you are creating an exam record for a phone call, desk chart, contact lens follow-up, etc., so that the patient notes are not documented as an office visit/patient encounter for meaningful use measures.

   – Select **Print Auto Letter [MU, QRM]** to print the auto letter.
   – Select **Print Alternate Spectacle Rx** to print the alternate spectacle Rx.
   – Select **Print Trial Contact Rx** to print the trial contact lens Rx.
   – Select **Print Clinical Summary [MU]** to print the clinical summary that contains information from the Patient Report and clinical summary CCR
   – Select **Create No Med/No Allergy entry [MU]** if the patient does not have any medication or medication allergies and you did *not* click the No SYSTEMIC Medications [MU] and No Medication Allergies [MU] buttons on the Patient SYSTEMIC Medications and allergies [MU] window.

For more information on selecting Activities, go "To set up general preferences" on page 67.

For more information on coding, go to "Selecting Diagnosis & Procedure Codes" on page 301.

NOTE	If the Assessment/Plan and Patient Management sections of the EMR are incomplete, a yellow warning message appears; however, you will not be prevented from finalizing and closing the EMR.

3. Select the **CLOSE record** or **FINALIZE record** radio button.

NOTES	
	• If you choose to close the record, you will be able to open the record at a later time and review it and make changes. Note that you can update exam coding selections (for services only) in closed exams. If the fee slip for the updated exam has not been recorded in OfficeMate, the line item(s) on the fee slip will be updated. If the fee slip for the updated exam has already been recorded in OfficeMate, the fee slip will not be updated. Closing exam records gives you the ability to review the record at the end of the day before you finalize it. • If you choose to finalize the record, you will be able to open the record at a later time, but you will not be permitted to make changes. You will only be able to make additions and changes to the EMR in an addendum. For information on adding addendums, go to "Adding Addendums to EMRs" on page 383.

4. Select the provider signing off on the exam from the **Sign-off Provider** drop-down menu.
5. If this is a VSP exam, select the appropriate **VSP EHM** check boxes to participate in the Eye Health Management program.

NOTE	The VSP EHM check boxes may already be selected based on the findings recorded in the exam or from the patient's history.

The EHM information, associated diagnosis codes, and dilation information are sent when the claim and order are transmitted to VSP.

6. Click **Save/Exit**.

Finalizing Multiple EMRs

1. Click the **Chart Search** tab on the ExamWRITER Control Center window.
2. Search for a group of exams to finalize:
   a. Choose a date range for your search from the date **From** and **to** boxes.
   b. Select an exam status from the **Status** drop-down menu.
   c. Select a provider from the **Provider** drop-down menu.
   d. Click **Search**.
3. Click **Finalize**.

   The Confirm window opens.
4. Click **Yes** to finalize all of the closed exams that are displayed

Adding Addendums to EMRs

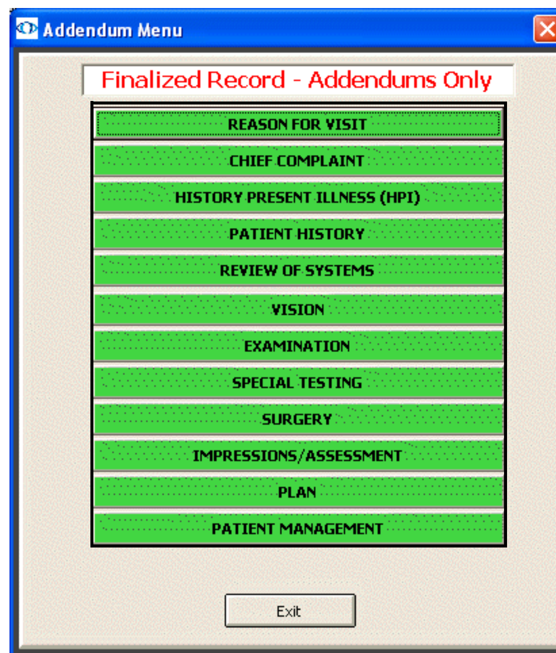
15

Addendums are notes or modifications added to an exam after it has been finalized. The original content of the exam remains intact; the addendum merely provides updated or corrected information. To add addendums to a finalized exam, perform the following steps:

For more information on adding notes, watch the "Creating Notes or Addendums" video.

1. Open a finalized exam. For more information on opening exams, go to "Opening Saved Patient Exam Records" on page 153.
2. Click the **Addendum** icon on the ExamWRITER chart window.

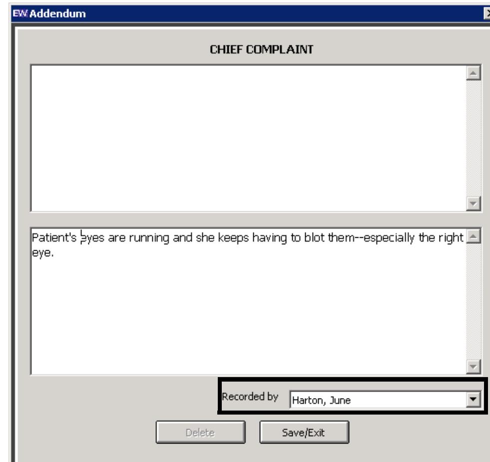
   The Addendum Menu window opens.
3. Select a category type to which you want to add an addendum.



   The Addendum window opens.
4. Type the addendum's text.
5. Select the person recording the addendum.

6. Click **Save/Exit**.

   The date you recorded the addendum and the name of the person recording it appears in the saved addendum and in the finalized exam.



Red text denoting the addendum and its associated category appears in the top right corner of the ExamWRITER chart window. The date and time is stamped to the addendum, and if security is active, the name of the person recording the addendum is also recorded. For more information on activating security, go to “Setting Up Preferences” on page 66.

Reporting Immunization, Public Health, & Meaningful Use

16

In this chapter:

- Generating Immunization Registry Files, 385
- Generating Public Health Files, 386
- Reporting MIPS Information, 387
- Reporting Medicaid Meaningful Use, 390
- Reporting Medicaid Quality Measures, 392

These reporting features are related to such CMS incentive programs as MIPS and meaningful use, so that you can receive incentive payments or avoid payment penalties.

For more information about...	Go to...
MIPS	qpp.cms.gov/learn/qpp
Medicaid meaningful use	www.cms.gov/EHRIncentivePrograms

You must have both OfficeMate and ExamWRITER to meet CMS incentive program requirements. If you are using the standalone version of ExamWRITER (without OfficeMate), you will not satisfy the requirements.

Generating Immunization Registry Files

For information on managing and viewing immunizations for a patient in ExamWRITER, watch the “Immunization Registry Reporting” video.

Submitting electronic data to an immunization registry helps your practice meet MIPS Advancing Care Information and Medicaid meaningful use criteria. ExamWRITER gives you the ability to generate and electronically submit CVX-coded immunization information to an immunization registry.

1. From the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu and select **Immunization Registry [MU]**.
2. Record the sending and receiving facility information, the receiving application, and the reporting date range.
3. Click **Generate HL7 V2.3.1 Immunization Files** to generate and send the files to the specified receiving facility.

   OfficeMate Administration creates a separate file for each immunization in the DATA\eDocuments\ImmunizationRegistry folder. You can print the files or

view them in Notepad. File names follow the format: VXU_V04_231_Patient ID_date.

Files include the following information:

– Summary of immunizations

– History of all immunizations received including: immunization, date given, patient name, patient identifier, and patient demographic information.

Generating Public Health Files

Submitting syndromic surveillance data (protected health information and the ICD-10 codes) to public health agencies helps your practice meet meaningful use criteria. ExamWRITER provides you with the ability to generate files and electronically submit syndromic surveillance data to a public health agency.

1. From the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu and select **Public Health Surveillance [MU]**.
2. Record the sending and receiving facility information, receiving application, reporting date range, and ICD-10 code being reported (the health agency requesting the file will send you this information).
3. Click **Generate HL7 V2.3.1 Public Health Files** to generate and send the files to the specified receiving facility.

   OfficeMate Administration creates a separate file for each patient for the date range entered in the DATA\eDocuments\PublicHealth folder. Files are similar to immunization files, except they contain ICD-10 codes. You can

print the files or view them in Notepad. Files names follow the format: ADT_A28_231_Patient ID_date.

Public Health File Generator

Sending/Receiving Setup

Fill out the form based on requirements specified by your local public health agency.

Sending Application
* Application Name: OfficeMate
Universal ID: OSS
Universal ID Type Code: L

Sending Facility
* Facility Name
Universal ID
Universal ID Type Code

Receiving Application
* Application Name
Universal ID
Universal ID Type Code

Receiving Facility
* Facility Name
Universal ID
Universal ID Type Code

Public Health Criteria
* Reporting From Date
* Reporting Through Date
* Diagnosis Code (ICD-9)
Generate HL7 V2.3.1 Public Health Files

* Fields values are mandatory.

Reporting MIPS Information

You can gather and prepare to report on measures that are part of the MIPS (Merit-Based Incentive Payment System) program beginning in 2017. This program consists of the following three components:

- Reporting Clinical Practice Improvement Activities, 387
- Reporting Advancing Care Improvement, 387

Reporting Quality Measures, 389For more information on MIPS, go to the Eyefinity MIPS Resource Center.

Reporting Clinical Practice Improvement Activities

In this new performance category for 2017, you're rewarded for care focused on care coordination, beneficiary engagement, and patient safety. The Improvement Activities category is worth 15% of your total MIPS score.

You may select activities that match your practice's goals from a list of more than 90 options. Medium weighted activities are worth 10 points, and heavily weighted activities are worth 20 points. You must select different activities every year.

❖ From the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu, select **Merit-Based Incentive Payment System (MIPS)**, and then select **Clinical Practice Improvement Activities**.

The 2017 MIPS Improvement Activities document opens and details the activities most applicable to eyecare practices.

Reporting Advancing Care Improvement

Information that you record in OfficeMate and ExamWRITER, specifically in fields that display [MU], is tied to meaningful use criteria and is reported in the MIPS Advancing Care Improvement Reporting window.

The MIPS Advancing Care Improvement Reporting window shows you how you are using your certified software. This window helps you see where you have met meaningful use (MU) requirements and where you have not, and helps ensure you qualify for the incentive payments. This window lists the percentage-based objectives.

NOTE	A permissible exclusion can count as having met an objective.

You can use the MIPS Advancing Care Improvement Reporting window to do the following:

- Keep track of the core objectives and their meaningful use criteria.
- Calculate the percentage of a criteria that you meet so that you can report the data in your attestation application.
- Generate a meaningful use report that you can send to the government.

To better understand advancing care information and its criteria, go to https://qpp.cms.gov/measures/aci.

NOTE	Both the MIPS Advancing Care Improvement Reporting window and the CMS MIPS Quality window can help you gather meaningful use information and determine if you qualify for stimulus money. For more information on CMS MIPS quality reporting, go to the "Reporting Quality Measures" on page 389.

1. From the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu, select **Merit-Based Incentive Payment System (MIPS)**, select **Advancing Care Information**, and then select Medicare if you are participating in the **Medicare** program or select Medicaid if you are participating in the **Medicaid** program.

NOTES	• In 2017 and 2018, there are slightly different objectives for reporting advancing care improvement information in the Medicare and Medicaid programs. • To access your Stage 1 - 2011 Edition, Stage 1 - 2014 Edition, and Stage 2 - 2014 Edition meaningful use reports for historical or auditing purposes, from the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu, select **CMS Meaningful Use Reporting - Hx**, and then select the appropriate stage and edition.

2. Select a line from the **Meaningful Use Criteria**.

   The description appears in the right column.
3. Select a date range from the **Reporting From Date** and **Reporting Through Date** fields.
4. Select a provider from the **Provider** drop-down menu.

5. Click **Calculate** to populate the Calculated Values fields.

   The calculated values are displayed in the Numerator, Denominator, and Percentage fields.

6. Click **Generate MU Report** to generate the Meaningful Use report.

   The report, an XML-based file, is placed in your DATA\eDocuments folder.

Reporting Quality Measures

If you plan to participate in the MIPS program for a full year, then you must have started documenting the NQF and CMS Quality measures in January.

The CMS MIPS Quality window gathers data about measures that can help you achieve Advancing Care Information and Quality categories. The CMS MIPS Quality window calculates the numerator, denominator, exclusions, performance rate, and reporting rate for each measures.

Each reporting criteria requires a different procedure and/or diagnosis code or Rx Norm code to be present within one or more patient exams. Data that you record in OfficeMate Administration and ExamWRITER that displays [QRM] next to it are quality reporting measures that are reported in the CMS Quality Reporting window.

To better understand quality reporting and its criteria, go to https://qpp.cms.gov/measures/quality.

1. From the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu, select **Merit-Based Incentive Payment System (MIPS)**, and then select **Quality**.

For more information on documenting MIPS quality measures, see the MIPS 2017 Quality Measures documents at www.eyefinity.com/education-and-support/OM-EW-Documentation.html.

2. Select the extent of reporting criteria that you want to view.
3. Select a line in **Reporting Criteria**.

   The related reporting criteria description is displayed in the right side of the window.

4. Select a date range from the **Reporting From Date** and **Reporting Through Date** fields.
5. Select a provider from the **Provider** drop-down menu.
6. Click **Calculate** to populate the Calculated Meaningful Use Metrics fields.

   The Generate button is enabled.

7. To view the details of each measure that you calculated, including dates, exam numbers, patient names, CPT codes, and ICD-10 codes, select **Measure Details** from the drop-down menu next to the Generate button, and then click **Generate**.

8. To generate CAT III files, select **QRDA Documents** from the drop-down menu next to the Generate button, and then click **Generate**.

9. To generate the data for a MIPS report and save it to a file, select **MIPS Report** from the drop-down menu next to the **Generate** button, and then click Generate.

   The XML file is created. The XML report opens in a browser. An XML-based report file is placed in the DATA\eDocuments folder. Additionally, the MIPS Quality Scorecard opens and displays your progress towards obtaining CMS Quality points.

10. To clear the metrics and description for the selected reporting criteria, click **Reset** or select another criteria.

11. To close the window, click **Exit**.

Reporting Medicaid Meaningful Use

Information that you record in OfficeMate and ExamWRITER, specifically in fields that display [MU], is tied to meaningful use criteria and is reported in the CMS Meaningful Use Reporting window.

For information about how to meet the measures and achieve and report meaningful use in OfficeMate/ExamWRITER, go to the applicable "Achieving Meaningful Use" document and watch the Meaningful Use Modified Stage 2 videos.

To better understand meaningful use and its criteria, go to www.cms.gov/EHRIncentivePrograms/.

The CMS Meaningful Use Reporting window shows you how you are using your certified software. This window helps you see where you have met meaningful use (MU) requirements and where you have not, and helps ensure you qualify for the incentive payments. This window lists the percentage-based objectives.

NOTE	A permissible exclusion can count as having met an objective.

You can use the CMS Meaningful Use Reporting window to do the following:

- Keep track of the core objectives and their meaningful use criteria.
- Calculate the percentage of a criteria that you meet so that you can report the data in your attestation application.
- Generate a meaningful use report that you can send to the government.

NOTE	Both the CMS Meaningful Use Reporting window and the CMS Quality Reporting window can help you gather meaningful use information and determine if you qualify for stimulus money. For more information on CMS quality reporting, go to the "Reporting Medicaid Quality Measures" on page 392.

1. From the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu and select **Stage 2 2015 CMS Meaningful Use Reporting**.

NOTE	To access your Stage 1 - 2011 Edition, Stage 1 - 2014 Edition, or Stage 2 - 2014 Edition meaningful use reports for historical or auditing purposes, from the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu, select **CMS Meaningful Use Reporting - Hx**, and then select the appropriate stage and edition.

2. Select a line from the **Meaningful Use Criteria**.

   The description appears in the right column.

3. Select a date range from the **Reporting From Date** and **Reporting Through Date** fields.
4. Select a provider from the **Provider** drop-down menu.

5. Click **Calculate Percentage** to populate the Calculated Values fields.

   The calculated values are displayed in the Numerator, Denominator, and Percentage fields.

6. Click **Generate MU Report** to generate the Meaningful Use report.

   The report, an XML-based file, is placed in your DATA\eDocuments folder.

Reporting Medicaid Quality Measures

The CMS Quality Reporting window gathers data about quality measures that can help you achieve meaningful use and participate in the Physician Quality Reporting System (PQRS). The CMS Quality Reporting window calculates the numerator, denominator, exclusions, performance rate, and reporting rate for quality measures.

The percentages displayed in the window are required for reporting purposes only. The actual value of the percentage reported will not affect the incentive dollars for the Medicaid Incentive Program. If the value is zero, report it as zero.

Each reporting criteria requires a different procedure and/or diagnosis code or Rx Norm code to be present within one or more patient exams. Data that you record in OfficeMate Administration and ExamWRITER that displays [QRM] next to it are quality reporting measures that are reported in the CMS Quality Reporting window.

For information about reporting CQMs, watch the "Clinical Quality Measures (CQMs) 2014 Edition" video.

NOTE Both the CMS Quality Reporting window and the CMS Meaningful Use Reporting window can help you gather Medicaid meaningful use information and determine if you qualify for stimulus money. For more information on CMS meaningful use, go to the "Reporting Medicaid Meaningful Use" on page 390.

To better understand quality reporting and its criteria, go to www.cms.gov/EHRIncentivePrograms/.

1. From the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu and select **2016 Edition - CMS Quality Reporting**.

NOTE	To access your 2011 Edition, 2014 Edition, or 2015 Edition CMS quality reports for historical or auditing purposes, from the OfficeMate Administration or ExamWRITER main window, click the **Reports** menu, select **CMS Quality Reporting - Hx**, and then select the appropriate edition.

2. Select the extent of reporting criteria that you want to view.
3. Select a line in **Reporting Criteria**.

   The related reporting criteria description is displayed in the right side of the window.
4. Select a date range from the **Reporting From Date** and **Reporting Through Date** fields.
5. Select a provider from the **Provider** drop-down menu.
6. Click **Calculate** to populate the Calculated Meaningful Use Metrics fields.

   The Create QRDA Documents button is enabled.
7. Click **Create QRDA Documents** to generate the data and save it to a file.

   The XML file is created. The XML report opens in a browser. An XML-based report file is placed in the DATA\eDocuments folder.
8. To clear the metrics and description for the selected reporting criteria, click **Reset** or select another criteria.
9. To close the window, click **Exit**.

Getting Support

17

In this chapter:

- Phone Support, 395
- Online Support, 395
- Terms of Support, 395

Eyefinity considers our Customer Care department the backbone of a successful, positive relationship between our company and you, our client. Our goal is to continually enhance the level of service provided by our Customer Care department. Eyefinity offers reasonable annual software maintenance agreement fees and, simultaneously, must establish and enforce our service guidelines in order to keep these fees equitable. This chapter outlines our service guidelines and policies.

Phone Support

Eyefinity offers toll-free customer care from 6:00am to 5:00pm Pacific Time. Dial 800.942.5353 and choose option 1 to reach our Customer Care team.

Your calls are answered live by our knowledgeable Customer Care team who will assist you with your support issues. Eyefinity's service levels are equal to or better than the best service levels provided by any competitive help desk service in our industry today.

Online Support

For more support information on ExamWRITER or any of the OfficeMate Suite products, go to the OfficeMate and ExamWRITER support Web pages at http://www.eyefinity.com. You can e-mail your support questions to the Eyefinity Customer Care department at officematesupport@eyefinity.com.

We highly encourage you to seek out answers to your questions in our online support community where you can create and update support cases, access our growing knowledge base of information, ask questions and get answers from your peers, and contribute your ideas to improving Eyefinity products. Go to http://www.eyefinity.com/education-and-support/Support-Community.html to access the new Eyefinity Support Community.

Terms of Support

The Maintenance & Support is a mandatory agreement all clients must maintain each year through the payment of an annual fee for each software product licensed from Eyefinity. This Maintenance & Support includes the annual OfficeMate/Report WRITER/ExamWRITER license, all software upgrades, and toll-free help desk services for our software applications.

The Eyefinity business model requires us to amortize our annual investment in software application development and customer care across our broad base of clients using Eyefinity software. By requiring that everyone invest by paying this low annual fee each year, we can retain lower fees. If fewer clients participate, the result would be substantially higher fees to amortize these services across fewer clients.

Backing Up & Restoring Data

18

In this chapter:

- Determining Your SQL Database Server & Name, 398
- Determining the Location of Your DATA Folder, 398
- Automatically Backing Up Databases, 399
- Manually Backing Up Databases, 402
- Restoring Databases, 403

Back up your OfficeMate/ExamWRITER database files on a regular basis! A full database backup is the best way to make sure that you can recover your OfficeMate/ExamWRITER database files in the event of a database corruption, hardware or software failure, computer virus attack, fire, theft, or natural disaster.

Share this information with your backup service provider or your certified operating system and network technician.

NOTES	
	• Eyefinity limits the support it provides exclusively to its own products and, therefore, does *not* provide assistance or support for any issues related to the backup and restoration of data. Eyefinity does not guarantee nor validate the integrity of backup files. • Eyefinity highly recommends employing a certified operating system and network technician to advise you on recommended data backup procedures. • Eyefinity recommends backing up your OfficeMate and OfficeMate data *every day*. • Eyefinity recommends using *multiple* back up methods and backing up your data to *multiple* files in case one backup file is lost or corrupt. • The OfficeMate/ExamWRITER programs do *not* provide backup functions.

Read this document carefully to ensure a successful backup and recovery plan.

There are two areas that must be backed up to ensure a successful recovery plan:

- **The database.**
- **The DATA folder.** For more information, go to “Determining the Location of Your DATA Folder” on page 398.

Determining Your SQL Database Server & Name

Your data backup provider or certified operating system and networking technician will need to know the SQL server instance and database name to be able to properly set up the backup system.

To determine your SQL server instance and database name, perform the following steps:

1. Open OfficeMate or ExamWRITER.
2. Click **Help**.
3. Click **About OfficeMate**, **About ExamWRITER**, or **About Administration**, depending upon which software you have open.

   The About window opens.
4. Look for the *Server* and *Database Name* information.
5. Tell your data backup provider or certified operating system and networking technician the SQL server instance and database name.

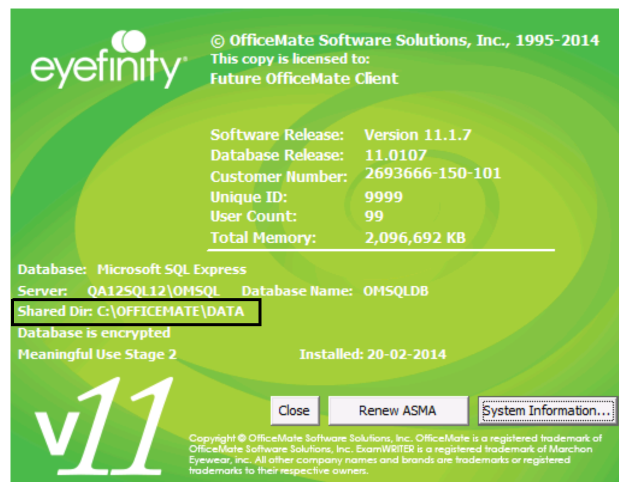
Determining the Location of Your DATA Folder

In addition to backing up your database, you must also back up critical files that are stored in your DATA folder. The DATA folder contains such files as eDocuments, electronic claims, etc. Your data backup provider or certified operating system and networking technician will need to know the location of your DATA folder to be able to properly set up the backup system.

To determine the location of your DATA folder, perform the following steps:

1. Open OfficeMate or ExamWRITER.
2. Click **Help**.
3. Click **About OfficeMate**, **About ExamWRITER**, or **About Administration**, depending upon which software you have open.

   The About window opens.
4. Look for the *Shared Dir* or *Data Dir* information to determine the location of the DATA folder.



NOTE	The DATA folder is usually located at \\Server\OfficeMate\DATA.

5. Tell your data backup provider or certified operating system and networking technician where your DATA folder is located.

Automatically Backing Up Databases

This section tells you how to automatically back up your database and includes the following topics:

- Choosing an Automatic Backup Method, 399
- Automatically Backing Up a SQL Database, 401

Choosing an Automatic Backup Method

Eyefinity recommends using *multiple* back up methods and backing up your data to *multiple* files in case one backup file is corrupt. Work with your data backup provider or certified operating system and networking technician to determine which solution is best for you.

Use the following table to help you decide which backup method(s) are best suited for your practice.

Backup Method	Advantages	Disadvantages	Recommended Solution
Online	• Provider installs, sets up, and maintains the backup software • Backups are automated • Easy restoration process • Off-site backup, not susceptible to local disasters or theft • Low cost to set up and maintain	• Backup times vary depending on the speed and reliability of your internet connection • Backups are subject to the bandwidth and data transfer limitations set by your internet service provider	**DataHEALTH** 800.269.3666 or sales@eyefinity.com **Practice Shadow by Think Smart Group, Inc.** 800.941.4913.
Local	• Ideal for large practices with in-house IT • No need to worry about data limitations or service interruptions	• Requires more technical knowledge to install, backup, and restore • Requires investment in backup software and hardware • Additional expenses for off-site, secure, physical storage • Unsecured backups are susceptible to theft, fire, or natural disaster	For SQL databases: **Veritas Backup Exec with Agent for Applications and Databases** www.veritas.com

Although there are many types of backup media that you can use to back up your database files (for example, CD-R, DVD-R, USB flash drives, and external hard drives), Eyefinity recommends using DataHEALTH for data backup and off-site

storage. DataHEALTH protects your practice by automatically backing up, encrypting, and storing your data in a secure, off-site data center. If you experience a data loss, all of your lost files are recoverable anytime with the click of a button. DataHEALTH also offers the following benefits:

- Provides a level of service that exceeds industry standards for your data storage and recovery needs.
- Automatically backs up and verifies your OfficeMate/ExamWRITER database files.
- DataHEALTH is the only cloud backup company to be URAC HIPAA Security Business Accredited along with FIPS 140-2 encryption validated.
- DataHEALTH's cloud backup service is powered by Asigra: an enterprise-level, awarding-winning cloud backup software.
- DataHEALTH's cloud backup powered by Asigra goes through five key checks to ensure that your data is always restorable.
- DataHEALTH's Backup Support professionals have restored data expediently for thousands of customers.
- Cloud backup with DataHEALTH is cost effective. Pricing starts at $20.00/month, which is less than $1/day.
- DataHEALTH has certified advanced cloud backup professionals on staff.
- DataHEALTH's technical support and customer service staff are based in the United States. In a time of emergency, you want support that is stateside. No worries of dealing with language barriers!

DataHEALTH offers a free 30-day, obligation-free trial. For more information on this offer and DataHEALTH, contact Eyefinity at 800.269.3666 or www.eyefinity.com/strategic-partners/CertifiedPartners.html.

Automatically Backing Up a SQL Database

1. Review the documentation and recommendations provided by your backup provider or backup solution.
2. Tell your data backup provider or certified operating system and networking technician the SQL server instance and database name. For information about finding your SQL server instance and database name, go to "Determining Your SQL Database Server & Name" on page 398.

NOTE	SQL databases cannot be treated like other files within Windows. SQL databases require such specialized software as SQL Server Management Studio or Veritas Backup Exec with Agent for Applications and Databases to ensure a complete and valid backup. Copying a SQL database without using specialized SQL database management software will cause irreparable damage to the database.

3. Tell your data backup provider or certified operating system and networking technician where your DATA folder is located. For information about finding

your DATA folder, go to "Determining the Location of Your DATA Folder" on page 398.

NOTE	• The DATA folder contains such files as eDocuments, electronic claims, etc. These files reside outside of your SQL databases and do not require specialized software to perform a backup. • If you are storing eDocuments or electronic claims in a location other than the DATA folder, ensure that you also navigate to the location of these documents and back them up.

Manually Backing Up Databases

Eyefinity recommends manual backups only as a temporary measure before upgrading or applying patches to the OfficeMate/ExamWRITER software. Manual backups are not intended to replace automatic backups.

This section tells you how to manually back up your database and includes the following topics:

- Preparing for a Manual Backup, 402
- Manually Backing Up a SQL Database, 402

Preparing for a Manual Backup

1. Review your backup device and media manufacturer's replacement recommendations and ensure that your backup device and media are within their useful product lifecycle.
2. Clearly label the backup media that you are using for each day of the week that your office is open for business.
3. Review the HIPAA security and privacy requirements and ensure that your backup procedures are compliant.

Manually Backing Up a SQL Database

NOTE	Eyefinity highly recommends employing a certified operating system and network technician to advise you on recommended data backup procedures.

1. Close OfficeMate and ExamWRITER on all of your computers.

NOTE	The integrity of your backup is severely compromised, and in some cases invalidated, if you perform a backup while OfficeMate and ExamWRITER are open.

2. Tell your certified operating system and networking technician the SQL server instance and database name. For information about finding your SQL

server instance and database name, go to "Determining Your SQL Database Server & Name" on page 398.

NOTE	SQL databases cannot be treated like other files within Windows. SQL databases require such specialized software as SQL Server Management Studio or Veritas Backup Exec with Agent for Applications and Databases to ensure a complete and valid backup. Copying a SQL database without using specialized SQL database management software will cause irreparable damage to the database.

3. Tell your certified operating system and networking technician where your DATA folder is located. For information about finding your DATA folder, go to "Determining the Location of Your DATA Folder" on page 398.

NOTE	• The DATA folder contains such files as eDocuments, electronic claims, etc. These files reside outside of your SQL databases and do not require specialized software to perform a backup. • If you are storing eDocuments or electronic claims in a location other than the DATA folder, ensure that you also navigate to the location of these documents and back them up.

Restoring Databases

NOTE	If you need to restore data from a backup, ensure that your staff is properly trained to restore data. If you are not familiar with your restoration procedures, contact your certified operating system and networking technician or the manufacturer of your backup media.

1. Close OfficeMate and ExamWRITER on all of your computers.
2. Follow the instructions in your backup program to restore the SQL server instance and database name. For information about finding your SQL server instance and database name, go to "Determining Your SQL Database Server & Name" on page 398.

NOTE	SQL databases cannot be treated like other files within Windows. SQL databases require such specialized software as SQL Server Management Studio or Veritas Backup Exec with Agent for Applications and Databases to ensure a complete and valid restoration. Copying a SQL database without using specialized SQL database management software will cause irreparable damage to the database.

3. Follow the instructions in your backup program to restore your DATA folder to its proper location. For information about finding the proper location of

your DATA folder, go to "Determining the Location of Your DATA Folder" on page 398.

NOTE	
	• The DATA folder contains the Access databases and such files as eDocuments, electronic claims, etc. • If you are storing eDocuments or electronic claims in a location other than the DATA folder, ensure that you restore those files to their proper locations.

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